RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System (AMH)

Patch 4 Addendum

Version 3.0 Patch 4
June 2005

Office of Information Technology
Albuquerque, New Mexico
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1.0 Introduction

Please review these changes and add a copy of them to any printed documentation your site may be using for Behavioral Health System v3.0. These changes will be integrated into future versions of the software and user manuals and will no longer be considered an addendum at the time of the next release.

Patch 4
Patch 4 of the Behavioral Health System v3.0 contains the following changes:

- New prompts added to the Regular Visit screen. (Section 2.0)
- Patient Education changes:
  - A new prompt has been added to display the client’s education history when entering patient education data. (Section 3.1)
  - The patient education entry screen has been updated to accommodate a new comment field. The comment data is passed to PCC. (Section 3.2)
  - The printed encounter form now has a comment field in the patient education section.
  - All patient education data elements will now display on the health summary.

- A new prompt has been added to display the client’s health factor history when entering health factors. (Section 4.0)

- A new group data entry option has been added, allowing you to define a group and repeatedly re-use that group definition, if appropriate. (Section 5.0)

- Intake document modifications:
  - The Intake document has been modified to add new fields for initial intake and to prompt for these fields. 6.1
  - A print intake document option has been added as a selection item to the Intake document update screen. 6.2

- Suicide Form changes:
  - Several changes have been made to the Suicide form. 7.0
  - The Suicide reports have been modified to accommodate the changes in the Suicide form.

- The Treatment Plan menu and reports have been modified.
  - The Treatment Plan menu has been rearranged. 8.1
  - A new prompt has been added when running the Treatment Plan reports.
The Treatment Plan reports have been modified to display patient name, DOB, chart, date established, date next review, date resolved, responsible provider, and program.

A new Treatment Plan Report has been added that will list all treatment plans on file.

New IPV/DV options:
- A new prompt has been added to display intimate partner violence/domestic violence history when entering IPV screening. (Section 9.1)
- There are now 5 new IPV/DV Screening reports which are controlled by a security key (Section 9.2)
- The IPV/DV exam now passes the examining provider to PCC.

Behavioral Health export option changes:
- The Behavioral Health export option has been rewritten to include additional data elements and the suicide forms.
- A new option has been added to the export option, allowing the re-export of data for a date range.

Health factors and IPV/DV screenings have been added to the BH section of the health summary.

When printing group encounter forms, the header of the display will read: Computer Generated Group Encounter.

Administrative Entry now prompts for Number Served.

Patch 3
No patch addendum for patch 3. Please refer to the patch 3 note file for details of the changes included in patch 3.

Patch 2
No patch addendum for patch 2. Please refer to the patch 3 note file for details of the changes included in patch 2.

Patch 1
No patch addendum for patch 2. Please refer to the patch 3 note file for details of the changes included in patch 2.
2.0 Regular Visit Screen

The Visit(s) screens (except for No Show) have been modified to accommodate two new prompts and one revised prompt: Arrival Time, SOAP/Progress Note, and IPV/DV Screening.

```
* BEHAVIORAL HEALTH VISIT UPDATE * [press <F1>E when visit entry is complete]
Encounter Date: JAN 27, 2005                     User: USER, LORI AN
Patien Name: JONES, ABBY   DOB: 11/10/57    HR#: 197364
---------------------------------------------------------------------------
PROGRAM: MENTAL HEALTH   LOCATION OF ENCOUNTER: CIMARRON HOSPITAL
CLINIC: MENTAL HEALTH    APPOINTMENT OR WALK-IN: APPOINTMENT
TYPE OF CONTACT: OUTPATIENT    ARRIVAL TIME: 12:00
COMMUNITY OF SERVICE: BLACK RIVER FALLS HC Any Secondary Prov.
Chief Complaint:
SOAP/PROGRESS NOTE <press enter> Comment/Next Appointment <press enter>:
Display Current Medications? N MEDICATIONS PRESCRIBED <enter>: PURPOSE OF VISIT (POVS) <enter>:
Any Patient Education Done? N Placement Disposition:
Any Health Factors to enter? N IPV/DV Screening? N
*** Administrative Data Items for this Visit ***
ACTIVITY: ACTIVITY TIME:   # SERVED: 1 VISIT FLAG: INTERPRETER?
Any CPT Codes to enter? Y LOCAL SERVICE SITE: STAGING TOOL UPDATE?
COMMAND: Press <PF1>H for help Insert
```

Figure 2-1: Modified Regular Visit Screen
3.0 Patient Education Entry Screen

3.1 New Display Patient Education History Option

The patient education entry screen has been modified to include a display of a client’s education history.

Type Y at the “Display Patient Education History?” prompt to display the client’s patient education history for the past 2 years from both the Behavior Health system and the Patient Care Component. The history will be displayed in reverse chronological order.
3.2 New Fields

The patient education entry has been modified to include a display of a patient’s education history and to capture comments.

After entering an education topic the Patient Education Entry screen displays. To exit this screen use F1 C or F1 E.

<table>
<thead>
<tr>
<th>EDUCATION TOPIC: CD-MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDIVIDUAL/GROUP:</td>
</tr>
<tr>
<td>MINUTES:</td>
</tr>
<tr>
<td>LEVEL OF UNDERSTANDING</td>
</tr>
<tr>
<td>PROVIDER:</td>
</tr>
<tr>
<td>COMMENT:</td>
</tr>
</tbody>
</table>

*Figure 3-3: Modified Patient Education entry screen*
4.0 **Modified Health Factor Entry Screen**

The health factor entry has been modified to include a display of a patient’s health factor history.

![Figure 4-1: New “Display Health Factor History” prompt.](image)

Type Y at the “Display Health Factor History?” prompt to display the patient’s health factor history for the past 2 years from both the Behavior Health module and the Patient Care Component. The history will be displayed in reverse chronological order.

![Figure 4-2: Historical listing of the client’s health factors](image)
5.0 **Group Form Data Entry Using Group Definition (GP)**

Use this new option to define a group and then apply that group definition each time the group session is held. This eliminates redundant entry of the basic information for the group meetings.

Figure 5-1 shows the master screen for group entry, sections 5.1 through 5.7 explain each of the available options.

![Figure 5-1: Group Entry Screen](image)

<table>
<thead>
<tr>
<th>Group Entry</th>
<th>Jan 28, 2005 09:45:13</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Group Name</td>
<td>Activity</td>
</tr>
<tr>
<td>01/28/05</td>
<td>MARITAL SESSION, TUE GROUP TRE M MENTA JONES,PA</td>
<td>OUT 56 - MAR</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

1. Add a New Group
2. Display Group Entry
3. Duplicate Group
4. Delete Group
5. Print Encounter Forms
6. Review/Edit Group Visits
7. Add No Show Visit
Q. Quit

Select Action:++/

---

5.1 **Add a New Group (1)**

Use this option to add a new group entry.

**To add a new group, follow these steps:**

1. Type 1 at the “Select Action:” prompt.

2. You will be prompted to enter several items as part of the group definition. These items will be used when creating a visit for each patient in the group. The items are as listed below:

   - Providers (Primary or Secondary) who facilitated the group
   - Encounter Date
   - Arrival Time
   - Program
   - Group Name
   - Community of Service
   - Clinic
   - Activity code
- Encounter Location
- Activity Time (total time the group session lasted)
- Type of Contact
- POV or DSM (Primary Group Topic)
- CPT Code(s) (if relevant)
- S/O/A/P (Standard Group Note)
- Patients attending the group session

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

Add/View/Update Providers (Primary or Secondary) for this Group? Y  
Encounter Date: JAN 28, 2005    Arrival Time: 12:00
Program:                      Community of Service:  
Group Name:                   Activity:  
Clinic:                       Activity Time:  
Encounter Location:          Type of Contact:
POV or DSM (Primary Group Topic) <press enter>:  
CPT Code(s) <press enter>:  
S/O/A/P (Standard Group Note) <press enter>:  
Patients <press enter>:  

Figure 5-2: Screen used for entering group definition

3. Once all of this information is entered, including the clients who attend the  
group session, the Group Definition confirmation screen will display (Figure  
5-3).

4. Type Y at the “Do you wish to continue on to add patient visits for this  
group:” prompt to confirm that the values entered are correct.
You have added the following group definition, please review it carefully before you proceed.

**DATE OF SERVICE:** JAN 28, 2005 12:00

**GROUP NAME:** MARITAL SESSION, TUESDAY'S

**LOCATION OF ENCOUNTER:** CIMARRON HOSPITAL

**COMMUNITY OF SERVICE:** LAKE CITY

**TYPE OF CONTACT:** OUTPATIENT

**CLINIC:** MENTAL HEALTH

**PROVIDER:** JONES, PATSY

**POV:** 56

**SUBJECTIVE/OBJECTIVE:** Tuesday Evening group session on marital issues.

**PATIENT:** GUMP, FOREST

**PATIENT:** JONES, ABBY

**PATIENT:** SMITH, AARON

Select one of the following:

Y   Yes, group definition is accurate, continue on to add visits

N   No, I wish to edit the group definition

Do you wish to continue on to add patient visits for this group: Y/

---

5. A visit record will be created for each patient in the group. You will be prompted to enter additional data specific to the individual patient after each record is created.

6. Record the number of minutes this client spent in the group session at the “Time this patient spent in group:” prompt.

7. If there are additional POV’s for this client, enter them at the “Enter Another Problem-POV:” prompt.

8. Type Y at the “Edit?” prompt to add any additional comments to the standard SOAP note. Otherwise type N.
Adding records for each individual patient in this group.

Now adding record for GUMP, FOREST

Creating new record for GUMP, FOREST.

Time this patient spent in group: 60//

Patient's Diagnoses from last visit:
12/16/04  22  SLEEP DISORDER
Provider: DG AXIS IV:

Enter ANOTHER Problem-POV:
SOAP/PROGRESS NOTE:
Tuesday Evening group session on marital issues.

Edit? NO//

Generating PCC Visit.

---

5.2 Display Group Entry (2)

Use this option to display a group entry. No editing will be allowed using this option.

To display a group entry, follow these steps:
1. Type 2 at the “Select Action:” prompt.
2. Select the group to display.
3. The data for the selected group will display.
5.3 Duplicate Group (3)

Use this option to duplicate a group for all subsequent occurrences of the group session that was created using option 1 – Add a group. You will be asked to select the group definition to duplicate, enter the date the subsequent group session occurred, and then edit any information about the group that needs to be changed. For example, if a patient who was defined to the group did not attend this session then the user would remove the patient from the group definition. Another example would be if the session length was 90 minutes this time and 60 minutes the last time, the user would edit the group definition by changing the minutes.

To duplicate a group, follow these steps:
1. Type 3 at the “Select Action:” prompt.
2. Type the number of the group you want to duplicate at the “Select Group Entry:” prompt.
3. Type the date for the new group entry at the “Enter Date for the New Group Entry:” prompt.
4. The Group Encounter Documentation screen displays (Figure 5-7).

Select GROUP ENTRY: (1-2): 1

Enter Date for the new group entry: 1/2/2005
5. Review the information to confirm it is accurate for this instance of the group session. Be sure to press enter at the prompts that request the user to press enter to display the data for those items.

6. Once you confirm that all data is accurate, you will be prompted to enter data for individual patient visit as shown above in section 5.1.

5.4 Delete Group (4)

Use this option to delete a group definition. This option deletes the group definition not the visits that are associated with the group. This option allows you to delete older groups and any groups that was entered in error.

5.5 Print Encounter Forms (5)

Use this option to print encounter forms for the client visits within the group.

To print encounter forms, follow these steps:
1. Type 5 at the “Select Action:” prompt.
2. Type the number of the group at the “Select Group Entry:” prompt.
3. Select the type of encounter form(s) you want printed by typing the character of the option at the “Enter response:” prompt.
4. Type the name of an output device at the “Device:” prompt.
Select Action: +// 5  Print Encounter Forms
Select GROUP ENTRY: (1-2): 1

Forms will be generated for the following patient visits:
GUMP, FOREST                     JAN 28, 2005@12:00
JONES, ABBY                      JAN 28, 2005@12:00
SMITH, AARON                     JAN 28, 2005@12:00

Select one of the following:
F  Full Encounter Form
S  Suppress Subjective/Objective/Chief Complaint Encounter Form
B  Both a Suppressed&Full
T  2 copies of the Suppressed
E  2 copies of the Full

Enter response: E// B  Both a Suppressed&Full
DEVICE: HOME// [ENT]

Figure 5-8: Printing encounter forms

5.6 Review/Edit Group Visits (6)

Use this option to review the individual patient visits created by the group entry process. You can also edit a patient visit record that was created by the group process if a piece of data was entered in error. You can also use this option to delete a visit if it was created in error.

