RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

User Manual Addendum

Version 4.0 Patch 5
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1.0 Introduction

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

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

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

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

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

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

1.1 Primary Menu

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

```
                ******************************************
                **       IHS Behavioral Health System       **
                ******************************************
                          Version 4.0 (Patch 5)

                           DEMO INDIAN HOSPITAL


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

Select Behavioral Health Information System Option:
```

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

1.2 Preparations

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

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

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

1.3 Security Keys

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

Table 1: Security Keys

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

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

2.0 Orientation

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

2.1 Standard Conventions (Roll and Scroll)

2.1.1 Caps Lock

Always work with the Caps Lock on.

2.1.2 Default Entries

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

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

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

2.1.3 Help

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

2.1.4 To Back Out

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

2.1.5 Exit

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

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

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

2.1.6 Same Entries

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

2.1.7 Lookup

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

Example:

```
PATIENT NAME: 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 usually displayed when a multiple page report reaches the bottom of a display screen and there are additional pages in the report. Press the Return key to see the next page or type a caret (^) to exit the report.

2.1.9 Dates and Times

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

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

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

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

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

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

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

2.1.10 Stop

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

2.1.11 Delete

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

2.2 ListMan (Roll and Scroll)

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

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

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

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

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

  1 DKR W&&RMAN,RAE      SE100003         31   F32.0   MAJOR DEPRESSIVE DIS
  2 DKR     --            -----       60  36   95      RPMS BH TRAINING
  3 DKR     --            -----       30  32   F42.    HOARDING DISORDER
```

```
?? for more actions

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

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

Figure 2-3: ListMan secondary options screen

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

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

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

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

2.3 ScreenMan (Roll and Scroll)

2.3.1 Using the ScreenMan Window

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

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

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

Activity:     Activity Time:        # Served: 1      Interpreter?

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


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

Figure 2-4: Using ScreenMan sample screen 1

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

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

2.3.2 Using the Pop-up Window

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

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

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

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

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

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

Figure 2-5: Using ScreenMan, sample screen 2

Press Enter to open a text editor screen.

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

Figure 2-6: Using ScreenMan, sample screen 3

2.4 Full Screen Text Editor (Roll and Scroll)

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

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

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

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

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

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

Below is a sample Text Edit screen:

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


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

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

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

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

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

Activity:     Activity Time:        # Served: 1      Interpreter?

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

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

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

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

2.5 Word Processing Editors (Roll and Scroll)

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

```
1>
```

Figure 2-9: RPMS line editor default

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

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

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

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


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

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

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

2. At the "Select User's Toolbox Option" prompt, type **Edit User Characteristics** and a window will be displayed.

3. Press the down arrow key on your keyboard to move to the Preferred Editor field. To change your preferred editor to the Screen Editor, type **SC**. Continue to press the down arrow until the cursor reaches the "Command:" prompt.

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

```
                          EDIT USER CHARACTERISTICS
NAME: SIGMA,SAMANTHA A                                        PAGE 1 OF 1
_____________________________________________________________________________

                  INITIAL: SAS                          PHONE:
                NICK NAME:                       OFFICE PHONE:
                                                   VOICE PAGER:
                                                 DIGITAL PAGER:


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

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

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


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

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

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

2.6 Pop-up Windows (GUI)

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

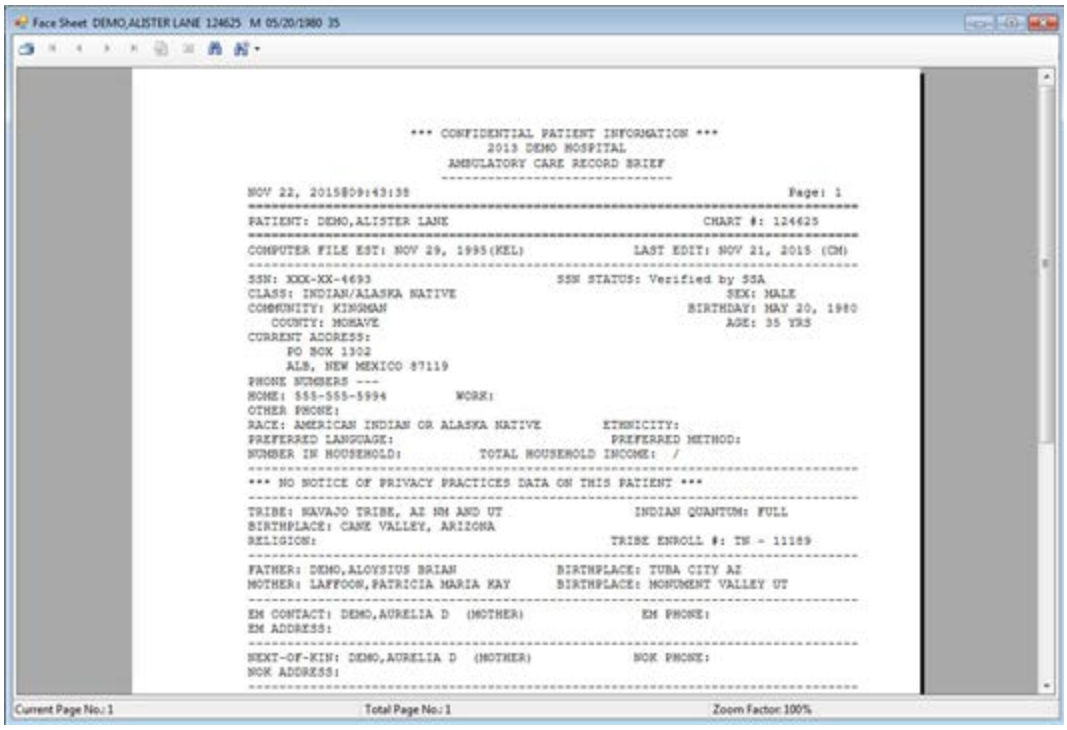


Figure 2-12: Sample pop-up window

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

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

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

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

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

2.6.1 Buttons on Title Bar

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

2.6.2 Buttons on the Toolbar

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

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

Print Report Button

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

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

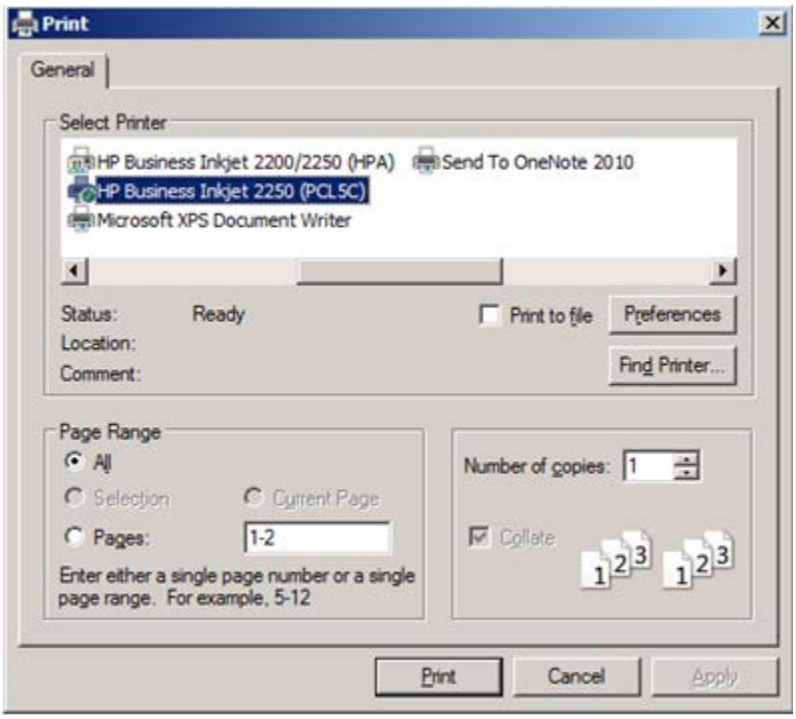


Figure 2-14: Sample Print dialog box

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

Move to Page Buttons

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

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

Go To Page

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

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

Figure 2-15: Go to Page dialog box

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

Find Text

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

Figure 2-16: Find Text dialog box

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

Zoom Button

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

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

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

2.7 Using the Calendar (GUI)

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

Figure 2-17: Sample Date and Time field

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

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

Otherwise, follow these steps:

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

Figure 2-18: Sample Calendar for Date Field

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

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

Figure 2-19: Change Year

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

Figure 2-20: List of Months to Select

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

2.8 Using the Search Window (GUI)

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

Figure 2-21: Community search window

This type of window has similar functionality for other fields.

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

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

2.9 Using the Search/Select Window (GUI)

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

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

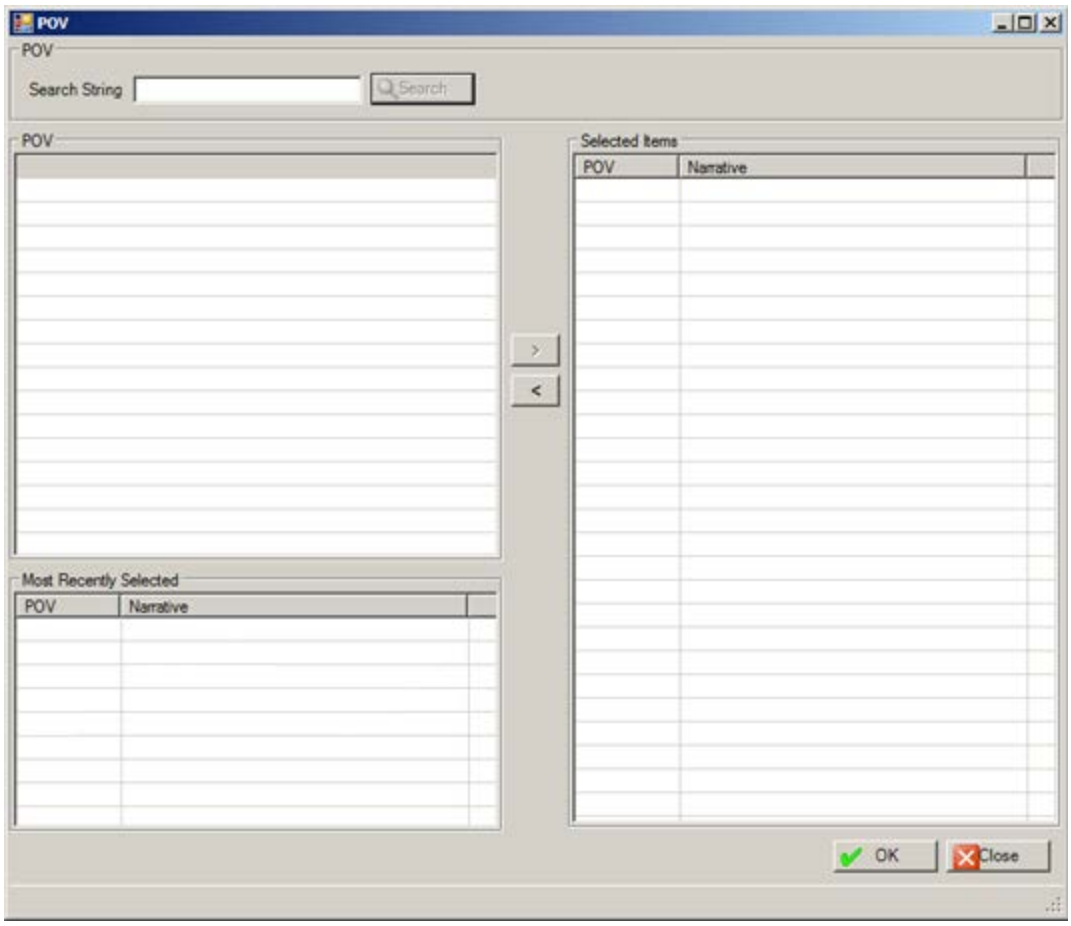


Figure 2-22: Sample Search/Select window

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

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

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

2.10 Using the Multiple Select Window (GUI)

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

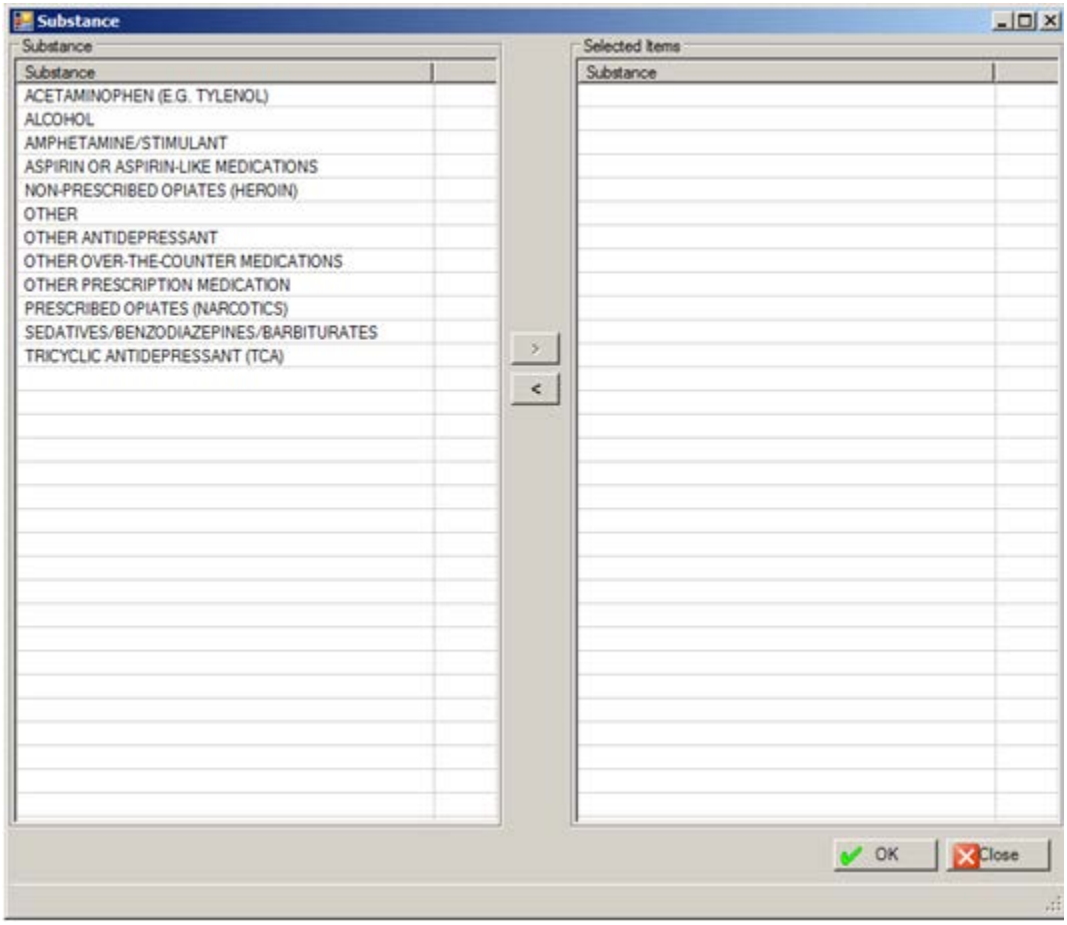


Figure 2-23: Sample AXIS IV multiple select window

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

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

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

3. When the **Selected Item** list box is complete, click the **OK**.

2.11 Free Text Fields (GUI)

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

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

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

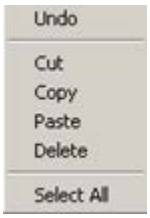


Figure 2-24: Right-Click Menu to Aid in Editing Text

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

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

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

2.12 Selecting a Patient

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

2.12.1 Patient Selection (Roll and Scroll)

The application displays the “Select Patient” prompt.

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

2.12.2 Patient Selection (GUI)

Select a patient in the following circumstances:

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

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

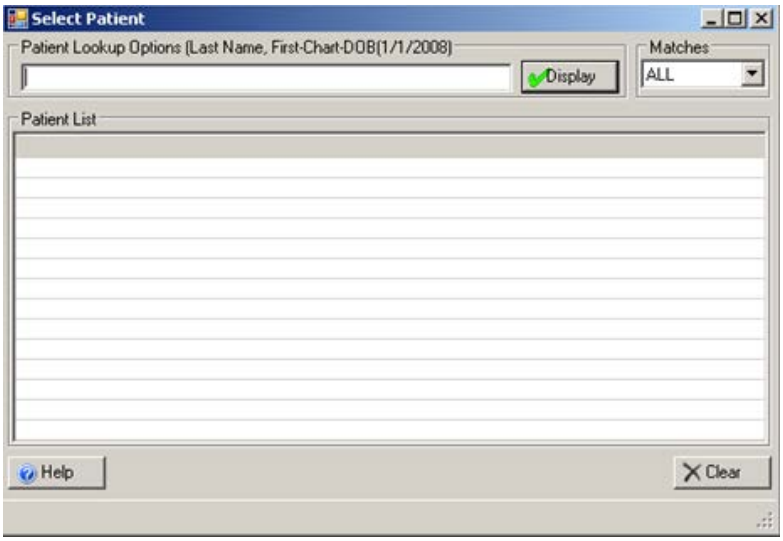


Figure 2-25: Select Patient dialog box

- Use the **Help** button to access the online help for this dialog box.
- Use the **Clear** button to remove all data from the **Patient List** box and from the text box near the top.

1. At the field, type a few characters of the patient's last name (at least 3), Social Security Number (SSN), Health Record Number (HRN), or date of birth (use format MM/DD/YYYY) in the Patient Lookup Options field.

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

2. Determine the number of matches by selecting an option from the **Matches** drop-down list (the default is All).

3. Click **Display**.

4. The application retrieves the valid candidates and displays them in the **Patient List** box. If there are no candidates, then the list box remains empty. In addition, a message will display in the bottom left corner stating: 0 records found.

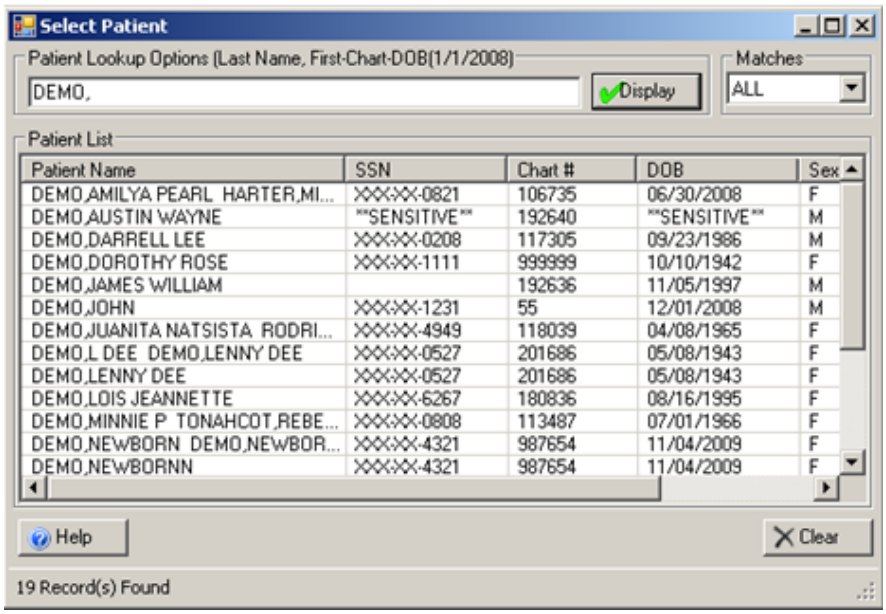


Figure 2-26: Sample Select Patient dialog box

5. Use the scroll bars to scroll through the retrieved names.

6. Double-click the patient to use. The selected patient becomes the active patient.

2.13 Sensitive Patient Tracking

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

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

GUI Example

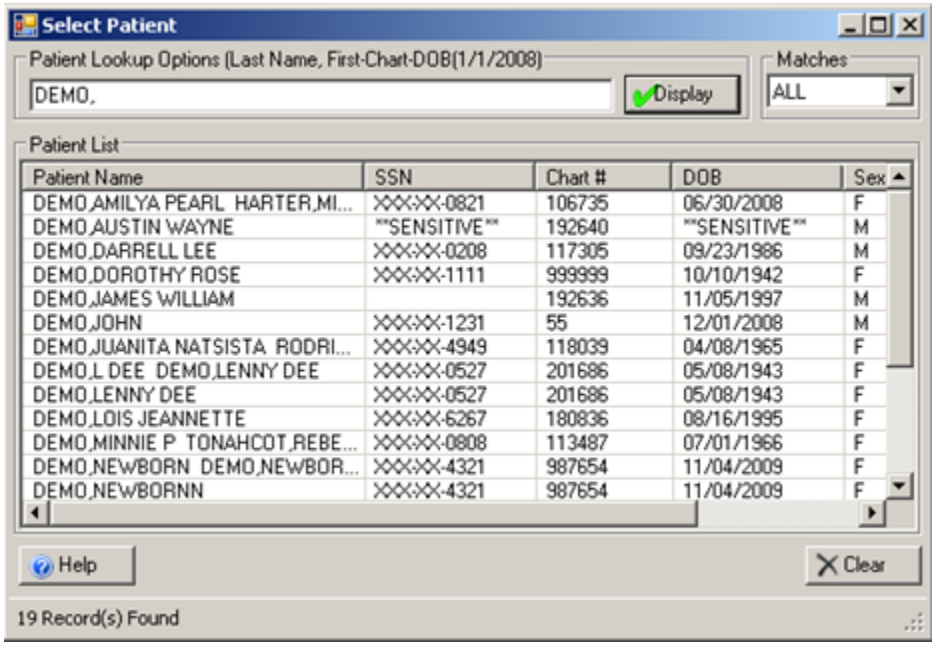


Figure 2-27: Sample Select Patient dialog box showing sensitive patient

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

Figure 2-28: Warning message displayed in GUI

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

Roll and Scroll Example

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

1. The Restricted Record warning message is shown below.

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

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

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

2. A simple warning message is shown below.

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

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

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

2.14 Electronic Signature

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

2.14.1 Creating Your Electronic Signature

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

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


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

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

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

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

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

4. When the following prompt appears in RPMS:

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

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

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

5. When the following prompt appears in RPMS:

```
Enter code:
```

Figure 2-34: Prompt for a new code

The above prompt is where you enter a new code.

6. Enter a new code (using between 6 and 20 characters) with Caps Lock ON. However, when you enter the electronic signature (on a note for example), it can be in lower case. (No special characters are allowed in the code.)

7. If you forget the code, it must be cleared out by your Site Manager; then you must create a new one. You are the only one who can enter your electronic signature code.

2.14.2 Electronic Signature Usage

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

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

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

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

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

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

2.14.3 Data Entry Requirements (Roll and Scroll)

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

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

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

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

2.14.4 Assign PCC Visit

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

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

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

2.14.5 Signing a Note (GUI)

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

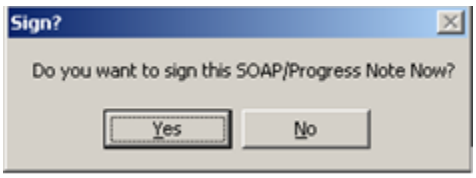


Figure 2-36: Sign dialog box

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

Figure 2-37: Electronic Signature dialog box

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

b. If you enter an invalid electronic signature and click **OK**, the application displays the Invalid notice that states: Invalid Signature Code. Click **OK** and the focus returns to the **Electronic Signature** dialog box.

c. Click **Close** on the **Electronic Signature** dialog box and the application displays the **Are You Sure?** dialog box.

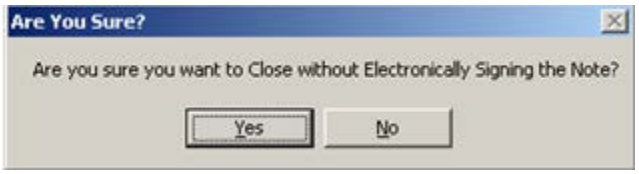


Figure 2-38: Are you Sure dialog box

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

Figure 2-39: Text of Message

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

2.14.6 Signing a Note (Roll and Scroll)

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

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

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

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

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

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

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

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

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

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

2.15 Login to GUI

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

Figure 2-43: Initial login dialog box

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

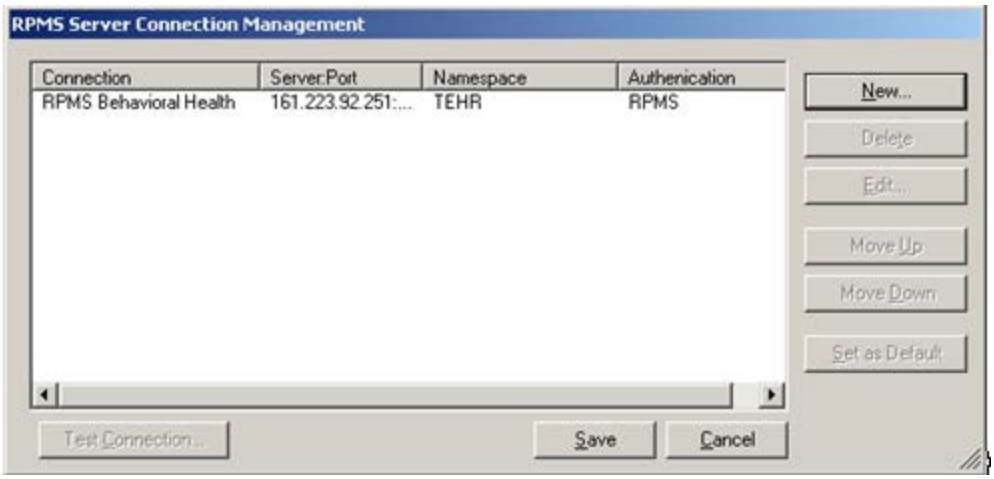


Figure 2-44: Sample RPMS Server Connection Management dialog box

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

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

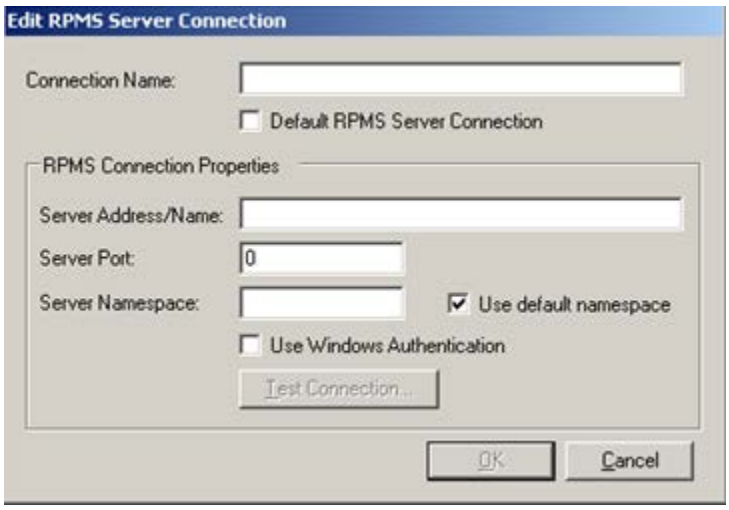


Figure 2-45: Sample Edit RPMS Server Connection dialog box

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

3. At the **Connection Name** field, type the name of the connection (your choice of words).

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

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

6. At the **Server Namespace** field, consider the following:

   If your site has multiple databases on one server, you will additionally need to type the namespace, which is typically a text string, e.g., DEVEH.

7. At the **Use default namespace** field, select this checkbox if the Server Namespace is the default one to use.

   After populating the above fields, the Test Connection button becomes active.

8. At the **Test Connection** field, click this button to display the **Test Login** dialog box.

   a. Populate the **Access Code** and **Verify Code** fields and then click **OK**.

   b. After clicking **OK**, if the connection is correct, the application displays the Connection Test message that states: RPMS login was successful.

   c. Otherwise, the application will display an error message. Click **OK** to return to the **Test Login** dialog box.

9. After the Edit RPMS Server Connection dialog box is complete, click **OK** (otherwise, click **Cancel**). The OK process saves the information, and this information displays on the **RPMS Server Connection Management** dialog box.

10. After the RPMS Server Connection Management dialog box is complete, click **Save** (otherwise, click **Cancel**).

11. After clicking **Save** on the **RPMS Server Connection Management** dialog box, the application displays the **IHS Behavioral Health System Login** dialog box.

Figure 2-46: Sample login dialog box

The designated server displays in the RPMS Server field.

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

    Do not use the field with the checkbox.

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

2.16 RPMS Behavioral Health System Tree

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

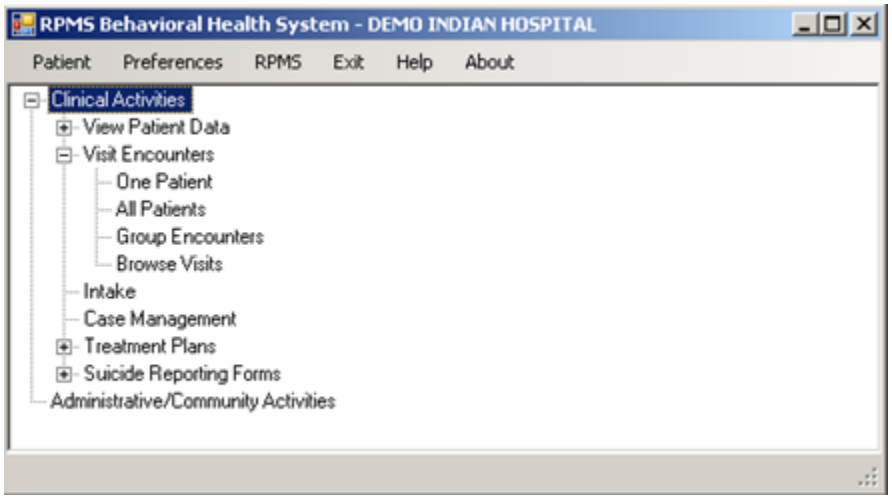


Figure 2-47: Tree structure for the RPMS Behavioral Health System

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

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

Patient Menu

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

Preferences Menu

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

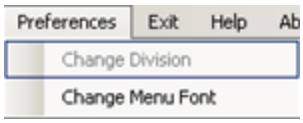


Figure 2-48: Menu options on the Preferences menu

1. At the **Change Division** field, select the Division to use. Use the **Change Division** option to change the **RPMS Division on the Select Division** dialog box. This option applies to a site that uses more than one RPMS database.

2. At the **Change Menu Font** field, to access the **Font** dialog box. Use this option to change the font on the tree structure.

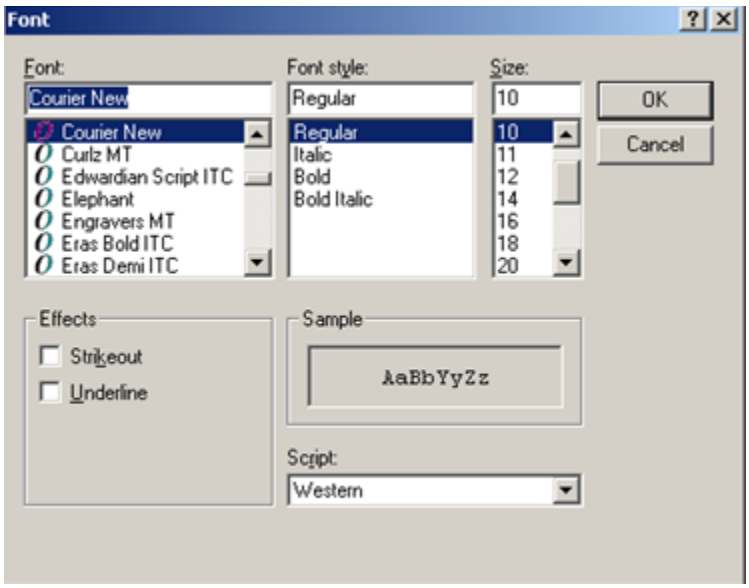


Figure 2-49: Font dialog box

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

   b. Change the Script option if you need to the see the text displayed in another language and you have that language pack installed on the machine you are using. If the language pack is not installed on your machine, the display does not change by selecting another script.

   c. Click **OK** to apply your changes to the text on the tree structure. (Otherwise, click **Cancel**.)

RPMS Menu

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

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

Exit Menu

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

Help Menu

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

About Menu

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

3.0 Data Entry

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

3.1 Roll and Scroll

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

```
            ********************************************
            **       IHS Behavioral Health System       **
            ********************************************
                          Version 4.0 (Patch 5)

                          DEMO INDIAN HOSPITAL


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

Select Behavioral Health Information System Option:  DE
```

Figure 3-1: Data Entry Module

The **DE** option has the following options

```
                  ********************************************
                  **       IHS Behavioral Health System       **
                  **             Data Entry Menu              **
                  ********************************************
                             Version 4.0 (patch 5)

                             DEMO INDIAN HOSPITAL


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

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

Figure 3-2: Data Entry menu

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

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

3.2 RPMS Behavioral Health System Graphical User Interface (GUI)

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

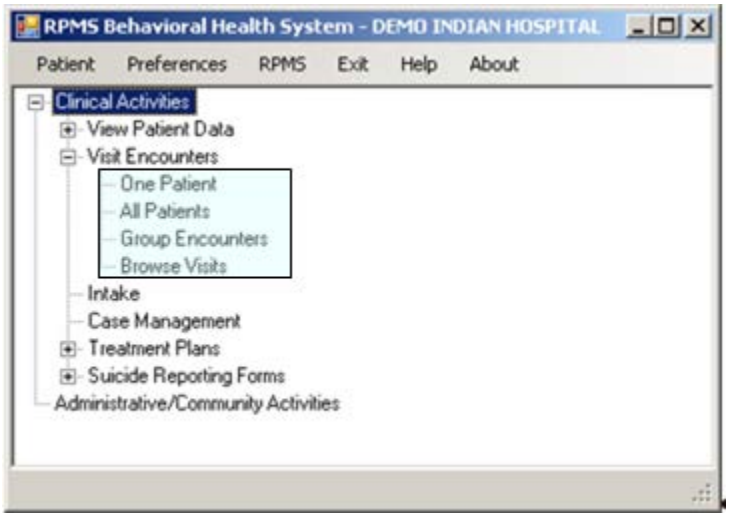


Figure 3-3: Location of Visit Encounters category on tree structure

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

4.0 One Patient Visit Data

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

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

```
            ********************************************
            **       IHS Behavioral Health System       **
            **             Data Entry Menu              **
            ********************************************
                        Version 4.0 (patch 5)

                            SELLS HOSPITAL


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

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

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

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

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

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

Follow these steps:

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

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

```
Ok? Yes//
```

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

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

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

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

Last Visit (excl no shows): OCT 29, 2015  BETAAAA,BJ  REGULAR VISIT
            F32.3     MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE WITH PSYCHOTIC
                      FEATURES
**********  LAST 6 AXIS V VALUES RECORDED.  (GAF SCORES)  **********
 04/20/2009  04/20/2009  04/22/2009  04/29/2009  05/01/2009  07/01/2009
     55          75          33          77          44          65
Pending Appointments:
                  Select the appropriate action   Q for QUIT
AV Add Visit              LD List Visit Dates       GS GAF Scores
EV Edit Visit             TP Treatment Plan Update  OI Desg Prov/Flag/Pers Hx
DR Display Record         CD Update Case Data       EH Edit EHR Visit
ES Edit SOAP              ID Intake Document        PPL Problem List Update
DE Delete Visit           AP Appointments           SN Sign Note
PF Print Encounter Form   HS Health Summary         TN TIU Note Display
LV Last BH Visit          DM Display Meds           MM Send Mail Message
BV Browse Visits          LA Interim Lab Reports    FS Face Sheet
Select Action: Q//    Q
```

Figure 4-3: Sample Patient Data Entry window

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

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

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

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

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

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

4.1.1 List Visit Dates (LD)

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

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

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

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

   If N was used, do the following:

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

   If D was used, do the following:

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

   If P was used, do the following:

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

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

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

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

TIU DOCUMENTS
-------------

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

Figure 4-4: Sample list of visit dates window

4.1.2 GAF Scores (GS)

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

1. At the "Select Action" prompt, type GS.
2. At the "Browse which subset of visits for patient" prompt, use one of the following:

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

If N was used, the following prompts display:

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

If D was used, the following prompts display:

a. At the “Enter Beginning Date of Visit” prompt, type the beginning date of the date range.

b. At the “Enter Ending Date of Visit” prompt, type the beginning date of the date range.

c. The GAF Scores window displays.

If A was used, the GAF Scores window displays.

If R was used, the following prompts display:

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

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

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

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

b. The GAF Scores window displays.

If P was used, the following prompts display:

a. At the “Which Program” prompt, type the program to be used.

b. The GAF Scores window displays.

4.1.3 Face Sheet (FS)

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

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


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

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

PREFERRED LANGUAGE:                              PREFERRED METHOD:
NUMBER IN HOUSEHOLD:          TOTAL HOUSEHOLD INCOME:  /
------------------------------------------------------------------------------
NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT : NO     DATE :
ACKNOWLEDGEMENT OF RECEIPT OF NPP SIGNED : NO
------------------------------------------------------------------------------
TRIBE: WHITE MOUNTAIN APACHE TRB, AZ              INDIAN QUANTUM: FULL
BIRTHPLACE:
RELIGION:                                        TRIBE ENROLL #: TN - 25480
------------------------------------------------------------------------------
FATHER: DEMO,ROGER                       BIRTHPLACE:
MOTHER: ENOS,LUPE V                      BIRTHPLACE:
------------------------------------------------------------------------------
EM CONTACT:
EM ADDRESS:
------------------------------------------------------------------------------
                       *** THIRD PARTY ELIGIBILITY ***

------------------------------------------------------------------------------
THE PATIENT IS ALSO REGISTERED AT:
2013 DEMO-3 TRIBAL CLINIC                CHART #: 146458
------------------------------------------------------------------------------
    ***  ELIGIBILITY FOR CARE: CHS & DIRECT  ***

                     *** CONFIDENTIAL PATIENT INFORMATION ***









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

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

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

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

Follow these steps.

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

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

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

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

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

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

4. The Update BH Forms window displays.

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

   1 BJB ALPHAA,CHELSEA M WW116431    60  16  F84.0     AUTISM SPECTRUM DISORDER
   2 BJB ALPHAA,CHELSEA M WW116431    30  13  F10.24    ALCOHOL-INDUCED BIPOLAR AND
   3 BJB ALPHAA,CHELSEA M WW116431    15  19  F42.      HOARDING DISORDER
*  4  JC ALPHAA,CHELSEA M 876543      60  13  F32.3     MAJOR DEPRESSIVE DISORDER, S
*  5  JC ALPHAA,CHELSEA M 876543      60  13  T43.205A  ANTIDEPRESSANT DISCONTINUATI
   6  DG ALPHAA,CHELSEA M WW116431    11  22  F32.1     MAJOR DEPRESSIVE DISORDER, S
   7  DG ALPHAA,CHELSEA M WW116431    20  15  F10.259   ALCOHOL-INDUCED PSYCHOTIC DI
   8  ST DEMO,DOROTHY ROS WW999999    1   99    97      ADMINISTRATIVE

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

Figure 4-6: Sample Update BH Forms window

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

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

4.2.1 Add Patient Visit (AV)

Use the AV option to add a patient visit.

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

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

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

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

Any Patient Education Done?  N      Any Screenings to Record? N
Any Measurements?  N                Any Health Factors to enter? N
Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Placement Disposition:
Visit Flag:      Local Service Site:
_____________________________________________________________________________
COMMAND:                                    Press <PF1>H for help    Insert
```

Figure 4-7: Sample Behavioral Health Visit Update screen

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

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

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

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

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

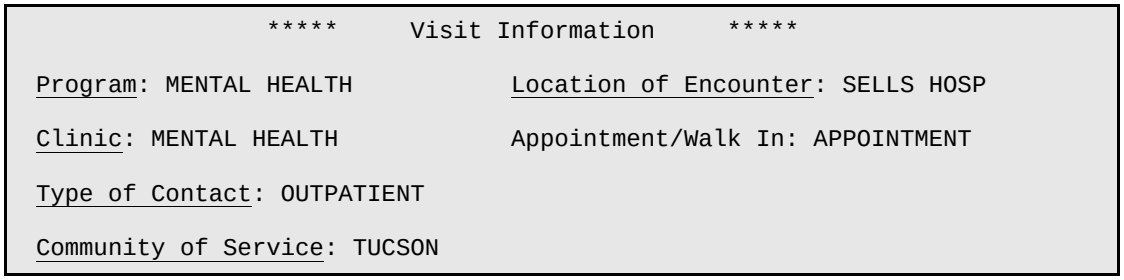


Figure 4-8: Sample Visit Information pop-up

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

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

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

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

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

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

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

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

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

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

   The underlined prompts are required.

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

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

7. At the “Chief Complaint/Presenting Problem” prompt, type the text of the chief complaint or presenting problem using 2 to 80 characters in length. This information describes the major reason the patient sought services.

8. At the “SOAP/Progress Note <press enter>” prompt, press Enter to access an input window. Populate it with the text of the note. You can enter the notes using any of the standard formats, such as SOAP, DAP, or Free Text.

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

```
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

Figure 4-10: Window to enter the note

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

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

9. At the "Comment/Next Appointment <press enter>" prompt, press Enter to access an input window. Populate it with the text of the comment about the next appointment. This field is not used for appointment scheduling.

10. At the "PURPOSE OF VISIT (POVS) <enter>" prompt, press Enter to access the Purpose of Visit Update pop-up.

```
     ******* 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:
```

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

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

a. At the "DIAGNOSIS: prompt, type the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-5 diagnostic code). Section Appendix C: provides more information about DSM copyright and trademark information.

b. At the "NARRATIVE" prompt, type the narrative for the diagnosis (using 2–80 characters) or use one of the coded narratives by specifying its number.

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

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

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

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


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

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

The underlined prompts are required.

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

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

```
QUANTITY: 1
MODIFIER:
MODIFIER 2:
```

Figure 4-13: Prompts for the code entered

c. At the “Quantity” prompt, type the number of CPT codes to use to help facilitate billing.

d. At the “Modifier” prompt, type the modifier for the CPT code. Up to two modifiers can be used. The modifier is a two-digit code.

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

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

13. At the “Activity Time” prompt, type the activity time, using any number between 1 and 9999 (no decimal digits). This is how much provider time was involved in

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

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

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

16. At the "Any Patient Education Done?" prompt, type **Y** (yes) or **N** (no).

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

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

 Display Patient Education History?  N

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

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

a. At the "Display Patient Education History?" prompt, type **Y** (yes) or **N** (no) to display the Behavioral Health and PCC patient education history. This is all education provided in the past 2 years by BH programs. This display is shown in the Output Browser window. You must Quit this window to return to prompts.

b. At the "EDUCATION TOPIC" prompt, type the education topic used at this encounter. For a complete list of the current Education Topics, use "?" at the prompt to view the whole list.

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

```
EDUCATION TOPIC: ABD-COMPLICATIONS

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

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

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

The underlined prompts are required.

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

d. At the “Individual/Group” prompt, type if the education is for an individual or for a group.

e. At the “Readiness to Learn” prompt, type one of the following:

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

f. At the “Level of Understanding” prompt, type the level of understanding. This is a required field. Use one of the following:

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

g. At the “Provider” prompt, type the name of the provider for the visit (can be changed). The default is the current logon user.

h. At the “Minutes” prompt, type the number of minutes spent on education, using any integer 1 - 9999.

i. At the “Comment” prompt, type any comments about the education topic for the visit, if any.

j. At the “Status (Goal)” prompt, type the status of the education, if any. Use one of the following:

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

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

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

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

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

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

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

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

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

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

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

a. At the “Display IPV/DV screening History?” prompt, type **Y** (yes) or **N** (no). If Y was used, the IPV/DV screening history displays on another screen. The display includes screenings entered in both BHS and PCC.

b. At the “IPV Screening/Exam Result” prompt, type the result of the intimate partner violence/domestic violence screening. Use one of the following:

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

c. At the “IPV Screening Provider” prompt, type the IPV/DV provider name.

d. At the “IPV Comment” prompt, type the text of any comment related to the IPV/DV screening, using 2–245 characters.

e. At the “Display Alcohol screening History?” prompt, type **Y** (yes) or **N** (no).

   If Y was used, the alcohol screening history displays on another screen. The display includes screenings entered in both BHS and PCC.

f. At the “Alcohol Screening Result: prompt, type the result of the alcohol screening. Use one of the following:

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

g. At the “Alcohol Screening Provider” prompt, type the provider name for the alcohol screening.

h. At the “Alcohol Screening Comment” prompt, type the text of any comment related to the alcohol screening, using 2–245 characters.

i. At the “Display Depression screening History?” prompt, type **Y** (yes) or **N** (no). If Y was used, the depression screening history displays on another screen.

j. At the “Depression Screening Result” prompt, type the result of the depression screening. Use one of the following:

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

k. At the “Depression Screening Provider” prompt, type the provider name for the depression screening.

l. At the “Dep Screening Comment” prompt, type the text of any comment related to the depression screening, using 2–245 characters.

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

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

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

```
      ***  Measurements  ***

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

Figure 4-17: Sample Measurements pop-up

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

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

a. At the "Measurement" prompt, type the type of measurement being taken on the patient. Then the application populates the Description field.

b. At the "Value" prompt, type the numeric value of the measurement. If you populate this field with a value outside the valid value range, the application provides information about what valid values can be used for the field.

c. At the "Provider" prompt, type the name of the provider.

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

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

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

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

 HEALTH FACTOR
```

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

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

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

```
LEVEL/SERVERITY

QUANTITY
```

```
COMMENTS
```

Figure 4-19: Other fields for health factor data

c. At the "Level/Severity" prompt, type **M** (Minimal), **MO** (Moderate), or **H** (Heavy/Severe).

d. At the "Quantity" prompt, type any integer between 0 and 99999.

e. At the "Comments" prompt, type any comments regarding the health factor.

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

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

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

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


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

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

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

Figure 4-20: Sample display of current medications

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

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

- Type **+** to display the new screen of information (does not apply to the last screen).
- Type **–** to display the previous screen of information (does not apply to the first screen).
- Type **Q** to exit the window. Focus moves to the next prompt.

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

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

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




<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

Figure 4-21: screen to enter medication

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

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

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

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

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

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

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

23. At the "Visit Flag" prompt, type the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You

can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

24. At the “Local Service Site” prompt, type the local service site.

4.2.2 Edit Record (EV)

Use the EV option to edit a particular visit.

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

   The Behavioral Health Record Edit window displays.

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




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

Figure 4-23: Sample Behavioral Health Record Edit window

The underlined fields are required.

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

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

4. At the “Location of Service” prompt, type where the service took place.
5. At the “Program” prompt, type the name of the program with which the provider is affiliated.

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

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

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




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

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

The underlined fields are required.

a. At the “PROVIDER” prompt, type the name of the service provider.

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

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

13. At the “Local Service Site” prompt, type the name of the local service site.

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

15. At the “Activity Time” prompt, type the number of minutes spent on the activity. This is how much provider time was involved in providing and documenting the service or performing the activity. Please note, 0 (zero) is not allowed as a valid entry.

16. At the “# Served” prompt, type the number served at the encounter, any integer between 0 and 999.

17. At the “Interpreter Utilized” prompt, type **Y** (yes) or **N** (no). Use Y only if an interpreter is required to communicate with the patient.

18. At the “Chief Complaint/Presenting Problem” prompt, type the text that describes the major reason the patient sought services.

19. At the “SOAP/PROGRESS NOTE” prompt, press Enter to access another window to populate with the text of the note. The note can be edited only if it is unsigned.

20. At the “Comment/Next Appointment” prompt, type the text of the comments about the next appointment.

21. At the “Medications Prescribed” prompt, press Enter to access another window where you enter the medications prescribed.

22. At the “Edit Purpose of Visits?” prompt, type **Y** (yes) or **N** (no). Use Y to access the Purpose of Visit Update pop-up.

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

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

The underlined fields are required.

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

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

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

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

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

```
Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:
```

Figure 4-26: Fields that define the prevention activities

The underlined prompts are required.

a. At the "Prevention Activities" prompt, type the prevention activity.

b. At the Target" prompt, type the target for the activity that can one of the following: **A** (Adult), **Y** (Youth), or **F** (Family).

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

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

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

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


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

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

The underlined fields are required.

a. At the "CPT Code" prompt, type the CPT Code. These E&M codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient.

b. More than one CPT Code can be used.

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

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

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

```
             ******* PATIENT HEALTH FACTOR UPDATE *******
Examples of health factors:  Tobacco Use, Alcohol 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 4-28: Sample Patient Health Factor Update pop-up.

a. At the "Display Health Factor History?" prompt, type **Y** (yes) or **N** (no). If Y was used, the health factor history displays on another screen.

b. At the "HEALTH FACTOR" prompt, type the health factor. The following pop-up displays where other data about the health factor can be specified.

```
LEVEL/SEVERITY

QUANTITY

COMMENTS
```

Figure 4-29: Fields for health factor data

c. At the “Level/Severity” type one of the following: **M** (minimal), **MO** (moderate), or **H** (heavy/severe).

d. At the “Quantity” prompt, type any number between 0 and 99999 (no decimal points).

e. At the “Comment” prompt, type the text of a comment related to the patient’s health factor.

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

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

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

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

 Display Patient Education History?  N

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

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

a. At the “Display Patient Education History?” prompt, type **Y** (yes) or **N** (no). Use Y to display all education provided in the last two years by BH programs. This history is displayed in the Output Browser window.

b. At the “EDUCATION TOPIC” prompt, type the education topic name. The following pop-up displays where you enter data about the education topic:

```
EDUCATION TOPIC: ABD-COMPLICATIONS

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

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

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

The underlined fields are required.

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

d. At the “Individual/Group” prompt, type if the education is for an individual or for a group.

e. At the “Readiness to Learn” prompt, type one of the following:

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

f. At the “Level of Understanding” prompt, type the level of understanding. Use one of the following:

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

g. At the “Provider” prompt, the name of the provider for the visit (can be changed). The default is the current logon user.

h. At the “Minutes” prompt, type the number of minutes spent on education, using any integer 1 - 9999.

i. At the “Comment” prompt, type the text of any comments about the education topic for the visit, if any.

j. At the “Status (Goal)” prompt, type the status of the education, if any. Use one of the following:

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

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

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

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

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

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

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

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

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

a. At the "Display IPV/DV screening History?" prompt, type **Y** (yes) or **N** (no). If you use Y, the IPV/DV screening history displays on another screen.

b. At the "IPV Screening/Exam Result" prompt, type the result of the intimate partner violence/domestic violence screening. Use one of the following:

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

c. At the "IPV Screening Provider" prompt, type the IPV/DV provider name.

d. At the "IPV Comment" prompt, type the text of any comment related to the IPV/DV screening, using 2–245 characters.

e. At the "Display Alcohol screening History?" prompt, type **Y** (yes) or **N** (no). If Y was used, the alcohol screening history displays on another screen.

f. At the "Alcohol Screening Result" prompt, type the result of the alcohol screening. Use one of the following:

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

g. At the “Alcohol Screening Provider” prompt, type the provider name for the alcohol screening.

h. At the “Alcohol Screening Comment” prompt, type the text of any comment related to the alcohol screening, using 2–245 characters.

i. At the “Display Depression screening History?” prompt, type **Y** (yes) or **N** (no). If Y was used, the depression screening history displays on another screen.

j. At the “Depression Screening Result” prompt, type the result of the depression screening. Use one of the following:

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

k. At the “Depression Screening Provider” prompt, type the provider name for the depression screening.

l. At the “Dep Screening Comment” prompt, type the text of any comment related to the depression screening, using 2–245 characters.

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

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

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

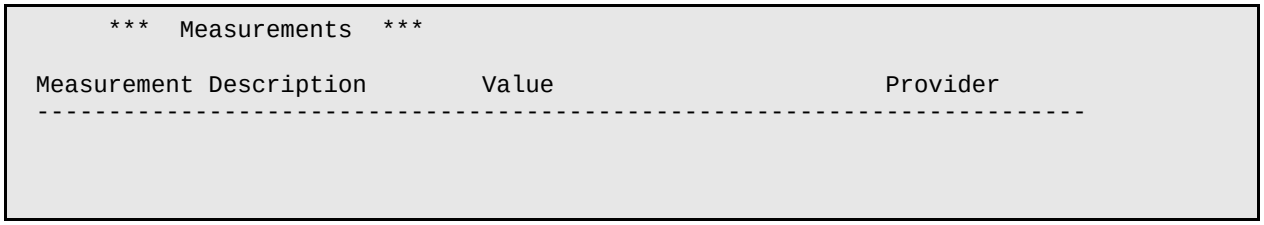


Figure 4-33: Sample Measurements pop-up

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

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

c. At the “Provider” prompt, type the name of the provider.

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

29. At the “Placement Disposition” prompt, type the placement disposition. This is a required field used when hospitalization or placement in a treatment facility is required.

30. At the “Referred to” prompt, type the name of the facility, using 2-30 characters in length. This field is required when the Placement Disposition is populated.

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

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

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

The Other Information window displays.

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


Update, add or append any of the following data

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

Figure 4-34: Other Information window

Use Option 10 to exit the Other Information window.

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

- If there was not an appointment the patient was checked in for using the scheduling package, you return to the previous window.
- If there was an appointment the patient was checked in for using the scheduling package, the application displays more prompts. Please note the following about these prompts:

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

Below are the prompts for linking:

```
Generating PCC Visit.


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

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

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

Figure 4-35: Continuing prompts

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

```
------------------------------------------------------------------------------
Date of Encounter:  Tuesday  MAR 09, 2010      * unsigned note
------------------------------------------------------------------------------
 #  PRV PATIENT NAME         HRN      LOC  ACT PROB      NARRATIVE
   1  BJB BETAA,EMILY MAE WW129608    WW   11  F84.0     AUTISM SPECTRUM DISORDER
   2  BJB BETAA,EMILY MAE WW129608    WW   11  F10.24    ALCOHOL-INDUCED BIPOLAR AND
   3  BJB SIGMAAA,DAVID R WW145072    WW   12  F42.      HOARDING DISORDER




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

```
DE   Delete Record        EH   Edit EHR Record      Q    Quit
```

Figure 4-36: Prompts that continue

Below is how the record looks in the BH application:

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

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


SUBJECTIVE/OBJECTIVE: TEST

COMMENT/NEXT APPOINTMENT:
TEST

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:


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

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

Note already signed, no E Sig necessary.
```

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

Figure 4-37: Display Record information

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

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

Update, add or append any of the following data

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

Figure 4-38: Other information screen

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

4.2.3 Display Record (DR)

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

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

   The BH VISIT RECORD DISPLAY window displays.

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

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

=============== BH RECORD FILE ===============
DATE OF SERVICE:       MAR 26, 2009@09:00
PROGRAM:               MENTAL HEALTH
LOCATION OF ENCOUNTER: SELLS HOSP
COMMUNITY OF SERVICE:  TUCSON
PATIENT:               ALPHA,GLEN DALE
PT AGE:                37
CLINIC:                MENTAL HEALTH
```

```
APPT/WALK-IN:          APPOINTMENT
POSTING DATE:          MAR 03, 2014
WHO ENTERED RECORD:    GARCIA,RYAN
DATE LAST MODIFIED:    MAR 04, 2014
USER LAST UPDATE:      THETA,SHIRLEY
DATE/TIME LAST MODIFI: MAR 04, 2014@12:15:16
EDIT HISTORY:
  Mar 03, 2014 3:27 pm       GARCIA,RYAN
EXTRACT FLAG:          ADD
CREATED BY BH?:        YES
CHIEF COMPLAINT:       major pain in left arm


SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:


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

Figure 4-39: Sample BH Visit Record Display window

4.2.4 Delete Record (DE)

Use the DE option to delete a particular record.

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

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

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

4.2.5 Print Encounter Form (PF)

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

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

3. At the "What type of form do you want to print" prompt, type the form type you want to print. Use one of the following:

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

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

4. At the "DEVICE" prompt, type the device to output the data.

Below is the data for a suppressed encounter form.

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

  S/O/A/P:
  Behavioral Health Visit



                                            Feb 23, 2009@12:00      Page 2

  See GAMMAAA,DENISE for details.
_______________________________________________________________________________

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

```
       F42.        HOARDING DISORDER


_____________________________________________________________________________

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

Figure 4-40: Sample Suppressed Encounter Form

4.2.6 Health Summary (HS)

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

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

   The PCC Health Summary for the patient displays.

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


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

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

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

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

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

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


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


                        NO ALLERGY INFORMATION RECORDED

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

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

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

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

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


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


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

Figure 4-41: Sample Health Summary for the patient

4.2.7 SOAP.CC Edit (ES)

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

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

      If N was used, the other prompts continue.

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

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

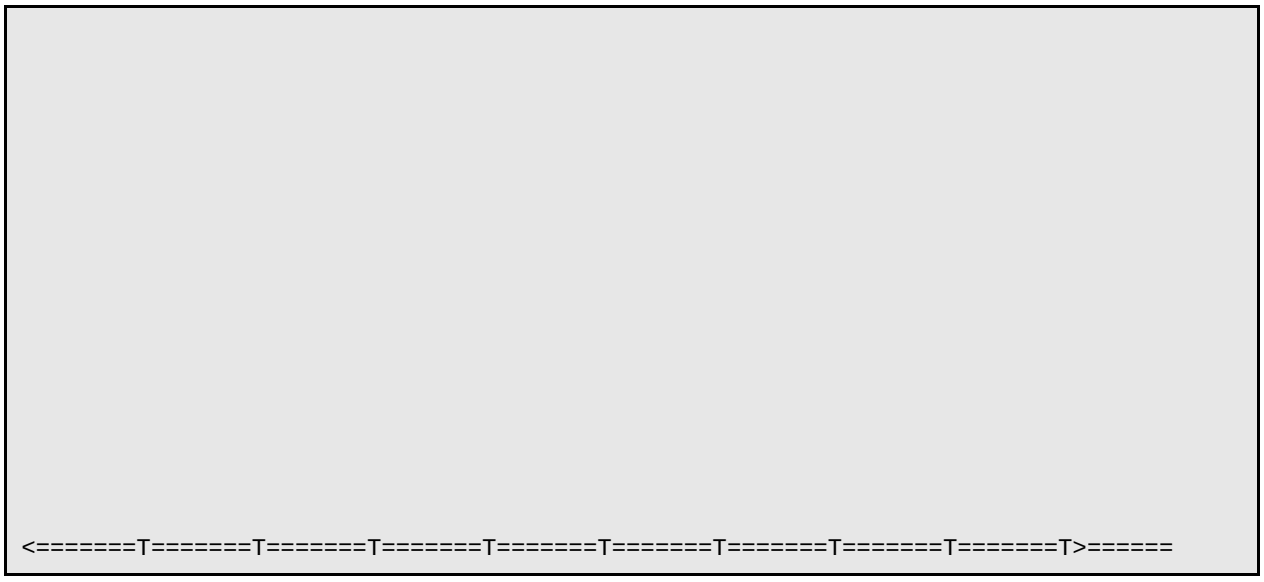


Figure 4-42: Window to enter the note

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

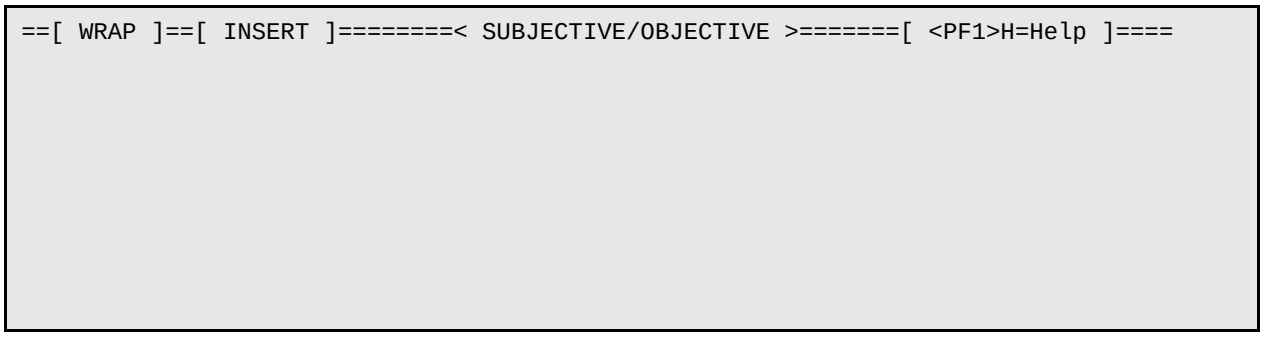
What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

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

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

      If N was used, the other prompts continue.

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



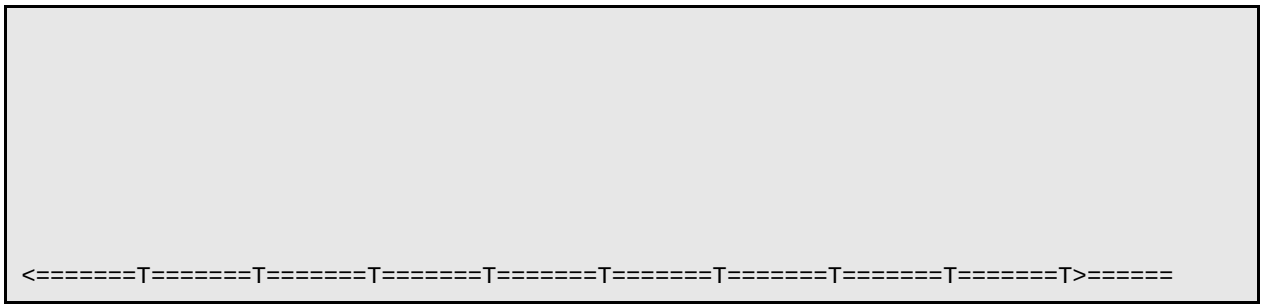


Figure 4-43: Window to enter the note

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

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

6. At the "MEDICATIONS PRESCRIBED - No existing text" if there is existing text, it appears below the MEDICATIONS PRESCRIBED prompt. You can edit this text (just like entering new note).

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

      If Y was used, you access another window where you can edit the text of the MEDICATIONS PRESCRIBED note.

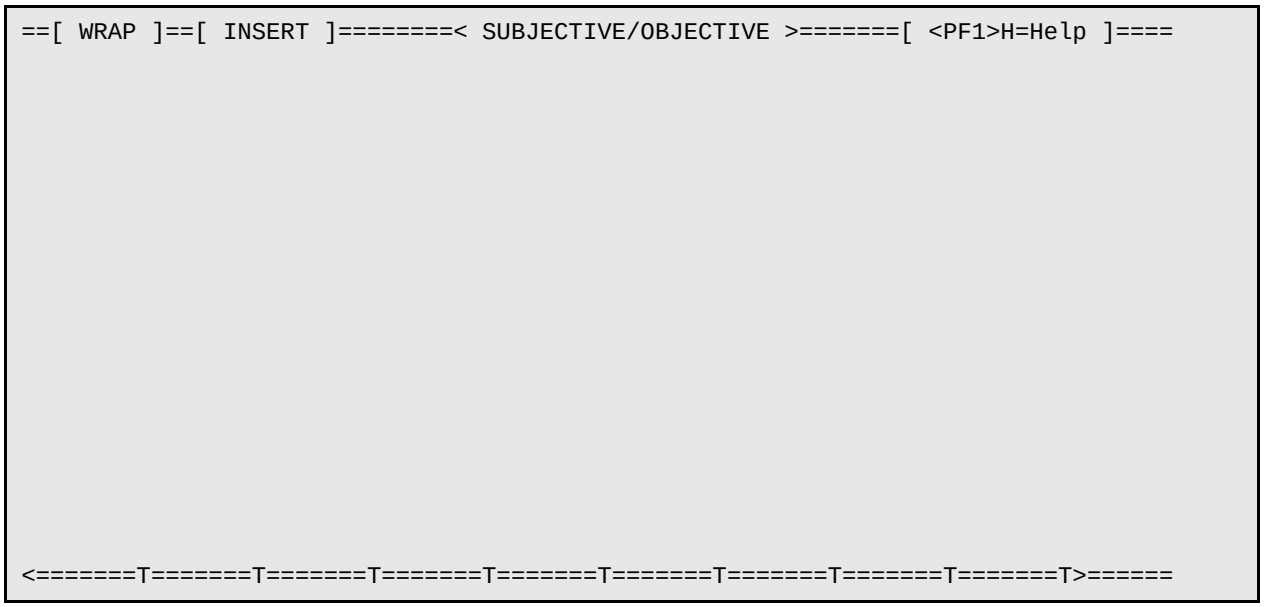


Figure 4-44: Window to enter the note

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

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

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

4.2.8 Switch Dates (SD)

Use the SD option to

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

   The application changes the date of the encounter.

4.2.9 Edit EHR Visit (EH)

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

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

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

```
        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):
```

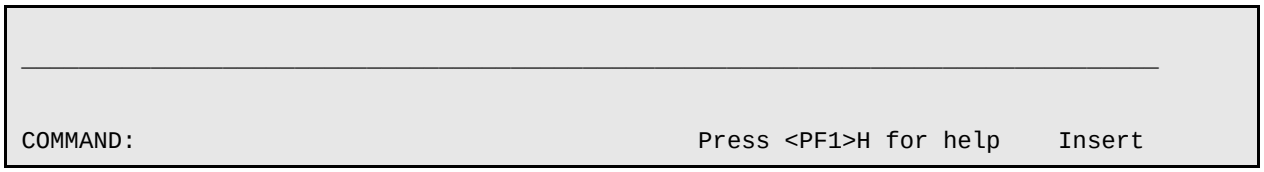


Figure 4-45: Sample information about editing a BH visit entered through the EHR.

The underlined fields are required.

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

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

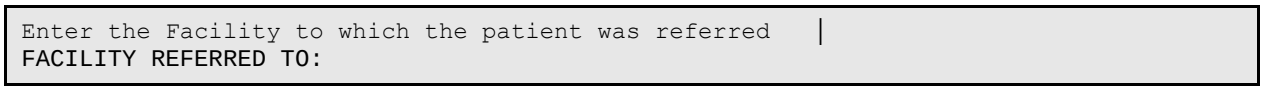
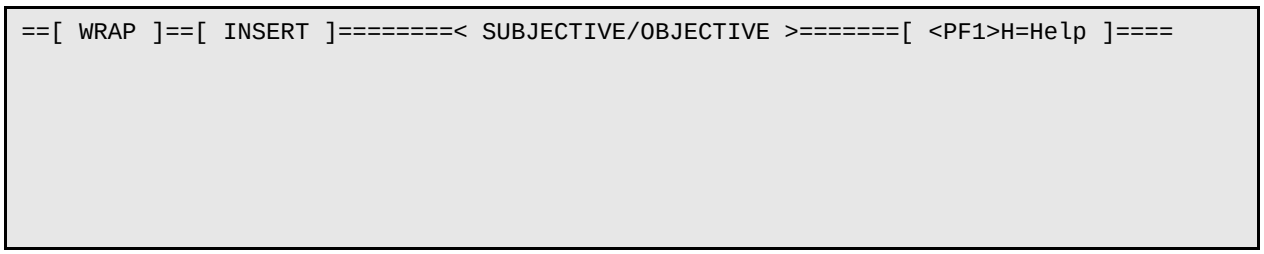


Figure 4-46: Pop-up window asking for facility referred to

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

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

7. At the “Interpreter Utilized” prompt, type **Y** (yes) or **N** (no). This indicates if an interpreter was used in the visit. Use Y if an interpreter was required to communicate with the patient.
8. At the “Comment/Next Appt (press Enter)” prompt, press Enter to access another window where you can populate the field with the text of a comment about the next appointment.



```
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

Figure 4-47: Window to enter the note

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

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

9. At the "Local Service Site" prompt, type the local service site for the visit.

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

4.2.10 Sign Note (SN)

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

1. At the "Select Action" prompt, type **SN**.

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

```
------------------------------------------------------------------------------
            Behavioral Health visits for ALPHA,CHELSEA MARIE
------------------------------------------------------------------------------
 #     PROVIDER   LOC  DATE      ACT CONT PATIENT      PROB    NARRATIVE
```

```
-------------------------------------------------------------------------------
1    THETA,SHIRLE WW   05/12/2009    OUTP WW 116431    F42.    HOARDING DISORDER
```

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

The prompts continue.

2. At the "Which record do you want to display" prompt, type the number of the record you want to use.

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

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

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

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

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

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

4.2.11 Display TIU Note (TN)

Use the TN option to display a particular TIU note.

1. At the "Select Action" prompt, type **TN**.
2. At the "Display Note for Which Record" prompt, type the number of the record to use.
3. The contents of the specified note displays.

4.3 Display Record Options (DSP)

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

4.4 Visit Window (GUI)

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

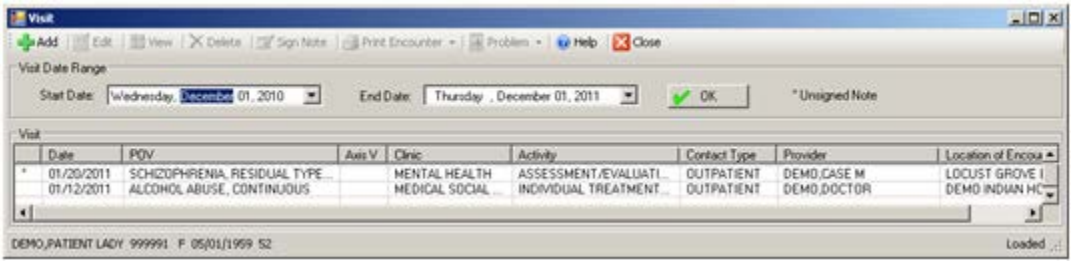


Figure 4-49: Visit window for one patient

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

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

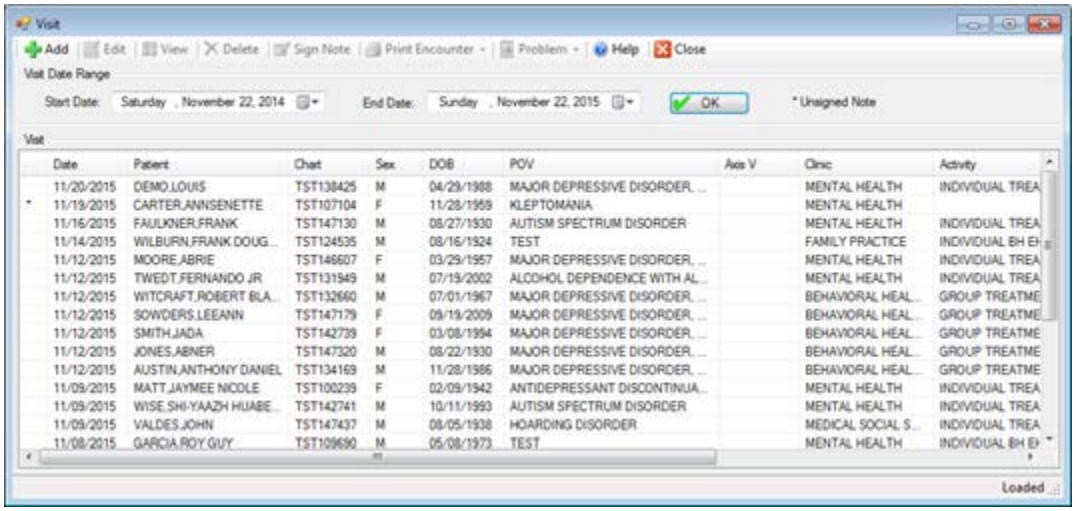


Figure 4-50: Sample Visit window for all patients

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

The following are features of both windows.

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

Feature	Functionality
Visit Window for One Patient	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 list 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).
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.
Visit List Box	The **Visit** list 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. See section 2.14.5 Signing a Note (GUI) for more information.
Add Button	Establish the patient you want to use in the add process. Use the **Add** button to add a new Visit record. You access the **Visit Data Entry - Add Visit** dialog box.
Edit Button	Use the **Edit** button to edit a particular Visit record. You access the **Visit Data Entry - Edit Visit** dialog box.
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 box, except for the Intake and **Suicide Form** tabs.
Delete Button	Use the **Delete** button to delete a particular Visit record. The application confirms the deletion. **Note** that Visit records with a signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.
Sign Note Button	Use the **Sign Note** button to sign the note of an "unsigned" record (asterisk (*) in the first column).
Problem Button	Select a record and then click the **Problem** button to access either a **BH Problem List** or the **PCC Problem** list.

Feature	Functionality
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.
Problem Button	Select a visit and then click the **Problem** button to manage the patient's Behavioral Health and PCC problems.
Help Button	Use the **Help** button on the Visit window to access the online help for the window.
Close Button	Use the **Close** button on the Visit window to exit the window.

4.5 Add/Edit Visit Data Entry

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

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

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

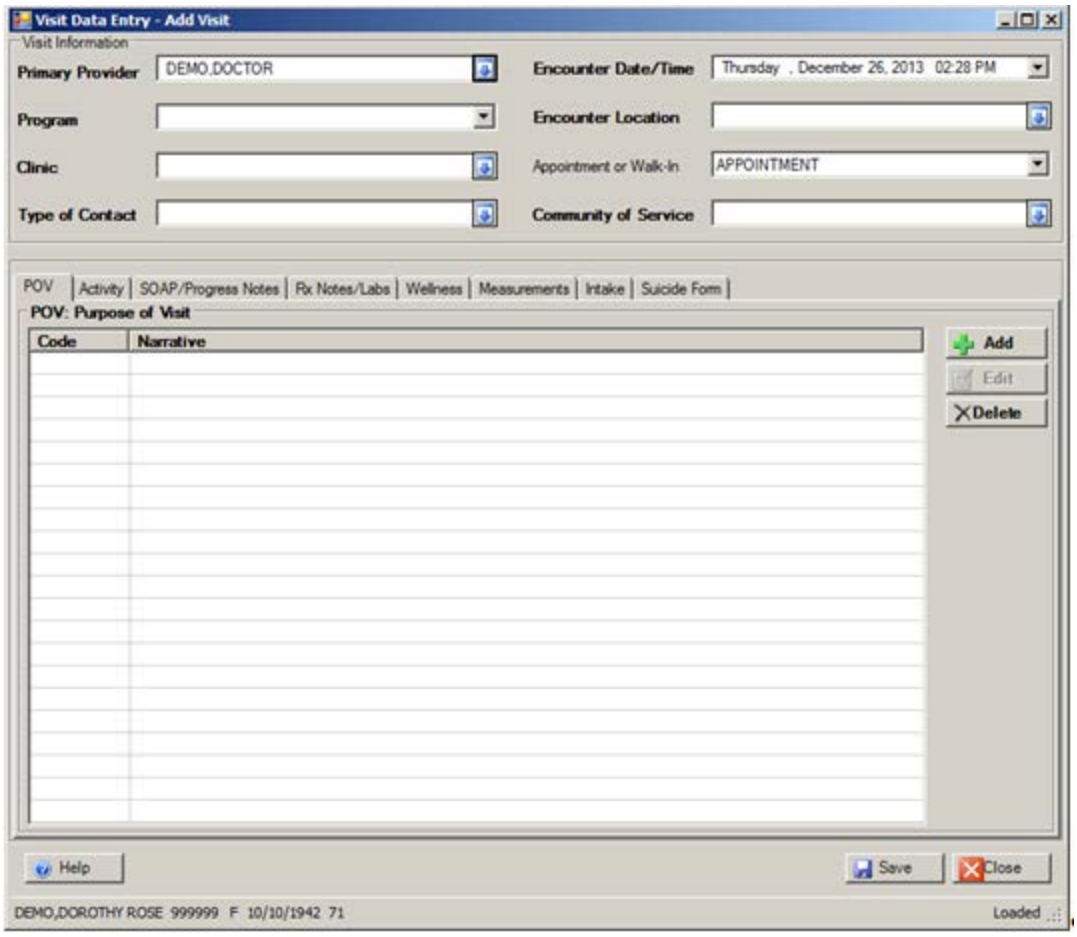


Figure 4-51: Sample Visits Data Entry - Add Visit window

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

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

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

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

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

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

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

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

4.5.1 Visit Information Group Box

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

Figure 4-52: Sample Visit Information group box

The fields in bold text are required.

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

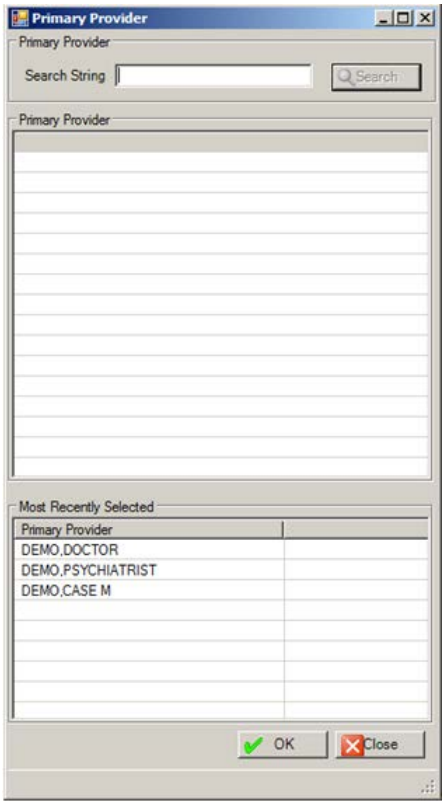
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the Provider list box. Select a retrieved record and click **OK** to populate the Provider field.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

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

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

3. At the **Program** field, select the program associated with the visit from the drop-down list.

   Mental health

   Social services

   Other

   Chemical Dependency

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

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

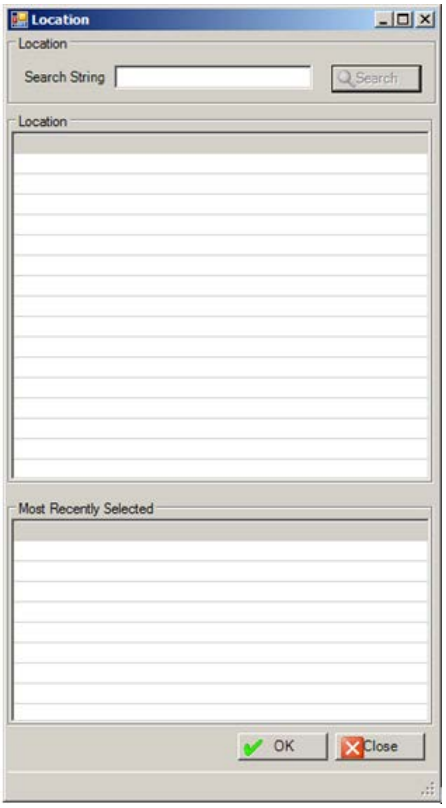
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the location and then clicking **Search**. The retrieved locations will populate the Location list box. Select a location and click **OK** to populate the Encounter Location field. (Otherwise,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

Figure 4-54: Sample Location search window

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

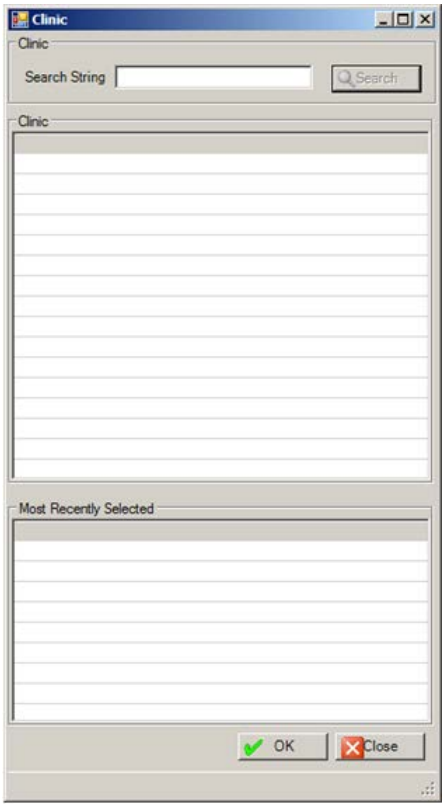
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the clinic and then clicking **Search**. The retrieved clinics and their codes will populate the Clinic list box. Select a clinic and click **OK** to populate the Clinic field. (Otherwise,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

Figure 4-55: Sample Clinic search window

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

   Appointment

   Walk In

   Unspecified (for non-patient contact)

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

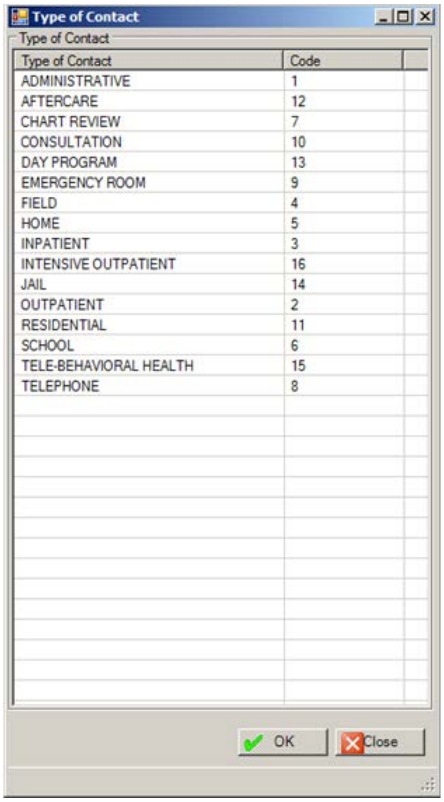
Screen Capture	What to do
	Use this window as follows: (1) Select a type of contact from the list. (2) Click **OK** to populate the "Type of Contact" field. (Otherwise, click **Close.**)

Figure 4-56: Sample Type of Contact window

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

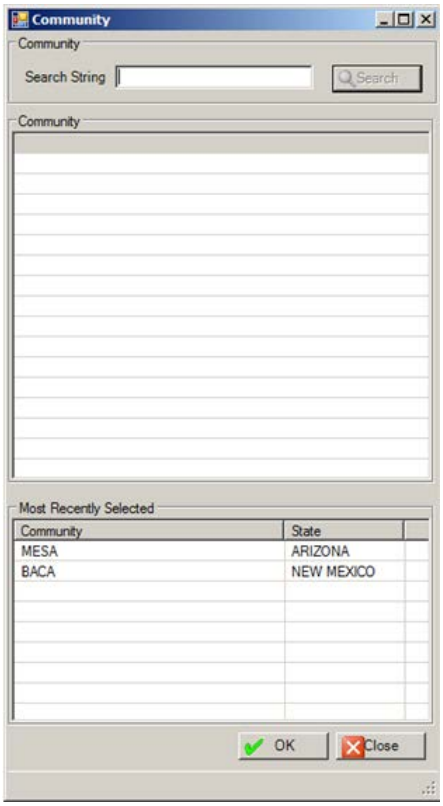
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and then clicking **Search**. The retrieved community names and their states will populate the Community list box. Select a community and click **OK** to populate the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

Figure 4-57: Sample Community search window

4.5.2 POV Tab

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

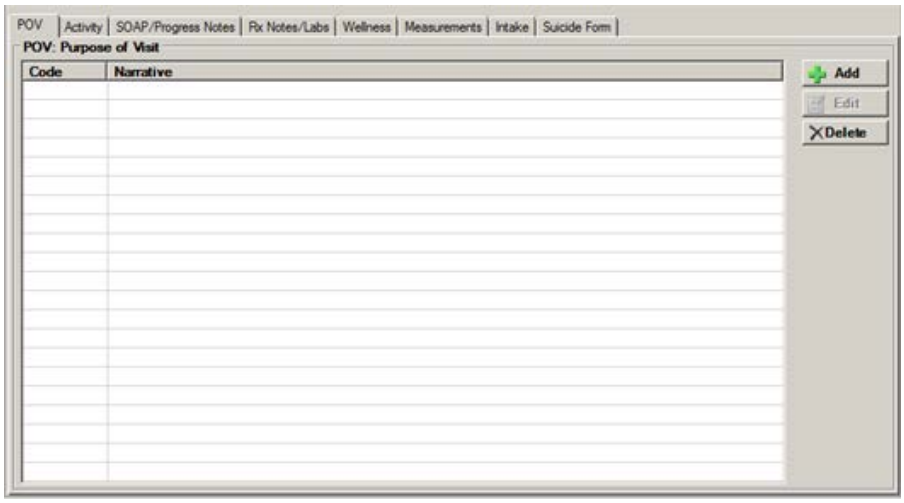


Figure 4-58: Sample POV Tab on Visit Data Entry window

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

Add Button

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

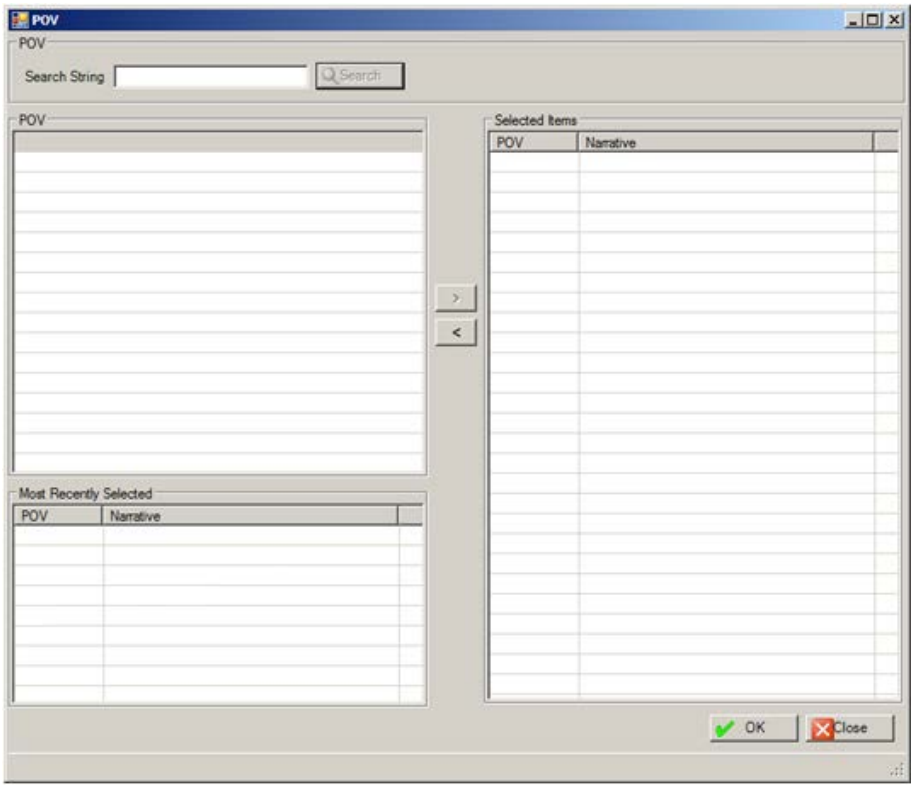


Figure 4-59: Sample POV search/select window

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

Delete Button

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

Edit Button

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

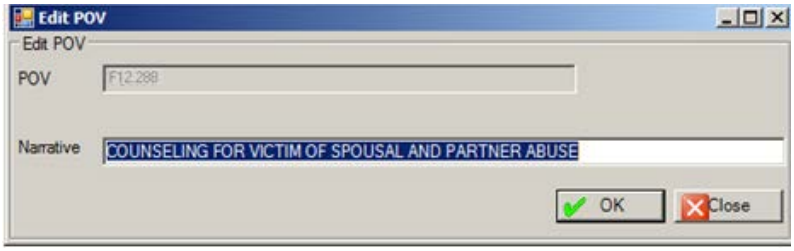


Figure 4-60: Edit POV dialog box

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

4.5.3 Activity Tab

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

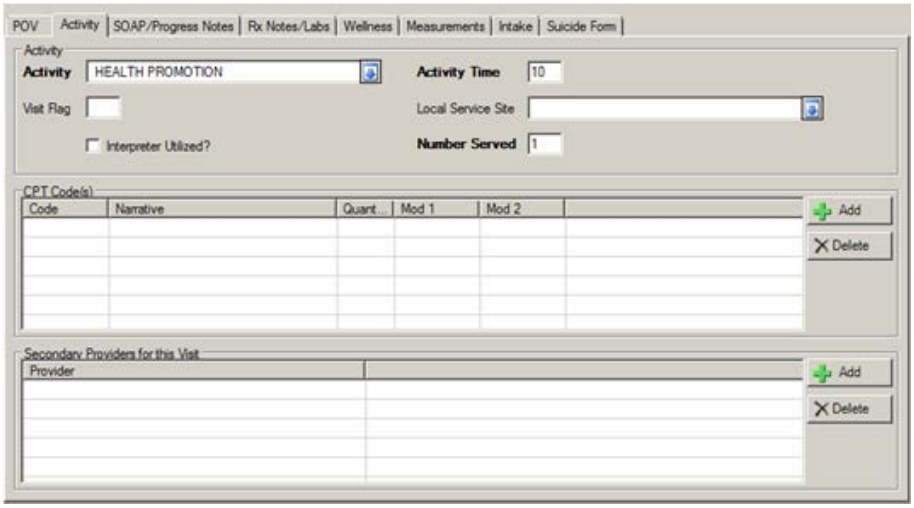


Figure 4-61: Sample Activity Tab on the Visit Data Entry window

Activity Group Box

Below is the **Activity** group box.

Figure 4-62: Sample Activity group box

The fields in bold text are required.

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

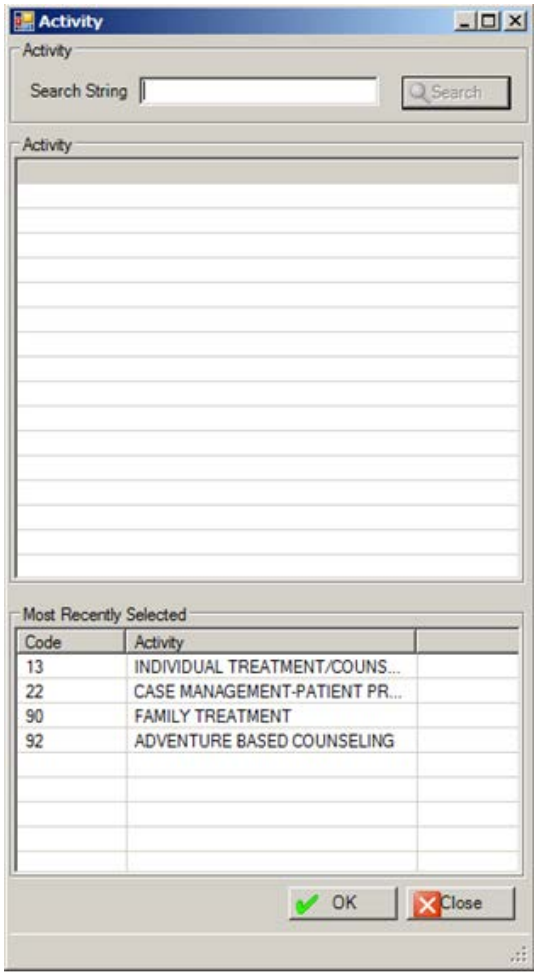
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the activity name and then clicking **Search**. The retrieved activity code and activity name will populate the Activity list box. Select a retrieved record and click **OK** to populate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

Figure 4-63: Sample Activity search window

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

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

4. At the **Local Service Site** field, select the local service site. Click the drop-down list to access the **Local Service Site** window.

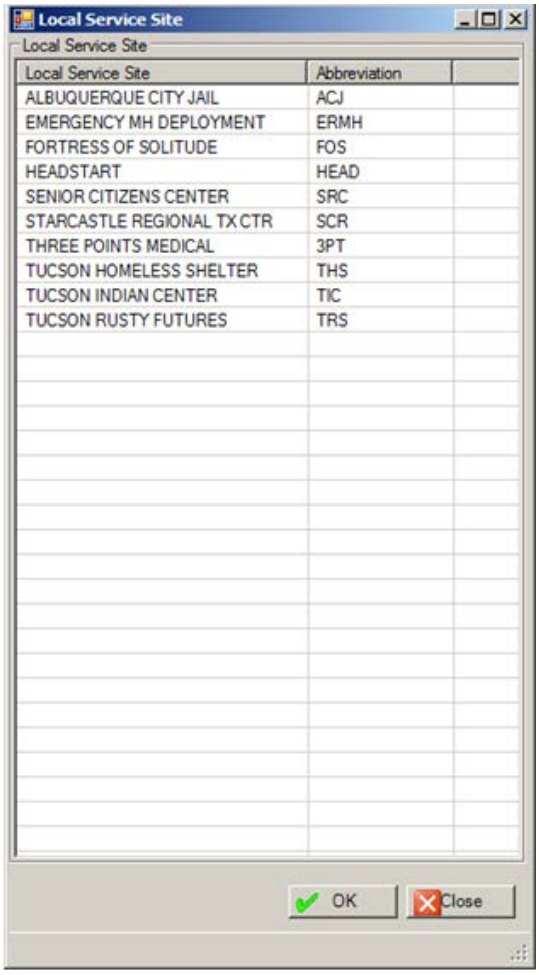
Screen Capture	What to do
	Use this dialog box in one of two ways: (1) Select a local service site from the list. (2) Click **OK** to populate the "Local Service Site" field. (Otherwise, click **Close**.)

Figure 4-64: Sample Local Service Site window

5. At the **Interpreter Utilized?** field, select this check box if an interpreter is required to communicate with the patient.

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

CPT Codes Group Box

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

You can add or delete records in this group box.

Delete Button

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

Add Button

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

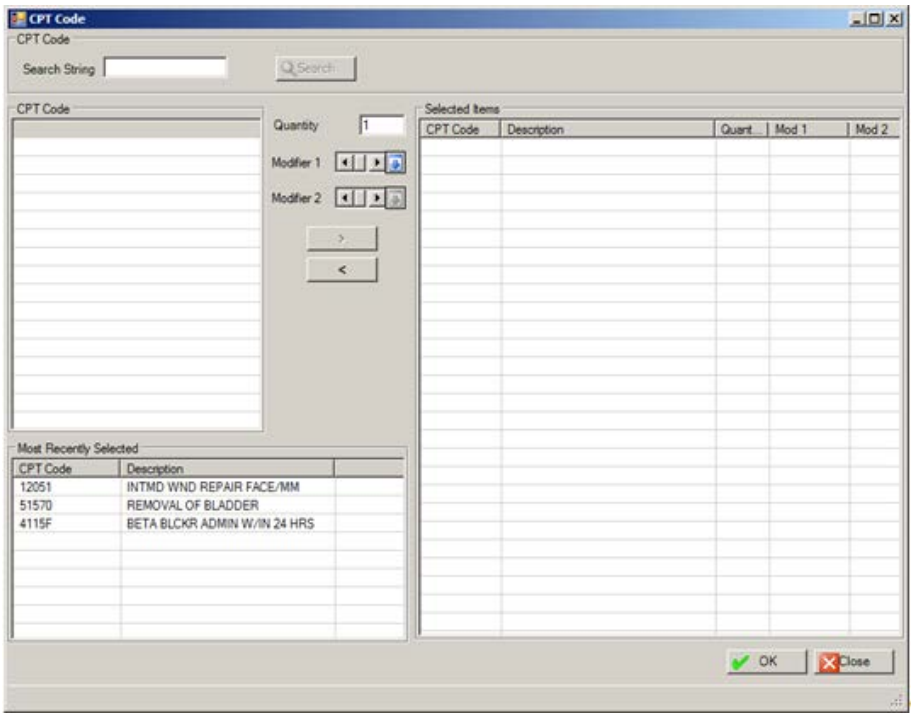


Figure 4-65: Sample CPT Codes search/select window

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

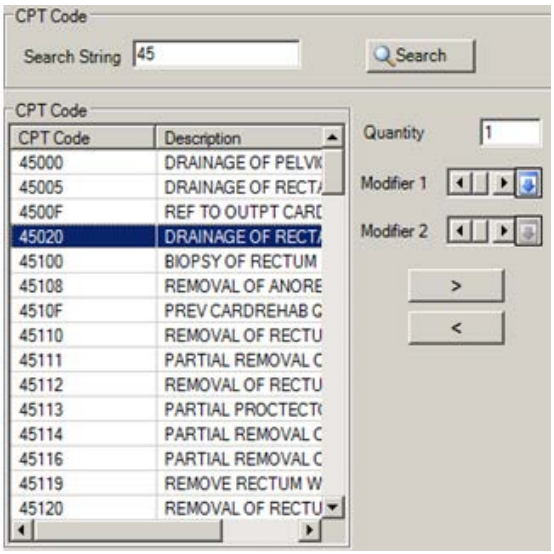


Figure 4-66: Sample CPT Code search results

a. Select a retrieved CPT Code.

b. At the **Quantity** field, type the number of CPT codes to use to help facilitate billing.

c. At the **Modifier** field, select the modifier for the CPT code. Click the drop-down list to access the **CPT Modifier** search window.

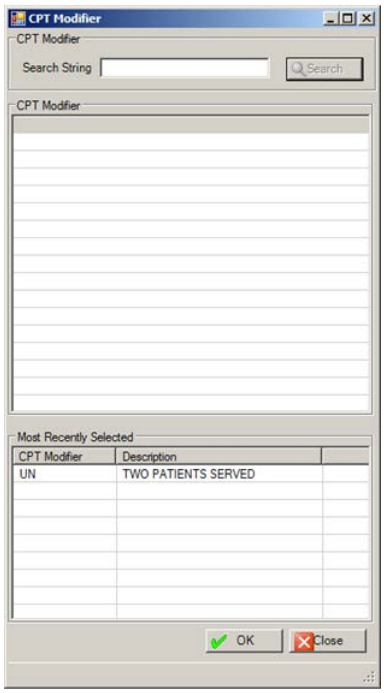
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the CPT Modifier name and then clicking **Search**. The retrieved CPT Modifier names and their descriptions will populate the CPT Modifier list box. Select a CPT modifier and click **OK** to save the modifier. (Otherwise, click **Close**.) (2) Select a CPT modifier in the Most Recently Selected list box and click **OK** to save the modifier. (Otherwise, click **Close**.)

Figure 4-67: Sample CPT Modifier search window

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

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

5. Another way to populate the **Selected Items** list box is to select a CPT code in the **Most Recently Selected** list box and then click the right-pointing arrow.

6. Remove a selected CPT code in the **Selected Items** list box by clicking the left-pointing arrow.

7. When the Selected Items list box is complete, click **OK** to save the data and add it to the CPT Code(s) group box. (Otherwise, click **Close**.)

Secondary Provides for this Visit Group Box

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

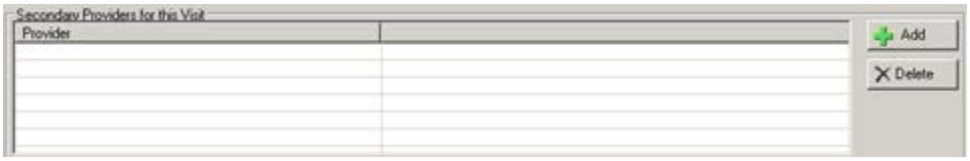


Figure 4-68: Sample Secondary Providers for this Visit group box

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

Add Button

1. Click **Add**.

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

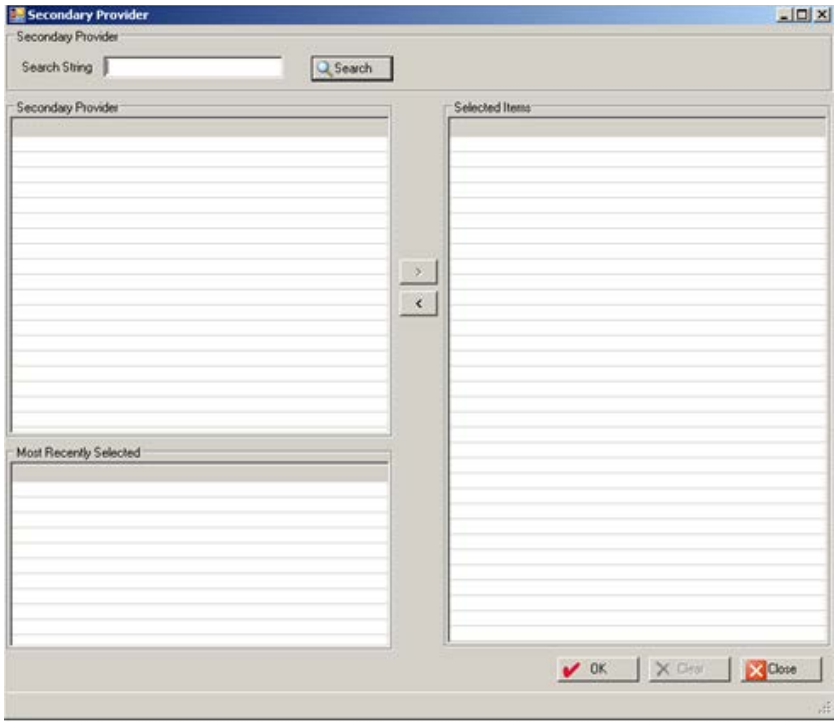


Figure 4-69: Sample Secondary Provider multiple search/select window

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

Delete Button

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

4.5.4 SOAP/Progress Notes Tab

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

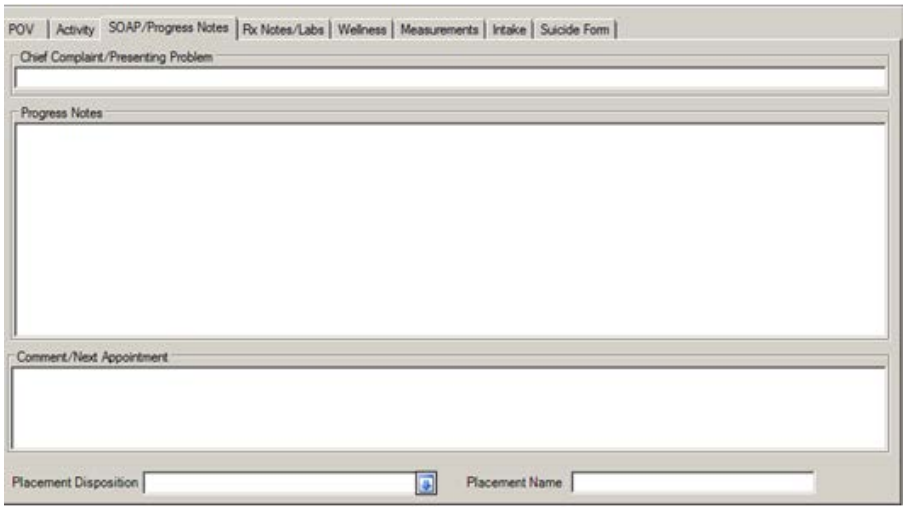


Figure 4-70: Sample SOAP/Progress Notes tab

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

1. At the **Chief Complaint/Presenting Problem** field, type the chief complaint or presenting problem using 2 to 80 characters in length. This is a Free Text field that describes the major reason the patient sought services.

2. At the **Progress Notes** field, type the text of the progress note for the visit. A SOAP or progress note must be entered in the context of a visit. This is a Free Text field.

3. At the **Comments/Next Appointment** field, type the text of any additional notes or comments about the client's next appointment. This is a Free Text field.

4. At the "Placement Disposition" field, select the placement disposition.

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

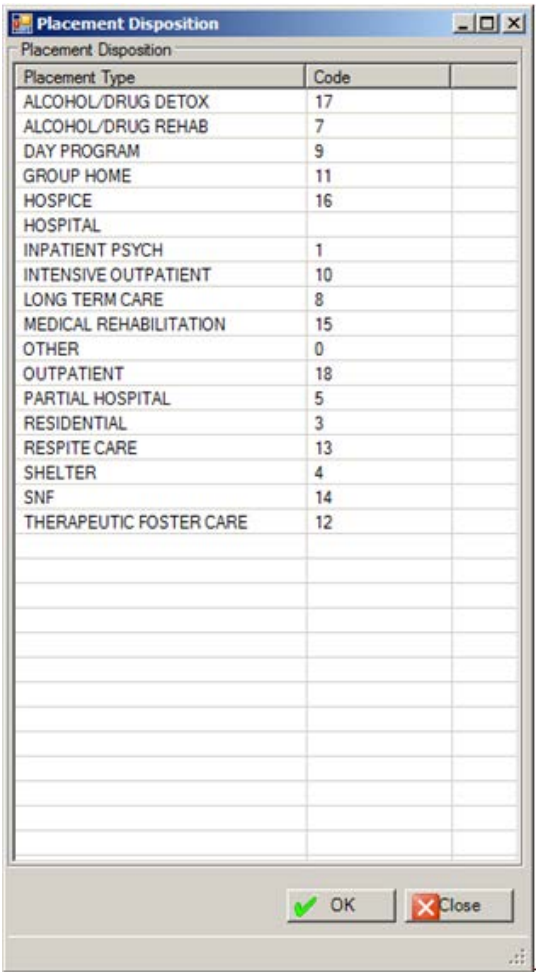
Screen Capture	What to do
	Use this dialog box in one of two ways: (1) Select a Placement Type. (2) Click **OK** to populate Placement Disposition field. (Otherwise, click **Close**.)

Figure 4-71: Sample Placement Disposition dialog box

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

4.5.5 Rx Notes/Labs Tab

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

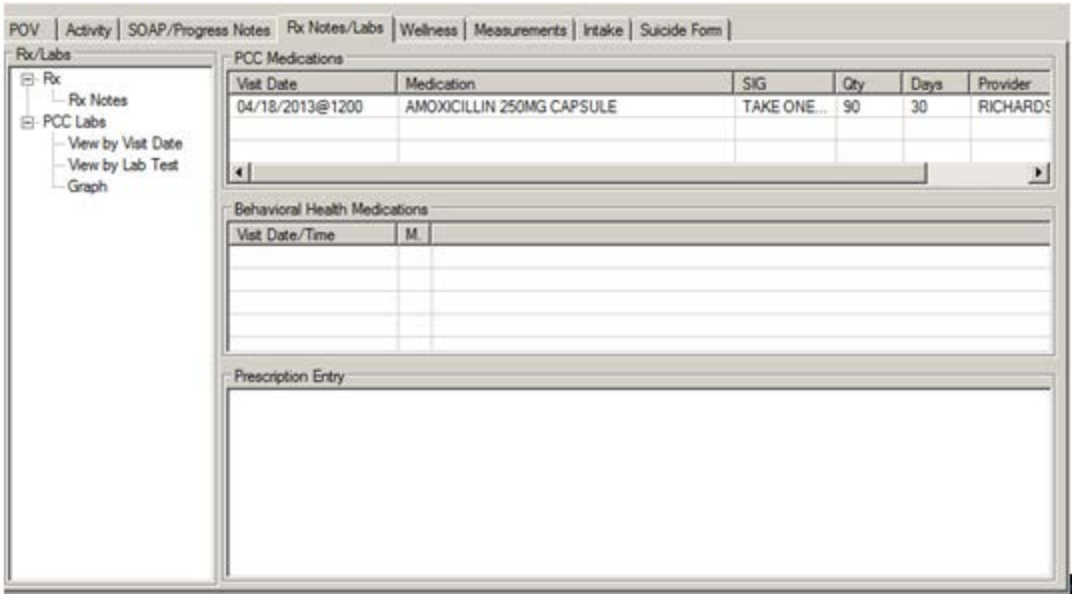


Figure 4-72: Sample Rx Notes/Labs tab

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

RX Data

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

PCC Medications List Box

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

Behavioral Medication List Box

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

Prescription Entry Field

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

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

PCC Labs

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

View by Visit Date

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

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

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

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

You can edit either or both dates.

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

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

View by Lab Test

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

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

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

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

You can edit either or both dates.

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

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

Graph

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

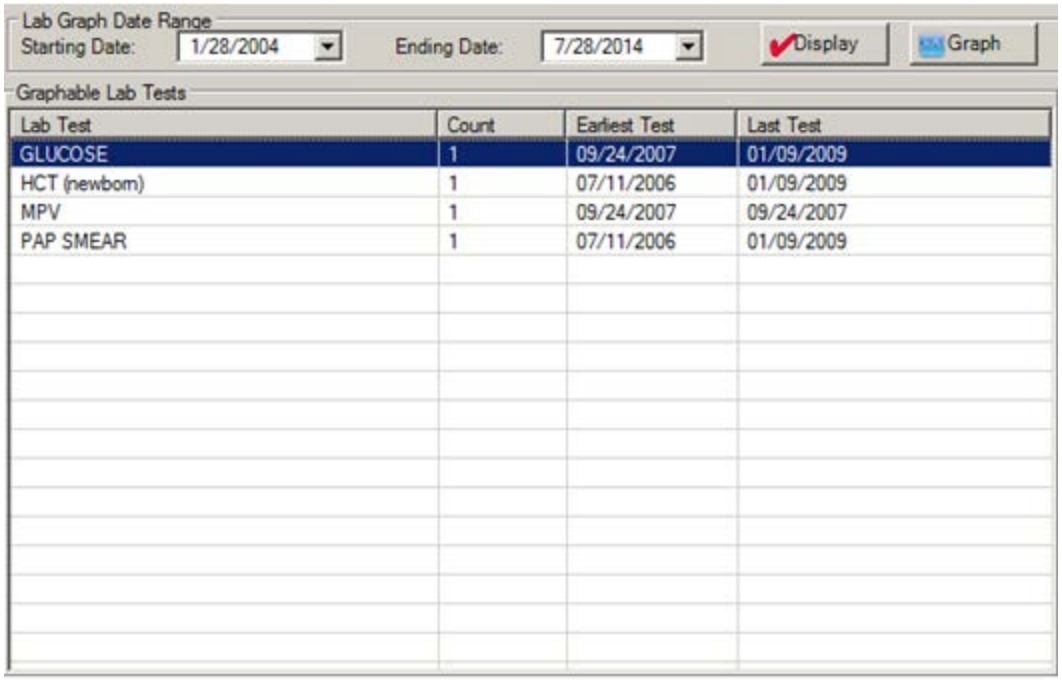


Figure 4-75: Sample group boxes for Graph option

Lab Graph Date Range

The default date range is one year. This date range determines the data displayed in the **Graphable Lab Tests** list box. You can edit either or both dates.

1. At the **Starting Date** field, click the drop-down list and select a date from the calendar that determines the starting date of the date range.
2. At the **Ending Date** field, click the drop-down list and select a date from the calendar that determines the ending date of the date range.
3. When the date range is correct, click **Display** to refresh the data in the **Graphable Lab Tests** list box. The "new" date range stays in effect until you change it again.

Graphable Lab Tests

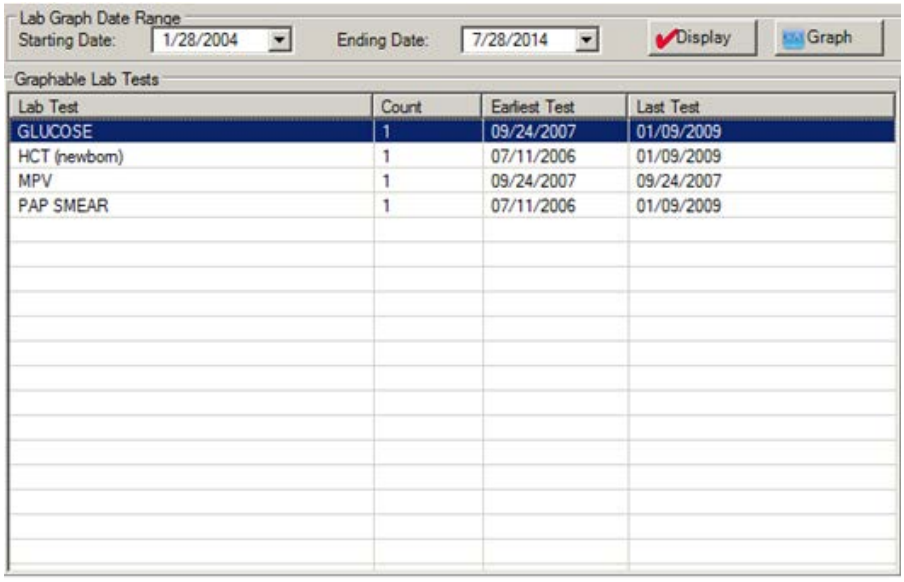


Figure 4-76: Sample Graphable Lab Tests list box

To graph a lab test, select one lab test record and then click **Graph**.

This causes the data to be entered into an Excel spreadsheet and the graph of the particular lab test is shown.

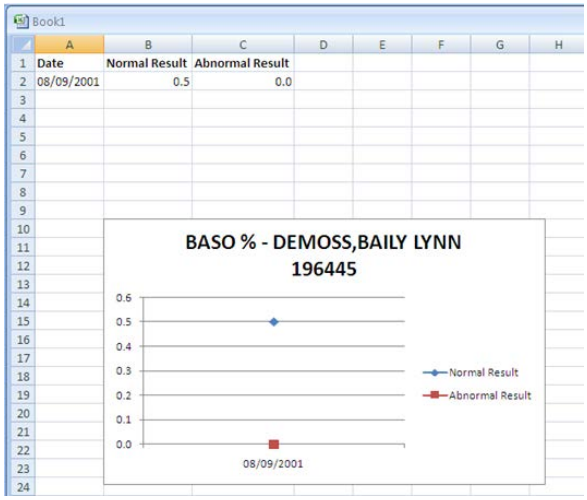


Figure 4-77: Sample graph of a particular lab test

You can save this data, if needed.

4.5.6 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 4-78: Sample Wellness tab

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

Patient Education

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

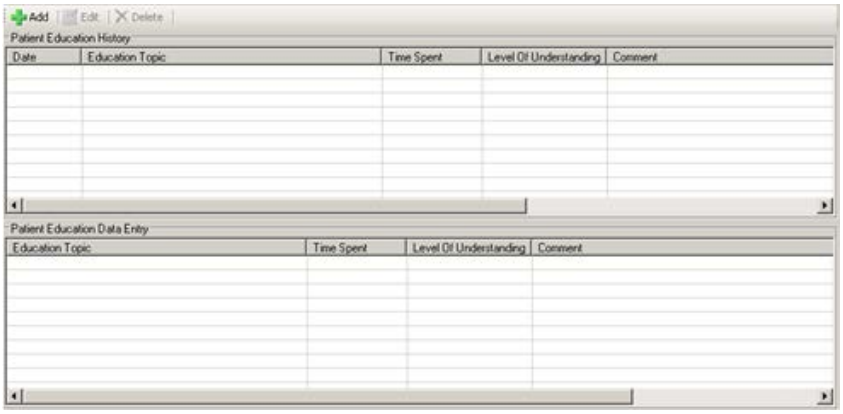


Figure 4-79: Sample Patient Education group boxes

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

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

Add/Edit Patient Education Record

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

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

   OR

2. Select an education record to edit and click **Edit**.

3. The **Education Topic** select window displays.

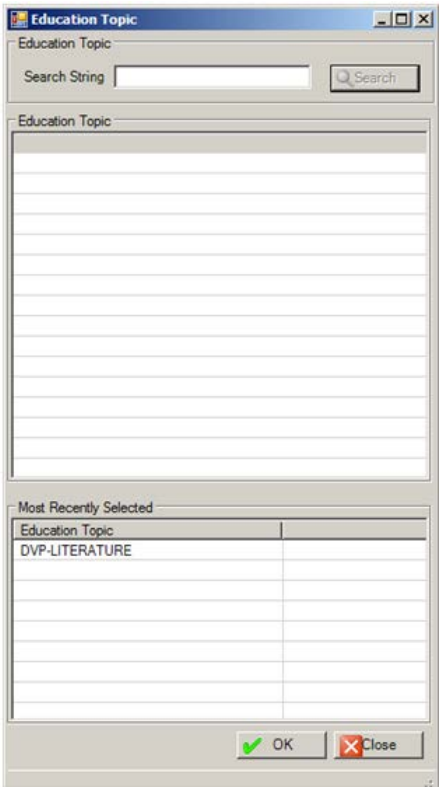
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the education topic and then clicking **Search**. The retrieved education topics will populate the Education Topic list box. Select a retrieved record and click **OK**. (Otherwise, click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

Figure 4-80: Sample Education Topic select window

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

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

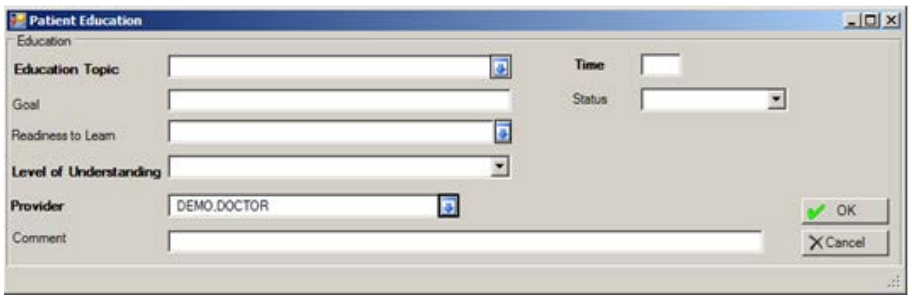


Figure 4-81: Sample Patient Education dialog box

The fields in bold text are required.

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

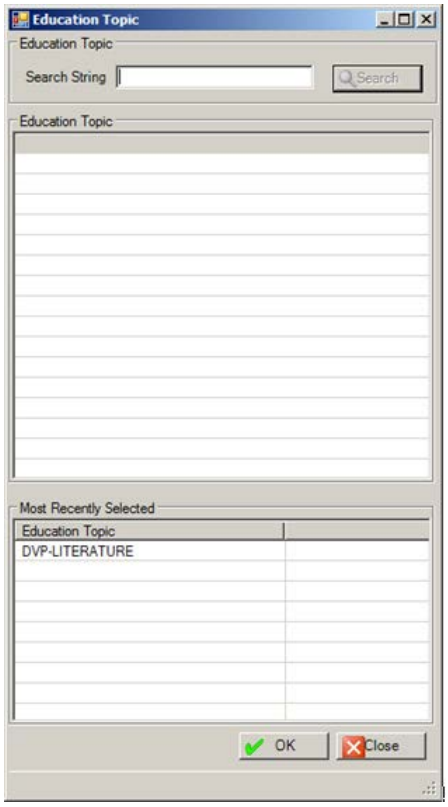
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the education topic and then clicking Search. The retrieved education topics will populate the Education Topic list box. Select a retrieved record and click **OK** to populate the Education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

Figure 4-82: Sample Education Topic select window

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

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

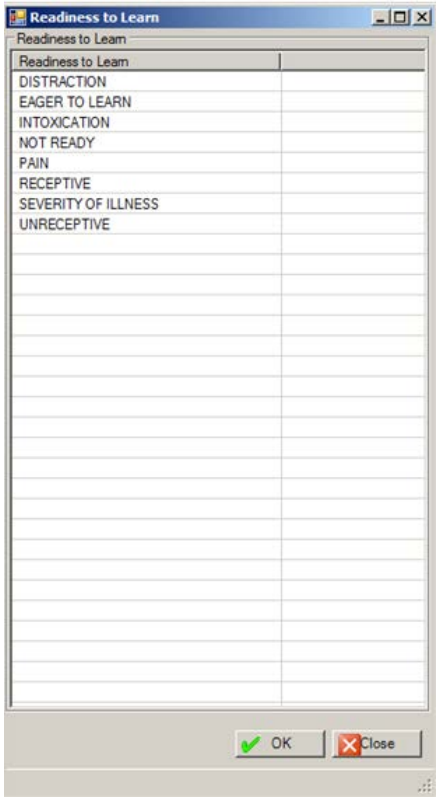
Screen Capture	What to do
	Use this window as follows: (1) Select a readiness to learn option. (2) Click **OK** to add the option to the Readiness to Learn field. (Otherwise, click **Close**.)

Figure 4-83: Sample Readiness to Learn select window

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

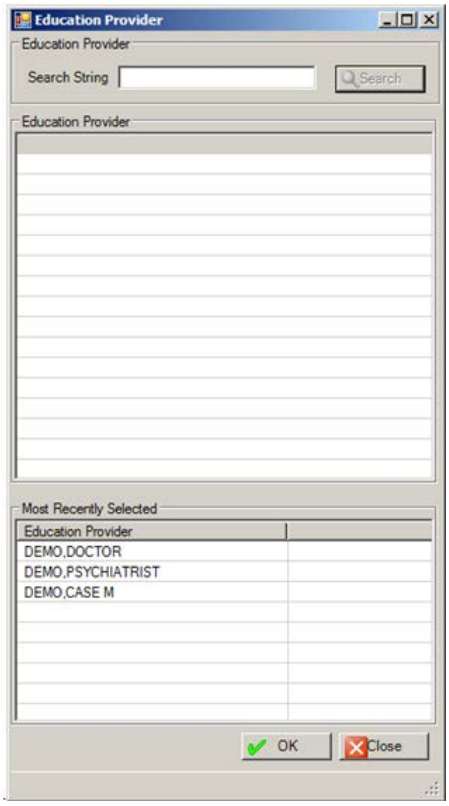
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the last name of the education provider and then clicking Search. The retrieved provider names will populate the Education Provider list box. Select a retrieved record and click **OK**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

Figure 4-84: Sample Education Provider select window

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

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

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

If **Cancel** was used, 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 box. Click **No** and the focus returns to the **Patient Education** dialog box.

If Edit was used, after the dialog box is complete, click **OK** and the fields are updated. Otherwise, click **Cancel**.

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.

Delete Patient Education Record

1. Select a record in the Patient Education Data Entry grid to delete.
2. Click **Delete**.
3. At the "Are You Sure" warning message, click **Yes** to remove the selected record. (Otherwise, click **No**.)

Health Factors

Select the **Health Factors** option on the Wellness tree structure to display the **Health Factor** list boxes: **Health Factors History** and **Health Factors Data Entry**.

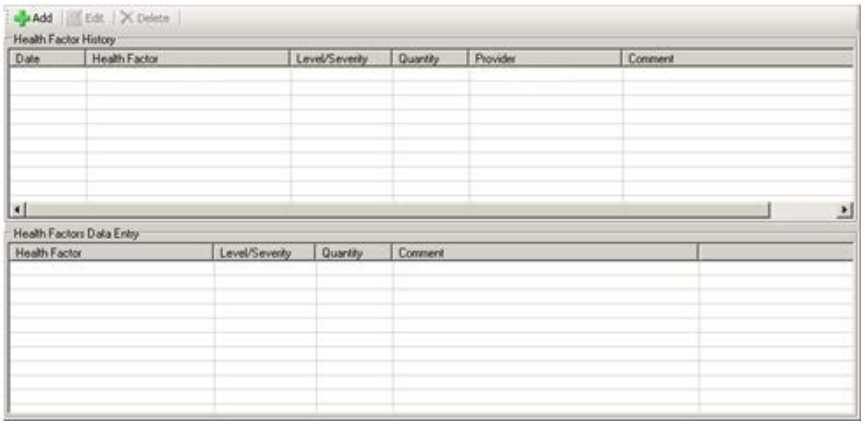


Figure 4-85: Sample Health Factors list boxes

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

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

Add/Edit Health Factor Record

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

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

   OR

2. Select a record to edit and click **Edit**.

3. The **Health Factors** search window displays.

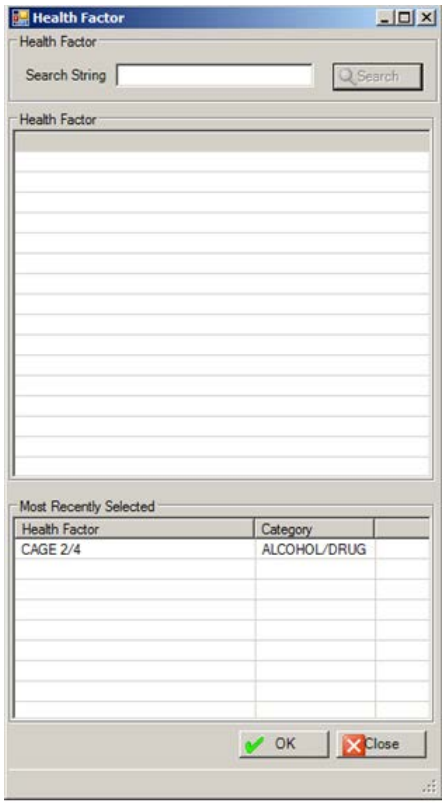
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the health factor and then clicking Search. The retrieved health factors will populate the Health Factor list box. Select a retrieved record and click **OK** to populate the Health Factor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

Figure 4-86: Sample Health Factor search window

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

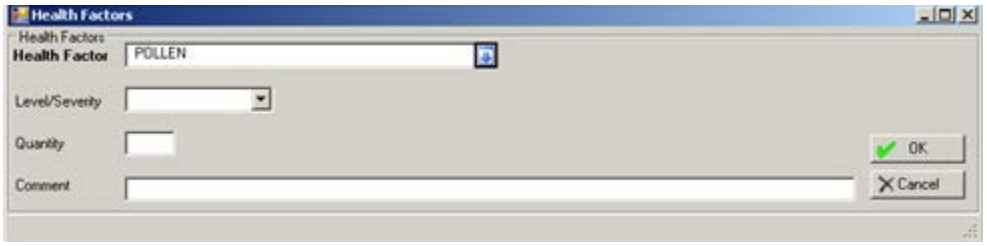


Figure 4-87: Sample Health Factors dialog box

The fields in bold text are required.

4. At the **Health Factor** field, determine if you want to change the field. The application populates this field with what was selected on the **Health Factors** select window. To change this selection, click the drop-down list to access the **Health Factor** search window. Refer to Step 2 above for more information about this window.

5. At the **Level/Severity** field, select an option from the drop-down list, if applicable:

   Minimal

   Moderate

   Heavy/Severe

6. At the **Quantity** field, type the quantity associated with the health factor, if any.

7. At the **Comment** field, type the text of any comment for clarification about the documented health factor. This is a Free Text field.

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

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

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

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

Delete Health Factor Record

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

2. Click **Delete**.

3. The application displays the "Are You Sure" warning message, click **Yes** to delete the selected record. (Otherwise, click **No**.)

Screening

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

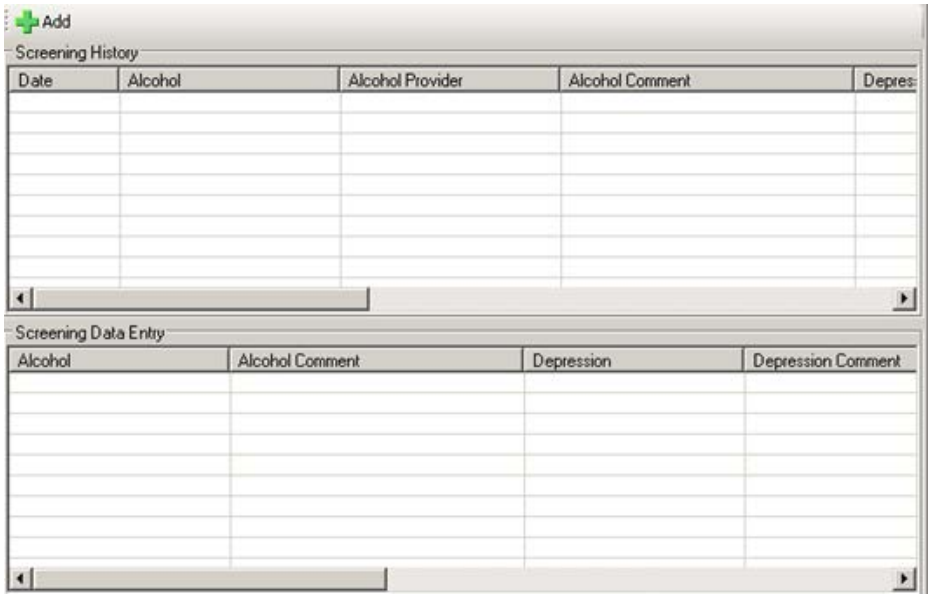


Figure 4-88: Sample Screening group boxes

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

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

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

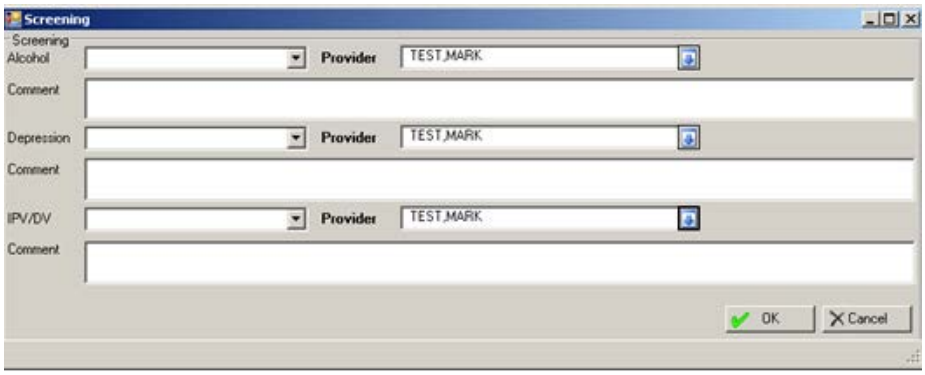


Figure 4-89: Screening dialog box

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

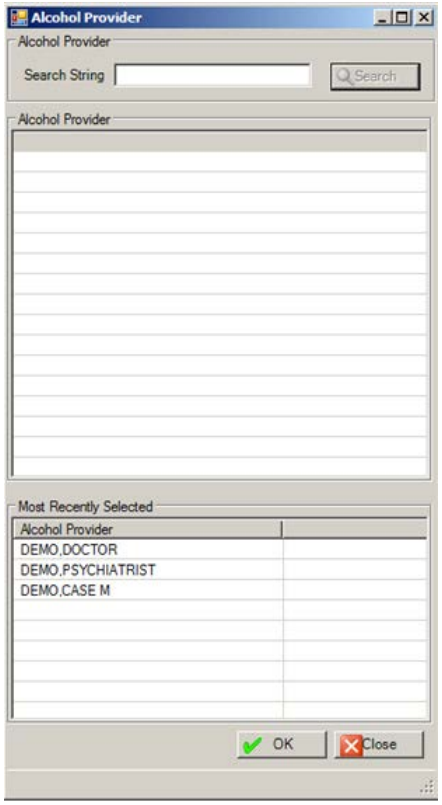
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the last name of the provider and then clicking **Search**. The retrieved providers will populate the Alcohol Provider list box. Select a retrieved record and click **OK** to populate the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

Figure 4-90: Sample Alcohol Provider search window

3. At the **Comment** field, type the text of any comment related to the alcohol screening, using 2–245 characters.

4. At the **Depression** field, select the outcome of the depression screening. Use one of the following:

   - Negative (denies symptoms of depression)
   - Positive (provides positive answers to depression screening; further evaluation is warranted)
   - Unable to screen (provider unable to conduct the screening)
   - Patient Refused Screening (patient declines exam or screening)

5. At the **Provider** field, select the name of the provider for the depression screening. Click the drop-down list and select another one from the **Depression Provider** search window, if needed.

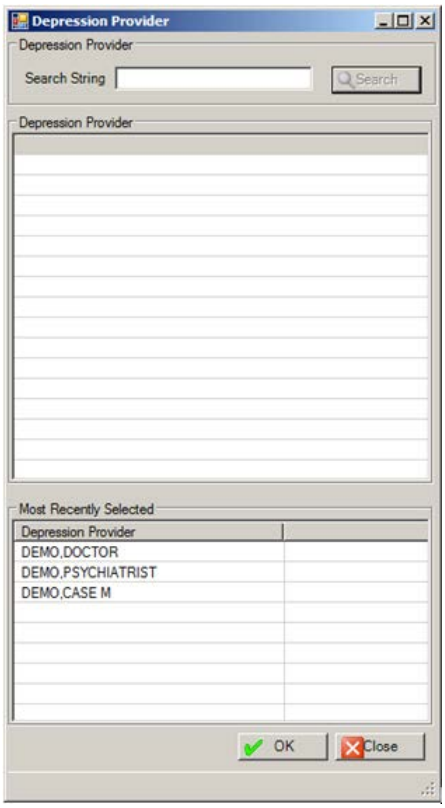
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the last name of the provider and then clicking **Search**. The retrieved providers will populate the Depression Provider list box. Select a retrieved record and click **OK** to populate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

Figure 4-91: Sample Depression Provider search window

6. At the **Comment** field, type the text of any comment related to the depression screening, using 2–245 characters.

7. At the **IPV/DV** field, select the intimate partner violence/domestic violence screening. Use one of the following:

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

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

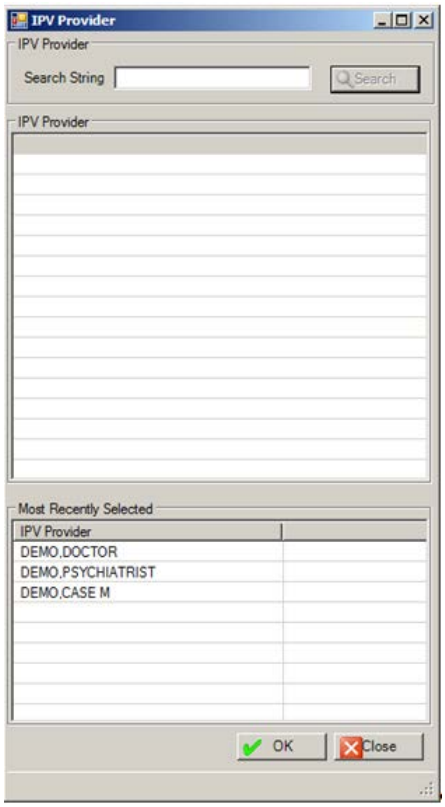
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the last name of the provider and then clicking **Search**. The retrieved providers will populate the IPV Provider list box. Select a retrieved record and click **OK** to populate the Provider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

Figure 4-92: Sample IPV Provider search window

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

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

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

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

4.5.7 Measurements Tab

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

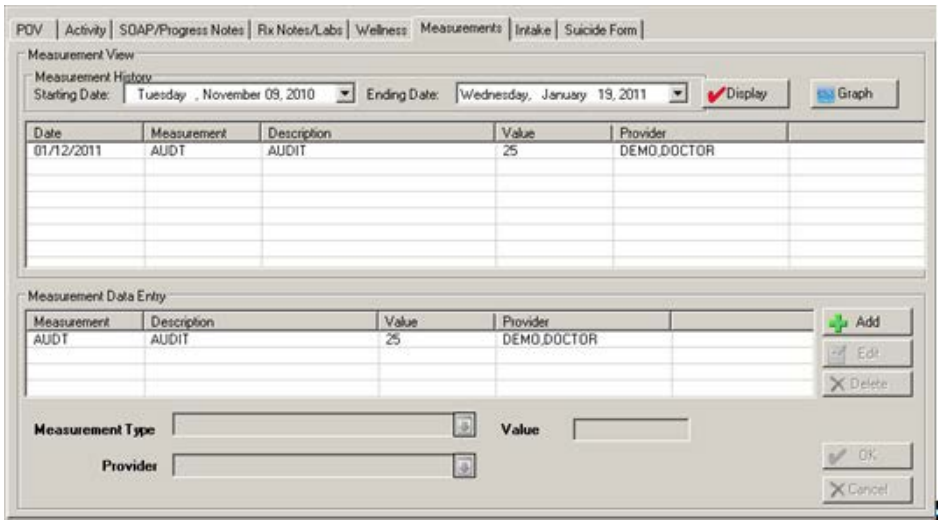


Figure 4-93: Sample Measurements tab

Measurement View Group Box

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

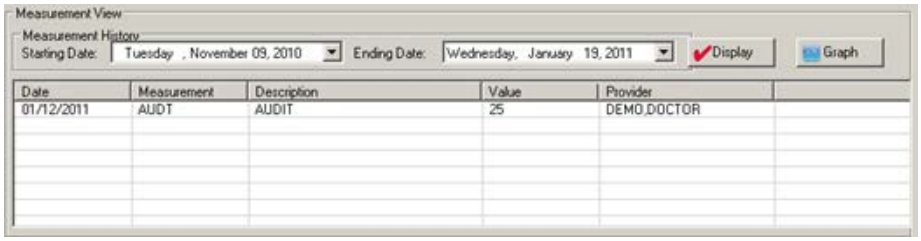


Figure 4-94: Sample Measurement View group box

Change Date Range

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

Graph

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

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

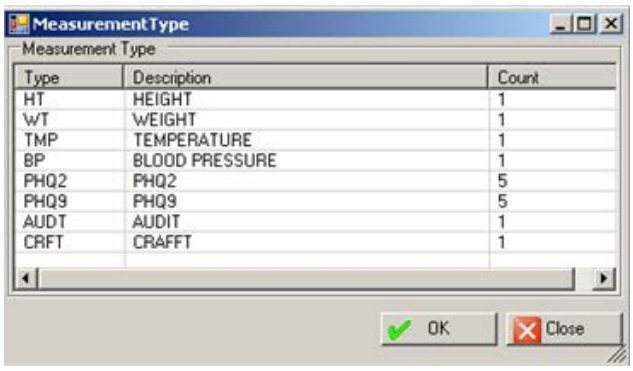


Figure 4-95: Sample Measurement Type dialog box

3. Select the measurement type to graph.

4. Click **OK** to cause the application to (automatically) use the data to display a graph in MS Excel. (Otherwise, click **Close**.)

5. The focus moves to the MS Excel application with the data shown. The data automatically displays in the form of a line graph. You can create a graph of your choice from the selected data.

Below is a sample line graph.

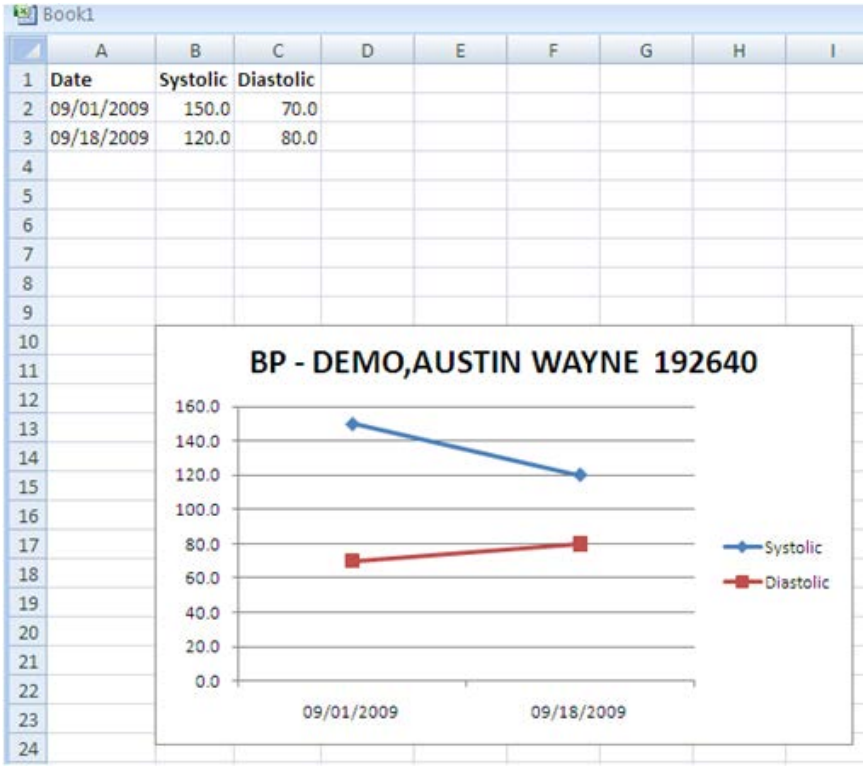


Figure 4-96: Sample line graph

You can save the data, if needed.

Measurement Data Entry Group Box

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

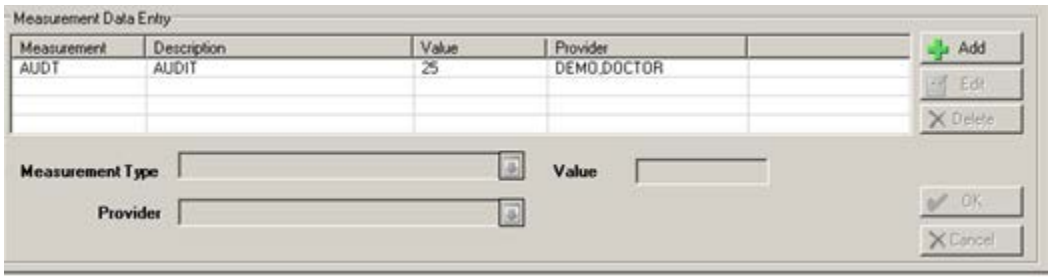


Figure 4-97: Sample Measurement Data Entry group box

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

Delete Button

1. Select the measurement to delete. Measurements can only be deleted from the encounter record where they were first recorded.
2. Click **Delete**.
3. At the "Are You Sure" confirmation, click **Yes** to remove the selected measurement record from the Measurement Data Entry group box. (Otherwise, click **No**.)

Add/Edit Button

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

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

   OR

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

   This field is inactive when editing a record.

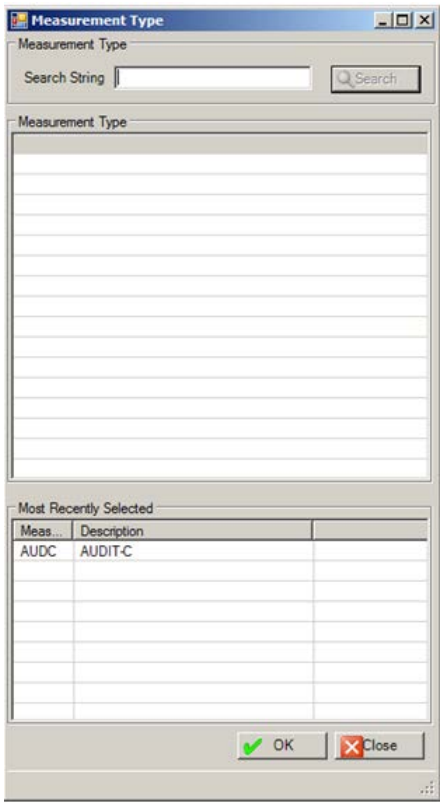
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the measurement type and then clicking **Search**. The retrieved measurement types will populate the Measurement Type list box. Select a retrieved record and click **OK** to populate the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

Figure 4-98: Measurement Type select window

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

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

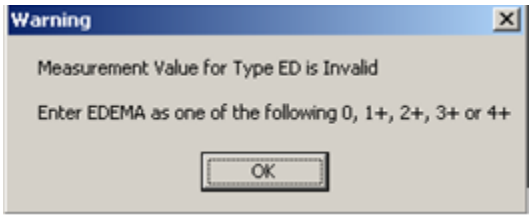


Figure 4-99: Sample Value outside the acceptable range warning

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

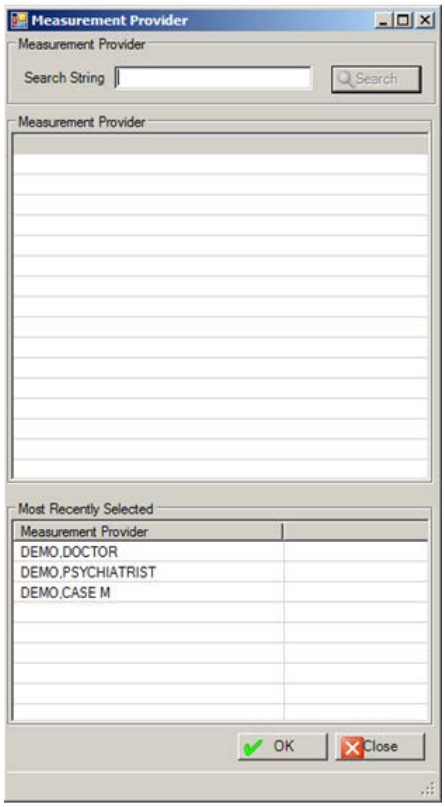
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the last name of the provider and then clicking **Search**. The retrieved provider names will populate the Measurement Provider list box. Select a retrieved record and click **OK** to populate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

Figure 4-100: Sample Measurement Provider search window

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

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

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

4.5.8 Intake Tab (GUI)

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

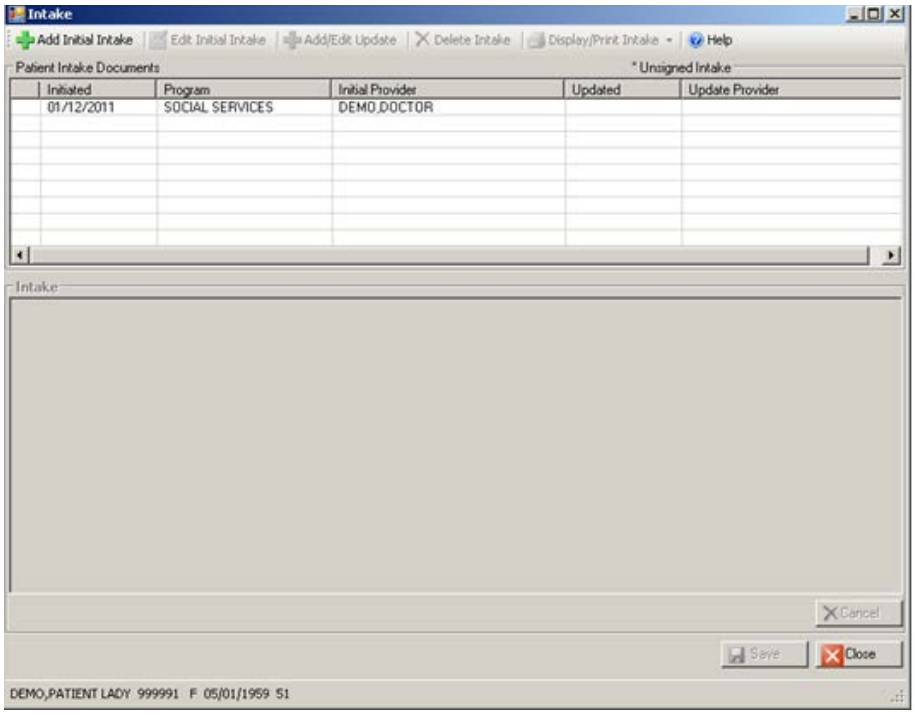


Figure 4-101: Initial Intake window

Section 12.2 provides more information the Intake (GUI).

4.5.9 Suicide Form

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

4.5.10 Select PCC Visit Window

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

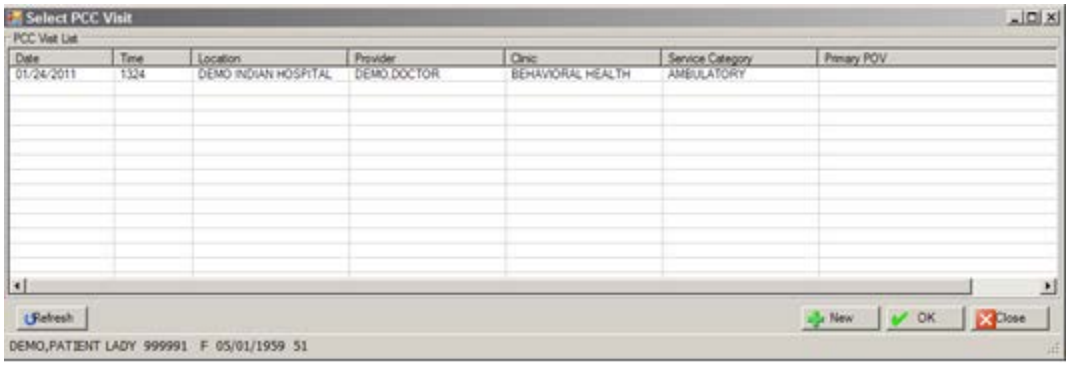


Figure 4-102: Sample Select PCC Visit window

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

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

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

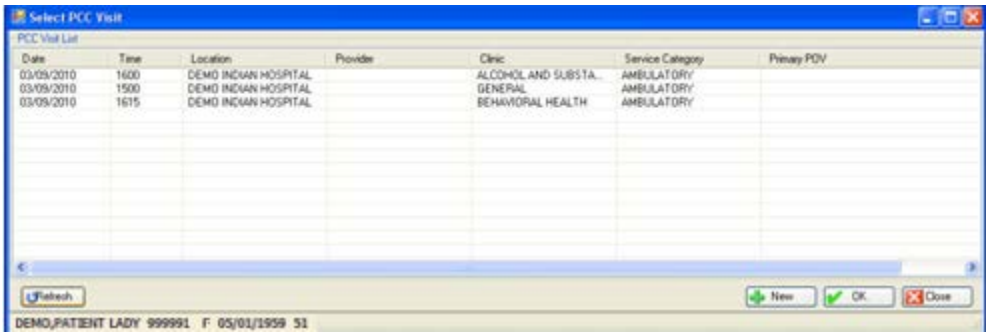


Figure 4-103: Select PCC Visit window with more visits

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

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

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

=============== VISIT FILE ===============
VISIT/ADMIT DATE&TIME: MAR 09, 2010@16:15
DATE VISIT CREATED:    MAR 09, 2010
TYPE:                  IHS
PATIENT NAME:          BETAA,EMILY MAE
LOC. OF ENCOUNTER:     DEMO INDIAN HOSPITAL
SERVICE CATEGORY:      AMBULATORY
CLINIC:                BEHAVIORAL HEALTH
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:    MAR 09, 2010
WALK IN/APPT:          WALK IN
HOSPITAL LOCATION:     BJB BH
CREATED BY USER:       BETA,BETAS
OPTION USED TO CREATE: SD IHS PCC LINK  - < - When it has been linked, it will
                                              always show this option

APPT DATE&TIME:        MAR 09, 2010@16:15
USER LAST UPDATE:      BETA,BETAA
VCN:                   47887.3A
OLD/UNUSED UNIQUE VIS: 5059010002565343
DATE/TIME LAST MODIFI: MAR 09, 2010@16:57:35
```

```
CHART AUDIT STATUS:    REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (: 102320002565343
VISIT ID:              3C5N-WWX


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

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

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

Figure 4-104: Information from PCC

4.6 Browse Visits (GUI)

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

1. Select **Browse Visits** on the RPMS Behavioral Health System (GUI) tree structure.

2. The **Browse Visits** dialog box displays.

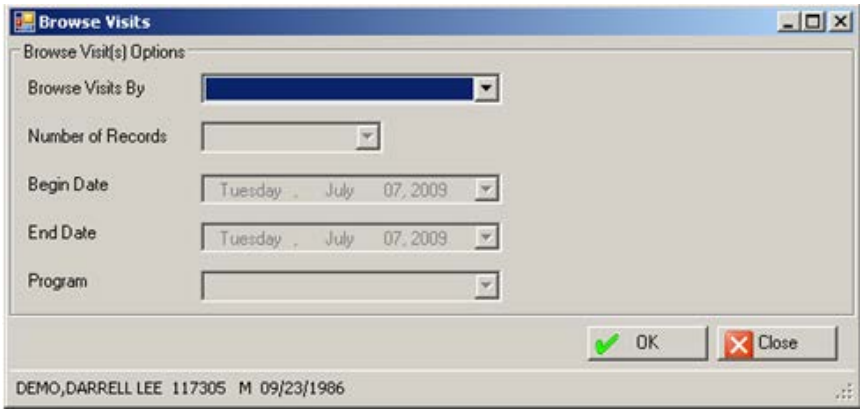


Figure 4-105: Sample Browse Visits dialog box

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

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

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

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

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

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

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

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

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

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

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

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

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

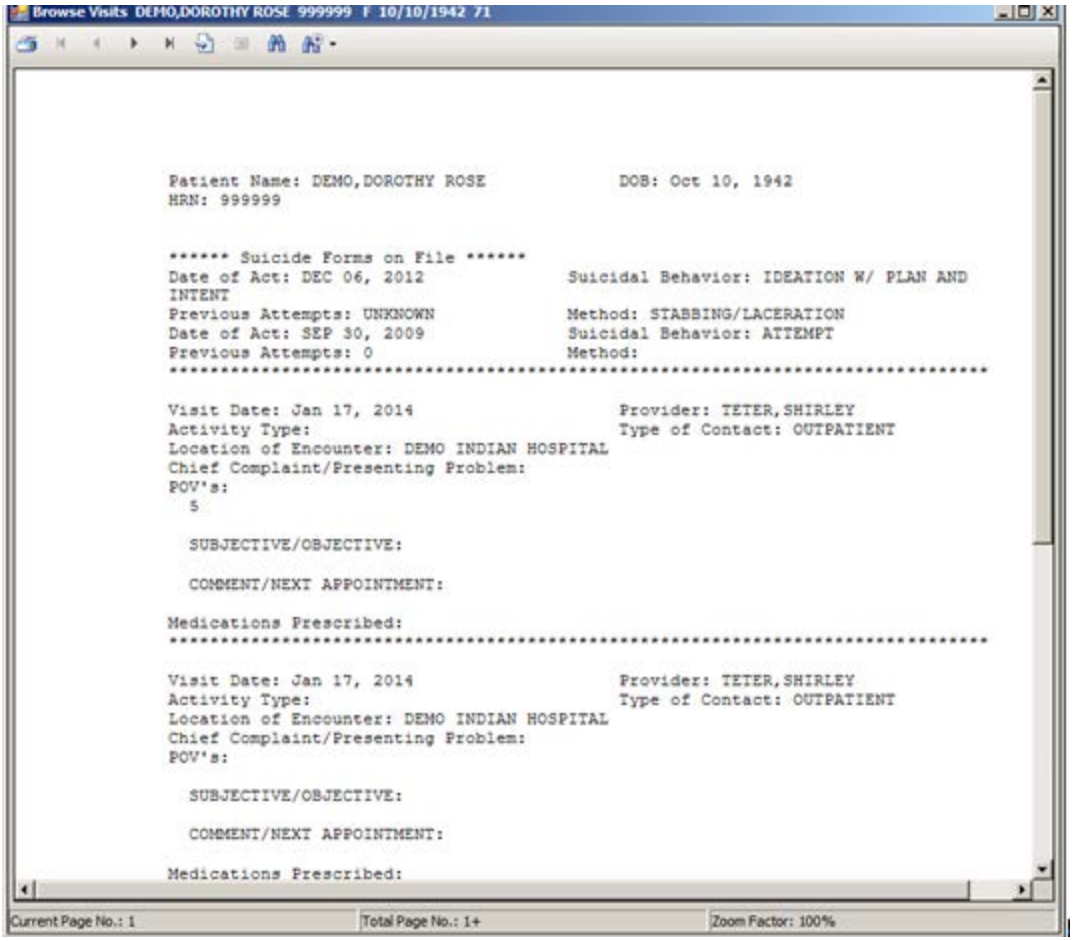


Figure 4-106: Sample of data in Browse Window

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

4.7 View Patient Data

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

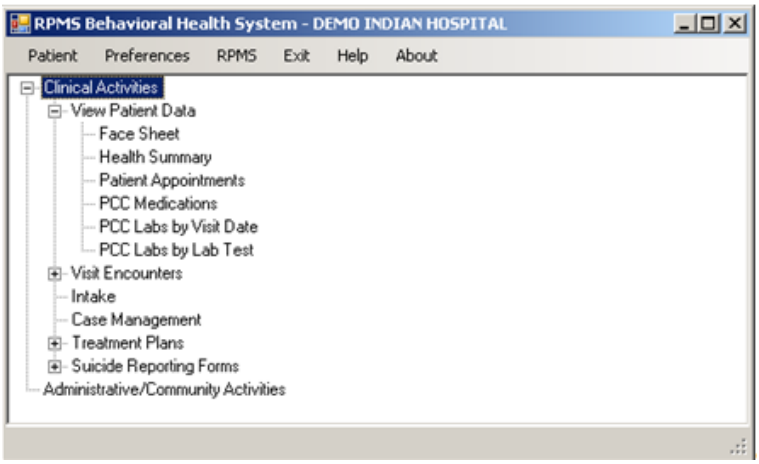


Figure 4-107: RPMS Behavioral Health System tree structure for View Patient Data

The data applies to the current patient.

4.7.1 Face Sheet

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

4.7.2 Health Summary

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

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

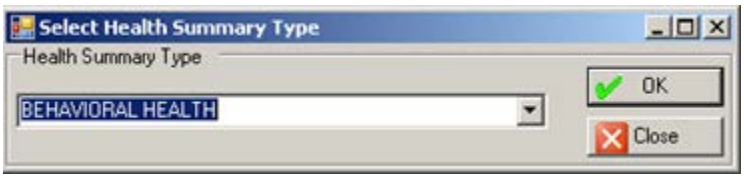


Figure 4-108: Select Health Summary Type dialog box

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

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

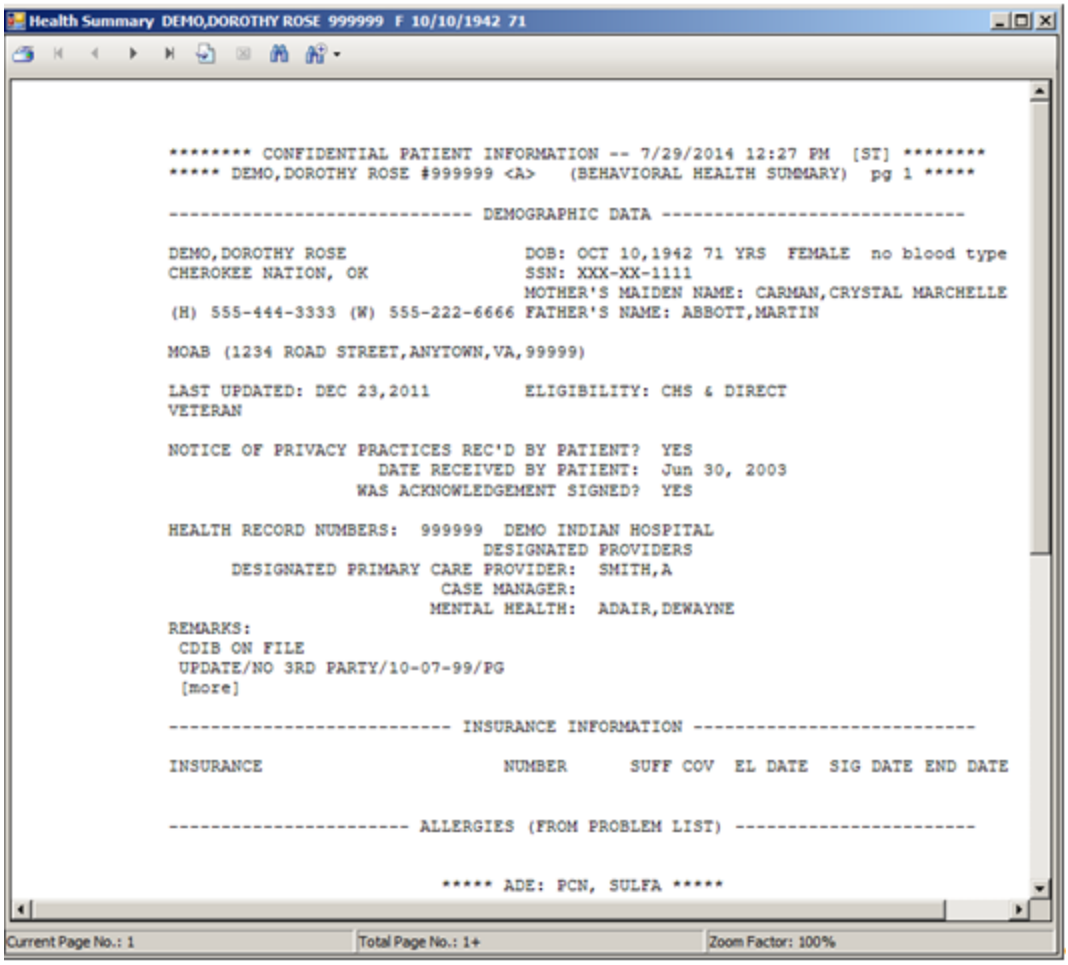


Figure 4-109: Sample Health Summary pop-up window

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

4.7.3 Patient Appointments

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

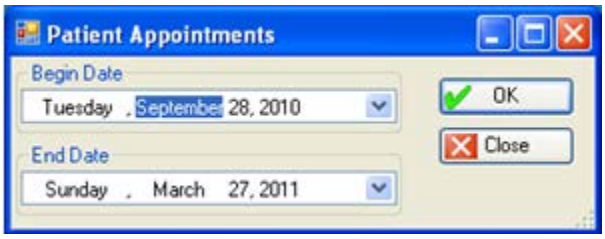


Figure 4-110: Sample Patient Appointments dialog

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

You can edit either or both dates.

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

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

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

4.7.4 PCC Medications

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

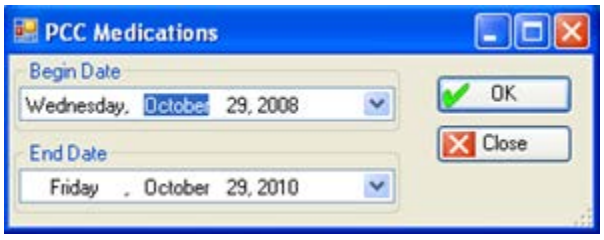


Figure 4-111: Sample PCC Medications dialog box

The default date Start Date is one year previous.

You can edit either or both dates.

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

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

4.7.5 PCC Labs by Visit Date

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

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

The default Begin Date is one year previous.

You can edit either or both dates.

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

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

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

4.7.6 PCC Labs by Lab Test

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

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

The default Begin Date is one year previous.

You can edit either or both dates.

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

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

2. At the **End Date** field, click the drop-down list and select a date from the calendar. This establishes the ending date of the date range.

3. When this dialog box is complete, click **OK** (otherwise, click **Close**).

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

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

5.0 Group Encounters

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

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

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

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

The application displays the Group Entry window.

```
GROUP ENTRY                  Mar 16, 2009 17:09:31          Page:    1 of   14
Group Entry                * - Unsigned Group Note
      Date     Group Name           Activity   Prg Cln    Prov      TOC POV

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

Figure 5-1: Sample Group Entry window

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

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

Use the Quit action to dismiss this window.

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

5.1.1 Add New Group

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

1. At the "Select Action" prompt, type **1**.
2. At the "Enter Date of the Group Activity" prompt, type the date of the new group activity.

   The Group Encounter Documentation window displays.

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

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 14, 2009             Arrival Time: 12:00
Program:                                 Community of Service:
Group Name:                              Clinic:
Activity:                                Activity Time:
Encounter Location:                      Type of Contact:
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N           CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
_____________________________________________________________________________




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

Figure 5-2: Sample Group Encounter Documentation window

The underlined fields are required.

3. At the "Add/View/Update Providers (Primary or Secondary) for this Group?" prompt, type **Y** (yes) or **N** (no).

   If Y was used, the add function is available. This is the *only place* to add providers for the group encounter. The following pop-up displays.

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

Figure 5-3: Sample Secondary Providers pop-up

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

a. At the “PROVIDER” prompt, type the provider name.

b. At the “PRIMARY/SECONDARY” prompt, type the provider type by using **P** for primary or **S** for secondary. Only one primary provider can be used, whereas, multiple secondary providers are allowed.

Below are more fields on the Group Encounter Documentation window.

4. At the “Encounter Date” prompt, type the encounter date. The default shows the date of the new group activity (that was entered before you accessed this window).

5. At the “Arrival Time” prompt, type the arrival time of the group encounter. The default shows 12:00.

6. At the “Program” prompt, type the program for the group encounter. Use one of the following:

   M (Mental Health)
   S (Social Services)
   C (Chemical Dependency)
   O (Other)

7. At the “Community of Service” prompt, type the name of community of service where the encounter took place.

8. At the “Group Name” prompt, type the name of the group encounter, using between 1 and 30 characters in length.

9. At the “Clinic” prompt, type the clinic (by number or name).

10. At the “Activity” prompt, type the activity of the group encounter.

11. At the “Activity Time” prompt. Type the number of minutes (no decimal digits) the provider(s) spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry. The time is divided equally among each of the group participants.

12. At the “Encounter Location” prompt, type the name of the location for the encounter.

13. At the “Type of Contact” prompt, type the contact type (the activity setting).

14. At the “POV or DSM (Primary Group Topic)” prompt, press Enter to access the POV or DSM Diagnosis pop-up.

```
POV or DSM Diagnosis (Primary Group Topic)

 CODE    NARRATIVE
```

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

a. At the “Code” prompt, type an MHSS Problem/DSM IV POV code, using 2–80 characters.

b. After populating the Code field, the application populates the Narrative for the particular code (but can be edited). Note: the special characters “or ‘ cannot be the first character of the POV narrative.

Below are more fields on the Group Encounter Documentation window.

15. At the “Chief Complaint/Presenting Problem” prompt, type the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patient sought services.

16. At the “Any Patient Education Done?” prompt, type **Y** (yes) or **N** (no).

    If Y was used, the Patient Education for this Group Activity pop-up displays.

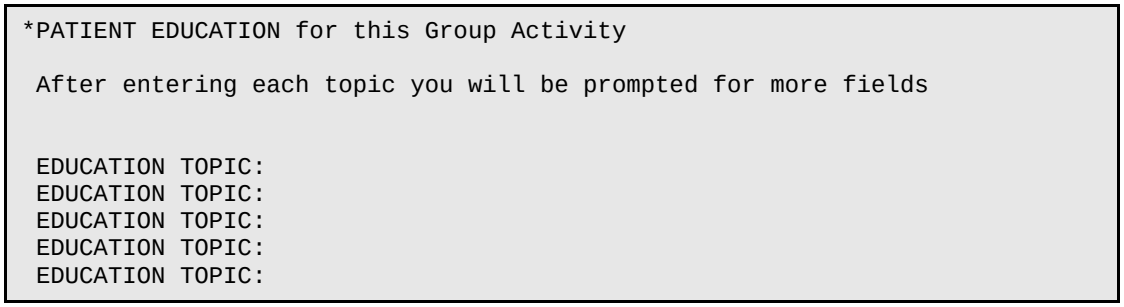


Figure 5-5: Sample Patient Education enter/edit screen

a. At the “EDUCATION TOPIC” prompt, type the education topic code.

b. After populating this field, the following pop-up displays.

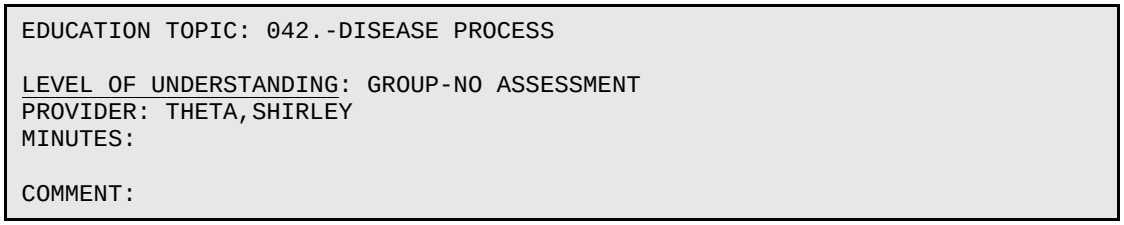


Figure 5-6: Sample pop-up for education data

The underlined fields are required.

c. At the “Level of Understanding” prompt, the application automatically populates with GROUP-NO ASSESSMENT. You cannot change this field.

d. At the “Provider” prompt, the application automatically populates with the current logon user. This can be changed.

e. At the “Minutes” prompt, type the number of minutes spent on education, using any integer 1–9999.

f. At the “Comment” prompt, type the text of any comment about the education topic, using 2–100 characters.

Below are more fields on the Group Encounter Documentation window.

17. At the “CPT Code(s) <press enter>” prompt, press Enter to access another window where you specify the CPT or HCPCS codes associated with the group encounter.

```
CPT Code(s)
-------------------------------------------------------------------
CPT CODE:
CPT CODE:
CPT CODE:
CPT CODE:
```

Figure 5-7: Sample pop-up for CPT Code(s) data

a. At the “CPT CODE” prompt, type the CPT code to be used for the group.

Another pop-up window displays.

```
QUANTITY: 1
MODIFIER:
MODIFIER 2:
```

Figure 5-8: Sample secondary pop-up window

b. At the “Quantity” prompt, type the quantity associated with the CPT code.

c. At the “Modifier” prompt, type the modified associated with the CPT code.

d. At the “Modifier 2” prompt, type the second modified associated with the CPT code.

After completing the Modifier 2 prompt, the focus returns to the CPT CODE prompt.

Below are more fields on the Group Encounter Documentation window.

18. At the “S/O/A/P (Standard Group Note) <press enter>” prompt, press Enter to access another window where you enter the text of a group note.

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

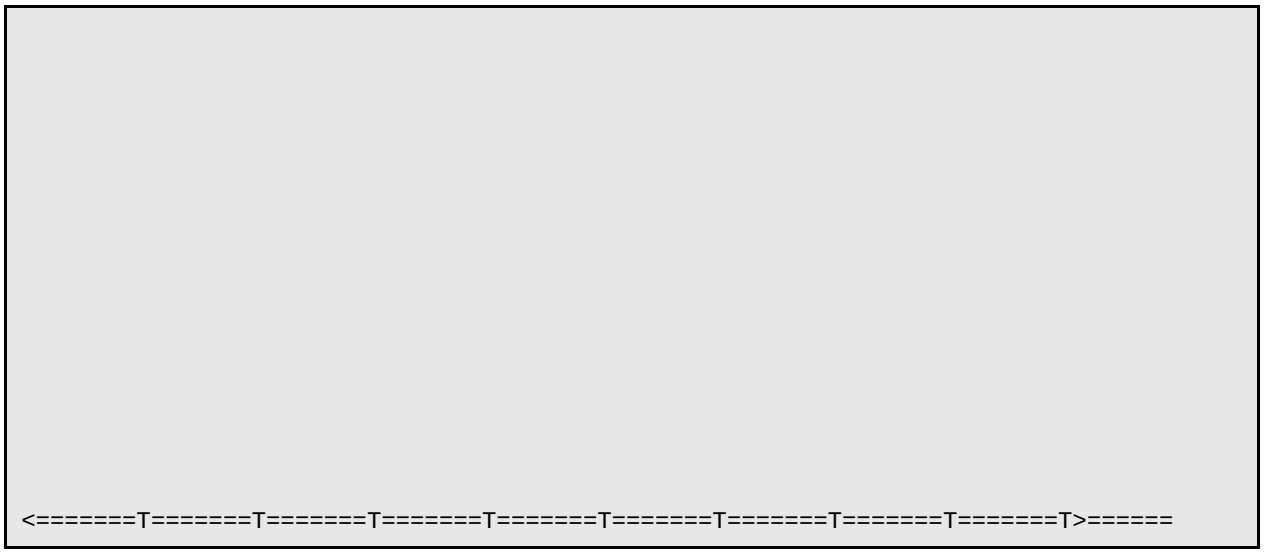


Figure 5-9: Window to enter the note

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

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

19. At the "Patients <press enter>" prompt, press Enter to access the Patients pop-up:

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

PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
```

Figure 5-10: Sample pop-up for Patients

a. At the "PATIENT" prompt, type the patient name, HRN, DOB, or Social Security Number.

b. More than one patient name can be used.

After you save and exit, the application displays the following choices:

```
     Select one of the following:

          Y         Yes, group definition is accurate, continue on to add visits
          N         No, I wish to edit the group definition
          Q         I wish to QUIT and exit

Do you wish to continue on to add patient visits for this group: Y//
```

Figure 5-11: Questions upon exit

- Type **Y** to continue adding the patient's individual visit associated with the group visit. The focus returns to the record for the first patient.
- Type **N** to edit the group definition.
- Type **Q** to quit and exit. The focus returns to the Group Entry screen.

After completing the group definition, completing the documentation for the individual patients, and saving, the application will display an option to sign all SOAP/Progress Notes or to leave them unsigned.

5.1.2 Edit Group Definition

Use option 8 to edit a selected unsigned group entry record.

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

1. At the "Select Action" prompt, type **8**.
2. At the "Select GROUP ENTRY" prompt, select a group to edit.
3. The Group Encounter Documentation window displays.

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


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

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

Figure 5-12: Sample Group Encounter Documentation window

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

5.1.3 Review/Edit Group Visits

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

1. At the "Select Action" prompt, type **6**.
2. At the "Select GROUP ENTRY" prompt, type the group entry to review/edit.

   If the group has a signed note, the application displays the message: The notes associated with this group entry have been signed. You can edit other items in this entry but not the notes. Press Enter to continue.

   After populating the Select GROUP ENTRY field, the Enter/Edit Patient Group Data window displays.

```
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 5-13: Sample Enter/Edit Patient Group Data window

Use the Q action to exit the window.

Delete a Patient's Group Visit (X)

Use the X action to remove a particular patient's group visit.

1. At the "Select Action" prompt, type **X**.
2. At the "Enter PATIENT GROUP ENTRY" prompt, type the group number.
3. The application displays the BH record data.

4. At the end of the data, the application verifies that you want to delete the particular patient's visit. Type **Y** (yes) or **N** (no).

Display Patient's Group Visit (D)

Use the D action to display a particular patient's group visit.

1. At the "Select Action" prompt, type **D**.
2. The BH Visits Record Display window (view only) displays.

Edit Patient's Group Visit (AE)

Use the AE option to edit a patient's group visit.

1. At the "Select Action" prompt, type **AE**.
2. At the "Enter PATIENT GROUP ENTRY" prompt, type the group number.

The BEHAVIORAL HEALTH RECORD EDIT windows for the particular patient displays.

```
* BEHAVIORIAL HEALTH RECORD EDIT *           [press <F1>E to exit]
Encounter Date: NOV 3,2006@12:00               User: THETA,SHIRLEY
Patient Name: TEST,JEREMY ISSAC  DOB: 6/15/81  HRN: 104683
--------------------------------------------------------------------------------
Date:    NOV 3,2006@12:00         Location of Service:  DEMO HOSPITAL
Program: MENTAL HEALTH            Outside Location:
Clinic:  MENTAL HEALTH            Appt/Walk-in: UNSPECIFIED   Visit Flag:
Type of Contact: OUTPATIENT       Community: RED LAKE
Providers <press enter>:          Local Service Site:
Activity:  91         Activity Time: 40  #Served:  1  Interpreter Utilized:
Chief Complaint/Presenting Problem:
SOAP/PROGRESS NOTE:    Comment/Next Appointment:     Medications Prescribed:
Edit Purpose of Visits?: N      Edit Treated Medical Problems?  N
Edit CPT Codes?     Edit Health Factors?  N
Edit Patient Education?: N
Edit Any Screening Exams?  N    Edit Measurements?  N
Placement Disposition:                 Referred To:
_______________________________________________________________________________




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

Figure 5-14: Sample Behavioral Health Record Edit window

If you cannot change the note, the applicable field on the Behavioral Health Record Edit window will read: SOAP/PROGRESS NOTE SIGNED/UNEDITABLE. In this case, as you tab through the fields, the application will skip the Note field.

The underlined fields are required. Section 4.1.3 provides more information about the prompts on this window.

5.1.4 Display Group Entry

Use action 2 to display group entry data for a specified group.

1. At the "Select Action" prompt, type **2**.
2. At the "Select GROUP ENTRY" prompt, type the number of the group.

The application displays the Output Browser window showing the group data.

```
OUTPUT BROWSER                Mar 27, 2009 17:46:48          Page:    1 of    1



DATE OF SERVICE: NOV 29, 2010@14:39     PROGRAM: MENTAL HEALTH
  GROUP NAME: TESTING LINK 1            POSTING DATE: NOV 29, 2010
  LOCATION OF ENCOUNTER: KANAKANAK HOSPITAL
  COMMUNITY OF SERVICE: KODIAK          ACTIVITY TYPE: 91
  TYPE OF CONTACT: OUTPATIENT           ACTIVITY TIME: 60
  WHO ENTERED RECORD: GAMMMA,RYAN       DATE LAST MODIFIED: NOV 29, 2010
  CLINIC: MENTAL HEALTH                 USER LAST UPDATE: GAMMMA,RYAN
  SIGNED?: YES                          ELECTRONIC SIGNATURE BLOCK: Ryan Gamma
  DATE/TIME ESIG APPLIED: NOV 29, 2010@14:40:50
PROVIDER: GAAMMA,RYAN                   PRIMARY/SECONDARY: PRIMARY
POV: F33.1
  NARRATIVE: MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MODERATE
SUBJECTIVE/OBJECTIVE:
CPT CODE: 90853                         QUANTITY: 1
CPT CODE: 90836                         QUANTITY: 1
PATIENTS: SMITH,ALPHA JUSTIN
PATIENTS: MOORE,ALPHA JAMES
PATIENTS: WATERS,ALPHA RASHELL
MHSS RECORD: FEB 18, 2014@13:44
MHSS RECORD: FEB 18, 2014@13:44
MHSS RECORD: FEB 18, 2014@13:44


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

Figure 5-15: Sample Output Browser window

3. At the "Select Action" prompt, type one of the following:

   + to view the next screen (does not apply to the last screen)
   - to view the previous (does not apply to the first screen)
   Q to quit the Output Browser screen and the focus returns to the Group Entry.

5.1.5 Print Encounter Forms

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

1. At the "Select Action" prompt, type **5**.

2. At the “Select GROUP ENTRY” prompt, type the group to use.

   The application states: Forms will be generated for the following patient visits. After this message, the application displays the names of the patients in the group.

3. At the “Enter response” prompt, type one of the following:

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

   - A full encounter form (option F) prints all data for a patient encounter including the S/O/A/P note.
   - The suppressed report (option S) does NOT display the following information: Chief Complaint, SOAP note, measurement data, screenings.

4. At the “Device” prompt, type the device to output the encounter form.

Below is a sample full encounter form report.

```
           ********** CONFIDENTIAL PATIENT INFORMATION **********
  PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Oct 01, 2009@17:38:44
             ***  Computer Generated Group Encounter Record  ***
                            Group Name: Mond DV
********************************************************************************
  Date:  Sep 28, 2009         Primary Provider: GAMMA,DENISE
                                                BETAA,BJ
  Arrival Time: 10:00
  Program:  SOCIAL SERVICES
  Clinic:  MEDICAL SOCIAL SERVICES      Appointment Type:  UNSPECIFIED
_______________________________________________________________________________
                                                Number        Activity/Service
  Community: TAHLEQUAH                          Served: 1     Time: 44 minutes
  Time spent in group session: 88
  Activity: 14-FAMILY/GROUP TREATMENT-PATIENT PRESENT
  Type of Contact: OUTPATIENT
_______________________________________________________________________________
  CHIEF COMPLAINT/PRESENTING PROBLEM:  test pt ed
  S/O/A/P:
  GROUP NOTE
  This is the first meeting of the Domestic Violence group. Focus of today’s
  session was establishing group rules and discussing expectations.

  PROVIDER SIGNATURE:   /es/ DENISE GAMMA, MSW, LCSW
                             Signed: Sep 28, 2009 15:07
_______________________________________________________________________________
_______________________________________________________________________________
  COMMENT/NEXT APPOINTMENT:
_______________________________________________________________________________
  BH POV CODE      PURPOSE OF VISIT (POV)
  OR DIAGNOSIS    [PRIMARY ON FIRST LINE]
_______________________________________________________________________________
       F84.0          AUTISM SPECTRUM DISORDER
```

```
      F10.24         ALCOHOL-INDUCED BIPOLAR AND

_____________________________________________________________________________
  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      PURPOSE OF VISIT (POV)
  OR DIAGNOSIS    [PRIMARY ON FIRST LINE]
_____________________________________________________________________________
                   PROVIDER SIGNATURE:
  Jan 15, 2010                          BETTTA,LORI
Enter RETURN to continue or '^' to exit:
```

Figure 5-16: 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.

1. At the "Select Action" prompt, type **3**.
2. At the "Select GROUP ENTRY" prompt, type the number of the group to duplicate in order to create a new group.
3. At the "Enter Date for the new group entry" prompt, type the date for the new group.

The Group Encounter Documentation window displays.

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

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



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

Figure 5-17: Sample Group Encounter Documentation window

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

5.1.7 Add No Show visit

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

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

1. At the “Select Action” prompt, type **7**.
2. At the “Select GROUP ENTRY” prompt, type the number of the group to use.
3. At the “Select PATIENT NAME” prompt, type the name of the patient who failed to attend the group session.
4. At the “Enter PRIMARY PROVIDER” prompt, type the primary provider name.

The Behavioral Health Visit Update window displays. Section 4.2.1 provides more information about using this window.

5.1.8 Sign Notes

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

1. At the "Select Action" prompt, type **9**.
2. At the "Select Group Entry" prompt, type the number of the record to use.

If you are NOT the primary provider, the application displays the following message. Press Enter and the focus returns to the Group Entry window.

```
You are not the primary provider for this group, no electronic
signature will be applied and no PCC link will occur.
The primary provider will need to sign these at a later time.
Press enter to continue....:
```

Figure 5-18: Message about the primary provider

If there is a record but no visits were created for this group, the application displays the following message. Press Enter and the focus returns to the Group Entry window.

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

Figure 5-19: Message about no visits created

If the provider opted out of E-Signature, the application displays the following information:

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

Figure 5-20: Message when provider opted out of E-Signature

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

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

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

=============== BH RECORD FILE ===============
DATE OF SERVICE:       JUL 09, 2009@09:55
PROGRAM:               MENTAL HEALTH
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE:  TAHLEQUAH
ACTIVITY TYPE:         17
ACTIVITY TYPE NAME:    PSYCHOLOGICAL TESTING-PATIENT PRESENT
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               ALPPHA,CHELSEA MARIE
```

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

Figure 5-21: Sample BH Visit Record Display window

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

If Y was used, the focus stays on the window.

If N was used, the application prompts: Enter your Current Signature Code. Type **Y** (yes) to enter your signature code, otherwise type **N** (no). Section 2.14.6 provides more information about signing a note.

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

5.1.9 Delete Group

Use action 4 to remove a particular group encounter record with an unsigned note.

1. At the "Select Action" prompt, type **4**.
2. At the "Select GROUP ENTRY" prompt, type the number of the group to delete.

   The application displays the data associated with the group visit.
3. At the "Are you sure you want to remove/delete both the group definition and all associated individual patient records" prompt, type **Y** (yes) or **N** (no).

   Please note that the user must hold a specific key in order to delete group encounters with signed notes. Removing the group definition will also remove the related individual patient encounter records.

5.2 Group Entry Window (GUI)

The following shows where the Group Encounter function is located on the RPMS Behavioral Health System (GUI) tree structure.

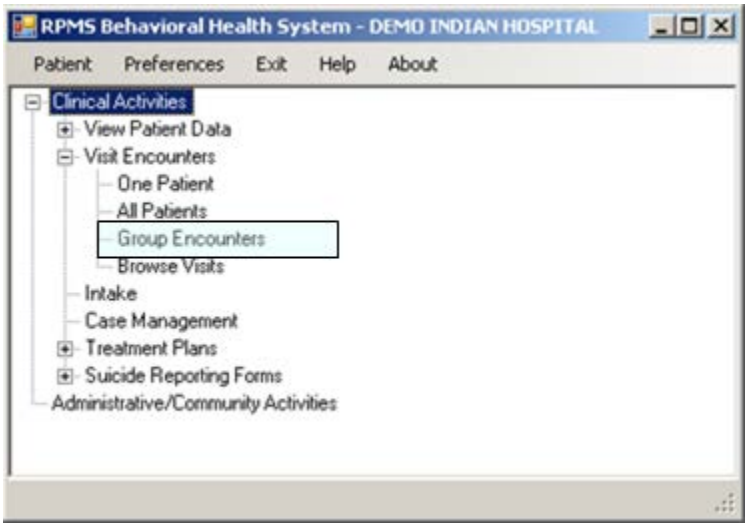


Figure 5-22: Group Encounters location on tree structure

Click the **Group Encounters** option to access the **Group Entry** window.

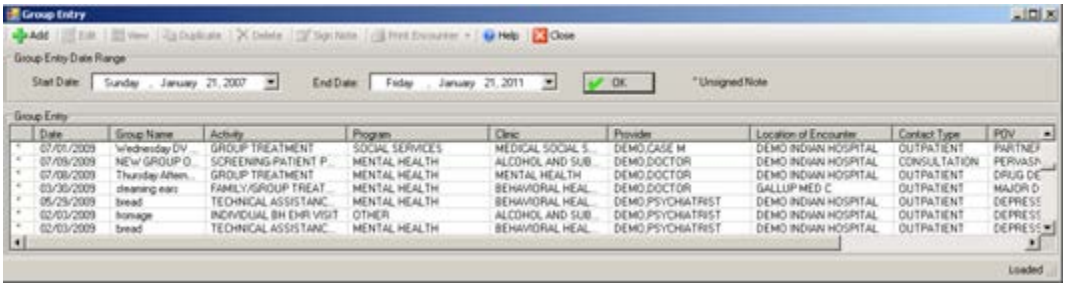


Figure 5-23: Sample Group Entry window

The following table provides information about the features on the Group Entry window.

Feature	Functionality
Group Entry Date Range Group Box	The **Group Entry** window displays the group encounters in the date range shown in the **Group Entry Date Range** group box (default is one year). The default view is sorted by date (from most recent). Change the date range by accessing the calendar under the drop-down list for the date. After changing the date range, click **OK** to update the display in the **Group Entry** group box.
Group Entry List Box	This list box shows the records in the particular group entry date range. The asterisk (*) in the first column indicates that the particular record contains an unsigned note. When this type of record is selected, the **Sign Note** button becomes active.
Add Button	Use the ***Add*** button to add a new group encounter record on the **Group Data Entry - Add Group Data** window.
Edit Button	Use the **Edit** button to change the highlighted group encounter record on the **Group Data Entry - Edit Group Data** window.

Feature	Functionality
View Button	Use the **View** button (or double-click on a record) to view the highlighted group encounter record on the **Group Data Entry - View Group Data** window. This window has the same fields as the **Add/Edit group** data window.
Duplicate Button	Use the **Duplicate** button to duplicate an existing group encounter record in order to create a new one. You will need to edit any information that would be different for the new encounter group. 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.
Delete Button	After selecting the particular record and clicking **Delete**, the "Are You Sure" confirmation message displays, asking if you are sure you want to delete. Click **Yes** (otherwise, click **No**). The Yes process removes the selected group encounter record from the group box. If Yes was used, the group definition and all individual patient records will be removed. Note that Group Encounter records with signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.
Print Encounter Button	Select the group encounter record to print and click the **Print Encounter** button. It will print one of the following: Full, Suppressed, Both Full and Suppressed. 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.
Help Button	Use the **Help** button to access the online help for the Group Entry window.
Close Button	Use the **Close** button to dismiss the Group Entry window.
Sign Note Button	Use the **Sign Note** button to sign a particular "unsigned" group encounter record (asterisk (*) in the first column).

The following applies to the information about the Sign Note button:

Click Sign Note button to access the **Sign?** dialog box where you type your electronic signature. Section 2.14.5 provides more information.

If the primary provider has opted out of E-Sig will pass to PCC, the application displays the **Message** regarding this.

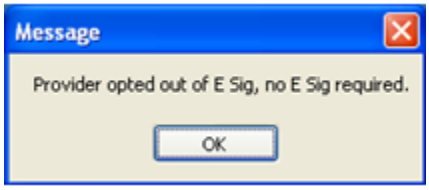


Figure 5-24: Message stating that the provider opted out of E Sig

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

5.3 Add/Edit Group Data (GUI)

1. Click the **Add** button to add a new group data record on the Group Data Entry - Add Group Data window.

   OR

2. Use the **Edit** button to change the highlighted group encounter record on the Group Data Entry - Edit Group Data window.

All Patient Education entries created before the installation date for BHS v4.0 will continue to display the CPT field.

Below is the Group Data Entry - Add Group Data window. (The same fields appear on the Group Data Entry - Edit Group Data window.)

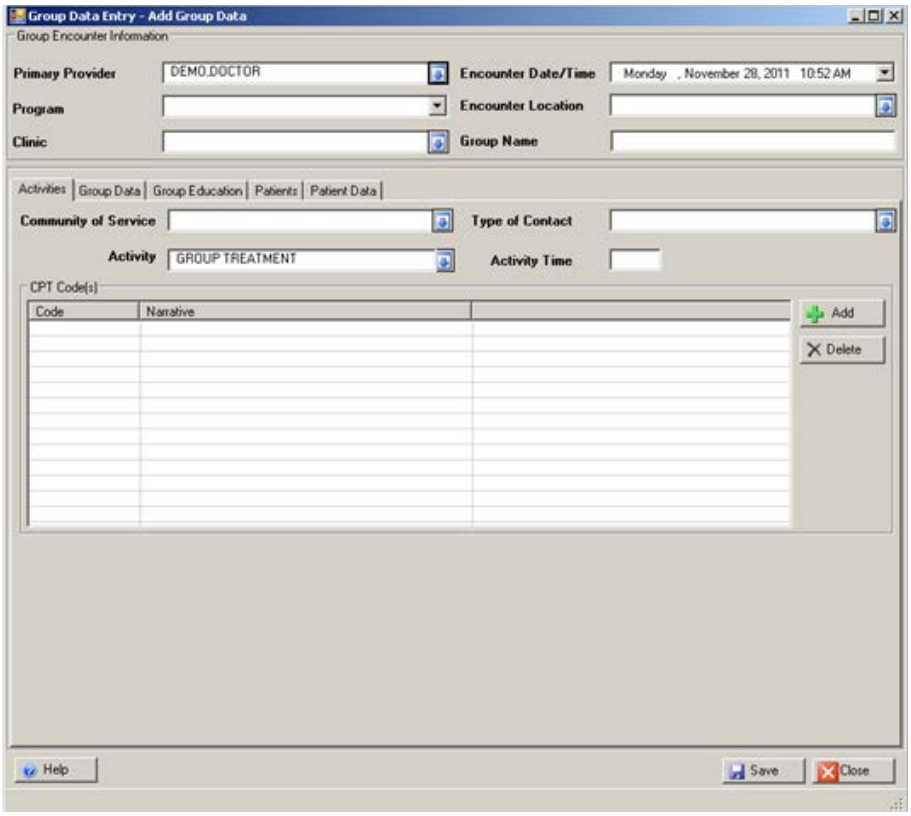


Figure 5-25: Group Data Entry - Add Group Data window

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

Feature	Functionality
Group Encounter Information group box	The fields in this group box display the existing data (cannot be changed). All editing is completed in the Group Encounter Information group box or on the Patient Data tab if the group has already been saved. • If the group has been signed the other fields can still be edited (does not apply to the note section). • If you access an unsigned group data record, you can edit the note.
Help button	Click this button to access the online help system about this window.
Save button	Click this button to save the changes and dismiss the window.

The following applies to the Save process:

- If you added a SOAP/Progress note, the application displays the **Sign?** confirmation message that asks if you want to sign the SOAP/Progress note now.
  - Click **No** to leave the note unsigned.

– Click **Yes** and the application will display the **Electronic Signature** dialog box displays. Section 2.14.5 provides more information about electronic signature (GUI).

The following applies to the Close process:

- The Close process displays the **Continue?** dialog box that asks: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add group data window. Click **No** to remain on the add group data window.

Other features to consider are:

- If you access an unsigned group data record, you can edit the note.
- The Patient Data tab is the only place you can do any editing after a group has been saved.
- If you access an unsigned group data record, then you can edit everything on that tab except the note.

5.3.1 Group Encounter Information Group Box

The add window has the following (active) fields.

Figure 5-26: Sample Group Encounter Information group box

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

The fields in bold text are required.

1. At the **Primary Provider** field, select the primary provider for the group encounter. The default is the current provider.

   Change this field by clicking the drop-down list to access the **Primary Provider** search/select window. Here you can search for a primary provider name.

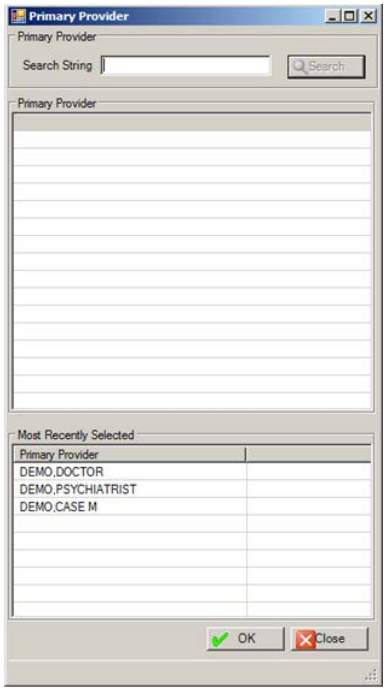
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a name and click **OK** to populate the Primary Provider field.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

Figure 5-27: Sample Primary Provider search/select window

2. At the **Encounter Date/Time** field, select the encounter date and time. The default is the current date and time.

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

3. At the **Program** field, select the program associated with the visit. Click the drop down list and use one of the following:

   Mental Health

   Social Services

   Other

   Chemical Dependency

   After selecting a program, the application automatically populates the Clinic and Encounter Location fields if the defaults were set in the Site Parameters menu. These fields are inactive on the edit window.

4. At the **Encounter Location** field, select the location of the group encounter. Change this field by clicking the drop-down list to access the **Location** search window. Here you can search for a location name.

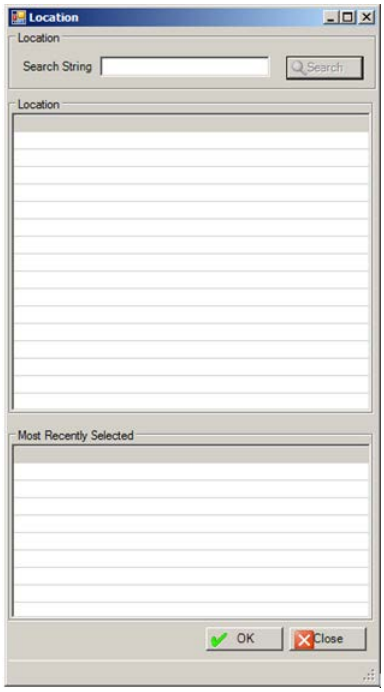
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the location and then clicking **Search**. The retrieved locations will populate the Location list box. Select a location and click **OK** to populate the Encounter Location field. (Otherwise,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

Figure 5-28: Sample Location search window

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

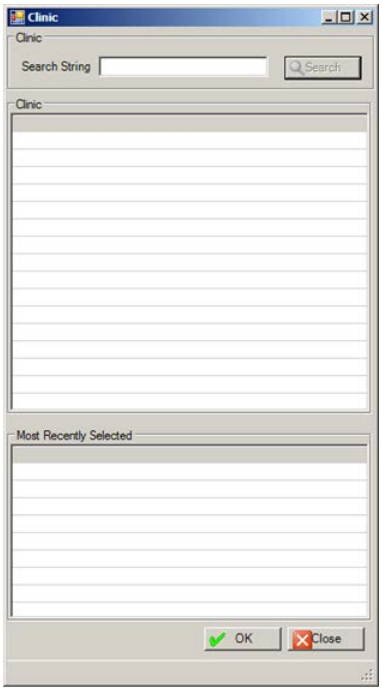
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the clinic and then clicking **Search**. The retrieved clinics and their codes will populate the Clinic list box. Select a clinic and click **OK** to populate the Clinic field. (Otherwise,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

Figure 5-29: Clinic search window

6. At the **Group Name** field, type the name of the group encounter, using between 1 and 30 characters in length. This is a Free Text field.

5.3.2 Activities Tab

Use the **Activities** tab to specify the community of service, type of contact, activity, and activity code. In addition, you can add CPT codes in the lower group box.

The information on this tab is read-only when using the **Edit Group Data** window.

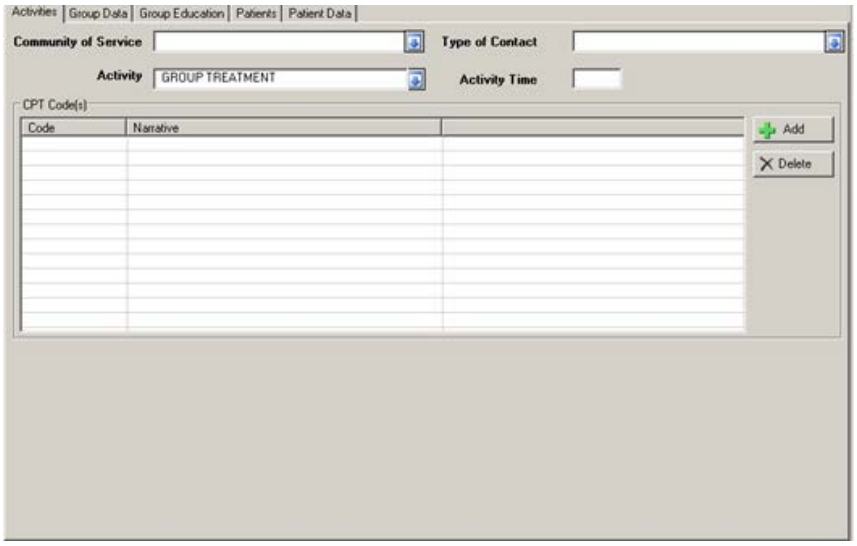


Figure 5-30: Sample Activities tab

Fields

Below are the fields for the **Activities** tab.

1. At the **Community of Service** field, select the community of service where the group encounter took place. Change this field by clicking the drop-down list to access the **Community** search window. Here you search for the community name.

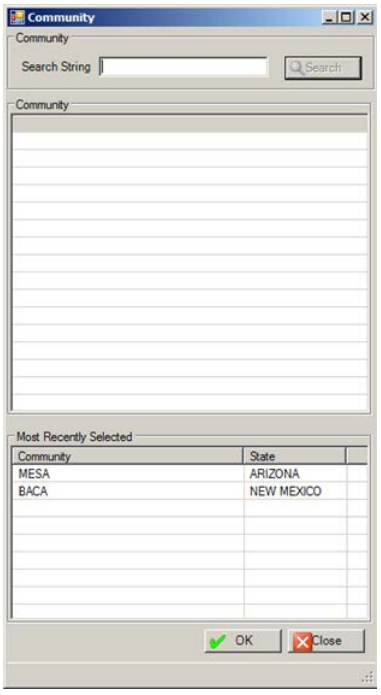
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and then clicking **Search**. The retrieved community names and their states will populate the Community list box. Select a community and click **OK** to populate the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

Figure 5-31: Sample Community search window

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

Screen Capture	What to do
	Use this window as follows: (1) Select a type of contact from the list. (2) Click **OK** to populate the "Type of Contact" field. (Otherwise, click **Close.**)

Figure 5-32: Sample Type of Contact window

3. At the **Activity** field, select the activity for the group encounter. The default is Group Treatment. Change this field by clicking the drop-down list to access the **Activity** search window. Here you search for an activity name or its code.

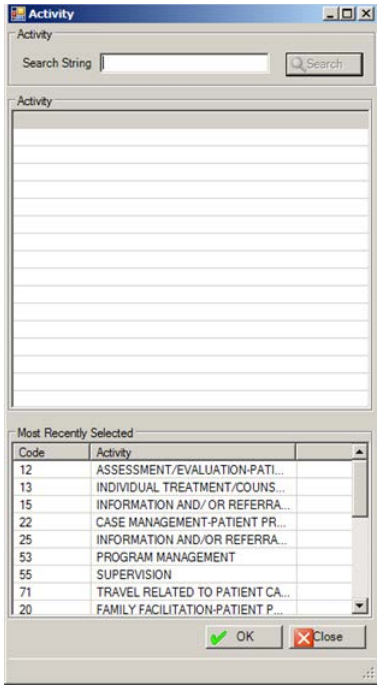
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the activity name or code and then clicking **Search**. The retrieved activities will populate the Activity list box. Select an activity and click **OK** to populate the Activity field.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

Figure 5-33: Sample Activity search window

4. At the **Activity Time** field, type the number of minutes spent on the activity for the group, using any integer between 1 and 9999. Please note, 0 (zero) is not a valid entry.

CPT Codes Group Box

Use the **CPT Code** group box to manage the CPT codes associated with the activity for the group.

Add Button

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

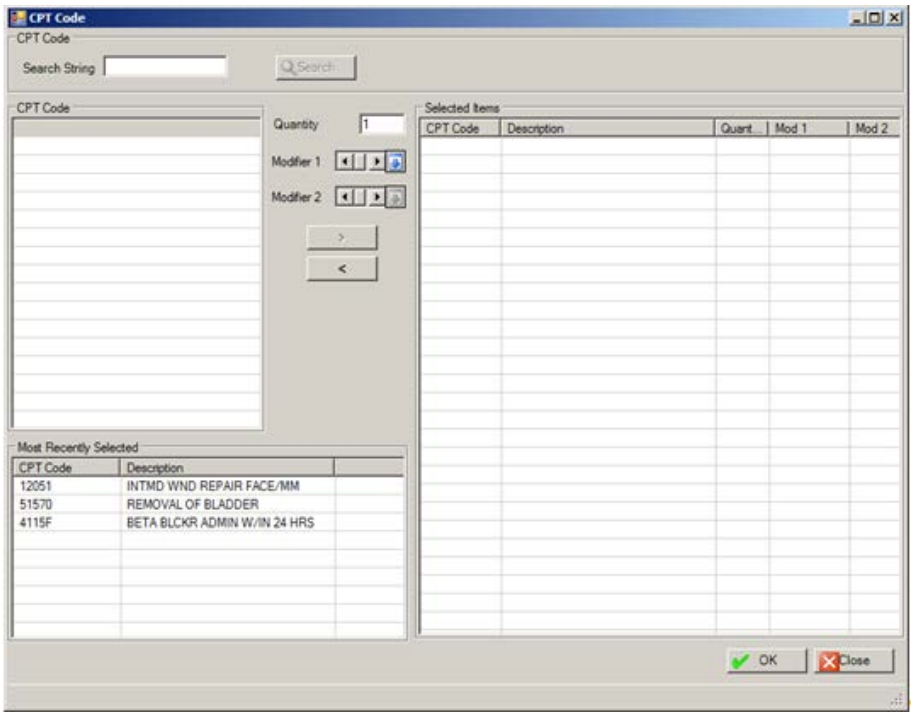


Figure 5-34: Sample CPT Codes search/select window

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

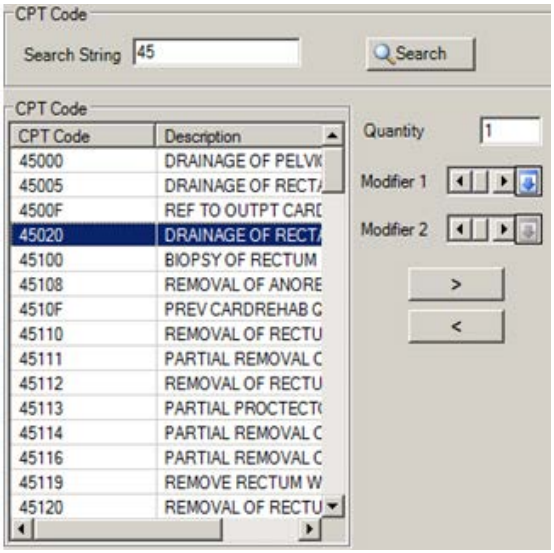


Figure 5-35: Sample CPT Code search results

a. Select a retrieved CPT Code.

b. At the **Quantity** field, type the number of CPT codes to use to help facilitate billing.

c. At the **Modifier** field, select the modifier for the CPT code. Click the drop-down list to access the **CPT Modifier** search window.

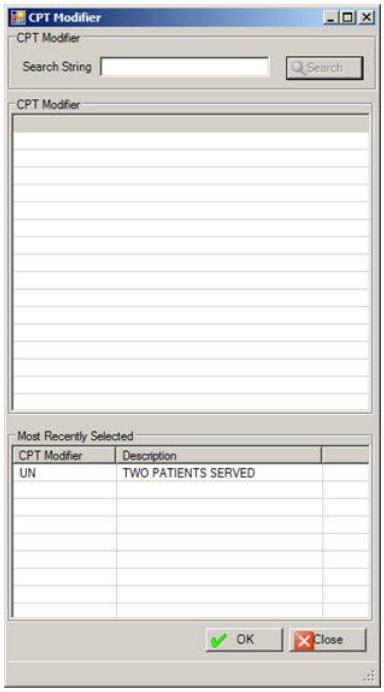
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the CPT Modifier name and then clicking **Search**. The retrieved CPT Modifier names and their descriptions will populate the CPT Modifier list box. Select a CPT modifier and click **OK** to save the modifier. (Otherwise, click **Close**.) (2) Select a CPT modifier in the Most Recently Selected list box and click **OK** to save the modifier. (Otherwise, click **Close**.)

Figure 5-36: Sample CPT Modifier search window

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

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

5. Another way to populate the **Selected Items** list box is to select a CPT code in the **Most Recently Selected** list box and then click the right-pointing arrow

6. Remove a selected CPT code in the **Selected Items** list box by clicking the left-pointing arrow.

7. When the **Selected Items** list box is complete, click **OK** to save the data and to add the data to the CPT Code(s) group box. (Otherwise, click **Close**.)

Delete Button

1. Select a CPT code record to delete.

2. Click **Delete**.

3. At the "Are You Sure" confirmation message, click **Yes** and the selected record will be removed from the CPT Code(s) group box. (Otherwise, click **No**).

5.3.3 Group Data Tab

Use the **Group Data** tab to specify secondary providers, POV code, group note, and CPT codes for the group encounter.

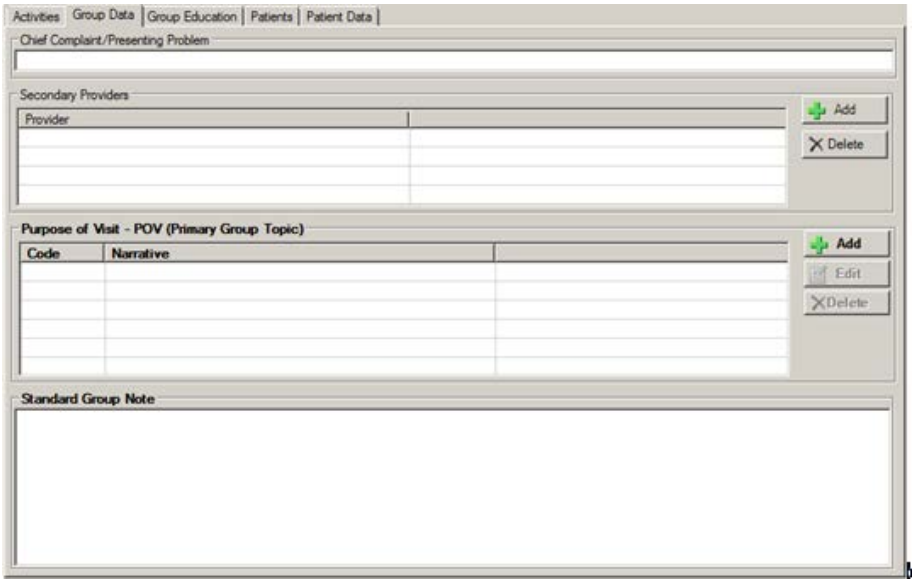


Figure 5-37: Sample Group Data tab

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

The group box names in bold text are required.

Chief Complaint/Presenting Problem Field

In the field, type the chief complaint or presenting problem using 2 to 80 characters. This information describes the major reason the patients sought services.

Secondary Providers Group Box

Use the **Secondary Providers** group box to add or delete secondary providers for the group encounter.

Figure 5-38: Sample Secondary Providers group box

Add Button

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

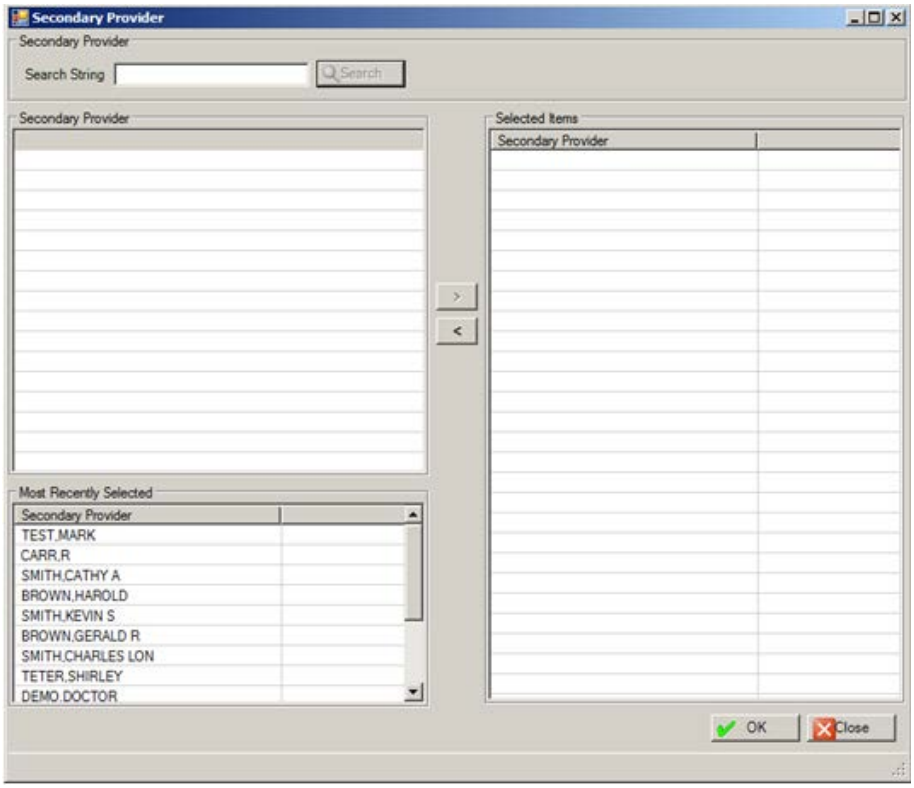


Figure 5-39: Sample Secondary Providers search/select window

Use the **Secondary Providers** multiple search/select window in the following manner:

a. At the **Search String** field, type a few characters of the search criteria.

b. Click **Search** and the retrieved the records display in **Secondary Provider** list box.

c. To add one or more selected records from the **Secondary Provider** list box to the **Selected Items Secondary Provider** list box, click the right-pointing arrow button.

d. Another way to add records to the **Selected Items Secondary Provider** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.

e. Similarly, you can remove one or more selected records from the **Selected Items Secondary Provider** list box by clicking the left-pointing arrow button.

f. When the records in the **Selected Items Secondary Provider** list box is complete, click **OK** and the records populate the **Secondary Providers** group box. (Otherwise, click **Close**.)

Delete Button

1. Select a secondary provider record to delete.
2. Click **Delete**.
3. At the "Are you Sure" confirmation message, click **Yes** to remove the selected secondary provider. Otherwise, click **No**.

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

Use this group box to add, edit, or delete POV codes and their narratives associated with the group encounter. These are POVs for all group members and will display as such on the Patient Data Tab and the printed encounter record unless edited or deleted on the Patient Data tab.

At least one POV record is required for a group encounter.

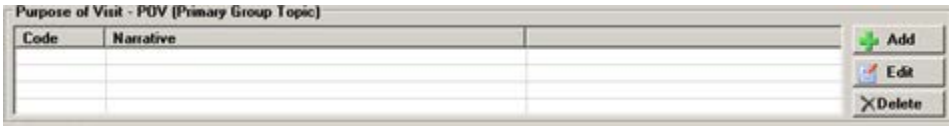


Figure 5-40: Sample POV group box

You can add, edit, or delete POV records in this group box

Delete Button

1. Select a POV record to delete.
2. Click **Delete**.
3. At the "Are you Sure" confirmation message, click **Yes** to remove the selected POV record. Otherwise, click **No**.

Add Button

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

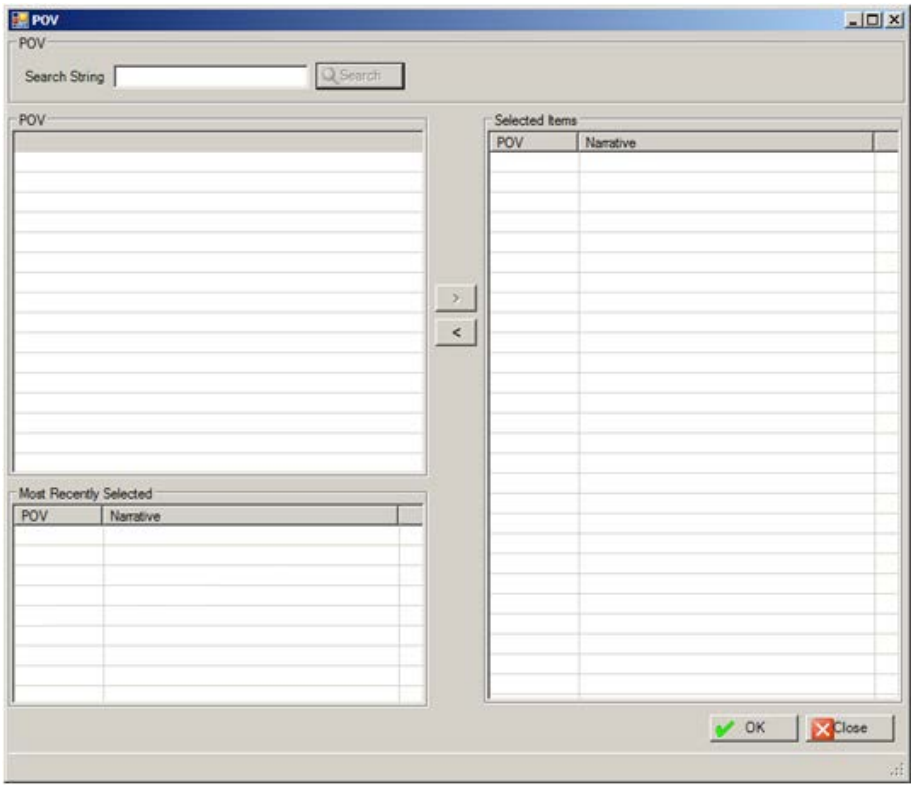


Figure 5-41: Sample POV multiple select/search window

Use the POV multiple search/select window in the following manner:

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

Edit Button

Use the **Edit** button to change the Narrative part of a POV record in the group box.

1. Select a POV record to edit.

2. Click **Edit**.

3. The **Edit POV** dialog box displays.

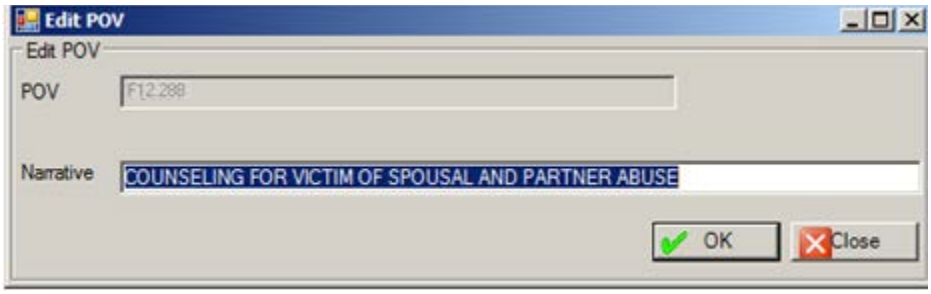


Figure 5-42: Edit POV dialog box

4. At the **Narrative** field, type the new POV narrative, using 2–80 characters.

> **Note**: The special characters " or ' cannot be the first character of the POV narrative. The Narrative field is a Free Text field.

5. Click **OK** to change the narrative of the selected code on the POV group box. Otherwise, click **Close** to not change the narrative.

Standard Group Note Field

Use **Standard Group Note** field to type the text of a group note for the group encounter. This is a Free Text field.

You must be on the **Patient Data** tab to do any editing after the group has been saved.

5.3.4 Group Education Tab

Use the **Group Education** tab to add, change, or delete education data about the group encounter.

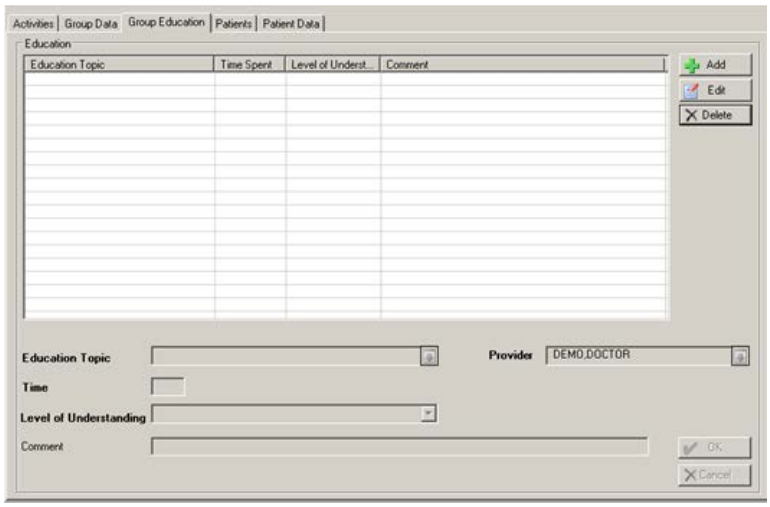


Figure 5-43: Sample Group Education tab

The information on this tab is read-only when using the **Edit Group Data** window.

Add/Edit Group Education Record

The **Add** and **Edit** functions use the same fields.

All Group Education entries created before the installation date for BHS v4.0 will continue to display the Goal and CPT fields.

1. Click **Add** to activate the fields below the education grid.

   OR

2. Select a record to edit and click **Edit**.

3. At the **Education Topic** field, select the education topic for the group encounter. Click the drop-down list to access the **Education Topic** search window. Here you search for an education code.

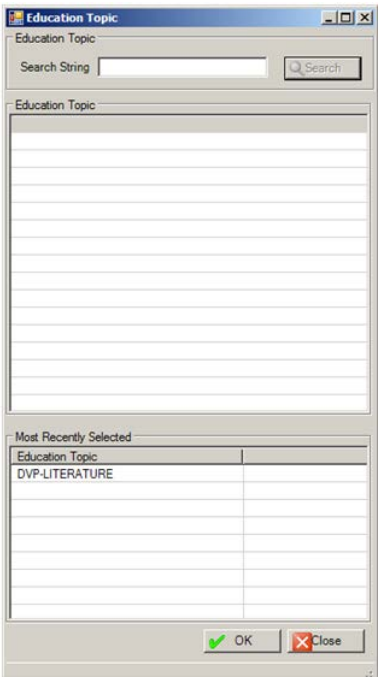
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the education topic and then clicking **Search**. The retrieved education topics will populate the Education Topic list box. Select a retrieved record and click **OK** to populate the Education Topic field. (Otherwise, click **Close**.) (2) Select an education topic in the Most Recently Selected list box and click **OK** to populate the Education Topic field. (Otherwise, click **Close**.)

Figure 5-44: Sample Education Topic select window

4. At the **Provider** field, select the provider for the group education. Click the drop down list to access the **Education Provider** search window. Here you search for a provider name.

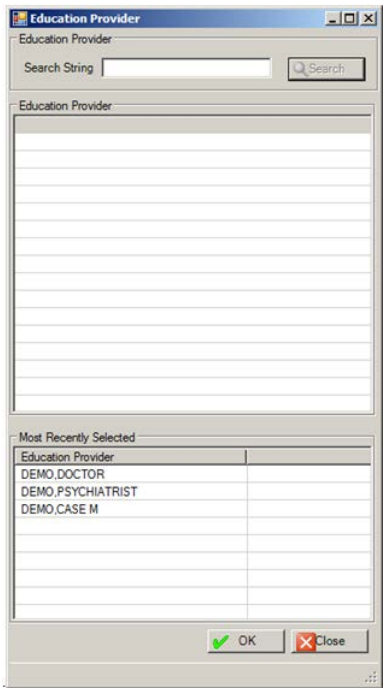
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Education Provider list box. Select a retrieved record and click **OK** to populate the Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Provider field. (Otherwise, click **Close**.)

Figure 5-45: Sample Education Provider select window

5. At the **Time** field, type the time spent on the education topic, using any integer 1 - 9999. The understood units of measure are minutes.

6. At the **Level of Understanding** field, select the level of understanding about the education topic. The default is Group-No Assessment (the only choice).

7. At the **Comment** field, type any comments about the education topic for the group encounter.

   Click **Cancel** to clear the fields on the **Group Education** tab.

   Click **OK** when all fields are complete. This adds a record to the Education grid.

Delete Group Education Record

1. Select a group education record to delete.

2. Click **Delete**.

3. At the "Are You Sure" confirmation message, click **Yes** to remove the selected Education record from the group box. (Otherwise, click **No**.)

> **Note**: The Group Education can be removed only prior to saving the group. Once the group has been saved, there is currently no way to remove it in the group format.

5.3.5 Patients Tab

The **Patients** tab shows the patients in the group encounter.

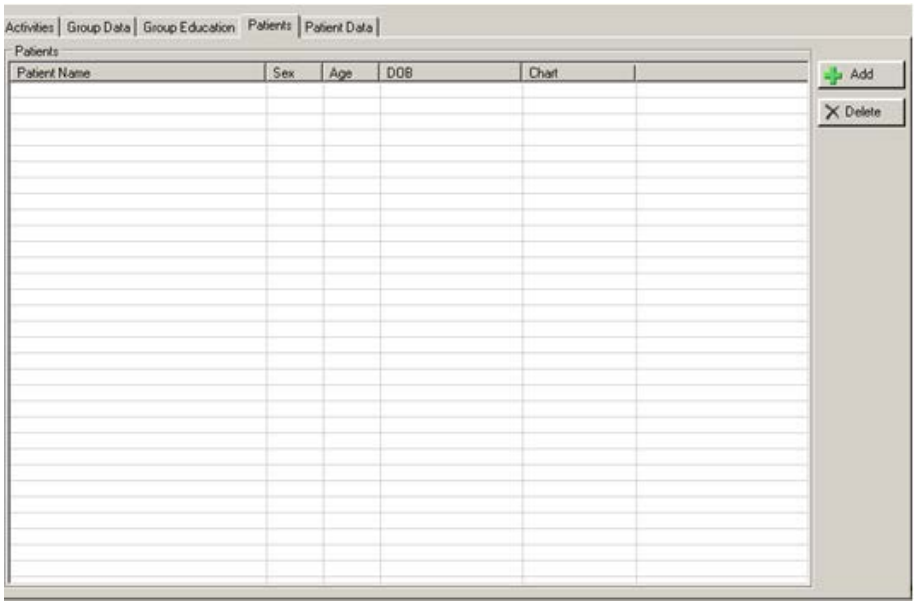


Figure 5-46: Sample Patients tab

The information on this tab is read-only when using the **Edit Group Data** window.

You can add or delete patient records on this tab (on the "Add" window).

Add Patient Record

The **Add** button requires that the POV group box and the Standard Note Group Note (on the Group Data tab) be populated.

1. Click **Add** to access the **Select Multiple Patients** window.

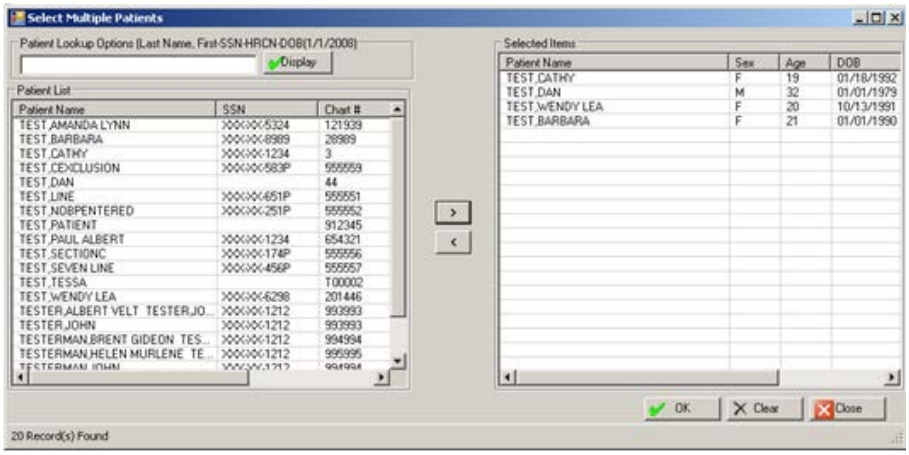


Figure 5-47: Sample Select Multiple Patients dialog box

Use this dialog box add one or more patients to the **Patients** tab.

2. At the **Patient Lookup** field, type the patient name, HRM, DOB, or SSN.
3. Click **Display**.
4. The retrieved patients display in the **Patient List** box.
5. Select one or more patient names from the **Patient List** group box and click the right-pointing arrow to add them to the **Selected Items** list box.
6. If needed, select a patient name from the **Selected Items** list box and click the left-pointing arrow to move the patient name to the **Patient List** box.
7. When the **Selected Item** list box is complete, do one of the following:
   - Click **OK** to have the patient names to populate the **Patients** group box (on the Patients tab). This closes the **Select Multiple Patients** dialog box.
   - Click **Clear** to have all of the patient names removed from the **Selected Items** group box and the focus stays on the **Select Multiple Patients** window.
   - Click **Close** to close **Select Multiple Patients** window and no patient names are added to the **Patients** group box.

Delete Patient Record

1. Select a patient record to delete.
2. Click **Delete**.
3. At the "Are You Sure" confirmation message, click **Yes** to remove the selected patient record from the Patient group box. (Otherwise, click **No**.)

Note:	Leave the clients who no showed or canceled in the group because it is possible to do the "no show" within the group definition on the Patient Data tab in the Time In Activity field.

5.3.6 Patient Data Tab

Use the **Patient Data** tab to add POV, group note, and comment/next appointment information for a particular patient in the group encounter.

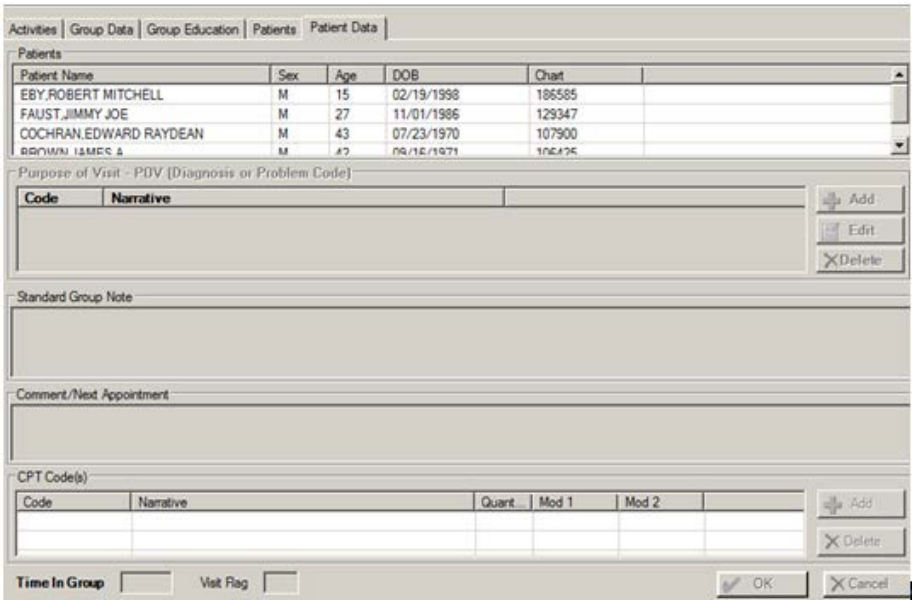


Figure 5-48: Sample Patient Data tab

The following table provides information about the features on this window.

Features	Functionality
Patients list field	Select a patient by double-clicking the name in the Patients list box in order to activate the other group boxes.
OK button	Click **OK** after selecting a patient record and changing or adding new patient data to save the patient data.
Cancel; button	Click **Cancel** to not save the changes and to dismiss the **Patient Data** tab.

Patients List Box

The **Patients** list box shows the patients in the group encounter.

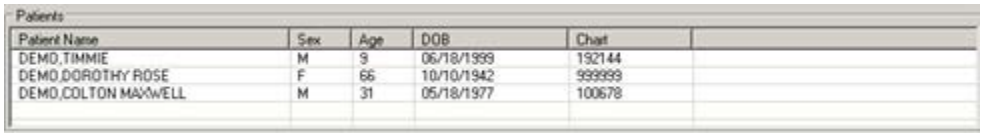


Figure 5-49: Sample Patients group box

Double-click one of the patient names in order to use the other group boxes and fields.

After completing the information for the first patient, click **OK**. The focus returns to the **Patients** list box. Then double-click the next patient. After completing the information for the second patient, click **OK**. Repeat this process until all of the patients are complete. Then click **Save** to save all of the information.

If you are in ADD mode and you have clicked **OK** and then try to go to the **Group Data** tab, the application displays the **Continue** warning.

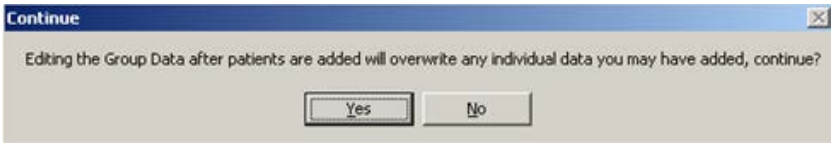


Figure 5-50: Warning Message

- Click **Yes** to overwrite any added individual data. This focus will go to the Group Data tab.
- Click **No** to not overwrite any added individual data. The focus will go to the Patients Data tab.

Purpose of Visit - POV (Diagnosis or Problem Code) Group Box

Use the **Purpose of Visit - POV (Diagnosis or Problem Code)** group box to add, edit, or delete a POV for the selected patient. (Be sure to double-click a patient name before adding/changing the data in this group box.)

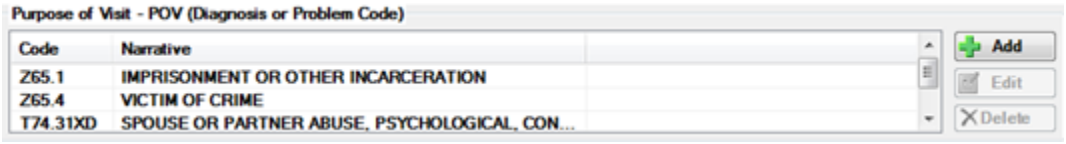


Figure 5-51: Sample POV group box

This is required data for the group encounter record.

You can add, edit, or delete POV code records.

Delete Button

1. Select a POV record to delete.
2. Click **Delete**.
3. At the "Are You Sure" confirmation message, click **Yes** to remove the selected POV record from the POV group box. (Otherwise, click **No**.)

Add Button

1. Click **Add**.
2. The **POV** multiple search/select window displays.

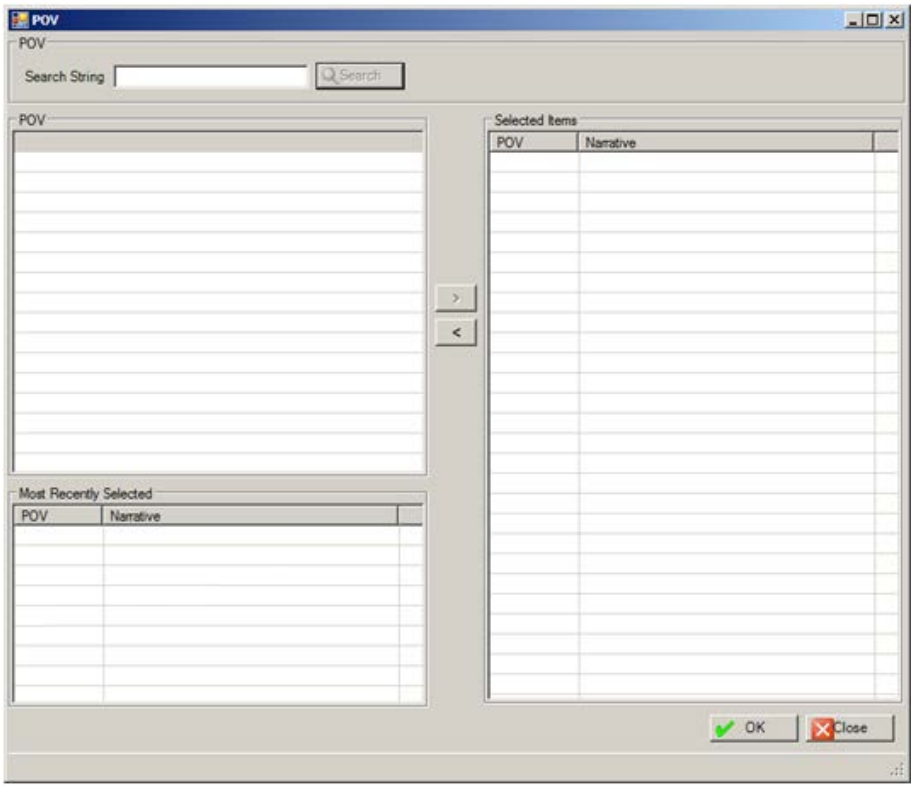


Figure 5-52: Sample POV multiple select/search window

Use the POV multiple search/select window in the following manner:

a. At the **Search String** field, type a few characters of the search criteria.

b. Click **Search** and the retrieved the records display in POV list box (the POV and its narrative).

c. To add one or more selected records from the POV list box to the **Selected Items** list box, click the right-pointing arrow button.

d. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.

e. Another way to add records to the **Selected Items** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.

f. When the records in the **Selected Items** list box is complete, click **OK** and the records populate the **Purpose of Visit (POV)** group box. (Otherwise, click **Close**.)

Edit Button

1. Select a POV record to edit.

2. Click **Edit** to display the **Edit POV** dialog box.

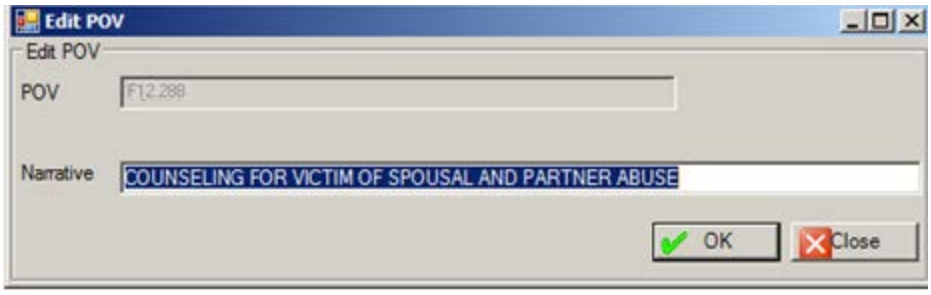


Figure 5-53: Sample Edit POV dialog box

3. At the **Narrative** field, change the text of the narrative, using 2–80 characters. Note: the special characters (such as “, *, ‘) cannot be the first character of the POV narrative. The Narrative field is a Free Text field.

4. Click **OK** to change the narrative of the selected code on the **POV** group box on the Patients Data tab.

5. Otherwise, click **Close** to not change the narrative.

Standard Group Note Field

Populate this Free Text field with the text of the Standard Group Note. This information, for example, could be about how the patient reacted in the group (on the Patient Data tab).

This is where to individualize the note for the patient in focus. The standard group note should never reference the individual patient but should have information about the individual patient’s participation in the group.

- This field is available for text entry by the primary provider of the record (only).
- This field is not available for text entry if the note for the group record is signed.

Comment/Next Appointment Field

Populate this Free Text field with the text of any comments about the next appointment for the selected patient. This field is available for text entry by the primary provider of the record (only).

CPT Codes Group Box

Use this group box to manage the CPT codes for the selected patient in the group.

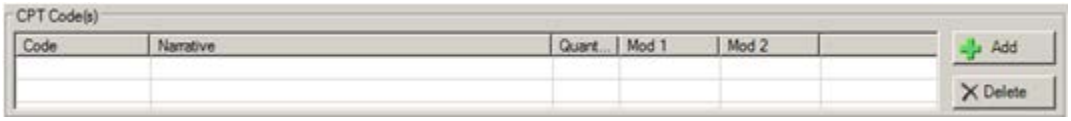


Figure 5-54: CPT Code(s) group box

You can add or delete CPT code records.

Delete Button

1. Select a CPT Code record to delete
2. Click **Delete**.
3. At the "Are You Sure?" confirmation, click **Yes** to remove the selected record from the **CPT Codes** group box. (Otherwise, click **No**).

Add Button

1. Click **Add**.
2. The **CPT Code** search/select window displays.

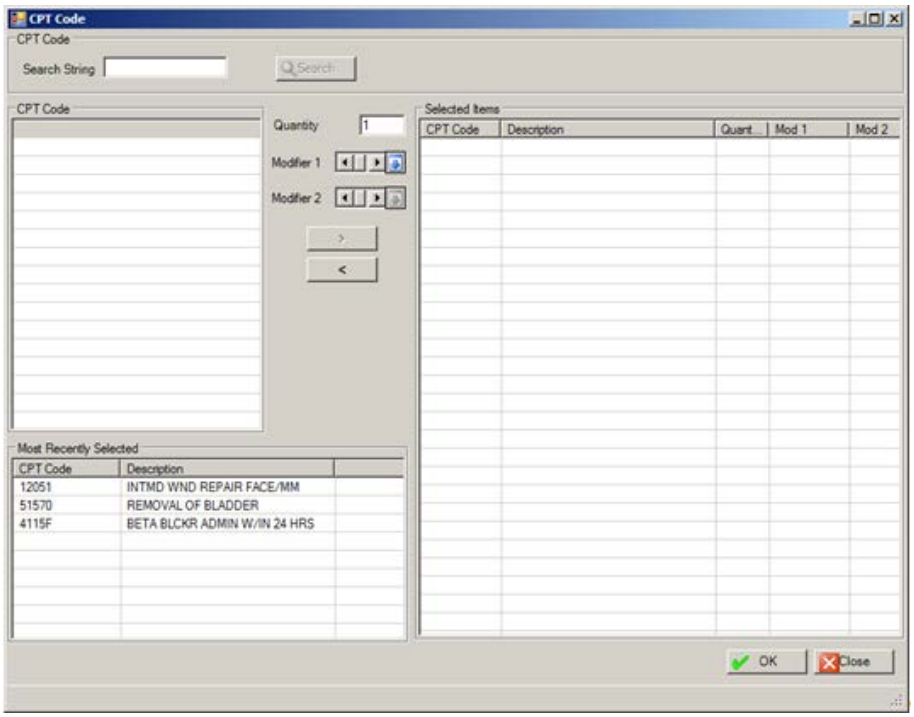


Figure 5-55: CPT Code search/select window

3. At the **Search String** field, type a search string to search for a particular CPT code. The CPT codes will display in the **CPT Code** field.

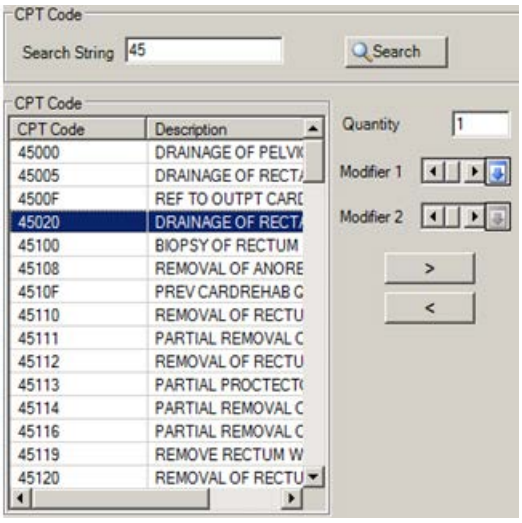


Figure 5-56: Sample CPT Code search results

4. At the **Quantity** field, type the number of the CPT code to use to help facilitate billing.

5. At the **Modifier** field, select the modifier for the CPT code. Click the drop-down list to access the **CPT Modifier** search window.

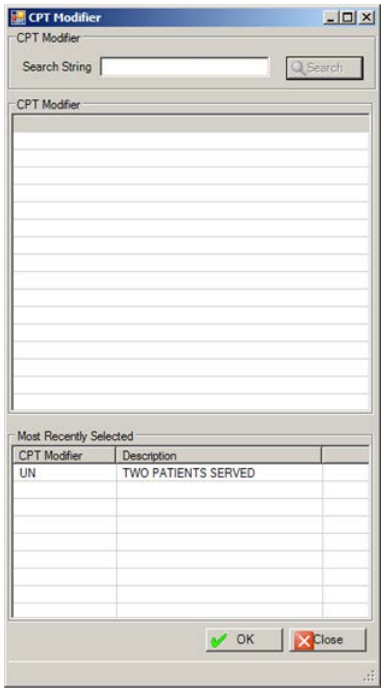
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by by typing the CPT Modifier name and then clicking **Search**. The retrieved CPT Modifier names and their descriptions will populate the CPT Modifier list box. Select a CPT modifier and click **OK** to save the modifier. (Otherwise, click **Close**.) (2) Select a CPT modifier in the Most Recently Selected list box and click **OK** to save the modifier. (Otherwise, click **Close**.)

Figure 5-57: Sample CPT Modifier search window

6. Remove a selected CPT code in the **Selected Items** list box by clicking the left-pointing arrow.

7. After the **Quantity** and **Modifier** fields are complete, click the right-pointing arrow to add the items to the **Selected Items** list box.

8. When the **Selected Items** list box is complete, click **OK** to save the data and to add the data to the CPT Code(s) group box. (Otherwise, click **Close**.)

Time in Group

Figure 5-58: Sample Time in Group field

1. At the **Time in Group** field, type the number of minutes in the group encounter (up to six digits).

2. This is required data for the group encounter record.

Consider the following:

- If the patient attended the whole group session, no changes need to be made to the **Time Spent** in Group field.
- If the patient was late or left early, the **Time Spent** in Group field needs to be changed to reflect the actual time in minutes that the patient was in the group.
- If the patient didn't attend at all, type a zero in the **Time In Group** field and then click **OK**. The application will display the No Show message that states: Changing Time in Group to zero removed this patient's POV and Note entry. You will now be prompted for a No Show POV. Click **OK**. After clicking **OK**, to access the **POV** search/select window. Here you can select one or more "no show" POVs. Click **OK** (otherwise, click **Cancel**). After clicking **OK**, the selected POVs will display in the **Purpose of Visits – POV** group box on the **Patient Data** tab (all existing POVs will be replaced by your selections).

Visit Flag

Figure 5-59: Visit Flag field

Use the **Visit Flag** field to specify the visit flag for the group encounter.

1. At the **Visit Flag** field, type any number between 0 and 999 (no decimal digits).

2. This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean

any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

6.0 Case Management

This section provides information about case management in the roll-and-scroll application, as well as in the RPMS Behavioral Health System (GUI).

6.1 Managing Case Data (Roll and Scroll)

Manage case data on the Patient Data Entry window by selecting the Update Case Data (CD) action. The application displays the Update BH Patient Case Data screen.

```
Update BH Patient Case Data   Mar 23, 2009 15:27:33          Page:    0 of    0
------------------------------------------------------------------------------
Patient Name: DEMO,DOROTHY ROSE   DOB: OCT 10, 1942   Sex: F   HRN: 99999
------------------------------------------------------------------------------

#   PROGRAM  OPEN      ADMIT     CLOSED   DISPOSITION           PROVIDER
1   MENTAL   12/19/15   12/19/15                                THETA,SHIRLEY
    Primary Problem: F10.259    ALCOHOL-INDUCED PSYCHOTIC DISORDER WITH MODERATE OR
    Next Review:
2   MENTAL   11/13/15   11/30/15                                THETA,SHIRLEY
    Primary Problem: F42.       HOARDING DISORDER
3   MENTAL   3/13/14   3/20/14   6/2/14   MUTUAL AGREEMENT TO   THETA,SHIRLEY
    Primary Problem: 11         DRUG WITHDRAWAL SYNDROME
          ?? for more actions  + next screen  - prev screen
OP   Open New Case        DC   Delete Case
ED   Edit Case Data       Q    Quit
Select Item(s):
```

Figure 6-1: Sample Update BH Patient Case Data screen.

Use the Quit (Q) option to exit the Update BH Patient Case Data screen.

6.1.1 Open New Case (OP)

Use the Open New Case (OP) option to create a new case. If you use the Open New Case (OP) option, the application displays that it is opening a case for the current patient.

Below are the prompts.

1. At the “Select Item” prompt, type **OP**.
2. At the “Enter Case Open Date” prompt, type the date to open the case. This is the first contact for an episode of care. The Update Patient Case Data window displays.

```
                  **********   UPDATE PATIENT CASE DATA   *********
 Patient Name: ALPHAA,CHELSEA MARIE

*****************************************************************************

                    CASE OPEN DATE: MAY 23,2009
                PROGRAM AFFILIATION: MENTAL HEALTH
                      PROVIDER NAME:
                     PRIMARY PROBLEM:

                     CASE ADMIT DATE:
                NEXT CASE REVIEW DATE:

                    DATE CASE CLOSED:
                         DISPOSITION:

COMMENT:
_____________________________________________________________________________


COMMAND:                                        Press <PF1>H for help    Insert
```

Figure 6-2: Sample Update Patient Case Data window

The underlined fields are required.

3. At the “Case Open Date” prompt, type the date the case was opened (can be edited).
4. At the “Program Affiliation” prompt, type the program affiliation, using one of the following:

   M Mental Health Defaults
   S Social Services Defaults
   C Chemical Dependency or Alcohol/Substance Abuse
   O Other

5. At the “Provider Name” prompt, type the name of the provider for the case.
6. At the Primary Problem” prompt, type the primary problem (name or code).
7. At the “Case Admit Date” prompt, type the admit date for the case. This is when a case management plan was developed and treatment began.
8. At the Next Case Review Date” prompt, type the next date for the case review.
9. At the “Date Case Closed” prompt, type the date the case was closed. This is when treatment has been discontinued (used when closing a case).
10. At the “Disposition” prompt, type the disposition for the case. This is the reason for closing a case. This is a required field when there is a date in the Date Case Closed field.

11. At the “Comment” prompt, type the text of a comment about the case, using 1–240 characters.

6.1.2 Edit Case Data (ED)

Use the Edit Case Data (ED) option to change a selected case. Use this option to edit an open case where you enter the admitted date when a case is admitted or to close the case when it is closed on the Update Patient Data window.

1. At the “Select Item(s)” prompt, type **ED**.
2. At the “Select BH Patient Case Data” prompt, type the number of the case data to edit.
3. The UPDATE PATIENT CASE DATA window displays.

   The fields on this window are the same as those when you use the Open New Case option. Section 6.1.1 provides more information.

6.1.3 Delete Case (DC)

Use the Delete Case (DC) option to remove a specified case from the Update BH Patient Case Data window.

1. At the “Select Item(s)” prompt, type **DC**.
2. At the “Select BH Patient Case Data” prompt, type the number of the case data to delete.
3. At the “Are you sure you want to delete this CASE? “ prompt, type **Y** (yes) or **N** (no.)

6.1.4 Designated Provider/Flag/Personal History (Roll and Scroll)

Use the OI (Desg Prov/Flag/Pers Hx) option on the Patient Data Entry window to update patient information.

1. At the “Select Action” prompt, type **OI**.

   The Update Patient Information window displays.

```
             *******  UPDATE PATIENT INFORMATION  *******
            Patient Name: DEMO,DARRELL LEE
            [press <F1>E when finished updating record]
_____________________________________________________________________________


  DESIGNATED MENTAL HEALTH PROVIDER:
DESIGNATED SOCIAL SERVICES PROVIDER:
        DESIGNATED CD A/SA PROVIDER:
```

```
          DESIGNATED OTHER PROVIDER:
      OTHER PROVIDER NON-RPMS:
      OTHER PROVIDER NON-RPMS:
   ========================================================================

 PATIENT FLAG FIELD:
 PATIENT FLAG NARRATIVE:

_____________________________________________________________________________


COMMAND:                                        Press <PF1>H for help    Insert
```

Figure 6-3: Sample Update Patient Information window

The data on this window applies to the current patient.

2. At the “Designated Mental Health Provider” prompt, type the RPMS provider name who has accepted designated Mental Health provider status for the patient.
3. At the “Designated Social Services Provider” prompt, type the PRMS provider name who has accepted designated Social Services provider status for the patient.
4. At the “Designated CD A/SA Provider” prompt, type the RPMS provider name who has accepted designated chemical dependency or alcohol/substance abuse provider status for the patient.
5. At the “Designated Other Provider” prompt, type the RPMS provider name who has accepted the designated other provider status for the patient.
6. At the “Other Provider Non-RPMS” prompt, type another behavioral health provider name not listed in RPMS (this could be a local doctor, school teacher, etc.), using between 2 and 40 characters. This is a Free-Text field.
7. At the “Patient Flag Field” prompt, type a locally-defined number field used to identify a specific group of patients (between 0 and 999). For example, 1 could designate patients with a family history of substance abuse, 2 could be used to identify patients enrolled in a special social services program, 3 could be used to identify patients enrolled in a special drug trial. In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.
8. At the “Patient Flag Narrative” prompt, type the narrative about the patient flag, using between 2 to 60 characters.

After you save or exit the Update Patient Information window, the application displays the Personal History window.

If the patient has an existing Personal History entry, the application displays this information (the date and the personal history factor). You can add another personal history factor, if needed.

Facilities often find personal history factors to be useful in developing reports for tracking diagnoses associated with personal history.

```
******************** PERSONAL HISTORY FOR DEMO,DOROTHY ROSE********************
TWIN
DIABETES
Enter PERSONAL HISTORY:
```

Figure 6-4: Sample Personal History window

Below are the prompts.

9. At the "Enter personal history" prompt, type the personal history factor for the current patient. If you do not want to add another personal history, use a caret (^) at the prompt. Choose from:

   ALCOHOL USE
   BOARDING SCHOOL
   CHILD ABUSE (VICTIM)
   DIABETES
   FETAL ALCOHOL SYNDROME
   GULF WAR VET
   PARTNER ABUSE (VICTIM)
   SUBSTANCE ABUSE
   SUICIDE ATTEMPT
   TESTING
   TWIN
   VIETNAM WAR VET
   WWII VET
   Chem
   co-occurring

10. After you have completed the personal history entry, the focus returns to the Patient Data Entry window.

    The personal history data entered here appears on the Patient List for Personal Hx Items report.

6.2 Case Management Window (GUI)

The figure below shows where the Case Management function is located on RPMS Behavioral Health System (GUI) tree structure.

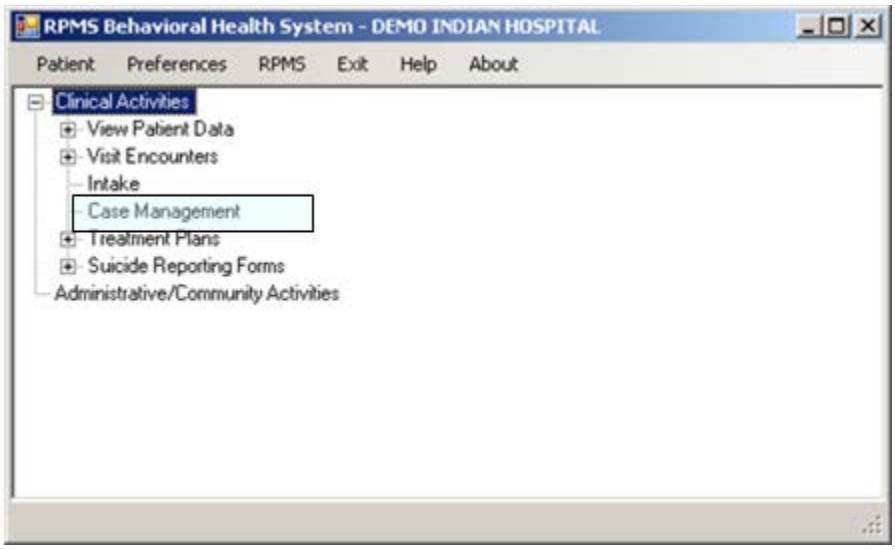


Figure 6-5: Case Management option on the RPMS Behavioral Health System (GUI) tree structure

Use the **Case Management** option to access the **Case Management** window for the current patient.

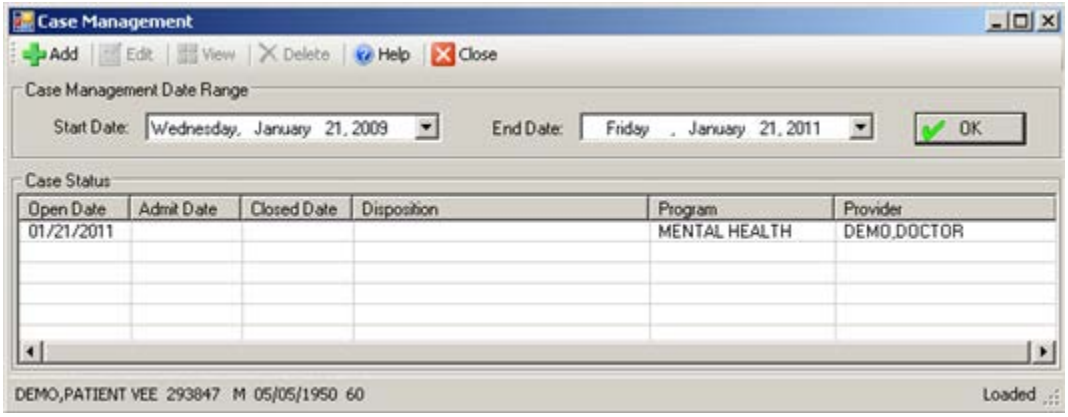


Figure 6-6: Sample Case Management window

You use the **Case Management** window to manage the case management records within a particular date range for the current patient (the name displays in the lower, left corner of the window).

The following table provides information about the features of this window.

Feature	Functionality
Case Management Date Range	The date range for the displayed case management records is shown in the **Case Status Date Range** group box. You can change the date range by accessing the calendar under the drop-down list for the date. After changing the date range, click **OK** to update the display in the **Case Status** group box.
Case Status Group Box	The **Case Status** group box displays the case management records in the case management data range.
Add Button	Establish the patient you want to use in the add process. Click **Add** to add a new case management record. You access the **Case Management–Add Case** window.
Edit Button	Click **Edit** to edit a particular case management record. The application displays the **Case Management–Edit Case** window.
View Button	Click **View** (or double-click on a record) to view the data in a selected Case Management record. The application displays the **Case Management–View Case** window. The fields are the same as those on the add/edit case window.
Delete Button	Click **Delete** to remove a selected Case Status record. After clicking **Delete**, the Are You Sure? confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected case status record from the group box (otherwise, click **No**.)
Help Button	Click **Help** to access the online help system for the **Case Management** window.
Close Button	Click **Close** to close the **Case Management** window.

6.3 Add/Edit Case Management Data (GUI)

Use this function to add or edit case management data.

1. Click **Add** and the **Case Management–Add Case** window displays.

   OR

2. To edit a selected record, click **Edit**. The **Case Management–Edit Case** window displays; this window has the same fields as the **Case Management–Add Case** window.

3. The following shows the **Case Management–Add Case** window.

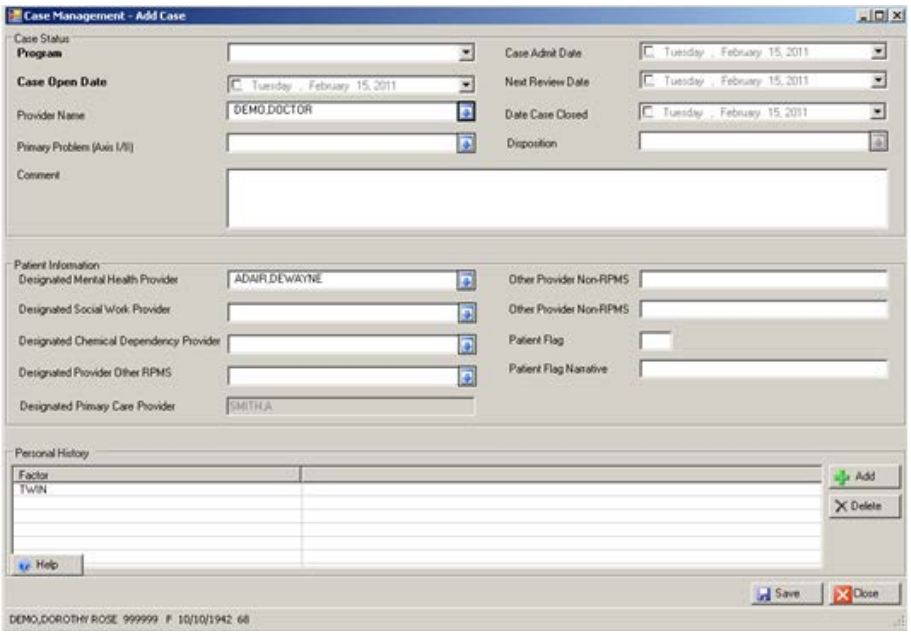


Figure 6-7: Sample Case Management–Add Case window

The following table provides information about the buttons on this window.

Button	Functionality
Save	Use to save the case management information on this window. This process dismisses the window.
Close	Click this button to display the **Continue?** dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add window. Click **No** and you remain on the add window where you can continue work on the **Add Case** window.
Help	Use to access the online help for this window.

6.3.1 Case Status Group Box

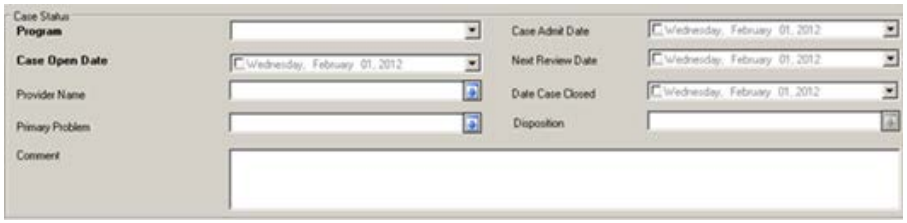


Figure 6-8: Fields in Case Status group box

The fields in bold text are required.

1. At the **Program** field, select the program ass associated with the new case. Use one of the following from the drop-down list:

   Mental Health

Social Services

Other

Chemical Dependency

2. At the **Case Admit Date** field, select the case admin date. This is when a case management plan was developed and treatment began. You can accept the default date by checking the check box in front of the date. The default is the current date. Click the drop-down list to access a calendar to change the field.

3. At the **Case Open Date** field, select the case open date. This is the first contact for an episode of care. The default is the current date. Click the drop-down list to access a calendar to change the field.

4. At the **Next Review Date** field, select the new review date. The default is the current date. Click the drop-down list to access a calendar to change the field. You can accept the default date by checking the check box in front of the date.

5. At the **Provider Name** field, select the primary provider for the case (the default is the current logon user). Click the drop-down list to access the **Primary Provider** search/select window.

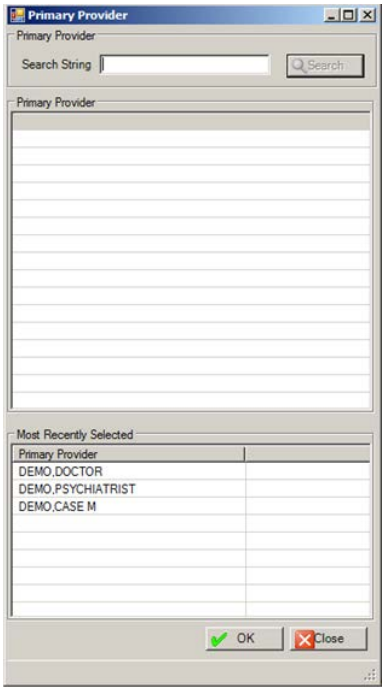
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a name and click **OK** to populate the Provider Name field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Provider Name field. (Otherwise, click **Close**.)

Figure 6-9: Sample Primary Provider search/select window

6. At the **Date Case Closed** field, select the date the case was closed. This is when treatment has been discontinued. The default is the current date. Click the drop-down list to access a calendar to change the field. You can accept the default date by checking the check box in front of the date.

7. At the **Primary Problem** field, select the primary problem for the case. Click the drop-down list to access the **POV** search window.

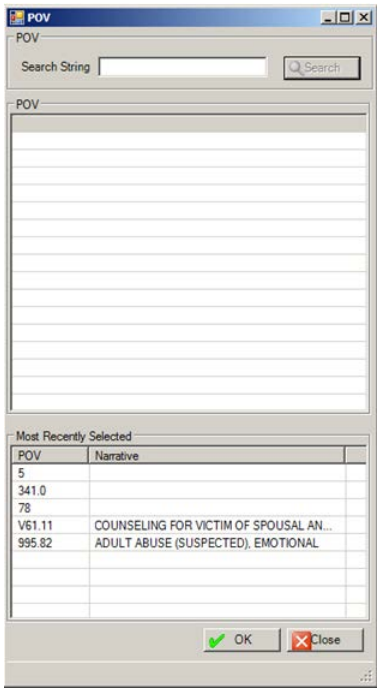
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the POV for the primary problem for the case and then **Search**. The retrieved POVs will populate the POV list box. Select a retrieved record and click **OK** to populate the Primary Problem field. (Otherwise, click Close.) (2) Select a record in the Most Recently Selected list box and click **OK** to populate the Primary Problem field. (Otherwise, click **Close**.)

Figure 6-10: Primary Problem/POV search window

8. At the **Disposition** field, select the reason for closing a case. Click the drop-down list to select an option on the **Disposition** select window. This is required when there is a date in the **Date Case Closed** field.

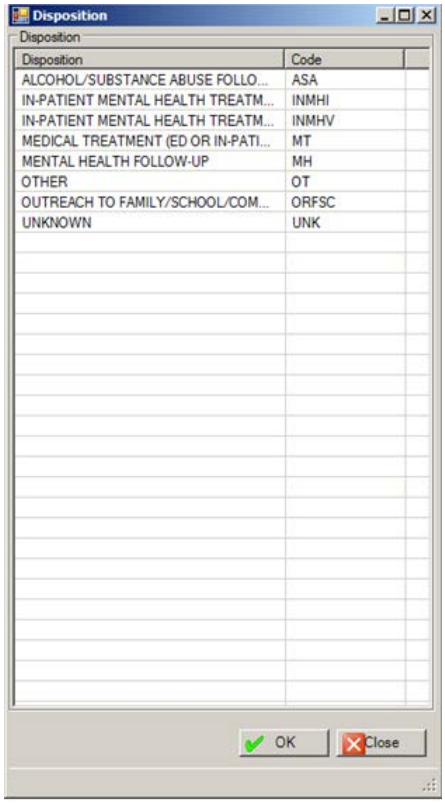
Screen Capture	What to do
	Use this search window as follow: (1) Select a Disposition option and click **OK** (otherwise, click **Cancel**). (2) If OK was used, the selected option populates the Disposition field.

Figure 6-11: Sample Disposition select window

9. At the **Comment** prompt, type a comment about the case, using 1–240 characters, in this Free Text field.

6.3.2 Patient Information Group Box

Use the **Patient Information** group box to supply information about various providers and other case management information.

Figure 6-12: Fields in the Patient Information group box

> **Note**: These fields should be cleared out whenever the case is closed; otherwise, the patient will continue to show up on the provider's case list. To clear the field, right-click and select **Clear**.

All fields are optional.

1. At the **Designated Mental Health Provider** field, select the RPMS provider name who has accepted designated mental health provider status for the patient. Click the drop-down list to access the **Designated Mental Health Provider** search window.

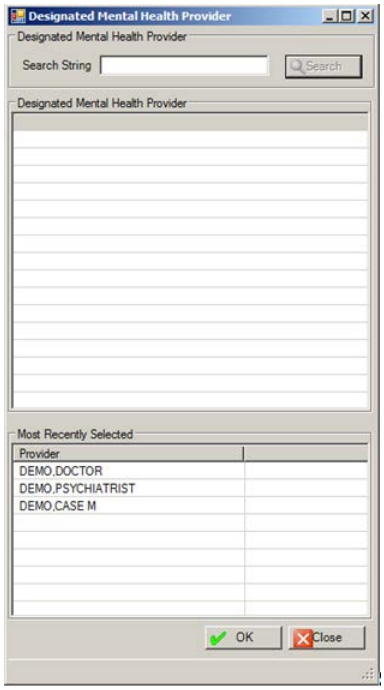
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the Designated Mental Health Provider list box. Select a retrieved record and click **OK** to populate the Designated Mental Health Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Designated Mental Health Provider field. (Otherwise, click **Close**.)

Figure 6-13: Sample Designated Mental Health Provider search window

2. At the **Other Provider Non-RPMS** field, type another Behavioral Health provider name not listed in RPMS, using between 2–40 characters (free text field).

3. At the **Designated Social Work Provider** field, select the RPMS provider who has accepted designated social work provider status for the patient. Click the drop-down list to access the **Designated Social Work Provider** search window.

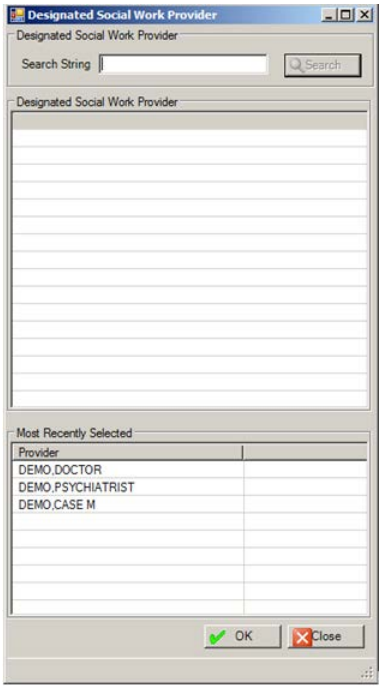
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the Designated Social Work Provider list box. Select a retrieved record and click **OK** to populate the Designated Social Work Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Designated Social Work Provider field. (Otherwise, click **Close**.)

Figure 6-14: Sample Designated Social Work Provider search window

4. At the **Other Provider Non-R**PMS prompt, type another provider name not listed in RPMS, using between 2–40 characters (Free Text field).

5. At the **Designated Chemical Dependency Provider** field, select the RPMS provider name who has accepted designated chemical dependency provider status for the patient. Click the drop-down list to access the **Designated Chemical Dependency Provider** search window.

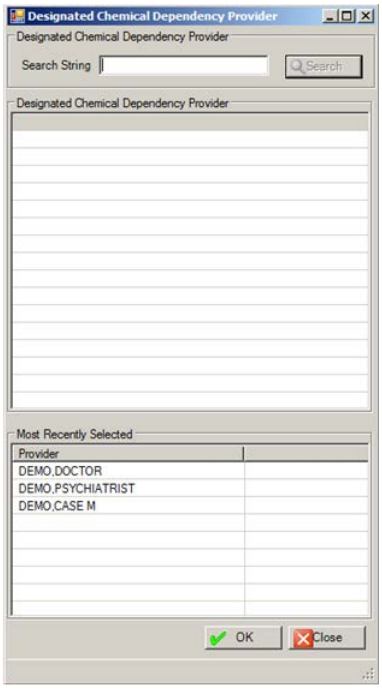
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the Designated Chemical Dependency Provider list box. Select a retrieved record and click **OK** to populate the Designated Chemical Dependency Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Designated Chemical Dependency Provider field. (Otherwise, click **Close**.)

Figure 6-15: Sample Designated Chemical Dependency Provider search window

6. At the **Patient Flag** field, type a locally-defined number field used to identify a specific group of patients (free text field), using 0–999. For example, 1 could designate patients with a family history of substance abuse, 2 could be used to identify patients enrolled in a special social services program, 3 could be used to identify patients enrolled in a special drug trial. In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.

7. At the **Designated Provider Other RPMS** field, select the RPMS provider who has accepted designated other RPMS provider status for the patient. Click the drop-down list to access the **Designated Other RPMS Provider** search window.

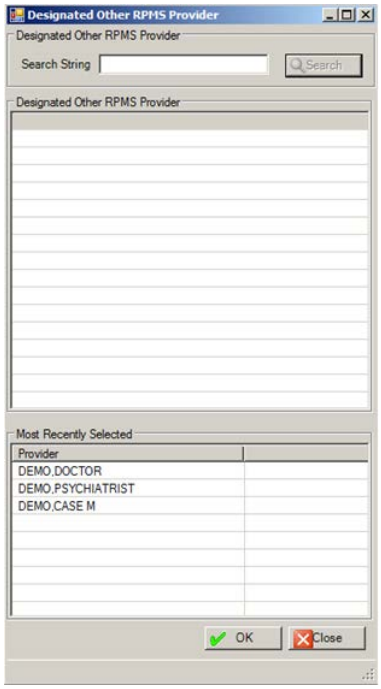
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the Designated Other RPMS Provider list box. Select a retrieved record and click **OK** to populate the Designated Provider Other RPMS field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Designated Provider Other RPMS field. (Otherwise, click **Close**.)

Figure 6-16: Sample Designated Provider Other RPMS search window

8. At the **Patient Flag Narrative** field, type the narrative about the patient flag, using between 2–60 characters.

9. At the **Designated Primary Care Provider** prompt, the application displays the name of the designated primary care provider for the patient (if any). This information is pulled from the Primary Care Provider application and is view-only.

6.3.3 Personal History Group Box

Use the **Personal History** group box to add or delete personal history data about the current patient.

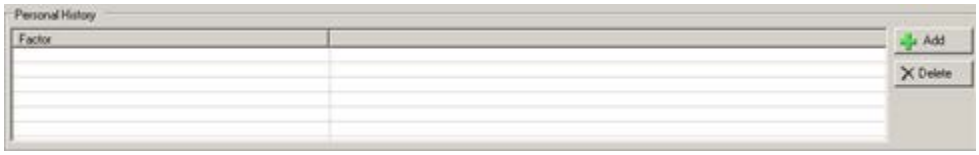


Figure 6-17: Sample Personal History group box

You only need to document personal history once, because it does become a permanent part of the patient's medical record. Facilities often find personal history factors to be useful in developing reports for tracking diagnosis associated with personal history.

Add Button

1. Click **Add**.
2. The **Personal History Factors** multiple select window where you can add one or more personal history factors.

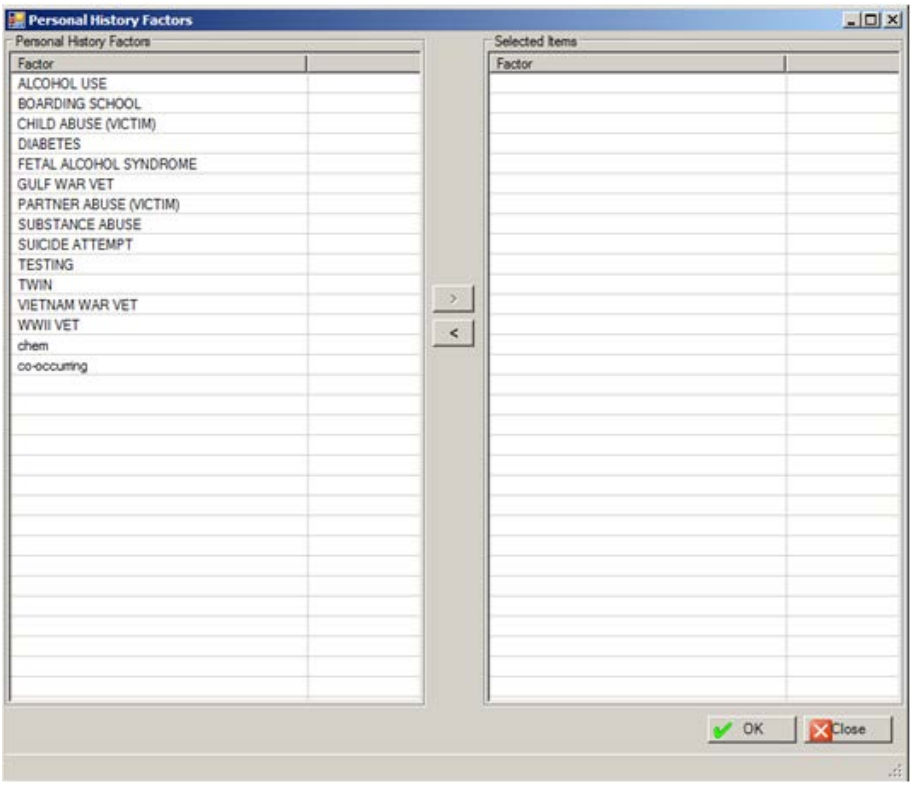


Figure 6-18: Sample Personal History Factors multiple select window

Use this multiple select window as follows:

a. To add one or more selected records from the **Personal History Factors** list box to the **Selected Items Factor** list box, click the right-pointing arrow button.

b. Similarly, you can remove one or more selected records from the **Selected Items Factor** list box by clicking the left-pointing arrow button.

c. When the **Selected Items Factor** list box is complete, click **OK** and the records populate the **Personal History** group box. (Otherwise, click **Close**.)

Delete Button

1. Select the personal history record to delete.
2. Click **Delete**.
3. At the "Are You Sure?" confirmation message, type **Y** (yes) or **N** (no).

7.0 Administrative/Community Activity

The Administrative/Community Activity option gives assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems.

7.1 Add Administrative/Community Activity Record (Roll and Scroll)

Below is the Update BH Forms window.

```
Update BH Forms               Apr 06, 2009 16:56:47          Page:    1 of    1
------------------------------------------------------------------------------
Date of Encounter:  Tuesday  MAR 31, 2009
------------------------------------------------------------------------------
 #  PRV PATIENT NAME         HRN      AT  ACT  PROB    NARRATIVE

   1 BJB ALPHAA,CHELSEA M WW116431    60  13   97     ADMINISTRATIVE
   2 rust ALPHAA,CHELSEA MWW116431    90  42   96     TRAINING NEEDS


                                      ?? for more actions
AV   Add Patient Visit      PF   Print Encounter Form TN   Display TIU Note
AC   Add Adm/Comm Activity  ID   Intake Document      AP   Appointments
EV   Edit Record           HS   Health Summary       MM   Send Mail Message
OI   Desg Prov/Flag        ES   SOAP/CC Edit         Q    Quit
DV   Display Visit         SD   Switch Dates
DE   Delete Record         EH   Edit EHR Record
Select Action: AV//
```

Figure 7-1: Sample Update BH Forms window

Use the AC option to add administrative/community activity record.

1. At the "Select Action" prompt, type **AC**.
2. At the "Enter Primary Provider" prompt, type the primary provider for the visit. The default is the current logon user.

   The application displays the Behavioral Health Record Update window, with the following fields automatically populated: Program, Location of Encounter, Arrival Time, Secondary Providers, Community of Service, # Served, Type of Contact. These fields are auto-populated based on the defaults set up on the site parameters menu. If you do not have defaults set up on the site parameters menu some of these fields might be blank.

```
* BEHAVIORAL HEALTH VISIT UPDATE *    [press <F1>E when visit entry is complete]
Encounter Date: JAN 17,2014@12:00              User: TETER,SHIRLEY
Patient Name:  DEMO,DOROTHY ROSE   DOB: 10/10/42    HR#:  999999
------------------------------------------------------------------------------
Arrival Time: 12:00
```

```
Display/Edit Visit Information  Y      Any Secondary Providers?: N
Chief Complaint/Presenting Problem:
SOAP/Progress Note <press enter>:   Comment/Next Appointment <press enter>:
PURPOSE OF VISIT (POVS) <enter>:    Any CPT Codes to enter?  Y

Activity:     Activity Time:        # Served: 1      Interpreter?

Any Patient Education Done?  N      Any Screenings to Record? N
Any Measurements?  N                Any Health Factors to enter? N
Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Placement Disposition:
Visit Flag:      Local Service Site:
_____________________________________________________________________________




COMMAND:                                        Press <PF1>H for help    Insert
```

Figure 7-2: Sample Behavioral Health Record Update

The underlined fields are required.

3. At the “Program” prompt, type the program associated with the record.
4. At the “Clinic” prompt, type the clinic to be used. The response must be a clinic that is included in the RPMS clinic code set.
5. At the “Location of Encounter” prompt, type the location of the encounter.
6. At the “Arrival Time” prompt, type the arrival time of the encounter (default is 12:00).
7. At the “Display/Edit Visit Information” prompt, type **Y** (yes) or **N** (no).

   If Y was used, the Visit Information pop-up displays.

```
               *****     Visit Information     *****

 Program: MENTAL HEALTH           Location of Encounter: DEMO INDIAN HOSPITAL

 Clinic: MENTAL HEALTH            Appointment/Walk In: APPOINTMENT

 Type of Contact: OUTPATIENT

 Community of Service: SELLS
```

   a. At the “Program” prompt, type the program

8. At the “Any Secondary Providers?” prompt, type **Y** (yes) or **N** (no) to indicate if there were any additional BHS providers who were also providing care during this particular encounter. Use Y to display the Enter/Edit Providers of Service pop-up.

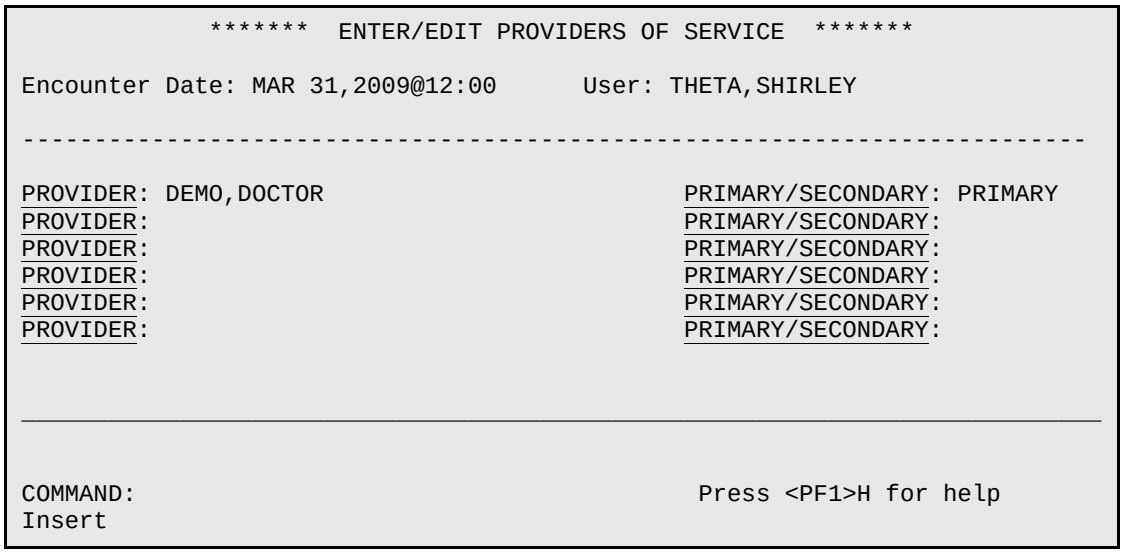


Figure 7-3: Sample Enter/Edit Providers of Service pop-up

The underlined fields are required.

a. At the “Provider” prompt, type the provider name.

b. At the “PRIMARY/SECONDARY” prompt, type **P** for primary or **S** for secondary.

   You can add one or more secondary providers.

The prompts for the Behavioral Health Record Update window continue.

9. At the “Community of Service” prompt, type the community of service where the encounter took place.

10. At the “Activity Code” prompt, type the activity code associated with the encounter. Section Appendix A: provides more information about Activity Codes and Definition.

11. At the “# Served” prompt, type the number of people served in the community activity, using any integer between 0 and 999.

12. At the “Activity Time” prompt, type the number of minutes spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry.

13. At the “Type of Contact” prompt, type the contact type (the activity setting).

14. At the Local Service Site” prompt, type the local service site for the encounter.

15. At the Any Prevention Activities to Record?” prompt, type **Y** (yes) or **N** (no).

    If **Y** was used, the Prevention Activities pop-up displays:

```
Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:


TARGET:
```

Figure 7-4: Pop-up for prevention activities

The Target field will be disabled until a Prevention Activity is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

The underlined fields are required.

a. At the "PREVENTION ACTIVITY" prompt, type the code for the prevention activity. These activities are recorded when recording non-patient activities. You can enter more than one, if needed.

b. At the "TARGET" prompt, type the code of the population the prevention activity is designed for: A (Adult), Y (Youth), F (Family), M (Mixed Adult & Youth), S (Staff), E (Elderly Only), W (Women).

The prompts for the Behavioral Health Record Update window continue.

16. At the "Purpose of Visits (POVS) <press enter>" prompt, press Enter to access the BH Record Entry–Purpose of Visit Update window.

```
    ******* BH RECORD ENTRY -  PURPOSE OF VISIT UPDATE *******

 Encounter Date: MAR 31,2009@12:00   User: THETA,SHIRLEY
 [press <F1>C to return to main screen]
--------------------------------------------------------------------------------

 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:

________________________________________________________________________________

COMMAND:                                        Press <PF1>H for help
Insert
```

Figure 7-5: Sample BH Record Entry POV window

The underlined fields are required.

a. At the “Problem Code” prompt, type the problem code that can either the Behavioral Health Purpose of Visit or the more specific DSM IV diagnostic code.

b. At the Narrative” prompt type the text of the narrative for the problem code, if needed.

The prompts for the Behavioral Health Record Update window continue.

17. At the “COMMENT (press enter)” prompt, press Enter to access another window where you can enter the text of comments about the Administrative/Community Activity.

7.2 Administrative/Community Activity Window (GUI)

Below shows where the **Administrative/Community Activities** function is located on RPMS Behavioral Health System (GUI) tree structure.

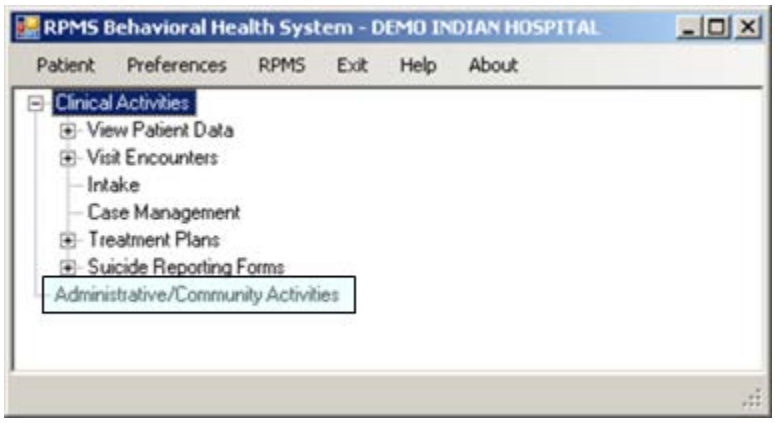


Figure 7-6: Administrative/Community Activities option on the RPMS Behavioral Health System (GUI) tree structure

After selecting the **Administrative/Community Activities** option from the RPMS Behavioral Health System (GUI) tree structure, the **Administrative/Community Activity** window displays.

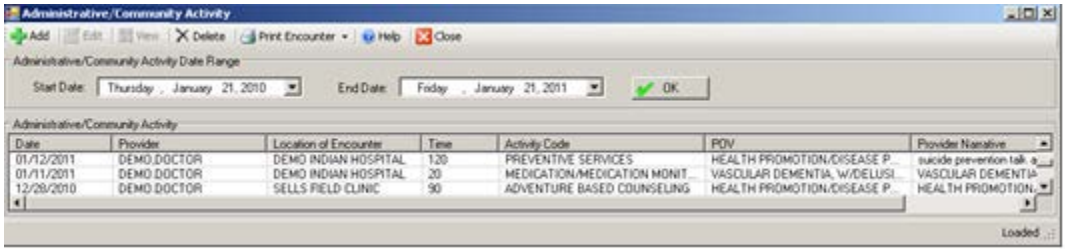


Figure 7-7: Sample Administrative/Community Activity window

The **Administrative/Community Activity** window shows the administrative / community activities records.

The following table provides information about the features on this window.

Features	Functionality
Administrative/Community Activity Date Range	This group box shows the date range for the records in the **Administrative/Community Activity** group box. You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click **OK** to display the records in **the Administrative/Community Activity** group box.
Administrative/Community Activity List Box	The records are listed in date order, within the administrative/community activity date range.
Add Button	Click **Add** to add a new administrative/community activity data record. You access the Administrative/Community Activity Data Entry–Add Administrative/Community Data.
Edit Button	Click **Edit** to edit a particular new administrative/community activity record. This function displays the Administrative/Community Activity Data Entry–Edit Administrative/Community Data. This window has the same fields as the Administrative/Community Activity Data Entry–Add Administrative/Community Data.
View Button	Highlight an administrative/community activity record on the **Administrative/Community Activity** window and click **View** to browse the data (or double-click on a record). The Com**munity Activity Data Entry–View Community Data** window displays; this is a view-only window. The fields are the same as for the data entry (add/edit) windows. Click **Close** to dismiss this window.
Delete Button	Click **Delete** to delete a particular record. The application confirms the deletion.
Help Button	Click **Help** to access the online help system for the **Administrative/Community Activity** window.
Close Button	Click **Close** to dismiss **the Administrative/Community Activity** window.
Print Encounter Button	Click **Print Encounter** to print/browse an administrative/community activity record. Highlight the record and click **Print Encounter**. Select one of the following options: **Full**, **Suppressed**, **Both Full** and **Suppressed**. Suppressed means the chief complaint/presenting problem information is suppressed for confidentiality. The application displays the **Print Encounter** pop-up window.

7.3 Add/Edit Administrative/Community Activity (GUI)

Click **Add** (on the **Administrative/Community Activity** window) to add new administrative/community activity data. This function displays the

Administrative/Community Activity Data Entry–Add Administrative/Community Data window.

Highlight a record (on the **Administrative/Community Activity** window) and click **Edit** to change the administrative/community activity data. This function displays the **Administrative/Community Activity Data Entry–Edit Administrative/Community Data** window. This window has the same fields as the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**.

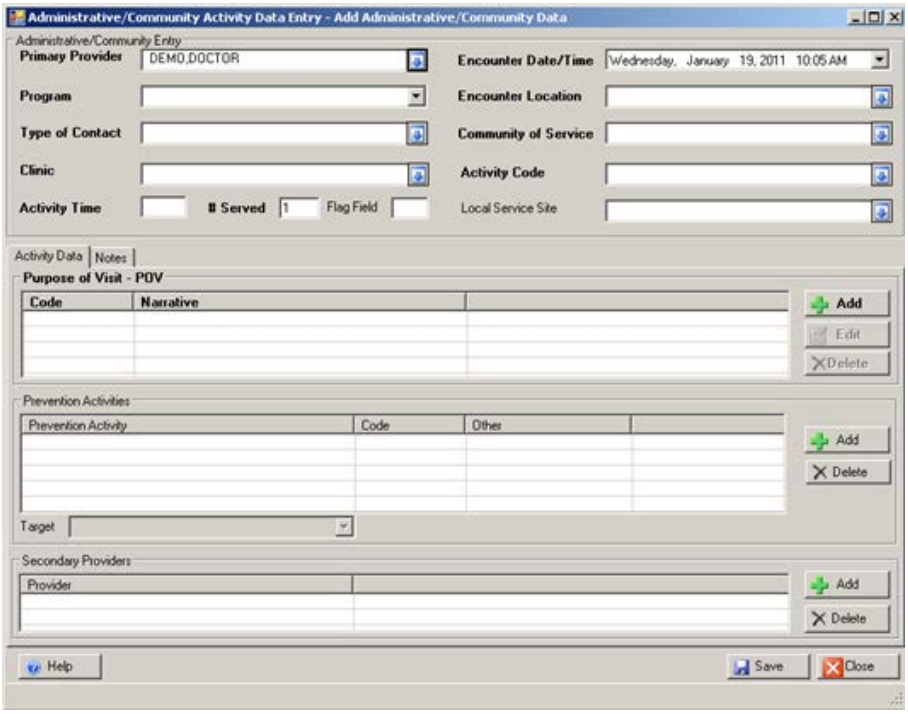


Figure 7-8: Sample Community Activity Data Entry–Add Community Data window

Click **Help** to access the online help for this window.

After you have completed the fields on this window, click **Save** (otherwise, click **Close**). The Save function adds a record to the **Administrative/Community Activity** window.

7.3.1 Administrative/Community Entry Group Box

Below is the **Administrative/Community Entry** group box.

Figure 7-9: Sample Community Entry group box

The fields in bold text are required.

1. At the **Primary Provider** field, select the primary provider name for the administrative/community activity. Click the drop-down list to access the **Primary Provider** search/select window where you search for the primary provider name.

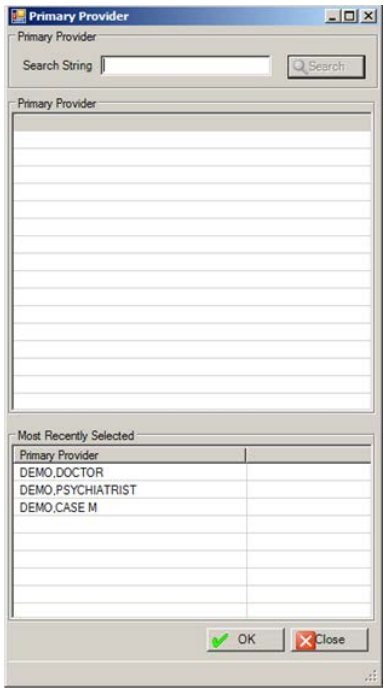
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a name and click **OK** to populate the Primary Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Primary Provider field. (Otherwise, click **Close**.)

Figure 7-10: Primary Provider search window

2. At the **Encounter Date/Time** field, type the date/time. The default is the current date and time. Change the date by clicking the drop-down list to access the calendar. You can change the time manually. You can select the hour, minutes, and AM/PM. If you make the hour and minutes, for example, 13:25, the application automatically changes the time to 1:25 PM.

3. At the **Program** field, type the program name. This is the program associated with the administrative/community activity. Use one of the following:

Mental Health

Social Services

Other

Chemical Dependency

After completing this field for a new record, the application automatically populates the remaining required fields if defaults were set up in the Site Parameters.

4. At the **Encounter Location** field, select the location where the administrative/community activity took place. Click the drop-down list to access the **Location** search window. Here you search for a location name.

Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the location and then clicking **Search**. The retrieved locations will populate the Location list box. Select a location and click **OK** to populate the Encounter Location field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Encounter Location field. (Otherwise, click **Close**.)

Figure 7-11: Sample Location search window

5. At the **Type of Contact** field, select the type of contact (the activity setting) for the administrative/community activity. Click the drop-down list to access the **Type of Contact** select window.

Screen Capture	What to do
	Use this window as follows: (1) Select a type of contact from the list. (2) Click **OK** to populate the "Type of Contact" field. (Otherwise, click **Close.**)

Figure 7-12: Sample Type of Contract select window

6. At the **Community of Service** prompt, select 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.

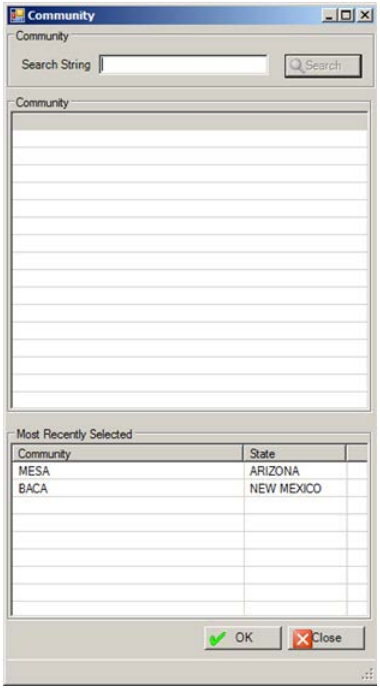
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and then clicking **Search**. The retrieved names will populate the Community list box. Select a retrieved record and click **OK** to populate the Community of Service field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Community of Service field. (Otherwise, click **Close**.)

Figure 7-13: Sample Community search/select window

7. At the **Clinic** field, select the clinic associated with the administrative/community activity. Click the drop-down list to access the **Clinic** search/select window. Here you search for the clinic by name or code.

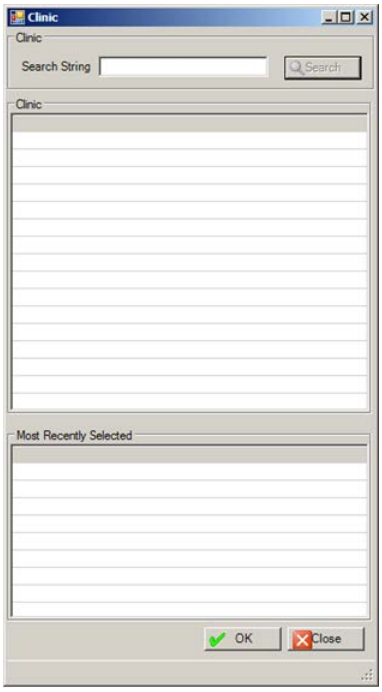
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the clinic name or code and then clicking **Search**. The retrieved records will populate the Clinic list box. Select a retrieved record and click **OK** to populate the Clinic field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Clinic field. (Otherwise, click **Close**.)

Figure 7-14: Clinic search/select window

8. At the **Activity Code** field, select the activity code associated with the administrative/community activity. Click the drop-down list to access the **Activity** search/select window. Here you search for the activity name. Section Appendix A: provides more information about the Activity Codes and Definitions.

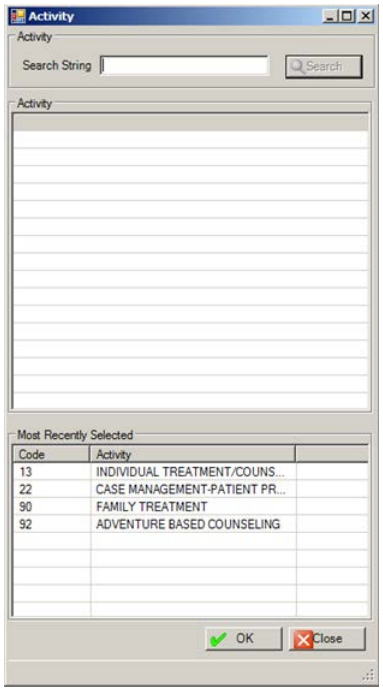
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the activity and then clicking **Search**. The retrieved records will populate the Activity list box. Select a retrieved record and click **OK** to populate the Activity Code field. (Otherwise, click **Close**.) (2) Select a record in the Most Recently Selected" list box and click **OK** to populate the Activity Code field. (Otherwise, click **Close**.)

Figure 7-15; Sample Activity search/select window

9. At the **Activity Time** field, type the number of minutes spent on the activity, using any integer between 1 and 9999.

10. At the **# Served** field, type the number of people served in the administrative/community activity, using any integer between 0 and 999.

11. At the **Flag Field** field, type any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

12. At the **Local Service Site** field, select the local service site associated with the administrative/community activity, if any. Click the drop-down list to access the **Local Service Site** select window.

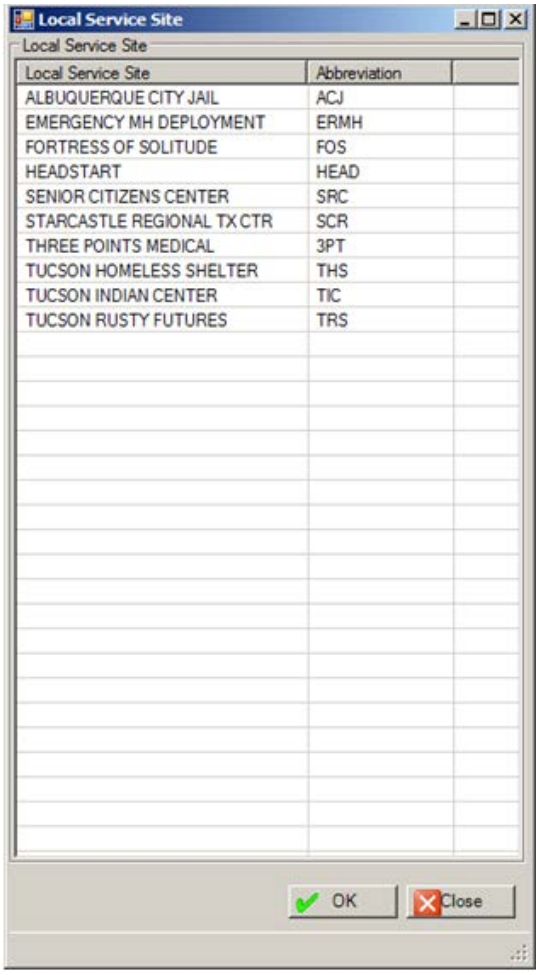
Screen Capture	What to do
	Use this window as follows: (1) Select a local service site from the list. (2) Click **OK** to populate the "Local Service Site" field. (Otherwise, click **Close.**)

Figure 7-16: Sample Local Service Site select window

7.3.2 Activity Data Tab

Use the **Activity Data** tab to specify the **Purpose of Visit - POV**, **Prevention Activities**, and **Secondary Providers** data.

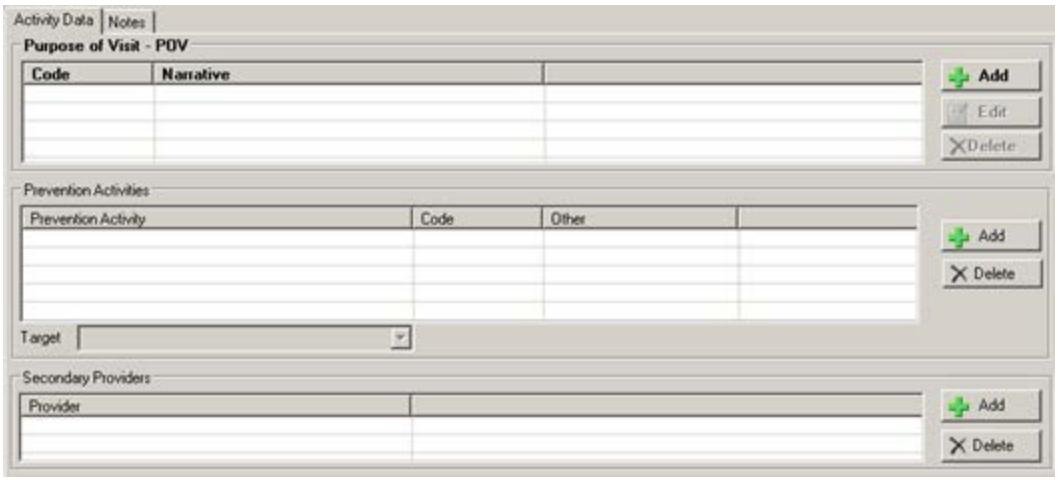


Figure 7-17: Sample Activity Data tab

Purpose of Visit–POV Group Box

The **Purpose of Visit - POV** group box lists the POVs associated with the administrative/community activity.

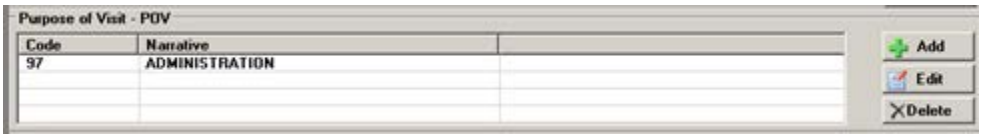


Figure 7-18: Sample POV group box

At least one POV is required for an administration/community activity record. You can add, change, or delete a record.

Add Button

1. Click **Add**.
2. The **POV** search/select window displays. Here you select one or more POVs.

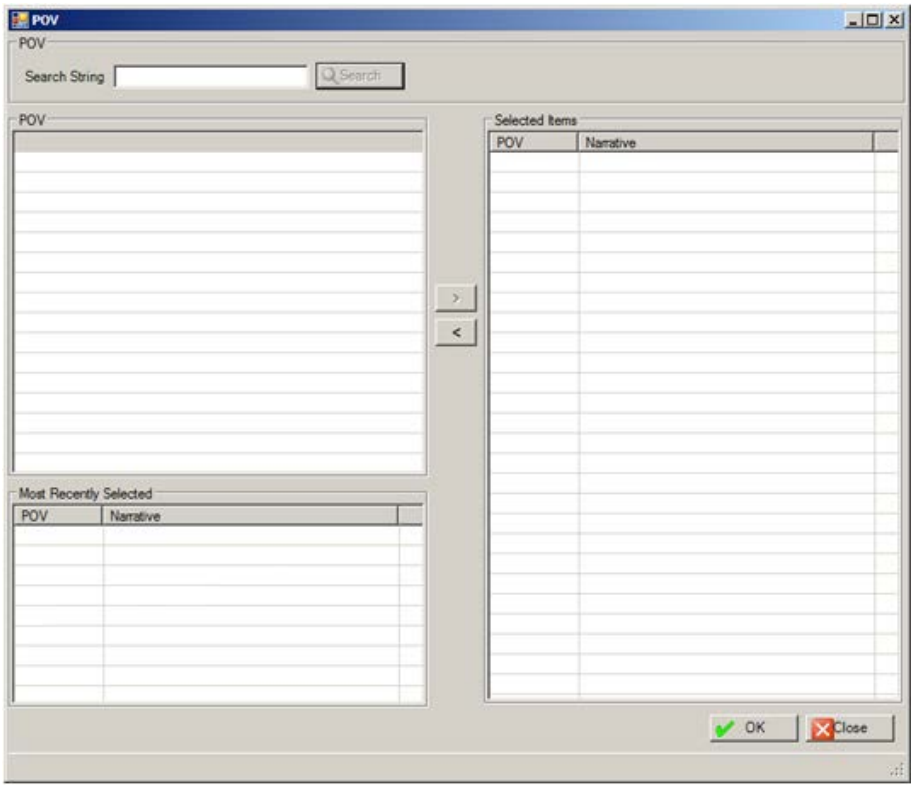


Figure 7-19: Sample POV search/select window

Use this search/select window as follows:

3. At the **Search String** field, type a few characters of the search criteria.
4. Click **Search** and the retrieved the records display in **POV** list box (the POV and its narrative).
5. To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the right-pointing arrow button.
6. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the left-pointing arrow button.
7. When the **Selected Item** list box is complete, click **OK** and the records populate the POV group box. (Otherwise, click **Close**.)

Edit Button

1. Select the POV record to change.
2. Click **Edit**.

   The application displays the **Edit POV** window.

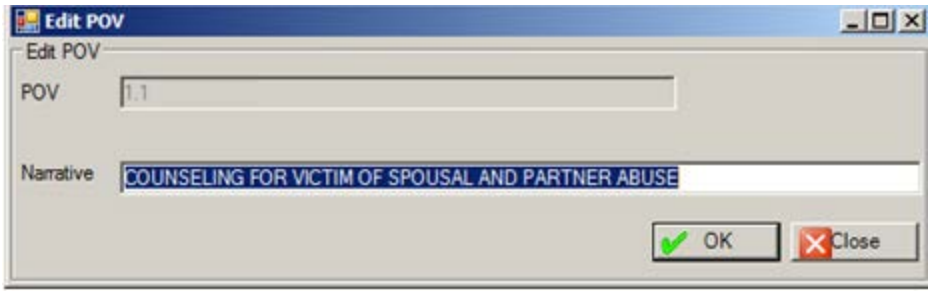


Figure 7-20: Edit POV window

a. At the Narrative field, type new POV narrative in the Narrative text box using 2–80 characters.

Note:	The special characters " or ' cannot be the first character of the POV narrative. This is a Free Text field.

b. Click **OK** to change the narrative of the selected record. (Otherwise, click **Close**.)

Delete Button

1. Select a record to delete.
2. Click **Delete**.
3. At the "Are You Sure?" confirmation message displays, click **Yes** to remove the selected group encounter record from the **POV** group box. (Otherwise, click **No**.)

Prevention Activities Group Box

The **Prevention Activities** group box lists the prevention activities associated with the administrative/community activity.

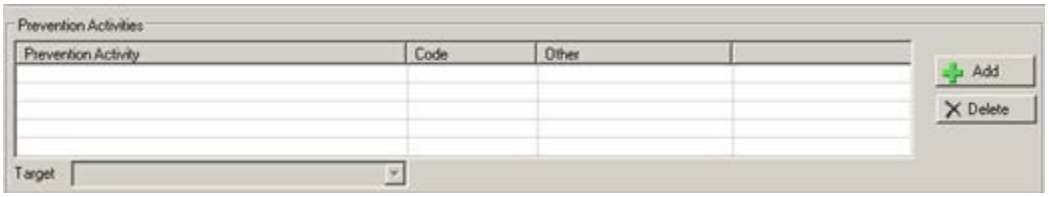


Figure 7-21: Sample Prevention Activities group box

The **Target** field will be disabled until a **Prevention Activity** is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

You can add/delete a prevention activity and/or specify the target group.

1. At the **Target** field, select the population for which the prevention activity is designed. The selected option applies to all of the prevention activities.

   Adult

Youth

Family

Mixed (Adult & Youth)

Staff

Elderly Only

Women

Add Button

1. Click **Add**.
2. The **Prevention Activity** multiple select window displays. Here you select one or more prevention activities.

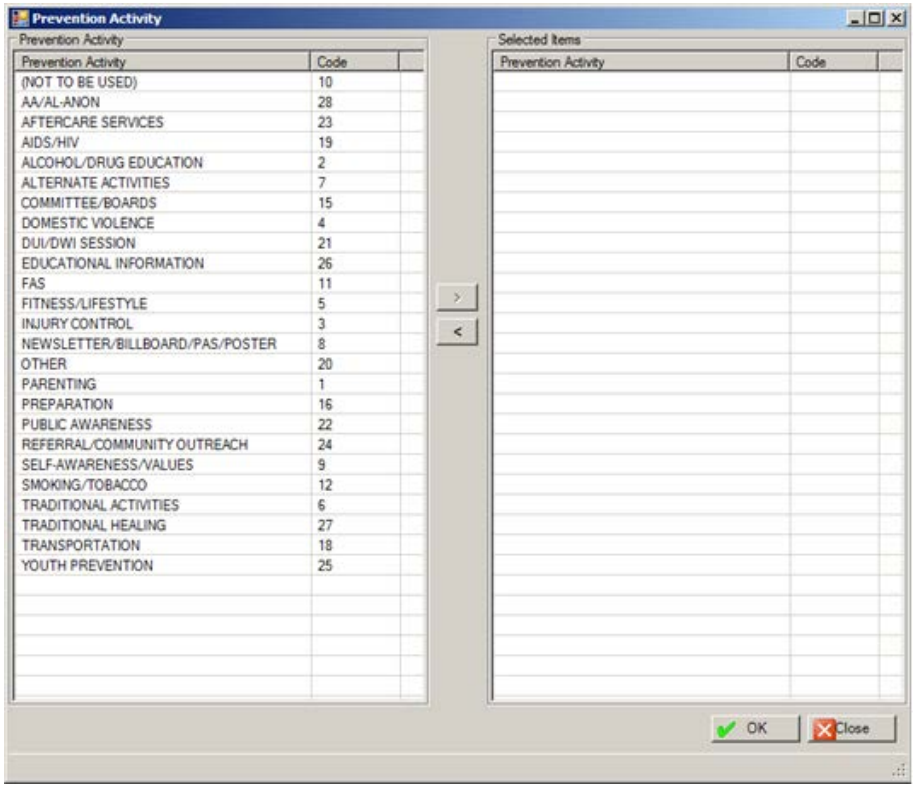


Figure 7-22: Prevention Activity multiple select window

Use this multiple select window as follows:

a. To add one or more selected records from the **Prevention Activity** list box to the **Selected Items Prevention Activity** list box, click the right-pointing arrow button.

b. Similarly, you can remove one or more selected records from the **Selected Items Prevention Activity** list box by clicking the left-pointing arrow button.

c. When the **Selected Items Prevent Activity** list box is complete, click **OK** and the records populate the **Prevention Activity** group box. (Otherwise, click **Close**.)

d. If you select **OTHER** (Code 20) on the **Prevention Activity** search/select window, the application displays the **Other** window.

Figure 7-23: Other window

e. At the **Other** field, type the text of the other prevention activity associated with this record (limited to 80 characters).

f. Click **OK** and the text populates the Other cell on the grid.

If you dismiss the **Other** window (with no data), the Other cell on the grid will be blank.

Delete Button

1. Select the prevention activity record to delete.
2. Click **Delete**.
3. At the "Are You Sure?" confirmation message displays, click **Yes** to remove the selected prevention activity record from the group box. (Otherwise, click **No**.)

Secondary Providers Group Box

The **Secondary Providers** group box lists the secondary providers associated with the administrative/community activity.

Figure 7-24: Sample Secondary Providers group box

You can add or delete a record.

Add Process

1. Click **Add** to access the **Secondary Providers** search/select window. Here you can select one or more secondary provider names.

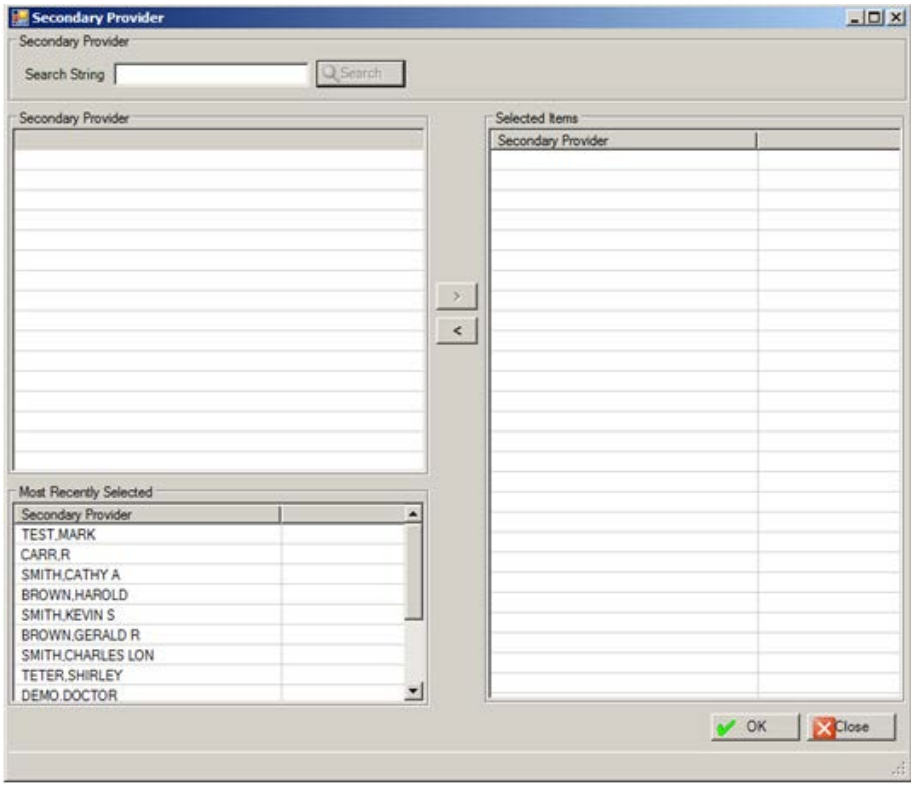


Figure 7-25: Secondary Providers search/select window

Use the **Secondary Providers** multiple search/select window in the following manner:

a. At the **Search String** field, type a few characters of the search criteria.

b. Click **Search** and the retrieved the records display in **Secondary Provider** list box.

c. To add one or more selected records from the **Secondary Provider** list box to the **Selected Items Secondary Provider** list box, click the right-pointing arrow button.

d. Another way to add records to the **Selected Items Secondary Provider** list box is to select one or more records in the **Most Recently Selected** list box and click the right-point arrow.

e. Similarly, you can remove one or more selected records from the **Selected Items Secondary Provider** list box by clicking the left-pointing arrow button.

f. When the **Selected Items Secondary Provider** list box is complete, click **OK** and the records populate the **Secondary Providers** group box. (Otherwise, click **Close**.)

Delete Process

1. Select the secondary provider record to remove.
2. Click **Delete**.
3. At the "Are You Sure?" confirmation message displays, click **Yes** to remove the selected secondary provider record from the group box. (Otherwise, click **No**.)

7.3.3 Notes Tab

Use the **Notes** field to enter any notes about the administrative/community activity.

Figure 7-26: Sample Notes field

This is a Free Text box.

8.0 Encounter and Treatment Plan Sharing (Roll and Scroll)

After the entry of a Visit or a Treatment plan, you will have the option to share it with a colleague through MailMan. In order to do this, you must be properly set up through Site Parameters as a provider who can share information.

Make sure that the provider being sent the plan should actually be using this function.

After the entry of a Visit or Treatment plan, you will be asked the question shown in Figure 8-1):

```
Do you want to share this visit information with other providers? N//
```

Figure 8-1: Question after entry of a visit or treatment plan

By answering the question with a Yes, you will be stepped through the process of sending the information via a MailMan message, as shown in Figure 8-2:

```
Send to: NUUUU,BILL          WBM
Send to:

Message will be sent to:    THETA,BILL

Do you want to attach a note to this mail message? N// YES
Enter the text of your note.

NOTE APPENDED TO MAIL MSG:
  No existing text
  Edit? NO//Y
 - Here the provider can append a note to his/her colleague.


Ready to send mail message?? Y// ES
Send Full or Suppressed Form:  (F/S): S// f  FULL  - The answer to this question
will determine which type of encounter form will be send in the message.

Sending Mailman message to distribution list
Message Sent
Press enter to continue....:
```

Figure 8-2: Sending a treatment plan through MailMan

9.0 Problem List

This section addresses the Problem List management for Roll and Scroll and the GUI.

9.1 BH Patient's Problem List (Roll and Scroll)

The PPL option appears on the Patient Data Entry and Update BH Forms windows.

Use the PPL option to manage the patient's problem list.

1. At the "Select Action" prompt, type PPL
2. The application displays the following information:

```
Problem List updates must be attached to a visit. If you are updating the
Problem List in the context of a patient visit select the appropriate existing
visit and then update the Problem List. If you are updating the Problem List
outside of the context of a patient visit, first create a chart review visit
and then update the Problem List.
Select record to associate the Problem List update to:  (1-5):
```

Figure 9-1: Message displayed by the application

3. At the "Enter ENCOUNTER DATE" prompt, type the encounter date for the problem list.

   The application displays the patient's problem list.

```
BH Problem List Update        Aug 23, 2011 14:05:45          Page:    1 of    1
------------------------------------------------------------------------------
Patient Name: DEMO,DUCK    DOB: FEB 05, 1975   Sex: M   HRN: 36219
------------------------------------------------------------------------------

BH Problem List Updated On: Aug 22, 2011  By: SIGMA,DARLA

1)   DX: F42.   Status: ACTIVE   Last Modified: 10/22/2015
     DSM Narrative: OBSESSIVE-COMPULSIVE DISORDER
     Provider Narrative: HOARDING DISORDER
     Date of Onset: 10/10/2015   Facility: DEMO INDIAN HOSPITAL
        Notes:
           STP Note #1 Added: 10/7/2015
           Narrative:  Treat physical illness from time to time


          Enter ?? for more actions                                        >>>
AP   Add BH Problem       DD   Detail Display        LR   Problem List Reviewed
EP   Edit BH Problem      NO   Add Note              HS   Health Summary
DE   Delete BH Problem    MN   Edit Note             FA   Face Sheet
AC   Activate BH Problem  RN   Remove Note           PC   PCC Prob List Display
IP   Inactivate BH Prob   NP   No Active BH Problems Q    Quit
Select Action: +//
```

Figure 9-2: Sample BH Problem List update window

At the “Select Action” prompt, type **Q** to exit this window.

9.1.1 Add BH Problem (AP)

Use the AP action to add a new BH problem for the current patient’s visit.

1. At the Select Action” prompt, type **AP**.

   The application displays information about the POV diagnosis assigned to the patient in the past 90 days.

2. At the “Choose a Diagnosis” prompt, type one of the diagnoses.

3. At the “Enter Diagnosis to Add to the Problem List” prompt, type the active diagnosis code to add to the problem list.

   The application displays the Provider Narrative for the particular problem (can be changed).

4. At the “STATUS” prompt, type one of the following: **A** (active), or **I** (Inactive).

5. At the “DATE OF ONSET” prompt, type the date of onset, when the problem was first diagnosed. (This can be left blank.)

6. At the “Add TREATMENT Note?” prompt, type **Y** (yes) to add a treatment or **N** (no).

   If N was used, the focus moves to the “Enter the Date the Problem List was Updated by the Provider” prompt.

   If Y was used, the following prompts will display:

   a. At the “PROVIDER NARRATIVE” prompt, type the text of the narrative for the treatment note.

   b. At the “AUTHOR” prompt, press Enter to use the default name or type a new one.

   c. At the “LONG/SHORT TERM TREATMENT” prompt, type **1** for Short Term or **2** for Long Term. This refers to the treatment described in the Treatment note.

      After completing the last prompt, the focus returns to the “Add TREATMENT Note?” prompt.

7. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the current date or type a new one.

8. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).

    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.2 Edit BH Problem (EP)

Use the EP action to edit a specified BH problem.

1. At the Select Action” prompt, type **EP**.
2. At the “Select Problem” prompt type the number of the problem to edit.
3. At the “Diagnosis” prompt, the current diagnosis displays. This can be changed, if needed.
4. At the “Provider narrative <text of narrative>” prompt, the text of the narrative displays. This can be changed, if needed.
5. At the “DATE OF ONSET” prompt, type the date of onset, when the problem was first diagnosed. (This can be left blank.)
6. At the “STATUS” prompt, the current status displays. This can be changed using **A** (active), or **I** (Inactive).
7. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the current date or type a new one.
8. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).

    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.3 Delete BH Problem (DE)

Use the DE action to delete a specified BH problem.

1. At the “Select Action” prompt, type **DE**.

2. At the "Select Action" prompt, type the action to execute, either **1** (Delete BH Problem) or **2** (Detail Display). Use 1 in this case.

3. At the "Select Problem" prompt, type the number of the problem to delete. The information about the particular problem displays:

```
Deleting the following BH Problem from DUCK DEMO's BH Problem List.

PROBLEM CODE: 9.1                       PATIENT NAME: DEMO,DUCK
  DATE LAST MODIFIED: SEP 07, 2011@14:07:46
  PROVIDER NARRATIVE: PRE-SENILE CONDITION
  FACILITY: DEMO INDIAN HOSPITAL        NMBR: 3
  DATE ENTERED: SEP 07, 2011@13:54:16   STATUS: ACTIVE
  USER LAST UPDATE: THETA,SHIRLEY

Please Note:  You are NOT permitted to delete a BH Problem without
entering a reason for the deletion.
```

Figure 9-3: Example of information displayed about the problem code

4. At the "Are you sure you want to delete this BH Problem?" prompt, type either **Y** (yes) or **N** (no).

   If N was used, the focus will return to the BH Problem List Update window.

   If Y was used, the following information will display:

```
Deleting Treatment Plan...

Treatment Plan for DEMO,DOROTHY ROSE DELETED.
Press enter to continue....:
```

Figure 9-4: Further information

Press Enter and the focus returns to the Updated Patient Treatment Plan window.

9.1.4 Activate BH Problem (AC)

Use the AC action to change the status of a selected inactive BH problem to be active.

1. At the "Select Action" prompt, type **AC**.

2. At the "Select Problem" prompt, type the number of the problem to activate.

   - If the particular problem is already active, the application will display the following message:

```
That problem is already ACTIVE!!
Press return to continue....:
```

Figure 9-5: Message displayed when the problem is already active

After pressing Enter, the focus returns to the BH Problem List Update window.

- If the particular problem is not active, the prompts continue:

3. At the "Enter the Date the Problem List was Updated by the Provider" prompt, press Enter to use the default date or type a new one.
4. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the BH Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.5 Inactivate BH Problem (IP)

Use the IP action to cause the status of a particular active BH problem to be inactive.

1. At the "Select Action" prompt, type **IP**.
2. At the "Select Problem" prompt, type the number of the problem to inactivate.
   - If the particular problem is already inactive, the application will display the following message:

```
That problem is already INACTIVE!!
Press return to continue....:
```

Figure 9-6: Message displayed when the problem is already inactive

After pressing Enter, the focus returns to the BH Problem List Update window.

- If the particular problem is not inactive, the prompts continue:

3. At the "Enter the Date the Problem List was Updated by the Provider" prompt, press Enter to use the default date or type a new one.
4. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.6 Detail Display (DD)

Use the DD action to display detail information about a selected BH problem.

1. At the "Select Action" prompt, type **DD**.
2. At the "Select Problem" prompt, type the number of the problem to use.

   The Behavioral Health Problem List information displays on the Output Browser screen.

```
OUTPUT BROWSER                Dec 05, 2011 11:53:53          Page:    1 of    1
Behavioral Health Problem Display


PROBLEM CODE:                 F42.
PATIENT NAME:                 DEMO,DOROTHY ROSE
DATE LAST MODIFIED:           DEC 07, 2015
PROVIDER NARRATIVE:           HOARDING DISORDER
FACILITY:                     DEMO INDIAN HOSPITAL
NMBR:                         1
DATE ENTERED:                 DEC 07, 2015
STATUS:                       ACTIVE
USER LAST UPDATE              DEMO,DOCTOR

Notes:

   1)  Date Added: 12/07/2015 Author: THETA,SHIRLEY
   Note Narrative: PT PRESENTS BX ASSOCIATED WITH HOARDING
```

Figure 9-7: Sample Problem Detail

9.1.7 Add Note (NO)

Use the NO action to add a note to a selected BH problem.

1. At the "Select Action" prompt, type **NO**.
2. At the "Select Action" prompt, type one of the following:

   1. Add Note
   2. No Active BH Problems

   Use 1 in this case.

   The application displays information about the patient's BH problem list.

3. At the "Add a new Problem Note for this Problem?" prompt, type **Y** to add a note. (Otherwise, type **N**.)

   If Y was used, the following prompt displays:

4. At the "NARRATIVE" prompt, type the text of the narrative of the note.

5. At the "AUTHOR" prompt, press Enter to use the default name or type a new one.

6. At the "LONG/SHORT TERM TREATMENT" prompt, type one of the following: **1** (for short) or **2** (for long).

The application will re-display the information about the problem and information about the notes.

```
Adding a Note to the following problem on DOROTHY ROSE DEMO's BH Problem List.

PROBLEM CODE:                F42.
PATIENT NAME:                DEMO,DOROTHY ROSE
DATE LAST MODIFIED:          DEC 07, 2015
PROVIDER NARRATIVE:          HOARDING DISORDER
FACILITY:                    DEMO INDIAN HOSPITAL
NMBR:                        1
DATE ENTERED:                DEC 07, 2015
STATUS:                      ACTIVE
USER LAST UPDATE             DEMO,DOCTOR

Notes:

   1)  Date Added: 12/07/2015 Author: THETA,SHIRLEY
   Note Narrative: PT PRESENTS BX ASSOCIATED WITH HOARDING
```

Figure 9-8: Example of information about the problem and information about the notes

7. At the "Add a new Problem Note for this Problem?" prompt, type **Y** (for yes) or **N** (for no).

   If Y was used, the prompts will repeat, starting with NARRATIVE.

   If N was used, the prompts will continue.

8. At the "Enter the Date the Problem List was Updated by the Provider" prompt, press Enter to use the default date or type another one.

9. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the BH Problem List.

   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.8 Edit Note (MN)

Use the MN action to edit the text of a selected note.

1. At the "Select Action" prompt, type **MN**.

2. At the “Select Problem” prompt, type the number of the problem having the note to be edited.

   The application displays information about the selected problem and information about any existing notes.

3. At the “Edit which one” prompt, type the number of the note to edit.

4. At the “NARRATIVE: <text of the problem>// - Replace” prompt, type in the Replace field with the replacement text for the narrative.

5. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following: **1** (for short) or **2** (for long).

6. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type another one.

7. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.

   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.9 Remove Note (RN)

Use the RN action to delete a selected note.

1. At the “Select Action” prompt, type **RN**.

2. At the “Select Problem” prompt, type the number of the problem having the note to be removed.

   The application displays information about the selected problem and information about any existing notes.

3. At the “Remove which one” prompt, type the number of the note to remove.

4. At the “Are you sure you want to delete this NOTE?” prompt, type **Y** (yes) or **N** (no).

   If N was used, the focus will return to the BH Problem List Updated window.

   If Y was used, the prompts will continue.

5. At the “Enter the Date the Problem List was Updated by the Provider” prompt, press Enter to use the default date or type another date.

6. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the Problem List.

   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the BH Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.10 No Active BH Problems (NP)

Use the NP action to specify the date when a particular provider indicated that the patient had no active BH problems. This action requires that there are no ACTIVE problems on the patient's BH problem list (otherwise, the application will display an error message).

1. At the "Select Action" prompt, type **NP**.
2. At the "Did the Provider indicate that the patient has No Active BH Problems" prompt, type **Y** (yes) or **N** (no).

   If N was used, the focus will return to the BH Problem List Update window.

   If Y was used, the prompts will continue:

3. At the "Enter the Date the Provider documented 'No Active BH Problems'" prompt, press Enter to use the default date or type another one.
4. At the "Enter the PROVIDER who documented 'No Active BH Problems'" prompt, type the provider name who documented that there are no active BH problems.

9.1.11 Problem List Reviewed (LR)

Use the LR action to indicate who and when the current patient's BH Problem List was reviewed.

1. At the "Select Action" prompt, type **LR**.
2. At the "Did the Provider indicate that he/she reviewed the Problem List?" prompt, type **Y** (yes) or **N** (no).

   If N was used, the application will display 'No Action Taken" and the focus will return to the BH Problem List Update window.

   If Y was used, the prompts continue.

3. At the "Enter the Date the Provider Reviewed the Problem List" prompt, press Enter to use the default date or type a new one.

4. At the “Enter the PROVIDER who Reviewed the Problem List” prompt, type the name of the provider who reviewed the BH Problem List.

9.1.12 PCC Problem List Display (PC)

Use the PC action to display the PCC problem list.

1. At the “Select Action” prompt, type **PC**.

   The application displays the message:

```
You are now leaving the Behavioral Health Problem List and will be taken
into the PCC Problem List for updating.


Do you wish to continue? Y//
```

Figure 9-9: Information displayed by the application

If N was used at the last prompt, focus will return to the BH Problem List Update window.

If Y was used, the PCC Problem List Display window displays.

```
PCC Problem List Display           Sep 07, 2011 15:46:04          Page:    1 of    3
------------------------------------------------------------------------------
Patient Name: DEMO,DOROTHY ROSE   DOB: OCT 10, 1942   Sex: F   HRN: 99999
------------------------------------------------------------------------------
Problem List Reviewed On: Dec 02, 2015  By: DEMO,DOCTOR
Problem List Updated On: Dec 02, 2015 By: THETA,WENDY

   Problem ID:  TST1    DX: ZZZ.999  Status: EPISODIC         Onset: 7/23/13
      Provider Narrative:  Sore throat symptom | sore throat
      SNOMED CONCEPT ID: 267102003
      Severity:  246112005

   2) Problem ID:  TST2    DX: M25.50   Status: CHRONIC          Onset:
      Provider Narrative:  Joint pain | chronic joint pain of left middle fi
      SNOMED CONCEPT ID: 57676002
      Severity:  246112005

   3) Problem ID:  TST3    DX: M25.50   Status: EPISODIC         Onset:
      Provider Narrative:  Joint pain |
+         Enter ?? for more actions                                        >>>
DD   Display a PCC Prob    A  Quit
Select Action: +//
```

Figure 9-10: Example of Problem List Update screen

Quit

At the “Select Action” prompt, type **Q** to quit the update screen.

Display a PCC Prob

1. At the "Select Action" prompt, type **DD**.
2. At the "Select Problem" prompt, type the number of the problem to use.

The application displays the PPC Prob information on the Output Browser.

```
DIAGNOSIS: M25.50                        PATIENT NAME: DEMO,ALISTER LANE
  DATE LAST MODIFIED: AUG 01, 2013@12:33:23
  PROVIDER NARRATIVE: Joint pain | chronic joint pain of left middle finger, fir
st joint                                 FACILITY: 2013 DEMO HOSPITAL
  NMBR: 2                                DATE ENTERED: AUG 01, 2013
  STATUS: CHRONIC                        USER LAST MODIFIED: DEMO,CATHERINE A
  ENTERED BY: DEMO,CATHERINE A          RECORDING PROVIDER: DEMO,CATHERINE A
SEVERITY: 246112005                      ENTERED BY: MOORE,CATHERINE A
  DATE/TIME ENTERED: AUG 01, 2013@12:33:23
  SEVERITY PREFERRED TERM (c): Severity
  SNOMED CT CONCEPT CODE: 57676002       SNOMED CT DESIGNATION CODE: 95910010
  SNOMED CONCEPT PREFERRED TERM (c): Joint pain









          Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 9-11: Sample information about the selected PCC problem

At the "Select Action" do one of the following:

- Type **+** to display the next screen (does not apply to the last screen)
- Type **–** to display the previous screen (does not apply to the first screen)
- Type **Q** to quit the screen.

9.2 Problem List (GUI)

This section addresses how to manage the problems for the selected patient on the Visit window for one patient.

After selecting a record and clicking the Problem button, select one of the following options:

- BH Problem List

- PCC Problem List

9.2.1 Behavior Health Problem List Window

After selecting the BH Problem List option, the **Behavioral Health Problem List** window displays.

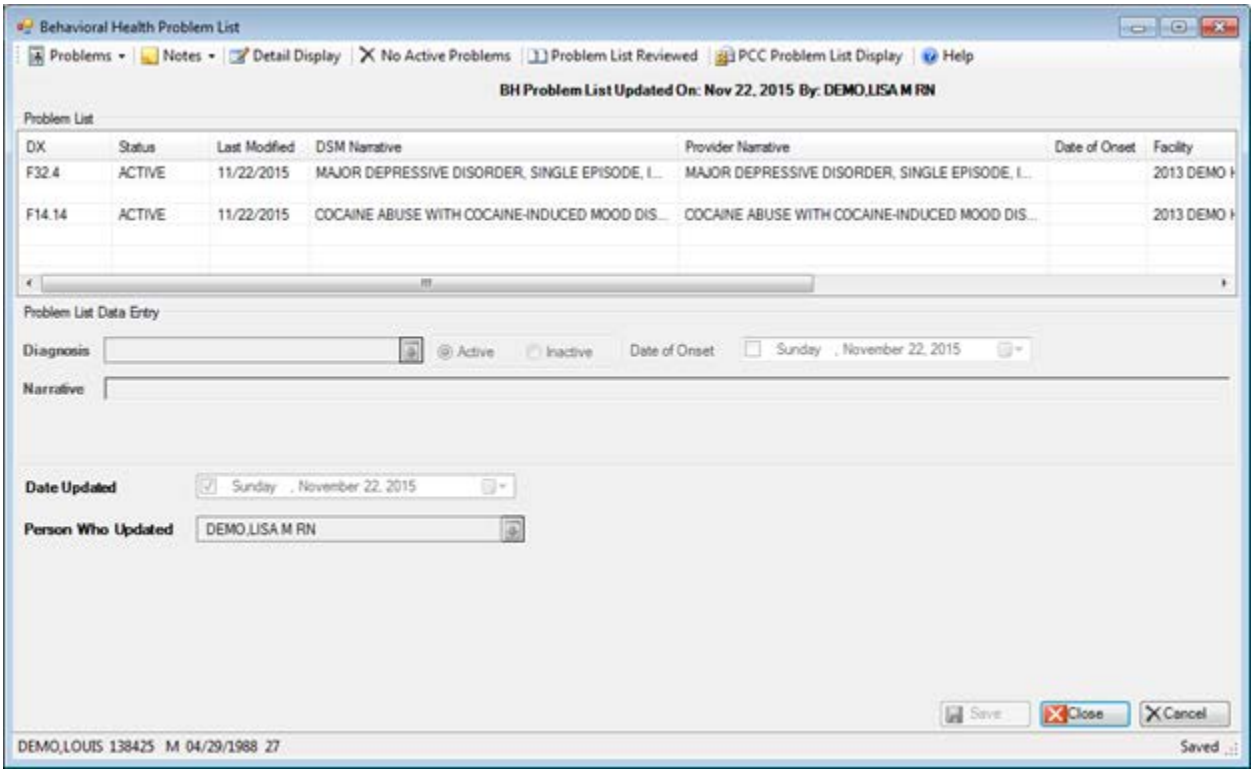


Figure 9-12: Sample Behavioral Health Problem List window

The current patient's problems display in the Problem List grid, including any associated notes. The note displays on the row below the problem.

The following table provides information about the features on this window.

Feature	Functionality
Help button	Click this button to access the online help for this window.
Close button	Click **Close** to leave the window.
Cancel button	Click this button to remain on the window and no action (like Add Problem) will be taken.

Add/Edit Problem

The Add and Edit function use the same fields.

1. Select **Problems** | **Add Problem** to access the fields in the **Problem List Data Entry** group box.

2. Select an existing problem and then select **Problems** | **Edit Problem**. All of the fields in the **Problem List Data Entry** group box are populated with existing data.

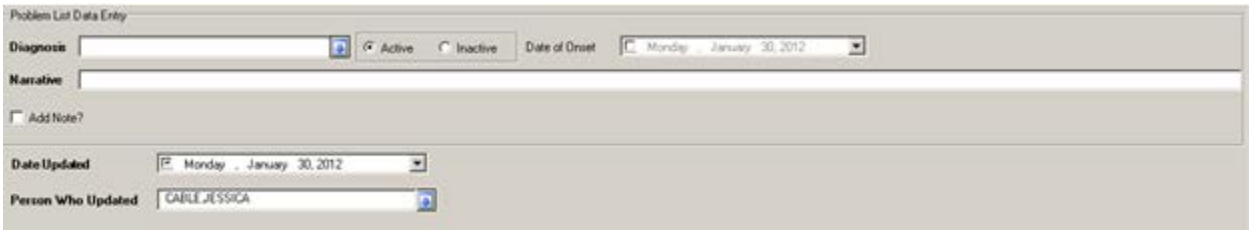


Figure 9-13: Sample Problem List Data Entry group box

The fields in bold are required.

1. At the **Diagnosis** field, click the drop-down list to access the **POV** select window. Here you select a POV to populate the **Diagnosis** and **Narrative** fields.

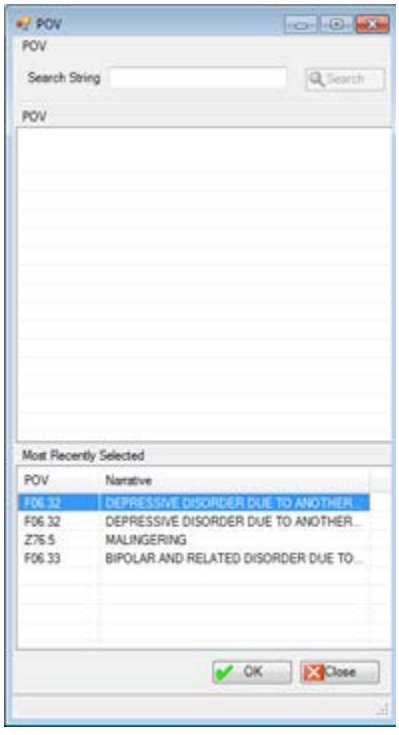
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the search criteria for the POV and then clicking **Search**. The retrieved POVs will populate the POV list box. Select a retrieved record and click **OK** to populate the Diagnosis and Narrative fields. (Otherwise, click **Close**.) (2) Select a record in the "Most Recently Selected list box and click **OK** to populate the Diagnosis and Narrative fields. (Otherwise, click **Close**.)

Figure 9-14: Sample POV select window

2. At the **Active/Inactive** radio button field, indicate if the selected diagnosis is Active or Inactive by selecting the appropriate radio button (Active is the default for a new problem).

3. At the **Date of Onset** field, select the Date of Onset which is the date when the problem was first diagnosed. For a new problem, the default is today's date.

   - To have no Date of Onset, uncheck the checkbox.
   - To change the Date of Onset, click the drop-down list to access a calendar. The checkbox will remain checked.

4. At the **Narrative** field, determine the diagnosis to use. This field is populated when you choose a diagnosis (can be changed). Type a new narrative in the Free Text field, if needed.

5. At the **Add Note?** field, select the **Add Note** field to display the **Note** group box.

Figure 9-15: Note group box

After the **Note** group box displays, you can uncheck the **Note** field to close the group box, if needed.

   a. At the **Note** field, type the text of the note, usually information about the treatment.

   b. At the **Author** field, type the name of the author of the note. The application populates this field with the current logon user. To change the name, click the drop-down list to access the **Primary Provider** select window. Here you can select another name.

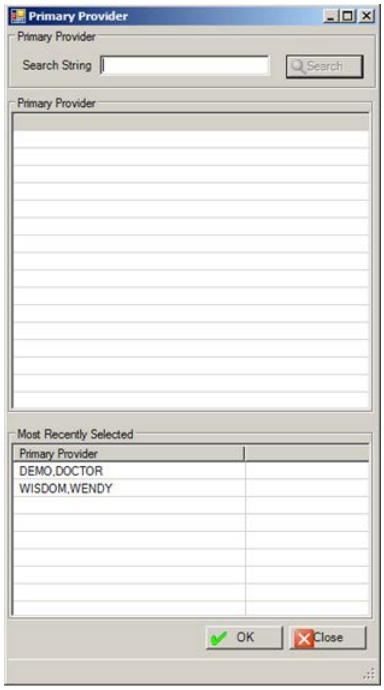
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the primary provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Author field. (Otherwise, click **Close**.) (2) Select a primary provider name in the Most Recently Selected list box and click **OK** to populate the Author field. (Otherwise, click **Close**.)

Figure 9-16: Primary Provider select window

c. At the **Long Term/Short Term** field, select either the Long Term or Short Term radio button, referring to the treatment described in the note.

6. At the **Date Updated** field, the application displays today's date (the default). To change the date, click the drop-down list to access the calendar where you can select another date.

7. At the **Person Who Updated** field, the application displays the default provider (who is the provider of the visit to which the Problem List item is associated). To change the name, click the drop-down list to access the **Primary Provider** select window. Here you select another primary provider.

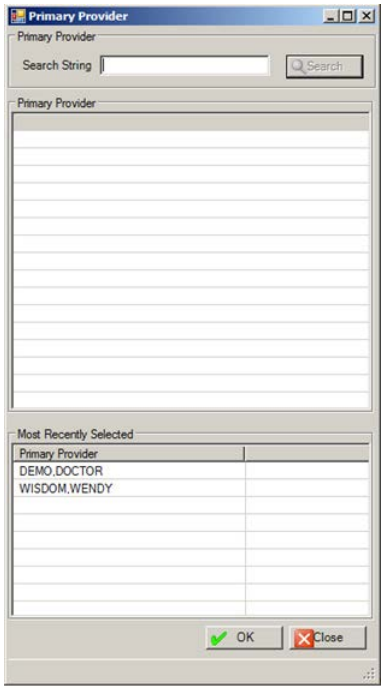
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.)

Figure 9-17: Primary Provider select window

8. If **Add** was used, after the **Problem List Data Entry** group box is complete, click **Save** to add the "new" problem to the **Problem List** grid. (Otherwise, click **Cancel**).

9. If **Edit** was used, after the **Problem List Data Entry** group box is complete, click **Save** to change the selected record on the **Problem List** grid. (Otherwise, click **Cancel**).

Delete Problem

1. Select an existing problem in the Problem List grid.

2. Select **Problems** | **Delete Problem**.

3. The **Problem List Reason for Delete** dialog box displays.

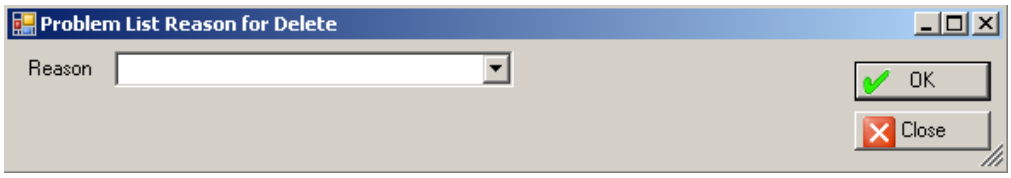


Figure 9-18: Problem List Reason for Delete dialog box

4. Click the drop-down list for the **Reason** field (required) and select an option.

DUPLICATE
ENTERED IN ERROR
OTHER

a. If you select **OTHER**, the dialog box changes.

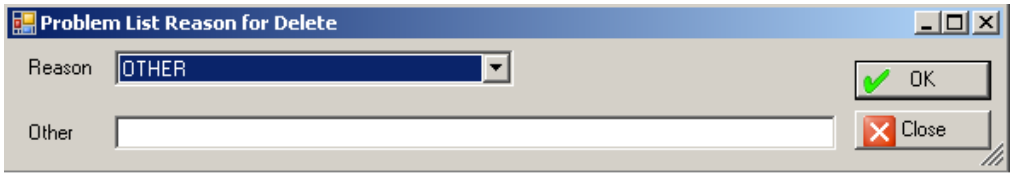


Figure 9-19: Problem List Reason for Delete when using OTHER

b. In this case, at the **Other** field, type the reason to delete the problem (required).

5. After the **Problem List Reason for Delete** dialog box is complete, click **OK** (otherwise, click **Close**).

   After clicking **OK**, the application activates the **Date Updated** and **Person Who Updated** fields.

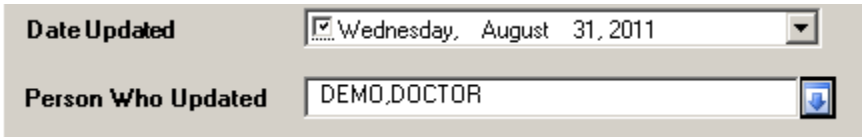


Figure 9-20: Active Date Updated and Person Who Updated fields

6. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date.

7. At the **Person Who Updated** field, select the provider who updated the information. The default is the provider of the visit to which the Problem List item is associated. The **Primary Provider** select window displays.

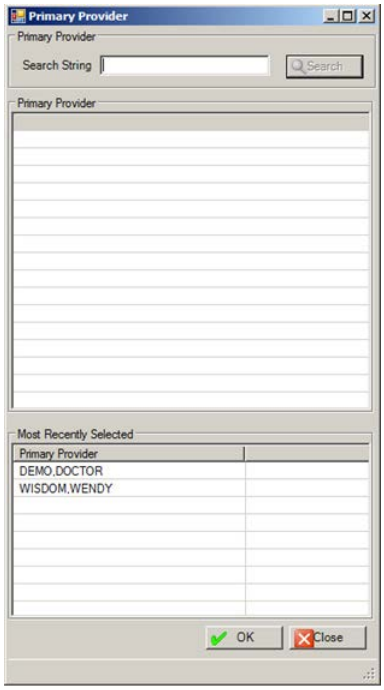
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.)

Figure 9-21: Primary Provider select window

8. After the active fields are complete, click **Save** to remove the problem from the Problem List grid. (Otherwise, click **Cancel**.)

Activate/Inactivate Problem

1. Select an existing problem in the Problem List grid.
2. Select **Problems** | **Activate** (or **Inactivate**).
3. The **Date Updated** and **Person Who Updated** fields display.

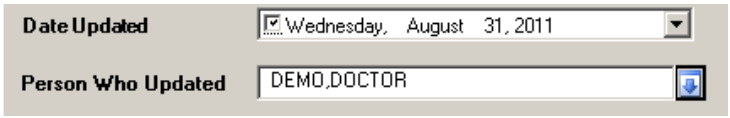


Figure 9-22: Sample active fields for Inactivate (or Activate) process

4. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date. The Activate action only works if the **Date Updated** is checked.
5. At the **Person Who Updated** field, select the person who updated the problem list. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

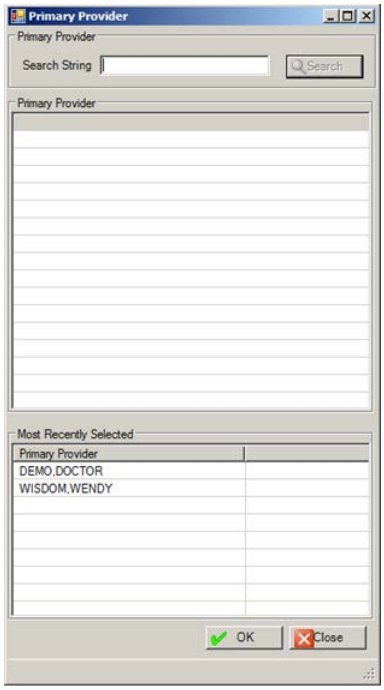
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the **Primary Provide**r list box. Select a retrieved record and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.) (2) Select a name in the **Most Recently Selected** list box and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.)

Figure 9-23: Primary Provider select window

6. After the active fields are complete, click **Save** to change the Status of the selected record on the **Problem List** grid. (Otherwise, click **Cancel**.)

Add/Edit Note

The Add Note and Edit Note functions use the same fields.

1. Select an existing problem in the **Problem List** grid. Select **Notes** | **Add Note**

   OR

2. Select an existing note in the **Problem List** grid. Select **Notes** | **Edit Note**. The fields become populated with existing data.

   The following shows the fields in the lower group box.

Figure 9-24: Active fields for adding a note

3. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date. The **Add Note** action only works if the **Date Updated** is checked.

4. At the **Person Who Updated** field, select the person who updated the problem list. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

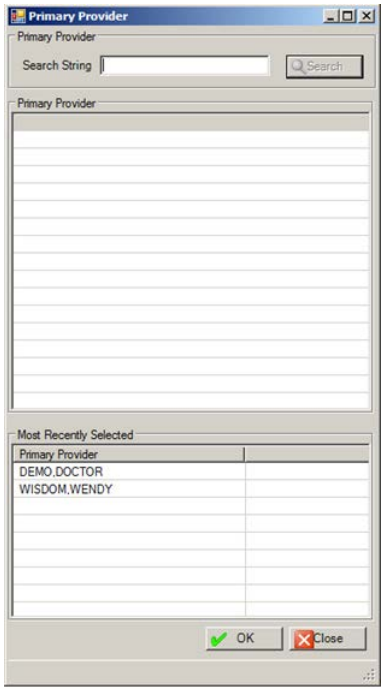
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.)

Figure 9-25: Primary Provider select window

5. At the **Note** field, type the text of the note (Free Text field), usually information about the treatment.

6. At the **Author** field, select the author of the note. To change the name, click the drop-down list to access the **Primary Provider** select window.

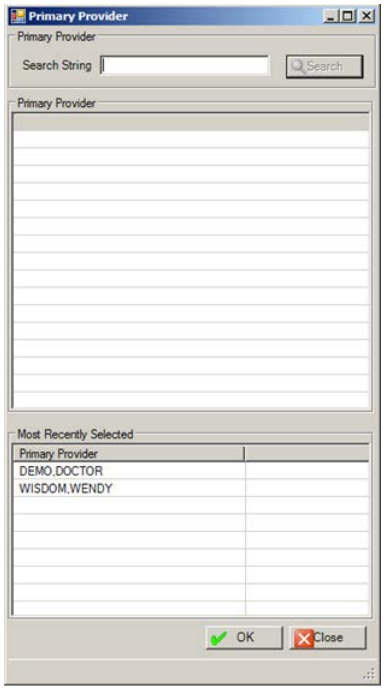
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Author field. (Otherwise, click **Close**.)

Figure 9-26: Primary Provider select window

7. At the **Long Term/Short Term** field, select either the Long Term or Short Term radio button, referring to the treatment described in the note.

8. After the lower group box is complete, click **Save** and the note will be added to the particular problem in the **Problem List** grid. (Otherwise, click **Cancel**.)

   After saving, the application gives the note a note number, displays when the note was added, and displays the note narrative.

   If **Edit** was used, after the **Note** group box is complete, click **Save** (otherwise, click **Cancel**). After clicking **Save**, the particular note will be changed (on the **Problem List** grid).

Remove Note

1. Select an existing note in the **Problem List** grid.

2. Select **Notes** | **Remove Note**.

3. The **Date Updated** and **Person Who Updated** fields become active.

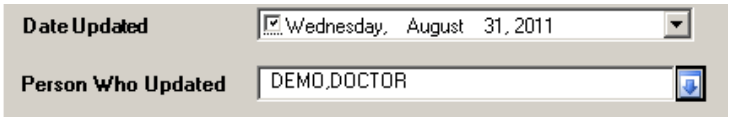


Figure 9-27: Active Date Updated and Person Who Updated fields

4. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the drop-down list to access the calendar. The Remove Note action only works if the **Date Updated** is checked.

5. At the **Person Who Updated** field, select the person who updated the information. Click the drop-down list to access the **Primary Provider** select window. Select the name of the person who updated the Problem List.

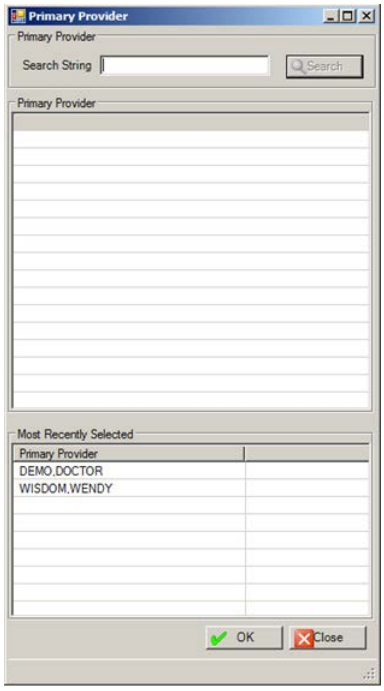
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Person Who Updated field. (Otherwise, click **Close**.)

Figure 9-28: Primary Provider select window

6. After the active fields are complete, click **Save** (otherwise, click **Cancel**). If Save was used, the prompts continue.

7. At the "Are you sure" confirmation message, click **Yes** to remove the note will be removed from the Problem List grid. (Otherwise, click **No**.)

Detail Display

1. Select a problem in the Problem List grid.

2. Click the **Detail Display** button.

3. The **BH Problem List Detail** pop-up for the particular patient displays.

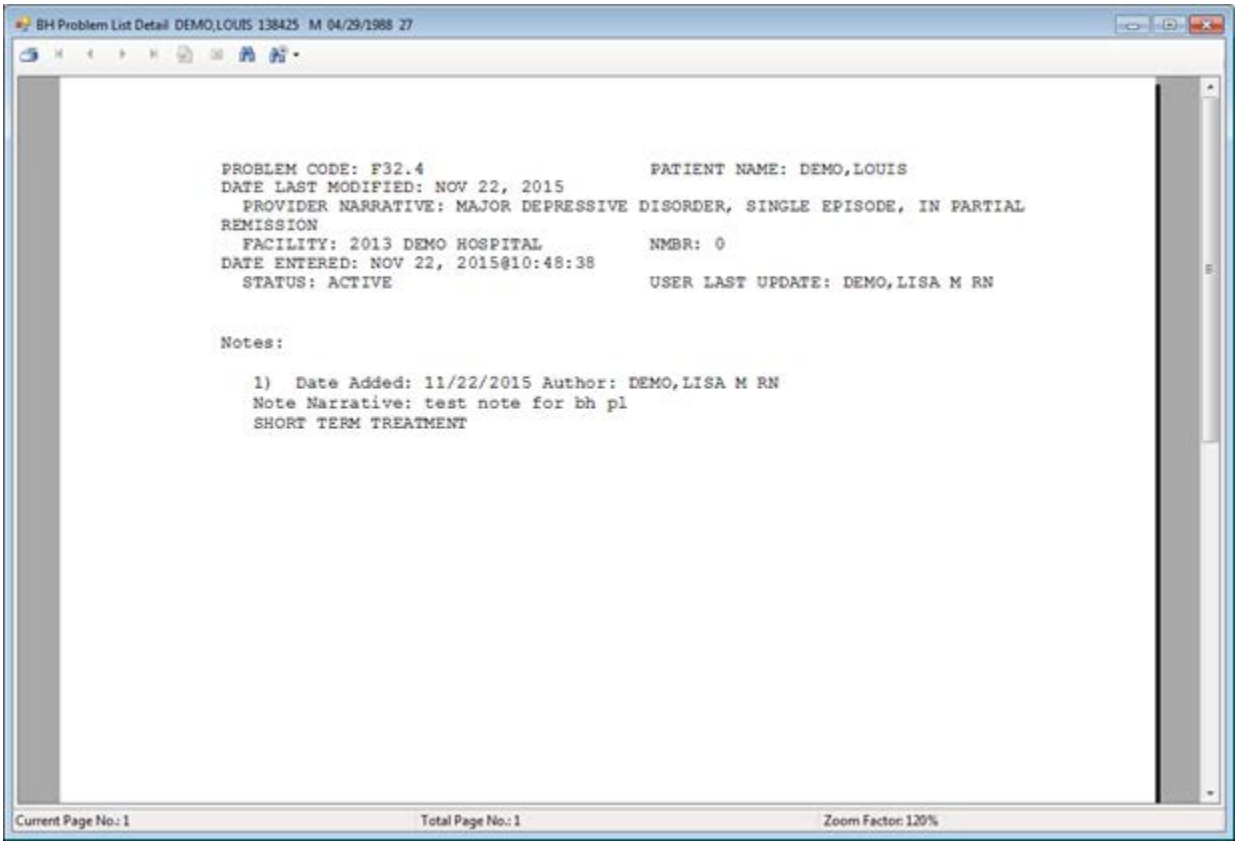


Figure 9-29: Sample BH Problem List Detail for a patient

Section 2.6 provides more information about using the controls on the pop-up window.

No Active Problems

Use the No Active Problems button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.

1. After clicking this button and if there are active problems, the application displays the following message: There are ACTIVE Problems on this patient's BH problem list. You cannot use this action item. Click **OK** to dismiss the message and the focus returns to the Behavioral Health Problem List window.

2. After clicking this button and there are no active problems, the application asks the following: Did the Provider indicate that the patient has No Active BH Problem? Click **Yes** (otherwise, click **No**).

   If Yes was used, the **Date Documented** and **Provider Who Documented** fields become active.

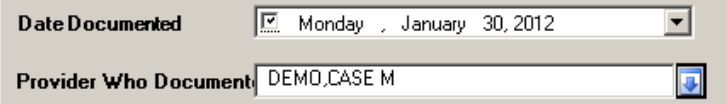


Figure 9-30: Sample Date Documented and Provider Who Documented fields

3. At the **Date Documented** field, select the date the provider documented that the patient has no active problems. The default is today's date. To change the date, click the drop-down list to access the calendar. The No Active Problems action only works if the **Date Documented** is checked.

4. At the **Person Who Documented** field, select the person who documented that the patient has no active problems. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

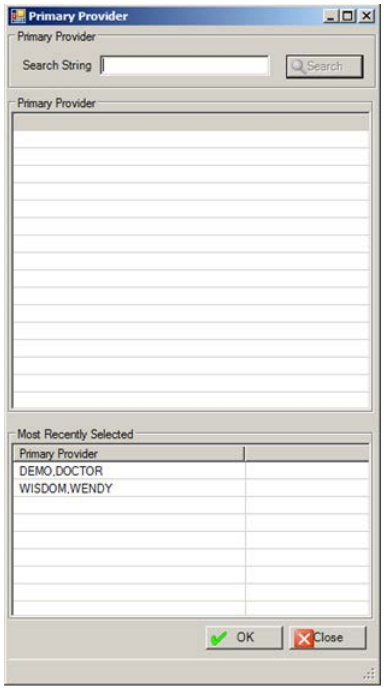
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Documented field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Person Who Documented field. (Otherwise, click **Close**.)

Figure 9-31: Primary Provider select window

5. After the active fields are complete, click **Save** (otherwise, click **Cancel**).

6. After clicking **Save**, the text below the action buttons will display information such as No Active BH Problem Documented on Dec 01, 2011 by DEMO,DOCTOR. Other text below the action buttons will display information such as: BH Problem List Reviewed on Dec 01, 2011 by DEMO,DOCTOR.

Problem List Reviewed

1. Click the **Problem List Reviewed** button to indicate that the current patient's problem list was reviewed.

2. The **Date Reviewed** and **Provider Who Reviewed** fields become active.

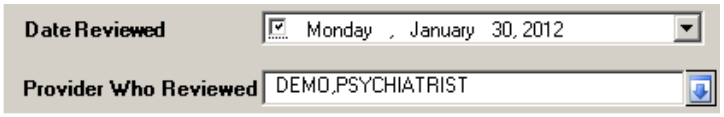


Figure 9-32: Sample Problem List Reviewed and Provider Who Reviewed fields

3. At the **Date Reviewed** field, select the date the provider reviewed the problem list. The default is today's date. To change the date, click the drop-down list to access the calendar and select another date. The Problem List Reviewed action only works if the **Date Reviewed** is checked.

4. At the **Person Who Reviewed** field, select the person who reviewed the problem list. To change the name, click the drop-down list to access the **Primary Provider** select window and select a name.

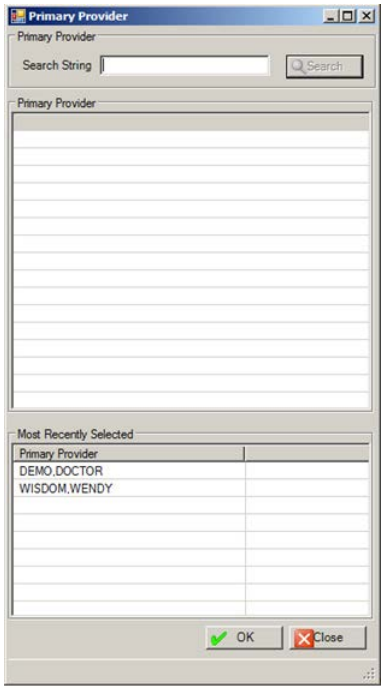
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a retrieved record and click **OK** to populate the Person Who Reviewed field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Person Who Reviewed field. (Otherwise, click **Close**.)

Figure 9-33: Primary Provider select window

5. After the active fields are complete, click **Save** (otherwise, click **Cancel**).

After clicking **Save**, the text below the action buttons (on the **Behavioral Health Problem List** window) will display information such as: BH Problem List Reviewed on December 1, 2011 by DEMO,DOCTOR.

PCC Problem List Display

Click the PCC Problem List Display button to move to the **PCC Problem List** window.

9.2.2 PCC Problem List Window

1. After selecting the **PPC Problem List** option (on the **Visit** window), the **PCC Problem List** window displays.

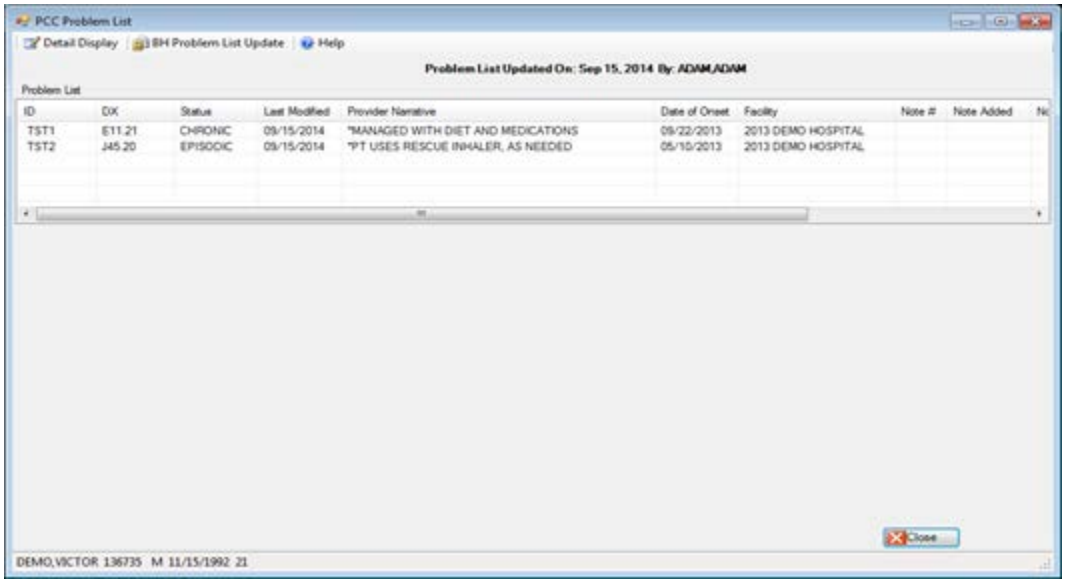


Figure 9-34: Sample PCC Problem List window

2. The current patient's PCC problems display in the **Problem List** grid, including any associated notes. The notes display on the row below the problem.
3. Click **Close** to leave the window.
4. Click **Help** to access the online help for this window.

Detail Display

1. Select a problem in the **Problem List** grid.
2. Click the **Detail Display** button.
3. The **PCC Problem List Detail** pop-up for the particular patient displays.

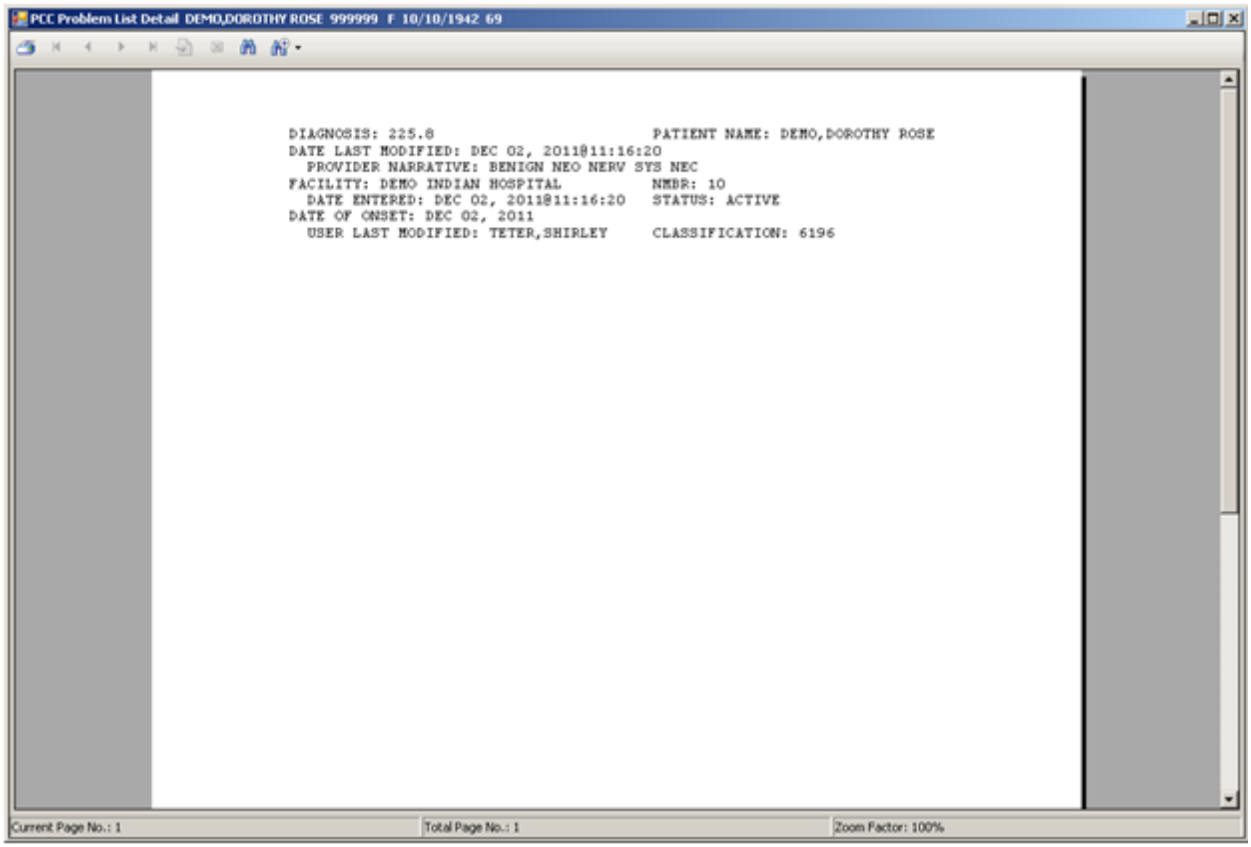


Figure 9-35: Sample PCC Problem List Detail pop-up window

Section 2.6 provides more information about using the controls on the pop-up window.

BH Problem List Update

1. Click the **BH Problem List Update** button to move to the **Behavioral Health Problem List** window.

2. Section 9.2.1 provides more information about this window.

10.0 Treatment Plans

You use the Treatment Plans feature to add or update treatment plans in Roll and Scroll and in the RPMS Behavioral Health System (GUI).

10.1 Patient Treatment Plans (Roll and Scroll)

Use the Update BH Patient Treatment Plans (TPU) option on the Data Entry Menu to access the Patient Treatment Plans menu.

```
                ******************************************
                **       IHS Behavioral Health System       **
                **          Patient Treatment Plans         **
                ******************************************
                           Version 4.0 (patch 5)

                            DEMO INDIAN HOSPITAL


   UP     (Add, Edit, Delete) a Treatment Plan
   DTP    Display/Print a Treatment Plan
   REV    Print List of Treatment Plans Needing Reviewed
   RES    Print List of Treatment Plans Needing Resolved
   ATP    Print List of All Treatment Plans on File
   NOTP   Patients w/Case Open but no Treatment Plan


Select Update BH Patient Treatment Plans Option:
```

Figure 10-1: Options on the Patient Treatment Plans menu

10.1.1 Add, Edit, Delete a Treatment Plan (UP)

Use the UP (Add, Edit, Delete a Treatment Plan) to access the Update Patient Treatment Plan window for a particular patient.

1. At the "Select Update BH Patient Treatment Plans Option, type **UP**.
2. At the "Select PATIENT NAME" prompt, type the name of the patient.
3. The Update Patient Treatment Plan window displays.

```
Update Patient Treatment Plan Apr 13, 2009 17:11:07          Page:    1 of    9
Patient Name:  ALPHAA,CHELSEA MARIE     DOB:  FEB 07, 1975   Sex:  F
                        TREATMENT PLANS CURRENTLY ON FILE

1)  Program:  SOCIAL SERVICES            Responsible Provider:  GAMMAA,RYAN
     Date Established:  MAR 27, 2009     Next Review Date:  APR 01, 2009
     Status:                             Date Resolved:
     Problem: eating

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  MAR 24, 2009     Next Review Date:  APR 15, 2009
```

```
     Status:                              Date Resolved:
     Problem: testing functionality of editing tp

3)  Program:  MENTAL HEALTH               Responsible Provider:  BETAAAA,BJ
     Date Established:  MAR 24, 2009      Next Review Date:  JUN 22, 2009
     Status:                              Date Resolved:
     Problem: TESTING BASED ON RYAN'S FINDINGS
+         Enter ?? for more actions
AD   Add Treatment Plan   RV   Enter TP Review      BV   Browse Visits
ED   Edit a Plan          DS   Disp/Print Plan      SP   Share a TP
DE   Delete Tx Plan       HS   Health Summary       Q    Quit
Select Action: AD//
```

Figure 10-2: Sample Update Patient Treatment Plan window

Use the Quit action to dismiss the Update Patient Treatment Plan window.

Add Treatment Plan (AD)

Use the AD action to add a new treatment plan for the current patient. The prompts are the same as when you edit a plan. The Edit a Plan section below provides more information about the prompts.

Edit a Plan (ED)

Use the ED action to change a selected treatment plan for the current patient.

1. At the “Select Action” prompt, type **ED**.
2. At the “Enter Date Established” prompt, type the date the treatment plan was established (you cannot change).
3. At the “Program” prompt, type the program for the treatment plan. Use one of the following: **M** (Mental Health), **S** (Social Services), **C** (Chemical Dependency), **O** (Other).
4. At the “Designated Provider” prompt, type the name of the designated provider for the treatment plan. The default is the current logon user.
5. At the “Case Admit Date” prompt, type the date the case was admitted.
6. At the “PROBLEM LIST” prompt, type the text of the problem, using up to 240 characters. The text should list and briefly describe multiple problems.
7. At the “DIAGNOSIS – No existing text – Edit? NO//” prompt, type **Y** (yes) to edit the text (otherwise, type **N** (no). If Y was used, the application displays the following where you can type the text of the diagnosis:

```
==[ WRAP ]==[ INSERT ]==============< DIAGNOSIS >============[ <PF1>H=Help ]====
```

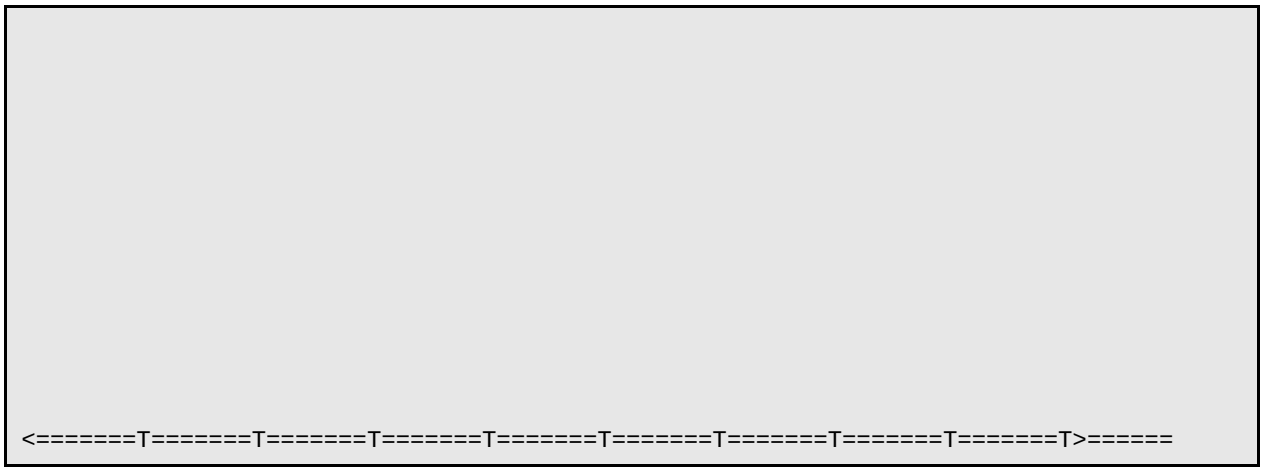


Figure 10-3: Window to add the text of the diagnosis

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

8. At the "Treatment Plan Narrative (Problems/Goals/Objectives/Methods) – No existing text – Edit? NO//" prompt, type **Y** (yes) to edit the text (otherwise, type **N** (no)." If Y was used, the application displays the following where you can type the text of the treatment plan:

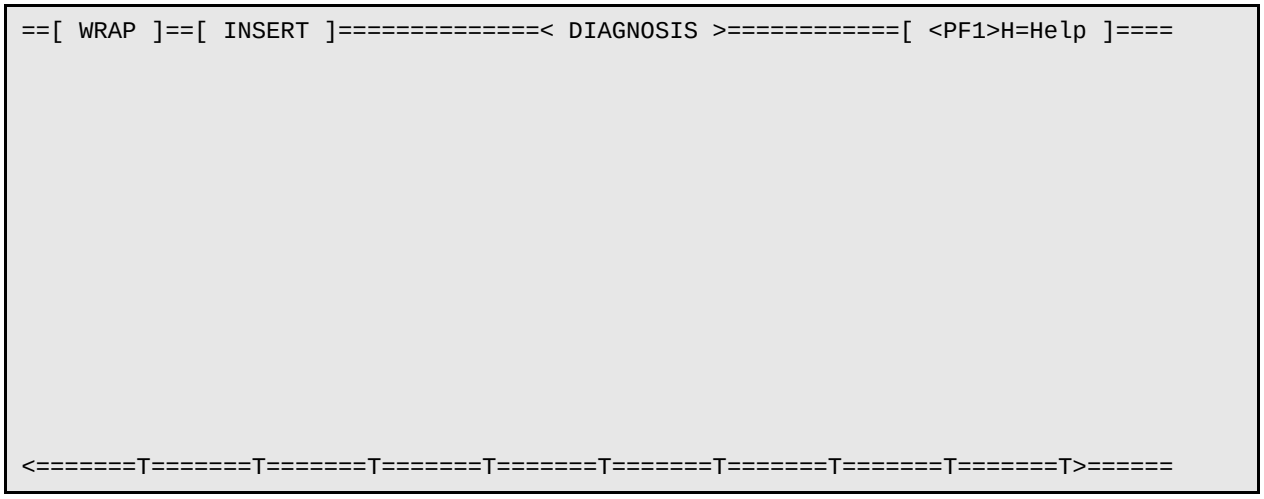


Figure 10 3: Window to add information about the treatment plan

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

9. At the “Anticipated Completion Date” prompt, type the date the treatment plan is anticipated to be completed.

10. At the “Review Date” prompt, type the date of the review.

11. At the “Concurring Supervisor” prompt, type the name of the concurring supervisor for the treatment plan.

12. At the “Date Concurred” prompt, type the date the concurring supervisor agreed to the treatment plan. Once a date is specified at this prompt, you cannot change it. The prompt displays only if you specified a concurring supervisor.

13. At the “Participants in the development of this plan” prompt, if there is a participant in the development of this plan, the application displays the name. If not, the “None recorded” message displays.

    The application allows you to do one of the following at this prompt: **A** - Add a Participant or **N** - NO Changes. If N was used, the next prompt “Date Closed” displays.

    If A was used, the following prompts display:

    a. At the “Enter the Participant Name” prompt, type the name of the participant.

    b. At the “Enter the Relationship to the Client” prompt, type the relationship of the participant to the patient.

       The application then lists the participants in the development of the plan. Below is an example:

```
Participants in the development of this plan:
   ------------------------------------------------------------------------
  1)  Alma Beta                          cousin

     Select one of the following:

          A         Add a Participant
          E         Edit an Existing Participant
          D         Delete a Participant
          N         No Change

Which action:
```

Figure 10-4: Sample of participants in the development of this plan

c. At the “Which action” prompt, use one of the following:

- Use the A option to add a participant. The prompts are the same as those shown above.
- Use the E option to edit a particular existing participant. After you indicate the participant name, the prompts are the same as the add option.
- Use the D option to delete a particular existing participant. The application asks to specify the one you want to delete. There is no confirmation about the deletion.
- Use the N option to continue onto the next prompt.

14. At the “Date Closed” prompt, type the date the treatment plan is to be closed.

Delete Tx Plan (DE)

Use the DE action to delete a particular treatment plan.

1. At the “Select Action” prompt, type **DE**.
2. At the “Select BH Treatment Plan” prompt, type the number of the treatment plan to remove.
3. At the “Are you sure you want to DELETE this Treatment Plan?” prompt, type **Y** (yes) to remove the particular treatment plan from the Update Patient Treatment Plan window. (Otherwise, type **N** (no).)

Enter TP Review (RV)

Use the RV action to access the Treatment Plan Update window of a specified treatment plan (for the current patient).

1. At the “Select Action” prompt, type **RV**.
2. At the “Select BH Treatment Plan” prompt, type the number of the treatment plan to review.
3. Note: the application could display the following message:

```
NOTE:  It is recommended you close out treatment plans using DSM-IV
diagnoses and create a new treatment plan using DSM-5 diagnoses.

Press enter to continue....:
```

Press Enter to continue.

The Treatment Plan Update window displays. This window has the following prompts.

4. At the “Select REVIEW DATE” prompt, press Enter to accept the displayed review date (you can change). If you do not enter a date here, you exit the RV process.
5. At the “Review Provider” prompt, type the name of the review provider.
6. At the “Review Supervisor” prompt, type the name of the review supervisor, if any.
7. At the “Progress Summary” prompt, type the text of the progress summary displays (if any).
8. At the “Edit?” prompt, type **Y** (yes) or **N** (no) to indicate if you want to edit the text of the progress summary. If Y was used, you access another window to edit the text.

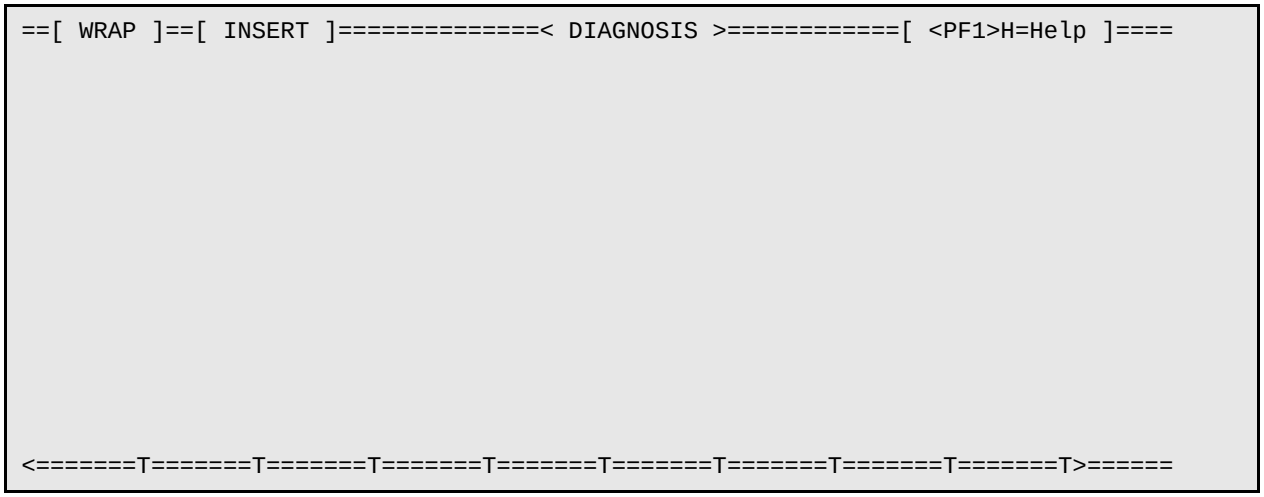


Figure 10 3: Window to add information about the treatment plan

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

9. At the “Select TX REVIEW PARTICIPANT NAME” prompt, type a new treatment review participant name, if needed.
10. At the “Relationship to Client” prompt, type the relationship to the client. This prompt does not display unless you added a name in the previous prompt.

11. At the “Next Review Date” prompt, type the next review date displays (you can change).

Disp/Print Plan (DS)

Use the DS action to display/print a specified treatment plan for the current patient.

1. At the “Select Action” prompt, type **DS**.
2. At the “Select BH Treatment Plan” prompt, type the number of the treatment plan to browse/print.
3. At the “What would do like to print” prompt, type **T** (Treatment Plan Only), **R** (Treatment Plan REVIEWS Only), or **B** (both Treatment Plan and Reviews).
4. At the “Do you wish to” prompt, type **P** (print output on paper) or **B** (browse output on screen).

   The browse option outputs 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 10-5: Sample display of treatment plan

Health Summary (HS)

Use the HS action to display/print a particular health summary for the current patient.

1. At the "Select Action" prompt, type **HS**.
2. At the "Select HEALTH SUMMARY TYPE NAME" prompt, type the health summary type to use.

   The application displays the Health Summary for the current patient on the Output Browser window.

Browse Visits (BV)

Use the BV action to browse the behavioral health visits for the current patient.

1. At the "Select Action" prompt, type **DS**.
2. At the "Browse which subset of visits for [patient name]" prompt, type one of the following: **L** (patient's last visit), **N** (patient's last n visits), **D** (visits in a date range), **A** (All of this patient's visits), or **P** (visits to one program). If you use N, D, or P, other prompts will display.
   a. If N was used, type the number of visits at the "How many visits should be displayed: (1-99)" prompt.
   b. If D was used, type the date range of the visits.
      - At the "Enter beginning Date of Visit" prompt, type the beginning date of the date range.
      - At the "Ending Date of Visit" prompt, type the ending date of the date range.
   c. If P was used, type the program at the "Visits to Which Program" prompt.

The BROWSE PATIENT'S VISITS window displays. The one below is for all visits.

```
BROWSE PATIENT'S VISITS       Apr 13, 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 10-6: Sample patient's behavioral health visits window

Share a TP (SP)

You need to have shared permission in order to use this option. (Use the Site parameters on the Manager utilities (Share Records); your name would need to be added to that list.)

10.1.2 Display/Print a Treatment Plan (DTP)

Use the DTP option (on the Patient Treatment Plans menu) to display/print the treatment plan for a specified patient.

1. At the "Select Update BH Patient Treatment Plans Option, type **DTP**.
2. At the "Select PATIENT NAME" prompt, type the name of the patient to use.

   If you use a patient with no treatment plan, the application will display a message to that effect.

If the patient has at least one treatment plan, the application will display the Display/Print Treatment Plan window.

```
Display/Print Treatment Plan  Apr 07, 2009 17:12:08          Page:    1 of    2
Patient Name:  DUCK,DONALD R     DOB:  JUN 07, 1978   Sex:  M
                       TREATMENT PLANS CURRENTLY ON FILE


1)  Program:  SOCIAL SERVICES            Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 12, 2009
     Status:                             Date Resolved:
     Problem: testing functionality

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 02, 2009
     Status:                             Date Resolved:
     Problem:

3)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 02, 2009
     Status:                             Date Resolved:
     Problem:
+         Enter ?? for more actions
DS   Disp/Print Plan      PS   Previous Screen      PL   Print List
HS   Health Summary       DN   Down a Line         SL   Search List
NS   Next Screen          UP   Up a Line           Q    Quit
Select Action: DS//
```

Figure 10-7: Sample Display/Print Treatment Plan window

The following actions are related to view functions on this window:

Action	Functionality
NS (Next Screen)	Use to display the next screen of information (does not work apply to the last screen).
PS (Previous Screen)	Use to display the previous screen of information (does not work apply to the first screen).
DN (Down a Line)	Use to display the next line of information following the one at the bottom of the current screen (does not apply to the last screen).
UP (Up a Line)	Use to display the line previous line of information before the top of the current screen (does not work apply to the first screen).
Q (Quit)	Use to dismiss the window.

Display/Print Plan (DS)

Use the DS action to browse/print a particular treatment plan. See Disp/Print Plan (DS) for more information about the display/print plan action.

Health Summary (HS)

Use the HS action to display a particular type of health summary for the current patient.

1. At the "Select Action" prompt, type **HS**.
2. At the "Select HEALTH SUMMARY TYPE NAME" prompt, type the health summary type to use.

The application displays the Health Summary for the current patient on the Output Browser window.

Print List (PL)

Use the PL action to display/print the treatment plans for the current patient.

1. At the "Select Action" prompt, type **PL**.
2. At the "Device" prompt, type the device to output the list of treatment plans.

The application displays the Display/Print Treatment Plan for the current patient.

```
Display/Print Treatment Plan  Apr 07, 2009 17:51:24          Page:    1 of    2
Patient Name:  DELTA,EDWIN RAY     DOB:  JUN 07, 1978   Sex:  M
                       TREATMENT PLANS CURRENTLY ON FILE

+---------------------------------------------------------------------------
1)  Program:  SOCIAL SERVICES            Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 12, 2009
     Status:                             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 10-8: Sample Display/Print Treatment Plan window

Search List (SL)

Use the SL action to search for a particular text string in the text of the treatment plans

1. At the "Select Action" prompt, type **SL**.

2. At the “Search for” prompt, type the text string to search for in the treatment plan.

   If the application finds the first occurrence of the text string, it highlights it and the prompts continue.

3. At the “Stop Here?” prompt, type **Y** (yes) or **N** (no).

   If N was used, the focus leaves the search sequence.

   If Y was used, the application will search for the next occurrence of the text string. If it finds it, the application will highlight it. If it does not find it, it displays the message: Text not found. Do you want to start at the beginning of the list? Type **Y** (yes) or **N** (no).

10.1.3 Print List of Treatment Plans Needing Reviewed (REV)

Use the REV option to print a list of treatment plans in a particular date range that need to be reviewed.

1. At the “Select Update BH Patient Treatment Plans Option, type **REV**.
2. At the “Enter Beginning Date” prompt, type the beginning date of the date range.
3. At the “Enter Ending Date” prompt, type the ending date of the date range.
4. At the “Run the Report for which Program” prompt, type which program to use: **O** (One Program) or **A** (All Programs).

   If O was used, type the number of the program to use at the “Which Program” prompt.

5. At the “List Treatment Plans for” prompt, type one of the following: **O** (One Provider) or **A** (All Providers).

   If O was used, type the name of the provider at the “Which Responsible Provider” prompt.

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).
7. At the “Device” prompt, type the device to output the list.

   Below is a sample Listing of Treatment Plans Due to be Reviewed.

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
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 10-9: Sample output treatment plans due to be reviewed

10.1.4 Print List of Treatment Plans Needing Resolved (RES)

Use the RES option to print a list of treatment plans in a particular date range that need to be resolved.

1. At the "Select Update BH Patient Treatment Plans Option, type **RES**.

   The prompts are the same as those for the Print List of Treatment Plans Needing Reviewed (REV). Section 10.1.3 provides more information.

   Below is a sample Listing of Treatment Plans Due to be Resolved.

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                  Page 1
                          DEMO INDIAN HOSPITAL
            LISTING OF TREATMENT PLANS DUE TO BE RESOLVED
                   Date Range: APR 07, 2008 to APR 07, 2009

PATIENT NAME           DOB       CHART # DATE         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 10-10: Sample output of treatment plans due to be resolved

10.1.5 Print List of All Treatment Plans on File (ATP)

Use the ATP option to print/browse a list of all patients who have a treatment plan on file (in a specified date range). This date range is the one during which the treatment plan was established.

1. At the "Select Update BH Patient Treatment Plans Option, type **ATP**.
2. At the "Enter BEGINNING Date" prompt, type the beginning date of the date range.
3. At the "Enter ENDING Date" prompt, type the ending date of the date range.
4. At the "Run the Report for which PROGRAM" prompt, type which program to use: **O** (One Program) or **A** (All Programs).

   If O was used, type the number of the program to use at the "Which Program" prompt.
5. At the "List treatment plans for" prompt, type **O** (one provider) or **A** (all providers).

   If O was used, type the name of the provider at the "Which Provider" prompt.
6. At the "Sort list by" prompt, type **P** (Responsible Provider), **N** (Patient Name), or **D** (Date Established).
7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).
8. At the "Device" prompt, type the device to output the list.

The application displays the Listing of Treatment Plans window.

```
            **********  CONFIDENTIAL PATIENT INFORMATION  **********
XX                                                                  Page 1
                           DEMO INDIAN HOSPITAL
                       LISTING OF TREATMENT PLANS
                  Date Established: JAN 13, 2009 to APR 13, 2009

PATIENT NAME           DOB       CHART # DATE         REVIEW DATE   ANTICIPATED
                                         ESTABLISHED                COMPLETION
                                                                    DATE
--------------------------------------------------------------------------------


ALPHAA,CHELSEA MARIE   2/7/75    116431  Feb 25, 2009 May 26, 2009  Feb 25, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 09, 2009 Jun 07, 2009  Mar 09, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 24, 2009 Jun 22, 2009  Mar 24, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
```

```
ALPHAA,GLEN DALE       11/10/81  108704  Apr 06, 2009 Jul 05, 2009  Apr 06, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 24, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,LORI

Enter RETURN to continue or '^' to exit:
```

Figure 10-11: Sample list of treatment plans

10.1.6 Patients w/Case Open but No Treatment Plan (NOTP)

Use the NOTP option to produce a report that lists all patients who have a case open date, no case closed date, and no treatment plan in place in a specified date range. This date range is during which the case was opened.

1. At the "Select Update BH Patient Treatment Plans Option, type **NOTP**.
2. At the "Enter BEGINNING Date" prompt, type the beginning date of the date range.
3. At the "Enter ENDING Date" prompt, type the ending date of the date range.
4. At the "List cases opened by" prompt, type **O** (one program) or **A** (all programs). This allows you to limit the report output to cases opened by one or all Programs.

   If O was used, type the name of the program at the "Review Cases opened by which Program" prompt.
5. At the "List cases opened by" prompt, type **O** (one provider) or **A** (all providers). This allows you to limit the report output to cases opened by one or all Providers.

   If O was used, type the name of the provider at the "Which Provider" prompt.
6. At the "Sort list by" prompt, type **P** (Responsible Provider), **N** (Patient Name), or **C** (Case Open Date).
7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).
8. At the "Do you wish to" prompt, type **P** (Print output) or **B** (Browse output on screen).

The LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE report displays.

```
                Case Open Dates: SEP 08, 2010 to DEC 07, 2010

PATIENT NAME           HRN     CASE OPEN PROGRAM     PROVIDER         LAST VISIT
                               DATE
--------------------------------------------------------------------------------
```

```
THETAA,ROLAND          258852  10/01/10  MENTAL HEA                      12/07/10
BETAAAA,MONTY          741147  11/03/10  MENTAL HEA                      12/07/10
DEMO,DOROTHY ROSE      999999  12/07/10  MENTAL HEA                      07/08/10
BETA,ROBERT JACOB      207365  11/22/10  CHEMICAL D  CHIII,JESSICA      12/07/10
```

Figure 10-12: Sample Listing of Cases with No Treatment Plan in Place report

10.2 Treatment Plan Window (GUI)

The RPMS Behavioral Health System (GUI) application provides ways to manage treatment plans for one patient

Below shows where the treatment plan functions are located.

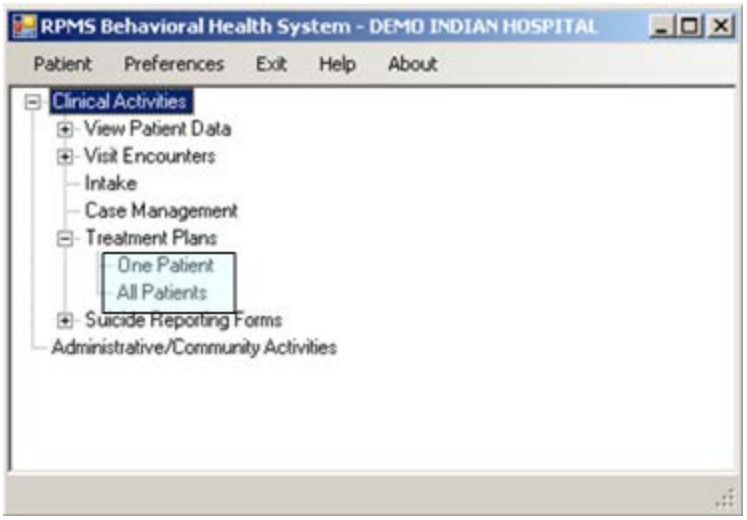


Figure 10-13: Location of Treatment Plan functions on tree structure

One way to access the **Treatment Plan** window is to use the **One Patient** option. You access the **Treatment Plan** window for the current patient.

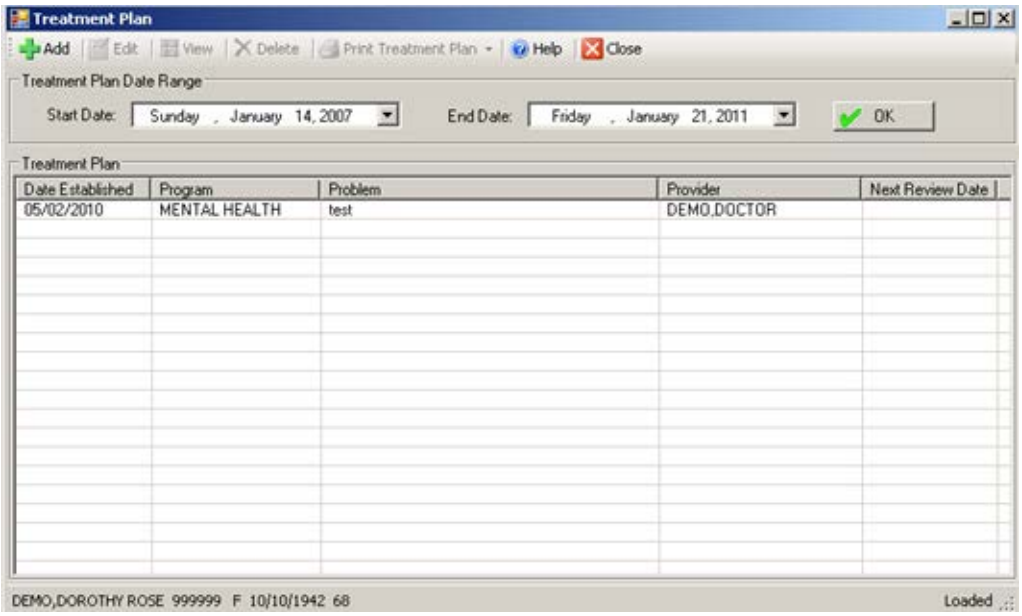


Figure 10-14: Sample Treatment Plan group box for current patient

Another way to access the **Treatment Plan** window is to use the **All Patients**. You access the **Treatment Plan** window for all patients.

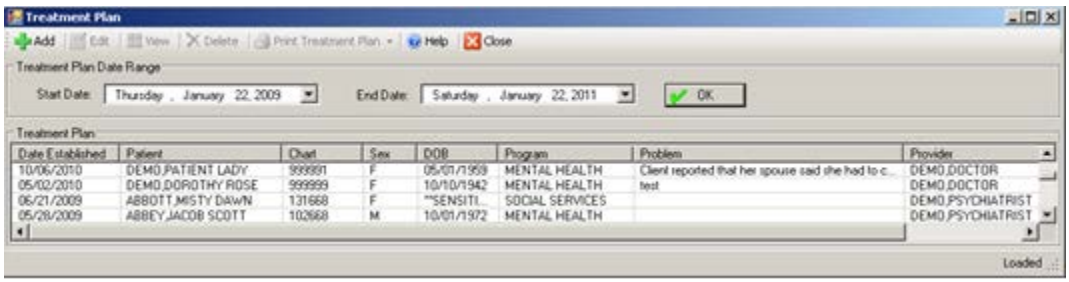


Figure 10-15: Sample Treatment Plan window for all patients

The following table provides information about the features of both windows.

Feature	Functionality
Treatment Plan Window for One Patient	The default Start Date is one year previous. If you change the **Start Date for the Treatment Plan** window for **One Patient**, this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).
Treatment Plan Window for All Patients	The default Start Date is one year previous. If you change the Start Date for the Treatment Plan window for **All Patients**, this change stays in effect until you exit the application. When you login the next time, the Start Date reverts to one year previous.
Treatment Plan Group Box	This group box shows the records within the Treatment Plan Date Range. They are in date order.

Feature	Functionality
Add Button	Establish the patient to use in the add process. Use the **Add** button to add a new treatment plan record on the **Treatment Plan - Add Treatment Plan** window.
Edit Button	Use the **Edit** button to edit a particular treatment plan record on the **Treatment Plan - Edit Treatment Pla**n window.
View Button	Highlight a treatment plan record and click **View** (or double-click on the plan) to view the **Treatment Plan - View Treatment Plan** window (view only). The fields are the same as those on the add/edit treatment plan dialog box.
Help Button	Use the **Help** button to access the online help system for the **Treatment Plan** window.
Close Button	Use the **Close** button to dismiss the Treatment Plan window.
Delete Button	Use the **Delete** button to delete a particular treatment plan record. The application confirms the deletion.
Print Treatment Plan Button	Use the **Print Treatment Plan** button to print a particular Treatment Plan record. The Print Treatment Plan button has three choices: (1) Treatment Plan Only, (2) Review Data Only, and (3) Treatment Plan and Review Data. Highlight a record and choose one of the Print Treatment Plan options. The application determines which of the options are active.

The following applies to the Print Treatment Plan button:

If you use Review Data Only (2) or Treatment Plan and Review Data (3) and if there is one or more reviews, the application displays the **Treatment Plan Reviews** dialog box.

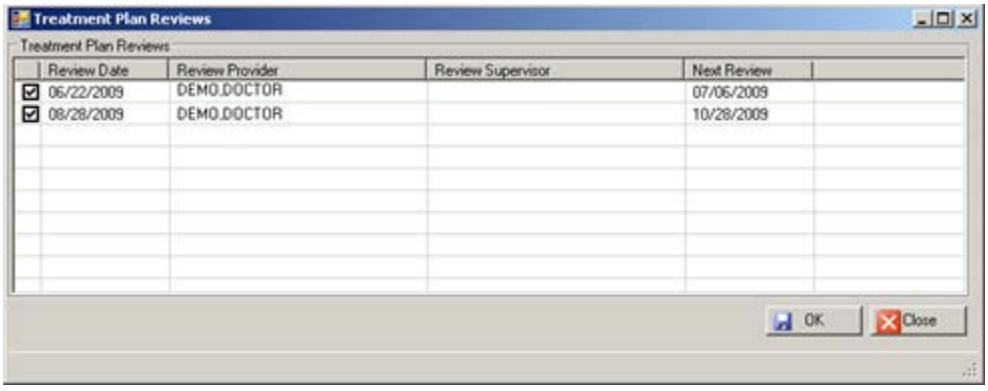


Figure 10-16: Sample Treatment Plan Reviews dialog box

Check each Treatment Plan Review record to use and click **OK**. Otherwise, click **Close** to exit the print routine.

The following shows the first page of the **Treatment Plan** pop-up window.

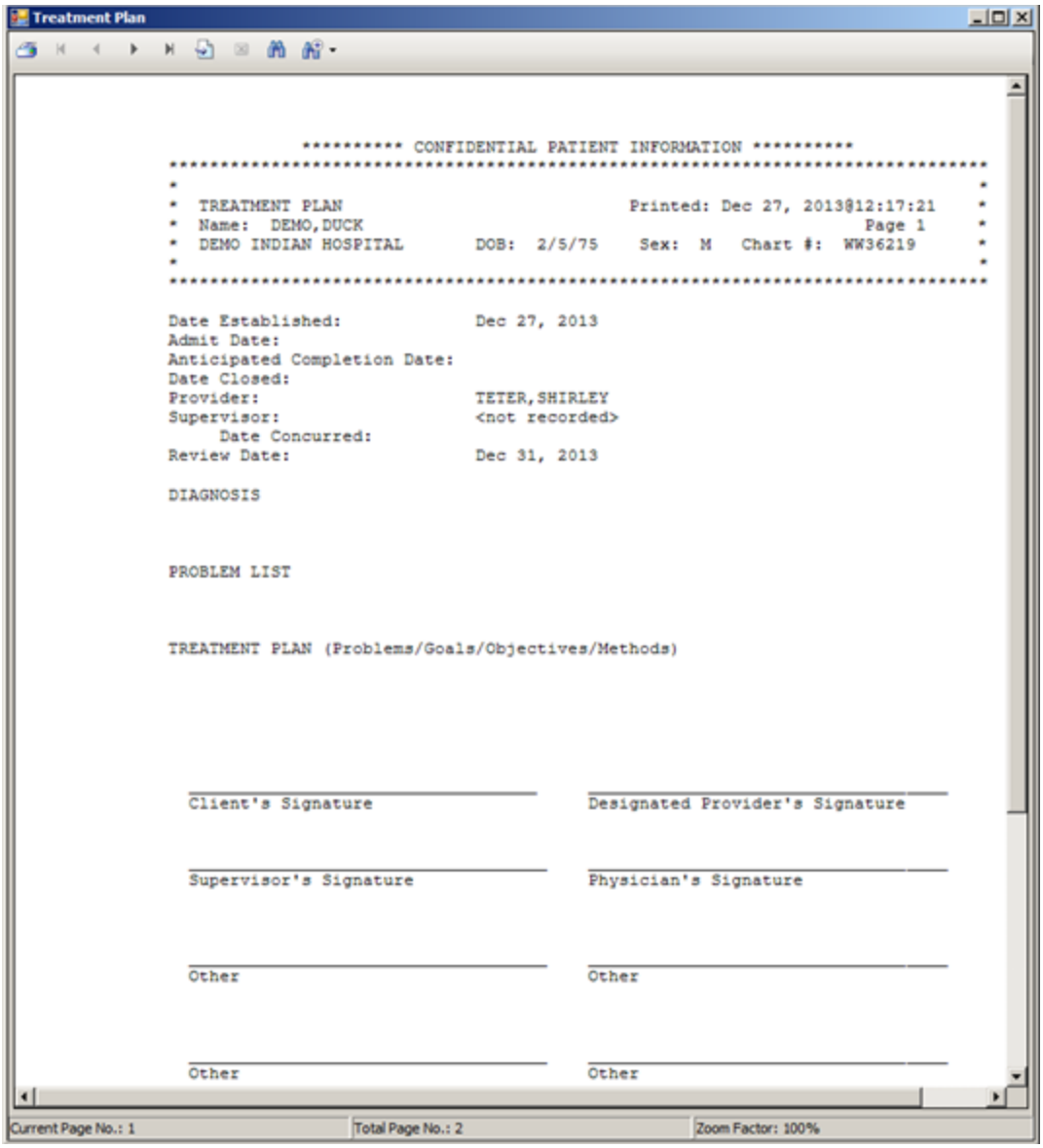


Figure 10-17: Sample Treatment Plan pop-up window

Section 2.6 provides more information about using the controls on this type of 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. The following shows the **Add Treatment Plan** window.

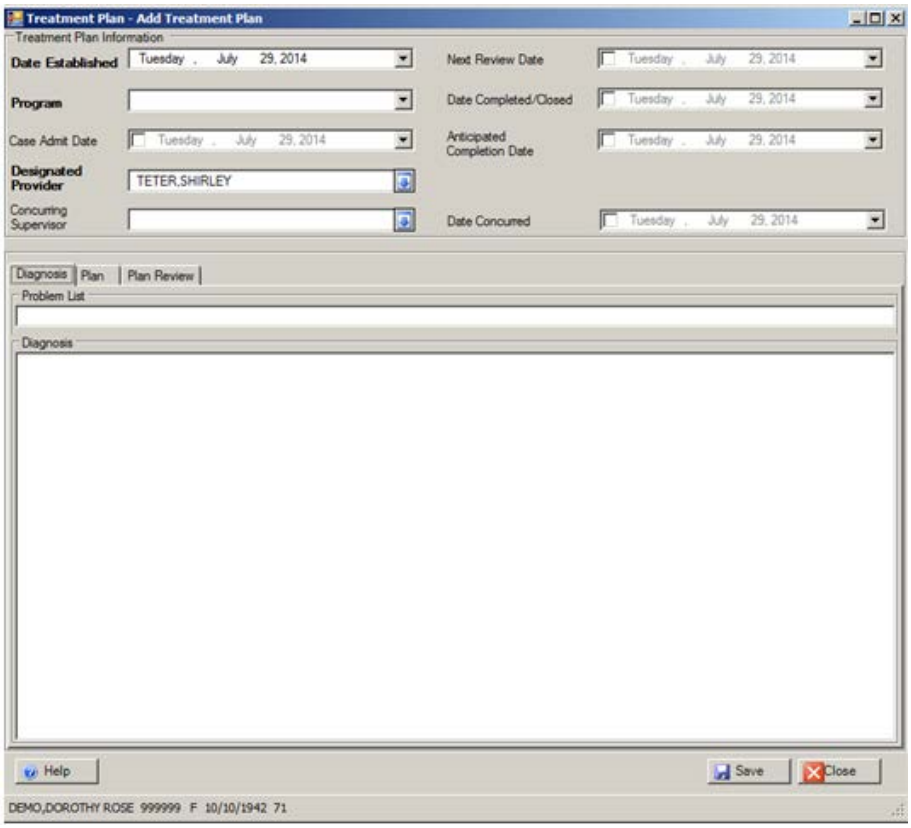


Figure 10-18: Sample Add Treatment Plan window

The following table provides information about the buttons on this window.

Button	Functionality
Help button	Use to access the online help system for the window.
Save button	Use to save the data on the window. The Save function adds/edits the treatment plan record on the **Treatment Plan** window.
Close button	Use to display the **Continue?** dialog box that states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add window. Click **No** and the focus remains on the add/edit treatment plan window.

10.3.1 Treatment Plan Information Group Box

Use the **Treatment Plan Information** group box to manage the basic information about the treatment plan.

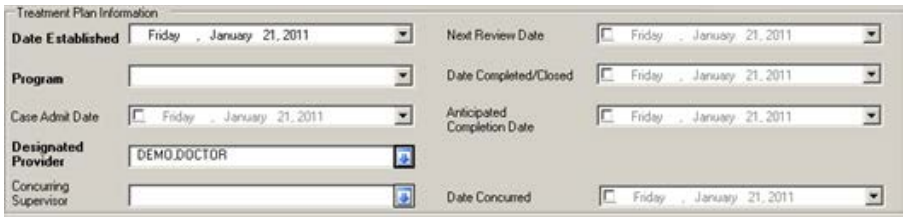


Figure 10-19: Sample Treatment Plan Information group box

The fields in bold text are required.

1. At the **Date Established** field, select the date the treatment plan was established. The default for a new record is the current date. Click the drop-down list to access the calendar to change this date.

2. At the **Next Review Date** field, select the date the treatment plan is expected to be reviewed. Click the drop-down list to access the calendar to change this date. Note that if a Date Completed/Closed is populated, this field will be inactive.

3. At the **Program** field, select the program used in the treatment plan. Click the drop-down list to select one of the following: Mental Health, Social Services, Other, or Chemical Dependency.

4. At the **Date Completed/Closed** field, select the date the treatment plan was completed or closed. Click the drop-down list to access the calendar to change this date.

5. At the **Case Admit Date** field, select the date the patient was admitted into care. Click the drop-down list to access the calendar to change this date.

6. At the **Anticipated Completion Date** field, select the anticipated completion date for the treatment plan. Click the drop-down list to access the calendar to change this date.

7. At the **Designated Provider** field, select the name of the designated provider for the treatment plan. Click the drop-down list to access the **Designated Provider** search dialog box where you search for the name of the designated provider.

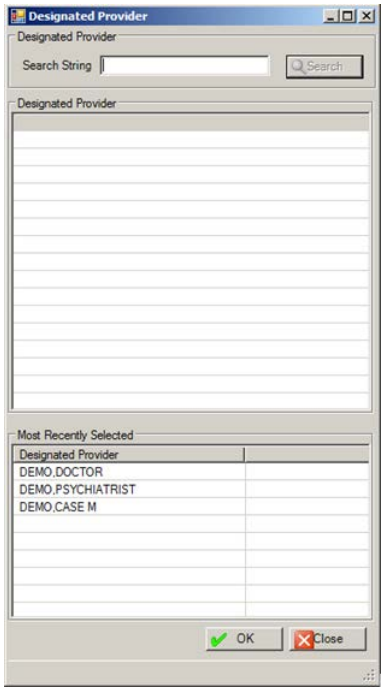
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the designated provider's last name and then clicking **Search**. The retrieved providers will populate the Designated Provider list box. Select a retrieved record and click **OK** to populate the Designated Provider field. (Otherwise, click **Close**.) (2) Select name in the Most Recently Selected list box and click **OK** to populate the Provider field. (Otherwise, click **Close**.)

Figure 10-20: Sample Designated Provider search window

8. At the **Concurring Supervisor** field, select the name of the concurring supervisor for the treatment plan. Click the drop-down list to access the **Concurring Supervisor** search dialog box where you search for the name of the supervisor.

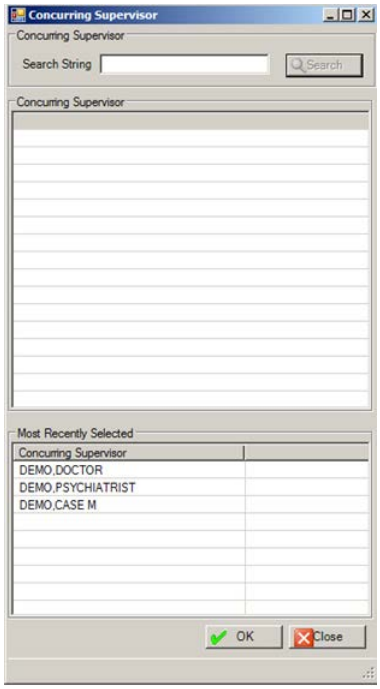
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing concurring supervisor's last name and then clicking **Search**. The retrieved names will populate the Concurring Supervisor list box. Select a retrieved record and click **OK** to populate the Concurring Supervisor field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Concurring Supervisor field. (Otherwise, click **Close**.)

Figure 10-21: Sample Concurring Supervisor search window

9. At the **Date Concurred** field, select the date that the concurring supervisor agreed to the treatment plan. This date cannot be before the Date Established. Click the drop-down list to access the calendar to change this date.

10.3.2 Diagnosis Tab

Use the **Diagnosis** tab to add diagnosis information. This includes the text of the diagnosis for the particular treatment plan (in the Diagnosis field) and the text of the problem list (in the Problem List field).

Figure 10-22: Diagnosis tab

Both fields are Free Text fields.

10.3.3 Plan Tab

Use the **Plan** tab to add participants to the plan as well as describing **the Problems / Goals / Objectives / Methods** of the plan.

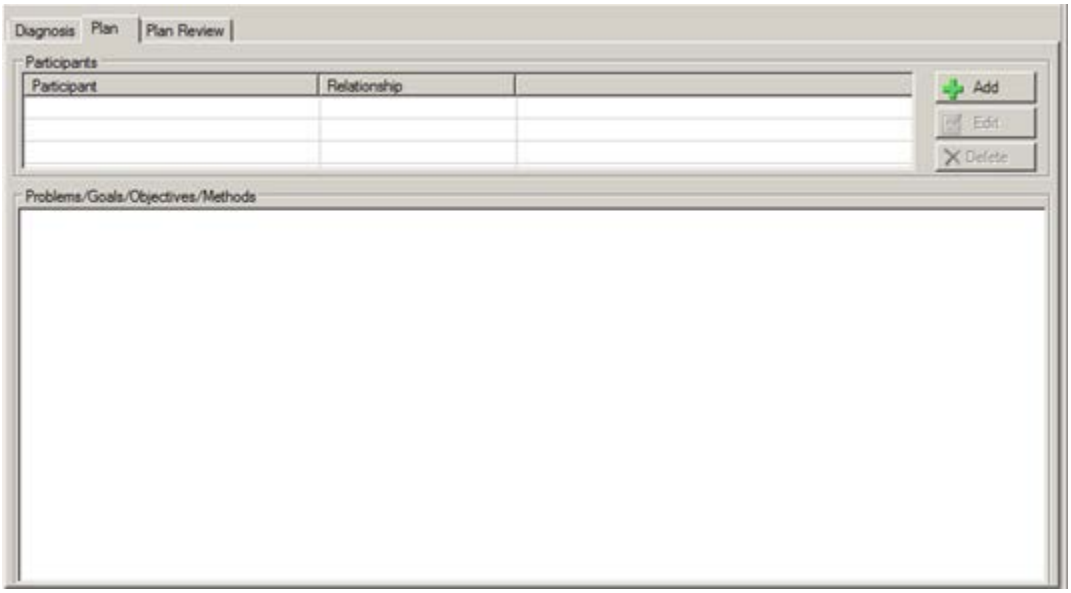


Figure 10-23: Sample Plan tab

Participants Group Box

Use the **Participants** group box to manage the participants in the treatment plan.

Delete Button

Use the Delete button to delete a selected participant record.

1. Select the participant record to delete.
2. Click **Delete**.
3. The application confirms the deletion. Type **Y** (yes) or **N** (no).

Add/Edit Button

The Add and Edit buttons use the same fields.

1. Click **Add** to add a record.

   OR

2. Select a record to edit and click **Edit**.

   The **Treatment Plan Participants** dialog box displays.

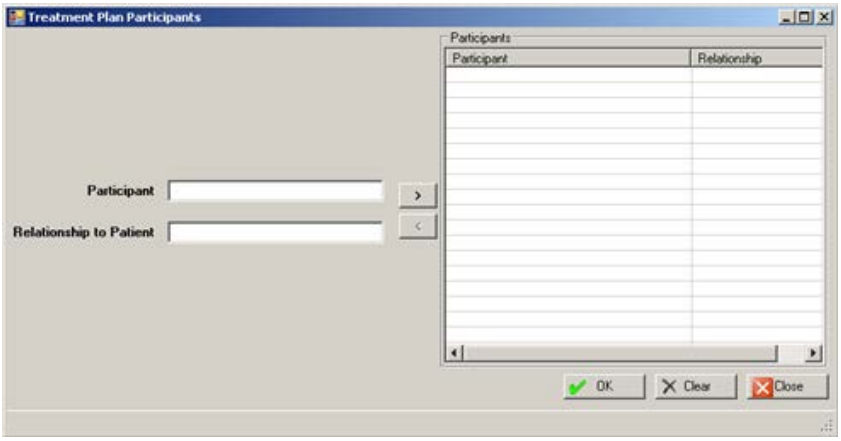


Figure 10-24: Sample Treatment Plan Participants dialog box

3. At the **Participant** field, type the participant name. This is a Free Text field.
4. At the **Relationship to Patient** field, type the participant's relationship to the patient of the treatment plan. This is a Free Text field.
5. After completing the **Participant** and **Relations** fields, do one of the following:
   a. Click the right-pointing arrow to add the information to the **Participants** list box. More than one participant/relationship record can be added to the **Participants** list box.
   b. Click **Clear** to remove the data in the **Participant** and **Relationship to Patient** fields.

6. Remove a highlighted record in the **Participants** list box by clicking the left-pointing arrow.

7. If Add was used, click **OK** to save the data. The data in the **Participants** list box will populate the **Participants** group box on the **Plan Review** tab of the add/edit treatment plan window. (Otherwise, click **Close**.)

8. If **Edit** was used, click **OK** to save the data. The data in the Participants list box will be updated.

Problems/Goals/Objectives/Methods

Populate this field with the text of the problems, goals, objective, or methods for the treatment plan. This is a Free Text field.

10.3.4 Plan Review Tab

Use the **Plan Review** tab to document the plan review of the treatment plan.

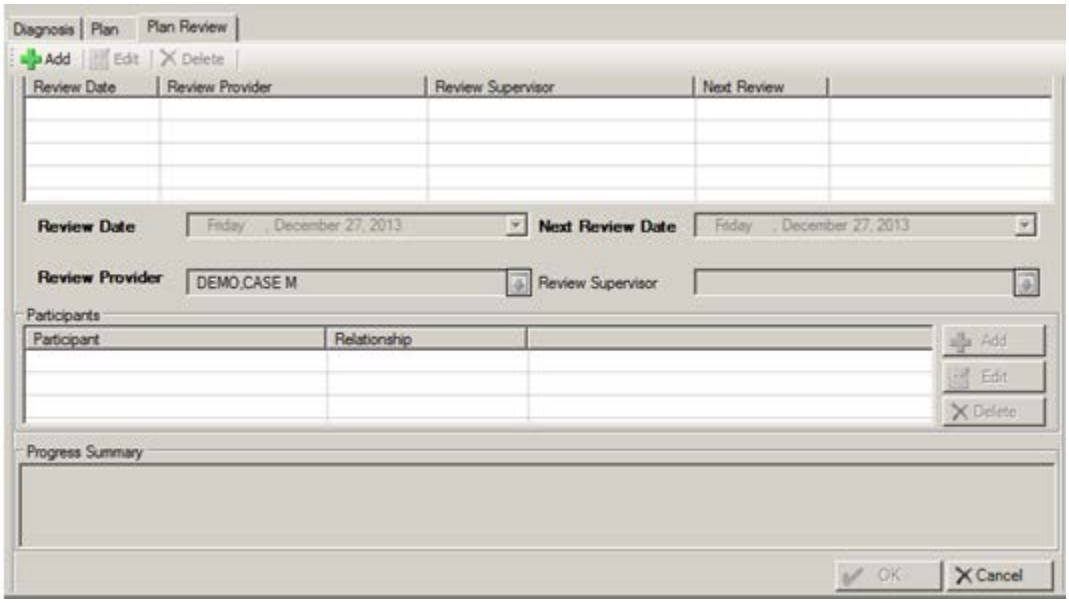


Figure 10-25: Sample Plan Review tab

When a record is selected in the grid for the plan review, you can do the following:

- Complete the fields for the plan review (below the grid)
- Complete the participants in the plan review (in the Participants group box)
- Complete the Progress Summary for the plan review (in the Progress Summary field)

After you have completed the fields and group boxes, click **OK** to save the plan review record. (Otherwise, click **Cancel**.)

Review Group Box

Use the top group box to document the review date, the review provider, and review supervisor, and next review date for the treatment plan.

Delete Button

Use the Delete button to delete a selected plan review record.

1. Select the plan review record to delete.
2. Click **Delete**.
3. At the "Are you sure" confirmation message, type **Y** (yes) to delete the record. (Otherwise, type **N** (no).

Edit Button

Use the Edit button to change a selected plan review record.

1. Select the plan review record to change.
1. Click **Edit**.
2. The fields for the selected plan become active. These fields are reviewed below (under Add button).

Add Button

Use to add a new review record. Populate the fields below the review grid as well as the Participants group box, and the Progress Summary field to complete the add process.

The fields for Review in bold text are required.

1. Click **Add**. The fields below the review grid become active.
2. At the **Review Date** field, select the date of the review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date.
3. At the **Next Review Date** field, select the date of the next review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date. Please note that changing the Next Review date here will also change the Next Review date on the Treatment Plan Information group box.
4. At the **Review Provider** field, select the provider who is doing the review (the default is the current user). Click the drop-down list to access the **Reviewing Provider** search/select window where you search for the provider name.

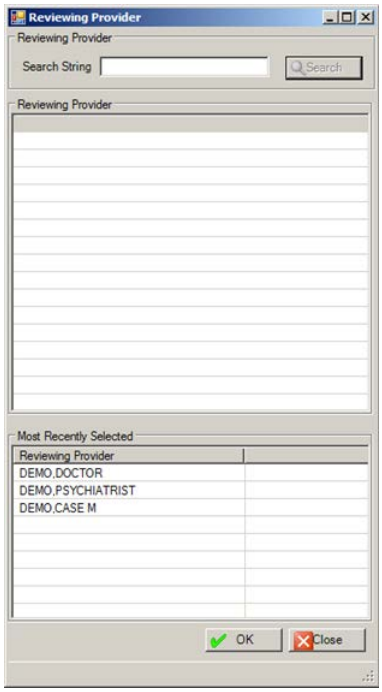
Screen Capture	What to do
	Use this search/select window in one of two ways: (1) Use the **Search S**tring field by typing the reviewing provider's last name and then clicking **Search**. The retrieved names will populate the Reviewing Provider list box. Select a retrieved record and click **OK** to populate the Review Provider field. (Otherwise, click **Close**.) (2) Select in the Most Recently Selected list box and click **OK** to populate the Review Provider field. (Otherwise, click **Close**.)

Figure 10-26: Sample Reviewing Provider search/select window

5. At the **Review Supervisor** field, select the review supervisor for the treatment plan. Click the drop-down list to access the **Reviewing Supervisor** search/select window where you search for the supervisor name.

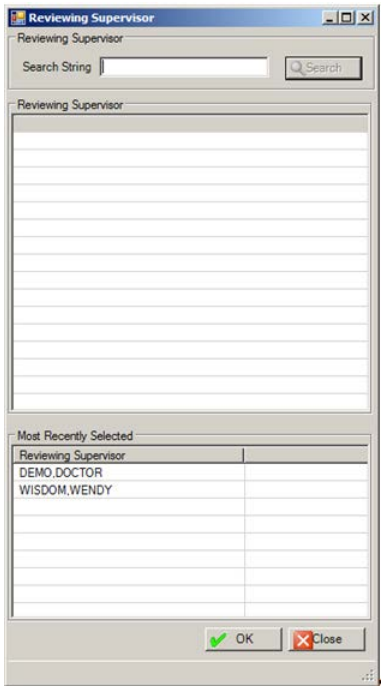
Screen Capture	What to do
	Use this search/select window in one of two ways: (1) Use the **Search String** field by typing the reviewing supervisor's last name clicking **Search**. The retrieved names will populate the Reviewing Supervisor list box. Select a retrieved record and click **OK** to populate the Review Supervisor field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Review Supervisor field. (Otherwise, click **Close**.)

Figure 10-27: Sample Reviewing Supervisor search/select window

Participants Group Box (Plan Review)

Use the **Participants** group box to display the participants in the plan review.

Add/Edit Button

The Add and Edit buttons used the same fields.

1. Click **Add** to access the Treatment Plan Participants dialog box.

   OR

2. Select a participant record to edit. Click **Edit** to access the **Treatment Plan Participants** dialog box.

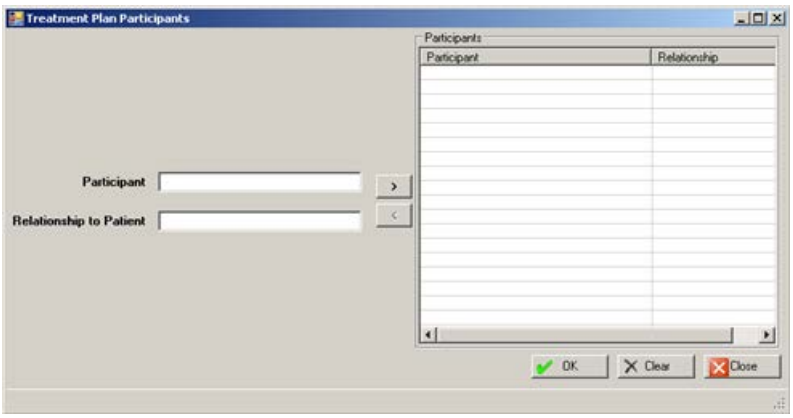


Figure 10-28: Treatment Plan Participants dialog box

3. At the **Participant** field, type the participant name. This is a Free Text field.
4. At the **Relationship to Patient** field, type the participant's relationship to the patient of the treatment plan. This is a Free Text field.
5. After completing the Participant and Relations fields, do one of the following:
   a. Click the right-pointing arrow to add the information to the **Participants** list box. More than one participant/relationship record can be added to the Participants list box.
   b. Click **Clear** to remove the data in the **Participant** and **Relationship to Patient** fields.
6. Remove a highlighted record in the **Participants** list box, click the left-pointing arrow.
7. If Add was used, click **OK** to save the data. The data in the **Participants** list box will populate the **Participants** group box on the **Plan Review** tab of the add/edit treatment plan window. (Otherwise, click **Close**.)
8. If Edit was used, click **OK** to save the data. The data in the **Participants** list box will be updated.

Delete Button

Use the Delete button to delete a selected Participants record.

1. Select a participant record to delete.
2. Click **Delete**.
3. On the "Are You Sure" confirmation message, click **Yes** to delete the record (otherwise, click **No**).

Progress Summary

Use the Progress Summary field to add the text of the progress of the plan review. This is a Free Text field.

11.0 Suicide Forms

You can manage suicide forms in Roll and Scroll as well as in the RPMS Behavioral Health System (GUI).

Please note: all of the fields are mandatory but not enforced. This means if you do not populate all of the fields, you can still save, but that suicide form will be considered Incomplete. If you do complete all of the fields, the suicide form will be considered Complete.

11.1 Suicide Reporting Forms (Roll and Scroll)

You use the SF (Suicide Reporting Forms - Update/Print) option on the IHS Behavioral Health System Data Entry Menu to manage suicide forms in Roll and Scroll.

The Add/Update Suicide Forms option on the Other Information window also accesses the suicide reporting forms.

After using the SF option, Figure 11-1 shows the two options:

```
   SFD    Review Suicide Reporting Forms by Date
   SFP    Update Suicide Reporting Form for a Patient

Select Suicide Reporting Forms - Update/Print Option:
```

Figure 11-1: Options available for managing suicide forms

11.1.1 Update Suicide Reporting Form for a Patient (SFP)

Use the SFP option to update the suicide report for a specified patient.

Below are the prompts.

1. At the “Select Patient Name” prompt, type the name of the patient to use.
2. The View/Update Suicide Form window for the selected patient displays.

```
View/Update Suicide Form      Apr 14, 2009 15:41:17          Page:    1 of    9
Suicide Forms on File for: ALPHAA,CHELSEA MARIE
HRN: 116431    FEMALE   DOB: Feb 07, 1975
Tribe: TOHONO O'ODHAM NATION OF   Community: TATRIA TOAK

1) Local Case #:                  Computer Case #: 505901090420060000034642
   Date of Act: SEP 04, 2006      Provider: GAMMAAA,DENISE
   Suicidal Behavior: ATTEMPT
   Method: HANGING  OTHER
2) Local Case #:                  Computer Case #: 5059011224200600000048688
   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.

Add/Edit Suicide Form

The add and edit functions use the same update form.

Add a Suicide Form (AF)

Use the AF action to add a suicide form for the current patient.

Below are the prompts.

1. At the "Select Item(s)" prompt, type **AF**.
2. At the "Provider Completing the form" prompt, type the name of the provider who is completing the form.
3. At the "Enter the Date of the Suicide Act" prompt, type the date of the suicide act.
4. The application displays the Updating IHS Suicide Form window. (See "Edit a Suicide Form" below for more information about this window.)

Edit a Suicide Form (EF)

Use the EF action to change a selected suicide form.

1. At the "Select Item(s)" prompt, type **EF**.
2. At the "Select Suicide Reporting Form List" prompt, type the number of the suicide form to change.
3. The application displays the Updating IHS Suicide Form window.

```
***  UPDATING IHS SUICIDE FORM  ***  F1 E to exit ***
Patient: ALPHAA,CHELSEA MARIE              FEMALE         HRN: 116431
DOB: Feb 07, 1975          Community Res: TATRIA TOAK
Tribe: TOHONO O'ODHAM NATION OF ARIZONA
Computer Generated Case #: 5059011224200600000486
Provider: LAMBDA,JAMES N          Initials:      Discipline:
--------------------------------------------------------------------------------
 1. Local Case #:             Provider: THETAAA,JAMES
 7. Employment Status:
 8. Date of Act: DEC 24,2006  11. Community where act Occurred:
12. Relationship Status: SINGLE             13. Education: COLLEGE GRAD
14. Suicidal Behavior: IDEATION W/ PLAN AND INTENT
15. Method (press enter):                   16. Previous Attempts: 2
17. Substance Use Involved:                 18. Location of Act: HOME OR VICINI
19. Contributing Factors (press enter):
20. Disposition: IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY)
21. Other Relevant Information:
_____________________________________________________________________________




COMMAND:                                    Press <PF1>H for help    Insert
```

Figure 11-3: Sample Updating IHS Suicide Form window

The underlined fields are required.

4. At the “Local Case #” prompt, type a local case number generated by the site (use 1-20 characters).

5. At the “Provider” prompt, type the name of the provider reporting this suicide case (the provider completing the form).

6. At the “Employment Status” prompt, type the employment status of the patient. Use one of the following: **P** (part-time), **F** (full-time), **S** (self-employed), **UE** (unemployed), **R** (retired), **ST** (student), **SE** (student and employed), **UNK** (unknown).

7. At the “Date of Act” prompt, type the date of the suicide act. The default is the current date (can be changed).

8. At the “Community where act Occurred” prompt, type the name of the community where the suicide act occurred.

9. At the “Relationship Status” prompt, type the relationship status. Use one of the following: **1** (single), 2 (married), **3** (divorced/separated), **4** (widowed), **5** (cohabiting/common law), **6** (same sex partnership), **9** (unknown).

10. At the “Education” prompt, type the level of patient’s education. Use one of the following:

    1 - Less than 12 years

2 - High School Graduate/GED
3 - Some College/Technical School
4 - Collage Graduate
5 - Post Graduate
6 – Unknown

If you use the "less than 12 years" option, the application asks for the following information:

a. At the "If less than 12 years, highest grad completed" prompt, type any whole number between 0 and 11.

The following fields are on the Updating IHS Suicide Form window.

11. At the "Suicidal Behavior" prompt, type the suicidal behavior for the suicide act. Use one of the following:

1 – Ideation W/ Plan and Intent
2 - Attempt
3 – Completed Suicide
6 – Att'd Suicide w/ Att'd Homicide
7 - Att'd Suicide w/ Compl Homicide
8 - Compl Suicide w/ Att'd Homicide
9 - Compl Suicide w/ Compl Homicide

12. At the "Method (press Enter)" prompt, press Enter to access the following pop-up.

```
*** If you need help type ?, not ?? ***
METHOD:
METHOD:
METHOD:
```

Figure 11-4: Sample fields on the pop-up

a. At the "Method" prompt, type a suicide method. More than one can be used.

1 - GUNSHOT
2 - HANGING
3 - MOTOR VEHICLE
4 - JUMPING
5 - STABBING/LACERATION
6 - CARBON MONOXIDE
7 - OVERDOSE
U – UNKNOWN

If you use Other in the Method field, the application asks the following information:

b. At the "Please describe the "OTHER" Method" prompt, type the text of the other method using between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

13. At the “Previous Attempts” prompt, type the number/character of previous suicide attempts. Use one of the following:

    0 0
    1 1
    2 2
    3 3 or more
    U Unknown

14. At the “Substance Use Involved” prompt, type the substance use involved in the suicide act. Use one of the following: **1** (none), **2** (alcohol and other drugs), **U** (unknown).

    If you use 2, the application displays the list of drug choices type.

```
For a list of drug choices type ??

SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
```

Figure 11-5: Sample of list of drug choices used

    a. At the “SUBSTANCE DRUG USED” prompt, type the substance drug used. More than one can be used.

    b. If you use OTHER at the SUBSTANCE DRUG USED prompt, the application asks for the following information: Drug if other. Type the name of the drug using 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

15. At the “Location of Act” prompt, type the location of the act.

    If you use Other in the Location of Act field, the application asks the following information:

    - At the Location of Act If Other” prompt, type the location of the act using between 1 and 80 characters.

16. At the “Contributing Factors (press Enter)” prompt, press Enter to access the Contributing Factors pop-up.

```
Enter all Contributing Factors. To see a list of choices type ??

FACTOR:
FACTOR:
FACTOR:
```

Figure 11-6: Fields on the pop-up

a. At the “Factor” prompt, type the contributing factor. More than one can be used.

   You cannot enter UNKNOWN if other legitimate values have already been entered. If you want to enter UNKNOWN you must first delete (using the '@') all other entries (the application confirms the deletion).

   If you use OTHER at the FACTOR prompt, the application asks the following information:

b. At the “Enter a brief description of the “Other” Contributing Factor” prompt, type a brief description using between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

17. At the “Disposition” prompt, type the disposition of the suicide act.

    If you use OTHER at the Disposition prompt, the application asks the following information:

    - At the “Disposition If Other” prompt, type the disposition using between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

18. At the “Other Relevant Information” prompt, press Enter to access another window where you populate the field with text of the other relevant information about the suicide act.

Figure 11-7: screen to enter other relevant information

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you leave the suicide form and if there are any missing data, the application lists what is missing and lists what actions you can take:

```
     Select one of the following:

          E         Edit and Complete the Form
          D         Delete the Incomplete Form
          L         Leave the Incomplete Form as is and Finish it Later

What do you want to do: E//
```

Figure 11-8: List of actions you can take

Use **E** to return to the form where you can edit and complete it.

Use **D** to delete the form (there is no confirmation).

Use **L** to leave the form incomplete (as is) and finish it later.

Display a Suicide Form (DF)

Use the DF action to display a specified suicide form.

1. At the "Select Item(s)" prompt, type **DF**.
2. At the "Select Suicide Reporting Form List" prompt, type the suicide form to display.
3. At the "Do you wish to" prompt, type one of the following: **P** (print output) or **B** (browse output on screen)

The form displays where you can browse the Suicide Reporting Form on the screen.

```
********** CONFIDENTIAL PATIENT INFORMATION [ST]  Apr 14, 2009 **********
Suicide Reporting Form                        Date Printed:  Apr 14, 2009

1. Case #: 505901122420060000048688    Local Case #:

2. PROVIDER INITIALS: RWL              3. PROVIDER DISCIPLINE: NUTRITION TECHNIC
4. SEX: FEMALE          5. DOB: FEB 07, 1975             6. AGE: 31
7. EMPLOYMENT STATUS:
8. DATE OF ACT: DEC 24, 2006
9. TRIBE: TOHONO O'ODHAM NATION OF ARIZONA
10. COMMUNITY OF RESIDENCE: TATRIA TOAK
```

```
11. COMMUNITY WHERE ACT OCCURRED:

12. RELATIONSHIP STATUS: SINGLE

13. EDUCATION:

14. SUICIDAL BEHAVIOR:
15. METHOD: OVERDOSE
    DRUGS W/OVERDOSE:
    ALCOHOL
16. PREVIOUS ATTEMPTS:

17. SUBSTANCE USE INVOLVED:

18. LOCATION OF ACT:

19. CONTRIBUTING FACTORS:
      HISTORY OF SUBSTANCE ABUSE/DEPENDENCE

20. DISPOSITION:

  Other Relevant Information: (OPTIONAL)



DATE LAST MODIFIED: DEC 08, 2010
USER LAST UPDATED:  THETA,SHIRLEY
EDIT HISTORY:
  May 15, 2009 12:01:24 pm   THETA,SHIRLEY
+         Enter ?? for more actions                                      >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 11-9: Sample Output Browser window for suicide act

Delete a Suicide Form (XF)

Use the XF action to remove a selected suicide form record.

1. At the "Select Item(s)" prompt, type **XF**.
2. At the "Select Suicide Reporting Form List" prompt, type the suicide form to remove.
3. At the "Are you sure you want to delete this suicide form?" prompt, type **Y** (yes) to delete the suicide form or **N** (no).

Browse Visits for this Patient (BV)

Use the BV action to browse the BH visits for the current patient.

1. At the "Select Item(s)" prompt, type **BV**.
2. At the "Browse which subset of visits for <patient name>" prompt, type one of the following: **L** (patient's last visit), **N** (patient's last n visits), **D** (visits in a date

range), **A** (All of this patient's visits), or **P** (visits to one program). If N, D, or P are used, other prompts will display.

a. If N was used, type the number of visits at the "How many visits should be displays: (1-99)" prompt.

b. If D was used, type the beginning date of visit and ending date of visit at the "Enter Beginning Date of Visit" and "Enter Ending Date of Visit" prompts.

c. If P was used, type the program to use at the "Visits to Which Program" prompt.

The BROWSE PATIENT'S VISITS window displays.

```
BROWSE PATIENT'S VISITS       Mar 05, 2014 10:18:31          Page:    1 of    2

Patient Name: DEMO,DARRELL LEE              DOB: Sep 23, 1986
HRN: 117305


****** Suicide Forms on File ******
Date of Act: MAY 15, 2009              Suicidal Behavior:
Previous Attempts:                     Method: OVERDOSE
********************************************************************************

Visit Date: Feb 22, 2014@13:33              Provider: TETER,SHIRLEY
Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:
  F42.      HOARDING DISORDER

  SUBJECTIVE/OBJECTIVE:

  COMMENT/NEXT APPOINTMENT:

Medications Prescribed
********************************************************************************
+         Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 11-10: Sample Browse Patient's Visits window

At the Select Action prompt, do one of the following:

- Type **+** to view the next screen (does not apply to the last screen)
- Type **–** to view the previous screen (does not apply to the first screen)
- Type **Q** to quit.

Health Summary for this Patient (HS)

Use the HS to display/print a particular health summary for the current patient.

1. At the "Select Item(s)" prompt, type **HS**.

2. The health summary for this patient displays on the Output Browser window.

```
OUTPUT BROWSER                Aug 04, 2014 11:15:54          Page:    1 of   24
PCC Health Summary for DEMO,DOROTHY ROSE


******** CONFIDENTIAL PATIENT INFORMATION -- 8/4/2014 11:15 AM  [ST] ********
***** DEMO,DOROTHY ROSE #999999 <A>   (BEHAVIORAL HEALTH SUMMARY)  pg 1 *****

---------------------------- DEMOGRAPHIC DATA ----------------------------

DEMO,DOROTHY ROSE                 DOB: OCT 10,1942 71 YRS  FEMALE  no blood type
CHEROKEE NATION, OK               SSN: XXX-XX-1111
                                  MOTHER'S MAIDEN NAME: CARMAN,CRYSTAL MARCHELLE
(H) 555-444-3333 (W) 555-222-6666 FATHER'S NAME: ABBOTT,MARTIN

MOAB (1234 ROAD STREET,ANYTOWN,VA,99999)

LAST UPDATED: DEC 23,2011         ELIGIBILITY: CHS & DIRECT
VETERAN

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  YES
                    DATE RECEIVED BY PATIENT:  Jun 30, 2003
+         Enter ?? for more actions                                        >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 11-11: Sample Health Summary report for current patient

At the Select Action prompt, do one of the following:

- Type **+** to view the next screen (does not apply to the last screen)
- Type **–** to view the previous screen (does not apply to the first screen)
- Type **Q** to quit.

11.1.2 Review Suicide Forms by Date (SFD)

Use the SFD option to review the suicide forms in a particular date range.

1. At the "Select Item(s)" prompt, type **SFD**.
2. At the "Select PATIENT NAME" prompt, type the name of the patient to use.

   The Review Suicide Reporting Forms window displays.

```
View/Update Suicide Form      Aug 04, 2014 11:23:13          Page:    1 of    1
Suicide Forms on File for: DEMO,DOROTHY ROSE
HRN: 999999    FEMALE   DOB: Oct 10, 1942
Tribe: CHEROKEE NATION, OK  Community: MOAB

1) Local Case #:                  Computer Case #: 505901120620120000060849
   Date of Act: DEC 06, 2012      Provider: WISDOM,WENDY
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method: STABBING/LACERATION
```

```
2) Local Case #:                    Computer Case #: 505901093020090000060849
   Date of Act: SEP 30, 2009        Provider: TETER,SHIRLEY
   Suicidal Behavior: ATTEMPT
   Method:
   [Incomplete Form]




          ?? for more actions  + next screen  - prev screen
AF   Add a Suicide Form                  BV   Browse Visits for this Patient
EF   Edit a Suicide Form                 HS   Health Summary for this Patient
DF   Display a Suicide Form              Q    Quit
XF   Delete a Suicide Form
Select Item(s): Quit//
```

Figure 11-12: Sample Review Suicide Report Forms window

The phrase "[Incomplete Form]" at the end of the suicide form record represents the Incomplete Suicide Reporting Form.

Section 11.1.1 provides more information about the add/edit/delete functions on this window.

11.2 Suicide Form Window (GUI)

The suicide form options are located under the Suicide Reporting Forms category on the tree structure for the RPMS Behavioral Health System (GUI) application.

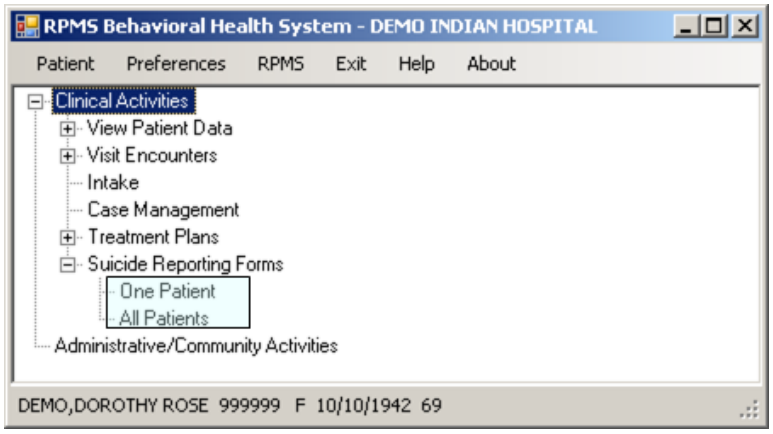


Figure 11-13: Location of Suicide Forms on the tree structure

One way to access the **Suicide Form** window is to select the **One Patient** option.

Note	You can access this window if you click the **Suicide Form** tab on the **Visit Data Entry – Add/Edit** window.

The application displays the **Suicide Form** window for **One Patient**. If you access the **Suicide Form** for one patient window and there is no current patient, you will be asked to select one.

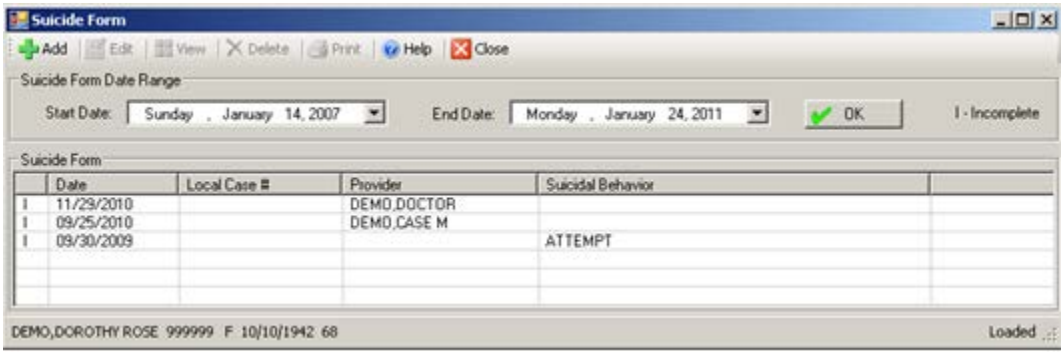


Figure 11-14: Suicide Form window for one patient

Another way to access the **Suicide Form** window is to select the **All Patients** option. The application displays the **Suicide Form** window for All Patients.

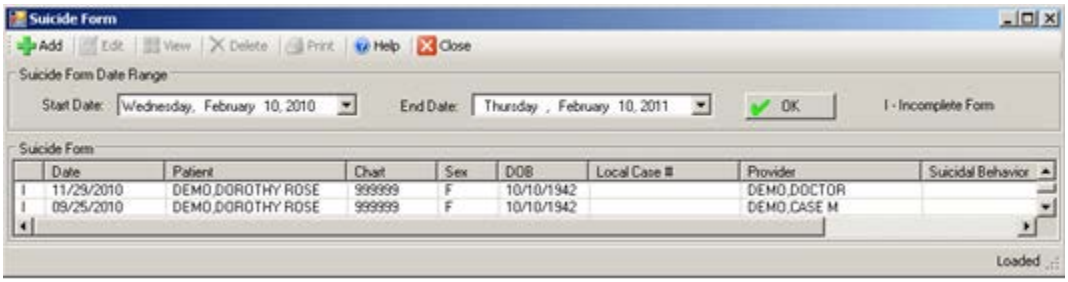


Figure 11-15: Sample Suicide Form window for all patients

Both windows function in the same way.

The following table provides information about the features of these windows.

Feature	Functionality
Suicide Form Window for One Patient	The default Start Date is one year previous. If you change the **Start Date for the Suicide Form** window for **One Patient**, this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).

Feature	Functionality
Suicide Form Window for All Patients	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. Please note: If you change the **Start Date for the Suicide Form** window for **One Patient**, this change stays in effect in future sessions of the GUI application for the Visit window for One Patient, the Suicide Form window for One Patient, and the Treatment Plan window for One Patient windows. 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.
Suicide Form Group Box	This group box displays the suicide form records in the date range. The records are listed by date. The "I" in the first column of the grid indicates the suicide form is incomplete.
Add Button	Establish the patient you want to use in the add process. Use this button to add a new suicide form record. You access the **Visit Data Entry - Add Suicide Entry** dialog box.
Edit Button	Use this button to edit the highlighted suicide form for the current patient on the **Visit Data Entry - Edit Suicide** Entry dialog box. The **Edit** button will be inactive if the patient does not have any previous visits (applies to the suicide form for the current patient).
View Button	Use this button (or double-click on a form) to browse the highlighted suicide form record. The application displays the **Suicide Form Data Entry - View Suicide Form** window. This is a view-only window has the same fields as the add/edit suicide form window.
Delete Button	Use this button to remove the highlighted suicide form record. On the "Are You Sure" confirmation message, click **Yes** to remove the selected suicide record (otherwise, click **No**).
Help Button	Use this button to access the online help for the **Suicide Forms** window.
Close Button	Use this button close the **Suicide Form** window.
Print Button	Use this button to output the highlighted suicide form record. After clicking **Print**, the application displays the first page of **the Suicide Reporting Form** pop-up window.

The following applies to the Print button:

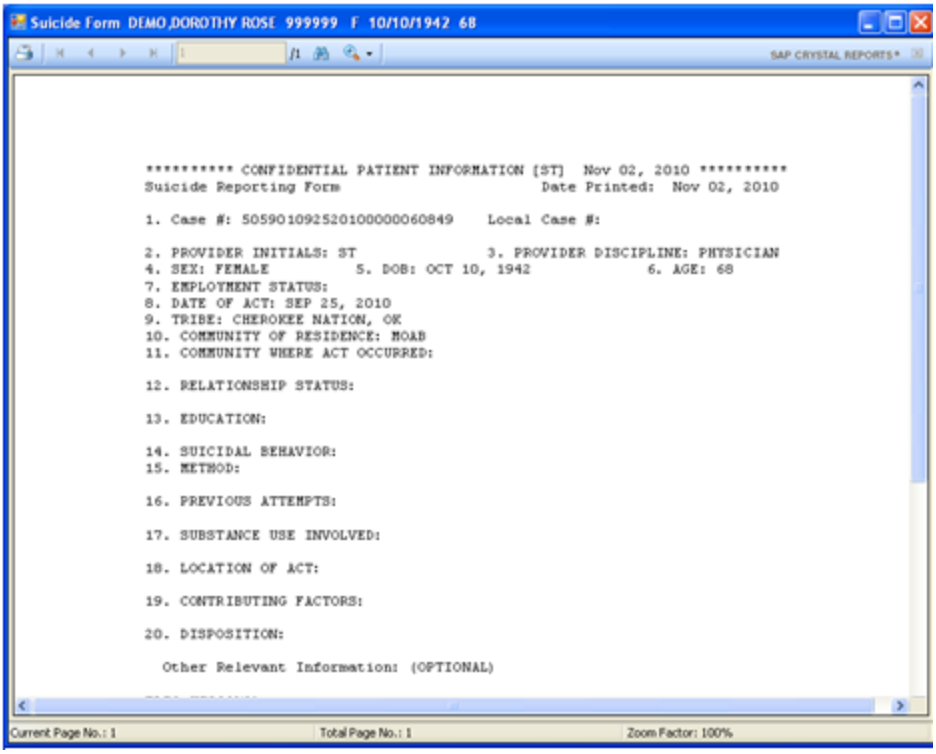


Figure 11-16: Sample Suicide Reporting Form

This window contains the following:

- Data from the Suicide Form
- Patient data, such as sex, DOB, Age
- Edit History, such as date last modified, user last update, and each update including date & time + person who modified

Section 2.6 provides more information about using the controls on this type of window.

11.3 Add/Edit Suicide Form (GUI)

1. Click **Add** to add a new suicide record. The **Suicide Form Data Entry – Add Suicide Form** displays.

   OR

2. Select a record to change and click **Edit**. The **Suicide Form Data Entry - Edit Suicide Form** displays.

Below are the fields on the **Suicide Form Data Entry - Add Suicide Form** window. (The same fields display on the **Suicide Form Data Entry - Edit Suicide Form** window.)

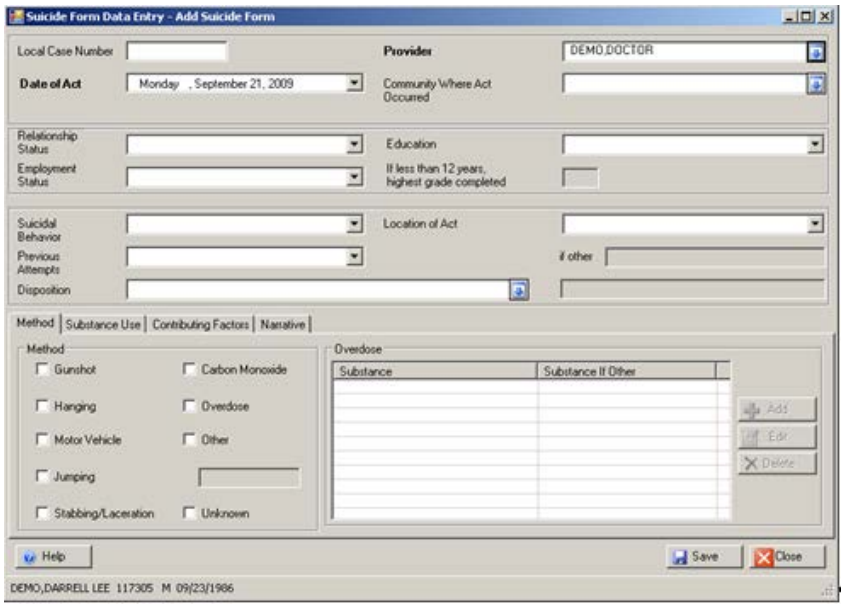


Figure 11-17: Sample Suicide Form Data Entry - Add Suicide Form window

All fields except the **Local Case Number** and the **Narrative** are required in order to save. If you try to save and have not completed the fields, the application displays the **Required** information message.

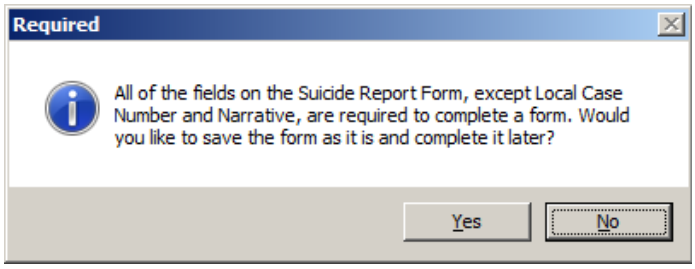


Figure 11-18: Required information message

- Click **Yes** to save the form and complete it later; the focus returns to the **Suicide Form** window.
- Click **No** to not save and the focus remains on the data entry form.

The following table provides information about the buttons on this window.

Button	Functionality
Save	Use this button to save the data.
Help	Use this button to access the online help system for this window.
Close	Use this button to display the **Continue?** dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add window. Click **No** and the focus remains on the add window where you can continue work on the suicide form.

11.3.1 Suicide Form Fields

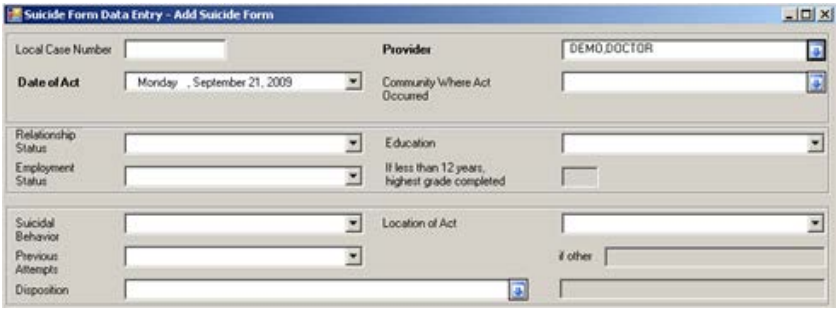


Figure 11-19: Fields on suicide form

The required fields are in bold text.

1. At the **Local Case Number** field, type the local case number or a health record number, if any (limited to 20 characters). This is a Free Text field.

2. At the **Provider** field, select the provider. For a new record, the application automatically populates this field with the current logon provider. To change click the drop-down list to access the **Provider** search window where you search for the provider name.

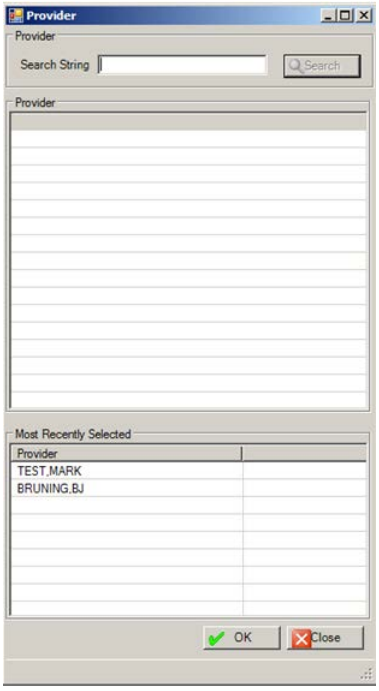
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the Provider list box. Select a retrieved record and click **OK** to populate the Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Provider field. (Otherwise, click **Close**.)

Figure 11-20: Sample Provider search window

3. At the **Date of Act** field, select the date of the act. For a new record, the current date displays. To change click the drop-down list to access a calendar where you select another date.

4. At the **Community Where Act Occurred** field, select the community where the act occurred. To change click the drop-down list to access the **Community** search/select window where you search for the community name.

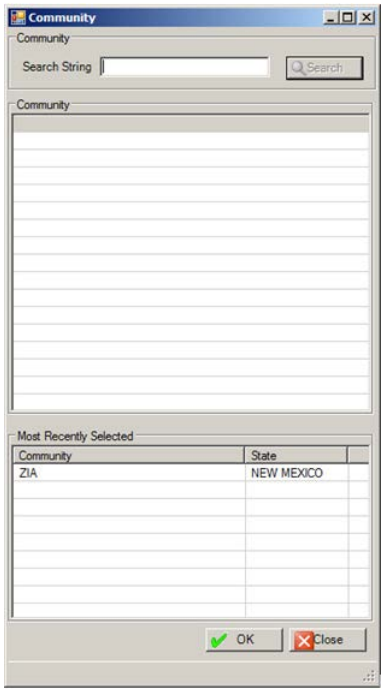
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and then clicking **Search**. The retrieved names will populate the Community list box. Select a retrieved record and click **OK** to populate the Community Where Act Occurred field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Community Where Act Occurred field. (Otherwise, click **Close**.)

Figure 11-21: Sample Community search/select window

5. At the **Relationship Status** field, select the patient's relationship status. Use one of the following:

   Single

   Married

   Divorced/Separated

   Widowed

   Cohabiting/Common Law

   Same Sex Partnership

   Unknown

6. At the **Education field**, select the level of education of the patient. Use one of the following:

   Less than 12 years

   High School Graduate/GED

   Some College/Technical School

   Collage Graduate

   Post Graduate

   Unknown

7. At the **Employment Status** field, select the status of the patient's employment. Click the drop-down list and use one the options.

   PART TIME

   FULL TIME

   UNEMPLOYED

   RETIRED

   STUDEMT

   STUDENT AND EMPLOYED

   UNKNOWN

8. At the **If less than 12 years, highest grade completed** field, type the highest grade the patient complete (0-11). This field becomes active when you populate the Education field with 'Less than 12 years'.

9. At the **Suicidal Behavior** field, select the type of suicidal activity. Click the drop-down list and use one the options.

   IDEATION W/ PLAN AND INTENT

   ATTEMPT

   COMPLETED SUICIDE

   ATT'D SUCICIE W/ATT'D HOMICIDE

   ATT'D SUICDIE W/COMPL HOMICIDE

COMPL SUICIDE W/ATT'D HOMICIDE

COMPL SUICIDE W/COMP'L HOMICIDE

10. At the **Location of Act** field, select the location of the suicidal act. Click the drop-down list and use one of the options.

    HOME OR VICNITY

    SCHOOL

    WORK

    JAIL/PRISON/DETENTION

    TREATMENT FACILITY

    MEDICAL FACILITY

    OTHER

    UNKNOWN

11. At the **Previous Attempts** field, select the previous suicide attempts. Use one of the options available on the drop-down list.

    0

    1

    2

    3 OR MORE

    UNKNOWN

12. At the **if other** field, type where the suicidal act occurred (limited to 80 characters). This field becomes active if you populate the Location of Act field with 'Other'. This is a Free Text field.

13. At the **Disposition** field, select the disposition of the suicide act. Click the drop-down list to access the **Disposition** select window.

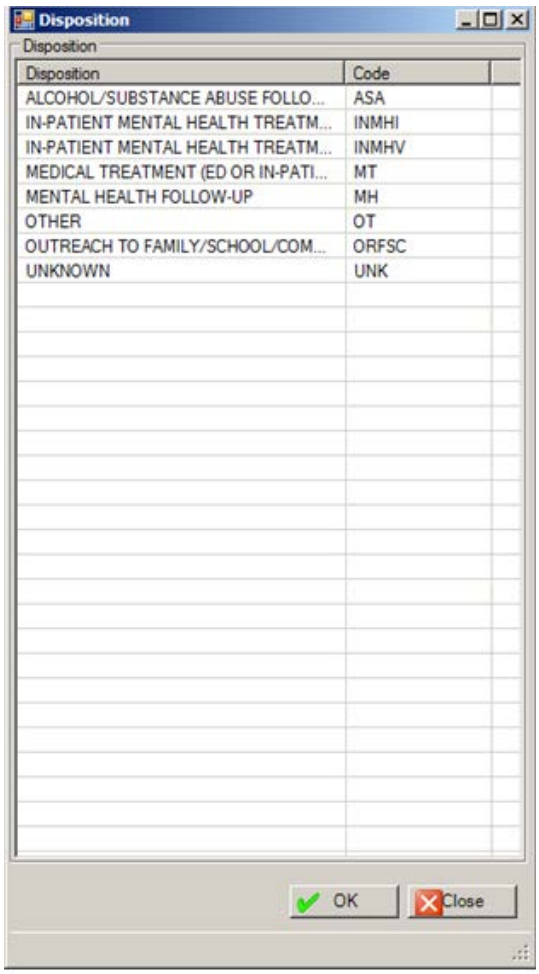
Screen Capture	What to do
	Use this window as follows: (1) Select a Disposition option and click **OK** and the selected option populates the Disposition field. (Otherwise, click **Cancel**.) (2) If Other was used, the field to the right becomes active. Populate this Free Text field with the disposition of the suicide act (limited to 80 characters).

Figure 11-22: Sample Disposition select window

11.3.2 Method Tab

Use the **Method** tab to indicate the method used in the suicide act as well as indicate the substance used in overdose cases.

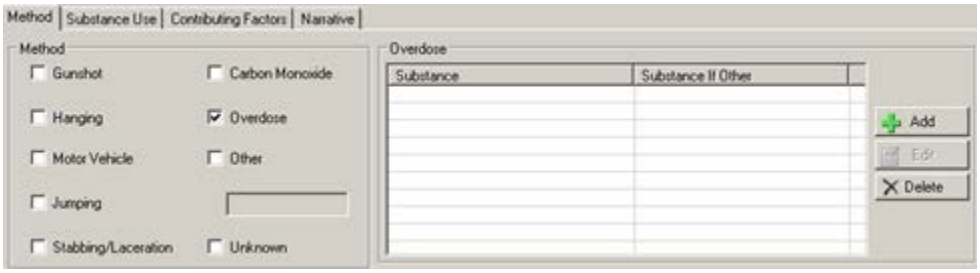


Figure 11-23: Sample Method tab

Method Group Box

1. Select one or more checkboxes in this group box that describe the method used in the suicide act. At least one is required.

2. Select the **Overdose** checkbox and the **Substance** multiple select window displays where you can add one or more categories of substances.

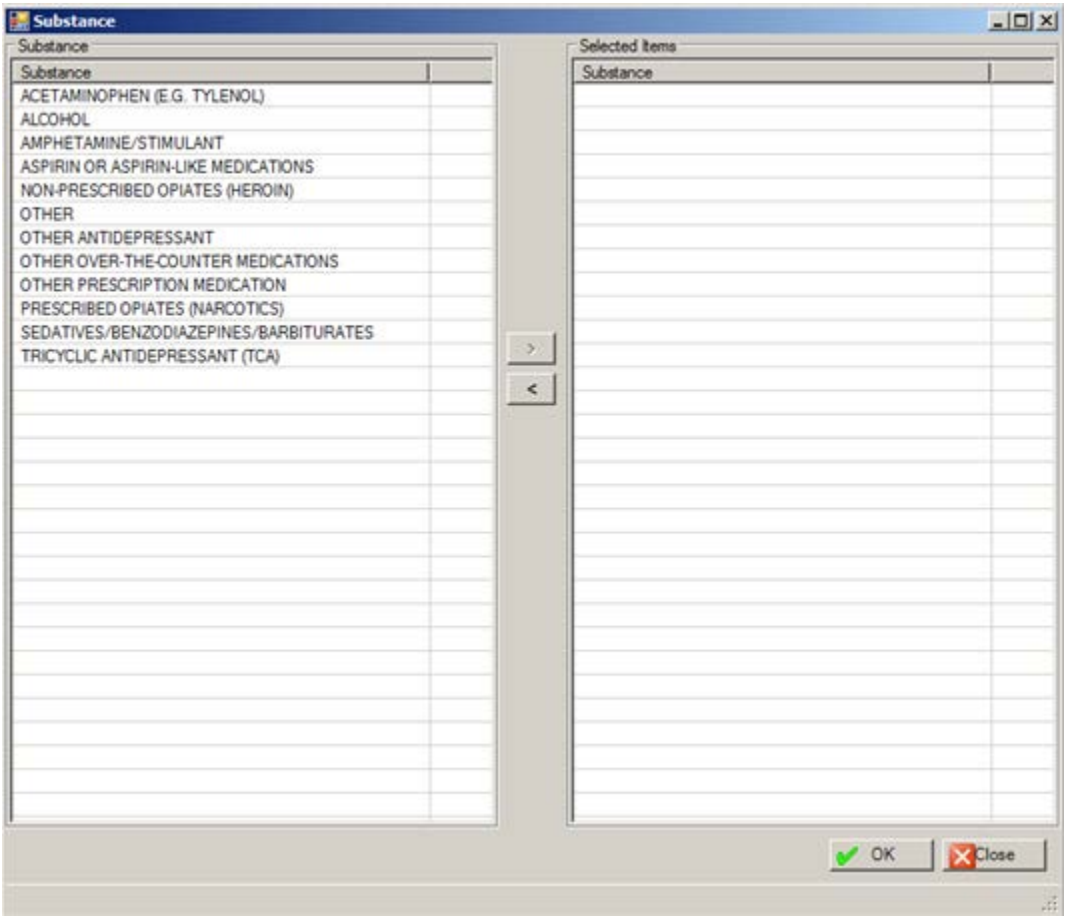


Figure 11-24: Sample Substance multiple select window

Use this search window as follows:

   a. Select an option in the **Substance** list box.

   b. Click the right-point arrow to add it to the **Selected Item Substance** list box.

   c. Likewise, select an option in the **Selected Item Substance** list box and click the left-point arrow to remove the option.

   d. When the **Selected Item** list box is complete, click **OK** and the options populate the Overdose group box.

3. When this window is complete, click **OK**. This action adds the substances to **Overdose** group box.

- If you select a substance with **OTHER** in its name and then click **OK**, the **OTHER** dialog box displays.

Figure 11-25: Sample Other dialog box

You must populate the Other Free Text field (limited to 80 characters) with a description of the other substance. Click **OK**. The description populates the **Substance If Other** cell on the Overdose group box.

4. If you select the **Other** checkbox, the field below the checkbox becomes active. Populate this Free Text field with the text that describes the other method used in the suicide act (limited to 80 characters).

5. If you select the **Overdose** checkbox under **Method**, the **Overdose** group box becomes available. The **Substance** multi-select window displays.

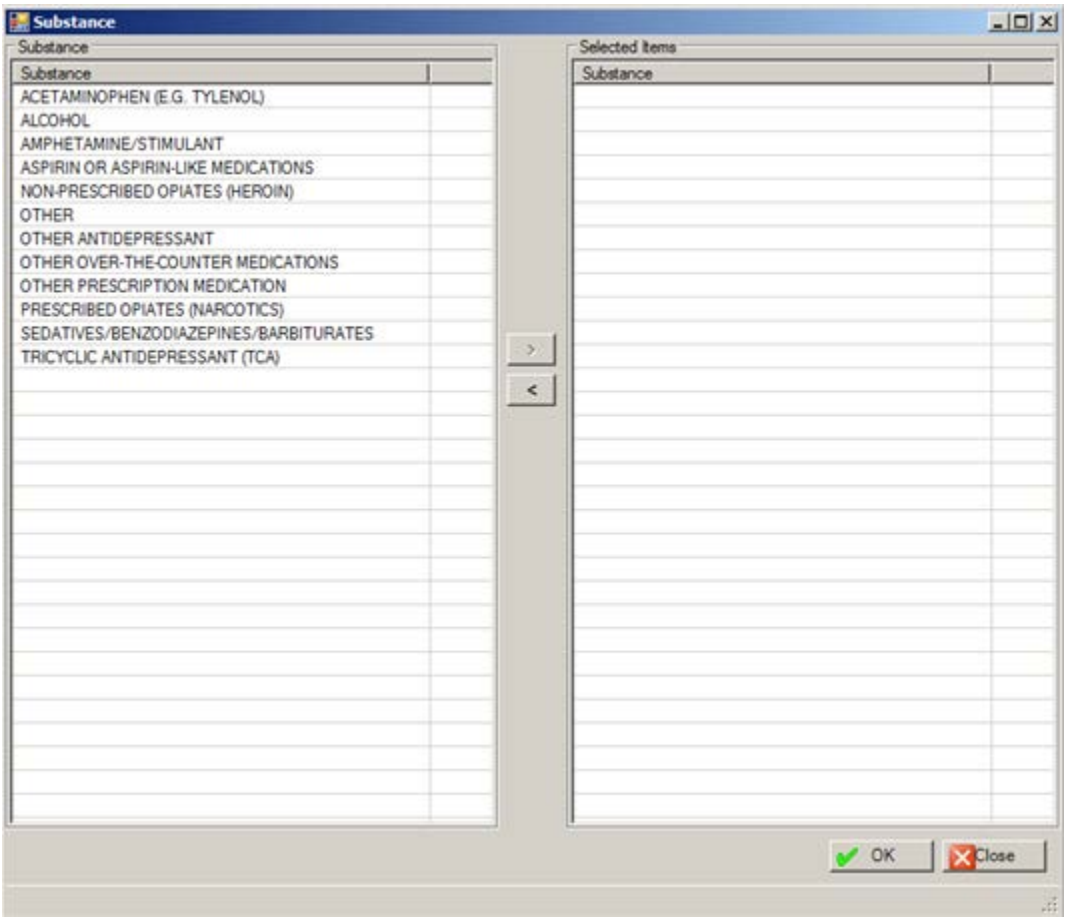


Figure 11-26: Sample Substance multi-select window

Use this search window as follows:

a. Select an option in the **Substance** list box.

b. Click the right-point arrow to add it to the **Selected Item Substance** list box.

c. Likewise, select an option in the **Selected Item Substance** list box and click the left-point arrow to remove it.

d. When the **Selected Item** list box is complete, click **OK** and the options populate the Overdose list box. (Otherwise, click **Cancel**.)

Overdose Group Box

This group box contains the categories of substances used in the overdose suicidal act. Once it is populated, the Add, Edit, and Delete buttons become active.

You can add, edit, or delete overdose substances.

Delete Button

1. Select a substance to delete.
2. Click **Delete**.
3. At the "Are you sure" confirmation message, click **Yes** to delete. (Otherwise, click **No**.)

Edit Button

1. Highlight the record with data in the "Substance if Other" column.
2. Click **Edit**.
3. The Other Antidepressant dialog box displays.

Figure 11-27: Sample Other Antidepressant dialog box

a. Change the antidepressant substance in the field.

b. Click **OK** to change the record.

4. The application displays the current "Substance If Other" data in the **Other** field. You can change the data, as needed. Click **OK** to dismiss the **Other** dialog box.

Add Button

1. Click **Add**.

2. The **Substance** multiple select window where you can add one or more substances.

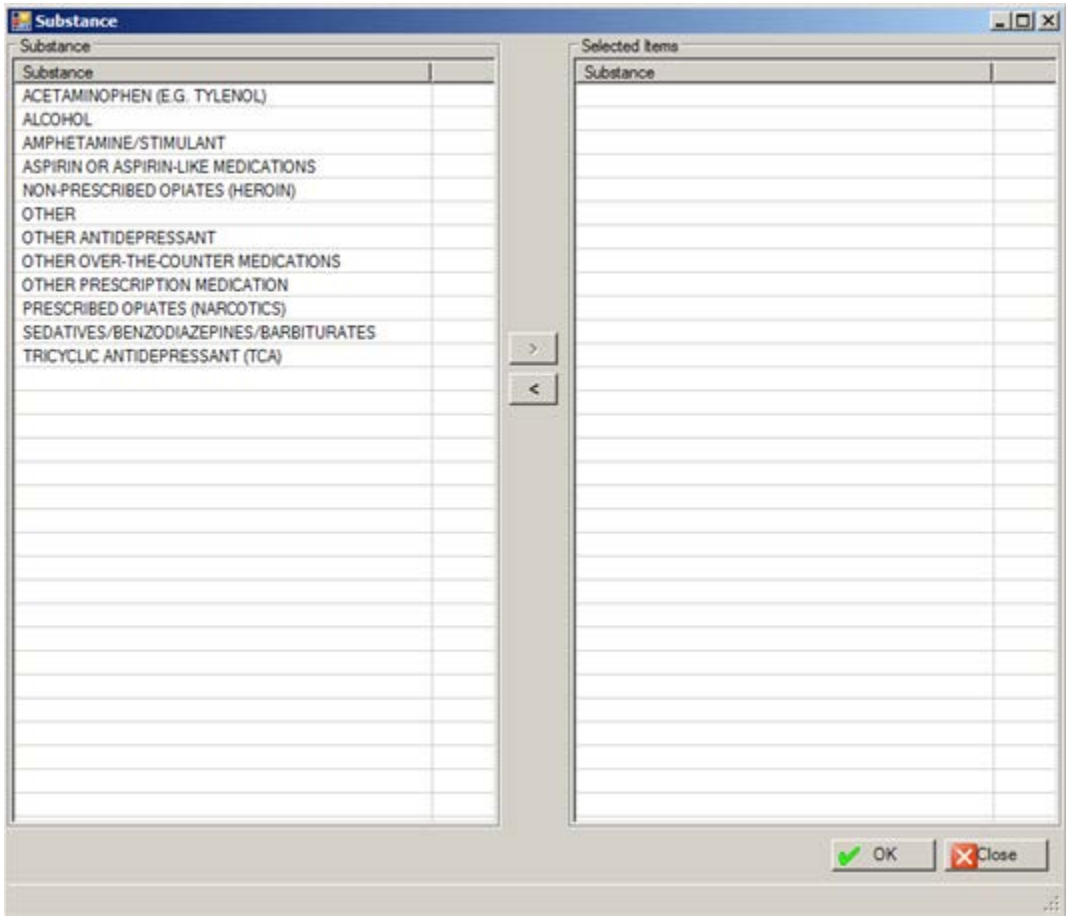


Figure 11-28: Sample Substance multi-select window

Use this search window as follows:

a. Select one or more substances in the **Substance** list box.

b. Click the right-point arrow to add them to the **Selected Item Substance** list box.

c. Likewise, select a substance in the **Selected Item Substance** list box and click the left-point arrow to remove the substance.

d. When the **Selected Item Substance** list box is complete, click **OK** and the substances populate the **Overdose** group box. (Otherwise, click **Close**.)

3. If you select a substance with **Other** in the title on the **Substance** multiple select window, the application displays the **Other** dialog box.

Figure 11-29: Other dialog box

a. Type the substance used in the overdose (limited to 80 characters). This is a Free Text field.

b. Click **OK** to have the "substance used" populated the "Substance if Other" column on the grid.

11.3.3 Substance Use Tab

Use the **Substance Use** tab to indicate the substances involved in the suicide incident as well as the categories of the substances involved.

Figure 11-30: Sample Substance Use tab

Substances Involved This Incident Group Box

1. Select one of the checkboxes in this group box that describes the substance used in the suicide act. At least one is required.

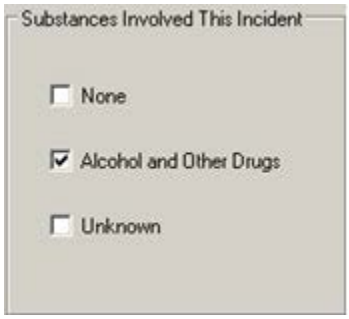


Figure 11-31: Substances Involved This Incident group box

2. If you select the **Alcohol and Other Drugs** checkbox, the application displays the **Substance** multiple select window where you can add one or more substances.

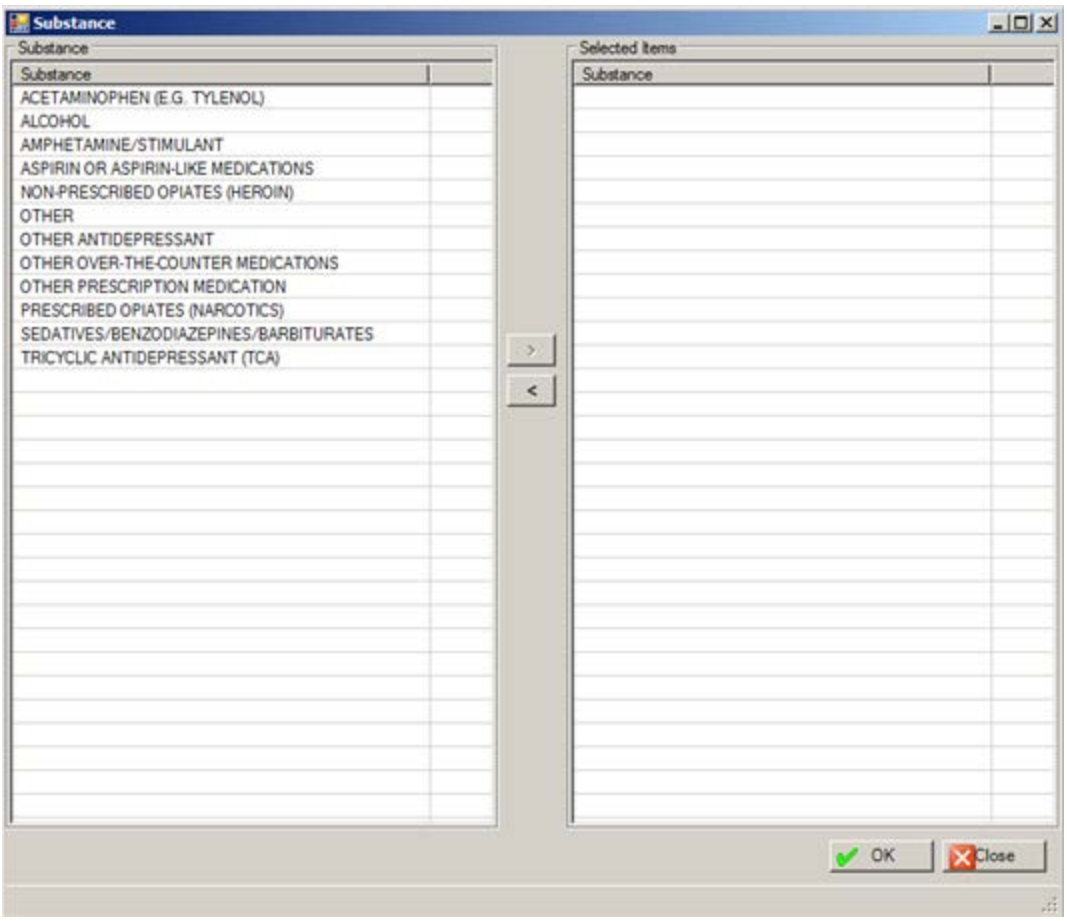


Figure 11-32: Sample Substance multi-select window

Use this search window as follows:

a. Select one or more substances in the **Substance** list box.

b. Click the right-point arrow to add them to the **Selected Item Substance** list box.

c. Likewise, select a substance in the **Selected Item Substance** list box and click the left-point arrow to remove the substance.

d. When the **Selected Item Substance** list box is complete, click **OK** and the substances populate the **Overdose** group box. (Otherwise, click **Close**.)

3. If you select the **Other** option (on the **Substance** multiple select window), the application displays the **Other** dialog box.

Figure 11-33: Other dialog box

a. Type the name of the “other substance” in the field (limited to 80 characters).

b. When this dialog box is complete, click **OK** to have the substance populate the Substances Involved list box. What appears in the **Other** field will populate **Substance If Other** column.

If you uncheck the **Alcohol and Other Drugs** checkbox, this action clears any data in the **Substances Involved** list box.

11.3.3.1 Substances Involved Group Box

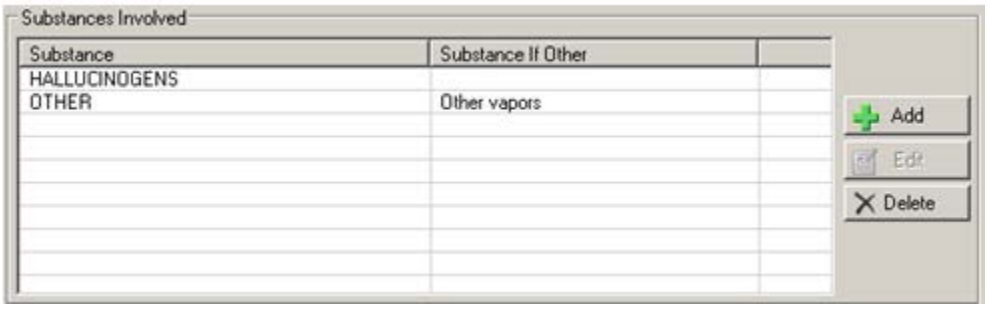


Figure 11-34: Sample Substances Involved group box

This group box contains the substances used immediately before or during the suicidal act. Once the **Alcohol and Other Drugs** checkbox is selected, the Add, Edit, and Delete buttons become active.

Add Button

Use the Add button to add one or more new records.

1. Click **Add**.
2. The **Substance** multiple select window where you can add one or more substances.

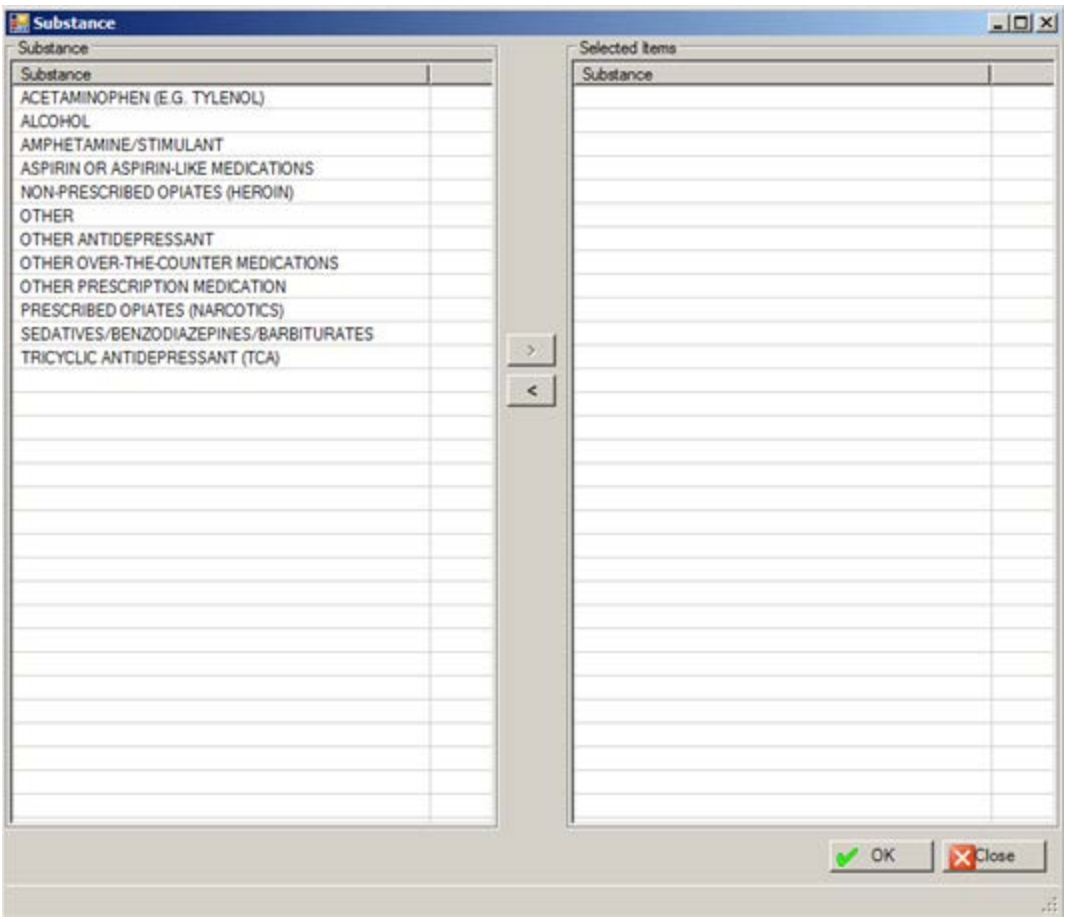


Figure 11-35: Sample Substance multi-select window

Use this search window as follows:

a. Select one or more substances in the **Substance** list box.

b. Click the right-point arrow to add them to the **Selected Item Substance** list box.

c. Likewise, select a substance in the **Selected Item Substance** list box and click the left-point arrow to remove the substance.

d. When the **Selected Item Substance** list box is complete, click **OK** and the substances populate the **Substances Involved** group box. (Otherwise, click **Close**.)

3. If you selected **Other** on the multiple select window, the application displays the **Other** dialog box.

Figure 11-36: Other dialog box

a. Type the name of the "other substance" in the field (limited to 80 characters).

b. When this dialog box is complete, click **OK** to have the substance populate the **Substances Involved** list box. What appears in the **Other** field will populate **Substance If Other** column.

Edit Button

Use the **Edit** button with **OTHER** records (Substance If **Other** column is populated).

1. Highlight the record to edit.
2. Click **Edit**.
3. The **Other** dialog box displays. Change the **Other** field and then click **OK** (otherwise, click **Close**). The **OK** function changes the data in the **Substance If Other** column.

Delete Button

Use the Delete button to remove a highlighted substance record.

1. Highlight the record to delete.
2. Click **Delete**.
3. On the "Are You Sure" confirmation, click **Yes** to delete the highlighted substance record. (Otherwise, click **No**.)

11.3.4 Contributing Factors Tab

Use the **Contributing Factors** tab to indicate one or more contributing factors associated with the suicide act.

Figure 11-37: Sample Contributing Factors tab

1. Select one or more check boxes that define the contributing factors to the suicide act. At least one is required.
2. If you select the **Other** checkbox, the field below the checkbox becomes active. Use this Free Text field to describe the "other" contributing factor (limited to 80 characters).

11.3.5 Narrative Tab

Use the **Narrative** tab to populate the **Other Relevant Information** Free Text field. (This is not a required field.)

Figure 11-38: Sample Other Relevant Information field

Populate this field with data that is not included elsewhere. This is **not** where you put the SOAP or progress note.

12.0 Intake

This section addresses how to manage intake/update documents in roll and scroll and the GUI.

12.1 Intake Documents (Roll and Scroll)

One place you can add/change/remove an intake document is to use the Intake Document (ID) option on the Patient Data Entry window.

```
PATIENT DATA ENTRY           Mar 11, 2009 17:15:55          Page:    1 of    1
Patient: DEMO,DOROTHY ROSE   HRN: 999999
         FEMALE  DOB: Oct 10, 1942   AGE: 66 YRS   SSN: XXX-XX-1111
Designated Providers:
 Mental Health:                        Social Services:
          A/SA:                                  Other:
     Other (2):                           Primary Care: SMITH,A

Last Visit (excl no shows): May 29, 2008  BETAAAA,BJ  REGULAR VISIT
            F42.      HOARDING DISORDER

Pending Appointments:
                  Select the appropriate action   Q for QUIT
AV Add Visit              LD List Visit Dates       GS GAF Scores
EV Edit Visit             TP Treatment Plan Update  OI Desg Prov/Flag/Pers Hx
DR Display Record         CD Update Case Data       EH Edit EHR Visit
ES Edit SOAP              ID Intake Document        PPL Problem List Update
DE Delete Visit           AP Appointments           SN Sign Note
PF Print Encounter Form   HS Health Summary         TN TIU Note Display
LV Last BH Visit          DM Display Meds           MM Send Mail Message
BV Browse Visits          LA Interim Lab Reports    FS Face Sheet
Select Action: Q//    Q
```

Figure 12-1: Sample Patient Data Entry window

At the “Select Action” prompt, type **ID**. The application as which Program you are associated. Then the Updated BH Intake Document window displays.

The other place you can add/change/remove an intake document is when you exit the visit encounter (display or add/edit) window. After you exit the last screen, the application displays the OTHER INFORMATION window.

```
                    *******  OTHER INFORMATION  *******



Update, add or append any of the following data

     1). Update any of the following information:
          Designated Providers, Patient Flag
     2). Patient Case Open/Admit/Closed Data
     3). Personal History Information
     4). Appointments (Scheduling System)
     5). Treatment Plan Update
```

```
     6). Print an Encounter Form
     7). Add/Update/Print Intake Document
     8). Add/Update Suicide Forms
     9). Problem List Update
     10)  None of the Above (Quit)
Choose one of the above:  (1-10): 7//
```

Figure 12-2: Options on the Other Information menu

Use option 7 (Add/Update/Print Intake Document) to access the Update BH Intake Document for the selected visit. You will be prompted for a Program. After specifying the program, the Update BH Intake Document for the current patient displays.

```
Update BH Intake Document     Jan 26, 2010 13:27:36          Page:    1 of    1
MENTAL HEALTH INTAKE DOCUMENTS        *unsigned document
Patient Name: DUCK,EDWIN RAY   DOB: JUN 07, 1978   Sex: M   HRN: 105321
                       INITIAL                       UPDATE
#  INITIATED  PROGRAM  PROVIDER            UPDATED  PROVIDER


*1  01/26/10  MENTAL H THETA,SHIRLEY
                                          *01/26/10 THETA,SHIRLEY
*2  12/29/09  MENTAL H GAMMAA,RYAN
*3  12/29/09  MENTAL H GAMMAA,RYAN
4   12/29/09  MENTAL H THETA,SHIRLEY
                                           12/29/09 THETA,SHIRLEY
                                          *12/29/09 THETA,SHIRLEY
*5  12/29/09  MENTAL H THETA,SHIRLEY
*6  12/14/09  MENTAL H GAMMAA,RYAN
*7  10/07/09           GAMMAA,RYAN
                                          *10/07/09 GAMMAA,RYAN
*8  04/21/09           GAMMAA,RYAN
          Enter ?? for more actions
I    Add Initial Intake                D    Delete Intake/Update
E    Edit Initial Intake               P    Display/Print Intake/Update
U    Add/Edit Update                   Q    Quit
Select Action: Q//
```

Figure 12-3: Sample Update BH Intake Document window

Use the Q (quit) option to exit the Update BH Intake Document window.

The asterisk (*) in the first column indicates that the particular record contains an unsigned intake/update document.

Please note the following information about intake and update documents on the Update BH Intake Document window:

- The intake documents are listed on the left side (under the Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side (under the Date Updated and Update Provider columns).

12.1.1 Add Initial Intake (I)

Use option I to create an initial intake document for the visit.

1. At the “Select Action” prompt, type **I**.

   The application displays a message that it is adding the Intake document for the patient.

2. At the “Do you wish to continue and add the Initial Intake document?” prompt, type **Y** to add the Intake document (otherwise, type **N**)

   If Y was used, the prompts continue.

3. At the “DATE” prompt, press Enter to use the default date which is the current date (you can change). This cannot be a future date.

4. At the “PROGRAM” prompt, press Enter to accept the default (Mental Health). Otherwise, type the program to use.

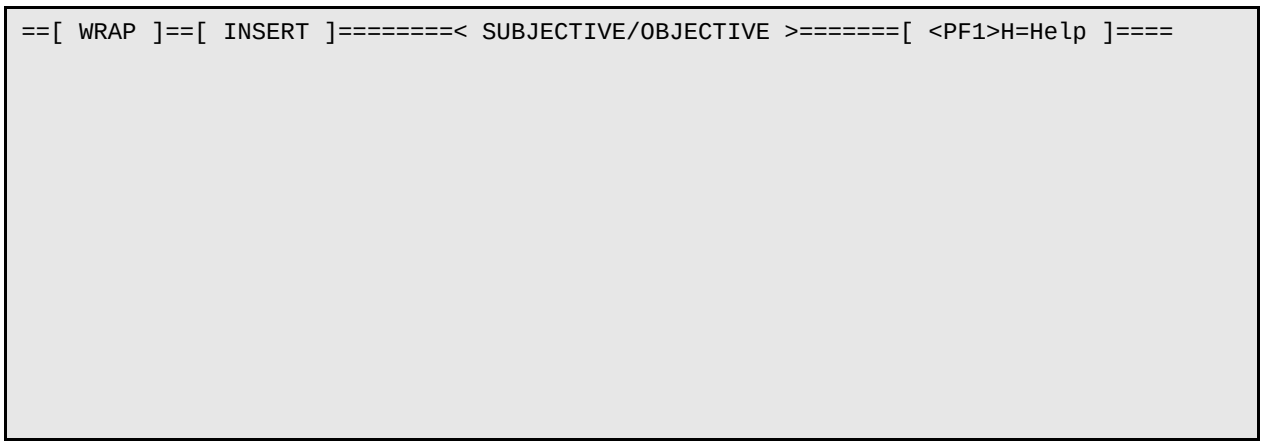
5. At the “PROVIDER” prompt, press Enter to accept the default provider (you can change).

6. At the “DATE LAST UPDATED” prompt, press Enter to use the default which is the current date (you can change). This cannot be future date.

7. At the “NARRATIVE - No Existing Text - Edit?” prompt, type **Y** to edit the narrative or **N** to not edit the narrative.

   If N was used, the application creates the Intake document. You must enter the Intake narrative before you can electronically sign the intake document. The application then prompts if you want to enter an Intake Narrative (Y or N). If N was used, the focus returns to the Update BH Intake Document window.

   If Y was used, the focus moves to another window to enter the text of the narrative.



```
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

Figure 12-4: screen to enter text

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you save and exit, the prompts continue.

8. At the "Enter your Current Signature Code" prompt, do one of the following:
   - Type your electronic signature to sign the document. This action marks the document as signed. You cannot edit it.
   - Press Enter to not sign the document. The document is marked as not signed. You can edit it.

12.1.2 Edit Initial Intake (E)

Use option E to change the selected initial intake document.

- Only the original intake provider or the person who entered the intake document can edit the document; other providers can only view or print the document.
- Editing an initial intake that was created before the installation of BHS v4.0 will result in a prompt to enter the program associated with the intake.

1. At the "Select Action" prompt, type **E**.
2. At the "CHOOSE" prompt, type **1** (Edit Initial Intake Document) or **2** (Quit). If 2 was used, the focus returns to the Update BH Intake Document. If 1 was used, the prompts continue.
3. At the "Select Intake" prompt, type the number of the intake document to edit.
   - If the specified intake document has been signed, you cannot edit it.

- If you are not the original author or the person who entered this document, you cannot edit it.

4. At the “DATE” prompt, press Enter to use the default (the current date). Otherwise, you can type another date (cannot be a future date).
5. At the “PROGRAM” prompt, type the program associated with the intake displays.
6. At the “PROVIDER” prompt, type the author of the initial intake document.
7. At the “DATE LAST UPDATED” prompt, press Enter to use the default (the current date). Otherwise, type a new date (cannot be a future date).
8. At the “NARRATIVE - No Existing Text - Edit?” prompt, type **Y** (yes) to edit the narrative or **N** (no) 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 N was used (for step 8), 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 Y was used, the focus returns to the Narrative prompt (as above). If N was used, the focus returns to the Update BH Intake Document window.

   If Y was used (for step 8), the focus moves to another window where you enter the text of the narrative.

Figure 12-5: screen to enter text

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you save and exit this window, the prompts continue:

9. At the "Enter your Current Signature Code" prompt, do one of the following:

   - Type your electronic signature to sign the document. This action marks the document as signed. You cannot edit it.
   - Press Enter to not sign the document. The document is marked as not signed. You can edit it.

12.1.3 Add/Edit Update (U)

Use option U to create a new update to a particular intake document or edit an existing, unsigned one where you are the provider.

- Only the person who originally entered the Intake document or the Intake document Provider can edit the document
- Other providers can only view or print the document.

1. At the "Select Action" prompt, type **U**.
2. At the "Select Intake" prompt, type the number of intake document to use.

   The following message displays:

```
You can either add a new Update to this Intake document or edit an
existing, unsigned one on which you are the provider.  Please select an Update
to edit or choose 1 to add a new one or 0 to quit.

     0    Quit/Exit Update
     1    Add new Update document
Select Action:  (0-1): 0//
```

Figure 12-6: Message from the application

3. At the "Select Action" prompt, you can either add a new update to this intake document, quit/exit the update process, or use the option to edit the Update.

   - If the Quit option was used, you leave the add/edit process.

- If the Add new Update document option was used, the prompts continue: The application displays a message that it is adding the Intake Update document for the patient.

4. At the “Do you wish to continue on to add the Intake Update? Prompt, type **Y** (yes) or **N** (no). If Y was used, the prompts continue.
5. At the “DATE” prompt, press Enter to use the default (current date). Otherwise, type a new date (cannot be a future date).
6. At the “PROVIDER” prompt, Press Enter to use the default provider. Otherwise, type the name of the provider for the update document.
7. At the “DATE LAST UPDATED” prompt, press Enter to use the default (current date). Otherwise, type a new date (cannot be a future date).
8. At the “NARRATIVE” prompt, the application displays the text of the narrative or displays “no existing text” if there is none.
9. At the “Edit?” prompt, type **Y** (yes) to edit the text of the narrative or **N** (no) to not edit the narrative.
    a. If N was used, the application creates the Intake Update document and displays the message that the narrative must be entered before an E Sig must be applied. At the “Do you wish to enter an Intake Narrative?” prompt, type Y (yes) or N (no).
    b. If Y was used, the focus moves to another window where you enter the text of the narrative.

Figure 12-7: screen to enter text

Listed below are the most commonly used RPMS text editor commands:

What is Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

After you save and leave this window, the application displays the next prompt.

10. At the "Enter your Current Signature Code" prompt, do one of the following:

    - Type your electronic signature to sign the document.
    - Press Enter to not sign the document

      If you press Enter, you can either add a new update to this intake document or edit an existing, unsigned one on which you are the Provider or the person who entered the Intake Document. The application displays the next prompt:

11. At the "Select Action" prompt, do one of the following:

```
0  Quit/Exit Update
1  Date Updated: MM/DD/YY   Provider: <provider name>
2  Add new Update document
```

Figure 12-8: Prompts for the actions you can take

    If 0 was used, the focus returns to the Update BH Intake Document window.

    If 2 was used, this action has the same prompts as Add/Edit Update (Section 12.1.3 provides more information).

    If 1 was used, the following prompts displays:

    a. At the "Date Updated" prompt, type the date the document was updated.
    b. At the "Provider" prompt, type the name of the provider who updated the document.

12.1.4 Delete Intake/Update (D)

Use option D to do one of the following:

- Delete Intake/Update
- Display/Print Intake/Update

Delete Intake/Update

You can delete only unsigned Intake documents you entered or on which you are the provider, unless you possess a special key or are listed on the Delete Override list.

1. At the "Select Intake" prompt, type the number of the Initial Intake to delete, or the Initial Intake with the Update to delete.

   The application gives you the following choices:

```
0  Quit/Exit
1  Date MM/DD/YY   Provider: <provider name>
```

Figure 12-9: Actions to take

   If 0 was used, the focus returns to the Update BH Intake Document window.

   If 1 was used, the application displays information about the intake document, including its narrative. Then the next prompt displays:

2. At the "Are you sure you want to delete this Initial Intake document?" prompt, type **Y** (yes) or **N** (no).

   If there are multiple documents you want to delete, the application repeats the process.

Display/Print Intake/Update

This action is the same as using option P on the Update BH Intake Document window. Section 12.1.5 provides more information about the print process.

12.1.5 Print Intake Document

Use option P to print/browse a particular intake document.

1. At the "Select Action" prompt, type **P**.
2. At the "Select Intake" prompt, type the number of the document to display/print.
3. At the "What would you like to print" prompt, type **I** (Intake document only), **U** (Update document only), **B** (both the Intake and Update documents), **Q** (quit/exit).
   a. If Q was used, the focus returns to the previous window.
   b. If U was used, another menu is displayed listing each of the updates and an option to print all updates or quit.

c. If B was used, the application will display a list of options. At the "Which Updates would you like to Print" prompt, type the number of the option to use.

4. At the "Do you wish to" prompt, type **P** to print output on paper or **B** browse output on screen.

   Below is sample Intake only report.

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
*****************************************************************************
*                                                                           *
*  INTAKE DOCUMENT                            Printed: Aug 30, 2009@16:31:52    *
*  Name:  ALPHAA,CHELSEA MARIE                                    Page 1     *
*  DEMO INDIAN HOSPITAL       DOB:  2/7/75    Sex:  F   Chart #:  WW116431     *
*                                                                           *
*****************************************************************************

Date Established:   MAY 12, 2009
  Author/Provider:    THETA,SHIRLEY
  Program:            MENTAL HEALTH
  Type of Document:   INITIAL

Intake Documentation/Narrative: This is a 34-year old female requesting
antidepressant medications, stating that she ran out of her previous prescription
since moving back to the reservation.

_____________________________________________          _____________________
                                                              DATE

_____________________________________________          _____________________
                                                              DATE
```

Figure 12-10: 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 **Select Program** dialog box displays.

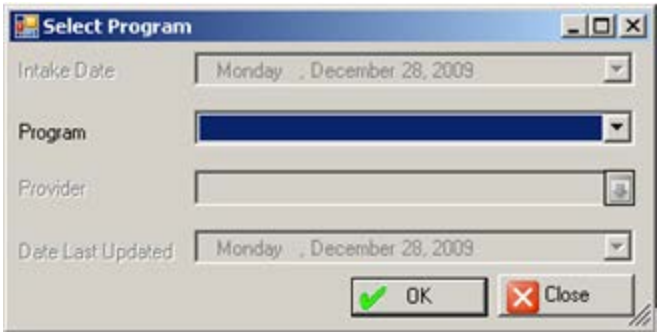


Figure 12-11: Select Program dialog box

1. At the **Program** field, click the drop-down list for the **Program** field and select an option.

2. Click **OK** (otherwise click **Close**).

The **OK** process displays the Intake window listing the intake documents for the particular program for the current patient. The current patient's name appears in the lower, left corner of the window.

> **Note**: The following window is the window that displays when you click the Intake tab on the **Add/Edit Visit Data Entry** window.

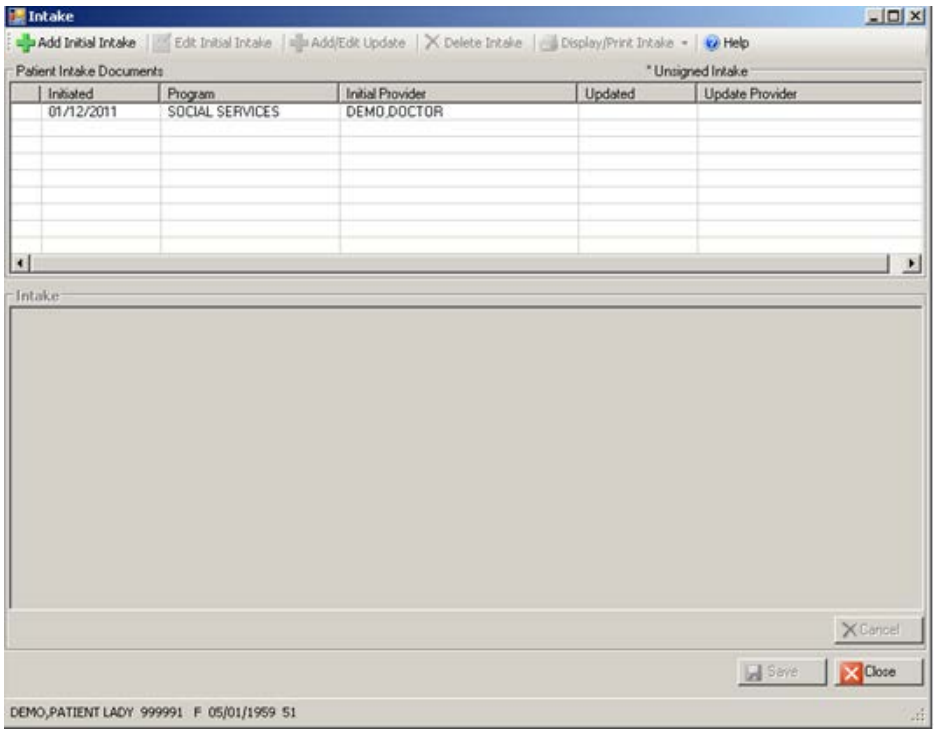


Figure 12-12: Sample Intake window

The asterisk (*) in the first column indicates that the particular record contains an unsigned intake/update document.

Use the **Help** button to access the online help for this window.

12.2.1 Patient Intake Documents List Box

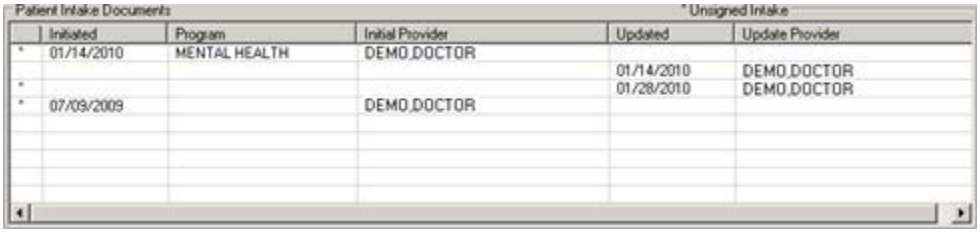


Figure 12-13: Sample Patient Intake Documents list box

The Patient Intake Documents list box displays the names of the current patient's intake documents and update documents (view only). You can distinguish the documents in the following manner:

- The intake documents are listed on the left side of the grid (under the Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side of the grid (under the Date Updated and Update Provider columns).

As you highlight a record in the **Patient Intake Documents** list box, the text of the document displays in the Intake group box.

All initial documents and updates created before the BHS v4.0 installation will remain unsigned and editable. The initial provider associated with the intake will be the provider for the intake document. Any edits or updates completed after the installation date will be subject to all business rules added in BHS v4.0.

12.2.2 Add Initial Intake

Use the Add Initial Intake button to add a new initial intake document.

1. Click **Add Initial Intake** to access the **Select Intake Parameters** dialog box.

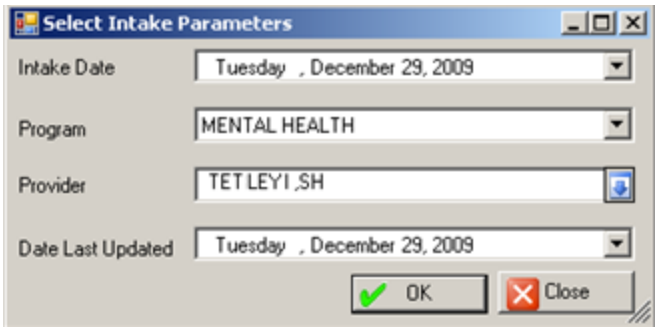


Figure 12-14: Sample Select Intake Parameters dialog box

2. At the **Intake Date** field, the current date displays. Change this by clicking the drop-down list and selecting another date from the calendar (cannot be a future date).

3. At the **Program** field, the default program displays (the one selected when you first accessed the Intake menu). You can change this by clicking the drop-down list and selecting another option.

Note:	If you change the Program, it will not be visible when you return to the list view. You have to back out of the Program selection screen again and select the Program associated with the document you just entered. We encourage you to NOT change the program. It is actually more efficient to back out and enter the correct program initially.

4. At the **Provider** field, the current login provider name displays. You can change this by clicking the drop-down list to access the **Primary Provider** search/select window.

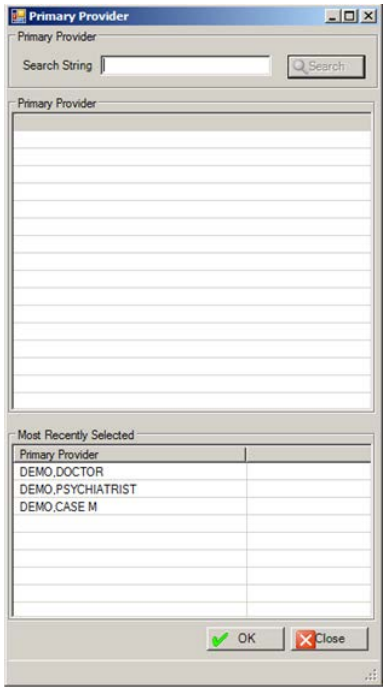
Screen Capture	What to do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the Primary Provider list box. Select a name and click **OK** to populate the Provider field. (Otherwise, click **Close**.) (2) Select a name in the Most Recently Selected list box and click **OK** to populate the Primary Provider field. (Otherwise, click **Close**.)

Figure 12-15: Sample Primary Provider search/select window

5. At the **Date Last Updated** field, the current date displays. Change this by clicking the drop-down list and selecting another date from the calendar (cannot be a future date).

After completing the **Select Intake Parameters** dialog box, click **OK** (otherwise, click **Close**). The **OK** function activates the Intake group box. Section 12.2.3 provides more information about this group box.

12.2.3 Intake Group Box

Figure 12-16: Sample of active Intake group box

When the **Intake** group box is active, use it to type the text of the document (intake or update). This text is the narrative for the document.

To exit the **Intake** group box, click **Cancel** to cause the Intake group box to become inactive.

After you have completed the **Intake** group box, click **Save** (otherwise click **Close**).

- If Close was used, the **Continue?** message displays: Unsaved Data Will Be Lost, Continue? Click **Yes** to lose any data and the focus returns to the GUI tree structure. Click **No** and the focus returns to the Intake group box.
- If Save was used, the **Intake Electronic Signature** dialog box displays. The Save process requires that there is intake narrative.

Figure 12-17: Intake Electronic Signature dialog box

To sign the particular document, do the following:

a. At the **Electronic Signature** field, type your electronic signature.
b. Click **OK**. This saves the document and marks it as signed. Signing a document locks the document from any future edits.

To **not** sign the particular document, do the following:

a. At the **Electronic Signature** field, do not type your electronic signature.
b. Click **Close**.
c. At the **Are You Sure?** dialog box displays that states: Are you sure you want to Close without Electronically Signing the Intake?" prompt, click **Yes** or **No**.
    - Click **Yes** to not sign it and to save the document marked as not signed. The application displays the Message: You did not Electronically Sign the Intake. Click **OK** to dismiss the Message. This type of document can be edited.
    - Click **No** and the focus returns to the **Intake Electronic Signature** dialog box.

12.2.4 Edit Initial Intake

Select an existing initial intake document and click the Edit Initial Intake button to edit the initial intake document.

- If the selected document has been signed, the application displays the Message: This Initial Intake document has been signed. You cannot edit it. Click **OK** to dismiss the message and you exit the edit process.
- Only the provider or the person who entered the intake can edit it; otherwise, the application displays the Message: You are not the provider or the person who entered the Intake, you cannot edit it. Click **OK** to dismiss the message and you exit the edit process.

If you are the provider or the person who entered the intake, the application displays the **Select Intake Parameters** dialog box. Section 12.2.2 provides more information the add initial intake process. After completing this dialog box, the text of the initial intake document will display in the Intake area of the Intake window. Section 12.2.3 provides more information about the intake group box.

12.2.5 Add/Edit Update

This button has two different labels, depending on the action you take.

Note:	If you select a signed Update document, the button reads Edit Update. After you click the Edit Update button, the application displays the Message: This Intake Update document has been signed. You cannot edit it. Click **OK** to dismiss the message and you exit the edit process. After the Provider locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the Delete Override Site Parameter.

If you select an **Intake document** (signed or unsigned), the button reads: **Add Update.**

If you select an unsigned **Update document**, the button reads: **Edit Update**.

In either case, the application displays the **Select Intake Parameters** dialog box. Section 12.2.2 provides more information about Add Initial Intake.

After completing this dialog box, the **Intake** group box will become active. Section 12.2.3 provides more information about the **Intake Group** Box.

12.2.6 Delete Intake

Use the Delete Intake button to delete a selected unsigned Intake document (in the Patient Intake Documents group box).

1. Select an unsigned Intake document to delete.

2. Click **Delete Intake**.

3. On the "Are You Sure" confirmation message, click **Yes** to delete (otherwise, use **No**).

   - Only the intake Provider or the person who entered the selected intake can use the Delete function. However, when a person is listed in the Delete Override section on the Site Parameters menu (in RPMS), that person can delete the document.
   - If the selected Intake document has an attached update document, the application displays the message: This intake document has updates associated with it. It cannot be deleted at this time. Click **OK** and you exit the Delete process.

12.2.7 Display/Print Intake

Use the **Display/ Print Intake** button to access the options for the display/print process.

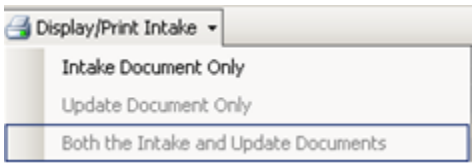


Figure 12-18: Options on the Display/Print Intake button

1. Highlight an Intake record and select one of options (only the valid options will be highlighted).

   If you selected **Update Document Only** or Both the **Intake and Update Documents**, the application displays the **Intake Updates** dialog box.

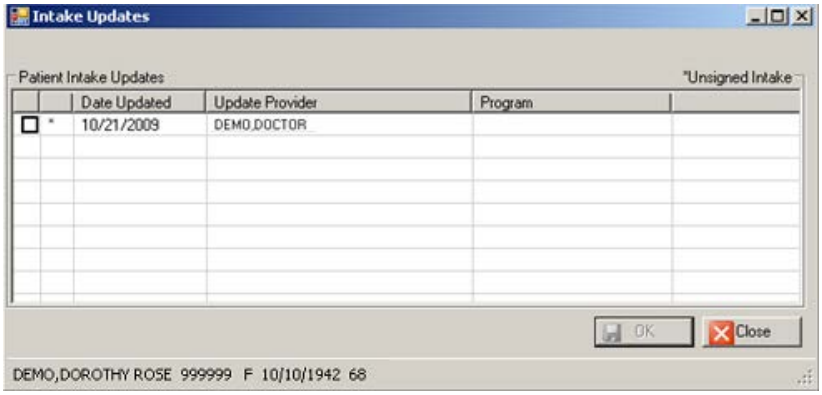


Figure 12-19: Sample Intake Updates dialog box

   Check the records you want to include in the output and click **OK** (otherwise, click **Close**).

The first page of the Intake (for the current patient) pop-up displays.

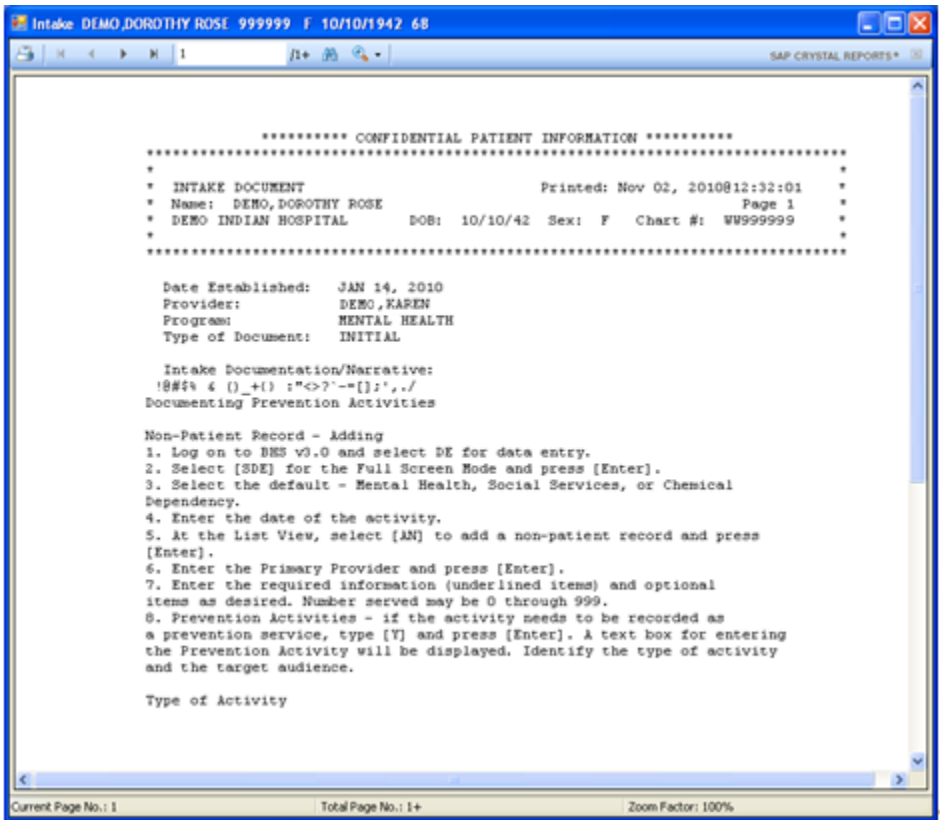


Figure 12-20: Sample Intake pop-up for current patient

Section 2.6 provides more information about using the controls on this type of window.

Appendix A: Activity Codes and Definitions

BHS activity codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to report activities. However, aggregate reports can be organized by these activity categories.

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

A.1 Patient Services - Patient Always Present (P)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

01–Twelve Step Work – Group (TSG)
Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

02–Twelve Step Work - Individual (TSI)
Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

03–Twelve Step Group (TSG)
Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, CoDA (Co-dependents Anonymous).and OA (Overeaters Anonymous).

04-Re-assessment, Patient Present (RAS)
Formal assessment activities intended to reevaluate the patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

11-Screening (SCN)
Services provided to determine in a preliminary way the nature and extent of the recipient's problem in order to link him/her to the most appropriate and available resource.

12-Assessment/Evaluation (EVL)

Formal assessment activities intended to define or delineate the client/patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

13-Individual Treatment/Counseling/Education (IND)

Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

15-Information and/or Referral (REF)

Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization.

16-Medication/Medication Monitoring (MED)

Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

17-Psychological Testing (TST)

Examination and assessment of client/patient's status through the use of standardized psychological, educational, or other evaluative test. Care must be exercised to assure that the interpretations of results from such testing are consistent with the socio-cultural milieu of the client/patient.

18-Forensic Activities (FOR)

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

19-Discharge Planning (DSG)

Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

20-Family Facilitation (FAC)

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

21-Follow-through/Follow-up (FOL)

Periodic evaluative review of a specific client/patient's progress after discharge.

22-Case Management (CAS)

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to

address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination.

23-Other Patient Services not identified here (OTH)
Any other patient services not identified in this list of codes.

47–Couples Treatment (CT)
Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.

48-Crisis Intervention (CIP)
Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

85-Art Therapy (ART)
The application of a variety of art modalities (drawing, painting, clay, and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.

86–Recreation Activities (REC)
Recreation and leisure activities with the purpose of improving and maintaining clients'/patients' general health and well-being.

88–Acupuncture (ACU)
The use of the Chinese practice of Acupuncture in the treatment of addiction disorders (including withdrawal symptoms and recovery) and other behavioral health disorders.

89–Methadone Maintenance (MET)
Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed methadone maintenance agency under the supervision of a physician. Services include methadone dosing, medical care, counseling and support and disease prevention and health promotion.

90–Family Treatment (FAM)
Family-centered therapy with an emphasis on the client/patient's functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences; often brief and solution focused.

91–Group Treatment (GRP)
This form of therapy involves groups of patients/clients who have similar problems that are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

92–Adventure Based Counseling (ABC)

The use of adventure-based practice to effect a change in behaviors (both increasing function and positive action and decreasing dysfunction and negative action) as it relates to health and/or mental health.

93–Relapse Prevention (REL)
Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

- Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
- Strategies for avoiding high-risk situations
- Strategies for coping with high-risk situations when encountered
- Strategies for coping with alcohol/drug cravings
- Strategies for coping with lapses to drug use to prevent full-blown relapses

94–Life Skills Training (LST)
Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

95–Cultural Activities - Pt. Present (CUL)
Participation in educational, social, or recreational activities for the purpose of supporting a client/patient's involvement, connection, and contribution to the patient's cultural background.

96–Academic Services (ACA)
Provision of alternative schooling under the guidelines of the state education program.

97–Health Promotion (HPR)
Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

A.2 Support Services - Patient Not Present (S)

Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

05-Re-assessment, Patient Not Present
Reassessment or reevaluation activities when patient is not present at time of service delivery.

24-Material/Basic Support (SUP)

Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

25-Information and/or Referral (INF)

Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization

26-Medication/Medication Monitoring (MEA)

Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

27-Forensic Activities (FOA)

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

28-Discharge Planning (DSA)

Collaborative service planning with other community caregivers to develop a goal oriented follow-up plan for a specific client/patient.

29-Family Facilitation (FAA)

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

30-Follow-up/Follow-through (FUA)

Periodic evaluative review of a specific client/patient's progress after discharge.

31-Case Management (CAA)

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

33-Technical Assistance

Task-specific assistance to achieve an identified end.

34-Other Support Services

Any other ancillary, adjunctive, or collateral services not identified here.

44-Screening

Activities associated with patient/client screening where no information is added to the patient/client's file.

45-Assessment/Evaluation
Assessment or evaluation activities when patient is not present at time of service delivery.

49-Crisis Intervention (CIA)
Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes:

35-Collaboration
Collaborative effort with other agency or agencies to address a community request.

36-Community Development
Planning and development efforts focused on identifying community issues and methods of addressing these needs.

37-Preventive Services
Activity, class, project, public service announcement, or other activity whose primary purpose is to prevent the use/abuse of alcohol or other substances and/or improve lifestyles, health, image, etc.

38-Patient Transport
Transportation of a client to or from an activity or placement, such as a medical appointment, program activity, or from home.

39-Other Community Services
Any other form of community services not identified here.

40-Referral
Referral of a client to another agency, counselor, or resource for services not available or provided by the referring agency/program. Referral is limited to providing the client with information and might extend to calling and setting up appointments for the client.

87-Outreach
Activities designed to locate and educate potential clients and motivate them to enter and accept treatment.

A.4 Education Training (E)

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job related knowledge, attitudes, and skills. Includes:

41- Education/Training Provided
42- Education/Training Received
43- Other Education/Training

A.5 Administration (A)

Activities for the benefit of the organization and/or activities that do not fit into any of the above categories. Includes:

32-Clinical Supervision Provided

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

50-Medical Rounds (General)

On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

51-Committee Work

Participation in the activities of a body of persons delegated to consider, investigate, take action on, or report on some matter.

52-Surveys/Research

Participation in activities aimed at identification and interpretation of facts, revision of accepted theories in the light of new facts, or practical application of such new or revised theories.

53-Program Management

The practice of leading, managing, and coordinating a complex set of cross-functional activities to define, develop, and deliver client services and to achieve agency/program objectives.

54-Quality Improvement

Participation in activities focused on improving the quality and appropriateness of medical or behavioral healthcare and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

55-Supervision

Participation in activities to ensure that personnel perform their duties effectively. This code does not include clinical supervision.

56-Records/Documentation

Review of clinical information in the medical record/chart or documentation of services provided to or on behalf of the client. This does not include the time spent in service delivery.

57-Child Protective Team Activities

Participation in a multi-disciplinary child protective team to evaluate alleged maltreatments of child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance their caregiver's capacity to provide a safer environment when possible.

58-Special Projects

A specifically-assigned task or activity which is completed over a period of time and intended to achieve a particular aim.

59-Other Administrative

Any other administrative activities not identified in this section.

60-Case Staffing (General)

A regular or ad-hoc forum for the exchange of clinical experience, ideas and recommendations.

66-Clinical Supervision Received

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

A.6 Consultation (L)

Problem-oriented effort designed to impart knowledge, increase understanding and insight, and/or modify attitudes to facilitate problem resolution. Includes:

61-Provider Consultation (PRO)

Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

62-Patient Consultation (Chart Review Only) (CHT)

Focus is a specific patient and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

63-Program Consultation
Focus is a programmatic effort to address specific needs.

64-Staff Consultation
Focus is a provider or group of providers addressing a type or class of problems.

65-Community Consultation
Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

A.7 Travel (T)

71-Travel Related to Patient Care
Staff travel to patient's home or other locations – related to provision of care. Patient is not in the vehicle.

72 Travel Not Related to Patient Care
Staff travel to meetings, community events, etc.

A.8 Placements (PL)

75-Placement (Patient Present) (OHP)
Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

76-Placement (Patient Not Present) (OHA)
Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences. This activity might include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

A.9 Cultural Issues (O)

81-Traditional Specialist Consult (Patient Not Present) (TRA)
Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

82-Traditional Specialist Consult (Patient Not Present) (TRA)

Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

83-Tribal Functions

Services offered during or in the context of a traditional tribal event, function, or affair—secular or religious. Community members gather to help and support individuals and families in need.

84-Cultural Education to Non-Tribal Agency/Personnel

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

Appendix B: Activity Codes that Pass to PCC

Activity Code	Description	Pass to PCC
01	Twelve Step Work – Group (TSG)	Yes
02	Twelve Step Work – Individual (TSI)	Yes
03	Twelve Step Group (TWG)	No
04	Re-Assessment, Patient Present	Yes
05	Re-Assessment, Patient Not Present	No
11	Screening – Patient Present (SCN)	Yes
12	Assessment/Evaluation – Patient Present (EVL)	Yes
13	Individual Treatment/Counsel/Education – Pt. Present (IND)	Yes
15	Information and Referral – Patient Present (REF)	Yes
16	Medication/Medication Monitoring – Pt. Present (MED)	Yes
17	Psychological Testing – Patient Present (TST)	Yes
18	Forensic Activities – Patient Present (FOR)	Yes
19	Discharge Planning – Patient Present (DSG)	Yes
20	Family Facilitation –Patient Present (FAC)	Yes
21	Follow Through/Follow Up – Patient Present (FOL)	Yes
22	Case Management – Patient Present (CAS)	Yes
23	Other Patient Services Not Identified – Patient Present (OTH)	Yes
24	Material/Basic Support – Patient Not Present (SUP)	No
25	Information and/or Referral – Patient Not Present (INF)	No
26	Medication/Medication Monitoring – Pt. Not Present (MEA)	Yes
27	Forensic Activities – Patient Not Present (FOA)	No
28	Discharge Planning – Patient Not Present (DSA)	No
29	Family Facilitation – Patient Not Present (FAA)	No
30	Follow Through/Follow Up – Patient Not Present (FUA)	No
31	Case Management – Patient Not Present (CAA)	Yes
32	Clinical Supervision Provided	No
33	Technical Assistance – Patient Not Present	No
34	Other Support Services – Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening – Patient Not Present	No
45	Assessment/Evaluation – Patient Not Present	No
47	Couples Treatment – Patient Present (CT)	Yes

Activity Code	Description	Pass to PCC
48	Crisis Intervention – Patient Present (CIP)	Yes
49	Crisis Intervention – Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes

Appendix C: DSM Copyright and Trademark Information

C.1 10.2 Copyright

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Appendix D: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

D.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

D.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

D.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

D.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

D.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

D.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

D.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

D.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

D.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

D.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

D.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

D.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

D.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

D.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

D.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

D.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Caret

The symbol ^ obtained by pressing Shift-6.

Command

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Data Elements

Data fields that are used in filling out forms in BHS.

Default Response

Many of the prompts in the BHS program contain responses that can be activated simply by pressing the Enter key. For example: “Do you really want to quit? No//.” Pressing the Enter key tells the system you do not want to quit. “No//” is considered the default response.

Device

The name of the printer to use when printing information. Home means the computer screen.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

Fileman

The database management system for RPMS.

Free Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

Frequency

The number of times a particular situation occurs in a given amount of time.

Full Screen Editor

A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

Menu

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical use interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

Security Keys

Tools used to grant/restrict access to certain applications, application features, and menus.

Site Manager

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu

A menu that is accessed through another menu.

Suicide

The act of causing one's own death.

Ideation with Intent and Plan–Serious thoughts of suicide or of taking action to take one's life with means and a specific plan

Attempt–A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

Completion–Fatal self-inflicted destructive act with explicit or inferred intent to die.

Terminal Emulator

A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor

A word processing program that entering and editing text.

Word Processing Field

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

Acronym	Term Meaning
A/SA	Alcohol and Substance Abuse
BH	Behavioral Health
BHS	Behavioral Health System
CAC	Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading of BHS and other software programs for the end users. The CAC is sometimes referred to as the application coordinator or a "super-user."
CD	Chemical Dependency
EHR	Indian Health Service RPMS Electronic Health Record
GPRA	Government Performance and Results Act; a federal law requiring federal agencies to demonstrate through annual reporting that they are using appropriated funds effectively to meet their Agency's missions.
GUI	Graphic User Interface, a Windows-like interface with drop-down menus, text boxes icons, and other controls that supports data entry using a combination of the computer mouse and keyboard.
HRCN	Health Record Chart Number
IHS	Indian Health Service
MH	Mental Health
IHS	Indian Health Service
RPMS	Resource and Patient Management System

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

Web: http://www.ihs.gov/helpdesk/

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