RESOURCE AND PATIENT MANAGEMENT SYSTEM

RPMS Behavioral Health System

(AMH)

User Manual

Version 4.0
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Office of Information Technology (OIT)
Division of Information Resource Management
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Preface

The Resource and Patient Management System (RPMS) Behavioral Health System (BHS) (namespace: AMH) v4.0 project was established by the Indian Health Service (IHS) Office of Information Technology (OIT) at the direction of the application business owners, the Division of Behavioral Health, to modify and update the legacy behavioral health (BH) application, AMH v3.0, to meet the changing health information system needs of BH providers. The new Behavioral Health System (BHS) version 4.0 includes a number of enhancements over v3.0 as requested by end users, and also a new Graphical User Interface (GUI), which will replace the previous BH GUI component in the IHS Patient Chart (BPC) application.

Many BH providers colocated at facilities that have deployed the RPMS Electronic Health Record (EHR) have transitioned to the EHR to document their services and support clinical care. However, a large number of BH providers are located at facilities that do not use the EHR. For these providers, BHS v4.0 can be utilized as a "standalone" yet integrated health information system. BHS v4.0 can also be utilized in combination with the EHR.

The BHS v4.0 is integrated with the RPMS suite of clinical and business office applications including the registration module for patient information and the Patient Care Component (PCC) for medical information. The PCC is the clinical repository for RPMS. While AMH does not require that PCC be operational in a specific site, it is dependent on the registration module, and it is strongly recommended that AMH be implemented as a complement to the PCC in order to take advantage of the other components of the RPMS that use the PCC. The link from AMH to the PCC can be modified at the facility level to accommodate local business practices and preferences.

The RPMS BHS is a discipline specific clinical subcomponent of RPMS that supports the documentation of individual and group BH encounters, intake information, treatment plans, case management information, administrative and community activities, and incidents of suicide.

The system captures and stores two basic kinds of information in a BHS data file: (1) clinical information about specific patients (stored in the BHS file in Diagnostic & Statistical Manual for Mental Disorders [DSM-IV] diagnostic terms or International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] V-Codes that are passed to PCC in ICD-9-CM Diagnostic format), and (2) information about both the clinical and nonclinical activities of providers, including Administrative Activities and Community Activities.

Confidentiality and privacy of protected health information is of particular concern to BH providers. Only BH providers should be given access to the BHS. Local program staff can control the specificity of clinical information that passes to the PCC. Sensitive issues can be masked to preclude inadvertent disclosure without significant loss of data for continuity of care, program management, and billing purposes. Different options can be selected to tailor an individual provider's reporting requirements when they differ from the rest of the program staff; however, it should be noted that the Data Link to PCC Option 3 has been removed. Facilities currently using AMH v3.0 with the Data Link to PCC Option 3 are advised instead to use the Data Link to PCC Options 4 or 5. Any RPMS server determined to have PCC Link Option 3 selected at the time of installation of BHS v4.0 will automatically be changed to PCC Link Option 5.

An option for recording formal Treatment Plan information is also available. Providers can store Treatment Plan data in the BHS patient file and generate a hard copy of the plan, including a routine review component, to meet clinical standards of care and quality assurance requirements.

Locally, BHS program staff can generate a BHS health summary for an identified patient that uses data from the BHS data file, the PCC data file, the Pharmacy data file, and the Registration file.

A very powerful set of standard and ad-hoc report writers, which use the BHS data file, data elements from the PCC and the Registration file, is available for local use.

On a regularly scheduled basis, BHS program staff will forward statistical extracts of site-specific data to Headquarters and merge the data into a service-wide data file that will serve as the aggregate common database for both IHS and Tribal programs using the system. Both Area Office and local programs will have access to these files using the standard IHS protocols.

In addition to providing more precise information to the local clinical staff involved in managing these conditions and linking these program services to the billing modules driven by PCC, the system captures the kinds of management-level data which has become particularly important for local, Service Unit, and area-wide accountability.

Aggregate national BHS data is routinely mined by the IHS Division of Behavioral Health to report on service population prevalence data and services provided, advocate for continued and enhanced services, and inform the development of prevention initiatives.

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1.0   Introduction

Behavioral and social problems, often related to or exacerbated by substance abuse, mental illness, and acute or chronic medical illness are common. However, it is often difficult to demonstrate the magnitude of the problem and the resources utilized in meeting the needs of patients with behavioral health (BH) problems beyond anecdotal evidence. In addition, it is often difficult to track and provide appropriate follow-up care to patients with behavioral problems.

The Behavioral Health System (BHS) is a module of the Resource and Patient Management System (RPMS) designed specifically for recording and tracking patient care related to BH. Version 4.0 combines the software functionality of the BHS Version 3.0 with the ability to electronically sign encounter records, the option to pass all behavioral health encounter records to the coding queue, and several other new data elements. The entire software package supports real-time data entry by BH providers for patient care and program management.

This software provides:

- Opportunities for improved patient outcome and continuity of care

- Standardized record-keeping

- Tools to meet regulatory and accreditation agency requirements

- Enhanced provider communication

- Optimized billing capture

- Report generation for epidemiology, program management, program planning, and justification for increased funding and staffing

- Assistance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), and Government Performance Reporting Act (GPRA) compliance standards

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

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

- **Reports Menu**: Use the Reports menu for tracking and managing patient, provider, and program statistics.

- **Manager Utilities Menu**: Use the Manager Utilities menu for setting site-specific parameters related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and Headquarters East (HQE) for mandated federal reporting and funding.

1.1   Primary Menu

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

```
                    ***********************************************
                    **       IHS Behavioral Health System      **
                    ***********************************************
                                   Version 4.0

                              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 BH 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 BH 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.

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
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 BHS and the RPMS BHS 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 Enter 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 one, two, or three question marks (**?**). If available, a narrative description of the expected entry or a list of choices will display.

2.1.4   To Back Out

Pressing the Shift+6 will generate the caret (^) symbol. This symbol terminates the current action and backs you out one level.

2.1.5   Exit

You can exit from RPMS at any time by typing **HALT** at a menu option prompt.

Type **RESTART** at a menu option prompt to return you to the "Access Code:" prompt.

Type **CONTINUE** at a menu option prompt to exit from RPMS and return to the same menu you were using when you signed 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 space bar and then Enter to repeat the last entry typed 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: WATERM
    1     WATERMAN,BARRY           M 05-05-1989 054270542 PIMC 101623
                                                              SE 101624
    2     WATERMAN,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 greater than and less than characters (< >) are usually displayed when a multiple page report reaches the bottom of a display screen and there are additional pages in the report. Press Enter 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 Ctrl+ C 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 if you are using a personal computer as a RPMS terminal, you cannot use the mouse to point or 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 typed at the "Select Action:" prompt to see the list of secondary options available.

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

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

?? 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:

- Type a plus sign (+) in a display that fills more than one page to see the next full screen (if you are not on the last screen).

- Type a minus sign (**-**) to display the previous screen (if you are not on the first screen). This command will only work if you have already reviewed several screens in the display.

- Press the up arrow on your keyboard to move the screen display back one line at a time.

- Press the down arrow on your keyboard to move the screen display forward one line at a time.

- Press the right arrow on your keyboard to move the screen display to the right.

- Press the left arrow on your keyboard to move the screen display to the left.

- Type **FS** in a multipage display to return to the first screen of the display.

- Type **LS** in a multipage display to go to the last screen in the display.

- Type **GO** and the page number of a multiscreen display to go directly to that screen.

- Type **RD** to redisplay the screen.

- Type **PS** to print the current screen.

- Type **PL** to print an entire single or multiscreen display (also called a list).

- Type **SL** to be prompted for a word that you wish to search for in the list. Press Enter after your word selection to be moved to the first occurrence of the word. For example, if you were several pages into a patient's Face Sheet and wanted to know the patient's age, you could type **SL**, then type **Age**, and press Enter to be moved to the age field.

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

- Type **QU** to close the screen and return to the menu.

2.3   ScreenMan (Roll-and-Scroll)

2.3.1   Using the ScreenMan Window

When using ScreenMan for entering data, press Enter to accept defaulted data values or after you enter a data value into a field. The Tab or arrow keys can be used to move between fields or bypass 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, they 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:  ALPHA,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. 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 notes that there was a secondary provider; but you must press Enter after typing **Y** to open the pop-up box and record the secondary provider information.

When you enter all data required for the patient encounter, typing **E** and pressing Enter will exit you from the screen. Type **Y** at the appropriate prompt to save your changes first.

2.3.2   Using the Pop-Up Window

When entering data in a pop-up window, press Enter to move between fields. After you have entered all the data, press Tab to move the cursor to the "Command" prompt (which has the Close option as the default). Press Enter to close the window and return to the original data entry screen.

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

Encounter Date: MAR 27,2001              User: DEMO,DOROTHY K
Patient Name: ALPHA,SALLY
----------------------------------------------------------------------

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

Pressing Enter at some data entry prompts opens a text editor screen.

```
+------------------------------------------------------------------+]
¦              ******  Enter/Edit Clinical Data Items  ******
¦ Encounter Date: MAR 27,2001          User: SMITH, STANLEY K.      ¦
¦ Patient Name:  ALPHA,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 BH system are coded entries or items selected from a table, there can be extensive text entry associated with clinical documentation, treatment plans, intake documents, etc. RPMS has two text editors: a line editor and a full-screen editor. Most users find it more convenient to use the full screen text editor.

In many ways, the full-screen text editor works just like a traditional word processor. The lines wrap automatically; the up, down, right, and left arrows move the cursor around the screen; and a combination of upper and lower case letters can be used. On the other hand, some of the conventions of a traditional word processing program do not apply to the RPMS full-screen editor. For example, the Delete key does not work. Delete text by moving one space to the right of the error and backspacing to remove the erroneous entry.

You have the option when entering a lengthy narrative to type the narrative in a traditional word processing application like Word or WordPerfect and paste the text into an 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

Figure 2-7 shows 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

You can display all of the commands available for the RPMS full screen editor by pressing the PF1 (F1) key, followed by the H key. 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:  ALPHA,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

When you have entered data for all desired fields, you can save the data and exit the the data entry screen by typing **E** followed by **S** when the cursor rests at the "Command:" prompt. Or, if the cursor is not at the "Command:" prompt, you can press the F1 key and then 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

Can be changed to the full screen editor, as follows:

1. At any menu prompt, use TBOX. ToolBox is a secondary menu option that all users have 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: Changing the Text Editor, Step 1

2. Select the "Edit User Characteristics" option from the list of TBOX menu options 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. Type **S** and press Enter to save your changes. Type **E** and press Enter to exit the screen. The Edit User Characteristics screen and fields are shown in the following example.

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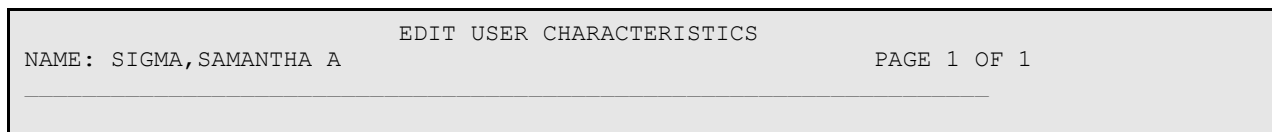
```
                INITIAL: SAS                              PHONE:
               NICK NAME:                          OFFICE PHONE:
                                                    VOICE PAGER:
                                                  DIGITAL PAGER:


    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
```

Figure 2-11: Changing the Text Editor, Steps 1–4

> **Note**:   See Section 2.4 for more information on using the full-
>   screen text editor.

2.6   Pop-Up Windows (GUI)

The application displays pop-up windows that have the same functional controls.
These are usually Crystal Report windows (such as the Health Summary).

Below is a sample pop-up window.
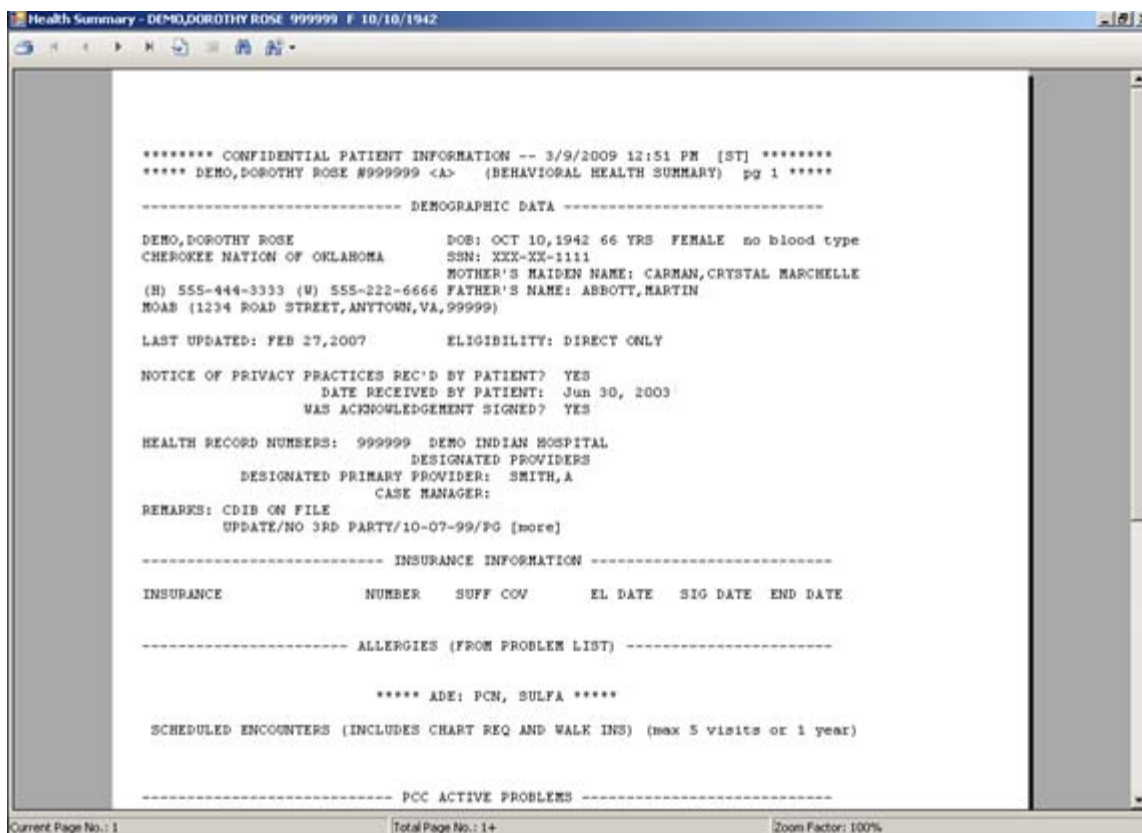
Figure 2-12: Sample pop-up window

You can scroll through the text on the current page by doing one of the following:

- Use the scroll bars.

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

The pop-up window only displays the first page (when you first access the window). If there is more than one page, you must use the Next Page and Last Page buttons to move to that page, or press the Page Down and Page Up buttons on your keyboard. See Section 2.6.2.2 for more information.

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 sections describes the functions of the various buttons on the toolbar.

2.6.2.1   Print Button

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

2.6.2.2   Move To Page Buttons

The Move To Page ⏮ ◀ ▶ ⏭ buttons provides the means of going to adjacent pages in the text of the window.

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

2.6.2.3   Go To Page Button

The Go To Page 🔖 button displays the Go to Page dialog box, where you can specify the desired page number.

2.6.2.4   Find Text

Click the Find Text 🔍 button to access the Find Text dialog box.

Figure 2-13: Find Text dialog box

Use the Find what field to type the text you want to find in the window. To search for the text string, click the Find Next button. The application searches the window for the text string and highlights 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 informing you that the application has finished searching the document. Click OK to close the information message. You are then returned to the Find Text dialog box (where you can specify another text string).

Click Cancel to dismiss the Find Text dialog box.

2.6.2.5   Zoom Button

Click the Zoom 🔍 button to increase the size of the text of the window (for easier reading, for example). This setting does not affect the output of the window.

2.7   Using the Calendar (GUI)

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

Figure 2-14: Sample Calendar for Date Field

The calendar always indicates the current date.

You can select another date by clicking on it; the selected date will display in the Date field.

Use the left or right arrow key to move from the current month to the next month.

If you right-click on the Month label, you can select Go to Today to return the displayed date (in the field) to the current date.

2.7.1   Changing the Month

You can select from another month's dates by clicking the appropriate arrow button (more than once, if needed).

If you left-click on the Month label, the application displays a list from which you can select another month.

January
February
March
April
May
June
July
August
September
October
November
December

Figure 2-15: List of months to select

2.7.2   Changing the Year

If you click on the Year label, the application displays up and down arrow buttons that you can click to change the year.

2008

Figure 2-16: Changing the year

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 2-17: 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.

Search String. Use this text box to type a few characters of the search criteria. Click Search to display the retrieved records in the Community group box. Select a record and click OK to populate the appropriate field on the open form.

Another way to populate the field is to select a record in the Most Recently Selected group 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 Axis I group box of the POV tab field accesses this type of window.
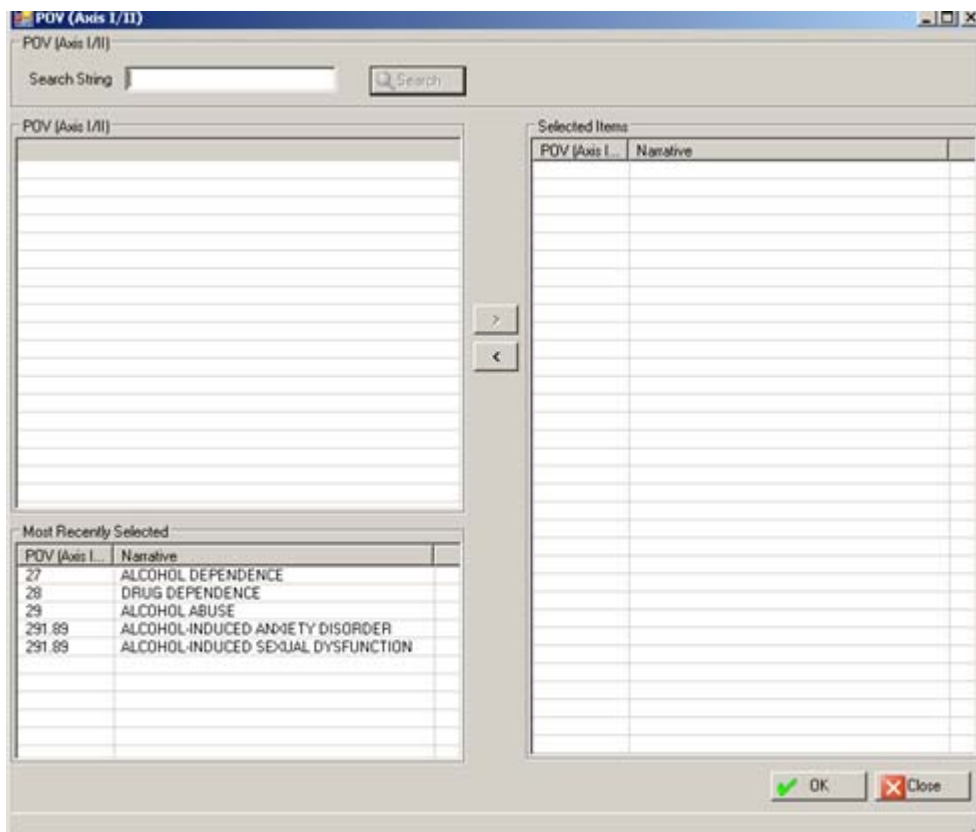
Figure 2-18: Sample Search/Select window

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 Axis I group box.

Search String. Type a few characters of the search criteria and then click Search. The application retrieves the records in the POV (Axis I/II) group box.

You can add one or more records from the Most Recently group box to the Selected Items group box by clicking the right arrow button.

You can add one or more records from the POV (Axis I/II) group box to the Selected Items group box by clicking the right arrow button.

Similarly, you can remove one or more records from the Selected Items group box by clicking the left arrow button.

When you have the records you want in the Selected Item group box, click OK. This adds the data to the Axis I group box.

2.10   Using Multiple Select Windows (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.
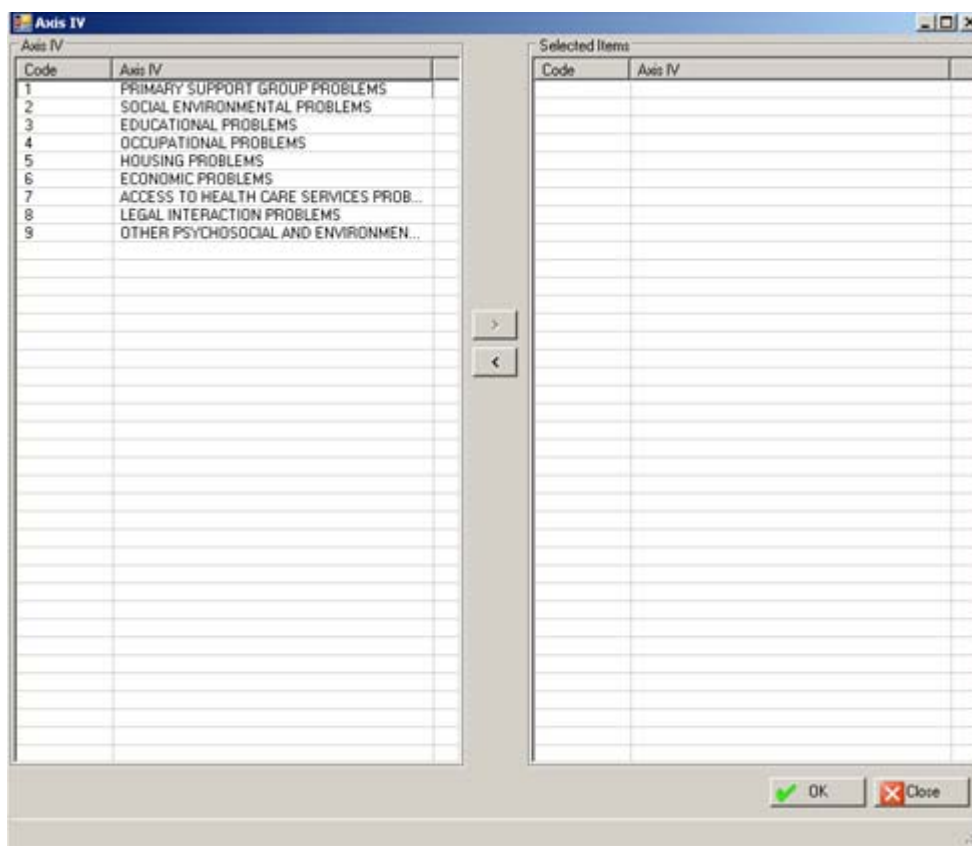
Figure 2-19: Sample AXIS IV multiple select window

Use the Close button to dismiss the window.

To add one or more Axis IV codes to the Selected Items group box, click the right arrow. (Select more than one code by holding down the Ctrl key and selecting the next code.)

Similarly, to move records from the Selected Items group box to the Axis IV group box, click the left arrow.

When you have the records you want in the Selected Item group box, click OK. This adds the codes to the Axis IV group box on the POV tab of the Visit Data Entry window.

2.11   Free Text fields (GUI)

Information is typed into Free Text fields. These fields do not include drop-down lists of options.

An example of the Free Text field is the Axis III field on the POV tab of the Visit Data Entry dialog box.

There is a context menu to aid in editing the text.
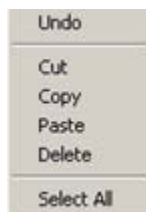
Figure 2-20: Context menu to aid in editing text

These options operate similarly to those in any Windows application. The options include:

Undo. Allows you to remove 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.

> **Hint**:   If you have a long Free Text field, you could type the contents of the field in a word processing application; here you could 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 BHS (GUI).

2.12.1   Patient Selection (Roll-and-Scroll)

You are prompted to select a patient at the "Select Patient" prompt. Use a few characters of the patient's last name (at least three), Social Security Number (SSN), Health Record Number (HRN), or date of birth (DOB) (use format MM/DD/YYYY). Note that other date formats cannot be used, such as 010109.

2.12.2   Patient Selection (GUI)

Select a patient in the following circumstances:

- When no patient has been selected and you selected the "One Patient" option (such as under Visit Encounters)

- To select a different patient, use the Patient Lookup Selection menu option or right-click on the menu tree.

In either case, the application displays the Select Patient window.
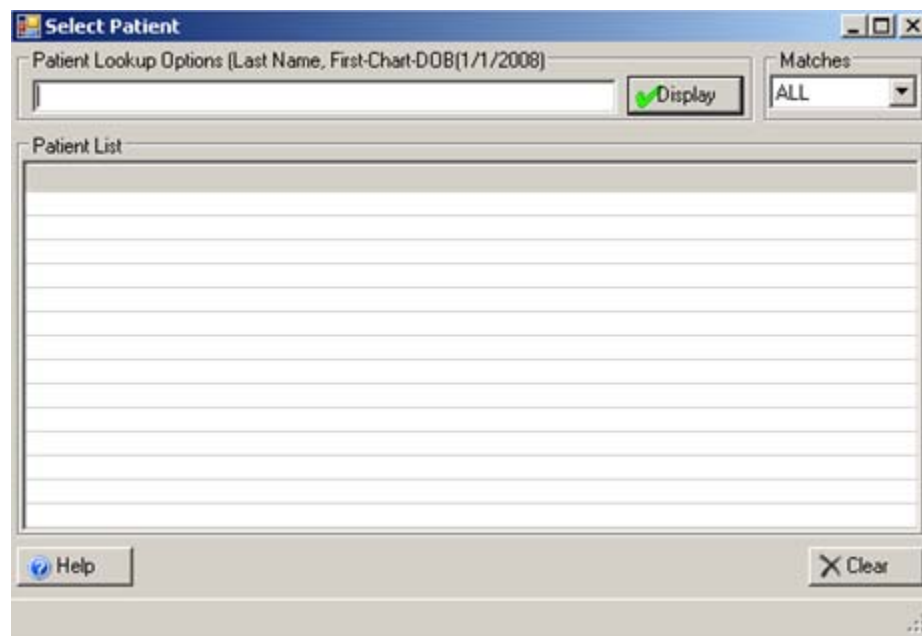
Figure 2-21: Select Patient window

Use the Help button to access the online help for this window.

Use the Clear button to remove all data from the Patient List group box and from the Patient Lookup Options field.

Use a few characters of the patient's last name (at least three), SSN, HRN, or date of birth (use format MM/DD/YYYY) in the Patient field. You can determine the number of matches by selecting an option from the Matches drop-down list (the default is All). Then click Display.

The application retrieves the valid candidates and displays them in the Patient List group box. If there are no candidates, the group box remains empty.
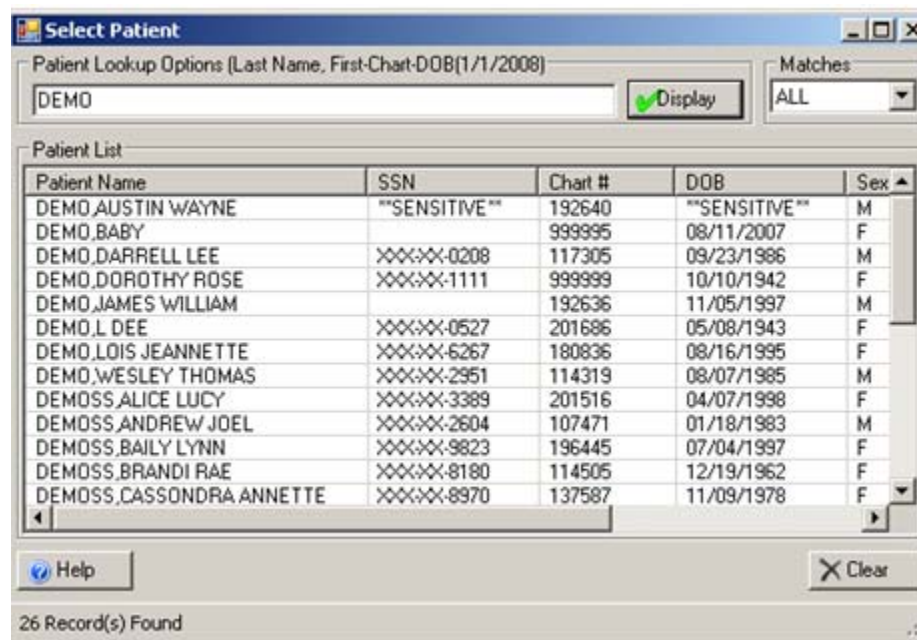
Figure 2-22: Sample Select Patient window

Use the scroll bars to scroll through the retrieved names. Double-click the patient record you want to use. The selected patient record becomes the active patient record.

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 record flagged as Sensitive will track access to the patient's record. In addition, warning messages will be displayed when staff (not holding special keys) accesses these records. If an individual chooses to continue accessing the record, a bulletin is sent to a designated mail group. For further information on Sensitive Patient Tracking, please see 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 in the Select Patient window.
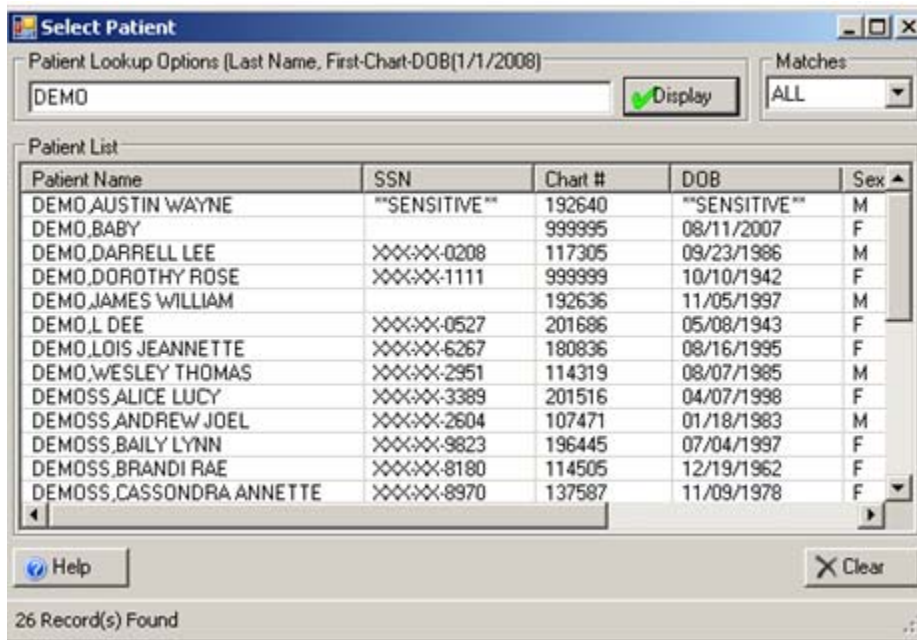
Figure 2-23: Sample Select Patient window showing sensitive patient

Below is the warning message an unauthorized individual will receive while in the GUI.

Figure 2-24: Warning message displayed in GUI

Click Yes to access the patient's record. (Otherwise, click No. You will be returned to the Select Patient window.)

There are two types of messages in the roll-and-scroll application.

Below is the longer warning message.

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

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

Figure 2-25: Warning message about restricted record in roll-and-scroll application

Below is the shorter warning message.

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

Figure 2-26: Shorter warning message in roll-and-scroll application

After you press Enter, you access the patient's record. If you type a caret (**^**), you will 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 to the GUI. Use the electronic signature to sign a SOAP/Progress note, Intake document, and Update document.

2.14.1   Creating Your Electronic Signature

Use the User's Toolbox option in RPMS to setup your own electronic signature. Use the option in bold (Electronic Signature Code Edit).

```
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 2-27: Options in the TBOX User's Toolbox

Prompts will appear for the electronic signature on Text Integration Utility (TIU) 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 credential.

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

Figure 2-28: Prompts that display at the beginning of the process

If the following prompt appears in RPMS, it means you already have an electronic signature code.

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

Figure 2-29: Prompt to enter your current electronic signature

If the following prompt appears in RPMS, you can enter a new code.

```
Enter code:
```

Figure 2-30: Prompt for a new code

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), the code can be in lower case. (No special characters are allowed in the code.)

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 the Version 4.0 install date. In this case, you would receive 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 DOCTOR
Signed: 05/14/2009  13:25
```

Figure 2-31: 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.

- If the current user is the primary provider and is trying to edit/enter the record, that person is permitted to electronically sign the SOAP/Progress Note.

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

2.14.5   Signing a Note (GUI)

If you have entered a SOAP/progress note, the application displays the Sign? dialog box.
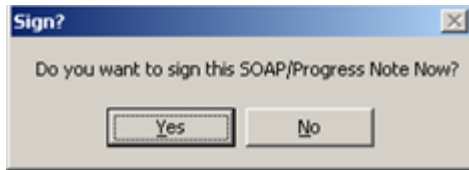
Figure 2-32: Sign dialog box

If you click No, the encounter record is saved without a signature to the note.

If you click Yes, the application displays the Electronic Signature window.
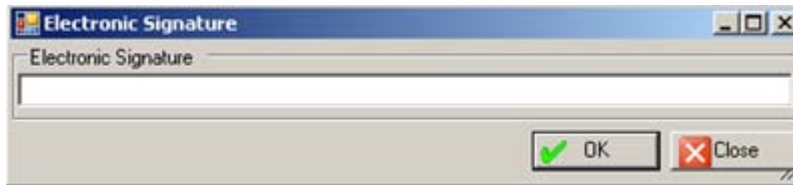
Figure 2-33: Electronic Signature window

Enter your valid electronic signature and click OK. This process saves the encounter with a signed note.

If you enter an invalid electronic signature and click OK, the application displays the Invalid notice, which states "Invalid Signature Code. Click OK and you return to the Electronic Signature dialog."

If you click Close in the Electronic Signature window, the application displays the Are You Sure? dialog box.
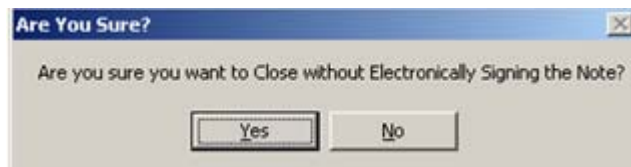
Figure 2-34: Are you Sure dialog box

If you click No, you return to the Electronic Signature window.

If you click Yes, the application displays the Message dialog box.

Figure 2-35: Message text

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 prompts for your signature.

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

Figure 2-36: Prompt 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 the note has already been signed, you receive a message about this situation.

```
The progress note has been electronically signed.  You will not be
able to edit the note.
You will be able to edit the other visit items when you press enter
to continue.
```

Figure 2-37: Message indicating progress note already signed.

If you edit the note and you are not the primary provider, you receive a message about this situation.

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

Figure 2-38: Message indicating only primary provider can sign a note

2.15   Log in to GUI

If this is the first time you log into the GUI or if the application has a new patch, the application will display the IHS Behavior Health System Login dialog box with *no* information in the RPMS Server field.

Figure 2-39: Initial login dialog box

Select the Click to Edit Connections option in the drop-down list. The application displays the RPMS Server Connection Management dialog box.
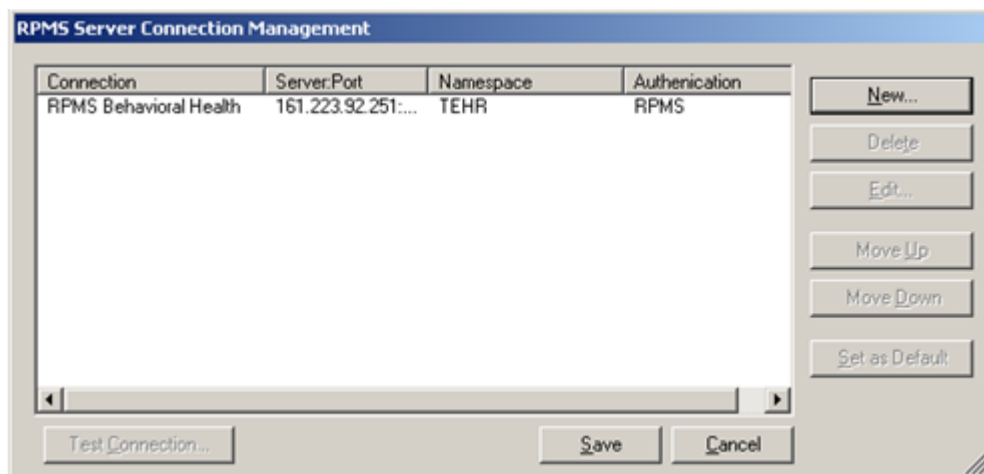
Figure 2-40: Sample RPMS Server Connection Management dialog box

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.
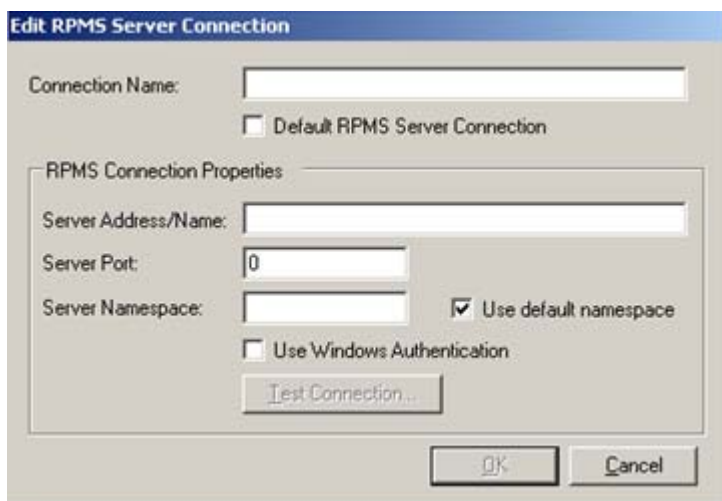
Figure 2-41: Sample Edit RPMS Server Connection dialog box

Do not select the Default RPMS Server Connection or Use Windows Authentication check boxes. The Test Connection button is not an active feature. Clicking the Text Connection button will result in a message stating that this functionality is not active.

Connection Name. Use this field to name your connection (your choice of words).

Server Address/Name. 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.

Server Port. Type the number of the server port. Your site manager will provide this information

Server Namespace. 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**.

Click OK to save the information. (Otherwise, click Cancel to exit the dialog box.)

After you have a server designated, the application displays the IHS Behavioral Health System Login dialog box.
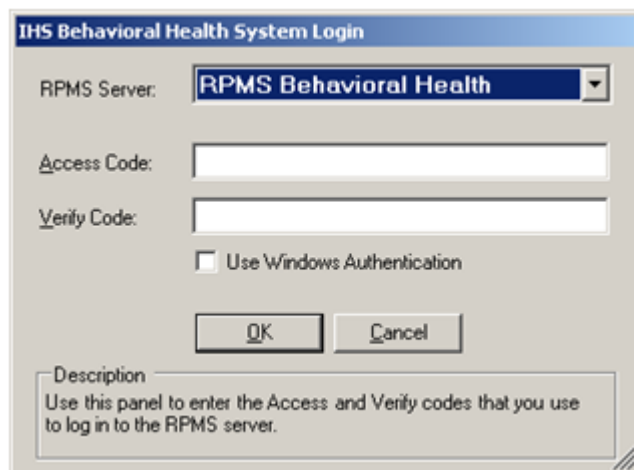
Figure 2-42: Sample login dialog box

The designated server displays in the RPMS Server field.

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 select the Use Windows Authentication check box.

Click OK to access the RPMS BHS tree. Otherwise, click Cancel to exit to login process.

2.16   RPMS BHS Tree

Below is the default display of the RPMS BHS tree structure.
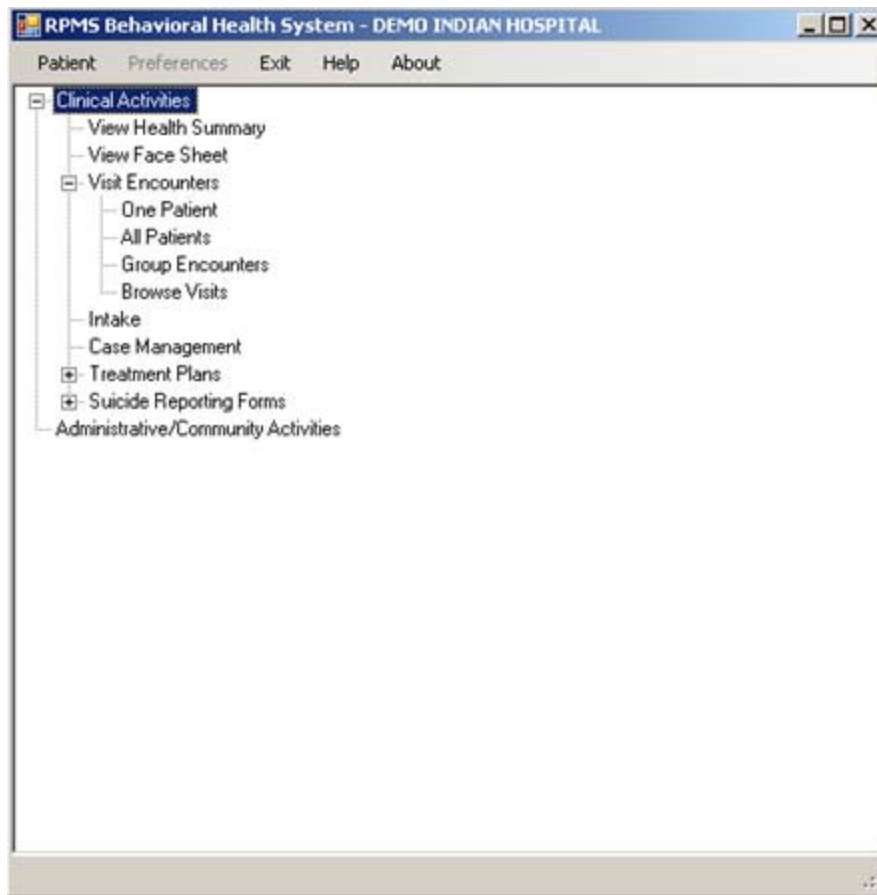
Figure 2-43: Tree structure for the RPMS BHS

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

- Click the Minimize button (-)to collapse the option. The icon will change to the Maximize button (+). The Treatment Plans and Suicide Reporting Forms options are collapsed in the screen capture above.

- Click the Maximize button (+) icon to expand the option. The icon will change to the Minimize (-) button. The Visit Encounters option is expanded in the screen capture above.

Use the Patient menu to select the current patient.

Use the Preferences menu to select another division. If your site has only one division, this menu option will be inactive.

Use the Exit menu to leave the application.

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

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 the roll-and-scroll application and for the RPMS BHS (GUI).

3.1   Roll-and-Scroll

Documentation of patient care and documentation of administrative and group encounters is handled through the Data Entry module of the BHS. Providers are encouraged to 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 provides access to the options for data entry.

```
          **********************************************
          **      IHS Behavioral Health System     **
          **********************************************
                        Version 4.0

                      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

When selecting the DE option from the main menu, the following options are available for documenting patient care, displaying data, and documenting treatment plans and suicide forms.

```
         ************************************************
         **        IHS Behavioral Health System       **
         **              Data Entry Menu              **
         ************************************************
                          Version 4.0

                       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

Below is an overview of the options in the Data Entry menu.

Enter/Edit Patient/Visit Data–Patient Centered (PDE). This option is used to document 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). This option is used to enter the appropriate set of defaults to be used in Data entry.

Group Form Data Entry Using Group Definition (GP). This option is used to enter encounter data when the encounter involves a group of patients.

Display Record Options (DSP). This option is used to display visit information about particular encounters.

Update BH Patient Treatment Plans (TPU). This option is used to manage treatment plans for a patient.

View/Update Designated Provider List (DPL). This option is used to update and manage a provider's patient panel.

Edit BH Data Elements of EHR created Visit (EHRE). This option is used to edit 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). This option is used to list the BH EHR visits that have no activity time.

Suicide Forms–Update/Print (SF). This option is used to update, review, and print IHS Suicide forms that have been entered into the BHS module.

3.2   RPMS BHS GUI

The data entry options are located under the Visit Encounters category on the tree structure for the RPMS BHS (GUI).
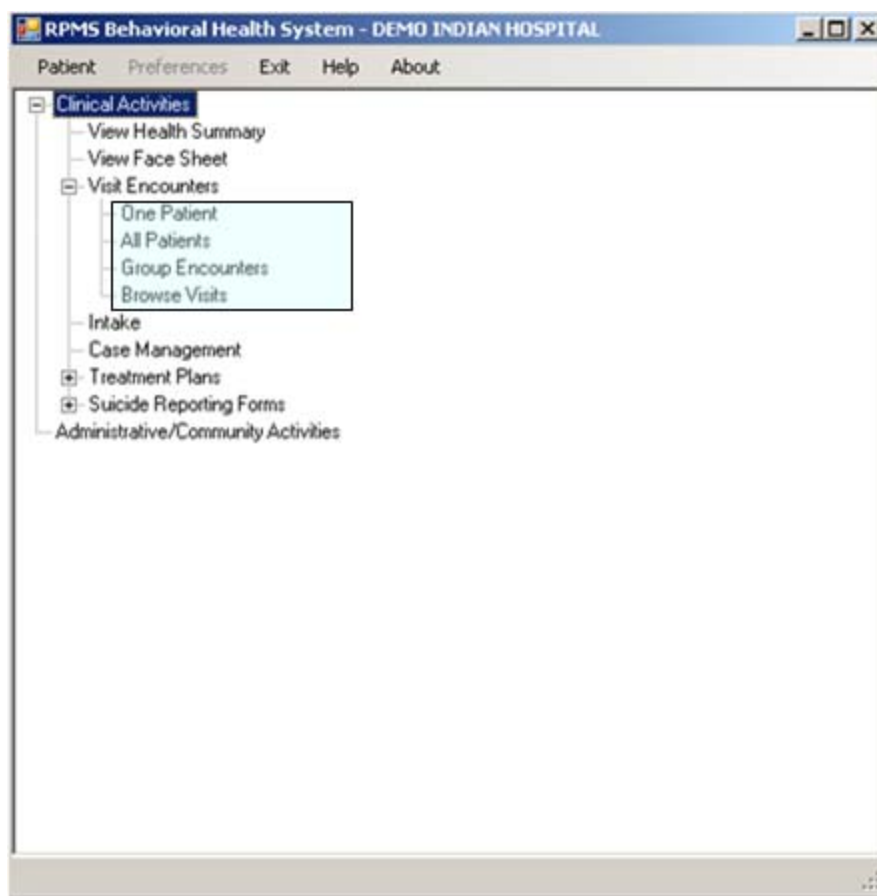
Figure 3-3: Location of Visit Encounters category on tree structure

One Patient. This option is used to manage the visits for the one patient within a particular date range.

All Patients. This option is used to manage the visits for all of the patients within a particular date range.

Group Encounters. This option is used to manage the Group Encounter data for group encounters within a particular date range.

Browse Visits. This option is 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 roll-and-scroll application and the RPMS BHS (GUI).

4.1   Enter/Edit Patient Visit Data (Roll-and-Scroll)

There are two ways to enter/edit patient visit data: using the PDE option or the SDE option on the Indian Health Service (IHS) BHS Data Entry Menu.

```
            ***********************************************
            **        IHS Behavioral Health System      **
            **              Data Entry Menu             **
            ***********************************************
                            Version 4.0

                           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
```

Figure 4-1: Options on the IHS BHS Data Entry menu

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

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

Use the PDE option in 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.

Below are the prompts:

- Enter Patient Name

    Specify the patient you want to use.

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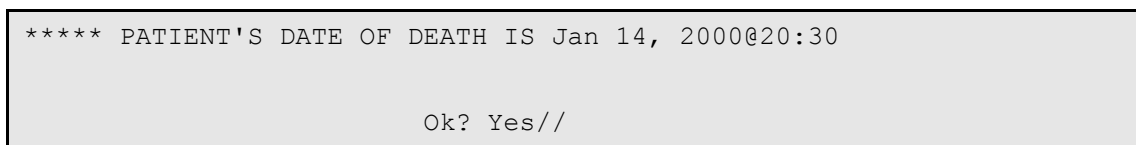
Figure 4-2: Information about patient's date of death

- If you type **NO** at the "OK?" prompt, you are returned to the "Enter Patient Name" prompt."
- If you type **YES** at the "OK?" prompt, the Patient Data Entry window displays.

If you enter the name of a living patient, the application displays 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
          314.9  ATTENTION-DEFICIT/HYPERACTIVITY DIS. NOS
**********  LAST 6 AXIS V VALUES RECORDED.  (GAF SCORES)  *********
 04/20/2009  04/20/2009  04/22/2009  04/29/2009  05/01/2009  07/01/2009
    55          75          33          77          44          65
Pending Appointments:
                 Select the appropriate action   Q for QUIT
AV Add Visit               LD List Visit Dates      GS GAF Scores
EV Edit Visit              TP Treatment Plan Update  OI Desg Prov/Flag/Pers Hx
DR Display Record          CD Update Case Data       EH Edit EHR Visit
ES Edit SOAP               ID Intake Document        PL 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 fields display when using the Add Visit and Edit Visit (EV) options in the Patient Data Entry window.

- Which set of defaults do you want to use in Data Entry

  Specify 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

- Enter ENCOUNTER DATE

  Specify the date of the encounter. See Section 2.1.9 for more information.

  The application displays the "Creating new record" message when adding a visit.

- Enter PRIMARY PROVIDER

  Specify the primary provider name (or press Enter to accept the default) for the visit.

  The application displays the Behavioral Health Visit Update screen.

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

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

Below are the prompts.

- Which set of defaults do you want to use in Data Entry

  Specify 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

- Enter ENCOUNTER DATE

  Specify the date of the encounter. The application displays the "Creating new record" message when adding a visit.

  The application displays the Update BH Forms window.

```
Update BH Forms              Mar 19, 2009 13:50:42        Page:   1 of   1
-------------------------------------------------------------------
Date of Encounter:  Monday  MAR 16, 2009        * unsigned note
-------------------------------------------------------------------
 #  PRV PATIENT NAME          HRN     AT   ACT   PROB    NARRATIVE
```

```
    1 BJB ALPHAA,CHELSEA M WW116431   60  16 295.15 SCHIZOPHRENIA, DISORGANIZED
    2 BJB ALPHAA,CHELSEA M WW116431   30  13 305.02 ALCOHOL ABUSE, EPISODIC,
    3 BJB ALPHAA,CHELSEA M WW116431   15  19  V60.0 LACK OF HOUSING
*   4  JC ALPHAA,CHELSEA M 876543     60  13 295.15 SCHIZOPHRENIA, DISORGANIZED
*   5  JC ALPHAA,CHELSEA M 876543     60  13 295.15 SCHIZOPHRENIA, DISORGANIZED
    6  DG ALPHAA,CHELSEA M WW116431   11  22 305.62 COCAINE ABUSE, EPISODIC
    7  DG ALPHAA,CHELSEA M WW116431   20  15     79 FINANCIAL NEEDS/ASSISTANCE
    8  ST DEMO,DOROTHY ROS WW999999   1   99     97 ADMINISTRATIVE



                                 ?? for more actions
AV   Add Patient Visit     PF   Print Encounter Form 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:
```

Figure 4-4: Sample Update BH Forms window

The asterisk (*) preceding the number of the encounter record indicates that the record contains an unsigned note. See Section 2.14 for more information.

Use the EV option to edit a selected record (patient visit); see Section 4.1.4 for more information. Use the AV option to add a patient visit.

When you use the AV option, the following prompts displays.

- TYPE THE PATIENT'S HRN, NAME, SSN OR DOB

  Specify the patient you want to use.

- Enter PRIMARY PROVIDER

  Specify the primary provider for the patient visit.

  The application displays the Behavioral Health Visit Update screen.

4.1.3   Using the Behavioral Health Visit Update Screen

Use this screen to enter patient visit data. The underlined field names are required fields.

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

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

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



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

Figure 4-5: Sample Behavioral Health Visit Update screen

If you save the data in the Behavioral Health Visit Update window and you are the primary provider, you will be asked if you want to sign the note for the visit. See Section 2.14.6 for more information.

The underlined fields in Figure 4-5 are required.

- Arrival Time

    The default is 12:00. Change this time if needed.

- Display/Edit Visit Information

    Type **N** or **Y** (the default). Type **Y** to access the Visit Information pop-up window. The underlined field names are required fields.

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

Program: MENTAL HEALTH               Location of Encounter: SELLS HOSP

Clinic: MENTAL HEALTH                Appointment/Walk In: APPOINTMENT

Type of Contact: OUTPATIENT

Community of Service: TUCSON
```

Figure 4-6: Sample Visit Information pop-up

The application automatically populates the fields in the Visit information pop-up according to which set of defaults you selected at the "Which set of defaults do you want to use in Data Entry" prompt.

The Visit Information pop-up has the following fields:

- **Program**. This field determines the program associated with the visit. Use one of the following: M (Mental Health), S (Social Services), O (Other), or C (Chemical Dependency).

- **Location of Encounter**. This field determines the location of the encounter.
- **Clinic**. The response must be a clinic that is included in the RPMS clinic code set.
- **Appointment/Walk-In**. This field determines the type of visit. Use one of the following: A (Appointment), W (Walk In), or U - Unspecified (for non-patient contact or telephone contact).
- **Type of Contact**. This field determines the type of contact (the activity setting).
- **Community of Service**. The response must be a community included in the RPMS community code set.

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

- Any Secondary Providers?

    Type **Y** or **N** (the default) to indicate if there were any additional BHS providers also providing care during this particular encounter. Type **Y** to access the Enter/Edit Providers of Service pop-up window.

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

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

PROVIDER: THETA,STUART                      PRIMARY/SECONDARY:
PRIMARY
PROVIDER:                                   PRIMARY/SECONDARY:
PROVIDER:                                   PRIMARY/SECONDARY:
PROVIDER:                                   PRIMARY/SECONDARY:
PROVIDER:                                   PRIMARY/SECONDARY:
PROVIDER:                                   PRIMARY/SECONDARY:
```
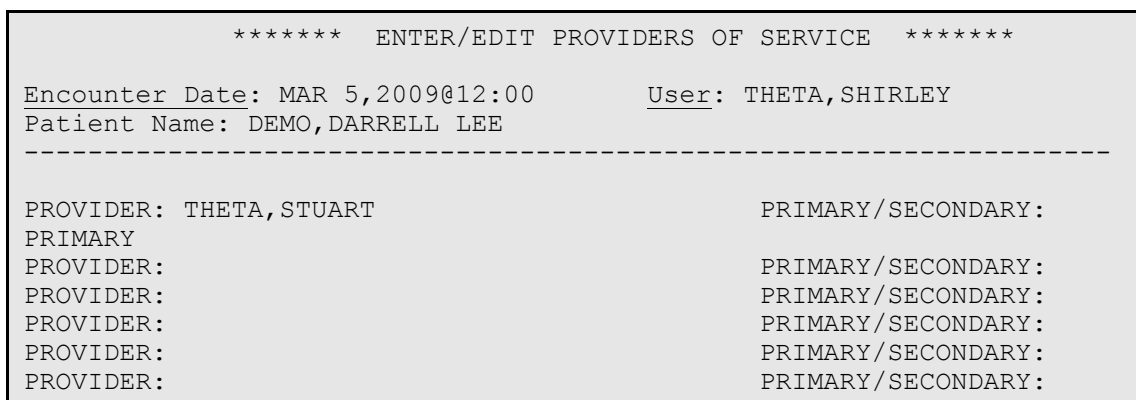
Figure 4-7: Sample Enter/Edit Providers of Services pop-up

Specify the secondary provider name at the PROVIDER field and populate the PRIMARY/SECONDARY field with SECONDARY (more than one secondary provider can be used).