To review/edit group visits, follow these steps:
1. Type 6 at the “Select Action:” prompt.
2. Type the number of the group at the “Select Group Entry:” prompt.
3. The Enter/Edit Patient Group Data screen displays (Figure 5-10).
4. Select the option you want to use by typing the appropriate character at the “Select Action:” prompt. These options are explained below.
Enter/Edit Patient Group Data Jan 31, 2005 08:33:40        Page:    1 of    1

<table>
<thead>
<tr>
<th>Group Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
</tr>
<tr>
<td>GUMP, FOREST</td>
</tr>
<tr>
<td>JONES, ABBY</td>
</tr>
<tr>
<td>SMITH, AARON</td>
</tr>
</tbody>
</table>

Enter ?? for more actions                                       >>>

AE   Add/Edit Patient's Group Visit     D    Display Patient's Group Visit
X    Delete a Patient's Group Visit     Q    Quit
Select Action:+//

![Figure 5-10: Enter/Edit Patient Group Data screen](image)

**Add/Edit Patient's Group Visit (AE)**

If you select this option, you will be asked to select the patient visit and then the Edit a Record screen will display. This screen is described in the Behavioral Health System User Manual.

**Delete a Patient's Group Visit (X)**

Use this option to delete a patient’s visit record.

**Display Patient's Group Visit (D)**

Use this option to display a patient’s visit record.

**5.7 Add No Show Visit (7)**

Use this option to add a no show visit for a patient who failed to show up for the scheduled group session. This option will display the No Show visit type entry screen.
6.0 Intake Document Modifications

6.1 New Date Value Fields

The Intake document now prompts you for additional date values fields. These fields are to document the exact date the intake was initiated and updated.

To access these new fields from the Patient Data Entry screen, type ID (Update Intake Document) at the “Select Action:” prompt.

6.2 New Print Intake Document Option (PI)

The intake document screen has a new option to Print Intake document.

To print an intake document, select the PI option and then enter the device on which to print the document.
Patient Name: USER, ABRAHAM  DOB: JAN 28, 1991  Sex: M

Designated MH Provider:
Designated SS Provider:
Desg CD A/SA Provider:
Desg Other Provider:
Desg Other (2) Provider:

============ BH INTAKE DOCUMENT =============
Initial Intake:  JAN 31, 2005
Provider:  SMITH, AMY LYNN
Last Update:  JAN 31, 2005
Provider:  SMITH, AMY LYNN

INTAKE DOCUMENTATION/NARRATIVE:

Enter ?? for more actions
ED   Update Intake Narrative            PI   Print Intake Document
DP   Update Desg Prov                   DI   Delete Intake Document
MI   Intake Document Send               Q    Quit
Select Action: Q//

Figure 6-2: New Print Intake Document option
7.0 Suicide Form Modifications

7.1 New and Deleted Fields

The following fields have been REMOVED from the suicide form:

- Intervention (Suicide Ideation/Attempt)
- Intervention (Completed Suicide)

The following fields have been ADDED to the suicide form:

- Lethality
  - Low
  - Medium
  - High
- Disposition
  - Mental Health Follow-Up
  - Alcohol/Substance Abuse Follow-up
  - In-patient Mental Health Treatment (Voluntary)
  - In-patient Mental Health Treatment (Involuntary)
  - Medical Treatment (ED or In-patient)
  - Outreach to Family/School/Community
  - Other: ________ (prompt for small text box)
  - Unknown

*** UPDATING IHS SUICIDE FORM *** F1 E to exit ***
Patient: USER, ABRAHAM                     MALE           HRN: 123386
DOB: Jan 28, 1900            Community Res: Unspecified
Tribe: CHOCTAW NATION OF OKLAHOMA
Computer Generated Case #: 505201013120050000661
Provider: JONES, PATSY            Initials:      Discipline:

1. Local Case #:                  Provider: JONES, PATSY
7. Employment Status:
8. Date of Act: JAN 31, 2005 11. Community where act Occurred:
12. Relationship Status: 13. Education:
14. Self Destructive Act:
17. Substance Use Involved: 18. Location of Act:
21. Disposition:
22. Other Relevant Information:

**Figure 7-1: Updated Suicide form**

7.2 Suicide Form Fields and Allowable Entries

Many of the allowable answers to selected questions on the suicide form have been changed. Below are all the allowable answers to the fields.
### Employment Status

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>PART-TIME</td>
</tr>
<tr>
<td>F</td>
<td>FULL-TIME</td>
</tr>
<tr>
<td>S</td>
<td>SELF-EMPLOYED</td>
</tr>
<tr>
<td>UE</td>
<td>UNEMPLOYED</td>
</tr>
<tr>
<td>ST</td>
<td>STUDENT</td>
</tr>
<tr>
<td>SE</td>
<td>STUDENT AND EMPLOYED</td>
</tr>
<tr>
<td>UNK</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

### Relationship Status

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SINGLE</td>
</tr>
<tr>
<td>2</td>
<td>MARRIED</td>
</tr>
<tr>
<td>3</td>
<td>DIVORCED/SEPARATED</td>
</tr>
<tr>
<td>4</td>
<td>WIDOWED</td>
</tr>
<tr>
<td>5</td>
<td>COHABITING/COMMON LAW</td>
</tr>
<tr>
<td>6</td>
<td>SAME SEX PARTNERSHIP</td>
</tr>
<tr>
<td>9</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

### Education

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>LESS THAN 12 YEARS</td>
</tr>
<tr>
<td>2</td>
<td>HIGH SCHOOL GRADUATE/GED</td>
</tr>
<tr>
<td>3</td>
<td>SOME COLLEGE/TECHNICAL SCHOOL</td>
</tr>
<tr>
<td>4</td>
<td>COLLEGE GRADUATE</td>
</tr>
<tr>
<td>5</td>
<td>POST GRADUATE</td>
</tr>
<tr>
<td>6</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

### Self Destructive Act

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IDEATION WITH PLAN AND INTENT</td>
</tr>
<tr>
<td>2</td>
<td>ATTEMPT</td>
</tr>
<tr>
<td>3</td>
<td>COMPLETED SUICIDE</td>
</tr>
<tr>
<td>4</td>
<td>ATTEMPTED SUICIDE WITH HOMICIDE</td>
</tr>
<tr>
<td>5</td>
<td>COMPLETED SUICIDE WITH HOMICIDE</td>
</tr>
</tbody>
</table>

### Previous Attempts

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3 OR MORE</td>
</tr>
<tr>
<td>U</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

### Location of Act

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HOME OR VICINITY</td>
</tr>
<tr>
<td>2</td>
<td>SCHOOL</td>
</tr>
<tr>
<td>3</td>
<td>WORK</td>
</tr>
<tr>
<td>4</td>
<td>JAIL/PRISON/DETENTION</td>
</tr>
<tr>
<td>5</td>
<td>TREATMENT FACILITY</td>
</tr>
<tr>
<td>6</td>
<td>MEDICAL FACILITY</td>
</tr>
<tr>
<td>7</td>
<td>OTHER</td>
</tr>
<tr>
<td>8</td>
<td>UNKNOWN</td>
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</table>

### Lethality

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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>LOW</td>
</tr>
<tr>
<td>M</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>H</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

### Substance Used Involved

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NONE</td>
</tr>
<tr>
<td>2</td>
<td>ALCOHOL AND OTHER DRUGS</td>
</tr>
<tr>
<td>U</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>

If alcohol and other drugs is selected, the user will be presented with the following drugs to select from:

- ALCOHOL
- AMPHETAMINE/STIMULANT

### Contributing Factors

- DEATH OF FRIEND OR RELATIVE
- DIVORCE/SEPARATION/BREAKUP OF RELATIONSHIP
- FINANCIAL STRESS
- HISTORY OF MENTAL ILLNESS
- HISTORY OF PHYSICAL ILLNESS
- HISTORY OF SUBSTANCE ABUSE/DEPENDENCE
- LEGAL
<table>
<thead>
<tr>
<th>Substance</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANNABIS (MARIJUANA)</td>
<td>OCCUPATIONAL/EDUCATIONAL PROBLEM</td>
</tr>
<tr>
<td>COCAINE</td>
<td>OTHER</td>
</tr>
<tr>
<td>HALLUCINOGENS</td>
<td>SUICIDE OF FRIEND OR RELATIVE</td>
</tr>
<tr>
<td>INHALANTS</td>
<td>UNKNOWN</td>
</tr>
<tr>
<td>NON-PRESCRIBED OPIATES (HEROIN)</td>
<td>VICTIM OF ABUSE (CURRENT)</td>
</tr>
<tr>
<td>OTHER</td>
<td>VICTIM OF ABUSE (PAST)</td>
</tr>
<tr>
<td>PRESCRIBED OPIATES (NARCOTICS)</td>
<td></td>
</tr>
<tr>
<td>SEDATIVES/BENZODIAZEPINES/BARBITURATES</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disposition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA</td>
<td>ALCOHOL/SUBSTANCE ABUSE FOLLOW-UP</td>
</tr>
<tr>
<td>INMHI</td>
<td>IN-PATIENT MENTAL HEALTH</td>
</tr>
<tr>
<td>INMHV</td>
<td>TREATMENT (IN Voluntary)</td>
</tr>
<tr>
<td>MT</td>
<td>MEDICAL TREATMENT (ED OR IN-PATIENT)</td>
</tr>
<tr>
<td>MH</td>
<td>MENTAL HEALTH FOLLOW-UP</td>
</tr>
<tr>
<td>OT</td>
<td>OTHER</td>
</tr>
<tr>
<td>ORFSC</td>
<td>OUTREACH TO FAMILY/SCHOOL/COMMUNITY</td>
</tr>
<tr>
<td>UNK</td>
<td>UNKNOWN</td>
</tr>
</tbody>
</table>
8.0 Treatment Plan Menu and Report Modifications

8.1 Updated Treatment Plan Menu

The Treatment Plan menu has been modified. It now displays as shown in Figure 8-1.

```
*******************************************************************************
**          IHS Behavioral Health System          **
**          Patient Treatment Plans            **
*******************************************************************************

Version 3.0

CIMARRON HOSPITAL

UP    (Add, Edit, Delete) a Treatment Plan
DTP    Display/Print a Treatment Plan
REV    Print List of Treatment Plans Needing Reviewed
RES    Print List of Treatment Plans Needing Resolved
ATP    Print List of All Treatment Plans on File

Select Update BH Patient Treatment Plans Option:
```

Figure 8-1: Updated treatment plan menu

8.2 Treatment Plan Report Modifications

All Treatment Plan reports now display the following items:

- Patient Name
- DOB (Date of Birth)
- Chart Number
- Date Established
- Review Date
- Resolve Date

These items will display as shown in Figure 8-2.

```
CIMARRON HOSPITAL

LISTING OF TREATMENT PLANS DUE TO BE REVIEWED
Date Range: JAN 01, 2000 to JAN 31, 2005

PATIENT NAME   DOB   CHART #  DATE ESTABLISHED  REVIEW DATE  RESOLVE DATE

Figure 8-2: Treatment report items
```
8.3 Print List of All Treatment Plans on File (ATP)

A new report was added to list all treatment plans entered during a specified date range.

To run the Print List of All Treatment Plans on File report, follow these steps:

1. From the Patient Treatment Plans menu, type ATP at the “Select Update BH Patient Treatment Plans Option:” prompt.

2. A description of the report displays.

3. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.

4. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.

5. You may run the listing by one provider or by all providers. Type O (One Provider) or A (All Providers) at the “List treatment plans for:” prompt.

6. Select how you would like to sort the list by typing P (Responsible Provider), N (Patient Name), or D (Date Established) at the “Sort list by:” prompt.

