RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

User Manual

Version 4.0, Patch 11
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Preface

The Behavioral Health System (AMH) is a module of the Resource and Patient Management System (RPMS) designed specifically for recording and tracking patient care related to behavioral health. AMH 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.

1.0 Introduction

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 number of behavioral health clinicians are located at facilities that do not use the EHR. For these providers, AMH v4.0 can be utilized as a standalone yet integrated module within the RPMS suite of clinical and practice management software.

AMH 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.

> **Note:** This date entry functionality is no longer maintained. All data entry should be done through the Graphical User Interface (GUI) module. Patient data look up and reports will continue to be available through the roll and scroll module.

1.1 Primary Menu

The **Primary Menu** option for this package is **IHS AMH (AMHMENU)** (Figure 1-1).

```
        ********************************************
        **       IHS       **
        ********************************************
        Version 4.0 (Patch 11)


        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 AMH menu example

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 an **AMH 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 (Table 1-1) 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 1-1: 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
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 AMH** and the **RPMS AMH 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** (//), press **Enter** to default to the entry displayed (Figure 2-1). 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 entry example

2.1.3 To Back Out

Pressing the number **6 key** while holding down the **Shift** key generates the **caret** (^) **symbol**. This symbol terminates the current action and backs the user out one level.

2.1.4 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**.

2.1.5 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 press **Enter** to repeat the last entry you used at the prompt.

2.1.6 Lookup

Be careful of misspellings. If unsure of the spelling of a name or an entry, type only the first few letters. **RPMS** displays all choices (Figure 2-2) that match those beginning letters.

Example:

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

Figure 2-2: Patient lookup screen example

2.1.7 Pause Indicator

The **angle bracket (<>) 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 **Enter** to see the next page or type a **caret** (^) **symbol** to exit the report.

2.1.8 Dates and Times

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

- **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 the user does 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 as follows.

Example:

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

2.1.9 Stop

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

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

Even if using a personal computer as an **RPMS** terminal, users cannot use the mouse for pointing and clicking to select a menu option.

View 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 (Figure 2-3), two **Question Marks** (**??**), are keyed at the **Select Action** prompt to view 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, users can do the following:

- Type a **Plus Sign** (+) in a display that fills more than one page to see the next full screen (when not on the last screen).
- Type a **Dash** (-) to display the previous screen (when not on the first screen). This command will only work if the user has already reviewed several screens in the display.
- Press the **Up Arrow** key to move the screen display back one line at a time.
- Press the **Down Arrow** key to move the screen display forward one line at a time.
- Press the **Right Arrow** key to move the screen display to the right.
- Press the **Left Arrow** key to move the screen display to the left.
- Type **FS** in a multi-page display to return to the first screen of the display.
- Type **LS** in a multi-page display to go to the last screen in the display.
- Type **GO** and the page number of a multi-screen display to go directly to that screen.
- Type **RD** to redisplay the screen.
- Type **PS** to print the current screen.
- Type **PL** to print an entire single or multi-screen display (called a list).
- Type **SL** to be prompted for a word to search for in the list. Press **Enter** after the word selection to move to the first occurrence of the word. For example, if the user is many pages into a patient's **Face Sheet** and wants to know the patient's age, type **SL**, then type **Age**, and press **Enter** to move to the age field.

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

2.3 ScreenMan (Roll and Scroll)

2.3.1 Using the ScreenMan Window

When using **ScreenMan** (Figure 2-4) for entering data, press **Enter** to accept defaulted data values or after entering 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 users do not want to enter a value. The system automatically fills in much of the demographic information when entering a 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: DEMO,SHIRLEY
Patient Name:  DEMO,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 example screen one

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

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

2.3.2 Using the Pop-up Window

Press **Enter** to move between fields, when inputting data in a screen (Figure 2-5). 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: DEMO,DOROTHY K
Patient Name: DEMO,SALLY
------------------------------------------------------------------

PROVIDER: DEMO,STEPHEN A    <TAB>   PRIMARY/SECONDARY: PRIMARY   <TAB>
PROVIDER: DEMO,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, example screen two

Press **Enter** to open a text editor screen (Figure 2-6).

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

Figure 2-6: Using ScreenMan, example screen three

2.4 Full Screen Text Editor (Roll and Scroll)

While many of the data entry items are coded entries from existing tables, there can be extensive free 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 Arrow** keys 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.

When entering a lengthy narrative, users have the option of typing the narrative in a traditional word processing application like **Word** or **Word Perfect** and then pasting the text into the open **RPMS** window.

Lists the most commonly used **RPMS** text-editor commands (Table 2-1).

Table 2-1: RPMS Text Editor commands

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

Figure 2-7 and Figure 2-8 show examples of **Text Edit** screens.

```
==[ 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, example screen one

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: DEMO,SHIRLEY
Patient Name:  DEMO,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, example screen two

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

  These commands will also save the data and exit the data entry screen.

2.5 Word Processing Editors (Roll and Scroll)

If users see what is displayed in Figure 2-9 when entering a word-processing field, then the default editor has been set to the RPMS line editor.

```
1>
```

Figure 2-9: RPMS Line Editor default

Users can change to the full-screen editor, as follows:

1. At any menu prompt, type **TBOX** (Figure 2-10). 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 displays.

3. Press the **Down Arrow** key to move to the **Preferred Editor** field. To change the preferred editor to the **Screen Editor**, type **SC**. Continue to press the **Down Arrow** key until the cursor reaches the **Command** prompt.

4. At the **Command** prompt, type **S** and press **Enter** to save all changes. Type **E** and press **Enter** to **Exit** the screen. Figure 2-11 shows the **Edit User Characteristics** screen and fields.

```
                          EDIT USER CHARACTERISTICS
NAME: DEMO,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 (Figure 2-12) that have the same functional controls on them. Generally, these are **Crystal Report** windows.

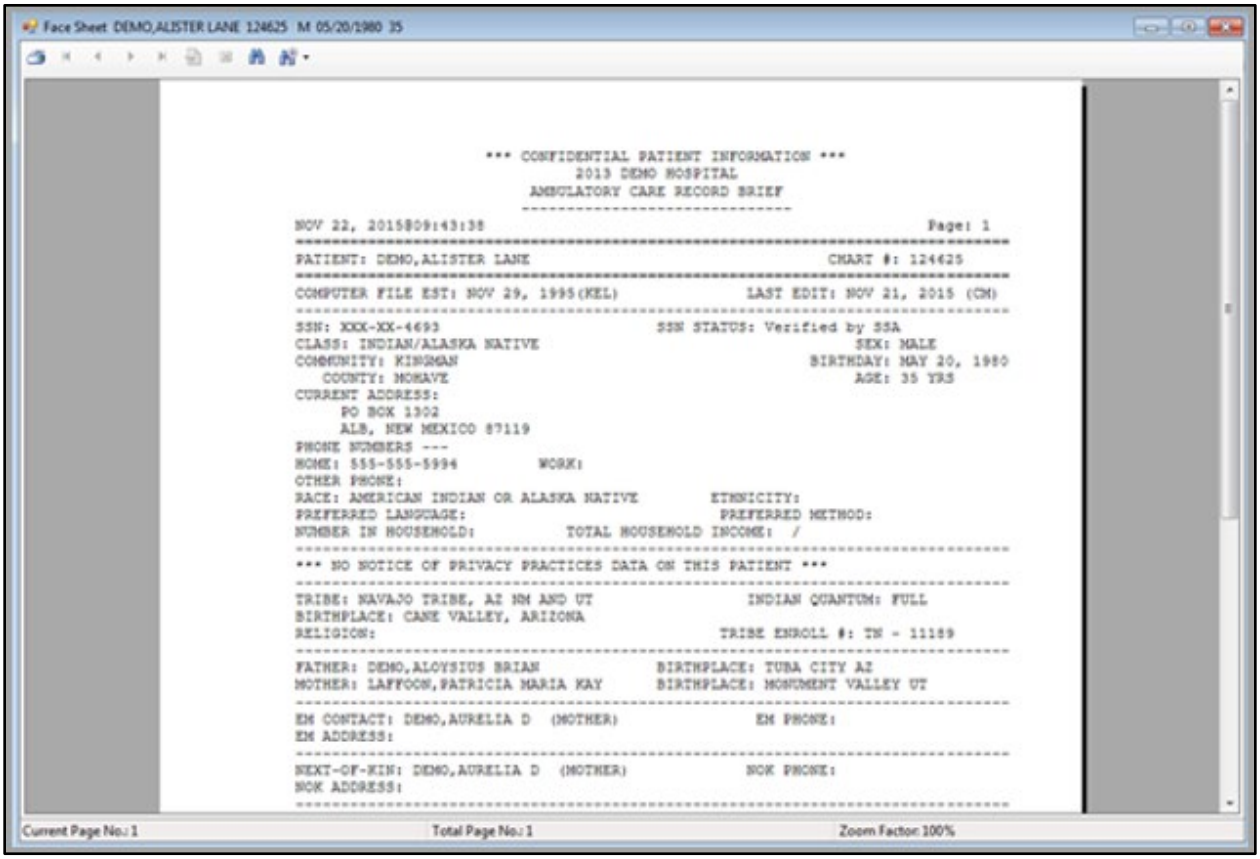


Figure 2-12 Pop-Up window example

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

- Use the scroll bar

Or

- Double-click any line of text. Then use the **Up** and **Down Arrow** keys to scroll.

The information on the last line of the pop-up window (Figure 2-13) 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: Last Line on the pop-up window example

The pop-up window only displays the first page (when the user first accesses 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 of the window function just as the **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.

2.6.2.1 Print Report Button

Use the **Print Report** button ( ) to output the text on the pop-up window. Once clicked, the **Print** dialog (Figure 2-14) displays.

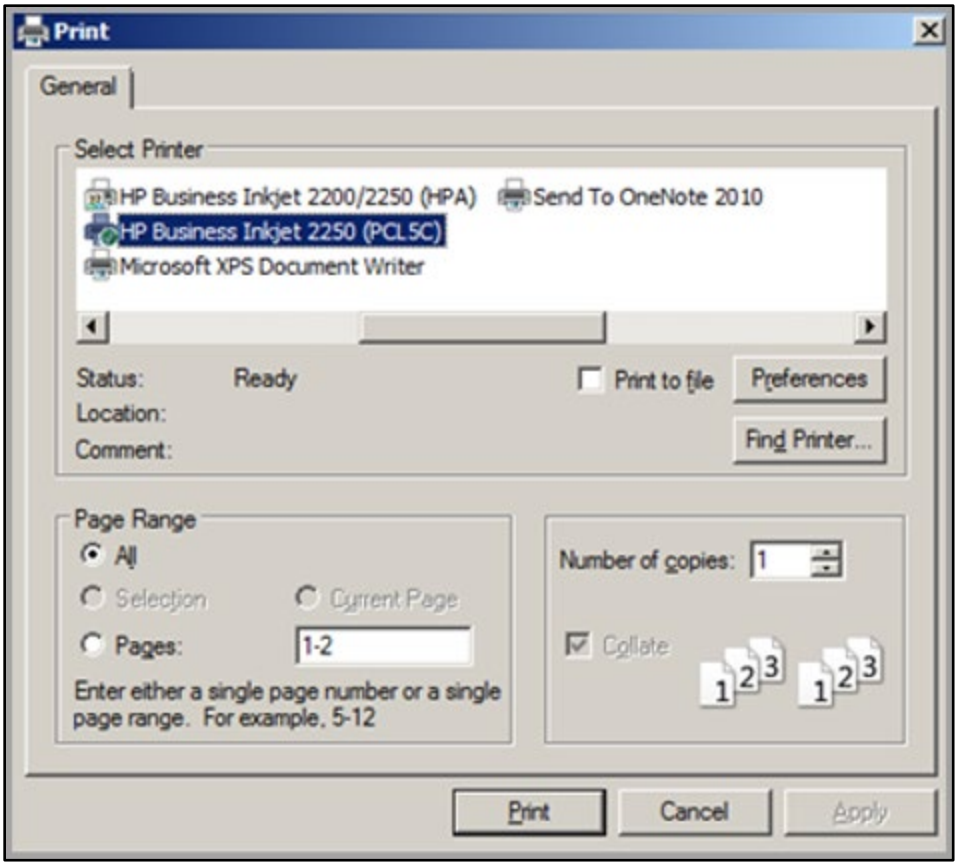


Figure 2-14: Print dialog

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

2.6.2.2 Move to Page Buttons

The **Move to Page** () buttons provide the means to go to adjacent pages in the text of the pop-up.

From left to right, the buttons do the following:

- Go to the first page
- Go to the previous page
- Go to the next page
- Go to the last page

2.6.2.3 Go to Page

Use the **Go to Page** button () to specify a page to move to. Once clicked, the application displays the **Go to Page** dialog (Figure 2-15).

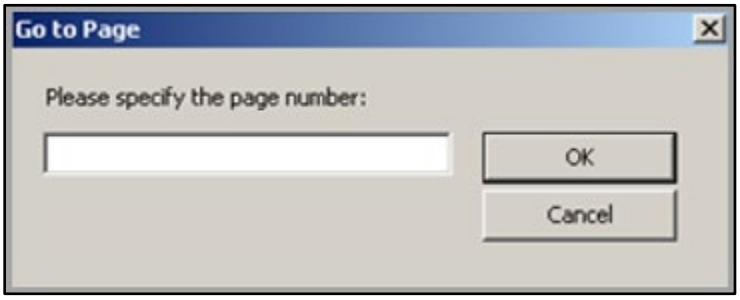


Figure 2-15: Go to Page dialog

1. Type the **page number** to go to in the free-text field.
2. Click **OK** to display the particular page of the pop-up (otherwise, click **Cancel**).

If a page is specified outside the range of pages in the pop-up, the application will display a blank page.

2.6.2.4 Find Text

Use the **Find Text** () button to access the **Find Text** dialog (Figure 2-16).

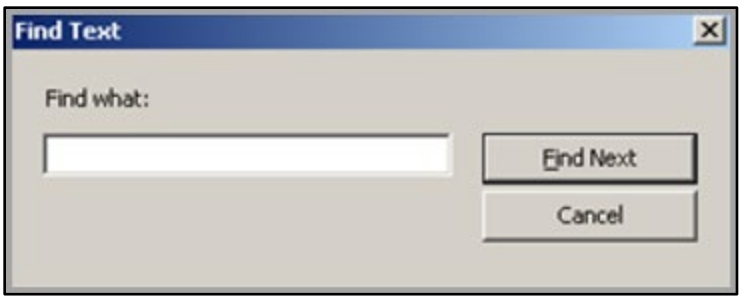


Figure 2-16: Find Text dialog

1. In the field, type the **text** to search for in the pop-up window.
2. Click **Find What** to search for the text screen. (Otherwise, click **Cancel**.)

   The **Find Next** function causes the application to search the text of the pop-up for the text string and to highlight the line of text containing the first occurrence of the text string.
3. Keep clicking **Find Next** to search for the next occurrence of the text string.

   When there are no other occurrences, the system displays the **Crystal Report Windows Forms Viewer** information message that states that the application has finished searching the document.
4. Click **OK** to close the information message. The focus returns to the **Find Text** dialog.

2.6.2.5 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 list.

Note:	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** in the field:

- Type **M** in the day item to set the day to Monday; type **09** in the month item to change 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 list** to display the calendar. The calendar always indicates the current date.

Figure 2-18: Calendar for Date Field example

2. Change to another **date** by clicking it. The selected date will display in the **Date** field.
3. Press the **Left** or **Right Arrow** key to move from month-and-day to the next month-and-day.
4. To change the year, click the **year label** and click the **Up** and **Down Arrow** buttons to step through the years.

Figure 2-19: Change Year

5. To display the previous or next month's calendar, click the **Left** or **Right Arrow** buttons.
6. To display a specific month, click the **month label**, and select from the list (Figure 2-20) displayed.

Figure 2-20: List of months to select

7. Right-click the **month label** to select **Go to Today** and return to today's **date**.
8. Press the **Up** and **Down Arrow** keys to step through the calendar week by week.
9. Press the **Left** or **Right Arrow** keys to step through the calendar day by day.

2.8 Using the Search Window (GUI)

Several fields in the application have a 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.

1. Click **Close** to dismiss the window and return to the previous window.
2. At the **Search String** field, type a few characters of the search criteria.
3. Click **Search** to display the retrieved records in the **Community** list box.
4. Select a **record** and click **OK** to populate the appropriate field on the open form. (Otherwise, click **Close**.)

> **Note:** 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 list that accesses a search/select window.

For example, the **Add** button on the **Purpose of Visit (POV)** tab of the **Visit Data Entry** screen displays the dialog in Figure 2-22.

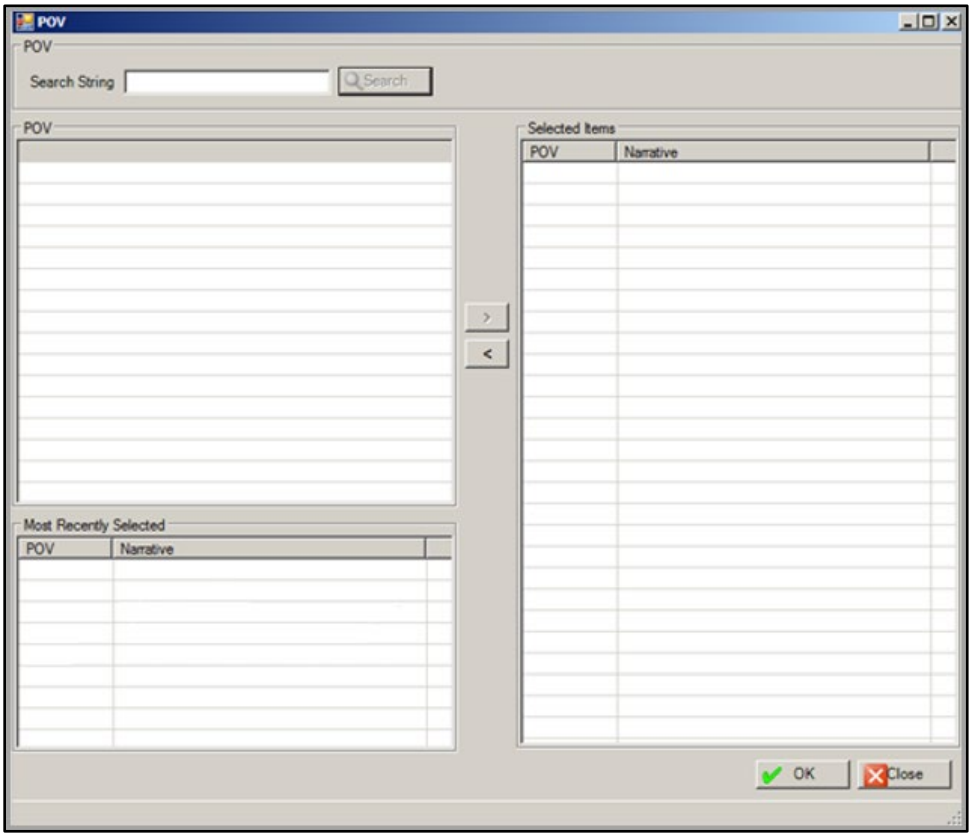


Figure 2-22: Sample Search/Select window

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

1. Click the **Close** button to dismiss the window and return to the previous window.
2. At the **Search String** field, type a few characters of the search criteria.
3. Click **Search** and the retrieved records display in the **POV** list box.
4. To add one or more records from the **POV** group box to the **Selected Items** list box, click the **Right Arrow** button.
5. To add one or more records from the **Most Recently Selected** list box to the **Selected Items** list box, click the **Right Arrow** button.

   Similarly, remove one or more selected records from the **Selected Items** list box by clicking the **Left 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 list that accesses a multiple-select window, for example, the **AXIS IV** select window (Figure 2-23), as shown below.

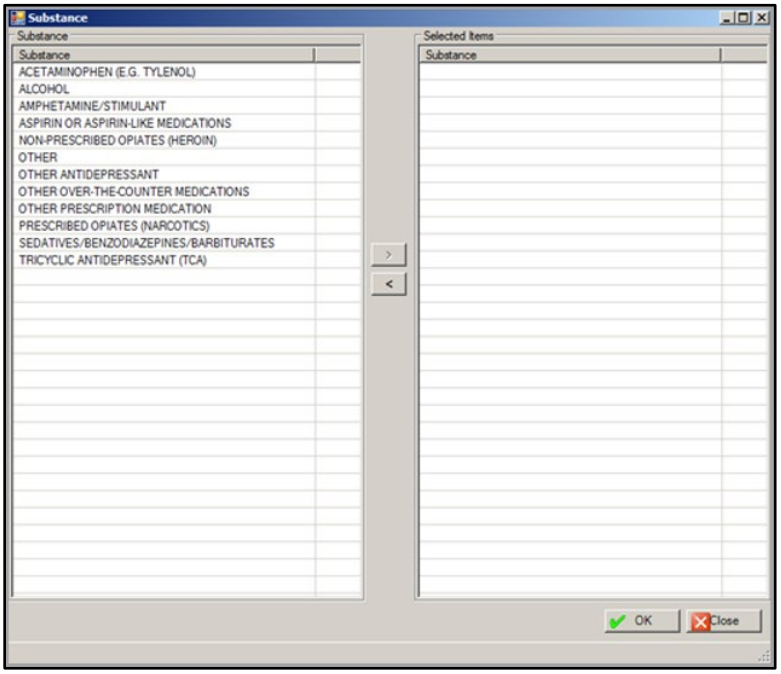


Figure 2-23: AXIS IV multiple-select window example

1. Click the **Close** button to dismiss the window.

2. To add one or more selected items in the **Substance** list box to the **Selected Items Substance** list box, click the **Right Arrow** button. Select more than one **code** by holding down the **Ctrl** key and selecting the next **code**.
3. To move one or more selected records from the **Selected Items Substance** list box to the **Substance** list box, click the **Left Arrow** button.
4. When the **Selected Item** list box is complete, click **OK**.

2.11 Free-Text Fields (GUI)

Free-text fields are fields that users can type information into. These fields do not have a list to select an option from to populate it.

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

There is a context menu to aid in editing the text (Figure 2-24).

Figure 2-24: Context menu aid in editing text

These options operate just like those in any **Windows** application. The meanings of the actions are as follows:

- **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:** For long **Free-Text** fields, users can type the contents of the field in a word processing application to check spelling and view the entire text string. Then, copy the text string from 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 AMH (GUI)**.

2.12.1 Patient Selection (Roll and Scroll)

The application displays the **Select Patient** prompt.

Type a few **characters (at least three)** of the patient's **last name**, **Social Security Number (SSN)**, **Health Record Number (HRN)**, or **date of birth** (use format MM/DD/YYYY).

The application accepts 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 the **One Patient** option has been selected (such as under **Visit Encounters**).
- To change patients. Change patients by selecting **Patient | Select** or right-clicking the **menu tree**.

In either case, the application displays the **Select Patient** dialog (Figure 2-25).

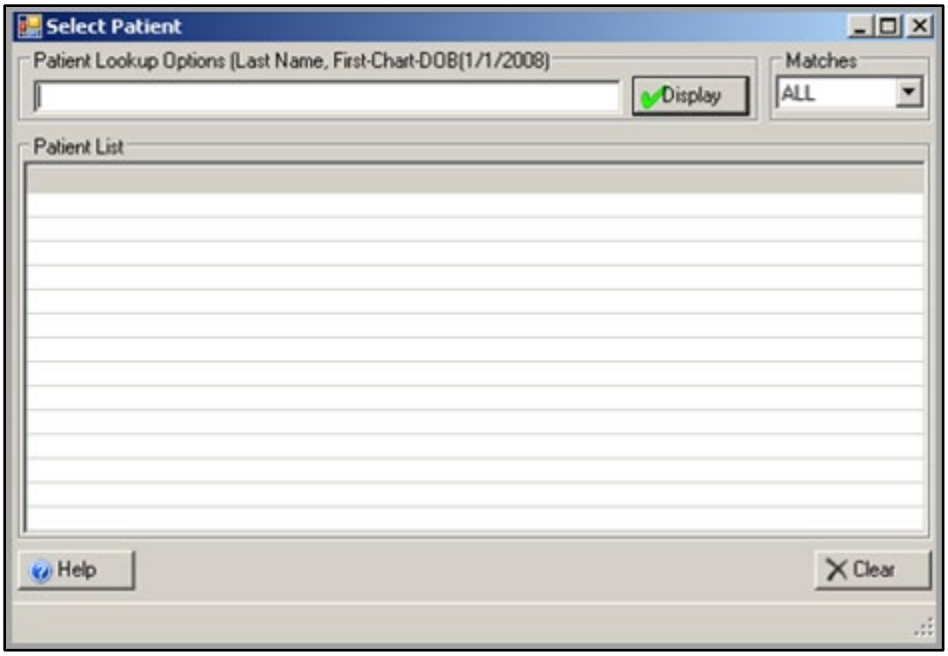


Figure 2-25: Select Patient dialog

- Click the **Help** button to access the **online help** for this dialog.
- Click 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 three)**, **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 accepts 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** list (the default is All).

3. Click **Display**.

Note:	The application retrieves the valid candidates and displays them in the **Patient List** box (Figure 2-26). If there are no candidates, the list box remains empty, and a message displays in the bottom-left corner stating **0 records found**.

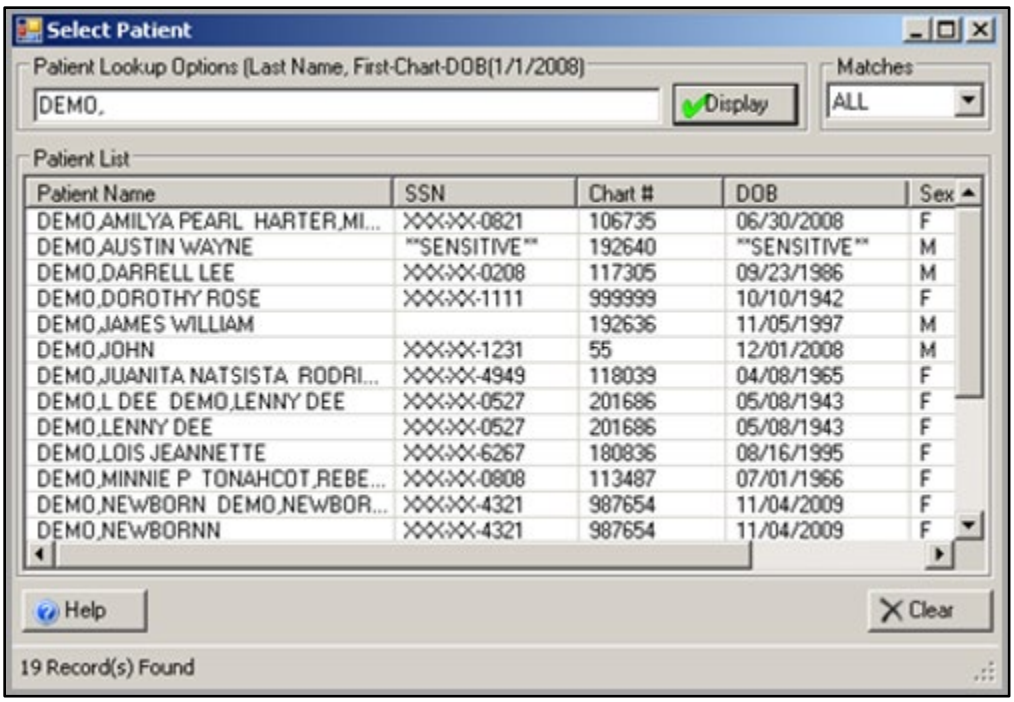


Figure 2-26: Select Patient dialog example

4. Use the **scroll bars** to scroll through the retrieved names.
5. Double-click the **patient** to select it. 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) tries to access 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, refer to 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 (Figure 2-27).

GUI Example

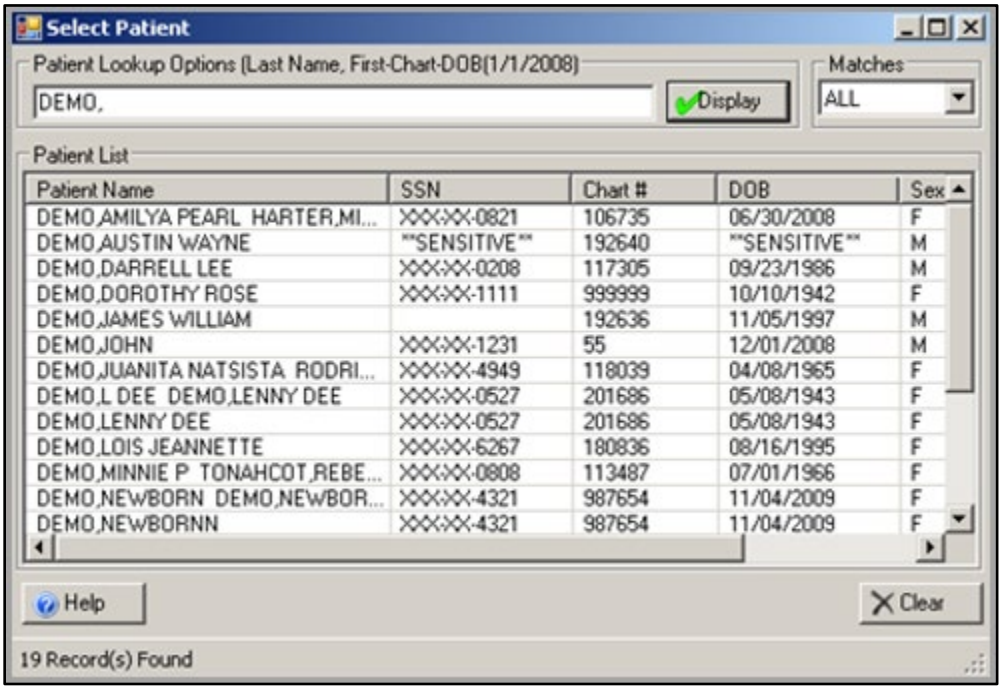


Figure 2-27: Select Patient dialog showing sensitive patient example

Figure 2-28 displays the warning message users 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 the user returns to the **Select Patient** dialog.)

Roll and Scroll Example

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

- The **Restricted Record** warning message is shown in Figure 2-29.

```
*** 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

- A simple **warning message** shown in Figure 2-30.

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

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

- Press **Enter** to access the patient's record.
- Type 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. 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

Prompts will appear for the electronic signature on **SOAP/progress** notes (Figure 2-32). Users should not enter their credentials (such as MD) under both the **block name** and **title** or it will appear twice. Make sure the signature block printed name contains the user's **name** and (optionally) **credentials**.

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

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

- When the following prompt appears in RPMS, it means the user already has an electronic signature code.

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

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

3. When the following **prompt** (Figure 2-34) appears in **RPMS**, enter a new **code**.

```
Enter code:
```

Figure 2-34: Prompt for a new code

4. Enter a new **code** (using between 6 and 20 characters) with **Caps Lock ON**.

   However, when the **electronic signature** is entered (on a note for example), it can be in lower case. No special characters are allowed in the code.

   - If you forget the **code**, it must be cleared out by the **Site Manager**. Then a new one must be created. You are the only user 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 **AMH**.
- 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.

Figure 2-35 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: Date/time stamp for electronic signature example

2.14.4 Assign PCC Visit

The application applies 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** determines 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)

After entering a **SOAP/progress note**, the application displays the **Sign?** dialog (Figure 2-36).

Figure 2-36: Sign dialog

1. Click **No** to save the encounter record without a signature to the note.
2. Click **Yes** and the application displays the **Electronic Signature** dialog (Figure 2-37).

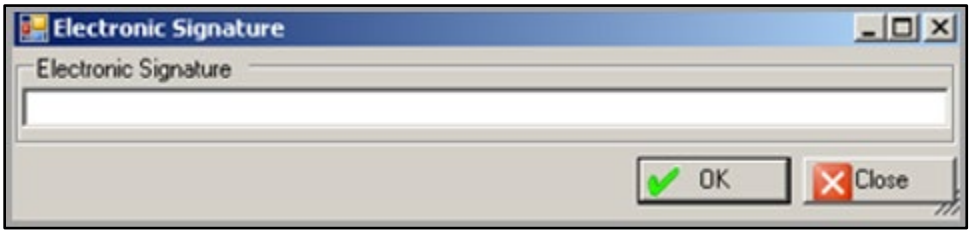


Figure 2-37: Electronic Signature dialog

3. Type your valid **electronic signature** and click **OK**. This process saves the encounter with a signed note.
   - If you enter an invalid **electronic signature** and click **OK**, the application displays the Invalid notice that states: **Invalid Signature Code**.
   - Click **OK** and the focus returns to the **Electronic Signature** dialog.
4. Click **Close** on the **Electronic Signature** dialog and the application displays the **Are You Sure?** Dialog (Figure 2-38).

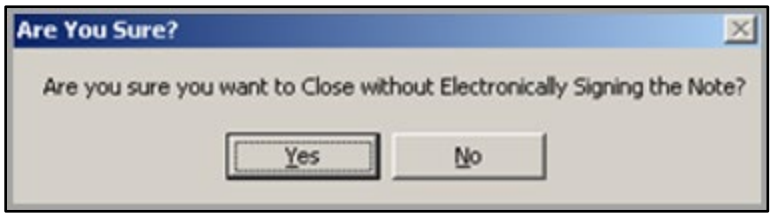


Figure 2-38: Are you Sure? dialog

5. Click **No** and the focus returns to the **Electronic Signature** dialog.
6. Click **Yes** and the application displays the **Message** dialog (Figure 2-39).

Figure 2-39: Message dialog

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

2.15 Login to GUI

If this is the user's first time logging into the GUI, the **IHS Behavior Health System Login** dialog (Figure 2-40) displays.

Figure 2-40: IHS AMH Login dialog example

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

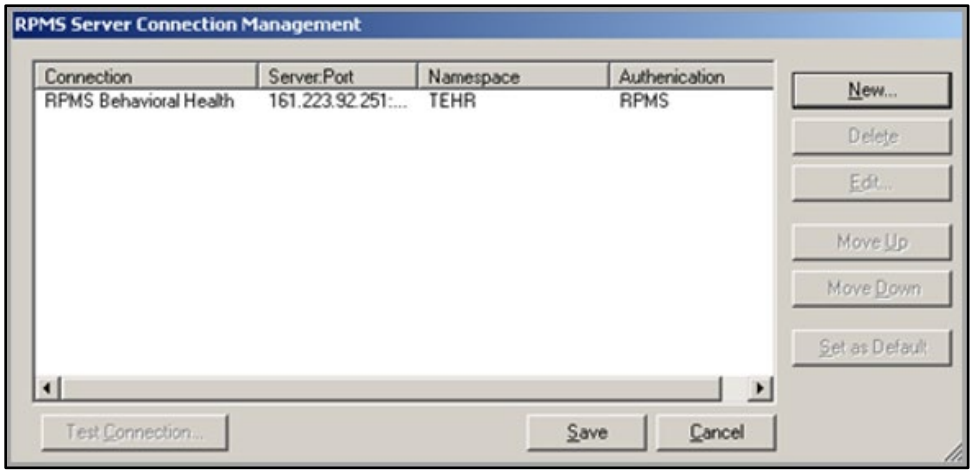


Figure 2-41: RPMS Server Connection Management dialog example

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.

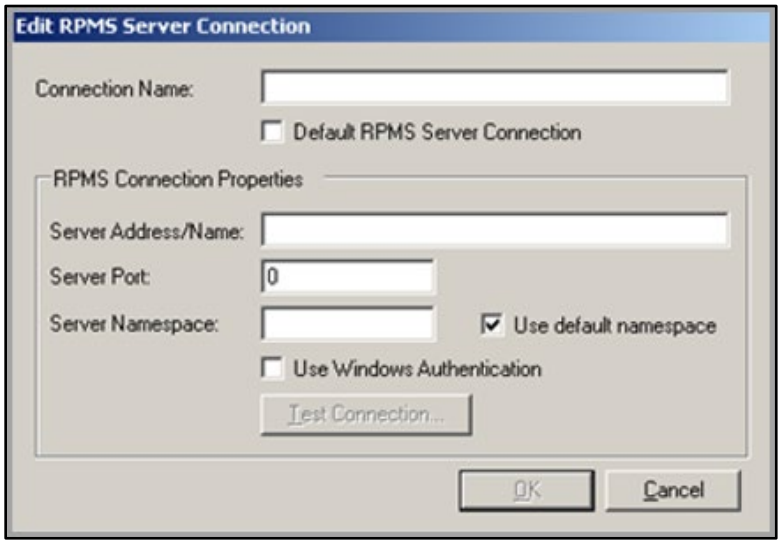


Figure 2-42: Edit RPMS Server Connection dialog example

   - Do not select the **Default RPMS Server Connection** or **Use Windows Authentication** checkboxes.

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 (**.**), for example, 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 (for example, **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. Click the **Test Connection** button to display the **Test Login** dialog.

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.

9. After the **Edit RPMS Server Connection** dialog is complete, click **OK** (otherwise, click **Cancel**).

   Clicking **OK** saves the information, and this information displays on the **RPMS Server Connection Management** dialog.

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

11. After clicking Save on the **RPMS Server Connection Management** dialog, the application displays the **IHS AMH Login** dialog (Figure 2-43).

Figure 2-43: Login dialog example

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 AMH** tree. (Otherwise, click **Cancel**.)

2.16 RPMS AMH Tree

Figure 2-44 is the default display of the **RPMS AMH** tree structure.

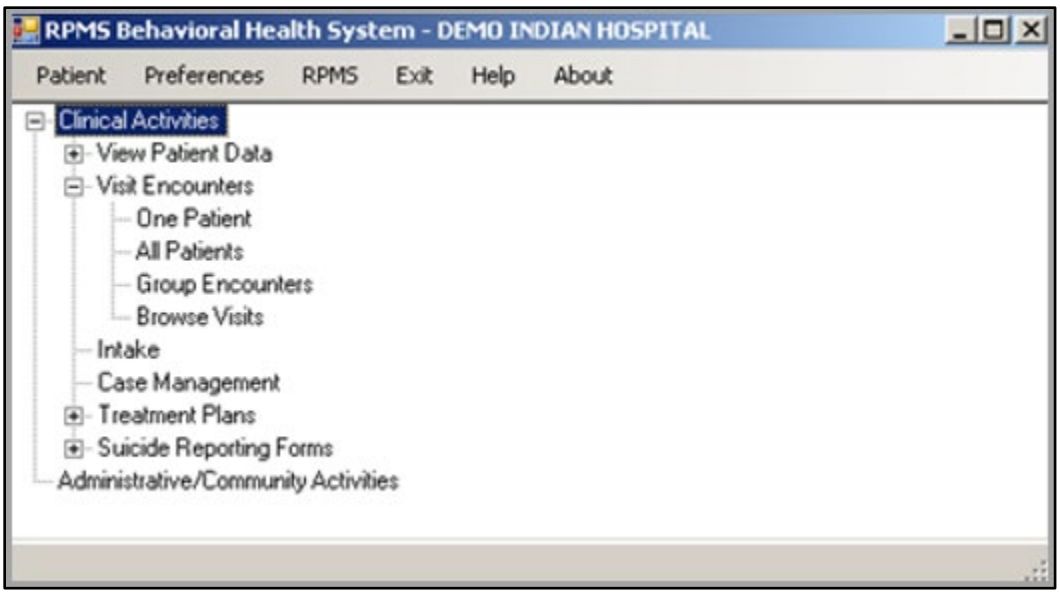


Figure 2-44: Tree structure for the RPMS AMH

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

- Click the **Minus** icon (**-**) to collapse the option. The icon will change to the **Plus** icon (+). The **View Patient Data**, **Treatment Plans**, and **Suicide Reporting Forms** options are collapsed in the screen capture above.
- Click the **Plus** icon (+) to expand the option. The icon will change to the **Minus** 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 (Figure 2-45) to select another division, as well as change the font on the main menu tree.

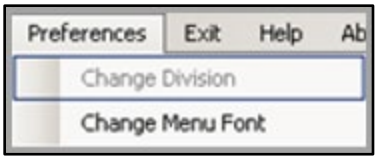


Figure 2-45: Preferences menu options

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. This option applies to a site that uses more than one RPMS database.
2. Select **Change Menu Font** to access the **Font** dialog (Figure 2-46). Use this option to change the font on the tree structure.

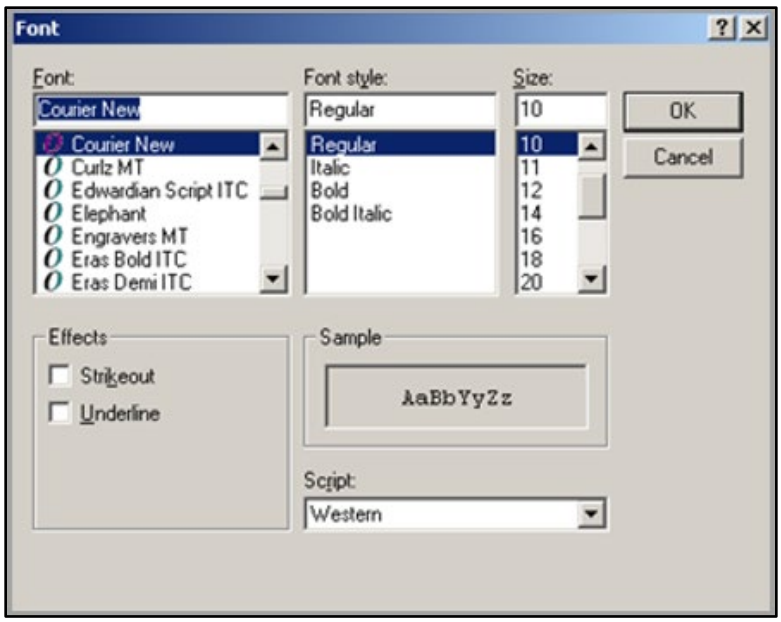


Figure 2-46: Font dialog

a. Use the **Font** dialog to change the Font name, style, and size of the text on the tree structure. In addition, you can add effects like Strikeout and Underline. These perform like those effects in Microsoft Word. Most users change the font size.

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

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

RPMS Menu

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

- On the **RPMS Terminal Emulator** window, select **File | Connect** to access the **Connect** dialog. Populate the **Host** field with the **IP address** and click **OK**.

Note: It is not necessary 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 log in (the application pre-populates the required fields).

- After completing the activities in **RPMS**, select **File | Exit** to 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:

Are you sure you want to Exit?

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 AMH (GUI)**.

3.1 Roll and Scroll

Documentation of patient care and documentation of administrative and group encounters all should be completed in the BHS GUI not the roll and scroll application. Below are screen shots to show the additional functionality available to view patient information, if needed.

```
            ******************************************
            **       IHS Behavioral Health System       **
            ******************************************
                          Version 4.0 (Patch 11)

                          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 includes the options as shown in Figure 3-2.

```
                  ******************************************
                  **       IHS Behavioral Health System       **
                  **             Data Entry Menu              **
                  ******************************************
                            Version 4.0 (Patch 11)

                             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

Table 3-1 provides an overview of the options on the **Data Entry** menu.

Table 3-1: Data Entry menu options

Option	Use
Enter/Edit Patient/Visit Data — Patient Centered (PDE)	Documents a patient encounter and displays all the information required for a single patient from a single screen.
Enter/Edit Visits Data — Full Screen Mode (SDE)	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 AMH Graphical User Interface (GUI)

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

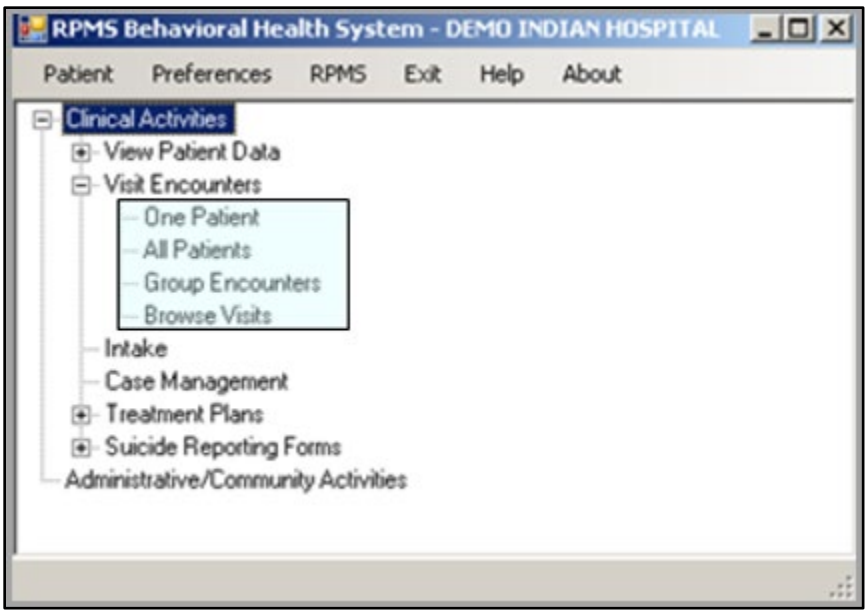


Figure 3-3: Location of Visit Encounters category on tree structure

- **One Patient:** Manage the **visits** for the one patient within a particular date range.
- **All Patients:** Manage the **visits** for all of the patients within a particular date range.
- **Group Encounters:** Manage the **Group Encounter** data for group encounters within a particular date range.
- **Browse Visits:** 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 AMH** and the **BHS GUI**.

4.1 Visit Window (GUI)

AMH (GUI) tree structure. You access the **Visit** window (Figure 4-1) for one patient.

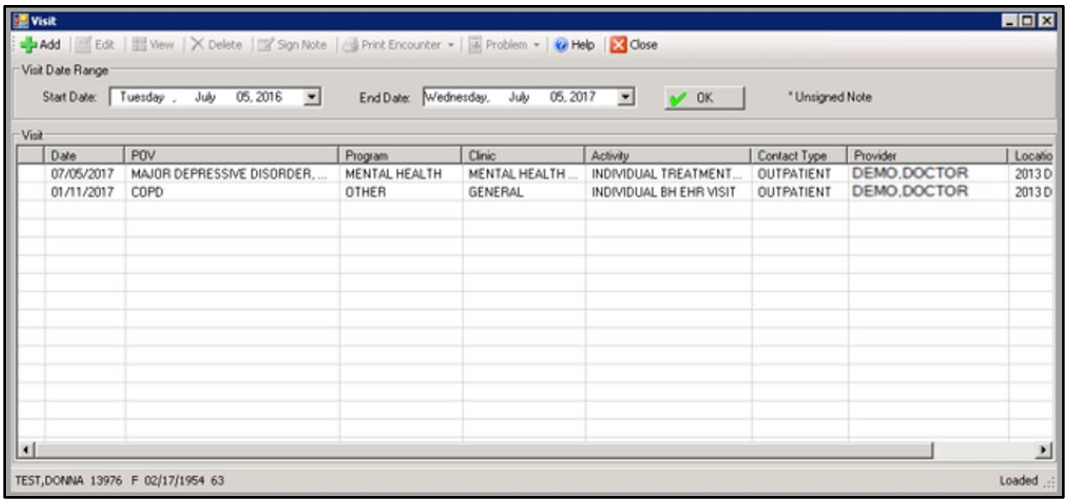


Figure 4-1: Visit window for one patient

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 AMH (GUI)** tree structure. You access the **Visit** window (Figure 4-2) for all patients.

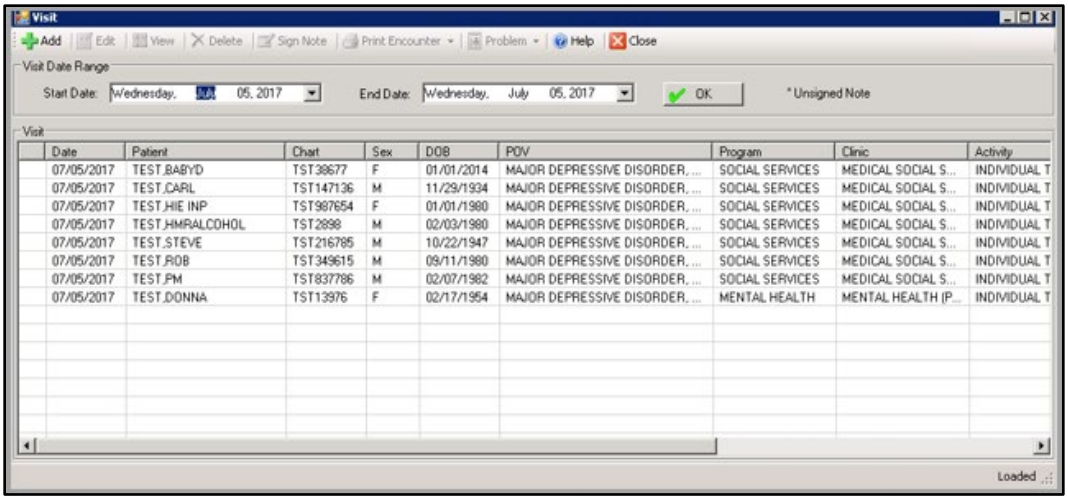


Figure 4-2: Sample Visit window for all patients

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. Table 4-1 provides information about the other features of the window.

Table 4-1: Visit window features and functions

Feature	Functionality
Visit window (for one patient)	The default **Start Date** is one year prior. Change the date range by clicking the 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 log in 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. Signing a Note (GUI) for more information.
Add button	Establish the patient 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.
Edit button	Use the **Edit** button to edit a particular Visit record. You access the **Visit Data Entry - Edit Visit** dialog.
View button	Use the **View** button (or double-click on a record) to browse a particular Visit record. This window has the same fields as the **add/edit visit** dialog, except for the Intake and **Suicide Form** tabs.

Feature	Functionality
Delete button	Use the **Delete** button to delete a particular Visit record. The application confirms the deletion. **Note:** 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.
Print Encounter button	Use the **Print Encounter** button to print the encounter data about a particular Visit record. The **Print Encounter** button has these options: Full, Suppressed, Both Full and Suppressed. Note that the **Intake** document 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	Click the **Help** button on the Visit window to access the online help for the window.
Close button	Click the **Close** button on the Visit window to exit the window.

4.2 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.

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

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

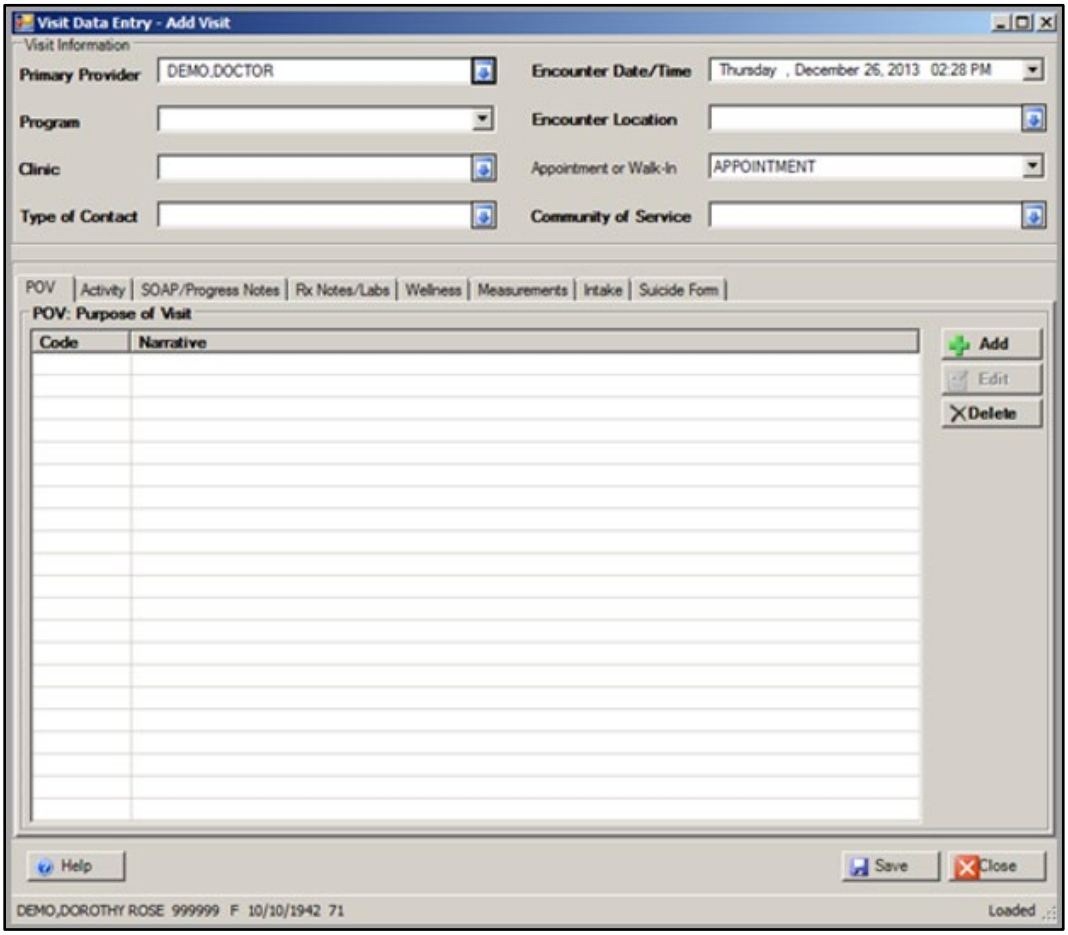


Figure 4-3: Visit Data Entry–Add Visit window

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

Table 4-2: Add Visit window features and functions

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 2.14.5provides 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 4.2.9 provides more information about this window.

  Be aware of the following about this option:

  – If the facility is not using the **Scheduling** package and does not have the **Interactive PCC Link** in the site parameters turned on, you will never be presented with the ability to link it to a **PCC** visit.
  – If there is no visit in **PCC** (patient never checked in, no appointment or walk in was ever created in the **Scheduling** package, and no other clinics saw the patient that day), then the option to link is never presented and the **BH** visit continues to create a new visit in **PCC**.
- The **Close** process displays the **Continue?** dialog. This dialog states: **Unsaved Data Will Be Lost, Continue?**
  – Click **Yes** to not save; this dismisses the data entry window.
  – Click **No** and the focus remains on the data entry window where you can continue work.

4.2.1 Visit Information Group Box

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

Figure 4-4: 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 list to access the **Primary Provider** search/select window (Figure 4-5).

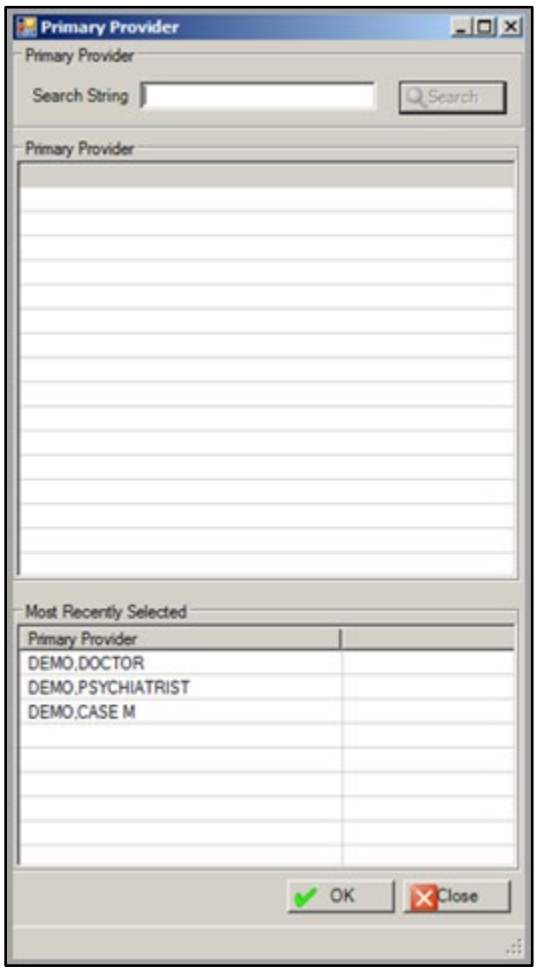
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the **Provider** list box. Select a **retrieved record** and click **OK** to populate the **Provider** 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 4-5: 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 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 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 list to access the **Location** search window (Figure 4-6).

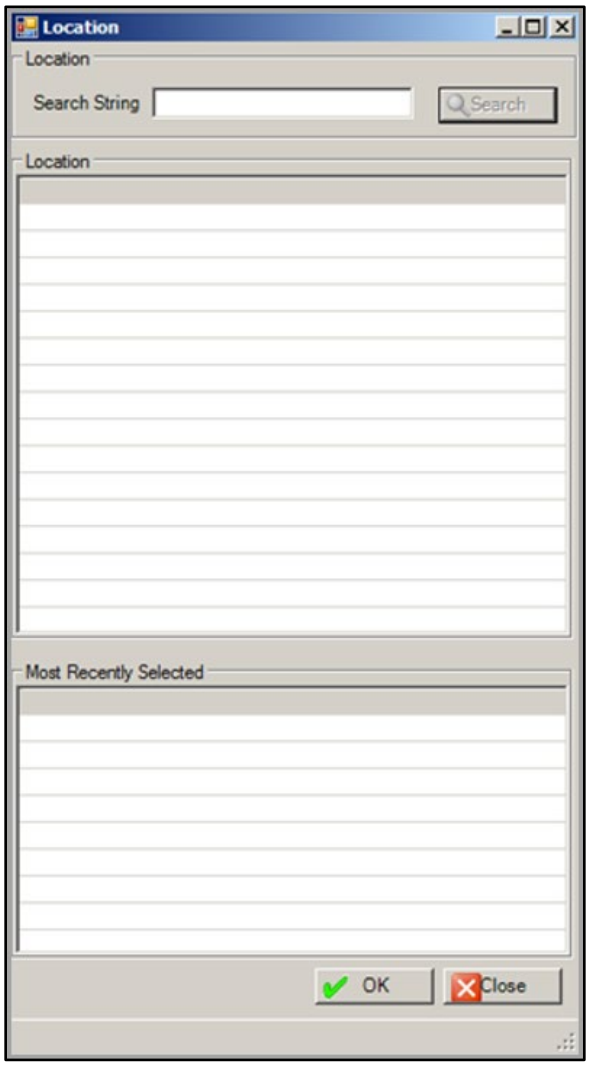
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the location and then clicking **Search**. The retrieved locations will populate the **Location** list box. Select a **location** and click **OK** to populate the **Encounter Location** 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 4-6: 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 **list** to access the **Clinic** search window (Figure 4-7).

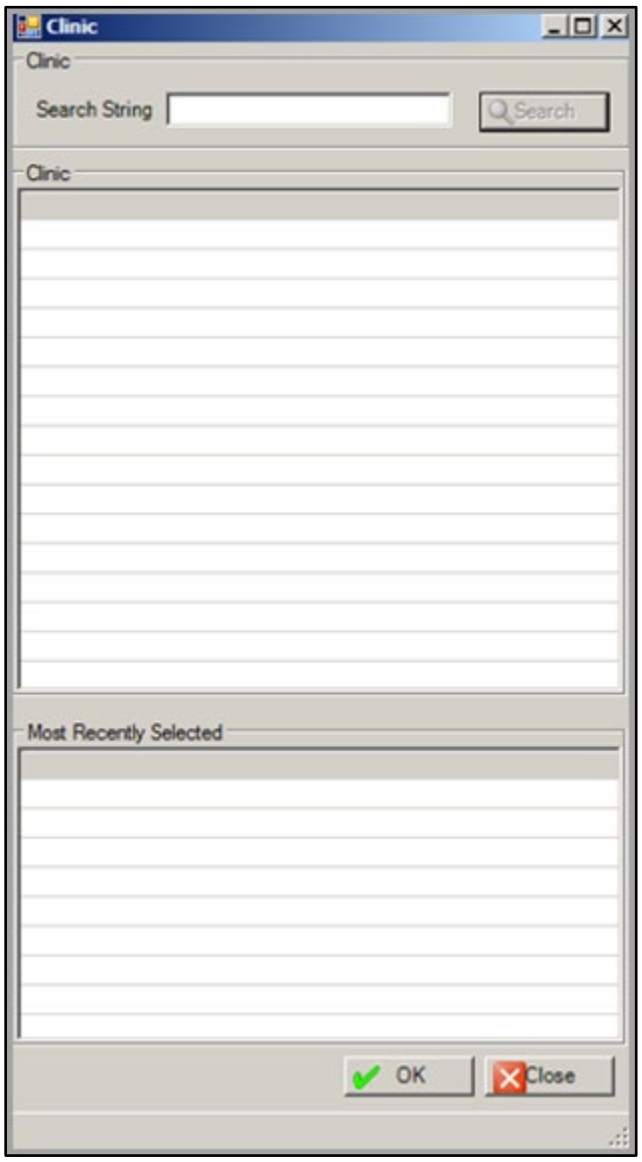
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **clinic** and then clicking **Search**. The retrieved clinics and their codes will populate the **Clinic** list box. Select a **clinic** and click **OK** to populate the **Clinic** 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 4-7: Clinic search window

6. At the **Appointment** or **Walk-In** field, select the type of visit form the 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 **list** to access the **Type of Contact** window (Figure 4-8).

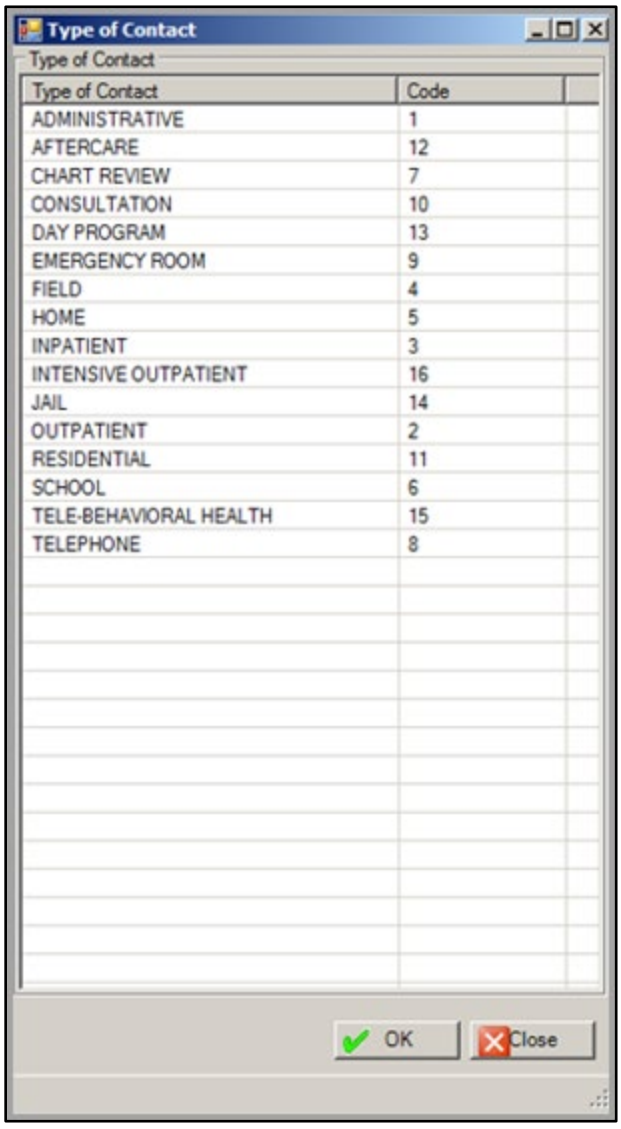
Screen Capture	What to Do
	Use this window as follows: (1) Select a **type** of contact from the list. (2) Click **OK** to populate the **Type of Contact** field. (Otherwise, click **Close**.)

Figure 4-8: 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 list to access the **Community** search window (Figure 4-9).

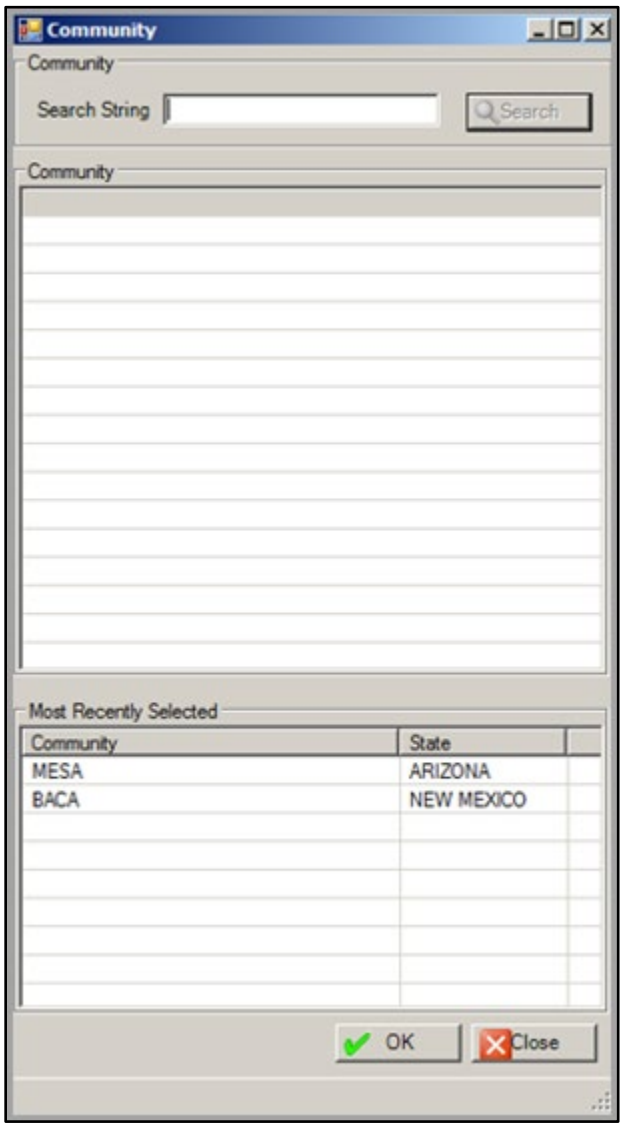
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **community name** and then clicking **Search**. The retrieved community names and their states will populate the **Community** list box. Select a **community** and click **OK** to 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 4-9: Community search window

4.2.2 POV Tab

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

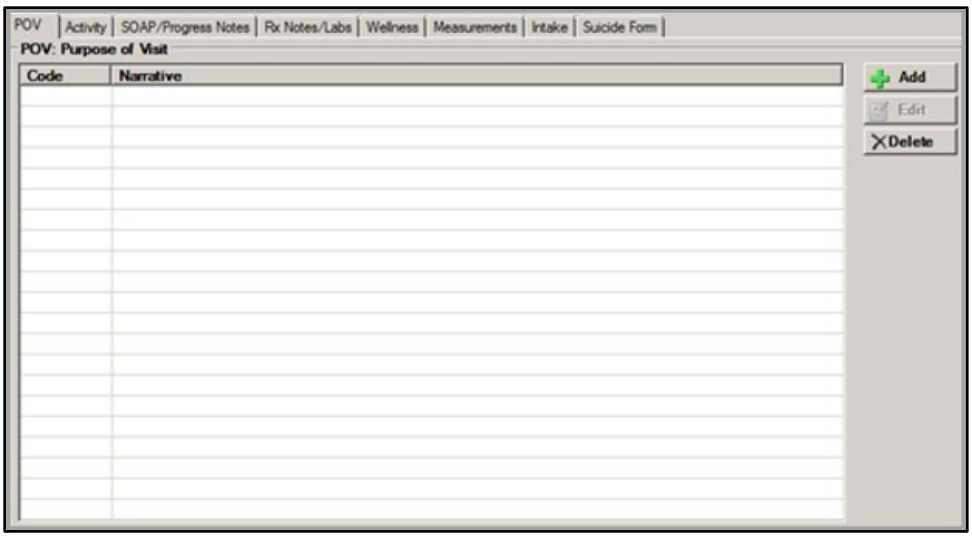


Figure 4-10: POV Tab on Visit Data Entry window

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

4.2.2.1 Add Button

1. Click **Add**.

   The **POV search/select** window (Figure 4-11) displays.

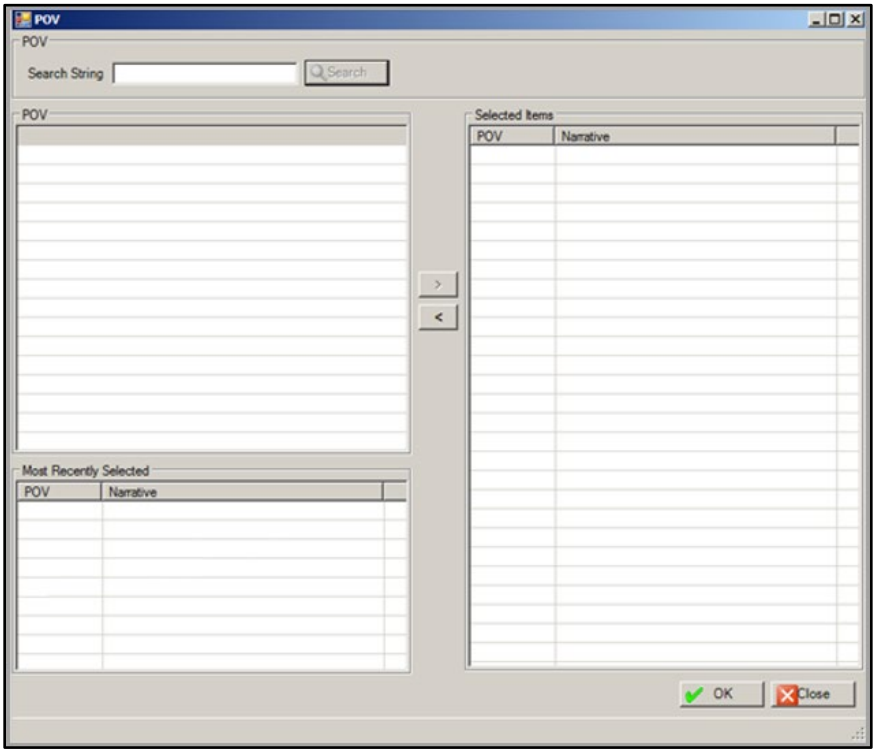


Figure 4-11: POV search/select window

2. At the **Search String** field, type a few characters of the search criteria.
3. Click **Search**. The retrieved the records display in POV list box (the POV and its narrative).
   a. To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the **Right Arrow** button.
   b. In addition, select one or more items in the **Most Recently Searched** list box and click the **Right Arrow** button. This adds those records to the **Selected Items** list box.
   c. Similarly, remove one or more selected records from the **Selected Items** list box by clicking the **Left Arrow** button.
4. When the records in the **Selected Item** list box is complete, click **OK** and the records populate the **POV** tab. (Otherwise, click **Close**.)

4.2.2.2 Delete Button

1. Select the **POV record** to delete.
2. Click the **Delete** button.

   The **Are You Sure** confirmation message displays.
3. Click **Yes** to remove the selected record from the list box. (Otherwise, click **No**.)

4.2.2.3 Edit Button

1. Select a **POV record** to edit.
2. Click **Edit**.

   The application displays the **Edit POV** dialog (Figure 4-12).

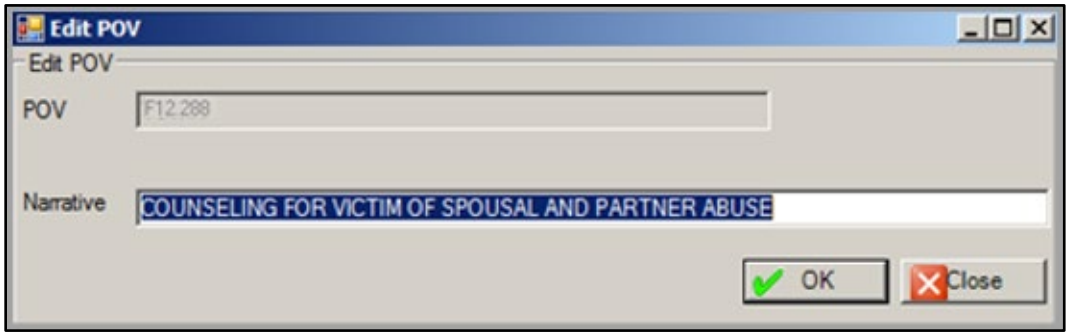


Figure 4-12: Edit POV dialog

3. At the **Narrative** field, type the new **POV** narrative, using **2–80** characters. This is a free-text field.

4. Click **OK** to save the change the narrative of the selected code on the **POV** tab. (Otherwise, click **Close**.)

4.2.2.4 Activity Tab

Use the **Activity** tab (Figure 4-13) to manage Activity data about the visit for the current patient.