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

- Chief Complaint/Presenting Problem

    Specify the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patient sought services.

- SOAP/Progress Note <press Enter>

Press Enter to access another 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 as text.

‒ Comment/Next Appointment <press Enter>

Press Enter to access another window. Populate it with the text of the comment about the next appointment. This field is not used for appointment scheduling.

‒ PURPOSE OF VISIT (POVS) <Enter>

Press Enter to access the Purpose of Visit Update pop-up window.

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

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


                        AXIS V:
_____
Patient's Diagnoses from last 4 visits:
7/8/09  28  DRUG DEPENDENCE
5/15/09  39  PT HAS PROBLEM
3/10/09  29  ALCOHOL ABUSE
3/10/09  291.0  ALCOHOL WITHDRAWAL DELIRIUM
Enter RETURN to continue or '^' to exit:
```

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

If you type a caret (^) at the last prompt, you will exit this pop-up window.

If press Enter at the last prompt, the cursor jumps to the DIAGNOSIS field.

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

At the Diagnosis field, specify the POV (the one- or two-digit BHS Purpose of Visit (POV) Code or the more specific five-digit DSM-IV-TR diagnostic code).

The application automatically populates the Narrative field (which can be changed). You can accept the narrative that is displayed or edit the narrative to more clearly identify the reason for the visit. For example, if Problem Code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient's housing issue–homeless, being evicted, etc.

> **Note:** The special characters *single quote* (') and *double quote* (") cannot be the first character of the POV narrative.

At the AXIS III field, press Enter to access another window. Populate the window with the patient's general medical conditions that were treated during the visit. This field should not be used to record the patient's medical history.

Populate the AXIS IV field with one of the major psychosocial or environmental problem codes.

Populate the AXIS V field with the patient's functional level using the GAF scale (0–100).

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

- Any CPT Codes to enter?

   Type **N** or **Y** (the default). Type **Y** to access the Add/Edit CPT Procedures pop-up window.

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


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

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

Specify the CPT code for BHS at the CPT Code field. 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.

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

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

- Activity

  Specify the activity code that documents the type of service or activity performed by the BH 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. See section Appendix A for more information.

- Activity Time

  Specify 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: zero is not allowed as a valid entry.

- # Served

  Specify the number served, using any number between 0 and 9999 (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.

- Interpreter?

  Type **1** (Yes) to indicate if the presence of an interpreter during the patient encounter, or press Enter to bypass this field if an interpreter was not present. Indicate 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.

- Any Patient Education Done?

  Type **Y** or **N** (the default). Type **Y** to access the Patient Education Enter/Edit pop-up window.

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

 Display Patient Education History?  N

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

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

You can display both the Behavioral Health and PCC patient education history if needed. Type **Y** at the Display Patient Education History? field.

After returning to the EDUCATION TOPIC field, specify the education topic used at this encounter. For a complete list of the current Education Topics, please see the IHS Patient Education Manual or type a question mark (**?**) at the prompt to view the whole list.

After entering the Education Topic, the application displays the following pop-up window.

```
EDUCATION TOPIC: ABD-COMPLICATIONS

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

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

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

- Education Topic. The education topic (can be changed). This is a required field.
- Individual/Group. Specify if the education for an individual or for a group. This is a required field.
- Readiness to Learn. Use one of the following:
  - Distraction. Use when the patient has limited readiness to learn because the distractions cannot be minimized.

- Eager to Learn. Use when the patient is exceedingly interested in receiving education.

- Intoxication. Use when the patient has decreased cognition due to intoxication with drugs or alcohol

- Not Ready. Use when the patient is not ready to learn.

- Pain. Use when the patient has a level of pain that limits readiness to learn.

- Receptive. Use when the patient is ready or willing to receive education.

- Severity of Illness. Use when the patient has a severity of illness that limits readiness to learn.

- Unreceptive. Use when the patient is NOT ready or willing to receive education.

- Level of Understanding. Specify the level of understanding. This is a required field. Use one of the following:

  - 1 (Poor)

  - 2 (Fair)

  - 3 (Good)

  - 4 (Group No Assessment)

  - 5 (Refused)

- Provider. The provider who provided the education. The default is the current logon user but this may be changed. This is a required field.

- Minutes. Specify the number of minutes spent on education. This is a required field.

- Goal. Populate with the text of the stated goal of the education, if any.

- Status (Goal). Specify 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

- Comment. Add comments about the education topic for the visit, if any.

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

- Any Screenings to Record?

Use these fields to record any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter. Type **N** to accept the default response if no screenings were completed during the visit. Type **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 4-12: Sample IPV, Alcohol Screening, and Depression Screening pop-up

The following provides information about the fields in the pop-up window.

- Display IPV/DV screening History?

  Type **Y** or **N**. If you type **Y**, the IPV/DV screening history displays on another screen. The display includes screenings entered in both BHS and PCC.

- IPV Screening/Exam Result

  Specify 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

- IPV Screening Provider. Specify the IPV/DV provider name.

- IPV Comment. Populate with the text of any comment related to the IPV/DV screening.

- Display Alcohol screening History? Type **Y** or **N.** If you type **Y**, the alcohol screening history displays on another screen. The display includes screenings entered in both BHS and PCC.

- Alcohol Screening Result. Specify the type of alcohol screening. Use one of the following:

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

- Alcohol Screening Provider. Specify the provider name for the alcohol screening.

- Alcohol Screening Comment. Populate with the text of any comment related to the alcohol screening.

- Display Depression screening History? Type **Y** or **N**. If you type **Y**, the depression screening history displays on another screen.

- Depression Screening Result. Specify the type of depression screening. Use one of the following:

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

- Depression Screening Provider. Specify the provider name for the depression screening.

- Depression Screening Comment. Populate with the text of any comment related to the depression screening.

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

- Any Measurement?

  Type **N** or **Y**. Type **Y** to access the Measurements pop-up.

```
       ***   Measurements   ***

 Measurement Description           Value               Provider
 -----------------------------------------------------------------
 PHQ9          PHQ9                   20                GAMMA,ROBERT
```

Figure 4-13: Sample Measurements pop-up

Specify the type of measurement being taken on the patient at the "Measurement" prompt. Then the application populates the Description field. See Section 4.1.4 for a listing of measurements.

Specify the numeric value of the measurement at the Value field. 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.

Specify the name of the provider who completed the measurement event. The default is the current logon user but this may be changed.

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.

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

- Any Health Factors to enter?

    Type **Y** or **N** (the default) to indicate that you want to record health status information about the patient. Type **Y** to access the Patient Health Factor Update pop-up window.

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

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

  HEALTH FACTOR
```

Figure 4-14: Sample Patient Health Factor Update pop-up.

- Display Health Factor History

  Type **N** or **Y** at the Display Health Factor History? field. If you type **Y**, the health factor history for the current patient displays on another screen.

- Health Factor

  Specify the health factor. The application displays other fields about the health factor.

```
LEVEL/SERVERITY

QUANTITY

COMMENTS
```

Figure 4-15: Other fields for health factor data

- Level/Severity

  Type **M** (Minimal), **MO** (Moderate), or **H** (Heavy/Severe).

- Quantity

  Type any integer between 0 and 99999.

- Comments

  Populate with any comments regarding the health factor.

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

- Display Current Medications?

  Type **Y** or **N** (the default) to display a list of currently dispensed medications. If you type **Y**, 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 4-16: 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.

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

- MEDICATIONS PRESCRIBED <enter>

  If you press Enter, you access another screen where you can enter the medications prescribed.

- Any Treated Medical Problems?

  Type **Y** or **N** (the default). Type **Y** to access a pop-up window where you can enter one or more medical problems.

```
---------------------------------------------------------------------


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

Figure 4-17: Sample medical problem pop-up

At the Medical Problem field, specify the medical problems treated by the provider on this BH encounter.

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

- Placement Disposition

  Specify the active disposition. Use this field when hospitalization or placement in a treatment facility is required. Type 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 4-18: Sample pop-up for facility name

Specify the name of the facility at the "FACILITY REFERRED TO" prompt.

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

- Visit Flag

  Specify the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value (0–999) to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. Later, you can retrieve all visits with a flag of 1, which will list all visits on which narcotics were prescribed.

- Local Service Site

  Specify the local service site.

4.1.4   Using the Behavioral Health Record Edit Window

Use the Behavioral Health Record Edit window to edit an existing visit.

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

```
Edit Patient Education?: N
Edit Any Screening Exams?  N    Edit Measurements?  N
Placement Disposition:                    Referred To:
_____


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

Figure 4-19: Sample Behavioral Health Record Edit window

The underlined field names are required fields.

- Date

  The date of the visit.

- Location of Service

  Where the service took place.

- Program

  Name of the program.

- Outside Location

  Name of the outside location (3 to 30 characters in length).

- Clinic

  Name of the clinic if the encounter took place with the context of a scheduled clinic.

- Appt/Walk-in

  Can be appointment, walk-in, or unspecified (for a nonpatient contact).

- Visit Flag

  Specify the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value (0-999) to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. Later you can retrieve all visits with a flag of 1, which will list all visits on which narcotics were prescribed.

- Type of Contact

  Type of contact (the activity setting).

- Community

  Name of the community.

- Providers <press enter>

    Press Enter to access the Enter/Edit Providers of Service pop-up window.

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

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


_____


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

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

Specify the provider at the PROVIDER field and populate the PRIMARY/SECONDARY field with the type of provider (primary or secondary).

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

- Local Service Site

    Name of the local service site.

- Activity

    The activity code that documents the type of service or activity performed by the BH 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 Appendix A for more information.

- Activity Time

    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. Note that zero is not allowed as a valid entry.

- # Served

    The number served at the encounter.

- Interpreter Utilized

  Type **Y** or **N**. Type **Y** only if an interpreter is required to communicate with the patient.

- Chief Complaint/Presenting Problem

  This information describes the major reason the patient sought services.

- SOAP/PROGRESS NOTE

  Text of the note. Press Enter to access another window. Populate it with the text of the note. The note can be edited only if it is unsigned.

- Comment/Next Appointment

  Populate with the text of the comments about the next appointment.

- Medications Prescribed

  Press Enter to access another window where you enter the medications prescribed.

- Edit Purpose of Visits?

  Type **Y** or **N**. Type **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:

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

                      AXIS V:
```

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

The following provides information about the fields on the Purpose of Visit Update pop-up window.

At the Diagnosis field, specify the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-IV-R diagnostic code).

At the Narrative field, you can accept the narrative that is displayed or edit the narrative to more clearly identify the reason for the visit. For example, if Problem Code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient's housing issue–homeless, being evicted, etc.

At the AXIS III field, press Enter to access another window. Populate this window with general medical conditions of the patient that were treated during the visit. This field should not be used to record the patient's medical history.
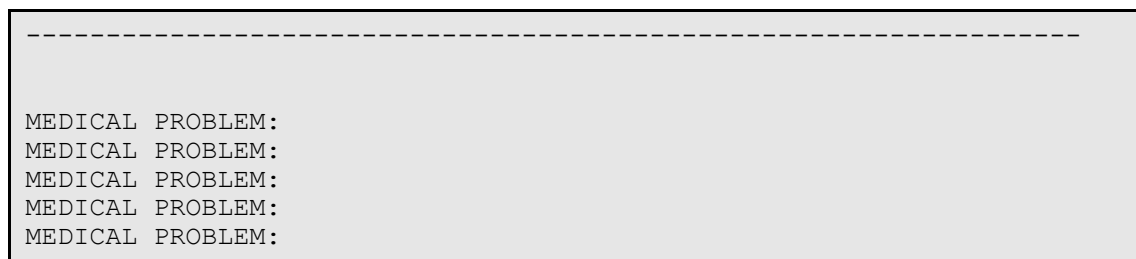
At the AXIS IV field, specify one or more of the nine major psychosocial or environmental problem codes.

At the AXIS V field, specify the patient's functional level using the Global Assessment of Functioning (GAF) scale. The field will accept numerical values between 0 and 100.

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

- Edit Treated Medical Problems?

    Type **Y** or **N**. Type **Y** to access a pop-up window where you enter the one or more medical problems.

```
  ------------------------------------------------------------------


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

Figure 4-22: Sample medical problem pop-up

- Medical Problem

    Specify the medical problems treated by the provider on this BH encounter.

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

- Edit Prevention Activities?

    Type **Y** or **N**. Type **Y** to access the Prevention Activities pop-up window.

```
Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:
```

Figure 4-23: Sample Prevention Activities pop-up window

Populate the "Prevention Activity" prompt with a new or existing MHSS Prevention Activity. These activities are recorded by the A/SA staff when recording nonpatient activities. For example, you could use 2 for Alcohol/Drug Education.

At the "Target" prompt, specify the target audience for the prevention activity. Choose from the following:

- A   Adult

- Y   Youth

- F   Family

- M   Mixed (Adult and Youth)

- S   Staff

- E   Elderly Only

- W   Women

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

- Edit CPT Codes?

    Type **Y** or **N**. Type **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 4-24: Sample Add/Edit CPT Procedures window

Specify the CPT or HCPCS code for BH services at the CPT Code field (more than one can be used). 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.

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

- Edit Health Factors?

  Type **Y** (yes) or **N** (no). Type **Y** to access the Patient Health Factor Update pop-up window.

```
          ******* 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 4-25: Sample Patient Health Factor Update pop-up.

Type **N** or **Y** at the Display Health Factor History? field. If you type **Y**, the health factor history displays on another screen.

Specify the health factor at the HEALTH FACTOR field. The following pop-up displays, allowing you to specify other data about the health factor.

```
LEVEL/SEVERITY

QUANTITY

COMMENTS
```

Figure 4-26: Fields for health factor data

- Level/Severity. Type one of the following : **M** (minimal), **MO** (moderate), or **H** (heavy/severe).
- Quantity. Type any number between 0 and 99999 (no decimal points).
- Comment. Populate with the text of a comment related to the patient's health factor.

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

- Edit Patient Education?

  Type **Y** or **N**. Type **Y** to access the Patient Education Enter/Edit pop-up window.

```
*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 4-27: Sample Patient Education enter/edit screen

You can display the patient education history if needed. Type **Y** at the Display Patient Education History? field.

Specify the education topic name at the EDUCATION TOPIC field. The following pop-up displays, allowing you to 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 4-28: Sample pop-up for education topic information

- Education Topic. The education topic (can be changed). This is a required field.

- Individual/Group. Specify if the education for an individual or for a group. This is a required field.

- Readiness to Learn. Use one of the following:

  - Distraction. Use when the patient has limited readiness to learn because the distractions cannot be minimized.

  - Eager to Learn. Use when the patient is exceedingly interested in receiving education.

  - Intoxication. Use when the patient has decreased cognition due to intoxication with drugs or alcohol

  - Not Ready. Use when the patient is not ready to learn.

  - Pain. Use when the patient has a level of pain that limits readiness to learn.

- Receptive. Use when the patient is ready or willing to receive education.
- Severity of Illness. Use when the patient has a severity of illness that limits readiness to learn.
- Unreceptive. Use when the patient is *not* ready or willing to receive education.

- Level of Understanding. Specify the level of understanding. This is a required field. Use one of the following:

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

- Provider. The provider who provided the education. The default is the current logon user but this may be changed. This is a required field.

- Minutes. Specify the number of minutes spent on education. This is a required field.

- Goal. Populate with the text of the stated goal of the education, if any.

- Status (Goal). Specify 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

- Comment. Add comments about the education topic for the visit, if any.

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

- Edit Any Screening Exams?

  Type **N** or **Y** for any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter. Type **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 4-29: Sample IPV, Alcohol Screening, and Depression Screening pop-up

- Display IPV/DV screening History? Type **Y** or **N**. If you type **Y**, the IPV/DV screening history displays on another screen.

- IPV Screening/Exam Result: Specify 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

- IPV Screening Provider. Specify the IPV/DV provider name.

- IPV Comment. Populate with the text of any comment related to the IPV/DV screening.

- Display Alcohol screening History? Type **Y** or **N**. If you type **Y**, the alcohol screening history displays on another screen.

- Alcohol Screening Result. Specify the type of alcohol screening. Use one of the following:

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

- Alcohol Screening Provider. Specify the provider name for the alcohol screening.

- Alcohol Screening Comment. Populate with the text of any comment related to the alcohol screening.

- Display Depression screening History? Type **Y** or **N**. If you type **Y**, the depression screening history displays on another screen.

- Depression Screening Result. Specify the type of depression screening. Use one of the following:
  - N–Negative
  - P–Positive
  - UAS–Unable to screen
  - REF–Patient Refused Screening

- Depression Screening Provider. Specify the provider name for the depression screening.

- Depression Screening Comment. Populate with the text of any comment related to the depression screening.

- Edit Measurements? Type **Y** or **N**. Type **Y** to access the Measurements pop-up.

```
      ***  Measurements  ***

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


```

Figure 4-30: Sample Measurements pop-up

Specify the type of measurement being taken on the patient at the "Measurement" prompt. Then the application populates the Description field.

Below are the Measurements that you can use.

```
ADM         ASTHMA WORK/SCHOOL DAYS MISSED
AG          ABDOMINAL GIRTH
AKBP        ANKLE BLOOD PRESSURE
ASFD        ASTHMA SYMPTOM FREE DAYS
ASQA        ASQ - AUTISM SCREEN
ASQF        ASQ - FINE MOTOR
ASQG        ASQ - GROSS MOTOR
ASQL        ASQ - LANGUAGE
ASQM        ASQ QUESTIONNAIRE (MOS)
ASQP        ASQ - PROBLEM SOLVING
ASQS        ASQ - SOCIAL
AUD         AUDIOMETRY
AUDC        AUDIT-C
AUDT        AUDIT
BP          BLOOD PRESSURE
BPF         BEST PEAK FLOW
CEF         CARDIAC EJECTION FRACTION
CRFT        CRAFFT
```

```
CXD        CERVIX DILATATION
ED         EDEMA
EF         EFFACEMENT
FEF        FEF 25-75
FH         FUNDAL HEIGHT
FT         FETAL HEART TONES
FVFC       FEV1/FVC
HC         HEAD CIRCUMFERENCE
HE         HEARING
HT         HEIGHT
O2         O2 SATURATION
PA         PAIN
PF         PEAK FLOW
PHQ2       PHQ2
PHQ9       PHQ9
PR         PRESENTATION
PU         PULSE
RS         RESPIRATIONS
SN         STATION (PREGNANCY)
TMP        TEMPERATURE
TON        TONOMETRY
VC         VISION CORRECTED
VU         VISION UNCORRECTED
WC         WAIST CIRCUMFERENCE
WT         WEIGHT
```

Figure 4-31: Measurements allowed

Specify the numeric value of the measurement at the Value field. The value must be in the valid numeric range for the measurement.

Specify the name of the provider at the Provider field.

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

- Placement Disposition

   Specify the active disposition. Use this field when hospitalization or placement in a treatment facility is required. Type either the number or first few letters of the placement type.

- Referred to

   Enter the name of the facility to which the patient is being referred, using 2–30 characters. This field is required when the Placement Disposition is populated.

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

- Enter your Current Signature Code

Populate with your (valid) signature code. This signature applies to the
SOAP/Progress Note associated with the current visit. See Section 2.14 for more
information.

If you do not populate with your electronic signature and you 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 application then 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). None of the Above (Quit)
Choose one of the above:  (1-8): 8//
```

Figure 4-32: Other Information window

You can exit using Option 8, or edit the visit using the other visits.

After you use Option 8, one of the following will happen:

• If there was no appointment for the patient in the scheduling package, you are
  returned to the previous window.

• If there was an appointment for the patient in 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 in the scheduling package and no other clinics saw the patient
    that day), then the option to link is never presented and the BH visit continues
    to create a new visit in PCC.

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: 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: BH
   Provider on Visit: BETA,BJ
   Primary POV: 799.9  Narrative: DIAGNOSIS OR CONDITION DEFERRED ON AXIS
4  Create New Visit

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

Figure 4-33: Continuing prompts

At this point, the application links to the visit you had selected and returns you 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   799.9 DIAGNOSIS OR CONDITION DEF
   2  BJB BETAA,EMILY MAE WW129608     WW   11      80 HOUSING
   3  BJB SIGMA,DAVID R WW145072       WW   12      83 MEDICAL TRANSPORTATION NEE



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       AP   Appointments
OI   Desg Prov/Flag       ES   SOAP/CC Edit         MM   Send Mail Message
DR   Display Record       SD   Switch Dates         Q    Quit
DE   Delete Record        EH   Edit EHR Record
```

Figure 4-34: Prompts that continue

Figure 4-35 shows the view in the BH application.

```
Select Action: AV// DR   Display Record
Display Which Record:  (1-3): 2

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:    BETA,BJ
DATE LAST MODIFIED:    MAR 12, 2010
USER LAST UPDATE:      BETA,BJ
DATE/TIME LAST MODIFI: MAR 12, 2010@09:28:55
EDIT HISTORY:
  Mar 12, 2010 9:28 am       BETA,BJ
EXTRACT FLAG:          ADD
CREATED BY BH?:        YES
DATE/TIME NOTE SIGNED: MAR 12, 2010@09:30
SIGNATURE BLOCK:       B J BETA

AXIS III:

AXIS IV:


SUBJECTIVE/OBJECTIVE: TEST

COMMENT/NEXT APPOINTMENT:
TEST

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:


=============== MHSS RECORD PROBLEMS (POVS) ===============
PROBLEM CODE:          80
PROBLEM CODE NARRATIV: HOUSING
PROVIDER NARRATIVE:    HOUSING

=============== MHSS RECORD PROVIDERS ===============
PROVIDER:              BETA,BJ
PROVIDER DISCIPLINE:   ACUPUNCTURIST
```

```
        PRIMARY/SECONDARY:      PRIMARY

        Note already signed, no E Sig necessary.

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

Figure 4-35: Display Record information

Now you are back at the list of eight and 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). None of the Above (Quit)
Choose one of the above:  (1-8): 8//


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


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          AP   Appointments
OI   Desg Prov/Flag       ES   SOAP/CC Edit            MM   Send Mail Message
DR   Display Record       SD   Switch Dates             Q   Quit
DE   Delete Record        EH   Edit EHR Record
Select Action: AV// Q   Quit


                 ************************************************
                 **        IHS Behavioral Health System       **
                 **              Data Entry Menu               **
                 ************************************************
                              Version 4.0

                           DEMO INDIAN HOSPITAL


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

```
   CR      Coding Review


You have 2 PENDING ALERTS
           Enter  "VA to jump to VIEW ALERTS option

Select Behavioral Health Data Entry Menu Option: DSP  Display Record Options

                  ************************************************
                  **         IHS Behavioral Health System      **
                  **      Data Entry Menu Display Options       **
                  ************************************************
                              Version 4.0

                           DEMO INDIAN HOSPITAL


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




Select Display Record Options Option: PCCV  Display a PCC Visit

Select PATIENT NAME:
  BETAA,EMILY MAE              <A>   F 03-01-1968 XXX-XX-1619    WW 129608
Enter VISIT date: T-3  (MAR 09, 2010)

PATIENT: BETAA,EMILY MAE has one or more VISITs on this date.

1  TIME: 15:00 LOC: WW   TYPE: I CAT: A CLINIC: GENERAL  DEC: 0 VCN:47887.2A
   Hospital Location: ADULT WALKIN
2  TIME: 16:00 LOC: WW   TYPE: I CAT: A CLINIC: ALCOHOL  DEC: 0 VCN:47887.1A
   Hospital Location: AOD
3  TIME: 16:15 LOC: WW   TYPE: I CAT: A CLINIC: BEHAVIOR DEC: 5 VCN:47887.3A
   Hospital Location: BH
   Primary Provider: BETA,BJ

Select one: 3
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: 5
DATE LAST MODIFIED:     MAR 12, 2010
WALK IN/APPT:           WALK IN
HOSPITAL LOCATION:      BH
CREATED BY USER:        BETA,BJ
OPTION USED TO CREATE: SD IHS PCC LINK  < - If the visit is linked, it will always
show this option
APPT DATE&TIME:         MAR 09, 2010@16:15
USER LAST UPDATE:       BETA,BJ
VCN:                    47887.3A
OLD/UNUSED UNIQUE VIS: 5059010002565343
DATE/TIME LAST MODIFI: MAR 12, 2010@09:31:13
CHART AUDIT STATUS:     INCOMPLETE
NDW UNIQUE VISIT ID (: 102320002565343
VISIT ID:               3C5N-WWX


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

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


POV:                    V60.1
ICD NARRATIVE:          INADEQUATE HOUSING
PROVIDER NARRATIVE:     HOUSING
V FILE IEN:             3224071


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

ACTIVITY TIME:          112
TOTAL TIME:             112
V FILE IEN:             38349
```

Figure 4-36: How it looks in PCC

4.1.5   Edit EHR Visit (EH)

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

- Enter Encounter Date

  Specify the date of the BH encounter that was entered for a particular patient through the EHR. The application displays the Edit Behavioral Health Specific Fields for an EHR Visit window.

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

                         AXIS V:
_____


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

Figure 4-37: Sample information about editing a BH visit entered through the EHR.

- Community of Service

  This indicates the community of service where the encounter took place.

- Activity Type

  This indicates the type of activity for the visit.

- Appt/Walk In

  This indicates the visit type: appointment, walk-in, or unspecified (for nonpatient contact).

- Placement Disposition

  This indicates 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 application displays the following pop-up window:

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

Figure 4-38: Pop-up window asking for facility referred to

- Facility Referred to

Use the facility 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.

- Interpreter Utilized

  This indicates if an interpreter was used in the visit. Type **Y** if an interpreter was required to communicate with the patient.

- Comment/Next Appt (press enter)

  Press Enter to access another window where you can populate the field with the text of a comment about the next appointment.

- Local Service Site

  This indicates the local service site for the visit.

- Flag (Local Use)

  This indicates any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value (0–999) to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. Later you can retrieve all visits with a flag of 1, which will list all visits on which narcotics were prescribed.

- AXIS III (press enter to update or TAB to bypass)

  If you press Enter, you access another window. Populate it with the text of the general medical conditions of the patient.

- AXIS IV

  Populate with one or more of the nine major psychosocial or environmental problem codes. This code must be from the list of codes approved by the American Psychiatric Association and included in DMS-IV-TR.

- AXIS V

  Populate with the patient's functional level, using the GAF scale. Use any numerical values between 0 and 100.

4.1.6   Edit SOAP (ES)

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

Type **ED** at the "Select Action" prompt to display the following prompts.

- Enter Encounter Date

    Specify the encounter date for this edit process.

- CHIEF COMPLAINT

    Specify the chief complaint (in text), if any. If there is existing text in this field, it can be changed. This information describes the major reason the patient sought services.

- SOAP/PROGRESS NOTE

    − No existing text

       If there is existing text, it appears below the SOAP/PROGRESS NOTE prompt. You can edit this text (similar to entering new note).

    − Edit? NO//

       If you type **Y** at the last prompt, you access another window where you can edit the text of the SOAP/Progress Note.

       If you type **N** at the last prompt, the other prompts continue.

- COMMENT/NEXT APPOINTMENT

    − No existing text

       If there is existing text, it appears below the "COMMENT/NEXT APPOINTMENT" prompt. You can edit this text (similar to entering new note).

    − Edit? NO//

       If you type **Y** at the last prompt, you access another window where you can edit the text of the COMMENT/NEXT APPOINTMENT note.

       If you type **N** at the last prompt, the other prompts continue.

- MEDICATIONS PRESCRIBED

    − No existing text

If there is existing text, it appears below the MEDICATIONS PRESCRIBED prompt. You can edit this text (similar to entering a new note).

− Edit? NO//

If you type **Y** at the last prompt, you access another window where you can edit the text of the MEDICATIONS PRESCRIBED note.

The electronic signature might be needed after you exit. See Section 2.14 for more information.

4.1.7 Delete Visit (DE)

Use the DE option to remove a specified visit for the current patient that was entered in error.

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

Encounter records containing unsigned or blank SOAP/Progress Notes can be edited or deleted.

Below are the prompts.

• "Enter Encounter Date"

Specify the encounter date you want to remove. If there is more than one, you will select the correct date.

The application displays the Confidential Patient Information about the encounter record.

• "Are you sure you want to DELETE this record?"

Type **Y** or **N**. If you type **Y**, the application displays "Record deleted. Press Enter to continue."

4.1.8 Sign Note (SN)

Use the SN option to sign a note (which is unsigned) in a visit record. You can only sign notes if you are the primary provider.

After using SN, the application displays the BH 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    56     MARITAL PROBLEM
```

Figure 4-39: List of records that can be changed

The prompts continue.

- "Which record do you want to display (1-x) where x is the number of the last record"

  Specify 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 display window, the application asks if you want to edit this record. If you type N**,** you exit the sign note process.

  If you type **Y**, the application displays the Behavioral Health Record Edit window.

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

- "Enter your Current Signature Code"

  Populate with your (valid) signature code. This signature applies to the SOAP/Progress Note associated with the current visit. See Section 2.14.6 for more information. After entering your signature code, the OTHER INFORMATION screen displays.

  If you do not populate with your electronic signature (or use an invalid code 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."

4.1.9   Print Encounter Form (PF)

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

- Enter Encounter Date

  Specify the encounter date that you want to print. If there is more than one, you will select which one.

- What type of form do you want to print

Specify the type of form you want to print. Use one of the following:

- − F Full Encounter Form
- − S Suppressed Encounter Form
- − B Both a Suppressed and 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. 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.

- Device

    Specify the device to print/browse 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: GAMMAA,DENISE
  Arrival Time: 12:00
  Program:  MENTAL HEALTH
  Clinic:  MENTAL HEALTH                 Appointment Type:
APPOINTMENT
_____
                                                Number
Activity/Service
  Community: TUCSON                        Served:      Time:  minutes
  Activity: 13-INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT
  Type of Contact: OUTPATIENT
_____
  Chief Complaint/Presenting Problem Suppressed for Confidentiality

  S/O/A/P:
  Behavioral Health Visit


                                   Feb 23, 2009@12:00      Page 2

  See GAMMAAA,DENISE for details.
_____

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



_____
  AXIS IV:   6 - ECONOMIC PROBLEMS
             8 - LEGAL INTERACTION PROBLEMS
  AXIS V:

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

Figure 4-40: Sample Suppressed Encounter Form

4.1.10 Last BH Visit (LV)

Use the LV option to display the last BH visit record for the current patient.

Below are the prompts.

- Do you want a particular provider's last visit

Type **Y** or **N**. If you type **Y**, other prompts display.

The application displays the BH Visit Record Display window.

```
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
ACTIVITY TYPE:         13
ACTIVITY TYPE NAME:    INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               ALPHA,GLEN DALE
PT AGE:                27
CLINIC:                MENTAL HEALTH
NUMBER SERVED:         1
APPT/WALK-IN:          WALK-IN
ACTIVITY TIME:         45
+        Enter ?? for more actions
+    Next Screen        -    Previous Screen     Q    Quit
Select Action: +//
```

Figure 4-41: Sample BH Visit Record Display window

4.1.11   Browse Visit (BV)

Use the BV option to browse behavioral health visits.

The prompts are below.

- Browse which subset of visits for [current patient name]

  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 type **N**, **D**, or **P**, other prompts will display.

The application displays the Browse Patient's Visit window. Below is the window that displays after selecting Option A.

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

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


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

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

  SUBJECTIVE/OBJECTIVE:
  testing ind visit info v4.0
+         Enter ?? for more actions
+   Next Screen       -    Previous Screen     Q   Quit
Select Action:+//
```

Figure 4-42: Sample Report window

4.1.12   List Visit Dates (LD)

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

The prompts are below.

- Browse which subset of visits for [current patient name]

  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 type **N**, **D**, or **P**, other prompts will display.

  The application displays the Browse Patient's Visit window.

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

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

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


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

Figure 4-43: Sample list of visit dates window

4.1.13   Display Record (DR)

Use the DR option to display the data about a specified visit.

Below are the prompts.

- Enter ENCOUNTER DATE

  Specify the date of the visit.

After specifying the date, the application displays the BH Visit Record Display window.

```
BH VISIT RECORD DISPLAY        Apr 13, 2009 14:46:26            Page:
1 of    4

Patient Name:          ALPHAA,CHELSEA MARIE
Chart #:               116431
Date of Birth:         FEB 07, 1975
Sex:                   F
Patient Flag           9
Flag Narrative         99

=============== BH RECORD FILE ===============
DATE OF SERVICE:       MAR 24, 2009
PROGRAM:               CHEMICAL DEPENDENCY
LOCATION OF ENCOUNTER: FIVE SANDOVAL INDIAN PROG, IN
OUTSIDE LOCATION       T5
COMMUNITY OF SERVICE:  RIO RANCHO
ACTIVITY TYPE:         11
ACTIVITY TYPE NAME:    SCREENING-PATIENT PRESENT
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               ALPHAA,CHELSEA MARIE
PT AGE:                34
CLINIC:                ALCOHOL AND SUBSTANCE
NUMBER SERVED:         1
APPT/WALK-IN:          WALK-IN
ACTIVITY TIME:         30
+        Enter ?? for more actions
+    Next Screen         -    Previous Screen       Q    Quit
Select Action: +//
```

Figure 4-44: Sample BH Visit Record Display window for a specified visit.

More visit data displays on the next screen.

After you exit the last screen, the application displays the OTHER INFORMATION screen.

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



Update, add or append any of the following data

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

Figure 4-45: Options on the Other Information menu

Use the options to update visit information about the patient, if needed. Otherwise, use Option 8 to exit.

4.2   Visit Window (GUI)

One way to access the Visit Window is to use the One Patient option on the RPMS BHS v4.0 GUI tree structure. The display will contain records for the individual patient in focus.
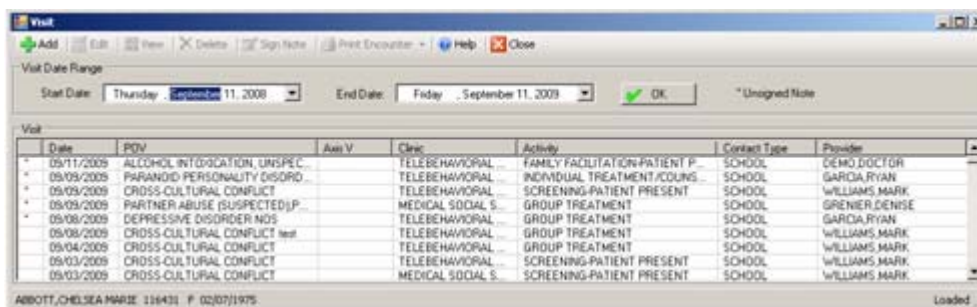
Figure 4-46: Visit window for one patient

Use the Visit window for one patient 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 BHS (GUI) tree structure.
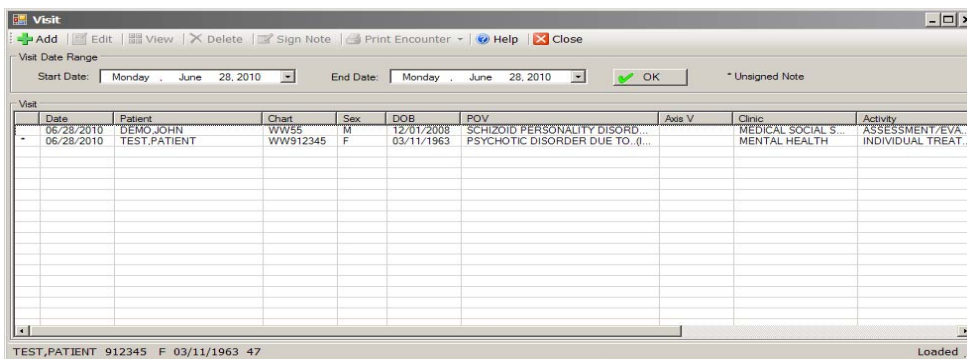
Figure 4-47: Sample Visit window for all patients

Use the Visit window for All Patients to manage the visits for all patients during a specified date range. 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.

4.2.1   Visit Date Range Group Box

The Visit Date Range group box shows the visits in the particular date range.

The date range can be changed 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 group box.

4.2.2   Visit Group Box

The Visit group box shows the Visit records in the particular Visits Date Range.

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

4.2.3   Add Button

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. See Section 4.3.

4.2.4   Edit Button

Use the Edit button to edit a particular Visit record.

- For the Visit window for one patient, access the Visit Data Entry–Edit Visit dialog box.

- For the Visit window for all patients, access the Visit Data Entry–Edit Visit dialog box.

4.2.5   View Button

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, except for the Intake tab.

4.2.6   Delete Button

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

Use the Delete button to delete a particular Visit record. The application confirms the deletion.

4.2.7   Sign Note Button

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

4.2.8   Print Encounter Button

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.

Note that the Intake document must be printed elsewhere and will not appear on a printed encounter form.

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

After selecting one of the options, the application displays the first page of the Print Encounter pop-up window.
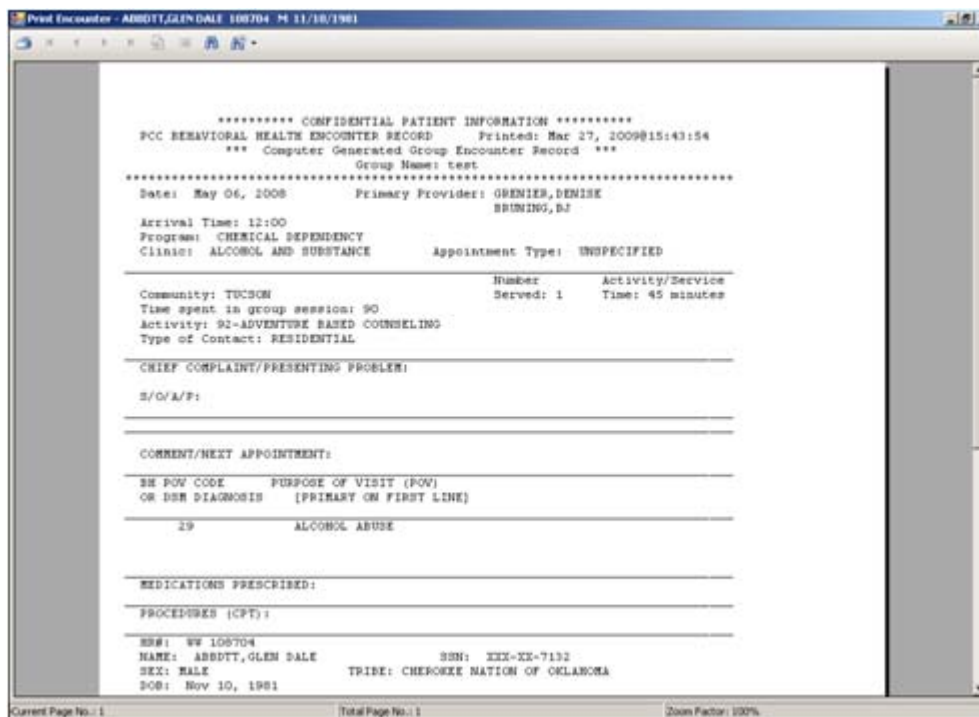
Figure 4-48: Sample Print Encounter pop-up

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

4.2.9   Help Button

Use the Help button in the Visit window to access the online help for the window.

4.2.10   Close Button

Use the Close button in the Visit window to exit the window.

4.3   Add/Edit Visit Data Entry

Use the Add button on the Visit window to add a new record. Establish the patient you want to use in the add process.

- Use the Add button to add a visit for the current patient. The application displays the Visit Data Entry–Add Visit dialog.

- Use the Edit button to edit the selected visit for the current patient. The application displays the Visit Data Entry–Edit Visit window. The Edit button will be inactive if the patient does not have any previous visits.

Below is a sample Visit Data Entry–Add Visit window. (The same fields appear on the Visit Data Entry–Edit Visit window.)

Figure 4-49: Sample Visits Data Entry–Add Visit window

Use the Help button to access online help about this window.

After adding or changing this dialog, click Save to save your changes. This dismisses the Add/Edit window. If you added a SOAP/Progress note, you will be asked if you want to sign the note. See Section 2.14.5 for more information.

- If there was no appointment for the patient in the scheduling package, you are returned to the Visit window.

- If there was an appointment for the patient in the scheduling package, the application displays the Select PCC Visit window. See Section 4.3.9 for more information. 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 visit in PCC.

Use the Close button to display the "Continue?" dialog. This dialog states "Unsaved Data Will Be Lost, Continue?"

- Click Yes to close without saving; this dismisses the data entry window.

- Click No and you remain in the data entry window where you can continue work.

The Free Text fields have a context menu for editing. See Section 2.11 for more information.

Several of the fields contain a search window. See Section 2.8 for more information.

The fields that contain dates can be changed by accessing a calendar. See Section 2.7 for more information.

Certain group boxes use the Search/Select window. See Section 2.9 for more information.

Some group boxes use the Multiple Select window. See Section 2.10.

4.3.1 Visit Information Group Box

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

Figure 4-50: Sample Visit Information group box

The fields in bold text are required.

- Primary Provider

  The default is the current provider. Change this field by clicking the drop-down list to access the Primary Provider search window. Here you can search for a provider name.

- Encounter Date/Time

  The default is the current date and time. The date can be changed by clicking the drop-down list to access the calendar. You can manually change the time. (This field can be changed during Edit).

- Program

  This field determines the program associated with the visit:

- Mental Health
- Social Services
- Other
- Chemical Dependency

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

- Encounter Location

  This field determines the location of the encounter. Change this field by clicking the drop-down list to access Location search window. Here you can search for the location name.

- Clinic

  This field determines the clinic if the encounter took place with the context of a scheduled clinic. Change this field by clicking the drop-down list to access the Clinic search window. Here you can search for the type of clinic.

- Appointment or Walk-In

  This field determines the type of visit. Use one of the following:

  - Appointment
  - Walk In
  - Unspecified (for non-patient contact)

- Type of Contact

  This field determines the type of contact (the activity setting). Select the type of contact from the drop-down list, if you need to change the information displayed.

- Community of Service

  This field determines the community of service where the encounter took place. Change this field by clicking the drop-down list to access the Community search window. Here you can search for the community name.

4.3.2   POV Tab

Use the POV tab to add, edit, or delete the Axis I, Axis II, and Axis IV codes, to enter the general medical conditions for Axis III, and to enter the GAF score.
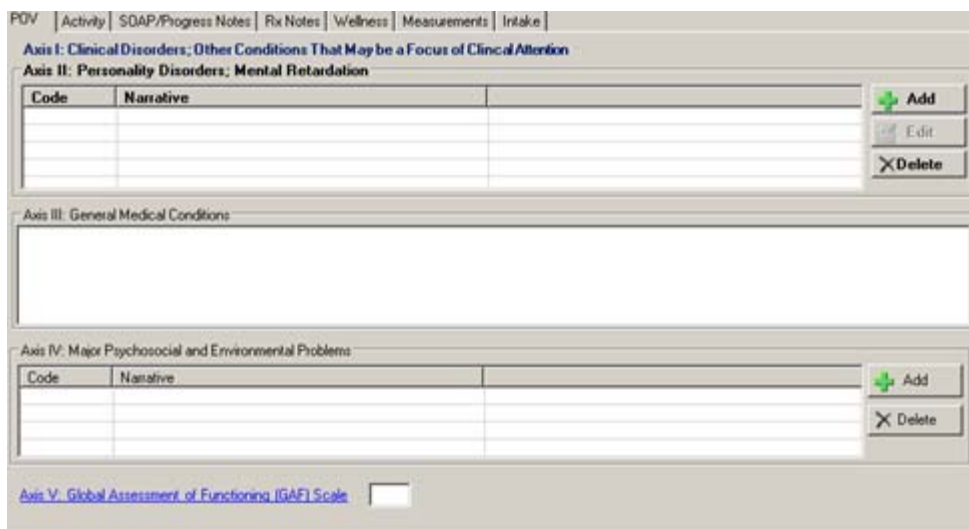
Figure 4-51: Sample POV Tab in Visit Data Entry window

4.3.2.1   Axis I/Axis II Group Box

Use the Axis I/Axis II group box to manage the POV codes for Axis I or Axis II issues.
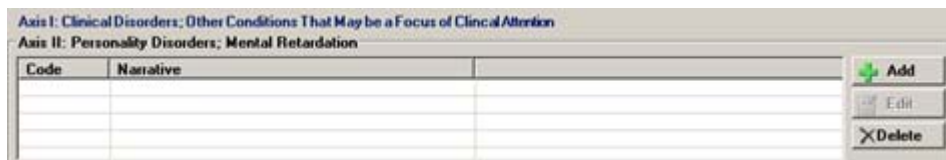
Figure 4-52: Sample Axis I/Axis II group box

You can add a new code, edit the narrative of a selected code, or delete a selected code.

Use the Delete button to remove a selected code from the group box. 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 code from the group box (otherwise, click No.)

Use the Add button to access the POV (Axis I/II) search/select window. Here you can add one or more POV codes associated with the visit. You can search by code number or POV narrative.

Use the Edit button to edit the POV narrative (not the code) of a selected record on the Edit POV dialog.
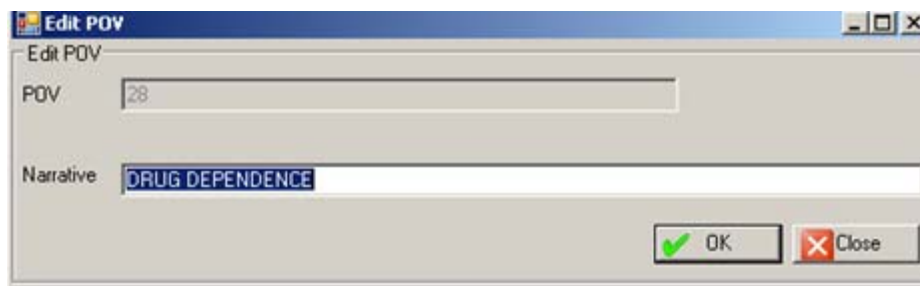
Figure 4-53: Edit POV dialog

The Narrative field is a Free Text field. Type the new POV narrative in the Narrative text box and click OK. This changes the narrative of the selected code. (Otherwise, click Close to keep the narrative without changes.)

4.3.2.2   Axis III Group Box

Use the Axis III group box to describe the client's general medical conditions. This field should only be used if the medical condition was treated during the visit. Populate it with the text of the condition (Free Text field).

4.3.2.3   Axis IV Group Box

Use the Axis IV group box to enter one or more of the psychosocial or environmental codes that identify the major category of the problem.
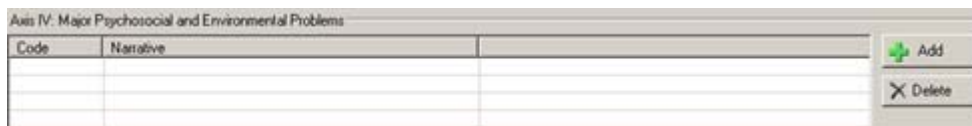
Figure 4-54: Sample Axis IV group box

Use the Add button to add the codes on the Axis IV multiple select dialog box. Here you can select one or more codes to populate this group box.

Use the Delete button to remove a selected code. 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 code from the group box (otherwise, click No.)

4.3.2.4   Axis V

Use the Axis V field to enter the GAF scale value (assessment of the client's functional level). This is a Free Text field limited to 3 numerical characters (0–100).

If you click the link on the Axis V label, the application displays a Global Assessment of Functioning pop-up window. This provides information about the GAF codes.
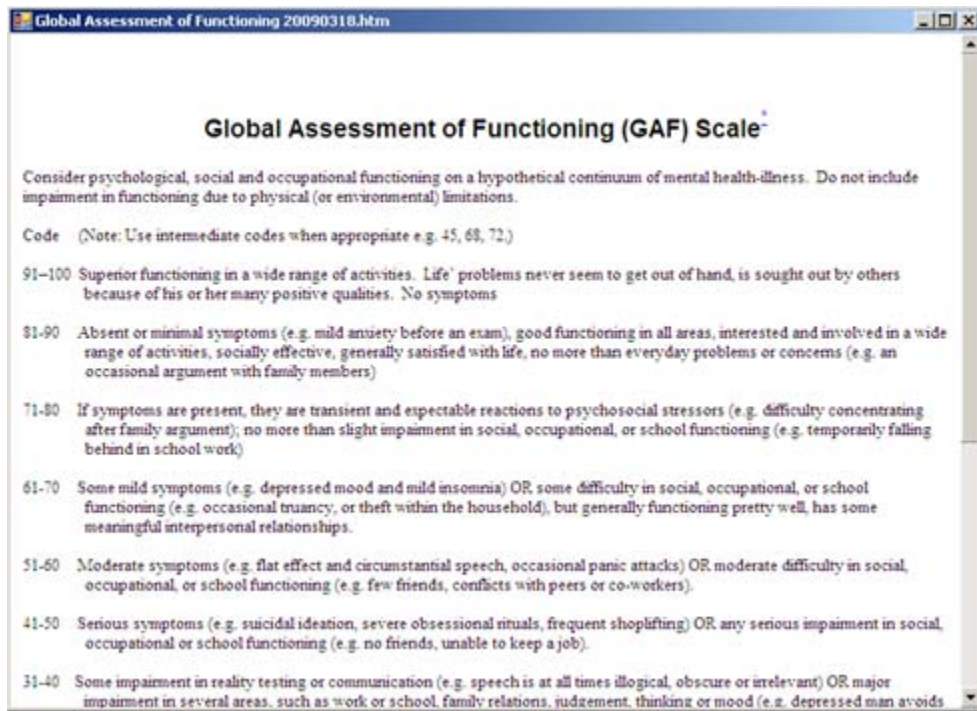
Figure 4-55: GAF scale

4.3.3   Activity Tab

Use the Activity tab to manage Activity data about the visit for the current patient.
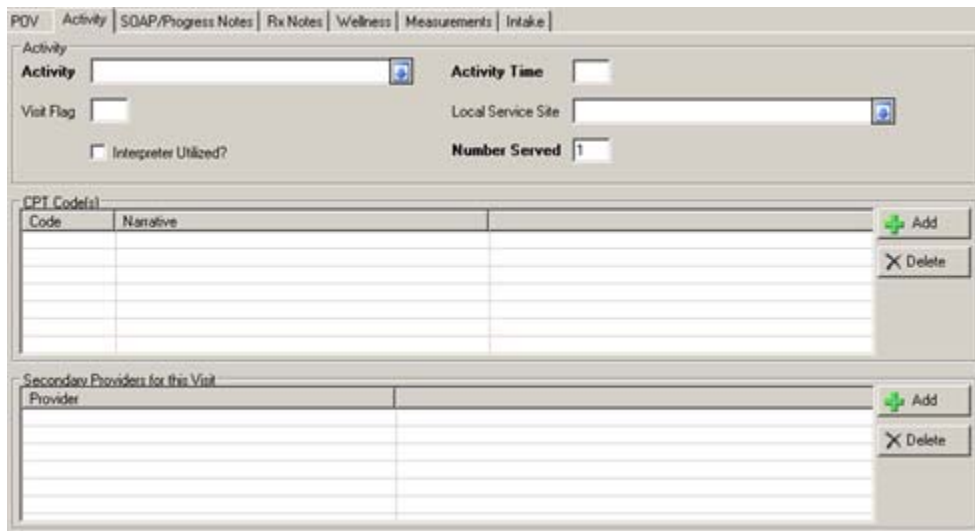
Figure 4-56: Sample Activity Tab in the Visit Data Entry window

4.3.3.1   Activity Group Box

Below is the Activity group box.

Figure 4-57: Sample Activity group box

The fields in bold text are required.

- Activity

  Populate with the activity code that documents the type of service or activity performed by the BH 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 can search for the activity name. See Appendix A for more information.

- Activity Time

  Populate with the activity time, using any number between 1 and 9999 (no decimal digits). This required field determines how much provider time was involved in providing and documenting the service or performing the activity. The understood units of measure are minutes.

- Visit Flag

  Populate with 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 (0–999) to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. Later you can retrieve all visits with a flag of 1, which will list all visits on which narcotics were prescribed. This is a Free Text field.

- Local Service Site

  Populate with the local service site. Click the drop-down list to select a local service site.

- Interpreter Utilized?

  Populate with Y or N to indicate if the presence of an interpreter is required during the patient encounter. Type **Yes** only if an interpreter is required to communicate with the patient.

- Number Served

    Populate with the number served, using any number between 1 and 9999 (no decimal digits). 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 administrative activities. The default is 1. Group activities or family counseling are examples where other numbers might be listed. This is a Free Text field.

4.3.3.2   CPT Codes Group Box

Use the CPT Codes group box to manage the CPT codes used during the encounter.
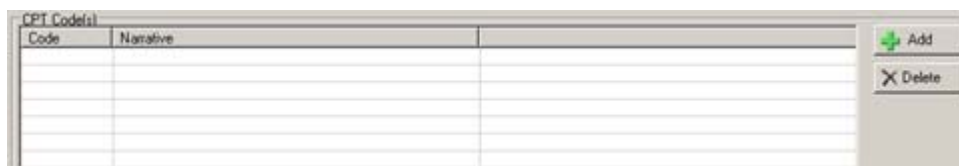
Figure 4-58: Sample CPT Codes group box

Click Add to access the CPT Code multiple search/select window. Here you can search for the CPT or HCPCS codes for BH services. 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. You can add one or more CPT codes to this group box.

Use the Delete button to remove a selected CPT code record from the group box. 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 code from the group box (otherwise, click No.)