7. Type the name of an output device at the “Device:” prompt.

8. The report is then displayed onscreen or printed. See Figure 8-4 a sample output.
Select one of the following:

O One Provider  
A All Providers

List treatment plans for: O// All Providers

Select one of the following:

P Responsible Provider  
N Patient Name  
D Date Established

Sort list by: P// P Responsible Provider

DEVICE: HOME// Virtual

---

**CONFIDENTIAL PATIENT INFORMATION**

CIMARRON HOSPITAL

LISTING OF TREATMENT PLANS

Date Established: JAN 01, 2000 to JAN 31, 2005

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DOB</th>
<th>CHART #</th>
<th>DATE</th>
<th>REVIEW DATE</th>
<th>RESOLVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZCASH, ROSEMARY</td>
<td>10/6/64</td>
<td>???</td>
<td>May 03, 2004</td>
<td>Jun 05, 2004</td>
<td>Aug 05, 2004</td>
</tr>
<tr>
<td>Program: MENTAL HEALTH</td>
<td>Responsible Provider: STUDENT,EIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program: CHEMICAL DEPENDENCY</td>
<td>Responsible Provider: STUDENT,EIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LINCOLN, AGATHA</td>
<td>3/12/93</td>
<td>200968</td>
<td>Jul 17, 2004</td>
<td>Sep 02, 2004</td>
<td></td>
</tr>
<tr>
<td>Program: CHEMICAL DEPENDENCY</td>
<td>Responsible Provider: STUDENT,EIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ELLISON, LIONEL</td>
<td>12/21/81</td>
<td>202358</td>
<td>Apr 01, 2004</td>
<td>Apr 01, 2004</td>
<td></td>
</tr>
<tr>
<td>Program: CHEMICAL DEPENDENCY</td>
<td>Responsible Provider: STUDENT,EIGHTEEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GEHRIG, BRENDA</td>
<td>2/24/62</td>
<td>232729</td>
<td>Jan 12, 2004</td>
<td>Jul 06, 2004</td>
<td>Apr 12, 2005</td>
</tr>
<tr>
<td>Program: CHEMICAL DEPENDENCY</td>
<td>Responsible Provider: STUDENT,ELEVEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAUNDERS, JOANNE</td>
<td>12/28/00</td>
<td>232728</td>
<td>Mar 01, 2004</td>
<td>Jul 07, 2004</td>
<td>Mar 01, 2005</td>
</tr>
<tr>
<td>Program: MENTAL HEALTH</td>
<td>Responsible Provider: STUDENT,ELEVEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Figure 8-3: Running the new ATP report

Figure 8-4: Sample ATP report output
9.0 New IPV/DV Options

9.1 Intimate Partner Violence/Domestic Violence Exam
Screening Entry Screen

A new screen has been added, allowing you to enter IPV/DV screenings. To access this screen, type Y at the “IPV/DV Screening?” prompt from any of the entry screens for the following visit types:

- R  Regular Visit
- I   Intake
- B  Abbreviated Version of Regular Visit
- C  Info/Contact
- S  Suspected Abuse and Neglect (NEW)
- U  Suspected Abuse and Neglect (F/U)
- A  A/SA Encounter

Intimate Partner Violence/Domestic Violence (IPV/DV) Screen

Display IPV/DV screening history?

Screening/Exam Result:

Provider: JONES, PATSY

COMMENT:

Figure 9-1: New IPV/DV screen

Screening/Exam Result
When entering IPV/DV screening the result values allowed are:

- N  NEGATIVE
- PR PRESENT
- PA PAST
- UAS UNABLE TO SCREEN
- REF PATIENT REFUSED SCREENING

Comments
Enter IPV/DV screening exam results with a comment.
Intimate Partner Violence/Domestic Violence (IPV/DV) Screen

Display IPV/DV screening history?

Screening/Exam Result:

Provider: JONES,PATSY

COMMENT: Current Physical Abuse; declined shelter; see SOAP notes.

---

**Display IPV/DV screening history?**

Type Y at the “Display IPV/DV screening history?” prompt to view the patient’s IPV/DV screening history as recorded in both the Behavioral Health module and in the Patient Care Component (PCC).

---

**New Intimate Partner Violence/Domestic Violence Reports**

Five new reports have been added to the Behavioral Health System v3.0 to report on IPV/DV screening. In order to access the IPV/DV reports the user must be assigned the AMHZ DV REPORTS security key. Due to the confidential nature of these reports this security key should only be assigned to providers who have a specific need for this information.
These reports can be found under the Patient Listings menu option under the Reports menu. RPTS > PAT > DVR.

To access the IPV/DV reports, follow these steps:

1. From the Behavioral Health System Report menu, type PAT at the “Select Reports menu Option:” prompt.

2. Type DVR at the “Select Patient Listings Option:” prompt.

3. The IPV/DV Reports menu displays (Figure 9-5). Sections 9.2.1 through 9.2.5 explain how to run each of these reports.
9.2.1 Tally/List Patients with IPV/DV Screening (DVP)

This report tallies and optionally lists all patients who have had an IPV screening (Exam Code 34) or a refusal documented in the specified date range.

This report tallies the clients by age, gender, 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.

To run the Tally/List Patients with IPV/DV Screening report, follow these steps:
1. Type DVP at the “Select IPV/DV Reports Option:” prompt.
2. A description of the report displays.
3. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.
4. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.
5. Type the number of the items which you would like tallied at the “Which items should be tallied:” prompt.
6. Type YES or NO at the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt.
7. Type YES or NO at the “Would you like to include a list of patients screened?” prompt.
8. Select how you would like the list to be sorted by typing the character of the option at the “How would you like the list to be sorted:” prompt.
9. Type YES or NO at the “Display the Patient's Designated Providers on the list?” prompt.
10. Type the name of an output device at the “Device:” prompt.

| Select IPV/DV Reports Option: DVP Tally/List Patients with IPV/DV Screening |
| USER, MARY ANN |

CIMARRON HOSPITAL

TALLY AND LISTING OF PATIENT'S RECEIVING IPV SCREENING, INCLUDING REFUSALS

This report will tally and optionally list all patients who have had IPV screening (Exam code 34) or a refusal documented in the time frame specified by the user.

This report will tally the patients by age, gender, 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

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Enter Beginning Date for Screening: 010100 (JAN 01, 2000)
Enter Ending Date for Screening: T (JAN 31, 2005)

Please select which items you wish to tally on this report:

0) Do not include any Tallies
1) Result of Screening
2) Gender
3) Age of Patient
4) Provider who Screened
5) Clinic
6) Date of Screening
7) Primary Provider on Visit
8) Designated MH Provider
9) Designated SS Provider
10) Designated ASA/CD Provider
11) Designated Primary Care Provider

Which items should be tallied: (0-11): // 1

Would you like to include IPV/DV Screenings documented in the PCC clinical database? N// YES

Would you like to include a list of patients screened? Y// YES

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   |
11. The report is then displayed onscreen or printed. See Figure 9-7 for some sample outputs.

<table>
<thead>
<tr>
<th>AA</th>
<th>Jan 31, 2005</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** IPV SCREENING PATIENT TALLY AND PATIENT LISTING ***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening Dates: Jan 01, 2000 to Jan 31, 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This report includes data from the PCC Clinical database</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Patients screened</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>By Result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NO RESULT RECORDED</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>PRESENT</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>UNABLE TO SCREEN</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEMALE</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>MALE</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>By Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 yrs</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>37 yrs</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>64 yrs</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>By Provider who screened</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUTCHER,HANK</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>STUDENT,THIRTEEN</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>By Primary Provider of Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUTCHER,HANK</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>CURTIS,A CLAYTON</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>STUDENT,THIRTEEN</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>By Designated Primary Care Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STUDENT,ONE</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>2</td>
<td>66.7%</td>
</tr>
</tbody>
</table>
By Clinic

ALCOHOL AND SUBSTANCE 1 33.3%
GENERAL 1 33.3%
MENTAL HEALTH 1 33.3%

By Date

Jan 31, 2005

By Designated Mental Health Provider

NYE, PATRICIA 1 33.3%
UNKNOWN 2 66.7%

By Designated Social Services Provider

MEARS, PRISCILLA 1 33.3%
UNKNOWN 2 66.7%

By Designated A/SA Provider

ALLISON, ARNOLD 1 33.3%

DATE

PATIENT NAME HRN AGE SCREENED RESULT CLINIC
SNOW, WILLIAM 202024 37 M 07/26/04 PRESENT ALCOHOL AND
SUBST
DXs: 27 ALCOHOL DEPENDENCE
Primary Provider on Visit: STUDENT, THIRTEEN
Provider who screened: STUDENT, THIRTEEN
RATHER, MIRIAM 225255 2 F 04/01/04 GENERAL
DXs: 250.00 DM TYPE 2
486. PNEUMONIA
Primary Provider on Visit: CURTIS, A CLAYTON

** IPV SCREENING PATIENT TALLY AND PATIENT LISTING **
Screening Dates: Jan 01, 2000 to Jan 31, 2005
This report includes data from the PCC Clinical database
9.2.2 Tally/List IPV/DV Screenings (DVS)

This report tallies and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in the time frame specified by the user. 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.

This report will list/tally ALL screenings done, not just the latest one, therefore if a patient was screened twice in the time period you select, both screenings will be included in the tally and list.

To run the Tally/List IPV/DV Screenings report, follow these steps:

1. Type DVS at the “Select IPV/DV Reports Option:” prompt.

2. A description of the report displays.

3. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.

4. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.

5. Type the number of the items which you would like tallied at the “Which items should be tallied:” prompt.

6. Type YES or NO at the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt.

7. Type YES or NO at the “Would you like to include a list of visits w/screening done?” prompt.
8. Select how you would like the list to be sorted by typing the character of the option at the “How would you like the list to be sorted:” prompt.

9. Type the name of an output device at the “Device:” prompt.

10. The report is then displayed onscreen or printed. See Figure 9-9 for some sample outputs.

Select IPV/DV Reports Option: **DVS** Tally/List IPV/DV Screenings

CIMARRON HOSPITAL

SMITH, AMY LYNN

TALLY AND LISTING OF ALL VISITS W/IPV SCREENING

This report will tally and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in the time frame specified by the user. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note:
- this report will optionally, look at both the Behavioral Health and PCC clinical databases for evidence of screening/refusal

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Enter Beginning Date for Screening: **010100** (JAN 01, 2000)
Enter Ending Date for Screening: T (JAN 31, 2005)

Please select which items you wish 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): // **1**

Would you like to include IPV/DV Screenings documented in the PCC clinical database? N// NO

Would you like to include a list of visits w/screening done? Y// YES

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// N  Patient Name
DEVICE: HOME

Figure 9-8: Running the DVS report

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Visits with Screening</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total Number of Patients screened</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

By Result

- PRESENT: 1 (50.0%)
- UNABLE TO SCREEN: 1 (50.0%)

By Gender

- MALE: 2 (100.0%)

By Age

- 37 yrs: 1 (50.0%)
- 64 yrs: 1 (50.0%)

By Provider who screened

- BUTCHER, HANK: 1 (50.0%)
- STUDENT, THIRTEEN: 1 (50.0%)

By Primary Provider of Visit

- BUTCHER, HANK: 1 (50.0%)
- STUDENT, THIRTEEN: 1 (50.0%)

By Designated Primary Care Provider

- STUDENT, ONE: 1 (50.0%)
  - UNKNOWN: 1 (50.0%)

By Clinic

- ALCOHOL AND SUBSTANCE: 1 (50.0%)
- MENTAL HEALTH: 1 (50.0%)

By Date
### Behavioral Health System (AMH) v3.0 Patch 4

#### Jul 26, 2004
- 1 patient: 50.0%

#### Sep 13, 2004
- 1 patient: 50.0%

### By Designated Mental Health Provider

<table>
<thead>
<tr>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYE, PATRICIA</td>
<td>1</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1</td>
</tr>
</tbody>
</table>

### By Designated Social Services Provider

<table>
<thead>
<tr>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEARS, PRISCILLA</td>
<td>1</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1</td>
</tr>
</tbody>
</table>

### By Designated A/SA Provider

<table>
<thead>
<tr>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLISON, ARNOLD</td>
<td>1</td>
</tr>
</tbody>
</table>

---

### *** IPV SCREENING VISIT TALLY AND VISIT LISTING ***

**Screening Dates: Jan 01, 2000 to Jan 31, 2005**

This report excludes PCC Clinics.

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>SCREENED RESULT</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 31, 2005</td>
<td>GUMP, FOREST</td>
<td>989898</td>
<td>64</td>
<td>UNABLE TO SCREEN</td>
<td></td>
</tr>
</tbody>
</table>

**Comment:**

- DXs: 44  ADULT ABUSE (SUSPECTED), UNSPECIFIED
- Primary Provider on Visit: BUTCHER, HANK
- Provider who screened: BUTCHER, HANK

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>SCREENED RESULT</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 31, 2005</td>
<td>SNOW, WILLIAM</td>
<td>202024</td>
<td>37</td>
<td>PRESENT</td>
<td></td>
</tr>
</tbody>
</table>

**DXs:** 27  ALCOHOL DEPENDENCE

**Primary Provider on Visit:** STUDENT, THIRTEEN

---

### 9.2.3 List all IPV/DV Screenings for Selected Patients (SSP)

This report lists 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.

#### To run the List all IPV/DV Screenings for Selected Patients report, follow these steps:

1. Type SSP at the “Select IPV/DV Reports Option:” prompt.

2. A description of the report displays.

3. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.
4. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.