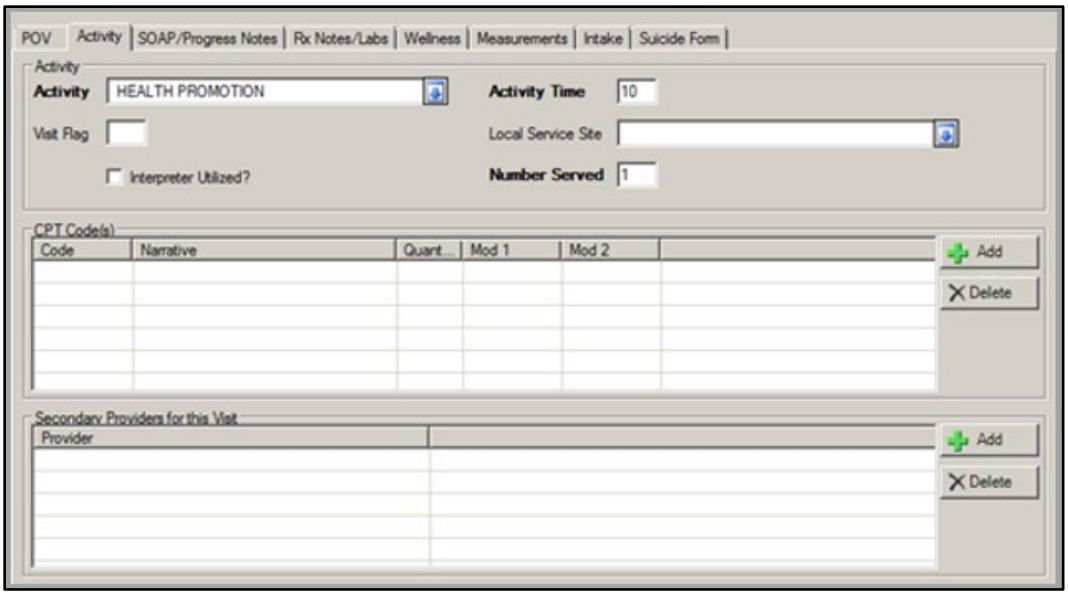


Figure 4-13: Activity tab on the Visit Data Entry window

4.2.2.5 Activity Group Box

Figure 4-14 shows the **Activity** group box.

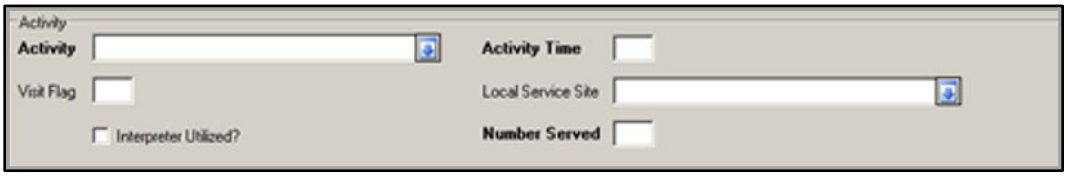


Figure 4-14: Activity group box

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.

2. Click the list to access the **Activity** search window (Figure 4-15) and search for the activity name. Appendix A: Activity Codes and Definitions provides more information.

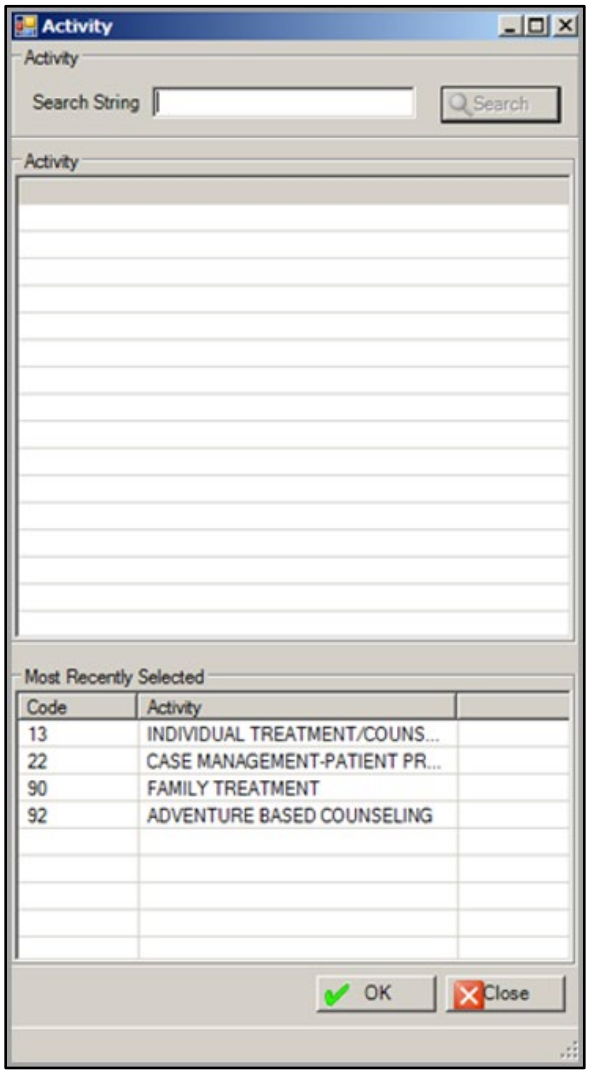
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **activity name** and then clicking **Search**. The retrieved activity code and activity name will populate the **Activity** list box. Select a **retrieved record** and click **OK** 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 4-15: Activity search window

3. 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.

4. 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 that will list all visits on which narcotics were prescribed.

5. At the **Local Service Site** field, select the **local service site**. Click the list to access the **Local Service Site** window (Figure 4-16).

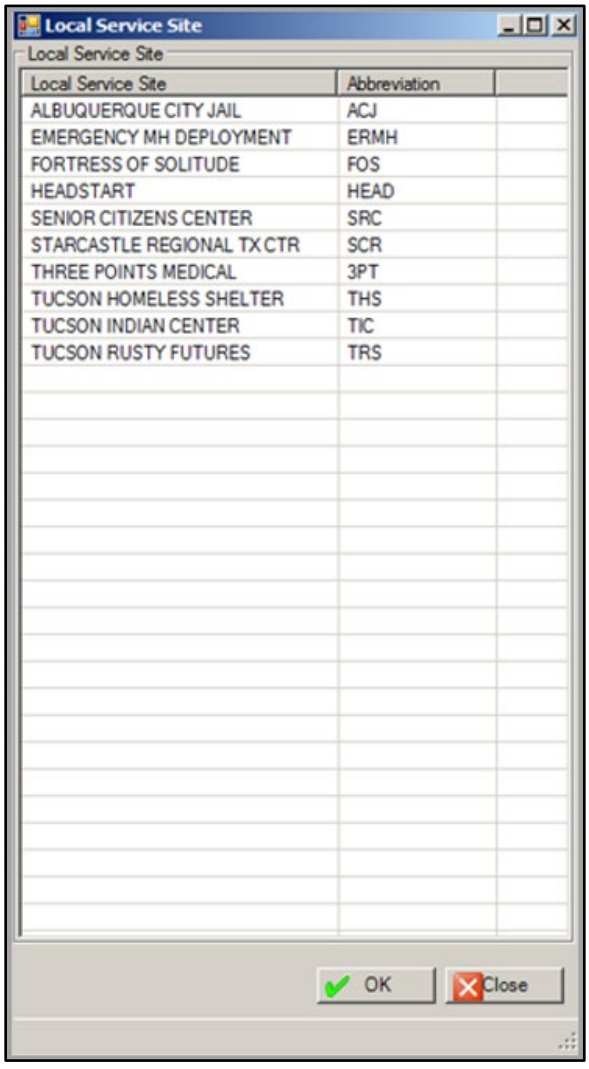
Screen Capture	What to Do
	Use this dialog in one of two ways: (1) Select a **local service site** from the list. (2) Click **OK** to populate the **Local Service Site** field. (Otherwise, click **Close**.)

Figure 4-16: Local Service Site window

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

7. 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.

4.2.2.6 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.

4.2.2.7 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**.)

4.2.2.8 Add Button

1. Click **Add**. The **CPT Code** search/select window (Figure 4-17) displays.

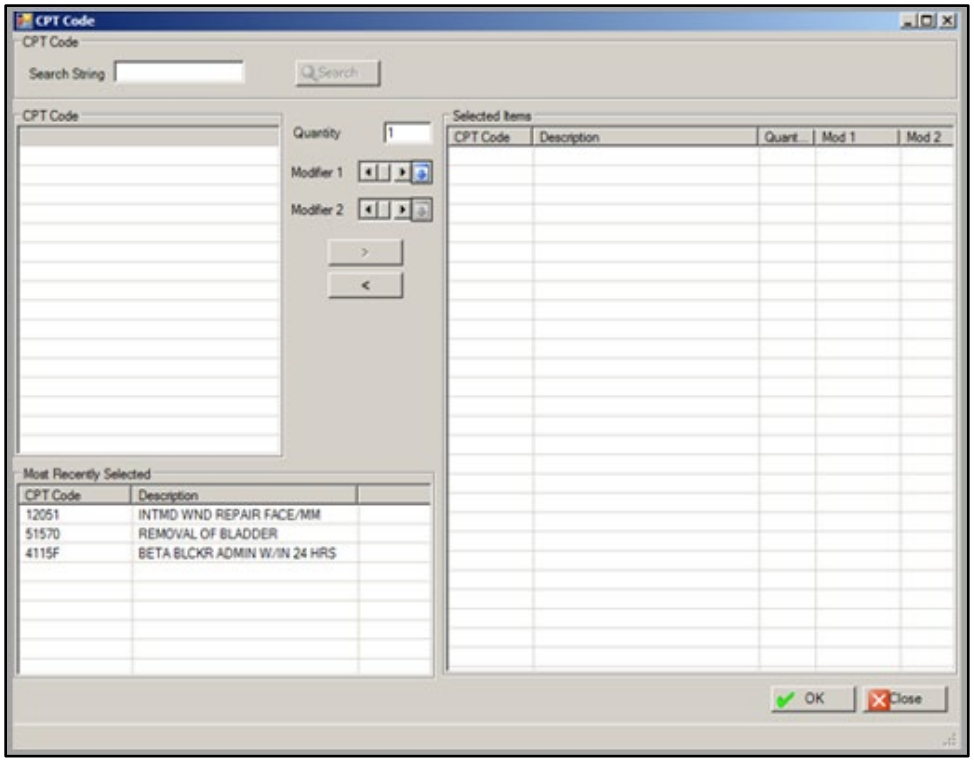


Figure 4-17: CPT Codes search/select window

2. At the **Search String** field, type a search string to search for a particular **CPT Code**.

3. Click **Search**. The **CPT Codes** that match the search criteria display in the **CPT Code** field (Figure 4-18).

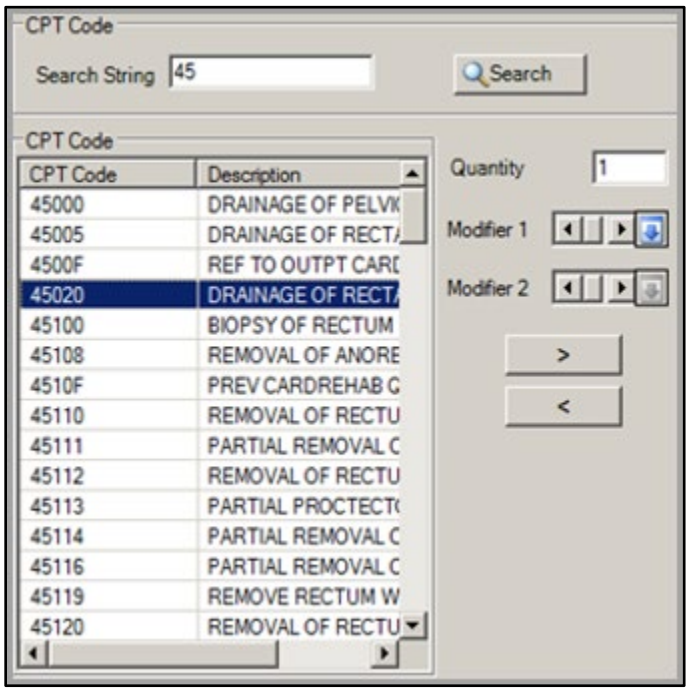


Figure 4-18: CPT Code search results example

4. Select a retrieved **CPT Code**.

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

6. At the **Modifier** field, select the **modifier** for the **CPT Code**. Click the list to access the **CPT Modifier** search window (Figure 4-19).

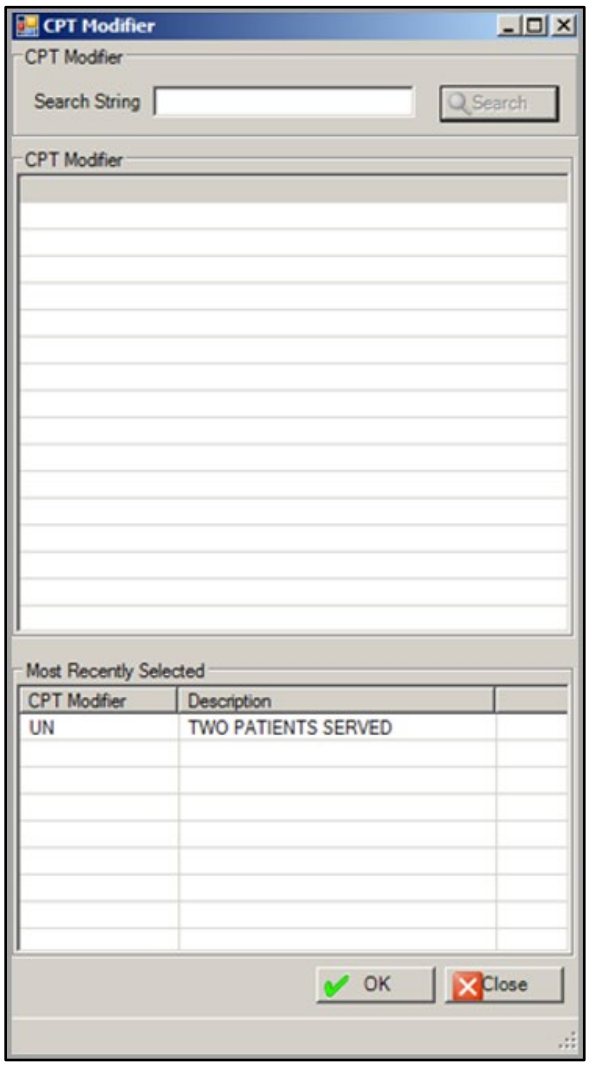
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **CPT Modifier** name and then clicking **Search**. The retrieved **CPT Modifier** names and their descriptions will populate the **CPT Modifier** list box. Select a **CPT modifier** 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 4-19: CPT Modifier search window

7. After the **Quantity** and **Modifier** fields are complete, click the **Right Arrow** button to add the items to the **Selected Items** list box.

   - More than one **CPT Code** can be used in the above process.
   - 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 Arrow** button.
   - Remove a selected **CPT Code** in the Selected Items list box by clicking the **Left Arrow** button.

8. 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**.)

4.2.2.9 Secondary Provides for this Visit Group Box

Use the **Secondary Providers** for this **Visit** group box (Figure 4-20) to manage the secondary providers used during the encounter.

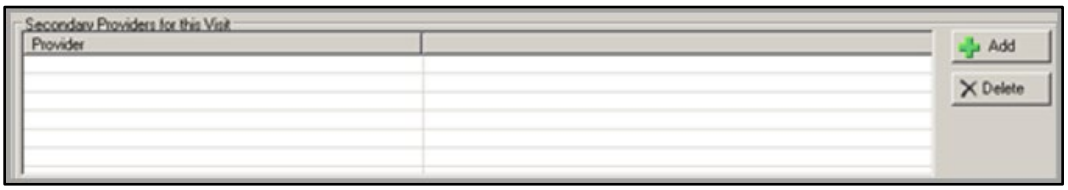


Figure 4-20: Sample Secondary Providers for this Visit group box

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

4.2.2.10 Add Button

1. Click **Add**.

   The **Secondary Providers** multiple search/select window (Figure 4-21) displays.

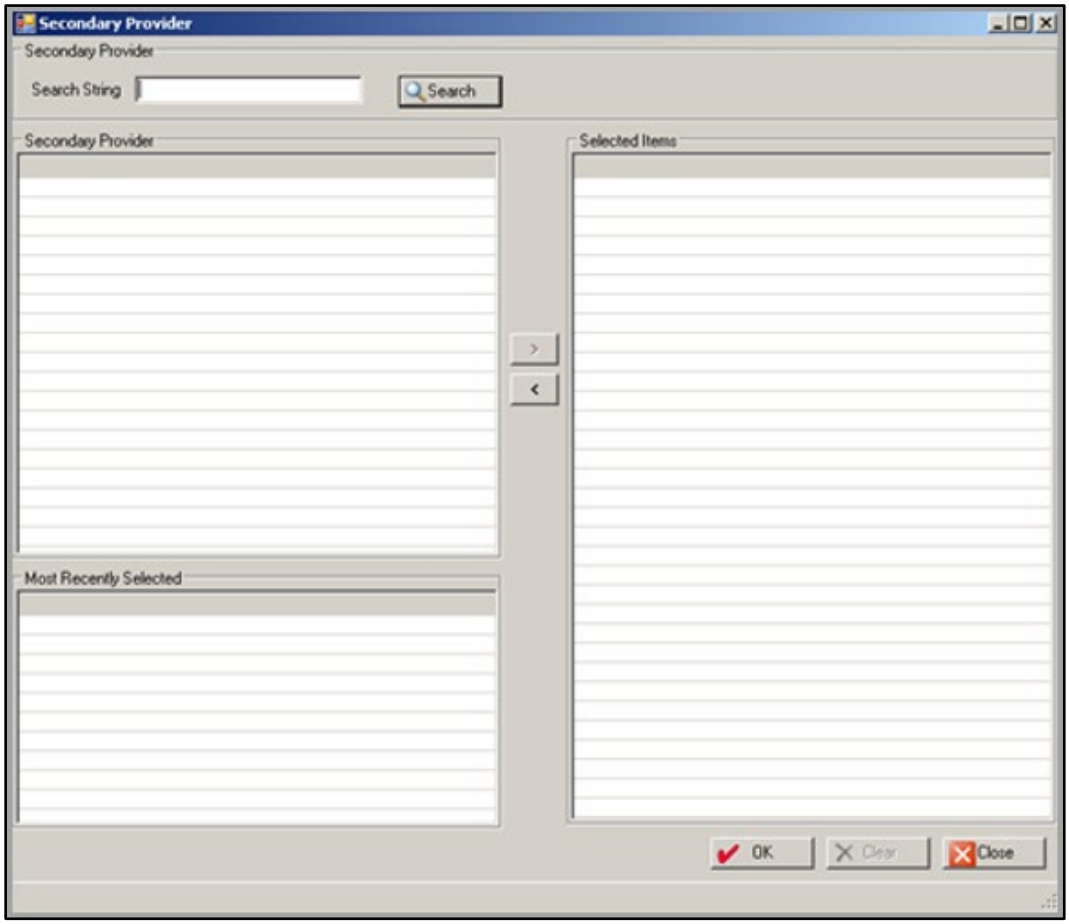


Figure 4-21: Secondary Provider multiple search/select window

2. At the **Search String** field, type a few characters of the **Secondary Provider's** last name.
3. Click **Search** and the retrieved records display in **Secondary Provider** list box.
   - To add one or more selected **records** from the **Secondary Providers** list box to the **Selected Items** list box, click the **Right Arrow** button.
   - To add one or more selected **records** from the **Most Recently Selected** list box to the **Selected Items** list box, click the **Right Arrow** button.
   - Similarly, you can remove one or more selected **records** from the **Selected Items** list box by clicking the **Left Arrow** button.
4. 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**.)

4.2.2.11 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** list for this **Visit** group box. (Otherwise, click **No**.)

4.2.3 SOAP/Progress Notes Tab

Use the **SOAP/Progress Notes** tab (Figure 4-22) 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.

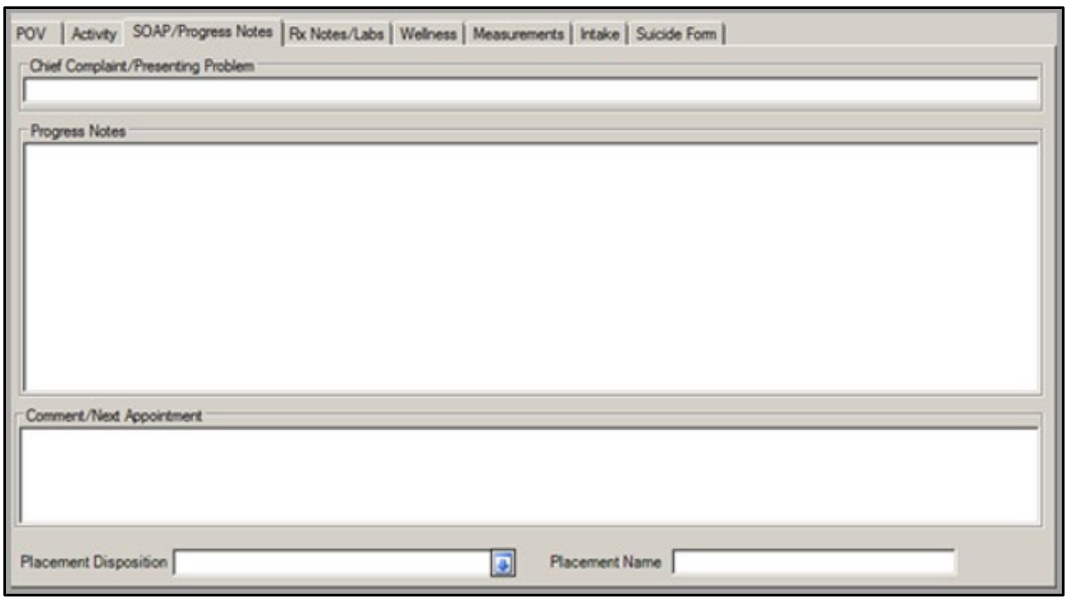


Figure 4-22: SOAP/Progress Notes tab

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, **2–80** 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 list to access the **Placement Disposition** dialog (Figure 4-23).

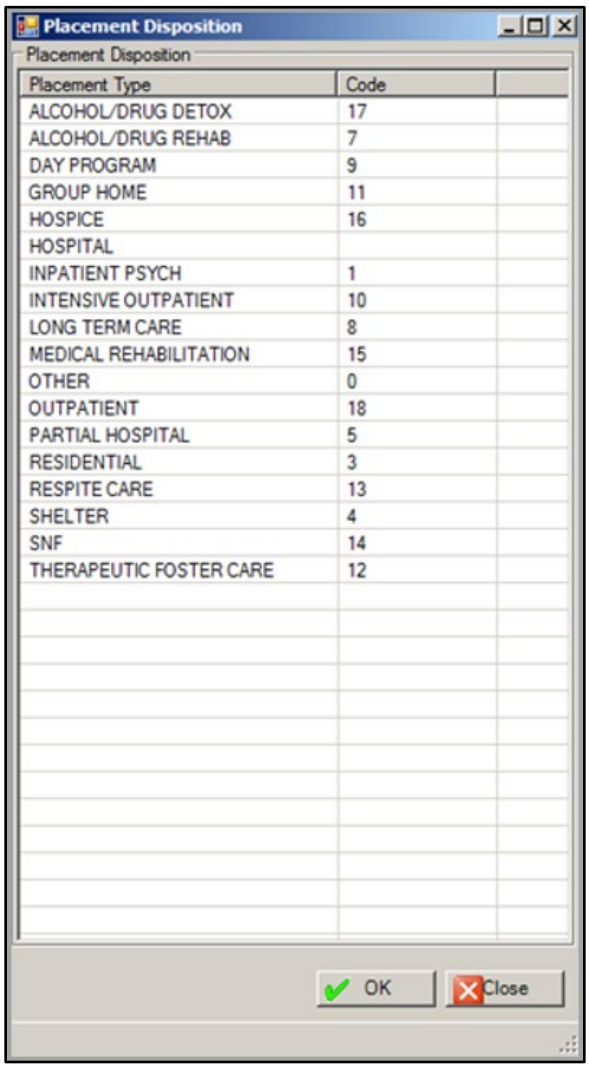
Screen Capture	What to do
	Use this dialog in one of two ways: (1) Select a **Placement Type**. (2) Click **OK** to populate **Placement Disposition** field. (Otherwise, click **Close**.)

Figure 4-23: Placement Disposition dialog

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

4.2.4 Rx Notes/Labs Tab

Use the **Rx Notes** tab (Figure 4-24) to view prescription data or lab tests data.

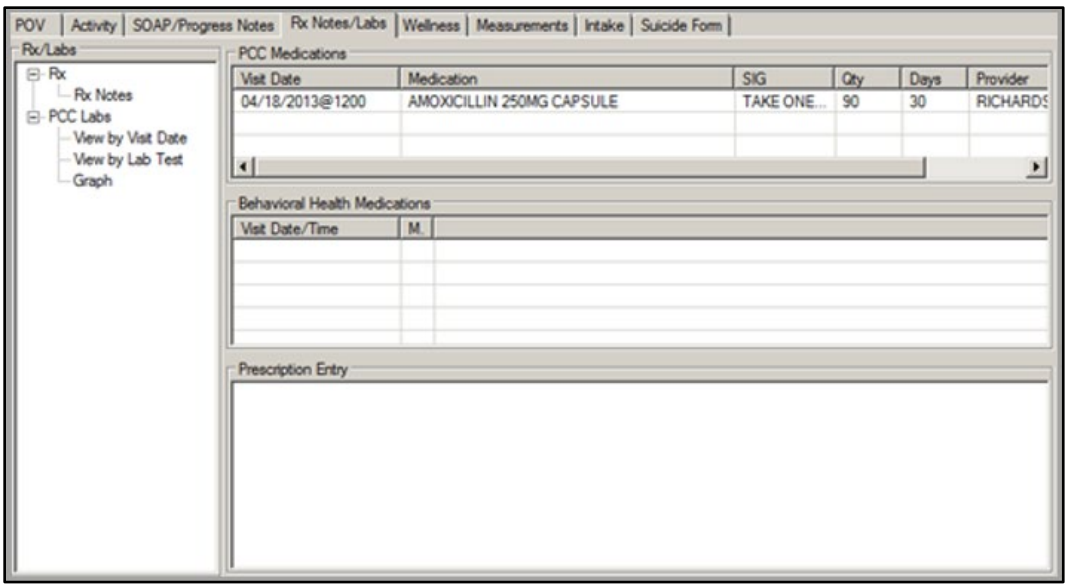


Figure 4-24: Rx Notes/Labs tab

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

4.2.4.1 RX Data

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

4.2.4.2 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.

4.2.4.3 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.

4.2.4.4 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.

4.2.4.5 PCC Labs

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

4.2.4.6 View by Visit Date

Select the **View by Visit Date** option to access the **View Labs by Visit Date** dialog (Figure 4-25).

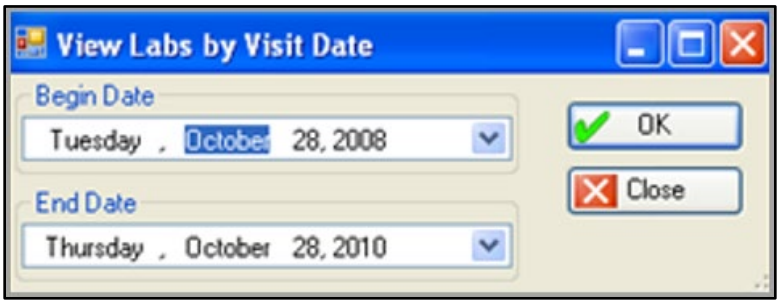


Figure 4-25: View Labs by Visit Date dialog

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

- The default **Begin Date** will be one year prior.
- 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 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 list to select a **date** from the calendar.
3. When this dialog is complete, click **OK** and the application displays 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 AMH (GUI)**.

4.2.4.7 View by Lab Test

If you select the **View by Lab Test** option, you access the **View Labs by Lab Test** dialog (Figure 4-26).

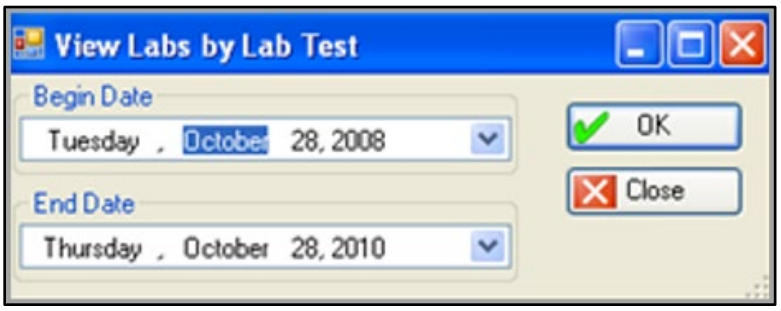


Figure 4-26: View Labs by Lab Test dialog

- The **View Labs by Lab Test** dialog has the following features:
- The default **Begin Date** will be one year prior.
- 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 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 list to select a date from the calendar.
3. When this dialog 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 AMH (GUI)**.

4.2.4.8 Graph

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

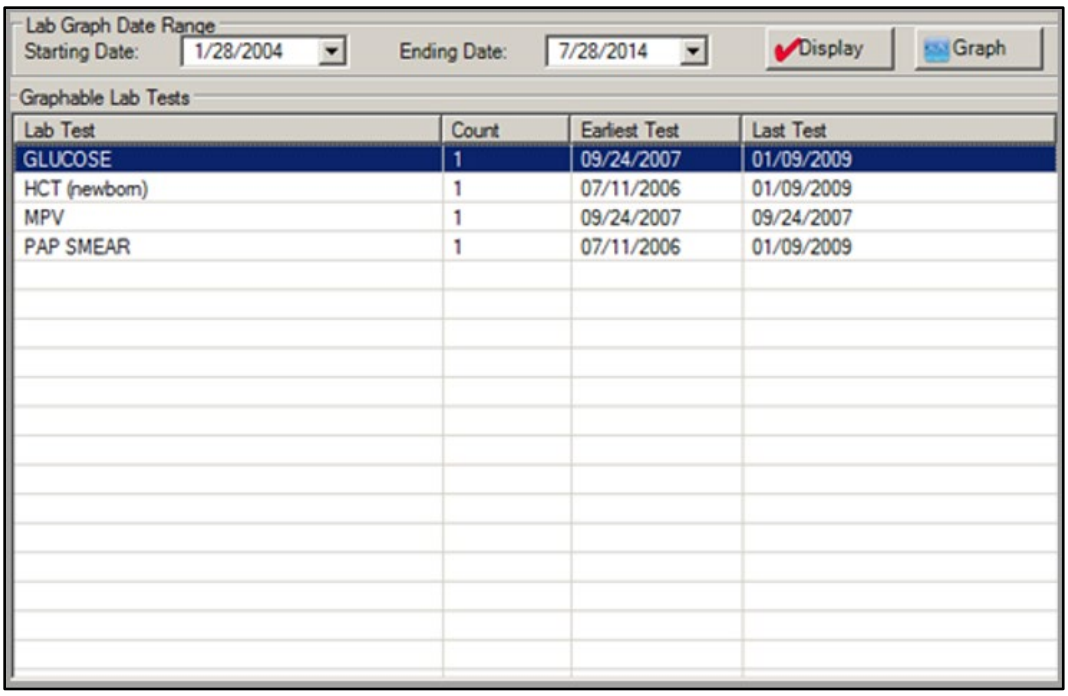


Figure 4-27: Graph option group box

4.2.4.9 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 **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 **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 a user changes it again.

4.2.4.10 Graphable Lab Tests

To graph a lab test (Figure 4-28), select one **lab test record** and then click **Graph**.

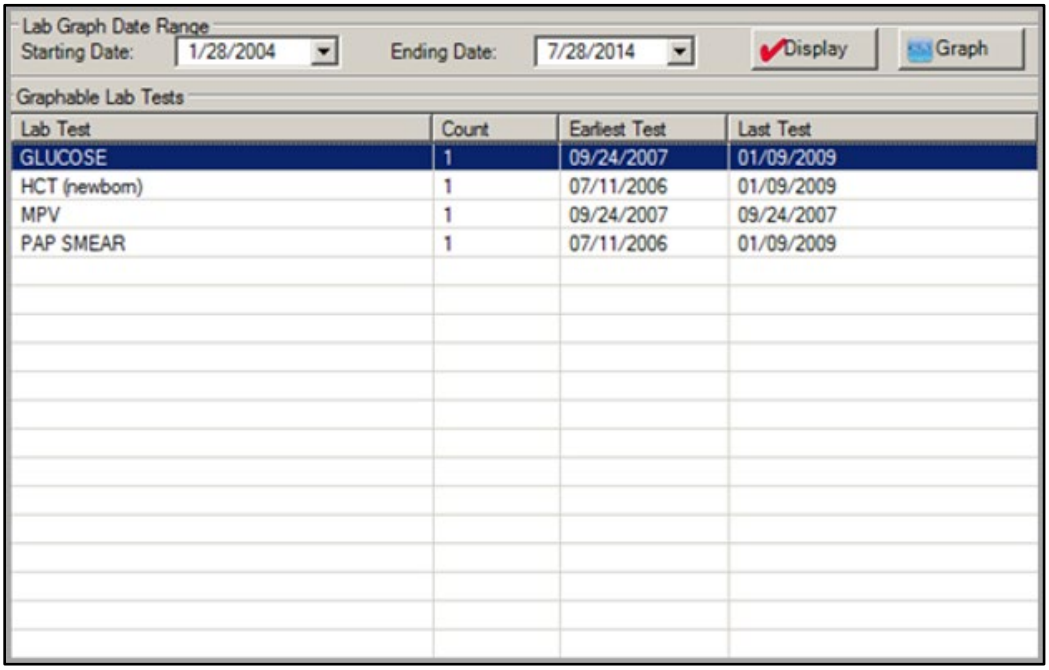


Figure 4-28: Graphable Lab Tests list box

This causes the data to be entered into an **Excel** spreadsheet and the graph of the particular lab test (Figure 4-29) is shown.

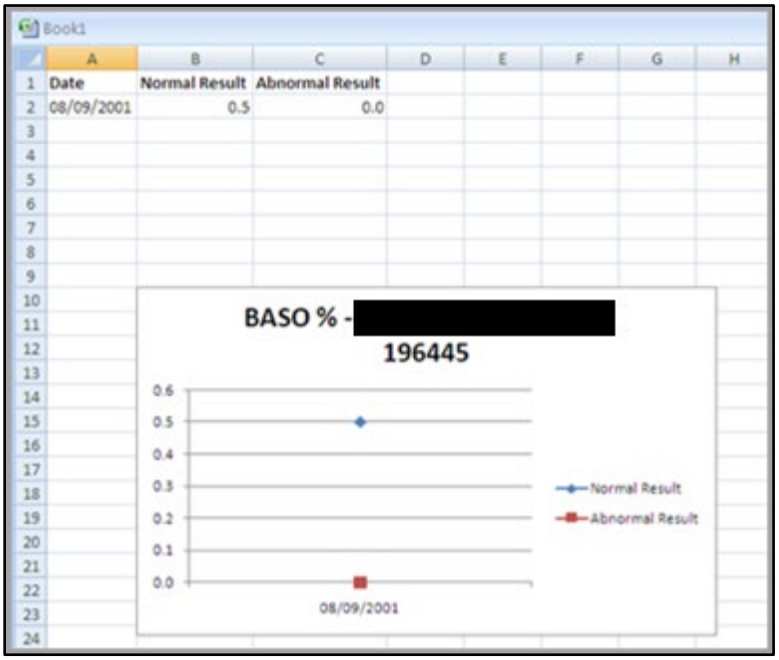


Figure 4-29: Graph of a lab test example

Save this data, if needed.

4.2.5 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 first accessing the **Wellness** tab, the application displays a tree structure.

Figure 4-30: Wellness tab

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

4.2.5.1 Patient Education

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**.

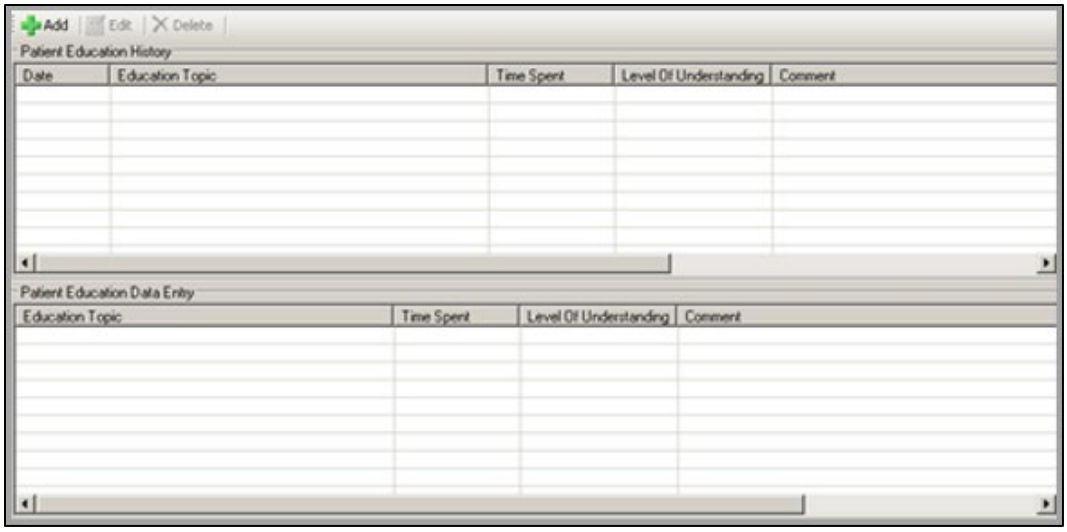


Figure 4-31: Patient Education group boxes

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** buttons.

4.2.5.2 Add/Edit Patient Education Record

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

Use one of the following:

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

Or

- Select an **education record** to edit and click **Edit**.

The **Education Topic** select window (Figure 4-32) displays.

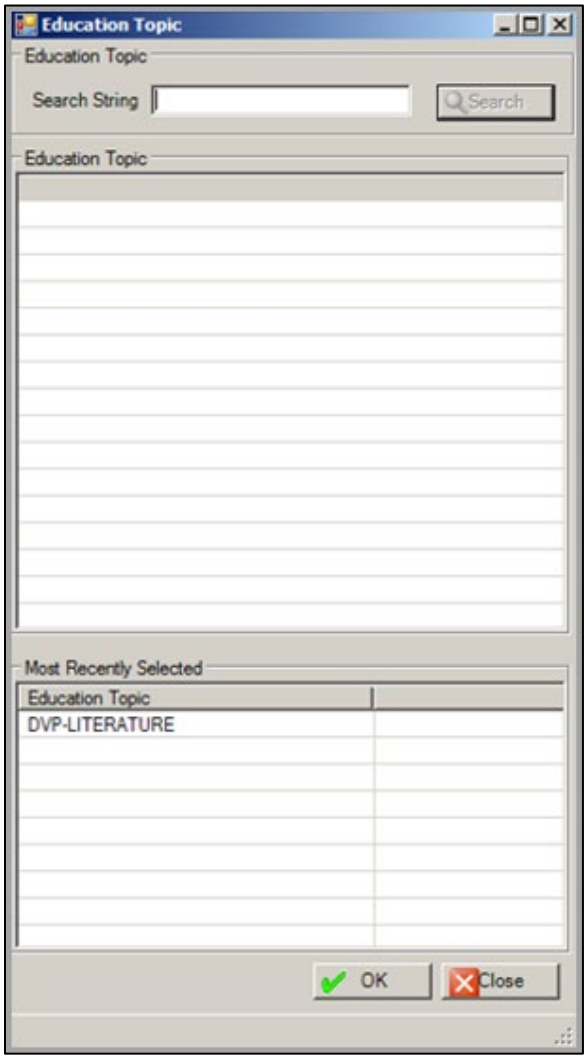
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the education topic and then clicking **Search**. The retrieved education topics will populate the **Education Topic** list box. Select a retrieved record and click **OK**. (Otherwise,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

Figure 4-32: Education Topic select window

- If the user clicks **Close**, the application displays the **Continue** warning: **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 with no data in the fields.
- If the user clicks **OK**, the **Patient Education** dialog (Figure 4-33) displays, with the **Education Topic** field populated.

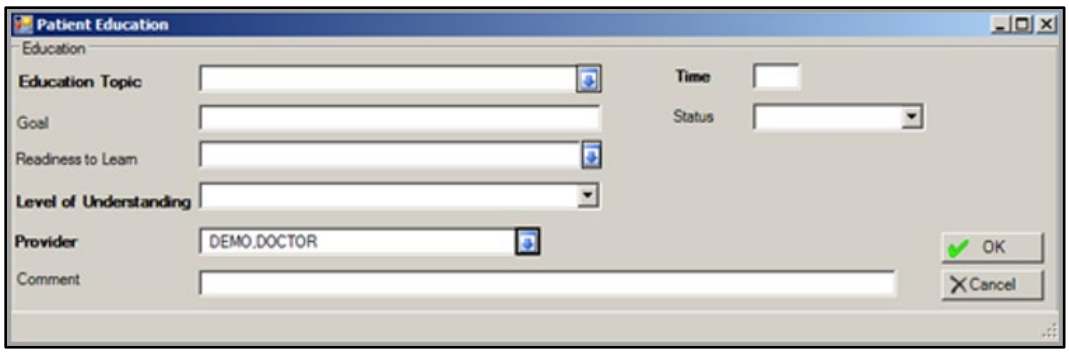


Figure 4-33: Patient Education dialog

- The fields in bold text are required:
  - Education Topic
  - Level of Understanding
  - Provider
- 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 list to access the **Education Topic** search window.

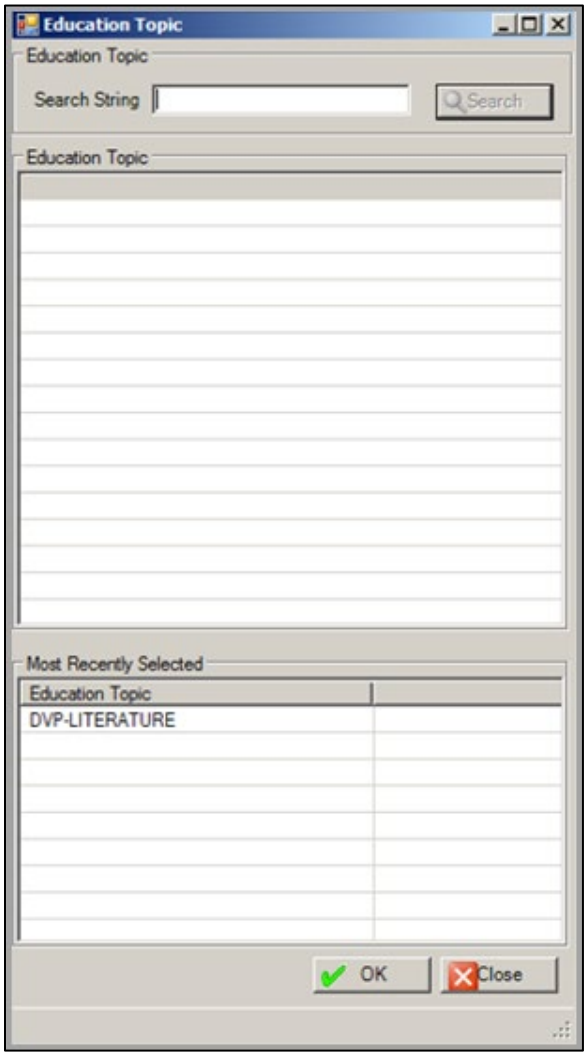
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **education topic** and then clicking **Search**. The retrieved education topics will populate the **Education Topic** list box. Select a **retrieved record** and click **OK** to populate 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 4-34: Education Topic select window

1. At the **Time** field, type the number of minutes spent on the education topic, using any integer **1–9999**.
2. At the **Goal** field, type the text of the stated goal of the education. For example, Patient plans to walk six times a week.
3. At the **Status** field, select the status of the education goal. Select 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

4. At the **Readiness to Learn** field, select the **Readiness to Learn** option. Click the list to display the **Readiness to Learn** select window.

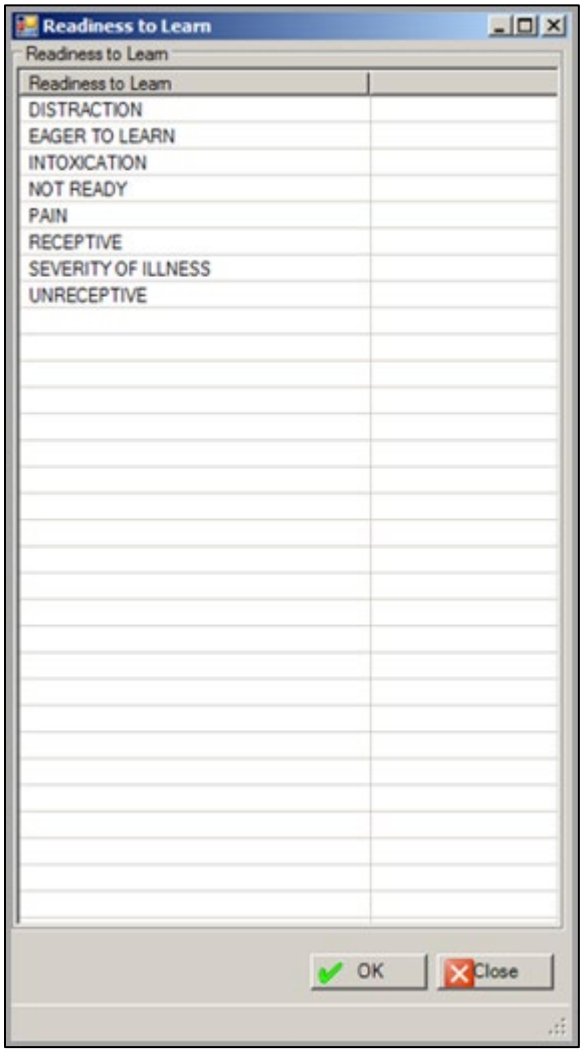
Screen Capture	What to Do
	Use this window as follows: (1) Select a **readiness to learn** option. (2) Click **OK** to add the option to the **Readiness to Learn** field. (Otherwise, click **Close**.)

Figure 4-35: Readiness to Learn select window

5. At the **Level of Understanding** field, select the level of understanding. Select 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

6. At the **Provider** field, select the provider for the patient education. Click the list to display the **Education Provider** select window.

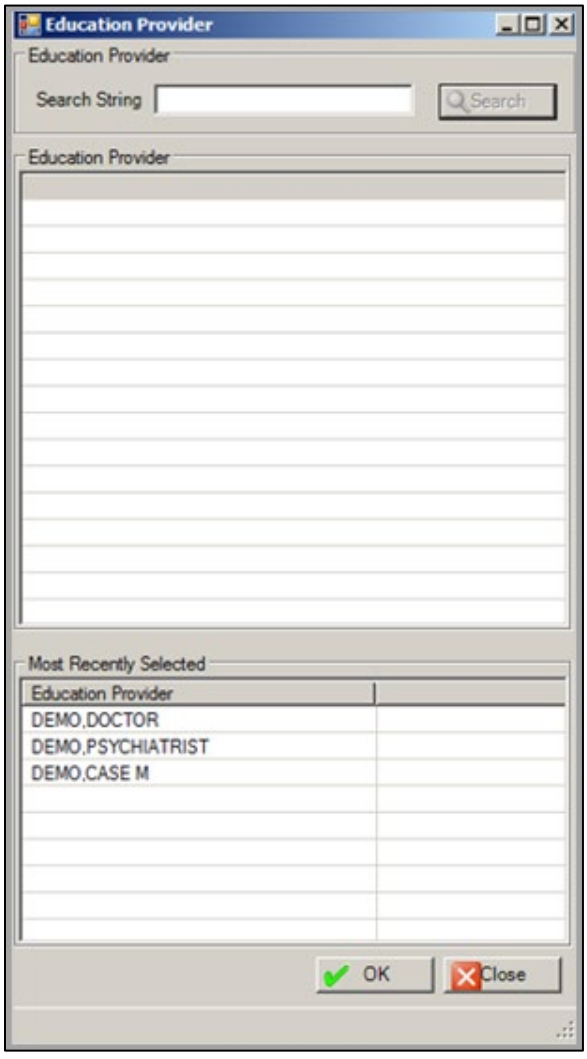
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **last name** of the education provider and then clicking **Search**. The retrieved provider names will populate the **Education Provider** list box. Select a **retrieved record** and 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 4-36: Education Provider select window

7. In the **Comment** field, type any comments about the education topic for the visit. This is a free-text field.

8. After the dialog is complete, click **OK**. (Otherwise, click **Cancel**.)

   - If the user clicks **OK**, the application saves the data and displays it on the **Education Topics Data Entry** grid.
   - If the user clicks **Cancel**, the application displays the **Continue?** warning:

     Canceling will lose all unsaved data, Continue?

     – Click **Yes** to not save and leave the **Patient Education** dialog. Click **No** and the focus returns to the **Patient Education** dialog.
     – If using **Edit**, click **OK** after the dialog is complete, and the fields will be 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.

4.2.5.3 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**.)

4.2.5.4 Health Factors

Select the **Health Factors** option on the **Wellness** tree structure to display the **Health Factor** list boxes:

- Health Factors History
- Health Factors Data Entry

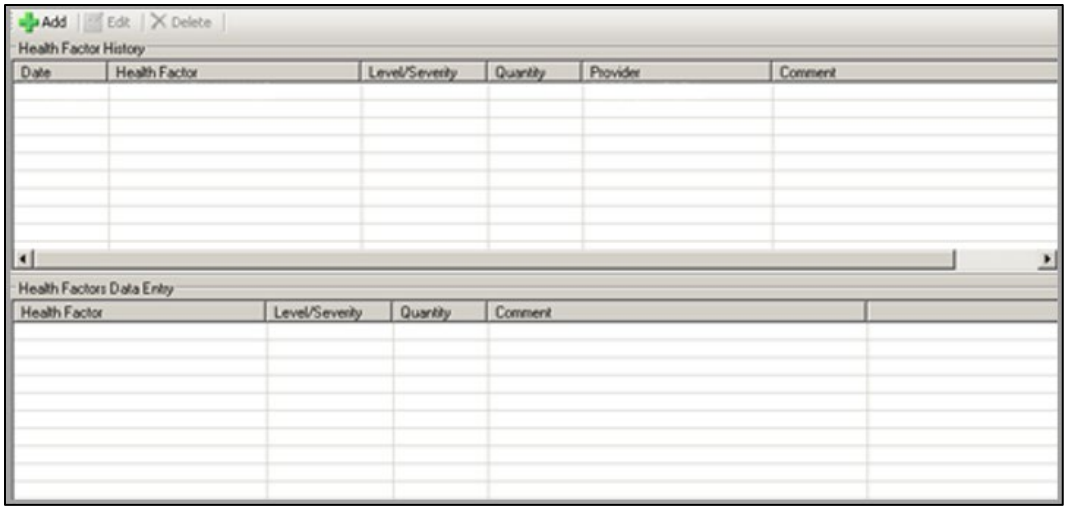


Figure 4-37: Sample Health Factors list boxes

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 and 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** buttons.

4.2.5.5 Add/Edit Health Factor Record

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

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

Or

- Select a record to edit and click **Edit**.

The **Health Factors** search window (Figure 4-38) displays.

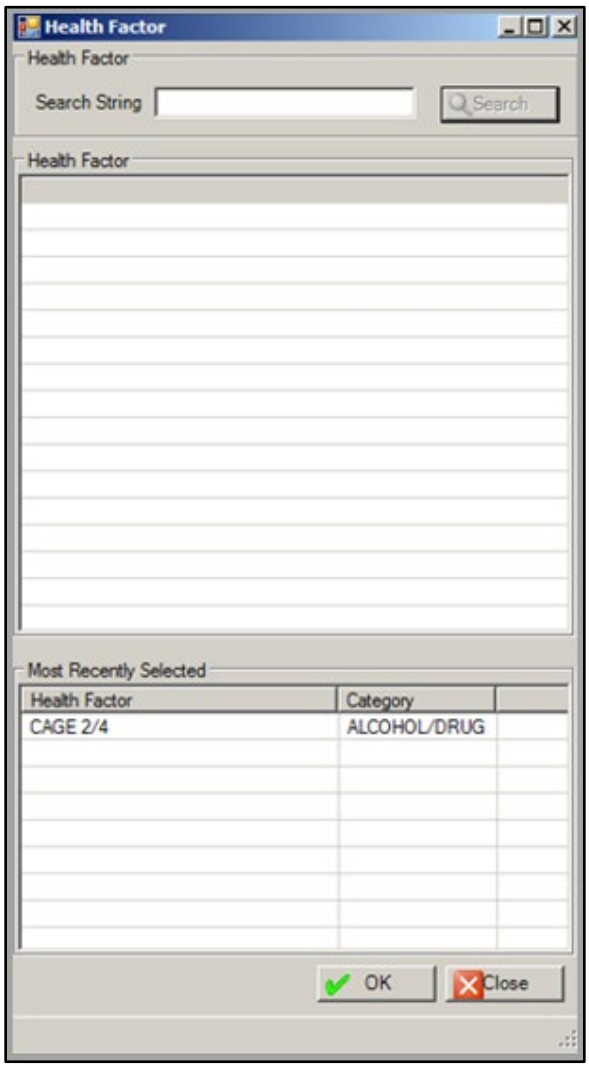
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **health factor** and then clicking the **Search** button. The retrieved health factors will populate the **Health Factor** list box. Select a retrieved record and click **OK** to populate the **Health Factor** field on the **Health Factors** dialog. (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. (Otherwise, click **Close**.)

Figure 4-38: Health Factor search window

The **Health Factors** dialog is shown in Figure 4-39.

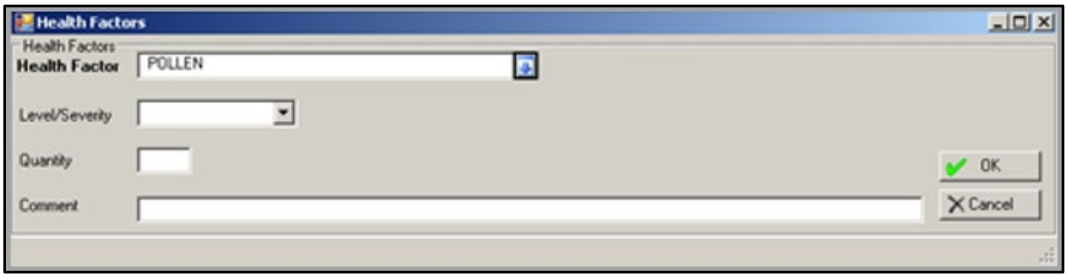


Figure 4-39: Health Factors dialog

The fields in bold text are required.

1. 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 list to access the **Health Factor** search window.
2. At the **Level/Severity** field, select an option from the list, if applicable:
   - Minimal
   - Moderate
   - Heavy/Severe
3. At the **Quantity** field, type the quantity associated with the health factor, if any.
4. At the **Comment** field, type the text of any comment for clarification about the documented health factor. This is a free-text field.
5. After the dialog is complete, click **OK**. (Otherwise, click **Cancel**.)
   - If the user clicks **OK**, the application saves your data and displays it on the **Health Factors Data Entry** grid.
   - If the user clicks **Cancel**, the application displays the **Continue?** message:

     Canceling will lose all unsaved data, Continue?

   - Click **Yes** to not save and leave the **Health Factors** dialog. Click **No** and the focus returns to the **Health Factors** dialog.
6. After editing a record and completing the dialog, click **OK** to change the selected record. (Otherwise, click **Cancel**.)

4.2.5.6 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**.)

4.2.5.7 Screening

Select the **Screening** option on the **Wellness** tree structure to display the screening list boxes:

- Screening History
- Screening Data Entry

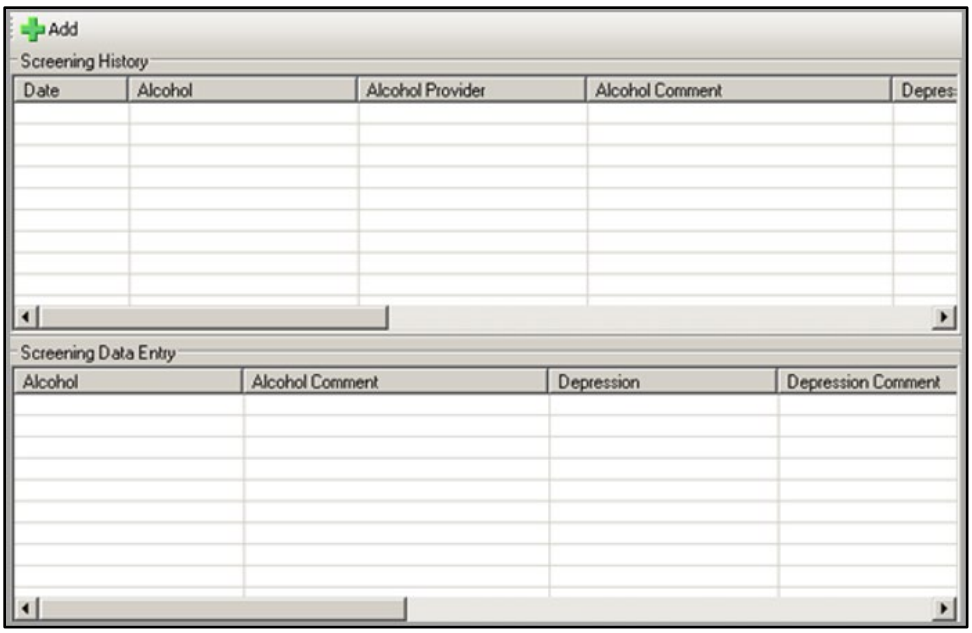


Figure 4-40: Screening group boxes

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

In either case, the **Screening** dialog (Figure 4-41) displays.

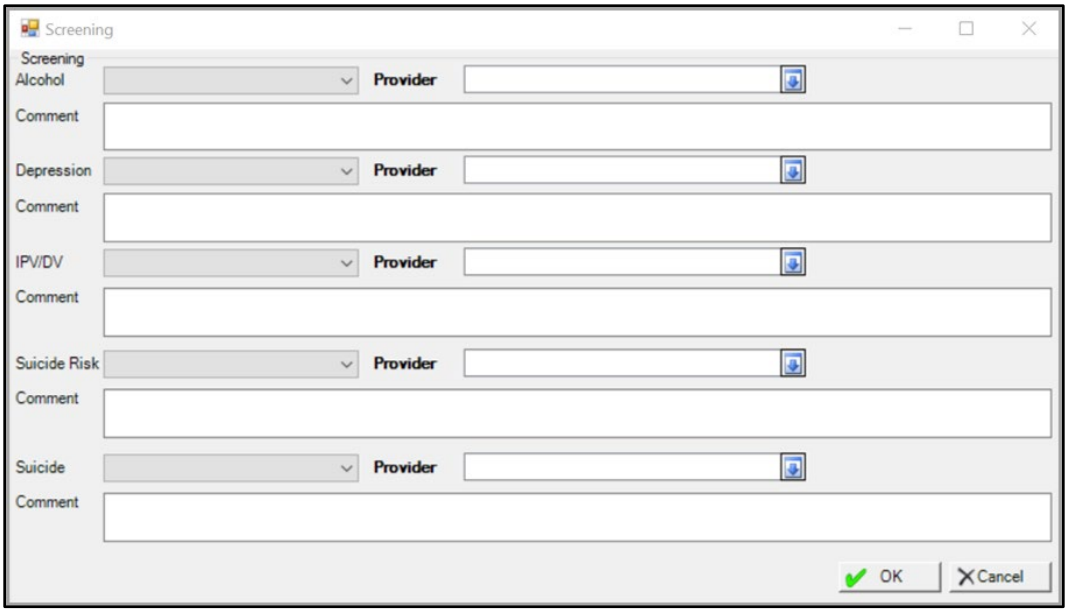


Figure 4-41: Screening dialog

4.2.6 Measurements Tab

Use the **Measurements** tab (Figure 4-42) to view existing measurements, as well as **add**, **edit**, or **delete V Measurement data** for the current patient visit.

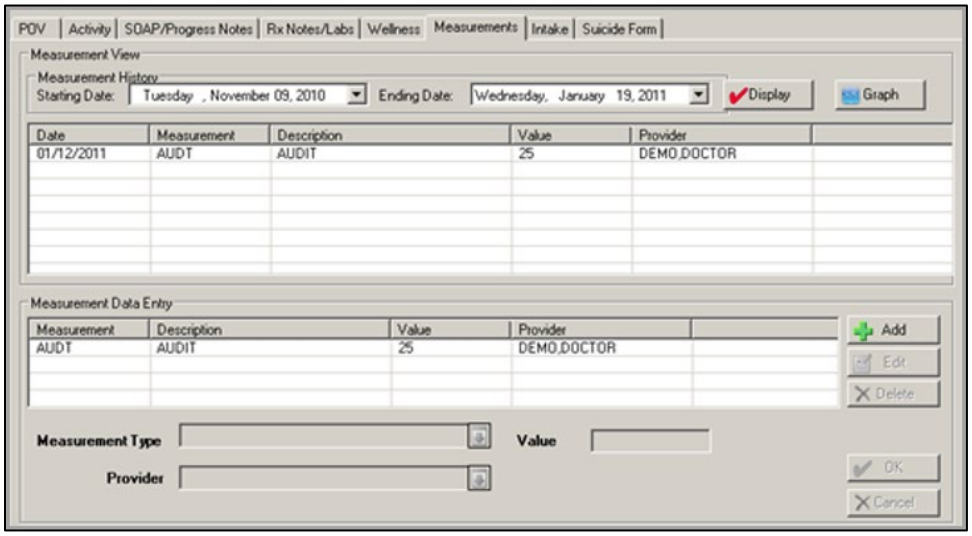


Figure 4-42: Measurements tab

4.2.6.1 Measurement View Group Box

This group box (Figure 4-43) displays the measurements for the current patient in the date range shown in the **Measurement History** group box.

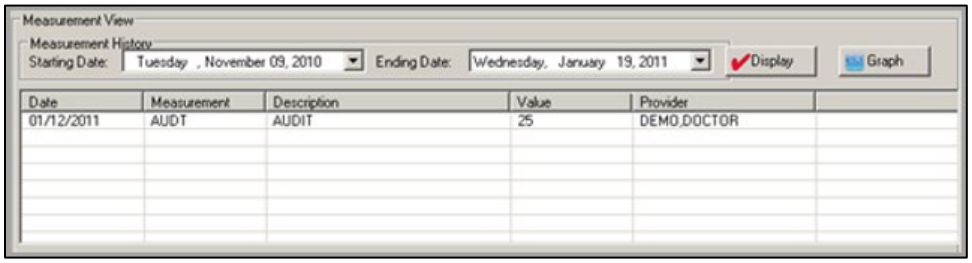


Figure 4-43: Measurement View group box example

4.2.6.2 Change Date Range

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

4.2.6.3 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**. The **Measurement Type** dialog (Figure 4-44) displays.

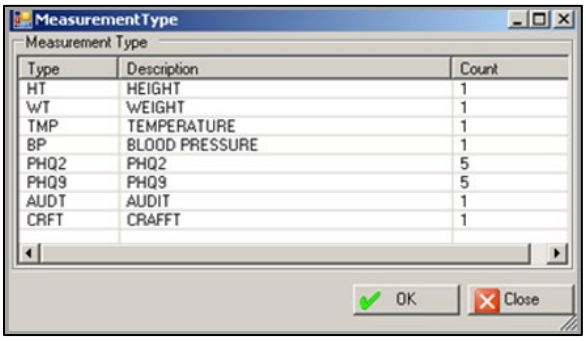


Figure 4-44: Measurement Type dialog

2. Select the **measurement type** to graph.

3. Click **OK**, and the application (automatically) uses the data to display a graph in **MS Excel**. (Otherwise, click **Close**.)

   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.

   Figure 4-45 shows a sample line graph.

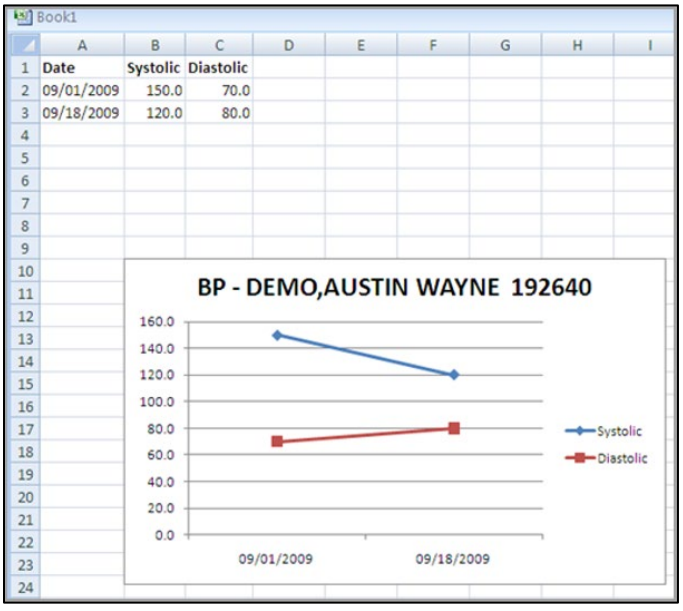


Figure 4-45: Sample line graph

Save the data, if needed.

4.2.6.4 Measurement Data Entry Group Box

Use this group box (Figure 4-46) to manage the measurements during the visit.

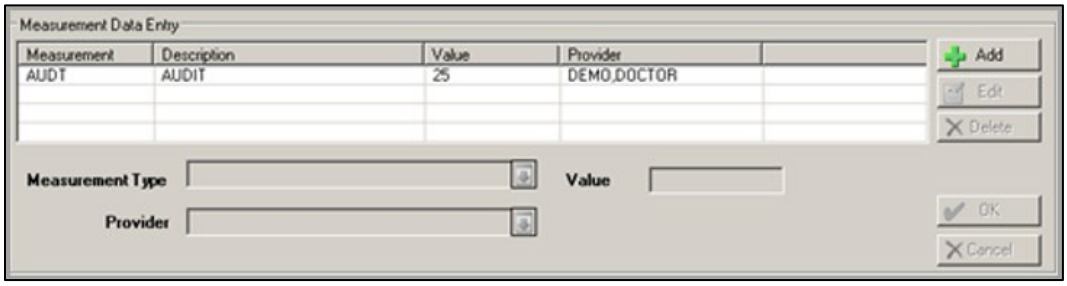


Figure 4-46: Measurement Data Entry group box

Add, **edit**, or **delete** measurement data entry records.

4.2.6.5 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**.)

4.2.6.6 Add/Edit Button

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

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

  Or

- Select a **record** to edit and click **Edit**. The fields are populated with existing data.

1. At the **Measurement Type** field, select a **V Measurement** type. Click the list to access the **Measurement Type** search window (Figure 4-47) and select a **type**.

This field is inactive when editing a record.

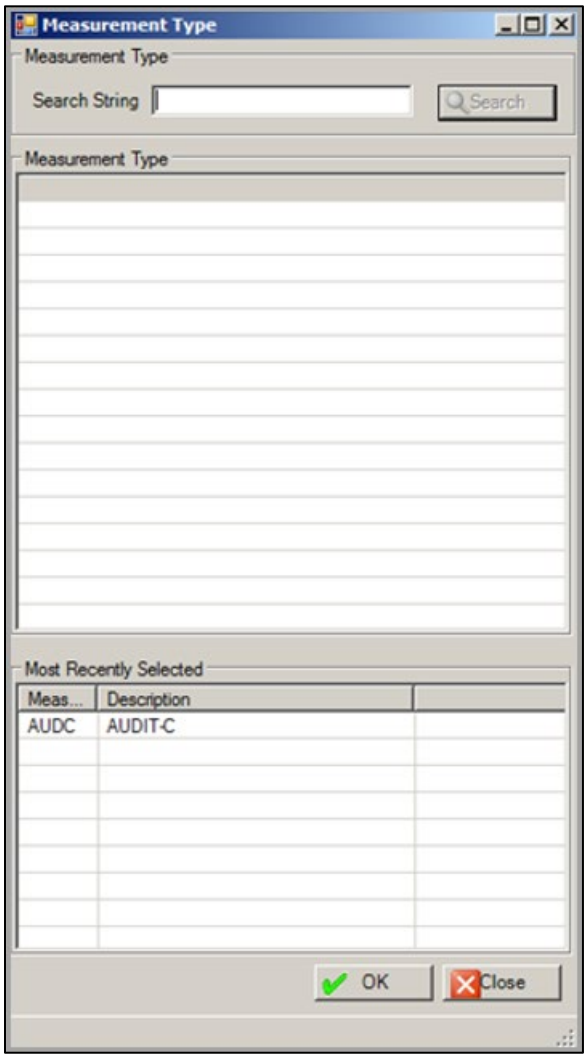
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the **measurement type** and then clicking **Search**. The retrieved measurement types will populate the **Measurement Type** list box. Select a **retrieved record** and click **OK** to 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 4-47: Measurement Type search window

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

   If the value is outside the accepted range, the **Warning** message (Figure 4-48) displays.

3. Click **OK** to dismiss the warning and populate with another valid numeric value.

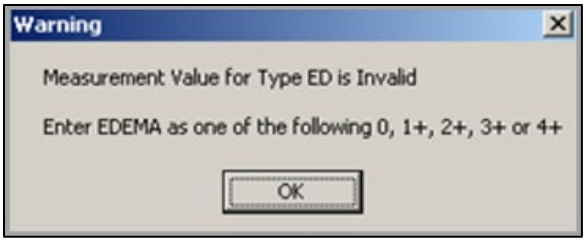


Figure 4-48: Warning dialog–invalid measurement value

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

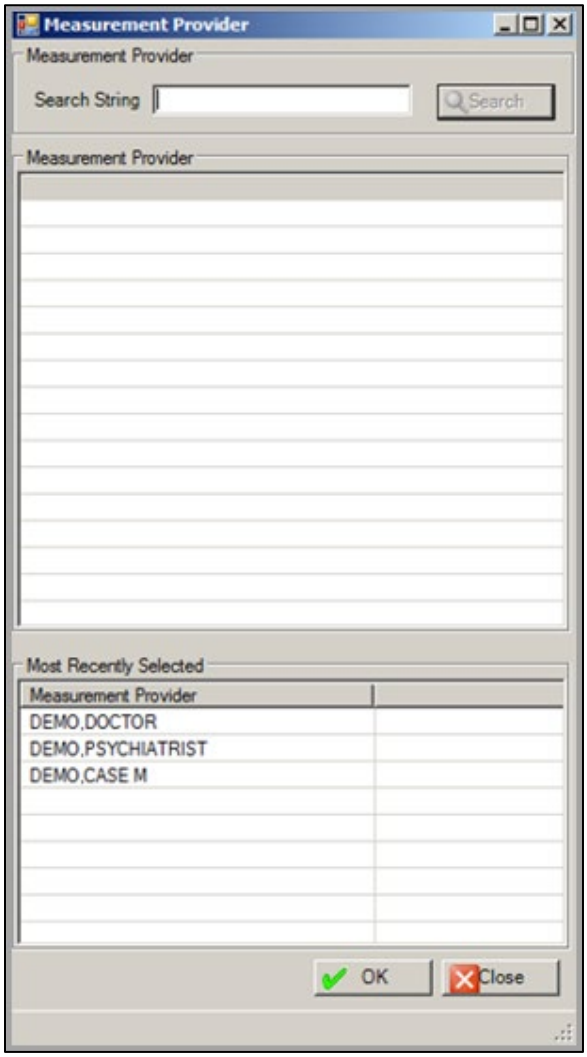
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the last name of the provider and then clicking **Search**. The retrieved provider names will populate the **Measurement Provider** list box. Select a **retrieved record** and click **OK** 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 4-49: Measurement Provider search window

5. Click **OK** on the **Measurement Data Entry** group box. (Otherwise, click **Cancel**.). Clicking **OK** 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).

6. After clicking **Edit** and changing the fields, click **OK** to change the **Value** and/or **Provider** in the grid. (Otherwise, click **Cancel**.)

4.2.7 Intake Tab (GUI)

After clicking the **Intake** tab, the **Intake** window (Figure 4-50) displays.

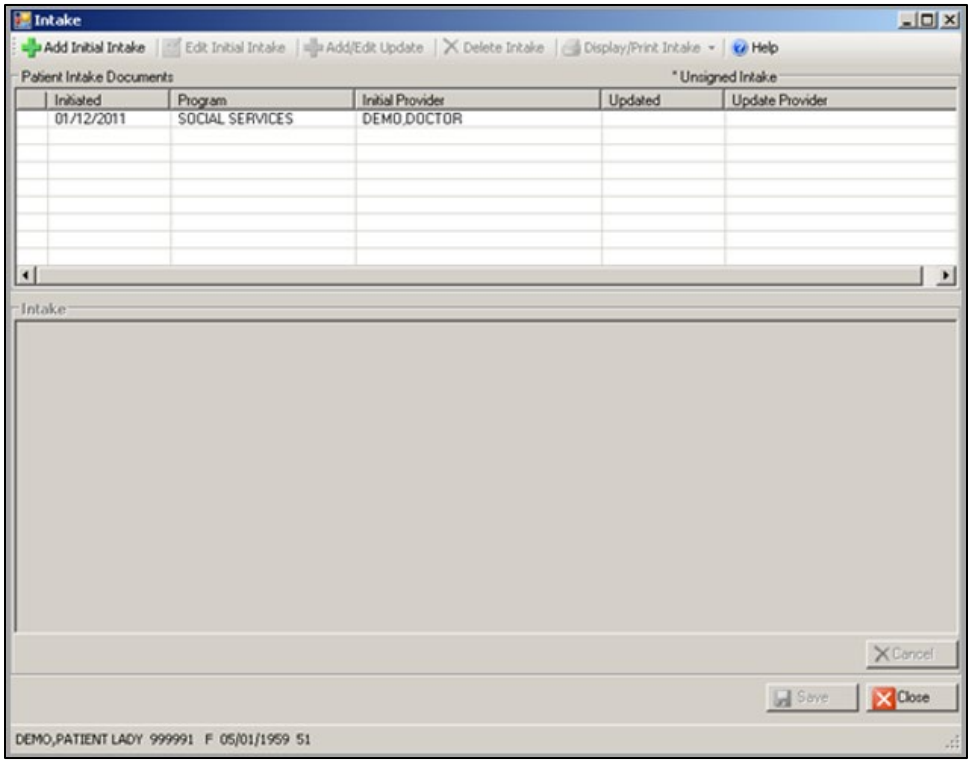


Figure 4-50: Initial Intake window

Section 11.1 provides more information on the **Intake (GUI)**.