4.3.3.3   Secondary Providers for this Visit Group Box

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

Figure 4-59: Sample Secondary Providers for this Visit group box

Click Add to access the Secondary Providers multiple search/select window. Here you can search for the last name of the secondary provider. You can add one or more secondary providers to this group box.

Use the Delete button to remove a selected secondary provider record from the group box. 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 provider from the group box (otherwise, click No.)

4.3.4   SOAP/Progress Notes Tab

Use the SOAP/Progress Notes tab on the Visit Data Entry window to manage the SOAP/progress notes associated with the current visit.
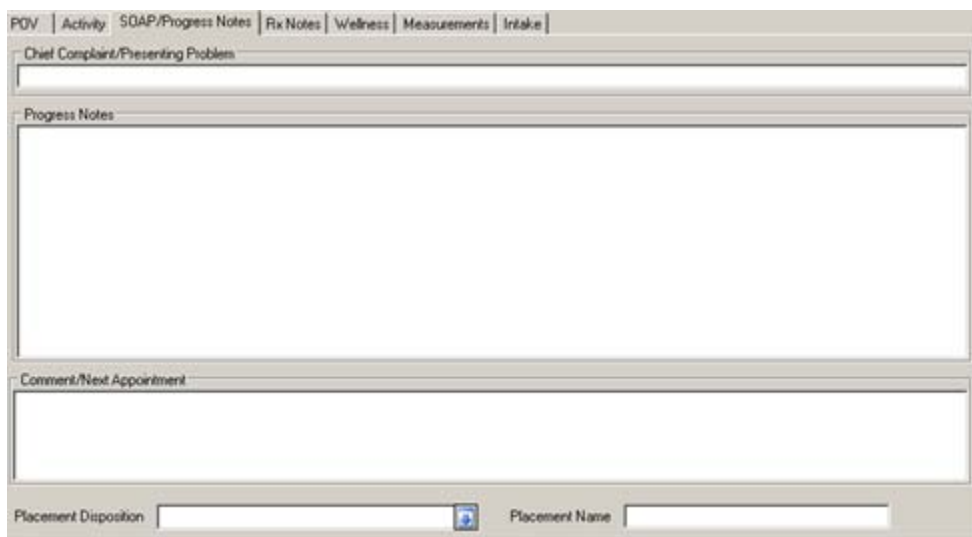
Figure 4-60: Sample SOAP/Progress Notes tab

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

- Chief Complaint/Presenting Problem

    Populate with the chief complaint or presenting problem using 2 to 80 characters. This is a Free Text field that describes the major reason the patient sought services.

- Progress Notes

    Populate with the text of the progress note for the visit. This is a Free Text field. A SOAP or progress note must be entered in the context of a visit.

- Comments/Next Appointment

    Populate with the text of any notes or comments about the client's next appointment. This is a Free Text field.

- 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 where you can select a placement type.

- Placement Name

  Populate with the name of the placement facility. This is a Free Text field.

4.3.5   Rx Notes Tab

Use the Rx Notes tab to view prescription data.
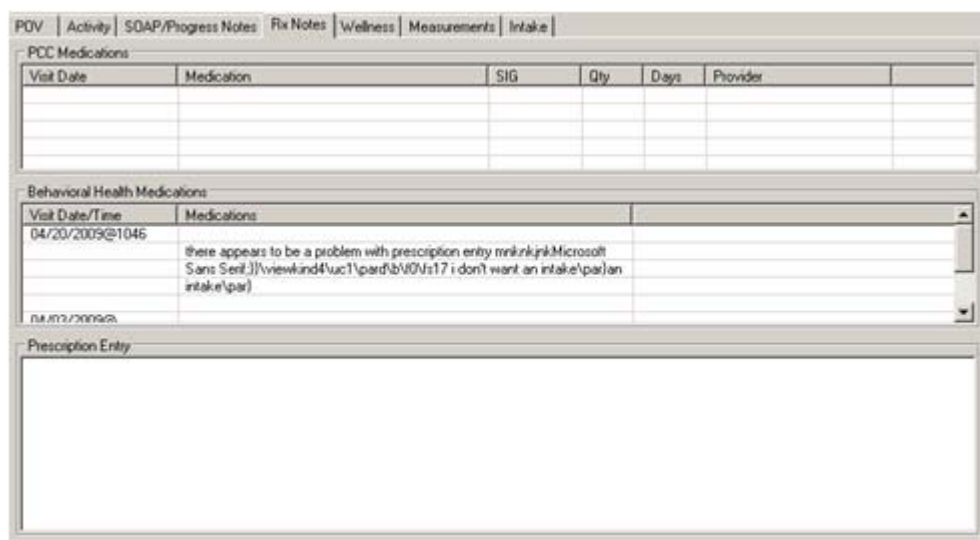
Figure 4-61: Sample Rx Notes tab

Use this tab to do the following:

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

- Use the Behavioral Medication group box to view the visit dates when the behavioral medication was prescribed and any associated notes.

- Use the Prescription Entry field to enter information about the patient's prescriptions. This information will be viewable in the Medications field for future visits. Items in the Medication field may 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. This field has a right-click menu that lets you cut, copy, or paste data (these functions are like the ones in MS Office).

4.3.6   Wellness Tab

Use the Wellness tab to view the BH/PCC wellness activities, as well as manage the education, health factors, and screenings for the visit.

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

Figure 4-62: Sample Wellness tab

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

4.3.6.1   Patient Education

Select the Patient Education option on the Wellness tree structure to display the patient education group boxes: Patient Education History and Patient Education Data Entry.
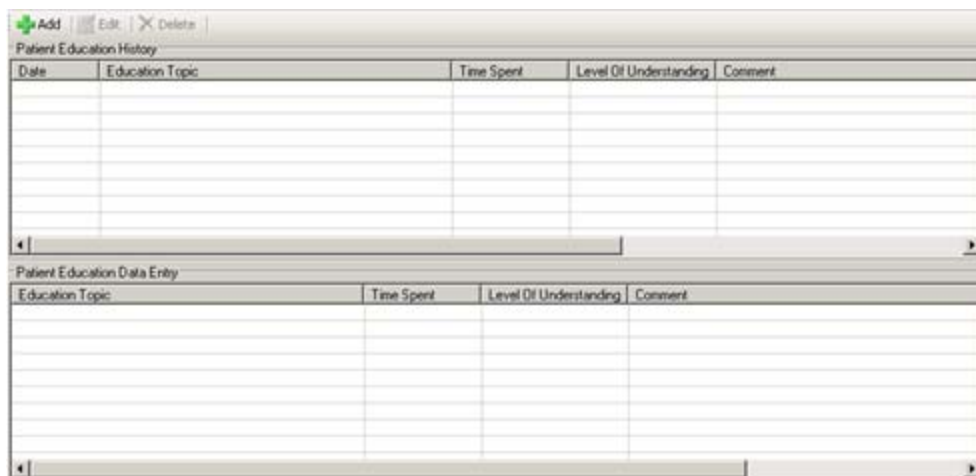
Figure 4-63: Sample Patient Education group boxes

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

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

Click the Add button to display the Education Topic select window. After selecting a topic, click OK. Otherwise, click Cancel.

If you click Cancel, the application displays the Patient Education window with no data in the fields. If you clicked OK, the application displays the Patient Education window, with the Education Topic field populated.
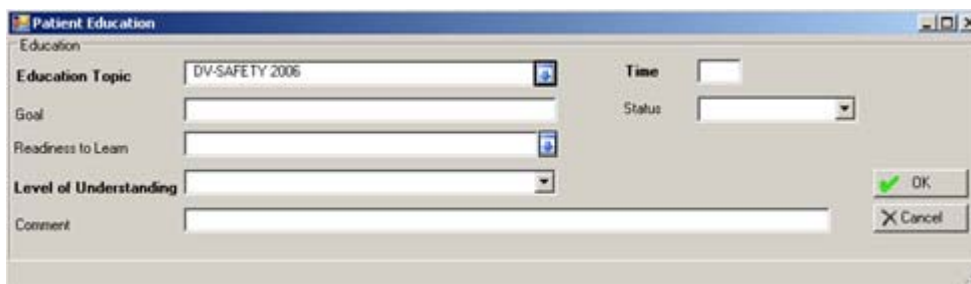
Figure 4-64: Sample Patient Education window

The fields in bold text are required.

- Education Topic

    The application populates this field with what you selected on the Education Topic select window. To change this selection, click the drop-down list to access the Education Topic search window. Here you can search for the education topic code.

- Time

  Populate the number of minutes spent on the patient education

- Goal

  Populate with text of the stated goal of the education. For example, "Patient plans to walk 6 times a week." This is a Free Text field.

- Status

  Populate with 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 precontemplation phase defined as "patient is not thinking about change")

- Readiness to Learn

  Click the drop-down list to display the Readiness to Learn select window dialog.

  The options are:

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

- Level of Understanding

  Populate with 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)

- Comment

  Add any comments about the education topic for the visit. This is a Free Text field.

  Click OK to save the added/changed information. This action dismisses the Patient Education window and populates the Patient Education Data Entry grid.

  Use the Cancel button to close without saving. The application displays the Continue? warning stating: "Canceling will lose all unsaved data, Continue?" Click Yes to close without saving and leave the Patient Education window. Click No to return to the Patient Education window.

4.3.6.1.1   *Edit Patient Education Record*

Select a record in the Patient Education Data Entry grid and click Edit. The application displays the Patient Education dialog, with the fields populated with the current data. See Add Education Topic Record (above) for more information about the fields. If the record was saved before the installation date for BHS v4.0 it will continue to display the CPT field. You can edit an education record if the visit has a signed note.

4.3.6.1.2   *Delete Patient Education Record*

Select a record in the Education Topics Data Entry grid and click Delete. The application displays the Are You Sure warning stating: "Are you sure you want to delete." Click Yes to delete the selected record (otherwise, click No.)

4.3.6.2   Health Factors

Select the Health Factors option on the Wellness tree structure to display the Health Factor group boxes: Health Factors History and Health Factors Data Entry.
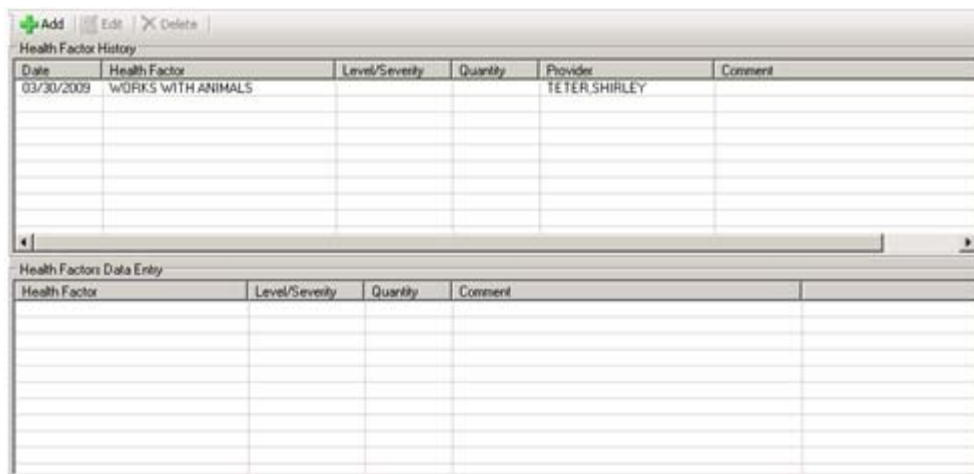
Figure 4-65: Sample Health Factors group boxes

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

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

The Health Factors History group box is read only. You can scroll through the data using the scroll bar.

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

4.3.6.2.1   *Add Health Factor Record*

Click the Add button to display the Health Factors search window. After selecting a health factor, click OK. Otherwise, click Cancel.

If you clicked Cancel, the application displays the Health Factors dialog with no data in the fields. If you clicked OK, the application displays the Health Factors window, with the Health Factor field populated.

Figure 4-66: Sample Health Factors window

The fields in bold text are required.

- Health Factor

  The application populates this field with what you selected on the Health Factors select window. To change this selection, click the drop-down list to access the Health Factor search window. Here you search for the health factor name.

- Level/Severity

  Populate with one of the following, if applicable:

  - Minimal
  - Moderate
  - Heavy/Severe
- Quantity

  Populate with the quantity associated with the health factor, if any.

- Comment

  Populate with the text of any comment for clarification about the documented health factor.

  Use the OK button to save your data and have it display the Health Factors Data Entry grid.

  Use the Cancel button to not save the data. The application displays the Continue? dialog box that states: "Canceling will lose all unsaved data, Continue?" Click Yes to close without saving and leave the Health Factors window. Click No to return to the Health Factors window.

4.3.6.2.2   *Edit Health Factor Record*

Select a record in the Health Factors Data Entry grid and click Edit. The application displays the Health Factors window with the fields populated with the current data. See Add Health Factor Record (above) for more information about the fields.

4.3.6.2.3   *Delete Health Factor Record*

Select a record in the Health Factors Data Entry grid and click Delete. The application displays the Are You Sure warning stating: "Are you sure you want to delete." Click Yes to delete the selected record (otherwise, click No.)

4.3.6.3   Screening

Select the Screening option on the Wellness tree structure to display the screening group boxes: Screening History and Screening Data Entry.
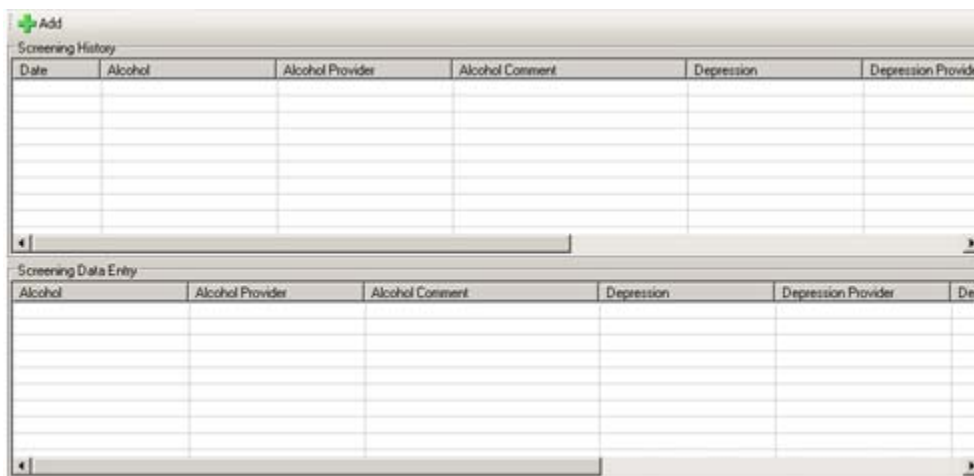
Figure 4-67: Sample Screening group boxes

The Screening History group box is read only. You can scroll through the data using the scroll bar.

- If the Screening Data Entry group box is empty, the Add button displays.

- If the Screening Data Entry group box is populated, the Edit button displays. You can edit a selected record by clicking the Edit button.

In either case, the Screening window displays.
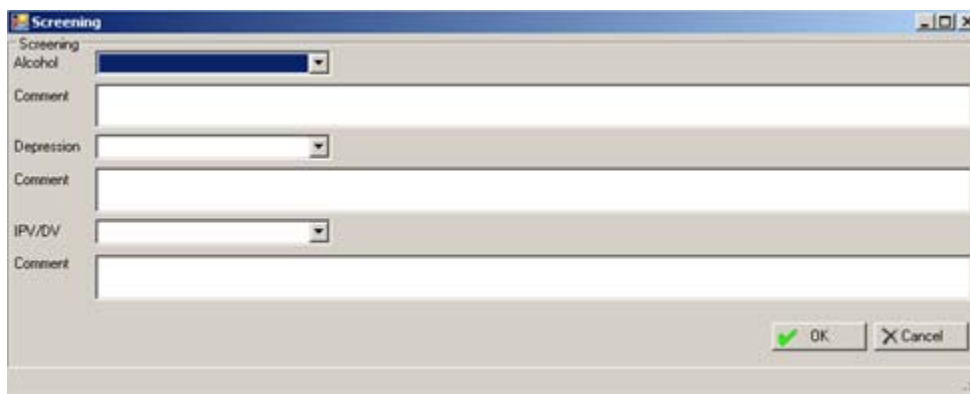
Figure 4-68: Screening window

- Alcohol

  Populate with 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)

- Comment

  Populate with the text of any comment related to the alcohol screening.

- Depression

  Populate with 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)

- Comment

  Populate with the text of any comment related to the depression screening.

- IPV/DV

  Populate with the intimate partner violence/domestic violence (IPV/DV) 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 (Admits both a past history of IPV/DV and being a current victim)
  - 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)

- Comment

  Populate with the text of any comment related to the IPV/DV screening.

  Use the OK button to save your data and have it display the Screening Data Entry grid.

  Use the Cancel button to not save the data. The application displays the Continue? dialog box, which states: "Canceling will lose all unsaved data, Continue?" Click Yes to close without saving and leave the Health Factors window. Click No to return to the Health Factors window.

4.3.7   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.
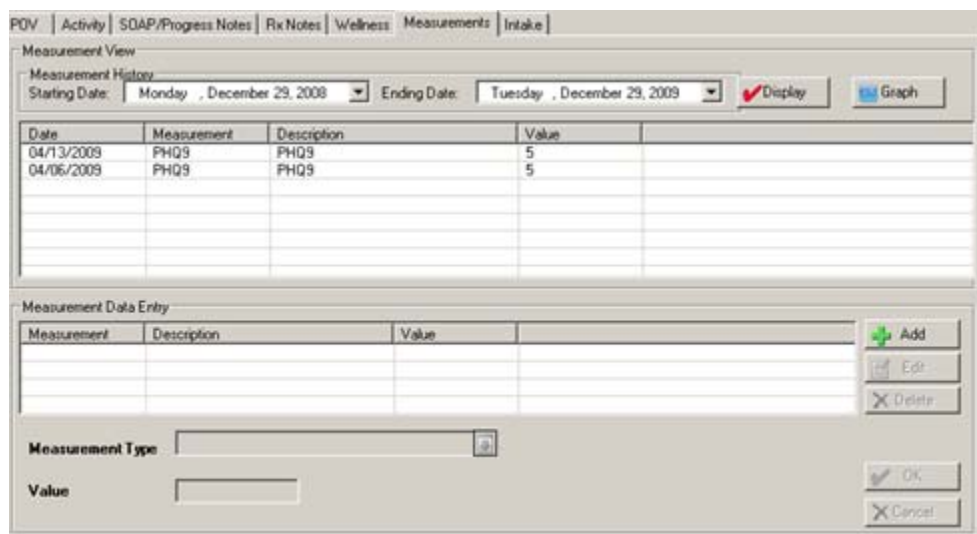
Figure 4-69: Sample Measurements tab

4.3.7.1   Measurement View Group Box

This group box displays the measurements for the current patient in the date range shown in the Data View group box. The date range can be changed by clicking the drop-down list to access the calendar. After changing the date range, click Display to refresh the Data View group box with the new data.
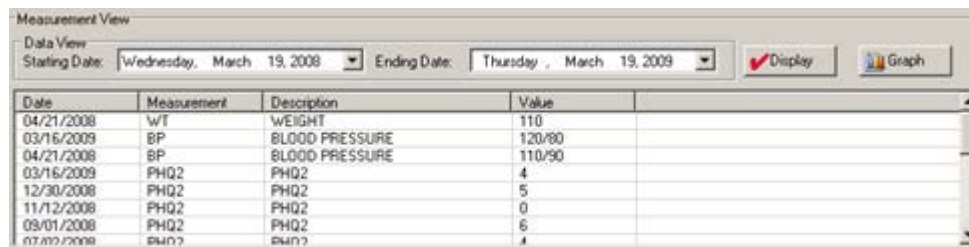
Figure 4-70: Sample Measurement View group box

To better utilize the data collected and viewed through the Measurement View group box, you can graph a measurement in the grid by clicking the Graph button. The application will display the Measurement Type window.
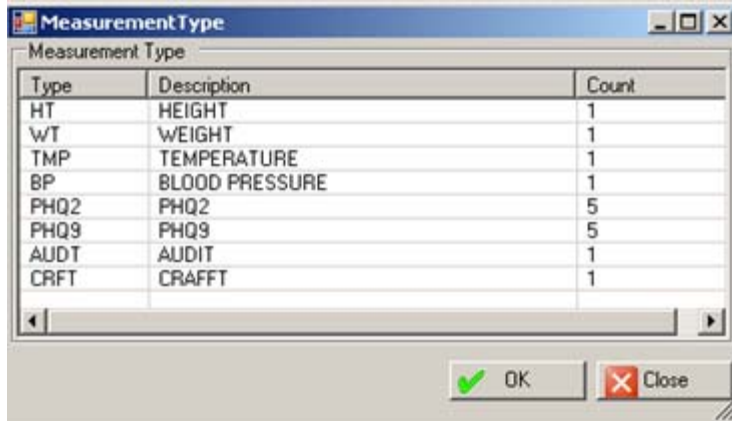
Figure 4-71: Sample Measurement Type window

Select the measurement type you want to graph. Then click OK. The application will (automatically) use the data to display a graph in MS Excel.

You are moved 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.
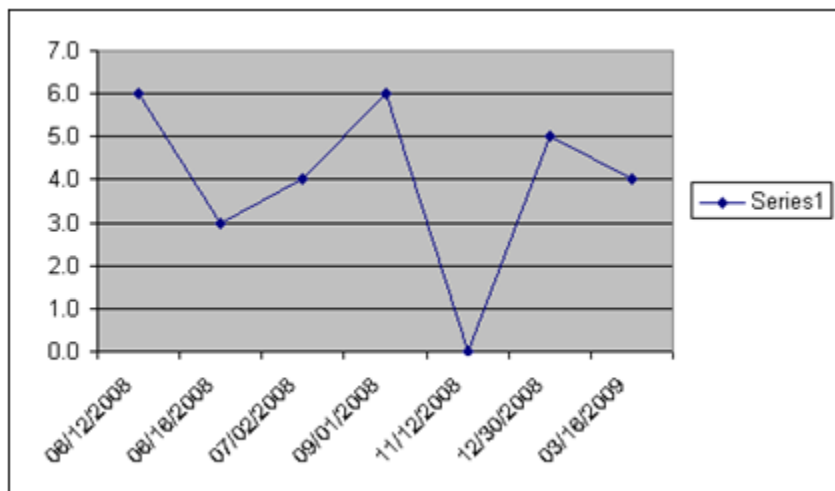
Figure 4-72: Sample line graph

4.3.7.2   Measurement Data Entry Group Box

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

Figure 4-73: Sample Measurement Data Entry group box

Use the Edit button to change the value of a selected measurement record. The value displays in the fields below the grid. After changing the Value field, click OK to change the Value in the grid.

Use the Cancel button to clear the data in the Measurement Type field.

Use the Delete button to delete a selected measurement record. Measurements can only be deleted from the encounter record where they were first recorded.

Click the Add button to activate the measurement fields for data entry.

The fields in bold text are required.

- Measurement Type

   Populate this field with a V Measurement type. Click the drop-down list to access the Measurement Type window. Select a type and click OK on the Measurement Data Type group box. This field is inactive when editing a record.

- Value

   Populate with the numeric value of the measurement. If the value is outside the accepted range, the application displays the Warning message. Click OK to dismiss the warning and populate with another valid numeric value.
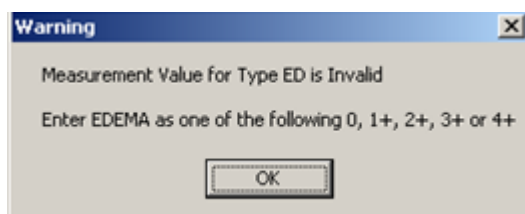
Figure 4-74: Sample Value outside the acceptable range warning

   Click OK on the Measurement Data Entry group box to have the new record display in the grid (showing the Measurement along with its description and value).

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

4.3.8 Intake Tab (GUI)

When you click the Intake tab, the application displays the Intake window.
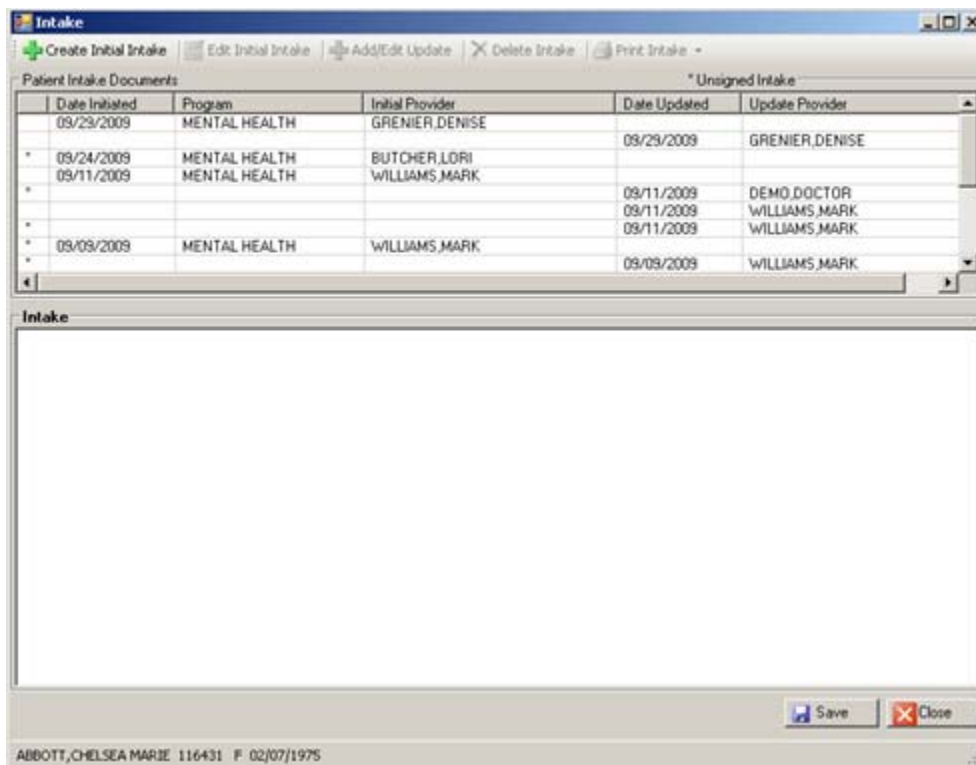
Figure 4-75: Initial Intake window

See Section 12.0 for more information.

4.3.9 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.
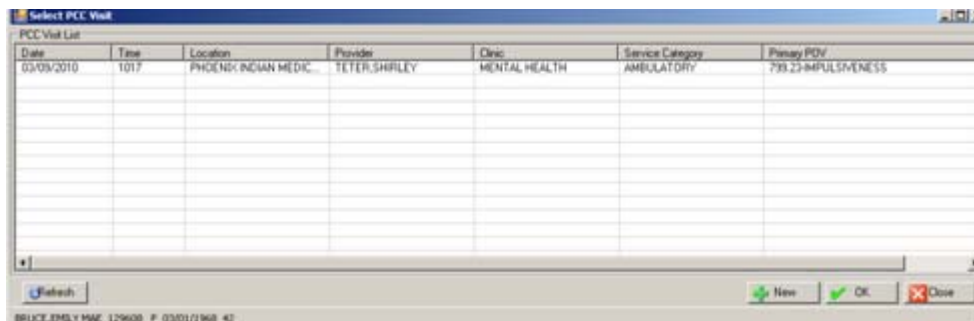
Figure 4-76: Sample Select PCC Visit window

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

If you don't see the visit you need to link to, you can choose a new one or leave it 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 4-77: 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, you will see the following screen.

```
Patient Name:          THETA,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:          THETA,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:     BH
CREATED BY USER:       BETA,BJ
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,BJ
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,BJ
AFF.DISC.CODE:         3A513
PRIMARY/SECONDARY:     PRIMARY
V FILE IEN:            4873643
=============== POV ===============
POV:                   799.9
ICD NARRATIVE:         UNK CAUSE MORB/MORT,NEC
PROVIDER NARRATIVE:    DIAGNOSIS OR CONDITION DEFERRED ON AXIS I
V FILE IEN:            3224050

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

Figure 4-78: Information from PCC

4.4   Browse Visits (GUI)

Use the Browse Visits option on the RPMS BHS (GUI) tree structure to access the
Browse Visits window. This dialog applies to the current patient.
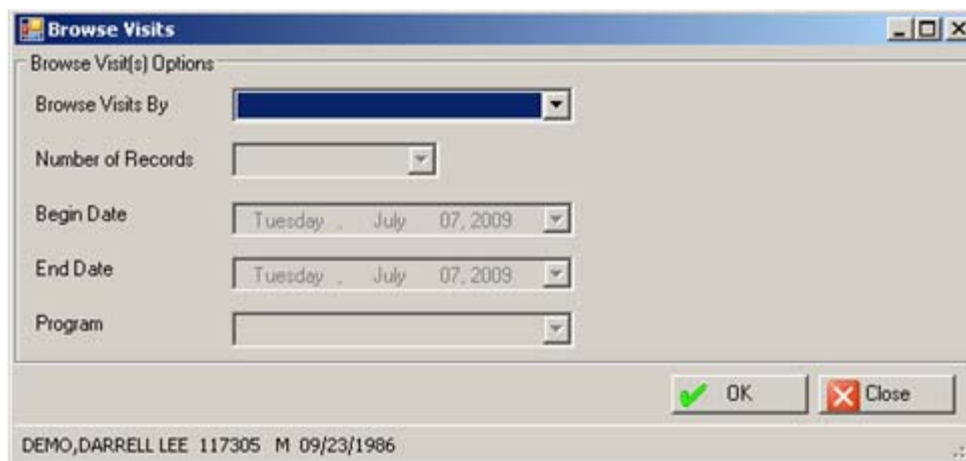
Figure 4-79: Sample Browse Visits window

Below are the fields.

- Browse Visits By

  Use 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 L or A option, the other fields will not be active.

- Number of Records

  If you use the N option in the first field, the Number of Records becomes active. Populate this field with the number of visits (use an integer).

- Begin Date/End Date

  If you use the D option in the first field, the Begin Date and End Date fields become active. Populate these fields with the date range.

- Program

  If you use the P option in the first field, the Program field becomes active. Populate this field with the name of the program.

After you click OK, the application displays the first page of the Browse Visits window.
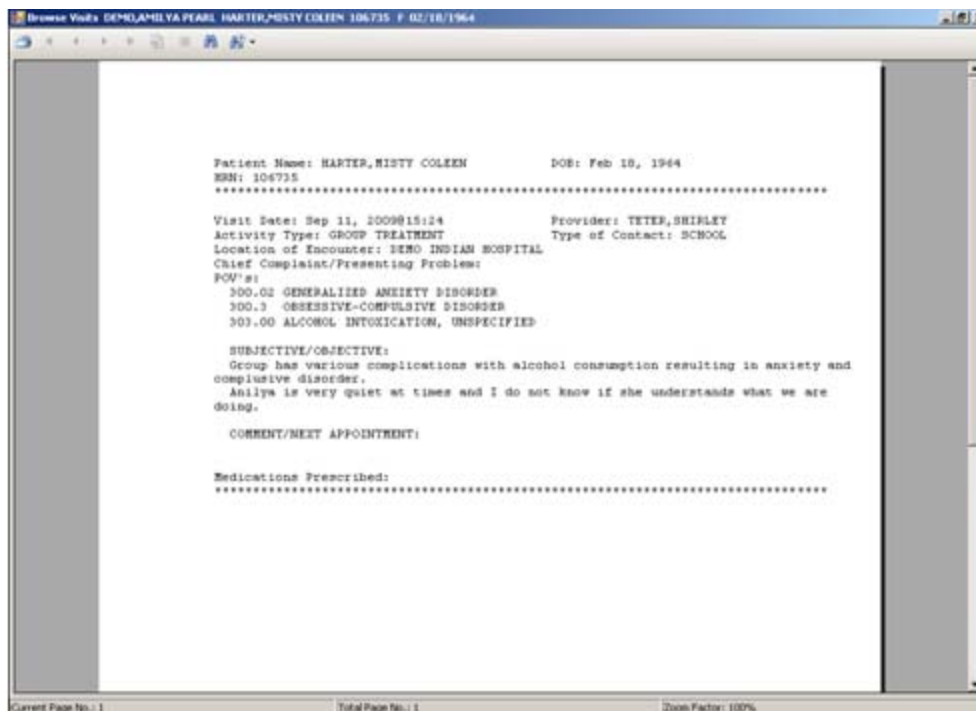
Figure 4-80: Sample of data in Browse Window

See Section 2.6 for more information about this type of window.

4.5   Clinical Activities (GUI)

The first two items under the Clinical Activities option on the tree structure for the RPMS BHS (GUI) are: View Health Summary and View Face Sheet.

4.5.1   View Health Summary

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

The application displays the Select Health Summary Type window.
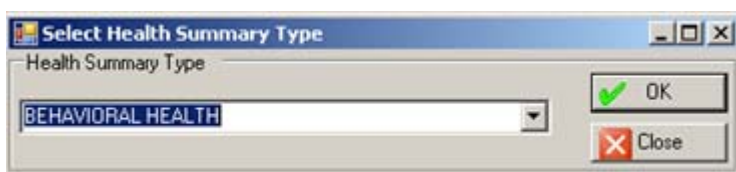
Figure 4-81: Select Health Summary Type window

Select the health summary type from the drop-down list and then click OK. (Otherwise, click Close to close without selecting a type).

After you click OK, the application displays the first page of the particular health summary type pop-up window. See Section 2.6 for more information about this type of window.

4.5.2   View Face Sheet

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

5.0   Group Encounters

This section provides information on how to enter or edit group encounter data for roll-and-scroll and the RPMS BHS (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 BHS data from a group form. Use 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.

- Enter Beginning Date

  Specify the beginning date of the date range for displaying Group definitions.

- Enter Ending Date

  Specify 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)  * 10/01/09 EDIT INTAKE           GROUP TRE  S   MEDIC  GAMMA,R   SCH 311. - D
2)  * 10/01/09 EDIT INTAKE           GROUP TRE  S   MEDIC  GAMMA,R   SCH 311. - D
3)  * 09/29/09 INTAKE GROUP          GROUP TRE  M   TELEB  GAMMA,R   SCH 296.20 -
4)    09/29/09 INTAKE GROUP          GROUP TRE  M   TELEB  GAMMA,R   SCH 296.20 -
5)    09/28/09 Mond DV               FAMILY/GR  S   MEDIC  OMEGA,D   OUT 43.2 - P
6)    09/25/09 GOAL STATUS           GROUP TRE  S   MEDIC  GAMMA,R   SCH 298.9 -
7)    09/25/09 Friday DV group       GROUP TRE  S   MEDIC  OMEGA,D   SCH 80 - HOU
8)  * 09/25/09 pov test              GROUP TRE  S   MEDIC  GAMMA,R   SCH 2 - CROS
9)    09/24/09 WW-GRIEF GROUP        LIFE SKIL  S   MEDIC  DELTA,W   OUT 24 - ADJ
10) * 09/24/09 WW-DEPRESSION GROUP   GROUP TRE  M   MENTA  DELTA,W   FIE 311. - D
11) * 09/22/09 mark edu status       GROUP TRE  M   TELEB  EPSILON   SCH 2 - CROS
12) * 09/22/09 PR465 test            GROUP TRE  M   TELEB  BETA,     SCH 27 - ALC
13)   09/22/09 TEST OF CC MARK       GROUP TRE  M   TELEB  EPSILON   SCH 2 - CROS
+         Enter ?? for more actions                                   >>>
1   Add a New Group                  6    Review/Edit Group Visits
2   Display Group Entry              7    Add No Show Visit
3   Duplicate Group                  8    Edit Group Definition
4   Delete Group                     9    Sign Notes
5   Print Encounter Forms            Q    Quit
Select Action:+//
```

Figure 5-1: Sample Group Entry window

The asterisk (*) preceding the Entry Date indicates that the record contains an unsigned group note. See Section 2.14 for more information.

Use Quit 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.

Below are the prompts.

- Enter Date of the Group Activity

   Specify the date of the new group activity.

The application displays the Group Encounter Documentation window.

```
*  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

Below are the fields on the Group Encounter Documentation screen.

- Add/View/Update Providers (Primary or Secondary) for this Group?

  Type **N** or **Y**. Type **Y** to add a group; this is the only place to add a group. If you type **Y**, the following pop-up displays.

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

Figure 5-3: Sample Secondary Providers pop-up

  Specify the provider name at the PROVIDER field and populate the PRIMARY/SECONDARY field with the type of provider. Only one primary provider can be used, whereas, you can use multiple secondary providers.

Below are more fields in the Group Encounter Documentation screen.

- Encounter Date

  Specify the encounter date. The default shows the date of the new group activity (which was entered before you accessed this window).

- Arrival Time

  Specify the arrival time of the encounter. The default is 12:00.

- Program

  Specify the program for the group encounter. Use one of the following:

  - M (Mental Health)
  - S (Social Services)
  - C (Chemical Dependency)
  - O (Other)
- Community of Service

  Specify the name of the community of service where the encounter took place.

- Group Name

  Specify the name of the group encounter using between 1 and 30 characters.

- Clinic

  Specify the clinic (by number or name).

- Activity

  Specify the activity of the group encounter.

- Activity Time

  Specify the number of minutes (no decimal digits) the provider(s) spent on the activity. Note that zero is not allowed as a valid entry. The time is divided equally among each of the group participants.

- Encounter Location

  Specify the name of the location for the encounter.

- Type of Contact

  Specify the type of contact (the activity setting).

- POV or DSM (Primary Group Topic)

  Specify the POV for the group topic. Press Enter to have the application display 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

At the Code field, specify with a MHSS Problem/DSM IV POV code.

The application populates the Narrative for the particular code but can be edited.

> **Note:** The special characters *single quote* (') and *double quote* (") cannot be the first character of the POV narrative.

Below are more fields in the Group Encounter Documentation screen.

- Chief Complaint/Presenting Problem

  Specify the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patient sought services.

- Any Patient Education Done?

  Type **Y** or **N**. If you type **Y**, the application displays the Patient Education for this Group Activity pop-up window.

```
*PATIENT EDUCATION for this Group Activity

 After entering each topic you will be prompted for more fields


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

Figure 5-5: Sample Patient Education enter/edit screen

The following provides information about the fields in the Patient Education Enter/Edit pop-up window.

Specify the education topic code at the EDUCATION TOPIC field. The following pop-up will display:

```
EDUCATION TOPIC: 042.-DISEASE PROCESS

LEVEL OF UNDERSTANDING: GROUP-NO ASSESSMENT
PROVIDER: THETA,SHIRLEY
MINUTES:

COMMENT:
```

Figure 5-6: Sample pop-up window for education data

- − Individual/Group. Application automatically populates with GROUP. You cannot change this field.
- − Level of Understanding. Application automatically populates with GROUP– NO ASSESSMENT. You cannot change this field.
- − Provider. Application automatically populates with the primary provider. This can be changed.
- − Minutes. Populate with the number of minutes spent on education.
- − Comment. Populate with the text of any comment about the education topic, using 2–100 characters.

Below are more fields on the Group Encounter Documentation screen.

- CPT Code(s) <press enter>

  Press Enter to access another window where you can specify the CPT or HCPCS codes associated with the group encounter.

- S/O/A/P (Standard Group Note) <press enter>

  Press Enter to access another window where you enter the text of a group note.

- Patients <press enter>

  Press Enter to access the Patients pop-up window.

```
Please enter all patients who participated in the group.
Remove any patients who were not present

PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
```
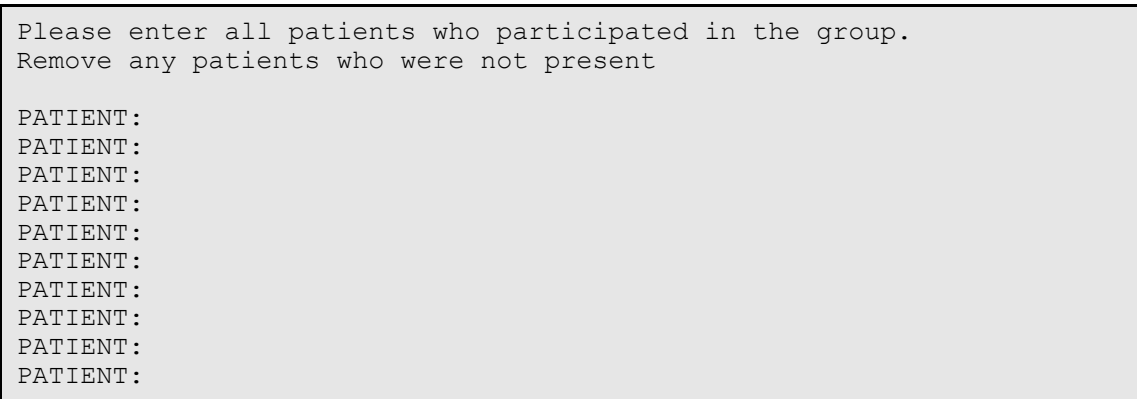
Figure 5-7: Sample pop-up window for patients

  Specify the patient name, HRN, DOB, or SSN at the PATIENT field.

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//
```
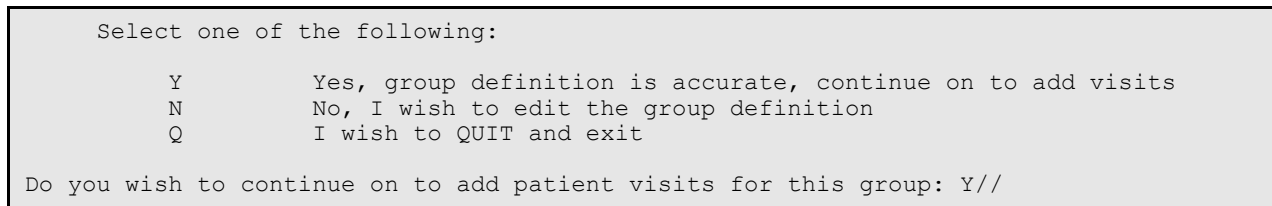
Figure 5-8: Questions upon exit

- Type **Y** to continue adding the patient's individual visit associated with the group visit. You are returned to the record for the first patient.

- Type **N** to edit the group definition.

- Type **Q** to quit and exit. You return to the Group Entry screen.

After a provider enters the group definition, completes documentation for the individual patients, and saves, the application will display an option to sign all SOAP/Progress Notes or to leave them unsigned.

5.1.2   Edit Group Definition

Use Option 8 to edit a selected 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 REVIEW/EDIT GROUP VISITS to modify visits within this group." In this case, the application returns you to the Group Entry window.

In all other cases, the application displays the Group Encounter Documentation window.

```
*  GROUP ENCOUNTER DOCUMENTATION  *          DEMO INDIAN HOSPITAL
------------------------------------------------------------------
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAY 15,2009@12:00       Arrival Time: 12:00
Program: MENTAL HEALTH                  Community of Service: ABERDEEN
Group Name: meeting on thur             Clinic: EMERGENCY MEDICINE
Activity: 25                            Activity Time: 6
Encounter Location: ABERDEEN AO         Type of Contact: CONSULTATION
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N          CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
_____

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

Figure 5-9: Sample Group Encounter Documentation window

See Section 5.1.1 for more information about the fields in this window.

5.1.3   Review/Edit Group Visits

Use Option 6 to review/edit the group visits with a particular group encounter.

Below are the prompts.

- Select GROUP ENTRY

    Specify the group entry that you want 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."

The application displays the Enter/Edit Patient Group Data window.

```
Enter/Edit Patient Group Data Mar 27, 2009 17:33:04    Page: 1 of 1
Group Entry
Patient Name                    Sex Age    DOB      HRN   Record Added
```

```
1) PHIIII,TERRY LYNN              F  40   05/10/1968  198794     yes
2) THETA,LOMIE                    M  23   06/23/1985  115697     yes


          Enter ?? for more actions                                    >>>
AE   Edit Patient's Group Visit         D    Display Patient's Group Visit
X    Delete a Patient's Group Visit     Q    Quit
Select Action:+//
```

Figure 5-10: Sample Enter/Edit Patient Group Data window

Use the Q action to exit the window.

5.1.3.1 Delete a Patient's Group Visit (X)

Use the X action to remove a particular patient's group visit. 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 (Y or N).

5.1.3.2 Display Patient's Group Visit (D)

Use the D action to display a particular patient's group visit. The application displays the BH Visits Record Display window (view only).

5.1.3.3 Edit Patient's Group Visit (AE)

If you use the AE action, the following prompts display:

- "Enter PATIENT GROUP ENTRY (1-X) where x is the number last group data record"

   Specify the group number.

The application displays the BEHAVIORAL HEALTH RECORD EDIT window for the particular patient.

```
* BEHAVIORIAL HEALTH RECORD EDIT *            [press <F1>E to exit]
Encounter Date: NOV 3,2006@12:00                  User: THETA,SHIRLEY
Patient Name: MU,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 Prevention Activities?  N  Edit CPT Codes?     Edit Health Factors?  N
```

```
Edit Patient Education?: N      Edit A/SA Data Values?  N
Edit Any Screening Exams?  N    Edit Measurements?  N
Placement Disposition:                    Referred To:
_____


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

Figure 5-11: Sample Behavioral Health Record Edit window

If 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 field, the application will skip this field.

The underlined fields are required. See Section 4.1.4 for more information.

5.1.4   Display Group Entry

Use Option 2 to display group entry data for a specified 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: JAN 13, 2010@12:00     PROGRAM: MENTAL HEALTH
  GROUP NAME: TEST                      LOCATION OF ENCOUNTER: LCO
OFFICE
  COMMUNITY OF SERVICE: TAHLEQUAH       ACTIVITY TYPE: 91
  TYPE OF CONTACT: OUTPATIENT           ACTIVITY TIME: 89
  CLINIC: BEHAVIORAL HEALTH             SIGNED?: YES
  ELECTRONIC SIGNATURE BLOCK: ryan gamma
  DATE/TIME ESIG APPLIED: JAN 13, 2010@11:52:22
PROVIDER: GAMMAA,RYAN                   PRIMARY/SECONDARY: PRIMARY
POV: 306.2
  NARRATIVE: CARDIOVASCULAR MALFUNCTION ARISING FROM MENTAL FACTORS
 SUBJECTIVE/OBJECTIVE:    NOTE
PATIENTS: THETA,JIMMY JOE
PATIENTS: ALPHA,JIMMY RAY
MHSS RECORD: JAN 13, 2010@12:00
MHSS RECORD: JAN 13, 2010@12:00
         Enter ?? for more actions                               >>
+    NEXT SCREEN        -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 5-12: Sample Output Browser window

5.1.5   Print Encounter Forms

Use Option 5 to print a specified encounter form for a particular group.

Below are the prompts.

- "Select GROUP ENTRY"

  Specify the group you want 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.

- "Enter response"

  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 S/O/A/P note. The suppressed report does *not* display the following information: Chief Complaint, SOAP note, measurement data, screenings.

- "Device"

  Specify the device to print/browse 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
_____
                                        Number        Activity/Service
 Community: TAHLEQUAH                    Served: 1      Time: 44 minutes
 Time spent in group session: 88
 Activity: 14-FAMILY/GROUP TREATMENT-PATIENT PRESENT
 Type of Contact: OUTPATIENT
_____
 CHIEF COMPLAINT/PRESENTING PROBLEM:  test pt ed
 S/O/A/P:
 GROUP NOTE
 This is the first meeting of the Domestic Violence group. Focus of today's
 session was establishing group rules and discussing expectations.
 COMMENT/NEXT APPOINTMENT:
_____
 BH POV CODE      PURPOSE OF VISIT (POV)
 OR DSM DIAGNOSIS    [PRIMARY ON FIRST LINE]
```

```
 _____
      311.            DEPRESSIVE DISORDER NOS


 _____
  MEDICATIONS PRESCRIBED:
 _____
  PROCEDURES (CPT):
 _____ PROVIDER
SIGNATURE:   /es/ DENISE GAMMA, MSW, LCSW
                             Signed: Sep 28, 2009 15:07

 _____
 _____
  HR#:  WW 209022
  NAME:  OMEGA,AARON RAY                    SSN:
  SEX: MALE                   TRIBE: CHEROKEE NATION OF OKLAHOMA
  DOB:  Jul 21, 1996
  RESIDENCE:  MISSOURI UNK
  FACILITY: DEMO INDIAN HOSPITAL     LOCATION: SELLS CHS ADMIN.
  COMMENT/NEXT APPOINTMENT:
 _____
  BH POV CODE      PURPOSE OF VISIT (POV)
  OR DSM DIAGNOSIS    [PRIMARY ON FIRST LINE]
 _____
                  PROVIDER SIGNATURE:
  Jan 15, 2010                        BETA,LORI
Enter RETURN to continue or '^' to exit:
```

Figure 5-13: Sample encounter form output

5.1.6   Duplicate Group

Use Option 3 to duplicate a particular group encounter. This creates a new group encounter.

To prevent inclusion of deceased patients in duplicated groups, the application will search the RPMS Patient Registration files for a Date of Death before displaying the patient's name, case number, etc.

Duplicating a group containing signed SOAP/Progress Notes will cause the SOAP/Progress Notes associated with the new group encounter to revert to unsigned status. The duplicated group will duplicate the standard group note only.

Below are the prompts.

- Select GROUP ENTRY

  Specify the group you want to duplicate in order to create a new group.

- Enter Date for the new group entry

  Specify the date for the new group.

The application displays the Group Encounter Documentation window.

```
*  GROUP ENCOUNTER DOCUMENTATION  *          DEMO INDIAN HOSPITAL
-----------------------------------------------------------------------
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 17,2009          Arrival Time: 12:00
Program: SOCIAL SERVICES             Community of Service: TAHLEQUAH
Group Name: MON DV  DG               Clinic: MEDICAL SOCIAL SERVICES
Activity: 81                         Activity Time: 60
Encounter Location: DEMO INDIAN HOSPIT  Type of Contact: OUTPATIENT
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N       CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
_____




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

Figure 5-14: Sample Group Encounter Documentation window

See Section 5.1.1 to review how to complete the Group Encounter Documentation window.

5.1.7   Add No Show visit

Use Option 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.

Below are the prompts.

- "Select GROUP ENTRY (1-x) where x is the number of the last group entry record"

    Specify the number of the group you want to use.

- "Select PATIENT NAME"

    Specify the name of the patient who failed to attend the group session.

- "Enter PRIMARY PROVIDER"

    Specify the primary provider name.

The application displays the Behavioral Health Visit Update window. See Section 4.1.3 for more information.

5.1.8 Sign Note

Use Option 9 (Sign Notes) to sign an unsigned SOAP/Progress note. Only the primary provider for the particular record can sign the note.

Below are the prompts.

- "Select Group Entry (1-x) where x is the number of the last record"

    Specify the record you want to use.

If you are *not* the primary provider, the application displays the following message. Press Enter to return 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 5-15: 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 to return to the Group Entry window.

```
There were no visits created for this group.
Press enter to continue....:
```

Figure 5-16: Message about no visits created

If you are the primary provider, the application displays the BH Visit Record Display window.

