



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **Behavioral Health System**

(AMH)

## **User Manual**

Version 4.0 Patch 4  
June 2014

Office of Information Technology  
Division of Information Technology  
Albuquerque, New Mexico

# Table of Contents

<b>1.0</b>	<b>Introduction.....</b>	<b>x</b>
1.1	Primary Menu .....	xi
1.2	Preparations .....	xi
1.3	Security Keys.....	xi
<b>2.0</b>	<b>Orientation .....</b>	<b>1</b>
2.1	Standard Conventions (Roll and Scroll).....	1
2.1.1	Caps Lock.....	1
2.1.2	Default Entries .....	1
2.1.3	Help .....	1
2.1.4	To Back Out.....	1
2.1.5	Exit .....	1
2.1.6	Same Entries.....	2
2.1.7	Lookup.....	2
2.1.8	Pause Indicator.....	2
2.1.9	Dates and Times .....	2
2.1.10	Stop .....	3
2.1.11	Delete .....	3
2.2	ListMan (Roll and Scroll).....	3
2.3	ScreenMan (Roll and Scroll).....	5
2.3.1	Using the ScreenMan Window .....	5
2.3.2	Using the Pop-up Window .....	6
2.4	Full Screen Text Editor (Roll and Scroll).....	7
2.5	Word Processing Editors (Roll and Scroll).....	8
2.6	Pop-up Windows (GUI).....	10
2.6.1	Buttons on Title Bar .....	10
2.6.2	Buttons on the Toolbar .....	11
2.7	Using the Calendar (GUI) .....	12
2.8	Using the Search Window (GUI).....	13
2.9	Using the Search/Select Window (GUI).....	14
2.10	Using the Multiple Select Window (GUI).....	16
2.11	Free Text Fields (GUI) .....	17
2.12	Selecting a Patient.....	17
2.12.1	Patient Selection (Roll and Scroll) .....	18
2.12.2	Patient Selection (GUI).....	18
2.13	Sensitive Patient Tracking .....	19
2.14	Electronic Signature.....	21
2.14.1	Creating Your Electronic Signature .....	21
2.14.2	Electronic Signature Usage .....	22
2.14.3	Data Entry Requirements (Roll and Scroll).....	22
2.14.4	Assign PCC Visit .....	23
2.14.5	Signing a Note (GUI) .....	23

2.14.6	Signing a Note (Roll and Scroll).....	24
2.15	Login to GUI .....	25
2.16	RPMS Behavioral Health System Tree.....	28
2.16.1	Patient Menu .....	28
2.16.2	Preferences Menu .....	28
2.16.3	RPMS Menu .....	29
2.16.4	Exit Menu .....	30
2.16.5	Help Menu .....	30
2.16.6	About Menu .....	30
<b>3.0</b>	<b>Data Entry.....</b>	<b>31</b>
3.1	Roll and Scroll .....	31
3.2	RPMS Behavioral Health System Graphical User Interface (GUI).....	32
<b>4.0</b>	<b>One Patient Visit Data .....</b>	<b>34</b>
4.1	Enter or Edit Patient Visit Data (Roll and Scroll).....	34
4.1.1	Enter or Edit Patient/Visit Data - Patient Centered (PDE) .....	34
4.1.2	Add/Edit Visit Data - Full Screen Mode (SDE).....	36
4.1.3	Using the Behavioral Health Visit Update Screen.....	37
4.1.4	Using the Behavioral Health Record Edit Window.....	49
4.1.5	Edit EHR Visit (EH).....	64
4.1.6	Edit SOAP (ES) .....	66
4.1.7	Delete Visit (DE) .....	67
4.1.8	Sign Note (SN) .....	67
4.1.9	Print Encounter Form (PF) .....	68
4.1.10	Last BH Visit (LV) .....	70
4.1.11	Browse Visit (BV).....	71
4.1.12	List Visit Dates (LD).....	72
4.1.13	Display Record (DR).....	73
4.2	Visit Window (GUI) .....	74
4.2.1	Visit Date Range Group Box .....	75
4.2.2	Visit Group Box.....	76
4.2.3	Add Button.....	76
4.2.4	Edit Button .....	76
4.2.5	View Button .....	76
4.2.6	Delete Button.....	76
4.2.7	Sign Note Button .....	76
4.2.8	Print Encounter Button .....	77
4.2.9	Problem Button.....	77
4.2.10	Help Button.....	77
4.2.11	Close Button.....	78
4.3	Add/Edit Visit Data Entry .....	78
4.3.1	Visit Information Group Box.....	79
4.3.2	POV Tab.....	81
4.3.3	Activity Tab.....	83
4.3.4	SOAP/Progress Notes Tab.....	86

4.3.5	Rx Notes/Labs Tab.....	88
4.3.6	Wellness Tab.....	92
4.3.7	Measurements Tab.....	101
4.3.8	Intake Tab (GUI).....	104
4.3.9	Suicide Form .....	105
4.3.10	Select PCC Visit Window .....	105
4.4	Browse Visits (GUI) .....	107
4.5	View Patient Data .....	109
4.5.1	Face Sheet .....	110
4.5.2	Health Summary.....	110
4.5.3	Patient Appointments .....	111
4.5.4	PCC Medications.....	111
4.5.5	PCC Labs by Visit Date .....	112
4.5.6	PCC Labs by Lab Test .....	112
<b>5.0</b>	<b>Group Encounters .....</b>	<b>114</b>
5.1	Group Form Data Entry Using Group Definition (Roll and Scroll) .....	114
5.1.1	Add New Group .....	115
5.1.2	Edit Group Definition .....	119
5.1.3	Review/Edit Group Visits .....	120
5.1.4	Display Group Entry .....	122
5.1.5	Print Encounter Forms.....	123
5.1.6	Duplicate Group.....	124
5.1.7	Add No Show visit .....	126
5.1.8	Sign Note.....	126
5.1.9	Delete Group .....	128
5.2	Group Entry Window (GUI).....	128
5.2.1	Group Entry Date Range Group Box .....	129
5.2.2	Group Entry Group Box .....	129
5.2.3	Add Button.....	129
5.2.4	Edit Button .....	129
5.2.5	View Button .....	129
5.2.6	Duplicate Button .....	129
5.2.7	Delete Button.....	130
5.2.8	Sign Note Button .....	130
5.2.9	Print Encounter Button .....	131
5.2.10	Help Button.....	131
5.2.11	Close Button.....	131
5.3	Add/Edit Group Data (GUI).....	132
5.3.1	Group Encounter Information Group Box .....	133
5.3.2	Activities Tab .....	135
5.3.3	Group Data Tab.....	136
5.3.4	Group Education Tab .....	139
5.3.5	Patients Tab .....	141
5.3.6	Patient Data Tab.....	142

<b>6.0</b>	<b>Case Management</b> .....	<b>149</b>
6.1	Managing Case Data (Roll and Scroll).....	149
6.1.1	Open New Case (OP).....	149
6.1.2	Edit Case Data (ED).....	151
6.1.3	Delete Case (DC).....	151
6.2	Designated Provider/Flag/Personal History (Roll and Scroll).....	151
6.3	Case Management Window (GUI).....	153
6.3.1	Case Management Date Range.....	154
6.3.2	Case Status Group Box.....	154
6.3.3	Add Button.....	154
6.3.4	Edit Button.....	154
6.3.5	View Button.....	155
6.3.6	Delete Button.....	155
6.3.7	Help Button.....	155
6.3.8	Close Button.....	155
6.4	Add/Edit Case Management Data (GUI).....	155
6.4.1	Case Status Group Box.....	157
6.4.2	Patient Information Group Box.....	158
6.4.3	Personal History Group Box.....	159
<b>7.0</b>	<b>Administrative/Community Activity</b> .....	<b>161</b>
7.1	Add Administrative/Community Activity Record (Roll and Scroll).....	161
7.2	Administrative/Community Activity Window (GUI).....	165
7.2.1	Administrative/Community Activity Date Range.....	166
7.2.2	Administrative/Community Activity Group box.....	166
7.2.3	Add Button.....	167
7.2.4	Edit Button.....	167
7.2.5	View Button.....	167
7.2.6	Delete Button.....	167
7.2.7	Print Encounter Button.....	167
7.2.8	Help Button.....	168
7.2.9	Close Button.....	168
7.3	Add/Edit Administrative/Community Activity (GUI).....	168
7.3.1	Administrative/Community Entry Group Box.....	170
7.3.2	Activity Data Tab.....	172
7.3.3	Notes Tab.....	175
<b>8.0</b>	<b>Encounter and Treatment Plan Sharing (Roll and Scroll)</b> .....	<b>176</b>
<b>9.0</b>	<b>Problem List</b> .....	<b>177</b>
9.1	BH Patient's Problem List (Roll and Scroll).....	177
9.1.1	Add BH Problem (AP).....	178
9.1.2	Edit BH Problem (EP).....	179
9.1.3	Delete BH Problem (DE).....	180
9.1.4	Activate BH Problem (AC).....	181
9.1.5	Inactivate BH Problem (IP).....	182

9.1.6	Detail Display (DD) .....	182
9.1.7	Add Note (NO).....	183
9.1.8	Edit Note (MN).....	185
9.1.9	Remove Note (RN).....	185
9.1.10	No Active BH Problems (NP).....	186
9.1.11	Problem List Reviewed (LR).....	187
9.1.12	PCC Problem List Display (PC) .....	187
9.2	Problem List (GUI).....	188
9.2.1	Behavior Health Problem List Window .....	189
9.2.2	PCC Problem List Window .....	198
<b>10.0</b>	<b>Treatment Plans.....</b>	<b>200</b>
10.1	Patient Treatment Plans (Roll and Scroll).....	200
10.1.1	Add, Edit, Delete a Treatment Plan (UP).....	200
10.1.2	Display/Print a Treatment Plan (DTP) .....	207
10.1.3	Print List of Treatment Plans Needing Reviewed (REV).....	210
10.1.4	Print List of Treatment Plans Needing Resolved (RES) .....	211
10.1.5	Print List of All Treatment Plans on File (ATP) .....	211
10.1.6	Patients w/Case Open but No Treatment Plan (NOTP).....	212
10.2	Treatment Plan Window (GUI).....	213
10.2.1	Treatment Plan Date Range.....	215
10.2.2	Treatment Plan Group Box.....	215
10.2.3	Add Button.....	216
10.2.4	Edit Button.....	216
10.2.5	View Button .....	216
10.2.6	Delete Button.....	216
10.2.7	Print Treatment Plan Button .....	216
10.2.8	Help .....	218
10.2.9	Close Button.....	218
10.3	Add/Edit Treatment Plan Record (GUI) .....	219
10.3.1	Treatment Plan Information Group Box.....	220
10.3.2	Diagnosis Tab.....	221
10.3.3	Plan Tab .....	222
10.3.4	Plan Review Tab .....	223
<b>11.0</b>	<b>Suicide Forms.....</b>	<b>226</b>
11.1	Suicide Reporting Forms (Roll and Scroll).....	226
11.1.1	Update Suicide Reporting Form for a Patient (SFP).....	226
11.1.2	Review Suicide Forms by Date (SFD) .....	234
11.2	Suicide Form Window (GUI) .....	235
11.2.1	Suicide Form Date Range .....	237
11.2.2	Suicide Form Group Box .....	238
11.2.3	Add Button.....	238
11.2.4	Edit Button.....	238
11.2.5	View Button .....	238
11.2.6	Delete Button.....	238

11.2.7	Print Button.....	238
11.2.8	Help Button.....	239
11.2.9	Close Button.....	239
11.3	Add/Edit Suicide Form (GUI) .....	239
11.3.1	Suicide Form Fields.....	241
11.3.2	Method Tab .....	243
11.3.3	Substance Use Tab .....	244
11.3.4	Contributing Factors Tab .....	247
11.3.5	Narrative Tab.....	247
<b>12.0</b>	<b>Intake.....</b>	<b>248</b>
12.1	Intake Documents (Roll and Scroll) .....	248
12.1.1	Add Initial Intake (I).....	249
12.1.2	Edit Initial Intake (E) .....	250
12.1.3	Add/Edit Update (U) .....	252
12.1.4	Delete Intake/Update (D).....	253
12.1.5	Print Intake Document .....	254
12.2	Intake (GUI).....	255
12.2.1	Patient Intake Documents Group Box .....	257
12.2.2	Add Initial Intake .....	258
12.2.3	Intake Group Box.....	259
12.2.4	Edit Initial Intake .....	260
12.2.5	Add/Edit Update .....	260
12.2.6	Delete Intake .....	261
12.2.7	Display/Print Intake.....	261
<b>13.0</b>	<b>Reports (Roll and Scroll Only).....</b>	<b>264</b>
13.1	Patient Listings (PAT).....	264
13.1.1	Active Client List (ACL).....	265
13.1.2	Patient General Retrieval (PGEN) .....	266
13.1.3	Designated Provider List (DP) .....	269
13.1.4	Patients with AT LEAST N Visits (GRT) .....	270
13.1.5	Patients Seen by Age and Sex (AGE) .....	271
13.1.6	Case Status Reports (CASE) .....	273
13.1.7	GAF Scores for Multiple Patients (GAFS) .....	279
13.1.8	Listing of No-Show Visits in a Date Range (NSDR).....	280
13.1.9	Patient List for Personal Hx Items (PERS) .....	282
13.1.10	Placements by Site/Patient (PPL).....	282
13.1.11	Listing of Patients with Selected Problems (PPR) .....	283
13.1.12	Screening Reports (SCRN) .....	285
13.1.13	Treatment Plans (TPR).....	315
13.1.14	Patients seen in groups w/Time in Group (TSG) .....	316
13.2	Behavioral Health Record/Encounter Reports (REC) .....	317
13.2.1	List Visit Records, Standard Output (LIST).....	317
13.2.2	List Behavioral Hlth Records, General Retrieval (GEN) .....	319
13.3	Workload/Activity Reports (WL).....	323

13.3.1	Activity Report (GRS1)	323
13.3.2	Activity Report by Primary Problem (GRS2)	325
13.3.3	Activity Record Counts (ACT)	326
13.3.4	Program Activity Time Reports (PROG)	328
13.3.5	Frequency of Activities (FACT)	328
13.3.6	Frequency of Activities by Category (FCAT)	330
13.3.7	Tally of Prevention Activities (PA)	331
13.4	Problem Specific Reports (PROB)	332
13.4.1	Abuse Report (ABU)	333
13.4.2	Frequency of Problems (FDX)	333
13.4.3	Frequency of Problem (Problem Code Groupings) (FPRB)	335
13.4.4	Frequency of Problems by Problem Category (FPRC)	337
13.4.5	Suicide Related Reports (SUIC)	339
13.5	Print Standard Behavioral Health Tables (TABL)	345
13.5.1	Print Activity Code Table (ACT)	345
13.5.2	Print Clinic Codes (CLN)	346
13.5.3	Print Behavioral Health Problem Codes (PROB)	346
<b>14.0</b>	<b>Manager Utilities Module (Roll and Scroll)</b>	<b>348</b>
14.1	Update Site Parameters (SITE)	348
14.2	Export Utility Menu (EXPT)	357
14.2.1	Generate BH Transactions for HQ (GEN)	358
14.2.2	Display a Log Entry (DISP)	359
14.2.3	Print Export Log (PRNT)	359
14.2.4	Re-generate Transactions (RGEN)	360
14.2.5	Re-set Data Export Log (RSET)	361
14.2.6	Check Records Before Export (CHK)	361
14.2.7	Print Error List for Export (ERRS)	362
14.2.8	Create OUTPUT File (OUTP)	362
14.2.9	Set Automated Export Option (SAE)	362
14.3	Re-Set Patient Flag Field Data (RPFF)	363
14.4	Display Log of Who Edited Record (DLWE)	363
14.5	Add/Edit Local Service Sites (ELSS)	364
14.6	Add Personal History Factors to Table (EPHX)	365
14.7	Delete BH General Retrieval Report Definitions (DRD)	365
14.8	Edit Other EHR Clinical Problem Code Crosswalk (EEPC)	366
14.9	Update Locations a User can See (UU)	367
<b>Appendix A:</b>	<b>Activity Codes and Definitions</b>	<b>369</b>
A.1	Patient Services - Patient Always Present (P)	369
A.2	Support Services - Patient Not Present (S)	372
A.3	Community Services (C)	374
A.4	Education Training (E)	375
A.5	Administration (A)	375
A.6	Consultation (L)	376
A.7	Travel (T)	377



A.8	Placements (PL) .....	377
A.9	Cultural Issues (O).....	377
<b>Appendix B:</b>	<b>Activity Codes that Pass to PCC.....</b>	<b>379</b>
<b>Appendix C:</b>	<b>ICD-9 Codes .....</b>	<b>381</b>
<b>Appendix D:</b>	<b>DSM Copyright and Trademark Information .....</b>	<b>385</b>
D.1	10.2 Copyright .....	385
D.2	10.3 Trademark .....	385
<b>Appendix E:</b>	<b>Rules of Behavior .....</b>	<b>386</b>
E.1	All RPMS Users .....	386
E.1.1	Access.....	386
E.1.2	Information Accessibility .....	387
E.1.3	Accountability .....	387
E.1.4	Confidentiality .....	388
E.1.5	Integrity.....	388
E.1.6	System Logon.....	388
E.1.7	Passwords.....	389
E.1.8	Backups.....	390
E.1.9	Reporting.....	390
E.1.10	Session Timeouts .....	390
E.1.11	Hardware .....	390
E.1.12	Awareness.....	391
E.1.13	Remote Access .....	391
E.2	RPMS Developers .....	392
E.3	Privileged Users.....	393
<b>Glossary.....</b>		<b>395</b>
<b>Acronym List .....</b>		<b>398</b>
<b>Contact Information .....</b>		<b>399</b>

## 1.0 Introduction

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

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

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

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

While this package is integrated with other modules of RPMS, including the Patient Care Component (PCC), the package uses security keys and site-specific parameters to maintain the confidentiality of patient data. The package is 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 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 (Patch 1)

                          DEMO INDIAN HOSPITAL

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

Select Behavioral Health Information System Option:

```

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

## 1.2 Preparations

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

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

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

## 1.3 Security Keys

Security keys should only be assigned to personnel with privileged access to confidential behavioral health data. Program Managers should meet with the Site Manager when assigning these keys, as shown in Table 1.

**Table 1: Security Keys**

Key	Permits Access To
AMHZMENU	Top-Level menu (AMHMENU)
AMHZMGR	Supervisory-Level/Manager options
AMHZ DATA ENTRY	Data Entry module
AMHZ RESET TRANS LOG	Reset the Export log
AMHZDECT	Data Entry Forms Count Menu option
AMHZHS	BHS Health Summary Component

---

<b>Key</b>	<b>Permits Access To</b>
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 Behavioral Health System and the RPMS Behavioral Health System Graphical User Interface (GUI).

### 2.1 Standard Conventions (Roll and Scroll)

#### 2.1.1 Caps Lock

Always work with the Caps Lock on.

#### 2.1.2 Default Entries

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

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

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

#### 2.1.3 Help

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

#### 2.1.4 To Back Out

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

#### 2.1.5 Exit

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

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

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

## 2.1.6 Same Entries

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

## 2.1.7 Lookup

Be careful of misspellings. If unsure of the spelling of a name or an entry, use only the first few letters. RPMS will display all choices that match those beginning letters, as shown in Figure 2-2.

PATIENT NAME: W&&RM					
1	W&&&RMAN, BARRY	M	05-05-1989	054270542	PIMC 101623
					SE 101624
2	W&&&MAN, CHRIS Y	F	06-16-1954	001290012	PIMC 100039
					HID 100040
					SE 100041

Figure 2-2: Patient lookup screen

## 2.1.8 Pause Indicator

The <> symbol is displays when a multiple page report reaches the bottom of a display screen and there are additional pages in the report.

1. Press Return to see the next page.
2. Type the 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.

- 130 – 1:30 PM
- 130A – 1:30 AM
- If the system prompts for both date and time, the acceptable formats are:
- T@1 – Today at 1 PM
- 4/3@830 – April 3 at 8:30 AM

### 2.1.10 Stop

Press C-Ctrl to stop a report or to exit from the program immediately.

### 2.1.11 Delete

Type @ (at sign) in a field to delete the existing data.

## 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.

The mouse pointer may not be used to select a menu item on the RPMS terminal.

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

In Figure 2-3, two question marks (??) were keyed at the “Select Action:” prompt to see the list of secondary options available.

#	PRV	PATIENT NAME	HRN	AT	ACT	PROB	NARRATIVE
1	DKR	W&&RMAN,RAE	SE100003		31	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, complete the following actions:

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



For example, if you were many pages into a patient's Face Sheet and wanted to know the patient's age, you could use SL, then type the age, and press Return to be moved to the Age field.

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

## 2.3 ScreenMan (Roll and Scroll)

### 2.3.1 Using the ScreenMan Window

When using ScreenMan for entering data, press Enter to accept defaulted data values or after you enter a data value into a field. Use the tab or arrow keys to move between fields or to 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, the system displays that information on the screen, as shown in Figure 2-4.

```

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

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

Activity:      Activity Time:             # Served: 1      Interpreter?

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

COMMAND:                                     Press <PF1>H for help      Insert

```

Figure 2-4: Using ScreenMan sample screen 1

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

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

### 2.3.2 Using the Pop-up Window

Press Enter to move between fields, when inputting data in a screen. Press Tab to move to the “Command” prompt (Close option by default). Press Enter to close the screen and return to the original data entry screen, as shown in Figure 2-5.

```

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

Encounter Date: MAR 27,2001          User: RH0000,DOROTHY K
Patient Name: MUUUUU,SALLY
-----

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

-----
Close      Refresh

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

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

```

Figure 2-5: Using ScreenMan, sample screen 2

Press Enter to open a text editor screen, as shown in Figure 2-6.

```

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

```

Figure 2-6: Using ScreenMan, sample screen 3

## 2.4 Full Screen Text Editor (Roll and Scroll)

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

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

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

Table 2 lists the most commonly used RPMS text editor commands.

**Table 2: 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 is a sample Text Edit screen:

```

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

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

```

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

Press **F1** and type **H** to display all available commands for the RPMS Full Screen Editor (Figure 2-8). Type a caret (^) to exit the Help screens.

```

* BEHAVIORAL HEALTH VISIT UPDATE *      [press <F1>E when visit entry is complete]
Encounter Date: OCT 1,2009                User: THETA,SHIRLEY
Patient Name:  ALPHAA,CHELSEA MARIE      DOB: 2/7/75      HR#: 116431

```

```

-----
Display/Edit Visit Information Y          Any Secondary Providers?: N

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

Activity:      Activity Time:      # Served: 1      Interpreter?

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

-----

COMMAND:                                     Press <PF1>H for help      Insert

```

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

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

## 2.5 Word Processing Editors (Roll and Scroll)

If you see Figure 2-9 when entering a word processing field, then your default editor has been set to the RPMS line editor.

```
1>
```

Figure 2-9: RPMS line editor default

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

1. At any menu prompt, type **TBOX**. ToolBox (Figure 2-10) is a secondary menu option that all users can access but do not normally see on their screen.

```

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

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

Change my Division
Display User Characteristics
Edit User Characteristics
Electronic Signature code Edit

```

```

Menu Templates ...
Spooler Menu ...
Switch UCI
TaskMan User
User Help

Select User's Toolbox Option: Edit User Characteristics

```

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

2. At the “Select User’s Toolbox Option” prompt, type “Edit User Characteristics” from TBOX and a window will be displayed.
3. Press the down arrow key on your keyboard to move to the Preferred Editor field. To change your preferred editor to the Screen Editor, type **SC**. Continue to press the down arrow until the cursor reaches the “Command:” prompt.
4. At the “Command” prompt, type **S** and press Enter to save your changes. Type **E** and press Enter to Exit the screen. The Edit User Characteristics screen and fields are shown in Figure 2-11.

```

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

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

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

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

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

```

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

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

## 2.6 Pop-up Windows (GUI)

The application displays pop-up windows (Figure 2-12) that have the same functional controls on them. Generally, these are Crystal Report windows

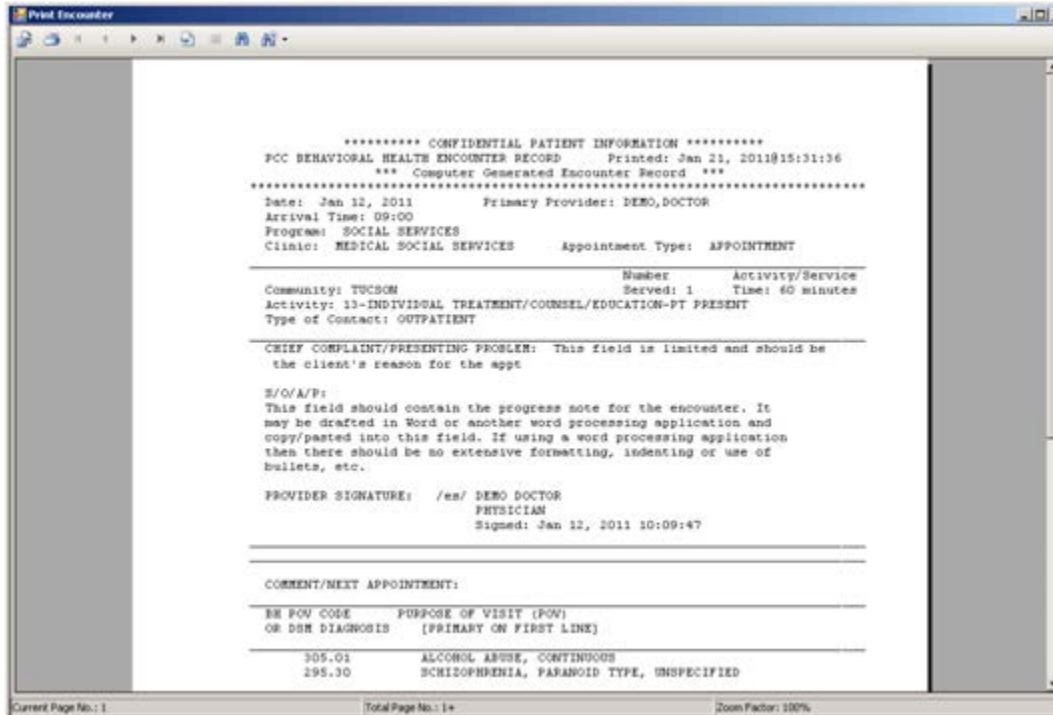


Figure 2-12: Sample pop-up window

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

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

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

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. Otherwise, you can specify the page number to move to. Section 2.6.2 provides more information about the buttons on the toolbar.


### 2.6.1 Buttons on Title Bar

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


## 2.6.2 Buttons on the Toolbar

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

### 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 pop-up.

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

### 2.6.2.3 Go To Page

Click the **Go To Page** button () to specify a page to move to. Figure 2-13 shows the Go To Page dialog.

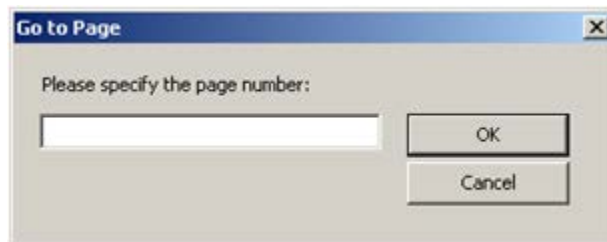


Figure 2-13: Go to Page dialog

Type the page number to go to (in the Free Text field) and click OK to displays the page. If a page outside the range of pages is enter, a blank page displays.

### 2.6.2.4 Find Text

Click the **Find Text**  button to display the dialog shown in Figure 2-14.




Figure 2-14: Find Text dialog

Click the **Find what** button to search for a text string. When found, the line of text is highlighted. Keep clicking the button to search for more occurrences.

When the system reaches the end of the search process, the application display a message: informing you that the application has finished searching the document. Click **OK** to close the message.

Click **Cancel** to close the dialog.

### 2.6.2.5 Zoom Button

Click Zoom  to change the size of the text of the pop-up (for easier reading, for example). This setting does not affect the output of the pop-up.

## 2.7 Using the Calendar (GUI)

Date and time fields exist throughout the GUI (Figure 2-15).



Figure 2-15: Sample Date and Time field

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

- Type in the field:
  - Type M in the day item set the day to Monday
  - Type 09 in the month item changes the month to September
- Place the cursor in an item (day of week, month, etc.) and press the up or down arrow keys to step through the available options.
- Click the date field's list to display the Calendar shown in Figure 2-16.



Figure 2-16: Sample Calendar for Date Field

The calendar always indicates the date for today. Set a different date by selecting it; the selected date will display in the Date field. To manipulate the calendar further:



- To change the year, click the year label and click the up and down button to step through the years (Figure 2-17).



Figure 2-17: Change Year

- To display the previous or next month's calendar, click the left or right arrow button.
- To display a specific month, click the month label, and select from the list displayed (Figure 2-18).



Figure 2-18: List of Months to Select

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

## 2.8 Using the Search Window (GUI)

Several fields in the application when clicked displays a search dialog. For example, the Community field would access the Community search dialog, as shown in Figure 2-19.



Figure 2-19: Community search dialog

This type of window has similar functionality for other fields.

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

Type a few characters in the **Search String** field and click **Search** to retrieve records. The retrieved records will display in the Community group box.

Select a record and click **OK** to open the form.

Select a record from the **Most Recently Selected** field and click OK.

Right-click the field and click **Clear** to remove the contents of the field.

## 2.9 Using the Search/Select Window (GUI)

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

For example, the **Add** button on the POV tab of the Visit Data Entry screen displays the dialog shown in Figure 2-20.

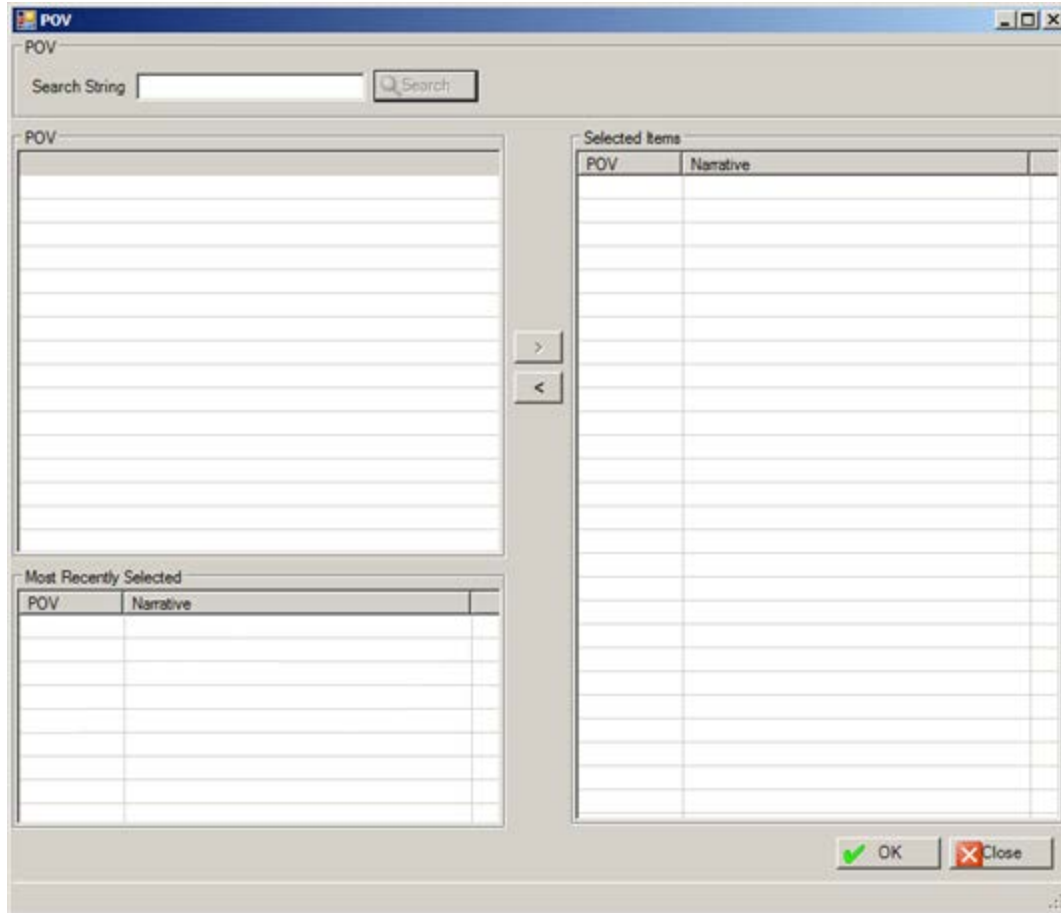


Figure 2-20: Sample Search/Select window

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

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

Type a few characters in the **Search String** field and click **Search** to retrieve records.

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

Click the right arrow button to add one or more records from the **POV** group box to the **Selected Items** group box.

Click the left-pointing arrow button to remove one or more selected records from the **Selected Items** group box.

When you have the records you want in the **Selected Item** group box, click the **OK**.

## 2.10 Using the Multiple Select Window (GUI)

Several fields in the application have fields that display a multiple select window, as shown in Figure 2-21.

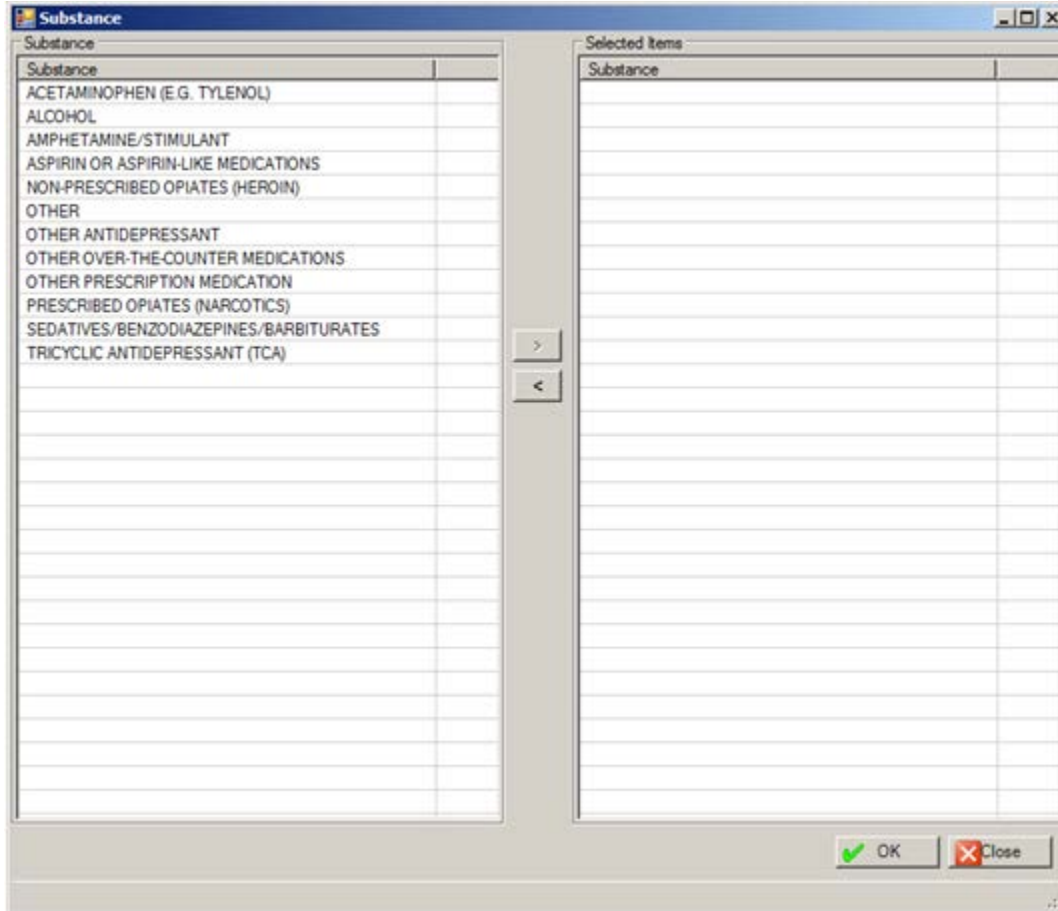


Figure 2-21: Sample multiple select window

Click **Close** to dismiss the window.

To add one or more selected items in the Substance group box to the **Selected Items** group box, click the right-pointing arrow. Select more than one code by holding down the Ctrl key and selecting the next code.

To move one or more selected records from the **Selected Items** group box to the **Substance** group box, click the left-pointing arrow.

When you have the records you want in the **Selected Item** group box, click the **OK**.

## 2.11 Free Text Fields (GUI)

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

An example of the free text field is the Progress Notes field.

To aid in editing the text, a context menu is available, as shown in Figure 2-22.

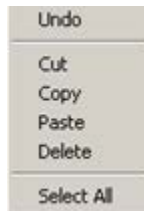


Figure 2-22: Context menu to aid in editing text

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

**Undo:** removes the last edit action.

**Cut:** removes the selected text from its current position and places it on the clipboard.

**Copy:** copies the selected text and places it on the clipboard (the text is NOT removed).

**Paste:** copies the contents of the clipboard and places it in the field at the current cursor position.

**Delete:** removes the selected text from its current position.

**Select All:** highlights all of the text in the current field.

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

## 2.12 Selecting a Patient

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

### 2.12.1 Patient Selection (Roll and Scroll)

You are asked to select a patient at the “Select Patient” prompt. Use a few characters of the patient’s last name (at least 3), Social Security Number (SSN), Health Record Number (HRN), or date of birth (use format MM/DD/YYYY). The application will accept either form of the patient’s name in the search criteria: LASTNAME,FIRSTNAME or LASTNAME, FIRSTNAME (space after the comma).

### 2.12.2 Patient Selection (GUI)

You 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)
- When you want to change patients. You can change patients by selecting Patient | Select or by right-clicking on the menu tree.

Figure 2-23 displays the Select Patient dialog.

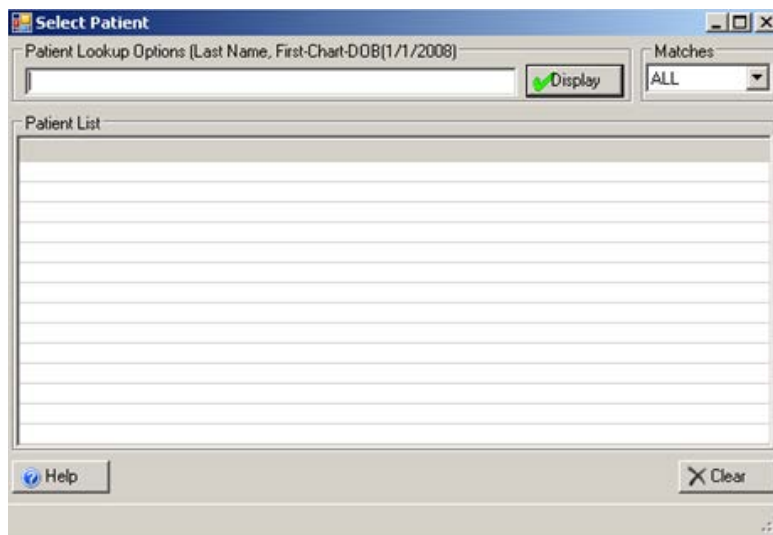


Figure 2-23: Select Patient dialog

Click **Help** to access the online help for this dialog.

Click **Clear** button to remove all data from the **Patient List** group box.

At the **Patient Lookup Options (Last Name, First Chart DOB (date))** field, type a few characters of the patient’s last name (at least 3), Social Security Number (SSN), Health Record Number (HRN), or date of birth (use format MM/DD/YYYY). You can determine the number of matches by selecting an option from the **Matches** drop-down list (the default is All).

Click **Display** to enter the search criteria.

The valid candidates are retrieved as shown in Figure 2-24 and displayed in the **Select Patient** window. If there are no candidates, then the group box remains empty. In addition, a message will display in the bottom left corner stating: 0 records found.

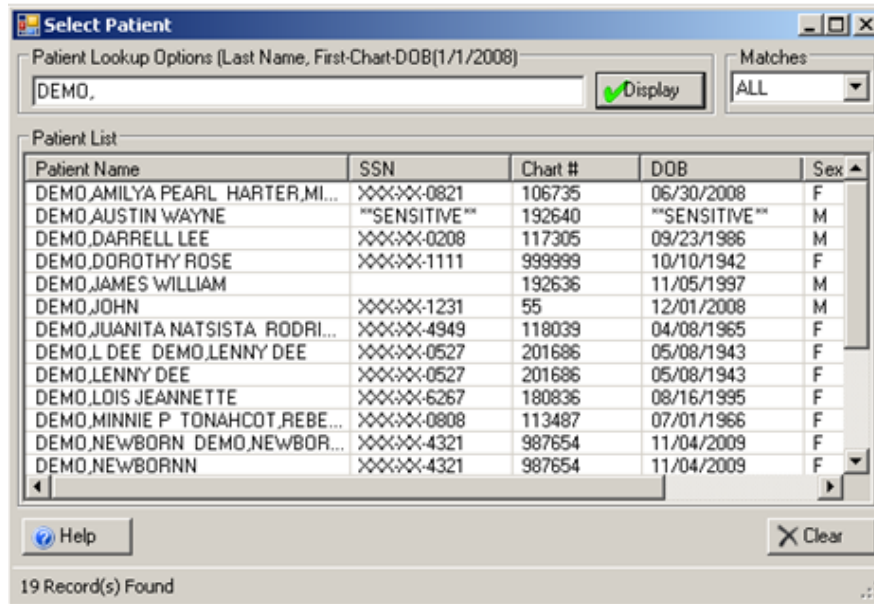


Figure 2-24: Sample Select Patient dialog

Use the scroll bars to scroll through the retrieved names. Double-click the patient you want to view.

## 2.13 Sensitive Patient Tracking

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

If a patient is listed as Sensitive in the Sensitive Patient Tracking application (Figure 2-25), the word SENSITIVE will be displayed in Social Security, Date of Birth, and Age columns on the Select Patient dialog.

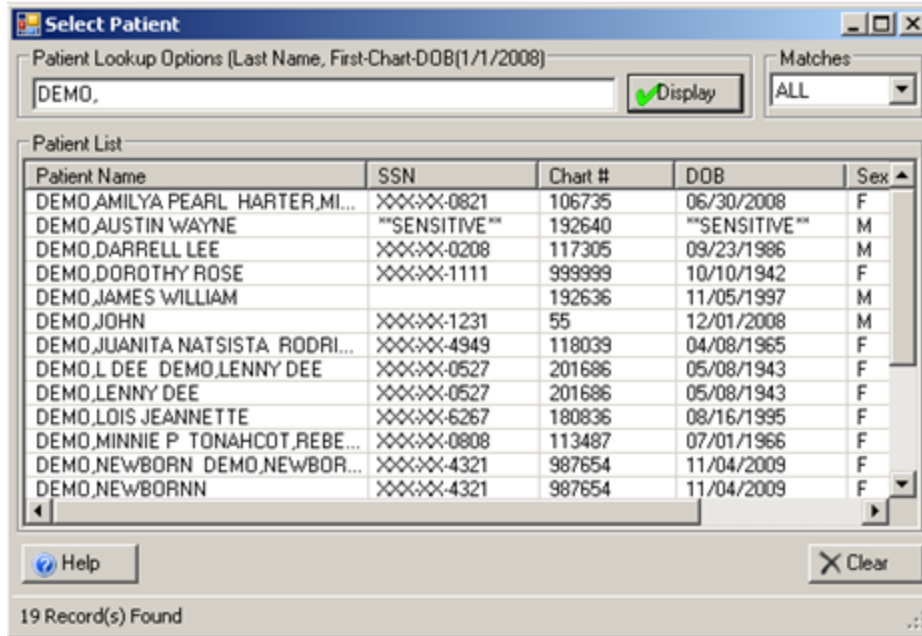


Figure 2-25: Sample Select Patient dialog showing sensitive patient

Figure 2-26 displays the Continue with this Record message.



Figure 2-26: Warning message displayed in GUI

Click **Yes** to access the patient's record.

Click **No** to return to the Select Patient dialog.

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

The Restricted Record warning message is shown in Figure 2-27.

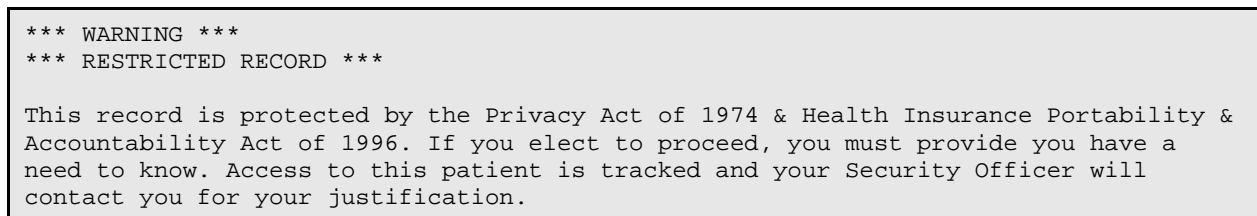


Figure 2-27: Warning message about restricted record in roll and scroll

A simple warning message is shown in Figure 2-28.



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

Figure 2-28: Shorter warning message in Roll and Scroll

Press Enter to access the patient's record.

Type ^ and the patient record will not display.

## 2.14 Electronic Signature

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

### 2.14.1 Creating Your Electronic Signature

The User's Toolbox option in RPMS will setup the electronic signature. Use the option in bold (Electronic Signature Code Edit), as shown in Figure 2-29:

```
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 2-29: Options on the TBOX User's Toolbox

Prompts will appear for the electronic signature on SOAP/progress notes, as shown in Figure 2-30. Do not enter credentials (such as MD) under both the block name to prevent the credentials from appearing twice. Ensure the printed signature block printed name contains the appropriate name and credentials.

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

Figure 2-30: Prompts that display at the beginning of the process


The prompt to enter the current electronic signature is shown in Figure 2-31.



Enter your Current Signature Code:

Figure 2-31: Prompt to enter your current electronic signature

Enter a new electronic signature code as shown in Figure 2-32.



Enter code:

Figure 2-32: Prompt for a new code

Enter a new code (using between 6 and 20 characters) with Caps Lock ON.  
(special characters are not allowed in the code.)

If you forget the code, it must be cleared out by your Site Manager and a new one must be created. 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 Health Record).

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

## 2.14.3 Data Entry Requirements (Roll and Scroll)

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

The sample in

Figure 2-33 shows the electronic signature and date/time stamp in the SOAP/Progress Note section of the printed encounter record.

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

Figure 2-33: Sample date/time stamp for electronic signature

#### 2.14.4 Assign PCC Visit

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

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

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

#### 2.14.5 Signing a Note (GUI)

If you have entered a SOAP/progress note, the **Sign?** dialog, as shown in Figure 2-34.

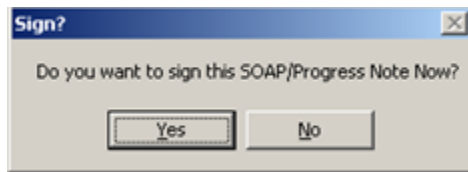


Figure 2-34: Sign dialog

Click **No** to save the note without a signature.

Click **Yes** to display the Electronic Signature dialog. In Figure 2-35.

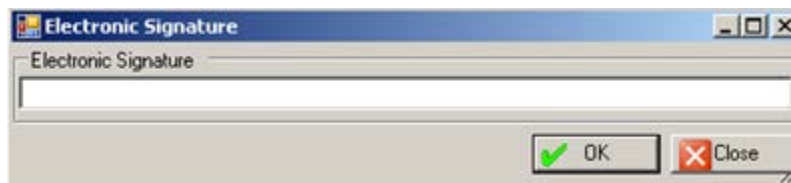


Figure 2-35: Electronic Signature dialog

Input a 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 that states: Invalid Signature Code. Click **OK** to return to the Electronic Signature dialog.

Click **Close** on the Electronic Signature dialog and the message 'Are You Sure?' dialog displays, as shown in Figure 2-36.

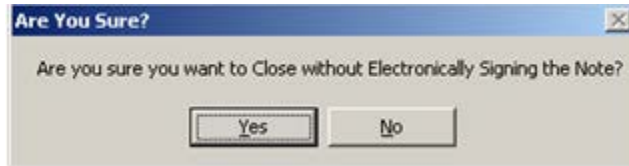


Figure 2-36: Are you Sure dialog

Click **No** to return to the Electronic Signature dialog.

Click **Yes** to display the Message dialog, as shown in Figure 2-37.



Figure 2-37: Text of Message

Click **OK** and the record will not have a signed note.

### 2.14.6 Signing a Note (Roll and Scroll)

Save and exit an encounter record, then enter a note; a prompt for a signature displays, as shown in Figure 2-38.

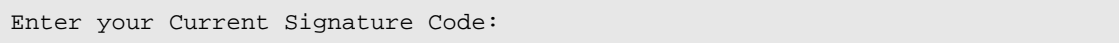


Figure 2-38: Prompt asking for your current signature code

If you use your valid electronic signature, the encounter record with a signed note is saved.

If you use an invalid electronic signature, the encounter with a signed note will not be saved.

If you edit a visit with a signed note, you get a message indicating that the note cannot be edited, as shown in Figure 2-39.

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

Figure 2-39: Message about progress note already signed.

If you edit the note with an unsigned note and you are not the primary provider, you will receive a message, as shown in Figure 2-40.

Only the Primary provider is permitted to sign a note.

Figure 2-40: Message about only primary provider can sign a note

## 2.15 Login to GUI

If this is the first time you login to the GUI, the **IHS Behavioral Health System Login** dialog display (Figure 2-41).



The screenshot shows a dialog box titled "IHS Behavioral Health System Login". It contains the following elements:

- RPMS Server:** A drop-down menu.
- Access Code:** A text input field.
- Verify Code:** A text input field.
- Use Windows Authentication
- Buttons:** "OK" and "Cancel".
- Description:** A text box containing the text: "Use this panel to enter the Access and Verify codes that you use to log in to the RPMS server."

Figure 2-41: Initial login dialog

Click **Edit Connections** option on the drop-down list for the RPMS Server field. The RPMS Server Connection Management dialog displays, as shown in Figure 2-42.

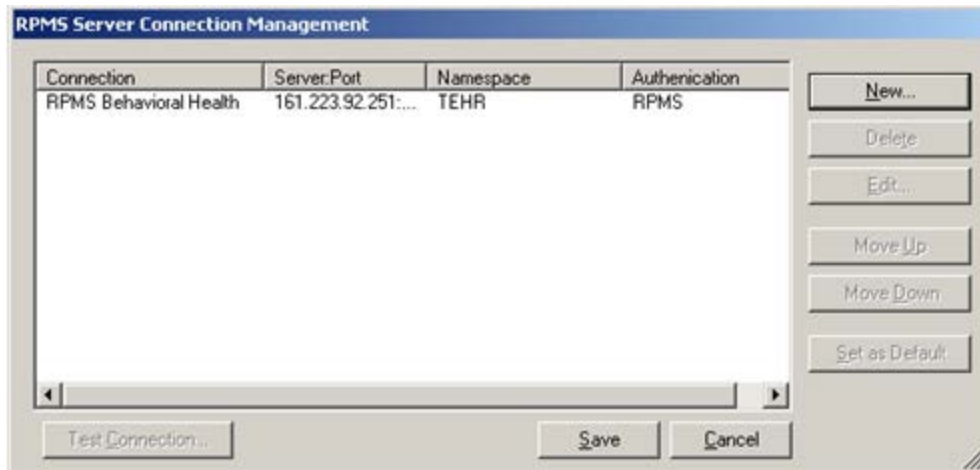


Figure 2-42: Sample RPMS Server Connection Management dialog

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

The **Edit RPMS Server Connection** dialog displays, as shown in Figure 2-43.

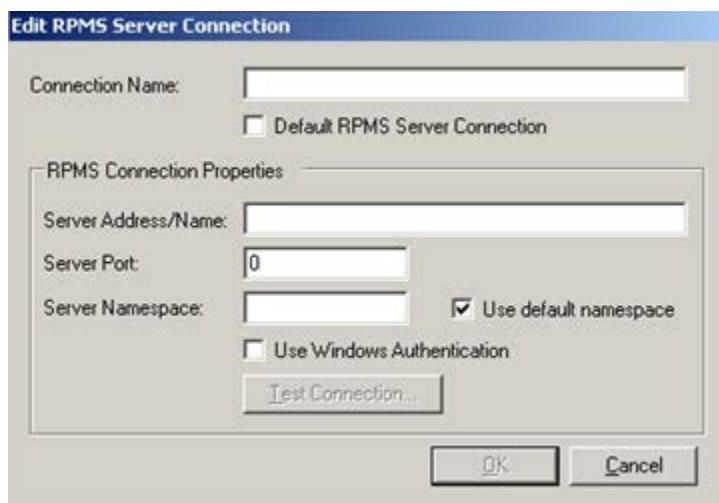


Figure 2-43: Sample Edit RPMS Server Connection dialog

Do not check the “Default RPMS Server Connection” or “Use Windows Authentication” checkboxes.

On the **Edit RPMS Server Connection** dialog, type one of the following:

- **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.

- **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.
- **Use default namespace:** Check this checkbox if the Server Namespace is the default one you want to use.
- **Test Connection:** After populating the fields, this button becomes active. Click it to display the Test Login dialog. Populate the “Access Code” and “Verify Code” fields and then click OK.

Click OK to accept and the application displays the Connection Test message that states: RPMS login was successful. Click OK to

If an error message displays, click **OK** to return to the Test Login dialog.

Click Save after the RPMS Server Connection Management dialog is complete.

Figure 2-44 displays the **IHS Behavioral Health System Login** dialog.

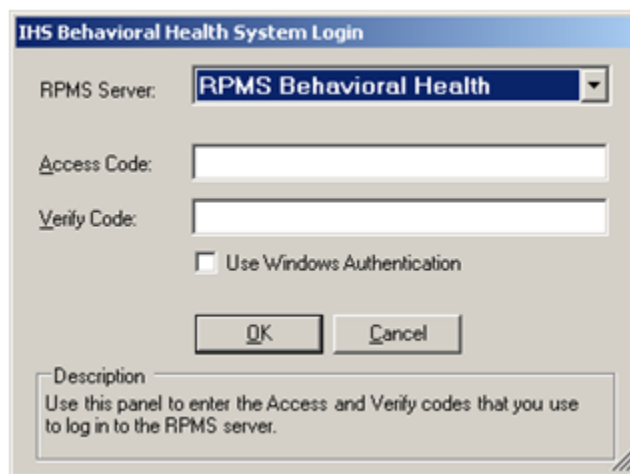


Figure 2-44: Sample login dialog

The designated server displays in the RPMS Server field.

Type the RPMS access and verify codes. These are the same access and verify codes used to open any RPMS session.

- Do not select the field with the checkbox.

Click OK to access the **RPMS Behavioral Health System** tree.

## 2.16 RPMS Behavioral Health System Tree

Below is the default display of the RPMS Behavioral Health System tree structure, as shown in Figure 2-45.

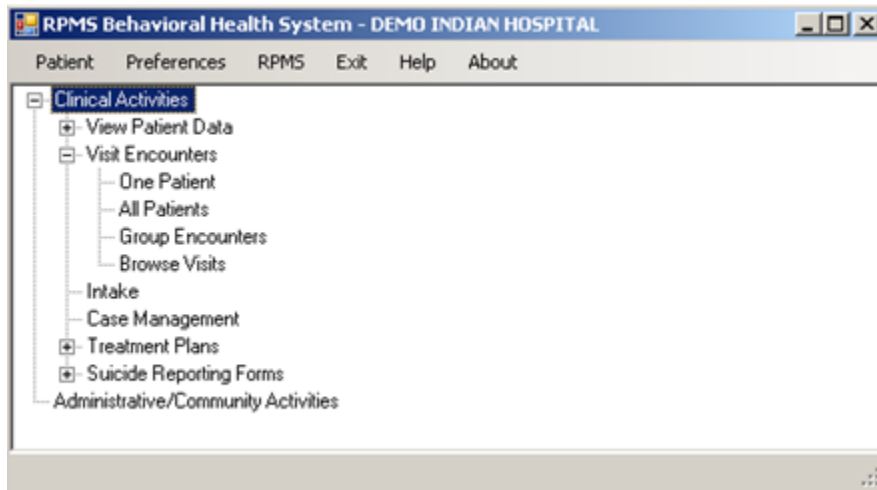


Figure 2-45: Tree structure for the RPMS Behavioral Health System

The tree structure is similar to any tree structure in Microsoft® Office™.

- Click the Minimize (-) icon to collapse the list. The icon will change to the Maximize (+) icon. The **View Patient Data**, **Treatment Plans** and **Suicide Reporting Forms** options are collapsed in Figure 2-45.
- Click the Maximize (+) icon to expand the list. The icon will change to the Minimize (-) icon. The Visit Encounters option is expanded in Figure 2-45.

### 2.16.1 Patient Menu

Select the current patient from the **Patient** menu.

### 2.16.2 Preferences Menu

Select another division as well as change the font on the main menu tree on the **Preferences** menu, as shown in Figure 2-46.

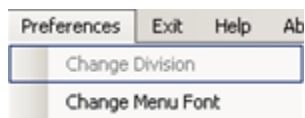


Figure 2-46: Menu options on the Preferences menu



## Change Division

Use the Change Division option to change the RPMS Division. This option applies to a site that uses more than one RPMS database.

## Change Menu Font

Use the Change Menu Font option to change the font on the tree structure. The application displays the Font dialog, as shown in Figure 2-47.

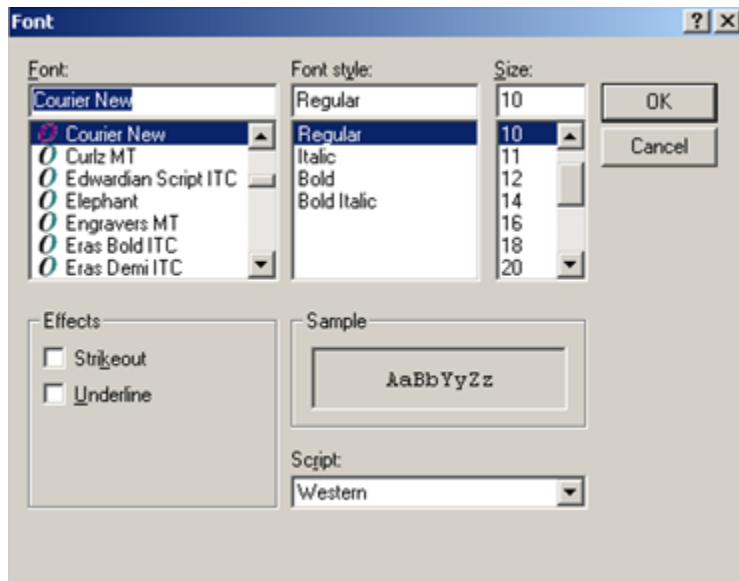


Figure 2-47: Font dialog

Use the **Font** dialog to change the Font name, style, and size of the text on the tree structure. In addition, you can add effects like “Strikeout” and “Underline” - these perform like those effects indicated in MS Word. Most users will change the font size.

Change the **Script** option if you need to see the text displayed in another language and you have that language pack installed on your computer. If the language pack is not installed on your computer, the display will not change by selecting another script.

Click **OK** to apply your changes to the text on the tree structure. (Otherwise, click **Cancel** and the changes will not be applied.)

### 2.16.3 RPMS Menu

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

2. On the RPMS Terminal Emulator window, select **File | Connect** to access the Connect dialog.
3. Type the IP address in the **Host** field.
4. Click **OK** to access the RPMS system and login.
5. Select **File | Exit** to return to the GUI.

#### 2.16.4 Exit Menu

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

#### 2.16.5 Help Menu

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

#### 2.16.6 About Menu

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

## 3.0 Data Entry

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

### 3.1 Roll and Scroll

Documentation of patient care and documentation of administrative and group encounters are handled through the Data Entry module of the Behavioral Health system (Figure 3-1). We recommend that providers do their own data entry at the time of a patient encounter. However, a provider can document patient care on a BHS Encounter Form for data entry later by trained program support staff. Choosing **DE** from the Behavioral Health main menu can access the options for data entry.

```

*****
**      IHS Behavioral Health System      **
*****
                Version 4.0 (Patch 4)
                DEMO INDIAN HOSPITAL

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

Select Behavioral Health Information System Option:  DE

```

Figure 3-1: Data Entry Module

The **DE** option has the options shown in Figure 3-2.

```

*****
**      IHS Behavioral Health System      **
**                Data Entry Menu        **
*****
                Version 4.0 (patch 4)
                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

Select Behavioral Health Data Entry Menu Option:  PDE

```

Figure 3-2: Data Entry menu

Below is an overview of the options on the Data Entry Menu.

**Enter/Edit Patient/Visit Data - Patient Centered (PDE):** documents a patient encounter and displays all the information required for a single patient from a single screen.

**Enter/Edit Visits Data - Full Screen Mode (SDE):** type the appropriate set of defaults to be used in Data entry.

**Group Form Data Entry Using Group Definition (GP):** type the encounter data when the encounter involves a group of patients.

**Display Record Options (DSP):** displays visit information about particular encounters.

**Update BH Patient Treatment Plans (TPU):** manages treatment plans for a patient.

**View/Update Designated Provider List (DPL):** updates and manages a provider's patient panel.

**Edit BH Data Elements of EHR created Visit (EHRE):** edits BH data for a visit that was created in the RPMS Electronic Health Record (EHR) application.

**Listing of EHR Visits with No Activity Time (EBAT):** lists the behavioral health EHR visits that have no activity time.

**Suicide Reporting Forms - Update/Print (SF):** updates, reviews, and prints IHS Suicide forms that have been entered into the BHS module.

## 3.2 RPMS Behavioral Health System Graphical User Interface (GUI)

The data entry options are located under the Visit Encounters category on the tree structure for the RPMS Behavioral Health System (GUI) (Figure 3-3).

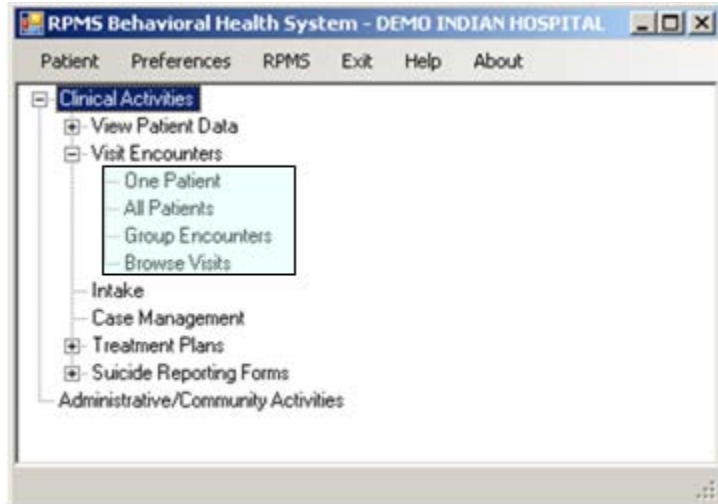


Figure 3-3: Location of Visit Encounters category on tree structure

**One Patient:** manages the visits for the one patient within a particular date range.

**All Patients:** manages the visits for all of the patients within a particular date range.

**Group Encounters:** manages the Group Encounter data for group encounters within a particular date range.

**Browse Visits:** displays visit information for the current patient within a particular date range.

## 4.0 One Patient Visit Data

This section provides information on how to manage the visit data of one patient for the RPMS BHS Roll and Scroll application and the BHS GUI.

### 4.1 Enter or 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 IHS Behavioral Health System Data Entry Menu.

```

*****
**          IHS Behavioral Health System          **
**                Data Entry Menu                **
*****
                        Version 4.0 (patch 4)

                        SELLS HOSPITAL

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

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

```

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

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

#### 4.1.1 Enter or Edit Patient/Visit Data - Patient Centered (PDE)

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

Below are the prompts:

##### Select 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 (Figure 4-2).

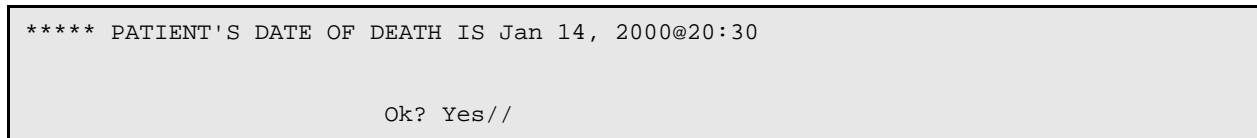


Figure 4-2: Information about patient's date of death

- Type **No** at the “OK” prompt to return to the “Enter Patient Name” prompt.
- Type **Yes** at the OK prompt to go to the Patient Data Entry window.

If the patient is living, the Patient Data Entry window displays as in Figure 4-3.

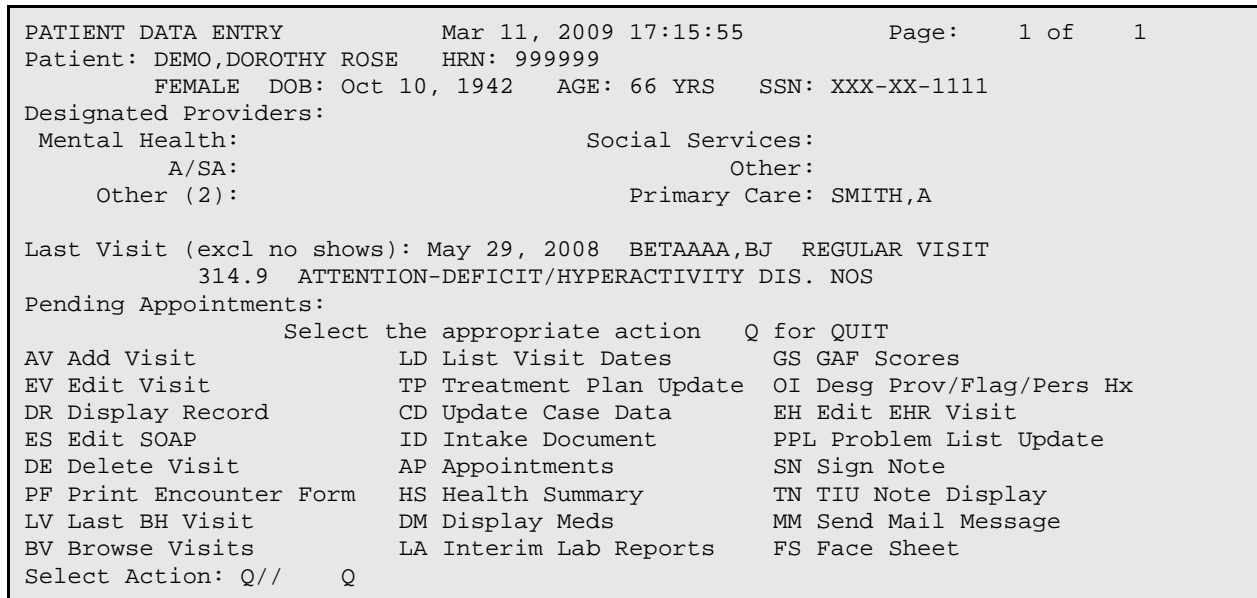


Figure 4-3: Sample Patient Data Entry window

The following fields display when using the Add Visit (**AV**) and Edit Visit (**EV**) options at the “Select Action” prompt.

### Which set of default 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), or O (Other).

### Enter ENCOUNTER DATE

Specify the date of the encounter. Section 2.1.9 provides more information about entering dates.

The application displays “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.

If you used Edit Visit (**EV**) option, the application displays the Behavioral Health Record Edit window. Section 4.1.4 provides more information about this window.

If you used the Add Visit (**AV**) option, the application displays the Behavioral Health Visit Update screen. Section 4.1.3 provides more information about this screen.

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

Use the SDE option to specify 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.

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 “Creating new record” message when adding a visit.

The application displays the Update BH Forms window (Figure 4-4).

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	SN	Sign Note
AC	Add Adm/Comm Activity	ID	Intake Document	TN	Display TIU Note
EV	Edit Record	HS	Health Summary	PPL	Patient's Problem List
OI	Desg Prov/Flag	ES	SOAP/CC Edit	AP	Appointments
DR	Display Record	SD	Switch Dates	MM	Send Mail Message
DE	Delete Record	EH	Edit EHR Record	Q	Quit
Select Action:					

Figure 4-4: Sample Update BH Forms window

The asterisk (\*) preceding the number of the encounter record indicates that the record contains an unsigned note. Section Electronic Signature 2.14 provides more information about the electronic signature.

Use the EV option to edit a selected record (patient visit). Section 4.1.4 provides more information about this option. Use the AV option to add a patient visit.

The PPL option is fully described below. Section 9.0 provides more information about the problem list.

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

#### **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 default is the current logon user).

The application displays the Behavioral Health Visit Update screen.

### 4.1.3 Using the Behavioral Health Visit Update Screen

Figure 4-5 shows the Behavioral Health Visit Update screen that is used to enter patient visit data.

```

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

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

Any Patient Education Done? N          Any Screenings to Record? N
Any Measurements? N                   Any Health Factors to enter? N

```

```

Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Placement Disposition:
Visit Flag:      Local Service Site:
-----
COMMAND:                               Press <PF1>H for help   Insert

```

Figure 4-5: Sample Behavioral Health Visit Update screen

If you save the data on 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. Section 2.14.6 provides more information about signing a note.

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

### Arrival Time

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

### Display/Edit Visit Information

Use N or Y (the default). Use Y to access the Visit Information pop-up, as shown in Figure 4-6.

```

          ***** 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 on 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 on the Site Parameters menu.

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

**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:** This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table.

**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 that is included in the RPMS community code set.

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

### Any Secondary Providers?

Use Y or N (the default) to indicate if there were any additional secondary BHS providers that were also providing care during this particular encounter. Use Y to access the Enter/Edit Providers of Service pop-up (Figure 4-7).

```

*****  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

The underlined fields are required.

**PROVIDER:** Specify the secondary provider name.

**PRIMARY/SECONDARY:** Populate with the type of provider. Only one primary provider can be used, while there can be more than one secondary provider.

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

### Chief Complaint/Presenting Problem

Specify the chief complaint or presenting problem using 2 to 80 characters in length. 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 Free 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 (Figure 4-8).

```

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

Use '^' at the last prompt to exit this pop-up window.

If you use Return at the last prompt, the cursor jumps to the **DIAGNOSIS** field.

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

**DIAGNOSIS:** Specify the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-5 diagnostic code). Section Appendix D: provides information about DSM copyright and trademark information.

**NARRATIVE:** Specify the text of the narrative for the diagnosis (using 2–80 characters) or use one of the coded narratives by specifying its number.

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

### Any CPT Codes to enter?

Use N or Y (the default). Use Y to access the Add/Edit CPT Procedures pop-up (Figure 4-9).

```

**** 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

The underlined fields are required.

**CPT Code:** Specify the CPT code for Behavioral Health services. The CPT field will also accept Healthcare Procedure Coding System (HCPCS) that are commonly used by Medicare. State and Local codes might be available if the facility's billing office has added them to the RPMS billing package. These codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient. More than one code can be used.

After specifying the CPT, HCPCS, or other billing code, the application prompts for quantities and up to two modifiers.

```

QUANTITY: 1
MODIFIER:
MODIFIER 2:

```

**Quantity:** use the Quantity field to determine the number of CPT codes to use to help facilitate billing.

**Modifier:** use the Modifier field to define the modifier for the CPT code. Up to two modifiers can be used. The modifier is a two-digit code.

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

**Activity**

Specify the activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and will affect the billing process. Section Appendix A: provides more information about activity codes and definitions.

**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, 0 (zero) is not allowed as a valid entry.

**# Served**

Specify the number served, using any number between 0 and 999 (no decimal digits). The default is 1. This refers to the number of people directly served during a given activity and is always used for direct patient care as well as for administrative activities. Group activities or family counseling are examples where other numbers might be listed.

**Interpreter?**

Use 1 (yes) or 0 (no) to indicate if an interpreter was present during the patient encounter. Use Yes only if an interpreter is required to communicate with the patient. This information is available when running reports but is not included on the printed encounter form.

**Any Patient Education Done?**

Use Y or N (the default). Use Y to access the Patient Education Enter/Edit pop-up (Figure 4-10).

```
*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

**Display Patient Education History?:** Use Y or N to display the Behavioral Health and PCC patient education history. This is all education provided in the past 2 years by BH programs. This display is shown in the Output Browser window. You must Quit this window to return to prompts.

**EDUCATION TOPIC:** 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 use “?” at the prompt to view the whole list.

After entering the Education Topic, the application displays the following pop-up (Figure 4-11):

```

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

The underlined prompts are required.

**Education Topic:** the education topic (can be changed).

**Individual/Group:** Specify if the education is for an individual or for a group.

**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 for the visit (can be changed). The default is the current logon user.

**Minutes:** Specify the number of minutes spent on education, using any integer 1 - 9999.

**Comment:** Add comments about the education topic for the visit, 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

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

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

#### Any Screenings to Record?

Use Y or N (the default). If you use Y, use the displayed fields to record any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter. Use N to accept the default response if no screenings were completed during the visit. Use Y to access the screen as shown in Figure 4-12.

```

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 on the pop-up.

**Display IPV/DV screening History?:** use Y or N. If you use 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 result of the intimate partner violence/domestic violence screening. Use one of the following:

- N - Negative
- PR - Present
- PAP - Past and Present
- PA - Past
- REF - Patient Refused Screening
- UAS - Unable to screen

**IPV Screening Provider:** Specify the IPV/DV provider name.

**IPV Comment:** Populate with the text of any comment related to the IPV/DV screening, using 2–245 characters.

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

**Alcohol Screening Result:** Specify the result of the 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, using 2–245 characters.

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

**Depression Screening Result:** Specify the result of the 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.

**Dep Screening Comment:** Populate with the text of any comment related to the depression screening, using 2–245 characters.

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

### Any Measurement?

Use N or Y. Use Y to access the Measurements pop-up (Figure 4-13).

*** Measurements ***		
Measurement Description	Value	Provider
-----	-----	-----

Figure 4-13: Sample Measurements pop-up

**Measurement:** Specify the type of measurement being taken on the patient. Then the application populates the Description field.

**Value :** Specify the numeric value of the measurement. If you populate this field with a value outside the valid value range, the application provides information about what valid values can be used for the field.

**Provider :** Specify the name of the provider.

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?

Use Y or N (the default) to indicate that you want to record health factor information about the patient. Use Y to access the Patient Health Factor Update pop-up (Figure 4-14).

```

***** 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?:** Use N or Y. If you use Y, the health factor history for the current patient displays on another screen. Use quit in order to continue with the prompts.

**HEALTH FACTOR:** Specify the health factor. This is the entry in the Health Factor file that most closely represents the patient's health factor status at the encounter for a given health factor category. The application displays other fields about the health factor (Figure 4-15).

```

LEVEL/SEVERITY
QUANTITY
COMMENTS

```

Figure 4-15: Other fields for health factor data

**Level/Severity:** use **M** (Minimal), **MO** (Moderate), or **H** (Heavy/Severe).

**Quantity:** use 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?

Use Y or N (the default) to display a list of currently dispensed medications. If you use Y, the list displays on the "Medication List for patient" window (Figure 4-16).

```

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>**

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

### **Placement Disposition**

Specify the active disposition. Use this field when hospitalization or placement in a treatment facility is required. Use either the number or first few letters of the placement type. After entering the disposition, the pop-up shown in Figure 4-17 displays:

```

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

```

Figure 4-17: Sample pop-up for facility name

**FACILITY REFERRED TO:** Specify the name of the facility to which the patient was referred.

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 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

Specify the local service site.

### 4.1.4 Using the Behavioral Health Record Edit Window

Use the Behavioral Health Record Edit window (Figure 4-18) to edit an existing visit data.

```

* 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 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 4-18: Sample Behavioral Health Record Edit window

The underlined fields are required.

#### **Date**

The date of the visit.

#### **Location of Service**

Where the service took place.

#### **Program**

Name of the program with which the provider is affiliated.

#### **Outside Location**

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

**Clinic**

This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table.

**Appt/Walk in**

Can be appointment, walk-in, or unspecified (for non-patient 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 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.

**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 (Figure 4-19).

```

***** 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 4-19: Sample Enter/Edit Providers of Service pop-up

**PROVIDER:** Specify the name of the service provider.

**PRIMARY/SECONDARY:** Specify the type of provider (primary or secondary). Only one primary provider can be used while there can be more than one secondary provider.

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

**Local Service Site**

Name of the local service site.

**Activity**

The activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Section Appendix A: provides more information about activity codes and definitions.

**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. Please note, 0 (zero) is not allowed as a valid entry.

**# Served**

The number served at the encounter, any integer between 0 and 999.

**Interpreter Utilized**

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

**Chief Complaint/Presenting Problem**

This information describes the major reason the patient needed services.

**SOAP/PROGRESS NOTE**

Press Enter to access another window that can be populated 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?

Use Y or N. Use Y to access the Purpose of Visit Update pop-up (Figure 4-20).

```

***** BH RECORD ENTRY - PURPOSE OF VISIT UPDATE *****
Encounter Date: MAR 5,2009@12:00      User: THETA,SHIRLEY
Patient Name: DEMO,DARRELL LEE      DOB: 9/23/86  HR#: 117305
[press <F1>C to return to main screen]
-----
DIAGNOSIS:          NARRATIVE:
DIAGNOSIS:          NARRATIVE:
DIAGNOSIS:          NARRATIVE:
DIAGNOSIS:          NARRATIVE:
-----
Patient's Diagnoses from last 5 visits:
5/6/10  312.32 KLEPTOMANIA
8/11/09  300.02 GENERALIZED ANXIETY DISORDER
9/11/09  300.3  OBSESSIVE-COMPULSIVE DISORDER

Enter RETURN to continue or '^' to exit:

```

Figure 4-20: Sample BH Record Entry - Purpose of Visit Update

The underlined fields are required.

**DIAGNOSIS** : Specify the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-5 diagnostic code). Section Appendix D: provides information about DSM copyright and trademark information.

**NARRATIVE**: Populate with the narrative associated with the diagnosis to more clearly identify the reason for the visit. For example, if Problem code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient's housing issue - homeless, being evicted, etc.

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

### Edit Prevention Activities

Press Enter to access another screen where you can enter prevention activities (Figure 4-21).

```

Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:

```

Figure 4-21: Fields that define the prevention activities

**Prevention Activity**: Indicate the prevention activity



**Target:** Indicate the target for the activity as one of the following: A (Adult), Y (Youth), or F (Family)

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

### Edit CPT Codes?

Use Y or N. Use Y to access the Add/Edit CPT Procedures pop-up (Figure 4-22).

```

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

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

```

Figure 4-22: Sample Add/Edit CPT Procedures window

The underlined fields are required.

**CPT Code:** Specify the CPT Code field (more than one can be used). These E&M codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient.

To edit a CPT Quantity or Modifier, highlight the CPT code and press Enter.

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

### Edit Health Factors?

Use Y(yes) or N (no). Use Y to access the Patient Health Factor Update pop-up (Figure 4-23).

```

***** 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 4-23: Sample Patient Health Factor Update pop-up

**Display Health Factor History?:** Use N or Y. If you use Y, the health factor history displays on another screen.

**HEALTH FACTOR:** Specify the health factor.

The following pop-up displays where you specify other data about the health factor (Figure 4-24).

```
LEVEL/SEVERITY:
QUANTITY
COMMENTS
```

Figure 4-24: Additional data items requested

**Level/Severity:** use one of the following : **M** (minimal), **MO** (moderate), or **H** (heavy/severe).

**Quantity:** use 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?

Use Y or N. Use Y to access the Patient Education Enter/Edit pop-up (Figure 4-25).

```
*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 4-25: Sample Patient Education enter/edit screen

**Display Patient Education History?:** Use Y or N. Use Y to display all education provided in the last two years by BH programs. This history is displayed in the Output Browser window.

**EDUCATION TOPIC:** Specify the education topic name. The following pop-up displays where you enter data about the education topic (Figure 4-26):

```
EDUCATION TOPIC: ABD-COMPLICATIONS

INDIVIDUAL/GROUP: INDIVIDUAL
READINESS TO LEARN:
LEVEL OF UNDERSTANDING:
```

<p><u>PROVIDER</u>: THETA, MARK <u>MINUTES</u>:  COMMENT: STATUS (Goal): GOAL COMMENT:</p>
--

Figure 4-26: Sample pop-up for education topic information

The underlined fields are required.

**Education Topic:** the education topic (can be changed).

**Individual/Group:** Specify if the education is for an individual or for a group.

**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. Use one of the following:

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

**Provider:** The provider for the visit (can be changed). The default is the current logon user.

**Minutes:** Specify the number of minutes spent on education, using any integer 1 - 9999.

**Comment:** Add comments about the education topic for the visit, 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

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

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

### Edit Any Screening Exams?

Use N or Y for any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter. Use Y to access the following pop-up screen (Figure 4-27).

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 4-27: Sample IPV, Alcohol Screening, and Depression Screening pop-up

**Display IPV/DV screening History?:** Use Y or N. If you use Y, the IPV/DV screening history displays on another screen.

**IPV Screening/Exam Result:** Specify the result of the intimate partner violence/domestic violence screening. Use one of the following:

- N - Negative
- PR - Present
- PAP - Past and Present

- PA - Past
- UAS - Unable to screen
- REF - Patient Refused Screening

**IPV Screening Provider:** Specify the IPV/DV provider name.

**IPV Comment:** Populate with the text of any comment related to the IPV/DV screening, using 2–245 characters.

**Display Alcohol screening History?:** Use Y or N. If you use Y, the alcohol screening history displays on another screen.

**Alcohol Screening Result:** Specify the result of the 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, using 2–245 characters.

**Display Depression screening History?:** Use Y or N. If you use Y, the depression screening history displays on another screen.

**Depression Screening Result:** Specify the result of the 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.

**Dep Screening Comment:** Populate with the text of any comment related to the depression screening, using 2–245 characters.

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

### Edit Measurements?

Use Y or N. Use Y to access the Measurements pop-up (Figure 4-28).

*** Measurements ***		
Measurement Description	Value	Provider
-----		

Figure 4-28: Sample Measurements pop-up

**Measurement:** Specify the type of measurement being taken on the patient. Then the application populates the Description field.

**Value:** Specify the numeric value of the measurement. The value must be in the valid numeric range for the measurement.

**Provider:** Specify the name of the provider.

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

#### Placement Disposition

This is a required field used when hospitalization or placement in a treatment facility is required.

#### Referred to

Name of the facility, using 2-30 characters in length. This field is required when the Placement Disposition is populated.

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

#### Enter your Current Signature Code

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

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 (Figure 4-29).

```

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

Update, add or append any of the following data

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

```

Figure 4-29: Other Information window

You can exit using option 10, or edit the visit using the other options.

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

- If there was not an appointment the patient was checked in for in the scheduling package, you return to the previous window.
- If there was an appointment the patient was checked in for 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 (Figure 4-30):

```

Generating PCC Visit.

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

1  TIME: 16:00 LOC: WW   TYPE: I CAT: A CLINIC: ALCOHOL  DEC: 0 VCN:47887.1A
   Hospital Location: BJB AOD
   Primary POV:      Narrative:
2  TIME: 15:00 LOC: WW   TYPE: I CAT: A CLINIC: GENERAL  DEC: 0 VCN:47887.2A
   Hospital Location: ADULT WALKIN
   Primary POV:      Narrative:
3  TIME: 16:15 LOC: WW   TYPE: I CAT: A CLINIC: BEHAVIOR DEC: 3 VCN:47887.3A
   Hospital Location: BJB BH

```

```

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

Select: (1-4): 3

```

Figure 4-30: Continuing prompts

At this point, the application links to the visit you had selected and returns you to the list view (Figure 4-31).

```

-----
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 SIGMAAA,DAVID R WW145072 WW 12 83 MEDICAL TRANSPORTATION NEE

?? for more actions
AV Add Patient Visit PF Print Encounter Form SN Sign Note
AC Add Adm/Comm Record ID Intake Document TN Display TIU Note
EV Edit Record HS Health Summary 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 4-31: Prompts that continue

At the “Select” prompt use DR and the Patient Information screen displays (Figure 4-32):

```

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

===== BH RECORD FILE =====
DATE OF SERVICE: MAR 09, 2010@12:00
PROGRAM: MENTAL HEALTH
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE: TAHLEQUAH
ACTIVITY TYPE: 11
ACTIVITY TYPE NAME: SCREENING-PATIENT PRESENT
TYPE OF CONTACT: OUTPATIENT
PATIENT: BETAA,EMILY MAE
PT AGE: 42
CLINIC: MENTAL HEALTH
NUMBER SERVED: 1
APPT/WALK-IN: WALK-IN
ACTIVITY TIME: 112
VISIT: MAR 09, 2010@16:15
POSTING DATE: MAR 12, 2010
WHO ENTERED RECORD: BRUNING,BJ

```



```

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

SUBJECTIVE/OBJECTIVE: TEST

COMMENT/NEXT APPOINTMENT:
TEST

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:

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

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

Note already signed, no E Sig necessary.

Press enter to continue...:

```

Figure 4-32: Display Record information

Once you are back at the Other Information list, you can simply quit and go back to the main menu to see what the PCC visit looks like that shown in Figure 4-33:

```

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

Update, add or append any of the following data

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

```

Figure 4-33: Other Information screen

At The “Choose one of the above, use 10 to exit. The Patient View screen displays as shown in Figure 4-34.

```

-----
Date of Encounter:  Tuesday  MAR 09, 2010          * unsigned note
-----
#  PRV PATIENT NAME          HRN      LOC  ACT  PROB      NARRATIVE
1  BJB BETAS,EMILY MAE  WW129608  WW  11   799.9  DIAGNOSIS OR CONDITION DEF
2  BJB BETAS,EMILY MAE  WW129608  WW  11     80  HOUSING
3  BJB SIGMAAA,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       PPL Patient's Problem List
OI  Desg Prov/Flag        ES  SOAP/CC Edit         AP  Appointments
DR  Display Record        SD  Switch Dates         MM  Send Mail Message
DE  Delete Record         EH  Edit EHR Record      Q   Quit
Select Action: AV// Q   Quit

```

Figure 4-34: Patient View screen

At the “Select Action” prompt, use Q to exit. The Data Entry Menu displays as shown in Figure 4-35.

```

*****
**          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 ...

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

```

Figure 4-35: Data Entry Menu

At the Select Behavioral Health Data Entry Menu Option prompt, use DSP to access the Data Entry Menu Display Option as shown in Figure 4-36.

```

*****
**          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:

```

Figure 4-36: Data Entry Menu Display options

At the “Display Record Options Option” prompt, use PCCV to access the PPC Visit Screen. The application displays the following prompt:

### Select PATIENT NAME

Specify the patient to be used.

### Enter VISIT date

Specify the date of the visit.

The application displays the PPC Visit Display screen, as shown in Figure 4-37.

```

PCC VISIT DISPLAY                                     Page:    1 of    3

Patient Name:          THETA,JIMMY JOE[m]
Chart #:               129347
Date of Birth:        NOV 01, 1986
Sex:                  M
Visit IEN:            2570481
===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: FEB 15, 2012@09:07
DATE VISIT CREATED:   FEB 15, 2012
TYPE:                 IHS
PATIENT NAME:         THETA,JIMMY JOE
LOC. OF ENCOUNTER:    DEMO INDIAN HOSPITAL
SERVICE CATEGORY:    AMBULATORY
CLINIC:               MEDICAL SOCIAL SERVICES
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:   FEB 15, 2012

```

```

WALK IN/APPT:          WALK IN
CREATED BY USER:      GAMMAA,RYAN
OPTION USED TO CREATE: AMHGRPC
USER LAST UPDATE:     GAMMAA,RYAN
OLD/UNUSED UNIQUE VIS: 5059010002570481
DATE/TIME LAST MODIFI: FEB 15, 2012@14:59:58
CHART AUDIT STATUS:   INCOMPLETE
NDW UNIQUE VISIT ID (: 102320002570481
VISIT ID:              3M6T-WWX
===== PROVIDERs =====
PROVIDER:              GAMMAA,RYAN
AFF.DISC.CODE:         1C9AAA
PRIMARY/SECONDARY:     PRIMARY
===== POVs =====
POV:                   303.02
ICD NARRATIVE:         AC ALCOH DEP INTOX-EPISOD
PROVIDER NARRATIVE:    ALCOHOL INTOXICATION, EPISODIC
===== ACTIVITY TIMES =====
ACTIVITY TIME:         60
TOTAL TIME:            60
TIME PATIENT SPENT IN: 100
+   Next Screen       -   Previous Screen       Q   Quit
Select Action: +// q   Quit

```

Figure 4-37: PCC Visit screen

#### 4.1.5 Edit EHR Visit (EH)

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

##### 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 (Figure 4-38).

```

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

```

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

Figure 4-38: Sample information about editing a BH visit entered through the EHR

The underlined fields are required.

### **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 non-patient 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 (Figure 4-39):

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

Figure 4-39: Pop-up window asking for facility referred to

**Facility Referred to:** Populate with 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 (Y = Yes or N = No). Use 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 to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

**4.1.6 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 the text for Chief Complaint, Comment/Next Appointment, and Medications Prescribed. Please note that this applies only to records with unsigned notes.

The following prompts display for the ES option.

**Enter ENCOUNTER DATE**

Specify the encounter date for this edit process.

**CHIEF COMPLAINT**

Specify the chief complaint (Free Text field), if any. The answer must be 2 – 80 characters in length. If there is existing text, you can change it. 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 (just like entering new note).

**Edit? NO//**

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

If you use N at this 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 (just like entering new note).

**Edit? NO//**

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

If you use N at this 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 (just like entering new note).

### **Edit? NO//**

If you use Y at this 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. Section 2.14 provides more information about electronic signatures. Only the primary provider is permitted to sign a note.

## **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 Note can be edited or deleted.

Below are the prompts.

### **Enter Encounter Date**

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

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

### **Are you sure you want to DELETE this record?**

Use Y or N. If you use Y, the application displays: Record deleted. Press enter to continue.

## **4.1.8 Sign Note (SN)**

Use the SN option to sign a note (that is not signed) in a visit record (Figure 4-40). You can only sign notes where you are the primary provider.

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

Behavioral Health visits for ALPHA, CHELSEA MARIE								
#	PROVIDER	LOC	DATE	ACT	CONT	PATIENT	PROB	NARRATIVE
1	THETA, SHIRLE WW		05/12/2009	OUTP	WW	116431	56	MARITAL PROBLEM

Figure 4-40: List of records that you can change

The prompts continue.

**Which record to 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 BH Visit Record Display window, the application asks if you want edit this record. If you use N, you exit the sign note process.

If you use Y, the application displays the Edit SOAP 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. Section 2.14.6 provides more information about signing a note. After entering your signature code, the OTHER INFORMATION screen displays.

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

#### 4.1.9 Print Encounter Form (PF)

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



**Enter Encounter Date**

Specify the date of the encounter 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 & Full
- T 2 copies of the Suppressed
- E 2 copies of the Full

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

**Device**

Specify the device to print/browse the data.

Figure 4-42 shows the data for a suppressed encounter form.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Mar 27, 2009@12:44:08
      *** Computer Generated Encounter Record ***
*****
Date: Feb 23, 2009           Primary Provider: GAMMAAA,DENISE
Arrival Time: 12:00
Program: MENTAL HEALTH
Clinic: MENTAL HEALTH           Appointment Type: APPOINTMENT
-----
Community: TUCSON                Number      Activity/Service
Activity: 13-INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT   Served:      Time: minutes
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 OR DIAGNOSIS	PURPOSE OF VISIT (POV) [PRIMARY ON FIRST LINE]
311.	DEPRESSIVE DISORDER NOS
Enter RETURN to continue or '^' to exit:	

Figure 4-41: 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**

Use Y or N. If you use Y, other prompts display.

The application displays the BH Visit Record Display window (Figure 4-42).

BH VISIT RECORD DISPLAY	Mar 27, 2009 15:06	Page:	1 of 5
Patient Name:	ALPHA,GLEN DALE		
Chart #:	108704		
Date of Birth:	NOV 10, 1981		
Sex:	M		
===== BH RECORD FILE =====			
DATE OF SERVICE:	MAR 26, 2009@09:00		
PROGRAM:	MENTAL HEALTH		
LOCATION OF ENCOUNTER:	SELLS HOSP		
COMMUNITY OF SERVICE:	TUCSON		
PATIENT:	ALPHA,GLEN DALE		
PT AGE:	37		
CLINIC:	MENTAL HEALTH		
APPT/WALK-IN:	APPOINTMENT		
POSTING DATE:	MAR 03, 2014		
WHO ENTERED RECORD:	GARCIA,RYAN		
DATE LAST MODIFIED:	MAR 04, 2014		
USER LAST UPDATE:	THETA,SHIRLEY		
DATE/TIME LAST MODIFI:	MAR 04, 2014@12:15:16		
EDIT HISTORY:			
	Mar 03, 2014 3:27 pm	GARCIA,RYAN	
EXTRACT FLAG:	ADD		
CREATED BY BH?:	YES		

```

CHIEF COMPLAINT:          major pain in left arm

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:

PROBLEM CODE NARRATIV: Dissociative amnesia, with dissociative fugue

===== MHSS RECORD PROVIDERS =====
PROVIDER:                  GARCIA,RYAN
PROVIDER DISCIPLINE:      BEHAVIORAL HEALTH AIDE/PRACT
PRIMARY/SECONDARY:       PRIMARY
                          Enter ?? for more actions
+   Next Screen          -   Previous Screen      Q   Quit
Select Action: +//

```

Figure 4-42: Sample BH Visit Record Display window

#### 4.1.11 Browse Visit (BV)

Use the BV option to browse the 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 use N, D, or P, other prompts will display.

The application displays the Browse Patient's Visit window (Figure 4-43), using the A option.

```

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: GAMMAAA,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:
  300.13

SUBJECTIVE/OBJECTIVE:
Pt is making progress on his problems, real or imaged
+       Enter ?? for more actions
+   Next Screen           -   Previous Screen           Q   Quit
Select Action:+//

```

Figure 4-43: 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 use N, D, or P, other prompts will display.

The application displays the Browse Patient's Visit window (Figure 4-44). This is one of the visit using the A option.

```

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

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

```

```

TIU DOCUMENTS
-----

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

```

Figure 4-44: Sample patient's visit 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 (Figure 4-45).

```

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@13:17
PROGRAM:           CHEMICAL DEPENDENCY
LOCATION OF ENCOUNTER: FIVE SANDOVAL INDIAN PROG, INC
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 4-45: 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 (Figure 4-46).

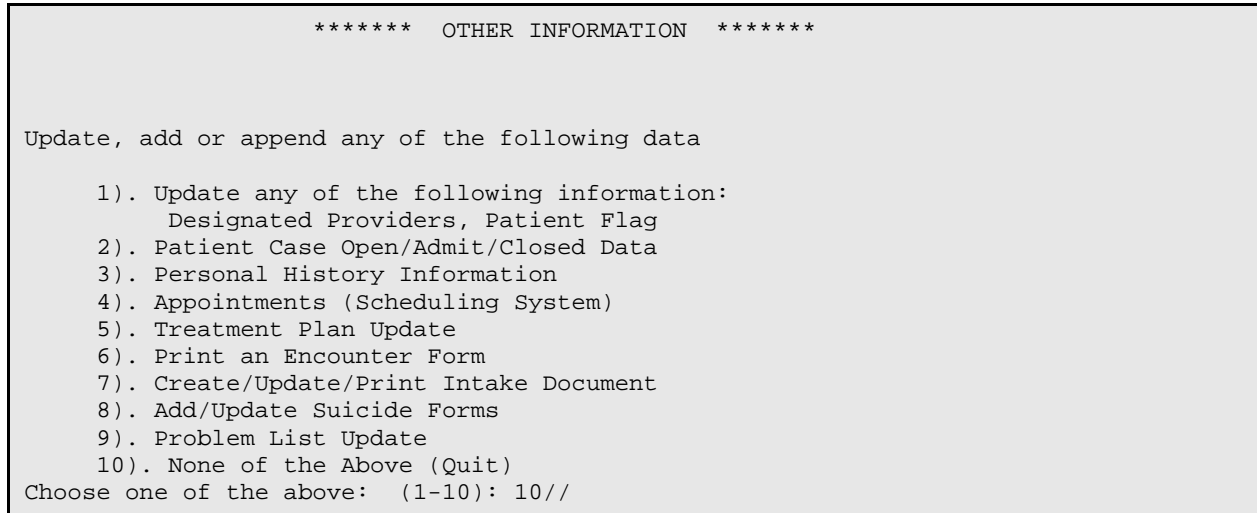


Figure 4-46: Options on the Other Information menu

Use the options to update visit information about the patient, if needed. Otherwise, use option 10 to exit.

## 4.2 Visit Window (GUI)

One way to access the Visit Window is to use the One Patient option on the RPMS Behavioral Health System (GUI) tree structure. You access the Visit Window for one patient (Figure 4-47).

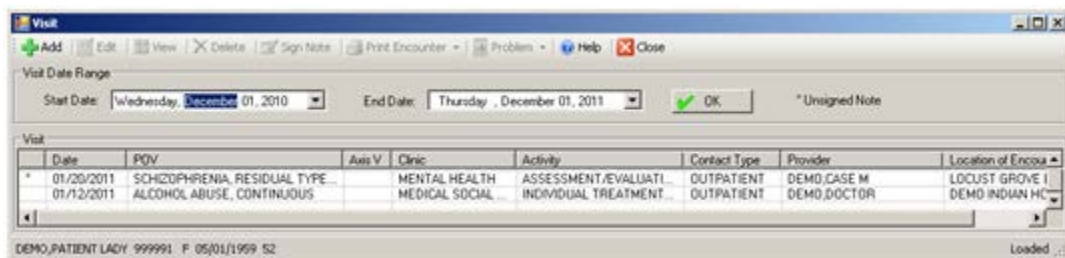


Figure 4-47: Visit window for one patient

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

Another way to access the Visit Window for the patient is to use the All Patients option on the RPMS Behavioral Health System (GUI) tree structure. You access the Visit Window for all patients (Figure 4-48).

Date	Patient	Chart	Sex	DOB	PDV	Axis V	Clinic	Activity
03/09/2009	ABBOTT,CHELSEA MARIE	116431	F	02/07/1975	MAJOR DEPRESSIVE DISORDER,	65	MENTAL HEALTH	INDIVIDUAL TREAT
03/05/2009	ABBOTT,CHELSEA MARIE	116431	F	02/07/1975	CANNABIS ABUSE, CONTINUOUS		MENTAL HEALTH	ASSESSMENT/EVA.
03/05/2009	ABBOTT,CHELSEA MARIE	116431	F	02/07/1975	VOCATIONAL REHABILITATION SE		MEDICAL SOCIAL S	TRADITIONAL SPEC
03/05/2009	ABBOTT,DIANA LEE	132745	F	09/15/1954	VOCATIONAL REHABILITATION SE		MEDICAL SOCIAL S	TRADITIONAL SPEC
02/27/2009	DUCK,EDWIN RAY	105321	M	06/07/1978	AMPHETAMINE DEPENDENCE, UN		GENERAL	INDIVIDUAL BH EH
02/24/2009	PEWITT,TERRY LYNN	198794	F	05/10/1968	SCREENING FOR DRUG ABUSE		MEDICAL SOCIAL S	ASSESSMENT/EVA.
02/24/2009	GUMP,JANE ELLEN		F	01/01/1990	PSYCHOLOGICAL TRAUMA, NOT E		MENTAL HEALTH	ASSESSMENT/EVA.
02/24/2009	GUMP,JANE ELLEN		F	01/01/1990	PSYCHOLOGICAL TRAUMA, NOT E		MENTAL HEALTH	ASSESSMENT/EVA.
02/24/2009	PEWITT,TERRY LYNN	198794	F	05/10/1968	SCREENING FOR ALCOHOLISM		MENTAL HEALTH	GROUP TREATMENT
02/24/2009	TUELL,LOMIE	115697	M	06/23/1965	SCREENING FOR ALCOHOLISM		MENTAL HEALTH	GROUP TREATMENT
02/24/2009	GUMP,JANE ELLEN		F	01/01/1990	PSYCHOLOGICAL TRAUMA, NOT E		MENTAL HEALTH	ASSESSMENT/EVA.
02/24/2009	GUMP,JANE ELLEN		F	01/01/1990	PSYCHOLOGICAL TRAUMA, NOT E		MENTAL HEALTH	ASSESSMENT/EVA.
02/23/2009	PEWITT,TERRY LYNN	198794	F	05/10/1968	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT
02/23/2009	CHEWEY,KACY MICHELLE	106774	F	09/03/1954	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT
02/23/2009	PEWITT,TERRY LYNN	198794	F	05/10/1968	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT
02/23/2009	CHEWEY,KACY MICHELLE	106774	F	09/03/1954	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT
02/23/2009	ABBOTT,CHELSEA MARIE	116431	F	02/07/1975	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT
02/23/2009	ABBOTT,CHELSEA MARIE	116431	F	02/07/1975	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT
02/23/2009	ABBOTT,CHELSEA MARIE	116431	F	02/07/1975	DEPRESSIVE DISORDER NOS		MENTAL HEALTH	GROUP TREATMENT

Figure 4-48: Sample Visit window for all patients

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

The following are features of both windows.

#### 4.2.1 Visit Date Range Group Box

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

##### 4.2.1.1 Visit Window for One Patient

The following applies to the Visit window for One Patient:

The default Start Date is one year previous.

You can change the date range by clicking the drop-down list to access a calendar. After the date range is changed, click OK to redisplay the records in the Visit group box.

**Note:** If you change the Start Date for the Visit window for One Patient, this change stays in effect in future sessions of the GUI application for the Visit window for One Patient (until you change it again).

#### 4.2.1.2 Visit Window for All Patients

The following applies to the Visit window for All Patients:

The default Start Date is today.

You can change the default Start Date and the application maintains that Start Date until you exit the application. Then, when you login again, the Start Date reverts to today's date.

#### 4.2.2 Visit Group Box

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

The asterisk (\*) in the first column indicates that the particular record contains an unsigned note. Section 2.14.5 provides more information about signing a note.

#### 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. Section 4.3 provides more information about this document.

#### 4.2.4 Edit Button

Use the Edit button to edit a particular Visit record. You access the Visit Data Entry - Edit Visit dialog.

#### 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 and Suicide Form tabs.

#### 4.2.6 Delete Button

**Note:** Visit records with a 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). Section 2.14.5 provides more information about signing a note.



## 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.

Please note that the Intake document and Suicide Reporting Form 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 4-47)

Print Encounter 0090,JOHN 55 M 12/01/2008 2

\*\*\*\*\* CONFIDENTIAL PATIENT INFORMATION \*\*\*\*\*  
 PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Feb 15, 2011@16:29:02  
 \*\*\* Computer Generated Encounter Record \*\*\*  
 \*\*\*\*\*

Date: Jan 10, 2011      Primary Provider: TEST,MARK  
 Arrival Time: 13:17  
 Program: OTHER  
 Clinic: BEHAVIORAL HEALTH      Appointment Type: APPOINTMENT

---

Community:	Number	Activity/Service
TUCSON	Served: 1	Time: 60 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  
 See TEST,MARK for details.

---

COMMENT/NEXT APPOINTMENT:

---

BE POV CODE	PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS	(PRIMARY ON FIRST LINE)
312.32	ELEPTORANIA

---

MEDICATIONS PRESCRIBED:

---

PROCEDURES (CPT):

---

MR#: WU 55  
 NAME: DEMO,JOHN      SSN: XXX-XX-1231  
 SEX: MALE      TRIBE: NAVAJO TRIBE, AZ NM AND UT  
 EOB: Dec 01, 2008

Current Page No.: 1      Total Page No.: 1+      Zoom Factor: 100%

Figure 4-49: Sample Print Encounter pop-up

Section 2.6 provides more information of this type of window.

## 4.2.9 Problem Button

Select a visit and then click the Problem button to manage the patient's Behavioral Health and PCC problems.

## 4.2.10 Help Button

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

### 4.2.11 Close Button

Use the Close button on 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.

- You use the Add button to add a visit for the current patient. The application displays the Visit Data Entry - Add Visit dialog.
- You use the Edit button to edit the selected visit for the current patient. The application displays the Visit Data Entry - Edit Visit dialog. The Edit button will be inactive if the patient does not have any previous visits.

Below is a sample Visit Data Entry - Add Visit dialog (Figure 4-50). (The same fields appear on the Visit Data Entry - Edit Visit dialog.)

Figure 4-50: 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 (otherwise, click Close).

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

- If there was not an appointment the patient was checked in for in the scheduling package, you return to the Visit window.
- If there was an appointment the patient was checked in for in the scheduling package and it is set to create a visit at check-in, the application displays the Select PCC Visit window. Section 4.3.9 provides more information about this window. Please note the following about this option:
  - If the facility is not using the scheduling package and doesn't have the Interactive PCC Link in the site parameters turned on, you will never be presented with the ability to link it to a PCC visit.
  - If there is no visit in PCC (patient never checked in, no appointment or walk in was ever created in the scheduling package and no other clinics saw the patient that day), then the option to link is never presented and the BH visit continues to create a new visits in PCC.

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

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

The Free Text fields have a right-click menu for editing. Section 2.11 provides more information about Free Text fields.

Several of the fields contain a search window. Section 2.8 provides more information about this type of window.

The fields that contain dates can be changed by accessing a calendar. Section 2.7 provides more information about using the calendar.

Certain group boxes use the search/select window. Section 2.9 provides more information about using this window.

Some group boxes use the multiple select window. Section 2.10 provides more information about using this type of window.

### 4.3.1 Visit Information Group Box

Use the Visit Information group box (Figure 4-51) to enter data about the visit.

Figure 4-51: 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 search for a provider name.

### **Encounter Date/Time**

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

### **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 the Location search window. Here you search for the location name.

### **Clinic**

This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table. Change this field by clicking the drop-down list to access the Clinic search window. Here you 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). Click the drop-down list to access the Type of Contact window and select another option, if needed.

### 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 search for the community name.

## 4.3.2 POV Tab

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

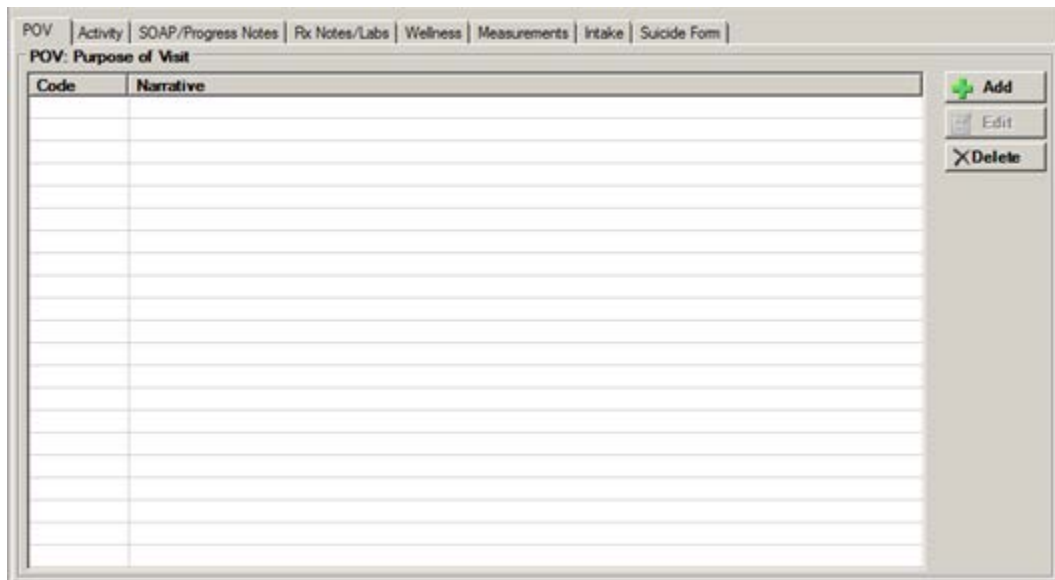


Figure 4-52: Sample POV Tab on Visit Data Entry window

### 4.3.2.1 Add Button

Use the Add button to add a new POV for the current patient. Click Add to access POV window.

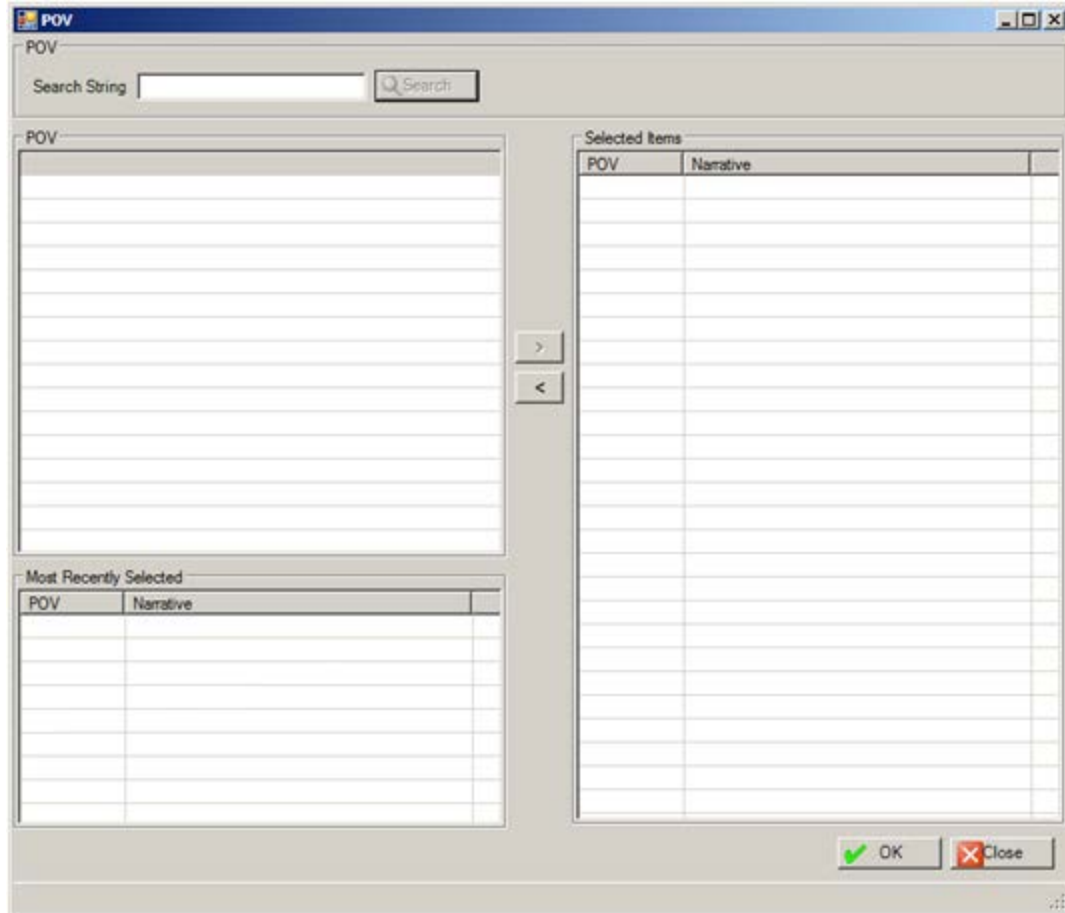


Figure 4-53: Sample POV search/select window

Section 2.9 provides information about using this type of window.

What appears in the Selected Items determines the POV for the encounter. These items populate the POV tab on the Visit Data Entry window.

#### 4.3.2.2 Edit Button

Select the POV code to enter and click Edit to access the Edit POV dialog. Use the Edit button to edit the POV narrative (not the code) of a selected record on the Edit POV dialog.

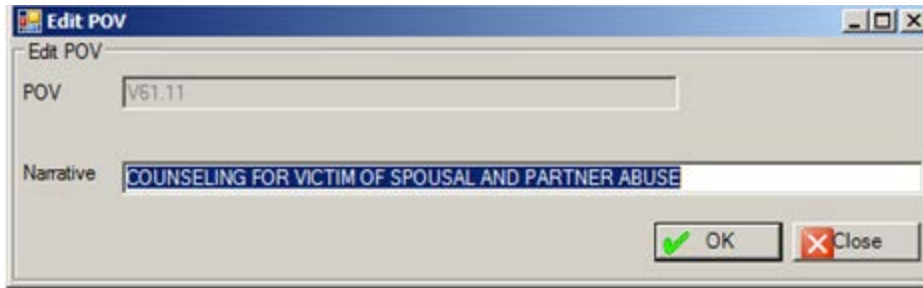


Figure 4-54: Edit POV dialog

The Narrative field is a Free Text field that can contain 2–80 characters. Type the new POV narrative in the Narrative text box and click OK (otherwise, click Close). The OK process changes the narrative of the selected record on the POV tab.

#### 4.3.2.3 Delete Button

Use the Delete button to delete a selected record on the POV tab of the Visit Data Entry screen. On the “Are You Sure” confirmation message, click Yes to delete the record (otherwise, click No).

### 4.3.3 Activity Tab

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

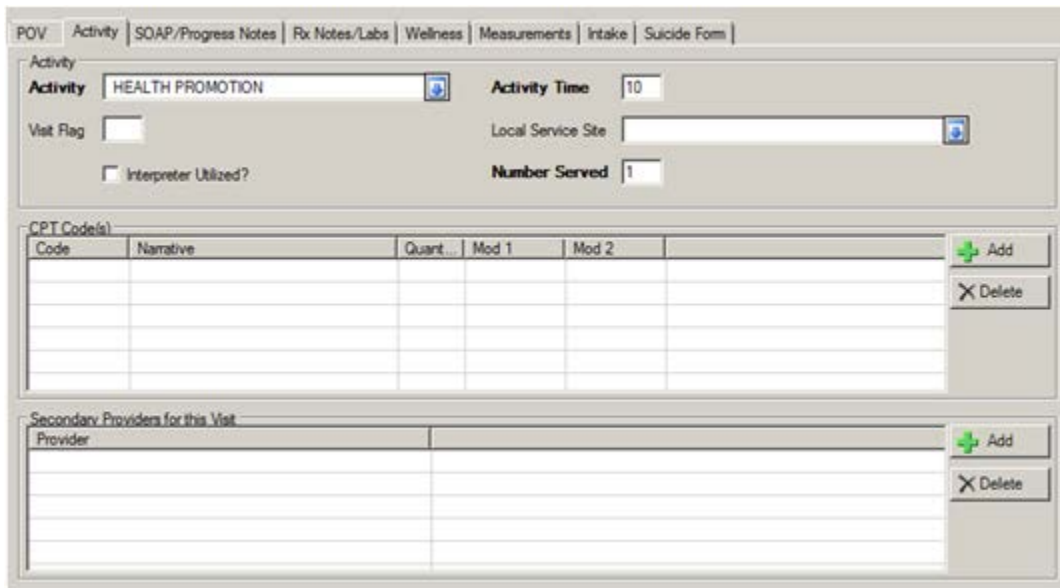


Figure 4-55: Sample Activity Tab on the Visit Data Entry window

#### 4.3.3.1 Activity Group Box

Below is the Activity group box.

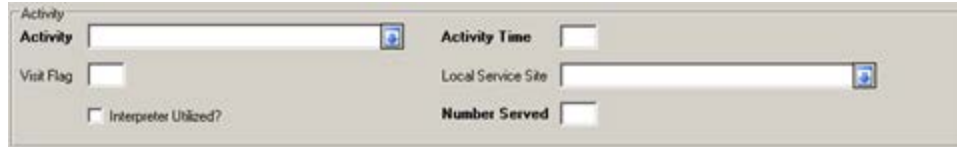
A screenshot of a software form titled "Activity". The form contains several fields: "Activity" (a drop-down menu with a blue arrow icon), "Activity Time" (a text input field), "Visit Flag" (a text input field), "Local Service Site" (a drop-down menu with a blue arrow icon), and "Number Served" (a text input field). There is also a checkbox labeled "Interpreter Utilized?". The labels "Activity", "Activity Time", "Visit Flag", "Local Service Site", and "Number Served" are in bold text.

Figure 4-56: 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 Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Click the drop-down list to access the Activity search window. Here you search for the activity name. Section Appendix A: provides more information about activity codes and definitions.

### **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 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**

Populate with the local service site. Click the drop-down list and select an option from the Local Service Site, if needed.

### **Interpreter Utilized?**

Select this checkbox if an interpreter is required to communicate with the patient.

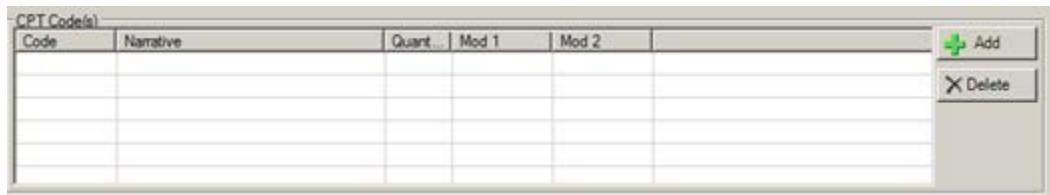


## Number Served

Populate with the number served, using any number between 1 and 9999 (no decimal digits). The default is 1. This required field refers to the number of people directly served during a given activity and always is used for direct patient care as well as for administrative activities. Group activities or family counseling are examples where other numbers might be listed.

### 4.3.3.2 CPT Code(s) Group Box

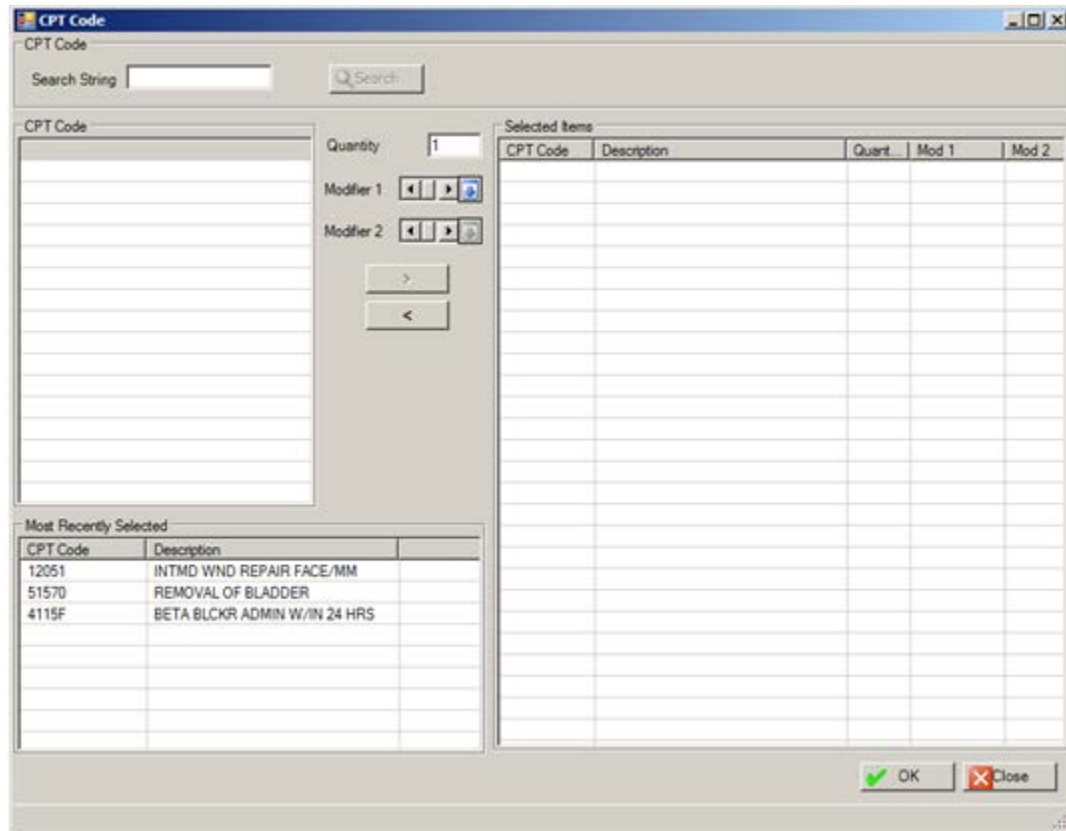
Use the CPT Code(s) group box to manage the CPT codes used during the encounter.



The image shows a window titled "CPT Code(s)" containing a table with the following columns: Code, Narrative, Quant., Mod 1, and Mod 2. To the right of the table are two buttons: "Add" (with a green plus icon) and "Delete" (with a red X icon).

Figure 4-57: Sample CPT Codes group box

Use the Add button to add the CPT Codes on the CPT Code multiple search/select window (Figure 4-58).



The image shows a window titled "CPT Code" with a search string field and a search button. Below the search field is a "CPT Code" list box. To the right of the list box are fields for "Quantity" (set to 1), "Modifier 1", and "Modifier 2", each with navigation buttons. Below these are ">" and "<" buttons. To the right is a "Selected Items" table with columns: CPT Code, Description, Quant., Mod 1, and Mod 2. At the bottom left is a "Most Recently Selected" table with columns: CPT Code and Description. The "Most Recently Selected" table contains the following data:

CPT Code	Description
12051	INTMD WND REPAIR FACE/MM
51570	REMOVAL OF BLADDER
4115F	BETA BLCKR ADMIN W/IN 24 HRS

At the bottom right of the window are "OK" and "Close" buttons.

Figure 4-58: CPT Code search/select window

Section 5.3.6.5 provides more information about this window. When the CPT Code window is complete, click OK to save the data and add the data to the CPT Code(s) group box.

Use the Delete button to remove a selected CPT code record from the group box. On the “Are You Sure” confirmation message, 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.

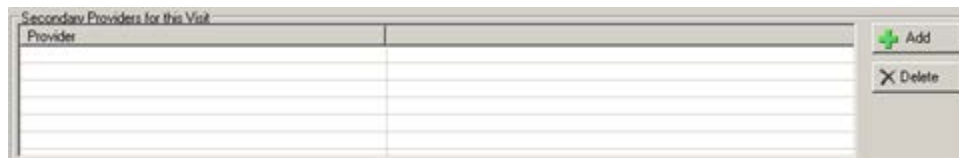


Figure 4-59: Sample Secondary Providers for this Visit group box

Click Add to access the Secondary Providers multiple search/select window. Here you 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. On the “Are You Sure” confirmation message, 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 note associated with the current visit, to enter the chief complaint/pressing problem, and to enter any comments about the next appointment.

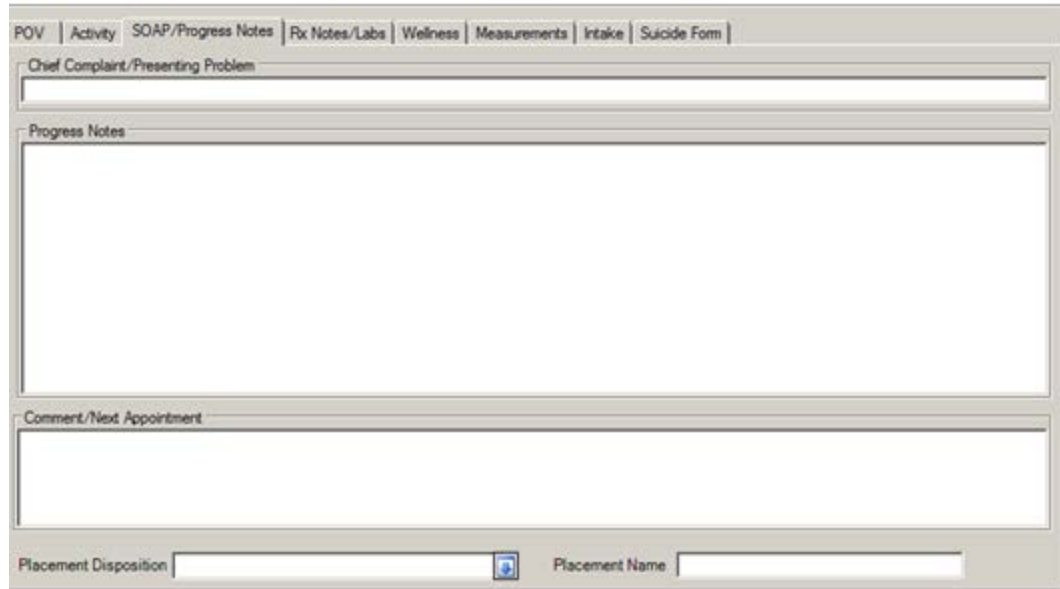


Figure 4-60: Sample SOAP/Progress Notes tab

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

### **Chief Complaint/Presenting Problem**

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

### **Progress Notes**

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

### **Comments/Next Appointment**

Populate this Free Text field with the text of any additional notes or comments about the client's next appointment.

### **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 where you can select a placement type.

### **Placement Name**

Populate with the name of the placement facility.

### 4.3.5 Rx Notes/Labs Tab

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

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

Figure 4-61: Sample Rx Notes/Labs tab

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

#### 4.3.5.1 Rx Data

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

- 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 behavioral health 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 can be copied and pasted into the Prescription Entry field. This feature is used by some sites to record notes for the psychiatrist such as doing a pill count with the patient, whether or not the patient is compliant with meds, etc. This field has a right-click menu that lets you cut, copy, or paste data (these functions are like the ones in MS Office).

### 4.3.5.2 PCC Labs

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

#### 4.3.5.2.1 View by Visit Date

If you select the View by Visit Date option, the application displays the View Labs by Visit Date dialog.



Figure 4-62: Sample View Labs by Visit Date dialog

The View Labs by Visit Date and View Labs by Lab Test dialogs have the following features:

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

You can edit either or both dates. Click the drop-down list and select a date from the calendar. When this dialog is complete, click OK (otherwise, click Close). The OK function displays a pop-up that shows the first page of the PCC labs by visit date within the particular date range.

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

#### 4.3.5.2.2 View by Lab Test

If you select the View by Lab Test option, the application displays the View Labs by Lab Test dialog.



Figure 4-63: Sample View Labs by Lab Test dialog

The View Labs by Visit Date and View Labs by Lab Test dialogs have the following features:

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

You can edit either or both dates. Click the drop-down list and select a date from the calendar. When this dialog is complete, click OK (otherwise, click Close). The OK function displays a pop-up that shows the first page of the PCC labs by lab test within the particular date range.

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

#### 4.3.5.2.3 Graph

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

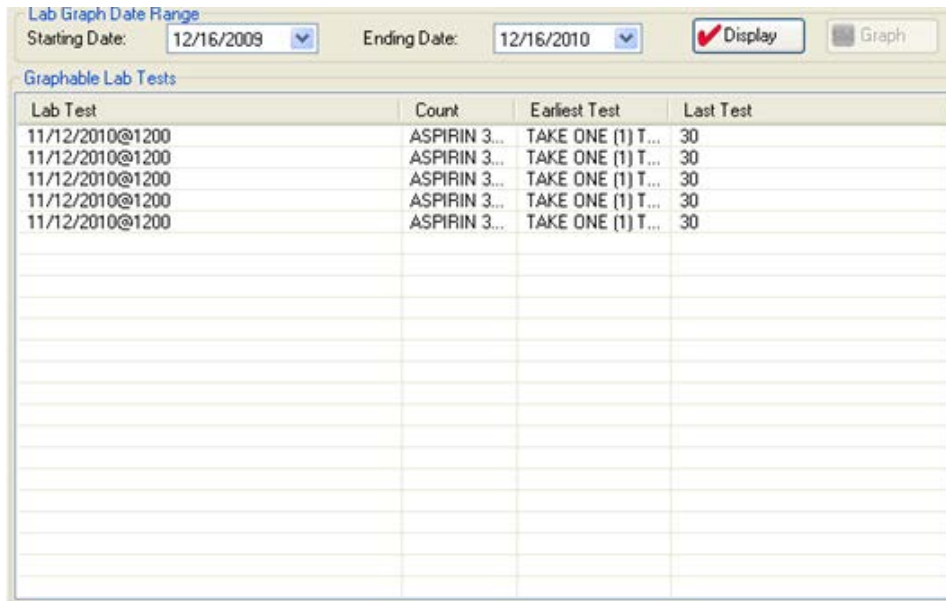


Figure 4-64: Sample group boxes for Graph option

### Lab Graph Date Range

The default date range is one year. This date range determines the data displayed in the Graphable Lab Tests group box. You can edit either or both dates. Click the drop-down list and select a date from the calendar. When this dialog is complete, click Display to refresh the data in the Graphable Lab Tests group box.

### Graphable Lab Tests

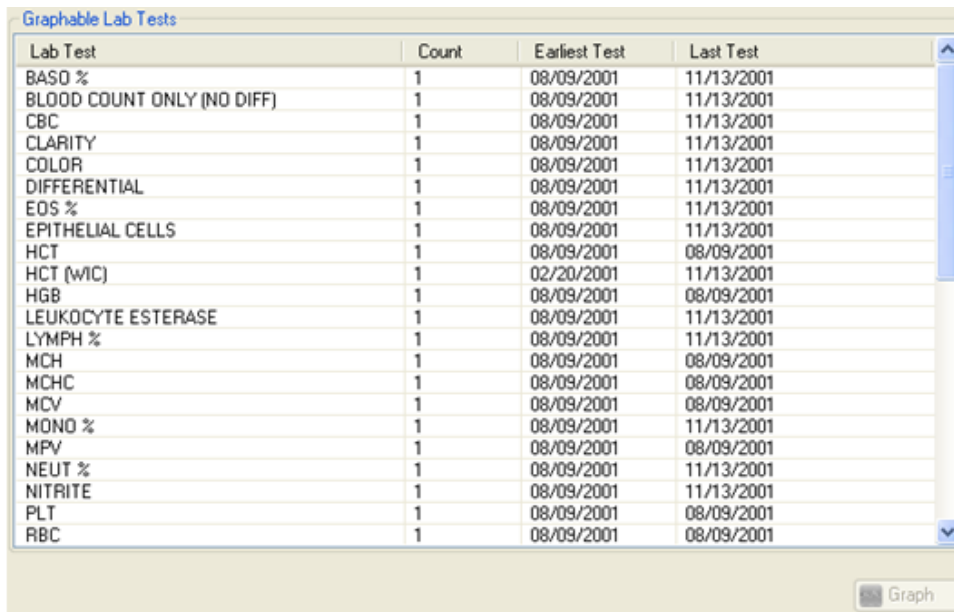


Figure 4-65: Sample Graphable Lab Tests group box

To graph a lab test, select one lab test record and then click the Graph button. This causes the data to be entered into an Excel spreadsheet and the graph of the particular lab test is shown.

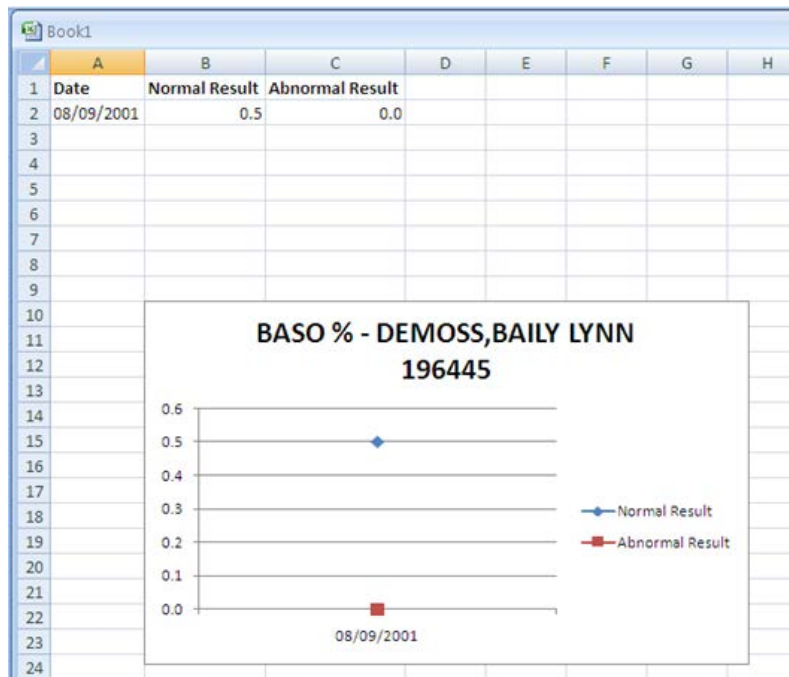


Figure 4-66: Sample graph of a particular lab test

You can save this data, if needed.

### 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 4-67: 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.

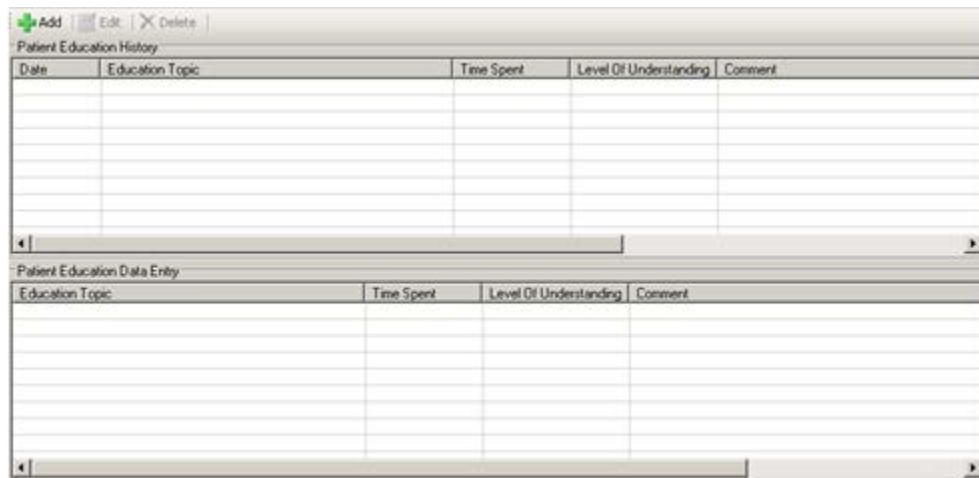


Figure 4-68: Sample Patient Education group boxes

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.

#### 4.3.6.1.1 Add Patient Education Record

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

If you clicked Close, the application displays the Continue warning that asks: Canceling will lose all unsaved data, Continue? Click Yes to return to the Patient Education Data Entry group box. Click No to display the Patient Education dialog with no data in the fields.

If you clicked OK, the application displays the Patient Education dialog, with the Education Topic field populated.

Figure 4-69: Sample Patient Education dialog

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 search for the education topic code.

#### **Time**

Populate the number of minutes spent on the education topic, using any integer 1 - 9999.

#### **Goal**

Populate with text of the stated goal of the education. For example, Patient plans to walk 6 times a week.

#### **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 pre-contemplation 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.

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

After clicking OK, the application saves the data and displays it on the Education Topics Data Entry grid.

After clicking Cancel, the application displays the “Continue?” warning stating: Canceling will lose all unsaved data, Continue? Click Yes to not save and leave the Patient Education dialog. Click No to return to the Patient Education dialog.

**4.3.6.1.2 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. Section 4.3.6.1.1 provides 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.

**4.3.6.1.3 Delete Patient Education Record**

Select a record in the Patient Education Data Entry grid and click Delete. On the “Are You Sure” warning message, 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 4-70: Sample Health Factors group boxes

Health Factors describe a component of the patient's health and wellness not documented as an ICD or CPT code or elsewhere. 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, 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 using the Add, Edit, or Delete button.

#### 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 Close.

If you clicked OK, the application displays the Health Factors dialog, with the Health Factor field populated.

Figure 4-71: Sample Health Factors dialog

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 this Free Text field with the text of any comment for clarification about the documented health factor.

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

After clicking OK, the application saves your data and displays it on the Health Factors Data Entry grid.

After clicking Cancel, the application displays the “Continue?” dialog that states: Canceling will lose all unsaved data, Continue? Click Yes to not save and leave the Health Factors dialog. Click No to return to the Health Factors dialog.

**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 dialog, with the fields populated with the current data. Section 4.3.6.2.1 (above) provides 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. On the “Are You Sure” confirmation message, 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.

The image shows two stacked dialog boxes. The top one is titled 'Add' and contains a 'Screening History' table with columns: Date, Alcohol, Alcohol Provider, Alcohol Comment, and Depres. The bottom one is titled 'Screening Data Entry' and contains a table with columns: Alcohol, Alcohol Comment, Depression, and Depression Comment. Both tables are currently empty.

Figure 4-72: 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, then the Add button displays.
- If the Screening Data Entry group box is populated, then the Edit button displays. You can edit a selected record by clicking the Edit button.

In either case, the Screening dialog displays.

The 'Screening' dialog box contains three sections for data entry. Each section has a dropdown menu for the screening type, a 'Provider' dropdown menu with 'TEST\_MARK' selected, and a 'Comment' text area. The sections are for 'Alcohol', 'Depression', and 'IPV/DV'. At the bottom right, there are 'OK' and 'Cancel' buttons.

Figure 4-73: Screening dialog

### 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)

**Provider**

This is the provider for the alcohol screening. Click the drop-down list and select another one from the Alcohol Provider search window, if needed.

**Comment**

Populate with the text of any comment related to the alcohol screening, using 2–245 characters.

**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)

**Provider**

This is the provider for the depression screening. Click the drop-down list and select another one from the Depression Provider search window, if needed.

**Comment**

Populate with the text of any comment related to the depression screening, using 2–245 characters.

**IPV/DV**

Populate with the intimate partner violence/domestic violence screening. Use one of the following:

- Negative (denies being a current victim of domestic violence)
- Present (admits being a victim of domestic violence)
- Past and Present
- Past (denies being a current victim but discloses being a past victim of domestic violence)
- Unable to screen (unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.))



- Patient Refused Screening (patient declined exam or screening)

### Provider

This is the provider for the IPV/DV screening. Click the drop-down list and select another one from the IPV Provider search window, if needed.

### Comment

Populate this Free Text field with the text of any comment related to the IPV/DV screening, using 2–245 characters.

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

After clicking OK, the application saves your data and displays it on the Screening Data Entry grid.

After clicking Cancel, the application displays the “Continue?” dialog that states: Canceling will lose all unsaved data, Continue? Click Yes to not save and leave the Screening dialog. Click No to return to the Screening dialog.

## 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.

The screenshot displays the 'Measurements' tab in the application. At the top, there are navigation tabs: POV, Activity, SOAP/Progress Notes, Rx Notes/Labs, Wellness, Measurements (selected), Intake, and Suicide Form. Below the tabs is the 'Measurement View' section, which includes a 'Measurement History' table with columns for Date, Measurement, Description, Value, and Provider. The table shows one entry: 01/12/2011, AUDT, AUDIT, 25, DEMO.DOCTOR. To the right of the table are 'Display' and 'Graph' buttons. Below the table is the 'Measurement Data Entry' section, which has a table with columns for Measurement, Description, Value, and Provider. It contains one entry: AUDT, AUDIT, 25, DEMO.DOCTOR. To the right of this table are 'Add', 'Edit', and 'Delete' buttons. At the bottom of the window, there are input fields for 'Measurement Type' and 'Provider', and 'Value'. There are also 'OK' and 'Cancel' buttons at the bottom right.

Figure 4-74: 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 Measurement History group box. Change the date range 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.

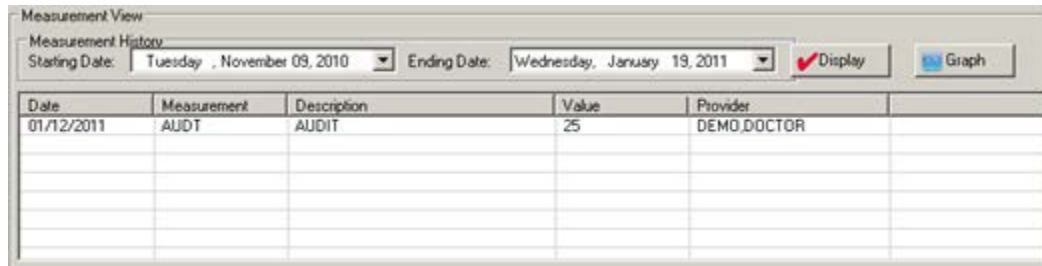


Figure 4-75: Sample Measurement View group box

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 dialog.

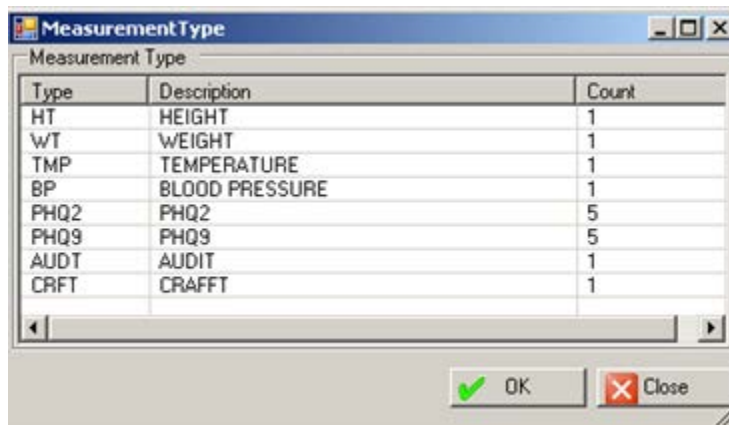


Figure 4-76: Sample Measurement Type dialog

Select the measurement type you want to graph. Then click OK to display the graph in MS Excel. (Otherwise, click Close).

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.

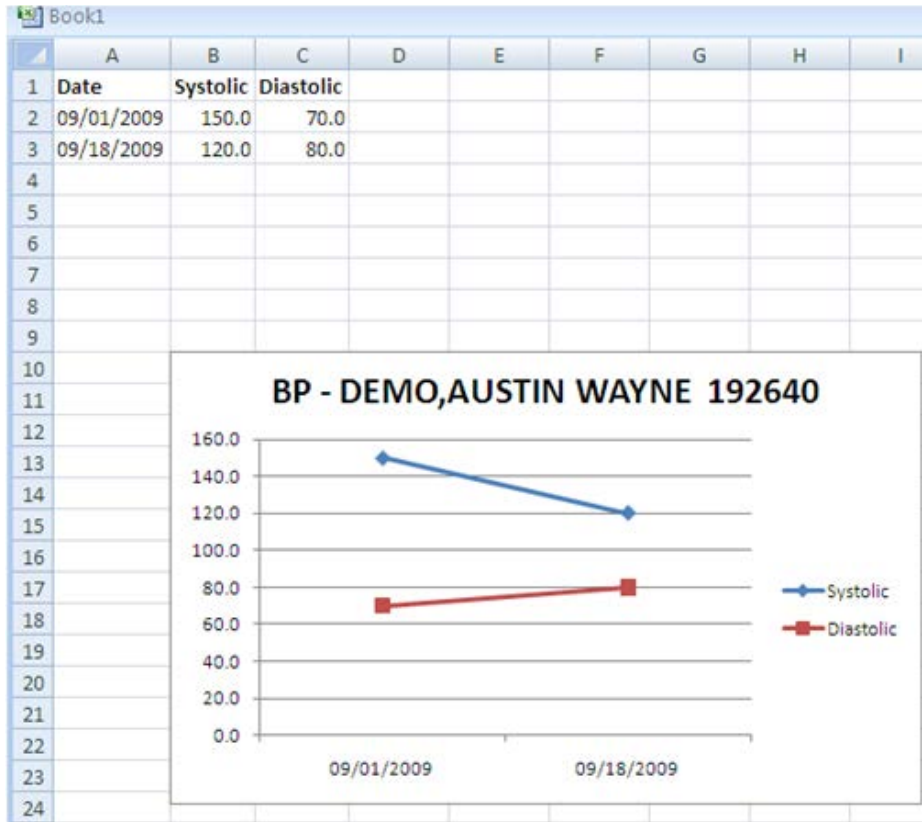


Figure 4-77: Sample line graph

You can save the data, if needed.

### 4.3.7.2 Measurement Data Entry Group Box

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

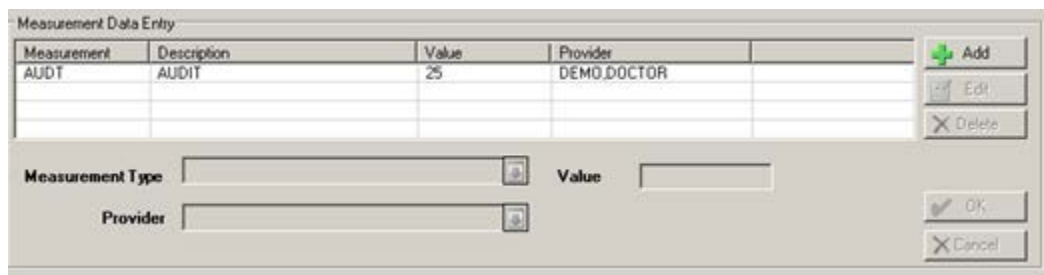


Figure 4-78: Sample Measurement Data Entry group box

Use the Edit button to change the value of a selected measurement record and/or the provider. The value and provider display in the fields below the grid. After changing the fields, click OK to change the Value and/or Provider in the grid. (Otherwise, click Cancel).

Use the Delete button to delete a selected measurement record. Measurements can only be deleted from the encounter record where they were first recorded. On the “Are You Sure” confirmation; click Yes to delete (otherwise, click No).

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 where you select a measurement type. 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.

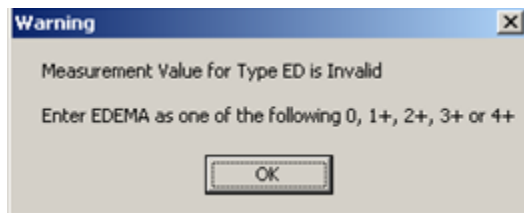


Figure 4-79: Sample Value outside the acceptable range warning

### **Provider**

Populate with the provider who entered the measurement data (the default is the primary provider). Click the drop-down list to access the Measurement Provider search window to change this field.

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

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.

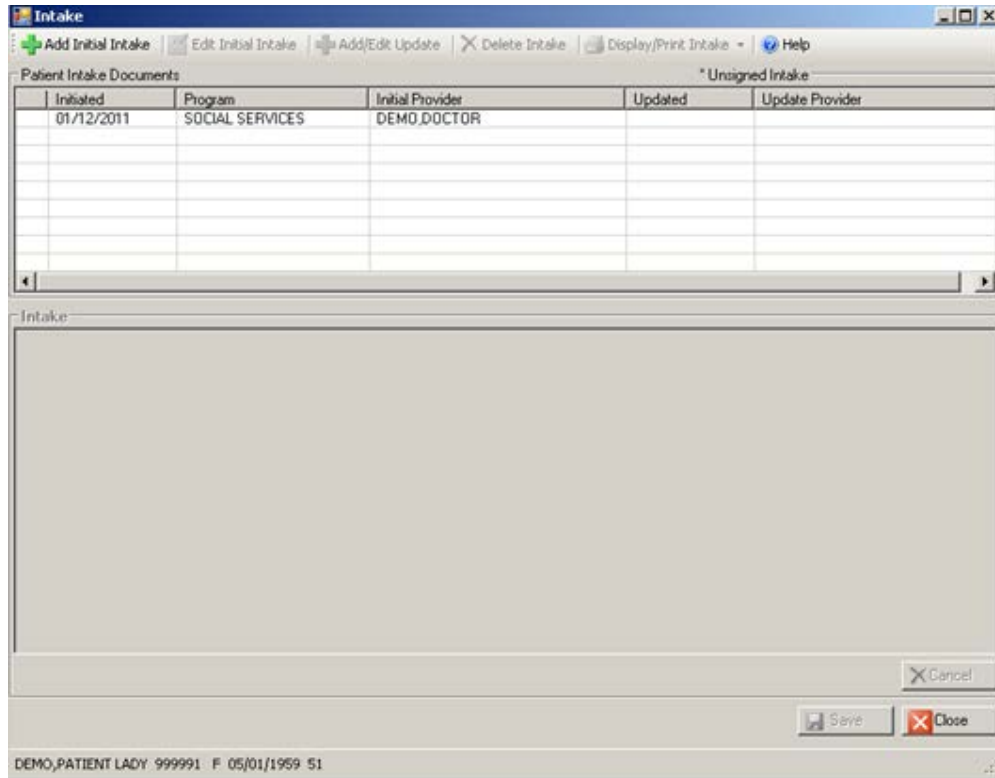


Figure 4-80: Initial Intake window

Section 12.2 provides more information about the Intake window.

### 4.3.9 Suicide Form

When you click the Suicide Form tab, the application displays the Suicide Form window. Section 11.2 provides more information about this window.

### 4.3.10 Select PCC Visit Window

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

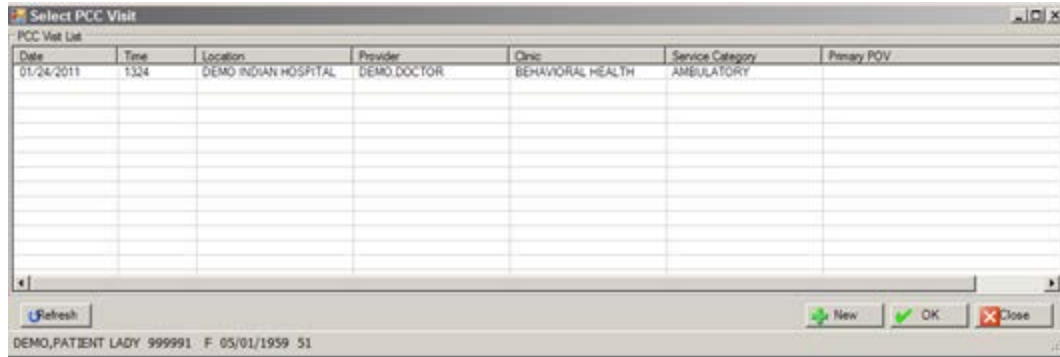


Figure 4-81: Sample Select PCC Visit window

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

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

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



Figure 4-82: Select PCC Visit window with more visits

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

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

```

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

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

```

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

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

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

===== POV =====
POV:                   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 4-83: Information from PCC

## 4.4 Browse Visits (GUI)

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

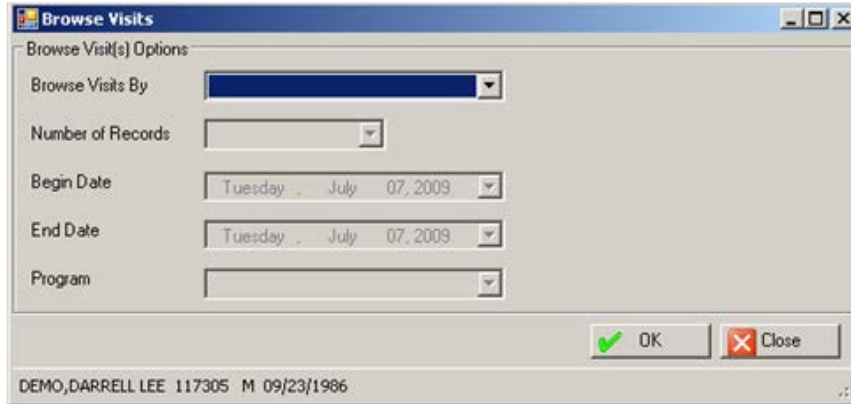


Figure 4-84: Sample Browse Visits dialog

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.



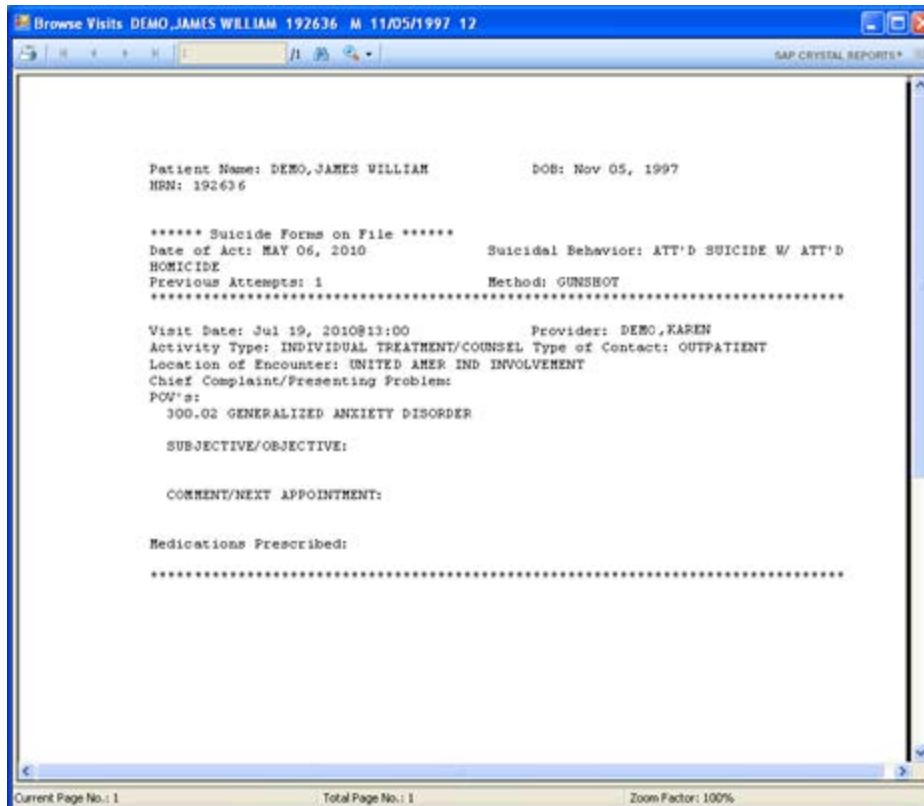


Figure 4-85: Sample of data in Browse Window

Section 2.6 provides more information about this type of window.

## 4.5 View Patient Data

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

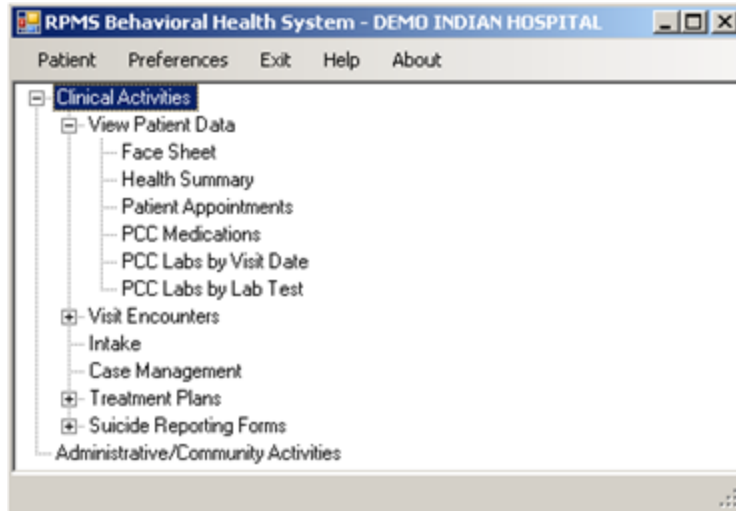


Figure 4-86: RPMS Behavioral Health System tree structure for View Patient Data

The data applies to the current patient.

If you want to change patients, right-click on any label to access the Change Patient option. After selecting the option, the application displays the Select Patient dialog. Section 2.12.2 provides for more information about this dialog.

#### 4.5.1 Face Sheet

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

#### 4.5.2 Health Summary

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

The application displays the Select Health Summary Type dialog.



Figure 4-87: Select Health Summary Type dialog

Select the health summary type from the drop-down list and then click OK. (Otherwise, click Close). The OK function displays a pop-up that shows the first page of the particular type of health summary. Section 2.6 provides more information about this type of window.

### 4.5.3 Patient Appointments

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



Figure 4-88: Sample Patient Appointments dialog

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

You can edit either or both dates. Click the drop-down list and select a date from the calendar. The application saves both default dates when you exit the application.

When this dialog is complete, click OK (otherwise, click Close). The OK function displays a pop-up that shows the first page of the appointments for the current patient in the particular date range. Section 2.6 provides more information about this type of window.

### 4.5.4 PCC Medications

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



Figure 4-89: Sample PCC Medications dialog

The default date Start Date is one year previous.

You can edit either or both dates. Click the drop-down list and select a date from the calendar. The application saves the default Begin Date when you exit the application.

When this dialog is complete, click OK (otherwise, click Close). The OK function displays a pop-up showing the first page of the Medication Prescribed in the Behavioral Health database within the particular date range.

### 4.5.5 PCC Labs by Visit Date

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



Figure 4-90: Sample View Labs by Visit Date dialog

The default Begin Date is one year previous.

You can edit either or both dates. Click the drop-down list and select a date from the calendar.

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

When this dialog is complete, click OK (otherwise, click Close). The OK function displays a pop-up that shows the first page of the PCC labs by visit date within the particular date range.

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

### 4.5.6 PCC Labs by Lab Test

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



Figure 4-91: Sample View Labs by Lab Test dialog

The default Begin Date is one year previous.

You can edit either or both dates. Click the drop-down list and select a date from the calendar.

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

When this dialog is complete, click OK (otherwise, click Close). The OK function displays a pop-up that shows the first page of the PCC labs by lab test within the particular date range.

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

## 5.0 Group Encounters

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

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

Use the Group Form Data Entry Using Group Definition (GP) option to enter MH/SS data from a group form. Use 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.

Figure 5-1 shows 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 GAMMAA,R	SCH 311. - D
2) * 10/01/09	EDIT INTAKE	GROUP TRE	S	MEDIC GAMMAA,R	SCH 311. - D
3) * 09/29/09	INTAKE GROUP	GROUP TRE	M	TELEB GAMMAA,R	SCH 296.20 -
4) 09/29/09	INTAKE GROUP	GROUP TRE	M	TELEB GAMMAA,R	SCH 296.20 -
5) 09/28/09	Mond DV	FAMILY/GR	S	MEDIC GAMMAAA,	OUT 43.2 - P
6) 09/25/09	GOAL STATUS	GROUP TRE	S	MEDIC GAMMAA,R	SCH 298.9 -
7) 09/25/09	Friday DV group	GROUP TRE	S	MEDIC GAMMAAA,	SCH 80 - HOU
8) * 09/25/09	pov test	GROUP TRE	S	MEDIC GAMMAA,R	SCH 2 - CROS
9) 09/24/09	WW-GRIEF GROUP	LIFE SKIL	S	MEDIC ALPHAA,W	OUT 24 - ADJ
10) * 09/24/09	WW-DEPRESSION GROUP	GROUP TRE	M	MENTA ALPHAA,W	FIE 311. - D
11) * 09/22/09	mark edu status	GROUP TRE	M	TELEB GAMMAAAA	SCH 2 - CROS
12) * 09/22/09	PR465 test	GROUP TRE	M	TELEB BETAAAA,	SCH 27 - ALC
13) 09/22/09	TEST OF CC MARK	GROUP TRE	M	TELEB BETAAAA	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. Section 2.14 provides more information about electronic signatures.

Use the Quit action to dismiss this window.

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

### 5.1.1 Add New Group

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

Below are the prompts.

#### Enter Date of the Group Activity

Specify the date of the new group activity.

Figure 5-2 shows 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 (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N                CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:

COMMAND:                                Press <PF1>H for help    Insert

```

Figure 5-2: Sample Group Encounter Documentation window

The underlined fields are required.

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

Use N or Y. Use Y to add a group; this is the only place to add one (Figure 5-3).

PROVIDER:	<u>PRIMARY / SECONDARY</u> :
PROVIDER:	<u>PRIMARY / SECONDARY</u> :
PROVIDER:	<u>PRIMARY / SECONDARY</u> :

Figure 5-3: Sample Secondary Providers pop-up

The underlined fields (on the pop-up) are required.

**PROVIDER:** Specify the provider name.

**PRIMARY/SECONDARY:** Populate with the type of provider. Only one primary provider can be used, whereas, you can use multiple secondary providers.

Below are more fields on the Group Encounter Documentation screen.

### **Encounter Date**

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

### **Arrival Time**

Specify the arrival time of the encounter. The default shows 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 community of service where the encounter took place.

### **Group Name**

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

### **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, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry. The time is divided equally among each of the group participants.

**Encounter Location**

Specify the name of the location for the encounter.

**Type of Contact**

Specify the type of contact (the activity setting).

**POV (Primary Group Topic)**

Specify the POV for the group topic. Press Enter to have the application display the POV or DSM Diagnosis pop-up (Figure 5-4).

POV (Primary Group Topic)	
CODE	NARRATIVE
-----	-----
_____	_____

Figure 5-4: Sample pop-up window for POV

**Code:** Specify with an MHSS Problem/DSM 5 POV code. Section Appendix D: provides information about DSM copyright and trademark information.

**Narrative:** Populate with narrative regarding the POV code using 2–80 characters.

Below are more fields on the Group Encounter Documentation screen.

**Chief Complaint/Presenting Problem**

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

**Any Patient Education Done?**

Use Y or N. If you use Y, the application displays the Patient Education for this Group Activity pop-up (Figure 5-5).

*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

**EDUCATION TOPIC:** Specify the education topic code. After populating this field, Figure 5-6 displays.

```

EDUCATION TOPIC: 041.04-DISEASE PROCESS
LEVEL OF UNDERSTANDING: GROUP-NO ASSESSMENT
PROVIDER: THETA, SHIRLEY
MINUTES: 34
COMMENT:

```

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

The underlined fields are required.

**Individual/Group:** The application automatically populates with GROUP. You cannot change this field.

**Level of Understanding:** The application automatically populates with GROUP-NO ASSESSMENT. You cannot change this field.

**Provider:** The application automatically populates with the current logon user. This can be changed.

**Minutes:** Populate with the number of minutes spent on education, using any integer 1–9999.

**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 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 (Figure 5-7):

```

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:
PATIENT:

```

Figure 5-7: Sample pop-up for Patients

**PATIENT:** Specify the patient name, HRN, DOB, or Social Security Number.

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

- Use Y to continue adding the patient's individual visit associated with the group visit. You return to the record for the first patient.
- Use N to edit the group definition.
- Use 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 unsigned group entry record.

If the selected group already has visits created, the application displays the message: This group already has visits created. You must use the REVIEW/EDIT GROUP VISITS to modify visits within this group. In this case, the application returns you to the Group Entry window.

**Select GROUP ENTRY**

Select the group to edit.

The application displays the Group Encounter Documentation window (Figure 5-9).

```

*  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 (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

Section 5.1.1 provides more information about the fields on this window.

### 5.1.3 Review/Edit Group Visits

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

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.

After populating the Select GROUP ENTRY field, the application displays the Enter/Edit Patient Group Data window (Figure 5-10).

```

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 of last group data record**

Specify the group number.

The application displays the BEHAVIORAL HEALTH RECORD EDIT window (Figure 5-11) 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: TEST,JEREMY ISSAC  DOB: 6/15/81  HRN: 104683
-----
Date:      NOV 3,2006@12:00          Location of Service:  DEMO HOSPITAL
Program:  MENTAL HEALTH              Outside Location:
Clinic:   MENTAL HEALTH              Appt/Walk-in: UNSPECIFIED  Visit Flag:
Type of Contact:  OUTPATIENT          Community:  RED LAKE
Providers <press enter>:              Local Service Site:
Activity:  91          Activity Time: 40  #Served:  1  Interpreter Utilized:
Chief Complaint/Presenting Problem:
SOAP/PROGRESS NOTE:      Comment/Next Appointment:      Medications Prescribed:
Edit Purpose of Visits?: N
Edit 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:
<hr/>	
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 fields, the application will skip this field.

The underlined fields are required. Section 4.1.4 provides more information about using the fields on this window.

### 5.1.4 Display Group Entry

Use action 2 on the GROUP DATA screen to display group entry data for a specified group.

The application displays the Output Browser window showing the group data (Figure 5-12).

OUTPUT BROWSER	Mar 27, 2009 17:46:48	Page: 1 of 1
<p>DATE OF SERVICE: NOV 29, 2010@14:39      PROGRAM: MENTAL HEALTH          GROUP NAME: TESTING LINK 1      POSTING DATE: NOV 29, 2010          LOCATION OF ENCOUNTER: KANAKANAK HOSPITAL          COMMUNITY OF SERVICE: KODIAK      ACTIVITY TYPE: 91          TYPE OF CONTACT: OUTPATIENT      ACTIVITY TIME: 60          WHO ENTERED RECORD: GAMMMA,RYAN      DATE LAST MODIFIED: NOV 29, 2010          CLINIC: MENTAL HEALTH      USER LAST UPDATE: GAMMMA,RYAN          SIGNED?: YES      ELECTRONIC SIGNATURE BLOCK: Ryan Gamma          DATE/TIME ESIG APPLIED: NOV 29, 2010@14:40:50          PROVIDER: GAAMMA,RYAN      PRIMARY/SECONDARY: PRIMARY          POV: 293.82          NARRATIVE: PSYCHOTIC DISORDER DUE TO..(INDICATE MEDICAL CONDITION),W/HALLUCIN.          POV: 296.24          NARRATIVE: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE W/PSYCHOTIC FEATU          RES          SUBJECTIVE/OBJECTIVE:          CPT CODE: 90853      QUANTITY: 1          CPT CODE: 90836      QUANTITY: 1          PATIENTS: SMITH,ALPHA JUSTIN          PATIENTS: MOORE,ALPHA JAMES          PATIENTS: WATERS,ALPHA RASHELL          MHSS RECORD: FEB 18, 2014@13:44          MHSS RECORD: FEB 18, 2014@13:44          MHSS RECORD: FEB 18, 2014@13:44</p>		

```

+          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 action 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.

Figure 5-13 shows 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,A,BJ
Arrival Time: 10:00
Program: SOCIAL SERVICES
Clinic: MEDICAL SOCIAL SERVICES      Appointment Type: UNSPECIFIED

```

Community: TAHLEQUAH Time spent in group session: 88 Activity: 14-FAMILY/GROUP TREATMENT-PATIENT PRESENT Type of Contact: OUTPATIENT	Number Served: 1	Activity/Service Time: 44 minutes
CHIEF COMPLAINT/PRESENTING PROBLEM: test pt ed S/O/A/P: GROUP NOTE This is the first meeting of the Domestic Violence group. Focus of today's session was establishing group rules and discussing expectations.		
PROVIDER SIGNATURE: /es/ DENISE GAMMA, MSW, LCSW Signed: Sep 28, 2009 15:07		
COMMENT/NEXT APPOINTMENT:		
BH POV CODE OR DIAGNOSIS	PURPOSE OF VISIT (POV) [PRIMARY ON FIRST LINE]	
299.80	ASPERGER'S DISORDER	
292.89	HALLUCINOGEN INTOXICATION	
299.01	AUTISTIC DISORDER, RESIDUAL	
MEDICATIONS PRESCRIBED:		
PROCEDURES (CPT):		
HR#: WW 209022 NAME: JONES, 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 OR DIAGNOSIS	PURPOSE OF VISIT (POV) [PRIMARY ON FIRST LINE]	
PROVIDER SIGNATURE: Jan 15, 2010 BETTTA, LORI Enter RETURN to continue or '^' to exit:		

Figure 5-13: Sample encounter form output

### 5.1.6 Duplicate Group

Use action 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 revert the SOAP/Progress Notes associated with the new group encounter to the unsigned status.

Please note: The SOAP/Progress Note for each individual patient is actually the standard group note plus the individual entry completed on the Patient Data tab. When a group is duplicated, the standard group note is retained but the individual note added on the Patient Data tab (as well as any other changes made on that tab) is not.

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.

Figure 5-14 shows 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 (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

Section 5.1.1 provides information about how to complete the Group Encounter Documentation window.

### 5.1.7 Add No Show visit

Use action 7 to enter a No Show visit for a client who failed to attend the group session.

**Note:** Any patient who is a no show or canceled should be removed from a duplicated group before the group documentation is completed.

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. Section 4.1.3 provides more information about this window.

### 5.1.8 Sign Note

Use action 9 to sign an unsigned SOAP/Progress note for a particular group encounter. Only the primary provider for the particular record can sign the note.

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 (Figure 5-15).

```
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 (Figure 5-16).

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

Figure 5-16: Message about no visits created

If the provider opted out of E-Signature, the application displays the information shown in Figure 5-17:

```
No E-Sig Required. Provider opted out of E-Sig
```

Figure 5-17: Message when provider opted out of E-Signature

If you are the primary provider, the application displays the BH Visit Record Display window (Figure 5-18).

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

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

===== BH RECORD FILE =====
DATE OF SERVICE:      JUL 09, 2009@09:55
PROGRAM:              MENTAL HEALTH
LOCATION OF ENCOUNTER:  DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE: TAHLEQUAH
ACTIVITY TYPE:        17
ACTIVITY TYPE NAME:   PSYCHOLOGICAL TESTING-PATIENT PRESENT
TYPE OF CONTACT:      OUTPATIENT
PATIENT:              ALPPHA,CHELSEA MARIE
PT AGE:               34
CLINIC:               MENTAL HEALTH
NUMBER SERVED:        1
+      Enter ?? for more actions
+  Next Screen      -  Previous Screen      Q  Quit
Select Action:  +//
```

Figure 5-18: Sample BH Visit Record Display window

After you quit this window, the application asks: Do you wish to edit this record? Use Y to edit the record. Use N to not edit the record.

After you use N, the application prompts: Enter your Current Signature Code. Section 2.14.6 more information about signing a note in roll and scroll.

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

### 5.1.9 Delete Group

Use action 4 to remove a particular group encounter record with an unsigned note. This option will remove/delete both the group definition and the associated patient encounter records. The application verifies that you want to delete the particular group encounter. Please note that the user must hold a specific key in order to delete group encounters with signed notes.

## 5.2 Group Entry Window (GUI)

Figure 5-19 shows where the Group Encounter function is located on the RPMS Behavioral Health System (GUI) tree structure.



Figure 5-19: Group Encounters location on tree structure

Click the Group Encounters option to access the Group Entry window (Figure 5-20).



Figure 5-20: 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).

You can change the date range by accessing the calendar under the drop-down list for the date. After changing the date range, click OK to update the display in the Group Entry group box.

### 5.2.2 Group Entry Group Box

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

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

### 5.2.3 Add Button

Use the Add button to add a new group encounter record. You access the Group Data Entry - Add Group Data window. Section 5.3 provides more information about adding a new group encounter.

### 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 view the highlighted group encounter record. This accesses the Group Data Entry - View 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 one. 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. Section 5.1.1 provides more information about adding/editing group data.

### 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 and clicking Delete, the “Are You Sure” confirmation message states: This will delete the Group Definition and all individual visits associated with this group, continue deleting? Click Yes to remove the selected group encounter record from the group box. (Otherwise, click No).

### 5.2.8 Sign Note Button

Use the Sign Note button to sign a particular “unsigned” group encounter record (asterisk (\*) in the first column). Section 2.14.5 provides more information about signing a note in the GUI.

If the primary provider has opted out of E-Sig will pass to PCC, the application displays the Message regarding this (Figure 5-21).



Figure 5-21: Message stating that the provider opted out of E Sig

The Message means that no electronic signature is required for the particular record. Click OK and you leave the Sign Note process.

## 5.2.9 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 5-22).

The screenshot shows a window titled "Print Encounter Group" with a standard Windows-style title bar. The main content area displays a text-based report with the following sections:

```

***** CONFIDENTIAL PATIENT INFORMATION *****
FCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Jan 21, 2013@17:04:15
*** Computer Generated Group Encounter Record ***
Group Name: fcsage
-----
Date: Feb 03, 2009      Primary Provider: DEMO,PSYCHIATRIST
Arrival Time: 08:00
Program: OTHER
Clinic: ALCOHOL AND SUBSTANCE      Appointment Type: UNSPECIFIED
-----
Community: IIA      Number:      Activity/Service
Time spent in group session: 99      Served: 1      Time: 49 minutes
Activity: 99-INDIVIDUAL BH EHR VISIT
Type of Contact: OUTPATIENT
-----
CHIEF COMPLAINT/PRESENTING PROBLER:
S/O/A/P:
fcsage
-----
COMMENT/NEXT APPOINTMENT:
-----
EHR POV CODE      PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS      [PRIMARY OR FIRST LINE]
-----
311.      DEPRESSIVE DISORDER NOS
-----
MEDICATIONS PRESCRIBED:
-----
PROCEDURES (CPT):
-----

```

At the bottom of the window, there is a status bar with the following information: "Current Page No.: 1", "Total Page No.: 1+", and "Zoom Factor: 100%".

Figure 5-22: Sample Print Encounter Group pop-up window

Section 2.6 provides more information about 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)

Click the Add button to add a new group data record. This accesses the Group Data Entry - Add Group Data window.

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.

Figure 5-23 shows the Group Data Entry - Add Group Data window. (The same fields appear on the Group Data Entry - Edit Group Data window.)

The screenshot shows a software window titled "Group Data Entry - Add Group Data". The window is divided into several sections:

- Group Encounter Information:** This section contains several input fields:
  - Primary Provider: DEMO.DOCTOR
  - Encounter Date/Time: Monday, November 28, 2011 10:52 AM
  - Program: (empty)
  - Encounter Location: (empty)
  - Clinic: (empty)
  - Group Name: (empty)
- Activities:** A tabbed interface with "Group Data" selected. Other tabs include "Group Education", "Patients", and "Patient Data".
- Community of Service:** (empty)
- Type of Contact:** (empty)
- Activity:** GROUP TREATMENT
- Activity Time:** (empty)
- CPT Code(s):** A table with two columns: "Code" and "Narrative". The table is currently empty. To the right of the table are "Add" and "Delete" buttons.
- Bottom Bar:** Contains "Help", "Save", and "Close" buttons.

Figure 5-23: 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 has been signed the other fields but not the note section 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 (otherwise, click Close).

The Save process saves your changes and dismisses the add/edit group data window. The data is saved on the Group Entry window.

- If you added a SOAP/Progress note, the application displays the “Sign?” confirmation message that asks if you want to sign the SOAP/Progress note now.
  - Click No to leave the note unsigned.
  - Click Yes and the application will display the electronic signature dialog and proceed in the same manner as used for individual encounter records (OK or continue, etc.). Section 2.14.5 provides more information about electronic signature (GUI).

The Close process displays the “Continue?” dialog. This dialog states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add group data window. Click No and you remain on the add window where you can continue work on the add group window.

Several of the fields contain a search window. Section 2.8 provides more information about this window.

The fields that contain dates can be changed by accessing a calendar. Section 2.7 provides more information about using the calendar.

Certain group boxes use the search/select window. Section 2.9 provides more information about this window.

Some group boxes use the multiple select window. Section 2.10 provides more information about this window.

### 5.3.1 Group Encounter Information Group Box

Figure 5-24 shows the (active) fields on the add window.

The screenshot shows a window titled "Group Data Entry - Add Group Data" with a sub-section "Group Encounter Information". It contains six fields: "Primary Provider" with a dropdown menu showing "DEMO.DOCTOR", "Encounter Date/Time" with a date and time picker showing "Thursday, December 26, 2013 03:20 PM", "Program" with a dropdown menu, "Encounter Location" with a dropdown menu, "Clinic" with a dropdown menu, and "Group Name" with a text input field.

Figure 5-24: Sample Group Encounter Information group box

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

The fields in bold text are required.

### **Primary Provider**

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

### **Encounter Date/Time**

The default is the current date and time. Change the date by clicking the drop-down list to access the calendar. You can change the time manually. You can select the hour, minutes, and AM/PM. If you make the hour and minutes, for example, 13:25, the application automatically changes the time to 1:25 PM.

### **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, or Chemical Dependency.

After selecting a program, the application automatically populates the Encounter Location and Clinic fields if you have the defaults set in the Site Parameters menu.

### **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.

### **Clinic**

This field shows the clinic if the group 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 a type of clinic.

### **Group Name**

Populate with the name of the group encounter, using between 1 and 30 characters in length.

## 5.3.2 Activities Tab

Use the Activities tab (Figure 5-25) to provide Activities data for the group encounter.

The screenshot shows the 'Activities' tab of the 'Group Data Entry' window. At the top, there are navigation tabs: 'Activities', 'Group Data', 'Group Education', 'Patients', and 'Patient Data'. The 'Activities' tab is selected. Below the tabs, there are four input fields: 'Community of Service' (a drop-down menu), 'Type of Contact' (a drop-down menu), 'Activity' (a drop-down menu), and 'Activity Time' (a text box). Below these fields is a table titled 'CPT Code(s)'. The table has five columns: 'Code', 'Narrative', 'Quant.', 'Mod 1', and 'Mod 2'. The table is currently empty. To the right of the table, there are two buttons: 'Add' (with a green plus icon) and 'Delete' (with a red X icon).

Figure 5-25: Activities tab of Group Data Entry

### 5.3.2.1 Fields at Top of Activities Tab

#### 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 search for the community name.

#### Type of Contact

This field shows the type of contact (the activity setting) for the group encounter. Change this field by clicking the drop-down list to access the Type of Contact window where you select an option.

#### 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.

### Activity Time

This field determines the number of minutes spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry.

#### 5.3.2.2 CPT Codes Group Box

Use the CPT Codes group box (Figure 5-26) to add or delete CPT codes associated with the group encounter.

Code	Narrative	Quant...	Mod 1	Mod 2

Figure 5-26: Sample CPT Codes group box

Click the Add button to access the CPT Code multiple search/select window. Section 5.3.6.5 provides more information about this window.

Click the Delete button to remove a selected CPT code record. On the “Are You Sure” confirmation message, click Yes to remove the selected CPT code record from the group box (otherwise, click No).

#### 5.3.3 Group Data Tab

Use the Group Data tab (Figure 5-27) to specify secondary providers, POV code, and group note information for the group encounter.

Figure 5-27: Sample Group Data tab

**Note:** Only the primary provider can change the data on the Group Data tab. Whoever is doing the data entry can change the information on this tab until such time the group has been saved; nothing on this tab can be edited after the group is saved – all editing takes place on the Patient Data Tab one patient at a time at that point.

The group box field names in bold text are required.

### 5.3.3.1 Chief Complaint/Presenting Problem Group Box

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

### 5.3.3.2 Secondary Providers Group Box

Use the Secondary Providers group box (Figure 5-28) to add or delete secondary providers for the group encounter.

Figure 5-28: 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. On the “Are You Sure” confirmation message, click Yes to remove the selected provider from the Secondary Providers group box (otherwise, click No).

### 5.3.3.3 Purpose of Visit - POV (Primary Group Topic) Group Box

The Purpose of Visit - POV (Primary Group Topic) group box (Figure 5-29) 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. At least one POV record is required for a group encounter.

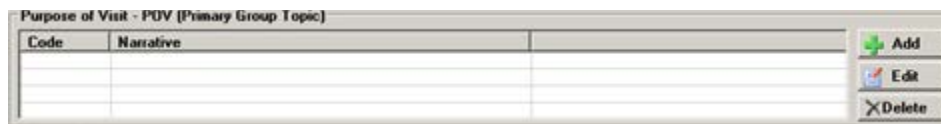


Figure 5-29: Sample POV group box

Click the Delete button to delete a selected POV record. On the “Are You Sure” confirmation message, click Yes to remove the selected POV record from the group box (otherwise, click No).

Click the Add button to access the POV 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 on the Edit POV dialog (Figure 5-30).

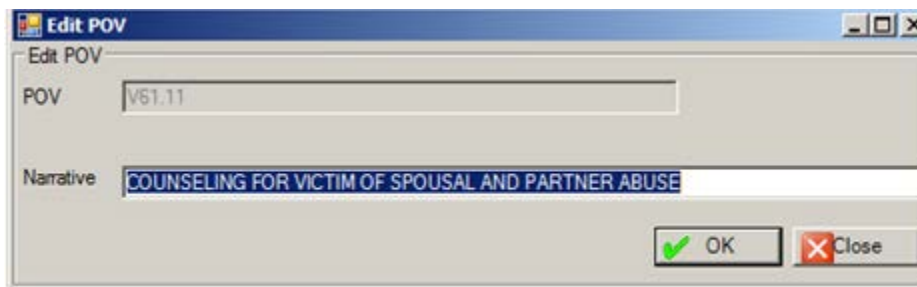


Figure 5-30: Edit POV dialog

The Narrative field is a Free Text field (can contain 2–80 characters). 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 “ or ‘ cannot be the first character of the POV narrative.

#### 5.3.3.4 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 be on the Patient Data Tab to do any editing after the group has been saved.

#### 5.3.4 Group Education Tab

Use the Group Education tab to add education data about the group encounter (Figure 5-31).

Figure 5-31: Sample Group Education tab

**Note:** Only the primary provider can change the data on the Group Education tab.

#### 5.3.4.1 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 search for an education code.

**Provider**

This is the provider for the group education. Click the drop down list to access the Education Provider search window. Here you search for a provider name.

**Time**

This field contains the time spent on the education topic, using any integer 1 - 9999. The understood units of measure are minutes.

**Level of Understanding**

This field contains the level of understanding about the education topic. The default is Group-No Assessment (the only choice).

**Comment**

Populate with any comments about the education topic for the group encounter.

Click Cancel to clear the fields on the Group Education tab.

Click OK when all fields are complete. This adds a record to the Education grid.

**5.3.4.2 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. Section 5.3.4.1 provides more information about the fields. All Group Education entries created before the installation date for BHS v4.0 will continue to display the Goal and CPT fields.

**5.3.4.3 Delete Group Education Record**

Use the Delete button to remove a selected record from the Group Education grid box. On the “Are You Sure” confirmation message, click Yes to remove the selected Education record from the group box (otherwise, click No).

**Note:** The Group Education can be removed only prior to saving the group. Once the group has been saved, there is currently no way to remove it in the group format.



### 5.3.5 Patients Tab

The Patients tab (Figure 5-32) shows the patients in the group encounter.

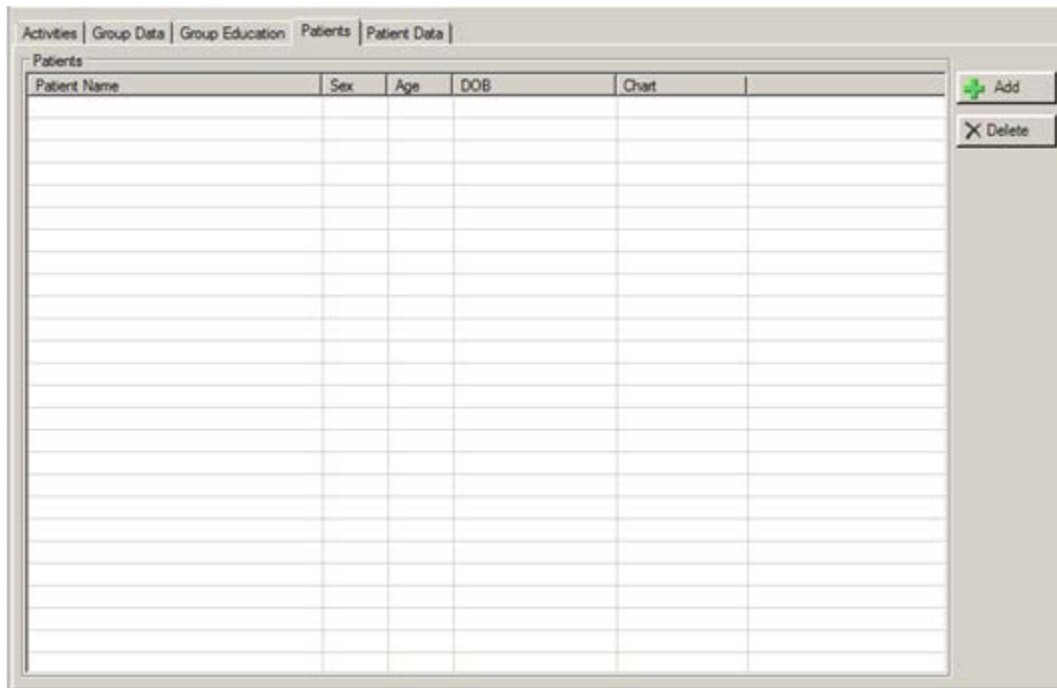


Figure 5-32: Sample Patients tab

**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 individual encounter record for that patient.

#### 5.3.5.1 Add Patient Record

The Add button requires that the POV group box and the Standard Note Group Note (on the Group Data tab) be populated. Click the Add button to access the Select Multiple Patients search/select window (Figure 5-33). Here you can add one or more patients to the group encounter; you can search for a patient by name, Social Security Number, HRCN, or DOB.

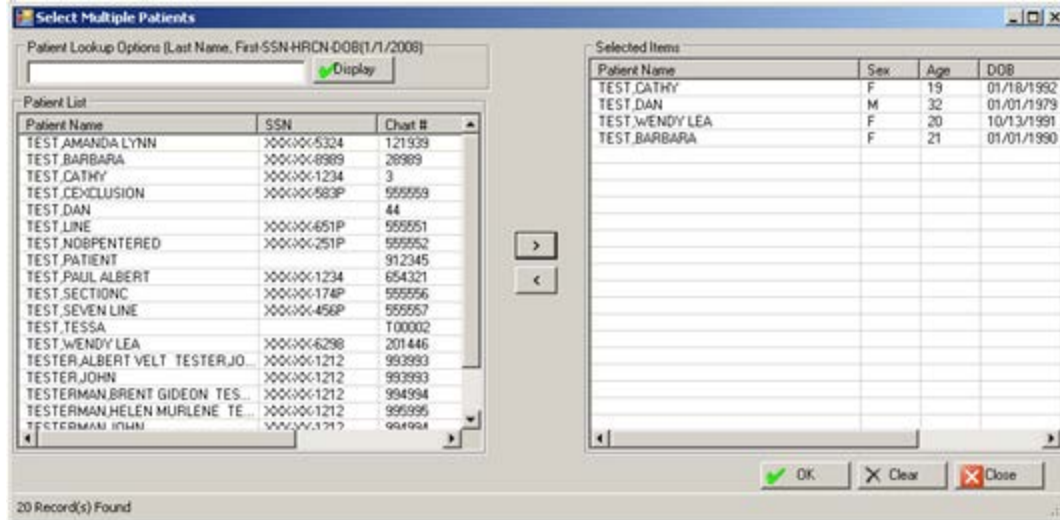


Figure 5-33: Sample Select Multiple Patients dialog

Use the OK button to have the patient names in the Selected Items group box to populate the Patients group box on the Patients tab.

Use the Clear button to clear all patient names on the dialog.

Use the Close button to close the dialog and no patient names are used.

### 5.3.5.2 Delete Patient Record

Use the Delete button to remove a patient from the group encounter. On the “Are You Sure” confirmation message, 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 do the no show within the group definition in the GUI.

### 5.3.6 Patient Data Tab

Use the Patient Data tab (Figure 5-34) to add POV, group note, and comment/next appointment information for a particular patient in the group encounter.

Patient Name	Sex	Age	DOB	Chart
EBY,ROBERT MITCHELL	M	15	02/19/1998	186585
FAUST,JIMMY JOE	M	27	11/01/1986	129347
COCHRAN,EDWARD RAYDEAN	M	43	07/23/1970	107900
BROWN,ISMEC A	M	47	09/18/1971	106175

Figure 5-34: Sample Patient Data tab

You need to select a patient by double-clicking the name 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.

### 5.3.6.1 Patients Group Box

The Patients group box shows the patients in the group encounter (Figure 5-35).

Patient Name	Sex	Age	DOB	Chart
DEMO,TIMMIE	M	9	06/18/1999	192144
DEMO,DOROTHY ROSE	F	66	10/10/1942	999999
DEMO,COLTON MAXWELL	M	31	05/18/1977	100678

Figure 5-35: 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 use 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 5-36).

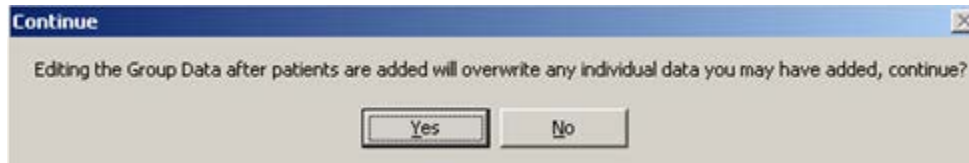


Figure 5-36: Warning Message

- 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.

### 5.3.6.2 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 (Figure 5-37).

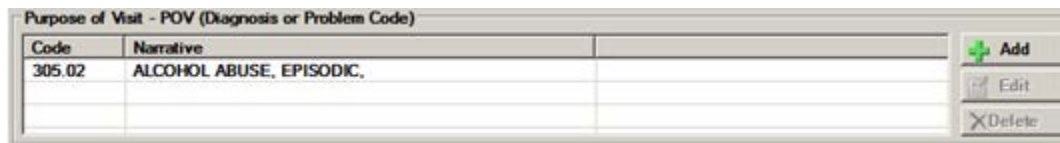


Figure 5-37: Sample POV group box

Section Appendix D: provides information about DSM copyright and trademark information.

This is required data for the group encounter record.

Use the Delete button to remove a selected POV. On the “Are You Sure” confirmation message, click Yes to remove the selected POV record from the group box (otherwise, click No).

Click the Add button to access the POV 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 dialog (Figure 5-38).

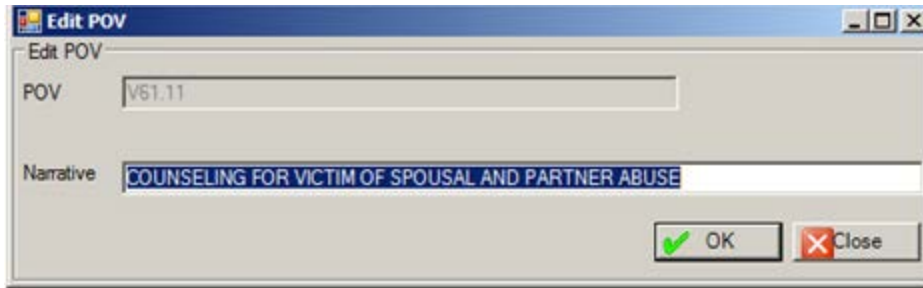


Figure 5-38: Sample Edit POV dialog

The Narrative field is a Free Text field (can contain 2-80 characters). Change the text of the 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 “ or ‘ cannot be the first character of the POV narrative.

### 5.3.6.3 Standard Group Note

This field will contain text of the Standard Group Note on the Group Data tab. You can add text about how the patient reacted in the group (on the Patient Data tab). 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.

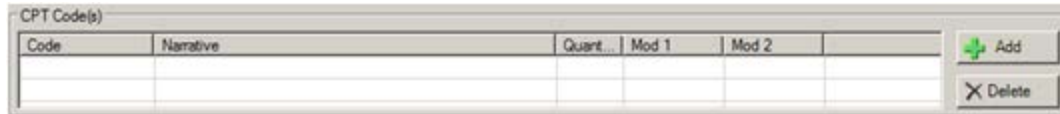
- This field is available for text entry by the primary provider of the record (only).
- This field is not available for text entry if the note for the group record is signed.

### 5.3.6.4 Comment/Next Appointment

Populate this Free Text field with the text of any comments about the next appointment for the selected patient. This field is available for text entry by the primary provider of the record (only).

### 5.3.6.5 CPT Code(s)

Populate the CPT Code(s) group box with the CPT codes associated with the selected patient (Figure 5-39).

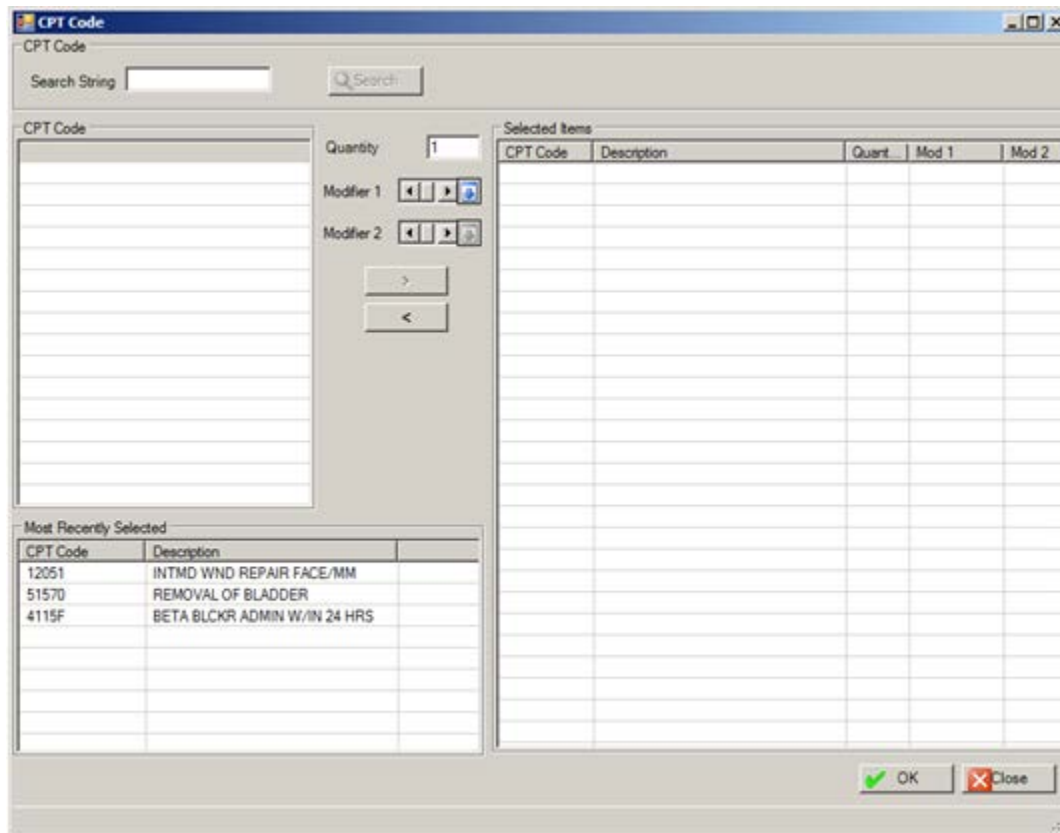


Code	Narrative	Quant...	Mod 1	Mod 2

Figure 5-39: CPT Code(s) group box

Use the Delete button to delete a selected record. On the “Are You Sure” confirmation message, click Yes to delete (otherwise, click No).

Use the Add button to add the CPT Codes on the CPT Code multiple search/select window (Figure 5-40).



CPT Code	Description	Quant	Mod 1	Mod 2

CPT Code	Description
12051	INTMD WND REPAIR FACE/MM
51570	REMOVAL OF BLADDER
4115F	BETA BLCKR ADMIN W/IN 24 HRS

Figure 5-40: CPT Code search/select window

The CPT codes in the Selected Items group box will populate CPT Code(s) group box on the Patient Data tab of the Group Data Entry dialog.

Remove a selected CPT code in the Selected Items group box by clicking the left-pointing arrow.

**Search String:** Use the Search String field to search for a particular CPT code. The CPT codes that match the search criteria will display in the CPT Code field (Figure 5-41).

CPT Code	Description
45000	DRAINAGE OF PELVX
45005	DRAINAGE OF RECTA
4500F	REF TO OUTPT CARD
45020	DRAINAGE OF RECTU
45100	BIOPSY OF RECTUM
45108	REMOVAL OF ANORE
4510F	PREV CARDREHAB G
45110	REMOVAL OF RECTU
45111	PARTIAL REMOVAL C
45112	REMOVAL OF RECTU
45113	PARTIAL PROTECTO
45114	PARTIAL REMOVAL C
45116	PARTIAL REMOVAL C
45119	REMOVE RECTUM W
45120	REMOVAL OF RECTU

Figure 5-41: Sample CPT Code search results

**Quantity:** use the Quantity field to determine the number of CPT codes to use to help facilitate billing.

**Modifier:** use the Modifier field to define the modifier for the CPT code. Click the drop-down list to access the CPT Modifier search window.

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

When the CPT Code search/select window is complete, click OK to save the data and add the data to the CPT Code(s) group box. (Otherwise, click Close.)

### 5.3.6.6 Time in Group

Populate this field (Figure 5-42) with the number of minutes in the group encounter (up to six digits).

Figure 5-42: Sample Time in Group field

This is required data for the group encounter record.

Consider the following:

- If the patient attended the whole group session, no changes need to be made to the Time Spent in Group field.

- If the patient was late or left early, the Time Spent in Group field needs to be changed to reflect the actual time in minutes that the patient was in the group.
- If the patient didn't attend at all, 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 the Group Note entered on the Group Data tab have been removed at this point).

### 5.3.6.7 Visit Flag

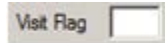


Figure 5-43: Visit Flag field

Specify the visit flag (Figure 5-43) by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.



## 6.0 Case Management

This section provides information about case management in Roll and Scroll as well as in the RPMS Behavioral Health System (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.

#	PROGRAM	OPEN	ADMIT	CLOSED	DISPOSITION	PROVIDER
1		1/17/12				
2	MENTAL	12/8/10				
3	MENTAL	12/7/10				
4	MENTAL	3/19/09	3/23/09			THETA, SHIRLEY
	Primary Problem: 11 DRUG WITHDRAWAL SYNDROME					
	Next Review:					
5	MENTAL	3/13/09	3/20/09		OTHER	THETA, SHIRLEY
	Primary Problem: 11 DRUG WITHDRAWAL SYNDROME					
	Next Review: 3/27/09					
6	MENTAL	3/13/09	3/20/09	4/2/09	MUTUAL AGREEMENT TO	THETA, SHIRLEY
	Primary Problem: 11 DRUG WITHDRAWAL SYNDROME					
	Next Review: 3/25/09					
?? for more actions + next screen - prev screen >>>						
OP	Open New Case		DC	Delete Case		
ED	Edit Case Data		Q	Quit		
Select Item(s): Quit//						

Figure 6-1: Sample Update BH Patient Case Data screen

Use the Quit (Q) option to exit the Update BH Patient Case Data screen.

#### 6.1.1 Open New Case (OP)

Use the Open New Case (OP) option to create a new case. If you use the Open New Case (OP) option, the application displays that it is opening a case for the current patient.

Below are the prompts.

##### 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: MENTAL HEALTH
PROVIDER NAME:
PRIMARY PROBLEM:

CASE ADMIT DATE:
NEXT CASE REVIEW DATE:

DATE CASE CLOSED:
DISPOSITION:

COMMENT:
-----
Exit      Save      Refresh

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

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 (you can change).

### 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 is the name of the provider for the case.

### 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 when treatment has been discontinued. (Used when 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.

**6.1.2 Edit Case Data (ED)**

Use the Edit Case Data (ED) option to change a selected case. Use this option to edit an open case where you enter the admitted date when a case is admitted or to close the case when it is closed on the Update Patient Data window. The fields on this window are the same as those when you use the Open New Case option. Section 6.1.1 provides more information about this option.

**6.1.3 Delete Case (DC)**

Use the Delete Case (DC) option to remove a specified case from the Update BH Patient Case Data window. The application verifies the deletion.

**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:	
<hr/>	
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 or Alcohol/Substance Abuse 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 Behavioral Health 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 in length.

After you save or exit the Update Patient Information window, the application displays the Personal History window.

If the patient has an existing Personal History entry, the application displays this information (the date and the personal history factor). You can add another personal history factor, if needed.

Facilities often find personal history factors to be useful in developing reports for tracking diagnoses associated with personal history.

Below are the prompts.

### Enter Personal History

Specify the personal history factor for the current patient. If you do not want to add another personal history, use “^” at the prompt. After you have finished the personal history entry, you return to the Patient Data Entry window.

The personal history data entered here appears on the Patient List for Personal Hx Items report.

## 6.3 Case Management Window (GUI)

Below shows where the Case Management function is located on RPMS Behavioral Health System (GUI) tree structure (Figure 6-4).

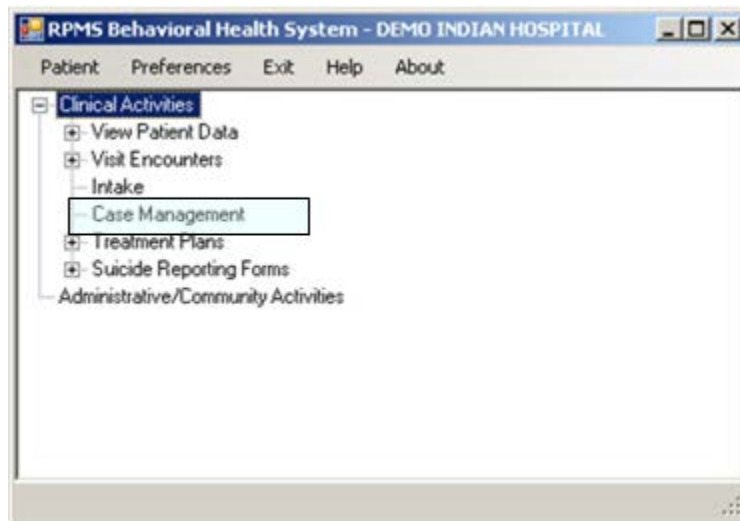


Figure 6-4: Case Management option on the RPMS Behavioral Health System (GUI) tree structure

Use the Case Management option to access the Case Management window (Figure 6-5) for the current patient.

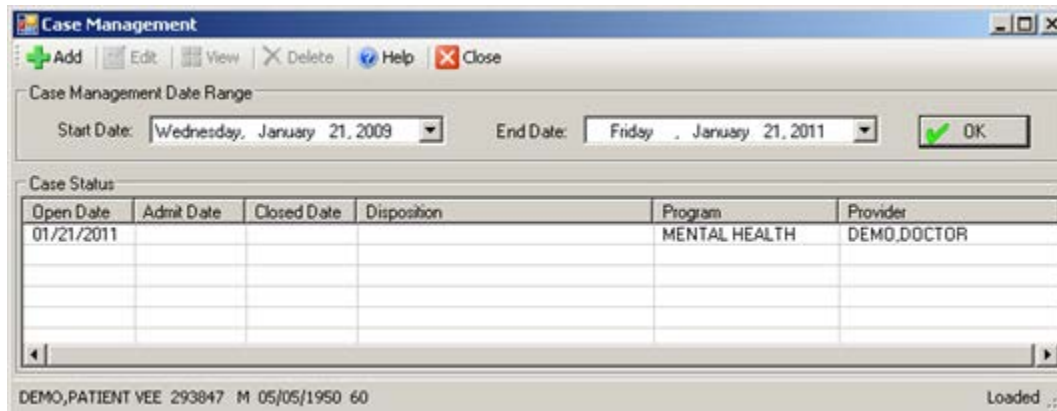


Figure 6-5: Sample Case Management window

You use the Case Management window to manage the case management records within a particular date range for the current patient (the name displays in the lower, left corner of the window).

### 6.3.1 Case Management Date Range

The date range for the displayed case management records is shown in the Case Status Date Range group box.

You can change the date range by accessing the calendar under the drop-down list for the date. After changing the date range, click OK to update the display in the Case Status group box.

### 6.3.2 Case Status Group Box

The Case Status group box displays the case management records in the case management 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 management record. You access the Case Management - Add Case window. Section 6.4 provides more information about this window.

### 6.3.4 Edit Button

Use the Edit button to edit a particular case management record. 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 on the add/edit case window. Section 6.4 provides more information about this window.

### 6.3.6 Delete Button

Use the Delete button to remove a selected Case Status record. On the “Are You Sure” confirmation message, click Yes to remove the selected case status record from the group box (otherwise, click No).

### 6.3.7 Help Button

Use the Help button to access the online help system for the Case Management window.

### 6.3.8 Close Button

Use the Close button to close 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).

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. This dialog states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add window. Click No and you remain on the add window where you can continue work on the Add Case window.

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

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

Several of the fields contain a search window. Section 2.8 provides more information about this window.

The fields that contain dates can be changed by accessing a calendar. Section 2.7 provides more information about using a calendar.

Certain fields use the search/select window. Section 2.9 provides more information about this window.



Some fields use the multiple-select window. Section 2.10 provides more information about this window.

### 6.4.1 Case Status Group Box

The screenshot shows a form titled 'Case Status Group Box'. It contains the following fields:

- Case Status**: A dropdown menu.
- Program**: A dropdown menu.
- Case Open Date**: A date field with a checkbox and a date value (Wednesday, February 01, 2012).
- Provider Name**: A text field with a search icon.
- Primary Problem**: A text field with a search icon.
- Comment**: A large text area.
- Case Admit Date**: A date field with a checkbox and a date value (Wednesday, February 01, 2012).
- Next Review Date**: A date field with a checkbox and a date value (Wednesday, February 01, 2012).
- Date Case Closed**: A date field with a checkbox and a date value (Wednesday, February 01, 2012).
- Disposition**: A text field with a search icon.

Figure 6-7: Fields in Case Status group box

The fields in bold text are required (Figure 6-7).

#### **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, or Chemical Dependency.

#### **Case Admit Date**

This is when a case management plan was developed and treatment began. You can accept the default date by selecting the checkbox 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 selecting the checkbox 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 selecting the checkbox in front of the date.

### Primary Problem

This is the primary problem for the case. Click the drop-down list to access the 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.

### Other Provider Non-RPMS

Populate with another Behavioral Health provider not listed in RPMS, using between 2–40 characters (Free Text field).

**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.

**Designated Provider Other RPMS**

This is the RPMS provider who has accepted designated other RPMS provider status for the patient. Click the drop-down list to access the Designated Other RPMS Provider search window.

**Patient Flag Narrative**

Populate with the narrative about the patient flag, using between 2–60 characters.

**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.

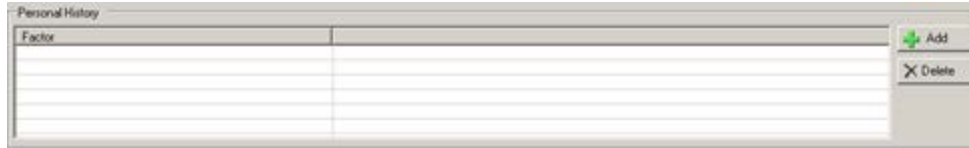


Figure 6-9: Sample Personal History group box

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. On the "Are You Sure" confirmation message, 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 option gives assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems.

### 7.1 Add Administrative/Community Activity Record (Roll and Scroll)

The AC (Add Adm/Comm Activity) option is found under the SDE option on the BH data entry window.

After using the AC option, 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  rust 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

Use the Add Adm/Comm Activity (AC) option to add the administrative/community activity data.

Below are the prompts.

#### Enter PRIMARY PROVIDER

This is the primary provider for the visit. The default is the current logon user.

The application displays the Behavioral Health Record Update window, with the following fields automatically populated: Program, Location of Encounter, Arrival Time, Secondary Providers, Community of Service, # Served, Type of Contact. These fields are auto-populated based on the defaults set up on the site parameters menu. If you do not have defaults set up on the site parameters menu some of these fields might be blank.

```

* BEHAVIORAL HEALTH 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 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 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?

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

```

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

```

```

Encounter Date: MAR 31,2009@12:00      User: THETA,SHIRLEY
-----
PROVIDER: DEMO,DOCTOR                PRIMARY/SECONDARY: PRIMARY
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
COMMAND:                               Press <PF1>H for help   Insert

```

Figure 7-3: Sample Enter/Edit Providers of Service pop-up

The underlined fields are required.

**PROVIDER:** Specify the provider name. You can add one or more secondary providers.

**PRIMARY/SECONDARY:** Indicate the type of provider. Only one Primary provider can be used, while you can use one or more secondary providers.

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. Appendix A: provides more information about activity codes and definitions.

### # Served

This is the number of people served in the community activity, using any integer between 0 and 999.

### Activity Time

This is the number of minutes spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry.

### 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?

Use Y or N. If you use Y, the Prevention Activities pop-up displays:

```

Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:
  
```

Figure 7-4: Pop-up for prevention activities

The Target field will be disabled until a Prevention Activity is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

The underlined fields are required.

**Prevention Activity:** populate with the code for the prevention activity. These activities are recorded when recording non-patient 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:
  
```



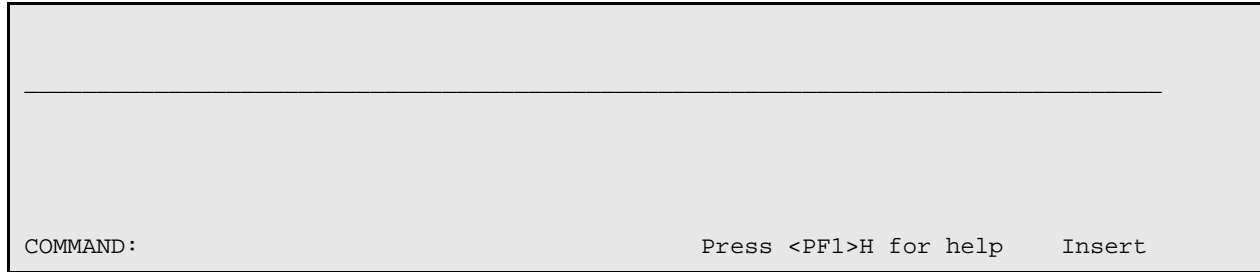


Figure 7-5: Sample BH Record Entry POV window

The underlined fields are required.

**Problem Code:** specify the problem code that can either the Behavioral Health Purpose of Visit or the more specific DSM-5 diagnostic code. Section Appendix D: provides information about DSM copyright and trademark information.

**Narrative:** populate with the text of the narrative for the problem code, if needed.

The prompts for the Behavioral Health Record Update window continue.

#### **COMMENT (press enter)**

Press Enter to access another window where you can enter the text of comments about the Administrative/Community Activity.

## 7.2 Administrative/Community Activity Window (GUI)

Below shows where the Administrative/Community Activities function is located on RPMS Behavioral Health System (GUI) tree structure (Figure 7-6).

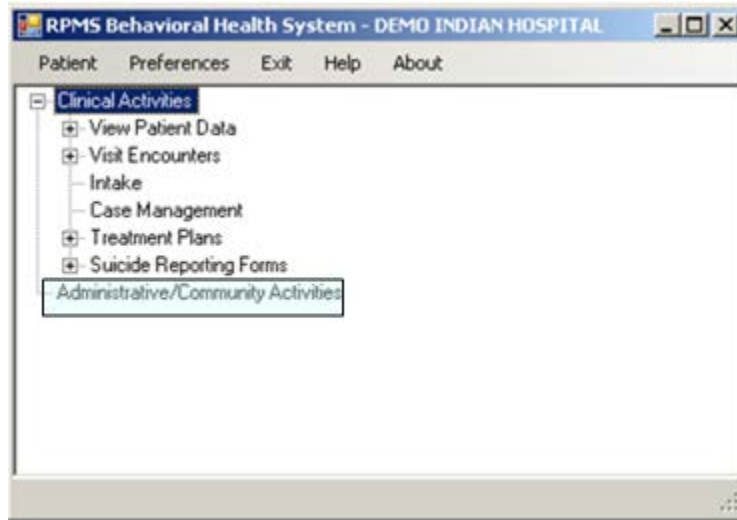


Figure 7-6: Administrative/Community Activities option on the RPMS Behavioral Health System (GUI) tree structure

After selecting the Administrative/Community Activities option from the RPMS Behavioral Health System (GUI) tree structure, the Administrative/Community Activity window displays (Figure 7-7).

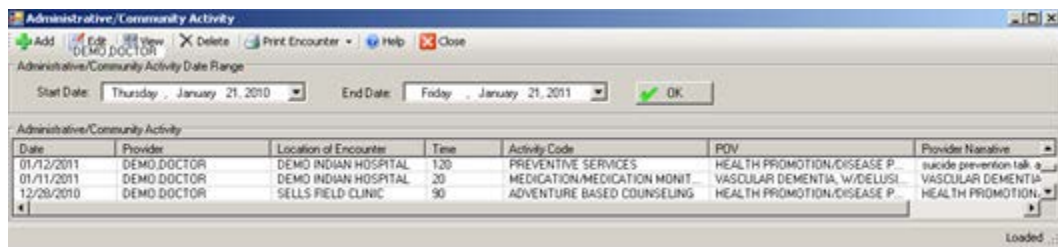


Figure 7-7: Sample Administrative/Community Activity window

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. You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click OK to display the records in the Administrative/Community Activity group box.

### 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 on the Administrative/Community Activity Data Entry - Add Administrative/Community Data window. Section 7.3 provides more information about the add function.

### 7.2.4 Edit Button

Use the Edit button to edit a particular administrative/community activity record on the Administrative/Community Activity Data Entry - Edit Administrative/Community Data window. This window has the same fields as the Administrative/Community Activity Data Entry - Add Administrative/Community Data window.

### 7.2.5 View Button

Highlight an administrative/community activity record and click View to browse the data (or double-click on a record) on the Community Activity Data Entry - View Community Data window (view-only). 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).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Jan 17, 2014@12:23:56
*** Computer Generated Encounter Record ***
-----
Date: Feb 23, 2013      Primary Provider: WISDOM, WENDY
Arrival Time: 08:00
Program: CHEMICAL DEPENDENCY
Clinic: ALCOHOL AND SUBSTANCE      Appointment Type:

-----
Community: WHITE EARTH      Number      Activity/Service
Activity: 97-HEALTH PROMOTION      Served: 10      Time: 480 minutes
Type of Contact: OUTPATIENT

CHIEF COMPLAINT/PRESENTING PROBLEM:

S/O/A/P:

-----
COMMENT/NEXT APPOINTMENT:
yttstlsltlctlfistfywuyfyj3gogogal

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

-----
1.1      HEALTH PROMOTION/DISEASE PREVENTION
February DOI class #2

PREVENTION ACTIVITIES:
ALCOHOL/DRUG EDUCATION

TARGET POPULATION FOR PREVENTION ACTIVITIES: ADULT

MEDICATIONS PRESCRIBED:

```

Figure 7-8: Sample output for a selected Administrative/Community Activity record

Suppressed means that the chief complaint/presenting problem information is suppressed for confidentiality. Section 2.6 provides 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 (on the Administrative/Community Activity window) to add new administrative/community activity data. This function displays the Administrative/Community Activity Data Entry - Add Administrative/Community Data window.

Highlight a record (on the Administrative/Community Activity window) and click Edit to change the administrative/community activity data. This function displays the Administrative/Community Activity Data Entry - Edit Administrative/Community Data window. This window has the same fields as the Administrative/Community Activity Data Entry - Add Administrative/Community Data (Figure 7-8).

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 to add a record to the Administrative/Community Activity window. (Otherwise, click Close).

Some fields access a search window. Section 2.8 provides more information on how to use this window.

Some fields access the calendar where you can change the date. Section 2.7 provides more information about using the calendar.

Some fields access the search/select window. Section 2.9 provides more information about this window.

Some fields are Free Text boxes. Section 2.11 provides more information about Free Text boxes.

### 7.3.1 Administrative/Community Entry Group Box

Figure 7-10 shows 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. Change the date by clicking the drop-down list to access the calendar. You can change the time manually. You can select the hour, minutes, and AM/PM. If you make the hour and minutes, for example, 13:25, the application automatically changes the time to 1:25 PM.

#### **Program**

This is the program associated with the administrative/community activity. Use one of the following: Mental Health, Social Services, Other, or 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 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 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 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 search for the activity name. Section Appendix A: Activity Codes and Definitions for more information about activity codes and definitions.

**Activity Time**

This the number of minutes spent on the activity, using any integer between 1 and 9999.

**Number Served**

This is the number of people served in the administrative/community activity, using any integer between 0 and 999.

**Flag Field**

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

**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

The screenshot shows the 'Activity Data' tab with three sections:

- Purpose of Visit - POV:** A table with columns 'Code' and 'Narrative'. It has 'Add', 'Edit', and 'Delete' buttons on the right.
- Prevention Activities:** A table with columns 'Prevention Activity', 'Code', and 'Other'. It has 'Add' and 'Delete' buttons on the right. Below the table is a 'Target' dropdown menu.
- Secondary Providers:** A table with a 'Provider' column. It has 'Add' and 'Delete' buttons on the right.

Figure 7-11: Sample Activity Data tab

Use the Activity Data tab (Figure 7-11) to specify the POV, prevention activities, and secondary providers data.

### 7.3.2.1 Purpose of Visit - POV Group Box

The POV group box (Figure 7-12) lists the POVs associated with the administrative/community activity.

The screenshot shows the 'Purpose of Visit - POV' group box with the following data:

Code	Narrative
97	ADMINISTRATION

Figure 7-12: Sample POV group box

At least one POV is required for an administration/community activity record. 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 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 dialog (Figure 7-13).



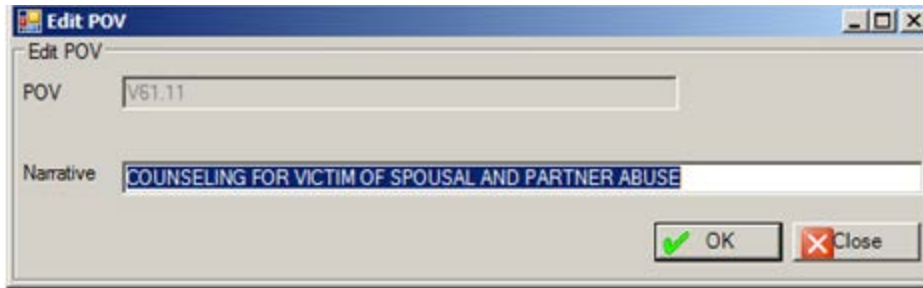


Figure 7-13: Edit POV dialog

The Narrative field is a Free Text field. Type the new POV narrative in the Narrative text box and click OK (otherwise, click Close). The OK process changes the narrative of the selected record. Note: the special characters “ or ‘ cannot be the first character of the POV narrative. The POV narrative field can contain 2–80 characters.

### 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. On the “Are You Sure” confirmation message, 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 (Figure 7-14) lists the prevention activities associated with the administrative/community activity.

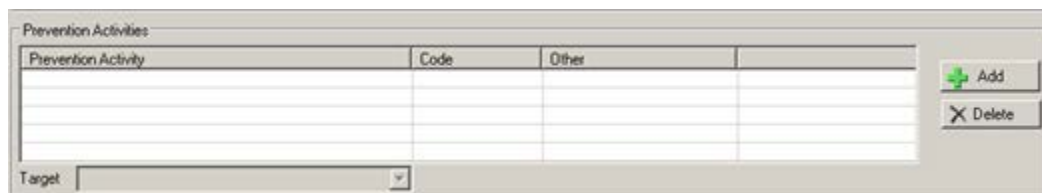


Figure 7-14: Sample Prevention Activities group box

The Target field will be disabled until a Prevention Activity is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

You can add/delete a prevention activity and/or specify the target group.

#### 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 & Youth)
- Staff
- Elderly Only
- Women

### 7.3.2.2.1 Add Button

Use the Add button to add a prevention activity record to the group box. 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 dialog (Figure 7-15).



Figure 7-15: Other dialog

Populate the Other field with text of the other prevention activity associated with this record (limited to 80 characters). When complete, click OK (otherwise, click Close). The OK process populates the Other cell on the grid. If you dismiss the Other dialog (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. On the “Are You Sure” confirmation message, 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 (Figure 7-16) 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 Provider 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. On the “Are You Sure” confirmation message, 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 (Figure 7-17) to enter any notes about the administrative/community activity.

The image shows a screenshot of a software window titled "Activity Data". At the top, there are two tabs: "Activity Data" and "Notes". The "Notes" tab is currently selected. Below the tabs, there is a large, empty rectangular text area for entering notes. The text area is bordered and has a light gray background.

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 Site Parameters as a provider who can share information.

Make sure that the provider being sent the plan should actually be using this function.

After the entry of a Visit or Treatment plan, you will be asked the question shown in Figure 8-1):

```
Do you want to share this visit information with other providers? N//
```

Figure 8-1: Question after entry of a visit or treatment plan

By answering the question with a Yes, you will be stepped through the process of sending the information via a MailMan message, as shown in Figure 8-2):

```
Send to: NUUUU,BILL          WBM
Send to:

Message will be sent to:    THETA,BILL

Do you want to attach a note to this mail message? N// YES
Enter the text of your note.

NOTE APPENDED TO MAIL MSG:
  No existing text
  Edit? NO//Y
  - Here the provider can append a note to his/her colleague.

Ready to send mail message?? Y// ES
Send Full or Suppressed Form: (F/S): S// f FULL - The answer to this question
will determine which type of encounter form will be send in the message.

Sending Mailman message to distribution list
Message Sent
Press enter to continue....:
```

Figure 8-2: Sending a treatment plan through MailMan

## 9.0 Problem List

This section addresses the Problem List management for Roll and Scroll and the GUI.

### 9.1 BH Patient's Problem List (Roll and Scroll)

The PPL option appears on the Patient Data Entry and Update BH Forms windows.

Use the PPL option to manage the patient's problem list.

The application displays the following information:

```
Problem List updates must be attached to a visit. If you are updating the
Problem List in the context of a patient visit select the appropriate existing
visit and then update the Problem List. If you are updating the Problem List
outside of the context of a patient visit, first create a chart review visit
and then update the Problem List.
Select record to associate the Problem List update to: (1-5):
```

Figure 9-1: Message displayed by the application

#### Enter ENCOUNTER DATE:

Populate with the encounter date for the problem list.

Figure 9-2 shows the patient's problem list.

```
BH Problem List Update          Aug 23, 2011 14:05:45          Page: 1 of 1
-----
Patient Name: DEMO,DUCK      DOB: FEB 05, 1975    Sex: M    HRN: 36219
-----

BH Problem List Updated On: Aug 22, 2011  By: SIGMA,DARLA

1)  DX: 301.0    Status: ACTIVE    Last Modified: 08/22/2011
    DSM Narrative: PARANOID PERSONALITY DISORDER
    Provider Narrative: PARANOID PERSONALITY DISORDER
    Date of Onset: 02/10/2009    Facility: DEMO INDIAN HOSPITAL
    Notes:
      STP Note #1 Added: 12/7/2010
      Narrative: Treat physical illness from time to time
      Note #2 Added: 12/9/2010

      Enter ?? for more actions                                >>>
AP  Add BH Problem      DD  Detail Display          LR  Problem List Reviewed
EP  Edit BH Problem     NO  Add Note              HS  Health Summary
DE  Delete BH Problem   MN  Edit Note            FA  Face Sheet
AC  Activate BH Problem RN  Remove Note          PC  PCC Prob List Display
IP  Inactivate BH Prob  NP  No Active BH Problems Q  Quit
Select Action: +//
Select Action: +//
```

Figure 9-2: Sample BH Problem List update window

Use the Q action to exit this window.

### 9.1.1 Add BH Problem (AP)

Use the AP action to add a new BH problem for the current patient's visit.

The application displays information about the POV diagnosis assigned to the patient in the past 90 days.

#### **Choose a Diagnosis**

Specify one of the diagnosis.

#### **Enter Diagnosis to Add to the Problem List**

Specify the active diagnosis code to add to the problem list.

The application displays the Provider Narrative for the particular problem (can be changed).

#### **STATUS**

Select one of the following: A (active), or I (Inactive).

#### **DATE OF ONSET**

Specify the date of onset, when the problem was first diagnosed. (This can be left blank.)

#### **Add TREATMENT Note?**

To add a treatment note, specify Y (yes). Otherwise, specify N (no).

If you used N, focus will go to the "Enter the Date the Problem List was Updated by the Provider" prompt.

If you used Y, the following prompts will display:

#### **PROVIDER NARRATIVE**

Specify the text of the narrative for the treatment note.

#### **AUTHOR**

Use the default name or specify a new one.

#### **LONG/SHORT TERM TREATMENT**

Use 1 for Short Term or 2 for Long Term. This refers to the treatment described in the Treatment note.

After completing the last prompt, focus returns to the “Add TREATMENT Note?” prompt.

**Enter the Date the Problem List was Updated by the Provider**

Use the current date or specify a new one.

**Enter the individual that updated the Problem List**

Specify the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

**9.1.2 Edit BH Problem (EP)**

Use the EP action to edit a specified BH problem.

The application displays the following prompts:

**Select Problem**

Specify the number of the problem to edit. After specifying a valid problem number, the prompts continue.

**Diagnosis**

The current diagnosis displays. This can be changed, if needed.

**Provider narrative <text of narrative>**

The text of the narrative displays. This can be changed, if needed.

**DATE OF ONSET**

This is the date of onset, when the problem was first diagnosed. (This can be left blank.)

**STATUS**

The current status displays. This can be changed using: A (active), or I (Inactive).

**Enter the Date the Problem List was Updated by the Provider**

Use the current date or specify a new one.

**Enter the individual that updated the Problem List**

Specify the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

**9.1.3 Delete BH Problem (DE)**

Use the DE action to delete a specified BH problem.

The application displays the following prompts:

**Select Action**

Specify the action to execute, either 1 (Delete BH Problem) or 2 (Detail Display). Use 1 in this case.

**Select Problem**

Specify the number of the problem to delete. After specifying a valid problem number, the displays information about the particular problem, for example:

```
Deleting the following BH Problem from DUCK DEMO's BH Problem List.

PROBLEM CODE: 9.1                PATIENT NAME: DEMO,DUCK
DATE LAST MODIFIED: SEP 07, 2011@14:07:46
PROVIDER NARRATIVE: PRE-SENILE CONDITION
FACILITY: DEMO INDIAN HOSPITAL    NMBR: 3
DATE ENTERED: SEP 07, 2011@13:54:16  STATUS: ACTIVE
USER LAST UPDATE: THETA,SHIRLEY

Please Note: You are NOT permitted to delete a BH Problem without
entering a reason for the deletion.
```

Figure 9-3: Example of information displayed about the problem code

**Are you sure you want to delete this BH Problem?**

Use either Y (yes) or N (no).

If you used N, focus will return to the BH Problem List Update window.

If you used Y, the following prompts will display:

**Enter the Provider who deleted the Problem**

Use the default name or specify the name of the provider who deleted the problem.



**REASON PROBLEM DELETED**

Use one of the following reasons: D (Duplicate), E (Entered in Error), or O (other). If you use O, other prompts will display.

**Enter the Date the Problem List was Updated by the Provider**

Use the default date or specify a new one.

**Enter the individual that updated the Problem List**

Use the default name or specify a new one.

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

**9.1.4 Activate BH Problem (AC)**

Use the AC action to cause the status of a particular inactive BH problem to be active.

The application displays the following prompts:

**Select Problem**

Specify the number of the problem to activate.

- If the particular problem is already active, the application will display the following message:

```
That problem is already ACTIVE!!
Press return to continue....:
```

Figure 9-4: Message displayed when the problem is already active

After pressing Enter, focus returns to the BH Problem List Update window.

- If the particular problem is not active, the prompts continue:

**Enter the Date the Problem List was Updated by the Provider**

Use the default date or specify a new one.

**Enter the individual that updated the Problem List**

Specify the name of the individual who updated the BH Problem List.

- If you are transcribing an update from a BHS provider, then enter the name of the provider.

- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

### 9.1.5 Inactivate BH Problem (IP)

Use the IP action to cause the status of a particular active BH problem to be inactive.

The application displays the following prompts:

#### **Select Problem**

Specify the number of the problem to inactivate.

- If the particular problem is already inactive, the application will display the following message:

```
That problem is already INACTIVE!!  
Press return to continue....:
```

Figure 9-5: Message displayed when the problem is already inactive

After pressing Enter, focus returns to the BH Problem List Update window.

- If the particular problem is not inactive, the prompts continue:

#### **Enter the Date the Problem List was Updated by the Provider**

Use the default date or specify a new one.

#### **Enter the individual that updated the Problem List**

Specify the name of the individual who updated the Problem List.

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

### 9.1.6 Detail Display (DD)

Use the DD option to display detail information about a selected BH problem.

The application displays the following prompts:

#### **Select Problem**

Specify the problem to use.

The application displays Behavioral Health Problem List information on the Output Browser screen.

OUTPUT BROWSER	Dec 05, 2011 11:53:53	Page:	1 of 1
Behavioral Health Problem Display			
PROBLEM CODE:	6.2		
PATIENT NAME:	DEMO,DOROTHY ROSE		
DATE LAST MODIFIED:	DEC 07, 2010		
PROVIDER NARRATIVE:	pt has terminal illness		
FACILITY:	DEMO INDIAN HOSPITAL		
NMBR:	1		
DATE ENTERED:	DEC 07, 2010		
STATUS:	ACTIVE		
USER LAST UPDATE	DEMO,DOCTOR		
ADD TO PCC PROBLEM LIST?:	YES		
Notes:			
1) Date Added: 12/07/2010 Author: THETA,SHIRLEY			
Note Narrative: Treat physical illness from time to time			
SHORT TERM TREATMENT			
2) Date Added: 12/09/2010 Author: THETA,SHIRLEY			
Note Narrative: physical ill			

Figure 9-6: Sample Problem Detail

### 9.1.7 Add Note (NO)

Use the NO option to add a note to a selected BH problem.

The application displays the following prompts:

#### Select Action

Select one of the following:

- 1 Add Note
- 2 No Active BH Problems

Use 1 in this case.

The application displays information about the patient's BH problem list.

#### Add a new Problem Note for this Problem?

Use Y to add a note. Otherwise, use N.

If you use Y, the following prompt displays:

#### NARRATIVE

Populate this field with the text of the narrative of the note.

**AUTHOR**

Use the default name or specify a new one.

**LONG/SHORT TERM TREATMENT**

Use one of the following: 1 (for short) or 2 (for long).

The application will re-display the information about the problem and information about the notes.

```

Adding a Note to the following problem on DOROTHY ROSE DEMO's BH Problem List.

PROBLEM CODE: 304.22                PATIENT NAME: DEMO,DOROTHY ROSE
DATE LAST MODIFIED: OCT 05, 2011@11:18:18
PROVIDER NARRATIVE: COCAINE DEPENDENCE, EPISODIC
FACILITY: DEMO INDIAN HOSPITAL      NMBR: 2
DATE ENTERED: OCT 05, 2011@11:18:18  STATUS: ACTIVE
USER LAST UPDATE: DEMO,DOCTOR

Notes:

1) Date Added: 12/01/2011 Author: DEMO,CASE M
   Note Narrative: Pt has problems will illegaldrugs
   SHORT TERM TREATMENT

2) Date Added: 12/05/2011 Author: DEMO,DOCTOR
   Note Narrative: Pt has resolved some of the problems with illegal drugs
   SHORT TERM TREATMENT

```

Figure 9-7: Example of information about the problem and information about the notes

**Add a new Problem Note for this Problem?**

Use Y (for yes) or N (for no).

If you used Y, the prompts will repeat, starting with NARRATIVE.

If you used N, the prompts will continue.

**Enter the Date the Problem List was Updated by the Provider**

Use the default date or specify another one.

**Enter the individual that updated the Problem List**

Specify the name of the individual who updated the BH Problem List.

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

### 9.1.8 Edit Note (MN)

Use the MN option to edit the text of a selected note.

The application displays the following prompts:

#### **Select Problem**

Specify the problem having the note to be edited.

The application displays information about the selected problem and information about any existing notes.

#### **Edit which one**

Specify the note to edit.

**NARRATIVE: <text of the problem>//  
Replace**

Populate the Replace field with the replacement text for the narrative.

#### **LONG/SHORT TERM TREATMENT**

Use one of the following: 1 (for short) or 2 (for long).

#### **Enter the Date the Problem List was Updated by the Provider**

Use the default date or specify another one.

#### **Enter the individual that updated the Problem List**

Specify the name of the individual who updated the BH Problem List.

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

### 9.1.9 Remove Note (RN)

Use the RN to delete a selected note.

The application displays the following prompts:

#### **Select Problem**

Specify the problem having the note to be removed.

The application displays information about the selected problem and information about any existing notes.

**Remove which one**

Specify the note to remove.

**Are you sure you want to delete this NOTE?**

Use Y (yes) or N (no).

If you used N, you will return to the BH Problem List Updated window.

If you used Y, the prompts will continue.

**Enter the Date the Problem List was Updated by the Provider**

Use the default date or specify another date.

**Enter the individual that updated the Problem List**

Specify the name of the individual who updated the Problem List.

- If you are transcribing an update from a BHS provider, then enter the name of the provider.
- If you are a data entry/coder correcting the BH Problem List (for instance, correcting the DSM code) then enter your own name.

**9.1.10 No Active BH Problems (NP)**

Use the NP action to specify the date when a particular provider indicated that the patient had no active BH problems. This action requires that there are no ACTIVE problems on the patient's BH problem list (otherwise, the application will display an error message).

The application displays the following prompts:

**Did the Provider indicate that the patient has No Active BH Problems**

Specify Y (yes) or N (no).

If you used N, focus will return to the BH Problem List Update window.

If you used Y, the prompts will continue:

**Enter the Date the Provider documented 'No Active BH Problems'**

Use the default date or specify another one.

**Enter the PROVIDER who documented 'No Active BH Problems'**

Specify the provider name who documented that there are no active BH problems.

### 9.1.11 Problem List Reviewed (LR)

Use the LR action to indicate who and when the current patient's BH Problem List was reviewed.

The application displays the following prompts:

**Did the Provider indicate that he/she reviewed the Problem List?**

Specify Y (yes) or N (no).

If N is used, the application will display "No Action Take" and focus will return to the BH Problem List Update window.

If Y is used, the prompts continue.

**Enter the Date the Provider Reviewed the Problem List**

Use the default date or specify a new one.

**Enter the PROVIDER who Reviewed the Problem List**

Specify the name of the provider who reviewed the BH Problem List.

### 9.1.12 PCC Problem List Display (PC)

Use the PC action to display the PCC problem list.

After using the PC action, the application displays the message:

```
You are now leaving the Behavioral Health Problem List and will be taken
into the PCC Problem List for updating.
```

```
Do you wish to continue? Y//
```

Figure 9-8: Information displayed by the application

If you used N at the last prompt, focus will return to the BH Problem List Update window.

If you used Y, the application displays the PCC Problem List Display window.

```
PCC Problem List Display          Sep 07, 2011 15:46:04          Page:    1 of    3
-----
Patient Name: DEMO,DOROTHY ROSE  DOB: OCT 10, 1942  Sex: F  HRN: 99999
-----
Problem List Reviewed On: Dec 02, 2011  By: DEMO,DOCTOR
Problem List Updated On: Jan 27, 2012  By: THETA,WENDY

1) Problem ID:   WW1    DX: 995.2    Status: ACTIVE    Onset:
   Provider Narrative:  ADE: PCN, SULFA
```

```

2) Problem ID:   WW2   DX: 493.90  Status: ACTIVE  Onset: 2/0/2001
   Provider Narrative: Asthma, Unspecified
   Classification:  2-MILD PERSISTENT

3) Problem ID:   WW7   DX: V15.89  Status: ACTIVE  Onset:
+   Enter ?? for more actions                                     >>>
DD  Display a PCC Prob   A  Quit
Select Action: +//

```

Figure 9-9: Example of Problem List Update screen

If you use DD at the “Select Action” prompt, the application displays the following prompt:

**Select Problem: (1-xx)**

Specify the problem to use.

The application displays the PPC Prob information on the Output Browser, as shown in Figure 9-10.

```

OUTPUT BROWSER                               Jan 02, 2014 11:33:46           Page: 1 of 1

DIAGNOSIS: V15.89                            PATIENT NAME: DEMO,DOROTHY ROSE
DATE LAST MODIFIED: SEP 07, 2011
PROVIDER NARRATIVE: pt has terminal illness
FACILITY: DEMO INDIAN HOSPITAL                NMBR: 7
DATE ENTERED: SEP 07, 2011                   STATUS: ACTIVE
ENTERED BY: THETA,SHIRLEY

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

```

Figure 9-10: Sample information about the selected PCC problem

## 9.2 Problem List (GUI)

This section addresses how to manage the problems for the selected patient on the Visit window for one patient.

After selecting a record and clicking the Problem button, select one of the following options:



- BH Problem List
- PCC Problem List

### 9.2.1 Behavior Health Problem List Window

After selecting the BH Problem List option, the application will display the Behavioral Health Problem List window.

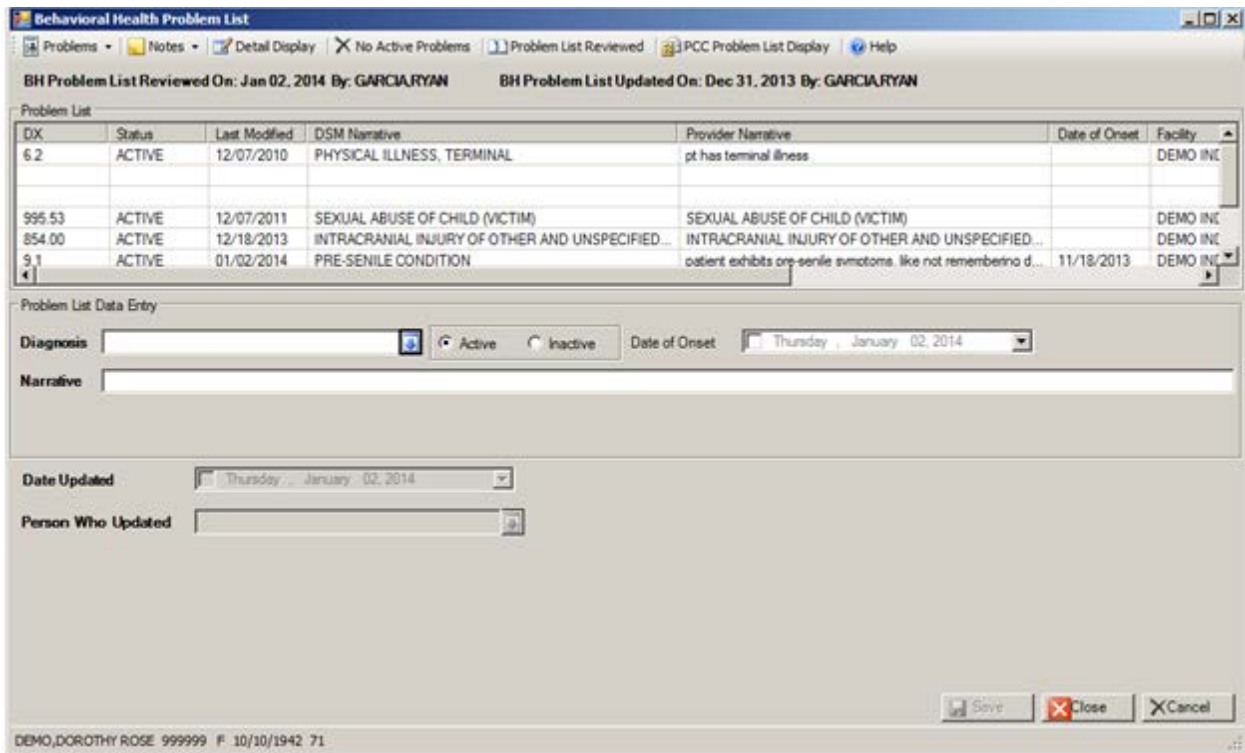


Figure 9-11: Sample Behavioral Health Problem List window

The current patient's problems display in the Problem List grid, including any associated notes. The note displays on the row below the problem.

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

The Save, Close, and Cancel controls have the following features:

- After clicking Save, the current action will execute (like Add Problem) and you will remain on the window.
- After clicking Close, you will leave the window.
- After clicking Cancel, you will remain on the window and no action (like Add Problem) will be taken.

This window has fields that use the following application features:

- The Free Text fields have a context menu for editing the text. Section 2.11 provides for more information.
- Several of the fields contain a search window. Section 2.8 provides more information.
- The fields that contain dates can be changed by accessing a calendar. Section 2.7 provides more information.
- The pop-up window has features that are useful. Section 2.6 provides more information.

### 9.2.1.1 Add Problem

Select Problems | Add Problem to activate the fields in the Problem List Data Entry group box.

The screenshot shows a 'Problem List Data Entry' form. It contains the following elements:
 

- Diagnosis**: A text input field with a search icon on the right.
- Active/Inactive**: Two radio buttons, with 'Active' selected.
- Date of Onset**: A date picker showing 'Monday, January 30, 2012'.
- Narrative**: A large text area.
- Add Note?**: A checkbox.
- Date Updated**: A date picker showing 'Monday, January 30, 2012'.
- Person Who Updated**: A dropdown menu showing 'GABLE, JESSICA'.

Figure 9-12: Sample Problem List Data Entry group box

The fields in bold are required.

#### Diagnosis

Click the drop-down list to access the POV select window. Here you select a POV to populate the Diagnosis and Narrative fields.

#### Active/Inactive radio button

Indicate if the selected diagnosis is Active or Inactive by selecting the appropriate radio button (Active is the default for a new problem).

#### Date of Onset

The Date of Onset is the date when the problem was first diagnosed. For a new problem, the default is today's date.

- To have no Date of Onset, uncheck the checkbox.
- To change the Date of Onset, click the drop-down list to access a calendar. The checkbox will remain checked.

#### Narrative

This field is populated by the application when you choose a diagnosis (can be changed).

### Add Note?

Check the Add Note field to display the Note group box.

Figure 9-13: Note group box

After the Note group box displays, you can uncheck the “Note” field to close the group box, if needed.

**Note:** Populate the Note field with the text of the note, usually information about the treatment.

**Author:** This is the author of the note. The application populates this field with the current logon user. To change the name, click the drop-down list to access the Primary Provider select window.

**Long Term/Short Term:** Select either the Long Term or Short Term radio button, referring to the treatment described in the note.

### Date Updated

The default is today’s date. To change the date, click the drop-down list to access the calendar.

### Person Who Updated

The default is the provider of the visit to which the Problem List item is associated. To change the name, click the drop-down list to access the Primary Provider select window.

After the Problem List Data Entry group box is complete, click Save to add the “new” problem to the Problem List grid. (Otherwise, click Cancel).

#### 9.2.1.2 Edit Problem

Select an existing problem in the Problem List grid and then select Problems | Edit Problem.

All of the fields in the Problem List Data Entry group box become active.

See Section 9.2.1.1 for more information about how to edit the fields.

After the Problem List Data Entry group box is complete, click Save to change the selected record on the Problem List grid. (Otherwise, click Cancel).

### 9.2.1.3 Delete Problem

Select an existing problem in the Problem List grid and then select Problems | Delete Problem. The application will display the Problem List Reason for Delete dialog.

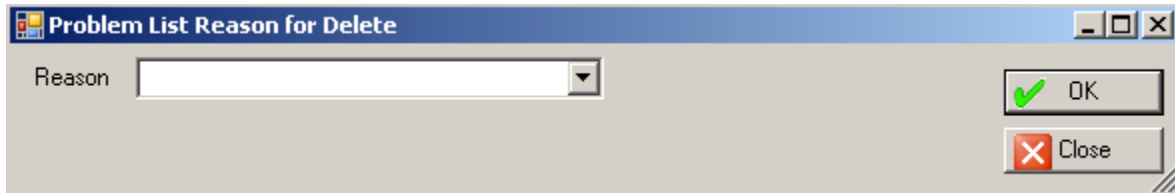


Figure 9-14: Problem List Reason for Delete dialog

Click the drop-down list for the Reason field (required) and select an option.

If you select OTHER, the dialog changes.



Figure 9-15: Problem List Reason for Delete when using OTHER

In this case, populate the Other field with the reason to delete the problem (required).

After the Problem List Reason for Delete dialog is complete, click OK (otherwise, click Close).

After clicking OK, the application activates the “Date Updated” and “Person Who Updated” fields.

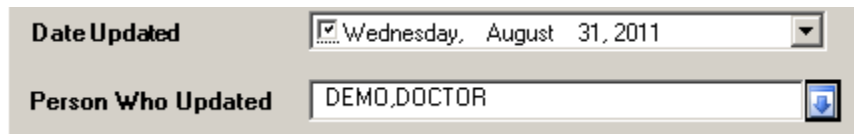


Figure 9-16: Active Date Updated and Person Who Updated fields

#### Date Updated

The default is today’s date. To change the date, click the drop-down list to access the calendar.

### Person Who Updated

The default is the provider of the visit to which the Problem List item is associated.

After the active fields are complete, click Save to remove the problem from the Problem List grid. (Otherwise, click Cancel).

#### 9.2.1.4 Activate/Inactivate Problem

Select an existing problem in the Problem List grid and then select Problems | Activate (or Inactivate).

The application activates the “Date Updated” and “Person Who Updated” fields.

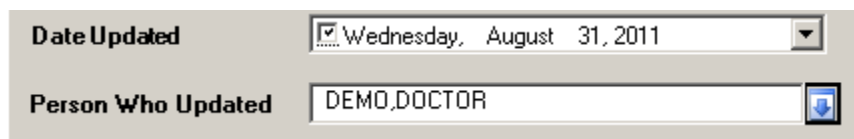


Figure 9-17: Sample active fields for Inactivate (or Activate) process

### Date Updated

The default is today’s date. To change the date, click the drop-down list to access the calendar. The Activate action only works if the “Date Updated” is checked.

### Person Who Updated

This is the person who updated the problem list. To change the name, click the drop-down list to access the Primary Provider select window and select a name.

After the active fields are complete, click Save to change the Status of the selected record on the Problem List grid. (Otherwise, click Cancel).

#### 9.2.1.5 Add Note

Select an existing problem in the Problem List grid and then select Notes | Add Note.

The application activates the fields in the lower group box.

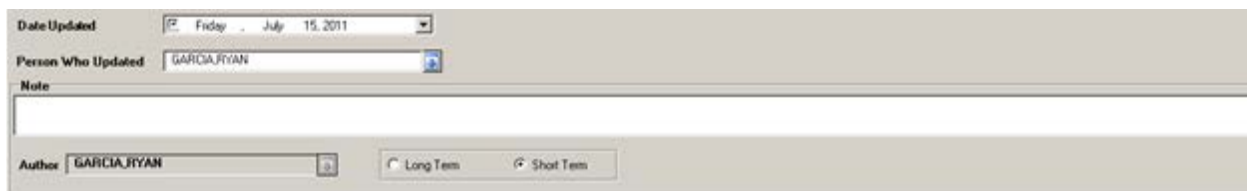


Figure 9-18: Active fields for adding a note

**Date Updated**

The default is today's date. To change the date, click the drop-down list to access the calendar. The Add Note action only works if the "Date Updated" is checked.

**Person Who Updated**

This is the person who updated the problem list. To change the name, click the drop-down list to access the Primary Provider select window and select a name.

**Note**

Populate the Note Free Text field with the text of the note, usually information about the treatment.

**Author**

This is the author of the note. To change the name, click the drop-down list to access the Primary Provider select window.

**Long Term/Short Term**

Select either the Long Term or Short Term radio button, referring to the treatment described in the note.

After the lower group box is complete, click Save and the note will be added to the particular problem in the Problem List grid. (Otherwise, click Cancel). After saving, the application gives the note a note number, displays when the note was added, and shows the note narrative.

**9.2.1.6 Edit Note**

Select an existing note in the Problem List grid and then select Notes | Edit Note.

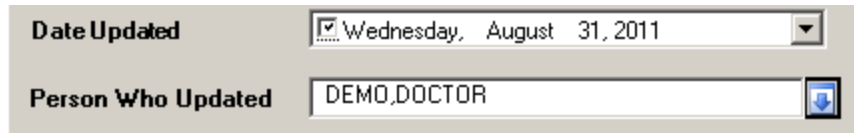
The application activates the fields in the lower group box.

Section 9.2.1.5 provides more information about the fields on this group box.

After the Note group box is complete, click Save to change the particular note on the Problem List grid. (Otherwise, click Cancel).

**9.2.1.7 Remove Note**

Select an existing note in the Problem List grid and then select Notes | Remove Note. The application activates the "Date Updated" and "Person Who Updated" fields.



The image shows two form fields. The first field is labeled 'Date Updated' and contains a date 'Wednesday, August 31, 2011' with a small calendar icon to its right. The second field is labeled 'Person Who Updated' and contains the text 'DEMO,DOCTOR' with a small blue arrow icon to its right.

Figure 9-19: Active Date Updated and Person Who Updated fields

### **Date Updated**

The default is today's date. To change the date, click the drop-down list to access the calendar. The Remove Note action only works if the "Date Updated" is checked.

### **Person Who Updated**

Click the drop-down list to access the Primary Provider select window. Select the name of the person who updated the Problem List.

After the active fields are complete, click Save (otherwise, click Cancel). After clicking Save, the application displays the "Are you sure" confirmation that asks: Are you sure you want to remove this note? Click Yes to remove the note will be removed from the Problem List grid. (Otherwise, click No).

#### **9.2.1.8 Detail Display**

Select a problem in the Problem List grid and then click the Detail Display button. The application will display the BH Problem List Detail pop-up for the particular patient.

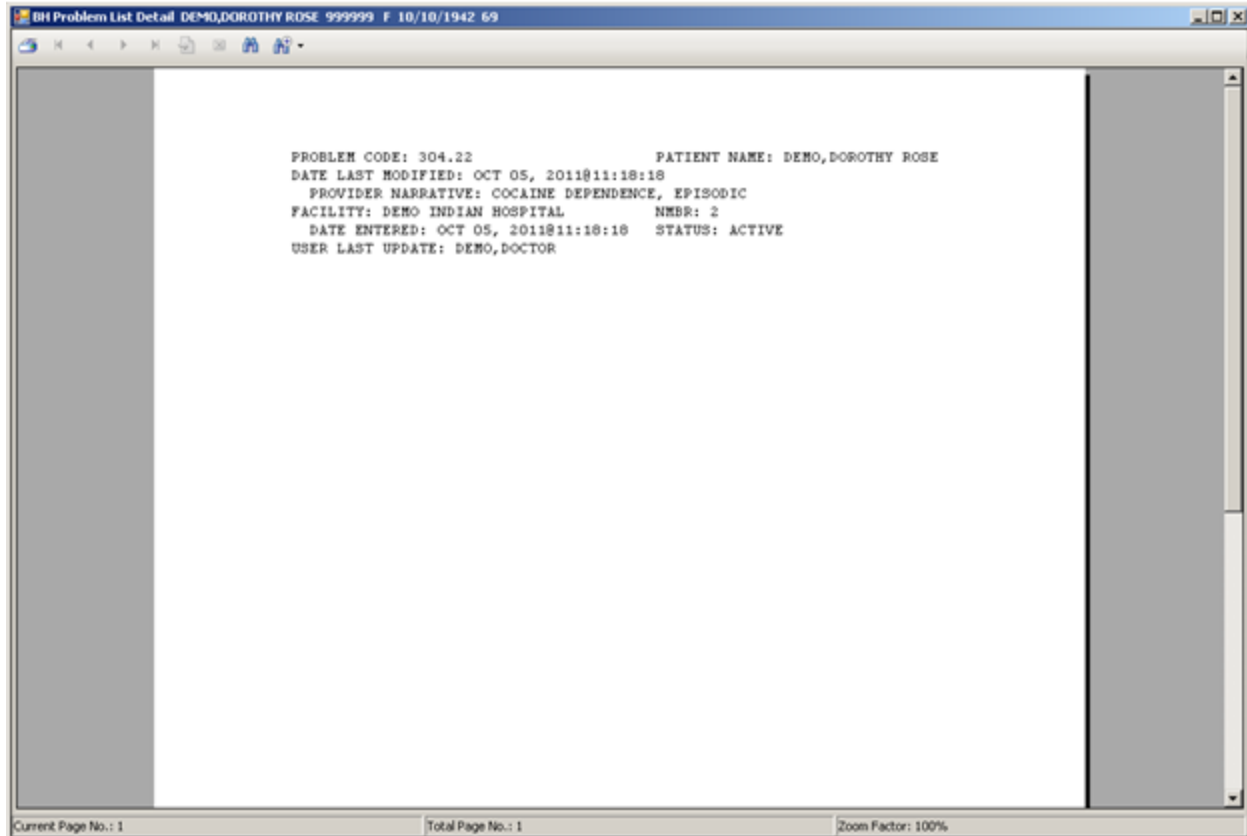


Figure 9-20: Sample BH Problem List Detail for a patient

### 9.2.1.9 No Active Problems

Use the No Active Problems button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.

After clicking this button and if there are active problems, the application displays the following message: There are ACTIVE Problems on this patient's BH problem list. You cannot use this action item. Click OK to dismiss the message. After clicking OK, focus returns to the Behavioral Health Problem List window.

After clicking this button and there are no active problems, the application asks the following: Did the Provider indicate that the patient has No Active BH Problem? Click Yes (otherwise, click No).

After clicking yes, the "Date Documented" and "Provider Who Documented" fields become active.



Figure 9-21: Sample Date Documented and Provider Who Documented fields

### **Date Documented**

This is the date the provider documented that the patient has no active problems. The default is today's date. To change the date, click the drop-down list to access the calendar. The No Active Problems action only works if the "Date Documented" is checked.

### **Person Who Documented**

This is the person who documented that the patient has no active problems. To change the name, click the drop-down list to access the Primary Provider select window.

After the active fields are complete, click Save (otherwise, click Cancel).

After clicking Save, the text below the action buttons will display information such as No Active BH Problem Documented on Dec 01, 2011 by DEMO,DOCTOR. Other text below the action buttons will display information such as: BH Problem List Reviewed on Dec 01, 2011 by DEMO,DOCTOR.

#### **9.2.1.10 Problem List Reviewed**

Click the Problem List Reviewed button to indicate that the current patient's problem list was reviewed. The "Date Reviewed" and "Provider Who Reviewed" fields become active.

Figure 9-22: Sample Problem List Reviewed and Provider Who Reviewed fields

### **Date Reviewed**

This is the date the provider reviewed the problem list. The default is today's date. To change the date, click the drop-down list to access the calendar. The Problem List Reviewed action only works if the "Date Reviewed" is checked.

### **Person Who Reviewed**

This is the person who reviewed the problem list. To change the name, click the drop-down list to access the Primary Provider select window.

After the active fields are complete, click Save (otherwise, click Cancel).

After clicking Save, the text below the action buttons (on the Behavioral Health Problem List window) will display information such as: BH Problem List Reviewed on December 1, 2011 by DEMO,DOCTOR.

### 9.2.1.11 PCC Problem List Display

Click the PCC Problem List Display button to move to the PCC Problem List window.

## 9.2.2 PCC Problem List Window

After selecting the PPC Problem List option (on the Visit window), the application will display the PCC Problem List window.

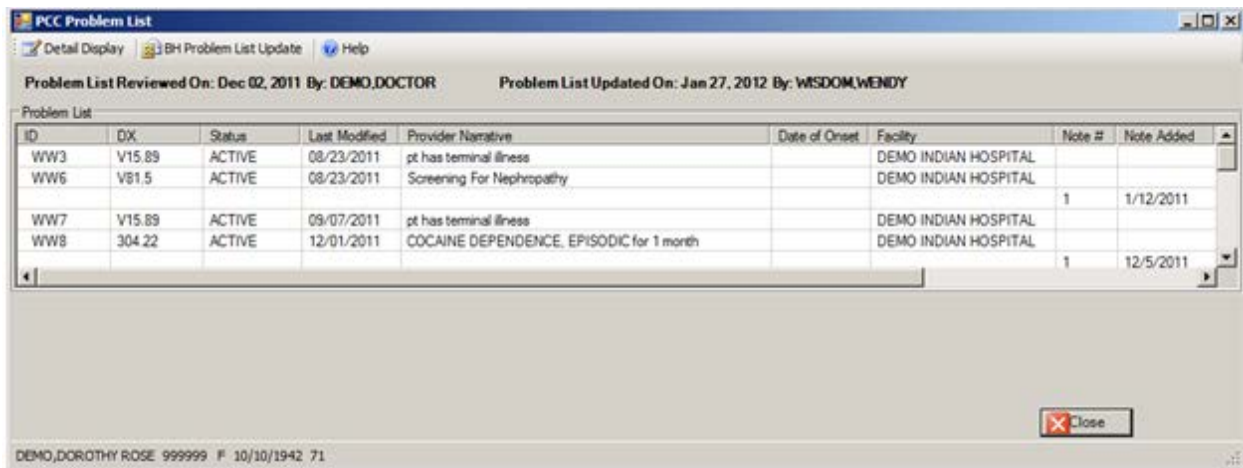


Figure 9-23: Sample PCC Problem List window

The current patient's PCC problems display in the Problem List grid, including any associated notes. The notes display on the row below the problem.

The Close process will leave the window.

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

### 9.2.2.1 Detail Display

Select a problem in the Problem List grid and then click the Detail Display button. The application will display the PCC Problem List Detail pop-up for the particular patient.

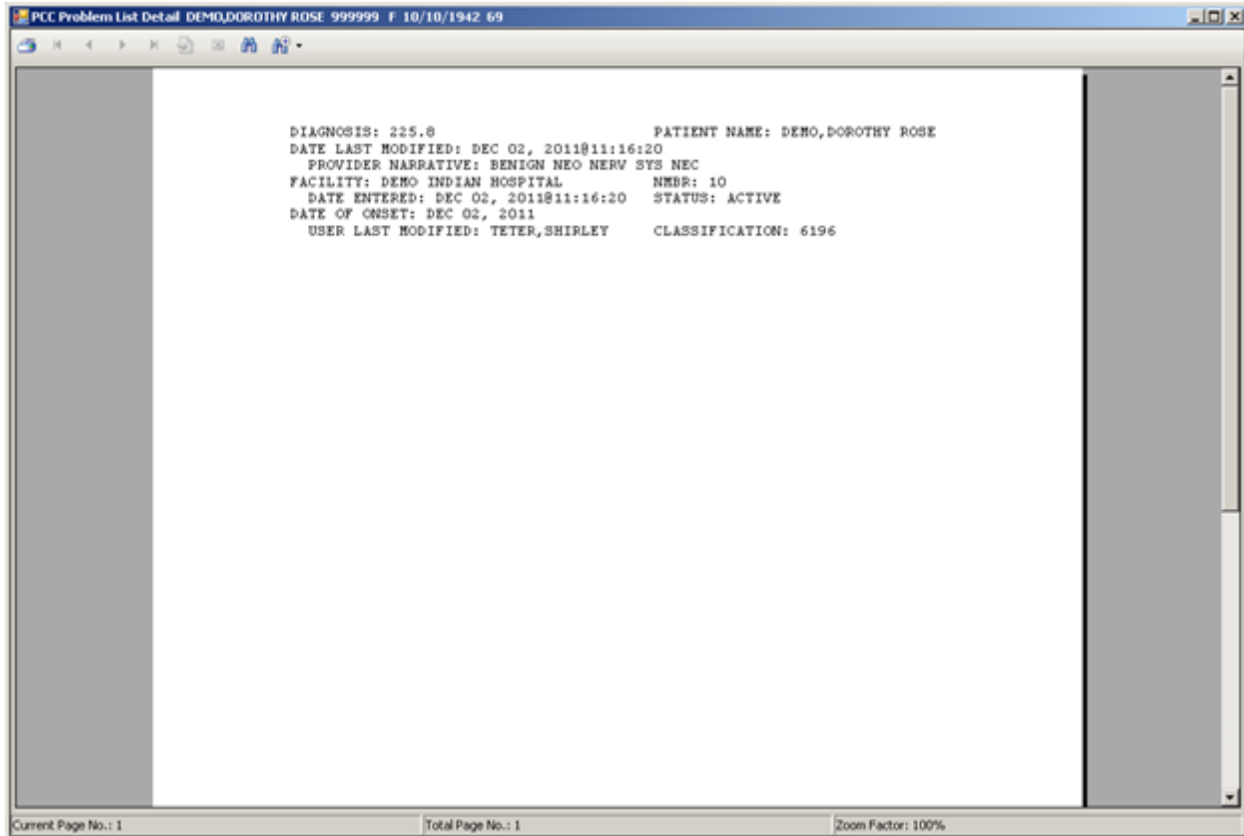


Figure 9-24: Sample PCC Problem List Detail pop-up window

Section 2.6 provides more information about using the pop-up window.

### 9.2.2.2 BH Problem List Update

Click the BH Problem List Update button to move to the Behavioral Health Problem List window. Section 9.2.1 provides more information about this window.

## 10.0 Treatment Plans

You use the Treatment Plans feature to add or update treatment plans in Roll and Scroll and in the RPMS Behavioral Health System (GUI).

### 10.1 Patient Treatment Plans (Roll and Scroll)

Use the Update BH Patient Treatment Plans (TPU) option on the Data Entry Menu to access the Patient Treatment Plans menu.

```

*****
**      IHS Behavioral Health System      **
**      Patient Treatment Plans          **
*****
                          Version 4.0 (patch 1)

                          DEMO INDIAN HOSPITAL

UP      (Add, Edit, Delete) a Treatment Plan
DTP     Display/Print a Treatment Plan
REV     Print List of Treatment Plans Needing Reviewed
RES     Print List of Treatment Plans Needing Resolved
ATP     Print List of All Treatment Plans on File
NOTP    Patients w/Case Open but no Treatment Plan

Select Update BH Patient Treatment Plans Option:

```

Figure 10-1: Options on the Patient Treatment Plans menu

#### 10.1.1 Add, Edit, Delete a Treatment Plan (UP)

Use the UP (Add, Edit, Delete a Treatment Plan) to access the Update Patient Treatment Plan window for a particular patient.

```

Update Patient Treatment Plan Apr 13, 2009 17:11:07      Page: 1 of 9
Patient Name: ALPHAA,CHELSEA MARIE      DOB: FEB 07, 1975      Sex: F
                          TREATMENT PLANS CURRENTLY ON FILE

1) Program: SOCIAL SERVICES      Responsible Provider: GAMMAA,RYAN
   Date Established: MAR 27, 2009      Next Review Date: APR 01, 2009
   Status:                               Date Resolved:
   Problem: eating

2) Program: MENTAL HEALTH      Responsible Provider: GAMMAA,RYAN
   Date Established: MAR 24, 2009      Next Review Date: APR 15, 2009
   Status:                               Date Resolved:
   Problem: testing functionality of editing tp

3) Program: MENTAL HEALTH      Responsible Provider: BETAAAA,BJ
   Date Established: MAR 24, 2009      Next Review Date: JUN 22, 2009
   Status:                               Date Resolved:
   Problem: TESTING BASED ON RYAN'S FINDINGS

```

+	Enter ?? for more actions				
AD	Add Treatment Plan	RV	Enter TP Review	BV	Browse Visits
ED	Edit a Plan	DS	Disp/Print Plan	SP	Share a TP
DE	Delete Tx Plan	HS	Health Summary	Q	Quit
Select Action: AD//					

Figure 10-2: Sample Update Patient Treatment Plan window

Use the Quit action to dismiss the Update Patient Treatment Plan window.

### 10.1.1.1 Add Treatment Plan (AD)

Use the AD action to add a new treatment plan for the current patient. The prompts are the same as when you edit a plan. Section 10.1.1.2 provides more information about the prompts.

### 10.1.1.2 Edit a Plan (ED)

Use the ED action to change a selected treatment plan for the current patient.

Below are the prompts.

#### Enter Date Established

The date the treatment plan was established (you cannot change).

#### Program

This is the program for the treatment plan. Use 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.

#### 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.

#### Diagnosis

The text of the diagnosis displays, if any.

#### Edit?

Use Y (yes) or N (no) to change the diagnosis text. If you use Y, you access another window where you can change the text.

**Treatment Plan Narrative (Problems/Goals/Objectives/Methods)**

The Narrative of the problems, goals, objectives, or methods of the treatment plan.

**Edit?**

Use Y (yes) or N (no) to change the narrative of the Treatment Plan. If you use Y, you access another window where you can change the text.

**Anticipated Completion Date**

This is the date the treatment plan is anticipated to be completed.

**Review Date**

This is the date of the 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. The prompt displays only if you specified a concurring supervisor.

**Participants in the development of this plan**

If there is a participant in the development of this plan, the application displays the name. If not, the “None recorded” message displays.

The application allows you to do one of the following at this prompt: A - Add a Participant or N - NO Changes.

If you specify N, the next prompt “Date Closed” displays.

If you specify A, the following prompts display:

**Enter the Participant Name:** specify the name of the participant.

**Enter the Relationship to the Client:** specify the relationship of the participant to the patient.

The application then lists the participants in the development of the plan. Below is an example:

```
Participants in the development of this plan:
```

```
-----  
1) Alma Beta                cousin
```

Select one of the following:	
A	Add a Participant
E	Edit an Existing Participant
D	Delete a Participant
N	No Change
Which action:	

Figure 10-3: Sample of participants in the development of this plan

At the “Which action” prompt, use one of the following:

- Use the A option to add a participant. The prompts are the same as those shown above.
- Use the E option to edit a particular existing participant. After you indicate the participant name, the prompts are the same as the add option.
- Use the D option to delete a particular existing participant. The application asks to specify the one you want to delete. There is no confirmation about the deletion.
- Use the N option to continue onto the next prompt.

#### **Date Closed**

This is the date the treatment plan is to be closed.

#### **10.1.1.3 Delete Tx Plan (DE)**

Use the DE action 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?**

Use Y (yes) or N (no). The Y option removes the particular treatment plan from the Update Patient Treatment Plan window.

#### **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.

Note: the application could display the following message:

NOTE: It is recommended you close out treatment plans using DSM-IV diagnoses and create a new treatment plan using DSM-5 diagnoses.

Press enter to continue....:

The application displays the Treatment Plan Update window. This window has the following prompts.

**Select REVIEW DATE**

The review date display (you can change). 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?**

Use Y (yes) or N (no) to indicate if you want to edit the text of the progress summary. If you use Y, you access another window to edit the text.

**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 (you can change).

**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**

Use T (Treatment Plan Only), R (Treatment Plan REVIEWS Only), or B (both Treatment Plan and Reviews).

**Do you wish to**

Use P (print output on paper) or B (browse output on screen).

You browse the output on the Output Browser window.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
*****
*
* TREATMENT PLAN                               Printed: Oct 27, 2009@09:49:14   *
* Name:  ALPHAA,CHELSEA MARIE                    Page 1                               *
* DEMO INDIAN HOSPITAL      DOB:  2/7/75      Sex:  F      Chart #:  WW116431   *
*
*****

Date Established:           Oct 01, 2009
Admit Date:
Anticipated Completion Date:
Date Close:                 Oct 01, 2009
Provider:                   GAMMA,DENISE
Supervisor:                 <not recorded>
    Date Concurred:
Review Date:
Participants in Plan Creation:
    Blair                    sister

DIAGNOSIS:

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		
+ NEXT SCREEN	- PREVIOUS SCREEN	Q	QUIT
Select Action: +//			

Figure 10-4: Sample display of treatment plan

### 10.1.1.6 Health Summary (HS)

Use the HS action to display/print a particular health summary for the current patient.

### 10.1.1.7 Browse Visits (BV)

Use the BV action to browse the behavioral health visits for the current patient.

Below are the prompts.

#### Browse which subset of visits for [patient name]

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 this patient's visits), or P (visits to one program). If you use N, D, or P, other prompts will display.

The application display the BROWSE PATIENT'S VISITS window. The one below is for all visits.

```

BROWSE PATIENT'S VISITS          Apr 13, 2009 17:51:51          Page: 1 of 395

Patient Name: CHIII,KIMBERLY YVETTE          DOB: Nov 23, 1966
HRN: 114108

***** Suicide Forms on File *****
Date of Act: OCT 10, 2008          Suicidal Behavior:
Previous Attempts:          Method:
Date of Act: MAR 24, 2008          Suicidal Behavior: IDEATION W/ PLAN AND I
Previous Attempts: UNKNOWN          Method: HANGING
*****

Visit Date: Sep 28, 2009@10:00          Provider: GAMMAAA,DENISE
Activity Type: FAMILY/GROUP TREATMENT-PATIE Type of Contact: OUTPATIENT
Location of Encounter: SAN XAVIER
Chief Complaint/Presenting Problem: test pt ed
POV's:
  43.2 PARTNER ABUSE (SUSPECTED),EMOTIONAL

SUBJECTIVE/OBJECTIVE:

```

```

testing build 9 for Patch 1
editing SOAP

COMMENT/NEXT APPOINTMENT:

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

```

Figure 10-5: 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:  DUCK,DONALD R      DOB:  JUN 07, 1978    Sex:  M
                TREATMENT PLANS CURRENTLY ON FILE

1)  Program:  SOCIAL SERVICES          Responsible Provider:  GAMMAA,RYAN
    Date Established:  APR 02, 2009    Next Review Date:  APR 12, 2009
    Status:
    Problem:  testing functionality
    Date Resolved:

2)  Program:  MENTAL HEALTH           Responsible Provider:  GAMMAA,RYAN
    Date Established:  APR 02, 2009    Next Review Date:  APR 02, 2009
    Status:
    Problem:
    Date Resolved:

3)  Program:  MENTAL HEALTH           Responsible Provider:  GAMMAA,RYAN
    Date Established:  APR 02, 2009    Next Review Date:  APR 02, 2009
    Status:
    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 10-6: Sample Display/Print Treatment Plan window

The following actions 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 when you are on the last screen).

Use PS (Previous Screen) to display the previous screen of information (does not work when you are 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 when you are on the last screen).

Use the UP (Up a Line) to display the line previous line of information before the top of the current screen (does not work when you are on the first screen).

### **Display/Print Plan (DS)**

Use the DS action to browse/print a particular treatment plan. Section 10.1.1.5 provides more information about the display/print plan action.

### **Health Summary (HS)**

Use the HS action to display a particular type of health summary for the current patient.

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.

### **10.1.2.1 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: 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 RETURN to continue or '^' to exit:

```

Figure 10-7: Sample Display/Print Treatment Plan window

**10.1.2.2 Search List (SL)**

Use the SL action 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?**

Use Y or N.

If you use N, you leave the search sequence.

If you use Y, it will search for the next occurrence of the text string. If it finds it, the application will highlight it. If it does not find it, it displays the message: Text not found. Do you want to start at the beginning of the list? 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

Use one of the following: O (One Provider) or A (All Providers). If you use O, other prompts will display.

#### Demo Patient Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude DEMO patients), O (include only DEMO patients).

#### Device

Specify the device to print/browse the output.

Below is a sample Listing of Treatment Plans Due to be Reviewed.

```

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
***** 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 10-8: 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.

The prompts are the same as those for the Print List of Treatment Plans Needing Reviewed (REV).

Below is a sample Listing of Treatment Plans Due to be Resolved.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX
                                DEMO INDIAN HOSPITAL
                                LISTING OF TREATMENT PLANS DUE TO BE RESOLVED
                                Date Range: APR 07, 2008 to APR 07, 2009
                                Page 1

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

Enter RETURN to continue or '^' to exit:

```

Figure 10-9: Sample output of treatment plans due to be resolved

### 10.1.5 Print List of All Treatment Plans on File (ATP)

Use the ATP option to print/browse a list of all patients who have a treatment plan on file (in a specified date range). This date range is the one during which the treatment plan was established.

Below are the prompts.

#### Enter BEGINNING Date

Specify the beginning date of the date range.

#### Enter ENDING Date

Specify the ending date of the date range.

#### Run the Report for which PROGRAM

Use O (one program) or A (all programs). If you use O, other prompts will display.

**List treatment plans for**

Use O (one provider) or A (all providers). If you use O, other prompts will display.

**Sort list by**

Use P (Responsible Provider), N (Patient Name), or D (Date Established).

**Demo Patient Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude DEMO patients), O (include only DEMO patients).

**Device**

Specify the device to browse/print the 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          Responsible Provider: BETAAAA,LORI
  Program: MENTAL HEALTH

Enter RETURN to continue or '^' to exit:

```

Figure 10-10: Sample list of treatment plans

### 10.1.6 Patients w/Case Open but No Treatment Plan (NOTP)

Use the NOTP option to produce a report that lists all patients who have a case open date, no case closed date, and no treatment plan in place in a specified date range. This date range is during which the case was opened.

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.

**List cases opened by**

Use O (one program) or A (all programs). If you use O, other prompts will display. This allows you to limit the report output to cases opened by one or all Programs.

**List cases opened by**

Use O (one provider) or A (all providers). If you use O, other prompts will display. This allows you to limit the report output to cases opened by one or all Providers.

**Sort list by**

Use P (Responsible Provider), N (Patient Name), or C (Case Open Date).

**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**

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.

Case Open Dates: SEP 08, 2010 to DEC 07, 2010					
PATIENT NAME	HRN	CASE OPEN DATE	PROGRAM	PROVIDER	LAST VISIT
THETAA, ROLAND	258852	10/01/10	MENTAL HEA		12/07/10
BETAAAA, MONTY	741147	11/03/10	MENTAL HEA		12/07/10
DEMO, DOROTHY ROSE	999999	12/07/10	MENTAL HEA		07/08/10
BETA, ROBERT JACOB	207365	11/22/10	CHEMICAL D	CHIII, JESSICA	12/07/10

Figure 10-11: Sample Listing of Cases with No Treatment Plan in Place report

## 10.2 Treatment Plan Window (GUI)

The RPMS Behavioral Health System (GUI) application provides ways to manage treatment plans for one patient

Below shows where the treatment plan functions are located.

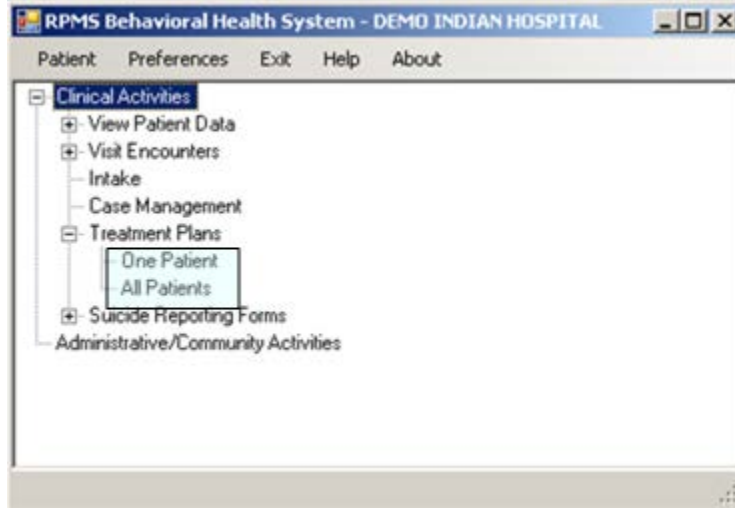


Figure 10-12: Location of Treatment Plan functions on tree structure

One way to access the Treatment Plan window is to use the One Patient option. You access the Treatment Plan window for the current patient.

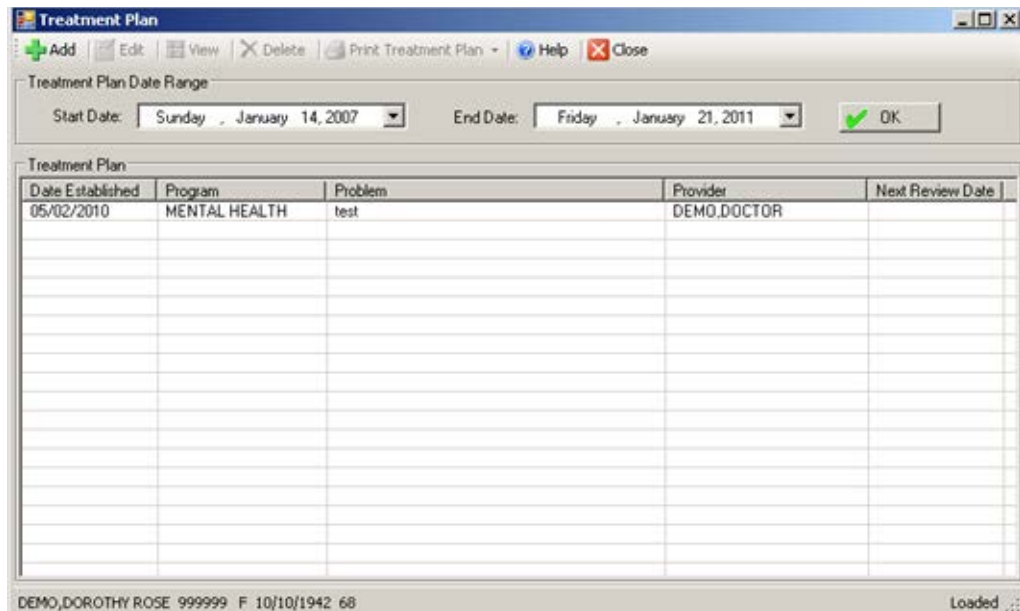
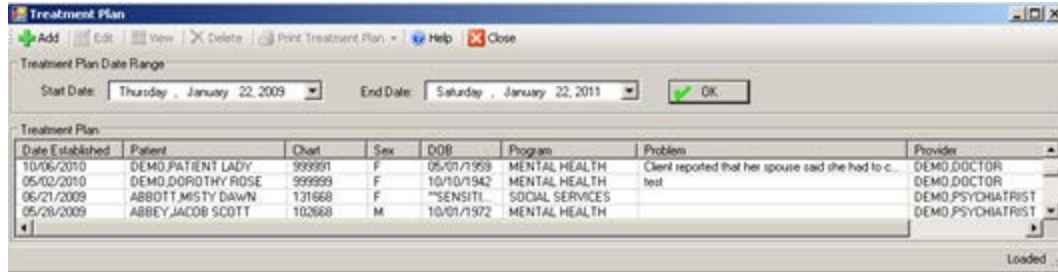


Figure 10-13: Sample Treatment Plan group box for current patient

Another way to access the Treatment Plan window is to use the All Patients. You access the Treatment Plan window for all patients.



Date Established	Patient	Chart	Sex	DOB	Program	Problem	Provider
10/06/2010	DEMO PATIENT LADY	999991	F	05/01/1959	MENTAL HEALTH	Client reported that her spouse said she had to c...	DEMO DOCTOR
05/02/2010	DEMO DOROTHY ROSE	999999	F	10/10/1942	MENTAL HEALTH	test	DEMO DOCTOR
06/21/2009	ABBOTT MISTY DAWN	131668	F	**SENSITL	SOCIAL SERVICES		DEMO PSYCHIATRIST
05/26/2009	ABBEY JACOB SCOTT	103668	M	10/01/1972	MENTAL HEALTH		DEMO PSYCHIATRIST

Figure 10-14: 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.

You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click OK to display the records in the Treatment Plan group box.

### 10.2.1.1 Treatment Plan Window for One Patient

The following applies to the Treatment Plan window for One Patient:

The default Start Date is one year previous.

If you change the Start Date for the Treatment Plan window for One Patient, this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).

### 10.2.1.2 Treatment Plan Window for All Patients

The following applies to the Treatment Plan window for All Patients:

The default Start Date is one year previous.

If you change the Start Date for the Treatment Plan window for All Patients, this change stays in effect until you exit the application. When you login the next time, the Start Date reverts to one year previous.

## 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. Use the Add button to add a new treatment plan record. You access the Treatment Plan - Add Treatment Plan window. Section 10.3 provides more information about the add process.

### 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 Treatment Plan - View Treatment Plan window (view only). The fields are the same as those on the add/edit treatment plan dialog. Section 10.3 provides more information about the view action.

### 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 Treatment Plan button to print a particular Treatment Plan record.

The Print Treatment Plan button has three choices: (1) Treatment Plan Only, (2) Review Data Only, and (3) Treatment Plan and Review Data.

Highlight a record and choose one of the Print Treatment Plan options. The application determines which of the options are active.

If you use Review Data Only (2) or Treatment Plan and Review Data (3) and if there is one or more reviews, the application displays the Treatment Plan Reviews dialog (Figure 10-15).

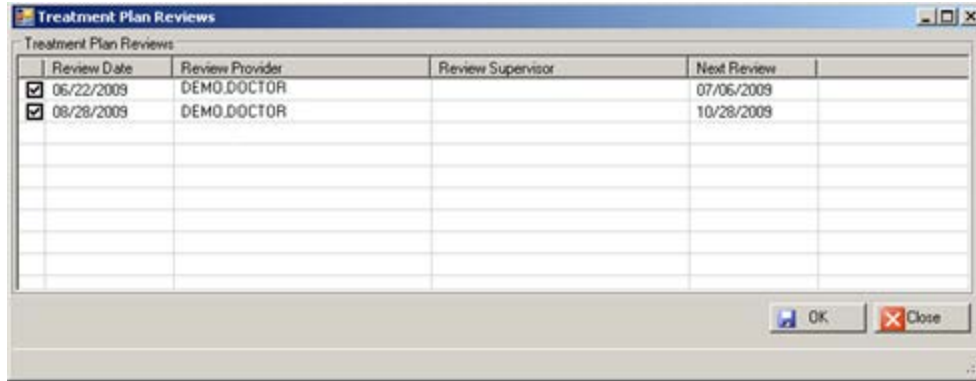


Figure 10-15: Sample Treatment Plan Reviews dialog

Check each Treatment Plan Review record you want to use and click OK. Otherwise, click Close to exit the print routine.

Figure 10-16 shows the first page of the Treatment Plan pop-up window.

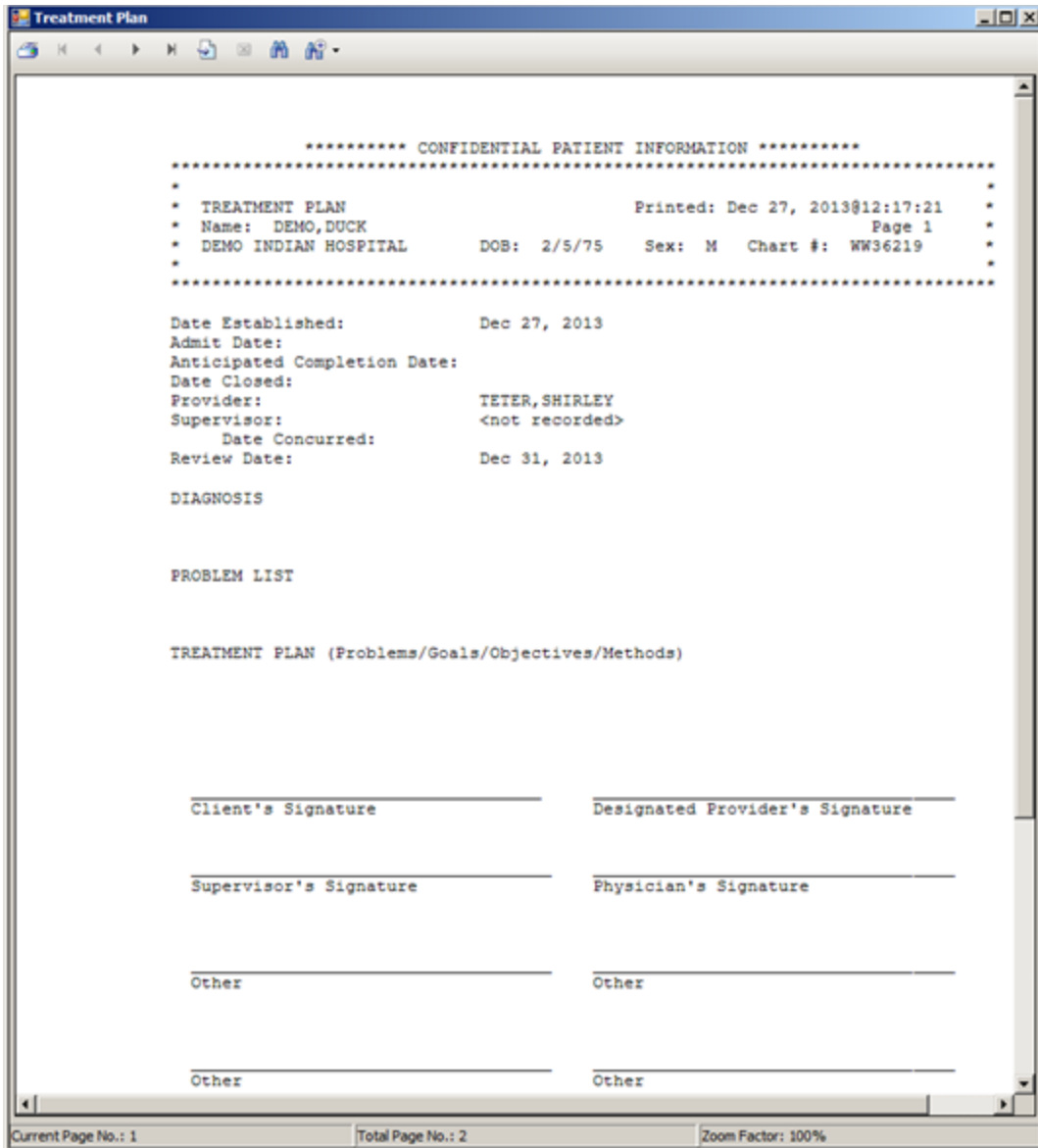


Figure 10-16: Sample Treatment Plan pop-up window

Section 2.6 provides more information about this type of window.

### 10.2.8 Help

Use the Help button to access the online help system for the Treatment Plan window.

### 10.2.9 Close Button

Use 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. Figure 10-17 shows the Add Treatment Plan window.

The screenshot shows a software window titled "Treatment Plan - Add Treatment Plan". The window is divided into two main sections. The top section, labeled "Treatment Plan Information", contains several data entry fields: "Date Established" (Friday, December 27, 2013), "Next Review Date" (Friday, December 27, 2013), "Program" (empty dropdown), "Date Completed/Closed" (Friday, December 27, 2013), "Case Admit Date" (Friday, December 27, 2013), "Anticipated Completion Date" (Friday, December 27, 2013), "Designated Provider" (DEMO\_CASE M), "Concurring Supervisor" (empty dropdown), and "Date Concluded" (Friday, December 27, 2013). The bottom section has three tabs: "Diagnosis", "Plan", and "Plan Review". The "Diagnosis" tab is selected, showing a large empty text area. At the bottom of the window are "Help", "Save", and "Close" buttons. The status bar at the bottom left displays "TEST,CATHY 3 F 01/18/1992 21".

Figure 10-17: Sample Add Treatment Plan window

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

Use the Save button to save the data on the window. The Save function adds/edits the treatment plan record on the Treatment Plan window.

Use the Close button to display the “Continue?” dialog. This dialog states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add window. Click No and you remain on the add/edit treatment plan window.

### 10.3.1 Treatment Plan Information Group Box

Use the Treatment Plan Information group box (Figure 10-18) to manage the basic information about the treatment plan.

Figure 10-18: 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 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, or 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. Click the drop-down list to access the Designated Provider search dialog where you search for the name of the designated 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 dialog where you 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 Diagnosis Tab

Use the Diagnosis tab (Figure 10-19) to add the text of the diagnosis for the particular treatment plan.



Figure 10-19: Diagnosis tab

Section 2.11 provides more information about Free Text fields.

### 10.3.3 Plan Tab

Use the Plan tab (Figure 10-20) to add participants to the plan as well as describing the Problems / Goals / Objectives / Methods of the plan.

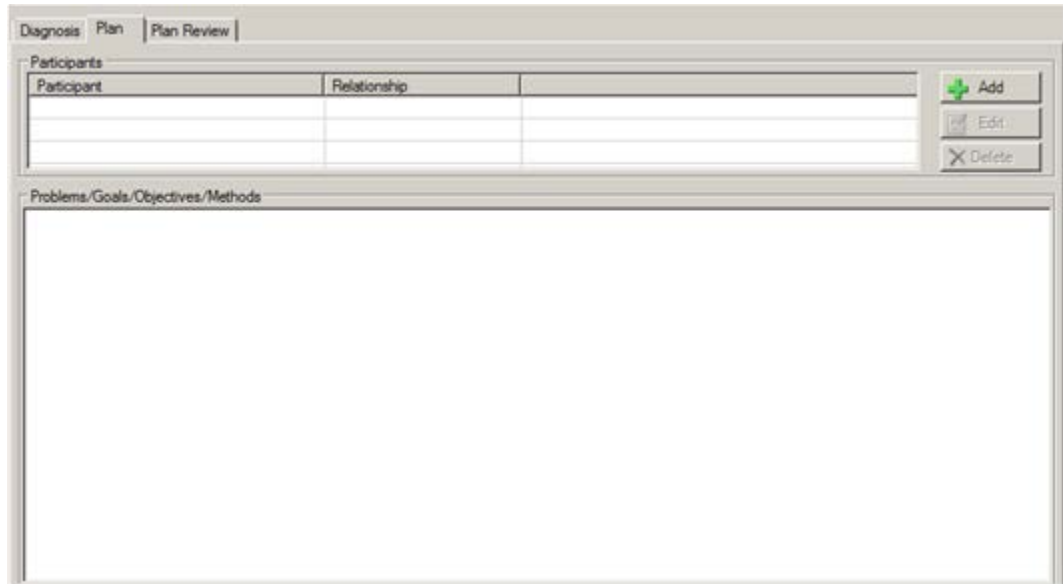


Figure 10-20: Sample Plan tab

#### 10.3.3.1 Participants Group Box

Use the Participants group box to manage the participants in the treatment plan.

Use the Edit button to change a selected participant record. The application displays the Treatment Plan Participants dialog with the fields populated. This dialog is reviewed below.

Use the Delete button to delete a selected participant record. The application confirms the deletion.

Use the Add button to add a new participant record on the Treatment Plan Participants dialog (Figure 10-21).

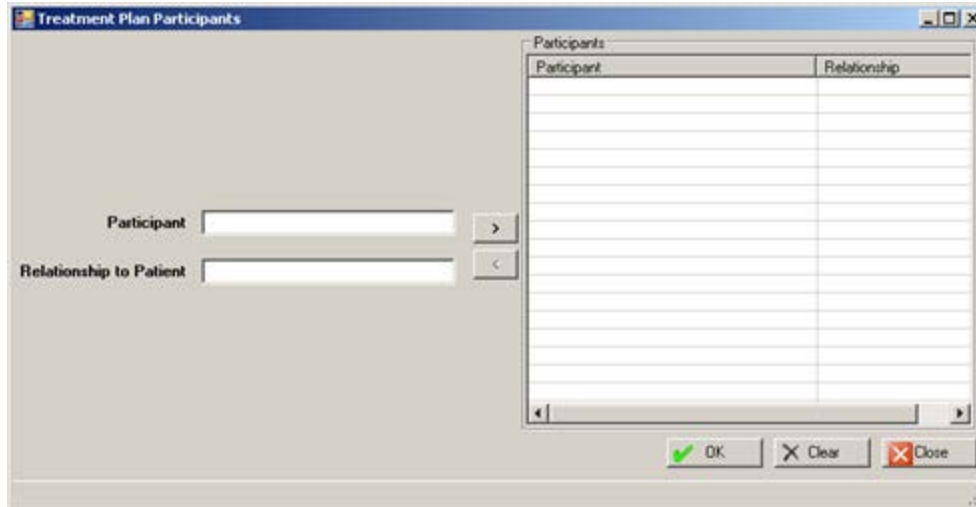


Figure 10-21: Sample Treatment Plan Participants dialog

The Participant field is a Free Text field where you add the participant name.

The Relationship to Patient is a Free Text field where you add the participant's relationship to the patient of the treatment plan.

After completing these fields, click the right-pointing 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-pointing arrow.

Use the Clear button to remove the data in the Participant and Relationship to Patient fields.

Use the OK button to save the data and to populate the Participants group box on the Plan Review tab of the add/edit treatment plan window.

Use the Close button to dismiss the dialog.

### 10.3.3.2 Problems/Goals/Objectives/Methods

Populate this field with the text of the problems, goals, objective, or methods for the treatment plan. Section 2.11 provides more information about Free Text fields.

### 10.3.4 Plan Review Tab

Use the Plan Review tab (Figure 10-22) to document the review of the treatment plan.

Figure 10-22: Sample Plan Review tab

When a record is selected in the grid for the plan review, you can do the following:

- Complete the fields for the plan review (below the grid)
- Complete the participants in the plan review (in the Participants group box)
- Complete the Progress Summary for the plan review (in the Progress Summary group box)

After you have completed the fields and group boxes, click OK to save the plan review record. (Otherwise, click Cancel).

#### 10.3.4.1 Review Group Box

Use the top group box to document the review date, the review provider, and review supervisor, and next review date for the treatment plan.

Use the Delete button to remove a selected review record. On the “Are you sure?” confirmation message, click Yes to delete (otherwise, click No).

Use the Edit button to change a selected review record. The data populates in the fields below the grid.

Use the Add button to add a new review record. You populate the fields below the review grid as well as the Participants group box, and the Progress Summary field to complete the add process.

The fields for Review in bold text are required.

**Review Date**

This is the date of the review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date.

**Next Review Date**

This is the date of the next review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date. Please note that changing the Next Review date here will also change the Next Review date on the Treatment Plan Information group box.

**Review Provider**

This is the provider who is doing the review (the default is the current user). Click the drop-down list to access the Reviewing Provider search window where you 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 search for the supervisor name.

**10.3.4.2 Participants Group Box (Plan Review)**

Use the participants group box to show the participants in the plan review. Click the Add button to access the Treatment Plan Participants dialog. Section 10.3.3.1 provides more information about completing this dialog.

Use the Edit button to edit a selected Participants record. The application displays the Treatment Plan Participants dialog with the fields populated with the current data. Section 10.3.3.1 provides more information about this dialog.

Use the Delete button to delete a selected Participants record. On the “Are You Sure” confirmation message, click Yes to delete (otherwise, click No).

**10.3.4.3 Progress Summary**

Use the Progress Summary field to add the text of the progress of the plan review. This is a Free Text field.

## 11.0 Suicide Forms

You can manage suicide forms in Roll and Scroll as well as in the RPMS Behavioral Health System (GUI).

Please note: all of the fields are mandatory but not enforced. This means if you do not populate all of the fields, you can still save, but that suicide form will be considered Incomplete. If you do complete all of the fields, the suicide form will be considered Complete.

### 11.1 Suicide Reporting Forms (Roll and Scroll)

You use the SF (Suicide Reporting Forms - Update/Print) option on the IHS Behavioral Health System Data Entry Menu to manage suicide forms in Roll and Scroll.

The Add/Update Suicide Forms option on the Other Information window also accesses the suicide reporting forms.

After using the SF option, Figure 11-1 shows the two options:

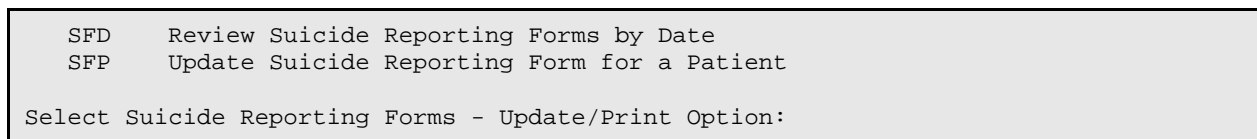


Figure 11-1: Options available for managing suicide forms

#### 11.1.1 Update Suicide Reporting Form for a Patient (SFP)

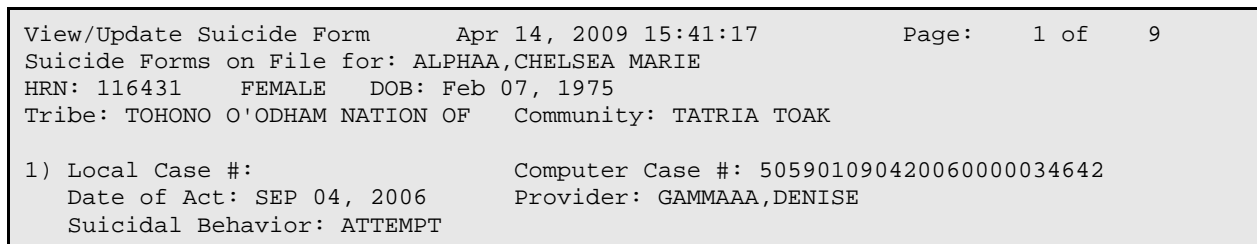
Use the SFP option to update the suicide report for a specified patient.

Below are the prompts.

##### Select Patient Name

Specify the patient you want to use.

The application displays the View/Update Suicide Form window for the selected patient.



```

Method: HANGING OTHER
2) Local Case #: Computer Case #: 505901122420060000048688
Date of Act: DEC 24, 2006 Provider: GAMMAAAA,JAMES N
Suicidal Behavior: IDEATION WITH PLAN AND INTENT
Method:
[Incomplete Form]
3) Local Case #: Computer Case #: 505901013120070000048688
Date of Act: JAN 31, 2007 Provider: BETAAA,LINZA
Suicidal Behavior: IDEATION WITH PLAN AND INTENT
Method: OVERDOSE
4) Local Case #: Computer Case #: 505901022220070000034642
+ ?? for more actions + next screen - prev screen
AF Add a Suicide Form BV Browse Visits for this Patient
EF Edit a Suicide Form HS Health Summary for this Patient
DF Display a Suicide Form Q Quit
XF Delete a Suicide Form
Select Item(s): Next Screen//

```

Figure 11-2: Sample View/Update Suicide Form window for the current patient

If any of the suicide forms are incomplete, the message “[Incomplete Form]” will display as the last line under the particular case.

Use the Quit action to dismiss this window.

### 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 action 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 action 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 #: 5059011224200600000486
Provider: LAMBDA,JAMES N          Initials:          Discipline:
-----
 1. Local Case #:          Provider: THETAAA,JAMES
 7. Employment Status:
 8. Date of Act: DEC 24,2006  11. Community where act Occurred:
12. Relationship Status: SINGLE          13. Education: COLLEGE GRAD
14. Suicidal Behavior: IDEATION W/ PLAN AND INTENT
15. Method (press enter):          16. Previous Attempts: 2
17. Substance Use Involved:          18. Location of Act: HOME OR VICINI
19. Contributing Factors (press enter):
20. Disposition: IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY)
21. Other Relevant Information:
-----
COMMAND:          Press <PF1>H for help          Insert

```

Figure 11-3: Sample Updating IHS Suicide Form window

The underlined fields are required.

### **Local Case #**

This is a local case number generated by the site (use 1-20 characters).

### **Provider**

This is the provider reporting this suicide case (the provider completing the form).

### **Employment Status**

This is the employment status of the patient. Use one of the following: P (part-time), F (full-time), S (self-employed), UE (unemployed), R (retired), ST (student), SE (student and employed), UNK (unknown).

### **Date of Act**

This is the date of the suicide act. 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. Use one of the following: 1 (single), 2 (married), 3 (divorced/separated), 4 (widowed), 5 (cohabiting/common law), 6 (same sex partnership), 9 (unknown). For example, if you used 4, the application populates the field with WIDOWED.

**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 use the “less than 12 years” option, the application asks for the following information: If less than 12 years, highest grad completed. Use any whole number between 0 and 11.

The following fields are on the Updating IHS Suicide Form window.

**Suicidal Behavior**

This is the suicidal behavior for the suicide act. Use one of the following:

- 1 – Ideation W/ Plan and Intent
- 2 - Attempt
- 3 – Completed Suicide
- 6 – Att'd Suicide w/ Att'd Homicide
- 7 - Att'd Suicide w/ Compl Homicide
- 8 - Compl Suicide w/ Att'd Homicide
- 9 - Compl Suicide w/ Compl Homicide

**Method (press Enter)**

Press Enter to access the following pop-up.

```

*** If you need help type ?, not ?? ***
METHOD:
METHOD:
METHOD:

```

Figure 11-4: Sample fields on the pop-up

**Method:** Populate the with a suicide method. More than one can be used.

If you use Other in the Method field, the application asks the following information: Please describe the "OTHER" Method. Use between 1 and 40 characters.

- 1 - GUNSHOT
- 2 - HANGING
- 3 - MOTOR VEHICLE
- 4 - JUMPING
- 5 - STABBING/LACERATION
- 6 - CARBON MONOXIDE
- 7 - OVERDOSE
- U - UNKNOWN

The following fields are on the Updating IHS Suicide Form window.

### Previous Attempts

Populate with the number of previous suicide attempts. Use 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. Use one of the following: 1 (none), 2 (alcohol and other drugs), U (unknown).

If you use 2, the application displays the list of drug choices type.

```

For a list of drug choices type ??
SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:

```



SUBSTANCE DRUG USED:

Figure 11-5: Sample of list of drug choices used

If you use 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 on the Updating IHS Suicide Form window.

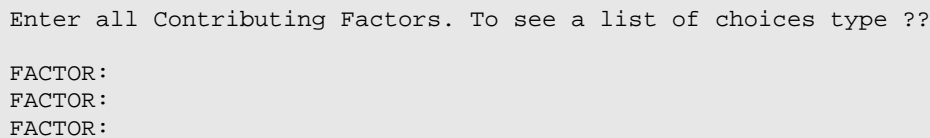
### Location of Act

Populate with the location of the act.

If you use Other in the Location of Act field, the application asks the following information: Location of Act If Other. Use between 1 and 80 characters.

### Contributing Factors (press enter)

Press Enter to access the Contributing Factors pop-up.



Enter all Contributing Factors. To see a list of choices type ??  
 FACTOR:  
 FACTOR:  
 FACTOR:

Figure 11-6: Fields on the pop-up

**Factor:** Populate 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 '@') all other entries (the application confirms the deletion).

If you use 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 on the Updating IHS Suicide Form window.

### Disposition

Populate with the disposition of the suicide act.

If you use OTHER at the Disposition prompt, the application asks the following information: Disposition If Other. Use between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

### Other Relevant Information

Press Enter to access another window where you populate the field with text of the other relevant information about the suicide act.

After you leave the suicide form and if there are any missing data, the application lists what is missing and lists what actions you can take:

```

Select one of the following:

E          Edit and Complete the Form
D          Delete the Incomplete Form
L          Leave the Incomplete Form as is and Finish it Later

What do you want to do: E//

```

Figure 11-7: List of actions you can take

Use E to return to the form where you can edit and complete it.

Use D to delete the form (there is no confirmation).

Use L to leave the form incomplete (as is) and finish it later.

#### 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 where you can browse the Suicide Reporting Form on the screen.

```

***** CONFIDENTIAL PATIENT INFORMATION [ST] Apr 14, 2009 *****
Suicide Reporting Form                               Date Printed: Apr 14, 2009

1. Case #: 505901122420060000048688      Local Case #:
2. PROVIDER INITIALS: RWL                 3. PROVIDER DISCIPLINE: NUTRITION TECHNIC
4. SEX: FEMALE                           5. DOB: FEB 07, 1975                 6. AGE: 31
7. EMPLOYMENT STATUS:
8. DATE OF ACT: DEC 24, 2006
9. TRIBE: TOHONO O'ODHAM NATION OF ARIZONA
10. COMMUNITY OF RESIDENCE: TATRIA TOAK
11. COMMUNITY WHERE ACT OCCURRED:

```

```

12. RELATIONSHIP STATUS: SINGLE

13. EDUCATION:

14. SUICIDAL BEHAVIOR:
15. METHOD: OVERDOSE
    DRUGS W/OVERDOSE:
    ALCOHOL
16. PREVIOUS ATTEMPTS:

17. SUBSTANCE USE INVOLVED:

18. LOCATION OF ACT:

19. CONTRIBUTING FACTORS:
    HISTORY OF SUBSTANCE ABUSE/DEPENDENCE

20. DISPOSITION:

    Other Relevant Information: (OPTIONAL)

DATE LAST MODIFIED: DEC 08, 2010
USER LAST UPDATED: THETA,SHIRLEY
EDIT HISTORY:
  May 15, 2009 12:01:24 pm  THETA,SHIRLEY
+      Enter ?? for more actions                                >>>
+  NEXT SCREEN          -  PREVIOUS SCREEN          Q  QUIT
Select Action: +//

```

Figure 11-8: Sample Output Browser window for suicide act

### 11.1.1.3 Delete a Suicide Form (XF)

Use the XF action 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?

Use Y (yes) or N (no).

### 11.1.1.4 Browse Visits for this Patient (BV)

Use the BV action to browse the BH visits for the current patient.

Below are the prompts.

**Browse which subset of visits for <patient name>**

Select one of the following: L (patient's last visit), N (patient's last n visits), D (visits in a date range), A (All of this patient's visits), or P (visits to one program).  
If you use N, D, or P, other prompts will display.

The application display the BROWSE PATIENT'S VISITS window.

```

BROWSE PATIENT'S VISITS      Mar 05, 2014 10:18:31      Page:    1 of    2

Patient Name: DEMO,DARRELL LEE      DOB: Sep 23, 1986
HRN: 117305

***** Suicide Forms on File *****
Date of Act: MAY 15, 2009      Suicidal Behavior:
Previous Attempts:      Method: OVERDOSE
*****

Visit Date: Feb 22, 2014@13:33      Provider: TETER,SHIRLEY
Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:
  38.2      narrative for problem

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

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

```

Figure 11-9: Sample Browse Patient's Visits window

**11.1.1.5 Health Summary for this Patient (HS)**

Use the HS to display/print a particular health summary for the current patient. After using HS, the application displays the health summary for this patient on 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.

**Demo Patient Inclusion/Exclusion**

Select one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

The application displays the Review Suicide Reporting Forms window.

```

REVIEW SUICIDE REPORTING FORMS Oct 04, 2010 12:14:10          Page: 1 of 2
Suicide Form Review: Jul 06, 2010 - Oct 04, 2010
I = Incomplete Form
  Date
No.  of Act  Patient              HRN   DOB       Suicidal Behavior    PRV Loc
1)  I  09/29/10  CHI,ROBERT MITCHELL  186585  02/19/98
2)  09/23/10  CHI,JIMMY RAY       146733  07/14/90  ATTEMPTED SUICIDE  WI  RJG 222
3)  I  09/16/10  CHI,ROBERT MITCHELL  186585  02/19/98
4)  09/15/10  CHIY,ROBERT MITCHELL 186585  02/19/98  ATTEMPT              RJG 798
5)  I  09/15/10  THETA,CHARLES       109767  10/27/60  IDEATION WITH PLAN A  RJG
6)  I  09/13/10  THETA,CYNTHIA MAE   110301  12/26/64
7)  I  09/01/10  CHI,ROBERT MITCHELL  186585  02/19/98
8)  08/30/10  ABELL,WALTER JR     211438  01/15/04  COMPLETED SUICIDE  WI  BH
9)  08/27/10  CHI,ROBERT MITCHELL  186585  02/19/98  IDEATION WITH PLAN A  RJG
10) I  08/11/10  SEASEAA,ALICIA MARI 169379  05/26/52  ATTEMPTED SUICIDE  WI  BJB
11) I  08/10/10  SEASEAA,ALICIA MARI 169379  05/26/52  ATTEMPT              BJB
12) I  08/10/10  TEST,BARBARA        28989   01/01/90
13) I  08/09/10  SEASEAA,ALICIA MARI 169379  05/26/52  ATTEMPTED SUICIDE  WI  BJB
+      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 11-10: Sample Review Suicide Report Forms window

The letter I to the left of the Date of Act represents the Incomplete Suicide Reporting Forms.

Section 11.1.1 provides more information about the add/edit/delete functions on this window.

## 11.2 Suicide Form Window (GUI)

The suicide form options are located under the Suicide Reporting Forms category on the tree structure for the RPMS Behavioral Health System (GUI) application.

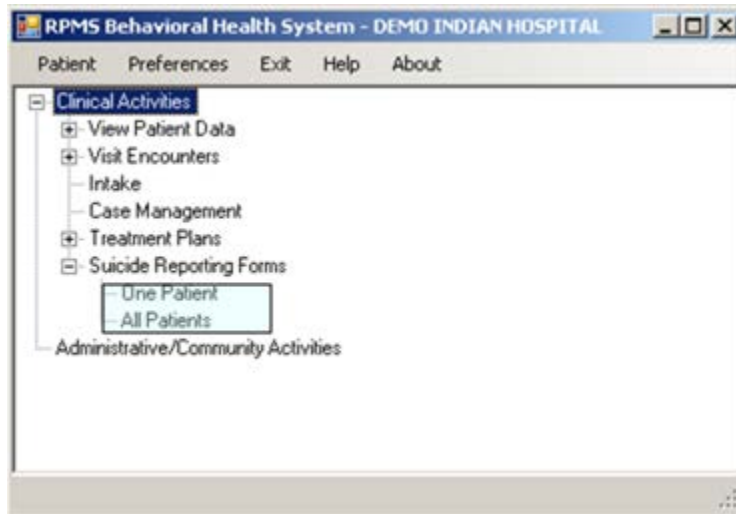


Figure 11-11: Location of Suicide Forms on the tree structure

One way to access the Suicide Form window is to select the One Patient option. Note: you can access this window if you click the Suicide Form tab on the Visit Data Entry – Add/Edit window. The application displays the Suicide Form window for One Patient. If you access the Suicide Form for one patient window and there is no current patient, you will be asked to select one.

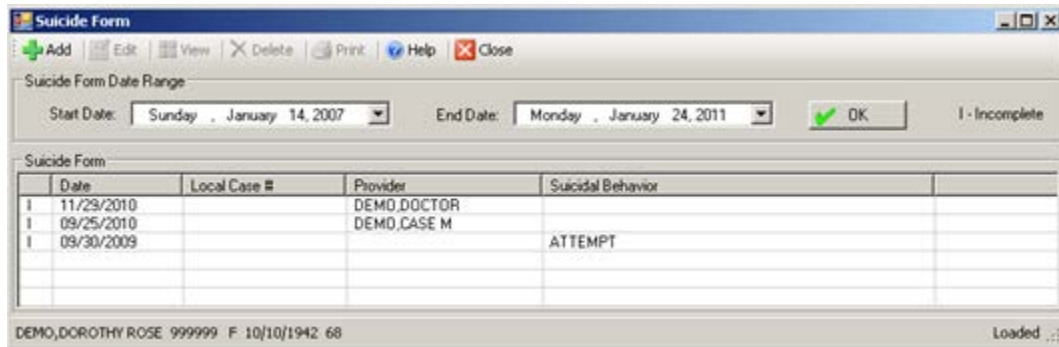


Figure 11-12: Suicide Form window for one patient

Another way to access the Suicide Form window is to select the All Patients option. The application displays the Suicide Form window for All Patients.

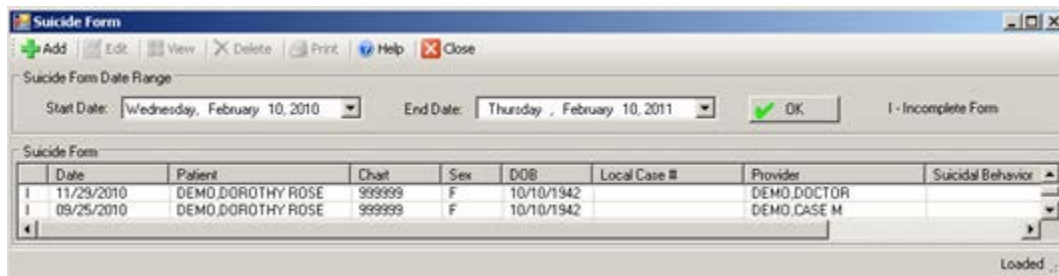


Figure 11-13: Sample Suicide Form window for all patients



Both windows function in the same way.

## 11.2.1 Suicide Form Date Range

The suicide form records are in the suicide form date range.

You can change the date range 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 redisplay, showing the information for the new date range.

### 11.2.1.1 Suicide Form Window for One Patient

The following applies to the Suicide Form window for One Patient:

The default Start Date is one year previous.

If you change the Start Date for the Suicide Form window for One Patient, this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).

### 11.2.1.2 Suicide Form Window for All Patients

The following applies to the Suicide Form window for All Patients:

The default Start Date is one year previous.

If you change the Start Date for the Suicide Form window for All Patients, this change stays in effect until you exit the application. When you login the next time, the Start Date reverts to one year previous.

**Note:** If you change the Start Date for the Suicide Form window for One Patient, this change stays in effect in future sessions of the GUI application for the Visit window for One Patient, the Suicide Form window for One Patient, and the Treatment Plan window for One Patient windows.

Similarly, if you change the Start Date for the Suicide Form window for All Patients, this change stays in effect in future sessions of the GUI application for the Visit window for All Patients, the Suicide Form window for All Patients, and the Treatment Plan window for All Patients windows.

### 11.2.2 Suicide Form Group Box

The Suicide Form group box displays the suicide form records in the date range. The records are listed by date. The “I” in the first column of the grid indicates the suicide form is incomplete.

### 11.2.3 Add Button

Establish the patient you want to use in the add process. Use the Add button to add a new suicide form record. You access the Visit Data Entry - Add Suicide Entry dialog. Section 11.3 provides more information about the dialog.

### 11.2.4 Edit Button

Use the Edit button to edit the highlighted suicide form for the current patient on the Visit Data Entry - Edit Suicide Entry dialog. The Edit button will be inactive if the patient does not have any previous visits (applies to the suicide form for the current patient). Section 11.3 provides more information about the dialog.

### 11.2.5 View Button

Use the View button (or double-click on a form) to browse the highlighted suicide form record. The application displays the Suicide Form Data Entry - View Suicide Form window. This is a view-only window has the same fields as the add/edit suicide form window.

### 11.2.6 Delete Button

Use the Delete button to remove the highlighted suicide form record. On the “Are You Sure” confirmation message, click Yes to remove the selected suicide record (otherwise, click No).

### 11.2.7 Print Button

Use the Print button on the Suicide Form window to output the highlighted suicide form record. After clicking Print, the application displays the first page of the Suicide Reporting Form pop-up window.

```

***** CONFIDENTIAL PATIENT INFORMATION [ST] Nov 02, 2010 *****
Suicide Reporting Form                               Date Printed: Nov 02, 2010

1. Case #: 505901092520100000060849   Local Case #:
2. PROVIDER INITIALS: ST                3. PROVIDER DISCIPLINE: PHYSICIAN
4. SEX: FEMALE                          5. DOB: OCT 10, 1942          6. AGE: 68
7. EMPLOYMENT STATUS:
8. DATE OF ACT: SEP 25, 2010
9. TRIBE: CHEROKEE NATION, OK
10. COMMUNITY OF RESIDENCE: MOAB
11. COMMUNITY WHERE ACT OCCURRED:

12. RELATIONSHIP STATUS:
13. EDUCATION:
14. SUICIDAL BEHAVIOR:
15. METHOD:
16. PREVIOUS ATTEMPTS:
17. SUBSTANCE USE INVOLVED:
18. LOCATION OF ACT:
19. CONTRIBUTING FACTORS:
20. DISPOSITION:

Other Relevant Information: (OPTIONAL)

```

Current Page No.: 1      Total Page No.: 1      Zoom Factor: 100%

Figure 11-14: Sample Suicide Reporting Form

This window contains the following:

- Data from the Suicide Form
- Patient data, such as sex, DOB, Age
- Edit History, such as date last modified, user last update, and each update including date & time + person who modified

Section 2.6 provides more information about this type of window.

### 11.2.8 Help Button

Use 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.

## 11.3 Add/Edit Suicide Form (GUI)

Below are the fields on the Suicide Form Data Entry - Add Suicide Form window. (The same fields display on the Suicide Form Data Entry - Edit Suicide Form window.)

Figure 11-15: Sample Suicide Form Data Entry - Add Suicide Form window

Use the Save button to save the information on this window.

All fields except the Local Case Number and the Narrative are required in order to save. If you try to save and have not completed the fields, the application displays the Required information message.

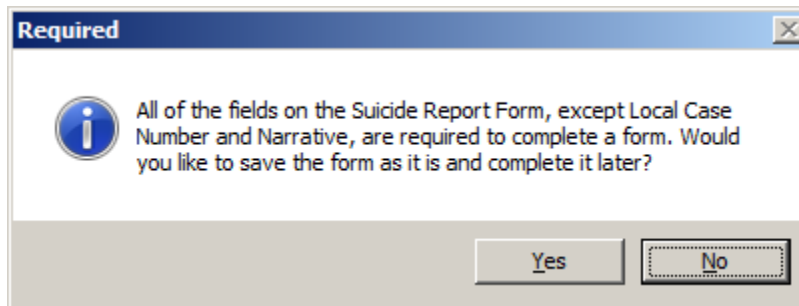


Figure 11-16: Required information message

- Click Yes to save the form and complete it later; you return to the Suicide Form window.
- Click No to not save and you remain on the data entry form.

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

Use the Close button to display the “Continue?” dialog. This dialog states: Unsaved Data Will Be Lost, Continue? Click Yes to not save; this dismisses the add window. Click No and you remain on the add window where you can continue work on the suicide form.

Some fields use free text. Section 2.11 provides more information about Free Text Fields.

Some fields use dates. Section 2.7 provides more information about Using the Calendar.

### 11.3.1 Suicide Form Fields

The required fields are in bold text.

#### **Local Case Number**

Populate with the local case number or a health record number, 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 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 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 search for the community name.

#### **Relationship Status**

This is the patient’s 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. Use 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 use one 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 (0–11).

**Suicidal Behavior**

This is the type of suicidal activity. Click the drop-down list and use one the options.

**Location of Act**

This is the location of the suicidal act. Click the drop-down list and use one of the options.

**Previous Attempts**

This is the previous suicide attempts. Use 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 where the suicidal act occurred (limited to 80 characters).

**Disposition**

Populate with the disposition of the suicide act. Click the drop-down list and use 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 11-17: Sample Method tab

#### 11.3.2.1 Method Group Box

Select one or more checkboxes in this group box that describe the method used in the suicide act. At least one is required.

If you select Overdose checkbox, 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 dialog displays.

Figure 11-18: Sample Other dialog

You must populate the Other Free Text field (limited to 80 characters) with a description of the other substance. Click OK. The description populates the Substance If Other cell on the Overdose group box.

If you select the Other checkbox, the field below the checkbox becomes active.  
Populate this Free Text field with the text that describes the other method used in the suicide act (limited to 80 characters).

### 11.3.2.2 Overdose Group Box

If you select the Overdose checkbox 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.

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 Overdose group box.

If you select a substance with Other in the title on the Substance multiple select window, the application displays the Other dialog.



Figure 11-19: Other dialog

Populate the Other Free Text field with the substance used in the overdose (limited to 80 characters). Click OK. The “substance used” 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 dialog. The application displays the current “Substance If Other” data in the Other field. You can change the data, as needed. Click OK to dismiss the Other dialog.

Use the Delete button to remove a selected substance record (in the Overdose group box). The application confirms the deletion on the Are You Sure confirmation. Click yes to confirm the deletion (otherwise, click No).

### 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.

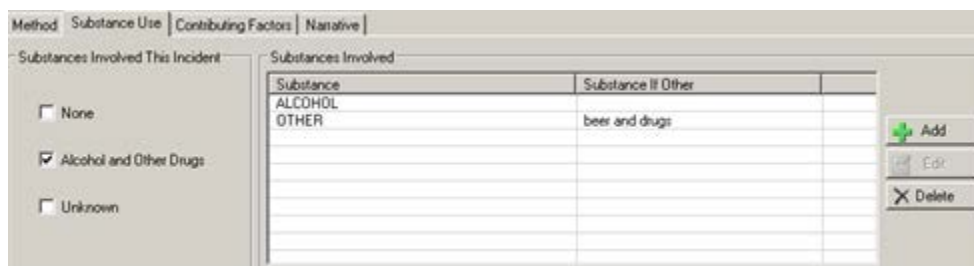
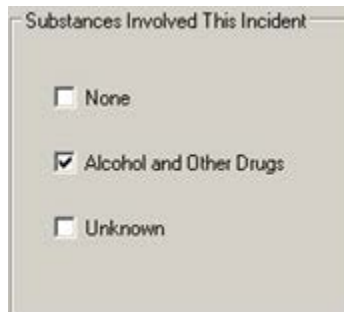


Figure 11-20: Sample Substance Use tab



### 11.3.3.1 Substances Involved This Incident Group Box

Select one of the checkboxes in this group box that describes the substance used in the suicide act. At least one is required.



The image shows a window titled "Substances Involved This Incident". Inside the window, there are three checkboxes arranged vertically. The first checkbox is labeled "None" and is unchecked. The second checkbox is labeled "Alcohol and Other Drugs" and is checked. The third checkbox is labeled "Unknown" and is unchecked.

Figure 11-21: Substances Involved This Incident group box

If you select the Alcohol and Other Drugs checkbox, the application displays the Substance multiple select window where you can add one or more substances. When this window is complete, click OK to add the substances to Substances Involved group box. (Otherwise, click Cancel).

If you select the Other option (on the Substance multiple select window), the application displays the Other dialog.



The image shows a dialog box titled "OTHER". It has a text input field with the label "Other" above it. To the right of the input field are two buttons: "OK" with a green checkmark icon and "Close" with a red X icon.

Figure 11-22: Other dialog

**Other:** Populate the Free Text field with the “other” substance used in this incident (limited to 80 characters). When this dialog is complete, click OK (otherwise, click Close). The OK function populates the Substances Involved group box.

If you uncheck the Alcohol and Other Drugs checkbox, this action clears any data in the Substances Involved group box.

### 11.3.3.2 Substances Involved Group Box

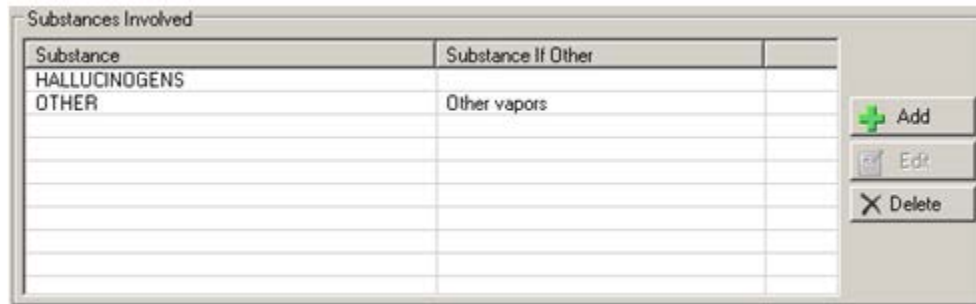


Figure 11-23: Sample Substances Involved group box

This group box contains the substances used immediately before or during the suicidal act. Once the Alcohol and Other Drugs checkbox is selected, the Add, Edit, and Delete buttons become active.

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 to add the substances to the Substances Involved group box. (Otherwise, click Close).

If you selected Other on the multiple select window, the application displays the Other dialog.



Figure 11-24: Other dialog

**Other:** Populate this Free Text field with the “other” substance used in this suicide act (limited to 80 characters). When this dialog is complete, click OK to populate the Substances if Other column on the grid. (Otherwise, click Close).

Use the Edit button with OTHER records (Substance If Other column is populated). Highlight the record and click Edit to display the Other dialog. Change the Other field and then click OK (otherwise, click Close). The OK function changes the data in the Substance If Other column.

Use the Delete button to remove a highlighted substance record. On the “Are You Sure” dialog, click Yes to delete the highlighted substance record. (Otherwise, click No).

### 11.3.4 Contributing Factors Tab

Use the Contributing Factors tab to indicate one or more contributing factors associated with the suicide act. At least one is required.

Figure 11-25: Sample Contributing Factors tab

If you select the Other checkbox, the field below the checkbox becomes active. Use this Free Text field to describe the “other” contributing factor (limited to 80 characters).

### 11.3.5 Narrative Tab

Use the Narrative tab to populate the “Other Relevant Information” Free Text field. (This is not a required field.)

Figure 11-26: Sample Other Relevant Information field

Populate this field with data that is not included elsewhere. This is **not** where you put the SOAP or progress note.

## 12.0 Intake

This section addresses how to manage intake/update documents in roll and scroll and the GUI.

### 12.1 Intake Documents (Roll and Scroll)

One of the places you can add/change/remove an intake document is when you exit the visit encounter (display or add/edit) window. After you exit the last screen, the application displays the OTHER INFORMATION window.

```

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

Update, add or append any of the following data

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

```

Figure 12-1: Options on the Other Information menu

Use option 7 (Add/Update/Print Intake Document) to access the Update BH Intake Document for the selected visit.

The other place you can 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 (you are associated with). After specifying the program, you 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 GAMMAA, RYAN
*3  12/29/09  MENTAL H GAMMAA, RYAN
4   12/29/09  MENTAL H THETA, SHIRLEY
                                12/29/09 THETA, SHIRLEY

```

```

*12/29/09 THETA,SHIRLEY
*5 12/29/09 MENTAL H THETA,SHIRLEY
*6 12/14/09 MENTAL H GAMMAA,RYAN
*7 10/07/09          GAMMAA,RYAN
*10/07/09 GAMMAA,RYAN
*8 04/21/09          GAMMAA,RYAN
   Enter ?? for more actions
I   Add Initial Intake          D   Delete Intake/Update
E   Edit Initial Intake         P   Display/Print Intake/Update
U   Add/Edit Update             Q   Quit
Select Action: Q//

```

Figure 12-2: 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 Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side (under the Date Updated and Update Provider columns).

### 12.1.1 Add Initial Intake (I)

Use option I to create an initial intake document for the visit.

After using I, the application displays a message that it is adding the Intake document for the patient.

Below are the prompts:

#### **Do you wish to continue to add the Intake Document?**

Use Y to add the Intake document (otherwise, use N). If you use N, you exit the create process.

If you use Y, the following prompts continue.

#### **DATE**

The default is the current date (you can change). This cannot be a future date.

#### **PROGRAM**

The default is Mental Health (you can change).

**PROVIDER**

This is the provider for the initial intake document.

**DATE LAST UPDATED**

The default is the current date (you can change). This cannot be future date.

**NARRATIVE****No Existing Text****Edit?**

Use Y to edit the narrative or N to not edit the narrative.

If you use 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 use N, you return to the Update BH Intake Document window.

If you use 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. You cannot edit it.
- Press Enter to not sign the document. After you press Enter, the document is marked as not signed. You can edit it.

**12.1.2 Edit Initial Intake (E)**

Use option E to change the selected initial intake document.

- Only the original intake provider or the person who entered the intake document can edit the document; other providers can only view or print the document.
- Editing an initial intake that was created before the installation of BHS v4.0 will result in a prompt to enter the program associated with the intake.

Below are the prompts:

**CHOOSE**

Use 1 (Edit Initial Intake Document) or 2 (Quit). If you use 2, you return to the Update BH Intake Document. If you use 1, the prompts continue.

**Select Intake (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 (you can change). This cannot be a future date.

**PROGRAM**

The program associated with the intake displays (you can change).

**PROVIDER**

This is the provider for the initial intake document.

**DATE LAST UPDATED**

The default is the current date (you can change). This cannot be a future date.

**NARRATIVE****No Existing Text****Edit?**

Use Y to edit the narrative or N to not edit the narrative. In order to edit the narrative, you must be the original provider or the person who entered or modified the document.

If you use 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 use Y, you return to the Narrative prompts (as above). If you use N, you return to the Update BH Intake Document window.

If you use 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 Intake document or the Intake 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 (choice 2 in Figure 12-3).

- If you select the update choice, 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 (you can change). This cannot be a future date.

#### PROVIDER

This is the provider for the update document.



**DATE LAST UPDATED**

The default is the current date (you can change). 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?**

Use Y to edit the text of the narrative or N to not edit the narrative. If you use 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 return to the Update BH Intake Document window.

If you use option 1, this action has the same prompts as Add/Edit Update ( section 12.1.3 provides more information).

If you use option 2, this action has the same prompts as Add/Edit Update (section 12.1.3 provides more information).

**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

You can delete only unsigned Intake documents you entered or on which you are the provider, unless you possess a special key or are listed on the Delete Override list.

Below are the prompts:

##### Select Intake

Specify the Initial Intake you want to delete, or the Initial Intake with 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 the example shown in Figure 12-5.

If you use option 0, you return 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? Use Y to delete or N to not delete.

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. Section 12.1.5 provides more information about the print process.

#### 12.1.5 Print Intake Document

Use option P to print/browse a particular intake document.

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**

Use I (Intake document only), U (Update document only), B (both the Intake and Update documents), Q (quit/exit).

If you use Q, you return to the previous window.

If you use U, another menu is displayed listing each of the updates and an option to print all updates.

If you use B, other prompts will display.

**Do you wish to**

Use 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 dialog.

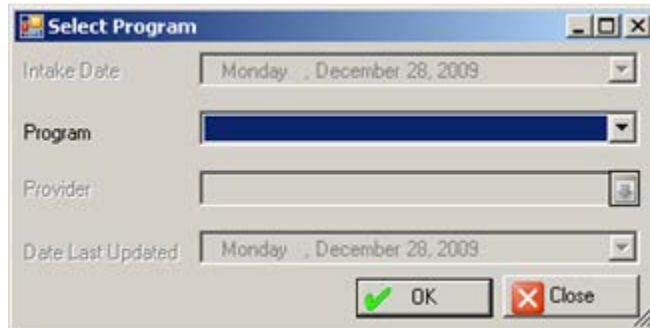


Figure 12-7: Select Program dialog

Click the drop-down list for the Program field and select an option. Then click OK (otherwise click Close).

The OK process displays the Intake window listing the intake documents for the particular program for the current patient. The current patient's name appears in the lower, left corner of the window.

**Note:** The following window is the window that displays when you click the Intake tab on the Add/Edit Visit Data Entry window.

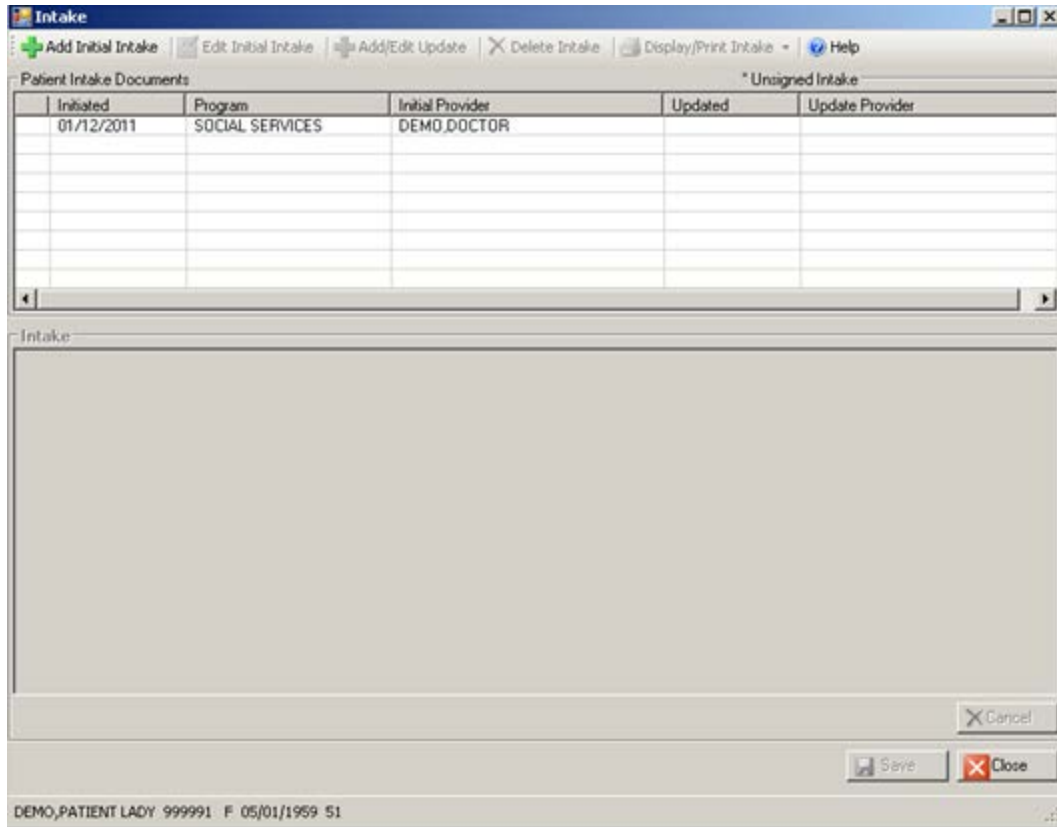


Figure 12-8: Sample Intake window

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

Initiated	Program	Initial Provider	Updated	Update Provider
* 01/14/2010	MENTAL HEALTH	DEMO.DOCTOR		
			01/14/2010	DEMO.DOCTOR
* 07/09/2009		DEMO.DOCTOR	01/28/2010	DEMO.DOCTOR

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 dialog.

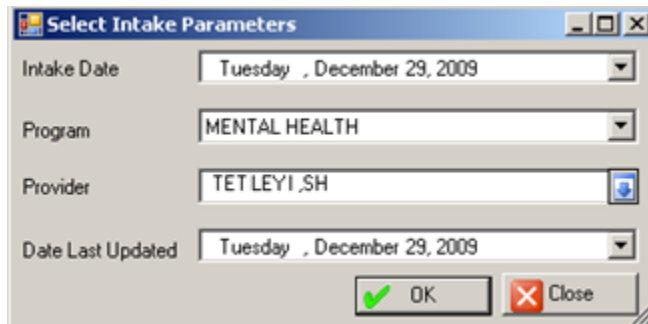


Figure 12-10: Sample Select Intake Parameters dialog

#### Intake Date

The default is the current date. You can change this 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. You can change this by clicking the drop-down list and selecting another option.

**Note:** If you change the Program, it will not be visible when you return to the list view. You have to back out of the Program selection screen again and select the Program associated with the document you just entered. We encourage you to NOT change the program. It is actually more efficient to back out and enter the correct program initially.

## Provider

The default is the current login provider. You can change this by clicking the drop-down list to access the Primary Provider search window. Section 2.8 provides more information about using this type of window.

## Date Last Updated

The default is the current date. You can change this 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 dialog, click OK (otherwise, click Close). The OK function activates the Intake group box. Section 12.2.3 provides more information the intake group box.

### 12.2.3 Intake Group Box

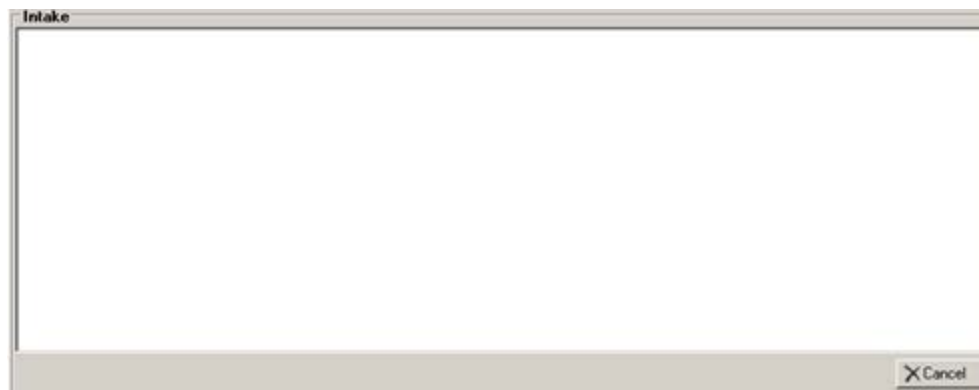


Figure 12-11: Sample of active Intake group box

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.

To exit the Intake group box, click Cancel. The Cancel function causes the Intake group box to become inactive.

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 return to the Intake group box.
- If you click Save, the application displays the Intake Electronic Signature dialog. The Save process requires that there is intake narrative.

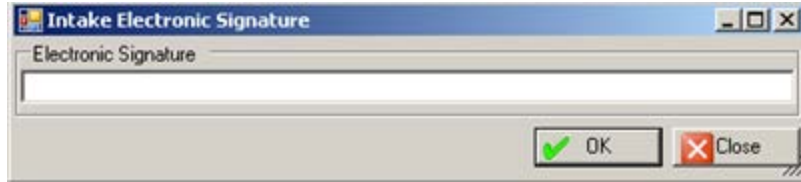


Figure 12-12: Intake Electronic Signature dialog

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 that states: Are you sure you want to Close without Electronically Signing the Intake?

- Click Yes to not sign it and to save the document marked as not signed. The application displays the Message: You did not Electronically Sign the Intake. Click OK to dismiss the Message. This type of document can be edited.
- Click No and you return to the Intake Electronic Signature dialog.

#### 12.2.4 Edit Initial Intake

Select an existing initial intake document and click the Edit Initial Intake button to edit the initial intake document.

- If the selected document has been signed, the application displays the Message: This Initial Intake document has been signed. You cannot edit it. Click OK to dismiss the message and you exit the edit process.
- Only the provider or the person who entered the intake can edit it; otherwise, the application displays the Message: You are not the provider or the person who entered the Intake, you cannot edit it. Click OK to dismiss the message and you exit the edit process.

If you are the provider or the person who entered the intake, the application displays the Select Intake Parameters dialog. Section 12.2.2 provides more information the add initial intake process. After completing this dialog, the text of the initial intake document will display in the Intake area of the Intake window. Section 12.2.3 provides more information about the intake group box.

#### 12.2.5 Add/Edit Update

This button has two different labels, depending on the action you take.



**Note:** If you select a signed Update document, the button reads Edit Update. After you click the Edit Update button, the application displays the Message: This Intake Update document has been signed. You cannot edit it. Click OK to dismiss the message and you exit the edit process.

After the Provider locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the Delete Override Site Parameter.

If you select an Intake document (signed or unsigned), the button reads: Add Update.

If you select an unsigned Update document, the button reads: Edit Update.

In either case, the application displays the Select Intake Parameters dialog. Section 12.2.2 provides more information about Add Initial Intake.

After completing this dialog, the Intake group box will become active. Section 12.2.3 provides more information about the Intake Group Box.

### 12.2.6 Delete Intake

Use the Delete Intake button to delete a selected unsigned Intake document (in the Patient Intake Documents group box).

On the “Are You Sure” confirmation message, click Yes to delete (otherwise, use No to not delete).

- 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.

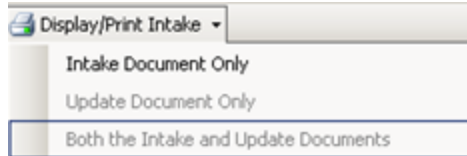


Figure 12-13: Options on the Display/Print Intake button

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 dialog.

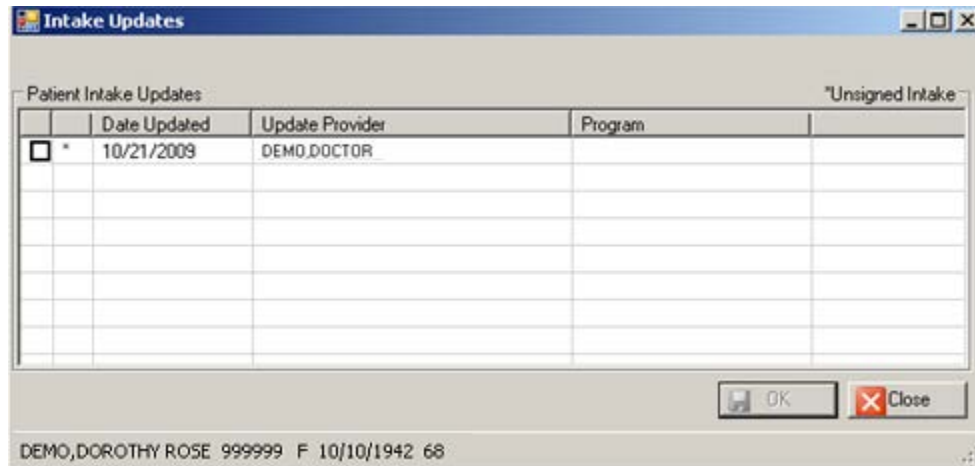


Figure 12-14: Sample Intake Updates dialog

Check the records you want to include in the output and click OK (otherwise, click Close).

The application displays the first page of the Intake (for the current patient) pop-up.

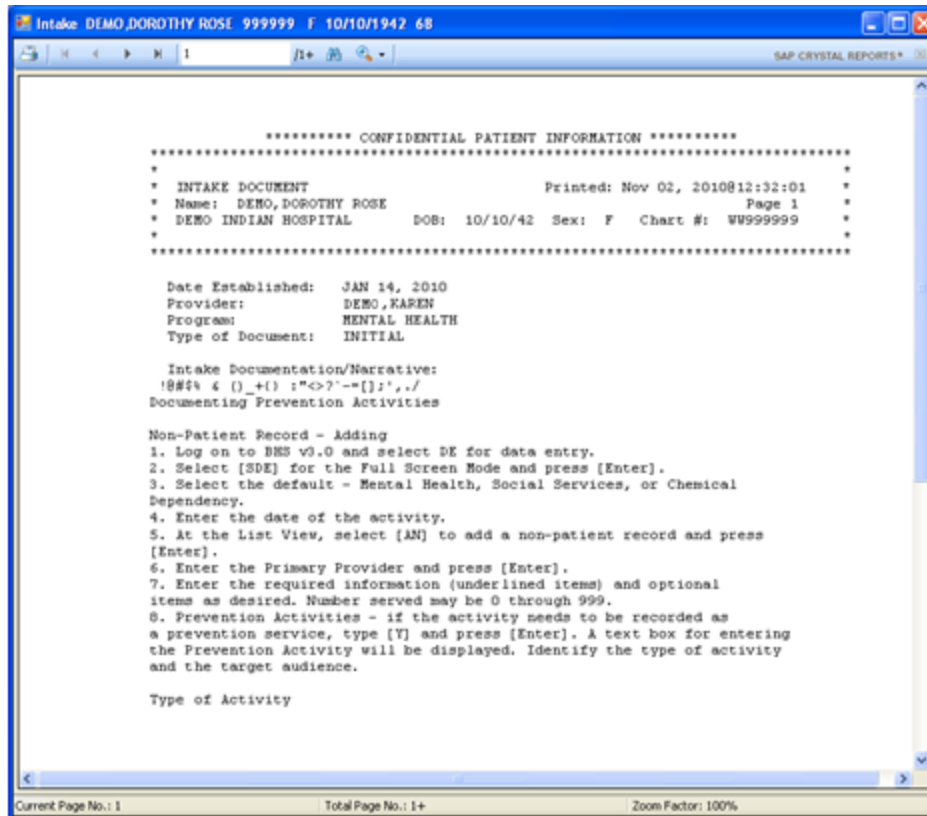


Figure 12-15: Sample Intake pop-up for current patient

Section 2.6 provides more information about this type of window.

## 13.0 Reports (Roll and Scroll Only)

The Reports menu of the Behavioral Health system provides numerous options for retrieving data from the patient file. You can obtain specific patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

The Reports menu (Figure 13-1) contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to the Behavioral Health system. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options are detailed in the following sections.

```

*****
**          IHS Behavioral Health System          **
**                      Reports                      **
*****
                          Version 4.0 (patch 4)

                          DEMO INDIAN HOSPITAL

PAT   Patient Listings ...
REC   Behavioral Health Record/Encounter Reports ...
WL    Workload/Activity Reports ...
PROB  Problem Specific Reports ...
TABL  Print Standard Behavioral Health Tables ...

Select Reports Menu Option:

```

Figure 13-1: Options on Report menu

Use this menu for tracking and managing patient, provider, and program statistics.

**Reminder:** The location screen (UU) and the list of Those Allowed to See All Visits found on the site parameters menu will impact the information displayed in the reports. For example, if your name has not been added to the list of those allowed to see all visits, the report will contain only those visits where you were a provider or completed the data entry.

### 13.1 Patient Listings (PAT)

The Patient Listings submenu (Figure 13-2) contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, that is a custom report that allows you to select which patients to include in the report as well as the items to print and the sort criteria.

ACL	Active Client List
PGEN	Patient General Retrieval
DP	Designated Provider List
GRT	Patients with AT LEAST N Visits
AGE	Patients Seen by Age and Sex (132 column print)
CASE	Case Status Reports ...
GAFS	GAF Scores for Multiple Patients
NSDR	Listing of No-Show Visits in a Date Range
PERS	Patient List for Personal Hx Items
PPL	Placements by Site/Patient
PPR	Listing of Patients with Selected Problems
SCRN	Screening Reports ...
TPR	Treatment Plans ...
TSG	Patients seen in groups w/Time in Group

Select Patient Listings Option:

Figure 13-2: Options on the Patient Listings reports

### 13.1.1 Active Client List (ACL)

Use the ACL option to review a list of patients who have been seen in a specified date range. You can further filter the report by a particular provider, if needed.

Below are the prompts.

#### Enter beginning Date

Specify the beginning date of the date range.

#### Enter ending Date

Specify the ending date of the date range.

**Note:** The date range considered should be one in which the patient should be seen in order to be considered active.

#### Limit the list to those patients who have seen a particular provider?

Use Y or N. If you use Y, other prompts display.

#### Demo Patient Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

You browse the output on the Output Browser window (Figure 13-3).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX
                                DEMO INDIAN HOSPITAL
                                ACTIVE CLIENT LIST
                                PROVIDER: ALL
                                ENCOUNTER DATES: NOV 17, 2010 TO FEB 15, 2011
                                Page 1

PATIENT NAME      CHART   SEX  DOB      LOCATION   PROVIDER   PROBLEM   #
                   NUMBER                SEEN        SEEN        CODES     VISITS
-----
AAA,GCOX          432432  F   11/28/70  DEMO INDIA WILLIAMS,M 293.82    1
ALPHA,JACOB SCO  102668  M   10/01/72  DEMO INDIA BRUNING,BJ 292.12    1
ALPHAA,CHELSEA   116431  F   02/07/75  LOCUST GRO BRUNING,BJ 293.82    2
                   SELLS FIEL GARCIA,RYA 296.32
ALPHAA,DIANA LE  192745  F   09/15/54  DEMO INDIA BRUNING,BJ 80         1
ALPHAA,MISTY DA  131668  F   04/21/46  DEMO INDIA BRUNING,BJ 314.01    3
                   RED LAKE M BUTCHER,LO

Enter RETURN to continue or '^' to exit:

```

Figure 13-3: Sample Output Browser data

Near the end of the report, the application displays the total number of patient.

### 13.1.2 Patient General Retrieval (PGEN)

Use the PGEN option to produce a report that shows a listing of patients based on selected criteria. The patients used on the report can be selected based on any selected print and sort criteria.

Below are the prompts.

#### Select and Print Patient List from

Use S (search template) or P (patient file). If you use S, other prompts will display.

#### Do you want to use a PREVIOUSLY DEFINED REPORT?

Use Y or N. If you use Y, other prompts will display.

The application displays the Patient Selection Menu (Figure 13-4).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:10:31          Page: 1 of 1
                                Patient Selection Menu
Patients can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Patients type Q.

1) Sex                        14) Medicaid Eligibility  27) Pts seen at a Locati

```

2) Race	15) Priv Ins Eligibility	28) Pts Seen in a Commun
3) Patient Age	16) Patient Flag Field	29) Pts w/Problem (DX)
4) Patient DOB	17) Case Open Date	30) Pts w/Problem (MHSS
5) Patient DOD	18) Case Admit Date	31) Pts seen by a Provid
6) Living Patients	19) Case Closed Date	32) Pts w/Education Done
7) Chart Facility	20) Case Disposition	33) Pts seen for an Acti
8) Community of Residen	21) Next Case Review Dat	34) Pts seen w/Type of C
9) County of Residence	22) Designated MH Prov	35) Pts seen w/Axis IV L
10) Tribe of Membership	23) Designated SS Provid	36) Pts w/Inpatient Disp
11) Eligibility Status	24) Designated A/SA Prov	37) Pts Last Health Fact
12) Class/Beneficiary	25) Designated Other Pro	
13) Medicare Eligibility	26) Personal History Ite	
Enter ?? for more actions		
S	Select Item(s) +	Next Screen Q Quit Item Selection
R	Remove Item(s) -	Previous Screen E Exit Report
Select Action: S//		

Figure 13-4: Sample Patient Selection Menu options

Use this menu to select the patients based on various criteria. If you do not specify any criteria (immediately use the Quit Item Selection option), the application selects all patients.

### Choose Type of Report

Use one of the following: T (total count only), S (sub-counts and total count), or D (detailed listing). If you select D (the detailed listing), the application displays the Print Item Selection Menu (Figure 13-5).

BH GENERAL RETRIEVAL		Apr 16, 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 the Quit Item Selection action to dismiss the menu.

Next, the application displays the Sort Item Selection Menu (Figure 13-6).

```

BH GENERAL RETRIEVAL          Apr 16, 2009 14:49:47          Page:    1 of    1

                          SORT ITEM SELECTION MENU
The Patients displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by patient name.

1) Patient Name              7) Community of Residen  13) Designated MH Prov
2) Sex                       8) County of Residence  14) Designated SS Provid
3) Race                      9) Tribe of Membership  15) Designated A/SA Prov
4) Patient DOB              10) Eligibility Status  16) Designated Other Pro
5) Patient DOD              11) Class/Beneficiary  17) Designated Other (2)
6) Patient Chart #         12) Patient Flag Field

Enter ?? for more actions
S  Select Item(s)          +  Next Screen           Q  Quit Item Selection
R  Remove Item(s)         -  Previous Screen       E  Exit Report
Select Action: S//

```

Figure 13-6: Sample Sort Item Selection Menu options

Use this menu to determine how the data will be sorted on the report. If you do not select any item (immediately use the Quit Item Selection option), the report will be sorted by patient name.

**Do you want a separate page for each Patient Name?**

Use Y or N.

**Would you like a custom title for this report?**

Use Y or N. If you use Y, other prompts will display.

**Do you wish to save this search/print/sort logic for future use?**

Use Y or N. If you use Y, other prompts will display.

**Demo Patient Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

The application provides a Report Summary that shows the criteria you selected.

**Do you wish to**

Use P (print output) or B (browse output on screen).



The application first displays the Patient Selection Criteria for the report.

After you move onto the next screen press Enter (to continue), the application displays the patient listing report (Figure 13-6).

***** CONFIDENTIAL PATIENT INFORMATION *****			
BH Patient Listing			Page 1
PATIENT NAME	SSN	COMM	RESIDENCE
-----			
A'PAT1,ALAYNA BROOKL	XXX-XX-2160	HOWE	
A'PAT1,WEBB AARON	XXX-XX-4769	PORUM	
ALPHA,ALICE ROCHELLE	XXX-XX-6378	COLCORD	
ALPHA,GERALDINE	XXX-XX-7097	MUSKOGEE	
Enter ?? for more actions			
+ NEXT SCREEN	- PREVIOUS SCREEN	Q QUIT	
Select Action: +//			

Figure 13-7: Sample Patient Listing report

### 13.1.3 Designated Provider List (DP)

Use the DP option to produce the designated mental health provider list report.

Below are the prompts.

#### Which Designated Provider?

Use one of the following: M (mental health), S (social services), C (chemical dependency or alcohol/substance abuse), O (other), T (other non-RPMS).

#### Run Report for

Use one of the following: 1 (one provider) or 2 (all providers). If you use 1, other prompts will display.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Designated Mental Health Provider List report (Figure 13-8).

***** CONFIDENTIAL PATIENT INFORMATION *****	
XX	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		F	01/01/90	TUCSON	Apr 15, 2009
MPAT11,SHERRY KEARNEY	197407	F	10/01/00	PEGGS	Sep 28, 2007
+ Enter ?? for more actions					>>>
+ NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT	
Select Action: +//					

Figure 13-8: Sample Designated Mental Health Provider List report (for all providers)

The report subtotals by provider.

### 13.1.4 Patients with AT LEAST N Visits (GRT)

Use the GRT option to produce a report that shows a list of patients who have been seen at least N number of times in a specified date range.

Below are the prompts.

#### Enter beginning Date

Specify the beginning date of the date range.

#### Enter ending Date

Specify the ending date of the date range.

#### Enter the minimum number of time the patient should have been seen

Use any number between 2 and 100.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the patients seen at least N times report (Figure 13-9).

***** CONFIDENTIAL PATIENT INFORMATION *****		
XX	DEMO INDIAN HOSPITAL	Page 1
PATIENTS SEEN AT LEAST 3 TIMES		
RECORD DATES: JAN 16, 2009 TO APR 16, 2009		

PATIENT NAME	CHART #	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS
ALPHAA,CHELSEA	116431	F	02/07/75	CEDAR CITY	BDOC111,BJ	1.1	67
				CHEVAK	BDOC222,LO	12	
				CHINLE CHA	CDOC1,JESS	14	
				CHINLE HOS	DEMO,DOCTO	15	
				DEMO INDIA	GDOC12,RYA	22	
+ Enter ?? for more actions							>>>
+ NEXT SCREEN		-	PREVIOUS SCREEN		Q	QUIT	
Select Action: +//							

Figure 13-9: Sample Patients Seen at least 3 Times report

### 13.1.5 Patients Seen by Age and Sex (AGE)

Use the AGE option to produce a report that tallies the number of patients, who have had an encounter, by age and sex. You will choose the item you want to tally. For example, you can tally problems treated, or activities by age and sex. Any tally by PROBLEM only includes the PRIMARY PROBLEM. You will be able to define the age groups to be used.

Below are the prompts.

#### Choose an item to tally by age and sex

Use one of the following:

- 1). Program Type
- 2). POV/Problem (Problem Code)
- 3). Problem/POV (Problem Category)
- 4). Problem/POV
- 5). Location of Service
- 6). Type of Contact of Visit
- 7). Activity Code
- 8). Activity Category
- 9). Community of Service

The item you select will display down the left column of the report. Age groups will be across the top.

#### Enter beginning Visit Date for Search

Specify the beginning date of the date range.

#### Enter ending Visit Date for Search

Specify the ending date of the date range.

The application displays the Visit Selection Menu (Figure 13-10).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:20:24          Page: 1 of 2
                          Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name              23) Next Case Review Dat  45) Axis V
2) Patient Sex               24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race              25) Interpreter Utilized 47) Primary Provider
4) Patient Age               26) Program              48) Primary Prov Discipl
5) Patient DOB               27) Visit Type           49) Primary Prov Affilia
6) Patient DOD               28) Location of Encounte 50) Prim/Sec Providers
7) Living Patients           29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility            30) Outside Location      52) POV (Prim or Sec)
9) Patient Community         31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid     32) County of Service     54) Primary POV
11) Patient Tribe            33) Community of Service  55) POV (Problem Categor
12) Eligibility Status       34) Activity Type         56) POV Diagnosis Catego
13) Class/Beneficiary        35) Days in Residential   57) Procedures (CPT)
14) Medicare Eligibility     36) Days in Aftercare     58) Education Topics Pro
15) Medicaid Eligibility     37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility      38) Local Service Site    60) Personal History Ite
17) Patient Encounters O     39) Number Served         61) Designated MH Prov
18) Patient Flag Field       40) Type of Contact        62) Designated SS Provid
19) Case Open Date           41) Activity Time         63) Designated A/SA Prov
20) Case Admit Date          42) Inpatient Dispositio  64) Designated Other Pro
21) Case Closed Date         43) PCC Visit Created
22) Case Disposition         44) Axis IV
+ Enter ?? for more actions
S Select Item(s)             + Next Screen              Q Quit Item Selection
R Remove Item(s)            - Previous Screen          E Exit Report
Select Action: S//

```

Figure 13-10: Sample Visit Selection Menu

Use this menu to select the visit selection criteria for the report. If you do not select any criteria (immediately use the Quit Item Selection), all visits will be selected.

#### **Do you wish to modify these age groups?**

The application displays the currently defined age groups. Answer Y or N to this prompt. If you use Y, other prompts will display. Use N to have the defined age groups listed across the top of the report.

#### **Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### **Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the Behavioral Health Record Listing report (Figure 13-11).

```

OUTPUT BROWSER                Apr 16, 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-5/CODE BY AGE AND
                                ENCOUNTER DATES:  OCT 18, 2008 TO A

                                SEX: BOTH
PROB DSM/CODE NARRATIVE                0-0        1-4        5-14        15-19        20-
-----
ACUTE STRESS REACTION                .          .          .          .
ADMINISTRATION                .          .          2          .
ADULT ABUSE (SUSPECTED),UNSPEC        .          .          .          .
ALCOHOL ABUSE                .          .          1          .
ALCOHOL ABUSE, CONTINUOUS                .          .          .          .
ALCOHOL ABUSE, EPISODIC,                .          .          .          1
ALCOHOL ABUSE, IN REMISSION                .          .          .          .
ALCOHOL ABUSE, UNSPECIFIED                .          .          1          1
+      Enter ?? for more actions                >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +//

```

Figure 13-11: Sample Behavioral Health Record Listing report

### 13.1.6 Case Status Reports (CASE)

Use the CASE option to access additional reports on the Case Status Reports menu (Figure 13-12).

```

ACO  Active Client List Using Case Open Date
ONS  Cases Opened But Patient Not Seen in N Days
TCD  Tally Cases Opened/Admitted/Closed
DOC  Duration of Care for Cases Opened and Closed
SENO Patients Seen x number of times w/no Case Open

Select Case Status Reports Option:

```

Figure 13-12: Options on the Case Status Reports menu

### 13.1.6.1 Active Client List Using Case Open Date (ACO)

Use the ACO option to produce a report that shows a list of patients who have a case open date without a case closed date.

Below are the prompts:

#### Run the Report for which program

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

#### Include cases opened by

Use one of the following: A(all provides) or O (one provider). If you use O, other prompts will display.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the active client list report (Figure 13-13).

***** CONFIDENTIAL PATIENT INFORMATION *****									
XX									Page 1
WHITE EARTH HEALTH CENTER									
ACTIVE CLIENT LIST (CASE OPEN DATE WITH NO CASE CLOSED DATE)									
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	CASE ADMIT DATE	PROVIDER SEEN	PROBLEM CODES		
ALPHA,ALICE ROC	183497	F	06/25/97	01/23/06		BETA,BETAA	296.31		
						CHII,RONAL	296.32		
						GAMMAAAA,RYA			
Case Provider:	GAMMAAA,DENISE				Next Case Review:				
ALPHA,JACOB SCO	102668	M	10/01/72	05/06/09		GAMMAAAA,RYA	39		
						MUUUU,KARE	93		
							292.12		
							V11.3		
							V71.02		
Case Provider:	GAMMA,RYAN				Next Case Review:	5/6/09			

Figure 13-13: Sample view of active client list

### 13.1.6.2 Cases Opened But Patient Not Seen in N Days (ONS)

Use the ONS option to produce a report that shows a list of patients who have a case open date, no closed date, and have not been seen in N days. The user will determine the number of days to use.

Below are the prompts:

#### Run the Report for which PROGRAM

Use one of the following: O (ONE program) or A (ALL programs). If you use O, other prompts will display.

#### Include cases opened by

Use one of the following: A (Any provider) or O (One Provider). If you use O, other prompts will display.

#### Enter the number of days since the patient has been seen

Specify the number of days (1-99999) to be used when determining which patients should be included in the report.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Cases Opened but Patient Not Seen in N Days report (Figure 13-14).

DEMO INDIAN HOSPITAL							
ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)							
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	PROVIDER	DATE LAST SEEN	# DAYS SINCE
Patient L	106299	F	11/28/85	01/01/06	GAMMAAA,DON	04/26/06	217
Patient M	102446	F	04/08/66	08/28/06	GAMMAAA,DON	03/28/06	246
Patient N	176203	M	03/04/60	10/10/05	GAMMAAA,DON	03/28/06	246
Patient O	164141	M	02/07/75	12/07/05	GAMMAAA,DON	04/25/06	218
Patient P	209591	F	04/16/62	07/25/06	ZETAAAA,MAT	07/25/06	127
Total Number of Patients: 5							
Total Number of Cases: 5							

Figure 13-14: Sample Cases Opened but Patient Not Seen in N Days report

### 13.1.6.3 Tally Cases Opened/Admitted/Closed (TCD)

Use the TCD option to produce a report that tallies the case open, admit, and closed dates in a specified time period.

Below are the prompts:

#### Enter beginning of Time Period

Specify the beginning date of the date range.

#### Enter ending of Time Period

Specify the ending date of the date range.

#### Run the Report for which PROGRAM

Use one of the following: O (one program) or A (All programs). If you use O, other prompts will display.

#### Include cases opened by

Use one of the following: A (Any provider) or O (One providers). If you use O, other prompts will display.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Tally of Cases Opened/Admitted/Closed report (Figure 13-15).

ALBUQUERQUE HOSPITAL	
TALLY OF CASES OPENED/ADMITTED/CLOSED	
-----	
Number of Cases Opened:	6
Number of Cases Admitted:	2
Number of Cases Closed:	2
Tally of Dispositions:	
PATIENT DIED	1
PATIENT DMOVED	1
RUN TIME (H.M.S):	0.0.0
End of report. PRESS ENTER:	

Figure 13-15: Tally of Cases Opened/Admitted/Closed report



### 13.1.6.4 Duration of Care for Cases Opened and Closed (DOC)

Use the DOC option to produce a report that shows a list of all closed cases in a specified date range. In order to be included in this report, the case must have both a case open and a case closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases can be selected based on Open date, Closed date, or both. Only those cases falling within the specified time frame will be counted.

Below are the prompts:

#### Enter Beginning Date

Specify the beginning date of the date range.

#### Enter Ending Date

Specify the ending date of the date range.

#### Please Select which Dates should be Used

Use one of the following: O (cases opened in that Date Range), C (cases closed in that Date Range), or B (cases either opened or closed in that Date Range).

#### Run the Report for which PROGRAM

Use one of the following: O (One program) or A (All programs). If you use O, other prompts will display.

#### Include cases opened by

Use one of the following: A (Any provider) or O (One provider). If you use O, other prompts will display.

#### Do you want each Provider on a separate page?

Use Y (for yes) or N (for no).

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Duration of Care report (Figure 13-16).

DURATION OF CARE REPORT						
PATIENT NAME	CHART NUMBER	CASE OPEN DATE	CASE CLOSED DATE	DURATION	POV	PROVIDER

Patient A	148367	05/22/08	08/22/08	92 days		BETA,B
Patient B	114077	06/27/08	08/28/08	62 days		BETA,B
Patient B	114077	07/25/08	08/21/08	27 days		BETA,B
Total Number of Cases for BETA,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		CHI,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

At the end of the report, the application provides the total number of cases for the provider and the average duration of care.

### 13.1.6.5 Patient Seen x number of times w/no Case Open (SENO)

Use the SENO option to produce a report that shows a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. The user, based on the program's standards of care, specifies when a case is to be opened. For example, a case will be opened if a patient has been seen at least three times.

Below are the prompts:

#### Enter Beginning Visit Date

Specify the beginning date of the date range.

#### Enter Ending Visit Date

Specify the ending date of the date range.

#### Run Report for which PROGRAM

Use one of the following: M (Mental Health), S (Social Services), O (Other), or C (Chemical Dependency).

**Include visits to**

Use one of the following: A (All providers) or O (One provider). If you use O, other prompts will display.

**Enter number of visits**

Specify the number of visits with no case opened.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen at least N times with no Case Open Date report (Figure 13-17).

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 NUMBER	SEX	DOB	# VISITS	LAST VISIT	LAST DX	PROVIDER
Patient G	101438	F	04/02/84	11	12/31/13	2	DOCTORX
Patient H	107900	M	07/23/70	7	12/26/13	303.02	BETA,B
Patient I	146375	M	12/27/84	5	12/02/13	12	BETA,KEITH N
Total Number of Patients: 3							

Figure 13-17: Sample Patients Seen at least N times with no Case Open Date report

### 13.1.7 GAF Scores for Multiple Patients (GAFS)

Use the GAFS option to produce a report that lists the GAF scores for multiple patients, sorted by patient. Only visits with GAF scores recorded will display on this list.

Below are the prompts.

**Enter Beginning Date of Visit**

Specify the beginning date of the date range.

**Enter Ending Date of Visit**

Specify the ending date of the date range.

**List visits/GAF Scores for which program**

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

**Include visits to**

Use one of the following: A (all providers) or O (one provider). If you use O, other prompts will display.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the GAF Scores for Multiple Patients report (Figure 13-18).

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 TYPE	Provider	PG	Diagnosis/POV
-----						
BETAAAA,MINNIE	145318	09/17/10	99 LJLKJLK	GAMMAA,RY	M	296.40-BIPOLAR I DISOR
DEMO,JAMES WILL	192636	07/19/10	75	GAAMMAA,D	M	300.02-GENERALIZED ANX
CHI,ROBERT MITC	186585	09/16/10	66 test	GAMMAA,RY	M	293.82-PSYCHOTIC DISOR
+ Enter ?? for more actions						>>>
+ NEXT SCREEN		-	PREVIOUS SCREEN	Q	QUIT	
Select Action: +//						

Figure 13-18: Sample GAF Scores for Multiple Patients report

### 13.1.8 Listing of No-Show Visits in a Date Range (NSDR)

Use the NSDR option to print a list of visits with POVs related to No Shows and Cancellations for multiple patients. The user will specify the date range, program, and provider.

Below are the prompts.

**Enter Beginning Date**

Specify the beginning date of the date range.

**Enter Ending Date**

Specify the ending date of the date range.

**Run the Report for which PROGRAM**

Use one of the following: O (ONE program) or A (All programs). If you use O, other prompts will display.

**Include visits for**

Use one of the following: A (All providers) or O (One provider). If you use O, other prompts will display.

**How would you like the report sorted**

Use P (patient name) or D (date of visit).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Behavioral Health No Show Appointment Listing report (Figure 13-19).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                DEMO INDIAN HOSPITAL
                Page 1

                BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
                Appointment Dates:  OCT 19, 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

At the end of the report, the application shows the total number of patient and the total number of no show visits.

### 13.1.9 Patient List for Personal Hx Items (PERS)

Use the PERS option to produce the List of Patients with Personal History Items report.

Below are the prompts.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

Figure 13-20 shows the List of Patients with Personal History Items report.

XX	DEMO INDIAN HOSPITAL			Jul 13, 2009@09:53:05	Page 1
PERSONAL HISTORY LIST BY PATIENT	PATIENT	SEX	AGE	CHART NUMBER	
-----					
	ALCOHOL USE				
	ALPHAA, SAUNDRA KAY	FEMALE	58	117175	
	BETA, BRENNNA KAY	FEMALE	21	155215	
	BETA, HEATHER LINDA PAIGE	FEMALE	73	142321	
	BETAA, STEVEN	MALE	29	188444	
	GAMMA, JANE ELLEN	FEMALE	19		
	GAMMA, TIMOTHY	MALE	29		
	PHIIIII, GREGORY SHANE	MALE	42	184929	
	SIGMAAA, AMY LYNN	FEMALE	65	130119	
	Enter ?? for more actions				>>>
+	NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT
Select Action: +//					

Figure 13-20: Sample List of Patients with Personal History Items report

The application will display a sub-count for each Personal History Item.

### 13.1.10 Placements by Site/Patient (PPL)

Use the PPL option to produce a report that shows a list of patients who have had a placement disposition recorded in a specified date range.

Below are the prompts.

#### Enter beginning Date

Specify the beginning date of the date range.

**Enter ending Date**

Specify the ending date of the date range.

**How would you like this report sorted**

Use P (alphabetically by patient name) or S (alphabetically by site referred to).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Placements report (Figure 13-21).

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX	DEMO INDIAN HOSPITAL PLACEMENTS				Page 1
PLACEMENT DATES: OCT 19, 2008 TO APR 17, 2009					
PATIENT NAME	HRN	DATE	POV	PLACEMENT	FACILITY REFERRED TO
-----					
ALPHA,JACOB SCOTT	102668	05/03/09	295.15	E	
APATT,CHELSEA MAR	116431	03/25/09	12	OUTPATIENT	
Placement Made by: GAMMAA,RYAN					
Designated SS Prov: BETA,BETAA					
BPATT,RUSTY LYNN	207396	04/06/09	15	OUTPATIENT	
Placement Made by: GAMMAA,RYAN					
BPATTTT,ADAM M	109943	04/07/09	311.	OUTPATIENT	
Placement Made by: GAMMAA,RYAN					
Enter ?? for more actions >>>					
+ NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT	
Select Action: +//					

Figure 13-21: Sample Placements report

Near the end of the report, the report shows subtotals by Placement Type, subtotals by Facility Referred, and the Total Number of Placements.

### 13.1.11 Listing of Patients with Selected Problems (PPR)

Use the PPR option to produce a report that lists all patients who have been seen for a particular diagnosis/problem in a specified date range. For example, you can enter all suicide problems codes (39, 40, and 41) and you will get a list of all patients seen for suicide and can then use this report to assist in follow up activities. The report will list the Designated Provider, the Patient Name, the date seen for this problem, and the date last seen.

Below are the prompts.

### Which Type

Use one of the following: P (Problem Code and all DSM codes grouped under it), or D (individual problem or DSM codes).

Below are prompts for the P type:

### Enter Problem Code

Enter the problem code. The application lists the problem/diagnosis codes that will be included. The next prompt allows you to enter another problem code.

### Enter Beginning Visit Date

Specify the beginning date of the date range.

### Enter Ending Visit Date

Specify the ending date of the date range.

### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report (Figure 13-22).

PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS
APATQ,ABIGAIL	103952	02/25/32	F	BJB	41		12/08/08	12/29/08
BPAT,ROBERT JACOB	207365	02/06/55	M	JC	41		12/29/08	01/05/09
FPAT12,AMANDA ROSE	186121	01/10/98	F	DG	40		12/01/08	12/30/08
YPATB,ANNEMARIE LEE	105883	02/11/44	F	DG	40		04/06/09	04/06/09
Designated MH Prov: GALPHA,DENISE								
Designated SS Prov: GAMMAA,RYAN								
Enter ?? for more actions >>>								
+ NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT				
Select Action: +//								

Figure 13-22: Sample Patients Seen with Selected Diagnosis/Problems report (P type)

Below are the prompts for the D (individual problem or DSM codes) type:



**Enter Problem/Diagnosis Code**

Specify the problem/diagnosis code. The next prompt allows you to enter another problem/diagnosis code.

**Enter beginning Visit Date**

Specify the beginning date of the date range.

**Enter ending Visit Date**

Specify the ending date of the date range.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report (Figure 13-23).

PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS
ALPHA,CHELSEA MARIE Designated SS Prov: BDOC11,BJ	116431	02/07/75	F	DG	311		04/06/09	04/16/09
ALPHA,MISTY DAWN Designated SS Prov: DEMO,PSYCHIATRIST	131668	04/21/46	F	rust	200.20		02/04/09	06/12/09

XX Apr 17, 2009 Page 1

PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS  
Visit Dates: Oct 19, 2008 to Apr 17, 2009

Enter ?? for more actions >>>

+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT

Select Action: +//

Figure 13-23: Sample Patients Seen with Selected Diagnosis/Problems report (D type)

**13.1.12 Screening Reports (SCRN)**

Use the SCRN option to access the Screening Reports menu (Figure 13-24).

*****
** IHS Behavioral Health System **
** Screening Reports **
*****
Version 4.0 (patch 4)

```

                                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 (Figure 13-25).

```

*****
**           IHS Behavioral Health System           **
**           IPV/DV Reports                         **
*****
                                Version 4.0 (patch 4)

                                DEMO INDIAN HOSPITAL

DVP   Tally/List Patients with IPV/DV Screening
DVS   Tally/List IPV/DV Screenings
ISSP  List all IPV/DV Screenings for Selected Patients
IPST  Tally/List Pts in Search Template w/IPV Screening
IVST  Tally List all IPV Screenings for Template of Pts

Select IPV/DV Reports Option:

```

Figure 13-25: Options on the IPV/DV Reports menu

#### 13.1.12.1.1 Tally/List Patients with IPV/DV Screening (DVP)

This report will tally and optionally list all patients who have had IPV screening (PCC Exam code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal

Below are prompts for the DVP report:

**Enter Beginning Date for Screening**

Enter the beginning date of the date range for the screening.

**Enter Ending Date for Screening**

Enter the ending date of the date range for the screening.

**Which items should be tallied: (0-11)**

Select which items you want to tally on this report (Figure 13-26):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 13-26: List of options from which to tally the report

The response must be a list or range, e.g., 1,3,5 or 2-4,8.

**Would you like to include IPV/DV Screenings documented in the PCC clinical database?**

Use Y (yes) or N (no).

**Would you like to include a list of patients screened?**

Use Y (yes) or N (no). If you use Y, the following prompt will display.

**How would you like the list to be sorted**

Figure 13-27 lists the possibilities.

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

How would you like the list to be sorted: H//

Figure 13-27: List of options to sort the list

The default is H (Health Record Number).

**Display the Patient's Designated Providers on the list?**

Use Y (yes) or N (no).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**DEVICE**

Specify the device to output the report.

Figure 13-28 shows a sample report.

PATIENT NAME	HRN	AGE	DATE SCREENED	RESULT	CLINIC
CHI, JIMMY FRED	143023	76	M 02/09/11	NEGATIVE	BEHAVIORAL HEALTH
Comment: test in ehr DXs: 312.33 Pyromania Primary Provider on Visit: GAMMA, RYAN Provider who screened: GAMMA, RYAN					
DEMO, AUSTIN WAYNE	192640	25	M 02/04/11	NEGATIVE	MENTAL HEALTH
Comment: Selected score and then it defaulted as me for provider - I don't have a problem with this DXs: 296.32 MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE Primary Provider on Visit: BETA, BJ Provider who screened: BETA, BJ					
Enter RETURN to continue or '^' to exit:					

Figure 13-28: Sample output of the IPV Screening Patient Tally and Patient Listing report

**13.1.12.1.2 Tally/List IPV/DV Screenings (DVS)**

This report will tally and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note:

- This report will optionally, look at both the Behavioral Health and PCC clinical databases for evidence of screening/refusal.

- Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the DVS report:

**Enter Beginning Date for Screening**

Enter the beginning date of the date range for the screening.

**Enter Ending Date for Screening**

Enter the ending date of the date range for the screening.

**Which items should be tallied: (0-11)**

Select which items (Figure 13-29) you want to tally on this report:

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied? (0-11)://

Figure 13-29: List of options from which to tally the report

The response must be a list or range, e.g., 1,3,5 or 2-4,8.

**Would you like to include IPV/DV Screenings documented in the PCC clinical database?**

Use Y (yes) or N (no).

**Would you like a list of visits w/screenings done?**

Use Y (yes) or N (no). If you use Y, the following prompt will display.

**How would you like the list to be sorted**

Figure 13-30 lists the options.

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

How would you like the list to be sorted? H//

Figure 13-30: List of options to sort the list

The default is H (Health Record Number).

### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

### DEVICE

Specify the device to output the report.

Figure 13-31 shows a sample report.

*** IPV SCREENING VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Oct. 31, 2013 to Dec. 30, 2013		
This report excludes PCC Clinics		
-----		
	#	% of patients
Total Number of Visits with Screening	2	
Total Number of Patients screened	2	
By Result		
NEGATIVE	1	50.0%
PRESENT	1	50.0%
By Provider who screened		
GARCIA, RYAN	1	50.0%
WISDOM, WENDY	1	50.0%
By Date		

Figure 13-31: Sample output of the IPV Screening Visit Tally and Visit Listing report

#### 13.1.12.1.3 List all IPV/DV Screenings for Selected Patients (ISSP)

This report will list all patients you select who have had IPV screening or a refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the ISSP report:

#### Enter Beginning Date for Screening

Enter the beginning date of the date range for the screening.

#### Enter Ending Date for Screening

Enter the ending date of the date range for the screening.

**Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?**

Use Y (yes) or N (no).

**Include which patients in the list**

Use one of the following: F (FEMALES only), M (MALES only), B (Both MALE and FEMALES).

**Would you like to restrict the report by Patient age range?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Which result value do you want included in this list: (1-7)**

Figure 13-32 shows the possible options.

- |   |
|---|
| 1) Normal/Negative                        |
| 2) Present                                |
| 3) Past                                   |
| 4) Present and Past                       |
| 5) Refused                                |
| 6) Unable to Screen                       |
| 7) Screenings done with no result entered |

Figure 13-32: List of options used to be included in the list

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g., to get only those patients who have had a result of Present enter 2 to get all patients who have had a screening result of Past or Present, enter 2,3).

**Include visits to ALL clinics?**

Use Y (yes) or N (no).

**Report should include visits whose PRIMARY PROVIDER on the visit is**

Figure 13-33 shows the possible options. If you use O, other prompts will display.

- |                              |                                       |
|------------------------------|---------------------------------------|
| Select one of the following: |                                       |
| O                            | One Provider Only                     |
| P                            | Any/All Providers (including unknown) |
| U                            | Unknown Provider Only                 |

Figure 13-33: Options for visits to be used on the report

**Select which providers who performed the screening should be included**

Figure 13-34 shows the possible options. If you use O, other prompts will display.

Select one of the following:
------------------------------

O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 13-34: Options for providers to be used on the report

**Would you like to limit the list to just patients who have a particular designated Mental Health provider?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Would you like to limit the list to just patients who have a particular designated Social Services provider?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Would you like to limit the list to just patients who have a particular designated ASA/CD provider?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Select Report Type**

Use one of the following: L (List of Patient Screenings) or S (Create a Search Template of Patients). If you use S, other prompts will display.

**How would you like the list to be sorted**

Figure 13-25 shows the possible selections. The default is H (Health Record Number).

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-35: List of options to sort the list

**Display the Patient's Designated Providers on the list?**

Use Y (yes) or N (no).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).



**DEVICE**

Specify the device to output the report.

The application displays the criteria for the report. After pressing Return, the application displays the report (Figure 13-36).

PATIENT NAME	HRN	AGE	DATE SCREENED	RESULT	CLINIC
XX Feb 15, 2011 Page 1 *** IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS *** Screening Dates: Nov 17, 2010 to Feb 15, 2011					
ALPHA,WILLA BELLE	110838	44	F 01/12/11	PAST	MENTAL HEALTH
DXs: 29.1 SCREENING FOR ALCOHOLISM Primary Provider on Visit: THETA,WENDY Provider who screened: THETA,WENDY					
ALPHA,KIMBERLY ANN	166488	59	F 12/14/10	PRESENT	MENTAL HEALTH
DXs: 39 SUICIDE (IDEATION) Primary Provider on Visit: GAMMA,RYAN Provider who screened: GAMMA,RYAN					
Enter RETURN to continue or '^' to exit:					

Figure 13-36: Sample IPV Screening Visit Listing for Selected Patients report

#### 13.1.12.1.4 Tally/List Pts in Search Template w/IPV Screening (IPST)

\*Please Note: This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF PATIENT'S RECEIVING IPV SCREENING, INCLUDING REFUSALS ONLY PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE ARE INCLUDED IN THIS REPORT

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest IPV screening (Exam code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

### 13.1.12.1.5 Tally/List all PIV Screenings for Template of Pts (IVST)

\*Please Note: This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF ALL VISITS W/IPV SCREENING, INCLUDING ONLY PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE ARE INCLUDED IN THIS REPORT

This report will tally and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. This report will optionally look at both Behavioral Health and PCC databases for evidence of screening/refusal.

### 13.1.12.2 Alcohol Screening Reports (ALC)

Use the ALC option to access the ALC Report menu (Figure 13-27).

```

*****
**      IHS Behavioral Health System      **
**      Alcohol Screening Reports        **
*****
Version 4.0 (patch 4)

DEMO INDIAN HOSPITAL

ASP  Tally/List Patients with Alcohol Screening
ALS  Tally/List Alcohol Screenings
ASSP List all IPV/DV Screenings for Selected Patients
APST Tally/List Pts in Search Template w/Alcohol Screening
AVST Tally List all Alcohol Screenings for Template of Pts

Select Alcohol Screening Reports Option:

```

Figure 13-37: Options on the ALC Reports menu

#### 13.1.12.2.1 Tally/List Patients with Alcohol Screening (ASP)

This report will tally and optionally list all patients who have had ALCOHOL screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts.

**Enter Beginning Date for Screening**

Specify the beginning date of the date range.

**Enter Ending Date for Screening**

Specify the ending date of the date range.

**Which items should be tallied**

Specify which items you would like to have displayed in the report. The application provides a list of items. Your response must be a list (like 1,3,5) or a range (2-4, 8).

**Would you like to include ALCOHOL Screenings documented in the PCC clinical database?**

Use Y (Yes) or N (No).

**Would you like to include a list of patients screened?**

Use Y (Yes) or N (No).

If you answered Yes to this question, the next prompt will display:

**How would you like this report sorted**

Use only one of the items in the list provided by the application.

**Display the Patient's Designated Providers on the list?**

Use Y (Yes) to display the patient's Designated Providers or N (No) to bypass this option.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Tally/List Patients with Alcohol Screenings report (Figure 13-38).

		Oct 07, 2010	Page 1
*** ALCOHOL SCREENING PATIENT TALLY AND PATIENT LISTING ***			
Screening Dates: Sep 07, 2010 to Oct 07, 2010			
This report excludes data from the PCC Clinical database			
-----			
		#	% of patients
Total Number of Patients screened		4	
By Result			
NEGATIVE		1	25.0%
POSITIVE		2	50.0%
REFUSED SCREENING		1	25.0%
By Gender			
F		3	75.0%
M		1	25.0%
By Age			
26 yrs		1	25.0%
27 yrs		1	25.0%
44 yrs		1	25.0%
48 yrs		1	25.0%

Figure 13-38: Sample Tally/List Patients with Alcohol Screenings report

**13.1.12.2.2 Tally/List Alcohol Screening (ALS)**

This report will tally and optionally list all visits on which ALCOHOL screening or a refusal was documented in a specified time frame.

Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the visits by age, gender, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts.

**Enter Beginning Date for Screening**

Specify the beginning date of the date range.

**Enter Ending Date for Screening**

Specify the ending date of the date range.

**Note:** This date range indicates when the screening was done.

**Which items to be tallied**

Specify which items you would like to have displayed in the report. The application provides a list. Your response must be list (like 1,3,5) or a range (2-4, 8).

**Would you like to include ALCOHOL Screenings documented in the PCC clinical database**

Use Y (Yes) or N (No).

**Would you like to include a list of visits w/screenings done?**

Use Y (Yes) or N (No).

**How would you like this report sorted**

The report can be sorted by only one of the items in the list.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Tally/List Alcohol Screenings report (Figure 13-39).

```

*** ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING ***
      Screening Dates: Sep 10, 2010 to Dec 09, 2010
      This report excludes PCC Clinics
-----
Total Number of Visits with Screening      #      % of patients
Total Number of Patients screen           4
  By Result
    NEGATIVE                             1      25.0%
    POSITIVE                              2      50.0%
    REFUSED SCREENING                     1      25.0%
  By Gender
    FEMALE                                3      75.0%
    MALE                                  1      25.0%
  By Age
    26 yrs                                1      25.0%
    27 yrs                                1      25.0%
    44 yrs                                1      25.0%
    48 yrs                                1      25.0%
  By Provider who screened
    ALPHAA, GEORGE C                       1      25.0%
    BETAA, FRANK S                         1      25.0%
    GAMMA, MATT                            1      25.0%
   OMICRON, STEVE N                        1      25.0%
  By Primary Provider of Visit
    ALPHAA, GEORGE C                       1      25.0%
    BETAA,FRANK S                          1      25.0%
    WEARY, MATT                            1      25.0%
   OMICRON, STEVE N                        1      25.0%
  By Designated Primary Care Provider
    UNKNOWN                                3      75.0%
    RHOOOO,HELEN K                        1      25.0%
  By Clinic
    ALCOHOL AND SUBSTANCE                   1      25.0%
    MEDICAL SOCIAL SERVICES                1      25.0%
    MENTAL HEALTH                          2      50.0%
  By Date
    Jul 25, 2006                           1      25.0%
    Aug 09, 2006                           1      25.0%
    Aug 17, 2006                           1      25.0%
    Aug 23, 2006                           1      25.0%
  By Designated Mental Health Provider
    UNKNOWN                                4      100.0%
  By Designated Social Services Provider
    UNKNOWN                                4      100.0%
  By Designated A/SA Provider
    UNKNOWN                                4      100.0%
PATIENT NAME      HRN      AGE      SCREENED  RESULT      CLINIC
Patient 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
---------------------------------------

Figure 13-39: Sample Tally/List Alcohol Screenings report

### 13.1.12.2.3 List All Alcohol Screenings for Selected Patients (ASSP)

This report will tally and optionally list all patients who have had an alcohol screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- refusal of exam code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

Below are the prompts.

#### **Enter Beginning Date for Screening**

Specify the beginning date of the date range.

#### **Enter Ending Date for Screening**

Specify the ending date of the date range.

#### **Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?**

Use Y (Yes) or N (No).

#### **Include which patients in the list**

Use F (Females Only), M (Males Only), or B (Both Male and Females).

**Would you like to restrict the report by Patient age range?**

Use Y (Yes) or N (no). If you wish to include visits from ALL age ranges, answer No. If you wish to list visits for only patients with a particular age range, enter Yes. If you use Yes, other prompts will display.

**Which result values do you want included on this list**

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

You can choose from the following:

- 1) Normal/Negative
- 2) Positive
- 3) Refused
- 4) Unable to Screen
- 5) Screenings done with no result entered

**Include visits to ALL clinics**

Use Y (Yes) or N (No). If No is used, additional prompts will display.

**Report should include visits whose PRIMARY PROVIDER on the visit is**

Use O (One Provider Only), P (Any/All Providers including Unknown), or U (Unknown Provider Only). If you use O, other prompts will display.

**Select which providers who performed the screening should be included**

Use O (One Provider Only), P (Any/All Providers including Unknown), or U (Unknown Provider Only). If you use O, other prompts will display.

**Would you like to limit the list to just patients who have a particular designated Mental Health provider?**

Use Y (Yes) or N (No). If Yes is used, additional prompts will display.

**Would you like to limit the list to just patients who have a particular designated Social Services provider?**

Use Y (Yes) or N (No). If Yes is used, additional prompts will display.

**Would you like to limit the list to just patients who have a particular designated ASA/CD provider?**

Use Y (Yes) or N (No). If Yes is used, additional prompts will display.



**Select Report Type**

Use L (List of Patient Screenings) or S (Create a Search Template of Patients).

**How would you like this report sorted**

The report can be sorted by only one of the items in the list.

**Display the Patient's Designated Providers on the list?**

Use Y (Yes) or N (no).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the criteria you selected for the report.

Then, the application displays the Tally/List Alcohol Screenings report (Figure 13-40).

XX	Oct 07, 2010	Page 1
*** ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS ***		
Screening Dates: Jul 09, 2010 to Oct 07, 2010		
	DATE	
PATIENT NAME	HRN	AGE
	SCREENED	CLINIC
-----		
SIGMAAAA,BRITTANY LYN	129079	41 F 08/03/10
Type/Result: ALCOHOL SCREENING NEGATIVE		
Primary Provider on Visit: BETA,BETAA		
Provider who screened: BETA,BETAA		
SIGSIG,ALICIA MARIE	169379	58 F 09/08/10
Type/Result: AUDT 21		
Primary Provider on Visit: BETA,BETAA		
Provider who screened: UNKNOWN		
Enter RETURN to continue or '^' to exit:		

Figure 13-40: Sample Alcohol Screenings Visit Listing for Selected Patients report

**13.1.12.2.4 Tally/List Pts in Search Template w/Alcohol Screenings (APST)**

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest ALCOHOL screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit) clinic, date of screen, designed PCP, MH Provider, SS Provider, and A/SA/ Provider.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal
- This is a tally of Patients, not visits or screenings

#### **13.1.12.2.5 Tally list all Alcohol Screenings for Template of Pts (AVST)**

This ALCOHOL report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF ALL VISITS W/ALCOHOL SCREENING ONLY  
PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE  
ARE INCLUDED IN THIS REPORT

This report will tally and optionally list all visits on which ALCOHOL screening or a refusal was documented in a specified time frame specified. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35

This report will tally the visits by age, gender, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A.SA Provider.

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

### 13.1.12.3 Depression Screening Reports (DEP)

Use the DEP option to access the Depression Screening Reports menu (Figure 13-41).

```

*****
**      IHS Behavioral Health System      **
**      Depression Screening Reports      **
*****
                          Version 4.0 (patch 4)

                          DEMO INDIAN HOSPITAL

DSP   Tally/List Patients with Depression Screening
DLS   Tally/List Depression Screenings
DSSP  List all Depression Screenings / Selected Patients
DPST  Tally/List Pts in Search Temp w/Depression Scrn
DVST  Tally List all Depression Scrn for Template of Pts

Select Depression Screening Reports Option:

```

Figure 13-41: Options on the 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 specified time frame. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (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.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

**Enter Beginning Date for Screening**

Specify the beginning date of the date range.

**Enter Ending Date for Screening**

Specify the ending date of the date range.

**Which items should be tallied: (0-11)**

Select which items you want to tally on this report (Figure 13-42):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 13-42: List of options from which to tally the report

**Would you like to include DEPRESSION Screenings documents in the PCC clinic database?**

Use Y (yes) or N (no).

**Would you like to include a list of patients screened.**

Use Y (yes) or N (no). If you use Y, the following will display (Figure 13-42).

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

How would you like the list to be sorted: H//

Figure 13-43: List of options to sort the list

**Display the Patient's Designated Providers on the list?**

Use Y (yes) or N (no).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**DEVICE**

Specify the device to output the report.

Below is a sample report (Figure 13-44).

	#	% of patients
By Age		
4 yrs	1	0.5%
5 yrs	1	0.5%
6 yrs	3	1.4%
7 yrs	2	0.9%
8 yrs	4	1.9%
9 yrs	1	0.5%
10 yrs	2	0.9%
11 yrs	6	2.8%
12 yrs	3	1.4%
13 yrs	1	0.5%
XX	Feb 15, 2011	Page 1
*** DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING ***		
Screening Dates: Nov 17, 2010 to Feb 15, 2011		
This report excludes data from the PCC Clinical database		
PATIENT NAME	HRN	AGE
	DATE	SCREENED
	CLINIC	
-----		
	#	% of patients
	89 yrs	1 0.5%
	92 yrs	1 0.5%
By Provider who screened		
	BRUNING, BJ	53 24.9%
	BUTCHER, LORI	5 2.3%
	CABLE, JESSICA	7 3.3%
	DEMO, DOCTOR	1 0.5%
	GARCIA, RYAN	53 24.9%
	GRENIER, DENISE	16 7.5%
	HAYS, HOWARD	1 0.5%
	IMHOFF, STEVE C	1 0.5%
BETA, MISTY DAWN	106371	28 F 01/12/11
Type/Result: DEPRESSION SCREENING		POSITIVE
Comment: TESTING EHR		
Primary Provider on Visit:		GAMMA, RYAN
Provider who screened:		GAMMA, RYAN
PI, WILLA BELLE	110838	44 F 01/12/11
		MENTAL HEALTH

```

Type/Result: DEPRESSION SCREENING NEGATIVE
Primary Provider on Visit: IOTA,WENDY
Provider who screened: IOTA,WENDY

THETA,JIMMY JOE      129347 24  M 01/31/11      MENTAL HEALTH
Type/Result: PHQ2  6
Primary Provider on Visit: GAMMA,RYAN
Provider who screened: GAMMA,RYAN
Enter RETURN to continue or '^' to exit:

```

Figure 13-44: Sample Tally/List Patients with Depression Screening report

### 13.1.12.3.2 Tally/List Depression Screenings (DLS)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in a specified time frame. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of exam code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

#### Enter Beginning Date for Screening

Specify the beginning date of the date range.

#### Enter Ending Date for Screening

Specify the ending date of the date range.

**Which items should be tallied: (0-11)**

Select which items you want to tally on this report (Figure 13-45):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Gender	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 13-45: List of options from which to tally the report

**Would you like to include DEPRESSION Screenings documents in the PCC clinic database?**

Use Y (yes) or N (no).

**Would you like to include a list of visits w/screening done?**

Use Y (yes) or N (no). If you use Y, the following prompt will display.

**How would you like to the list to be sorted.**

The following options will display (Figure 13-46).

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-46: List of options to sort the list

The default is H (Health Record Number).

**Display the Patient's Designated Providers on the list?**

Use Y (yes) or N (no).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**DEVICE**

Specify the device to output the report.

Figure 13-47 shows a sample report.

XX		Dec 26, 2013		Page 1	
*** DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING *** Screening Dates: Jan 01, 1980 to Dec 26, 2013 This report excludes PCC Clinics					
-----					
		#	% of patients		
Total Number of Visits with Screening		450			
Total Number of Patients screened		229			
By Result					
		14.1	35	7.8%	
DEPRESSION SCREENING NEGATIVE			115	25.6%	
DEPRESSION SCREENING PATIENT REFUSED SCREENING				143.1%	
DEPRESSION SCREENING POSITIVE			129	28.7%	
DEPRESSION SCREENING UNABLE TO SCREEN			15	3.3%	
PHQ2			1	0.2%	
PHQ2 0			2	0.4%	
PHQ2 1			5	1.1%	
PHQ2 2			8	1.8%	
PHQ2 3			16	3.6%	
PHQ2 4			11	2.4%	
PHQ2 5			13	2.9%	
PHQ2 6			2	0.4%	
PHQ2 7			1	0.2%	
PHQ2 COMPLETE BREECH			1	0.2%	
PHQ9 1			1	0.2%	
PHQ9 10			3	0.7%	
PHQ9 105			1	0.2%	
PHQ9 12			2	0.4%	
PHQ9 13			3	0.7%	
PHQ9 14			2	0.4%	
PHQ9 15			5	1.1%	
PHQ9 16			2	0.4%	
PHQ9 17			7	1.6%	
PHQ9 18			2	0.4%	
PHQ9 19			3	0.7%	
PHQ9 2.3			1	0.2%	
PHQ9 20			8	1.8%	
PHQ9 21			7	1.6%	
PHQ9 22			4	0.9%	
PHQ9 24			1	0.2%	
PHQ9 25			3	0.7%	
PHQ9 27			2	0.4%	
PHQ9 3			1	0.2%	
PHQ9 5			5	1.1%	
PHQ9 5.5			1	0.2%	
PHQ9 6			2	0.4%	
PHQ9 7			5	1.1%	
PHQ9 8			5	1.1%	
PHQ9 9			4	0.9%	
V79.0			2	0.4%	
-----					
PATIENT NAME		HRN	AGE	DATE SCREENED	CLINIC
-----					



```

FEATHER,KASSANDRA DA 101349 30 F 04/06/10 MEDICAL SOCIAL SERVI
Type/Result: PHQ9 17
DXs: 88 OTHER SOCIOLEGAL PROBLEMS
Primary Provider on Visit: BRUNING,BJ
Provider who screened: UNKNOWN

DURANT,COURTNEY NICO 101351 34 F 04/05/10 MENTAL HEALTH
Type/Result: PHQ2 2
DXs: 43.1 PARTNER ABUSE (SUSPECTED),PHYSICAL
27 ALCOHOL DEPENDENCE
304.22 COCAINE DEPENDENCE, EPISODIC
Primary Provider on Visit: BRUNING,BJ
Provider who screened: UNKNOW
Enter RETURN to continue or '^' to exit:

```

Figure 13-47: Sample Depression Screening Visit Tally and Visit Listing report

### 13.1.12.3.3 List all Depression Screenings / Selected Patients (DSSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of exam code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of Patients, not visits or screenings.

You will be able to choose the patients by age, gender, clinic, primary provider, or result of the screening.

Below are the prompts:

#### Enter Beginning Date for Screening

Specify the beginning date of the date range.

**Enter Ending Date for Screening**

Specify the ending date of the date range.

**Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?**

Use Y (yes) or N (no).

**Include which patients in the list**

Use one of the following: F (FEMALES only), M (MALES Only), or B (Both MALE and FEMALES).

**Would you like to restrict the report by Patient age range?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Which result values do you want included on this list**

Figure 13-48 shows the list from which to select.

- |   |
|---|
| 1) Normal/Negative                        |
| 2) Positive                               |
| 3) Refused                                |
| 4) Unable to Screen                       |
| 5) Screenings done with no result entered |

Figure 13-48: List of options from which to select

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

**Include visits to ALL clinics**

Use Y (yes) or N (no).

**Report should include visits whose PRIMARY PROVIDES on the visit is**

Figure 13-49 shows the options. If you use O, other prompts will display.

Select one of the following:

- |   |                                       |
|---|---------------------------------------|
| O | One Provider Only                     |
| P | Any/All Providers (including unknown) |
| U | Unknown Provider Only                 |

Figure 13-49: Options for visits to be used on the report

**Select which providers who performed the screening should be included**

Figure 13-50 shows the options. If you use O, other prompts will display.

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 13-50: Options for providers to be used on the report

**Would you like to limit the list to just patients who have a particular designated Mental Health provider?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Would you like to limit the list to just patients who have a particular designated Social Services provider?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Would you like to limit the list to just patients who have a particular designated ASA/CD provider?**

Use Y (yes) or N (no). If you use Y, other prompts will display.

**Select Report Type**

Use one of the following: L (List of Patient Screenings) or S (Create a Search Template of Patients). If you use S, other prompts will display.

**How would you like the list to be sorted**

Figure 13-51 shows the options.

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-51: List of options to sort the list

The default is H (Health Record Number).

**Display the Patient's Designated Providers on the list?**

Use Y (yes) or N (no).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**DEVICE**

Specify the device to output the report.

The application displays the criteria for the report. After pressing Enter, the application displays the report (Figure 13-52).

PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC
XX Feb 15, 2011 Page 1 *** DEPRESSION SCREENING VISIT LISTING FOR SELECTED PATIENTS *** Screening Dates: Nov 17, 2010 to Feb 15, 2011				
BETA,MISTY DAWN	106371	28	F 01/07/11	BEHAVIORAL HEALTH
Type/Result: DEPRESSION SCREENING POSITIVE Comment: testing ehr Primary Provider on Visit: GAMMA,RYAN Provider who screened: GAMMA,RYAN				
CHI,WILLA BELLE	110838	44	F 01/12/11	MENTAL HEALTH
Type/Result: DEPRESSION SCREENING POSITIVE Primary Provider on Visit: IOTA,WENDY Provider who screened: IOTA,WENDY				
Enter RETURN to continue or '^' to exit:				

Figure 13-52: Sample Depression Screening Visit Listing for Selected Patients report

**13.1.12.3.4 Tally/List Pts in Search Temp w/Depression Scrn (DPST)**

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of exam code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of Patients, not visits or screenings.

#### **13.1.12.3.5 Tally List all Depression Scrn for Template of Pts (DVST)**

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC exam code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will, optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done; if a patient had multiple screenings during the time period, all will be counted.

#### **13.1.12.4 PHQ-2 and PHQ-9 Scores for One Patient (PHQ)**

Use the PHQ option to produce a report that lists PHQ2 and PHQ9 Scores for one patient within a specified date range.

Below are the prompts:

##### **Select PATIENT NAME**

Specify the name of the patient whose scores are to be displayed.

**Browse which subset of visits for <name of patient>**

Use N (Patient's Last N Visits), D (Visits in a Date Range), or A (All of this patient's Visits). If you use N or D, other prompts will display.

**Limit by Clinic/Provider**

Use C (Visits to Selected Clinics), P (Visits to Selected Providers), or A (Include All Visits regardless of Clinic/Provider).

The application displays the PHQ-2/PHQ-9 Scores for One Patient report (Figure 13-53).

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 13-53: Sample PHQ-2 and PHQ-9 Scores for One Patient report

**13.1.12.5 PHQ-2 and PHQ-9 Scores for Multiple Patients (PHQS)**

Use the PHQS option to produce a report that lists PHQ-2 and PHQ-9 Scores for multiple patients, sorted by patient. Only visits with PHQ-2/PHQ-9 scores recorded will display on this list.

Below are the prompts.

**Enter Beginning Date of Visit**

Specify the beginning date of the date range.

**Enter Ending Date of Visit**

Specify the ending date of the date range.

**Clinic Selection**

Use one of the following: C (Visits at Selected Clinic) or A (Visit to All Clinics). If you use C, other prompts will display.

**Provider Selection**

Use one of the following: A (Visits to All Providers) or C (Visits to Selected Providers) or. If you use C, other prompts will display.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the PHQ-2 and PHQ-9 Scores for Multiple Patients report (Figure 13-54).

XX		Jul 13, 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		BETAAAA,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		GAMMAAA,DE	MENTA	311.-DEPRESSIV
ALPHAB,CHELSEA	116431	03/17/09	4		BETA,BETAA	MEDIC	305.02-ALCOHOL A
ALPHAB,CHELSEA	116431	03/12/09		17	BETA,BETAA	BEHAV	V11.0-PERSONAL
ALPHAB,CHELSEA	116431	03/10/09		19	GAMMAAA,DE	MENTA	296.32-MAJOR DEP
Enter RETURN to continue or '^' to exit:							

Figure 13-54: Sample PHQ-2 and PHQ-9 Scores for Multiple Patients report

**13.1.13 Treatment Plans (TPR)**

Use the TPR option to access the Treatment Plans menu (Figure 13-55).

ATP	Print List of All Treatment Plans on File
REV	Print List of Treatment Plans Needing Reviewed
RES	Print List of Treatment Plans Needing Resolved
NOTP	Patients w/Case Open but no Treatment Plan
Select Treatment Plans Option:	

Figure 13-55: Options on the Treatment Plans menu

Print List of All Treatment Plans on File (ATP): see section 10.1.5.

Print List of Treatment Plans Needing Reviewed (REV): see section 10.1.3.

Print List of Treatment Plans Needing Resolved (RES): see section 10.1.4.

Patients w/Case Open but no Treatment Plan (NOTP): see section 10.1.6.

### 13.1.14 Patients seen in groups w/Time in Group (TSG)

Use the TSG option to produce a report that shows a list of patients who have spent time in a group in a specified date range. It will list the patient, the primary provider, diagnosis, and time spent in the group.

Below are the prompts.

#### Enter beginning Date

Specify the beginning date of the date range.

#### Enter ending Date

Specify the ending date of the date range.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Patients Seen in Groups with Time Spent in Group report (Figure 13-56).

DEMO INDIAN HOSPITAL							
PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP							
DATES: JAN 17, 2009 TO APR 17, 2009							
PATIENT NAME	HRN	SEX	DOB	DATE	PROVIDER	PROBLEM	TIME
APHAAA,CHRISTAL	106299	F	11/28/85	04/20/09	BETA,BETAS	13	0
Total with provider BETAAAA,BJ					0		
Total for patient ALPHAA,CHRISTAL GAYL					0		
APHAAA,DIANA LE	192745	F	09/15/54	03/05/09	GAMMAA,DENISE	92	60
					03/25/09 Not Recorded	307.50	15
					04/21/09 THETAAAA,MARK	8.3	0

Figure 13-56: Sample Patients Seen in Groups with Time Spent in Group report



## 13.2 Behavioral Health Record/Encounter Reports (REC)

Use the REC option to list various records from the Behavioral Health patient file that are available on the BHS Encounter/Record Reports menu (Figure 13-57).

```

*****
**          IHS Behavioral Health System          **
**          Encounter/Record Reports             **
*****
                Version 4.0 (patch 4)

                DEMO INDIAN HOSPITAL

LIST  List Visit Records, STANDARD Output
GEN   List Behavioral Hlth Records, GENERAL RETRIEVAL

Select Behavioral Health Record/Encounter Reports Option:

```

Figure 13-57: Options on the Encounter/Record Reports menu

### 13.2.1 List Visit Records, Standard Output (LIST)

Use the LIST option to produce a report that shows a listing of visits in a specified date range. The visits can be selected based on any combination of selected criteria. The user will select the sort criteria for the report. Be sure to have a printer available that has 132-column print capability.

Below are the prompts.

#### Enter beginning Visit Date for Search

Specify the beginning date of the date range.

#### Enter ending Visit Date for Search

Specify the ending date of the date range.

The application displays the Visit Selection Menu (Figure 13-58).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:47:03          Page:    1 of    2
                Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name                23)  Next Case Review Dat   45)  Axis V
2)  Patient Sex                 24)  Appointment/Walk-In  46)  Flag (Visit Flag)
3)  Patient Race                25)  Interpreter Utilized 47)  Primary Provider
4)  Patient Age                 26)  Program              48)  Primary Prov Discipl
5)  Patient DOB                 27)  Visit Type           49)  Primary Prov Affilia
6)  Patient DOD                 28)  Location of Encounte 50)  Prim/Sec Providers
7)  Living Patients             29)  Clinic               51)  Prim/Sec Prov Discip
8)  Chart Facility              30)  Outside Location     52)  POV (Prim or Sec)
9)  Patient Community           31)  SU of Encounter      53)  POV (Prob Code Grps)

```

10) Patient County Resid	32) County of Service	54) Primary POV
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History Ite
17) Patient Encounters O	39) Number Served	61) Designated MH Prov
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-58: Sample Visit Selection Menu

Use this menu to select the visit criteria for the report. If you do not select any criteria (immediately use the Quit Item Selection), all visits will be selected.

### Type of Report to Print

Use one of the following: D (detailed using 132 column print) or B (brief (using 80 column print)).

The application displays the Sort Item Selection Menu (Figure 13-59).

BH GENERAL RETRIEVAL		Dec 26, 2013 09:55:56	Page: 1 of 2
SORT ITEM SELECTION MENU			
The Visits displayed can be SORTED by ONLY ONE of the following items.			
If you don't select a sort item, the report will be sorted by visit date.			
1) Patient Name	16) Program	31) Inpatient Dispositio	
2) Patient Sex	17) Visit Type	32) PCC Visit Created	
3) Patient Race	18) Location of Encounte	33) Axis V	
4) Patient DOB	19) Clinic	34) Flag (Visit Flag)	
5) Patient DOD	20) Outside Location	35) Primary Provider	
6) Patient Chart #	21) SU of Encounter	36) Primary Prov Discipl	
7) Patient Community	22) County of Service	37) Primary Prov Affilia	
8) Patient County Resid	23) Community of Service	38) Primary POV	
9) Patient Tribe	24) Activity Type	39) Designated MH Prov	
10) Eligibility Status	25) Days in Residential	40) Designated SS Provid	
11) Class/Beneficiary	26) Days in Aftercare	41) Designated A/SA Prov	
12) Patient Flag Field	27) Activity Category	42) Designated Other Pro	
13) Encounter Date	28) Local Service Site	43) Designated Other (2)	
14) Appointment/Walk-In	29) Number Served		
15) Interpreter Utilized	30) Type of Contact		
+ Enter ?? for more actions			
S Select Item(s)	+ Next Screen	Q Quit Item Selection	
R Remove Item(s)	- Previous Screen	E Exit Report	
Select Action: S//			

Figure 13-59: Sample Sort Item Selection Menu options

Use this menu to determine how the visit data will be sorted on the report. If you do not select any item (immediately use the Quit Item Selection option), the report will be sorted by visit date.

### Do you want a separate page for each Visit Date?

Use Y (yes) or N (no).

### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. Then, the application displays the Behavioral Health Record Listing report (Figure 13-60), which is the brief type.

```

***** 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 13-60: Sample Behavioral Health Record Listing report

## 13.2.2 List Behavioral Hlth Records, General Retrieval (GEN)

Use the GEN option to produce a report that shows a listing of visits selected by visit criteria. The visits printed can be selected based on any combination of selected items and the selected sort criteria.

If the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Below are the prompts.

**Select and Print Encounter List from**

Use one of the following: S (search template) or D (date range). The next prompts vary according to the option selected.

**Enter Beginning Encounter Date for search**

Define the beginning encounter date.

**Enter Ending Encounter Date for search**

Define the ending encounter date.

**Do you want to use a PREVIOUSLY DEFINED REPORT?**

Use Y or N. If you use Y, other prompts displays.

The application displays the Visit Selection Menu (Figure 13-61).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:02:48          Page: 1 of 2
                               Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program              48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type           49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte 50) Prim/Sec Providers
7) Living Patients             29) Clinic               51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location     52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter      53) POV (Prob Code Grps)
10) Patient County Resid       32) County of Service    54) Primary POV
11) Patient Tribe              33) Community of Service 55) POV (Problem Categor
12) Eligibility Status         34) Activity Type        56) POV Diagnosis Catego
13) Class/Beneficiary          35) Days in Residential  57) Procedures (CPT)
14) Medicare Eligibility       36) Days in Aftercare    58) Education Topics Pro
15) Medicaid Eligibility       37) Activity Category    59) Prevention Activity
16) Priv Ins Eligibility        38) Local Service Site   60) Personal History Ite
17) Patient Encounters O       39) Number Served        61) Designated MH Prov
18) Patient Flag Field         40) Type of Contact      62) Designated SS Provid
19) Case Open Date             41) Activity Time        63) Designated A/SA Prov
20) Case Admit Date            42) Inpatient Dispositio 64) Designated Other Pro
21) Case Closed Date           43) PCC Visit Created
22) Case Disposition           44) Axis IV

+          Enter ?? for more actions
S  Select Item(s)      +  Next Screen          Q  Quit Item Selection
R  Remove Item(s)     -  Previous Screen      E  Exit Report
Select Action: S//

```

Figure 13-61: Sample Visit Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The following prompts continue in the process:

### Choose Type of Report

Use one of the following: T (Total Count Only), S (Sub-counts and Total Count), D (Detailed Listing), F (Flag ASCII file (pre-defined record format)).

The application displays the Print Item Selection Menu (Figure 13-62).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:06          Page:    1 of    2
                                PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1) Patient Name                27) Interpreter Utilized  53) Primary Provider
2) Patient Sex                 28) Program              54) Primary Prov Discipl
3) Patient Race                29) Visit Type          55) Primary Prov Affilia
4) Patient Age                 30) Location of Encounte 56) Prim/Sec Providers
5) Patient DOB                 31) Clinic               57) Prim/Sec Prov Discip
6) Patient SSN                 32) Outside Location    58) POV (Prim or Sec)
7) Patient DOD                 33) SU of Encounter      59) DSM/Problem Code Nar
8) Patient Chart #             34) County of Service    60) POV (Prob Code Grps)
9) Patient Community           35) Community of Service 61) Primary POV
10) Patient County Resid       36) Chief Complaint/Pres 62) POV Problem Code Nar
11) Patient Tribe              37) Activity Type        63) POV (Problem Categor
12) Eligibility Status         38) Activity Type Narrat 64) POV Diagnosis Catego
13) Class/Beneficiary          39) Days in Residential  65) POV Prov Narrative
14) Medicare Eligibility       40) Days in Aftercare    66) Procedures (CPT)
15) Medicaid Eligibility       41) Activity Category    67) Education Topics Pro
16) Priv Ins Eligibility       42) Local Service Site   68) Prevention Activity
17) Patient Flag Field         43) Number Served        69) Treated Medical Prob
18) Patient Flag Narrati      44) Type of Contact      70) Personal History Ite
19) Case Open Date             45) Activity Time        71) Designated MH Prov
20) Case Admit Date            46) Inpatient Dispositio 72) Designated SS Provid
21) Case Closed Date           47) Place Referred To    73) Designated A/SA Prov
22) Case Disposition           48) PCC Visit Created    74) Designated Other Pro
23) Next Case Review Dat      49) Axis IV              75) Designated Other (2)
24) Encounter Date             50) Axis V
25) Encounter Date&Time        51) Comment
26) Appointment/Walk-In        52) Flag (Visit Flag)

+          Enter ?? for more actions
S  Select Item(s)      +  Next Screen          Q  Quit Item Selection
R  Remove Item(s)     -  Previous Screen       E  Exit Report
Select Action: S//

```

Figure 13-62: Print Item Selection Menu options

Use this menu to select the data items to be used on the report. Use the Q option when you have completed your selections.

```

BH GENERAL RETRIEVAL          Dec 26, 2013 09:55:56          Page:    1 of    2

          SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1) Patient Name              16) Program                    31) Inpatient Dispositio
2) Patient Sex               17) Visit Type                32) PCC Visit Created
3) Patient Race              18) Location of Encounte     33) Axis V
4) Patient DOB               19) Clinic                    34) Flag (Visit Flag)
5) Patient DOD               20) Outside Location         35) Primary Provider
6) Patient Chart #          21) SU of Encounter          36) Primary Prov Discipl
7) Patient Community        22) County of Service        37) Primary Prov Affilia
8) Patient County Resid     23) Community of Service     38) Primary POV
9) Patient Tribe            24) Activity Type            39) Designated MH Prov
10) Eligibility Status      25) Days in Residential      40) Designated SS Provid
11) Class/Beneficiary       26) Days in Aftercare       41) Designated A/SA Prov
12) Patient Flag Field      27) Activity Category        42) Designated Other Pro
13) Encounter Date          28) Local Service Site      43) Designated Other (2)
14) Appointment/Walk-In     29) Number Served
15) Interpreter Utilized    30) Type of Contact

+      Enter ?? for more actions
S      Select Item(s)      +      Next Screen          Q      Quit Item Selection
R      Remove Item(s)     -      Previous Screen       E      Exit Report
Select Action: S//

```

Figure 13-63: Options on the Sort Item Selection Menu

Use this menu to determine the sort criteria for the report. If you don't select any criteria (use Quit Item Selection) immediately, the report will be sorted by visit date.

**Do you want a separate page for each Visit Date?**

Use Y or N.

**Would you like a custom title for this report?**

Use Y or N. If you use Y, other prompts will display.

**Do you wish to save this SEARCH/PRINT/SORT logic for future use?**

Use Y or N. If you use Y, other prompts will display.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

The application displays the criteria for the report.

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the visit report (Figure 13-64).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                BH Visit Listing
                Record Dates: JAN 14, 2009 and JUL 13, 2009
                Page 1

PATIENT NAME          DOB          HRN          PROGRAM
-----
--
ALPHAA,CHELSEA MARIE  02/07/1975    WW116431    MENTAL
SIGMA,ALBERT TILLMAN  02/07/1975    WW164141    OTHER
SIGMA,ALBERT TILLMAN  02/07/1975    WW164141    MENTAL
SIGMA,ALBERT TILLMAN  02/07/1975    WW164141    SOCIAL

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

```

Figure 13-64: Sample visit report

### 13.3 Workload/Activity Reports (WL)

Use the WL option to view the Activity Workload Reports menu (Figure 13-65).

```

*****
**           IHS Behavioral Health System           **
**           Activity Workload Reports             **
*****
                Version 4.0 (patch 4)

                DEMO INDIAN HOSPITAL

GRS1  Activity Report
GRS2  Activity Report by Primary Problem
ACT   Activity Record Counts
PROG  Program Activity Time Reports (132 COLUMN PRINT)
FACT  Frequency of Activities
FCAT  Frequency of Activities by Category
PA    Tally of Prevention Activities

Select Workload/Activity Reports Option:

```

Figure 13-65: Options on the Activity Workload Reports menu

The Workload/Activity Reports menu has options to generate reports related specifically to the activities of Behavioral Health providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring Behavioral Health care.

#### 13.3.1 Activity Report (GRS1)

Use the GRS1 option to produce a report that will tally activities by service unit, facility, and provider. The report is patterned after GARS Report #1.

Below are the prompts.

**Enter beginning Encounter Date**

Specify the beginning encounter date for the date range.

**Enter ending Encounter Date**

Specify the ending encounter date for the date range.

**Run Report for which Program**

Use one the following: M - MENTAL HEALTH, S - SOCIAL SERVICES, C - CHEMICAL DEPENDENCY or ALCOHOL/SUBSTANCE ABUSE, O - OTHER, or A - ALL.

**Run Report for**

Use one of the following: 1 (ONE PROVIDER) or 2 (ALL PROVIDERS). If you use 1, other prompts will display.

**Include which providers**

Use one of the following: P (Primary Provider Only) or S (Both Primary and Secondary Providers).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Activity Report (Figure 13-66).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX                                     MAY 04, 2009Page 1
      ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM
      RECORD DATES: FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record. # served is a tally of the
number served data value.

                                     # RECS   ACT TIME   # PATS   # SERVED
                                     (hrs)
-----
AREA: TUCSON
SERVICE UNIT: SELLS
FACILITY: SELLS HOSP
PROVIDER: BETA, BJ (PSYCHIATRIST)
      13-INDIVIDUAL TREATMENT/COUNS      3       2.8       3       3
      16-MEDICATION/MEDICATION MONI     1       1.0       1       1
      91-GROUP TREATMENT                 2       1.5       2       2
      =====
PROVIDER TOTAL:                         6       5.3       6       6

```



```

PROVIDER:  BETABB,LORI (PHYSICIAN)
  11-SCREENING-PATIENT PRESENT          1      0.3      1      1
  13-INDIVIDUAL TREATMENT/COUNS        1      0.2      1      1
  22-CASE MANAGEMENT-PATIENT PR        2      0.7      1      2
                                     =====
PROVIDER TOTAL:                        4      1.3      3      4

PROVIDER:  DEMO,DOCTOR (PHYSICIAN)
  85-ART THERAPY                        4      0.7      4      4
                                     =====
PROVIDER TOTAL:                        4      0.7      4      4
Enter RETURN to continue or '^' to exit:

```

Figure 13-66: Sample Activity Report

Near the end of the report, there will be a Facility Total, SU Total, and Area Total.

### 13.3.2 Activity Report by Primary Problem (GRS2)

Use the GRS2 option to produce a report that will tally PRIMARY problems by service unit, facility, and by provider and activity.

The prompts are the same as those for the GRS1 report. Section 13.3.1 provides more information about the Activity Report.

The application displays the Activity Report by Primary Purpose report (Figure 13-67).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
xx                                     MAY 04, 2009Page 1
          ACTIVITY REPORT BY PRIMARY PURPOSE
          ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM
          RECORD DATES:  FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identified patients when
a patient name was entered on the record. # served is a tally of the
number served data value.

                                     # RECS   ACT TIME # PATS   # SERVED
                                     (hrs)
-----
AREA:  TUCSON
SERVICE UNIT:  SELLS
FACILITY:  SELLS HOSP
PROVIDER:  BETAAAA,BJ (PSYCHIATRIST)
ACTIVITY:  13-INDIVIDUAL TREATMENT/C
          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 13-67: Sample Activity Report by Primary Purpose report

### 13.3.3 Activity Record Counts (ACT)

Use the ACT option to produce a report that will generate a count of activity records for a selected item in a specified date range. You will be given the opportunity to select which visits will be included in the tabulation. For example, you can choose to tally activity time by Problem Code for only those with a discipline of Psychiatrist.

Below are the prompts.

#### Choose an item for calculating activity time and records counts

The application displays a list of items from which to choose.

#### Enter beginning Visit Date for Search

Specify the beginning visit date for the date range.

#### Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-68).

```

BH GENERAL RETRIEVAL           Dec 26, 2013 10:21:08           Page: 1 of 2
                               Visit Selection Menu
Visits can be selected based upon any of the following items. Select
as many as you wish, in any order or combination. An (*) asterisk indicates
items already selected. To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program              48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type           49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte 50) Prim/Sec Providers
7) Living Patients             29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location      52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid       32) County of Service     54) Primary POV
11) Patient Tribe              33) Community of Service  55) POV (Problem Categor
12) Eligibility Status         34) Activity Type         56) POV Diagnosis Catego
13) Class/Beneficiary          35) Days in Residential   57) Procedures (CPT)
14) Medicare Eligibility       36) Days in Aftercare     58) Education Topics Pro
15) Medicaid Eligibility       37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility       38) Local Service Site    60) Personal History It
17) Patient Encounters O       39) Number Served         61) Designated MH Prov
18) Patient Flag Field         40) Type of Contact       62) Designated SS Provid
19) Case Open Date             41) Activity Time         63) Designated A/SA Prov

```

20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-68: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

### Do you wish to

Use P (print output) or B (browse output on screen).

The application displays the Activity Record Counts report (Figure 13-69).

RECORD DATES: FEB 03, 2009 TO MAY 04, 2009							MAY 04, 2009	Page 1
NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM-5/CODE								
PROB	DSM/CODE	NARRATIVE	CODE	# RECS	# PATS	ACTIVITY TIME	# SERVED	
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 13-69: Sample Activity Record Counts report

### 13.3.4 Program Activity Time Reports (PROG)

Use the PROG option to produce a report that will generate a count of activity records, total activity time, and number of patient visits by Program and by a selected item within a specified date range. You will be given the opportunity to select which visits will be included on the report. For example, you might want to only report on those records on which the type of visits was Field. Note: if you choose to report on Problems, only the primary problem is included.

NOTE: If you choose to report on Problems, ONLY THE PRIMARY PROBLEM is included.

The prompts are the same as those for the ACT report. Section 13.3.3 provides more information about Activity Record Counts.

The application displays the record selection criteria. After pressing Enter, the application displays the Program Activity Time report (Figure 13-70).

```

Encounter Date range: FEB 03, 2009 to MAY 04, 2009

                                MENTAL HEALTH AND SOCIAL SERVI
                                ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGR
                                RECORD DATES: FEB 03, 2009 TO MA

                                SOCIAL SERVICES AND MENTAL HEALTH COMB                                SOCIAL SERV
                                NO. OF                                NO. OF                                TOTAL                                NO. OF                                NO. OF
PROVIDER                                RECORDS                                PATIENTS                                ACTIV TIME                                RECORDS                                PATIENT
-----
ALPHA,AAA                                15                                7                                3.6                                2                                2
BETA,BETAA                                33                                18                                22.6                                8                                4
BETAAAA,LORI                                16                                6                                5.0                                .                                .
CAAAA,JESSICA                                9                                2                                6.3                                .                                .
DEMO,CASE M                                1                                1                                0.0                                .                                .
DEMO,DOCTOR                                1                                1                                0.2                                1                                1
NUUUUUUU,AMY J                                3                                3                                2.0                                .                                .
GAMMMA,RYAN                                106                                30                                66.3                                24                                5
**** Patient Count TOAL is not an unduplicated count.

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

```

Figure 13-70: Sample Program Activity Time report

### 13.3.5 Frequency of Activities (FACT)

Use the FACT option to produce a report that will generate a list of the top N Activity Codes for selected visits.

Below are the prompts.

**Enter beginning Visit Date for Search**

Specify the beginning visit date for the date range.

**Enter ending Visit Date for Search**

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-71).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:23:22          Page: 1 of 2
                          Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program               48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type           49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte  50) Prim/Sec Providers
7) Living Patients             29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location      52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid       32) County of Service     54) Primary POV
11) Patient Tribe              33) Community of Service  55) POV (Problem Categor
12) Eligibility Status         34) Activity Type         56) POV Diagnosis Catego
13) Class/Beneficiary          35) Days in Residential   57) Procedures (CPT)
14) Medicare Eligibility       36) Days in Aftercare    58) Education Topics Pro
15) Medicaid Eligibility       37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility       38) Local Service Site   60) Personal History Ite
17) Patient Encounters O       39) Number Served        61) Designated MH Prov
18) Patient Flag Field         40) Type of Contact       62) Designated SS Provid
19) Case Open Date             41) Activity Time         63) Designated A/SA Prov
20) Case Admit Date            42) Inpatient Dispositio  64) Designated Other Pro
21) Case Closed Date           43) PCC Visit Created
22) Case Disposition           44) Axis IV
+ Enter ?? for more actions
S Select Item(s)      + Next Screen      Q Quit Item Selection
R Remove Item(s)     - Previous Screen  E Exit Report
Select Action: S//

```

Figure 13-71: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

**Select Type of Report**

Use one of the following: L (list of items with counts) or B (Bar Chart, requires 132 column printer).

**How many entries do you want to list (5-100)**

Specify the number of entries (any number 5-100).

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the Frequency of Activities report (Figure 13-72).

MAY 04, 2009		DEMO INDIAN HOSPITAL		Page 1	
TOP 10 Activity Code's.					
DATES: FEB 03, 2009 TO MAY 04, 2009					
No.	ACTIVITY TYPE	ACTIVITY CODE	# RECS	ACT TIME (HRS)	
1.	SCREENING-PATIENT PRESENT	11	55	34.8	
2.	INFORMATION AND/ OR REFERRAL-P	15	32	12.3	
3.	GROUP TREATMENT	91	30	17.1	
4.	INDIVIDUAL TREATMENT/COUNSEL/E	13	22	17.0	
5.	ASSESSMENT/EVALUATION-PATIENT	12	19	15.5	
6.	INDIVIDUAL BH EHR VISIT	99	19	0.6	
7.	ACADEMIC SERVICES	96	16	8.1	
8.	ART THERAPY	85	15	6.7	
RUN TIME (H.M.S): 0.0.0					
End of report. PRESS ENTER:					

Figure 13-72: Sample Frequency of Activities report

### 13.3.6 Frequency of Activities by Category (FCAT)

Use the FCAT option to produce a report that generates a list of the top N Activity Category for selected visits.

The prompts are the same as for the Frequency of Activities report. Section 13.3.5 Frequency of Activities report.

Below is a sample Frequency of Activities by Category report (Figure 13-73).

MAY 04, 2009		DEMO INDIAN HOSPITAL		Page 1	
TOP 10 Activity Category's.					
DATES: FEB 03, 2009 TO MAY 04, 2009					
No.	ACTIVITY CATEGORY	CATEGORY CODE	# RECS	ACT TIME (HRS)	
1.	PATIENT SERVICES	P	943	556778.2	
2.	SUPPORT SERVICES	S	56	52.9	
3.	ADMINISTRATION	A	21	26.6	

4.	PLACEMENTS	PL	6	2.8
5.	COMMUNITY SERVICES	C	2	9.0
6.	EDUCATION/TRAINING	E	2	1.5
7.	CULTURALLY ORIENTED	O	1	0.5
8.	TRAVEL	T	1	0.3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 13-73: Sample Frequency of Activities by Category report

### 13.3.7 Tally of Prevention Activities (PA)

Use the PA option to produce a report that will show a count of all visits with a prevention activity entered. It will also produce a tally/count of those prevention activities with Target Audience subtotals.

Below are the prompts.

#### Enter Beginning Visit Date

Specify the beginning visit date for the date range.

#### Enter Ending Visit Date

Specify the ending visit date for the date range.

#### Run the Report for which PROGRAM

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

#### Enter a code indicating which providers are of interest

Specify the Providers whose Prevention activities you want to tally. Use one of the following: A (all providers), S (Select set or Taxonomy of Providers), or O (one provider). If you use S or O, other prompts will display.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Device

Specify the device to browse/print the report.

The application displays the Tally of Prevention Activities report (Figure 13-74).

May 04, 2009	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 13-74: Sample Tally of Prevention Activities report

### 13.4 Problem Specific Reports (PROB)

Use the PROB option to produce a list of BH issues of particular concern to providers, managers, and administrators from a clinical and public health perspective. Figure 13-75 shows the Problem Specific Report menu.

```

*****
**      IHS Behavioral Health System      **
**      Problem Specific Reports          **
*****
                          Version 4.0 (patch 4)

                          DEMO INDIAN HOSPITAL

ABU   Abuse Report (Age&Sex)
FDSM  Frequency of Problems
FPRB  Frequency of Problems (Problem Code Groupings)
FPRC  Frequency of Problems by Problem Category
SUIC  Suicide Related Reports ...

Select Problem Specific Reports Option:
    
```

Figure 13-75: Options on the Problem Specific Reports menu



### 13.4.1 Abuse Report (ABU)

Use the ABU option to produce a report that focuses on patients who might have been victims of abuse or neglect. It will present, by age and sex, the number of individual patients who were seen for the Purpose of Visit (POV) – the application displays the POVs.

Below are the prompts.

**Enter Beginning Visit Date**

Specify the beginning visit date for the date range (during which the patient should have been seen with one of the above problems).

**Enter the Ending Visit Date**

Specify the ending visit date for the date range.

The application displays the current Age Groups.

**Do you wish to modify these age groups?**

Use Y or N at this prompt. If you use Y, other prompts will display. Use N to not modify the age groups.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Abuse Report by Age and Sex report. You need a 132 column printer to print the report.

### 13.4.2 Frequency of Problems (FDX)

Use the FDX option to produce a report that shows a list of the top N Problem/POV for selected visits.

Below are the prompts.

**Enter beginning Visit Date for Search**

Specify the beginning visit date for the date range.

**Enter ending Visit Date for Search**

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-76).

```

BH GENERAL RETRIEVAL          Dec 26, 2013 10:26:30          Page: 1 of 2
                          Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1) Patient Name                23) Next Case Review Dat  45) Axis V
2) Patient Sex                 24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race                25) Interpreter Utilized 47) Primary Provider
4) Patient Age                 26) Program                48) Primary Prov Discipl
5) Patient DOB                 27) Visit Type            49) Primary Prov Affilia
6) Patient DOD                 28) Location of Encounte  50) Prim/Sec Providers
7) Living Patients             29) Clinic                 51) Prim/Sec Prov Discip
8) Chart Facility              30) Outside Location      52) POV (Prim or Sec)
9) Patient Community           31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid      32) County of Service     54) Primary POV
11) Patient Tribe              33) Community of Service  55) POV (Problem Categor
12) Eligibility Status        34) Activity Type         56) POV Diagnosis Catego
13) Class/Beneficiary         35) Days in Residential  57) Procedures (CPT)
14) Medicare Eligibility      36) Days in Aftercare    58) Education Topics Pro
15) Medicaid Eligibility     37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility      38) Local Service Site   60) Personal History Ite
17) Patient Encounters O     39) Number Served        61) Designated MH Prov
18) Patient Flag Field        40) Type of Contact       62) Designated SS Provid
19) Case Open Date            41) Activity Time        63) Designated A/SA Prov
20) Case Admit Date           42) Inpatient Dispositio 64) Designated Other Pro
21) Case Closed Date          43) PCC Visit Created
22) Case Disposition          44) Axis IV
+      Enter ?? for more actions
S  Select Item(s)             +  Next Screen              Q  Quit Item Selection
R  Remove Item(s)            -  Previous Screen          E  Exit Report
Select Action: S//

```

Figure 13-76: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

#### Include which POVs

Use one of the following: P (primary POV only) or S (primary and secondary POVs).

#### Select Type of Report

Use one of the following: L (List of items with counts) or B (Bar Chart, requires 132 column printer).

#### How many entries do you want to list (5-100)

Specify the number of entries.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do you wish to**

Use P (print output) or B (browse output on screen).

The application displays the Frequency of Problems report (Figure 13-77).

JUN 09, 2009		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 22.9
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 13-77: Sample Frequency of Problems report

### 13.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

Use the FPRB option to produce a report that shows a list of the top N Problem/POV for visits that you select.

Below are the prompts.

**Enter beginning Visit Date for Search**

Specify the beginning visit date for the date range.

**Enter ending Visit Date for Search**

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-78).

BH GENERAL RETRIEVAL	Dec 26, 2013 10:29:11	Page:	1 of	2
Visit Selection Menu				

Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (\*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.

1) Patient Name	23) Next Case Review Dat	45) Axis V
2) Patient Sex	24) Appointment/Walk-In	46) Flag (Visit Flag)
3) Patient Race	25) Interpreter Utilized	47) Primary Provider
4) Patient Age	26) Program	48) Primary Prov Discipl
5) Patient DOB	27) Visit Type	49) Primary Prov Affilia
6) Patient DOD	28) Location of Encounte	50) Prim/Sec Providers
7) Living Patients	29) Clinic	51) Prim/Sec Prov Discip
8) Chart Facility	30) Outside Location	52) POV (Prim or Sec)
9) Patient Community	31) SU of Encounter	53) POV (Prob Code Grps)
10) Patient County Resid	32) County of Service	54) Primary POV
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History It
17) Patient Encounters O	39) Number Served	61) Designated MH Prov
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-78: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The prompts continue.

### **Include which POV/s**

Use one of the following: P (Primary POV only) or S (Primary and Secondary POVs).

### **Select Type of Report**

Use one of the following: L (List of items with counts) or B (Bar Chart, required 132 column printer).

### **How many entries do you want in the list (5-100)**

Specify the number of entries, using any whole number 5-100.

**Demo Patient/Inclusion/Exclusion**

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do You wish to**

Use one of the following: P (print output) or B (browse output on screen).

Figure 13-79 displays the Frequency of Problems by Code Grouping report.

JUN 09, 2009		DEMO INDIAN HOSPITAL			Page 1
TOP 10 POV/Problem (Problem Code)'s.					
PRIMARY POV Only					
DATES: MAR 11, 2009 TO JUN 09, 2009					
No.	PROB CODE NARRATIVE	PROBLEM (POV) CODE#	RECS	ACT TIME (HRS)	
1.	MAJOR DEPRESSIVE DISORDERS	14	123	94.2	
2.	ANXIETY DISORDER	18	30	14.2	
3.	SCHIZOPHRENIC DISORDER	13	29	25.8	
4.	CROSS-CULTURAL CONFLICT	2	19	15.0	
5.	MARITAL PROBLEM	56	18	5.4	
6.	ALCOHOL ABUSE	29	16	14.1	
7.	ILLNESS IN FAMILY	55	16	4.3	
8.	HOUSING	80	15	8.0	
9.	SENILE OR PRE-SENILE CONDITION	9	14	9.7	
10.	BIPOLAR DISORDER	15	13	5.2	
RUN TIME (H.M.S): 0.0.0					
End of report. PRESS ENTER:					

Figure 13-79: Sample Frequency of Problem by groupings report

### 13.4.4 Frequency of Problems by Problem Category (FPRC)

Use the FPRC option to produce a report that generates a list of the top N Problem/POV (Problem Category) for selected visits.

Below are the prompts

**Enter beginning Visit Date for Search**

Specify the beginning visit date for the date range.

**Enter ending Visit Date for Search**

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 13-80).

BH GENERAL RETRIEVAL	Dec 26, 2013 10:29:11	Page:	1 of	2
Visit Selection Menu				

Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (\*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.

1) Patient Name	23) Next Case Review Dat	45) Axis V
2) Patient Sex	24) Appointment/Walk-In	46) Flag (Visit Flag)
3) Patient Race	25) Interpreter Utilized	47) Primary Provider
4) Patient Age	26) Program	48) Primary Prov Discipl
5) Patient DOB	27) Visit Type	49) Primary Prov Affilia
6) Patient DOD	28) Location of Encounte	50) Prim/Sec Providers
7) Living Patients	29) Clinic	51) Prim/Sec Prov Discip
8) Chart Facility	30) Outside Location	52) POV (Prim or Sec)
9) Patient Community	31) SU of Encounter	53) POV (Prob Code Grps)
10) Patient County Resid	32) County of Service	54) Primary POV
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History Ite
17) Patient Encounters O	39) Number Served	61) Designated MH Prov
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro
21) Case Closed Date	43) PCC Visit Created	
22) Case Disposition	44) Axis IV	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-80: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

### Include which POV's

Use one of the following: P (Primary POV only) or S (Primary and Secondary POVs).

### Select Type of Report

Use one of the following: L (List of items with counts) or B (Bar Chart, requires 132 column printer).

### How many entries do you want in the list (5-100)

Specify the number of entries, using any whole number 5-100.

### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

**Do You wish to**

Use one of the following: P (print output) or B (browse output on screen).

The application displays the record selection criteria. After pressing Enter, the application displays the Frequency of Problems by Problem Category report (Figure 13-81).

JUN 09, 2009		Page 1	
DEMO INDIAN HOSPITAL			
TOP 10 Problem/POV (Problem Category)'s.			
PRIMARY POV Only			
DATES: MAR 11, 2009 TO JUN 09, 2009			
No.	CATEGORY NARRATIVE	CATEGORY CODE	# RECS ACT TIME (HRS)
1.	PSYCHOSOCIAL PROBLEMS	2	294 220.6
2.	MEDICAL/SOCIAL PROBLEMS	1	73 555798.6
3.	FAMILY LIFE PROBLEMS	5	37 11.5
4.	SOCIOECONOMIC PROBLEMS	8	27 12.4
5.	ADMINISTRATIVE PROBLEM	11	14 11.5
6.	ABUSE	3	10 5.1
7.	OTHER PATIENT RELATED	13	6 12.3
8.	EDUCATIONAL/LIFE PROBLEMS	10	8 5.9
9.	SCREENING	12	7 4.9
10.	PREGNANCY/CHILDBIRTH PROBLEMS	6	6 1.8
RUN TIME (H.M.S): 0.0.1			
End of report. PRESS ENTER:			

Figure 13-81: Sample Frequency of Problems by Problem Category report

### 13.4.5 Suicide Related Reports (SUIC)

Use the SUIC option to access the Suicide Reports menu (Figure 13-82).

*****	
**	IHS Behavioral Health System **
**	Suicide Reports **
*****	
Version 4.0 (patch 3)	
DEMO INDIAN HOSPITAL	
SSR	Aggregate Suicide Form Data - Standard
SAV	Aggregate Suicide Data Report - Selected Variables
SDEL	Output Suicide Data in Delimited Format
SGR	Listing of Suicide forms by Selected Variables
SUIC	Suicide Report (Age&Sex)
SPOV	Suicide Purpose of Visit Report
Select Suicide Related Reports Option:	

Figure 13-82: Options on Suicide Report menu

### 13.4.5.1 Aggregate Suicide Form Data - Standard (SSR)

This report will tally the data items specific to the Suicide Form for a date range, community, and type of suicidal behavior (specified by the user).

Below are the prompts.

#### Enter Beginning Date of Suicide Act

Specify the beginning date for the date range.

#### Enter Ending Date of Suicide Act

Specify the ending date for the date range.

#### Report on Suicide Forms for Suicide Acts that occurred in

Use one of the following: O (One particular Community) or A (All Communities). If you use O, other prompts will display.

#### Include which Suicidal Behaviors (0-9)

The application displays the suicide behaviors. You can respond with a list or a range.

#### Demo Patient/Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do You wish to

Use one of the following: P (print output) or B (browse output on screen).

Figure 13-82 shows the Aggregate Suicide Form Data - Standard report.

DEMO INDIAN HOSPITAL		Jul 13, 2009	Page 1	
***** AGGREGATE SUICIDE FORM DATA - STANDARD*****				
Act Occurred: Jan 14, 2009 - Jul 13, 2009				
Community where Act Occurred: ALL Communities				
-----				
Age Range: 20-24 years	Total # of Suicide Forms: 1		REPORT TOTALS	
Suicidal Behavior:	ATT SUICIDE W/ ATT HOMICIDE	1	100%	
Event logged by Discipline:	PSYCHIATRIST	1	100%	
Event logged by Provider:	GAMMAA,RYAN	1	100%	
Sex:	MALE	1	100%	
Employed:	PART-TIME	1	100%	



Tribe of Enrollment:	CHEROKEE NATION OF OKLAHOMA	1	100%
Community of Residence:	WELLING	1	100%
Relationship:	MARRIED	1	100%
Education:	COLLEGE GRADUATE	1	100%
Method:	GUNSHOT	1	100%
	HANGING	1	100%
Previous Attempts:	1	1	100%
Substance Use Involved:	NONE	1	100%
Location of Act:	WORK	1	100%
Disposition:	IN-PATIENT MENTAL HEALTH TREAT	1	100%
Contributing Factors:	DEATH OF FRIEND OR RELATIVE	1	100%
Age Range: 45-64 years	Total # of Suicide Forms: 13		
			REPORT TOTALS
Suicidal Behavior:	IDEATION WITH PLAN AND INTENT	4	31%
	ATTEMPT	3	23%
	ATT SUICIDE W/ ATT HOMICIDE	3	23%
	ATT SUICIDE W/ COMP HOMICIDE	2	15%
	COMP SUICIDE W/ ATT HOMICIDE	1	8%
Event logged by Discipline:	ACUPUNCTURIST	7	54%
	PSYCHIATRIST	6	46%
Event logged by Provider:	GAMMAAA, DENISE	1	8%
	BETAAAA, BJ	7	54%
	THETAA, RYAN	5	38%
Enter RETURN to continue or '^' to exit:			

Figure 13-83: Sample Aggregate Suicide Form Data - Standard report

### 13.4.5.2 Aggregate Suicide Form Data - Selected Variables (SAV)

This report will tally the selected data items for Suicide Forms in a particular date range.

### 13.4.5.3 Output Suicide Data in Delimited Format (SDEL)

This report will extract all data elements on the Suicide form in a delimited form for a specified date range.

### 13.4.5.4 Listing of Suicide forms by Selected Variables (SGR)

This report is a 'general retrieval' type report that will list the selected data items for Suicide Forms in a particular date range. The user can also specify how to display the items in the printed report.

### 13.4.5.5 Suicide Report (Age & Sex) (SUIC)

This report will present, by age and sex, the number of individual patients who were seen for the following POVs: 39, 40, and 41 as well as V62.84 (Suicidal Ideation).

### 13.4.5.6 Suicide Purpose of Visit Report (SPOV)

This report will display the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Encs). Any records containing the ICD-9 code v62, 84, Suicidal Ideation will be included in the tallies for Problem code 39. A display by age and gender is also included.

Below are the prompts.

#### Enter Beginning Visit Date

Specify the beginning visit date for the date range.

#### Enter Ending Visit Date

Specify the ending visit date for the date range.

#### Run the Report for which Program

Use one of the following: O (one program) or A (all programs). If you use O, other prompts will display.

#### Demo Patient Inclusion/Exclusion

Use one of the following: I (include all patients), E (exclude demo patients), O (include only demo patients).

#### Do you wish to

Use one of the following: P (print output) or B (browse output on screen)

Figure 13-84 shows the Suicide Purpose of Visit report.

```

Behavioral Health
*****
*   SUICIDE PURPOSE OF VISIT REPORT   *
*****
VISIT Date Range: OCT 31, 2006 through NOV 30, 2006
      BOTH MALE AND FEMALE PATIENTS' VISITS

39& v62.84 - Suicide Ideation: 40 - Suicide Attempt/Gesture:
      41 - Suicide Completed

```

AGE GROUP	# Encs	# w POV 39 & v62.84	w/ POV 40	w/ POV 41	w/ 39/40/41 & v62.84
	# %	# %	# %	# %	# %
1-4 yrs	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0
5-9 yrs	2 10.0	0 0.0	0 0.0	0 0.0	0 0.0
10-14 yrs	7 35.0	0 0.0	0 0.0	0 0.0	0 0.0

15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	6	30.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	5.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	20	100.0	0	0.0	0	0.0	0	0.0	0	0.0
MALE PATIENTS VISITS										
39& v62.84 - Suicide Ideation: 40 - Suicide Attempt/Gesture:										
41 - Suicide Completed										
AGE GROUP	#	Encs	#	w POV 39 & v62.84	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41 & v62.84
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	6	66.7	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0
FEMALE PATIENTS VISITS										
39& v62.84 - Suicide Ideation: 40 - Suicide Attempt/Gesture:										
41 - Suicide Completed										
AGE GROUP	#	Encs	#	w POV 39 & v62.84	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41 & v62.84
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	4	36.4	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS										
39& v62.84 - Suicide Ideation: 40 - Suicide Attempt/Gesture:										
41 - Suicide Completed										
AGE GROUP	#	Encs	#	w POV 39 & v62.84	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41 & v62.84

1-4 yrs	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	5	38.5	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - MALE PATIENTS										
39& v62.84 - Suicide Ideation: 40 - Suicide Attempt/Gesture:										
41 - Suicide Completed										
AGE GROUP	#	Encs	#	w/ POV 39 & v62.84	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41 & v62.84
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	50.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS										
39& v62.84 - Suicide Ideation: 40 - Suicide Attempt/Gesture:										
41 - Suicide Completed										
AGE GROUP	#	Encs	#	w/ POV 39 & v62.84	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41 & v62.84
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	3	33.3	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Figure 13-84: Sample Suicide Purpose of Visit report

## 13.5 Print Standard Behavioral Health Tables (TABL)

Use the TABL option to print the various BH tables (activity code, clinical codes, and BH Problem Codes).

The TABL option accesses the Print BH Standard Tables menu (Figure 13-85).

```

*****
**      IHS Behavioral Health System      **
**      Print BH Standard Tables         **
*****
Version 4.0 (patch 4)

DEMO INDIAN HOSPITAL

ACT   Print Activity Code Table
CLN   Print Clinic Codes
PROB  Print Behavioral Health Problem Codes

Select Print Standard Behavioral Health Tables Option:

```

Figure 13-85: Options on the Print BH Standard Tables menu

### 13.5.1 Print Activity Code Table (ACT)

Use the ACT option to print the activity code table (Figure 13-86).

CODE	DESCRIPTION	CATEGORY	PCC	MNE
01	TWELVE STEP WORK - GROUP	PATIENT SERV	YES	TSG
02	TWELVE STEP WORK - INDIVIDUAL	PATIENT SERV	YES	TSI
03	TWELVE STEP GROUP	PATIENT SERV	NO	TWG
04	RE-ASSESSMENT, PATIENT PRESENT	PATIENT SERV	YES	RAS
05	RE-ASSESSMENT, PATIENT NOT PRESENT	SUPPORT SERV	NO	
11	SCREENING-PATIENT PRESENT	PATIENT SERV	YES	SCN
12	ASSESSMENT/EVALUATION-PATIENT PRESENT	PATIENT SERV	YES	EVL
13	INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT	PATIENT SERV	YES	IND
14	FAMILY/GROUP TREATMENT-PATIENT PRESENT	PATIENT SERV	YES	FAM
15	INFORMATION AND/ OR REFERRAL-PATIENT PRESENT	PATIENT SERV	YES	REF
16	MEDICATION/MEDICATION MONITORING-PATIENT PRESENT	PATIENT SERV	YES	MED
17	PSYCHOLOGICAL TESTING-PATIENT PRESENT	PATIENT SERV	YES	TST

18	FORENSIC ACTIVITIES-PATIENT PRESENT	PATIENT SERV	YES	FOR
19	DISCHARGE PLANNING-PATIENT PRESENT	PATIENT SERV	YES	DSG
20	FAMILY FACILITATION-PATIENT PRESENT	PATIENT SERV	YES	FAC
21	FOLLOWTHROUGH/FOLLOWUP-PATIENT PRESENT	PATIENT SERV	YES	FOL
Enter RETURN to continue or '^' to exit:				

Figure 13-86: Sample Behavioral Health Activity Codes report

### 13.5.2 Print Clinic Codes (CLN)

Use the CLN option to print the activity code table (Figure 13-87).

CLINIC STOP LIST NAME	CODE	APR 16, 2009	14:22	PAGE 1
ALCOHOL AND SUBSTANCE	43			
AMBULANCE	0			
ANESTHESIOLOGY	0			
ANTICOAGULATION THERAPY	0			
AUDIOLOGY	35			
BEHAVIORAL HEALTH	0			
CANCER CHEMOTHERAPY	62			
CANCER SCREENING	58			
CARDIOLOGY	2			
CASE MANAGEMENT SERVICES	77			
CAST ROOM	55			
CHART REV/REC MOD	52			
CHEST AND TB	3			
CHIROPRACTIC	0			
CHRONIC DISEASE	50			
COLPOSCOPY	0			
COMPLEMENTARY MEDICINE	0			

Figure 13-87: Sample Clinic Stop List codes

### 13.5.3 Print Behavioral Health Problem Codes (PROB)

Use the PROB option to print the BH problem codes (Figure 13-88).

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 13-88: Sample Behavioral Health Problem Codes report

## 14.0 Manager Utilities Module (Roll and Scroll)

The Manager Utilities module, shown in Figure 14-1, provides options for Site Managers and program supervisors to customize BHS to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, resetting local flag fields, and verifying users who have edited particular patient records.

```

*****
**      IHS Behavioral Health System      **
**      Manager Utilities                 **
*****
Version 4.0 (patch 3)

DEMO INDIAN HOSPITAL

SITE  Update Site Parameters
EXPT  Export Utility Menu ...
RPFF  Re-Set Patient Flag Field Data
DLWE  Display Log of Who Edited Record
ELSS  Add/Edit Local Service Sites
EPHX  Add Personal History Factors to Table
DRD   Delete BH General Retrieval Report Definitions
EEPC  Edit Other EHR Clinical Problem Code Crosswalk
UU    Update Locations a User can See

Select Manager Utilities Option:

```

Figure 14-1: Options on the Manager Utilities menu

This menu might be restricted to the site manager and the program manager or the designee. Use this menu for setting site-specific options related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and IHS Headquarters for mandated federal reporting and funding.

### 14.1 Update Site Parameters (SITE)

Use the SITE option to modify the parameters in the Behavioral Health file. Individual sites use the Site Parameters file to set BHS to suit their program needs.

Below are the prompts.

#### Select MHSS SITE PARAMETERS

Specify the location where the program visits take place. If you use a new one, the application confirms that you are using the new one (use Y or N).

Figure 14-2 shows the Update BH Site Parameters window.



```

** UPDATE BH SITE PARAMETERS **           Site Name: ABERDEEN AO
=====
Update DEFAULT Values?  N

Default Health Summary Type:

Default response on form print:           Suppress Comment on Suppressed Form?
# of past POVs to display:               Exclude No Shows on last DX Display?
DSM-5 Implementation Date:
Update PCC Link Features?  N
Turn Off EHR to BH Link?
Turn on PCC Coding Queue?  NO             Update Provider Exceptions to E Sig?  N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits?  N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:

COMMAND:                                Press <PF1>H for help      Insert

```

Figure 14-2: Sample Update BH Site Parameters window

Below are the fields on the window.

### Update DEFAULT Values?

Use Y or N. If you use Y, the application displays Figure 14-3. All default settings are moved to this separate pop-up window.

```

**** Enter DEFAULT Values for each Data Item ****
MH Location: DEMO INDIAN HOSPITAL
MH Community: TAHLEQUAH                MH Clinic: MENTAL HEALTH
SS Location: DEMO INDIAN HOSPITAL
SS Community: TAHLEQUAH                SS Clinic: MEDICAL SOCIAL SERVI
Chemical Dependency Location: DEMO INDIAN HOSPITAL
Chemical Dependency Community: TAHLEQUAH
Chemical Dependency Clinic: BEHAVIORAL H
OTHER Location: DEMO INDIAN HOSPITAL
OTHER Community: TAHLEQUAH            OTHER Clinic: MENTAL HEAL

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

```

Figure 14-3: Pop-up for default values of BH site

Below are the prompts on the pop-up.

**MH/SS/CD/OTHER Location:** specify the name of the location where the program visits take place.

**MH/SS/CD/OTHER Community:** specify the name of the community where the program visits occur.

**MH/SS/CD/OTHER Clinic:** specify the name of the clinic where the program visits occur.

**Default Type of Contact:** Specify the type of contact setting or code (e.g., Administrative, Chart Review, etc.).

**Default Appt/Walk in Response:** Specify the type of visit that occurred (e.g., appointment, walk in, or unspecified).

**EHR Default Community:** Specify the name of the default community used in the EHR. In order to pass EHR behavioral health encounter records into the BHS v4.0 files, a Default Community of Service field was created on the BHS v4.0 site parameters' menu. If the facility has opted to pass behavioral health encounter records created in EHR to BHS v4.0, the application will populate the Community of Service field with the value entered in the site parameter "EHR Default Community" or, if that field is blank, with the default Mental Health community value. If the default Mental Health community value is blank, the field will be populated with the default Social Services community value; if that field is also blank, the field will be populated with the default Chemical Dependency value; and if that field is blank, the default Other Community value will be used. If none of the default community fields contains a value, no behavioral health record will be created.

Below are the fields on the update window.

### **Default HEALTH Summary Type**

Specify the type of health summary printed from within the BH package. Typically, the default value is the Mental Health/Social Services summary type. Refer to the Health Summary System Manuals for further information on the available types.

### **Default response on form print**

Your response applies to when you print a Mental Health/Social Services record. Use one of the following: B (both), F (full), S (suppressed form), T (Suppressed - 2 copies), E (Full - 2 copies). The suppressed report does NOT display the following information: Chief Complaint, SOAP note, measurement data, screenings.

A full encounter form prints all data for a patient encounter including the S/O/A/P note. The suppressed version of the encounter form will not display the S/O/A/P note for confidentiality reasons. It is important to note that the S/O/A/P and chief complaint will be suppressed, but the comment/next appt, activity code, and POV will still appear on the printed encounter.

**Suppress Comment on Suppressed Form?**

Use Y or N to suppress the provider's comments.

**# of past POVs to display**

Specify the number of the past POVs to be displayed on the Patient Data Entry screen. This response must be a whole number between 0 and 5.

**Exclude No Shows on last DX Display?**

Use Y or N.

**DSM-5 Implementation Date**

From the date listed forward the application will use the DSM-5 Code Set. Section Appendix D: provides information about DSM copyright and trademark information.

**Update PCC Link Features?**

Use Y or N. If you use Y, the application displays the Update PCC Link Feature Parameters pop-up window (Figure 14-4).

```

**** Update PCC Link Feature Parameters ****
=====
Type of PCC Link
Type of Visit to create in PCC
Interactive PCC Link?
Allow PCC Problem List Update?
Update PCC LINK Exceptions?

```

Figure 14-4: Fields on the Update PCC Link Feature Parameters pop-up

The underlined fields are required on the pop-up window.

**Type of PCC Link:** what you use determines the type of data that passes from BHS to the PCC. Use one of the following:

- **No Link Active.** Use this option to have the data link between the two modules turned off. No data is passed to the PCC visit file from the BHS system (including the Health Summary). Therefore, because the RPMS Third Party Billing Package processes encounters in PCC, an alternative billing process will need to be established. If you leave this field blank, it is the same as choosing this option and no data will pass to PCC.

- **Pass STND Code and Narrative.** Use this option to have all patient contacts in the Behavioral Health programs passed to the PCC visit file using the same ICD-9 or ICD-10 code and narrative, as defined by the program. This approach does not facilitate billing because all encounters will appear the same. For example, if the code and narrative are entered in the site parameters as 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-5 and Problem Codes passed as ICD codes as shown in the crosswalk along with the narrative as written by the provider. This link type is the one most preferred by billers and coders since the actual ICD code and narrative display in PCC.
- **Pass Codes and Canned Narrative.** Use this option to have both DSM-5 and Problem Codes converted to ICD codes as shown in the 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 ICD-9 Code to Use (Option 2 and 5 ONLY): V65.40
Standard ICD-10 Code to Use (Option 2 and 5 ONLY): Z71.9
Narrative for MH Program: MH/SS/SA COUNSELING
Narrative for SS Program: SS VISIT
```

Figure 14-5: Standard code to use screen

With each of these link types, standard data is passed to the PCC. You can specify those standards using the Standard Code to Use screen. The standard code, shown in the first line, will be passed if using Pass STND Code and Narrative. The narrative entered will be the only narrative passed if you have selected Pass STND Code and Narrative and Pass Codes and Canned Narrative options.

**Note:** The application shall continue to crosswalk codes as ICD-9 Codes until the implementation date of ICD-10, at which point all visits passing to PCC will have their codes crosswalked to ICD-10 Codes.

**Type of Visit to create in PCC:** what you use determines the type of visit created from the encounter record you enter into BHS. Use one of the following, depending on the classification of the BHS programs at your facility.

- I (IHS)
- C (Contract)
- 6 (638 Program)
- T (Tribal)
- O (Other)
- V (VA)
- P (Compacted Program)
- U (Urban Program)

**Interactive PCC Link?:** use Y or N. The BHS site parameters contain a question about an interactive PCC link to address an issue with the PIMS Scheduling package. Because it is possible to set up a clinic in the Scheduling package that initiates a PCC record at check in, some sites were creating two separate records for each individual patient encounter in the behavioral health clinics. If you leave the field blank, this is the same as using N (for this prompt) and the interactive link will not be turned on.

In the Scheduling package, if the clinic set-up response is YES to the question about creating an encounter at check in, then the Interactive PCC Link question in the BHS site parameters must also be answered YES. If the clinic set up in the Scheduling package has a negative response, then the Interactive Link question in BHS should be set to NO.

**Note:** There should never be a mismatched response where one package has YES and the other NO.

**Allow PCC Problem List Update?:** use Y or N to allow the ability to update a patient's PCC problem list from within BHS.

**Update PCC LINK Exceptions?:** (Figure 14-6) use Y or N to determine if you want to set data passing parameters for individuals that are different from the program default.

Provider Name	Type of PCC Link for this Provider
SIGMA, LORRAINE	NO LINK ACTIVE
MBETAA, MARY	PASS ALL DATA AS ENTERED

Figure 14-6: Setting up PCC link exceptions

Below are the fields on the update window.

### **Turn Off EHR to BH Link?**

Use Y or N. A site parameter was created to give sites the ability to “opt out” of the new behavioral health (BH) Electronic Health Record (EHR) visit functionality. This functionality allows BH providers to enter a visit into the EHR that passes first to PCC and then to the behavioral health database (AMH). These visits display in the EHR as well as the BH applications, BHS v4.0 and the RPMS Behavioral Health System v4.0 GUI.

The name of the site parameter is “Turn Off EHR to BH Link” and it is accessed via the BHS v4.0 Manager Utilities module SITE menu option. The default setting on this new site parameter is “NO” and no action is required if sites will be deploying the BH EHR functionality. If sites will not be deploying the BH EHR visit functionality, then the site parameter should be changed to “YES.”

### **Turn on PCC Coding Queue?**

Use Y (yes) or N (no).

- If you use Y, the visits will not be passed directly to the billing package. The visits will be marked as incomplete and must be reviewed by local data entry staff, billers, or coders.
- If you use N, all visits will continue to pass to PCC as complete.

Because the visits entered in the behavioral health system have always been marked as complete, the visits were going through PCC to the claims generator without review. With this version of the software, sites are given the option of transmission to the Coding Queue or continuing to send visits to PCC marked as complete.

In addition to establishing an option on the site parameters’ menu to turn on the Coding Queue, an option that can be placed on data entry staff’s RPMS menu has been created. Because the SOAP/Progress Notes related to visits created in BHS do not pass to PCC, the data entry staff, billers, and/or coders needed some method to access the notes for review. The option will allow them to review the specifics for a particular visit but will not give them full access to BHS. For example, they will not be able to view treatment plans, case status information, or the Suicide Reporting Forms.

Turning on the link to the Coding Queue in the Behavioral Health System should not be done if the PCC Coding Queue has not been activated. However, if the PCC Coding Queue has been activated and the site wants the BHS-generated visits to be reviewed, complete the following steps:

- a. Log in to BHS v4.0 and select the Manager Utilities menu.

- b. Select the Site Parameters option and enter the name of the site you want to update.
- c. On the site parameters entry window, scroll down to the “Turn on PCC Coding Queue” field.
- d. Use Y at this field.
- e. Save the changes to the site parameters.

Once the coding queue option has been turned on and the changes to the site parameters are saved, any visits documented in BHS v4.0 will be flagged as incomplete. Visits created the same day but before the site parameters were changed will still be marked as complete. The date and time the visit was entered in RPMS determines the flag to be applied, not the date and time of service.

### Update Provider Exceptions to E Sig?

Use Y (yes) or N (no). The electronic signature function is available on the PDE, SDE, Intake, and Group entry menus (in roll and scroll) and also available on the One Patient, All Patients, Intake, and Group entry menus (in the GUI). Only those encounter records with signed SOAP/Progress Notes will pass to PCC.

If you use Y, Figure 14-7 displays.

<p>Electronic Signature will not be activated for providers added to this list.</p> <p>PROVIDER:  PROVIDER:  PROVIDER:  PROVIDER:  PROVIDER:</p>
--

Figure 14-7: Place to list provider exceptions to electronic signature

Populate the PROVIDER field with the name of provider with exception to electronic signature.

Because some sites might still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a particular provider should be exempted from the electronic signature, those visits will pass to PCC but show up as unsigned on the visit entry display.

### Update those allowed to see all records?

Use Y or N to determine if you want to update those allowed to see all records.

- If the user’s name is added to this list, the user will be able to see all records entered into the system, whether the user was the provider of the visit or not, or whether the provider created the record or not.

- If the user's name is not added to this list, only those encounter records the user created or those on which the user was a provider will be visible to that user.

The Help prompt has been updated and provides the following information when the user types in a question mark (?): "If users need to see records other than their own, their names should be added to this list. Type a Y to update the list."

If you use Y, Figure 14-8 displays. You can add another user to the list. This new user will be able to see all visits when using the SDE or PDE options.

```
Enter only those users who should be permitted to see all Visit and Intake records
for all patients whether they were the provider of record or the user who entered
the record or not. Users not entered on this list will see only those Visits or
Intake records that they entered or for which they were the provider of record. This
parameter applies to the SDE menu option and all other options that display Visit
and Intake information.
```

```
-----
+THETA, SHIRLEY
  PHI, LISA M
  RHO, SUSAN P
  ALPHA, WENDY
```

Figure 14-8: List of names allowed to see all records

### Update those allowed to override delete?

Use Y or N to determine if you want to update those allowed to override delete.

If you use Y, Figure 14-9 displays. You can add another name to the list.

```
Enter only those users who should be permitted to delete any Intake
document, signed or unsigned, whether they are the user who
entered the Intake document or the provider of record.
```

```
-----
THETA, MARK
CHI, RONALD D SR
NU, KAREN
```

Figure 14-9: List of names allowed to delete any Intake document

### Update those allowed to share visits?

Use Y or N to update those allowed to share visit information via RPMS mail message.

If you use Y, Figure 14-10 displays. Here you can add a new name at the "User allowed to share visits via mail" prompt. All users permitted to share visit information via RPMS mail messages should be entered here.

```
Entering users into this field will give them access to send a copy of
a completed encounter form (either full or suppressed) to other
RPMS users. Keep confidentiality issues in mind when deciding on
```



```

who should be given this access.

User allowed to share visits via mail: BETA,BJ
User allowed to share visits via mail: ALPHA,WENDY
User allowed to share visits via mail: GAMMA,RYAN
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:

```

Figure 14-10: Sample pop-up to enter user names allowed to share visits via mail

### Update those allowed to order Labs?

Use Y or N to permit those allowed to order lab tests.

If you use Y, Figure 14-11 displays. Here you can add a new name at the “User Permitted to Order Labs” prompt. All users permitted to order lab tests should be entered here.

```

The users that you enter into this field will be given access to
order LAB tests through the SEND PATIENT option.
If a user is not entered here he/she will not be granted access to the
LAB SEND PATIENT option.

User Permitted to Order Labs:
User Permitted to Order Labs:
User Permitted to Order Labs:

```

Figure 14-11: Pop-up to enter user names allowed to order labs

### If you are using the RPMS Pharmacy System, enter the Division

Specify the name of the division for the RPMS Pharmacy System.

## 14.2 Export Utility Menu (EXPT)

Use the EXPT option to access the options on the Export Utility Menu (Figure 14-12).

```

                                DEMO INDIAN HOSPITAL

GEN   Generate BH Transactions for HQ
DISP  Display a Log Entry
PRNT  Print Export Log
RGEN  Re-generate Transactions
RSET  Re-set Data Export Log
CHK   Check Records Before Export
EDR   Re-Export BH Data in a Date Range
ERRS  Print Error List for Export

```

```

OUTP  Create OUTPUT File
SAE   Set Automated Export Option

Select Export Utility Menu Option:

```

Figure 14-12: Options on the Export Utility Menu

Use the options on this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes.

**Important:** This set of utilities should only be accessed and used by the site manager, the BH program manager, or designee.

These options should be familiar to site managers and other RPMS staff who generate exports. The recommended sequence for their use follows those from PCC- CHK, clean, GEN, DISP, ERRS, transmit. RGEN, RSET and OUTP should be reserved for expert use as required.

### 14.2.1 Generate BH Transactions for HQ (GEN)

Use the GEN option to generate BHS transactions to be sent to HQ. The transactions are for records posted between a specified date range.

The transactions are for records posted since the last time you did an export up until yesterday. Both BH visit records and Suicide forms will be exported.

You can “^” out at any prompt and the application will ask you to confirm your entries prior to generating transactions.

Figure 14-13 displays.

```

The inclusive dates for this run are DEC 28,2008 through APR 18,2009.
The location for this run is DEMO INDIAN HOSPITAL.
Do you want to continue? N//

```

Figure 14-13: Sample information before continuing

#### **Do you want to continue?**

Use Y or N. If you use N, you return to the Export Utility menu. If you use Y, the prompts continue.

#### **Do you want to QUEUE this to run at a later time?**

Use Y or N. If you use Y, the generation will be put in the queue. If you use N, the generate process continues. The BH export generally takes less than five minutes to generate. It will still tie up your computer while doing the export (but it is quick). Figure 14-14 shows a sample.

```

Enter beginning date for this run:   SEP 1, 2008

The inclusive dates for this run are   SEP 1, 2008   THROUGH   SEP 30, 2008
The location for this run is the _____HOSPITAL/CLINIC.

Do you want to continue (Y/N)  N// Y

Generating transactions.      Counting records      ( * 100*      )

*100* Transactions were generated.
Updating log entry.
Deleting cross reference entries (100)

RUN TIME   (H.M.S): 0.3.56

```

Figure 14-14: Sample information for generating the new log entry

### 14.2.2 Display a Log Entry (DISP)

Use the DISP option to display the extract log information in a specified date range.

#### Select MHSS EXTRACT LOG BEGINNING DATE

Specify the extract log beginning date. (You can view the extract date by using ? at this prompt.)

#### DEVICE

Select the device to output the log information.

Figure 14-15 shows the extract log information.

```

NUMBER: 2                               BEGINNING DATE: SEP 1, 2008
ENDING DATE: SEP 30, 2008@10:26:49
RUN STOP DATE/TIME: OCT 2, 1994@10:30:51
COUNT OF ERRORS: 2                     COUNT OF TRANSACTIONS: 98
COUNT OF RECORDS PROCESSED: 100        RUN LOCATION: _____
# ADDS: 97                               # MODS: 1
# DELETES: 0
TRANSMISSION STATUS: SUCCESSFULLY COMPLETED

```

Figure 14-15: Sample extract log information

### 14.2.3 Print Export Log (PRNT)

Use the PRNT option to display the export extract log report.

The application displays the previous selection beginning date.

#### START WITH BEGINNING DATE

Press Enter to accept the default date. Otherwise, specify the first beginning date of the date range.

**GO TO BEGINNING DATE**

Press Enter to accept to default date. Otherwise, specify the next beginning date.

**DEVICE**

Specify the device to print/browse the log.

The application displays the Mental Health/Social Service Export Extract Log (Figure 14-16).

*****MENTAL HEALTH/SOCIAL SERVICES*****						
***EXPORT EXTRACT LOG***						
					PAGE:	1
					REPORT DATE:	04/20/09
	ADDS	DEL	MODS	TRANS	ERROR	RECORD
3	10/24/06	12/21/06		39	10	45
	10/24/06	12/21/06				
4	12/20/06	05/14/07		256	34	278
	12/20/06	05/14/07				
5	05/13/07	08/22/07		128	55	181
	05/13/07	08/22/07				
6	08/21/07	10/03/08		537	77	595
	08/21/07	10/03/08				
7	10/02/08	11/17/08		21	4	17
	10/02/08	11/17/08				
8	11/16/08	12/10/08		185	12	180
	11/16/08	12/10/08				
9	12/09/08	12/29/08		33	0	33
	12/09/08	12/29/08				
TOTAL	0	0	0	1199	192	1329

Figure 14-16: Sample export extract log

#### 14.2.4 Re-generate Transactions (RGEN)

Use the RGEN option to re-generate transactions between two dates.

**Warning:** Do not use this option if you are not an expert user.

Below are the prompts.

#### Select MHSS EXTRACT LOG BEGINNING DATE

Specify the beginning date.

If you specified an existing date, Figure 14-17 displays.

Log entry 6 was for date range MAR 2, 2007 through JUN 16, 2007  
And generated 44 transactions from 67 records.

This routine will generate            transactions.

```
Do you want to regenerate the transactions for this run? N//
```

Figure 14-17: Sample information about re-generate transactions

## 14.2.5 Re-set Data Export Log (RSET)

Use the RSET option to reset the BH Data Transmission Log. You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place!

The BH Data Transmission log entry you choose will be **REMOVED** from the log file and all Utility and Data globals associated with that run will be killed!!

You must now select the Log Entry to be reset. <Select carefully>

The BH Data Transmission log entry you choose will be *removed* from the log file and all Utility and Data globals associated with that run will be killed.

## 14.2.6 Check Records Before Export (CHK)

Use the CHK option to review all records that were posted to the BH database since that last export was done. It will review all records that were posted from the day after the last date of that run up until 2 days ago.

Figure 14-18 shows the BH Export Record Review report.

DEMO INDIAN HOSPITAL						Page 1
BH EXPORT RECORD REVIEW						
Record Posting Dates: APR 19, 2009 and APR 20, 2009						
RECORD DATE	PATIENT	HRN	PGM	TYPE	ACT	TYPE
-----						
APR 20, 2009@09:44	ALPHA, CHELSEA MARIE	116431	S	OUTPATIENT	16	
E023-NO AFFILIATION FOR PROVIDER						
APR 20, 2009@09:51	DUCK, EDWIN RAY	105321	S	OUTPATIENT	85	
E023-NO AFFILIATION FOR PROVIDER						
APR 20, 2009@10:46	DUCK, EDWIN RAY	105321	S	OUTPATIENT	85	
E023-NO AFFILIATION FOR PROVIDER						
APR 20, 2009@10:56	SIGMA, SERGIO	206293	S	OUTPATIENT	15	
E023-NO AFFILIATION FOR PROVIDER						
RUN TIME (H.M.S): 0.0.0						
End of report. PRESS ENTER:						

Figure 14-18: Sample report about records before export

### 14.2.7 Print Error List for Export (ERRS)

Use the ERRS option to print/browse the report that shows all records that have been posted to the database and are still in error AFTER the latest Export/Generation.

If the records are listed here, they aren't passing to PCC and the billing package.

Below are the prompts.

#### Select MHSS EXTRACT LOG BEGINNING DATE

Specify the extract log beginning date. (You can view the extract date by using ? at this prompt.)

**Note:** The Check Records before Export option should have been used to determine all errors before running the generation. You can now correct these remaining errors before the next export/generation.

#### DEVICE

Specify the device to print/browse the report.

Figure 14-19 shows the MHSS Extract Log Error Report.

MHSS EXTRACT LOG ERROR REPORT						APR 20, 2009 13:15	PAGE 1
VISIT DATE	PATIENT	HRN	PGM	TYPE	ACT	TYPE	
AUG 21, 2006 17:44	ALPHAAA, STEVEN ALLAN	165583	S	OUTPATIENT		31	
ERROR: E021-NO PURPOSE OF VISIT							
68,1700							
ERROR: E023-NO AFFILIATION FOR PROVIDER							
Press ENTER to Continue:							

Figure 14-19: Sample MHSS Extract Log Error Report

### 14.2.8 Create OUTPUT File (OUTP)

Use the OUTP option to create an output file. Consult with the site manager on how to create an RPMS export.

### 14.2.9 Set Automated Export Option (SAE)

These options control the destination of the BHSX Export once it is generated. If no selection is made the application comes set with option 1 Automatically Send Export to HQ.

**Select HSS SITE Parameters**

Use the site parameter to set the destination for the export file.

**Auto Export Option**

Use one of the following: 1 Automatically Send Export to HQ, 2 Automatically Send Export to Area, 3 Automatically Send Export to Both Area and HQ, 4 Do Not Automatically Send Exports

**14.3 Re-Set Patient Flag Field Data (RPFF)**

Use the RPFF option to reset all patient flag fields to null. This should be done each time you want to flag patients for a different reason. You can reset one particular flag or all flags. You may use this reset option to reassign a particular flag or all flags as needed.

Below are the prompts.

**Reset which flags**

Use one of the following: A (all flags) or O (one particular flag). If you use O, other prompts will display.

**Are you sure you want to do this?**

Use Y or N. If you use Y, Figure 14-20 shows the information:

```
Hold on... resetting data..
All done.
```

Figure 14-20: Information from the application about the reset process

**14.4 Display Log of Who Edited Record (DLWE)**

Use the DLWE option to display a list of who edited a BH record.

Below are the prompts.

**Enter ENCOUNTER DATE**

Specify the date of the encounter.

**Enter LOCATION OF ENCOUNTER**

If known, specify the location. Otherwise press Enter.

**Enter PATIENT**

Specify the name of the patient.

Figure 14-21 shows the Behavioral Health Visits for the date specified. The following examples were visits with no location and no patient.

```

-----
Behavioral Health visits for 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 SCHIZOPHRENIA
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 14-21: Sample Behavioral Health Visits window

You can display the visit data for a particular record by responding the “Which record do you want to display?” prompt. Figure 14-22 shows the visit data.

```

MHSS RECORD LIST APR 20,2009 11:31 PAGE 1
DATE
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

End of report. Press enter:

```

Figure 14-22: Sample report about visit data of a particular record

## 14.5 Add/Edit Local Service Sites (ELSS)

Use the ELSS option to add/edit location service sites. If you add a new location service site, you give it a name and abbreviation. Counts of these visits can be recovered using the GEN option in Encounter Reports or ACT in the Workload reports.

Below are the prompts.

### Select MHSS LOCAL SERVICE SITES

Specify a new or existing local service site. Specify a new service site using 3-30 characters.

If you specify a new service site, the application confirms that you are adding this new service site (use Y or N); if you use N, the above prompt repeats.



If you specify an existing factor, for example, HEADSTART, the application displays the following prompt:

**LOCAL SERVICE SITE: HEADSTART//**

You can accept the existing service site by pressing Enter. Otherwise, you can give it a new service site name.

**ABBREVIATION: HEAD**

You can accept the abbreviation of the existing service site by pressing Enter. Otherwise, you can give it another abbreviation.

## 14.6 Add Personal History Factors to Table (EPHX)

Use the EPHX option to add personal history factors to the four-item list initially identified for use in BHS programs. Added items will be shown as items in the Personal History field any place this option exists in a Select or Print field in the GEN reports.

Below are the prompts.

**Enter a PERSONAL HISTORY FACTOR**

Specify a new or existing personal history factor. If you use a new factor, using 3-30 characters, with no numeric or starting with punctuation.

If you specify a new factor, the application confirms that you are adding this new factor (use Y or N); if you use N, the above prompt repeats.

If you specify an existing factor, for example, FAS, the application displays the following prompt:

**FACTOR: FAS//**

You can accept the existing factor by pressing Enter. Otherwise, you can give it a new factor name.

## 14.7 Delete BH General Retrieval Report Definitions (DRD)

Use the DRD option to delete a PCC Visit or Patient General Retrieval report definition. This option enables the user to delete a PCC Visit or Patient General Retrieval report definition. For example, if a provider had created multiple report definitions using GEN or PGEN and saved the logic, these reports may be deleted when the provider leaves the facility.

Below are the prompts.

**REPORT NAME**

Specify the name of the report whose definition you want to remove. You use ? at this prompt to view a list of existing definitions.

**Are you sure you want to delete the [report name] definition?**

The [report name] is the name of the report you specified in the previous prompt. Use Y or N at this confirmation prompt.

## 14.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

Use the EEPC option to loop through all MHSS PROBLEM/DSM-5 table entries created by EHR users to change the grouping from the generic 99.9 OTHER EHR CLINICAL grouping to a more specific MHSS PROBLEM CODE grouping.

In the RPMS behavioral health applications the Purpose of Visit (POV) is recorded as either a BH Problem Code or DSM-5 code. For the purpose of reports, these codes are grouped within larger problem code groupings and then again in overarching categories. For example, DSM-5 code 311 Depressive Disorder NOS is also stored as problem code grouping 14 Depressive Disorders and problem category Psychosocial Problems.

In the RPMS EHR, the POV is recorded using ICD-9 or SNOMED codes that are mapped to ICD codes and pulled into BHS, not DSM-5 codes. Many ICD and DSM numeric codes are identical. There may be instances when a provider selects an ICD code that does not have a matching DSM code. When this occurs it will be dynamically added to the MHSS PROBLEM/DSM-5 table. Once the ICD code is in the MHSS PROBLEM/DSM-5 table, then it is accessible to users in BHS or BH GUI as well.

These ICD codes that have been added to the MHSS PROBLEM/DSM-5 table will not have been automatically assigned to the appropriate BH problem code group. To ensure that these ICD codes are captured in BHS reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time.

Below are sample prompts for a site.

CODE: V72.3

ICD Narrative: GYNECOLOGIC EXAMINATION

Enter the Problem Code Grouping

Specify the grouping code for the above Code and ICD Narrative.

The application provides you with the ^ option so that you don't have to go all the way through the entries.

## 14.9 Update Locations a User can See (UU)

Use the UU option to specify the location a user can view in this application.

BHS v4.0 contains a new field called the BH User that will permit a site to screen the locations that a user may access to view or enter information.

If a site wants to limit the visits by location that a BH user can access then they will enter that user into this file and list all the facilities/locations that that user is allowed to “see” or access. If an entry is made in this file for a user that user will only be able to “lookup” patients with a health record at those facilities, only patients with health records at those facilities will display on patient lists and reports, and will only be able to view/access visits to those locations. If a user is not entered into this file that person will be able to see visits to all locations. This file will only be updated if a site is multi-divisional and there is a need to restrict the viewing of data between sites.

### Select BH USER NAME

Specify the user you want to use. This will add the user to the BH User file. A ScreenMan screen will pop-up and the manager can enter all of the locations that the user is able to access or “see” on the screen.

Figure 14-23 shows the Update Visit Locations a User can See window.

```

**** Update Visit Locations a User can See ****
USER: BETA,LORI

Location: DEMO INDIAN HOSPITAL
Location: SELLS HOSP
Location:
Location:
Location:

COMMAND:                                     Press <PF1>H for help   Insert

```

Figure 14-23: Sample Update Visit Locations a User can See window

### Location

Specify the location that the user can view in this application.

You can specify more than one location. If this is the case, use the next Location field.

In the above example, the provider Lori Beta will only be able to access visits to Demo Indian Hospital and Sells Hospital. If a patient that she is treating had a visit to Phoenix Hospital, she would not see that visit information. This logic applies to any option that displays or reports on visit data. For example, Lori Beta chooses option “Browse Visits” she would not see any visit in the visit list that was to a location other than the two listed above.

## Appendix A: Activity Codes and Definitions

BHS activity codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to report activities. However, aggregate reports can be organized by these activity categories.

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

### A.1 Patient Services - Patient Always Present (P)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

#### **01–Twelve Step Work – Group (TSG)**

Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

#### **02–Twelve Step Work - Individual (TSI)**

Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

#### **03–Twelve Step Group (TSG)**

Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, CoDA (Co-dependents Anonymous).and OA (Overeaters Anonymous).

#### **04-Re-assessment, Patient Present (RAS)**

Formal assessment activities intended to reevaluate the patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

#### **11-Screening (SCN)**

Services provided to determine in a preliminary way the nature and extent of the recipient's problem in order to link him/her to the most appropriate and available resource.

**12-Assessment/Evaluation (EVL)**

Formal assessment activities intended to define or delineate the client/patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

**13-Individual Treatment/Counseling/Education (IND)**

Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

**15-Information and/or Referral (REF)**

Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization.

**16-Medication/Medication Monitoring (MED)**

Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

**17-Psychological Testing (TST)**

Examination and assessment of client/patient's status through the use of standardized psychological, educational, or other evaluative test. Care must be exercised to assure that the interpretations of results from such testing are consistent with the socio-cultural milieu of the client/patient.

**18-Forensic Activities (FOR)**

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

**19-Discharge Planning (DSG)**

Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

**20-Family Facilitation (FAC)**

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

**21-Follow-through/Follow-up (FOL)**

Periodic evaluative review of a specific client/patient's progress after discharge.

**22-Case Management (CAS)**

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination.

**23-Other Patient Services not identified here (OTH)**

Any other patient services not identified in this list of codes.

**47-Couples Treatment (CT)**

Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.

**48-Crisis Intervention (CIP)**

Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

**85-Art Therapy (ART)**

The application of a variety of art modalities (drawing, painting, clay, and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.

**86-Recreation Activities (REC)**

Recreation and leisure activities with the purpose of improving and maintaining clients'/patients' general health and well-being.

**88-Acupuncture (ACU)**

The use of the Chinese practice of Acupuncture in the treatment of addiction disorders (including withdrawal symptoms and recovery) and other behavioral health disorders.

**89-Methadone Maintenance (MET)**

Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed methadone maintenance agency under the supervision of a physician. Services include methadone dosing, medical care, counseling and support and disease prevention and health promotion.

**90-Family Treatment (FAM)**

Family-centered therapy with an emphasis on the client/patient's functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences; often brief and solution focused.

**91-Group Treatment (GRP)**

This form of therapy involves groups of patients/clients who have similar problems that are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

**92–Adventure Based Counseling (ABC)**

The use of adventure-based practice to effect a change in behaviors (both increasing function and positive action and decreasing dysfunction and negative action) as it relates to health and/or mental health.

**93–Relapse Prevention (REL)**

Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

- Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
- Strategies for avoiding high-risk situations
- Strategies for coping with high-risk situations when encountered
- Strategies for coping with alcohol/drug cravings
- Strategies for coping with lapses to drug use to prevent full-blown relapses

**94–Life Skills Training (LST)**

Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

**95–Cultural Activities - Pt. Present (CUL)**

Participation in educational, social, or recreational activities for the purpose of supporting a client/patient's involvement, connection, and contribution to the patient's cultural background.

**96–Academic Services (ACA)**

Provision of alternative schooling under the guidelines of the state education program.

**97–Health Promotion (HPR)**

Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

## A.2 Support Services - Patient Not Present (S)

Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

**05-Re-assessment, Patient Not Present**

Reassessment or reevaluation activities when patient is not present at time of service delivery.



**24-Material/Basic Support (SUP)**

Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

**25-Information and/or Referral (INF)**

Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization

**26-Medication/Medication Monitoring (MEA)**

Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

**27-Forensic Activities (FOA)**

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

**28-Discharge Planning (DSA)**

Collaborative service planning with other community caregivers to develop a goal oriented follow-up plan for a specific client/patient.

**29-Family Facilitation (FAA)**

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

**30-Follow-up/Follow-through (FUA)**

Periodic evaluative review of a specific client/patient's progress after discharge.

**31-Case Management (CAA)**

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

**33-Technical Assistance**

Task-specific assistance to achieve an identified end.

**34-Other Support Services**

Any other ancillary, adjunctive, or collateral services not identified here.

**44-Screening**

Activities associated with patient/client screening where no information is added to the patient/client's file.

**45-Assessment/Evaluation**

Assessment or evaluation activities when patient is not present at time of service delivery.

**49-Crisis Intervention (CIA)**

Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

### A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes:

**35-Collaboration**

Collaborative effort with other agency or agencies to address a community request.

**36-Community Development**

Planning and development efforts focused on identifying community issues and methods of addressing these needs.

**37-Preventive Services**

Activity, class, project, public service announcement, or other activity whose primary purpose is to prevent the use/abuse of alcohol or other substances and/or improve lifestyles, health, image, etc.

**38-Patient Transport**

Transportation of a client to or from an activity or placement, such as a medical appointment, program activity, or from home.

**39-Other Community Services**

Any other form of community services not identified here.

**40-Referral**

Referral of a client to another agency, counselor, or resource for services not available or provided by the referring agency/program. Referral is limited to providing the client with information and might extend to calling and setting up appointments for the client.

**87-Outreach**

Activities designed to locate and educate potential clients and motivate them to enter and accept treatment.

## A.4 Education Training (E)

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job related knowledge, attitudes, and skills. Includes:

- 41- Education/Training Provided
- 42- Education/Training Received
- 43- Other Education/Training

## A.5 Administration (A)

Activities for the benefit of the organization and/or activities that do not fit into any of the above categories. Includes:

### **32-Clinical Supervision Provided**

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

### **50-Medical Rounds (General)**

On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

### **51-Committee Work**

Participation in the activities of a body of persons delegated to consider, investigate, take action on, or report on some matter.

### **52-Surveys/Research**

Participation in activities aimed at identification and interpretation of facts, revision of accepted theories in the light of new facts, or practical application of such new or revised theories.

### **53-Program Management**

The practice of leading, managing, and coordinating a complex set of cross-functional activities to define, develop, and deliver client services and to achieve agency/program objectives.

### **54-Quality Improvement**

Participation in activities focused on improving the quality and appropriateness of medical or behavioral healthcare and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

**55-Supervision**

Participation in activities to ensure that personnel perform their duties effectively. This code does not include clinical supervision.

**56-Records/Documentation**

Review of clinical information in the medical record/chart or documentation of services provided to or on behalf of the client. This does not include the time spent in service delivery.

**57-Child Protective Team Activities**

Participation in a multi-disciplinary child protective team to evaluate alleged maltreatments of child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance their caregiver's capacity to provide a safer environment when possible.

**58-Special Projects**

A specifically-assigned task or activity which is completed over a period of time and intended to achieve a particular aim.

**59-Other Administrative**

Any other administrative activities not identified in this section.

**60-Case Staffing (General)**

A regular or ad-hoc forum for the exchange of clinical experience, ideas and recommendations.

**66-Clinical Supervision Received**

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

**A.6 Consultation (L)**

Problem-oriented effort designed to impart knowledge, increase understanding and insight, and/or modify attitudes to facilitate problem resolution. Includes:

**61-Provider Consultation (PRO)**

Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

**62-Patient Consultation (Chart Review Only) (CHT)**

Focus is a specific patient and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

**63-Program Consultation**

Focus is a programmatic effort to address specific needs.

**64-Staff Consultation**

Focus is a provider or group of providers addressing a type or class of problems.

**65-Community Consultation**

Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

**A.7 Travel (T)****71-Travel Related to Patient Care**

Staff travel to patient's home or other locations – related to provision of care. Patient is not in the vehicle.

**72 Travel Not Related to Patient Care**

Staff travel to meetings, community events, etc.

**A.8 Placements (PL)****75-Placement (Patient Present) (OHP)**

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

**76-Placement (Patient Not Present) (OHA)**

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences. This activity might include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

**A.9 Cultural Issues (O)****81-Traditional Specialist Consult (Patient Not Present) (TRA)**

Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

**82-Traditional Specialist Consult (Patient Not Present) (TRA)**

Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

**83-Tribal Functions**

Services offered during or in the context of a traditional tribal event, function, or affair—secular or religious. Community members gather to help and support individuals and families in need.

**84-Cultural Education to Non-Tribal Agency/Personnel**

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

## Appendix B: Activity Codes that Pass to PCC

Activity Code	Description	Pass to PCC
01	Twelve Step Work – Group (TSG)	Yes
02	Twelve Step Work – Individual (TSI)	Yes
03	Twelve Step Group (TWG)	No
04	Re-Assessment, Patient Present	Yes
05	Re-Assessment, Patient Not Present	No
11	Screening – Patient Present (SCN)	Yes
12	Assessment/Evaluation – Patient Present (EVL)	Yes
13	Individual Treatment/Counsel/Education – Pt. Present (IND)	Yes
15	Information and Referral – Patient Present (REF)	Yes
16	Medication/Medication Monitoring – Pt. Present (MED)	Yes
17	Psychological Testing – Patient Present (TST)	Yes
18	Forensic Activities – Patient Present (FOR)	Yes
19	Discharge Planning – Patient Present (DSG)	Yes
20	Family Facilitation –Patient Present (FAC)	Yes
21	Follow Through/Follow Up – Patient Present (FOL)	Yes
22	Case Management – Patient Present (CAS)	Yes
23	Other Patient Services Not Identified – Patient Present (OTH)	Yes
24	Material/Basic Support – Patient Not Present (SUP)	No
25	Information and/or Referral – Patient Not Present (INF)	No
26	Medication/Medication Monitoring – Pt. Not Present (MEA)	Yes
27	Forensic Activities – Patient Not Present (FOA)	No
28	Discharge Planning – Patient Not Present (DSA)	No
29	Family Facilitation – Patient Not Present (FAA)	No
30	Follow Through/Follow Up – Patient Not Present (FUA)	No
31	Case Management – Patient Not Present (CAA)	Yes
32	Clinical Supervision Provided	No
33	Technical Assistance – Patient Not Present	No
34	Other Support Services – Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening – Patient Not Present	No
45	Assessment/Evaluation – Patient Not Present	No
47	Couples Treatment – Patient Present (CT)	Yes

<b>Activity Code</b>	<b>Description</b>	<b>Pass to PCC</b>
48	Crisis Intervention – Patient Present (CIP)	Yes
49	Crisis Intervention – Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes



## Appendix C: ICD-9 Codes

ICD Code	Description
042.	HIV disease
046.79	Other and unspecified prion disease of central nervous system
307.0	Adult on-set fluency disorder
331.0	Alzheimer's disease
331.19	Other frontotemporal dementia
331.82	Dementia with lewy bodies
332.0	Paralysis agitans
333.4	Huntington's chorea
781.99	Other systems involving nervous and musculoskeletal systems
970.0	Late effect of intracranial injury without skull fracture
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

ICD Code	Description
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
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

ICD Code	Description
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
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

<b>ICD Code</b>	<b>Description</b>
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
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: DSM Copyright and Trademark Information

### D.1 10.2 Copyright

In all instances where any portion of the WORK or DSM-5 appears, the source and copyright status of the material must appear where the text appears and in all marketing materials. The following notice shall be used:

*\*Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.™ Copyright ©2013 American Psychiatric Association. All Rights Reserved.*

*Unless authorized in writing by the APA, no part may be reproduced or used in a manner inconsistent with the APA's copyright. This prohibition applies to unauthorized uses or reproductions in any form.*

*The American Psychiatric Association is not affiliated with and is not endorsing this product.*

To the extent that such notice or any other copyright management information is embedded in the electronic product, LICENSEE agrees that it will not alter it or delete it. LICENSOR further agrees to require all USERS of its PRODUCT to maintain such copyright management information in its original form as provided by LICENSOR.

### D.2 10.3 Trademark

LICENSEE acknowledges that DSM and DSM-5 are registered trademarks of the American Psychiatric Association and may not be used commercially without prior approval. LICENSOR grants to LICENSEE permission to use the DSM and DSM-5 trademarks on a non-exclusive basis, as part of the PRODUCT, only with proper notice and only as necessary to accomplish LICENSEE's purpose as set out in Paragraph 1.2, above. The following notice shall be used:

*\*DSM and DSM-5 are registered trademarks of the American Psychiatric Association, and are used with permission herein. Use of these terms is prohibited without person of the American Psychiatric Association.*

## Appendix E: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

**Both documents are available at this IHS Web site: <http://security.ihs.gov/>.**

The ROB listed in the following sections are specific to RPMS.

### E.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

#### E.1.1 Access

##### **RPMS users shall**

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

##### **RPMS users shall not**

- Retrieve information for someone who does not have authority to access the information.

- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

### E.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

#### **RPMS users shall**

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

### E.1.3 Accountability

#### **RPMS users shall**

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

## E.1.4 Confidentiality

### **RPMS users shall**

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

### **RPMS users shall not**

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

## E.1.5 Integrity

### **RPMS users shall**

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

### **RPMS users shall not**

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

## E.1.6 System Logon

### **RPMS users shall**

- Have a unique User Identification/Account name and password.



- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

## E.1.7 Passwords

### **RPMS users shall**

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

### **RPMS users shall not**

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

### E.1.8 Backups

**RPMS users shall**

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

### E.1.9 Reporting

**RPMS users shall**

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

**RPMS users shall not**

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### E.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

**RPMS users shall**

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

### E.1.11 Hardware

**RPMS users shall**

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

**RPMS users shall not**

- Eat or drink near system equipment.

**E.1.12 Awareness****RPMS users shall**

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

**E.1.13 Remote Access**

**Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that**

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

**Remote RPMS users shall**

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

**Remote RPMS users shall not**

- Disable any encryption established for network, internet, and Web browser communications.

## E.2 RPMS Developers

### **RPMS developers shall**

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

### **RPMS developers shall not**

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## E.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

### **Privileged RPMS users shall**

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

**Privileged RPMS users shall not**

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## Glossary

### **Caret**

The symbol ^ obtained by pressing Shift-6.

### **Command**

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

### **Database**

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

### **Data Elements**

Data fields that are used in filling out forms in BHS.

### **Default Response**

Many of the prompts in the BHS program contain responses that can be activated simply by pressing the Enter key. For example: “Do you really want to quit? No//.” Pressing the Enter key tells the system you do not want to quit. “No//” is considered the default response.

### **Device**

The name of the printer to use when printing information. Home means the computer screen.

### **Fields**

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

### **Fileman**

The database management system for RPMS.

### **Free Text Field**

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

**Frequency**

The number of times a particular situation occurs in a given amount of time.

**Full Screen Editor**

A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

**Interface**

A boundary where two systems can communicate.

**Line Editor**

A word-processing editor that allows editing text line-by-line.

**Menu**

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

**Menu Tree/Tree Structure**

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

**Prompt**

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

**Roll-and-Scroll**

The roll-and-scroll data entry format captures the same information as the graphical user interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

**Security Keys**

Tools used to grant/restrict access to certain applications, application features, and menus.



**Site Manager**

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

**Submenu**

A menu that is accessed through another menu.

**Suicide**

The act of causing one's own death.

**Ideation with Intent and Plan**—Serious thoughts of suicide or of taking action to take one's life with means and a specific plan

**Attempt**—A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

**Completion**—Fatal self-inflicted destructive act with explicit or inferred intent to die.

**Terminal Emulator**

A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

**Text Editor**

A word processing program that entering and editing text.

**Word Processing Field**

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

## Acronym List

<b>A/SA</b>	Alcohol and Substance Abuse
<b>BH</b>	Behavioral Health
<b>BHS</b>	Behavioral Health System
<b>CAC</b>	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.”
<b>CD</b>	Chemical Dependency
<b>EHR</b>	Indian Health Service RPMS Electronic Health Record
<b>GPRA</b>	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.
<b>GUI</b>	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.
<b>HRCN</b>	Health Record Chart Number
<b>IHS</b>	Indian Health Service
<b>MH</b>	Mental Health

## Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

**Phone:** (888) 830-7280 (toll free)

**Web:** <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

**Email:** [support@ihs.gov](mailto:support@ihs.gov)