4.2.8 Suicide Form

Click the **Suicide Form** tab to display the **Suicide Form** window. Section 10.1 provides more information about the **Suicide Form** window (GUI).

4.2.9 Select PCC Visit Window

Access the **PCC Visit** window (Figure 4-51) after saving and signing a visit, and that visit was entered in the **Scheduling** package with the option to create a visit at check-in.

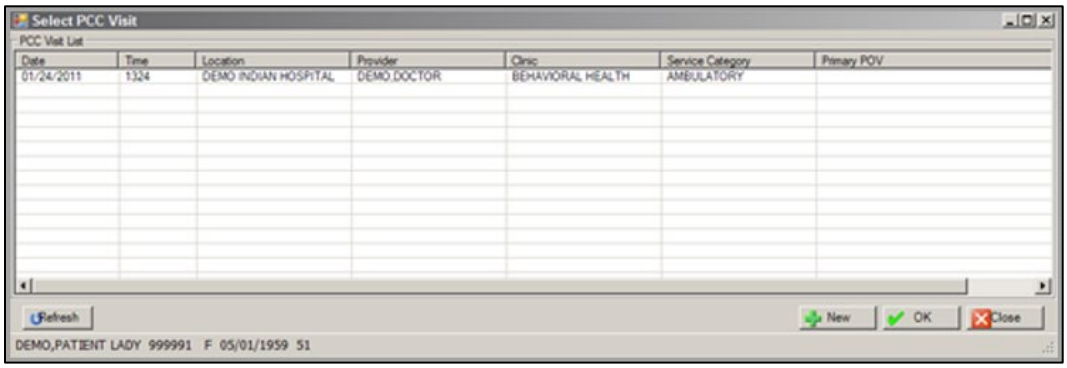


Figure 4-51: Select PCC Visit window with one visit

Users can do one of the following:

- Create a new **record.**

Or

- Link the entry with the one created by the **Scheduling** package (a **PCC** incomplete visit record).

If the displayed visits do not include the one needed to link to, choose a new one or wait until you have had a chance to check in the patient in the **Scheduling** package.

After checking in the patient in the **Scheduling** package, return to the **GUI** and click the **Refresh** button to load more visits.

