



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

User Manual Addendum

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1.0 Introduction

The Behavioral Health System is a module of the Resource and Patient Management System (RPMS) designed specifically for recording and tracking patient care related to behavioral health. The new Behavioral Health System (BHS) version 4.0 includes functionality available in the previous versions of the RPMS behavioral health software plus multiple new features and an enhanced graphical user interface.

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

Behavioral Health System v4.0 offers: Opportunities for improved patient outcome and continuity of care

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

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

- **Behavioral Health Data Entry Menu:** Use the Behavioral Health Data Entry menu for all aspects of recording data items related to patient care, case management, treatment planning, and follow-up.

1.1 Primary Menu

The primary menu option for this package is IHS Behavioral Health System (AMHMENU).

```

*****
**      IHS Behavioral Health System      **
*****
                          Version 4.0 (Patch 7)

                          DEMO INDIAN HOSPITAL

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

Select Behavioral Health Information System Option:

```

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

1.2 Preparations

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

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

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

1.3 Security Keys

Security keys should only be assigned to personnel with privileged access to confidential behavioral health data. Program Managers should meet with the Site Manager when assigning these keys.

Table 1: Security Keys

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

Key	Permits Access To
AMHZ DELETE SIGNED NOTE	Delete records containing signed notes
AMHZ UPDATE USER/LOCATIONS	Update the locations the user is permitted to access
AMHZ CODING REVIEW	Review records to ensure accurate coding

2.0 Orientation

The following provides information about using the Roll and Scroll RPMS Behavioral Health System and the RPMS Behavioral Health System Graphical User Interface (GUI).

2.1 Standard Conventions (Roll and Scroll)

2.1.1 Caps Lock

Always work with the Caps Lock on.

2.1.2 Default Entries

Any time a possible answer is followed by double slashes (//), pressing the Return key will default to the entry displayed. If you do not want to use the default response, type your new response after the double slashes (//).

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

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

2.1.3 Help

Online help can be obtained at any data entry field by typing 1, 2, or 3 question marks (?, ??, ???). If available, a narrative description of the expected entry or a list of choices will appear.

2.1.4 To Back Out

Pressing the number 6 while holding down the shift key will generate the caret (^) symbol. This symbol terminates the current action and backs you out one level.

2.1.5 Exit

Type **HALT** at a menu option prompt to exit from RPMS at any time.

Type **RESTART** at a menu option prompt to bring you out to the “Access Code:” prompt.

Type **CONTINUE** at a menu option prompt to exit from RPMS and to return to the same menu you were using when you next sign on to RPMS.

2.1.6 Same Entries

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

2.1.7 Lookup

Be careful of misspellings. If unsure of the spelling of a name or an entry, type only the first few letters. RPMS will display all choices that match those beginning letters.

Example:

PATIENT NAME: WARM						
1	WARMAN, BARRY	M	05-05-1989	054270542	PIMC 101623	
					SE 101624	
2	WARMAN, CHRIS Y	F	06-16-1954	001290012	PIMC 100039	
					HID 100040	
					SE 100041	

Figure 2-2: Patient lookup screen

2.1.8 Pause Indicator

The <> symbol is usually displayed when a multiple page report reaches the bottom of a display screen and there are additional pages in the report. Press the Return key to see the next page or type a caret (^) to exit the report.

2.1.9 Dates and Times

You can enter dates and times in a number of formats. If the system prompts for a date alone, the acceptable formats are:

- T (today)
- 3/28
- 0328
- 3-28
- 3.28
- T-1 (yesterday)
- T-30 (a month ago)
- T+7 (a week from today)

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

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

Example: 130 (1:30 PM)
130A (1:30 AM)

If the system prompts for both date and time, the acceptable formats are:

Example: T@1 (Today at 1 PM)
4/3@830

2.1.10 Stop

To stop a report while it is in processing mode or if you need an *emergency out*, press C-Ctrl and you will immediately exit from the program.

2.1.11 Delete

Typing the at sign (@) in a field containing data, will delete the existing data in that field.

2.2 ListMan (Roll and Scroll)

The BHS Reporting program uses a screen display called ListMan for review and entry of data. The system displays data in a window-type screen. Menu options for editing, displaying, or reviewing the data are displayed in the bottom portion of the window.

Even though you might be using a personal computer as a RPMS terminal, you cannot use the mouse for pointing and clicking to select a menu option.

You can see additional menu options for displaying, printing, or reviewing the data by typing two question marks (??) at the “Select Option:” prompt. Entering the symbol or letter mnemonic for an action at the “Select Action:” prompt will result in the indicated action.

In the following example, two question marks (??) were keyed at the “Select Action:” prompt to see the list of secondary options available.

#	PRV	PATIENT NAME	HRN	AT	ACT	PROB	NARRATIVE
1	DKR	W&&RMAN,RAE	SE100003		31	F32.0	MAJOR DEPRESSIVE DIS
2	DKR	--	-----	60	36	95	RPMS BH TRAINING
3	DKR	--	-----	30	32	F42.	HOARDING DISORDER

```

?? for more actions

AV  Add Patient Visit      DE  Delete Record          AP  Appointments
AC  Add Adm/Comm Activity  PE  Print Record          MM  Send Mail Message
ED  Edit Record            HS  Health Summary        Q   Quit
OT  Other Pat Info        SO  SOAP/CC Edit
DS  Display Record        SD  Switch Dates
Select Action: AV//??

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

```

Figure 2-3: ListMan secondary options screen

At the “Select Action” prompt, you can do the following:

- Use a plus sign (+) in a display that fills more than one page to see the next full screen (when you are not on the last screen).
- Use a minus sign (-) to display the previous screen (when you are not on the first screen). This command will only work if you have already reviewed several screens in the display.
- Use the up arrow key on your keyboard to move the screen display back one line at a time.
- Use the down arrow key on your keyboard to move the screen display forward one line at a time.
- Use the right arrow key on your keyboard to move the screen display to the right.
- Use the left arrow key on your keyboard to move the screen display to the left.
- Use FS in a multi-page display to return to the first screen of the display.
- Use LS in a multi-page display to go to the last screen in the display.
- Use GO and the page number of a multi-screen display to go directly to that screen.
- Use RD to redisplay the screen.
- Use PS to print the current screen.
- Use PL to print an entire single or multi-screen display (called a list).
- Use SL to be prompted for a word that you wish to search for in the list. Press the Return key after your word selection to be moved to the first occurrence of the word. For example, if you were many pages into a patient’s Face Sheet and

wanted to know the patient's age, you could type **SL**, then type age, and press the Return key to be moved to the age field.

- Use ADPL to either display or not display the list of menu options in the window at the bottom of the screen.
- Use QU to close the screen and return to the menu.

2.3 ScreenMan (Roll and Scroll)

2.3.1 Using the ScreenMan Window

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

```

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

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

Activity:      Activity Time:            # Served: 1      Interpreter?

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

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

```

Figure 2-4: Using ScreenMan sample screen 1

If you make a change or new entry on the form, press Enter to record the change. A confirmation dialog box might appear for further information. If necessary, a pop-up window might appear for further entry of information. For example, in the above example, typing **Y** at the “Any Secondary Providers” prompt indicates that there was a secondary provider; but you must press Enter after typing **Y** to open the dialog box and record the secondary provider information.

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

2.3.2 Using the Pop-up Window

Press Enter to move between fields, when inputting data in a screen. Press Tab to move to the “Command” prompt (Close option by default). Press Enter to close the screen and return to the original data entry screen.

```

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

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

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

-----
Close      Refresh

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

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

```

Figure 2-5: Using ScreenMan, sample screen 2

Press Enter to open a text editor screen.

```

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

```

Figure 2-6: Using ScreenMan, sample screen 3

2.4 Full Screen Text Editor (Roll and Scroll)

While many of the data entry items in the Behavioral Health system are coded entries or items selected from a table, there can be extensive text entry associated with clinical documentation, treatment plans, intake documents, etc. RPMS has two text editors, a line editor and a full screen editor. Most users find it more convenient to use the Full Screen Text Editor.

In many ways, the Full Screen Text Editor works just like a traditional word processor. The lines wrap automatically, the up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used. On the other hand, some of the conventions of a traditional word processing

program do not apply to the RPMS full screen editor. For example, the Delete key does not work. Delete text by moving one space to the right of the error and backspacing to remove the erroneous entry.

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

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

Below is a sample Text Edit screen:

```

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

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

```

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

Press **F1** and type **H** to display all available commands for the RPMS Full Screen Editor. Type a caret (^) to exit the Help screens.

```

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

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

Activity:      Activity Time:             # Served: 1      Interpreter?

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

```

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

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

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

2.5 Word Processing Editors (Roll and Scroll)

If you see what is displayed in the following example when entering a word processing field, then your default editor has been set to the RPMS line editor.

```
1>
```

Figure 2-9: RPMS line editor default

You can change to the full screen editor, as follows:

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

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

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

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

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

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

2. At the “Select User’s Toolbox Option” prompt, type **Edit User Characteristics** and a window will be displayed.
3. Press the down arrow key on your keyboard to move to the Preferred Editor field. To change your preferred editor to the Screen Editor, type **SC**. Continue to press the down arrow until the cursor reaches the “Command:” prompt.

4. At the “Command” prompt, type **S** and press Enter to save your changes. Type **E** and press Enter to Exit the screen. The Edit User Characteristics screen and fields.

```

                                EDIT USER CHARACTERISTICS
NAME: SIGMA,SAMANTHA A                                PAGE 1 OF 1
-----
                                INITIAL: SAS           PHONE:
                                NICK NAME:             OFFICE PHONE:
                                                VOICE PAGER:
                                                DIGITAL PAGER:

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

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

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

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

```

Figure 2-11: Change the Text Editor, steps 1-4

Note: Section 2.4 provides more information on using the Full Screen Text Editor.

2.6 Pop-up Windows (GUI)

The application displays pop-up windows that have the same functional controls on them. Generally, these are Crystal Report windows.

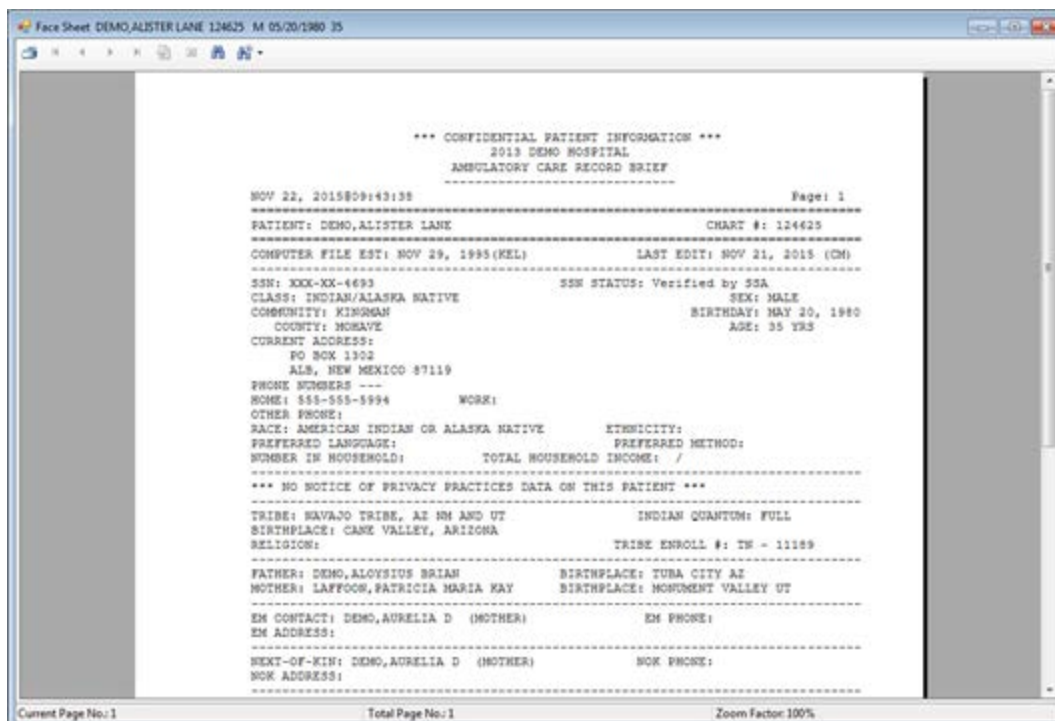


Figure 2-12: Sample pop-up window

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

- Use the scroll bar.
- Double click on any line of text. Then you can use the up and down arrows (on your keyboard) to scroll.

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



Figure 2-13: Sample last line on the pop-up window

The pop-up window only displays the first page (when you first access the window). If there is more than one page, use the “Next Page” and “Last Page” buttons to move to that page. Otherwise, specify the page number to move to. Section 2.6.2 provides more information on buttons on the toolbar.

2.6.1 Buttons on Title Bar

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

2.6.2 Buttons on the Toolbar

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

Note: The Close Current View () button does not function.

Print Report Button

Use the Print Report button to output the text on the pop-up window.


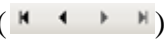
1. Click the Print Report () button
2. The Print dialog box displays.



Figure 2-14: Sample Print dialog box

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

Move to Page Buttons

The Move To Page () buttons provides the means of going to adjacent pages in the text of the pop-up.

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

Go To Page

Use the Go To Page button () to specify a page to move to.

After clicking the Go To Page button, the application displays the **Go To Page** dialog box.

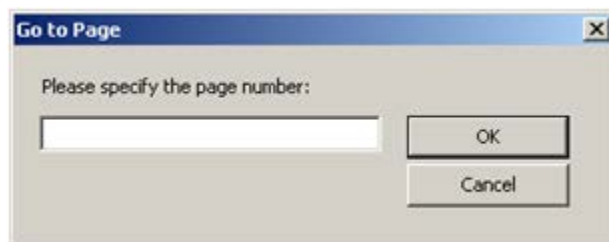


Figure 2-15: Go to Page dialog box

- Type the page number to go to in the Free Text field.
- Click **OK** and the particular page of the pop-up displays. (otherwise, click **Cancel**).
- If you specify a page outside the range of pages on the pop-up, the application will display a blank page.

Find Text


Click the Find Text () button to access the **Find Text** dialog box.




Figure 2-16: Find Text dialog box

- In the field, type the text to search for in the pop-up window.
- Click **Find What** to search for the text screen. (Otherwise, click **Cancel**.)
- The **Find Next** function causes the application to search the text of the pop-up for the text string and to highlight the line of text containing the first occurrence of the text string.
- Keep clicking **Find Next** to search for the next occurrence of the text string.
- When there are no other occurrences, the system displays the “Crystal Report Windows Forms Viewer” information message that states that the application has finished searching the document. Click **OK** to close the information message. The focus returns to the **Find Text** dialog box.

Zoom Button

Use the Zoom button to change the size of the text.

1. Click the Zoom () button.
2. Select a new size from the drop-down list.

This action changes the size of the text of the pop-up (for easier reading, for example). This setting does not affect the output of the pop-up.

2.7 Using the Calendar (GUI)

Date and time fields exist throughout the GUI (Figure 2-17).



Figure 2-17: Sample Date and Time field

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

- Type in the field:
 - Type **M** in the day item set the day to Monday
 - Type **09** in the month item changes the month to September
- Place the cursor in an item (day of week, month, etc.) and press the up or down arrow keys to step through the available options.

Otherwise, follow these steps:

1. Click the date field's drop-down list to display the calendar.



Figure 2-18: Sample Calendar for Date Field

2. The calendar always indicates the date for today.
3. Change to another date by clicking on it. The selected date will display in the Date field.

4. Use the left or right arrow key to move from month-and-day to the next month-and-day.
5. To change the year, click the year label and click the up and down button to step through the years.



Figure 2-19: Change Year

6. To display the previous or next month's calendar, click the left or right arrow button.
7. To display a specific month, click the month label, and select from the list displayed.



Figure 2-20: List of Months to Select

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

2.8 Using the Search Window (GUI)

Several fields in the application have a drop-down list that accesses a search window. For example, the Community field would access the **Community** search window.



Figure 2-21: Community search window

This type of window has similar functionality for other fields.

Click **Close** to dismiss the window and you return to the previous window.

1. At the **Search String** field, type a few characters of the search criteria.
2. Click **Search** to cause the retrieved records to display in the **Community** list box.
3. Select a record and click **OK** to populate the appropriate field on the open form. (Otherwise, click **Close**.)
4. Another way to populate the field is to select a record in the **Most Recently Selected** list box and click **OK**.

2.9 Using the Search/Select Window (GUI)

Several fields in the application have a drop-down list that accesses a search/select window.

For example, the **Add** button on the **POV** tab of the **Visit Data Entry** screen displays the dialog box below/

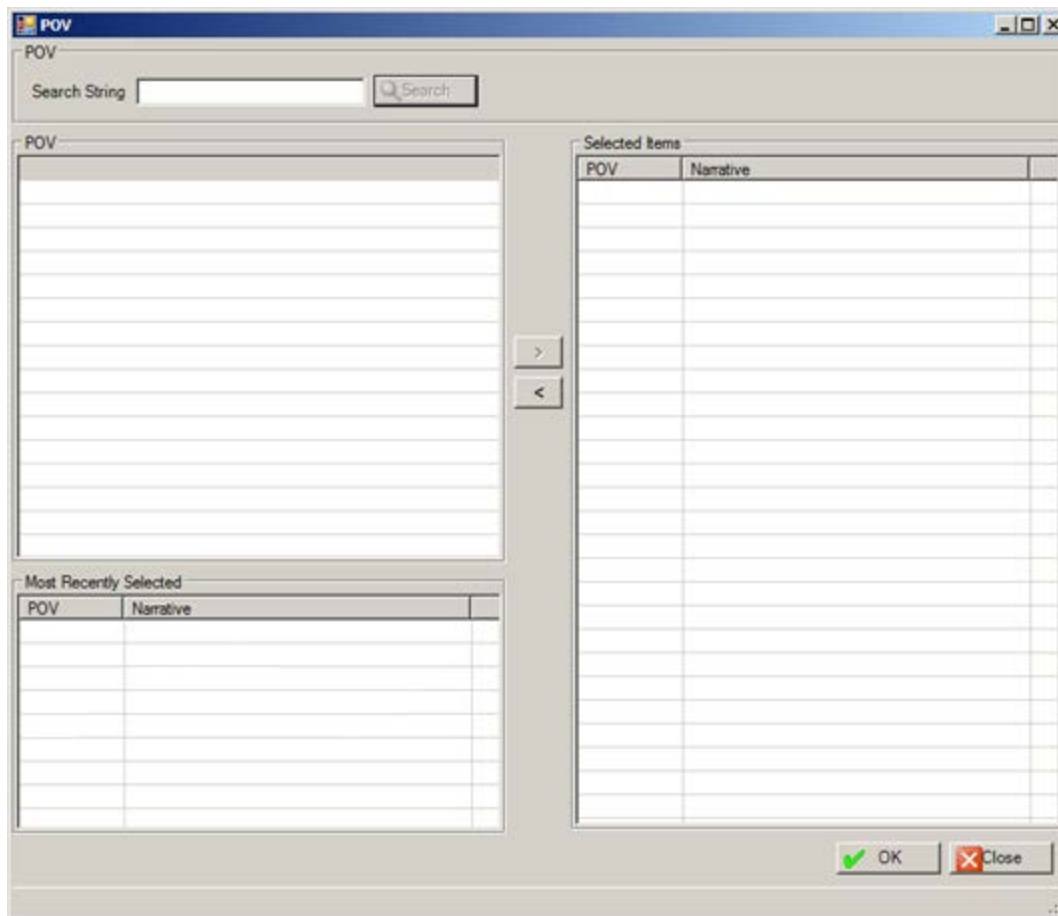


Figure 2-22: Sample Search/Select window

The following describes how to use this window. Other search/select windows work in a similar manner (for example Secondary Provider).

Use the **Close** button to dismiss the window and you return to the previous window.

1. At the **Search String** field, type a few characters of the search criteria
2. Click **Search** and the retrieved records display in the **POV** list box.
3. To add one or more records from the **POV** group box to the **Selected Items** list box, click the right-pointing arrow button.
4. To add one or more records from the **Most Recently Selected** list box to the **Selected Items** list box, click the right-pointing arrow button.
5. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
6. When the **Selected Item** list box is complete, click **OK**. (Otherwise, click **Close**.)

2.10 Using the Multiple Select Window (GUI)

Several fields in the application have a drop-down list that accesses a multiple select window. For example, the AXIS IV select window, as shown below.

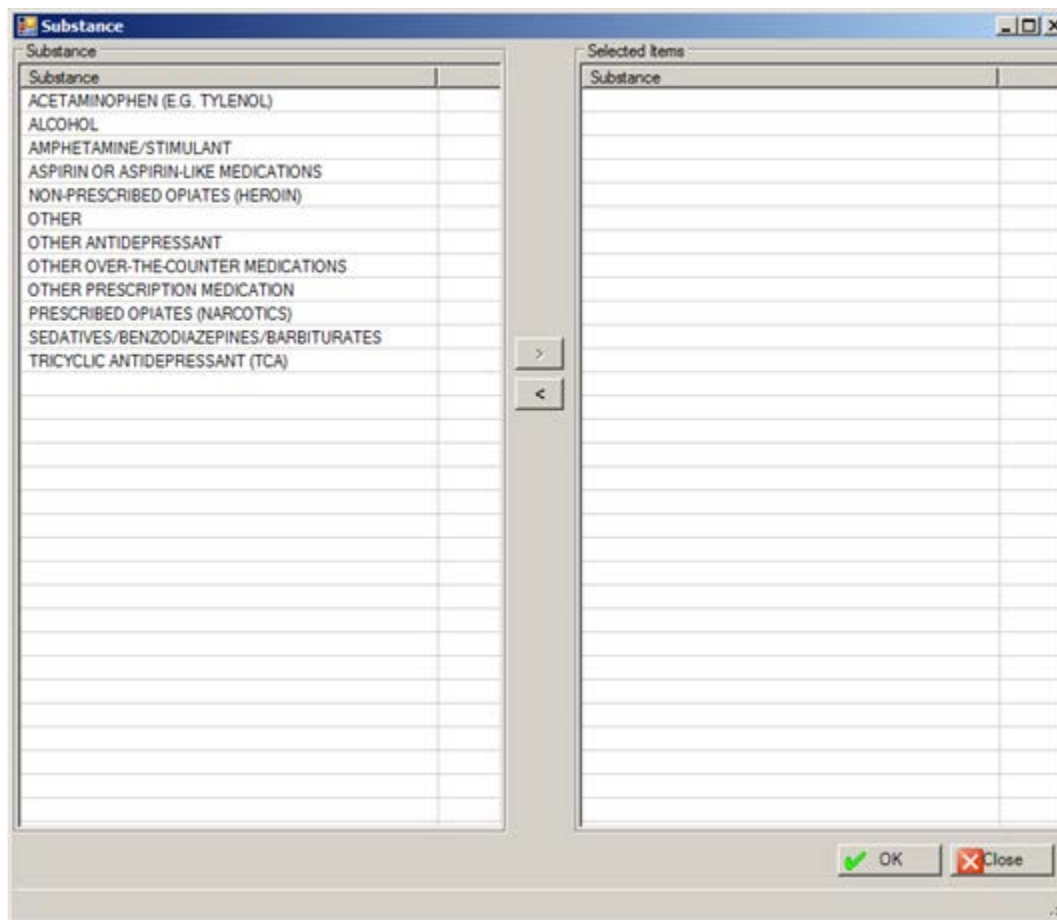


Figure 2-23: Sample AXIS IV multiple select window

Use the **Close** button to dismiss the window.

1. To add one or more selected items in the **Substance** list box to the **Selected Items Substance** list box, click the right-pointing arrow. Select more than one code by holding down the Ctrl key and selecting the next code.
2. To move one or more selected records from the **Selected Items Substance** list box to the **Substance** list box, click the left-pointing arrow.
3. When the **Selected Item** list box is complete, click the **OK**.

2.11 Free Text Fields (GUI)

Free Text fields are those fields that you can type information into; those types of fields do not have a drop-down list from which to select an option to populate it.

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

There is a context menu to aid in editing the text.

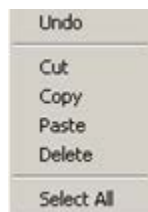


Figure 2-24: Right-Click Menu to Aid in Editing Text

These options operate just like those in any Windows application. Here are the meanings of the actions:

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

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

2.12 Selecting a Patient

The following provides information about selecting a patient in Roll and Scroll as well as the RPMS Behavioral Health System (GUI).

2.12.1 Patient Selection (Roll and Scroll)

The application displays the “Select Patient” prompt.

- Type a few characters of the patient’s last name (at least 3), Social Security Number (SSN), Health Record Number (HRN), or date of birth (use format MM/DD/YYYY).
- The application will accept either form of the patient’s name in the search criteria: LASTNAME,FIRSTNAME or LASTNAME, FIRSTNAME (space after the comma).

2.12.2 Patient Selection (GUI)

Select a patient in the following circumstances:

- When no patient has been selected and you select the “One Patient” option (such as under Visit Encounters)
- When you want to change patients. Change patients by selecting Patient | Select or by right-clicking on the menu tree.

In either case, the application displays the **Select Patient** dialog box.

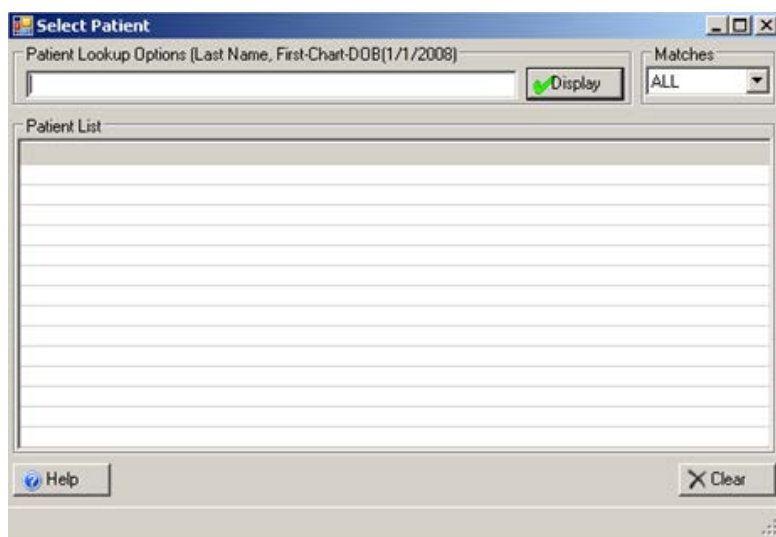


Figure 2-25: Select Patient dialog box

- Use the **Help** button to access the online help for this dialog box.
 - Use the **Clear** button to remove all data from the **Patient List** box and from the text box near the top.
1. At the field, type a few characters of the patient’s last name (at least 3), Social Security Number (SSN), Health Record Number (HRN), or date of birth (use format MM/DD/YYYY) in the Patient Lookup Options field.

The application will accept either form of the patient’s name in the search criteria: LASTNAME,FIRSTNAME or LASTNAME, FIRSTNAME (space after the comma).

2. Determine the number of matches by selecting an option from the **Matches** drop-down list (the default is All).
3. Click **Display**.
4. The application retrieves the valid candidates and displays them in the **Patient List** box. If there are no candidates, then the list box remains empty. In addition, a message will display in the bottom left corner stating: 0 records found.

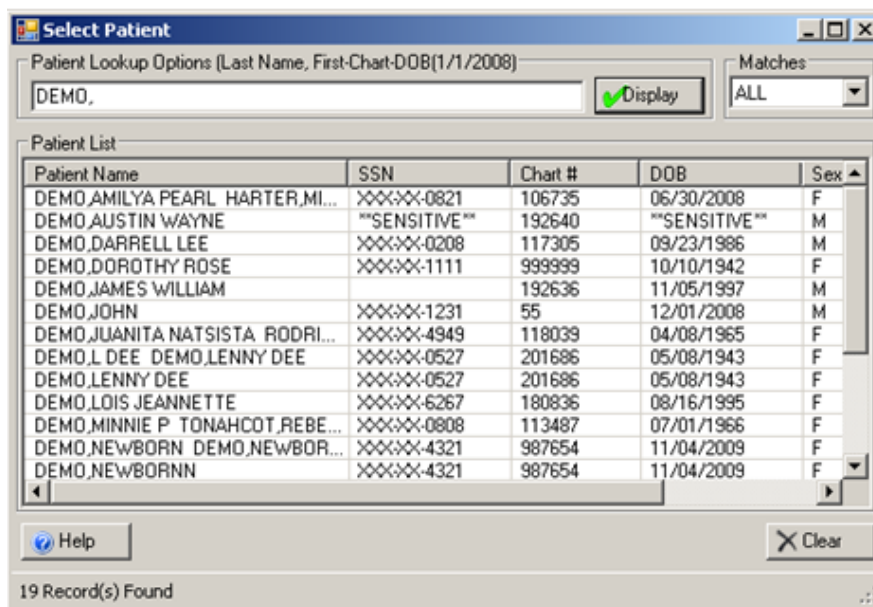


Figure 2-26: Sample Select Patient dialog box

5. Use the scroll bars to scroll through the retrieved names.
6. Double-click the patient to use. The selected patient becomes the active patient.

2.13 Sensitive Patient Tracking

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

If a patient is listed as Sensitive in the Sensitive Patient Tracking application, the word SENSITIVE will be displayed in Social Security, Date of Birth, and Age columns on the **Select Patient** dialog box.

GUI Example

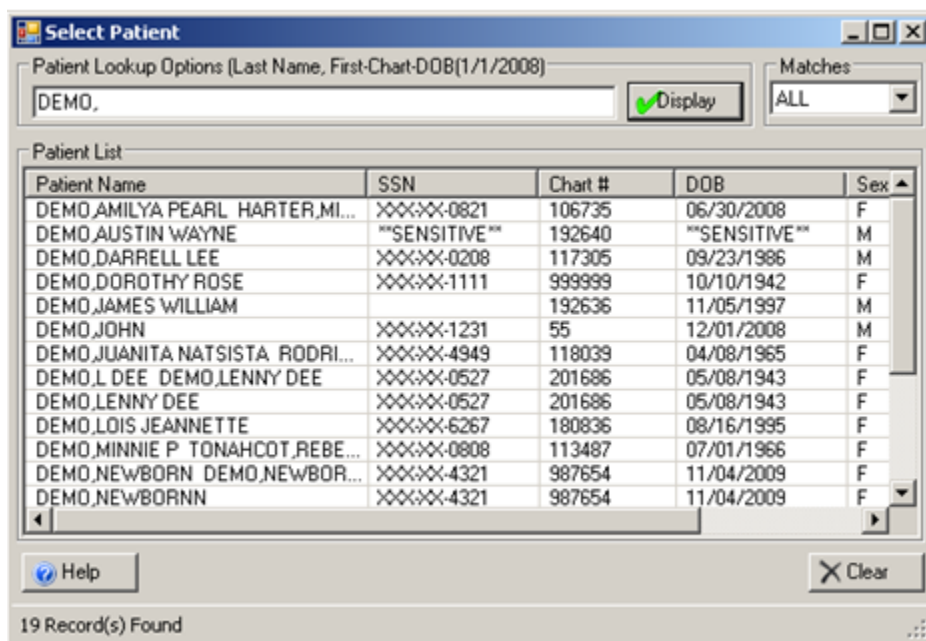


Figure 2-27: Sample Select Patient dialog box showing sensitive patient

Below is the warning message you receive while in the GUI.



Figure 2-28: Warning message displayed in GUI

Click **Yes** to access the patient's record. (Otherwise, click **No**. In this case you return to the **Select Patient** dialog box.)

Roll and Scroll Example

There can be two types of messages in Roll and Scroll.

1. The Restricted Record warning message is shown below.

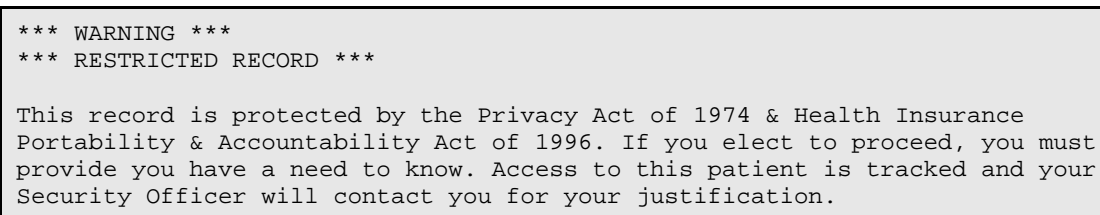


Figure 2-29: Warning message about restricted record in Roll and Scroll

2. A simple warning message is shown below.

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

Figure 2-30: Shorter warning message in Roll and Scroll

- Press Enter to access the patient's record.
- Use the caret (^) to not access the patient's record.

2.14 Electronic Signature

The following provides information about the electronic signature. This signature applies to Roll and Scroll as well as the GUI. You use the electronic signature to sign a SOAP/Progress note, Intake document, and Update document.

2.14.1 Creating Your Electronic Signature

1. At the "Select TIU Maintenance Menu Option" prompt, type **TBOX**.
2. Select the Electronic Signature Code Edit option.

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

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


Figure 2-31: Options on the TBOX User's Toolbox

3. Prompts will appear for the electronic signature on SOAP/progress notes. You should not enter your credentials (such as MD) under both the block name and title or it will appear twice. Make sure your signature block printed name contains your name and (optionally) your credentials.

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

Figure 2-32: Prompts that display at the beginning of the process

4. When the following prompt appears in RPMS:




Enter your Current Signature Code:

Figure 2-33: Prompt to enter your current electronic signature

The above prompt means you already have an electronic signature code.

5. When the following prompt appears in RPMS:



Enter code:

Figure 2-34: Prompt for a new code

The above prompt is where you enter a new code.

6. Enter a new code (using between 6 and 20 characters) with Caps Lock ON. However, when you enter the electronic signature (on a note for example), it can be in lower case. (No special characters are allowed in the code.)
7. If you forget the code, it must be cleared out by your Site Manager; then you must create a new one. You are the only one who can enter your electronic signature code.

2.14.2 Electronic Signature Usage

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

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

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

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

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

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

2.14.3 Data Entry Requirements (Roll and Scroll)

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

Below is a sample of the electronic signature and date/time stamp in the SOAP/Progress Note section of the printed encounter record.

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

Figure 2-35: Sample date/time stamp for electronic signature

2.14.4 Assign PCC Visit

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

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

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

2.14.5 Signing a Note (GUI)

1. If you have entered a SOAP/progress note, the application displays the **Sign?** dialog box.

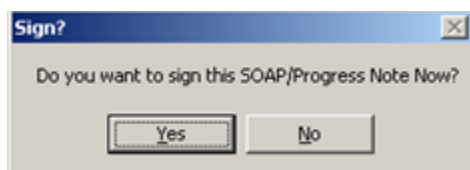


Figure 2-36: Sign dialog box

- Click **No** to save the encounter record without a signature to the note.
- Click **Yes** and the application displays the **Electronic Signature** dialog box.

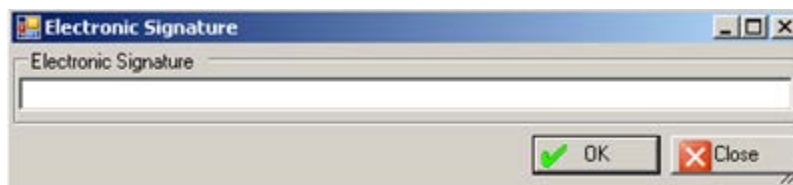


Figure 2-37: Electronic Signature dialog box

- a. Type your valid electronic signature and click **OK**. This process saves the encounter with a signed note.
- b. If you enter an invalid electronic signature and click **OK**, the application displays the Invalid notice that states: Invalid Signature Code. Click **OK** and the focus returns to the **Electronic Signature** dialog box.
- c. Click **Close** on the **Electronic Signature** dialog box and the application displays the **Are You Sure?** dialog box.

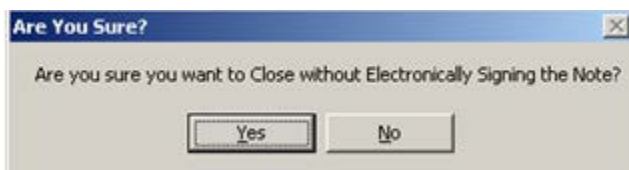


Figure 2-38: Are you Sure dialog box

- Click **No** and the focus returns to the **Electronic Signature** dialog box.
- Click **Yes** and the application displays the **Message** dialog box.



Figure 2-39: Text of Message

- Click **OK**. The encounter record will not have a signed note.

2.14.6 Signing a Note (Roll and Scroll)

After you save and exit an encounter record and you have entered a note, the application asks for your signature.



Figure 2-40: Prompt asking for your current signature code

- If you use your valid electronic signature, the application saves the encounter record with a signed note.
- If you use an invalid electronic signature, the application does not save the encounter with a signed note.

If you edit a visit with a signed note, the application displays a message indicating that the note cannot be edited.

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

Figure 2-41: Message about progress note already signed.

If you edit the note with an unsigned note and you are not the primary provider, you get a message about this situation.

Only the Primary provider is permitted to sign a note.

Figure 2-42: Message about only primary provider can sign a note

2.15 Login to GUI

If this is the first time you login to the GUI, the **IHS Behavior Health System Login** dialog box displays.

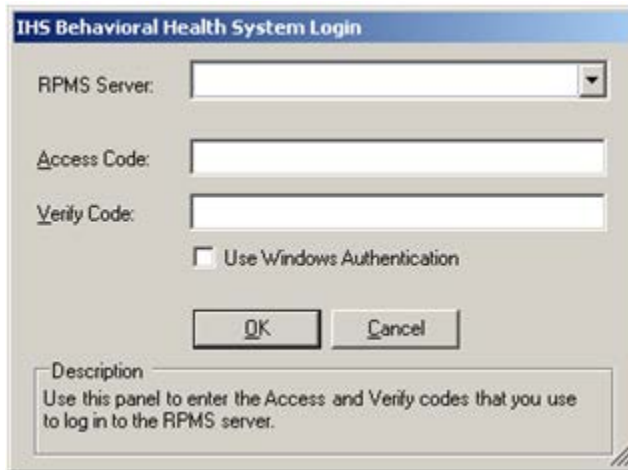


Figure 2-43: Initial login dialog box

1. Click **Edit Connections** option on the drop-down list for the **RPMS Server** field. The **RPMS Server Connection Management** dialog box displays.

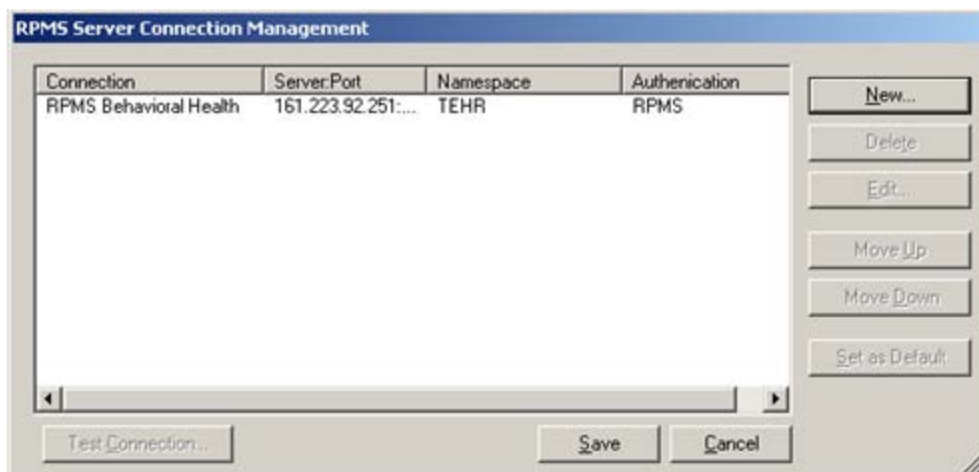


Figure 2-44: Sample RPMS Server Connection Management dialog box

2. Click **New** to create a new connection or select an existing connection and click **Edit**.

The application displays the **Edit RPMS Server Connection** dialog box.

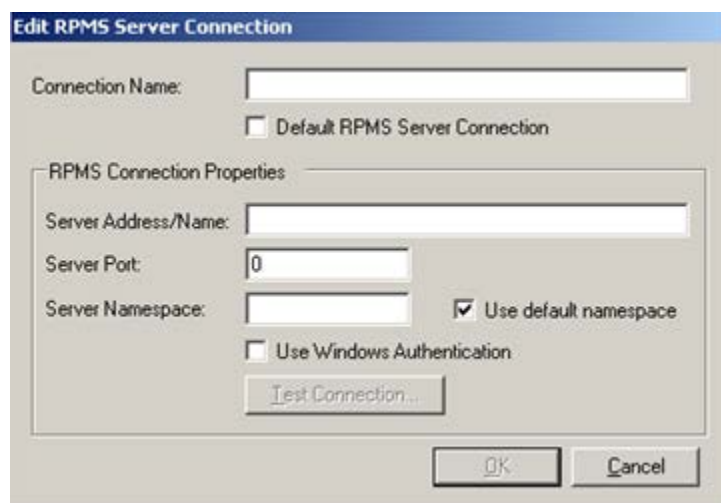


Figure 2-45: Sample Edit RPMS Server Connection dialog box

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

3. At the **Connection Name** field, type the name of the connection (your choice of words).
4. At the **Server Address/Name** field, type the number, including punctuation, of the server's IP address. An IP address is typically four groups of two or three numbers, separated by a period (.), e.g., 161.223.99.999. Your Site Manager will provide this information.

5. At the **Server Post** field, type the number of the server port. Your Site Manager will provide this information.
6. At the **Server Namespace** field, consider the following:

If your site has multiple databases on one server, you will additionally need to type the namespace, which is typically a text string, e.g., DEVEH.
7. At the **Use default namespace** field, select this checkbox if the Server Namespace is the default one to use.

After populating the above fields, the Test Connection button becomes active.
8. At the **Test Connection** field, click this button to display the **Test Login** dialog box.
 - a. Populate the **Access Code** and **Verify Code** fields and then click **OK**.
 - b. After clicking **OK**, if the connection is correct, the application displays the Connection Test message that states: RPMS login was successful.
 - c. Otherwise, the application will display an error message. Click **OK** to return to the **Test Login** dialog box.
9. After the Edit RPMS Server Connection dialog box is complete, click **OK** (otherwise, click **Cancel**). The OK process saves the information, and this information displays on the **RPMS Server Connection Management** dialog box.
10. After the RPMS Server Connection Management dialog box is complete, click **Save** (otherwise, click **Cancel**).
11. After clicking **Save** on the **RPMS Server Connection Management** dialog box, the application displays the **IHS Behavioral Health System Login** dialog box.

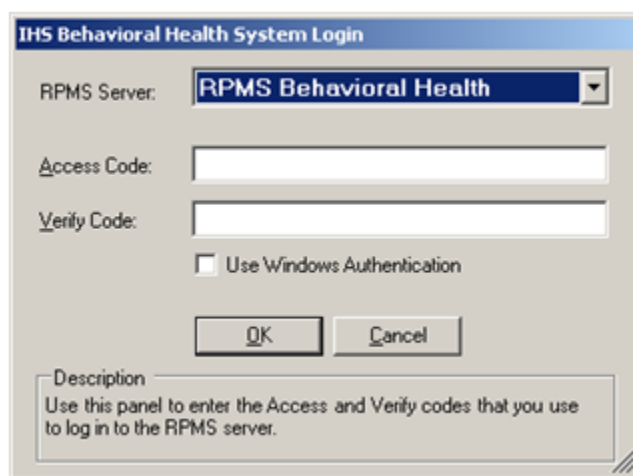


Figure 2-46: Sample login dialog box

The designated server displays in the RPMS Server field.

12. Type your RPMS access and verify codes. These are the same access and verify codes that you would use to open any RPMS session.

Do not use the field with the checkbox.

13. Click **OK** to access the RPMS Behavioral Health System tree. (Otherwise, click **Cancel**.)

2.16 RPMS Behavioral Health System Tree

Below is the default display of the RPMS Behavioral Health System tree structure.

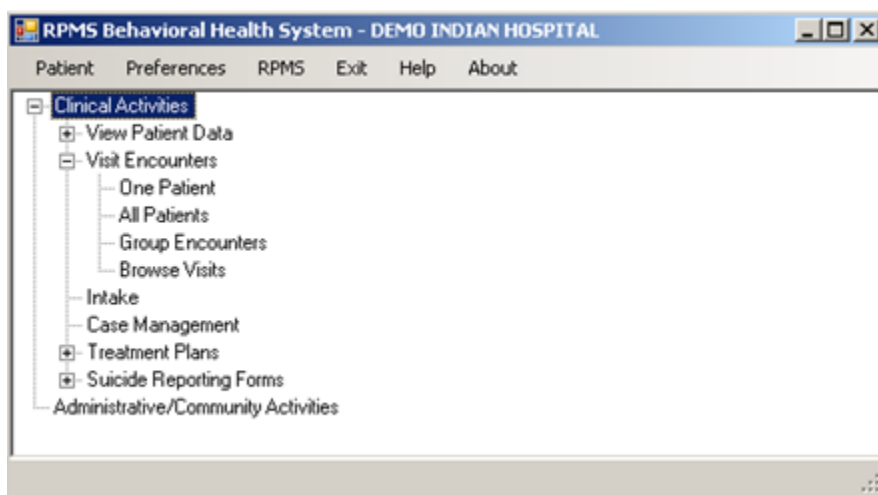


Figure 2-47: Tree structure for the RPMS Behavioral Health System

The tree structure is similar to any tree structure in MS Office.

- Click the - icon to collapse the option. The icon will change to the + icon. The **View Patient Data**, **Treatment Plans** and **Suicide Reporting Forms** options are collapsed in the screen capture above.
- Click the + icon to expand the option. The icon will change to the - icon. The **Visit Encounters** option is expanded in the screen capture above.

Patient Menu

Use the **Patient** menu to select the current patient.

Preferences Menu

Use the **Preferences** menu to select another division as well as change the font on the main menu tree.

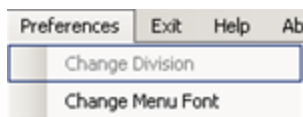


Figure 2-48: Menu options on the Preferences menu

1. At the **Change Division** field, select the Division to use. Use the **Change Division** option to change the **RPMS Division on the Select Division** dialog box. This option applies to a site that uses more than one RPMS database.
2. At the **Change Menu Font** field, to access the **Font** dialog box. Use this option to change the font on the tree structure.

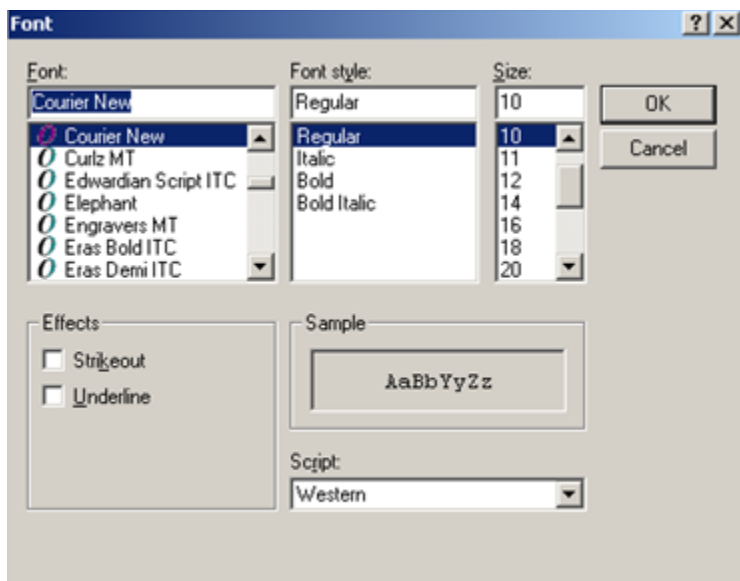


Figure 2-49: Font dialog box

- a. Use the **Font** dialog box to change the Font name, style, and size of the text on the tree structure. In addition, you can add effects like “Strikeout” and “Underline” - these perform like those effects indicated in MS Word. Most users will change the font size.
- b. Change the Script option if you need to see the text displayed in another language and you have that language pack installed on the machine you are using. If the language pack is not installed on your machine, the display does not change by selecting another script.
- c. Click **OK** to apply your changes to the text on the tree structure. (Otherwise, click **Cancel**.)

RPMS Menu

Use the RPMS menu to access the RPMS system (roll and scroll). After clicking the RPMS menu, the application displays the RPMS Terminal emulator window.

- On the RPMS Terminal Emulator window, select **File | Connect** to access the **Connect** dialog box. Populate the **Host** field with the IP address and click **OK** (note, you do not need to populate any other fields). After clicking **OK**, you access the RPMS system. Then, login as you normally do.
- After populating the fields on the RPMS Terminal Emulator window, they remain the same the next time you logon (the application pre-populates the required fields).
- After you have completed the activities in RPMS, select **File | Exit** and you will return to the GUI part of the application.

Exit Menu

Use the **Exit** menu to leave the application. The application displays the Exit information message that asks: Are you sure you want to Edit? Click **Yes** to exit (otherwise, click **No**).

Help Menu

Use the **Help** menu to access the online help system for the application.

About Menu

Use the **About** menu to view information about the application (such as its version number).

3.0 Data Entry

This section provides an overview of the data entry process for Roll and Scroll application and for the RPMS Behavioral Health System (GUI).

3.1 Roll and Scroll

Documentation of patient care and documentation of administrative and group encounters are handled through the Data Entry module of the Behavioral Health system. We recommend that providers do their own data entry at the time of a patient encounter. However, a provider can document patient care on a BHS Encounter Form for data entry later by trained program support staff. Choosing DE from the Behavioral Health main menu can access the options for data entry.

```

*****
**          IHS Behavioral Health System          **
*****
                          Version 4.0 (Patch 7)

                          DEMO INDIAN HOSPITAL

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

Select Behavioral Health Information System Option:  DE

```

Figure 3-1: Data Entry Module

The **DE** option has the following options

```

*****
**          IHS Behavioral Health System          **
**          Data Entry Menu                      **
*****
                          Version 4.0 (Patch 7)

                          DEMO INDIAN HOSPITAL

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

Select Behavioral Health Data Entry Menu Option:  PDE

```

Figure 3-2: Data Entry menu

The table below provides an overview of the options on the Data Entry menu.

Option	How Used
Enter/Edit Patient/Visit Data - Patient Centered (PDE)	Documents a patient encounter and display all the information required for a single patient from a single screen.
Enter/Edit Visits Data - Full Screen Mode (SDE)	Enters the appropriate set of defaults to be used in Data entry.
Group Form Data Entry Using Group Definition (GP)	Enters encounter data when the encounter involves a group of patients.
Display Record Options (DSP)	Displays visit information about particular encounters.
Update BH Patient Treatment Plans (TPU)	Manages treatment plans for a patient.
View/Update Designated Provider List (DPL)	Updates and manages a provider's patient panel.
Edit BH Data Elements of EHR created Visit (EHRE)	Edits the BH data for a visit that was created in the RPMS Electronic Health Record application (EHR).
Listing of EHR Visits with No Activity Time (EBAT)	Lists the behavioral health EHR visits that have no activity time.
Suicide Forms - Update/Print (SF)	Updates, reviews, and prints IHS Suicide forms that have been entered into the BHS module.

3.2 RPMS Behavioral Health System Graphical User Interface (GUI)

The data entry options are located under the **Visit Encounters** category on the tree structure for the RPMS Behavioral Health System (GUI).

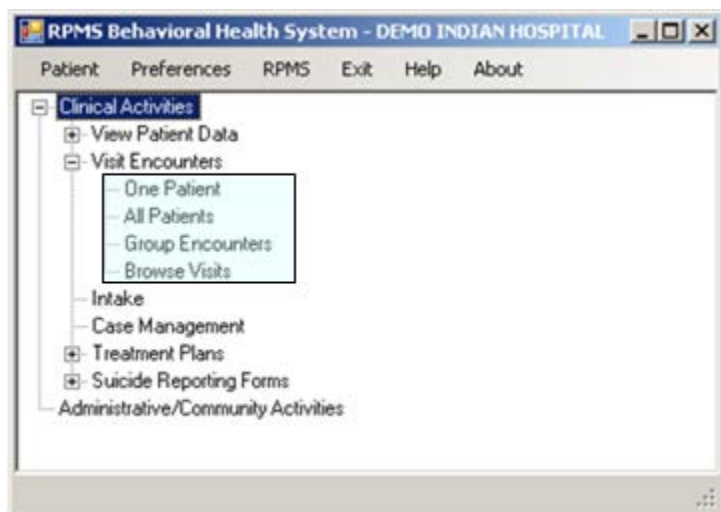


Figure 3-3: Location of Visit Encounters category on tree structure

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

4.0 One Patient Visit Data

This section provides information on how to manage the visit data of one patient for the RPMS Behavioral Health System (BHS) Roll and Scroll and the BHS GUI.

There are two ways to enter/edit patient visit data: using the PDE option or the SDE option on the IHS Behavioral Health System Data Entry Menu.

```

*****
**          IHS Behavioral Health System          **
**                Data Entry Menu                **
*****
                Version 4.0 (Patch 7)

                SELLS HOSPITAL

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

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

```

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

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

4.1 Enter/Edit Patient/Visit Data - Patient Centered (PDE)

Use the PDE option on the Data Entry Menu to add or edit patient visit data. This option was designed specifically for a provider to document a patient encounter and to display all the information for a single patient from a single screen.

Follow these steps:

1. At the “Select Behavioral Health Data Entry Menu Option” prompt, type **PDE**.
2. At the “Select patient name” prompt, type the name of the patient to be used.
 - a. If you enter the name of a deceased patient, the application displays the patient’s date of death.

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

Ok? Yes//

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

- At the “OK?” prompt, type **NO** and the focus returns to the “Enter Patient Name” prompt.
- At the “OK?” prompt, type **YES** and the focus goes to the Patient Data Entry window.

b. Type the name of a living patient and the Patient Data Entry window displays.

```

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

Last Visit (excl no shows): OCT 29, 2015  BETAAAA,BJ  REGULAR VISIT
          F32.3   MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE WITH PSYCHOTIC
                   FEATURES
***** LAST 6 AXIS V VALUES RECORDED. (GAF SCORES) *****
04/20/2009  04/20/2009  04/22/2009  04/29/2009  05/01/2009  07/01/2009
          55           75           33           77           44           65

Pending Appointments:
          Select the appropriate action   Q for QUIT
AV Add Visit           LD List Visit Dates           GS GAF Scores
EV Edit Visit          TP Treatment Plan Update       OI Desg Prov/Flag/Pers Hx
DR Display Record      CD Update Case Data           EH Edit EHR Visit
ES Edit SOAP           ID Intake Document            PPL Problem List Update
DE Delete Visit        AP Appointments              SN Sign Note
PF Print Encounter Form HS Health Summary            TN TIU Note Display
LV Last BH Visit       DM Display Meds              MM Send Mail Message
BV Browse Visits       LA Interim Lab Reports        FS Face Sheet
Select Action: Q//    Q

```

Figure 4-3: Sample Patient Data Entry window

The following actions are described under Add/Edit Visit Data - Full Screen Mode (SDE). Section 4.2 provides more information.

AV - Add Visit
 EV - Edit Visit
 DR - Display Record
 ES - Edit Soap
 DE – Delete Visit
 PF – Print Encounter Form
 ID – Intake Document
 AP – Appointments
 HS – Health Summary
 OI – Desg Prov/Flag/Pers Hx
 EH – Edit EHR Visit

PPL – Problem List
SN – Sign Note
TN – TIU Note Display
MM – Send Mail Message

The Treatment Plan Update (TP) is covered under Treatment Plans. Section 10.0 provides more information.

The Update Case Data (CD) is covered under Managing Case Data. Section 6.1 provides more information.

The next section provides information about actions not covered anywhere else.

4.1.1 List Visit Dates (LD)

Use the LD option to list the current patient's visit dates.

1. At the "Select Action" prompt, type **LD**.
2. At the "Browse which subset of visits for [current patient name]" prompt, use one of the following:

L Patient's Last Visit
N Patient's Last N Visits
D Visits in Date Range
A All of this Patient's Visits
P Visits to one Program

If you use N, D, or P, other prompts will display.

If N was used, do the following:

- Type the number of visits to display at the "How many visits should be displayed: (1-99)" prompt. Type any number between 1 and 99.

If D was used, do the following:

- a. Type the beginning date of the date range at the "Enter Beginning Date of Visit" prompt.
- b. Type the ending date of the date range at the "Enter Ending Date of Visit" prompt.

If P was used, do the following:

- Type the program to be used at the "Visits to Which Program?" prompt. Use one of the following: **M** Mental Health Defaults, **S** Social Services Defaults, **C** Chemical Dependency or Alcohol/Substance Abuse, **O** Other

The Browse Patient's Visit window displays. This is one of the visit using the A option.

```

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

Patient Name: ALPHA,GLEN DALE      DOB: Nov 10, 1981
HRN: 108704
*****
Visit Date: Mar 22, 2013@09:49      Provider: GAMMA,RYAN
Activity Type: INDIVIDUAL BH EHR VISIT      Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:
    291.2      Alcohol-induced Persisting Dementia
    V62.84      Suicidal Ideation

TIU DOCUMENTS
-----

TIU DOCUMENT:  BH PSYCHIATRIC PROGRESS NOTE
AUTHOR: GARCIA,RYAN
SIGNED BY: GAMMqA,RYAN      STATUS: COMPLETED
LOCATION: 14 MENTAL HEALTH
-----
Enter ?? for more actions
+   Next Screen      -   Previous Screen      Q   Quit
Select Action:+//

```

Figure 4-4: Sample list of visit dates window

4.1.2 GAF Scores (GS)

Use the GS option to display visit with GAF scored recorded.

1. At the “Select Action” prompt, type GS.
2. At the “Browse which subset of visits for patient” prompt, use one of the following:
 - N** (Patient's Last N Visits)
 - D** (visits in a Date Range)
 - A** (All of the Patient's Visits)
 - R** (Visits to One Program)
 - P** (Visits to One Program)

If N was used, the following prompts display:

- a. At the “How many visits should be displayed: (1-99)” prompt, type any number 1 – 99 (5 is the default).
- b. The GAF Scores window displays.

If D was used, the following prompts display:

- a. At the “Enter Beginning Date of Visit” prompt, type the beginning date of the date range.
- b. At the “Enter Ending Date of Visit” prompt, type the beginning date of the date range.
- c. The GAF Scores window displays.

If A was used, the GAF Scores window displays.

If R was used, the following prompts display:

- a. At the “Choose” prompt, type one of the following: **1** (Visits in a Date Range), **2** (Visits to One Program), **3** (Visits to One Provider).

If 1 was used, you will be prompted to type the beginning and ending date of the date range.

If 2 was used, you will be prompted to type the program.

If 3 was used, you will be prompted to type the name of the provider.

- b. The GAF Scores window displays.

If P was used, the following prompts display:

- a. At the “Which Program” prompt, type the program to be used.
- b. The GAF Scores window displays.

4.1.3 Face Sheet (FS)

Use the FS option to display the Demographic Face Sheet for the patient.

```

OUTPUT BROWSER                Aug 21, 2014 12:23:19                Page: 1 of 3
Demographic Face Sheet For DEMO,JEANETTE

*** CONFIDENTIAL PATIENT INFORMATION ***
                2013 DEMO HOSPITAL
                AMBULATORY CARE RECORD BRIEF
                -----
AUG 21, 2014@12:23:18                Page: 1
=====
PATIENT: DEMO,JEANETTE                CHART #: 146457
=====
COMPUTER FILE EST: OCT 11, 2012(HAR)                LAST EDIT: OCT 11, 2012 (MAY)
=====
SSN: XXX-XX-4701                SSN STATUS UNKNOWN
CLASS: INDIAN/ALASKA NATIVE                SEX: FEMALE
COMMUNITY: RIVERSIDE                BIRTHDAY: MAY 08, 1998
COUNTY: RIVERSIDE                AGE: 16 YRS
CURRENT ADDRESS:
RT. 1, BOX 45

```

```

ALB, NEW MEXICO 87119
PHONE NUMBERS ---
HOME: 555-555-1072          WORK: 555-999-1945
OTHER PHONE: NONE

PREFERRED LANGUAGE:                PREFERRED METHOD:
NUMBER IN HOUSEHOLD:                TOTAL HOUSEHOLD INCOME: /
-----
NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT : NO      DATE :
ACKNOWLEDGEMENT OF RECEIPT OF NPP SIGNED : NO
-----
TRIBE: WHITE MOUNTAIN APACHE TRB, AZ                INDIAN QUANTUM: FULL
BIRTHPLACE:
RELIGION:                TRIBE ENROLL #: TN - 25480
-----
FATHER: DEMO,ROGER                BIRTHPLACE:
MOTHER: ENOS,LUPE V                BIRTHPLACE:
-----
EM CONTACT:
EM ADDRESS:
-----
*** THIRD PARTY ELIGIBILITY ***
-----
THE PATIENT IS ALSO REGISTERED AT:
2013 DEMO-3 TRIBAL CLINIC                CHART #: 146458
-----
*** ELIGIBILITY FOR CARE: CHS & DIRECT ***

*** CONFIDENTIAL PATIENT INFORMATION ***

Enter ?? for more actions
+ NEXT SCREEN          - PREVIOUS SCREEN          Q QUIT          >>>

```

Figure 4-5: Sample Face Sheet data for the patient

4.2 Add/Edit Visit Data - Full Screen Mode (SDE)

Use the SDE option on the Data Entry Menu to enter/edit visit data for one or more patients. This option does not include access to other treatment information, such as the patient's treatment plan or case status.

Follow these steps.

1. At the "Select Behavioral Health Data Entry Menu Option" prompt, type **SDE**.
2. At the "Which set of defaults do you want to use in Data Entry" field, type the program with which the provider is affiliated so that the predefined defaults for clinic, location, community and program will be automatically applied to the visit. Use one of the following:

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

3. At the “Enter ENCOUNTER DATE” field, type the date of the encounter. The acceptable formats are:

T (today)
 3/28
 0328
 3-28
 3.28
 T-1 (yesterday)
 T-30 (a month ago)
 T+7 (a week from today)

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

The application displays “Creating new record” message when adding a visit.

4. The Update BH Forms window displays.

Update BH Forms		Mar 19, 2009 13:50:42		Page: 1 of 1			
Date of Encounter: Monday MAR 16, 2009		* unsigned note					
#	PRV	PATIENT NAME	HRN	AT	ACT	PROB	NARRATIVE
1	BJB	ALPHAA,CHELSEA M	WW116431	60	16	F84.0	AUTISM SPECTRUM DISORDER
2	BJB	ALPHAA,CHELSEA M	WW116431	30	13	F10.24	ALCOHOL-INDUCED BIPOLAR AND
3	BJB	ALPHAA,CHELSEA M	WW116431	15	19	F42.	HOARDING DISORDER
* 4	JC	ALPHAA,CHELSEA M	876543	60	13	F32.3	MAJOR DEPRESSIVE DISORDER, S
* 5	JC	ALPHAA,CHELSEA M	876543	60	13	T43.205A	ANTIDEPRESSANT DISCONTINUATI
6	DG	ALPHAA,CHELSEA M	WW116431	11	22	F32.1	MAJOR DEPRESSIVE DISORDER, S
7	DG	ALPHAA,CHELSEA M	WW116431	20	15	F10.259	ALCOHOL-INDUCED PSYCHOTIC DI
8	ST	DEMO,DOROTHY ROS	WW999999	1	99	97	ADMINISTRATIVE
?? for more actions							
AV	Add Patient Visit	PF	Print Encounter Form	SN	Sign Note		
AC	Add Adm/Comm Activity	ID	Intake Document	TN	Display TIU Note		
EV	Edit Record	HS	Health Summary	PPL	Patient's Problem List		
OI	Desg Prov/Flag	ES	SOAP/CC Edit	AP	Appointments		
DR	Display Record	SD	Switch Dates	MM	Send Mail Message		
DE	Delete Record	EH	Edit EHR Record	Q	Quit		
Select Action:							

Figure 4-6: Sample Update BH Forms window

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

- The “PPL” option is fully described below. Section 9.1 provides more information.
- The AC option is fully described below. Section 7.0 provides more information.
- The OI option is fully described below. Section 6.1.4 provides more information.
- The ID option is fully described below. Section 12.1 provides more information.
- The PPL option is fully described below. Section 9.1 provides more information.

4.2.1 Add Patient Visit (AV)

Use the AV option to add a patient visit.

1. At the “Select Action” prompt, type **AV**.
2. At the “TYPE THE PATIENT’S HRN, NAME, SSN OR DOB” prompt, type the name of the patient to use.
3. At the “Enter PRIMARY PROVIDER” field, type the primary provider name for the patient visit (the default is the current logon user).

The Behavioral Health Visit Update screen displays. This screen is available when using the EV or AV options on the Updated BH Forms window.

```

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

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

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

COMMAND:                                     Press <PF1>H for help   Insert

```

Figure 4-7: Sample Behavioral Health Visit Update screen

If you are the primary provider and you save the data on the Behavioral Health Visit Update window, the application asks if you want to sign the note for the visit. Section 2.14.6 provides more information on signing a note (Roll and Scroll).

The underlined fields on the Behavioral Health Visit Update screen are required.

4. At the “Arrival Time” prompt, type the arrival time. The default is 12:00. Change this time if needed. Anything between 6 AM and 6 PM will be recorded correctly by entering a number or military time. Between 6 PM and 6 AM, use military time or append the number with an A or P.

Examples:

130 (1:30 PM)

130A (1:30 AM)

5. At the “Display/Edit Visit Information” prompt, type **N** (no) or **Y** (yes). Use **Y** to access the Visit Information pop-up.

***** Visit Information *****	
<u>Program</u> : MENTAL HEALTH	<u>Location of Encounter</u> : SELLS HOSP
<u>Clinic</u> : MENTAL HEALTH	Appointment/Walk In: APPOINTMENT
<u>Type of Contact</u> : OUTPATIENT	
<u>Community of Service</u> : TUCSON	

Figure 4-8: Sample Visit Information pop-up

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

The underlined fields on the Visit Information pop-up are required.

- a. At the “Program” prompt, type the program associated with the visit. Use one of the following: **M** (Mental Health), **S** (Social Services) **O** (Other), or **C** (Chemical Dependency).
- b. At the “Location of Encounter;” prompt, type the location of the encounter.
- c. At the “Clinic” prompt, type the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table.
- d. At the “Appointment/Walk-In” prompt, type the visit type. Use one of the following: **A** (Appointment), **W** (Walk In), or **U** - Unspecified (for non-patient contact or telephone contact).
- e. At the “Type of Contact” prompt, type the contact type (the activity setting).
- f. At the “Community of Service” prompt, type the community of service. The response must be a community that is included in the RPMS community code set.

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

6. At the “Any Secondary Providers?” prompt, type **Y** (yes) or **N** (no) to indicate if there are any additional secondary BHS provides that were also providing care during this particular encounter.

Use **Y** to access the Enter/Edit Providers of Service pop-up.

```

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

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

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

```

Figure 4-9: Sample Enter/Edit Providers of Services pop-up

The underlined prompts are required.

- a. At the “PROVIDER” prompt, type the secondary provider name.
- b. At the “PRIMARY/SECONDARY” prompt, type the name of the secondary provider (more than one secondary provider can be used).

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

7. At the “Chief Complaint/Presenting Problem” prompt, type the text of the chief complaint or presenting problem using 2 to 80 characters in length. This information describes the major reason the patient sought services.
8. At the “SOAP/Progress Note <press enter>” prompt, press Enter to access an input window. Populate it with the text of the note. You can enter the notes using any of the standard formats, such as SOAP, DAP, or Free Text.

```

==[ WRAP ]==[ INSERT ]===== < SUBJECTIVE/OBJECTIVE >===== [ <PF1>H=Help ]====

```

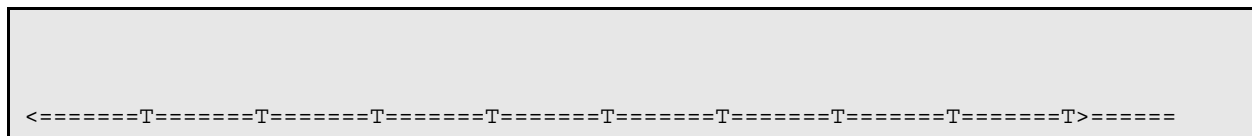


Figure 4-10: Window to enter the note

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

9. At the “Comment/Next Appointment <press enter>” prompt, press Enter to access an input window. Populate it with the text of the comment about the next appointment. This field is not used for appointment scheduling.
10. At the “PURPOSE OF VISIT (POVS) <enter>” prompt, press Enter to access the Purpose of Visit Update pop-up.

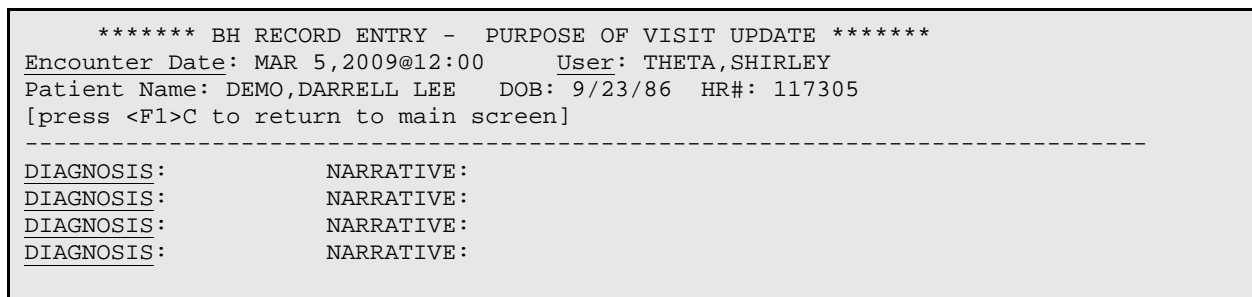


Figure 4-11: Sample BH Record Entry - Purpose of Visit Update

When recording a patient visit, at least one Diagnosis and Narrative are required. The underlined fields are required.

- a. At the “DIAGNOSIS:” prompt, type the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-5 diagnostic code). Section Appendix C: provides more information about DSM copyright and trademark information.
- b. At the “NARRATIVE” prompt, type the narrative for the diagnosis (using 2–80 characters) or use one of the coded narratives by specifying its number.

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

11. At the “Any CPT Codes to enter?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Add/Edit CPT Procedures pop-up.

```

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

Cpt Code:
Cpt Code:
Cpt Code:
Cpt Code:
Cpt Code:

```

Figure 4-12: Sample Add/Edit CPT Procedures window

The underlined prompts are required.

- a. At the “CPT Code” prompt, type the CPT code for Behavioral Health services. The CPT field will also accept Healthcare Procedure Coding System (HCPCS) that are commonly used by Medicare. State and Local codes might be available if the facility’s billing office has added them to the RPMS billing package. These codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient. More than one code can be used.
- b. After specifying the CPT, HCPCS, or other billing code, the prompts for quantities and up to two modifiers display.

```

QUANTITY: 1
MODIFIER:
MODIFIER 2:

```

Figure 4-13: Prompts for the code entered

- c. At the “Quantity” prompt, type the number of CPT codes to use to help facilitate billing.
- d. At the “Modifier” prompt, type the modifier for the CPT code. Up to two modifiers can be used. The modifier is a two-digit code.

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

12. At the “Activity” prompt, type the activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and will affect the billing process. Section Appendix A: provides more information about the Activity Codes and Definitions.
13. At the “Activity Time” prompt, type the activity time, using any number between 1 and 9999 (no decimal digits). This is how much provider time was involved in

providing and documenting the service or performing the activity. The understood units of measure are minutes. Please note, 0 (zero) is not allowed as a valid entry.

14. At the “# Served” prompt, type the number served, using any number between 0 and 999 (no decimal digits). The default is 1. This refers to the number of people directly served during a given activity and is always used for direct patient care as well as for administrative activities. Group activities or family counseling are examples where other numbers might be listed.
15. At the “Interpreter?” prompt, type **1** (yes) or **0** (no) to indicate if an interpreter was present during the patient encounter. Use **Yes** only if an interpreter is required to communicate with the patient. This information is available when running reports but is not included on the printed encounter form.
16. At the “Any Patient Education Done?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Patient Education Enter/Edit pop-up.

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

Display Patient Education History?  N

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

Figure 4-14: Sample Patient Education enter/edit screen

- a. At the “Display Patient Education History?” prompt, type **Y** (yes) or **N** (no) to display the Behavioral Health and PCC patient education history. This is all education provided in the past 2 years by BH programs. This display is shown in the Output Browser window. You must Quit this window to return to prompts.
- b. At the “EDUCATION TOPIC” prompt, type the education topic used at this encounter. For a complete list of the current Education Topics, use “?” at the prompt to view the whole list.

After entering the Education Topic, the following pop-up displays:

```
EDUCATION TOPIC: ABD-COMPLICATIONS

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

COMMENT: STATUS (Goal): GOAL COMMENT:

Figure 4-15: Sample pop-up for education topic information

The underlined prompts are required.

- c. At the “Education Topic” prompt, type the education topic (can be changed).
- d. At the “Individual/Group” prompt, type if the education is for an individual or for a group.
- e. At the “Readiness to Learn” prompt, type one of the following:
 - Distraction: use when the patient has limited readiness to learn because the distractions cannot be minimized.
 - Eager to Learn: use when the patient is exceedingly interested in receiving education.
 - Intoxication: use when the patient has decreased cognition due to intoxication with drugs or alcohol
 - Not Ready: use when the patient is not ready to learn.
 - Pain: use when the patient has a level of pain that limits readiness to learn.
 - Receptive: use when the patient is ready or willing to receive education.
 - Severity of Illness: use when the patient has a severity of illness that limits readiness to learn.
 - Unreceptive: use when the patient is NOT ready or willing to receive education.
- f. At the “Level of Understanding” prompt, type the level of understanding. This is a required field. Use one of the following:
 - 1 (Poor)
 - 2 (Fair)
 - 3 (Good)
 - 4 (Group No Assessment)
 - 5 (Refused)
- g. At the “Provider” prompt, type the name of the provider for the visit (can be changed). The default is the current logon user.
- h. At the “Minutes” prompt, type the number of minutes spent on education, using any integer 1 - 9999.
- i. At the “Comment” prompt, type any comments about the education topic for the visit, if any.
- j. At the “Status (Goal)” prompt, type the status of the education, if any. Use one of the following:

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

k. At the “Goal” prompt, type the text of the stated goal of the education, if any.

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

17. At the “Any Screenings to Record?” prompt, type **Y** (yes) or **N** (no).

Use **N** to accept the default response if no screenings were completed during the visit.

Use **Y** to access the following pop-up screen.

```

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

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

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

```

Figure 4-16: Sample IPV, Alcohol Screening, and Depression Screening pop-up

The following provides information about the fields on the pop-up.

- a. At the “Display IPV/DV screening History?” prompt, type **Y** (yes) or **N** (no). If **Y** was used, the IPV/DV screening history displays on another screen. The display includes screenings entered in both BHS and PCC.
- b. At the “IPV Screening/Exam Result” prompt, type the result of the intimate partner violence/domestic violence screening. Use one of the following:
 - N - Negative
 - PR - Present
 - PAP - Past and Present
 - PA - Past
 - REF - Patient Refused Screening
 - UAS - Unable to screen
 - Referral Needed

- c. At the “IPV Screening Provider” prompt, type the IPV/DV provider name.
- d. At the “IPV Comment” prompt, type the text of any comment related to the IPV/DV screening, using 2–245 characters.
- e. At the “Display Alcohol screening History?” prompt, type **Y** (yes) or **N** (no).
If Y was used, the alcohol screening history displays on another screen. The display includes screenings entered in both BHS and PCC.
- f. At the “Alcohol Screening Result: prompt, type the result of the alcohol screening. Use one of the following:
 - N - Negative
 - P - Positive
 - UAS - Unable to screen
 - REF - Patient Refused Screening
 - Referral Needed
- g. At the “Alcohol Screening Provider” prompt, type the provider name for the alcohol screening.
- h. At the “Alcohol Screening Comment” prompt, type the text of any comment related to the alcohol screening, using 2–245 characters.
- i. At the “Display Depression screening History?” prompt, type **Y** (yes) or **N** (no). If Y was used, the depression screening history displays on another screen.
- j. At the “Depression Screening Result” prompt, type the result of the depression screening. Use one of the following:
 - N - Negative
 - P - Positive
 - UAS - Unable to screen
 - REF - Patient Refused Screening
 - Referral Needed
- k. At the “Depression Screening Provider” prompt, type the provider name for the depression screening.
- l. At the “Dep Screening Comment” prompt, type the text of any comment related to the depression screening, using 2–245 characters.

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

Note: The Suicide Risk Assessment is not available in the roll and scroll.

18. At the “Any Measurement?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Measurements pop-up.

*** Measurements ***		
Measurement Description	Value	Provider

Figure 4-17: Sample Measurements pop-up

Measurements will print on the Full encounter form only (not on the Suppressed encounter form).

Measurements can only be deleted from the encounter record where they were first recorded.

- At the “Measurement” prompt, type the type of measurement being taken on the patient. Then the application populates the Description field.
- At the “Value” prompt, type the numeric value of the measurement. If you populate this field with a value outside the valid value range, the application provides information about what valid values can be used for the field.
- At the “Provider” prompt, type the name of the provider.

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

19. At the “Any Health Factors to enter?” prompt, type **Y** (yes) or **N** (no) to indicate that you want to record health factor information about the patient. Use **Y** to access the Patient Health Factor Update pop-up.

***** PATIENT HEALTH FACTOR UPDATE *****
Examples of health factors: Tobacco Use, Alcohol Cage, TB Status
Patient Name: DEMO,DARRELL LEE

Display Health Factor History? N
After entering each factor you will be prompted for additional data items
HEALTH FACTOR

Figure 4-18: Sample Patient Health Factor Update pop-up.

- At the “Display Health Factor History?” prompt, type **Y** (yes) or **N** (no). Use **Y** to have the health factor history for the current patient display on another screen.

- b. At the “HEALTH FACTOR” prompt, type the health factor that most closely represents the patient’s health factor status at the encounter for a given health factor category. The other fields about the health factor displays.

LEVEL/SERVERITY
QUANTITY
COMMENTS

Figure 4-19: Other fields for health factor data

- c. At the “Level/Severity” prompt, type **M** (Minimal), **MO** (Moderate), or **H** (Heavy/Severe).
- d. At the “Quantity” prompt, type any integer between 0 and 99999.
- e. At the “Comments” prompt, type any comments regarding the health factor.

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

20. At the “Display Current Medications?” prompt, type **Y** (yes) or **N** (no) to display a list of currently dispensed medications.

If **Y** was used, the list displays on the Output Browser window.

```

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

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

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

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

```

Figure 4-20: Sample display of current medications

This Output Browser screen is the same as using the Display Meds (DM) option on the Patient Data Entry screen.

At the Select Action prompt, do one of the following:

- Type + to display the new screen of information (does not apply to the last screen).
- Type – to display the previous screen of information (does not apply to the first screen).

- Type **Q** to exit the window. Focus moves to the next prompt.

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

21. At the “MEDICATIONS PRESCRIBED <enter>” prompt, press Enter to access another screen where you can enter the medications prescribed.

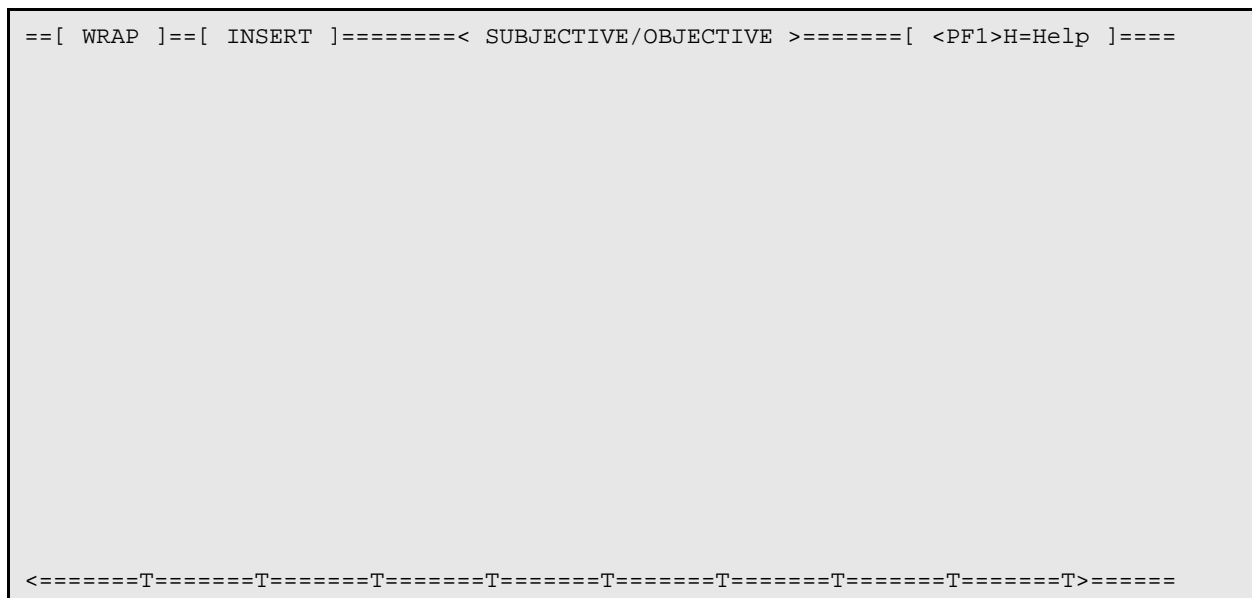


Figure 4-21: screen to enter medication

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

22. At the “Placement Disposition” prompt, type the active disposition. Use this prompt when hospitalization or placement in a treatment facility is required. Use either the number or first few letters of the placement type. After entering the disposition, the following pop-up displays:

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

Figure 4-22: Sample pop-up for facility name

- a. At the “FACILITY REFERRED TO” prompt, type the name of the facility to which the patient was referred.

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

23. At the “Visit Flag” prompt, type the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.
24. At the “Local Service Site” prompt, type the local service site.

4.2.2 Edit Record (EV)

Use the EV option to edit a particular visit.

1. At the “Select Action “prompt, type **EV**.
2. At the “Edit Which Record” prompt, type the number of the visit.

The Behavioral Health Record Edit window displays.

```

* BEHAVIORIAL HEALTH RECORD EDIT *                [press <F1>E to exit]
Encounter Date: APR 3,2009                        User: THETA,SHIRLEY
Patient Name: ALPHAA,CHELSEA MARIE  DOB: 2/7/75  HRN: 116431
-----
Date:      APR 3,2009@11:45                Location of Service:  CHINLE HOSP
Program:   MENTAL HEALTH                   Outside Location:
Clinic:    BEHAVIORAL HEAL                 Appt/Walk-in: UNSPECIFIED  Visit Flag:
Type of Contact: OUTPATIENT                Community: CHINLE
Providers <press enter>:                   Local Service Site:
Activity:  91          Activity Time: 20  #Served: 1  Interpreter Utilized:
Chief Complaint/Presenting Problem: none
SOAP/PROGRESS NOTE:      Comment/Next Appointment:      Medications Prescribed:
Edit Purpose of Visits?: N      Edit Treated Medical Problems?  N
Edit CPT Codes?      Edit Health Factors?  N
Edit Patient Education?: N
Edit Any Screening Exams? N      Edit Measurements?  N
Placement Disposition:                Referred To:
-----
COMMAND:                                Press <PF1>H for help      Insert

```

Figure 4-23: Sample Behavioral Health Record Edit window

The underlined fields are required.

3. At the “Date” prompt, type the date/time of the visit. Some examples of acceptable formats are:

T@1 (Today at 1 PM)

4/3@830

4. At the “Location of Service” prompt, type where the service took place.
5. At the “Program” prompt, type the name of the program with which the provider is affiliated.
6. At the “Outside Location” prompt, type the name of the outside location (3 to 30 characters in length).
7. At the “Clinic” prompt, type the name of the clinic. This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table.
8. At the “Appt/Walk-in” prompt, type the appointment type, which can be appointment, walk-in, or unspecified (for non-patient contact).
9. At the “Visit Flag” prompt, type the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.
10. At the “Type of Contact” prompt, type the contact type (the activity setting).
11. At the “Community” prompt, type the name of the community.
12. At the “Providers <press enter>” prompt, press Enter to access the Enter/Edit Providers of Service pop-up.

```

***** ENTER/EDIT PROVIDERS OF SERVICE *****
[press <F1>C to return to main screen]
Encounter Date: MAR 16,2009           User: BETAAAAA,LORI
Patient Name: DEMO,DOROTHY ROSE
-----
PROVIDER: THETA,SHIRLEY                PRIMARY/SECONDARY: PRIMARY
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
-----
COMMAND:                               Press <PF1>H for help   Insert

```

Figure 4-24: Sample Enter/Edit Providers of Service pop-up

The underlined fields are required.

- a. At the “PROVIDER” prompt, type the name of the service provider.
- b. At the “PRIMARY/SECONDARY” prompt, type the provider type (primary or secondary). Only one primary provider can be used while there can be more than one secondary provider.

The following are the fields on the Behavioral Health Record Edit window.

13. At the “Local Service Site” prompt, type the name of the local service site.
14. At the “Activity” prompt, type the activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. See section Appendix A: for more information.
15. At the “Activity Time” prompt, type the number of minutes spent on the activity. This is how much provider time was involved in providing and documenting the service or performing the activity. Please note, 0 (zero) is not allowed as a valid entry.
16. At the “# Served” prompt, type the number served at the encounter, any integer between 0 and 999.
17. At the “Interpreter Utilized” prompt, type **Y** (yes) or **N** (no). Use **Y** only if an interpreter is required to communicate with the patient.
18. At the “Chief Complaint/Presenting Problem” prompt, type the text that describes the major reason the patient sought services.
19. At the “SOAP/PROGRESS NOTE” prompt, press Enter to access another window to populate with the text of the note. The note can be edited only if it is unsigned.
20. At the “Comment/Next Appointment” prompt, type the text of the comments about the next appointment.
21. At the “Medications Prescribed” prompt, press Enter to access another window where you enter the medications prescribed.
22. At the “Edit Purpose of Visits?” prompt, type **Y** (yes) or **N** (no). Use **Y** to access the Purpose of Visit Update pop-up.

```

***** BH RECORD ENTRY - PURPOSE OF VISIT UPDATE *****
Encounter Date: MAR 5,2009@12:00      User: THETA,SHIRLEY
Patient Name: DEMO,DARRELL LEE      DOB: 9/23/86  HR#: 117305
[press <F1>C to return to main screen]
-----
DIAGNOSIS:          NARRATIVE:
DIAGNOSIS:          NARRATIVE:
DIAGNOSIS:          NARRATIVE:
DIAGNOSIS:          NARRATIVE:
-----
Patient's Diagnoses from last 5 visits:
11/16/15  F84.0  AUTISM SPECTRUM DISORDER
11/1/15   F10.24 ALCOHOL-INDUCED BIPOLAR AND RELATED DISORDER WITH MO
10/16/15  F42.   HOARDING DISORDER
Enter RETURN to continue or '^' to exit:

```

Figure 4-25: Sample BH Record Entry - Purpose of Visit Update

The underlined fields are required.

- a. At the “Diagnosis” prompt, type the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-IV-TR diagnostic code).
- b. At the “Narrative” prompt, either accept the narrative that is displayed or edit the narrative to more clearly identify the reason for the visit. For example, if Problem code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient’s housing issue - homeless, being evicted, etc.

The following are the fields on the Behavioral Health Record Edit window.

23. At the “Edit Prevention Activities” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access a pop-up to enter one or more medical problems.