5. Type YES or NO at the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?” prompt.

6. Type F (Females Only), M (Males Only), or B (Both Male and Females) at the “Include which patients in the list:” prompt.

7. Type YES or NO at the “Would you like to restrict the report by Patient age range?” prompt.

8. Type an age range at the “Enter an Age Range (e.g. 5-12,1-1):” prompt.

9. Type the number of the value you would like included on your report at the “Which result values do you want included on this list:” prompt.

10. Type YES or NO at the “Include visits to ALL clinics?” prompt.

11. Type O (One Provider Only), P (Any/All Providers (including unknown)), or U (Unknown Provider Only) at the “Report should include visits whose Primary Provider on the visit is:” prompt.

12. Type O (One Provider Only), P (Any/All Providers (including unknown)), or U (Unknown Provider Only) at the “Select which providers who performed the screening should be included:” prompt.

13. Type YES or NO at the “Would you like to limit the list to just patients who have a particular designated Mental Health provider?” prompt.

14. Type YES or NO at the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt.

15. Type YES or NO at the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt.

16. Type L (List of Patient Screenings) or S (Create a Search Template of Patients) at the “Select Report Type:” prompt.

17. Select how you would like the list to be sorted by typing the character of the option at the “How would you like the list to be sorted:” prompt.

18. Type the name of an output device at the “Device:” prompt.

19. The report is then displayed onscreen or printed. See Figure 9-11 for a sample output.
SMITH, AMY LYNN
CIMARRON HOSPITAL

LISTING OF PATIENTS RECEIVING IPV SCREENING, INCLUDING REFUSALS

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.

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Enter Beginning Date for Screening: 010100 (JAN 01, 2000)
Enter Ending Date for Screening: T (JAN 31, 2005)

Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)? N// YES

Select one of the following:

F             FEMALES Only
M             MALES Only
B             Both MALE and FEMALES

Include which patients in the list: F// FEMALES Only

Would you like to restrict the report by Patient age range? YES// YES

Enter an Age Range (e.g. 5-12, 1-1): 15-44

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)

1) Normal/Negative
2) Present
3) Past
4) Refused
5) Unable to Screen
6) Screenings done with no result entered

Which result values do you want included on this list: (1-6): 1-6

Include visits to ALL clinics? Yes// YES

Select one of the following:
Select which providers who performed the screening should be included: P
Any/All Providers (including unknown)

Would you like to limit the list to just patients who have a particular designated Mental Health provider? N// NO

Would you like to limit the list to just patients who have a particular designated Social Services provider? N// NO

Would you like to limit the list to just patients who have a particular designated ASA/CD provider? N// NO

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// R Result of Exam

Display the Patient's Designated Providers on the list? N// YES

DEVICE: HOME// 0;P-OTHER80 Virtual

Figure 9-10: Running the SSP report

*** IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS ***
Screening Dates: Jan 01, 2000 to Jan 31, 2005
9.2.4 **Tally/List Pts in Search Template w/IPV Screening (PST)**

This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

This report tallies and lists all patients who are members of a user defined search template. It tallies and lists their latest IPV screening (Exam code 34) or a refusal documented in the time frame specified by the user.

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.

**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.

To run the **Tally/List Pts in Search Template w/IPV Screening** report, follow these steps:

1. Type **PST** at the “Select IPV/DV Reports Option:” prompt.

2. A description of the report displays.

3. Press the Enter key at the “Press enter to continue:” prompt.

4. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.

5. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.

6. Type the name of the search template at the “Enter Patient Search Template name:” prompt.

7. Type the number of the items which you would like tallied at the “Which items should be tallied:” prompt.
8. Type **YES** or **NO** at the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt.

9. Type **YES** or **NO** at the “Would you like to include a list of patients screened?” prompt.

10. Select how you would like the list to be sorted by typing the character of the option at the “How would you like the list to be sorted:” prompt.

11. Type **YES** or **NO** at the “Display the Patient's Designated Providers on the list?” prompt.

12. Type the name of an output device at the “Device:” prompt.

13. The report is then displayed onscreen or printed. See Figure 9-13 for some sample outputs.

---

Select IPV/DV Reports Option: **PST** Tally/List Pts in Search Template w/IPV Screening

CIMARRON HOSPITAL

*Please Note: This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

TALLY AND LISTING OF PATIENT'S RECEIVING IPV SCREENING, INCLUDING REFUSALS
ONLY PATIENTS WHO ARE MEMBERS OF A USER DEFINED SEARCH TEMPLATE ARE INCLUDED IN THIS REPORT

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest IPV screening (Exam code 34) or a refusal documented in the time frame specified by the user. 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.

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.

Press enter to continue: [ENT]

Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.
Enter Beginning Date for Screening: 010100 (JAN 01, 2000)
Enter Ending Date for Screening: T (JAN 31, 2005)
Enter Patient SEARCH TEMPLATE name: LORI DM PATS
(Jan 06, 2005) User #1 File #9000001 INQ

Please select which items you wish 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): // 1-11

Would you like to include IPV/DV Screenings documented in the PCC clinical database? N// YES

Would you like to include a list of patients screened? Y// YES

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// D Date Screened

Display the Patient's Designated Providers on the list? N// YES

DEVICE: HOME// [ENT]

---

** Figure 9-12: Running the PST report **

<table>
<thead>
<tr>
<th></th>
<th>Jan 31, 2005</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>** *** IPV SCREENING PATIENT TALLY AND PATIENT LISTING *****</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening Dates: Jan 01, 2000 to Jan 31, 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This report includes data from the PCC Clinical database</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEARCH TEMPLATE OF PATIENTS: LORI DM PATS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Patients in TEMPLATE:</td>
<td>3,465</td>
<td></td>
</tr>
<tr>
<td>Total Number of Patients screened</td>
<td>2</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total Number of Patients screened</td>
<td>#</td>
<td>% of patients</td>
</tr>
</tbody>
</table>
### By Result

<table>
<thead>
<tr>
<th>Result</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO RESULT RECORDED</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>UNABLE TO SCREEN</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>MALE</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 yrs</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>64 yrs</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Provider who screened

<table>
<thead>
<tr>
<th>Provider</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNKNOWN</td>
<td>2</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### By Primary Provider of Visit

<table>
<thead>
<tr>
<th>Provider</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURTIS,A CLAYTON</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Designated Primary Care Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT,ONE</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Clinic

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Date

<table>
<thead>
<tr>
<th>Date</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 13, 2004</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### By Designated Mental Health Provider

### By Designated Social Services Provider

### By Designated A/SA Provider

---

*** IPV SCREENING PATIENT TALLY AND PATIENT LISTING ***

Screening Dates: Jan 01, 2000 to Jan 31, 2005

This report includes data from the PCC Clinical database
SEARCH TEMPLATE OF PATIENTS: LORI DM PATS
Listing of those patients screened

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>DATE</th>
<th>SCREENED RESULT</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RATHER, MIRIAM</td>
<td>225255</td>
<td>2</td>
<td>04/01/04</td>
<td></td>
<td>GENERAL</td>
</tr>
</tbody>
</table>
9.2.5 **Tally List all IPV Screenings for Template of Patients (VST)**

This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

This report tallies and optionally lists all visits on which a IPV screening (Exam code 34) or a refusal was documented in the time frame specified by the user.

This report tallies 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 databases for evidence of screening/refusal.
To run the Tally List all IPV Screenings for Template of Patients report, follow these steps:

1. Type VST at the “Select IPV/DV Reports Option:” prompt.

2. A description of the report displays.

3. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.

4. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.

5. Type the name of the search template at the “Enter Patient Search Template name:” prompt.

6. Type the number of the items which you would like tallied at the “Which items should be tallied:” prompt.

7. Type YES or NO at the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt.

8. Type YES or NO at the “Would you like to include a list of patients screened?” prompt.

9. Select how you would like the list to be sorted by typing the character of the option at the “How would you like the list to be sorted:” prompt.

10. Type the name of an output device at the “Device:” prompt.

11. The report is then displayed onscreen or printed. See Figure 9-15 for some sample outputs.

Select IPV/DV Reports Option: VST Tally List all IPV Screenings for Template of Pts

*Please Note: This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

This report will tally and optionally list all visits on which IPV screening (Exam code 34) or a refusal was documented in the time frame specified by the user. 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 databases for evidence of screening/refusal

Please enter the date range during which the screening was done.
To get all screenings ever put in a long date range like 01/01/1980 to the present date.

Enter Beginning Date for Screening: 010100 (JAN 01, 2000)
Enter Ending Date for Screening: T (JAN 31, 2005)

Enter Patient SEARCH TEMPLATE name: LORI DM PATS
(Jan 06, 2005) User #1 File #9000001 INQ

Please select which items you wish to tally on this report:

0) Do not include any Tallies
1) Result of Screening
2) Gender
3) Age of Patient
4) Provider who Screened
5) Clinic
6) Date of Screening
7) Primary Provider on Visit
8) Designated MH Provider
9) Designated SS Provider
10) Designated ASA/CD Provider
11) Designated Primary Care Provider

Which items should be tallied: (0-11): // 1-11

Would you like to include IPV/DV Screenings documented in the PCC clinical database? N// YES
Would you like to include a list of patients screened? Y// YES

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// Age of Patient at Screening
DEVICE: HOME// 0;P-OTHER80 Virtual

---

**IPV SCREENING VISIT TALLY AND VISIT LISTING**
Screening Dates: Jan 01, 2000 to Jan 31, 2005
This report includes data from the PCC Clinical database
SEARCH TEMPLATE OF PATIENTS: LORI DM PATS

<table>
<thead>
<tr>
<th>#</th>
<th>Total Number of Visits with Screening</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Total Number of Patients screened</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Total Number of Patients in Template</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,465</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
By Result

NO RESULT RECORDED  1  25.0%
UNABLE TO SCREEN    3  75.0%

By Gender

FEMALE        1  25.0%
MALE          3  75.0%

By Age

2 yrs          1  25.0%
64 yrs         3  75.0%

By Provider who screened

BUTCHER,HANK   1  25.0%
UNKNOWN       3  75.0%

By Primary Provider of Visit

BUTCHER,HANK   1  25.0%
CURTIS,A CLAYTON 1  25.0%
UNKNOWN       2  50.0%

By Designated Primary Care Provider

STUDENT,ONE   3  75.0%
UNKNOWN       1  25.0%

By Clinic

GENERAL       1  25.0%
MENTAL HEALTH 1  25.0%
UNKNOWN       2  50.0%

By Date

AA                           Jan 31, 2005  Page 2

*** IPV SCREENING VISIT TALLY AND VISIT LISTING ***
Screening Dates: Jan 01, 2000 to Jan 31, 2005
This report includes data from the PCC Clinical database
SEARCH TEMPLATE OF PATIENTS: LORI DM PATS

<table>
<thead>
<tr>
<th>Date</th>
<th>#</th>
<th>% of patients screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 01, 2004</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Sep 05, 2004</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Sep 13, 2004</td>
<td>2</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

By Designated Mental Health Provider

By Designated Social Services Provider
### IPV SCREENING VISIT TALLY AND VISIT LISTING

**Screening Dates:** Jan 01, 2000 to Jan 31, 2005

This report includes data from the PCC Clinical database

**SEARCH TEMPLATE OF PATIENTS:** LORI DM PATS

**Listing of those patients screened**

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>SCREENED RESULT</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/04</td>
<td>RATHER, MIRIAM</td>
<td>225255</td>
<td>2</td>
<td>F</td>
<td>GENERAL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>250.00 DM TYPE 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>486. PNEUMONIA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary Provider on Visit: CURTIS, A CLAYTON</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary who screened: UNKNOWN</td>
<td></td>
</tr>
<tr>
<td>09/13/04</td>
<td>GUMP, FOREST</td>
<td>989898</td>
<td>64</td>
<td>M 09/13/04 UNABLE TO SCREEN</td>
<td>MENTAL HEALTH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comment: COMMENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DXs: 44 ADULT ABUSE (SUSPECTED), UNSPECIFIED</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary Provider on Visit: BUTCHER, HANK</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary who screened: BUTCHER, HANK</td>
<td></td>
</tr>
<tr>
<td>09/05/04</td>
<td>GUMP, FOREST</td>
<td>989898</td>
<td>64</td>
<td>M 09/05/04 UNABLE TO SCREEN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comment: THIS IS MY COMMENT FOR THIS REFUSAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary Provider on Visit: UNKNOWN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary who screened: UNKNOWN</td>
<td></td>
</tr>
<tr>
<td>09/13/04</td>
<td>GUMP, FOREST</td>
<td>989898</td>
<td>64</td>
<td>M 09/13/04 UNABLE TO SCREEN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Comment: COMMENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary Provider on Visit: UNKNOWN</td>
<td></td>
</tr>
</tbody>
</table>

---

**Listing of those NOT screened**

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>SCREENED RESULT</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ELLIOTT, MARIE</td>
<td>100015</td>
<td>80</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MAYS, KAIA</td>
<td>100016</td>
<td>71</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CARSON, KRISTIN</td>
<td>100018</td>
<td>49</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DARROUGH, MARCIE</td>
<td>100020</td>
<td>52</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SNOW, SHAWN</td>
<td>100027</td>
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*Figure 9-15: Sample VST output*
10.0 Appendix A: Activity Codes and Definitions

BHS activity codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to record activities. However, aggregate reports can be organized by these activity categories.