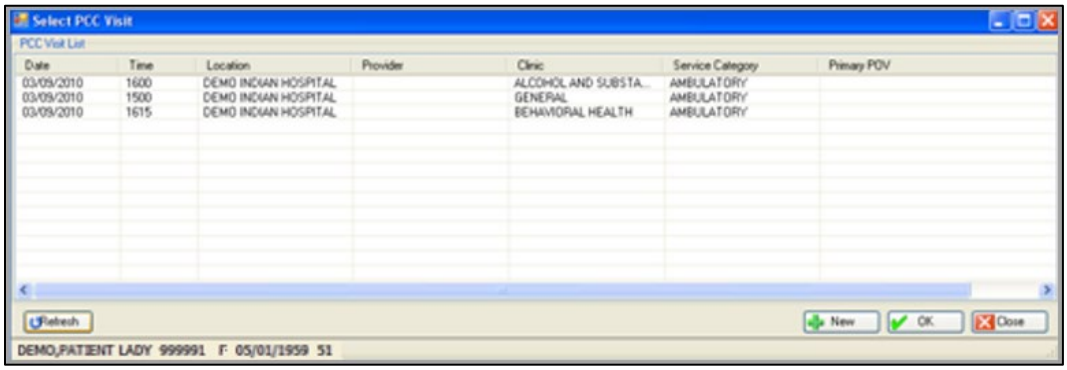


Figure 4-52: Select PCC Visit window with multiple visits

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

If you access **PCC** (Figure 4-53**)**, this is what you will see:

```
Patient Name:          DEMO,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:          DEMO,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:              DEMO,DOCTOR
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:            DEMO,DOCTOR
DATE/TIME LAST MODIFI: NOV 16, 2015@10:43:44
LAST MODIFIED BY:      DEMO,DOCTOR
V FILE IEN:            3211018

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

Figure 4-53: Information from PCC

4.3 Browse Visits (GUI)

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

1. Select **Browse Visits** on the **RPMS AMH (GUI)** tree structure.

   The **Browse Visits** dialog displays.

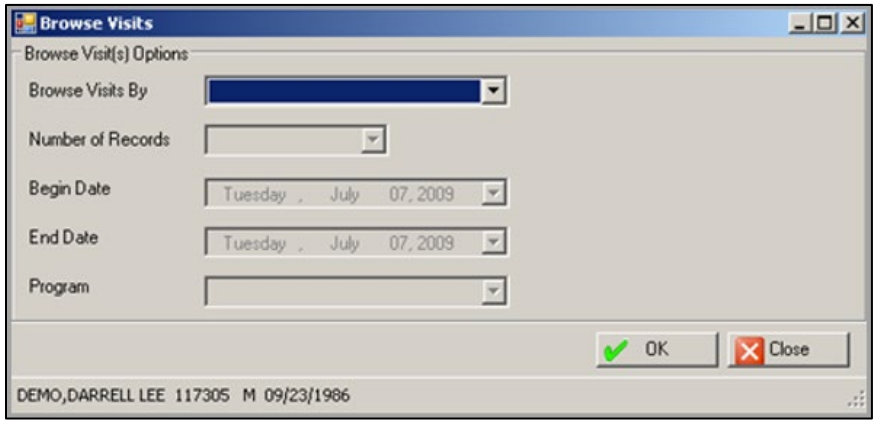


Figure 4-54: Browse Visits dialog example

2. 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 using option **A** or **L**, the other fields will not be active.
     - If **N** was used in the **Browse Visits By** field, the **Number of Records** field becomes active.

3. At the **Number of Records** field, select an **option** from the list.

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

4. At the **Begin Date** field, select the beginning date from the list.

5. At the **End Date** field, select the ending date from the list.

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

6. At the **Program** field, select the **program** from the list:

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

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

   After clicking **OK**, the first page of the **Browse Visits** window displays.

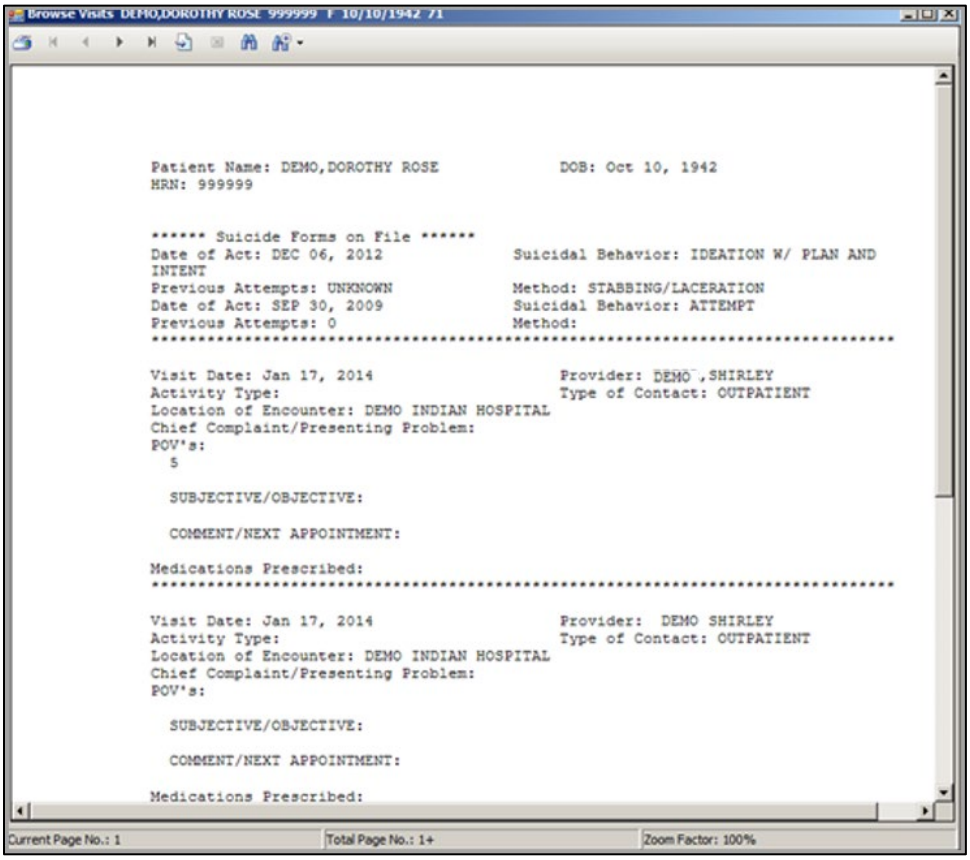


Figure 4-55: Data in Browse Window example

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

4.4 View Patient Data

When you expand the **View Patient Data** option on the tree structure (Figure 4-56) for the **RPMS AMH (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
- PCC Labs by Lab Test

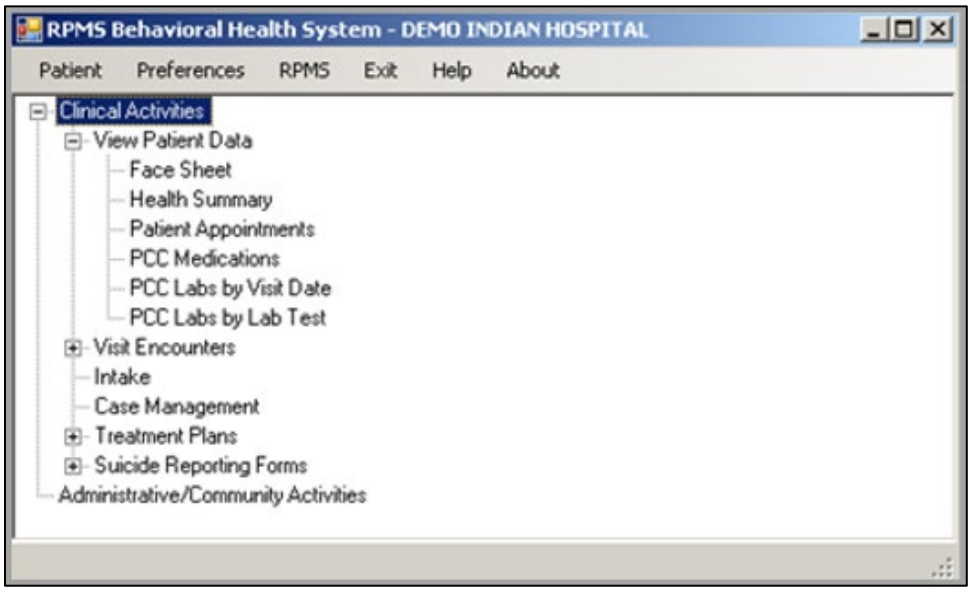


Figure 4-56: RPMS AMH tree structure for View Patient Data

The data applies to the current patient.

4.4.1 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.

4.4.2 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 (Figure 4-57) displays.

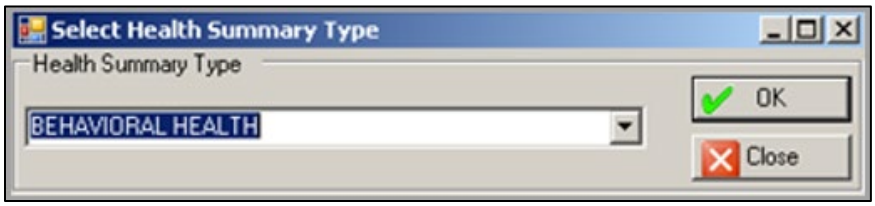


Figure 4-57: Select Health Summary Type dialog

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

   After clicking **OK**, a pop-up (Figure 4-58) that shows the first page of the particular type of heath summary displays.

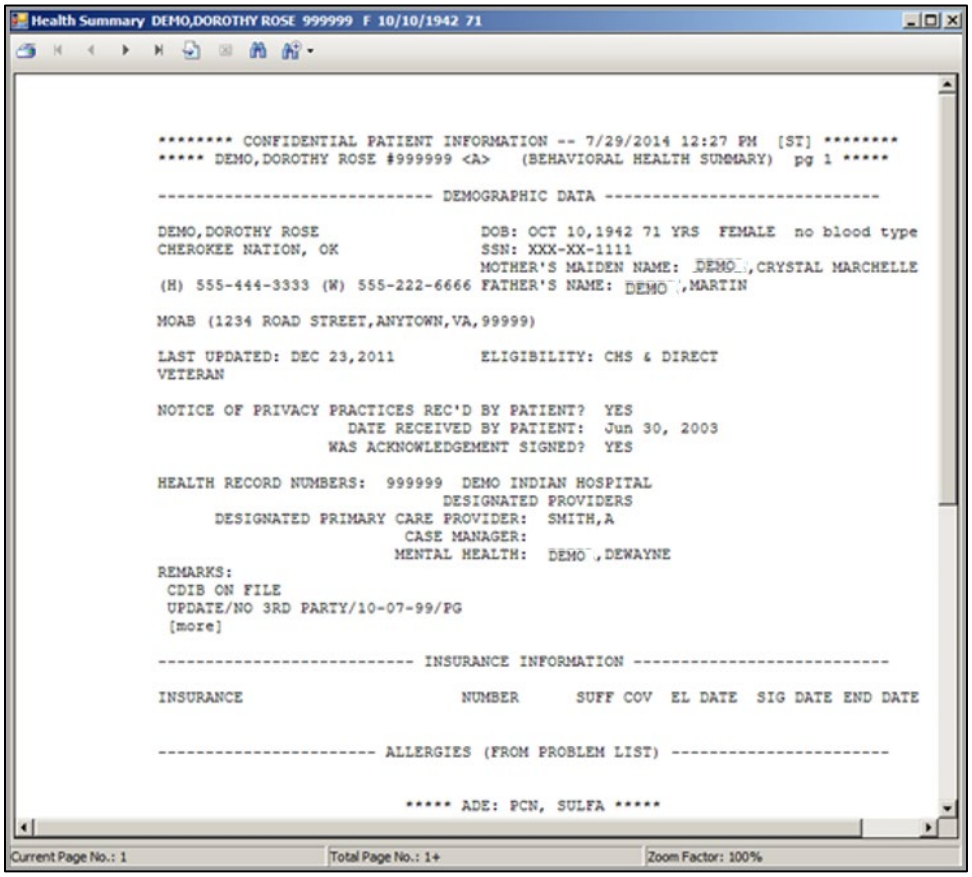


Figure 4-58: Sample Health Summary pop-up window

If there is more than one page, use the **Next Page** and **Last Page** buttons to move to other pages. Otherwise, specify the page number to move to. Section 2.6 provides more information about the controls on this window.

4.4.3 Patient Appointments

Use the **Patient Appointments** option to view the appointments of the current patient in a particular date range. The **Patient Appointments** dialog (Figure 4-59) displays.

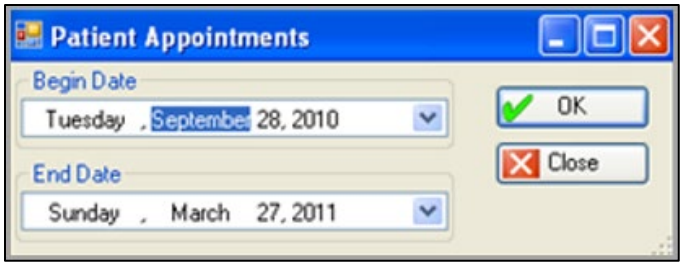


Figure 4-59: Sample Patient Appointments dialog

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 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 list and select a date from the calendar. This established the ending date of the date range.
3. When this dialog is complete, click **OK** . (Otherwise, click **Close**.)

   If **OK** was used, a pop-up displays showing 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.

4.4.4 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 (Figure 4-60) displays.

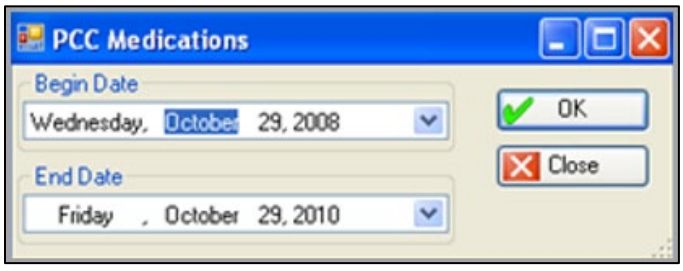


Figure 4-60: Sample PCC Medications dialog

The default date **Start Date** is one year previous.

You can edit either or both dates.

1. At the **Begin Date** field, click the 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 list and select a date from the calendar. This established the ending date of the date range.
3. When this dialog is complete, click **OK**. (Otherwise, click **Close**.)

After clicking **OK**, a pop-up displays, showing the first page of the **Medication Prescribed** in the **Behavioral Health** database within the particular date range.

4.4.5 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.

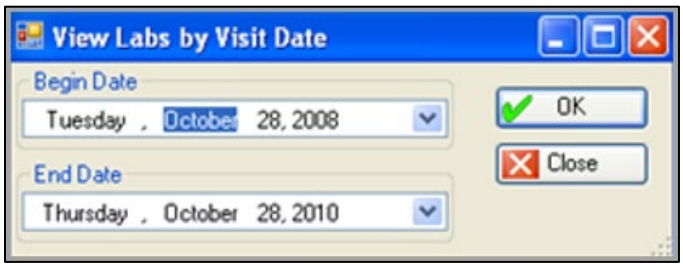


Figure 4-61: Sample View Labs by Visit Date dialog

The default **Begin Date** is one year previous.

You can edit either or both dates.

1. At the **Begin Date** field, click the 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 list and select a date from the calendar. This establishes the ending date of the date range.
3. When this dialog is complete, click **OK**. (Otherwise, click **Close**.)

After clicking **OK**, 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.

4.4.6 PCC Labs by Lab Test

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

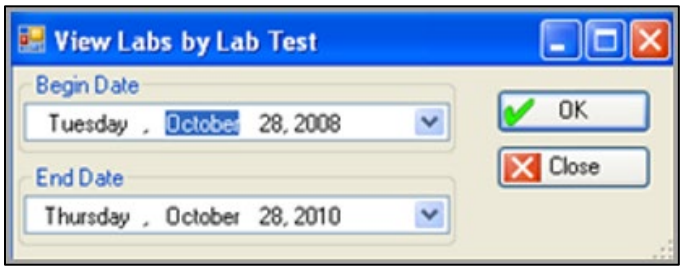


Figure 4-62: Sample View Labs by Lab Test dialog

The default **Begin Date** is one year previous.

You can edit either or both dates.

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

3. When this dialog is complete, click **OK**. (Otherwise, click **Close**.)

After clicking **OK**, 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 the **RPMS AMH (GUI)**.

5.1 Group Entry Window (GUI)

The following shows where the **Group Encounter** function is located on the **RPMS AMH (GUI)** tree structure (Figure 5-1).

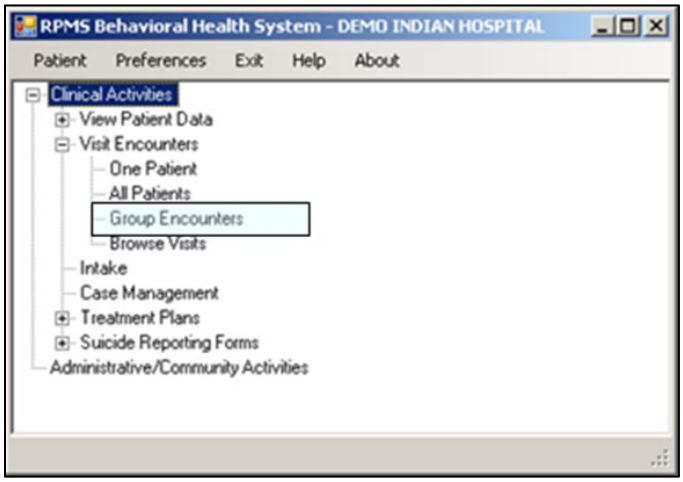


Figure 5-1: Group Encounters location on tree structure

Click the **Group Encounters** option to access the **Group Entry** window.

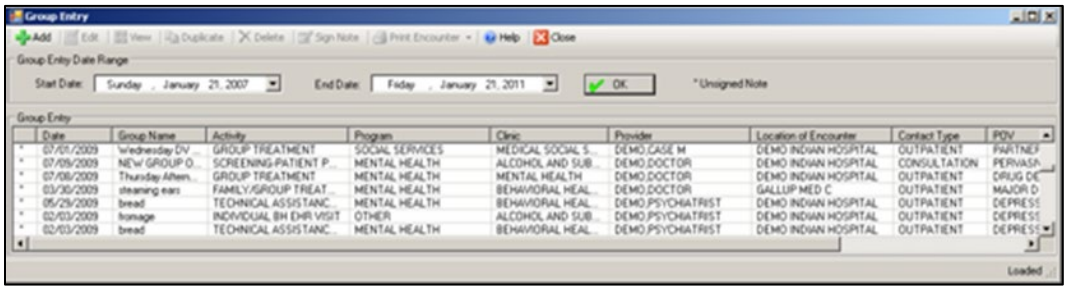


Figure 5-2: Group Entry window

Table 5-1 provides information about the features on the **Group Entry** window.

Table 5-1: Group Entry window features and functions

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 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	Click the **Add** button to add a new group encounter record on the **Group Data Entry-Add Group Data** window.
Edit button	Click the **Edit** button to change the selected group encounter record on the **Group Data Entry-Edit Group Data** window.
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**). Clicking **Yes** 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.

Feature	Functionality
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 the **Sign Note** button to access the **Sign?** dialog where you type your electronic signature. Section 2.14.5 provides more information.

If the primary provider has opted out of **E Sig**, it will pass to **PCC** and the application displays the **Message** (Figure 5-3) regarding this.

Figure 5-3: 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 leave the **Sign Note** process.

5.2 Add/Edit Group Data (GUI)

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

  Or

- 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 (Figure 5-4). (The same fields appear on the **Group Data Entry–Edit Group Data** window.)

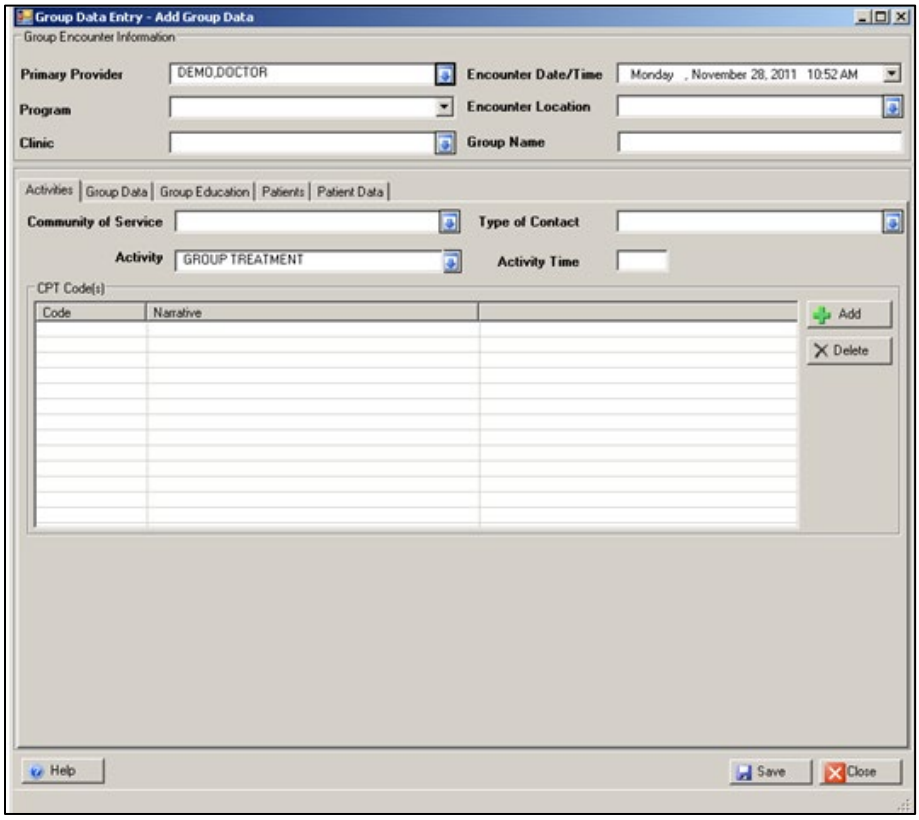


Figure 5-4: Group Data Entry–Add Group Data window

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

Table 5-2: Group Data Entry–Add Group Data window features and functionality

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 displays the **Electronic Signature** dialog. Section 2.14 provides more information about electronic signature (GUI).

The following applies to the **Close** process:

- The **Close** process displays the **Continue?** dialog:

  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.

5.2.1 Group Encounter Information Group Box

The **Add** window (Figure 5-5) has the following (active) fields.

Figure 5-5: 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 list to access the **Primary Provider** search/select window (Figure 5-6). Here you can search for a primary provider name.

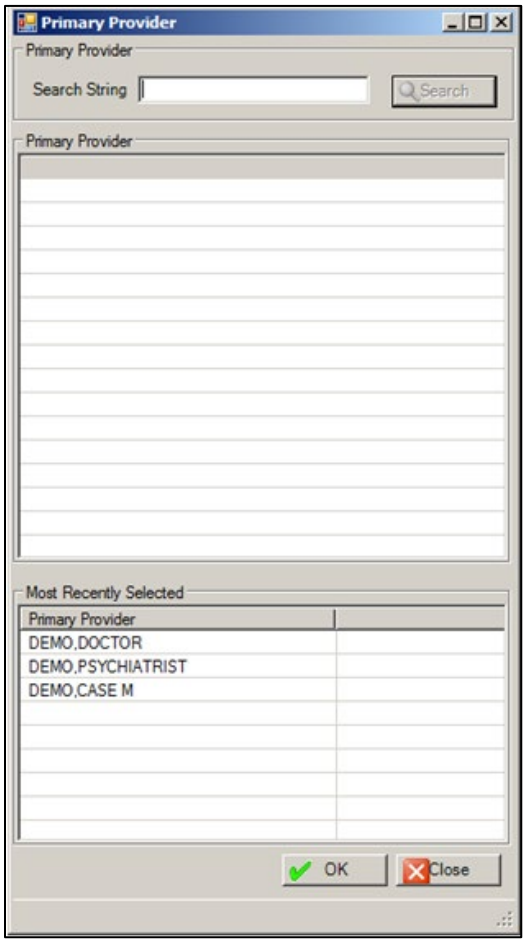
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a name and click **OK** to populate the **Primary Provider** 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 5-6: 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 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 **list** and use one of the following:

   - Mental Health

- Social Services
- Chemical Dependency
- Other

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 list to access the **Location** search window (Figure 5-7). Here you can search for a location name.

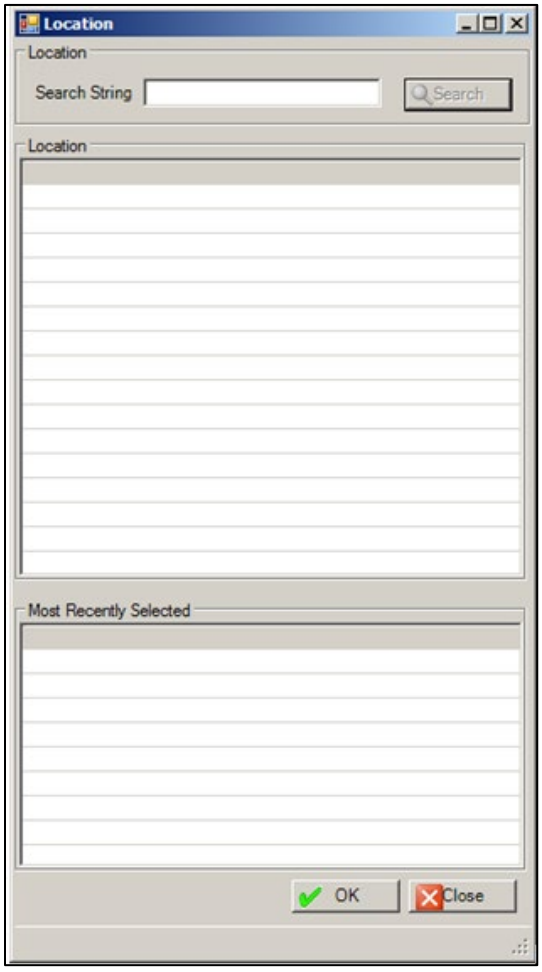
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the location and then clicking **Search**. The retrieved locations will populate the **Location** list box. Select a location and click **OK** to populate the **Encounter Location** field. (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 5-7: 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 list to access the **Clinic** search window (Figure 5-8). Here you can search for a type of clinic.

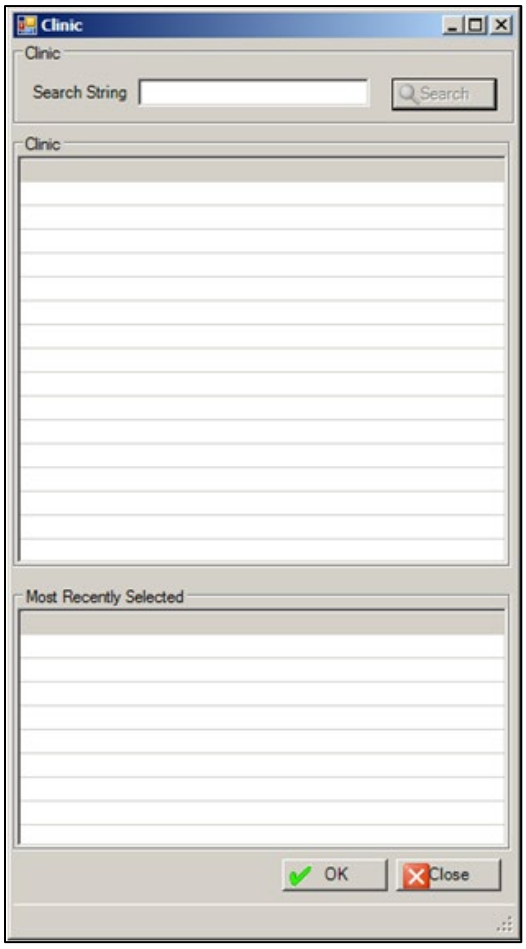
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the clinic and then clicking **Search**. The retrieved clinics and their codes will populate the **Clinic** list box. Select a clinic and click **OK** to populate the **Clinic** field. (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 5-8: Clinic search window

6. At the **Group Name** field, type the name of the **group encounter**, using between **1** and **30** characters. This is a free-text field.

5.2.2 Activities Tab

Use the **Activities** tab (Figure 5-9) 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.

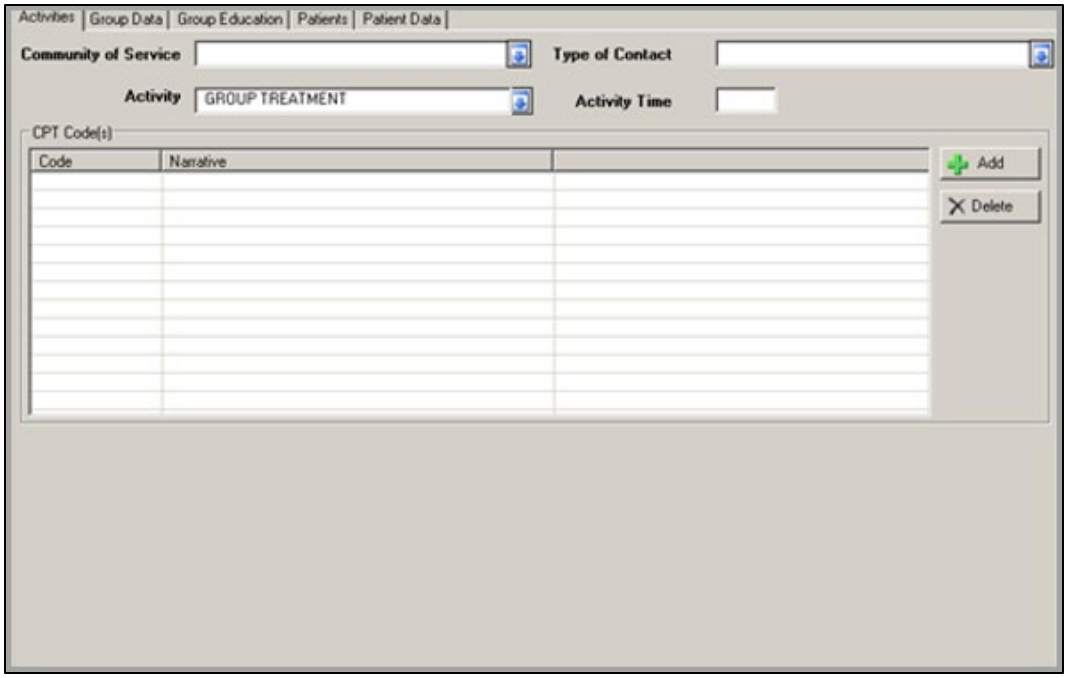


Figure 5-9: Activities tab

5.2.2.1 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 **list** to access the **Community** search window (Figure 5-10). Here you search for the **community name**.

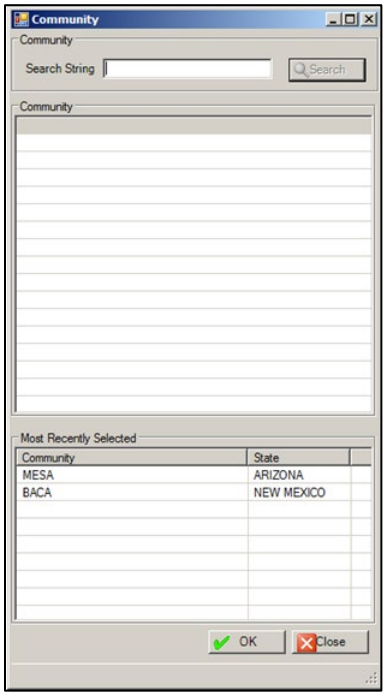
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and then clicking **Search**. The retrieved community names and their states will populate the **Community** list box. Select a community and click **OK** to populate 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 5-10: 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 list to access the **Type of Contact** window (Figure 5-11) where you select an option.

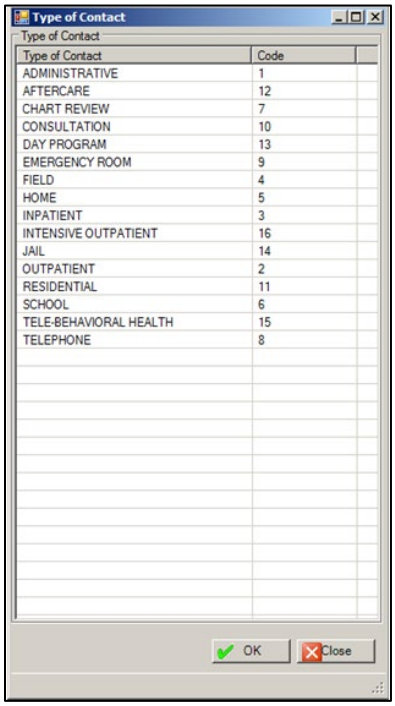
Screen Capture	What to Do
	Use the **Type of Contact** window as follows: (1) Select a type of contact from the list. (2) Click **OK** to populate the **Type of Contact** field. (Otherwise, click **Close.**)

Figure 5-11: 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 list to access the **Activity** search window (Figure 5-12). Here you search for an activity name or its code.

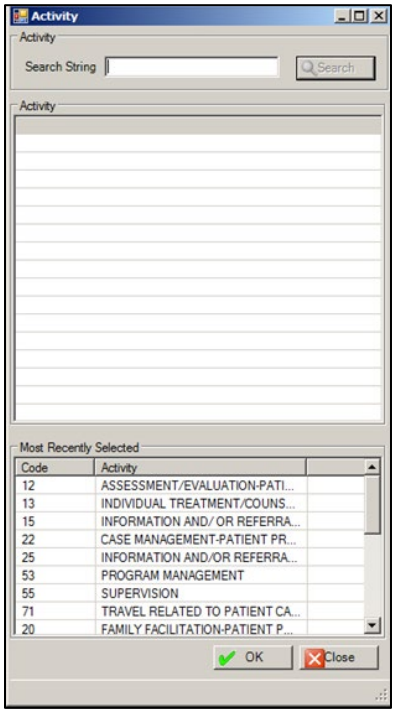
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the activity name or code and then clicking **Search**. The retrieved activities will populate the **Activity** list box. Select an activity and click **OK** to populate the **Activity** 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 5-12: 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**. Be aware that zero is not a valid entry.

5.2.2.2 CPT Codes Group Box

Use the **CPT Code** group box to manage the **CPT Codes** associated with the activity for the group.

5.2.2.2.1 Add Button

1. Click **Add**.

The **CPT Code search/select** window (Figure 5-13) displays.

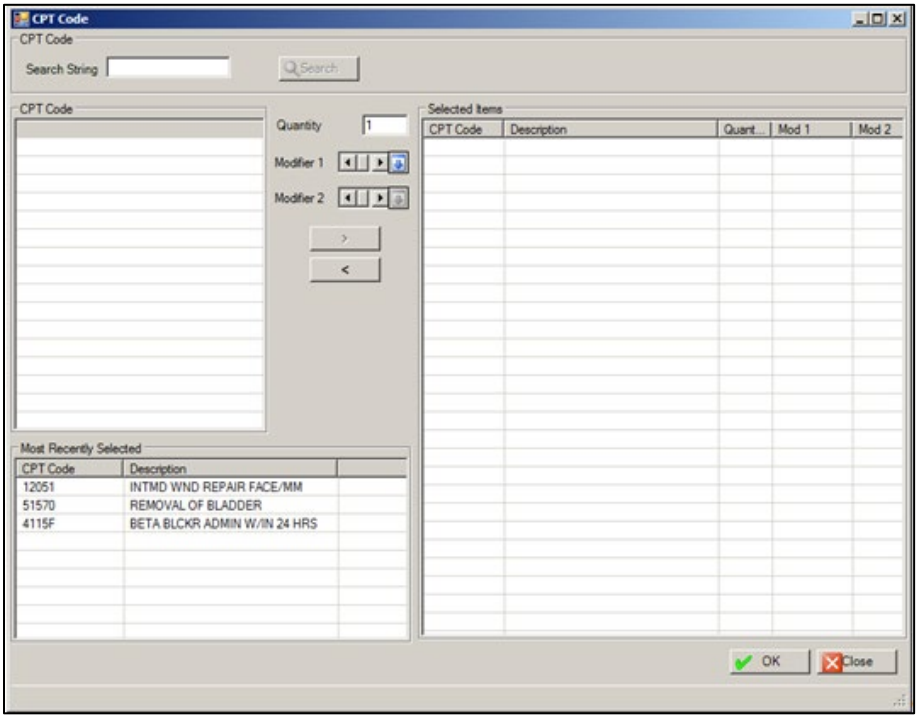


Figure 5-13: CPT Code search/select window

2. At the **Search String** field, type a search string to search for a particular **CPT Code**.

3. Click **Search**. The **CPT Codes** display in the **CPT Code** list field (Figure 5-14).

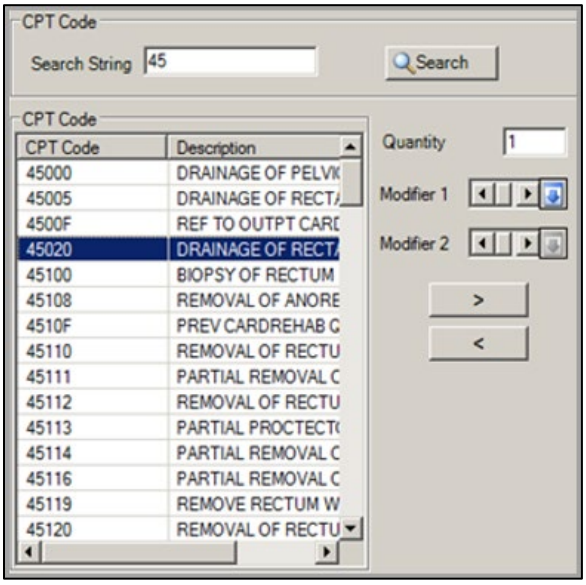


Figure 5-14: CPT Code search results

a. Select a retrieved **CPT Code**.

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

b. At the **Modifier** field, select the **modifier** for the **CPT Code**. Click the **list** to access the **CPT Modifier** search window (Figure 5-15).

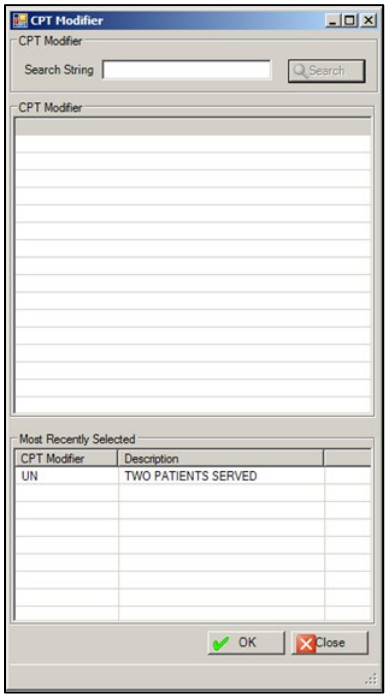
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the CPT Modifier name and then clicking **Search**. The retrieved CPT Modifier names and their descriptions will populate the **CPT Modifier** list box. Select a CPT modifier and click **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 5-15: CPT Modifier search window

c. After the **Quantity** and **Modifier** fields are complete, click the **Right Arrow** button to add the items to the **Selected Items** list box.

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

4. 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 Arrow** button.

5. Remove a selected **CPT Code** in the **Selected Items** list box by clicking the **Left Arrow** button.

6. 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**.)

5.2.2.2.2 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**.)

5.2.3 Group Data Tab

Use the **Group Data** tab (Figure 5-16) to specify **secondary providers**, **POV code**, **group note**, and **CPT Codes** for the group encounter.

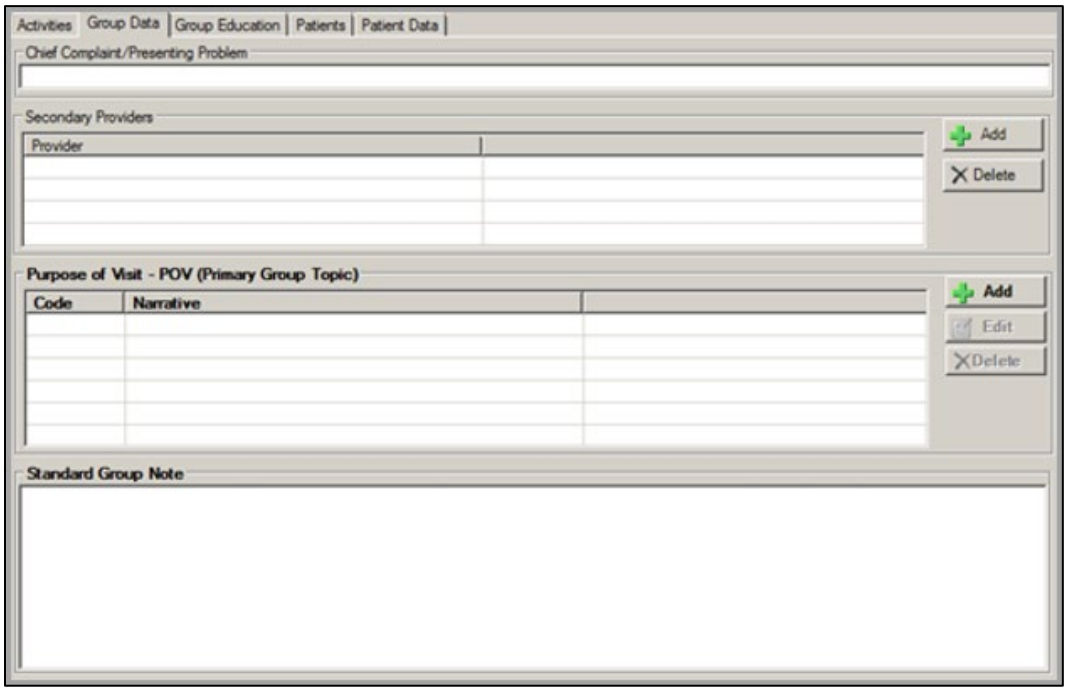


Figure 5-16: Group Data tab

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.

5.2.3.1 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 patient sought services.

5.2.3.2 Secondary Providers Group Box

Use the **Secondary Providers** group box (Figure 5-17) to add or delete secondary providers for the group encounter.

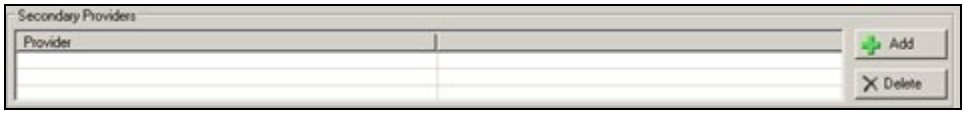


Figure 5-17: Secondary Providers group box

5.2.3.2.1 Add Button

1. Click **Add**.

   The **Secondary Provider** multiple search/select window (Figure 5-18) displays.

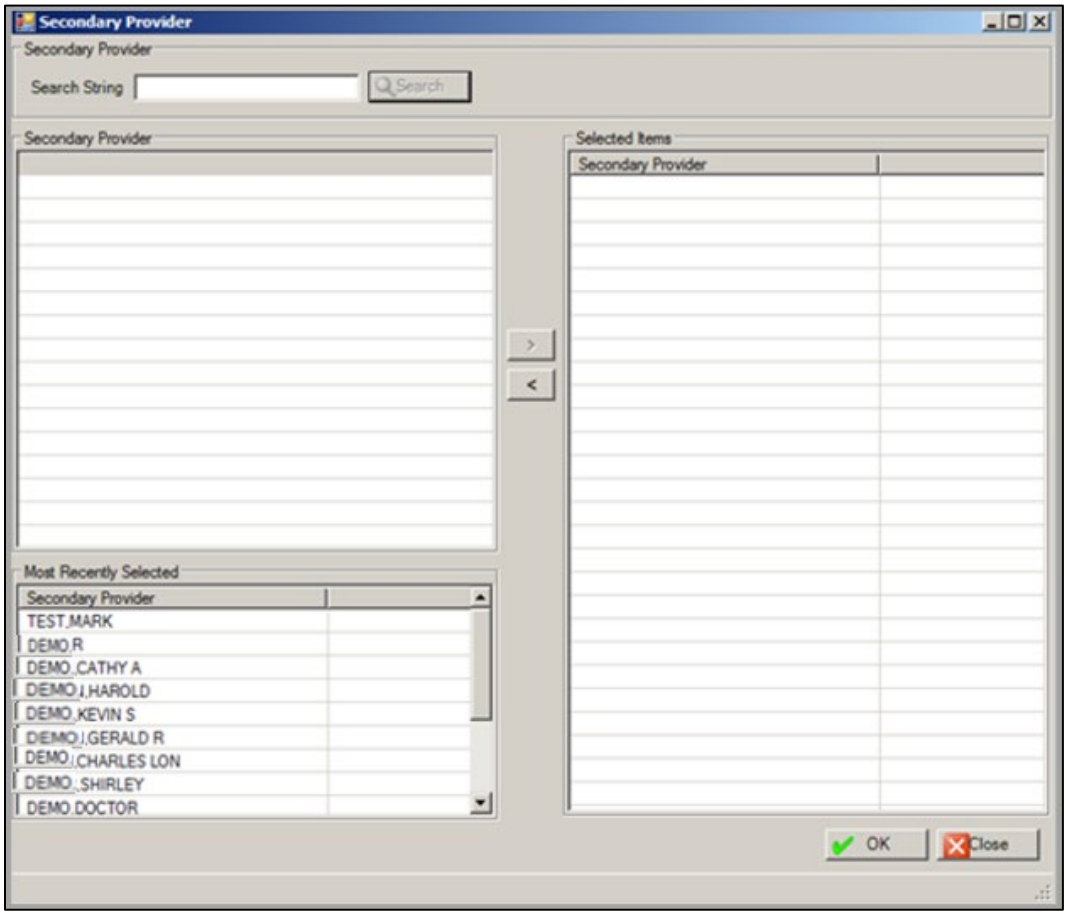


Figure 5-18: Secondary Providers search/select window

Use the **Secondary Providers** multiple search/select window in the following manner:

2. At the **Search String** field, type a few characters of the search criteria.
3. Click **Search** and the retrieved the records display in **Secondary Provider** list box.

4. To add one or more selected records from the **Secondary Provider** list box to the **Selected Items Secondary Provider** list box, click the **Right Arrow** button.

5. 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 Arrow** button.

6. Similarly, you can remove one or more selected records from the **Selected Items Secondary Provider** list box by clicking the **Left Arrow** button.

7. 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**.)

5.2.3.2.2 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 **Close**.)

5.2.3.3 Purpose of Visit–POV (Primary Group Topic) Group Box

Use this group box (Figure 5-19) to add, edit, or delete **POV codes** and their narratives associated with the group encounter. These are **POV**s 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.

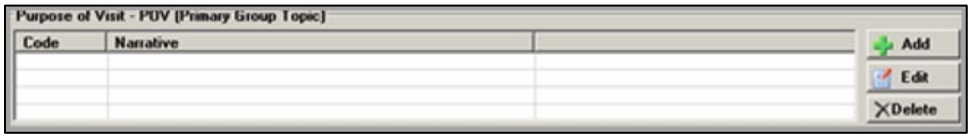


Figure 5-19: POV group box

Users can **add**, **edit**, or **delete POV** records in this group box.

5.2.3.3.1 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**.)

5.2.3.3.2 Add Button

1. Click **Add**.

   The **POV multiple search/select** window (Figure 5-20) displays.

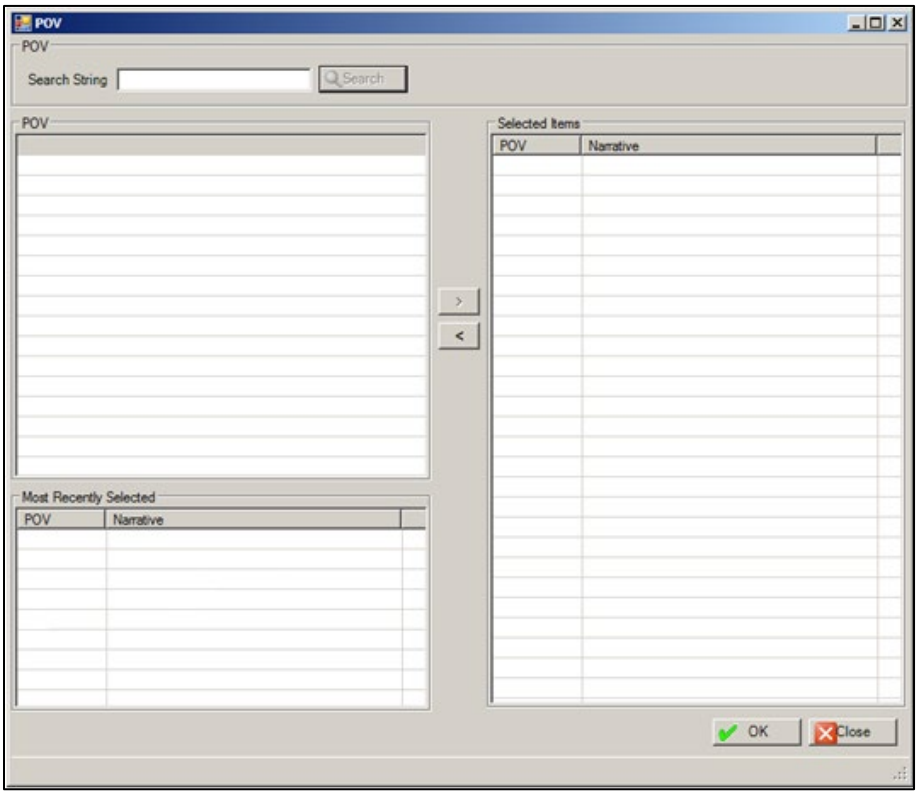


Figure 5-20: POV multiple select/search window

   Use the **POV multiple search/select** window in the following manner:

2. At the **Search String** field, type a few characters of the **search criteria**.
3. Click **Search** and the retrieved records display in **POV** list box (the **POV** and its narrative).
4. To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the **Right Arrow** button.
5. 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 Arrow** button.
6. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the **Left Arrow** button.
7. 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**.)

5.2.3.3.3 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 (Figure 5-21) displays.

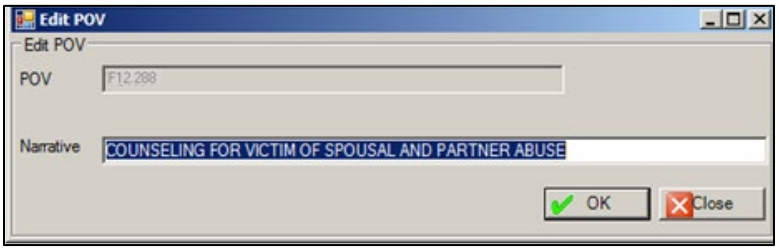


Figure 5-21: Edit POV dialog

4. At the **Narrative** field, type the new **POV narrative**, using **2–80** characters.

> **Note:** The special characters double or single quotation marks (**“** 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.)

5.2.3.4 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.

5.2.4 Group Education Tab

Use the **Group Education** tab (Figure 5-22) to **add**, **change**, or **delete** education data about the group encounter.

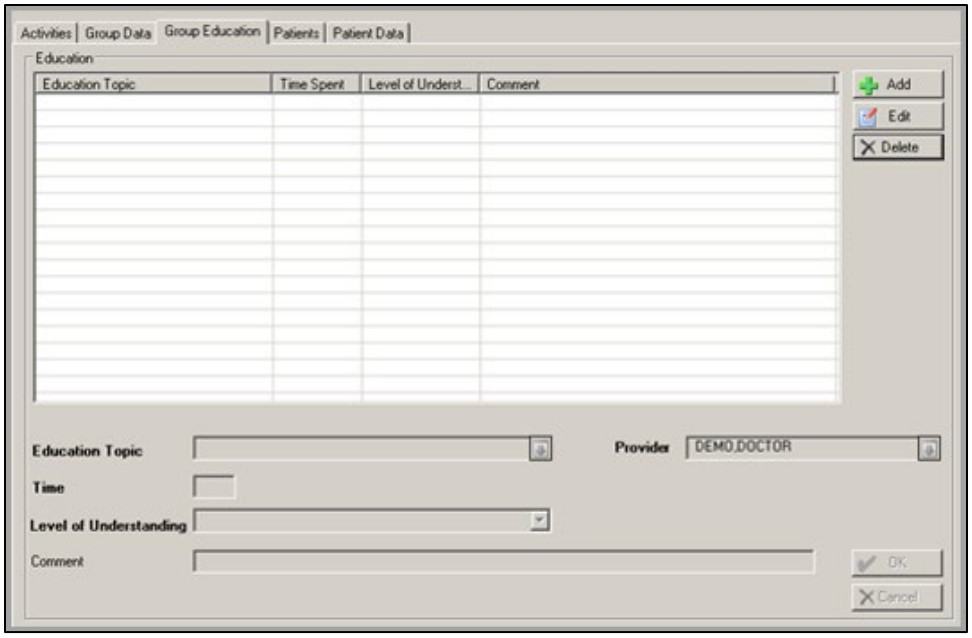


Figure 5-22: Sample Group Education tab

The information on this tab is read-only when using the **Edit Group Data** window.

5.2.4.1 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.

- Click **Add** to activate the fields below the education grid.

  Or

- Select a **record** to edit and click **Edit**.

1. At the **Education Topic** field, select the **education topic** for the group encounter. Click the **list** to access the **Education Topic** search window (Figure 5-23). Here you search for an education code.

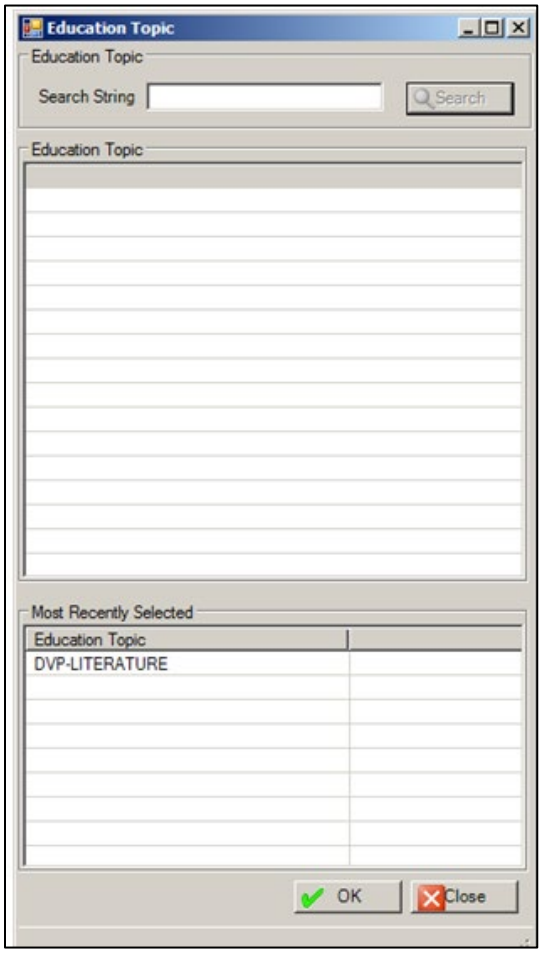
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the education topic and then clicking **Search**. The retrieved education topics will populate the **Education Topic** list box. Select a retrieved record and click **OK** to populate the **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 5-23: Education Topic select window

2. At the **Provider** field, select the provider for the group education. Click the list to access the **Education Provider** search window (Figure 5-24). Here you search for a provider name.

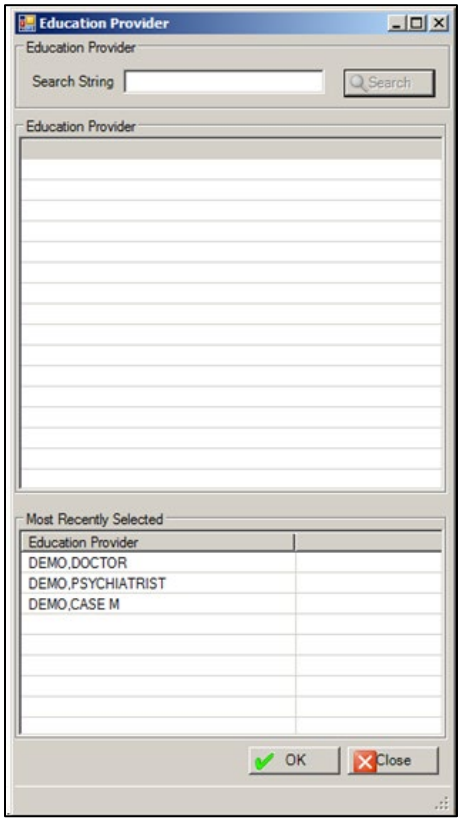
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the **Education Provider** list box. Select a retrieved record and click **OK** to populate the **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 5-24: Education Provider search window

3. At the **Time** field, type the time spent on the education topic, using any integer (**1–9999**). The understood units of measure are minutes.

4. At the **Level of Understanding** field, select the **level of understanding** about the education topic. The default is **Group-No Assessment** (the only choice).

5. At the **Comment** field, type any comments about the education topic for the group encounter.

6. Click **Cancel** to clear the fields on the **Group Education** tab.

7. Click **OK** when all fields are complete. This adds a record to the **Education** grid.

5.2.4.2 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:** **Group Education** can be removed only prior to saving the group. Once the group has been saved, there is currently no means to remove it in the group format.

5.2.5 Patients Tab

The **Patients** tab (Figure 5-25) shows the patients in the group encounter.

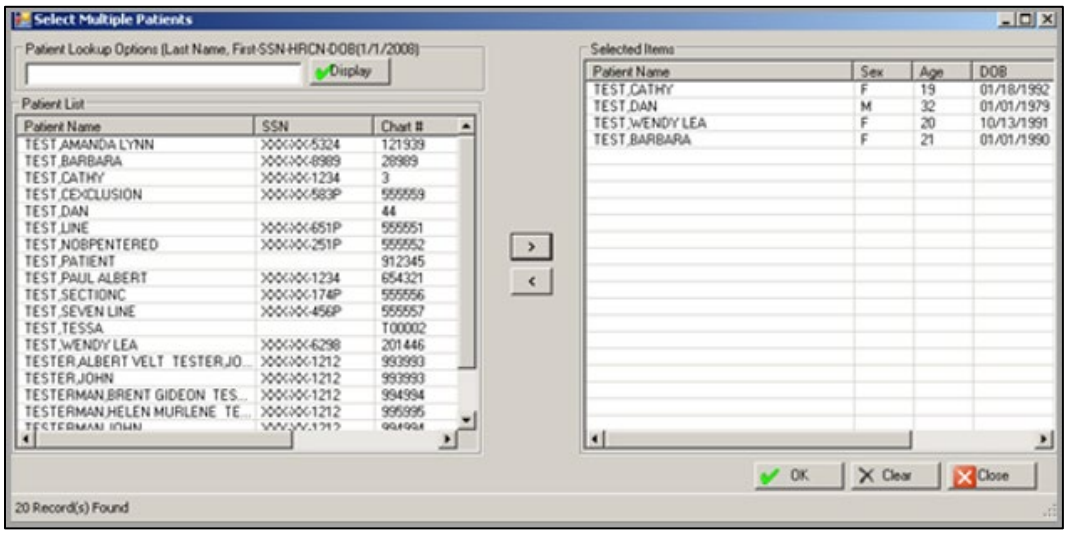


Figure 5-25: Patients tab

The information on this tab is read only when using the **Edit Group Data** window.

Add or delete **patient records** on this tab (on the **Add** window).

5.2.5.1 Add Patient Record

The **Add** button requires that the **POV group box** and the **Standard Note Group Note** (on the **Group Data** tab) are populated.

1. Click **Add** to access the **Select Multiple Patients** dialog (Figure 5-26).

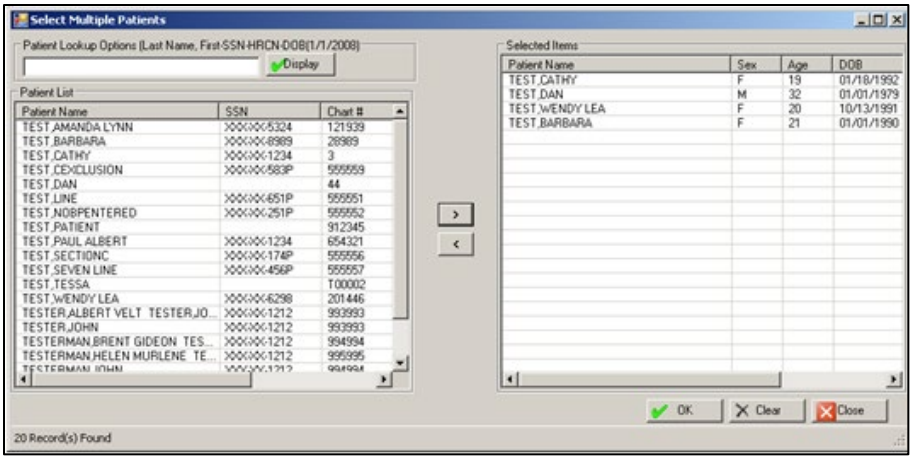


Figure 5-26: Select Multiple Patients dialog

Use this dialog to add one or more patients to the **Patients** tab.

2. At the **Patient Lookup** field, type the **patient name**, **HRN**, **DOB**, or **SSN**.
3. Click **Display**.

   The retrieved patients display in the **Patient List** box.

4. Select one or more **patient names** from the **Patient List** group box and click the **Right Arrow** button to add them to the **Selected Items** list box.

   - If needed, select a **patient name** from the **Selected Items** list box and click the **Left Arrow** button to move the **patient name** to the **Patient List** box.

5. 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.
   - 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.

5.2.5.2 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.

5.2.6 Patient Data Tab

Use the **Patient Data** tab (Figure 5-27) to add **POV**, **group note**, and **comment/next appointment** information for a particular patient in the group encounter.

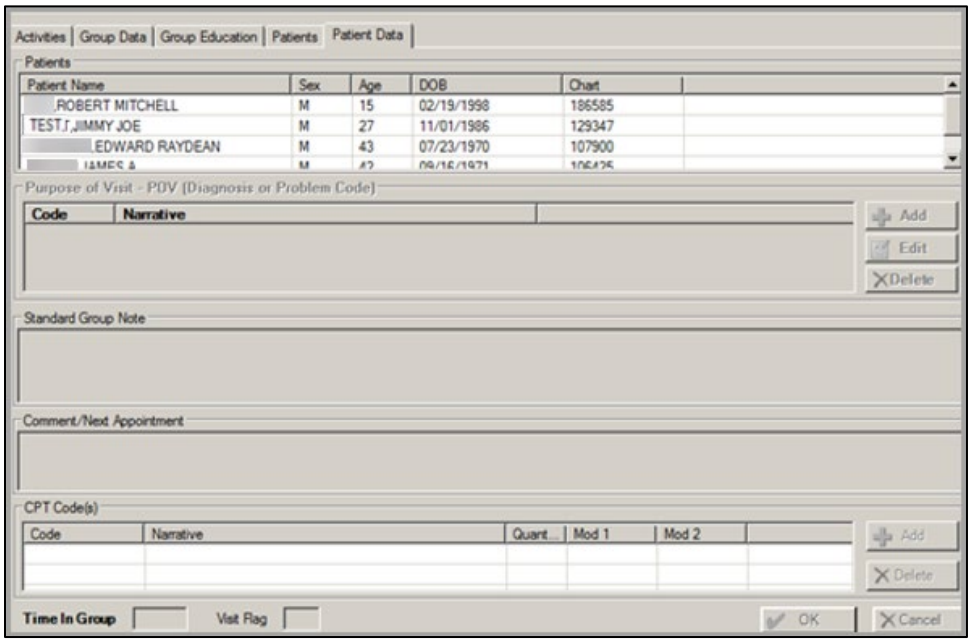


Figure 5-27: Patient Data tab

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

Table 5-3: Patient Data features and functionality

Features	Functionality
Patients list field	Select a patient by double-clicking the name in the Patients list box 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.

5.2.6.1 Patients List Box

The **Patients** list box (Figure 5-28) shows the patients in the group encounter.

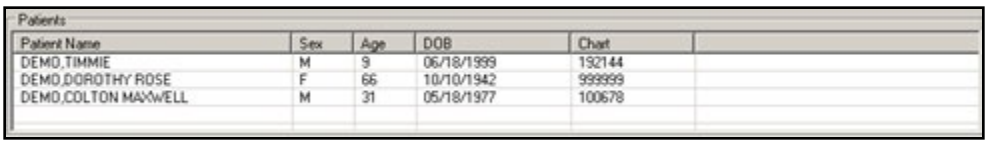


Figure 5-28: Patients list box

1. Double-click one of the patient names in order to use the other group boxes and fields.
2. After completing the information for the first patient, click **OK**. The focus returns to the **Patients** list box.
3. 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.
4. Click **Save** to save all of the information.

If you are in **ADD** mode, clicked **OK**, and then try to go to the **Group Data** tab, the application displays the **Continue** warning (Figure 5-29).

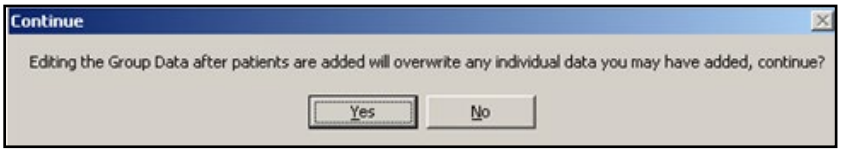


Figure 5-29: Continue warning message

- 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.

5.2.6.2 Purpose of Visit–POV (Diagnosis or Problem Code) Group Box

Use the **Purpose of Visit–POV (Diagnosis or Problem Code)** group box (Figure 5-30) 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.)

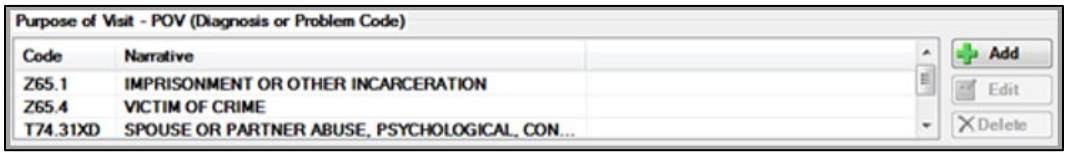


Figure 5-30: POV group box

This is required data for the group encounter record.

You can add, edit, or delete **POV** code records.

5.2.6.2.1 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**.)

5.2.6.2.2 Add Button

Click **Add**. The **POV** multiple search/select window (Figure 5-31) displays.

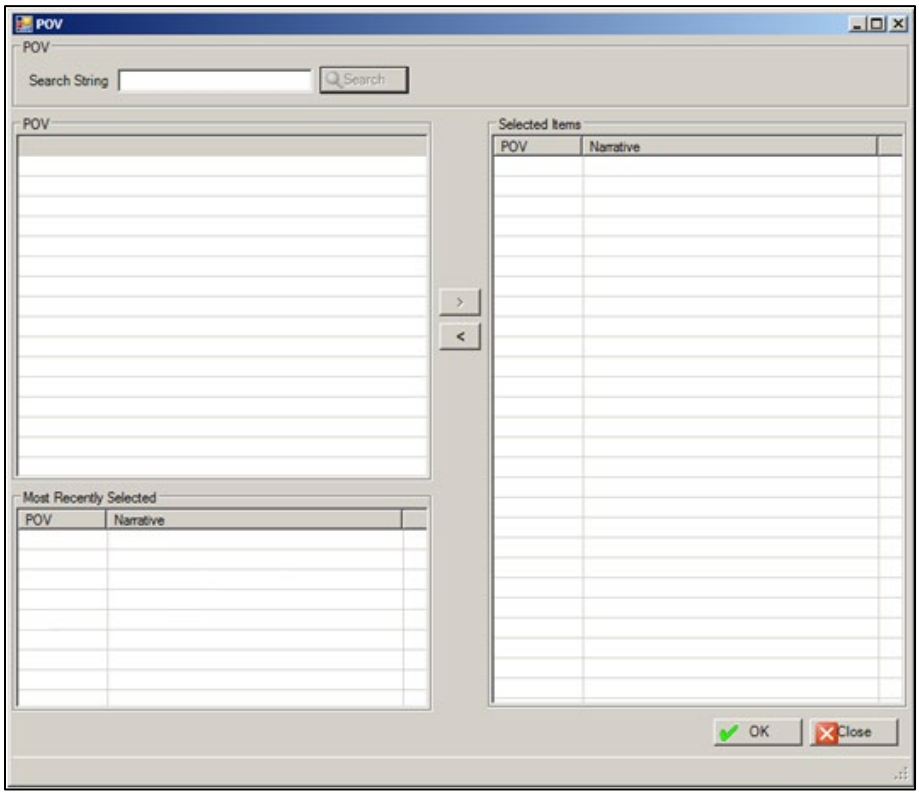


Figure 5-31: POV multiple select/search window

Use the **POV** multiple search/select window in the following manner:

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 Arrow** button.

- Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the **Left Arrow** button.
- 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 Arrow** button.

4. When the records in the **Selected Items** list box are complete, click **OK** and the records populate the **Purpose of Visit (POV)** group box. (Otherwise, click **Close**.)

5.2.6.2.3 Edit Button

1. Select a **POV** record to edit.
2. Click **Edit** to display the **Edit POV** dialog (Figure 5-32).

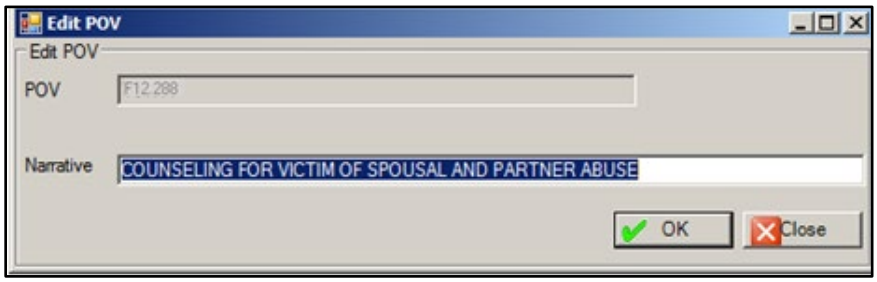


Figure 5-32: Edit POV dialog

3. At the **Narrative** field, change the text of the narrative, using **2–80** characters.

> **Note:** The special characters single and double quotation marks and asterisk (‘, “, *,) 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 **Patient Data** tab.
5. Otherwise, click **Close** to not change the narrative.

5.2.6.3 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 users can 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.

5.2.6.4 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).

5.2.6.5 CPT Codes Group Box

Use this group box (Figure 5-33) to manage the **CPT Codes** for the selected patient in the group.

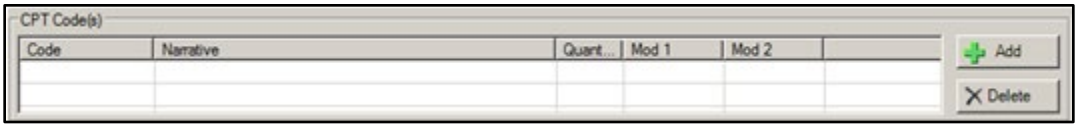


Figure 5-33: CPT Code(s) group box

Users can add or delete **CPT Code** records.

5.2.6.5.1 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**.)

5.2.6.5.2 Add Button

1. Click **Add**.

The **CPT Code** search/select window (Figure 5-34) displays.

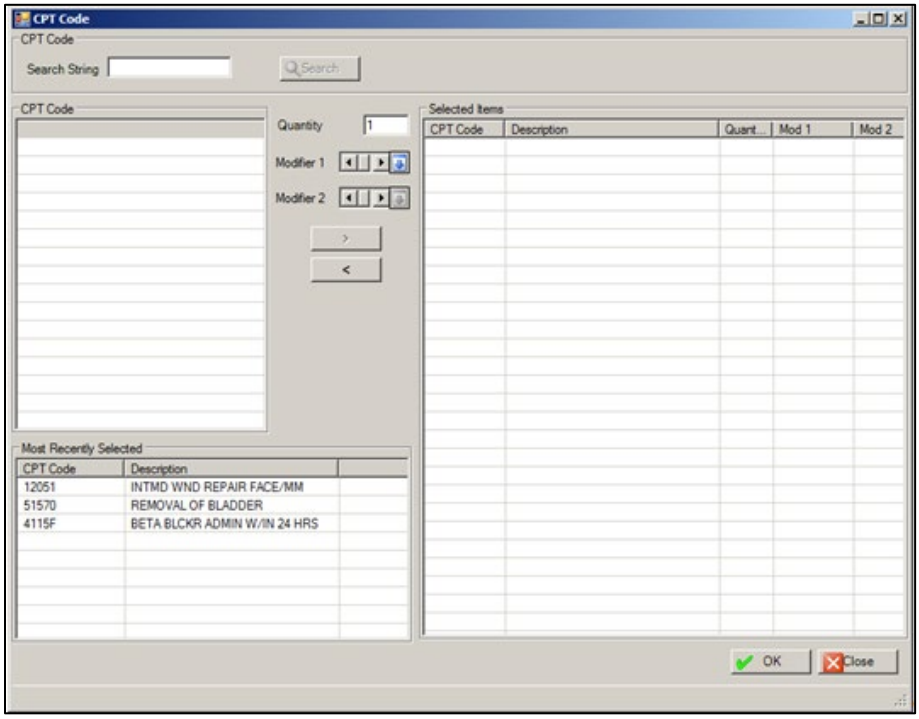


Figure 5-34: CPT Code search/select window

2. At the **Search String** field (Figure 5-35), type a search string to search for a particular **CPT Code**. The **CPT Codes** will display in the **CPT Code** field.

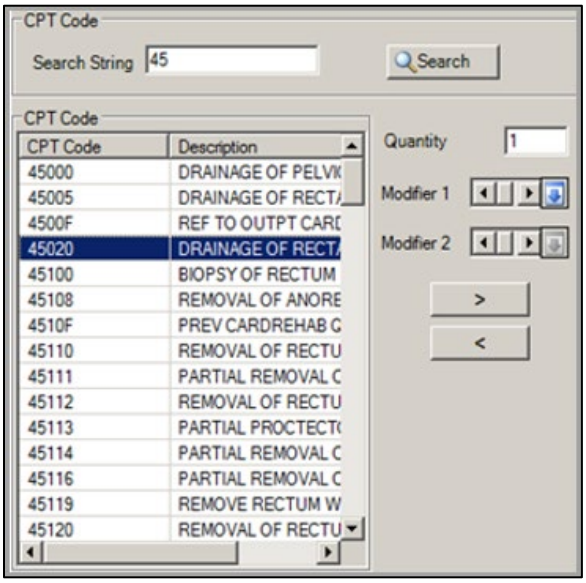


Figure 5-35: CPT Code search results

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

4. At the **Modifier** field, select the **modifier** for the **CPT Code**. Click the list to access the **CPT Modifier** search window (Figure 5-36).

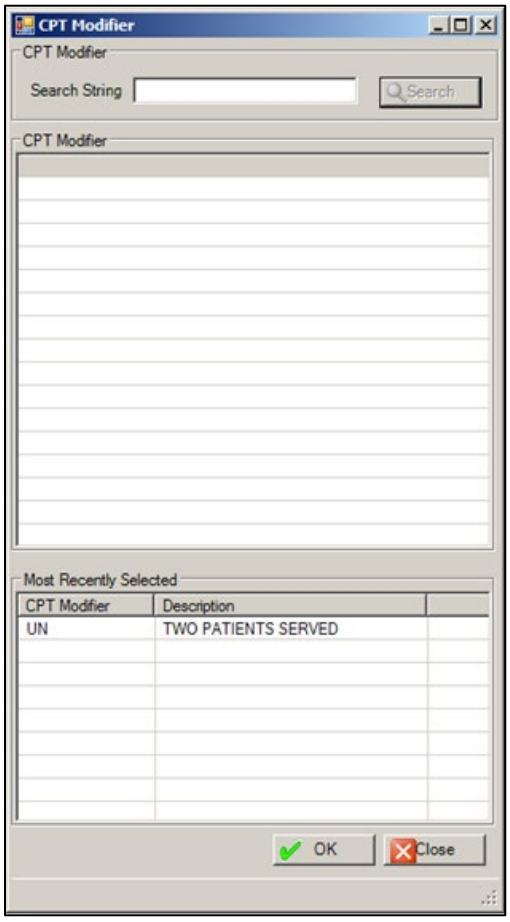
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by by typing the CPT Modifier name and then clicking **Search**. The retrieved CPT Modifier names and their descriptions will populate the **CPT Modifier** list box. Select a CPT modifier and click **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 5-36: CPT Modifier search window

5. Remove a selected **CPT Code** in the **Selected Items** list box by clicking the **Left Arrow** button.

6. After the **Quantity** and **Modifier** fields are complete, click the **Right Arrow** button to add the items to the **Selected Items** list box.

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**.)

5.2.6.6 Time in Group

1. At the **Time in Group** field (Figure 5-37), type the **number of minutes** in the group encounter (up to **six digits**).

Figure 5-37: Time in Group field

This is required data for the **group encounter** record.

Consider the following:

- If the patient attended the whole group session, no changes need to be made to the **Time in Group** field.
- If the patient was late or left early, the **Time in Group** field must be changed to reflect the actual time in minutes that the patient was in the group.
- If the patient did not attend at all, type a **zero** in the **Time in Group** field and 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 are now prompted for a **No Show POV**. Click **OK**.
- After clicking **OK**, 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).

5.2.6.7 Visit Flag

Use the **Visit Flag** field (Figure 5-38) to specify the **visit flag** for the group encounter.

Figure 5-38: Visit Flag field

- At the **Visit Flag** field, type 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. Users can later 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 **RPMS AMH (GUI)**.

6.1 Case Management Window (GUI)

The figure below shows where the **Case Management** function is located on **RPMS AMH (GUI)** tree structure (Figure 6-1).

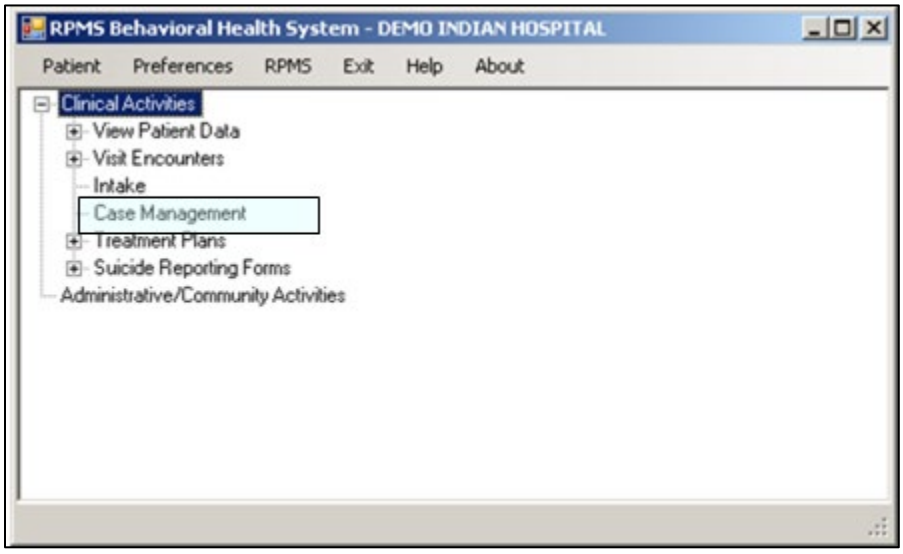


Figure 6-1: Case Management option on the RPMS AMH (GUI) tree structure

Use the **Case Management** option to access the **Case Management** window (Figure 6-2) for the current patient.

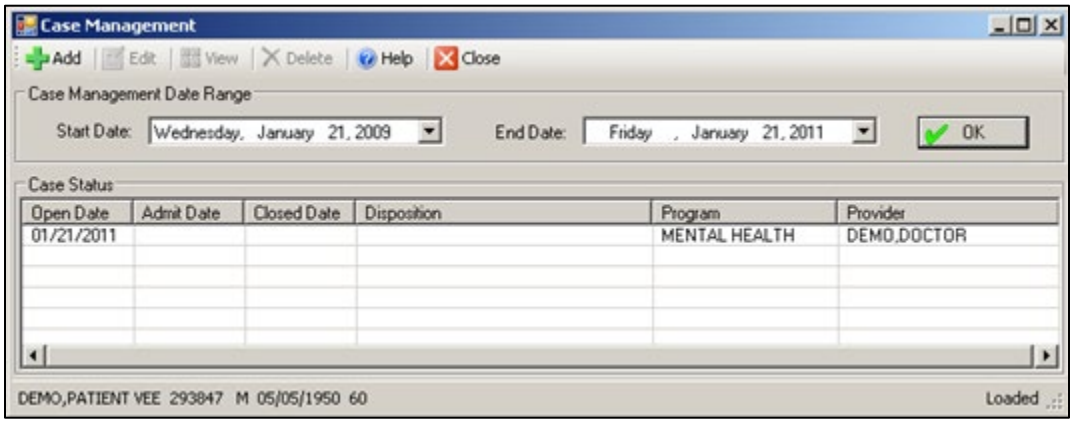


Figure 6-2: Case Management window

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).

Table 6-1provides information about the features of the **Case Management** window.

Table 6-1: Case Management window features and functionality

Feature	Functionality
Case Management Date Range Group Box	The date range for the displayed case management records is shown in the **Case Status Date Range** group box. Change the date range by accessing the calendar under the 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 to use in the add process. Click **Add** to add a new case management record and 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 windows.
Delete Button	Click **Delete** to remove a selected Case Status record. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking to verify deletion. 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.

6.2 Add/Edit Case Management Data (GUI)

Use this function to add or edit **case management** data.

- Click **Add** and the **Case Management–Add Case** window displays.

  Or

- 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.

The following shows the **Case Management–Add Case** window.

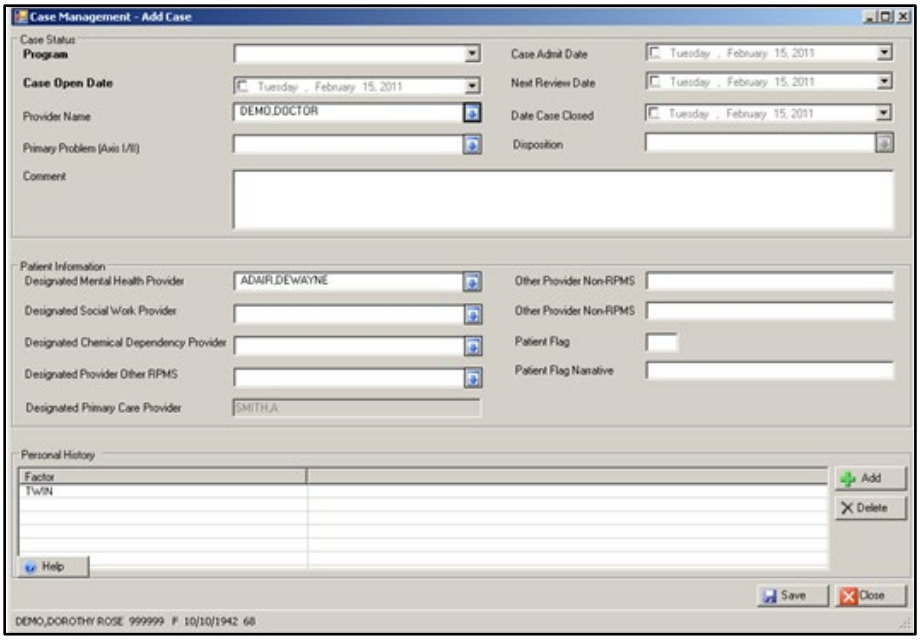


Figure 6-3: Case Management–Add Case window

Table 6-2 provides information about the buttons on this window.

Table 6-2: Case Management–Add Case window buttons and functions

Button	Functionality
Save	Click to save the case management information on this window. This process dismisses the window.
Close	Click to display the **Continue?** dialog. This dialog states: "Unsaved Data Will Be Lost, Continue?" Click **Yes** to not save; this dismisses the add window. Click **No** to remain on the **Add Case** window and continue work.

Button	Functionality
Help	Click to access the online help for this window.

6.2.1 Case Status Group Box

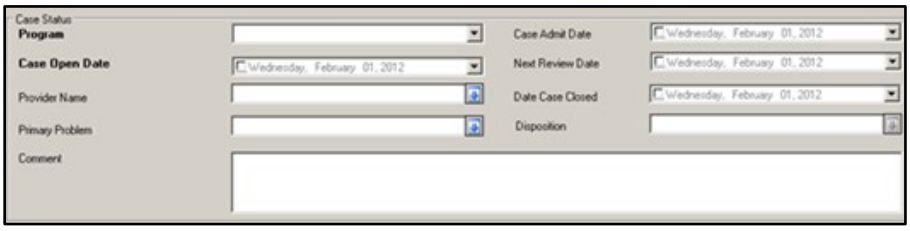


Figure 6-4: Fields in Case Status group box

The fields in bold text are required.

1. At the **Program** field, select the program associated with the new case. Use one of the following from the list:
   - Mental Health
   - Social Services
   - Chemical Dependency
   - Other
2. At the **Case Admit Date** field, select the **Case Admin** date. This is when a case management plan was developed, and treatment began. Accept the default date by selecting the check box in front of the date. The default is the current date. Click the **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 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 list to access a calendar to change the field. 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 logged-in user). Click the list to access the **Primary Provider** search/select window (Figure 6-5).

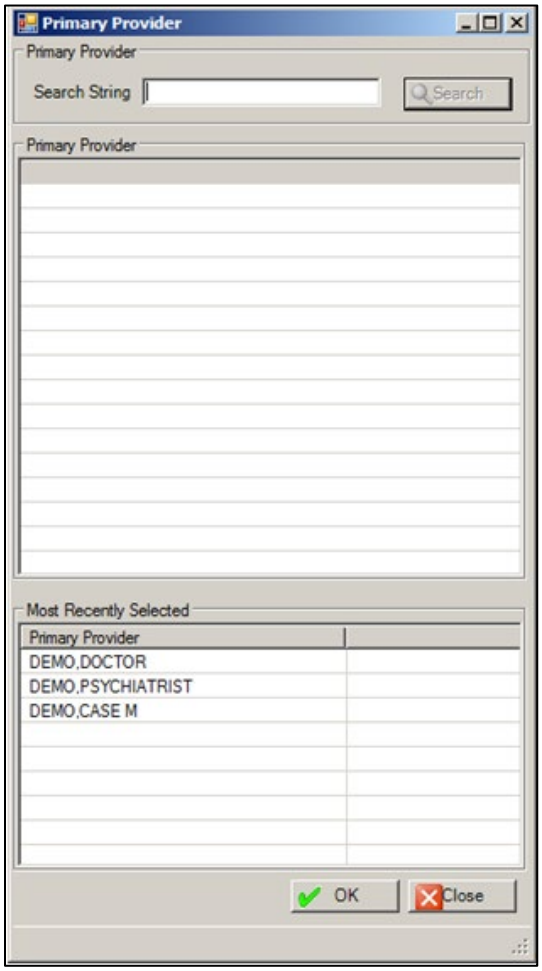
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a name and click **OK** to populate the **Provider Name** 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 6-5: 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.
   a. Click the list to access a calendar to change the field.
   b. Accept the default date by selecting the check box in front of the date.
7. At the **Primary Problem** field, select the primary problem for the case.
   a. Click the list to access the **POV** search window (Figure 6-6).

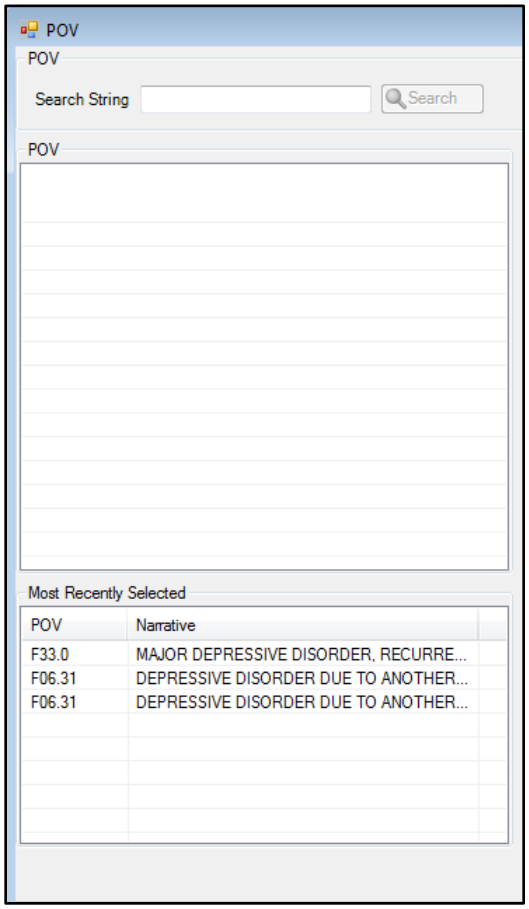
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the POV for the primary problem for the case and then **Search**. The retrieved POVs will populate the **POV** list box. Select a retrieved record and click **OK** to populate the **Primary 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 6-6: Primary Problem/POV search window

8. At the **Disposition** field, select the reason for closing a case. Click the list to select an option on the **Disposition** select window (Figure 6-7). This is required when there is a date in the **Date Case Closed** field.

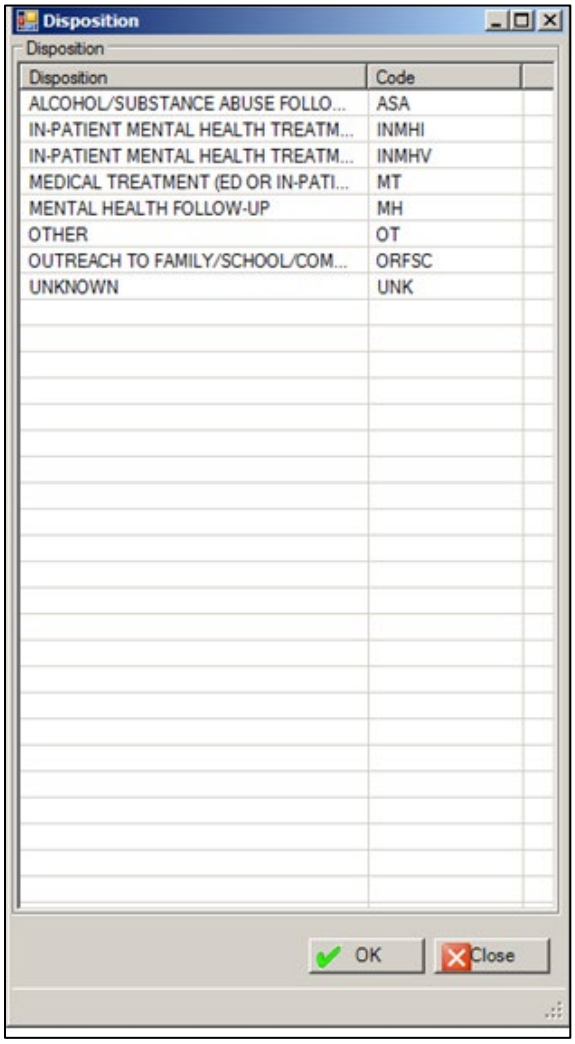
Screen Capture	What to Do
	Use this search window as follow: (1) Select a Disposition option and click **OK** (otherwise, click **Cancel**). (2) After clicking **OK**, the selected option populates the **Disposition** field.

Figure 6-7: Disposition select window

9. At the **Comment** prompt, type a comment about the case, using **1–240** characters in this free-text field.

6.2.2 Patient Information Group Box

Use the **Patient Information** group box to supply information about various providers and other case management information.

Figure 6-8: Fields in the Patient Information group box

Note: These fields should be cleared out whenever the case is closed; otherwise, the patient will continue to show up on the provider's case list. To clear the field, right-click and select **Clear**.

All fields are optional.

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 list to access the **Designated Mental Health Provider** search window (Figure 6-9).

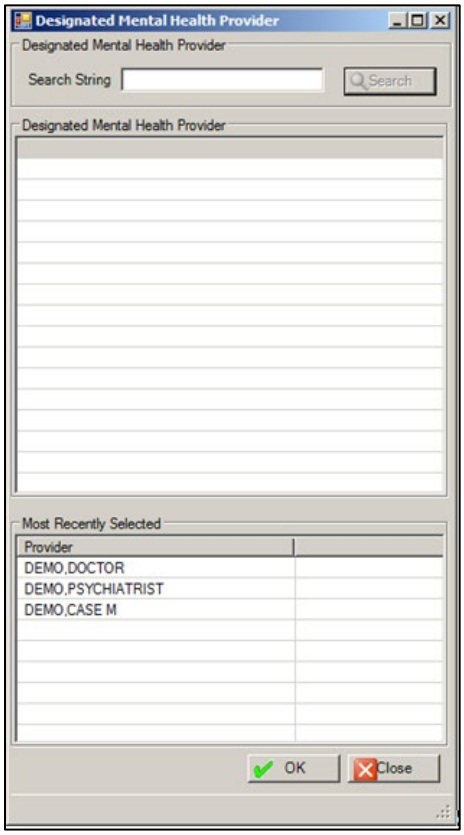
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the **Designated Mental Health Provider** list box. Select a retrieved record and click **OK** 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 6-9: 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 list to access the **Designated Social Work Provider** search window (Figure 6-10).

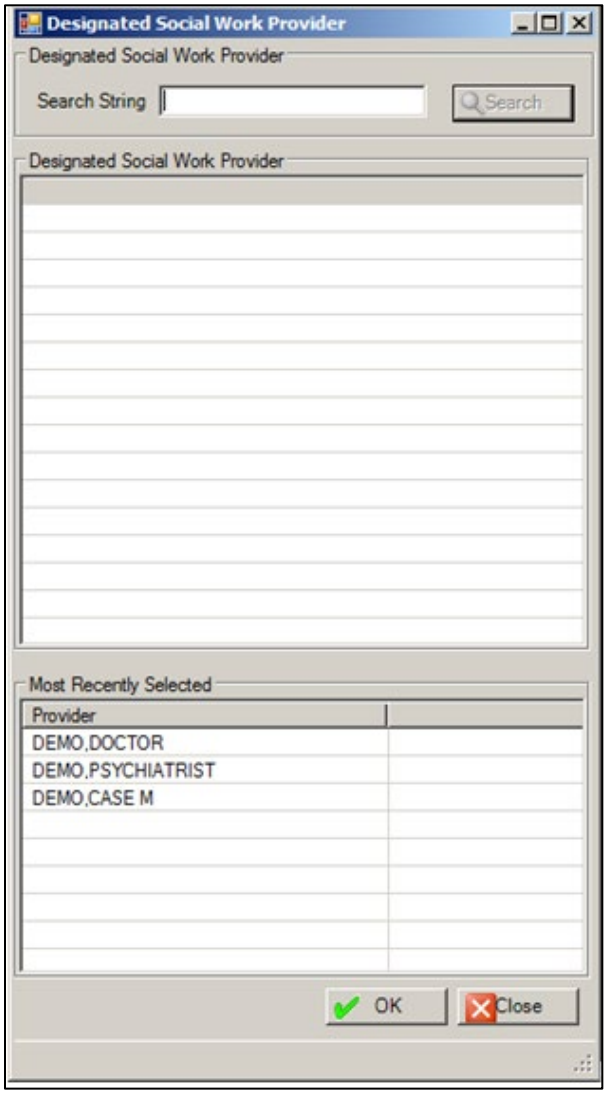
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the **Designated Social Work Provider** list box. Select a retrieved record and click **OK** 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 6-10: Designated Social Work Provider search window

4. At the **Other Provider Non-RPMS** prompt, type another provider name not listed in RPMS, using **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 list to access the **Designated Chemical Dependency Provider** search window (Figure 6-11).

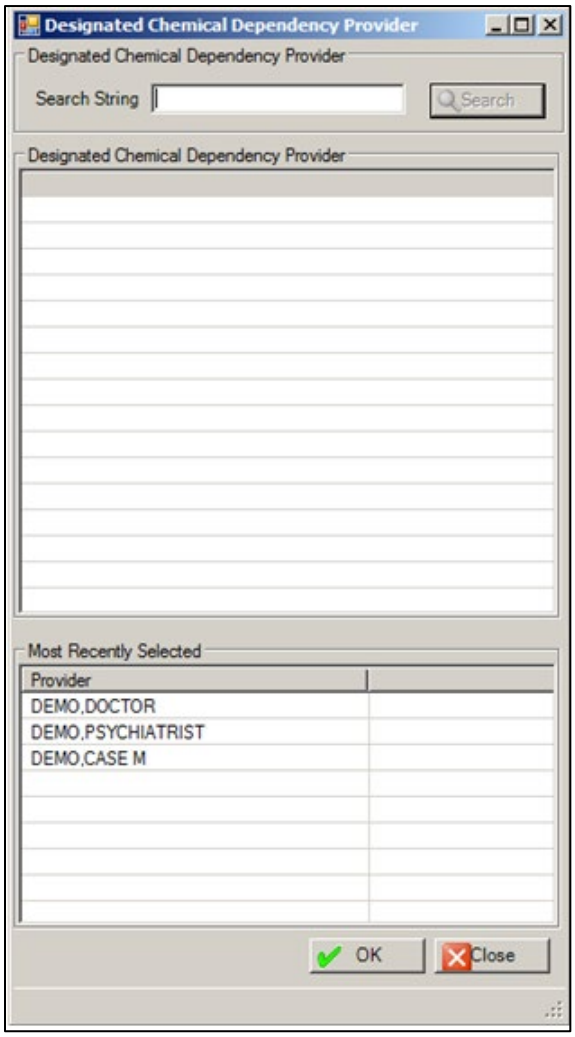
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the **Designated Chemical Dependency Provider** list box. Select a retrieved record and click **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 6-11: 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 the **Designated Other RPMS Provider** status for the patient. Click the list to access the **Designated Other RPMS Provider** search window (Figure 6-12).

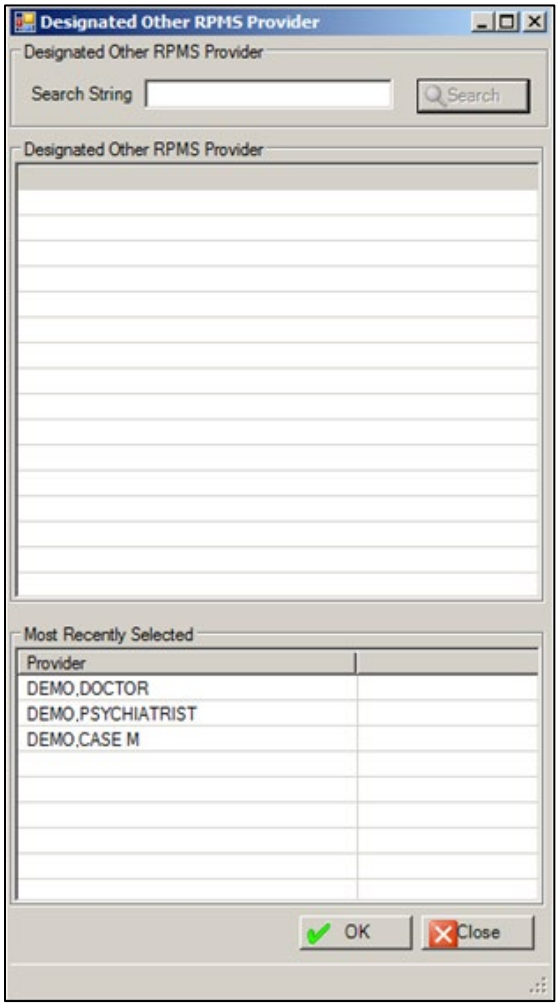
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved providers will populate the **Designated Other RPMS Provider** list box. Select a retrieved record and click **OK**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

Figure 6-12: Designated Other RPMS Provider search window

8. At the **Patient Flag Narrative** field, type the narrative about the patient flag, using **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.

6.2.3 Personal History Group Box

Use the **Personal History** group box to add or delete personal history data about the current patient.

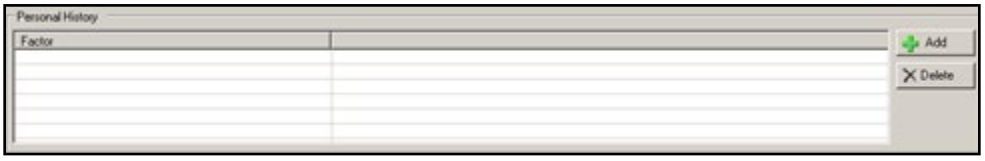


Figure 6-13: Sample Personal History group box

Users need to document personal history only once, because it becomes 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.

6.2.3.1 Add Button

1. Click **Add**.

The **Personal History Factors** multiple select window (Figure 6-14) displays, where users can add one or more personal history factors.

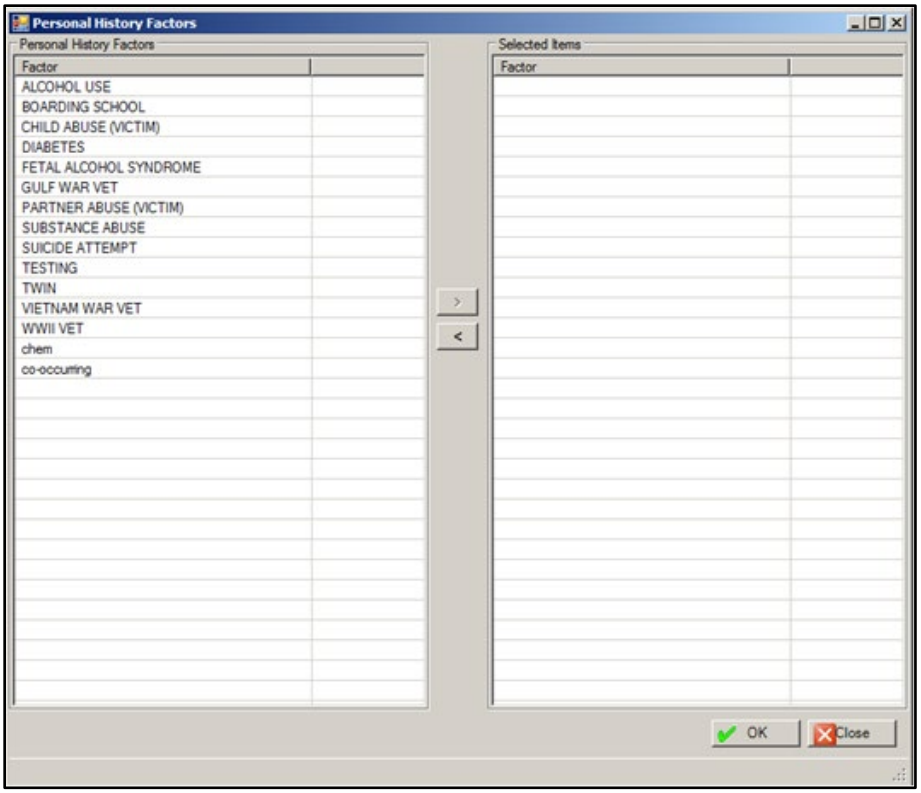


Figure 6-14: Personal History Factors multiple select window

Use this multiple select window as follows:

2. To add one or more selected records from the **Personal History Factors** list box to the **Selected Items Factor** list box, click the **Right Arrow** button.

3. Similarly, you can remove one or more selected records from the **Selected Items Factor** list box by clicking the **Left Arrow** button.

4. When the **Selected Items Factor** list box is complete, click **OK** and the records populate the **Personal History** group box. (Otherwise, click **Close**.)

6.2.3.2 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 Administrative/Community Activity Window (GUI)

Below shows where the **Administrative/Community Activities** function is located on **RPMS AMH (GUI)** tree structure.

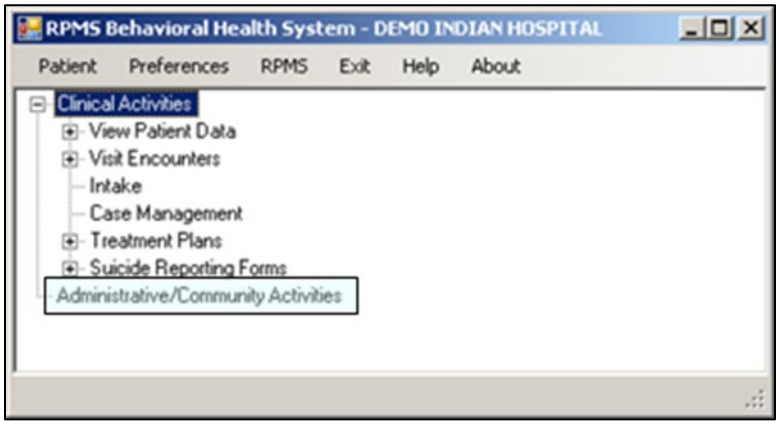


Figure 7-1: Administrative/Community Activities option on the RPMS AMH (GUI) tree structure

After selecting the **Administrative/Community Activities** option from the **RPMS AMH (GUI)** tree structure, the **Administrative/Community Activity** window displays.

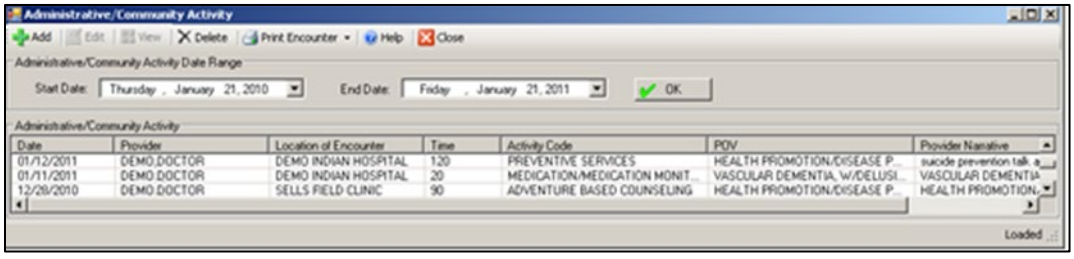


Figure 7-2: Sample Administrative/Community Activity window

The **Administrative/Community Activity** window shows the administrative/community activities records.

The following table (Table 7-1) provides information about the features on this window.

Table 7-1: Administrative/Community Activity window features and functions

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 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 and 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.

7.2 Add/Edit Administrative/Community Activity (GUI)

1. Click **Add** on the **Administrative/Community Activity** window (Figure 7-3) to add new administrative/community activity data. This function displays the **Administrative/Community Activity Data Entry–Add Administrative/Community Data** window.

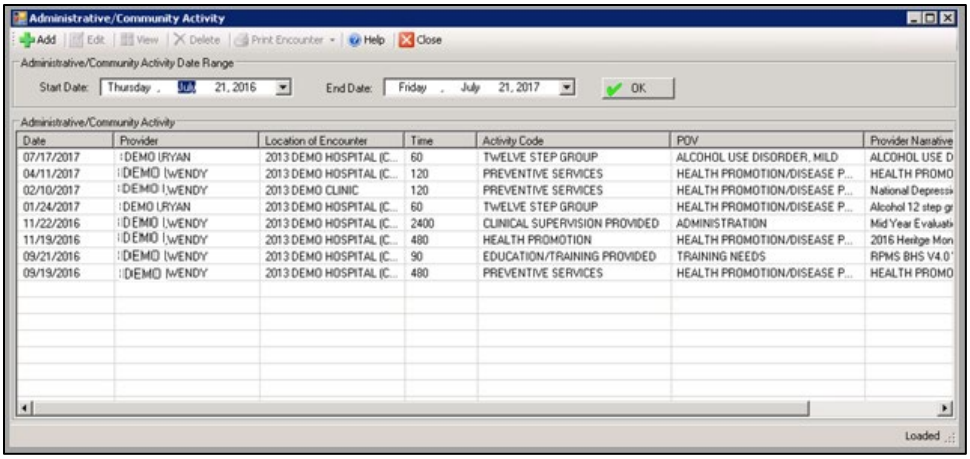


Figure 7-3: Sample Community Activity Data Entry list view

2. 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 (Figure 7-4). This window has the same fields as the **Administrative/ Community Activity Data Entry–Add Administrative/ Community Data**.

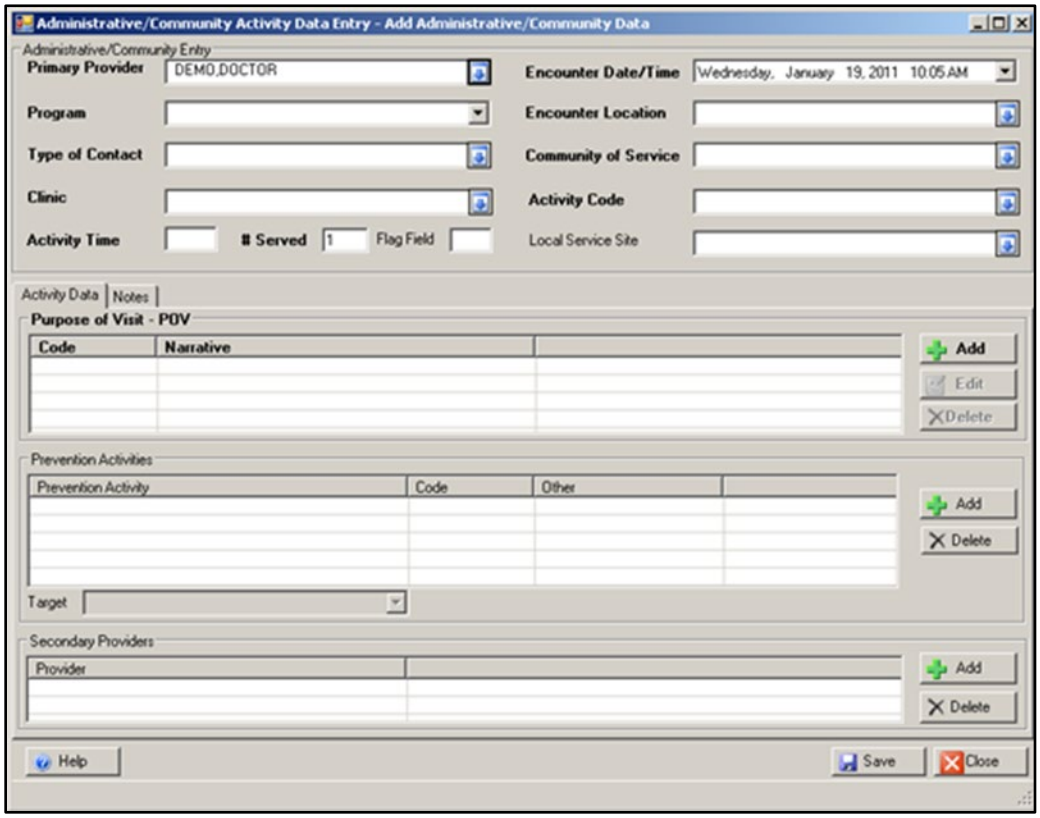


Figure 7-4: Community Activity Data Entry–Add Administrative/Community Data window

3. Click **Help** to access the online help for this window.

4. After completing the fields on this window, click **Save**. (Otherwise, click **Close**). Clicking **Save** adds a record to the **Administrative/Community Activity** window.

7.2.1 Administrative/Community Entry Group Box

Below is the **Administrative/Community Entry** group box (Figure 7-5).

Figure 7-5: Administrative/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 list to access the **Primary Provider search/select** window (Figure 7-6) and search for the primary provider name.

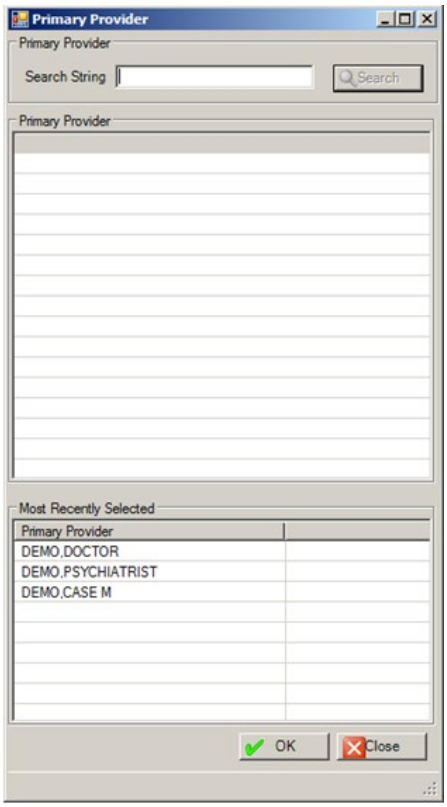
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the provider's last name and then clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a name and click **OK** to populate the **Primary Provider** 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 7-6: 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 list to access the calendar. Users can change the time manually and select the hour, minutes, and **AM/PM**. If you enter the hour and minutes as **13:25**, for example, 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
   - Chemical Dependency
   - Other

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 list to access the **Location** search window (Figure 7-7) and search for a location name.

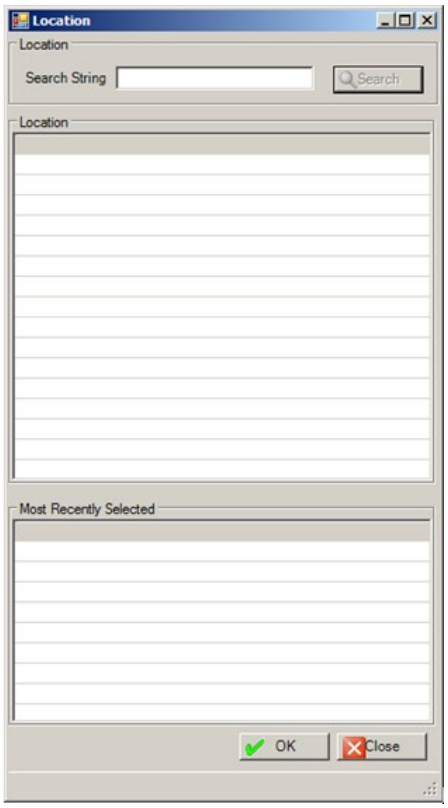
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the location and clicking **Search**. The retrieved locations will populate the **Location** list box. Select a location and click **OK** to populate the **Encounter Location** field. (Otherwise, 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 7-7: 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 list to access the **Type of Contact** select window (Figure 7-8).

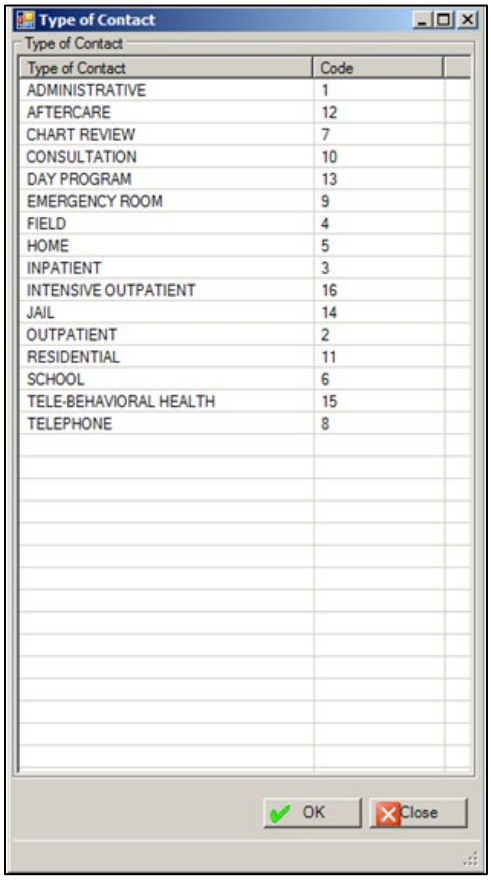
Screen Capture	What to Do
	Use this window as follows: (1) Select a type of contact from the list. (2) Click **OK** to populate the **Type of Contact** field. (Otherwise, click **Close.**)

Figure 7-8: Type of Contact select window

6. At the **Community of Service** prompt, select the community of service where the encounter took place. Click the list to access the **Community** search window (Figure 7-9) and search for a community name.

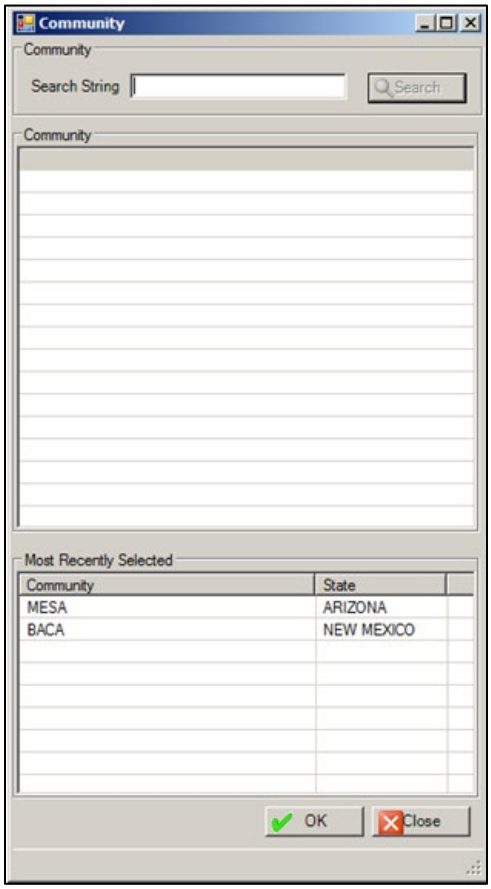
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and then clicking **Search**. The retrieved names will populate the **Community** list box. Select a retrieved record and click **OK** to populate the **Community of 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 7-9: Community search/select window

7. At the **Clinic** field, select the clinic associated with the administrative/community activity. Click the list to access the **Clinic** search/select window (Figure 7-10) and search for the clinic by name or code.

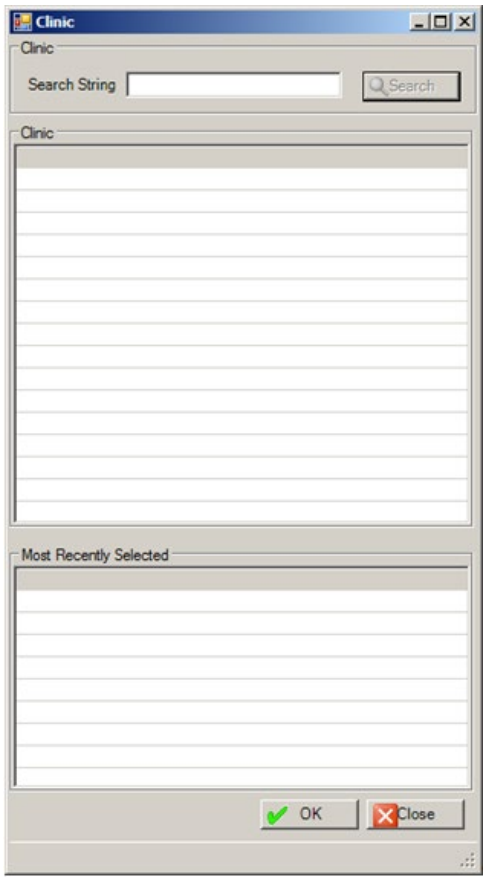
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the clinic name or code and then clicking **Search**. The retrieved records will populate the **Clinic** list box. Select a retrieved record and click **OK** to populate the **Clinic** 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 7-10: Clinic search/select window

8. At the **Activity Code** field, select the activity code associated with the administrative/community activity. Click the list to access the **Activity** search/select window (Figure 7-11) and search for the activity name. Appendix A: Activity Codes and Definitions provides more information.

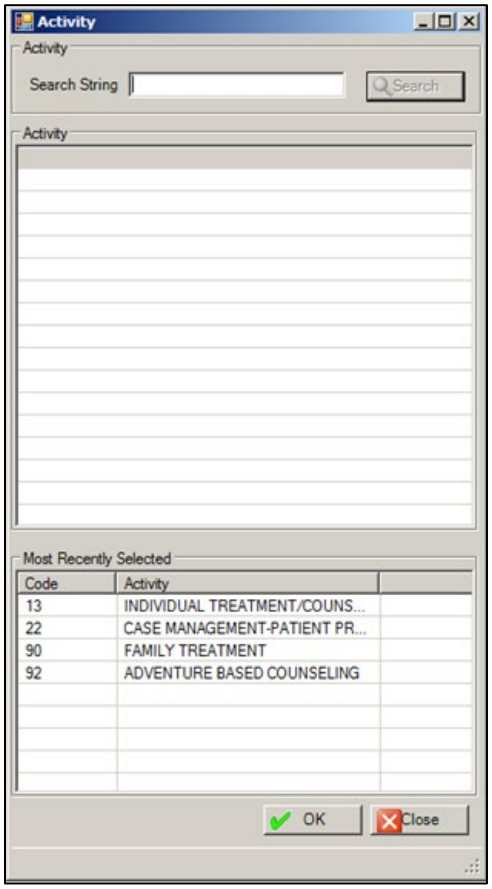
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the activity and then clicking **Search**. The retrieved records will populate the Activity list box. Select a retrieved record and click **OK** to populate the **Activity Code** field. (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 7-11: 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, 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** that will list all visits on which narcotics were prescribed.

12. At the **Local Service Site** window (Figure 7-12) select the local service site associated with the administrative/community activity, if any. Click the list to access the **Local Service Site** select window.

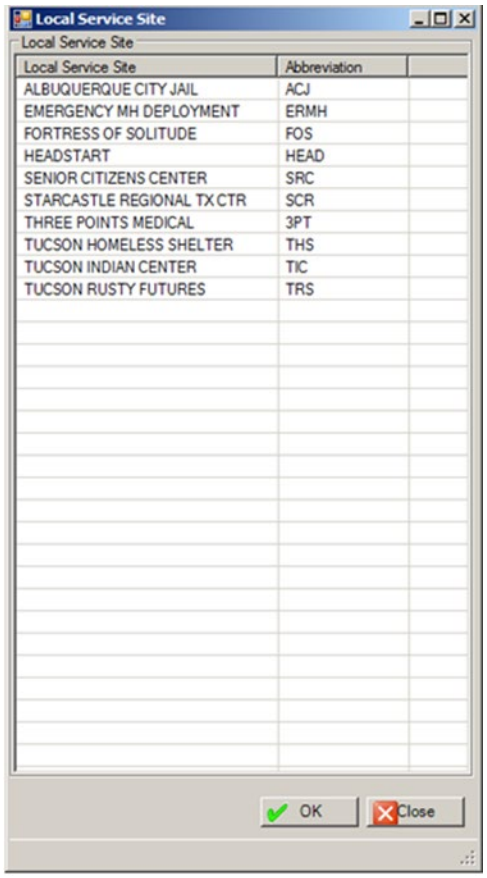
Screen Capture	What to Do
	Use this window as follows: (1) Select a **local service site** from the list. (2) Click **OK** to populate the **Local Service Site** field. (Otherwise, click **Close**.)

Figure 7-12: Local Service Site select window

7.2.2 Activity Data Tab

Use the **Activity Data** tab (Figure 7-13) to specify the **Purpose of Visit–POV**, **Prevention Activities**, and **Secondary Providers** data.

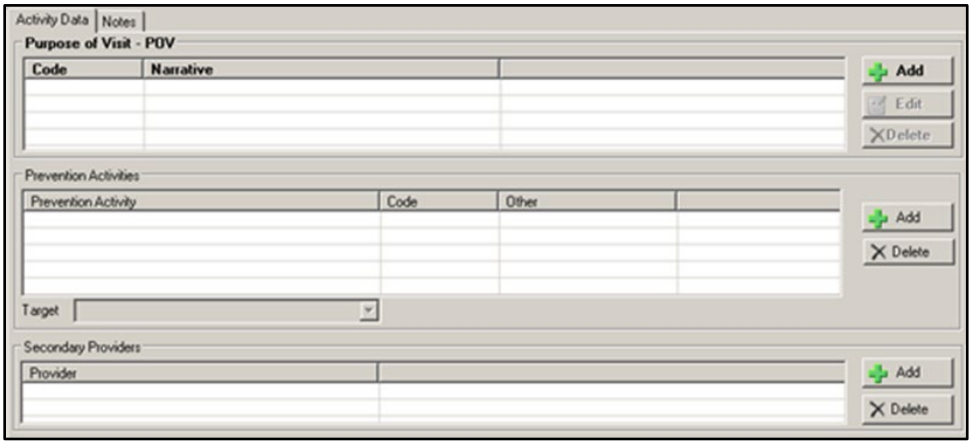


Figure 7-13: Activity Data tab

7.2.2.1 Purpose of Visit–POV Group Box

The **Purpose of Visit–POV** group box (Figure 7-14) lists the **POVs** associated with the administrative/community activity.

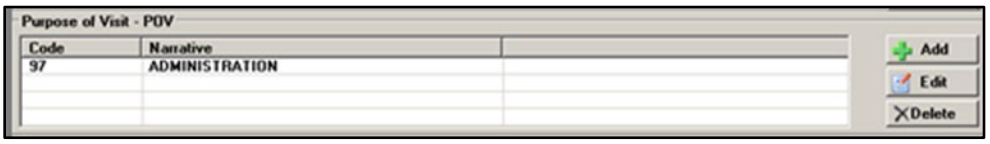


Figure 7-14: POV Group Box

At least one **POV** is required for an administration/community activity record. Users can **add**, **change**, or **delete** a record.

7.2.2.1.1 Add Button

1. Click **Add**.

   The **POV** search/select window (Figure 7-15) displays. Select one or more **POVs**.

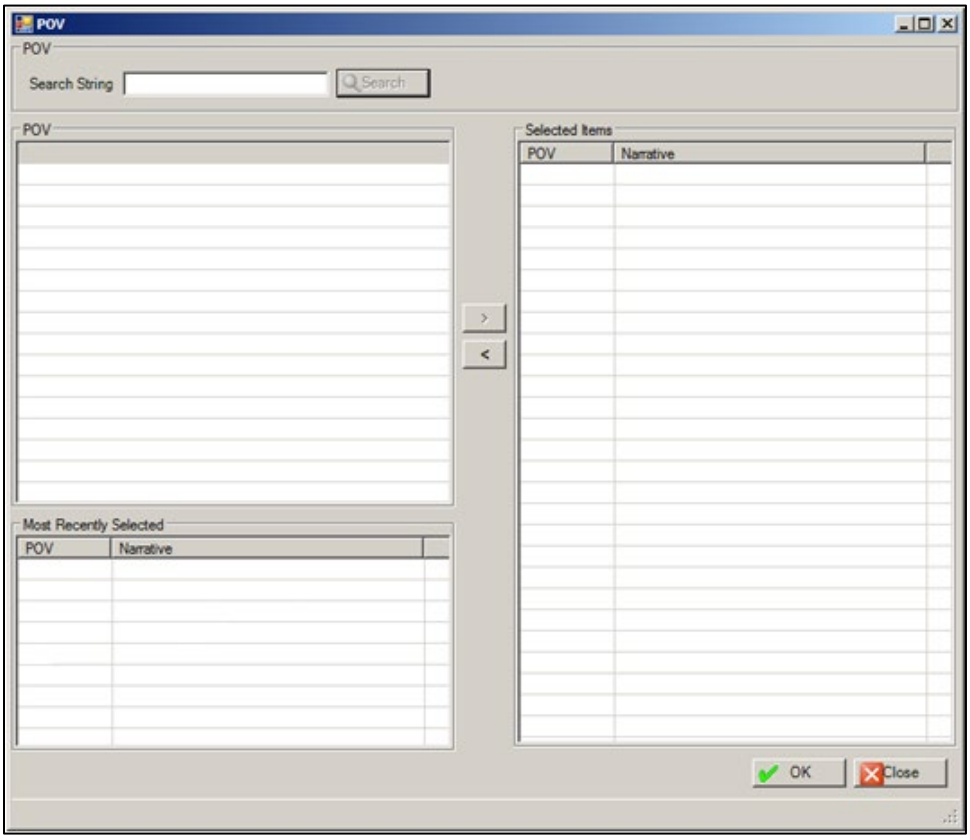


Figure 7-15: POV Search/Select window

   Use this search/select window as follows:

2. At the **Search String** field, type a few characters of the search criteria.

3. Click **Search** and the retrieved the records display in **POV** list box (the POV and its narrative).

   a. To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the **Right Arrow** button.

   b. Similarly, you can remove one or more selected records from the **Selected Items** list box by clicking the **Left Arrow** button.

4. When the **Selected Item** list box is complete, click **OK** and the records populate the **POV** group box. (Otherwise, click **Close**.)

7.2.2.1.2 Edit Button

1. Select the **POV** record to change.

2. Click **Edit**.

   The application displays the **Edit POV** window (Figure 7-16).

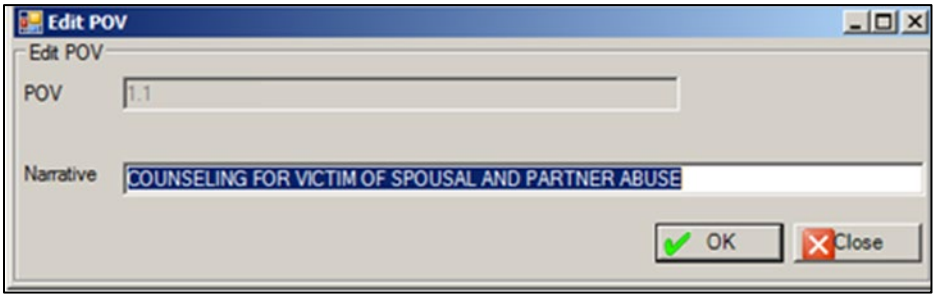


Figure 7-16: Edit POV window

3. At the **Narrative** field, type new **POV narrative** in the **Narrative** text box using **2–80** characters.

> **Note:** The special characters double or single quotation marks (**“** or **‘**) cannot be the first character of the POV narrative. This is a free-text field.

4. Click **OK** to change the narrative of the selected record. (Otherwise, click **Close**.)

7.2.2.1.3 Delete Button

1. Select a **record** to delete.

2. Click **Delete**.

   The **Are You Sure?** confirmation message displays.

3. Click **Yes** to remove the selected group encounter record from the **POV** group box. (Otherwise, click **No**.)

7.2.2.2 Prevention Activities Group Box

The **Prevention Activities** group box (Figure 7-17) lists the prevention activities associated with the administrative/community activity.

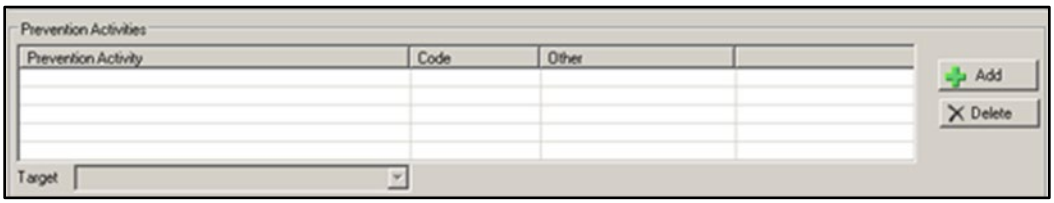


Figure 7-17: Prevention Activities group box

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.

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
   - Men

7.2.2.2.1 Add Button

1. Click **Add**.

   The **Prevention Activity** multiple select window displays.

2. Select one or more **prevention activities**. (Figure 7-18).

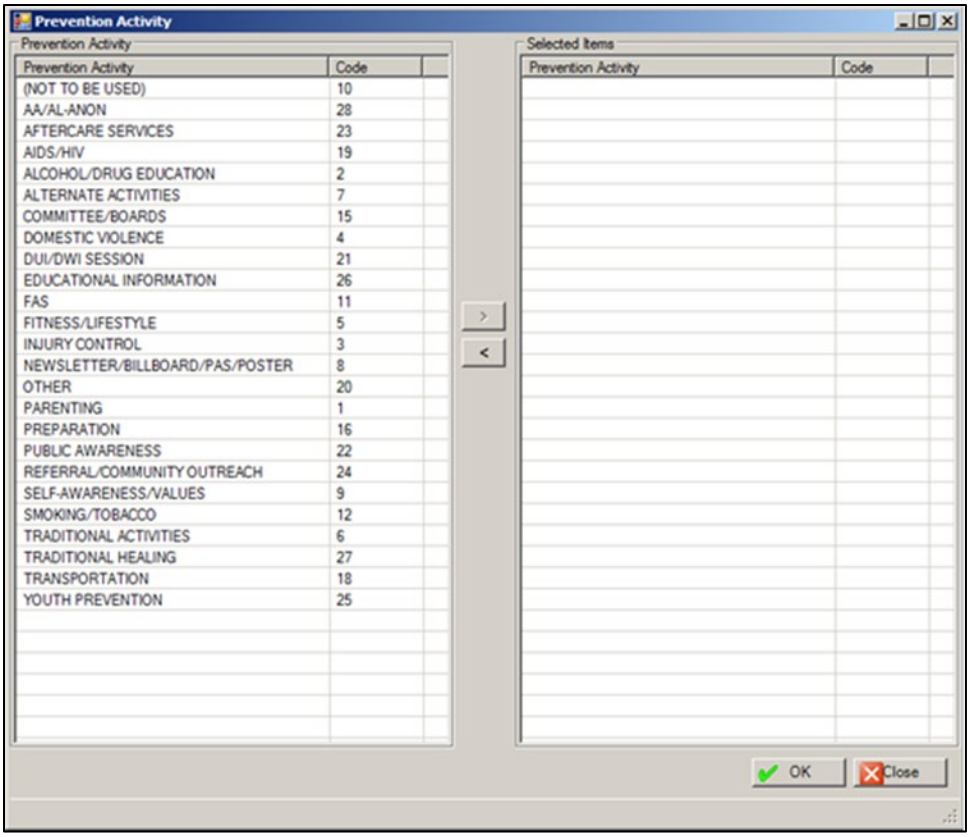


Figure 7-18: Prevention Activity multiple select window

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 Arrow** button.

a. Similarly, remove one or more selected records from the **Selected Items Prevention Activity** list box by clicking the **Left Arrow** button.

b. When the **Selected Items Prevent Activity** list box is complete, click **OK** and the records populate the **Prevention Activity** group box. (Otherwise, click **Close**.)

c. If you select **OTHER (Code 20)** on the **Prevention Activity** search/select window, the application displays the **Other** window (Figure 7-19).

Figure 7-19: Other window

d. At the **Other** field, type the **text** of the other prevention activity associated with this record (limited to **80** characters).

e. 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.

7.2.2.2.2 Delete Button

1. Select the **prevention activity record** to delete.
2. Click **Delete**.
3. At the **Are You Sure?** confirmation message, click **Yes** to remove the selected **prevention activity record** from the group box. (Otherwise, click **No**.)