```
BH VISIT RECORD DISPLAY        Aug 24, 2009 16:05:04            Page:
1 of    4

Patient Name:           ALPHA,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:               ALPHA,CHELSEA MARIE
PT AGE:                34
CLINIC:                MENTAL HEALTH
NUMBER SERVED:         1
+        Enter ?? for more actions
+    Next Screen          -     Previous Screen      Q    Quit
Select Action: +//
```

Figure 5-17: 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 leave record unedited.

After you type **N**, the application prompts: "Enter your Current Signature Code." See Section 2.14.6 for more information.

> **Note**: No Show notes are not included in this and must be signed individually.

5.1.9   Delete Group

Use Option 4 to remove a particular group encounter record with an unsigned note. The application verifies that you want to delete the particular group encounter. 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)

Below shows where the Group Encounter function is located on the RPMS BHS (GUI) tree structure.
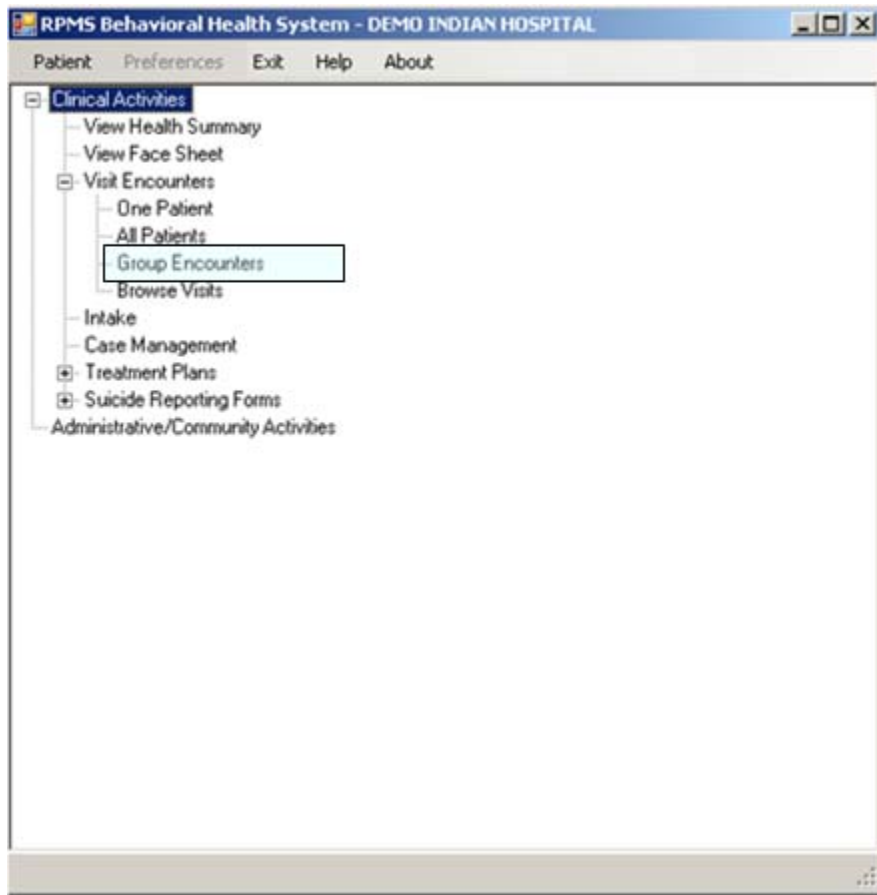
Figure 5-18: Group Encounters location in tree structure

Click the Group Encounters option to access the Group Entry window.
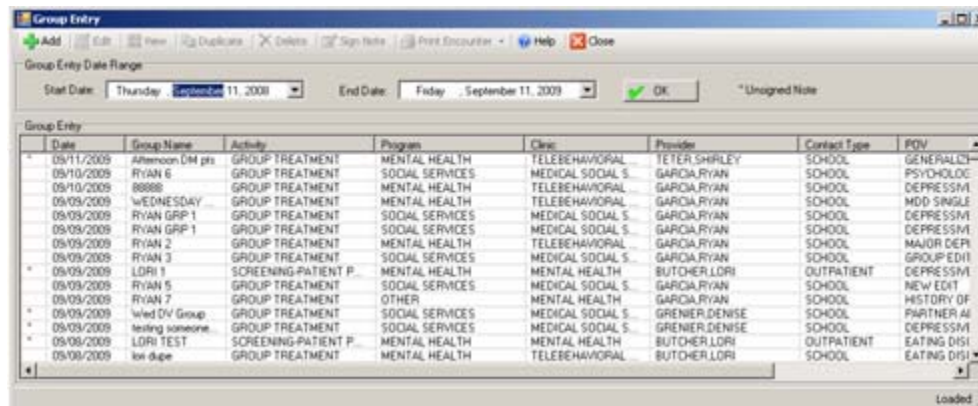
Figure 5-19: Sample Group Entry window

5.2.1   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).

The date range can be changed 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.

5.2.2   Group Entry Group Box

The Group Entry group box shows the record in the particular group entry date range.

The asterisk (*) in the first column indicates that the particular record contains an unsigned note. When you select this type of record, the Sign Note button becomes active. See Section 2.14.5 for more information.

5.2.3   Add Button

Use the Add button to add a new group encounter record. You will access the Group Data Entry–Add Group Data window. See Section 5.3 for more information.

5.2.4   Edit Button

Use the Edit button to change the highlighted group encounter record. This accesses the Group Data Entry–Edit Group Data window.

5.2.5   View Button

Use the View button (or double-click on a record) to browse the highlighted group encounter record. This accesses the Group Data Entry–Browse Group Data window. This window has the same fields as the Add/Edit group data window.

5.2.6   Duplicate Button

You can duplicate an existing group encounter in order to create a new group encounter. You will need to edit any information that would be different for the new encounter group.

To prevent inclusion of deceased patients in duplicated groups, the application will search the RPMS Patient Registration files for a Date of Death before displaying the patient's name, case number, etc.

Duplicating a group containing signed SOAP/Progress Notes causes the notes to revert to unsigned status (for the SOAP/Progress Notes associated with the new group encounter). The duplicated group will duplicate the standard group note only and not the individual patient group note.

Select an existing group encounter and then click Duplicate. The application displays the Group Data Entry–Duplicate Group Data window.

The fields are the same as those on the Group Data Entry–Add Group Data window. The duplicated group encounter will have a default date/time as the current date/time. See Section 5.1.1 for more information.

5.2.7   Delete Button

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

After selecting the particular record, the "Are You Sure" confirmation message displays, asking if you are sure you want to delete. Click Yes to remove the selected group encounter record from the group box (otherwise, click No.) If you click Yes, the group definition and all individual patient records will be removed.

5.2.8   Sign Note Button

Use the Sign Note button to sign a particular unsigned group encounter record (asterisk (*) in the first column). See Section 2.14.5 for more information.

5.2.9   Print Encounter Button

Select the group encounter record you want to print and click the Print Encounter button. Here you will select one of the following: Full, Suppressed, Both Full and Suppressed.

The full option prints all data for the group encounter, including the SOAP note.

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

The application displays the first page of the Print Encounter Group pop-up window.
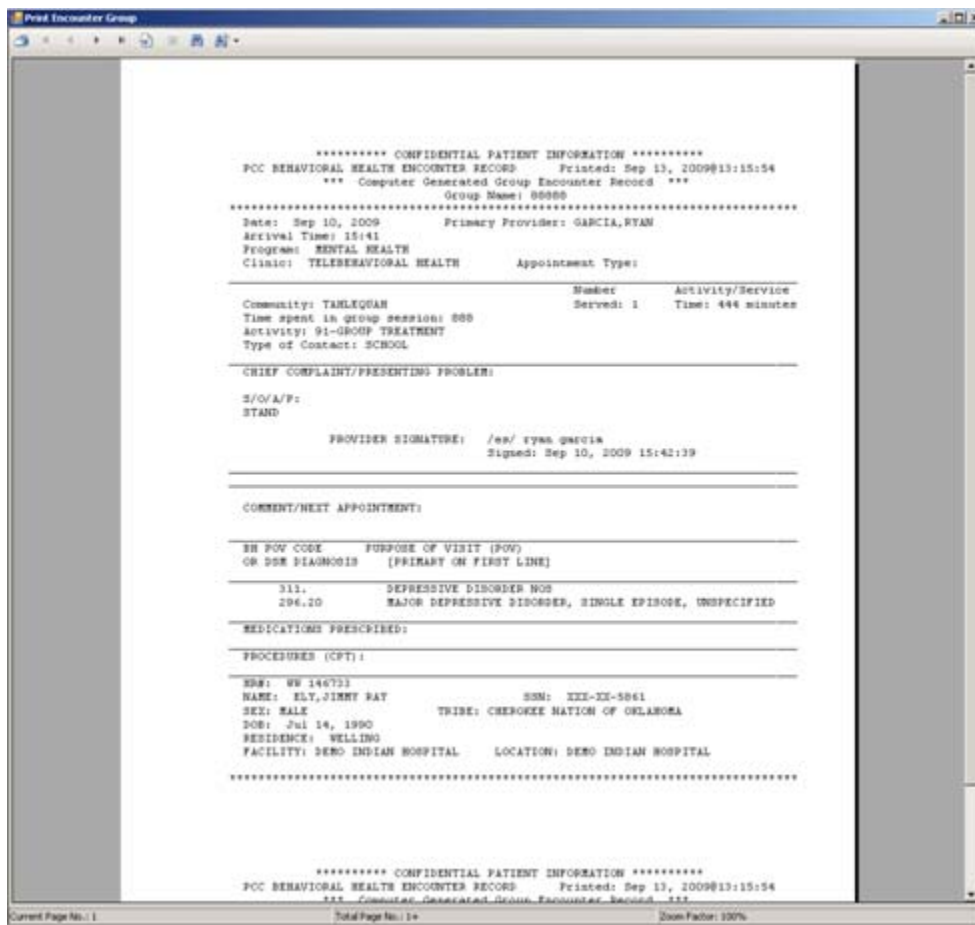
Figure 5-20: Sample Print Encounter Group pop-up window

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

5.2.10   Help Button

Use the Help button to access the online help for the Group Entry window.

5.2.11   Close Button

Use the Close button to dismiss the Group Entry window.

5.3   Add/Edit Group Data (GUI)

Use the Edit button to change the highlighted group encounter record. This accesses 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 5-21: Group Data Entry–Add Group Data window

The fields in the Group Encounter Information group box on the Edit Group Data window will be inactive and will display the existing data (cannot be changed). All editing is completed on the Patient Data tab if the group has already been saved. If the group note has been signed the other fields can still be edited.

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 it is signed, then you can edit everything on that tab except the note; if unsigned, you can edit anything on the tab.

Use the Help button to access online help about this window.

After changing this window, click Save to save your changes. This action dismisses the add/edit group data window.

- If you added a SOAP/Progress note, the application will display the electronic signature dialog and proceed in the same manner as used for individual encounter records (OK or continue, etc.). See Section 2.14.5 for more information.

Use the Close button to display the "Continue?" dialog box. This dialog box states: "Unsaved Data Will Be Lost, Continue?" Click Yes to close without saving; this dismisses the add group data window. Click No and you will remain in the Add window where you can continue work in the Add Group window.

Several of the fields contain a search window. See Section 2.8 for more information.

The fields that contain dates can be changed by accessing a calendar. See Section 2.7 for more information.

Certain group boxes use the search/select window. See Section 2.9 window for more information.

Some group boxes use the Multiple Select window. See Section 2.10.

5.3.1   Group Encounter Information Group Box

The add window has the following (active) fields.

Figure 5-22: Sample Group Encounter Information group box

These fields are not active (and cannot be changed) in the Edit Group Data window.

The fields in bold text are required.

- Primary Provider

  The default is the current provider. This field can be changed by clicking the drop-down list to access the Primary Provider search window. Here you can search for a provider name.

- Encounter Date/Time

  The default is the current date and time. The date can be changed by clicking the drop-down list to access the calendar. The time can be changed 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.

- Program

  This field determines 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, Community of Service, Type of Contact, and Encounter Location fields if you have the defaults set in the Site Parameters menu.

    You cannot change these fields when you edit the record.

- Group Name

  Populate with the name of the group encounter using between 1 and 30 characters. This is a Free Text field.

- Clinic

  This field shows the clinic if the group encounter took place within the context of a scheduled clinic. Change this field by clicking the drop-down list to access the Clinic search window. Here you can search for a type of clinic.

- Community of Service

  This field shows 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 can search for the community name.

- Type of Contact

  The field shows the type of contact (the activity setting) for the group encounter. Change this field by clicking the drop-down list and selecting the type of contact.

- Activity

  This field determines the activity for the group encounter. The default is Group Treatment. Change this field by clicking the drop-down list to access the Activity search window. Here you search for an activity name or its code.

- Encounter Location

  This field shows 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.

- Activity Time

  This field determines the number of minutes spent on the activity. Note that zero is not allowed as a valid entry.

5.3.2   Group Data Tab

Use the Group Data tab to specify secondary providers, POV code, group note, and CPT codes for the group encounter.

Figure 5-23: Sample Group Data tab

> **Note**: Information on the Group Data, Group Education, and
> Patients tabs can only be changed up until the point that the
> encounter is saved. Once the encounter is saved only
> information on the Patient Data tab may be edited.

The group box fields in bold text are required.

5.3.2.1   Chief Complaint/Presenting Problem Group Box

Specify the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patient sought services. This is a Free Text field.

5.3.2.2   Secondary Providers Group Box

Use the Secondary Providers group box to add or delete secondary providers for the group encounter.
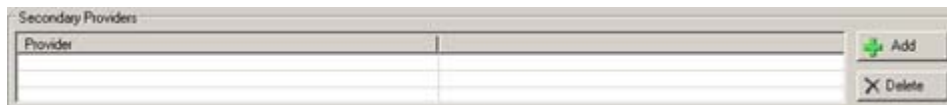
Figure 5-24: Sample Secondary Providers group box

Click the Add button on the Secondary Providers group box to access the Secondary Provider multiple search/select window. Here you can add one or more secondary providers for the group encounter.

Select a secondary provider you want to delete and click Delete. The selected record is removed from the Secondary Providers group box. 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 provider from the group box (otherwise, click No.)

5.3.2.3   Purpose of Visit–POV (Primary Group Topic) Group Box

The Purpose of Visit–POV (Primary Group Topic) group box lets you 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.

Figure 5-25: Sample POV group box

Click the Delete button to delete a selected POV 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 POV record from the group box (otherwise, click No.)

Click the Add button to access the POV (Axis I/II) multiple search/select window. Here you can add one or more POVs to the group encounter. The application populates the Code and Narrative for the record.

Use the Edit button to change the Narrative part of a POV record in the group box. Select a POV record and click Edit to display the Edit POV window.
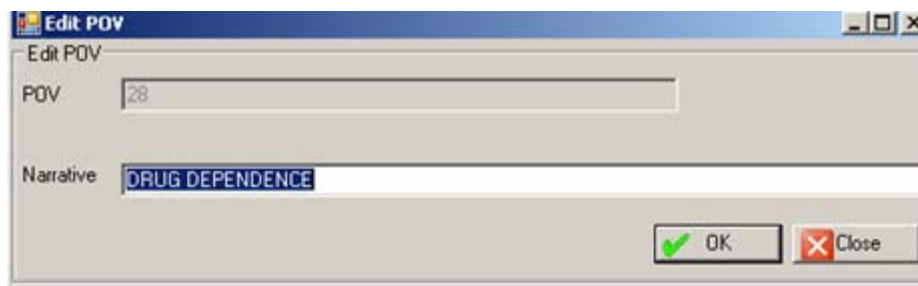
Figure 5-26: Edit POV window

> The Narrative field is a Free Text field. Type the new POV narrative in the
> Narrative text box and click OK. This changes the narrative of the selected
> code. (Otherwise, click Close to not change the narrative.)

> **Note:** The special characters *single quote* (') and *double quote*
> (") cannot be the first character of the POV narrative.

5.3.2.4   Standard Group Note Group Box

The Standard Group Note field is where you enter a group note for the group
encounter. This is a Free Text field. You must populate this field in order to click on
any of the other tabs.

5.3.2.5   CPT Codes Group Box

Use the CPT Codes group box to add or delete CPT codes associated with the group
encounter.
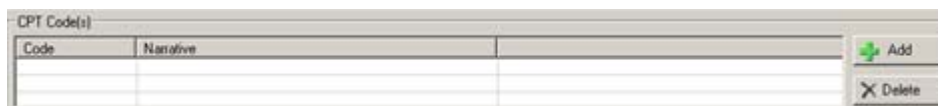
Figure 5-27: Sample CPT Codes group box

Click the Add button to access the CPT Code multiple search/select window. Here you
can add one or more CPT codes to the group encounter. The application populates the
Code and Narrative for the record.

Click the Delete button to remove a selected CPT code 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 CPT code record from the group box
(otherwise, click No.)

5.3.3   Group Education Tab

Use the Group Education tab to add education data about the group encounter.

Figure 5-28: Sample Group Education tab

5.3.3.1   Add Group Education Record

Click Add on the Group Education tab to activate the fields below the education grid.

The fields in bold text are required.

- Education Topic

  This is the education topic for the group encounter. Click the drop-down list to access the Education Topic search window. Here you can search for an education code.

- Provider

  This is the provider for the group education. The default is the logon provider but this can be changed. Click the drop down list to access the Education Provider search window. Here you can search for a provider name.

- Time

  This field contains the time spent on the education topic. The understood units of measure are minutes.

- Level of Understanding

  This field contains the level of understanding about the education topic. The default is 4-Group No Assessment (the only option).

- Comment

  Populate with any comments about the education topic for the group encounter. This is a Free Text field.

  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.

5.3.3.2 Edit Group Education Record

Select a record in the Education grid and click Edit to display the information about the record in the fields below the Education grid. See Section 5.2.2.1 for more information about the field. All Group Education entries created before the installation date for BHS v4.0 will continue to display the Goal and CPT fields.

5.3.3.3 Delete Group Education Record

Use the Delete button to remove a selected record from the Group Education grid box. 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 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.

5.3.4 Patients Tab

The Patients tab shows the patients in the group encounter.

Figure 5-29: Sample Patients tab

> **Note**:   Only the person entering the group can change the data on
> the Patients tab. Once the group is saved, there is no way to
> remove a patient other than to delete the encounter record
> for that patient.

5.3.4.1   Add Patient Record

Click the Add button to access the Select Multiple Patients search/select window. Here
you can add one or more patients to the group encounter; you can search for a patient
by name, HRN, DOB, or SSN.

5.3.4.2   Delete Patient Record

Use the Delete button to remove a patient from the group encounter. 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 patient record from the group box
(otherwise, click No.)

Leave clients who no showed or canceled in the group since it is possible to perform
the no show within the group definition in the GUI.

5.3.5   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.

Figure 5-30: Sample Patient Data tab

You need to select a patient in the Patients group box in order to activate the other group boxes.

After you select a patient record and change or add new patient data, click OK to save the group data.

Use the Cancel button to not save your changes and to dismiss the add/edit group data entry window.

5.3.5.1   Patients Group Box

The Patients group box shows the patients in the group encounter.

Figure 5-31: Sample Patients group box

You must double-click one of the patient names in order to use the other group boxes.

After you have completed the information for the first patient, click OK. Your cursor returns to the Patients group box. Then you can double-click on the next patient. After completing the information for the second patient, click OK. Repeat this process until you have completed all of the patients. Then you can click the Save button 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.
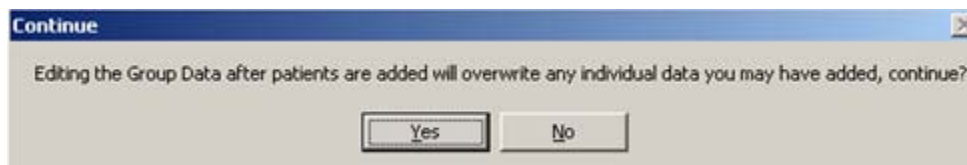
Figure 5-32: Warning Message

- Click Yes to overwrite any individual data you have added. You will go to the Group Data tab.

- Click No to not overwrite any individual data you have added. You will go to the Patients Data tab.

5.3.5.2   Purpose of Visit–POV (DSM Diagnosis or Problem Code) Group Box

Use the Purpose of Visit - POV (DSM Diagnosis or Problem Code) group box to add, edit, or delete a POV for the selected patient. (You must select a patient before you can add/change the data in this group box.)
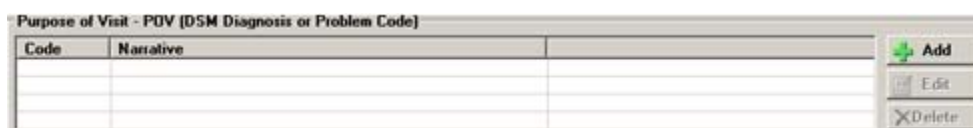
Figure 5-33: Sample POV group box

This is required data for the group encounter record.

Use the Delete button to remove a selected POV. 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 POV record from the group box (otherwise, click No.)

Click the Add button to access the POV (Axis I/II) search window. Here you can select one or more POVs to be used in the Purpose of Visit group box.

Use the Edit button to change the Narrative part of a POV record in the group box. Select a POV record and click Edit to display the Edit POV window.
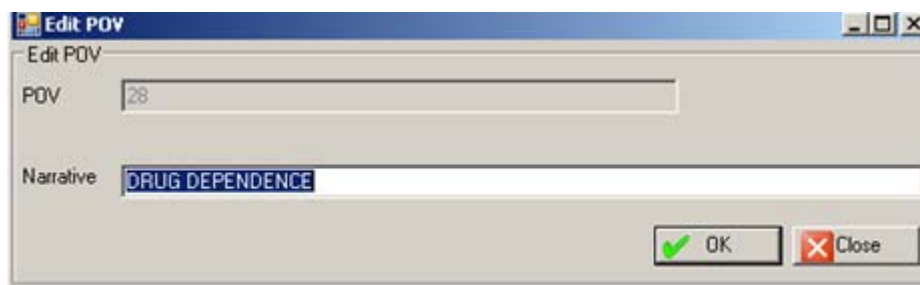
Figure 5-34: Sample Edit POV window

The Narrative field is a Free Text field. Type the new POV narrative in the Narrative text box and click OK. This changes the narrative of the selected code. (Otherwise, click Close to not change the narrative.)

> **Note:** The special characters *single quote* (') and *double quote* (") cannot be the first character of the POV narrative.

5.3.5.3   Standard Group Note (Patient Data Tab)

This field will populate with the text of the Standard Group Note that was entered on the Group Data tab. You can add text about how the patient reacted in the group. This is a Free Text field.

This is where the user individualizes the note for the patient in focus. The standard group note should never reference the individual patient but should have information about the individual patient's participation in the group.

- This field is available for text entry by the primary provider of the record (only).

- This field is not available for text entry if the note for the group record is signed.

5.3.5.4   Comment/Next Appointment

Populate this field with the text of any comments about the next appointment for the selected patient. This is a Free Text field. This field is available for text entry by the primary provider of the record (only).

5.3.5.5   Time in Group

Populate this field with the number of minutes in the group encounter (up to six digits).

Figure 5-35: Sample Time in Group field

This is required data for the group encounter record.

Consider the following:

- If patient attended the whole group session, no changes need to be made to the Time Spent in Group field.

- If 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 patient didn't attend at all, you need to type a zero in the Time Spent in Group field and then click OK. The application will prompt you to select one of the No Show POVs and enter a new note for that patient. (POVs and Group Note entered on the Group Data tab have been removed at this point).

6.0   Case Management

This section provides information about case management in the roll-and-scroll application, as well as in the RPMS BHS (GUI).

6.1   Managing Case Data (Roll-and-Scroll)

You 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.

```
Update BH Patient Case Data   Mar 23, 2009 15:27:33        Page:  0 of   0
----------------------------------------------------------------
Patient Name: DEMO,DOROTHY ROSE   DOB: OCT 10, 1942   Sex: F   HRN: 99999
----------------------------------------------------------------

#   PROGRAM  OPEN     ADMIT    CLOSED   DISPOSITION         PROVIDER
1   CHEMIC   10/16/09
2   OTHER    10/6/09                                        BETA,BJ
3   MENTAL   9/30/09
4   SOCIAL   9/1/09                                         GAMMA,DENISE
    COMMENT: Ind case opened. Group therapy 1 x week.  **
    Primary Problem: 43.1 PARTNER ABUSE (SUSPECTED),PH  Next Review: S
5   MENTAL   8/28/09   8/28/09                             SIGMA,MARK
    COMMENT: TEST COMMENT AGAIN **
    Primary Problem: 300.00 ANXIETY DISORDER NOS      Next Review: 9/28/09
6   MENTAL   8/28/09   8/28/09   8/28/09  MUTUAL AGREEMENT TO  EPSILON,LORI
    Primary Problem:                           Next Review: 8/28/09
7   MENTAL   8/28/09            8/28/09   PATIENT DROPPED OUT
8   MENTAL   8/28/09                                       GAMMA,DENISE
          ?? for more actions  + next screen  - prev screen
OP   Open New Case        DC   Delete Case
ED   Edit Case Data       Q    Quit
Select Item(s):
```

Figure 6-1: Sample Update BH Patient Case Data screen.

Use the Delete Case (DC) option to remove a specified case from the Update BH Patient Case Data window. The application verifies the deletion.

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. The fields on this window are the same as those when you use the Open New Case option.

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.

- "Enter Case Open Date"

  Specify the date to open the case. This is the first contact for an episode of care. The application displays the Update Patient Case Data window.

```
                **********  UPDATE PATIENT CASE DATA   *********
 Patient Name: ALPHAA,CHELSEA MARIE

 ****************************************************************

                    CASE OPEN DATE: MAY 23,2009
                PROGRAM AFFILIATION:
                     PROVIDER NAME: THETA,SHIRLEY
                   PRIMARY PROBLEM:

                   CASE ADMIT DATE:
            NEXT CASE REVIEW DATE:

                   DATE CASE CLOSED:
                       DISPOSITION:

COMMENT:
_____



COMMAND:                                 Press <PF1>H for help
Insert
```
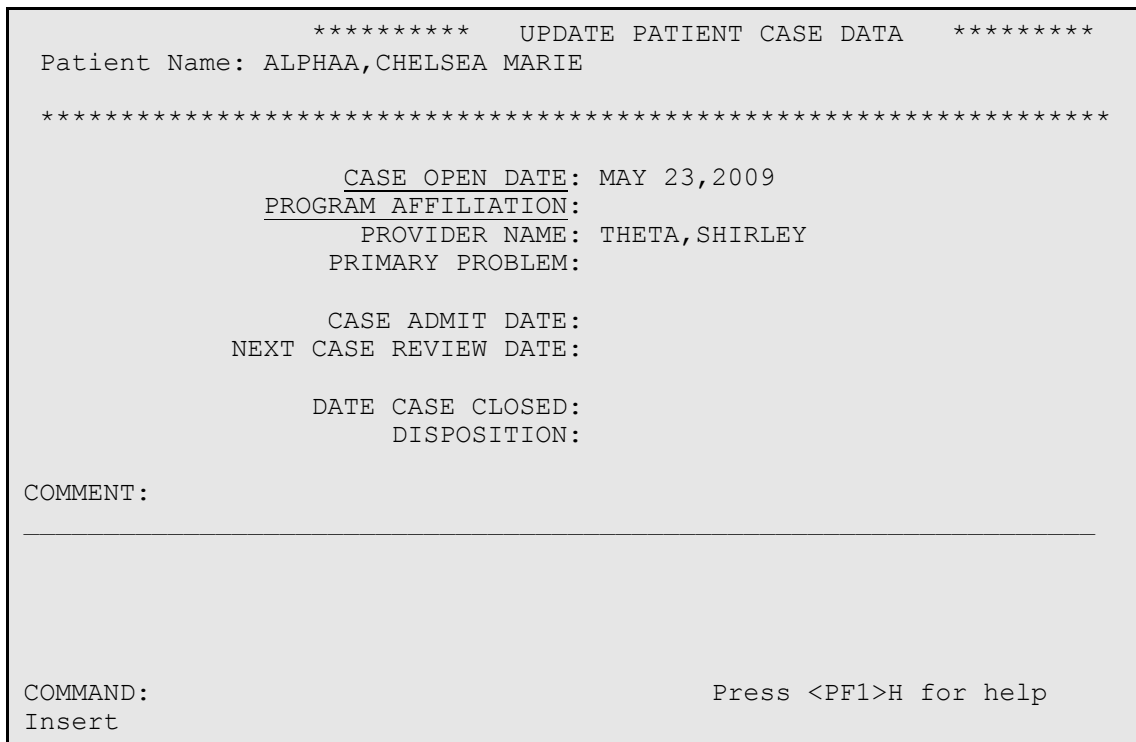
Figure 6-2: Sample Update Patient Case Data window

The underlined fields are required.

- Case Open Date

  This is the date the case was opened (can be edited).

- Program Affiliation

  Specify 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

- Provider Name

  This displays the provider name (default is current logon name). You can edit this name, if needed.

- Primary Problem

  Specify the primary problem (name or code).

- Case Admit Date

  Specify the admit date for the case. This is when a case management plan was developed and treatment began.

- Next Case Review Date

  Specify the next date for the case review.

- Date Case Closed

  Specify the date the case was closed. This is used when treatment has been discontinued. (Closing a case.)

- Disposition

  Specify 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.

- Comment

  Populate with a comment about the case, using 1–240 characters.

6.2   Designated Provider/Flag/Personal History (Roll-and-Scroll)

Use the OI (Desg Prov/Flag/Pers Hx) option on the Patient Data Entry window to access the Update Patient Information window.

```
         *******  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.

Below are the fields.

- Designated Mental Health Provider

  This is the RPMS provider who has accepted designated Mental Health provider status for the patient.

- Designated Social Services Provider

  This is the PRMS provider who has accepted designated Social Services provider status for the patient.

- Designated CD A/SA Provider

  This is the RPMS provider who has accepted designated Chemical Dependency provider status for the patient.

- Designated Other Provider

  This is the RPMS provider who has accepted the designated Other Provider status for the patient.

- Other Provider Non-RPMS

  Populate with another provider 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.

- Patient Flag Field

  Populate with 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.

- Patient Flag Narrative

  Populate with 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. You can add another Personal H Factor, if needed.

Facilities often find Personal History Factors to be useful in developing reports for tracking diagnosis associated with personal history.

Below are the prompts.

- Enter Personal History

  Specify the Personal History Factor for the current patient. This is a required field. If you do not want to add another personal history, type a caret (^) at the prompt.

6.3   Case Management Window (GUI)

Below shows where the Case Management function is located on RPMS BHS (GUI) tree structure.
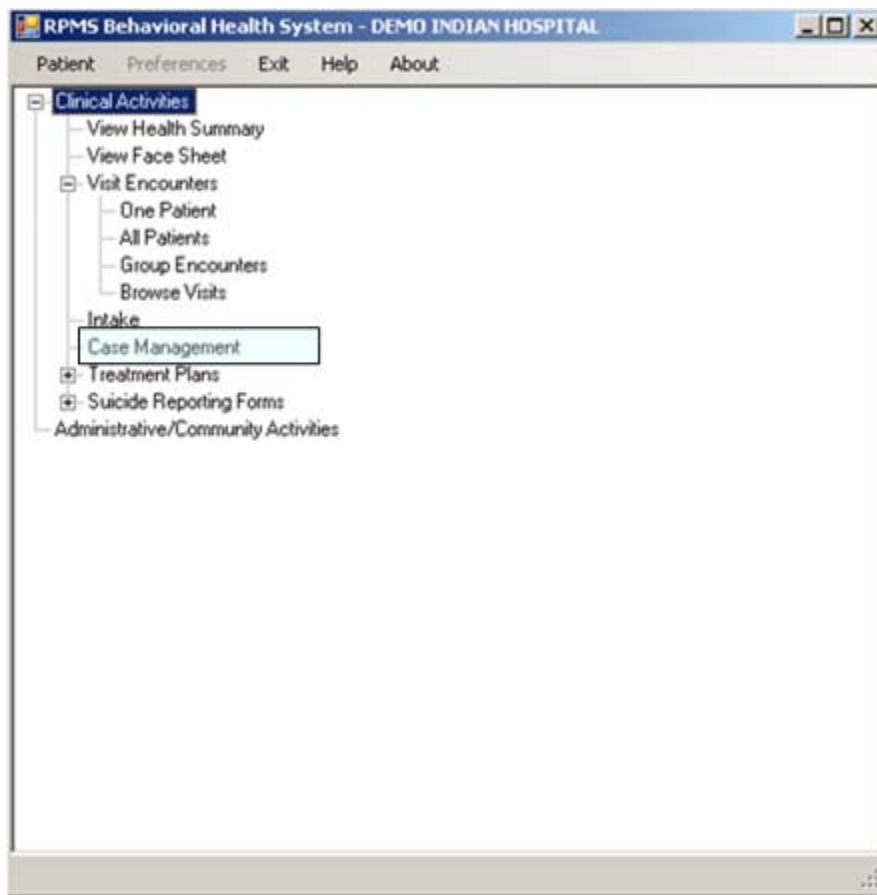
Figure 6-4: Case Management option on the RPMS BHS (GUI) tree structure

Use the Case Management option to access the Case Management window for the current patient.
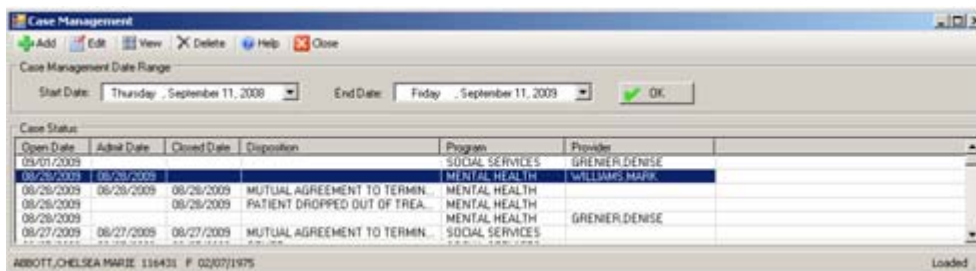
Figure 6-5: Sample Case Management window

The Case Management window is used 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).

6.3.1 Case Management Data Range

The date range for the displayed case status records is shown in the Case Status Date Range group box.

The date range can be changed 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.

6.3.2 Case Status Group Box

The Case Status group box displays the case status records in the established data range.

6.3.3 Add Button

Establish the patient you want to use in the add process. Use the Add button to add a new case status record or other case management data for the patient. You access the Case Management–Add Case window. See Section 6.4 for more information.

6.3.4 Edit Button

Use the Edit button to edit a particular case status record or other case management data for the patient. The application displays the Case Management–Edit Case window.

6.3.5 View Button

Use the View button (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 in the Add/Edit Case window. See Section 6.4 for more information.

6.3.6 Delete Button

Use the Delete button 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.)

> **Note**: Using the Delete button on the Case Status list view only deletes the Case Status information. All other Case Management data will remain unless deleted from within the Case Management Add/Edit screen.

6.3.7   Help Button

Use the Help button to access the online help system for the Case Management window.

6.4   Add/Edit Case Management Data (GUI)

Use the Add button to add a case management record for the current patient.

After you click Add, the Case Management–Add Case window displays.

Figure 6-6: Sample Case Management–Add Case window

To edit a record, select the record and click the Edit button. The Case Management–Edit Case window displays; this window has the same fields as the Case Management–Add Case window.

Click Save to save the case management information on this window. This process dismisses the window.

Use the Close 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 in the Add Case window.

The Free Text fields have a context menu for editing. See Section 2.11 for more information.

Several of the fields contain a search window. See Section 2.8 for more information.

The fields that contain dates can be changed by accessing a calendar. See Section 2.7 for more information.

Certain fields use the search/select window. See Section 2.9 for more information.

Some fields use the multiple-select window. See Section 2.10.

6.4.1   Case Status Group Box

Figure 6-7: Fields in Case Status group box

The fields in bold text are required.

- Program

  This field determines the program associated with the new case. Use one of the following from the drop-down list:

  − Mental Health
  − Social Services
  − Other
  − Chemical Dependency

- 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.

- 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.

- Next 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.

- Provider Name

  This is the primary provider for the case. Click the drop-down list to access the Primary Provider search window.

- Date Case 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.

- Primary Problem (Axis I/II)

  This is the primary problem for the case. Click the drop-down list to access the Primary Problem/POV search window.

- Disposition

  This is the reason for closing a case. Click the drop-down list to select an option on the Disposition window. This is required when there is a date in the Date Case Closed field.

- Comment

  Enter a comment about the case, using 1–240 characters, in this Free Text field.

6.4.2 Patient Information Group Box

Use the Patient Information group box to supply information about various providers and other case management information.

Figure 6-8: 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.

- Designated Mental Health Provider

  This is the RPMS provider 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.

- Designated Other Provider

  This is the RPMS provider who has accepted the designated Other Provider status for the patient.

- Designated Social Work Provider

  This is 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.

- Other Provider Non-RPMS

  Populate with another Provider not listed in RPMS, using between 2–40 characters (Free Text field).

- Designated Chemical Dependency Provider

  This is the RPMS provider 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.

- Patient Flag

  Populate with 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.

- Patient Flag Narrative

  Populate with the narrative about the patient flag, using between 2–60 characters. This is a Free Text field.

- Designated Primary Care Provider

  This is a view-only field that displays the name of the designated primary care provider for the patient (if any). This information is pulled from the Primary Care Provider application.

6.4.3   Personal History Group Box

Use the Personal History group box to add or delete personal history data about the current patient.
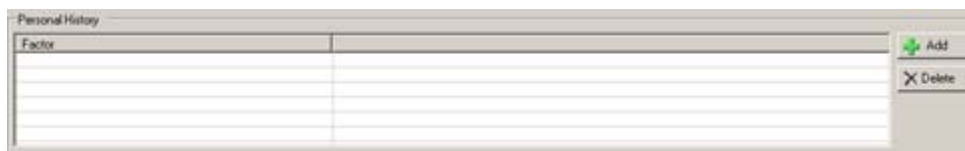
Figure 6-9: Sample Personal History group box

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.

Click the Add button to access the Personal History Factors search window where you can add one or more personal history factors.

Use the Delete button to remove a selected personal history 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 personal history record from the group box (otherwise, click No.)

7.0 Administrative/Community Activity

The Administrative/Community Activity gives assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems.

7.1 Add Administrative/Community Activity Record (Roll-and-Scroll)

The AC (Add Adm/Comm Activity) option is found under the SDE option in the BH data entry window.

Below are the prompts for the SDE option.

- Which set of defaults do you want to use in Data Entry

  Specify the program with which the provider is affiliated. If the site has defaults set up on the Site Parameters menu, Clinic, Location, Community and Program will automatically default for the visit. Use one of the following:

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

- Enter Encounter Date

  Specify the date of the encounter.

  The application displays 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    311. DEPRESSIVE DISORDER NOS
  2 RG ALPHAA,CHELSEA MWW116431    90  15 295.72 SCHIZOAFFECTIVE DISORDER, CH


                                  ?? 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

The prompts continue.

- "Select Action"

  Use AC (Add Adm/Comm Activity).

- "Enter Primary Provider"

  This is the primary provider for the visit.

  If the site has defaults set up on the Site Parameter menu the application displays the Behavioral Health Record Update window, with the following fields automatically populated: Program, Location of Encounter, Arrival Time, Provider, Community of Service, # Served, and Type of Contact, and Any Prevention Activities to Record?

```
                         * BEHAVIORAL HEALTH RECORD UPDATE *
Encounter Date: MAR 31,2009                        User: THETA,SHIRLEY
[press <F1>E when visit entry is complete]
--------------------------------------------------------------------------------
PROGRAM: SOCIAL SERVICES                    CLINIC:  MEDICAL SOCIAL SERVICES
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
                    ARRIVAL TIME: 12:00
                      FLAG FIELD:
            Any SECONDARY PROVIDERS? N
                COMMUNITY OF SERVICE: TAHLEQUAH
                       ACTIVITY CODE:        # SERVED: 1
                       ACTIVITY TIME:
                     TYPE OF CONTACT: SCHOOL
                 LOCAL SERVICE SITE:
Any Prevention Activities to Record? N
PURPOSE OF VISIT (POVS) <press enter>:
COMMENT (press enter):
```

Figure 7-2: Sample Behavioral Health Record Update

The underlined fields (such as Arrival Time) are required.

- Program

  This is the program associated with the record.

- Clinic

  The response must be a clinic that is included in the RPMS clinic code set.

- Location of Encounter

  This is the location of the encounter.

- Arrival Time

  This is the arrival time of the encounter (default is 12:00).

- Flag Field

  This indicates any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value (0–999) 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.

- Any Secondary Providers?

  Type **Y** or **N** (the default) to indicate if there were any additional BHS providers providing care during this particular encounter. Type **Y** to display the Enter/Edit Providers of Service pop-up window.

```
               *******  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 window

  One or more secondary providers can be added. Type the provider name at the Provider field and type "SECONDARY" at the Primary/Secondary field.

The prompts for the Behavioral Health Record Update window continue.

- Community of Service

  This is the community of service where the encounter took place.

- Activity Code

  This is the activity code associated with the encounter. See Appendix A for more information.

- # Served

This is the number of people served in the community activity.

- Activity Time

  This is the number of minutes spent on the activity. Note that zero is not allowed as a valid entry.

- Type of Contact

  This is the type of contact (the activity setting).

- Local Service Site

  This is the local service site for the encounter.

- Any Prevention Activities to Record?

  Type **Y** or **N**. If you type **Y**, the Prevention Activities pop-up window displays:

```
Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:


TARGET:
```

Figure 7-4: Pop-up for prevention activities

- − Prevention Activity. Populate with the code for the prevention activity. These activities are recorded when recording nonpatient activities. You can enter more than one, if needed.
- − Target. This is what population the prevention activity is designed for: A (Adult), Y (Youth), F (Family), M (Mixed Adult & Youth), S (Staff), E (Elderly Only), W (Women).

The prompts for the Behavioral Health Record Update window continue.

- "Purpose of Visits (POVS) <press enter>"

  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
```
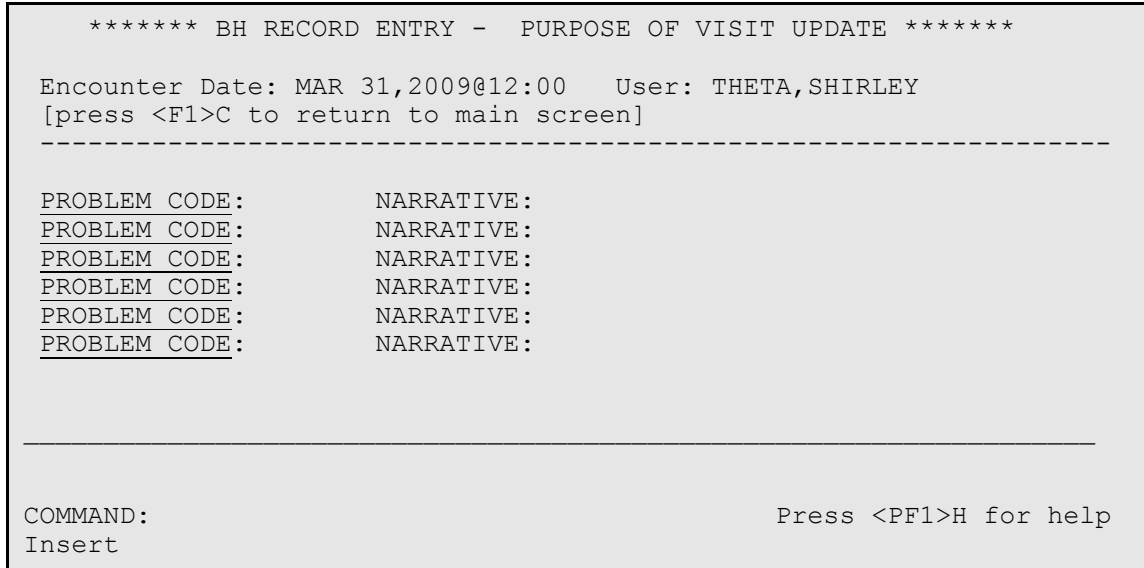
Figure 7-5: Sample BH Record Entry POV window

  − Problem Code. Specify the problem code, which can either be the Behavioral Health Purpose of Visit or the more specific DSM IV diagnostic code.

  − Narrative. Populate with the text of the narrative for the problem code, if needed.

7.2   Administrative/Community Activity Window (GUI)

Figure 7-6 shows where the Administrative/Community Activities function is located on the RPMS BHS (GUI) tree structure.
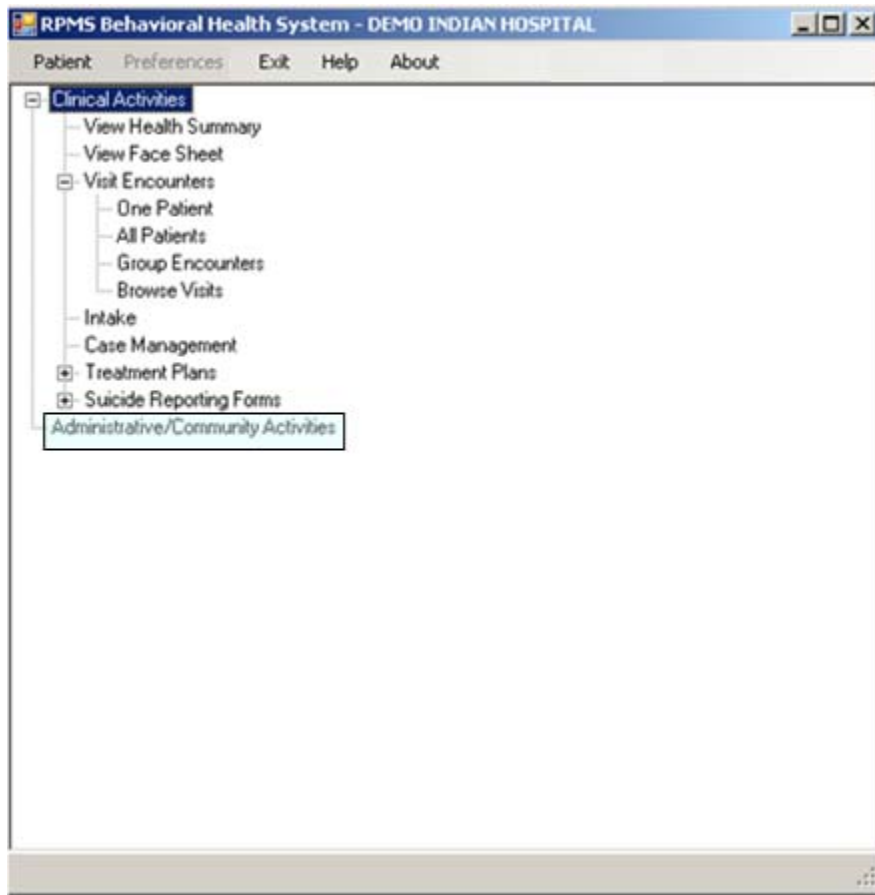
Figure 7-6: Administrative/Community Activities option on the RPMS BHS (GUI) tree structure

After selecting the Administrative/Community Activities option from the RPMS BHS (GUI) tree structure, the Administrative/Community Activity window displays.
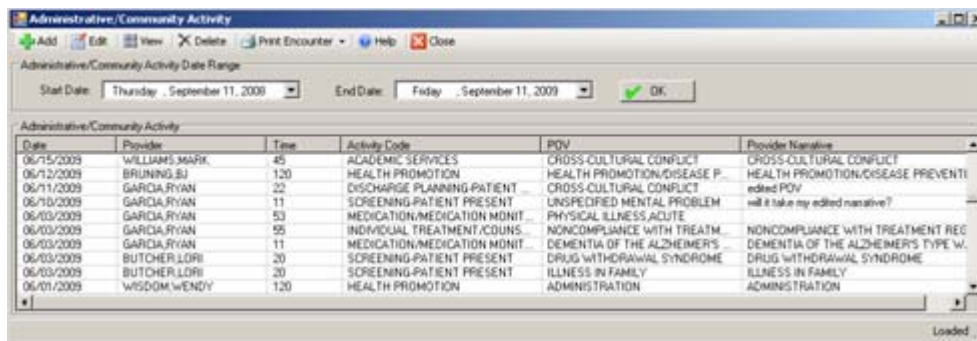
Figure 7-7: Sample Administrative/Community Activity window

The Administrative/Community Activity window shows the administrative/community activities records.

7.2.1   Administrative/Community Activity Date Range

The Administrative/Community Activity Date Range group box shows the date range for the records in the Administrative/Community Activity group box. The date range can be changed by accessing the calendar under the drop-down list for the date. After the date range has changed, click OK to display the records in the Administrative/Community Activity group box.

7.2.2   Administrative/Community Activity Group box

The records are listed in date order, within the administrative/community activity date range.

7.2.3   Add Button

Use the Add button to add a new administrative/community activity data record. You access the Administrative/Community Activity Data Entry –Add Administrative/Community Data. See Section 7.3 for more information.

7.2.4   Edit Button

Use the Edit button to edit a particular administrative/community activity record. This function displays the Administrative/Community Activity Data Entry–Edit Administrative/Community Data window. This window has the same fields as the Add Administrative/Community Data window.

7.2.5   View Button

Highlight an administrative/community activity record on the Administrative/Community Activity window and click View to browse the data (or double-click on a record). The Community Activity Data Entry–View Community Data window displays; this is a view-only window. The fields are the same as for the data entry (add/edit) windows. Click Close to dismiss this window.

7.2.6   Delete Button

Use the Delete button to delete a particular record. The application confirms the deletion.

7.2.7   Print Encounter Button

Use the Print Encounter button to print/browse an administrative/community activity record. Highlight the record and click Print Encounter. Select one of the following options: Full, Suppressed, Both Full and Suppressed. The first page of the output displays on the Print Encounter pop-up window.
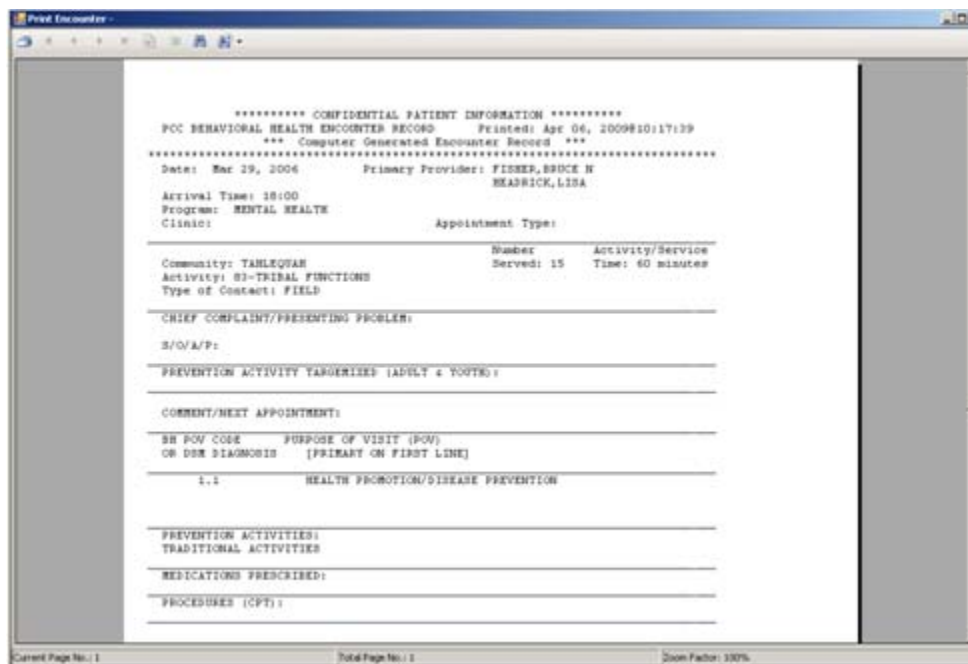
Figure 7-8: Sample output for a selected Administrative/Community Activity record

See Section 2.6 for more information about using this window.

7.2.8   Help Button

Use the Help button to access the online help system for the Administrative/Community Activity window.

7.2.9   Close Button

Use the Close button to dismiss the Administrative/Community Activity window.

7.3   Add/Edit Administrative/Community Activity (GUI)

Click Add (in the Administrative/Community Activity window) to add a new administrative/community activity record. This function displays the Add Administrative/Community Data window.

Highlight a record (in the Administrative/Community Activity window) and click Edit to change the administrative/community activity data. This function displays the Edit Administrative/Community Data window. This window has the same fields as the Add Administrative/Community Data window.

Figure 7-9: Sample Community Activity Data Entry–Add Community Data window

Use the Help button to access the online help for this window.

After you have completed the fields on this window, click Save. This adds a record to the Administrative/Community Activity window. Otherwise, click Close to dismiss the add/edit window.

Some fields access a search window. See Section 2.8 for more information on how to use this window.

Some fields access the calendar where the date can be changed. See Section 2.7 for more information.

Some fields access the search/select window. See Section 2.9 for more information on how to use this window.

Some fields are Free Text fields. See Section 2.11 for more information.

7.3.1   Administrative/Community Entry Group Box

Below is the Administrative/Community Entry group box.

Figure 7-10: Sample Community Entry group box

The fields in bold text are required.

- Primary Provider

  This is the primary provider for the administrative/community activity. Click the drop-down list to access the Primary Provider search window where you search for the primary provider name.

- Encounter Date/Time

  The default is the current date and time. The date can be changed by clicking the drop-down list to access the calendar. The time can be changed 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.

- Program

  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 you have defaults set up in the Site Parameters.

- Encounter Location

  This is the location where the administrative/community activity took place. Click the drop-down list to access the Location search window. Here you can search for a location name.

- Type of Contact

This is the type of contact (the activity setting) for the administrative/community activity. Click the drop-down list to access the Type of Contact list.

- Community of Service

  This is the community of service where the encounter took place. Click the drop-down list to access the Community search window. Here you can search for a community name.

- Clinic

  This is the clinic associated with the administrative/community activity. Click the drop-down list to access to the Clinic search window. Here you can search for the clinic by name or code.

- Activity Code

  This is the activity code associated with the administrative/community activity. Click the drop-down list to access the Activity search window. Here you can search for the activity name. See Appendix A for more information.

- Activity Time

  This the number of minutes spent on the activity.

- Number Served

  This is the number of people served in the administrative/community activity.

- Flag Field

  This indicates any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value (0–999) 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.

- Local Service Site

  This is the local service site associated with the administrative/community activity, if any. Click the drop-down list to access the Local Service Site list.

7.3.2   Activity Data Tab

Figure 7-11: Sample Activity Data tab

Use the Activity Data tab to specify the POV, prevention activities, and secondary providers data.

7.3.2.1   Purpose of Visit - POV Group Box

The POV group box lists the POVs associated with the administrative/community activity.

Figure 7-12: Sample POV group box

You can add, change, or delete a record.

7.3.2.1.1   *Add Button*

Use the Add button to add a new POV. Click Add to access the POV search/select window. Here you can select one or more POVs.

7.3.2.1.2   *Edit Button*

Use the Edit button to change the Narrative part of a POV record in the group box. Highlight a POV record and click Edit to display the Edit POV window.
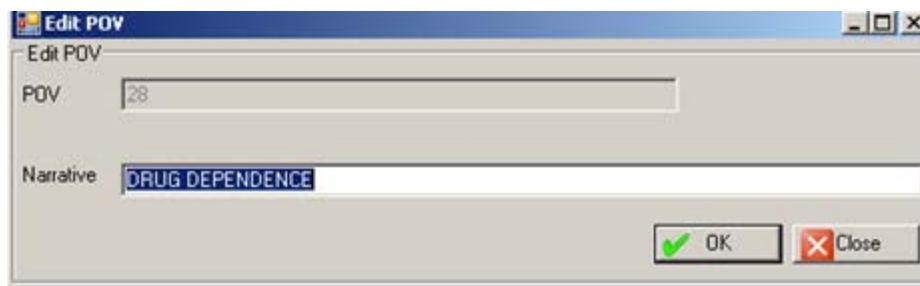
Figure 7-13: Edit POV dialog

> The Narrative field is a Free Text field. Type the new POV narrative in the
> Narrative text box and click OK. This changes the narrative of the selected
> record. (Otherwise, click Close to not change the narrative.)

> **Note:** The special characters *single quote* (') and *double quote*
> (") cannot be the first character of the POV narrative.

7.3.2.1.3   *Delete Button*

Use the Delete button to remove a record. Select a POV record to want to remove and
click Delete. 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
group encounter record from the group box (otherwise, click No.)

7.3.2.2   Prevention Activities Group Box

The Prevention Activities group box lists the prevention activities associated with the
administrative/community activity.
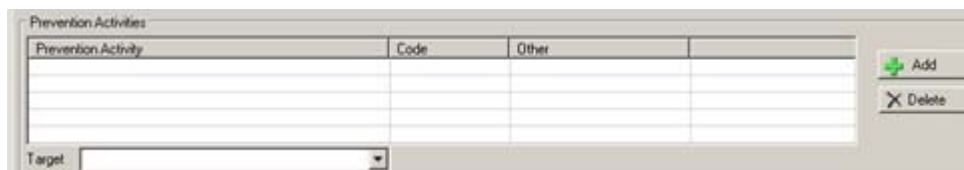
Figure 7-14: Sample Prevention Activities group box

You can add/delete a prevention activity and/or specify the target group.

- Target

    This is the population for which the prevention activity is designed. The selected
    option applies to all of the prevention activities.

    − Adult
    − Youth
    − Family

- Mixed (Adult and Youth)
- Staff
- Elderly Only
- Women

7.3.2.2.1　　*Add Button*

Click the Add button to access the Prevention Activity search/select window. Here you select one or more prevention activities.