```

Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:

```

Figure 4-26: Fields that define the prevention activities

The underlined prompts are required.

- a. At the “Prevention Activities” prompt, type the prevention activity.
- b. At the Target” prompt, type the target for the activity that can one of the following: **A** (Adult), **Y** (Youth), or **F** (Family).

The following are the fields on the Behavioral Health Record Edit window.

24. At the “Edit CPT Codes?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Add/Edit CPT Procedures pop-up.

```

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

Cpt Code:
Cpt Code:
Cpt Code:
Cpt Code:
Cpt Code:

```

Figure 4-27: Sample Add/Edit CPT Procedures window

The underlined fields are required.

- a. At the “CPT Code” prompt, type the CPT Code. These E&M codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient.
- b. More than one CPT Code can be used.

The following are the fields on the Behavioral Health Record Edit window.

25. At the “Edit Health Factors?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Patient Health Factor Update pop-up.

```

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

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

HEALTH FACTOR

```

Figure 4-28: Sample Patient Health Factor Update pop-up.

- a. At the “Display Health Factor History?” prompt, type **Y** (yes) or **N** (no). If **Y** was used, the health factor history displays on another screen.
- b. At the “HEALTH FACTOR” prompt, type the health factor. The following pop-up displays where other data about the health factor can be specified.

```

LEVEL/SEVERITY

QUANTITY

COMMENTS

```

Figure 4-29: Fields for health factor data

- c. At the “Level/Severity” type one of the following: **M** (minimal), **MO** (moderate), or **H** (heavy/severe).
- d. At the “Quantity” prompt, type any number between 0 and 99999 (no decimal points).
- e. At the “Comment” prompt, type the text of a comment related to the patient’s health factor.

The following are the fields on the Behavioral Health Record Edit window.

26. At the “Edit Patient Education?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Patient Education Enter/Edit pop-up.

```

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

Display Patient Education History?  N

EDUCATION TOPIC:
EDUCATION TOPIC:
EDUCATION TOPIC:
EDUCATION TOPIC:
EDUCATION TOPIC:

```

Figure 4-30: Sample Patient Education enter/edit screen

- a. At the “Display Patient Education History?” prompt, type **Y** (yes) or **N** (no). Use **Y** to display all education provided in the last two years by BH programs. This history is displayed in the Output Browser window.
- b. At the “EDUCATION TOPIC” prompt, type the education topic name. The following pop-up displays where you enter data about the education topic:

```

EDUCATION TOPIC: ABD-COMPLICATIONS

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

COMMENT:
STATUS (Goal):
GOAL COMMENT:

```

Figure 4-31: Sample pop-up for education topic information

The underlined fields are required.

- c. At the “Education Topic” prompt, type the education topic (can be changed).

- d. At the “Individual/Group” prompt, type if the education is for an individual or for a group.
- e. At the “Readiness to Learn” prompt, type one of the following:
 - Distraction: use when the patient has limited readiness to learn because the distractions cannot be minimized.
 - Eager to Learn: use when the patient is exceedingly interested in receiving education.
 - Intoxication: use when the patient has decreased cognition due to intoxication with drugs or alcohol
 - Not Ready: use when the patient is not ready to learn.
 - Pain: use when the patient has a level of pain that limits readiness to learn.
 - Receptive: use when the patient is ready or willing to receive education.
 - Severity of Illness: use when the patient has a severity of illness that limits readiness to learn.
 - Unreceptive: use when the patient is NOT ready or willing to receive education.
- f. At the “Level of Understanding” prompt, type the level of understanding. Use one of the following:
 - 1 (Poor)
 - 2 (Fair)
 - 3 (Good)
 - 4 (Group No Assessment)
 - 5 (Refused)
- g. At the “Provider” prompt, the name of the provider for the visit (can be changed). The default is the current logon user.
- h. At the “Minutes” prompt, type the number of minutes spent on education, using any integer 1 - 9999.
- i. At the “Comment” prompt, type the text of any comments about the education topic for the visit, if any.
- j. At the “Status (Goal)” prompt, type the status of the education, if any. Use one of the following:
 - GS - goal set
 - GM - goal met
 - GNM - goal not met
 - GNS - goal not set
- k. At the “Goal” prompt, type the text of the stated goal of the education, if any.

The following are the fields on the Behavioral Health Record Edit window.

27. At the “Edit Any Screening Exams?” prompt, type **Y** (yes) or **N** (no) for any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter.

Use **Y** to access the following pop-up screen.

```

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

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

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

```

Figure 4-32: Sample IPV, Alcohol Screening, and Depression Screening pop-up

- a. At the “Display IPV/DV screening History?” prompt, type **Y** (yes) or **N** (no). If you use **Y**, the IPV/DV screening history displays on another screen.
- b. At the “IPV Screening/Exam Result” prompt, type the result of the intimate partner violence/domestic violence screening. Use one of the following:
 - N - Negative
 - PR - Present
 - PAP - Past and Present
 - PA - Past
 - UAS - Unable to screen
 - REF - Patient Refused Screening
 - Referral Needed
- c. At the “IPV Screening Provider” prompt, type the IPV/DV provider name.
- d. At the “IPV Comment” prompt, type the text of any comment related to the IPV/DV screening, using 2–245 characters.
- e. At the “Display Alcohol screening History?” prompt, type **Y** (yes) or **N** (no). If **Y** was used, the alcohol screening history displays on another screen.
- f. At the “Alcohol Screening Result” prompt, type the result of the alcohol screening. Use one of the following:
 - N - Negative
 - P - Positive
 - UAS - Unable to screen

- REF - Patient Refused Screening
 - Referral Needed
- g. At the “Alcohol Screening Provider” prompt, type the provider name for the alcohol screening.
 - h. At the “Alcohol Screening Comment” prompt, type the text of any comment related to the alcohol screening, using 2–245 characters.
 - i. At the “Display Depression screening History?” prompt, type **Y** (yes) or **N** (no). If **Y** was used, the depression screening history displays on another screen.
 - j. At the “Depression Screening Result” prompt, type the result of the depression screening. Use one of the following:
 - N - Negative
 - P - Positive
 - UAS - Unable to screen
 - REF - Patient Refused Screening
 - Referral Needed
 - k. At the “Depression Screening Provider” prompt, type the provider name for the depression screening.
 - l. At the “Dep Screening Comment” prompt, type the text of any comment related to the depression screening, using 2–245 characters.

The following are the fields on the Behavioral Health Record Edit window.

Note: The Suicide Risk Assessment is not available in the roll and scroll.

28. At the “Edit Measurements?” prompt, type **Y** (yes) or **N** (no).

Use **Y** to access the Measurements pop-up.

*** Measurements ***		
Measurement Description	Value	Provider

Figure 4-33: Sample Measurements pop-up

- a. At the “Measurement” prompt, type the measurement type being taken on the patient. Then the application populates the Description field.

- b. At the “Value” prompt, type the numeric value of the measurement. The value must be in the valid numeric range for the measurement.
- c. At the “Provider” prompt, type the name of the provider.

The following are the fields on the Behavioral Health Record Edit window.

- 29. At the “Placement Disposition” prompt, type the placement disposition. This is a required field used when hospitalization or placement in a treatment facility is required.
- 30. At the “Referred to” prompt, type the name of the facility, using 2-30 characters in length. This field is required when the Placement Disposition is populated.

After you exit the window, the application displays the following prompt about your signature code. This prompt only displays where you are the primary provider for the visit and the SOAP/Progress Note is unsigned.

- 31. At the “Enter your Current Signature Code” prompt, type your (valid) signature code. This signature applies to the SOAP/Progress Note associated with the current visit. Section 2.14 provides more information on the Electronic Signature.

If you do not populate with your electronic signature and leave the window, the application will display the message: No PCC Link. Note not signed. After you press Enter to continue, the application displays the message: There is no electronic signature, this visit will not be passed to PCC.

The Other Information window displays.

```

***** OTHER INFORMATION *****

Update, add or append any of the following data

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

```

Figure 4-34: Other Information window

Use Option 10 to exit the Other Information window.

After you use Option 10, one of the following will happen:

- If there was not an appointment the patient was checked in for using the scheduling package, you return to the previous window.
- If there was an appointment the patient was checked in for using the scheduling package, the application displays more prompts. Please note the following about these prompts:
 - If the facility is not using the scheduling package and doesn't have the Interactive PCC Link in the site parameters turned on, you will never be presented with the ability to link it to a PCC visit.
 - If there is no visit in PCC (patient never checked in, no appointment or walk in was ever created using the scheduling package and no other clinics saw the patient that day), then the option to link is never presented and the BH visit continues to create a new visit in PCC.

Below are the prompts for linking:

```

Generating PCC Visit.

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

1 TIME: 16:00 LOC: WW TYPE: I CAT: A CLINIC: ALCOHOL DEC: 0
VCN:47887.1A
Hospital Location: BJB AOD
Primary POV: Narrative:
2 TIME: 15:00 LOC: WW TYPE: I CAT: A CLINIC: GENERAL DEC: 0
VCN:47887.2A
Hospital Location: ADULT WALKIN
Primary POV: Narrative:
3 TIME: 16:15 LOC: WW TYPE: I CAT: A CLINIC: BEHAVIOR DEC: 3
VCN:47887.3A
Hospital Location: BJB BH
Provider on Visit: BETA,BETA
Primary POV: F42. Narrative: HOARDING DISORDER
4 Create New Visit

Select: (1-4): 3

```

Figure 4-35: Continuing prompts

At this point, the application links to the visit you had selected and returns the focus to the list view.

Date of Encounter: Tuesday MAR 09, 2010				* unsigned note			

#	PRV	PATIENT NAME	HRN	LOC	ACT	PROB	NARRATIVE
1	BJB	BETAA,EMILY MAE	WW129608	WW	11	F84.0	AUTISM SPECTRUM DISORDER
2	BJB	BETAA,EMILY MAE	WW129608	WW	11	F10.24	ALCOHOL-INDUCED BIPOLAR AND
3	BJB	SIGMAAA,DAVID R	WW145072	WW	12	F42.	HOARDING DISORDER

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

Figure 4-36: Prompts that continue

Below is how the record looks in the BH application:

```

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

===== BH RECORD FILE =====
DATE OF SERVICE:     MAR 09, 2010@12:00
PROGRAM:             MENTAL HEALTH
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE: TAHLEQUAH
ACTIVITY TYPE:       11
ACTIVITY TYPE NAME:  SCREENING-PATIENT PRESENT
TYPE OF CONTACT:    OUTPATIENT
PATIENT:            BETAA,EMILY MAE
PT AGE:             42
CLINIC:             MENTAL HEALTH
NUMBER SERVED:      1
APPT/WALK-IN:       WALK-IN
ACTIVITY TIME:      112
VISIT:              MAR 09, 2010@16:15
POSTING DATE:       MAR 12, 2010
WHO ENTERED RECORD: BRUNING,BJ
DATE LAST MODIFIED: MAR 12, 2010
USER LAST UPDATE:   BETA,BETAA
DATE/TIME LAST MODIFI: MAR 12, 2010@09:28:55
EDIT HISTORY:
  Mar 12, 2010 9:28 am      BETA,BETAS
EXTRACT FLAG:        ADD
CREATED BY BH?:      YES
DATE/TIME NOTE SIGNED: MAR 12, 2010@09:30
SIGNATURE BLOCK:     BETAS BETA

SUBJECTIVE/OBJECTIVE: TEST

COMMENT/NEXT APPOINTMENT:
TEST

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:

===== MHSS RECORD PROBLEMS (POVS) =====
PROBLEM CODE:        F42.
PROBLEM CODE NARRATIV: HOARDING DISORDER
PROVIDER NARRATIVE:  HOARDING DISORDER

```

```

===== MHSS RECORD PROVIDERS =====
PROVIDER:                BETA,BETAS
PROVIDER DISCIPLINE:    ACUPUNCTURIST
PRIMARY/SECONDARY:      PRIMARY

Note already signed, no E Sig necessary.

Press enter to continue....:

```

Figure 4-37: Display Record information

Once you are back at the Other Information list, you can simply quit and go back to the main menu to see what the PCC visit looks like:

```

***** OTHER INFORMATION *****

Update, add or append any of the following data

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

```

Figure 4-38: Other information screen

At The “Choose one of the above” prompt, type **10** to exit.

4.2.3 Display Record (DR)

Use the DR option to display information about a selected record. (This works like the LV option of PDE)

1. At the “Select Action” prompt, type **DR**.
2. At the “Display Which Record” prompt, type the number of the record.

The BH VISIT RECORD DISPLAY window displays.

```

BH VISIT RECORD DISPLAY           Mar 27, 2009 15:06           Page:    1 of    5

Patient Name:                ALPHA,GLEN DALE
Chart #:                      108704
Date of Birth:                NOV 10, 1981
Sex:                          M

===== BH RECORD FILE =====

```

```

DATE OF SERVICE:      MAR 26, 2009@09:00
PROGRAM:              MENTAL HEALTH
LOCATION OF ENCOUNTER: SELLS HOSP
COMMUNITY OF SERVICE: TUCSON
PATIENT:              ALPHA,GLEN DALE
PT AGE:               37
CLINIC:               MENTAL HEALTH
APPT/WALK-IN:        APPOINTMENT
POSTING DATE:         MAR 03, 2014
WHO ENTERED RECORD:  GARCIA,RYAN
DATE LAST MODIFIED:  MAR 04, 2014
USER LAST UPDATE:    THETA,SHIRLEY
DATE/TIME LAST MODIFI: MAR 04, 2014@12:15:16
EDIT HISTORY:
  Mar 03, 2014 3:27 pm      GARCIA,RYAN
EXTRACT FLAG:         ADD
CREATED BY BH?:       YES
CHIEF COMPLAINT:     major pain in left arm

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:

===== MHSS RECORD PROBLEMS (POVS) =====
PROBLEM CODE:         F42.
PROBLEM CODE NARRATIV: HOARDING DISORDER
PROVIDER NARRATIVE:   HOARDING DISORDER
===== MHSS RECORD PROVIDERS =====
PROVIDER:              BETA,BETAS
PROVIDER DISCIPLINE:  ACUPUNCTURIST
PRIMARY/SECONDARY:    PRIMARY

```

Figure 4-39: Sample BH Visit Record Display window

4.2.4 Delete Record (DE)

Use the DE option to delete a particular record.

1. At the “Select Action” prompt, type **DE**.
2. At the “Display Which Record” prompt, type the number of the record to delete.

The application displays the information about the record.

3. At the “Are you sure you want to DELETE this record?” prompt, type **Y** (yes) or **N** (no).

If **Y** was used, the application displays: Record deleted. Press enter to continue.

4.2.5 Print Encounter Form (PF)

Use the PF option to print/browse the encounter form for a specified date.

1. At the “Select Action” prompt, type **PF**.
2. At the “Print Which Record” prompt, type the number of the record.
3. At the “What type of form do you want to print” prompt, type the form type you want to print. Use one of the following:

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

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

Below is the data for a suppressed encounter form.

```

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

S/O/A/P:
Behavioral Health Visit

Feb 23, 2009@12:00          Page 2

See GAMMAAA,DENISE for details.

```

```

COMMENT/NEXT APPOINTMENT:
Behavioral Health Visit - COMMENT Suppressed
See GAMMAAA,DENISE for details.

BH POV CODE      PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS [PRIMARY ON FIRST LINE]

      F42.          HOARDING DISORDER

Enter RETURN to continue or '^' to exit:

```

Figure 4-40: Sample Suppressed Encounter Form

4.2.6 Health Summary (HS)

Use the HS option to display the health summary information about a selected record.

1. At the “Select Action” prompt, type **HS**.
2. At the “Patient” prompt, the patient’s HRN, name, SSM or DOB.
3. At the “Select HEALTH SUMMARY TYPE NAME” prompt, type the health summary type to use.

The PCC Health Summary for the patient displays.

```

OUTPUT BROWSER          Aug 21, 2014 11:28:05          Page:    1 of    7
PCC Health Summary for DEMO,JEANETTE

***** CONFIDENTIAL PATIENT INFORMATION -- 8/21/2014 11:27 AM [ST] *****
***** DEMO,JEANETTE #146457      (ADULT REGULAR SUMMARY)  pg 1 *****

----- DEMOGRAPHIC DATA -----

DEMO,JEANETTE          DOB: MAY 8,1998  16 YRS  FEMALE  no blood type
WHITE MOUNTAIN APACHE TRB, AZ  SSN: XXX-XX-4701
                                MOTHER'S MAIDEN NAME: ENOS,LUPE V
(H) 555-555-1072 (W) 555-999-1945 FATHER'S NAME: DEMO,ROGER
OTHER PHONE: NONE
RIVERSIDE (RT. 1, BOX 45,ALB,NM,87119)

LAST UPDATED: OCT 11,2012          ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT? NO
                                DATE RECEIVED BY PATIENT:
                                WAS ACKNOWLEDGEMENT SIGNED? NO

HEALTH RECORD NUMBERS:  146457  2013 DEMO HOSPITAL
                                146458  2013 DEMO-3 TRIBAL CLINIC
DESIGNATED PRIMARY CARE PROVIDER: <none identified>

```



```

----- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -----

                                NO ALLERGY INFORMATION RECORDED

Allergy List Reviewed On:                By:
Allergy List Updated On:                By:
No Active Allergies Documented On:      By:

----- ALLERGIES (FROM PROBLEM LIST) -----

                                ***** NONE RECORDED *****

Allergy List Reviewed On:                By:
Allergy List Updated On:                By:
No Active Allergies documented On:      By:

Problem List Reviewed On:                By:
Problem List Updated On:                By:
No Active Problems Documented On:      By:

----- ACTIVE PROBLEMS -----

Problem List Reviewed On:                By:
Problem List Updated On:                By:
No Active Problems Documented On:      By:
+      Enter ?? for more actions                >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +//

```

Figure 4-41: Sample Health Summary for the patient

4.2.7 SOAP.CC Edit (ES)

Use the ES option (on the Patient Data Entry window) to edit the SOAP note for a specified patient visit as well the text for Chief Complaint, Comment/Next Appointment, and Medications Prescribed. Please note that this applies only to records with unsigned notes.

1. At the “Select Action” prompt, type **ES**.
2. At the “Edit Which Record” prompt, type the number of the record.
3. At the “CHIEF COMPLAINT” prompt, type the chief complaint (Free-Text), if any, using between 2-80 characters in length. If there is existing text, you can change it. This information describes the major reason the patient sought services.
4. At the “SOAP/PROGRESS NOTE No existing text” prompt, if there is existing text, it appears below the SOAP/PROGRESS NOTE prompt. You can edit this text (just like entering new note).

- a. At the Edit? NO//” prompt, type **Y** (yes) or **N** (no).

If N was used, the other prompts continue.

If Y was used, you access another window where you can edit the text of the SOAP/Progress Note.

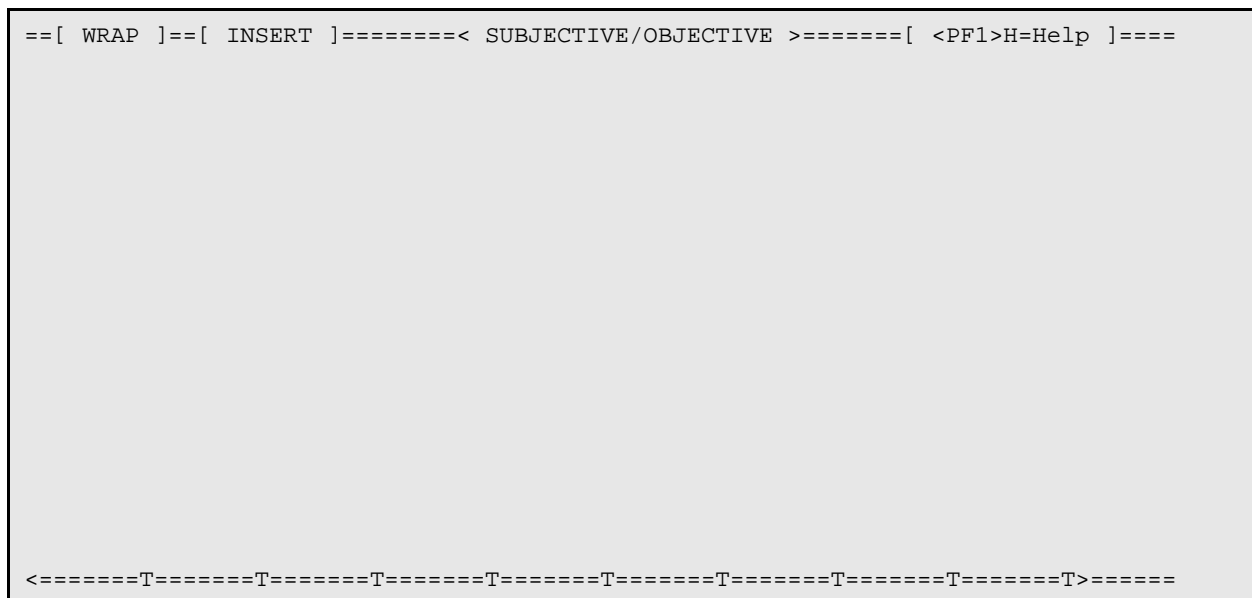


Figure 4-42: Window to enter the note

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

5. At the “COMMENT/NEXT APPOINTMENT - No existing text” prompt, if there is existing text, it appears below the COMMENT/NEXT APPOINTMENT prompt. You can edit this text (just like entering new note).

- a. At the Edit? NO//” prompt, type **Y** (yes) or **N** (no).

If N was used, the other prompts continue.

If Y was used, you access another window where you can edit the text of the COMMENT/NEXT APPOINTMENT note.



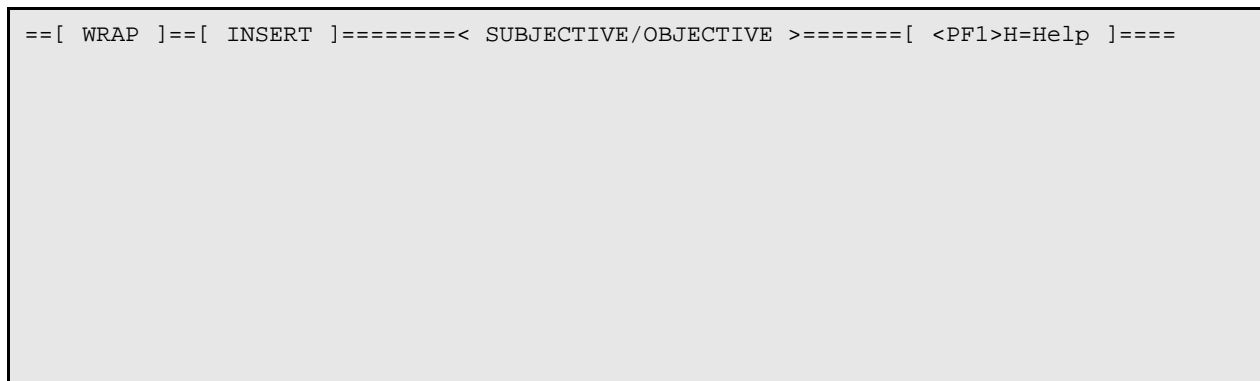


Figure 4-43: Window to enter the note

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

6. At the “MEDICATIONS PRESCRIBED - No existing text” if there is existing text, it appears below the MEDICATIONS PRESCRIBED prompt. You can edit this text (just like entering new note).
 - a. At the Edit? NO//” prompt, type **Y** (yes) or **N** (no).
 If Y was used, you access another window where you can edit the text of the MEDICATIONS PRESCRIBED note.



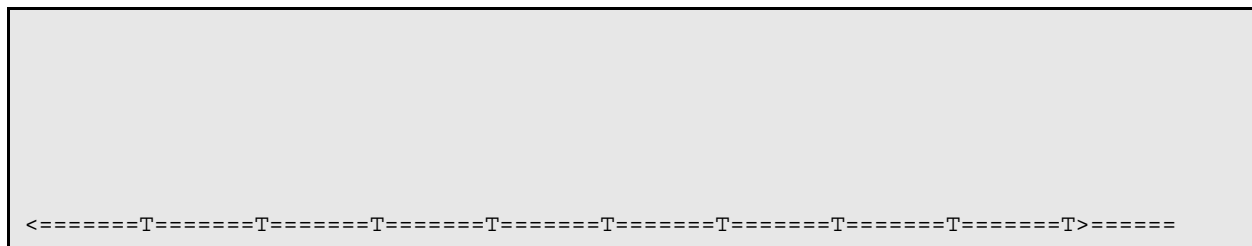


Figure 4-44: Window to enter the note

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

The electronic signature might be needed after you exit. Section 2.14 provides more information about the Electronic Signature.

4.2.8 Switch Dates (SD)

Use the SD option to

1. At the “Select Action” prompt, type **SD**.
2. At the “Enter Date” prompt, type date to be used.

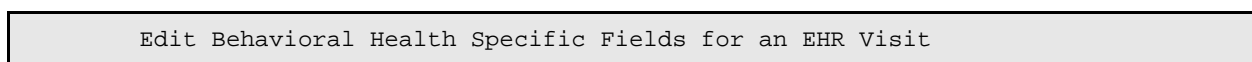
The application changes the date of the encounter.

4.2.9 Edit EHR Visit (EH)

Use the EH option to edit a selected BH visit that was entered in the Electronic Health Record (EHR) application. (The same prompts display if you use the EHRE (Edit BH Data Elements of EHR created Visit) option on the IHS Behavioral Health System Data Entry Menu. In this option, you specify the patient name before specifying the encounter date.)

1. At the “Select Action” prompt on the Patient Data Entry screen, type **EH**.
2. At the “Edit Which Record” prompt, type the number of the BH encounter that was entered for a particular patient through the EHR.

The Edit Behavioral Health Specific Fields for an EHR Visit window displays.



```

Patient: DELTA,EDWIN RAY   HRN: 105321
Visit Date: FEB 27, 2009@13:47   Provider: GAMMAA,RYAN
-----
Community of Service: ALBUQUERQUE
Activity Type: 99 INDIVIDUAL BH EHR VI
Appt/Walk In: UNSPECIFIED
Placement Disposition:
Interpreter Utilized:           Comment/Next Appt (press enter)
Local Service Site:
Flag (Local Use):
-----
COMMAND:                               Press <PF1>H for help   Insert

```

Figure 4-45: Sample information about editing a BH visit entered through the EHR.

The underlined fields are required.

3. At the “Community of Service” prompt, type the community of service where the encounter took place.
4. At the “Activity Type” prompt, type the activity type for the visit.
5. At the “Appt/Walk In” prompt, type the visit type: appointment, walk-in, or unspecified (for non-patient contact).
6. At the “Placement Disposition” prompt, type any active disposition (such as Alcohol/Drug Rehab). This is used when hospitalization or placement in a treatment facility is required.

After you populate this field, the following pop-up window displays:

```

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

```

Figure 4-46: Pop-up window asking for facility referred to

- a. At the “Facility Referred to” prompt, type the facility name to which the patient was referred, using 2 - 30 characters in length. This is a Free Text field.

The prompts continue on the Edit Behavioral Health Specific Fields for an EHR Visit window.

7. At the “Interpreter Utilized” prompt, type **Y** (yes) or **N** (no). This indicates if an interpreter was used in the visit. Use **Y** if an interpreter was required to communicate with the patient.

8. At the “Comment/Next Appt (press Enter)” prompt, press Enter to access another window where you can populate the field with the text of a comment about the next appointment.

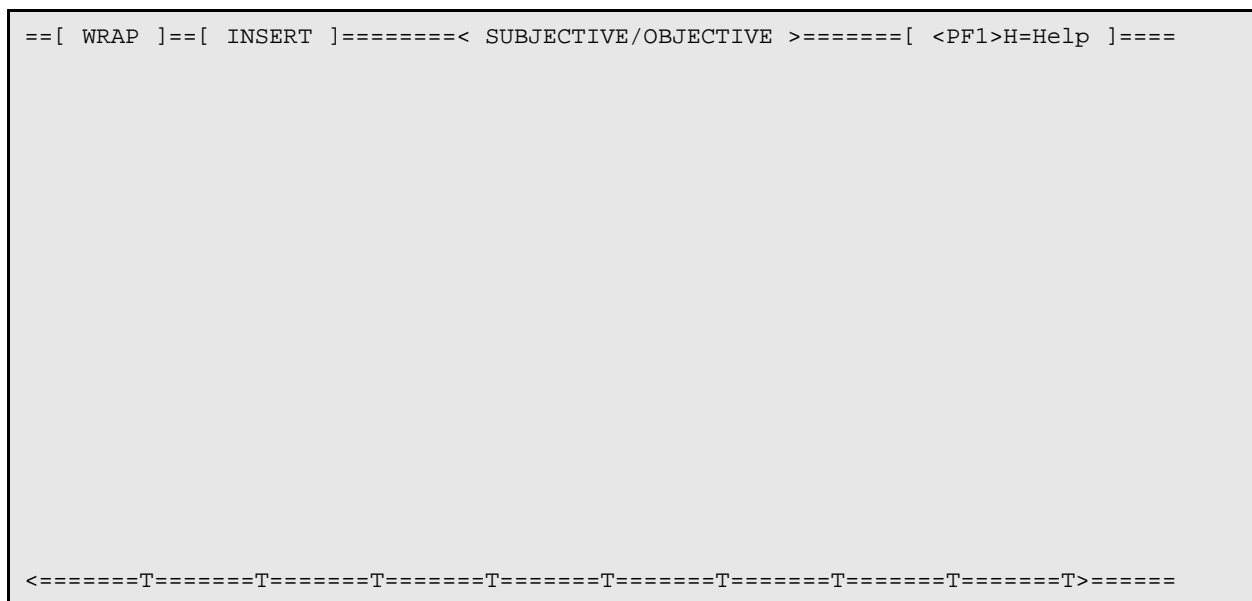


Figure 4-47: Window to enter the note

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

9. At the “Local Service Site” prompt, type the local service site for the visit.
10. At the “Flag (Local Use)” prompt, type any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

4.2.10 Sign Note (SN)

Use the SN option to sign a note (that is not signed) in a visit record. You can only sign notes where you are the primary provider.

1. At the “Select Action” prompt, type **SN**.

After using SN, one or two actions happen: (1) if there are no notes to sign, the application displays the message: There are no records with unsigned notes that need to be signed; or (2) if there are notes to be signed, the application displays the Behavioral Health visits for the current patient where you are the primary provider. Please note that visits with a blank SOAP/Progress Note will not appear on the list.

Behavioral Health visits for ALPHA, CHELSEA MARIE								
#	PROVIDER	LOC	DATE	ACT	CONT	PATIENT	PROB	NARRATIVE
1	THETA, SHIRLE	WW	05/12/2009	OUTP	WW	116431	F42.	HOARDING DISORDER

Figure 4-48: List of records that you can change

The prompts continue.

- At the “Which record do you want to display” prompt, type the number of the record you want to use.

The application displays the BH Visit Record Display window (for the particular record).

After you quit the BH Visit Record Display window, the application asks if you want edit this record.

- If N was used, you exit the sign note process.
- If Y was used, the application displays the Edit SOAP window.

After you save and exit this window, the application displays the signature code prompt.

- At the “Enter your Current Signature Code” prompt, type your (valid) signature code. This signature applies to the SOAP/Progress Note associated with the current visit. Section 2.14.6 provides more information about signing a note. After typing your signature code, the OTHER INFORMATION screen displays.

If you do not populate with your electronic signature (or use an invalid one three times) you will leave the window. After you quit, the application displays the message: There is no electronic signature; this visit will not be passed to PCC.

4.2.11 Display TIU Note (TN)

Use the TN option to display a particular TIU note.

- At the “Select Action” prompt, type **TN**.
- At the “Display Note for Which Record” prompt, type the number of the record to use.

- The contents of the specified note displays.

4.3 Display Record Options (DSP)

Use the DSP option to access the Data Entry Menu Display Options.

4.4 Visit Window (GUI)

One way to access the **Visit** window is to use the **One Patient** option on the RPMS Behavioral Health System (GUI) tree structure. You access the **Visit** window for one patient.

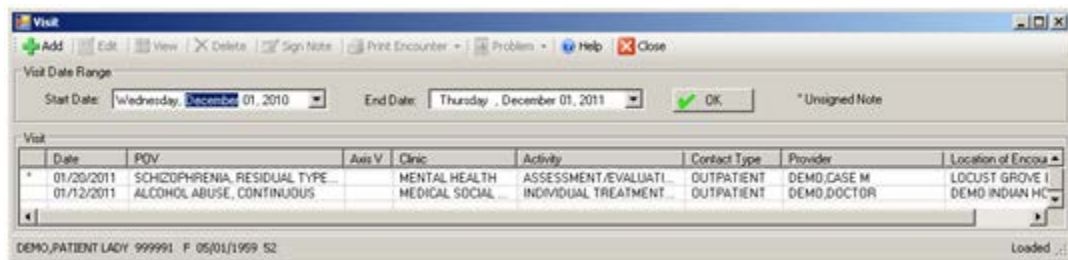


Figure 4-49: Visit window for one patient

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

Another way to access the **Visit** window for the patient is to use the **All Patients** option on the RPMS Behavioral Health System (GUI) tree structure. You access the **Visit** window for all patients.

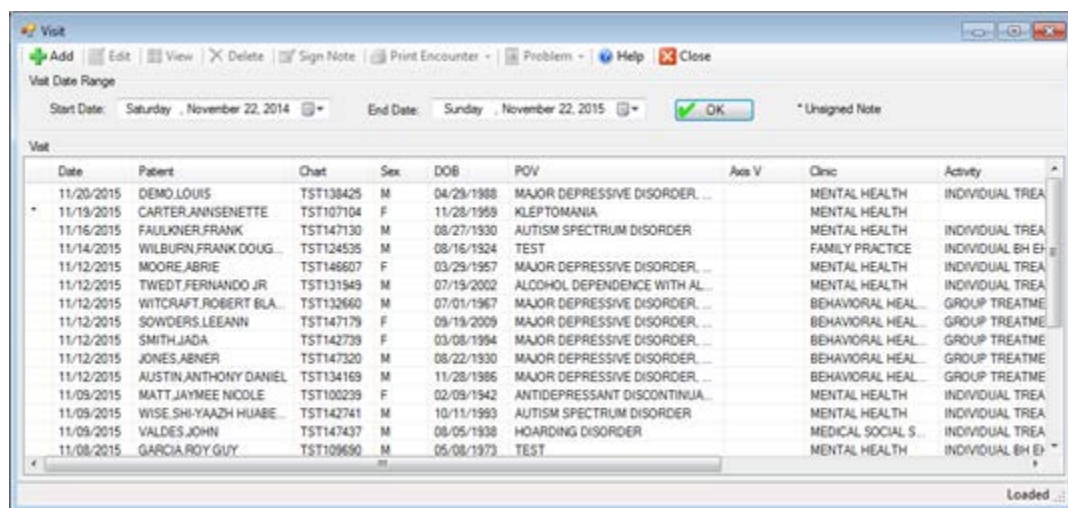


Figure 4-50: Sample Visit window for all patients

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

The following are features of both windows.

The following table provides information about the other features of the window.

Feature	Functionality
Visit Window for One Patient	<p>The default Start Date is one year previous.</p> <p>You can change the date range by clicking the drop-down list to access a calendar. After the date range is changed, click OK to redisplay the records in the Visit list box.</p> <p>Note: if you change the Start Date for the Visit window for One Patient, this change stays in effect in future sessions of the GUI application for the Visit window for One Patient (until you change it again).</p>
Visit Window for All Patients	<p>The default Start Date is today.</p> <p>You can change the default Start Date and the application maintains that Start Date until you exit the application. Then, when you login again, the Start Date reverts to today's date.</p>
Visit List Box	<p>The Visit list box shows the Visit records in the particular Visit Date Range.</p> <p>The asterisk (*) in the first column indicates that the particular record contains an unsigned note. See section 2.14.5 Signing a Note (GUI) for more information.</p>
Add Button	<p>Establish the patient you want to use in the add process. Use the Add button to add a new Visit record. You access the Visit Data Entry - Add Visit dialog box.</p>
Edit Button	<p>Use the Edit button to edit a particular Visit record. You access the Visit Data Entry - Edit Visit dialog box.</p>
View Button	<p>Use the View button (or double-click on a record) to browse a particular Visit record. This window has the same fields as the add/edit visit dialog box, except for the Intake and Suicide Form tabs.</p>
Delete Button	<p>Use the Delete button to delete a particular Visit record. The application confirms the deletion.</p> <p>Note that Visit records with a signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.</p>
Sign Note Button	<p>Use the Sign Note button to sign the note of an "unsigned" record (asterisk (*) in the first column).</p>
Problem Button	<p>Select a record and then click the Problem button to access either a BH Problem List or the PCC Problem list.</p>

Feature	Functionality
Print Encounter Button	<p>Use the Print Encounter button to print the encounter data about a particular Visit record. The Print Encounter button has these options: Full, Suppressed, Both Full and Suppressed.</p> <p>Please note that the Intake document and Suicide Reporting Form must be printed elsewhere and will not appear on a printed encounter form.</p> <p>The suppressed report does NOT display the following information: Chief Complaint, SOAP note, measurement data, patient education data, screenings.</p> <p>After selecting one of the options, the application displays the first page of the Print Encounter pop-up window.</p>
Problem Button	Select a visit and then click the Problem button to manage the patient's Behavioral Health and PCC problems.
Help Button	Use the Help button on the Visit window to access the online help for the window.
Close Button	Use the Close button on the Visit window to exit the window.

4.5 Add/Edit Visit Data Entry

Use the **Add** button on the **Visit** window to add a new record.

1. Establish the patient to use in the add process.
2. Do one of the following:
 - Click **Add** to add a visit for the current patient. The application displays the **Visit Data Entry–Add Visit** dialog box.
 - Click **Edit** to edit the selected visit for the current patient. The application displays the **Visit Data Entry–Edit** Visit dialog box. The **Edit** button will be inactive if the patient does not have any previous visits.

Below is a sample **Visit Data Entry - Add Visit** dialog box. (The same fields appear on the **Visit Data Entry - Edit Visit** dialog box.)

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

The table below provides information about the features on this window.

Feature	Functionality
Help button	Click this button to access the online help about this window.
Save button	Click this button after adding or changing this window. (See below for more information).
Close button	Click this button to not save any changed. (See below for more information).

The Save process saves the changes and dismisses the add/edit window. If you added a SOAP/Progress note, you will be asked if you want to sign the note. Section 2.14.5 provides more information about the Electronic Signature (GUI).

- If there was not an appointment the patient was checked in for in the scheduling package, you return to the **Visit** window.
- If there was an appointment the patient was checked in for in the scheduling package and it is set to create a visit at check-in, the application displays the

Select PCC Visit window. Section 4.3.9 provides more information about this window. Please note the following about this option:

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

The Close process displays the **Continue?** dialog box. This dialog box states: **Unsaved Data Will Be Lost, Continue?**

- Click **Yes** to not save; this dismisses the data entry window.
- Click **No** and the focus remains on the data entry window where you can continue work.

4.5.1 Visit Information Group Box

Use the **Visit Information** group box to enter data about the visit.

Figure 4-52: Sample Visit Information group box

The fields in bold text are required.

1. At the **Primary Provider** field, select the primary provider. The default is the current provider. Change this field by clicking the drop-down list to access the **Primary Provider** search/select window.

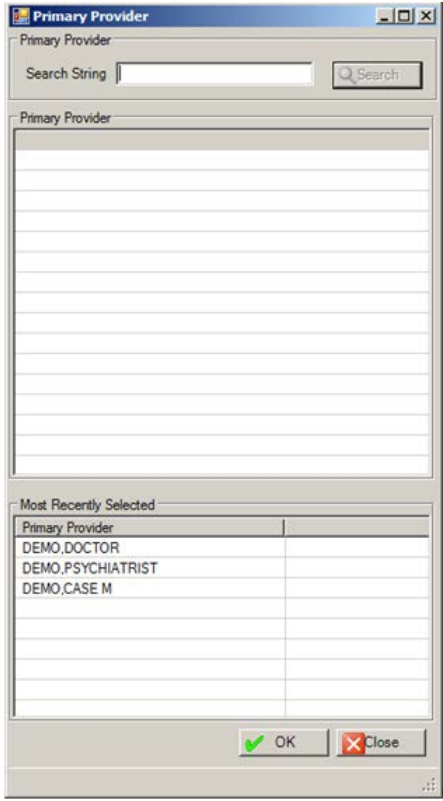
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 4-53: Sample Primary Provider search/select window

- At the **Enter Date/Time** field, type the date/time. The default is the current date and time. Change the date by clicking the drop-down list to access the calendar. You can manually change the time. (This field can be changed during Edit).
- At the **Program** field, select the program associated with the visit from the drop-down list.

Mental health

Social services

Other

Chemical Dependency

After selecting the program, the application automatically populates the remaining fields if the defaults were set up on the Site Parameters menu.

- At the **Encounter Location** field, type the encounter location. This field determines the location of the encounter. Change this field by clicking the drop-down list to access the **Location** search window.

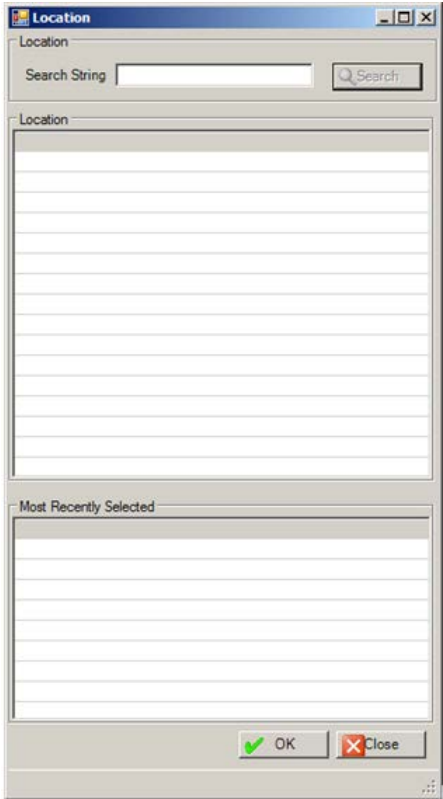
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the location and then clicking Search. The retrieved locations will populate the Location list box. Select a location and click OK to populate the Encounter Location field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Encounter Location field. (Otherwise, click Close.)</p>

Figure 4-54: Sample Location search window

- At the **Clinic** field, select the name of the clinic. This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table. Change this field by clicking the drop-down list to access the **Clinic** search window.

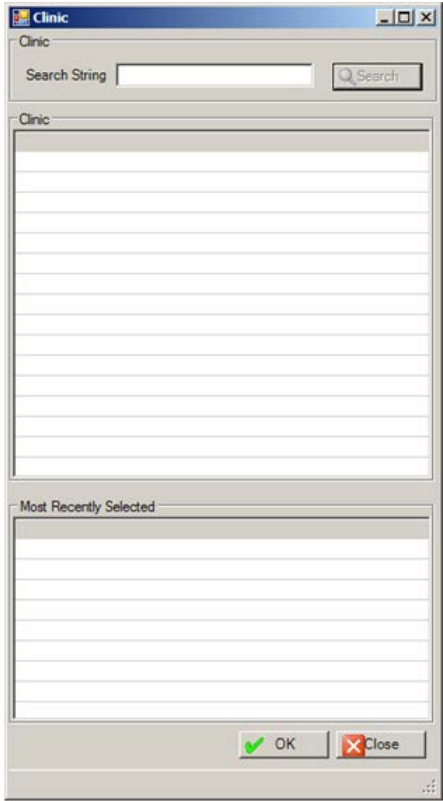
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the clinic and then clicking Search. The retrieved clinics and their codes will populate the Clinic list box. Select a clinic and click OK to populate the Clinic field. (Otherwise, click Close.)</p> <p>(2) Select a clinic in the Most Recently Selected list box and click OK to populate the Clinic field. (Otherwise, click Close.)</p>

Figure 4-55: Sample Clinic search window

6. At the **Appointment or Walk-In** field, select the type of visit form the drop-down list. Use one of the following:

Appointment

Walk In

Unspecified (for non-patient contact)

7. At the **Type of Contact** field, type the contract type (the activity setting). Click the drop-down list to access the **Type of Contact** window.


Screen Capture	What to do																																		
 <p>The screenshot shows a window titled "Type of Contact" with a table listing various contact types and their corresponding codes. The table has two columns: "Type of Contact" and "Code".</p> <table border="1" data-bbox="332 283 771 945"> <thead> <tr> <th>Type of Contact</th> <th>Code</th> </tr> </thead> <tbody> <tr><td>ADMINISTRATIVE</td><td>1</td></tr> <tr><td>AFTERCARE</td><td>12</td></tr> <tr><td>CHART REVIEW</td><td>7</td></tr> <tr><td>CONSULTATION</td><td>10</td></tr> <tr><td>DAY PROGRAM</td><td>13</td></tr> <tr><td>EMERGENCY ROOM</td><td>9</td></tr> <tr><td>FIELD</td><td>4</td></tr> <tr><td>HOME</td><td>5</td></tr> <tr><td>INPATIENT</td><td>3</td></tr> <tr><td>INTENSIVE OUTPATIENT</td><td>16</td></tr> <tr><td>JAIL</td><td>14</td></tr> <tr><td>OUTPATIENT</td><td>2</td></tr> <tr><td>RESIDENTIAL</td><td>11</td></tr> <tr><td>SCHOOL</td><td>6</td></tr> <tr><td>TELE-BEHAVIORAL HEALTH</td><td>15</td></tr> <tr><td>TELEPHONE</td><td>8</td></tr> </tbody> </table> <p>At the bottom of the window, there are two buttons: "OK" (with a green checkmark icon) and "Close" (with a red X icon).</p>	Type of Contact	Code	ADMINISTRATIVE	1	AFTERCARE	12	CHART REVIEW	7	CONSULTATION	10	DAY PROGRAM	13	EMERGENCY ROOM	9	FIELD	4	HOME	5	INPATIENT	3	INTENSIVE OUTPATIENT	16	JAIL	14	OUTPATIENT	2	RESIDENTIAL	11	SCHOOL	6	TELE-BEHAVIORAL HEALTH	15	TELEPHONE	8	<p>Use this window as follows:</p> <ol style="list-style-type: none"> (1) Select a type of contact from the list. (2) Click OK to populate the “Type of Contact” field. (Otherwise, click Close.)
Type of Contact	Code																																		
ADMINISTRATIVE	1																																		
AFTERCARE	12																																		
CHART REVIEW	7																																		
CONSULTATION	10																																		
DAY PROGRAM	13																																		
EMERGENCY ROOM	9																																		
FIELD	4																																		
HOME	5																																		
INPATIENT	3																																		
INTENSIVE OUTPATIENT	16																																		
JAIL	14																																		
OUTPATIENT	2																																		
RESIDENTIAL	11																																		
SCHOOL	6																																		
TELE-BEHAVIORAL HEALTH	15																																		
TELEPHONE	8																																		

Figure 4-56: Sample Type of Contact window

8. At the **Community of Service** field, type the name of the community of service where the encounter took place. Change this field by clicking the drop-down list to access the **Community** search window.

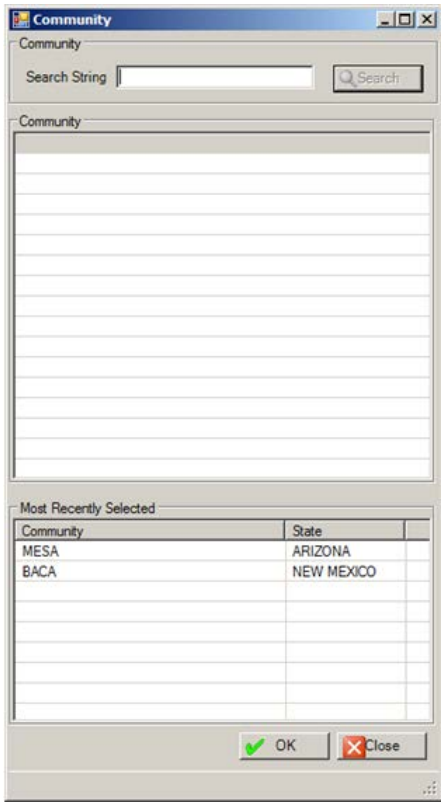
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the community name and then clicking Search. The retrieved community names and their states will populate the Community list box. Select a community and click OK to populate the Community of Service field. (Otherwise, click Close.)</p> <p>(2) Select a community in the Most Recently Selected list box and click OK to populate the Community of Service field. (Otherwise, click Close.)</p>

Figure 4-57: Sample Community search window

4.5.2 POV Tab

Use the **POV** tab to add, edit, or delete the **Purpose of Visit (POV)** for the encounter.

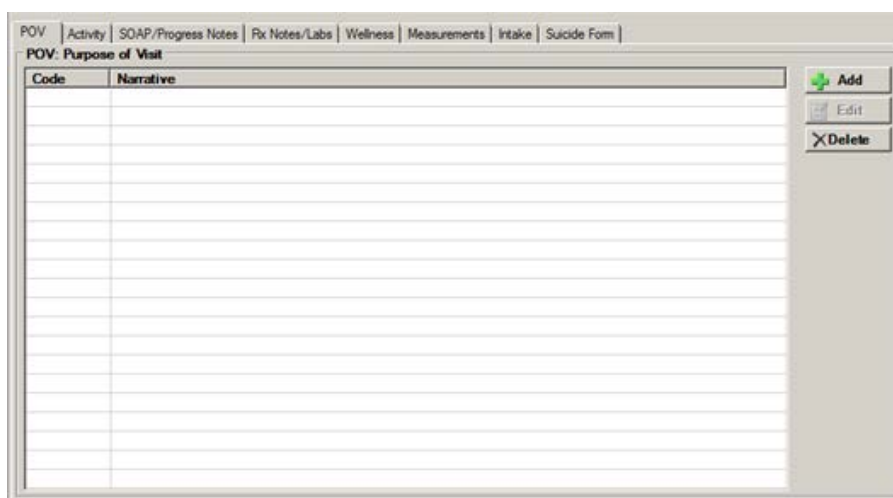


Figure 4-58: Sample POV Tab on Visit Data Entry window

You can add, edit, or delete POV records on this window.

Add Button

1. Click **Add**.
2. The **POV** search/select window displays.

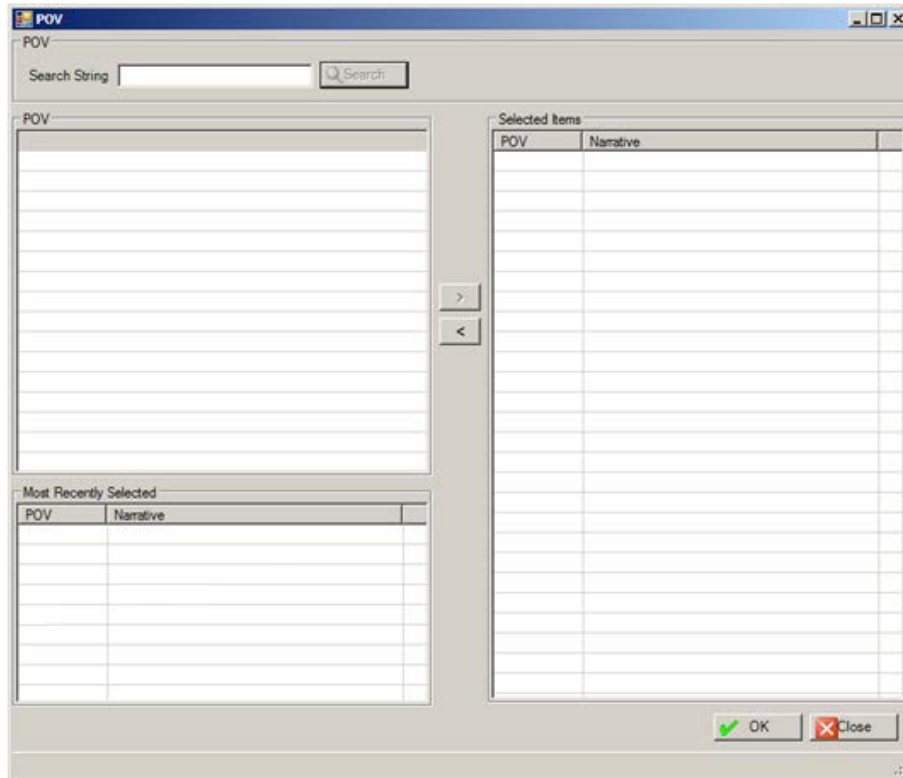


Figure 4-59: Sample POV search/select window

1. At the **Search String** field, type a few characters of the search criteria.
2. Click **Search** and the retrieved records display in **POV** list box (the POV and its narrative).
3. To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the right-pointing arrow button.
4. In addition, select one or more items in the **Most Recently Search** list box and click the right-pointing arrow button. This adds those records to the **Selected Items** list box.
5. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
6. When the records in the **Selected Item** list box is complete, click **OK** and the records populate the **POV** tab. (Otherwise, click **Close**.)

Delete Button

1. Select the POV record to delete.
2. Click the **Delete**.
3. The **Are You Sure** confirmation message, click **Yes** to remove the selected record from the list box. (Otherwise, click **No**.)

Edit Button

1. Select a POV record to edit.
2. Click **Edit**.
3. The application displays the **Edit POV** dialog box

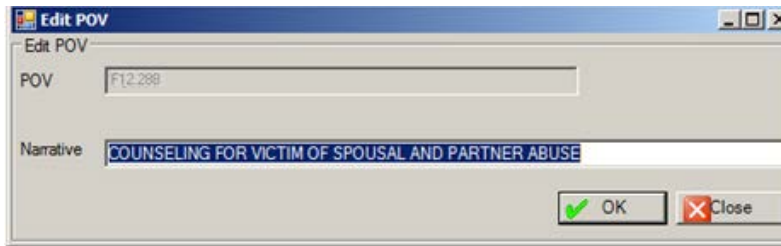


Figure 4-60: Edit POV dialog box

- a. At the **Narrative** field, type the new POV narrative, using 2–80 characters. This is a Free Text field.
- b. Click **OK** to save the change the narrative of the selected code on the POV tab. (Otherwise, click **Close**.)

4.5.3 Activity Tab

Use the **Activity** tab to manage Activity data about the visit for the current patient.

POV | Activity | SOAP/Progress Notes | Rx Notes/Labs | Wellness | Measurements | Intake | Suicide Form

Activity

Activity HEALTH PROMOTION **Activity Time** 10

Visit Flag Local Service Site

Interpreter Utilized? **Number Served** 1

CPT Code(s)

Code	Narrative	Quant	Mod 1	Mod 2	

Secondary Providers for this Visit

Provider	

Figure 4-61: Sample Activity Tab on the Visit Data Entry window

Activity Group Box

Below is the **Activity** group box.

Activity

Activity **Activity Time**

Visit Flag Local Service Site

Interpreter Utilized? **Number Served**

Figure 4-62: Sample Activity group box

The fields in bold text are required.

1. At the **Activity** field, select the activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Click the drop-down list to access the **Activity** search window. Here you search for the activity name. Section Appendix A: provides more information about the Activity Codes and Definitions.

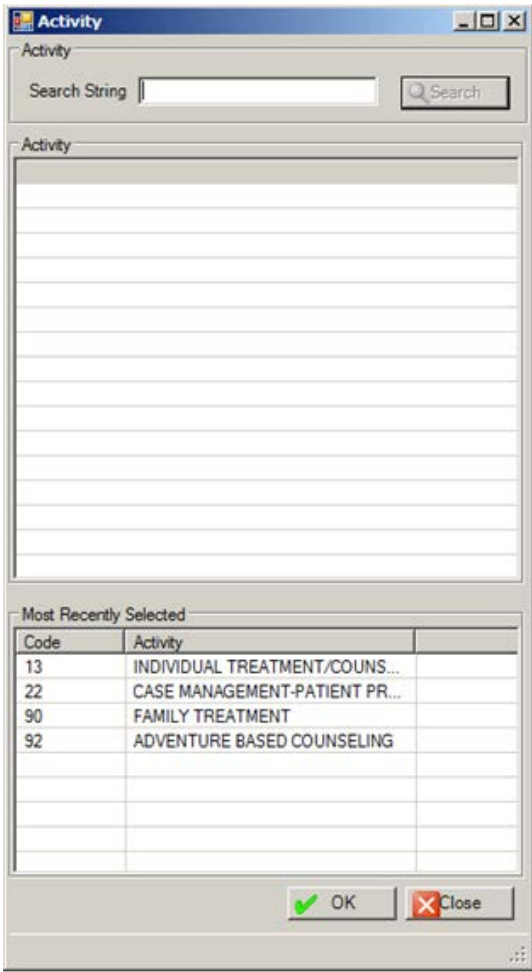
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the activity name and then clicking Search. The retrieved activity code and activity name will populate the Activity list box. Select a retrieved record and click OK to populate the Activity field. (Otherwise, click Close.)</p> <p>(2) Select an activity record in the Most Recently Selected list box and click OK to populate the Activity field. (Otherwise, click Close.)</p>

Figure 4-63: Sample Activity search window

2. At the **Activity Time** field, type the activity time, using any number between 1 and 9999 (no decimal digits). The understood units of measure are minutes. This required field determines how much provider time was involved in providing and documenting the service or performing the activity.
3. At the **Visit Flag** field, type the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.
4. At the **Local Service Site** field, select the local service site. Click the drop-down list to access the **Local Service Site** window.

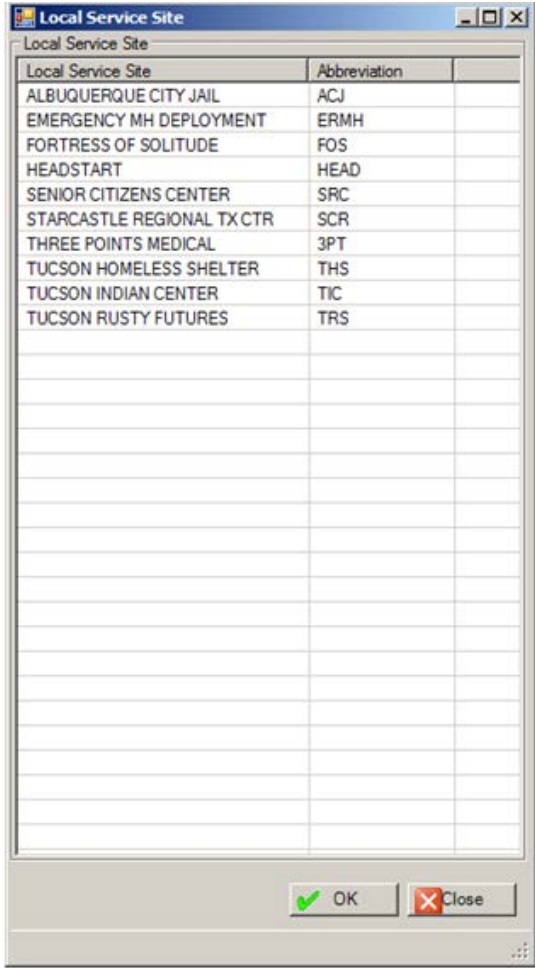
Screen Capture	What to do
	<p>Use this dialog box in one of two ways:</p> <p>(1) Select a local service site from the list.</p> <p>(2) Click OK to populate the “Local Service Site” field. (Otherwise, click Close.)</p>

Figure 4-64: Sample Local Service Site window

5. At the **Interpreter Utilized?** field, select this check box if an interpreter is required to communicate with the patient.
6. At the **Number Served** field, type the number served, using any number between 1 and 9999 (no decimal digits). The default is 1. This required field refers to the number of people directly served during a given activity and always is used for direct patient care as well as for administrative activities. Group activities or family counseling are examples where other numbers might be listed.

CPT Codes Group Box

Use the CPT Codes group box to manage the CPT codes used during the encounter.

You can add or delete records in this group box.

Delete Button

1. Select a CPT code record to delete.
2. Click **Delete**.
3. At the **Are you sure you want to delete?** confirmation message, click **Yes** to delete the record. (Otherwise, click **No**.)

Add Button

1. Click **Add**.
2. The **CPT Code** search/select window displays.

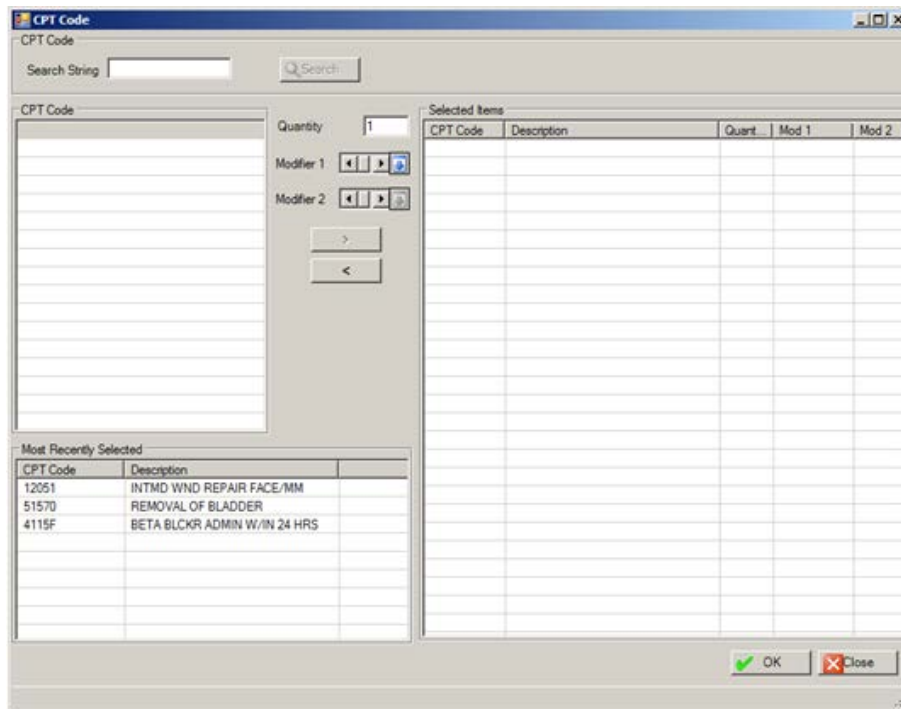


Figure 4-65: Sample CPT Codes search/select window

3. At the **Search String** field, type a search string to search for a particular CPT code. Then click **Search**. The CPT codes that match the search criteria will display in the **CPT Code** field.

CPT Code

Search String

CPT Code	Description	Quantity
45000	DRAINAGE OF PELVK	1
45005	DRAINAGE OF RECT	
4500F	REF TO OUTPT CARL	
45020	DRAINAGE OF RECT	
45100	BIOPSY OF RECTUM	
45108	REMOVAL OF ANORE	
4510F	PREV CARDREHAB G	
45110	REMOVAL OF RECTU	
45111	PARTIAL REMOVAL C	
45112	REMOVAL OF RECTU	
45113	PARTIAL PROCTECTI	
45114	PARTIAL REMOVAL C	
45116	PARTIAL REMOVAL C	
45119	REMOVE RECTUM W	
45120	REMOVAL OF RECTU	

Quantity

Modifier 1

Modifier 2

>

<

Figure 4-66: Sample CPT Code search results

- Select a retrieved CPT Code.
- At the **Quantity** field, type the number of CPT codes to use to help facilitate billing.
- At the **Modifier** field, select the modifier for the CPT code. Click the drop-down list to access the **CPT Modifier** search window.

Screen Capture	What to do				
<p>CPT Modifier</p> <p>Search String <input type="text"/> <input type="button" value="Search"/></p> <p>CPT Modifier</p> <table border="1"> <thead> <tr> <th>CPT Modifier</th> <th>Description</th> </tr> </thead> <tbody> <tr><td>UN</td><td>TWO PATIENTS SERVED</td></tr> </tbody> </table> <p>Most Recently Selected</p> <p>OK Close</p>	CPT Modifier	Description	UN	TWO PATIENTS SERVED	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the CPT Modifier name and then clicking Search. The retrieved CPT Modifier names and their descriptions will populate the CPT Modifier list box. Select a CPT modifier and click OK to save the modifier. (Otherwise, click Close.)</p> <p>(2) Select a CPT modifier in the Most Recently Selected list box and click OK to save the modifier. (Otherwise, click Close.)</p>
CPT Modifier	Description				
UN	TWO PATIENTS SERVED				

Figure 4-67: Sample CPT Modifier search window

4. After the **Quantity** and **Modifier** fields are complete, click the right-pointing arrow to add the items to the **Selected Items** list box.

More than one CPT Code can be used in the above process.

5. Another way to populate the **Selected Items** list box is to select a CPT code in the **Most Recently Selected** list box and then click the right-pointing arrow.
6. Remove a selected CPT code in the **Selected Items** list box by clicking the left-pointing arrow.
7. When the Selected Items list box is complete, click **OK** to save the data and add it to the CPT Code(s) group box. (Otherwise, click **Close**.)

Secondary Provides for this Visit Group Box

Use the **Secondary Providers for this Visit** group box to manage the secondary providers used during the encounter.

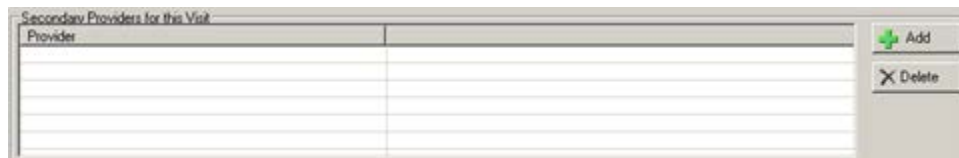


Figure 4-68: Sample Secondary Providers for this Visit group box

You can add or delete records on the **Secondary Provider** group box.

Add Button

1. Click **Add**.
2. The **Secondary Providers** multiple search/select window displays.

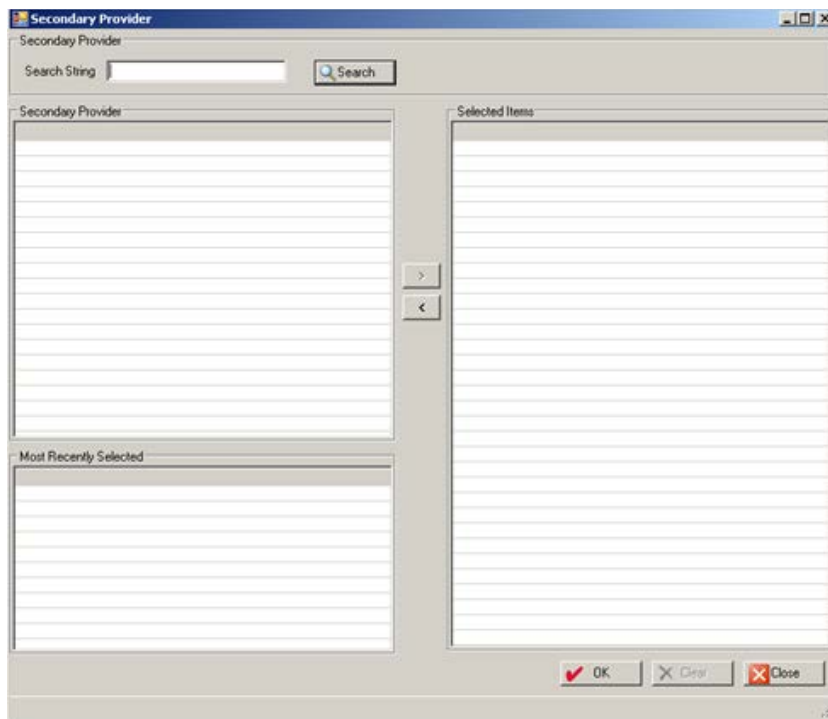


Figure 4-69: Sample Secondary Provider multiple search/select window

3. At the **Search String** field, type a few characters of the Secondary Provider's last name.
4. Click **Search** and the retrieved records display in **Secondary Provider** list box.
5. To add one or more selected records from the **Secondary Providers** list box to the **Selected Items** list box, click the right-pointing arrow button.
6. To add one or more selected records from the **Most Recently Selected** list box to the **Selected Items** list box, click the right-pointing arrow button.
7. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
8. When the Selected Items list box is complete, click **OK** and these items populate the **Secondary Providers** for this **Visit** group box. (Otherwise, click **Close**.)

Delete Button

1. Select the provider record to delete.
2. Click **Delete**.
3. At the **Are You Sure** confirmation message, click **Yes** to remove the selected provider from the **Secondary Providers** for this **Visit** group box. (Otherwise, click **No**.)

4.5.4 SOAP/Progress Notes Tab

Use the **SOAP/Progress Notes** tab on the **Visit Data Entry** window to manage the SOAP/progress note associated with the current visit, to enter the chief complaint/pressing problem, and to enter any comments about the next appointment.

Figure 4-70: Sample SOAP/Progress Notes tab

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

1. At the **Chief Complaint/Presenting Problem** field, type the chief complaint or presenting problem using 2 to 80 characters in length. This is a Free Text field that describes the major reason the patient sought services.
2. At the **Progress Notes** field, type the text of the progress note for the visit. A SOAP or progress note must be entered in the context of a visit. This is a Free Text field.
3. At the **Comments/Next Appointment** field, type the text of any additional notes or comments about the client's next appointment. This is a Free Text field.
4. At the "Placement Disposition" field, select the placement disposition.

Use this field when hospitalization or placement in a treatment facility is required. Click the drop-down list to access the **Placement Disposition** dialog box.

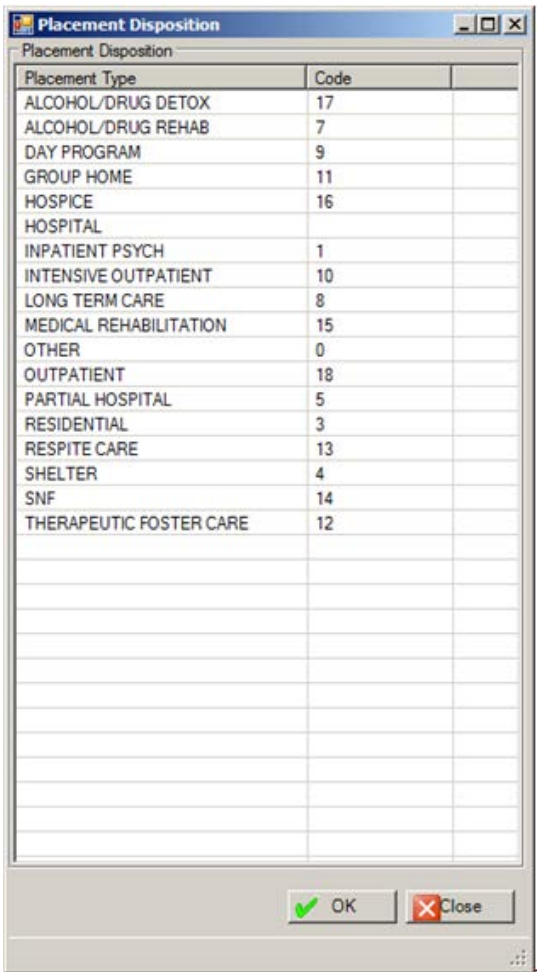
Screen Capture	What to do																																						
 <table border="1"> <thead> <tr> <th>Placement Type</th> <th>Code</th> </tr> </thead> <tbody> <tr><td>ALCOHOL/DRUG DETOX</td><td>17</td></tr> <tr><td>ALCOHOL/DRUG REHAB</td><td>7</td></tr> <tr><td>DAY PROGRAM</td><td>9</td></tr> <tr><td>GROUP HOME</td><td>11</td></tr> <tr><td>HOSPICE</td><td>16</td></tr> <tr><td>HOSPITAL</td><td></td></tr> <tr><td>INPATIENT PSYCH</td><td>1</td></tr> <tr><td>INTENSIVE OUTPATIENT</td><td>10</td></tr> <tr><td>LONG TERM CARE</td><td>8</td></tr> <tr><td>MEDICAL REHABILITATION</td><td>15</td></tr> <tr><td>OTHER</td><td>0</td></tr> <tr><td>OUTPATIENT</td><td>18</td></tr> <tr><td>PARTIAL HOSPITAL</td><td>5</td></tr> <tr><td>RESIDENTIAL</td><td>3</td></tr> <tr><td>RESPITE CARE</td><td>13</td></tr> <tr><td>SHELTER</td><td>4</td></tr> <tr><td>SNF</td><td>14</td></tr> <tr><td>THERAPEUTIC FOSTER CARE</td><td>12</td></tr> </tbody> </table>	Placement Type	Code	ALCOHOL/DRUG DETOX	17	ALCOHOL/DRUG REHAB	7	DAY PROGRAM	9	GROUP HOME	11	HOSPICE	16	HOSPITAL		INPATIENT PSYCH	1	INTENSIVE OUTPATIENT	10	LONG TERM CARE	8	MEDICAL REHABILITATION	15	OTHER	0	OUTPATIENT	18	PARTIAL HOSPITAL	5	RESIDENTIAL	3	RESPITE CARE	13	SHELTER	4	SNF	14	THERAPEUTIC FOSTER CARE	12	<p>Use this dialog box in one of two ways:</p> <ol style="list-style-type: none"> (1) Select a Placement Type. (2) Click OK to populate Placement Disposition field. (Otherwise, click Close.)
Placement Type	Code																																						
ALCOHOL/DRUG DETOX	17																																						
ALCOHOL/DRUG REHAB	7																																						
DAY PROGRAM	9																																						
GROUP HOME	11																																						
HOSPICE	16																																						
HOSPITAL																																							
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LONG TERM CARE	8																																						
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OTHER	0																																						
OUTPATIENT	18																																						
PARTIAL HOSPITAL	5																																						
RESIDENTIAL	3																																						
RESPITE CARE	13																																						
SHELTER	4																																						
SNF	14																																						
THERAPEUTIC FOSTER CARE	12																																						

Figure 4-71: Sample Placement Disposition dialog box

5. At the **Placement Name** field, type the name of the placement facility.

4.5.5 Rx Notes/Labs Tab

Use the **Rx Notes** tab to view prescription data or lab tests data.

Visit Date	Medication	SIG	Qty	Days	Provider
04/18/2013@1200	AMOXICILLIN 250MG CAPSULE	TAKE ONE...	90	30	RICHARD S.

Figure 4-72: Sample Rx Notes/Labs tab

The **Rx/Labs** group box controls what is displayed on the right side of the tab.

RX Data

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

PCC Medications List Box

Use the **PCC Medications** list box to view PCC medications prescribed for the current patient. The entire medication history might not be present here.

Behavioral Medication List Box

Use the **Behavioral Medication** list box to view the visit dates when behavioral health medication was prescribed and any associated notes.

Prescription Entry Field

Use the **Prescription Entry** field to type information about the patient's prescriptions. This is a Free Text field. This field has a context menu that lets you cut, copy, or paste data (these functions are like the ones in MS Office).

This information will be viewable in the Medications field for future visits. Items in the Medication field can be copied and pasted into the Prescription Entry field. This feature is used by some sites to record notes for the psychiatrist such as doing a pill count with the patient, whether or not the patient is compliant with meds, etc.

PCC Labs

When the **PCC Labs** is selected in the **Rx/Labs** group box, you can select what you want to view about the PCC Labs: **View by Visit**, **View by Lab Test**, or **Graph**.

View by Visit Date

If you select the **View by Visit Date** option, you access the **View Labs by Visit Date** dialog box.



Figure 4-73: Sample View Labs by Visit Date dialog box

The **View Labs by Visit Date** dialog box has the following features:

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

You can edit either or both dates.

1. At the **Begin Date** field, select the beginning date of the date range by clicking the drop-down list to select a date from the calendar.
2. At the **End Date** field, select the ending date of the date range by clicking the drop-down list to select a date from the calendar.
3. When this dialog box is complete, click **OK** and the first page of the PCC labs for the patient by visit date within the particular date range pop-up window. (Otherwise, click **Close**.) Section 2.6 provides more information about the controls on the pop-up window.

This same functionality is available on the tree structure for the RPMS Behavioral Health System (GUI).

View by Lab Test

If you select the **View by Lab Test** option, you access the **View Labs by Lab Test** dialog box.



Figure 4-74: Sample View Labs by Lab Test dialog box

The **View Labs by Lab Test** dialog box has the following features:

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

You can edit either or both dates.

1. At the **Begin Date** field, select the beginning date of the date range by clicking the drop-down list to select a date from the calendar.
2. At the **End Date** field, select the ending date of the date range by clicking the drop-down list to select a date from the calendar.
3. When this dialog box is complete, click **OK** and the application displays the first page of the PCC labs by lab test for the patient within the particular date range pop-up window. (Otherwise, click **Close**). Section 2.6 provides more information about the controls on the pop-up window.

This same function is available on the tree structure for the RPMS Behavioral Health System (GUI).

Graph

If you select the **Graph** option, the right side of the tab changes to two boxes: **Lab Graph Date Range** and **Graphable Lab Tests**.

When you first access the **Wellness** tab, the application displays a tree structure.



Figure 4-78: Sample Wellness tab

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

Patient Education

1. Select the **Patient Education** option on the Wellness tree structure to display the patient education list boxes: **Patient Education History** and **Patient Education Data Entry**.

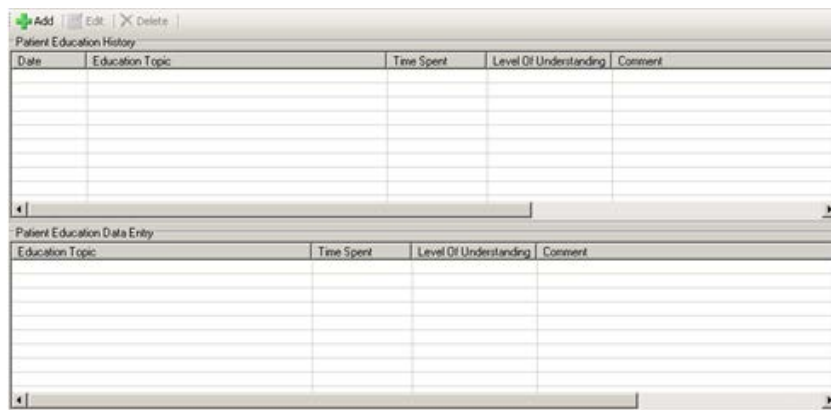


Figure 4-79: Sample Patient Education group boxes

The **Patient Education History** list box is read-only. Scroll through the data using the scroll bar.

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

Add/Edit Patient Education Record

The **Add** and **Edit** function use the same fields.

1. Click **Add** to add an education record.

OR

2. Select an education record to edit and click **Edit**.
3. The **Education Topic** select window displays.

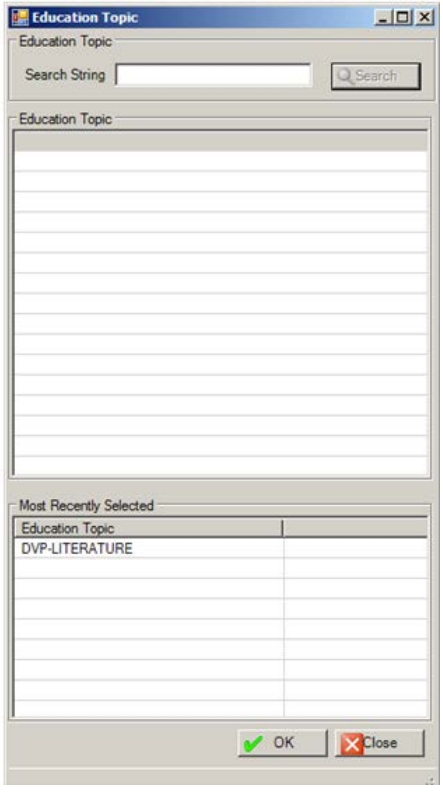
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the education topic and then clicking Search. The retrieved education topics will populate the Education Topic list box. Select a retrieved record and click OK. (Otherwise, click Close.)</p> <p>(2) Select an education topic in the Most Recently Selected list box, click OK. (Otherwise, click Close.)</p>

Figure 4-80: Sample Education Topic select window

If **Close** was used, the application displays the Continue warning that asks: Canceling will lose all unsaved data, Continue? Click **Yes** and the focus returns to the **Patient Education Data Entry** group box. Click **No** to display the **Patient Education** dialog box with no data in the fields.

If **OK** was used, the **Patient Education** dialog box displays, with the **Education Topic** field populated.

Figure 4-81: Sample Patient Education dialog box

The fields in bold text are required.

- At the **Education Topic** field, determine if you want to change the field. The application populates this field with what was selected on the Education Topic select window. To change this selection, click the drop-down list to access the **Education Topic** search window.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <ol style="list-style-type: none"> Use the Search String field by typing the education topic and then clicking Search. The retrieved education topics will populate the Education Topic list box. Select a retrieved record and click OK to populate the Education Topic field. (Otherwise, click Close.) Select an education topic in the Most Recently Selected list box and click OK to populate the Education Topic field. (Otherwise, click Close.)

Figure 4-82: Sample Education Topic select window

- At the **Time** field, type the number of minutes spent on the education topic, using any integer 1 - 9999.

6. At the **Goal** field, type text of the stated goal of the education. For example, Patient plans to walk 6 times a week.
7. At the **Status** field, select the status of the education goal. Use one of the following:
 - Goal Set (the preparation phase defined as “patient ready to change” (patient is active))
 - Goal Met (the action phase defined as “patient actively making the change” or maintenance phase defined as “patient is sustaining the behavior change”)
 - Goal Not Met (the contemplation phase defined as “patient is unsure about the change” or relapse when the patient started making the change and did not succeed due to ambivalence or other reason)
 - Goal Not Set (the pre-contemplation phase defined as “patient is not thinking about change”)
8. At the **Readiness to Learn** field, select the Readiness to Learn option. Click the drop-down list to display the **Readiness to Learn** select window.

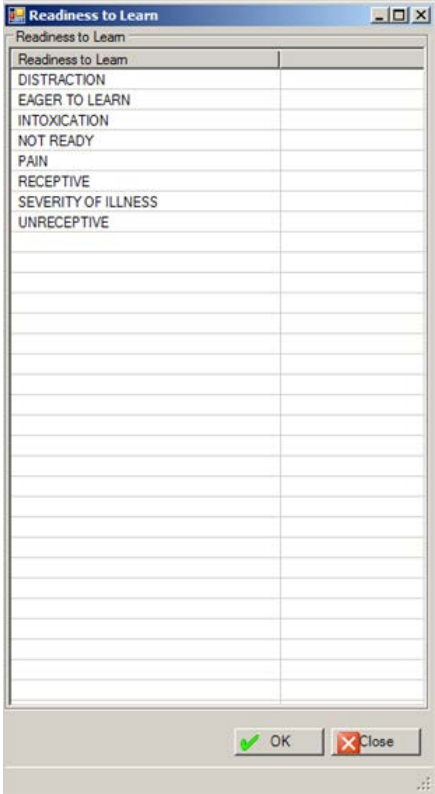
Screen Capture	What to do
	<p>Use this window as follows:</p> <ol style="list-style-type: none"> (1) Select a readiness to learn option. (2) Click OK to add the option to the Readiness to Learn field. (Otherwise, click Close.)

Figure 4-83: Sample Readiness to Learn select window

9. At the **Level of Understanding** field, select the level of understanding. Use one of the following:
- Poor (does not verbalize understanding; unable to return demonstration or teach-back correctly)
 - Fair (verbalizes need for more education; incomplete return demonstration or teach-back indicates partial understanding)
 - Good (verbalizes understanding; able to return demonstration or teach-back correctly)
 - Group No Assessment (education provided in group; unable to evaluate individual response)
 - Refused (refuses education)
10. At the **Provider** field, select the provider for the patient education. Click the drop-down list to display the **Education Provider** select window.

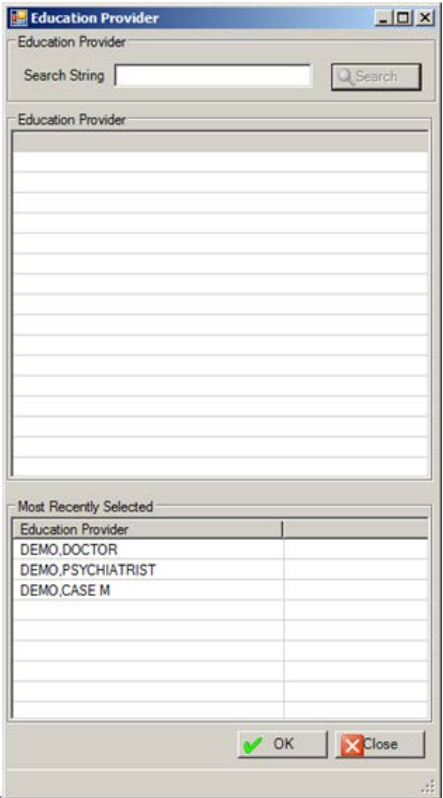
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the last name of the education provider and then clicking Search. The retrieved provider names will populate the Education Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 4-84: Sample Education Provider select window

11. At the **Comment** field, type any comments about the education topic for the visit. This is a Free Text field.

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

The **Health Factors History** list box is read-only. Scroll through the data using the scroll bar.

You can add/edit data in the **Health Factors Data Entry** list box by using the **Add**, **Edit**, or **Delete** button.

Add/Edit Health Factor Record

The **Add** and **Edit** function use the same fields.

1. Click **Add** to add a record.

OR

2. Select a record to edit and click **Edit**.
3. The **Health Factors** search window displays.

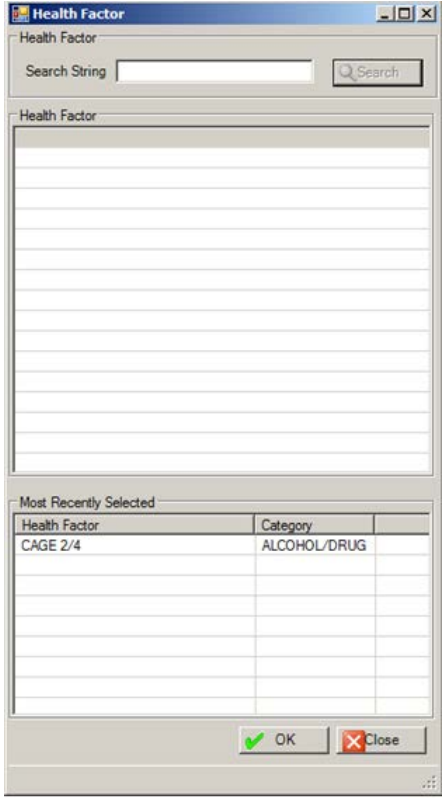
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the health factor and then clicking Search. The retrieved health factors will populate the Health Factor list box. Select a retrieved record and click OK to populate the Health Factor field on the Health Factors dialog box. (Otherwise, click Close.)</p> <p>(2) Select an education provider name in the Most Recently Selected list box and click OK to populate the Health Factor field on the Health Factors dialog box. (Otherwise, click Close.)</p>

Figure 4-86: Sample Health Factor search window

The **Health Factors** dialog box is shown below.

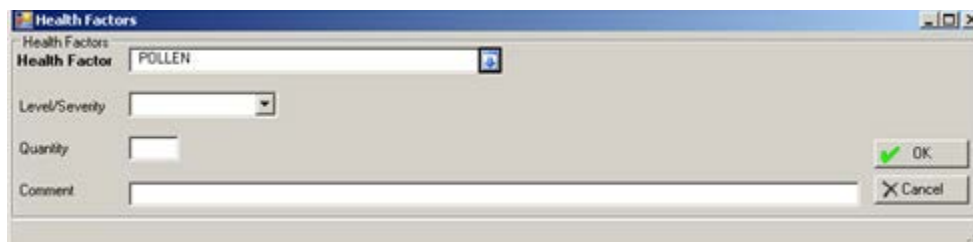


Figure 4-87: Sample Health Factors dialog box

The fields in bold text are required.

4. At the **Health Factor** field, determine if you want to change the field. The application populates this field with what was selected on the **Health Factors** select window. To change this selection, click the drop-down list to access the **Health Factor** search window. Refer to Step 2 above for more information about this window.
5. At the **Level/Severity** field, select an option from the drop-down list, if applicable:
 - Minimal**
 - Moderate**
 - Heavy/Severe**
6. At the **Quantity** field, type the quantity associated with the health factor, if any.
7. At the **Comment** field, type the text of any comment for clarification about the documented health factor. This is a Free Text field.
8. After the dialog box is complete, click **OK** (otherwise, click **Cancel**).

If **OK** was used, the application saves your data and displays it on the Health Factors Data Entry grid.

If **Cancel** was used, the application displays the **Continue?** dialog box that states: Canceling will lose all unsaved data, Continue? Click **Yes** to not save and leave the **Health Factors** dialog box. Click **No** and the focus returns to the **Health Factors** dialog box.

When editing a record, after the dialog box is complete, click **OK** to change the selected record (otherwise, click **Cancel**).

Delete Health Factor Record

1. Select a record in the Health Factors Data Entry grid to delete.

2. Click **Delete**.
3. The application displays the “Are You Sure” warning message; click **Yes** to delete the selected record. (Otherwise, click **No**.)

Screening

Select the **Screening** option on the Wellness tree structure to display the screening list boxes: **Screening History** and **Screening Data Entry**.

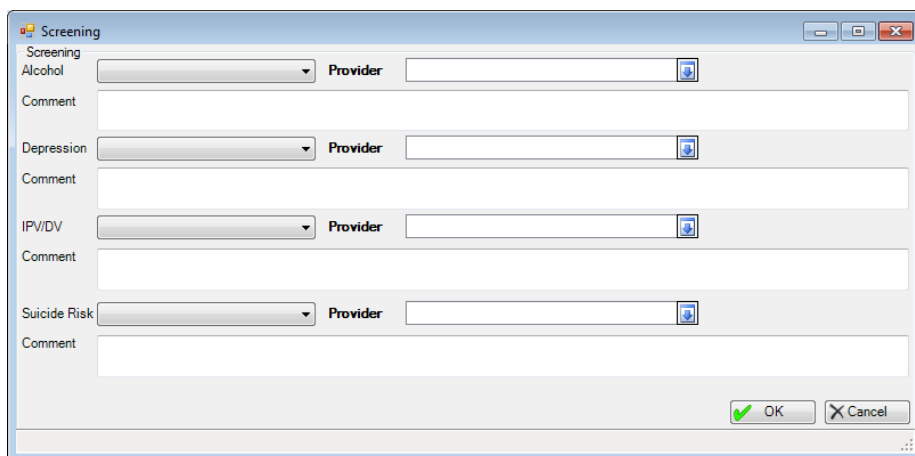
The screenshot shows two stacked data entry windows. The top window, titled 'Screening History', has a header with a green plus icon and the word 'Add'. Below the header is a table with five columns: 'Date', 'Alcohol', 'Alcohol Provider', 'Alcohol Comment', and 'Depres'. The table is currently empty. The bottom window, titled 'Screening Data Entry', has a table with four columns: 'Alcohol', 'Alcohol Comment', 'Depression', and 'Depression Comment'. This table is also empty. Both windows have horizontal scroll bars at the bottom.

Figure 4-88: Sample Screening group boxes

The **Screening History** list box is read-only. Scroll through the data using the scroll bar.

- If the **Screening Data Entry** list box is empty, then the **Add** button displays.
- If the **Screening Data Entry** list box is populated, then the **Edit** button displays. You can edit a selected record by clicking the **Edit** button.

In either case, the **Screening** dialog box displays.



The screenshot shows a 'Screening' dialog box with the following fields:

- Alcohol**: A dropdown menu for the screening outcome, a 'Provider' label, and a dropdown menu for the provider name. Below it is a 'Comment' text area.
- Depression**: A dropdown menu for the screening outcome, a 'Provider' label, and a dropdown menu for the provider name. Below it is a 'Comment' text area.
- IPV/DV**: A dropdown menu for the screening outcome, a 'Provider' label, and a dropdown menu for the provider name. Below it is a 'Comment' text area.
- Suicide Risk**: A dropdown menu for the screening outcome, a 'Provider' label, and a dropdown menu for the provider name. Below it is a 'Comment' text area.

At the bottom right of the dialog box, there are 'OK' and 'Cancel' buttons.

Figure 4-89: Screening dialog box

1. At the **Alcohol** field, select the outcome of the alcohol screening. Use one of the following:
 - Negative (patient's screening does not indicate risky alcohol use)
 - Positive (patient's screening indicates risky alcohol use)
 - Unable to screen (provider unable to conduct the screening)
 - Patient Refused Screening (patient declined exam or screening)
 - Referral Needed
2. At the **Provider** field, select the name of the provider for the alcohol screening. Click the drop-down list and select another one from the **Alcohol Provider** search window, if needed.

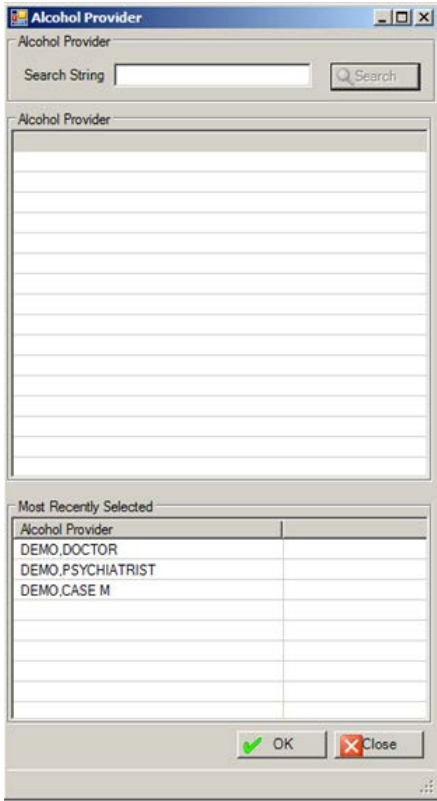
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the last name of the provider and then clicking Search. The retrieved providers will populate the Alcohol Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 4-90: Sample Alcohol Provider search window

3. At the **Comment** field, type the text of any comment related to the alcohol screening, using 2–245 characters.
4. At the **Depression** field, select the outcome of the depression screening. Use one of the following:
 - Negative (denies symptoms of depression)
 - Positive (provides positive answers to depression screening; further evaluation is warranted)
 - Unable to screen (provider unable to conduct the screening)
 - Patient Refused Screening (patient declines exam or screening)
 - Referral Needed
5. At the **Provider** field, select the name of the provider for the depression screening. Click the drop-down list and select another one from the **Depression Provider** search window, if needed.

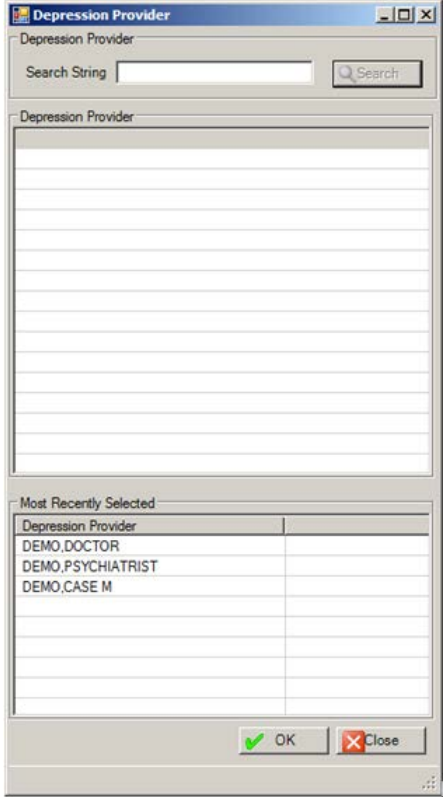
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the last name of the provider and then clicking Search. The retrieved providers will populate the Depression Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 4-91: Sample Depression Provider search window

6. At the **Comment** field, type the text of any comment related to the depression screening, using 2–245 characters.
7. At the **IPV/DV** field, select the intimate partner violence/domestic violence screening. Use one of the following:
 - Negative (denies being a current victim of domestic violence)
 - Present (admits being a victim of domestic violence)
 - Past and Present
 - Past (denies being a current victim but discloses being a past victim of domestic violence)
 - Unable to screen (unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.))
 - Patient Refused Screening (patient declined exam or screening)
 - Referral Needed

8. At the **Provider** field, select the name of the provider for the IPV/DV screening. Click the drop-down list and select another one from the **IPV/DV Provider** search window, if needed.

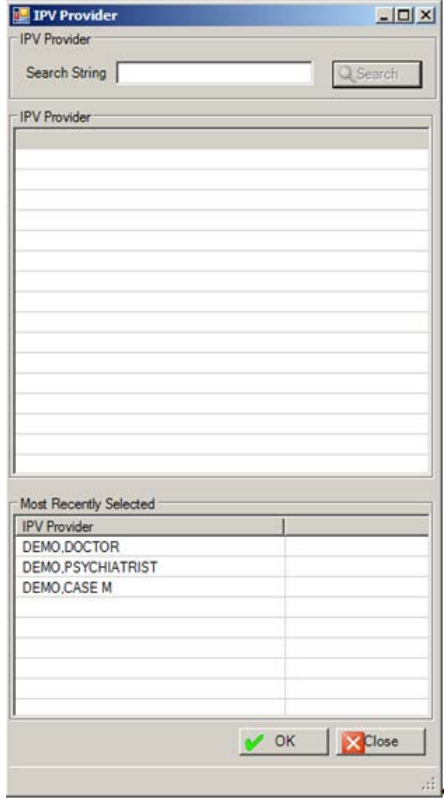
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the last name of the provider and then clicking Search. The retrieved providers will populate the IPV Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 4-92: Sample IPV Provider search window

9. At the **Comment** field, type the text of any comment related to the IPV/DV screening, using 2–245 characters. This is a Free Text field.

After the dialog box is complete, click **OK** (otherwise, click **Cancel**).

If **OK** was used, the application saves your data and displays it on the Screening Data Entry grid.

If **Cancel** was used, the application displays the **Continue?** dialog box that states: Canceling will lose all unsaved data, Continue? Click **Yes** to not save and leave the **Screening** dialog box. Click **No** and the focus returns to the **Screening** dialog box.

4.5.7 Measurements Tab

Use the **Measurements** tab to view existing measurements as well as add, edit, or delete V Measurement data for the current patient visit.

The screenshot shows the 'Measurements' tab in the Behavioral Health System. The window title is 'POV | Activity | SOAP/Progress Notes | Rx Notes/Labs | Wellness | Measurements | Intake | Suicide Form'. The 'Measurement View' section includes a 'Measurement History' table with columns: Date, Measurement, Description, Value, and Provider. The table contains one row: 01/12/2011, AUDIT, AUDIT, 25, DEMO.DOCTOR. Below the table is a 'Measurement Data Entry' section with a table for adding new measurements and buttons for 'Add', 'Edit', and 'Delete'. At the bottom, there are dropdown menus for 'Measurement Type' and 'Provider', and buttons for 'OK' and 'Cancel'.

Figure 4-93: Sample Measurements tab

Measurement View Group Box

This group box displays the measurements for the current patient in the date range shown in the **Measurement History** group box.

The screenshot shows the 'Measurement View' group box. It includes a 'Measurement History' section with a table of data and buttons for 'Display' and 'Graph'. The table contains one row: 01/12/2011, AUDIT, AUDIT, 25, DEMO.DOCTOR.

Figure 4-94: Sample Measurement View group box

Change Date Range

1. At the **Starting Date** field, select a new date. Click the drop-down list to display a calendar where you select another starting date.
2. At the **Ending Date** field, select a new date. Click the drop-down list to display a calendar where you select another ending date.
3. Click **Display** to refresh the record in group box.

Graph

To better utilize the data collected and viewed through the **Measurement View** group box, you can graph a measurement in the grid.

1. Click **Graph**.
2. The **Measurement Type** dialog box displays.

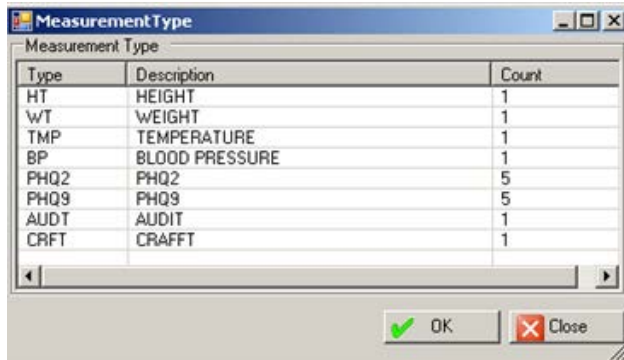


Figure 4-95: Sample Measurement Type dialog box

3. Select the measurement type to graph.
4. Click **OK** to cause the application to (automatically) use the data to display a graph in MS Excel. (Otherwise, click **Close**.)
5. The focus moves to the MS Excel application with the data shown. The data automatically displays in the form of a line graph. You can create a graph of your choice from the selected data.

Below is a sample line graph.

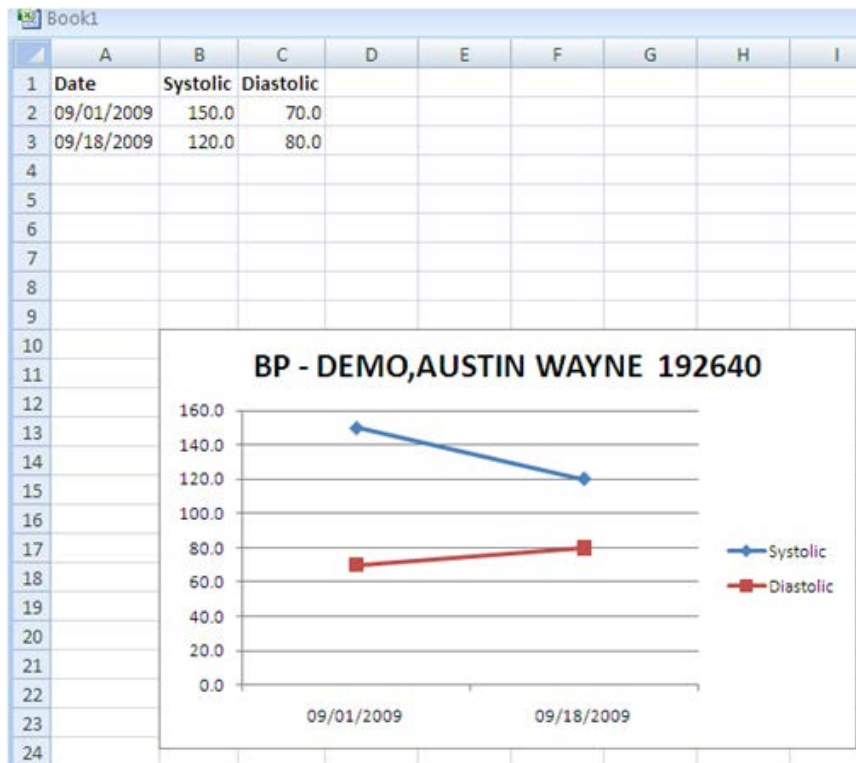


Figure 4-96: Sample line graph

You can save the data, if needed.

Measurement Data Entry Group Box

Use this group box to manage the measurements during the visit.

The screenshot shows the "Measurement Data Entry" group box. It contains a table with the following data:

Measurement	Description	Value	Provider
AUDT	AUDIT	25	DEMO.DOCTOR

Below the table are input fields for "Measurement Type" and "Provider", and a "Value" field. On the right side, there are buttons for "Add", "Edit", "Delete", "OK", and "Cancel".

Figure 4-97: Sample Measurement Data Entry group box

You can add, edit, or delete measurement data entry records.

Delete Button

1. Select the measurement to delete. Measurements can only be deleted from the encounter record where they were first recorded.
2. Click **Delete**.

- At the “Are You Sure” confirmation, click **Yes** to remove the selected measurement record from the Measurement Data Entry group box. (Otherwise, click **No**.)

Add/Edit Button

The **Add** and **Edit** function use the same fields.

- Click **Add** to activate the measurement fields for data entry. The fields in bold text are required.

OR

- Select a record to edit and click **Edit**. The fields are populated with existing data.
- At the **Measurement Type** field, select a V Measurement type. Click the drop-down list to access the **Measurement Type** search window where you select a type.

This field is inactive when editing a record.

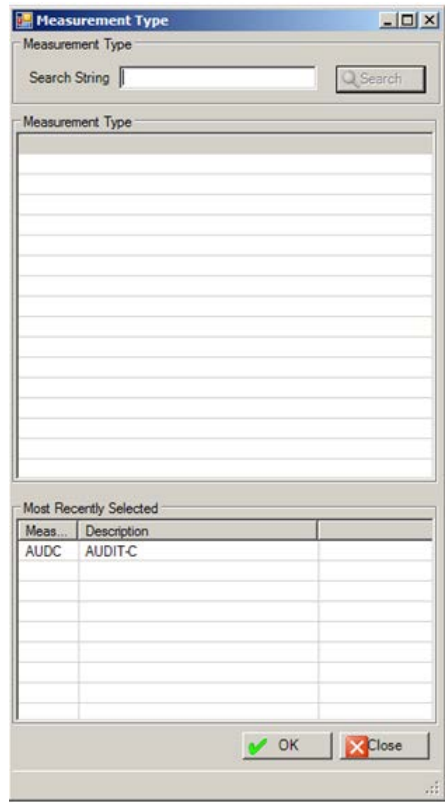
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the measurement type and then clicking Search. The retrieved measurement types will populate the Measurement Type list box. Select a retrieved record and click OK to populate the Measurement Type field. (Otherwise, click Close.)</p> <p>(2) Select a measurement type in the Most Recently Selected list box and click OK to populate the Measurement Type field. (Otherwise, click Close.)</p>

Figure 4-98: Measurement Type select window

4. At the **Value** field, type the numeric value of the measurement.

If the value is outside the accepted range, the **Warning** message displays. Click **OK** to dismiss the warning and populate with another valid numeric value.



Figure 4-99: Sample Value outside the acceptable range warning

5. At the **Provider** field, select the provider who entered the measurement data (the default is the primary provider). Click the drop-down list to access the **Measurement Provider** search window to change this field.

Screen Capture	What to do
A screenshot of the "Measurement Provider" search window. It has a title bar with standard window controls. Below the title bar is a "Search String" input field with a "Search" button. Underneath is a large empty list box labeled "Measurement Provider". At the bottom, there is a "Most Recently Selected" list box containing three entries: "DEMO DOCTOR", "DEMO PSYCHIATRIST", and "DEMO CASE M". At the very bottom are "OK" and "Close" buttons.	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the last name of the provider and then clicking Search. The retrieved provider names will populate the Measurement Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 4-100: Sample Measurement Provider search window

6. Click **OK** on the Measurement Data Entry group box. (Otherwise, click **Cancel**). The OK process causes a new record to display in the grid (showing the Measurement along with its description, value, and provider).

Measurements and Patient Education will print on the Full encounter form only (not on the Suppressed encounter form).

- If **Edit** was used, after changing the fields, click **OK** to change the Value and/or Provider in the grid. (Otherwise, click **Cancel**.)

4.5.8 Intake Tab (GUI)

When you click the **Intake** tab, the **Intake** window displays.

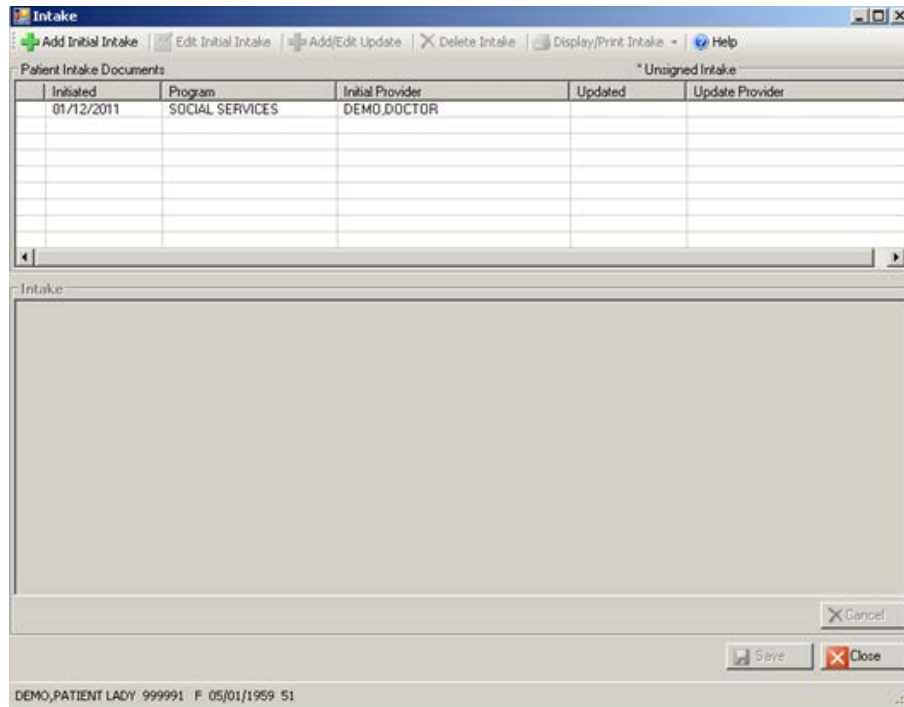


Figure 4-101: Initial Intake window

Section 12.2 provides more information the Intake (GUI).

4.5.9 Suicide Form

When you click the **Suicide Form** tab, the **Suicide Form** window displays. Section 11.2 provides more information about the Suicide Form Window (GUI).

4.5.10 Select PCC Visit Window

You access the PCC Visit window after you have saved and signed a visit and that visit was entered in the scheduling package with the option to create a visit at check-in.

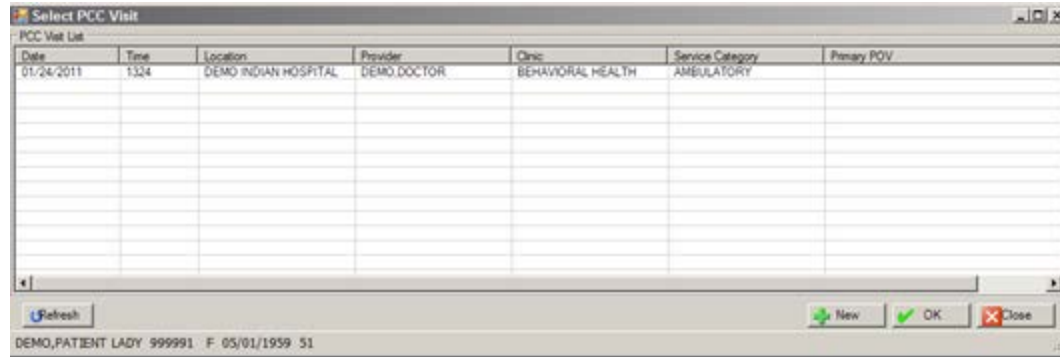


Figure 4-102: Sample Select PCC Visit window

You can do one of the following: either create a new record or link the entry with the one created by the scheduling package (a PCC incomplete visit record).

If you don't think that any displayed visit is the one needed to link to, you can choose a new one or leave it alone until you have had a chance to check in the patient in the Scheduling package.

After checking in the patient in the Scheduling package, you can return to the GUI where you can now click the Refresh button and pull up more visits.

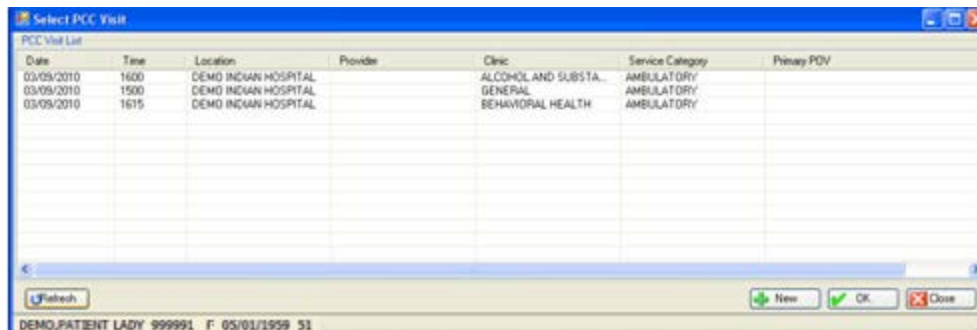


Figure 4-103: Select PCC Visit window with more visits

Then you can highlight the entry you just put in, click **OK** and it will link the two in PCC.

If you access PCC, this is what you will see:

```

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

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: MAR 09, 2010@16:15
DATE VISIT CREATED:   MAR 09, 2010
TYPE:                 IHS
PATIENT NAME:        BETAA,EMILY MAE

```

```

LOC. OF ENCOUNTER:      DEMO INDIAN HOSPITAL
SERVICE CATEGORY:     AMBULATORY
CLINIC:                BEHAVIORAL HEALTH
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:   MAR 09, 2010
WALK IN/APPT:        WALK IN
HOSPITAL LOCATION:    BJB BH
CREATED BY USER:      BETA,BETAS
OPTION USED TO CREATE: SD IHS PCC LINK - < - When it has been linked, it will
                    always show this option

APPT DATE&TIME:       MAR 09, 2010@16:15
USER LAST UPDATE:     BETA,BETAA
VCN:                  47887.3A
OLD/UNUSED UNIQUE VIS: 5059010002565343
DATE/TIME LAST MODIFI: MAR 09, 2010@16:57:35
CHART AUDIT STATUS:   REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (: 102320002565343
VISIT ID:             3C5N-WWX

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

===== POV =====
POV:                  F10.24
ICD NARRATIVE:       Alcohol dependence with alcohol-induced mood disorder
PROVIDER NARRATIVE:  ALCOHOL-INDUCED BIPOLAR AND RELATED DISORDER WITH MODERAT
DATE/TIME ENTERED:   NOV 16, 2015@10:43:44
ENTERED BY:          BETA,BETAA
DATE/TIME LAST MODIFI: NOV 16, 2015@10:43:44
LAST MODIFIED BY:    BETA,BETAA
V FILE IEN:          3211018

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

```

Figure 4-104: Information from PCC

4.6 Browse Visits (GUI)

Use the Browse Visits option on the RPMS Behavioral Health System (GUI) tree structure to access the **Browse Visits** dialog box. This dialog box applies to the current patient.

1. Select **Browse Visits** on the RPMS Behavioral Health System (GUI) tree structure.
2. The **Browse Visits** dialog box displays.

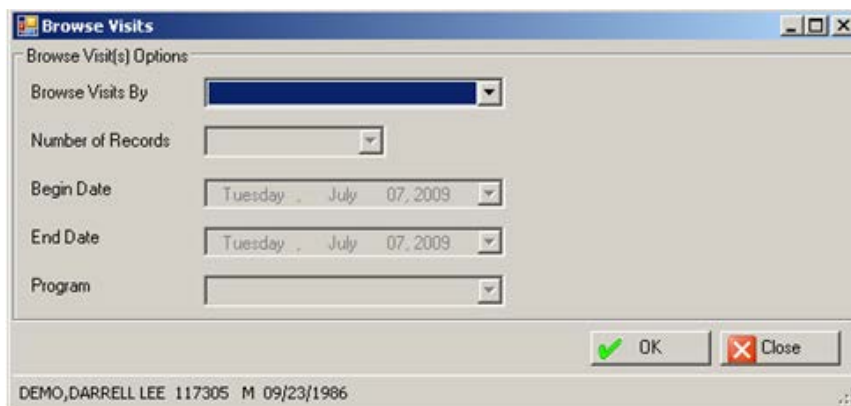


Figure 4-105: Sample Browse Visits dialog box

3. At the **Browse Visits By** field, select one of the following:

- L** (Patient's Last Visit)
- N** (Patient's Last N Visits)
- D** (visits in a Date Range)
- A** (All of the Patient's Visits)
- P** (Visits to One Program)

If you use the A or L option, the other fields will not be active.

If N was used in the **Browse Visits By** field, the Number of Records field becomes active.

4. At the **Number of Records** field, select an option from the drop-down list.

If D was used in the Browse Visits field, the Begin Date and End Date fields become active.

5. At the **Begin Date** field, select the beginning date from the drop-down list.
6. At the **End Date** field, select the ending date from the drop-down list.

If P was used in the Browse Visits field, the Program field becomes active.

7. At the **Program** field, select the program from the drop-down list:

- M-Mental Health
- S-Social Services
- O-Other
- C-Chemical Dependence

8. Click **OK**. (Otherwise, click **Close**.)

If OK was used, the first page of the **Browse Visits** window displays.

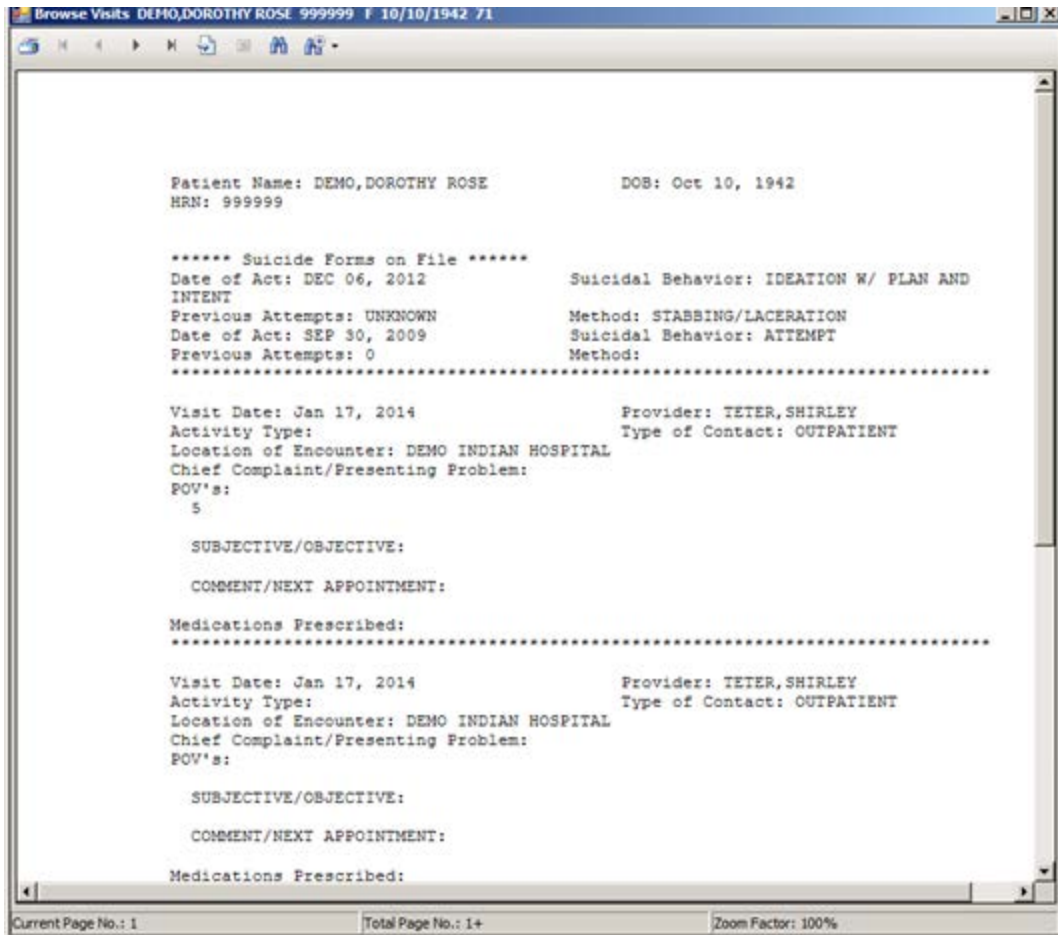


Figure 4-106: Sample of data in Browse Window

Section 2.6 provides more information about using the controls on this type of window.

4.7 View Patient Data

When you expand the View Patient Data option on the tree structure for the RPMS Behavioral Health System (GUI), you can select any of the sub-options to view particular patient data: **Face Sheet**, **Health Summary**, **PCC Medications**, **PCC Labs by Visit Date**, or **PCC Labs by Lab Test**.

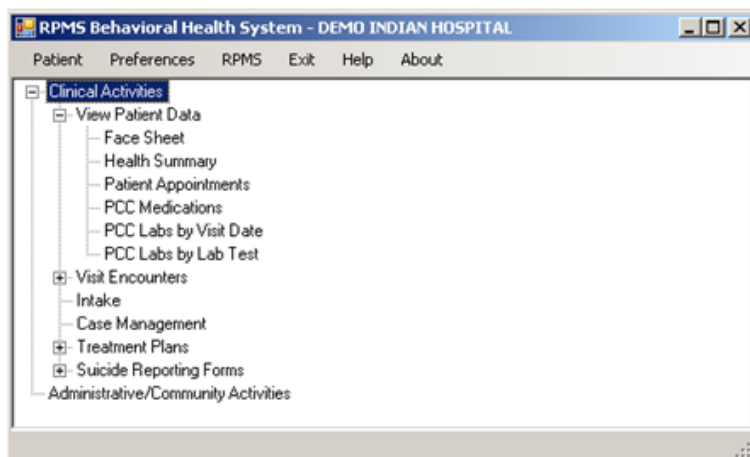


Figure 4-107: RPMS Behavioral Health System tree structure for View Patient Data

The data applies to the current patient.

4.7.1 Face Sheet

Use the **Face Sheet** option to view the first page of the Ambulatory Care Record Brief pop-up window for the current patient. Section 2.6 provides more information about this type of window.

4.7.2 Health Summary

Use the **Health Summary** option to view the selected health summary type report for the current patient.

The **Select Health Summary Type** dialog box displays.



Figure 4-108: Select Health Summary Type dialog box

1. At the field, select the health summary type from the drop-down list.
2. Click **OK**. (Otherwise, click **Close**).

If OK was used, a pop-up that shows the first page of the particular type of health summary displays.

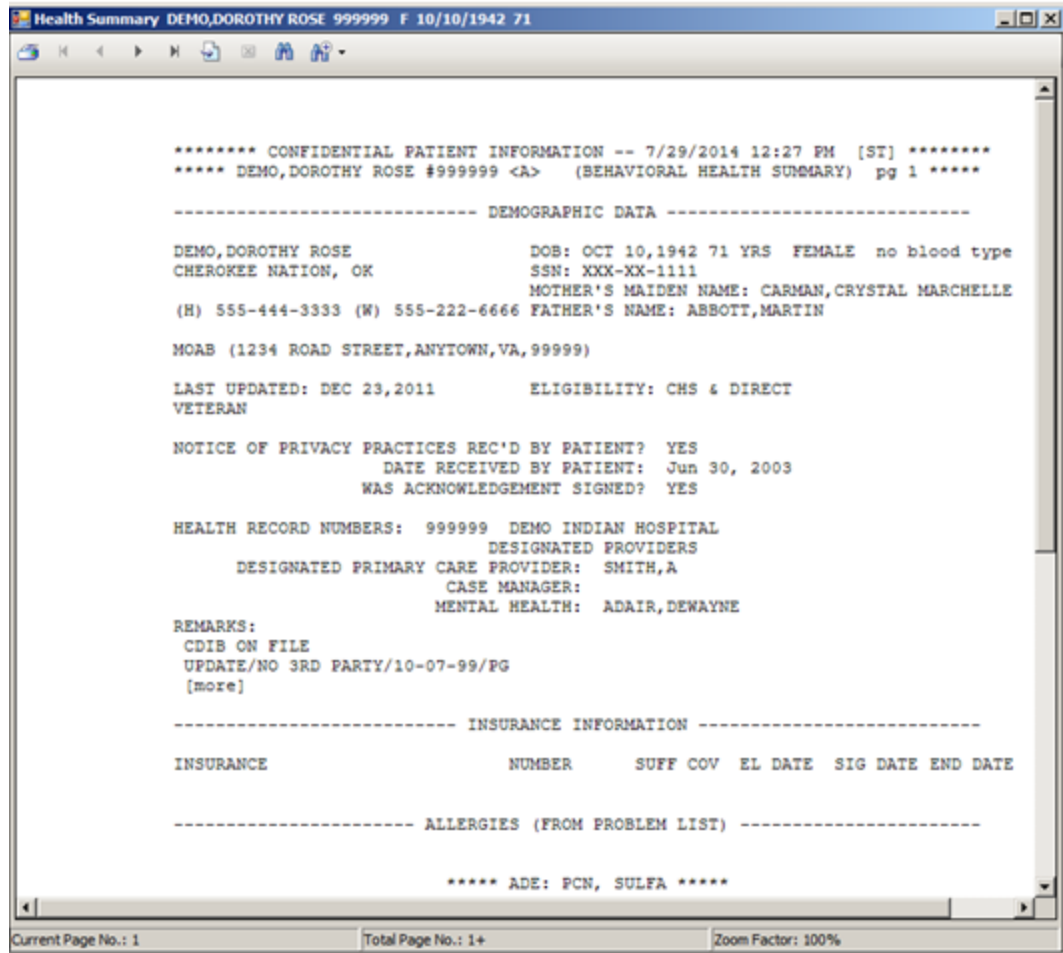


Figure 4-109: Sample Health Summary pop-up window

If there is more than one page, you must use the “Next Page” and “Last Page” buttons to move to that page. Otherwise, you can specify the page number to move to. Section 2.6 provides more information about the controls on this window.

4.7.3 Patient Appointments

Use the **Patient Appointments** option to view the appointments of the current patient in a particular date range. The **Patient Appointments** dialog box displays.

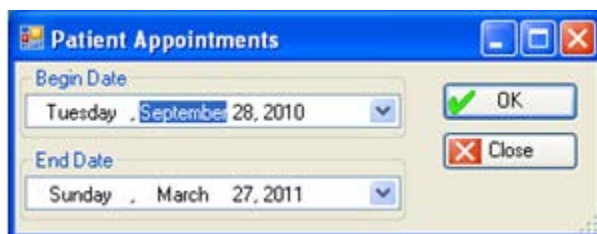


Figure 4-110: Sample Patient Appointments dialog

The default Begin Date is three months previous and the default End Date is three months in the future.

You can edit either or both dates.

1. At the **Begin Date** field, click the drop-down list and select a date from the calendar. This established the beginning date of the date range.
2. At the **End Date** field, click the drop-down list and select a date from the calendar. This established the ending date of the date range.
3. When this dialog box is complete, click **OK** (otherwise, click **Close**). If OK was used, a pop-up displays that shows the first page of the appointments for the current patient in the particular date range.

The application saves both default dates when you exit the application.

Section 2.6 provides more information about using the controls of this type of window.

4.7.4 PCC Medications

Use the **PCC Medications** option to view the PCC medications for the current patient in a particular date range. The **PCC Medications** dialog box displays.

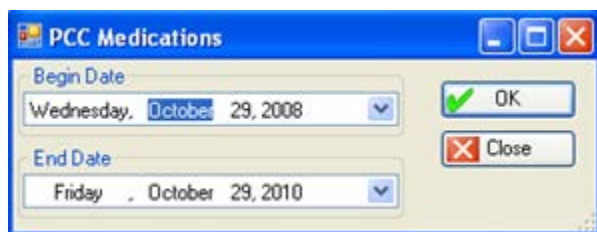


Figure 4-111: Sample PCC Medications dialog box

The default date Start Date is one year previous.

You can edit either or both dates.

1. At the **Begin Date** field, click the drop-down list and select a date from the calendar. This established the beginning date of the date range.
2. At the **End Date** field, click the drop-down list and select a date from the calendar. This established the ending date of the date range.
3. When this dialog box is complete, click **OK** (otherwise, click **Close**).

If OK was used, a pop-up displays that shows the first page of the Medication Prescribed in the Behavioral Health database within the particular date range.

4.7.5 PCC Labs by Visit Date

Use the **PCC Labs by Visit Date** option to view the PCC Labs for a current patient in a particular visit date range. The application displays the **View Labs by Visit Date** dialog box.



Figure 4-112: Sample View Labs by Visit Date dialog box

The default Begin Date is one year previous.

You can edit either or both dates.

1. At the **Begin Date** field, click the drop-down list and select a date from the calendar. This establishes the beginning date of the date range.
2. At the **End Date** field, click the drop-down list and select a date from the calendar. This establishes the ending date of the date range.
3. When this dialog box is complete, click **OK** (otherwise, click **Close**).

If OK was used, the first page of the PCC labs by visit date within the particular date range displays.

This same function is available when entering/changing visit encounter data for one patient on the Rx Notes/Labs tab.

4.7.6 PCC Labs by Lab Test

Use the **PCC Labs by Lab Test** option to view the PCC Labs for the current patient in a particular lab test date range. The application displays the **View Labs by Lab Test** dialog box.



Figure 4-113: Sample View Labs by Lab Test dialog box

The default Begin Date is one year previous.

You can edit either or both dates.

1. At the **Begin Date** field, click the drop-down list and select a date from the calendar. This establishes the beginning date of the date range.

If you change the Begin Date in View Labs by Lab Test, the application applies this change to the Begin Date for the View Labs by Visit Date. The application saves your default Begin Date when you exit the application.

2. At the **End Date** field, click the drop-down list and select a date from the calendar. This establishes the ending date of the date range.
3. When this dialog box is complete, click **OK** (otherwise, click **Close**).

If OK was used, a pop-up displays that shows the first page of the PCC labs by lab test within the particular date range.

This same function is available when entering/changing visit encounter data for one patient on the **Rx Notes/Labs** tab.

5.0 Group Encounters

This section provides information on how to enter or edit group encounter data for Roll and Scroll and the RPMS Behavioral Health System (GUI).

5.1 Group Form Data Entry Using Group Definition (Roll and Scroll)

Use the Group Form Data Entry Using Group Definition (GP) option to enter MH/SS data from a group form. Use GP when the encounter involves a group of patients. This process allows you to enter data into each participant's record without entering an encounter record for each patient.

1. At the "Select Behavioral Health Data Entry Menu Option" prompt, type **GP**.
2. At the "Enter Beginning Date" prompt, type the beginning date of the date range for displaying Group definitions.
3. At the "Enter Ending Date" prompt, type the ending date of the date range for displaying Group definitions.

The application displays the Group Entry window.

GROUP ENTRY		Mar 16, 2009 17:09:31		Page: 1 of 14				
Group	Entry	* - Unsigned Group Note						
Date	Group Name	Activity	Prg	Cln	Prov	TOC	POV	
1)	* 11/01/15	EDIT INTAKE	GROUP	TRE	S	MEDIC	GAMMAA,R	SCH F84.0-AUTISM
2)	* 11/01/15	EDIT INTAKE	GROUP	TRE	S	MEDIC	GAMMAA,R	SCH F42.-HOARDI
3)	* 10/29/15	INTAKE GROUP	GROUP	TRE	M	TELEB	GAMMAA,R	SCH T43.205A-ANT
4)	10/29/15	INTAKE GROUP	GROUP	TRE	M	TELEB	GAMMAA,R	SCH F32.1-MAJOR
5)	10/28/15	Mond DEP	FAMILY/GR		S	MEDIC	GAMMAAA,	OUT F32.3-MAJOR
6)	10/25/15	GOAL STATUS	GROUP	TRE	S	MEDIC	GAMMAA,R	SCH F10.259-ALCO
7)	10/25/15	Friday DEP group	GROUP	TRE	S	MEDIC	GAMMAAA,	SCH F32.2-MAJOR
+	Enter ?? for more actions						>>>	
1	Add a New Group		6	Review/Edit Group Visits				
2	Display Group Entry		7	Add No Show Visit				
3	Duplicate Group		8	Edit Group Definition				
4	Delete Group		9	Sign Notes				
5	Print Encounter Forms		Q	Quit				
Select Action:+//								

Figure 5-1: Sample Group Entry window

The asterisk (*) preceding the Entry Date indicates that the record contains an unsigned group note.

At the "Select Action" prompt, press Enter to view the next page of data about Group Entry.

Use the Quit action to dismiss this window.

Note: You can edit group records only with the group screens, not on the individual data entry side (PDE, SDE).

5.1.1 Add New Group

Use action 1 (Add a New Group) to add a new group to the list of groups.

1. At the “Select Action” prompt, type **1**.
2. At the “Enter Date of the Group Activity” prompt, type the date of the new group activity.

The Group Encounter Documentation window displays.

```

*  GROUP ENCOUNTER DOCUMENTATION  *                DEMO INDIAN HOSPITAL
-----
NOTE: Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 14, 2009                Arrival Time: 12:00
Program:                                Community of Service:
Group Name:                                Clinic:
Activity:                                Activity Time:
Encounter Location:                    Type of Contact:
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N                CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:

COMMAND:                                Press <PF1>H for help    Insert

```

Figure 5-2: Sample Group Encounter Documentation window

The underlined fields are required.

3. At the “Add/View/Update Providers (Primary or Secondary) for this Group?” prompt, type **Y** (yes) or **N** (no).

If Y was used, the add function is available. This is the *only place* to add providers for the group encounter. The following pop-up displays.

```

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

```

Figure 5-3: Sample Secondary Providers pop-up

The underlined fields (on the pop-up) are required.

- a. At the “PROVIDER” prompt, type the provider name.
- b. At the “PRIMARY/SECONDARY” prompt, type the provider type by using **P** for primary or **S** for secondary. Only one primary provider can be used, whereas, multiple secondary providers are allowed.

Below are more fields on the Group Encounter Documentation window.

4. At the “Encounter Date” prompt, type the encounter date. The default shows the date of the new group activity (that was entered before you accessed this window).
5. At the “Arrival Time” prompt, type the arrival time of the group encounter. The default shows 12:00.
6. At the “Program” prompt, type the program for the group encounter. Use one of the following:
 - M** (Mental Health)
 - S** (Social Services)
 - C** (Chemical Dependency)
 - O** (Other)
7. At the “Community of Service” prompt, type the name of community of service where the encounter took place.
8. At the “Group Name” prompt, type the name of the group encounter, using between 1 and 30 characters in length.
9. At the “Clinic” prompt, type the clinic (by number or name).
10. At the “Activity” prompt, type the activity of the group encounter.
11. At the “Activity Time” prompt. Type the number of minutes (no decimal digits) the provider(s) spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry. The time is divided equally among each of the group participants.
12. At the “Encounter Location” prompt, type the name of the location for the encounter.
13. At the “Type of Contact” prompt, type the contact type (the activity setting).
14. At the “POV or DSM (Primary Group Topic)” prompt, press Enter to access the POV or DSM Diagnosis pop-up.

POV or DSM Diagnosis (Primary Group Topic)

CODE	NARRATIVE
------	-----------



Figure 5-4: Sample pop-up window for POV

- a. At the “Code” prompt, type an MHSS Problem/DSM IV POV code, using 2–80 characters.
- b. After populating the Code field, the application populates the Narrative for the particular code (but can be edited). Note: the special characters “or ‘ cannot be the first character of the POV narrative.

Below are more fields on the Group Encounter Documentation window.

15. At the “Chief Complaint/Presenting Problem” prompt, type the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patient sought services.
16. At the “Any Patient Education Done?” prompt, type **Y** (yes) or **N** (no).

If **Y** was used, the Patient Education for this Group Activity pop-up displays.

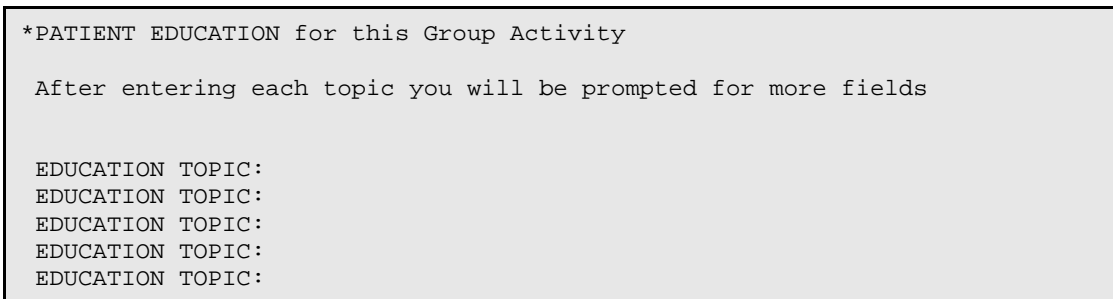


Figure 5-5: Sample Patient Education enter/edit screen

- a. At the “EDUCATION TOPIC” prompt, type the education topic code.
- b. After populating this field, the following pop-up displays.

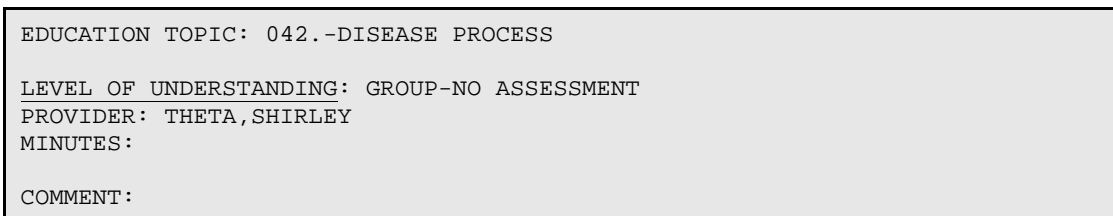


Figure 5-6: Sample pop-up for education data

The underlined fields are required.

- c. At the “Level of Understanding” prompt, the application automatically populates with GROUP-NO ASSESSMENT. You cannot change this field.
- d. At the “Provider” prompt, the application automatically populates with the current logon user. This can be changed.
- e. At the “Minutes” prompt, type the number of minutes spent on education, using any integer 1–9999.
- f. At the “Comment” prompt, type the text of any comment about the education topic, using 2–100 characters.

Below are more fields on the Group Encounter Documentation window.

17. At the “CPT Code(s) <press enter>” prompt, press Enter to access another window where you specify the CPT or HCPCS codes associated with the group encounter.

```
CPT Code(s)
-----
CPT CODE:
CPT CODE:
CPT CODE:
CPT CODE:
```

Figure 5-7: Sample pop-up for CPT Code(s) data

- a. At the “CPT CODE” prompt, type the CPT code to be used for the group. Another pop-up window displays.

```
QUANTITY: 1
MODIFIER:
MODIFIER 2:
```

Figure 5-8: Sample secondary pop-up window

- b. At the “Quantity” prompt, type the quantity associated with the CPT code.
- c. At the “Modifier” prompt, type the modified associated with the CPT code.
- d. At the “Modifier 2” prompt, type the second modified associated with the CPT code.

After completing the Modifier 2 prompt, the focus returns to the CPT CODE prompt.

Below are more fields on the Group Encounter Documentation window.

18. At the “S/O/A/P (Standard Group Note) <press enter>” prompt, press Enter to access another window where you enter the text of a group note.

```
==[ WRAP ]==[ INSERT ]===== < SUBJECTIVE/OBJECTIVE >===== [ <PF1>H=Help ]=====
```



Figure 5-9: Window to enter the note

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

19. At the “Patients <press enter>” prompt, press Enter to access the Patients pop-up:

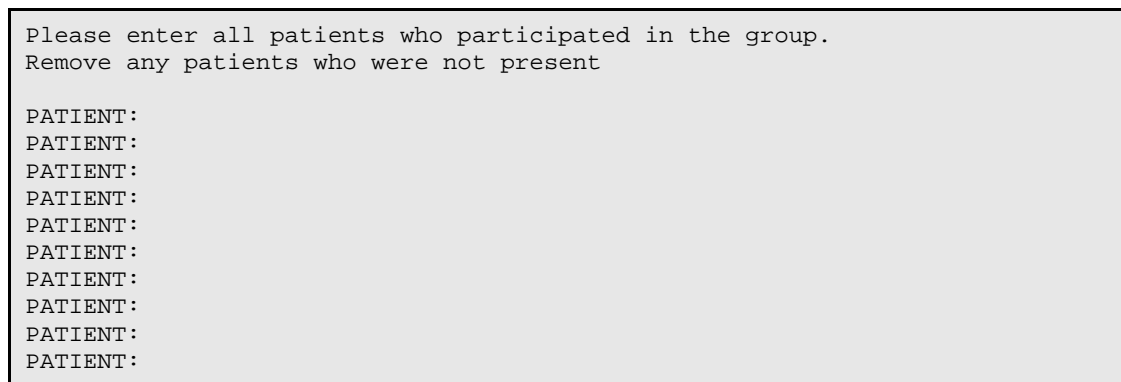


Figure 5-10: Sample pop-up for Patients

- a. At the “PATIENT” prompt, type the patient name, HRN, DOB, or Social Security Number.
- b. More than one patient name can be used.

After you save and exit, the application displays the following choices:

```

Select one of the following:

      Y          Yes, group definition is accurate, continue on to add visits
      N          No, I wish to edit the group definition
      Q          I wish to QUIT and exit

Do you wish to continue on to add patient visits for this group: Y//

```

Figure 5-11: Questions upon exit

- Type **Y** to continue adding the patient's individual visit associated with the group visit. The focus returns to the record for the first patient.
- Type **N** to edit the group definition.
- Type **Q** to quit and exit. The focus returns to the Group Entry screen.

After completing the group definition, completing the documentation for the individual patients, and saving, the application will display an option to sign all SOAP/Progress Notes or to leave them unsigned.

5.1.2 Edit Group Definition

Use option 8 to edit a selected unsigned group entry record.

If the selected group already has visits created, the application displays the message: This group already has visits created. You must use the REVIEW/EDIT GROUP VISITS to modify visits within this group. In this case, the focus returns to the Group Entry window.

1. At the "Select Action" prompt, type **8**.
2. At the "Select GROUP ENTRY" prompt, select a group to edit.
3. The Group Encounter Documentation window displays.

```

*   GROUP ENCOUNTER DOCUMENTATION   *           DEMO INDIAN HOSPITAL
-----
NOTE: Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group? Y
Encounter Date: MAY 15,2009@12:00           Arrival Time: 12:00
Program: MENTAL HEALTH                       Community of Service: ABERDEEN
Group Name: meeting on thur                  Clinic: EMERGENCY MEDICINE
Activity: 25                                 Activity Time: 6
Encounter Location: ABERDEEN AO              Type of Contact: CONSULTATION
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done? N               CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:

```

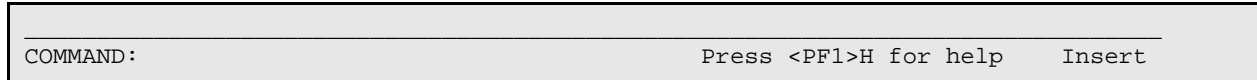


Figure 5-12: Sample Group Encounter Documentation window

Section 5.1.1 provides more information about the fields on this window.

5.1.3 Review/Edit Group Visits

Use action 6 to review/edit the group visits with a particular unsigned group encounter.

1. At the “Select Action” prompt, type **6**.
2. At the “Select GROUP ENTRY” prompt, type the group entry to review/edit.

If the group has a signed note, the application displays the message: The notes associated with this group entry have been signed. You can edit other items in this entry but not the notes. Press Enter to continue.

After populating the Select GROUP ENTRY field, the Enter/Edit Patient Group Data window displays.

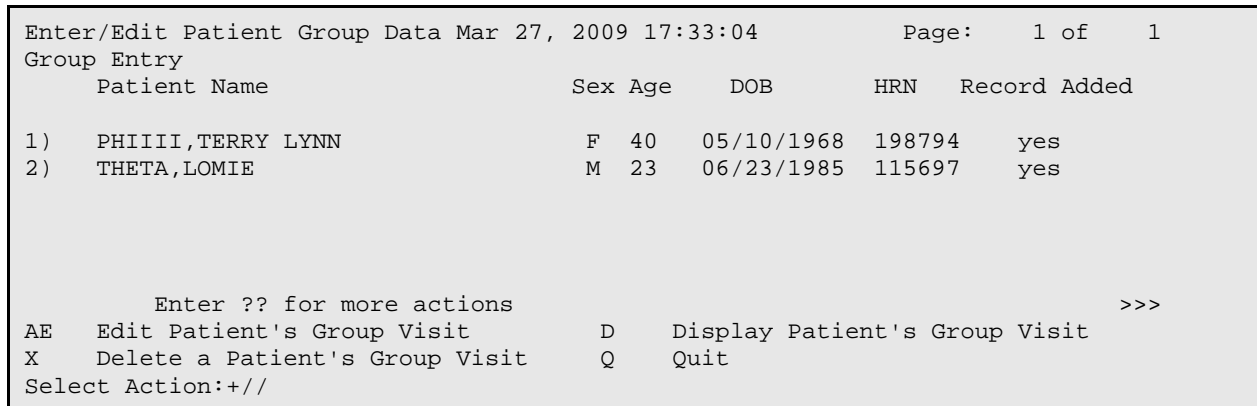


Figure 5-13: Sample Enter/Edit Patient Group Data window

Use the Q action to exit the window.

Delete a Patient’s Group Visit (X)

Use the X action to remove a particular patient’s group visit.

1. At the “Select Action” prompt, type **X**.
2. At the “Enter PATIENT GROUP ENTRY” prompt, type the group number.
3. The application displays the BH record data.

- At the end of the data, the application verifies that you want to delete the particular patient's visit. Type **Y** (yes) or **N** (no).

Display Patient's Group Visit (D)

Use the D action to display a particular patient's group visit.

- At the "Select Action" prompt, type **D**.
- The BH Visits Record Display window (view only) displays.

Edit Patient's Group Visit (AE)

Use the AE option to edit a patient's group visit.

- At the "Select Action" prompt, type **AE**.
- At the "Enter PATIENT GROUP ENTRY" prompt, type the group number.

The BEHAVIORAL HEALTH RECORD EDIT windows for the particular patient displays.

```

* BEHAVIORIAL HEALTH RECORD EDIT *                               [press <F1>E to exit]
Encounter Date: NOV 3,2006@12:00                               User: THETA,SHIRLEY
Patient Name: TEST,JEREMY ISSAC DOB: 6/15/81 HRN: 104683
-----
Date: NOV 3,2006@12:00 Location of Service: DEMO HOSPITAL
Program: MENTAL HEALTH Outside Location:
Clinic: MENTAL HEALTH Appt/Walk-in: UNSPECIFIED Visit Flag:
Type of Contact: OUTPATIENT Community: RED LAKE
Providers <press enter>: Local Service Site:
Activity: 91 Activity Time: 40 #Served: 1 Interpreter Utilized:
Chief Complaint/Presenting Problem:
SOAP/PROGRESS NOTE: Comment/Next Appointment: Medications Prescribed:
Edit Purpose of Visits?: N Edit Treated Medical Problems? N
Edit CPT Codes? Edit Health Factors? N
Edit Patient Education?: N
Edit Any Screening Exams? N Edit Measurements? N
Placement Disposition: Referred To:
-----
COMMAND: Press <PF1>H for help Insert

```

Figure 5-14: Sample Behavioral Health Record Edit window

If you cannot change the note, the applicable field on the Behavioral Health Record Edit window will read: SOAP/PROGRESS NOTE SIGNED/UNEDITABLE. In this case, as you tab through the fields, the application will skip the Note field.

The underlined fields are required. Section 4.1.3 provides more information about the prompts on this window.

5.1.4 Display Group Entry

Use action 2 to display group entry data for a specified group.

1. At the “Select Action” prompt, type **2**.
2. At the “Select GROUP ENTRY” prompt, type the number of the group.

The application displays the Output Browser window showing the group data.

```

OUTPUT BROWSER                               Mar 27, 2009 17:46:48                               Page: 1 of 1

DATE OF SERVICE: NOV 29, 2010@14:39          PROGRAM: MENTAL HEALTH
GROUP NAME: TESTING LINK 1                    POSTING DATE: NOV 29, 2010
LOCATION OF ENCOUNTER: KANAKANAK HOSPITAL
COMMUNITY OF SERVICE: KODIAK                  ACTIVITY TYPE: 91
TYPE OF CONTACT: OUTPATIENT                   ACTIVITY TIME: 60
WHO ENTERED RECORD: GAMMMA,RYAN              DATE LAST MODIFIED: NOV 29, 2010
CLINIC: MENTAL HEALTH                         USER LAST UPDATE: GAMMMA,RYAN
SIGNED?: YES                                  ELECTRONIC SIGNATURE BLOCK: Ryan Gamma
DATE/TIME ESIG APPLIED: NOV 29, 2010@14:40:50
PROVIDER: GAAMMA,RYAN                         PRIMARY/SECONDARY: PRIMARY
POV: F33.1
NARRATIVE: MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MODERATE
SUBJECTIVE/OBJECTIVE:
CPT CODE: 90853                               QUANTITY: 1
CPT CODE: 90836                               QUANTITY: 1
PATIENTS: SMITH,ALPHA JUSTIN
PATIENTS: MOORE,ALPHA JAMES
PATIENTS: WATERS,ALPHA RASHELL
MHSS RECORD: FEB 18, 2014@13:44
MHSS RECORD: FEB 18, 2014@13:44
MHSS RECORD: FEB 18, 2014@13:44

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

```

Figure 5-15: Sample Output Browser window

3. At the “Select Action” prompt, type one of the following:
 - + to view the next screen (does not apply to the last screen)
 - to view the previous (does not apply to the first screen)
 - Q** to quit the Output Browser screen and the focus returns to the Group Entry.

5.1.5 Print Encounter Forms

Use action 5 to print a specified encounter form for a particular group.

1. At the “Select Action” prompt, type **5**.

2. At the “Select GROUP ENTRY” prompt, type the group to use.

The application states: Forms will be generated for the following patient visits.
After this message, the application displays the names of the patients in the group.

3. At the “Enter response” prompt, type one of the following:

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

- A full encounter form (option F) prints all data for a patient encounter including the S/O/A/P note.
- The suppressed report (option S) does NOT display the following information: Chief Complaint, SOAP note, measurement data, screenings.

4. At the “Device” prompt, type the device to output the encounter form.

Below is a sample full encounter form report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Oct 01, 2009@17:38:44
*** Computer Generated Group Encounter Record ***
          Group Name: Mond DV
*****
Date: Sep 28, 2009          Primary Provider: GAMMA,DENISE
                               BETA, BJ
Arrival Time: 10:00
Program: SOCIAL SERVICES
Clinic: MEDICAL SOCIAL SERVICES          Appointment Type: UNSPECIFIED

Community: TAHLEQUAH          Number Served: 1          Activity/Service Time: 44 minutes
Time spent in group session: 88
Activity: 14-FAMILY/GROUP TREATMENT-PATIENT PRESENT
Type of Contact: OUTPATIENT

CHIEF COMPLAINT/PRESENTING PROBLEM: test pt ed
S/O/A/P:
GROUP NOTE
This is the first meeting of the Domestic Violence group. Focus of today's
session was establishing group rules and discussing expectations.

PROVIDER SIGNATURE: /es/ DENISE GAMMA, MSW, LCSW
Signed: Sep 28, 2009 15:07

COMMENT/NEXT APPOINTMENT:

BH POV CODE          PURPOSE OF VISIT (POV)
OR DIAGNOSIS          [PRIMARY ON FIRST LINE]

F84.0          AUTISM SPECTRUM DISORDER

```


The Group Encounter Documentation window displays.

```

*   GROUP ENCOUNTER DOCUMENTATION   *           DEMO INDIAN HOSPITAL
-----
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 17,2009           Arrival Time: 12:00
Program: SOCIAL SERVICES              Community of Service: TAHLEQUAH
Group Name: MON DV  DG                Clinic: MEDICAL SOCIAL SERVICES
Activity: 81                          Activity Time: 60
Encounter Location: DEMO INDIAN HOSPIT  Type of Contact: OUTPATIENT
POV (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N           CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:

COMMAND:                               Press <PF1>H for help   Insert

```

Figure 5-17: Sample Group Encounter Documentation window

Section 5.1.1 provides more information about how to complete the Group Encounter Documentation window.

5.1.7 Add No Show visit

Use action 7 to enter a No Show visit for a client who failed to attend the group session.

Note: Any patient who is a no show or canceled should be removed from a duplicated group before the group documentation is completed.

1. At the “Select Action” prompt, type **7**.
2. At the “Select GROUP ENTRY” prompt, type the number of the group to use.
3. At the “Select PATIENT NAME” prompt, type the name of the patient who failed to attend the group session.
4. At the “Enter PRIMARY PROVIDER” prompt, type the primary provider name.

The Behavioral Health Visit Update window displays. Section 4.2.1 provides more information about using this window.

5.1.8 Sign Notes

Use action 9 to sign an unsigned SOAP/Progress note for a particular group encounter. Only the primary provider for the particular record can sign the note.

1. At the “Select Action” prompt, type **9**.
2. At the “Select Group Entry” prompt, type the number of the record to use.

If you are NOT the primary provider, the application displays the following message. Press Enter and the focus returns to the Group Entry window.

```
You are not the primary provider for this group, no electronic
signature will be applied and no PCC link will occur.
The primary provider will need to sign these at a later time.
Press enter to continue....:
```

Figure 5-18: Message about the primary provider

If there is a record but no visits were created for this group, the application displays the following message. Press Enter and the focus returns to the Group Entry window.

```
There were no visits created for this group.
Press enter to continue....:
```

Figure 5-19: Message about no visits created

If the provider opted out of E-Signature, the application displays the following information:

```
No E-Sig Required. Provider opted out of E-Sig
```

Figure 5-20: Message when provider opted out of E-Signature

If you are the primary provider, the BH Visit Record Display window displays.

```
BH VISIT RECORD DISPLAY          Aug 24, 2009 16:05:04          Page:    1 of    4

Patient Name:          ALPPHA,CHELSEA MARIE
Chart #:               116431
Date of Birth:        FEB 07, 1975
Sex:                  F
Patient Flag:         9
Flag Narrative:       99

===== BH RECORD FILE =====
DATE OF SERVICE:      JUL 09, 2009@09:55
PROGRAM:              MENTAL HEALTH
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE: TAHLEQUAH
ACTIVITY TYPE:        17
ACTIVITY TYPE NAME:   PSYCHOLOGICAL TESTING-PATIENT PRESENT
TYPE OF CONTACT:      OUTPATIENT
PATIENT:              ALPPHA,CHELSEA MARIE
```

```

PT AGE:                34
CLINIC:                MENTAL HEALTH
NUMBER SERVED:        1
+      Enter ?? for more actions
+      Next Screen      -      Previous Screen      Q      Quit
Select Action: +//

```

Figure 5-21: Sample BH Visit Record Display window

After you quit this window, the application asks: Do you wish to edit this record? Type **Y** to edit the record. Type **N** to not edit the record.

If **Y** was used, the focus stays on the window.

If **N** was used, the application prompts: Enter your Current Signature Code. Type **Y** (yes) to enter your signature code, otherwise type **N** (no). Section 2.14.6 provides more information about signing a note.

Note: No Show notes are not included in this and must be signed individually.

5.1.9 Delete Group

Use action 4 to remove a particular group encounter record with an unsigned note.

1. At the “Select Action” prompt, type **4**.
2. At the “Select GROUP ENTRY” prompt, type the number of the group to delete.

The application displays the data associated with the group visit.

3. At the “Are you sure you want to remove/delete both the group definition and all associated individual patient records” prompt, type **Y** (yes) or **N** (no).

Please note that the user must hold a specific key in order to delete group encounters with signed notes. Removing the group definition will also remove the related individual patient encounter records.

5.2 Group Entry Window (GUI)

The following shows where the Group Encounter function is located on the RPMS Behavioral Health System (GUI) tree structure.

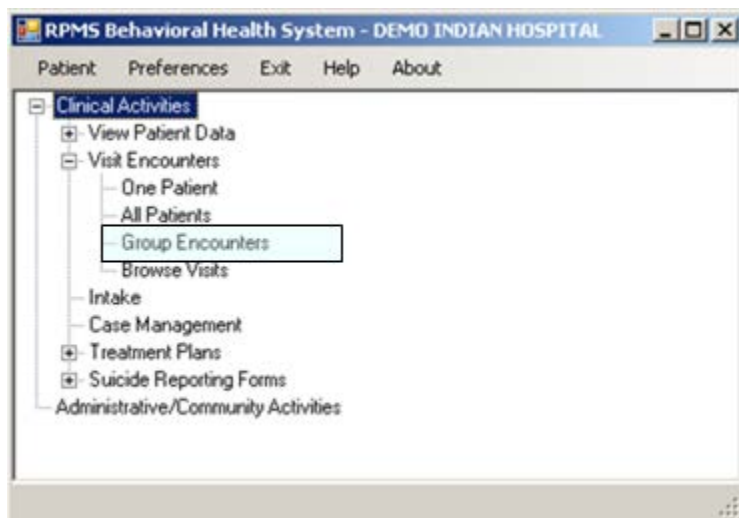


Figure 5-22: Group Encounters location on tree structure

Click the **Group Encounters** option to access the **Group Entry** window.

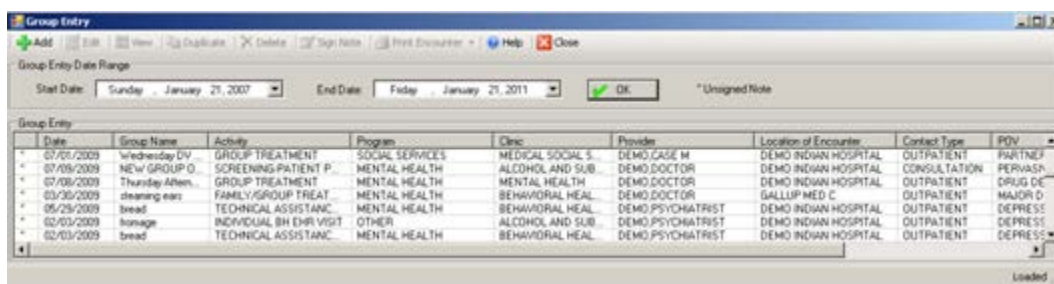


Figure 5-23: Sample Group Entry window

The following table provides information about the features on the Group Entry window.

Feature	Functionality
Group Entry Date Range Group Box	The Group Entry window displays the group encounters in the date range shown in the Group Entry Date Range group box (default is one year). The default view is sorted by date (from most recent). Change the date range by accessing the calendar under the drop-down list for the date. After changing the date range, click OK to update the display in the Group Entry group box.
Group Entry List Box	This list box shows the records in the particular group entry date range. The asterisk (*) in the first column indicates that the particular record contains an unsigned note. When this type of record is selected, the Sign Note button becomes active.
Add Button	Use the Add button to add a new group encounter record on the Group Data Entry - Add Group Data window.
Edit Button	Use the Edit button to change the highlighted group encounter record on the Group Data Entry - Edit Group Data window.

Feature	Functionality
View Button	Use the View button (or double-click on a record) to view the highlighted group encounter record on the Group Data Entry - View Group Data window. This window has the same fields as the Add/Edit group data window.
Duplicate Button	<p>Use the Duplicate button to duplicate an existing group encounter record in order to create a new one. You will need to edit any information that would be different for the new encounter group.</p> <p>To prevent inclusion of deceased patients in duplicated groups, the application will search the RPMS Patient Registration files for a Date of Death before displaying the patient's name, case number, etc.</p> <p>Duplicating a group containing signed SOAP/Progress Notes causes the notes to revert to unsigned status (for the SOAP/Progress Notes associated with the new group encounter). The duplicated group will duplicate the standard group note only and not the individual patient group note.</p> <p>Select an existing group encounter and then click Duplicate. The application displays the Group Data Entry - Duplicate Group Data window.</p> <p>The fields are the same as those on the Group Data Entry - Add Group Data window. The duplicated group encounter will have a default date/time as the current date/time.</p>
Delete Button	<p>After selecting the particular record and clicking Delete, the "Are You Sure" confirmation message displays, asking if you are sure you want to delete. Click Yes (otherwise, click No). The Yes process removes the selected group encounter record from the group box. If Yes was used, the group definition and all individual patient records will be removed.</p> <p>Note that Group Encounter records with signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.</p>
Print Encounter Button	<p>Select the group encounter record to print and click the Print Encounter button. It will print one of the following: Full, Suppressed, Both Full and Suppressed.</p> <p>The full option prints all data for the group encounter, including the SOAP note.</p> <p>The suppressed report does NOT display the following information: Chief Complaint, SOAP note, measurement data, screenings.</p> <p>The application displays the first page of the Print Encounter Group pop-up window.</p>
Help Button	Use the Help button to access the online help for the Group Entry window.
Close Button	Use the Close button to dismiss the Group Entry window.
Sign Note Button	Use the Sign Note button to sign a particular "unsigned" group encounter record (asterisk (*) in the first column).

The following applies to the information about the Sign Note button:

Click Sign Note button to access the **Sign?** dialog box where you type your electronic signature. Section 2.14.5 provides more information.

If the primary provider has opted out of E-Sig will pass to PCC, the application displays the **Message** regarding this.



Figure 5-24: Message stating that the provider opted out of E Sig

The **Message** means that no electronic signature is required for the particular record. Click **OK** and you leave the Sign Note process.

5.3 Add/Edit Group Data (GUI)

1. Click the **Add** button to add a new group data record on the Group Data Entry - Add Group Data window.

OR

2. Use the **Edit** button to change the highlighted group encounter record on the Group Data Entry - Edit Group Data window.

All Patient Education entries created before the installation date for BHS v4.0 will continue to display the CPT field.

Below is the Group Data Entry - Add Group Data window. (The same fields appear on the Group Data Entry - Edit Group Data window.)

Figure 5-25: Group Data Entry - Add Group Data window

The following table provides information about the features on this window.

Feature	Functionality
Group Encounter Information group box	The fields in this group box display the existing data (cannot be changed). All editing is completed in the Group Encounter Information group box or on the Patient Data tab if the group has already been saved. <ul style="list-style-type: none"> • If the group has been signed the other fields can still be edited (does not apply to the note section). • If you access an unsigned group data record, you can edit the note.
Help button	Click this button to access the online help system about this window.
Save button	Click this button to save the changes and dismiss the window.

The following applies to the Save process:

- If you added a SOAP/Progress note, the application displays the **Sign?** confirmation message that asks if you want to sign the SOAP/Progress note now.
 - Click **No** to leave the note unsigned.

- Click **Yes** and the application will display the **Electronic Signature** dialog box displays. Section 2.14.5 provides more information about electronic signature (GUI).

The following applies to the Close process:

- The Close process displays the **Continue?** dialog box that asks: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add group data window. Click **No** to remain on the add group data window.

Other features to consider are:

- If you access an unsigned group data record, you can edit the note.
- The Patient Data tab is the only place you can do any editing after a group has been saved.
- If you access an unsigned group data record, then you can edit everything on that tab except the note.

5.3.1 Group Encounter Information Group Box

The add window has the following (active) fields.

Figure 5-26: Sample Group Encounter Information group box

These fields are not active (and cannot be changed) on the **Edit Group Data** window.

The fields in bold text are required.

1. At the **Primary Provider** field, select the primary provider for the group encounter. The default is the current provider.

Change this field by clicking the drop-down list to access the **Primary Provider** search/select window. Here you can search for a primary provider name.

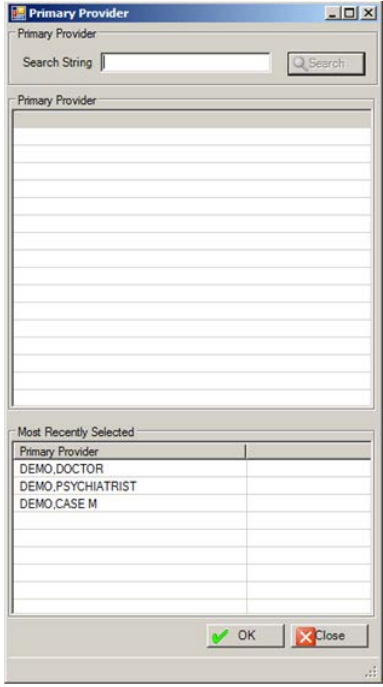
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a name and click OK to populate the Primary Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Primary Provider field. (Otherwise, click Close.)</p>

Figure 5-27: Sample Primary Provider search/select window

- At the **Encounter Date/Time** field, select the encounter date and time. The default is the current date and time.

Change the date by clicking the drop-down list to access the calendar. You can select the hour, minutes, and AM/PM. If you make the hour and minutes, for example, 13:25, the application automatically changes the time to 1:25 PM. In addition, you can change the time manually.

- At the **Program** field, select the program associated with the visit. Click the drop down list and use one of the following:

Mental Health

Social Services

Other

Chemical Dependency

After selecting a program, the application automatically populates the Clinic and Encounter Location fields if the defaults were set in the Site Parameters menu. These fields are inactive on the edit window.

4. At the **Encounter Location** field, select the location of the group encounter. Change this field by clicking the drop-down list to access the **Location** search window. Here you can search for a location name.


Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the location and then clicking Search. The retrieved locations will populate the Location list box. Select a location and click OK to populate the Encounter Location field. (Otherwise, click Close.)</p> <p>(2) Select a location in the Most Recently Selected list box and click OK to populate the Encounter Location field. (Otherwise, click Close.)</p>

Figure 5-28: Sample Location search window

5. At the **Clinic** field, select the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table. Change this field by clicking the drop-down list to access the **Clinic** search window. Here you can search for a type of clinic.

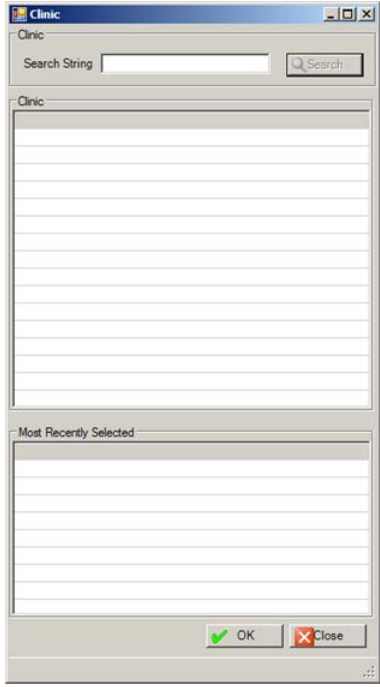
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the clinic and then clicking Search. The retrieved clinics and their codes will populate the Clinic list box. Select a clinic and click OK to populate the Clinic field. (Otherwise, click Close.)</p> <p>(2) Select a clinic in the Most Recently Selected list box and click OK to populate the Clinic field. (Otherwise, click Close.)</p>

Figure 5-29: Clinic search window

- At the **Group Name** field, type the name of the group encounter, using between 1 and 30 characters in length. This is a Free Text field.

5.3.2 Activities Tab

Use the **Activities** tab to specify the community of service, type of contact, activity, and activity code. In addition, you can add CPT codes in the lower group box.

The information on this tab is read-only when using the **Edit Group Data** window.

Figure 5-30: Sample Activities tab

Fields

Below are the fields for the **Activities** tab.

1. At the **Community of Service** field, select the community of service where the group encounter took place. Change this field by clicking the drop-down list to access the **Community** search window. Here you search for the community name.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the community name and then clicking Search. The retrieved community names and their states will populate the Community list box. Select a community and click OK to populate the Community of Service field. (Otherwise, click Close.)</p> <p>(2) Select a community in the Most Recently Selected list box and click OK to populate the Community of Service field. (Otherwise, click Close.)</p>

Figure 5-31: Sample Community search window

- At the **Type of Contact** field, select the type of contact (the activity setting) for the group encounter. Change this field by clicking the drop-down list to access the **Type of Contact** window where you select an option.

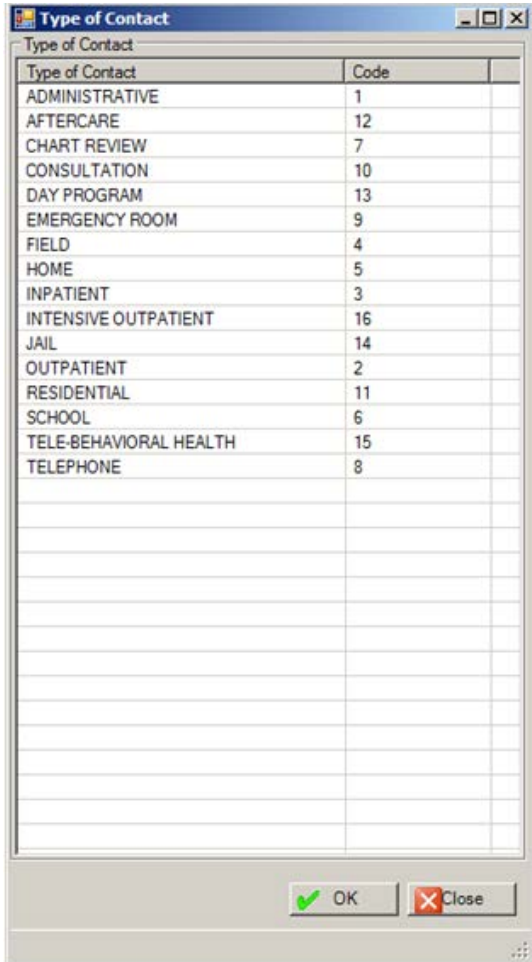
Screen Capture	What to do																																		
 <p>The screenshot shows a window titled "Type of Contact" with a table listing various contact types and their corresponding codes. The table has two columns: "Type of Contact" and "Code".</p> <table border="1"> <thead> <tr> <th>Type of Contact</th> <th>Code</th> </tr> </thead> <tbody> <tr><td>ADMINISTRATIVE</td><td>1</td></tr> <tr><td>AFTERCARE</td><td>12</td></tr> <tr><td>CHART REVIEW</td><td>7</td></tr> <tr><td>CONSULTATION</td><td>10</td></tr> <tr><td>DAY PROGRAM</td><td>13</td></tr> <tr><td>EMERGENCY ROOM</td><td>9</td></tr> <tr><td>FIELD</td><td>4</td></tr> <tr><td>HOME</td><td>5</td></tr> <tr><td>INPATIENT</td><td>3</td></tr> <tr><td>INTENSIVE OUTPATIENT</td><td>16</td></tr> <tr><td>JAIL</td><td>14</td></tr> <tr><td>OUTPATIENT</td><td>2</td></tr> <tr><td>RESIDENTIAL</td><td>11</td></tr> <tr><td>SCHOOL</td><td>6</td></tr> <tr><td>TELE-BEHAVIORAL HEALTH</td><td>15</td></tr> <tr><td>TELEPHONE</td><td>8</td></tr> </tbody> </table> <p>At the bottom of the window, there are two buttons: "OK" (with a green checkmark icon) and "Close" (with a red X icon).</p>	Type of Contact	Code	ADMINISTRATIVE	1	AFTERCARE	12	CHART REVIEW	7	CONSULTATION	10	DAY PROGRAM	13	EMERGENCY ROOM	9	FIELD	4	HOME	5	INPATIENT	3	INTENSIVE OUTPATIENT	16	JAIL	14	OUTPATIENT	2	RESIDENTIAL	11	SCHOOL	6	TELE-BEHAVIORAL HEALTH	15	TELEPHONE	8	<p>Use this window as follows:</p> <ol style="list-style-type: none"> Select a type of contact from the list. Click OK to populate the "Type of Contact" field. (Otherwise, click Close.)
Type of Contact	Code																																		
ADMINISTRATIVE	1																																		
AFTERCARE	12																																		
CHART REVIEW	7																																		
CONSULTATION	10																																		
DAY PROGRAM	13																																		
EMERGENCY ROOM	9																																		
FIELD	4																																		
HOME	5																																		
INPATIENT	3																																		
INTENSIVE OUTPATIENT	16																																		
JAIL	14																																		
OUTPATIENT	2																																		
RESIDENTIAL	11																																		
SCHOOL	6																																		
TELE-BEHAVIORAL HEALTH	15																																		
TELEPHONE	8																																		

Figure 5-32: Sample Type of Contact window

- At the **Activity** field, select the activity for the group encounter. The default is Group Treatment. Change this field by clicking the drop-down list to access the **Activity** search window. Here you search for an activity name or its code.

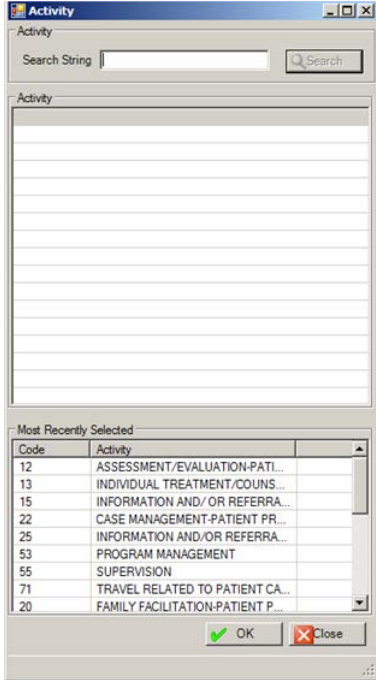
Screen Capture	What to do																				
 <p>The screenshot shows a software window titled "Activity". At the top, there is a "Search String" input field and a "Search" button. Below this is a large, empty list box labeled "Activity". At the bottom of the window, there is a section titled "Most Recently Selected" which contains a table with two columns: "Code" and "Activity". The table lists several activity codes and their corresponding names. Below the table are "OK" and "Close" buttons.</p> <table border="1" data-bbox="342 667 699 863"> <thead> <tr> <th>Code</th> <th>Activity</th> </tr> </thead> <tbody> <tr> <td>12</td> <td>ASSESSMENT/EVALUATION-PATI...</td> </tr> <tr> <td>13</td> <td>INDIVIDUAL TREATMENT/COUNS...</td> </tr> <tr> <td>15</td> <td>INFORMATION AND/OR REFERRA...</td> </tr> <tr> <td>22</td> <td>CASE MANAGEMENT-PATIENT PR...</td> </tr> <tr> <td>25</td> <td>INFORMATION AND/OR REFERRA...</td> </tr> <tr> <td>53</td> <td>PROGRAM MANAGEMENT</td> </tr> <tr> <td>55</td> <td>SUPERVISION</td> </tr> <tr> <td>71</td> <td>TRAVEL RELATED TO PATIENT CA...</td> </tr> <tr> <td>20</td> <td>FAMILY FACILITATION-PATIENT P...</td> </tr> </tbody> </table>	Code	Activity	12	ASSESSMENT/EVALUATION-PATI...	13	INDIVIDUAL TREATMENT/COUNS...	15	INFORMATION AND/OR REFERRA...	22	CASE MANAGEMENT-PATIENT PR...	25	INFORMATION AND/OR REFERRA...	53	PROGRAM MANAGEMENT	55	SUPERVISION	71	TRAVEL RELATED TO PATIENT CA...	20	FAMILY FACILITATION-PATIENT P...	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the activity name or code and then clicking Search. The retrieved activities will populate the Activity list box. Select an activity and click OK to populate the Activity field. (Otherwise, click Close.)</p> <p>(2) Select a record in the Most Recently Selected list box and click OK to populate the Activity field. (Otherwise, click Close.)</p>
Code	Activity																				
12	ASSESSMENT/EVALUATION-PATI...																				
13	INDIVIDUAL TREATMENT/COUNS...																				
15	INFORMATION AND/OR REFERRA...																				
22	CASE MANAGEMENT-PATIENT PR...																				
25	INFORMATION AND/OR REFERRA...																				
53	PROGRAM MANAGEMENT																				
55	SUPERVISION																				
71	TRAVEL RELATED TO PATIENT CA...																				
20	FAMILY FACILITATION-PATIENT P...																				