7.2.2.3 Secondary Providers Group Box

The **Secondary Providers** group box (Figure 7-20) lists the secondary providers associated with the administrative/community activity.

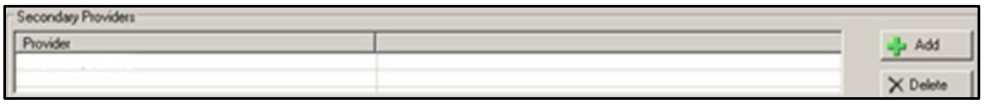


Figure 7-20: Secondary Providers group box

Add or delete a record.

7.2.2.3.1 Add Process

1. Click **Add** to access the **Secondary Providers** search/select window (Figure 7-21). Select one or more **secondary provider names**.

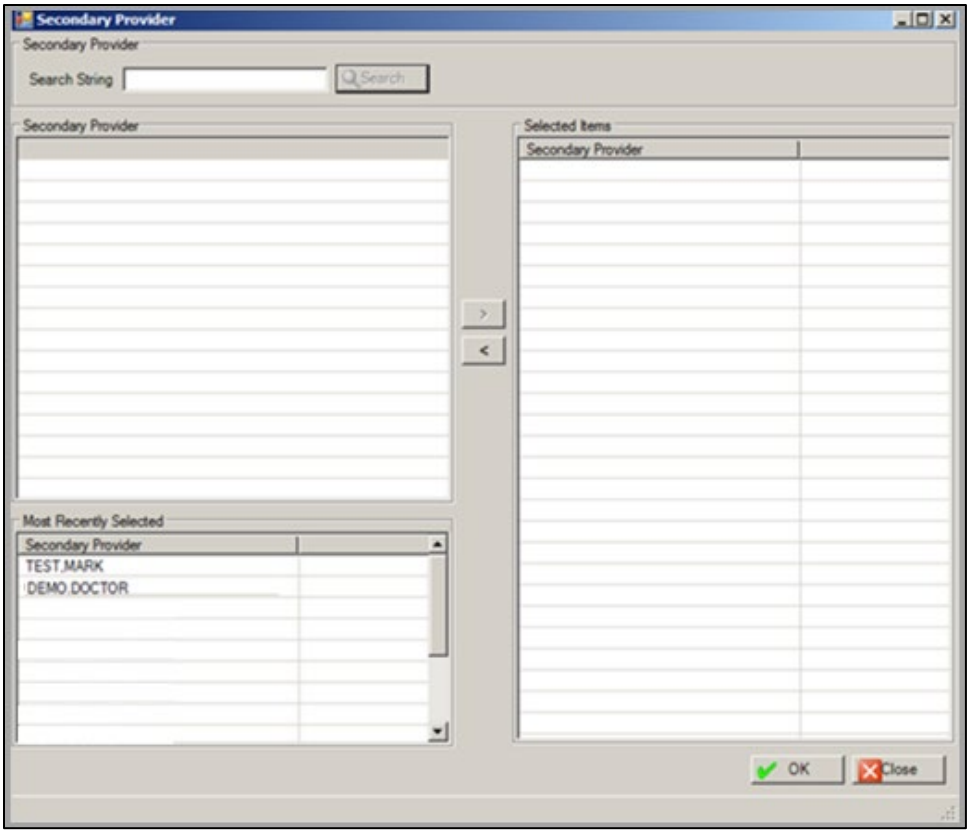


Figure 7-21: Secondary Providers search/select window

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 Arrow** button.

- 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 Arrow** button.
- Similarly, you can remove one or more selected records from the **Selected Items Secondary Provider** list box by clicking the **Left Arrow** button.

a. When the **Selected Items Secondary Provider** list box is complete, click **OK** and the records populate the **Secondary Providers** group box. (Otherwise, click **Close**.)

7.2.2.3.2 Delete Process

1. Select the **secondary provider record** to remove.
2. Click **Delete**.
3. At the **Are You Sure?** confirmation message, click **Yes** to remove the selected **secondary provider record** from the group box. (Otherwise, click **No**.)

7.2.3 Notes Tab

Use the **Notes** field (Figure 7-22) to enter any notes about the administrative/community activity.

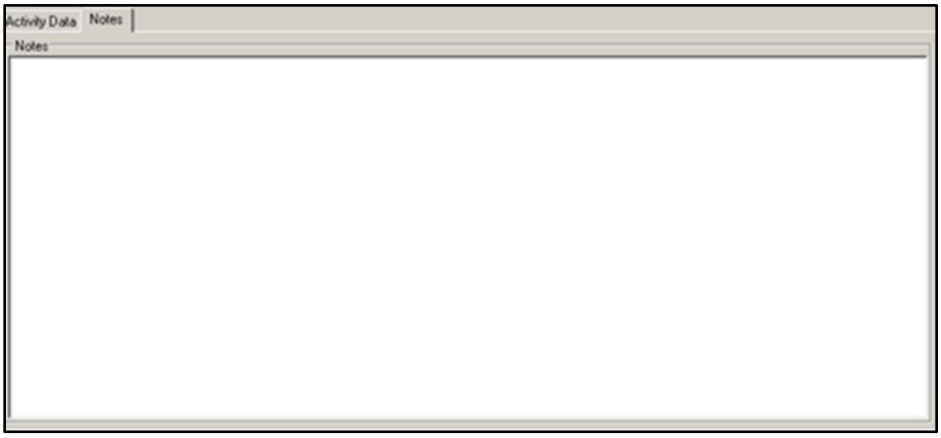


Figure 7-22: Notes field

This is a free-text box.

8.0 Problem List

This section addresses the **Problem List management** for the GUI.

8.1 Problem List (GUI)

This section addresses how to manage the problems for a 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 (display only)

8.1.1 Behavior Health Problem List Window

After selecting the **BH Problem List** option, the **Behavioral Health Problem List** window (Figure 8-1) displays.

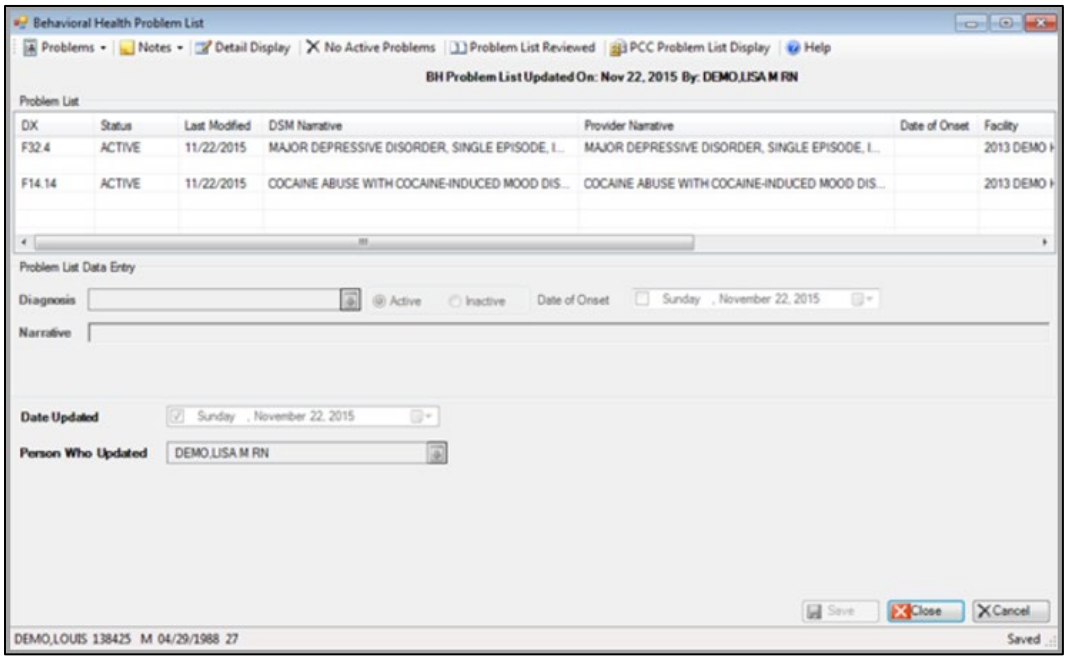


Figure 8-1: Behavioral Health Problem List window

The current patient's problems display in the **Problem List** grid, including any associated notes. The note displays on the row below the problem.

Table 8-1 provides information about the features on this window.

Table 8-1: Behavioral Health Problem List window features and functionality

Feature	Functionality
Help Button	Click to access online help for this window.
Close Button	Click to leave the window.
Cancel Button	Click to remain on the window; no action (like **Add Problem**) will be taken.

8.1.1.1 Add/Edit Problem

The **Add** and **Edit** functions 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 (Figure 8-2) are populated with existing data.

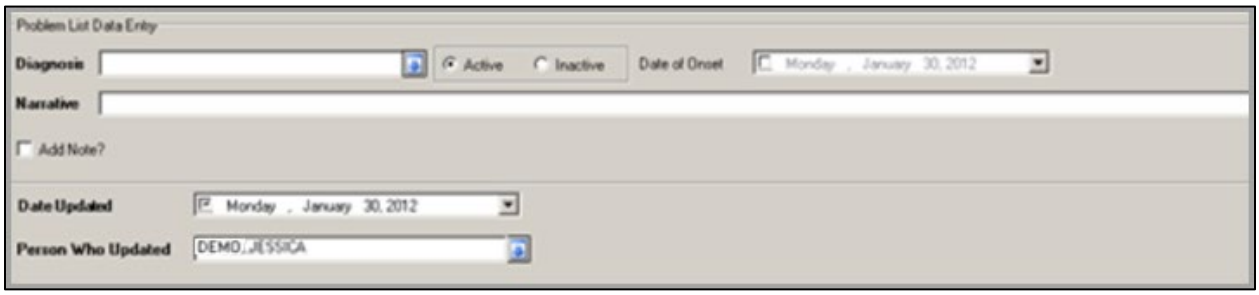


Figure 8-2: Problem List Data Entry group box

The following fields in bold are required:

- **Diagnosis**
- **Narrative**
- **Date Updated**
- **Person Who Updated**

3. At the **Diagnosis** field, click the list to access the **POV** select window (Figure 8-3). Select a **POV** to populate the **Diagnosis** and **Narrative** fields.
4. At the **Active/Inactive** option button, indicate if the selected diagnosis is **Active** or **Inactive** by selecting the appropriate option button (**Active** is the default for a new problem).
5. 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.

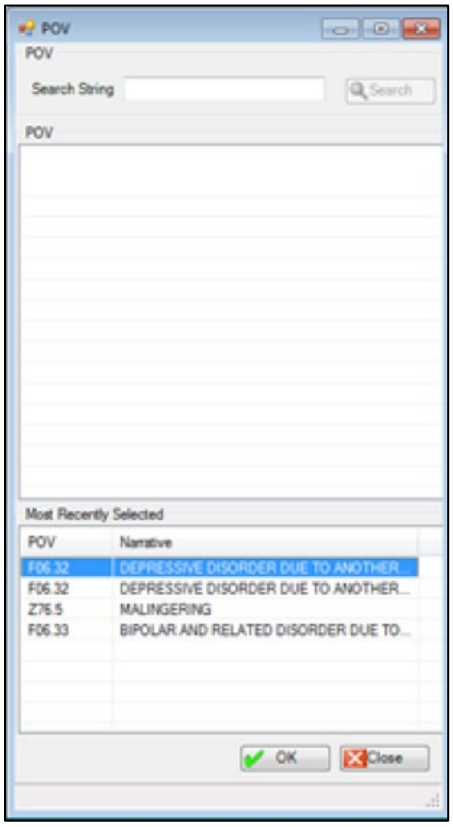
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the search criteria for the POV and clicking **Search**. The retrieved POVs will populate the **POV** list box. Select a retrieved record and click **OK** to populate the **Diagnosis** 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 8-3: POV select window

- To have no **Date of Onset**, clear the check box.
- To change the **Date of Onset**, click the list to access a calendar. The check box will remain selected.

6. 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.

7. At the **Add Note?** field, select the **Add Note** field to display the **Note** group box (Figure 8-4).

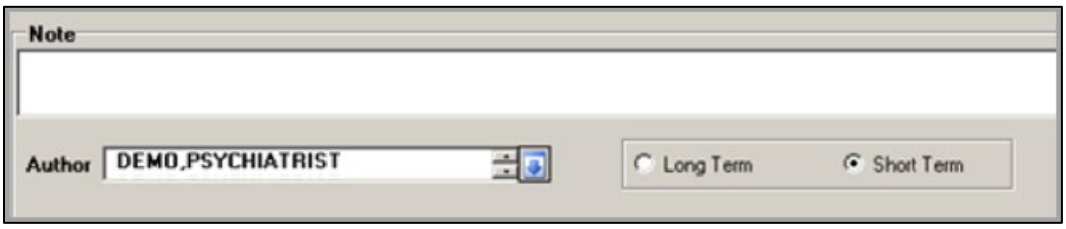


Figure 8-4: Note group box

After the **Note** group box displays, you can clear 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.

a. 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 **list** to access the **Primary Provider** select window (Figure 8-5) to select another name.

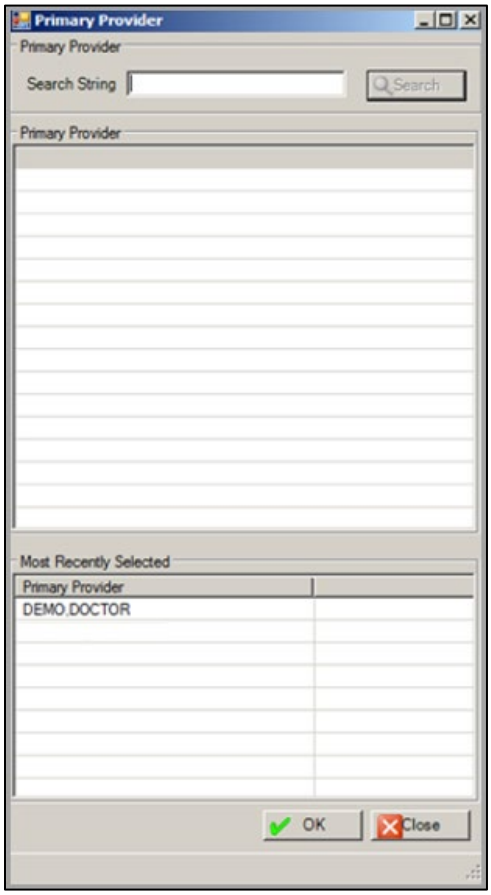
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the primary provider's last name and clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a retrieved record and click **OK** to populate the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

Figure 8-5: Primary Provider select window

b. At the **Long-Term/Short-Term** field, select either the **Long-Term** or **Short-Term** option button, referring to the treatment described in the note.

8. At the **Date Updated** field, the application displays today's date (the default). To change the date, click the **list** to access the calendar where you can select another date.

9. 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 list to access the **Primary Provider** select window (Figure 8-6) to select another primary provider.

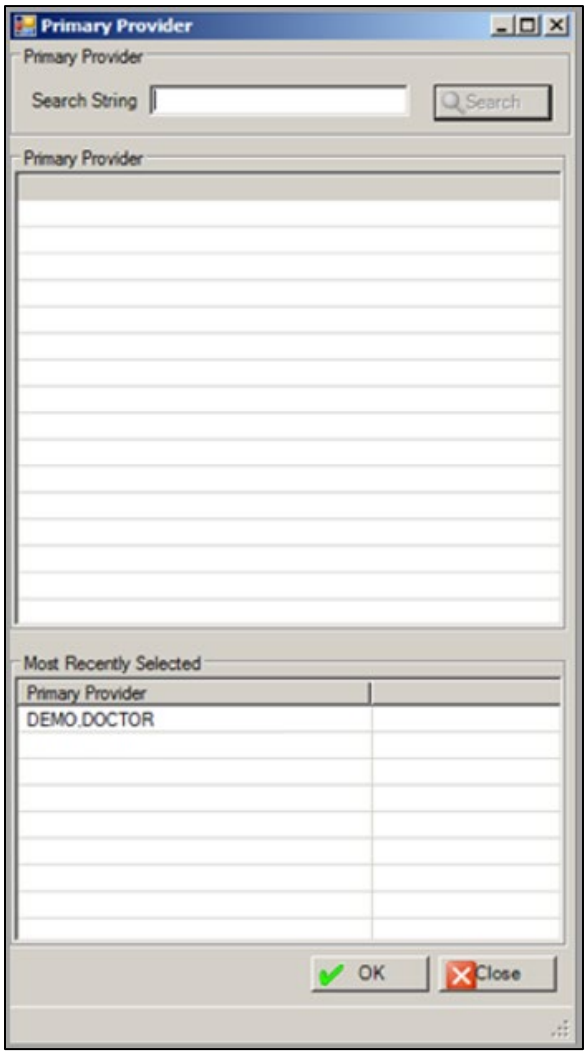
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the primary provider's last name and clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a retrieved record and click **OK** to populate the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

Figure 8-6: Primary Provider select window

10. 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**).

11. 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**).

8.1.1.2 Delete Problem

1. Select an **existing problem** in the **Problem List** grid.
2. Select **Problems | Delete Problem**.

   The **Problem List Reason for Delete** dialog (Figure 8-7) displays.

Figure 8-7: Problem List Reason for Delete dialog

3. Click the list for the **Reason** field (Figure 8-8) (required) and select an option.
   - **DUPLICATE**
   - **ENTERED IN ERROR**
   - **OTHER**

   If you select **OTHER**, the dialog changes to include a text field.

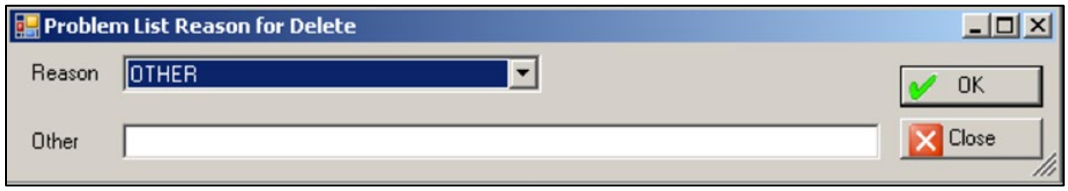


Figure 8-8: Problem List Reason for Delete dialog with OTHER selected from Reason list

   In this case, at the **Other** field, type the **reason** to delete the problem (required).

4. After the **Problem List Reason for Delete** dialog is complete, click **OK**. (Otherwise, click **Close**.)
5. After clicking **OK**, the application activates the **Date Updated** and **Person Who Updated** fields (Figure 8-9).

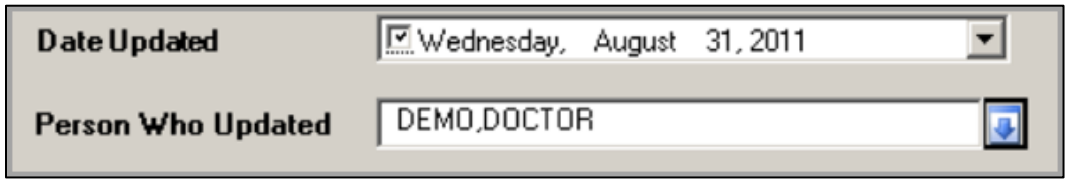


Figure 8-9: Active Date Updated and Person Who Updated fields

6. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the **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 (Figure 8-10) displays.

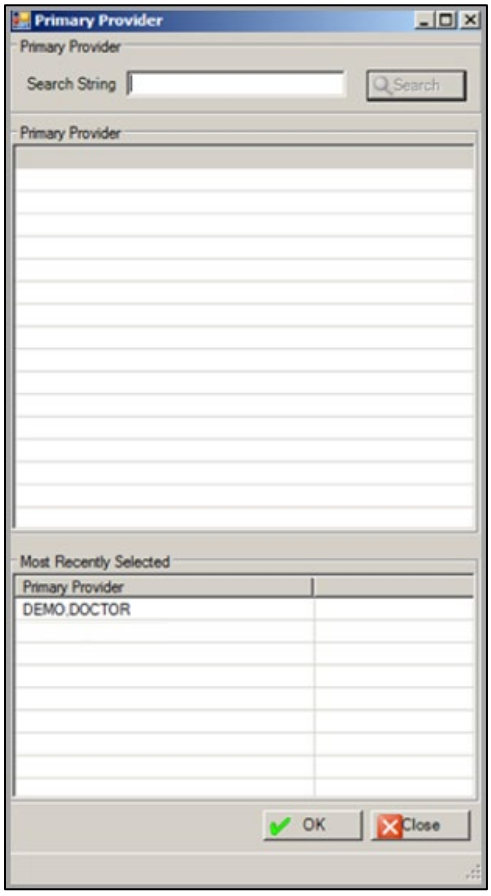
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the primary provider's last name and clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a retrieved record and click **OK** to populate the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

Figure 8-10: 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**.)

8.1.1.3 Activate/Inactivate Problem

1. Select an existing problem in the **Problem List** grid.
2. Select **Problems | Activate** (or **Inactivate)**.

The **Date Updated** and **Person Who Updated** fields display.

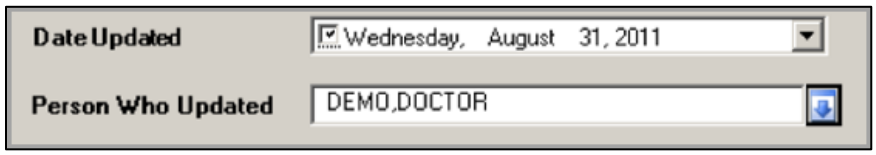


Figure 8-11: Date Updated and Person Who Updated fields

3. At the **Date Updated** field, select the update date. The default is today's date. To change the date, click the **list** to access the calendar and select another date. The **Activate** 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 list to access the **Primary Provider** select window and select a **name**.

5. After the active fields are complete, click **Save** to change the **Status** of the selected record on the **Problem List** grid. (Otherwise, click **Cancel**.)

8.1.1.4 Add/Edit Note

The **Add Note** and **Edit Note** functions use the same fields.

- Select an existing **problem** in the **Problem List** grid. Select **Notes | Add Note**.

Or

- Select an existing **note** in the **Problem List** grid. Select **Notes | Edit Note**.

The fields become populated with existing data. Figure 8-12 shows the fields in the lower group box.

Figure 8-12: Active fields for editing a note

1. At the **Date Updated** field, select the **update date**. The default is today's date. To change the date, click the **list** to access the calendar and select **another date**. The **Add Note** action only works if the **Date Updated** is checked.

2. At the **Person Who Updated** field, select the **person** who updated the problem list. To change the name, click the list to access the **Primary Provider** select window and select a **name**.

3. At the **Note** field, type the text of the note (free-text field), usually information about the treatment.

4. At the **Author** field, select the **author** of the note. To change the name, click the list to access the **Primary Provider** select window. See Figure 8-5.

5. At the **Long Term/Short Term** field, select either the **Long Term** or **Short Term** option button, referring to the treatment described in the note.

6. 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).

8.1.1.5 Remove Note

1. Select an existing **note** in the **Problem List** grid.

2. Select **Notes | Remove Note**.

   The **Date Updated** and **Person Who Updated** fields become active. See Figure 8-9.

3. At the **Date Updated** field, select the **update date**. The default is today's date. To change the date, click the **list** to access the calendar. The **Remove Note** action only works if the **Date Updated** is checked.

4. At the **Person Who Updated** field, select the **person** who updated the information. Click the list to access the **Primary Provider** select window. Select the **name** of the person who updated the **Problem List**. See Figure 8-10.

5. After the active fields are complete, click **Save**. (Otherwise, click **Cancel**.) If **Save** was used, the prompts continue.

6. At the **Are You Sure?** confirmation message, click **Yes** to remove the note, which will be removed from the **Problem List** grid. (Otherwise, click **No**.)

8.1.1.6 Detail Display

1. Select a **problem** in the **Problem List** grid.

2. Click the **Detail Display** button.

The **BH Problem List Detail** pop-up (Figure 8-13) for the particular patient displays.

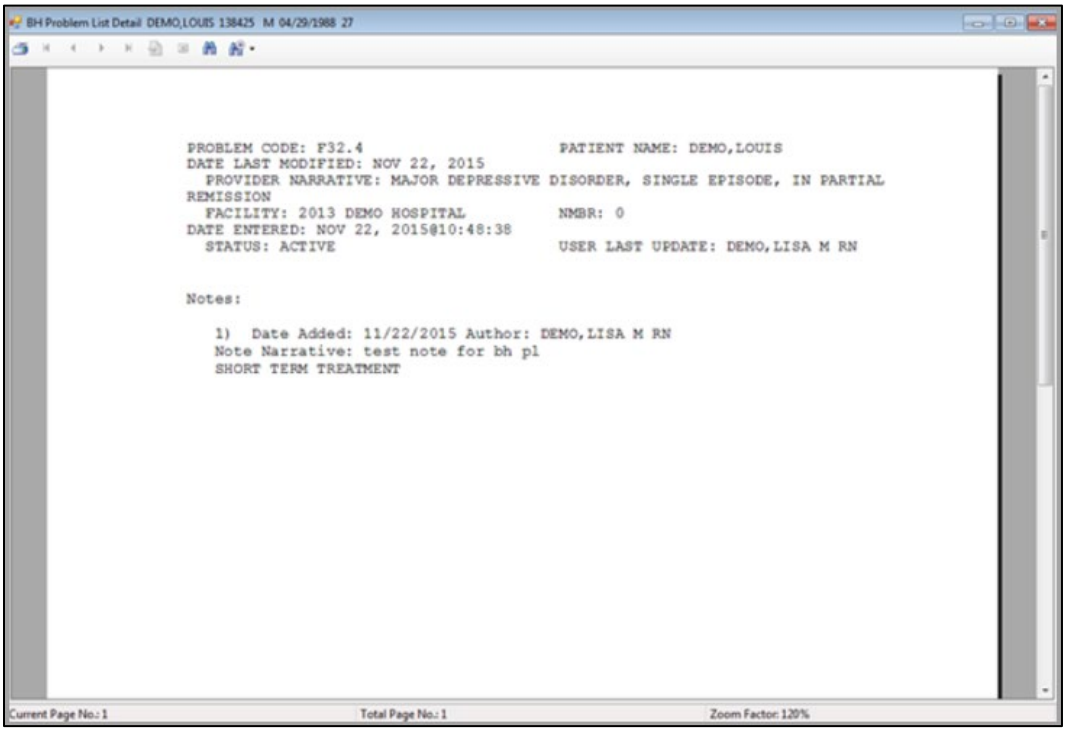


Figure 8-13: BH Problem List Detail for selected demo patient

Section 2.6 provides more information about using the controls on the pop-up window.

8.1.1.7 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.

2. Click **OK** to dismiss the message and the focus returns to the **Behavioral Health Problem List** window.

After clicking this button and there are no active problems, the application asks the following:

Did the Provider indicate that the patient has No Active BH Problem?

3. Click **Yes**. (Otherwise, click **No**.)

   If **Yes** was used, the **Date Documented** and **Provider Who Documented** fields (Figure 8-14) become active.

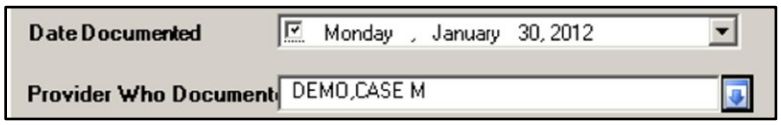


Figure 8-14: Date Documented and Provider Who Documented fields

4. 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 list to access the calendar. The **No Active Problems** action only works if the **Date Documented** is checked.

5. At the **Person Who Documented** field, select the person who documented that the patient has no active problems. To change the name, click the **list** to access the **Primary Provider** select window and select a **name**.

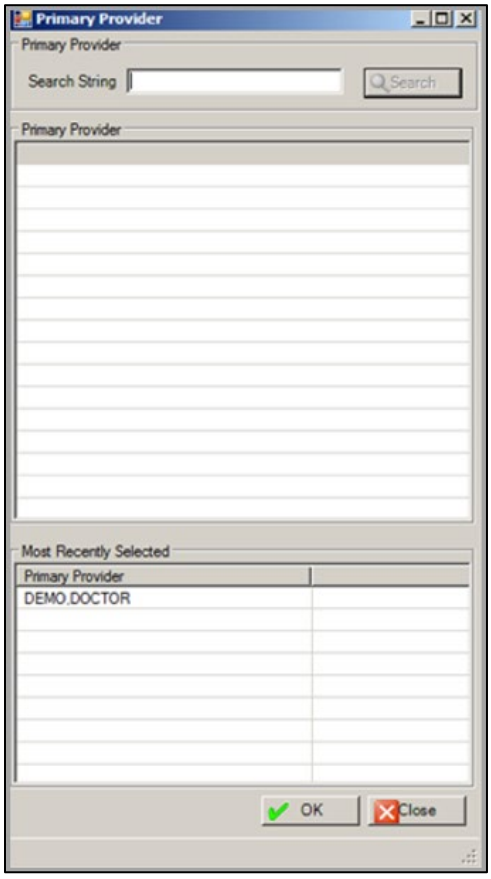
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the primary provider's last name and clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a retrieved record and click **OK** to populate the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

Figure 8-15: Primary Provider select window

6. After the active fields are complete, click **Save**. (Otherwise, click **Cancel**.)
7. 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

8.1.1.8 Problem List Reviewed

1. Click the **Problem List Reviewed** button to indicate that the current patient's problem list was reviewed.

The **Date Reviewed** and **Provider Who Reviewed** fields (Figure 8-16) become active.

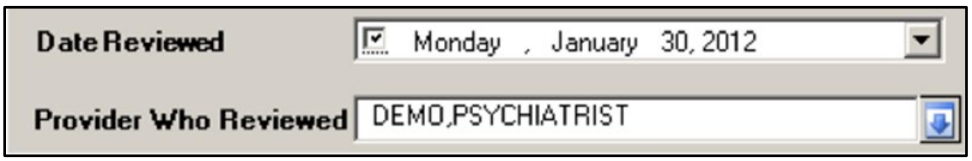


Figure 8-16: Date Reviewed and Provider Who Reviewed fields

2. 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 list to access the calendar and select another date. The **Problem List Reviewed** action only works if the **Date Reviewed** is selected.

3. At the **Person Who Reviewed** field, select the person who reviewed the problem list. To change the name, click the **list** to access the **Primary Provider** select window (Figure 8-17) and select a **name**.

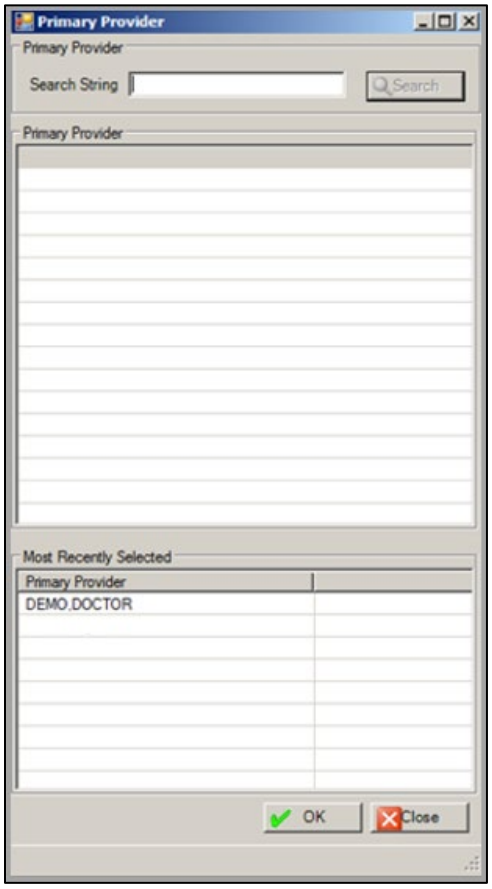
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the primary provider's last name and clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a retrieved record and click **OK** to populate the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

Figure 8-17: Primary Provider select window

4. 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

8.1.1.9 PCC Problem List Display

Click the **PCC Problem List Display** button to move to the **PCC Problem List** window (Figure 8-18).

8.1.1.10 PCC Problem List Window

1. After selecting the **PCC Problem List** option (on the **Visit** window), the **PCC Problem List** window (Figure 8-18) displays.

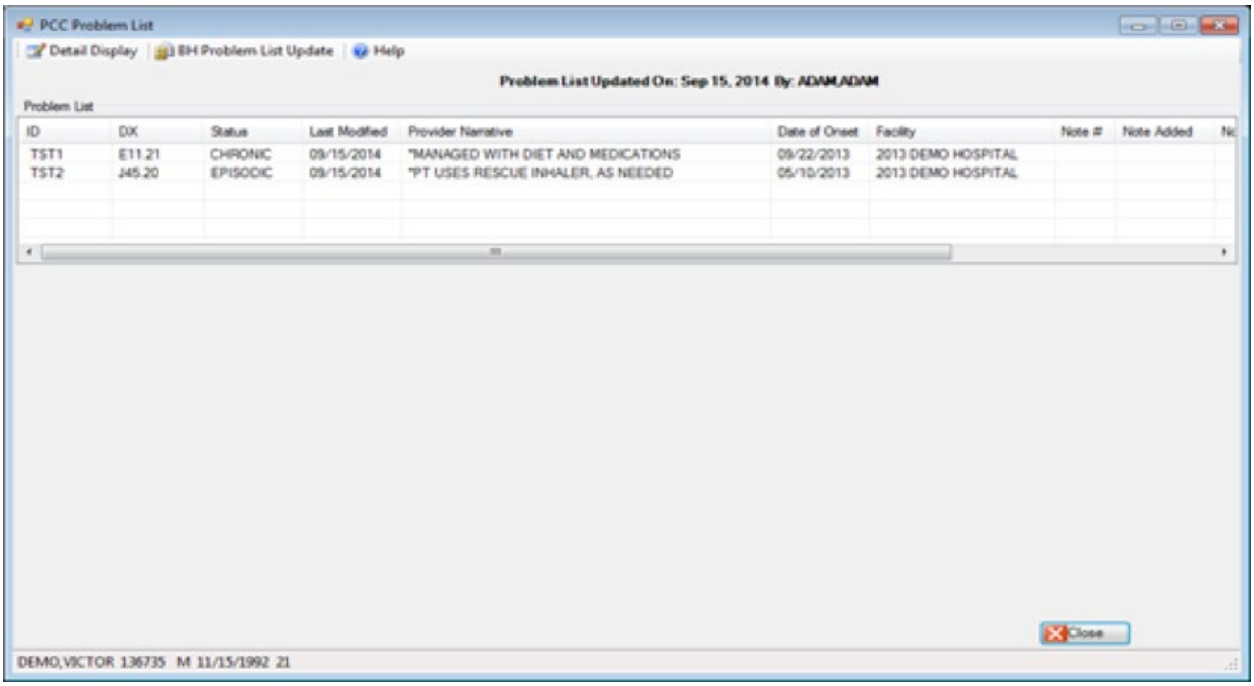


Figure 8-18: PCC Problem List window

   The current patient's PCC problems display in the **Problem List** grid, including any associated notes. The notes display on the row below the problem.

2. Click **Close** to leave the window.

3. Click **Help** to access the online help for this window.

8.1.1.11 Detail Display

1. Select a **problem** in the **Problem List** grid.

2. Click the **Detail Display** button.

   The **PCC Problem List Detail** pop-up (Figure 8-19) for the particular patient displays.

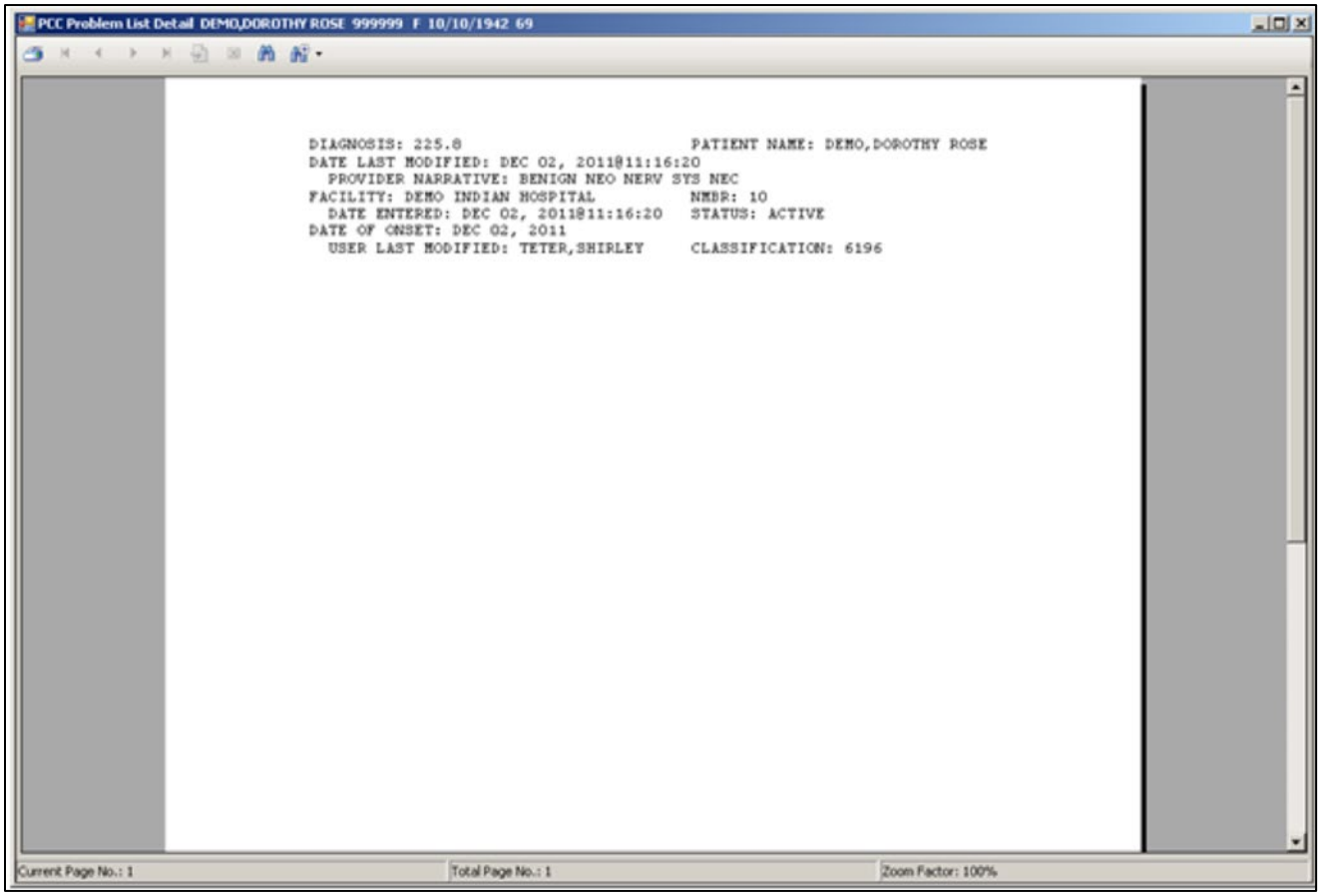


Figure 8-19: PCC Problem List Detail pop-up

Section 2.6 provides more information about using the controls on the pop-up window.

8.1.1.12 BH Problem List Update

1. Click the **BH Problem List Update** button to move to the **Behavioral Health Problem List** window.

   Section 8.1.1 provides more information about this window.

9.0 Treatment Plans

Use the **Treatment Plans** feature to add or update treatment plans in the **RPMS AMH (GUI)**.

9.1 Treatment Plan Window (GUI)

The **RPMS AMH (GUI)** application provides ways to manage treatment plans for one patient.

Figure 9-1 shows where the treatment plan functions are located on the **Clinical Activities** tree structure.

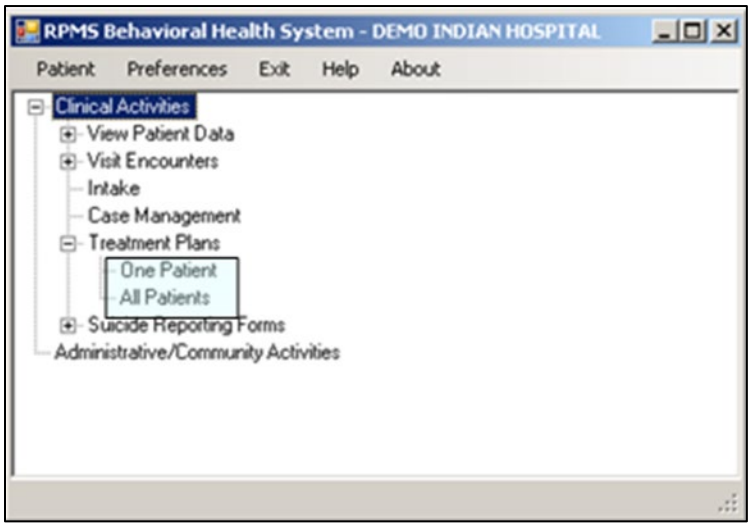


Figure 9-1: Location of Treatment Plan functions on tree structure

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 9-2).

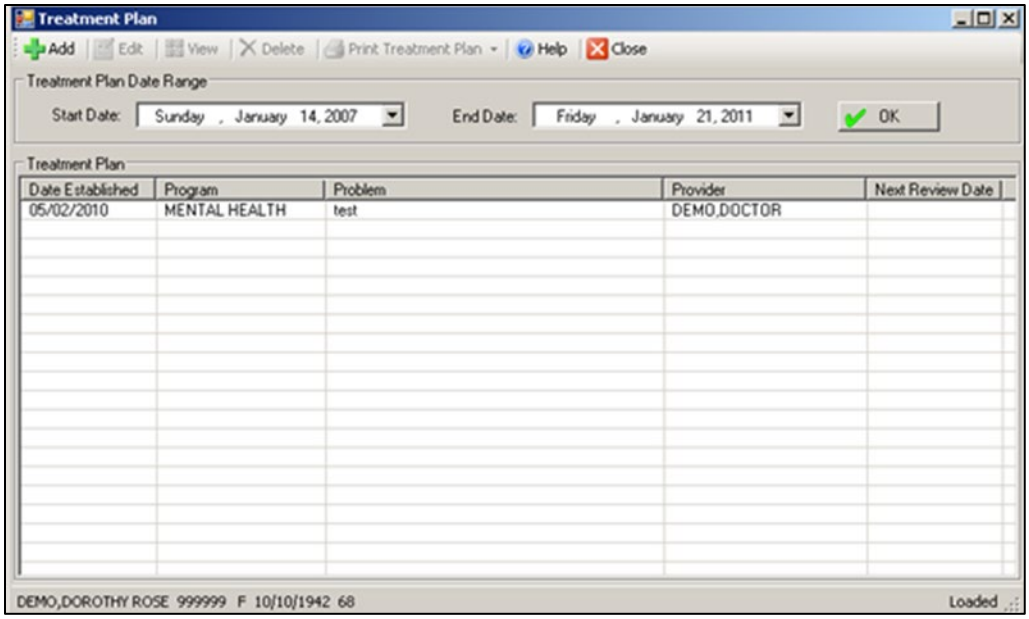


Figure 9-2: Sample Treatment Plan group box for current patient

Another way to access the **Treatment Plan** window is to use **All Patients**. You access the **Treatment Plan** window for all patients.

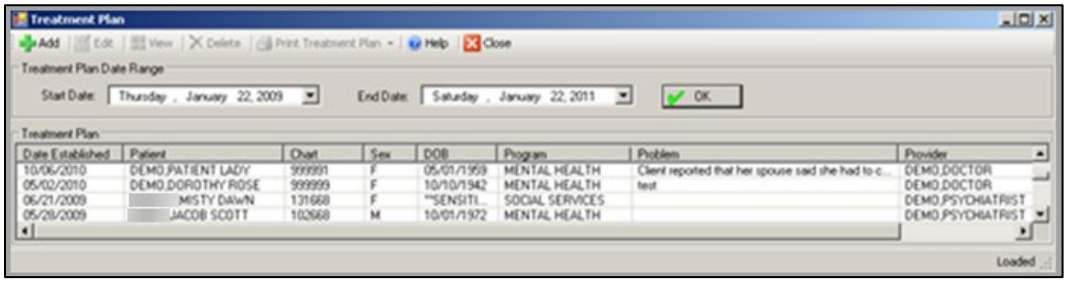


Figure 9-3: Sample Treatment Plan window for all patients

Table 9-1 provides information about the features of both windows.

Table 9-1: Treatment Plan window features and functionality

Feature	Functionality
Treatment Plan Window for One Patient	The default **Start Date** is one year prior. Changing the **Start Date** for the **Treatment Plan** window for One Patient 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 prior. Changing the **Start Date** for the **Treatment Plan** window for All Patients stays in effect until you exit the application. When you log in the next time, the Start Date reverts to one year previous.

Feature	Functionality
Treatment Plan Group Box	This group box shows the records within the Treatment Plan Date Range. They are in date order.
Add Button	Establish the patient to use in the add process. Click the **Add** button to add a new treatment plan record on the **Treatment Plan - Add Treatment Plan** window.
Edit Button	Click the **Edit** button to edit a particular treatment plan record on the **Treatment Plan - Edit Treatment Plan** window.
View Button	Select 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.
Help Button	Click the **Help** button to access the online help system for the **Treatment Plan** window.
Close Button	Click the **Close** button to dismiss the **Treatment Plan** window.
Delete Button	Click 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 are reviews, the application displays the **Treatment Plan Reviews** dialog (Figure 9-4).

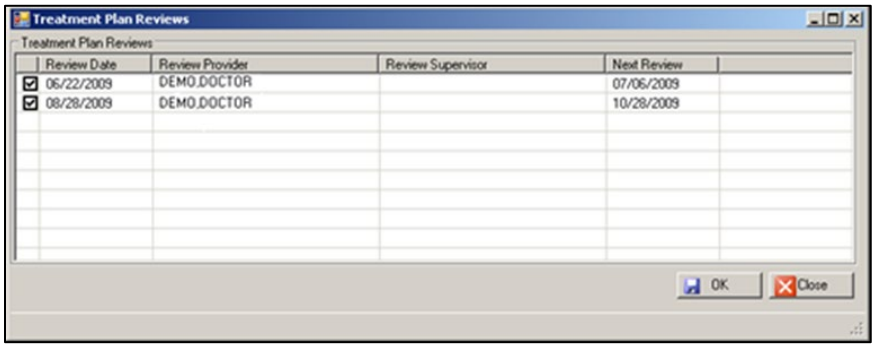


Figure 9-4: Treatment Plan Reviews dialog

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 9-5).

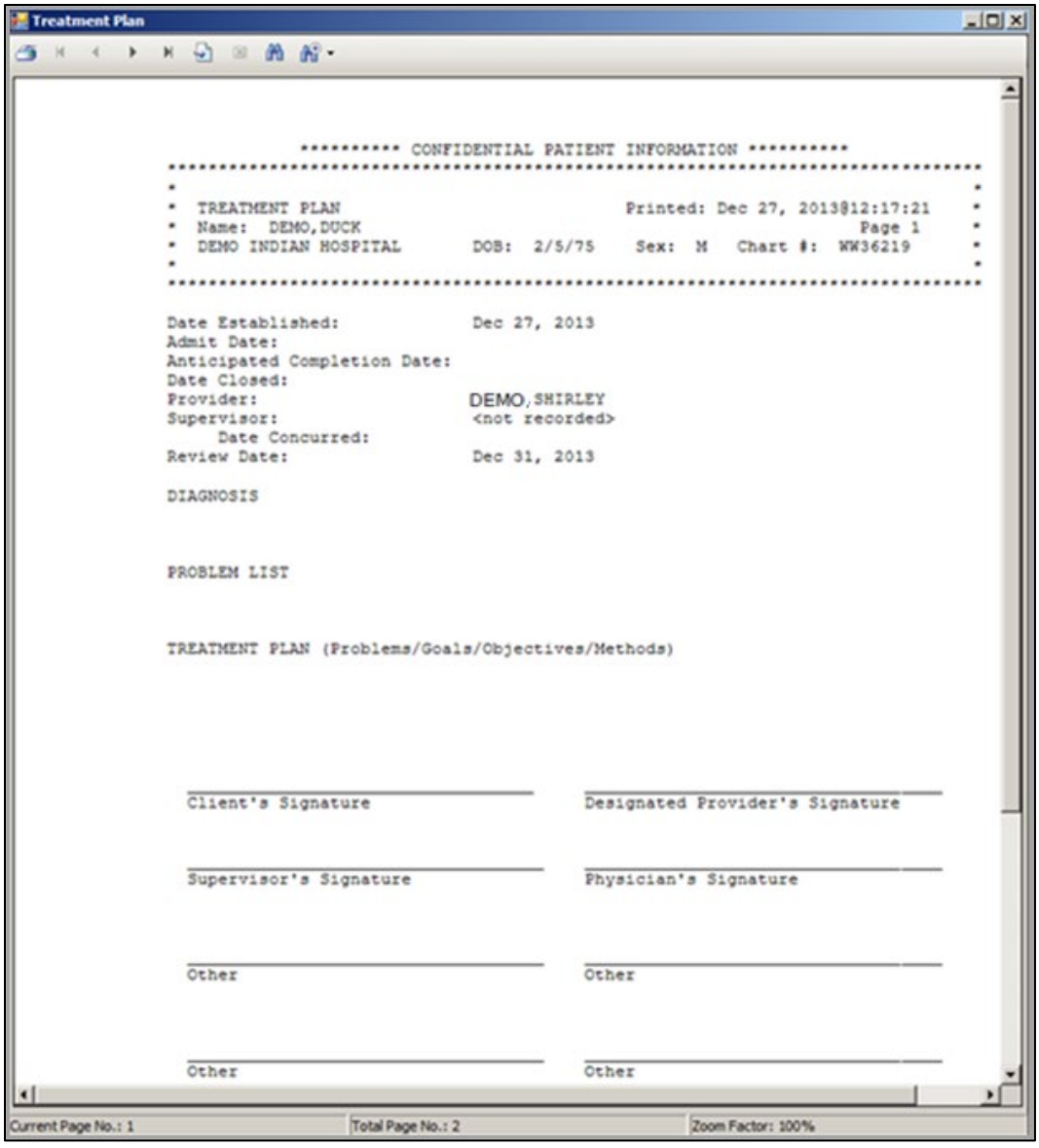


Figure 9-5: Sample Treatment Plan pop-up window

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

9.2 Add/Edit Treatment Plan Record (GUI)

1. Click the **Add** button on the **Treatment Plan** window to display the **Treatment Plan–Add Treatment Plan** window.

2. Click the **Edit** button on the **Treatment Plan** window to display the **Treatment Plan–Edit Treatment Plan** window.

Both windows have the same fields. Figure 9-6 shows the **Add Treatment Plan** window.

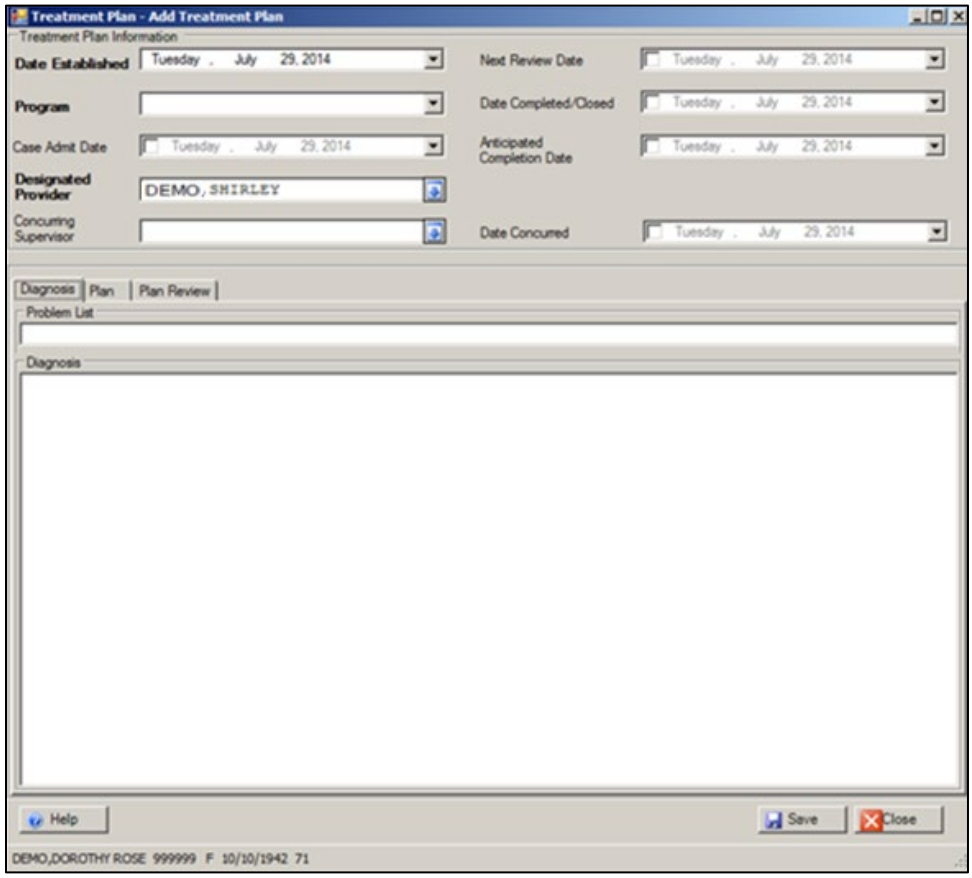


Figure 9-6: Add Treatment Plan window

Table 9-2 provides information about the buttons on this window.

Table 9-2: Add Treatment Plan window buttons and functionality.

Button	Functionality
Help Button	Click to access the online help system for the window.
Save Button	Click to save the data on the window. The Save function adds/edits the treatment plan record on the **Treatment Plan** window.
Close Button	Click to display the **Continue?** dialog 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.

9.2.1 Treatment Plan Information Group Box

Use the **Treatment Plan Information** group box (Figure 9-7) to manage the basic information about the treatment plan.

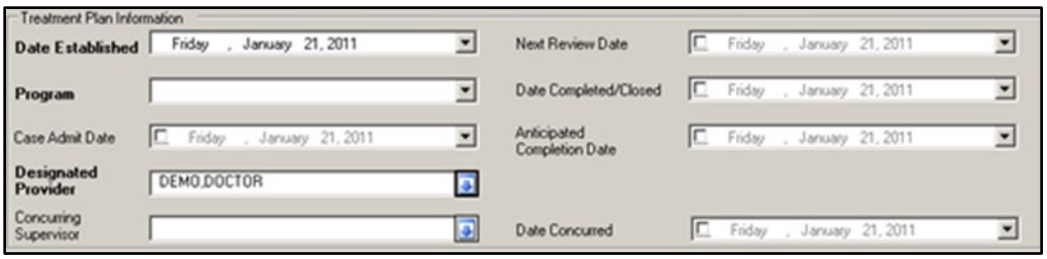


Figure 9-7: Treatment Plan Information group box

The fields in bold text are required (**Date Established**, **Program**, and **Designated Provider**).

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 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 list to access the calendar to change this date. Be aware that if **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 list to select one of the following:

   - Mental Health
   - Social Services
   - Other
   - Chemical Dependency

4. At the **Date Completed/Closed** field, select the date the treatment plan was completed or closed. Click the 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 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 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 list to access the **Designated Provider** search dialog (Figure 9-8) to search for the name of the designated provider.

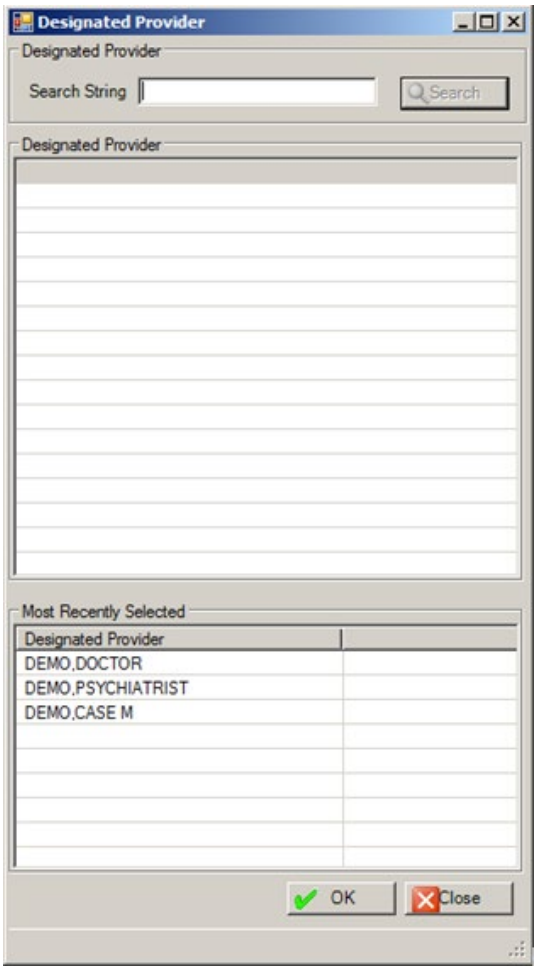
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the designated provider's last name and then clicking **Search**. The retrieved providers will populate the **Designated Provider** list box. Select a retrieved record and click **OK**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

Figure 9-8: Designated Provider search window

8. At the **Concurring Supervisor** field, select the name of the concurring supervisor for the treatment plan. Click the list to access the **Concurring Supervisor** search dialog (Figure 9-9) and search for the name of the supervisor.

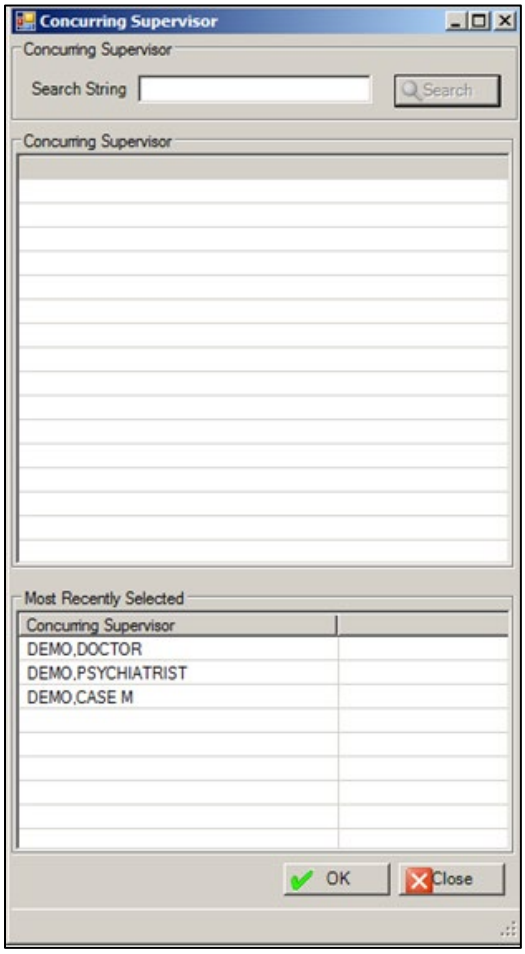
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing concurring supervisor's last name and then clicking **Search**. The retrieved names will populate the **Concurring Supervisor** list box. Select a retrieved record and click **OK** to populate 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 9-9: 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 list to access the calendar to change this date.

9.2.2 Diagnosis Tab

Use the **Diagnosis** tab (Figure 9-10) 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 9-10: Diagnosis tab

Both fields are free-text fields.

9.2.3 Plan Tab

Use the **Plan** tab (Figure 9-11) to add participants to the plan, as well as describing the **Problems / Goals / Objectives / Methods** of the plan.

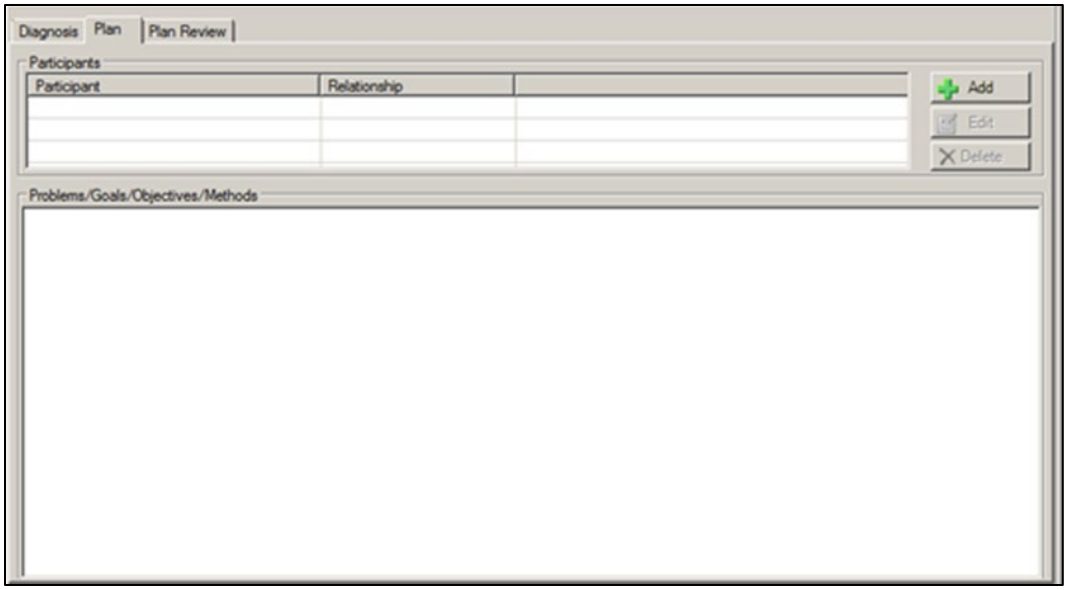


Figure 9-11: Plan tab

9.2.3.1 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.

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

OR

- Select a record to edit and click **Edit**.

Treatment Plan Participants

The **Treatment Plan Participants** dialog displays.

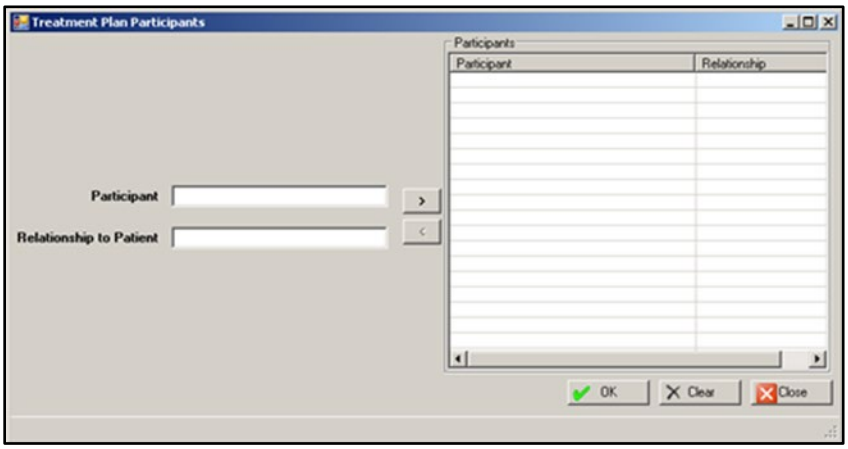


Figure 9-12: Treatment Plan Participants dialog

1. At the **Participant** field, type the **participant name**. This is a free-text field.
2. At the **Relationship to Patient** field, type the **participant's relationship** to the patient of the treatment plan. This is a free-text field.
3. After completing the **Participant and Relations** fields, do one of the following:
4. Click the **Right Arrow** button to add the information to the **Participants** list box. More than one participant/relationship record can be added to the **Participants** list box.

5. Click **Clear** to remove the data in the **Participant** and **Relationship to Patient** fields.

   - Remove a highlighted record in the **Participants** list box by clicking the **Left Arrow** button.
   - 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**.)
   - If **Edit** was used, click **OK** to save the data. The data in the **Participants** list box will be updated.

9.2.3.2 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.

9.2.4 Plan Review Tab

Use the **Plan Review** tab to document the plan review of the treatment plan.

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**.)

9.2.4.1 Review Group Box

Use the top group box to document the review date, the review provider, and review supervisor, and next review date for the treatment plan.

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.
2. Click **Edit**.
3. 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 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 list to access the calendar to change the date. Be aware 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 list to access the **Reviewing Provider** search/select window (Figure 9-13) where you search for the provider name.

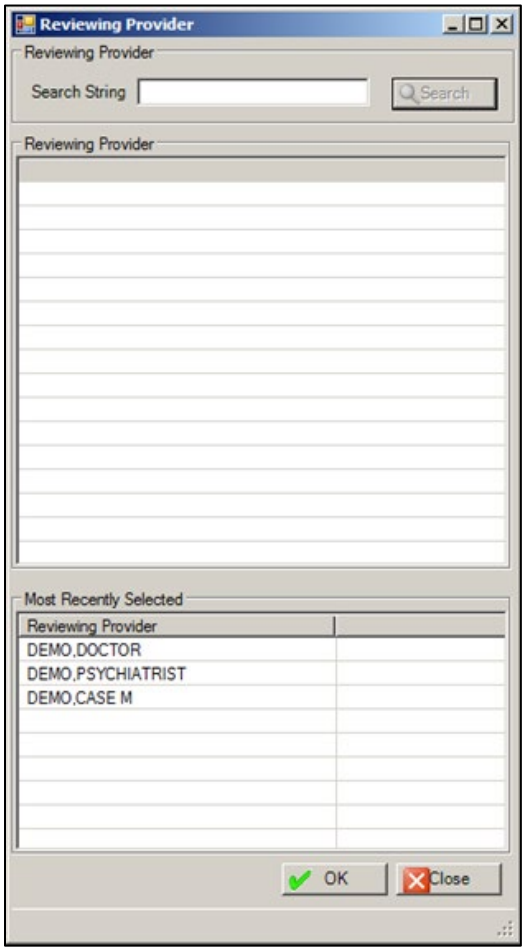
Screen Capture	What to Do
	Use this search/select window in one of two ways: (1) Use the **Search String** field by typing the reviewing provider's last name and then clicking **Search**. The retrieved names will populate the **Reviewing Provider** list box. Select a retrieved record and click **OK**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

Figure 9-13: Reviewing Provider search/select window

5. At the **Review Supervisor** field, select the review supervisor for the treatment plan. Click the list to access the **Reviewing Supervisor** search/select window (Figure 9-14) where you search for the supervisor name.

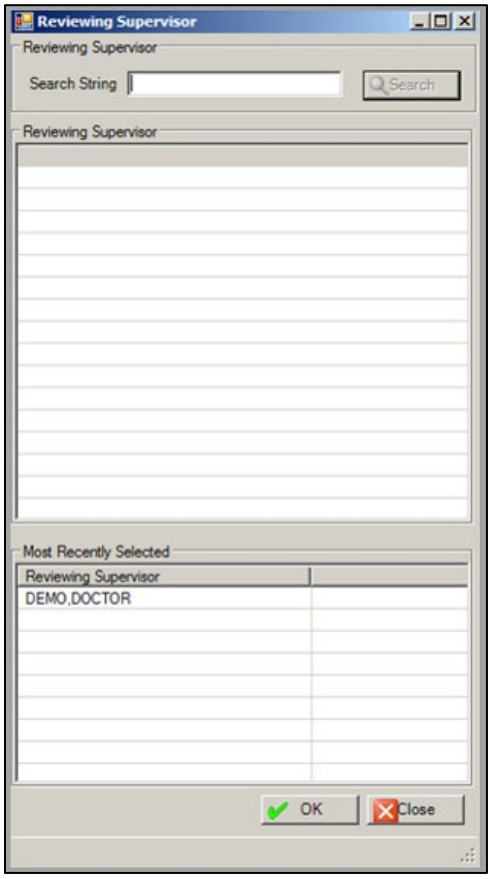
Screen Capture	What to Do
	Use this search/select window in one of two ways: (1) Use the **Search String** field by typing the reviewing supervisor's last name clicking **Search**. The retrieved names will populate the **Reviewing Supervisor** list box. Select a retrieved record and click **OK** to populate 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 9-14: Reviewing Supervisor search/select window

9.2.4.2 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 use the same fields.

- Click **Add** to access the **Treatment Plan Participants** dialog.

Or

- Select a **participant record** to edit. Click **Edit** to access the **Treatment Plan Participants** dialog (Figure 9-15).

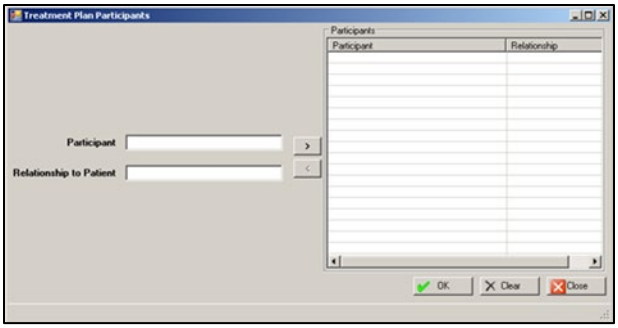


Figure 9-15: Treatment Plan Participants dialog

1. At the **Participant** field, type the participant name. This is a free-text field.
2. At the **Relationship to Patient** field, type the participant's relationship to the patient of the treatment plan. This is a free-text field.
3. After completing the **Participant** and **Relations** fields, do one of the following:
   - Click the **Right Arrow** button to add the information to the **Participants** list box. More than one participant/relationship record can be added to the **Participants** list box.
   - Click **Clear** to remove the data in the **Participant** and **Relationship to Patient** fields.
6. To remove a selected record in the **Participants** list box, click the **Left Arrow** button.
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**.

9.2.4.3 Progress Summary

Use the **Progress Summary** field to add the text of the progress of the plan review. This is a free-text field.

10.0 Suicide Forms

Users can manage suicide forms in the **RPMS AMH (GUI)**.

> **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 the suicide form will be considered Incomplete. If you do complete all of the fields, the suicide form will be considered Complete.

10.1 Suicide Form Window (GUI)

The suicide form options are located under the **Suicide Reporting Forms** category on the tree structure for the **RPMS AMH (GUI)** (Figure 10-1) application.

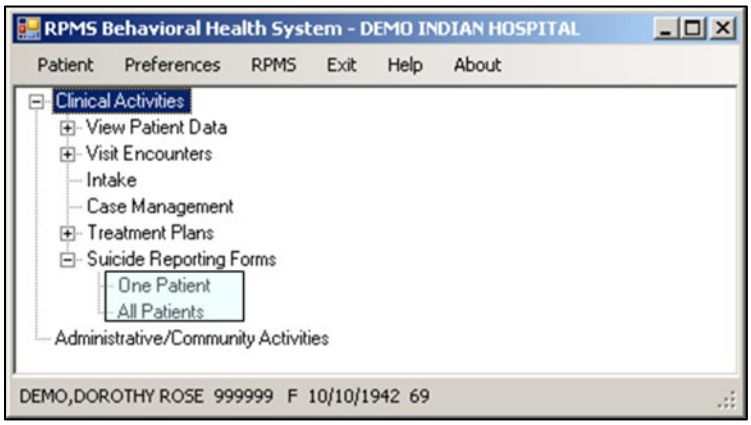


Figure 10-1: Location of Suicide Forms on the tree structure

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 (Figure 10-2) and there is no current patient, you will be prompted to select one.

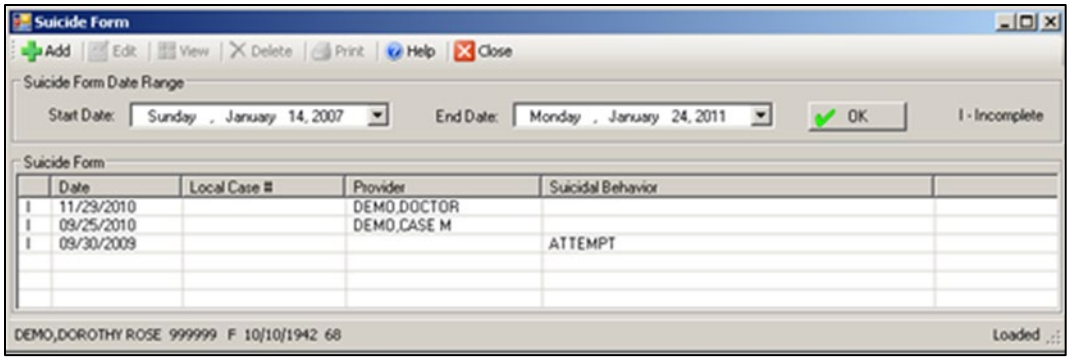


Figure 10-2: Suicide Form window for one patient

Another way to access the **Suicide Form** window is to select the **All Patients** option (Figure 10-3). The application displays the **Suicide Form** window for **All Patients**.

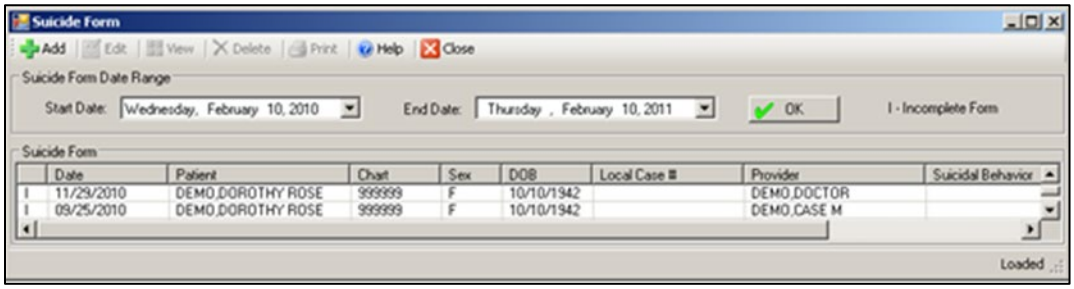


Figure 10-3: Sample Suicide Form window for all patients

Both windows function in the same way.

Table 10-1 provides information about the features of these windows.

Table 10-1: Suicide Form window features and functionality

Feature	Functionality
Suicide Form Window for One Patient	The default Start Date is one year prior. 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 prior. 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 log in the next time, the Start Date reverts to one year previous. Be aware 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. 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.
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.
Edit Button	Click this button to edit the highlighted suicide form for the current patient on the **Visit Data Entry - Edit Suicide** Entry dialog. The **Edit** button will be inactive if the patient does not have any previous visits (applies to the suicide form for the current patient).
View Button	Click 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	Click this button to access the online help for the **Suicide Forms** window.
Close Button	Click this button close the **Suicide Form** window.
Print Button	Click 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 (Figure 10-4) applies to the **Print** button.

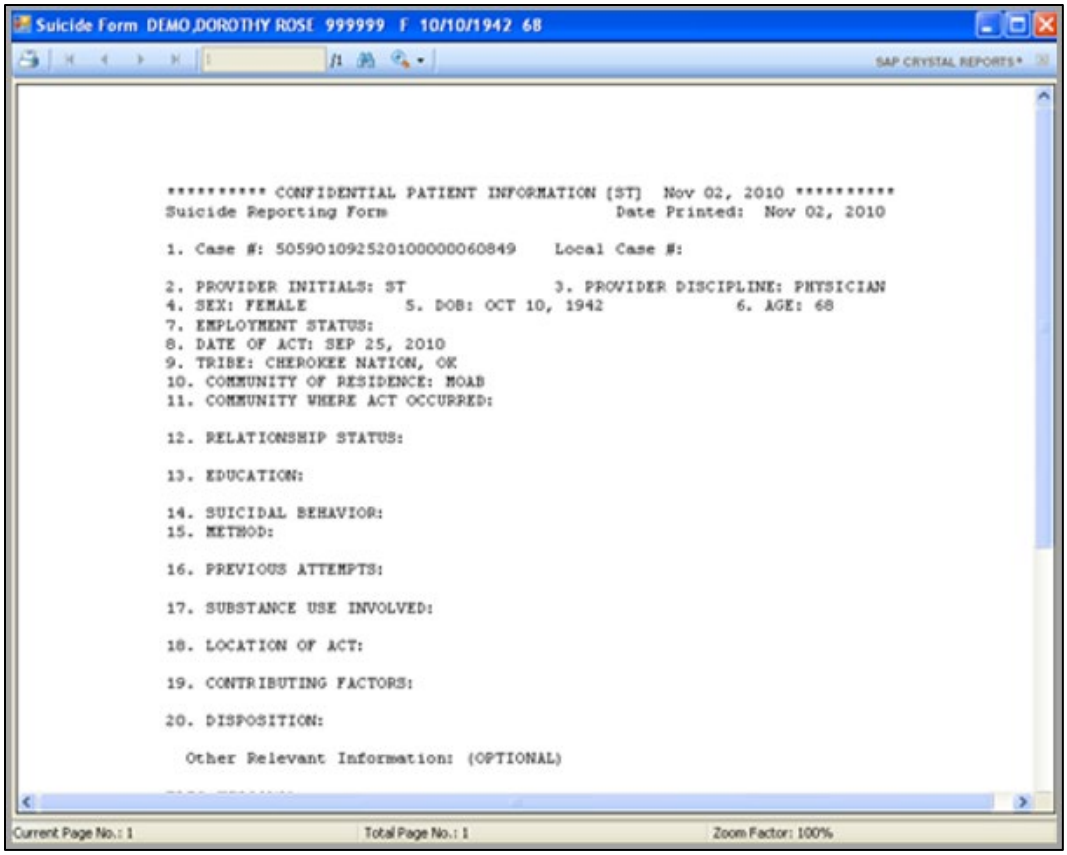


Figure 10-4: Suicide Reporting Form

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 and time as well as the person who modified the record.

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

10.2 Add/Edit Suicide Form (GUI)

- Click **Add** to add a new suicide record. The **Suicide Form Data Entry–Add Suicide Form** displays.

  Or

- 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 (Figure 10-5). (The same fields display on the **Suicide Form Data Entry–Edit Suicide Form** window.)

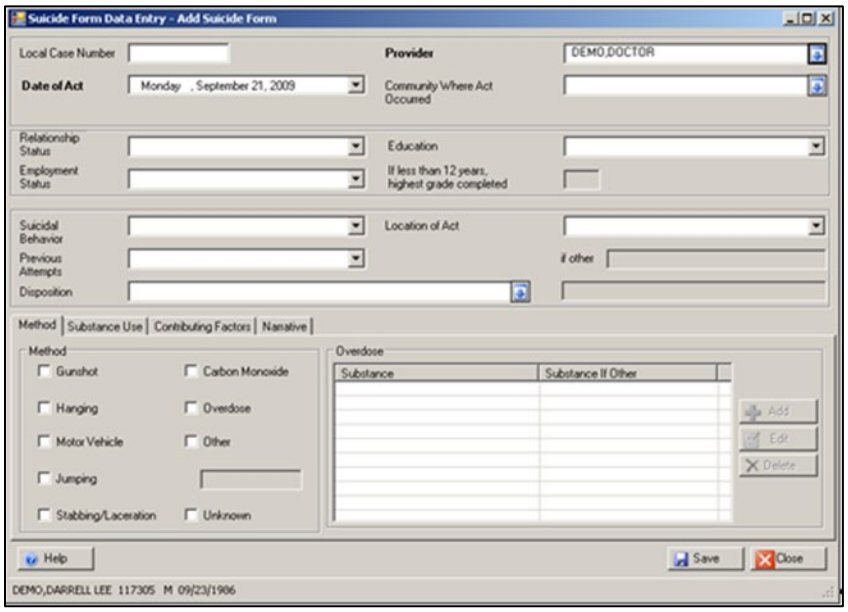


Figure 10-5: Sample Suicide Form Data Entry–Add Suicide Form window

All fields except the **Local Case Number** and the **Narrative** (Figure 10-6) are required in order to save. Attempting to save with incomplete fields results in the application displaying the Required information message.

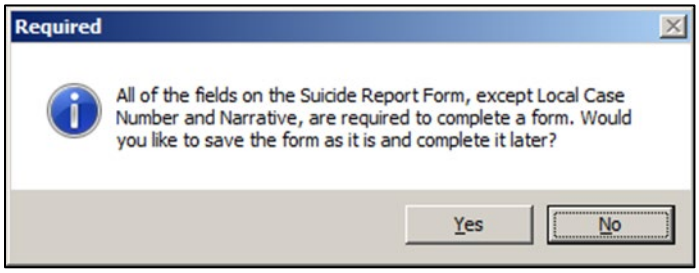


Figure 10-6: Required Information message

- Click **Yes** to save the form and complete it later. The focus returns to the **Suicide Form** window.
- Click **No** to not save. The focus remains on the data entry form.

Table 10-2 provides information about the buttons on this window.

Table 10-2: Suicide Form buttons and functionality

Button	Functionality
Save	Use this button to save the data.

Button	Functionality
Help	Use this button to access the online help system for this window.
Close	Use this button to display the **Continue?** dialog. This dialog states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add window. Click **No** and the focus remains on the add window where you can continue work on the suicide form.

10.2.1 Suicide Form Fields

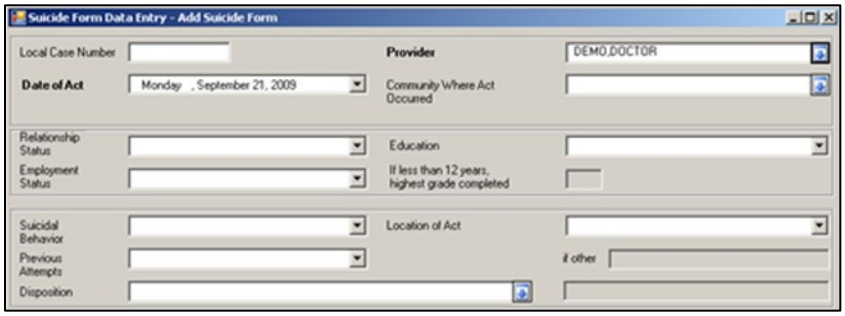


Figure 10-7: Fields on Suicide Form

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 list to access the **Provider** search window (Figure 10-8) where you search for the provider's name.

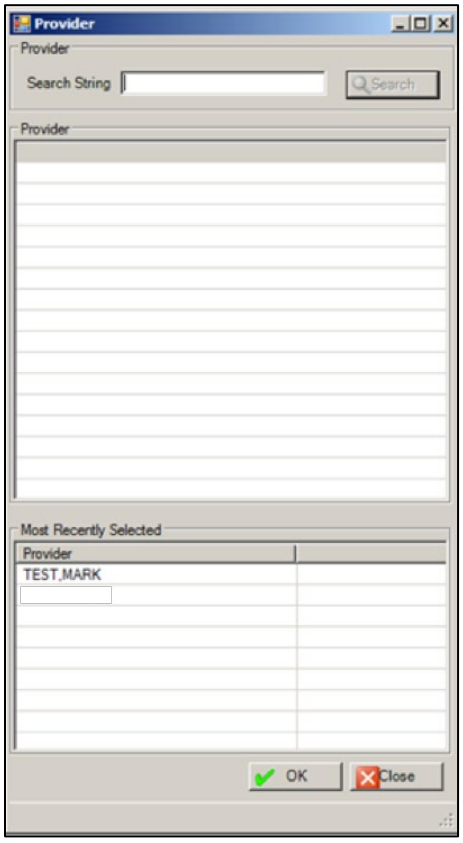
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and clicking **Search**. The retrieved names will populate the **Provider** list box. Select a retrieved record and click **OK** to populate the **Provider** field. Otherwise, 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 10-8: 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 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 list to access the **Community Search/Select** window (Figure 10-9) where you search for the community name.

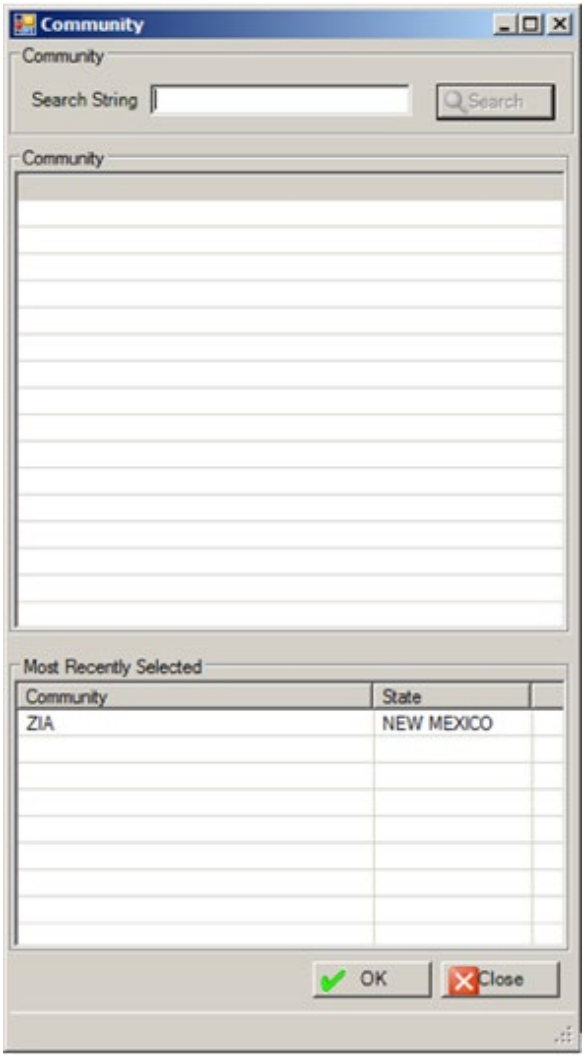
Screen Capture	What to Do
	Use this search window in one of two ways: (1) Use the **Search String** field by typing the community name and clicking **Search**. The retrieved names will populate the **Community** list box. Select a retrieved record and click **OK** to populate the **Community Where Act 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 10-9: 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 list and select one of the options.

   - PART TIME
   - FULL TIME
   - UNEMPLOYED
   - RETIRED
   - STUDENT
   - STUDENT AND EMPLOYED
   - UNKNOWN

8. At the **If less than 12 years, highest grade completed** field, type the highest grade the patient completed (**0–11**). This field becomes active when you populate the Education field with **Less than 12 years**.

9. At the **Suicidal Behavior** field, select the type of suicidal activity. Click the list and select one of 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 list and select one of the options.

    - HOME OR VICINITY

- SCHOOL
- WORK
- JAIL/PRISON/DETENTION
- TREATMENT FACILITY
- MEDICAL FACILITY
- OTHER
- UNKNOWN

11. At the **Previous Attempts** field, select the previous suicide attempts. Select one of the options available from the 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 list to access the **Disposition** select window (Figure 10-10).

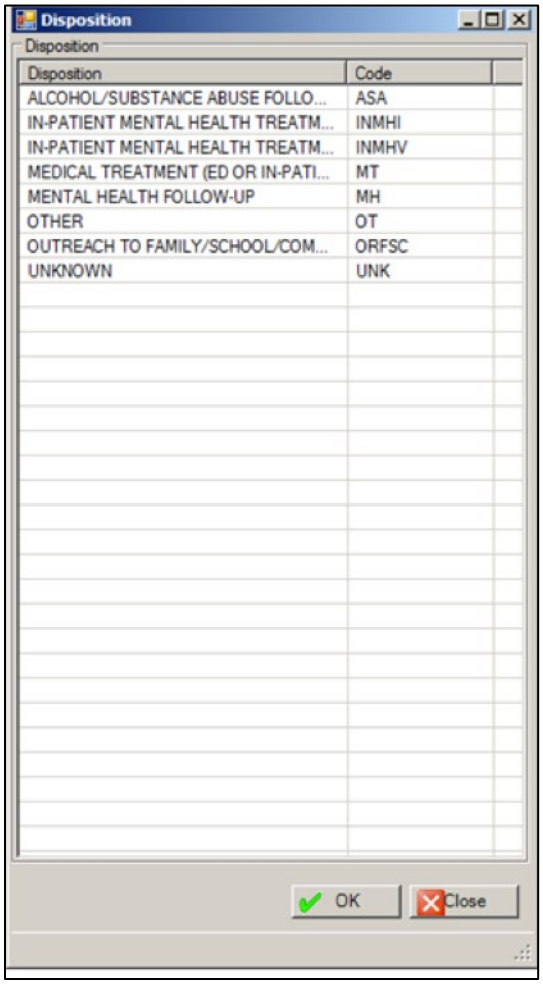
Screen Capture	What to Do
	Use this window as follows: (1) Select a Disposition option and click **OK**; the selected option populates the **Disposition** field. (2) If **Other** was selected, the field to the right becomes active. Populate this free-text field with the disposition of the suicide act (limited to 80 characters).

Figure 10-10: Disposition Select window

10.2.2 Method Tab

Use the **Method** tab (Figure 10-11) to indicate the method used in the suicide act as well as indicate the substance used in overdose cases.

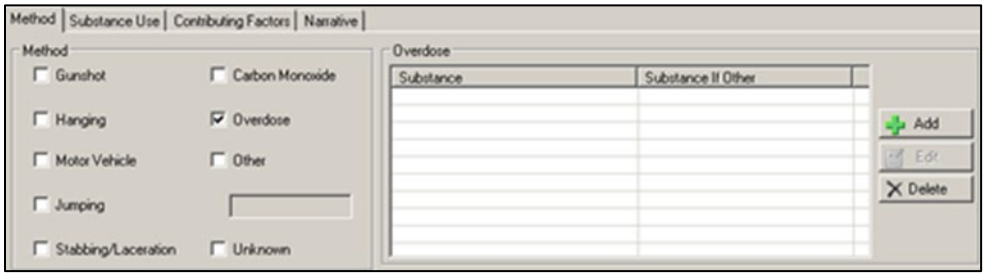


Figure 10-11: Method tab

10.2.2.1 Method Group Box

1. Select one or more **check boxes** in this group box that describe the method used in the suicide act. At least one is required.

2. Select the **Overdose** check box and the **Substance Multiple Select** window (Figure 10-12) displays where you can add one or more categories of substances.

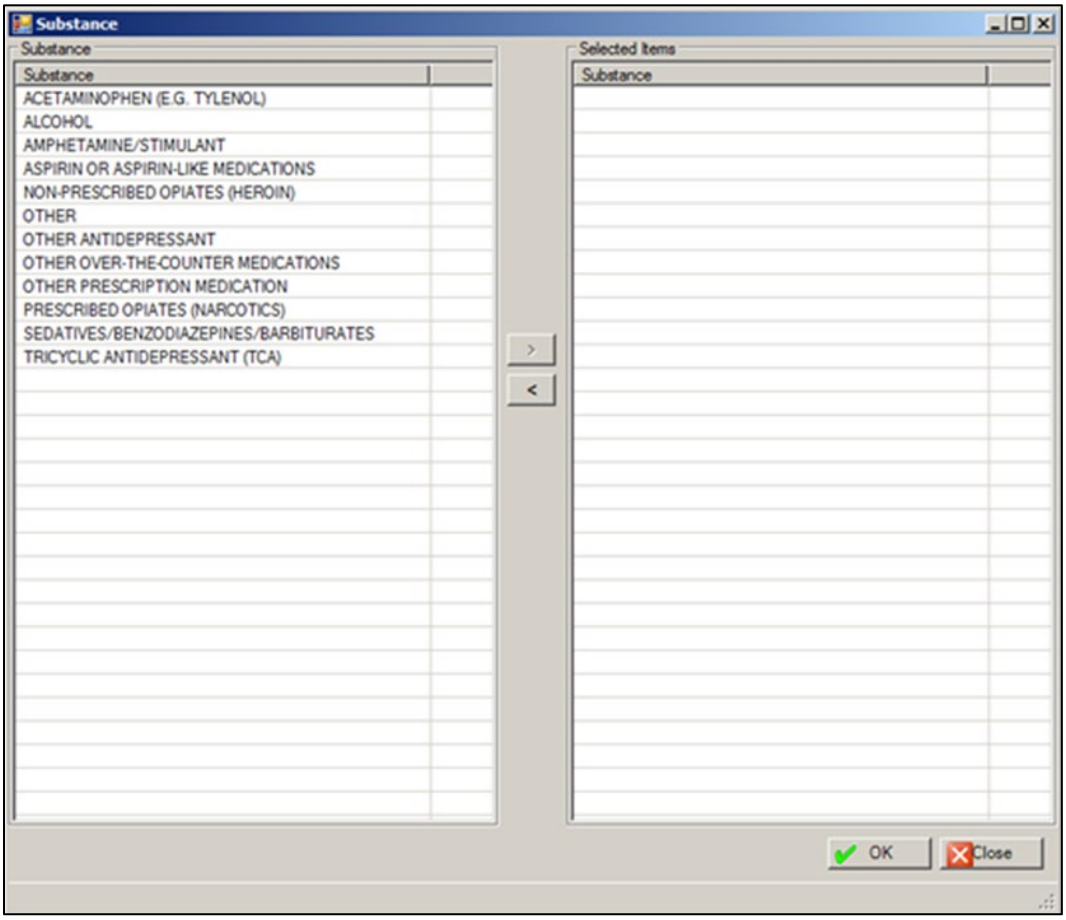


Figure 10-12: Substance Multiple Select window

Use this search window as follows:

a. Select an option in the **Substance** list box.

b. Click the **Right Arrow** button 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 Arrow** button 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 (Figure 10-13) displays.

Figure 10-13: Other dialog

You must populate the **Other** free-text field (limited to **80** characters) with a description of the other substance. Click **OK**. The description populates the **Substance If Other** cell on the **Overdose** group box.

4. If you select the **Other** check box, the field below the check box becomes active. Populate this free-text field with text that describes the 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 (Figure 10-14) displays.

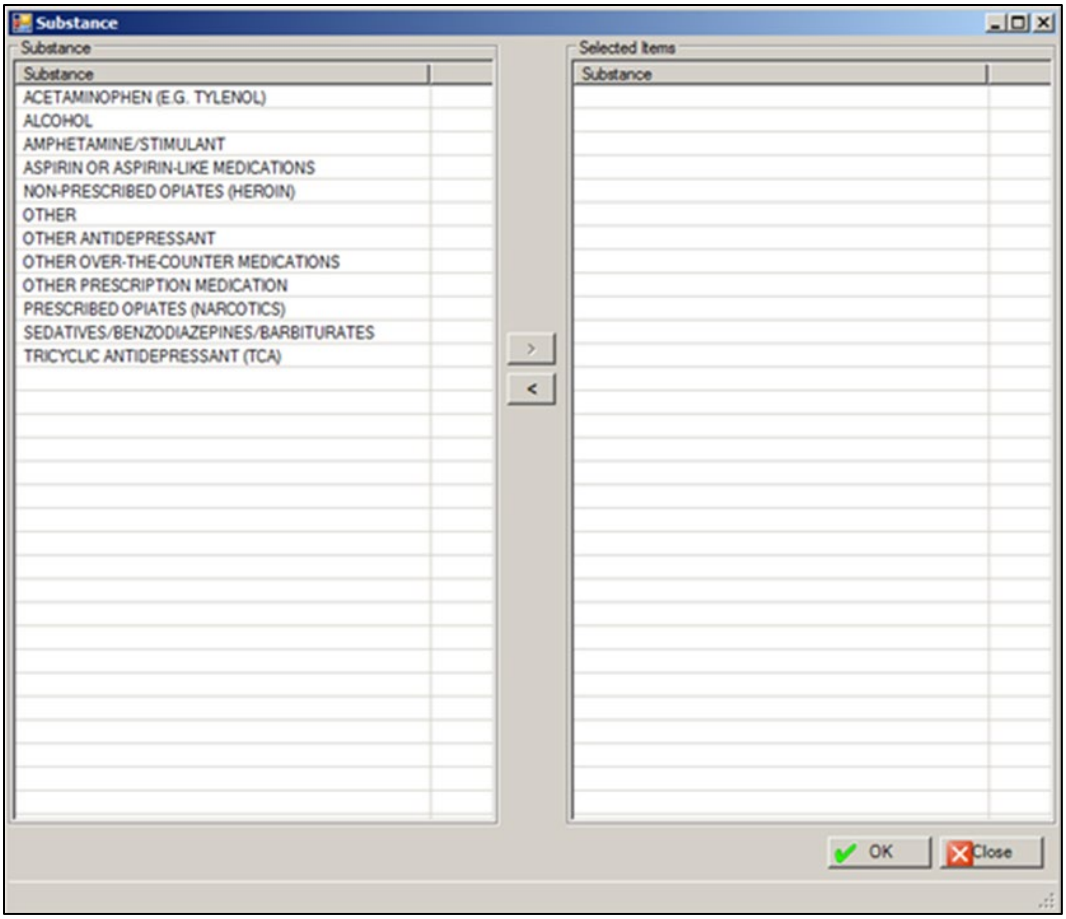


Figure 10-14: Substance Multi-Select window

Use this search window as follows:

a. Select an option in the **Substance** list box.

b. Click the **Right Arrow** button 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 Arrow** button 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**.)

10.2.2.2 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. Add, edit, or delete overdose substances.

10.2.2.2.1 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**.)

10.2.2.2.2 Edit Button

1. Highlight the **record** with data in the **Substance if Other** column.
2. Click **Edit**.

   The **Other Antidepressant** dialog (Figure 10-15) displays.

Figure 10-15: Other Antidepressant dialog

   a. Change the **antidepressant substance** in the field.
   b. Click **OK** to change the record.

   The application displays the current **Substance If Other** data in the **Other** field. You can change the data, as needed.

3. Click **OK** to dismiss the **Other** dialog.

10.2.2.2.3 Add Button

1. Click **Add**.

The **Substance** multiple select window where you can add one or more substances displays.

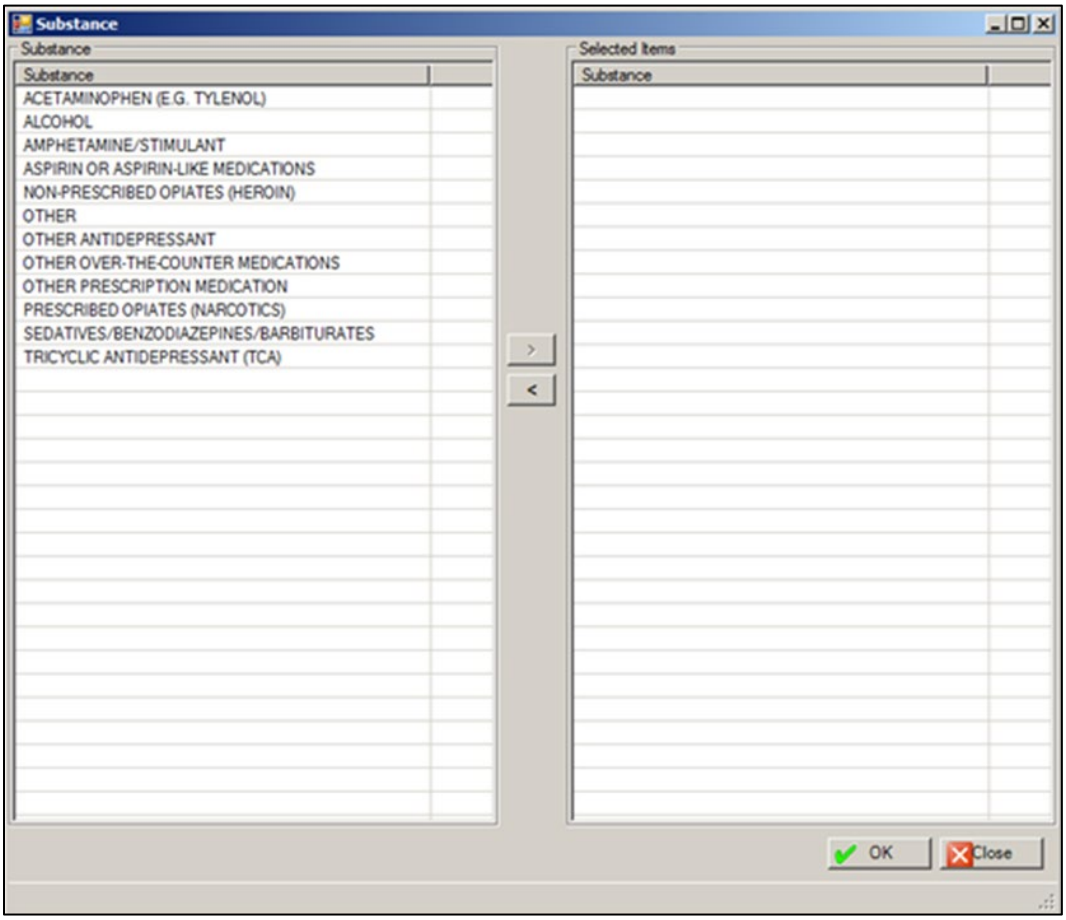


Figure 10-16: Substance multi-select window

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**.)

2. If you select a substance with **Other** in the title on the **Substance Multiple Select** window, the application displays the **Other** dialog (Figure 10-17).

Figure 10-17: Other dialog

a. Type the **substance** used in the overdose (limited to **80** characters). This is a free-text field.

b. Click **OK** to populate the substance used in the **Substance If Other** column on the grid.

10.2.3 Substance Use Tab

Use the **Substance Use** tab (Figure 10-18) to indicate the substances involved in the suicide incident, as well as the categories of the substances involved.

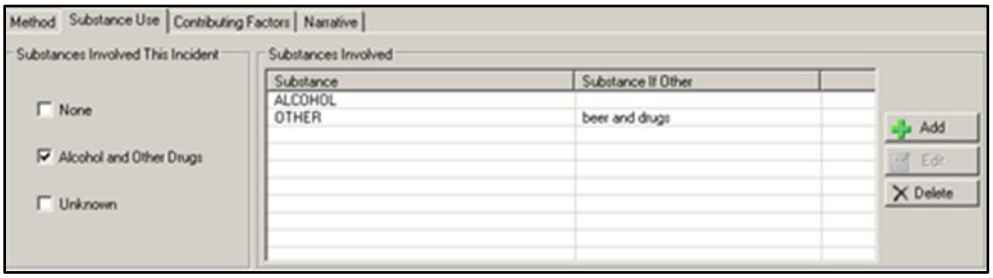


Figure 10-18: Substance Use tab

10.2.3.1 Substances Involved This Incident Group Box

1. Select one of the **checkboxes** in this group box that describes the substance (Figure 10-19) used in the suicide act. At least one is required.

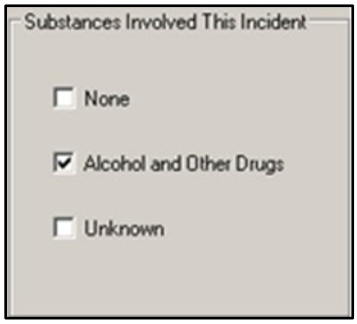


Figure 10-19: Substances Involved This Incident group box

2. If you select the **Alcohol and Other Drugs** checkbox, the application displays the **Substance multiple select** window (Figure 10-20) where you can add one or more substances.

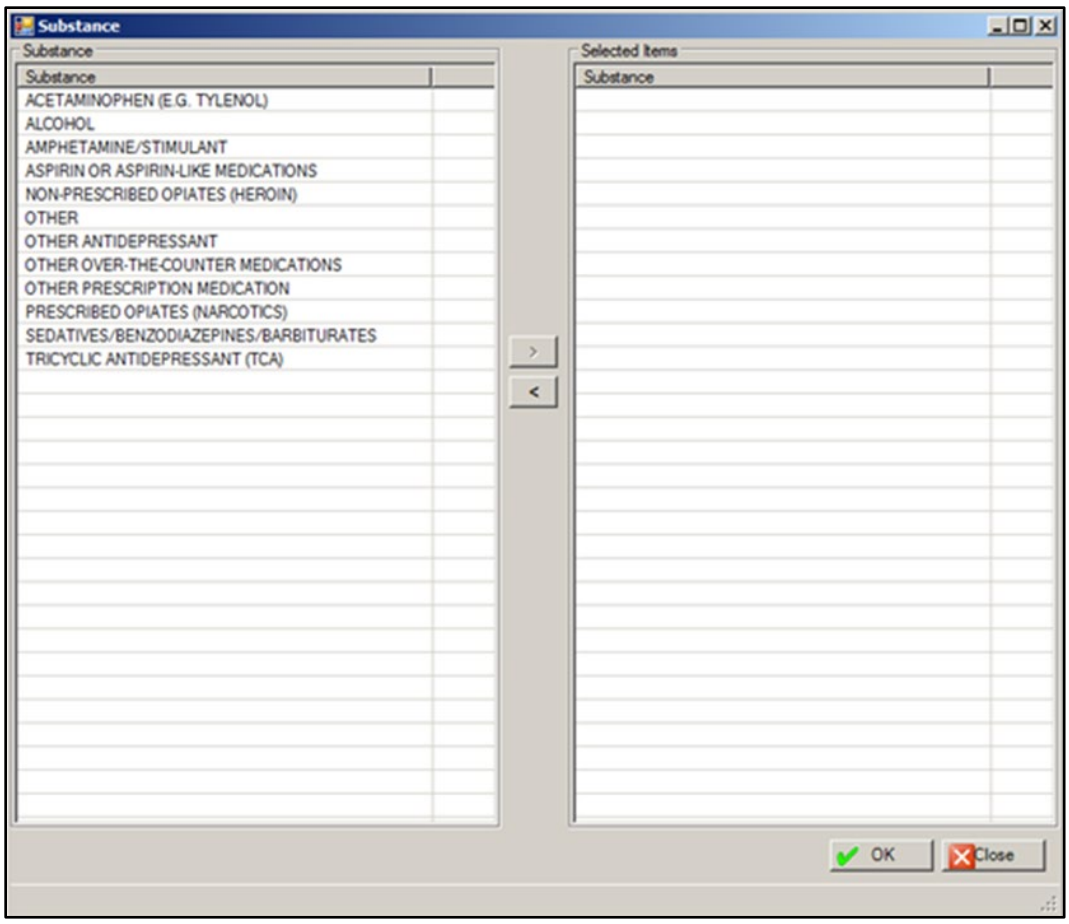


Figure 10-20: Substance multi-select window

Use this search window as follows:

a. Select one or more **substances** in the **Substance** list box.

b. Click the **Right Arrow** button 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 Arrow** button 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 (Figure 10-21).

Figure 10-21: Other dialog

a. Type the name of the other **substance** in the field (limited to **80** characters).

b. When this dialog 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.

10.2.3.2 Substances Involved Group Box

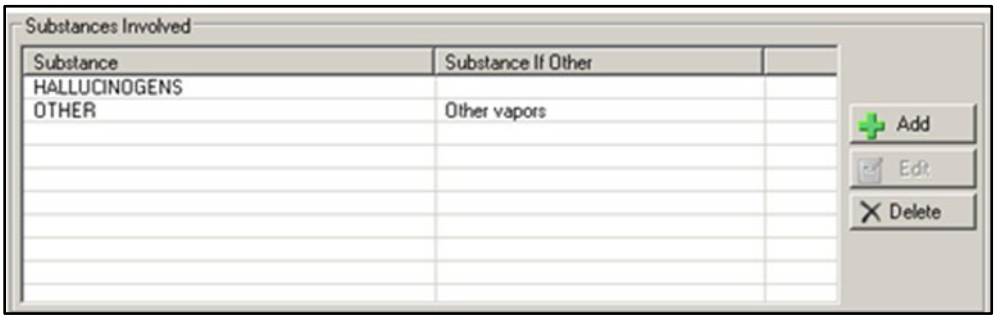


Figure 10-22: Substances Involved group box

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.

10.2.3.2.1 Add Button

Use the **Add** button to add one or more new records.

1. Click **Add**.

The **Substance** multiple select window where you can add one or more substances.

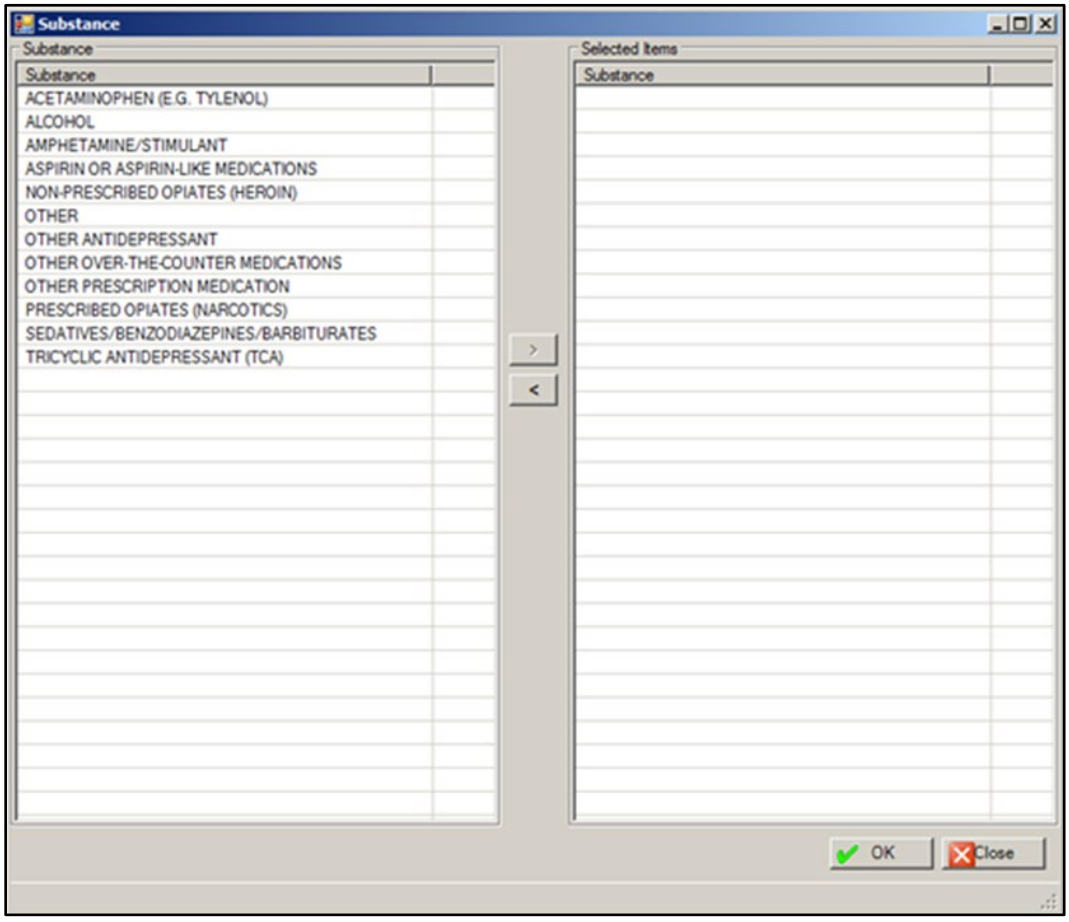


Figure 10-23: Substance multi-select window

Use this search window as follows:

a. Select one or more **substances** in the **Substance** list box.

b. Click the **Right Arrow** button 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 Arrow** button 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.**)

2. If you selected **Other** on the multiple select window, the application displays the **Other** dialog.

Figure 10-24: Other dialog

a. Type the name of the **other substance** in the field (limited to **80** characters).

b. When this dialog 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.

10.2.3.2.2 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 displays. Change the **Other** field and then click **OK** (otherwise, click **Close**). The **OK** function changes the data in the **Substance If Other** column.

10.2.3.2.3 Delete Button

Use the **Delete** button to remove a selected substance record.

1. Select the **record** to delete.
2. Click **Delete**.

On the **Are You Sure** confirmation, click **Yes** to delete the selected substance record. (Otherwise, click **No**.)

10.2.4 Contributing Factors Tab

Use the **Contributing Factors** tab (Figure 10-25) to indicate one or more contributing factors associated with the suicide act.

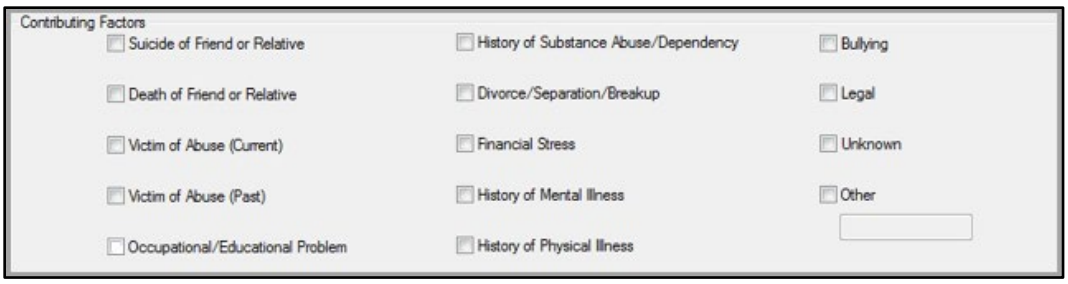


Figure 10-25: Contributing Factors tab

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).

10.2.5 Narrative Tab

Use the **Narrative** tab to populate the **Other Relevant Information** free-text field. (This is not a required field.)

Figure 10-26: 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**.

11.0 Intake

This section addresses how to manage **intake/update** documents in the GUI.

11.1 Intake (GUI)

There are two ways to work with the **Patient Intake** documents in the GUI:

- Use the **Intake** option on the GUI tree structure.
- 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 (Figure 11-1) displays.

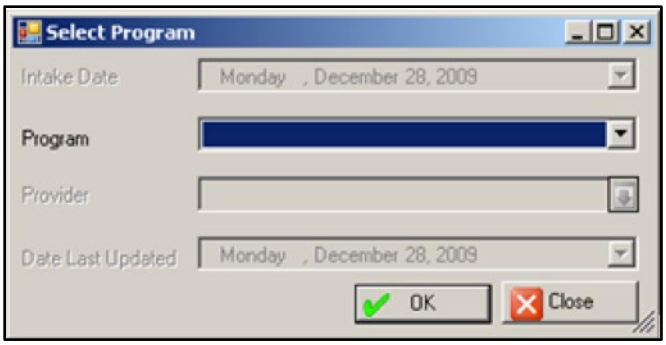


Figure 11-1: Select Program dialog

1. At the **Program** field, click the list for the **Program** field and select an option.
2. Click **OK** (otherwise click **Close**).

   The **OK** process displays the **Intake** window (Figure 11-2) 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.

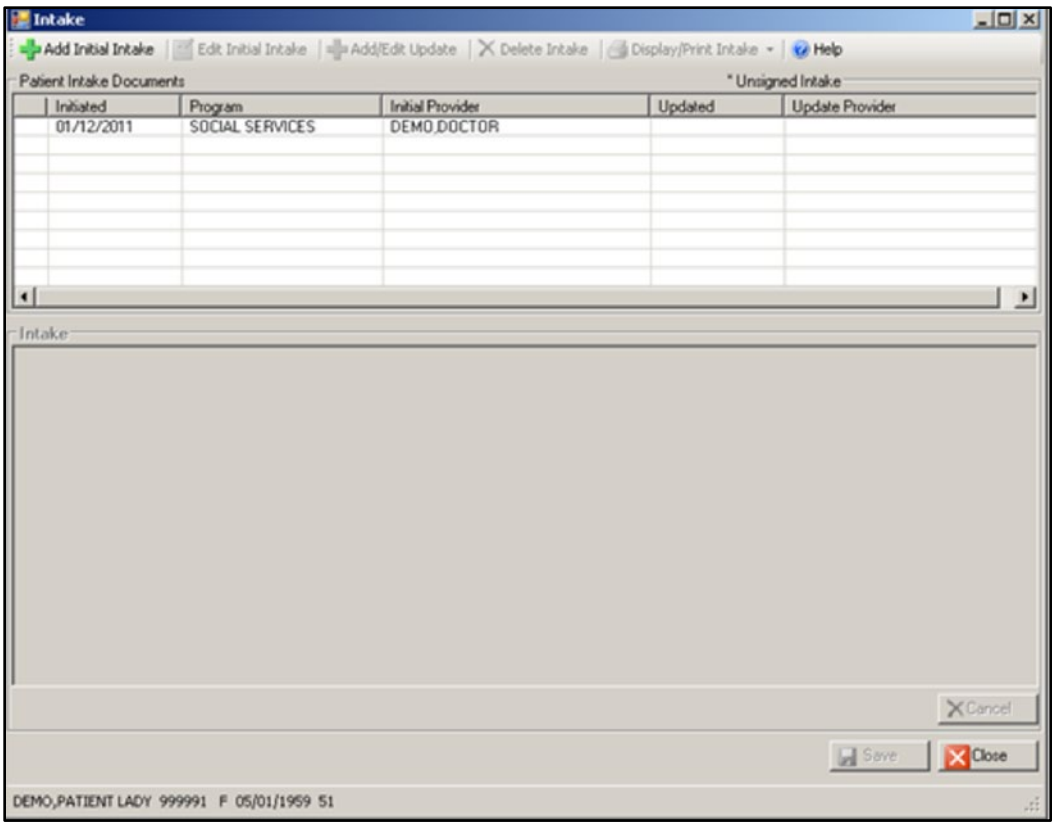


Figure 11-2: Intake window

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.

11.1.1 Patient Intake Documents List Box

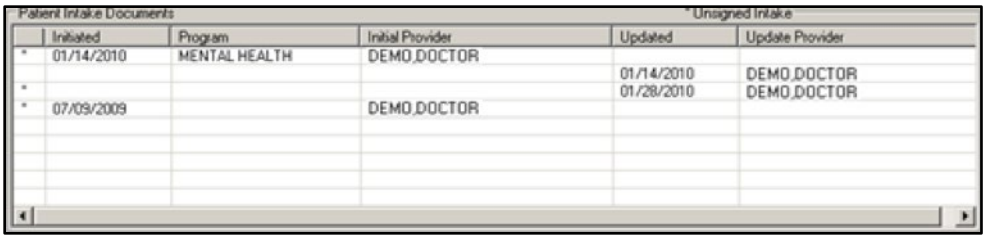


Figure 11-3: Patient Intake Documents list box

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**.

11.1.2 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 (Figure 11-4).

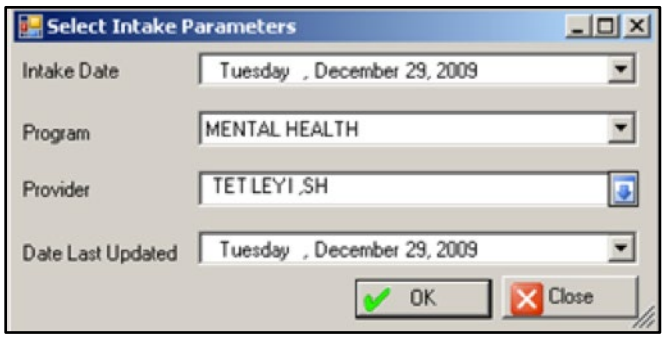


Figure 11-4: Select Intake Parameters dialog

2. At the **Intake Date** field, the current date displays. Change this by clicking the 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 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 list to access the **Primary Provider** search/select window (Figure 11-5).

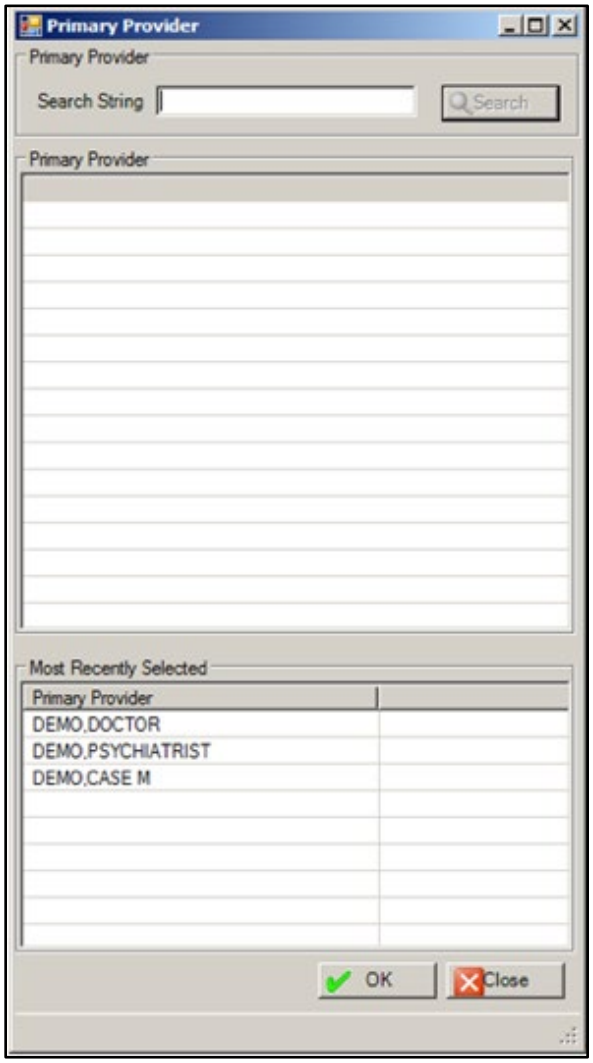
Screen Capture	What to Do
	Use this window in one of two ways: 1 Use the **Search String** field by typing the Provider's last name and clicking **Search**. The retrieved names will populate the **Primary Provider** list box. Select a name and click **OK** to populate the **Provider** field. Otherwise, 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 11-5: Primary Provider search/select window

5. At the **Date Last Updated** field, the current date displays. Change this by clicking the own list and selecting another date from the calendar (cannot be a future date).

After completing the **Select Intake Parameters** dialog, click **OK** (otherwise, click **Close**). The **OK** function activates the Intake group box. Section 11.1.3 provides more information about this group box.

11.1.3 Intake Group Box

Figure 11-6: 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 completing the **Intake** group box, click **Save** (otherwise click **Close**).

- If the user clicked **Close**, 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 the user clicked **Save**, the **Intake Electronic Signature** dialog (Figure 11-7) displays. The **Save** process requires that there is intake narrative.

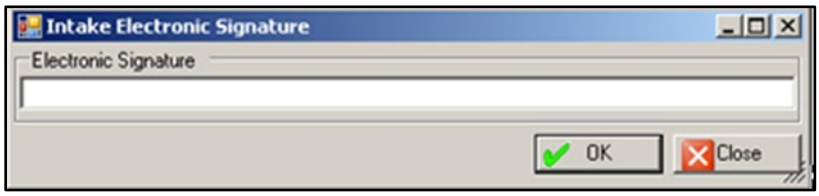


Figure 11-7: Intake Electronic Signature dialog

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:

1. At the **Electronic Signature** field, do not type your electronic signature.

2. Click **Close**.
3. Click **Yes** or **No** at the **Are You Sure?** dialog display, which states: **Are you sure you want to Close without Electronically Signing the Intake?**.
   - Click **Yes** to not sign it and to save the document marked as not signed. The application displays the message: **You did not Electronically Sign the Intake**. Click **OK** to dismiss the message. This type of document can be edited.
   - Click **No** and the focus returns to the **Intake Electronic Signature** dialog.

11.1.4 Edit Initial Intake

Select an existing initial intake document and click the **Edit Initial Intake** button to edit the initial intake document.

- If the selected document has been signed, the application displays the message: "**This Initial Intake document has been signed. You cannot edit it**. Click **OK** to dismiss the message and you exit the edit process.
- Only the provider or the person who entered the intake can edit it; otherwise, the application displays the message: **You are not the provider or the person who entered the Intake, you cannot edit it**. Click **OK** to dismiss the message and exit the edit process.

If you are the provider or the person who entered the intake, the application displays the **Select Intake Parameters** dialog. Section 11.1.2 provides more information on the add initial intake process. After completing this dialog, the text of the initial intake document will display in the Intake area of the **Intake** window. Section 11.1.3 provides more information about the intake group box.

11.1.5 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 exit the edit process.

After the **Provider** locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the **Delete Override Site Parameter**.

If you select an **Intake** document (signed or unsigned), the button reads: **Add Update**.

If you select an unsigned **Update** document, the button reads: **Edit Update**.

In either case, the application displays the **Select Intake Parameters** dialog. Section 11.1.2 provides more information about **Add Initial Intake**.

After completing this dialog, the **Intake** group box will become active. Section 11.1.3 provides more information about the **Intake** group box.

11.1.6 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, click **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.

4. Click **OK** and you exit the **Delete** process.

11.1.7 Display/Print Intake

Use the **Display/ Print Intake** button to access the options for the display/print process (Figure 11-8).

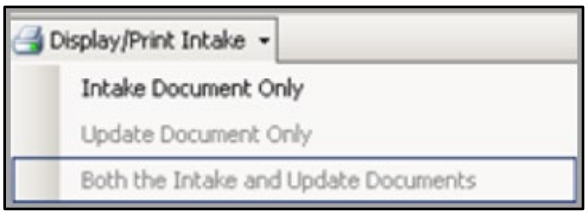


Figure 11-8: Options on the Display/Print Intake button

1. Highlight an **Intake record** and select one of options (only the valid options will be highlighted).

   If you select **Update Document Only** or **Both the Intake and Update Documents**, the application displays the **Intake Updates** dialog (Figure 11-9).

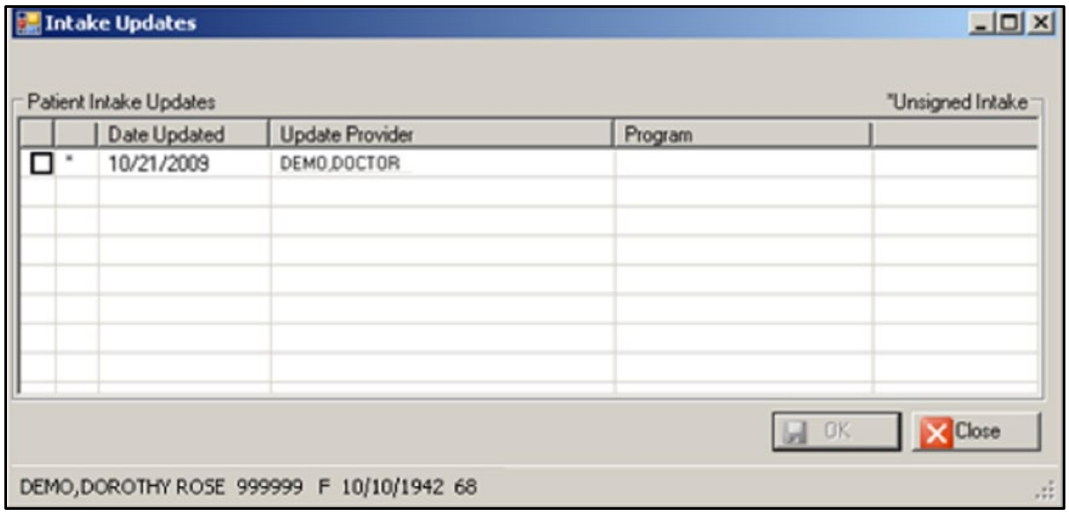


Figure 11-9: Intake Updates dialog

2. 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 (Figure 11-10) displays.

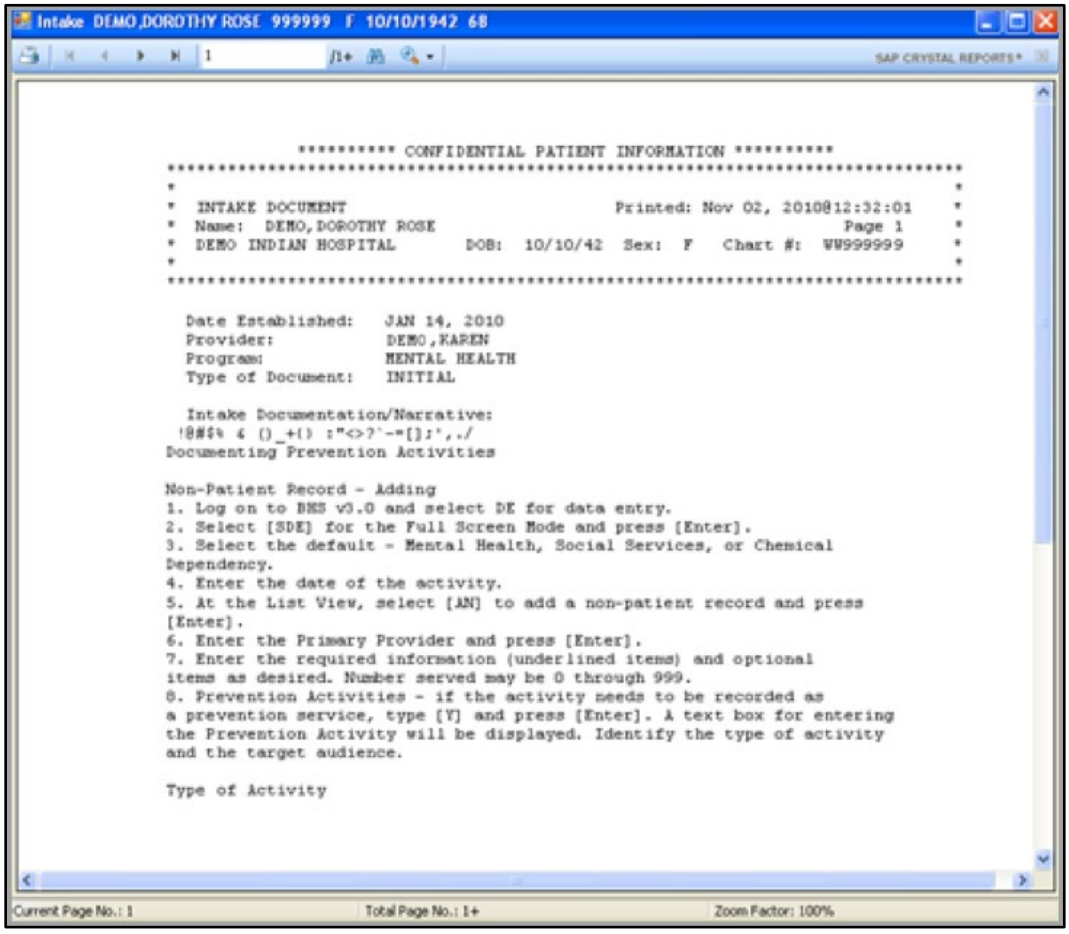


Figure 11-10: Intake pop-up window

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

12.0 Reports (Roll and Scroll Only)

The **Reports menu** of the **AMH** provides numerous options for retrieving data from the patient file. You can obtain specific patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

The **Reports** menu (Figure 12-1) contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to the **AMH**. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options are detailed in the following sections.