- If you use OTHER (Code 20) on the Prevention Activity search/select window, the application displays the Other window.
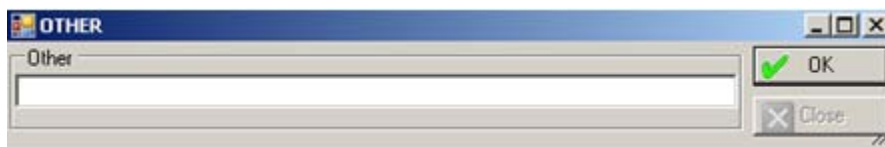
Figure 7-15: Other window

Populate the Other field with text of the other prevention activity associated with this record (limited to 80 characters). When complete, click OK. This 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.

7.3.2.2.2　　*Delete Button*

Use the Delete button to remove a prevention activity record. Select the prevention activity record you want to remove and click Delete. 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 prevention activity record from the group box (otherwise, click No.)

7.3.2.3　　**Secondary Providers Group Box**

The Secondary Providers group box lists the secondary providers associated with the administrative/community activity.
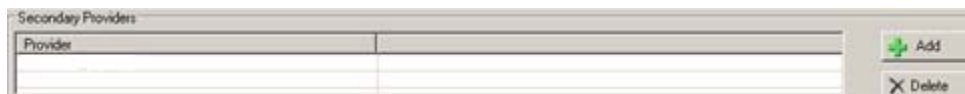
Figure 7-16: Sample Secondary Providers group box

You can add or delete a record.

Click the Add button on the Secondary Providers group box to access the Secondary Providers search/select window. Here you can select one or more secondary provider names.

Select the secondary provider record you want to remove and click Delete. 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 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.

Figure 7-17: Sample Notes field

This is a Free Text field.

8.0   Encounter and Treatment Plan Sharing (Roll-and-Scroll)

After the entry of a Visit or a Treatment plan, you will have the option to share it with a colleague through MailMan. In order to do this, you must be properly set up through the 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 following question:

```
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:

```
Send to: PHI,BILL          WBM
Send to:

Message will be sent to:    PHI,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 sent 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 (Roll-and-Scroll)

Use the PL option on the Patient Data Entry screen to modify items on the patient's BH problem list.

1. Type PL at the "Select Action" prompt and press Enter.

2. The system displays the Behavioral Health Patient Diagnosis List Update menu.

```
Behavioral Health Patient Diagnosis List Update menu

         1)   Add a Problem to BH Diagnosis List
         2)   Modify a Problem on BH Diagnosis List
         3)   Remove a Problem from BH Diagnosis List
         4)   Inactivate an Active Problem on BH Diagnosis List
         5)   Activate an Inactive Problem on BH Diagnosis List
         6)   Add a Treatment Note to a BH Problem
         7)   Modify a Treatment Note of BH Problem
         8)   Remove a Treatment Note to BH Problem
         9)   Display Patient's BH Diagnosis List
        10)   Display a Patient's PCC Problem List
        11)   Quit
Choose One:  (1-11): 11//
```

Figure 9-1: Updating a problem list

Use the options on Behavioral Health Patient Diagnosis List Update menu to specify the action and the problem list. The following sections explain how to use each of the options.

9.1 Add a Problem

Use Option 1 (Add a Problem to BH Diagnosis List) to add a problem to a patient's problem list.

After using 1, the application will display the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts:

- Enter PROBLEM DIAGNOSIS

    Specify the name or number of the problem that you want to add to the list.

- Provider Narrative

Populate with the text of the narrative to describe the problem.

- Date of Onset

  Specify the date that the problem was first diagnosed.

- Status

  Type **A** (Active) or **I** (Inactive). The default is **A**. Type **I**, for example, when the problem is no longer an ongoing issue.

- Add TREATMENT NOTES? (Y/N)

  Type **Y** or **N**. If you type **Y**, the application displays other prompts where you provide the narrative for the treatment notes (using 2–205 characters in length). These notes will be numbered.

- Add this PROBLEM to the PCC Problem List

  Type **Y** or **N**. If you type **N**, you exit the window.

  If you type **Y**, the application displays the ACTIVE PROBLEMS AND NOTES for the patient.

  Below is an example of the list.

```
******************  ACTIVE PROBLEMS AND NOTES  ********************

  WW33      01/18/07  latent yaws  (ONSET: 01/20/06)
  WW33   01/18/07   updated for editing.
  WW34      04/08/08  Chronic Depression
  WW35      04/08/08  Agoraphobia With Panic Disorder
  WW36      04/16/08  Trial anti-dep  (ONSET: 04/16/08)
  WW37      04/29/08  Unspecified Type Schizophrenia, Unspecified State
                  (ONSET: 04/29/08)
  WW38      07/24/08  DEPRESSION  (ONSET: 04/08/08)
  WW39      11/12/08  MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE  (ONSET:
                  06/01/08)
  WW40      06/01/03  PRENATAL

********** No INACTIVE Problems on file for this Patient

Press any key to continue
```

Figure 9-2: Sample list of active problems and notes for the patient

After you press any key (to continue), the application asks "Are you sure?" to ensure that you really what to add the problem to the PCC problem list. Type **Y** (yes) or **N** (no).

9.2   Modify a Problem

Use Option 2 (Modify a Problem on BH Diagnosis List) to edit a problem record on a patient's list of problems.

After typing **2**, the application will display the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- "Enter MH/SS Problem Number"

  Specify the problem number you want to edit.

- "PROBLEM CODE"

  The application displays the problem code that can be changed.

- "Provider Narrative"

  Populate with the text of the narrative about the problem diagnosis.

- "Status"

  Type **A** (Active) or **I** (inactive).

- "Date of Onset"

  Specify the date that the problem was first diagnosed.

9.3   Remove a Problem

Use Option 3 (Remove a Problem from BH Diagnosis List) to delete a problem on a patient's problem list.

After typing **3**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- "Enter MH/SS Problem Number"

  Use the problem number you want to remove.

- "Are you sure that you want to remove MH/SS Problem Number x?"

  Here "x" is the problem number you entered. Type **Y** (yes) or **N** (no).

9.4 Inactivate an Active Problem

Use Option 4 (Inactivate an Active Problem on BH Diagnosis List) to inactivate a currently active problem on a patient's list.

After typing **4**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts

- "Enter MH/SS Problem Number"

  Here you use the problem number you want to make inactive.

  The problem number you entered will be placed on the inactive list.

9.5 Activate an Inactive Problem

Use Option 5 (Activate an Active Problem on BH Diagnosis List) to activate a currently inactive problem on a patient's list.

After typing **5**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts

- "Enter MH/SS Problem Number"

  Use the problem number you want to make active.

  The problem number you entered will be placed on the active list.

9.6 Add a Treatment Note

Use Option 6 (Add a Treatment Note to a BH Problem) to add a treatment note to a problem on a patient's list.

After typing **6**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- "Enter MH/SS Problem Number"

  Use the problem number to which you want to add a treatment note.

- "Treatment Note #x (where x is the number of the treatment note)"

  - NARRATIVE

    Populate with the text of the treatment note narrative using 2–205 characters (required).

- "LONG/SHORT TERM TREATMENT"

  Type **S** (short) or **L** (long).

- "AUTHOR"

  Use the name of the person who entered the text of the narrative.

9.7   Modify a Treatment Note

Use Option 7 (Modify a Treatment Note of BH Problem) to modify a treatment note on a patient's list.

After typing **7**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- "Enter MH/SS Problem Number"

  Use the problem number to which you want to modify a treatment note.

- "Enter Treatment Plan to Modify?"

  Use the number of the treatment note that you want to modify. For example, say there are two notes for problem number 2; these notes are numbered 2-1 and 2-2. If you want to modify the first number, you would use 1 (for Note # 2-1) at this prompt.

- "NARRATIVE"

  Populate with the text of the treatment note narrative, using 2–205 characters in length.

- "LONG/SHORT TERM TREATMENT"

  Type **S** (short) or **L** (long).

- "AUTHOR"

  Use the name of the person who entered the text of the narrative.

9.8   Remove a Treatment Note

Use Option 8 (Remove a Treatment Note to BH Problem) to delete a treatment note on a patient's list.

After typing **8**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- "Enter MH/SS Problem Number"

  Type the problem number whose note you want to remove.

- "Enter Treatment Plan to REMOVE"

  Use the number of the treatment note that you want to modify. For example, say there are two notes for problem number 2; these notes are numbered 2-1 and 2-2. If you want to remove the note of the first problem, you would use 1 (for Note # 2-1) at this prompt.

- "Are you sure you want to remove Treatment Plan Number x? (where x is a number)"

  Type **Y** (yes) or **N** (no).

9.9   Display BH Problem List

Use Option 9 (Display Patient's BH Diagnosis List) to display a selected patient's problem list.

After typing **9**, the system will display the BEHAVIORAL HEALTH Diagnosis list for the patient. This is a view-only window.

9.10   Update PCC Problem List

Use Option 10 (Update the Patient's PCC Problem List) to review a selected patient's PCC problem list.

Below are the prompts.

- "Location where Problem List update occurred"

  This is the location where the problem list update happened. You can accept the default by pressing Enter or populate with another location.

- "Date Problem List Updated"

Specify the date the problem list is updated.

The application displays the PCC Problem List Update window showing the problem list for the patient.

```
PCC Problem List Update        Apr 06, 2009 16:21:16        Page:  1 of    2
---------------------------------------------------------------------------
Patient Name: ALPHAA,CHELSEA MARIE   DOB: FEB 07, 1975   Sex: F   HRN: 11
---------------------------------------------------------------------------

   1) Problem ID:   WW33   DX: 102.8   Status: ACTIVE   Onset: 1/20/2006
      Provider Narrative:  latent yaws
        Notes:
          WW Note#3 1/18/2007  updated for editing.

   2) Problem ID:   WW34   DX: 311.    Status: ACTIVE   Onset:
      Provider Narrative:  Chronic Depression

   3) Problem ID:   WW35   DX: 300.21  Status: ACTIVE   Onset:
      Provider Narrative:  Agoraphobia With Panic Disorder

   4) Problem ID:   WW36   DX: 311.    Status: ACTIVE   Onset: 4/16/2008
      Provider Narrative:  Trial anti-dep
+         Enter ?? for more actions                          >>>
AP   Add Problem to PCC Problem List    IP   Inactivate a PCC Problem
EP   Edit a PCC Problem List Entry      DD   Display a PCC Problem List Entry
DE   Delete a Problem from the PCC List Q    Quit
AC   Activate a PCC Problem List Entry
Select Action: +//
```

Figure 9-3: Sample PCC Problem list for the patient record you selected

Type **Q** (quit) to dismiss this window.

Type a plus sign (+) to display more problem list records (if any).

Use the following actions at the "Select Action" prompt:

- Add Problem to PCC Problem List. Type **AP** to add a problem to the PCC problem list.

- Edit a PCC Problem List Entry. Type **EP** to edit a PCC problem list entry.

- Delete a Problem from the PCC List. Type **DE** to remove a PCC problem list entry.

- Activate a PCC Problem. Type **AC** to activate an inactive PCC problem.

- Inactivate a PCC Problem. Type **IP** to inactive an active PCC problem.

- Display a PCC Problem List Entry. Type **DD** to display a specified problem list entry. After specifying the problem number, the application displays the data on the Output Browser window.

```
OUTPUT BROWSER              Apr 13, 2009 14:19:09        Page:  1 of    1
```

```
DIAGNOSIS: 311.                        PATIENT NAME: ALPHAA,CHELSEA MARIE
  DATE LAST MODIFIED: APR 16, 2008     CLASS: PERSONAL HISTORY
  PROVIDER NARRATIVE: Trial anti-dep   FACILITY: DEMO INDIAN HOSPITAL
  NMBR: 36                             DATE ENTERED: APR 16, 2008
  STATUS: ACTIVE                       DATE OF ONSET: APR 16, 2008




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

Figure 9-4: Sample display of PCC problem

10.0   Treatment Plans

You use the Treatment Plans feature to add or update treatment plans in roll-and-scroll and in the RPMS BHS (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

                             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

Use the UP option to add, edit, or delete a treatment plan.

Use the DTP option to display/print the treatment plan for a particular patient.

Use the REV option to print a list of treatment plans needing to be reviewed.

Use the RES option to print a list of treatment plans needing to be resolved.

Use the ATP option to print a list of all treatment plans on file.

Use the NOTP option to access patients with an open case but no treatment plan.

10.1.1 Add, Edit, Delete a Treatment Plan (UP)

Use the UP option (Add, Edit, Delete a Treatment Plan) to access the Update Patient Treatment Plan window for the current user.

```
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: Transportation for doctor's appointments

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  MAR 24, 2009    Next Review Date:  APR 15, 2009
     Status:                           Date Resolved:
     Problem: "Feeling down all the time"

3)  Program:  MENTAL HEALTH              Responsible Provider:  BETAAAA,BJ
     Date Established:  MAR 24, 2009    Next Review Date:  JUN 22, 2009
     Status:                           Date Resolved:
     Problem: Chronic Depression
+        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

Type **Quit** to dismiss the Update Patient Treatment Plan window.

10.1.1.1 Add Treatment Plan (AD)

Use the AD option to add a new treatment plan for the current patient. The prompts are the same as for editing a plan. See Section 10.1.1.2 for more information.

10.1.1.2 Edit a Plan (ED)

Use the ED option to change a selected treatment plan for the current patient.

Below are the prompts.

- "Date Established"

  The date the treatment plan was established (cannot be changed).

- "Program"

  This is the program for the treatment plan. Type one of the following: **M** (Mental Health), **S** (Social Services), **C** (Chemical Dependency), **O** (Other).

- "Designated Provider"

  This is the name of the designated provider for the treatment plan.

- "Case Admit Date"

  This is the date the case was admitted.

- "AXIS I"

  The text of the AXIS I displays, if any.

- "Edit?"

  Type **Y** (yes) or **N** (no) to change the AXIS I text. If you type **Y**, you access another window where the text can be changed.

- "AXIS II"

  The text of the AXIS II displays, if any.

- "Edit?"

  Type **Y** (yes) or **N** (no) to change the AXIS I text. If you type **Y**, you access another window where the text can be changed.

- "AXIS III"

  The text of the AXIS III displays. This text describes the general medical conditions of the patient.

- "Edit?'

  Type **Y** (yes) or **N** (no) to change the AXIS I text. If you type **Y**, you access another window where the text can be changed.

- "Select AXIS IV"

  The value for the AXIS IV displays (can be changed). This is one of the major psychosocial or environmental problem codes. Use one of the following: 1 (primary support group problems), 2 (social environmental problems), 3 (educational problems), 4 (occupational problems), 5 (housing problems), 6 (economic problems), 7 (access to healthcare services problems), 8 (legal interaction problems), 9 (other psychosocial or environmental problem).

- "AXIS V"

  The value for the AXIS V displays (can be changed). This is the functional level using the GAF scale (0–100).

- "Problem List"

Populate this field with the text of the problem, using up to 240 characters. The text should list and briefly describe multiple problems.

- "Treatment Plan Narrative (Problems/Goals/Objectives/Methods)"

  The Narrative of the problems, goals, objectives, or methods of the treatment plan.

- "Edit?"

  Type **Y** (yes) or **N** (no) to change the AXIS I text. If you type **Y**, you access another window where the text can be changed.

- "Anticipated Completion Date"

  This is the date the treatment plan is anticipated to be completed.

- "Next Review Date"

  This is the date of the next review.

- "Concurring Supervisor"

  This is the name of the concurring supervisor for the treatment plan.

- "Date Concurred"

  This is the date the concurring supervisor agreed to the treatment plan. Once a date is specified at this prompt, you cannot change it.

- "Date Closed/Resolved"

  This is the date the treatment plan is to be closed or resolved.

10.1.1.3 Delete Tx Plan (DE)

Use the DE option to delete a particular treatment plan.

Below are the prompts.

- "Select BH Treatment Plan"

  Specify the treatment plan you want to remove.

- "Are you sure you want to DELETE this Treatment Plan?"

  Type **Y** (yes) or **N** (no).

10.1.1.4 Enter TP Review (RV)

Use the RV action to access the Treatment Plan Update window of a specified treatment plan (for the current patient).

Below are the prompts.

- "Select BH Treatment Plan"

  Specify the treatment plan you want to review.

The application displays the Treatment Plan Update window. This window has the following prompts.

- "Select REVIEW DATE"

  This is the date of the review, which can be changed. If you do not enter a date here, you exit the RV process.

- "Review Provider"

  Specify the name of the review provider.

- "Review Supervisor"

  Specify the name of the review supervisor, if any.

- "Progress Summary"

  The text of the progress summary displays (if any).

- "Edit?"

  Type **Y** (yes) or **N** (no) to change the AXIS I text. If you type **Y**, you access another window where the text can be changed.

- "Select TX REVIEW PARTICIPANT NAME"

  You can specify a new treatment review participant name, if needed.

- "Relationship to Client"

  This prompt does not display unless you added a name in the previous prompt. This prompt allows you to specify the relationship to the client.

- "Next Review Date"

  The next review date displays (can be changed).

10.1.1.5 Disp/Print Plan (DS)

Use the DS action to display/print a specified treatment plan for the current patient.

Below are the prompts.

- "Select BH Treatment Plan"

  Specify the treatment plan you want to browse/print.

- "What would do like to print"

  Type **T** (Treatment Plan Only), **R** (Treatment Plan REVIEWS Only), or **B** (both Treatment Plan and Reviews).

- "Do you wish to"

  Type **P** (print output on paper) or **B** (browse output on screen).

  The browse output option displays the output on the Output Browser window.

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
*****************************************************************************
*                                                                           *
*  TREATMENT PLAN                          Printed: Oct 27, 2009@09:49:14   *
*  Name:  ALPHA,CHELSEA MARIE                                    Page 1     *
*  DEMO INDIAN HOSPITAL   DOB:  2/7/75    Sex:  F   Chart #:  WW116431       *
*                                                                           *
*****************************************************************************

Date Established:         Oct 01, 2009
Admit Date:
Resolve By:
Date Closed/Completed:    Oct 01, 2009
Provider:                 GAMMA,DENISE
Supervisor:               <not recorded>              Date Concurred:
Next Review Date:

DIAGNOSIS:
AXIS I

AXIS II

AXIS III

AXIS IV
AXIS V
PROBLEM LIST

TREATMENT PLAN (Problems/Goals/Objectives/Methods)
*****************************************************************************




  _____    _____
   Client's Signature                Designated Provider's Signature
```

```
 _____   _____
 Supervisor's Signature             Physician's Signature



 _____   _____
 Other                              Other



 _____   _____
 Other                              Other

 Date of Review:          Oct 01, 2009

 Reviewing Provider:      SIGMA,MARK

 Reviewing Supervisor:    <<not recorded>>

 Next Review Date:        Oct 01, 2009

 Progress Summary:

 Participants in Review:

  PARTICIPANT NAME               RELATIONSHIP TO CLIENT
Enter RETURN to continue or '^' to exit:
```

Figure 10-3: Sample display of treatment plan

10.1.1.6 Health Summary (HS)

Use the HS option to display/print a particular health summary for the current patient.

10.1.1.7 Browse Visits (BV)

Use the BV option to browse the behavioral health visits for the current patient.

Below are the prompts.

- "Browse which subset of visits for [patient name]"

  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 type **N**, **D**, or **P**, other prompts will display.

The application display the BROWSE PATIENT'S VISITS window. The window below is for all visits.

```
BROWSE PATIENT'S VISITS        Apr 13, 2009 17:51:51        Page: 1 of  395

Patient Name: CHI,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: Sep 28, 2009@10:00              Provider: GAMMA,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:
  43.2   PARTNER ABUSE (SUSPECTED),EMOTIONAL

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

Figure 10-4: Sample patient's behavioral health visits window

10.1.1.8 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.

Below are the prompts.

- "Select PATIENT NAME"

  Specify the patient you want 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:  DELTA,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 10-5: Sample Display/Print Treatment Plan window

The following options are related to view functions:

Use Q (Quit) to dismiss the window.

Use NS (Next Screen) to display the next screen of information (does not work on the last screen).

Use PS (Previous Screen) to display the previous screen of information (does not work on the first screen).

Use the DN (Down a Line) to display the next line of information following the one at the bottom of the current screen (does not work on the last screen).

Use the UP (Up a Line) to display the previous line of information before the top of the current screen (does not work when you are on the first screen).

10.1.2.1 Display/Print Plan (DS)

Use the DS action to browse/print a particular treatment plan. See Section 10.1.1.5 for more information.

10.1.2.2 Health Summary (HS)

Use the HS action to display a particular type of health summary for the current patient.

Below are the prompts.

- "Select Health Summary Type Name"

    Specify the type of health summary you want to use.

The application displays the Health Summary for the current patient on the Output Browser window.

10.1.2.3 Print List (PL)

Use the PL action to display/print the treatment plans for the current patient.

Below are the prompts.

- "Device"

    Specify the device you want to print/browse 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:                             Date Resolved:
    Problem: medical transportation needed

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
    Date Established:  APR 02, 2009      Next Review Date:  APR 02, 2009
    Status:                             Date Resolved:
    Problem: Chronic Depression

3)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
    Date Established:  APR 02, 2009      Next Review Date:  APR 02, 2009
    Status:                             Date Resolved:
    Problem:


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

Figure 10-6: Sample Display/Print Treatment Plan window

10.1.2.4 Search List (SL)

Use the SL option to search the text of the treatment plans for a particular text string.

Below are the prompts.

- "Search for"

    Specify the text string for which you want to search in the treatment plans.

    If the application finds the first occurrence of the text string, it highlights it and asks:

- "Stop Here?"

    Type **Y** or **N**.

    If you type **N**, you leave the search sequence.

    If you type **Y**, it will search for the next occurrence of the text string. If found, 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? Use Y or N."

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.

- 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

    Indicate which program to use: **O** (One Program) or **A** (All Programs). If you use **O**, other prompts will display.

- List Treatment Plans for

    Type one of the following: **O** (One Provider) or **A** (All Providers). If you type **O**, other prompts will display.

- Demo Patient Inclusion/Exclusion

    Type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).

- Device

    Specify the device to print/browse the output.

    Below is a sample Listing of Treatment Plans Due to be Reviewed.

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                    Page 1
                          DEMO INDIAN HOSPITAL
             LISTING OF TREATMENT PLANS DUE TO BE REVIEWED
                   Date Range: APR 07, 2008 to APR 07, 2009

PATIENT NAME              DOB        CHART # DATE          REVIEW DATE   ANTICIPATED
                                             ESTABLISHED                 COMPLETION
                                                                         DATE
--------------------------------------------------------------------------------

ALPHA,ALICE ROCHELLE   6/25/97    183497  Dec 01, 2005 Feb 23, 2009  Feb 23, 2009
    Program: MENTAL HEALTH        Responsible Provider: BETAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75     116431  Mar 21, 2006 Sep 30, 2008
    Program: CHEMICAL DEPENDENCY  Responsible Provider: GAMMAA,DENISE
ALPHAA,GLEN DALE       11/10/81   108704  Dec 10, 2007 May 06, 2008  Dec 10, 2008
    Program: MENTAL HEALTH        Responsible Provider: BETAAA,BJ

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

Figure 10-7: 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.

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"

  Indicate which program to use: **O** (One Program) or **A** (All Programs). If you use
  O, other prompts will display.

- "List Treatment Plans for"

  Type one of the following: **O** (One Provider) or **A** (All Providers). If you type **O**,
  other prompts will display.

- "Demo Patient Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O**
  (include only DEMO patients).

- "Device"

Specify the device to print/browse the output.

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          REVIEW DATE   ANTICIPATED
                                           ESTABLISHED                 COMPLETION
                                                                       DATE
----------------------------------------------------------------------------

ALPHA,ALICE ROCHELLE   6/25/97   183497  Dec 01, 2005 Feb 23, 2009  Feb 23, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Jun 27, 2007               Jul 02, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,GLEN DALE       11/10/81  108704  Dec 10, 2007 May 06, 2008  Dec 10, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 03, 2008 Mar 18, 2008  Apr 07, 2008
   Program: MENTAL HEALTH        Responsible Provider: GAMMAA,DENISE
SIGMA,ALBERT TILLMAN   2/7/75    164141  Apr 01, 2008 Aug 01, 2008  Sep 30, 2008
   Program: MENTAL HEALTH        Responsible Provider: GAMMAA,DENISE

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

Figure 10-8: 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). 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"

  Type **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "List treatment plans for"

  Type **O** (one provider) or **A** (all providers). If you type **O**, other prompts will display.

- "Sort list by"

Type **P** (Responsible Provider), **N** (Patient Name), or **D** (Date Established).

- "Demo Patient Inclusion/Exclusion"

  Type 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 information.

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         REVIEW DATE   ANTICIPATED
                                           ESTABLISHED                COMPLETION
                                                                      DATE
------------------------------------------------------------------------------

ALPHAA,CHELSEA MARIE   2/7/75    116431  Feb 25, 2009 May 26, 2009  Feb 25, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 09, 2009 Jun 07, 2009  Mar 09, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 24, 2009 Jun 22, 2009  Mar 24, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,GLEN DALE      11/10/81  108704  Apr 06, 2009 Jul 05, 2009  Apr 06, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 24, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,LORI

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

Figure 10-9: Sample list of treatment plans

10.1.6   Patients with Case Open but No Treatment Plan (NOTP)

Use the NOTP option to produce a report that lists all patients who have a case open datewith no case closed date, and no treatment plan in place 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.

- "Run the Report for which PROGRAM"

Type **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "List treatment plans for"

  Type **O** (one provider) or **A** (all providers). If you type **O**, other prompts will display.

- "Sort list by"

  Type **P** (Responsible Provider), **N** (Patient Name), or **C** (Case Open Date).

- "Demo Patient Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).

- "Do you wish to"

  Specify **P** (Print output) or **B** (Browse output on screen).

The application displays the LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE report.

```
          **********  CONFIDENTIAL PATIENT INFORMATION  *********
ZZ                                                                   Page 1
                          DEMO INDIAN HOSPITAL
          LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE
               Case Open Dates: JAN 01, 2000 to APR 13, 2009

PATIENT NAME            HRN     CASE OPEN PROGRAM      PROVIDER      LAST VISIT
                                DATE
--------------------------------------------------------------------------------
SIGMA,ABBIGAYLE MARIE  175103  04/03/09  MENTAL HEA  ALPHA,D1       03/18/09
ALPHAA,CHELSEA MARIE   116431  04/09/09  SOCIAL SER  SIGMA,D2       06/04/09
BETA,EDWIN RAY         105321  04/09/09  MENTAL HEA  SIGMA,D10      04/22/09
ALPHAA,CHELSEA MARIE   116431  04/09/09  MENTAL HEA  SIGMA,D8       06/04/09
ALPHAA,CHELSEA MARIE   116431  04/10/09  SOCIAL SER  SIGMA,D6       06/04/09
+      Enter ?? for more actions                                   >>>
+    NEXT SCREEN       -    PREVIOUS SCREEN      Q     QUIT
Select Action: +//
```

Figure 10-10: Sample Listing of Cases with No Treatment Plan in Place report

10.2   Treatment Plan Window (GUI)

The RPMS BHS (GUI) application provides ways to manage treatment plans for one patient

Figure 10-11 shows where the treatment plan functions are located.
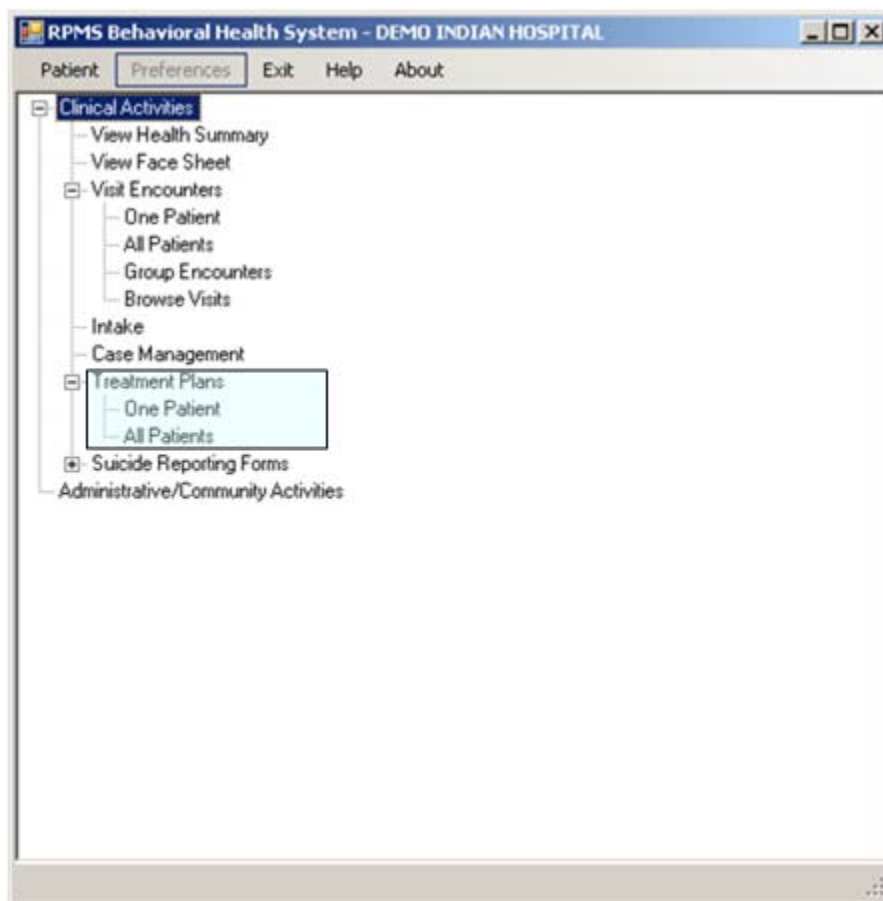
Figure 10-11: Location of Treatment Plan functions on tree structure

One way to access the Treatment Plan window is to use the One Patient option. Access the Treatment Plan window for the current patient.
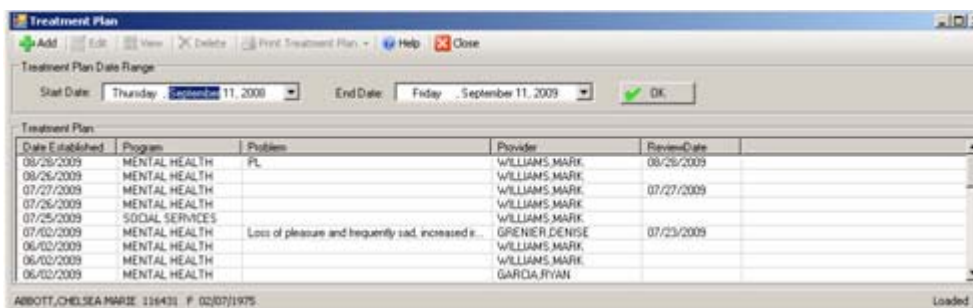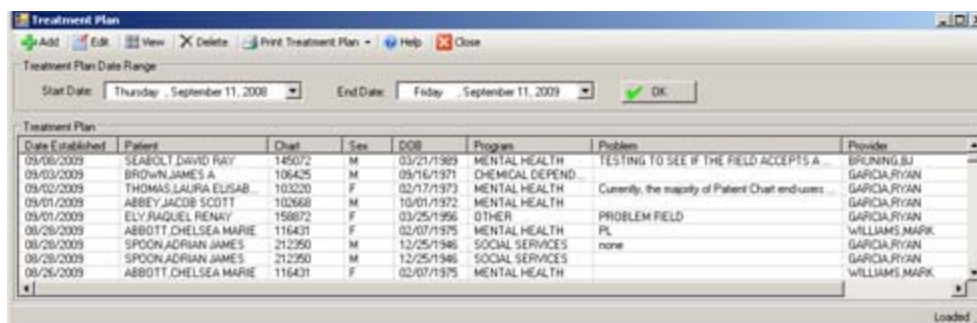
Figure 10-12: Sample Treatment Plan group box for current patient

Another way to access the Treatment Plan window is to use All Patients. Selecting this option accesses the Treatment Plan window for all patients.

Figure 10-13: Sample Treatment Plan window for all patients

The following are features of both windows.

10.2.1   Treatment Plan Date Range

The treatment plan records are those within the date range shown in the Treatment Plan Date Range group box.

The date range can be changed by clicking the date drop-down list and selecting a new date from the calendar. After the date range has changed, click OK to display the records in the Treatment Plan group box.

10.2.2   Treatment Plan Group Box

The Treatment Plan group box shows the records within the Treatment Plan Date Range. They are in date order.

10.2.3   Add Button

Establish the patient you want to use in the add process. Click the Add button to add a new treatment plan record. You access the Treatment Plan–Add Treatment Plan window. See Section 10.3 for more information.

10.2.4   Edit Button

Use the Edit button to edit a particular treatment plan record. The application displays the Treatment Plan–Edit Treatment Plan window.

10.2.5 View Button

Highlight a treatment plan record and click View (or double-click on the plan) to view the selected treatment plan data. The fields are the same as those on the add/edit treatment plan dialog. See Section 10.3.

10.2.6 Delete Button

Use the Delete button to delete a particular treatment plan record. The application confirms the deletion.

10.2.7 Print Treatment Plan Button

Use the Print 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.

If you select Review Data Only (2) or Treatment Plan and Review Data (3), the application displays the Treatment Plan Review window.

Figure 10-14: Sample Treatment Plan Reviews window

Check each Treatment Plan Review record you want to print and click OK. Otherwise, click Close to exit the print routine.

The application displays the first page of the Treatment Plan pop-up window.
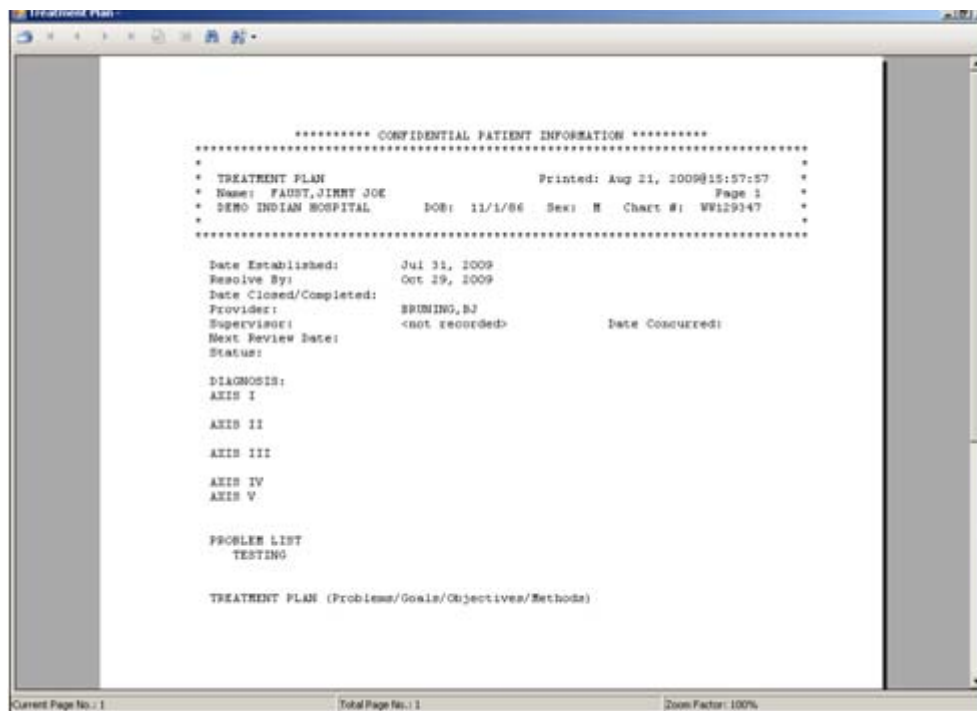
Figure 10-15: Sample Treatment Plan pop-up window

See Section 2.6 for more information about the controls in this window.

10.2.8   Help

Click the Help button to access the online help system for the Treatment Plan window.

10.2.9   Close Button

Click the Close button to dismiss the Treatment Plan window.

10.3   Add/Edit Treatment Plan Record (GUI)

Click the Add button on the Treatment Plan window to display the Treatment Plan–Add Treatment Plan window.

Click the Edit button on the Treatment Plan window to display the Treatment Plan–Edit Treatment Plan window.

Both windows have the same fields. Below is the Add Treatment Plan window.
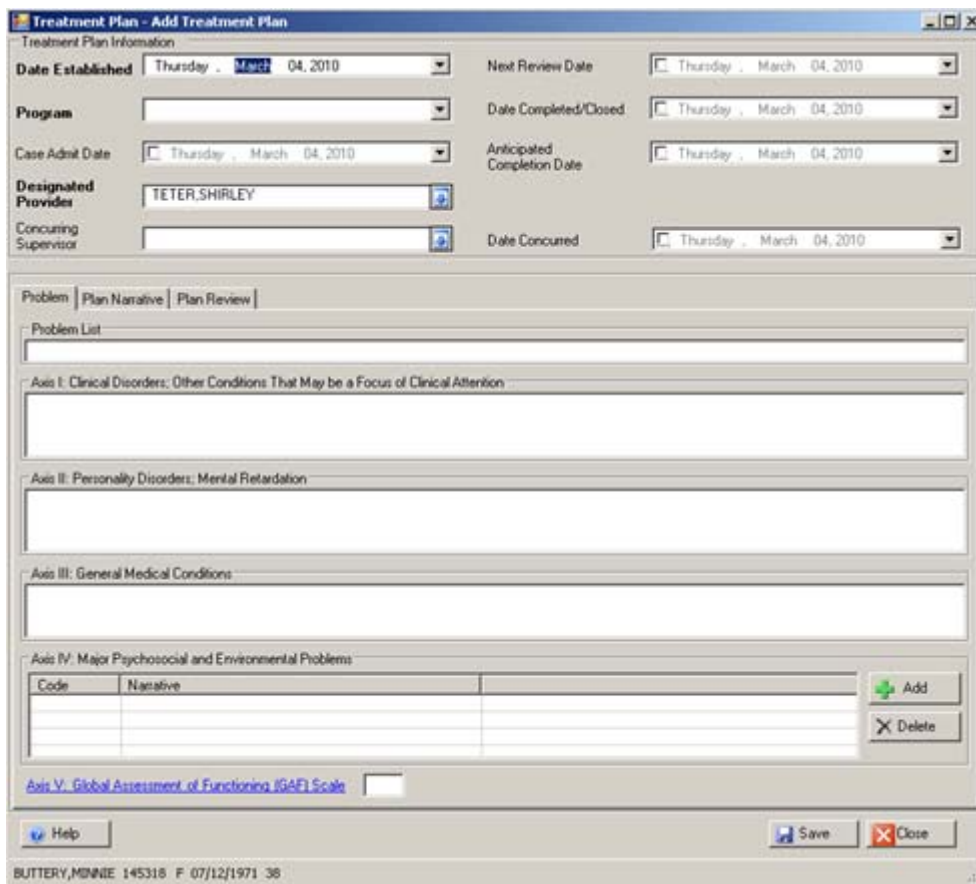
Figure 10-16: Sample Add Treatment Plan window

Click the Help button to access the online help system for the window.

Click the Save button to save the data on the window. This dismisses the window.

Use the Close button to display the "Continue?" dialog box. This dialog box states: "Unsaved Data Will Be Lost, Continue?" Click Yes to close without saving; this dismisses the add window. Click No and you will remain in 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 10-17: Sample Treatment Plan Information group box

The fields in bold text are required.

- Date Established

  This is the date the treatment plan was established. The default for a new record is the current date.

- Next Review Date

  This is 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 field is populated, this field will be inactive.

- Program

  This is the program used in the treatment plan. Click the drop-down list to use one of the following:

  − Mental Health
  − Social Services
  − Other
  − Chemical Dependency

- Date Completed/Closed

  This is the date the treatment plan was completed or closed. Click the drop-down list to access the calendar to change this date.

- Case Admit Date

  This is the date the patient was admitted into care. Click the drop-down list to access the calendar to change this date.

- Anticipated Completion Date

  This is the anticipated completion date for the treatment plan. Click the drop-down list to access the calendar to change this date.

- Designated Provider

This is the name of the designated provider for the treatment plan. The default is the logon provider. Click the drop-down list to access the Designated Provider search/select dialog where you search for the name of the provider.

- Concurring Supervisor

  This is the name of the concurring supervisor for the treatment plan. Click the drop-down list to access the Concurring Supervisor search/select dialog box where you can search for the name of the supervisor.

- Date Concurred

  This is the date that the concurring supervisor agreed to the treatment plan. This date cannot be before the Date Established.

10.3.2   Problem Tab

Use the Problem tab to manage the Axis I through V data as well as the problem list.

Figure 10-18: Sample Problem tab

10.3.2.1   Problem List Group Box

Populate this field with the text of the problem.

10.3.2.2   Axis I Group box

Use the Axis I field to enter the text of clinical disorders or other conditions that might be a focus of clinical attention for the treatment plan. This is a Free Text field.

10.3.2.3 Axis II Group Box

Use the Axis II field to enter the text of personality disorders or mental retardation to be used in the treatment plan. This is a Free Text field.

10.3.2.4 Axis III Group Box

Use the Axis III field to enter the text of a general medical condition to be used in the treatment plan. This is a Free Text field.

10.3.2.5 Axis IV Group Box

Use the Axis IV group box to enter one or more of the psychosocial or environmental codes that identify the major category of the problem.
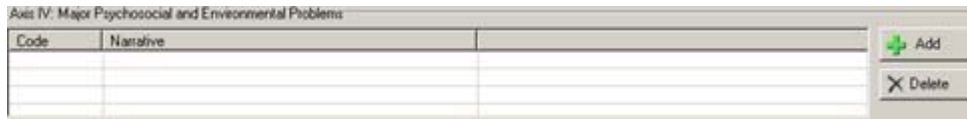
Figure 10-19: Sample Axis IV group box

Click the Add button to add the codes using the Axis IV multiple select dialog. Here you can select one or more codes to populate this group box.

Click the Delete button to remove a highlighted code. 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 code from the group box (otherwise, click No.)

10.3.2.6 Axis V Field

Use the Axis V field to enter the GAF scale value (assessment of the client's functional level). This field is limited to three characters (0 - 100).

If you click the link on the Axis V label, the application displays the Global Assessment of Functioning pop-up window. This provides information about the GAF codes.
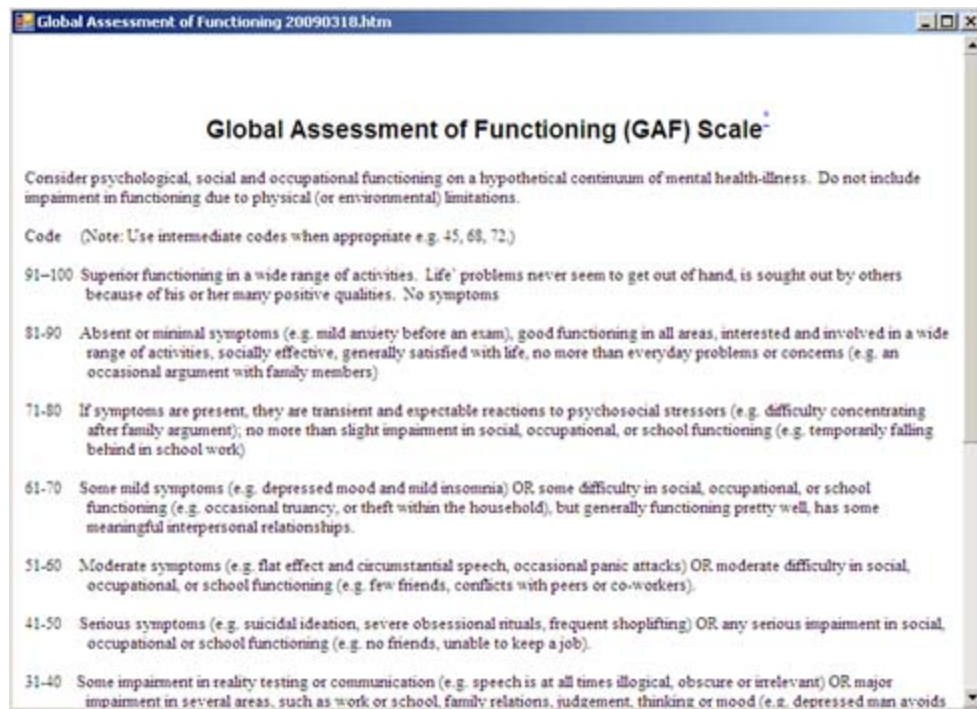
Figure 10-20: GAF Scale

10.3.3   Plan Narrative Tab

Populate this field with the text of the problems, goals, objective, or methods for the treatment plan. See Section 2.11 for more information.

10.3.4   Plan Review Tab

Use the Plan Review tab to document the review of the treatment plan.

Figure 10-21: Sample Plan Review tab

10.3.4.1 Review Group Box

The top group box is used to document the review date, the next review date, the review provider, and review supervisor for the treatment plan.

Click the Delete button to remove a selected review record.

Click the Edit button to change a selected review record. The data populates in the fields below the grid.

Click the Add button 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.

After you have completed the fields and group boxes, click OK to save the plan review record. (Otherwise, click Cancel to not save.)

The required fields for a Review are in bold text.

- Review Date

   This is the date of the review. The default is the current date. Click the drop-down list to access the calendar to change the date.

- Next Review Date

This is the date of the next review. The default is the current date. Click the drop-down list to access the calendar to change the date. Note that changing the Next Review date here will also change the Next Review date in the Treatment Plan Information group box.

- Review Provider

    This is the provider conducting the review. The default is the logon provider. Click the drop-down list to access the Reviewing Provider search window where you can search for the provider name.

- Review Supervisor

    This is the review supervisor for the treatment plan. Click the drop-down list to access the Reviewing Supervisor search window where you can search for the supervisor name.

10.3.4.2 Participants Group Box

Click the participants group box to manage the participants in the treatment plan. This group box becomes active after you add/edit a Plan Review record.

Click the Add button to add a new participant record. The application displays the Treatment Plan Participants window.
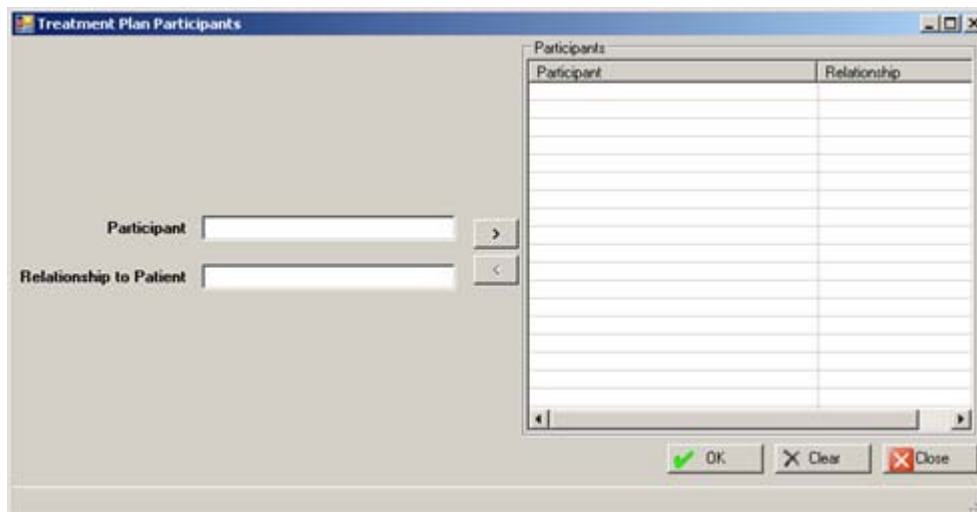
Figure 10-22: Sample Treatment Plan Participants window

The Participant field is a Free Text field where you can add the participant name.

The Relationship to Patient is a Free Text field where you can add the participant's relationship to the patient of the treatment plan.

After completing these fields, click the right arrow to add the information to the Participants group box.

You can remove a highlighted record in the Participants group box by clicking the left arrow.

Click the Clear button to remove the data in the Participant and Relationship to Patient fields.

Click the OK button to save the data and to populate the Participants group box in the add/edit treatment plan window Plan Review tab.

Click the Close button to dismiss the dialog box.

10.3.4.3 Progress Summary

Use the Progress Summary field to add the text of the progress of the treatment plan. This group box becomes active after you add/edit a plan review. This is a Free Text field.

11.0   Suicide Forms

You can manage suicide forms in the roll-and-scroll as well as in the RPMS BHS
(GUI).

11.1   Suicide Reporting Forms (Roll-and-Scroll)

Use the SF (Suicide Reporting Forms–Update/Print) option in the IHS Behavioral
Health System Data Entry Menu to manage suicide forms in roll and scroll.

After using the SF option, the application displays the following two options:

```
    SFD     Review Suicide Reporting Forms by Date
    SFP     Update Suicide Reporting Form for a Patient

Select Suicide Reporting Forms - Update/Print Option:
```

Figure 11-1: Options available for managing suicide forms

11.1.1   Update Suicide Reporting Form for a Patient (SFP)

Use the SFP option to update the suicide report for a specified patient.

Below are the prompts.

- "Select Patient Name"

  Specify the patient you want to use.

The application displays the View/Update Suicide Form window for the selected
patient.

```
View/Update Suicide Form      Apr 14, 2009 15:41:17          Page:   1 of   9
Suicide Forms on File for: ALPHAA,CHELSEA MARIE
HRN: 116431    FEMALE   DOB: Feb 07, 1975
Tribe: TOHONO O'ODHAM NATION OF   Community: TATRIA TOAK

1) Local Case #:                  Computer Case #: 50590109042006000034642
   Date of Act: SEP 04, 2006      Provider: GAMMA,DENISE
   Suicidal Behavior: ATTEMPT
   Method: HANGING  OTHER
2) Local Case #:                  Computer Case #: 50590112242006000048688
   Date of Act: DEC 24, 2006      Provider: PHI,JAMES N
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method: OVERDOSE  OTHER
3) Local Case #:                  Computer Case #: 50590101312007000048688
   Date of Act: JAN 31, 2007      Provider: BETA,LINZA
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
```

```
   Method: OVERDOSE
4) Local Case #:                     Computer Case #: 50590102222007000034642
+         ?? 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

Type **Quit** to dismiss this window.

11.1.1.1 Add/Edit Suicide Form

The Add and Edit functions use the same update form.

11.1.1.1.1   Add a Suicide Form (AF)

Use the AF option to add a suicide form for the current patient.

Below are the prompts.

- "Provider Completing the form"

  This is the name of the provider who is completing the form.

- "Enter the Date of the Suicide Act"

  Specify the date of the suicide act.

The application displays the Updating IHS Suicide Form window.

11.1.1.1.2   Edit a Suicide Form (EF)

Use the EF option to change a selected suicide form. The application displays the
Updating IHS Suicide Form window.

11.1.1.1.3   Updating IHS Suicide Form

Below is a sample Updating IHS Suicide Form.

```
***  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 #: 50590112242006000000486
Provider: LAMBDA,JAMES N          Initials:     Discipline:
-------------------------------------------------------------------------------
 1. Local Case #:             Provider: PHI,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 to be able to save the form; all other fields except for Local Case Number and Narrative are required but not enforced. The required but not enforced fields may be completed after the form has been saved.

- Local Case #

  This is a local case number generated by the site (use 1–20 characters).

- Provider

  This is the provider reporting this suicidal behavior (the provider completing the form).

- Employment Status

  This is the employment status of the patient. Type one of the following: **P** (part time), **F** (full time), **S** (self employed), **UE** (unemployed), R (retired), **ST** (student), **SE** (student and employed), **UNK** (unknown).

- Date of Act

  This is the date of the suicide act (required). The default is the current date (can be changed).

- Community where act Occurred

  This is the name of the community where the suicide act occurred.

- Relationship Status

  This is the relationship status. Type one of the following: **1** (single), **2** (married), **3** (divorced/separated), **4** (widowed), **5** (cohabiting/common law), **6** (same sex partnership), **9** (unknown).

- Education

  This is 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 select the Option 1, the application asks for the following information: "If less than 12 years, highest grade completed. Use any whole number between 0 and 12."

The following fields are in the Updating IHS Suicide Form window.

- Suicidal Behavior

  This is the suicidal behavior for the suicide act.

- Method (press Enter)

  Press Enter to access the following pop-up window.

```
*** If you need help type ?, not ?? ***
METHOD:
METHOD:
METHOD:
```

Figure 11-4: Sample fields on the pop-up

Populate the Method field with a suicide method. More than one can be used.

If you type **Other** in the Method field, the application asks the following information: "Please describe the "OTHER" Method. Use between 1 and 40 characters."

The following fields are in the Updating IHS Suicide Form window.

- Previous Attempts

  Populate with the number of previous suicide attempts. Type one of the following:

  - **0** 0
  - **1** 1
  - **2** 2
  - **3** 3 or more
  - **U** Unknown

- Substance Use Involved

Populate with the substance use involved in the suicide act. Type one of the following: **1** (none), **2** (alcohol and other drugs), **U** (unknown).

If you type **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

If you type **OTHER** at the "SUBSTANCE DRUG USED" prompt, the application asks for the following information: "Drug if other. Use between 1 and 40 characters."

The following fields are in the Updating IHS Suicide Form window.

- Location of Act

  Populate with the location of the act.

  If you type **Other** in the Location of Act field, the application asks the following information: "Location of Act If Other. Use between 1 and 80 characters."

The following fields are in the Updating IHS Suicide Form window.

- Contributing Factors (press enter)

  Press Enter to access the Contributing Factors pop-up window.

```
Enter all Contributing Factors. To see a list of choices type ??

FACTOR:
FACTOR:
FACTOR:
```

Figure 11-6: Fields in the pop-up window

Populate the Factor field with 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 at sign [@]) all other entries (the application confirms the deletion).

If you type **OTHER** at the "FACTOR" prompt, the application asks the following information: "Enter a brief description of the "Other" Contributing Factor. Use between 1 and 40 characters."

The following fields are in the Updating IHS Suicide Form window.

- Disposition

    Populate with the disposition of the suicide act.

    If you type OTHER at the "Disposition" prompt, the application asks the following information: "Disposition If Other. Use between 1 and 80 characters."

The following fields are in the Updating IHS Suicide Form window.

- Other Relevant Information

    Press Enter to access another window where you can populate the field with text of the other relevant information about the suicide act.

11.1.1.2   Display a Suicide Form (DF)

Use the DF action to display a specified suicide form.

Below are the prompts.

- Select Suicide Reporting Form List (1-x) (where x is the number of last form)

    Specify the suicide form you want to display.