Figure 5-33: Sample Activity search window

- At the **Activity Time** field, type the number of minutes spent on the activity for the group, using any integer between 1 and 9999. Please note, 0 (zero) is not a valid entry.

CPT Codes Group Box

Use the **CPT Code** group box to manage the CPT codes associated with the activity for the group.

Add Button

- Click **Add**.
- The **CPT Code** search/select window displays.

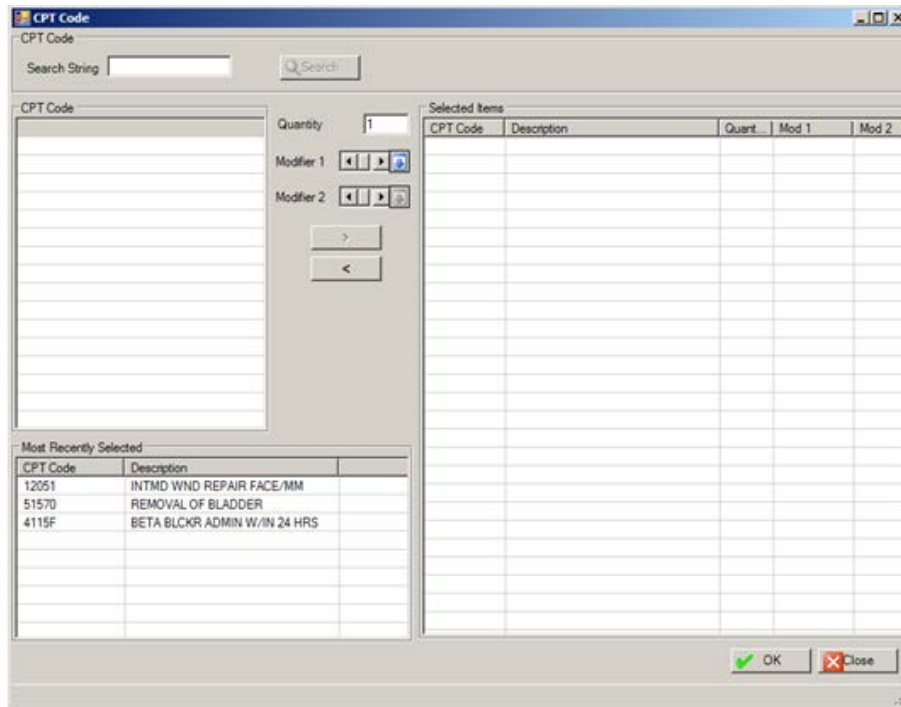


Figure 5-34: Sample CPT Codes search/select window

3. At the **Search String** field, type a search string to search for a particular CPT code. Then click **Search**. The CPT codes will display in the **CPT Code** list field.

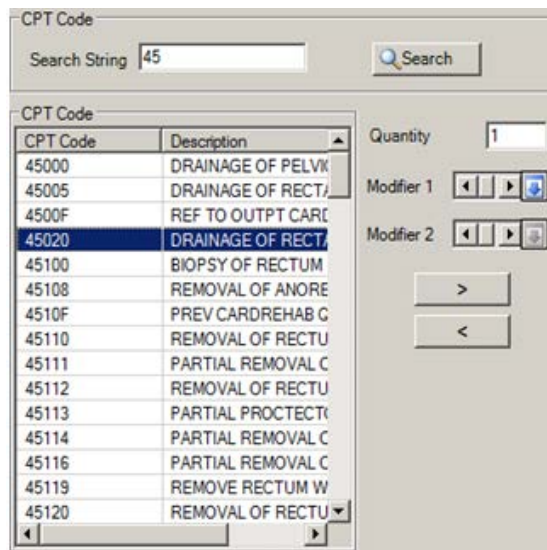


Figure 5-35: Sample CPT Code search results

- a. Select a retrieved CPT Code.
- b. At the **Quantity** field, type the number of CPT codes to use to help facilitate billing.

- c. At the **Modifier** field, select the modifier for the CPT code. Click the drop-down list to access the **CPT Modifier** search window.

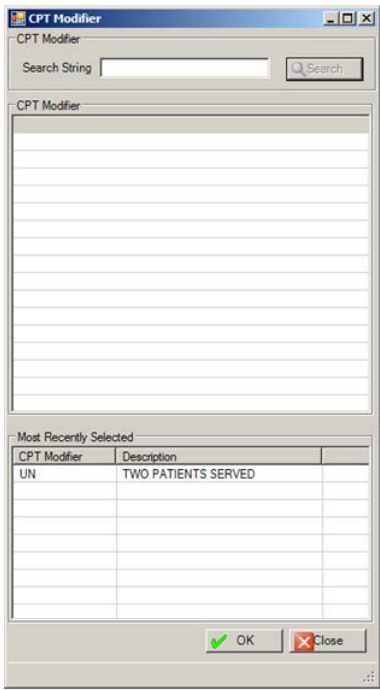
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the CPT Modifier name and then clicking Search. The retrieved CPT Modifier names and their descriptions will populate the CPT Modifier list box. Select a CPT modifier and click OK to save the modifier. (Otherwise, click Close.)</p> <p>(2) Select a CPT modifier in the Most Recently Selected list box and click OK to save the modifier. (Otherwise, click Close.)</p>

Figure 5-36: Sample CPT Modifier search window

4. After the **Quantity** and **Modifier** fields are complete, click the right-pointing arrow to add the items to the **Selected Items** list box.

More than one CPT Code can be used in the above process.

5. Another way to populate the **Selected Items** list box is to select a CPT code in the **Most Recently Selected** list box and then click the right-pointing arrow
6. Remove a selected CPT code in the **Selected Items** list box by clicking the left-pointing arrow.
7. When the **Selected Items** list box is complete, click **OK** to save the data and to add the data to the CPT Code(s) group box. (Otherwise, click **Close**.)

Delete Button

1. Select a CPT code record to delete.
2. Click **Delete**.
3. At the “Are You Sure” confirmation message, click **Yes** and the selected record will be removed from the CPT Code(s) group box. (Otherwise, click **No**).

5.3.3 Group Data Tab

Use the **Group Data** tab to specify secondary providers, POV code, group note, and CPT codes for the group encounter.

The screenshot shows the 'Group Data' tab in a software interface. At the top, there are navigation tabs: 'Activities', 'Group Data', 'Group Education', 'Patients', and 'Patient Data'. Below these is a text field for 'Chief Complaint/Presenting Problem'. The next section is 'Secondary Providers', which contains a table with a 'Provider' column and an 'Add' button. Below that is 'Purpose of Visit - POV (Primary Group Topic)', which has a table with 'Code' and 'Narrative' columns, and 'Add', 'Edit', and 'Delete' buttons. At the bottom is a large text area for 'Standard Group Note'.

Figure 5-37: Sample Group Data tab

Note: Only the primary provider can change the data on the Group Data tab. Whoever is doing the data entry can change the information on this tab until such time the group has been saved; nothing on this tab can be edited after the group is saved – all editing takes place on the Patient Data tab.

The group box names in bold text are required.

Chief Complaint/Presenting Problem Field

In the field, type the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patients sought services.

Secondary Providers Group Box

Use the **Secondary Providers** group box to add or delete secondary providers for the group encounter.

This is a close-up of the 'Secondary Providers' section from the previous screenshot. It shows a table with one column labeled 'Provider' and an 'Add' button to the right of the table.

Figure 5-38: Sample Secondary Providers group box

Add Button

1. Click **Add**.
2. The **Secondary Provider** multiple search/select window displays.

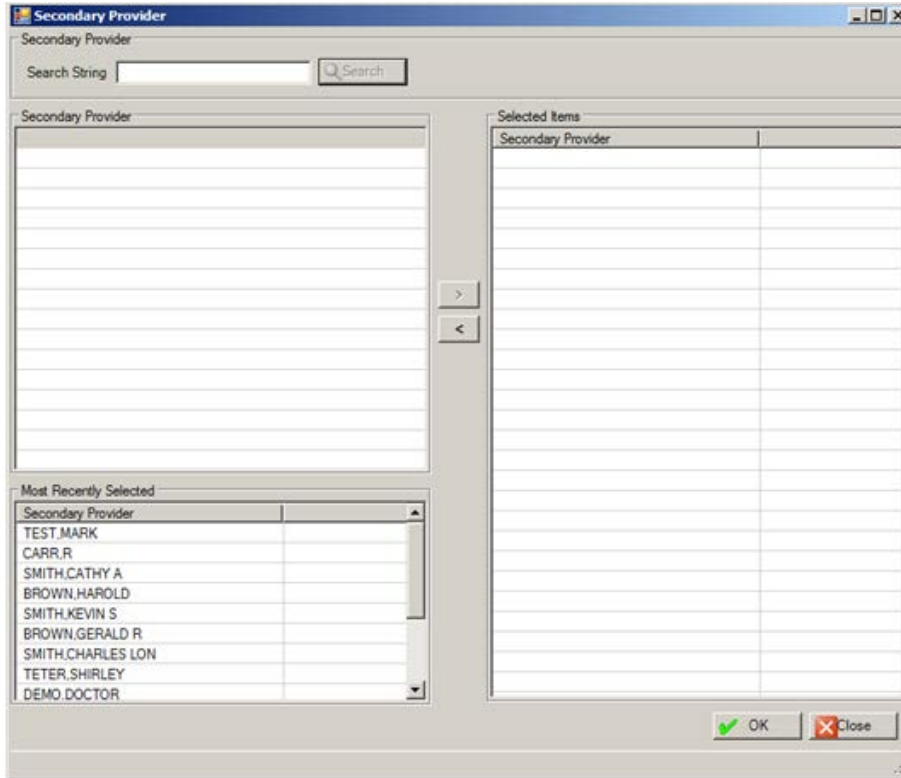


Figure 5-39: Sample Secondary Providers search/select window

Use the **Secondary Providers** multiple search/select window in the following manner:

- a. At the **Search String** field, type a few characters of the search criteria.
- b. Click **Search** and the retrieved records display in **Secondary Provider** list box.
- c. To add one or more selected records from the **Secondary Provider** list box to the **Selected Items Secondary Provider** list box, click the right-pointing arrow button.
- d. Another way to add records to the **Selected Items Secondary Provider** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.
- e. Similarly, you can remove one or more selected records from the **Selected Items Secondary Provider** list box by clicking the left-pointing arrow button.

- f. When the records in the **Selected Items Secondary Provider** list box is complete, click **OK** and the records populate the **Secondary Providers** group box. (Otherwise, click **Close**.)

Delete Button

1. Select a secondary provider record to delete.
2. Click **Delete**.
3. At the “Are you Sure” confirmation message, click **Yes** to remove the selected secondary provider. Otherwise, click **No**.

Purpose of Visit - POV (Primary Group Topic) Group Box

Use this group box to add, edit, or delete POV codes and their narratives associated with the group encounter. These are POVs for all group members and will display as such on the Patient Data Tab and the printed encounter record unless edited or deleted on the Patient Data tab.

At least one POV record is required for a group encounter.

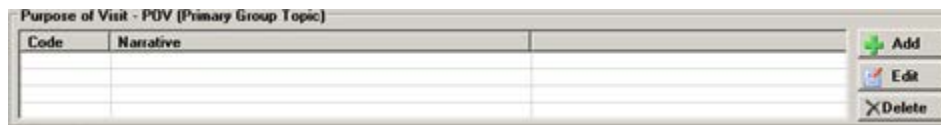


Figure 5-40: Sample POV group box

You can add, edit, or delete POV records in this group box

Delete Button

1. Select a POV record to delete.
2. Click **Delete**.
3. At the “Are you Sure” confirmation message, click **Yes** to remove the selected POV record. Otherwise, click **No**.

Add Button

1. Click **Add**.
2. The **POV** multiple search/select window displays.

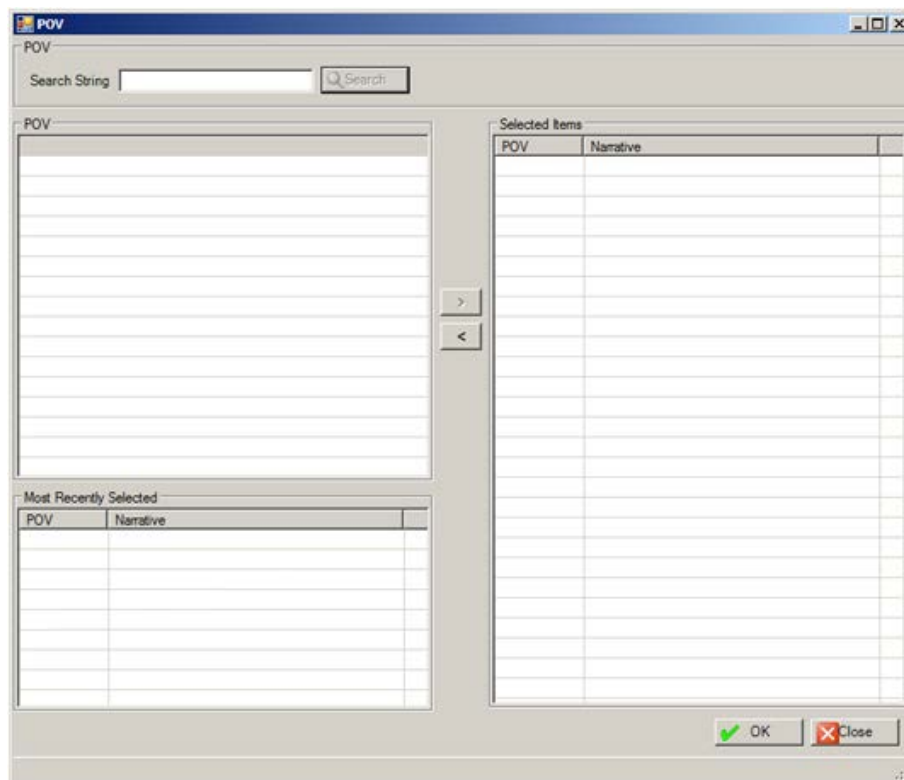


Figure 5-41: Sample POV multiple select/search window

Use the POV multiple search/select window in the following manner:

3. At the **Search String** field, type a few characters of the search criteria.
4. Click **Search** and the retrieved records display in POV list box (the POV and its narrative).
5. To add one or more selected records from the POV list box to the **Selected Items** list box, click the right-pointing arrow button.
6. Another way to add records to the **Selected Items** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.
7. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
8. When the records in the **Selected Items** list box is complete, click **OK** and the records populate the **Purpose of Visit (POV)** group box. (Otherwise, click **Close**.)

Edit Button

Use the **Edit** button to change the Narrative part of a POV record in the group box.

1. Select a POV record to edit.

2. Click **Edit**.
3. The **Edit POV** dialog box displays.

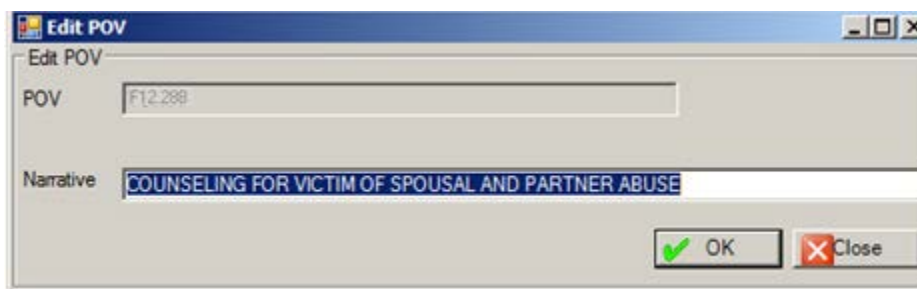


Figure 5-42: Edit POV dialog box

4. At the **Narrative** field, type the new POV narrative, using 2–80 characters.

Note: The special characters “ or ‘ cannot be the first character of the POV narrative. The Narrative field is a Free Text field.

5. Click **OK** to change the narrative of the selected code on the POV group box. Otherwise, click **Close** to not change the narrative.

Standard Group Note Field

Use **Standard Group Note** field to type the text of a group note for the group encounter. This is a Free Text field.

You must be on the **Patient Data** tab to do any editing after the group has been saved.

5.3.4 Group Education Tab

Use the **Group Education** tab to add, change, or delete education data about the group encounter.

The screenshot displays a software window titled 'Group Education'. At the top, there are tabs for 'Activities', 'Group Data', 'Group Education', 'Patients', and 'Patient Data'. The 'Group Education' tab is active. Below the tabs is a table with the following columns: 'Education Topic', 'Time Spent', 'Level of Underst...', and 'Comment'. The table is currently empty. To the right of the table are three buttons: 'Add' (with a green plus icon), 'Edit' (with a blue pencil icon), and 'Delete' (with a red X icon). Below the table are several input fields: 'Education Topic' (a dropdown menu), 'Time' (a text box), 'Level of Understanding' (a dropdown menu), and 'Comment' (a text box). To the right of these fields is a 'Provider' dropdown menu showing 'DEMO.DOCTOR'. At the bottom right of the window are 'OK' and 'Cancel' buttons.

Figure 5-43: Sample Group Education tab

The information on this tab is read-only when using the **Edit Group Data** window.

Add/Edit Group Education Record

The **Add** and **Edit** functions use the same fields.

All Group Education entries created before the installation date for BHS v4.0 will continue to display the Goal and CPT fields.

1. Click **Add** to activate the fields below the education grid.

OR

2. Select a record to edit and click **Edit**.
3. At the **Education Topic** field, select the education topic for the group encounter. Click the drop-down list to access the **Education Topic** search window. Here you search for an education code.

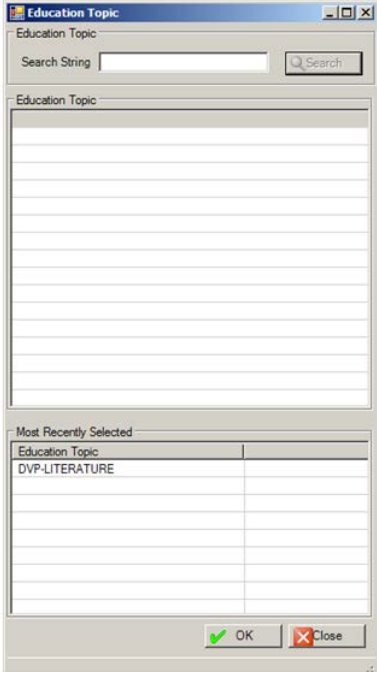
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the education topic and then clicking Search. The retrieved education topics will populate the Education Topic list box. Select a retrieved record and click OK to populate the Education Topic field. (Otherwise, click Close.)</p> <p>(2) Select an education topic in the Most Recently Selected list box and click OK to populate the Education Topic field. (Otherwise, click Close.)</p>

Figure 5-44: Sample Education Topic select window

- At the **Provider** field, select the provider for the group education. Click the drop down list to access the **Education Provider** search window. Here you search for a provider name.

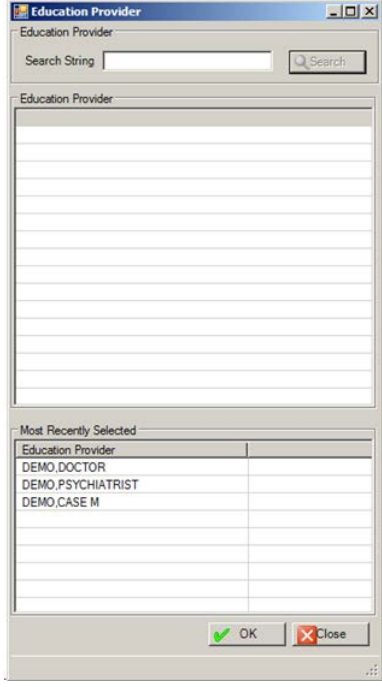
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Education Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 5-45: Sample Education Provider select window

5. At the **Time** field, type the time spent on the education topic, using any integer 1 - 9999. The understood units of measure are minutes.
6. At the **Level of Understanding** field, select the level of understanding about the education topic. The default is Group-No Assessment (the only choice).
7. At the **Comment** field, type any comments about the education topic for the group encounter.

Click **Cancel** to clear the fields on the **Group Education** tab.

Click **OK** when all fields are complete. This adds a record to the Education grid.

Delete Group Education Record

1. Select a group education record to delete.
2. Click **Delete**.
3. At the "Are You Sure" confirmation message, click **Yes** to remove the selected Education record from the group box. (Otherwise, click **No**.)

Note: The Group Education can be removed only prior to saving the group. Once the group has been saved, there is currently no way to remove it in the group format.

5.3.5 Patients Tab

The **Patients** tab shows the patients in the group encounter.

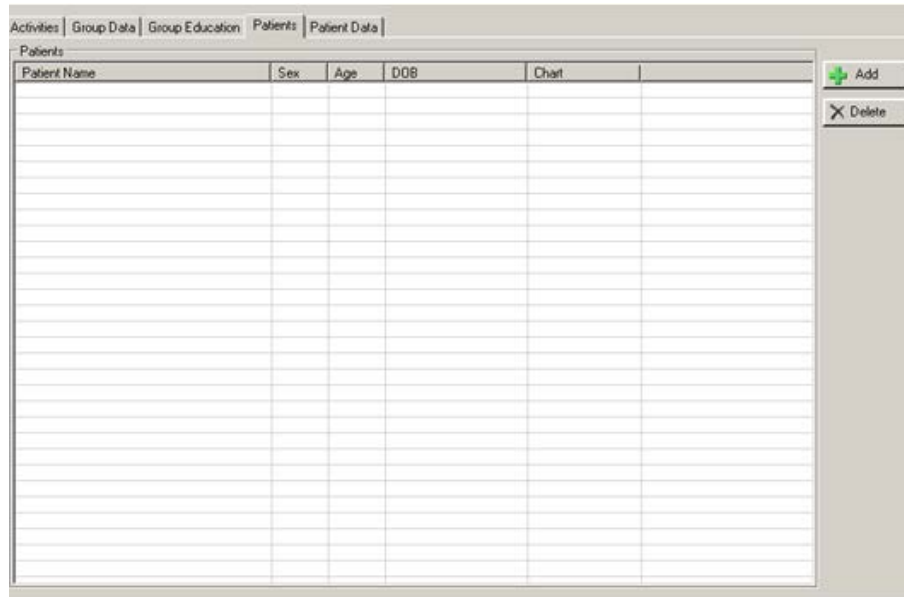


Figure 5-46: Sample Patients tab

The information on this tab is read-only when using the **Edit Group Data** window.

You can add or delete patient records on this tab (on the “Add” window).

Add Patient Record

The **Add** button requires that the POV group box and the Standard Note Group Note (on the Group Data tab) be populated.

1. Click **Add** to access the **Select Multiple Patients** window.

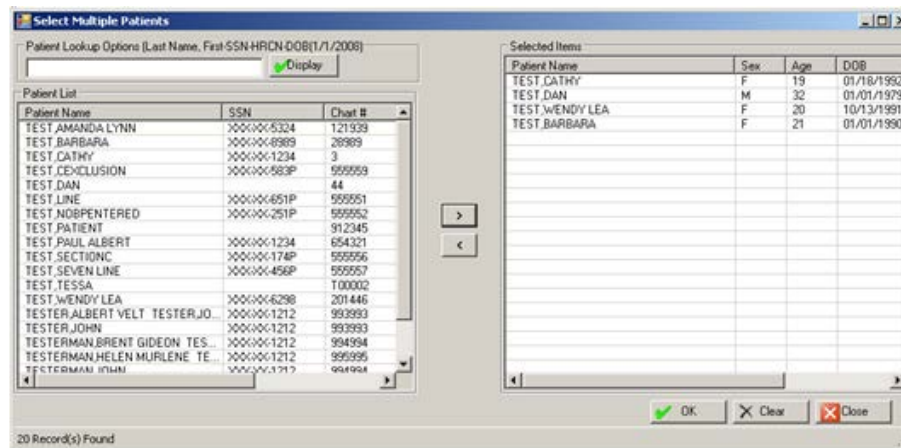


Figure 5-47: Sample Select Multiple Patients dialog box

Use this dialog box add one or more patients to the **Patients** tab.

2. At the **Patient Lookup** field, type the patient name, HRM, DOB, or SSN.
3. Click **Display**.
4. The retrieved patients display in the **Patient List** box.
5. Select one or more patient names from the **Patient List** group box and click the right-pointing arrow to add them to the **Selected Items** list box.
6. If needed, select a patient name from the **Selected Items** list box and click the left-pointing arrow to move the patient name to the **Patient List** box.
7. When the **Selected Item** list box is complete, do one of the following:
 - Click **OK** to have the patient names to populate the **Patients** group box (on the Patients tab). This closes the **Select Multiple Patients** dialog box.
 - Click **Clear** to have all of the patient names removed from the **Selected Items** group box and the focus stays on the **Select Multiple Patients** window.
 - Click **Close** to close **Select Multiple Patients** window and no patient names are added to the **Patients** group box.

Delete Patient Record

1. Select a patient record to delete.
2. Click **Delete**.
3. At the “Are You Sure” confirmation message, click **Yes** to remove the selected patient record from the Patient group box. (Otherwise, click **No**.)

Note: Leave the clients who no showed or canceled in the group because it is possible to do the “no show” within the group definition on the Patient Data tab in the Time In Activity field.

5.3.6 Patient Data Tab

Use the **Patient Data** tab to add POV, group note, and comment/next appointment information for a particular patient in the group encounter.

Patient Name	Sex	Age	DOB	Chart
EBY,ROBERT MITCHELL	M	15	02/19/1998	186585
FAUST,JIMMY JOE	M	27	11/01/1986	129347
COCHRAN,EDWARD RAYDEAN	M	43	07/23/1970	107900
BORWANI ISMEEL A	M	47	09/16/1971	106476

Figure 5-48: Sample Patient Data tab

The following table provides information about the features on this window.

Features	Functionality
Patients list field	Select a patient by double-clicking the name in the Patients list box in order to activate the other group boxes.
OK button	Click OK after selecting a patient record and changing or adding new patient data to save the patient data.
Cancel; button	Click Cancel to not save the changes and to dismiss the Patient Data tab.

Patients List Box

The **Patients** list box shows the patients in the group encounter.

Patient Name	Sex	Age	DOB	Chart
DEMO,TIMMIE	M	9	06/18/1999	192144
DEMO,DOROTHY ROSE	F	66	10/10/1942	999999
DEMO,COLTON MAXWELL	M	31	05/18/1977	100678

Figure 5-49: Sample Patients group box

Double-click one of the patient names in order to use the other group boxes and fields.

After completing the information for the first patient, click **OK**. The focus returns to the **Patients** list box. Then double-click the next patient. After completing the information for the second patient, click **OK**. Repeat this process until all of the patients are complete. Then click **Save** to save all of the information.

If you are in ADD mode and you have clicked **OK** and then try to go to the **Group Data** tab, the application displays the **Continue** warning.

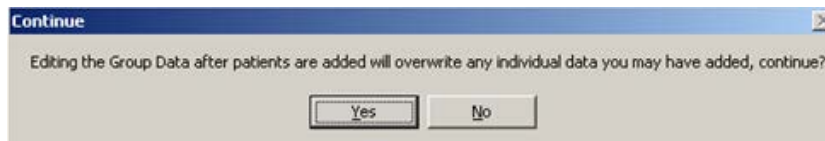


Figure 5-50: Warning Message

- Click **Yes** to overwrite any added individual data. This focus will go to the Group Data tab.
- Click **No** to not overwrite any added individual data. The focus will go to the Patients Data tab.

Purpose of Visit - POV (Diagnosis or Problem Code) Group Box

Use the **Purpose of Visit - POV (Diagnosis or Problem Code)** group box to add, edit, or delete a POV for the selected patient. (Be sure to double-click a patient name before adding/changing the data in this group box.)

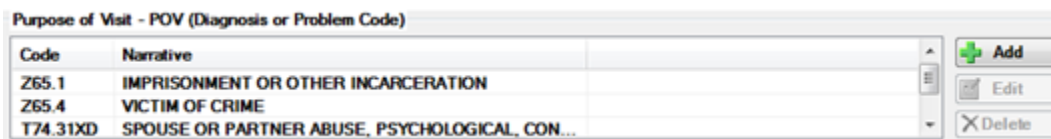


Figure 5-51: Sample POV group box

This is required data for the group encounter record.

You can add, edit, or delete POV code records.

Delete Button

1. Select a POV record to delete.
2. Click **Delete**.
3. At the “Are You Sure” confirmation message, click **Yes** to remove the selected POV record from the POV group box. (Otherwise, click **No**.)

Add Button

1. Click **Add**.
2. The **POV** multiple search/select window displays.

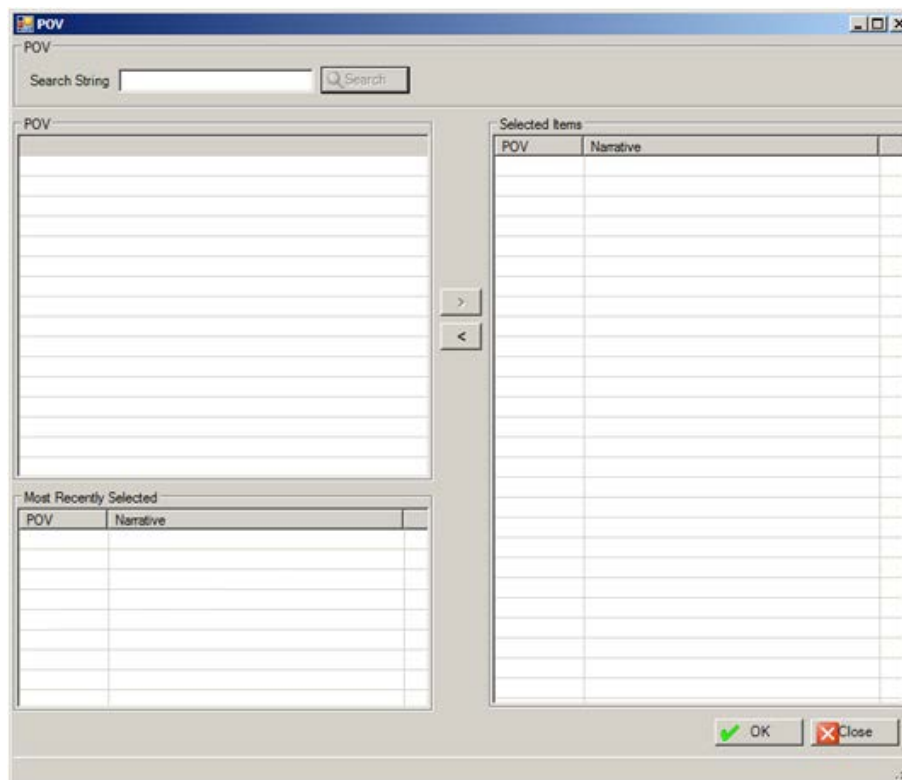


Figure 5-52: Sample POV multiple select/search window

Use the POV multiple search/select window in the following manner:

- a. At the **Search String** field, type a few characters of the search criteria.
- b. Click **Search** and the retrieved records display in POV list box (the POV and its narrative).
- c. To add one or more selected records from the POV list box to the **Selected Items** list box, click the right-pointing arrow button.
- d. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
- e. Another way to add records to the **Selected Items** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.
- f. When the records in the **Selected Items** list box is complete, click **OK** and the records populate the **Purpose of Visit (POV)** group box. (Otherwise, click **Close**.)

Edit Button

1. Select a POV record to edit.
2. Click **Edit** to display the **Edit POV** dialog box.

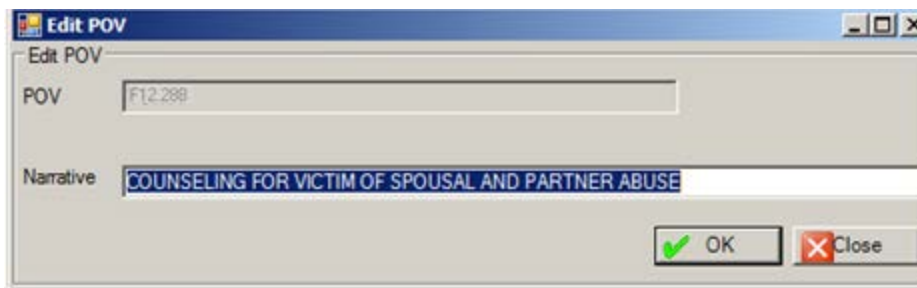


Figure 5-53: Sample Edit POV dialog box

3. At the **Narrative** field, change the text of the narrative, using 2–80 characters. Note: the special characters (such as “, *, ‘) cannot be the first character of the POV narrative. The Narrative field is a Free Text field.
4. Click **OK** to change the narrative of the selected code on the **POV** group box on the Patients Data tab.
5. Otherwise, click **Close** to not change the narrative.

Standard Group Note Field

Populate this Free Text field with the text of the Standard Group Note. This information, for example, could be about how the patient reacted in the group (on the Patient Data tab).

This is where to individualize the note for the patient in focus. The standard group note should never reference the individual patient but should have information about the individual patient’s participation in the group.

- This field is available for text entry by the primary provider of the record (only).
- This field is not available for text entry if the note for the group record is signed.

Comment/Next Appointment Field

Populate this Free Text field with the text of any comments about the next appointment for the selected patient. This field is available for text entry by the primary provider of the record (only).

CPT Codes Group Box

Use this group box to manage the CPT codes for the selected patient in the group.



Figure 5-54: CPT Code(s) group box

You can add or delete CPT code records.

Delete Button

1. Select a CPT Code record to delete
2. Click **Delete**.
3. At the “Are You Sure?” confirmation, click **Yes** to remove the selected record from the **CPT Codes** group box. (Otherwise, click **No**).

Add Button

1. Click **Add**.
2. The **CPT Code** search/select window displays.

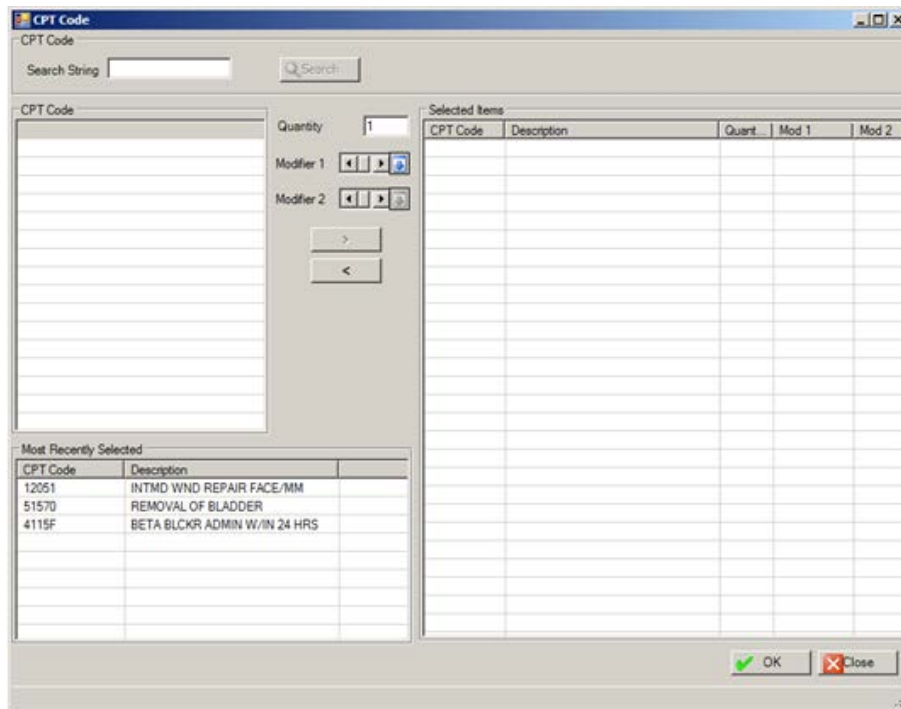


Figure 5-55: CPT Code search/select window

3. At the **Search String** field, type a search string to search for a particular CPT code. The CPT codes will display in the **CPT Code** field.

Figure 5-56: Sample CPT Code search results

4. At the **Quantity** field, type the number of the CPT code to use to help facilitate billing.
5. At the **Modifier** field, select the modifier for the CPT code. Click the drop-down list to access the **CPT Modifier** search window.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the CPT Modifier name and then clicking Search. The retrieved CPT Modifier names and their descriptions will populate the CPT Modifier list box. Select a CPT modifier and click OK to save the modifier. (Otherwise, click Close.)</p> <p>(2) Select a CPT modifier in the Most Recently Selected list box and click OK to save the modifier. (Otherwise, click Close.)</p>

Figure 5-57: Sample CPT Modifier search window

6. Remove a selected CPT code in the **Selected Items** list box by clicking the left-pointing arrow.
7. After the **Quantity** and **Modifier** fields are complete, click the right-pointing arrow to add the items to the **Selected Items** list box.
8. When the **Selected Items** list box is complete, click **OK** to save the data and to add the data to the CPT Code(s) group box. (Otherwise, click **Close**.)

Time in Group



Figure 5-58: Sample Time in Group field

1. At the **Time in Group** field, type the number of minutes in the group encounter (up to six digits).
2. This is required data for the group encounter record.

Consider the following:

- If the patient attended the whole group session, no changes need to be made to the **Time Spent** in Group field.
- If the patient was late or left early, the **Time Spent** in Group field needs to be changed to reflect the actual time in minutes that the patient was in the group.
- If the patient didn't attend at all, type a zero in the **Time In Group** field and then click **OK**. The application will display the No Show message that states: Changing Time in Group to zero removed this patient's POV and Note entry. You will now be prompted for a No Show POV. Click **OK**. After clicking **OK**, to access the **POV** search/select window. Here you can select one or more "no show" POVs. Click **OK** (otherwise, click **Cancel**). After clicking **OK**, the selected POVs will display in the **Purpose of Visits – POV** group box on the **Patient Data** tab (all existing POVs will be replaced by your selections).

Visit Flag



Figure 5-59: Visit Flag field

Use the **Visit Flag** field to specify the visit flag for the group encounter.

1. At the **Visit Flag** field, type any number between 0 and 999 (no decimal digits).
2. This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean

any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

6.0 Case Management

This section provides information about case management in the roll-and-scroll application, as well as in the RPMS Behavioral Health System (GUI).

6.1 Managing Case Data (Roll and Scroll)

Manage case data on the Patient Data Entry window by selecting the Update Case Data (CD) action. The application displays the Update BH Patient Case Data screen.

#	PROGRAM	OPEN	ADMIT	CLOSED	DISPOSITION	PROVIDER
1	MENTAL	12/19/15	12/19/15			THETA, SHIRLEY
	Primary Problem: F10.259 ALCOHOL-INDUCED PSYCHOTIC DISORDER WITH MODERATE OR Next Review:					
2	MENTAL	11/13/15	11/30/15			THETA, SHIRLEY
	Primary Problem: F42. HOARDING DISORDER					
3	MENTAL	3/13/14	3/20/14	6/2/14	MUTUAL AGREEMENT TO	THETA, SHIRLEY
	Primary Problem: 11 DRUG WITHDRAWAL SYNDROME					
	?? for more actions + next screen - prev screen					
OP	Open New Case		DC	Delete Case		
ED	Edit Case Data		Q	Quit		
Select Item(s):						

Figure 6-1: Sample Update BH Patient Case Data screen.

Use the Quit (Q) option to exit the Update BH Patient Case Data screen.

6.1.1 Open New Case (OP)

Use the Open New Case (OP) option to create a new case. If you use the Open New Case (OP) option, the application displays that it is opening a case for the current patient.

Below are the prompts.

1. At the “Select Item” prompt, type **OP**.
2. At the “Enter Case Open Date” prompt, type the date to open the case. This is the first contact for an episode of care. The Update Patient Case Data window displays.

```

***** UPDATE PATIENT CASE DATA *****
Patient Name: ALPHAA,CHELSEA MARIE
*****

CASE OPEN DATE: MAY 23,2009
PROGRAM AFFILIATION: MENTAL HEALTH
PROVIDER NAME:
PRIMARY PROBLEM:

CASE ADMIT DATE:
NEXT CASE REVIEW DATE:

DATE CASE CLOSED:
DISPOSITION:

COMMENT:
_____

COMMAND: Press <PF1>H for help Insert

```

Figure 6-2: Sample Update Patient Case Data window

The underlined fields are required.

3. At the “Case Open Date” prompt, type the date the case was opened (can be edited).
4. At the “Program Affiliation” prompt, type the program affiliation, using one of the following:
 - M** Mental Health Defaults
 - S** Social Services Defaults
 - C** Chemical Dependency or Alcohol/Substance Abuse
 - O** Other
5. At the “Provider Name” prompt, type the name of the provider for the case.
6. At the Primary Problem” prompt, type the primary problem (name or code).
7. At the “Case Admit Date” prompt, type the admit date for the case. This is when a case management plan was developed and treatment began.
8. At the Next Case Review Date” prompt, type the next date for the case review.
9. At the “Date Case Closed” prompt, type the date the case was closed. This is when treatment has been discontinued (used when closing a case).
10. At the “Disposition” prompt, type the disposition for the case. This is the reason for closing a case. This is a required field when there is a date in the Date Case Closed field.

11. At the “Comment” prompt, type the text of a comment about the case, using 1–240 characters.

6.1.2 Edit Case Data (ED)

Use the Edit Case Data (ED) option to change a selected case. Use this option to edit an open case where you enter the admitted date when a case is admitted or to close the case when it is closed on the Update Patient Data window.

1. At the “Select Item(s)” prompt, type **ED**.
2. At the “Select BH Patient Case Data” prompt, type the number of the case data to edit.
3. The UPDATE PATIENT CASE DATA window displays.

The fields on this window are the same as those when you use the Open New Case option. Section 6.1.1 provides more information.

6.1.3 Delete Case (DC)

Use the Delete Case (DC) option to remove a specified case from the Update BH Patient Case Data window.

1. At the “Select Item(s)” prompt, type **DC**.
2. At the “Select BH Patient Case Data” prompt, type the number of the case data to delete.
3. At the “Are you sure you want to delete this CASE?” prompt, type **Y** (yes) or **N** (no.)

6.1.4 Designated Provider/Flag/Personal History (Roll and Scroll)

Use the OI (Desg Prov/Flag/Pers Hx) option on the Patient Data Entry window to update patient information.

1. At the “Select Action” prompt, type **OI**.

The Update Patient Information window displays.

```

***** UPDATE PATIENT INFORMATION *****
Patient Name: DEMO,DARRELL LEE
[press <F1>E when finished updating record]

-----

DESIGNATED MENTAL HEALTH PROVIDER:
DESIGNATED SOCIAL SERVICES PROVIDER:
DESIGNATED CD A/SA PROVIDER:

```

```

DESIGNATED OTHER PROVIDER:
OTHER PROVIDER NON-RPMS:
OTHER PROVIDER NON-RPMS:
=====

PATIENT FLAG FIELD:
PATIENT FLAG NARRATIVE:

COMMAND:                                     Press <PF1>H for help   Insert

```

Figure 6-3: Sample Update Patient Information window

The data on this window applies to the current patient.

2. At the “Designated Mental Health Provider” prompt, type the RPMS provider name who has accepted designated Mental Health provider status for the patient.
3. At the “Designated Social Services Provider” prompt, type the PRMS provider name who has accepted designated Social Services provider status for the patient.
4. At the “Designated CD A/SA Provider” prompt, type the RPMS provider name who has accepted designated chemical dependency or alcohol/substance abuse provider status for the patient.
5. At the “Designated Other Provider” prompt, type the RPMS provider name who has accepted the designated other provider status for the patient.
6. At the “Other Provider Non-RPMS” prompt, type another behavioral health provider name not listed in RPMS (this could be a local doctor, school teacher, etc.), using between 2 and 40 characters. This is a Free-Text field.
7. At the “Patient Flag Field” prompt, type a locally-defined number field used to identify a specific group of patients (between 0 and 999). For example, 1 could designate patients with a family history of substance abuse, 2 could be used to identify patients enrolled in a special social services program, 3 could be used to identify patients enrolled in a special drug trial. In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.
8. At the “Patient Flag Narrative” prompt, type the narrative about the patient flag, using between 2 to 60 characters.

After you save or exit the Update Patient Information window, the application displays the Personal History window.

If the patient has an existing Personal History entry, the application displays this information (the date and the personal history factor). You can add another personal history factor, if needed.

Facilities often find personal history factors to be useful in developing reports for tracking diagnoses associated with personal history.

```
***** PERSONAL HISTORY FOR DEMO,DOROTHY ROSE*****
TWIN
DIABETES
Enter PERSONAL HISTORY:
```

Figure 6-4: Sample Personal History window

Below are the prompts.

9. At the “Enter personal history” prompt, type the personal history factor for the current patient. If you do not want to add another personal history, use a caret (^) at the prompt. Choose from:

ALCOHOL USE
 BOARDING SCHOOL
 CHILD ABUSE (VICTIM)
 DIABETES
 FETAL ALCOHOL SYNDROME
 GULF WAR VET
 PARTNER ABUSE (VICTIM)
 SUBSTANCE ABUSE
 SUICIDE ATTEMPT
 TESTING
 TWIN
 VIETNAM WAR VET
 WWII VET
 Chem
 co-occurring

10. After you have completed the personal history entry, the focus returns to the Patient Data Entry window.

The personal history data entered here appears on the Patient List for Personal Hx Items report.

6.2 Case Management Window (GUI)

The figure below shows where the Case Management function is located on RPMS Behavioral Health System (GUI) tree structure.

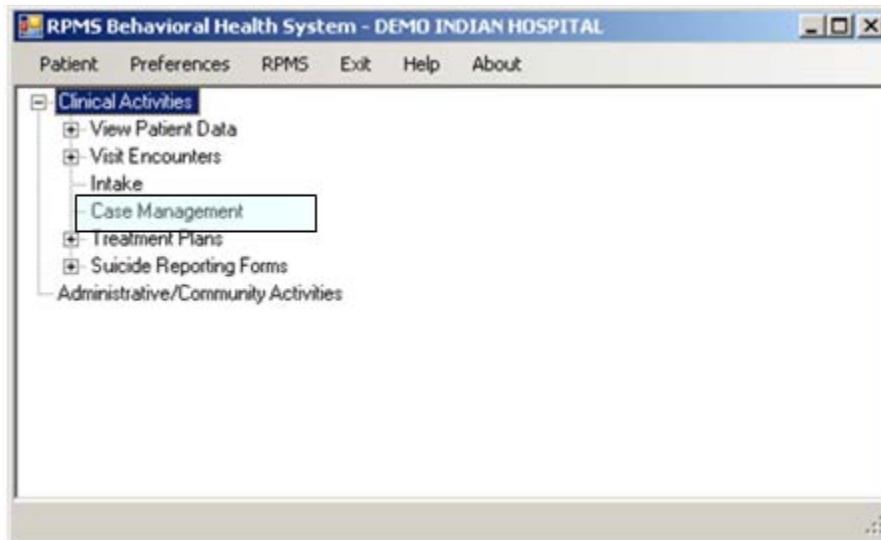


Figure 6-5: Case Management option on the RPMS Behavioral Health System (GUI) tree structure

Use the **Case Management** option to access the **Case Management** window for the current patient.

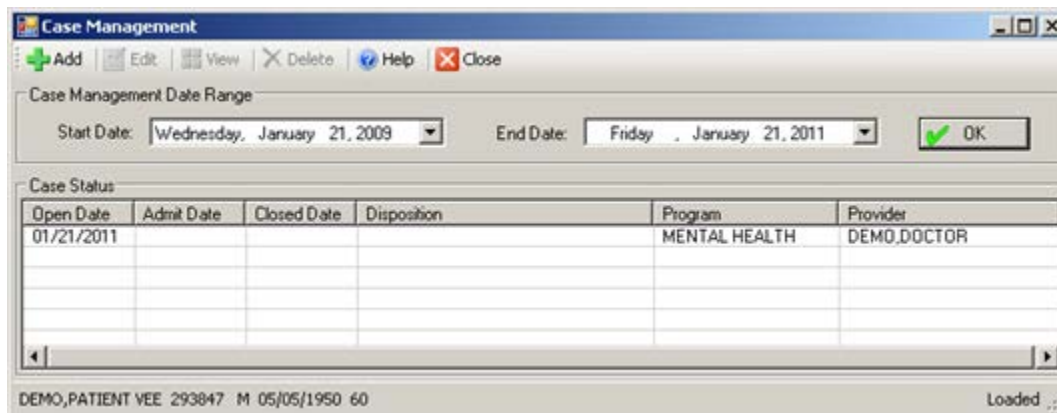


Figure 6-6: Sample Case Management window

You use the **Case Management** window to manage the case management records within a particular date range for the current patient (the name displays in the lower, left corner of the window).

The following table provides information about the features of this window.

Feature	Functionality
Case Management Date Range	The date range for the displayed case management records is shown in the Case Status Date Range group box. You can change the date range by accessing the calendar under the drop-down list for the date. After changing the date range, click OK to update the display in the Case Status group box.
Case Status Group Box	The Case Status group box displays the case management records in the case management data range.
Add Button	Establish the patient you want to use in the add process. Click Add to add a new case management record. You access the Case Management–Add Case window.
Edit Button	Click Edit to edit a particular case management record. The application displays the Case Management–Edit Case window.
View Button	Click View (or double-click on a record) to view the data in a selected Case Management record. The application displays the Case Management–View Case window. The fields are the same as those on the add/edit case window.
Delete Button	Click Delete to remove a selected Case Status record. After clicking Delete , the Are You Sure? confirmation message displays, asking if you are sure you want to delete. Click Yes to remove the selected case status record from the group box (otherwise, click No .)
Help Button	Click Help to access the online help system for the Case Management window.
Close Button	Click Close to close the Case Management window.

6.3 Add/Edit Case Management Data (GUI)

Use this function to add or edit case management data.

1. Click **Add** and the **Case Management–Add Case** window displays.

OR

2. To edit a selected record, click **Edit**. The **Case Management–Edit Case** window displays; this window has the same fields as the **Case Management–Add Case** window.
3. The following shows the **Case Management–Add Case** window.

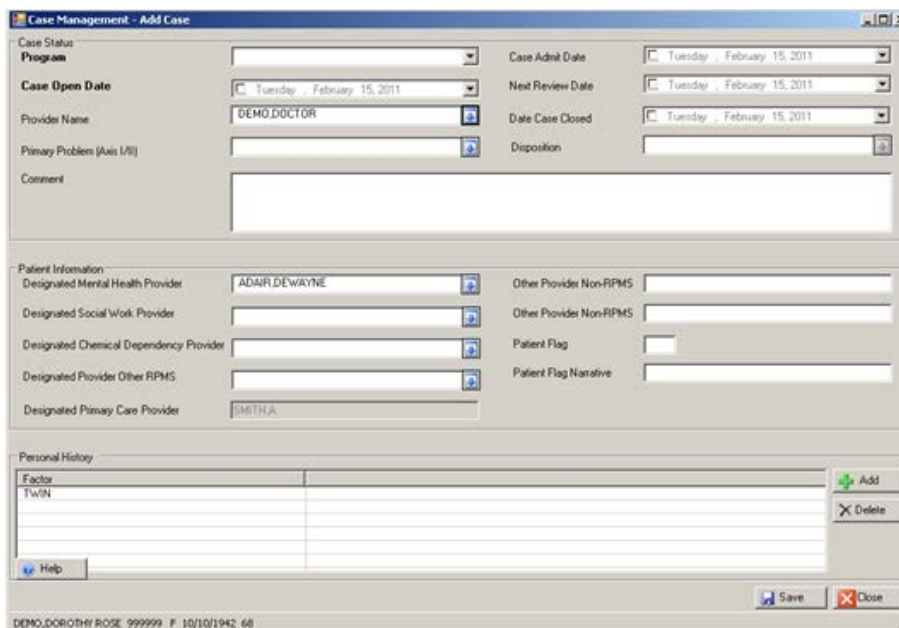


Figure 6-7: Sample Case Management–Add Case window

The following table provides information about the buttons on this window.

Button	Functionality
Save	Use to save the case management information on this window. This process dismisses the window.
Close	Click this button to display the Continue? dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add window. Click No and you remain on the add window where you can continue work on the Add Case window.
Help	Use to access the online help for this window.

6.3.1 Case Status Group Box

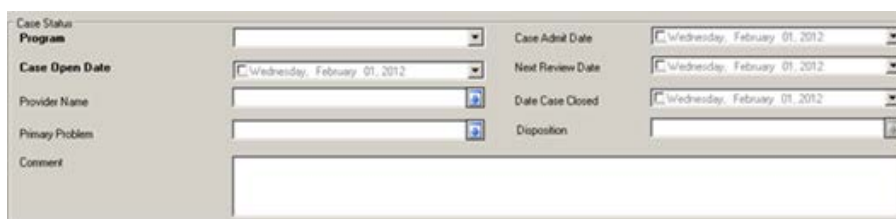


Figure 6-8: Fields in Case Status group box

The fields in bold text are required.

1. At the **Program** field, select the program associated with the new case. Use one of the following from the drop-down list:

Mental Health

Social Services

Other

Chemical Dependency

2. At the **Case Admit Date** field, select the case admit date. This is when a case management plan was developed and treatment began. You can accept the default date by checking the check box in front of the date. The default is the current date. Click the drop-down list to access a calendar to change the field.
3. At the **Case Open Date** field, select the case open date. This is the first contact for an episode of care. The default is the current date. Click the drop-down list to access a calendar to change the field.
4. At the **Next Review Date** field, select the new review date. The default is the current date. Click the drop-down list to access a calendar to change the field. You can accept the default date by checking the check box in front of the date.
5. At the **Provider Name** field, select the primary provider for the case (the default is the current logon user). Click the drop-down list to access the **Primary Provider** search/select window.

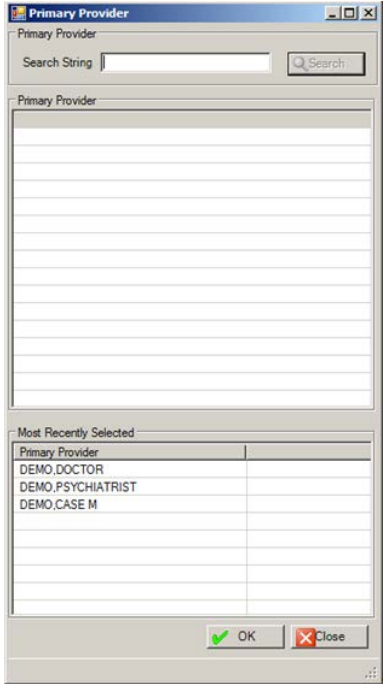
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a name and click OK to populate the Provider Name field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider Name field. (Otherwise, click Close.)</p>

Figure 6-9: Sample Primary Provider search/select window

6. At the **Date Case Closed** field, select the date the case was closed. This is when treatment has been discontinued. The default is the current date. Click the drop-down list to access a calendar to change the field. You can accept the default date by checking the check box in front of the date.
7. At the **Primary Problem** field, select the primary problem for the case. Click the drop-down list to access the **POV** search window.

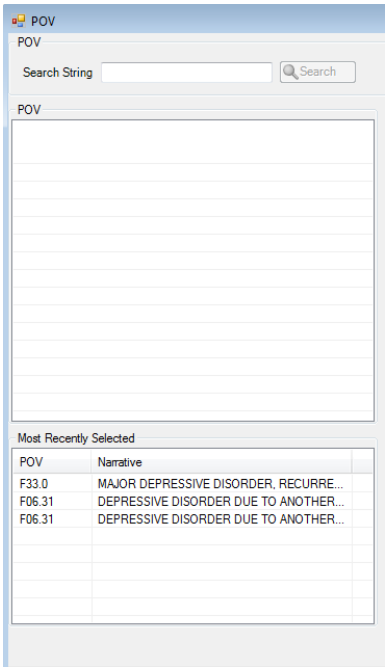
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the POV for the primary problem for the case and then Search. The retrieved POVs will populate the POV list box. Select a retrieved record and click OK to populate the Primary Problem field. (Otherwise, click Close.)</p> <p>(2) Select a record in the Most Recently Selected list box and click OK to populate the Primary Problem field. (Otherwise, click Close.)</p>

Figure 6-10: Primary Problem/POV search window

8. At the **Disposition** field, select the reason for closing a case. Click the drop-down list to select an option on the **Disposition** select window. This is required when there is a date in the **Date Case Closed** field.

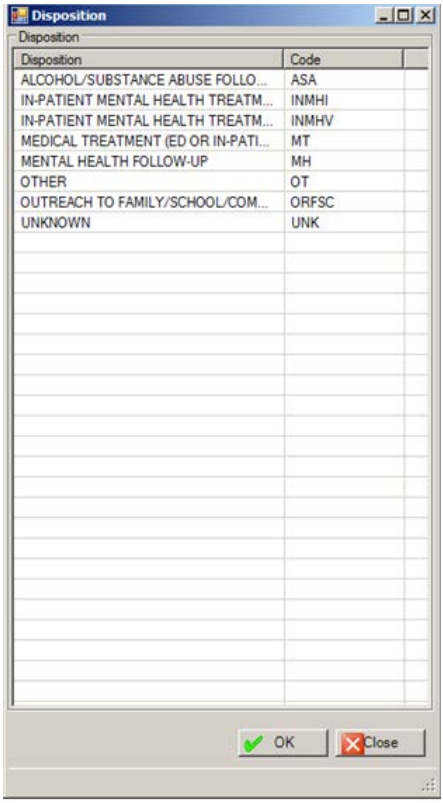
Screen Capture	What to do
	<p>Use this search window as follow:</p> <ol style="list-style-type: none"> (1) Select a Disposition option and click OK (otherwise, click Cancel). (2) If OK was used, the selected option populates the Disposition field.

Figure 6-11: Sample Disposition select window

9. At the **Comment** prompt, type a comment about the case, using 1–240 characters, in this Free Text field.

6.3.2 Patient Information Group Box

Use the **Patient Information** group box to supply information about various providers and other case management information.



Figure 6-12: Fields in the Patient Information group box

Note: These fields should be cleared out whenever the case is closed; otherwise, the patient will continue to show up on the provider's case list. To clear the field, right-click and select **Clear**.

All fields are optional.

1. At the **Designated Mental Health Provider** field, select the RPMS provider name who has accepted designated mental health provider status for the patient. Click the drop-down list to access the **Designated Mental Health Provider** search window.

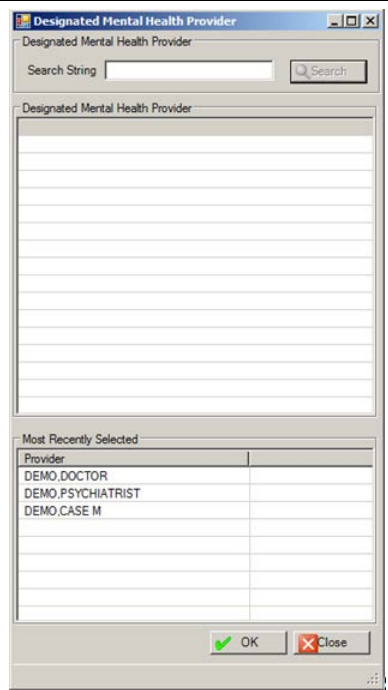
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Designated Mental Health Provider list box. Select a retrieved record and click OK to populate the Designated Mental Health Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Designated Mental Health Provider field. (Otherwise, click Close.)</p>

Figure 6-13: Sample Designated Mental Health Provider search window

2. At the **Other Provider Non-RPMS** field, type another Behavioral Health provider name not listed in RPMS, using between 2–40 characters (free text field).
3. At the **Designated Social Work Provider** field, select the RPMS provider who has accepted designated social work provider status for the patient. Click the drop-down list to access the **Designated Social Work Provider** search window.

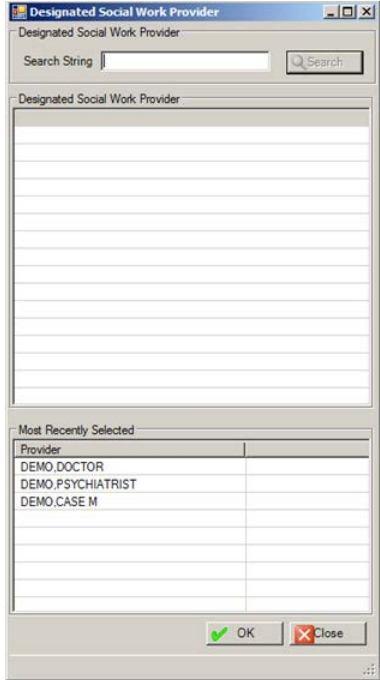
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Designated Social Work Provider list box. Select a retrieved record and click OK to populate the Designated Social Work Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Designated Social Work Provider field. (Otherwise, click Close.)</p>

Figure 6-14: Sample Designated Social Work Provider search window

4. At the **Other Provider Non-RPMS** prompt, type another provider name not listed in RPMS, using between 2–40 characters (Free Text field).
5. At the **Designated Chemical Dependency Provider** field, select the RPMS provider name who has accepted designated chemical dependency provider status for the patient. Click the drop-down list to access the **Designated Chemical Dependency Provider** search window.

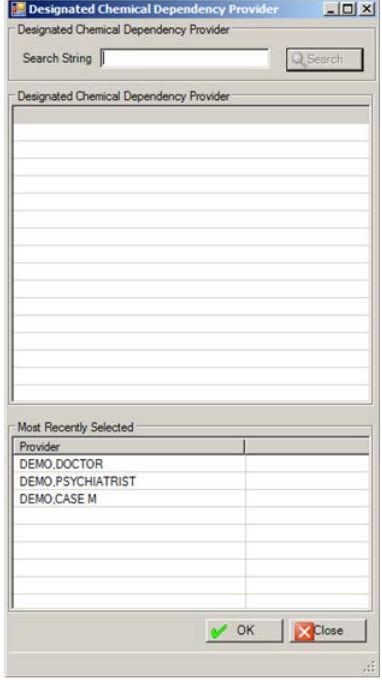
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Designated Chemical Dependency Provider list box. Select a retrieved record and click OK to populate the Designated Chemical Dependency Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Designated Chemical Dependency Provider field. (Otherwise, click Close.)</p>

Figure 6-15: Sample Designated Chemical Dependency Provider search window

6. At the **Patient Flag** field, type a locally-defined number field used to identify a specific group of patients (free text field), using 0–999. For example, 1 could designate patients with a family history of substance abuse, 2 could be used to identify patients enrolled in a special social services program, 3 could be used to identify patients enrolled in a special drug trial. In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.
7. At the **Designated Provider Other RPMS** field, select the RPMS provider who has accepted designated other RPMS provider status for the patient. Click the drop-down list to access the **Designated Other RPMS Provider** search window.

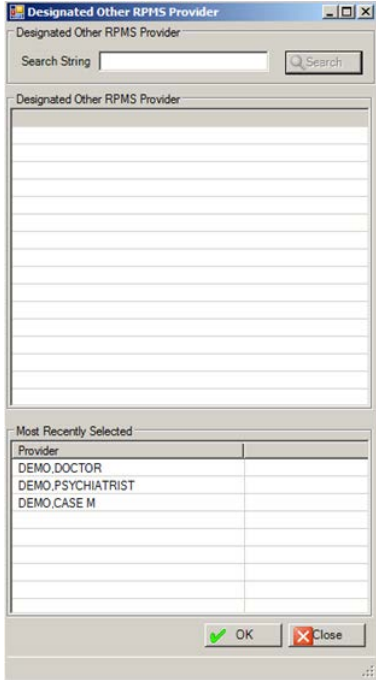
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Designated Other RPMS Provider list box. Select a retrieved record and click OK to populate the Designated Provider Other RPMS field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Designated Provider Other RPMS field. (Otherwise, click Close.)</p>

Figure 6-16: Sample Designated Provider Other RPMS search window

8. At the **Patient Flag Narrative** field, type the narrative about the patient flag, using between 2–60 characters.
9. At the **Designated Primary Care Provider** prompt, the application displays the name of the designated primary care provider for the patient (if any). This information is pulled from the Primary Care Provider application and is view-only.

6.3.3 Personal History Group Box

Use the **Personal History** group box to add or delete personal history data about the current patient.

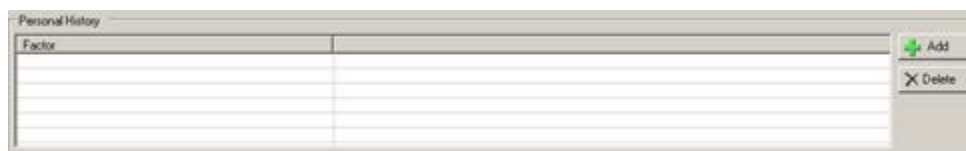


Figure 6-17: Sample Personal History group box

You only need to document personal history once, because it does become a permanent part of the patient's medical record. Facilities often find personal history factors to be useful in developing reports for tracking diagnosis associated with personal history.

Add Button

1. Click **Add**.
2. The **Personal History Factors** multiple select window where you can add one or more personal history factors.

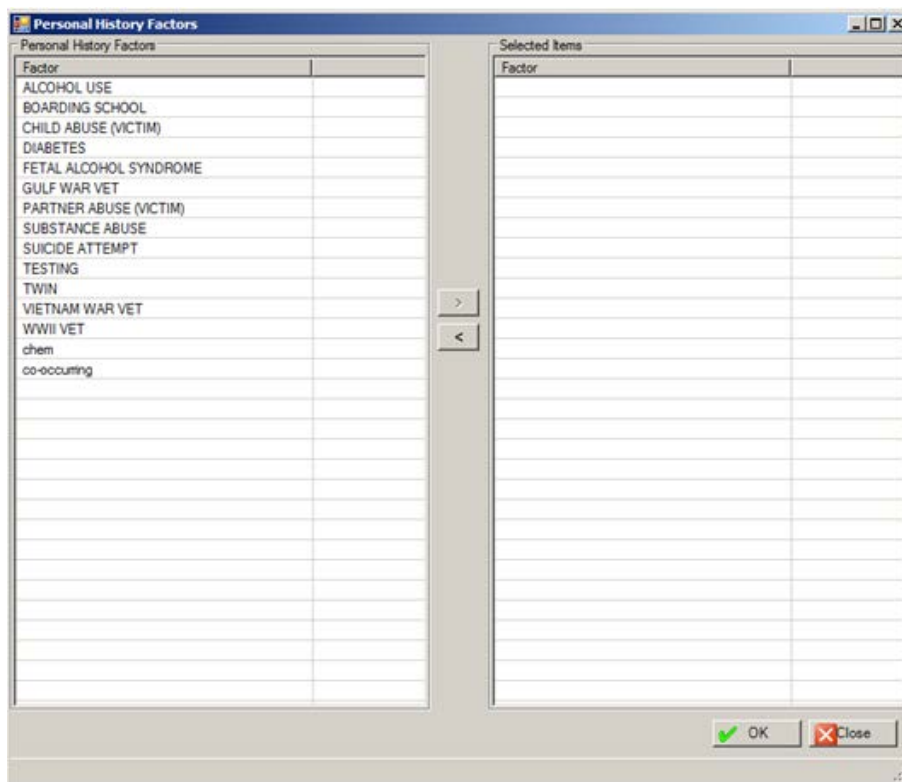


Figure 6-18: Sample Personal History Factors multiple select window

Use this multiple select window as follows:

- a. To add one or more selected records from the **Personal History Factors** list box to the **Selected Items Factor** list box, click the right-pointing arrow button.
- b. Similarly, you can remove one or more selected records from the **Selected Items Factor** list box by clicking the left-pointing arrow button.
- c. When the **Selected Items Factor** list box is complete, click **OK** and the records populate the **Personal History** group box. (Otherwise, click **Close**.)

Delete Button

1. Select the personal history record to delete.
2. Click **Delete**.
3. At the “Are You Sure?” confirmation message, type **Y** (yes) or **N** (no).

7.0 Administrative/Community Activity

The Administrative/Community Activity option gives assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems.

7.1 Add Administrative/Community Activity Record (Roll and Scroll)

Below is the Update BH Forms window.

```

Update BH Forms                Apr 06, 2009 16:56:47                Page:    1 of    1
-----
Date of Encounter:  Tuesday MAR 31, 2009
-----
#  PRV PATIENT NAME                HRN        AT  ACT  PROB  NARRATIVE
1  BJB ALPHAA,CHELSEA M WW116431    60  13  97    ADMINISTRATIVE
2  rust ALPHAA,CHELSEA MWW116431    90  42  96    TRAINING NEEDS

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

Figure 7-1: Sample Update BH Forms window

Use the AC option to add administrative/community activity record.

1. At the "Select Action" prompt, type **AC**.
2. At the "Enter Primary Provider" prompt, type the primary provider for the visit. The default is the current logon user.

The application displays the Behavioral Health Record Update window, with the following fields automatically populated: Program, Location of Encounter, Arrival Time, Secondary Providers, Community of Service, # Served, Type of Contact. These fields are auto-populated based on the defaults set up on the site parameters menu. If you do not have defaults set up on the site parameters menu some of these fields might be blank.

```

* BEHAVIORAL HEALTH VISIT UPDATE *      [press <F1>E when visit entry is complete]
Encounter Date: JAN 17,2014@12:00      User: TETER,SHIRLEY
Patient Name: DEMO,DOROTHY ROSE      DOB: 10/10/42      HR#: 999999
-----
Arrival Time: 12:00
  
```

```

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

Activity:      Activity Time:      # Served: 1      Interpreter?

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

COMMAND:                                     Press <PF1>H for help      Insert

```

Figure 7-2: Sample Behavioral Health Record Update

The underlined fields are required.

3. At the “Program” prompt, type the program associated with the record.
4. At the “Clinic” prompt, type the clinic to be used. The response must be a clinic that is included in the RPMS clinic code set.
5. At the “Location of Encounter” prompt, type the location of the encounter.
6. At the “Arrival Time” prompt, type the arrival time of the encounter (default is 12:00).
7. At the “Display/Edit Visit Information” prompt, type **Y** (yes) or **N** (no).

If Y was used, the Visit Information pop-up displays.

```

*****      Visit Information      *****

Program: MENTAL HEALTH      Location of Encounter: DEMO INDIAN HOSPITAL
Clinic: MENTAL HEALTH      Appointment/Walk In: APPOINTMENT
Type of Contact: OUTPATIENT
Community of Service: SELLS

```

- a. At the “Program” prompt, type the program
8. At the “Any Secondary Providers?” prompt, type **Y** (yes) or **N** (no) to indicate if there were any additional BHS providers who were also providing care during this particular encounter. Use Y to display the Enter/Edit Providers of Service pop-up.

```

***** ENTER/EDIT PROVIDERS OF SERVICE *****
Encounter Date: MAR 31,2009@12:00      User: THETA,SHIRLEY
-----
PROVIDER: DEMO,DOCTOR                PRIMARY/SECONDARY: PRIMARY
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
-----
COMMAND:                               Press <PF1>H for help
Insert

```

Figure 7-3: Sample Enter/Edit Providers of Service pop-up

The underlined fields are required.

- a. At the “Provider” prompt, type the provider name.
- b. At the “PRIMARY/SECONDARY” prompt, type **P** for primary or **S** for secondary.

You can add one or more secondary providers.

The prompts for the Behavioral Health Record Update window continue.

9. At the “Community of Service” prompt, type the community of service where the encounter took place.
10. At the “Activity Code” prompt, type the activity code associated with the encounter. Section Appendix A: provides more information about Activity Codes and Definition.
11. At the “# Served” prompt, type the number of people served in the community activity, using any integer between 0 and 999.
12. At the “Activity Time” prompt, type the number of minutes spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry.
13. At the “Type of Contact” prompt, type the contact type (the activity setting).
14. At the Local Service Site” prompt, type the local service site for the encounter.
15. At the Any Prevention Activities to Record?” prompt, type **Y** (yes) or **N** (no).

If **Y** was used, the Prevention Activities pop-up displays:

```

Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:

```

Figure 7-4: Pop-up for prevention activities

The Target field will be disabled until a Prevention Activity is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

The underlined fields are required.

- a. At the “PREVENTION ACTIVITY” prompt, type the code for the prevention activity. These activities are recorded when recording non-patient activities. You can enter more than one, if needed.
- b. At the “TARGET” prompt, type the code of the population the prevention activity is designed for: A (Adult), Y (Youth), F (Family), M (Mixed Adult & Youth), S (Staff), E (Elderly Only), W (Women), (Men).

The prompts for the Behavioral Health Record Update window continue.

16. At the “Purpose of Visits (POVS) <press enter>” prompt, press Enter to access the BH Record Entry–Purpose of Visit Update window.

```

***** BH RECORD ENTRY - PURPOSE OF VISIT UPDATE *****

Encounter Date: MAR 31,2009@12:00   User: THETA,SHIRLEY
[press <F1>C to return to main screen]

-----

PROBLEM CODE:          NARRATIVE:
PROBLEM CODE:          NARRATIVE:
PROBLEM CODE:          NARRATIVE:
PROBLEM CODE:          NARRATIVE:
PROBLEM CODE:          NARRATIVE:
PROBLEM CODE:          NARRATIVE:

-----

COMMAND:                               Press <PF1>H for help
Insert

```

Figure 7-5: Sample BH Record Entry POV window

The underlined fields are required.

- a. At the “Problem Code” prompt, type the problem code that can either be the Behavioral Health Purpose of Visit or the more specific DSM IV diagnostic code.
- b. At the Narrative” prompt type the text of the narrative for the problem code, if needed.

The prompts for the Behavioral Health Record Update window continue.

17. At the “COMMENT (press enter)” prompt, press Enter to access another window where you can enter the text of comments about the Administrative/Community Activity.

7.2 Administrative/Community Activity Window (GUI)

Below shows where the **Administrative/Community Activities** function is located on RPMS Behavioral Health System (GUI) tree structure.



Figure 7-6: Administrative/Community Activities option on the RPMS Behavioral Health System (GUI) tree structure

After selecting the **Administrative/Community Activities** option from the RPMS Behavioral Health System (GUI) tree structure, the **Administrative/Community Activity** window displays.

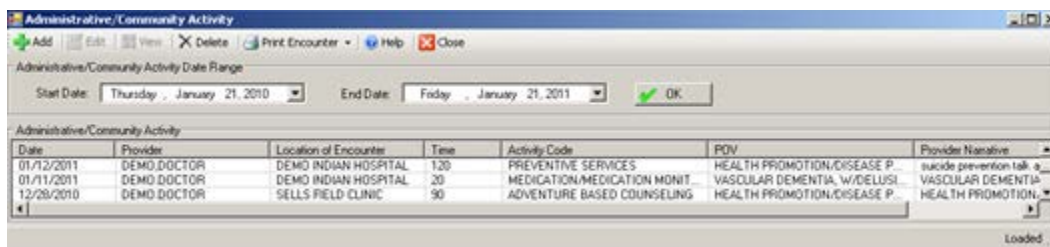


Figure 7-7: Sample Administrative/Community Activity window

The **Administrative/Community Activity** window shows the administrative / community activities records.

The following table provides information about the features on this window.

Features	Functionality
Administrative/Community Activity Date Range	This group box shows the date range for the records in the Administrative/Community Activity group box. You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click OK to display the records in the Administrative/Community Activity group box.
Administrative/Community Activity List Box	The records are listed in date order, within the administrative/community activity date range.
Add Button	Click Add to add a new administrative/community activity data record. You access the Administrative/Community Activity Data Entry–Add Administrative/Community Data.
Edit Button	Click Edit to edit a particular new administrative/community activity record. This function displays the Administrative/Community Activity Data Entry–Edit Administrative/Community Data. This window has the same fields as the Administrative/Community Activity Data Entry–Add Administrative/Community Data.
View Button	Highlight an administrative/community activity record on the Administrative/Community Activity window and click View to browse the data (or double-click on a record). The Community Activity Data Entry–View Community Data window displays; this is a view-only window. The fields are the same as for the data entry (add/edit) windows. Click Close to dismiss this window.
Delete Button	Click Delete to delete a particular record. The application confirms the deletion.
Help Button	Click Help to access the online help system for the Administrative/Community Activity window.
Close Button	Click Close to dismiss the Administrative/Community Activity window.
Print Encounter Button	Click Print Encounter to print/browse an administrative/community activity record. Highlight the record and click Print Encounter . Select one of the following options: Full , Suppressed , Both Full and Suppressed . Suppressed means the chief complaint/presenting problem information is suppressed for confidentiality. The application displays the Print Encounter pop-up window.

7.3 Add/Edit Administrative/Community Activity (GUI)

Click **Add** (on the **Administrative/Community Activity** window) to add new administrative/community activity data. This function displays the

Administrative/Community Activity Data Entry–Add Administrative/Community Data window.

Highlight a record (on the **Administrative/Community Activity** window) and click **Edit** to change the administrative/community activity data. This function displays the **Administrative/Community Activity Data Entry–Edit Administrative/Community Data** window. This window has the same fields as the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**.

Figure 7-8: Sample Community Activity Data Entry–Add Community Data window

Click **Help** to access the online help for this window.

After you have completed the fields on this window, click **Save** (otherwise, click **Close**). The Save function adds a record to the **Administrative/Community Activity** window.

7.3.1 Administrative/Community Entry Group Box

Below is the **Administrative/Community Entry** group box.

Figure 7-9: Sample Community Entry group box

The fields in bold text are required.

1. At the **Primary Provider** field, select the primary provider name for the administrative/community activity. Click the drop-down list to access the **Primary Provider** search/select window where you search for the primary provider name.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a name and click OK to populate the Primary Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Primary Provider field. (Otherwise, click Close.)</p>

Figure 7-10: Primary Provider search window

2. At the **Encounter Date/Time** field, type the date/time. The default is the current date and time. Change the date by clicking the drop-down list to access the calendar. You can change the time manually. You can select the hour, minutes, and AM/PM. If you make the hour and minutes, for example, 13:25, the application automatically changes the time to 1:25 PM.
3. At the **Program** field, type the program name. This is the program associated with the administrative/community activity. Use one of the following:

Mental Health**Social Services****Other****Chemical Dependency**

After completing this field for a new record, the application automatically populates the remaining required fields if defaults were set up in the Site Parameters.

- At the **Encounter Location** field, select the location where the administrative/community activity took place. Click the drop-down list to access the **Location** search window. Here you search for a location name.

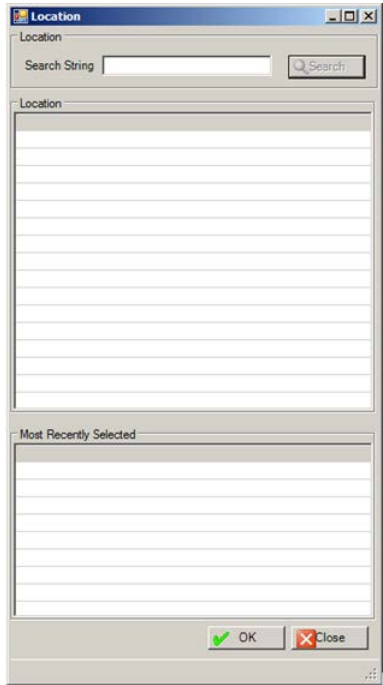
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the location and then clicking Search. The retrieved locations will populate the Location list box. Select a location and click OK to populate the Encounter Location field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Encounter Location field. (Otherwise, click Close.)</p>

Figure 7-11: Sample Location search window

- At the **Type of Contact** field, select the type of contact (the activity setting) for the administrative/community activity. Click the drop-down list to access the **Type of Contact** select window.

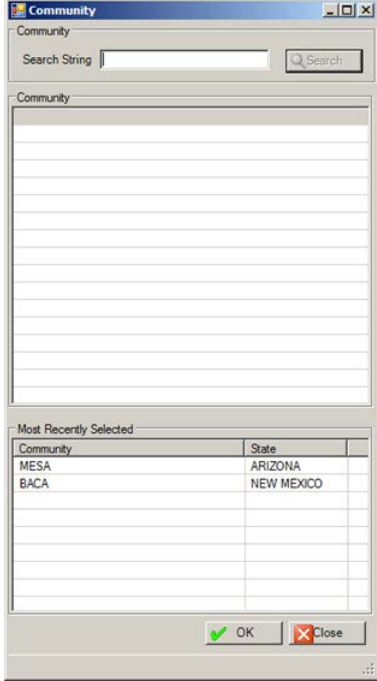
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the community name and then clicking Search. The retrieved names will populate the Community list box. Select a retrieved record and click OK to populate the Community of Service field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Community of Service field. (Otherwise, click Close.)</p>

Figure 7-13: Sample Community search/select window

- At the **Clinic** field, select the clinic associated with the administrative/community activity. Click the drop-down list to access the **Clinic** search/select window. Here you search for the clinic by name or code.

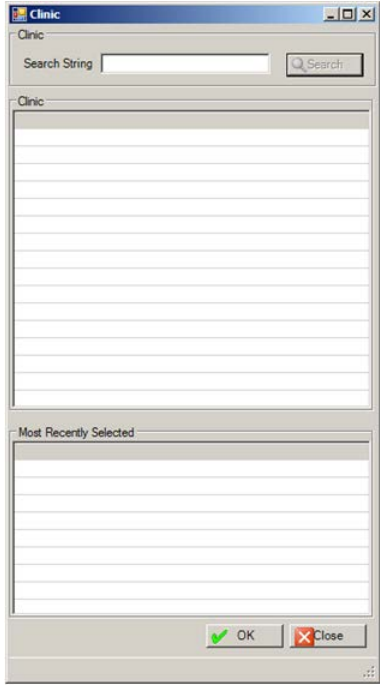
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the clinic name or code and then clicking Search. The retrieved records will populate the Clinic list box. Select a retrieved record and click OK to populate the Clinic field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Clinic field. (Otherwise, click Close.)</p>

Figure 7-14: Clinic search/select window

8. At the **Activity Code** field, select the activity code associated with the administrative/community activity. Click the drop-down list to access the **Activity** search/select window. Here you search for the activity name. Section Appendix A: provides more information about the Activity Codes and Definitions.

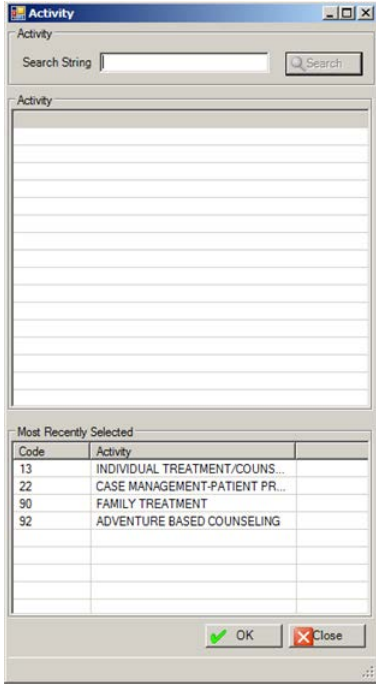
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the activity and then clicking Search. The retrieved records will populate the Activity list box. Select a retrieved record and click OK to populate the Activity Code field. (Otherwise, click Close.)</p> <p>(2) Select a record in the Most Recently Selected” list box and click OK to populate the Activity Code field. (Otherwise, click Close.)</p>

Figure 7-15; Sample Activity search/select window

9. At the **Activity Time** field, type the number of minutes spent on the activity, using any integer between 1 and 9999.
10. At the **# Served** field, type the number of people served in the administrative/community activity, using any integer between 0 and 999.
11. At the **Flag Field** field, type any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.
12. At the **Local Service Site** field, select the local service site associated with the administrative/community activity, if any. Click the drop-down list to access the **Local Service Site** select window.

The screenshot shows the 'Activity Data' tab with three main sections:

- Purpose of Visit - POV:** A table with columns 'Code' and 'Narrative'. It is currently empty. To the right are buttons for '+ Add', 'Edit', and 'X Delete'.
- Prevention Activities:** A table with columns 'Prevention Activity', 'Code', and 'Other'. It is currently empty. To the right are buttons for '+ Add' and 'X Delete'. Below this table is a 'Target' dropdown menu.
- Secondary Providers:** A table with a 'Provider' column. It is currently empty. To the right are buttons for '+ Add' and 'X Delete'.

Figure 7-17: Sample Activity Data tab

Purpose of Visit–POV Group Box

The **Purpose of Visit - POV** group box lists the POVs associated with the administrative/community activity.

The screenshot shows the 'Purpose of Visit - POV' group box with a table containing one entry:

Code	Narrative
97	ADMINISTRATION

To the right of the table are buttons for '+ Add', 'Edit', and 'X Delete'.

Figure 7-18: Sample POV group box

At least one POV is required for an administration/community activity record. You can add, change, or delete a record.

Add Button

1. Click **Add**.
2. The **POV** search/select window displays. Here you select one or more POVs.

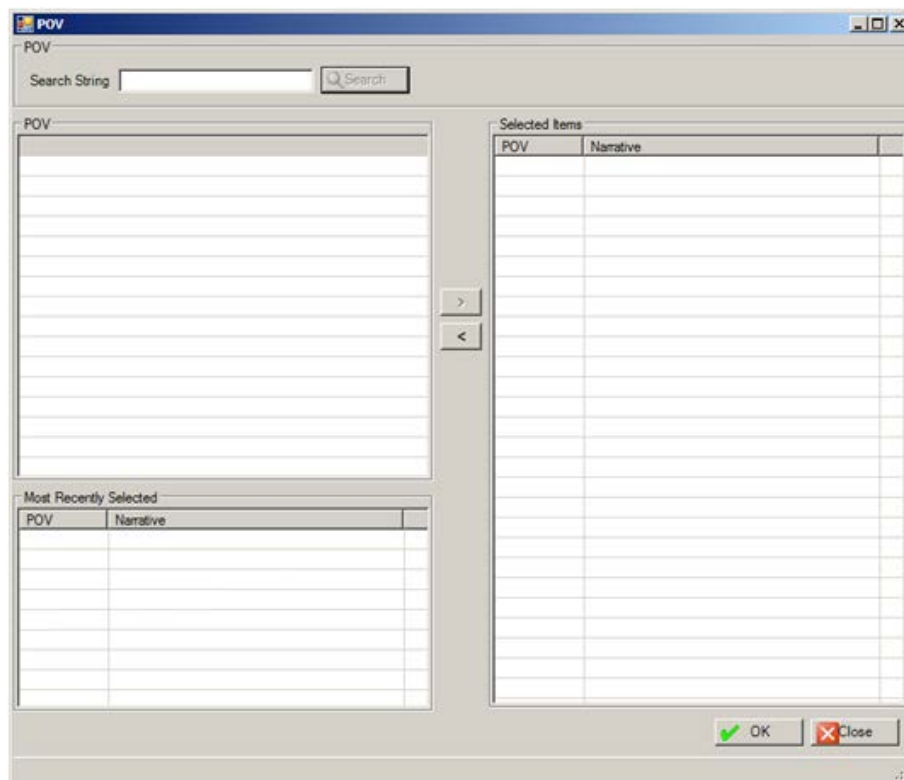


Figure 7-19: Sample POV search/select window

Use this search/select window as follows:

3. At the **Search String** field, type a few characters of the search criteria.
4. Click **Search** and the retrieved records display in **POV** list box (the POV and its narrative).
5. To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the right-pointing arrow button.
6. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
7. When the **Selected Item** list box is complete, click **OK** and the records populate the POV group box. (Otherwise, click **Close**.)

Edit Button

1. Select the POV record to change.
2. Click **Edit**.

The application displays the **Edit POV** window.

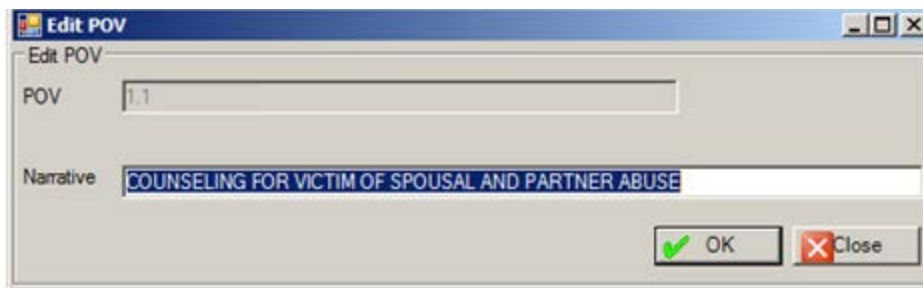


Figure 7-20: Edit POV window

- a. At the Narrative field, type new POV narrative in the Narrative text box using 2–80 characters.

Note: The special characters “ or ‘ cannot be the first character of the POV narrative. This is a Free Text field.

- b. Click **OK** to change the narrative of the selected record. (Otherwise, click **Close**.)

Delete Button

1. Select a record to delete.
2. Click **Delete**.
3. At the “Are You Sure?” confirmation message displays, click **Yes** to remove the selected group encounter record from the **POV** group box. (Otherwise, click **No**.)

Prevention Activities Group Box

The **Prevention Activities** group box lists the prevention activities associated with the administrative/community activity.

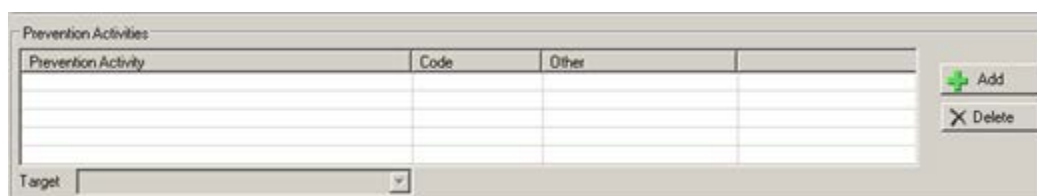


Figure 7-21: Sample Prevention Activities group box

The **Target** field will be disabled until a **Prevention Activity** is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

You can add/delete a prevention activity and/or specify the target group.

1. At the **Target** field, select the population for which the prevention activity is designed. The selected option applies to all of the prevention activities.

Adult

- a. To add one or more selected records from the **Prevention Activity** list box to the **Selected Items Prevention Activity** list box, click the right-pointing arrow button.
- b. Similarly, you can remove one or more selected records from the **Selected Items Prevention Activity** list box by clicking the left-pointing arrow button.
- c. When the **Selected Items Prevent Activity** list box is complete, click **OK** and the records populate the **Prevention Activity** group box. (Otherwise, click **Close**.)
- d. If you select **OTHER** (Code 20) on the **Prevention Activity** search/select window, the application displays the **Other** window.



Figure 7-23: Other window

- e. At the **Other** field, type the text of the other prevention activity associated with this record (limited to 80 characters).
- f. Click **OK** and the text populates the Other cell on the grid.
If you dismiss the **Other** window (with no data), the Other cell on the grid will be blank.

Delete Button

1. Select the prevention activity record to delete.
2. Click **Delete**.
3. At the “Are You Sure?” confirmation message displays, click **Yes** to remove the selected prevention activity record from the group box. (Otherwise, click **No**.)

Secondary Providers Group Box

The **Secondary Providers** group box lists the secondary providers associated with the administrative/community activity.



Figure 7-24: Sample Secondary Providers group box

You can add or delete a record.

Add Process

1. Click **Add** to access the **Secondary Providers** search/select window. Here you can select one or more secondary provider names.

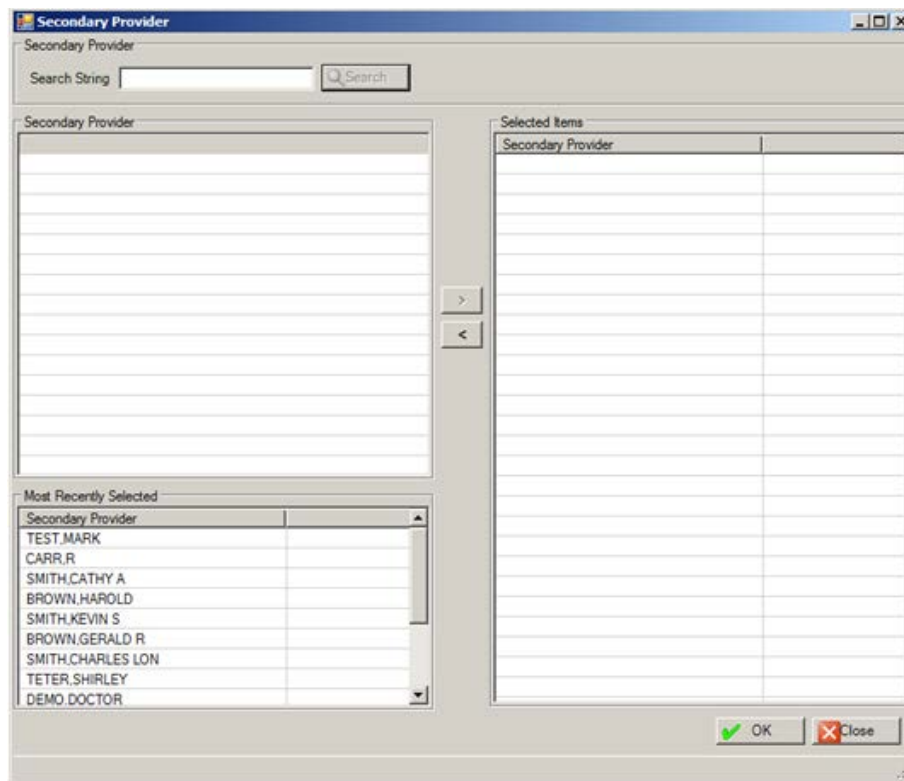


Figure 7-25: Secondary Providers search/select window

Use the **Secondary Providers** multiple search/select window in the following manner:

- a. At the **Search String** field, type a few characters of the search criteria.
- b. Click **Search** and the retrieved records display in **Secondary Provider** list box.
- c. To add one or more selected records from the **Secondary Provider** list box to the **Selected Items Secondary Provider** list box, click the right-pointing arrow button.
- d. Another way to add records to the **Selected Items Secondary Provider** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.
- e. Similarly, you can remove one or more selected records from the **Selected Items Secondary Provider** list box by clicking the left-pointing arrow button.
- f. When the **Selected Items Secondary Provider** list box is complete, click **OK** and the records populate the **Secondary Providers** group box. (Otherwise, click **Close**.)

Delete Process

1. Select the secondary provider record to remove.
2. Click **Delete**.
3. At the “Are You Sure?” confirmation message displays, click **Yes** to remove the selected secondary provider record from the group box. (Otherwise, click **No**.)

7.3.3 Notes Tab

Use the **Notes** field to enter any notes about the administrative/community activity.

A screenshot of a software interface showing a tabbed window. The active tab is labeled 'Notes'. Below the tab, there is a large, empty rectangular text area for entering notes. The window title bar shows 'Activity Data' and 'Notes'.

Figure 7-26: Sample Notes field

This is a Free Text box.

8.0 Encounter and Treatment Plan Sharing (Roll and Scroll)

After the entry of a Visit or a Treatment plan, you will have the option to share it with a colleague through MailMan. In order to do this, you must be properly set up through Site Parameters as a provider who can share information.

Make sure that the provider being sent the plan should actually be using this function.

After the entry of a Visit or Treatment plan, you will be asked the question shown in Figure 8-1):

```
Do you want to share this visit information with other providers? N//
```

Figure 8-1: Question after entry of a visit or treatment plan

By answering the question with a Yes, you will be stepped through the process of sending the information via a MailMan message, as shown in Figure 8-2:

```
Send to: NUUUU,BILL          WBM
Send to:

Message will be sent to:    THETA,BILL

Do you want to attach a note to this mail message? N// YES
Enter the text of your note.