```
                ******************************************
                **       IHS Behavioral Health System       **
                **                  Reports                 **
                ******************************************
                           Version 4.0 (Patch 11)

                           DEMO INDIAN HOSPITAL

   PAT    Patient Listings ...
   REC    Behavioral Health Record/Encounter Reports ...
   WL     Workload/Activity Reports ...
   PROB   Problem Specific Reports ...
   TABL   Print Standard Behavioral Health Tables ...

Select Reports Menu Option:
```

Figure 12-1: Options on Report menu example

Use this menu for tracking and managing patient, provider, and program statistics.

Note: The location screen (**UU**) and the list of **Those Allowed to See All Visits** found on the site parameters menu will impact the information displayed in the reports. For example, if your name has not been added to the list of those allowed to see all visits, the report will contain only those visits where you were a provider or completed the data entry.

12.1 Patient Listings (PAT)

The **Patient Listings** submenu (Figure 12-2) contains report options for generating lists of patients by various criteria. Also included is the **Patient General Retrieval** option, that is a custom report that allows you to select which patients to include in the report as well as the items to print and the sort criteria.

```
   ACL    Active Client List
   PGEN   Patient General Retrieval
   DP     Designated Provider List
   GRT    Patients with AT LEAST N Visits
   AGE    Patients Seen by Age and Sex (132 column print)
   CASE   Case Status Reports ...
   GAFS   GAF Scores for Multiple Patients
   NSDR   Listing of No-Show Visits in a Date Range
   PERS   Patient List for Personal Hx Items
   PPL    Placements by Site/Patient
   PPR    Listing of Patients with Selected Problems
   SB     SBIRT Report
   SCRN   Screening Reports ...
   TPR    Treatment Plans ...
   TSG    Patients seen in groups w/Time in Group

Select Patient Listings Option:
```

Figure 12-2: Options on the Patient Listings reports example

12.1.1 Active Client List (ACL)

Use the **ACL** option to review a list of patients who have been seen in a specified date range. You can further filter the report by a particular provider, if needed.

Below are the prompts:

- Enter beginning Date
  - Specify the beginning date of the date range.
- Enter ending Date
  - Specify the ending date of the date range.

> **Note:** The date range considered should be one in which the patient should be seen in order to be considered active.

- Limit the list to those patients who have seen a particular provider?
  - Type **Y** (yes)

  Or
  - **N** (no).

  If you type **Y**, other prompts display.
- Demo Patient Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)

- **O** (include only demo patients)

- Do you want to use:
  - **P** (print output)

  Or

  - **B** (browse output on screen)

Browse the output on the **Output Browser** window (Figure 12-3).

```
                          ACTIVE CLIENT LIST
                        PROVIDER: PROVIDER R
                ENCOUNTER DATES:  OCT 1, 2015 TO NOV 24, 2015
PATIENT NAME CHART  SEX   DOB    LOCATION     PROVIDER  PROBLEM      #
             NUMBER              SEEN         SEEN     CODES   VISITS
-------------------------------------------------------------------------
CLIENT A    106529  F   03/05/30  CHENEGA     PROVIDER R   F32.3     4
                                  DEMO HOSPI   STUDENT,EI   F10.24
CLIENT B    901234  F  04/04/76  DEMO HOSPI   PROVIDER R   F42.
CLIENT C    200042  M  03/23/83  CHENEGA      PROVIDER R   F32.1     3
                                  DEMO HOSPI   STUDENT,FO   F32.3
                                               STUDENT,TW   F32.3
CLIENT D   107468   M  05/20/69  DEMO HOSPI   PROVIDER R   F84.0     2
                                               F32.2
CLIENT E   432098   M  04/04/75  DEMO HOSPI   PROVIDER R   F42.      1
CLIENT F   200614   F  05/17/90  CHENEGA      PROVIDER R    1.1      3
                                               STUDENT,TW   F10.24
Total Number of Patients: 6
```

Figure 12-3: Output Browser data example

Near the end of the report, the application displays the total number of patients.

12.1.2 Patient General Retrieval (PGEN)

Use the **PGEN** option to produce a report that shows a listing of patients based on selected criteria. The patients used on the report can be selected based on any selected print and sort criteria.

Below are the prompts:

- Select and Print Patient List from
  - Use **S** (search template)

  Or

  - **P** (patient file)

  If you use **S**, other prompts will display.

- Do you want to use a PREVIOUSLY DEFINED REPORT?
  - Use **Y** or **N**. If you use **Y**, other prompts will display.

The application displays the **Patient Selection Menu** (Figure 12-4).

```
BH GENERAL RETRIEVAL          Dec 26, 2015 09:10:31          Page:    1 of    1
                        Patient Selection Menu
Patients can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Patients type Q.

1)  Sex                     14)  Medicaid Eligibility  27)  Pts seen at a Locati
2)  Race                    15)  Priv Ins Eligibility  28)  Pts Seen in a Commun
3)  Patient Age             16)  Patient Flag Field    29)  Pts w/Problem (DX)
4)  Patient DOB             17)  Case Open Date        30)  Pts w/Problem (MHSS
5)  Patient DOD             18)  Case Admit Date       31)  Pts seen by a Provid
6)  Living Patients         19)  Case Closed Date      32)  Pts w/Education Done
7)  Chart Facility          20)  Case Disposition      33)  Pts seen for an Acti
8)  Community of Residen    21)  Next Case Review Dat  34)  Pts seen w/Type of C
9)  County of Residence     22)  Designated MH Prov    35)  Pts seen w/Axis IV L
10)  Tribe of Membership    23)  Designated SS Provid  36)  Pts w/Inpatient Disp
11)  Eligibility Status     24)  Designated A/SA Prov  37)  Pts Last Health Fact
12)  Class/Beneficiary      25)  Designated Other Pro
13)  Medicare Eligibility   26)  Personal History Ite

          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-4: Patient Selection Menu options example

Use this menu to select the patients based on various criteria. If you do not specify any criteria (immediately use the **Quit Item Selection** option), the application selects all patients.

Choose **Type of Report**.

Use one of the following:

- **T** (total count only)
- **S** (sub-counts and total count)
- **D** (detailed listing)

If you select **D** (the detailed listing), the application displays the **Print Item Selection Menu** (Figure 12-5).

```
BH GENERAL RETRIEVAL          Apr 16, 2015 14:46:31          Page:    1 of    1
                        PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1)  Patient Name            13)  Class/Beneficiary     25)  Case Disposition
2)  Sex                     14)  Medicare Eligibility  26)  Next Case Review Dat
3)  Race                    15)  Medicaid Eligibility  27)  Designated MH Prov
```

```
4)  Patient Age            16)  Priv Ins Eligibility  28)  Designated SS Provid
5)  Patient DOB            17)  Mailing Address-City  29)  Designated A/SA Prov
6)  Patient SSN            18)  Home Phone            30)  Designated Other Pro
7)  Patient DOD            19)  Mother's Name         31)  Designated Other (2)
8)  Patient Chart #        20)  Patient Flag Field    32)  Personal History Ite
9)  Community of Residen   21)  Patient Flag Narrati  33)  Pts Last Health Fact
10)  County of Residence   22)  Case Open Date
11)  Tribe of Membership   23)  Case Admit Date
12)  Eligibility Status    24)  Case Closed Date


          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-5: Print Item Selection Menu options example

Use this menu to determine the data items on the report. Select the items in the order that you want them to appear on the output. When through selecting, use the **Quit Item Selection** action to dismiss the menu.

Next, the application displays the **Sort Item Selection Menu** (Figure 12-6).

```
BH GENERAL RETRIEVAL          Apr 16, 2009 14:49:47          Page:    1 of    1

                         SORT ITEM SELECTION MENU
The Patients displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by patient name.

1)  Patient Name           7)  Community of Residen   13)  Designated MH Prov
2)  Sex                    8)  County of Residence    14)  Designated SS Provid
3)  Race                   9)  Tribe of Membership    15)  Designated A/SA Prov
4)  Patient DOB            10)  Eligibility Status    16)  Designated Other Pro
5)  Patient DOD            11)  Class/Beneficiary     17)  Designated Other (2)
6)  Patient Chart #        12)  Patient Flag Field




          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-6: Sort Item Selection Menu options example

Use this menu to determine how the data will be sorted on the report. If you do not select any item (immediately use the **Quit Item Selection** option), the report will be sorted by patient name.

- Do you want a separate page for each Patient Name?
  - Use **Y** or **N**.

- Would you like a custom title for this report?
  - Use **Y** or **N**. If you use **Y**, other prompts will display.
- Do you want to save this search/print/sort logic for future use?
  - Use **Y** or **N**. If you use **Y**, other prompts will display.
- Demo Patient Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)

  The application provides a **Report Summary** that shows the criteria you selected.

- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application first displays the **Patient Selection Criteria** for the report.

After you move onto the next screen press **Enter** (to continue), and the application displays the patient listing report (Figure 12-7).

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
                              BH Patient Listing                        Page 1
PATIENT NAME              SSN       COMM RESIDENCE
--------------------------------------------------

A'PAT1,ALAYNA BROOKL   XXX-XX-2160  HOWE
A'PAT1,WEBB AARON      XXX-XX-4769  PORUM
DEMO,ALICE ROCHELLE    XXX-XX-6378  COLCORD
DEMO,GERALDINE         XXX-XX-7097  MUSKOGEE
          Enter ?? for more actions
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 12-7: Patient Listing report example

12.1.3 Designated Provider List (DP)

Use the **DP** option to produce the designated mental health provider list report.

Below are the prompts:

- Which Designated Provider?

Use one of the following:

- **M** (mental health)
- **S** (social services)
- **C** (chemical, dependency or alcohol/substance abuse)
- **O** (other)
- **T** (other non-RPMS)

- Run Report for?

  Use one of the following:

  - **1** (one provider) or
  - **2** (all providers).

  If you use **1**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)

- Do you want to use:

  - **P** (print output)

  Or

  - **B** (browse output on screen)

The application displays the Designated Mental Health Provider List report (Figure 13 8).

```
           ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                Page 1
                          DEMO INDIAN HOSPITAL
                   DESIGNATED MENTAL HEALTH PROVIDER LIST
                              PROVIDER: ALL

PATIENT NAME              CHART #    SEX   DOB      COMMUNITY   LAST VISIT
-------------------------------------------------------------------------------

PROVIDER:  GPROVIDER,D

DEMO,ALICE ROCHELLE       183497     F   06/25/97   COLCORD      Jan 05, 2009
DEMO,GLEN DALE            108704     M   11/10/81   TAHLEQUAH    Apr 14, 2009
DEMO,JANE ELLEN                      F   01/01/90   TUCSON       Apr 15, 2009
MPAT11,SHERRY KEARNEY     197407     F   10/01/00   PEGGS        Sep 28, 2007
+         Enter ?? for more actions                                      >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 12-8: Designated Mental Health Provider List report (for all providers) example

The report subtotals by provider.

12.1.4 Patients with AT LEAST N Visits (GRT)

Use the **GRT** option to produce a report that shows a list of patients who have been seen at least N number of times in a specified date range.

Below are the prompts:

- Enter beginning Date
  - Specify the beginning date of the date range.
- Enter ending Date
  - Specify the ending date of the date range.
- Enter the minimum number of time the patient should have been seen

  Use any number between **2** and **100**.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the patients seen at least **N** times report (Figure 12-9).

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                Page 1
                           DEMO INDIAN HOSPITAL
                     PATIENTS SEEN AT LEAST 3 TIMES
                 RECORD DATES:  JAN 16, 2009  TO  APR 16, 2015


PATIENT NAME      CHART # SEX  DOB       LOCATION    PROVIDER    PROBLEM  #
                                         SEEN        SEEN        CODES    VISITS
--------------------------------------------------------------------------------
DEMO,CHELSEA    116431   F   02/07/75    CEDAR CITY  BDOC111,BJ  1.1         67
                                         CHEVAK      BDOC222,LO  12
                                         CHINLE CHA  CDOC1,JESS  14
                                         CHINLE HOS  DEMO,DOCTO  15
                                         DEMO INDIA  GDOC12,RYA  22
```

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

Figure 12-9: Patients Seen at least 3 Times report example

12.1.5 Patients Seen by Age and Sex (AGE)

Use the **AGE** option to produce a report that tallies the number of patients, who have had an encounter, by age and sex. You will choose the item you want to tally. For example, you can tally problems treated, or activities by age and sex. Any tally by **PROBLEM** only includes the **PRIMARY PROBLEM**. You will be able to define the age groups to be used.

Below are the prompts:

- Choose an item to tally by age and sex.

  Use one of the following:

  - 1) Program Type
  - 2) POV/Problem (Problem Code)
  - 3) Problem/POV (Problem Category)
  - 4) Problem/POV
  - 5) Location of Service
  - 6) Type of Contact of Visit
  - 7) Activity Code
  - 8) Activity Category
  - 9) Community of Service

  The item you select will display down the left column of the report. Age groups will be across the top.

- Enter beginning Visit Date for Search
  - Specify the beginning date of the date range.
- Enter ending Visit Date for Search
  - Specify the ending date of the date range.

The application displays the **Visit Selection Menu** (Figure 12-10).

```
BH GENERAL RETRIEVAL          Dec 26, 2015 09:20:24          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
```

```
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-10: Visit Selection Menu example

Use this menu to select the visit selection criteria for the report. If you do not select any criteria (immediately use the **Quit Item Selection**), all visits will be selected.

- Do you want to modify these age groups?

  The application displays the currently defined age groups. Answer **Y** or **N** to this prompt. If you use **Y**, other prompts will display. Use **N** to have the defined age groups listed across the top of the report.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the criteria for the report. After pressing **Enter**, the application displays the **Behavioral Health Record Listing** report (Figure 12-11).

```
OUTPUT BROWSER                Apr 16, 2015 15:20:53          Page:    1 of   23
```

```
                    BEHAVIORAL HEALTH RECORD LISTING

REPORT REQUESTED BY: DEMO,SHIRLEY

The following visit listing contains BH visits selected based on the
following criteria:

                            RECORD SELECTION CRITERIA

Encounter Date range:  OCT 18, 2008 to APR 16, 2015


Report Type: RECORD COUNTS BY AGE/SEX
             ********** CONFIDENTIAL PATIENT INFORMATION **********
                                  BEHAVIORAL HEALTH RECORD/ENCOUNTER COUNTS
                                            PROBLEM DSM-5/CODE BY AGE AND
                                       ENCOUNTER DATES:  OCT 18, 2008  TO  A

                                                                SEX: BOTH
PROB DSM/CODE NARRATIVE                    0-0      1-4      5-14     15-19    20-
-------------------------------------------------------------------------------
ACUTE STRESS REACTION                        .        .        .        .
ADMINISTRATION                               .        .        2        .
ADULT ABUSE (SUSPECTED),UNSPEC               .        .        .        .
ALCOHOL ABUSE                                .        .        1        .
ALCOHOL ABUSE, CONTINUOUS                    .        .        .        .
ALCOHOL ABUSE, EPISODIC,                     .        .        .        1
ALCOHOL ABUSE, IN REMISSION                  .        .        .        .
ALCOHOL ABUSE, UNSPECIFIED                   .        .        1        1
+         Enter ?? for more actions                                      >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 12-11: Behavioral Health Record Listing report example

12.1.6 Case Status Reports (CASE)

Use the **CASE** option to access additional reports on the **Case Status Reports** menu (Figure 12-12).

```
   ACO    Active Client List Using Case Open Date
   ONS    Cases Opened But Patient Not Seen in N Days
   TCD    Tally Cases Opened/Admitted/Closed
   DOC    Duration of Care for Cases Opened and Closed
   SENO   Patients Seen x number of times w/no Case Open

Select Case Status Reports Option:
```

Figure 12-12: Options on the Case Status Reports menu example

12.1.6.1 Active Client List Using Case Open Date (ACO)

Use the **ACO** option to produce a report that shows a list of patients who have a case open date without a case closed date.

Below are the prompts:

- Run the Report for which program

  Use one of the following:

  – **O** (one program)

  Or

  – **A** (all programs)

  If you use **O**, other prompts will display.

- Include cases opened by

  Use one of the following:

  – **A** (all provides)

  Or

  – **O** (one provider)

  If you use **O**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the active client list report (Figure 12-13).

```
                          ACTIVE CLIENT LIST
                         PROVIDER: PROVIDER R
                ENCOUNTER DATES:  OCT 1, 2015 TO NOV 24, 2015
PATIENT NAME CHART  SEX   DOB    LOCATION     PROVIDER  PROBLEM      #
             NUMBER              SEEN         SEEN     CODES   VISITS
-------------------------------------------------------------------------
CLIENT A    106529  F   03/05/30  CHENEGA      PROVIDER R   F32.3     4
                                  DEMO HOSPI   STUDENT,EI   F10.24
CLIENT B    901234  F   04/04/76  DEMO HOSPI   PROVIDER R   F42.
CLIENT C    200042  M   03/23/83  CHENEGA      PROVIDER R   F32.1     3
                                  DEMO HOSPI   STUDENT,FO   F32.3
                                               STUDENT,TW   F32.3
CLIENT D   107468   M   05/20/69  DEMO HOSPI   PROVIDER R   F84.0     2
                                                            F32.2
CLIENT E   432098   M   04/04/75  DEMO HOSPI   PROVIDER R   F42.      1
CLIENT F   200614   F   05/17/90  CHENEGA      PROVIDER R   1.1       3
                                                  STUDENT,TW   F10.24
Total Number of Patients: 6
```

Figure 12-13: View of active client list example

12.1.6.2 Cases Opened but Patient Not Seen in N Days (ONS)

Use the **ONS** option to produce a report that shows a list of patients who have a case open date, no closed date, and have not been seen in **N** days. The user will determine the number of days to use.

Below are the prompts:

- Run the Report for which PROGRAM

  Use one of the following:

  – **O** (ONE program)

  Or

  – **A** (ALL programs)

  If you use **O**, other prompts will display.

- Include cases opened by

  Use one of the following:

  – **A** (Any provider)

  Or

  – **O** (One Provider)

  If you use **O**, other prompts will display.

- Enter the number of days since the patient has been seen

  – Specify the number of days (**1-99999**) to be used when determining which patients should be included in the report.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the **Cases Opened but Patient Not Seen in N Days** report (Figure 12-14).

```
                              DEMO INDIAN HOSPITAL
                  ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)

PATIENT NAME  CHART   SEX  DOB      CASE OPEN  PROVIDER     DATE LAST  # DAYS
              NUMBER                DATE                    SEEN        SINCE
Patient L     106299  F  11/28/85  01/01/06   GAMMAAA,DON  04/26/06   217
Patient M     102446  F  04/08/66  08/28/06   GAMMAAA,DON  03/28/06   246
Patient N     176203  M  03/04/60  10/10/05   GAMMAAA,DON  03/28/06   246
Patient O     164141  M  02/07/75  12/07/05   GAMMAAA,DON  04/25/06   218
Patient P     209591  F  04/16/62  07/25/06   ZETAAAA,MAT  07/25/06   127

 Total Number of Patients: 5
 Total Number of Cases: 5
```

Figure 12-14: Cases Opened but Patient Not Seen in N Days report example

12.1.6.3 Tally Cases Opened/Admitted/Closed (TCD)

Use the **TCD** option to produce a report that tallies the case open, admit, and closed dates in a specified time period.

Below are the prompts:

- Enter beginning of Time Period
  – Specify the beginning date of the date range.
- Enter ending of Time Period
  – Specify the ending date of the date range.
- Run the Report for which PROGRAM

  Use one of the following:

  – **O** (one program)

Or

– **A** (All programs).

If you use O, other prompts will display.

- Include cases opened by

  Use one of the following:

  – **A** (Any provider)

  Or

  – **O** (One providers).

  If you use **O**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the **Tally of Cases Opened/Admitted/Closed** report (Figure 12-15).

```
                              ALBUQUERQUE HOSPITAL
                         TALLY OF CASES OPENED/ADMITTED/CLOSED

------------------------------------------------------------------------------

          Number of Cases Opened:      6

          Number of Cases Admitted:    2

          Number of Cases Closed:      2

          Tally of Dispositions:
               PATIENT DIED                        1
               PATIENT DMOVED                      1
RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 12-15: Tally of Cases Opened/Admitted/Closed report example

12.1.6.4 Duration of Care for Cases Opened and Closed (DOC)

Use the **DOC** option to produce a report that shows a list of all closed cases in a specified date range. In order to be included in this report, the case must have both a case open and a case closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases can be selected based on **Open date**, **Closed date**, or both. Only those cases falling within the specified time frame will be counted.

Below are the prompts:

- Enter Beginning Date
  - Specify the beginning date of the date range.
- Enter Ending Date
  - Specify the ending date of the date range.
- Select which Dates should be Used

  Use one of the following:
  - **O** (cases opened in that Date Range)
  - **C** (cases closed in that Date Range)
  - **B** (cases either opened or closed in that **Date Range**)
- Run the Report for which PROGRAM

  Use one of the following:
  - **O** (One program)

  Or
  - **A** (All programs).

  If you use **O**, other prompts will display.
- Include cases opened by

  Use one of the following:
  - **A** (Any provider)

  Or
  - **O** (One provider).

  If you use **O**, other prompts will display.
- Do you want each Provider on a separate page?

  Use one of the following:
  - **Y** (for yes)

Or

– **N** (for no).

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the **Duration of Care** report (Figure 12-16).

```
           ********** CONFIDENTIAL PATIENT INFORMATION **********

                              DEMO HOSPITAL
                    Case Dates: May 24, 2008 to May 24, 2010
                         DURATION OF CARE REPORT

PATIENT NAME CHART     CASE OPEN   CASE CLOSED  DURATION  POV  PROVIDER
             NUMBER    DATE        DATE
-------------------------------------------------------------------------
Patient A    148367    05/22/08    08/22/08     92 days         BETA,B
Patient B    114077    06/27/08    08/28/08     62 days         BETA,B
Patient B    114077    07/25/08    08/21/08     27 days         BETA,B
Total Number of Cases for DEMO,B: 3
Average Duration of Care: 60.33 days

Patient C    211053    04/19/08     08/16/08    119 days 72.1  DEMO,ROBER
Total Number of Cases for DEMO,ROBERTA: 1
Average Duration of Care: 119.00 days

Patient D    146565    08/01/08    08/16/08     15 days  305.62 DEMO,MAUDE
Total Number of Cases for DEMO,MAUDE: 1
Average Duration of Care: 15.00 days

Patient E    148256    07/25/08    09/01/08     38 days         DEMO,VICTOR
Total Number of Cases for DEMO,VICTOR L: 1
Average Duration of Care: 38.00 days

Patient F    106030    05/22/08    08/30/08     100 days      DEMO,GEO
Total Number of Cases for DEMO,GEORGE G: 1
Average Duration of Care: 100.00 days

Total Number of Cases: 7
Average Duration of Care: 64.71 days
```

Figure 12-16: Duration of Care report example

At the end of the report, the application provides the total number of cases for the provider and the average duration of care.

12.1.6.5 Patient Seen X Number of Times with No Case Open (SENO)

Use the **SENO** option to produce a report that shows a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. The user, based on the program's standards of care, specifies when a case is to be opened. For example, a case will be opened if a patient has been seen at least three times.

Below are the prompts:

- Enter Beginning Visit Date
  - Specify the beginning date of the date range.
- Enter Ending Visit Date
  - Specify the ending date of the date range.
- Run Report for which PROGRAM

  Use one of the following:
  - **M** (Mental Health)
  - **S (**Social Services)
  - **O** (Other)
  - **C** (Chemical Dependency)
- Include visits to

  Use one of the following:
  - **A** (All providers)

  Or
  - **O** (One provider)

  If you use **O**, other prompts will display.
- Enter number of visits
  - Specify the number of visits with no case opened.
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:

– **P** (print output)

Or

– **B** (browse output on screen)

The application displays the **Patients Seen at least N times with no Case Open Date** report (Figure 12-17).

```
              PATIENTS SEEN AT LEAST 3 TIMES WITH NO CASE OPEN DATE
                VISIT DATE RANGE: Oct 01, 2015 to Jan 01, 2016
                       VISITS TO PROGRAM: MENTAL HEALTH
PATIENT NAME  CHART   SEX   DOB       #     LAST VISIT   LAST    PROVIDER
              NUMBER               VISITS                DX
-------------------------------------------------------------------------
CLIENT SR     116431   F   02/07/75   14    10/10/15     F02.80  PROVIDER B
CLIENT BA     188444   M   10/14/79   22    10/28/15     F19.181 PROVIDER B
CLIENT BK     113419   M   07/18/85    5    10/02/15    T74.31XD PROVIDER B
CLIENT AB     201295   M   05/14/41    4    11/22/15     Z59.5   PROVIDER F
CLIENT CA     171659   F   12/07/94    4    12/09/15     F64.1   PROVIDER B
CLIENT SM     152608   M   02/25/86    4    12/19/15     F54     PROVIDER B
CLIENT YE     194181   M   08/21/98    7    11/19/15     F15.24  PROVIDER Y

Total Number of Patients: 3
```

Figure 12-17: Patients Seen at least N times with no Case Open Date report example

12.1.7 GAF Scores for Multiple Patients (GAFS)

Use the **GAFS** option to produce a report that lists the **GAF scores** for multiple patients, sorted by patient. Only visits with **GAF scores** recorded will display on this list.

Below are the prompts:

- Enter Beginning Date of Visit
  - Specify the beginning date of the date range.
- Enter Ending Date of Visit
  - Specify the ending date of the date range.
- List visits/GAF Scores for which program

  Use one of the following:

  – **O** (one program)

  Or

  – **A** (all programs)

  If you use **O**, other prompts will display.

- Include visits to

Use one of the following:

– **A** (all providers)

Or

– **O** (one provider)

If you use **O**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the **GAF Scores** for **Multiple Patients** report (Figure 12-18).

```
   XX                              Apr 17, 2009                        Page 1

                        GAF SCORES FOR MULTIPLE PATIENTS
                    Visit Dates: Oct 19, 2008 to Apr 17, 2009
                                  Program: ALL
                                 Provider: ALL

PATIENT NAME     HRN    Date     GAF TYPE    Provider  PG Diagnosis/POV
-------------------------------------------------------------------------------

DEMO,MINNIE   145318 09/17/10 99  DEMO,RY M  296.40-BIPOLAR I DISOR

DEMO,JAMES WILL  192636 07/19/10 75          DEMO,D M  300.02-GENERALIZED ANX

DEMO,ROBERT MITC  186585 09/16/10 66  test    DEMO,RY M  293.82-PSYCHOTIC DISOR
+         Enter ?? for more actions                                        >>>
+    NEXT SCREEN               PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 12-18: GAF Scores for Multiple Patients report example

12.1.8 Listing of No-Show Visits in a Date Range (NSDR)

Use the **NSDR option** to print a list of visits with **POVs** related to **No Shows** and **Cancellations** for multiple patients. The user will specify the date range, program, and provider.

Below are the prompts:

- Enter Beginning Date
  - Specify the beginning date of the date range.
- Enter Ending Date
  - Specify the ending date of the date range.
- Run the Report for which PROGRAM

  Use one of the following:
  - **O** (ONE program)

  Or
  - **A** (All programs)

  If you use **O**, other prompts will display.
- Include visits for

  Use one of the following:
  - **A** (All providers)

  Or
  - **O** (One provider).

  If you use **O**, other prompts will display.
- How would you like the report sorted
  - Use **P** (patient name)

  Or
  - **D** (date of visit).
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the **Behavioral Health No Show Appointment Listing** report (Figure 12-19).

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
                          DEMO INDIAN HOSPITAL                    Page 1

              BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
            Appointment Dates:  OCT 19, 2014 and APR 17, 2015

PATIENT NAME        HRN    DATE/TIME          PROVIDER     PG  POV
--------------------------------------------------------------------------------
DEMO,ROBERT JACOB   207365 Jan 05, 2009@12:00 DEMO,JESSIC M  8-FAILED APPOI
DEMO,CHARLES R  112383 Dec 30, 2008       DEMO,BJ   M  8.1-PATIENT CANC
DEMO,BEULAH      140325 Feb 12, 2009@12:00 DEMO,RYAN  S  8-FAILED APPOI
DEMO,RACHEL MAE    201836 Jan 06, 2009@12:00 DEMO,MIC O  8.3-DID NOT WAIT

Total # of Patients: 4     Total # of No Show Visits: 4

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

Figure 12-19: Behavioral Health No Show Appointment Listing report example

At the end of the report, the application shows the total number of patients and the total number of **No Show** visits.

12.1.9 Patient List for Personal Hx Items (PERS)

Use the **PERS** option to produce the **List of Patients with Personal History Items** report.

Below are the prompts:

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

Figure 12-20 shows the **List of Patients with Personal History Items** report.

```
XX                            DEMO INDIAN HOSPITAL
PERSONAL HISTORY LIST BY PATIENT            Jul 13, 2015@09:53:05       Page 1
          PATIENT                          SEX       AGE  CHART NUMBER
--------------------------------------------------------------------------------
```

```
                ALCOHOL USE
          DEMO,SAUNDRA KAY                FEMALE    58   117175
          DEMO,BRENNA KAY                 FEMALE    21   155215
          DEMO,HEATHER LINDA PAIGE        FEMALE    73   142321
          DEMO,STEVEN                     MALE      29   188444
          DEMO,JANE ELLEN                 FEMALE    19
          DEMO,TIMOTHY                    MALE      29
          DEMO,GREGORY SHANE              MALE      42   184929
          DEMO,AMY LYNN                   FEMALE    65   130119

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

Figure 12-20: List of Patients with Personal History Items report example

The application will display a sub-count for each **Personal History Item**.

12.1.10 Placements by Site/Patient (PPL)

Use the **PPL** option to produce a report that shows a list of patients who have had a placement disposition recorded in a specified date range.

Below are the prompts:

- Enter beginning Date
  - Specify the **beginning date** of the date range.
- Enter ending Date
  - Specify the **ending date** of the date range.
- How would you like this report sorted?
  - **P** (alphabetically by patient name)

  Or
  - **S** (alphabetically by site referred to)
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the **Placements** report (Figure 12-21).

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                    Page 1
                            DEMO INDIAN HOSPITAL
                                 PLACEMENTS
              PLACEMENT DATES:  OCT 19, 2014  TO  APR 17, 2015

PATIENT NAME        HRN    DATE       POV   PLACEMENT      FACILITY REFERRED TO
                           PLACED
--------------------------------------------------------------------------------
DEMO,JACOB SCOTT   102668  05/03/09 295.15 E
DEMO,CHELSEA MAR   116431  03/25/09 12     OUTPATIENT
   Placement Made by:  DEMO,RYAN
   Designated SS Prov: DEMO,BETAA
DEMO,RUSTY LYNN    207396  04/06/09 15     OUTPATIENT
   Placement Made by:  DEMO,RYAN
DEMO,ADAM M        109943   04/07/09 311.   OUTPATIENT
   Placement Made by:  DEMO,RYAN
         Enter ?? for more actions                                    >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 12-21: Placements report example

Near the end of the report, the report shows subtotals by **Placement Type**, subtotals by **Facility Referred**, and the **Total Number of Placements**.

12.1.11 Listing of Patients with Selected Problems (PPR)

Use the **PPR** option to produce a report that lists all patients who have been seen for a particular diagnosis/problem in a specified date range. For example, you can enter all suicide problems codes (**39**, **40**, and **41**) and you will get a list of all patients seen for suicide and can then use this report to assist in follow up activities. The report will list the **Designated Provider**, the **Patient Name**, the **date seen** for this problem, and the **date last seen**.

Below are the prompts.

- Which Type

  Use one of the following:

  – **P** (Problem Code and all DSM Codes grouped under it)
  – **D** (Individual Problem or DSM Codes)

Below are prompts for the **P** type:

- Enter Problem Code
  – Enter the problem code. The application lists the problem/diagnosis codes that will be included. The next prompt allows you to enter another problem code.
- Enter Beginning Visit Date
  – Specify the beginning date of the date range.

- Enter Ending Visit Date
  - Specify the ending date of the date range.
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the **Patients Seen with Selected Diagnosis/Problems** report (Figure 12-22).

```
   XX                              Apr 17, 2015                        Page 1

                PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
                  Visit Dates: Oct 19, 2008 to Apr 17, 2009

PATIENT NAME               HRN    DOB      SEX PROV DX DX     DATE SEEN LAST VIS
--------------------------------------------------------------------------------
DEMO,ABIGAIL              103952 02/25/32  F  BJB     41     12/08/08  12/29/08
DEMO,ROBERT JACOB         207365 02/06/55  M  JC      41     12/29/08  01/05/09
DEMO,AMANDA ROSE          186121 01/10/98  F  DG      40     12/01/08  12/30/08
DEMO,ANNEMARIE LEE        105883 02/11/44  F  DG      40     04/06/09  04/06/09
   Designated MH Prov: DEMO,DENISE
   Designated SS Prov: DEMO,RYAN
          Enter ?? for more actions                                        >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 12-22: Patients Seen with Selected Diagnosis/Problems report (P type) example

Below are the prompts for the **D** (**individual problem** or **DSM codes**) type:

- Enter Problem/Diagnosis Code
  - Specify the problem/diagnosis code. The next prompt allows you to enter another problem/diagnosis code.
- Enter beginning Visit Date
  - Specify the beginning date of the date range.
- Enter ending Visit Date
  - Specify the ending date of the date range.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the **Patients Seen with Selected Diagnosis/Problems** report (Figure 12-23).

```
   XX                              Oct 17, 2015                        Page 1

                PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
                  Visit Dates: Oct 19, 2008 to Apr 17, 2009

PATIENT NAME               HRN    DOB      SEX PROV DX DX     DATE SEEN LAST VIS
-------------------------------------------------------------------------------
DEMO,CHELSEA MARIE       116431 02/07/75  F  DG      F33.1    10/06/15  10/16/15
   Designated SS Prov: BDOC11,BJ
DEMO,MISTY DAWN          131668 04/21/46  F  rust    200.20   02/04/09  06/12/09
   Designated SS Prov: DEMO,PSYCHIATRIST



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

Figure 12-23: Patients Seen with Selected Diagnosis/Problems report (D type) example

12.1.12 SBIRT Report (SB)

Use the **SB** option to produce a report that will tally and optionally list all patients who have had a positive screening result for risky or harmful alcohol use in an **Ambulatory Care** setting in the time frame specified by the user. These tallies will also be further defined to show if the patient received a **Brief Negotiated Interview (BNI)**, **Brief Intervention (BI)**, and/or **Referral to Treatment (RT)** within seven days of the positive screen result. Visits from **PCC** and **AMH** will be included.

Below are the prompts:

- Enter Beginning Date
  - Specify the beginning date of the date range.
- Enter Ending Date
  - Specify the ending date of the date range.

- Include which patients in the list

  Use one of the following:

  – **F** (FEMALES only)
  – **M** (MALES only)
  – **B** (Both MALE and FEMALES)
- Would you like to restrict the report by **Patient age range**?

  – Use **Y** (yes)

  Or

  – **N** (no). If you use **Y**, other prompts will display.
- Include patients who were seen by which providers during the report period

  Select one of the following:

  – **O** (One Provider Only)
  – **P** (Any/All Providers)
- Patient Lists

  Select one of the following:

  – **1** (Those with a Positive Alcohol Screening)
  – **2** (Those with at least 1 Positive Alcohol Screening with BNI/BI or RT)
  – **3** (Those with all Positive Alcohol Screenings without BNI/BI or RT)
  – **0** (No Lists)
- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the SBIRT report (Figure 12-24).

```
          SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)
                Screening Dates: Jul 10, 2015 to Jul 10, 2017
------------------------------------------------------------------------------
                                          Number             Percent
                                          ------             -------
```

```
Patients screened for alcohol use             28

Patients screened Positive
  (at least once)                              9                   32.1%

Patients Screened Positive w/
BNI/BI on same day as screen                   5                   55.6%

Patients Screened Positive w/
  BNI/BI 1-3 days after screen                 1                   11.1%

Patients Screened Positive w/
  BNI/BI 4-7 days after screen                 0                    0.0%

Patients Screened Positive referred
  for treatment w/in 7 days                    0                    0.0%

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

Figure 12-24: SBIRT Report example

12.1.13 Screening Reports (SCRN)

Use the **SCRN** option to access the Screening Reports menu (Figure 12-25).

```
                ********************************************
                **       IHS Behavioral Health System       **
                **             Screening Reports            **
                ********************************************
                           Version 4.0 (Patch 11)

                            DEMO INDIAN HOSPITAL


   IPV    IPV/DV Reports ...
   ALC    Alcohol Screening Reports ...
   DEP    Depression Screening Reports ...
   SRA    Suicide Risk Assessment Reports ...
   PHQ    PHQ-2, PHQ-9 and PHQ-T Scores for One Patient
   PHQS   PHQ-2 PHQ-9, PHQ-9T Scores for Multiple Patients
   GAD    GAD-2 and GAD-7 Scores for One Patient
   GADS   GAD-2 AND GAD-7 Scores for Multiple Patients

Select Screening Reports Option:
```

Figure 12-25: Options on the Screening Reports menu example

12.1.13.1 IPV/DV Reports (IPV)

Use the **IPV** option to access the **IPV/DV Report** menu (Figure 12-26).

```
                ********************************************
```

```
                **       IHS Behavioral Health System       **
                **             IPV/DV Reports               **
                ********************************************
                           Version 4.0 (Patch 11)


                            DEMO INDIAN HOSPITAL



   DVP    Tally/List Patients with IPV/DV Screening
   DVS    Tally/List IPV/DV Screenings
   ISSP   List all IPV/DV Screenings for Selected Patients
   IPST   Tally/List Pts in Search Template w/IPV Screening
   IVST   Tally List all IPV Screenings for Template of Pts

Select IPV/DV Reports Option:
```

Figure 12-26: Options on the IPV/DV Reports menu example

12.1.13.1.1 Tally/List Patients with IPV/DV Screening (DVP)

This report will tally and optionally list all patients who have had **IPV** screening (**PCC Exam code 34**) or a refusal documented in a specified time frame. This report will tally the patients by **age**, **gender**, **result**, **provider** (either exam provider, if available or primary provider on the visits), **clinic**, **date of screening**, **designated PCP**, **MH Provider**, **SS Provider**, and **A/SA Provider**.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

Below are prompts for the DVP report:

- Enter Beginning Date for Screening
  - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
  - Enter the ending date of the date range for the screening.
- Which items should be tallied: (0-11)
  - Select which items you want to tally on this report (Figure 12-27):

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care Provider
Which items should be tallied: (0-11)://
```

Figure 12-27: List of options from which to tally the report example

The response must be a list or range, e.g., **1**, **3**, **5**, or **2–4**, **8**.

- Would you like to include IPV/DV Screenings documented in the PCC clinical database?
  - Use **Y** (yes)

  Or
  - **N** (no)
- Would you like to include a list of patients screened?
  - Use **Y** (yes)

  Or
  - **N** (no)

  If you use **Y**, the following prompt will display.
- How would you like the list to be sorted

Figure 12-28 lists the possibilities.

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted: H//
```

Figure 12-28: List of options to sort the list example

The default is **H (Health Record Number)**.

- Display the **Patient's Designated Providers** on the list?
  - Use **Y** (yes)

Or

- **N** (no)

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)

- DEVICE
  - Specify the device to output the report.

Figure 12-29 shows a sample report.

```
   XXX                          May 18, 2016                              Page 1

              ***IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS***
                    Screening Dates: May 18, 2009 to May 18, 2016

Patient Name       HRN    AGE    DATE      RESULT      CLINIC
-------------------------------------------------------------------------------
DEMO,CECILE      103465  42  F 07/09/16   NEGATIVE    TELEBEHAVIORAL HE
      Comment: Exposure to violence as a child
  DXs:   T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER
  Primary Provider on Visit:  DEMO,RYAN
    Provider who screened:    DEMO,RYAN

DEMO,CANDI LYNN  115655  40  F 12/19/15   NEGATIVE    MENTAL HEALTH
   Comment: Patient says she wouldn't tolerate DV since she was a child abuse victim
and spent years in counseling to deal with her issues.
   DXs:  F42. HOARDING DISORDER
   Primary Provider on Visit: DEMO,DENNY
    Provider who screened:    DEMO,CHARLENE

EPSILON, JANICE   116431  18  F 01/15/15   NEGATIVE    MEDICAL SOCIAL SERVI
  Comment: Patient denies any current domestic violence.
  DXs:  F84.0 AUTISM SPECTRUM DISORDER
  Primary Provider on Visit: DEMO,GLORIA
    Provider who screened:   DEMO,GLORIA:
```

Figure 12-29: Output of the IPV Screening Patient Tally and Patient Listing report example

12.1.13.1.2 Tally/List IPV/DV Screenings (DVS)

This report will tally and optionally list all visits on which **IPV** screening (Exam Code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Notes: This report will optionally look at both the **Behavioral Health** and **PCC** clinical databases for evidence of screening/refusal.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the **DVS** report:

- Enter Beginning Date for Screening
  - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
  - Enter the ending date of the date range for the screening.
- Which items should be tallied: (0-11)
  - Select which items (Figure 12-30) you want to tally on this report:

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care Provider
Which items should be tallied? (0-11)://
```

Figure 12-30: List of options from which to tally the report example

The response must be a list or range, e.g., **1**,**3**,**5** or **2–4**,**8**.

- Would you like to include IPV/DV Screenings documented in the PCC clinical database?
  - Use **Y** (yes)

  Or
  - **N** (no)
- Would you like a list of visits w/screenings done?
  - Use **Y** (yes) Or

  N (no).
  - If you use **Y**, the following prompt will display.
- How would you like the list to be sorted?

  Figure 12-31 lists the options.

```
Select one of the following:

          H         Health Record Number
```

```
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted? H//
```

Figure 12-31: List of options to sort the list example

The default is **H (Health Record Number)**.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- DEVICE

  Specify the device to output the report.

Figure 12-32 shows a sample report.

```
                  *** IPV SCREENING VISIT TALLY AND VISIT LISTING ***
                Screening Dates: Oct. 31, 2013 to Dec. 30, 2013
                       This report excludes PCC Clinics

------------------------------------------------------------------------------
                                              #      % of patients
 Total Number of Visits with Screening         2
     Total Number of Patients screened         2

                              By Result

                              NEGATIVE         1       50.0%
                               PRESENT         1       50.0%

              By Provider who screened

                           DEMO,RYAN          1       50.0%
                          DEMO,WENDY          1       50.0%

                               By Date
```

Figure 12-32: Output of the IPV Screening Visit Tally and Visit Listing report example

12.1.13.1.3 List All IPV/DV Screenings for Selected Patients (ISSP)

This report will list all patients you select who have had **IPV** screening or a refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

- Enter the date range during which the screening was done.

  To get all screenings ever put in a long date range like 01/01/1980 to the present date.

- Below are prompts for the ISSP report:
  - Enter Beginning Date for Screening
    Enter the beginning date of the date range for the screening.
  - Enter Ending Date for Screening
    Enter the ending date of the date range for the screening.
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?

  Use one of the following:
  - **Y** (yes)

  Or
  - **N** (no)
- Include which patients in the list

  Use one of the following:
  - **F** (FEMALES only)
  - **M** (MALES only)
  - **B** (Both MALE and FEMALES)
- **Would you like to restrict the report by patient age range?**
  - Use **Y** (yes)

  Or
  - **N** (no)

  If you use **Y**, other prompts will display.
- Which result value do you want included in this list: (**1-7**)

  Figure 12-33 shows the possible options.

```
1)  Normal/Negative
2)  Present
```

```
   3)  Past
   4)  Present and Past
   5)  Refused
   6)  Unable to Screen
   7)  Screenings done with no result entered
   8)  Referral Needed
```

Figure 12-33: List of options to include in the list example

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g., to get only those patients who have had a result of **Present** enter **2** to get all patients who have had a screening result of **Past** or **Present**, enter **2**,**3**).

- Include visits to ALL clinics?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

Report should include visits whose **PRIMARY PROVIDER** on the visit is one of the possible options on Figure 12-34. If you use **O**, other prompts will display.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 12-34: Options for visits to include on the report example

Select which providers who performed the screening should be included.

Figure 12-35 shows the possible options. If you use **O**, other prompts will display.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 12-35: Options for providers to include on the report example

- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?

  Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?

Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?

  Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Select **Report Type**

  Use one of the following:

  – **L** (List of **Patient Screenings**)
  – **S** (Create a **Search Template of Patients**)

  If you use **S**, other prompts will display.

- How would you like the list to be sorted?

  Figure 12-36 shows the possible selections. The default is **H (Health Record Number**).

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 12-36: List of options to sort the list example

- Display the **Patient's Designated Providers** on the list?

  Use **Y** (yes) or **N** (no).

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- DEVICE

  Specify the device to output the report.

The application displays the criteria for the report. After pressing **Enter**, the application displays the report (Figure 13 37).

```
   XXX                          May 18, 2016                              Page 1

              ***IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS***
                    Screening Dates: May 18, 2009 to May 18, 2016

Patient Name       HRN    AGE    DATE      RESULT      CLINIC
-------------------------------------------------------------------------
DEMO,CECILE      103465  42  F 10/09/15   NEGATIVE    TELEBEHAVIORAL HE
      Comment: Exposure to violence as a child
  DXs:   T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER
  Primary Provider on Visit:  DEMO, RYAN
    Provider who screened:    DEMO,RYAN

DEMO,CANDI LYNN  115655  40  F 12/19/15   NEGATIVE    MENTAL HEALTH
   Comment: Patient says she wouldn't tolerate DV since she was a child abuse victim
and spent years in counseling to deal with her issues.
   DXs:  F42. HOARDING DISORDER
   Primary Provider on Visit: DEMO,DENNY
    Provider who screened:    DEMO,CHARLENE

DEMO, JANICE   116431  18  F 01/15/16   NEGATIVE    MEDICAL SOCIAL SERVI
  Comment: Patient denies any current domestic violence.
  DXs:  F84.0 AUTISM SPECTRUM DISORDER
  Primary Provider on Visit: DEMO,GLORIA
    Provider who screened:   DEMO,GLORIA
```

Figure 12-37: IPV Screening Visit Listing for Selected Patients report example

12.1.13.1.4 Tally/List Pts in Search Template w/IPV Screening (IPST)

> **Note:** This **IPV/DV** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of patient's receiving screening, including refusals only patients who are members of a user-defined search template are included in this report.

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **IPV** screening (**Exam Code 34**) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

12.1.13.1.5 Tally List All PIV Screenings for Template of Pts (IVST)

> **Note:** This **IPV/DV** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of all visits w/IPV screening, including only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which **IPV** screening (**Exam Code 34**) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. This report will optionally look at both **Behavioral Health** and **PCC** databases for evidence of screening/refusal.

12.1.13.2 Alcohol Screening Reports (ALC)

Use the **ALC** option to access the **ALC Report** menu (Figure 12-38).

```
                ********************************************
                **       IHS Behavioral Health System       **
                **         Alcohol Screening Reports        **
                ********************************************
                            Version 4.0 (Patch 11)

                             DEMO INDIAN HOSPITAL

   ASP    Tally/List Patients with Alcohol Screening
   ALS    Tally/List Alcohol Screenings
   ASSP   List all IPV/DV Screenings for Selected Patients
   APST   Tally/List Pts in Search Template w/Alcohol Screening
   AVST   Tally List all Alcohol Screenings for Template of Pts

Select Alcohol Screening Reports Option:
```

Figure 12-38: Options on the ALC Reports menu example

12.1.13.2.1 Tally/List Patients with Alcohol Screening (ASP)

This report will tally and optionally list all patients who have had ALCOHOL screening, or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1

- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

Enter the **date range** during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

- Enter Beginning Date for Screening.

  Specify the beginning date of the date range.

- Enter Ending Date for Screening.

  Specify the ending date of the date range.

- Which items should be tallied?

  Specify which items you would like to have displayed in the report. The application provides a list of items. Your response must be a list (like **1**,**3**,**5**) or a range (**2-4**, **8**).

- Would you like to include ALCOHOL Screenings documented in the **PCC** clinical database?

  Use **Y** (Yes) or **N** (No).

- Would you like to include a list of patients screened?

  Use **Y** (Yes) or **N** (No).

- If you answered **Yes** to this question, the next prompt will display:
  - How would you like this report sorted?

  - Use only one of the items in the list provided by the application.
- Display the **Patient's Designated Providers** on the list?
  - Use **Y** (Yes) to display the patient's Designated Providers or **N** (No) to bypass this option.
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the **Tally/List Patients with Alcohol Screenings** report (Figure 12-39).

```
  XX                              Oct 07, 2010                        Page 1

        ***  ALCOHOL SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                Screening Dates: Sep 07, 2010 to Oct 07, 2010
           This report excludes data from the PCC Clinical database

-------------------------------------------------------------------------------
                                            #      % of patients

   Total Number of Patients screened        4
                  By Result
                  NEGATIVE                  1          25.0%
                  POSITIVE                  2          50.0%
                  REFUSED SCREENING         1          25.0%

                  By Gender
                         F                  3          75.0%
                         M                  1          25.0%

                  By Age
                  26 yrs                    1       25.0%
                  27 yrs                    1       25.0%
                  44 yrs                    1       25.0%
                  48 yrs                    1       25.0%
```

Figure 12-39: Tally/List Patients with Alcohol Screenings report example

12.1.13.2.2 Tally/List Alcohol Screening (ALS)

This report will tally and optionally list all visits on which ALCOHOL screening, or a refusal was documented in a specified time frame.

Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the visits by age, gender, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated **PCP**, **MH Provider**, **SS Provider**, and **A/SA Provider**.

Notes: This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

- Enter Beginning Date for Screening
  - Specify the beginning date of the date range.
- Enter Ending Date for Screening
  - Specify the ending date of the date range.

Note: This date range indicates when the screening was done.

- Which items to be tallied?

Specify which items you would like to have displayed in the report. The application provides a list. Your response must be a list (like **1**,**3**,**5**) or a range (**2-4**, **8**).

- Would you like to include ALCOHOL Screenings documented in the **PCC** clinical database?

  Use **Y** (Yes) or **N** (No).

- Would you like to include a list of visits w/screenings done?

  Use **Y** (Yes) or **N** (No).

- How would you like this report sorted?

  The report can be sorted by only one of the items in the list.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the **Tally/List Alcohol Screenings** report (Figure 12-40).

```
         ***  ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING  ***
                Screening Dates: Sep 10, 2010 to Dec 09, 2010
                       This report excludes PCC Clinics

------------------------------------------------------------------------
                                        #      % of patients
Total Number of Visits with Screening    4
      Total Number of Patients screen    4
           By Result
                  NEGATIVE               1     25.0%
                  POSITIVE               2     50.0%
                  REFUSED SCREENING      1     25.0%
           By Gender
                  FEMALE                 3     75.0%
                  MALE                   1     25.0%
           By Age
                  26 yrs                1      25.0%
                  27 yrs                1      25.0%
                  44 yrs                1      25.0%
                  48 yrs                1      25.0%
```

```
         By Provider who screened
            DEMO, GEORGE C            1      25.0%
            DEMO, FRANK S              1      25.0%
            DEMO, MATT                 1      25.0%
            DEMO, STEVE N            1      25.0%
        By Primary Provider of Visit
            DEMO, GEORGE C            1      25.0%
            DEMO,FRANK S               1      25.0%
            DEMO, MATT                 1      25.0%
            DEMO, STEVE N            1      25.0%
      By Designated Primary Care Provider
            UNKNOWN                     3      75.0%
            DEMO,HELEN K             1      25.0%
      By Clinic
            ALCOHOL AND SUBSTANCE        1     25.0%
            MEDICAL SOCIAL SERVICES      1     25.0%
            MENTAL HEALTH                2     50.0%
      By Date
             Jul 25, 2006                1     25.0%
             Aug 09, 2006                1     25.0%
             Aug 17, 2006                1     25.0%
             Aug 23, 2006                1     25.0%
      By Designated Mental Health Provider
             UNKNOWN                     4     100.0%
      By Designated Social Services Provider
             UNKNOWN                     4     100.0%
      By Designated A/SA Provider
             UNKNOWN                     4     100.0%
PATIENT NAME   HRN      AGE     SCREENED RESULT      CLINIC
------------------------------------------------------------------------------
Patient H      114551   26 F   08/17/09 POSITIVE
   DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER
Primary Provider on Visit:  Provider B
       Provider who screened:  Provider B

Patient J   116475    27 F       08/23/09 REFUSED SCREENIN
   DXs: F84.0    AUTISM SPECTRUM DISORDER
   Primary Provider on Visit:  Provider A
        Provider who screened: Provider A
```

Figure 12-40: Tally/List Alcohol Screenings report example

12.1.13.2.3 List All Alcohol Screenings for Selected Patients (ASSP)

This report will tally and optionally list all patients who have had an alcohol screening, or a refusal documented in a specified time frame. **Alcohol Screening** is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR

- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

Below are the prompts:

- Enter Beginning Date for Screening

  Specify the beginning date of the date range.

- Enter Ending Date for Screening

  Specify the ending date of the date range.

- Would you like to include screenings documented in non-behavioral health clinics (those documented in **PCC**)?

  Use **Y** (Yes) or **N** (No).

- Include which patients in the list?
  - **F** (Females Only)
  - **M** (Males Only)
  - **B** (Both Male and Females)
- Would you like to restrict the report by **Patient age range**?

  Type **Y** (Yes) or **N** (no). If you want to include visits from ALL age ranges, answer **No**. If you want to list visits for only patients with a particular age range, enter **Yes**. If you use **Yes**, other prompts will display.

- Which result values do you want included on this list?

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (for example, to get only those patients who have had a result of **Positiv**e, enter **2**; to get all patients who have had a screening result of **Positive** or **Refused,** enter **2**,**3**).

- You can choose from the following:
  - **1** Normal/Negative
  - **2** Positive
  - **3** Refused
  - **4** Unable to Screen
  - **5** Screenings done with no result entered
  - **6** Referral Needed
- Include visits to ALL clinics?

  Use **Y** (Yes) or **N** (No). If **No** is used, additional prompts will display.

- Report should include visits whose PRIMARY PROVIDER on the visit is:
  - **O** (One Provider Only)
  - **P** (Any/All Providers including Unknown)
  - **U** (Unknown Provider Only)

  If you use **O**, other prompts will display.

- Select which providers who performed the screening should be included:
  - **O** (One Provider Only),
  - **P** (Any/All Providers including Unknown), or
  - **U** (Unknown Provider Only).

  If you use **O**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?

  Use **Y** (Yes) or **N** (No). If **Yes** is used, additional prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?

  Use **Y** (Yes) or **N** (No). If **Yes** is used, additional prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?

Use **Y** (Yes) or **N** (No). If **Yes** is used, additional prompts will display.

- Select a **Report Type**.
  - **L** (List of Patient Screenings)
  - **S** (Create a Search Template of Patients)
- How would you like this report sorted?

  The report can be sorted by only one of the items in the list.
- Display the **Patient's Designated Providers** on the list?

  Use **Y** (Yes) or **N** (no).
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

  The application displays the criteria you selected for the report.

Then, the application displays the **Tally/List Alcohol Screenings** report (Figure 12-41).

```
   XX                              Oct 07, 2010                        Page 1

        ***  ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
                Screening Dates: Jul 09, 2010 to Oct 07, 2010

                                    DATE
PATIENT NAME            HRN    AGE   SCREENED            CLINIC
-------------------------------------------------------------------------------

SIGMAAAAA,BRITTANY LYN  129079 41  F 08/03/10            BEHAVIORAL HEALTH
   Type/Result: ALCOHOL SCREENING  NEGATIVE
   Primary Provider on Visit:  BETA,BETAA
       Provider who screened:  BETA,BETAA

SIGSIG,ALICIA MARIE     169379 58  F 09/08/10            ALCOHOL AND SUBSTANC
   Type/Result: AUDT  21
   Primary Provider on Visit:  BETA,BETAA
       Provider who screened:  UNKNOWN
```

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

Figure 12-41: Alcohol Screenings Visit Listing for Selected Patients report example

12.1.13.2.4 Tally/List Pts in Search Template with Alcohol Screenings (APST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Alcohol Screening** or a refusal documented in a specified time frame. **Alcohol Screening** is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit) clinic, date of screen, designed PCP, MH Provider, SS Provider, and A/SA/ Provider.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.
- This is a tally of **Patients**, not visits or screenings.

12.1.13.2.5 Tally/List All Alcohol Screenings for Template of Pts (AVST)

This **ALCOHOL** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

> **Note:** Tally and listing of all visits w/alcohol screening only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which **Alcohol Screening** or a refusal was documented in a specified time frame specified. **Alcohol Screening** is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)

- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the visits by age, gender, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A.SA Provider.

- This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

12.1.13.3 Depression Screening Reports (DEP)

Use the **DEP** option to access the **Depression Screening Reports** menu (Figure 12-42).

```
                ******************************************
                **       IHS Behavioral Health System       **
                **       Depression Screening Reports       **
                ******************************************
                           Version 4.0 (Patch 11)

                            DEMO INDIAN HOSPITAL


   DSP    Tally/List Patients with Depression Screening
   DLS    Tally/List Depression Screenings
   DSSP   List all Depression Screenings / Selected Patients
   DPST   Tally/List Pts in Search Temp w/Depression Scrn
   DVST   Tally List all Depression Scrn for Template of Pts

Select Depression Screening Reports Option:
```

Figure 12-42: Options on the Depression Screening Reports menu example

12.1.13.3.1 Tally/List Patient with Depression Screening (DSP)

This report will tally and optionally list all patients who have had **Depression Screening** or a refusal documented in the specified time frame. **Depression Screening** is defined as any of the following documented:

- Depression Screening Exam (Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1

- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusals.

This is a tally of patients, not visits or screening.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

- Enter Beginning Date for Screening

  Specify the beginning date of the date range.

- Enter Ending Date for Screening

  Specify the ending date of the date range.

- Which items should be tallied: (**0-11**)

  Select which items you want to tally on this report (Figure 12-43):

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
Which items should be tallied: (0-11)://
```

Figure 12-43: List of options from which to tally the report example

- Would you like to include **Depression Screenings** documents in the PCC clinic database?

  Use **Y** (yes) or **N** (no).

- Would you like to include a list of patients screened?

Use **Y** (yes) or **N** (no). If you use **Y**, the following will display (Figure 12-44).

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted: H//
```

Figure 12-44: List of options to sort the list example

- Display the **Patient's Designated Providers** on the list?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)
- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- **DEVICE**

  Specify the device to output the report.

Below is a sample report (Figure 12-45).

```
                                    #      % of patients
                          By Age

                           4 yrs         1       0.5%
                           5 yrs         1       0.5%
                           6 yrs         3       1.4%
                           7 yrs         2       0.9%
                           8 yrs         4       1.9%
                           9 yrs         1       0.5%
                          10 yrs         2       0.9%
                          11 yrs         6       2.8%
                          12 yrs         3       1.4%
                          13 yrs         1       0.5%
```

```
   XX                              Feb 15, 2011                        Page 1

        ***  DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                Screening Dates: Nov 17, 2010 to Feb 15, 2011
            This report excludes data from the PCC Clinical database

                                    DATE
PATIENT NAME          HRN    AGE    SCREENED            CLINIC
-------------------------------------------------------------------------------
                                             #      % of patients
                              89 yrs         1         0.5%
                              92 yrs         1         0.5%

              By Provider who screened

                                  DEMO,BJ       53       24.9%
                                  DEMO,LORI      5       2.3%
                                  DEMO,JESSICA   7       3.3%
                                  DEMO,DOCTOR    1       0.5%
                                  DEMO,RYAN     53       24.9%
                                  DEMO,DENISE   16       7.5%
                                  DEMO,HOWARD    1       0.5%
                                  DEMO,STEVE C   1       0.5%

BETA,MISTY DAWN   106371 28  F 01/12/11            TELEBEHAVIORAL HEALT
   Type/Result: DEPRESSION SCREENING  POSITIVE
   Comment: TESTING EHR
   Primary Provider on Visit:  DEMO,RYAN
       Provider who screened:  DEMO,RYAN

DEMO,WILLA BELLE     110838 44  F 01/12/11            MENTAL HEALTH
   Type/Result: DEPRESSION SCREENING  NEGATIVE
   Primary Provider on Visit:  DEMO,WENDY
       Provider who screened:  DEMO,WENDY


DEMO,JIMMY JOE       129347 24  M 01/31/11            MENTAL HEALTH
   Type/Result: PHQ2  6
   Primary Provider on Visit:  DEMO,RYAN
       Provider who screened:  DEMO,RYAN
Enter RETURN to continue or '^' to exit:
```

Figure 12-45: Tally/List Patients with Depression Screening report example

12.1.13.3.2 Tally/List Depression Screenings (DLS

This report will tally and optionally list all visits on which **Depression Screening** or a **refusal** was documented in a specified time frame. **Depression Screening** is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR

- Refusal of Exam Code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

> **Notes:** This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.
>
> This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

- Enter Beginning Date for Screening
  - Specify the beginning date of the date range.
- Enter Ending Date for Screening
  - Specify the ending date of the date range.
- Which items should be tallied: (**0-11**)
  - Select which items you want to tally on this report (Figure 12-46):

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
Which items should be tallied: (0-11)://
```

Figure 12-46: List of options from which to tally the report example

- Would you like to include **Depression Screenings** documents in the **PCC** clinic database?

  Use one of the following:

  - **Y** (yes)

  Or

  - **N** (no)
- Would you like to include a list of visits w/screening done?

Use one of the following:

– **Y** (yes)

Or

– **N** (no)

If you use **Y**, the following prompt will display.

- How would you like the list to be sorted?

  The following options will display (Figure 12-47).

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 12-47: List of options to sort the list example

The default is **H (Health Record Number)**.

- Display the **Patient's Designated Providers** on the list?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- **DEVICE**

  Specify the device to output the report.

Figure 12-48 shows a sample report.

```
XX                              Dec 26, 2013                          Page 1

       ***  DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING  ***
```

```
                Screening Dates: Jan 01, 1980 to Dec 26, 2013
                       This report excludes PCC Clinics

------------------------------------------------------------------------------
                                                #      % of patients
 Total Number of Visits with Screening        450
     Total Number of Patients screened        229

                               By Result

                                 14.1           35        7.8%
        DEPRESSION SCREENING  NEGATIVE         115        25.6%
DEPRESSION SCREENING  PATIENT REFUSED SCREENING        143.1%
        DEPRESSION SCREENING  POSITIVE         129        28.7%
DEPRESSION SCREENING  UNABLE TO SCREEN          15        3.3%
                       REFERRAL NEEDED          15        3.3%
                                 PHQ2            1        0.2%
                               PHQ2  0           2        0.4%
                               PHQ2  1           5        1.1%
                               PHQ2  2           8        1.8%
                               PHQ2  3          16        3.6%
                               PHQ2  4          11        2.4%
                               PHQ2  5          13        2.9%
                               PHQ2  6           2        0.4%
                               PHQ2  7           1        0.2%
                  PHQ2  COMPLETE BREECH          1        0.2%
                               PHQ9  1           1        0.2%
                              PHQ9  10           3        0.7%
                             PHQ9  10.5          1        0.2%
                              PHQ9  12           2        0.4%
                              PHQ9  13           3        0.7%
                              PHQ9  14           2        0.4%
                              PHQ9  15           5        1.1%
                              PHQ9  16           2        0.4%
                              PHQ9  17           7        1.6%
                              PHQ9  18           2        0.4%
                              PHQ9  19           3        0.7%
                              PHQ9  20           8        1.8%
                              PHQ9  21           7        1.6%
                              PHQ9  22           4        0.9%
                              PHQ9  24           1        0.2%
                              PHQ9  25           3        0.7%
                              PHQ9  27           2        0.4%
                               PHQ9  3           1        0.2%
                               PHQ9  5           5        1.1%
                              PHQ9  5.5          1        0.2%
                               PHQ9  6           2        0.4%
                               PHQ9  7           5        1.1%
                               PHQ9  8           5        1.1%
                               PHQ9  9           4        0.9%
                              PHQT  12           2        0.4%
                              PHQT  13           3        0.7%
                              PHQT  14           2        0.4%
                              PHQT  15           5        1.1%
                              PHQT  16           2        0.4%
                              PHQT  17           7        1.6%
                              PHQT  18           2        0.4%
```

```
                              PHQT  19          3       0.7%
                              PHQT  20          8       1.8%
                              PHQT  21          7       1.6%
                              PHQT  22          4       0.9%
                              PHQT  24          1       0.2%
                              PHQT  25          3       0.7%
                              PHQT  27          2       0.4%
                               V79.0            2       0.4%

                                    DATE
PATIENT NAME          HRN    AGE   SCREENED            CLINIC
-------------------------------------------------------------------------------

DEMO,KASSANDRA DA  101349 30  F 04/06/10           MEDICAL SOCIAL SERVI
   Type/Result: PHQ9  17
   DXs: 88       OTHER SOCIOLEGAL PROBLEMS
   Primary Provider on Visit:  DEMO,DOCTOR
       Provider who screened:  UNKNOWN

DURANT,COURTNEY NICO  101351 34  F 04/05/10           MENTAL HEALTH
   Type/Result: PHQ2  2
   DXs: 43.1     PARTNER ABUSE (SUSPECTED),PHYSICAL
        27       ALCOHOL DEPENDENCE
        304.22   COCAINE DEPENDENCE, EPISODIC
   Primary Provider on Visit:  DEMO,DOCTOR
       Provider who screened:  UNKNOW
Enter RETURN to continue or '^' to exit:
```

Figure 12-48: Depression Screening Visit Tally and Visit Listing report example

12.1.13.3.3 List All Depression Screenings/Selected Patients (DSSP)

This report will tally and optionally list all patients who have had **Depression Screening** or a **refusal** documented in the time frame specified by the user. **Depression Screening** is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of Exam Code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

This is a tally of Patients, not visits or screenings.

You will be able to choose the patients by age, gender, clinic, primary provider, or result of the screening.

Below are the prompts:

- Enter **Beginning Date for Screening**
  - Specify the beginning date of the date range.
- Enter **Ending Date for Screening**
  - Specify the ending date of the date range.
- Would you like to include screenings documented in non-behavioral health clinics (those documented in **PCC**)?

  Use one of the following:

  - **Y** (yes)

  Or

  - **N** (no)
- Include which patients in the list.

  Use one of the following:

  - **F** (FEMALES only)
  - **M** (MALES Only)
  - **B** (Both MALE and FEMALES)
- Would you like to restrict the report by **Patient age range**?

  Use one of the following:

  - **Y** (yes)

  Or

  - **N** (no)

  If you use **Y**, other prompts will display.

- Which result values do you want included on this list?

Figure 12-49 shows the list from which to select.

```
   1)  Normal/Negative
   2)  Positive
   3)  Refused
   4)  Unable to Screen
   5)  Screenings done with no result entered
   6)  Referral Needed
```

Figure 12-49: List of options from which to select example

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (for example, to get only those patients who have had a result of **Positive**, enter **2** to get all patients who have had a screening result of **Positive** or **Refused**, enter **2,3**).

- Include visits to **ALL** clinics.

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)
- Report should include visits whose **PRIMARY PROVIDES** on the visit is.

Figure 12-50 shows the options. If you use **O**, other prompts will display.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 12-50: Options for visits to include on the report example

- Select which providers who performed the screening should be included.

Figure 12-51 shows the options. If you use **O**, other prompts will display.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 12-51: Options for providers to include on the report example

- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?

Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?

  Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?

  Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Select **Report Type**.

  Use one of the following:

  – **L** (List of Patient Screenings)

  Or

  – **S** (Create a Search Template of Patients)
  If you use **S**, other prompts will display.

- How would you like the list to be sorted?

Figure 12-52 shows the options.

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 12-52: List of options to sort the list example

- The default is **H** (Health Record Number).
- Display the **Patient's Designated Providers** on the list?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)
- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

- **DEVICE**

  Specify the device to output the report.

The application displays the criteria for the report. After pressing **Enter**, the application displays the report (Figure 12-53).

```
   XX                              Feb 15, 2011                        Page 1

       ***  DEPRESSION SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
                 Screening Dates: Nov 17, 2010 to Feb 15, 2011

                                    DATE
PATIENT NAME          HRN    AGE   SCREENED            CLINIC
--------------------------------------------------------------------------------

BETA,MISTY DAWN       106371 28  F 01/07/11           BEHAVIORAL HEALTH
   Type/Result: DEPRESSION SCREENING  POSITIVE
   Comment: testing ehr
   Primary Provider on Visit:  DEMO,RYAN
       Provider who screened:  DEMO,RYAN

DEMO,WILLA BELLE       110838 44  F 01/12/11            MENTAL HEALTH
   Type/Result: DEPRESSION SCREENING  POSITIVE
   Primary Provider on Visit:  DEMO,WENDY
       Provider who screened:  DEMO,WENDY

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

Figure 12-53: Depression Screening Visit Listing for Selected Patients report example

12.1.13.3.4 Tally/List Pts in Search Temp with Depression Screening (DPST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Depression Screening** or a refusal documented in the time frame specified by the user. **Depression Screening** is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of Exam Code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

12.1.13.3.5 Tally/List All Depression Screenings for Templates of Pts (DVST)

This report will tally and optionally list all visits on which **Depression Screening** or a refusal was documented in the time frame specified by the user. **Depression Screening** is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: This report will, optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of visits with a screening done; if a patient had multiple screenings during the time period, all will be counted.

12.1.13.4 Suicide Risk Assessment Reports (SRA)

Use the **SRA** option to access the **Suicide Risk Assessment Report** menu (Figure 12-54).

```
          ******************************************
          **       IHS Behavioral Health System       **
          **             IPV/DV Reports               **
          ******************************************
```

```
                          Version 4.0 (Patch 11)

                           DEMO INDIAN HOSPITAL


   SRP    Tally/List Patients with Suicide Risk Assessment
   SRS    Tally/List Suicide Risk Assessments
   SRSP   List all Suicide Risk Assess for Selected Patients
   SRST   Tally/List Pts in Srch Temp w/ Suic Risk Assess
   STST   Tally/List all Suic Risk Assess for Template pts

Select Suicide Risk Assessment Reports Option:
```

Figure 12-54: Options on the IPV/DV Reports menu example

12.1.13.4.1 Tally/List Patients with Suicide Risk Assessment (SRP)

This report will tally and optionally list all patients who have had a **Suicide Risk Assessment (PCC Exam code 43)** or a **Refusal** documented in a specified time frame. This report will tally the patients by age, gender, result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

Below are prompts for the **SRP** report:

- Enter Beginning Date for Screening.
  - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening.
  - Enter the ending date of the date range for the screening.
- Which items should be tallied: (**0-11**)

  Select which items you want to tally on this report (Figure 12-55):

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
Which items should be tallied: (0-11)://
```

Figure 12-55: List of options from which to tally the report example

The response must be a list or range, for example, **1**,**3**,**5** or **2-4**,**8**.

- Would you like to include **Suicide Risk Assessments** documented in the **PCC** clinical database?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)
- Would you like to include a list of patients screened?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

  If you use **Y**, the following prompt will display.

- How would you like the list to be sorted?

  Figure 12-56 lists the possibilities.

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted: H//
```

Figure 12-56: List of options to sort the list example

The default is **H (Health Record Number)**.

- Display the **Patient's Designated Providers** on the list?

  Use **Y** (yes) or **N** (no).

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)

- **O** (include only demo patients)

- Do you want to use:
  - **P** (print output)

  Or

  - **B** (browse output on screen)

  Figure 12-57 shows a sample report.

```
       ***  SUICIDE RISK ASSESSMENT PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Jun 29, 2015 to Jun 29, 2017
              This report includes data from the PCC Clinical database

                                    DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
--------------------------------------------------------------------------------

DEMO,ANNSENETTE     107104 56  F 04/08/16 LOW              MEDICAL SOCIAL SE
   DXs: F10.10   ALCOHOL USE DISORDER, MILD
   Primary Provider on Visit:  DEMO,RYAN
       Provider who screened:  DEMO,RYAN


DEMO,SHAYNE LYNN     113441 46  F 02/08/16 REFERRAL NEEDED  MENTAL HEALTH (PS
   DXs: F43.10   TESTING
   Primary Provider on Visit:  DEMO,LORI
       Provider who screened:  DEMO,LORI
```

Figure 12-57: Output of the Suicide Risk Assessment Patient Tally and Patient Listing report example

12.1.13.4.2 Tally/List Suicide Risk Assessments (SRS)

This report will tally and optionally list all visits on which a **Suicide Risk Assessment (Exam Code 43)** or a **Refusal** was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

> **Note:** This report will optionally look at both the **Behavioral Health** and **PCC** clinical databases for evidence of screening/refusal.
>
> Enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the **SRS** report:

- Enter Beginning Date for Screening
  - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening

– Enter the ending date of the date range for the screening.

- Which items should be tallied: (**0-11**)

  Select which items (Figure 12-58) you want to tally on this report:

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
Which items should be tallied? (0-11)://
```

Figure 12-58: List of options from which to tally the report example

The response must be a list or range, for example, **1**,**3**,**5** or **2–4**,**8**.

- Would you like to include **IPV/DV Screenings** documented in the **PCC** clinical database?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

- Would you like a list of visits w/screenings done?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

  If you use **Y**, the following prompt will display.

- How would you like the list to be sorted?

  Figure 12-59 lists the options.

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

```
How would you like the list to be sorted? H//
```

Figure 12-59: List of options to sort the list example

The default is **H (Health Record Number)**.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

Figure 12-60 shows a sample report.

```
         ***  SUICIDE RISK ASSESSMENT VISIT TALLY AND VISIT LISTING  ***
                 Screening Dates: Jun 29, 2016 to Jun 29, 2017
                        This report includes PCC Clinics

------------------------------------------------------------------------------
                                                #      % of patients
 Total Number of Visits with Screening          11
     Total Number of Patients screened           9


   RG                              Jun 29, 2017                       Page 1

         ***  SUICIDE RISK ASSESSMENT VISIT TALLY AND VISIT LISTING  ***
                 Screening Dates: Jun 29, 2016 to Jun 29, 2017
                        This report includes PCC Clinics


                                    DATE
PATIENT NAME           HRN    AGE   SCREENED RESULT           CLINIC
------------------------------------------------------------------------------
DEMO,CARL JR         118338 23  M 11/16/16 MODERATE
   DXs: F33.2    MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, SEVERE
        F10.20   ALCOHOL DEPENDENCE, UNCOMPLICATED due to diabetes
   Primary Provider on Visit:  DEMO,RYAN
        Provider who screened: DEMO,RYAN
DEMO,CARL JR         118338 23  M 11/20/16 MODERATE
   DXs: F33.3    MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE WITH PSYCHOTIC
        F10.20   ALCOHOL DEPENDENCE, UNCOMPLICATED due to NEUROCOGNITIVE DAMA
   Primary Provider on Visit:  DEMO,RYAN
        Provider who screened: DEMO,RYAN
DEMO,CARL JR         118338 23  M 12/14/16 LOW
   DXs: F33.3    MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE WITH PSYCHOTIC
```

Figure 12-60: Output of the Suicide Risk Assessment Screening Visit Tally and Visit Listing report example

12.1.13.4.3 List All Suicide Risk Assess for Selected Patients (SRSP)

This report will list all patients you select who have had a **Suicide Risk Assessment** or a Refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Below are prompts for the **ISSP** report:

- Enter Beginning Date for Screening
  - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
  - Enter the ending date of the date range for the screening.
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?

  Use one of the following:

  - **Y** (yes)

  Or

  - **N** (no)
- Include which patients in the list.

  Use one of the following:

  - **F** (FEMALES only)
  - **M** (MALES only)
  - **B** (Both MALE and FEMALES)
- Would you like to restrict the report by Patient age range?

  - **Y** (yes)

  Or

  - **N** (no)

  If you use **Y**, other prompts will display.

- Which result value do you want included in this list: (1-7)

  Figure 12-61 shows the possible options.

```
1)  Low
```

```
   2)  Moderate
   3)  High
   4)  Refused
   5)  Unable to Screen
   6)  Referral Needed
   7)  Screenings done with no result entered
```

Figure 12-61: List of options used to include in the list example

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (for example, to get only those patients who have had a result of **Present**, enter **2** to get all patients who have had a screening result of **Past** or **Present**, enter **2,3**).

- Include visits to ALL clinics?
  - **Y** (yes)

  Or
  - **N** (no)
- Report should include visits whose PRIMARY PROVIDER on the visit is.

Figure 12-62 shows the possible options. If you use **O**, other prompts will display.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 12-62: Options for visits to include on the report example

Select which providers who performed the screening should be included.

Figure 12-63 shows the possible options. If you use **O**, other prompts will display.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 12-63: Options for providers to include on the report example

- Would you like to limit the list to just patients who have a particular designated **Mental Health provide**r?

  Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services provider**?

Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD provider**?

  Use **Y** (yes) or **N** (no). If you use **Y**, other prompts will display.

- Select **Report Type**.

  Use one of the following:

  – **L** (List of Patient Screenings)

  Or

  – **S** (Create a Search Template of Patients)

  If you use **S**, other prompts will display.

- How would you like the list to be sorted?

Figure 12-64 shows the possible selections. The default is **H (Health Record Number)**.

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 12-64: List of options to sort the list example

- Display the **Patient's Designated Providers** on the list?

  Use **Y** (yes) or **N** (no).

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- **DEVICE**
- Specify the device to output the report.

The application displays the criteria for the report. After pressing **Enter**, the application displays the report (Figure 12-65).

```
      ***  SUICIDE RISK ASSESSMENT VISIT LISTING FOR SELECTED PATIENTS  ***
                  Screening Dates: Jun 30, 2015 to Jun 30, 2017

                                    DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
--------------------------------------------------------------------------------

DEMO,CECILE         103465  42  F  04/08/16 LOW              MEDICAL SOCIAL SE
   DXs: F10.10   ALCOHOL USE DISORDER, MILD
   Primary Provider on Visit:  DEMO,RYAN
        Provider who screened: DEMO,RYAN

DEMO,CANDI LYNN     115655  55  F 10/02/15 LOW              GENERAL
   DXs: F10.10   Alcohol abuse | TESTING
   Primary Provider on Visit:  DEMO,RYAN
        Provider who screened: DEMO,RYAN
```

Figure 12-65: Suicide Risk Assessment Visit Listing for Selected Patients report example

12.1.13.4.4 Tally/List Pts in Search Temp with Suicide Risk Assess (SRST)

> **Note:** This **Suicide Risk Assessment** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of patients receiving suicide risk assessment, including refusals, only patients who are members of a user-defined search template are included in this report.

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Suicide Risk Assessment (Exam code 34)** or a **Refusal** documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will, optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

12.1.13.4.5 Tally/List All Suicide Risk Assess for Template Pts (STST)

> **Note:** This **Suicide Risk Assessment** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of all visits w/suicide risk assessment, only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which a **Suicide Risk Assessment (Exam code 43)** or a **Refusal** was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. This report will optionally look at both **Behavioral Health** and **PCC** databases for evidence of screening/refusal.

12.1.13.5 PHQ-2 and PHQ-9 Scores for One Patient (PHQ)

Use the **PHQ** option to produce a report that lists **PHQ2**, **PHQ9**, and **PHQT Scores** for one patient within a specified date range.

Below are the prompts:

- Select PATIENT NAME
  - Specify the name of the patient whose scores are to be displayed.
- Browse which subset of visits for <name of patient>.

  Use one of the following:
  - **N** (Patient's Last N Visits)
  - **D** (Visits in a Date Range)
  - **A** (All of this patient's Visits)

  If you use **N** or **D**, other prompts will display.
- Limit by **Clinic/Provider**.

  Use one of the following:
  - **C** (Visits to Selected Clinics)
  - **P** (Visits to Selected Providers)
  - **A** (Include All Visits regardless of Clinic/Provider)

The application displays the **PHQ-2/PHQ-9/PHQT Scores for One Patient** report (Figure 12-66).

```
              PHQ-2, PHQ-9 and PHQ-9T SCORES FOR MULTIPLE PATIENTS
                   Visit Dates: Mar 09, 2015 to Mar 09, 2016
                              Clinic: ALL Clinics
                            Providers: ALL Providers

PATIENT NAME     HRN    Date     PHQ2 PHQ9 PHQT Provider  CLINIC Diagnosis/POV
-------------------------------------------------------------------------------

DEMO,JOSEPH     147423 03/03/16          23   DEMO,RY BEHAV  F43.11-POST-T
```

```
DEMO,AMBER DA  118957 03/05/16           5    DEMO,WE BEHAV  R45.851-Suicid


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

Figure 12-66: PHQ-2 and PHQ-9 Scores for One Patient report example

12.1.13.6 PHQ-2 and PHQ-9 (PHQS) Scores for Multiple Patients

Use the **PHQS** option to produce a report that lists **PHQ-2** and **PHQ-9 Scores** for multiple patients, sorted by patient. Only visits with **PHQ-2/PHQ-9** scores recorded will display on this list.

Below are the prompts:

- Enter Beginning Date of Visit.
  - Specify the beginning date of the date range.
- Enter Ending Date of Visit.
  - Specify the ending date of the date range.
- Clinic Selection.

  Use one of the following:

  - **C** (Visits at Selected Clinic)

  Or

  - **A** (Visit to All Clinics)

  If you use **C**, other prompts will display.

- **Provider Selection**.

  Use one of the following:

  - **A** (Visits to All Providers)

  Or

  - **C** (Visits to Selected Providers)

  If you use **C**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:

– **P** (print output)

Or

– **B** (browse output on screen)

The application displays the PHQ-2 and PHQ-9 Scores for Multiple Patients report (Figure 12-67).

```
   XX                              Jul 13, 2016                        Page 1

                  PHQ-2 and PHQ-9 SCORES FOR MULTIPLE PATIENTS
                   Visit Dates: Jan 04, 2009 to Jul 13, 2009
                              Clinic: ALL Clinics
                            Providers: ALL Providers

PATIENT NAME     HRN    Date     PHQ-2 PHQ-9 Provider    CLINIC Diagnosis/POV
-------------------------------------------------------------------------------

DEMO,JACOB SCO 102668 02/07/16         3    DEMO,RYA  MENTA

DEMO,CHELSEA   116431 05/19/16   3     3    DEMO,DE  MENTA  F32.0-MAJOR DEPRESS
DEMO,CHELSEA   116431 03/17/16   4          DEMO,BETAA  MEDIC  F32.3-MAJOR DEPRESS
DEMO,CHELSEA   116431 03/10/16        19    DEMO,DE  MENTA  F42.-HOARDING DISOR


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

Figure 12-67: PHQ-2 and PHQ-9 Scores for Multiple Patients report example

12.1.13.7 GAD-2 and GAD-7 Scores for One Patient (GAD)

Use the **GAD** option to produce a report that lists **GAD2**, and **GAD7 Scores** for one patient within a specified date range.

Below are the prompts:

- Select PATIENT NAME.
  - Specify the name of the patient whose scores are to be displayed.
- Browse which subset of visits for <name of patient>.

  Use one of the following:
  - **N** (Patient's Last N Visits)
  - **D** (Visits in a Date Range)
  - **A** (All of this patient's Visits)

  If you use **N** or **D**, other prompts will display.
- Limit by Clinic/Provider.

  Use one of the following:
  - **C** (Visits to Selected Clinics)

- **P** (Visits to Selected Providers)
- **A** (Include All Visits regardless of Clinic/Provider)

The application displays the **GAD-2/GAD-7 Scores** for **One Patient** report (Figure 12-68).

```
GAD2/GAD7                    Jul 05, 2017 11:00:33          Page:    1 of    1
Patient Name: TEST,DONNA                   DOB: Feb 17, 1954
HRN: 13976
********************************************************************************
Date      GAD2 GAD7      PROVIDER       CLINIC        Diagnosis/POV
--------------------------------------------------------------------------------
04/24/17  2    20        DEMO,DONNA   GENERAL       R51. - headache
11/18/16  2 2  20        DEMO,DONNA   GENERAL       Z00.00 - routine exam
06/01/16  2                           GENERAL
03/10/16                 DEMO,DONNA   GENERAL       R05. - TEST
03/07/16  2 4  15 2      DEMO,DONNA   GENERAL       J45.991 - COUGH ASTHMA REL


          Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
```

Figure 12-68: GAD-2 and GAD-7 Scores for One Patient report example

12.1.13.8 GAD-2 and GAD-7 Scores for Multiple Patients (GADS)

Use the **GADS** option to produce a report that lists **GAD-2** and **GAD-7 Scores** for multiple patients, sorted by patient. Only visits with **GAD-2/GAD-7 scores** recorded will display on this list.

Below are the prompts:

- Enter Beginning Date of Visit.
  - Specify the beginning date of the date range.
- Enter Ending Date of Visit.
  - Specify the ending date of the date range.
- Clinic Selection.

  Use one of the following:

  - **C** (Visits at Selected Clinic)

  Or

  - **A** (Visit to All Clinics).

  If you use **C**, other prompts will display.

- Provider Selection.

  Use one of the following:

  - **A** (Visits to All Providers)

Or

– **C** (Visits to Selected Providers)

If you use **C**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – Use **P** (print output)

  Or

  – **B** (browse output on screen)

  The application displays the **GAD-2** and **GAD-7 Scores** for **Multiple Patients** report (Figure 12-69).

```
   XX                              Jul 05, 2017                          Page 1

                  GAD-2 and GAD-7 SCORES FOR MULTIPLE PATIENTS
                   Visit Dates: Jul 05, 2015 to Jul 05, 2017
                              Clinic: ALL Clinics
                           Providers: ALL Providers

PATIENT NAME     HRN    Date     GAD2  GAD7   Provider    CLINIC Diagnosis/POV
-------------------------------------------------------------------------------

DEMO,JACOB SCO 102668 02/07/16         3    DEMO,RYA  MENTA

DEMO,CHELSEA   116431 05/19/16   3     3    DEMO,DE  MENTA  F32.0-MAJOR DEPRESS
DEMO,CHELSEA   116431 03/17/16   4          DEMO,BETAA  MEDIC  F32.3-MAJOR DEPRESS
DEMO,CHELSEA   116431 03/10/16        14    DEMO,DE  MENTA  F42.-HOARDING DISOR


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

Figure 12-69: GAD-2 and GAD-7 Scores for Multiple Patients report example

12.1.14 Treatment Plans (TPR)

Use the **TPR** option to access the **Treatment Plans** menu (Figure 12-70).

```
   ATP    Print List of All Treatment Plans on File
   REV    Print List of Treatment Plans Needing Reviewed
   RES    Print List of Treatment Plans Needing Resolved
   NOTP   Patients w/Case Open but no Treatment Plan
```

```
Select Treatment Plans Option:
```

Figure 12-70: Options on the Treatment Plans menu example

12.1.15 Patients Seen in Groups with Time in Group (TSG)

Use the **TSG** option to produce a report that shows a list of patients who have spent time in a group in a specified date range. It will list the patient, the primary provider, diagnosis, and time spent in the group.

Below are the prompts:

- Enter beginning Date
  - Specify the beginning date of the date range.
- Enter ending Date
  - Specify the ending date of the date range.
- Demo Patient/Inclusion/Exclusion

  Use one of the following:
  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the **Patients Seen in Groups with Time Spent in Group** report (Figure 12-71).

```
                          DEMO INDIAN HOSPITAL
                PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP
                    DATES:  JAN 17, 2009  TO  APR 17, 2009


PATIENT NAME      HRN    SEX  DOB       DATE     PROVIDER       PROBLEM  TIME
--------------------------------------------------------------------------------

DEMO,CHRYSTAL   106299  F   11/28/85  04/20/09 DEMO,BETAS      F42       0
          Total with provider DEMO,BJ          0
          Total for patient DEMO,CHRYSTAL GAYL  0

DEMO,DIANA LE   192745  F   09/15/54  03/05/09 DEMO,DENISE   F33.0     60
                                      03/25/09 Not Recorded    F31.3     15
                                      04/21/09 DEMO,MARK   F42.       0
                                               DEMO,MARK   F33.0     60
```

Figure 12-71: Patients Seen in Groups with Time Spent in Group report example

12.2 Behavioral Health Record/Encounter Reports (REC)

Use the **REC** option to list various records from the **Behavioral Health** patient file that are available on the **BHS Encounter/Record Reports** menu (Figure 12-72).

```
                ******************************************
                **       IHS Behavioral Health System       **
                **         Encounter/Record Reports         **
                ******************************************
                            Version 4.0 (Patch 11)

                            DEMO INDIAN HOSPITAL


   LIST   List Visit Records, STANDARD Output
   GEN    List Behavioral Hlth Records, GENERAL RETRIEVAL

Select Behavioral Health Record/Encounter Reports Option:
```

Figure 12-72: Options on the Encounter/Record Reports menu example

12.2.1 List Visit Records, Standard Output (LIST)

Use the **LIST** option to produce a report that shows a listing of visits in a specified date range. The visits can be selected based on any combination of selected criteria. The user will select the sort criteria for the report.

Be sure to have a printer available that has 132-column print capability.

Below are the prompts:

- Enter Beginning Visit Date for Search
  - Specify the beginning date of the date range.
- Enter Ending Visit Date for Search
  - Specify the ending date of the date range.

The application displays the **Visit Selection Menu** (Figure 12-73).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 09:47:03          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
```

```
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
12)  Patient County Resid  36)  Activity Type         60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential   61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare     62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category     63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site    64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served         65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact       66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time         67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio  68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created     69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV               70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV

+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-73: Visit Selection Menu example

Use this menu to select the visit criteria for the report. If you do not select any criteria (immediately use the **Quit Item Selection**), all visits will be selected.

- Type of Report to Print

  Use one of the following:

  – **D** (detailed using 132-column print)

  Or

  – **B** (brief (using 80-column print)

  The application displays the **Sort Item Selection Menu** (Figure 12-74).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 09:55:56          Page:    1 of    2

                        SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1)  Patient Name           18)  Visit Type            35)  Flag (Visit Flag)
2)  Patient Sex            19)  Location of Encounte  36)  Primary Provider
3)  Patient DOB            20)  Clinic                37)  Primary Prov Discipl
4)  Patient DOD            21)  Outside Location      38)  Primary Prov Affilia
5)  Patient Chart #        22)  SU of Encounter       39)  Primary POV
6)  Ethnicity              23)  County of Service     40)  IPV SCREENING
```

```
7)  Veteran Status Y/N      24)  Community of Service  41)  ALCOHOL SCREENING
8)  Patient Community       25)  Activity Type         42)  DEPRESSION SCRFEENIN
9)  Patient County Resid    26)  Days in Residential   43)  SUICIDE RISK ASSESSM
10)  Patient Tribe          27)  Days in Aftercare     44)  Designated MH Prov
11)  Eligibility Status     28)  Activity Category     45)  Designated SS Provid
12)  Class/Beneficiary      29)  Local Service Site    46)  Designated A/SA Prov
13)  Patient Flag Field     30)  Number Served         47)  Designated Other Pro
14)  Encounter Date         31)  Type of Contact       48)  Designated Other (2)
15)  Appointment/Walk-In    32)  Inpatient Dispositio
16)  Interpreter Utilized   33)  PCC Visit Created
17)  Program                34)  Axis V
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-74: Sort Item Selection Menu options example

Use this menu to determine how the visit data will be sorted on the report. If you do not select any item (immediately use the **Quit Item Selection** option), the report will be sorted by visit date.

- Do you want a separate page for each Visit Date?
  - Use **Y** (yes)

  Or

  - **N** (no)
- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or

  - **B** (browse output on screen)

  The application displays the criteria for the report. Then, the application displays the **Behavioral Health Record Listing** report (Figure 12-75), which is the brief type.

```
                        BEHAVIORAL HEALTH RECORD LISTING
                    Visit Dates:  DEC 23, 2011 and JAN 23, 2012
================================================================================
 DATE     PROV LOC  PATIENT NAME  ACT CONT AT  HRN        PROB      NARRATIVE
--------------------------------------------------------------------------------
12/23/11  WW   WW   DEMO,CHARLES  13 OUTP  88  WW109767   F84.0     AUTISM SPEC
                                                          F10.24    ALCOHOL DEP
```

```
12/23/11  VA   WW   DEMO,JIMM     13 OUTP  60  WW129347   F42.      HOARDING DI
12/27/11  DJS  1337 DEMO,DANNY    91 OUTP  10  WW176178   F42.      HOARDING DI
12/27/11  DJS  1337 DEMO,ALISO    91 OUTP  10  WW193661   F32.3     MAJOR DEPRE
12/27/11  DJS  1337 DEMO,ROBERT   91 OUTP  10  WW186585   F32.1     MAJOR DEPRE
12/27/11  DJS  1337 DEMO,CLAUDIA  91 OUTP  10  WW177791   F32.3     MAJOR DEPRE
12/28/11  RJG  WW   DEMO,RYAN J   13 OUTP  90  WW163449   F84.0     AUTISM SPEC
12/28/11  RJG  WW   DEMO,JADA KAR 13 OUTP  90  WW173042   F10.25    ALCOHOL DEP
12/28/11  GB   WW   DEMO,REBECC   11 OUTP  50  WW113487   T43.205A  ANTIDEPRESS

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER
```

Figure 12-75: Behavioral Health Record Listing report example

12.2.2 List Behavioral Health Records, General Retrieval (GEN)

Use the **GEN** option to produce a report that shows a listing of visits selected by visit criteria. The visits printed can be selected based on any combination of selected items and the selected sort criteria.

If the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Below are the prompts:

- Select and Print Encounter List from

  Use one of the following:

  – **S** (search template)

  Or

  – **D** (date range)

  The next prompts vary according to the option selected.

- Enter Beginning Encounter Date for search
  – Define the beginning encounter date.
- Enter Ending Encounter Date for search
  – Define the ending encounter date.
- Do you want to use a PREVIOUSLY DEFINED REPORT?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, other prompts display.

The application displays the **Visit Selection Menu** (Figure 12-76).

```
BH GENERAL RETRIEVAL          June 26, 2017 10:02:48          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
12)  Patient County Resid  36)  Activity Type         60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential   61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare     62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category     63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site    64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served         65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact       66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time         67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio  68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created     69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV               70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)

+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-76: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

The following prompts continue in the process:

- Choose Type of Report. Use one of the following:
  - **T** (Total Count Only)
  - **S** (Sub-counts and Total Count)
  - **D** (Detailed Listing)
  - **F** (Flag ASCII file (pre-defined record format)

The application displays the **Print Item Selection Menu** (Figure 12-77).

```
BH GENERAL RETRIEVAL          June 26, 2017 10:06          Page:    1 of    2
```

```
                          PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1)  Patient Name           29)  Interpreter Utilized  57)  Primary Prov Affilia
2)  Patient Sex            30)  Program               58)  Prim/Sec Providers
3)  Patient Race           31)  Visit Type            59)  Prim/Sec Prov Discip
4)  Patient Age            32)  Location of Encounte  60)  POV (Prim or Sec)
5)  Patient DOB            33)  Clinic                61)  DX/Problem Code Narr
6)  Patient SSN            34)  Outside Location      62)  POV (Prob Code Grps)
7)  Patient DOD            35)  SU of Encounter       63)  Primary POV
8)  Patient Chart #        36)  County of Service     64)  POV Problem Code Nar
9)  Ethnicity              37)  Community of Service  65)  POV (Problem Categor
10)  Veteran Status Y/N    38)  Chief Complaint/Pres  66)  POV Diagnosis Catego
11)  Patient Community     39)  Activity Type         67)  POV Prov Narrative
12)  Patient County Resid  40)  Activity Type Narrat  68)  Procedures (CPT)
13)  Patient Tribe         41)  Days in Residential   69)  Education Topics Pro
14)  Eligibility Status    42)  Days in Aftercare     70)  Prevention Activity
15)  Class/Beneficiary     43)  Activity Category     71)  Treated Medical Prob
16)  Medicare Eligibility  44)  Local Service Site    72)  IPV SCREENING
17)  Medicaid Eligibility  45)  Number Served         73)  ALCOHOL SCREENING
18)  Priv Ins Eligibility  46)  Type of Contact       74)  DEPRESSION SCRFEENIN
19)  Patient Flag Field    47)  Activity Time         75)  SUICIDE RISK ASSESSM
20)  Patient Flag Narrati  48)  Inpatient Dispositio  76)  Personal History Ite
21)  Case Open Date        49)  Place Referred To     77)  Designated MH Prov
22)  Case Admit Date       50)  PCC Visit Created     78)  Designated SS Provid
23)  Case Closed Date      51)  Axis IV               79)  Designated A/SA Prov
24)  Case Disposition      52)  Axis V                80)  Designated Other Pro
25)  Next Case Review Dat  53)  Comment               81)  Designated Other (2)
26)  Encounter Date        54)  Flag (Visit Flag)
27)  Encounter Date&Time   55)  Primary Provider
28)  Appointment/Walk-In   56)  Primary Prov Discipl

+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-77: Print Item Selection Menu options example

Use the **Sort Item Selection Menu** (Figure 12-78) to select the data items to be used on the report. Use option **Q** when you have completed your selections.

```
BH GENERAL RETRIEVAL          June 26, 2017 09:55:56          Page:    1 of    2

                          SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1)  Patient Name           18)  Visit Type            35)  Flag (Visit Flag)
2)  Patient Sex            19)  Location of Encounte  36)  Primary Provider
3)  Patient DOB            20)  Clinic                37)  Primary Prov Discipl
4)  Patient DOD            21)  Outside Location      38)  Primary Prov Affilia
5)  Patient Chart #        22)  SU of Encounter       39)  Primary POV
6)  Ethnicity              23)  County of Service     40)  IPV SCREENING
```

```
7)  Veteran Status Y/N      24)  Community of Service  41)  ALCOHOL SCREENING
8)  Patient Community       25)  Activity Type         42)  DEPRESSION SCRFEENIN
9)  Patient County Resid    26)  Days in Residential   43)  SUICIDE RISK ASSESSM
10)  Patient Tribe          27)  Days in Aftercare     44)  Designated MH Prov
11)  Eligibility Status     28)  Activity Category     45)  Designated SS Provid
12)  Class/Beneficiary      29)  Local Service Site    46)  Designated A/SA Prov
13)  Patient Flag Field     30)  Number Served         47)  Designated Other Pro
14)  Encounter Date         31)  Type of Contact       48)  Designated Other (2)
15)  Appointment/Walk-In    32)  Inpatient Dispositio
16)  Interpreter Utilized   33)  PCC Visit Created
17)  Program                34)  Axis V

+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-78: Options on the Sort Item Selection Menu example

Use this menu to determine the sort criteria for the report. If you do not select any criteria (use **Quit Item Selection**) immediately, the report will be sorted by visit date.

- Do you want a separate page for each Visit Date?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)
- Would you like a custom title for this report?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

  If you use **Y**, other prompts will display.
- Do you want to save this SEARCH/PRINT/SORT logic for future use?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, other prompts will display.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

The application displays the criteria for the report.

- Do you want to use:
  - **P** (print output)

  Or
  - **B** (browse output on screen)

The application displays the criteria for the report. After pressing **Enter**, the application displays the visit report (Figure 12-79).

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
                              BH Visit Listing                        Page 1
                   Record Dates:  JAN 14, 2009 and JUL 13, 2009

PATIENT NAME          DOB           HRN         PROGRAM
------------------------------------------------------------

--                                                MENTAL
DEMO,CHELSEA MARIE  02/07/1975    WW116431    MENTAL
DEMO,ALBERT TILLMAN  02/07/1975    WW164141    OTHER
DEMO,ALBERT TILLMAN  02/07/1975    WW164141    MENTAL
DEMO,ALBERT TILLMAN  02/07/1975    WW164141    SOCIAL

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

Figure 12-79: Visit report example

12.3 Workload/Activity Reports (WL)

Use the **WL** option to view the **Activity Workload Reports** menu (Figure 12-80).

```
                ******************************************
                **       IHS Behavioral Health System       **
                **         Activity Workload Reports        **
                ******************************************
                           Version 4.0 (Patch 11)

                            DEMO INDIAN HOSPITAL


   GRS1   Activity Report
   GRS2   Activity Report by Primary Problem
   ACT    Activity Record Counts
   PROG   Program Activity Time Reports (132 COLUMN PRINT)
```

```
   FACT   Frequency of Activities
   FCAT   Frequency of Activities by Category
   PA     Tally of Prevention Activities

Select Workload/Activity Reports Option:
```

Figure 12-80: Options on the Activity Workload Reports menu example

The **Workload/Activity Reports** menu has options to generate reports related specifically to the activities of **Behavioral Health** providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring **Behavioral Health** care.