- Do you wish to

    Use P (print output) or B (browse output on screen)

The application displays the form in the Output Browser where you can browse the Suicide Reporting Form on the screen.

```
OUTPUT BROWSER                    Apr 14, 2009 16:25:44          Page:  1 of   3




********** CONFIDENTIAL PATIENT INFORMATION [ST]  Apr 14, 2009 **********
Suicide Reporting Form                          Date Printed:  Apr 14, 2009

1. Case #: 50590112242006000048688     Local Case #:

2. PROVIDER INITIALS: RWL              3. PROVIDER DISCIPLINE: PSYCHOLOGIST
4. SEX: FEMALE         5. DOB: FEB 07, 1975           6. AGE: 31
7. EMPLOYMENT STATUS:
8. DATE OF ACT: DEC 24, 2006
```

```
9. TRIBE: TOHONO O'ODHAM NATION OF ARIZONA
10. COMMUNITY OF RESIDENCE: TATRIA TOAK
11. COMMUNITY WHERE ACT OCCURRED:

12. RELATIONSHIP STATUS: SINGLE

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

Figure 11-7: Sample Output Browser window for suicide act

11.1.1.3 Delete a Suicide Form (XF)

Use the XF option to remove a selected suicide form record.

Below are the prompts.

- "Select Suicide Reporting Form List (1-x) (where x is the number of last form)"

  Specify the suicide form you want to remove.

- "Are you sure you want to delete this suicide form?"

  Type **Y** (yes) or **N** (no).

11.1.1.4 Browse Visits for this Patient (BV)

Use the BV option to browse the BH visits for the current patient.

Below are the prompts.

- "Use one of the following." Type **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.

The application displays the BROWSE PATIENT'S VISITS window.

11.1.1.5 Health Summary for this Patient (HS)

Use the HS option to display/print a particular health summary for the current patient. After typing **HS**, the application displays the health summary for this patient in the Output Browser window.

11.1.2 Review Suicide Forms by Date (SFD)

Use the SFD option to review the suicide forms in a particular date range.

Below are the prompts.

- "Enter Beginning Suicide form date"

  Specify the beginning date of the date range.

- "Enter Ending Suicide form date"

  Specify the ending date of the date range.

The application displays the Review Suicide Reporting Forms window.

```
REVIEW SUICIDE REPORTING FORMS Apr 14, 2009 16:40:10     Page:    1 of   3
Suicide Form Review: Jan 14, 2009 - Apr 14, 2009
      Date
No.   of Act   Patient              HRN    DOB     Suicidal Behavior    PRV Loc

1)    01/21/09 SIGMA,AARON LEE      194180 04/16/98                      DG
2)    02/19/09 RHOOOOO,BEULAH       140325 08/18/89 ATTEMPT              RG897
3)    02/20/09 ALPHAA,CHELSEA MARIE 116431 02/07/75                      WW
4)    02/24/09 THETAA,TERESA ANN    119034 04/05/76 ATTEMPT              RG
5)    03/01/09 ALPHAA,CHELSEA MARIE 116431 02/07/75                      DG
6)    03/06/09 ALPHAA,CHELSEA MARIE 116431 02/07/75 ATTEMPT              DG
7)    03/20/09 PHIIII,TERRY LYNN    198794 05/10/68 COMPLETED SUICIDE WI RG222
8)    03/21/09 SIGMA,SERGIO         206293 09/08/65 ATTEMPT              RG222
9)    03/21/09 THETAAAAA,DONNA LEE  116076 10/20/67 IDEATION WITH PLAN A RG222
10)   03/24/09 ALPHAA,CHELSEA MARIE 116431 02/07/75                      RG
11)   03/25/09 ALPHAA,DIANA LEE     192745 09/15/54                      BJB
12)   03/25/09 ALPHAA,MARY SUE      108168 02/03/84 COMPLETED SUICIDE    BJB
13)   03/25/09 SIGMA,SERGIO         206293 09/08/65 COMPLETED SUICIDE WI RG222
14)   03/26/09 GAMMA,MACY NICOLE    143670 11/12/70 ATTEMPT              LB  SKL
+        Enter ?? for more actions                                >>>
AF   Add Form          DE   Delete Form           Q    Quit
EF   Edit Form         +    Next Screen
DF   Display Form      -    Previous Screen
Select Action:+//
```

Figure 11-8: Sample Review Suicide Report Forms window

See Section 11.1.1. for more information about the add/edit/delete functions in this window.

11.2   Suicide Form Window (GUI)

The suicide forms options are located under the Suicide Reporting Forms category on the tree structure for the RPMS BHS (GUI) application.
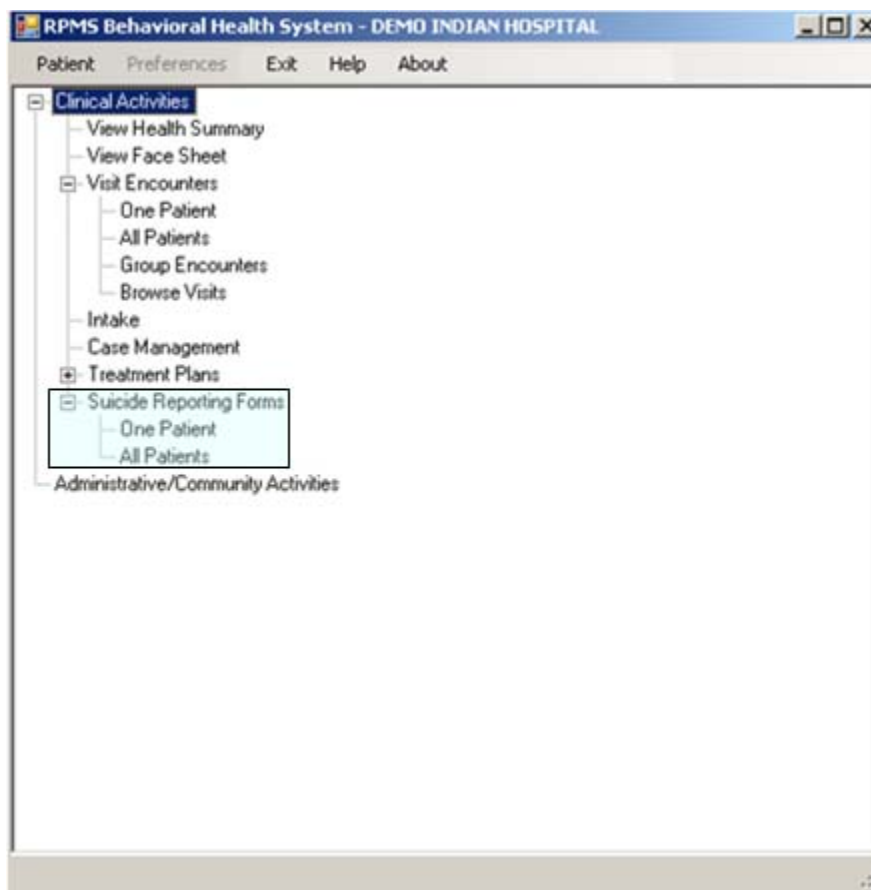
Figure 11-9: Location of Suicide Forms in the tree structure

One way to access the Suicide Form window is to select the One Patient option. 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 a patient.
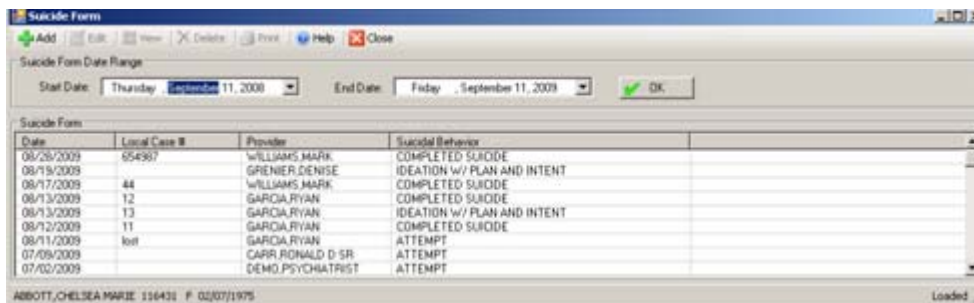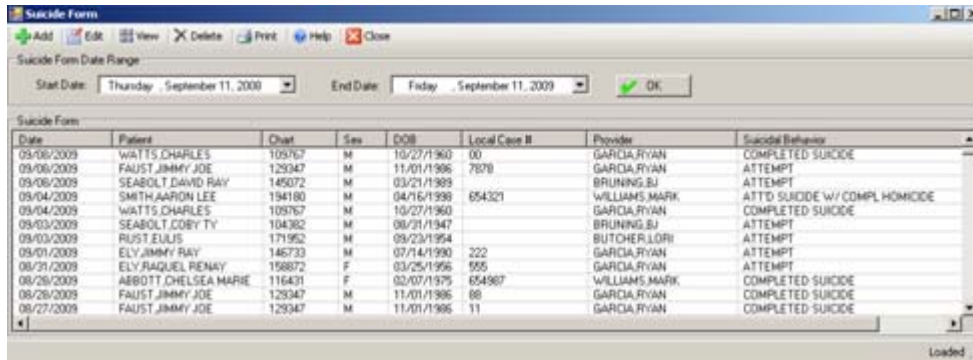
Figure 11-10: Suicide Form window for one patient

Another way to access the Suicide Form window is to select the All Patient option. The application displays the Suicide Form window for All Patients.

Figure 11-11: Sample Suicide Form window for all patients

Both windows function in the same manner.

11.2.1   Suicide Form Date Range

The suicide form records are in the suicide from date range.

The default date range is one year. The date range can be changed by clicking the drop-down list and selecting a new date from the calendar. After all changes to the date range are complete, click OK. The window redisplays, showing the information for the new date range.

11.2.2   Suicide Form Group Box

The Suicide Form group box displays the suicide form record in the date range. The records are listed by date.

11.2.3   Add Button

Establish the patient you want to use in the add process. Click Add to add a new suicide form record. The Suicide Form Data Entry–Add Suicide Entry dialog box will display. See Section 11.3 for more information. See Section 11.3 for more information.

11.2.4   Edit Button

Use the Edit button to edit the highlighted suicide form for the current patient on the Suicide Form Data Entry–Edit Suicide Entry dialog box. The Edit button will be inactive if the patient does not have any previous Suicide Reporting Forms on file (applies to the suicide form for the current patient). See Section 11.3 for more information.

11.2.5   View Button

Use the View button (or double-click on a form) to browse the highlighted suicide 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.

11.2.6   Delete Button

Use the Delete button to remove a highlighted suicide 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 suicide record (otherwise, click No.)

11.2.7   Print Button

Use the Print button on the Suicide Form window to output a highlighted suicide record. After clicking Print, the application displays the first page of the Suicide Reporting Form pop-up window.

Figure 11-12: Sample Suicide Reporting Form

This window contains the following:

- Data from the Suicide Form

- Patient data, such as sex, DOB, Age, Employment Status

- Edit History, such as date last modified, user last update, and each update including date and time and the name of the individual who modified the form

See Section 2.6 for more information about the controls in this pop-up window.

11.2.8   Help Button

Click the Help button to access the online help system for the Suicide Form window.

11.2.9   Close Button

Use the Close button close the Suicide Form window. If no data has been entered, the application displays the "Continue?" dialog box. This dialog box states: "Unsaved Data Will Be Lost, Continue?" Click Yes to close without saving; this dismisses the Add window. Click No and you will remain in the Add/Edit window, where you can continue work on the suicide form. If some of the fields have been completed, clicking Close will display a dialog box stating: "All of the fields on the Suicide Reporting Form, except Narrative, are required to complete a form. Would you like to save the form as it is and complete it later?" Click Yes to close and save, or No to dismiss the form without saving.

11.3   Add/Edit Suicide Form (GUI)

Below are the fields in the Suicide Form Data Entry–Add Suicide Form window. (The same fields display in the Suicide Form Data Entry–Edit Suicide Form window.)

Figure 11-13: Sample Suicide Form Data Entry–Add Suicide Form window

Click the Save button to save the information on this window.

All fields except the Local Case Number and Narrative are required in order to save. If you try to save without completing the fields, the application displays the Required field dialog box.
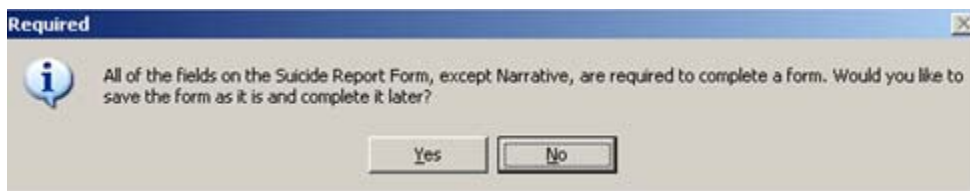
Figure 11-14: Required information message

- Click Yes to save the form and complete it later; you are returned to the Suicide Form window.

- Click No to close without saving and you remain in the data entry form.

Use the Help button to access the online help system for this window.

Some fields use free text. See Section 2.11 for more information.

Some fields use dates. See Section 2.7 for more information.

11.3.1   Suicide Form Fields

Below are the fields.

- Local Case Number

  Populate with the local case number or an HRN, if any (limited to 20 characters). This is a Free Text field.

- 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 can search for the provider name.

- Date of Act

  For a new record, the application automatically populates this field with the current date. To change, click the drop-down list to access a calendar where you can select another date.

- Community Where Act Occurred

  Populate with the community where the act occurred. To change, click the drop-down list to access the Community search window, where you can search for the community name.

- Relationship Status

  This is the relationship status. Use one of the following:

  - Single
  - Married
  - Divorced/Separated
  - Widowed
  - Cohabiting/Common Law
  - Same Sex Partnership
  - Unknown

- Education

  This is the level of education of the patient. Select one of the following:

  - Less than 12 years
  - High School Graduate/GED
  - Some College/Technical School
  - Collage Graduate

- – Post Graduate
- – Unknown

- Employment Status

  This is the status of the patient's employment. Click the drop-down list and select one of the options.

- If less than 12 years, highest grade completed

  This field becomes active when you populate the Education field with Less Than 12 Years. Populate with the number representing the highest grade completed in education.

- Suicidal Behavior

  This is the type of suicidal activity. Click the drop-down list and select one the options.

- Location of Act

  This is the location of the suicidal act. Click the drop-down list and select one of the options.

- Previous Attempts

  Select the patient's previous number of suicide attempts. Select one of the options available on the drop-down list.

- If other

  This field becomes active if you populate the Location of Act field with Other. Populate the If Other Free Text field with the location where the suicidal act occurred (limited to 80 characters).

- Disposition

  Populate with the disposition of the suicide act. Click the drop-down list and select one the options.

  If you populate this field with Other, the field to the right becomes active. Populate this Free Text field with the disposition of the suicide act (limited to 80 characters).

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 11-15: Sample Method tab

11.3.2.1 Method Group Box

Click one or more check boxes in this group box that describe the method used in the suicide act. At least one is required.

If you select the Overdose check box, the application displays the Substance multiple select window where you can add one or more categories of substances. 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 window displays.

Figure 11-16: Sample Other window

You must populate the Other field (limited to 80 characters). (You cannot dismiss the window.) Click OK. This action populates the Substance If Other cell in the Overdose group box.

If you check the Other check box, the field below the check box becomes active. Populate this Free Text field with the text that describes the other method used in the suicide act (limited to 80 characters).

11.3.2.2 Overdose Group Box

If you select the Overdose check box under Method, the Overdose group box becomes available. 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.

Click the Add button to add one or more new records. The application displays the Substance multiple select window where you can add one or more substances. When this window is complete, click OK. This action adds the substances to Overdose group box.

If you select Other on the Substance multiple select window, the application displays the Other window.
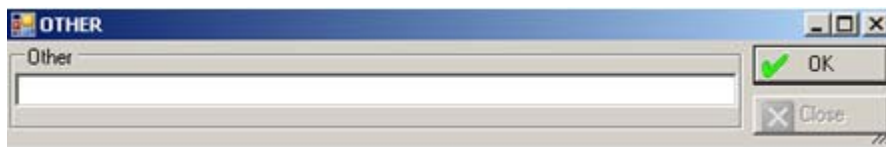
Figure 11-17: Other window

Populate the Other Free Text field with the substance used in the overdose (limited to 80 characters). Click OK; this action populates the "Substance if Other" column on the grid.

Highlight the record with data in the "Substance if Other" column and click Edit to display the Other window. The application displays the current Substance If Other data in the Other field. The data can be changed, as needed. Click OK to dismiss the Other window.

Use the Delete button to remove a selected substance record (in the Overdose group box). The application confirms the deletion.

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.
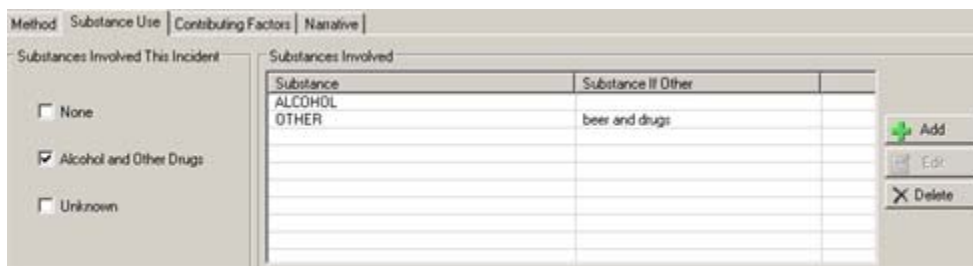
Figure 11-18: Sample Substance Use tab

11.3.3.1   Substances Involved This Incident Group Box

Click one of the check boxes in this group box that describes the substance used in the suicide act. At least one is required.
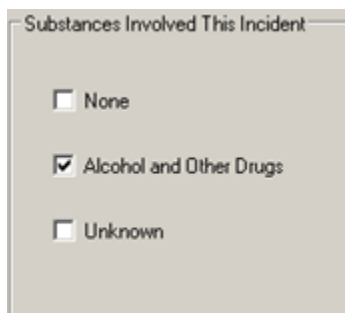
Figure 11-19: Substances Involved This Incident group box

If you select the Alcohol and Other Drugs check box, the application displays the Substance multiple select window where you can add one or more substances. When this window is complete, click OK. This action adds the substances to the Substances Involved group box.

If you select the Other option (on the Substance multiple select window), the application displays the Other window.

Figure 11-20: Other window

Populate the Other Free Text field with the "other" substance used in this incident (limited to 80 characters). Click OK; this action populates the Substances Involved group box.

If you uncheck the Alcohol and Other Drugs check box, this action clears any data in the Substances Involved group box.

11.3.3.2 Substances Involved Group Box
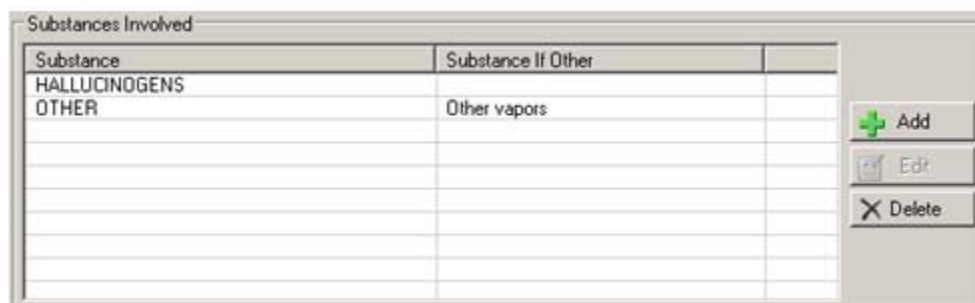
Figure 11-21: Sample Substances Involved group box

This group box contains the substances used immediately before or during the suicidal act. Once the Alcohol and Other Drugs checkbox is checked, the Add, Edit, and Delete buttons become active.

Use the Add button to add one or more new records. The application displays the Substance multiple select window where you can add one or more substances. When this window is complete, click OK. This action adds the substances to Substances Involved group box.

If you selected Other on the multiple select window, the application displays the Other window.

Figure 11-22: Other window

Populate the Other Free Text field with the "other" substance used in this suicide act (limited to 80 characters). Click OK; this action populates the Substances if Other column on the grid.

Use the Edit button with OTHER records (Substance If Other column is populated). Highlight the record and click Edit to display the Other window. The application displays the current "Substance If Other" data in the Other field. The data can be changed, as needed. Click OK to dismiss the Other window.

Use the Delete button to remove a highlighted substance record. The application confirms the deletion.

11.3.4   Contributing Factors Tab

Use the Contributing Factors tab to indicate one or more contributing factors associated with the suicide act.

Figure 11-23: Sample Contributing Factors tab

Check one or more for the checkboxes that describe the contributing factors for the suicide act. At least one is required.

If you check the Other check box, the field below the check box 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.)

Figure 11-24: 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 the roll-and-scroll application and the GUI.

12.1   Intake Documents (Roll-and-Scroll)

It is possible to add/change/remove an intake document when you exit the Visit Encounter (Display or Add/Edit) window. After exiting 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). None of the Above (Quit)
Choose one of the above:  (1-8): 8//
```

Figure 12-1: Options in the Other Information menu

Use Option 7 (Add/Update/Print Intake Document) to access the Update BH Intake Document for the selected visit.

Another place to add/change/remove an intake document is to use the Intake Document (ID) option on the Patient Data Entry window. You will be prompted for a Program (one you are associated with). After specifying the program, you will access the Update BH Intake Document for the current patient.

```
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 GAMMA,RYAN
*3  12/29/09  MENTAL H GAMMA,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 GAMMA,RYAN
*7  10/07/09          GAMMA,RYAN
                                           *10/07/09 GAMMA,RYAN
*8  04/21/09          GAMMA,RYAN
         Enter ?? for more actions
I   Add Initial Intake                 D    Delete Intake/Update
E   Edit Initial Intake                P    Display/Print Intake/Update
U   Add/Edit Update                    Q    Quit
Select Action: Q//
```

Figure 12-2: Sample Update BH Intake Document 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 Initiated, Program, and Initial Provider columns).

- The update documents are listed on the right side (under the Updated and Update Provider columns).

12.1.1   Add Initial Intake (I)

Use Option I to create an initial intake document for the visit.

After typing **I**, the application indicates that it is adding the Intake document for the patient.

Below are the prompts:

- "Do you wish to continue to add the Intake Document?"

  Type **Y** to add the Intake document (otherwise, type **N**). If you type **N**, you exit the create process.

  If you type **Y**, the following prompts continue.

- "DATE"

  The default is the current date (can be changed). This cannot be a future date.

- "PROGRAM"

The default is the Program associated with the visit if the Intake/Update option is accessed by selecting option 7 after entering a visit. If the Intake/Update option is accessed via the ID option on the PDE menu the default Program is the same as originally selected when accessing this option.

- "PROVIDER"

  This is the provider for the initial intake document. The default is the current logon provider (can be changed).

- "DATE LAST UPDATED"

  The default is the current date (can be changed). This cannot be a future date.

- "NARRATIVE"
  - "No Existing Text"
  - "Edit?"

  Type **Y** to edit the narrative or **N** to exit without editing the narrative.

  If you type **N**, 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 you type **N**, you are returned to the Update BH Intake Document window.

  If you type **Y**, you move to another window to enter the text of the narrative. After you save and exit, the application displays the following prompt:

- Enter your Current Signature Code

  Do one of the following:

  - Specify your electronic signature to sign the document. This action marks the document as signed. It cannot be edited.
  - Press Enter to leave without signing the document. After you press Enter, the document is marked as not signed. It can be edited.

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.

Below are the prompts:

- "CHOOSE"

  Type **1** (Edit Initial Intake Document) or **2** (Quit). If you type **2**, you are returned to the Update BH Intake Document. If you type **1**, the prompts continue.

- "Select Intake Update (1 of x)" where x is the number of the last intake document.

  Specify the intake document you want to edit.

  − If the specified intake document has been signed, you cannot edit it.
  − If you are not the original author or the person who entered this document, you cannot edit it.

- "DATE"

  The default is the current date (can be changed). This cannot be a future date.

- "PROGRAM"

  The program associated with the intake displays (can be changed).

- "PROVIDER"

  This is the provider for the initial intake document.

- "DATE LAST UPDATED"

  The default is the current date (can be changed). This cannot be a future date.

- "NARRATIVE"

  − "No Existing Text"
  − "Edit?"

  Type **Y** to edit the narrative or **N** to leave without editing the narrative.

  If you type **N**, the application displays that the Intake document was created and that an intake narrative must be entered before an electronic signature can be applied. Then the application asks if you want to enter an Intake Narrative (Y or N). If you type **Y**, you return to the Narrative prompts (as above). If you type **N**, you return to the Update BH Intake Document window.

  If you type **Y**, you move to another window where you enter the text of the narrative. After you save and exit this window, the prompts continue:

- "Enter your Current Signature Code"

  Do one of the following:

  − Specify 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. If you press Enter, 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 on which you are the provider.

- Only the person who originally entered the Update document or the Update document Provider can edit the document

- Other providers can only view or print the document.

Below are the prompts.

- "Select Intake: (1-x)" where x is the document number

  Specify the intake document you want to use.

  After specifying the document, the application displays the following message:

```
You can either add a new Update to this Intake document or edit an
existing, unsigned one on which you are the provider.  Please select an Update to
edit or choose 1 to add a new one or 0 to quit.

     0     Quit/Exit Update
     1     Date Updated: 01/26/10   Provider: THETA,SHIRLEY        MENTAL HEALTH
     2     Add new Update document
Select Action:  (0-1): 0//
```

Figure 12-3: Message from the application

> **Note**: If there is no Update document to edit, the second choice will *not* display. In this case there would only be 2 choices: Quit or Add New Update Document.

- "Select Action"

  You can either add a new update to this intake document, quit/exit the update process, or use the option to edit the Update (Option 2 in Figure 12-3).

  − If you select an update to edit, the prompts display. These are the same prompts as in Add new Update document.
  − If you select the Quit option, you leave the add/edit process.
  − If you select the Add new Update document option, the prompts follow.

- "DATE"

  The default is the current date (can be changed). This cannot be a future date.

- "PROVIDER"

  This is the provider for the update document. The default is the current logon provider (can be changed).

- "DATE LAST UPDATED"

  The default is the current date (can be changed). This cannot be a future date.

- "NARRATIVE"

  The application displays the text of the narrative or displays "no existing text" if there is none.

- "Edit?"

  Type **Y** to edit the text of the narrative or **N** to not edit the narrative. If you type **Y**, you go to another window where you enter the text of the narrative. After you save and leave this window, the application displays the next prompt.

- "Enter your Current Signature Code"

  Do one of the following:

  − Specify 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:

- "Select Action"

  You can do one of the following:

```
0 Quit/Exit Update
1 Date Updated: MM/DD/YY    Provider: <provider name>
2 Add new Update document
```

Figure 12-4: Prompts for the actions you can take

The following statements apply to the example shown in Figure 12-4.

If you use Option 0, you are returned to the Update BH Intake Document window.

If you use Option 1, this action has the same prompts as Add/Edit Update (see Section 4.1.6.3)

If you use Option 2, this action has the same prompts as Add/Edit Update (see Section 4.1.6.3).

12.1.4   Delete Intake/Update (D)

Use Option D to do one of the following:

- Delete Intake/Update

- Display/Print Intake/Update

12.1.4.1 Delete Intake/Update

Unsigned Intake documents can only be deleted by the provider or those individuals who are listed on the Delete Override list on the Site Parameters menu.

Below are the prompts:

- Select Intake

    Specify the Initial Intake you want to delete, or the Update you want to delete.

    The application gives you the following choices:

```
0  Quit/Exit
1  Date MM/DD/YY    Provider: <provider name>
```

Figure 12-5: Actions to take

The following statements apply to the example shown in Figure 12-5.

If you use Option 0, you are returned to the Update BH Intake Document window.

You can use Option 1 if you are the intake provider or the person who entered this Initial Intake document. If you meet one of the criteria, the application displays that you can now select which Intake or Update document to delete. Initial Intake documents that have Updates associated with them cannot be deleted.

When you specify a document to delete, the application asks: "Are you sure you want to delete this <name of document> document?" Type **Y** to delete or **N** to cancel the operation.

If there are multiple documents you want to delete, the application repeats the process.

12.1.4.2 Display/Print Intake/Update

This action is the same as using option P on the Update BH Intake Document window. See Section 12.1.5.

12.1.5   Print Intake Document

Use Option P to print/browse a particular intake document.

Below are the prompts.

- "Select Intake Update (1-x)" where x is the number of the last intake record

  Specify the document you want to display/print.

- "What would you like to print"

  Type **I** (Intake document only), **U** (Update document only), **B** (both the Intake and Update documents), **Q** (quit/exit).

  If you type **Q**, you return to the previous window.

  If you type **U**, another menu is displayed listing each of the updates and an option to print all updates.

  If you type **B**, other prompts will display.

- "Do you wish to"

  Type **P** to print output on paper or **B** browse output on screen.

  Below is sample Intake only report.

```
***************** CONFIDENTIAL PATIENT INFORMATION **********************
*************************************************************************
*                                                                       *
*   INTAKE DOCUMENT                         Printed: Aug 30, 2009@16:31:52   *
*   Name:  ALPHAA,CHELSEA MARIE                                 Page 1      *
*   DEMO INDIAN HOSPITAL   DOB:  2/7/75    Sex:  F   Chart #:  WW116431      *
*                                                                       *
*************************************************************************

  Date Established:    MAY 12, 2009
  Author/Provider:     THETA,SHIRLEY
  Program:             MENTAL HEALTH
  Type of Document:    INITIAL

  Intake Documentation/Narrative: This is a 34-year old female requesting
antidepressant medications, stating that she ran out of her previous prescription
since moving back to the reservation.


_____
                                                              DATE


_____
                                                     DATE
```

Figure 12-6: Sample intake document report

12.2   Intake (GUI)

There are two ways to work with the Patient Intake documents in the GUI:

- Method 1: Use the Intake option on the GUI tree structure.

- Method 2: Use the Intake tab on the Add/Edit Visit Data Entry window.

Either method accesses the same Intake window.

The following provides information about using the Intake option on the GUI tree structure.

The Intake option applies to the current patient. After selecting the Intake option, the application displays the Select Program window if a patient is not already selected.
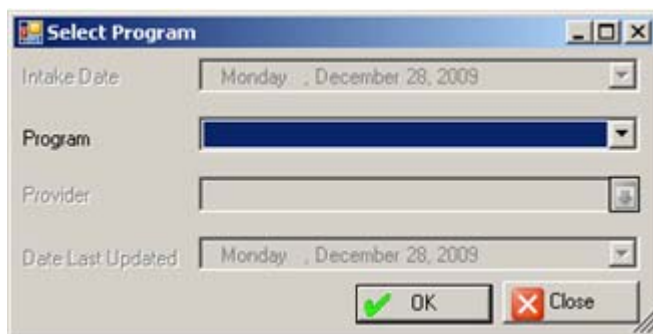
Figure 12-7: Select Program window

Click the drop-down list for the Program field and select an option. Then click OK (otherwise click Close).

Click Close to exit the process.

Click OK to display 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**:   Figure 12-8 shows the window that displays when you access the Intake window.
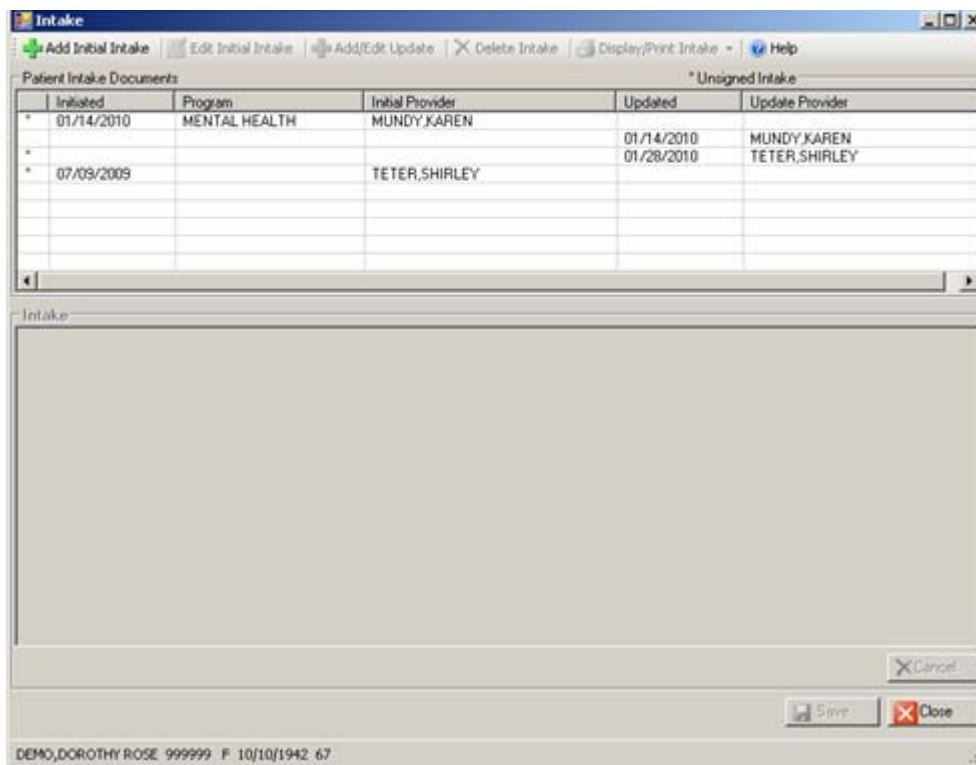
Figure 12-8: Sample Intake window

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 Group Box

Figure 12-9: Sample Patient Intake Documents group box

The Patient Intake Documents group 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 group 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 Add Initial Intake button to add a new initial intake document. Click this button to access the Select Intake Parameters window.
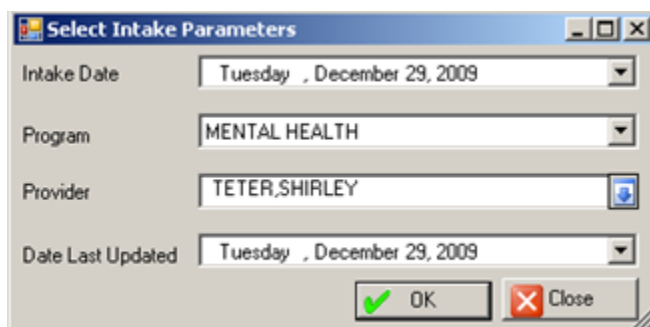
Figure 12-10: Sample Select Intake Parameters window

- Intake Date

  The default is the current date. The date can be changed by clicking the drop-down list and selecting another date from the calendar. This cannot be a future date.

- Program

  The default is the program you selected when you first accessed the Intake menu. This can be changed 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.

- Provider

The default is the current login provider. This can be changed by clicking the drop-down list to access the Primary Provider search window. See Section 2.8 for more information about using this type of window.

- Date Last Updated

    The default is the current date. This can be changed by clicking the drop-down list and selecting another date from the calendar. This cannot be a future date.

After completing the Select Intake Parameters window, click OK. This activates the Intake group box. See Section 12.2.2 for more information.

12.2.3   Intake Group Box
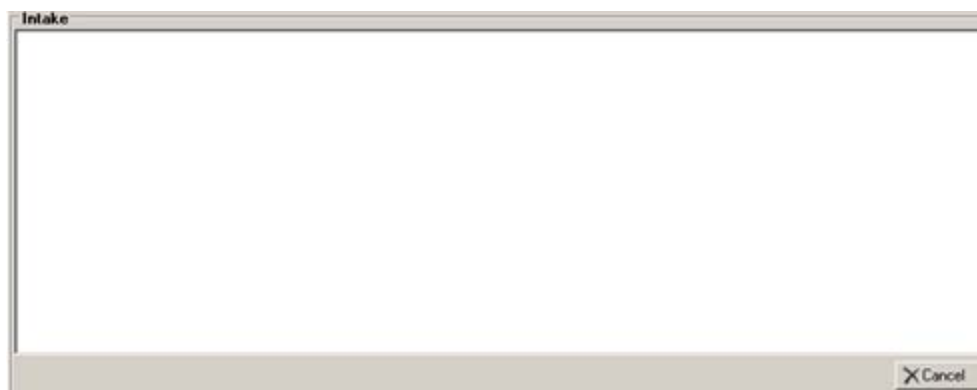
Figure 12-11: Sample of active Intake group box

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.

After you have completed the Intake group box, click Save (otherwise click Close).

- If you click Close, the application displays the Continue? message: "Unsaved Data Will Be Lost, Continue?" Click Yes to lose any data and you return to the GUI tree structure. Click No and you are returned to the Intake group box.

- If you click Save, the application displays the Intake Electronic Signature window.

Figure 12-12: Intake Electronic Signature window

To sign the particular document, type your electronic signature and click OK. This saves the document and marks it as signed. Signing a document locks the document from any future edits.

Otherwise, do not use your electronic signature and click Close. The application displays the Are You Sure? dialog box, which states: Are you sure you want to Close without Electronically Signing the Intake?"

- Click Yes to exit without signing 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 you are returned to the Intake Electronic Signature window.

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 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. See Section 12.2.1 for more information. After completing this dialog box, the text of the initial intake document will display in the Intake area of the Intake window. See Section 12.2.2 for more information.

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. See Section 12.2.1 for more information.

After completing this dialog box, the Intake group box will become active. See Section 12.2.2 for more information.

12.2.6   Delete Intake

Use the Delete Intake button to delete a selected unsigned Intake document (in the Patient Intake Documents group box).

After you click Delete, the "Are You Sure" confirmation message displays asking: "Are you sure you want to delete?" Click Yes to delete (otherwise, click No to exit without deleting).

- Only the intake provider or the person who entered the selected intake can use the Delete function. However, when a person is listed in the Delete Override section on the Site Parameters menu (in RPMS), that person can delete the document.

- If the selected Intake document has an attached update document, the application displays the message: "This intake document has updates associated with it. It cannot be deleted at this time." Click OK on the message and you exit the Delete process.

12.2.7   Display/Print Intake

Use the Display/ Print Intake button to access the options for the display/print process.
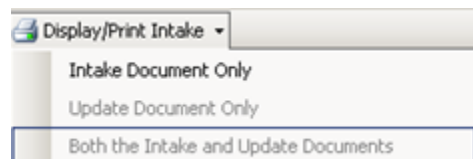
Figure 12-13: Options on the Display/Print Intake button

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 window.
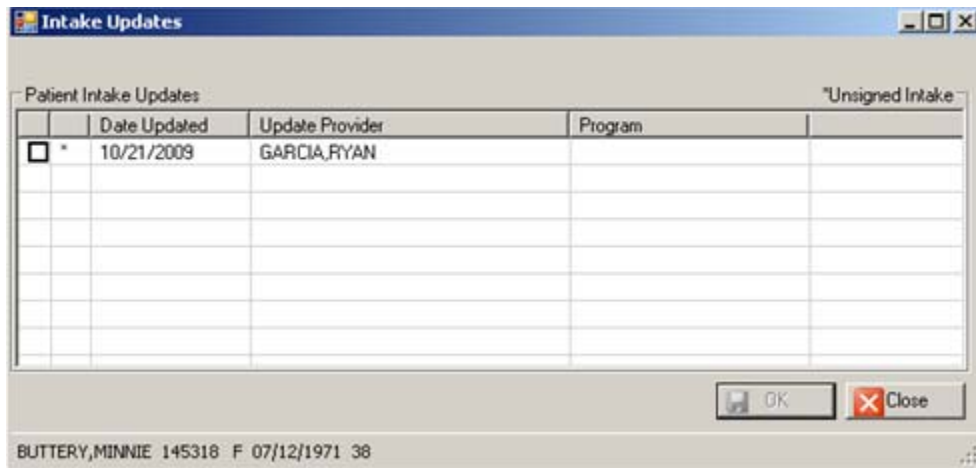
Figure 12-14: Sample Intake Updates window

Check the records you want to include in the output and click OK (otherwise, click Close to exit without printing).

The application displays the Intake (for the current patient) window.
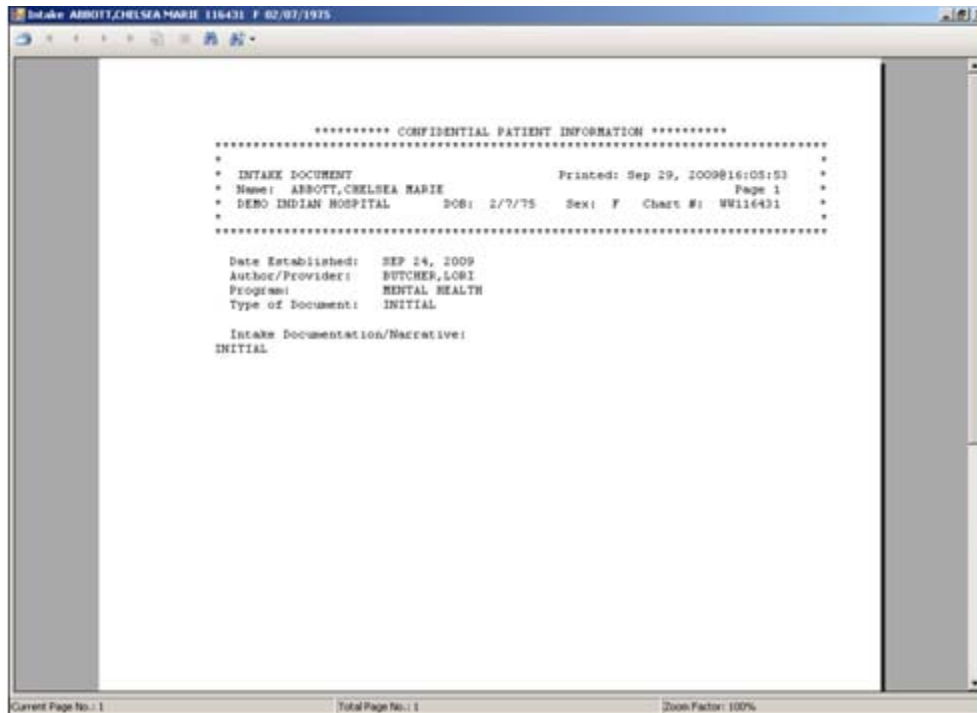
Figure 12-15: Sample Intake window for current patient

See Section 2.6 for more information about using the buttons on this window.

13.0   Reports (Roll-and-Scroll Only)

The Reports menu of the BHS provides numerous options for retrieving data from the patient file. You can obtain specific patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

The Reports menu contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to the BHS. 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

                          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 contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, which 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.

```
                 **********************************************
                 **        IHS Behavioral Health System      **
                 **            Patient Listings               **
                 **********************************************
                                 Version 4.0

                             DEMO INDIAN HOSPITAL


     ACL    Active Client List
     PGEN   Patient General Retrieval
     DP     Designated Provider List
     GRT    Patients with AT LEAST N Visits
     AGE    Patients Seen by Age and Sex (132 column print)
     CASE   Case Status Reports ...
     GAFS   GAF Scores for Multiple Patients
     NSDR   Listing of No-Show Visits in a Date Range
     PERS   Patient List for Personal Hx Items
     PPL    Placements by Site/Patient
     PPR    Listing of Patients with Selected Problems
     SCRN   Screening Reports ...
     TPR    Treatment Plans ...
     TSG    Patients seen in groups w/Time in Group

Select Patient Listings Option:
```

Figure 13-2: Options on the Patient Listings reports

13.1.1   Active Client List (ACL)

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.

- "Limit the list to those patients who have seen a particular provider?"

Type **Y** or **N**. If you type **Y**, other prompts display.

- "Select one of the following:"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

You browse the output on the Output Browser window.

```
OUTPUT BROWSER                 Apr 16, 2009 14:36:51        Page:   1 of   15



          ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                     Page 1
                          DEMO INDIAN HOSPITAL
                           ACTIVE CLIENT LIST
                            PROVIDER: ALL
            ENCOUNTER DATES:  JAN 16, 2009  TO  APR 16, 2009


PATIENT NAME        CHART   SEX  DOB      LOCATION     PROVIDER    PROBLEM   #
                    NUMBER                SEEN         SEEN        CODES   VISITS
---------------------------------------------------------------------------
ALPHAA,CHELSEA      116431   F   02/07/75 CEDAR CITY  BDOCTOR,BJ  1.1 67
                                          CHEVAK      BDOC,LO     12
                                          CHINLE CHA  CDOCC,JESS  14
                                          CHINLE HOS  DEMO,DOCTO  15
                                          DEMO INDIA  GDOCCC,RYA  22
```

Figure 13-3: Sample Output Browser data

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"

  Type **S** (search template) or P (patient file). If you type **S**, other prompts will display.

- "Do you want to use a previously defined report?"

  Type **Y** or **N**. If you type **Y**, other prompts will display.

  The application displays the Patient Selection Menu.

```
BH GENERAL RETRIEVAL         Apr 16, 2009 14:43:06      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                   15)  Priv Ins Eligibility  29)  Pts w/Problem (DX)
2)   Race                  16)  Patient Flag Field    30)  Pts w/Problem (MHSS
3)   Patient Age           17)  Case Open Date        31)  Pts seen by a Provid
4)   Patient DOB           18)  Case Admit Date       32)  Pts w/Education Done
5)   Patient DOD           19)  Case Closed Date      33)  Pts seen for an Acti
6)   Living Patients       20)  Case Disposition      34)  Pts seen w/Type of C
7)   Chart Facility        21)  Next Case Review Dat  35)  Pts seen w/Axis IV L
8)   Community of Residen  22)  Designated MH Prov    36)  Pts w/Inpatient Disp
9)   County of Residence   23)  Designated SS Provid  37)  Pts Last Health Fact
10)  Tribe of Membership   24)  Designated A/SA Prov  38)  Pts w/ A/SA Componen
11)  Eligibility Status    25)  Designated Other Pro  39)  Pts w/ Days in Res T
12)  Class/Beneficiary     26)  Personal History Ite  40)  Pts w/ Days Aftercar
13)  Medicare Eligibility  27)  Pts seen at a Locati  41)  Pts w/ A/SA Type of
14)  Medicaid Eligibility  28)  Pts Seen in a Commun
         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"

  Type one of the following: **T** (total count only), **S** (subcounts and total count), or **D**
  (detailed listing).

  The application displays the Print Item Selection Menu.

```
BH GENERAL RETRIEVAL         Apr 16, 2009 14:46:31         Page:   1 of   1
                        PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1)   Patient Name          13)  Class/Beneficiary     25)  Case Disposition
2)   Sex                   14)  Medicare Eligibility  26)  Next Case Review Dat
3)   Race                  15)  Medicaid Eligibility  27)  Designated MH Prov
4)   Patient Age           16)  Priv Ins Eligibility  28)  Designated SS Provid
5)   Patient DOB           17)  Mailing Address-City  29)  Designated A/SA Prov
6)   Patient SSN           18)  Home Phone            30)  Designated Other Pro
7)   Patient DOD           19)  Mother's Name         31)  Designated Other (2)
8)   Patient Chart #       20)  Patient Flag Field    32)  Personal History Ite
9)   Community of Residen  21)  Patient Flag Narrati  33)  Pts Last Health Fact
10)  County of Residence   22)  Case Open Date
11)  Tribe of Membership   23)  Case Admit Date
12)  Eligibility Status    24)  Case Closed Date



         Enter ?? for more actions
S    Select Item(s)       +    Next Screen        Q    Quit Item Selection
```

```
R    Remove Item(s)      -    Previous Screen     E    Exit Report
Select Action: S//
```

Figure 13-5: Sample Print Item Selection Menu options

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 Quit Item Selection action to dismiss the menu.

Next, the application displays the Sort Item Selection Menu.

```
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?"

  Type **Y** or **N**.

- "Would you like a custom title for this report?"

  Type **Y** or **N**. If you type **Y**, other prompts will display.

- "Do you wish to save this search/print/sort logic for future use?"

  Type **Y** or **N**. If you type **Y**, other prompts will display.

- "Demo Patient Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

The application provides a Report Summary that tells the criteria you selected.

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the patient listing report.

```
OUTPUT BROWSER                Apr 16, 2009 14:55:31        Page:   2 of 7350

+
      Patients will be sorted by:  Patient Name


            ********** 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?"

  Type 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"

  Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the designated mental health provider list report.

```
OUTPUT BROWSER          Apr 16, 2009 15:02:18    Page:    1 of    5



          ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                             Page 1
                        DEMO INDIAN HOSPITAL
                 DESIGNATED MENTAL HEALTH PROVIDER LIST
                        PROVIDER: ALL

PATIENT NAME             CHART #   SEX   DOB      COMMUNITY   LAST VISIT
----------------------------------------------------------------------

PROVIDER:  GPROVIDER,D

ALPHA,ALICE ROCHELLE     183497    F   06/25/97   COLCORD     Jan 05, 2009
ALPHAA,GLEN DALE         108704    M   11/10/81   TAHLEQUAH   Apr 14, 2009
GPAT,JANE ELLEN          114455    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"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the patients seen at least N times report.

```
OUTPUT BROWSER             Apr 16, 2009 15:07:42        Page:   1 of   10



          ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                          Page 1
                        DEMO INDIAN HOSPITAL
                  PATIENTS SEEN AT LEAST 3 TIMES
              RECORD DATES:  JAN 16, 2009  TO  APR 16, 2009


PATIENT NAME        CHART #SEX   DOB        LOCATION    PROVIDER    PROBLEM  #
                                            SEEN        SEEN        CODES    VISITS
----------------------------------------------------------------------------
ALPHAA,CHELSEA    116431   F   02/07/75  CEDAR CITY  BDOC111,BJ  1.1 67
                              CHEVAK       BDOC222,LO   12
                              CHINLE CHA   CDOC1,JESS   14
                              CHINLE HOS   DEMO,DOCTO   15
                              DEMO INDIA   GDOC12,RYA   22
+        Enter ?? for more actions                      >>>
+   NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-9: Sample Patients Seen at least Three 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.

```
BH GENERAL RETRIEVAL     Apr 16, 2009 15:16:17    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          29)  Clinic              57)  POV (Problem Categor
2)   Patient Sex           30)  Outside Location    58)  POV Diagnosis Catego
3)   Patient Race          31)  SU of Encounter     59)  Procedures (CPT)
4)   Patient Age           32)  County of Service   60)  Education Topics Pro
5)   Patient DOB           33)  Community of Service 61) Prevention Activity
6)   Patient DOD           34)  Activity Type       62)  Days Used Alcohol
7)   Living Patients       35)  A/SA Component      63)  Days Used Drugs
8)   Chart Facility        36)  A/SA Type of Contact 64) Days Hospitalized
9)   Patient Community     37)  Days in Residential 65)  Drug/Alc Related Arr
10)  Patient County Resid  38)  Days in Aftercare   66)  Staging Average
11)  Patient Tribe         39)  Activity Category   67)  Alcohol/Sub Stage
12)  Eligibility Status    40)  Local Service Site  68)  Physical Stage
13)  Class/Beneficiary     41)  Number Served       69)  Emotional Stage
14)  Medicare Eligibility  42)  Type of Contact     70)  Social Stage
15)  Medicaid Eligibility  43)  Activity Time       71)  Cul/Spirit Stage
16)  Priv Ins Eligibility  44)  Inpatient Dispositio 72) Behavioral Stage
17)  Patient Encounters O  45)  PCC Visit Created   73)  Voc/Educ Stage
18)  Patient Flag Field    46)  Axis IV             74)  A/SA Recommended Pla
19)  Case Open Date        47)  Axis V              75)  A/SA Actual Placemen
20)  Case Admit Date       48)  Flag (Visit Flag)   76)  A/SA Difference Reas
21)  Case Closed Date      49)  Primary Provider    77)  Personal History Ite
22)  Case Disposition      50)  Primary Prov Discipl 78) Designated MH Prov
23)  Next Case Review Dat  51)  Primary Prov Affilia 79) Designated SS Provid
24)  Appointment/Walk-In   52)  Prim/Sec Providers  80)  Designated A/SA Prov
25)  Interpreter Utilized  53)  Prim/Sec Prov Discip 81) Designated Other Pro
26)  Program               54)  POV (Prim or Sec)
27)  Visit Type            55)  POV (Prob Code Grps)
28)  Location of Encounte  56)  Primary POV
+          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. Type **Y** or **N** to this prompt. If you type **Y**, other prompts will display. Type **N** to have the defined age groups listed across the top of the report.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Behavioral Health Record Listing report.

```
OUTPUT BROWSER      Apr 16, 2009 15:20:53   Page:   1 of  23



BEHAVIORAL HEALTH RECORD LISTING

REPORT REQUESTED BY: THETA,SHIRLEY

The following visit listing contains BH visits selected based on the
following criteria:

                       RECORD SELECTION CRITERIA

Encounter Date range:  OCT 18, 2008 to APR 16, 2009


Report Type: RECORD COUNTS BY AGE/SEX
            ********** CONFIDENTIAL PATIENT INFORMATION **********
                 BEHAVIORAL HEALTH RECORD/ENCOUNTER COUNTS
                     PROBLEM DSM IV TR/CODE BY AGE AND
                   ENCOUNTER DATES:  OCT 18, 2008  TO  A

SEX: BOTH
PROB DSM/CODE NARRATIVE                    0-0     1-4     5-14    15-19   20-
-----------------------------------------------------------------------------
ACUTE STRESS REACTION                       .       .       .       .
ADMINISTRATION                              .       .       2       .
ADULT ABUSE (SUSPECTED),UNSPEC              .       .       .       .
ALCOHOL ABUSE                               .       .       1       .
ALCOHOL ABUSE, CONTINUOUS                   .       .       .       .
ALCOHOL ABUSE, EPISODIC,                    .       .       .       1
```

```
ALCOHOL ABUSE, IN REMISSION                  .        .        .      .
ALCOHOL ABUSE, UNSPECIFIED                   .        .        1      1
+        Enter ?? for more actions                                >>>
+    NEXT SCREEN         -    PREVIOUS SCREEN       Q    QUIT
Select Action: +//
```

Figure 13-11: Sample Behavioral Health Record Listing report

13.1.6   Case Status Reports (CASE)

Use the CASE option to access the options on the Case Status Reports menu.

```
   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:

- "List visits to which program"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "Include Visits to"

  Type one of the following: **1** (one provider) or **2** (all provides). If you type **1**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the active client list report.