NOTE APPENDED TO MAIL MSG:
  No existing text
  Edit? NO//Y
  - Here the provider can append a note to his/her colleague.

Ready to send mail message?? Y// ES
Send Full or Suppressed Form: (F/S): S// f FULL - The answer to this question
will determine which type of encounter form will be send in the message.

Sending Mailman message to distribution list
Message Sent
Press enter to continue....:
```

Figure 8-2: Sending a treatment plan through MailMan

9.0 Problem List

This section addresses the Problem List management for Roll and Scroll and the GUI.

9.1 BH Patient's Problem List (Roll and Scroll)

The PPL option appears on the Patient Data Entry and Update BH Forms windows.

Use the PPL option to manage the patient's problem list.

1. At the "Select Action" prompt, type PPL
2. The application displays the following information:

Problem List updates must be attached to a visit. If you are updating the Problem List in the context of a patient visit select the appropriate existing visit and then update the Problem List. If you are updating the Problem List outside of the context of a patient visit, first create a chart review visit and then update the Problem List.
Select record to associate the Problem List update to: (1-5):

Figure 9-1: Message displayed by the application

3. At the "Enter ENCOUNTER DATE" prompt, type the encounter date for the problem list.

The application displays the patient's problem list.

```

BH Problem List Update          Aug 23, 2011 14:05:45          Page: 1 of 1
-----
Patient Name: DEMO,DUCK      DOB: FEB 05, 1975      Sex: M      HRN: 36219
-----
BH Problem List Updated On: Aug 22, 2011  By: SIGMA,DARLA

1)  DX: F42.  Status: ACTIVE  Last Modified: 10/22/2015
    DSM Narrative: OBSESSIVE-COMPULSIVE DISORDER
    Provider Narrative: HOARDING DISORDER
    Date of Onset: 10/10/2015  Facility: DEMO INDIAN HOSPITAL
    Notes:
      STP Note #1 Added: 10/7/2015
      Narrative: Treat physical illness from time to time

          Enter ?? for more actions                                >>>
AP  Add BH Problem          DD  Detail Display          LR  Problem List Reviewed
EP  Edit BH Problem         NO  Add Note              HS  Health Summary
DE  Delete BH Problem       MN  Edit Note             FA  Face Sheet
AC  Activate BH Problem     RN  Remove Note          PC  PCC Prob List Display
IP  Inactivate BH Prob     NP  No Active BH Problems Q  Quit
Select Action: +//

```

Figure 9-2: Sample BH Problem List update window

At the “Select Action” prompt, type **Q** to exit this window.

9.1.1 Add BH Problem (AP)

Use the AP action to add a new BH problem for the current patient’s visit.

1. At the “Select Action” prompt, type **AP**.

The application displays information about the POV diagnosis assigned to the patient in the past 90 days.

2. At the “Choose a Diagnosis” prompt, type one of the diagnoses.
3. At the “Enter Diagnosis to Add to the Problem List” prompt, type the active diagnosis code to add to the problem list.

The application displays the Provider Narrative for the particular problem (can be changed).

4. At the “STATUS” prompt, type one of the following: **A** (active), or **I** (Inactive).
5. At the “DATE OF ONSET” prompt, type the date of onset, when the problem was first diagnosed. (This can be left blank.)
6. At the “Add TREATMENT Note?” prompt, type **Y** (yes) to add a treatment or **N** (no).

If N was used, the focus moves to the “Enter the Date the Problem List was Updated by the Provider” prompt.

If Y was used, the following prompts will display:

- a. At the “PROVIDER NARRATIVE” prompt, type the text of the narrative for the treatment note.
- b. At the “AUTHOR” prompt, press Enter to use the default name or type a new one.
- c. At the “LONG/SHORT TERM TREATMENT” prompt, type **1** for Short Term or **2** for Long Term. This refers to the treatment described in the Treatment note.

After completing the last prompt, the focus returns to the “Add TREATMENT Note?” prompt.

7. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the current date or type a new one.

8. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.2 Edit BH Problem (EP)

Use the EP action to edit a specified BH problem.

1. At the “Select Action” prompt, type **EP**.
2. At the “Select Problem” prompt type the number of the problem to edit.
3. At the “Diagnosis” prompt, the current diagnosis displays. This can be changed, if needed.
4. At the “Provider narrative <text of narrative>” prompt, the text of the narrative displays. This can be changed, if needed.
5. At the “DATE OF ONSET” prompt, type the date of onset, when the problem was first diagnosed. (This can be left blank.)
6. At the “STATUS” prompt, the current status displays. This can be changed using **A** (active), or **I** (Inactive).
7. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the current date or type a new one.
8. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.3 Delete BH Problem (DE)

Use the DE action to delete a specified BH problem.

1. At the “Select Action” prompt, type **DE**.

2. At the “Select Action” prompt, type the action to execute, either **1** (Delete BH Problem) or **2** (Detail Display). Use 1 in this case.
3. At the “Select Problem” prompt, type the number of the problem to delete. The information about the particular problem displays:

```
Deleting the following BH Problem from DUCK DEMO's BH Problem List.

PROBLEM CODE: 9.1                PATIENT NAME: DEMO,DUCK
DATE LAST MODIFIED: SEP 07, 2011@14:07:46
PROVIDER NARRATIVE: PRE-SENILE CONDITION
FACILITY: DEMO INDIAN HOSPITAL    NMBR: 3
DATE ENTERED: SEP 07, 2011@13:54:16  STATUS: ACTIVE
USER LAST UPDATE: THETA,SHIRLEY

Please Note:  You are NOT permitted to delete a BH Problem without
entering a reason for the deletion.
```

Figure 9-3: Example of information displayed about the problem code

4. At the “Are you sure you want to delete this BH Problem?” prompt, type either **Y** (yes) or **N** (no).

If N was used, the focus will return to the BH Problem List Update window.

If Y was used, the following information will display:

```
Deleting Treatment Plan...

Treatment Plan for DEMO,DOROTHY ROSE DELETED.
Press enter to continue....:
```

Figure 9-4: Further information

Press Enter and the focus returns to the Updated Patient Treatment Plan window.

9.1.4 Activate BH Problem (AC)

Use the AC action to change the status of a selected inactive BH problem to be active.

1. At the “Select Action” prompt, type **AC**.
2. At the “Select Problem” prompt, type the number of the problem to activate.
 - If the particular problem is already active, the application will display the following message:

```
That problem is already ACTIVE!!
Press return to continue....:
```

Figure 9-5: Message displayed when the problem is already active

After pressing Enter, the focus returns to the BH Problem List Update window.

- If the particular problem is not active, the prompts continue:
3. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type a new one.
 4. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.5 Inactivate BH Problem (IP)

Use the IP action to cause the status of a particular active BH problem to be inactive.

1. At the “Select Action” prompt, type **IP**.
2. At the “Select Problem” prompt, type the number of the problem to inactivate.
 - If the particular problem is already inactive, the application will display the following message:

```
That problem is already INACTIVE!!
Press return to continue....:
```

Figure 9-6: Message displayed when the problem is already inactive

After pressing Enter, the focus returns to the BH Problem List Update window.

- If the particular problem is not inactive, the prompts continue:
3. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type a new one.
 4. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the Problem List.
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.6 Detail Display (DD)

Use the DD action to display detail information about a selected BH problem.

1. At the “Select Action” prompt, type **DD**.
2. At the “Select Problem” prompt, type the number of the problem to use.

The Behavioral Health Problem List information displays on the Output Browser screen.

OUTPUT BROWSER	Dec 05, 2011 11:53:53	Page:	1 of	1
Behavioral Health Problem Display				
PROBLEM CODE:	F42.			
PATIENT NAME:	DEMO,DOROTHY ROSE			
DATE LAST MODIFIED:	DEC 07, 2015			
PROVIDER NARRATIVE:	HOARDING DISORDER			
FACILITY:	DEMO INDIAN HOSPITAL			
NMBR:	1			
DATE ENTERED:	DEC 07, 2015			
STATUS:	ACTIVE			
USER LAST UPDATE	DEMO,DOCTOR			
Notes:				
1) Date Added: 12/07/2015 Author: THETA,SHIRLEY				
Note Narrative: PT PRESENTS BX ASSOCIATED WITH HOARDING				

Figure 9-7: Sample Problem Detail

9.1.7 Add Note (NO)

Use the NO action to add a note to a selected BH problem.

1. At the “Select Action” prompt, type **NO**.
2. At the “Select Action” prompt, type one of the following:
 1. Add Note
 2. No Active BH Problems

Use 1 in this case.

The application displays information about the patient’s BH problem list.

3. At the “Add a new Problem Note for this Problem?” prompt, type **Y** to add a note. (Otherwise, type **N**.)

If Y was used, the following prompt displays:

4. At the “NARRATIVE” prompt, type the text of the narrative of the note.

5. At the “AUTHOR” prompt, press Enter to use the default name or type a new one.
6. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following: **1** (for short) or **2** (for long).

The application will re-display the information about the problem and information about the notes.

```

Adding a Note to the following problem on DOROTHY ROSE DEMO's BH Problem List.

PROBLEM CODE:           F42.
PATIENT NAME:           DEMO,DOROTHY ROSE
DATE LAST MODIFIED:     DEC 07, 2015
PROVIDER NARRATIVE:     HOARDING DISORDER
FACILITY:               DEMO INDIAN HOSPITAL
NMBR:                   1
DATE ENTERED:           DEC 07, 2015
STATUS:                 ACTIVE
USER LAST UPDATE       DEMO,DOCTOR

Notes:

1) Date Added: 12/07/2015 Author: THETA,SHIRLEY
Note Narrative: PT PRESENTS BX ASSOCIATED WITH HOARDING

```

Figure 9-8: Example of information about the problem and information about the notes

7. At the “Add a new Problem Note for this Problem?” prompt, type **Y** (for yes) or **N** (for no).
 - If **Y** was used, the prompts will repeat, starting with **NARRATIVE**.
 - If **N** was used, the prompts will continue.
8. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type another one.
9. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.8 Edit Note (MN)

Use the MN action to edit the text of a selected note.

1. At the “Select Action” prompt, type **MN**.

2. At the “Select Problem” prompt, type the number of the problem having the note to be edited.

The application displays information about the selected problem and information about any existing notes.

3. At the “Edit which one” prompt, type the number of the note to edit.
4. At the “NARRATIVE: <text of the problem>// - Replace” prompt, type in the Replace field with the replacement text for the narrative.
5. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following: **1** (for short) or **2** (for long).
6. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type another one.
7. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.9 Remove Note (RN)

Use the RN action to delete a selected note.

1. At the “Select Action” prompt, type **RN**.
2. At the “Select Problem” prompt, type the number of the problem having the note to be removed.

The application displays information about the selected problem and information about any existing notes.

3. At the “Remove which one” prompt, type the number of the note to remove.
4. At the “Are you sure you want to delete this NOTE?” prompt, type **Y** (yes) or **N** (no).

If N was used, the focus will return to the BH Problem List Updated window.

If Y was used, the prompts will continue.

5. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type another date.

6. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the Problem List.
 - If you are transcribing an update from a BHS provider, then enter the name of the provider.
 - If you are a data entry/coder correcting the BH Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.10 No Active BH Problems (NP)

Use the NP action to specify the date when a particular provider indicated that the patient had no active BH problems. This action requires that there are no ACTIVE problems on the patient’s BH problem list (otherwise, the application will display an error message).

1. At the “Select Action” prompt, type **NP**.
2. At the “Did the Provider indicate that the patient has No Active BH Problems” prompt, type **Y** (yes) or **N** (no).

If N was used, the focus will return to the BH Problem List Update window.

If Y was used, the prompts will continue:

3. At the “Enter the Date the Provider documented ‘No Active BH Problems’” prompt, press Enter to use the default date or type another one.
4. At the “Enter the PROVIDER who documented ‘No Active BH Problems’” prompt, type the provider name who documented that there are no active BH problems.

9.1.11 Problem List Reviewed (LR)

Use the LR action to indicate who and when the current patient’s BH Problem List was reviewed.

1. At the “Select Action” prompt, type **LR**.
2. At the “Did the Provider indicate that he/she reviewed the Problem List?” prompt, type **Y** (yes) or **N** (no).

If N was used, the application will display “No Action Taken” and the focus will return to the BH Problem List Update window.

If Y was used, the prompts continue.

3. At the “Enter the Date the Provider Reviewed the Problem List” prompt, press Enter to use the default date or type a new one.

4. At the “Enter the PROVIDER who Reviewed the Problem List” prompt, type the name of the provider who reviewed the BH Problem List.

9.1.12 PCC Problem List Display (PC)

Use the PC action to display the PCC problem list.

1. At the “Select Action” prompt, type **PC**.

The application displays the message:

```
You are now leaving the Behavioral Health Problem List and will be taken
into the PCC Problem List for updating.
```

```
Do you wish to continue? Y//
```

Figure 9-9: Information displayed by the application

If N was used at the last prompt, focus will return to the BH Problem List Update window.

If Y was used, the PCC Problem List Display window displays.

```
PCC Problem List Display          Sep 07, 2011 15:46:04          Page:    1 of    3
-----
Patient Name: DEMO,DOROTHY ROSE  DOB: OCT 10, 1942   Sex: F   HRN: 99999
-----
Problem List Reviewed On: Dec 02, 2015  By: DEMO,DOCTOR
Problem List Updated On: Dec 02, 2015 By: THETA,WENDY

Problem ID:  TST1    DX: ZZZ.999  Status: EPISODIC          Onset: 7/23/13
Provider Narrative:  Sore throat symptom | sore throat
SNOMED CONCEPT ID: 267102003
Severity:    246112005

2) Problem ID:  TST2    DX: M25.50  Status: CHRONIC          Onset:
Provider Narrative:  Joint pain | chronic joint pain of left middle fi
SNOMED CONCEPT ID: 57676002
Severity:    246112005

3) Problem ID:  TST3    DX: M25.50  Status: EPISODIC          Onset:
Provider Narrative:  Joint pain |
+      Enter ?? for more actions                                >>>
DD  Display a PCC Prob  A  Quit
Select Action: +//
```

Figure 9-10: Example of Problem List Update screen

Quit

At the “Select Action” prompt, type **Q** to quit the update screen.

Display a PCC Prob

1. At the “Select Action” prompt, type **DD**.
2. At the “Select Problem” prompt, type the number of the problem to use.

The application displays the PPC Prob information on the Output Browser.

```

DIAGNOSIS: M25.50                                PATIENT NAME: DEMO,ALISTER LANE
  DATE LAST MODIFIED: AUG 01, 2013@12:33:23
  PROVIDER NARRATIVE: Joint pain | chronic joint pain of left middle finger, fir
st joint
  NMBR: 2                                         FACILITY: 2013 DEMO HOSPITAL
  STATUS: CHRONIC                               DATE ENTERED: AUG 01, 2013
  ENTERED BY: DEMO,CATHERINE A                 USER LAST MODIFIED: DEMO,CATHERINE A
  SEVERITY: 246112005                          RECORDING PROVIDER: DEMO,CATHERINE A
  DATE/TIME ENTERED: AUG 01, 2013@12:33:23    ENTERED BY: MOORE,CATHERINE A
  SEVERITY PREFERRED TERM (c): Severity
  SNOMED CT CONCEPT CODE: 57676002          SNOMED CT DESIGNATION CODE: 95910010
  SNOMED CONCEPT PREFERRED TERM (c): Joint pain

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

```

Figure 9-11: Sample information about the selected PCC problem

At the “Select Action” do one of the following:

- Type **+** to display the next screen (does not apply to the last screen)
- Type **-** to display the previous screen (does not apply to the first screen)
- Type **Q** to quit the screen.

9.2 Problem List (GUI)

This section addresses how to manage the problems for the selected patient on the Visit window for one patient.

After selecting a record and clicking the Problem button, select one of the following options:

- BH Problem List

- PCC Problem List

9.2.1 Behavior Health Problem List Window

After selecting the BH Problem List option, the **Behavioral Health Problem List** window displays.

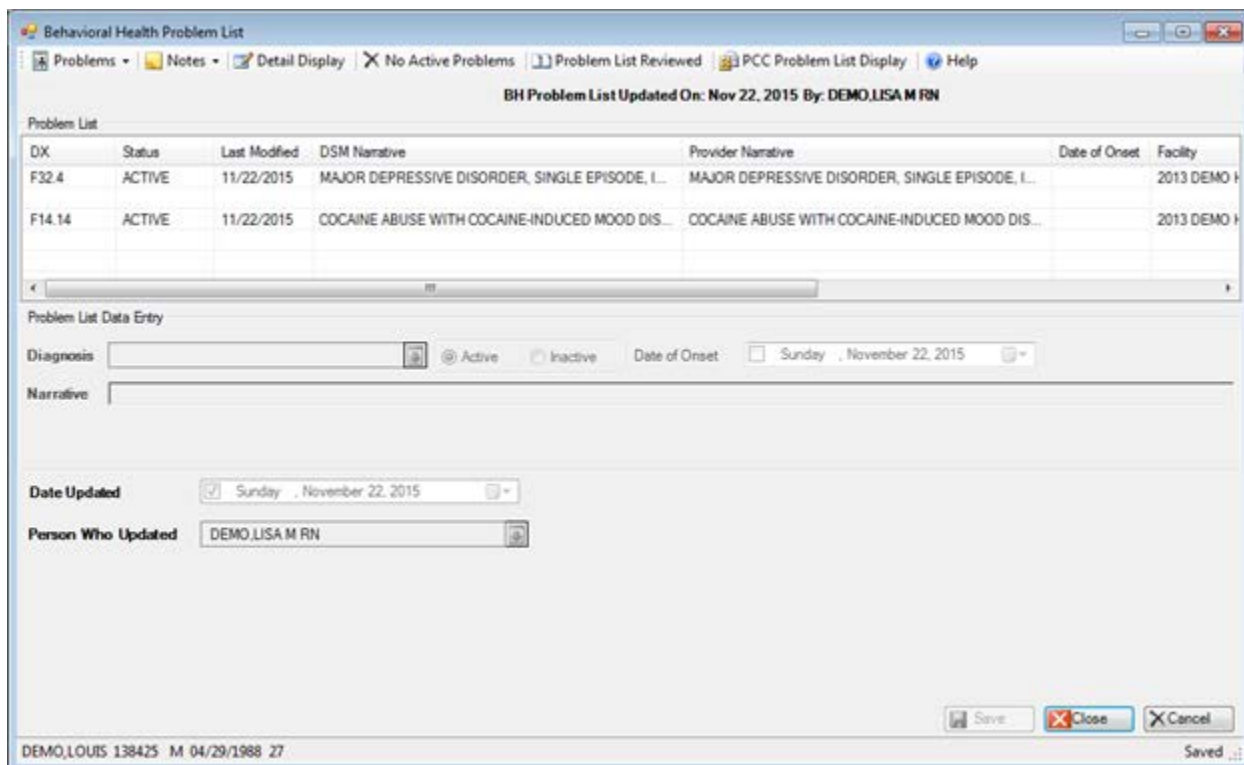


Figure 9-12: Sample Behavioral Health Problem List window

The current patient's problems display in the Problem List grid, including any associated notes. The note displays on the row below the problem.

The following table provides information about the features on this window.

Feature	Functionality
Help button	Click this button to access the online help for this window.
Close button	Click Close to leave the window.
Cancel button	Click this button to remain on the window and no action (like Add Problem) will be taken.

Add/Edit Problem

The Add and Edit function use the same fields.

1. Select **Problems** | **Add Problem** to access the fields in the **Problem List Data Entry** group box.
2. Select an existing problem and then select **Problems** | **Edit Problem**. All of the fields in the **Problem List Data Entry** group box are populated with existing data.

Figure 9-13: Sample Problem List Data Entry group box

The fields in bold are required.

1. At the **Diagnosis** field, click the drop-down list to access the **POV** select window. Here you select a POV to populate the **Diagnosis** and **Narrative** fields.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the search criteria for the POV and then clicking Search. The retrieved POVs will populate the POV list box. Select a retrieved record and click OK to populate the Diagnosis and Narrative fields. (Otherwise, click Close.)</p> <p>(2) Select a record in the “Most Recently Selected” list box and click OK to populate the Diagnosis and Narrative fields. (Otherwise, click Close.)</p>

Figure 9-14: Sample POV select window

2. At the **Active/Inactive** radio button field, indicate if the selected diagnosis is Active or Inactive by selecting the appropriate radio button (Active is the default for a new problem).
3. At the **Date of Onset** field, select the Date of Onset which is the date when the problem was first diagnosed. For a new problem, the default is today's date.
 - To have no Date of Onset, uncheck the checkbox.
 - To change the Date of Onset, click the drop-down list to access a calendar. The checkbox will remain checked.
4. At the **Narrative** field, determine the diagnosis to use. This field is populated when you choose a diagnosis (can be changed). Type a new narrative in the Free Text field, if needed.
5. At the **Add Note?** field, select the **Add Note** field to display the **Note** group box.



Figure 9-15: Note group box

After the **Note** group box displays, you can uncheck the **Note** field to close the group box, if needed.

- a. At the **Note** field, type the text of the note, usually information about the treatment.
- b. At the **Author** field, type the name of the author of the note. The application populates this field with the current logon user. To change the name, click the drop-down list to access the **Primary Provider** select window. Here you can select another name.

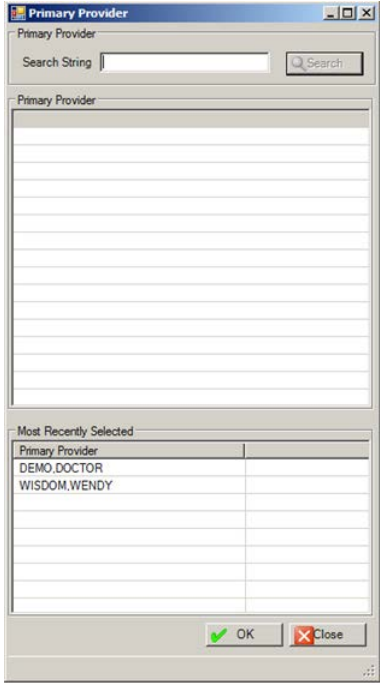
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the primary provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Author field. (Otherwise, click Close.)</p> <p>(2) Select a primary provider name in the Most Recently Selected list box and click OK to populate the Author field. (Otherwise, click Close.)</p>

Figure 9-16: Primary Provider select window

- c. At the **Long Term/Short Term** field, select either the Long Term or Short Term radio button, referring to the treatment described in the note.
6. At the **Date Updated** field, the application displays today's date (the default). To change the date, click the drop-down list to access the calendar where you can select another date.
7. At the **Person Who Updated** field, the application displays the default provider (who is the provider of the visit to which the Problem List item is associated). To change the name, click the drop-down list to access the **Primary Provider** select window. Here you select another primary provider.

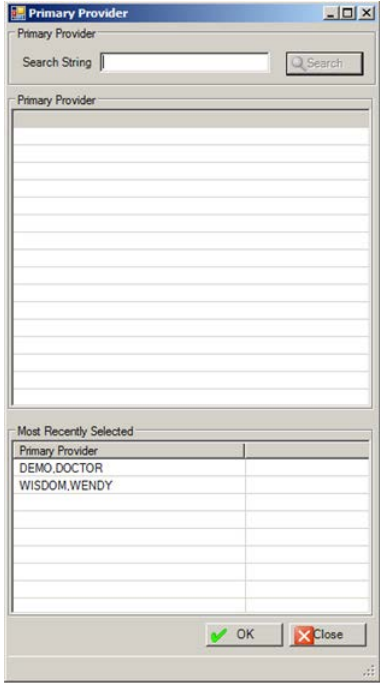
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p>

Figure 9-17: Primary Provider select window

8. If **Add** was used, after the **Problem List Data Entry** group box is complete, click **Save** to add the “new” problem to the **Problem List** grid. (Otherwise, click **Cancel**).
9. If **Edit** was used, after the **Problem List Data Entry** group box is complete, click **Save** to change the selected record on the **Problem List** grid. (Otherwise, click **Cancel**).

Delete Problem

1. Select an existing problem in the Problem List grid.
2. Select **Problems | Delete Problem**.
3. The **Problem List Reason for Delete** dialog box displays.

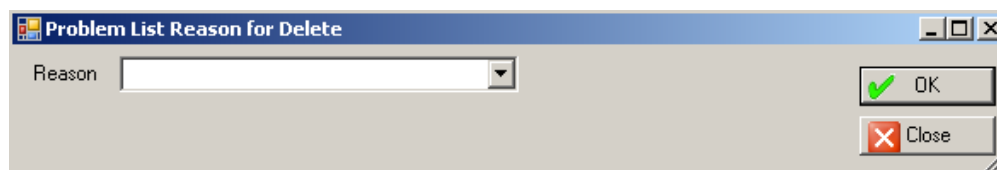


Figure 9-18: Problem List Reason for Delete dialog box

4. Click the drop-down list for the **Reason** field (required) and select an option.

DUPLICATE
ENTERED IN ERROR
OTHER

- a. If you select **OTHER**, the dialog box changes.



Figure 9-19: Problem List Reason for Delete when using OTHER

- b. In this case, at the **Other** field, type the reason to delete the problem (required).
5. After the **Problem List Reason for Delete** dialog box is complete, click **OK** (otherwise, click **Close**).

After clicking **OK**, the application activates the **Date Updated** and **Person Who Updated** fields.

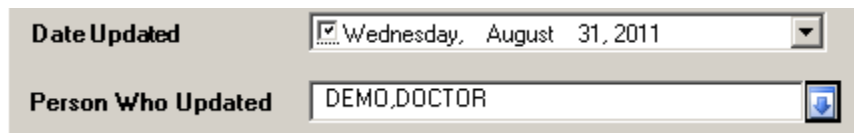


Figure 9-20: Active Date Updated and Person Who Updated fields

6. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date.
7. At the **Person Who Updated** field, select the provider who updated the information. The default is the provider of the visit to which the Problem List item is associated. The **Primary Provider** select window displays.

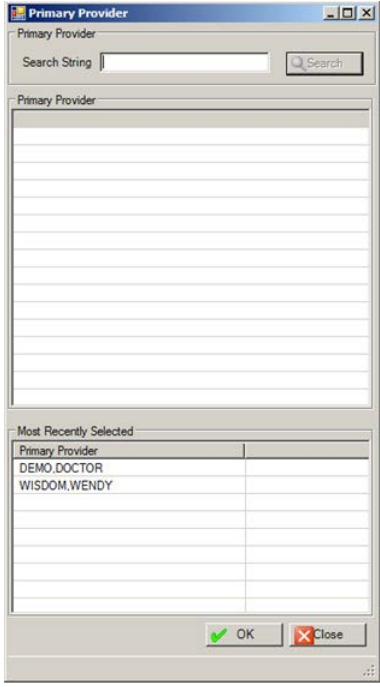
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p>

Figure 9-21: Primary Provider select window

- After the active fields are complete, click **Save** to remove the problem from the Problem List grid. (Otherwise, click **Cancel**.)

Activate/Inactivate Problem

- Select an existing problem in the Problem List grid.
- Select **Problems | Activate** (or **Inactivate**).
- The **Date Updated** and **Person Who Updated** fields display.

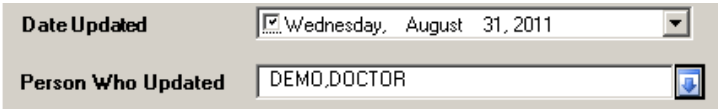


Figure 9-22: Sample active fields for Inactivate (or Activate) process

- At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date. The Activate action only works if the **Date Updated** is checked.
- At the **Person Who Updated** field, select the person who updated the problem list. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

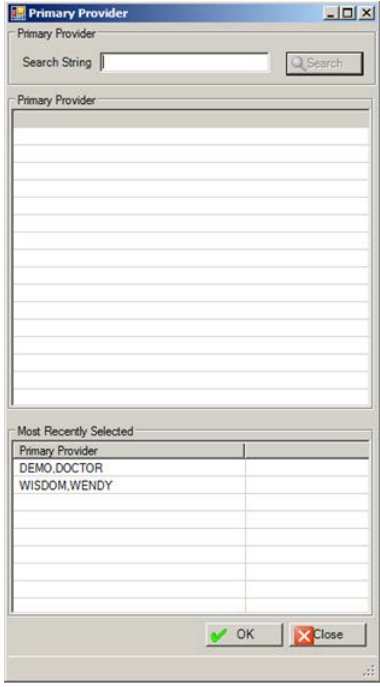
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p>

Figure 9-23: Primary Provider select window

- After the active fields are complete, click **Save** to change the Status of the selected record on the **Problem List** grid. (Otherwise, click **Cancel**.)

Add/Edit Note

The Add Note and Edit Note functions use the same fields.

- Select an existing problem in the **Problem List** grid. Select **Notes | Add Note**
OR
- Select an existing note in the **Problem List** grid. Select **Notes | Edit Note**. The fields become populated with existing data.

The following shows the fields in the lower group box.

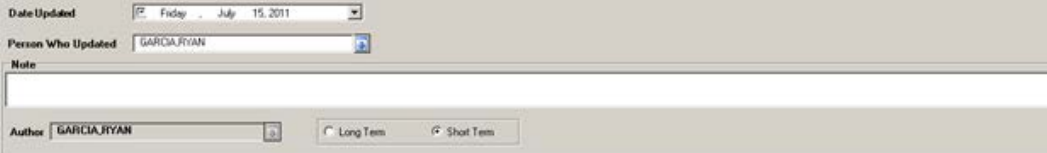


Figure 9-24: Active fields for adding a note

3. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date. The **Add Note** action only works if the **Date Updated** is checked.
4. At the **Person Who Updated** field, select the person who updated the problem list. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

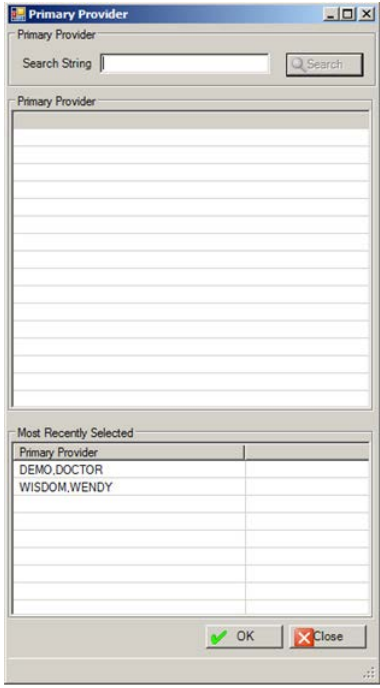
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p>

Figure 9-25: Primary Provider select window

5. At the **Note** field, type the text of the note (Free Text field), usually information about the treatment.
6. At the **Author** field, select the author of the note. To change the name, click the drop-down list to access the **Primary Provider** select window.

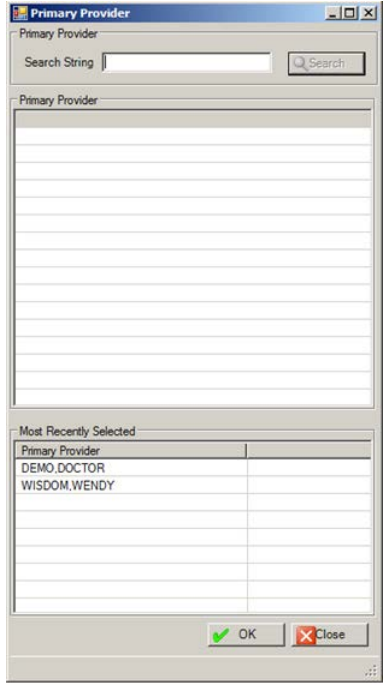
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Author field. (Otherwise, click Close.)</p>

Figure 9-26: Primary Provider select window

- At the **Long Term/Short Term** field, select either the Long Term or Short Term radio button, referring to the treatment described in the note.
- After the lower group box is complete, click **Save** and the note will be added to the particular problem in the **Problem List** grid. (Otherwise, click **Cancel**.)

After saving, the application gives the note a note number, displays when the note was added, and displays the note narrative.

If **Edit** was used, after the **Note** group box is complete, click **Save** (otherwise, click **Cancel**). After clicking **Save**, the particular note will be changed (on the **Problem List** grid).

Remove Note

- Select an existing note in the **Problem List** grid.
- Select **Notes | Remove Note**.
- The **Date Updated** and **Person Who Updated** fields become active.

Date Updated Wednesday, August 31, 2011

Person Who Updated DEMO,DOCTOR

Figure 9-27: Active Date Updated and Person Who Updated fields

- At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar. The Remove Note action only works if the **Date Updated** is checked.
- At the **Person Who Updated** field, select the person who updated the information. Click the drop-down list to access the **Primary Provider** select window. Select the name of the person who updated the Problem List.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Updated field. (Otherwise, click Close.)</p>

Figure 9-28: Primary Provider select window

- After the active fields are complete, click **Save** (otherwise, click **Cancel**). If Save was used, the prompts continue.
- At the "Are you sure" confirmation message, click **Yes** to remove the note will be removed from the Problem List grid. (Otherwise, click **No**.)

Detail Display

- Select a problem in the Problem List grid.
- Click the **Detail Display** button.

3. The **BH Problem List Detail** pop-up for the particular patient displays.

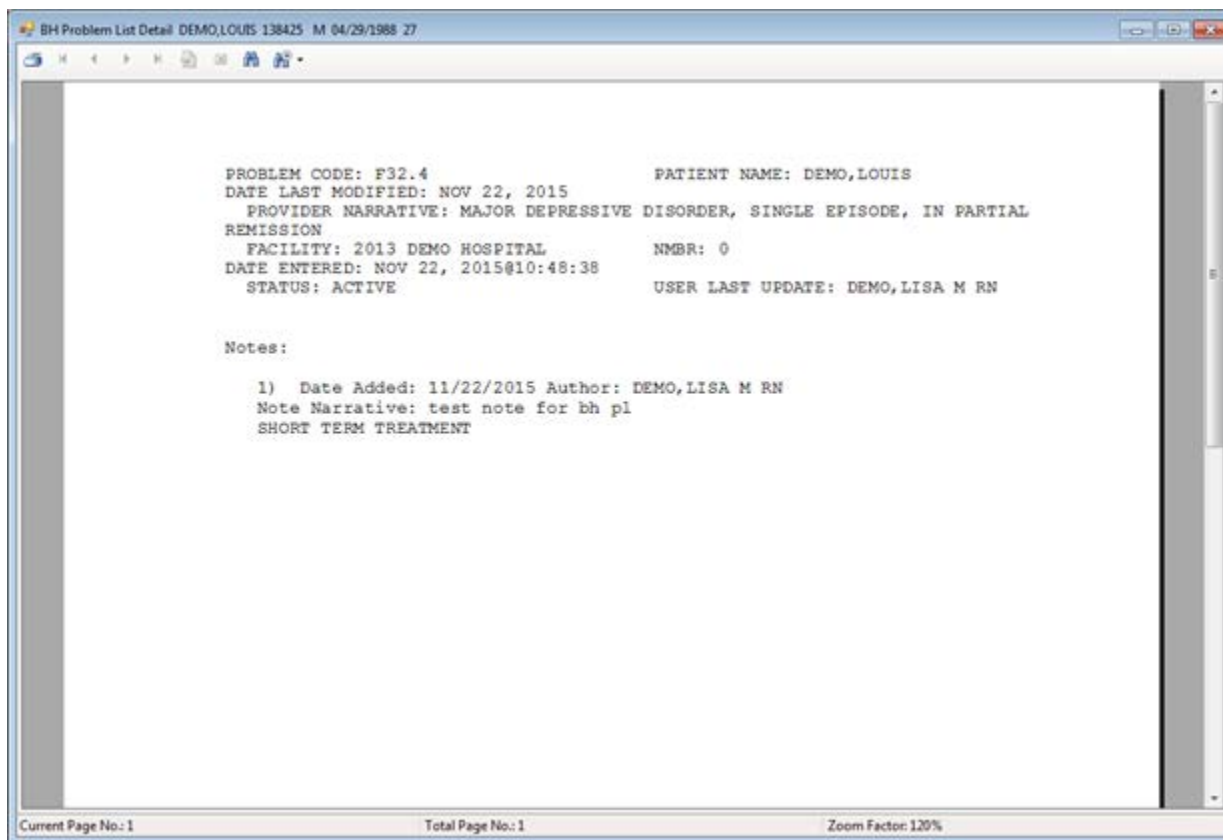


Figure 9-29: Sample BH Problem List Detail for a patient

Section 2.6 provides more information about using the controls on the pop-up window.

No Active Problems

Use the No Active Problems button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.

1. After clicking this button and if there are active problems, the application displays the following message: There are ACTIVE Problems on this patient's BH problem list. You cannot use this action item. Click **OK** to dismiss the message and the focus returns to the Behavioral Health Problem List window.
2. After clicking this button and there are no active problems, the application asks the following: Did the Provider indicate that the patient has No Active BH Problem? Click **Yes** (otherwise, click **No**).

If Yes was used, the **Date Documented** and **Provider Who Documented** fields become active.

The image shows two input fields. The first is labeled 'Date Documented' and has a checked checkbox followed by a date selector showing 'Monday, January 30, 2012'. The second is labeled 'Provider Who Documented' and contains the text 'DEMO_CASE M' with a search icon to its right.

Figure 9-30: Sample Date Documented and Provider Who Documented fields

3. At the **Date Documented** field, select the date the provider documented that the patient has no active problems. The default is today's date. To change the date, click the drop-down list to access the calendar. The No Active Problems action only works if the **Date Documented** is checked.
4. At the **Person Who Documented** field, select the person who documented that the patient has no active problems. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

Screen Capture	What to do
<p>The screenshot shows a window titled 'Primary Provider'. It has a 'Search String' field with a 'Search' button. Below is a large empty list box labeled 'Primary Provider'. At the bottom, there is a 'Most Recently Selected' section with a table containing two rows: 'DEMO.DOCTOR' and 'WISDOM.WENDY'. At the very bottom are 'OK' and 'Close' buttons.</p>	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Documented field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Documented field. (Otherwise, click Close.)</p>

Figure 9-31: Primary Provider select window

5. After the active fields are complete, click **Save** (otherwise, click **Cancel**).
6. After clicking **Save**, the text below the action buttons will display information such as No Active BH Problem Documented on Dec 01, 2011 by DEMO,DOCTOR. Other text below the action buttons will display information such as: BH Problem List Reviewed on Dec 01, 2011 by DEMO,DOCTOR.

Problem List Reviewed

1. Click the **Problem List Reviewed** button to indicate that the current patient's problem list was reviewed.
2. The **Date Reviewed** and **Provider Who Reviewed** fields become active.

Figure 9-32: Sample Problem List Reviewed and Provider Who Reviewed fields

3. At the **Date Reviewed** field, select the date the provider reviewed the problem list. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date. The Problem List Reviewed action only works if the **Date Reviewed** is checked.
4. At the **Person Who Reviewed** field, select the person who reviewed the problem list. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click OK to populate the Person Who Reviewed field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Person Who Reviewed field. (Otherwise, click Close.)</p>

Figure 9-33: Primary Provider select window

5. After the active fields are complete, click **Save** (otherwise, click **Cancel**).

After clicking **Save**, the text below the action buttons (on the **Behavioral Health Problem List** window) will display information such as: BH Problem List Reviewed on December 1, 2011 by DEMO,DOCTOR.

PCC Problem List Display

Click the PCC Problem List Display button to move to the **PCC Problem List** window.

9.2.2 PCC Problem List Window

1. After selecting the **PPC Problem List** option (on the **Visit** window), the **PCC Problem List** window displays.

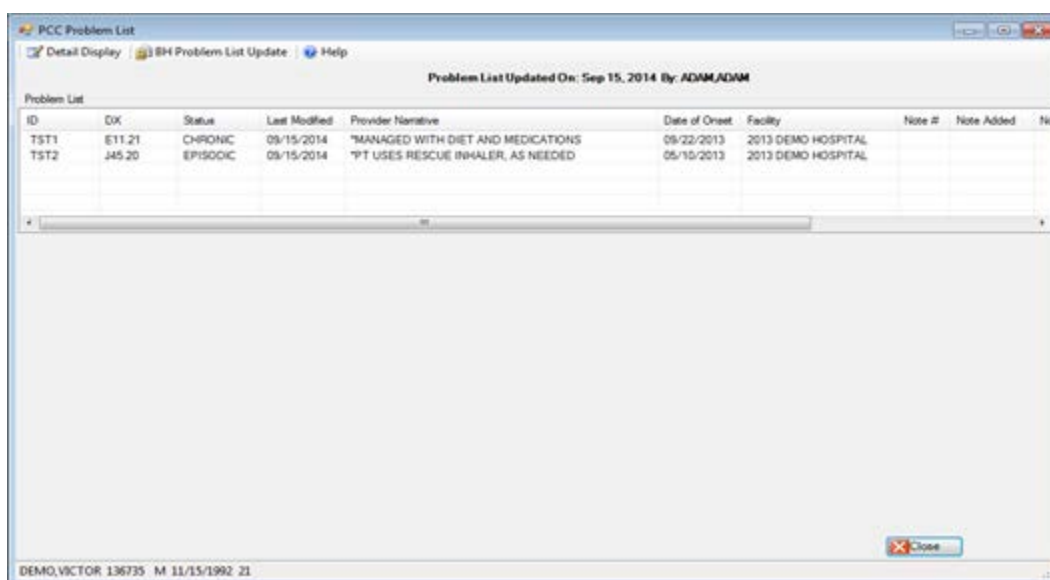


Figure 9-34: Sample PCC Problem List window

2. The current patient's PCC problems display in the **Problem List** grid, including any associated notes. The notes display on the row below the problem.
3. Click **Close** to leave the window.
4. Click **Help** to access the online help for this window.

Detail Display

1. Select a problem in the **Problem List** grid.
2. Click the **Detail Display** button.
3. The **PCC Problem List Detail** pop-up for the particular patient displays.

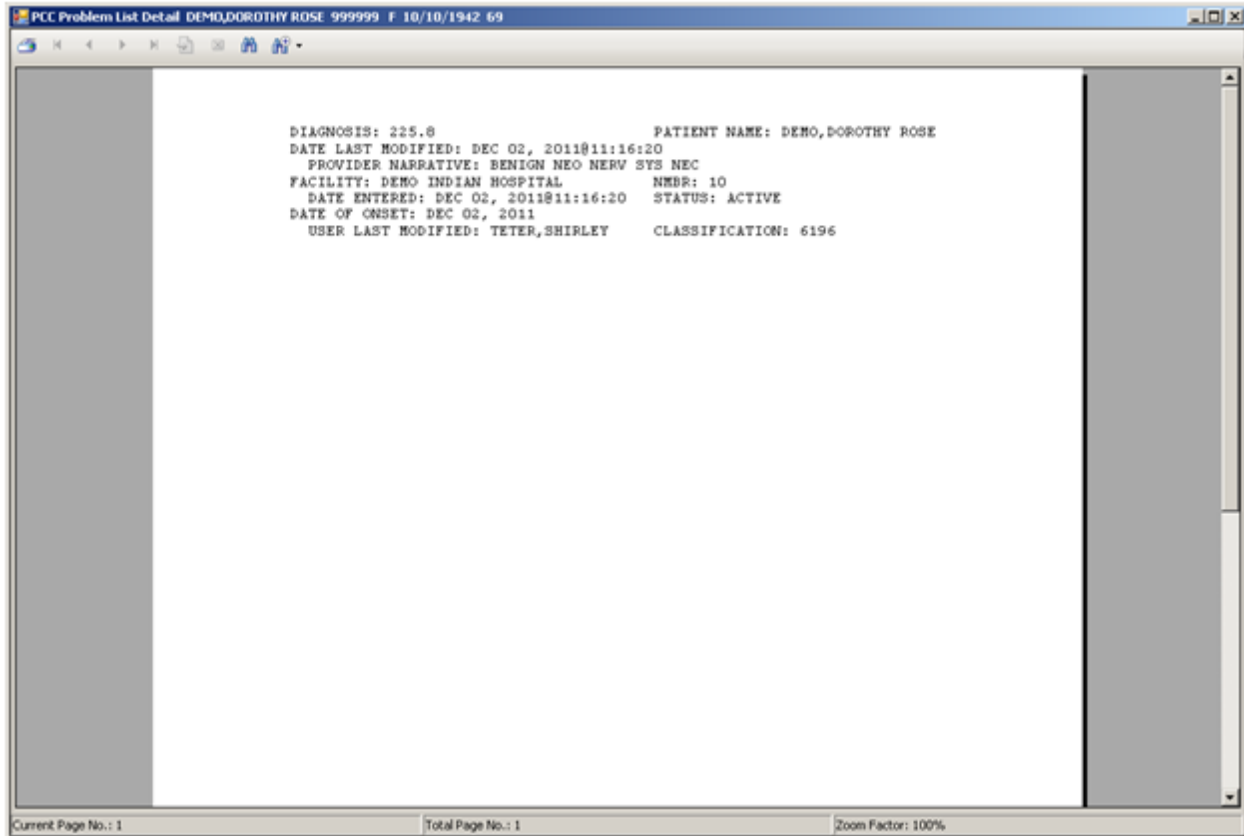


Figure 9-35: Sample PCC Problem List Detail pop-up window

Section 2.6 provides more information about using the controls on the pop-up window.

BH Problem List Update

1. Click the **BH Problem List Update** button to move to the **Behavioral Health Problem List** window.
2. Section 9.2.1 provides more information about this window.

10.0 Treatment Plans

You use the Treatment Plans feature to add or update treatment plans in Roll and Scroll and in the RPMS Behavioral Health System (GUI).

10.1 Patient Treatment Plans (Roll and Scroll)

Use the Update BH Patient Treatment Plans (TPU) option on the Data Entry Menu to access the Patient Treatment Plans menu.

```

*****
**      IHS Behavioral Health System      **
**      Patient Treatment Plans          **
*****
Version 4.0 (Patch 7)

DEMO INDIAN HOSPITAL

UP      (Add, Edit, Delete) a Treatment Plan
DTP     Display/Print a Treatment Plan
REV     Print List of Treatment Plans Needing Reviewed
RES     Print List of Treatment Plans Needing Resolved
ATP     Print List of All Treatment Plans on File
NOTP    Patients w/Case Open but no Treatment Plan

Select Update BH Patient Treatment Plans Option:

```

Figure 10-1: Options on the Patient Treatment Plans menu

10.1.1 Add, Edit, Delete a Treatment Plan (UP)

Use the UP (Add, Edit, Delete a Treatment Plan) to access the Update Patient Treatment Plan window for a particular patient.

1. At the “Select Update BH Patient Treatment Plans Option, type **UP**.”
2. At the “Select PATIENT NAME” prompt, type the name of the patient.
3. The Update Patient Treatment Plan window displays.

```

Update Patient Treatment Plan Apr 13, 2009 17:11:07      Page: 1 of 9
Patient Name: ALPHAA,CHELSEA MARIE      DOB: FEB 07, 1975      Sex: F
TREATMENT PLANS CURRENTLY ON FILE

1) Program: SOCIAL SERVICES      Responsible Provider: GAMMAA,RYAN
   Date Established: MAR 27, 2009      Next Review Date: APR 01, 2009
   Status:                          Date Resolved:
   Problem: eating

2) Program: MENTAL HEALTH      Responsible Provider: GAMMAA,RYAN
   Date Established: MAR 24, 2009      Next Review Date: APR 15, 2009

```

```

Status:                               Date Resolved:
Problem: testing functionality of editing tp

3) Program: MENTAL HEALTH              Responsible Provider: BETAAAA,BJ
Date Established: MAR 24, 2009         Next Review Date: JUN 22, 2009
Status:                               Date Resolved:
Problem: TESTING BASED ON RYAN'S FINDINGS
+      Enter ?? for more actions
AD  Add Treatment Plan   RV   Enter TP Review      BV   Browse Visits
ED  Edit a Plan          DS   Disp/Print Plan   SP   Share a TP
DE  Delete Tx Plan      HS   Health Summary   Q    Quit
Select Action: AD//

```

Figure 10-2: Sample Update Patient Treatment Plan window

Use the Quit action to dismiss the Update Patient Treatment Plan window.

Add Treatment Plan (AD)

Use the AD action to add a new treatment plan for the current patient. The prompts are the same as when you edit a plan. The Edit a Plan section below provides more information about the prompts.

Edit a Plan (ED)

Use the ED action to change a selected treatment plan for the current patient.

1. At the “Select Action” prompt, type **ED**.
2. At the “Enter Date Established” prompt, type the date the treatment plan was established (you cannot change).
3. At the “Program” prompt, type the program for the treatment plan. Use one of the following: **M** (Mental Health), **S** (Social Services), **C** (Chemical Dependency), **O** (Other).
4. At the “Designated Provider” prompt, type the name of the designated provider for the treatment plan. The default is the current logon user.
5. At the “Case Admit Date” prompt, type the date the case was admitted.
6. At the “PROBLEM LIST” prompt, type the text of the problem, using up to 240 characters. The text should list and briefly describe multiple problems.
7. At the “DIAGNOSIS – No existing text – Edit? NO//” prompt, type **Y** (yes) to edit the text (otherwise, type **N** (no). If Y was used, the application displays the following where you can type the text of the diagnosis:

```

==[ WRAP ]==[ INSERT ]===== < DIAGNOSIS >===== [ <PF1>H=Help ]====

```



Figure 10-3: Window to add the text of the diagnosis

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

- At the “Treatment Plan Narrative (Problems/Goals/Objectives/Methods) – No existing text – Edit? NO//” prompt, type **Y** (yes) to edit the text (otherwise, type **N** (no).” If Y was used, the application displays the following where you can type the text of the treatment plan:

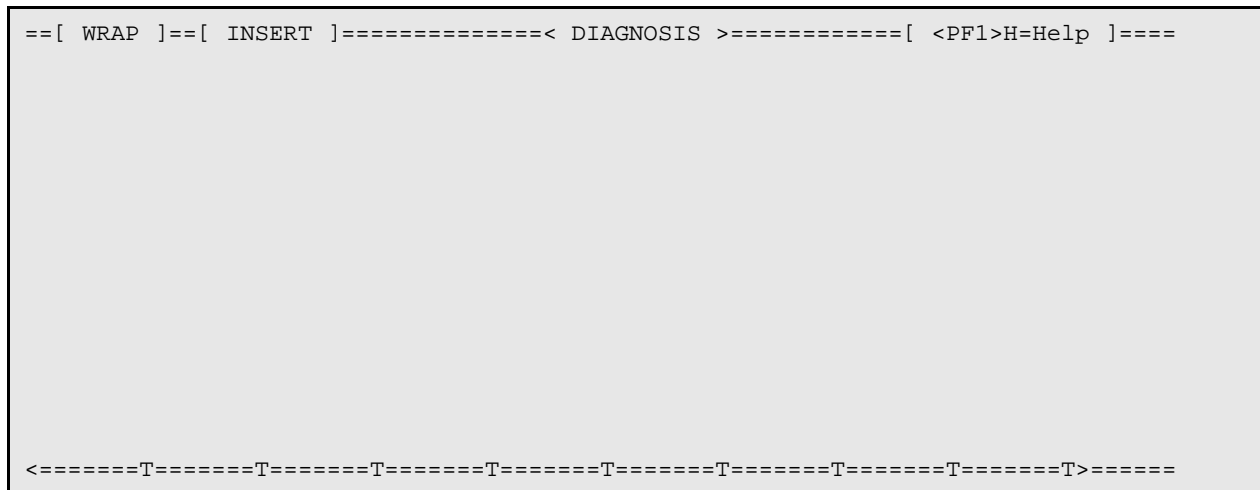


Figure 10 3: Window to add information about the treatment plan

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

9. At the “Anticipated Completion Date” prompt, type the date the treatment plan is anticipated to be completed.
10. At the “Review Date” prompt, type the date of the review.
11. At the “Concurring Supervisor” prompt, type the name of the concurring supervisor for the treatment plan.
12. At the “Date Concurred” prompt, type the date the concurring supervisor agreed to the treatment plan. Once a date is specified at this prompt, you cannot change it. The prompt displays only if you specified a concurring supervisor.
13. At the “Participants in the development of this plan” prompt, if there is a participant in the development of this plan, the application displays the name. If not, the “None recorded” message displays.

The application allows you to do one of the following at this prompt: **A** - Add a Participant or **N** - NO Changes. If N was used, the next prompt “Date Closed” displays.

If A was used, the following prompts display:

- a. At the “Enter the Participant Name” prompt, type the name of the participant.
- b. At the “Enter the Relationship to the Client” prompt, type the relationship of the participant to the patient.

The application then lists the participants in the development of the plan. Below is an example:

```

Participants in the development of this plan:
-----
1) Alma Beta                cousin

Select one of the following:

A      Add a Participant
E      Edit an Existing Participant
D      Delete a Participant
N      No Change

Which action:

```

Figure 10-4: Sample of participants in the development of this plan

- c. At the “Which action” prompt, use one of the following:
 - Use the A option to add a participant. The prompts are the same as those shown above.
 - Use the E option to edit a particular existing participant. After you indicate the participant name, the prompts are the same as the add option.
 - Use the D option to delete a particular existing participant. The application asks to specify the one you want to delete. There is no confirmation about the deletion.
 - Use the N option to continue onto the next prompt.

14. At the “Date Closed” prompt, type the date the treatment plan is to be closed.

Delete Tx Plan (DE)

Use the DE action to delete a particular treatment plan.

1. At the “Select Action” prompt, type **DE**.
2. At the “Select BH Treatment Plan” prompt, type the number of the treatment plan to remove.
3. At the “Are you sure you want to DELETE this Treatment Plan?” prompt, type **Y** (yes) to remove the particular treatment plan from the Update Patient Treatment Plan window. (Otherwise, type **N** (no).)

Enter TP Review (RV)

Use the RV action to access the Treatment Plan Update window of a specified treatment plan (for the current patient).

1. At the “Select Action” prompt, type **RV**.
2. At the “Select BH Treatment Plan” prompt, type the number of the treatment plan to review.
3. Note: the application could display the following message:

NOTE: It is recommended you close out treatment plans using DSM-IV diagnoses and create a new treatment plan using DSM-5 diagnoses.

Press enter to continue....:

Press Enter to continue.

The Treatment Plan Update window displays. This window has the following prompts.

4. At the “Select REVIEW DATE” prompt, press Enter to accept the displayed review date (you can change). If you do not enter a date here, you exit the RV process.
5. At the “Review Provider” prompt, type the name of the review provider.
6. At the “Review Supervisor” prompt, type the name of the review supervisor, if any.
7. At the “Progress Summary” prompt, type the text of the progress summary displays (if any).
8. At the “Edit?” prompt, type **Y** (yes) or **N** (no) to indicate if you want to edit the text of the progress summary. If **Y** was used, you access another window to edit the text.

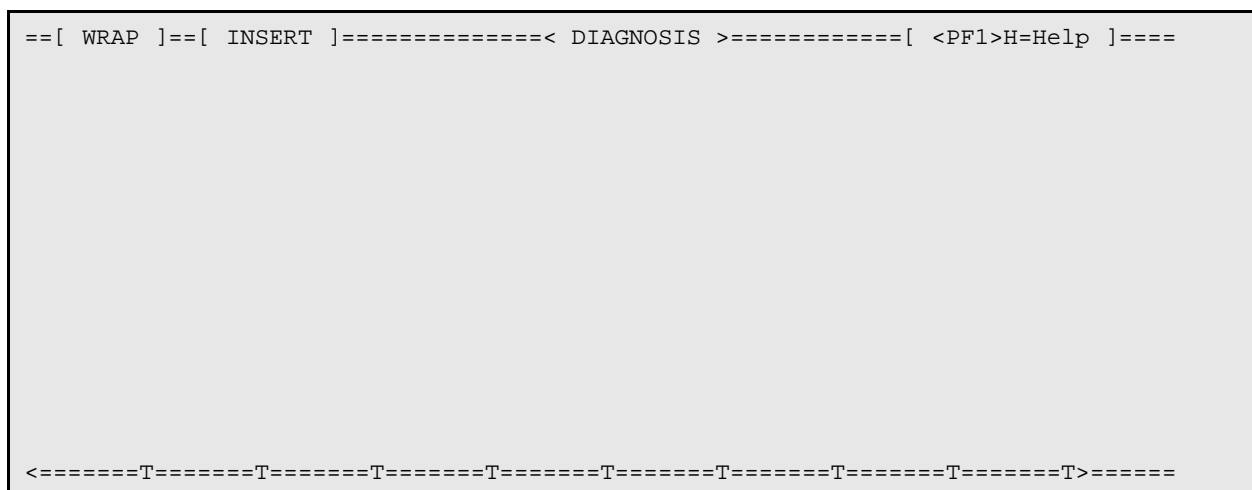


Figure 10 3: Window to add information about the treatment plan

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

9. At the “Select TX REVIEW PARTICIPANT NAME” prompt, type a new treatment review participant name, if needed.
10. At the “Relationship to Client” prompt, type the relationship to the client. This prompt does not display unless you added a name in the previous prompt.

Supervisor's Signature	Physician's Signature
_____	_____
Other	Other
_____	_____
Other	Other
_____	_____
+ NEXT SCREEN	- PREVIOUS SCREEN
Select Action: +//	Q QUIT

Figure 10-5: Sample display of treatment plan

Health Summary (HS)

Use the HS action to display/print a particular health summary for the current patient.

1. At the “Select Action” prompt, type **HS**.
2. At the “Select HEALTH SUMMARY TYPE NAME” prompt, type the health summary type to use.

The application displays the Health Summary for the current patient on the Output Browser window.

Browse Visits (BV)

Use the BV action to browse the behavioral health visits for the current patient.

1. At the “Select Action” prompt, type **DS**.
2. At the “Browse which subset of visits for [patient name]” prompt, type one of the following: **L** (patient’s last visit), **N** (patient’s last n visits), **D** (visits in a date range), **A** (All of this patient’s visits), or **P** (visits to one program). If you use N, D, or P, other prompts will display.
 - a. If N was used, type the number of visits at the “How many visits should be displayed: (1-99)” prompt.
 - b. If D was used, type the date range of the visits.
 - At the “Enter beginning Date of Visit” prompt, type the beginning date of the date range.
 - At the “Ending Date of Visit” prompt, type the ending date of the date range.
 - c. If P was used, type the program at the “Visits to Which Program” prompt.

The BROWSE PATIENT'S VISITS window displays. The one below is for all visits.

```

BROWSE PATIENT'S VISITS      Apr 13, 2016 17:51:51      Page:      1 of 395

Patient Name: CHIII,KIMBERLY YVETTE      DOB: Nov 23, 1966
HRN: 114108

***** Suicide Forms on File *****
Date of Act: OCT 10, 2008      Suicidal Behavior:
Previous Attempts:      Method:
Date of Act: MAR 24, 2008      Suicidal Behavior: IDEATION W/ PLAN AND I
Previous Attempts: UNKNOWN      Method: HANGING
*****

Visit Date: Nov 28, 2015@10:00      Provider: GAMMAAA,DENISE
Activity Type: FAMILY/GROUP TREATMENT-PATIE Type of Contact: OUTPATIENT
Location of Encounter: SAN XAVIER
Chief Complaint/Presenting Problem: test pt ed
POV's:
  F33.0 MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MILD

SUBJECTIVE/OBJECTIVE:
testing
editing SOAP

COMMENT/NEXT APPOINTMENT:

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

```

Figure 10-6: Sample patient's behavioral health visits window

Share a TP (SP)

You need to have shared permission in order to use this option. (Use the Site parameters on the Manager utilities (Share Records); your name would need to be added to that list.)

10.1.2 Display/Print a Treatment Plan (DTP)

Use the DTP option (on the Patient Treatment Plans menu) to display/print the treatment plan for a specified patient.

1. At the "Select Update BH Patient Treatment Plans Option, type **DTP**."
2. At the "Select PATIENT NAME" prompt, type the name of the patient to use.

If you use a patient with no treatment plan, the application will display a message to that effect.

If the patient has at least one treatment plan, the application will display the Display/Print Treatment Plan window.

```

Display/Print Treatment Plan Apr 07, 2009 17:12:08 Page: 1 of 2
Patient Name: DUCK,DONALD R DOB: JUN 07, 1978 Sex: M
TREATMENT PLANS CURRENTLY ON FILE

1) Program: SOCIAL SERVICES Responsible Provider: GAMMAA,RYAN
   Date Established: APR 02, 2009 Next Review Date: APR 12, 2009
   Status: Date Resolved:
   Problem: testing functionality

2) Program: MENTAL HEALTH Responsible Provider: GAMMAA,RYAN
   Date Established: APR 02, 2009 Next Review Date: APR 02, 2009
   Status: Date Resolved:
   Problem:

3) Program: MENTAL HEALTH Responsible Provider: GAMMAA,RYAN
   Date Established: APR 02, 2009 Next Review Date: APR 02, 2009
   Status: Date Resolved:
   Problem:
+ Enter ?? for more actions
DS Disp/Print Plan PS Previous Screen PL Print List
HS Health Summary DN Down a Line SL Search List
NS Next Screen UP Up a Line Q Quit
Select Action: DS//

```

Figure 10-7: Sample Display/Print Treatment Plan window

The following actions are related to view functions on this window:

Action	Functionality
NS (Next Screen)	Use to display the next screen of information (does not work apply to the last screen).
PS (Previous Screen)	Use to display the previous screen of information (does not work apply to the first screen).
DN (Down a Line)	Use to display the next line of information following the one at the bottom of the current screen (does not apply to the last screen).
UP (Up a Line)	Use to display the line previous line of information before the top of the current screen (does not work apply to the first screen).
Q (Quit)	Use to dismiss the window.

Display/Print Plan (DS)

Use the DS action to browse/print a particular treatment plan. See Disp/Print Plan (DS) for more information about the display/print plan action.

Health Summary (HS)

Use the HS action to display a particular type of health summary for the current patient.

1. At the “Select Action” prompt, type **HS**.
2. At the “Select HEALTH SUMMARY TYPE NAME” prompt, type the health summary type to use.

The application displays the Health Summary for the current patient on the Output Browser window.

Print List (PL)

Use the PL action to display/print the treatment plans for the current patient.

1. At the “Select Action” prompt, type **PL**.
2. At the “Device” prompt, type the device to output the list of treatment plans.

The application displays the Display/Print Treatment Plan for the current patient.

```

Display/Print Treatment Plan Apr 07, 2009 17:51:24          Page:    1 of    2
Patient Name:  DELTA,EDWIN RAY      DOB: JUN 07, 1978    Sex:  M
                TREATMENT PLANS CURRENTLY ON FILE

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
1) Program:  SOCIAL SERVICES          Responsible Provider:  GAMMAA,RYAN
   Date Established:  APR 02, 2009    Next Review Date:  APR 12, 2009
   Status:
   Problem:  testing functionality
   Date Resolved:

2) Program:  MENTAL HEALTH           Responsible Provider:  GAMMAA,RYAN
   Date Established:  APR 02, 2009    Next Review Date:  APR 02, 2009
   Status:
   Problem:
   Date Resolved:

3) Program:  MENTAL HEALTH           Responsible Provider:  GAMMAA,RYAN
   Date Established:  APR 02, 2009    Next Review Date:  APR 02, 2009
   Status:
   Problem:
   Date Resolved:

Enter RETURN to continue or '^' to exit:

```

Figure 10-8: Sample Display/Print Treatment Plan window

Search List (SL)

Use the SL action to search for a particular text string in the text of the treatment plans

1. At the “Select Action” prompt, type **SL**.

- At the “Search for” prompt, type the text string to search for in the treatment plan.

If the application finds the first occurrence of the text string, it highlights it and the prompts continue.

- At the “Stop Here?” prompt, type **Y** (yes) or **N** (no).

If **N** was used, the focus leaves the search sequence.

If **Y** was used, the application will search for the next occurrence of the text string. If it finds it, the application will highlight it. If it does not find it, it displays the message: Text not found. Do you want to start at the beginning of the list? Type **Y** (yes) or **N** (no).

10.1.3 Print List of Treatment Plans Needing Reviewed (REV)

Use the **REV** option to print a list of treatment plans in a particular date range that need to be reviewed.

- At the “Select Update BH Patient Treatment Plans Option, type **REV**.
- At the “Enter Beginning Date” prompt, type the beginning date of the date range.
- At the “Enter Ending Date” prompt, type the ending date of the date range.
- At the “Run the Report for which Program” prompt, type which program to use: **O** (One Program) or **A** (All Programs).

If **O** was used, type the number of the program to use at the “Which Program” prompt.

- At the “List Treatment Plans for” prompt, type one of the following: **O** (One Provider) or **A** (All Providers).

If **O** was used, type the name of the provider at the “Which Responsible Provider” prompt.

- At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).

- At the “Device” prompt, type the device to output the list.

Below is a sample Listing of Treatment Plans Due to be Reviewed.

***** CONFIDENTIAL PATIENT INFORMATION *****	Page 1
XX	
DEMO INDIAN HOSPITAL LISTING OF TREATMENT PLANS DUE TO BE REVIEWED Date Range: APR 07, 2008 to APR 07, 2009	

PATIENT NAME	DOB	CHART #	DATE ESTABLISHED	REVIEW DATE	ANTICIPATED COMPLETION DATE
ALPHA,ALICE ROCHELLE	6/25/97	183497	Dec 01, 2005	Feb 23, 2009	Feb 23, 2009
Program: MENTAL HEALTH		Responsible Provider: BETAAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 21, 2006	Sep 30, 2008	
Program: CHEMICAL DEPENDENCY		Responsible Provider: GAMMAA,DENISE			
ALPHAA,GLEN DALE	11/10/81	108704	Dec 10, 2007	May 06, 2008	Dec 10, 2008
Program: MENTAL HEALTH		Responsible Provider: BETAAA,BJ			

Enter RETURN to continue or '^' to exit:

Figure 10-9: Sample output treatment plans due to be reviewed

10.1.4 Print List of Treatment Plans Needing Resolved (RES)

Use the RES option to print a list of treatment plans in a particular date range that need to be resolved.

1. At the “Select Update BH Patient Treatment Plans Option, type **RES**.

The prompts are the same as those for the Print List of Treatment Plans Needing Reviewed (REV). Section 10.1.3 provides more information.

Below is a sample Listing of Treatment Plans Due to be Resolved.

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX					Page 1
DEMO INDIAN HOSPITAL					
LISTING OF TREATMENT PLANS DUE TO BE RESOLVED					
Date Range: APR 07, 2008 to APR 07, 2009					
PATIENT NAME	DOB	CHART #	DATE ESTABLISHED	REVIEW DATE	ANTICIPATED COMPLETION DATE
ALPHA,ALICE ROCHELLE	6/25/97	183497	Dec 01, 2005	Feb 23, 2009	Feb 23, 2009
Program: MENTAL HEALTH		Responsible Provider: BETAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Jun 27, 2007		Jul 02, 2008
Program: MENTAL HEALTH		Responsible Provider: BETAA,BJ			
ALPHAA,GLEN DALE	11/10/81	108704	Dec 10, 2007	May 06, 2008	Dec 10, 2008
Program: MENTAL HEALTH		Responsible Provider: BETAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 03, 2008	Mar 18, 2008	Apr 07, 2008
Program: MENTAL HEALTH		Responsible Provider: GAMMAA,DENISE			

Enter RETURN to continue or '^' to exit:

Figure 10-10: Sample output of treatment plans due to be resolved

10.1.5 Print List of All Treatment Plans on File (ATP)

Use the ATP option to print/browse a list of all patients who have a treatment plan on file (in a specified date range). This date range is the one during which the treatment plan was established.

1. At the “Select Update BH Patient Treatment Plans Option, type **ATP**.”
2. At the “Enter BEGINNING Date” prompt, type the beginning date of the date range.
3. At the “Enter ENDING Date” prompt, type the ending date of the date range.
4. At the “Run the Report for which PROGRAM” prompt, type which program to use: **O** (One Program) or **A** (All Programs).

If O was used, type the number of the program to use at the “Which Program” prompt.

5. At the “List treatment plans for” prompt, type **O** (one provider) or **A** (all providers).

If O was used, type the name of the provider at the “Which Provider” prompt.

6. At the “Sort list by” prompt, type **P** (Responsible Provider), **N** (Patient Name), or **D** (Date Established).

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).

8. At the “Device” prompt, type the device to output the list.

The application displays the Listing of Treatment Plans window.

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX					Page 1
DEMO INDIAN HOSPITAL LISTING OF TREATMENT PLANS Date Established: JAN 13, 2009 to APR 13, 2009					
PATIENT NAME	DOB	CHART #	DATE ESTABLISHED	REVIEW DATE	ANTICIPATED COMPLETION DATE
ALPHAA,CHELSEA MARIE	2/7/75	116431	Feb 25, 2009	May 26, 2009	Feb 25, 2010
Program: MENTAL HEALTH			Responsible Provider: BETAAAA,BJ		
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 09, 2009	Jun 07, 2009	Mar 09, 2010
Program: MENTAL HEALTH			Responsible Provider: BETAAAA,BJ		
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 24, 2009	Jun 22, 2009	Mar 24, 2010
Program: MENTAL HEALTH			Responsible Provider: BETAAAA,BJ		

ALPHAA,GLEN DALE	11/10/81	108704	Apr 06, 2009	Jul 05, 2009	Apr 06, 2010
Program: MENTAL HEALTH		Responsible	Provider: BETAAAA,BJ		
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 24, 2009		
Program: MENTAL HEALTH		Responsible	Provider: BETAAAA,LORI		
Enter RETURN to continue or '^' to exit:					

Figure 10-11: Sample list of treatment plans

10.1.6 Patients w/Case Open but No Treatment Plan (NOTP)

Use the NOTP option to produce a report that lists all patients who have a case open date, no case closed date, and no treatment plan in place in a specified date range. This date range is during which the case was opened.

1. At the “Select Update BH Patient Treatment Plans Option, type **NOTP**.”
2. At the “Enter BEGINNING Date” prompt, type the beginning date of the date range.
3. At the “Enter ENDING Date” prompt, type the ending date of the date range.
4. At the “List cases opened by” prompt, type **O** (one program) or **A** (all programs). This allows you to limit the report output to cases opened by one or all Programs.

If O was used, type the name of the program at the “Review Cases opened by which Program” prompt.

5. At the “List cases opened by” prompt, type **O** (one provider) or **A** (all providers). This allows you to limit the report output to cases opened by one or all Providers.

If O was used, type the name of the provider at the “Which Provider” prompt.

6. At the “Sort list by” prompt, type **P** (Responsible Provider), **N** (Patient Name), or **C** (Case Open Date).
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).
8. At the “Do you wish to” prompt, type **P** (Print output) or **B** (Browse output on screen).

The LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE report displays.

Case Open Dates: SEP 08, 2010 to DEC 07, 2010					
PATIENT NAME	HRN	CASE OPEN DATE	PROGRAM	PROVIDER	LAST VISIT

THETAA, ROLAND	258852	10/01/10	MENTAL HEA		12/07/10
BETAAAA, MONTY	741147	11/03/10	MENTAL HEA		12/07/10
DEMO, DOROTHY ROSE	999999	12/07/10	MENTAL HEA		07/08/10
BETA, ROBERT JACOB	207365	11/22/10	CHEMICAL D	CHIII, JESSICA	12/07/10

Figure 10-12: Sample Listing of Cases with No Treatment Plan in Place report

10.2 Treatment Plan Window (GUI)

The RPMS Behavioral Health System (GUI) application provides ways to manage treatment plans for one patient

Below shows where the treatment plan functions are located.

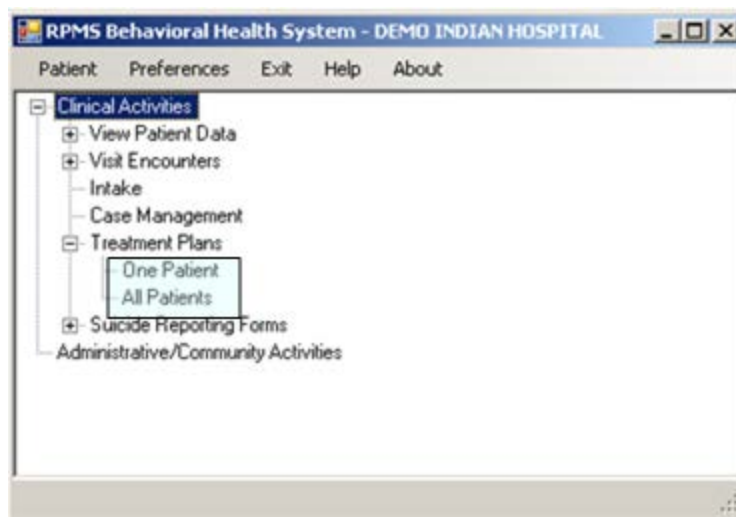


Figure 10-13: Location of Treatment Plan functions on tree structure

One way to access the **Treatment Plan** window is to use the **One Patient** option. You access the **Treatment Plan** window for the current patient.

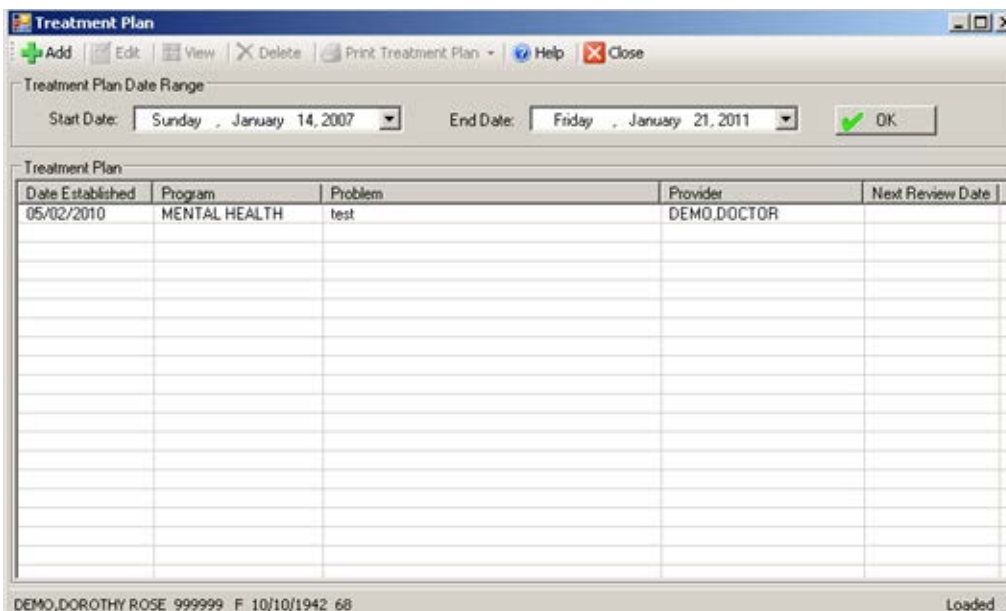


Figure 10-14: Sample Treatment Plan group box for current patient

Another way to access the **Treatment Plan** window is to use the **All Patients**. You access the **Treatment Plan** window for all patients.

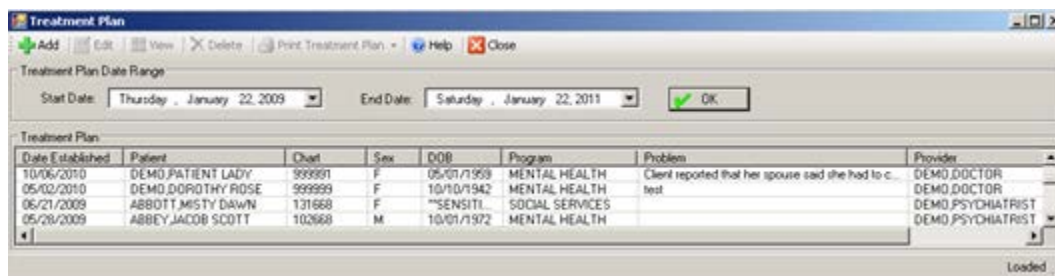


Figure 10-15: Sample Treatment Plan window for all patients

The following table provides information about the features of both windows.

Feature	Functionality
Treatment Plan Window for One Patient	The default Start Date is one year previous. If you change the Start Date for the Treatment Plan window for One Patient , this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).
Treatment Plan Window for All Patients	The default Start Date is one year previous. If you change the Start Date for the Treatment Plan window for All Patients , this change stays in effect until you exit the application. When you login the next time, the Start Date reverts to one year previous.
Treatment Plan Group Box	This group box shows the records within the Treatment Plan Date Range. They are in date order.

Feature	Functionality
Add Button	Establish the patient to use in the add process. Use the Add button to add a new treatment plan record on the Treatment Plan - Add Treatment Plan window.
Edit Button	Use the Edit button to edit a particular treatment plan record on the Treatment Plan - Edit Treatment Plan window.
View Button	Highlight a treatment plan record and click View (or double-click on the plan) to view the Treatment Plan - View Treatment Plan window (view only). The fields are the same as those on the add/edit treatment plan dialog box.
Help Button	Use the Help button to access the online help system for the Treatment Plan window.
Close Button	Use the Close button to dismiss the Treatment Plan window.
Delete Button	Use the Delete button to delete a particular treatment plan record. The application confirms the deletion.
Print Treatment Plan Button	Use the Print Treatment Plan button to print a particular Treatment Plan record. The Print Treatment Plan button has three choices: (1) Treatment Plan Only, (2) Review Data Only, and (3) Treatment Plan and Review Data. Highlight a record and choose one of the Print Treatment Plan options. The application determines which of the options are active.

The following applies to the Print Treatment Plan button:

If you use Review Data Only (2) or Treatment Plan and Review Data (3) and if there is one or more reviews, the application displays the **Treatment Plan Reviews** dialog box.



Figure 10-16: Sample Treatment Plan Reviews dialog box

Check each Treatment Plan Review record to use and click **OK**. Otherwise, click **Close** to exit the print routine.

The following shows the first page of the **Treatment Plan** pop-up window.

Both windows have the same fields. The following shows the **Add Treatment Plan** window.

Figure 10-18: Sample Add Treatment Plan window

The following table provides information about the buttons on this window.

Button	Functionality
Help button	Use to access the online help system for the window.
Save button	Use to save the data on the window. The Save function adds/edits the treatment plan record on the Treatment Plan window.
Close button	Use to display the Continue? dialog box that states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add window. Click No and the focus remains on the add/edit treatment plan window.

10.3.1 Treatment Plan Information Group Box

Use the **Treatment Plan Information** group box to manage the basic information about the treatment plan.

Figure 10-19: Sample Treatment Plan Information group box

The fields in bold text are required.

1. At the **Date Established** field, select the date the treatment plan was established. The default for a new record is the current date. Click the drop-down list to access the calendar to change this date.
2. At the **Next Review Date** field, select the date the treatment plan is expected to be reviewed. Click the drop-down list to access the calendar to change this date. Note that if a Date Completed/Closed is populated, this field will be inactive.
3. At the **Program** field, select the program used in the treatment plan. Click the drop-down list to select one of the following: Mental Health, Social Services, Other, or Chemical Dependency.
4. At the **Date Completed/Closed** field, select the date the treatment plan was completed or closed. Click the drop-down list to access the calendar to change this date.
5. At the **Case Admit Date** field, select the date the patient was admitted into care. Click the drop-down list to access the calendar to change this date.
6. At the **Anticipated Completion Date** field, select the anticipated completion date for the treatment plan. Click the drop-down list to access the calendar to change this date.
7. At the **Designated Provider** field, select the name of the designated provider for the treatment plan. Click the drop-down list to access the **Designated Provider** search dialog box where you search for the name of the designated provider.

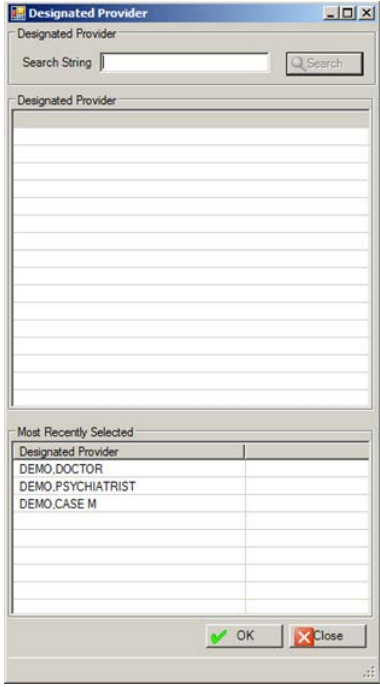
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the designated provider's last name and then clicking Search. The retrieved providers will populate the Designated Provider list box. Select a retrieved record and click OK to populate the Designated Provider field. (Otherwise, click Close.)</p> <p>(2) Select name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 10-20: Sample Designated Provider search window

8. At the **Concurring Supervisor** field, select the name of the concurring supervisor for the treatment plan. Click the drop-down list to access the **Concurring Supervisor** search dialog box where you search for the name of the supervisor.

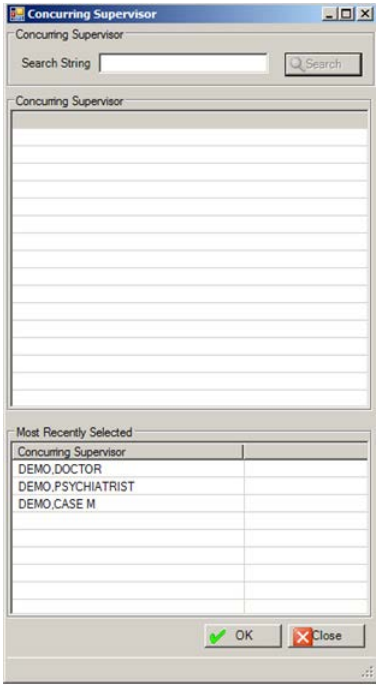
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing concurring supervisor's last name and then clicking Search. The retrieved names will populate the Concurring Supervisor list box. Select a retrieved record and click OK to populate the Concurring Supervisor field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Concurring Supervisor field. (Otherwise, click Close.)</p>

Figure 10-21: Sample Concurring Supervisor search window

9. At the **Date Concurred** field, select the date that the concurring supervisor agreed to the treatment plan. This date cannot be before the Date Established. Click the drop-down list to access the calendar to change this date.

10.3.2 Diagnosis Tab

Use the **Diagnosis** tab to add diagnosis information. This includes the text of the diagnosis for the particular treatment plan (in the Diagnosis field) and the text of the problem list (in the Problem List field).

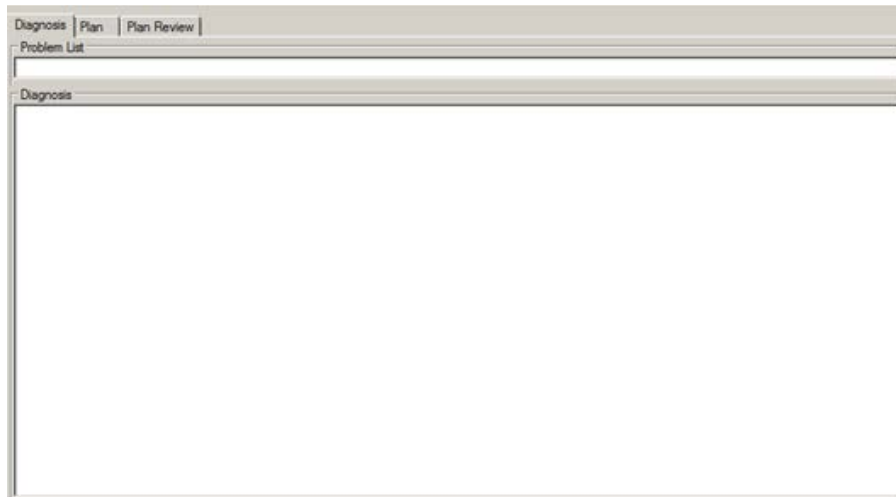


Figure 10-22: Diagnosis tab

Both fields are Free Text fields.

10.3.3 Plan Tab

Use the **Plan** tab to add participants to the plan as well as describing **the Problems / Goals / Objectives / Methods** of the plan.

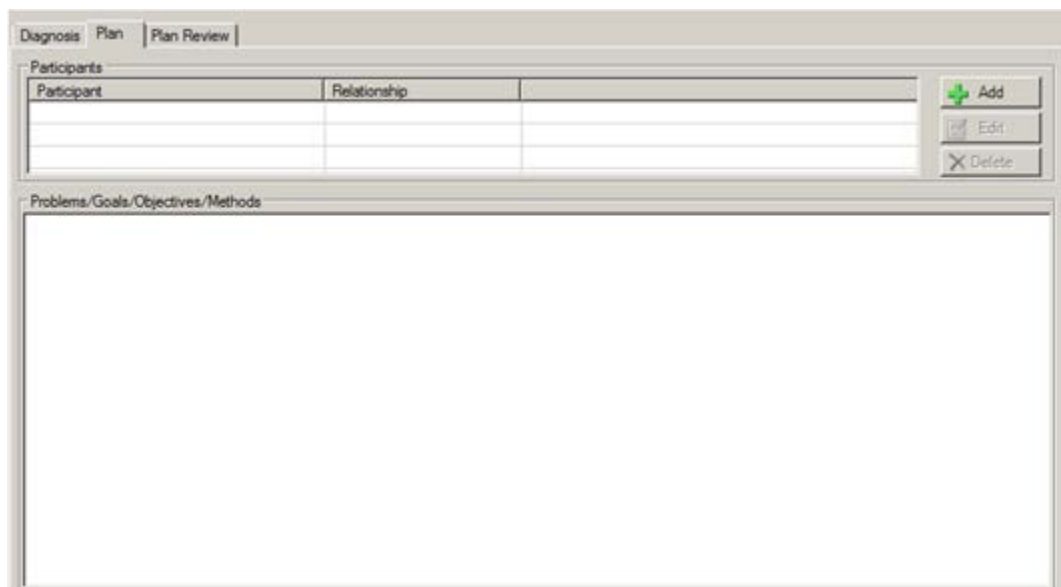


Figure 10-23: Sample Plan tab

Participants Group Box

Use the **Participants** group box to manage the participants in the treatment plan.

Delete Button

Use the Delete button to delete a selected participant record.

1. Select the participant record to delete.
2. Click **Delete**.
3. The application confirms the deletion. Type **Y** (yes) or **N** (no).

Add/Edit Button

The Add and Edit buttons use the same fields.

1. Click **Add** to add a record.

OR

2. Select a record to edit and click **Edit**.

The **Treatment Plan Participants** dialog box displays.

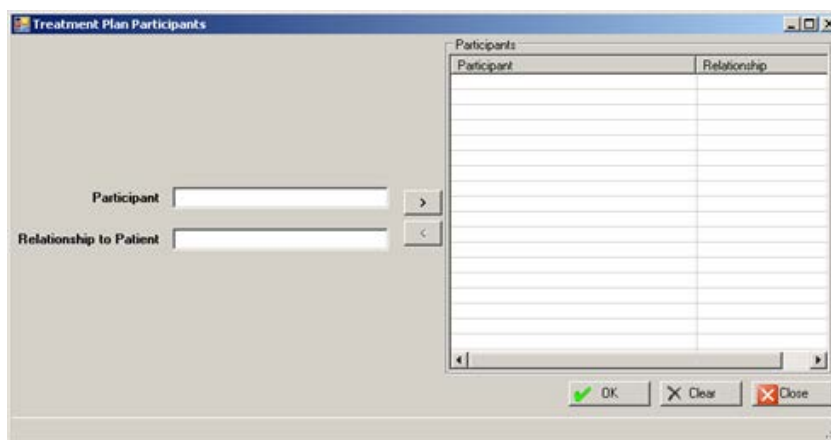


Figure 10-24: Sample Treatment Plan Participants dialog box

3. At the **Participant** field, type the participant name. This is a Free Text field.
4. At the **Relationship to Patient** field, type the participant's relationship to the patient of the treatment plan. This is a Free Text field.
5. After completing the **Participant** and **Relations** fields, do one of the following:
 - a. Click the right-pointing arrow to add the information to the **Participants** list box. More than one participant/relationship record can be added to the **Participants** list box.
 - b. Click **Clear** to remove the data in the **Participant** and **Relationship to Patient** fields.

6. Remove a highlighted record in the **Participants** list box by clicking the left-pointing arrow.
7. If **Add** was used, click **OK** to save the data. The data in the **Participants** list box will populate the **Participants** group box on the **Plan Review** tab of the add/edit treatment plan window. (Otherwise, click **Close**.)
8. If **Edit** was used, click **OK** to save the data. The data in the **Participants** list box will be updated.

Problems/Goals/Objectives/Methods

Populate this field with the text of the problems, goals, objective, or methods for the treatment plan. This is a Free Text field.

10.3.4 Plan Review Tab

Use the **Plan Review** tab to document the plan review of the treatment plan.

Figure 10-25: Sample Plan Review tab

When a record is selected in the grid for the plan review, you can do the following:

- Complete the fields for the plan review (below the grid)
- Complete the participants in the plan review (in the **Participants** group box)
- Complete the **Progress Summary** for the plan review (in the **Progress Summary** field)

After you have completed the fields and group boxes, click **OK** to save the plan review record. (Otherwise, click **Cancel**.)

Review Group Box

Use the top group box to document the review date, the review provider, and review supervisor, and next review date for the treatment plan.

Delete Button

Use the Delete button to delete a selected plan review record.

1. Select the plan review record to delete.
2. Click **Delete**.
3. At the “Are you sure” confirmation message, type **Y** (yes) to delete the record. (Otherwise, type **N** (no).

Edit Button

Use the Edit button to change a selected plan review record.

1. Select the plan review record to change.
1. Click **Edit**.
2. The fields for the selected plan become active. These fields are reviewed below (under Add button).

Add Button

Use to add a new review record. Populate the fields below the review grid as well as the Participants group box, and the Progress Summary field to complete the add process.

The fields for Review in bold text are required.

1. Click **Add**. The fields below the review grid become active.
2. At the **Review Date** field, select the date of the review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date.
3. At the **Next Review Date** field, select the date of the next review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date. Please note that changing the Next Review date here will also change the Next Review date on the Treatment Plan Information group box.
4. At the **Review Provider** field, select the provider who is doing the review (the default is the current user). Click the drop-down list to access the **Reviewing Provider** search/select window where you search for the provider name.

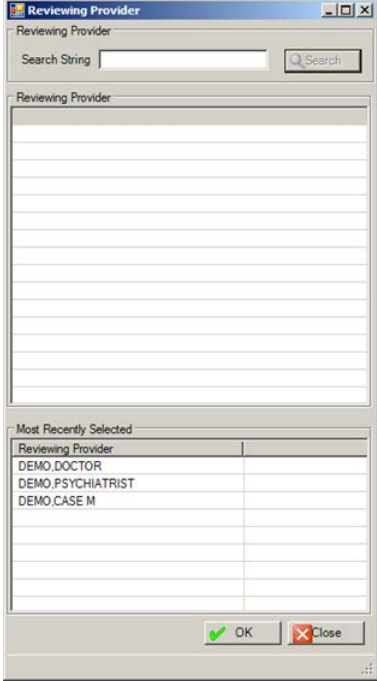
Screen Capture	What to do
	<p>Use this search/select window in one of two ways:</p> <p>(1) Use the Search String field by typing the reviewing provider's last name and then clicking Search. The retrieved names will populate the Reviewing Provider list box. Select a retrieved record and click OK to populate the Review Provider field. (Otherwise, click Close.)</p> <p>(2) Select in the Most Recently Selected list box and click OK to populate the Review Provider field. (Otherwise, click Close.)</p>

Figure 10-26: Sample Reviewing Provider search/select window

- At the **Review Supervisor** field, select the review supervisor for the treatment plan. Click the drop-down list to access the **Reviewing Supervisor** search/select window where you search for the supervisor name.

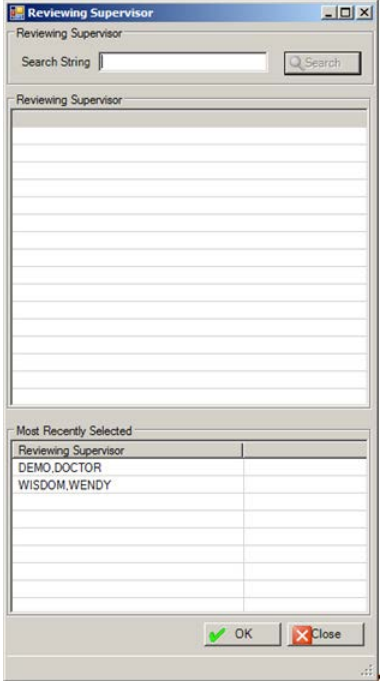
Screen Capture	What to do
	<p>Use this search/select window in one of two ways:</p> <p>(1) Use the Search String field by typing the reviewing supervisor's last name clicking Search. The retrieved names will populate the Reviewing Supervisor list box. Select a retrieved record and click OK to populate the Review Supervisor field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Review Supervisor field. (Otherwise, click Close.)</p>

Figure 10-27: Sample Reviewing Supervisor search/select window

Participants Group Box (Plan Review)

Use the **Participants** group box to display the participants in the plan review.

Add/Edit Button

The Add and Edit buttons used the same fields.

1. Click **Add** to access the Treatment Plan Participants dialog box.
- OR
2. Select a participant record to edit. Click **Edit** to access the **Treatment Plan Participants** dialog box.

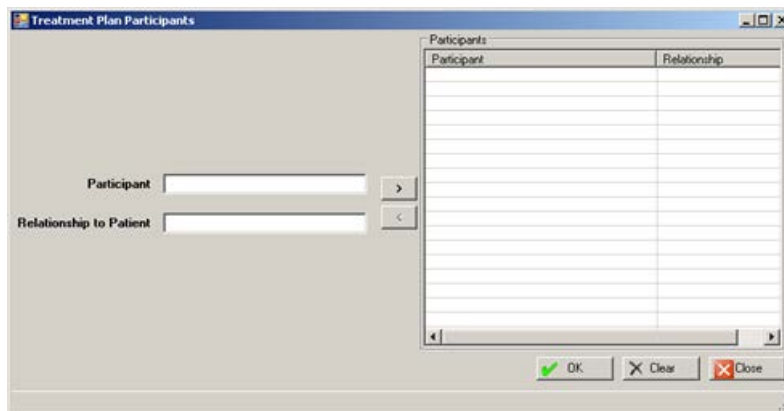


Figure 10-28: Treatment Plan Participants dialog box

3. At the **Participant** field, type the participant name. This is a Free Text field.
4. At the **Relationship to Patient** field, type the participant's relationship to the patient of the treatment plan. This is a Free Text field.
5. After completing the Participant and Relations fields, do one of the following:
 - a. Click the right-pointing arrow to add the information to the **Participants** list box. More than one participant/relationship record can be added to the Participants list box.
 - b. Click **Clear** to remove the data in the **Participant** and **Relationship to Patient** fields.
6. Remove a highlighted record in the **Participants** list box, click the left-pointing arrow.
7. If Add was used, click **OK** to save the data. The data in the **Participants** list box will populate the **Participants** group box on the **Plan Review** tab of the add/edit treatment plan window. (Otherwise, click **Close**.)
8. If Edit was used, click **OK** to save the data. The data in the **Participants** list box will be updated.

Delete Button

Use the Delete button to delete a selected Participants record.

1. Select a participant record to delete.
2. Click **Delete**.
3. On the "Are You Sure" confirmation message, click **Yes** to delete the record (otherwise, click **No**).

Progress Summary

Use the Progress Summary field to add the text of the progress of the plan review.
This is a Free Text field.

11.0 Suicide Forms

You can manage suicide forms in Roll and Scroll as well as in the RPMS Behavioral Health System (GUI).

Please note: all of the fields are mandatory but not enforced. This means if you do not populate all of the fields, you can still save, but that suicide form will be considered Incomplete. If you do complete all of the fields, the suicide form will be considered Complete.

11.1 Suicide Reporting Forms (Roll and Scroll)

You use the SF (Suicide Reporting Forms - Update/Print) option on the IHS Behavioral Health System Data Entry Menu to manage suicide forms in Roll and Scroll.

The Add/Update Suicide Forms option on the Other Information window also accesses the suicide reporting forms.

After using the SF option, Figure 11-1 shows the two options:

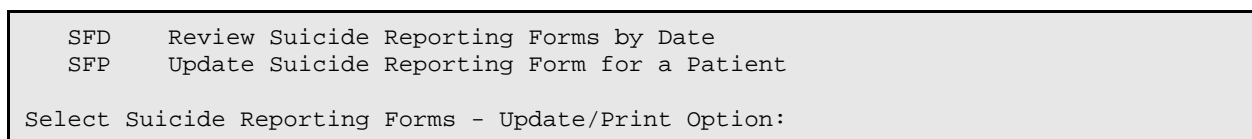


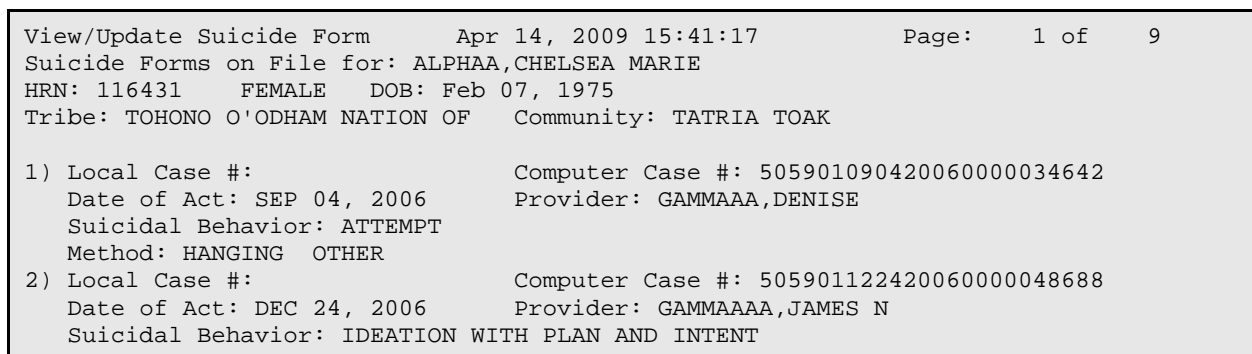
Figure 11-1: Options available for managing suicide forms

11.1.1 Update Suicide Reporting Form for a Patient (SFP)

Use the SFP option to update the suicide report for a specified patient.

Below are the prompts.

1. At the “Select Patient Name” prompt, type the name of the patient to use.
2. The View/Update Suicide Form window for the selected patient displays.



```

Method:
[Incomplete Form]
3) Local Case #:                Computer Case #: 505901013120070000048688
   Date of Act: JAN 31, 2007    Provider: BETAAA,LINZA
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method: OVERDOSE
4) Local Case #:                Computer Case #: 505901022220070000034642
+      ?? for more actions + next screen - prev screen
AF  Add a Suicide Form          BV  Browse Visits for this Patient
EF  Edit a Suicide Form         HS  Health Summary for this Patient
DF  Display a Suicide Form      Q   Quit
XF  Delete a Suicide Form
Select Item(s): Next Screen//

```

Figure 11-2: Sample View/Update Suicide Form window for the current patient

If any of the suicide forms are incomplete, the message “[Incomplete Form]” will display as the last line under the particular case.

Use the Quit action to dismiss this window.

Add/Edit Suicide Form

The add and edit functions use the same update form.

Add a Suicide Form (AF)

Use the AF action to add a suicide form for the current patient.

Below are the prompts.

1. At the “Select Item(s)” prompt, type **AF**.
2. At the “Provider Completing the form” prompt, type the name of the provider who is completing the form.
3. At the “Enter the Date of the Suicide Act” prompt, type the date of the suicide act.
4. The application displays the Updating IHS Suicide Form window. (See “Edit a Suicide Form” below for more information about this window.)

Edit a Suicide Form (EF)

Use the EF action to change a selected suicide form.

1. At the “Select Item(s)” prompt, type **EF**.
2. At the “Select Suicide Reporting Form List” prompt, type the number of the suicide form to change.
3. The application displays the Updating IHS Suicide Form window.

```

*** UPDATING IHS SUICIDE FORM *** F1 E to exit ***
Patient: ALPHAA,CHELSEA MARIE                FEMALE                HRN: 116431
DOB: Feb 07, 1975                Community Res: TATRIA TOAK
Tribe: TOHONO O'ODHAM NATION OF ARIZONA
Computer Generated Case #: 5059011224200600000486
Provider: LAMBDA,JAMES N                Initials:                Discipline:
-----
1. Local Case #:                Provider: THETAAA,JAMES
7. Employment Status:
8. Date of Act: DEC 24,2006 11. Community where act Occurred:
12. Relationship Status: SINGLE                13. Education: COLLEGE GRAD
14. Suicidal Behavior: IDEATION W/ PLAN AND INTENT
15. Method (press enter):                16. Previous Attempts: 2
17. Substance Use Involved:                18. Location of Act: HOME OR VICINI
19. Contributing Factors (press enter):
20. Disposition: IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY)
21. Other Relevant Information:
-----
COMMAND:                Press <PF1>H for help                Insert

```

Figure 11-3: Sample Updating IHS Suicide Form window

The underlined fields are required.

4. At the “Local Case #” prompt, type a local case number generated by the site (use 1-20 characters).
5. At the “Provider” prompt, type the name of the provider reporting this suicide case (the provider completing the form).
6. At the “Employment Status” prompt, type the employment status of the patient. Use one of the following: **P** (part-time), **F** (full-time), **S** (self-employed), **UE** (unemployed), **R** (retired), **ST** (student), **SE** (student and employed), **UNK** (unknown).
7. At the “Date of Act” prompt, type the date of the suicide act. The default is the current date (can be changed).
8. At the “Community where act Occurred” prompt, type the name of the community where the suicide act occurred.
9. At the “Relationship Status” prompt, type the relationship status. Use one of the following: **1** (single), **2** (married), **3** (divorced/separated), **4** (widowed), **5** (cohabiting/common law), **6** (same sex partnership), **9** (unknown).
10. At the “Education” prompt, type the level of patient’s education. Use one of the following:
 - 1** - Less than 12 years

- 2 - High School Graduate/GED
- 3 - Some College/Technical School
- 4 - Collage Graduate
- 5 - Post Graduate
- 6 – Unknown

If you use the “less than 12 years” option, the application asks for the following information:

- a. At the “If less than 12 years, highest grad completed” prompt, type any whole number between 0 and 11.

The following fields are on the Updating IHS Suicide Form window.

- 11. At the “Suicidal Behavior” prompt, type the suicidal behavior for the suicide act. Use one of the following:

- 1 – Ideation W/ Plan and Intent
- 2 - Attempt
- 3 – Completed Suicide
- 6 – Att’d Suicide w/ Att’d Homicide
- 7 - Att’d Suicide w/ Compl Homicide
- 8 - Compl Suicide w/ Att’d Homicide
- 9 - Compl Suicide w/ Compl Homicide

- 12. At the “Method (press Enter)” prompt, press Enter to access the following pop-up.

```
*** If you need help type ?, not ?? ***
METHOD:
METHOD:
METHOD:
```

Figure 11-4: Sample fields on the pop-up

- a. At the “Method” prompt, type a suicide method. More than one can be used.
 - 1 - GUNSHOT
 - 2 - HANGING
 - 3 - MOTOR VEHICLE
 - 4 - JUMPING
 - 5 - STABBING/LACERATION
 - 6 - CARBON MONOXIDE
 - 7 - OVERDOSE
 - U – UNKNOWN

If you use Other in the Method field, the application asks the following information:

- b. At the “Please describe the “OTHER” Method” prompt, type the text of the other method using between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

13. At the “Previous Attempts” prompt, type the number/character of previous suicide attempts. Use one of the following:

0 0
1 1
2 2
3 3 or more
U Unknown

14. At the “Substance Use Involved” prompt, type the substance use involved in the suicide act. Use one of the following: **1** (none), **2** (alcohol and other drugs), **U** (unknown).

If you use 2, the application displays the list of drug choices type.

```
For a list of drug choices type ??
SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
```

Figure 11-5: Sample of list of drug choices used

- a. At the “SUBSTANCE DRUG USED” prompt, type the substance drug used. More than one can be used.
- b. If you use OTHER at the SUBSTANCE DRUG USED prompt, the application asks for the following information: Drug if other. Type the name of the drug using 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

15. At the “Location of Act” prompt, type the location of the act.

If you use Other in the Location of Act field, the application asks the following information:

- At the Location of Act If Other” prompt, type the location of the act using between 1 and 80 characters.

16. At the “Contributing Factors (press Enter)” prompt, press Enter to access the Contributing Factors pop-up.

```
Enter all Contributing Factors. To see a list of choices type ??
FACTOR:
FACTOR:
FACTOR:
```

Figure 11-6: Fields on the pop-up

- a. At the “Factor” prompt, type the contributing factor. More than one can be used.

You cannot enter UNKNOWN if other legitimate values have already been entered. If you want to enter UNKNOWN you must first delete (using the '@') all other entries (the application confirms the deletion).

If you use OTHER at the FACTOR prompt, the application asks the following information:

- b. At the “Enter a brief description of the “Other” Contributing Factor” prompt, type a brief description using between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

17. At the “Disposition” prompt, type the disposition of the suicide act.

If you use OTHER at the Disposition prompt, the application asks the following information:

- At the “Disposition If Other” prompt, type the disposition using between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

18. At the “Other Relevant Information” prompt, press Enter to access another window where you populate the field with text of the other relevant information about the suicide act.

```

==[ WRAP ]==[ INSERT ]===== < SUBJECTIVE/OBJECTIVE >===== [ <PF1>H=Help ]=====

<-----T-----T-----T-----T-----T-----T-----T-----T-----T----->-----

```

Figure 11-7: screen to enter other relevant information

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you leave the suicide form and if there are any missing data, the application lists what is missing and lists what actions you can take:

```

Select one of the following:

      E      Edit and Complete the Form
      D      Delete the Incomplete Form
      L      Leave the Incomplete Form as is and Finish it Later

What do you want to do: E//

```

Figure 11-8: List of actions you can take

Use **E** to return to the form where you can edit and complete it.

Use **D** to delete the form (there is no confirmation).

Use **L** to leave the form incomplete (as is) and finish it later.

Display a Suicide Form (DF)

Use the DF action to display a specified suicide form.

1. At the “Select Item(s)” prompt, type **DF**.
2. At the “Select Suicide Reporting Form List” prompt, type the suicide form to display.
3. At the “Do you wish to” prompt, type one of the following: **P** (print output) or **B** (browse output on screen)

The form displays where you can browse the Suicide Reporting Form on the screen.

```

***** CONFIDENTIAL PATIENT INFORMATION [ST] Apr 14, 2009 *****
Suicide Reporting Form                               Date Printed: Apr 14, 2009

1. Case #: 505901122420060000048688      Local Case #:

2. PROVIDER INITIALS: RWL                  3. PROVIDER DISCIPLINE: NUTRITION TECHNIC
4. SEX: FEMALE                            5. DOB: FEB 07, 1975                    6. AGE: 31
7. EMPLOYMENT STATUS:
8. DATE OF ACT: DEC 24, 2006
9. TRIBE: TOHONO O'ODHAM NATION OF ARIZONA
10. COMMUNITY OF RESIDENCE: TATRIA TOAK

```

```

11. COMMUNITY WHERE ACT OCCURRED:
12. RELATIONSHIP STATUS: SINGLE
13. EDUCATION:
14. SUICIDAL BEHAVIOR:
15. METHOD: OVERDOSE
    DRUGS W/OVERDOSE:
    ALCOHOL
16. PREVIOUS ATTEMPTS:
17. SUBSTANCE USE INVOLVED:
18. LOCATION OF ACT:
19. CONTRIBUTING FACTORS:
    HISTORY OF SUBSTANCE ABUSE/DEPENDENCE
20. DISPOSITION:

    Other Relevant Information: (OPTIONAL)

DATE LAST MODIFIED: DEC 08, 2010
USER LAST UPDATED: THETA,SHIRLEY
EDIT HISTORY:
  May 15, 2009 12:01:24 pm  THETA,SHIRLEY
+   Enter ?? for more actions                                >>>
+   NEXT SCREEN          -   PREVIOUS SCREEN          Q   QUIT
Select Action: +//

```

Figure 11-9: Sample Output Browser window for suicide act

Delete a Suicide Form (XF)

Use the XF action to remove a selected suicide form record.

1. At the “Select Item(s)” prompt, type **XF**.
2. At the “Select Suicide Reporting Form List” prompt, type the suicide form to remove.
3. At the “Are you sure you want to delete this suicide form?” prompt, type **Y** (yes) to delete the suicide form or **N** (no).

Browse Visits for this Patient (BV)

Use the BV action to browse the BH visits for the current patient.

1. At the “Select Item(s)” prompt, type **BV**.
2. At the “Browse which subset of visits for <patient name>” prompt, type one of the following: **L** (patient’s last visit), **N** (patient’s last n visits), **D** (visits in a date

range), **A** (All of this patient's visits), or **P** (visits to one program). If N, D, or P are used, other prompts will display.

- a. If N was used, type the number of visits at the "How many visits should be displays: (1-99)" prompt.
- b. If D was used, type the beginning date of visit and ending date of visit at the "Enter Beginning Date of Visit" and "Enter Ending Date of Visit" prompts.
- c. If P was used, type the program to use at the "Visits to Which Program" prompt.

The BROWSE PATIENT'S VISITS window displays.

```

BROWSE PATIENT'S VISITS      Mar 05, 2014 10:18:31      Page: 1 of 2
Patient Name: DEMO,DARRELL LEE      DOB: Sep 23, 1986
HRN: 117305

***** Suicide Forms on File *****
Date of Act: MAY 15, 2009      Suicidal Behavior:
Previous Attempts:      Method: OVERDOSE
*****

Visit Date: Feb 22, 2014@13:33      Provider: TETER,SHIRLEY
Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:
  F42.      HOARDING DISORDER

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

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

```

Figure 11-10: Sample Browse Patient's Visits window

At the Select Action prompt, do one of the following:

- Type + to view the next screen (does not apply to the last screen)
- Type – to view the previous screen (does not apply to the first screen)
- Type **Q** to quit.

Health Summary for this Patient (HS)

Use the HS to display/print a particular health summary for the current patient.

1. At the "Select Item(s)" prompt, type **HS**.

2. The health summary for this patient displays on the Output Browser window.

```

OUTPUT BROWSER          Aug 04, 2014 11:15:54          Page:    1 of    24
PCC Health Summary for DEMO,DOROTHY ROSE

***** CONFIDENTIAL PATIENT INFORMATION -- 8/4/2014 11:15 AM [ST] *****
***** DEMO,DOROTHY ROSE #999999 <A> (BEHAVIORAL HEALTH SUMMARY) pg 1 *****

----- DEMOGRAPHIC DATA -----

DEMO,DOROTHY ROSE          DOB: OCT 10,1942 71 YRS  FEMALE  no blood type
CHEROKEE NATION, OK       SSN: XXX-XX-1111
                           MOTHER'S MAIDEN NAME: CARMAN,CRYSTAL MARCHELLE
(H) 555-444-3333 (W) 555-222-6666 FATHER'S NAME: ABBOTT,MARTIN

MOAB (1234 ROAD STREET,ANYTOWN,VA,99999)

LAST UPDATED: DEC 23,2011      ELIGIBILITY: CHS & DIRECT
VETERAN

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT? YES
                           DATE RECEIVED BY PATIENT: Jun 30, 2003
+      Enter ?? for more actions                                >>>
+      NEXT SCREEN      -      PREVIOUS SCREEN      Q      QUIT
Select Action: +//

```

Figure 11-11: Sample Health Summary report for current patient

At the Select Action prompt, do one of the following:

- Type + to view the next screen (does not apply to the last screen)
- Type - to view the previous screen (does not apply to the first screen)
- Type Q to quit.

11.1.2 Review Suicide Forms by Date (SFD)

Use the SFD option to review the suicide forms in a particular date range.

1. At the “Select Item(s)” prompt, type **SFD**.
2. At the “Select PATIENT NAME” prompt, type the name of the patient to use.

The Review Suicide Reporting Forms window displays.

```

View/Update Suicide Form    Aug 04, 2014 11:23:13    Page:    1 of    1
Suicide Forms on File for: DEMO,DOROTHY ROSE
HRN: 999999    FEMALE    DOB: Oct 10, 1942
Tribe: CHEROKEE NATION, OK  Community: MOAB

1) Local Case #:          Computer Case #: 505901120620120000060849
   Date of Act: DEC 06, 2012    Provider: WISDOM,WENDY
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method: STABBING/LACERATION

```

```

2) Local Case #:                               Computer Case #: 505901093020090000060849
   Date of Act: SEP 30, 2009                   Provider: TETER,SHIRLEY
   Suicidal Behavior: ATTEMPT
   Method:
   [Incomplete Form]

           ?? for more actions  + next screen  - prev screen
AF  Add a Suicide Form                       BV  Browse Visits for this Patient
EF  Edit a Suicide Form                       HS  Health Summary for this Patient
DF  Display a Suicide Form                    Q   Quit
XF  Delete a Suicide Form
Select Item(s): Quit//

```

Figure 11-12: Sample Review Suicide Report Forms window

The phrase “[Incomplete Form]” at the end of the suicide form record represents the Incomplete Suicide Reporting Form.

Section 11.1.1 provides more information about the add/edit/delete functions on this window.

11.2 Suicide Form Window (GUI)

The suicide form options are located under the Suicide Reporting Forms category on the tree structure for the RPMS Behavioral Health System (GUI) application.

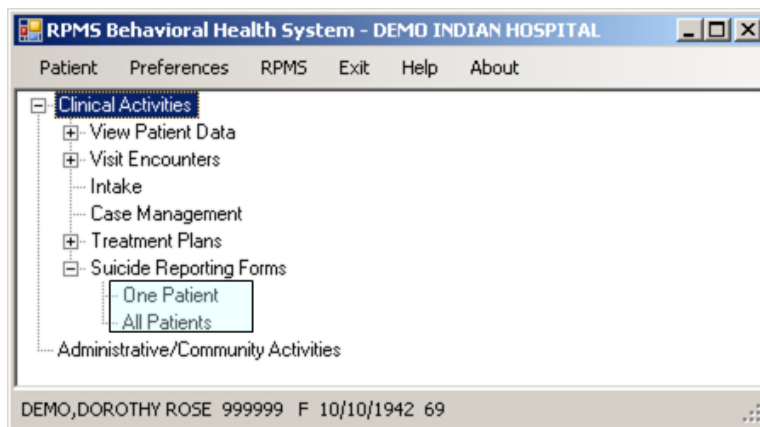


Figure 11-13: Location of Suicide Forms on the tree structure

One way to access the **Suicide Form** window is to select the **One Patient** option.

Note You can access this window if you click the **Suicide Form** tab on the **Visit Data Entry – Add/Edit** window.

The application displays the **Suicide Form** window for **One Patient**. If you access the **Suicide Form** for one patient window and there is no current patient, you will be asked to select one.

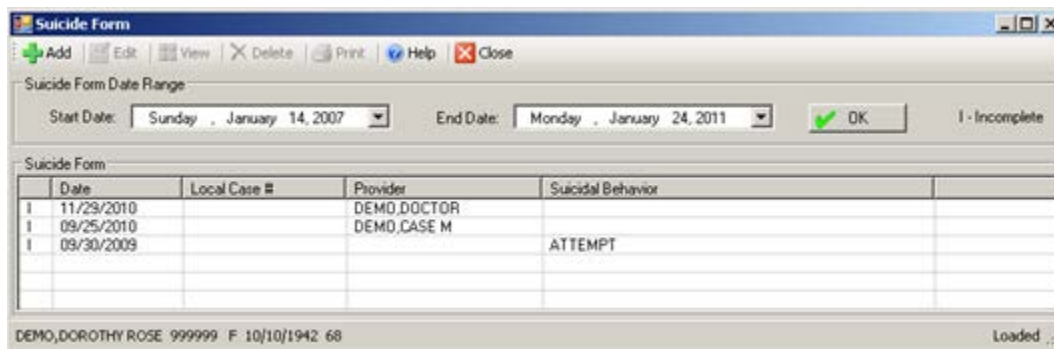


Figure 11-14: Suicide Form window for one patient

Another way to access the **Suicide Form** window is to select the **All Patients** option. The application displays the **Suicide Form** window for All Patients.

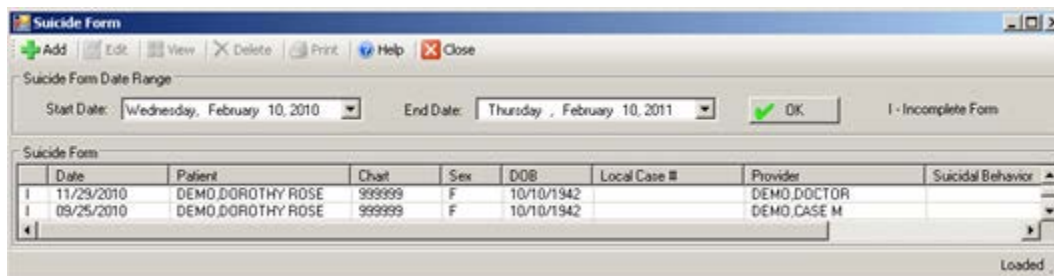


Figure 11-15: Sample Suicide Form window for all patients

Both windows function in the same way.

The following table provides information about the features of these windows.

Feature	Functionality
Suicide Form Window for One Patient	The default Start Date is one year previous. If you change the Start Date for the Suicide Form window for One Patient , this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).

Feature	Functionality
Suicide Form Window for All Patients	<p>The default Start Date is one year previous.</p> <p>If you change the Start Date for the Suicide Form window for All Patients, this change stays in effect until you exit the application. When you login the next time, the Start Date reverts to one year previous.</p> <p>Please note: If you change the Start Date for the Suicide Form window for One Patient, this change stays in effect in future sessions of the GUI application for the Visit window for One Patient, the Suicide Form window for One Patient, and the Treatment Plan window for One Patient windows.</p> <p>Similarly, if you change the Start Date for the Suicide Form window for All Patients, this change stays in effect in future sessions of the GUI application for the Visit window for All Patients, the Suicide Form window for All Patients, and the Treatment Plan window for All Patients windows.</p>
Suicide Form Group Box	This group box displays the suicide form records in the date range. The records are listed by date. The "I" in the first column of the grid indicates the suicide form is incomplete.
Add Button	Establish the patient you want to use in the add process. Use this button to add a new suicide form record. You access the Visit Data Entry - Add Suicide Entry dialog box.
Edit Button	Use this button to edit the highlighted suicide form for the current patient on the Visit Data Entry - Edit Suicide Entry dialog box. The Edit button will be inactive if the patient does not have any previous visits (applies to the suicide form for the current patient).
View Button	Use this button (or double-click on a form) to browse the highlighted suicide form record. The application displays the Suicide Form Data Entry - View Suicide Form window. This is a view-only window has the same fields as the add/edit suicide form window.
Delete Button	Use this button to remove the highlighted suicide form record. On the "Are You Sure" confirmation message, click Yes to remove the selected suicide record (otherwise, click No).
Help Button	Use this button to access the online help for the Suicide Forms window.
Close Button	Use this button close the Suicide Form window.
Print Button	Use this button to output the highlighted suicide form record. After clicking Print , the application displays the first page of the Suicide Reporting Form pop-up window.

The following applies to the Print button:

***** CONFIDENTIAL PATIENT INFORMATION [ST] Nov 02, 2010 *****
 Suicide Reporting Form Date Printed: Nov 02, 2010

1. Case #: 505901092520100000060849 Local Case #:
 2. PROVIDER INITIALS: ST 3. PROVIDER DISCIPLINE: PHYSICIAN
 4. SEX: FEMALE 5. DOB: OCT 10, 1942 6. AGE: 68
 7. EMPLOYMENT STATUS:
 8. DATE OF ACT: SEP 25, 2010
 9. TRIBE: CHEROKEE NATION, OK
 10. COMMUNITY OF RESIDENCE: NOAB
 11. COMMUNITY WHERE ACT OCCURRED:
 12. RELATIONSHIP STATUS:
 13. EDUCATION:
 14. SUICIDAL BEHAVIOR:
 15. METHOD:
 16. PREVIOUS ATTEMPTS:
 17. SUBSTANCE USE INVOLVED:
 18. LOCATION OF ACT:
 19. CONTRIBUTING FACTORS:
 20. DISPOSITION:
 Other Relevant Information: (OPTIONAL)

Current Page No.: 1 Total Page No.: 1 Zoom Factor: 100%

Figure 11-16: Sample Suicide Reporting Form

This window contains the following:

- Data from the Suicide Form
- Patient data, such as sex, DOB, Age
- Edit History, such as date last modified, user last update, and each update including date & time + person who modified

Section 2.6 provides more information about using the controls on this type of window.

11.3 Add/Edit Suicide Form (GUI)

1. Click **Add** to add a new suicide record. The **Suicide Form Data Entry – Add Suicide Form** displays.

OR

2. Select a record to change and click **Edit**. The **Suicide Form Data Entry - Edit Suicide Form** displays.

Below are the fields on the **Suicide Form Data Entry - Add Suicide Form** window. (The same fields display on the **Suicide Form Data Entry - Edit Suicide Form** window.)

Figure 11-17: Sample Suicide Form Data Entry - Add Suicide Form window

All fields except the **Local Case Number** and the **Narrative** are required in order to save. If you try to save and have not completed the fields, the application displays the **Required** information message.

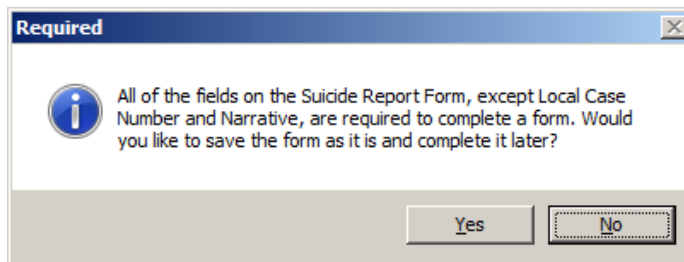


Figure 11-18: Required information message

- Click **Yes** to save the form and complete it later; the focus returns to the **Suicide Form** window.
- Click **No** to not save and the focus remains on the data entry form.

The following table provides information about the buttons on this window.

Button	Functionality
Save	Use this button to save the data.
Help	Use this button to access the online help system for this window.
Close	Use this button to display the Continue? dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add window. Click No and the focus remains on the add window where you can continue work on the suicide form.

11.3.1 Suicide Form Fields

Figure 11-19: Fields on suicide form

The required fields are in bold text.

1. At the **Local Case Number** field, type the local case number or a health record number, if any (limited to 20 characters). This is a Free Text field.
2. At the **Provider** field, select the provider. For a new record, the application automatically populates this field with the current logon provider. To change click the drop-down list to access the **Provider** search window where you search for the provider name.

Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Provider list box. Select a retrieved record and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Provider field. (Otherwise, click Close.)</p>

Figure 11-20: Sample Provider search window

3. At the **Date of Act** field, select the date of the act. For a new record, the current date displays. To change click the drop-down list to access a calendar where you select another date.
4. At the **Community Where Act Occurred** field, select the community where the act occurred. To change click the drop-down list to access the **Community** search/select window where you search for the community name.

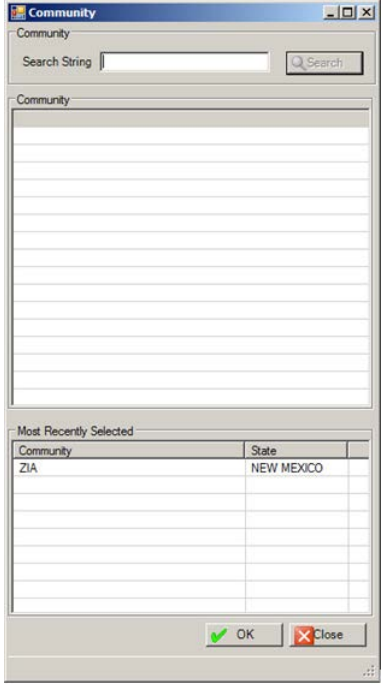
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the community name and then clicking Search. The retrieved names will populate the Community list box. Select a retrieved record and click OK to populate the Community Where Act Occurred field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Community Where Act Occurred field. (Otherwise, click Close.)</p>

Figure 11-21: Sample Community search/select window

5. At the **Relationship Status** field, select the patient's relationship status. Use one of the following:

Single

Married

Divorced/Separated

Widowed

Cohabiting/Common Law

Same Sex Partnership

Unknown

6. At the **Education field**, select the level of education of the patient. Use one of the following:

Less than 12 years

High School Graduate/GED

Some College/Technical School

Collage Graduate

Post Graduate

Unknown

7. At the **Employment Status field**, select the status of the patient's employment. Click the drop-down list and use one the options.

PART TIME

FULL TIME

UNEMPLOYED

RETIRED

STUDEMNT

STUDENT AND EMPLOYED

UNKNOWN

8. At the **If less than 12 years, highest grade completed field**, type the highest grade the patient completed (0-11). This field becomes active when you populate the Education field with 'Less than 12 years'.
9. At the **Suicidal Behavior field**, select the type of suicidal activity. Click the drop-down list and use one the options.

IDEATION W/ PLAN AND INTENT

ATTEMPT

COMPLETED SUICIDE

ATT'D SUCICIE W/ATT'D HOMICIDE

ATT'D SUICDIE W/COMPL HOMICIDE

COMPL SUICIDE W/ATT'D HOMICIDE**COMPL SUICIDE W/COMP'L HOMICIDE**

10. At the **Location of Act** field, select the location of the suicidal act. Click the drop-down list and use one of the options.

HOME OR VICINITY**SCHOOL****WORK****JAIL/PRISON/DETENTION****TREATMENT FACILITY****MEDICAL FACILITY****OTHER****UNKNOWN**

11. At the **Previous Attempts** field, select the previous suicide attempts. Use one of the options available on the drop-down list.

0**1****2****3 OR MORE****UNKNOWN**

12. At the **if other** field, type where the suicidal act occurred (limited to 80 characters). This field becomes active if you populate the Location of Act field with 'Other'. This is a Free Text field.

13. At the **Disposition** field, select the disposition of the suicide act. Click the drop-down list to access the **Disposition** select window.

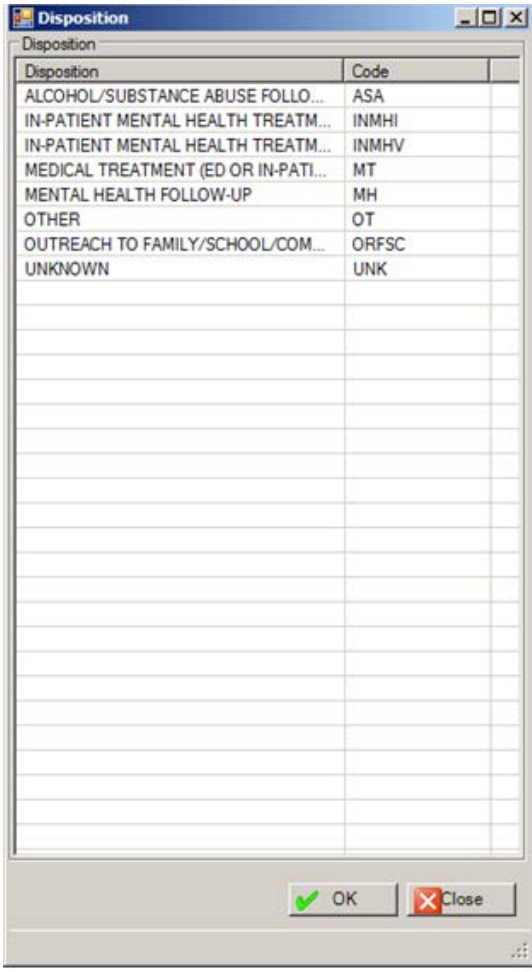
Screen Capture	What to do
	<p>Use this window as follows:</p> <ol style="list-style-type: none"> (1) Select a Disposition option and click OK and the selected option populates the Disposition field. (Otherwise, click Cancel.) (2) If Other was used, the field to the right becomes active. Populate this Free Text field with the disposition of the suicide act (limited to 80 characters).

Figure 11-22: Sample Disposition select window

11.3.2 Method Tab

Use the **Method** tab to indicate the method used in the suicide act as well as indicate the substance used in overdose cases.

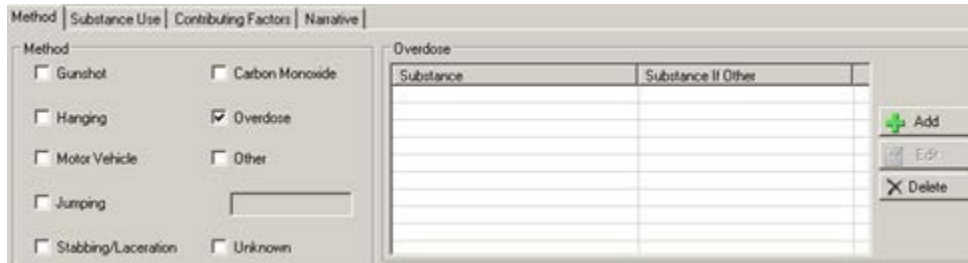


Figure 11-23: Sample Method tab

Method Group Box

1. Select one or more checkboxes in this group box that describe the method used in the suicide act. At least one is required.
2. Select the **Overdose** checkbox and the **Substance** multiple select window displays where you can add one or more categories of substances.

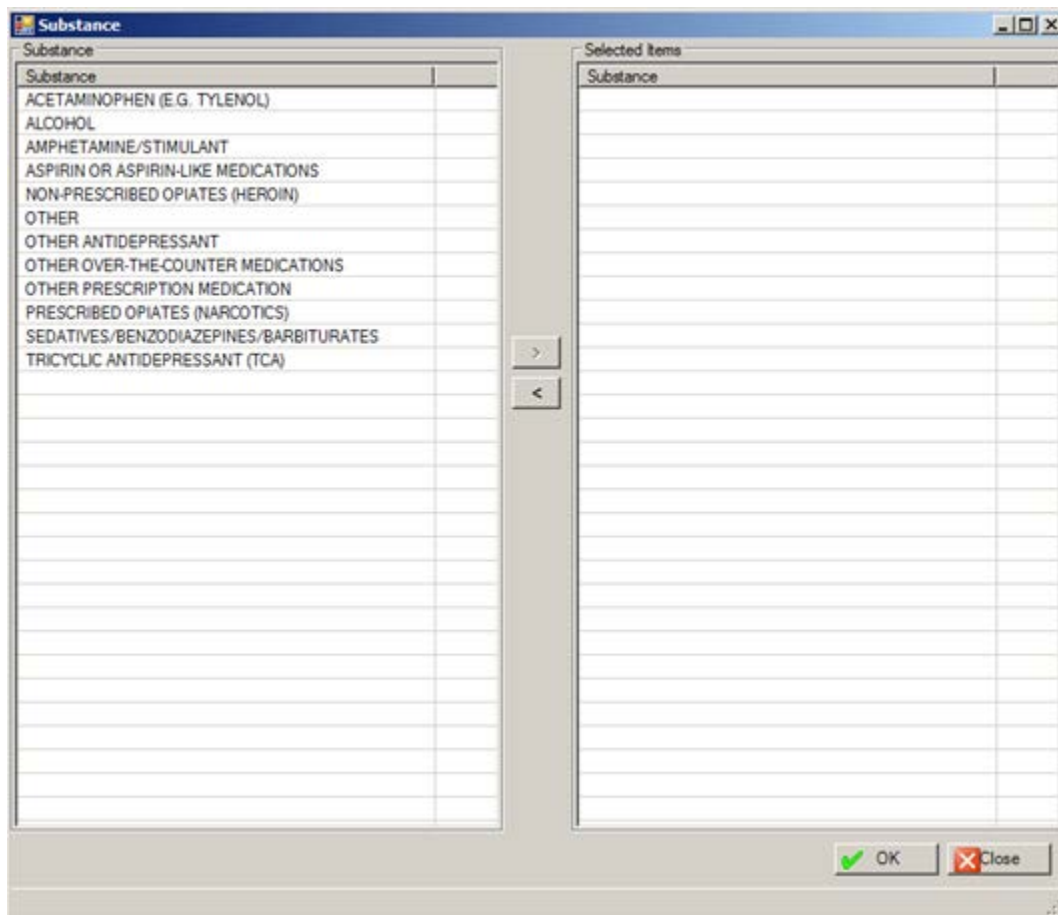


Figure 11-24: Sample Substance multiple select window

Use this search window as follows:

- a. Select an option in the **Substance** list box.
 - b. Click the right-point arrow to add it to the **Selected Item Substance** list box.
 - c. Likewise, select an option in the **Selected Item Substance** list box and click the left-point arrow to remove the option.
 - d. When the **Selected Item** list box is complete, click **OK** and the options populate the Overdose group box.
3. When this window is complete, click **OK**. This action adds the substances to **Overdose** group box.

- If you select a substance with **OTHER** in its name and then click **OK**, the **OTHER** dialog box displays.

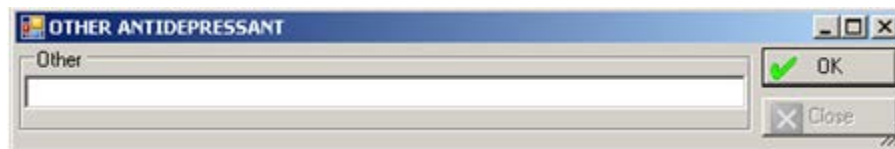


Figure 11-25: Sample Other dialog box

You must populate the Other Free Text field (limited to 80 characters) with a description of the other substance. Click **OK**. The description populates the **Substance If Other** cell on the Overdose group box.

4. If you select the **Other** checkbox, the field below the checkbox becomes active. Populate this Free Text field with the text that describes the other method used in the suicide act (limited to 80 characters).
5. If you select the **Overdose** checkbox under **Method**, the **Overdose** group box becomes available. The **Substance** multi-select window displays.

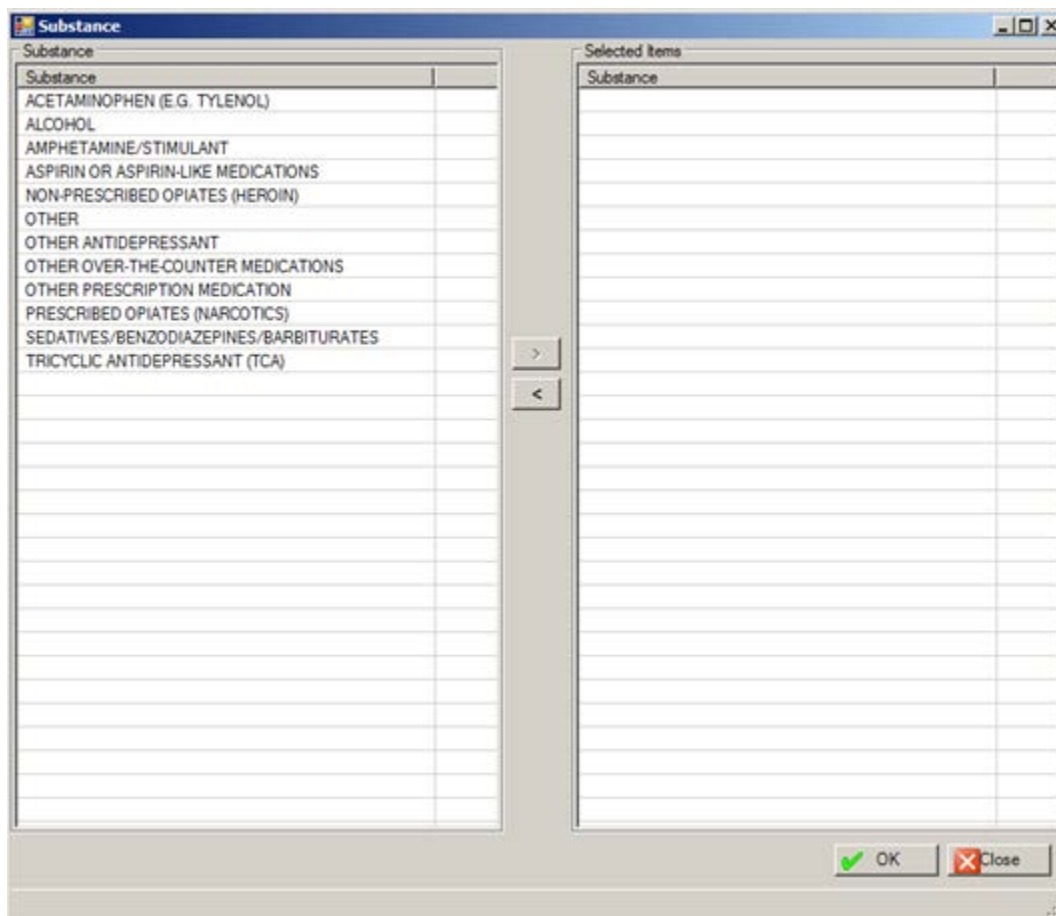


Figure 11-26: Sample Substance multi-select window

Use this search window as follows:

- a. Select an option in the **Substance** list box.
- b. Click the right-point arrow to add it to the **Selected Item Substance** list box.
- c. Likewise, select an option in the **Selected Item Substance** list box and click the left-point arrow to remove it.
- d. When the **Selected Item** list box is complete, click **OK** and the options populate the Overdose list box. (Otherwise, click **Cancel**.)

Overdose Group Box

This group box contains the categories of substances used in the overdose suicidal act. Once it is populated, the Add, Edit, and Delete buttons become active.

You can add, edit, or delete overdose substances.

Delete Button

1. Select a substance to delete.
2. Click **Delete**.
3. At the “Are you sure” confirmation message, click **Yes** to delete. (Otherwise, click **No**.)

Edit Button

1. Highlight the record with data in the “Substance if Other” column.
2. Click **Edit**.
3. The Other Antidepressant dialog box displays.

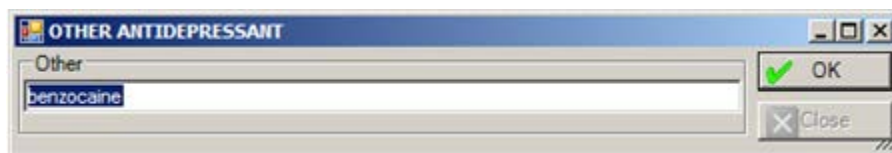


Figure 11-27: Sample Other Antidepressant dialog box

- a. Change the antidepressant substance in the field.
- b. Click **OK** to change the record.
4. The application displays the current “Substance If Other” data in the **Other** field. You can change the data, as needed. Click **OK** to dismiss the **Other** dialog box.

Add Button

1. Click **Add**.

2. The **Substance** multiple select window where you can add one or more substances.

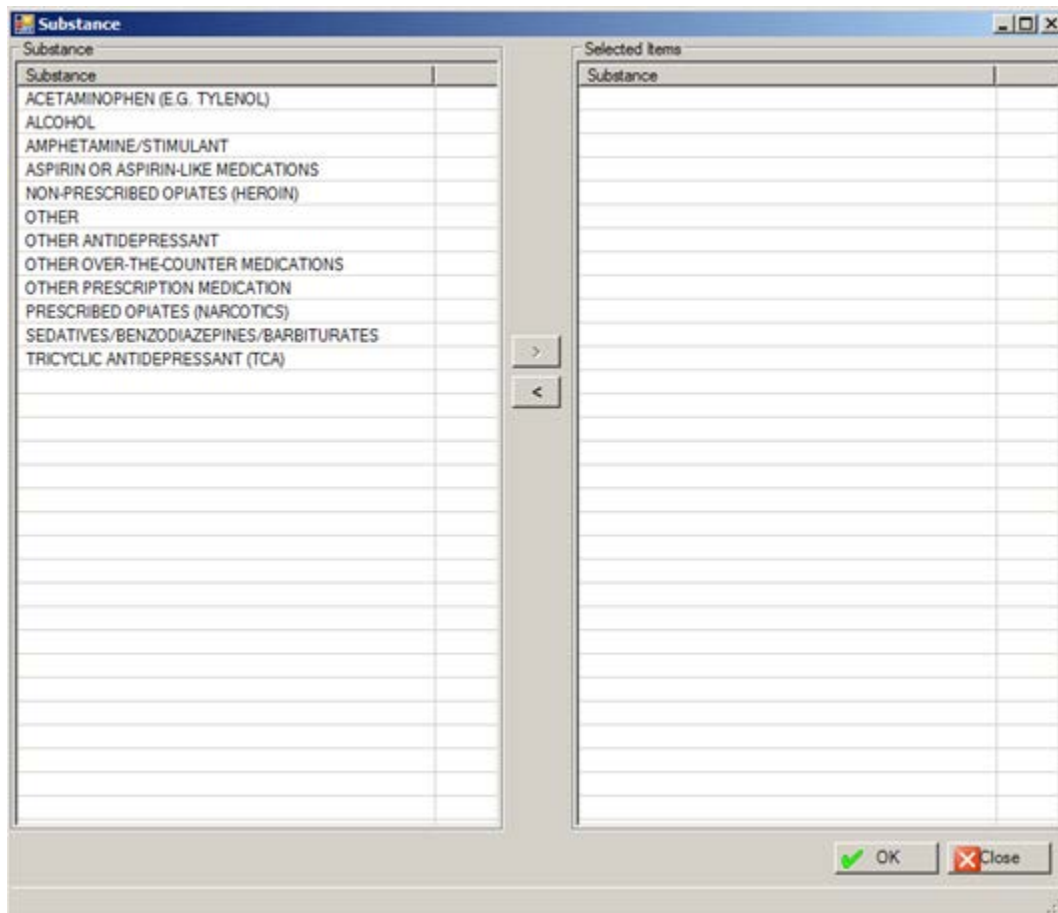


Figure 11-28: Sample Substance multi-select window

Use this search window as follows:

- a. Select one or more substances in the **Substance** list box.
 - b. Click the right-point arrow to add them to the **Selected Item Substance** list box.
 - c. Likewise, select a substance in the **Selected Item Substance** list box and click the left-point arrow to remove the substance.
 - d. When the **Selected Item Substance** list box is complete, click **OK** and the substances populate the **Overdose** group box. (Otherwise, click **Close**.)
3. If you select a substance with **Other** in the title on the **Substance** multiple select window, the application displays the **Other** dialog box.



Figure 11-29: Other dialog box

- a. Type the substance used in the overdose (limited to 80 characters). This is a Free Text field.
- b. Click **OK** to have the “substance used” populated the “Substance if Other” column on the grid.

11.3.3 Substance Use Tab

Use the **Substance Use** tab to indicate the substances involved in the suicide incident as well as the categories of the substances involved.

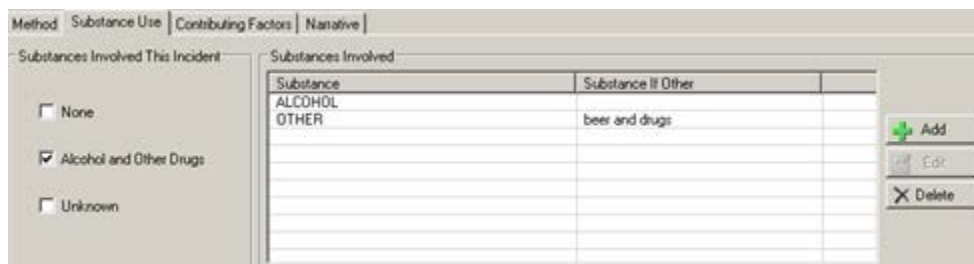


Figure 11-30: Sample Substance Use tab

Substances Involved This Incident Group Box

1. Select one of the checkboxes in this group box that describes the substance used in the suicide act. At least one is required.

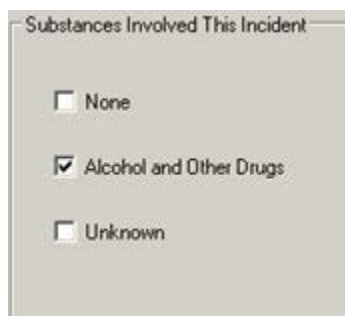


Figure 11-31: Substances Involved This Incident group box

2. If you select the **Alcohol and Other Drugs** checkbox, the application displays the **Substance** multiple select window where you can add one or more substances.

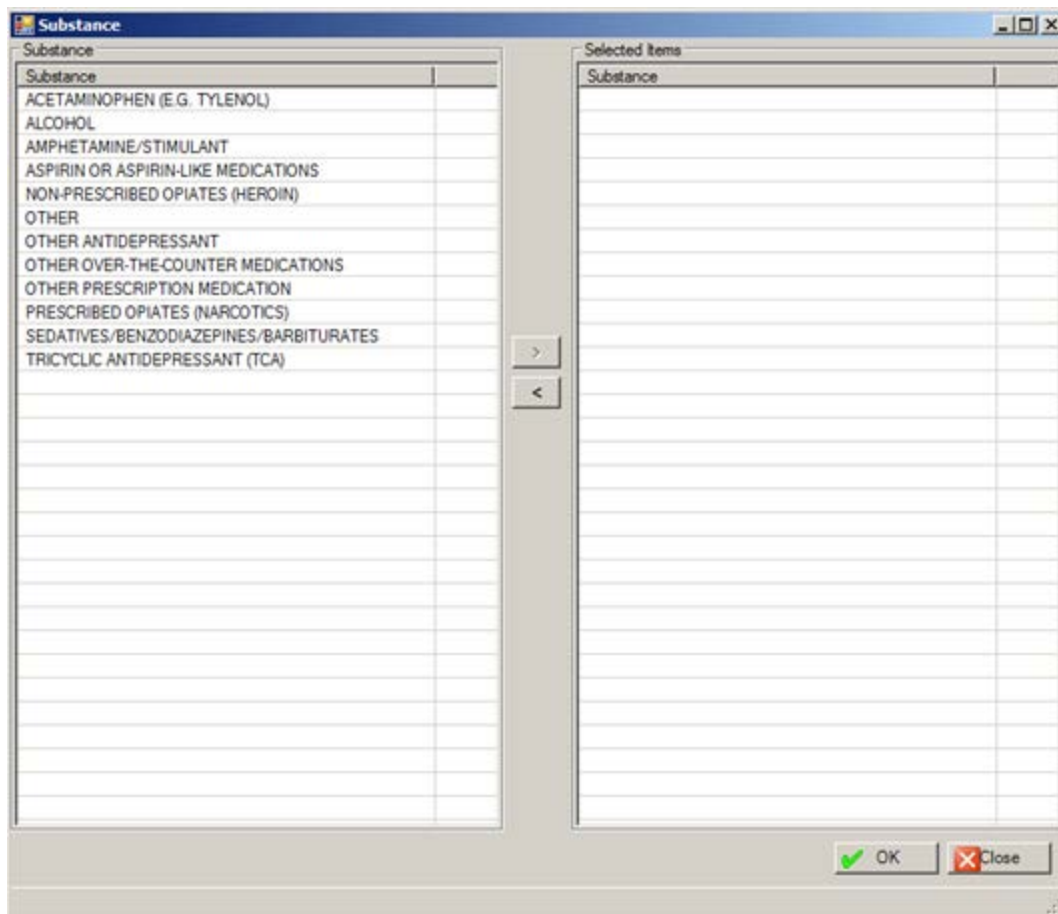


Figure 11-32: Sample Substance multi-select window

Use this search window as follows:

- a. Select one or more substances in the **Substance** list box.
 - b. Click the right-point arrow to add them to the **Selected Item Substance** list box.
 - c. Likewise, select a substance in the **Selected Item Substance** list box and click the left-point arrow to remove the substance.
 - d. When the **Selected Item Substance** list box is complete, click **OK** and the substances populate the **Overdose** group box. (Otherwise, click **Close**.)
3. If you select the **Other** option (on the **Substance** multiple select window), the application displays the **Other** dialog box.



Figure 11-33: Other dialog box

- a. Type the name of the “other substance” in the field (limited to 80 characters).
- b. When this dialog box is complete, click **OK** to have the substance populate the Substances Involved list box. What appears in the **Other** field will populate **Substance If Other** column.

If you uncheck the **Alcohol and Other Drugs** checkbox, this action clears any data in the **Substances Involved** list box.

11.3.3.1 Substances Involved Group Box

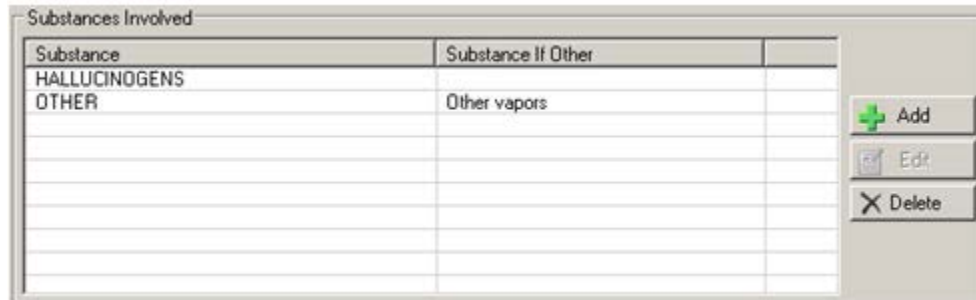


Figure 11-34: Sample Substances Involved group box

This group box contains the substances used immediately before or during the suicidal act. Once the **Alcohol and Other Drugs** checkbox is selected, the Add, Edit, and Delete buttons become active.

Add Button

Use the Add button to add one or more new records.

1. Click **Add**.
2. The **Substance** multiple select window where you can add one or more substances.



Figure 11-36: Other dialog box

- a. Type the name of the “other substance” in the field (limited to 80 characters).
- b. When this dialog box is complete, click **OK** to have the substance populate the **Substances Involved** list box. What appears in the **Other** field will populate **Substance If Other** column.

Edit Button

Use the **Edit** button with **OTHER** records (Substance If **Other** column is populated).

1. Highlight the record to edit.
2. Click **Edit**.
3. The **Other** dialog box displays. Change the **Other** field and then click **OK** (otherwise, click **Close**). The **OK** function changes the data in the **Substance If Other** column.

Delete Button

Use the Delete button to remove a highlighted substance record.

1. Highlight the record to delete.
2. Click **Delete**.
3. On the “Are You Sure” confirmation, click **Yes** to delete the highlighted substance record. (Otherwise, click **No**.)

11.3.4 Contributing Factors Tab

Use the **Contributing Factors** tab to indicate one or more contributing factors associated with the suicide act.

Figure 11-37: Sample Contributing Factors tab

1. Select one or more check boxes that define the contributing factors to the suicide act. At least one is required.
2. If you select the **Other** checkbox, the field below the checkbox becomes active. Use this Free Text field to describe the “other” contributing factor (limited to 80 characters).

11.3.5 Narrative Tab

Use the **Narrative** tab to populate the **Other Relevant Information** Free Text field. (This is not a required field.)

The image shows a rectangular text input field with a thin border. The title 'Other Relevant Information' is located in the top-left corner of the field's header area. The rest of the field is empty, indicating it is a free text input.

Figure 11-38: Sample Other Relevant Information field

Populate this field with data that is not included elsewhere. This is **not** where you put the SOAP or progress note.

12.0 Intake

This section addresses how to manage intake/update documents in roll and scroll and the GUI.

12.1 Intake Documents (Roll and Scroll)

One place you can add/change/remove an intake document is to use the Intake Document (ID) option on the Patient Data Entry window.

```

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

Last Visit (excl no shows): May 29, 2008  BETAAAA,BJ  REGULAR VISIT
        F42.          HOARDING DISORDER

Pending Appointments:
        Select the appropriate action  Q for QUIT
AV Add Visit                    LD List Visit Dates          GS GAF Scores
EV Edit Visit                   TP Treatment Plan Update    OI Desg Prov/Flag/Pers Hx
DR Display Record              CD Update Case Data         EH Edit EHR Visit
ES Edit SOAP                   ID Intake Document          PPL Problem List Update
DE Delete Visit                AP Appointments             SN Sign Note
PF Print Encounter Form        HS Health Summary           TN TIU Note Display
LV Last BH Visit               DM Display Meds             MM Send Mail Message
BV Browse Visits               LA Interim Lab Reports      FS Face Sheet
Select Action: Q//  Q
  
```

Figure 12-1: Sample Patient Data Entry window

At the “Select Action” prompt, type **ID**. The application as which Program you are associated. Then the Updated BH Intake Document window displays.

The other place you can add/change/remove an intake document is when you exit the visit encounter (display or add/edit) window. After you exit the last screen, the application displays the OTHER INFORMATION window.

```

*****  OTHER INFORMATION  *****

Update, add or append any of the following data

1). Update any of the following information:
    Designated Providers, Patient Flag
2). Patient Case Open/Admit/Closed Data
3). Personal History Information
4). Appointments (Scheduling System)
5). Treatment Plan Update
  
```

```

6). Print an Encounter Form
7). Add/Update/Print Intake Document
8). Add/Update Suicide Forms
9). Problem List Update
10) None of the Above (Quit)
Choose one of the above: (1-10): 7//

```

Figure 12-2: Options on the Other Information menu

Use option 7 (Add/Update/Print Intake Document) to access the Update BH Intake Document for the selected visit. You will be prompted for a Program. After specifying the program, the Update BH Intake Document for the current patient displays.

```

Update BH Intake Document      Jan 26, 2010 13:27:36      Page: 1 of 1
MENTAL HEALTH INTAKE DOCUMENTS      *unsigned document
Patient Name: DUCK,EDWIN RAY      DOB: JUN 07, 1978      Sex: M      HRN: 105321
          INITIAL                      UPDATE
#  INITIATED  PROGRAM  PROVIDER                      UPDATED  PROVIDER

*1  01/26/10  MENTAL H THETA, SHIRLEY
                                *01/26/10 THETA, SHIRLEY
*2  12/29/09  MENTAL H GAMMAA, RYAN
*3  12/29/09  MENTAL H GAMMAA, RYAN
4   12/29/09  MENTAL H THETA, SHIRLEY
                                12/29/09 THETA, SHIRLEY
                                *12/29/09 THETA, SHIRLEY
*5  12/29/09  MENTAL H THETA, SHIRLEY
*6  12/14/09  MENTAL H GAMMAA, RYAN
*7  10/07/09                      GAMMAA, RYAN
                                *10/07/09 GAMMAA, RYAN
*8  04/21/09                      GAMMAA, RYAN
    Enter ?? for more actions
I   Add Initial Intake              D   Delete Intake/Update
E   Edit Initial Intake              P   Display/Print Intake/Update
U   Add/Edit Update                  Q   Quit
Select Action: Q//

```

Figure 12-3: Sample Update BH Intake Document window

Use the Q (quit) option to exit the Update BH Intake Document window.

The asterisk (*) in the first column indicates that the particular record contains an unsigned intake/update document.

Please note the following information about intake and update documents on the Update BH Intake Document window:

- The intake documents are listed on the left side (under the Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side (under the Date Updated and Update Provider columns).

12.1.1 Add Initial Intake (I)

Use option I to create an initial intake document for the visit.

1. At the “Select Action” prompt, type **I**.

The application displays a message that it is adding the Intake document for the patient.

2. At the “Do you wish to continue and add the Initial Intake document?” prompt, type **Y** to add the Intake document (otherwise, type **N**)

If Y was used, the prompts continue.

3. At the “DATE” prompt, press Enter to use the default date which is the current date (you can change). This cannot be a future date.
4. At the “PROGRAM” prompt, press Enter to accept the default (Mental Health). Otherwise, type the program to use.
5. At the “PROVIDER” prompt, press Enter to accept the default provider (you can change).
6. At the “DATE LAST UPDATED” prompt, press Enter to use the default which is the current date (you can change). This cannot be future date.
7. At the “NARRATIVE - No Existing Text - Edit?” prompt, type **Y** to edit the narrative or **N** to not edit the narrative.

If N was used, the application creates the Intake document. You must enter the Intake narrative before you can electronically sign the intake document. The application then prompts if you want to enter an Intake Narrative (Y or N). If N was used, the focus returns to the Update BH Intake Document window.

If Y was used, the focus moves to another window to enter the text of the narrative.

```
==[ WRAP ]==[ INSERT ]===== < SUBJECTIVE/OBJECTIVE >===== [ <PF1>H=Help ]=====
```

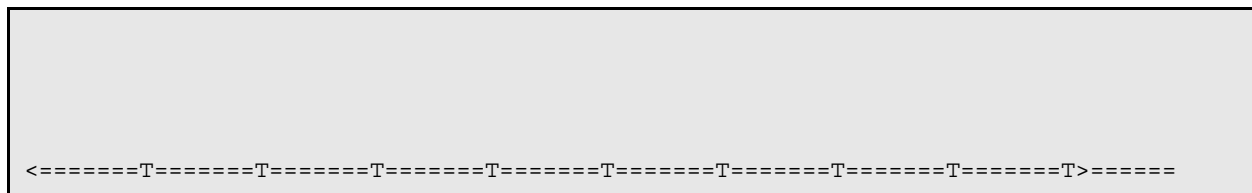


Figure 12-4: screen to enter text

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you save and exit, the prompts continue.

8. At the “Enter your Current Signature Code” prompt, do one of the following:
 - Type your electronic signature to sign the document. This action marks the document as signed. You cannot edit it.
 - Press Enter to not sign the document. The document is marked as not signed. You can edit it.

12.1.2 Edit Initial Intake (E)

Use option E to change the selected initial intake document.

- Only the original intake provider or the person who entered the intake document can edit the document; other providers can only view or print the document.
 - Editing an initial intake that was created before the installation of BHS v4.0 will result in a prompt to enter the program associated with the intake.
1. At the “Select Action” prompt, type **E**.
 2. At the “CHOOSE” prompt, type **1** (Edit Initial Intake Document) or **2** (Quit). If 2 was used, the focus returns to the Update BH Intake Document. If 1 was used, the prompts continue.
 3. At the “Select Intake” prompt, type the number of the intake document to edit.
 - If the specified intake document has been signed, you cannot edit it.

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you save and exit this window, the prompts continue:

9. At the “Enter your Current Signature Code” prompt, do one of the following:
 - Type your electronic signature to sign the document. This action marks the document as signed. You cannot edit it.
 - Press Enter to not sign the document. The document is marked as not signed. You can edit it.

12.1.3 Add/Edit Update (U)

Use option U to create a new update to a particular intake document or edit an existing, unsigned one where you are the provider.

- Only the person who originally entered the Intake document or the Intake document Provider can edit the document
 - Other providers can only view or print the document.
1. At the “Select Action” prompt, type **U**.
 2. At the “Select Intake” prompt, type the number of intake document to use.

The following message displays:

```

You can either add a new Update to this Intake document or edit an
existing, unsigned one on which you are the provider. Please select an Update
to edit or choose 1 to add a new one or 0 to quit.

    0   Quit/Exit Update
    1   Add new Update document
Select Action:  (0-1): 0//
```

Figure 12-6: Message from the application

3. At the “Select Action” prompt, you can either add a new update to this intake document, quit/exit the update process, or use the option to edit the Update.
 - If the Quit option was used, you leave the add/edit process.

- If the Add new Update document option was used, the prompts continue: The application displays a message that it is adding the Intake Update document for the patient.
4. At the “Do you wish to continue on to add the Intake Update? Prompt, type **Y** (yes) or **N** (no). If **Y** was used, the prompts continue.
 5. At the “DATE” prompt, press Enter to use the default (current date). Otherwise, type a new date (cannot be a future date).
 6. At the “PROVIDER” prompt, Press Enter to use the default provider. Otherwise, type the name of the provider for the update document.
 7. At the “DATE LAST UPDATED” prompt, press Enter to use the default (current date). Otherwise, type a new date (cannot be a future date).
 8. At the “NARRATIVE” prompt, the application displays the text of the narrative or displays “no existing text” if there is none.
 9. At the “Edit?” prompt, type **Y** (yes) to edit the text of the narrative or **N** (no) to not edit the narrative.
 - a. If **N** was used, the application creates the Intake Update document and displays the message that the narrative must be entered before an E Sig must be applied. At the “Do you wish to enter an Intake Narrative?” prompt, type **Y** (yes) or **N** (no).
 - b. If **Y** was used, the focus moves to another window where you enter the text of the narrative.

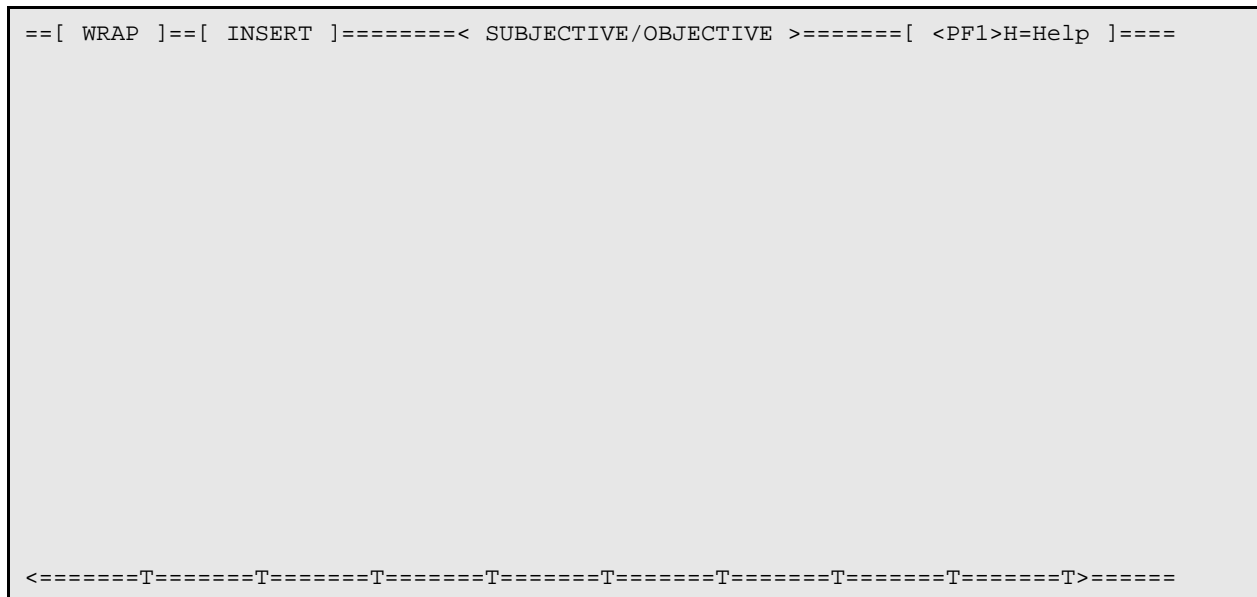


Figure 12-7: screen to enter text

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you save and leave this window, the application displays the next prompt.

10. At the “Enter your Current Signature Code” prompt, do one of the following:

- Type your electronic signature to sign the document.
- Press Enter to not sign the document

If you press Enter, you can either add a new update to this intake document or edit an existing, unsigned one on which you are the Provider or the person who entered the Intake Document. The application displays the next prompt:

11. At the “Select Action” prompt, do one of the following:

```
0 Quit/Exit Update
1 Date Updated: MM/DD/YY   Provider: <provider name>
2 Add new Update document
```

Figure 12-8: Prompts for the actions you can take

If 0 was used, the focus returns to the Update BH Intake Document window.

If 2 was used, this action has the same prompts as Add/Edit Update (Section 12.1.3 provides more information).

If 1 was used, the following prompts displays:

- a. At the “Date Updated” prompt, type the date the document was updated.
- b. At the “Provider” prompt, type the name of the provider who updated the document.

12.1.4 Delete Intake/Update (D)

Use option D to do one of the following:

- Delete Intake/Update
- Display/Print Intake/Update

Delete Intake/Update

You can delete only unsigned Intake documents you entered or on which you are the provider, unless you possess a special key or are listed on the Delete Override list.

1. At the “Select Intake” prompt, type the number of the Initial Intake to delete, or the Initial Intake with the Update to delete.

The application gives you the following choices:

```
0 Quit/Exit
1 Date MM/DD/YY   Provider: <provider name>
```

Figure 12-9: Actions to take

If 0 was used, the focus returns to the Update BH Intake Document window.

If 1 was used, the application displays information about the intake document, including its narrative. Then the next prompt displays:

2. At the “Are you sure you want to delete this Initial Intake document?” prompt, type **Y** (yes) or **N** (no).

If there are multiple documents you want to delete, the application repeats the process.

Display/Print Intake/Update

This action is the same as using option **P** on the Update BH Intake Document window. Section 12.1.5 provides more information about the print process.

12.1.5 Print Intake Document

Use option **P** to print/browse a particular intake document.

1. At the “Select Action” prompt, type **P**.
2. At the “Select Intake” prompt, type the number of the document to display/print.
3. At the “What would you like to print” prompt, type **I** (Intake document only), **U** (Update document only), **B** (both the Intake and Update documents), **Q** (quit/exit).
 - a. If **Q** was used, the focus returns to the previous window.
 - b. If **U** was used, another menu is displayed listing each of the updates and an option to print all updates or quit.

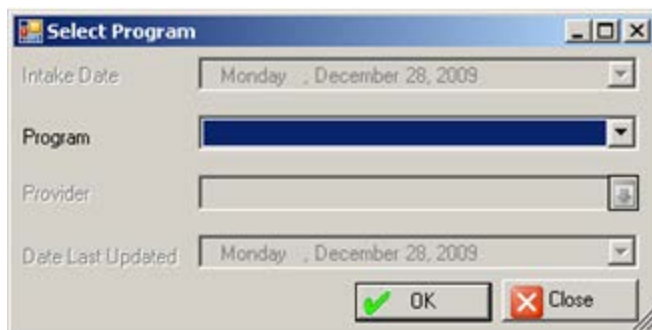


Figure 12-11: Select Program dialog box

1. At the **Program** field, click the drop-down list for the **Program** field and select an option.
2. Click **OK** (otherwise click **Close**).

The **OK** process displays the Intake window listing the intake documents for the particular program for the current patient. The current patient's name appears in the lower, left corner of the window.

Note: The following window is the window that displays when you click the Intake tab on the **Add/Edit Visit Data Entry** window.

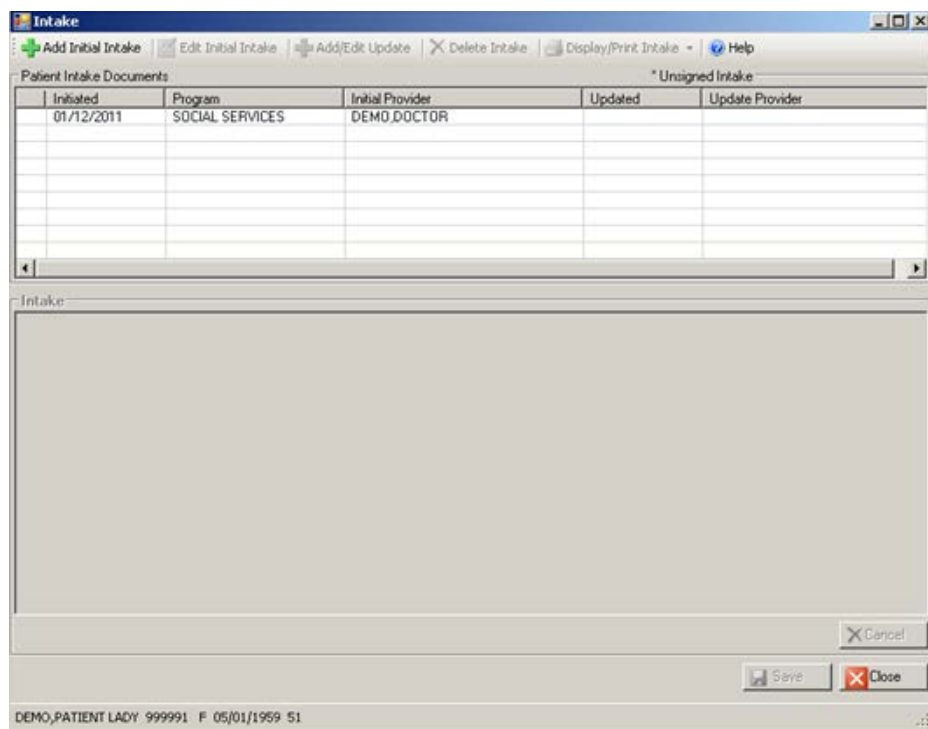


Figure 12-12: Sample Intake window

The asterisk (*) in the first column indicates that the particular record contains an unsigned intake/update document.

Use the **Help** button to access the online help for this window.

12.2.1 Patient Intake Documents List Box

Initiated	Program	Initial Provider	Updated	Update Provider
* 01/14/2010	MENTAL HEALTH	DEMO_DOCTOR		
* 07/09/2009		DEMO_DOCTOR	01/14/2010	DEMO_DOCTOR
			01/28/2010	DEMO_DOCTOR

Figure 12-13: Sample Patient Intake Documents list box

The Patient Intake Documents list box displays the names of the current patient's intake documents and update documents (view only). You can distinguish the documents in the following manner:

- The intake documents are listed on the left side of the grid (under the Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side of the grid (under the Date Updated and Update Provider columns).

As you highlight a record in the **Patient Intake Documents** list box, the text of the document displays in the Intake group box.

All initial documents and updates created before the BHS v4.0 installation will remain unsigned and editable. The initial provider associated with the intake will be the provider for the intake document. Any edits or updates completed after the installation date will be subject to all business rules added in BHS v4.0.

12.2.2 Add Initial Intake

Use the Add Initial Intake button to add a new initial intake document.

1. Click **Add Initial Intake** to access the **Select Intake Parameters** dialog box.

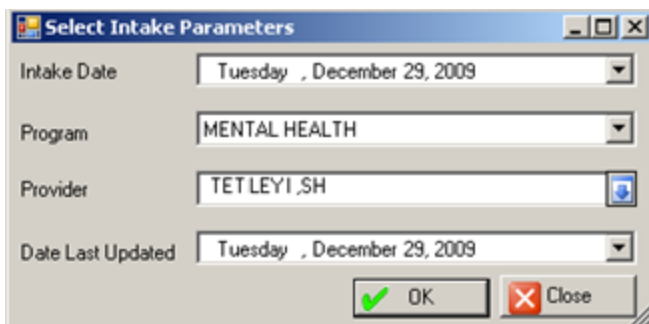


Figure 12-14: Sample Select Intake Parameters dialog box

2. At the **Intake Date** field, the current date displays. Change this by clicking the drop-down list and selecting another date from the calendar (cannot be a future date).
3. At the **Program** field, the default program displays (the one selected when you first accessed the Intake menu). You can change this by clicking the drop-down list and selecting another option.

Note: If you change the Program, it will not be visible when you return to the list view. You have to back out of the Program selection screen again and select the Program associated with the document you just entered. We encourage you to NOT change the program. It is actually more efficient to back out and enter the correct program initially.

4. At the **Provider** field, the current login provider name displays. You can change this by clicking the drop-down list to access the **Primary Provider** search/select window.

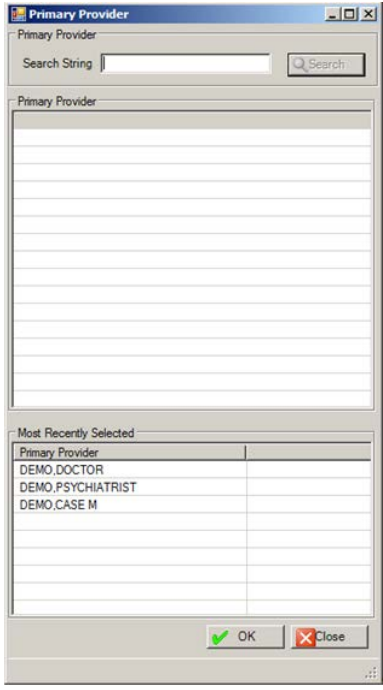
Screen Capture	What to do
	<p>Use this search window in one of two ways:</p> <p>(1) Use the Search String field by typing the provider's last name and then clicking Search. The retrieved names will populate the Primary Provider list box. Select a name and click OK to populate the Provider field. (Otherwise, click Close.)</p> <p>(2) Select a name in the Most Recently Selected list box and click OK to populate the Primary Provider field. (Otherwise, click Close.)</p>

Figure 12-15: Sample Primary Provider search/select window

- At the **Date Last Updated** field, the current date displays. Change this by clicking the drop-down list and selecting another date from the calendar (cannot be a future date).

After completing the **Select Intake Parameters** dialog box, click **OK** (otherwise, click **Close**). The **OK** function activates the Intake group box. Section 12.2.3 provides more information about this group box.

12.2.3 Intake Group Box



Figure 12-16: Sample of active Intake group box

When the **Intake** group box is active, use it to type the text of the document (intake or update). This text is the narrative for the document.

To exit the **Intake** group box, click **Cancel** to cause the Intake group box to become inactive.

After you have completed the **Intake** group box, click **Save** (otherwise click **Close**).

- If Close was used, the **Continue?** message displays: Unsaved Data Will Be Lost, Continue? Click **Yes** to lose any data and the focus returns to the GUI tree structure. Click **No** and the focus returns to the Intake group box.
- If Save was used, the **Intake Electronic Signature** dialog box displays. The Save process requires that there is intake narrative.



Figure 12-17: Intake Electronic Signature dialog box

To sign the particular document, do the following:

- a. At the **Electronic Signature** field, type your electronic signature.
- b. Click **OK**. This saves the document and marks it as signed. Signing a document locks the document from any future edits.

To **not** sign the particular document, do the following:

- a. At the **Electronic Signature** field, do not type your electronic signature.
- b. Click **Close**.
- c. At the **Are You Sure?** dialog box displays that states: Are you sure you want to Close without Electronically Signing the Intake?" prompt, click **Yes** or **No**.
 - Click **Yes** to not sign it and to save the document marked as not signed. The application displays the Message: You did not Electronically Sign the Intake. Click **OK** to dismiss the Message. This type of document can be edited.
 - Click **No** and the focus returns to the **Intake Electronic Signature** dialog box.

12.2.4 Edit Initial Intake

Select an existing initial intake document and click the Edit Initial Intake button to edit the initial intake document.

- If the selected document has been signed, the application displays the Message: This Initial Intake document has been signed. You cannot edit it. Click **OK** to dismiss the message and you exit the edit process.
- Only the provider or the person who entered the intake can edit it; otherwise, the application displays the Message: You are not the provider or the person who entered the Intake, you cannot edit it. Click **OK** to dismiss the message and you exit the edit process.

If you are the provider or the person who entered the intake, the application displays the **Select Intake Parameters** dialog box. Section 12.2.2 provides more information the add initial intake process. After completing this dialog box, the text of the initial intake document will display in the Intake area of the Intake window. Section 12.2.3 provides more information about the intake group box.

12.2.5 Add/Edit Update

This button has two different labels, depending on the action you take.

Note: If you select a signed Update document, the button reads Edit Update. After you click the Edit Update button, the application displays the Message: This Intake Update document has been signed. You cannot edit it. Click **OK** to dismiss the message and you exit the edit process.

After the Provider locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the Delete Override Site Parameter.

If you select an **Intake document** (signed or unsigned), the button reads: **Add Update**.

If you select an unsigned **Update document**, the button reads: **Edit Update**.

In either case, the application displays the **Select Intake Parameters** dialog box. Section 12.2.2 provides more information about Add Initial Intake.

After completing this dialog box, the **Intake** group box will become active. Section 12.2.3 provides more information about the **Intake Group Box**.

12.2.6 Delete Intake

Use the Delete Intake button to delete a selected unsigned Intake document (in the Patient Intake Documents group box).

1. Select an unsigned Intake document to delete.

2. Click **Delete Intake**.
3. On the “Are You Sure” confirmation message, click **Yes** to delete (otherwise, use **No**).
 - Only the intake Provider or the person who entered the selected intake can use the Delete function. However, when a person is listed in the Delete Override section on the Site Parameters menu (in RPMS), that person can delete the document.
 - If the selected Intake document has an attached update document, the application displays the message: This intake document has updates associated with it. It cannot be deleted at this time. Click **OK** and you exit the Delete process.

12.2.7 Display/Print Intake

Use the **Display/ Print Intake** button to access the options for the display/print process.

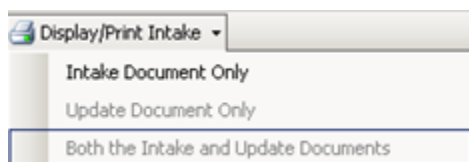


Figure 12-18: Options on the Display/Print Intake button

1. Highlight an Intake record and select one of options (only the valid options will be highlighted).

If you selected **Update Document Only** or Both the **Intake and Update Documents**, the application displays the **Intake Updates** dialog box.

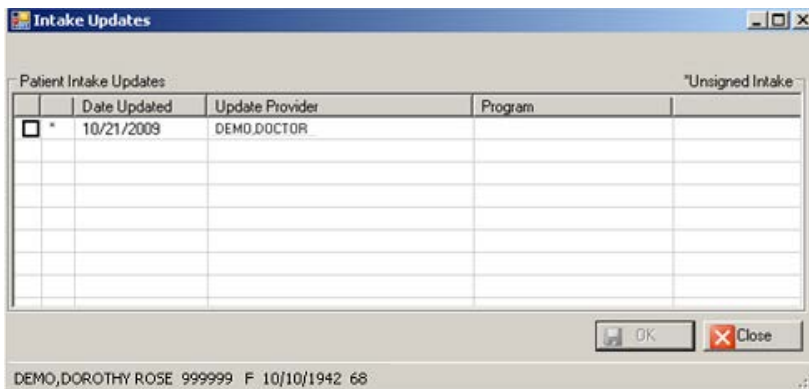


Figure 12-19: Sample Intake Updates dialog box

Check the records you want to include in the output and click **OK** (otherwise, click **Close**).

The first page of the Intake (for the current patient) pop-up displays.

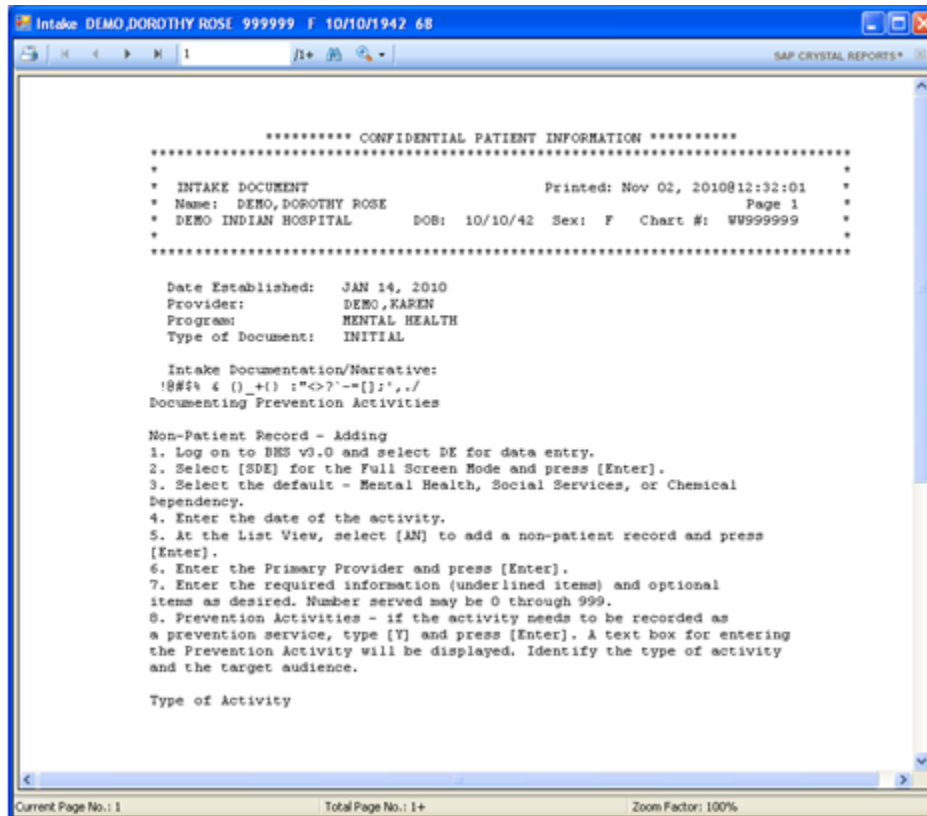


Figure 12-20: Sample Intake pop-up for current patient

Section 2.6 provides more information about using the controls on this type of window.

13.0 Reports (Roll and Scroll Only)

The Reports menu of the Behavioral Health system provides numerous options for retrieving data from the patient file. You can obtain specific patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

The Reports menu (Figure 13-1) contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to the Behavioral Health system. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options are detailed in the following sections.

```

*****
**      IHS Behavioral Health System      **
**              Reports                   **
*****
                Version 4.0 (Patch 7)

                DEMO INDIAN HOSPITAL

PAT   Patient Listings ...
REC   Behavioral Health Record/Encounter Reports ...
WL    Workload/Activity Reports ...
PROB  Problem Specific Reports ...
TABL  Print Standard Behavioral Health Tables ...

Select Reports Menu Option:

```

Figure 13-1: Options on Report menu

Use this menu for tracking and managing patient, provider, and program statistics.

Reminder: The location screen (UU) and the list of Those Allowed to See All Visits found on the site parameters menu will impact the information displayed in the reports. For example, if your name has not been added to the list of those allowed to see all visits, the report will contain only those visits where you were a provider or completed the data entry.

13.1 Patient Listings (PAT)

The Patient Listings submenu (Figure 13-2) contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, that is a custom report that allows you to select which patients to include in the report as well as the items to print and the sort criteria.

ACL	Active Client List
PGEN	Patient General Retrieval
DP	Designated Provider List
GRT	Patients with AT LEAST N Visits
AGE	Patients Seen by Age and Sex (132 column print)
CASE	Case Status Reports ...
GAFS	GAF Scores for Multiple Patients
NSDR	Listing of No-Show Visits in a Date Range
PERS	Patient List for Personal Hx Items
PPL	Placements by Site/Patient
PPR	Listing of Patients with Selected Problems
SCRN	Screening Reports ...
TPR	Treatment Plans ...
TSG	Patients seen in groups w/Time in Group

Select Patient Listings Option:

Figure 13-2: Options on the Patient Listings reports

13.1.1 Active Client List (ACL)

Use the ACL option to review a list of patients who have been seen in a specified date range. You can further filter the report by a particular provider, if needed.

Below are the prompts.

Enter beginning Date

Specify the beginning date of the date range.

Enter ending Date

Specify the ending date of the date range.

Note: The date range considered should be one in which the patient should be seen in order to be considered active.

Limit the list to those patients who have seen a particular provider?

Use Y or N. If you use Y, other prompts display.

Demo Patient Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

You browse the output on the Output Browser window (Figure 13-3).

ACTIVE CLIENT LIST							
PROVIDER: PROVIDER R							
ENCOUNTER DATES: OCT 1, 2015 TO NOV 24, 2015							
PATIENT NAME	CHART NUMBER	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS
CLIENT A	106529	F	03/05/30	CHENEGA	PROVIDER R	F32.3	4
				DEMO HOSPI	STUDENT,EI	F10.24	
CLIENT B	901234	F	04/04/76	DEMO HOSPI	PROVIDER R	F42.	
CLIENT C	200042	M	03/23/83	CHENEGA	PROVIDER R	F32.1	3
				DEMO HOSPI	STUDENT,FO	F32.3	
					STUDENT,TW	F32.3	
CLIENT D	107468	M	05/20/69	DEMO HOSPI	PROVIDER R	F84.0	2
						F32.2	
CLIENT E	432098	M	04/04/75	DEMO HOSPI	PROVIDER R	F42.	1
CLIENT F	200614	F	05/17/90	CHENEGA	PROVIDER R	1.1	3
					STUDENT,TW	F10.24	
Total Number of Patients: 6							

Figure 13-3: Sample Output Browser data

Near the end of the report, the application displays the total number of patient.

13.1.2 Patient General Retrieval (PGEN)

Use the PGEN option to produce a report that shows a listing of patients based on selected criteria. The patients used on the report can be selected based on any selected print and sort criteria.

Below are the prompts.

Select and Print Patient List from

Use S (search template) or P (patient file). If you use S, other prompts will display.

Do you want to use a PREVIOUSLY DEFINED REPORT?

Use Y or N. If you use Y, other prompts will display.

The application displays the Patient Selection Menu (Figure 13-4).

BH GENERAL RETRIEVAL		Dec 26, 2015 09:10:31		Page: 1 of 1	
Patient Selection Menu					
Patients can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Patients type Q.					
1) Sex	14) Medicaid Eligibility	27) Pts seen at a Locati			
2) Race	15) Priv Ins Eligibility	28) Pts Seen in a Commun			
3) Patient Age	16) Patient Flag Field	29) Pts w/Problem (DX)			
4) Patient DOB	17) Case Open Date	30) Pts w/Problem (MHSS)			
5) Patient DOD	18) Case Admit Date	31) Pts seen by a Provid			
6) Living Patients	19) Case Closed Date	32) Pts w/Education Done			
7) Chart Facility	20) Case Disposition	33) Pts seen for an Acti			

```

8) Community of Residen  21) Next Case Review Dat  34) Pts seen w/Type of C
9) County of Residence  22) Designated MH Prov   35) Pts seen w/Axis IV L
10) Tribe of Membership 23) Designated SS Provid  36) Pts w/Inpatient Disp
11) Eligibility Status  24) Designated A/SA Prov  37) Pts Last Health Fact
12) Class/Beneficiary   25) Designated Other Pro
13) Medicare Eligibility 26) Personal History Ite

      Enter ?? for more actions
S   Select Item(s)      +   Next Screen           Q   Quit Item Selection
R   Remove Item(s)     -   Previous Screen      E   Exit Report
Select Action: S//

```

Figure 13-4: Sample Patient Selection Menu options

Use this menu to select the patients based on various criteria. If you do not specify any criteria (immediately use the Quit Item Selection option), the application selects all patients.

Choose Type of Report

Use one of the following: T (total count only), S (sub-counts and total count), or D (detailed listing). If you select D (the detailed listing), the application displays the Print Item Selection Menu (Figure 13-5).

```

BH GENERAL RETRIEVAL          Apr 16, 2015 14:46:31          Page: 1 of 1
                        PRINT ITEM SELECTION MENU
The following data items can be printed. Choose the items in the order you
want them to appear on the printout. Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1) Patient Name              13) Class/Beneficiary    25) Case Disposition
2) Sex                       14) Medicare Eligibility 26) Next Case Review Dat
3) Race                      15) Medicaid Eligibility 27) Designated MH Prov
4) Patient Age               16) Priv Ins Eligibility 28) Designated SS Provid
5) Patient DOB               17) Mailing Address-City 29) Designated A/SA Prov
6) Patient SSN               18) Home Phone           30) Designated Other Pro
7) Patient DOD               19) Mother's Name        31) Designated Other (2)
8) Patient Chart #           20) Patient Flag Field   32) Personal History Ite
9) Community of Residen     21) Patient Flag Narrati 33) Pts Last Health Fact
10) County of Residence     22) Case Open Date
11) Tribe of Membership     23) Case Admit Date
12) Eligibility Status      24) Case Closed Date

      Enter ?? for more actions
S   Select Item(s)      +   Next Screen           Q   Quit Item Selection
R   Remove Item(s)     -   Previous Screen      E   Exit Report
Select Action: S//

```

Figure 13-5: Sample Print Item Selection Menu options

Use this menu to determine the data items on the report. Select the items in the order that you want them to appear on the output. When through selecting, use the Quit Item Selection action to dismiss the menu.

Next, the application displays the Sort Item Selection Menu (Figure 13-6).

```

BH GENERAL RETRIEVAL          Apr 16, 2009 14:49:47          Page:    1 of    1

                          SORT ITEM SELECTION MENU
The Patients displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by patient name.

1) Patient Name              7) Community of Residen  13) Designated MH Prov
2) Sex                      8) County of Residence  14) Designated SS Provid
3) Race                     9) Tribe of Membership  15) Designated A/SA Prov
4) Patient DOB             10) Eligibility Status  16) Designated Other Pro
5) Patient DOD            11) Class/Beneficiary  17) Designated Other (2)
6) Patient Chart #        12) Patient Flag Field

                          Enter ?? for more actions
S   Select Item(s)         +   Next Screen           Q   Quit Item Selection
R   Remove Item(s)        -   Previous Screen       E   Exit Report
Select Action: S//

```

Figure 13-6: Sample Sort Item Selection Menu options

Use this menu to determine how the data will be sorted on the report. If you do not select any item (immediately use the Quit Item Selection option), the report will be sorted by patient name.

Do you want a separate page for each Patient Name?

Use Y or N.

Would you like a custom title for this report?

Use Y or N. If you use Y, other prompts will display.

Do you wish to save this search/print/sort logic for future use?

Use Y or N. If you use Y, other prompts will display.

Demo Patient Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

The application provides a Report Summary that shows the criteria you selected.

Do you wish to

Use P (print output) or B (browse output on screen).

The application first displays the Patient Selection Criteria for the report.

After you move onto the next screen press Enter (to continue), the application displays the patient listing report (Figure 13-6).


```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                BH Patient Listing
                                Page 1
PATIENT NAME                    SSN                    COMM RESIDENCE
-----
A'PAT1,ALAYNA BROOKL  XXX-XX-2160  HOWE
A'PAT1,WEBB AARON    XXX-XX-4769  PORUM
ALPHA,ALICE ROCHELLE XXX-XX-6378  COLCORD
ALPHA,GERALDINE      XXX-XX-7097  MUSKOGEE
Enter ?? for more actions
+   NEXT SCREEN        -   PREVIOUS SCREEN      Q   QUIT
Select Action: +//

```

Figure 13-7: Sample Patient Listing report

13.1.3 Designated Provider List (DP)

Use the DP option to produce the designated mental health provider list report.

Below are the prompts.

Which Designated Provider?

Use one of the following: M (mental health), S (social services), C (chemical, dependency or alcohol/substance abuse), O (other), T (other non-RPMS).

Run Report for

Use one of the following: 1 (one provider) or 2 (all providers). If you use 1, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Designated Mental Health Provider List report (Figure 13-8).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX
                                DEMO INDIAN HOSPITAL
                                DESIGNATED MENTAL HEALTH PROVIDER LIST
                                PROVIDER: ALL
                                Page 1
PATIENT NAME                    CHART #        SEX   DOB        COMMUNITY    LAST VISIT
-----
PROVIDER:  GPROVIDER,D
ALPHA,ALICE ROCHELLE          183497        F    06/25/97  COLCORD      Jan 05, 2009

```

ALPHAA,GLEN DALE	108704	M	11/10/81	TAHLEQUAH	Apr 14, 2009
GPAT,JANE ELLEN		F	01/01/90	TUCSON	Apr 15, 2009
MPAT11,SHERRY KEARNEY	197407	F	10/01/00	PEGGS	Sep 28, 2007
+ Enter ?? for more actions					>>>
+ NEXT SCREEN	- PREVIOUS SCREEN	Q	QUIT		
Select Action: +//					

Figure 13-8: Sample Designated Mental Health Provider List report (for all providers)

The report subtotals by provider.

13.1.4 Patients with AT LEAST N Visits (GRT)

Use the GRT option to produce a report that shows a list of patients who have been seen at least N number of times in a specified date range.

Below are the prompts.

Enter beginning Date

Specify the beginning date of the date range.

Enter ending Date

Specify the ending date of the date range.

Enter the minimum number of time the patient should have been seen

Use any number between 2 and 100.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the patients seen at least N times report (Figure 13-9).

***** CONFIDENTIAL PATIENT INFORMATION *****							
XX							Page 1
DEMO INDIAN HOSPITAL							
PATIENTS SEEN AT LEAST 3 TIMES							
RECORD DATES: JAN 16, 2009 TO APR 16, 2015							
PATIENT NAME	CHART #	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS
ALPHAA,CHELSEA	116431	F	02/07/75	CEDAR CITY	BDOC111,BJ	1.1	67
				CHEVAK	BDOC222,LO	12	
				CHINLE CHA	CDOC1,JESS	14	

	CHINLE HOS	DEMO,DOCTO	15	
	DEMO INDIA	GDOC12,RYA	22	
+	Enter ?? for more actions			>>>
+	NEXT SCREEN	-	PREVIOUS SCREEN	Q QUIT
Select Action: +//				

Figure 13-9: Sample Patients Seen at least 3 Times report

13.1.5 Patients Seen by Age and Sex (AGE)

Use the AGE option to produce a report that tallies the number of patients, who have had an encounter, by age and sex. You will choose the item you want to tally. For example, you can tally problems treated, or activities by age and sex. Any tally by PROBLEM only includes the PRIMARY PROBLEM. You will be able to define the age groups to be used.

Below are the prompts.

Choose an item to tally by age and sex

Use one of the following:

- 1). Program Type
- 2). POV/Problem (Problem Code)
- 3). Problem/POV (Problem Category)
- 4). Problem/POV
- 5). Location of Service
- 6). Type of Contact of Visit
- 7). Activity Code
- 8). Activity Category
- 9). Community of Service

The item you select will display down the left column of the report. Age groups will be across the top.

Enter beginning Visit Date for Search

Specify the beginning date of the date range.

Enter ending Visit Date for Search

Specify the ending date of the date range.

The application displays the Visit Selection Menu (Figure 13-10).

BH GENERAL RETRIEVAL	Dec 26, 2015 09:20:24	Page:	1 of	2
Visit Selection Menu				
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.				

1)	Patient Name	23)	Next Case Review Dat	45)	Axis V
2)	Patient Sex	24)	Appointment/Walk-In	46)	Flag (Visit Flag)
3)	Patient Race	25)	Interpreter Utilized	47)	Primary Provider
4)	Patient Age	26)	Program	48)	Primary Prov Discipl
5)	Patient DOB	27)	Visit Type	49)	Primary Prov Affilia
6)	Patient DOD	28)	Location of Encounte	50)	Prim/Sec Providers
7)	Living Patients	29)	Clinic	51)	Prim/Sec Prov Discip
8)	Chart Facility	30)	Outside Location	52)	POV (Prim or Sec)
9)	Patient Community	31)	SU of Encounter	53)	POV (Prob Code Grps)
10)	Patient County Resid	32)	County of Service	54)	Primary POV
11)	Patient Tribe	33)	Community of Service	55)	POV (Problem Categor
12)	Eligibility Status	34)	Activity Type	56)	POV Diagnosis Catego
13)	Class/Beneficiary	35)	Days in Residential	57)	Procedures (CPT)
14)	Medicare Eligibility	36)	Days in Aftercare	58)	Education Topics Pro
15)	Medicaid Eligibility	37)	Activity Category	59)	Prevention Activity
16)	Priv Ins Eligibility	38)	Local Service Site	60)	Personal History Ite
17)	Patient Encounters O	39)	Number Served	61)	Designated MH Prov
18)	Patient Flag Field	40)	Type of Contact	62)	Designated SS Provid
19)	Case Open Date	41)	Activity Time	63)	Designated A/SA Prov
20)	Case Admit Date	42)	Inpatient Dispositio	64)	Designated Other Pro
21)	Case Closed Date	43)	PCC Visit Created		
22)	Case Disposition	44)	Axis IV		
+	Enter ?? for more actions				
S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report
Select Action: S//					

Figure 13-10: Sample Visit Selection Menu

Use this menu to select the visit selection criteria for the report. If you do not select any criteria (immediately use the Quit Item Selection), all visits will be selected.

Do you wish to modify these age groups?

The application displays the currently defined age groups. Answer Y or N to this prompt. If you use Y, other prompts will display. Use N to have the defined age groups listed across the top of the report.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the Behavioral Health Record Listing report (Figure 13-11).

OUTPUT BROWSER	Apr 16, 2015 15:20:53	Page:	1 of 23
----------------	-----------------------	-------	---------

```

                                BEHAVIORAL HEALTH RECORD LISTING

REPORT REQUESTED BY: THETA,SHIRLEY

The following visit listing contains BH visits selected based on the
following criteria:

                                RECORD SELECTION CRITERIA

Encounter Date range:  OCT 18, 2008 to APR 16, 2015

Report Type: RECORD COUNTS BY AGE/SEX
                ***** CONFIDENTIAL PATIENT INFORMATION *****
                                BEHAVIORAL HEALTH RECORD/ENCOUNTER COUNTS
                                PROBLEM DSM-5/CODE BY AGE AND
                                ENCOUNTER DATES:  OCT 18, 2008 TO A

                                SEX: BOTH
PROB DSM/CODE NARRATIVE                0-0        1-4        5-14        15-19        20-
-----
ACUTE STRESS REACTION                  .          .          .          .
ADMINISTRATION                          .          .          2          .
ADULT ABUSE (SUSPECTED),UNSPEC         .          .          .          .
ALCOHOL ABUSE                          .          .          1          .
ALCOHOL ABUSE, CONTINUOUS               .          .          .          .
ALCOHOL ABUSE, EPISODIC,                .          .          .          1
ALCOHOL ABUSE, IN REMISSION             .          .          .          .
ALCOHOL ABUSE, UNSPECIFIED              .          .          1          1
+      Enter ?? for more actions                                     >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +/-
    
```

Figure 13-11: Sample Behavioral Health Record Listing report

13.1.6 Case Status Reports (CASE)

Use the CASE option to access additional reports on the Case Status Reports menu (Figure 13-12).

```

ACO   Active Client List Using Case Open Date
ONS   Cases Opened But Patient Not Seen in N Days
TCD   Tally Cases Opened/Admitted/Closed
DOC   Duration of Care for Cases Opened and Closed
SENO  Patients Seen x number of times w/no Case Open

Select Case Status Reports Option:
    
```

Figure 13-12: Options on the Case Status Reports menu

13.1.6.1 Active Client List Using Case Open Date (ACO)

Use the ACO option to produce a report that shows a list of patients who have a case open date without a case closed date.

Below are the prompts:

Run the Report for which program

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

Include cases opened by

Use one of the following: A(all provides) or O (one provider). If you use O, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the active client list report (Figure 13-13).

ACTIVE CLIENT LIST							
PROVIDER: PROVIDER R							
ENCOUNTER DATES: OCT 1, 2015 TO NOV 24, 2015							
PATIENT NAME	CHART NUMBER	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS
CLIENT A	106529	F	03/05/30	CHENEGA	PROVIDER R	F32.3	4
				DEMO HOSPI	STUDENT,EI	F10.24	
CLIENT B	901234	F	04/04/76	DEMO HOSPI	PROVIDER R	F42.	
CLIENT C	200042	M	03/23/83	CHENEGA	PROVIDER R	F32.1	3
				DEMO HOSPI	STUDENT,FO	F32.3	
					STUDENT,TW	F32.3	
CLIENT D	107468	M	05/20/69	DEMO HOSPI	PROVIDER R	F84.0	2
						F32.2	
CLIENT E	432098	M	04/04/75	DEMO HOSPI	PROVIDER R	F42.	1
CLIENT F	200614	F	05/17/90	CHENEGA	PROVIDER R	1.1	3
					STUDENT,TW	F10.24	
Total Number of Patients: 6							

Figure 13-13: Sample view of active client list

13.1.6.2 Cases Opened But Patient Not Seen in N Days (ONS)

Use the ONS option to produce a report that shows a list of patients who have a case open date, no closed date, and have not been seen in N days. The user will determine the number of days to use.

Below are the prompts:

Run the Report for which PROGRAM

Use one of the following: O (ONE program) or A (ALL programs). If you use O, other prompts will display.

Include cases opened by

Use one of the following: A (Any provider) or O (One Provider). If you use O, other prompts will display.

Enter the number of days since the patient has been seen

Specify the number of days (1-99999) to be used when determining which patients should be included in the report.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Cases Opened but Patient Not Seen in N Days report (Figure 13-14).

DEMO INDIAN HOSPITAL							
ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)							
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	PROVIDER	DATE LAST SEEN	# DAYS SINCE
Patient L	106299	F	11/28/85	01/01/06	GAMMAAA, DON	04/26/06	217
Patient M	102446	F	04/08/66	08/28/06	GAMMAAA, DON	03/28/06	246
Patient N	176203	M	03/04/60	10/10/05	GAMMAAA, DON	03/28/06	246
Patient O	164141	M	02/07/75	12/07/05	GAMMAAA, DON	04/25/06	218
Patient P	209591	F	04/16/62	07/25/06	ZETAAAA, MAT	07/25/06	127
Total Number of Patients: 5							
Total Number of Cases: 5							

Figure 13-14: Sample Cases Opened but Patient Not Seen in N Days report

13.1.6.3 Tally Cases Opened/Admitted/Closed (TCD)

Use the TCD option to produce a report that tallies the case open, admit, and closed dates in a specified time period.

Below are the prompts:

Enter beginning of Time Period

Specify the beginning date of the date range.

Enter ending of Time Period

Specify the ending date of the date range.

Run the Report for which PROGRAM

Use one of the following: O (one program) or A (All programs). If you use O, other prompts will display.

Include cases opened by

Use one of the following: A (Any provider) or O (One providers). If you use O, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Tally of Cases Opened/Admitted/Closed report (Figure 13-15).

ALBUQUERQUE HOSPITAL	
TALLY OF CASES OPENED/ADMITTED/CLOSED	

Number of Cases Opened:	6
Number of Cases Admitted:	2
Number of Cases Closed:	2
Tally of Dispositions:	
PATIENT DIED	1
PATIENT DMOVED	1
RUN TIME (H.M.S):	0.0.0
End of report. PRESS ENTER:	

Figure 13-15: Tally of Cases Opened/Admitted/Closed report

13.1.6.4 Duration of Care for Cases Opened and Closed (DOC)

Use the DOC option to produce a report that shows a list of all closed cases in a specified date range. In order to be included in this report, the case must have both a case open and a case closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases can be selected based on Open date, Closed date, or both. Only those cases falling within the specified time frame will be counted.

Below are the prompts:

Enter Beginning Date

Specify the beginning date of the date range.

Enter Ending Date

Specify the ending date of the date range.

Please Select which Dates should be Used

Use one of the following: O (cases opened in that Date Range), C (cases closed in that Date Range), or B (cases either opened or closed in that Date Range).

Run the Report for which PROGRAM

Use one of the following: O (One program) or A (All programs). If you use O, other prompts will display.

Include cases opened by

Use one of the following: A (Any provider) or O (One provider). If you use O, other prompts will display.

Do you want each Provider on a separate page?

Use Y (for yes) or N (for no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Duration of Care report (Figure 13-16).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
DEMO HOSPITAL
Case Dates: May 24, 2008 to May 24, 2010
DURATION OF CARE REPORT
PATIENT NAME CHART      CASE OPEN   CASE CLOSED  DURATION  POV  PROVIDER
                NUMBER      DATE        DATE
-----
Patient A      148367     05/22/08    08/22/08    92 days          BETA,B
Patient B      114077     06/27/08    08/28/08    62 days          BETA,B
Patient B      114077     07/25/08    08/21/08    27 days          BETA,B
Total Number of Cases for BETA,A,B: 3
Average Duration of Care: 60.33 days

Patient C      211053     04/19/08    08/16/08    119 days 72.1  SIGMA,ROBER
Total Number of Cases for SIGMA,ROBERTA: 1

```

Average Duration of Care: 119.00 days						
Patient D	146565	08/01/08	08/16/08	15 days	305.62	THETA, MAUDE
Total Number of Cases for THETA, MAUDE: 1						
Average Duration of Care: 15.00 days						
Patient E	148256	07/25/08	09/01/08	38 days		THA, VICTOR
Total Number of Cases for THA, VICTOR L: 1						
Average Duration of Care: 38.00 days						
Patient F	106030	05/22/08	08/30/08	100 days		UPSILON, GEO
Total Number of Cases for UPSILON, GEORGE G: 1						
Average Duration of Care: 100.00 days						
Total Number of Cases: 7						
Average Duration of Care: 64.71 days						

Figure 13-16: Sample Duration of Care report

At the end of the report, the application provides the total number of cases for the provider and the average duration of care.

13.1.6.5 Patient Seen x number of times w/no Case Open (SENO)

Use the SENO option to produce a report that shows a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. The user, based on the program's standards of care, specifies when a case is to be opened. For example, a case will be opened if a patient has been seen at least three times.

Below are the prompts:

Enter Beginning Visit Date

Specify the beginning date of the date range.

Enter Ending Visit Date

Specify the ending date of the date range.

Run Report for which PROGRAM

Use one of the following: M (Mental Health), S (Social Services), O (Other), or C (Chemical Dependency).

Include visits to

Use one of the following: A (All providers) or O (One provider). If you use O, other prompts will display.

Enter number of visits

Specify the number of visits with no case opened.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen at least N times with no Case Open Date report (Figure 13-17).

PATIENTS SEEN AT LEAST 3 TIMES WITH NO CASE OPEN DATE							
VISIT DATE RANGE: Oct 01, 2015 to Jan 01, 2016							
VISITS TO PROGRAM: MENTAL HEALTH							
PATIENT NAME	CHART NUMBER	SEX	DOB	# VISITS	LAST VISIT	LAST DX	PROVIDER
CLIENT SR	116431	F	02/07/75	14	10/10/15	F02.80	PROVIDER B
CLIENT BA	188444	M	10/14/79	22	10/28/15	F19.181	PROVIDER B
CLIENT BK	113419	M	07/18/85	5	10/02/15	T74.31XD	PROVIDER B
CLIENT AB	201295	M	05/14/41	4	11/22/15	Z59.5	PROVIDER F
CLIENT CA	171659	F	12/07/94	4	12/09/15	F64.1	PROVIDER B
CLIENT SM	152608	M	02/25/86	4	12/19/15	F54	PROVIDER B
CLIENT YE	194181	M	08/21/98	7	11/19/15	F15.24	PROVIDER Y
Total Number of Patients: 3							

Figure 13-17: Sample Patients Seen at least N times with no Case Open Date report

13.1.7 GAF Scores for Multiple Patients (GAFS)

Use the GAFS option to produce a report that lists the GAF scores for multiple patients, sorted by patient. Only visits with GAF scores recorded will display on this list.

Below are the prompts.

Enter Beginning Date of Visit

Specify the beginning date of the date range.

Enter Ending Date of Visit

Specify the ending date of the date range.

List visits/GAF Scores for which program

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

Include visits to

Use one of the following: A (all providers) or O (one provider). If you use O, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the GAF Scores for Multiple Patients report (Figure 13-18).

PATIENT NAME	HRN	Date	GAF TYPE	Provider	PG	Diagnosis/POV
BETAAAA,MINNIE	145318	09/17/10	99 LJLKJLK	GAMMAA,RY	M	296.40-BIPOLAR I DISOR
DEMO,JAMES WILL	192636	07/19/10	75	GAAMMAA,D	M	300.02-GENERALIZED ANX
CHI,ROBERT MITC	186585	09/16/10	66 test	GAMMAA,RY	M	293.82-PSYCHOTIC DISOR
+ Enter ?? for more actions						>>>
+ NEXT SCREEN		-	PREVIOUS SCREEN	Q	QUIT	
Select Action: +//						

Figure 13-18: Sample GAF Scores for Multiple Patients report

13.1.8 Listing of No-Show Visits in a Date Range (NSDR)

Use the NSDR option to print a list of visits with POVs related to No Shows and Cancellations for multiple patients. The user will specify the date range, program, and provider.

Below are the prompts.

Enter Beginning Date

Specify the beginning date of the date range.

Enter Ending Date

Specify the ending date of the date range.

Run the Report for which PROGRAM

Use one of the following: O (ONE program) or A (All programs). If you use O, other prompts will display.

Include visits for

Use one of the following: A (All providers) or O (One provider). If you use O, other prompts will display.

How would you like the report sorted

Use P (patient name) or D (date of visit).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Behavioral Health No Show Appointment Listing report (Figure 13-19).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                                DEMO INDIAN HOSPITAL
                                Page 1

                                BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
                                Appointment Dates: OCT 19, 2014 and APR 17, 2015

PATIENT NAME          HRN      DATE/TIME          PROVIDER          PG  POV
-----
BPAT,ROBERT JACOB    207365  Jan 05, 2009@12:00  CBETA,JESSIC M    8-FAILED APPOI
FPAT1111,CHARLES R   112383  Dec 30, 2008        BETAAAA,BJ    M    8.1-PATIENT CANC
RPAT111,BEULAH       140325  Feb 12, 2009@12:00  GAMMAA,RYAN   S    8-FAILED APPOI
VPAT1,RACHEL MAE     201836  Jan 06, 2009@12:00  LAMBDAAA,MIC  O    8.3-DID NOT WAIT

Total # of Patients: 4      Total # of No Show Visits: 4

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

```

Figure 13-19: Sample Behavioral Health No Show Appointment Listing report

At the end of the report, the application shows the total number of patient and the total number of no show visits.

13.1.9 Patient List for Personal Hx Items (PERS)

Use the PERS option to produce the List of Patients with Personal History Items report.

Below are the prompts.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

Figure 13-20 shows the List of Patients with Personal History Items report.

XX	DEMO INDIAN HOSPITAL				
PERSONAL HISTORY LIST BY PATIENT		SEX	AGE	CHART NUMBER	Page 1
PATIENT					

ALCOHOL USE					
ALPHAA, SAUNDRA KAY		FEMALE	58	117175	
BETA, BRENNNA KAY		FEMALE	21	155215	
BETA, HEATHER LINDA PAIGE		FEMALE	73	142321	
BETAA, STEVEN		MALE	29	188444	
GAMMA, JANE ELLEN		FEMALE	19		
GAMMA, TIMOTHY		MALE	29		
PHIIIII, GREGORY SHANE		MALE	42	184929	
SIGMAAA, AMY LYNN		FEMALE	65	130119	
Enter ?? for more actions					>>>
+ NEXT SCREEN	- PREVIOUS SCREEN	Q	QUIT		
Select Action: +//					

Figure 13-20: Sample List of Patients with Personal History Items report

The application will display a sub-count for each Personal History Item.

13.1.10 Placements by Site/Patient (PPL)

Use the PPL option to produce a report that shows a list of patients who have had a placement disposition recorded in a specified date range.

Below are the prompts.

Enter beginning Date

Specify the beginning date of the date range.

Enter ending Date

Specify the ending date of the date range.

How would you like this report sorted

Use P (alphabetically by patient name) or S (alphabetically by site referred to).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Placements report (Figure 13-21).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX
                                DEMO INDIAN HOSPITAL
                                PLACEMENTS
                                PLACEMENT DATES: OCT 19, 2014 TO APR 17, 2015
                                Page 1
PATIENT NAME          HRN      DATE      POV     PLACEMENT      FACILITY REFERRED TO
                                PLACED
-----
ALPHA,JACOB SCOTT    102668  05/03/09  295.15  E
APATT,CHELSEA MAR    116431  03/25/09  12      OUTPATIENT
  Placement Made by: GAMMAA,RYAN
  Designated SS Prov: BETA,BETAA
BPATT,RUSTY LYNN     207396  04/06/09  15      OUTPATIENT
  Placement Made by: GAMMAA,RYAN
BPATTTT,ADAM M       109943  04/07/09  311.    OUTPATIENT
  Placement Made by: GAMMAA,RYAN
  Enter ?? for more actions
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +//
  
```

Figure 13-21: Sample Placements report

Near the end of the report, the report shows subtotals by Placement Type, subtotals by Facility Referred, and the Total Number of Placements.

13.1.11 Listing of Patients with Selected Problems (PPR)

Use the PPR option to produce a report that lists all patients who have been seen for a particular diagnosis/problem in a specified date range. For example, you can enter all suicide problems codes (39, 40, and 41) and you will get a list of all patients seen for suicide and can then use this report to assist in follow up activities. The report will list the Designated Provider, the Patient Name, the date seen for this problem, and the date last seen.

Below are the prompts.

Which Type

Use one of the following: P (Problem Code and all DSM codes grouped under it), or D (individual problem or DSM codes).

Below are prompts for the P type:

Enter Problem Code

Enter the problem code. The application lists the problem/diagnosis codes that will be included. The next prompt allows you to enter another problem code.

Enter Beginning Visit Date

Specify the beginning date of the date range.

Enter Ending Visit Date

Specify the ending date of the date range.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report (Figure 13-22).

PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS
APATQ,ABIGAIL	103952	02/25/32	F	BJB	41		12/08/08	12/29/08
BPAT,ROBERT JACOB	207365	02/06/55	M	JC	41		12/29/08	01/05/09
FPAT12,AMANDA ROSE	186121	01/10/98	F	DG	40		12/01/08	12/30/08
YPATB,ANNEMARIE LEE	105883	02/11/44	F	DG	40		04/06/09	04/06/09
Designated MH Prov: GALPHA,DENISE								
Designated SS Prov: GAMMAA,RYAN								
Enter ?? for more actions >>>								
+ NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT				
Select Action: +//								

Figure 13-22: Sample Patients Seen with Selected Diagnosis/Problems report (P type)

Below are the prompts for the D (individual problem or DSM codes) type:

Enter Problem/Diagnosis Code

Specify the problem/diagnosis code. The next prompt allows you to enter another problem/diagnosis code.

Enter beginning Visit Date

Specify the beginning date of the date range.

Enter ending Visit Date

Specify the ending date of the date range.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report (Figure 13-23).

PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS
ALPHA,CHELSEA MARIE	116431	02/07/75	F	DG	F33.1		10/06/15	10/16/15
Designated SS Prov: BDOC11,BJ								
ALPHA,MISTY DAWN	131668	04/21/46	F	rust	200.20		02/04/09	06/12/09
Designated SS Prov: DEMO,PSYCHIATRIST								

XX Oct 17, 2015 Page 1

PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
Visit Dates: Oct 19, 2008 to Apr 17, 2009

Enter ?? for more actions >>>

+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT

Select Action: +//

Figure 13-23: Sample Patients Seen with Selected Diagnosis/Problems report (D type)

13.1.12 Screening Reports (SCRN)

Use the SCRN option to access the Screening Reports menu (Figure 13-24).

**	IHS Behavioral Health System **
**	Screening Reports **

Version 4.0 (Patch 7)	
DEMO INDIAN HOSPITAL	
IPV	IPV/DV Reports ...
ALC	Alcohol Screening Reports ...
DEP	Depression Screening Reports ...

```

PHQ    PHQ-2, PHQ-9 and PHQ-T Scores for One Patient
PHQS   PHQ-2 PHQ-9, PHQ-9T Scores for Multiple Patients

Select Screening Reports Option:

```

Figure 13-24: Options on the Screening Reports menu

13.1.12.1 IPV/DV Reports (IPV)

Use the IPV option to access the IPV/DV Report menu (Figure 13-25).

```

*****
**      IHS Behavioral Health System      **
**              IPV/DV Reports              **
*****
                Version 4.0 (Patch 7)

                DEMO INDIAN HOSPITAL

DVP    Tally/List Patients with IPV/DV Screening
DVS    Tally/List IPV/DV Screenings
ISSP   List all IPV/DV Screenings for Selected Patients
IPST   Tally/List Pts in Search Template w/IPV Screening
IVST   Tally List all IPV Screenings for Template of Pts

Select IPV/DV Reports Option:

```

Figure 13-25: Options on the IPV/DV Reports menu

13.1.12.1.1 Tally/List Patients with IPV/DV Screening (DVP)

This report will tally and optionally list all patients who have had IPV screening (PCC Exam code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal

Below are prompts for the DVP report:

Enter Beginning Date for Screening

Enter the beginning date of the date range for the screening.

Enter Ending Date for Screening

Enter the ending date of the date range for the screening.

Which items should be tallied: (0-11)

Select which items you want to tally on this report (Figure 13-26):

```

0) Do not include any Tallies          6) Date of Screening
1) Result of Screening                 7) Primary Provider on Visit
2) Gender                              8) Designated MH Provider
3) Age of Patient                      9) Designated SS Provider
4) Provider who Screened               10) Designated ASA/CD Provider
5) Clinic                              11) Designated Primary Care Provider
Which items should be tallied: (0-11):://

```

Figure 13-26: List of options from which to tally the report

The response must be a list or range, e.g., 1,3,5 or 2-4,8.

Would you like to include IPV/DV Screenings documented in the PCC clinical database?

Use Y (yes) or N (no).

Would you like to include a list of patients screened?

Use Y (yes) or N (no). If you use Y, the following prompt will display.

How would you like the list to be sorted

Figure 13-27 lists the possibilities.

```

Select one of the following:

H      Health Record Number
N      Patient Name
P      Provider who screened
C      Clinic
R      Result of Exam
D      Date Screened
A      Age of Patient at Screening
G      Gender of Patient
T      Terminal Digit HRN

How would you like the list to be sorted: H//

```

Figure 13-27: List of options to sort the list

The default is H (Health Record Number).

Display the Patient's Designated Providers on the list?

Use Y (yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

DEVICE

Specify the device to output the report.

Figure 13-28 shows a sample report.

Patient Name	HRN	AGE	DATE	RESULT	CLINIC
XXX					
May 18, 2016					
Page 1					
IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS					
Screening Dates: May 18, 2009 to May 18, 2016					
BETAA,CECILE	103465	42 F	07/09/16	NEGATIVE	TELEBEHAVIORAL HE
Comment: Exposure to violence as a child					
DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER					
Primary Provider on Visit: GAMMAA, RYAN					
Provider who screened: GAMMAA,RYAN					
DELTA,CANDI LYNN	115655	40 F	12/19/15	NEGATIVE	MENTAL HEALTH
Comment: Patient says she wouldn't tolerate DV since she was a child abuse victim and spent years in counseling to deal with her issues.					
DXs: F42. HOARDING DISORDER					
Primary Provider on Visit: ALPHAA,DENNY					
Provider who screened: BETA,CHARLENE					
EPSILON, JANICE	116431	18 F	01/15/15	NEGATIVE	MEDICAL SOCIAL SERVI
Comment: Patient denies any current domestic violence.					
DXs: F84.0 AUTISM SPECTRUM DISORDER					
Primary Provider on Visit: DELTA,GLORIA					
Provider who screened: DELTA,GLORIA:					

Figure 13-28: Sample output of the IPV Screening Patient Tally and Patient Listing report

13.1.12.1.2 Tally/List IPV/DV Screenings (DVS)

This report will tally and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note:

- This report will optionally, look at both the Behavioral Health and PCC clinical databases for evidence of screening/refusal.
- Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the DVS report:

Enter Beginning Date for Screening

Enter the beginning date of the date range for the screening.

Enter Ending Date for Screening

Enter the ending date of the date range for the screening.

Which items should be tallied: (0-11)

Select which items (Figure 13-29) you want to tally on this report:

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied? (0-11)://

Figure 13-29: List of options from which to tally the report

The response must be a list or range, e.g., 1,3,5 or 2-4,8.

Would you like to include IPV/DV Screenings documented in the PCC clinical database?

Use Y (yes) or N (no).

Would you like a list of visits w/screenings done?

Use Y (yes) or N (no). If you use Y, the following prompt will display.

How would you like the list to be sorted

Figure 13-30 lists the options.

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

How would you like the list to be sorted? H//

Figure 13-30: List of options to sort the list

The default is H (Health Record Number).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

DEVICE

Specify the device to output the report.

Figure 13-31 shows a sample report.

*** IPV SCREENING VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Oct. 31, 2013 to Dec. 30, 2013		
This report excludes PCC Clinics		

	#	% of patients
Total Number of Visits with Screening	2	
Total Number of Patients screened	2	
By Result		
NEGATIVE	1	50.0%
PRESENT	1	50.0%
By Provider who screened		
GARCIA, RYAN	1	50.0%
WISDOM, WENDY	1	50.0%
By Date		

Figure 13-31: Sample output of the IPV Screening Visit Tally and Visit Listing report

13.1.12.1.3 List all IPV/DV Screenings for Selected Patients (ISSP)

This report will list all patients you select who have had IPV screening or a refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the ISSP report:

Enter Beginning Date for Screening

Enter the beginning date of the date range for the screening.

Enter Ending Date for Screening

Enter the ending date of the date range for the screening.

Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?

Use Y (yes) or N (no).

Include which patients in the list

Use one of the following: F (FEMALES only), M (MALES only), B (Both MALE and FEMALES).

Would you like to restrict the report by Patient age range?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Which result value do you want included in this list: (1-7)

Figure 13-32 shows the possible options.

- | |
|---|
| 1) Normal/Negative |
| 2) Present |
| 3) Past |
| 4) Present and Past |
| 5) Refused |
| 6) Unable to Screen |
| 7) Screenings done with no result entered |
| 8) Referral Needed |

Figure 13-32: List of options used to be included in the list

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g., to get only those patients who have had a result of Present enter 2 to get all patients who have had a screening result of Past or Present, enter 2,3).

Include visits to ALL clinics?

Use Y (yes) or N (no).

Report should include visits whose PRIMARY PROVIDER on the visit is

Figure 13-33 shows the possible options. If you use O, other prompts will display.

Select one of the following:

- | | |
|---|---------------------------------------|
| O | One Provider Only |
| P | Any/All Providers (including unknown) |
| U | Unknown Provider Only |

Figure 13-33: Options for visits to be used on the report

Select which providers who performed the screening should be included

Figure 13-34 shows the possible options. If you use O, other prompts will display.

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 13-34: Options for providers to be used on the report

Would you like to limit the list to just patients who have a particular designated Mental Health provider?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Would you like to limit the list to just patients who have a particular designated Social Services provider?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Would you like to limit the list to just patients who have a particular designated ASA/CD provider?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Select Report Type

Use one of the following: L (List of Patient Screenings) or S (Create a Search Template of Patients). If you use S, other prompts will display.

How would you like the list to be sorted

Figure 13-25 shows the possible selections. The default is H (Health Record Number).

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-35: List of options to sort the list

Display the Patient's Designated Providers on the list?

Use Y (yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

DEVICE

Specify the device to output the report.

The application displays the criteria for the report. After pressing Return, the application displays the report (Figure 13-36).

Patient Name	HRN	AGE	DATE	RESULT	CLINIC
XXX					
May 18, 2016					
Page 1					
IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS					
Screening Dates: May 18, 2009 to May 18, 2016					
BETAA,CECILE	103465	42 F	10/09/15	NEGATIVE	TELEBEHAVIORAL HE
Comment: Exposure to violence as a child					
DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER					
Primary Provider on Visit: GAMMAA, RYAN					
Provider who screened: GAMMAA,RYAN					
DELTA,CANDI LYNN	115655	40 F	12/19/15	NEGATIVE	MENTAL HEALTH
Comment: Patient says she wouldn't tolerate DV since she was a child abuse victim and spent years in counseling to deal with her issues.					
DXs: F42. HOARDING DISORDER					
Primary Provider on Visit: ALPHAA,DENNY					
Provider who screened: BETA,CHARLENE					
EPSILON, JANICE	116431	18 F	01/15/16	NEGATIVE	MEDICAL SOCIAL SERVI
Comment: Patient denies any current domestic violence.					
DXs: F84.0 AUTISM SPECTRUM DISORDER					
Primary Provider on Visit: DELTA,GLORIA					
Provider who screened: DELTA,GLORIA					

Figure 13-36: Sample IPV Screening Visit Listing for Selected Patients report

13.1.12.1.4 Tally/List Pts in Search Template w/IPV Screening (IPST)

Note: This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF PATIENT'S RECEIVING IPV SCREENING, INCLUDING REFUSALS ONLY PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE ARE INCLUDED IN THIS REPORT

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest IPV screening (Exam code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

13.1.12.1.5 Tally/List all PIV Screenings for Template of Pts (IVST)

*Please Note: This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF ALL VISITS W/IPV SCREENING, INCLUDING ONLY PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE ARE INCLUDED IN THIS REPORT

This report will tally and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. This report will optionally look at both Behavioral Health and PCC databases for evidence of screening/refusal.

13.1.12.2 Alcohol Screening Reports (ALC)

Use the ALC option to access the ALC Report menu (Figure 13-27).

```

*****
**      IHS Behavioral Health System      **
**      Alcohol Screening Reports        **
*****
Version 4.0 (Patch 7)

DEMO INDIAN HOSPITAL

ASP  Tally/List Patients with Alcohol Screening
ALS  Tally/List Alcohol Screenings
ASSP List all IPV/DV Screenings for Selected Patients
APST Tally/List Pts in Search Template w/Alcohol Screening
AVST Tally List all Alcohol Screenings for Template of Pts

Select Alcohol Screening Reports Option:

```

Figure 13-37: Options on the ALC Reports menu

13.1.12.2.1 Tally/List Patients with Alcohol Screening (ASP)

This report will tally and optionally list all patients who have had ALCOHOL screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1

- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- refusal of exam code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts.

Enter Beginning Date for Screening

Specify the beginning date of the date range.

Enter Ending Date for Screening

Specify the ending date of the date range.

Which items should be tallied

Specify which items you would like to have displayed in the report. The application provides a list of items. Your response must be a list (like 1,3,5) or a range (2-4, 8).

Would you like to include ALCOHOL Screenings documented in the PCC clinical database?

Use Y (Yes) or N (No).

Would you like to include a list of patients screened?

Use Y (Yes) or N (No).

If you answered Yes to this question, the next prompt will display:

How would you like this report sorted

Use only one of the items in the list provided by the application.

Display the Patient's Designated Providers on the list?

Use Y (Yes) to display the patient's Designated Providers or N (No) to bypass this option.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Tally/List Patients with Alcohol Screenings report (Figure 13-38).

XX		Oct 07, 2010		Page 1	
*** ALCOHOL SCREENING PATIENT TALLY AND PATIENT LISTING ***					
Screening Dates: Sep 07, 2010 to Oct 07, 2010					
This report excludes data from the PCC Clinical database					

		#	% of patients		
Total Number of Patients screened		4			
By Result					
NEGATIVE		1	25.0%		
POSITIVE		2	50.0%		
REFUSED SCREENING		1	25.0%		
By Gender					
F		3	75.0%		
M		1	25.0%		
By Age					
26 yrs		1	25.0%		
27 yrs		1	25.0%		
44 yrs		1	25.0%		
48 yrs		1	25.0%		

Figure 13-38: Sample Tally/List Patients with Alcohol Screenings report

13.1.12.2.2 Tally/List Alcohol Screening (ALS)

This report will tally and optionally list all visits on which ALCOHOL screening or a refusal was documented in a specified time frame.

Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)

- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- refusal of exam code 35

This report will tally the visits by age, gender, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts.

Enter Beginning Date for Screening

Specify the beginning date of the date range.

Enter Ending Date for Screening

Specify the ending date of the date range.

Note: This date range indicates when the screening was done.

Which items to be tallied

Specify which items you would like to have displayed in the report. The application provides a list. Your response must be list (like 1,3,5) or a range (2-4, 8).

Would you like to include ALCOHOL Screenings documented in the PCC clinical database

Use Y (Yes) or N (No).

Would you like to include a list of visits w/screenings done?

Use Y (Yes) or N (No).

How would you like this report sorted

The report can be sorted by only one of the items in the list.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Tally/List Alcohol Screenings report (Figure 13-39).

```

*** ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING ***
      Screening Dates: Sep 10, 2010 to Dec 09, 2010
      This report excludes PCC Clinics
-----

```

	#	% of patients
Total Number of Visits with Screening	4	
Total Number of Patients screen	4	
By Result		
NEGATIVE	1	25.0%
POSITIVE	2	50.0%
REFUSED SCREENING	1	25.0%
By Gender		
FEMALE	3	75.0%
MALE	1	25.0%
By Age		
26 yrs	1	25.0%
27 yrs	1	25.0%
44 yrs	1	25.0%
48 yrs	1	25.0%
By Provider who screened		
ALPHAA, GEORGE C	1	25.0%
BETAA, FRANK S	1	25.0%
GAMMA, MATT	1	25.0%
OMICRON, STEVE N	1	25.0%
By Primary Provider of Visit		
ALPHAA, GEORGE C	1	25.0%
BETAA, FRANK S	1	25.0%
WEARY, MATT	1	25.0%
OMICRON, STEVE N	1	25.0%
By Designated Primary Care Provider		
UNKNOWN	3	75.0%
RHOOOO, HELEN K	1	25.0%
By Clinic		
ALCOHOL AND SUBSTANCE	1	25.0%
MEDICAL SOCIAL SERVICES	1	25.0%
MENTAL HEALTH	2	50.0%
By Date		
Jul 25, 2006	1	25.0%
Aug 09, 2006	1	25.0%
Aug 17, 2006	1	25.0%
Aug 23, 2006	1	25.0%
By Designated Mental Health Provider		
UNKNOWN	4	100.0%
By Designated Social Services Provider		
UNKNOWN	4	100.0%
By Designated A/SA Provider		
UNKNOWN	4	100.0%

PATIENT NAME	HRN	AGE	SCREENED RESULT	CLINIC
Patient H	114551	26 F	08/17/09 POSITIVE	
DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER				
Primary Provider on Visit: Provider B				
Provider who screened: Provider B				
Patient J	116475	27 F	08/23/09 REFUSED SCREENIN	
DXs: F84.0 AUTISM SPECTRUM DISORDER				
Primary Provider on Visit: Provider A				
Provider who screened: Provider A				

Figure 13-39: Sample Tally/List Alcohol Screenings report

13.1.12.2.3 List All Alcohol Screenings for Selected Patients (ASSP)

This report will tally and optionally list all patients who have had an alcohol screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

Below are the prompts.

Enter Beginning Date for Screening

Specify the beginning date of the date range.

Enter Ending Date for Screening

Specify the ending date of the date range.

Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?

Use Y (Yes) or N (No).

Include which patients in the list

Use F (Females Only), M (Males Only), or B (Both Male and Females).

Would you like to restrict the report by Patient age range?

Use Y (Yes) or N (no). If you wish to include visits from ALL age ranges, answer No. If you wish to list visits for only patients with a particular age range, enter Yes. If you use Yes, other prompts will display.

Which result values do you want included on this list

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

You can choose from the following:

- 1) Normal/Negative
- 2) Positive
- 3) Refused
- 4) Unable to Screen
- 5) Screenings done with no result entered
- 6) Referral Needed

Include visits to ALL clinics

Use Y (Yes) or N (No). If No is used, additional prompts will display.

Report should include visits whose PRIMARY PROVIDER on the visit is

Use O (One Provider Only), P (Any/All Providers including Unknown), or U (Unknown Provider Only). If you use O, other prompts will display.

Select which providers who performed the screening should be included

Use O (One Provider Only), P (Any/All Providers including Unknown), or U (Unknown Provider Only). If you use O, other prompts will display.

Would you like to limit the list to just patients who have a particular designated Mental Health provider?

Use Y (Yes) or N (No). If Yes is used, additional prompts will display.

Would you like to limit the list to just patients who have a particular designated Social Services provider?

Use Y (Yes) or N (No). If Yes is used, additional prompts will display.

Would you like to limit the list to just patients who have a particular designated ASA/CD provider?

Use Y (Yes) or N (No). If Yes is used, additional prompts will display.

Select Report Type

Use L (List of Patient Screenings) or S (Create a Search Template of Patients).

How would you like this report sorted

The report can be sorted by only one of the items in the list.

Display the Patient's Designated Providers on the list?

Use Y (Yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the criteria you selected for the report.

Then, the application displays the Tally/List Alcohol Screenings report (Figure 13-40).

XX	Oct 07, 2010	Page 1
*** ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS ***		
Screening Dates: Jul 09, 2010 to Oct 07, 2010		
PATIENT NAME	HRN	DATE AGE SCREENED CLINIC

SIGMAAAA,BRITTANY LYN	129079 41	F 08/03/10 BEHAVIORAL HEALTH
Type/Result: ALCOHOL SCREENING NEGATIVE		
Primary Provider on Visit: BETA,BETAA		
Provider who screened: BETA,BETAA		

```

SIGSIG,ALICIA MARIE      169379 58  F 09/08/10      ALCOHOL AND SUBSTANC
Type/Result: AUDT  21
Primary Provider on Visit:  BETA,BETAA
Provider who screened:  UNKNOWN

Enter RETURN to continue or '^' to exit:

```

Figure 13-40: Sample Alcohol Screenings Visit Listing for Selected Patients report

13.1.12.2.4 Tally/List Pts in Search Template w/Alcohol Screenings (APST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest ALCOHOL screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit) clinic, date of screen, designed PCP, MH Provider, SS Provider, and A/SA/ Provider.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal
- This is a tally of Patients, not visits or screenings

13.1.12.2.5 Tally list all Alcohol Screenings for Template of Pts (AVST)

This ALCOHOL report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF ALL VISITS W/ALCOHOL SCREENING ONLY
 PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE
 ARE INCLUDED IN THIS REPORT

This report will tally and optionally list all visits on which ALCOHOL screening or a refusal was documented in a specified time frame specified. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the visits by age, gender, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A.SA Provider.

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

13.1.12.3 Depression Screening Reports (DEP)

Use the DEP option to access the Depression Screening Reports menu (Figure 13-41).

```

*****
**      IHS Behavioral Health System      **
**      Depression Screening Reports      **
*****
                          Version 4.0 (Patch 7)

                          DEMO INDIAN HOSPITAL

DSP   Tally/List Patients with Depression Screening
DLS   Tally/List Depression Screenings
DSSP  List all Depression Screenings / Selected Patients
DPST  Tally/List Pts in Search Temp w/Depression Scrn
DVST  Tally List all Depression Scrn for Template of Pts

Select Depression Screening Reports Option:

```

Figure 13-41: Options on the Depression Screening Reports menu

13.1.12.3.1 Tally/List Patient with Depression Screening (DSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the specified time frame. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (Exam code 36)

- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC exam code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusals.
- This is a tally of Patients, not visits or screening.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

Enter Beginning Date for Screening

Specify the beginning date of the date range.

Enter Ending Date for Screening

Specify the ending date of the date range.

Which items should be tallied: (0-11)

Select which items you want to tally on this report (Figure 13-42):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 13-42: List of options from which to tally the report

Would you like to include DEPRESSION Screenings documents in the PCC clinic database?

Use Y (yes) or N (no).

Would you like to include a list of patients screened.

Use Y (yes) or N (no). If you use Y, the following will display (Figure 13-42).

```
Select one of the following:

H      Health Record Number
N      Patient Name
P      Provider who screened
C      Clinic
R      Result of Exam
D      Date Screened
A      Age of Patient at Screening
G      Gender of Patient
T      Terminal Digit HRN

How would you like the list to be sorted: H//
```

Figure 13-43: List of options to sort the list

Display the Patient's Designated Providers on the list?

Use Y (yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

DEVICE

Specify the device to output the report.

Below is a sample report (Figure 13-44).

	#	% of patients
By Age		
4 yrs	1	0.5%
5 yrs	1	0.5%
6 yrs	3	1.4%
7 yrs	2	0.9%
8 yrs	4	1.9%
9 yrs	1	0.5%
10 yrs	2	0.9%
11 yrs	6	2.8%
12 yrs	3	1.4%
13 yrs	1	0.5%

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*** DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING ***
 Screening Dates: Nov 17, 2010 to Feb 15, 2011
 This report excludes data from the PCC Clinical database

PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

			#	% of patients
		89 yrs	1	0.5%
		92 yrs	1	0.5%
By Provider who screened				
			53	24.9%
			5	2.3%
			7	3.3%
			1	0.5%
			53	24.9%
			16	7.5%
			1	0.5%
			1	0.5%
BETA, MISTY DAWN	106371	28 F	01/12/11	TELEBEHAVIORAL HEALT
Type/Result: DEPRESSION SCREENING POSITIVE				
Comment: TESTING EHR				
Primary Provider on Visit: GAMMA, RYAN				
Provider who screened: GAMMA, RYAN				
PI, WILLA BELLE	110838	44 F	01/12/11	MENTAL HEALTH
Type/Result: DEPRESSION SCREENING NEGATIVE				
Primary Provider on Visit: IOTA, WENDY				
Provider who screened: IOTA, WENDY				
THETA, JIMMY JOE	129347	24 M	01/31/11	MENTAL HEALTH
Type/Result: PHQ2 6				
Primary Provider on Visit: GAMMA, RYAN				
Provider who screened: GAMMA, RYAN				
Enter RETURN to continue or '^' to exit:				

Figure 13-44: Sample Tally/List Patients with Depression Screening report

13.1.12.3.2 Tally/List Depression Screenings (DLS)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in a specified time frame. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- refusal of exam code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

Enter Beginning Date for Screening

Specify the beginning date of the date range.

Enter Ending Date for Screening

Specify the ending date of the date range.

Which items should be tallied: (0-11)

Select which items you want to tally on this report (Figure 13-45):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11):://

Figure 13-45: List of options from which to tally the report

Would you like to include DEPRESSION Screenings documents in the PCC clinic database?

Use Y (yes) or N (no).

Would you like to include a list of visits w/screening done?

Use Y (yes) or N (no). If you use Y, the following prompt will display.

How would you like to the list to be sorted.

The following options will display (Figure 13-46).

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic

R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-46: List of options to sort the list

The default is H (Health Record Number).

Display the Patient's Designated Providers on the list?

Use Y (yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

DEVICE

Specify the device to output the report.

Figure 13-47 shows a sample report.

XX		Dec 26, 2013		Page 1	
*** DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING ***					
Screening Dates: Jan 01, 1980 to Dec 26, 2013					
This report excludes PCC Clinics					

		#	% of patients		
Total Number of Visits with Screening		450			
Total Number of Patients screened		229			
By Result					
		14.1	35	7.8%	
DEPRESSION SCREENING NEGATIVE			115	25.6%	
DEPRESSION SCREENING PATIENT REFUSED SCREENING				143.1%	
DEPRESSION SCREENING POSITIVE			129	28.7%	
DEPRESSION SCREENING UNABLE TO SCREEN			15	3.3%	
REFERRAL NEEDED			15	3.3%	
PHQ2			1	0.2%	
PHQ2 0			2	0.4%	
PHQ2 1			5	1.1%	
PHQ2 2			8	1.8%	
PHQ2 3			16	3.6%	
PHQ2 4			11	2.4%	
PHQ2 5			13	2.9%	
PHQ2 6			2	0.4%	
PHQ2 7			1	0.2%	
PHQ2 COMPLETE BREECH			1	0.2%	
PHQ9 1			1	0.2%	
PHQ9 10			3	0.7%	
PHQ9 10.5			1	0.2%	

PHQ9	12	2	0.4%
PHQ9	13	3	0.7%
PHQ9	14	2	0.4%
PHQ9	15	5	1.1%
PHQ9	16	2	0.4%
PHQ9	17	7	1.6%
PHQ9	18	2	0.4%
PHQ9	19	3	0.7%
PHQ9	20	8	1.8%
PHQ9	21	7	1.6%
PHQ9	22	4	0.9%
PHQ9	24	1	0.2%
PHQ9	25	3	0.7%
PHQ9	27	2	0.4%
PHQ9	3	1	0.2%
PHQ9	5	5	1.1%
PHQ9	5.5	1	0.2%
PHQ9	6	2	0.4%
PHQ9	7	5	1.1%
PHQ9	8	5	1.1%
PHQ9	9	4	0.9%
PHQT	12	2	0.4%
PHQT	13	3	0.7%
PHQT	14	2	0.4%
PHQT	15	5	1.1%
PHQT	16	2	0.4%
PHQT	17	7	1.6%
PHQT	18	2	0.4%
PHQT	19	3	0.7%
PHQT	20	8	1.8%
PHQT	21	7	1.6%
PHQT	22	4	0.9%
PHQT	24	1	0.2%
PHQT	25	3	0.7%
PHQT	27	2	0.4%
V79.0		2	0.4%

PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

FEATHER,KASSANDRA DA	101349	30	F 04/06/10	MEDICAL SOCIAL SERVI
Type/Result: PHQ9 17				
DXs: 88 OTHER SOCIOLEGAL PROBLEMS				
Primary Provider on Visit: BRUNING,BJ				
Provider who screened: UNKNOWN				
DURANT,COURTNEY NICO	101351	34	F 04/05/10	MENTAL HEALTH
Type/Result: PHQ2 2				
DXs: 43.1 PARTNER ABUSE (SUSPECTED), PHYSICAL				
27 ALCOHOL DEPENDENCE				
304.22 COCAINE DEPENDENCE, EPISODIC				
Primary Provider on Visit: BRUNING,BJ				
Provider who screened: UNKNOW				
Enter RETURN to continue or '^' to exit:				

Figure 13-47: Sample Depression Screening Visit Tally and Visit Listing report

13.1.12.3.3 List all Depression Screenings / Selected Patients (DSSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of exam code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of Patients, not visits or screenings.

You will be able to choose the patients by age, gender, clinic, primary provider, or result of the screening.

Below are the prompts:

Enter Beginning Date for Screening

Specify the beginning date of the date range.

Enter Ending Date for Screening

Specify the ending date of the date range.

Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?

Use Y (yes) or N (no).

Include which patients in the list

Use one of the following: F (FEMALES only), M (MALES Only), or B (Both MALE and FEMALES).

Would you like to restrict the report by Patient age range?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Which result values do you want included on this list

Figure 13-48 shows the list from which to select.

- | | |
|----|--|
| 1) | Normal/Negative |
| 2) | Positive |
| 3) | Refused |
| 4) | Unable to Screen |
| 5) | Screenings done with no result entered |
| 6) | Referral Needed |

Figure 13-48: List of options from which to select

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

Include visits to ALL clinics

Use Y (yes) or N (no).

Report should include visits whose PRIMARY PROVIDES on the visit is

Figure 13-49 shows the options. If you use O, other prompts will display.

- | | |
|------------------------------|---------------------------------------|
| Select one of the following: | |
| O | One Provider Only |
| P | Any/All Providers (including unknown) |
| U | Unknown Provider Only |

Figure 13-49: Options for visits to be used on the report

Select which providers who performed the screening should be included

Figure 13-50 shows the options. If you use O, other prompts will display.

- | | |
|------------------------------|---------------------------------------|
| Select one of the following: | |
| O | One Provider Only |
| P | Any/All Providers (including unknown) |
| U | Unknown Provider Only |

Figure 13-50: Options for providers to be used on the report

Would you like to limit the list to just patients who have a particular designated Mental Health provider?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Would you like to limit the list to just patients who have a particular designated Social Services provider?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Would you like to limit the list to just patients who have a particular designated ASA/CD provider?

Use Y (yes) or N (no). If you use Y, other prompts will display.

Select Report Type

Use one of the following: L (List of Patient Screenings) or S (Create a Search Template of Patients). If you use S, other prompts will display.

How would you like the list to be sorted

Figure 13-51 shows the options.

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-51: List of options to sort the list

The default is H (Health Record Number).

Display the Patient's Designated Providers on the list?

Use Y (yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

DEVICE

Specify the device to output the report.

The application displays the criteria for the report. After pressing Enter, the application displays the report (Figure 13-52).

XX	Feb 15, 2011	Page 1
*** DEPRESSION SCREENING VISIT LISTING FOR SELECTED PATIENTS ***		

Screening Dates: Nov 17, 2010 to Feb 15, 2011				
PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

BETA,MISTY DAWN	106371	28	F 01/07/11	BEHAVIORAL HEALTH
Type/Result: DEPRESSION SCREENING POSITIVE				
Comment: testing ehr				
Primary Provider on Visit: GAMMA,RYAN				
Provider who screened: GAMMA,RYAN				
CHI,WILLA BELLE	110838	44	F 01/12/11	MENTAL HEALTH
Type/Result: DEPRESSION SCREENING POSITIVE				
Primary Provider on Visit: IOTA,WENDY				
Provider who screened: IOTA,WENDY				
Enter RETURN to continue or '^' to exit:				

Figure 13-52: Sample Depression Screening Visit Listing for Selected Patients report

13.1.12.3.4 Tally/List Pts in Search Temp w/Depression Scrn (DPST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of exam code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of Patients, not visits or screenings.

13.1.12.3.5 Tally List all Depression Scrn for Template of Pts (DVST)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC exam code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will, optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done; if a patient had multiple screenings during the time period, all will be counted.

13.1.12.4 PHQ-2 and PHQ-9 Scores for One Patient (PHQ)

Use the PHQ option to produce a report that lists PHQ2, PHQ9, and PHQT Scores for one patient within a specified date range.

Below are the prompts:

Select PATIENT NAME

Specify the name of the patient whose scores are to be displayed.

Browse which subset of visits for <name of patient>

Use N (Patient's Last N Visits), D (Visits in a Date Range), or A (All of this patient's Visits). If you use N or D, other prompts will display.

Limit by Clinic/Provider

Use C (Visits to Selected Clinics), P (Visits to Selected Providers), or A (Include All Visits regardless of Clinic/Provider).

The application displays the PHQ-2/PHQ-9/PHQT Scores for One Patient report (Figure 13-53).

PHQ-2, PHQ-9 and PHQ-9T SCORES FOR MULTIPLE PATIENTS								
Visit Dates: Mar 09, 2015 to Mar 09, 2016								
Clinic: ALL Clinics								
Providers: ALL Providers								
PATIENT NAME	HRN	Date	PHQ2	PHQ9	PHQT	Provider	CLINIC	Diagnosis/POV
SPIRO,JOSEPH	147423	03/03/16			23	GARCIA,RY	BEHAV	F43.11-POST-T
THOMAS,AMBER DA	118957	03/05/16			5	WISDOM,WE	BEHAV	R45.851-Suicid
Enter ?? for more actions								>>>
+ NEXT SCREEN		- PREVIOUS SCREEN			Q	QUIT		
Select Action: +//								

Figure 13-53: Sample PHQ-2 and PHQ-9 Scores for One Patient report

13.1.12.5 PHQ-2 and PHQ-9 Scores for Multiple Patients (PHQS)

Use the PHQS option to produce a report that lists PHQ-2 and PHQ-9 Scores for multiple patients, sorted by patient. Only visits with PHQ-2/PHQ-9 scores recorded will display on this list.

Below are the prompts.

Enter Beginning Date of Visit

Specify the beginning date of the date range.

Enter Ending Date of Visit

Specify the ending date of the date range.

Clinic Selection

Use one of the following: C (Visits at Selected Clinic) or A (Visit to All Clinics). If you use C, other prompts will display.

Provider Selection

Use one of the following: A (Visits to All Providers) or C (Visits to Selected Providers) or. If you use C, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the PHQ-2 and PHQ-9 Scores for Multiple Patients report (Figure 13-54).

XX		Jul 13, 2016				Page 1		
PHQ-2 and PHQ-9 SCORES FOR MULTIPLE PATIENTS Visit Dates: Jan 04, 2009 to Jul 13, 2009 Clinic: ALL Clinics Providers: ALL Providers								
PATIENT NAME	HRN	Date	PHQ-2	PHQ-9	Provider	CLINIC	Diagnosis/POV	
ALPHAA,JACOB SCO	102668	02/07/16		3	GAMMA,RYA	MENTA		
ALPHAB,CHELSEA	116431	05/19/16	3	3	GAMMAAA,DE	MENTA	F32.0-MAJOR DEPRESS	
ALPHAB,CHELSEA	116431	03/17/16	4		BETA,BETAA	MEDIC	F32.3-MAJOR DEPRESS	
ALPHAB,CHELSEA	116431	03/10/16		19	GAMMAAA,DE	MENTA	F42.-HOARDING DISOR	
Enter RETURN to continue or '^' to exit:								

Figure 13-54: Sample PHQ-2 and PHQ-9 Scores for Multiple Patients report

13.1.13 Treatment Plans (TPR)

Use the TPR option to access the Treatment Plans menu (Figure 13-55).

ATP	Print List of All Treatment Plans on File
REV	Print List of Treatment Plans Needing Reviewed
RES	Print List of Treatment Plans Needing Resolved
NOTP	Patients w/Case Open but no Treatment Plan
Select Treatment Plans Option:	

Figure 13-55: Options on the Treatment Plans menu

Print List of All Treatment Plans on File (ATP): see section 10.1.5.

Print List of Treatment Plans Needing Reviewed (REV): see section 10.1.3.

Print List of Treatment Plans Needing Resolved (RES): see section 10.1.4.

Patients w/Case Open but no Treatment Plan (NOTP): see section 10.1.6.

13.1.14 Patients seen in groups w/Time in Group (TSG)

Use the TSG option to produce a report that shows a list of patients who have spent time in a group in a specified date range. It will list the patient, the primary provider, diagnosis, and time spent in the group.

Below are the prompts.

Enter beginning Date

Specify the beginning date of the date range.

Enter ending Date

Specify the ending date of the date range.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen in Groups with Time Spent in Group report (Figure 13-56).

DEMO INDIAN HOSPITAL							
PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP							
DATES: JAN 17, 2009 TO APR 17, 2009							
PATIENT NAME	HRN	SEX	DOB	DATE	PROVIDER	PROBLEM	TIME
APHAAA,CHRISTAL	106299	F	11/28/85	04/20/09	BETA,BETAS	F42	0
Total with provider BETAAAA,BJ					0		
Total for patient ALPHAA,CHRISTAL GAYL					0		
APHAAA,DIANA LE	192745	F	09/15/54	03/05/09	GAMMAA,DENISE	F33.0	60
				03/25/09	Not Recorded	F31.3	15
				04/21/09	THETAAAA,MARK	F42.	0
					THETAAAA,MARK	F33.0	60

Figure 13-56: Sample Patients Seen in Groups with Time Spent in Group report

13.2 Behavioral Health Record/Encounter Reports (REC)

Use the REC option to list various records from the Behavioral Health patient file that are available on the BHS Encounter/Record Reports menu (Figure 13-57).

```

*****
**      IHS Behavioral Health System      **
**      Encounter/Record Reports          **
*****
Version 4.0 (Patch 7)

DEMO INDIAN HOSPITAL

LIST  List Visit Records, STANDARD Output
GEN   List Behavioral Hlth Records, GENERAL RETRIEVAL
    
```

Select Behavioral Health Record/Encounter Reports Option:

Figure 13-57: Options on the Encounter/Record Reports menu

13.2.1 List Visit Records, Standard Output (LIST)

Use the LIST option to produce a report that shows a listing of visits in a specified date range. The visits can be selected based on any combination of selected criteria. The user will select the sort criteria for the report.

Be sure to have a printer available that has 132-column print capability.

Below are the prompts.

Enter beginning Visit Date for Search

Specify the beginning date of the date range.

Enter ending Visit Date for Search

Specify the ending date of the date range.

The application displays the Visit Selection Menu (Figure 13-58).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:47:03          Page: 1 of 2
                          Visit Selection Menu
Visits can be selected based upon any of the following items. Select
as many as you wish, in any order or combination. An (*) asterisk indicates
items already selected. To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program              48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type           49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte 50) Prim/Sec Providers
7) Living Patients             29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location      52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid       32) County of Service     54) Primary POV
11) Patient Tribe              33) Community of Service  55) POV (Problem Categor
12) Eligibility Status         34) Activity Type         56) POV Diagnosis Catego
13) Class/Beneficiary          35) Days in Residential   57) Procedures (CPT)
14) Medicare Eligibility       36) Days in Aftercare     58) Education Topics Pro
15) Medicaid Eligibility       37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility        38) Local Service Site    60) Personal History Ite
17) Patient Encounters O       39) Number Served         61) Designated MH Prov
18) Patient Flag Field         40) Type of Contact       62) Designated SS Provid
19) Case Open Date             41) Activity Time         63) Designated A/SA Prov
20) Case Admit Date            42) Inpatient Dispositio  64) Designated Other Pro
21) Case Closed Date           43) PCC Visit Created
22) Case Disposition           44) Axis IV

+          Enter ?? for more actions
S  Select Item(s)      +  Next Screen          Q  Quit Item Selection

```

```

R   Remove Item(s)          -   Previous Screen      E   Exit Report
Select Action: S//

```

Figure 13-58: Sample Visit Selection Menu

Use this menu to select the visit criteria for the report. If you do not select any criteria (immediately use the Quit Item Selection), all visits will be selected.

Type of Report to Print

Use one of the following: D (detailed using 132 column print) or B (brief (using 80 column print)).

The application displays the Sort Item Selection Menu (Figure 13-59).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:55:56          Page: 1 of 2

                          SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1) Patient Name              16) Program                  31) Inpatient Dispositio
2) Patient Sex               17) Visit Type              32) PCC Visit Created
3) Patient Race              18) Location of Encounte    33) Axis V
4) Patient DOB               19) Clinic                   34) Flag (Visit Flag)
5) Patient DOD               20) Outside Location         35) Primary Provider
6) Patient Chart #           21) SU of Encounter          36) Primary Prov Discipl
7) Patient Community         22) County of Service        37) Primary Prov Affilia
8) Patient County Resid      23) Community of Service    38) Primary POV
9) Patient Tribe             24) Activity Type           39) Designated MH Prov
10) Eligibility Status       25) Days in Residential     40) Designated SS Provid
11) Class/Beneficiary        26) Days in Aftercare       41) Designated A/SA Prov
12) Patient Flag Field       27) Activity Category        42) Designated Other Pro
13) Encounter Date           28) Local Service Site      43) Designated Other (2)
14) Appointment/Walk-In      29) Number Served
15) Interpreter Utilized     30) Type of Contact

+   Enter ?? for more actions
S   Select Item(s)           +   Next Screen              Q   Quit Item Selection
R   Remove Item(s)          -   Previous Screen          E   Exit Report
Select Action: S//

```

Figure 13-59: Sample Sort Item Selection Menu options

Use this menu to determine how the visit data will be sorted on the report. If you do not select any item (immediately use the Quit Item Selection option), the report will be sorted by visit date.

Do you want a separate page for each Visit Date?

Use Y (yes) or N (no).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. Then, the application displays the Behavioral Health Record Listing report (Figure 13-60), which is the brief type.

BEHAVIORAL HEALTH RECORD LISTING									
Visit Dates: DEC 23, 2011 and JAN 23, 2012									
DATE	PROV	LOC	PATIENT NAME	ACT	CONT	AT	HRN	PROB	NARRATIVE
12/23/11	WW	WW	BETA, CHARLES	13	OUTP	88	WW109767	F84.0 F10.24	AUTISM SPEC ALCOHOL DEP
12/23/11	VA	WW	UPSILON, JIMM	13	OUTP	60	WW129347	F42.	HOARDING DI
12/27/11	DJS	1337	ETA, DANNY LU	91	OUTP	10	WW176178	F42.	HOARDING DI
12/27/11	DJS	1337	LAMBDA, ALISO	91	OUTP	10	WW193661	F32.3	MAJOR DEPRE
12/27/11	DJS	1337	SIGMA, ROBERT	91	OUTP	10	WW186585	F32.1	MAJOR DEPRE
12/27/11	DJS	1337	XI, CLAUDIA M	91	OUTP	10	WW177791	F32.3	MAJOR DEPRE
12/27/11	DJS	1337	RHO, JADA KAR	91	OUTP	10	WW173042	F32.3	MAJOR DEPRE
12/27/11	DJS	WW	ETA, DANNY LU	13	OUTP	55	WW176178	F10.24	ALCOHOL DEP
12/27/11	DJS	1086	OMICRON, BOB	91	OUTP	10	WW198993	T43.205A	ANTIDEPRESS
12/28/11	RJG	1150	SIGMA, ROBERT	16	OUTP	60	WW186585	T43.205A	ANTIDEPRESS
12/28/11	RJG	WW	IOTA, MISTY R	13	OUTP	60	WW106371	F32.3	MAJOR DEPRE
12/28/11	RJG	WW	ZETA, RYAN J	13	OUTP	90	WW163449	F84.0	AUTISM SPEC
12/28/11	RJG	WW	RHO, JADA KAR	13	OUTP	90	WW173042	F10.25	ALCOHOL DEP
12/28/11	GB	WW	KAPPA, REBECC	11	OUTP	50	WW113487	T43.205A	ANTIDEPRESS

RUN TIME (H.M.S): 0.0.0
End of report. PRESS ENTER

Figure 13-60: Sample Behavioral Health Record Listing report

13.2.2 List Behavioral Hlth Records, General Retrieval (GEN)

Use the GEN option to produce a report that shows a listing of visits selected by visit criteria. The visits printed can be selected based on any combination of selected items and the selected sort criteria.

If the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Below are the prompts.

Select and Print Encounter List from

Use one of the following: S (search template) or D (date range). The next prompts vary according to the option selected.

Enter Beginning Encounter Date for search

Define the beginning encounter date.

Enter Ending Encounter Date for search

Define the ending encounter date.

Do you want to use a PREVIOUSLY DEFINED REPORT?

Use Y or N. If you use Y, other prompts displays.

The application displays the Visit Selection Menu (Figure 13-61).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:02:48          Page: 1 of 2
                          Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program              48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type           49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte 50) Prim/Sec Providers
7) Living Patients             29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location     52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid       32) County of Service     54) Primary POV
11) Patient Tribe              33) Community of Service 55) POV (Problem Categor
12) Eligibility Status         34) Activity Type         56) POV Diagnosis Catego
13) Class/Beneficiary          35) Days in Residential   57) Procedures (CPT)
14) Medicare Eligibility       36) Days in Aftercare    58) Education Topics Pro
15) Medicaid Eligibility       37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility        38) Local Service Site    60) Personal History Ite
17) Patient Encounters O       39) Number Served        61) Designated MH Prov
18) Patient Flag Field         40) Type of Contact       62) Designated SS Provid
19) Case Open Date             41) Activity Time         63) Designated A/SA Prov
20) Case Admit Date            42) Inpatient Dispositio 64) Designated Other Pro
21) Case Closed Date           43) PCC Visit Created
22) Case Disposition           44) Axis IV

+          Enter ?? for more actions
S  Select Item(s)      +  Next Screen          Q  Quit Item Selection
R  Remove Item(s)     -  Previous Screen      E  Exit Report
Select Action: S//

```

Figure 13-61: Sample Visit Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The following prompts continue in the process:

Choose Type of Report

Use one of the following: T (Total Count Only), S (Sub-counts and Total Count), D (Detailed Listing), F (Flag ASCII file (pre-defined record format)).

The application displays the Print Item Selection Menu (Figure 13-62).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:06          Page:    1 of    2
                                PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1) Patient Name                27) Interpreter Utilized  53) Primary Provider
2) Patient Sex                 28) Program              54) Primary Prov Discipl
3) Patient Race                29) Visit Type           55) Primary Prov Affilia
4) Patient Age                 30) Location of Encounte  56) Prim/Sec Providers
5) Patient DOB                 31) Clinic                57) Prim/Sec Prov Discip
6) Patient SSN                 32) Outside Location     58) POV (Prim or Sec)
7) Patient DOD                 33) SU of Encounter      59) DSM/Problem Code Nar
8) Patient Chart #             34) County of Service    60) POV (Prob Code Grps)
9) Patient Community           35) Community of Service  61) Primary POV
10) Patient County Resid       36) Chief Complaint/Pres  62) POV Problem Code Nar
11) Patient Tribe              37) Activity Type         63) POV (Problem Categor
12) Eligibility Status         38) Activity Type Narrat  64) POV Diagnosis Catego
13) Class/Beneficiary          39) Days in Residential   65) POV Prov Narrative
14) Medicare Eligibility       40) Days in Aftercare    66) Procedures (CPT)
15) Medicaid Eligibility       41) Activity Category     67) Education Topics Pro
16) Priv Ins Eligibility        42) Local Service Site    68) Prevention Activity
17) Patient Flag Field         43) Number Served         69) Treated Medical Prob
18) Patient Flag Narrati       44) Type of Contact       70) Personal History Ite
19) Case Open Date             45) Activity Time         71) Designated MH Prov
20) Case Admit Date            46) Inpatient Dispositio  72) Designated SS Provid
21) Case Closed Date           47) Place Referred To    73) Designated A/SA Prov
22) Case Disposition           48) PCC Visit Created     74) Designated Other Pro
23) Next Case Review Dat       49) Axis IV               75) Designated Other (2)
24) Encounter Date             50) Axis V
25) Encounter Date&Time        51) Comment
26) Appointment/Walk-In        52) Flag (Visit Flag)

+          Enter ?? for more actions
S  Select Item(s)      +  Next Screen          Q  Quit Item Selection
R  Remove Item(s)     -  Previous Screen       E  Exit Report
Select Action: S//

```

Figure 13-62: Print Item Selection Menu options

Use this menu to select the data items to be used on the report. Use the Q option when you have completed your selections.

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:55:56          Page:    1 of    2
                                SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1) Patient Name                16) Program              31) Inpatient Dispositio
2) Patient Sex                 17) Visit Type           32) PCC Visit Created
3) Patient Race                18) Location of Encounte  33) Axis V
4) Patient DOB                 19) Clinic                34) Flag (Visit Flag)
5) Patient DOD                 20) Outside Location     35) Primary Provider
6) Patient Chart #             21) SU of Encounter      36) Primary Prov Discipl
7) Patient Community           22) County of Service    37) Primary Prov Affilia
8) Patient County Resid       23) Community of Service  38) Primary POV

```

9) Patient Tribe	24) Activity Type	39) Designated MH Prov
10) Eligibility Status	25) Days in Residential	40) Designated SS Provid
11) Class/Beneficiary	26) Days in Aftercare	41) Designated A/SA Prov
12) Patient Flag Field	27) Activity Category	42) Designated Other Pro
13) Encounter Date	28) Local Service Site	43) Designated Other (2)
14) Appointment/Walk-In	29) Number Served	
15) Interpreter Utilized	30) Type of Contact	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-63: Options on the Sort Item Selection Menu

Use this menu to determine the sort criteria for the report. If you don't select any criteria (use Quit Item Selection) immediately, the report will be sorted by visit date.

Do you want a separate page for each Visit Date?

Use Y or N.

Would you like a custom title for this report?

Use Y or N. If you use Y, other prompts will display.

Do you wish to save this SEARCH/PRINT/SORT logic for future use?

Use Y or N. If you use Y, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

The application displays the criteria for the report.

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the visit report (Figure 13-64).

***** CONFIDENTIAL PATIENT INFORMATION *****			
BH Visit Listing			Page 1
Record Dates: JAN 14, 2009 and JUL 13, 2009			
PATIENT NAME	DOB	HRN	PROGRAM

--			MENTAL
ALPHAA, CHELSEA MARIE	02/07/1975	WW116431	MENTAL
SIGMA, ALBERT TILLMAN	02/07/1975	WW164141	OTHER
SIGMA, ALBERT TILLMAN	02/07/1975	WW164141	MENTAL
SIGMA, ALBERT TILLMAN	02/07/1975	WW164141	SOCIAL

```

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

```

Figure 13-64: Sample visit report

13.3 Workload/Activity Reports (WL)

Use the WL option to view the Activity Workload Reports menu (Figure 13-65).

```

*****
**           IHS Behavioral Health System           **
**           Activity Workload Reports             **
*****
                Version 4.0 (Patch 7)

                DEMO INDIAN HOSPITAL

GRS1  Activity Report
GRS2  Activity Report by Primary Problem
ACT   Activity Record Counts
PROG  Program Activity Time Reports (132 COLUMN PRINT)
FACT  Frequency of Activities
FCAT  Frequency of Activities by Category
PA    Tally of Prevention Activities

Select Workload/Activity Reports Option:

```

Figure 13-65: Options on the Activity Workload Reports menu

The Workload/Activity Reports menu has options to generate reports related specifically to the activities of Behavioral Health providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring Behavioral Health care.

13.3.1 Activity Report (GRS1)

Use the GRS1 option to produce a report that will tally activities by service unit, facility, and provider. The report is patterned after GARS Report #1.

Below are the prompts.

Enter beginning Encounter Date

Specify the beginning encounter date for the date range.

Enter ending Encounter Date

Specify the ending encounter date for the date range.

Run Report for which Program

Use one the following: M - MENTAL HEALTH. S - SOCIAL SERVICES, C - CHEMICAL DEPENDENCY or ALCOHOL/SUBSTANCE ABUSE, O - OTHER, or A - ALL.

Run Report for

Use one of the following: 1 (ONE PROVIDER) or 2 (ALL PROVIDERS). If you use 1, other prompts will display.

Include which providers

Use one of the following: P (Primary Provider Only) or S (Both Primary and Secondary Providers).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Activity Report (Figure 13-66).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX                                     MAY 04, 2009Page 1
ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM
RECORD DATES: FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record. # served is a tally of the
number served data value.

```

	# RECS	ACT TIME (hrs)	# PATS	# SERVED

AREA: TUCSON				
SERVICE UNIT: SELLS				
FACILITY: SELLS HOSP				
PROVIDER: BETAA,BJ (PSYCHIATRIST)				
13-INDIVIDUAL TREATMENT/COUNS	3	2.8	3	3
16-MEDICATION/MEDICATION MONI	1	1.0	1	1
91-GROUP TREATMENT	2	1.5	2	2
	=====	=====	=====	=====
PROVIDER TOTAL:	6	5.3	6	6
PROVIDER: BETABB,LORI (PHYSICIAN)				
11-SCREENING-PATIENT PRESENT	1	0.3	1	1
13-INDIVIDUAL TREATMENT/COUNS	1	0.2	1	1
22-CASE MANAGEMENT-PATIENT PR	2	0.7	1	2
	=====	=====	=====	=====
PROVIDER TOTAL:	4	1.3	3	4
PROVIDER: DEMO,DOCTOR (PHYSICIAN)				
85-ART THERAPY	4	0.7	4	4

PROVIDER TOTAL:	=====	=====	=====	=====
	4	0.7	4	4
Enter RETURN to continue or '^' to exit:				

Figure 13-66: Sample Activity Report

Near the end of the report, there will be a Facility Total, SU Total, and Area Total.

13.3.2 Activity Report by Primary Problem (GRS2)

Use the GRS2 option to produce a report that will tally PRIMARY problems by service unit, facility, and by provider and activity.

The prompts are the same as those for the GRS1 report. Section 13.3.1 provides more information about the Activity Report.

The application displays the Activity Report by Primary Purpose report (Figure 13-67).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
xx                                     MAY 04, 2009Page 1
          ACTIVITY REPORT BY PRIMARY PURPOSE
          ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM
          RECORD DATES: FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identified patients when
a patient name was entered on the record. # served is a tally of the
number served data value.

                                     # RECS   ACT TIME # PATS   # SERVED
                                     (hrs)
-----
AREA: TUCSON
SERVICE UNIT: SELLS
FACILITY: SELLS HOSP
PROVIDER: BETAAAA,BJ (PSYCHIATRIST)
ACTIVITY: 13-INDIVIDUAL TREATMENT/C
          F32.0-MAJOR DEPRESS
                                     1         1.0         1         1
                                     =====
ACTIVITY TOTAL:                       1         1.0         1         1

ACTIVITY: 16-MEDICATION/MEDICATION
          F42.-HOARDING DISOR
                                     1         1.0         1         1
                                     =====
ACTIVITY TOTAL:                       1         1.0         1         1

                                     =====
PROVIDER TOTAL:                       2         2.0         2         2

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

```

Figure 13-67: Sample Activity Report by Primary Purpose report

13.3.3 Activity Record Counts (ACT)

Use the ACT option to produce a report that will generate a count of activity records for a selected item in a specified date range. You will be given the opportunity to select which visits will be included in the tabulation. For example, you can choose to tally activity time by Problem Code for only those with a discipline of Psychiatrist.

Below are the prompts.

Choose an item for calculating activity time and records counts

The application displays a list of items from which to choose.

Enter beginning Visit Date for Search

Specify the beginning visit date for the date range.

Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-68).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:21:08          Page: 1 of 2
          Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program              48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type           49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte 50) Prim/Sec Providers
7) Living Patients             29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location     52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid       32) County of Service    54) Primary POV
11) Patient Tribe              33) Community of Service 55) POV (Problem Categor
12) Eligibility Status         34) Activity Type        56) POV Diagnosis Catego
13) Class/Beneficiary          35) Days in Residential  57) Procedures (CPT)
14) Medicare Eligibility       36) Days in Aftercare    58) Education Topics Pro
15) Medicaid Eligibility       37) Activity Category    59) Prevention Activity
16) Priv Ins Eligibility       38) Local Service Site   60) Personal History Ite
17) Patient Encounters O       39) Number Served        61) Designated MH Prov
18) Patient Flag Field         40) Type of Contact       62) Designated SS Provid
19) Case Open Date             41) Activity Time        63) Designated A/SA Prov
20) Case Admit Date            42) Inpatient Dispositio 64) Designated Other Pro
21) Case Closed Date           43) PCC Visit Created
22) Case Disposition           44) Axis IV
+          Enter ?? for more actions
S  Select Item(s)              +  Next Screen              Q  Quit Item Selection
R  Remove Item(s)              -  Previous Screen          E  Exit Report
Select Action: S//

```

Figure 13-68: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Activity Record Counts report (Figure 13-69).

MAY 04, 2009 Page 1						
RECORD DATES: FEB 03, 2009 TO MAY 04, 2009						
NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM-5/CODE						
PROB DSM/CODE	NARRATIVE	CODE	# RECS	# PATS	ACTIVITY TIME	# SERVED
GENERALIZED ANXIETY DIS		F41.1	1	1	1.0	1
MAJOR DEPRESSIVE DISORD		F32.9	1	1	0.0	1
SUICIDE (ATTEMPT/GESTUR		40	1	1	0.9	1
Suicidal ideations		R45.851	1	1	0.0	1
Suicide attempt		T14.91	1	1	0.0	1

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

Figure 13-69: Sample Activity Record Counts report

13.3.4 Program Activity Time Reports (PROG)

Use the PROG option to produce a report that will generate a count of activity records, total activity time, and number of patient visits by Program and by a selected item within a specified date range. You will be given the opportunity to select which visits will be included on the report. For example, you might want to only report on those records on which the type of visits was Field. Note: if you choose to report on Problems, only the primary problem is included.

NOTE: If you choose to report on Problems, ONLY THE PRIMARY PROBLEM is included.

The prompts are the same as those for the ACT report. Section 13.3.3 provides more information about Activity Record Counts.

The application displays the record selection criteria. After pressing Enter, the application displays the Program Activity Time report (Figure 13-70).

```

Encounter Date range:  FEB 03, 2009 to MAY 04, 2009

                                MENTAL HEALTH AND SOCIAL SERVI
                                ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGR
                                RECORD DATES:  FEB 03, 2009 TO MA

                                SOCIAL SERVICES AND MENTAL HEALTH COMB                SOCIAL SERV
                                NO. OF        NO. OF        TOTAL                NO. OF        NO. OF
PROVIDER                RECORDS        PATIENTS        ACTIV TIME                RECORDS        PATIENT
-----
ALPHA,AAA                15             7             3.6                       2             2
BETA,BETAA              33            18            22.6                      8             4
BETAAAA,LORI            16             6             5.0                       .             .
CAAAA,JESSICA           9              2             6.3                       .             .
DEMO,CASE M             1              1             0.0                       .             .
DEMO,DOCTOR             1              1             0.2                       1             1
NUUUUUUU,AMY J         3              3             2.0                       .             .
GAMMA,RYAN             106            30            66.3                      24            5
**** Patient Count TOAL is not an unduplicated count.

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

```

Figure 13-70: Sample Program Activity Time report

13.3.5 Frequency of Activities (FACT)

Use the FACT option to produce a report that will generate a list of the top N Activity Codes for selected visits.

Below are the prompts.

Enter beginning Visit Date for Search

Specify the beginning visit date for the date range.

Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-71).

```

BH GENERAL RETRIEVAL                Dec 26, 2013 10:23:22                Page: 1 of 2
                                Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name                    23) Next Case Review Dat  45) Axis V
2) Patient Sex                     24) Appointment/Walk-In  46) Flag (Visit Flag)

```

3) Patient Race	25) Interpreter Utilized	47) Primary Provider
4) Patient Age	26) Program	48) Primary Prov Discipl
5) Patient DOB	27) Visit Type	49) Primary Prov Affilia
6) Patient DOD	28) Location of Encounte	50) Prim/Sec Providers
7) Living Patients	29) Clinic	51) Prim/Sec Prov Discip
8) Chart Facility	30) Outside Location	52) POV (Prim or Sec)
9) Patient Community	31) SU of Encounter	53) POV (Prob Code Grps)
10) Patient County Resid	32) County of Service	54) Primary POV
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History It
17) Patient Encounters O	39) Number Served	61) Designated MH Prov
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-71: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

Select Type of Report

Use one of the following: L (list of items with counts) or B (Bar Chart, requires 132 column printer).

How many entries do you want to list (5-100)

Specify the number of entries (any number 5-100).

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the Frequency of Activities report (Figure 13-72).

MAY 04, 2009	DEMO INDIAN HOSPITAL	Page 1
TOP 10 Activity Code's.		

```

DATES:  FEB 03, 2009  TO  MAY 04, 2009

```

No.	ACTIVITY TYPE	ACTIVITY CODE	# RECS	ACT TIME (HRS)
1.	SCREENING-PATIENT PRESENT	11	55	34.8
2.	INFORMATION AND/ OR REFERRAL-P	15	32	12.3
3.	GROUP TREATMENT	91	30	17.1
4.	INDIVIDUAL TREATMENT/COUNSEL/E	13	22	17.0
5.	ASSESSMENT/EVALUATION-PATIENT	12	19	15.5
6.	INDIVIDUAL BH EHR VISIT	99	19	0.6
7.	ACADEMIC SERVICES	96	16	8.1
8.	ART THERAPY	85	15	6.7

```

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:

```

Figure 13-72: Sample Frequency of Activities report

13.3.6 Frequency of Activities by Category (FCAT)

Use the FCAT option to produce a report that generates a list of the top N Activity Category for selected visits.

The prompts are the same as for the Frequency of Activities report. Section 13.3.5 Frequency of Activities report.

Below is a sample Frequency of Activities by Category report (Figure 13-73).

```

MAY 04, 2009

```

DEMO INDIAN HOSPITAL

Page 1

```

TOP 10 Activity Category's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

```

No.	ACTIVITY CATEGORY	CATEGORY CODE	# RECS	ACT TIME (HRS)
1.	PATIENT SERVICES	P	943	556778.2
2.	SUPPORT SERVICES	S	56	52.9
3.	ADMINISTRATION	A	21	26.6
4.	PLACEMENTS	PL	6	2.8
5.	COMMUNITY SERVICES	C	2	9.0
6.	EDUCATION/TRAINING	E	2	1.5
7.	CULTURALLY ORIENTED	O	1	0.5
8.	TRAVEL	T	1	0.3

```

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:

```

Figure 13-73: Sample Frequency of Activities by Category report

13.3.7 Tally of Prevention Activities (PA)

Use the PA option to produce a report that will show a count of all visits with a prevention activity entered. It will also produce a tally/count of those prevention activities with Target Audience subtotals.

Below are the prompts.

Enter Beginning Visit Date

Specify the beginning visit date for the date range.

Enter Ending Visit Date

Specify the ending visit date for the date range.

Run the Report for which PROGRAM

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

Enter a code indicating which providers are of interest

Specify the Providers whose Prevention activities you want to tally. Use one of the following: A (all providers), S (Select set or Taxonomy of Providers), or O (one provider). If you use S or O, other prompts will display.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Device

Specify the device to browse/print the report.

The application displays the Tally of Prevention Activities report (Figure 13-74).

May 04, 2009	Behavioral Health		Page: 1

* TALLY OF PREVENTION ACTIVITIES *			

VISIT Date Range: FEB 03, 2009 through MAY 04, 2009			
PREVENTION ACTIVITY		# of visits	% of visits

Total # Visits w/Prevention Activity:		3	
Total # of Prevention Activities recorded:		5	
AIDS/HIV		1	33.3
YOUTH	1	100.0	
OTHER		1	33.3
NOT RECORDED	1	100.0	
PUBLIC AWARENESS		1	33.3
NOT RECORDED	1	100.0	
SELF-AWARENESS/VALUES		1	33.3
ADULT	1	100.0	

SMOKING/TOBACCO			1	33.3
YOUTH	1	100.0		
TARGET TOTALS				
ADULT	1	33.3		
NOT RECORDED	1	33.3		
YOUTH	1	33.3		
RUN TIME (H.M.S): 0.0.0				
Enter RETURN to continue or '^' to exit:				

Figure 13-74: Sample Tally of Prevention Activities report

13.4 Problem Specific Reports (PROB)

Use the PROB option to produce a list of BH issues of particular concern to providers, managers, and administrators from a clinical and public health perspective. Figure 13-75 shows the Problem Specific Report menu.

**	IHS Behavioral Health System **
**	Problem Specific Reports **

Version 4.0 (Patch 7)	
DEMO INDIAN HOSPITAL	
ABU	Abuse Report (Age&Sex)
FDSM	Frequency of Problems
FPRB	Frequency of Problems (Problem Code Groupings)
FPRC	Frequency of Problems by Problem Category
SUIC	Suicide Related Reports ...
Select Problem Specific Reports Option:	

Figure 13-75: Options on the Problem Specific Reports menu

13.4.1 Abuse Report (ABU)

Use the ABU option to produce a report that focuses on patients who might have been victims of abuse or neglect. It will present, by age and sex, the number of individual patients who were seen for the Purpose of Visit (POV) – the application displays the POVs.

Below are the prompts.

Enter Beginning Visit Date

Specify the beginning visit date for the date range (during which the patient should have been seen with one of the above problems).

Enter the Ending Visit Date

Specify the ending visit date for the date range.

The application displays the current Age Groups.

Do you wish to modify these age groups?

Use Y or N at this prompt. If you use Y, other prompts will display. Use N to not modify the age groups.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Abuse Report by Age and Sex report. You need a 132 column printer to print the report.

13.4.2 Frequency of Problems (FDX)

Use the FDX option to produce a report that shows a list of the top N Problem/POV for selected visits.

Below are the prompts.

Enter beginning Visit Date for Search

Specify the beginning visit date for the date range.

Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-76).

BH GENERAL RETRIEVAL	Dec 26, 2013 10:26:30	Page:	1 of 2
Visit Selection Menu			
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.			
1) Patient Name	23) Next Case Review Dat	45) Axis V	
2) Patient Sex	24) Appointment/Walk-In	46) Flag (Visit Flag)	
3) Patient Race	25) Interpreter Utilized	47) Primary Provider	
4) Patient Age	26) Program	48) Primary Prov Discipl	
5) Patient DOB	27) Visit Type	49) Primary Prov Affilia	
6) Patient DOD	28) Location of Encounte	50) Prim/Sec Providers	
7) Living Patients	29) Clinic	51) Prim/Sec Prov Discip	
8) Chart Facility	30) Outside Location	52) POV (Prim or Sec)	

9) Patient Community	31) SU of Encounter	53) POV (Prob Code Grps)
10) Patient County Resid	32) County of Service	54) Primary POV
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History Ite
17) Patient Encounters O	39) Number Served	61) Designated MH Prov
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-76: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

Include which POVs

Use one of the following: P (primary POV only) or S (primary and secondary POVs).

Select Type of Report

Use one of the following: L (List of items with counts) or B (Bar Chart, requires 132 column printer).

How many entries do you want to list (5-100)

Specify the number of entries.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Frequency of Problems report (Figure 13-77).

JUN 09, 2009	DEMO INDIAN HOSPITAL	Page 1
TOP 10 Problem/POV's. PRIMARY POV Only		

DATES: MAR 11, 2009 TO JUN 09, 2009				
No.	PROB DSM/CODE NARRATIVE	CODE	# RECS	ACT TIME (HRS)
1.	MAJOR DEPRESSIVE DISORDER,RECU	F33.9	150	114.8
2.	GENERALIZED ANXIETY DISORDER	F41.1	52	28.8
3.	UNSPECIFIED ATTENTIONN-DEFICIT	F90.9	48	35.5
4.	BIPOLAR DISORDER, UNSPECIFIED	F31.9	33	26.1
5.	OBSESSIVE-COMPULSIVE DISORDER	F42	32	21.1
6.	PANIC DISORDER	F41.0	32	72.9
7.	ANOREXIA NERVOSA, RESTRICTING	F50.01	31	27.4
8.	ALCOHOL USE DISORDER, MODERAT	F10.20	25	7.9
9.	HEALTH/HOMEMAKER NEEDS	1	21	17.6
10.	INSOMNIA DISORDER	G47.00	20	32.3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 13-77: Sample Frequency of Problems report

13.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

Use the FPRB option to produce a report that shows a list of the top N Problem/POV for visits that you select.

Below are the prompts.

Enter beginning Visit Date for Search

Specify the beginning visit date for the date range.

Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-78).

BH GENERAL RETRIEVAL		Dec 26, 2013 10:29:11		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1)	Patient Name	23)	Next Case Review Dat	45)	Axis V
2)	Patient Sex	24)	Appointment/Walk-In	46)	Flag (Visit Flag)
3)	Patient Race	25)	Interpreter Utilized	47)	Primary Provider
4)	Patient Age	26)	Program	48)	Primary Prov Discipl
5)	Patient DOB	27)	Visit Type	49)	Primary Prov Affilia
6)	Patient DOD	28)	Location of Encounte	50)	Prim/Sec Providers
7)	Living Patients	29)	Clinic	51)	Prim/Sec Prov Discip
8)	Chart Facility	30)	Outside Location	52)	POV (Prim or Sec)
9)	Patient Community	31)	SU of Encounter	53)	POV (Prob Code Grps)
10)	Patient County Resid	32)	County of Service	54)	Primary POV
11)	Patient Tribe	33)	Community of Service	55)	POV (Problem Categor
12)	Eligibility Status	34)	Activity Type	56)	POV Diagnosis Catego
13)	Class/Beneficiary	35)	Days in Residential	57)	Procedures (CPT)
14)	Medicare Eligibility	36)	Days in Aftercare	58)	Education Topics Pro
15)	Medicaid Eligibility	37)	Activity Category	59)	Prevention Activity

16) Priv Ins Eligibility	38) Local Service Site	60) Personal History Ite
17) Patient Encounters O	39) Number Served	61) Designated MH Prov
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-78: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The prompts continue.

Include which POV/s

Use one of the following: P (Primary POV only) or S (Primary and Secondary POVs).

Select Type of Report

Use one of the following: L (List of items with counts) or B (Bar Chart, required 132 column printer).

How many entries do you want in the list (5-100)

Specify the number of entries, using any whole number 5-100.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do You wish to

Use one of the following: P (print output) or B (browse output on screen).

Figure 13-79 displays the Frequency of Problems by Code Grouping report.

JUN 09, 2009		Page 1	
DEMO INDIAN HOSPITAL			
TOP 10 POV/Problem (Problem Code)'s.			
PRIMARY POV Only			
DATES: MAR 11, 2009 TO JUN 09, 2009			
No.	PROB CODE NARRATIVE	PROBLEM (POV) CODE#	RECS ACT TIME (HRS)
1.	MAJOR DEPRESSIVE DISORDERS	14	123 94.2

2.	ANXIETY DISORDER	18	30	14.2
3.	SCHIZOPHRENIC DISORDER	13	29	25.8
4.	CROSS-CULTURAL CONFLICT	2	19	15.0
5.	MARITAL PROBLEM	56	18	5.4
6.	ALCOHOL ABUSE	29	16	14.1
7.	ILLNESS IN FAMILY	55	16	4.3
8.	HOUSING	80	15	8.0
9.	SENILE OR PRE-SENILE CONDITION	9	14	9.7
10.	BIPOLAR DISORDER	15	13	5.2
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 13-79: Sample Frequency of Problem by groupings report

13.4.4 Frequency of Problems by Problem Category (FPRC)

Use the FPRC option to produce a report that generates a list of the top N Problem/POV (Problem Category) for selected visits.

Below are the prompts

Enter beginning Visit Date for Search

Specify the beginning visit date for the date range.

Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-80).

BH GENERAL RETRIEVAL		Dec 26, 2013 10:29:11	Page: 1 of 2
Visit Selection Menu			
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.			
1) Patient Name	23) Next Case Review Dat	45) Axis V	
2) Patient Sex	24) Appointment/Walk-In	46) Flag (Visit Flag)	
3) Patient Race	25) Interpreter Utilized	47) Primary Provider	
4) Patient Age	26) Program	48) Primary Prov Discipl	
5) Patient DOB	27) Visit Type	49) Primary Prov Affilia	
6) Patient DOD	28) Location of Encounte	50) Prim/Sec Providers	
7) Living Patients	29) Clinic	51) Prim/Sec Prov Discip	
8) Chart Facility	30) Outside Location	52) POV (Prim or Sec)	
9) Patient Community	31) SU of Encounter	53) POV (Prob Code Grps)	
10) Patient County Resid	32) County of Service	54) Primary POV	
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor	
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego	
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)	
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro	
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity	
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History Ite	
17) Patient Encounters O	39) Number Served	61) Designated MH Prov	
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid	
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov	

20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-80: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

Include which POV's

Use one of the following: P (Primary POV only) or S (Primary and Secondary POVs).

Select Type of Report

Use one of the following: L (List of items with counts) or B (Bar Chart, requires 132 column printer).

How many entries do you want in the list (5-100)

Specify the number of entries, using any whole number 5-100.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do You wish to

Use one of the following: P (print output) or B (browse output on screen).

The application displays the record selection criteria. After pressing Enter, the application displays the Frequency of Problems by Problem Category report (Figure 13-81).

JUN 09, 2009		Page 1		
DEMO INDIAN HOSPITAL				
TOP 10 Problem/POV (Problem Category)'s.				
PRIMARY POV Only				
DATES: MAR 11, 2009 TO JUN 09, 2009				
No.	CATEGORY NARRATIVE	CATEGORY CODE	# RECS	ACT TIME (HRS)

1.	PSYCHOSOCIAL PROBLEMS	2	294	220.6
2.	MEDICAL/SOCIAL PROBLEMS	1	73	555798.6
3.	FAMILY LIFE PROBLEMS	5	37	11.5
4.	SOCIOECONOMIC PROBLEMS	8	27	12.4

5.	ADMINISTRATIVE PROBLEM	11	14	11.5
6.	ABUSE	3	10	5.1
7.	OTHER PATIENT RELATED	13	6	12.3
8.	EDUCATIONAL/LIFE PROBLEMS	10	8	5.9
9.	SCREENING	12	7	4.9
10.	PREGNANCY/CHILDBIRTH PROBLEMS	6	6	1.8
RUN TIME (H.M.S): 0.0.1				
End of report. PRESS ENTER:				

Figure 13-81: Sample Frequency of Problems by Problem Category report

13.4.5 Suicide Related Reports (SUIC)

Use the SUIC option to access the Suicide Reports menu (Figure 13-82).

```

*****
**          IHS Behavioral Health System          **
**                Suicide Reports                **
*****
                Version 4.0 (Patch 7)

                DEMO INDIAN HOSPITAL

SSR   Aggregate Suicide Form Data - Standard
SAV   Aggregate Suicide Data Report - Selected Variables
SDEL  Output Suicide Data in Delimited Format
SGR   Listing of Suicide forms by Selected Variables
SUIC  Suicide Report (Age&Sex)
SPOV  Suicide Purpose of Visit Report

Select Suicide Related Reports Option:

```

Figure 13-82: Options on Suicide Report menu

13.4.5.1 Aggregate Suicide Form Data - Standard (SSR)

This report will tally the data items specific to the Suicide Form for a date range, community, and type of suicidal behavior (specified by the user).

Below are the prompts.

Enter Beginning Date of Suicide Act

Specify the beginning date for the date range.

Enter Ending Date of Suicide Act

Specify the ending date for the date range.

Report on Suicide Forms for Suicide Acts that occurred in

Use one of the following: O (One particular Community) or A (All Communities). If you use O, other prompts will display.

Include which Suicidal Behaviors (0-9)

The application displays the suicide behaviors. You can respond with a list or a range.

Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do You wish to

Use one of the following: P (print output) or B (browse output on screen).

Figure 13-82 shows the Aggregate Suicide Form Data - Standard report.

DEMO INDIAN HOSPITAL		Jul 13, 2009	Page 1	
***** AGGREGATE SUICIDE FORM DATA - STANDARD*****				
Act Occurred: Jan 14, 2009 - Jul 13, 2009				
Community where Act Occurred: ALL Communities				

Age Range: 20-24 years	Total # of Suicide Forms: 1			
			REPORT TOTALS	
Suicidal Behavior:	ATT SUICIDE W/ ATT HOMICIDE		1	100%
Event logged by Discipline:	PSYCHIATRIST		1	100%
Event logged by Provider:	GAMMAA,RYAN		1	100%
Sex:	MALE		1	100%
Employed:	PART-TIME		1	100%
Tribe of Enrollment:	CHEROKEE NATION OF OKLAHOMA		1	100%
Community of Residence:	WELLING		1	100%
Relationship:	MARRIED		1	100%
Education:	COLLEGE GRADUATE		1	100%
Method:	GUNSHOT		1	100%
	HANGING		1	100%
Previous Attempts:	1		1	100%
Substance Use Involved:	NONE		1	100%
Location of Act:	WORK		1	100%
Disposition:	IN-PATIENT MENTAL HEALTH TREAT		1	100%
Contributing Factors:	DEATH OF FRIEND OR RELATIVE		1	100%
Age Range: 45-64 years	Total # of Suicide Forms: 13			
			REPORT TOTALS	
Suicidal Behavior:	IDEATION WITH PLAN AND INTENT		4	31%
	ATTEMPT		3	23%

	ATT SUICIDE W/ ATT HOMICIDE	3	23%
	ATT SUICIDE W/ COMP HOMICIDE	2	15%
	COMP SUICIDE W/ ATT HOMICIDE	1	8%
Event logged by Discipline:	ACUPUNCTURIST	7	54%
	PSYCHIATRIST	6	46%
Event logged by Provider:	GAMMAAA, DENISE	1	8%
	BETAAAA, BJ	7	54%
	THETAA, RYAN	5	38%
Enter RETURN to continue or '^' to exit:			

Figure 13-83: Sample Aggregate Suicide Form Data - Standard report

13.4.5.2 Aggregate Suicide Form Data - Selected Variables (SAV)

This report will tally the selected data items for Suicide Forms in a particular date range.

13.4.5.3 Output Suicide Data in Delimited Format (SDEL)

This report will extract all data elements on the Suicide form in a delimited form for a specified date range.

13.4.5.4 Listing of Suicide forms by Selected Variables (SGR)

This report is a 'general retrieval' type report that will list the selected data items for Suicide Forms in a particular date range. The user can also specify how to display the items in the printed report.

13.4.5.5 Suicide Report (Age & Sex) (SUIC)

This report will present, by age and sex, the number of individual patients who were seen for the following POVs: 39, 40, and 41 as well as V62.84 (Suicidal Ideation).

13.4.5.6 Suicide Purpose of Visit Report (SPOV)

This report will display the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Encs). Any records containing the ICD-9 code v62, 84, Suicidal Ideation will be included in the tallies for Problem code 39. A display by age and gender is also included.

Below are the prompts.

Enter Beginning Visit Date

Specify the beginning visit date for the date range.

Enter Ending Visit Date

Specify the ending visit date for the date range.

Run the Report for which Program

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

Demo Patient Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

Do you wish to

Use one of the following: P (print output) or B (browse output on screen)

Figure 13-84 shows the Suicide Purpose of Visit report.

Behavioral Health										

* SUICIDE PURPOSE OF VISIT REPORT *										

VISIT Date Range: OCT 31, 2006 through NOV 30, 2006										
BOTH MALE AND FEMALE PATIENTS' VISITS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs	# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/		
		V62.84/R45.851 & T14.91 V62.84/R45.8								
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	7	35.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	6	30.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	5.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	20	100.0	0	0.0	0	0.0	0	0.0	0	0.0
MALE PATIENTS VISITS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs	# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/		
		V62.84/R45.851 & T14.91 V62.84/R45.8								
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

10-14 yrs	6	66.7	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0
FEMALE PATIENTS VISITS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	4	36.4	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	5	38.5	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - MALE PATIENTS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91 - Suicide Attempt/Gesture; 41 - Suicide Completed										

AGE GROUP	# Encs		# w POV 39 V62.84/R45.851		w/ POV 40 & T14.91		w/ POV 41		w/ 39/40/41/ V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	50.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39 V62.84/R45.851		w/ POV 40 & T14.91		w/ POV 41		w/ 39/40/41/ V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	3	33.3	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Figure 13-84: Sample Suicide Purpose of Visit report

13.5 Print Standard Behavioral Health Tables (TABL)

Use the TABL option to print the various BH tables (activity code, clinical codes, and BH Problem Codes).

The TABL option accesses the Print BH Standard Tables menu (Figure 13-85).

```

*****
**           IHS Behavioral Health System           **
**           Print BH Standard Tables             **
*****
Version 4.0 (Patch 7)

DEMO INDIAN HOSPITAL
    
```

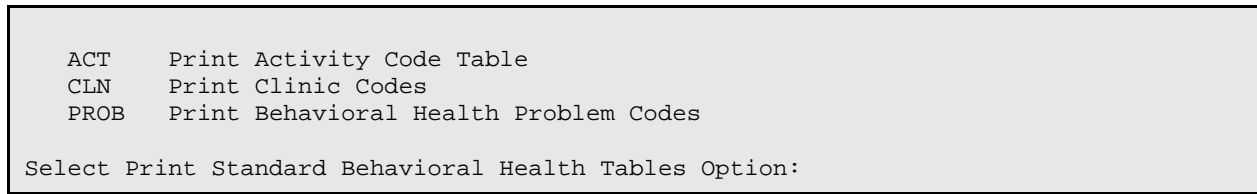


Figure 13-85: Options on the Print BH Standard Tables menu

13.5.1 Print Activity Code Table (ACT)

Use the ACT option to print the activity code table (Figure 13-86).

```

XX                                     May 04, 2009                             Page 1

***** BEHAVIORAL HEALTH ACTIVITY CODES *****

CODE DESCRIPTION                                CATEGORY    PCC    MNE
-----
01  TWELVE STEP WORK - GROUP                    PATIENT SERV  YES    TSG
02  TWELVE STEP WORK - INDIVIDUAL                PATIENT SERV  YES    TSI
03  TWELVE STEP GROUP                            PATIENT SERV  NO     TWG
04  RE-ASSESSMENT, PATIENT PRESENT                PATIENT SERV  YES    RAS
05  RE-ASSESSMENT, PATIENT NOT PRESENT            SUPPORT SERV  NO
11  SCREENING-PATIENT PRESENT                     PATIENT SERV  YES    SCN
12  ASSESSMENT/EVALUATION-PATIENT PRESENT         PATIENT SERV  YES    EVL
13  INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT PATIENT SERV  YES    IND
14  FAMILY/GROUP TREATMENT-PATIENT PRESENT        PATIENT SERV  YES    FAM
15  INFORMATION AND/ OR REFERRAL-PATIENT PRESENT  PATIENT SERV  YES    REF
16  MEDICATION/MEDICATION MONITORING-PATIENT PRESENT PATIENT SERV  YES    MED
17  PSYCHOLOGICAL TESTING-PATIENT PRESENT         PATIENT SERV  YES    TST
18  FORENSIC ACTIVITIES-PATIENT PRESENT           PATIENT SERV  YES    FOR
19  DISCHARGE PLANNING-PATIENT PRESENT            PATIENT SERV  YES    DSG
20  FAMILY FACILITATION-PATIENT PRESENT           PATIENT SERV  YES    FAC
21  FOLLOWTHROUGH/FOLLOWUP-PATIENT PRESENT        PATIENT SERV  YES    FOL

Enter RETURN to continue or '^' to exit:

```

Figure 13-86: Sample Behavioral Health Activity Codes report

13.5.2 Print Clinic Codes (CLN)

Use the CLN option to print the activity code table (Figure 13-87).

CLINIC STOP LIST NAME	CODE	APR 16, 2009 14:22	PAGE 1
ALCOHOL AND SUBSTANCE	43		
AMBULANCE	0		
ANESTHESIOLOGY	0		
ANTICOAGULATION THERAPY	0		
AUDIOLOGY	35		
BEHAVIORAL HEALTH	0		
CANCER CHEMOTHERAPY	62		
CANCER SCREENING	58		
CARDIOLOGY	2		
CASE MANAGEMENT SERVICES	77		
CAST ROOM	55		
CHART REV/REC MOD	52		
CHEST AND TB	3		
CHIROPRACTIC	0		
CHRONIC DISEASE	50		
COLPOSCOPY	0		
COMPLEMENTARY MEDICINE	0		

Figure 13-87: Sample Clinic Stop List codes

14.0 Manager Utilities Module (Roll and Scroll)

The Manager Utilities module, shown in Figure 14-1, provides options for Site Managers and program supervisors to customize BHS to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, resetting local flag fields, and verifying users who have edited particular patient records.

```

*****
**      IHS Behavioral Health System      **
**      Manager Utilities                 **
*****
Version 4.0 (Patch 7)

DEMO INDIAN HOSPITAL

SITE  Update Site Parameters
EXPT  Export Utility Menu ...
RPFF  Re-Set Patient Flag Field Data
DLWE  Display Log of Who Edited Record
ELSS  Add/Edit Local Service Sites
EPHX  Add Personal History Factors to Table
DRD   Delete BH General Retrieval Report Definitions
EEPC  Edit Other EHR Clinical Problem Code Crosswalk
UU    Update Locations a User can See

Select Manager Utilities Option:

```

Figure 14-1: Options on the Manager Utilities menu

This menu might be restricted to the site manager and the program manager or the designee. Use this menu for setting site-specific options related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and IHS Headquarters for mandated federal reporting and funding.

14.1 Update Site Parameters (SITE)

Use the SITE option to modify the parameters in the Behavioral Health file. Individual sites use the Site Parameters file to set BHS to suit their program needs.

Below are the prompts.

Select MHSS SITE PARAMETERS

Specify the location where the program visits take place. If you use a new one, the application confirms that you are using the new one (use Y or N).

Figure 14-2 shows the Update BH Site Parameters window.


```

** UPDATE BH SITE PARAMETERS **      Site Name: ABERDEEN AO
=====
Update DEFAULT Values?  N

Default Health Summary Type:

Default response on form print:      Suppress Comment on Suppressed Form?
# of past POVs to display:          Exclude No Shows on last DX Display?
DSM-5 Implementation Date:

Update PCC Link Features?  N
Turn Off EHR to BH Link?

Turn on PCC Coding Queue?  NO      Update Provider Exceptions to E Sig?  N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits?  N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:

-----

COMMAND:                               Press <PF1>H for help      Insert

```

Figure 14-2: Sample Update BH Site Parameters window

Below are the fields on the window.

Update DEFAULT Values?

Use Y or N. If you use Y, the application displays Figure 14-3. All default settings are moved to this separate pop-up window.

```

**** Enter DEFAULT Values for each Data Item ****
MH Location: DEMO INDIAN HOSPITAL
MH Community: TAHLEQUAH           MH Clinic: MENTAL HEALTH
SS Location: DEMO INDIAN HOSPITAL
SS Community: TAHLEQUAH           SS Clinic: MEDICAL SOCIAL SERVI
Chemical Dependency Location: DEMO INDIAN HOSPITAL
Chemical Dependency Community: TAHLEQUAH
Chemical Dependency Clinic: BEHAVIORAL H
OTHER Location: DEMO INDIAN HOSPITAL
OTHER Community: TAHLEQUAH        OTHER Clinic: MENTAL HEAL

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

```

Figure 14-3: Pop-up for default values of BH site

Below are the prompts on the pop-up.

MH/SS/CD/OTHER Location: specify the name of the location where the program visits take place.

MH/SS/CD/OTHER Community: specify the name of the community where the program visits occur.

MH/SS/CD/OTHER Clinic: specify the name of the clinic where the program visits occur.

Default Type of Contact: Specify the type of contact setting or code (e.g., Administrative, Chart Review, etc.).

Default Appt/Walk in Response: Specify the type of visit that occurred (e.g., appointment, walk in, or unspecified).

EHR Default Community: Specify the name of the default community used in the EHR. In order to pass EHR behavioral health encounter records into the BHS v4.0 files, a Default Community of Service field was created on the BHS v4.0 site parameters' menu. If the facility has opted to pass behavioral health encounter records created in EHR to BHS v4.0, the application will populate the Community of Service field with the value entered in the site parameter "EHR Default Community" or, if that field is blank, with the default Mental Health community value. If the default Mental Health community value is blank, the field will be populated with the default Social Services community value; if that field is also blank, the field will be populated with the default Chemical Dependency value; and if that field is blank, the default Other Community value will be used. If none of the default community fields contains a value, no behavioral health record will be created.

Below are the fields on the update window.

Default HEALTH Summary Type

Specify the type of health summary printed from within the BH package. Typically, the default value is the Mental Health/Social Services summary type. Refer to the Health Summary System Manuals for further information on the available types.

Default response on form print

Your response applies to when you print a Mental Health/Social Services record. Use one of the following: B (both), F (full), S (suppressed form), T (Suppressed - 2 copies), E (Full - 2 copies). The suppressed report does NOT display the following information: Chief Complaint, SOAP note, measurement data, screenings.

A full encounter form prints all data for a patient encounter including the S/O/A/P note. The suppressed version of the encounter form will not display the S/O/A/P note for confidentiality reasons. It is important to note that the S/O/A/P and chief complaint will be suppressed, but the comment/next appt, activity code, and POV will still appear on the printed encounter.

Suppress Comment on Suppressed Form?

Use Y or N to suppress the provider's comments.

of past POVs to display

Specify the number of the past POVs to be displayed on the Patient Data Entry screen. This response must be a whole number between 0 and 5.

Exclude No Shows on last DX Display?

Use Y or N.

DSM-5 Implementation Date

From the date listed forward the application will use the DSM-5 Code Set. Section Appendix D: provides information about DSM copyright and trademark information.

Update PCC Link Features?

Use Y or N. If you use Y, the application displays the Update PCC Link Feature Parameters pop-up window (Figure 14-4).

```

**** Update PCC Link Feature Parameters ****
=====
Type of PCC Link
Type of Visit to create in PCC
Interactive PCC Link?
Allow PCC Problem List Update?
Update PCC LINK Exceptions?

```

Figure 14-4: Fields on the Update PCC Link Feature Parameters pop-up

The underlined fields are required on the pop-up window.

Type of PCC Link: what you use determines the type of data that passes from BHS to the PCC. Use one of the following:

- **No Link Active.** Use this option to have the data link between the two modules turned off. No data is passed to the PCC visit file from the BHS system (including the Health Summary). Therefore, because the RPMS Third Party Billing Package processes encounters in PCC, an alternative billing process will need to be established. If you leave this field blank, it is the same as choosing this option and no data will pass to PCC.
- **Pass STND Code and Narrative.** Use this option to have all patient contacts in the Behavioral Health programs passed to the PCC visit file using the same

ICD-10 code and narrative, as defined by the program. This approach does not facilitate billing because all encounters will appear the same. For example, if the code and narrative are entered in the site parameters as Z71.9, Encounter, all encounters will have the ICD code of Z71.9 and narrative of Encounter.

- **Pass All Data as Entered (No Masking).** Use this option to have all DSM-5 and Problem Codes passed as ICD codes as shown in the crosswalk along with the narrative as written by the provider. This link type is the one most preferred by billers and coders since the actual ICD code and narrative display in PCC.
- **Pass Codes and Canned Narrative.** Use this option to have both DSM-5 and Problem Codes converted to ICD codes as shown in the 1crosswalk and passed with a single standard narrative, as defined by the program, for all contacts. This type of link facilitates billing by passing the POV entered in BH applications as ICD codes although the standard narrative is not passed to the Health Summary.

For “Pass STND Code and Narrative” and “Pass Codes and Canned Narrative” options, the application displays the Standard Code to Use pop-up.

```
Standard ICD-9 Code to Use (Option 2 and 5 ONLY): V65.40
Standard ICD-10 Code to Use (Option 2 and 5 ONLY): Z71.9
Narrative for MH Program: MH/SS/SA COUNSELING
Narrative for SS Program: SS VISIT
```

Figure 14-5: Standard code to use screen

With each of these link types, standard data is passed to the PCC. You can specify those standards using the Standard Code to Use screen. The standard code, shown in the first line, will be passed if using Pass STND Code and Narrative. The narrative entered will be the only narrative passed if you have selected Pass STND Code and Narrative and Pass Codes and Canned Narrative options.

Type of Visit to create in PCC: what you use determines the type of visit created from the encounter record you enter into BHS. Use one of the following, depending on the classification of the BHS programs at your facility.

- I (IHS)
- C (Contract)
- 6 (638 Program)
- T (Tribal)
- O (Other)
- V (VA)

- P (Compacted Program)
- U (Urban Program)

Interactive PCC Link?: use Y or N. The BHS site parameters contain a question about an interactive PCC link to address an issue with the PIMS Scheduling package. Because it is possible to set up a clinic in the Scheduling package that initiates a PCC record at check in, some sites were creating two separate records for each individual patient encounter in the behavioral health clinics. If you leave the field blank, this is the same as using N (for this prompt) and the interactive link will not be turned on.

In the Scheduling package, if the clinic set-up response is YES to the question about creating an encounter at check in, then the Interactive PCC Link question in the BHS site parameters must also be answered YES. If the clinic set up in the Scheduling package has a negative response, then the Interactive Link question in BHS should be set to NO.

Note: There should never be a mismatched response where one package has YES and the other NO.

Allow PCC Problem List Update?: use Y or N to allow the ability to update a patient's PCC problem list from within BHS.

Update PCC LINK Exceptions?: (Figure 14-6) use Y or N to determine if you want to set data passing parameters for individuals that are different from the program default.

Provider Name	Type of PCC Link for this Provider
SIGMA, LORRAINE	NO LINK ACTIVE
CZZ, BILL	PASS CODE AND STND NARRATIVE
DELTA, GREG	PASS STND CODE AND NARRATIVE
MBETAA, MARY	PASS ALL DATA AS ENTERED

Figure 14-6: Setting up PCC link exceptions

Below are the fields on the update window.

Turn Off EHR to BH Link?

Use Y or N. A site parameter was created to give sites the ability to “opt out” of the new behavioral health (BH) Electronic Health Record (EHR) visit functionality. This functionality allows BH providers to enter a visit into the EHR that passes first to PCC and then to the behavioral health database (AMH). These visits display in the EHR as well as the BH applications, BHS v4.0 and the RPMS Behavioral Health System v4.0 GUI.

The name of the site parameter is “Turn Off EHR to BH Link” and it is accessed via the BHS v4.0 Manager Utilities module SITE menu option. The default

setting on this new site parameter is “NO” and no action is required if sites will be deploying the BH EHR functionality. If sites will not be deploying the BH EHR visit functionality, then the site parameter should be changed to “YES.”

Turn on PCC Coding Queue?

Use Y (yes) or N (no).

- If you use Y, the visits will not be passed directly to the billing package. The visits will be marked as incomplete and must be reviewed by local data entry staff, billers, or coders.
- If you use N, all visits will continue to pass to PCC as complete.

Because the visits entered in the behavioral health system have always been marked as complete, the visits were going through PCC to the claims generator without review. With this version of the software, sites are given the option of transmission to the Coding Queue or continuing to send visits to PCC marked as complete.

In addition to establishing an option on the site parameters’ menu to turn on the Coding Queue, an option that can be placed on data entry staff’s RPMS menu has been created. Because the SOAP/Progress Notes related to visits created in BHS do not pass to PCC, the data entry staff, billers, and/or coders needed some method to access the notes for review. The option will allow them to review the specifics for a particular visit but will not give them full access to BHS. For example, they will not be able to view treatment plans, case status information, or the Suicide Reporting Forms.

Turning on the link to the Coding Queue in the Behavioral Health System should not be done if the PCC Coding Queue has not been activated. However, if the PCC Coding Queue has been activated and the site wants the BHS-generated visits to be reviewed, complete the following steps:

- a. Log in to BHS v4.0 and select the Manager Utilities menu.
- b. Select the Site Parameters option and enter the name of the site you want to update.
- c. On the site parameters entry window, scroll down to the “Turn on PCC Coding Queue” field.
- d. Use Y at this field.
- e. Save the changes to the site parameters.

Once the coding queue option has been turned on and the changes to the site parameters are saved, any visits documented in BHS v4.0 will be flagged as incomplete. Visits created the same day but before the site parameters were

changed will still be marked as complete. The date and time the visit was entered in RPMS determines the flag to be applied, not the date and time of service.

Update Provider Exceptions to E Sig?

Use Y (yes) or N (no). The electronic signature function is available on the PDE, SDE, Intake, and Group entry menus (in roll and scroll) and also available on the One Patient, All Patients, Intake, and Group entry menus (in the GUI). Only those encounter records with signed SOAP/Progress Notes will pass to PCC.

If you use Y, Figure 14-7 displays.

<p>Electronic Signature will not be activated for providers added to this list.</p> <p>PROVIDER: PROVIDER: PROVIDER: PROVIDER: PROVIDER:</p>
--

Figure 14-7: Place to list provider exceptions to electronic signature

Populate the PROVIDER field with the name of provider with exception to electronic signature.

Because some sites might still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a particular provider should be exempted from the electronic signature, those visits will pass to PCC but show up as unsigned on the visit entry display.

Update those allowed to see all records?

Use Y or N to determine if you want to update those allowed to see all records.

- If the user's name is added to this list, the user will be able to see all records entered into the system, whether the user was the provider of the visit or not, or whether the provider created the record or not.
- If the user's name is not added to this list, only those encounter records the user created or those on which the user was a provider will be visible to that user.

The Help prompt has been updated and provides the following information when the user types in a question mark (?): "If users need to see records other than their own, their names should be added to this list. Type a Y to update the list."

If you use Y, Figure 14-8 displays. You can add another user to the list. This new user will be able to see all visits when using the SDE or PDE options.

Enter only those users who should be permitted to see all Visit and Intake records for all patients whether they were the provider of record or the user who entered the record or not. Users not entered on this list will see only those Visits or Intake records that they entered or for which they were the provider of record. This parameter applies to the SDE menu option and all other options that display Visit and Intake information.

```
+THETA, SHIRLEY
PHI, LISA M
RHO, SUSAN P
ALPHA, WENDY
```

Figure 14-8: List of names allowed to see all records

Update those allowed to override delete?

Use Y or N to determine if you want to update those allowed to override delete.

If you use Y, Figure 14-9 displays. You can add another name to the list.

Enter only those users who should be permitted to delete any Intake document, signed or unsigned, whether they are the user who entered the Intake document or the provider of record.

```
THETA, MARK
CHI, RONALD D SR
NU, KAREN
```

Figure 14-9: List of names allowed to delete any Intake document

Update those allowed to share visits?

Use Y or N to update those allowed to share visit information via RPMS mail message.

If you use Y, Figure 14-10 displays. Here you can add a new name at the “User allowed to share visits via mail” prompt. All users permitted to share visit information via RPMS mail messages should be entered here.

Entering users into this field will give them access to send a copy of a completed encounter form (either full or suppressed) to other RPMS users. Keep confidentiality issues in mind when deciding on who should be given this access.

```
User allowed to share visits via mail: BETA, BJ
User allowed to share visits via mail: ALPHA, WENDY
User allowed to share visits via mail: GAMMA, RYAN
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
```


Figure 14-10: Sample pop-up to enter user names allowed to share visits via mail

Update those allowed to order Labs?

Use Y or N to permit those allowed to order lab tests.

If you use Y, Figure 14-11 displays. Here you can add a new name at the “User Permitted to Order Labs” prompt. All users permitted to order lab tests should be entered here.

```
The users that you enter into this field will be given access to
order LAB tests through the SEND PATIENT option.
If a user is not entered here he/she will not be granted access to the
LAB SEND PATIENT option.
```

```
User Permitted to Order Labs:
User Permitted to Order Labs:
User Permitted to Order Labs:
```

Figure 14-11: Pop-up to enter user names allowed to order labs

If you are using the RPMS Pharmacy System, enter the Division

Specify the name of the division for the RPMS Pharmacy System.

14.2 Export Utility Menu (EXPT)

Use the EXPT option to access the options on the Export Utility Menu (Figure 14-12).

```

                                DEMO INDIAN HOSPITAL

GEN      Generate BH Transactions for HQ
DISP     Display a Log Entry
PRNT     Print Export Log
RGEN     Re-generate Transactions
RSET     Re-set Data Export Log
CHK      Check Records Before Export
EDR      Re-Export BH Data in a Date Range
ERRS     Print Error List for Export
OUTP     Create OUTPUT File
SAE      Set Automated Export Option

Select Export Utility Menu Option:
```

Figure 14-12: Options on the Export Utility Menu

Use the options on this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes.

Important: This set of utilities should only be accessed and used by the site manager, the BH program manager, or designee.

These options should be familiar to site managers and other RPMS staff who generate exports. The recommended sequence for their use follows those from PCC- CHK, clean, GEN, DISP, ERRS, transmit. RGEN, RSET and OUTP should be reserved for expert use as required.

14.2.1 Generate BH Transactions for HQ (GEN)

Use the GEN option to generate BHS transactions to be sent to HQ. The transactions are for records posted between a specified date range.

The transactions are for records posted since the last time you did an export up until yesterday. Both BH visit records and Suicide forms will be exported.

You can “^” out at any prompt and the application will ask you to confirm your entries prior to generating transactions.

Figure 14-13 displays.

```
The inclusive dates for this run are DEC 28,2008 through APR 18,2009.
The location for this run is DEMO INDIAN HOSPITAL.
Do you want to continue? N//
```

Figure 14-13: Sample information before continuing

Do you want to continue?

Use Y or N. If you use N, you return to the Export Utility menu. If you use Y, the prompts continue.

Do you want to QUEUE this to run at a later time?

Use Y or N. If you use Y, the generation will be put in the queue. If you use N, the generate process continues. The BH export generally takes less than five minutes to generate. It will still tie up your computer while doing the export (but it is quick). Figure 14-14 shows a sample.

```
Enter beginning date for this run:  SEP 1, 2008

The inclusive dates for this run are  SEP 1, 2008  THROUGH  SEP 30, 2008
The location for this run is the _____HOSPITAL/CLINIC.

Do you want to continue (Y/N)  N// Y

Generating transactions.      Counting records      ( * 100*      )

*100* Transactions were generated.
Updating log entry.
```

```
Deleting cross reference entries (100)
RUN TIME (H.M.S): 0.3.56
```

Figure 14-14: Sample information for generating the new log entry

14.2.2 Display a Log Entry (DISP)

Use the DISP option to display the extract log information in a specified date range.

Select MHSS EXTRACT LOG BEGINNING DATE

Specify the extract log beginning date. (You can view the extract date by using ? at this prompt.)

DEVICE

Select the device to output the log information.

Figure 14-15 shows the extract log information.

```
NUMBER: 2                      BEGINNING DATE: SEP 1, 2008
ENDING DATE: SEP 30, 2008@10:26:49
RUN STOP DATE/TIME: OCT 2, 1994@10:30:51
COUNT OF ERRORS: 2           COUNT OF TRANSACTIONS: 98
COUNT OF RECORDS PROCESSED: 100      RUN LOCATION: _____
# ADDS: 97                     # MODS: 1
# DELETES: 0
TRANSMISSION STATUS: SUCCESSFULLY COMPLETED
```

Figure 14-15: Sample extract log information

14.2.3 Print Export Log (PRNT)

Use the PRNT option to display the export extract log report.

The application displays the previous selection beginning date.

START WITH BEGINNING DATE

Press Enter to accept the default date. Otherwise, specify the first beginning date of the date range.

GO TO BEGINNING DATE

Press Enter to accept to default date. Otherwise, specify the next beginning date.

DEVICE

Specify the device to print/browse the log.

The application displays the Mental Health/Social Service Export Extract Log (Figure 14-16).

```

*****MENTAL HEALTH/SOCIAL SERVICES*****
***EXPORT EXTRACT LOG***
PAGE: 1
REPORT DATE: 04/20/09
=====
      ADDS      DEL      MODS      TRANS      ERROR      RECORD
=====
3  10/24/06  12/21/06                39      10      45
   10/24/06  12/21/06
4  12/20/06  05/14/07                256     34     278
   12/20/06  05/14/07
5  05/13/07  08/22/07                128     55     181
   05/13/07  08/22/07
6  08/21/07  10/03/08                537     77     595
   08/21/07  10/03/08
7  10/02/08  11/17/08                 21      4      17
   10/02/08  11/17/08
8  11/16/08  12/10/08                185     12     180
   11/16/08  12/10/08
9  12/09/08  12/29/08                 33      0      33
   12/09/08  12/29/08
=====
TOTAL                0          0          0        1199     192     1329

```

Figure 14-16: Sample export extract log

14.2.4 Re-generate Transactions (RGEN)

Use the RGEN option to re-generate transactions between two dates.

Warning: Do not use this option if you are not an expert user.

Below are the prompts.

Select MHSS EXTRACT LOG BEGINNING DATE

Specify the beginning date.

If you specified an existing date, Figure 14-17 displays.

```

Log entry 6 was for date range MAR 2, 2007 through JUN 16, 2007
And generated 44 transactions from 67 records.

This routine will generate      transactions.

Do you want to regenerate the transactions for this run? N//

```

Figure 14-17: Sample information about re-generate transactions

14.2.5 Re-set Data Export Log (RSET)

Use the RSET option to reset the BH Data Transmission Log. You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place!

The BH Data Transmission log entry you choose will be REMOVED from the log file and all Utility and Data globals associated with that run will be killed!!

You must now select the Log Entry to be reset. <Select carefully>

The BH Data Transmission log entry you choose will be *removed* from the log file and all Utility and Data globals associated with that run will be killed.

14.2.6 Check Records Before Export (CHK)

Use the CHK option to review all records that were posted to the BH database since that last export was done. It will review all records that were posted from the day after the last date of that run up until 2 days ago.

Figure 14-18 shows the BH Export Record Review report.

DEMO INDIAN HOSPITAL						Page 1
BH EXPORT RECORD REVIEW						
Record Posting Dates: APR 19, 2009 and APR 20, 2009						
RECORD DATE	PATIENT	HRN	PGM	TYPE	ACT	TYPE
APR 20, 2009@09:44	ALPHA, CHELSEA MARIE	116431	S	OUTPATIENT	16	
E023-NO AFFILIATION FOR PROVIDER						
APR 20, 2009@09:51	DUCK, EDWIN RAY	105321	S	OUTPATIENT	85	
E023-NO AFFILIATION FOR PROVIDER						
APR 20, 2009@10:46	DUCK, EDWIN RAY	105321	S	OUTPATIENT	85	
E023-NO AFFILIATION FOR PROVIDER						
APR 20, 2009@10:56	SIGMA, SERGIO	206293	S	OUTPATIENT	15	
E023-NO AFFILIATION FOR PROVIDER						
RUN TIME (H.M.S): 0.0.0						
End of report. PRESS ENTER:						

Figure 14-18: Sample report about records before export

14.2.7 Print Error List for Export (ERRS)

Use the ERRS option to print/browse the report that shows all records that have been posted to the database and are still in error AFTER the latest Export/Generation.

If the records are listed here, they aren't passing to PCC and the billing package.

Below are the prompts.

Select MHSS EXTRACT LOG BEGINNING DATE

Specify the extract log beginning date. (You can view the extract date by using ? at this prompt.)

Note: The Check Records before Export option should have been used to determine all errors before running the generation. You can now correct these remaining errors before the next export/generation.

DEVICE

Specify the device to print/browse the report.

Figure 14-19 shows the MHSS Extract Log Error Report.

MHSS EXTRACT LOG ERROR REPORT				APR 20, 2009	13:15	PAGE 1
VISIT DATE	PATIENT	HRN	PGM	TYPE	ACT	TYPE

AUG 21, 2006 17:44	ALPHAAA, STEVEN ALLAN	165583	S	OUTPATIENT		31
ERROR: E021-NO PURPOSE OF VISIT						
68,1700						
ERROR: E023-NO AFFILIATION FOR PROVIDER						
Press ENTER to Continue:						

Figure 14-19: Sample MHSS Extract Log Error Report

14.2.8 Create OUTPUT File (OUTP)

Use the OUTP option to create an output file. Consult with the site manager on how to create an RPMS export.

14.2.9 Set Automated Export Option (SAE)

These options control the destination of the BHSX Export once it is generated. If no selection is made the application comes set with option 1 Automatically Send Export to HQ.

Select HSS SITE Parameters

Use the site parameter to set the destination for the export file.

Auto Export Option

Use one of the following: 1 Automatically Send Export to HQ, 2 Automatically Send Export to Area, 3 Automatically Send Export to Both Area and HQ, 4 Do Not Automatically Send Exports

14.3 Re-Set Patient Flag Field Data (RPFF)

Use the RPFF option to reset all patient flag fields to null. This should be done each time you want to flag patients for a different reason. You can reset one particular flag or all flags. You may use this reset option to reassign a particular flag or all flags as needed.

Below are the prompts.

Reset which flags

Use one of the following: A (all flags) or O (one particular flag). If you use O, other prompts will display.

Are you sure you want to do this?

Use Y or N. If you use Y, Figure 14-20 shows the information:

```
Hold on... resetting data..
All done.
```

Figure 14-20: Information from the application about the reset process

14.4 Display Log of Who Edited Record (DLWE)

Use the DLWE option to display a list of who edited a BH record.

Below are the prompts.

Enter ENCOUNTER DATE

Specify the date of the encounter.

Enter LOCATION OF ENCOUNTER

If known, specify the location. Otherwise press Enter.

Enter PATIENT

Specify the name of the patient.

Figure 14-21 shows the Behavioral Health Visits for the date specified. The following examples were visits with no location and no patient.

Behavioral Health visits for Dec 10, 2015									
#	PROVIDER	LOC	COMMUNITY	ACT	CONT	PATIENT	PROB	NARRATIVE	
1	BJB	ALPHAA, CHELSEA	M	WW116431	60	16	F84.0	AUTISM SPECTRUM DISORDER	
2	BJB	ALPHAA, CHELSEA	M	WW116431	30	13	F10.24	ALCOHOL-INDUCED BIPOLAR AND	
3	BJB	ALPHAA, CHELSEA	M	WW116431	15	19	F42.	HOARDING DISORDER	

*	4	JC	ALPHAA,CHELSEA M	876543	60	13	F32.3	MAJOR DEPRESSIVE DISORDER, S
*	5	JC	ALPHAA,CHELSEA M	876543	60	13	T43.205A	ANTIDEPRESSANT DISCONTINUATI
	6	DG	ALPHAA,CHELSEA M	WW116431	11	22	F32.1	MAJOR DEPRESSIVE DISORDER, S
	7	DG	ALPHAA,CHELSEA M	WW116431	20	15	F10.259	ALCOHOL-INDUCED PSYCHOTIC DI
	8	ST	DEMO,DOROTHY ROS	WW999999	1	99	97	ADMINISTRATIVE

Which record do you want to display: (1-7):

Figure 14-21: Sample Behavioral Health Visits window

You can display the visit data for a particular record by responding the “Which record do you want to display?” prompt. Figure 14-22 shows the visit data.

MHSS RECORD LIST				APR 20,2009 11:31		PAGE 1
DATE	WHO ENTERED RECORD	LAST MOD	USER	LAST UPDATE		
CREATED	DATE/TIME EDITED	WHO EDITED				
04/10/09	BETAAAA,BJ	04/10/09	BETAAAA,BJ			
	APR 10,2009 12:01	BETAAAA,BJ				

End of report. Press enter:

Figure 14-22: Sample report about visit data of a particular record

14.5 Add/Edit Local Service Sites (ELSS)

Use the ELSS option to add/edit location service sites. If you add a new location service site, you give it a name and abbreviation. Counts of these visits can be recovered using the GEN option in Encounter Reports or ACT in the Workload reports.

Below are the prompts.

Select MHSS LOCAL SERVICE SITES

Specify a new or existing local service site. Specify a new service site using 3-30 characters.

If you specify a new service site, the application confirms that you are adding this new service site (use Y or N); if you use N, the above prompt repeats.

If you specify an existing factor, for example, HEADSTART, the application displays the following prompt:

LOCAL SERVICE SITE: HEADSTART//

You can accept the existing service site by pressing Enter. Otherwise, you can give it a new service site name.

ABBREVIATION: HEAD

You can accept the abbreviation of the existing service site by pressing Enter. Otherwise, you can give it another abbreviation.

14.6 Add Personal History Factors to Table (EPHX)

Use the EPHX option to add personal history factors to the four-item list initially identified for use in BHS programs. Added items will be shown as items in the Personal History field any place this option exists in a Select or Print field in the GEN reports.

Below are the prompts.

Enter a PERSONAL HISTORY FACTOR

Specify a new or existing personal history factor. If you use a new factor, using 3-30 characters, with no numeric or starting with punctuation.

If you specify a new factor, the application confirms that you are adding this new factor (use Y or N); if you use N, the above prompt repeats.

If you specify an existing factor, for example, FAS, the application displays the following prompt:

FACTOR: FAS//

You can accept the existing factor by pressing Enter. Otherwise, you can give it a new factor name.

14.7 Delete BH General Retrieval Report Definitions (DRD)

Use the DRD option to delete a PCC Visit or Patient General Retrieval report definition. This option enables the user to delete a PCC Visit or Patient General Retrieval report definition. For example, if a provider had created multiple report definitions using GEN or PGEN and saved the logic, these reports may be deleted when the provider leaves the facility.

Below are the prompts.

REPORT NAME

Specify the name of the report whose definition you want to remove. You use ? at this prompt to view a list of existing definitions.

Are you sure you want to delete the [report name] definition?

The [report name] is the name of the report you specified in the previous prompt. Use Y or N at this confirmation prompt.

14.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

Use the EEPC option to loop through all MHSS PROBLEM/DSM-5 table entries created by EHR users to change the grouping from the generic 99.9 OTHER EHR CLINICAL grouping to a more specific MHSS PROBLEM CODE grouping.

In the RPMS behavioral health applications the Purpose of Visit (POV) is recorded as either a BH Problem Code or DSM-5 code. For the purpose of reports, these codes are grouped within larger problem code groupings and then again in overarching categories. For example, DSM-5 code 311 Depressive Disorder NOS is also stored as problem code grouping 14 Depressive Disorders and problem category Psychosocial Problems.

In the RPMS EHR, the POV is recorded using ICD-9 or SNOMED codes that are mapped to ICD codes and pulled into BHS, not DSM-5 codes. Many ICD and DSM numeric codes are identical. There may be instances when a provider selects an ICD code that does not have a matching DSM code. When this occurs it will be dynamically added to the MHSS PROBLEM/DSM-5 table. Once the ICD code is in the MHSS PROBLEM/DSM-5 table, then it is accessible to users in BHS or BH GUI as well.

These ICD codes that have been added to the MHSS PROBLEM/DSM-5 table will not have been automatically assigned to the appropriate BH problem code group. To ensure that these ICD codes are captured in BHS reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time.

Below are sample prompts for a site.

CODE: V72.3

ICD Narrative: GYNECOLOGIC EXAMINATION

Enter the Problem Code Grouping

Specify the grouping code for the above Code and ICD Narrative.

The application provides you with the ^ option so that you don't have to go all the way through the entries.

14.9 Update Locations a User can See (UU)

Use the UU option to specify the location a user can view in this application.

BHS v4.0 contains a new field called the BH User that will permit a site to screen the locations that a user may access to view or enter information.

If a site wants to limit the visits by location that a BH user can access then they will enter that user into this file and list all the facilities/locations that that user is allowed to “see” or access. If an entry is made in this file for a user that user will only be able to “lookup” patients with a health record at those facilities, only patients with health records at those facilities will display on patient lists and reports, and will only be able to view/access visits to those locations. If a user is not entered into this file that person will be able to see visits to all locations. This file will only be updated if a site is multi-divisional and there is a need to restrict the viewing of data between sites.

Select BH USER NAME

Specify the user you want to use. This will add the user to the BH User file. A ScreenMan screen will pop-up and the manager can enter all of the locations that the user is able to access or “see” on the screen.

Figure 14-23 shows the Update Visit Locations a User can See window.

```

**** Update Visit Locations a User can See ****
USER: BETA,LORI

Location: DEMO INDIAN HOSPITAL
Location: SELLS HOSP
Location:
Location:
Location:

COMMAND:                                     Press <PF1>H for help   Insert

```

Figure 14-23: Sample Update Visit Locations a User can See window

Location

Specify the location that the user can view in this application.

You can specify more than one location. If this is the case, use the next Location field.

In the above example, the provider Lori Beta will only be able to access visits to Demo Indian Hospital and Sells Hospital. If a patient that she is treating had a visit to Phoenix Hospital, she would not see that visit information. This logic applies to any option that displays or reports on visit data. For example, Lori Beta chooses option “Browse Visits” she would not see any visit in the visit list that was to a location other than the two listed above.

Appendix A: Activity Codes and Definitions

BHS activity codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to report activities. However, aggregate reports can be organized by these activity categories.

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

A.1 Patient Services - Patient Always Present (P)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

01–Twelve Step Work – Group (TSG)

Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

02–Twelve Step Work - Individual (TSI)

Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

03–Twelve Step Group (TSG)

Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, CoDA (Co-dependents Anonymous).and OA (Overeaters Anonymous).

04-Re-assessment, Patient Present (RAS)

Formal assessment activities intended to reevaluate the patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

11-Screening (SCN)

Services provided to determine in a preliminary way the nature and extent of the recipient's problem in order to link him/her to the most appropriate and available resource.

12-Assessment/Evaluation (EVL)

Formal assessment activities intended to define or delineate the client/patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

13-Individual Treatment/Counseling/Education (IND)

Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

15-Information and/or Referral (REF)

Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization.

16-Medication/Medication Monitoring (MED)

Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

17-Psychological Testing (TST)

Examination and assessment of client/patient's status through the use of standardized psychological, educational, or other evaluative test. Care must be exercised to assure that the interpretations of results from such testing are consistent with the socio-cultural milieu of the client/patient.

18-Forensic Activities (FOR)

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

19-Discharge Planning (DSG)

Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

20-Family Facilitation (FAC)

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

21-Follow-through/Follow-up (FOL)

Periodic evaluative review of a specific client/patient's progress after discharge.

22-Case Management (CAS)

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to

address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination.

23-Other Patient Services not identified here (OTH)

Any other patient services not identified in this list of codes.

47-Couples Treatment (CT)

Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.

48-Crisis Intervention (CIP)

Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

85-Art Therapy (ART)

The application of a variety of art modalities (drawing, painting, clay, and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.

86-Recreation Activities (REC)

Recreation and leisure activities with the purpose of improving and maintaining clients'/patients' general health and well-being.

88-Acupuncture (ACU)

The use of the Chinese practice of Acupuncture in the treatment of addiction disorders (including withdrawal symptoms and recovery) and other behavioral health disorders.

89-Methadone Maintenance (MET)

Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed methadone maintenance agency under the supervision of a physician. Services include methadone dosing, medical care, counseling and support and disease prevention and health promotion.

90-Family Treatment (FAM)

Family-centered therapy with an emphasis on the client/patient's functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences; often brief and solution focused.

91-Group Treatment (GRP)

This form of therapy involves groups of patients/clients who have similar problems that are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

92-Adventure Based Counseling (ABC)

The use of adventure-based practice to effect a change in behaviors (both increasing function and positive action and decreasing dysfunction and negative action) as it relates to health and/or mental health.

93–Relapse Prevention (REL)

Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

- Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
- Strategies for avoiding high-risk situations
- Strategies for coping with high-risk situations when encountered
- Strategies for coping with alcohol/drug cravings
- Strategies for coping with lapses to drug use to prevent full-blown relapses

94–Life Skills Training (LST)

Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

95–Cultural Activities - Pt. Present (CUL)

Participation in educational, social, or recreational activities for the purpose of supporting a client/patient's involvement, connection, and contribution to the patient's cultural background.

96–Academic Services (ACA)

Provision of alternative schooling under the guidelines of the state education program.

97–Health Promotion (HPR)

Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

A.2 Support Services - Patient Not Present (S)

Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

05-Re-assessment, Patient Not Present

Reassessment or reevaluation activities when patient is not present at time of service delivery.

24-Material/Basic Support (SUP)

Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

25-Information and/or Referral (INF)

Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization

26-Medication/Medication Monitoring (MEA)

Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

27-Forensic Activities (FOA)

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

28-Discharge Planning (DSA)

Collaborative service planning with other community caregivers to develop a goal oriented follow-up plan for a specific client/patient.

29-Family Facilitation (FAA)

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

30-Follow-up/Follow-through (FUA)

Periodic evaluative review of a specific client/patient's progress after discharge.

31-Case Management (CAA)

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

33-Technical Assistance

Task-specific assistance to achieve an identified end.

34-Other Support Services

Any other ancillary, adjunctive, or collateral services not identified here.

44-Screening

Activities associated with patient/client screening where no information is added to the patient/client's file.

45-Assessment/Evaluation

Assessment or evaluation activities when patient is not present at time of service delivery.

49-Crisis Intervention (CIA)

Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes:

35-Collaboration

Collaborative effort with other agency or agencies to address a community request.

36-Community Development

Planning and development efforts focused on identifying community issues and methods of addressing these needs.

37-Preventive Services

Activity, class, project, public service announcement, or other activity whose primary purpose is to prevent the use/abuse of alcohol or other substances and/or improve lifestyles, health, image, etc.

38-Patient Transport

Transportation of a client to or from an activity or placement, such as a medical appointment, program activity, or from home.

39-Other Community Services

Any other form of community services not identified here.

40-Referral

Referral of a client to another agency, counselor, or resource for services not available or provided by the referring agency/program. Referral is limited to providing the client with information and might extend to calling and setting up appointments for the client.

87-Outreach

Activities designed to locate and educate potential clients and motivate them to enter and accept treatment.

A.4 Education Training (E)

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job related knowledge, attitudes, and skills. Includes:

- 41- Education/Training Provided
- 42- Education/Training Received
- 43- Other Education/Training

A.5 Administration (A)

Activities for the benefit of the organization and/or activities that do not fit into any of the above categories. Includes:

32-Clinical Supervision Provided

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

50-Medical Rounds (General)

On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

51-Committee Work

Participation in the activities of a body of persons delegated to consider, investigate, take action on, or report on some matter.

52-Surveys/Research

Participation in activities aimed at identification and interpretation of facts, revision of accepted theories in the light of new facts, or practical application of such new or revised theories.

53-Program Management

The practice of leading, managing, and coordinating a complex set of cross-functional activities to define, develop, and deliver client services and to achieve agency/program objectives.

54-Quality Improvement

Participation in activities focused on improving the quality and appropriateness of medical or behavioral healthcare and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

55-Supervision

Participation in activities to ensure that personnel perform their duties effectively. This code does not include clinical supervision.

56-Records/Documentation

Review of clinical information in the medical record/chart or documentation of services provided to or on behalf of the client. This does not include the time spent in service delivery.

57-Child Protective Team Activities

Participation in a multi-disciplinary child protective team to evaluate alleged maltreatments of child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance their caregiver's capacity to provide a safer environment when possible.

58-Special Projects

A specifically-assigned task or activity which is completed over a period of time and intended to achieve a particular aim.

59-Other Administrative

Any other administrative activities not identified in this section.

60-Case Staffing (General)

A regular or ad-hoc forum for the exchange of clinical experience, ideas and recommendations.

66-Clinical Supervision Received

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

A.6 Consultation (L)

Problem-oriented effort designed to impart knowledge, increase understanding and insight, and/or modify attitudes to facilitate problem resolution. Includes:

61-Provider Consultation (PRO)

Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

62-Patient Consultation (Chart Review Only) (CHT)

Focus is a specific patient and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

63-Program Consultation

Focus is a programmatic effort to address specific needs.

64-Staff Consultation

Focus is a provider or group of providers addressing a type or class of problems.

65-Community Consultation

Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

A.7 Travel (T)**71-Travel Related to Patient Care**

Staff travel to patient's home or other locations – related to provision of care. Patient is not in the vehicle.

72 Travel Not Related to Patient Care

Staff travel to meetings, community events, etc.

A.8 Placements (PL)**75-Placement (Patient Present) (OHP)**

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

76-Placement (Patient Not Present) (OHA)

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences. This activity might include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

A.9 Cultural Issues (O)**81-Traditional Specialist Consult (Patient Not Present) (TRA)**

Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

82-Traditional Specialist Consult (Patient Not Present) (TRA)

Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

83-Tribal Functions

Services offered during or in the context of a traditional tribal event, function, or affair—secular or religious. Community members gather to help and support individuals and families in need.

84-Cultural Education to Non-Tribal Agency/Personnel

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

Appendix B: Activity Codes that Pass to PCC

Activity Code	Description	Pass to PCC
01	Twelve Step Work – Group (TSG)	Yes
02	Twelve Step Work – Individual (TSI)	Yes
03	Twelve Step Group (TWG)	No
04	Re-Assessment, Patient Present	Yes
05	Re-Assessment, Patient Not Present	No
11	Screening – Patient Present (SCN)	Yes
12	Assessment/Evaluation – Patient Present (EVL)	Yes
13	Individual Treatment/Counsel/Education – Pt. Present (IND)	Yes
15	Information and Referral – Patient Present (REF)	Yes
16	Medication/Medication Monitoring – Pt. Present (MED)	Yes
17	Psychological Testing – Patient Present (TST)	Yes
18	Forensic Activities – Patient Present (FOR)	Yes
19	Discharge Planning – Patient Present (DSG)	Yes
20	Family Facilitation –Patient Present (FAC)	Yes
21	Follow Through/Follow Up – Patient Present (FOL)	Yes
22	Case Management – Patient Present (CAS)	Yes
23	Other Patient Services Not Identified – Patient Present (OTH)	Yes
24	Material/Basic Support – Patient Not Present (SUP)	No
25	Information and/or Referral – Patient Not Present (INF)	No
26	Medication/Medication Monitoring – Pt. Not Present (MEA)	Yes
27	Forensic Activities – Patient Not Present (FOA)	No
28	Discharge Planning – Patient Not Present (DSA)	No
29	Family Facilitation – Patient Not Present (FAA)	No
30	Follow Through/Follow Up – Patient Not Present (FUA)	No
31	Case Management – Patient Not Present (CAA)	Yes
32	Clinical Supervision Provided	No
33	Technical Assistance – Patient Not Present	No
34	Other Support Services – Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening – Patient Not Present	No
45	Assessment/Evaluation – Patient Not Present	No
47	Couples Treatment – Patient Present (CT)	Yes

Activity Code	Description	Pass to PCC
48	Crisis Intervention – Patient Present (CIP)	Yes
49	Crisis Intervention – Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes

Appendix C: DSM Copyright and Trademark Information

C.1 10.2 Copyright

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Appendix D: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: <http://security.ihs.gov/>.

The ROB listed in the following sections are specific to RPMS.

D.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

D.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

D.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

D.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

D.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

D.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

D.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

D.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

D.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

D.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

D.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

D.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

D.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

D.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

D.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

D.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Caret

The symbol ^ obtained by pressing Shift-6.

Command

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Data Elements

Data fields that are used in filling out forms in BHS.

Default Response

Many of the prompts in the BHS program contain responses that can be activated simply by pressing the Enter key. For example: “Do you really want to quit? No//.” Pressing the Enter key tells the system you do not want to quit. “No//” is considered the default response.

Device

The name of the printer to use when printing information. Home means the computer screen.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

Fileman

The database management system for RPMS.

Free Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

Frequency

The number of times a particular situation occurs in a given amount of time.

Full Screen Editor

A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

Menu

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical user interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

Security Keys

Tools used to grant/restrict access to certain applications, application features, and menus.

Site Manager

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu

A menu that is accessed through another menu.

Suicide

The act of causing one's own death.

Ideation with Intent and Plan—Serious thoughts of suicide or of taking action to take one's life with means and a specific plan

Attempt—A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

Completion—Fatal self-inflicted destructive act with explicit or inferred intent to die.

Terminal Emulator

A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor

A word processing program that entering and editing text.

Word Processing Field

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

Acronym	Term Meaning
A/SA	Alcohol and Substance Abuse
BH	Behavioral Health
BHS	Behavioral Health System
CAC	Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading of BHS and other software programs for the end users. The CAC is sometimes referred to as the application coordinator or a "super-user."
CD	Chemical Dependency
EHR	Indian Health Service RPMS Electronic Health Record
GPRA	Government Performance and Results Act; a federal law requiring federal agencies to demonstrate through annual reporting that they are using appropriated funds effectively to meet their Agency's missions.
GUI	Graphic User Interface, a Windows-like interface with drop-down menus, text boxes icons, and other controls that supports data entry using a combination of the computer mouse and keyboard.
HRCN	Health Record Chart Number
IHS	Indian Health Service
MH	Mental Health
IHS	Indian Health Service
RPMS	Resource and Patient Management System

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

Web: <http://www.ihs.gov/helpdesk/>

Email: support@ihs.gov