12.3.1 Activity Report (GRSI)

Use the **GRS1** option to produce a report that will tally activities by service unit, facility, and provider. The report is patterned after **GARS Report #1**.

Below are the prompts:

- Enter beginning Encounter Date.
  - Specify the beginning encounter date for the date range.
- Enter ending Encounter Date.
  - Specify the ending encounter date for the date range.
- Run Report for which Program.

  Use one the following:
  - **M**–MENTAL HEALTH
  - **S**–SOCIAL SERVICES
  - **C**–CHEMICAL DEPENDENCY or ALCOHOL/SUBSTANCE ABUSE
  - **O**–OTHER
  - **A**–ALL
- Run Report for ???.

  Use one of the following:
  - **1** (ONE PROVIDER)

  Or
  - **2** (ALL PROVIDERS)

  If you use **1**, other prompts will display.
  - Include which providers.

  Use one of the following:
  - **P** (Primary Provider Only)

Or

– **S** (Both Primary and Secondary Providers)

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

  The application displays the **Activity Report** (Figure 12-81).

```
           ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                    MAY 04, 2009Page 1
         ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM
                RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

                                          # RECS    ACT TIME  # PATS   # SERVED
                                                    (hrs)
-------------------------------------------------------------------------------
AREA:  TUCSON
  SERVICE UNIT:  SELLS
     FACILITY:  SELLS HOSP
        PROVIDER:  DEMO,BJ (PSYCHIATRIST)
           13-INDIVIDUAL TREATMENT/COUNS         3       2.8        3          3
           16-MEDICATION/MEDICATION MONI         1       1.0        1          1
           91-GROUP TREATMENT                    2       1.5        2          2
                                              =======   =======  =======    =======
        PROVIDER TOTAL:                          6       5.3        6          6

        PROVIDER:  DEMO,LORI (PHYSICIAN)
           11-SCREENING-PATIENT PRESENT          1       0.3        1          1
           13-INDIVIDUAL TREATMENT/COUNS         1       0.2        1          1
           22-CASE MANAGEMENT-PATIENT PR         2       0.7        1          2
                                              =======   =======  =======    =======
        PROVIDER TOTAL:                          4       1.3        3          4

        PROVIDER:  DEMO,DOCTOR (PHYSICIAN)
           85-ART THERAPY                        4       0.7        4          4
                                              =======   =======  =======    =======
        PROVIDER TOTAL:                          4       0.7        4          4
Enter RETURN to continue or '^' to exit:
```

Figure 12-81: Activity Report example

Near the end of the report, there will be a **Facility Total**, **SU Total**, and **Area Total**.

12.3.2 Activity Report by Primary Problem (GRS2)

Use the **GRS2** option to produce a report that will tally PRIMARY problems by service unit, facility, and by provider and activity.

The prompts are the same as those for the **GRS1** report. Section 12.3.1 provides more information about the **Activity Report**.

The application displays the **Activity Report by Primary Purpose** report (Figure 12-82).

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
xx                                                    MAY 04, 2009Page 1
                      ACTIVITY REPORT BY PRIMARY PURPOSE
          ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM
                 RECORD DATES:  FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identified patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

                                          # RECS    ACT TIME # PATS    # SERVED
                                                     (hrs)
-------------------------------------------------------------------------------
AREA:  TUCSON
   SERVICE UNIT:  SELLS
     FACILITY:  SELLS HOSP
       PROVIDER:  DEMO,BJ (PSYCHIATRIST)
         ACTIVITY:  13-INDIVIDUAL TREATMENT/C
             F32.0-MAJOR DEPRESS                1       1.0        1         1
                                              =======   =======  =======   =======
         ACTIVITY TOTAL:                        1       1.0        1         1

         ACTIVITY:  16-MEDICATION/MEDICATION
             F42.-HOARDING DISOR                1       1.0        1         1
                                              =======   =======  =======   =======
         ACTIVITY TOTAL:                        1       1.0        1         1

                                              =======   =======  =======   =======
       PROVIDER TOTAL:                          2       2.0        2         2

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

Figure 12-82: Activity Report by Primary Purpose report example

12.3.3 Activity Record Counts (ACT)

Use the **ACT** option to produce a report that will generate a count of activity records for a selected item in a specified date range. You will be given the opportunity to select which visits will be included in the tabulation. For example, you can choose to tally activity time by Problem Code for only those with a discipline of Psychiatrist.

Below are the prompts:

- Choose an item for calculating activity time and records counts.
  - The application displays a list of items from which to choose.
- Enter Beginning Visit Date for Search
  - Specify the beginning visit date for the date range.
- Enter Ending Visit Date for Search
  - Specify the ending visit date for the date range.

  The application displays the **Visit Selection Menu** (Figure 12-83).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 10:21:08          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
12)  Patient County Resid  36)  Activity Type         60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential   61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare     62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category     63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site    64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served         65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact       66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time         67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio  68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created     69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV               70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-83: Sort Item Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

  The application displays the **Activity Record Counts** report (Figure 13 84).

```
                                                    MAY 04, 2009  Page 1
               RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
             NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM-5/CODE

PROB DSM/CODE NARRATIVE   CODE            # RECS  # PATS    ACTIVITY  # SERVED
                                                           TIME

-------------------------------------------------------------------------------
GENERALIZED ANXIETY DIS   F41.1               1       1       1.0         1
MAJOR DEPRESSIVE DISORD   F32.9               1       1       0.0         1
SUICIDE (ATTEMPT/GESTUR   40                  1       1       0.9         1
Suicidal ideations        R45.851             1       1       0.0         1
Suicide attempt           T14.91              1       1       0.0         1


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

Figure 12-84: Activity Record Counts report example

12.3.4 Program Activity Time Reports (PROG)

Use the **PROG** option to produce a report that will generate a count of activity records, total activity time, and number of patient visits by Program and by a selected item within a specified date range. You will be given the opportunity to select which visits will be included on the report. For example, you might want to only report on those records on which the type of visits was Field.

> **Note:** If you choose to report on Problems, ONLY THE PRIMARY PROBLEM is included.

The prompts are the same as those for the **ACT** report. Section 12.3.3 provides more information about **Activity Record Counts**.

The application displays the record selection criteria. After pressing **Enter**, the application displays the **Program Activity Time** report (Figure 12-85).

```
Encounter Date range:  FEB 03, 2009 to MAY 04, 2009


                         MENTAL HEALTH AND SOCIAL SERVI
              ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGR
                        RECORD DATES:  FEB 03, 2009  TO  MA

                    SOCIAL SERVICES AND MENTAL HEALTH COMB           SOCIAL SERV
                       NO. OF     NO. OF      TOTAL           NO. OF     NO. OF
PROVIDER               RECORDS    PATIENTS  ACTIV TIME        RECORDS    PATIENT
-------------------------------------------------------------------------------

DEMO,AAA                  15          7        3.6              2          2
DEMO,BETAA                33         18       22.6              8          4
DEMO,LORI                 16          6        5.0              .          .
DEMO,JESSICA               9          2        6.3              .          .
DEMO,CASE M                1          1        0.0              .          .
DEMO,DOCTOR                1          1        0.2              1          1
DEMO,AMY J                 3          3        2.0              .          .
DEMO,RYAN                106         30       66.3             24          5
**** Patient Count TOAL is not an unduplicated count.

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

Figure 12-85: Program Activity Time report example

12.3.5 Frequency of Activities (FACT)

Use the **FACT** option to produce a report that will generate a list of the top **N Activity Codes** for selected visits.

Below are the prompts:

- Enter beginning Visit Date for Search
  - Specify the beginning visit date for the date range.
- Enter ending Visit Date for Search
  - Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 12-86).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 10:23:22          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
12)  Patient County Resid  36)  Activity Type         60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential   61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare     62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category     63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site    64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served         65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact       66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time         67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio  68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created     69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV               70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-86: Sort Item Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- Select Type of Report.

  Use one of the following:

  – **L** (list of items with counts)

  Or

  – **B** (Bar Chart, requires 132 column printer)
- How many entries do you want to list (5–100)

  – Specify the number of entries (any number 5–100).

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the criteria for the report. After pressing **Enter**, the application displays the **Frequency of Activities** report (Figure 12-87).

```
  MAY 04, 2009                                                        Page 1
                            DEMO INDIAN HOSPITAL

TOP 10 Activity Code's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

No.   ACTIVITY TYPE                    ACTIVITY CODE    # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------------
1.    SCREENING-PATIENT PRESENT        11               55           34.8
2.    INFORMATION AND/ OR REFERRAL-P   15               32           12.3
3.    GROUP TREATMENT                  91               30           17.1
4.    INDIVIDUAL TREATMENT/COUNSEL/E   13               22           17.0
5.    ASSESSMENT/EVALUATION-PATIENT    12               19           15.5
6.    INDIVIDUAL BH EHR VISIT          99               19            0.6
7.    ACADEMIC SERVICES                96               16            8.1
8.    ART THERAPY                      85               15            6.7

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 12-87: Frequency of Activities report example

12.3.6 Frequency of Activities by Category (FCAT)

Use the **FCAT** option to produce a report that generates a list of the top **N Activity Category** for selected visits.

The prompts are the same as for the Frequency of Activities report. Section 12.3.5 **Frequency of Activities** report.

Below is a sample **Frequency of Activities by Category** report (Figure 12-88).

```
  MAY 04, 2009                                                        Page 1
                            DEMO INDIAN HOSPITAL
```

```
TOP 10 Activity Category's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

No.   ACTIVITY CATEGORY               CATEGORY CODE    # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------------
1.    PATIENT SERVICES                P                943       556778.2
2.    SUPPORT SERVICES                S                56           52.9
3.    ADMINISTRATION                  A                21           26.6
4.    PLACEMENTS                      PL               6             2.8
5.    COMMUNITY SERVICES              C                2             9.0
6.    EDUCATION/TRAINING              E                2             1.5
7.    CULTURALLY ORIENTED             O                1             0.5
8.    TRAVEL                          T                1             0.3

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 12-88: Frequency of Activities by Category report example

12.3.7 Tally of Prevention Activities (PA)

Use the PA option to produce a report that will show a count of all visits with a prevention activity entered. It will also produce a tally/count of those prevention activities with Target Audience subtotals.

Below are the prompts:

- Enter Beginning Visit Date
  - Specify the beginning visit date for the date range.
- Enter Ending Visit Date
  - Specify the ending visit date for the date range.
- Run the Report for which PROGRAM.

  Use one of the following:

  - **O** (one program)

  Or

  - **A** (all programs)

  If you use **O**, other prompts will display.

- Enter a code indicating which providers are of interest.

  Specify the **Providers** whose **Prevention** activities you want to tally.

  Use one of the following:

  - **A** (all providers)
  - **S** (Select set or Taxonomy of Providers)
  - **O** (one provider)

If you use **S** or **O**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Device
  – Specify the device to browse/print the report.

The application displays the **Tally of Prevention Activities** report (Figure 13 89).

```
May 04, 2009                                                          Page: 1
                          Behavioral Health
                     **********************************
                    *   TALLY OF PREVENTION ACTIVITIES  *
                     **********************************
              VISIT Date Range: FEB 03, 2009 through MAY 04, 2009
     PREVENTION ACTIVITY                    # of visits    % of visits
-------------------------------------------------------------------------------

Total # Visits w/Prevention Activity:        3
Total # of Prevention Activities recorded:   5

 AIDS/HIV                                    1              33.3
    YOUTH           1       100.0

 OTHER                                       1              33.3
    NOT RECORDED    1       100.0

 PUBLIC AWARENESS                            1              33.3
    NOT RECORDED    1       100.0

 SELF-AWARENESS/VALUES                       1              33.3
    ADULT           1       100.0

 SMOKING/TOBACCO                             1              33.3
    YOUTH           1       100.0

TARGET TOTALS

    ADULT           1        33.3
    NOT RECORDED    1        33.3
    YOUTH           1        33.3

RUN TIME (H.M.S): 0.0.0
Enter RETURN to continue or '^' to exit:
```

Figure 12-89: Tally of Prevention Activities report example

12.4 Problem Specific Reports (PROB)

Use the **PROB** option to produce a list of BH issues of particular concern to providers, managers, and administrators from a clinical and public health perspective. Figure 12-90 shows the Problem Specific Report menu.

```
                ******************************************
                **       IHS Behavioral Health System       **
                **         Problem Specific Reports         **
                ******************************************
                            Version 4.0 (Patch 11)

                             DEMO INDIAN HOSPITAL


   ABU    Abuse Report (Age&Sex)
   FDSM   Frequency of Problems
   FPRB   Frequency of Problems (Problem Code Groupings)
   FPRC   Frequency of Problems by Problem Category
   SUIC   Suicide Related Reports ...

Select Problem Specific Reports Option:
```

Figure 12-90: Options on the Problem Specific Reports menu example

12.4.1 Abuse Report (ABU)

Use the **ABU** option to produce a report that focuses on patients who might have been victims of abuse or neglect. It will present, by age and sex, the number of individual patients who were seen for the Purpose of Visit (POV)–the application displays the POVs.

Below are the prompts:

- Enter Beginning Visit Date

  Specify the beginning visit date for the date range (during which the patient should have been seen with one of the above problems).

- Enter the Ending Visit Date

  Specify the ending visit date for the date range.

  The application displays the current Age Groups.

- Do you want to modify these age groups?

  Use one of the following:

  – **Y** (yes)

  Or

  – **N** (no)

If you use **Y**, other prompts will display. Use **N** to not modify the age groups.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

The application displays the **Abuse Report** by **Age** and **Sex** report. You need a 132-column printer to print the report.

12.4.2 Frequency of Problems (FDX)

Use the FDX option to produce a report that shows a list of the top N Problem/POV for selected visits.

Below are the prompts:

- Enter beginning Visit Date for Search

  Specify the beginning visit date for the date range.

- Enter ending Visit Date for Search

  Specify the ending visit date for the date range.

  The application displays the Visit Selection Menu (Figure 12-91).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 10:26:30          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
```

```
12)  Patient County Resid  36)  Activity Type          60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential    61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare      62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category      63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site     64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served          65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact        66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time          67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio   68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created      69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV                70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-91: Sort Item Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- Include which POVs.

  Use one of the following:

  – **P** (primary POV only)

  Or

  – **S** (primary and secondary POVs)
- Select Type of Report.

  Use one of the following:

  – **L** (List of items with counts)

  Or

  – **B** (Bar Chart, requires 132 column printer)
- How many entries do you want to list (5-100)

  Specify the number of entries.
- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)
- Do you want to use:

– **P** (print output)

Or

– **B** (browse output on screen)

The application displays the **Frequency of Problems** report (Figure 12-92).

```
  JUN 09, 2009                                                        Page 1
                            DEMO INDIAN HOSPITAL

TOP 10 Problem/POV's.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   PROB DSM/CODE NARRATIVE          CODE             # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------------
1.    MAJOR DEPRESSIVE DISORDER,RECU  F33.9           150      114.8
2.    GENERALIZED ANXIETY DISORDER    F41.1            52       28.8
3.    UNSPECIFIED ATTENTIONN-DEFICIT  F90.9            48       35.5
4.    BIPOLAR DISORDER, UNSPECIFIED   F31.9            33       26.1
5.    OBSESSIVE-COMPULSIVE DISORDER   F42              32       21.1
6.    PANIC DISORDER                  F41.0            32       72.9
7.    ANOREXIA NERVOSA, RESTRICTING   F50.01           31       27.4
8.    ALCOHOL USE DISORDER, MODERAT   F10.20           25        7.9
9.    HEALTH/HOMEMAKER NEEDS            1              21       17.6
10.   INSOMNIA DISORDER               G47.00           20       32.3
RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 12-92: Frequency of Problems report example

12.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

Use the FPRB option to produce a report that shows a list of the top N Problem/POV for visits that you select.

Below are the prompts:

- Enter beginning Visit Date for Search

  Specify the beginning visit date for the date range.

- Enter ending Visit Date for Search

  Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 12-93).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 10:29:11          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.
```

```
1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
12)  Patient County Resid  36)  Activity Type         60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential   61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare     62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category     63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site    64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served         65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact       66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time         67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio  68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created     69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV               70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-93: Sort Item Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The prompts continue:

- Include which POV/s.

  Use one of the following:

  – **P** (Primary POV only)

  Or

  – **S** (Primary and Secondary POVs)
- Select Type of Report.

  Use one of the following:

  – **L** (List of items with counts)

  Or

  – **B** (Bar Chart, required 132 column printer)
- How many entries do you want in the list (5-100).

- Specify the number of entries, using any whole number 5-100.

- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)

- Do you want to use:

  - **P** (print output)

  Or

  - **B** (browse output on screen)

  Figure 12-94 displays the **Frequency of Problems by Code Grouping** report.

```
  JUN 09, 2009                                                        Page 1
                            DEMO INDIAN HOSPITAL
TOP 10 POV/Problem (Problem Code)'s.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   PROB CODE NARRATIVE              PROBLEM (POV) CODE# RECS  ACT TIME (HRS)
-------------------------------------------------------------------------------
1.    MAJOR DEPRESSIVE DISORDERS       14               123          94.2
2.    ANXIETY DISORDER                 18               30           14.2
3.    SCHIZOPHRENIC DISORDER           13               29           25.8
4.    CROSS-CULTURAL CONFLICT          2                19           15.0
5.    MARITAL PROBLEM                  56               18            5.4
6.    ALCOHOL ABUSE                    29               16           14.1
7.    ILLNESS IN FAMILY                55               16            4.3
8.    HOUSING                          80               15            8.0
9.    SENILE OR PRE-SENILE CONDITION   9                14            9.7
10.   BIPOLAR DISORDER                 15               13            5.2

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 12-94: Frequency of Problem by groupings report example

12.4.4 Frequency of Problems by Problem Category (FPRC)

Use the **FPRC** option to produce a report that generates a list of the top **N Problem/POV (Problem Category)** for selected visits.

The prompts are below:

- Enter beginning Visit Date for Search.

  Specify the beginning visit date for the date range.

- Enter ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu (Figure 12-95).

```
BH GENERAL RETRIEVAL          Dec 26, 2013 10:29:11          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           25)  Next Case Review Dat  49)  Primary Provider
2)  Patient Sex            26)  Appointment/Walk-In   50)  Primary Prov Discipl
3)  Patient Race           27)  Interpreter Utilized  51)  Primary Prov Affilia
4)  Patient Age            28)  Program               52)  Prim/Sec Providers
5)  Patient DOB            29)  Visit Type            53)  Prim/Sec Prov Discip
6)  Patient DOD            30)  Location of Encounte  54)  POV (Prim or Sec)
7)  Ethnicity              31)  Clinic                55)  POV (Prob Code Grps)
8)  Veteran Status Y/N     32)  Outside Location      56)  Primary POV
9)  Living Patients        33)  SU of Encounter       57)  POV (Problem Categor
10)  Chart Facility        34)  County of Service     58)  POV Diagnosis Catego
11)  Patient Community     35)  Community of Service  59)  Procedures (CPT)
12)  Patient County Resid  36)  Activity Type         60)  Education Topics Pro
13)  Patient Tribe         37)  Days in Residential   61)  Prevention Activity
14)  Eligibility Status    38)  Days in Aftercare     62)  IPV SCREENING
15)  Class/Beneficiary     39)  Activity Category     63)  ALCOHOL SCREENING
16)  Medicare Eligibility  40)  Local Service Site    64)  DEPRESSION SCRFEENIN
17)  Medicaid Eligibility  41)  Number Served         65)  SUICIDE RISK ASSESSM
18)  Priv Ins Eligibility  42)  Type of Contact       66)  Personal History Ite
19)  Patient Encounters O  43)  Activity Time         67)  Designated MH Prov
20)  Patient Flag Field    44)  Inpatient Dispositio  68)  Designated SS Provid
21)  Case Open Date        45)  PCC Visit Created     69)  Designated A/SA Prov
22)  Case Admit Date       46)  Axis IV               70)  Designated Other Pro
23)  Case Closed Date      47)  Axis V
24)  Case Disposition      48)  Flag (Visit Flag)
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 12-95: Sort Item Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- Include which POVs.

  Use one of the following:

  – **P** (Primary POV only)

  Or

  – **S** (Primary and Secondary POVs).
- Select Type of Report.

Use one of the following:

- **L** (List of items with counts)

Or

- **B** (Bar Chart, requires 132 column printer)

- How many entries do you want in the list (5-100)?
  - Specify the number of entries, using any whole number 5-100.
- Demo Patient/Inclusion/Exclusion

  Use one of the following:

  - **I** (include all patients)
  - **E** (exclude demo patients)
  - **O** (include only demo patients)
- Do you want to use:
  - **P** (print output)

  Or

  - **B** (browse output on screen)

The application displays the record selection criteria. After pressing **Enter**, the application displays the **Frequency of Problems by Problem Category** report (Figure 12-96).

```
  JUN 09, 2009                                                        Page 1
                              DEMO INDIAN HOSPITAL

TOP 10 Problem/POV (Problem Category)'s.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   CATEGORY NARRATIVE               CATEGORY CODE    # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------------
1.    PSYCHOSOCIAL PROBLEMS            2                294         220.6
2.    MEDICAL/SOCIAL PROBLEMS          1                73        555798.6
3.    FAMILY LIFE PROBLEMS             5                37           11.5
4.    SOCIOECONOMIC PROBLEMS           8                27           12.4
5.    ADMINISTRATIVE PROBLEM           11               14           11.5
6.    ABUSE                            3                10            5.1
7.    OTHER PATIENT RELATED            13               6            12.3
8.    EDUCATIONAL/LIFE PROBLEMS        10               8             5.9
9.    SCREENING                        12               7             4.9
10.   PREGNANCY/CHILDBIRTH PROBLEMS    6                6             1.8

RUN TIME (H.M.S): 0.0.1
End of report.  PRESS ENTER:
```

Figure 12-96: Frequency of Problems by Problem Category report example

12.4.5 Suicide Related Reports (SUIC)

Use the **SUIC** option to access the **Suicide Reports** menu (Figure 12-97).

```
                ******************************************
                **       IHS Behavioral Health System       **
                **              Suicide Reports             **
                ******************************************
                           Version 4.0 (Patch 11)

                            DEMO INDIAN HOSPITAL


   SSR    Aggregate Suicide Form Data - Standard
   SAV    Aggregate Suicide Data Report - Selected Variables
   SDEL   Output Suicide Data in Delimited Format
   SGR    Listing of Suicide forms by Selected Variables
   SUIC   Suicide Report (Age&Sex)
   SPOV   Suicide Purpose of Visit Report

Select Suicide Related Reports Option:
```

Figure 12-97: Options on Suicide Report menu example

12.4.5.1 Aggregate Suicide Form Data–Standard (SSR)

This report will tally the data items specific to the Suicide Form for a date range, community, and type of suicidal behavior (specified by the user).

Below are the prompts:

- Enter Beginning Date of Suicide Act.
  - Specify the beginning date for the date range.
- Enter Ending Date of Suicide Act.
  - Specify the ending date for the date range.
- Report on Suicide Forms for Suicide Acts that occurred in:

  Use one of the following:

  - **O** (One particular Community)

  Or

  - **A** (All Communities)

  If you use **O**, other prompts will display.

- Include which Suicidal Behaviors (0-9)

  The application displays the suicide behaviors. You can respond with a list or a range.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

- Do you want to:

  Use one of the following:

  - **P** (print output)

  Or

  - **B** (browse output on screen)

Figure 12-98shows the **Aggregate Suicide Form Data–Standard** report.

```
DEMO INDIAN HOSPITAL              Jul 13, 2009                      Page 1

               ***** AGGREGATE SUICIDE FORM DATA - STANDARD*****
                   Act Occurred: Jan 14, 2009 - Jul 13, 2009
                 Community where Act Occurred: ALL Communities
--------------------------------------------------------------------------------

Age Range: 20-24 years        Total # of Suicide Forms: 1
                                                              REPORT TOTALS
           Suicidal Behavior:  ATT SUICIDE W/ ATT HOMICIDE       1     100%

  Event logged by Discipline:  PSYCHIATRIST                      1     100%

    Event logged by Provider:  DEMO,RYAN                        1     100%

                         Sex:  MALE                             1     100%

                    Employed:  PART-TIME                        1     100%

         Tribe of Enrollment:  CHEROKEE NATION OF OKLAHOMA      1     100%

      Community of Residence:  WELLING                         1     100%

                Relationship:  MARRIED                          1     100%

                   Education:  COLLEGE GRADUATE                 1     100%

                      Method:  GUNSHOT                          1     100%
                               HANGING                          1     100%

           Previous Attempts:  1                                1     100%

      Substance Use Involved:  NONE                             1     100%

              Location of Act:  WORK                            1     100%

                  Disposition:  IN-PATIENT MENTAL HEALTH TREAT  1     100%

        Contributing Factors:  DEATH OF FRIEND OR RELATIVE      1     100%
```

```
Age Range: 45-64 years        Total # of Suicide Forms: 13
                                                          REPORT TOTALS
           Suicidal Behavior:  IDEATION WITH PLAN AND INTENT      4      31%
                               ATTEMPT                            3      23%
                               ATT SUICIDE W/ ATT HOMICIDE        3      23%
                               ATT SUICIDE W/ COMP HOMICIDE       2      15%
                               COMP SUICIDE W/ ATT HOMICIDE       1       8%

  Event logged by Discipline:  ACUPUNCTURIST                      7      54%
                               PSYCHIATRIST                       6      46%

    Event logged by Provider:  DEMO,DENISE                     1       8%
                               DEMO,BJ                         7      54%
                               DEMO,RYAN                        5      38%
 Race:  AMERICAN INDIAN OR ALASKA NATIVE                          1     100%
                  Ethnicity:  NOT HISPANIC OR LATINO              1     100%
           Veteran's Status:  NO                                  1     100%


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

Figure 12-98: Aggregate Suicide Form Data–Standard report example

12.4.5.2 Aggregate Suicide Form Data–Selected Variables (SAV)

This report will tally the selected data items for **Suicide Forms** in a particular date range.

12.4.5.3 Output Suicide Data in Delimited Format (SDEL)

This report will extract all data elements on the **Suicide Form** in a delimited form for a specified date range.

12.4.5.4 Listing of Suicide Forms by Selected Variables (SGR)

This report is a **general retrieval** type report that will list the selected data items for Suicide Forms in a particular date range. The user can also specify how to display the items in the printed report.

12.4.5.5 Suicide Report (Age & Sex) (SUIC)

This report will present, by age and sex, the number of individual patients who were seen for the following POVs: 39, 40, and 41 as well as V62.84 (Suicidal Ideation).

12.4.5.6 Suicide Purpose of Visit Report (SPOV)

This report will display the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Encs). Any records containing the ICD-9 code v62, 84, Suicidal Ideation will be included in the tallies for Problem Code 39. A display by age and gender is also included.

Below are the prompts:

- Enter Beginning Visit Date.

  Specify the beginning visit date for the date range.

- Enter Ending Visit Date.

  Specify the ending visit date for the date range.

- Run the Report for which Program?

  Use one of the following:

  – **O** (one program)

  Or

  – **A** (all programs)

  If you use O, other prompts will display.

- Demo Patient Inclusion/Exclusion.

  Use one of the following:

  – **I** (include all patients)
  – **E** (exclude demo patients)
  – **O** (include only demo patients)

- Do you want to use:

  – **P** (print output)

  Or

  – **B** (browse output on screen)

Figure 12-99 shows the **Suicide Purpose of Visit** report.

```
                        Behavioral Health
                    ************************************
                    *   SUICIDE PURPOSE OF VISIT REPORT  *
                    ************************************
                  VISIT Date Range: OCT 31, 2006 through NOV 30, 2006
                       BOTH MALE AND FEMALE PATIENTS' VISITS

        39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide
Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs        # w POV 39     w/ POV 40   w/ POV 41     w/ 39/40/41/
                           V62.84/R45.851 & T14.91                  V62.84/R45.8
            #     %    #       %    #      %    #      %    #      %
 1-4 yrs    0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 5-9 yrs    2  10.0    0     0.0    0    0.0    0    0.0    0    0.0
 10-14 yrs  7  35.0    0     0.0    0    0.0    0    0.0    0    0.0
 15-19 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 20-24 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
```

```
 25-34 yrs  6  30.0    0     0.0    0    0.0    0    0.0    0    0.0
 35-44 yrs  2  10.0    0     0.0    0    0.0    0    0.0    0    0.0
 45-54 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 55-64 yrs  1   5.0    0     0.0    0    0.0    0    0.0    0    0.0
 65-74 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 75-84 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 85+ yrs    2  10.0    0     0.0    0    0.0    0    0.0    0    0.0

TOTAL       20 100.0   0     0.0    0    0.0    0    0.0    0    0.0


                          MALE PATIENTS VISITS
         39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide
Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs        # w POV 39     w/ POV 40   w/ POV 41     w/ 39/40/41/
                           V62.84/R45.851 & T14.91                  V62.84/R45.8
            #    %    #      %      #      %     #      %     #      %
 1-4 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
 5-9 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
 10-14 yrs  6  66.7   0    0.0      0     0.0    0    0.0     0    0.0
 15-19 yrs  0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
 20-24 yrs  0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
 25-34 yrs  2  22.2   0    0.0      0     0.0    0    0.0     0    0.0
 35-44 yrs  1  11.1   0    0.0      0     0.0    0    0.0     0    0.0
 45-54 yrs  0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
55-64 yrs   0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
65-74 yrs   0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
75-84 yrs   0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
85+ yrs     0   0.0   0    0.0      0     0.0    0    0.0     0    0.0

TOTAL       9   100.0 0    0.0      0     0.0    0    0.0     0    0.0

                       FEMALE PATIENTS VISITS
                  39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide
Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs        # w POV 39     w/ POV 40   w/ POV 41     w/ 39/40/41/
                           V62.84/R45.851 & T14.91                  V62.84/R45.8
             #    %    #      %      #      %     #      %     #      %
1-4 yrs      0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
5-9 yrs      2  18.2   0    0.0      0     0.0    0    0.0     0    0.0
10-14 yrs    1   9.1   0    0.0      0     0.0    0    0.0     0    0.0
15-19 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
20-24 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
25-34 yrs    4  36.4   0    0.0      0     0.0    0    0.0     0    0.0
35-44 yrs    1   9.1   0    0.0      0     0.0    0    0.0     0    0.0
45-54 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
55-64 yrs    1   9.1   0    0.0      0     0.0    0    0.0     0    0.0

65-74 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
75-84 yrs    0   0.0   0    0.0      0     0.0    0    0.0     0    0.0
85+ yrs      2  18.2   0    0.0      0     0.0    0    0.0     0    0.0

TOTAL       11 100.0   0    0.0      0     0.0    0    0.0     0    0.0

         UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS
```

```
                39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide
Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs        # w POV 39     w/ POV 40   w/ POV 41     w/ 39/40/41/
                          V62.84/R45.851 & T14.91                  V62.84/R45.8
            #      %     #      %      #      %     #      %      #      %
1-4 yrs     0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
5-9 yrs     1    7.7     0    0.0      0    0.0     0    0.0      0    0.0
10-14 yrs   2   15.4     0    0.0      0    0.0     0    0.0      0    0.0
15-19 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
20-24 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
25-34 yrs   5   38.5     0    0.0      0    0.0     0    0.0      0    0.0
35-44 yrs   2   15.4     0    0.0      0    0.0     0    0.0      0    0.0
45-54 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
55-64 yrs   1    7.7     0    0.0      0    0.0     0    0.0      0    0.0
65-74 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
75-84 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
 85+ yrs    2   15.4     0    0.0      0    0.0     0    0.0      0    0.0

TOTAL      13  100.0     0    0.0      0    0.0     0    0.0      0    0.0

               UNDUPLICATED PATIENT COUNT - MALE PATIENTS
                39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide
Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs        # w POV 39     w/ POV 40   w/ POV 41     w/ 39/40/41/
                          V62.84/R45.851 & T14.91                  V62.84/R45.8
            #      %     #      %      #      %     #      %      #      %
1-4 yrs     0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
5-9 yrs     0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
10-14 yrs   1   25.0     0    0.0      0    0.0     0    0.0      0    0.0
15-19 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
20-24 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
25-34 yrs   2   50.0     0    0.0      0    0.0     0    0.0      0    0.0
35-44 yrs   1   25.0     0    0.0      0    0.0     0    0.0      0    0.0
45-54 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
55-64 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
65-74 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
75-84 yrs   0    0.0     0    0.0      0    0.0     0    0.0      0    0.0
85+ yrs     0    0.0     0    0.0      0    0.0     0    0.0      0    0.0

TOTAL       4  100.0     0    0.0      0    0.0     0    0.0      0    0.0

              UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS
                39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide
Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs        # w POV 39     w/ POV 40   w/ POV 41     w/ 39/40/41/
                          V62.84/R45.851 & T14.91                  V62.84/R45.8
             #     %      #      %      #      %     #      %      #      %
1-4 yrs      0   0.0      0    0.0      0    0.0     0    0.0      0    0.0
5-9 yrs      1  11.1      0    0.0      0    0.0     0    0.0      0    0.0
10-14 yrs    1  11.1      0    0.0      0    0.0     0    0.0      0    0.0
15-19 yrs    0   0.0      0    0.0      0    0.0     0    0.0      0    0.0
20-24 yrs    0   0.0      0    0.0      0    0.0     0    0.0      0    0.0
25-34 yrs    3  33.3      0    0.0      0    0.0     0    0.0      0    0.0
35-44 yrs    1  11.1      0    0.0      0    0.0     0    0.0      0    0.0
```

```
45-54 yrs     0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
55-64 yrs     1  11.1     0     0.0     0    0.0     0    0.0      0    0.0
65-74 yrs     0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
75-84 yrs     0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
85+ yrs       2  22.2     0     0.0     0    0.0     0    0.0      0    0.0

TOTAL         9 100.0     0     0.0     0    0.0     0    0.0      0    0.0
```

Figure 12-99: Suicide Purpose of Visit report example

12.5 Print Standard Behavioral Health Tables (TABL)

Use the **TABL** option to print the various BH tables (activity code, clinical codes, and BH Problem Codes).

The **TABL** option accesses the **Print BH Standard Tables** menu (Figure 12-100).

```
                ********************************************
                **       IHS Behavioral Health System       **
                **         Print BH Standard Tables         **
                ********************************************
                            Version 4.0 (Patch 11)

                             DEMO INDIAN HOSPITAL


   ACT    Print Activity Code Table
   CLN    Print Clinic Codes

Select Print Standard Behavioral Health Tables Option:
```

Figure 12-100: Options on the Print BH Standard Tables menu example

12.5.1 Print Activity Code Table (ACT)

Use the **ACT** option to print the **Activity Code** table (Figure 12-101).

```
XX                                  May 04, 2009               Page 1

            ********** BEHAVIORAL HEALTH ACTIVITY CODES **********

CODE DESCRIPTION                                        CATEGORY     PCC   MNE
-------------------------------------------------------------------------------
01   TWELVE STEP WORK - GROUP                        PATIENT SERV  YES   TSG

02   TWELVE STEP WORK - INDIVDUAL                    PATIENT SERV  YES   TSI

03   TWELVE STEP GROUP                               PATIENT SERV  NO    TWG

04   RE-ASSESSMENT, PATIENT PRESENT                  PATIENT SERV  YES   RAS

05   RE-ASSESSMENT, PATIENT NOT PRESENT              SUPPORT SERV  NO
```

```
11   SCREENING-PATIENT PRESENT                              PATIENT SERV  YES   SCN

12   ASSESSMENT/EVALUATION-PATIENT PRESENT                  PATIENT SERV  YES   EVL

13   INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT      PATIENT SERV  YES   IND

14   FAMILY/GROUP TREATMENT-PATIENT PRESENT                 PATIENT SERV  YES   FAM

15   INFORMATION AND/ OR REFERRAL-PATIENT PRESENT           PATIENT SERV  YES   REF

16   MEDICATION/MEDICATION MONITORING-PATIENT PRESENT       PATIENT SERV  YES   MED

17   PSYCHOLOGICAL TESTING-PATIENT PRESENT                  PATIENT SERV  YES   TST

18   FORENSIC ACTIVITIES-PATIENT PRESENT                    PATIENT SERV  YES   FOR

19   DISCHARGE PLANNING-PATIENT PRESENT                     PATIENT SERV  YES   DSG

20   FAMILY FACILITATION-PATIENT PRESENT                    PATIENT SERV  YES   FAC

21   FOLLOWTHROUGH/FOLLOWUP-PATIENT PRESENT                 PATIENT SERV  YES   FOL

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

Figure 12-101: Behavioral Health Activity Codes report example

12.5.2 Print Clinic Codes (CLN)

Use the **CLN** option to print the activity code table (Figure 12-102).

```
CLINIC STOP LIST                                  APR 16,2009  14:22    PAGE 1
NAME                              CODE
------------------------------------------------------------------------------
ALCOHOL AND SUBSTANCE             43
AMBULANCE                          0
ANESTHESIOLOGY                     0
ANTICOAGULATION THERAPY            0
AUDIOLOGY                         35
BEHAVIORAL HEALTH                  0
CANCER CHEMOTHERAPY               62
CANCER SCREENING                  58
CARDIOLOGY                         2
CASE MANAGEMENT SERVICES          77
CAST ROOM                         55
CHART REV/REC MOD                 52
CHEST AND TB                       3
CHIROPRACTIC                       0
CHRONIC DISEASE                   50
COLPOSCOPY                         0
COMPLEMENTARY MEDICINE             0
```

Figure 12-102: Clinic Stop List codes example

13.0 Manager Utilities Module (Roll and Scroll)

The **Manager Utilities** module, shown in Figure 13-1, provides options for Site Managers and program supervisors to customize AMH to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, resetting local flag fields, and verifying users who have edited particular patient records.

```
                ******************************************
                **       IHS Behavioral Health System       **
                **            Manager Utilities             **
                ******************************************
                           Version 4.0 (Patch 11)

                             DEMO INDIAN HOSPITAL


   SITE   Update Site Parameters
   EXPT   Export Utility Menu ...
   RPFF   Re-Set Patient Flag Field Data
   DLWE   Display Log of Who Edited Record
   ELSS   Add/Edit Local Service Sites
   EPHX   Add Personal History Factors to Table
   DRD    Delete BH General Retrieval Report Definitions
   EEPC   Edit Other EHR Clinical Problem Code Crosswalk
   UU     Update Locations a User can See

Select Manager Utilities Option:
```

Figure 13-1: Options on the Manager Utilities menu example

This menu might be restricted to the site manager and the program manager or the designee. Use this menu for setting site-specific options related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and IHS Headquarters for mandated federal reporting and funding.

13.1 Update Site Parameters (SITE)

Use the **SITE** option to modify the parameters in the **Behavioral Health** file. Individual sites use the **Site Parameters** file to set AMH to suit their program needs.

Below are the prompts:

- Select MHSS SITE PARAMETERS

  Specify the location where the program visits take place. If you use a new one, the application confirms that you are using the new one (use **Y** or **N**).

Figure 13-2 shows the Update BH Site Parameters window.

```
** UPDATE BH SITE PARAMETERS **      Site Name: ABERDEEN AO
================================================================================
Update DEFAULT Values?  N
Update Hospital Location Defaults?  N
Default Health Summary Type:

Default response on form print:         Suppress Comment on Suppressed Form?
# of past POVs to display:              Exclude No Shows on last DX Display?
DSM-5 Implementation Date:
Update PCC Link Features?  N
Turn Off EHR to BH Link?
Turn on PCC Coding Queue?  NO          Update Provider Exceptions to E Sig?  N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits? N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:
_____________________________________________________________________________




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

Figure 13-2: Update BH Site Parameters window example

Below are the fields on the window:

- Update DEFAULT Values?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, the application displays Figure 13-3. All default settings are moved to this separate pop-up window.

```
          ****  Enter DEFAULT Values for each Data Item ****
 MH Location: DEMO INDIAN HOSPITAL
 MH Community: TAHLEQUAH                 MH Clinic: MENTAL HEALTH
 SS Location: DEMO INDIAN HOSPITAL
 SS Community: TAHLEQUAH                 SS Clinic: MEDICAL SOCIAL SERVI
 Chemical Dependency Location: DEMO INDIAN HOSPITAL
 Chemical Dependency Community: TAHLEQUAH
 Chemical Dependency Clinic: BEHAVIORAL H
 OTHER Location: DEMO INDIAN HOSPITAL
 OTHER Community: TAHLEQUAH             OTHER Clinic: MENTAL HEAL

 Default Type of Contact: OUTPATIENT
 Default Appt/Walk In Response: APPOINTMENT
 EHR Default Community: TAHLEQUAH
```

Figure 13-3: Pop-up for default values of BH site example

Below are the prompts on the pop-up:

- **MH/SS/CD/OTHER Location:** Specify the name of the location where the program visits take place.
- **MH/SS/CD/OTHER Community:** Specify the name of the community where the program visits occur.
- **MH/SS/CD/OTHER Clinic:** Specify the name of the clinic where the program visits occur.
- **Default Type of Contact:** Specify the type of contact setting or code (e.g., Administrative, Chart Review, etc.).
- **Default Appt/Walk in Response:** Specify the type of visit that occurred (e.g., appointment, walk in, or unspecified).
- **EHR Default Community:** Specify the name of the default community used in the EHR. In order to pass EHR behavioral health encounter records into the **AMH v4.0** files, a **Default Community of Service** field was created on the **AMH v4.0 Site Parameters'** menu. If the facility has opted to pass behavioral health encounter records created in EHR to **AMH v4.0**, the application will populate the **Community of Service** field with the value entered in the site parameter **EHR Default Community** or, if that field is blank, with the default Mental Health community value. If the default **Mental Health** community value is blank, the field will be populated with the default **Social Services** community value; if that field is also blank, the field will be populated with the default **Chemical Dependency** value; and if that field is blank, the default **Other Community** value will be used. If none of the default community fields contains a value, no behavioral health record will be created.

Below are the fields on the update window:

- Update Hospital Location Defaults?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, the application displays Figure 13-4. All default settings are moved to this separate pop-up window.

```
MENTAL HEALTH HOSPITAL LOCATION:

SOCIAL SERVICES HOSPITAL LOCATION:

CHEMICAL DEP/ALCOHOL HOSPITAL LOCATION:
```

```
OTHER PROGRAM HOSPITAL LOCATION
```

Figure 13-4: Pop-up for Update Hospital Location Defaults of BH site example

Below are the prompts on the pop-up:

- **Mental Health Location:** Specify the name of the **Mental Health Hospital Location** where the program visits take place. This depends on how it is set up in the Scheduling application and will populate the **Hospital Location** field in EHR.
- **Social Services Hospital Location:** Specify the name of the **Social Services Hospital Location** where the program visits take place. This depends on how it is set up in the Scheduling application and will populate the **Hospital Location** field in EHR.
- **Chemical Dep/Alcohol Hospital Location:** Specify the name of the **Chemical Dependence/Alcohol Health Hospital Location** Where the program visits take place. This depends on how it is set up in the Scheduling application and will populate the **Hospital Location** field in EHR.
- **Other Hospital Location:** Specify the name of the **Other Health Hospital Location** where the program visits take place. This depends on how it is set up in the Scheduling application and will populate the **Hospital Location** field in EHR.
- **Default HEALTH Summary Type:** Specify the type of health summary printed from within the **AMH** package. Typically, the default value is the **Mental Health/Social Services** summary type. Refer to the **Health Summary System Manuals** for further information on the available types.
- **Default Response on Form Print:** Your response applies to when you print a **Mental Health/Social Services** record. Use one of the following:
  - **B** (both)
  - **F** (full)
  - **S** (suppressed form)
  - **T** (Suppressed–2 copies)
  - **E** (Full–2 copies)
- The suppressed report does NOT display the following information:
  - **Chief Complaint**
  - **SOAP Note**
  - **Measurement Data**
  - **Screenings**

A full encounter form prints all data for a patient encounter including the **SOAP** note. The suppressed version of the encounter form will not display the **SOAP** note for confidentiality reasons. It is important to note that the **SOAP** and **Chief Complaint** will be suppressed, but the comment/next appt, activity code, and POV will still appear on the printed encounter.

- Suppress Comment on Suppressed Form?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  Select **Y** to suppress the provider's comments.

- Number of past POVs to display.

  Specify the number of past POVs to be displayed on the **Patient Data Entry** screen. This response must be a whole number between zero and five.

- Exclude No Shows on last DX Display?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

- DSM-5 Implementation Date.

  From the date listed forward the application will use the **DSM-5 Code Set**. Appendix C: DSM Copyright and Trademark provides additional information.

- Update PCC Link Features?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, the application displays the **Update PCC Link Feature Parameters** pop-up (Figure 13-5).

```
**** Update PCC Link Feature Parameters ****
=================================================

Type of PCC Link

Type of Visit to create in PCC
```

```
Interactive PCC Link?

Allow PCC Problem List Update?

Update PCC LINK Exceptions?
```

Figure 13-5: Fields on the Update PCC Link Feature Parameters pop-up example

The underlined fields are required on the pop-up.

- Type of PCC Link:

  What you use determines the type of data that passes from **AMH** to the **PCC**.

Use one of the following:

- No Link Active.

  Use this option to have the data link between the two modules turned off. No data is passed to the PCC visit file from the AMH application (including the Health Summary). Therefore, because the **RPMS Third Party Billing Package** processes encounters in PCC, an alternative billing process will need to be established. If you leave this field blank, it is the same as choosing this option and no data will pass to PCC.

- Pass STND Code and Narrative.

  Use this option to have all patient contacts in the **Behavioral Health** programs passed to the PCC visit file using the same **ICD-10** code and narrative, as defined by the program. This approach does not facilitate billing because all encounters will appear the same. For example, if the code and narrative are entered in the site parameters as **Z71.9, Encounter**, all encounters will have the ICD code of **Z71.9** and narrative of **Encounter**.

- Pass All Data as Entered (No Masking).

Use this option to have all **DSM-5-TR** and **Problem Codes** passed as **ICD** codes as shown in the crosswalk along with the narrative as written by the provider. This link type is the one most preferred by billers and coders since the actual **ICD** code and narrative display in PCC.

- Pass Codes and Canned Narrative.

  Use this option to have both **DSM-5-TR** and **Problem Codes** converted to **ICD** codes as shown in the 1crosswalk and passed with a single standard narrative, as defined by the program, for all contacts. This type of link facilitates billing by passing the POV entered in AMH as **ICD** codes although the standard narrative is not passed to the Health Summary.

For **Pass STND Code and Narrative** and **Pass Codes and Canned Narrative** options, the application displays the **Standard Code to Use** pop-up (Figure 13-6).

```
Standard ICD-9 Code to Use (Option 2 and 5 ONLY): V65.40

Standard ICD-10 Code to Use (Option 2 and 5 ONLY): Z71.9

Narrative for MH Program: MH/SS/SA COUNSELING

Narrative for SS Program: SS VISIT
```

Figure 13-6: Standard code to use screen example

With each of these link types, standard data is passed to the PCC. You can specify those standards using the **Standard Code to Use** screen. The standard code, shown in the first line, will be passed if using **Pass STND Code and Narrative**. The narrative entered will be the only narrative passed if you have selected **Pass STND Code and Narrative** and **Pass Codes and Canned Narrative** options.

- Type of Visit to create in PCC:

  What you use determines the type of visit created from the encounter record you enter into AMH. Use one of the following, depending on the classification of the BH programs at your facility.

  - **I (IHS)**
  - **(Contract)**
  - **(638 Program)**
  - **(Tribal)**
  - **O (Other)**
  - **V (VA)**
  - **P (Compacted Program)**

- **U (Urban Program)**

- Interactive PCC Link?:

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  The AMH site parameters contain a question about an interactive PCC link to address an issue with the **PIMS Scheduling** package. Because it is possible to set up a clinic in the Scheduling package that initiates a PCC record at check in, some sites were creating two separate records for each individual patient encounter in the behavioral health clinics. Leaving the field blank is the same as using **N** (for this prompt) and the interactive link will not be turned on.

  In the **Scheduling** package, if the clinic set-up response is **YES** to the question about creating an encounter at check in, then the **Interactive PCC Link** question in the AMH site parameters must also be answered **YES**. If the clinic set up in the **Scheduling** package has a negative response, then the **Interactive Link** question in AMH should be set to **NO**.

  Note: There should never be a mismatched response where one package has **YES** and the other **NO**.

- Allow PCC Problem List Update?:

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  Use **Y** to allow the ability to update a patient's PCC problem list from within AMH.

- Update PCC LINK Exceptions? (Figure 13-7):

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

Use **Y** to determine if you want to set data passing parameters for individuals that are different from the program default.

```
Provider Name          Type of PCC Link for this Provider
DEMO,LORRAINE          NO LINK ACTIVE
DEMO,BILL              PASS CODE AND STND NARRATIVE
DEMO,GREG              PASS STND CODE AND NARRATIVE
DEMO,MARY              PASS ALL DATA AS ENTERED
```

Figure 13-7: Setting up PCC link exceptions example

Below are the fields on the update window:

- Turn Off EHR to BH Link?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  A site parameter was created to give sites the ability to opt out of the new **Behavioral Health (BH) Electronic Health Record (EHR)** visit functionality. This functionality allows BH providers to enter a visit into the EHR that passes first to PCC and then to the behavioral health database (AMH). These visits display in the **EHR** as well as the **BH** applications, **AMH v4.0** and the **RPMS AMH v4.0 GUI**.

  The name of the site parameter is **Turn Off EHR to BH Link** and it is accessed via the **AMH v4.0 Manager Utilities** module **SITE** menu option. The default setting on this new site parameter is **NO** and no action is required if sites will be deploying the **BH EHR** functionality. If sites will not be deploying the **BH EHR** visit functionality, then the site parameter should be changed to **YES**.

- Turn on PCC Coding Queue?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

If you use **Y**, the visits will not be passed directly to the billing package. The visits will be marked as incomplete and must be reviewed by local data entry staff, billers, or coders.

If you use **N**, all visits will continue to pass to PCC as complete.

Because the visits entered in the AMH have always been marked as complete, the visits were going through PCC to the claims generator without review. With this version of the software, sites are given the option of transmission to the **Coding Queue** or continuing to send visits to PCC marked as complete.

In addition to establishing an option on the site parameters' menu to turn on the **Coding Queue**, an option that can be placed on data entry staff's RPMS menu has been created. Because the **SOAP/Progress Notes** related to visits created in AMH do not pass to PCC, the data entry staff, billers, and/or coders needed some method to access the notes for review. The option will allow them to review the specifics for a particular visit but will not give them full access to AMH. For example, they will not be able to view treatment plans, case status information, or the Suicide Reporting Forms.

Turning on the link to the **Coding Queue** in the **AMH** should not be done if the **PCC Coding Queue** has not been activated. However, if the **PCC Coding Queue** has been activated and the site wants the AMH generated visits to be reviewed, complete the following steps:

1. Log in to **AMH v4.0** and select the **Manager Utilities** menu.
2. Select the **Site Parameters** option and enter the name of the site you want to update.
3. On the site parameters entry window, scroll down to the **Turn on PCC Coding Queue** field.
4. Type **Y** at this field.
5. Save the changes to the site parameters.

   Once the coding queue option has been turned on and the changes to the site parameters are saved, any visits documented in **AMH v4.0** will be flagged as incomplete. Visits created the same day but before the site parameters were changed will still be marked as complete. The date and time the visit was entered in RPMS determines the flag to be applied, not the date and time of service.

- Update Provider Exceptions to E Sig?

  Use one of the following:

  – **Y** (Yes)

Or

– **N** (No)

The electronic signature function is available on the **PDE**, **SDE**, **Intake**, and **Group entry** menus (in roll and scroll) and also available on the **One Patient**, **All Patients**, **Intake**, and **Group entry** menus (in the GUI). Only those encounter records with signed SOAP/Progress Notes will pass to PCC.

If you use **Y**, Figure 13-8 displays.

```
Electronic Signature will not be activated for providers added to
this list.

PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
```

Figure 13-8: Place to list provider exceptions to electronic signature example

Populate the **PROVIDER** field with the name of provider with exception to electronic signature.

Because some sites might still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a particular provider should be exempted from the electronic signature, those visits will pass to PCC but show up as unsigned on the visit entry display.

- Update those allowed to see all records?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  Use **Y** to determine if you want to update those allowed to see all records.

- If the user's name is added to this list, the user will be able to see all records entered into the system, whether the user was the provider of the visit or not, or whether the provider created the record or not.
- If the user's name is not added to this list, only those encounter records the user created or those on which the user was a provider will be visible to that user.

The **Help** prompt has been updated and provides the following information when the user types in a question mark (**?**): If users need to see records other than their own, their names should be added to this list. Type a **Y** to update the list.

If you use **Y**, Figure 13-9 displays. You can add another user to the list. This new user will be able to see all visits when using the **SDE** or **PDE** options.

```
Enter only those users who should be permitted to see all Visit and Intake
records for all patients whether they were the provider of record or the
user who entered the record or not. Users not entered on this list will see
only those Visits or Intake records that they entered or for which they
were the provider of record. This parameter applies to the SDE menu option
and all other options that display Visit and Intake information.
 ------------------------------------------------------------------------
+DEMO,SHIRLEY
 DEMO,LISA M
 DEMO,SUSAN P
 DEMO,WENDY
```

Figure 13-9: List of names allowed to see all records example

- Update those allowed to override delete?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  Use **Y** to determine if you want to update those allowed to override delete.

  If you use **Y**, Figure 13-10 displays. You can add another name to the list.

```
Enter only those users who should be permitted to delete any Intake
document, signed or unsigned, whether they are the user who
entered the Intake document or the provider of record.
------------------------------------------------------------------------

DEMO,MARK
DEMO,RONALD D SR
DEMO,KAREN
```

Figure 13-10: List of names allowed to delete any Intake document example

- Update those allowed to share visits?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

Use **Y** to update those allowed to share visit information via RPMS mail message.

If you use **Y**, Figure 13-11 displays. Here you can add a new name at the **User allowed to share visits via mail** prompt. All users permitted to share visit information via RPMS mail messages should be entered here.

```
Entering users into this field will give them access to send a copy of
 a completed encounter form (either full or suppressed) to other
 RPMS users.  Keep confidentiality issues in mind when deciding on
 who should be given this access.

 User allowed to share visits via mail: DEMO,BJ
 User allowed to share visits via mail: DEMO,WENDY
 User allowed to share visits via mail: DEMO,RYAN
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
```

Figure 13-11: Sample pop-up to enter user names allowed to share visits via mail example

- Update those allowed to order Labs?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  Use **Y** to permit those allowed to order lab tests.

  If you use **Y**, Figure 13-12 displays. Here you can add a new name at the **User Permitted to Order Labs** prompt. All users permitted to order lab tests should be entered here.

```
The users that you enter into this field will be given access to
order LAB tests through the SEND PATIENT option.
If a user is not entered here he/she will not be granted access to the
LAB SEND PATIENT option.


User Permitted to Order Labs:
User Permitted to Order Labs:
User Permitted to Order Labs:
```

Figure 13-12: Pop-up to enter user names allowed to order labs example

If you are using the **RPMS Pharmacy System**, enter the **Division**.

Specify the name of the division for the **RPMS Pharmacy System**.

13.2 Export Utility Menu (EXPT)

Use the **EXPT** option to access the options on the Export Utility Menu (Figure 13-13).

```
                              DEMO INDIAN HOSPITAL


   GEN    Generate BH Transactions for HQ
   DISP   Display a Log Entry
   PRNT   Print Export Log
   RGEN   Re-generate Transactions
   RSET   Re-set Data Export Log
   CHK    Check Records Before Export
   EDR    Re-Export BH Data in a Date Range
   ERRS   Print Error List for Export
   OUTP   Create OUTPUT File
   SAE    Set Automated Export Option

Select Export Utility Menu Option:
```

Figure 13-13: Options on the Export Utility Menu example

Use the options on this menu to pass data from your facility to the **IHS Headquarters** office for statistical reporting purposes.

Warning:	This set of utilities should only be accessed and used by the site manager, the BH program manager, or designee.

These options should be familiar to site managers and other RPMS staff who generate exports. The recommended sequence for their use follows those from **PCC- CHK**, **clean**, **GEN**, **DISP**, **ERRS**, and **transmit**. **RGEN**, **RSET**, and **OUTP** should be reserved for expert use as required.

13.2.1 Generate BH Transactions for HQ (GEN)

Use the **GEN** option to generate **AMH transactions** to be sent to **HQ**. The transactions are for records posted between a specified date range.

The transactions are for records posted since the last time you did an export up until yesterday. Both **BH** visit records and **Suicide** forms will be exported.

Type the caret (^) at any prompt and the application will ask you to confirm your entries prior to generating transactions.

Figure 13-14 displays.

```
The inclusive dates for this run are DEC 28,2008 through APR 18,2009.
The location for this run is DEMO INDIAN HOSPITAL.
Do you want to continue? N//
```

Figure 13-14: Sample information before continuing example

- Do you want to continue?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, the prompts continue. If you use **N**, you return to the Export Utility menu.

- Do you want to QUEUE this to run at a later time?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, the generation will be put in the queue. If you use **N**, the generate process continues. The **BH export** generally takes less than five minutes to generate. It will still tie up your computer while doing the export (but it is quick). Figure 13-15 shows a sample.

```
Enter beginning date for this run:   SEP 1, 2008

  The inclusive dates for this run are   SEP 1, 2008   THROUGH   SEP 30, 2008
  The location for this run is the _________________HOSPITAL/CLINIC.

  Do you want to continue (Y/N)  N// Y

  Generating transactions.     Counting records    (  * 100*    )

  *100* Transactions were generated.
  Updating log entry.
  Deleting cross reference entries (100)

  RUN TIME  (H.M.S): 0.3.56
```

Figure 13-15: Sample information for generating the new log entry example

13.2.2 Display a Log Entry (DISP)

Use the DISP option to display the extract log information in a specified date range.

- Select MHSS EXTRACT LOG BEGINNING DATE

Specify the extract log beginning date. (You can view the extract date by typing a question mark [?] at this prompt.)

- DEVICE

  Select the device to output the log information.

Figure 13-16 shows the extract log information.

```
NUMBER:  2                          BEGINNING DATE:  SEP 1,  2008
      ENDING DATE:   SEP 30, 2008@10:26:49
      RUN STOP DATE/TIME:   OCT 2, 1994@10:30:51
      COUNT OF ERRORS:  2        COUNT OF TRANSACTIONS:  98
      COUNT OF RECORDS PROCESSED:  100         RUN LOCATION:  _____________
      # ADDS:  97                    # MODS:  1
      # DELETES: 0
      TRANSMISSION STATUS:  SUCCESSFULLY COMPLETED
```

Figure 13-16: Sample extract log information example

13.2.3 Print Export Log (PRNT)

Use the PRNT option to display the export extract log report.

The application displays the previous selection beginning date.

- START WITH BEGINNING DATE

  Press **Enter** to accept the default date. Otherwise, specify the first beginning date of the date range.

- GO TO BEGINNING DATE

  Press **Enter** to accept to default date. Otherwise, specify the next beginning date.

- DEVICE

  Specify the device to print/browse the log.

The application displays the **Mental Health/Social Service Export Extract Log** (Figure 13-17).

```
                  *****MENTAL HEALTH/SOCIAL SERVICES*****
                         ***EXPORT EXTRACT LOG***          PAGE:   1
                                                        REPORT DATE:   04/20/09
                           ADDS    DEL     MODS    TRANS  ERROR   RECORD
 ============================================================================
3    10/24/06  12/21/06                              39     10      45
     10/24/06  12/21/06
4    12/20/06  05/14/07                             256     34     278
     12/20/06  05/14/07
5    05/13/07  08/22/07                             128     55     181
     05/13/07  08/22/07
6    08/21/07  10/03/08                             537     77     595
```

```
     08/21/07  10/03/08
7    10/02/08  11/17/08                              21      4      17
     10/02/08  11/17/08
8    11/16/08  12/10/08                             185     12     180
     11/16/08  12/10/08
9    12/09/08  12/29/08                              33      0      33
     12/09/08  12/29/08
                           ------  ------  ------  -----  -----  ------
TOTAL                      0       0       0       1199   192    1329
```

Figure 13-17: Sample export extract log example

13.2.4 Re-generate Transactions (RGEN)

Use the **RGEN** option to re-generate transactions between two dates.

Warning: Do not use this option if you are not an expert user.

The prompts are below:

- Select MHSS EXTRACT LOG BEGINNING DATE

  Specify the beginning date.

If you specified an existing date, Figure 13-18 displays.

```
Log entry 6  was for date range MAR 2, 2007 through JUN 16, 2007
And generated 44 transactions from 67 records.

This routine will generate     transactions.

Do you want to regenerate the transactions for this run?  N//
```

Figure 13-18: Sample information about re-generate transactions example

13.2.5 Re-set Data Export Log (RSET)

Use the **RSET** option to reset the **BH Data Transmission Log**. You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place.

The **BH Data Transmission** log entry you choose will be REMOVED from the log file and all Utility and Data globals associated with that run will be killed.

Warning: You must now select the Log Entry to be reset. <Select carefully>

The BH Data Transmission log entry you choose will be removed from the log file and all Utility and Data globals associated with that run will be killed.

13.2.6 Check Records Before Export (CHK)

Use the **CHK** option to review all records that were posted to the BH database since the last export. It will review all records that were posted from the day after the last date of that run up until two days ago.

Figure 13-19 shows the BH Export Record Review report.

```
                              DEMO INDIAN HOSPITAL                        Page 1
                           BH EXPORT RECORD REVIEW
                 Record Posting Dates:  APR 19, 2009 and APR 20, 2009


RECORD DATE            PATIENT               HRN     PGM  TYPE            ACT TYPE
-------------------------------------------------------------------------------

APR 20, 2009@09:44     DEMO,CHELSEA MARIE 116431   S   OUTPATIENT        16
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@09:51     DEMO,EDWIN RAY       105321   S   OUTPATIENT         85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:46     DEMO,EDWIN RAY       105321   S   OUTPATIENT         85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:56     DEMO,SERGIO         206293   S   OUTPATIENT         15
E023-NO AFFILIATION FOR PROVIDER

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-19: Sample report about records before export example

13.2.7 Print Error List for Export (ERRS)

Use the ERRS option to print/browse the report that shows all records that have been posted to the database and are still in error AFTER the latest Export/Generation.

If the records are listed here, they aren't passing to PCC and the billing package.

Below are the prompts:

- Select MHSS EXTRACT LOG BEGINNING DATE

  Specify the extract log beginning date. (You can view the extract date by typing a question mark [**?**] at this prompt.)

> **Note:** Use the **Check Records before Export** option to determine all errors before running the generation. Correct these remaining errors before the next export/generation.

- DEVICE

Specify the device to print/browse the report.

Figure 13-20 shows the **MHSS Extract Log Error Report**.

```
MHSS EXTRACT LOG ERROR REPORT                  APR 20,2009  13:15    PAGE 1
                                                                       ACT
VISIT DATE           PATIENT              HRN     PGM  TYPE            TYPE
-------------------------------------------------------------------------------


AUG 21,2006  17:44   ALPHAAA,STEVEN ALLAN  165583  S    OUTPATIENT      31
ERROR: E021-NO PURPOSE OF VISIT

 68,1700
ERROR: E023-NO AFFILIATION FOR PROVIDER

Press ENTER to Continue:
```

Figure 13-20: Sample MHSS Extract Log Error Report example

13.2.8 Create OUTPUT File (OUTP)

Use the **OUTP** option to create an output file. Consult with the site manager on how to create an RPMS export.

13.2.9 Set Automated Export Option (SAE)

These options control the destination of the **BHSX Export** once it is generated. If no selection is made the application comes set with **option 1 Automatically Send Export to HQ**.

- Select HSS SITE Parameters

  Use the site parameter to set the destination for the export file.

- Auto Export Option

  Use one of the following:

  - **1** Automatically Send Export to HQ
  - **2** Automatically Send Export to Area
  - **3** Automatically Send Export to Both Area and HQ
  - **4** Do Not Automatically Send Exports

13.3 Re-Set Patient Flag Field Data (RPFF)

Use the **RPFF** option to reset all patient flag fields to null. This should be done each time you want to flag patients for a different reason. You can reset one particular flag or all flags. You may use this reset option to reassign a particular flag, or all flags as needed.

Below are the prompts:

- Reset which flags:

  Use one of the following:

  – **A** (all flags)

  Or

  – **O** (one particular flag)

  If you use **O**, other prompts will display.

- Are you sure you want to do this?

  Use one of the following:

  – **Y** (Yes)

  Or

  – **N** (No)

  If you use **Y**, Figure 13-21 shows the information.

```
Hold on... resetting data..
All done.
```

Figure 13-21: Information from the application about the reset process example

13.4 Display Log of Who Edited Record (DLWE)

Use the **DLWE** option to display a list of who edited a **BH** record.

Below are the prompts:

- Enter ENCOUNTER DATE
  - Specify the date of the encounter.
- Enter LOCATION OF ENCOUNTER
  - If known, specify the location. Otherwise, press Enter.
- Enter PATIENT
  - Specify the name of the patient.

Figure 13-22 shows the **Behavioral Health Visits** for the date specified. The following examples were visits with no location and no patient.

```
------------------------------------------------------------------------------
            Behavioral Health visits for Dec 10, 2015
------------------------------------------------------------------------------
 #     PROVIDER   LOC  COMMUNITY ACT CONT PATIENT      PROB    NARRATIVE
------------------------------------------------------------------------------
   1 BJB DEMO,CHELSEA M WW116431    60  16  F84.0     AUTISM SPECTRUM DISORDER
```

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

Which record do you want to display:  (1-7):
```

Figure 13-22: Behavioral Health Visits window example

You can display the visit data for a particular record by responding the **Which record do you want to display?** prompt. Figure 13-23 shows the visit data.

```
MHSS RECORD LIST                                APR 20,2009  11:31    PAGE 1
DATE
CREATED      WHO ENTERED RECORD   LAST MOD   USER LAST UPDATE
         DATE/TIME EDITED         WHO EDITED
-------------------------------------------------------------------------------

04/10/09     DEMO,BJ           04/10/09   DEMO,BJ
         APR 10,2009  12:01       DEMO,BJ

End of report.  Press enter:
```

Figure 13-23: Report about visit data of a particular record example

13.5 Add/Edit Local Service Sites (ELSS)

Use the **ELSS** option to add/edit location service sites. If you add a new location service site, you give it a name and abbreviation. Counts of these visits can be recovered using the **GEN** option in **Encounter Reports** or **ACT** in the **Workload** reports.

The prompts are below:

- Select MHSS LOCAL SERVICE SITES

  Specify a new or existing local service site. Specify a new service site using **3–30** characters.

  If you specify a new service site, the application confirms that you are adding this new service site (use **Y** or **N**); if you use **N**, the above prompt repeats.

  If you specify an existing factor, for example, **HEADSTART**, the application displays the following prompt:

- LOCAL SERVICE SITE: HEADSTART//

You can accept the existing service site by pressing **Enter**. Otherwise, you can give it a new service site name.

- ABBREVIATION: HEAD

  You can accept the abbreviation of the existing service site by pressing Enter. Otherwise, you can give it another abbreviation.

13.6 Add Personal History Factors to Table (EPHX)

Use the **EPHX** option to add personal history factors to the four-item list initially identified for use in **BH** programs. Added items will be shown as items in the Personal History field any place this option exists in a Select or Print field in the GEN reports.

The prompts are below:

- Enter a PERSONAL HISTORY FACTOR

  Specify a new or existing personal history factor. If you use a new factor, using **3–30** characters, with no numeric or starting with punctuation.

  If you specify a new factor, the application confirms that you are adding this new factor (use **Y** or **N**); if you use **N**, the above prompt repeats.

  If you specify an existing factor, for example, **FAS**, the application displays the following prompt:

- FACTOR: FAS//

  You can accept the existing factor by pressing **Enter**. Otherwise, you can give it a new factor name.

13.7 Delete BH General Retrieval Report Definitions (DRD)

Use the **DRD** option to delete a **PCC Visit** or **Patient General Retrieval** report definition. This option enables the user to delete a **PCC Visit** or **Patient General Retrieval** report definition. For example, if a provider had created multiple report definitions using **GEN** or **PGEN** and saved the logic, these reports may be deleted when the provider leaves the facility.

The prompts are below:

- REPORT NAME

  Specify the name of the report whose definition you want to remove. Use a question mark (**?**) at this prompt to view a list of existing definitions.

- Are you sure you want to delete the [report name] definition?

The [**report name**] is the name of the report you specified in the previous prompt.

Use one of the following at the confirmation prompt:

– **Y** (Yes)

Or

– **N** (No)

13.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

Use the **EEPC** option to loop through all **MHSS PROBLEM/DSM-5** table entries created by EHR users to change the grouping from the generic **99.9 OTHER EHR CLINICAL** grouping to a more specific **MHSS PROBLEM CODE** grouping.

In the RPMS behavioral health applications, the Purpose of Visit (POV) is recorded as either a **BH Problem Code** or **DSM-5** code. For the purpose of reports, these codes are grouped within larger problem code groupings and then again in overarching categories. For example, **DSM-5 code F32.0 Major Depressive Disorder, Single Episode, Mild** is also stored as problem code grouping **14 Depressive Disorders** and problem category **Psychosocial Problems**.

In the **RPMS EHR**, the POV is recorded using **ICD-10** or **SNOMED** codes that are mapped to **ICD** codes and pulled into **AMH**, not **DSM-5** codes. Many **ICD** and **DSM** numeric codes are identical. There may be instances when a provider selects an ICD code that does not have a matching DSM code. When this occurs, it will be dynamically added to the **MHSS PROBLEM/DSM-5** table. Once the **ICD** code is in the **MHSS PROBLEM/DSM-5** table, then it is accessible to users in **AMH** as well.

These **ICD** codes that have been added to the **MHSS PROBLEM/DSM-5** table will not have been automatically assigned to the appropriate **BH** problem code group. To ensure that these **ICD** codes are captured in **AMH** reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time.

Below are sample prompts for a site:

- CODE: V72.3
- ICD Narrative: GYNECOLOGIC EXAMINATION

13.8.1 Enter the Problem Code Grouping

Specify the grouping code for the above **Code** and **ICD Narrative**.

The application provides you with the caret (^) option so that you don’t have to go all the way through the entries.

13.9 Update Locations a User Can See (UU)

Use the **UU** option to specify the location a user can view in this application.

AMH v4.0 contains a new field called **BH User** that will permit a site to screen the locations that a user may access to view or enter information.

If a site wants to limit the visits by location that a BH user can access then they will enter that user into this file and list all the facilities/locations that that user is allowed to see or access. If an entry is made in this file for a user, that user will only be able to look up patients with a health record at those facilities, only patients with health records at those facilities will display on patient lists and reports, and that user will only be able to view/access visits to those locations. If a user is not entered into this file, that person will be able to see visits to all locations. This file will only be updated if a site is multi-divisional and there is a need to restrict the viewing of data between sites.

- Select BH USER NAME

  Specify the user you want to use. This will add the user to the **BH User** file. A **ScreenMan** screen will pop-up and the manager can enter all of the locations that the user is able to access or see on the screen.

Figure 13-24 shows the Update Visit Locations a User can See window.

```
****  Update Visit Locations a User can See ****
USER: DEMO,LORI

Location: DEMO INDIAN HOSPITAL
Location: SELLS HOSP
Location:
Location:
Location:

_____________________________________________________________________________




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

Figure 13-24: Update Visit Locations a User can See screen example

- Location

Specify the location that the user can view in this application.

Users can specify more than one location. If this is the case, use the next **Location** field.

In the above example, the provider Lori Demo will only be able to access visits to Demo Indian Hospital and Sells Hospital. If a patient that she is treating had a visit to Phoenix Hospital, she would not see that visit information. This logic applies to any option that displays or reports on visit data. For example, Lori Beta chooses option **Browse Visits**, she would not see any visit in the visit list that was to a location other than the two listed above.

Appendix A Activity Codes and Definitions

AMH 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.—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.–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.

67-Opiate Treatment/Maintenance (OPI)

Services related to opioid treatment and/or maintenance when the patient is present.

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.

68-Opiate Treatment/Maintenance (OPI)

Services related to opioid treatment and/or maintenance when the patient is not present.

A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes the following:

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

Activity Code	Description	Pass to PCC
34	Other Support Services–Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening–Patient Not Present	No
45	Assessment/Evaluation–Patient Not Present	No
47	Couples Treatment–Patient Present (CT)	Yes
48	Crisis Intervention–Patient Present (CIP)	Yes
49	Crisis Intervention–Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
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
67	Opiate Treatment/Maintenance–Patient Present (OPI)	Yes

Activity Code	Description	Pass to PCC
68	Opiate Treatment/Maintenance–Patient Not Present (OPI)	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

In all instances where any portion of the WORK or DSM-5 appears, the source and copyright status of the material must appear where the text appears and in all marketing materials. The following notice shall be used:

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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 an 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 website.

Note: Users must be logged on to the **IHS D1 Intranet** to access these documents.

https://home.ihs.gov/security/index.cfmhttp://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 mechanisms 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—A 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
AMH	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	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
PCC	Patient Care Component
RPMS	Resource and Patient Management System

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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