```
      ********** CONFIDENTIAL PATIENT INFORMATION **********
Page 1
WHITE EARTH HEALTH CENTER
Encounter Dates: JAN 22, 2008 to JAN 21, 2009
ACTIVE CLIENT LIST (CASE OPEN DATE WITH NO CASE CLOSED DATE)

PATIENT NAME CHART  SEX  DOB      CASE OPEN CASE ADMIT PROVIDER    PROBLEM
             NUMBER                DATE      DATE      SEEN       CODES
------------------------------------------------------------------------
BETAA,AUGUST 385656  M  12/17/34  05/03/96            DELTA,BI   94

OMEGA,BEV    496879  F  07/17/50  08/21/96            DELTA,BI   79

KARET,BERNIE 45224   M  12/25/48  10/30/96            PSI,   53
```

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 patient 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:

- "List Visits to which program"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "Include Visits to"

  Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- "Enter the number of days since the patient has been seen"

  Specify the number of days to be used when determining which patients should be included in the report.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Cases Opened but Patient Not Seen in N Days report.

```
DEMO INDIAN HOSPITAL
```

```
ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)

PATIENT NAME   CHART    SEX  DOB      CASE OPEN  PROVIDER    DATE LAST   # DAYS
               NUMBER                 DATE                   SEEN        SINCE
  Patient L    106299   F   11/28/85  01/01/06   GAMMA,DON   04/26/06    217
  Patient M    102446   F   04/08/66  08/28/06   GAMMA,DON   03/28/06    246
  Patient N    176203   M   03/04/60  10/10/05   GAMMA,DON   03/28/06    246
  Patient O    164141   M   02/07/75  12/07/05   GAMMA,DON   04/25/06    218
  Patient P    209591   F   04/16/62  07/25/06   RHO,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 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.

- "List Visits to which program"

  Type one of the following: **O** (one program) or **A** (All programs). If you type **O**, other prompts will display.

- "Include Visits to"

  Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally of Cases Opened/Admitted/Closed report.

```
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 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.

- "Run Report for"

  Type 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).

- "List Visits to which program"

  Type one of the following: **O** (one program) or **A** (All programs). If you type **O**, other prompts will display.

- "Include Visits to"

Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Duration of Care report.

```
DURATION OF CARE REPORT
  PATIENT NAME   CHART   CASE OPEN   CASE CLOSED   DURATION   POV   PROVIDER
                 NUMBER  DATE        DATE

Patient A        148367  05/22/08    08/22/08      92 days          BETA,B
Patient B        114077  06/27/08    08/28/08      62 days          BETA,B
Patient B        114077  07/25/08    08/21/08      27 days          BETA,B
    Total Number of Cases for BETAA,B: 3
    Average Duration of Care: 60.33 days

Patient C        211053  04/19/08    08/16/08      119 days   72.1  SIGMA,RO
    Total Number of Cases for SIGMA,ROBERTA: 1
    Average Duration of Care: 119.00 days

Patient D        146565  08/01/08    08/16/08       15 days   305.62 THETA,MAUDE
    Total Number of Cases for THETA,MAUDE: 1
    Average Duration of Care: 15.00 days

Patient E        148256  07/25/08    09/01/08       38 days          THA,VICTOR L
    Total Number of Cases for THA,VICTOR L: 1
    Average Duration of Care: 38.00 days

Patient F        106030  05/22/08    08/30/08       100 days         UPSILON,GEORGE G
    Total Number of Cases for UPSILON,GEORGE G: 1
    Average Duration of Care: 100.00 days

    Total Number of Cases: 7
    Average Duration of Care: 64.71 days
```

Figure 13-16: Sample Duration of Care report

13.1.6.5 Patient Seen x number of times w/no Case Open (SENO)

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 for search"

  Specify the beginning date of the date range.

- "Enter ending Visit Date for search"

  Specify the ending date of the date range.

- "List visits to which program"

  Type one of the following: **O** (one program) or **A** (all programs. If you type **O** other prompts will display.

- "Include visits to"

  Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- "Enter number of visits"

  Specify the number of visits that may occur before a case should be opened.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **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.

```
                           DEMO INDIAN HOSPITAL
             PATIENTS SEEN AT LEAST 2 TIMES WITH NO CASE OPEN DATE
                  VISIT DATE RANGE: Jun 02, 2008 to Nov 29, 2008

                      VISITS TO PROGRAM: MENTAL HEALTH
  PATIENT NAME   CHART   SEX  DOB        #      LAST VISIT    LAST       PROVIDER
                 NUMBER                  VISITS               DX
 --------------------------------------------------------------------------------

  Patient G      116431  F    02/07/75   3      11/14/08      43.1     BETA,B
  Patient H      142538  F    10/10/42   3      11/27/08      27       BETA,B
  Patient I      113419  M    07/18/85   3      08/16/08      296.33   BETA,KEITH N
  Patient J      201295  M    05/14/41   4      08/22/08      296.40   GAMMA, THO
  Patient K      194181  M    08/21/98   2      06/19/08      314.9    SIGMA,JOH

     Total Number of Patients: 5
```

Figure 13-17: Sample Patients Seen at least N times with no Case Open Date report

13.1.7   GAF Scores for Multiple Patients (GAFS)

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"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "Include visits to"

  Type one of the following: **A** (all providers) or **O** (one provider). If you type **O**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the GAF Scores for Multiple Patients report.

```
  XX                              Apr 17, 2009                         Page 1

                       GAF SCORES FOR MULTIPLE PATIENTS
                  Visit Dates: Oct 19, 2008 to Apr 17, 2009
                              Program: ALL
                              Provider: ALL

PATIENT NAME      HRN    Date    GAF Provider      PG Diagnosis/POV
--------------------------------------------------------------------------

ALPHAA,CHELSEA    116431 04/10/09 01  GAMMAA,RYAN  M  311.-DEPRESSIVE DISORDER
ALPHAB,CHELSEA    116431 03/31/09 65  GAMMAA,RYAN  S  295.72-SCHIZOAFFECTIVE DISO
APAT1,CALLIE FA   114607 11/25/08 55  CHIII,JESSIC C  V26.41-PROCREATIVE COUNSELI
BPATTTTTT,SARAH   106245 02/12/09 44  GAMMAA,RYAN  M  290.41-VASCULAR DEMENTIA, W
B1PAT,RGY LYN     207396 04/07/09 77  GAMMAA,RYAN  M  15-BIPOLAR DISORDER
BPAT22222,IRENE   127171 12/25/08 55  CHIII,JESSIC C  80-HOUSING
+        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"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "Include visits to"

  Type one of the following: **A** (all providers) or **O** (one provider). If you type **O**, other prompts will display.

- "How would you like the report sorted"

  Type **P** (patient name) or **D** (date of visit).

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Behavioral Health No Show Appointment Listing report.

```
OUTPUT BROWSER              Apr 17, 2009 13:01:58        Page:   1 of   1



          ********** CONFIDENTIAL PATIENT INFORMATION **********
```

```
                              DEMO INDIAN HOSPITAL                    Page 1

BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
Appointment Dates:  OCT 19, 2008 and APR 17, 2009

PATIENT NAME         HRN    DATE/TIME             PROVIDER     PG  POV
-------------------------------------------------------------------------
BPAT,ROBERT JACOB    207365 Jan 05, 2009@12:00 CBETA,JESSIC M  8-FAILED APPOI
FPAT1111,CHARLES R   112383 Dec 30, 2008        BETAAAA,BJ   M  8.1-PATIENT CANC
RPAT111,BEULAH       140325 Feb 12, 2009@12:00 GAMMAA,RYAN  S  8-FAILED APPOI
VPAT1,RACHEL MAE     201836 Jan 06, 2009@12:00 LAMBDAAA,MIC O  8.3-DID NOT WAIT

Total # of Patients: 4     Total # of No Show Visits: 4

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

Figure 13-19: Sample Behavioral Health No Show Appointment Listing report

13.1.9   Patient List for Personal Hx Items (PERS)

Use the PERS option to produce the List of Patients with Personal History Items
report.

Below are the prompts.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O**
  (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the List of Patients with Personal History Items report.

```
XX                           DEMO INDIAN HOSPITAL
PERSONAL HISTORY LIST BY PATIENT             Jul 13, 2009@09:53:05
Page 1
           PATIENT                          SEX     AGE  CHART NUMBER
--------------------------------------------------------------------


              ALCOHOL USE
          ALPHAA,SAUNDRA KAY              FEMALE   58   117175
          BETA,BRENNA KAY                 FEMALE   21   155215
          BETA,HEATHER LINDA PAIGE        FEMALE   73   142321
          BETAA,STEVEN                    MALE     29   188444
          GAMMA,JANE ELLEN                FEMALE   19
          GAMMA,TIMOTHY                   MALE     29
          PHIIIII,GREGORY SHANE           MALE     42   184929
          SIGMAAA,AMY LYNN                FEMALE   65   130119
```

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

Figure 13-20: Sample List of Patients with Personal History Items report

13.1.10 Placements by Site/Patient (PPL)

Use the PPL option to produce a report that shows a list of patients who have had a placement disposition recorded in the past year. The user will specify the date range during which the patient had a placement.

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

  Type **P** (alphabetically by patient name) or **S** (alphabetically by site referred to).

- Demo Patient/Inclusion/Exclusion

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- Do you wish to

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Placements report.

```
OUTPUT BROWSER              Apr 17, 2009 13:11:50        Page:   1 of   15


         ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                           Page 1
                          DEMO INDIAN HOSPITAL
                             PLACEMENTS
            PLACEMENT DATES:  OCT 19, 2008  TO  APR 17, 2009

PATIENT NAME        HRN    DATE     POV    PLACEMENT      FACILITY REFERRED TO
                           PLACED
ALPHA,JACOB SCOTT   102668  05/03/09 295.15 OUTPATIENT     DEMO HOSPITAL
APATT,CHELSEA MAR   116431  03/25/09 12     OUTPATIENT     TEST HOSPITAL
```

```
   Placement Made by: GAMMA,RYAN
   Designated SS Prov: BETA,BJ
BPATT,RGY LYNN      207396  04/06/09 15     OUTPATIENT      DEMO RTC
   Placement Made by: GAMMA,RYAN
BPATTTT,ADAM M      109943  04/07/09 311.0  OUTPATIENT      TEST GROUP HOME
   Placement Made by: GAMMA,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, 41) and you will receive 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"

  Type 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 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"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report.

```
OUTPUT BROWSER        Apr 17, 2009 13:23:29    Page:    1 of    2


   XX                          Apr 17, 2009                     Page 1

PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
Visit Dates: Oct 19, 2008 to Apr 17, 2009

PATIENT NAME                HRN    DOB      SEX PROV DX DX    DATE SEEN LAST VIS
--------------------------------------------------------------------------------
APATQ,ABIGAIL               103952 02/25/32  F   BJB    41    12/08/08  12/29/08
BPAT,ROBERT JACOB           207365 02/06/55  M   JC     41    12/29/08  01/05/09
FPAT12,AMANDA ROSE          186121 01/10/98  F   DG     40    12/01/08  12/30/08
WPAT123,ANTHONY DON         161347 02/01/93  M   JC     40    11/25/08  11/25/08
YPATAAA,DEANNA L            107893 10/02/81  F   JC     40    12/29/08  12/29/08
YPATB,ANNEMARIE LEE         105883 02/11/44  F   DG     40    04/06/09  04/06/09
   Designated MH Prov: GALPHA,DENISE
   Designated SS Prov: GALPHA,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"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report.

```
OUTPUT BROWSER          Apr 17, 2009 13:26:02   Page:   1 of   1



ST                           Apr 17, 2009                      Page 1

PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
Visit Dates: Oct 19, 2008 to Apr 17, 2009

PATIENT NAME              HRN    DOB     SEX PROV DX DX    DATE SEEN LAST VIS
------------------------------------------------------------------------------
ALPHA,CHELSEA MARIE      116431 02/07/75  F   DG     43.3   04/06/09  04/16/09
   Designated SS Prov: BDOC11,BJ
ALPHA,MISTY DAWN         131668 04/21/46  F   RG     200.20 02/04/09  06/12/09
   Designated SS Prov: DEMO,PSYCHIATRIST




        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.

```
            ***********************************************
            **       IHS Behavioral Health System      **
            **            Screening Reports            **
            ***********************************************
                          Version 4.0

                       DEMO INDIAN HOSPITAL


    IPV    IPV/DV Reports ...
    ALC    Alcohol Screening Reports ...
    DEP    Depression Screening Reports ...
    PHQ    PHQ-2 and PHQ-9 Scores for One Patient
    PHQS   PHQ-2 and PHQ-9 Scores for Multiple Patients

Select Screening Reports Option:
```

Figure 13-24: Options on the Screening Reports menu

13.1.12.1 IPV/DV Reports (IPV)

Use the IPV option to access the IPV/DV Report menu.

```
             ***********************************************
             **        IHS Behavioral Health System      **
             **              IPV/DV Reports              **
             ***********************************************
                              Version 4.0

                           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.

13.1.12.1.2   *Tally/List IPV/DV Screenings (DVS)*

This report will tally and optionally list all visits on which IPV screening (PCC Exam code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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.

13.1.12.1.4   *Tally/List Pts in Search Template w/IPV Screening (IPST)*

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest IPV screening (PCC Exam code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

13.1.12.1.5 Tally/List all PIV Screenings for Template of Pts (IVST)

This report will tally and optionally list all visits on which IPV screening (PCC Exam code 34) or a refusal was documented in a specified time frame specified. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. Only patients who are members of a user-defined search template are included in this report. This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

13.1.12.2 Alcohol Screening Reports (ALC)

Use the ALC option to access the ALC Report menu.

```
          ***********************************************
          **         IHS Behavioral Health System     **
          **           Alcohol Screening Reports      **
          ***********************************************
                          Version 4.0

                       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 13-26: Options on the ALC Reports menu

13.1.12.2.1 Tally/List Patients with Alcohol Screening (ASP)

This report will tally and optionally list all patients who have had an alcohol screening (Exam code 35) or a refusal documented in a specified time frame. 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 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.

- "Type a number or numbers of the items to be included"

  Specify which items you would like to have displayed in the report. If you select 0, there will be no tally for the various fields. To select all items and tally the information, type 1-11.

- "Include Alcohol Screenings documented in the PCC database"

  Type **Y** (Yes) or **N** (No).

- "Include a list of patients screened"

  Type **Y** (Yes) or **N** (No).

- "How would you like this report sorted"

  Type only one of the items in the list.

- "Do you wish to"

  Type **Y** (Yes) to display the patient's Designated Providers or **N** (No) to bypass this option.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally/List Patients with Alcohol Screenings report.

```
Total Number of Patients screened          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
         DR12, GEORGE  C         1       25.0%
         DR22, FRANK S           1       25.0%
         DR33, MATT              1       25.0%
         DR44, STEVE N           1       25.0%

                 By Primary Provider of Visit
         DR111, FRANK S          1       25.0%
         DR222, MATT             1       25.0%
         DR333, STEVE N          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%

  PATIENT NAME    HRN    AGE    SCREENED    RESULT       CLINIC
  Patient Q     114551  26 F   08/17/06    POSITIVE    ALCOHOL AND SUBST
  DXs: 29.1      SCREENING FOR ALCOHOLISM
       29.2      SCREENING FOR DRUG ABUSE
       995.81    ADULT ABUSE (SUSPECTED), PHYSICAL
  Primary Provider on Visit:  DR222, FRANK  S
  Provider who screened:  DR44, FRANK S

  Patient R      116475  27 F   08/23/06    REFUSED SCREENIN  MENTAL HEALTH
  DXs: 14.1      SCREENING FOR DEPRESSION
  Primary Provider on Visit:  DR222, GEORGE C
  Provider who screened:  DR33, GEORGE C
```

Figure 13-27: Sample Tally/List Patients with Alcohol Screenings report

13.1.12.2.2 *Tally/List Alcohol Screening (ALS)*

This report will tally and optionally list all visits on which an alcohol screening (Exam Code 35) or a refusal was documented in a 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.

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.

- "Type a number or numbers of the items to be included"

Specify which items you would like to have displayed in the report. If you select 0 there will be no tally for the various fields. To select all items and tally the information, type 1-11.

- "Include Alcohol Screenings documented in the PCC database"

  Type **Y** (Yes) or **N** (No).

- "Include a list of visits with alcohol screenings"

  Type **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"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **Y** (Yes) to display the patient's Designated Providers or **N** (No) to bypass this option.

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally/List Alcohol Screenings report.

```
Total Number of Visits with Screening     4
     Total Number of Patients screened       4
          By Result
                    NEGATIVE                 1      25.0%
                    POSITIVE                 2      50.0%
                    REFUSED SCREENING        1      25.0%
          By Gender
                    FEMALE                   3      75.0%
                    MALE                     1      25.0%
          By Age
                    26 yrs                   1      25.0%
                    27 yrs                   1      25.0%
                    44 yrs                   1      25.0%
                    48 yrs                   1      25.0%
     By Provider who screened
          ALPHAA, GEORGE C                   1      25.0%
          BETAA, FRANK S                     1      25.0%
          GAMMA, MATT                        1      25.0%
          OMICRON, STEVE N                   1      25.0%
     By Primary Provider of Visit
          ALPHAA, GEORGE C                   1      25.0%
          BETAA,FRANK S                      1      25.0%
          WEARY, MATT                        1      25.0%
          OMICRON, STEVE N                   1      25.0%
```

```
       By Designated Primary Care Provider
             UNKNOWN                      3      75.0%
             RHOOOOO,HELEN K              1      25.0%
       By Clinic
             ALCOHOL AND SUBSTANCE        1      25.0%
             MEDICAL SOCIAL SERVICES      1      25.0%
             MENTAL HEALTH                2      50.0%
       By Date
             Jul 25, 2006                 1      25.0%
             Aug 09, 2006                 1      25.0%
             Aug 17, 2006                 1      25.0%
             Aug 23, 2006                 1      25.0%
       By Designated Mental Health Provider
             UNKNOWN                      4     100.0%
       By Designated Social Services Provider
             UNKNOWN                      4     100.0%
       By Designated A/SA Provider
             UNKNOWN                      4     100.0%
PATIENT NAME     HRN        AGE        SCREENED    RESULT        CLINIC
    Patient T11  4551       26  F      08/17/06    POSITIVE
  DXs: 29.1      SCREENING FOR ALCOHOLISM
       29.2      SCREENING FOR DRUG ABUSE
       995.81    ADULT ABUSE (SUSPECTED), PHYSICAL
Primary Provider on Visit:  BETA, FRANK S
Provider who screened: DOC22, FRANK S

    Patient U     116475   27  F     08/23/06 REFUSED SCREENIN
  DXs: 14.1      SCREENING FOR DEPRESSION
  Primary Provider on Visit:  DOC22, GEORGE C
  Provider who screened: DOC555, GEORGE C
```

Figure 13-28: 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. You will select the patients based on age, gender, result, provider, or clinic where the screening was done.

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.

- "Include Screenings documented in non-behavioral health clinics"

  Type **Y** (Yes) or **N** (No).

- "Include Screenings for"

  Type **F** (Females Only), **M** (Males Only), or **B** (Both Male and Females).

- "Restrict Age Range"

Type **Y** (Yes) or **N** (No). If Yes is used, other prompts will display.

- "Include visits to all clinics"

  Type **Y** (Yes) or **N** (No). If No is used, additional prompts will display.

- "Include Primary Provider on the visit"

  Type **O** (One Provider Only), **P** (Any/All Providers including Unknown), or **U** (Unknown Provider Only).

- "Select providers who performed the screening"

  Type **O** (One Provider Only), **P** (Any/All Providers including Unknown), or **U** (Unknown Provider Only).

- "Limit list to just patients who have a particular designated Mental Health Provider"

  Type **Y** (Yes) or **N** (No). If Yes is used, additional prompts will display.

- "Limit list to just patients who have a particular designated Social Services Provider"

  Type **Y** (Yes) or **N** (No). If Yes is used, additional prompts will display.

- "Limit list to just patients who have a particular designated ASA/CD Provider"

  Type **Y** (Yes) or **N** (No). If Yes is used, additional prompts will display.

- "Select Report Type"

  Type **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.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally/List Alcohol Screenings report.

```
     ***  ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
               Screening Dates: Jan 11, 2009 to Jul 10, 2009


                                   DATE
PATIENT NAME           HRN    AGE   SCREENED    RESULT    CLINIC
-----------------------------------------------------------------------
No data to report.
```

Figure 13-29: Sample Alcohol Screenings Visit Listing for Selected Patients report

13.1.12.2.4 *Tally/List Pts in Search Template w/Alcohol Screenings (APST)*

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest alcohol screening (Exam Code 35) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

13.1.12.2.5 *Tally list all Alcohol Screenings for Template of Pts (AVST)*

This report will tally and optionally list all visits on which an alcohol screening (Exam Code 35) or a refusal was documented in a specified time frame specified. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. Only patients who are members of a user-defined search template are included in this report. This alcohol screening report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

13.1.12.3 Depression Screening Reports (DEP)

Use the DEP option to access the Depression Screening Reports menu.

```
          *********************************************
          **      IHS Behavioral Health System      **
          **       Depression Screening Reports      **
          *********************************************
                         Version 4.0

                     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 13-30: Options on the Depressing Screening Reports menu

13.1.12.3.1   Tally/List Patient with Depression Screening (DSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)

- Measurements: PHQ2, PHQ9

- Diagnoses V79.0, 14.1

- Education Topics: DEP-SCR

- Refusal of PCC exam code 36

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.

13.1.12.3.2   Tally/List Depression Screenings (DLS)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)

- Measurements: PHQ2, PHQ9

- Diagnoses V79.0, 14.1

- Education Topics: DEP-SCR

- Refusal of PCC Exam Code 36

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 BH 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 screening or a refusal was documented in the time frame specified by the user.

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

- 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 BH 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.

13.1.12.3.4   *Tally/List Pts in Search Temp w/Depression Scrn (DPST)*

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)

- Measurements: PHQ2, PHQ9

- Diagnoses V79.0, 14.1

- Education Topics: DEP-SCR

- Refusal of PCC Exam Code 36

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 BH databases for evidence of screening/refusal.

- This is a tally of patients, not visits or screenings.

13.1.12.3.5   *Tally List all Depression Scrn for Template of Pts (DVST)*

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)

- Measurements: PHQ2, PHQ9

- Diagnoses V79.0, 14.1

- Education Topics: DEP-SCR

- Refusal of PCC Exam Code 36

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 BH 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 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:

- "Select patient"

    Specify the name of the patient whose scores are to be displayed.

- "List Visit to"

    Type **N** (Patient's Last N Visits), **D** (Visits in a Date Range), or **A** (All of this patient's Visits). If you type **N** or **D**, other prompts will display.

- "Include Visits to"

    Type **C** (Visits to Selected Clinics), **P** (Visits to Selected Providers), or **A** (Include All Visits regardless of Clinic/Provider).

- "Do you wish to"

    Type **P** (print output) or **B** (browse output on screen).

The application displays the PHQ-2/PHQ-9 Scores for One Patient report.

```
PHQ-2/PHQ-9 Scores                    Oct. 03,2008 18:37         Page 1 of 1

Patient Name: Doe, Jane              DOB: Dec 11, 1976
HRN: 123942
*****************************************************************************
Date           PHQ-2  PHQ-9 PROVIDER     CLINIC  Diagnosis/POV
----------------------------------------------------------------------
  10/01/08     5      21    GAMMA, JOHN   MENT    311. - Depressive Disorder, Not Els
  09/30/08     1            GAMMA, JOHN   MENT    311. - Depressive Disorder, Not Els
  09/19/08     3      24    GAMMA, JOHN   MENT    311. - Depressive Disorder, Not Els
  09/19/08     0            GAMMA, JOHN   ALCO    305.02 - ALCOHOL ABUSE,
  09/12/08            14    KAPPA, ADAM   MEDSS   305.02 - ALCOHOL ABUSE,
  07/18/06     4      19    DELTA, JAMES  BH      13 - SCHIZOPHRENIC DISORDER
  06/01/05     2            GAMMA, DON    PC      311 - DEPRESSIVE DISOCER,NOS

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

Figure 13-31: 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 Visit Date"

Specify the beginning date of the date range.

- "Enter ending Visit Date"

  Specify the ending date of the date range.

- "Run the Report for which clinic"

  Type one of the following: **C** (one clinic) or **A** (all clinics). If you type **C**, other prompts will display.

- "Include visits to"

  Type one of the following: **A** (all providers) or **C** (one provider) or. If you type **C**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the PHQ-2 and PHQ-9 Scores for Multiple Patients report.

```
   XX                         Jul 13, 2009                        Page 1
                   PHQ-2 and PHQ-9 SCORES FOR MULTIPLE PATIENTS
                    Visit Dates: Jan 04, 2009 to Jul 13, 2009
                              Clinic: ALL Clinics
                            Providers: ALL Providers

PATIENT NAME       HRN     Date    PHQ-2 PHQ-9 Provider    CLINIC Diagnosis/POV
--------------------------------------------------------------------------------

ALPHAA,JACOB SCO  102668 02/07/09        3     GAMMA,RYA  MENTA

ALPHAB,CHELSEA    116431 07/11/09  3           DEMO,LO    MENTA  22-SLEEP DIS
ALPHAB,CHELSEA    116431 07/02/09        17    DEMO,PSYCH MENTA  296.31-MAJOR DEP
ALPHAB,CHELSEA    116431 05/19/09  3           GAMMA,DE   MENTA  311.-DEPRESSIV
ALPHAB,CHELSEA    116431 03/17/09  4           BETA,BJ    MEDIC  305.02-ALCOHOL A
ALPHAB,CHELSEA    116431 03/12/09        17    BETA,BJ    BEHAV  V11.0-PERSONAL
ALPHAB,CHELSEA    116431 03/10/09        19    GAMMA,DE   MENTA  296.32-MAJOR DEP

ALPHAB,GLEN DAL   108704 04/11/09  4           BETA,BJ    MENTA  296.32-DEPRESSED
ALPHAB,GLEN DAL   108704 03/27/09        21    GAMMA,DE   MENTA  311.-testing v
ALPHAB,GLEN DAL   108704 03/18/09  4           BETA,BJ    MEDIC  300.6-DEPERSONA

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

Figure 13-32: 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.

```
   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 13-33: 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"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen in Groups with Time Spent in Group report.

```
        ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                   Page 1
                       DEMO INDIAN HOSPITAL
          PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP
             DATES:  JAN 17, 2009  TO  APR 17, 2009


PATIENT NAME      HRN   SEX  DOB       DATE     PROVIDER      PROBLEM  TIME
---------------------------------------------------------------------------

APHAAA,CHRYSTAL   106299  F   11/28/85  04/20/09 BETA,BJ       13 0
         Total with provider BETAAAA,BJ          0
         Total for patient ALPHAA,CHRYSTAL GAYL  0


APHAAA,DIANA LE   192745  F   09/15/54  03/05/09 GAMMA,DENISE  92 60
                                        03/25/09 Not Recorded  307.50   15
                                        04/21/09 SIGMA,MARK    8.3 0
                                                 SIGMA,MARK    311.     60
         Enter ?? for more actions
+    Next Screen           -     Previous Screen     Q    Quit
```

Figure 13-34: 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 BH patient file that are available on the BHS Encounter/Record Reports menu.

```
              ************************************************
              **        IHS Behavioral Health System      **
              **         Encounter/Record Reports          **
              ************************************************
                             Version 4.0

                         DEMO INDIAN HOSPITAL


      LIST    List Visit Records, STANDARD Output
      GEN     List Behavioral Hlth Records, GENERAL RETRIEVAL

   Select Behavioral Health Record/Encounter Reports Option:
```

Figure 13-35: 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.

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.

```
BH GENERAL RETRIEVAL    Apr 16, 2009 15:16:17    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         29)  Clinic             57)  POV (Problem Categor
2)   Patient Sex          30)  Outside Location   58)  POV Diagnosis Catego
3)   Patient Race         31)  SU of Encounter    59)  Procedures (CPT)
4)   Patient Age          32)  County of Service  60)  Education Topics Pro
5)   Patient DOB          33)  Community of Service 61) Prevention Activity
6)   Patient DOD          34)  Activity Type      62)  Days Used Alcohol
7)   Living Patients      35)  A/SA Component     63)  Days Used Drugs
8)   Chart Facility       36)  A/SA Type of Contact 64) Days Hospitalized
9)   Patient Community    37)  Days in Residential 65) Drug/Alc Related Arr
10)  Patient County Resid 38)  Days in Aftercare  66)  Staging Average
11)  Patient Tribe        39)  Activity Category  67)  Alcohol/Sub Stage
12)  Eligibility Status   40)  Local Service Site 68)  Physical Stage
13)  Class/Beneficiary    41)  Number Served      69)  Emotional Stage
14)  Medicare Eligibility 42)  Type of Contact    70)  Social Stage
15)  Medicaid Eligibility 43)  Activity Time      71)  Cul/Spirit Stage
16)  Priv Ins Eligibility 44)  Inpatient Dispositio 72) Behavioral Stage
17)  Patient Encounters O 45)  PCC Visit Created  73)  Voc/Educ Stage
18)  Patient Flag Field   46)  Axis IV            74)  A/SA Recommended Pla
19)  Case Open Date       47)  Axis V             75)  A/SA Actual Placemen
20)  Case Admit Date      48)  Flag (Visit Flag)  76)  A/SA Difference Reas
21)  Case Closed Date     49)  Primary Provider   77)  Personal History Ite
22)  Case Disposition     50)  Primary Prov Discipl 78) Designated MH Prov
23)  Next Case Review Dat 51)  Primary Prov Affilia 79) Designated SS Provid
24)  Appointment/Walk-In  52)  Prim/Sec Providers 80)  Designated A/SA Prov
25)  Interpreter Utilized 53)  Prim/Sec Prov Discip 81) Designated Other Pro
26)  Program              54)  POV (Prim or Sec)
27)  Visit Type           55)  POV (Prob Code Grps)
28)  Location of Encounte 56)  Primary POV
+         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 13-36: 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"

  Type 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.

```
BH GENERAL RETRIEVAL       Apr 17, 2009 15:21:06    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          22)  County of Service    43)  Days Hospitalized
2)   Patient Sex           23)  Community of Service  44)  Drug/Alc Related Arr
3)   Patient Race          24)  Activity Type         45)  Staging Average
4)   Patient DOB           25)  A/SA Component        46)  Alcohol/Sub Stage
5)   Patient DOD           26)  A/SA Type of Contact  47)  Physical Stage
6)   Patient Chart #       27)  Days in Residential   48)  Emotional Stage
7)   Patient Community     28)  Days in Aftercare     49)  Social Stage
8)   Patient County Resid  29)  Activity Category     50)  Cul/Spirit Stage
9)   Patient Tribe         30)  Local Service Site    51)  Behavioral Stage
10)  Eligibility Status    31)  Number Served         52)  Voc/Educ Stage
11)  Class/Beneficiary     32)  Type of Contact       53)  A/SA Recommended Pla
12)  Patient Flag Field    33)  Inpatient Dispositio  54)  A/SA Actual Placemen
13)  Encounter Date        34)  PCC Visit Created     55)  A/SA Difference Reas
14)  Appointment/Walk-In   35)  Axis V                56)  Designated MH Prov
15)  Interpreter Utilized  36)  Flag (Visit Flag)     57)  Designated SS Provid
16)  Program               37)  Primary Provider      58)  Designated A/SA Prov
17)  Visit Type            38)  Primary Prov Discipl  59)  Designated Other Pro
18)  Location of Encounte  39)  Primary Prov Affilia  60)  Designated Other (2)
19)  Clinic                40)  Primary POV
20)  Outside Location      41)  Days Used Alcohol
21)  SU of Encounter       42)  Days Used Drugs
+         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 13-37: 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.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O**
  (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Behavioral Health Record Listing report.

```
********** CONFIDENTIAL PATIENT INFORMATION **********
            DEMO INDIAN HOSPITAL                                     Page 1

        BEHAVIORAL HEALTH RECORD LISTING
     Visit Dates:  OCT 19, 2008 and APR 17, 2009
===============================================================================
```

```
 DATE      PROV LOC  PATIENT NAME ACT CONT AT  HRN        PROB   NARRATIVE
 ----------------------------------------------------------------------------
10/20/08  DG   WW   ALPHA1,CHELS  12 OUTP 30  WW116431   311.   DEPRESSIVE DISO
10/22/08  DG   WW   ALPHA1,CHELS  12 OUTP 90  WW116431   311.   DEPRESSIVE DISO
10/22/08  DG   WW   ALPHA1,CHELS  12 OUTP 88  WW116431   311.   Mask Narrative
11/03/08  GHH  WW   ALPHA,ALTHEA  99 OUTP     WW123942   300.00 Situational Anx
11/06/08  GHH  WW   ALPHA,ALTHEA  99 OUTP     WW123942   311.   Depression
                                                         300.00 Anxiety
11/11/08  BJB  1202 FPAT11,AMAND  12 OUTP 120 WW186121   V71.01 OBSERVATION OF
11/12/08  DGC  WW   SIGMA,MACEY   05 OUTP 20  WW104376   V61.01 FAMILY DISRUPTI


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

Figure 13-38: 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.

Below are the prompts.

- "Select and Print Encounter List from"

  Type one of the following: **S** (search template) or **D** (date range). The next prompts vary according to the option selected.

- "Do you want to use a previously defined report?"

  Type **Y** or **N**. If you type **Y**, other prompts displays.

The application displays the Visit Selection Menu.

```
BH GENERAL RETRIEVAL      Apr 17, 2009 15:21:06    Page:  1 of   2

                    Visit Selection Menu
Visits can be selected based on 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 visit type Q.

1)   Patient Name         29)  Clinic               57)  POV (Problem Categor
2)   Patient Sex          30)  Outside Location     58)  POV Diagnosis Catego
3)   Patient Race         31)  SU of Encounter      59)  Procedures (CPT)
4)   Patient DOB          32)  County of Service    60)  Education Topics Pro
5)   Patient DOD          33)  Community of Service 61)  Prevention Activity
6)   Patient Chart #      34)  Activity Type        62)  Days Used Alcohol
7)   Patient Community    35)  A/SA Component       63)  Days Used Drugs
8)   Patient County Resid 36)  A/SA Type of Contact 64)  Days Hospitalized
9)   Patient Tribe        37)  Days in Residential  65)  Durg/Alc Related Arr
10)  Patient County Resid 38)  Days in Aftercare    66)  Staging Average
11)  Patient Tribe        39)  Activity Category    67)  Alcohol/Sub Stage
12)  Eligibility Status   40)  Local Service Site   68)  Physical Stage
13)  Class/Beneficiary    41)  Number Served        69)  Emotional Stage
```

```
14)  Medicare Eligibility  42)  Type of Contact       70)  Social Stage
15)  Medicaid Eligibility  43)  Activity Time         71)  Cul/Spirit Stage
16)  Priv Ins Eligibility  44)  Inpatient Dispositio  72)  Behavioral Stage
17)  Patient Encounters O  45)  PCC Visit Created     73)  Voc/Educ Stage
18)  Patient Flag Field    46)  Axis IV               74)  A/SA Recommended Pla
19)  Case Open Date        47)  Axis V                75)  A/SA Actual Placemen
20)  Case Admit Date       48)  Flag (Visit Flag)     76)  A/SA Difference Reas
21)  Case Closed Date      49)  Primary Provider      77)  Personal History Ite
22)  Case Disposition      50)  Primary Prov Discipl  78)  Designated MH Prov
23)  Next Case Review Dat  51)  Primary Prov Affilia  79)  Designated SS Provid
24)  Appointment/Walk-In   52)  Prim/Sec Providers    80)  Designated A/SA Prov
25)  Interpreter Utilized  53)  Prim/Sec Prov Discip  81)  Designated Other Pro
26)  Program               54)  POV (Prim or Sec)
27)  Visit Type            55)  POV (Prob Code Grps)
28)  Location of Encounte  56)  Primary POV
+          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 13-39: 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.

- "Choose Type of Report"

  Type 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.

```
BH GENERAL RETRIEVAL    Apr 17, 2009 15:59:50    Page:    1 of    3
                     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          32)  Outside Location      63)  Primary POV
2)   Patient Sex           33)  SU of Encounter       64)  POV Problem Code Nar
3)   Patient Race          34)  County of Service     65)  POV (Problem Categor
4)   Patient Age           35)  Community of Service  66)  POV Diagnosis Catego
5)   Patient DOB           36)  Chief Complaint/Pres  67)  POV Prov Narrative
6)   Patient SSN           37)  Activity Type         68)  Procedures (CPT)
7)   Patient DOD           38)  Activity Type Narrat  69)  Education Topics Pro
8)   Patient Chart #       39)  A/SA Component        70)  Prevention Activity
9)   Patient Community     40)  A/SA Type of Contact  71)  Treated Medical Prob
10)  Patient County Resid  41)  Days in Residential   72)  Days Used Alcohol
11)  Patient Tribe         42)  Days in Aftercare     73)  Days Used Drugs
12)  Eligibility Status    43)  Activity Category     74)  Days Hospitalized
13)  Class/Beneficiary     44)  Local Service Site    75)  Drug/Alc Related Arr
14)  Medicare Eligibility  45)  Number Served         76)  Staging Average
15)  Medicaid Eligibility  46)  Type of Contact       77)  Alcohol/Sub Stage
16)  Priv Ins Eligibility  47)  Activity Time         78)  Physical Stage
17)  Patient Flag Field    48)  Inpatient Dispositio  79)  Emotional Stage
18)  Patient Flag Narrati  49)  Place Referred To     80)  Social Stage
19)  Case Open Date        50)  PCC Visit Created     81)  Cul/Spirit Stage
20)  Case Admit Date       51)  Axis IV               82)  Behavioral Stage
21)  Case Closed Date      52)  Axis V                83)  Voc/Educ Stage
```

```
22)  Case Disposition    53)  Comment                84)  A/SA Recommended Pla
23)  Next Case Review Dat 54)  Flag (Visit Flag)     85)  A/SA Actual Placemen
24)  Encounter Date       55)  Primary Provider      86)  A/SA Difference Reas
25)  Encounter Date&Time  56)  Primary Prov Discipl  87)  Personal History Ite
26)  Appointment/Walk-In  57)  Primary Prov Affilia  88)  Designated MH Prov
27)  Interpreter Utilized 58)  Prim/Sec Providers    89)  Designated SS Provid
28)  Program              59)  Prim/Sec Prov Discip  90)  Designated A/SA Prov
29)  Visit Type           60)  POV (Prim or Sec)     91)  Designated Other Pro
30)  Location of Encounte 61)  DSM/Problem Code Nar  92)  Designated Other (2)
31)  Clinic               62)  POV (Prob Code Grps)
+         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 13-40: 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.

The application displays the Visit Selection Menu

```
BH GENERAL RETRIEVAL    Jul 13, 2009 11:47:47    Page:   1 of   3
                        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         32)  Outside Location      63)  Primary POV
2)   Patient Sex          33)  SU of Encounter       64)  POV Problem Code Nar
3)   Patient Race         34)  County of Service     65)  POV (Problem Categor
4)   Patient Age          35)  Community of Service  66)  POV Diagnosis Catego
5)   Patient DOB          36)  Chief Complaint/Pres  67)  POV Prov Narrative
6)   Patient SSN          37)  Activity Type         68)  Procedures (CPT)
7)   Patient DOD          38)  Activity Type Narrat  69)  Education Topics Pro
8)   Patient Chart #      39)  A/SA Component        70)  Prevention Activity
9)   Patient Community    40)  A/SA Type of Contact  71)  Treated Medical Prob
10)  Patient County Resid 41)  Days in Residential   72)  Days Used Alcohol
11)  Patient Tribe        42)  Days in Aftercare     73)  Days Used Drugs
12)  Eligibility Status   43)  Activity Category     74)  Days Hospitalized
13)  Class/Beneficiary    44)  Local Service Site    75)  Drug/Alc Related Arr
14)  Medicare Eligibility 45)  Number Served         76)  Staging Average
15)  Medicaid Eligibility 46)  Type of Contact       77)  Alcohol/Sub Stage
16)  Priv Ins Eligibility 47)  Activity Time         78)  Physical Stage
17)  Patient Flag Field   48)  Inpatient Dispositio  79)  Emotional Stage
18)  Patient Flag Narrati 49)  Place Referred To     80)  Social Stage
19)  Case Open Date       50)  PCC Visit Created     81)  Cul/Spirit Stage
20)  Case Admit Date      51)  Axis IV               82)  Behavioral Stage
21)  Case Closed Date     52)  Axis V                83)  Voc/Educ Stage
22)  Case Disposition     53)  Comment               84)  A/SA Recommended Pla
23)  Next Case Review Dat 54)  Flag (Visit Flag)     85)  A/SA Actual Placemen
24)  Encounter Date       55)  Primary Provider      86)  A/SA Difference Reas
25)  Encounter Date&Time  56)  Primary Prov Discipl  87)  Personal History Ite
26)  Appointment/Walk-In  57)  Primary Prov Affilia  88)  Designated MH Prov
27)  Interpreter Utilized 58)  Prim/Sec Providers    89)  Designated SS Provid
28)  Program              59)  Prim/Sec Prov Discip  90)  Designated A/SA Prov
29)  Visit Type           60)  POV (Prim or Sec)     91)  Designated Other Pro
30)  Location of Encounte 61)  DSM/Problem Code Nar  92)  Designated Other (2)
31)  Clinic               62)  POV (Prob Code Grps)

+         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 13-41: Items on Print Item Selection menu

Choose the items in the order you want them to appear on the report.

After selecting the items and then using **Q**, the application displays the Sort Item Selection Menu.

```
BH GENERAL RETRIEVAL    Apr 17, 2009 16:02:04   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          22) County of Service    43) Days Hospitalized
2)  Patient Sex           23) Community of Service  44) Drug/Alc Related Arr
3)  Patient Race          24) Activity Type         45) Staging Average
4)  Patient DOB           25) A/SA Component         46) Alcohol/Sub Stage
5)  Patient DOD           26) A/SA Type of Contact   47) Physical Stage
6)  Patient Chart #       27) Days in Residential    48) Emotional Stage
7)  Patient Community     28) Days in Aftercare      49) Social Stage
8)  Patient County Resid  29) Activity Category      50) Cul/Spirit Stage
9)  Patient Tribe         30) Local Service Site     51) Behavioral Stage
10) Eligibility Status    31) Number Served          52) Voc/Educ Stage
11) Class/Beneficiary     32) Type of Contact        53) A/SA Recommended Pla
12) Patient Flag Field    33) Inpatient Dispositio   54) A/SA Actual Placemen
13) Encounter Date        34) PCC Visit Created      55) A/SA Difference Reas
14) Appointment/Walk-In   35) Axis V                 56) Designated MH Prov
15) Interpreter Utilized  36) Flag (Visit Flag)      57) Designated SS Provid
16) Program               37) Primary Provider       58) Designated A/SA Prov
17) Visit Type            38) Primary Prov Discipl   59) Designated Other Pro
18) Location of Encounte  39) Primary Prov Affilia   60) Designated Other (2)
19) Clinic                40) Primary POV
20) Outside Location      41) Days Used Alcohol
21) SU of Encounter       42) Days Used Drugs
+         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 13-42: 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?"

  Type **Y** or **N**.

- "Would you like a custom title for this report?"

  Type **Y** or **N**. If you type **Y**, other prompts will display.

- "Do you wish to save this search/print/sort logic for future use?"

Type **Y** or **N**. If you type **Y**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

   Type 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"

   Type **P** (print output) or **B** (browse output on screen).

The application displays the visit report.

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
                         BH Visit Listing
Page 1
                  Record Dates:  JAN 14, 2009 and JUL 13, 2009

PATIENT NAME            DOB           HRN          PROGRAM
----------------------------------------------------------
ALPHA,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 13-43: Sample visit report

13.3   Workload/Activity Reports (WL)

Use the WL option to view the Activity Workload Reports menu.

```
                  *********************************************
                  **       IHS Behavioral Health System     **
                  **          Activity Workload Reports      **
                  *********************************************
                               Version 4.0

                            DEMO INDIAN HOSPITAL


      GRS1   Activity Report (GARS #1)
      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 13-44: Options on the Activity Workload Reports menu

The Workload/Activity Reports menu has options to generate reports related
specifically to the activities of BH providers. Included are options for generating
reports that categorize and tabulate activity times, frequency of activities, and primary
problems requiring HB care.

13.3.1   Activity Report (GARS #1) (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"

  Type one the following:

  - **M**–MENTAL HEALTH
  - **S**–SOCIAL SERVICES
  - **C**–CHEMICAL DEPENDENCY or ALCOHOL/SUBSTANCE ABUSE
  - **O**–OTHER

- – **A**–ALL
- "Run Report for"

   Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- "Include which providers"

   Type one of the following: **P** (primary provider only) or **S** (both primary and secondary providers).

- "Demo Patient/Inclusion/Exclusion"

   Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

   Type **P** (print output) or **B** (browse output on screen).

The application displays the Activity Report.

```
********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                              MAY 04, 2009Page 1
ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM
RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record.  # served is a tally of the number served
data value.


                                      # RECS    ACT TIME # PATS   # SERVED
                                               (hrs)
----------------------------------------------------------------------
AREA:  TUCSON
  SERVICE UNIT:  SELLS
    FACILITY:  SELLS HOSP
      PROVIDER:  BETAA,BJ (PSYCHIATRIST)
        13-INDIVIDUAL TREATMENT/COUNS        3       2.8       3 3
        16-MEDICATION/MEDICATION MONI        1       1.0       1          1
        91-GROUP TREATMENT                   2       1.5       2          2
                                          =======  =======  =======   =======
      PROVIDER TOTAL:                        6       5.3       6          6

      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 13-45: Sample Activity Report

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. This report is patterned after GARS Report #2.

The prompts are the same as those for the GRS1 report. See Section 12.3.1 for more information.

The application displays the Activity Report by Primary Purpose report.

```
          ********** 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
            311.-DEPRESSIVE DISORDER NOS      1      1.0       1          1
                                           =======  ======= =======  =======
       ACTIVITY TOTAL:                        1      1.0       1          1

         ACTIVITY:  16-MEDICATION/MEDICATION
            295.15-SCHIZOPHRENIA, DISORGAN    1      1.0       1          1
                                           =======  ======= =======  =======
       ACTIVITY TOTAL:                        1      1.0       1          1

                                           =======  ======= =======  =======
       PROVIDER TOTAL:                        2      2.0       2          2

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

Figure 13-46: 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.

```
BH GENERAL RETRIEVAL      Apr 17, 2009 15:21:06   Page:    1 of    2

                        Visit Selection Menu
Visits can be selected based on 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 visit type Q.

1)   Patient Name          29)  Clinic               57)  POV (Problem Categor
2)   Patient Sex           30)  Outside Location      58)  POV Diagnosis Catego
3)   Patient Race          31)  SU of Encounter       59)  Procedures (CPT)
4)   Patient DOB           32)  County of Service     60)  Education Topics Pro
5)   Patient DOD           33)  Community of Service  61)  Prevention Activity
6)   Patient Chart #       34)  Activity Type         62)  Days Used Alcohol
7)   Patient Community     35)  A/SA Component        63)  Days Used Drugs
8)   Patient County Resid  36)  A/SA Type of Contact  64)  Days Hospitalized
9)   Patient Tribe         37)  Days in Residential   65)  Durg/Alc Related Arr
10)  Patient County Resid  38)  Days in Aftercare     66)  Staging Average
11)  Patient Tribe         39)  Activity Category     67)  Alcohol/Sub Stage
12)  Eligibility Status    40)  Local Service Site    68)  Physical Stage
13)  Class/Beneficiary     41)  Number Served         69)  Emotional Stage
14)  Medicare Eligibility  42)  Type of Contact       70)  Social Stage
15)  Medicaid Eligibility  43)  Activity Time         71)  Cul/Spirit Stage
16)  Priv Ins Eligibility  44)  Inpatient Dispositio  72)  Behavioral Stage
17)  Patient Encounters O  45)  PCC Visit Created     73)  Voc/Educ Stage
18)  Patient Flag Field    46)  Axis IV               74)  A/SA Recommended Pla
19)  Case Open Date        47)  Axis V                75)  A/SA Actual Placemen
20)  Case Admit Date       48)  Flag (Visit Flag)     76)  A/SA Difference Reas
21)  Case Closed Date      49)  Primary Provider      77)  Personal History Ite
22)  Case Disposition      50)  Primary Prov Discipl  78)  Designated MH Prov
23)  Next Case Review Dat  51)  Primary Prov Affilia  79)  Designated SS Provid
24)  Appointment/Walk-In   52)  Prim/Sec Providers    80)  Designated A/SA Prov
25)  Interpreter Utilized  53)  Prim/Sec Prov Discip  81)  Designated Other Pro
26)  Program               54)  POV (Prim or Sec)
27)  Visit Type            55)  POV (Prob Code Grps)
28)  Location of Encounte  56)  Primary POV
+         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 13-47: 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

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- Do you wish to

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Activity Record Counts report.

```
                                            MAY 04, 2009   Page 1
                RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
             NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM IV TR/CODE

PROB DSM/CODE NARRATIVE    CODE            # RECS   # PATS    ACTIVITY  # SERVED
                                                              TIME


--------------------------------------------------------------------------------
ADMINISTRATION             97                4        4        0.1        4
ALCOHOL ABUSE              29                4        4        1.2        4
ALCOHOL ABUSE, EPISODIC    305.02            5        2        4.1        5
ALCOHOL ABUSE, UNSPECIF    305.00            4        2        2.0        4
ALCOHOL DEPENDENCE         27                3        3        2.0        3
ALCOHOL DEPENDENCE, IN     303.93            2        2        1.5        2
ALCOHOLISM IN FAMILY       V61.41            4        4        0.7        4
AMPHETAMINE DEPENDENCE,    304.40            1        1        0.0        1



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

Figure 13-48: 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.
> If you choose to report on Problems, *only the primary*
> *problem* is included.

The prompts are the same as those for the ACT report. See Section 12.3.3 for more information.

The application displays the record selection criteria. After pressing Enter, the application displays the Program Activity Time report.

```
                                      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
-------------------------------------------------------------------------------

???                   15          7        3.6              2          2
BRUNING,BJ            33         18       22.6              8          4
BUTCHER,LORI          16          6        5.0              .          .
CABLE,JESSICA          9          2        6.3              .          .
DEMO,CASE M            1          1        0.0              .          .
DEMO,DOCTOR            1          1        0.2              1          1
FRANKLIN,AMY J         3          3        2.0              .          .
GARCIA,RYAN          106         30       66.3             24          5
Report Type: PROGRAM ACTIVITY REPORT

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

Figure 13-49: 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.

```
BH GENERAL RETRIEVAL    Apr 17, 2009 15:21:06    Page:   1 of    2

                      Visit Selection Menu
Visits can be selected based on 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 visit type Q.

1)  Patient Name          29)  Clinic                 57)  POV (Problem Categor
```

```
2)   Patient Sex          30)  Outside Location     58)  POV Diagnosis Catego
3)   Patient Race         31)  SU of Encounter      59)  Procedures (CPT)
4)   Patient DOB          32)  County of Service    60)  Education Topics Pro
5)   Patient DOD          33)  Community of Service 61)  Prevention Activity
6)   Patient Chart #      34)  Activity Type        62)  Days Used Alcohol
7)   Patient Community     35)  A/SA Component       63)  Days Used Drugs
8)   Patient County Resid 36)  A/SA Type of Contact 64)  Days Hospitalized
9)   Patient Tribe        37)  Days in Residential  65)  Durg/Alc Related Arr
10)  Patient County Resid 38)  Days in Aftercare    66)  Staging Average
11)  Patient Tribe        39)  Activity Category    67)  Alcohol/Sub Stage
12)  Eligibility Status   40)  Local Service Site   68)  Physical Stage
13)  Class/Beneficiary    41)  Number Served        69)  Emotional Stage
14)  Medicare Eligibility 42)  Type of Contact      70)  Social Stage
15)  Medicaid Eligibility 43)  Activity Time        71)  Cul/Spirit Stage
16)  Priv Ins Eligibility 44)  Inpatient Dispositio 72)  Behavioral Stage
17)  Patient Encounters O 45)  PCC Visit Created    73)  Voc/Educ Stage
18)  Patient Flag Field   46)  Axis IV              74)  A/SA Recommended Pla
19)  Case Open Date       47)  Axis V               75)  A/SA Actual Placemen
20)  Case Admit Date      48)  Flag (Visit Flag)    76)  A/SA Difference Reas
21)  Case Closed Date     49)  Primary Provider     77)  Personal History Ite
22)  Case Disposition     50)  Primary Prov Discipl 78)  Designated MH Prov
23)  Next Case Review Dat 51)  Primary Prov Affilia 79)  Designated SS Provid
24)  Appointment/Walk-In  52)  Prim/Sec Providers   80)  Designated A/SA Prov
25)  Interpreter Utilized 53)  Prim/Sec Prov Discip 81)  Designated Other Pro
26)  Program              54)  POV (Prim or Sec)
27)  Visit Type           55)  POV (Prob Code Grps)
28)  Location of Encounte 56)  Primary POV
+         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 13-50: 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"

  Type 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"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Frequency of Activities report.

```
OUTPUT BROWSER                May 04, 2009 17:24:29       Page:   1 of   3



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:  FEB 03, 2009 to MAY 04, 2009


Report Type: FREQUENCY REPORT (TOP TEN)


  MAY 04, 2009                                       Page 1
DEMO INDIAN HOSPITAL

TOP 10 Activity Code's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

No.   ACTIVITY TYPE                  ACTIVITY CODE   # RECS   ACT TIME (HRS)
---------------------------------------------------------------1.   SCREENING-
PATIENT PRESENT                      11     55            34.8
2.    INFORMATION AND/ OR REFERRAL-P 15     32            12.3
3.    GROUP TREATMENT                91     30            17.1
4.    INDIVIDUAL TREATMENT/COUNSEL/E 13     22            17.0
5.    ASSESSMENT/EVALUATION-PATIENT  12     19            15.5
6.    INDIVIDUAL BH EHR VISIT        99     19             0.6
7.    ACADEMIC SERVICES              96     16             8.1
8.    ART THERAPY                    85     15             6.7
+        Enter ?? for more actions                  >>>
+    NEXT SCREEN      -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-51: 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. See Section 13.3.5
report.

Below is a sample Frequency of Activities by Category report.

```
  MAY 04, 2009                                       Page 1
                     DEMO INDIAN HOSPITAL

TOP 10 Activity Category's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

No.   ACTIVITY CATEGORY                 CATEGORY CODE    # RECS   ACT TIME (HRS)
```

```
--------------------------------------------------------------------------------
1.    PATIENT SERVICES                  P                943        556778.2
2.    SUPPORT SERVICES                  S                 56            52.9
3.    ADMINISTRATION                    A                 21            26.6
4.    PLACEMENTS                        PL                 6             2.8
5.    COMMUNITY SERVICES                C                  2             9.0
6.    EDUCATION/TRAINING                E                  2             1.5
7.    CULTURALLY ORIENTED               O                  1             0.5
8.    TRAVEL                            T                  1             0.3

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-52: 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 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.