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).

- 11-Screening (SCN)
  Services provided to determine in a preliminary way the nature and extent of the recipient's problem in order to link him/her to the most appropriate and available resource.

- 12-Assessment/Evaluation (EVL)
  Formal assessment activities intended to define or delineate the client/patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

- 13-Individual Treatment/Counseling/Education (IND)
  Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

- 15-Information and/or Referral (REF)
  Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are
those that direct or guide a client/patient to appropriate services provided outside of your organization.

- **16-Medication/Medication Monitoring (MED)**
  Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

- **17-Psychological Testing (TST)**
  Examination and assessment of client/patient's status through the use of standardized psychological, educational, or other evaluative test. Care must be exercised to assure that the interpretations of results from such testing are consistent with the socio-cultural milieu of the client/patient.

- **18-Forensic Activities (FOR)**
  Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

- **19-Discharge Planning (DSG)**
  Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

- **20-Family Facilitation (FAC)**
  Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

- **21-Follow-through/Follow-up (FOL)**
  Periodic evaluative review of a specific client/patient's progress after discharge.

- **22-Case Management (CAS)**
  Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination.

- **23-Other Patient Services not identified here (OTH)**
  Any other patient services not identified in this list of codes.

- **47 – Couples Treatment (CT)**
  Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.

- **48-Crisis Intervention (CIP)**
  Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client’s distress.
• **85 – Art Therapy (ART)**
  The application of a variety of art modalities (drawing, painting, clay and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.

• **86 – Recreation Activities (REC)**
  Recreation and leisure activities with the purpose of improving and maintaining clients’/patients’ general health and well-being.

• **88 – Acupuncture (ACU)**
  The use of the Chinese practice of Acupuncture in the treatment of addiction disorders (including withdrawal symptoms and recovery) and other behavioral health disorders.

• **89 – Methadone Maintenance (MET)**
  Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed, ethadone 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 which 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 his/her cultural background.

• **96 – Academic Services (ACA)**
  Provision of alternative schooling under the guidelines of the state education program.

• **97 – Health Promotion (HPR)**
  Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices.

**Support Services - Patient Not Present (S)**
Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

• **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 when the patient is not present.

• **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 health care designed to address the presenting symptoms of an emergency and to ameliorate the client’s distress.

**Community Services (C)**  
Assistance to community organizations, planning groups, and citizens’ efforts to develop solutions for community problems.

• **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 may extend to calling and setting up appointments for the client.

• 87 – Outreach
Activities designed to locate and educate potential clients and motivate them to enter and accept treatment.

Education/Training (E)
Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job-related knowledge, attitudes, and skills. Includes:

• 41- Education/Training Provided • 42- Education/Training Received

• 43- Other Education/Training

Administration (A)
Activities for the benefit of the organization and/or activities that do not fit into any of the above categories. Includes:

• 32- Clinical Supervision Provided
Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.
• **50- Medical Rounds (General)**
  On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

• **51- Committee Work**
  Participation in the activities of a body of persons delegated to consider, investigate, take action on, or report on some matter.

• **52- Surveys/Research**
  Participation in activities aimed at identification and interpretation of facts, revision of accepted theories in the light of new facts, or practical application of such new or revised theories.

• **53- Program Management**
  The practice of leading, managing, and coordinating a complex set of cross-functional activities to define, develop, and deliver client services and to achieve agency/program objectives.

• **54- Quality Improvement**
  Participation in activities focused on improving the quality and appropriateness of medical or behavioral health care 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.

**Consultation (L)**
Problem-oriented effort designed to impart knowledge, increase understanding and insight, and/or modify attitudes to facilitate problem resolution. Includes:

• **61- Provider Consultation (PRO)**
  Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

• **62- Patient Consultation (Chart Review Only) (CHT)**
  Focus is a specific patient and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

• **63- Program Consultation**
  Focus is a programmatic effort to address specific needs.

• **64- Staff Consultation**
  Focus is a provider or group of providers addressing a type or class of problems.

• **65- Community Consultation**
  Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

**Travel (T)**

• **71- Travel Related to Patient Care**
  Staff travel to patient’s home or other locations – related to provision of care. Patient is not in the vehicle.

• **72- Travel Not Related to Patient Care**
  Staff travel to meetings, community events, etc.

**Placements (PL)**

• **75- Placement (Patient Present) (OHP)**
  Selection of an appropriate level of service, based on assessment of a patient’s individual needs and preferences.
• **76- Placement (Patient Not Present) (OHA)**
  Selection of an appropriate level of service, based on assessment of a patient’s individual needs and preferences. This activity may include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

**Cultural Issues (O)**

• **81- Traditional Specialist Consult (Patient Present) (TRD)**
  Seeking recommendation or service from a recognized Indian spiritual leader or traditional practitioner with the patient present. Such specialists may 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 traditional practitioner (patient not present). Such specialists may 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.
11.0 Appendix B: POV Codes

Purpose of Visit (POV) 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 record activities; however, aggregate reports can be organized by these broad POV categories. The POV codes include DSM-IV-TR codes as well as BHS problem codes.

The following tables show the ICD-9-CM Code (shown in the parentheses) that is passed to the Patient Care Component (PCC) when that BHS problem code is entered as a purpose of visit (POV). Codes marked with the asterisk (*) will have the phrase “See (Provider’s Name) for details of this problem” appended to the narrative that is passed to the PCC. Codes marked with a bullet (•) will have the phrase “Diagnostic Impression” prefaced to the information passed to the PCC. See the Setting Site Parameters section of this manual for other options that may be used for passing POV information to the PCC.

In the Definitions section of the POV Codes, note that the Psychosocial Problems category includes the full range of DSM-IV-TR diagnostic codes. The v-codes shown are ICD-9-CM v-Codes. DSM-IV-TR v-Codes or ICD-9-CM v-Codes cannot be directly entered into the system for POVs. Instead a BHS problem code or DSM IV-TR code must be entered. The corresponding ICD-9-CM v-Code will pass to PCC.

In the tables below, the problem code is presented first, followed by the narrative and ICD-9-CM Code. Most problem codes have corresponding ICD-9-CM codes but some do not.

11.1 Medical/Social Problems Category

1  Health/Homemaker Needs (v60.4)
1.1 Health Promotion/Disease Prevention (v65.49)
2  Cross-Cultural Conflict (v62.4) *
3  Unspecified Mental Disorder (v40.9) *
4  Physical Disability/Rehabilitation (v57.9)
5  Physical Illness, Acute (v15.89)
6.1 Physical Illness, Chronic (v15.89)
6.2 Physical Illness, Terminal (v15.89)
7  Non-Compliance w/Treatment Regimen (v15.81)
8  Failed Appointment, No Show (v15.81)
8.1 Patient Cancelled, Rescheduled
8.11 Patient Cancelled, Not Rescheduled (v15.81)
8.2 Provider Cancelled, Rescheduled
8.21 Provider Cancelled, Not Rescheduled
8.3 Did Not Wait to Be Seen (v15.81)
8.4 Malingering (v65.2)
## 11.2 Psychosocial Problems Category

### Note:
When you use these problem codes, the ICD-9-CM code shown in parentheses is passed to the PCC (using the IHS Standard Crosswalk in Option 3) prefaced by the phrase “Diagnostic Impression.”

<table>
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<th>Category</th>
<th>Code Number</th>
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<td>9.2  Senile Dementia, Uncomplicated (290.0)</td>
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<td>10   Alcohol Withdrawal Delirium (291.0)</td>
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<td>11   Drug Withdrawal Syndrome (292.0)</td>
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<tr>
<td>12   Other Organic Mental Disorder/NOS (294.9)</td>
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<tr>
<td>12.1 Substance-Induced Delirium, Dementia, Amnestic and other Cognitive Disorders (294.9)</td>
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<td><strong>Other Psychoses</strong></td>
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<td>13   Schizophrenic Disorder (295.90)</td>
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<td>14   Major Depressive Disorder (311)</td>
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<td>14.2 Alcohol or Drug Induced Mood Disorder (296.90)</td>
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<td>15   Bipolar Disorder (296.80)</td>
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<td>16   Delusional Disorder (297.1)</td>
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<td><strong>Neurotic, Personality and Other Non-psychotic Disorders</strong></td>
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<td>19   Personality Disorder (301.9)</td>
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<td>20   Psychosexual Disorder (302.9)</td>
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<td>21   Communication Disorder NOS (307.9)</td>
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<td>22   Sleep Disorder (307.47)</td>
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<td>23   Eating Disorder (307.50)</td>
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<td>26   Impulse Control Disorder (312.30)</td>
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<td>28   Drug Dependence (304.90)</td>
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<td>29   Alcohol Abuse (305.00)</td>
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</table>
30 Drug Abuse (305.90) •

**Disorders First Evident in Infancy, Childhood, or Adolescence**
31 Disorder of Infancy, Childhood/Adol. (313.9) •
32 Pervasive Developmental Disorder (299.80) •
35 Unspecified Mental Retardation (319) •

**Other**
36 Psychological Factor Affecting a Medical Condition (316) •
37 Factitious Disorder (300.19) •
37.1 Somatoform Disorders (300.82) •
38 Other Suspected Mental Condition (v71.09)
38.1 Diagnosis Deferred, Axis I or Axis II (799.9)

**Suicide**
39 Suicide Ideation (300.9)
40 Suicide Attempt/Gesture (300.9)
41 Suicide Completed (798.1) *

### 11.3 Abuse Category

**Child Abuse (Focus of Attention is on Victim)**
42 Child Abuse (Suspected), Unspecified (995.50) *
42.1 Child Abuse (Suspected), Physical (995.54) *
42.11 Shaken Baby Syndrome (995.55) *
42.2 Child Abuse (Suspected), Emotional (995.51) *
42.3 Child Abuse (Suspected), Sexual (995.53) *
42.4 Other Abuse & Neglect (multiple forms of abuse/neglect) (995.59) *

**Partner Abuse (Focus of Attention is on Victim)**
43 Partner Abuse (Suspected), Unspecified (995.80) *
43.1 Partner Abuse (Suspected), Physical (995.81) *
43.2 Partner Abuse (Suspected), Emotional (995.82) *
43.3 Partner Abuse (Suspected), Sexual (995.83) *
43.4 Other Partner Abuse & Neglect (multiple forms of abuse/neglect) (995.85) *

**Adult Abuse (Focus of Attention is on Victim)**
44 Adult Abuse (Suspected), Unspecified (995.80) *
44.1 Adult Abuse (Suspected), Physical (995.81) *
44.2 Adult Abuse (Suspected), Emotional (995.82) *
44.3 Adult Abuse (Suspected), Sexual (995.83) *
44.4 Other Partner Abuse & Neglect (multiple forms of abuse/neglect) (995.85) *
Child/Partner/Adult Abuse (Focus is on Perpetrator)

45.1  Abusive Behavior (Alleged), Physical/Emotional; Adult Victim; focus on perpetrator who is also a partner. (v61.12) *
45.11 Abusive Behavior (Alleged), Physical/Emotional; Adult Victim; focus on perpetrator who is not the victim’s partner (v62.83) *
45.12 Abusive Behavior (Alleged), Physical/Emotional; Child Victim; focus is on perpetrator who is victim’s parent (v61.22) *
45.13 Abusive Behavior (Alleged), Physical/Emotional; Child Victim; Focus is on perpetrator who is not victim’s parent (v62.83) *
45.3  Abusive Behavior (Alleged), Sexual; Adult Victim; focus is on perpetrator who is also a partner (v61.12) *
45.31 Abusive Behavior (Alleged), Sexual; Adult Victim; focus is on perpetrator who is not the victim’s partner (v62.83) *
45.32 Abusive Behavior (Alleged), Sexual; Child Victim; focus is on perpetrator who is victim’s parent (v61.22) *
45.33 Abusive Behavior (Alleged), Sexual; Child Victim; focus is on perpetrator who is not victim’s parent (v62.83) *

Rape

46  Rape (Alleged/Suspected) (995.83)
46.2 Incest Survivor (Alleged) (v15.41) *

11.4 Neglect Category

47  Child Neglect (Suspected), Nutritional (995.52)
47.1 Child Neglect (Suspected), Other than Nutritional (995.51)
48  Adult Neglect (Suspected), Unspecified (995.80)
48.1 Adult Neglect (Suspected), Nutritional (995.84)
49  Partner Neglect (Suspected), Unspecified (995.80)
49.1 Partner Neglect (Suspected), Nutritional (995.84)
49.9 Exploitation (Adult) (995.80)

11.5 Family Life Problems Category

50  Traumatic Bereavement (v62.82)
51  Alcohol Related Birth Defect (v13.7) *
51.1 Fetal Alcohol Syndrome (760.71)
52  Child Or Adolescent Antisocial Behavior (v71.02)
53  Adult/Child Relationship (v61.20)
54  Uncomplicated Grief Reaction (v62.82)
54.1 Death, Patient Expired
54.2 Dying, End of Life Care (v66.7)
55  Illness in Family (v61.49)
56  Marital Problem (v61.10)
11.6 Pregnancy/Childbirth Problems Category

63  Pregnancy Conflict (v61.8) *
64  Adoption Referral (v68.89) *
64.1 Adoption Counseling (v61.29) *
65  Family Planning (v25.09)
66  Pregnancy Concerns (v61.8) *
67  Teenage Pregnancy (v61.8) *
68  High Risk Pregnancy (v23.9)
69  Other Childbearing Problems (v61.8) *

11.7 Socioeconomic Problems Category

78  Alternate Health Resources (v68.89)
79  Financial Needs/Assistance (v60.2)
79.1 Inadequate Personal Resources (v60.2)
79.2 Inadequate Access to Resources (v60.2)
80  Housing (v60.1)
81  Nutrition (v65.3)
82  Employment (v62.2)
82.1 Unemployment (v62.0)
83  Transportation (v60.8)
84  Occupational Maladjustment (v62.2)
85  Other Socioeconomic Problems (v60.8)

11.8 Sociolegal Problems Category

86  Forensic: Criminal (v62.5)
87  Forensic: Civil (v62.5)
88  Other Sociolegal Problems (v62.5)

11.9 Educational/Life Problems Category

89  Academic Problem (v62.3)
89.1 Alternative Education Services
90  School Behavior Problem (v62.3)
91  School Dropout (v62.3)
92  Vocational Rehabilitation Services (v57.22)
93  Peer Conflict (v62.81)
94  Phase of Life Problems (v62.89)
94.1 Religious or Spiritual Problem (v62.89)
94.2 Borderline Intellectual Functioning (v62.89)

11.10 Administrative Problems Category
95  Continuing Education
96  Training Needs
97  Administration
98  Employee Assistance Program
99  Other Administrative Problems

11.11 Out of Home Care Category
70  Day/Night Care (v60.8)
71  Domiciliary Care (v60.8)
72  Foster Care (v60.4)
72.1 Foster Care – Counseling (v61.29)
73  Halfway House (v66.9)
74  Hospice Care (v66.9)
75  Nursing Care (v66.9)
76  Respite Care (v66.9)
77  Institutional Care (v66.9)

11.12 Other Patient Related Problems Category
38.2  Med Refill – Issue of Repeat Prescription (v68.1)

11.13 Screenings Category
14.1  Screening for Depression (v79.0)
29.1  Screening for Alcoholism (v79.1)
29.2  Screening for Drug Abuse (v79.8)
12.0 Appendix C: POV Code Definitions

The v-codes shown are corresponding ICD-9-CM v-codes. DSM-IV-TR v-codes or ICD-9-CM v-codes cannot be directly entered into the system for POVs. Instead a BHS problem code or DSM IV-TR code must be entered. The corresponding ICD-9-CM v-code will pass to PCC. Most problem codes have corresponding ICD-9-CM codes but some do not.

Note:

* v-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."

• ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative

12.1 Medical/Social Problems Category

1-(v60.4) Health/Homemaker Needs - Problems associated with monitoring the patient and providing care in the home.

1.1 – (v65.49) Health Promotion/Disease Prevention – Problems with self-care or health maintenance associated with a disease, illness or condition which may be remedied or prevented with the provision of health promotion and disease prevention services.

2- *(v62.4) Cross-Cultural Conflict - Problems which arise from cultural beliefs or experience. Concerns expressed in traditional or cultural terms/ways.

3- *(v40.9) Unspecified Mental Disorder (Non-Psychotic) - Problems which for the time being cannot be completely specified in clear diagnostic terms.

4- (v57.9) Physical Disability/Rehabilitation - Problems of physical restoration and social and emotional adjustment to physical disability.

5- (v15.89) Physical Illness, Acute - Social and emotional adjustment problems associated with acute illness.

6.1– (v15.89) Physical Illness, Chronic – Social and emotional problems associated with long-term illness and the care associated with this state.
6.2– (v15.89) Physical Illness, Terminal – Social and emotional problems associated with terminal illness and the care associated with this state.

7- (v15.81) Noncompliance with Treatment Regimen - Noncompliance that is apparently not due to mental disorder.

8- (v15.81) Failed Appointment/No Show

8.1- Patient Cancelled, Rescheduled

8.11- (v15.81) Patient Cancelled, Not Rescheduled

8.2- Provider Cancelled, Rescheduled

8.21- Provider Cancelled, Not Rescheduled

8.3- (v15.81) Did Not Wait to Be Seen

8.4– (v65.2) Malingering – the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.

12.2 Psychosocial Problems Category

The Psychosocial Problems category includes the full range of DSM-IV-TR diagnostic codes.

12.2.1 Organic Mental Disorders

9.1- 290.10 Presenile Dementia, Uncomplicated

294.10 Dementia of the Alzheimer’s Type, with early onset, without Behavioral Disturbance

294.11 Dementia of the Alzheimer’s Type, with early onset, with Behavioral Disturbance

9.2- 290.0 Senile Dementia, Uncomplicated

294.10 Dementia of the Alzheimer’s Type, with late onset, without Behavioral Disturbance

294.10 Dementia due to … (general medical condition) without Behavioral Disturbance

294.11 Dementia of the Alzheimer’s Type, with late onset, with Behavioral Disturbance
294.11  Dementia due to ...(general medical condition) with Behavioral Disturbance

**Alcoholic Withdrawal Delirium**

10-  291.0•  Alcohol Intoxication Delirium
     291.0•  Alcohol Withdrawal Delirium
     291.81  Alcohol Withdrawal
     291.9  Alcohol-Related Disorder NOS

**Drug Withdrawal Syndrome**

292.0  Amphetamine Withdrawal
292.0  Cocaine Withdrawal
292.0  Nicotine withdrawal
292.0  Opioid Withdrawal

11-  292.0•  Other (or Unknown) Substance Withdrawal
     292.0  Sedative, Hypnotic or Anxiolytic Withdrawal
     292.89  Amphetamine Intoxication
     292.89  Cannabis Intoxication
     292.89  Cocaine Intoxication
     292.89  Hallucinogen Intoxication
     292.89  Inhalant Intoxication
     292.89  Opioid Intoxication
     292.89  Other (or Unknown) Substance-Induced Intoxication
     292.89  Phencyclidine Intoxication
     292.89  Sedative-, Hypnotic-, or Anxiolytic-Induced Intoxication
     292.89  Hallucinogen Persisting Perception Disorder
     292.9  Caffeine-Related Disorder NOS

**Other Organic Mental Disorder NOS**

294.8  Amnestic Disorder NOS
294.8  Dementia NOS
293.0  Delirium Due to...(Indicate Med. Condition)
293.89  Anxiety or Catatonic Disorder Due to …(Indicate Med. Condition)

293.9  Mental Disorder NOS Due to...(Indicate Med. Condition)
294.0  Amnestic Disorder Due to...(Indicate Med. Condition)

12-  294.9•  Cognitive Disorder NOS
     780.09  Delirium NOS
     290.40  Vascular Dementia, Uncomplicated
     290.41  Vascular Dementia, W/Delirium
     290.42  Vascular Dementia, W/Delusions
     290.43  Vascular Dementia, W/Depressed Mood

12.1-  294.9•  Substance-Induced Delirium, Dementia, Amnestic and other Cognitive Disorders
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<tr>
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<td>291.2</td>
<td>Alcohol-Induced Persisting Dementia</td>
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<tr>
<td>292.81</td>
<td>Amphetamine Intoxication Delirium</td>
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<tr>
<td>292.81</td>
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<td>Cocaine Intoxication Delirium</td>
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<td>Other (or Unknown) Substance-Induced Delirium</td>
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<td>292.81</td>
<td>Phencyclidine Intoxication Delirium</td>
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<td>292.81</td>
<td>Sedative, Hypnotic, or Anxiolytic Intoxication Delirium</td>
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<td>292.81</td>
<td>Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium</td>
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<td>292.82</td>
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<td>292.82</td>
<td>Other (or Unknown) Substance-Induced Persisting Dementia</td>
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<td>Sedative, Hypnotic, or Anxiolytic-Induced Persisting Amnestic Disorder</td>
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### 12.2.2 Other Psychoses

**Schizophrenic Disorder**

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<td>295.11</td>
<td>Schizophrenia, Disorganized Type, Subchronic</td>
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<tr>
<td>295.12</td>
<td>Schizophrenia, Disorganized Type, Chronic</td>
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<tr>
<td>295.13</td>
<td>Schizophrenia, Disorganized Type, Subchronic W/Acute Exacerbation</td>
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<td>295.14</td>
<td>Schizophrenia, Disorganized Type, Chronic W/Acute Exacerbation</td>
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<tr>
<td>295.15</td>
<td>Schizophrenia, Disorganized Type, In Remission</td>
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<tr>
<td>295.20</td>
<td>Schizophrenia, Catatonic Type</td>
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<td>295.21</td>
<td>Schizophrenia, Catatonic Type, Subchronic</td>
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<td>295.22</td>
<td>Schizophrenia, Catatonic Type, Chronic</td>
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<td>295.23</td>
<td>Schizophrenia, Catatonic Type, Subchronic, W/Acute Exacerbation</td>
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<td>295.24</td>
<td>Schizophrenia, Catatonic Type, Chronic, W/Acute Exacerbation</td>
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<td>295.25</td>
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<td>295.30</td>
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<td>295.31</td>
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<td>295.32</td>
<td>Schizophrenia, Paranoid Type, Chronic</td>
</tr>
</tbody>
</table>
295.33  Schizophrenia, Paranoid Type, Subchronic, W/Acute Exacerbation
295.34  Schizophrenia, Paranoid Type, Chronic, W/Acute Exacerbation
295.35  Schizophrenia, Paranoid Type, In Remission
295.60  Schizophrenia, Residual Type, Unspecified
295.61  Schizophrenia, Residual Type, Subchronic
295.62  Schizophrenia, Residual Type, Chronic
295.63  Schizophrenia, Residual Type, Subchronic, W/Acute Exacerbation
295.64  Schizophrenia, Residual Type, Chronic, W/Acute Exacerbation
13-
295.65  Schizophrenia, Residual Type, In Remission
295.90  Schizophrenia, Undifferentiated Type, Unspecified
295.91  Schizophrenia, Undifferentiated Type, Subchronic
295.92  Schizophrenia, Undifferentiated Type, Chronic
295.93  Schizophrenia, Undifferentiated Type, Subchronic, w/Acute Exacerbation
295.94  Schizophrenia, Undifferentiated Type, Chronic, W/Acute Exacerbation
295.95  Schizophrenia, Undifferentiated Type, In Remission

Major Depressive Disorder

300.4  Dysthymic Disorder
311•  Depressive Disorder NOS
14-
296.20  Major Depressive Disorder, Single Episode, Unspecified
296.21  Major Depressive Disorder, Single Episode, Mild
296.22  Major Depressive Disorder, Single Episode, Moderate
296.23  Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
296.24  Major Depressive Disorder, Single Episode, Severe with Psychotic Features
296.25  Major Depressive Disorder, Single Episode, In Partial Remission
296.26  Major Depressive Disorder, Single Episode, In Full Remission
296.30  Major Depressive Disorder, Recurrent, Unspecified
296.31  Major Depressive Disorder, Recurrent, Mild
296.32  Major Depressive Disorder, Recurrent, Moderate
296.33  Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
296.34  Major Depressive Disorder, Recurrent, Severe With Psychotic Features
296.35  Major Depressive Disorder, Recurrent, In Partial Remission
296.36  Major Depressive Disorder, Recurrent, In Full Remission
293.83  Mood Disorder Due to...(Indicate Med. Condition)
Alcohol-Induced Mood Disorder

**Alcohol or Drug Induced Mood Disorder NOS**

Amphetamine-Induced Mood Disorder

Cocaine-Induced Mood Disorder

Hallucinogen-Induced Mood Disorder

Inhalant-Induced Mood Disorder

Opioid-Induced Mood Disorder

Other (or Unknown) Substance-Induced Mood Disorder

Phencyclidine-Induced Mood Disorder

Sedative-, Hypnotic- or Anxiolytic-Induced Mood Disorder

Bipolar Disorder

Bipolar I Disorder, Single Manic Episode, Unspecified

Bipolar I Disorder, Single Manic Episode, Mild

Bipolar I Disorder, Single Manic Episode, Moderate

Bipolar I Disorder, Single Manic Episode, Severe, Without Psychotic Features

Bipolar I Disorder, Single Manic Episode, Severe, with Psychotic Features

Bipolar I Disorder, Single Manic Episode, In Partial Remission

Bipolar I Disorder, Single Manic Episode, In Full Remission

Bipolar I Disorder, Most Recent Episode Manic, Unspecified

Bipolar I Disorder, Most Recent Episode Hypomanic

Bipolar I Disorder, Most Recent Episode Manic, Mild

Bipolar I Disorder, Most Recent Episode Manic, Moderate

Bipolar I Disorder, Most Recent Episode Manic, Severe without Psychotic Features

Bipolar I Disorder, Most Recent Episode manic, Severe with Psychotic Features

Bipolar I Disorder, Most Recent Episode manic, In Partial Remission

Bipolar I Disorder, Most Recent Episode manic, In Full Remission

Bipolar I Disorder, Most Recent Episode Depressed, Unspecified

Bipolar I Disorder, Most Recent Episode Depressed, Mild

Bipolar I Disorder, Most Recent Episode Depressed, Moderate

Bipolar I Disorder, Most Recent Episode Depressed, Severe, Without Psychotic Features
296.54  Bipolar I Disorder, Most Recent Episode Depressed, Severe, With Psychotic Features
296.55  Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
296.56  Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.60  Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.61  Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62  Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296.63  Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
296.64  Bipolar I Disorder, Most Recent Episode Mixed, Severe, With Psychotic Features
296.65  Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
296.66  Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
296.7  Bipolar I Disorder, Most Recent Episode Unspecified,
15- 296.80• Bipolar Disorder NOS
296.89  Bipolar II Disorder
296.90  Mood Disorder NOS
301.13  Cyclothymic Disorder

**Delusional Disorder**
16- 297.1• Delusional Disorder
297.3  Shared Psychotic Disorder

**Psychotic Disorder NOS**
295.40  Schizophreniform Disorder, Unspecified
295.41  Schizophreniform Disorder, Subchronic
295.42  Schizophreniform Disorder, Chronic
295.43  Schizophreniform Disorder, Subchronic, W/Acute Exacerbation
295.44  Schizophreniform Disorder, Chronic, With Acute Exacerbation
295.45  Schizophreniform Disorder, In Remission
295.70  Schizoaffective Disorder, Unspecified
295.71  Schizoaffective Disorder, Subchronic
295.72  Schizoaffective Disorder, Chronic
295.73  Schizoaffective Disorder, Subchronic, W/Acute Exacerbation
295.74  Schizoaffective Disorder, Chronic, With Acute Exacerbation
295.75  Schizoaffective Disorder, In Remission
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>298.8</td>
<td>Brief Psychotic Disorder</td>
</tr>
<tr>
<td>298.9*</td>
<td>Psychotic Disorder NOS</td>
</tr>
<tr>
<td>293.81</td>
<td>Psychotic Disorder Due to...(Indicate Med.Cond.), W/Delusions</td>
</tr>
<tr>
<td>293.82</td>
<td>Psychotic Disorder Due to...(Indicate Med.Cond.), W/Hallucinations</td>
</tr>
<tr>
<td>17.1-</td>
<td>Alcohol or Drug Induced Psychotic Disorder</td>
</tr>
<tr>
<td>291.3</td>
<td>Alcohol-Induced Psychotic Disorder, With Hallucinations</td>
</tr>
<tr>
<td>292.11</td>
<td>Amphetamine-Induced Psychotic Disorder, with Delusions</td>
</tr>
<tr>
<td>292.11</td>
<td>Cannabis-Induced Psychotic Disorder with Delusions</td>
</tr>
<tr>
<td>292.11</td>
<td>Cocaine-Induced Psychotic Disorder with Delusions</td>
</tr>
<tr>
<td>292.11</td>
<td>Hallucinogen-Induced Psychotic Disorder with Delusions</td>
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<td>292.11</td>
<td>Inhalant-Induced Psychotic Disorder with Delusions</td>
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<tr>
<td>292.11</td>
<td>Opioid-Induced Psychotic Disorder with Delusions</td>
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<tr>
<td>292.11</td>
<td>Other (or Unknown) Substance-Induced Psychotic Disorder with Delusions</td>
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<tr>
<td>292.11</td>
<td>Phencyclidine-Induced Psychotic Disorder with Delusions</td>
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<td>292.11</td>
<td>Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Delusions</td>
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<td>292.12</td>
<td>Amphetamine-Induced Psychotic Disorder with Hallucinations</td>
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<td>292.12</td>
<td>Cannabis-Induced Psychotic Disorder with Hallucinations</td>
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<td>292.12</td>
<td>Hallucinogen-Induced Psychotic Disorder with Hallucinations</td>
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<td>292.12</td>
<td>Inhalant-Induced Psychotic Disorder with Hallucinations</td>
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<td>292.12</td>
<td>Opioid-Induced Psychotic Disorder with Hallucinations</td>
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<td>Other (or Unknown) Substance-Induced Psychotic Disorder with Hallucinations</td>
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<td>292.12</td>
<td>Phencyclidine-Induced Psychotic Disorder with Hallucinations</td>
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<tr>
<td>292.12</td>
<td>Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations</td>
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</table>

### 12.2.3 Neurotic, Personality and Other Nonpsychotic Disorders

#### Anxiety Disorder

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<td>18-</td>
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<tr>
<td>300.00*</td>
<td>Anxiety Disorder NOS</td>
</tr>
<tr>
<td>300.01</td>
<td>Panic Disorder, Without Agoraphobia</td>
</tr>
<tr>
<td>300.02</td>
<td>Generalized Anxiety Disorder</td>
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<tr>
<td>300.12</td>
<td>Dissociative Amnesia</td>
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<td>300.13</td>
<td>Dissociative Fugue</td>
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<td>Dissociative Identity Disorder</td>
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<td>300.15</td>
<td>Dissociative Disorder NOS</td>
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</table>
300.21  Panic Disorder, With Agoraphobia
300.22  Agoraphobia Without history of Panic Disorder
300.23  Social Phobia
300.29  Specific Phobia
300.3  Obsessive-Compulsive Disorder
300.6  Depersonalization Disorder
300.9  Unspecified Mental Disorder (Nonpsychotic)
308.3  Acute Stress Reaction
309.81  Post-Traumatic Stress Disorder
293.84  Anxiety Disorder Due to...(Indicate Med. Condition)

18.1-  300.00•  Alcohol or Drug Induced Anxiety Disorder
291.5  Alcohol-Induced Psychotic Disorder, With Delusions
291.89  Alcohol-Induced Anxiety Disorder
292.89  Amphetamine-Induced Anxiety Disorder
292.89  Caffeine-Induced Anxiety Disorder
292.89  Cannabis-Induced Anxiety Disorder
292.89  Cocaine-Induced Anxiety Disorder
292.89  Hallucinogen-Induced Anxiety Disorder
292.89  Inhalant-Induced Anxiety Disorder
292.89  Other (or Unknown) Substance-Induced Anxiety Disorder
292.89  Phencyclidine-Induced Anxiety Disorder
292.89  Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder

Personality Disorder
301.0  Paranoid Personality Disorder
301.20  Schizoid Personality Disorder
301.22  Schizotypal Personality Disorder
301.4  Obsessive-Compulsive Personality Disorder
301.50  Histrionic Personality Disorder
301.6  Dependent Personality Disorder
301.7  Antisocial Personality Disorder
301.81  Narcissistic Personality Disorder
301.82  Avoidant Personality Disorder
301.83  Borderline Personality Disorder
19-  301.9•  Personality Disorder NOS
310.1  Personality Change Due to...(Indicate Med. Condition)

Psychosexual Disorder
302.2  Pedophilia
302.3  Transvestic Fetishism
302.4  Exhibitionism
302.6  Gender Identity Disorder in Children
302.6  Gender Identity Disorder NOS
302.70  Sexual Dysfunction NOS
302.71  Hypoactive Sexual Desire Disorder
302.72  Female Sexual Arousal Disorder
302.72  Male Erectile Disorder
302.73  Female Orgasmic Disorder
302.74  Male Orgasmic Disorder
302.75  Premature Ejaculation
302.76  Dyspareunia (Not Due to a General Medical Condition)
302.79  Sexual Aversion Disorder
302.81  Fetishism
302.82  Voyeurism
302.83  Sexual Masochism
302.84  Sexual Sadism
302.85  Gender Identity Disorder in Adolescents or Adults
302.89  Frotteurism
302.9  Paraphilia NOS
20- 302.9•  Sexual Disorder NOS
306.51  Vaginismus (Not Due to a General Medical Condition)
607.84  Male Erectile Disorder Due to ; ; ; (Indicate General Medical Condition)
608.89  Male Dyspareunia Due to ; ; ; (Indicate General Medical Condition)
608.89  Male Hypoactive Sexual Desire Disorder Due to ; ; ; (Indicate General Medical Condition)
608.89  Other Male Sexual Dysfunction Due to ; ; ; (Indicate General Medical Condition)
625.0  Female Dyspareunia Due to ; ; ; (Indicate General Medical Condition)
625.8  Female Hypoactive Sexual Desire Disorder Due to ; ; ; (Indicate General Medical Condition)
625.8  Other Female Sexual Dysfunction Due to ; ; ; (Indicate General Medical Condition)
20.1- 302.9•  Alcohol or Drug Induced Psychosexual Disorder
291.89  Alcohol-Induced Sexual Dysfunction
292.89  Amphetamine-Induced Sexual Dysfunction
292.89  Cocaine-Induced Sexual Dysfunction
292.89  Opioid-Induced Sexual Dysfunction
292.89  Other (or Unknown) Substance-Induced Sexual Dysfunction
292.89  Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction

Communication Disorder NOS
307.0  Stuttering
307.20  Tic Disorder NOS
307.21  Transient Tic Disorder
307.22  Chronic Motor or Vocal Tic Disorder
307.23  Tourette's Disorder
307.3   Stereotypic Movement Disorder
21-    307.9•  Communication Disorder NOS

Medication Induced Disorder
332.1   Neuroleptic-Induced Parkinsonism
333.1   Medication-Induced Postural Tremor
333.7   Neuroleptic-Induced Acute Dystonia
333.82  Neuroleptic-Induced Tardive Dyskinesia
333.90  Medication-Induced Movement Disorder NOS
333.92  Neuroleptic Malignant Syndrome
333.99  Neuroleptic-Induced Acute Akathisia
21.1-  995.2•  Adverse Effects of Medication, NOS

Sleep Disorder
307.42  Primary Insomnia; Insomnia Related to...(Indicate Axis I or Axis II)
307.44  Hypersomnia Related to...(Indicate Axis I or Axis II)
307.44  Primary Hypersomnia
307.45  Circadian Rhythm Sleep Disorder
307.46  Sleep Terror Disorder
307.46  Sleepwalking Disorder
22-    307.47•  Dyssomonia NOS
307.47  Parasomnia NOS
307.47  Nightmare Disorder
347.00  Narcolepsy without Cataplexy
347.01  Narcolepsy with Cataplexy
347.10  Narcolepsy condition without Cataplexy
347.11  Narcolepsy condition with Cataplexy
780.52  Sleep Disorder Due to…(Indicate General Medical Condition), Insomnia Type
780.54  Sleep Disorder Due to…(Indicate General Medical Condition), Hypersomnia Type
780.59  Sleep Disorder Due to…(Indicate General Medical Condition), Mixed Type)
780.59  Sleep Disorder Due to…(Indicate General Medical Condition), Parasomnia type
22.1-  307.47•  Alcohol or Drug Induced Sleep Disorder
291.89  Alcohol-Induced Sleep Disorder
292.89  Amphetamine-Induced Sleep Disorder
292.89  Caffeine-Induced Sleep Disorder
292.89  Cocaine-Induced Sleep Disorder
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292.89 Opioid-Induced Sleep Disorder
292.89 Other (or Unknown) Substance-Induced Sleep Disorder
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder

Eating Disorder
307.1 Anorexia Nervosa
23- 307.50• Eating Disorder NOS
307.51 Bulimia Nervosa
307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood

Adjustment Disorder
309.0 Adjustment Disorder With Depressed Mood
309.21 Separation Anxiety Disorder
309.24 Adjustment Disorder With Anxiety
309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.3 Adjustment Disorder With Disturbance of Conduct
309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
24- 309.9• Adjustment Disorder, Unspecified

Disruptive Behavior Disorder NOS
312.81 Conduct Disorder, Childhood Onset Type
312.82 Conduct Disorder, Adolescent Onset Type
312.89 Conduct Disorder, Unspecified Onset
25- 312.9• Disruptive Behavior Disorder NOS

Impulse Control Disorder
26- 312.30• Impulse Control Disorder NOS
312.31 Pathological Gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent Explosive Disorder
312.39 Trichotillomania

12.2.4 Alcohol and Drug Abuse

Alcohol Dependence
27- 303.90• Alcohol Dependence, Unspecified
303.91 Alcohol Dependence, Continuous
303.92 Alcohol Dependence, Episodic
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<td>303.93</td>
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<td>304.00</td>
<td>Opioid Dependence, Unspecified</td>
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**Note:**

- **28-** Indicates a section that is likely not fully spelled out or is a placeholder for additional content.
- **304.90•** Indicates a note or exception, possibly emphasizing a specific condition or context.
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**Alcohol Abuse**

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**Drug Abuse**

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12.2.5 Disorders First Evident in Infancy, Childhood, or Adolescence

Disorder of Infancy, Childhood and Adolescence

313.23 Selective Mutism
313.81 Oppositional Defiant Disorder
313.82 Identity Problem
313.89 Reactive Attachment Disorder of Infancy or Early Childhood

313.9• Disorders of Infancy, Childhood, or Adolescence NOS
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
314.01 Attention-Deficit Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS

Pervasive Developmental Disorder

299.00 Autistic Disorder, Active
299.01 Autistic Disorder, Residual
299.10 Childhood Disintegrative Disorder, Active
299.11 Childhood Disintegrative Disorder, Residual
32- 299.80• Pervasive Developmental Disorder NOS, Active
299.80  Asperger's Disorder
299.80  Rett's Disorder, Active
299.81  Pervasive Developmental Disorder NOS, Residual
        Asperger's, Rett's Disorder, Residual
307.6  Enuresis (Not Due to a General Medical Condition)
307.7  Encopresis, Without Constipation and Overflow
        Incontinence
315.00 Reading Disorder
315.1  Mathematics Disorder
315.2  Disorders of Written Expression
315.31  Expressive Language Disorder
315.32  Mixed Receptive-Expressive Language Disorder
315.39  Phonological Disorder
315.4  Developmental Coordination Disorder
315.9  Learning Disorder NOS
787.6  Encopresis, With Constipation and Overflow Incontinence

Unspecified Mental Retardation
35- 319• Mental Retardation, Severity Unspecified
        317  Mild Mental Retardation
        318.0  Moderate Mental Retardation
        318.1  Severe Mental Retardation
        318.2  Profound Mental Retardation

12.2.6 Other

Psychological Factor Affecting a Medical Condition
36- 316• (Specified Psych. Factor) Affecting...(Indicate Med.Cond.)

Factitious Disorder
300.16  Factitious Disorder W/ Psychological Signs and Symptoms
37- 300.19• Factitious Disorder NOS
        300.19  Factitious Disorder with Combined Psychological/Physical
                Signs and Symptoms
        300.19  Factitious Disorder with Predominantly Physical Signs and
                Symptoms

Somatoform Disorder
300.7  Body Dysmorphic Disorder
300.7  Hypochondriasis
300.81  Somatization Disorder
37.1- 300.82• Somatoform Disorder NOS
        300.82  Undifferentiated Somatoform Disorder
300.11 Conversion Disorder
307.80 Pain Disorder Associated With Psychological Features
307.89 Pain Disorder Associated With Both Psych. and Med. Condition

Other Suspected Mental Condition
780.93 Age Related Cognitive Decline
38- (v71.09) Other Suspected Mental Condition

Diagnosis Deferred
38.1- 799.9 Diagnosis or Condition Deferred on Axis I
799.9 Diagnosis Deferred on Axis II

Suicide
39- 300.9 Suicide (Ideation) - Thinking about, including talking about, taking one's life.
40- 300.9 Suicide (Attempt/Gesture) - Any effort directed at harming one's self.
41-798.1• Suicide (Completed) - Intentional self inflicted death requires follow-up to complete suicide registry information.

12.3 Abuse Category

Child Abuse (Focus of Attention is on Victim)
42*-995.50 Child Abuse (Suspected), Unspecified - Willful abuse of children requiring protective actions.
42.1*-995.54 Physical Abuse of Child (Victim)
42.11*-995.55 Shaken Baby Syndrome
42.2*-995.51 Child Abuse (Emotional) (Suspected)
42.3*-995.53 Sexual Abuse of Child (Victim)
42.4*- 995.59 Other child abuse & neglect (multiple forms of abuse/neglect)

Partner Abuse (Focus of Attention is on Victim)
43*- 995.80 Partner Abuse (Suspected), Unspecified
43.1*- 995.81 Partner Abuse (Suspected), Physical
43.2*- 995.82 Partner Abuse (Suspected), Emotional
43.3*- 995.83 Partner Abuse (Suspected), Sexual
43.4*- 995.85 Other partner abuse & neglect (multiple forms of abuse/neglect)

Adult Abuse (Focus of Attention is on Victim)
44*- 995.80 Adult Abuse, (Suspected), Unspecified
44.1*  995.81  Adult Abuse, (Suspected), Physical
44.2*  995.82  Adult Abuse, (Suspected), Emotional
44.3*  995.83  Adult Abuse, (Suspected), Sexual
44.4*  995.85  Other partner abuse & neglect (multiple forms of abuse/neglect)

**Child/Partner/Adult Abuse (Focus is on Perpetrator)**

45.1*  v61.12  Abusive Behavior (Alleged), Physical/Emotional; adult victim; focus on perpetrator who is also a partner
45.11*  v62.83  Abusive Behavior (Alleged); adult victim; focus on perpetrator who is not the victim’s partner
45.12*  v61.22  Abusive Behavior (Alleged), Physical/Emotional; child victim; focus on perpetrator who is victim’s parent
45.13*  v62.83  Abusive Behavior (Alleged), Physical/Emotional; child victim; focus is on perpetrator who isn’t victim’s parent
45.3*  v61.12  Abusive Behavior (Alleged), Sexual; adult victim; focus is on perpetrator who is also a partner
45.31*  v62.83  Abusive Behavior (Alleged); Sexual; adult victim; focus is on perpetrator who is not the victim’s partner
45.32*  v61.22  Abusive Behavior (Alleged); Sexual; child victim; focus on perpetrator who is victim’s parent
45.33*  v62.83  Abusive Behavior (Alleged); Sexual; child victim; focus is on perpetrator who is not victim’s parent

**Rape**

46-  995.83  Rape (Alleged/Suspected)
46.2*  v15.41  Incest Survivor - Current or historical information which is relevant to present situation/problem/issue.

### 12.4  Neglect Category

47-  995.52  Neglect of Child (Victim); Nutritional
47.1-  995.51  Child Neglect (Suspected), Other than Nutritional
48-  995.80  Adult Neglect (Suspected) Unspecified
48.1-  995.84  Adult Neglect (Suspected), Nutritional
49-  995.80  Partner Neglect (Suspected) Unspecified
49.1-  995.84  Partner Neglect (Suspected), Nutritional
49.9-  995.80  Exploitation (Adult)

### 12.5  Family Life Problems Category

50-  v62.82  Traumatic Bereavement
51*  v13.7  Alcohol Related Birth Defect (ARBD)
51.1*  760.71  Fetal Alcohol Syndrome (FAS)
52-  v71.02  Child or Adolescent Antisocial Behavior
53- v61.20 Adult/Child Relationship
54- v62.82 Uncomplicated Grief Reaction
54.1- Death, Patient Expired
54.2- v66.7 Dying, End of Life Care
55- v61.49 Illness in Family
56- v61.10 Marital Problem
57- v61.8 Sibling Conflict
58- v61.0 Separation/Divorce
59- v61.8 Family Conflict
60- v62.81 Interpersonal Relationships
61- v71.01 Adult Antisocial Behavior
62- v61.8 Other Family Life Problems

12.6 Pregnancy/Childbirth Problems Category

63*- v61.8 Pregnancy Conflict
64*- v68.89 Adoption (Referral)
64.1*- v61.29 Adoption (Counseling)
65- v25.09 Family Planning
66*- v61.8 Pregnancy Concerns
67*- v61.8 Teenage Pregnancy
68- v23.9 High Risk Pregnancy
69*- v61.8 Other Childbearing Problems.

12.7 Socioeconomic Problems Category

78- v68.89 Alternate Health Resources
79- v60.2 Financial Needs/Assistance
79.1- v60.2 Inadequate Personal Resources
79.2- v60.2 Inadequate Access to Resources
80- v60.1 Housing
81- v65.3 Nutrition
82- v62.2 Employment
82.1- v62.0 Unemployment
83- v60.8 Transportation
84- v62.2 Occupational Maladjustment
85- v60.8 Other Socioeconomic Problems

12.8 Sociolegal Problems Category

86- v62.5 Forensic: Criminal
87- v62.5 Forensic: Civil
88- v62.5 Other Sociolegal Problems
12.9 Educational/Life Problems Category

89- v62.3 Academic Problem
89.1- Alternative Education Services
90- v62.3 School Behavior Problem
91- v62.3 School Dropout
92- v57.22 Vocational Rehabilitation Services
93- v62.81 Peer Conflict
94- v62.89 Phase of Life Problems
94.1- v62.89 Religious or Spiritual Problem
94.2- v62.89 Borderline Intellectual Functioning

12.10 Administrative Problems Category

95- Continuing Education
96- Training Needs
97- Administration
98- Employee Assistance Program
99- Other Administrative Problems

12.11 Out of Home Care Category

70- v60.8 Day/night Care
71- v60.8 Domiciliary Care
72- v60.4 Foster Care
72.1- v61.29 Foster Care (Counseling)
73- v66.9 Halfway House
74- v66.9 Hospice Care
75- v66.9 Nursing Care
76- v66.9 Respite Care
77- v66.9 Institutional Care

12.12 Other Patient Related Problems Category

38.2- v68.1 Med Refill – Issue of Repeat Prescription

12.13 Screenings Category

14.1- (v79.0) Screening for Depression
29.1- (v79.1) Screening for Alcoholism
29.2- (v79.8) Screening for Drug Abuse
### 13.0 Appendix D: Activity Codes that Pass to PCC

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<td>Twelve Step Group (TWG)</td>
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<td>Assessment/Evaluation – Patient Present (EVL)</td>
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<td>Individual Treatment/Counsel/Education – Pt. Present (IND)</td>
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<td>Information and Referral – Patient Present (REF)</td>
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<td>Psychological Testing – Patient Present (TST)</td>
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<td>Follow Through/Follow Up – Patient Present (FOL)</td>
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<td>Case Staffing (General)</td>
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<td>61</td>
<td>Provider Consultation (PRO)</td>
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<td>62</td>
<td>Patient Consultation (Chart Review) (CHT)</td>
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<td>63</td>
<td>Program Consultation</td>
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<td>Staff Consultation</td>
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<td>Community Consultation</td>
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<td>Clinical Supervision Received</td>
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<td>Travel Related to Patient Care</td>
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<td>Placement – Patient Not Present (OHA)</td>
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<td>Traditional Specialist Consult – Patient Present (TRD)</td>
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<td>Traditional Specialist Consult – Patient Not Present (TRA)</td>
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<td>83</td>
<td>Tribal Functions</td>
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<td>84</td>
<td>Cultural Education to Non-Tribal Agency/Personnel</td>
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<td>Art Therapy (ART)</td>
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<td>Acupuncture (ACU)</td>
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<td>Group Treatment (GRP)</td>
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<td>Adventure Based Counseling (ABC)</td>
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<td>Relapse Prevention (REL)</td>
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<td>Life Skills Training (LST)</td>
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<td>Cultural Activities (CUL)</td>
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<td>Academic Services (ACA)</td>
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<td>Health Promotion (HPR)</td>
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14.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk by:

Phone: (505) 248-4371 or
       (888) 830-7280

Fax:  (505) 248-4363

Web:  http://www.rpms.ihs.gov/TechSupp.asp

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