- "Run the Report for which Program"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "Enter a code indicating which providers are of interest"

  Specify the Providers whose Prevention activities you want to tally. Type one of the following: **A** (all providers), **S** (Select set or Taxonomy of Providers), or **O** (one provider). If you type **S** or **O**, other prompts will display.

- "Demo Patient/Inclusion/Exclusion"

  Type 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.

```
May 04, 2009                                              Page: 1
                            Behavioral Health
                  ************************************
                  *    TALLY OF PREVENTION ACTIVITIES   *
                  ************************************
            VISIT Date Range: FEB 03, 2009 through MAY 04, 2009
      PREVENTION ACTIVITY                    # of visits    % of visits
-------------------------------------------------------------------------

Total # Visits w/Prevention Activity:      3
Total # of Prevention Activities recorded:  5

 AIDS/HIV                                     1             33.3
    YOUTH          1      100.0

 OTHER                                        1             33.3
    NOT RECORDED   1      100.0

 PUBLIC AWARENESS                             1             33.3
    NOT RECORDED   1      100.0

 SELF-AWARENESS/VALUES                        1             33.3
    ADULT          1      100.0

 SMOKING/TOBACCO                              1             33.3
    YOUTH          1      100.0

TARGET TOTALS

    ADULT          1       33.3
    NOT RECORDED   1       33.3
    YOUTH          1       33.3

RUN TIME (H.M.S): 0.0.0
Enter RETURN to continue or '^' to exit:
```

Figure 13-53: 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.

```
              ***********************************************
              **        IHS Behavioral Health System      **
              **          Problem Specific Reports        **
              ***********************************************
                              Version 4.0

                          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 13-54: 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 following POV.

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?"

  Type **Y** or **N** at this prompt. If you type **Y**, other prompts will display. Type **N** to not modify the age groups.

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Abuse by Age and Sex report. You need a 132 column printer to print the report.

13.4.2 Frequency of Problems (FDSM)

Use the FDSM option to produce a report 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.

```
BH GENERAL RETRIEVAL    Apr 17, 2009 15:21:06    Page:    1 of    2

                     Visit Selection Menu
Visits can be selected based on 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 visit type Q.

1)   Patient Name         29)  Clinic               57)  POV (Problem Categor
2)   Patient Sex          30)  Outside Location     58)  POV Diagnosis Catego
3)   Patient Race         31)  SU of Encounter      59)  Procedures (CPT)
4)   Patient DOB          32)  County of Service    60)  Education Topics Pro
5)   Patient DOD          33)  Community of Service 61)  Prevention Activity
6)   Patient Chart #      34)  Activity Type        62)  Days Used Alcohol
7)   Patient Community    35)  A/SA Component       63)  Days Used Drugs
8)   Patient County Resid 36)  A/SA Type of Contact 64)  Days Hospitalized
9)   Patient Tribe        37)  Days in Residential  65)  Durg/Alc Related Arr
10)  Patient County Resid 38)  Days in Aftercare    66)  Staging Average
11)  Patient Tribe        39)  Activity Category    67)  Alcohol/Sub Stage
12)  Eligibility Status   40)  Local Service Site   68)  Physical Stage
13)  Class/Beneficiary    41)  Number Served        69)  Emotional Stage
14)  Medicare Eligibility 42)  Type of Contact      70)  Social Stage
15)  Medicaid Eligibility 43)  Activity Time        71)  Cul/Spirit Stage
16)  Priv Ins Eligibility 44)  Inpatient Dispositio 72)  Behavioral Stage
17)  Patient Encounters O 45)  PCC Visit Created    73)  Voc/Educ Stage
18)  Patient Flag Field   46)  Axis IV              74)  A/SA Recommended Pla
19)  Case Open Date       47)  Axis V               75)  A/SA Actual Placemen
20)  Case Admit Date      48)  Flag (Visit Flag)    76)  A/SA Difference Reas
21)  Case Closed Date     49)  Primary Provider     77)  Personal History Ite
22)  Case Disposition     50)  Primary Prov Discipl 78)  Designated MH Prov
23)  Next Case Review Dat 51)  Primary Prov Affilia 79)  Designated SS Provid
24)  Appointment/Walk-In  52)  Prim/Sec Providers   80)  Designated A/SA Prov
25)  Interpreter Utilized 53)  Prim/Sec Prov Discip 81)  Designated Other Pro
```

```
26)   Program                54)   POV (Prim or Sec)
27)   Visit Type             55)   POV (Prob Code Grps)
28)   Location of Encounte   56)   Primary POV
+          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 13-55: 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"

  Type one of the following: **P** (primary POV only) or **S** (primary and secondary POVs).

- "Select Type of Report"

  Type 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"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do you wish to"

  Type **P** (print output) or **B** (browse output on screen).

The application displays the Frequency of Problems report.

```
  JUN 09, 2009                                           Page 1
                          DEMO INDIAN HOSPITAL

TOP 10 Problem/POV's.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   PROB DSM/CODE NARRATIVE         CODE          # RECS   ACT TIME
                                                             (HRS)
--------------------------------------------------------------------------
1.    DEPRESSIVE DISORDER NOS         311.          150      114.8
2.    ANXIETY DISORDER NOS            300.00        52        28.8
3.    CROSS-CULTURAL CONFLICT         2             48        35.5
4.    SCHIZOPHRENIA, DISORGANIZED TY  295.15        33        26.1
5.    PARANOID PERSONALITY DISORDER   301.0         32        21.1
6.    PHYSICAL ILLNESS,ACUTE          5             32        72.9
```

```
7.     DEMENTIA OF THE ALZHEIMER'S TY   290.0           31        27.4
8.     MARITAL PROBLEM                  56              25         7.9
9.     HEALTH/HOMEMAKER NEEDS           1               21        17.6
10.    MAJOR DEPRESSIVE DISORDER, REC   296.32          20        32.3

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-56: 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.

```
BH GENERAL RETRIEVAL   Apr 17, 2009 15:21:06    Page:   1 of   2

                      Visit Selection Menu
Visits can be selected based on 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 visit type Q.

1)   Patient Name         29)  Clinic             57)  POV (Problem Categor
2)   Patient Sex          30)  Outside Location   58)  POV Diagnosis Catego
3)   Patient Race         31)  SU of Encounter    59)  Procedures (CPT)
4)   Patient DOB          32)  County of Service  60)  Education Topics Pro
5)   Patient DOD          33)  Community of Service 61) Prevention Activity
6)   Patient Chart #      34)  Activity Type      62)  Days Used Alcohol
7)   Patient Community    35)  A/SA Component     63)  Days Used Drugs
8)   Patient County Resid 36)  A/SA Type of Contact 64) Days Hospitalized
9)   Patient Tribe        37)  Days in Residential 65)  Durg/Alc Related Arr
10)  Patient County Resid 38)  Days in Aftercare  66)  Staging Average
11)  Patient Tribe        39)  Activity Category  67)  Alcohol/Sub Stage
12)  Eligibility Status   40)  Local Service Site 68)  Physical Stage
13)  Class/Beneficiary    41)  Number Served      69)  Emotional Stage
14)  Medicare Eligibility 42)  Type of Contact    70)  Social Stage
15)  Medicaid Eligibility 43)  Activity Time      71)  Cul/Spirit Stage
16)  Priv Ins Eligibility 44)  Inpatient Dispositio 72)  Behavioral Stage
17)  Patient Encounters O 45)  PCC Visit Created  73)  Voc/Educ Stage
18)  Patient Flag Field   46)  Axis IV            74)  A/SA Recommended Pla
19)  Case Open Date       47)  Axis V             75)  A/SA Actual Placemen
20)  Case Admit Date      48)  Flag (Visit Flag)  76)  A/SA Difference Reas
21)  Case Closed Date     49)  Primary Provider   77)  Personal History Ite
22)  Case Disposition     50)  Primary Prov Discipl 78)  Designated MH Prov
23)  Next Case Review Dat 51)  Primary Prov Affilia 79)  Designated SS Provid
```

```
24)  Appointment/Walk-In   52)  Prim/Sec Providers   80)  Designated A/SA Prov
25)  Interpreter Utilized  53)  Prim/Sec Prov Discip 81)  Designated Other Pro
26)  Program               54)  POV (Prim or Sec)
27)  Visit Type            55)  POV (Prob Code Grps)
28)  Location of Encounte  56)  Primary POV
+        Enter ?? for more actions
S    Select Item(s)      +   Next Screen        Q   Quit Item Selection
R    Remove Item(s)      -   Previous Screen    E   Exit Report
Select Action: S//
```

Figure 13-57: Sample 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"

    Type one of the following: **P** (Primary POV only) or **S** (Primary and Secondary POVs).

- "Select Type of Report"

    Type 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"

    Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do You wish to"

    Type one of the following: **P** (print output) or **B** (browse output on screen).

The application displays the Frequency of Problems by Category report.

```
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                          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 13-58: 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.

```
BH GENERAL RETRIEVAL      Apr 17, 2009 15:21:06    Page:   1 of   2

                      Visit Selection Menu
Visits can be selected based on 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 visit type Q.

1)   Patient Name         29) Clinic              57) POV (Problem Categor
2)   Patient Sex          30) Outside Location    58) POV Diagnosis Catego
3)   Patient Race         31) SU of Encounter     59) Procedures (CPT)
4)   Patient DOB          32) County of Service   60) Education Topics Pro
5)   Patient DOD          33) Community of Service 61) Prevention Activity
6)   Patient Chart #      34) Activity Type       62) Days Used Alcohol
7)   Patient Community    35) A/SA Component      63) Days Used Drugs
8)   Patient County Resid 36) A/SA Type of Contact 64) Days Hospitalized
9)   Patient Tribe        37) Days in Residential 65) Durg/Alc Related Arr
10)  Patient County Resid 38) Days in Aftercare   66) Staging Average
11)  Patient Tribe        39) Activity Category   67) Alcohol/Sub Stage
12)  Eligibility Status   40) Local Service Site  68) Physical Stage
13)  Class/Beneficiary    41) Number Served       69) Emotional Stage
14)  Medicare Eligibility 42) Type of Contact     70) Social Stage
15)  Medicaid Eligibility 43) Activity Time       71) Cul/Spirit Stage
16)  Priv Ins Eligibility 44) Inpatient Dispositio 72) Behavioral Stage
17)  Patient Encounters O 45) PCC Visit Created   73) Voc/Educ Stage
18)  Patient Flag Field   46) Axis IV             74) A/SA Recommended Pla
```

```
19)  Case Open Date       47)  Axis V               75)  A/SA Actual Placemen
20)  Case Admit Date      48)  Flag (Visit Flag)    76)  A/SA Difference Reas
21)  Case Closed Date     49)  Primary Provider     77)  Personal History Ite
22)  Case Disposition     50)  Primary Prov Discipl 78)  Designated MH Prov
23)  Next Case Review Dat 51)  Primary Prov Affilia 79)  Designated SS Provid
24)  Appointment/Walk-In  52)  Prim/Sec Providers   80)  Designated A/SA Prov
25)  Interpreter Utilized 53)  Prim/Sec Prov Discip 81)  Designated Other Pro
26)  Program              54)  POV (Prim or Sec)
27)  Visit Type           55)  POV (Prob Code Grps)
28)  Location of Encounte 56)  Primary POV
+         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 visit data that will be selected for the report. If you do not select an item (immediately use the Quit Item Selection option), all visits will be used.

- "Include which POV/s"

  Type one of the following: **P** (Primary POV only) or **S** (Primary and Secondary POVs).

- "Select Type of Report"

  Type 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"

  Type 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.

```
   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 13-60: 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.

```
               ************************************************
               **        IHS Behavioral Health System       **
               **              Suicide Reports               **
               ************************************************
                               Version 4.0

                           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 13-61: Options on Suicide Report menu

13.4.5.1 Aggregate Suicide Form Data - Standard (SSR)

This report will tally the data items 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 for Search"

  Specify the beginning date for the date range.

- "Enter ending Date for Search"

  Specify the ending date for the date range.

- "Run the Report for which Program"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display

- "Run the Report for which type of Suicidal Behavior"

  Use one of the following: Ideation with Plan and Intent, Attempt, Completed Suicide, Attempted Suicide with Attempted Homicide, Attempted Suicide with Completed Homicide, Completed Suicide with Attempted Homicide, Completed Suicide with Completed Homicide or All of the Above (also includes blanks).

- "Demo Patient/Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do You wish to"

  Type one of the following: **P** (print output) or **B** (browse output on screen).

The application displays 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: 25-44 years    Total # of Suicide Forms: 3
                                                   REPORT     TOTALS
Self Destructive Act:  ATTEMPT                     3          100%
Event logged by Discipline:  MEDICAL SOCIAL WORKER 3          100%
Event logged by Provider:  GRENWAY, DON            3          100%


Sex:      FEMALE                                   1          33%
          MALE                                     2          67%
Employed:    UNEMPLOYED                            3          100%
Tribe of Enrollment:  CHEROKEE NATION OF OKLAHOMA  3          100%
Community of Residence:  MUSKOGEE                  2          67%
                         TAHLEQUAH                 1          33%
Relationship:  SINGLE                              3          100%
Education:   HIGH SCHOOL GRADUATE/GED              1          33%
             SOME COLLEGE/TECHNICAL SCHOOL         2          67%
Method:    HANGING                                 3          100%
```

```
        OTHER                                      3        100%
Method if Other:    Drowning                       1         33%
                    Suicide by Cop                 1         33%
                    MVA                            1         33%
Previous Attempts:  0                              1         33%
                    2                              1         33%
                    3 OR MORE                      1         33%
Substance Use Involved:  ALCOHOL AND OTHER DRUGS   3        100%
Location of Act:  OTHER                            3        100%
Other location of Act:      Cabin in the woods     1         33%
                            Grandparent's Farm     1         33%
Lethality:   MEDIUM                                3        100%
Disposition:  OTHER                                3        100%
Disposition if OTHER:   County Psychiatric Facility 1        33%
                        Juvenile Treatment Facility 1        33%
                        Foster Care                1         33%
Contributing Factors:   LEGAL                      1         33%
                        OTHER                      3        100%
Contributing Factor if OTHER:   Test Results       1         33%
                                cont fact 8        1         33%
Substance Drugs:   OTHER                           3        100%
                        Other Substance Test       1         33%
                        Other substance            1         33%
                        other alcohol and drugs    1         33%


Age Range: 45-64 years        Total # of Suicide Forms:
                                          REPORT      TOTALS
Self Destructive Act:  ATTEMPT             1          100%
Event logged by Discipline:  MEDICAL SOCIAL WORKER  1     100%
Event logged by Provider:  BETAA,B         1          100%

Sex:      FEMALE                           1          100%
Employed:      DATA NOT ENTERED            1          100%
Tribe of Enrollment: CHEROKEE NATION OF OKLAHOMA   1     100%
Community of Residence:    TAHLEQUAH       1          100%
Relationship:     SAME SEX PARTNERSHIP     1          100%
Education:   COLLEGE GRADUATE              1          100%
Method:    OTHER                           1          100%
Method if Other:   drowning                1          100%
Previous Attempts:   UNKNOWN               1          100%
Substance Use Involved:   NONE             1          100%

Location of Act:    OTHER                  1          100%
Other location of Act:    Lake Bemidji     1          100%
Lethality:     MEDIUM                      1          100%
Disposition:   MENTAL HEALTH FOLLOW-UP     1          100%
Contributing Factors:   UNKNOWN            1          100%

Age Range: 65-125 years       Total # of Suicide Forms: 1
                                          REPORT      TOTALS
Self Destructive Act:   ATTEMPT            1          100%
Event logged by Discipline: MEDICAL SOCIAL WORKER   1     100%
Event logged by Provider: BETAA,B          1          100%

Sex:      FEMALE                           1          100%
Employed:    RETIRED                       1          100%
Tribe of Enrollment: CHOCTAW NATION OF OKLAHOMA   1     100%
Community of Residence:    SAWYER          1          100%
Relationship:    SINGLE                    1          100%
Education:  LESS THAN 12 YEARS             1          100%
Method:    GUNSHOT                         1          100%
           OVERDOSE                        1          100%
Previous Attempts:    UNKNOWN              1          100%
Substance Use Involved: NONE               1          100%
Location of Act:    OTHER                  1          100%
```

```
Other location of Act:    Adult Day Care Center     1         100%
Lethality:    HIGH                                  1         100%
Disposition:   IN-PATIENT MENTAL HEALTH TREAT       1         100%
Contributing Factors:  FINANCIAL STRESS             1         100%
                       HISTORY OF PHYSICAL ILLNESS  1         100%


Age Range: ALL AGES           Total # of Suicide Forms: 5
                                           REPORT    TOTALS
Self Destructive Act:      ATTEMPT            5       100%
Event logged by Discipline: MEDICAL SOCIAL WORKER  5   100%
Event logged by Provider:  GAMMA, DON         3        60%
                           BETAA, B           2        40%


Sex:            FEMALE                        3        60%
                MALE                          2        40%
Employed:   RETIRED                           1        20%
            UNEMPLOYED                        3        60%
            DATA NOT ENTERED                  1        20%
Tribe of Enrollment:   CHEROKEE NATION OF OKLAHOMA   4   80%
                       CHOCTAW NATION OF OKLAHOMA    1   20%
Community of Residence:   MUSKOGEE            2        40%
                          SAWYER              1        20%
                          TAHLEQUAH           2        40%
Relationship:     SINGLE                      4        80%
                  SAME SEX PARTNERSHIP        1        20%
Education:    LESS THAN 12 YEARS              1        20%
              HIGH SCHOOL GRADUATE/GED        1        20%
              SOME COLLEGE/TECHNICAL SCHOOL   2        40%
              COLLEGE GRADUATE                1        20%
Method:         GUNSHOT                       1        20%
                HANGING                       3        60%
                OVERDOSE                      1        20%
                OTHER                         4        80%
Method if Other:    drowning                  2        40%
                    Suicide by cop            1        20%
                    MVA                       1        20%
Previous Attempts:  0                         1        20%
                    2                         1        40%
                    3 OR MORE                 1        20%
                    UNKNOWN                   2        40%
Substance Use Involved:  NONE                 2        40%
                    ALCOHOL AND OTHER DRUGS   3        60%
Location of Act:  OTHER                       5       100%
Other location of Act:  Adult Day Care Center 1        20%
                        Lake Bemidji          1        20%
                        Grandparent's Farm    1        20%
                        Cabin in Woods        1        20%
Lethality:   HIGH                             1        20%
             MEDIUM                           4        80%
Disposition:   MENTAL HEALTH FOLLOW-UP        1        20%
               IN-PATIENT MENTAL HEALTH TREAT 1        20%
               OTHER                          3        60%
Disposition if OTHER:   County Psychiatric Facility 1  20%
                        Juvenile Treatment Facility 1  20%
                        Foster Care           1        20%
Contributing Factors:   FINANCIAL STRESS      1        20%
                        HISTORY OF PHYSICAL ILLNESS 1  20%
                        LEGAL                 1        20%
                        UNKNOWN               1        20%
                        OTHER                 3        60%
Contributing Factor if OTHER:  Test Results   1        20%
                               cont fact 8    1        20%
Substance Drugs:    OTHER                     3        60%
                        Other Substance Test  1        20%
                        Other substance       1        20%
```

```
                              other alcohol and drugs  1      20%


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

Figure 13-62: 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.

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"

  Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- "Demo Patient Inclusion/Exclusion"

  Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- "Do You wish to"

  Type one of the following: **P** (print output) or **B** (browse output on screen)

The application displays the Suicide Purpose of Visit report.

```
                 *    SUICIDE PURPOSE OF VISIT REPORT   *
               VISIT Date Range: OCT 31, 2006 through NOV 30, 2006
                     BOTH MALE AND FEMALE PATIENTS' VISITS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
            #    %     #      %     #     %     #      %    #      %
 1-4 yrs    0   0.0    0     0.0    0    0.0    0     0.0   0     0.0
 5-9 yrs    2  10.0    0     0.0    0    0.0    0     0.0   0     0.0
 10-14 yrs  7  35.0    0     0.0    0    0.0    0     0.0   0     0.0
 15-19 yrs  0   0.0    0     0.0    0    0.0    0     0.0   0     0.0
 20-24 yrs  0   0.0    0     0.0    0    0.0    0     0.0   0     0.0
 25-34 yrs  6  30.0    0     0.0    0    0.0    0     0.0   0     0.0
 35-44 yrs  2  10.0    0     0.0    0    0.0    0     0.0   0     0.0
 45-54 yrs  0   0.0    0     0.0    0    0.0    0     0.0   0     0.0
 55-64 yrs  1   5.0    0     0.0    0    0.0    0     0.0   0     0.0
 65-74 yrs  0   0.0    0     0.0    0    0.0    0     0.0   0     0.0
 75-84 yrs  0   0.0    0     0.0    0    0.0    0     0.0   0     0.0
 85+ yrs    2  10.0    0     0.0    0    0.0    0     0.0   0     0.0

TOTAL      20 100.0    0     0.0    0    0.0    0     0.0   0     0.0


                         MALE PATIENTS VISITS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP   # Encs     # w POV 39    w/ POV 40    w/ POV 41    w/ 39/40/41
      #    %     #       %      #      %     #      %     #      %
 1-4 yrs    0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 5-9 yrs    0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 10-14 yrs  6  66.7    0     0.0     0      0.0    0     0.0    0     0.0
 15-19 yrs  0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 20-24 yrs  0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 25-34 yrs  2  22.2    0     0.0     0      0.0    0     0.0    0     0.0
 35-44 yrs  1  11.1    0     0.0     0      0.0    0     0.0    0     0.0
 45-54 yrs  0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 55-64 yrs  0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 65-74 yrs  0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 75-84 yrs  0   0.0    0     0.0     0      0.0    0     0.0    0     0.0
 85+ yrs    0   0.0    0     0.0     0      0.0    0     0.0    0     0.0

TOTAL       9  100.0 0     0.0      0      0.0    0     0.0    0     0.0

                    FEMALE PATIENTS VISITS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
```

```
AGE GROUP     # Encs    # w POV 39    w/ POV 40    w/ POV 41    w/ 39/40/41
              #    %     #      %      #      %     #      %     #      %
1-4 yrs       0   0.0    0    0.0      0    0.0     0    0.0     0    0.0
5-9 yrs       2  18.2    0    0.0      0    0.0     0    0.0     0    0.0
10-14 yrs     1   9.1    0    0.0      0    0.0     0    0.0     0    0.0
15-19 yrs     0   0.0    0    0.0      0    0.0     0    0.0     0    0.0
20-24 yrs     0   0.0    0    0.0      0    0.0     0    0.0     0    0.0
25-34 yrs     4  36.4    0    0.0      0    0.0     0    0.0     0    0.0
35-44 yrs     1   9.1    0    0.0      0    0.0     0    0.0     0    0.0
45-54 yrs     0   0.0    0    0.0      0    0.0     0    0.0     0    0.0
55-64 yrs     1   9.1    0    0.0      0    0.0     0    0.0     0    0.0

65-74 yrs     0   0.0    0    0.0      0    0.0     0    0.0     0    0.0
75-84 yrs     0   0.0    0    0.0      0    0.0     0    0.0     0    0.0
85+ yrs       2  18.2    0    0.0      0    0.0     0    0.0     0    0.0

TOTAL        11 100.0    0    0.0      0    0.0     0    0.0     0    0.0


          UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP     # Encs      # w POV 39    w/ POV 40    w/ POV 41     w/ 39/40/41
     #      %      #        %    #       %     #       %      #       %
1-4 yrs    0   0.0     0    0.0    0   0.0   0   0.0     0    0.0
5-9 yrs    1   7.7     0    0.0    0   0.0   0   0.0     0    0.0
10-14 yrs  2  15.4     0    0.0    0   0.0   0   0.0     0    0.0
15-19 yrs  0   0.0     0    0.0    0   0.0   0   0.0     0    0.0
20-24 yrs  0   0.0     0    0.0    0   0.0   0   0.0     0    0.0
25-34 yrs  5  38.5     0    0.0    0   0.0   0   0.0     0    0.0
35-44 yrs  2  15.4     0    0.0    0   0.0   0   0.0     0    0.0
45-54 yrs  0   0.0     0    0.0    0   0.0   0   0.0     0    0.0
55-64 yrs  1   7.7     0    0.0    0   0.0   0   0.0     0    0.0
65-74 yrs  0   0.0     0    0.0    0   0.0   0   0.0     0    0.0
75-84 yrs  0   0.0     0    0.0    0   0.0   0   0.0     0    0.0
 85+ yrs   2  15.4     0    0.0    0   0.0   0   0.0     0    0.0

TOTAL     13 100.0     0    0.0    0   0.0   0   0.0     0    0.0


            UNDUPLICATED PATIENT COUNT - MALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP     # Encs    # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
        #      %    #      %     #      %    #      %      #      %
1-4 yrs    0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
5-9 yrs    0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
10-14 yrs  1  25.0    0    0.0    0   0.0   0   0.0     0    0.0
15-19 yrs  0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
20-24 yrs  0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
25-34 yrs  2  50.0    0    0.0    0   0.0   0   0.0     0    0.0
35-44 yrs  1  25.0    0    0.0    0   0.0   0   0.0     0    0.0
45-54 yrs  0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
55-64 yrs  0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
65-74 yrs  0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
75-84 yrs  0   0.0    0    0.0    0   0.0   0   0.0     0    0.0
85+ yrs    0   0.0    0    0.0    0   0.0   0   0.0     0    0.0

TOTAL      4 100.0    0    0.0    0   0.0   0   0.0     0    0.0


          UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP     # Encs    # w POV 39    w/ POV 40    w/ POV 41    w/ 39/40/41
              #    %     #    %     #      %      #    %      #    %
1-4 yrs    0   0.0    0  0.0    0   0.0     0   0.0     0   0.0
5-9 yrs    1  11.1    0  0.0    0   0.0     0   0.0     0   0.0
10-14 yrs  1  11.1    0  0.0    0   0.0     0   0.0     0   0.0
15-19 yrs  0   0.0    0  0.0    0   0.0     0   0.0     0   0.0
20-24 yrs  0   0.0    0  0.0    0   0.0     0   0.0     0   0.0
```

```
25-34 yrs    3  33.3     0  0.0   0   0.0    0   0.0    0   0.0
35-44 yrs    1  11.1     0  0.0   0   0.0    0   0.0    0   0.0
45-54 yrs    0   0.0     0  0.0   0   0.0    0   0.0    0   0.0
55-64 yrs    1  11.1     0  0.0   0   0.0    0   0.0    0   0.0
65-74 yrs    0   0.0     0  0.0   0   0.0    0   0.0    0   0.0
75-84 yrs    0   0.0     0  0.0   0   0.0    0   0.0    0   0.0
85+ yrs      2  22.2     0  0.0   0   0.0    0   0.0    0   0.0

TOTAL        9 100.0     0   0.0  0   0.0    0   0.0    0   0.0
```

Figure 13-63: 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, BH Problem/DSM IV, and BH Problem Codes).

The TABL option accesses the Print BH Standard Tables menu.

```
                  *********************************************
                  **        IHS Behavioral Health System      **
                  **          Print BH Standard Tables        **
                  *********************************************
                                  Version 4.0

                             DEMO INDIAN HOSPITAL


     ACT     Print Activity Code Table
     CLN     Print Clinic Codes
     DSM     Print Behavioral Health Problem/DSM IV Table
     PROB    Print Behavioral Health Problem Codes

  Select Print Standard Behavioral Health Tables Option:
```

Figure 13-64: 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.

```
XX                       May 04, 2009            Page 1

********** BEHAVIORAL HEALTH ACTIVITY CODES **********

CODE DESCRIPTION                                    CATEGORY     PCC   MNE
-------------------------------------------------------------------------
01    TWELVE STEP WORK - GROUP                       PATIENT SERV YES   TSG

02    TWELVE STEP WORK - INDIVDUAL                   PATIENT SERV YES   TSI

03    TWELVE STEP GROUP                              PATIENT SERV NO    TWG
```

```
04   RE-ASSESSMENT, PATIENT PRESENT                    PATIENT SERV  YES   RAS

05   RE-ASSESSMENT, PATIENT NOT PRESENT                SUPPORT SERV  NO

11   SCREENING-PATIENT PRESENT                         PATIENT SERV  YES   SCN

12   ASSESSMENT/EVALUATION-PATIENT PRESENT             PATIENT SERV  YES   EVL

13   INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT PATIENT SERV  YES   IND

14   FAMILY/GROUP TREATMENT-PATIENT PRESENT            PATIENT SERV  YES   FAM

15   INFORMATION AND/ OR REFERRAL-PATIENT PRESENT      PATIENT SERV  YES   REF

16   MEDICATION/MEDICATION MONITORING-PATIENT PRESENT  PATIENT SERV  YES   MED

17   PSYCHOLOGICAL TESTING-PATIENT PRESENT             PATIENT SERV  YES   TST

18   FORENSIC ACTIVITIES-PATIENT PRESENT               PATIENT SERV  YES   FOR

19   DISCHARGE PLANNING-PATIENT PRESENT                PATIENT SERV  YES   DSG
Enter RETURN to continue or '^' to exit:
```

Figure 13-65: Sample Behavioral Health Activity Codes report

13.5.2   Print Clinic Codes (CLN)

Use the CLN option to print the activity code table.

```
CLINIC STOP LIST                            APR 16,2009  14:22
PAGE 1
NAME                          CODE
------------------------------------------------------------------

ALCOHOL AND SUBSTANCE         43
AMBULANCE                     A3
ANTICOAGULATION THERAPY       D1
AUDIOLOGY                     35
BEHAVIORAL HEALTH             C4
CANCER CHEMOTHERAPY           62
CANCER SCREENING              58
CARDIOLOGY                    02
CASE MANAGEMENT SERVICES      77
CAST ROOM                     55
CHART REV/REC MOD             52
CHEST AND TB                  03
CHIROPRACTIC                  A6
CHRONIC DISEASE               50
COLPOSCOPY                    C3
COMPLEMENTARY MEDICINE        A5
```

Figure 13-66: Sample Clinic Stop List codes

13.5.3   Print Behavioral Health Problem/DSM IV Table (DSM)

Use the DSM option to print the BH Problem/DSM IV Table codes.

```
XX                            May 04, 2009              Page 1

********** BEHAVIORAL HEALTH PROBLEM/DSM CODES **********

CODE      NARRATIVE                                   PROBLEM ICD-9
                                                      CODE    CODE
-----------------------------------------------------------------
.9999     UNCODED DIAGNOSIS                           99.9    .9999

010.00    PRIM TB COMPLEX-UNSPEC                      99.9    010.00

011.41    TB LUNG FIBROSIS-NO EXAM                    6.1     011.41

030.9     LEPROSY NOS                                 99.9    030.9

034.0     STREP SORE THROAT                           5       034.0

054.10    GENITAL HERPES NOS                          99.9    054.10

1         HEALTH/HOMEMAKER NEEDS                      1       V60.4


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

Figure 13-67: Sample Behavioral Health Problem/DSM Codes report

13.5.4   Print Behavioral Health Problem Codes (PROB)

Use the PROB option to print the BH problem codes.

```
XX                            May 04, 2009              Page 1

********** BEHAVIORAL HEALTH PROBLEM CODES **********

CODE  NARRATIVE                                   PROBLEM CATEGORY
-----------------------------------------------------------------
1     HEALTH/HOMEMAKER NEEDS                      MEDICAL/SOCIAL PROBL

1.1   HEALTH PROMOTION/DISEASE PREVENTION         MEDICAL/SOCIAL PROBL

2     CROSS-CULTURAL CONFLICT                     MEDICAL/SOCIAL PROBL

3     UNSPECIFIED MENTAL DISORDER(NON-PSYCHOTIC)  MEDICAL/SOCIAL PROBL

4     PHYSICAL DISABILITY/REHABILITATION          MEDICAL/SOCIAL PROBL

5     PHYSICAL ILLNESS,ACUTE                      MEDICAL/SOCIAL PROBL

6.1   PHYSICAL ILLNESS, CHRONIC                   MEDICAL/SOCIAL PROBL

6.2   PHYSICAL ILLNESS, TERMINAL                  MEDICAL/SOCIAL PROBL


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

Figure 13-68: Sample Behavioral Health Problem Codes report

13.6   Manager Utilities Module (Roll-and-Scroll)

The Manager Utilities module 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

                         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 13-69: 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.

13.7   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 (type **Y** or **N**).

The application displays the Update BH Site Parameters window.

```
** UPDATE BH SITE PARAMETERS **        Site Name: SITEXXX
========================================================================
Update DEFAULT Values?  N

Default Health Summary Type: BEHAOVIRAL HEALTH

Default response on form print: FULL    Suppress Comment on
Suppressed Form? NO
# of past POVs to display: 1             Exclude No Shows on last DX
Display? N

Update PCC Link Features?  N
Turn Off EHR to BH Link?  NO
Turn on PCC Coding Queue? YES            Update Provider Exception
to E Sig? N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits? N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:
_____



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

Figure 13-70: Sample Update BH Site Parameters window

Below are the fields on the window.

- Update DEFAULT Values?

    Type **Y** or **N**. If you type **Y**, the application displays the following pop-up. 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 13-71: 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 BH 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 in 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. Type one of the following: **B** (both), **F** (full), **S** (suppressed form), **T** (Suppressed - 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?

  Type **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 number between 0 and 5.

- Exclude No Shows on last DX Display?

  Type **Y** or **N**.

- Update PCC Link Features?

  Type **Y** or **N**. If you type **Y**, the application displays the Update PCC Link Feature Parameters pop-up window.

```
**** 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 13-72: 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-9 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 v65.40, Encounter, all encounters will have the ICD code of v65.40 and narrative of Encounter.

- Pass All Data as Entered (No Masking). Use this option to have all DSM IV and Problem Codes passed as ICD-9 codes as shown in the crosswalk along with the narrative as written by the provider. 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 IV and Problem Codes converted to ICD-9 codes as shown in the crosswalk and passed with a single standard narrative, as defined by the program, for all contacts. 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 Code to Use (Option 2 ONLY): V65.40

Narrative for MH Program: MH/SS/SA COUNSELING

Narrative for SS Program: SS VISIT
```

Figure 13-73: 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 (required). 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?" Type **Y** or **N**. The BHS site parameters contain a question about an interactive PCC link to address an issue with the PIMS Scheduling package. Because it is possible to set up a clinic in the Scheduling package that initiates a PCC record at check in, some sites were creating two separate records for each individual patient encounter in the behavioral health clinics. If you leave the field blank, this is the same as typing 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?" Type **Y** or **N** to allow that ability to update a patient's PCC problem list from within BHS (required).

- "Update PCC LINK Exceptions?" Type **Y** or **N** to determine if you want to set data passing parameters for individuals who 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 13-74: Setting up PCC link exceptions

Below are the fields on the update window.

- Turn Off EHR to BH Link?

  Type **Y** or **N**. A site parameter was created to give sites the ability to "opt out" of the new BH 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 BHS 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?

  Type **Y** (yes) or **N** (no).

  - If you type **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 type **N**, all visit 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 on 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:

1. Log in to BHS v4.0 and select the Manager Utilities menu.

2. Select the Site Parameters option and enter the name of the site you want to update.

3. On the site parameters entry window, scroll down to the Turn on PCC Coding Queue field.

4. Type **Y** at this field.

5. 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?"

  Type **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 type **Y**, the application displays the following pop-up.

```
Electronic Signature will not be activated for providers added to
this list.

PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
```

Figure 13-75: 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 may still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a 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?

  Type **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 type **Y**, the following pop-up displays. You can add another name to the list. This new name will be able to see all visits for a day 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 13-76: List of names allowed to see all records

- "Update those allowed to override delete?"

  Type **Y** or **N** to determine if you want to update those allowed to override delete.

  If you type **Y**, the following pop-up 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 13-77: List of names allowed to delete any Intake document

- "Update those allowed to share visits?"

  Type **Y** or **N** to update those allowed to share visit information via RPMS mail message.

  If you type **Y**, the application displays the following pop-up. 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 13-78: Sample pop-up to enter user names allowed to share visits via mail

- "Update those allowed to order Labs?"

    Type **Y** or **N** to permit those allowed to order lab tests.

    If you type **Y**, the application displays the following pop-up. Here you can add a new name at the "User Permitted to Order Labs" prompt. All users permitted to order laboratory 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 13-79: 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.

13.8   Export Utility Menu (EXPT)

Use the EXPT option to access the options on the Export Utility Menu.

```
                    ***********************************************
                    **        IHS Behavioral Health System       **
                    **                  Export Utility           **
                    ***********************************************
                                   Version 4.0

                                DEMO INDIAN HOSPITAL


        GEN     Generate BH Transactions for HQ
        DISP    Display a Log Entry
        PRNT    Print Export Log
        RGEN    Re-generate Transactions
        RSET    Re-set Data Export Log
        CHK     Check Records Before Export
        EDR     Re-Export BH Data in a Date Range
        ERRS    Print Error List for Export
        OUTP    Create OUTPUT File

    Select Export Utility Menu Option:
```

Figure 13-80: 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.

13.8.1   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 type a caret (^) to exit out at any prompt and the application will ask you to confirm your entries prior to generating transactions.

The application displays the following information:

```
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 13-81: Sample information before continuing

- "Do you want to continue?"

  Type **Y** or **N**. If you type **N**, you return to the Export Utility menu. If you type **Y**, the prompts continue.

- "Do you want to QUEUE this to run at a later time?"

  Type **Y** or **N**. If you type **Y**, the generation will be put in the queue. If you type **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).

```
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 13-82: Sample information for generating the new log entry

13.8.2   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.)

- "Select MHSS EXTRACT LOG ENDING DATE"

  Specify the extract log ending date.

The application displays the extract log information.

```
NUMBER:  2                            BEGINNING DATE:  SEP 1,  2008
     ENDING DATE:   SEP 30, 2008@10:26:49
     RUN STOP DATE/TIME:   OCT 2, 1994@10:30:51
     COUNT OF ERRORS:  2        COUNT OF TRANSACTIONS:  98
     COUNT OF RECORDS PROCESSED:  100        RUN LOCATION:  _____
     # ADDS:  97                        # MODS:  1
     # DELETES: 0
     TRANSMISSION STATUS:  SUCCESSFULLY COMPLETED
```

Figure 13-83: Sample extract log information

13.8.3   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.

```
                *****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 13-84: Sample export extract log

13.8.4   Regenerate 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, the application displays the following information (example uses Log Entry 3).

```
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 13-85: Sample information about re-generate transactions

13.8.5   Reset 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.

13.8.6   Check Records Before Export (CHK)

Use the CHK option to review records that were posted between two dates. The application displays the two dates, such as APR 19, 2009 and APR 20, 2009 inclusive. If the entries are hitting this list, they aren't passing to PCC and the billing package.

> **Note**:   This option will review all records that were posted form the
>   day after the last date of that run up until two days ago.

The application displays the BH Export Record Review report.

```
                       DEMO INDIAN HOSPITAL                    Page 1
                        BH EXPORT RECORD REVIEW
               Record Posting Dates:  APR 19, 2009 and APR 20, 2009


RECORD DATE            PATIENT               HRN    PGM  TYPE       ACT TYPE
------------------------------------------------------------------------
APR 20, 2009@09:44    ALPHA,CHELSEA MARIE 116431   S    OUTPATIENT   16
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@09:51    DELTA,EDWIN RAY      105321   S    OUTPATIENT   85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:46    DELTA,EDWIN RAY      105321   S    OUTPATIENT   85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:56    SIGMA,SERGIO         206293   S    OUTPATIENT   15
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:00    ALPHA,CHRYSTAL GAYL 106299   M    OUTPATIENT   94
E023-NO AFFILIATION FOR PROVIDER

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

Figure 13-86: Sample report about records before export

13.8.7   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 typing a questions mark (**?**) 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.

The application displays the MHSS Extract Log Error Report.

```
MHSS EXTRACT LOG ERROR REPORT              APR 20,2009  13:15     PAGE 1
                                                                  ACT
VISIT DATE           PATIENT                 HRN    PGM  TYPE      TYPE
------------------------------------------------------------------------


AUG 21,2006  17:44   ALPHAA,STEVEN ALLAN   165583  S    OUTPATIENT  31
ERROR: E021-NO PURPOSE OF VISIT
Press ENTER to Continue:
```

Figure 13-87: Sample MHSS Extract Log Error Report

13.8.8   Create OUTPUT File (OUTP)

Use the OUTP option to create an output file. Consult with the site manager on how to create a RPMS export.

13.9   ReSet 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"

  Type one of the following: **A** (all flags) or **O** (one particular flag). If you type **O**, other prompts will display.

- "Are you sure you want to do this?"

  Type **Y** or **N**. If you type **Y**, the application shows the following information:

```
Hold on... resetting data..
All done.
```

Figure 13-88: Information from the application about the reset process

13.10   Display Log of Who Edited Record (DLWE)

Use the DLWE option to display a list of who edited BH records of a specified patient.

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. Otherwise, press Enter.

The application displays the Behavioral Health Visits for the date specified. The following examples were visits with no location and no patient.

```
--------------------------------------------------------------------------------
           Behavioral Health visits for APR 10, 2009
--------------------------------------------------------------------------------
 #      PROVIDER   LOC   COMMUNITY ACT CONT PATIENT      PROB     NARRATIVE
--------------------------------------------------------------------------------
1    GAMMAA,RYAN   WW    TAHLEQUAH    OUTP WW 116431     14
2    BETAAAA,BJ    WW    TAHLEQUAH 99 OUTP WW 108704     296.32   DEPRESSED
3    GAMMAA,RYAN   WW    TAHLEQUAH 13 ADMI -----         14.1     jaljvsl
4    GAMMAA,RYAN   LC    ABIQUIU   76 INTE WW 105321     15       BIPOLAR DISORDE
5    GAMMAA,RYAN   WW    TAHLEQUAH 16 OUTP WW 116431     311.     DEPRESSIVE DISO
6    GAMMAA,RYAN   WW    TAHLEQUAH 19 OUTP WW 116431     314.9    ATTENTION-DEFIC
7    GAMMAA,RYAN   WW    TAHLEQUAH 16 OUTP WW 116431     295.15   SCHIZOPHRENIA,

Which record do you want to display:  (1-7):
```

Figure 13-89: 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. The application display visit data.

```
MHSS RECORD LIST                          APR 20,2009  11:31     PAGE 1
DATE
CREATED       WHO ENTERED RECORD    LAST MOD   USER LAST UPDATE
         DATE/TIME EDITED           WHO EDITED
------------------------------------------------------------------


04/10/09      BETAAAA,BJ            04/10/09   BETAAAA,BJ
         APR 10,2009  12:01    BETAAAA,BJ
         APR 10,2009  12:04    BETAAAA,BJ
         APR 10,2009  12:05    BETAAAA,BJ
         APR 10,2009  12:06    BETAAAA,BJ

End of report.  Press enter:
```

Figure 13-90: Sample report about visit data of a particular record

13.11   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 (type **Y** or **N**); if you type **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.

13.12   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.

13.13   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 can type a question mark (**?**) 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. Type **Y** or **N** at this confirmation prompt.

13.14   Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

Use the EEPC option to loop through all MHSS PROBLEM/DSM IV table entries created by EHR users to change the grouping from the generic 99.9 OTHER EHR CLINICAL grouping to a more specific MHSS PROBLEM CODE grouping.

In the RPMS behavioral health applications the POV is recorded as either a BH Problem Code or DSM-IV TR code. For the purpose of reports, these codes are grouped within larger problem code groupings and then again in overarching categories. For example, DSM-IV TR Code 311 Depressive Disorder NOS is also stored as problem code grouping 14 Depressive Disorders and problem category Psychosocial Problems.

In the RPMS EHR, the POV is recorded using ICD-9 codes, not DSM-IV TR codes. Many ICD and DSM numeric codes are identical. There may be instances when a provider selects an ICD code that does not have a matching DSM code. When this occurs it will be dynamically added to the MHSS PROBLEM/DSM IV table. Once the ICD-9 code is in the MHSS PROBLEM/DSM IV table, then it is accessible to users in BHS or BH GUI as well.

These ICD-9 codes that have been added to the MHSS PROBLEM/DSM IV table will not have been automatically assigned to the appropriate BH problem code group. To ensure that these ICD-9 codes are captured in BHS reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time.

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 caret (^) option so that you don't have to go all the way through the entries.

13.15 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 multidivisional 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.

The application displays 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 13-91: 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.

Patient Services - Patient Always Present (P)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

- 01–Twelve Step Work–Group (TSG)

  Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem–alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

- 02–Twelve Step Work–Individual (TSI)

  Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem–alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

- 03–Twelve Step Group (TSG)

  Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, Co-dependents Anonymous (CoDA).and Overeaters Anonymous (OA).

- 04-Reassessment, 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.

Support Services–Patient Not Present (S)

Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

- 05-Reassessment, Patient Not Present

  Reassessment or reevaluation activities when patient is not present at time of service delivery.

- 24-Material/Basic Support (SUP)

  Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

- 25-Information and/or Referral (INF)

  Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization

- 26-Medication/Medication Monitoring (MEA)

  Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

- 27-Forensic Activities (FOA)

  Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

- 28-Discharge Planning (DSA)

  Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

- 29-Family Facilitation (FAA)

  Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

- 30-Follow-up/Follow-through (FUA)

  Periodic evaluative review of a specific client/patient's progress after discharge.

- 31-Case Management (CAA)

  Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

- 33-Technical Assistance

  Task-specific assistance to achieve an identified end.

- 34-Other Support Services

  Any other ancillary, adjunctive, or collateral services not identified here.

- 44-Screening

  Activities associated with patient/client screening where no information is added to the patient/client's file.

- 45-Assessment/Evaluation

  Assessment or evaluation activities when patient is not present at time of service delivery.

- 49-Crisis Intervention (CIA)

  Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

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.

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

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 multidisciplinary 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.

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.

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.

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.

Cultural Issues (O)

- 81-Traditional Specialist Consult (Patient Present) (TRD)

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
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

Activity Code	Description	Pass to PCC
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes

Appendix C: ICD-9CM v Codes

ICD Code	Description
v11.0	Personal history of Schizophrenia
v11.1	Personal history of affective disorders
v11.2	Personal history of neurosis
v11.3	Personal history of alcoholism
v11.8	Personal history of other mental disorders
v11.9	Personal history of unspecified mental disorder
v13.21	Personal history of pre-term labor
v13.7	Personal history of perinatal problems
v15.41	History of physical abuse (includes rape)
v15.42	History of emotional abuse or neglect
v15.49	Psychological trauma, not elsewhere classified
v15.52	Personal History of Traumatic Brain Injury (TBI)
v15.81	History of noncompliance with medical treatment
v15.82	History of tobacco use
v15.89	Other personal history presenting hazards to health
v15.9	Unspecified personal history presenting hazards to health
v17.0	Family history of psychiatric condition
v18.4	Family history of mental retardation
v23.9	Supervision of unspecified high risk pregnancy
v25.09	General counseling and advice on contraceptive management; family planning advice
v26.33	Genetic counseling
v26.41	Procreative counseling and advice using natural family planning
v26.49	Other procreative management counseling and advice
v40.0	Mental and behavioral problems with learning
v40.1	Mental and behavioral problems with communication including speech
v40.2	Other mental problems
v40.3	Other behavioral problems
v40.9	Unspecified mental or behavioral problem
v57.9	Care involving unspecified rehabilitation procedure
v60.0	Lack of housing
v60.1	Inadequate housing
v60.2	Inadequate material resources
v60.3	Person living alone
v60.4	No other household member able to render care
v60.5	Holiday relief care
v60.6	Person living in a residential institution
v60.8	Other specified housing or economic circumstances
v60.81	Foster care (status)
v60.89	Unspecified housing or economic circumstances
v61.01	Family disruption due to family member on military deployment

ICD Code	Description
v61.02	Family disruption due to return of family member from military deployment
v61.03	Family disruption due to divorce or legal separation
v61.04	Family disruption due to parent-child estrangement
v61.05	Family disruption due to child in welfare custody
v61.06	Family disruption due to child in foster care or in care of non-parental family member
v61.07	Family disruption due to death of family member
v61.08	Family disruption due to other extended absence of family member
v61.09	Other family disruption
v61.10	Counseling for marital and partner problems, unspecified
v61.11	Counseling for victim of spousal and partner abuse
v61.12	Counseling for perpetrator of spousal and partner abuse
v61.20	Counseling for parent-child problem, unspecified
v61.21	Counseling for victim of child abuse
v61.22	Counseling for perpetrator of parental child abuse
v61.23	Counseling for parent-biological child problem
v61.24	Counseling for parent-adopted child problem
v61.25	Counseling for parent (guardian)-foster child problem
v61.3	Problems with aged parents or in-laws
v61.41	Alcoholism in family
v61.49	Other health problems within family
v61.5	Multiparity
v61.6	Illegitimacy or illegitimate pregnancy
v61.7	Other unwanted pregnancy
v61.8	Other specified family circumstances
v61.9	Unspecified family circumstances
v62.0	Unemployment
v62.1	Adverse effects of work environment
v62.21	Personal current military deployment status
v62.22	Personal history of return from military deployment
v62.29	Other occupational circumstances or maladjustment
v62.3	Educational circumstances
v62.4	Social maladjustment
v62.5	Legal circumstances
v62.6	Refusal of treatment for reasons of religion or conscience
v62.81	Interpersonal problems, not elsewhere classified
v62.82	Bereavement, uncomplicated
v62.83	Counseling for perpetrator of physical/sexual abuse
v62.84	Suicidal ideation
v62.89	Other psychological or physical stress, not elsewhere classified (life circumstance problems; phase of life problems, borderline intellectual functioning; religious or spiritual problem)
v62.9	Unspecified psychosocial circumstance
v63.0	Residence remote from hospital or other health care facility

ICD Code	Description
v63.1	Medical services in home not available
v63.2	Person awaiting admission to adequate facility elsewhere
v63.8	Other specified reasons for unavailability of medical facilities
v63.9	Unspecified reason for unavailability of medical facilities
v65.0	Healthy person accompanying a sick person
v65.11	Pediatric pre-birth visit for expectant mother
v65.19	Other person consulting on behalf of another person
v65.2	Person feigning illness
v65.3	Dietary surveillance and counseling
v65.40	Other unspecified counseling
v65.41	Exercise counseling
v65.42	Counseling on substance use and abuse
v65.43	Counseling on injury prevention
v65.44	HIV Counseling
v65.45	Counseling on other sexually transmitted diseases
v65.49	Other specified counseling
v65.5	Person with feared complaint in whom no diagnosis was made
v65.8	Other reasons for seeking consultation
v65.9	Unspecified reason for consultation
v66.3	Convalescence following psychotherapy and other treatment for mental disorder
v66.7	Encounter for palliative care (end of life care)
v67.3	Follow-up examination following psychotherapy and other treatment for mental disorder
v68.1	Issue of repeat prescriptions
v68.2	Request for expert evidence
v68.81	Referral of patient without examination or treatment
v68.89	Encounter for other specified administrative purpose
v68.9	Encounters for unspecified administrative purpose
v69.0	Problems related to lifestyle – lack of exercise
v69.1	Problems related to lifestyle – Inappropriate diet and eating habits
v69.2	Problems related to lifestyle – High risk sexual behavior
v69.3	Problems related to lifestyle – gambling and betting
v69.4	Problems related to lifestyle – lack of adequate sleep
v69.5	Problems related to lifestyle – behavioral insomnia of childhood
v69.8	Other problems related to lifestyle; self-damaging behavior
v69.9	Unspecified problem related to lifestyle
v70.1	General psychiatric examination, requested by the authority
v70.2	General psychiatric examination, other and unspecified
v71.01	Observation of adult antisocial behavior
v71.02	Observation of childhood or adolescent antisocial behavior
v71.09	Observation of other suspected mental condition
v71.81	Observation and evaluation for other specified suspected conditions, abuse and neglect

ICD Code	Description
v71.89	Observation and evaluation for other specified suspected conditions not found
v79.0	Special screening for depression
v79.1	Special screening for alcoholism
v79.2	Special screening for mental retardation
v79.3	Special screening for developmental handicaps in early childhood
v79.8	Special screening for other specified mental disorders and developmental handicaps
v79.9	Special screening for unspecified mental disorder and developmental handicap
v80.01	Special Screening for Traumatic Brain Injury (TBI)

Appendix D: 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 (RoBs) 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 RoBs 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 RoBs listed in the following sections are specific to RPMS.

All RPMS Users

In addition to these rules, each application might include additional RoBs that can be defined within the documentation of that application (e.g., PCC, Dental, Pharmacy).

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 their 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 job or by divulging information to anyone not authorized to know that information.

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 might be afforded additional privileges based on the function they perform such as system administrator or application administrator.

- Acquire a written preauthorization in accordance with IHS polices and procedures prior to interconnection to or transferring data from RPMS.

Accountability

RPMS Users Shall:

- Behave in an ethical, technically proficient, informed, and tRGworthy manner.

- Log out of the system whenever they leave the vicinity of their PC.

- 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 entRGed 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 IT information processes.

Confidentiality

RPMS Users Shall:

- Be aware of the sensitivity of electronic and hardcopy information, and protect it accordingly.

- Store hardcopy 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 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.

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.

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).

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 password immediately if password has been seen, guessed, or otherwise compromised; and report the compromise or suspected compromise to their ISSO.

- Keep user identifications (ID) 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.

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.

- Store backups away from the system in a secure environment.

Reporting

RPMS Users Shall:

- Contact and inform their ISSO that they have identified an IT security incident and will 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

Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than five 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 your screen after some period of inactivity.

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

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.

Remote Access

Each subscriber organization establishes its own policies for determining which employees can 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 non-recovery of temporary files created in processing sensitive data, virus protection, intrusion detection, and provides 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.

RPMS Developers

RPMS Developers Users 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, 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; 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.

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, 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 back up 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; 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

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

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 Return key. For example: "Do you really want to quit? No//." Pressing the Return 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.

EHR

Indian Health Service RPMS Electronic Health Record

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.

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.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

MH

Mental Health

Menu

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical use interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

RPMS

Resource and Patient Management System; a suite of clinical and administrative software packages used within the Indian healthcare delivery system.

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 for entering and editing text.

TUI

Text Integration Utilities, a document management application. This application is used to create and store a wide variety of clinical note templates in the RPMS Electronic Health Record.

Word Processing Field

This is a field that allows users to write, edit, and format text for letters, MailMan messages, etc.

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov