



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

User Manual

Version 4.0 Patch 1
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1.0 Introduction

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

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

Behavioral Health System v4.0 offers:

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

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

- **Behavioral Health Data Entry Menu:** Use the Behavioral Health Data Entry menu for all aspects of recording data items related to patient care, case management, treatment planning, and follow-up.
- **Reports Menu:** Use the Reports menu for tracking and managing patient, provider, and program statistics.
- **Manager Utilities Menu:** Use the Manager Utilities menu for setting site-specific parameters related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and HQE for mandated federal reporting and funding.

1.1 Primary Menu

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

```

*****
**      IHS Behavioral Health System      **
*****
                Version 4.0 (Patch 1)

                DEMO INDIAN HOSPITAL

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

Select Behavioral Health Information System Option:

```

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

1.2 Preparations

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

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

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

1.3 Security Keys

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

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

Key	Permits Access To
AMHZ DV REPORTS	Screening Reports
AMHZ SUICIDE FORM ENTRY	Suicide Form Data Entry Menu
AMHZ SUICIDE FORM REPORTS	Suicide Form Reports Menu
AMHZ DELETE RECORD	Delete unsigned records
AMHZ DELETE SIGNED NOTE	Delete records containing signed notes
AMHZ UPDATE USER/LOCATIONS	Update the locations the user is permitted to access
AMHZ CODING REVIEW	Review records to ensure accurate coding

2.0 Orientation

The following provides information about using the roll-and-scroll RPMS Behavioral Health System and the RPMS Behavioral Health System GUI.

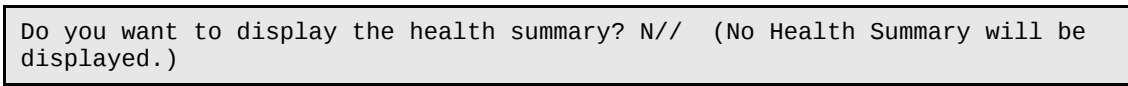
2.1 Standard Conventions (Roll and Scroll)

2.1.1 Caps Lock

Always work with the Caps Lock on.

2.1.2 Default Entries

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



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

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

2.1.3 Help

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

2.1.4 To Back Out

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

2.1.5 Exit

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

Type **RESTART** at a menu option prompt to return to the “Access Code:” prompt.

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

2.1.6 Same Entries

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

2.1.7 Lookup

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

Example:

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

Figure 2-2: Patient lookup screen

2.1.8 Pause Indicator

The <> symbol is usually displayed when a multiple page report reaches the bottom of a display screen and there are additional pages in the report. Press Enter to see the next page or type a caret (^) to exit the report.

2.1.9 Dates and Times

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

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

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

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

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

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

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

2.1.10 Stop

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

2.1.11 Delete

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

2.2 ListMan (Roll and Scroll)

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

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

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

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

Update BH Forms		Mar 29, 2001 11:50:37				Page: 1 of 1	
Date of Encounter:		Tuesday MAR 27, 2001					

#	PRV	PATIENT NAME	HRN	AT	ACT	PROB	NARRATIVE
1	DKR	W&&RMAN, RAE	SE100003		31	14	SEVERE DEPRESSION
2	DKR	--	-----	60	36	95	RPMS BH TRAINING
3	DKR	--	-----	30	32	84	EMPLOYEE COUNSELING

```

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

Select Action: AV/??

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

```

Figure 2-3: ListMan secondary options screen

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

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

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

2.3 ScreenMan (Roll and Scroll)

2.3.1 Using the ScreenMan Window

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

```

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

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

Activity:      Activity Time:      # Served: 1      Interpreter?

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

COMMAND:
Insert
Press <PF1>H for help

```

Figure 2-4: Using ScreenMan Sample Screen 1

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

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

2.3.2 Using the Pop-Up Window

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

```

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

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

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

Close      Refresh

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

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

```

Figure 2-5: Using ScreenMan, Sample Screen 2

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

```

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

```

Figure 2-6: Using ScreenMan, Sample Screen 3

2.4 Full Screen Text Editor (Roll and Scroll)

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

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

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

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

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

Below is a sample Text Edit screen:

```

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

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

```

Figure 2-7: Using Text Editor, Sample Screen 1

You can display all of the commands available for the RPMS Full Screen Editor by pressing the PF1 (F1) key, followed by the H key. Type a caret (^) to exit the help screens.

```

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

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

Activity:      Activity Time:             # Served: 1      Interpreter?
Any Patient Education Done?  N             Any Screenings to Record? N
Any Measurements?  N                Any Health Factors to enter? N

```

```

Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Any Treated Medical Problems? N    Placement Disposition:
Visit Flag:      Local Service Site:
_____

COMMAND:                                     Press <PF1>H for help
Insert

```

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

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

2.5 Word Processing Editors (Roll and Scroll)

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

```
1>
```

Figure 2-9: RPMS line editor default

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

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

```

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

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

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

Select User's Toolbox Option: Edit User Characteristics

```

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

2. Select the “Edit User Characteristics” option from the list of TBOX menu options and a window will be displayed.
3. Use the down arrow key on your keyboard to move to the Preferred Editor field. To change your preferred editor to the Screen Editor, type **SC**. Continue to press the down arrow until the cursor reaches the “Command:” prompt.
4. Type **S** and press Enter to save your changes. Type **E** and press Enter to exit the screen. The Edit User Characteristics screen and fields are shown in the following example.

EDIT USER CHARACTERISTICS										
NAME: SIGMA, SAMANTHA A	PAGE 1 OF 1									
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">INITIAL: SAS</td> <td style="width: 50%;">PHONE:</td> </tr> <tr> <td>NICK NAME:</td> <td>OFFICE PHONE:</td> </tr> <tr> <td></td> <td>VOICE PAGER:</td> </tr> <tr> <td></td> <td>DIGITAL PAGER:</td> </tr> </table> ASK DEVICE TYPE AT SIGN-ON: DON'T ASK AUTO MENU: YES, MENUS GENERATED TYPE-AHEAD: ALLOWED TEXT TERMINATOR: PREFERRED EDITOR: SCREEN EDITOR - VA FILEMAN			INITIAL: SAS	PHONE:	NICK NAME:	OFFICE PHONE:		VOICE PAGER:		DIGITAL PAGER:
INITIAL: SAS	PHONE:									
NICK NAME:	OFFICE PHONE:									
	VOICE PAGER:									
	DIGITAL PAGER:									
Want to edit VERIFY CODE (Y/N):										
Exit Save Refresh										
Enter a command or '^' followed by a caption to jump to a specific field.										
COMMAND: S Press <PF1>H for help Insert E										

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

Note: Refer to Section 2.4 for more information on using the Full Screen Text Editor.

2.6 Pop-Up Windows (GUI)

The application displays pop-up windows with the same functional controls on them. Mostly these are Crystal Report windows (like the Health Summary).

Below is a sample pop-up window.

Figure 2-12: Sample pop-up window

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

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

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

The pop-up window only displays the first page (when you first access the window). If there is more than one page, you must press the **Next Page** and **Last Page** buttons to move to that page. Otherwise, you can specify the page number to move to. Refer to Section 2.6.2 Buttons on the Toolbar or more information.

2.6.1 Buttons on Title Bar

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

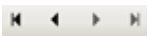
2.6.2 Buttons on the Toolbar

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

2.6.2.1 Print Button

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

2.6.2.2 Move To Page Buttons

The **Move To Page**  buttons provide the means of going to adjacent pages in the text of the pop-up window.

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

2.6.2.3 Go To Page

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

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



Figure 2-13: **Go to Page** dialog box

Type the page number to go to (in the free text field) and then click **OK** (otherwise, click **Cancel**). After clicking **OK**, the application will display the particular page of the pop-up.

If you specify a page outside the range of pages on the pop-up window, the application will display a blank page.

2.6.2.4 Find Text

Click **Find Text**  to access the **Find Text** dialog box.



Figure 2-14: Find Text dialog box

Use the Find What text box to specify the text you want to find in the text of the pop-up window. To search for the text string, click **Find Next** (otherwise, click **Cancel**). The Find Next function causes the application to search the text of the pop-up for the text string and to highlight the line of text containing the first occurrence of the text string. Keep clicking **Find Next** to search for the next occurrence of the text string.

When there are no other occurrences, the system displays the “Crystal Report Windows Forms Viewer” information message informing you that the application has finished searching the document. Click **OK** to close the information message. You are returned to the **Find Text** dialog box (where you can specify another text string).

2.6.2.5 Zoom Button

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

2.7 Using the Calendar (GUI)

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



Figure 2-15: Sample Calendar for **Date** Field

The calendar always indicates the date for today.

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

Use the left or right arrow key to move from month-and-day to the next month-and-day.

If you right-click on the month label, you can select “Go to Today” to return the displayed date (in the field) to today’s date.

2.7.1 Changing the Month

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

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



Figure 2-16: List of Months to Select

2.7.2 Changing the Year

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



Figure 2-17: Changing the Year

2.8 Using the Search Window (GUI)

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



Figure 2-18: **Community** search window

This type of window has similar functionality for other fields.

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

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

Another way to populate the field is to select a record in the **Most Recently Selected** group box and click **OK**.

Once the field is populated on the form, you can remove its contents by right-clicking on the field and selecting the **Clear** option.

2.9 Using the Search/Select Window (GUI)

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

For example, the **Add** button on the **Axis I** group box on the **POV** tab field accesses this type of window.

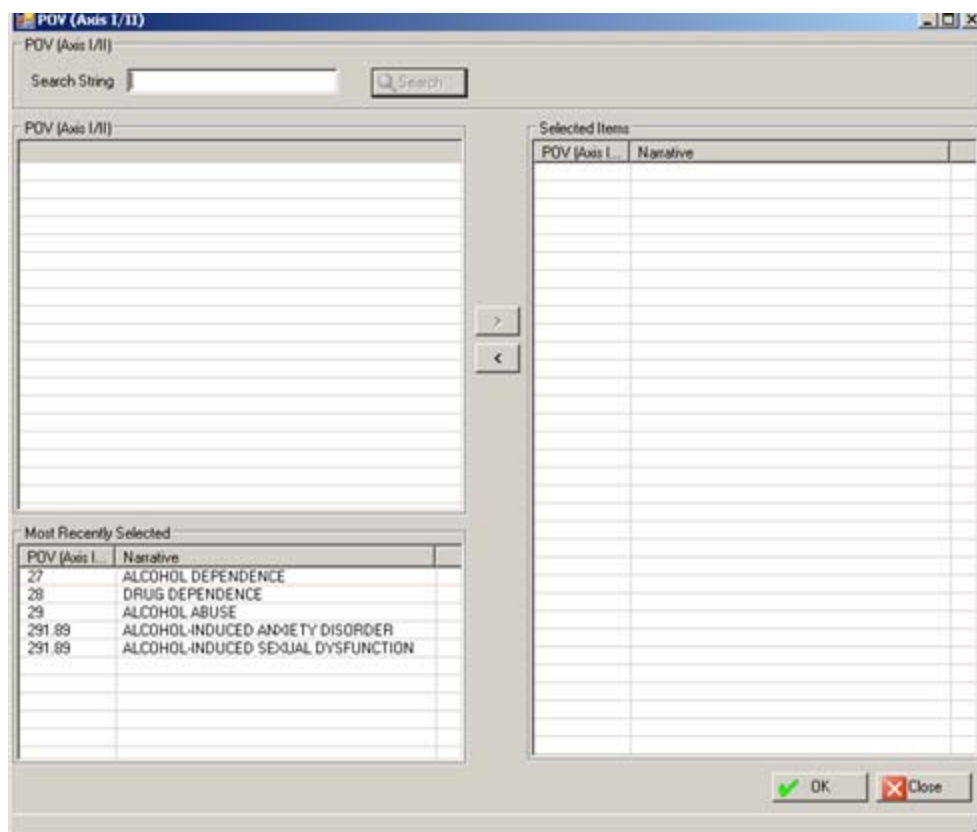


Figure 2-19: Sample search/select window

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

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

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

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

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

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

When you have the records you want in the **Selected Item** group box, click **OK** (otherwise, click **Close**). The OK function adds the data to the appropriate area.

Once the field is populated on the form, you can remove its contents by right-clicking on the field and selecting the **Clear** option.

2.10 Using the Multiple Select Window (GUI)

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

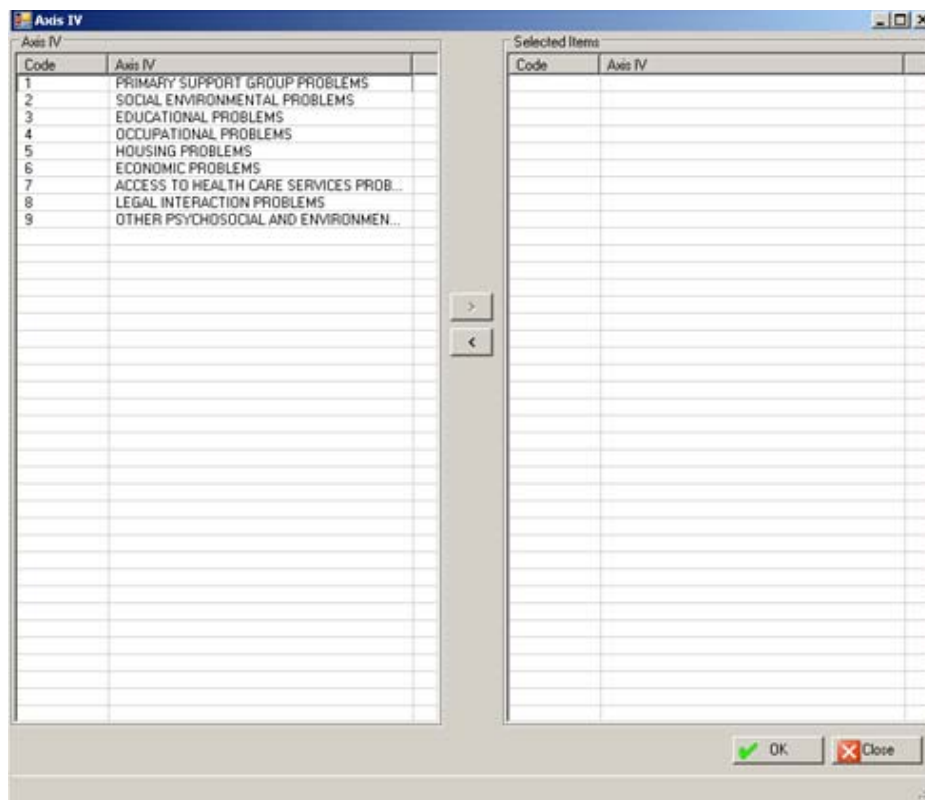


Figure 2-20: Sample **AXIS IV** multiple select window

Click **Close** to dismiss the window.

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

Similarly, to move one or more selected records from the Selected Items group box to the Axis IV group box, click the left-pointing arrow.

When you have the records you want in the **Selected Item** group box, click **OK** (otherwise, click **Close**). The OK function adds the codes to the appropriate area.

Once the field is populated on the form, you can remove its contents by right-clicking on the field and selecting the **Clear** option.

2.11 Free Text Fields (GUI)

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

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

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

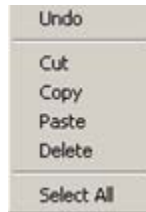


Figure 2-21: Context menu to aid in editing text

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

Undo: removes the last edit action.

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

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

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

Delete: removes the selected text from its current position.

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

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

2.12 Selecting a Patient

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

2.12.1 Patient Selection (Roll and Scroll)

You are asked to select a patient at the “Select Patient” prompt. Use a few characters of the patient’s last name (at least three), Social Security Number (SSN), Health Record Number (HRN), or date of birth (use format MM/DD/YYYY).

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

2.12.2 Patient Selection (GUI)

You select a patient in the following circumstances:

- When no patient has been selected and you selected the **One Patient** option (such as under **Visit Encounters**).
- When you want to change patients. You can change patients by selecting **Patient** and then **Select**, or by right-clicking on the menu tree.

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

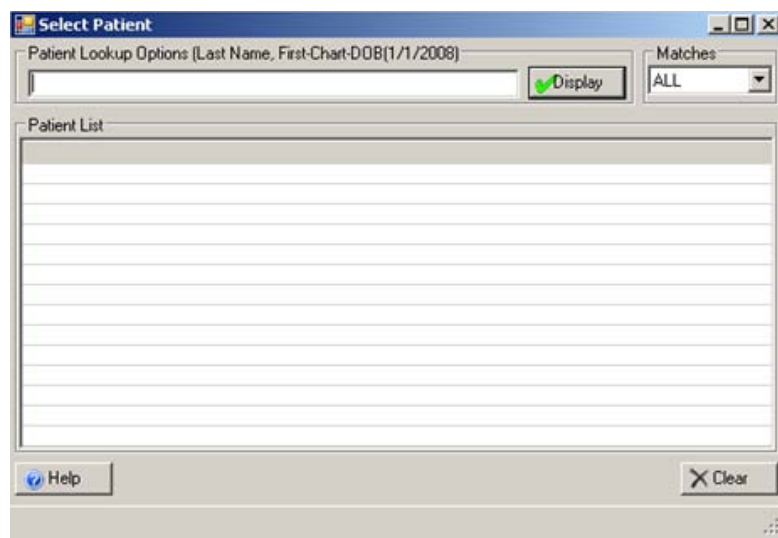


Figure 2-22: **Select Patient** dialog box

Use the **Help** button to access the online help for this dialog.

Use the **Clear** button to remove all data from the Patient List group box and from the text box near the top.

Use a few characters of the patient’s last name (at least 3), SSN, HRN, or date of birth (use format MM/DD/YYYY) in the **Patient Lookup Options** field. You can determine the number of matches by selecting an option from the **Matches** drop-down list (the default is All). Then click **Display**.

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

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

Patient Name	SSN	Chart #	DOB	Sex
DEMO,AMILYA PEARL HARTER,MI...	XXXX-0821	106735	06/30/2008	F
DEMO,AUSTIN WAYNE	***SENSITIVE**	192640	***SENSITIVE**	M
DEMO,DARRELL LEE	XXXX-0208	117305	09/23/1986	M
DEMO,DOROTHY ROSE	XXXX-1111	999999	10/10/1942	F
DEMO,JAMES WILLIAM		192636	11/05/1997	M
DEMO,JOHN	XXXX-1231	55	12/01/2008	M
DEMO,JUANITA NATSISTA RODRI...	XXXX-4949	118039	04/08/1965	F
DEMO,L DEE DEMO,LENNY DEE	XXXX-0527	201686	05/08/1943	F
DEMO,LENNY DEE	XXXX-0527	201686	05/08/1943	F
DEMO,LOIS JEANNETTE	XXXX-6267	180836	08/16/1995	F
DEMO,MINNIE P. TONAHOT,REBE...	XXXX-0808	113487	07/01/1966	F
DEMO,NEWBORN DEMO,NEWBOR...	XXXX-4321	987654	11/04/2009	F
DEMO,NEWBORNN	XXXX-4321	987654	11/04/2009	F

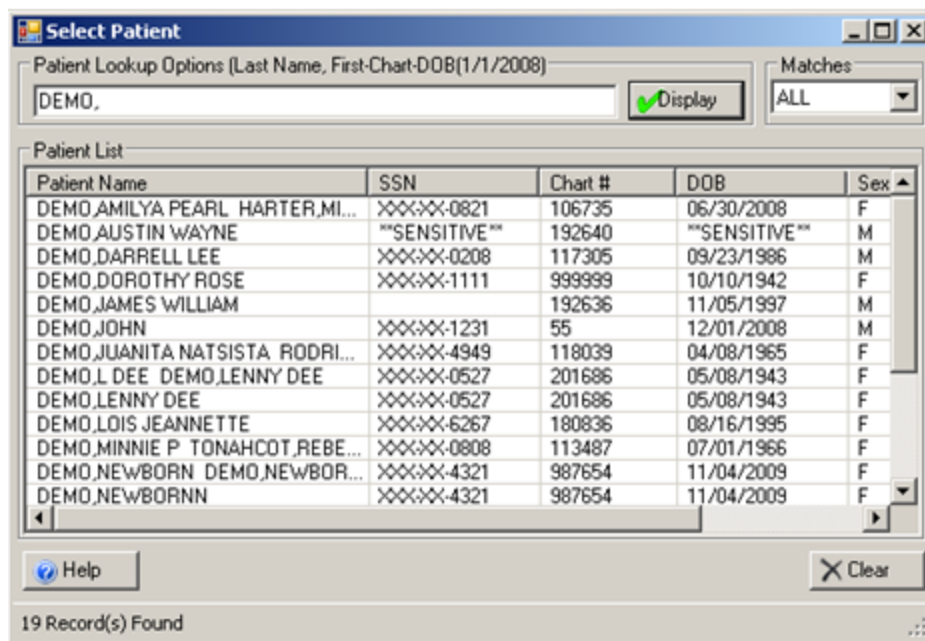
Figure 2-23: Sample **Select Patient** dialog box

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

2.13 Sensitive Patient Tracking

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

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

Figure 2-24: Sample **Select Patient** dialog box showing sensitive patient

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

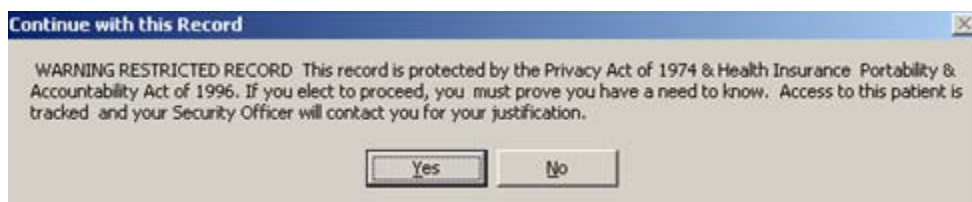


Figure 2-25: Warning message displayed in GUI

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

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

Below is the longer warning message.

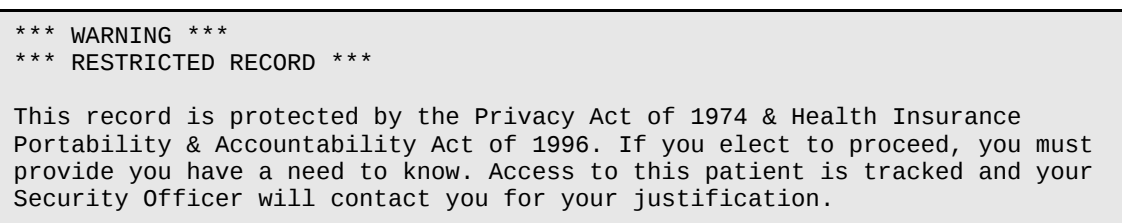


Figure 2-26: Warning message about restricted record in the roll-and-scroll application

Below is the shorter warning message.

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

Figure 2-27: Shorter warning message in the roll-and-scroll application

After you press Enter, you access the patient's record. If you type a caret (^), you do not access the patient's record.

2.14 Electronic Signature

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

2.14.1 Creating Your Electronic Signature

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

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

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

Figure 2-28: Options on the TBOX User's Toolbox

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

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

Figure 2-29: Prompts that display at the beginning of the process

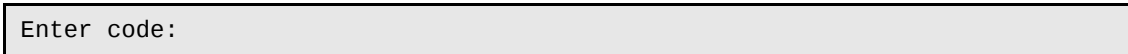
The following prompt appears in RPMS:



Enter your Current Signature Code:

Figure 2-30: Prompt to enter your current electronic signature

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



Enter code:

Figure 2-31: Prompt for a new code

The above prompt is where you enter a new code.

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

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

2.14.2 Electronic Signature Usage

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

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

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

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

Electronic signatures do not apply to BH encounters created in the Electronic Health Record (EHR).

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

2.14.3 Data Entry Requirements (Roll and Scroll)

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

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

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

Figure 2-32: Sample date/time stamp for electronic signature

2.14.4 Assign PCC Visit

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

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

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

2.14.5 Signing a Note (GUI)

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

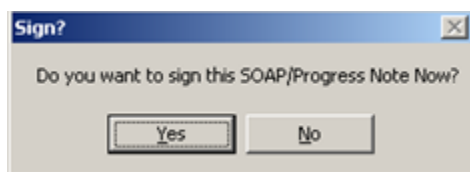


Figure 2-33: **Sign?** dialog box

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

If you click **Yes**, the application displays the **Electronic Signature** window.



Figure 2-34: **Electronic Signature** window

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

If you enter an invalid electronic signature and click **OK**, the application displays the Invalid notice that states: Invalid Signature Code. Click **OK** and you return to the **Electronic Signature** window.

If you click **Close** on the **Electronic Signature** window, the application displays the **Are You Sure?** dialog box.

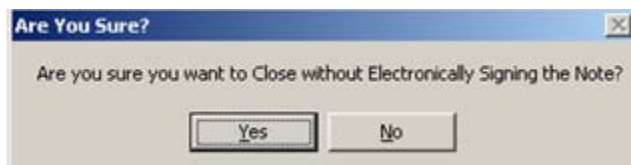


Figure 2-35: **Are you Sure?** dialog box

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

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



Figure 2-36: Text of Message

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

2.14.6 Signing a Note (Roll and Scroll)

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

Enter your Current Signature Code:

Figure 2-37: Prompt for current signature code

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

If you use an invalid electronic signature, the application does not save the encounter with a signed note.

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

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

Figure 2-38: Message about progress note already signed.

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

Only the Primary provider is permitted to sign a note.

Figure 2-39: Message about only primary provider can sign a note

2.15 Login to GUI

If this is the first time you login to the GUI, the application will display the **IHS Behavior Health System Login** dialog box with *no* information in the **RPMS Server** field.



Figure 2-40: Initial login dialog box

You need to access the **Click to Edit Connections** option on the drop-down list for the **RPMS Server** field. The application displays the **RPMS Server Connection Management** dialog box.

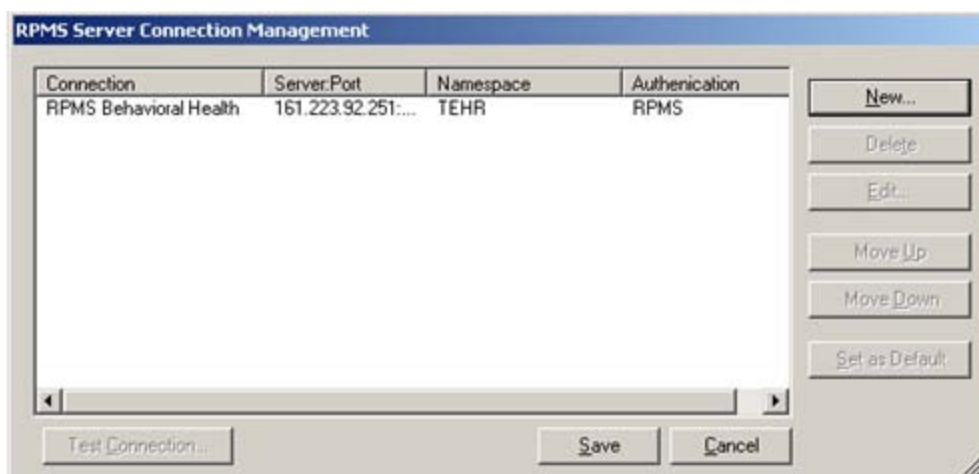


Figure 2-41: Sample **RPMS Server Connection Management** dialog box

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

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

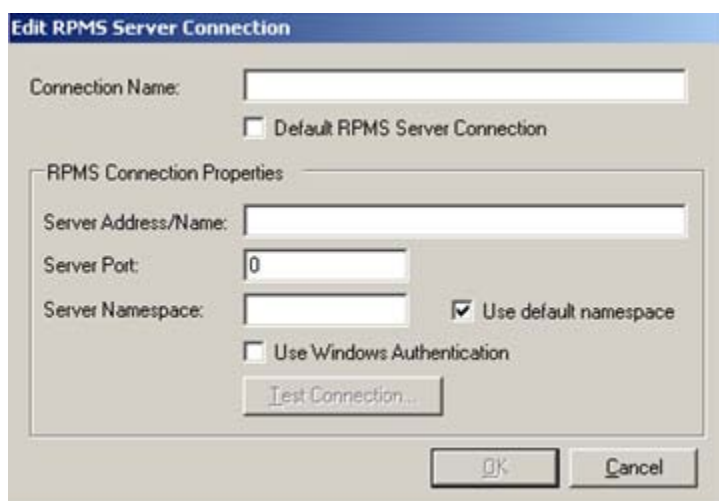


Figure 2-42: Sample **Edit RPMS Server Connection** dialog box

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

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

Server Address/Name: Type the number, including punctuation, of the server's IP address. An IP address is typically four groups of two or three numbers, separated by a period (.), e.g., 161.223.99.999. Your site manager will provide this information.

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

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

Use default namespace: Select this checkbox if the Server Namespace is the default namespace you want to use.

Test Connection: After populating the fields, this button becomes active. Click it to display the **Test Login** dialog box. Populate the **Access Code** and **Verify Code** fields and then click **OK**.

- After clicking **OK**, if the connection is correct, the application displays the Connection Test message that states: RPMS login was successful.
- Otherwise, the application will display an error message; click **OK** to return to the **Test Login** dialog box.

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

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

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

Figure 2-43: Sample login dialog box

The designated server displays in the **RPMS Server** field.

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

Do not select the field with the checkbox.

Click **OK** (otherwise, click Cancel). The **OK** process accesses the RPMS Behavioral Health System tree.

2.16 RPMS Behavioral Health System Tree

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

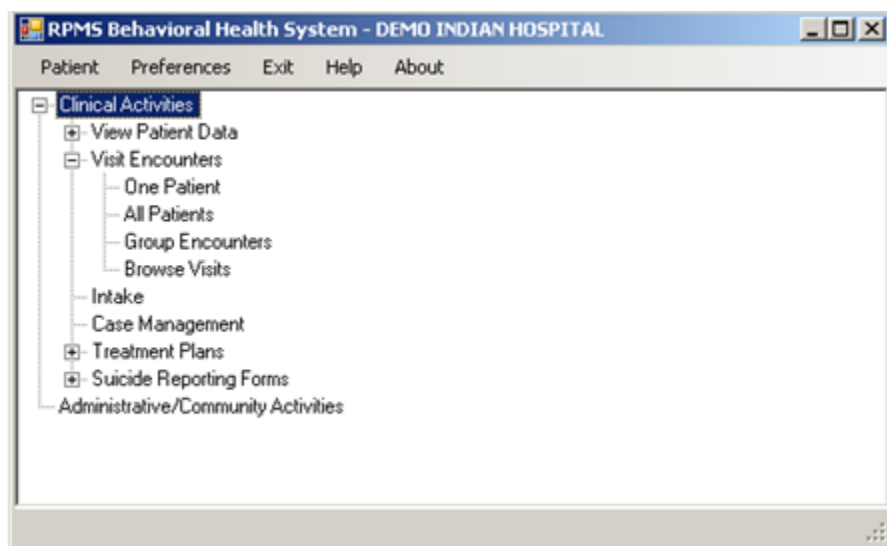


Figure 2-44: Tree structure for the RPMS Behavioral Health System

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

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

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

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

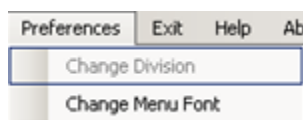


Figure 2-45: Menu options on the **Preferences** menu

- **Change Division**

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

- **Change Menu Font**

Use the **Change Menu Font** option to change the font on the tree structure. The application displays the **Font** dialog box.

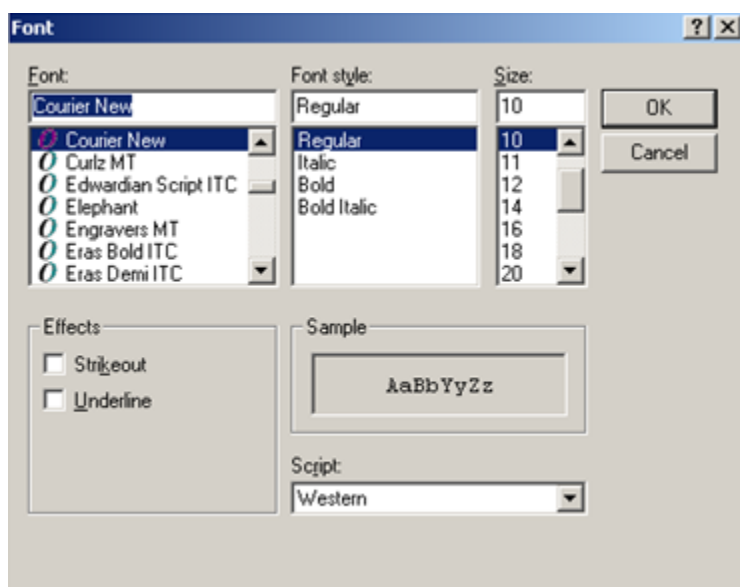


Figure 2-46: **Font** dialog box

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

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

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

- Use the **Exit** menu to leave the application. The application displays the Exit information message that asks: Are you sure you want to Edit? Click **Yes** to exit (otherwise, click **No**).
- Use the **Help** menu to access the online help system for the application.
- Use the **About** menu to view information about the application (such as its version number).

3.0 Data Entry

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

3.1 Roll and Scroll

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

```

*****
**          IHS Behavioral Health System          **
*****
                        Version 4.0 (Patch 1)

                        DEMO INDIAN HOSPITAL

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

Select Behavioral Health Information System Option:  DE

```

Figure 3-1: Data Entry Module

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

```

*****
**          IHS Behavioral Health System          **
**          Data Entry Menu                      **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

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

```

SF Suicide Forms - Update/Print
Select Behavioral Health Data Entry Menu Option: PDE

Figure 3-2: Data Entry menu

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

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

3.2 RPMS Behavioral Health System GUI

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

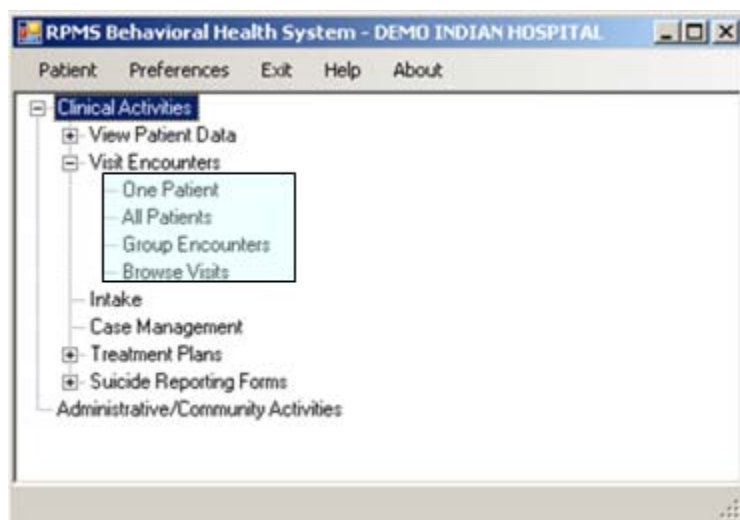


Figure 3-3: Location of **Visit Encounters** category on tree structure

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

4.0 One Patient Visit Data

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

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

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

```

*****
**          IHS Behavioral Health System          **
**              Data Entry Menu                  **
*****
Version 4.0 (patch 1)

SELLS HOSPITAL

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

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

```

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

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

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

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

Below are the prompts:

Enter Patient Name

Specify the patient you want to use.

If you enter the name of a deceased patient, the application displays the patient's date of death.

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

Ok? Yes//

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

- If you type **NO** at the “OK” prompt, you are returned to the “Enter Patient Name” prompt.
- If you type **YES** at the “OK” prompt, you proceed to the Patient Data Entry window.

If you enter the name of a living patient, the application displays the Patient Data Entry window.

```

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

Last Visit (excl no shows): May 29, 2008  BETAAAA,BJ  REGULAR VISIT
        314.9  ATTENTION-DEFICIT/HYPERACTIVITY DIS. NOS
***** LAST 6 AXIS V VALUES RECORDED. (GAF SCORES) *****
04/20/2009  04/20/2009  04/22/2009  04/29/2009  05/01/2009  07/01/2009
        55          75          33          77          44          65

Pending Appointments:
        Select the appropriate action  Q for QUIT
AV Add Visit          LD List Visit Dates  GS GAF Scores
EV Edit Visit         TP Treatment Plan Update  OI Desg Prov/Flag/Pers Hx
DR Display Record    CD Update Case Data    EH Edit EHR Visit
ES Edit SOAP         ID Intake Document    PL Problem List Update
DE Delete Visit      AP Appointments      SN Sign Note
PF Print Encounter Form  HS Health Summary    TN TIU Note Display
LV Last BH Visit      DM Display Meds      MM Send Mail Message
BV Browse Visits      LA Interim Lab Reports  FS Face Sheet
Select Action: Q//    Q
  
```

Figure 4-3: Sample Patient Data Entry window

The following fields display when using the Add Visit (AV) and Edit Visit (EV) options on the Patient Data Entry window.

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

Specify the program with which the provider is affiliated so that the predefined defaults for clinic, location, community, and program will be automatically applied to the visit. Use one of the following:

- M Mental Health Defaults
- S Social Services Defaults

- C Chemical Dependency or Alcohol/Substance Abuse
- O Other

Enter ENCOUNTER DATE

Specify the date of the encounter. Refer to Section 2.1.9 Dates and Time for more information.

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

Enter PRIMARY PROVIDER

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

If you used Edit Visit (EV) option, the application displays the Behavioral Health Record Edit window. Refer to Section 4.1.4 Using the Behavioral Health Record Edit Window for more information.

If you used the Add Visit (AV) option, the application displays the Behavioral Health Visit Update screen. Refer to Section 4.1.3 Using the Behavioral Health Record Update Screen for more information.

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

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

Below are the prompts.

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

Specify the program with which the provider is affiliated so that the predefined defaults for clinic, location, community and program will be automatically applied to the visit. Use one of the following:

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

Enter ENCOUNTER DATE

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

The application displays the Update BH Forms window.

Update BH Forms		Mar 19, 2009 13:50:42		Page: 1 of 1			
Date of Encounter: Monday MAR 16, 2009				* unsigned note			
#	PRV	PATIENT NAME	HRN	AT	ACT	PROB	NARRATIVE
1	BJB	ALPHAA,CHELSEA M	WW116431	60	16	295.15	SCHIZOPHRENIA, DISORGANIZED
2	BJB	ALPHAA,CHELSEA M	WW116431	30	13	305.02	ALCOHOL ABUSE, EPISODIC,
3	BJB	ALPHAA,CHELSEA M	WW116431	15	19	V60.0	LACK OF HOUSING
*	4	JC	ALPHAA,CHELSEA M	876543	60	13	295.15 SCHIZOPHRENIA, DISORGANIZED
*	5	JC	ALPHAA,CHELSEA M	876543	60	13	295.15 SCHIZOPHRENIA, DISORGANIZED
6	DG	ALPHAA,CHELSEA M	WW116431	11	22	305.62	COCAINE ABUSE, EPISODIC
7	DG	ALPHAA,CHELSEA M	WW116431	20	15	79	FINANCIAL NEEDS/ASSISTANCE
8	ST	DEMO,DOROTHY ROS	WW999999	1	99	97	ADMINISTRATIVE
?? for more actions							
AV	Add Patient Visit	PF	Print Encounter Form	SN	Sign Note		
AC	Add Adm/Comm Activity	ID	Intake Document	TN	Display TIU Note		
EV	Edit Record	HS	Health Summary	AP	Appointments		
OI	Desg Prov/Flag	ES	SOAP/CC Edit	MM	Send Mail Message		
DR	Display Record	SD	Switch Dates	Q	Quit		
DE	Delete Record	EH	Edit EHR Record				
Select Action:							

Figure 4-4: Sample Update BH Forms window

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

Use the EV option to edit a selected record (patient visit); refer to Section 4.1.4 Using the Behavioral Health Record Window for more information. Use the AV option to add a patient visit.

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

- “TYPE THE PATIENT’S HRN, NAME, SSN OR DOB”
Specify the patient you want to use.
- “Enter PRIMARY PROVIDER”
Specify the primary provider for the patient visit (the default is the current logon user).

The application displays the Behavioral Health Visit Update screen.

4.1.3 Using the Behavioral Health Visit Update Screen

Use this screen to enter patient visit data.

* BEHAVIORAL HEALTH VISIT UPDATE * [press <F1>E when visit entry is complete]

Encounter Date: MAR 5, 2009		User: THETA, SHIRLEY	
Patient Name: DEMO, DARRELL LEE		DOB: 9/23/86	HR#: 117305

Arrival Time: 12:00			
Display/Edit Visit Information Y		Any Secondary Providers?: N	
Chief Complaint/Presenting Problem:			
SOAP/Progress Note <press enter>:		Comment/Next Appointment <press enter>:	
PURPOSE OF VISIT (POVS) <enter>:		Any CPT Codes to enter? Y	
Activity:	Activity Time:	# Served: 1	Interpreter??
Any Patient Education Done? N		Any Screenings to Record? N	
Any Measurements? N		Any Health Factors to enter? N	
Display Current Medications? N		MEDICATIONS PRESCRIBED <enter>:	
Any Treated Medical Problems? N		Placement Disposition:	
Visit Flag:	Local Service Site:		
COMMAND:		Press <PF1>H for help	
Insert			

Figure 4-5: Sample Behavioral Health Visit Update screen

If you save the data on the Behavioral Health Visit Update window and you are the primary provider, you will be asked if you want to sign the (note for the) visit. Refer to Section 2.14.6 Signing a Note (Roll and Scroll) for more information.

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

- **Arrival Time**

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

- **Display/Edit Visit Information**

Use N or Y (the default). Type **Y** to access the Visit Information pop-up.

***** Visit Information *****	
<u>Program</u> : MENTAL HEALTH	<u>Location of Encounter</u> : SELLS HOSP
<u>Clinic</u> : MENTAL HEALTH	Appointment/Walk In: APPOINTMENT
<u>Type of Contact</u> : OUTPATIENT	
<u>Community of Service</u> : TUCSON	

Figure 4-6: Sample Visit Information pop-up

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

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

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

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

Any Secondary Providers?

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

***** ENTER/EDIT PROVIDERS OF SERVICE *****	
Encounter Date: MAR 5,2009@12:00	User: THETA, SHIRLEY
Patient Name: DEMO,DARRELL LEE	

<u>PROVIDER:</u> THETA, STUART	<u>PRIMARY/SECONDARY:</u> PRIMARY
<u>PROVIDER:</u>	<u>PRIMARY/SECONDARY:</u>
<u>PROVIDER:</u>	<u>PRIMARY/SECONDARY:</u>
<u>PROVIDER:</u>	<u>PRIMARY/SECONDARY:</u>
<u>PROVIDER:</u>	<u>PRIMARY/SECONDARY:</u>
<u>PROVIDER:</u>	<u>PRIMARY/SECONDARY:</u>

Figure 4-7: Sample Enter/Edit Providers of Services pop-up

The underlined fields are required.

- **PROVIDER:** Specify the secondary provider name.
- **PRIMARY/SECONDARY:** Populate with **SECONDARY** (more than one secondary provider can be used).

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

- **Chief Complaint/Presenting Problem**

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

- **SOAP/Progress Note <press enter>**

Press Enter to access another window. Populate it with the text of the note. You can enter the notes using any of the standard formats, such as SOAP, DAP, or free text.

- **Comment/Next Appointment <press enter>**

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

- **PURPOSE OF VISIT (POVS) <enter>**

Press Enter to access the Purpose of Visit (POV) Update pop-up window. The following shows the Purpose of Visit Update pop-up window.

```

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

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

                        AXIS V:      GAF Scale Type

-----
Patient's Diagnoses from last 4 visits:
7/8/09  28  DRUG DEPENDENCE
5/15/09  39  PT HAS PROBLEM
3/10/09  29  ALCOHOL ABUSE
3/10/09  291.0  ALCOHOL WITHDRAWAL DELIRIUM

Enter RETURN to continue or '^' to exit:

```

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

Type a caret (^) at the last prompt to exit this pop-up window.

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

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

- **DIAGNOSIS:** Specify the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-IV-TR diagnostic code).

- After populating the Diagnosis field, the application automatically populates the Narrative field (that you can change). You can accept the narrative that is displayed or edit the narrative to more clearly identify the reason for the visit. For example, if Problem Code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient's housing issue – homeless, being evicted, etc. Note: the special characters, “, or ‘ cannot be the first character of the POV narrative. The POV narrative field can contain 2–80 characters.
- **AXIS III:** Press Enter to access another window. Populate it with the general medical conditions of the patient that were treated during the visit. This field should not be used to record the patient's medical history.
- **AXIS IV:** Populate with one of the major psychosocial or environmental problem codes.
- **AXIS V:** Populate with the patient's functional level using the GAF scale (0-100).
- **GAF Scale Type:** Populate with the acronym for the specific GAF Scale used, using up to 20 characters in length.

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

- Any CPT Codes to enter?

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

```

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

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

```

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

The underlined fields are required.

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

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

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

- **Activity**

Specify the activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and will affect the billing process. Refer to Section 15.0 Appendix A: Activity Codes and Definitions for more information.

- **Activity Time**

Specify the activity time, using any number between 1 and 9999 (no decimal digits). This is how much provider time was involved in providing and documenting the service or performing the activity. The understood units of measure are minutes. Please note: 0 (zero) is not allowed as a valid entry.

- **# Served**

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

- **Interpreter?**

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

- **Any Patient Education Done?**

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

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

Display Patient Education History?  N

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

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

- **Display Patient Education History?:** Type **Y** or **N** to display the Behavioral Health and PCC patient education history. This is all education provided in the past two years by BH programs. This display is shown in the Output Browser window.
- **EDUCATION TOPIC:** Specify the education topic used at this encounter. For a complete list of the current Education Topics, please see the IHS Patient Education Manual or type a question mark (?) at the prompt to view the whole list.

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

<u>EDUCATION TOPIC:</u> ABD-COMPLICATIONS INDIVIDUAL/GROUP: INDIVIDUAL READINESS TO LEARN: <u>LEVEL OF UNDERSTANDING:</u> PROVIDER: THETA, MARK <u>MINUTES:</u> COMMENT: STATUS (Goal): GOAL COMMENT:
--

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

The underlined prompts are required.

- **Education Topic:** the education topic (can be changed).
- **Individual/Group:** Specify if the education is for an individual or for a group.
- **Readiness to Learn:** use one of the following:
 - **Distraction:** use when the patient has limited readiness to learn because the distractions cannot be minimized.
 - **Eager to Learn:** use when the patient is exceedingly interested in receiving education.
 - **Intoxication:** use when the patient has decreased cognition due to intoxication with drugs or alcohol
 - **Not Ready:** use when the patient is not ready to learn.
 - **Pain:** use when the patient has a level of pain that limits readiness to learn.
 - **Receptive:** use when the patient is ready or willing to receive education.
 - **Severity of Illness:** use when the patient has a severity of illness that limits readiness to learn.
 - **Unreceptive:** use when the patient is *not* ready or willing to receive education.
- **Level of Understanding:** Specify the level of understanding. This is a required field. Use one of the following:

- 1 (Poor)
- 2 (Fair)
- 3 (Good)
- 4 (Group No Assessment)
- 5 (Refused)
- **Provider:** the provider for the visit (can be changed). The default is the current logon user.
- **Minutes:** Specify the number of minutes spent on education, using any integer 1–9999.
- **Comment:** Add comments about the education topic for the visit, if any.
- **Status (Goal):** Specify the status of the education, if any. Use one of the following:
 - GS–goal set
 - GM–goal met
 - GNM–goal not met
 - GNS–goal not set
- **Goal:** Populate with the text of the stated goal of the education, if any.

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

- **Any Screenings to Record?**

Type **Y** or **N** (the default). If you use **Y**, use the displayed fields to record any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter. Type **N** to accept the default response if no screenings were completed during the visit. Type **Y** to access the following pop-up screen.

```

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

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

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

Figure 4-12: Sample IPV, Alcohol Screening, and Depression Screening pop-up

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

- **Display IPV/DV screening History?:** Type **Y** or **N**. If you type **Y**, the Intimate Partner Violence/Domestic Violence (IPV/DV) screening history displays on another screen. The display includes screenings entered in both BHS and PCC.
- **IPV Screening/Exam Result:** Specify the result of the intimate partner violence/domestic violence screening. Type one of the following:
 - **N**–Negative
 - **PR**–Present
 - **PAP**–Past and Present
 - **PA**–Past
 - **REF**–Patient Refused Screening
 - **UAS**–Unable to screen
- **IPV Screening Provider:** Specify the IPV/DV provider name.
- **IPV Comment:** Populate with the text of any comment related to the IPV/DV screening, using 2–245 characters.
- **Display Alcohol screening History?:** Type **Y** or **N**. If you type **Y**, the alcohol screening history displays on another screen. The display includes screenings entered in both BHS and PCC.
- **Alcohol Screening Result:** Specify the result of the alcohol screening. Type one of the following:
 - **N**–Negative
 - **P**–Positive
 - **UAS**–Unable to screen
 - **REF**–Patient Refused Screening
- **Alcohol Screening Provider:** Specify the provider name for the alcohol screening.
- **Alcohol Screening Comment:** Populate with the text of any comment related to the alcohol screening, using 2–245 characters.
- **Display Depression screening History?:** type **Y** or **N**. If you type **Y**, the depression screening history displays on another screen.
- **Depression Screening Result:** Specify the result of the depression screening. Type one of the following:
 - **N**–Negative
 - **P**–Positive
 - **UAS**–Unable to screen
 - **REF**–Patient Refused Screening
- **Depression Screening Provider:** Specify the provider name for the depression screening.

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

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

- **Any Measurement?**

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

*** Measurements ***		
Measurement Description	Value	Provider

Figure 4-13: Sample Measurements pop-up

- **Measurement:** Specify the type of measurement being taken on the patient. Then the application populates the Description field.
- **Value :** Specify the numeric value of the measurement. If you populate this field with a value outside the valid value range, the application provides information about what valid values can be used for the field.
- **Provider :** Specify the name of the provider.
 - Measurements will print on the Full encounter form only (not on the Suppressed encounter form).
 - Measurements can only be deleted from the encounter record where they were first recorded.

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

- **Any Health Factors to enter?**

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

***** PATIENT HEALTH FACTOR UPDATE *****
Examples of health factors: Tobacco Use, Alcohol Use, TB Status
Patient Name: DEMO,DARRELL LEE

Display Health Factor History? N
After entering each factor you will be prompted for additional data items
HEALTH FACTOR

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

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

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

LEVEL/SEVERITY

QUANTITY

COMMENTS

Figure 4-15: Other fields for health factor data

- **Level/Severity:** Type **M** (Minimal), **MO** (Moderate), or **H** (Heavy/Severe).
- **Quantity:** use any integer between 0 and 99999.
- **Comments:** populate with any comments regarding the health factor.

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

- **Display Current Medications?**

Type **Y** or **N** (the default) to display a list of currently dispensed medications. If you type **Y**, the list displays on the Output Browser window.

OUTPUT BROWSER	Mar 11, 2009 17:59:30	Page: 1 of 1
Medication List for DEMO,DARRELL LEE		
*** Medications Prescribed entries in BH Database for last 2 years ***		
The last of each type of medication from the PCC Database is displayed below.		
TERBUTALINE 5MG TAB	# ?	7/17/08
Sig: TAKE TWO (2) TABLETS BY MOUTH DAILY ON TUESDAY, THURSDAY, SATURDAY, AND S		
DEXAMETHASONE 0.5MG TAB	# ?	7/17/08
Sig: TAKE ONE (1) TABLET BY MOUTH EVERY MORNING [OUTSIDE MED]		
Enter ?? for more actions >>>		
+ NEXT SCREEN	- PREVIOUS SCREEN	Q QUIT
Select Action: +/-		

Figure 4-16: Sample display of current medications

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

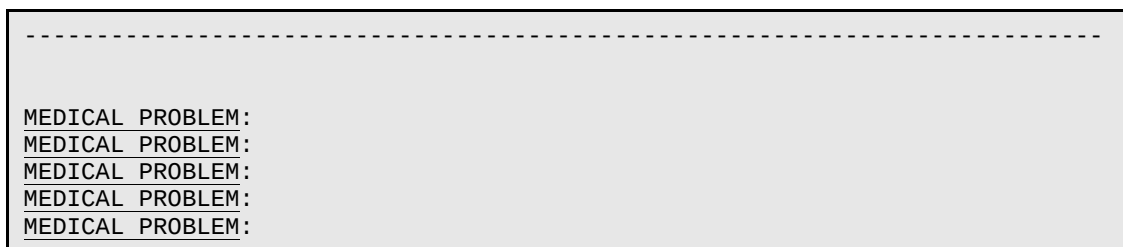
The following are the fields on the Behavioral Health Visit Update screen.

- **MEDICATIONS PRESCRIBED <enter>**

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

- **Any Treated Medical Problems?**

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



A screenshot of a pop-up form titled "MEDICAL PROBLEM:". It contains five identical rows, each with the text "MEDICAL PROBLEM:" followed by a dashed line for input. The form is enclosed in a black border.

Figure 4-17: Sample medical problem pop-up

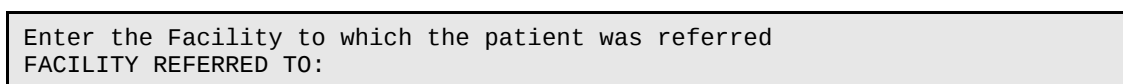
The underlined fields are required.

- **Medical Problem:** Specify the medical problems treated by the provider on this behavioral health encounter.

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

- **Placement Disposition**

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



A screenshot of a pop-up form with a single text input field. The text inside the field reads: "Enter the Facility to which the patient was referred". Below the input field, the text "FACILITY REFERRED TO:" is displayed. The form is enclosed in a black border.

Figure 4-18: Sample pop-up for facility name

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

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

- **Visit Flag**

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

- **Local Service Site**

Specify the local service site.

4.1.4 Using the Behavioral Health Record Edit Window

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

```

* BEHAVIORIAL HEALTH RECORD EDIT *                [press <F1>E to exit]
Encounter Date: APR 3,2009                        User: THETA,SHIRLEY
Patient Name: ALPHAA,CHELSEA MARIE  DOB: 2/7/75  HRN: 116431
-----
Date:      APR 3,2009@11:45      Location of Service:  CHINLE HOSP
Program: MENTAL HEALTH          Outside Location:
Clinic:  BEHAVIORAL HEAL        Appt/Walk-in: UNSPECIFIED  Visit Flag:
Type of Contact: OUTPATIENT      Community: CHINLE
Providers <press enter>:         Local Service Site:
Activity:  91      Activity Time: 20  #Served:  1  Interpreter Utilized:
Chief Complaint/Presenting Problem: none
SOAP/PROGRESS NOTE:      Comment/Next Appointment:      Medications
Prescribed:
Edit Purpose of Visits?: N      Edit Treated Medical Problems?  N
Edit CPT Codes?      Edit Health Factors?  N
Edit Patient Education?: N
Edit Any Screening Exams?  N      Edit Measurements?  N
Placement Disposition:      Referred To:
-----
COMMAND:                                Press <PF1>H for help
Insert

```

Figure 4-19: Sample Behavioral Health Record Edit window

The underlined fields are required.

- **Date**
The date of the visit.
- **Location of Service**
Where the service took place.
- **Program**
Name of the program with which the provider is affiliated.
- **Outside Location**
Name of the outside location (3 to 30 characters in length).
- **Clinic**
This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table.
- **Appt/Walk-in**
Can be appointment, walk-in, or unspecified (for non-patient contact).
- **Visit Flag**

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

- **Type of Contact**

Type of contact (the activity setting).

- **Community**

Name of the community.

- **Providers <press enter>**

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

```

*****  ENTER/EDIT PROVIDERS OF SERVICE  *****
[press <F1>C to return to main screen]
Encounter Date: MAR 16,2009           User: BETAAAAA,LORI
Patient Name: DEMO,DOROTHY ROSE
-----
PROVIDER: THETA, SHIRLEY                PRIMARY/SECONDARY: PRIMARY
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
PROVIDER:                               PRIMARY/SECONDARY:
-----
COMMAND:                               Press <PF1>H for help
Insert

```

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

The underlined fields are required.

- **PROVIDER:** Specify the name of the service provider.
- **PRIMARY/SECONDARY:** Specify the type of provider (primary or secondary).

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

- **Local Service Site**

Name of the local service site.

- **Activity**

The activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Refer to Section 15.0 Appendix A: Activity Codes and Definitions for more information.

- **Activity Time**

The number of minutes spent on the activity. This is how much provider time was involved in providing and documenting the service or performing the activity. Please note: 0 (zero) is not allowed as a valid entry.

- **# Served**

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

- **Interpreter Utilized**

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

- **Chief Complaint/Presenting Problem**

This information describes the major reason the patient sought services.

- **SOAP/PROGRESS NOTE**

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

- **Comment/Next Appointment**

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

- **Medications Prescribed**

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

- **Edit Purpose of Visits?**

Type **Y** or **N**. Type **Y** to access the Purpose of Visit Update pop-up.

```

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

```

<u>DIAGNOSIS:</u>	NARRATIVE:
AXIS III (press enter to update or TAB to bypass): AXIS IV: AXIS IV: AXIS IV: AXIS IV: AXIS V: GAF Scale Type: Patient's Diagnoses from last 5 visits: 5/6/10 312.32 KLEPTOMANIA 8/11/09 300.02 GENERALIZED ANXIETY DISORDER 9/11/09 300.3 OBSESSIVE-COMPULSIVE DISORDER Enter RETURN to continue or '^' to exit:	

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

The underlined fields are required.

- **Diagnosis** : Specify the POV (the one- or two-digit BHS Purpose of Visit Code or the more specific five-digit DSM-IV-TR diagnostic code).
- **Narrative**: You can accept the narrative that is displayed or edit the narrative to more clearly identify the reason for the visit. For example, if Problem code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient's housing issue - homeless, being evicted, etc.
- **AXIS III**: Press Enter to access another window and populate this it with the general medical conditions of the patient that were treated during the visit. This field should not be used to record the patient's medical history.
- **AXIS IV**: Specify one or more of the nine major psychosocial or environmental problem codes.
- **AXIS V**: Specify the patient's functional level using the Global Assessment of Functioning (GAF) scale. The field will accept numerical values between 0 and 100.
- **GAF Scale Type**: Populate with the acronym for the GAF Scale Type, using up to 20 characters.

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

- **Edit Treated Medical Problems?**

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

****Enter/Edit Treated Medical Problems**** [press <F1>C to return to main	
<u>MEDICAL PROBLEM:</u> <u>MEDICAL PROBLEM:</u>	

```

MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:

```

Figure 4-22: Sample medical problem pop-up

The underlined fields are required.

- **Medical Problem:** Specify the medical problems treated by the provider on this behavioral health encounter.

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

- **Edit CPT Codes?**

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

```

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

```

```

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

```

Figure 4-23: Sample Add/Edit CPT Procedures window

The underlined fields are required.

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

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

- **Edit Health Factors?**

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

```

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

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

HEALTH FACTOR

```

Figure 4-24: Sample Patient Health Factor Update pop-up.

- **Display Health Factor History?:** Type **N** or **Y**. If you type **Y**, the health factor history displays on another screen.
- **HEALTH FACTOR:** Specify the health factor. The following pop-up displays where you specify other data about the health factor.

LEVEL/SEVERITY

QUANTITY

COMMENTS

Figure 4-25: Fields for health factor data

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

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

- Edit Patient Education?

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

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

Display Patient Education History?  N

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

Figure 4-26: Sample Patient Education enter/edit screen

- **Display Patient Education History?:** Type **Y** or **N**. Type **Y** to display all education provided in the last two years by BH programs. This history is displayed in the Output Browser window.
- **EDUCATION TOPIC:** Specify the education topic name. The following pop-up displays where you enter data about the education topic:

EDUCATION TOPIC: ABD-COMPLICATIONS

INDIVIDUAL/GROUP: INDIVIDUAL

READINESS TO LEARN:

LEVEL OF UNDERSTANDING:

PROVIDER: THETA, MARK

MINUTES:

COMMENT:

STATUS (Goal):

GOAL COMMENT:

Figure 4-27: Sample pop-up for education topic information

The underlined fields are required.

- **Education Topic:** the education topic (can be changed).
- **Individual/Group:** Specify if the education is for an individual or for a group.
- **Readiness to Learn:** Use one of the following:
 - Distraction: use when the patient has limited readiness to learn because the distractions cannot be minimized.
 - Eager to Learn: use when the patient is exceedingly interested in receiving education.
 - Intoxication: use when the patient has decreased cognition due to intoxication with drugs or alcohol
 - Not Ready: use when the patient is not ready to learn.
 - Pain: use when the patient has a level of pain that limits readiness to learn.
 - Receptive: use when the patient is ready or willing to receive education.
 - Severity of Illness: use when the patient has a severity of illness that limits readiness to learn.
 - Unreceptive: use when the patient is NOT ready or willing to receive education.
- **Level of Understanding:** Specify the level of understanding. Use one of the following:
 - 1 (Poor)
 - 2 (Fair)
 - 3 (Good)
 - 4 (Group No Assessment)
 - 5 (Refused)
- **Provider:** The provider for the visit (can be changed). The default is the current logon user.
- **Minutes:** Specify the number of minutes spent on education, using any integer 1 - 9999.
- **Comment:** Add comments about the education topic for the visit, if any.

- **Status (Goal):** Specify the status of the education, if any. Use one of the following:
 - GS–goal set
 - GM–goal met
 - GNM–goal not met
 - GNS–goal not set
- **Goal:** Populate with the text of the stated goal of the education, if any.

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

- **Edit Any Screening Exams?**

Type **N** or **Y** for any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter. Type **Y** to access the following pop-up screen.

```

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

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

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

Figure 4-28: Sample IPV, Alcohol Screening, and Depression Screening pop-up

- **Display IPV/DV screening History?:** Use Y or N. If you use Y, the IPV/DV screening history displays on another screen.
- **IPV Screening/Exam Result:** Specify the result of the intimate partner violence/domestic violence screening. Use one of the following:
 - N–Negative
 - PR–Present
 - PAP–Past and Present
 - PA–Past
 - UAS–Unable to screen
 - REF–Patient Refused Screening
- **IPV Screening Provider:** Specify the IPV/DV provider name.
- **IPV Comment:** Populate with the text of any comment related to the IPV/DV screening, using 2–245 characters.

- **Display Alcohol screening History?:** Type **Y** or **N**. If you type **Y**, the alcohol screening history displays on another screen.
- **Alcohol Screening Result:** Specify the result of the alcohol screening. Use one of the following:
 - N–Negative
 - P–Positive
 - UAS–Unable to screen
 - REF–Patient Refused Screening
- **Alcohol Screening Provider:** Specify the provider name for the alcohol screening.
- **Alcohol Screening Comment:** Populate with the text of any comment related to the alcohol screening, using 2–245 characters.
- **Display Depression screening History?:** Type **Y** or **N**. If you type **Y**, the depression screening history displays on another screen.
- **Depression Screening Result:** Specify the result of the depression screening. Type one of the following:
 - N–Negative
 - P–Positive
 - UAS–Unable to screen
 - REF–Patient Refused Screening
- **Depression Screening Provider:** Specify the provider name for the depression screening.
- **Dep Screening Comment:** Populate with the text of any comment related to the depression screening, using 2–245 characters.

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

- **Edit Measurements?**

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

*** Measurements ***		
Measurement Description	Value	Provider

Figure 4-29: Sample Measurements pop-up

- **Measurement:** Specify the type of measurement being taken on the patient. Then the application populates the Description field.
- **Value:** Specify the numeric value of the measurement. The value must be in the valid numeric range for the measurement.

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

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

- **Placement Disposition**

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

- **Referred to**

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

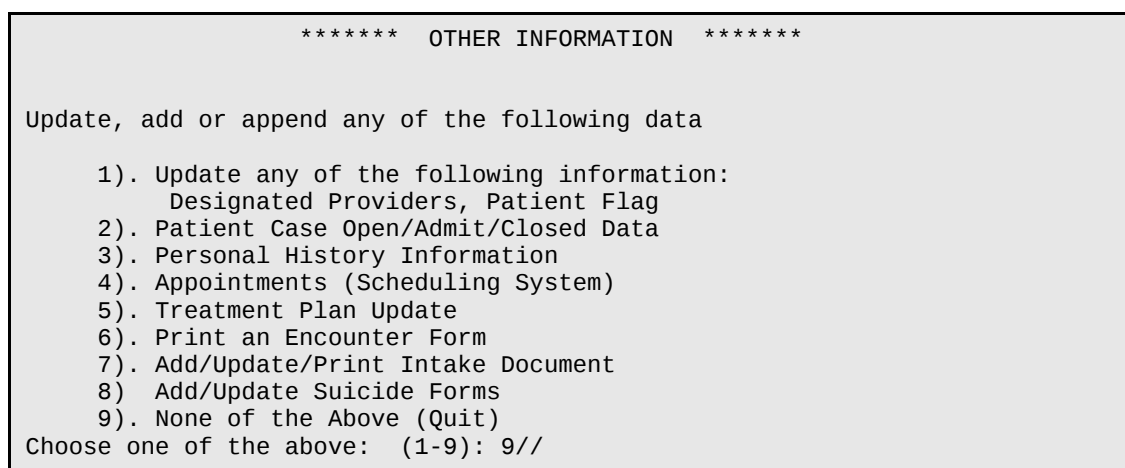
After you exit the window, the application displays the following prompt about your signature code. This prompt only displays where you are the primary provider for the visit and the SOAP/Progress Note is unsigned.

- **Enter your Current Signature Code**

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

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

The application then displays the Other Information window.



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

Update, add or append any of the following data

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

Figure 4-30: Other Information window

You can exit using Option 9, or edit the visit using the other options.

After you use Option 9, one of the following will happen:

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

Below are the prompts for linking:

```

Generating PCC Visit.

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

1  TIME: 16:00 LOC: WW   TYPE: I CAT: A CLINIC: ALCOHOL  DEC: 0
VCN:47887.1A
   Hospital Location: BJB AOD
   Primary POV:      Narrative:
2  TIME: 15:00 LOC: WW   TYPE: I CAT: A CLINIC: GENERAL  DEC: 0
VCN:47887.2A
   Hospital Location: ADULT WALKIN
   Primary POV:      Narrative:
3  TIME: 16:15 LOC: WW   TYPE: I CAT: A CLINIC: BEHAVIOR DEC: 3
VCN:47887.3A
   Hospital Location: BJB BH
   Provider on Visit: BETA,BETA
   Primary POV: 799.9 Narrative: DIAGNOSIS OR CONDITION DEFERRED ON AXIS
4  Create New Visit

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

Figure 4-31: Continuing prompts

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

```

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

                                ?? for more actions
  
```

AV	Add Patient Visit	PF	Print Encounter Form	SN	Sign Note
AC	Add Adm/Comm Record	ID	Intake Document	TN	Display TIU Note
EV	Edit Record	HS	Health Summary	AP	Appointments
OI	Desg Prov/Flag	ES	SOAP/CC Edit	MM	Send Mail Message
DR	Display Record	SD	Switch Dates	Q	Quit
DE	Delete Record	EH	Edit EHR Record		

Figure 4-32: Prompts that continue

Below is how the record looks in the BH application:

```

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

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

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

AXIS III:

AXIS IV:

SUBJECTIVE/OBJECTIVE: TEST

COMMENT/NEXT APPOINTMENT:
TEST

NOTE FORWARDED TO:

MEDICATIONS PRESCRIBED:

```

```

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

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

Note already signed, no E Sig necessary.

Press enter to continue....:

```

Figure 4-33: Display Record information

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

```

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

Update, add or append any of the following data

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

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

AV  Add Patient Visit    PF  Print Encounter Form SN  Sign Note
AC  Add Adm/Comm Record  ID  Intake Document      TN  Display TIU Note
EV  Edit Record          HS  Health Summary       AP  Appointments
OI  Desg Prov/Flag       ES  SOAP/CC Edit        MM  Send Mail Message
DR  Display Record       SD  Switch Dates        Q   Quit
DE  Delete Record       EH  Edit EHR Record

Select Action: AV// Q  Quit

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

```

Version 4.0

DEMO INDIAN HOSPITAL

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

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

```

*****
**          IHS Behavioral Health System          **
**      Data Entry Menu Display Options          **
*****
  
```

Version 4.0

DEMO INDIAN HOSPITAL

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

Select Display Record Options Option: PCCV Display a PCC Visit

Select PATIENT NAME:

BETAA,EMILY MAE <A> F 03-01-1968 XXX-XX-1619 WW 129608

Enter VISIT date: T-3 (MAR 09, 2010)

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

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

Select one: 3

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

===== VISIT FILE =====

VISIT/ADMIT DATE&TIME:	MAR 09, 2010@16:15
DATE VISIT CREATED:	MAR 09, 2010
TYPE:	IHS
PATIENT NAME:	BETAA, EMILY MAE
LOC. OF ENCOUNTER:	DEMO INDIAN HOSPITAL
SERVICE CATEGORY:	AMBULATORY
CLINIC:	BEHAVIORAL HEALTH
DEPENDENT ENTRY COUNT:	5
DATE LAST MODIFIED:	MAR 12, 2010
WALK IN/APPT:	WALK IN
HOSPITAL LOCATION:	BJB BH
CREATED BY USER:	BETA, BETAS
OPTION USED TO CREATE:	SD IHS PCC LINK < - If the visit is linked, it will always show this option

APPT DATE&TIME:	MAR 09, 2010@16:15
USER LAST UPDATE:	BETA, BETAS
VCN:	47887.3A
OLD/UNUSED UNIQUE VIS:	5059010002565343
DATE/TIME LAST MODIFI:	MAR 12, 2010@09:31:13
CHART AUDIT STATUS:	INCOMPLETE
NDW UNIQUE VISIT ID (:	102320002565343
VISIT ID:	3C5N-WWX

===== PROVIDER =====

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

===== POV =====

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

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

===== ACTIVITY TIMES =====

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

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

Figure 4-34: How it looks in PCC

4.1.5 Edit EHR Visit (EH)

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

- **Enter Encounter Date**

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

```

Edit Behavioral Health Specific Fields for an EHR Visit
Patient: DELTA,EDWIN RAY   HRN: 105321
Visit Date: FEB 27, 2009@13:47   Provider: GAMMAA,RYAN
-----
Community of Service: ALBUQUERQUE
Activity Type: 99 INDIVIDUAL BH EHR VI
Appt/Walk In: UNSPECIFIED
Placement Disposition:
Interpreter Utilized:      Comment/Next Appt (press enter)
Local Service Site:
Flag (Local Use):
  AXIS III (press enter to update or TAB to bypass):
    AXIS IV:
    AXIS IV:
    AXIS IV:
    AXIS V:      GAF Scale Type:
-----
COMMAND:
Insert
Press <PF1>H for help

```

Figure 4-35: Sample information about editing a BH visit entered through the EHR.

The underlined fields are required.

- **Community of Service**

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

- **Activity Type**

This indicates the type of activity for the visit.

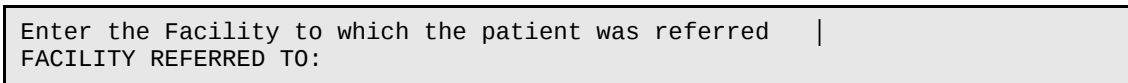
- **Appt/Walk In**

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

- **Placement Disposition**

This indicates any active disposition (such as Alcohol/Drug Rehab). This is used when hospitalization or placement in a treatment facility is required.

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



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

Figure 4-36: Pop-up window asking for facility referred to

- **Facility Referred to**

Populate with the facility to which the patient was referred, using 2–30 characters in length. This is a free text field.

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

- **Interpreter Utilized**

This indicates if an interpreter was used in the visit (Y = Yes or N = No). Type **Y** if an interpreter was required to communicate with the patient.

- **Comment/Next Appt (press enter)**

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

- **Local Service Site**

This indicates the local service site for the visit.

- **Flag (Local Use)**

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

- **AXIS III (press Enter to update or Tab to bypass)**

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

- **AXIS IV**

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

- **AXIS V**

Populate with the patient's functional level, using the Global Assessment of Functioning (GAF) scale. Use any numerical values between 0 and 100.

- **Scale Type**

Populate with the acronym for the GAF Scale Type using up to 20 characters.

4.1.6 Edit SOAP (ES)

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

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

- "Enter Encounter Date"

Specify the encounter date for this edit process.

- "CHIEF COMPLAINT"

Specify the chief complaint (free-text), if any. If there is existing text, you can change it. This information describes the major reason the patient sought services.

- "SOAP/PROGRESS NOTE"

No existing text

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

- "Edit? NO//"

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

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

- "COMMENT/NEXT APPOINTMENT"

No existing text

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

- "Edit? NO//"

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

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

- “MEDICATIONS PRESCRIBED”

No existing text

If there is existing text, it appears below the “MEDICATIONS PRESCRIBED” prompt. You can edit this text (just like entering new note).

- “Edit? NO//”

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

The electronic signature might be needed after you exit. Refer to Section 2.14 Electronic Signature for more information.

4.1.7 Delete Visit (DE)

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

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

Encounter records containing unsigned, or a blank SOAP/Progress Note can be edited or deleted.

Below are the prompts.

- “Enter Encounter Date”

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

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

- “Are you sure you want to DELETE this record?”

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

4.1.8 Sign Note (SN)

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

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

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

Figure 4-37: List of records that you can change

The prompts continue.

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

Specify the number of the record you want to use.

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

After you quit the BH Visit Record Display window, the application asks if you want edit this record. If you type **N**, you exit the sign note process.

If you type **Y**, the application displays the Edit SOAP window.

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

- “Enter your Current Signature Code”

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

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

4.1.9 Print Encounter Form (PF)

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

- “Enter Encounter Date”

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

- “What type of form do you want to print”

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

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

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

- “Device”

Specify the device to print/browse the data.

Below is the data for a suppressed encounter form.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Mar 27, 2009@12:44:08
*** Computer Generated Encounter Record ***
*****
Date: Feb 23, 2009           Primary Provider: GAMMAAA,DENISE
Arrival Time: 12:00
Program: MENTAL HEALTH
Clinic: MENTAL HEALTH           Appointment Type: APPOINTMENT

Community: TUCSON                Number      Activity/Service
Activity: 13-INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT   Served:      Time: minutes
Type of Contact: OUTPATIENT

Chief Complaint/Presenting Problem Suppressed for Confidentiality

S/O/A/P:
Behavioral Health Visit

```

Feb 23, 2009@12:00		Page 2				
See GAMMAAA,DENISE for details.						
COMMENT/NEXT APPOINTMENT: Behavioral Health Visit - COMMENT Suppressed See GAMMAAA,DENISE for details.						
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">BH POV CODE</td> <td>PURPOSE OF VISIT (POV)</td> </tr> <tr> <td>OR DSM DIAGNOSIS</td> <td>[PRIMARY ON FIRST LINE]</td> </tr> </table>			BH POV CODE	PURPOSE OF VISIT (POV)	OR DSM DIAGNOSIS	[PRIMARY ON FIRST LINE]
BH POV CODE	PURPOSE OF VISIT (POV)					
OR DSM DIAGNOSIS	[PRIMARY ON FIRST LINE]					
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">311.</td> <td>DEPRESSIVE DISORDER NOS</td> </tr> </table>			311.	DEPRESSIVE DISORDER NOS		
311.	DEPRESSIVE DISORDER NOS					
AXIS IV: 6 - ECONOMIC PROBLEMS 8 - LEGAL INTERACTION PROBLEMS AXIS V:						
Enter RETURN to continue or '^' to exit:						

Figure 4-38: Sample Suppressed Encounter Form

4.1.10 Last BH Visit (LV)

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

Below are the prompts.

- “Do you want a particular provider’s last visit”

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

The application displays the BH Visit Record Display window.

BH VISIT RECORD DISPLAY		Mar 27, 2009 15:06	Page: 1 of 5
Patient Name:	ALPHA,GLEN DALE		
Chart #:	108704		
Date of Birth:	NOV 10, 1981		
Sex:	M		
Flag Narrative:	NONE		
===== BH RECORD FILE =====			
DATE OF SERVICE:	MAR 26, 2009@09:00		
PROGRAM:	MENTAL HEALTH		
LOCATION OF ENCOUNTER:	SELLS HOSP		
COMMUNITY OF SERVICE:	TUCSON		
ACTIVITY TYPE:	13		
ACTIVITY TYPE NAME:	INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT		
TYPE OF CONTACT:	OUTPATIENT		
PATIENT:	ALPHA,GLEN DALE		
PT AGE:	27		
CLINIC:	MENTAL HEALTH		

```

NUMBER SERVED:          1
APPT/WALK-IN:          WALK-IN
ACTIVITY TIME:         45
+      Enter ?? for more actions
+   Next Screen      -   Previous Screen      Q   Quit
Select Action: +//

```

Figure 4-39: Sample BH Visit Record Display window

4.1.11 Browse Visit (BV)

Use the BV option to browse behavioral health visits.

The prompts are below.

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

Type one of the following:

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

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

The application displays the Browse Patient’s Visit window. Below is the window using the **A** option.

```

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

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

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

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

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

```

Select Action:+//

Figure 4-40: Sample Report window

4.1.12 List Visit Dates (LD)

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

The prompts are below.

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

Type one of the following:

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

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

The application displays the Browse Patient's Visit window.

BROWSE PATIENT'S VISITS		Mar 27, 2009 15:25:54	Page:	1 of	1
Patient Name: ALPHA,GLEN DALE		DOB: Nov 10, 1981			
HRN: 108704					

Date	Provider	DX	NARRATIVE		
Mar 26, 2009@09:00	GAMMAAA,DENISE	311.	testing v4.0 provide		
Mar 23, 2009@11:41	GAMMAAA,DENISE	311.	Depressive Disorder,		
Jan 22, 2009@15:03	GAMMAAA,DENISE	311.	Depressive Disorder,		
May 06, 2008@14:23	GAMMAAA,DENISE	311.	Depressive Disorder,		
Apr 18, 2008	BETAAAA,BJ	295.33	Paranoid Type Schizo		
Apr 07, 2008@14:07	GAMMAAA,DENISE	311.	Depressive Disorder,		
Apr 04, 2008@14:13	GAMMAAA,DENISE	311.	Depressive Disorder,		
Feb 18, 2008@17:03	GAMMAAA,DENISE	311.	Depressive Disorder,		
Feb 12, 2008@16:24	GAMMAAA,DENISE	311.	Depressive Disorder,		
Jan 22, 2008@12:06	BETAAAA,BJ	295.33	Paranoid Type Schizo		
Jan 11, 2008@12:00	GAMMAAA,DENISE	296.31	MAJOR DEPRESSIVE DIS		
Aug 29, 2007@08:53	BETAAAA,BJ	295.33	Paranoid Type Schizo		
Feb 02, 2006@12:00	BETAAAA,BJ	13	SCHIZOPHRENIC DISORD		
Enter ?? for more actions					
+ Next Screen		- Previous Screen		Q Quit	
Select Action:+//					

Figure 4-41: Sample list of visit dates window

4.1.13 Display Record (DR)

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

Below are the prompts

- “Enter ENCOUNTER DATE”

Specify the date of the visit.

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

BH VISIT RECORD DISPLAY		Apr 13, 2009 14:46:26	Page: 1 of 4
Patient Name:	ALPHAA,CHELSEA MARIE		
Chart #:	116431		
Date of Birth:	FEB 07, 1975		
Sex:	F		
Patient Flag	9		
Flag Narrative	99		
===== BH RECORD FILE =====			
DATE OF SERVICE:	MAR 24, 2009		
PROGRAM:	CHEMICAL DEPENDENCY		
LOCATION OF ENCOUNTER:	FIVE SANDOVAL INDIAN PROG, INC		
OUTSIDE LOCATION	T5		
COMMUNITY OF SERVICE:	RIO RANCHO		
ACTIVITY TYPE:	11		
ACTIVITY TYPE NAME:	SCREENING-PATIENT PRESENT		
TYPE OF CONTACT:	OUTPATIENT		
PATIENT:	ALPHAA,CHELSEA MARIE		
PT AGE:	34		
CLINIC:	ALCOHOL AND SUBSTANCE		
NUMBER SERVED:	1		
APPT/WALK-IN:	WALK-IN		
ACTIVITY TIME:	30		
Enter ?? for more actions			
+ Next Screen	- Previous Screen	Q	Quit
Select Action: +//			

Figure 4-42: Sample BH Visit Record Display window for a specified visit.

More visit data displays on the next screen.

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

***** OTHER INFORMATION *****
Update, add or append any of the following data
1). Update any of the following information:
Designated Providers, Patient Flag
2). Patient Case Open/Admit/Closed Data
3). Personal History Information
4). Appointments (Scheduling System)
5). Treatment Plan Update
6). Print an Encounter Form
7). Create/Update/Print Intake Document

8) Add/Update Suicide Forms
 9). None of the Above (Quit)
 Choose one of the above: (1-9): 9//

Figure 4-43: Options on the Other Information menu

Use the options to update visit information about the patient, if needed. Otherwise, use Option 9 to exit.

4.2 Visit Window (GUI)

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

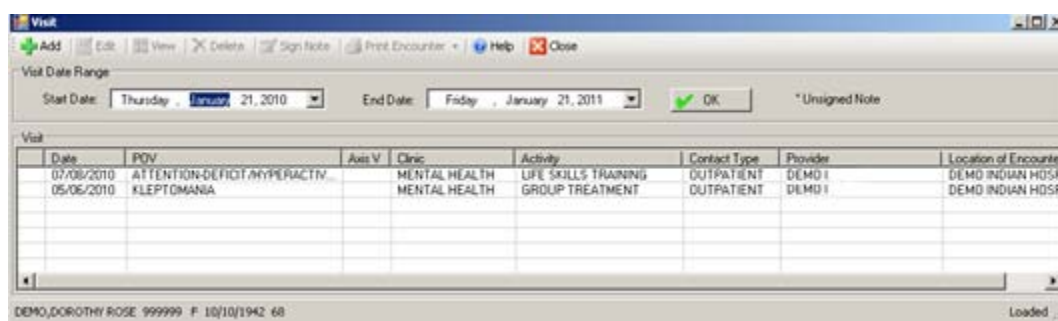


Figure 4-44: **Visit** window for one patient

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

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

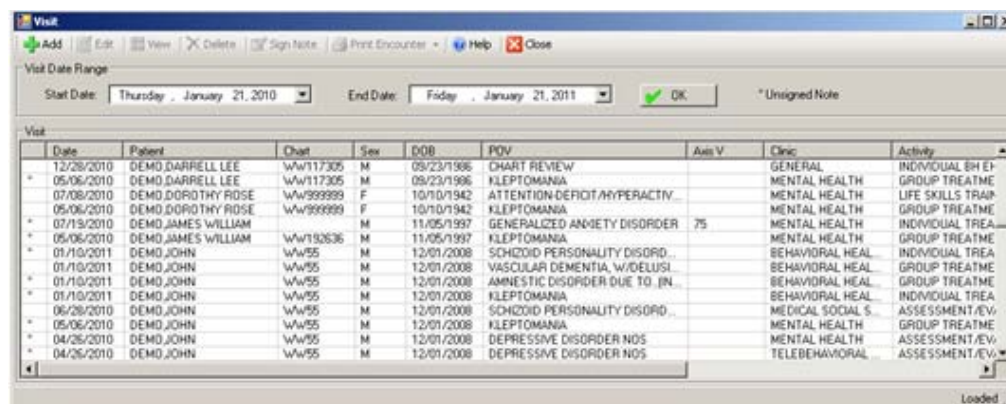


Figure 4-45: Sample **Visit** window for all patients

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

The following are features of both windows.

4.2.1 Visit Date Range Group Box

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

4.2.1.1 Visit Window for One Patient

The following applies to the **Visit** window for one patient:

The default start date is one year previous.

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

Note: If you change the start date for the **Visit** window for one patient, this change stays in effect in future sessions of the GUI application for the **Visit** window for one patient (until you change it again).

4.2.1.2 Visit Window for All Patients

The following applies to the **Visit** window for all patients:

The default start date is today.

You can change the default start date and the application maintains that start date until you exit the application. Then, when you log in again, the start date reverts to today's date.

4.2.2 Visit Group Box

The **Visit** group box shows the visit records in the particular visit date range.

The asterisk (*) in the first column indicates that the particular record contains an unsigned note. Refer to Section 2.14.5 Signing a Note (GUI) for more information.

4.2.3 Add Button

Establish the patient you want to use in the add process. Click **Add** to add a new visit record. You will access the **Visit Data Entry–Add Visit** dialog box. Refer to Section 4.3 Add/Edit Visit Data Entry for more information.

4.2.4 Edit Button

Click **Edit** to edit a particular visit record. You will access the **Visit Data Entry–Edit Visit** dialog box.

4.2.5 View Button

Click **View** (or double-click on a record) to browse a particular visit record. This window has the same fields as the add/edit visit dialog, except for the **Intake** and **Suicide Form** tabs.

4.2.6 Delete Button

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

Click **Delete** to delete a particular visit record. The application confirms the deletion.

4.2.7 Sign Note Button

Click **Sign Note** to sign the note of an “unsigned” record (asterisk [*] in the first column). Refer to Section 2.14.5 Signing a Note (GUI) for more information.

4.2.8 Print Encounter Button

Click **Print Encounter** to print the encounter data about a particular visit record. The **Print Encounter** button has these options: **Full**, **Suppressed**, **Both Full and Suppressed**.

Please note that the Intake document and Suicide Reporting Form must be printed elsewhere and will not appear on a printed encounter form.

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

After selecting one of the options, the application displays the first page of the **Print Encounter** pop-up window.

Print Encounter DEMO, JOHN SS 14 12/01/2008 2

***** CONFIDENTIAL PATIENT INFORMATION *****

PCC BEHAVIORAL HEALTH ENCOUNTER RECORD Printed: Feb 15, 2011@16:29:01

*** Computer Generated Encounter Record ***

Date: Jan 10, 2011 Primary Provider: TEST, MARK

Arrival Time: 13:17

Program: OTHER

Clinic: BEHAVIORAL HEALTH Appointment Type: APPOINTMENT

Community: TUCSON	Number	Activity/Service
Activity: 13-INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT	Served: 1	Time: 60 minutes
Type of Contact: OUTPATIENT		

Chief Complaint/Presenting Problem Suppressed for Confidentiality

S/O/A/P:

Behavioral Health Visit

See TEST, MARK for details.

COMMENT/NEXT APPOINTMENT:

ICD-9 CODE	PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS	(PRIMARY ON FIRST LINE)

312.32	DEPRESSION
--------	------------

MEDICATIONS PRESCRIBED:

PROCEDURES (CPT):

MR#: WW 55 SSN: XXX-XX-1234

NAME: DEMO, JOHN TRIBE: NAVAJO TRIBE, AZ NM AND UT

SEX: MALE

DOB: Dec 01, 2008

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

Figure 4-46: Sample **Print Encounter** pop-up window

Refer to Section 2.6 Pop-up Window to review the features of this type of window.

4.2.9 Help Button

Click **Help** on the **Visit** window to access the online help for the window.

4.2.10 Close Button

Click **Close** on the **Visit** window to exit the window.

4.3 Add/Edit Visit Data Entry

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

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

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

Figure 4-47: Sample **Visits Data Entry–Add Visit** window

Click **Help** to access online help about this window.

After adding or changing this dialog, click **Save** (otherwise, click **Close**).

The Save process saves the changes and dismisses the **Add/Edit** window. If you added a SOAP/Progress note, you will be asked if you want to sign the note. Refer to Section 2.14.5 Electronic Signature (GUI) for more information.

- If there was not an appointment the patient was checked in for in the scheduling package, you return to the **Visit** window.
- If there was an appointment the patient was checked in for in the scheduling package and it is set to create a visit at check-in, the application displays the **Select PCC Visit** window. Refer to Section 4.3.9 Select PCC Visit Window for more information. Please note the following about this option:
 - If the facility is not using the scheduling package and doesn't have the Interactive PCC Link in the site parameters turned on, you will never be presented with the ability to link it to a PCC visit.

- If there is no visit in PCC (patient never checked in, no appointment or walk in was ever created in the scheduling package and no other clinics saw the patient that day), then the option to link is never presented and the BH visit continues to create a new visit in PCC.

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

- Click **Yes** to close without saving; this dismisses the data entry window.
- Click **No** and you remain on the data entry window where you can continue work.

The free text fields have a context menu for editing. Refer to Section 2.11 Free Text Fields for more information.

Several of the fields contain a search window. Refer to Section 2.8 Using the Search Window for more information.

The fields that contain dates can be changed by accessing a calendar. Refer to Section 2.7 Using the Calendar for more information.

Certain group boxes use the search/select window. Refer to Section 2.9 Using the Search/Select window for more information.

Some group boxes use the multiple select window. Refer to Section 2.10 Using the Multiple Select window.

4.3.1 Visit Information Group Box

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

Figure 4-48: Sample **Visit Information** group box

The fields in bold text are required.

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

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

- **Program**

This field determines the program associated with the visit:

- Mental health
- Social services
- Other
- Chemical Dependency

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

- **Encounter Location**

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

- **Clinic**

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

- **Appointment or Walk-In**

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

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

- **Type of Contact**

This field determines the type of contact (the activity setting). Click the drop-down list to access the **Type of Contact** window and select another option, if needed.

- **Community of Service**

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

4.3.2 POV Tab

Use the **POV** tab to add, edit, or delete the Axis I, Axis II, and Axis IV codes, to enter the general medical conditions for Axis III, and to enter the GAF score and scale type.

Figure 4-49: Sample **POV** Tab on **Visit Data Entry** window

4.3.2.1 Axis I/Axis II Group Box

Use the **Axis I/Axis II** group box to manage the POV codes for Axis I or Axis II issues.

Figure 4-50: Sample **Axis I/Axis II** group box

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

Click **Delete** to remove a selected code from the group box. After clicking **Delete**, the “Are You Sure” confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected code from the group box (otherwise, click **No**.)

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

Click **Edit** to edit the POV narrative (not the code) of a selected record on the **Edit POV** dialog box.

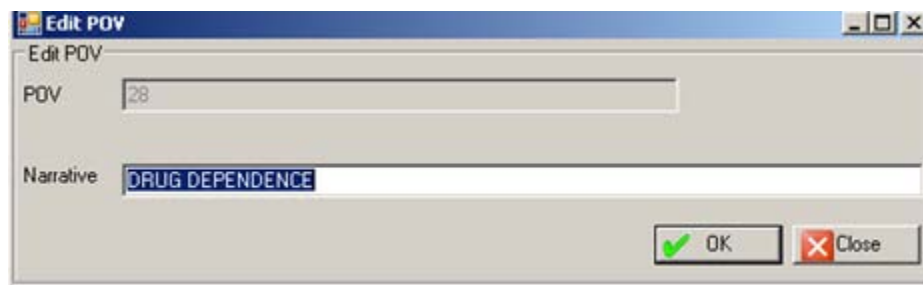


Figure 4-51: **Edit POV** dialog box

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

4.3.2.2 Axis III Group Box

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

4.3.2.3 Axis IV Group Box

Use the **Axis IV** group box to enter one or more of the psychosocial or environmental codes that identify the major category of the problem.

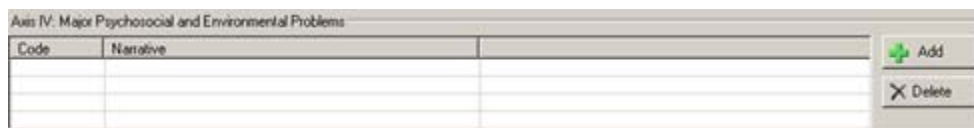


Figure 4-52: Sample **Axis IV** group box

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

Click **Delete** to remove a selected code. After clicking **Delete**, the “Are You Sure” confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected code from the group box (otherwise, click **No**.)

4.3.2.4 Axis V

Use the **Axis V** field to enter the GAF scale value (assessment of the client’s functional level). This field is limited to three numerical characters (0–100).



Axis V: [GAF Scale Type](#)

Figure 4-53: Sample **Axis V** area

Once you populate the **Axis V** field, the **GAF Scale Type** field becomes active. Here you can enter the GAF scale type - enter the acronym for the GAF Scale Type, using up to 20 characters.

If you click the link on the **GAF Scale Type** label, the application displays a Global Assessment of Functioning pop-up. This provides information about the Global Assessment Scale of Functioning (GAF) Scale and the Children's Global Assessment Scale (CGAS).

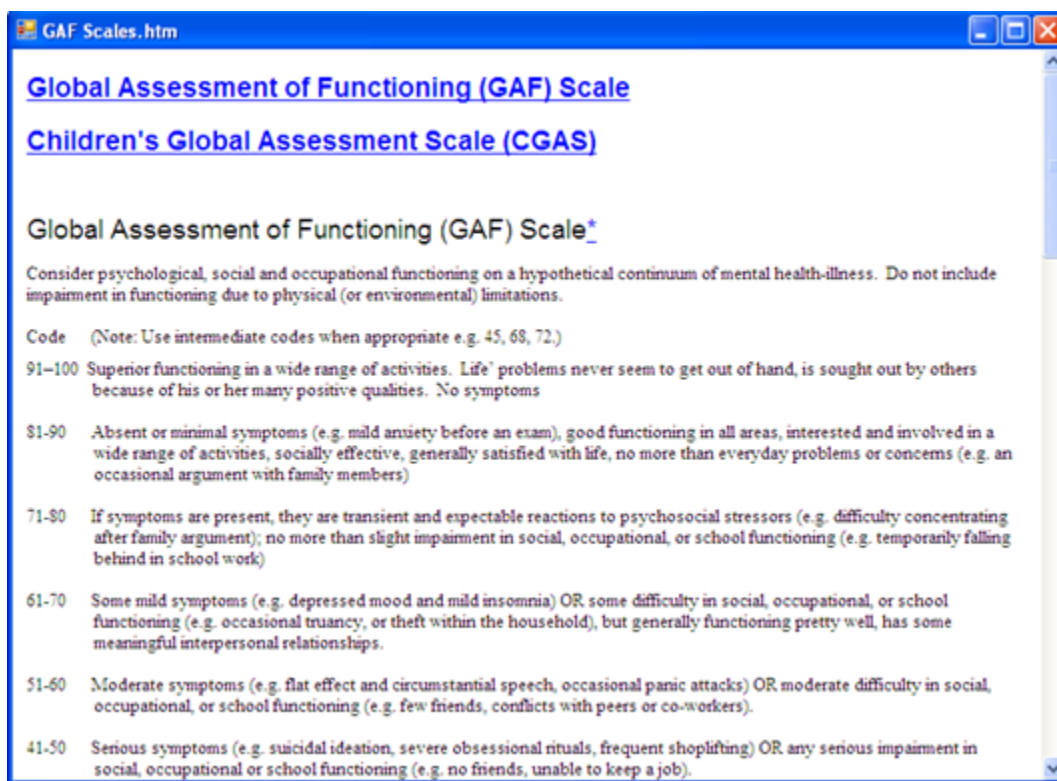


Figure 4-54: Global Assessment of Functioning (GAF) scale

4.3.3 Activity Tab

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

The screenshot shows the 'Activity' tab of the 'Visit Data Entry' window. At the top, there are several tabs: PDV, Activity, SOAP/Progress Notes, Rx Notes/Labs, Wellness, Measurements, Intake, and Suicide Form. The 'Activity' tab is selected. Below the tabs, there are several input fields: 'Activity' (a dropdown menu showing 'HEALTH PROMOTION'), 'Activity Time' (a text box with '10'), 'Visit Flag' (a checkbox), 'Local Service Site' (a dropdown menu), 'Number Served' (a text box with '1'), and 'Interpreter Utilized?' (a checkbox). Below these fields are two tables. The first table is titled 'CPT Code(s)' and has columns for 'Code' and 'Narrative'. It has an 'Add' button (with a green plus icon) and a 'Delete' button (with a red X icon) to its right. The second table is titled 'Secondary Providers for this Visit' and has a 'Provider' column. It also has an 'Add' button (with a green plus icon) and a 'Delete' button (with a red X icon) to its right.

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

4.3.3.1 Activity Group Box

Below is the **Activity** group box.

The screenshot shows the 'Activity' group box. It contains the following fields: 'Activity' (a dropdown menu), 'Activity Time' (a text box), 'Visit Flag' (a checkbox), 'Local Service Site' (a dropdown menu), 'Number Served' (a text box), and 'Interpreter Utilized?' (a checkbox). The fields 'Activity', 'Activity Time', 'Local Service Site', and 'Number Served' are bolded, indicating they are required.

Figure 4-56: Sample **Activity** group box

The fields in bold text are required.

- **Activity**

Populate with the activity code that documents the type of service or activity performed by the Behavioral Health provider. These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Click the drop-down list to access the Activity search window. Here you search for the activity name. Refer to Section 15.0 Appendix A: Activity Codes and Definitions for more information.

- **Activity Time**

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

- **Visit Flag**

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

- **Local Service Site**

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

- **Interpreter Utilized?**

Check this check box if an interpreter is required to communicate with the patient.

- **Number Served**

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

4.3.3.2 CPT Codes Group Box

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

Code	Narrative

Figure 4-57: Sample **CPT Codes** group box

Click **Add** to access **the CPT Code** multiple search/select window. Here you search for the CPT code for Behavioral Health services. After selecting a code, the application automatically populates the **Narrative** field. These E&M or HCPCS codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient. You can add one or more CPT codes to this group box.

Click **Delete** to remove a selected CPT code record from the group box. After clicking **Delete**, the “Are You Sure” confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected code from the group box (otherwise, click **No**.)

4.3.3.3 Secondary Providers for this Visit Group Box

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

Figure 4-58: Sample secondary providers for this **Visit** group box

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

Click **Delete** to remove a selected secondary provider record from the group box. After clicking **Delete**, the “Are You Sure” confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected provider from the group box (otherwise, click **No**.)

4.3.4 SOAP/Progress Notes Tab

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

Figure 4-59: Sample **SOAP/Progress Notes** tab

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

- **Chief Complaint/Presenting Problem**

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

- **Progress Notes**

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

- **Comments/Next Appointment**

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

- **Placement Disposition**

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

- **Placement Name**

Populate with the name of the placement facility.

4.3.5 Rx Notes/Labs Tab

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

The screenshot shows the 'Rx Notes/Labs' tab selected in the top navigation bar. The left sidebar contains a tree view for 'Rx/Labs' with sub-items 'Rx Notes' and 'PCC Labs'. Under 'PCC Labs', there are three options: 'View by Visit Date', 'View by Lab Test', and 'Graph'. The main content area is divided into three sections: 'PCC Medications' (a table with columns: Visit Date, Medication, SIG, Qty, Days, Provider), 'Behavioral Health Medications' (a table with column: Visit Date/Time), and 'Prescription Entry' (a large text area for notes).

Figure 4-60: Sample **Rx Notes/Labs** tab

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

4.3.5.1 Rx Data

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

- Use the **PCC Medications** group box to view PCC medications prescribed for the current patient. The entire medication history might not be present here.
- Use the **Behavioral Medication** group box to view the visit dates when behavioral health medication was prescribed and any associated notes.
- Use the **Prescription Entry** field to enter information about the patient's prescriptions. This information will be viewable in the **Medications** field for future visits. Items in the **Medication** field can be copied and pasted into the **Prescription Entry** field. This feature is used by some sites to record notes for the psychiatrist such as doing a pill count with the patient, whether or not the patient is compliant with meds, etc. This field has a right-click menu that lets you cut, copy, or paste data (these functions are like the ones in MS Office).

4.3.5.2 PCC Labs

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

4.3.5.2.1 *View by Visit Date*

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



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

The **View Labs by Visit Date** and **View Labs by Lab Test** dialog boxes have the following features:

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

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

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

4.3.5.2.2 *View by Lab Test*

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



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

The **View Labs by Visit Date** and **View Labs by Lab Test** dialog boxes have the following features:

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

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

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

4.3.5.2.3 *Graph*

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

Lab Graph Date Range

Starting Date: 12/16/2009 Ending Date: 12/16/2010

Graphable Lab Tests

Lab Test	Count	Earliest Test	Last Test
11/12/2010@1200	ASPIRIN 3...	TAKE ONE (1) T...	30
11/12/2010@1200	ASPIRIN 3...	TAKE ONE (1) T...	30
11/12/2010@1200	ASPIRIN 3...	TAKE ONE (1) T...	30
11/12/2010@1200	ASPIRIN 3...	TAKE ONE (1) T...	30
11/12/2010@1200	ASPIRIN 3...	TAKE ONE (1) T...	30

Figure 4-63: Sample group boxes for **Graph** option

- **Lab Graph Date Range**

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

- **Graphable Lab Tests**

Graphable Lab Tests

Lab Test	Count	Earliest Test	Last Test
BASO %	1	08/09/2001	11/13/2001
BLOOD COUNT ONLY (NO DIFF)	1	08/09/2001	11/13/2001
CBC	1	08/09/2001	11/13/2001
CLARITY	1	08/09/2001	11/13/2001
COLOR	1	08/09/2001	11/13/2001
DIFFERENTIAL	1	08/09/2001	11/13/2001
EOS %	1	08/09/2001	11/13/2001
EPITHELIAL CELLS	1	08/09/2001	11/13/2001
HCT	1	08/09/2001	08/09/2001
HCT (WIC)	1	02/20/2001	11/13/2001
HGB	1	08/09/2001	08/09/2001
LEUKOCYTE ESTERASE	1	08/09/2001	11/13/2001
LYMPH %	1	08/09/2001	11/13/2001
MCH	1	08/09/2001	08/09/2001
MCHC	1	08/09/2001	08/09/2001
MCV	1	08/09/2001	08/09/2001
MONO %	1	08/09/2001	11/13/2001
MPV	1	08/09/2001	08/09/2001
NEUT %	1	08/09/2001	11/13/2001
NITRITE	1	08/09/2001	11/13/2001
PLT	1	08/09/2001	08/09/2001
RBC	1	08/09/2001	08/09/2001

Figure 4-64: Sample **Graphable Lab Tests** group box

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

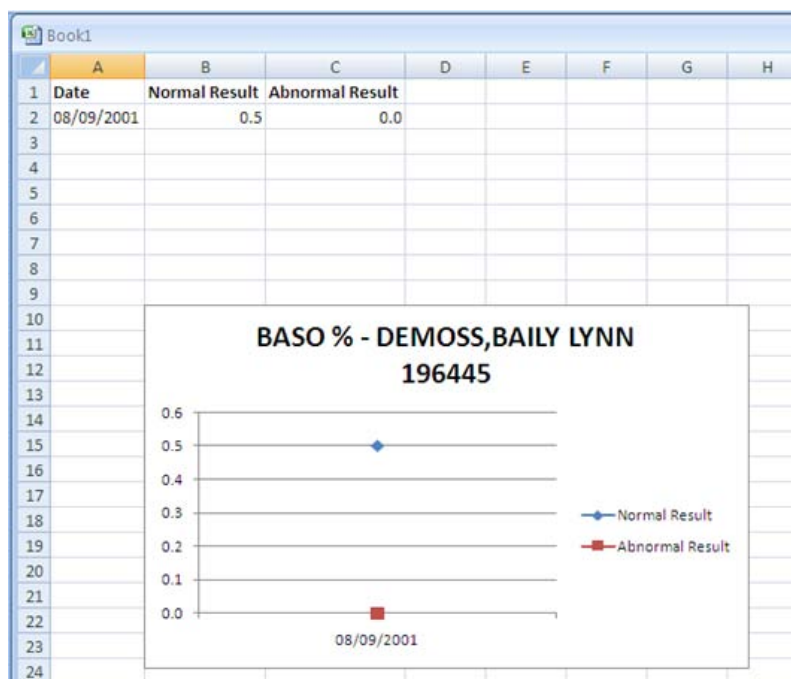


Figure 4-65: Sample graph of a particular laboratory test

You can save this data, if needed.

4.3.6 Wellness Tab

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

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

Figure 4-66: Sample **Wellness** tab

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

4.3.6.1 Patient Education

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

 A screenshot of a software window titled 'Patient Education' with two sub-sections. The top sub-section, 'Patient Education History', contains a table with five columns: 'Date', 'Education Topic', 'Time Spent', 'Level Of Understanding', and 'Comment'. The bottom sub-section, 'Patient Education Data Entry', contains a table with four columns: 'Education Topic', 'Time Spent', 'Level Of Understanding', and 'Comment'. Both tables are currently empty. Above the top table are buttons for 'Add', 'Edit', and 'Delete'.
Figure 4-67: Sample **Patient Education** group boxes

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

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

4.3.6.1.1 Add Patient Education Record

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

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

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

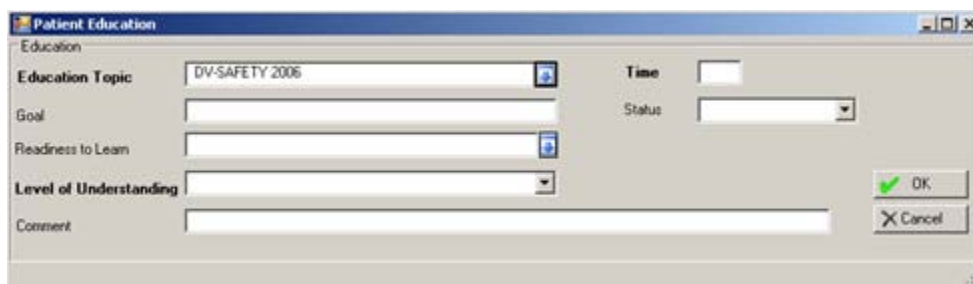


Figure 4-68: Sample **Patient Education** dialog box

The fields in bold text are required.

- **Education Topic**

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

- **Time**

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

- **Goal**

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

- **Status**

Populate with the status of the education goal. Use one of the following:

- Goal Set (the preparation phase defined as “patient ready to change” (patient is active)
- Goal Met (the action phase defined as “patient actively making the change” or maintenance phase defined as “patient is sustaining the behavior change”)

- Goal Not Met (the contemplation phase defined as “patient is unsure about the change” or relapse when the patient started making the change and did not succeed due to ambivalence or other reason)
- Goal Not Set (the precontemplation phase defined as “patient is not thinking about change”)

- **Readiness to Learn**

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

The options are:

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

- **Level of Understanding**

Populate with the level of understanding. Use one of the following:

- Poor (does not verbalize understanding; unable to return demonstration or teach-back correctly)
- Fair (verbalizes need for more education; incomplete return demonstration or teach-back indicates partial understanding)
- Good (verbalizes understanding; able to return demonstration or teach-back correctly)
- Group No Assessment (education provided in group; unable to evaluate individual response)
- Refused (refuses education)

- **Comment**

Add any comments about the education topic for the visit. This is a free text field.

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

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

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

4.3.6.1.2 *Edit Patient Education Record*

Select a record in the Patient Education Data Entry grid and click **Edit**. The application displays the **Patient Education** dialog box, with the fields populated with the current data. Refer to Section 4.3.6.2.1 Add Education Record for more information about the fields. If the record was saved before the installation date for BHS v4.0, it will continue to display the **CPT** field. You can edit an education record if the visit has a signed note.

4.3.6.1.3 *Delete Patient Education Record*

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

4.3.6.2 Health Factors

Select the **Health Factors** option on the Wellness tree structure to display the health factor group boxes: **Health Factors History** and **Health Factors Data Entry**.

Health Factor History					
Date	Health Factor	Level/Severity	Quantity	Provider	Comment

Health Factors Data Entry			
Health Factor	Level/Severity	Quantity	Comment

Figure 4-69: Sample **Health Factors** group boxes

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

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

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

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

4.3.6.2.1 *Add Health Factor Record*

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

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

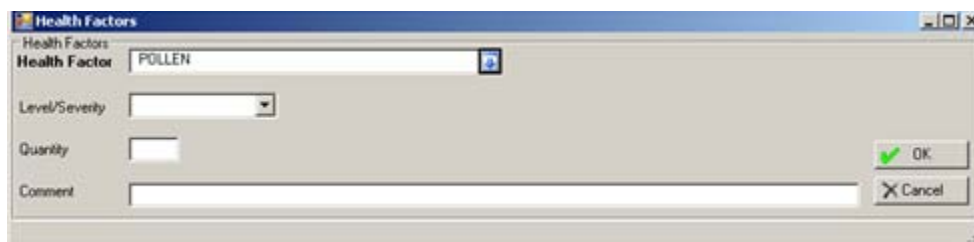


Figure 4-70: Sample **Health Factors** window

The fields in bold text are required.

- **Health Factor**

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

- **Level/Severity**

Populate with one of the following, if applicable:

- Minimal
- Moderate
- Heavy/Severe

- **Quantity**

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

- **Comment**

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

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

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

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

4.3.6.2.2 *Edit Health Factor Record*

Select a record in the Health Factors Data Entry grid and click **Edit**. The application displays the **Health Factors** dialog box, with the fields populated with the current data. Refer to Section 4.3.6.2.1 Add Health Factor Record (above) for more information about the fields.

4.3.6.2.3 *Delete Health Factor Record*

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

4.3.6.3 **Screening**

Select the **Screening** option on the Wellness tree structure to display the screening group boxes: **Screening History** and **Screening Data Entry**.

The screenshot shows two stacked data entry grids. The top grid, titled 'Screening History', has five columns: 'Date', 'Alcohol', 'Alcohol Provider', 'Alcohol Comment', and 'Depression'. The bottom grid, titled 'Screening Data Entry', has four columns: 'Alcohol', 'Alcohol Comment', 'Depression', and 'Depression Comment'. Both grids are currently empty, showing only header rows and several blank rows for data entry.

Figure 4-71: Sample Screening group boxes

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

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

In either case, the **Screening** window displays.

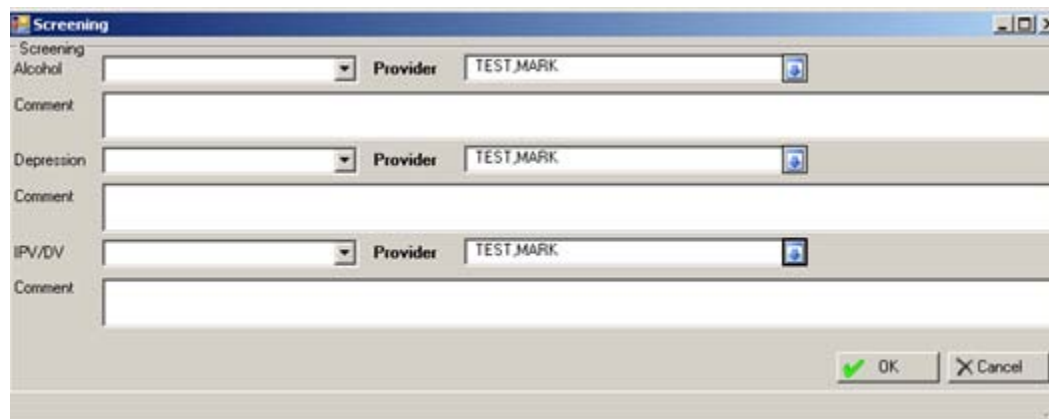
The screenshot shows a software window titled "Screening". It contains three vertically stacked sections. Each section has a label on the left ("Alcohol", "Depression", "IPV/DV"), a dropdown menu, a "Provider" label followed by a text field containing "TEST.MARK", and a "Comment" label followed by a large text area. At the bottom right of the window are "OK" and "Cancel" buttons. The window has a standard Windows-style title bar and a scroll bar on the right side.

Figure 4-72: **Screening** window

- **Alcohol**

Populate with the outcome of the alcohol screening. Use one of the following:

- Negative (patient's screening does not indicate risky alcohol use)
- Positive (patient's screening indicates risky alcohol use)
- Unable to screen (provider unable to conduct the screening)
- Patient Refused Screening (patient declined exam or screening)

- **Provider**

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

- **Comment**

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

- **Depression**

Populate with the outcome of the depression screening. Use one of the following:

- Negative (denies symptoms of depression)
- Positive (provides positive answers to depression screening; further evaluation is warranted)

- Unable to screen (provider unable to conduct the screening)
- Patient Refused Screening (patient declines exam or screening)
- **Provider**

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

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

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

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

Provider

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

Comment

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

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

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

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

4.3.7 Measurements Tab

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

Figure 4-73: Sample **Measurements** tab

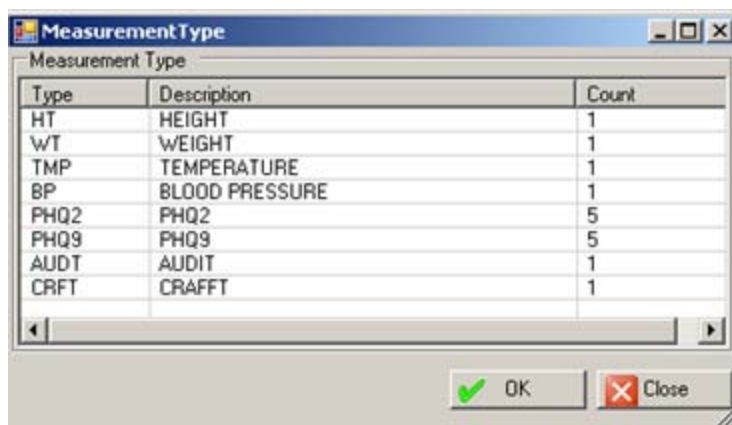
4.3.7.1 Measurement View Group Box

This group box displays the measurements for the current patient in the date range shown in the **Measurement History** group box. Change the date range by clicking the drop-down list to access the calendar. After changing the date range, click **Display** to refresh the **Data View** group box with the new data.

Date	Measurement	Description	Value	Provider
01/12/2011	AUDT	AUDIT	25	DEMO.DOCTOR

Figure 4-74: Sample **Measurement View** group box

To better utilize the data collected and viewed through the **Measurement View** group box, you can graph a measurement in the grid by clicking **Graph**. The application will display the **Measurement Type** window.

Figure 4-75: Sample **Measurement Type** window

Select the measurement type you want to graph. Then click **OK** (otherwise, click **Close**). The OK process causes the application to (automatically) use the data to display a graph in MS Excel.

You are moved to the MS Excel application with the data shown. The data automatically displays in the form of a line graph. You can create a graph of your choice from the selected data.

Below is a sample line graph.

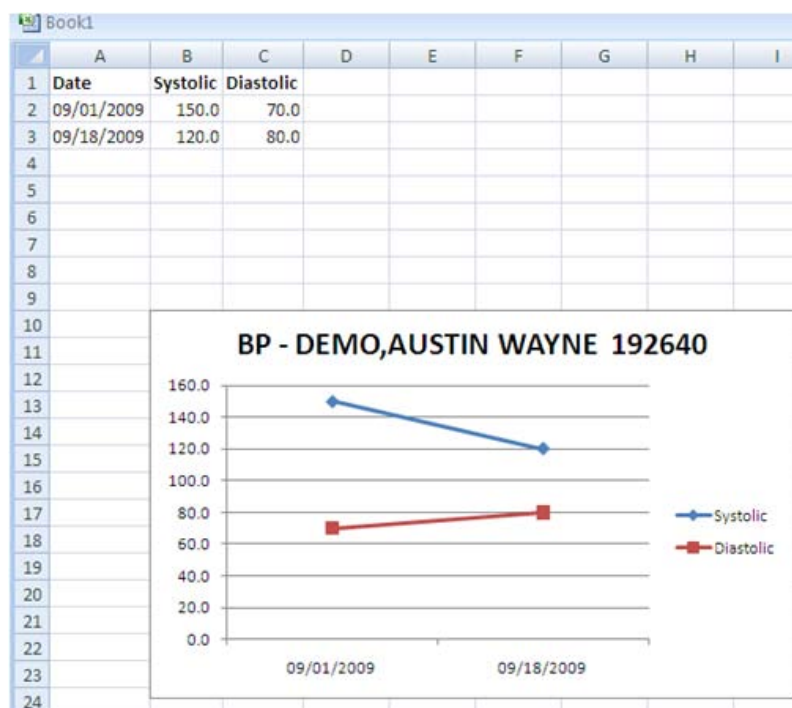


Figure 4-76: Sample line graph

You can save the data, if needed.

4.3.7.2 Measurement Data Entry Group Box

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

Measurement	Description	Value	Provider
AUDT	AUDIT	25	DEMO DOCTOR

Measurement Type: Value:
 Provider:

Figure 4-77: Sample **Measurement Data Entry** group box

Click **Edit** button to change the value of a selected measurement record and/or the provider. The value and provider display in the fields below the grid. After changing the fields, click **OK** (otherwise, click **Cancel**). The OK process changes the value and/or provider in the grid.

Click **Delete** to delete a selected measurement record. Measurements can only be deleted from the encounter record where they were first recorded. After clicking **Delete**, the application displays the “Are You Sure” confirmation; click **Yes** to delete (otherwise, click **No**).

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

The fields in bold text are required.

- **Measurement Type**

Populate this field with a V Measurement type. Click the drop-down list to access the **Measurement Type** window where you select a type. This field is inactive when editing a record.

- **Value**

Populate with the numeric value of the measurement. If the value is outside the accepted range, the application displays the **Warning** dialog box. Click **OK** to dismiss the warning and populate with another valid numeric value.

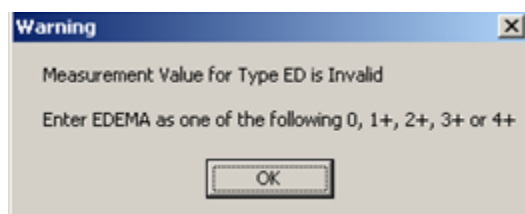


Figure 4-78: Sample value outside the acceptable range warning

- **Provider**

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

Click **OK** on the Measurement Data Entry group box (otherwise, click **Cancel**). The OK process causes a new record to display in the grid (showing the measurement along with its description, value, and provider).

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

4.3.8 Intake Tab (GUI)

When you click the **Intake** tab, the application displays the Intake window.

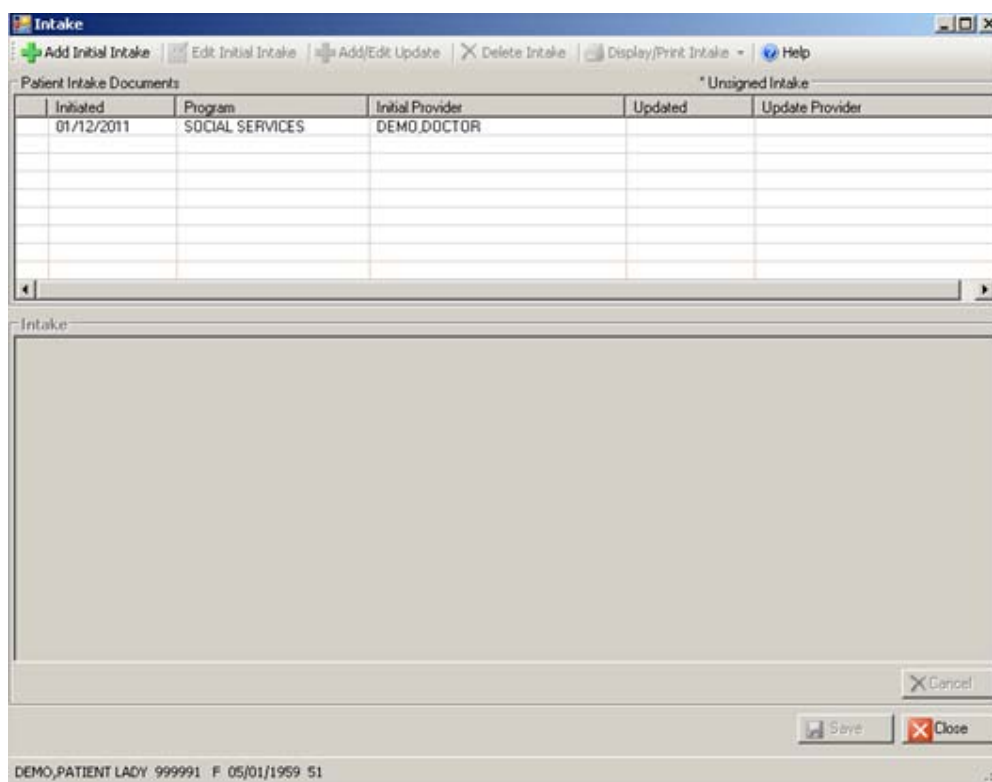


Figure 4-79: Initial **Intake** window

Refer to Section 12.2 Intake (GUI) for more information.

4.3.9 Suicide Form

When you click the **Suicide Form** tab, the application displays the **Suicide Form** window. Refer to Section 11.2 Suicide Form Window (GUI) for more information.

4.3.10 Select PCC Visit Window

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

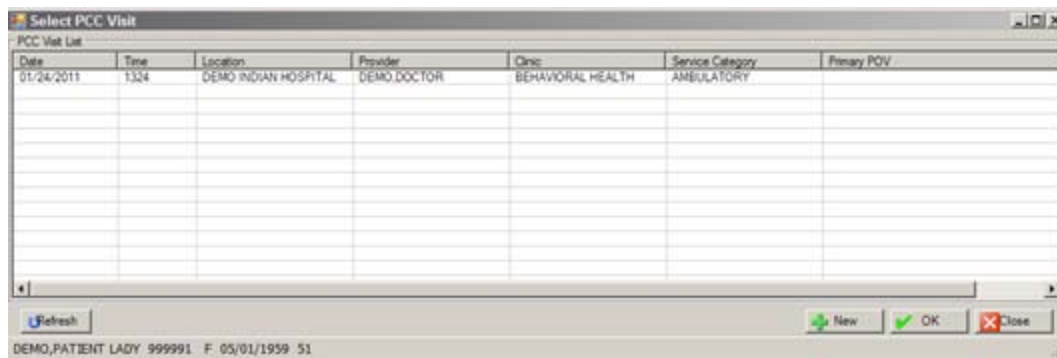


Figure 4-80: Sample **Select PCC Visit** window

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

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

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



Figure 4-81: Select **PCC Visit** window with more visits

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

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

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

```

Sex:                F
Visit IEN:          2565343

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: MAR 09, 2010@16:15
DATE VISIT CREATED:  MAR 09, 2010
TYPE:               IHS
PATIENT NAME:       BETAA,EMILY MAE
LOC. OF ENCOUNTER:  DEMO INDIAN HOSPITAL
SERVICE CATEGORY:  AMBULATORY
CLINIC:             BEHAVIORAL HEALTH
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED: MAR 09, 2010
WALK IN/APPT:       WALK IN
HOSPITAL LOCATION:  BJB BH
CREATED BY USER:    BETA,BETAS
OPTION USED TO CREATE: SD IHS PCC LINK - < - When it has been linked, it
will always show this option

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

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

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

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

```

Figure 4-82: Information from PCC

4.4 Browse Visits (GUI)

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

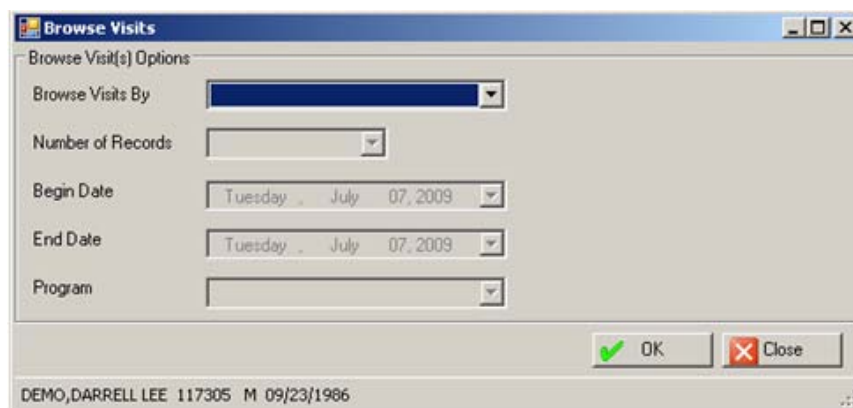


Figure 4-83: Sample **Browse Visits** window

Below are the fields.

- **Browse Visits By**

Use one of the following:

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

If you use the **L** or **A** option, the other fields will not be active.

- **Number of Records**

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

- **Begin Date/End Date**

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

- **Program**

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

After you click **OK**, the application displays the first page of the **Browse Visits** window.

The screenshot shows a web browser window titled "Browse Visits: DEMO, JAMES WILLIAM 192636 M 11/05/1997 12". The window displays a form with the following information:

Patient Name: DEMO, JAMES WILLIAM DOB: Nov 05, 1997
 HRN: 192636

***** Suicide Forms on File *****
 Date of Act: MAY 06, 2010 Suicidal Behavior: ATT'D SUICIDE W/ ATT'D
 HOMICIDE
 Previous Attempts: 1 Method: GUNSHOT

Visit Date: Jul 19, 2010@13:00 Provider: DEMO, KAREN
 Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
 Location of Encounter: UNITED AMER IND INVOLVEMENT
 Chief Complaint/Presenting Problem:
 POV's:
 300.02 GENERALIZED ANXIETY DISORDER

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

At the bottom of the window, it says "Current Page No.: 1", "Total Page No.: 1", and "Zoom Factor: 100%".

Figure 4-84: Sample of data in **Browse** window

Refer to Section 2.6 Pop-up Windows (GUI) for more information about this type of window.

4.5 View Patient Data

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

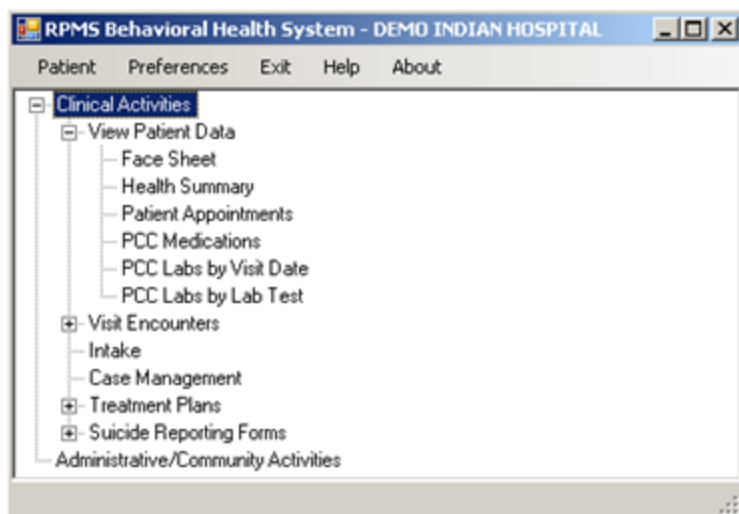


Figure 4-85: RPMS Behavioral Health System tree structure for View Patient Data

The data applies to the current patient.

4.5.1 Face Sheet

Use the **Face Sheet** option to view the first page of the **Ambulatory Care Record Brief** pop-up window for the current patient. Refer to Section 2.6 Pop-up Windows (GUI) for more information about this type of window.

If you want to change patients, right-click on the Face Sheet label to access the **Change Patient** option. After selecting the option, the application displays the **Select Patient** dialog. Refer to Section 2.12.2 Patient Selection (GUI) for more information about this dialog.

4.5.2 Health Summary

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

The application displays the **Select Health Summary Type** window.



Figure 4-86: Select Health Summary Type window

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

4.5.3 Patient Appointments

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

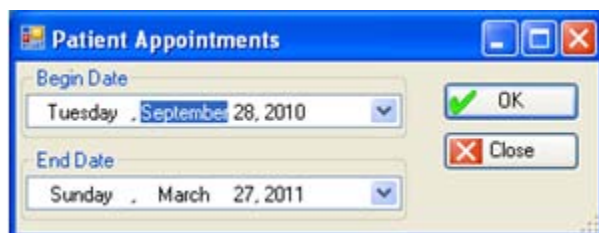


Figure 4-87: Sample **Patient Appointments** window

The default begin date is three months previous and the default end date is three months in the future.

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

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

4.5.4 PCC Medications

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



Figure 4-88: Sample **PCC Medications** window

The default date start date is one year previous.

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

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

4.5.5 PCC Labs by Visit Date

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



Figure 4-89: Sample **View Labs by Visit Date** window

The default begin date is one year previous.

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

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

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

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

4.5.6 PCC Labs by Lab Test

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



Figure 4-90: Sample **View Labs by Lab Test** window

The default Begin Date is one year previous.

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

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

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

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

5.0 Group Encounters

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

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

Use the Group Form Data Entry Using Group Definition (GP) option to enter MH/SS data from a group form. Use when the encounter involves a group of patients. This process allows you to enter data into each participant's record without entering an encounter record for each patient.

- Enter Beginning Date

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

- Enter Ending Date

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

The application displays the Group Entry window.

GROUP ENTRY		Mar 16, 2009 17:09:31					Page:		1 of 14		
Group	Entry	* - Unsigned Group Note									
	Date	Group Name	Activity	Prg	Clm	Prov	TOC	POV			
1)	*	10/01/09	EDIT INTAKE	GROUP TRE	S	MEDIC	GAMMAA,R	SCH 311.	-	D	
2)	*	10/01/09	EDIT INTAKE	GROUP TRE	S	MEDIC	GAMMAA,R	SCH 311.	-	D	
3)	*	09/29/09	INTAKE GROUP	GROUP TRE	M	TELEB	GAMMAA,R	SCH 296.20	-		
4)		09/29/09	INTAKE GROUP	GROUP TRE	M	TELEB	GAMMAA,R	SCH 296.20	-		
5)		09/28/09	Mond DV	FAMILY/GR	S	MEDIC	GAMMAAA	OUT 43.2	-	P	
6)		09/25/09	GOAL STATUS	GROUP TRE	S	MEDIC	GAMMAA,R	SCH 298.9	-		
7)		09/25/09	Friday DV group	GROUP TRE	S	MEDIC	GAMMAAA	SCH 80	-	HOU	
8)	*	09/25/09	pov test	GROUP TRE	S	MEDIC	GAMMAA,R	SCH 2	-	CROS	
9)		09/24/09	WW-GRIEF GROUP	LIFE SKIL	S	MEDIC	ALPHAA,W	OUT 24	-	ADJ	
10)	*	09/24/09	WW-DEPRESSION GROUP	GROUP TRE	M	MENTA	ALPHAA,W	FIE 311.	-	D	
11)	*	09/22/09	mark edu status	GROUP TRE	M	TELEB	GAMMAAAA	SCH 2	-	CROS	
12)	*	09/22/09	PR465 test	GROUP TRE	M	TELEB	BETAAAA	SCH 27	-	ALC	
13)		09/22/09	TEST OF CC MARK	GROUP TRE	M	TELEB	BETAAAA	SCH 2	-	CROS	
+		Enter ?? for more actions								>>>	
1	Add a New Group			6	Review/Edit Group Visits						
2	Display Group Entry			7	Add No Show Visit						
3	Duplicate Group			8	Edit Group Definition						
4	Delete Group			9	Sign Notes						
5	Print Encounter Forms			Q	Quit						
Select Action:+//											

Figure 5-1: Sample Group Entry window

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

Type **Quit** to dismiss this window.

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

5.1.1 Add New Group

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

Below are the prompts.

- “Enter Date of the Group Activity”

Specify the date of the new group activity.

The application displays the Group Encounter Documentation window.

* GROUP ENCOUNTER DOCUMENTATION *	DEMO INDIAN HOSPITAL
----- NOTE: Please enter all standard information about this group activity. After you leave this screen a record will be created for each patient. At that time you can add additional information for each patient.	
Add/View/Update Providers (Primary or Secondary) for this Group? Y	
Encounter Date: MAR 14, 2009	Arrival Time: 12:00
Program:	Community of Service:
Group Name:	Clinic:
Activity:	Activity Time:
Encounter Location:	Type of Contact:
POV or DSM (Primary Group Topic) <press enter>:	
Chief Complaint/Presenting Problem:	
Any Patient Education Done? N	CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:	
Patients <press enter>:	
COMMAND: Press <PF1>H for help Insert	

Figure 5-2: Sample Group Encounter Documentation window

The underlined fields are required.

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

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

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

Figure 5-3: Sample Secondary Providers pop-up

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

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

Below are more fields on the Group Encounter Documentation screen.

- **Encounter Date**
Specify the encounter date. The default shows the date of the new group activity (that was entered before you accessed this window).
- **Arrival Time**
Specify the arrival time of the encounter. The default shows 12:00.
- **Program**
Specify the program for the group encounter. Type one of the following:
 - **M** (Mental Health)
 - **S** (Social Services)
 - **C** (Chemical Dependency)
 - **O** (Other)
- **Community of Service**
Specify the name of the community of service where the encounter took place.
- **Group Name**
Specify the name of the group encounter, using between 1 and 30 characters in length.
- **Clinic**
Specify the clinic (by number or name).
- **Activity**
Specify the activity of the group encounter.
- **Activity Time**
Specify the number of minutes (no decimal digits) the provider(s) spent on the activity, using any integer between 1 and 9999. Please note: 0 (zero) is not allowed as a valid entry. The time is divided equally among each of the group participants.

- **Encounter Location**
Specify the name of the location for the encounter.
- **Type of Contact**
Specify the type of contact (the activity setting).
- **POV or DSM (Primary Group Topic)**
Specify the POV for the group topic. Press Enter to have the application display the POV or DSM Diagnosis pop-up.

POV or DSM Diagnosis (Primary Group Topic)	
CODE	NARRATIVE
-----	-----

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

- **Code:** Specify with an MHSS Problem/DSM IV POV code.
After populating the Code field, the application populates the Narrative for the particular code (but can be edited). Note: the special characters “ or ‘ cannot be the first character of the POV narrative. The POV narrative can contain 2–80 characters.

Below are more fields on the Group Encounter Documentation screen.

- **Chief Complaint/Presenting Problem**
Specify the chief complaint or presenting problem using 2 to 80 characters in length. This information describes the major reason the patient sought services.
- **Any Patient Education Done?**
Type **Y** or **N**. If you type **Y**, the application displays the Patient Education for this Group Activity pop-up.

*PATIENT EDUCATION for this Group Activity After entering each topic you will be prompted for more fields EDUCATION TOPIC: EDUCATION TOPIC: EDUCATION TOPIC: EDUCATION TOPIC: EDUCATION TOPIC:

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

- **EDUCATION TOPIC:** Specify the education topic code. After populating this field, the application displays the following pop-up.

EDUCATION TOPIC: 042. -DISEASE PROCESS

LEVEL OF UNDERSTANDING: GROUP-NO ASSESSMENT

PROVIDER: THETA, SHIRLEY

MINUTES:

COMMENT:

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

The underlined fields are required.

- Individual/Group: The application automatically populates with GROUP. You cannot change this field.
- Level of Understanding: The application automatically populates with GROUP-NO ASSESSMENT. You cannot change this field.
- Provider: The application automatically populates with the current logon user. This can be changed.
- Minutes: Populate with the number of minutes spent on education, using any integer 1–9999.
- Comment: Populate with the text of any comment about the education topic, using 2–100 characters.

Below are more fields on the Group Encounter Documentation screen.

- CPT Code(s) <press enter>
Press Enter to access another window where you specify the CPT or HCPCS codes associated with the group encounter.
- S/O/A/P (Standard Group Note) <press enter>
Press Enter to access another window where you enter the text of a group note.
- Patients <press enter>
Press Enter to access the Patients pop-up:

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

PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:

```
PATIENT:
PATIENT:
PATIENT:
```

Figure 5-7: Sample pop-up for Patients

- PATIENT: Specify the patient name, HRN, DOB, or SSN.

After you save and exit, the application displays the following choices:

```
Select one of the following:

Y      Yes, group definition is accurate, continue on to add visits
N      No, I wish to edit the group definition
Q      I wish to QUIT and exit

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

Figure 5-8: Questions upon exit

- Type **Y** to continue adding the patient's individual visit associated with the group visit. You return to the record for the first patient.
- Type **N** to edit the group definition.
- Type **Q** to quit and exit. You return to the Group Entry screen.

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

5.1.2 Edit Group Definition

Use Option 8 to edit a selected unsigned group entry record.

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

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

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

Add/View/Update Providers (Primary or Secondary) for this Group? Y
Encounter Date: MAY 15,2009@12:00      Arrival Time: 12:00
Program: MENTAL HEALTH                  Community of Service: ABERDEEN
Group Name: meeting on thur             Clinic: EMERGENCY MEDICINE
```

Activity: 25	Activity Time: 6
Encounter Location: ABERDEEN AO	Type of Contact: CONSULTATION
POV or DSM (Primary Group Topic) <press enter>:	
Chief Complaint/Presenting Problem:	
Any Patient Education Done? N	CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:	
Patients <press enter>:	
COMMAND: Press <PF1>H for help	
Insert	

Figure 5-9: Sample Group Encounter Documentation window

Refer to Section 5.1.1 Add New Group for more information about the fields on this window.

5.1.3 Review/Edit Group Visits

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

Below are the prompts.

- “Select GROUP ENTRY”

Specify the group entry that you want to review/edit.

If the group has a signed note, the application displays the message: The notes associated with this group entry have been signed. You can edit other items in this entry but not the notes. Press Enter to continue.

After populating the Select GROUP ENTRY field, the application displays the Enter/Edit Patient Group Data window.

Enter/Edit Patient Group Data Mar 27, 2009 17:33:04					Page:	1 of	1
Group Entry							
	Patient Name	Sex	Age	DOB	HRN	Record	
Added							
1)	PHIIII,TERRY LYNN	F	40	05/10/1968	198794	yes	
2)	THETA, LOMIE	M	23	06/23/1985	115697	yes	
Enter ?? for more actions							
>>>							
AE	Edit Patient's Group Visit	D	Display Patient's Group Visit				
X	Delete a Patient's Group Visit	Q	Quit				
Select Action: +//							

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

Type **Q** to exit the window.

5.1.3.1 Delete a Patient's Group Visit (X)

Type **X** to remove a particular patient's group visit. The application displays the BH record data. At the end of the data, the application verifies that you want to delete the particular patient's visit (Y or N).

5.1.3.2 Display Patient's Group Visit (D)

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

5.1.3.3 Edit Patient's Group Visit (AE)

If you type **AE**, the following prompts display:

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

Specify the group number.

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

```

* BEHAVIORIAL HEALTH RECORD EDIT *                               [press <F1>E to exit]
Encounter Date: NOV 3,2006@12:00                                User: THETA,SHIRLEY
Patient Name: TEST,JEREMY ISSAC  DOB: 6/15/81  HRN: 104683
-----
Date:      NOV 3,2006@12:00      Location of Service:  DEMO HOSPITAL
Program:   MENTAL HEALTH        Outside Location:
Clinic:    MENTAL HEALTH        Appt/Walk-in: UNSPECIFIED  Visit Flag:
Type of Contact: OUTPATIENT      Community:  RED LAKE
Providers <press enter>:         Local Service Site:
Activity:  91      Activity Time: 40  #Served:  1  Interpreter Utilized:
Chief Complaint/Presenting Problem:
SOAP/PROGRESS NOTE:      Comment/Next Appointment:      Medications
Prescribed:
Edit Purpose of Visits?: N      Edit Treated Medical Problems?  N
Edit CPT Codes?      Edit Health Factors?  N
Edit Patient Education?: N
Edit Any Screening Exams?  N      Edit Measurements?  N
Placement Disposition:      Referred To:

COMMAND:                                     Press <PF1>H for help
Insert

```

Figure 5-11: Sample Behavioral Health Record Edit window

If you cannot change the note, the applicable field on the Behavioral Health Record Edit window will read: SOAP/PROGRESS NOTE SIGNED/UNEDITABLE. In this case, as you tab through the fields, the application will skip this field.

The underlined fields are required. Refer to Section 4.1.4 Using the Behavioral Health Record Edit Window for more information.

5.1.4 Display Group Entry

Use Action 2 to display group entry data for a specified group.

The application displays the Output Browser window showing the group data.

OUTPUT BROWSER	Mar 27, 2009 17:46:48	Page: 1 of 1
DATE OF SERVICE: NOV 29, 2010@14:39 PROGRAM: MENTAL HEALTH GROUP NAME: TESTING LINK 1 POSTING DATE: NOV 29, 2010 LOCATION OF ENCOUNTER: KANAKANAK HOSPITAL COMMUNITY OF SERVICE: KODIAK ACTIVITY TYPE: 91 TYPE OF CONTACT: OUTPATIENT ACTIVITY TIME: 60 WHO ENTERED RECORD: GARCIA, RYAN DATE LAST MODIFIED: NOV 29, 2010 CLINIC: MENTAL HEALTH USER LAST UPDATE: GARCIA, RYAN SIGNED?: YES ELECTRONIC SIGNATURE BLOCK: Ryan Garcia DATE/TIME ESIG APPLIED: NOV 29, 2010@14:40:50 PROVIDER: GAAMMA, RYAN PRIMARY/SECONDARY: PRIMARY POV: 293.82 NARRATIVE: PSYCHOTIC DISORDER DUE TO..(INDICATE MEDICAL CONDITION),W/HALLUCIN. POV: 296.24 NARRATIVE: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE W/PSYCHOTIC FEATU RES SUBJECTIVE/OBJECTIVE: + Enter ?? for more actions >>> + NEXT SCREEN - PREVIOUS SCREEN Q QUIT Select Action: +//		

Figure 5-12: Sample Output Browser window

5.1.5 Print Encounter Forms

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

Below are the prompts.

- “Select GROUP ENTRY”

Specify the group you want to use.

The application states: Forms will be generated for the following patient visits.
After this message, the application displays the names of the patients in the group.

- “Enter response”

Type one of the following:

- **F** (Full Encounter Form)

- S (Suppressed Encounter Form)
- B (Both a Suppressed & Full)
- T (2 copies of the Suppressed)
- E (2 copies of the Full)

A full encounter form prints all data for a patient encounter including the S/O/A/P note. The suppressed report does *not* display the following information: Chief Complaint, SOAP note, measurement data, screenings.

- “Device”

Specify the device to print/browse the encounter form.

Below is a sample full encounter form report.

***** CONFIDENTIAL PATIENT INFORMATION *****		
PCC BEHAVIORAL HEALTH ENCOUNTER RECORD		Printed: Oct 01, 2009@17:38:44
*** Computer Generated Group Encounter Record ***		
Group Name: Mond DV		

Date: Sep 28, 2009	Primary Provider: GAMMA, DENISE BETAA, BJ	
Arrival Time: 10:00		
Program: SOCIAL SERVICES		
Clinic: MEDICAL SOCIAL SERVICES	Appointment Type: UNSPECIFIED	
Community: TAHLEQUAH	Number Served: 1	Activity/Service Time: 44 minutes
Time spent in group session: 88		
Activity: 14-FAMILY/GROUP TREATMENT-PATIENT PRESENT		
Type of Contact: OUTPATIENT		
CHIEF COMPLAINT/PRESENTING PROBLEM: test pt ed		
S/O/A/P:		
GROUP NOTE		
This is the first meeting of the Domestic Violence group. Focus of today's session was establishing group rules and discussing expectations.		
COMMENT/NEXT APPOINTMENT:		
BH POV CODE OR DSM DIAGNOSIS	PURPOSE OF VISIT (POV) [PRIMARY ON FIRST LINE]	
311.	DEPRESSIVE DISORDER NOS	
MEDICATIONS PRESCRIBED:		
PROCEDURES (CPT):		
PROVIDER SIGNATURE: /es/ DENISE GAMMA, MSW, LCSW Signed: Sep 28, 2009 15:07		
HR#: WW 209022		
NAME: JONES, AARON RAY		SSN:
SEX: MALE	TRIBE: CHEROKEE NATION OF OKLAHOMA	

DOB: Jul 21, 1996	
RESIDENCE: MISSOURI UNK	
FACILITY: DEMO INDIAN HOSPITAL	LOCATION: SELLS CHS ADMIN.
COMMENT/NEXT APPOINTMENT:	
BH POV CODE	PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS	[PRIMARY ON FIRST LINE]
PROVIDER SIGNATURE:	
Jan 15, 2010	BETTITA, LORI
Enter RETURN to continue or '^' to exit:	

Figure 5-13: Sample encounter form output

5.1.6 Duplicate Group

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

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

Duplicating a group containing signed SOAP/Progress Notes will revert the SOAP/Progress Notes associated with the new group encounter to the unsigned status.

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

Below are the prompts.

- "Select GROUP ENTRY"
Specify the group you want to duplicate in order to create a new group.
- "Enter Date for the new group entry"
Specify the date for the new group.

The application displays the Group Encounter Documentation window.

* GROUP ENCOUNTER DOCUMENTATION *	DEMO INDIAN HOSPITAL

NOTE: Please enter all standard information about this group activity. After you leave this screen a record will be created for each patient. At that time you can add additional information for each patient.	
Add/View/Update Providers (Primary or Secondary) for this Group? Y	

Encounter Date: MAR 17, 2009	Arrival Time: 12:00
Program: SOCIAL SERVICES	Community of Service: TAHLEQUAH
Group Name: MON DV DG	Clinic: MEDICAL SOCIAL SERVICES
Activity: 81	Activity Time: 60
Encounter Location: DEMO INDIAN HOSPIT	Type of Contact: OUTPATIENT
POV or DSM (Primary Group Topic) <press enter>:	
Chief Complaint/Presenting Problem:	
Any Patient Education Done? N	CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:	
Patients <press enter>:	
COMMAND: Insert	Press <PF1>H for help

Figure 5-14: Sample Group Encounter Documentation window

Refer to Section 5.1.1 Add New Group to review how to complete the Group Encounter Documentation window.

5.1.7 Add No Show visit

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

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

Below are the prompts.

- Select GROUP ENTRY (1-x) where x is the number of the last group entry record
Specify the number of the group you want to use.
- Select PATIENT NAME
Specify the name of the patient who failed to attend the group session.
- Enter PRIMARY PROVIDER
Specify the primary provider name.

The application displays the Behavioral Health Visit Update window. Refer to Section 4.1.3 Using the Behavioral Health Visit Update Window for more information.

5.1.8 Sign Note

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

Below are the prompts.

- Select Group Entry (1-x) where x is the number of the last record
Specify the record you want to use.

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

```
You are not the primary provider for this group, no electronic
signature will be applied and no PCC link will occur.
The primary provider will need to sign these at a later time.
Press enter to continue....:
```

Figure 5-15: Message about the primary provider

If there is a record but no visits were created for this group, the application displays the following message. Press Enter to return to the Group Entry window.

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

Figure 5-16: Message about no visits created

If the provider opted out of E-Signature, the application displays the following information:

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

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

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

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

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

===== BH RECORD FILE =====
DATE OF SERVICE:   JUL 09, 2009@09:55
PROGRAM:           MENTAL HEALTH
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE: TAHLEQUAH
ACTIVITY TYPE:     17
ACTIVITY TYPE NAME: PSYCHOLOGICAL TESTING-PATIENT PRESENT
TYPE OF CONTACT:   OUTPATIENT
PATIENT:           ALPPHA,CHELSEA MARIE
PT AGE:            34
CLINIC:            MENTAL HEALTH
```

```

NUMBER SERVED:      1
+      Enter ?? for more actions
+   Next Screen      -   Previous Screen      Q   Quit
Select Action: +/-

```

Figure 5-18: Sample BH Visit Record Display window

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

After you type **N**, the application prompts: Enter your Current Signature Code. Refer to Section 2.14.6 Signing a Note (Roll and Scroll) for more information.

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

5.1.9 Delete Group

Use Action 4 to remove a particular group encounter record with an unsigned note. The application verifies that you want to delete the particular group encounter. Please note that the user must hold a specific key in order to delete group encounters with signed notes. Removing the group definition will also remove the related individual patient encounter records.

5.2 Group Entry Window (GUI)

The figure below shows where the Group Encounter function is located on the RPMS Behavioral Health System (GUI) tree structure.

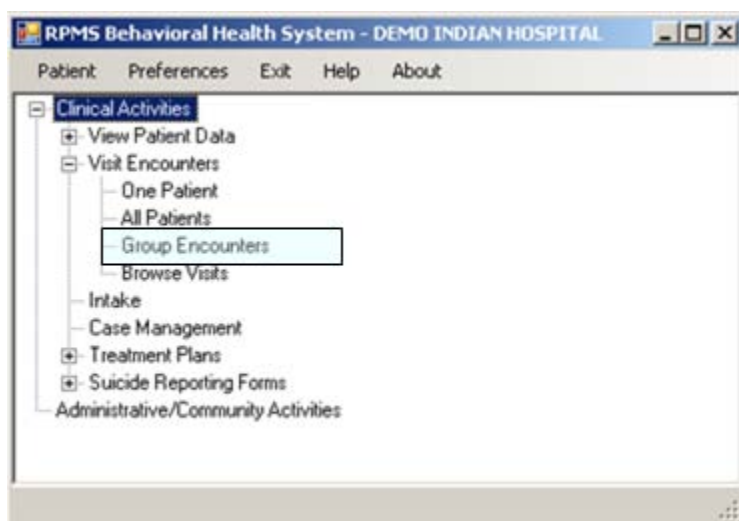
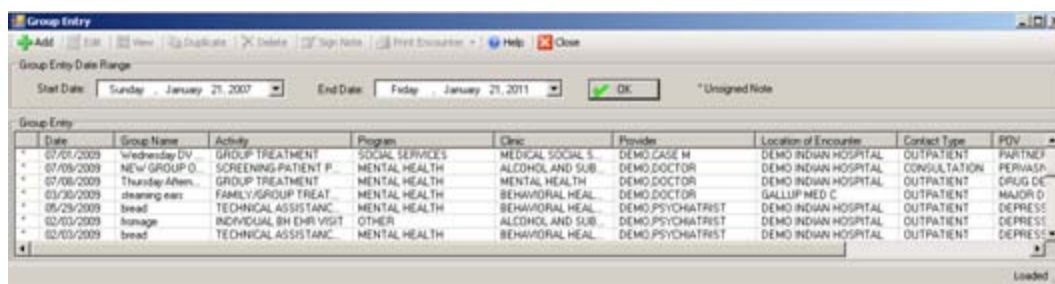


Figure 5-19: Group Encounters location on tree structure

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

Figure 5-20: Sample **Group Entry** window

5.2.1 Group Entry Date Range Group Box

The **Group Entry** window displays the group encounters in the date range shown in the **Group Entry Date Range** group box (default is one year). The default view is sorted by date (from most recent).

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

5.2.2 Group Entry Group Box

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

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

5.2.3 Add Button

Click **Add** to add a new group encounter record. You access the **Group Data Entry–Add Group Data** window. Refer to Section 5.3 Add/Edit Group Data (GUI) for more information.

5.2.4 Edit Button

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

5.2.5 View Button

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

5.2.6 Duplicate Button

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

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

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

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

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

5.2.7 Delete Button

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

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

5.2.8 Sign Note Button

Click **Sign Note** to sign a particular “unsigned” group encounter record (asterisk (*) in the first column). Refer to Section 2.14.5 Signing a Note (GUI) for more information.

If the primary provider has opted out of E-Sig, the visit will pass to PCC, and the application displays a **Message** dialog box regarding this.

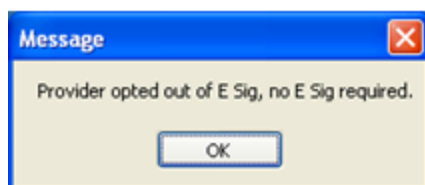


Figure 5-21: Message stating that the provider opted out of E Sig

The message means that no electronic signature is required for the particular record. Click **OK** to leave the Sign Note process.

5.2.9 Print Encounter Button

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

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

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

The application displays the first page of the **Print Encounter Group** pop-up window.

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

Refer to Section 2.6 Pop-up Windows (GUI) for more information about this type of window.

5.2.10 Help Button

Click **Help** to access the online help for the **Group Entry** window.

5.2.11 Close Button

Click **Close** to dismiss the **Group Entry** window.

5.3 Add/Edit Group Data (GUI)

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

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

All Patient Education entries created before the installation date for BHS v4.0 will continue to display the **CPT** field.

Below is the **Group Data Entry–Add Group Data** window. (The same fields appear on the **Group Data Entry–Edit Group Data** window.)

The screenshot shows the 'Group Data Entry - Add Group Data' window. It has a title bar with standard window controls. The main area is divided into several sections:

- Group Encounter Information:** Contains fields for Primary Provider (set to 'DEMO DOCTOR'), Encounter Date/Time (set to 'Wednesday, April 08, 2009 03:05 PM'), Program, Group Name, Clinic, Community of Service, Type of Contact, Activity (set to 'GROUP TREATMENT'), Encounter Location, and Activity Time.
- Secondary Providers:** A table with columns for Provider, Add, and Delete.
- Purpose of Visit - POV (Primary Group Topic):** A table with columns for Code, Narrative, Add, Edit, and Delete.
- Standard Group Note:** A large text area for notes.
- CPT Code(s):** A table with columns for Code, Narrative, Add, and Delete.

At the bottom of the window, there are buttons for Help, Save, and Close.

Figure 5-23: **Group Data Entry–Group Data** window

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

If you access an unsigned group data record, you can edit the note.

The **Patient Data** tab is the only place you can do any editing after a group has been saved. If it is signed, then you can edit everything on that tab except the note; if unsigned, you can edit anything on the tab.

Click **Help** to access online help about this window.

After changing this window, click **Save** (otherwise, click **Close**).

The Save process saves your changes and dismisses the **Add/Edit Group Data** window.

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

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

Several of the fields contain a search window. Refer to Section 2.8 Using the Search Window for more information.

The fields that contain dates can be changed by accessing a calendar. Refer to Section 2.7 Using the Calendar for more information.

Certain group boxes use the search/select window. Refer to Section 2.9 Using the Search/Select window for more information.

Some group boxes use the multiple select window. Refer to Section 2.10 Using the Multiple Select window.

5.3.1 Group Encounter Information Group Box

The add window has the following (active) fields.

Figure 5-24: Sample **Group Encounter Information** group box

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

The fields in bold text are required.

- **Primary Provider**

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

- **Encounter Date/Time**

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

- **Program**

This field determines the program associated with the visit. Click the drop down list and select one of the following:

- **Mental Health**
- **Social Services**
- **Other**
- **Chemical Dependency**

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

You cannot change these fields when you edit the record.

- **Group Name**

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

- **Clinic**

This field identifies the clinic context. The response must be a clinic that is listed in the RPMS Standard Code Book table. Change this field by clicking the drop-down list to access the **Clinic** search window. Here you can search for a type of clinic.

- **Community of Service**

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

- **Type of Contact**

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

- **Activity**

This field determines the activity for the group encounter. The default is Group Treatment. Change this field by clicking the drop-down list to access the **Activity** search window. Here you search for an activity name or its code.

- **Encounter Location**

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

- **Activity Time**

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

5.3.2 Group Data Tab

Use the **Group Data** tab to specify secondary providers, POV code, group note, and CPT codes for the group encounter.

The screenshot shows the 'Group Data' tab with the following sections:

- Secondary Providers:** A table with one row and one column labeled 'Provider'. To the right are 'Add' and 'Delete' buttons.
- Purpose of Visit - PDV (Primary Group Topic):** A table with two columns: 'Code' and 'Narrative'. To the right are 'Add', 'Edit', and 'Delete' buttons.
- Standard Group Note:** A large text area for notes.
- CPT Code(s):** A table with two columns: 'Code' and 'Narrative'. To the right are 'Add' and 'Delete' buttons.

Figure 5-25: Sample **Group Data** tab

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

The group box names in bold text are required.

5.3.2.1 Chief Complaint/Presenting Problem Group Box

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

5.3.2.2 Secondary Providers Group Box

Use the **Secondary Providers** group box to add or delete secondary providers for the group encounter.

The screenshot shows the 'Secondary Providers' group box with a table containing one row and one column labeled 'Provider'. To the right of the table are 'Add' and 'Delete' buttons.

Figure 5-26: Sample **Secondary Providers** group box

Click **Add** on the **Secondary Providers** group box to access the **Secondary Provider** multiple search/select window. Here you can add one or more secondary providers for the group encounter.

Select a secondary provider you want to delete and click **Delete**. After clicking **Delete**, the **Are You Sure?** dialog box displays, asking if you are sure you want to delete. Click **Yes** to remove the selected provider from the **Secondary Providers** group box (otherwise, click **No**.)

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

The **Purpose of Visit–POV (Primary Group Topic)** group box lets you add, edit, or delete POV codes and their narratives associated with the group encounter. These are POVs for all group members and will display as such on the **Patient Data** tab and the printed encounter record unless edited or deleted on the **Patient Data** tab.

At least one POV record is required for a group encounter.



Figure 5-27: Sample **POV** group box

Click **Delete** to delete a selected POV record. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected POV record from the group box (otherwise, click **No**.)

Click **Add** to access the **POV (Axis I/II)** multiple search/select window. Here you can add one or more POVs to the group encounter. The application populates the Code and Narrative for the record.

Click **Edit** to change the Narrative part of a POV record in the group box. Select a POV record and click **Edit** to display the **Edit POV** window.

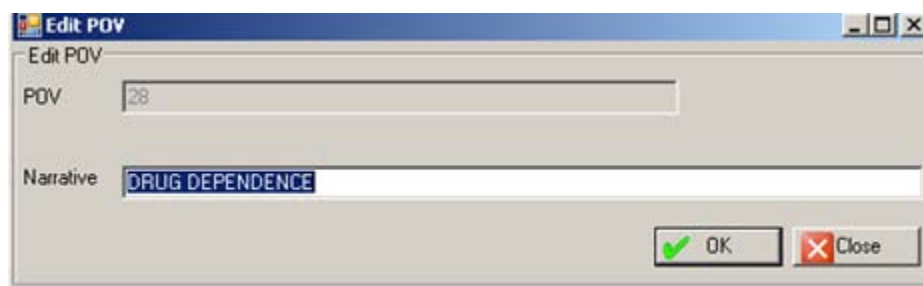


Figure 5-28: **Edit POV** window

The **Narrative** field is a free text field. Type the new POV narrative in the **Narrative** text box and click **OK**. This changes the narrative of the selected code. (Otherwise, click **Close** to keep the narrative intact.) Note: the special characters “ or ‘ cannot be the first character of the POV narrative. The POV narrative field can contain 2–80 characters.

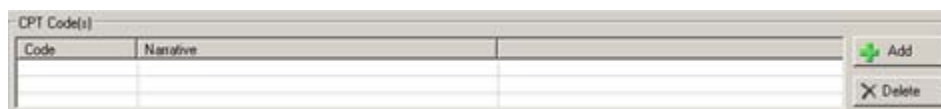
5.3.2.4 Standard Group Note Group Box

The **Standard Group Note** field is where you enter a group note for the group encounter. This is a free text field.

You must be on the **Patient Data** tab to do any editing after the group has been saved.

5.3.2.5 CPT Codes Group Box

Use the **CPT Codes** group box to add or delete CPT codes associated with the group encounter.



The image shows a window titled "CPT Code(s)". It contains a table with two columns: "Code" and "Narrative". There are two empty rows in the table. To the right of the table are two buttons: "Add" (with a green plus icon) and "Delete" (with a red X icon).

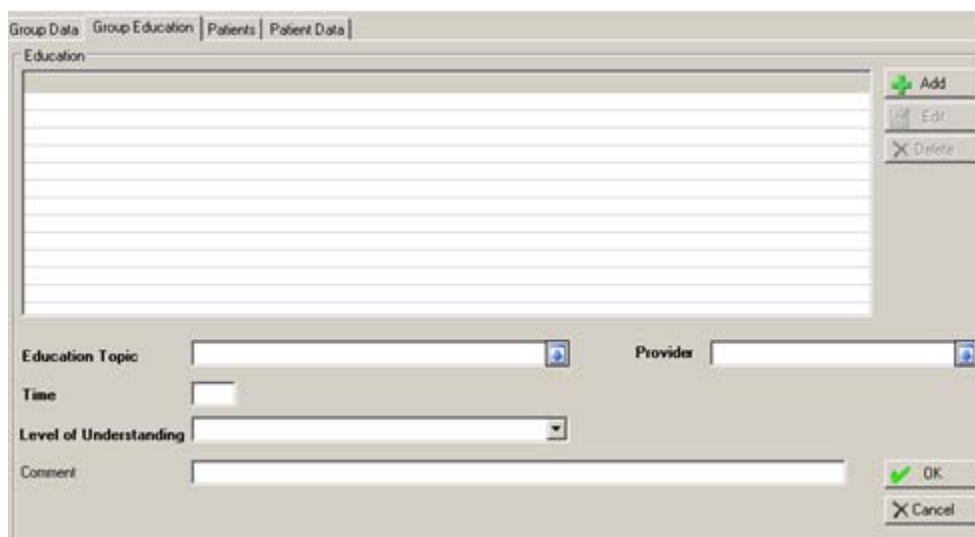
Figure 5-29: Sample **CPT Codes** group box

Click **Add** to access the **CPT Code** multiple search/select window. Here you can add one or more CPT codes to the group encounter. The application populates the Code and Narrative for the record.

Click **Delete** to remove a selected CPT code record. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected CPT code record from the group box (otherwise, click **No**.)

5.3.3 Group Education Tab

Use the **Group Education** tab to add education data about the group encounter.



The image shows a window titled "Group Data" with tabs for "Group Data", "Group Education", "Patients", and "Patient Data". The "Group Education" tab is selected. The main area is titled "Education" and contains a large table with many empty rows. To the right of the table are three buttons: "Add" (with a green plus icon), "Edit" (with a pencil icon), and "Delete" (with a red X icon). Below the table are several input fields: "Education Topic" (a text box with a blue arrow button), "Provider" (a text box with a blue arrow button), "Time" (a text box), "Level of Understanding" (a dropdown menu), and "Comment" (a text box). At the bottom right are two buttons: "OK" (with a green checkmark icon) and "Cancel" (with a red X icon).

Figure 5-30: Sample **Group Education** tab

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

5.3.3.1 Add Group Education Record

Click **Add** on the **Group Education** tab to activate the fields below the education grid.

The fields in bold text are required.

- **Education Topic**

This is the education topic for the group encounter. Click the drop-down list to access the **Education Topic** search window. Here you search for an education code.

- **Provider**

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

- **Time**

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

- **Level of Understanding**

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

- **Comment**

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

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

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

5.3.3.2 Edit Group Education Record

Select a record in the Education grid and click **Edit** to display the information about the record in the fields below the Education grid. Refer to Section 5.3.3.1 Add Group Education Record for more information about the fields. All Group Education entries created before the installation date for BHS v4.0 will continue to display the **Goal** and **CPT** fields.

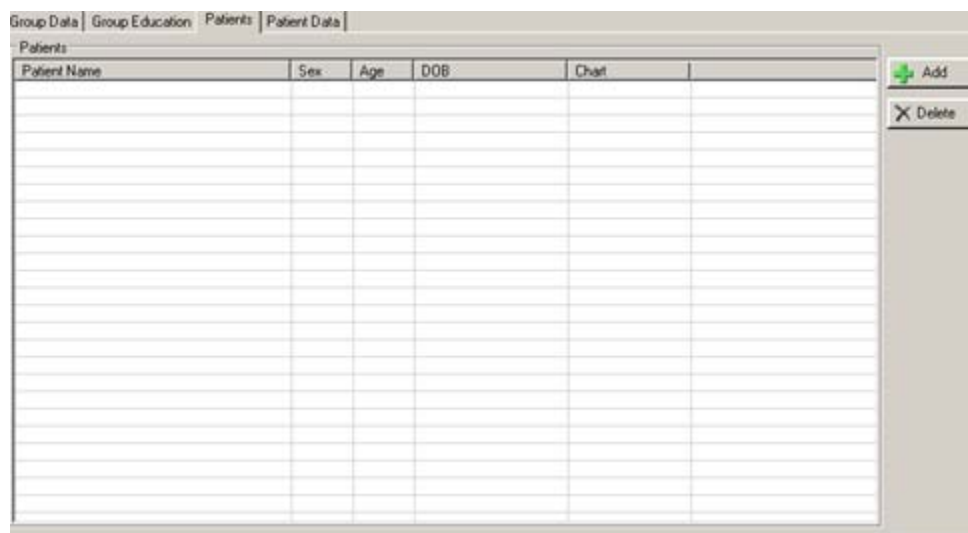
5.3.3.3 Delete Group Education Record

Click **Delete** to remove a selected record from the Group Education grid box. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected Education record from the group box (otherwise, click **No**.)

Note: The group education can be removed only prior to saving the group. Once the group has been saved, there is currently no way to remove it in the group format.

5.3.4 Patients Tab

The **Patients** tab shows the patients in the group encounter.



Patient Name	Sex	Age	DOB	Chart

Figure 5-31: Sample **Patients** tab

Note: Only the person entering the group can change the data on the **Patients** tab. Once the group is saved, there is no way to remove a patient other than to delete the individual encounter record for that patient.

5.3.4.1 Add Patient Record

The **Add** button requires that the **POV** group box and the Standard Note Group **Note** (on the **Group Data** tab) be populated. Click **Add** to access the **Select Multiple Patients** search/select window. Here you can add one or more patients to the group encounter; you can search for a patient by name, HRN, DOB, or SSN.

5.3.4.2 Delete Patient Record

Click **Delete** to remove a patient from the group encounter. After clicking **Delete**, the **Are You Sure?** dialog box displays, asking if you are sure you want to delete. Click **Yes** to remove the selected patient record from the group box (otherwise, click **No**.)

Leave clients who no showed or canceled in the group since it is possible to do the no show within the group definition in the GUI.

5.3.5 Patient Data Tab

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

The screenshot shows the 'Patient Data' tab selected. It contains a table with patient information and several input fields for additional data.

Patient Name	Sex	Age	DOB	Chart
DEMO, TIMMIE	M	9	06/18/1999	132144
DEMO, DOROTHY ROSE	F	66	10/10/1942	999999
DEMO, COLTON MAXWELL	M	31	05/18/1977	100678

Below the table, there is a section for 'Purpose of Visit : POV (DSM Diagnosis or Problem Code)' with columns for 'Code' and 'Narrative'. To the right of this section are buttons for 'Add', 'Edit', and 'Delete'. Below this is a 'Standard Group Note' text area, followed by a 'Comment/Next Appointment' text area. At the bottom left is a 'Time In Group' field, and at the bottom right are 'OK' and 'Cancel' buttons.

Figure 5-32: Sample **Patient Data** tab

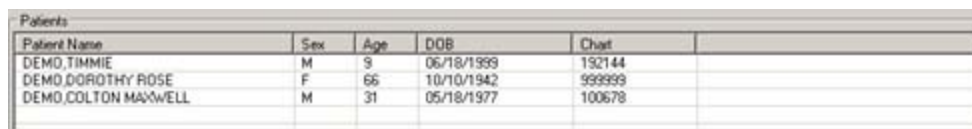
You need to select a patient by double-clicking the name in the **Patients** group box in order to activate the other group boxes.

After you select a patient record and change or add new patient data, click **OK** to save the group data.

Click **Cancel** to not save your changes and to dismiss the add/edit group data entry window.

5.3.5.1 Patients Group Box

The **Patients** group box shows the patients in the group encounter.



Patient Name	Sex	Age	DOB	Chart
DEMO, TIMMIE	M	9	06/18/1999	192144
DEMO, DOROTHY ROSE	F	66	10/10/1942	999999
DEMO, COLTON MAXWELL	M	31	05/18/1977	100678

Figure 5-33: Sample **Patients** group box

You must double-click one of the patient names in order to use the other group boxes.

After you have completed the information for the first patient, click **OK**. Your cursor returns to the **Patients** group box. Then you can double-click on the next patient. After completing the information for the second patient, click **OK**. Repeat this process until you have completed all of the patients. Then you can click **Save** to save all of the information.

If you are in ADD mode and you have clicked **OK** and then try to go to the **Group Data** tab, the application displays the **Continue** dialog box.

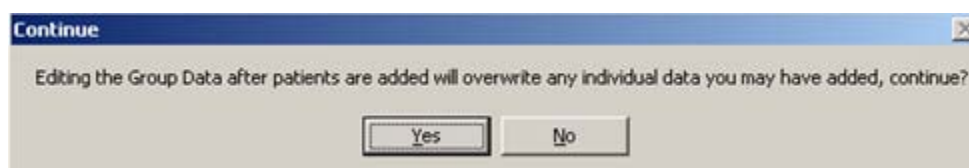


Figure 5-34: Warning Message

- Click **Yes** to overwrite any individual data you have added. You will go to the **Group Data** tab.
- Click **No** to not overwrite any individual data you have added. You will go to the **Patients Data** tab.

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

Use the **Purpose of Visit–POV (DSM Diagnosis or Problem Code)** group box to add, edit, or delete a POV for the selected patient. (You must double-click a patient name before you can add/change the data in this group box.)



Code	Narrative

Figure 5-35: Sample POV group box

This is required data for the group encounter record.

Click **Delete** to remove a selected POV. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected POV record from the group box (otherwise, click **No**.)

Click **Add** to access the **POV (Axis I/II)** search window. Here you can select one or more POVs to be used in the **Purpose of Visit** group box.

Click **Edit** to change the narrative part of a POV record in the group box. Select a POV record and click **Edit** to display the **Edit POV** window.

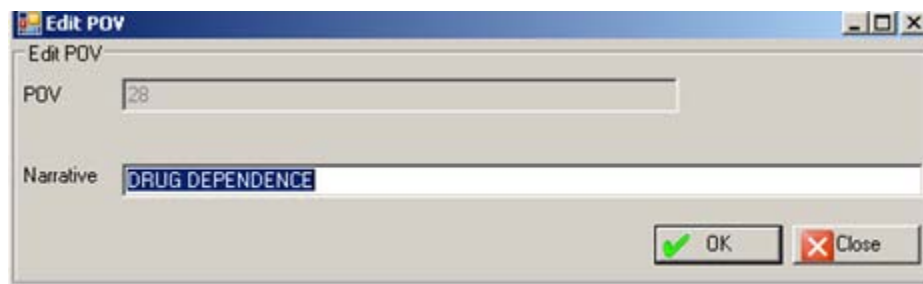


Figure 5-36: Sample **Edit POV** window

The **Narrative** field is a free text field. Change the text of the narrative in the **Narrative** text box and click **OK**. This changes the narrative of the selected code. (Otherwise, click **Close** to not change the narrative.) Note: the special characters “ or ‘ cannot be the first character of the POV narrative. The **POV Narrative** field can contain 2–80 characters.

5.3.5.3 Standard Group Note

This field will contain text of the **Standard Group Note** on the **Group Data** tab. You can add text about how the patient reacted in the group (on the **Patient Data** tab). This is a free-text field.

This is where the user individualizes the note for the patient in focus. The standard group note should never reference the individual patient but should have information about the individual patient’s participation in the group.

- This field is available for text entry by the primary provider of the record (only).
- This field is not available for text entry if the note for the group record is signed.

5.3.5.4 Comment/Next Appointment

Populate this free text field with the text of any comments about the next appointment for the selected patient. This is a free-text field. This field is available for text entry by the primary provider of the record (only).

5.3.5.5 Time in Group

Populate this field with the number of minutes in the group encounter (up to six digits).

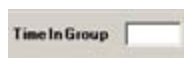


Figure 5-37: Sample **Time in Group** field

This is required data for the group encounter record.

Consider the following:

- If the patient attended the whole group session, no changes need to be made to the **Time Spent in Group** field.
- If the patient was late or left early, the **Time Spent in Group** field needs to be changed to reflect the actual time in minutes that the patient was in the group.
- If the patient didn't attend at all, you need to type a zero in the Time Spent in Group field and then click **OK**. The application will prompt you to select one of the No Show POVs and enter a new note for that patient. (POVs and the Group Note entered on the **Group Data** tab have been removed at this point).

6.0 Case Management

This section provides information about case management in the roll-and-scroll application, as well as in the RPMS Behavioral Health System (GUI).

6.1 Managing Case Data (Roll and Scroll)

Manage case data on the Patient Data Entry window by selecting the Update Case Data (CD) action. The application displays the Update BH Patient Case Data screen.

Update BH Patient Case Data		Mar 23, 2009 15:27:33		Page: 0 of 0	

Patient Name: DEMO,DOROTHY ROSE		DOB: OCT 10, 1942		Sex: F HRN: 99999	

#	PROGRAM	OPEN	ADMIT	CLOSED	DISPOSITION PROVIDER
1	CHEMIC	10/16/09			
2	OTHER	10/6/09			BETA, BETAA
3	MENTAL	9/30/09			
4	SOCIAL	9/1/09			GAMMAAA, DENISE
COMMENT: Ind case opened. Group therapy 1 x week. **					
Primary Problem: 43.1 PARTNER ABUSE (SUSPECTED),PH Next Review: S					
5	MENTAL	8/28/09	8/28/09		THETAAAA, MARK
COMMENT: TEST COMMENT AGAIN **					
Primary Problem: 300.00 ANXIETY DISORDER NOS Next Review: 9/28/09					
6	MENTAL	8/28/09	8/28/09	8/28/09	MUTUAL AGREEMENT TO BETTTAA, LORI
Primary Problem: Next Review: 8/28/09					
7	MENTAL	8/28/09		8/28/09	PATIENT DROPPED OUT
8	MENTAL	8/28/09			GAMMAAAAA, DENISE
?? for more actions + next screen - prev screen					
OP	Open New Case		DC	Delete Case	
ED	Edit Case Data		Q	Quit	
Select Item(s):					

Figure 6-1: Sample Update BH Patient Case Data screen.

Use the Quit (Q) option to exit the Update BH Patient Case Data screen.

6.1.1 Open New Case (OP)

Use the Open New Case (OP) option to create a new case. If you use the Open New Case (OP) option, the application displays that it is opening a case for the current patient.

Below are the prompts.

- “Enter Case Open Date”

Specify the date to open the case. This is the first contact for an episode of care. The application displays the Update Patient Case Data window.

```

*****      UPDATE PATIENT CASE DATA      *****
Patient Name: ALPHAA,CHELSEA MARIE
*****

          CASE OPEN DATE: MAY 23,2009
      PROGRAM AFFILIATION: MENTAL HEALTH
          PROVIDER NAME:
          PRIMARY PROBLEM:

          CASE ADMIT DATE:
      NEXT CASE REVIEW DATE:

          DATE CASE CLOSED:
          DISPOSITION:

COMMENT:
_____

COMMAND:                                     Press <PF1>H for help
Insert

```

Figure 6-2: Sample Update Patient Case Data window

The underlined fields are required.

- **Case Open Date**

This is the date the case was opened (can be edited).

- **Program Affiliation**

Specify the program affiliation, typing one of the following:

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

- **Provider Name**

This is the name of the provider for the case.

- **Primary Problem**

Specify the primary problem (name or code).

- **Case Admit Date**

Specify the admit date for the case. This is when a case management plan was developed and treatment began.

- **Next Case Review Date**

Specify the next date for the case review.

- **Date Case Closed**

Specify the date the case was closed. This is when treatment has been discontinued. (Used when closing a case.)

- **Disposition**

Specify the disposition for the case. This is the reason for closing a case. This is a required field when there is a date in the **Date Case Closed** field.

- **Comment**

Populate with a comment about the case, using 1–240 characters.

6.1.2 Edit Case Data (ED)

Use the Edit Case Data (ED) option to change a selected case. Use this option to edit an open case where you enter the admitted date when a case is admitted or to close the case when it is closed on the Update Patient Data window. The fields on this window are the same as those when you use the Open New Case option. Refer to Section 6.1.1 Open New Case for more information.

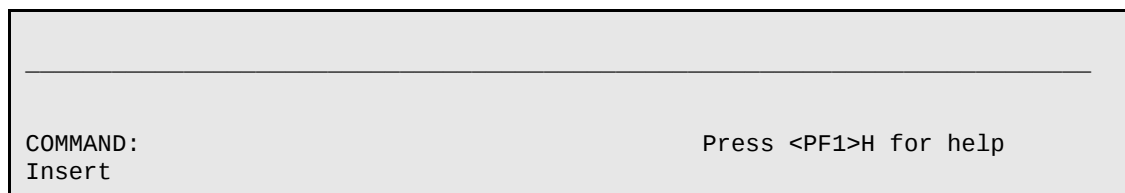
6.1.3 Delete Case (DC)

Use the Delete Case (DC) option to remove a specified case from the Update BH Patient Case Data window. The application verifies the deletion.

6.2 Designated Provider/Flag/Personal History (Roll and Scroll)

Use the OI (Desg Prov/Flag/Pers Hx) option on the Patient Data Entry window to access the Update Patient Information window.

***** UPDATE PATIENT INFORMATION ***** Patient Name: DEMO,DARRELL LEE [press <F1>E when finished updating record] DESIGNATED MENTAL HEALTH PROVIDER: DESIGNATED SOCIAL SERVICES PROVIDER: DESIGNATED CD A/SA PROVIDER: DESIGNATED OTHER PROVIDER: OTHER PROVIDER NON-RPMS: OTHER PROVIDER NON-RPMS: ===== PATIENT FLAG FIELD: PATIENT FLAG NARRATIVE:



COMMAND:
Insert

Press <PF1>H for help

Figure 6-3: Sample Update Patient Information window

The data on this window applies to the current patient.

Below are the fields.

- **Designated Mental Health Provider**

This is the RPMS provider who has accepted designated Mental Health provider status for the patient.

- **Designated Social Services Provider**

This is the PRMS provider who has accepted designated Social Services provider status for the patient.

- **Designated CD A/SA Provider**

This is the RPMS provider who has accepted designated Chemical Dependency or Alcohol/Substance Abuse provider status for the patient.

- **Designated Other Provider**

This is the RPMS provider who has accepted the designated Other provider status for the patient.

- **Other Provider Non-RPMS**

Populate with another Behavioral Health provider not listed in RPMS (this could be a local doctor, school teacher, etc.), using between 2 and 40 characters. This is a free-text field.

- **Patient Flag Field**

Populate with a locally-defined number field used to identify a specific group of patients (between 0 and 999). For example, 1 could designate patients with a family history of substance abuse, 2 could be used to identify patients enrolled in a special social services program, 3 could be used to identify patients enrolled in a special drug trial. In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.

- **Patient Flag Narrative**

Populate with the narrative about the patient flag, using between 2 to 60 characters in length.

After you save or exit the Update Patient Information window, the application displays the Personal History window.

If the patient has an existing Personal History entry, the application displays this information (the date and the personal history factor). You can add another personal history factor, if needed.

Facilities often find personal history factors to be useful in developing reports for tracking diagnoses associated with personal history.

Below are the prompts.

- “Enter Personal History”

Specify the personal history factor for the current patient. If you do not want to add another personal history, type a caret (^) at the prompt. After you have completed the personal history entry, you return to the Patient Data Entry window.

The personal history data entered here appears on the Patient List for Personal Hx Items report.

6.3 Case Management Window (GUI)

The figure below shows where the Case Management function is located on RPMS Behavioral Health System (GUI) tree structure.

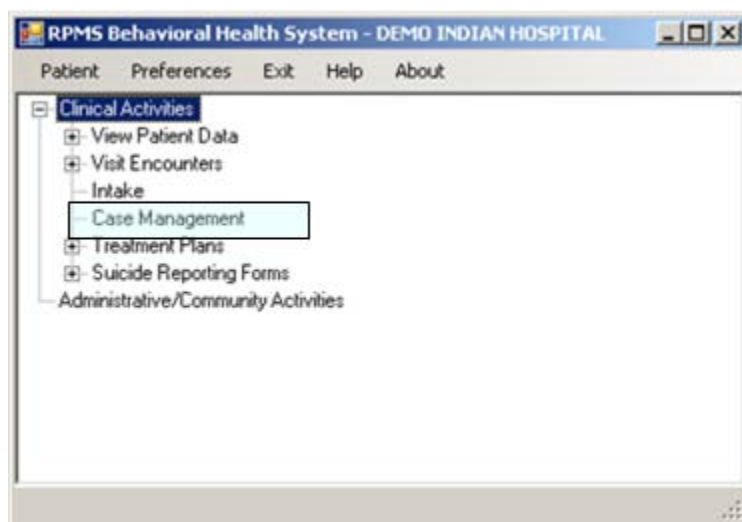


Figure 6-4: **Case Management** option on the RPMS Behavioral Health System (GUI) tree structure

Use the **Case Management** option to access the **Case Management** window for the current patient.

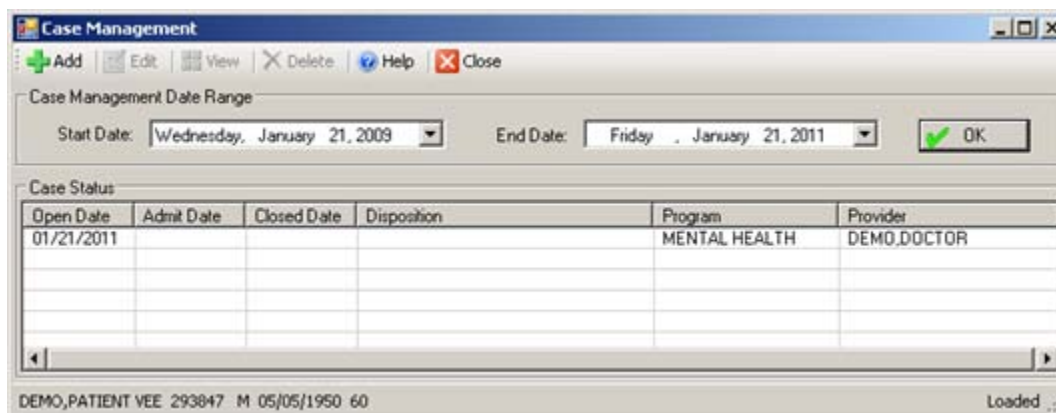


Figure 6-5: Sample **Case Management** window

You use the **Case Management** window to manage the case management records within a particular date range for the current patient (the name displays in the lower, left corner of the window).

6.3.1 Case Management Date Range

The date range for the displayed case management records is shown in the Case Status Date Range group box.

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

6.3.2 Case Status Group Box

The **Case Status** group box displays the case management records in the case management data range.

6.3.3 Add Button

Establish the patient you want to use in the add process. Click **Add** to add a new case management record. You access the **Case Management–Add Case** window. Refer to Section 6.4 Add Case Management Data (GUI) for more information.

6.3.4 Edit Button

Click **Edit** to edit a particular case management record. The application displays the **Case Management–Edit Case** window.

6.3.5 View Button

Click **View** (or double-click on a record) to view the data in a selected Case Management record. The application displays the **Case Management–View Case** window. The fields are the same as those on the add/edit case window. Refer to Section 6.4 Add Case Management Data (GUI) for more information.

6.3.6 Delete Button

Click **Delete** to remove a selected Case Status record. After clicking Delete, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected case status record from the group box (otherwise, click **No**.)

6.3.7 Help Button

Click **Help** to access the online help system for the **Case Management** window.

6.3.8 Close Button

Click **Close** to close the **Case Management** window.

6.4 Add/Edit Case Management Data (GUI)

Click **Add** to add a case management record for the current patient.

After you click **Add**, the **Case Management–Add Case** window displays.

Figure 6-6: Sample **Case Management–Add Case** window

To edit a record, select the record and click **Edit**. The **Case Management–Edit Case** window displays; this window has the same fields as the **Case Management–Add Case** window.

Click **Save** to save the case management information on this window. This process dismisses the window.

Click **Close** to display the **Continue?** dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add window. Click **No** and you remain on the add window where you can continue work on the **Add Case** window.

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

The free text fields have a context menu for editing. Refer to Section 2.11 Free Text Fields for more information.

Several of the fields contain a search window. Refer to Section 2.8 Using the Search Window for more information.

The fields that contain dates can be changed by accessing a calendar. Refer to Section 2.7 Using the Calendar for more information.

Certain fields use the search/select window. Refer to Section 2.9 Using the Search/Select window for more information.

Some fields use the multiple-select window. Refer to Section 2.10 Using the Multiple Select window.

6.4.1 Case Status Group Box

The screenshot shows a software interface for a 'Case Status' group box. It includes the following fields:

- Case Status**: A dropdown menu.
- Case Open Date**: A date picker showing 'Monday, October 26, 2009'.
- Provider Name**: A text field containing 'DEMO.DOCTOR' with a search icon.
- Primary Problem (Add / All)**: A text field with a search icon.
- Comment**: A large text area.
- Case Admit Date**: A date picker showing 'Monday, October 26, 2009'.
- Next Review Date**: A date picker showing 'Monday, October 26, 2009'.
- Date Case Closed**: A date picker showing 'Monday, October 26, 2009'.
- Disposition**: A dropdown menu.

Figure 6-7: Fields in **Case Status** group box

The fields in bold text are required.

- **Program**

This field determines the program associated with the new case. Use one of the following from the drop-down list:

- Mental Health

- Social Services
- Other
- Chemical Dependency

- **Case Admit Date**

This is when a case management plan was developed and treatment began. You can accept the default date by checking the check box in front of the date. The default is the current date. Click the drop-down list to access a calendar to change the field.

- **Case Open Date**

This is the first contact for an episode of care. The default is the current date. Click the drop-down list to access a calendar to change the field.

- **Next Review Date**

The default is the current date. Click the drop-down list to access a calendar to change the field. You can accept the default date by checking the check box in front of the date.

- **Provider Name**

This is the primary provider for the case (the default is the current logon user). Click the drop-down list to access the **Primary Provider** search window.

- **Date Case Closed**

This is when treatment has been discontinued. The default is the current date. Click the drop-down list to access a calendar to change the field. You can accept the default date by checking the check box in front of the date.

- **Primary Problem (Axis I/II)**

This is the primary problem for the case. Click the drop-down list to access the **Primary Problem/POV** search window.

- **Disposition**

This is the reason for closing a case. Click the drop-down list to select an option on the **Disposition** window. This is required when there is a date in the **Date Case Closed** field.

- **Comment**

Enter a comment about the case, using 1–240 characters, in this free text field.

6.4.2 Patient Information Group Box

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

The screenshot shows a 'Patient Information' group box with the following fields:

- Designated Mental Health Provider: Text field with a drop-down arrow.
- Designated Social Work Provider: Text field with a drop-down arrow.
- Designated Chemical Dependency Provider: Text field with a drop-down arrow.
- Designated Provider Other RPMS: Text field with a drop-down arrow.
- Designated Primary Care Provider: Text field containing 'SMITH, A'.
- Other Provider Non-RPMS: Text field.
- Other Provider Non-RPMS: Text field.
- Patient Flag: Text field.
- Patient Flag Narrative: Text field.

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

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

All fields are optional.

- **Designated Mental Health Provider**

This is the RPMS provider who has accepted designated mental health provider status for the patient. Click the drop-down list to access the **Designated Mental Health Provider** search window.

- **Other Provider Non-RPMS**

Populate with another Behavioral Health provider not listed in RPMS, using between 2–40 characters (free text field).

- **Designated Social Work Provider**

This is the RPMS provider who has accepted designated social work provider status for the patient. Click the drop-down list to access the **Designated Social Work Provider** search window.

- **Other Provider Non-RPMS**

Populate with another provider not listed in RPMS, using between 2–40 characters (free text field).

- **Designated Chemical Dependency Provider**

This is the RPMS provider who has accepted designated chemical dependency provider status for the patient. Click the drop-down list to access the **Designated Chemical Dependency Provider** search window.

- **Patient Flag**

Populate with a locally-defined number field used to identify a specific group of patients (free text field), using 0–999. For example, 1 could designate patients with a family history of substance abuse, 2 could be used to identify patients enrolled in a special social services program, 3 could be used to identify patients enrolled in a special drug trial. In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.

- **Designated Provider Other RPMS**

This is the RPMS provider who has accepted designated other RPMS provider status for the patient. Click the drop-down list to access the **Designated Provider Other RPMS** search window.

- **Patient Flag Narrative**

Populate with the narrative about the patient flag, using between 2–60 characters.

- **Designated Primary Care Provider**

This is a view-only field that displays the name of the designated primary care provider for the patient (if any). This information is pulled from the Primary Care Provider application.

6.4.3 Personal History Group Box

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

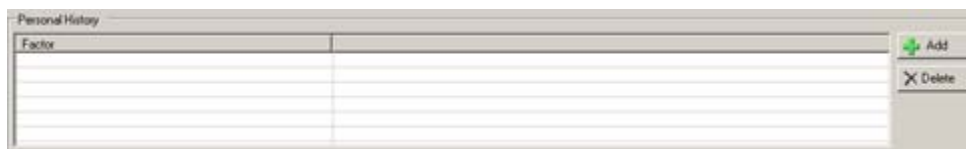


Figure 6-9: Sample **Personal History** group box

You only need to document personal history once, because it does become a permanent part of the patient’s medical record. Facilities often find personal history factors to be useful in developing reports for tracking diagnosis associated with personal history.

Click **Add** to access the **Personal History Factors** search window where you can add one or more personal history factors.

Click **Delete** to remove a selected personal history record. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected personal history record from the group box (otherwise, click **No**.)

7.0 Administrative/Community Activity

The Administrative/Community Activity option gives assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems.

7.1 Add Administrative/Community Activity Record (Roll and Scroll)

The AC (Add Adm/Comm Activity) option is found under the SDE option on the BH data entry window.

After using the AC option, the application displays the Update BH Forms window.

Update BH Forms		Apr 06, 2009 16:56:47		Page: 1 of 1			

Date of Encounter: Tuesday MAR 31, 2009							

#	PRV	PATIENT NAME	HRN	AT	ACT	PROB	NARRATIVE
1	BJB	ALPHAA,CHELSEA M	WW116431	60	13	311.	DEPRESSIVE DISORDER NOS
2	rst	ALPHAA,CHELSEA M	WW116431	90	15	295.72	SCHIZOAFFECTIVE DISORDER, CH
?? for more actions							
AV	Add Patient Visit	PF	Print Encounter Form	TN	Display TIU Note		
AC	Add Adm/Comm Activity	ID	Intake Document	AP	Appointments		
EV	Edit Record	HS	Health Summary	MM	Send Mail Message		
OI	Desg Prov/Flag	ES	SOAP/CC Edit	Q	Quit		
DV	Display Visit	SD	Switch Dates				
DE	Delete Record	EH	Edit EHR Record				
Select Action: AV//							

Figure 7-1: Sample Update BH Forms window

Use the Add Adm/Comm Activity (AC) option to add the administrative/community activity data.

Below are the prompts.

- “Enter Primary Provider”

This is the primary provider for the visit. The default is the current logon user.

The application displays the Behavioral Health Record Update window, with the following fields automatically populated: Program, Location of Encounter, Arrival Time, Secondary Providers, Community of Service, # Served, Type of Contact. These fields are autopopulated based on the defaults set up on the site parameters menu. If you do not have defaults set up on the site parameters menu, some of these fields might be blank.

```

* BEHAVIORAL HEALTH RECORD UPDATE *
Encounter Date: MAR 31,2009                      User: THETA,SHIRLEY
[press <F1>E when visit entry is complete]
-----
PROGRAM: SOCIAL SERVICES                      CLINIC: MEDICAL SOCIAL SERVICES
      LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
      ARRIVAL TIME: 12:00
      FLAG FIELD:
Any SECONDARY PROVIDERS? N
      COMMUNITY OF SERVICE: TAHLEQUAH
      ACTIVITY CODE:                      # SERVED: 1
      ACTIVITY TIME:
      TYPE OF CONTACT: SCHOOL
      LOCAL SERVICE SITE:
Any Prevention Activities to Record? N
PURPOSE OF VISIT (POVS) <press enter>:
COMMENT (press enter):

```

Figure 7-2: Sample Behavioral Health Record Update

The underlined fields are required.

- **Program**
This is the program associated with the record.
- **Clinic**
The response must be a clinic that is included in the RPMS clinic code set.
- **Location of Encounter**
This is the location of the encounter.
- **Arrival Time**
This is the arrival time of the encounter (default is 12:00).
- **Flag Field**
This indicates any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.
- **Any Secondary Providers?**
Type **Y** or **N** (the default) to indicate if there were any additional BHS providers who were also providing care during this particular encounter. Type **Y** to display the Enter/Edit Providers of Service pop-up.

```

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

Encounter Date: MAR 31,2009@12:00      User: THETA,SHIRLEY

-----

PROVIDER: DEMO, DOCTOR                PRIMARY/SECONDARY: PRIMARY
PROVIDER:                             PRIMARY/SECONDARY:
PROVIDER:                             PRIMARY/SECONDARY:
PROVIDER:                             PRIMARY/SECONDARY:
PROVIDER:                             PRIMARY/SECONDARY:
PROVIDER:                             PRIMARY/SECONDARY:

-----

COMMAND:                               Press <PF1>H for help
Insert

```

Figure 7-3: Sample Enter/Edit Providers of Service pop-up

The underlined fields are required.

- **PROVIDER:** Specify the provider name. You can add one or more secondary providers.
- **PRIMARY/SECONDARY:** Use SECONDARY when adding secondary providers.

The prompts for the Behavioral Health Record Update window continue.

- “Community of Service”
This is the community of service where the encounter took place.
- “Activity Code”
This is the activity code associated with the encounter. Refer to Section 15.0 Appendix A: Activity Codes and Definitions for more information.
- “# Served”
This is the number of people served in the community activity, using any integer between 0 and 999.
- “Activity Time”
This is the number of minutes spent on the activity, using any integer between 1 and 9999. Please note, 0 (zero) is not allowed as a valid entry.
- “Type of Contact”
This is the type of contact (the activity setting).

- “Local Service Site”

This is the local service site for the encounter.

- “Any Prevention Activities to Record?”

Type **Y** or **N**. If you type **Y**, the Prevention Activities pop-up displays:

```

Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:

TARGET:

```

Figure 7-4: Pop-up for prevention activities

The Target field will be disabled until a Prevention Activity is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

The underlined fields are required.

- **Prevention Activity:** populate with the code for the prevention activity. These activities are recorded when recording non-patient activities. You can enter more than one, if needed.
- **Target:** This is what population the prevention activity is designed for: A (Adult), Y (Youth), F (Family), M (Mixed Adult & Youth), S (Staff), E (Elderly Only), W (Women).

The prompts for the Behavioral Health Record Update window continue.

- “Purpose of Visits (POVS) <press enter>”

Press Enter to access the BH Record Entry–Purpose of Visit Update window.

```

***** BH RECORD ENTRY - PURPOSE OF VISIT UPDATE *****

Encounter Date: MAR 31,2009@12:00   User: THETA,SHIRLEY
[press <F1>C to return to main screen]
-----

PROBLEM CODE:      NARRATIVE:
PROBLEM CODE:      NARRATIVE:
PROBLEM CODE:      NARRATIVE:
PROBLEM CODE:      NARRATIVE:

COMMAND:
Insert

Press <PF1>H for help

```

Figure 7-5: Sample BH Record Entry POV window

The underlined fields are required.

- **Problem Code:** specify the problem code that can either the Behavioral Health Purpose of Visit or the more specific DSM IV diagnostic code.
- **Narrative:** populate with the text of the narrative for the problem code, if needed.

The prompts for the Behavioral Health Record Update window continue.

- “COMMENT (press enter)”

Press Enter to access another window where you can enter the text of comments about the Administrative/Community Activity.

7.2 Administrative/Community Activity Window (GUI)

Below shows where the Administrative/Community Activities function is located on RPMS Behavioral Health System (GUI) tree structure.

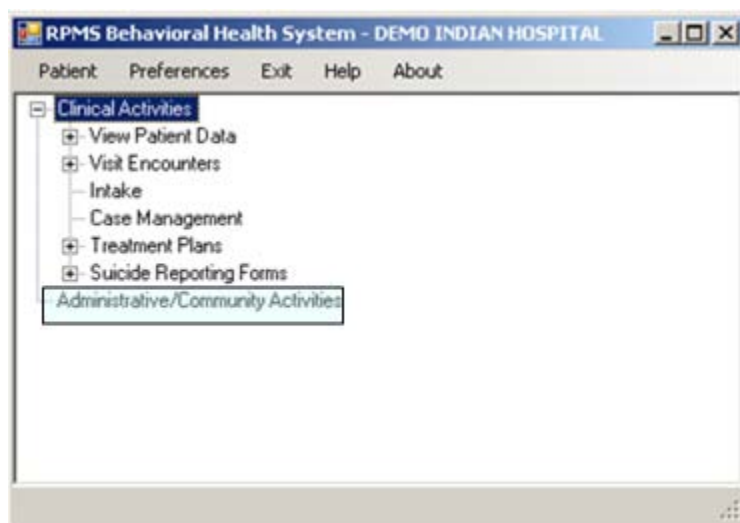


Figure 7-6: **Administrative/Community Activities** option on the RPMS Behavioral Health System (GUI) tree structure

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

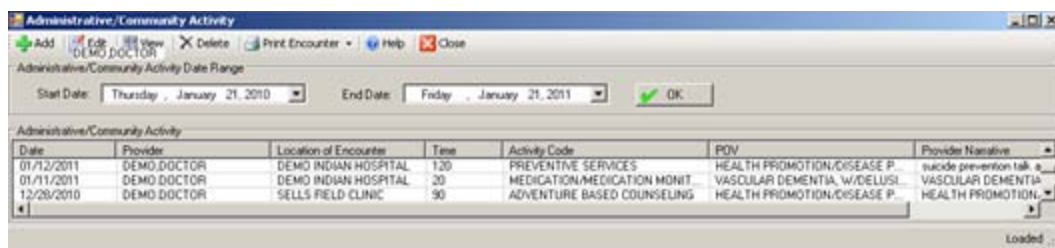


Figure 7-7: Sample **Administrative/Community Activity** window

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

7.2.1 Administrative/Community Activity Date Range

The **Administrative/Community Activity Date Range** group box shows the date range for the records in the **Administrative/Community Activity** group box. You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click **OK** to display the records in the **Administrative/Community Activity** group box.

7.2.2 Administrative/Community Activity Group box

The records are listed in date order, within the administrative/community activity date range.

7.2.3 Add Button

Click **Add** to add a new administrative/community activity data record. You access the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**. Refer to Section 7.3 Add/Edit Administrative/Community Activity (GUI) for more information.

7.2.4 Edit Button

Click **Edit** to edit a particular new administrative/community activity record. This function displays the **Administrative/Community Activity Data Entry–Edit Administrative/Community Data**. This window has the same fields as the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**.

7.2.5 View Button

Highlight an administrative/community activity record on the **Administrative/Community Activity** window and click **View** to browse the data (or double-click on a record). The **Community Activity Data Entry–View Community Data** window displays; this is a view-only window. The fields are the same as for the data entry (add/edit) windows. Click **Close** to dismiss this window.

7.2.6 Delete Button

Click **Delete** to delete a particular record. The application confirms the deletion.

7.2.7 Print Encounter Button

Click **Print Encounter** to print/browse an administrative/community activity record. Highlight the record and click **Print Encounter**. Select one of the following options: **Full**, **Suppressed**, **Both Full and Suppressed**. The first page of the output displays on the **Print Encounter** pop-up window.

The screenshot shows a window titled "Print Encounter" with a standard Windows-style title bar. The main content area displays a formatted text report for a patient encounter. The report includes a header with "CONFIDENTIAL PATIENT INFORMATION", a title "POC BEHAVIORAL HEALTH ENCOUNTER RECORD", and a timestamp "Printed: Jan 21, 2011@17:38:53". It also indicates it is a "Computer Generated Encounter Record". The patient information section lists the date as Jan 12, 2011, arrival time as 12:00, program as MENTAL HEALTH, clinic as MENTAL HEALTH, and primary provider as DEMO, DOCTOR. A table follows with columns for "Community", "Activity", "Type of Contact", "Number Served", and "Activity/Service Time". The data row shows "THREE POINTS", "37-PREVENTIVE SERVICES", "OUTPATIENT", "60", and "120 minutes". Below this is a section for "CHIEF COMPLAINT/PRESENTING PROBLEM:" followed by a blank line and "S/O/A/P:". Another section for "COMMENT/NEXT APPOINTMENT:" contains a note about administrative entries and prevention services. The "BN POV CODE" and "PURPOSE OF VISIT (POV)" section shows "1.1" and "HEALTH PROMOTION/DISEASE PREVENTION" with a sub-note "suicide prevention talk at high school". The "PREVENTION ACTIVITIES:" section lists "YOUTH PREVENTION". The footer of the window shows "Current Page No.: 1", "Total Page No.: 1", and "Zoom Factor: 100%".

```

***** CONFIDENTIAL PATIENT INFORMATION *****
POC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Jan 21, 2011@17:38:53
*** Computer Generated Encounter Record ***
*****
Date: Jan 12, 2011          Primary Provider: DEMO, DOCTOR
Arrival Time: 12:00
Program: MENTAL HEALTH
Clinic: MENTAL HEALTH          Appointment Type:

Community: THREE POINTS      Number Served: 60    Activity/Service Time: 120 minutes
Activity: 37-PREVENTIVE SERVICES
Type of Contact: OUTPATIENT

CHIEF COMPLAINT/PRESENTING PROBLEM:

S/O/A/P:

COMMENT/NEXT APPOINTMENT:
administrative entries and prevention services are recorded on the
Admin/Community Activities option. Although these generally are not
printed out, this is a sample of what they would look like when printed.
No electronic signature is available for these entries since they
should never include Patient Identifying Information

BN POV CODE    PURPOSE OF VISIT (POV)
OR DSM DIAGNOSIS  [PRIMARY ON FIRST LINE]

1.1            HEALTH PROMOTION/DISEASE PREVENTION
               suicide prevention talk at high school

PREVENTION ACTIVITIES:
YOUTH PREVENTION

```

Figure 7-8: Sample output for a selected Administrative/Community Activity record

Refer to Section 2.6 Pop-up Windows for more information about using this window.

7.2.8 Help Button

Click **Help** to access the online help system for the **Administrative/Community Activity** window.

7.2.9 Close Button

Click **Close** to dismiss the **Administrative/Community Activity** window.

7.3 Add/Edit Administrative/Community Activity (GUI)

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

Highlight a record (on the **Administrative/Community Activity** window) and click **Edit** to change the administrative/community activity data. This function displays the **Administrative/Community Activity Data Entry–Edit Administrative/Community Data** window. This window has the same fields as the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**.

The screenshot shows a software window titled "Administrative/Community Activity Data Entry - Add Administrative/Community Data". The window is divided into several sections:

- Administrative/Community Entry:** This section contains several input fields:
 - Primary Provider:** A text box with "DEMO.DOCTOR" and a dropdown arrow.
 - Program:** A dropdown menu.
 - Type of Contact:** A text box with a dropdown arrow.
 - Clinic:** A text box with a dropdown arrow.
 - Activity Time:** A text box.
 - Encounter Date/Time:** A date/time picker showing "Wednesday, January 19, 2011 10:05 AM".
 - Encounter Location:** A text box with a dropdown arrow.
 - Community of Service:** A text box with a dropdown arrow.
 - Activity Code:** A text box with a dropdown arrow.
 - Local Service Site:** A text box with a dropdown arrow.
 - # Served:** A numeric input field with "1".
 - Flag Field:** A checkbox.
- Activity Data | Notes:** A tabbed interface with "Activity Data" selected.
- Purpose of Visit - POV:** A table with columns "Code" and "Narrative". It has an "Add" button (green plus icon) and a "Delete" button (red X icon).
- Prevention Activities:** A table with columns "Prevention Activity", "Code", and "Other". It has an "Add" button (green plus icon) and a "Delete" button (red X icon).
- Secondary Providers:** A table with a "Provider" column. It has an "Add" button (green plus icon) and a "Delete" button (red X icon).
- Target:** A dropdown menu.
- Buttons:** At the bottom of the window, there are "Help" (blue question mark icon), "Save" (blue floppy disk icon), and "Close" (red X icon) buttons.

Figure 7-9: Sample **Community Activity Data Entry–Add Community Data** window

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

After you have completed the fields on this window, click **Save** (otherwise, click **Close**). The Save function adds a record to the **Administrative/Community Activity** window.

Some fields access a search window. Refer to Section 2.8 Using the Search Window (GUI) for more information on how to use this window.

Some fields access the calendar where you can change the date. Refer to Section 2.7 Using the Calendar for more information.

Some fields access the search/select window. Refer to Section 2.9 Using the Search/Select window for more information.

Some fields are free text boxes. Refer to Section 2.11 Free Text Fields for more information.

7.3.1 Administrative/Community Entry Group Box

Below is the **Administrative/Community Entry** group box.

Figure 7-10: Sample **Community Entry** group box

The fields in bold text are required.

- **Primary Provider**

This is the primary provider for the administrative/community activity. Click the drop-down list to access the **Primary Provider** search window where you search for the primary provider name.

- **Encounter Date/Time**

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

- **Program**

This is the program associated with the administrative/community activity. Use one of the following:

- Mental Health
- Social Services
- Other
- Chemical Dependency

After completing this field for a new record, the application automatically populates the remaining required fields if you have defaults set up in the Site Parameters.

- **Encounter Location**

This is the location where the administrative/community activity took place. Click the drop-down list to access the **Location** search window. Here you search for a location name.

- **Type of Contact**

This is the type of contact (the activity setting) for the administrative/community activity. Click the drop-down list to access the **Type of Contact** list.

- **Community of Service**

This is the community of service where the encounter took place. Click the drop-down list to access the **Community** search window. Here you search for a community name.

- **Clinic**

This is the clinic associated with the administrative/community activity. Click the drop-down list to access to the **Clinic** search window. Here you search for the clinic by name or code.

- **Activity Code**

This is the activity code associated with the administrative/community activity. Click the drop-down list to access the **Activity** search window. Here you search for the activity name. Refer to Section 15.0 Appendix A: Activity Codes and Definitions for more information.

- **Activity Time**

This the number of minutes spent on the activity, using any integer between 1 and 9999.

- **Number Served**

This is the number of people served in the administrative/community activity, using any integer between 0 and 999.

- **Flag Field**

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

- **Local Service Site**

This is the local service site associated with the administrative/community activity, if any. Click the drop-down list to access the **Local Service Site** list.

7.3.2 Activity Data Tab

The screenshot shows the 'Activity Data' tab with three main sections:

- Purpose of Visit - POV:** A table with columns 'Code' and 'Narrative'. To the right are buttons for 'Add' (green plus), 'Edit' (pencil), and 'Delete' (X).
- Prevention Activities:** A table with columns 'Prevention Activity', 'Code', and 'Other'. To the right are buttons for 'Add' (green plus) and 'Delete' (X). Below the table is a 'Target' dropdown menu.
- Secondary Providers:** A table with a 'Provider' column. To the right are buttons for 'Add' (green plus) and 'Delete' (X).

Figure 7-11: Sample **Activity Data** tab

Use the **Activity Data** tab to specify the POV, prevention activities, and secondary providers data.

7.3.2.1 Purpose of Visit–POV Group Box

The **POV** group box lists the POVs associated with the administrative/community activity.

The screenshot shows the 'Purpose of Visit - POV' group box with a table containing one entry:

Code	Narrative
97	ADMINISTRATION

To the right of the table are buttons for 'Add' (green plus), 'Edit' (pencil), and 'Delete' (X).

Figure 7-12: Sample **POV** group box

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

7.3.2.1.1 *Add Button*

Click **Add** to add a new POV. Click **Add** to access the **POV** search/select window. Here you select one or more POVs.

7.3.2.1.2 *Edit Button*

Click **Edit** to change the **Narrative** field of a POV record in the group box. Highlight a POV record and click **Edit** to display the **Edit POV** window.

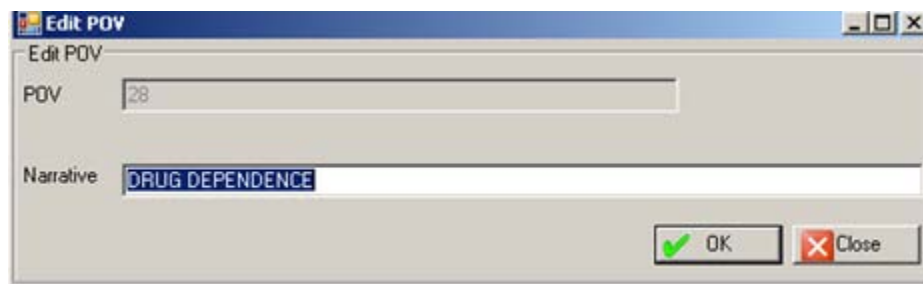


Figure 7-13: **Edit POV** window

The **Narrative** field is a free text field. Type the new POV narrative in the **Narrative** text box and click **OK** (otherwise, click **Close**). The OK process changes the narrative of the selected record. Note: the special characters “ or ‘ cannot be the first character of the POV narrative. The POV narrative field can contain 2–80 characters.

7.3.2.1.3 *Delete Button*

Click **Delete** to remove a record. Select a POV record to want to remove and click **Delete**. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected group encounter record from the group box (otherwise, click **No**.)

7.3.2.2 **Prevention Activities Group Box**

The **Prevention Activities** group box lists the prevention activities associated with the administrative/community activity.

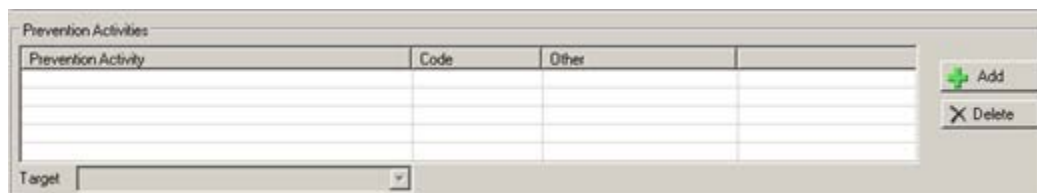


Figure 7-14: Sample **Prevention Activities** group box

The **Target** field will be disabled until a Prevention Activity is entered. In addition, the **Target** field will be disabled if all of the prevention activities are deleted.

You can add/delete a prevention activity and/or specify the target group.

- **Target**

This is the population for which the prevention activity is designed. The selected option applies to all of the prevention activities.

- Adult
- Youth
- Family
- Mixed (Adult & Youth)
- Staff
- Elderly Only
- Women

7.3.2.2.1 **Add Button**

Click **Add** to add a prevention activity record to the group box. Click **Add** to access the **Prevention Activity** search/select window. Here you select one or more prevention activities.

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

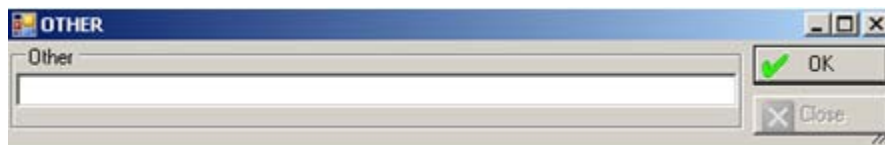


Figure 7-15: **Other** window

Populate the **Other** field with text of the other prevention activity associated with this record (limited to 80 characters). When complete, click **OK** (otherwise, click **Close**). The OK process populates the **Other** cell on the grid. If you dismiss the **Other** window (with no data), the **Other** cell on the grid will be blank.

7.3.2.2.2 **Delete Button**

Click **Delete** to remove a prevention activity record. Select the prevention activity record you want to remove and click **Delete**. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected prevention activity record from the group box (otherwise, click **No**.)

7.3.2.3 **Secondary Providers Group Box**

The **Secondary Providers** group box lists the secondary providers associated with the administrative/community activity.



Figure 7-16: Sample **Secondary Providers** group box

You can add or delete a record.

Click **Add** on the **Secondary Providers** group box to access the **Secondary Providers** search/select window. Here you can select one or more secondary provider names.

Select the secondary provider record you want to remove and click **Delete**. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected secondary provider record from the group box (otherwise, click **No**.)

7.3.3 Notes Tab

Use the **Notes** field to enter any notes about the administrative/community activity.



Figure 7-17: Sample **Notes** field

This is a free text box.

8.0 Encounter and Treatment Plan Sharing (Roll and Scroll)

After the entry of a Visit or a Treatment plan, you will have the option to share it with a colleague through MailMan. In order to do this, you must be properly set up through Site Parameters as a provider who can share information.

Make sure that the provider being sent the plan should actually be using this function.

After the entry of a Visit or Treatment plan, you will be asked the following question:

Do you want to share this visit information with other providers? N//

Figure 8-1: Question after entry of a visit or treatment plan

By answering the question with a **Yes**, you will be walked through the process of sending the information via a MailMan message:

```
Send to: NUUUU,BILL          WBM
Send to:

Message will be sent to:    THETA,BILL

Do you want to attach a note to this mail message? N// YES
Enter the text of your note.

NOTE APPENDED TO MAIL MSG:
  No existing text
  Edit? NO//Y
  - Here the provider can append a note to his/her colleague.

Ready to send mail message?? Y// ES
Send Full or Suppressed Form: (F/S): S// f FULL - The answer to this
question will determine which type of encounter form will be send in the
message.

Sending Mailman message to distribution list
Message Sent
Press enter to continue....:
```

Figure 8-2: Sending a treatment plan through MailMan

9.0 Problem List (Roll and Scroll)

Use the PL option on the Patient Data Entry screen to modify items on the patient's Behavioral Health problem list.

After using the PL option, the application displays the Behavioral Health Patient Diagnosis List Update menu.

```
Behavioral Health Patient Diagnosis List Update menu

    1) Add a Problem to BH Diagnosis List
    2) Modify a Problem on BH Diagnosis List
    3) Remove a Problem from BH Diagnosis List
    4) Inactivate an Active Problem on BH Diagnosis List
    5) Activate an Inactive Problem on BH Diagnosis List
    6) Add a Treatment Note to a BH Problem
    7) Modify a Treatment Note of BH Problem
    8) Remove a Treatment Note to BH Problem
    9) Display Patient's BH Diagnosis List
   10) Display a Patient's PCC Problem List
   11) Quit
Choose One: (1-11): 11//
```

Figure 9-1: Updating a problem list

Use the options on Behavioral Health Patient Diagnosis List Update menu to modify the current patient's problem list.

9.1 Add a Problem

Use Option 1 (Add a Problem to BH Diagnosis List) to add a problem to a patient's problem list.

After typing **1**, the application will display the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts:

- “Enter PROBLEM DIAGNOSIS”
Specify the name or number of the problem that you want to add to the list.
- “Provider Narrative”
Populate with the text of the narrative to describe the problem, using 2–160 characters.
- “Date of Onset”
Specify the date that the problem was first diagnosed.

- “Status”
Type **A** (Active) or **I** (Inactive). The default is **A**. Type **I**, for example, when the problem is no longer an ongoing issue.
- “Add TREATMENT NOTES? (Y/N)”
Type **Y** or **N**. If you type **Y**, the application displays other prompts where you provide the narrative for the treatment notes (using 2 - 205 characters in length). These notes will be numbered.
- “Add this PROBLEM to the PCC Problem List”
Type **Y** or **N**. If you type **N**, you exit the window.

If you type **Y**, the application displays the ACTIVE PROBLEMS AND NOTES for the patient.

Below is an example of the list.

```

***** ACTIVE PROBLEMS AND NOTES *****
WW33      01/18/07  latent yaws  (ONSET: 01/20/06)
WW33      01/18/07  updated for editing.
WW34      04/08/08  Chronic Depression
WW35      04/08/08  Agoraphobia With Panic Disorder
WW36      04/16/08  Trial anti-dep  (ONSET: 04/16/08)
WW37      04/29/08  Unspecified Type Schizophrenia, Unspecified State
                (ONSET: 04/29/08)
WW38      07/24/08  DEPRESSION  (ONSET: 04/08/08)
WW39      11/12/08  MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
(ONSET:
                06/01/08)
WW40      06/01/03  PRENATAL
***** No INACTIVE Problems on file for this Patient
Press any key to continue

```

Figure 9-2: Sample list of active problems and notes for the patient

After you press any key (to continue), the application prompts “Are you sure?” to ensure that you really want to add the problem to the PCC problem list. Type **Y** (yes) or **N** (no).

If you type **Y** (yes), the application redisplay the PROVIDER NARRATIVE that was previously entered. This gives you the opportunity to change it, if needed.

9.2 Modify a Problem

Use Option 2 (Modify a Problem on BH Diagnosis List) to edit a problem record on a patient’s list of problems.

After typing **2**, the application will display the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- “Enter MH/SS Problem Number”
Specify the problem number you want to edit.
- “PROBLEM CODE”
The application displays the problem code that you can change.
- “Provider Narrative”
Populate with the text of the narrative about the problem diagnosis, using 2–160 characters.
- “Status”
Type **A** (Active) or **I** (inactive).
- “Date of Onset”
Specify the date that the problem was first diagnosed.

9.3 Remove a Problem

Use Option 3 (Remove a Problem from BH Diagnosis List) to delete a problem on a patient’s problem list.

After typing **3**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- “Enter MH/SS Problem Number”
Specify the problem number you want to remove.
- “Are you sure that you want to remove MH/SS Problem Number x?”
Here “x” is the problem number you entered. Type **Y** (yes) or **N** (no).

9.4 Inactivate an Active Problem

Use Option 4 (Inactivate an Active Problem on BH Diagnosis List) to inactivate a currently active problem on a patient’s problem list.

After typing **4**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- “Enter MH/SS Problem Number”

Here you type the problem number you want to make inactive. The problem number you entered will be placed on the inactive list.

9.5 Activate an Inactive Problem

Use Option 5 (Activate an Active Problem on BH Diagnosis List) to activate a currently inactive problem on a patient’s problem list.

After typing **5**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts

- Enter MH/SS Problem Number

Type the problem number you want to make active. The problem number you entered will be placed on the active list.

9.6 Add a Treatment Note

Use Option 6 (Add a Treatment Note to a BH Problem) to add a treatment note to a problem on a patient’s problem list.

After typing **6**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- “Enter MH/SS Problem Number”

Type the problem number to which you want to add a treatment note.

- “Treatment Note #x” (where x is the number of the treatment note)
- “NARRATIVE”

Populate with the text of the treatment note narrative, using 2–205 characters in length (required).

- “LONG/SHORT TERM TREATMENT”

Type **S** (short) or **L** (long).

- “AUTHOR”

Type the name of the person who entered the text of the narrative (the default is the current logon user).

9.7 Modify a Treatment Note

Use Option 7 (Modify a Treatment Note of BH Problem) to modify a treatment note on a patient’s problem list.

After typing 7, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts.

- “Enter MH/SS Problem Number”

Type the problem number to which you want to modify a treatment note.

- “Enter Treatment Plan to Modify?”

Type the number of the treatment note that you want to modify. For example, say there are two notes for problem number 2; these notes are numbered 2-1 and 2-2. If you want to modify the first number, you would type **1** (for note # 2-1) at this prompt.

- “NARRATIVE”

Populate with the text of the treatment note narrative, using 2–205 characters in length.

- “LONG/SHORT TERM TREATMENT”

Type **S** (short) or **L** (long).

- “AUTHOR”

Use the name of the person who entered the text of the narrative.

9.8 Remove a Treatment Note

Use Option 8 (Remove a Treatment Note to BH Problem) to delete a treatment note on a patient’s list.

After typing **8**, the application displays the BEHAVIORAL HEALTH Diagnosis List for the patient.

Below are the prompts

- “Enter MH/SS Problem Number”

Type the problem number whose note you want to remove.

- “Enter Treatment Plan to REMOVE”

Type the number of the treatment note that you want to modify. For example, say there are two notes for Problem Number 2; these notes are numbered 2-1 and 2-2. If you want to remove the note of the first problem, you would type **1** (for note # 2-1) at this prompt.

- “Are you sure you want to remove Treatment Plan Number x?” (where x is a number)

Type **Y** (yes) or **N** (no).

9.9 Display BH Problem List

Use Option 9 (Display Patient’s BH Diagnosis List) to display a selected patient’s problem list.

After typing **9**, the system will display the BEHAVIORAL HEALTH Diagnosis list for the patient. This is a view-only window.

9.10 Update PCC Problem List

Use Option 10 (Update the Patient’s PCC Problem List) to review a selected patient’s PCC problem list.

Below are the prompts.

- “Location where Problem List update occurred”

This is the location where the problem list update happened. You can accept the default by pressing Enter or populate with another location.

- “Date Problem List Updated”

Specify the date the problem list is updated.

The application displays the PCC Problem List Update window showing the problem list for the patient.

PCC Problem List Update	Apr 06, 2009 16:21:16	Page:	1 of	2

Patient Name: ALPHAA,CHELSEA MARIE	DOB: FEB 07, 1975	Sex: F	HRN: 11	

1) Problem ID: WW33 DX: 102.8 Status: ACTIVE Onset: 1/20/2006				
Provider Narrative: latent yaws				
Notes:				
WW Note#3 1/18/2007 updated for editing.				

```

2) Problem ID:  WW34   DX: 311.   Status: ACTIVE   Onset:
   Provider Narrative:  Chronic Depression

3) Problem ID:  WW35   DX: 300.21 Status: ACTIVE   Onset:
   Provider Narrative:  Agoraphobia With Panic Disorder

4) Problem ID:  WW36   DX: 311.   Status: ACTIVE   Onset: 4/16/2008
   Provider Narrative:  Trial anti-dep
+      Enter ?? for more actions                                     >>>
AP  Add Problem to PCC Problem List      IP  Inactivate a PCC Problem
EP  Edit a PCC Problem List Entry        DD  Display a PCC Problem List
Entry
DE  Delete a Problem from the PCC List Q   Quit
AC  Activate a PCC Problem List Entry
Select Action: +//

```

Figure 9-3: Sample PCC Problem list for the patient record you selected

Use the action Q (quit) to dismiss this window.

Use the plus (+) action to display more problem list records (if any).

Type the following actions at the “Select Action” prompt:

- **Add Problem to PCC Problem List:** Type **AP** to add a problem to the PCC problem list.
- **Edit a PCC Problem List Entry:** Type **EP** to edit a particular record on the PCC problem list.
- **Delete a Problem from the PCC List:** Type **DE** to remove a particular record on the PCC problem list.
- **Activate a PCC Problem:** Type **AC** to activate an inactive PCC problem.
- **Inactivate a PCC Problem:** Type **IP** to inactive an active PCC problem.
- **Display a PCC Problem List Entry:** Type **DD** to display a specified problem list entry. After specifying the problem number, the application displays the data on the Output Browser window.

```

OUTPUT BROWSER           Apr 13, 2009 14:19:09           Page:    1 of    1

DIAGNOSIS: 311.                PATIENT NAME: ALPHAA,CHELSEA MARIE
DATE LAST MODIFIED: APR 16, 2008
PROVIDER NARRATIVE: Trial anti-dep
FACILITY: DEMO INDIAN HOSPITAL    NMBR: 36
DATE ENTERED: APR 16, 2008        STATUS: ACTIVE

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

```

Figure 9-4: Sample display of PCC problem

10.0 Treatment Plans

You use the Treatment Plans feature to add or update treatment plans in the roll-and-scroll application and in the RPMS Behavioral Health System (GUI).

10.1 Patient Treatment Plans (Roll and Scroll)

Use the Update BH Patient Treatment Plans (TPU) option on the Data Entry Menu to access the Patient Treatment Plans menu.

```

*****
**          IHS Behavioral Health System          **
**          Patient Treatment Plans              **
*****
                          Version 4.0 (patch 1)

                          DEMO INDIAN HOSPITAL

UP      (Add, Edit, Delete) a Treatment Plan
DTP     Display/Print a Treatment Plan
REV     Print List of Treatment Plans Needing Reviewed
RES     Print List of Treatment Plans Needing Resolved
ATP     Print List of All Treatment Plans on File
NOTP    Patients w/Case Open but no Treatment Plan

Select Update BH Patient Treatment Plans Option:

```

Figure 10-1: Options on the Patient Treatment Plans menu

10.1.1 Add, Edit, Delete a Treatment Plan (UP)

Use UP (Add, Edit, Delete a Treatment Plan) to access the Update Patient Treatment Plan window for a particular patient.

```

Update Patient Treatment Plan Apr 13, 2009 17:11:07      Page: 1 of 9
Patient Name:  ALPHA,CHelsea MARIE      DOB:  FEB 07, 1975      Sex:  F
                          TREATMENT PLANS CURRENTLY ON FILE

1)  Program:  SOCIAL SERVICES      Responsible Provider:  GAMMAA,RYAN
    Date Established:  MAR 27, 2009      Next Review Date:  APR 01, 2009
    Status:
    Problem:  eating      Date Resolved:

2)  Program:  MENTAL HEALTH      Responsible Provider:  GAMMAA,RYAN
    Date Established:  MAR 24, 2009      Next Review Date:  APR 15, 2009
    Status:
    Problem:  testing functionality of editing tp      Date Resolved:

3)  Program:  MENTAL HEALTH      Responsible Provider:  BETAAAA,BJ
    Date Established:  MAR 24, 2009      Next Review Date:  JUN 22, 2009
    Status:
    Problem:  TESTING BASED ON RYAN'S FINDINGS      Date Resolved:

```

+ Enter ?? for more actions					
AD	Add Treatment Plan	RV	Enter TP Review	BV	Browse Visits
ED	Edit a Plan	DS	Disp/Print Plan	SP	Share a TP
DE	Delete Tx Plan	HS	Health Summary	Q	Quit
Select Action: AD//					

Figure 10-2: Sample Update Patient Treatment Plan window

Type **Quit** to dismiss the Update Patient Treatment Plan window.

10.1.1.1 Add Treatment Plan (AD)

Use the AD action to add a new treatment plan for the current patient. The prompts are the same as when you edit a plan. Refer to Section 10.1.1.2 Edit a Plan (ED) for more information.

10.1.1.2 Edit a Plan (ED)

Use the ED action to change a selected treatment plan for the current patient.

Below are the prompts.

- “Date Established”
The date the treatment plan was established (you cannot change).
- “Program”
This is the program for the treatment plan. Type one of the following: **M** (Mental Health), **S** (Social Services), **C** (Chemical Dependency), **O** (Other).
- “Designated Provider”
This is the name of the designated provider for the treatment plan.
- “Case Admit Date”
This is the date the case was admitted.
- “AXIS I”
The text of the AXIS I displays, if any.
- “Edit?”
Type **Y** (yes) or **N** (no) to change the AXIS I text. If you type **Y**, you access another window where you can change the text.
- “AXIS II”
The text of the AXIS II displays, if any.

- “Edit?”
Type **Y** (yes) or **N** (no) to change the AXIS II text. If you type **Y**, you access another window where you can change the text.
- “AXIS III”
The text of the AXIS III displays. This text describes the general medical conditions of the patient.
- “Edit?”
Type **Y** (yes) or **N** (no) to change the AXIS III text. If you type **Y**, you access another window where you can change the text.
- “Select AXIS IV”
The value for the AXIS IV displays (you can change). This is one of the major psychosocial or environmental problem codes. Type one of the following: **1** (primary support group problems), **2** (social environmental problems), **3** (educational problems), **4** (occupational problems), **5** (housing problems), **6** (economic problems), **7** (access to health care services problems), **8** (legal interaction problems), **0** (other psychosocial or environmental problem).
- “AXIS V”
The value for the AXIS V displays (you can change). This is the functional level using the GAF scale (0–100).
- “GAF Scale Type”
The acronym for the GAF Scale Type, using up to 20 characters.
- “Problem List”
Populate this field with the text of the problem, using up to 240 characters. The text should list and briefly describe multiple problems.
- “Treatment Plan Narrative (Problems/Goals/Objectives/Methods)”
The narrative of the problems, goals, objectives, or methods of the treatment plan.
- “Edit?”
Type **Y** (yes) or **N** (no) to change the narrative of the Treatment Plan. If you type **Y**, you access another window where you can change the text.
- “Anticipated Completion Date”
This is the date the treatment plan is anticipated to be completed.
- “Review Date”

This is the date of the review.

- “Concurring Supervisor”

This is the name of the concurring supervisor for the treatment plan.

- “Date Concurred”

This is the date the concurring supervisor agreed to the treatment plan. Once a date is specified at this prompt, you cannot change it. The prompt displays only if you specified a concurring supervisor.

- “Participants in the development of this plan”

If there is a participant in the development of this plan, the application displays the name. If not, the “None recorded” message displays.

The application allows you to do one of the following at this prompt: A–Add a Participant or N–NO Changes.

If you type **N**, the next prompt, “Date Closed,” displays.

If you type **A**, the following prompts display:

- “Enter the Participant Name”: specify the name of the participant.
- “Enter the Relationship to the Client”: specify the relationship of the participant to the patient.

The application then lists the participants in the development of the plan. Below is an example:

```

Participants in the development of this plan:
-----
1)  Alma Beta                               cousin

      Select one of the following:

          A      Add a Participant
          E      Edit an Existing Participant
          D      Delete a Participant
          N      No Change

Which action:
  
```

Figure 10-3: Sample of participants in the development of this plan.

At the “Which action” prompt, use one of the following:

- Use the **A** option to add a participant. The prompts are the same as those shown above.

- Use the E option to edit a particular existing participant. After you indicate the participant name, the prompts are the same as the add option.
- Use the D option to delete a particular existing participant. The application asks to specify the one you want to delete. There is no confirmation about the deletion.
- Use the N option to continue onto the next prompt.
- “Date Closed”
This is the date the treatment plan is to be closed.

10.1.1.3 Delete Tx Plan (DE)

Use the DE action to delete a particular treatment plan.

Below are the prompts.

- “Select BH Treatment Plan”
Specify the treatment plan you want to remove.
- “Are you sure you want to DELETE this Treatment Plan?”
Type **Y** (yes) or **N** (no). The Y option removes the particular treatment plan from the Update Patient Treatment Plan window.

10.1.1.4 Enter TP Review (RV)

Use the RV action to access the Treatment Plan Update window of a specified treatment plan (for the current patient).

Below are the prompts.

- “Select BH Treatment Plan”
Specify the treatment plan you want to review.

The application displays the Treatment Plan Update window. This window has the following prompts.

- “Select REVIEW DATE”
The review date display (you can change). If you do not enter a date here, you exit the RV process.
- “Review Provider”
Specify the name of the review provider.
- “Review Supervisor”

Specify the name of the review supervisor, if any.

- “Progress Summary”

The text of the progress summary displays (if any).

- “Edit?”

Type **Y** (yes) or **N** (no) to indicate if you want to edit the text of the progress summary. If you type **Y**, you access another window to edit the text.

- “Select TX REVIEW PARTICIPANT NAME”

You can specify a new treatment review participant name, if needed.

- “Relationship to Client”

This prompt does not display unless you added a name in the previous prompt. This prompt allows you to specify the relationship to the client.

- “Next Review Date”

The next review date displays (you can change).

10.1.1.5 Disp/Print Plan (DS)

Use the DS action to display/print a specified treatment plan for the current patient.

Below are the prompts.

- “Select BH Treatment Plan”

Specify the treatment plan you want to browse/print.

- “What would do like to print”

Type **T** (Treatment Plan Only), **R** (Treatment Plan REVIEWS Only), or **B** (both Treatment Plan and Reviews).

- “Do you wish to”

Type **P** (print output on paper) or **B** (browse output on screen).

Browse the output on the Output Browser window.

***** CONFIDENTIAL PATIENT INFORMATION *****			

*			*
* TREATMENT PLAN		Printed: Oct 27, 2009@09:49:14	*
* Name: ALPHAA, CHELSEA MARIE		Page 1	*
* DEMO INDIAN HOSPITAL	DOB: 2/7/75	Sex: F Chart #: WW116431	*
*			*

Date Established:	Oct 01, 2009
Admit Date:	
Anticipated Completion Date:	
Date Close:	Oct 01, 2009
Provider:	GAMMA, DENISE
Supervisor:	<not recorded>
Date Concurred:	
Review Date:	
Participants in Plan Creation:	
Blair	sister
DIAGNOSIS:	
AXIS I	
AXIS II	
AXIS III	
AXIS IV	
AXIS V	GAF Scale Type
PROBLEM LIST	
TREATMENT PLAN (Problems/Goals/Objectives/Methods)	

_____ Client's Signature	_____ Designated Provider's Signature
_____ Supervisor's Signature	_____ Physician's Signature
_____ Other	_____ Other
_____ Other	_____ Other
Date of Review:	Oct 01, 2009
Reviewing Provider:	WILLIAMS, MARK
Reviewing Supervisor:	<<not recorded>>
Next Review Date:	Oct 01, 2009
Progress Summary:	
Participants in Review:	
PARTICIPANT NAME	RELATIONSHIP TO CLIENT
Enter RETURN to continue or '^' to exit:	

Figure 10-4: Sample display of treatment plan

10.1.1.6 Health Summary (HS)

Use the HS action to display/print a particular health summary for the current patient.

10.1.1.7 Browse Visits (BV)

Use the BV action to browse the behavioral health visits for the current patient.

Below are the prompts.

- Browse which subset of visits for [patient name]
Type one of the following: **L** (patient's last visit), **N** (patient's last n visits), **D** (visits in a date range), **A** (All of this patient's visits), or **P** (visits to one program). If you type **N**, **D**, or **P**, other prompts will display.

The application display the BROWSE PATIENT'S VISITS window. The one below is for all visits.

BROWSE PATIENT'S VISITS		Apr 13, 2009 17:51:51	Page: 1 of 395
Patient Name: CHIII,KIMBERLY YVETTE		DOB: Nov 23, 1966	
HRN: 114108			
***** Suicide Forms on File *****			
Date of Act: OCT 10, 2008	Suicidal Behavior:		
Previous Attempts:	Method:		
Date of Act: MAR 24, 2008	Suicidal Behavior: IDEATION W/ PLAN		
AND I			
Previous Attempts: UNKNOWN	Method: HANGING		

Visit Date: Sep 28, 2009@10:00		Provider: GAMMAAA,DENISE	
Activity Type: FAMILY/GROUP TREATMENT-PATIE		Type of Contact: OUTPATIENT	
Location of Encounter: SAN XAVIER			
Chief Complaint/Presenting Problem: test pt ed			
POV's:			
43.2 PARTNER ABUSE (SUSPECTED),EMOTIONAL			
SUBJECTIVE/OBJECTIVE:			
+ Enter ?? for more actions			
+ Next Screen	- Previous Screen	Q	Quit
Select Action:++//			

Figure 10-5: Sample patient's behavioral health visits window

10.1.1.8 Share a TP (SP)

You need to have shared permission in order to use this option. (Use the Site parameters on the Manager utilities (Share Records); your name would need to be added to that list.)

10.1.2 Display/Print a Treatment Plan (DTP)

Use the DTP option (on the Patient Treatment Plans menu) to display/print the treatment plan for a specified patient.

Below are the prompts.

- “Select PATIENT NAME”

Specify the patient you want to use.

If you use a patient with no treatment plan, the application will display a message to that effect.

If the patient has at least one treatment plan, the application will display the Display/Print Treatment Plan window.

Display/Print Treatment Plan Apr 07, 2009 17:12:08		Page: 1 of 2								
Patient Name: DUCK,DONALD R DOB: JUN 07, 1978 Sex: M										
TREATMENT PLANS CURRENTLY ON FILE										
<table border="0"> <tr> <td>1) Program: SOCIAL SERVICES</td> <td>Responsible Provider: GAMMAA,RYAN</td> </tr> <tr> <td>Date Established: APR 02, 2009</td> <td>Next Review Date: APR 12, 2009</td> </tr> <tr> <td>Status:</td> <td>Date Resolved:</td> </tr> <tr> <td colspan="2">Problem: testing functionality</td> </tr> </table>			1) Program: SOCIAL SERVICES	Responsible Provider: GAMMAA,RYAN	Date Established: APR 02, 2009	Next Review Date: APR 12, 2009	Status:	Date Resolved:	Problem: testing functionality	
1) Program: SOCIAL SERVICES	Responsible Provider: GAMMAA,RYAN									
Date Established: APR 02, 2009	Next Review Date: APR 12, 2009									
Status:	Date Resolved:									
Problem: testing functionality										
<table border="0"> <tr> <td>2) Program: MENTAL HEALTH</td> <td>Responsible Provider: GAMMAA,RYAN</td> </tr> <tr> <td>Date Established: APR 02, 2009</td> <td>Next Review Date: APR 02, 2009</td> </tr> <tr> <td>Status:</td> <td>Date Resolved:</td> </tr> <tr> <td colspan="2">Problem:</td> </tr> </table>			2) Program: MENTAL HEALTH	Responsible Provider: GAMMAA,RYAN	Date Established: APR 02, 2009	Next Review Date: APR 02, 2009	Status:	Date Resolved:	Problem:	
2) Program: MENTAL HEALTH	Responsible Provider: GAMMAA,RYAN									
Date Established: APR 02, 2009	Next Review Date: APR 02, 2009									
Status:	Date Resolved:									
Problem:										
<table border="0"> <tr> <td>3) Program: MENTAL HEALTH</td> <td>Responsible Provider: GAMMAA,RYAN</td> </tr> <tr> <td>Date Established: APR 02, 2009</td> <td>Next Review Date: APR 02, 2009</td> </tr> <tr> <td>Status:</td> <td>Date Resolved:</td> </tr> <tr> <td colspan="2">Problem:</td> </tr> </table>			3) Program: MENTAL HEALTH	Responsible Provider: GAMMAA,RYAN	Date Established: APR 02, 2009	Next Review Date: APR 02, 2009	Status:	Date Resolved:	Problem:	
3) Program: MENTAL HEALTH	Responsible Provider: GAMMAA,RYAN									
Date Established: APR 02, 2009	Next Review Date: APR 02, 2009									
Status:	Date Resolved:									
Problem:										
+ Enter ?? for more actions										
DS Disp/Print Plan	PS Previous Screen	PL Print List								
HS Health Summary	DN Down a Line	SL Search List								
NS Next Screen	UP Up a Line	Q Quit								
Select Action: DS//										

Figure 10-6: Sample Display/Print Treatment Plan window

The following actions are related to view functions:

- Type **Q** (Quit) to dismiss the window.
- Type **NS** (Next Screen) to display the next screen of information (does not work when you are on the last screen).
- Type **PS** (Previous Screen) to display the previous screen of information (does not work when you are on the first screen).

- Type **DN** (Down a Line) to display the next line of information following the one at the bottom of the current screen (does not work when you are on the last screen).
- Type **UP** (Up a Line) to display the line previous line of information before the top of the current screen (does not work when you are on the first screen).

10.1.2.1 Display/Print Plan (DS)

Use the DS action to browse/print a particular treatment plan. Refer to Section 10.1.1.5 Disp/Print Plan (DS) for more information.

10.1.2.2 Health Summary (HS)

Use the HS action to display a particular type of health summary for the current patient.

Below are the prompts.

- “Select Health Summary Type Name”

Specify the type of health summary you want to use.

The application displays the Health Summary for the current patient on the Output Browser window.

10.1.2.3 Print List (PL)

Use the PL action to display/print the treatment plans for the current patient.

Below are the prompts.

- “Device”

Specify the device you want to print/browse the list of treatment plans.

The application displays the Display/Print Treatment Plan for the current patient.

Display/Print Treatment Plan Apr 07, 2009 17:51:24		Page: 1 of 2
Patient Name: DELTA,EDWIN RAY		DOB: JUN 07, 1978 Sex: M
TREATMENT PLANS CURRENTLY ON FILE		
+-----		
1) Program: SOCIAL SERVICES	Responsible Provider: GAMMAA,RYAN	
Date Established: APR 02, 2009	Next Review Date: APR 12, 2009	
Status:	Date Resolved:	
Problem: testing functionality		
2) Program: MENTAL HEALTH	Responsible Provider: GAMMAA,RYAN	
Date Established: APR 02, 2009	Next Review Date: APR 02, 2009	
Status:	Date Resolved:	
Problem:		

3) Program: MENTAL HEALTH	Responsible Provider: GAMMAA, RYAN
Date Established: APR 02, 2009	Next Review Date: APR 02, 2009
Status:	Date Resolved:
Problem:	

Enter RETURN to continue or '^' to exit:

Figure 10-7: Sample Display/Print Treatment Plan window

10.1.2.4 Search List (SL)

Use the SL action to search the text of the treatment plans for a particular text string.

Below are the prompts.

- “Search for”

Specify the text string for which you want to search in the treatment plans.

If the application finds the first occurrence of the text string, it highlights it and prompts:

- “Stop Here?”

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

If you type **N**, you leave the search sequence.

If you type **Y**, it will search for the next occurrence of the text string. If it finds it, the application will highlight it. If it does not find it, it displays the message: Text not found. Do you want to start at the beginning of the list? Type **Y** or **N**.

10.1.3 Print List of Treatment Plans Needing Reviewed (REV)

Use the REV option to print a list of treatment plans in a particular date range that need to be reviewed.

- “Enter Beginning Date”

Specify the beginning date of the date range.

- “Enter Ending Date”

Specify the ending date of the date range.

- “Run the Report for which Program”

Indicate which program to use: **O** (One Program) or **A** (All Programs). If you use **O**, other prompts will display.

- “List Treatment Plans for”

Type one of the following: **O** (One Provider) or **A** (All Providers). If you type **O**, other prompts will display.

- “Demo Patient Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).

- “Device”

Specify the device to print/browse the output.

Below is a sample Listing of Treatment Plans Due to be Reviewed.

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX					Page 1
DEMO INDIAN HOSPITAL					
LISTING OF TREATMENT PLANS DUE TO BE REVIEWED					
Date Range: APR 07, 2008 to APR 07, 2009					
PATIENT NAME	DOB	CHART #	DATE ESTABLISHED	REVIEW DATE	ANTICIPATED COMPLETION DATE

ALPHA,ALICE ROCHELLE	6/25/97	183497	Dec 01, 2005	Feb 23, 2009	Feb 23, 2009
Program: MENTAL HEALTH		Responsible Provider: BETAAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 21, 2006	Sep 30, 2008	
Program: CHEMICAL DEPENDENCY		Responsible Provider: GAMMAA,DENISE			
ALPHAA,GLEN DALE	11/10/81	108704	Dec 10, 2007	May 06, 2008	Dec 10, 2008
Program: MENTAL HEALTH		Responsible Provider: BETAAA,BJ			
Enter RETURN to continue or '^' to exit:					

Figure 10-8: Sample output treatment plans due to be reviewed

10.1.4 Print List of Treatment Plans Needing Resolved (RES)

Use the RES option to print a list of treatment plans in a particular date range that need to be resolved.

The prompts are the same as those for the Print List of Treatment Plans Needing Reviewed (REV).

Below is a sample Listing of Treatment Plans Due to be Resolved.

***** CONFIDENTIAL PATIENT INFORMATION *****	
XX	Page 1
DEMO INDIAN HOSPITAL	
LISTING OF TREATMENT PLANS DUE TO BE RESOLVED	
Date Range: APR 07, 2008 to APR 07, 2009	

PATIENT NAME	DOB	CHART #	DATE ESTABLISHED	REVIEW DATE	ANTICIPATED COMPLETION DATE

ALPHA,ALICE ROCHELLE	6/25/97	183497	Dec 01, 2005	Feb 23, 2009	Feb 23, 2009
Program: MENTAL HEALTH		Responsible Provider: BETAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Jun 27, 2007		Jul 02, 2008
Program: MENTAL HEALTH		Responsible Provider: BETAA,BJ			
ALPHAA,GLEN DALE	11/10/81	108704	Dec 10, 2007	May 06, 2008	Dec 10, 2008
Program: MENTAL HEALTH		Responsible Provider: BETAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 03, 2008	Mar 18, 2008	Apr 07, 2008
Program: MENTAL HEALTH		Responsible Provider: GAMMAA,DENISE			
Enter RETURN to continue or '^' to exit:					

Figure 10-9: Sample output of treatment plans due to be resolved

10.1.5 Print List of All Treatment Plans on File (ATP)

Use the ATP option to print/browse a list of all patients who have a treatment plan on file (in a specified date range). This date range is the one during which the treatment plan was established.

Below are the prompts.

- “Enter BEGINNING Date”
Specify the beginning date of the date range.
- “Enter ENDING Date”
Specify the ending date of the date range.
- “Run the Report for which PROGRAM”
Type **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.
- “List treatment plans for”
Type **O** (one provider) or **A** (all providers). If you type **O**, other prompts will display.
- “Sort list by”
Type **P** (Responsible Provider), **N** (Patient Name), or **D** (Date Established).
- “Demo Patient Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).

- “Device”

Specify the device to browse/print the information.

The application displays the Listing of Treatment Plans window.

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX	DEMO INDIAN HOSPITAL LISTING OF TREATMENT PLANS Date Established: JAN 13, 2009 to APR 13, 2009				Page 1
PATIENT NAME	DOB	CHART #	DATE ESTABLISHED	REVIEW DATE	ANTICIPATED COMPLETION DATE

ALPHAA,CHELSEA MARIE	2/7/75	116431	Feb 25, 2009	May 26, 2009	Feb 25, 2010
Program: MENTAL HEALTH		Responsible Provider: BETAAAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 09, 2009	Jun 07, 2009	Mar 09, 2010
Program: MENTAL HEALTH		Responsible Provider: BETAAAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 24, 2009	Jun 22, 2009	Mar 24, 2010
Program: MENTAL HEALTH		Responsible Provider: BETAAAA,BJ			
ALPHAA,GLEN DALE	11/10/81	108704	Apr 06, 2009	Jul 05, 2009	Apr 06, 2010
Program: MENTAL HEALTH		Responsible Provider: BETAAAA,BJ			
ALPHAA,CHELSEA MARIE	2/7/75	116431	Mar 24, 2009		
Program: MENTAL HEALTH		Responsible Provider: BETAAAA,LORI			
Enter RETURN to continue or '^' to exit:					

Figure 10-10: Sample list of treatment plans

10.1.6 Patients w/Case Open but No Treatment Plan (NOTP)

Use the NOTP option to produce a report that lists all patients who have a case open date, no case closed date, and no treatment plan in place in a specified date range. This date range is during which the case was opened.

Below are the prompts.

- “Enter BEGINNING Date”

Specify the beginning date of the date range.

- “Enter ENDING Date”

Specify the ending date of the date range.

- “List cases opened by”

Type **O** (one program) or **A** (all programs). If you type **O**, other prompts will display. This allows you to limit the report output to cases opened by one or all Programs.

- “List cases opened by”
Type **O** (one provider) or **A** (all providers). If you type **O**, other prompts will display. This allows you to limit the report output to cases opened by one or all Providers.
- “Sort list by”
Type **P** (Responsible Provider), **N** (Patient Name), or **C** (Case Open Date).
- “Demo Patient Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude DEMO patients), **O** (include only DEMO patients).
- “Do you wish to”
Specify **P** (Print output) or **B** (Browse output on screen).

The application displays the LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE report.

Case Open Dates: SEP 08, 2010 to DEC 07, 2010					
PATIENT NAME	HRN	CASE OPEN DATE	PROGRAM	PROVIDER	LAST VISIT

THETAA, ROLAND	258852	10/01/10	MENTAL HEA		12/07/10
BETAAAA, MONTY	741147	11/03/10	MENTAL HEA		12/07/10
DEMO, DOROTHY ROSE	999999	12/07/10	MENTAL HEA		07/08/10
BETA, ROBERT JACOB	207365	11/22/10	CHEMICAL D	CHIII, JESSICA	12/07/10

Figure 10-11: Sample Listing of Cases with No Treatment Plan in Place report

10.2 Treatment Plan Window (GUI)

The RPMS Behavioral Health System (GUI) application provides ways to manage treatment plans for one patient

The figure below shows where the treatment plan functions are located.

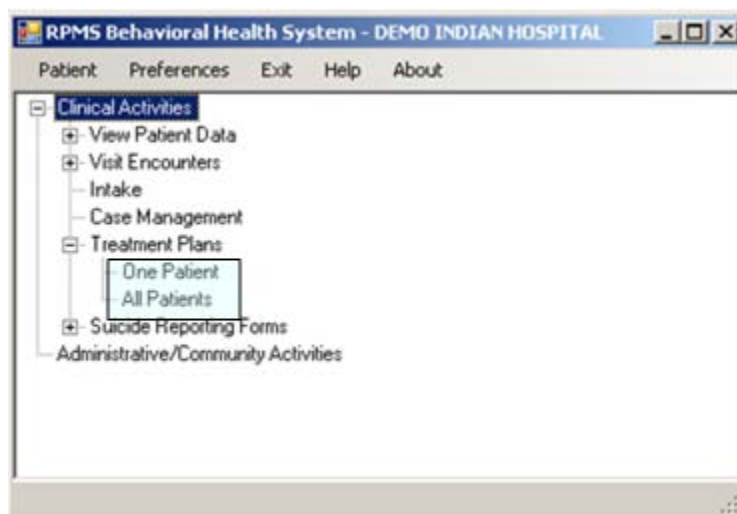


Figure 10-12: Location of Treatment Plan functions on tree structure

One way to access the **Treatment Plan** window is to use the **One Patient** option. You access the **Treatment Plan** window for the current patient.

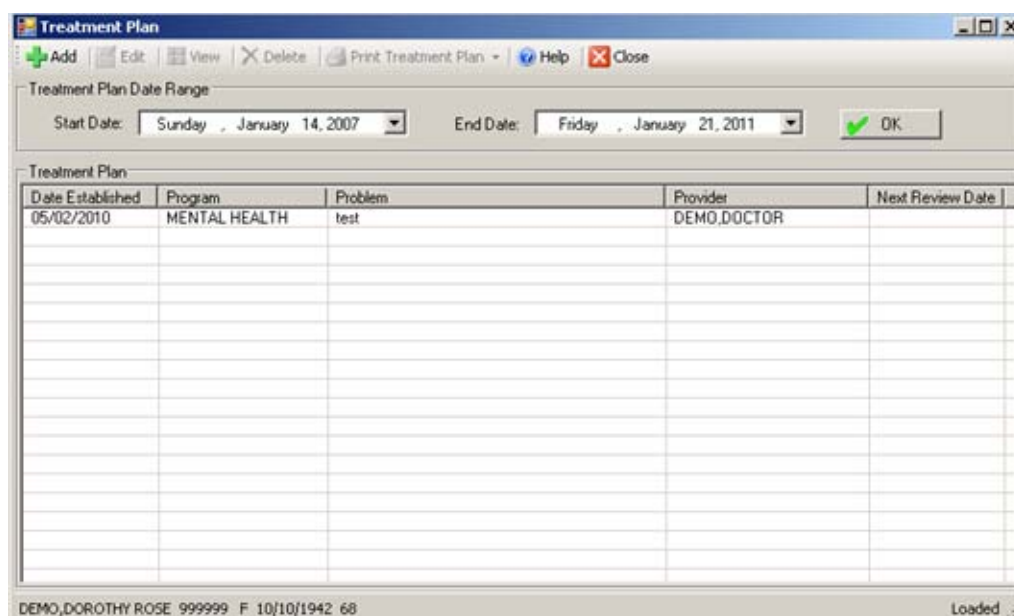


Figure 10-13: Sample **Treatment Plan** group box for current patient

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

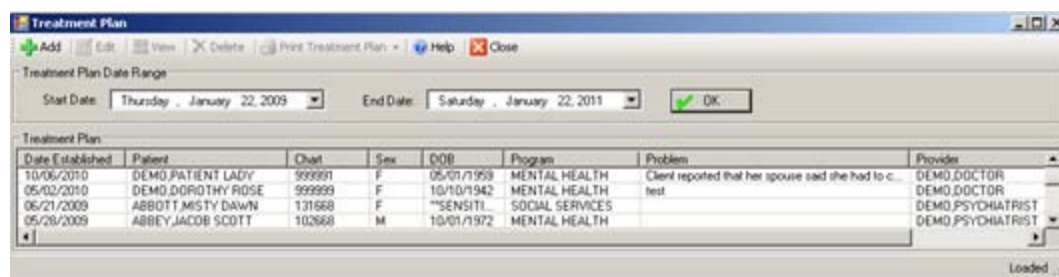


Figure 10-14: Sample **Treatment Plan** window for all patients

The following are features of both windows.

10.2.1 Treatment Plan Date Range

The treatment plan records are those within the date range shown in the **Treatment Plan Date Range** group box.

You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click **OK** to display the records in the **Treatment Plan** group box.

10.2.1.1 Treatment Plan Window for One Patient

The following applies to the **Treatment Plan** window for one patient:

The default Start Date is one year previous.

If you change the Start Date for the **Treatment Plan** window for one patient, this change stays in effect in future sessions of the GUI application for the **Treatment Plan** window (until you change it again).

10.2.1.2 Treatment Plan Window for All Patients

The following applies to the **Treatment Plan** window for all patients:

The default start date is one year previous.

If you change the start date for the **Treatment Plan** window for all patients, this change stays in effect until you exit the application. When you login the next time, the start date reverts to one year previous.

10.2.2 Treatment Plan Group Box

The **Treatment Plan** group box shows the records within the treatment plan date range. They are in date order.

10.2.3 Add Button

Establish the patient you want to use in the add process. Click **Add** to add a new treatment plan record. You access the **Treatment Plan–Add Treatment Plan** window. Refer to Section 10.3 Add/Edit Treatment Plan Record (GUI) for more information.

10.2.4 Edit Button

Click **Edit** to edit a particular treatment plan record. The application displays the **Treatment Plan–Edit Treatment Plan** window.

10.2.5 View Button

Highlight a treatment plan record and click **View** (or double-click on the plan) to view the selected treatment plan data. The fields are the same as those on the add/edit **Treatment Plan** dialog box. Refer to Section 10.3 Add/Edit Treatment Plan Record (GUI) for more information.

10.2.6 Delete Button

Click **Delete** to delete a particular treatment plan record. The application confirms the deletion.

10.2.7 Print Treatment Plan Button

Click **Print** button to print a particular Treatment Plan record.

The **Print Treatment Plan** button has three options: (1) **Treatment Plan Only**, (2) **Review Data Only**, and (3) **Treatment Plan and Review Data**.

Highlight a record and choose one of the **Print Treatment Plan** options.

If you select **Review Data Only** (2) or **Treatment Plan and Review Data** (3) and if there is one or more reviews, the application displays the **Treatment Plan Reviews** window.



Figure 10-15: Sample **Treatment Plan Reviews** window

Check each Treatment Plan Review record you want to use and click **OK**. Otherwise, click **Close** to exit the print routine.

The application displays the first page of the **Treatment Plan** pop-up window.

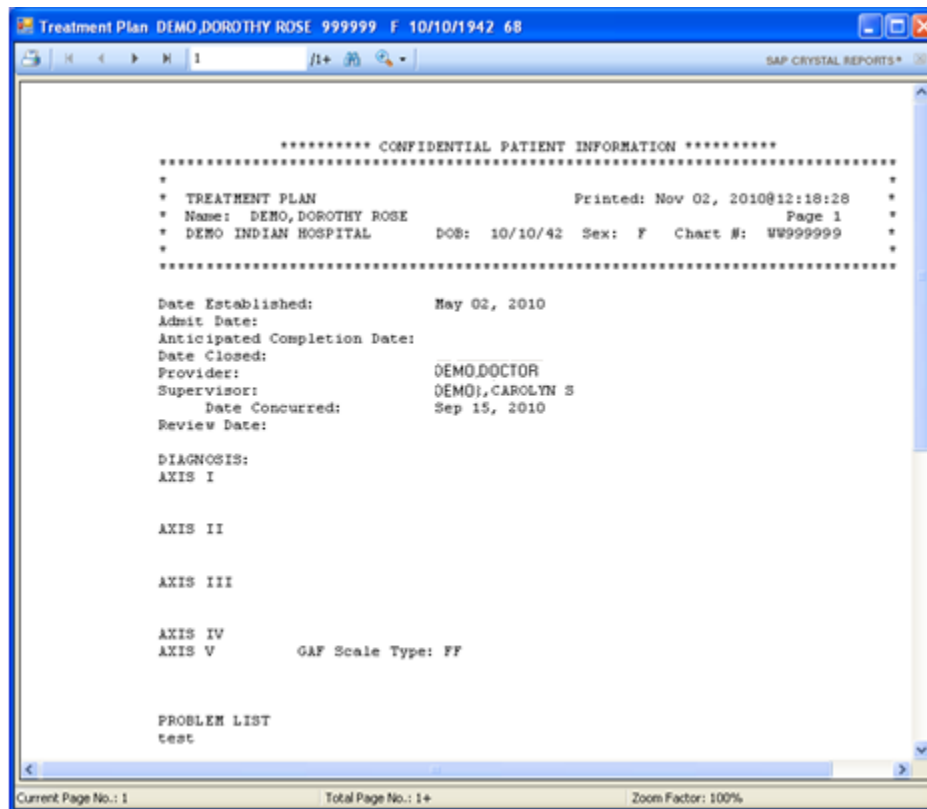


Figure 10-16: Sample **Treatment Plan** pop-up window

Refer to Section 2.6 Pop-up Windows (GUI) for more information about this type of window.

10.2.8 Help

Click **Help** to access the online help system for the **Treatment Plan** window.

10.2.9 Close Button

Click **Close** to dismiss the **Treatment Plan** window.

10.3 Add/Edit Treatment Plan Record (GUI)

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

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

Both windows have the same fields. Below is the **Add Treatment Plan** window.

Treatment Plan - Add Treatment Plan

Treatment Plan Information

Date Established: Friday, January 21, 2011

Next Review Date: Friday, January 21, 2011

Program: [Empty]

Date Completed/Closed: Friday, January 21, 2011

Case Admit Date: Friday, January 21, 2011

Anticipated Completion Date: Friday, January 21, 2011

Designated Provider: DEMO.DOCTOR

Concurring Supervisor: [Empty]

Date Concurred: Friday, January 21, 2011

Problem | Plan | Plan Review

Problem List

Axis I: Clinical Disorders; Other Conditions That May be a Focus of Clinical Attention

Axis II: Personality Disorders; Mental Retardation

Axis III: General Medical Conditions

Axis IV: Major Psychosocial and Environmental Problems

Code	Narrative

Axis V: [Empty] [GAF Scale Type](#) [Empty]

Help Save Close

DEMO,DOROTHY ROSE 999999 F 10/10/1942 68

Figure 10-17: Sample **Add Treatment Plan** window

Click **Help** to access the online help system for the window.

Click **Save** to save the data on the window. The Save function adds/edits the treatment plan record on the **Treatment Plan** window.

Click **Close** to display the **Continue?** dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the add window. Click **No** and you remain on the add/edit treatment plan window.

10.3.1 Treatment Plan Information Group Box

Use the **Treatment Plan Information** group box to manage the basic information about the treatment plan.

The screenshot shows a window titled "Treatment Plan Information". It contains the following fields:

- Date Established**: Friday, January 21, 2011
- Next Review Date**: Friday, January 21, 2011
- Program**: (empty)
- Date Completed/Closed**: Friday, January 21, 2011
- Case Admit Date**: Friday, January 21, 2011
- Anticipated Completion Date**: Friday, January 21, 2011
- Designated Provider**: DEMO DOCTOR
- Concurring Supervisor**: (empty)
- Date Concurred**: Friday, January 21, 2011

Figure 10-18: Sample **Treatment Plan Information** group box

The fields in bold text are required.

- **Date Established**

This is the date the treatment plan was established. The default for a new record is the current date.

- **Next Review Date**

This is the date the treatment plan is expected to be reviewed. Click the drop-down list to access the calendar to change this date. Note that if a **Date Completed/Closed** field is populated, this field will be inactive.

- **Program**

This is the program used in the treatment plan. Click the drop-down list to use one of the following:

- Mental Health
- Social Services
- Other
- Chemical Dependency

- **Date Completed/Closed**

This is the date the treatment plan was completed or closed. Click the drop-down list to access the calendar to change this date.

- **Case Admit Date**

This is the date the patient was admitted into care. Click the drop-down list to access the calendar to change this date.

- **Anticipated Completion Date**

This is the anticipated completion date for the treatment plan. Click the drop-down list to access the calendar to change this date.

- **Designated Provider**

This is the name of the designated provider for the treatment plan. Click the drop-down list to access the **Designated Provider** search/select window where you search for the name of the provider.

- **Concurring Supervisor**

This is the name of the concurring supervisor for the treatment plan. Click the drop-down list to access the **Concurring Supervisor** search/select window where you search for the name of the supervisor.

- **Date Concurred**

This is the date that the concurring supervisor agreed to the treatment plan. This date cannot be before the date established.

10.3.2 Problem Tab

Use the **Problem** tab to manage the Axis I through V data as well as the problem list.

Problem | Plan | Plan Review

Problem List

Axis I: Clinical Disorders; Other Conditions That May be a Focus of Clinical Attention

Axis II: Personality Disorders; Mental Retardation

Axis III: General Medical Conditions

Axis IV: Major Psychosocial and Environmental Problems

Code	Narrative

Axis V: GAF Scale Type

+ Add
X Delete

Figure 10-19: Sample **Problem** tab

10.3.2.1 Problem List Group Box

Populate this field with the text of the problem.

10.3.2.2 Axis I Group Box

Use the **Axis I** field to enter the text of clinical disorders or other conditions that might be a focus of clinical attention for the treatment plan. This is a free text field.

10.3.2.3 Axis II Group Box

Use the **Axis II** field to enter the text of personality disorders or mental retardation to be used in the treatment plan. This is a free text field.

10.3.2.4 Axis III Group Box

Use the **Axis III** field to enter the text of a general medical condition to be used in the treatment plan. This is a free text field.

10.3.2.5 Axis IV Group Box

Use the **Axis IV** group box to enter one or more of the psychosocial or environmental codes that identify the major category of the problem.

Axis IV: Major Psychosocial and Environmental Problems

Code	Narrative

+ Add
X Delete

Figure 10-20: Sample **Axis IV** group box

Click **Add** to add the codes using the **Axis IV** multiple select window. Here you select the one or more codes to populate this group box.

Click **Delete** to remove a highlighted code. After clicking **Delete**, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected code from the group box (otherwise, click **No**.)

10.3.2.6 Axis V

Use the **Axis V** field to enter the GAF scale value (assessment of the client's functional level). This is a free text field limited to three characters (0–100).

At the **GAF Scale Type** field, populate with the acronym for the specific GAF Scale used, using up to 20 characters in length.

If you click the link on the **GAF Scale Type** label, the application displays the **Global Assessment of Functioning** pop-up window. This provides information about the GAF codes.

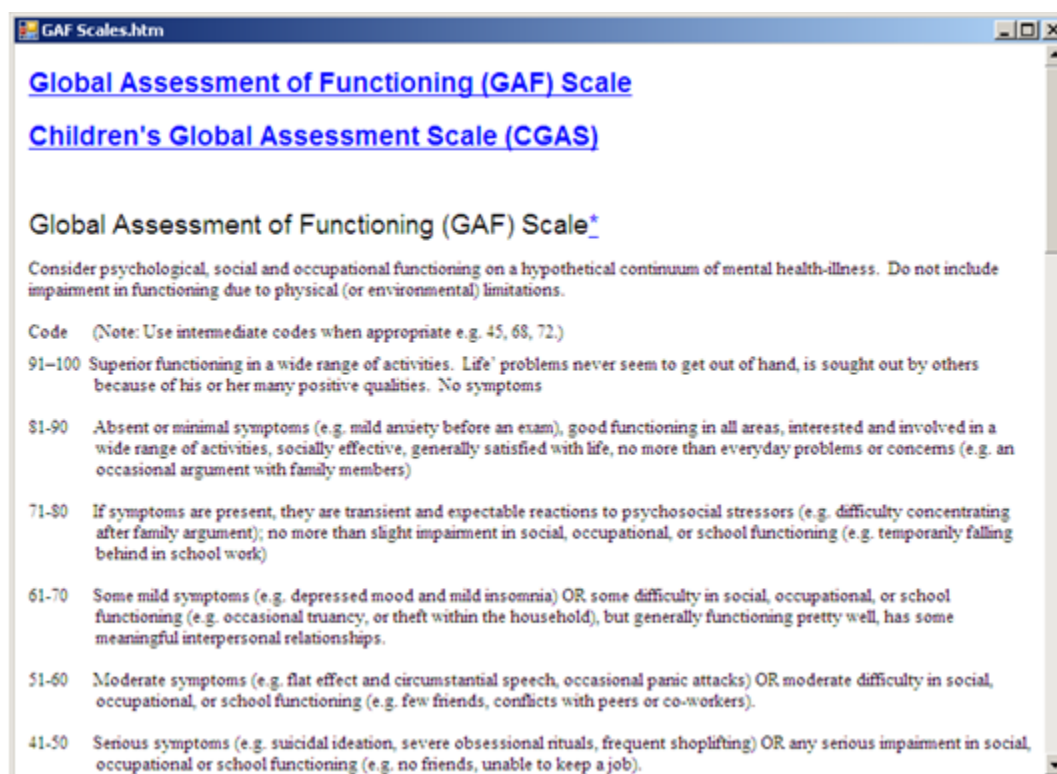


Figure 10-21: Global Assessment of Functioning (GAF) Scale

10.3.3 Plan Tab

Use the **Plan** tab to add participants to the plan as well as describing the Problems/Goals/Objectives/Methods of the plan.

The screenshot shows a software window with three tabs: 'Problem', 'Plan' (selected), and 'Plan Review'. The 'Plan' tab contains two main sections. The top section, titled 'Participants', features a table with two columns: 'Participant' and 'Relationship'. To the right of the table are three buttons: 'Add' (with a green plus icon), 'Edit' (with a pencil icon), and 'Delete' (with a red X icon). The bottom section, titled 'Problems/Goals/Objectives/Methods', is a large, empty rectangular box.

Figure 10-22: Sample **Plan** tab

10.3.3.1 Participants Group Box

Use the **Participants** group box to manage the participants in the treatment plan.

Click **Edit** to change a selected participant record. The application displays the **Treatment Plan Participants** window with the fields populated. This window is reviewed below.

Click **Delete** to delete a selected participant record. The application confirms the deletion.

Click **Add** to add a new participant record. The application displays the **Treatment Plan Participants** window.

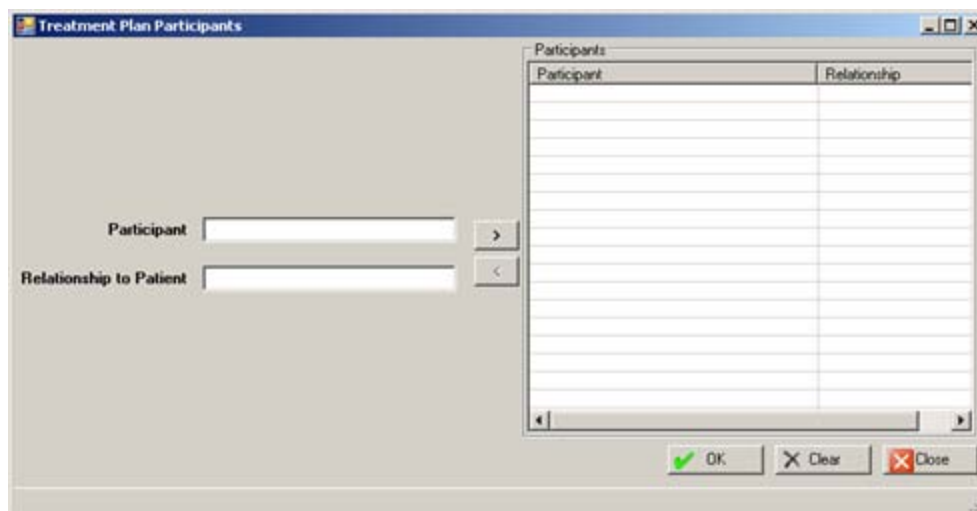


Figure 10-23: Sample **Treatment Plan Participants** window

The **Participant** field is a free text field where you add the participant name.

The **Relationship to Patient** is a free text field where you add the participant's relationship to the patient of the treatment plan.

After completing these fields, click the right-pointing arrow to add the information to the **Participants** group box.

You can remove a highlighted record in the **Participants** group box by clicking the left-pointing arrow.

Use the **Clear** button to remove the data in the **Participant** and **Relationship to Patient** fields.

Use the **OK** button to save the data and to populate the Participants group box on the add/edit treatment plan window **Plan Review** tab.

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

10.3.3.2 Problems/Goals/Objectives/Methods

Populate this field with the text of the problems, goals, objective, or methods for the treatment plan. Refer to Section 2.11 Free Text Fields for more information.

10.3.4 Plan Review Tab

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

Figure 10-24: Sample **Plan Review** tab

When a record is selected in the grid for the plan review, you can do the following:

- Complete the fields for the plan review (below the grid)
- Complete the participants in the plan review (in the **Participants** group box)
- Complete the progress summary for the plan review (in the **Progress Summary** group box)

After you have completed the fields and group boxes, click **OK** (otherwise, click **Cancel**). The OK process saves the plan review record.

10.3.4.1 Review Group Box

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

Click **Delete** to remove a selected review record. After clicking **Delete**, the application displays the **Are You Sure?** confirmation message: Are you sure you want to delete this entry. Click **Yes** to delete (otherwise, click **No**).

Click **Edit** to change a selected review record. The data populates in the fields below the grid.

Click **Add** to add a new review record. You populate the fields below the review grid as well as the **Participants** group box, and the **Progress Summary** field to complete the add process.

The fields for review in bold text are required.

- **Review Date**

This is the date of the review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date.

- **Next Review Date**

This is the date of the next review. The default is the current date for a new record. Click the drop-down list to access the calendar to change the date. Please note that changing the next review date here will also change the next review date on the **Treatment Plan Information** group box.

- **Review Provider**

This is the provider who is doing the review (the default is the current user). Click the drop-down list to access the **Reviewing Provider** search window where you search for the provider name.

- **Review Supervisor**

This is the review supervisor for the treatment plan. Click the drop-down list to access the **Reviewing Supervisor** search window where you search for the supervisor name.

10.3.4.2 Participants Group Box (Plan Review)

Use the **Participants** group box to show the participants in the plan review. Click **Add** to access the **Treatment Plan Participants** window. Refer to Section 10.3.3.1 Participants Group Box for more information about completing this window.

Click **Edit** to edit a selected Participants record. The application displays the **Treatment Plan Participants** window with the fields populated with the current data. Refer to Section 10.3.3.1 Participants Group Box for more information about this window.

Click **Delete** to delete a selected Participants record. The application confirms the deletion by displaying the **Are You Sure?** confirmation message: Are you sure you want to delete this entry. Click **Yes** to delete (otherwise, click **No**).

10.3.4.3 Progress Summary

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

11.0 Suicide Forms

You can manage suicide forms in the roll-and-scroll application, as well as in the RPMS Behavioral Health System (GUI).

Please note: all of the fields are mandatory but not enforced. This means if you do not populate all of the fields, you can still save, but that suicide form will be considered incomplete. If you do complete all of the fields, the suicide form will be considered complete.

11.1 Suicide Reporting Forms (Roll and Scroll)

Use the SF (Suicide Reporting Forms–Update/Print) option on the IHS Behavioral Health System Data Entry Menu to manage suicide forms in the roll-and-scroll application.

The Add/Update Suicide Forms option on the Other Information window also accesses the suicide reporting forms.

After using the SF option, the application displays the following two options:

SFD	Review Suicide Reporting Forms by Date
SFP	Update Suicide Reporting Form for a Patient
Select Suicide Reporting Forms - Update/Print Option:	

Figure 11-1: Options available for managing suicide forms

11.1.1 Update Suicide Reporting Form for a Patient (SFP)

Use the SFP option to update the suicide report for a specified patient.

Below are the prompts.

- “Select Patient Name”

Specify the patient you want to use.

The application displays the View/Update Suicide Form window for the selected patient.

View/Update Suicide Form	Apr 14, 2009 15:41:17	Page: 1 of 9
Suicide Forms on File for: ALPHAA,CHELSEA MARIE		
HRN: 116431 FEMALE DOB: Feb 07, 1975		
Tribe: TOHONO O'ODHAM NATION OF Community: TATRIA TOAK		
1) Local Case #: Computer Case #: 505901090420060000034642		
Date of Act: SEP 04, 2006 Provider: GAMMAAA,DENISE		
Suicidal Behavior: ATTEMPT		

```

Method: HANGING  OTHER
2) Local Case #:          Computer Case #: 505901122420060000048688
   Date of Act: DEC 24, 2006   Provider: GAMMAAAA, JAMES N
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method:
   [Incomplete Form]
3) Local Case #:          Computer Case #: 505901013120070000048688
   Date of Act: JAN 31, 2007   Provider: BETAAA, LINZA
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method: OVERDOSE
4) Local Case #:          Computer Case #: 505901022220070000034642
+      ?? for more actions + next screen - prev screen
AF  Add a Suicide Form      BV  Browse Visits for this Patient
EF  Edit a Suicide Form     HS  Health Summary for this Patient
DF  Display a Suicide Form  Q   Quit
XF  Delete a Suicide Form
Select Item(s): Next Screen//

```

Figure 11-2: Sample View/Update Suicide Form window for the current patient

If any of the suicide forms are incomplete, the message “[Incomplete Form]” will display as the last line under the particular case.

Use the Quit action to dismiss this window.

11.1.1.1 Add/Edit Suicide Form

The Add and Edit functions use the same update form.

11.1.1.1.1 Add a Suicide Form (AF)

Use the AF action to add a suicide form for the current patient.

Below are the prompts.

- “Provider Completing the form”
This is the name of the provider who is completing the form.
- “Enter the Date of the Suicide Act”
Specify the date of the suicide act.

The application displays the Updating IHS Suicide Form window.

11.1.1.1.2 Edit a Suicide Form (EF)

Use the EF action to change a selected suicide form. The application displays the Updating IHS Suicide Form window.

11.1.1.1.3 Updating IHS Suicide Form

Below is a sample Updating IHS Suicide Form.

```

***  UPDATING IHS SUICIDE FORM  ***  F1 E to exit  ***

```

Patient: ALPHAA,CHELSEA MARIE	FEMALE	HRN: 116431
DOB: Feb 07, 1975	Community Res: TATRIA TOAK	
Tribe: TOHONO O'ODHAM NATION OF ARIZONA		
Computer Generated Case #: 5059011224200600000486		
Provider: LAMBDA,JAMES N	Initials:	Discipline:

1. Local Case #:	<u>Provider</u> : THETAAA,JAMES	
7. Employment Status:		
8. Date of Act: DEC 24,2006	11. Community where act Occurred:	
12. Relationship Status: SINGLE	13. Education: COLLEGE GRAD	
14. Suicidal Behavior: IDEATION W/ PLAN AND INTENT		
15. Method (press enter):	16. Previous Attempts: 2	
17. Substance Use Involved:	18. Location of Act: HOME OR VICINI	
19. Contributing Factors (press enter):		
20. Disposition: IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY)		
21. Other Relevant Information:		

COMMAND:	Press <PF1>H for help	
Insert		

Figure 11-3: Sample Updating IHS Suicide Form window

The underlined fields are required.

- **Local Case #**
This is a local case number generated by the site (use 1–20 characters).
- **Provider**
This is the provider reporting this suicide case (the provider completing the form).
- **Employment Status**
This is the employment status of the patient. Type one of the following: **P** (part time), **F** (full time), **S** (self employed), **UE** (unemployed), **R** (retired), **ST** (student), **SE** (student and employed), **UNK** (unknown).
- **Date of Act**
This is the date of the suicide act. The default is the current date (can be changed).
- **Community where Act Occurred**
This is the name of the community where the suicide act occurred.
- **Relationship Status**
This is the relationship status. Type one of the following: **1** (single), **2** (married), **3** (divorced/separated), **4** (widowed), **5** (cohabiting/common law), **6** (same sex partnership), **9** (unknown).

- Education

- This is the level of patient's education. Type one of the following:
- **1**–Less than 12 years
- **2**–High School Graduate/GED
- **3**– College/Technical School
- **4**–Collage Graduate
- **5**–Post Graduate
- **6**–Unknown

If you use the “less than 12 years” option, the application asks for the following information: If less than 12 years, highest grad completed. Use any whole number between 0 and 12.

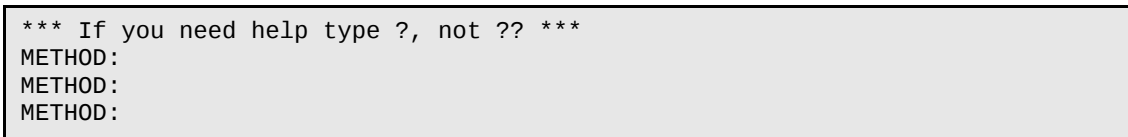
The following fields are on the Updating IHS Suicide Form window.

- Suicidal Behavior

This is the suicidal behavior for the suicide act.

- Method (press Enter)

Press Enter to access the following pop-up.



```
*** If you need help type ?, not ?? ***
METHOD:
METHOD:
METHOD:
```

Figure 11-4: Sample fields on the pop-up

- **Method:** Populate the with a suicide method. More than one can be used. If you use Other in the Method field, the application asks the following information: Please describe the “OTHER” Method. Use between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

- Previous Attempts

Populate with the number of previous suicide attempts. Type one of the following:

- **0** 0
- **1** 1
- **2** 2
- **3** 3 or more
- **U** Unknown

- Substance Use Involved

Populate with the substance use involved in the suicide act. Type one of the following: **1** (none), **2** (alcohol and other drugs), **U** (unknown).

If you type **2**, the application displays the list of drug choices type.

For a list of drug choices type ??

SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:

Figure 11-5: Sample of list of drug choices used

If you type **OTHER** at the “SUBSTANCE DRUG USED” prompt, the application asks for the following information: Drug if other. Use between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

- Location of Act

Populate with the location of the act.

If you type **Other** in the Location of Act field, the application asks the following information: Location of Act If Other. Use between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

- Contributing Factors (press Enter)

Press Enter to access the Contributing Factors pop-up.

Enter all Contributing Factors. To see a list of choices type ??

FACTOR:
FACTOR:
FACTOR:

Figure 11-6: Fields on the pop-up

- **Factor:** Populate with the contributing factor. More than one can be used. You cannot enter **UNKNOWN** if other legitimate values have already been entered. If you want to enter **UNKNOWN** you must first delete (using the '@') all other entries (the application confirms the deletion).

If you type **OTHER** at the “FACTOR” prompt, the application asks the following information: Enter a brief description of the “Other” Contributing Factor. Use between 1 and 40 characters.

The following fields are on the Updating IHS Suicide Form window.

- Disposition

Populate with the disposition of the suicide act.

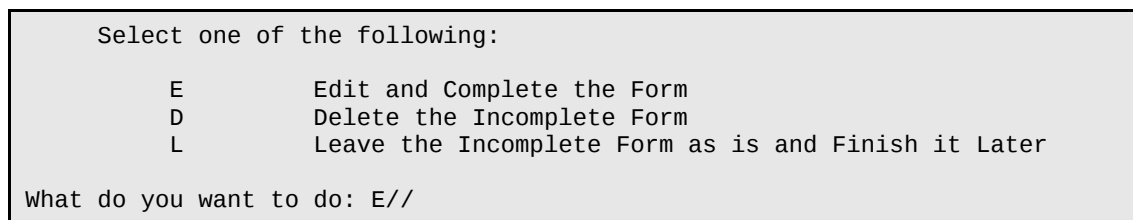
If you type **OTHER** at the “Disposition” prompt, the application prompts for the following information: Disposition If Other. Use between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

- Other Relevant Information

Press Enter to access another window where you populate the field with text of the other relevant information about the suicide act.

After you leave the suicide form and if there are any missing data, the application lists what is missing and lists what actions you can take:



Select one of the following:

E	Edit and Complete the Form
D	Delete the Incomplete Form
L	Leave the Incomplete Form as is and Finish it Later

What do you want to do: E//

Figure 11-7: List of actions you can take

If you indicate **E**, you return to the form where you can edit and complete it.

If you indicate, **D**, the application will delete the form (there is no confirmation).

If you indicate **L**, you leave the form incomplete (as is) and can finish it later.

11.1.1.2 Display a Suicide Form (DF)

Use the DF action to display a specified suicide form.

Below are the prompts.

- Select Suicide Reporting Form List (1-x) (where x is the number of last form)
Specify the suicide form you want to display.
- Do you wish to
Type **P** (print output) or **B** (browse output on screen)

The application displays the form on the Output Browser where you can browse the Suicide Reporting Form on the screen.

OUTPUT BROWSER	Apr 14, 2009 16:25:44	Page: 1 of 3
***** CONFIDENTIAL PATIENT INFORMATION [ST] Apr 14, 2009 ***** Suicide Reporting Form Date Printed: Apr 14, 2009		
1. Case #: 505901122420060000048688 Local Case #:		
2. PROVIDER INITIALS: RWL 3. PROVIDER DISCIPLINE: NUTRITION TECHNIC		
4. SEX: FEMALE 5. DOB: FEB 07, 1975 6. AGE: 31		
7. EMPLOYMENT STATUS:		
8. DATE OF ACT: DEC 24, 2006		
9. TRIBE: TOHONO O'ODHAM NATION OF ARIZONA		
10. COMMUNITY OF RESIDENCE: TATRIA TOAK		
11. COMMUNITY WHERE ACT OCCURRED:		
12. RELATIONSHIP STATUS: SINGLE		
+ Enter ?? for more actions		
>>>		
+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT		
Select Action: +/-		

Figure 11-8: Sample Output Browser window for suicide act

11.1.1.3 Delete a Suicide Form (XF)

Use the XF action to remove a selected suicide form record.

Below are the prompts.

- “Select Suicide Reporting Form List (1-x) (where x is the number of last form)”
Specify the suicide form you want to remove.
- “Are you sure you want to delete this suicide form?”
Type **Y** (yes) or **N** (no).

11.1.1.4 Browse Visits for this Patient (BV)

Use the BV action to browse the BH visits for the current patient.

Below are the prompts.

Type one of the following: **L** (patient's last visit), **N** (patient's last n visits), **D** (visits in a date range), **A** (All of this patient's visits), or **P** (visits to one program). If you use **N**, **D**, or **P**, other prompts will display.

The application display the BROWSE PATIENT'S VISITS window.

11.1.1.5 Health Summary for this Patient (HS)

Use HS to display/print a particular health summary for the current patient. After typing **HS**, the application displays the health summary for this patient on the Output Browser window.

11.1.2 Review Suicide Forms by Date (SFD)

Use the SFD option to review the suicide forms in a particular date range.

Below are the prompts.

- “Enter Beginning Suicide form date”
Specify the beginning date of the date range.
- “Enter Ending Suicide form date”
Specify the ending date of the date range.

The application displays the Review Suicide Reporting Forms window.

REVIEW SUICIDE REPORTING FORMS					Oct 04, 2010 12:14:10	Page:	1 of 2
Suicide Form Review:					Jul 06, 2010 - Oct 04, 2010		
I = Incomplete Form							
No.	Date	Patient	HRN	DOB	Suicidal Behavior	PRV	Loc
1)	I 09/29/10	CHI, ROBERT MITCHELL	186585	02/19/98		MAW	123
2)	09/23/10	CHI, JIMMY RAY	146733	07/14/90	ATTEMPTED SUICIDE	WI	RJG 222
3)	I 09/16/10	CHI, ROBERT MITCHELL	186585	02/19/98			RJG
4)	09/15/10	CHIY, ROBERT MITCHELL	186585	02/19/98	ATTEMPT		RJG 798
5)	I 09/15/10	THETA, CHARLES	109767	10/27/60	IDEATION WITH PLAN A	RJG	
6)	I 09/13/10	THETA, CYNTHIA MAE	110301	12/26/64			LB
7)	I 09/01/10	CHI, ROBERT MITCHELL	186585	02/19/98			RJG
8)	08/30/10	ABELL, WALTER JR	211438	01/15/04	COMPLETED SUICIDE	WI	BH
9)	08/27/10	CHI, ROBERT MITCHELL	186585	02/19/98	IDEATION WITH PLAN A	RJG	
10)	I 08/11/10	SEASEAA, ALICIA MARI	169379	05/26/52	ATTEMPTED SUICIDE	WI	BJB
11)	I 08/10/10	SEASEAA, ALICIA MARI	169379	05/26/52	ATTEMPT		BJB
12)	I 08/10/10	TEST, BARBARA	28989	01/01/90			SPR
13)	I 08/09/10	SEASEAA, ALICIA MARI	169379	05/26/52	ATTEMPTED SUICIDE	WI	BJB
+ Enter ?? for more actions					>>>		
AF	Add Form	DE	Delete Form	Q	Quit		
EF	Edit Form	+	Next Screen				
DF	Display Form	-	Previous Screen				
Select Action: +//							

Figure 11-9: Sample Review Suicide Report Forms window

The letter I to the left of the Date of Act represents the Incomplete Suicide Reporting Forms.

Refer to Section 11.1.1 Update Suicide Reporting for a Patient for more information about the add/edit/delete functions on this window.

11.2 Suicide Form Window (GUI)

The suicide form options are located under the **Suicide Reporting Forms** category on the tree structure for the RPMS Behavioral Health System (GUI) application.

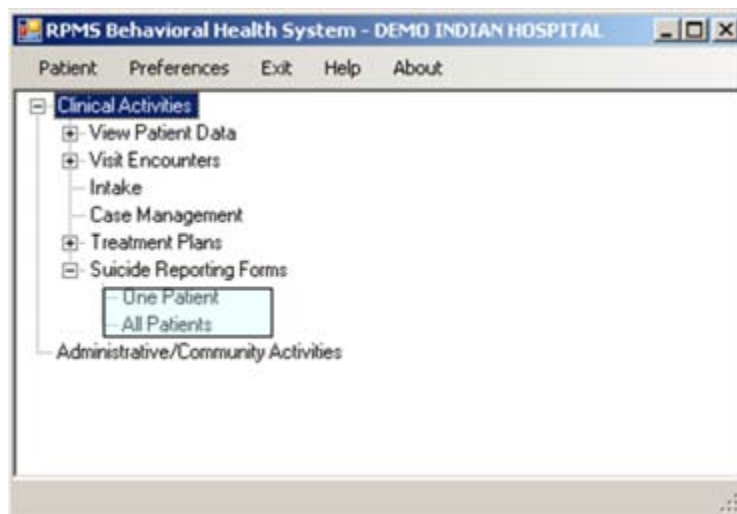


Figure 11-10: Location of Suicide Forms on the tree structure

One way to access the **Suicide Form** window is to select the **One Patient** option. Note: you can access this window if you click the **Suicide Form** tab on the **Visit Data Entry–Add/Edit** window. The application displays the **Suicide Form** window for one patient. If you access the Suicide Form for one patient window and there is no current patient, you will be asked to select one.

Date	Local Case #	Provider	Suicidal Behavior
11/29/2010		DEMO,DOCTOR	
09/25/2010		DEMO,CASE M	
09/30/2009			ATTEMPT

DEMO,DOROTHY ROSE 999999 F 10/10/1942 68

Figure 11-11: **Suicide Form** window for one patient

Another way to access the **Suicide Form** window is to select the **All Patients** option. The application displays the **Suicide Form** window for all patients.

The screenshot shows a window titled "Suicide Form" with a menu bar (Add, Edit, View, Delete, Print, Help, Close) and a "Suicide Form Date Range" section. The date range is set from Wednesday, February 10, 2010, to Thursday, February 10, 2011. Below this is a table with the following data:

	Date	Patient	Chart	Sex	DOB	Local Case #	Provider	Suicidal Behavior
I	11/29/2010	DEMO,DOROTHY ROSE	999999	F	10/10/1942		DEMO,DOCTOR	
I	09/25/2010	DEMO,DOROTHY ROSE	999999	F	10/10/1942		DEMO,CASE M	

At the bottom right of the window, it says "Loaded .j2".

Figure 11-12: Sample **Suicide Form** window for all patients

Both windows function in the same way.

11.2.1 Suicide Form Date Range

The suicide form records are in the suicide form date range.

You can change the date range by clicking the drop-down list and selecting a new date from the calendar. After all changes to the date range are complete, click **OK**. The window redisplay, showing the information for the new date range.

11.2.1.1 Suicide Form Window for One Patient

The following applies to the **Suicide Form** window for one patient:

The default start date is one year previous.

If you change the start date for the **Suicide Form** window for one patient, this change stays in effect in future sessions of the GUI application for the **Treatment Plan** window (until you change it again).

11.2.1.2 Suicide Form Window for All Patients

The following applies to the **Suicide Form** window for all patients:

The default start date is one year previous.

If you change the start date for the **Suicide Form** window for all patients, this change stays in effect until you exit the application. When you login the next time, the start date reverts to one year previous.

Note: If you change the start date for the **Suicide Form** window for one patient, this change stays in effect in future sessions of the GUI application for the **Visit** window for one patient, the **Suicide Form** window for one patient, and the **Treatment Plan** window for one patient windows.

Similarly, if you change the start date for the **Suicide Form** window for all patients, this change stays in effect in future sessions of the GUI application for the **Visit** window for all patients, the **Suicide Form** window for all patients, and the **Treatment Plan** window for all patients windows.

11.2.2 Suicide Form Group Box

The **Suicide Form** group box displays the suicide form records in the date range. The records are listed by date. The “I” in the first column of the grid indicates the suicide form is incomplete.

11.2.3 Add Button

Establish the patient you want to use in the add process. Click **Add** to add a new suicide form record. You access the **Visit Data Entry–Add Suicide Entry** window. Refer to Section 11.3 Add/Edit Suicide Form (GUI) for more information.

11.2.4 Edit Button

Click **Edit** to edit the highlighted suicide form for the current patient on the **Visit Data Entry–Edit Suicide Entry** window. The **Edit** button will be inactive if the patient does not have any previous visits (applies to the suicide form for the current patient). Refer to Section 11.3 Add/Edit Suicide Form (GUI) for more information.

11.2.5 View Button

Click **View** (or double-click on a form) to browse the highlighted suicide form record. The application displays the **Suicide Form Data Entry–View Suicide Form** window. This is a view-only window has the same fields as the **Add/Edit Suicide Form** window.

11.2.6 Delete Button

Click **Delete** to remove the highlighted suicide form record. After clicking Delete, the **Are You Sure?** confirmation message displays, asking if you are sure you want to delete. Click **Yes** to remove the selected suicide record (otherwise, click **No**.)

11.2.7 Print Button

Click **Print** on the **Suicide Form** window to output the highlighted suicide form record. After clicking **Print**, the application displays the first page of the **Suicide Reporting Form** pop-up window.

***** CONFIDENTIAL PATIENT INFORMATION [ST] Nov 02, 2010 *****
Suicide Reporting Form Date Printed: Nov 02, 2010

1. Case #: 505901092520100000060849 Local Case #:
2. PROVIDER INITIALS: ST 3. PROVIDER DISCIPLINE: PHYSICIAN
4. SEX: FEMALE 5. DOB: OCT 10, 1942 6. AGE: 68
7. EMPLOYMENT STATUS:
8. DATE OF ACT: SEP 25, 2010
9. TRIBE: CHEROKEE NATION, OK
10. COMMUNITY OF RESIDENCE: MOAB
11. COMMUNITY WHERE ACT OCCURRED:
12. RELATIONSHIP STATUS:
13. EDUCATION:
14. SUICIDAL BEHAVIOR:
15. METHOD:
16. PREVIOUS ATTEMPTS:
17. SUBSTANCE USE INVOLVED:
18. LOCATION OF ACT:
19. CONTRIBUTING FACTORS:
20. DISPOSITION:
Other Relevant Information: (OPTIONAL)

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

Figure 11-13: Sample Suicide Reporting Form

This window contains the following:

- Data from the Suicide Form
- Patient data, such as sex, DOB, Age
- Edit history, such as date last modified, user last update, and each update including date and time + person who modified

Refer to Section 2.6 Pop-up Windows (GUI) for more information about this type of window.

11.2.8 Help Button

Click **Help** to access the online help system for the **Suicide Form** window.

11.2.9 Close Button

Click **Close** to close the **Suicide Form** window.

11.3 Add/Edit Suicide Form (GUI)

Below are the fields on the **Suicide Form Data Entry–Add Suicide Form** window. (The same fields display on the **Suicide Form Data Entry–Edit Suicide Form** window.)

The screenshot shows the 'Suicide Form Data Entry - Add Suicide Form' window. It features several input fields and dropdown menus for data entry. The fields include: Local Case Number, Date of Act (set to Monday, September 21, 2009), Provider (set to DEMO_DOCTOR), Community Where Act Occurred, Relationship Status, Employment Status, Education, If less than 12 years, highest grade completed, Suicidal Behavior, Previous Attempts, Disposition, Location of Act, and # other. There is a section for Method with checkboxes for Gunshot, Hanging, Motor Vehicle, Jumping, Stabbing/Laceration, Carbon Monoxide, Overdose, Other, and Unknown. A table for Overdose substances is also present with columns for Substance and Substance If Other. Buttons for Help, Save, and Close are located at the bottom of the window.

Figure 11-14: Sample **Suicide Form Data Entry–Add Suicide Form** window

Click **Save** to save the information on this window.

All fields except the **Local Case Number** and the **Narrative** are required in order to save. If you try to save and have not completed the fields, the application displays the **Required** dialog box.

The screenshot shows a 'Required' dialog box. It has a blue header bar with the word 'Required'. Below the header is an information icon and a message: 'All of the fields on the Suicide Report Form, except Narrative, are required to complete a form. Would you like to save the form as it is and complete it later?'. At the bottom are two buttons: 'Yes' and 'No'.

Figure 11-15: **Required** dialog box

- Click **Yes** to save the form and complete it later; you return to the **Suicide Form** window.
- Click **No** to not save and you remain on the data entry form.

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

Click **Close** to display the **Continue?** dialog box. This dialog box states: Unsaved Data Will Be Lost, Continue? Click **Yes** to not save; this dismisses the **Add** window. Click **No** and you remain on the add window where you can continue work on the suicide form.

Some fields use free text. Refer to Section 2.11 Free Text Fields for more information.

Some fields use dates. Refer to Section 2.7 Using the Calendar for more information.

11.3.1 Suicide Form Fields

The required fields are in bold text.

- **Local Case Number**

Populate with the local case number or a health record number, if any (limited to 20 characters). This is a free form text field.

- **Provider**

For a new record, the application automatically populates this field with the current logon provider. To change click the drop-down list to access the **Provider** search window where you search for the provider name.

- **Date of Act**

For a new record, the application automatically populates this field with the current date. To change click the drop-down list to access a calendar where you select another date.

- **Community Where Act Occurred**

Populate with the community where the act occurred. To change click the drop-down list to access the **Community** search window where you search for the community name.

- **Relationship Status**

This is the relationship status. Use one of the following:

- Single
- Married
- Divorced/Separated
- Widowed
- Cohabiting/Common Law
- Same Sex Partnership

- Unknown

- **Education**

This is the level of education of the patient. Use one of the following:

- Less than 12 years
- High School Graduate/GED
- Some College/Technical School
- Collage Graduate
- Post Graduate
- Unknown

- **Employment Status**

This is the status of the patient's employment. Click the drop-down list and use one the options.

- **If less than 12 years, highest grade completed**

This field becomes active when you populate the **Education** field with 'Less than 12 years'. Populate with the number representing the highest grade completed in education (1–11).

- **Suicidal Behavior**

This is the type of suicidal activity. Click the drop-down list and use one the options.

- **Location of Act**

This is the location of the suicidal act. Click the drop-down list and use one of the options.

- **Previous Attempts**

This is the previous suicide attempts. Use one of the options available on the drop-down list.

- **if other**

This field becomes active if you populate the **Location of Act** field with **Other**. Populate the **If Other** free text field where the suicidal act occurred (limited to 80 characters).

- **Disposition**

Populate with the disposition of the suicide act. Click the drop-down list and use one the options.

If you populate this field with **Other**, the field to the right becomes active.
Populate this free text field with the disposition of the suicide act (limited to 80 characters).

11.3.2 Method Tab

Use the **Method** tab to indicate the method used in the suicide act as well as indicate the substance used in overdose cases.

Figure 11-16: Sample **Method** tab

11.3.2.1 Method Group Box

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

If you select the **Overdose** check box, the application displays the **Substance** multiple select window where you can add one or more categories of substances. When this window is complete, click **OK**. This action adds the substances to **Overdose** group box.

If you select a substance with OTHER in its name and then click **OK**, the **OTHER** window displays.

Figure 11-17: Sample **Other** window

You must populate the **Other** field (limited to 80 characters). (You cannot dismiss the dialog.) Click **OK** (otherwise, click **Close**). The OK function populates the **Substance If Other** cell on the **Overdose** group box.

If you select the **Other** check box, the field below the check box becomes active.
Populate this free text field with the text that describes the other method used in the suicide act (limited to 80 characters).

11.3.2.2 Overdose Group Box

If you select the **Overdose** check box under Method, the **Overdose** group box becomes available. This group box contains the categories of substances used in the overdose suicidal act. Once it is populated, the **Add**, **Edit**, and **Delete** buttons become active.

Click **Add** to add one or more new records. The application displays the **Substance** multiple select window where you can add one or more substances. When this window is complete, click **OK**. This action adds the substances to **Overdose** group box.

If you select a substance with Other in the title on the **Substance** multiple select window, the application displays the **Other** window.



Figure 11-18: **Other** window

Populate the **Other** free text field with the substance used in the overdose (limited to 80 characters). Click **OK** (otherwise, click **Close**). The OK function populates the **Substance if Other** column on the grid.

Highlight the record with data in the **Substance if Other** column and click **Edit** to display the **Other** window. The application displays the current **Substance If Other** data in the **Other** field. You can change the data, as needed. Click **OK** to dismiss the **Other** window.

Click **Delete** to remove a selected substance record (in the **Overdose** group box). The application confirms the deletion.

11.3.3 Substance Use Tab

Use the **Substance Use** tab to indicate the substances involved in the suicide incident as well as the categories of the substances involved.

Figure 11-19: Sample **Substance Use** tab

11.3.3.1 Substances Involved in This Incident Group Box

Select one of the check boxes in this group box that describes the substance used in the suicide act. At least one is required.

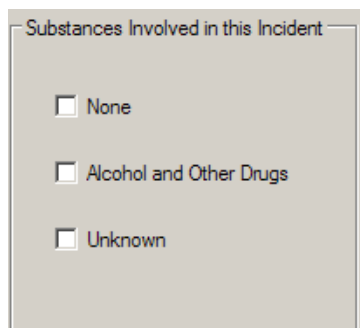
A screenshot of a software window titled "Substances Involved in this Incident". It contains three vertically stacked checkboxes, each with a label to its right: "None", "Alcohol and Other Drugs", and "Unknown". All checkboxes are currently unchecked.

Figure 11-20: **Substances Involved This Incident** group box

If you select the **Alcohol and Other Drugs** check box, the application displays the **Substance** multiple select window where you can add one or more substances. When this window is complete, click **OK** (otherwise, click **Cancel**). The OK function adds the substances to **Substances Involved** group box.

If you select the **Other** option (on the **Substance** multiple select window), the application displays the **Other** window.

A screenshot of a software window titled "OTHER". It features a text input field with the placeholder text "Other". To the right of the input field are two buttons: "OK" with a green checkmark icon and "Close" with a grey 'X' icon.

Figure 11-21: **Other** window

- **Other:** Populate the free text field with the “other” substance used in this incident (limited to 80 characters). When this window is complete, click **OK** (otherwise, click **Close**). The OK function populates the **Substances Involved** group box.

If you deselect the **Alcohol and Other Drugs** check box, this action clears any data in the **Substances Involved** group box.

11.3.3.2 Substances Involved Group Box

Substance	Substance If Other
HALLUCINOGENS	
OTHER	Other vapors

Figure 11-22: Sample **Substances Involved** group box

This group box contains the substances used immediately before or during the suicidal act. Once the **Alcohol and Other Drugs** checkbox is selected, the **Add**, **Edit**, and **Delete** buttons become active.

Click **Add** to add one or more new records. The application displays the **Substance** multiple select window where you can add one or more substances. When this window is complete, click **OK** (otherwise, click **Close**). The OK function adds the substances to the **Substances Involved** group box.

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

Figure 11-23: **Other** window

- **Other:** Populate this free text field with the “other” substance used in this suicide act (limited to 80 characters). When this window is complete, click **OK** (otherwise, click **Close**). The OK function populates the **Substances if Other** column on the grid.

Use the **Edit** button with OTHER records (**Substance If Other** column is populated). Highlight the record and click **Edit** to display the **Other** window. Change the **Other** field and then click **OK** (otherwise, click **Close**). The OK function changes the data in the **Substance If Other** column.

Click **Delete** to remove a highlighted substance record. The application displays the **Are You Sure?** dialog box that asks: Are you sure you want to delete? Click **Yes** (otherwise, click **No**). The Yes function deletes the highlighted substance record.

11.3.4 Contributing Factors Tab

Use the **Contributing Factors** tab to indicate one or more contributing factors associated with the suicide act.

Figure 11-24: Sample **Contributing Factors** tab

Select one or more of the checkboxes that describe the contributing factors for the suicide act. At least one is required.

If you select the **Other** check box, the field below the check box becomes active. Use this free text field to describe the “other” contributing factor (limited to 80 characters).

11.3.5 Narrative Tab

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

Figure 11-25: Sample **Other Relevant Information** field

Populate this field with data that is not included elsewhere. This is *not* where you put the SOAP or progress note.

12.0 Intake

This section addresses how to manage intake/update documents in the roll-and-scroll application and the GUI.

12.1 Intake Documents (Roll and Scroll)

You can add/change/remove an intake document when you exit the visit encounter (display or add/edit) window. After you exit the last screen, the application displays the OTHER INFORMATION window.

```

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

Update, add or append any of the following data

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

```

Figure 12-1: Options on the Other Information menu

Use Option 7 (Add/Update/Print Intake Document) to access the Update BH Intake Document for the selected visit.

The other place you can add/change/remove an intake document is to use the Intake Document (ID) option on the Patient Data Entry window. You will be prompted for a Program (you are associated with). After specifying the program, you access the Update BH Intake Document for the current patient.

```

Update BH Intake Document      Jan 26, 2010 13:27:36      Page:    1 of    1
MENTAL HEALTH INTAKE DOCUMENTS      *unsigned document
Patient Name: DUCK,EDWIN RAY      DOB: JUN 07, 1978      Sex: M      HRN: 105321
                                INITIAL      UPDATE
#  INITIATED  PROGRAM  PROVIDER      UPDATED  PROVIDER

*1  01/26/10  MENTAL H THETA,SHIRLEY      *01/26/10  THETA,SHIRLEY
*2  12/29/09  MENTAL H GAMMAA,RYAN
*3  12/29/09  MENTAL H GAMMAA,RYAN
4   12/29/09  MENTAL H THETA,SHIRLEY      12/29/09  THETA,SHIRLEY
                                *12/29/09  THETA,SHIRLEY
*5  12/29/09  MENTAL H THETA,SHIRLEY

```

*6	12/14/09	MENTAL H	GAMMAA,RYAN	
*7	10/07/09		GAMMAA,RYAN	
				*10/07/09 GAMMAA,RYAN
*8	04/21/09		GAMMAA,RYAN	
	Enter ?? for more actions			
I	Add Initial Intake		D	Delete Intake/Update
E	Edit Initial Intake		P	Display/Print Intake/Update
U	Add/Edit Update		Q	Quit
Select Action: Q//				

Figure 12-2: Sample Update BH Intake Document window

Use the Q (quit) option to exit the Update BH Intake Document window.

The asterisk (*) in the first column indicates that the particular record contains an unsigned intake/update document.

Please note the following information about intake and update documents on the Update BH Intake Document window:

- The intake documents are listed on the left side (under the Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side (under the Date Updated and Update Provider columns).

12.1.1 Add Initial Intake (I)

Use Option I to create an initial intake document for the visit.

After using I, the application displays that it is adding the Intake document for the patient.

Below are the prompts:

- “Do you wish to continue to add the Intake Document?”
Type **Y** to add the Intake document (otherwise, type **N**). If you type **N**, you exit the create process. If you type **Y**, the following prompts continue.
- “DATE”
The default is the current date (you can change). This cannot be a future date.
- “PROGRAM”
The default is Mental Health (you can change).
- “PROVIDER”
This is the provider for the initial intake document.

- “DATE LAST UPDATED”

The default is the current date (you can change). This cannot be future date.

- “NARRATIVE/No Existing Text/Edit?”

Type **Y** to edit the narrative or **N** to not edit the narrative.

If you type **N**, the application creates the Intake document. You must enter the Intake narrative before you can electronically sign the intake document. The application then prompts if you want to enter an intake narrative (Y or N). If you type **N**, you return to the Update BH Intake Document window.

If you type **Y**, you move to another window to enter the text of the narrative. After you save and exit, the application displays the following prompt:

- “Enter your Current Signature Code”

Do one of the following:

- Specify your electronic signature to sign the document. This action marks the document as signed. You cannot edit it.
- Press Enter to not sign the document. After you press Enter, the document is marked as not signed. You can edit it.

12.1.2 Edit Initial Intake (E)

Use Option E to change the selected initial intake document.

- Only the original intake provider or the person who entered the intake document can edit the document; other providers can only view or print the document.
- Editing an initial intake that was created before the installation of BHS v4.0 will result in a prompt to enter the program associated with the intake.

Below are the prompts:

- “CHOOSE”

Type **1** (Edit Initial Intake Document) or **2** (Quit). If you type **2**, you return to the Update BH Intake Document. If you type **1**, the prompts continue.

- “Select Intake (1 of x) where x is the number of the last intake document.”

Specify the intake document you want to edit.

- If the specified intake document has been signed, you cannot edit it.
- If you are not the original author or the person who entered this document, you cannot edit it.

- “DATE”
The default is the current date (you can change). This cannot be a future date.
- “PROGRAM”
The program associated with the intake displays (you can change).
- “PROVIDER”
This is the provider for the initial intake document.
- “DATE LAST UPDATED”
The default is the current date (you can change). This cannot be a future date.
- “NARRATIVE/No Existing Text/Edit?”
Type **Y** to edit the narrative or **N** to not edit the narrative.

If you type **N**, the application displays that the Intake document was created and that an intake narrative must be entered before an electronic signature can be applied. Then the application asks if you want to enter an Intake Narrative (Y or N). If you type **Y**, you return to the Narrative prompts (as above). If you type **N**, you return to the Update BH Intake Document window.

If you type **Y**, you move to another window where you enter the text of the narrative. After you save and exit this window, the prompts continue:

- “Enter your Current Signature Code”
Do one of the following:
 - Specify your electronic signature to sign the document. This action marks the document as signed. You cannot edit it.
 - Press Enter to not sign the document. If you press Enter, the document is marked as not signed. You can edit it.

12.1.3 Add/Edit Update (U)

Use Option U to create a new update to a particular intake document or edit an existing, unsigned one on which you are the provider.

- Only the person who originally entered the intake document or the intake document provider can edit the document
- Other providers can only view or print the document.

Below are the prompts.

- “Select Intake: (1-x) where x is the document number”

Specify the intake document you want to use.

After specifying the document, the application displays the following message:

```

You can either add a new Update to this Intake document or edit an
existing, unsigned one on which you are the provider. Please select an
Update to edit or choose 1 to add a new one or 0 to quit.

      0      Quit/Exit Update
      1      Date Updated: 01/26/10   Provider: THETA,SHIRLEY      MENTAL
HEALTH
      2      Add new Update document
Select Action: (0-1): 0//
  
```

Figure 12-3: Message from the application

Note: If there is no update document to edit, the second choice will *not* display. In this case, there would only be two choices: Quit or Add New Update Document.

- “Select Action”

You can either add a new update to this intake document, quit/exit the update process, or use the option to edit the Update (Choice 2 in Figure 12-3).

- If you select the update choice, the prompts display. These are the same prompts as in Add new Update document.
- If you select the Quit option, you leave the add/edit process.
- If you select the Add new Update document option, the prompts follow.

- “DATE”

The default is the current date (you can change). This cannot be a future date.

- “PROVIDER”

This is the provider for the update document.

- “DATE LAST UPDATED”

The default is the current date (you can change). This cannot be a future date.

- “NARRATIVE”

The application displays the text of the narrative or displays “no existing text” if there is none.

- “Edit?”

Type **Y** to edit the text of the narrative or **N** to not edit the narrative. If you type **Y**, you go to another window where you enter the text of the narrative. After you save and leave this window, the application displays the next prompt.

- “Enter your Current Signature Code”

Do one of the following:

- Specify your electronic signature to sign the document.
- Press Enter to not sign the document

If you press Enter, you can either add a new update to this intake document or edit an existing, unsigned one on which you are the Provider or the person who entered the Intake Document. The application displays the next prompt:

- “Select Action”

You can do one of the following:

```
0  Quit/Exit Update
1  Date Updated: MM/DD/YY   Provider: <provider name>
2  Add new Update document
```

Figure 12-4: Prompts for the actions you can take

The following statements apply to the example shown in Figure 12-4.

- If you use Option 0, you return to the Update BH Intake Document window.
- If you use Option 1, this action has the same prompts as Add/Edit Update (refer to Section 12.1.3 Add/Edit Update).
- If you use Option 2, this action has the same prompts as Add/Edit Update (Section 12.1.3 Add/Edit Update).

12.1.4 Delete Intake/Update (D)

Use Option D to do one of the following:

1. Delete Intake/Update
2. Display/Print Intake/Update

12.1.4.1 Delete Intake/Update

You can delete only unsigned Intake documents you entered or on which you are the provider, unless you possess a special key or are listed on the Delete Override list.

Below are the prompts:

- Select Intake

Specify the Initial Intake you want to delete, or the Initial Intake with the Update you want to delete.

The application gives you the following choices:

0	Quit/Exit
1	Date MM/DD/YY Provider: <provider name>

Figure 12-5: Actions to take

The following statements apply the example shown in Figure 12-5.

If you use Option 0, you return to the Update BH Intake Document window.

You can use Option 1 if you are the intake provider or the person who entered this Initial Intake document. If you meet one of the criteria, the application displays that you can now select which Intake or Update document to delete. Initial Intake documents that have Updates associated with them cannot be deleted.

When you specify a document to delete, the application prompts: “Are you sure you want to delete this <name of document> document?” Type **Y** to delete or **N** to not delete.

If there are multiple documents you want to delete, the application repeats the process.

12.1.4.2 Display/Print Intake/Update

This action is the same as using Option P on the Update BH Intake Document window. Refer to Section 12.1.5 Print Intake Document.

12.1.5 Print Intake Document

Use Option P to print/browse a particular intake document.

Below are the prompts.

- “Select Intake Update (1-x) where x is the number of the last intake record”
Specify the document you want to display/print.
- “What would you like to print”
Type **I** (Intake document only), **U** (Update document only), **B** (both the Intake and Update documents), **Q** (quit/exit).

If you type **Q**, you return to the previous window.

If you type **U**, another menu is displayed listing each of the updates and an option to print all updates.

If you type **B**, other prompts will display.

- “Do you wish to”

Type **P** to print output on paper or **B** browse output on screen.

Below is sample Intake only report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
*****
*
* INTAKE DOCUMENT Printed: Aug 30, 2009@16:31:52 *
* Name: ALPHAA,CHELSEA MARIE Page 1 *
* DEMO INDIAN HOSPITAL DOB: 2/7/75 Sex: F Chart #: WW116431 *
*
*****
Date Established: MAY 12, 2009
Author/Provider: THETA,SHIRLEY
Program: MENTAL HEALTH
Type of Document: INITIAL

Intake Documentation/Narrative: This is a 34-year old female requesting
antidepressant medications, stating that she ran out of her previous prescription
since moving back to the reservation.

_____
DATE

_____
DATE

```

Figure 12-6: Sample intake document report

12.2 Intake (GUI)

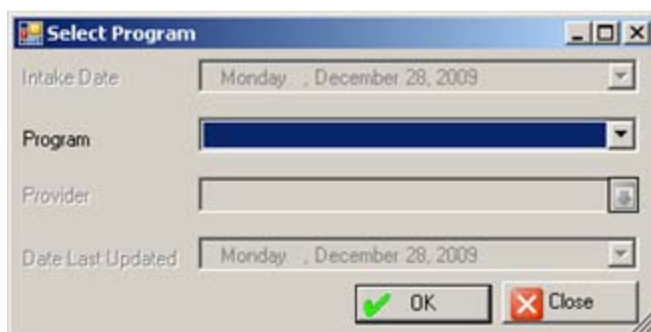
There are two ways to work with the Patient Intake documents in the GUI:

- Method 1: Use the **Intake** option on the GUI tree structure.
- Method 2: Use the **Intake** tab on the **Add/Edit Visit Data Entry** window.

Either method accesses the same **Intake** window.

The following provides information about using the Intake option on the GUI tree structure.

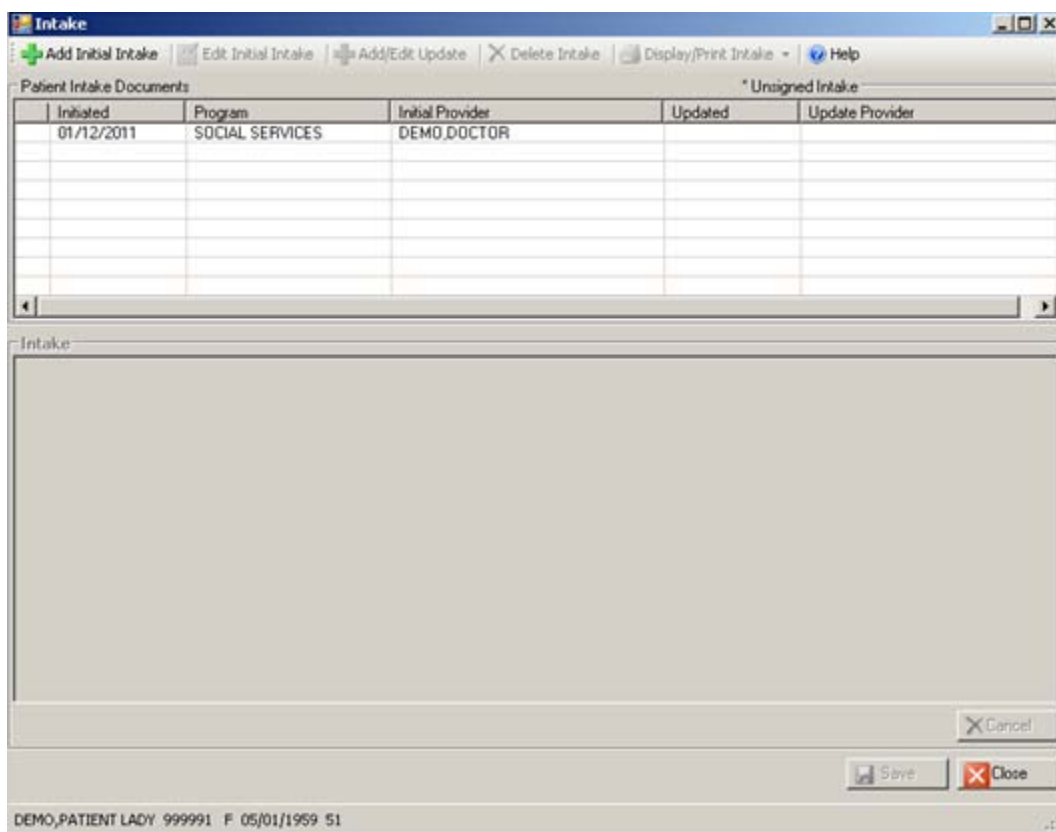
The **Intake** option applies to the current patient. After selecting the **Intake** option, the application displays the **Select Program** window.

Figure 12-7: **Select Program** window

Click the drop-down list for the Program field and select an option. Then click **OK** (otherwise click **Close**).

The OK process displays the Intake window listing the intake documents for the particular program for the current patient. The current patient's name appears in the lower, left corner of the window.

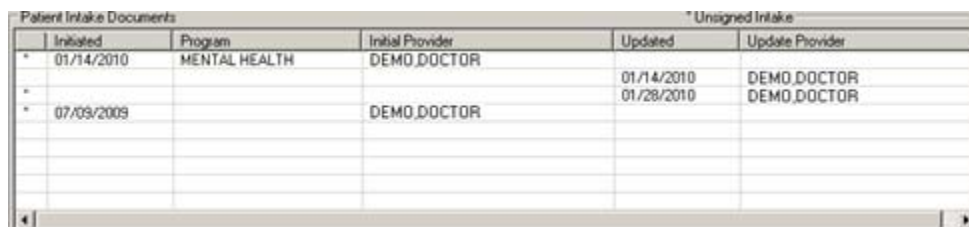
Note: The following window is the window that displays when you click the **Intake** tab on the **Add/Edit Visit Data Entry** window.

Figure 12-8: Sample **Intake** window

The asterisk (*) in the first column indicates that the particular record contains an unsigned intake/update document.

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

12.2.1 Patient Intake Documents Group Box



Initiated	Program	Initial Provider	Updated	Update Provider
* 01/14/2010	MENTAL HEALTH	DEMO DOCTOR	01/14/2010	DEMO DOCTOR
* 07/09/2009		DEMO DOCTOR	01/28/2010	DEMO DOCTOR

Figure 12-9: Sample **Patient Intake Documents** group box

The **Patient Intake Documents** group box displays the names of the current patient's intake documents and update documents (view only). You can distinguish the documents in the following manner:

- The intake documents are listed on the left side of the grid (under the **Date Initiated**, **Program**, and **Initial Provider** columns).
- The update documents are listed on the right side of the grid (under the **Date Updated** and **Update Provider** columns).

As you highlight a record in the **Patient Intake Documents** group box, the text of the document displays in the Intake group box.

All initial documents and updates created before the BHS v4.0 installation will remain unsigned and editable. The initial provider associated with the intake will be the provider for the intake document. Any edits or updates completed after the installation date will be subject to all business rules added in BHS v4.0.

12.2.2 Add Initial Intake

Click **Add Initial Intake** to add a new initial intake document. Click this button to access the **Select Intake Parameters** window.

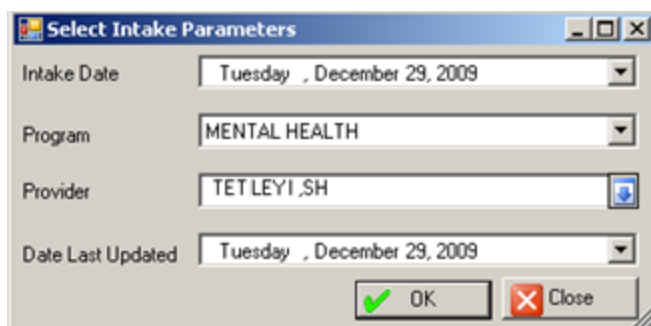


Figure 12-10: Sample **Select Intake Parameters** window

- **Intake Date**

The default is the current date. You can change this by clicking the drop-down list and selecting another date from the calendar. This cannot be a future date.

- **Program**

The default is the program you selected when you first accessed the **Intake** menu. You can change this by clicking the drop-down list and selecting another option.

Note: If you change the program, it will not be visible when you return to the list view. You have to back out of the Program selection screen again and select the program associated with the document you just entered. You are strongly encouraged *not* to change the program. It is actually more efficient to back out and enter the correct program initially.

- **Provider**

The default is the current login provider. You can change this by clicking the drop-down list to access the Primary Provider search window. Refer to Section 2.8 Using the Search Window (GUI) for more information about using this type of window.

- **Date Last Updated**

The default is the current date. You can change this by clicking the drop-down list and selecting another date from the calendar. This cannot be a future date.

After completing the Select Intake Parameters window, click **OK** (otherwise, click **Close**). The OK function activates the Intake group box. Refer to Section 12.2.3 Intake Group Box for more information.

12.2.3 Intake Group Box



Figure 12-11: Sample of active **Intake** group box

When the **Intake** group box is active, use it to type the text of the document (intake or update). This text is the narrative for the document.

To exit the **Intake** group box, click **Cancel**. The Cancel function causes the **Intake** group box to become inactive.

After you have completed the Intake group box, click **Save** (otherwise click **Close**).

- If you click **Close**, the application displays the **Continue?** message: Unsaved Data Will Be Lost, Continue? Click **Yes** to lose any data and you return to the GUI tree structure. Click **No** and you return to the Intake group box.
- If you click **Save**, the application displays the **Intake Electronic Signature** window.

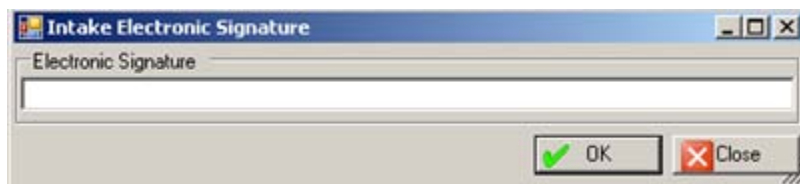


Figure 12-12: **Intake Electronic Signature** window

To sign the particular document, type your electronic signature and click **OK**. This saves the document and marks it as signed. Signing a document locks the document from any future edits.

Otherwise, do not use your electronic signature and click **Close**. The application displays the **Are You Sure?** dialog box that states: Are you sure you want to Close without Electronically Signing the Intake?

- Click **Yes** to not sign it and to save the document marked as not signed. The application displays the Message: You did not Electronically Sign the Intake. Click **OK** to dismiss the Message. This type of document can be edited.

- Click **No** and you return to the **Intake Electronic Signature** window.

12.2.4 Edit Initial Intake

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

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

If you are the provider or the person who entered the intake, the application displays the **Select Intake Parameters** dialog box. Refer to Section 12.2.2 Add Initial Intake for more information. After completing this dialog box, the text of the initial intake document will display in the Intake area of the **Intake** window. Refer to Section 12.2.3 Intake Group Box for more information.

12.2.5 Add/Edit Update

This button has two different labels, depending on the action you take.

Note: If you select a signed update document, the button reads **Edit Update**. After you click the **Edit Update** button, the application displays the message: This intake update document has been signed. You cannot edit it. Click **OK** to dismiss the message and you exit the edit process.

After the provider locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the delete override site parameter.

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

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

In either case, the application displays the **Select Intake Parameters** dialog box. Refer to Section 12.2.2 Add Initial Intake for more information.

After completing this dialog box, the **Intake** group box will become active. Refer to Section 12.2.3 Intake Group Box for more information.

12.2.6 Delete Intake

Click **Delete Intake** to delete a selected unsigned intake document (in the **Patient Intake Documents** group box).

After you click **Delete**, the **Are You Sure?** confirmation message displays asking: Are you sure you want to delete? Click **Yes** to delete (otherwise, click **No** to not delete).

- Only the intake provider or the person who entered the selected intake can use the Delete function. However, when a person is listed in the **Delete Override** section on the **Site Parameters** menu (in RPMS), that person can delete the document.
- If the selected intake document has an attached update document, the application displays the message: This intake document has updates associated with it. It cannot be deleted at this time. Click **OK** on the message and you exit the Delete process.

12.2.7 Display/Print Intake

Click **Display/Print Intake** to access the options for the display/print process.

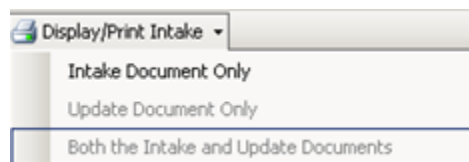


Figure 12-13: Options for the **Display/Print Intake** button

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

If you selected **Update Document Only** or **Both the Intake and Update Documents**, the application displays the **Intake Updates** window.

Patient Intake Updates				Unsigned Intake
	Date Updated	Update Provider	Program	
☒	10/21/2009	DEMO.DOCTOR		
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				

DEMO,DOROTHY ROSE 999999 F 10/10/1942 68

Figure 12-14: Sample Intake Updates window

Check the records you want to include in the output and click **OK** (otherwise, click **Close**).

The application displays the first page of the **Intake** (for the current patient) pop-up window.

***** CONFIDENTIAL PATIENT INFORMATION *****

* INTAKE DOCUMENT Printed: Nov 02, 2010 12:32:01 *

* Name: DEMO,DOROTHY ROSE Page 1 *

* DEMO INDIAN HOSPITAL DOB: 10/10/42 Sex: F Chart #: W9999999 *

Date Established: JAN 14, 2010

Provider: DEMO,KAREN

Program: MENTAL HEALTH

Type of Document: INITIAL

Intake Documentation/Narrative:

!@#% & ()_+{} : "<>?'-=[\];',./

Documenting Prevention Activities

Non-Patient Record - Adding

1. Log on to BHS v3.0 and select DE for data entry.
2. Select [SDE] for the Full Screen Mode and press [Enter].
3. Select the default - Mental Health, Social Services, or Chemical Dependency.
4. Enter the date of the activity.
5. At the List View, select [AN] to add a non-patient record and press [Enter].
6. Enter the Primary Provider and press [Enter].
7. Enter the required information (underlined items) and optional items as desired. Number served may be 0 through 999.
8. Prevention Activities - if the activity needs to be recorded as a prevention service, type [Y] and press [Enter]. A text box for entering the Prevention Activity will be displayed. Identify the type of activity and the target audience.

Type of Activity

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

Figure 12-15: Sample **Intake** pop-up window for current patient

Refer to Section 2.6 Pop-up Windows (GUI) for more information about this type of window.

13.0 Reports (Roll and Scroll Only)

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

The Reports menu contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to the Behavioral Health system. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options are detailed in the following sections.

```

*****
**          IHS Behavioral Health System          **
**                      Reports                      **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

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

Select Reports Menu Option:

```

Figure 13-1: Options on Report menu

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

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

13.1 Patient Listings (PAT)

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

```

*****
**          IHS Behavioral Health System          **
**                Patient Listings                **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

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

Select Patient Listings Option:

```

Figure 13-2: Options on the Patient Listings reports

13.1.1 Active Client List (ACL)

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

Below are the prompts.

- “Enter beginning Date”
Specify the beginning date of the date range.
- “Enter ending Date”
Specify the ending date of the date range.
- “Limit the list to those patients who have seen a particular provider?”
Type **Y** or **N**. If you type **Y**, other prompts display.
- “Demo Patient Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

You browse the output on the Output Browser window.

***** CONFIDENTIAL PATIENT INFORMATION *****							
XX							Page 1
DEMO INDIAN HOSPITAL							
ACTIVE CLIENT LIST							
PROVIDER: ALL							
ENCOUNTER DATES: NOV 17, 2010 TO FEB 15, 2011							
PATIENT NAME	CHART NUMBER	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS

AAA, GCOX	432432	F	11/28/70	DEMO INDIA	WILLIAMS, M	293.82	1
ALPHA, JACOB SCO	102668	M	10/01/72	DEMO INDIA	BRUNING, BJ	292.12	1
ALPHAA, CHELSEA	116431	F	02/07/75	LOCUST GRO SELLS FIEL	BRUNING, BJ GARCIA, RYA	293.82 296.32	2
ALPHAA, DIANA LE	192745	F	09/15/54	DEMO INDIA	BRUNING, BJ	80	1
ALPHAA, MISTY DA	131668	F	04/21/46	DEMO INDIA RED LAKE M	BRUNING, BJ BUTCHER, LO	314.01	3
Enter RETURN to continue or '^' to exit:							

Figure 13-3: Sample Output Browser data

13.1.2 Patient General Retrieval (PGEN)

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

Below are the prompts.

- “Select and Print Patient List from”
Type **S** (search template) or **P** (patient file). If you type **S**, other prompts will display.
- “Do you want to use a PREVIOUSLY DEFINED REPORT?”
Type **Y** or **N**. If you type **Y**, other prompts will display.

The application displays the Patient Selection Menu.

BH GENERAL RETRIEVAL		Apr 16, 2009 14:43:06	Page: 1 of 1
Patient Selection Menu			
Patients can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Patients type Q.			
1) Sex	15) Priv Ins Eligibility	29) Pts w/Problem (DX)	

2) Race	16) Patient Flag Field	30) Pts w/Problem (MHSS
3) Patient Age	17) Case Open Date	31) Pts seen by a Provid
4) Patient DOB	18) Case Admit Date	32) Pts w/Education Done
5) Patient DOD	19) Case Closed Date	33) Pts seen for an Acti
6) Living Patients	20) Case Disposition	34) Pts seen w/Type of C
7) Chart Facility	21) Next Case Review Dat	35) Pts seen w/Axis IV L
8) Community of Residen	22) Designated MH Prov	36) Pts w/Inpatient Disp
9) County of Residence	23) Designated SS Provid	37) Pts Last Health Fact
10) Tribe of Membership	24) Designated A/SA Prov	38) Pts w/ A/SA Componen
11) Eligibility Status	25) Designated Other Pro	39) Pts w/ Days in Res T
12) Class/Beneficiary	26) Personal History It	40) Pts w/ Days Aftercar
13) Medicare Eligibility	27) Pts seen at a Locati	41) Pts w/ A/SA Type of
14) Medicaid Eligibility	28) Pts Seen in a Commun	
Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-4: Sample Patient Selection Menu options

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

- “Choose Type of Report”

Type one of the following: **T** (total count only), **S** (subcounts and total count), or **D** (detailed listing).

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

BH GENERAL RETRIEVAL		Apr 16, 2009 14:46:31	Page: 1 of 1
PRINT ITEM SELECTION MENU			
The following data items can be printed. Choose the items in the order you want them to appear on the printout. Keep in mind that you have an 80 column screen available, or a printer with either 80 or 132 column width.			
1) Patient Name	13) Class/Beneficiary	25) Case Disposition	
2) Sex	14) Medicare Eligibility	26) Next Case Review Dat	
3) Race	15) Medicaid Eligibility	27) Designated MH Prov	
4) Patient Age	16) Priv Ins Eligibility	28) Designated SS Provid	
5) Patient DOB	17) Mailing Address-City	29) Designated A/SA Prov	
6) Patient SSN	18) Home Phone	30) Designated Other Pro	
7) Patient DOD	19) Mother's Name	31) Designated Other (2)	
8) Patient Chart #	20) Patient Flag Field	32) Personal History It	
9) Community of Residen	21) Patient Flag Narrati	33) Pts Last Health Fact	
10) County of Residence	22) Case Open Date		
11) Tribe of Membership	23) Case Admit Date		
12) Eligibility Status	24) Case Closed Date		
S Select Item(s)	+ Next Screen	Q Quit Item Selection	
R Remove Item(s)	- Previous Screen	E Exit Report	
Select Action: S//			

Figure 13-5: Sample Print Item Selection Menu options

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

Next, the application displays the Sort Item Selection Menu.

BH GENERAL RETRIEVAL		Apr 16, 2009 14:49:47		Page: 1 of 1	
SORT ITEM SELECTION MENU					
The Patients displayed can be SORTED by ONLY ONE of the following items. If you don't select a sort item, the report will be sorted by patient name.					
1) Patient Name	7) Community of Residen	13) Designated MH Prov			
2) Sex	8) County of Residence	14) Designated SS Provid			
3) Race	9) Tribe of Membership	15) Designated A/SA Prov			
4) Patient DOB	10) Eligibility Status	16) Designated Other Pro			
5) Patient DOD	11) Class/Beneficiary	17) Designated Other (2)			
6) Patient Chart #	12) Patient Flag Field				
Enter ?? for more actions					
S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report
Select Action: S//					

Figure 13-6: Sample Sort Item Selection Menu options

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

- “Do you want a separate page for each Patient Name?”
Type **Y** or **N**.
- “Would you like a custom title for this report?”
Type **Y** or **N**. If you type **Y**, other prompts will display.
- “Do you wish to save this search/print/sort logic for future use?”
Type **Y** or **N**. If you type **Y**, other prompts will display.
- “Demo Patient Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

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

- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

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

After you move onto the next screen press Enter (to continue), the application displays the patient listing report.

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

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

Figure 13-7: Sample Patient Listing report

13.1.3 Designated Provider List (DP)

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

Below are the prompts.

- “Which Designated Provider?”

Type one of the following:

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

- “Run Report for”

Type one of the following: **1** (one provider) or **2** (all providers). If you type **1**, other prompts will display.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the Designated Mental Health Provider List report.

OUTPUT BROWSER		Apr 16, 2009 15:02:18		Page: 1 of 5	
***** CONFIDENTIAL PATIENT INFORMATION *****					
XX					Page 1
DEMO INDIAN HOSPITAL DESIGNATED MENTAL HEALTH PROVIDER LIST PROVIDER: ALL					
PATIENT NAME		CHART #	SEX	DOB	COMMUNITY LAST VISIT

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

Figure 13-8: Sample Designated Mental Health Provider List report (for all providers)

The report subtotals by provider.

13.1.4 Patients with AT LEAST N Visits (GRT)

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

Below are the prompts.

- “Enter beginning Date”
Specify the beginning date of the date range.
- “Enter ending Date”
Specify the ending date of the date range.
- “Enter the minimum number of time the patient should have been seen”
Type any number between 2 and 100.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the patients seen at least N times report.

***** CONFIDENTIAL PATIENT INFORMATION *****							
XX							Page 1
DEMO INDIAN HOSPITAL							
PATIENTS SEEN AT LEAST 3 TIMES							
RECORD DATES: JAN 16, 2009 TO APR 16, 2009							
PATIENT NAME	CHART #	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS

ALPHAA,CHELSEA	116431	F	02/07/75	CEDAR CITY	BDOC111,BJ	1.1	67
				CHEVAK	BDOC222,LO	12	
				CHINLE CHA	CDOC1,JESS	14	
				CHINLE HOS	DEMO,DOCTO	15	
				DEMO INDIA	GDOC12,RYA	22	
+	Enter ?? for more actions						>>>
+	NEXT SCREEN	-	PREVIOUS SCREEN		Q	QUIT	
Select Action: +/-							

Figure 13-9: Sample Patients Seen at least 3 Times report

13.1.5 Patients Seen by Age and Sex (AGE)

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

Below are the prompts.

- “Choose an item to tally by age and sex”

Type one of the following:

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

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

- “Enter beginning Visit Date for search”
Specify the beginning date of the date range.
- “Enter ending Visit Date for search”
Specify the ending date of the date range.

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 16, 2009 15:16:17		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient Age	32) County of Service	60) Education Topics Pro			
5) Patient DOB	33) Community of Service	61) Prevention Activity			
6) Patient DOD	34) Activity Type	62) Days Used Alcohol			
7) Living Patients	35) A/SA Component	63) Days Used Drugs			
8) Chart Facility	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Community	37) Days in Residential	65) Drug/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History It			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-10: Sample Visit Selection Menu

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

- “Do you wish to modify these age groups?”

The application displays the currently defined age groups. Type **Y** or **N** to this prompt. If you type **Y**, other prompts will display. Type **N** to have the defined age groups listed across the top of the report.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the Behavioral Health Record Listing report.

OUTPUT BROWSER

Apr 16, 2009 15:20:53

Page: 1 of 23

BEHAVIORAL HEALTH RECORD LISTING

REPORT REQUESTED BY: THETA,SHIRLEY

The following visit listing contains BH visits selected based on the following criteria:

RECORD SELECTION CRITERIA

Encounter Date range: OCT 18, 2008 to APR 16, 2009

Report Type: RECORD COUNTS BY AGE/SEX

CONFIDENTIAL PATIENT INFORMATION *****

BEHAVIORAL HEALTH RECORD/ENCOUNTER COUNTS

PROBLEM DSM IV TR/CODE BY AGE AND

ENCOUNTER DATES: OCT 18, 2008 TO A

SEX: BOTH

PROB DSM/CODE NARRATIVE	0-0	1-4	5-14	15-19	20-
-----	-----	-----	-----	-----	-----
ACUTE STRESS REACTION	.	.	.	.	
ADMINISTRATION	.	.	2	.	
ADULT ABUSE (SUSPECTED),UNSPEC	.	.	.	.	
ALCOHOL ABUSE	.	.	1	.	
ALCOHOL ABUSE, CONTINUOUS	.	.	.	.	
ALCOHOL ABUSE, EPISODIC,	.	.	.	1	
ALCOHOL ABUSE, IN REMISSION	.	.	.	.	
ALCOHOL ABUSE, UNSPECIFIED	.	.	1	1	
+ Enter ?? for more actions					>>>
+ NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT	

Select Action: +//

Figure 13-11: Sample Behavioral Health Record Listing report

13.1.6 Case Status Reports (CASE)

Use the CASE option to access additional reports on the Case Status Reports menu.

ACO	Active Client List Using Case Open Date
ONS	Cases Opened But Patient Not Seen in N Days
TCD	Tally Cases Opened/Admitted/Closed
DOC	Duration of Care for Cases Opened and Closed
SENO	Patients Seen x number of times w/no Case Open

Select Case Status Reports Option:

Figure 13-12: Options on the Case Status Reports menu

13.1.6.1 Active Client List Using Case Open Date (ACO)

Use the ACO option to produce a report that shows a list of patients who have a case open date without a case closed date.

Below are the prompts:

- “Run the Report for which program”
Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.
- “Include cases opened by”
Type one of the following: **A** (all provides) or **O** (one provider). If you type **O**, other prompts will display.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the active client list report.

***** CONFIDENTIAL PATIENT INFORMATION *****								
Page 1								
WHITE EARTH HEALTH CENTER								
Encounter Dates: JAN 22, 2008 to JAN 21, 2009								
ACTIVE CLIENT LIST (CASE OPEN DATE WITH NO CASE CLOSED DATE)								
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	CASE ADMIT DATE	PROVIDER SEEN	PROBLEM CODES	
ALPHA, ALICE ROC	183497	F	06/25/97	01/23/06		BETA, BETAA	296.31	
						CHII, RONAL	296.32	
						GAMMAAAA, RYA		
Case Provider: GAMMAAAA, DENISE				Next Case Review:				
ALPHA, JACOB SCO	102668	M	10/01/72	05/06/09		GAMMAAAA, RYA	39	
						MUUUU, KARE	93	

		292.12
		V11.3
		V71.02
Case Provider: GAMMA, RYAN	Next Case Review: 5/6/09	

Figure 13-13: Sample view of active client list

13.1.6.2 Cases Opened But Patient Not Seen in N Days (ONS)

Use the ONS option to produce a report that shows a list of patients who have a case open date, no closed date, and have not been seen in N days. The user will determine the number of days to use.

Below are the prompts:

- “Run the Report for which PROGRAM”
Type one of the following: **O** (ONE program) or **A** (ALL programs). If you type **O**, other prompts will display.
- “Include cases opened by”
Type one of the following: **A** (Any provider) or **O** (One Provider). If you type **O**, other prompts will display.
- “Enter the number of days since the patient has been seen”
Specify the number of days (1–99999) to be used when determining which patients should be included in the report.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Cases Opened but Patient Not Seen in N Days report.

DEMO INDIAN HOSPITAL ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)								
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	PROVIDER	DATE LAST SEEN	# DAYS SINCE	
Patient L	106299	F	11/28/85	01/01/06	GAMMAAA, DON	04/26/06	217	
Patient M	102446	F	04/08/66	08/28/06	GAMMAAA, DON	03/28/06	246	
Patient N	176203	M	03/04/60	10/10/05	GAMMAAA, DON	03/28/06	246	
Patient O	164141	M	02/07/75	12/07/05	GAMMAAA, DON	04/25/06	218	
Patient P	209591	F	04/16/62	07/25/06	ZETAAAA, MAT	07/25/06	127	

Total Number of Patients: 5
Total Number of Cases: 5

Figure 13-14: Sample Cases Opened but Patient Not Seen in N Days report

13.1.6.3 Tally Cases Opened/Admitted/Closed (TCD)

Use the TCD option to produce a report that tallies the case open, admit, and closed dates in a specified time period.

Below are the prompts:

- “Enter beginning of Time Period”
Specify the beginning date of the date range.
- “Enter ending of Time Period”
Specify the ending date of the date range.
- “Run the Report for which PROGRAM”
Type one of the following: **O** (one program) or **A** (All programs). If you type **O**, other prompts will display.
- “Include cases opened by”
Type one of the following: **A** (Any provider) or **O** (One provider). If you type **O**, other prompts will display.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally of Cases Opened/Admitted/Closed report.

ALBUQUERQUE HOSPITAL
TALLY OF CASES OPENED/ADMITTED/CLOSED

Number of Cases Opened:	6
Number of Cases Admitted:	2
Number of Cases Closed:	2
Tally of Dispositions:	
PATIENT DIED	1

PATIENT DMOVED	1
RUN TIME (H.M.S): 0.0.0	
End of report. PRESS ENTER:	

Figure 13-15: Tally of Cases Opened/Admitted/Closed report

13.1.6.4 Duration of Care for Cases Opened and Closed (DOC)

Use the DOC option to produce a report that shows a list of all closed cases in a specified date range. In order to be included in this report, the case must have both a case open and a case closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases can be selected based on Open date, Closed date, or both. Only those cases falling within the specified time frame will be counted.

Below are the prompts:

- “Enter Beginning Date”
Specify the beginning date of the date range.
- “Enter Ending Date”
Specify the ending date of the date range.
- “Please Select which Dates should be Used”
Type one of the following: **O** (cases opened in that date range), **C** (cases closed in that date range), or **B** (cases either opened or closed in that date range).
- “Run the Report for which PROGRAM”
Type one of the following: **O** (One program) or **A** (All programs). If you type **O**, other prompts will display.
- “Include cases opened by”
Type one of the following: **A** (Any provider) or **O** (One provider). If you type **O**, other prompts will display.
- “Do you want each Provider on a separate page?”
Type **Y** (for yes) or **N** (for no).
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Duration of Care report.

DURATION OF CARE REPORT						
PATIENT NAME	CHART NUMBER	CASE OPEN DATE	CASE CLOSED DATE	DURATION	POV	PROVIDER
Patient A	148367	05/22/08	08/22/08	92 days		BETA, B
Patient B	114077	06/27/08	08/28/08	62 days		BETA, B
Patient B	114077	07/25/08	08/21/08	27 days		BETA, B
Total Number of Cases for BETA, B: 3						
Average Duration of Care: 60.33 days						
Patient C	211053	04/19/08	08/16/08	119 days	72.1	SIGMA, RO
Total Number of Cases for SIGMA, ROBERTA: 1						
Average Duration of Care: 119.00 days						
Patient D	146565	08/01/08	08/16/08	15 days	305.62	THETA, MAUDE
Total Number of Cases for THETA, MAUDE: 1						
Average Duration of Care: 15.00 days						
Patient E	148256	07/25/08	09/01/08	38 days		CHI, VICTOR L
Total Number of Cases for THA, VICTOR L: 1						
Average Duration of Care: 38.00 days						
Patient F	106030	05/22/08	08/30/08	100 days		UPSILON, GEORGE
Total Number of Cases for UPSILON, GEORGE G: 1						
Average Duration of Care: 100.00 days						
Total Number of Cases: 7						
Average Duration of Care: 64.71 days						

Figure 13-16: Sample Duration of Care report

At the end of the report, the application provides the total number of cases for the provider and the average duration of care.

13.1.6.5 Patient Seen x Number of Times w/no Case Open (SENO)

Use the SENO option to produce a report that shows a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. The user, based on the program's standards of care, specifies when a case is to be opened. For example, a case will be opened if a patient has been seen at least three times.

Below are the prompts:

- "Enter Beginning Visit Date"
Specify the beginning date of the date range.
- "Enter Ending Visit Date"
Specify the ending date of the date range.

- “Run Report for which PROGRAM”
Type one of the following: **M** (Mental Health), **S** (Social Services), **O** (Other), or **C** (Chemical Dependency).
- “Include visits to”
Type one of the following: **A** (All providers) or **O** (One provider). If you type **O**, other prompts will display.
- “Enter number of visits”
Specify the number of visits with no case opened.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen at least N times with no Case Open Date report.

DEMO INDIAN HOSPITAL							
PATIENTS SEEN AT LEAST 2 TIMES WITH NO CASE OPEN DATE							
VISIT DATE RANGE: Jun 02, 2008 to Nov 29, 2008							
VISITS TO PROGRAM: MENTAL HEALTH							
PATIENT NAME	CHART NUMBER	SEX	DOB	# VISITS	LAST VISIT	LAST DX	PROVIDER
Patient G	116431	F	02/07/75	3	11/14/08	43.1	BETA, B
Patient H	142538	F	10/10/42	3	11/27/08	27	BETA, B
Patient I	113419	M	07/18/85	3	08/16/08	296.33	BETA, KEITH N
Patient J	201295	M	05/14/41	4	08/22/08	296.40	GAMMA, THO
Patient K	194181	M	08/21/98	2	06/19/08	314.9	SIGMA, JOH
Total Number of Patients: 5							

Figure 13-17: Sample Patients Seen at least N times with no Case Open Date report

13.1.7 GAF Scores for Multiple Patients (GAFS)

Use the GAFS option to produce a report that lists the GAF scores for multiple patients, sorted by patient. Only visits with GAF scores recorded will display on this list.

Below are the prompts.

- “Enter Beginning Date of Visit”
Specify the beginning date of the date range.
- “Enter Ending Date of Visit”
Specify the ending date of the date range.
- “List visits/GAF Scores for which program”
Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.
- “Include visits to”
Type one of the following: **A** (all providers) or **O** (one provider). If you type **O**, other prompts will display.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the GAF Scores for Multiple Patients report.

XX	Apr 17, 2009					Page 1
GAF SCORES FOR MULTIPLE PATIENTS						
Visit Dates: Oct 19, 2008 to Apr 17, 2009						
Program: ALL						
Provider: ALL						
PATIENT NAME	HRN	Date	GAF TYPE	Provider	PG	Diagnosis/POV

BETAAAA, MINNIE	145318	09/17/10	99 CGAS	GAMMAA, RY M	296.40	-BIPOLAR I DISOR
DEMO, JAMES WILL	192636	07/19/10	75	GAAMMAA, D M	300.02	-GENERALIZED ANX
CHI, ROBERT MITC	186585	09/16/10	66 test	GAMMAA, RY M	293.82	-PSYCHOTIC DISOR
+ Enter ?? for more actions						>>>
+ NEXT SCREEN		-	PREVIOUS SCREEN	Q	QUIT	
Select Action: +//						

Figure 13-18: Sample GAF Scores for Multiple Patients report

13.1.8 Listing of No-Show Visits in a Date Range (NSDR)

Use the NSDR option to print a list of visits with POVs related to No Shows and Cancellations for multiple patients. You will specify the date range, program, and provider.

Below are the prompts.

- “Enter Beginning Date”
Specify the beginning date of the date range.
- “Enter Ending Date”
Specify the ending date of the date range.
- “Run the Report for which PROGRAM”
Type one of the following: **O** (ONE program) or **A** (All programs). If you type **O**, other prompts will display.
- “Include visits for”
Type one of the following: **A** (All providers) or **O** (One provider). If you type **O**, other prompts will display.
- “How would you like the report sorted”
Type **P** (patient name) or **D** (date of visit).
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Behavioral Health No Show Appointment Listing report.

***** CONFIDENTIAL PATIENT INFORMATION *****					
DEMO INDIAN HOSPITAL					
Page 1					
BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING					
Appointment Dates: OCT 19, 2008 and APR 17, 2009					
PATIENT NAME	HRN	DATE/TIME	PROVIDER	PG	POV

BPAT,ROBERT JACOB	207365	Jan 05, 2009@12:00	CBETA, JESSIC	M	8-FAILED APPOI
FPAT1111,CHARLES R	112383	Dec 30, 2008	BETAAAA,BJ	M	8.1-PATIENT CANC
RPAT111,BEULAH	140325	Feb 12, 2009@12:00	GAMMAA,RYAN	S	8-FAILED APPOI
VPAT1,RACHEL MAE	201836	Jan 06, 2009@12:00	LAMBDAAA,MIC	O	8.3-DID NOT WAIT

Total # of Patients: 4		Total # of No Show Visits: 4	
Enter ?? for more actions >>>			
+ NEXT SCREEN	- PREVIOUS SCREEN	Q	QUIT
Select Action: +//			

Figure 13-19: Sample Behavioral Health No Show Appointment Listing report

At the end of the report, the application shows the total number of patients and the total number of no show visits.

13.1.9 Patient List for Personal Hx Items (PERS)

Use the PERS option to produce the List of Patients with Personal History Items report.

Below are the prompts.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the List of Patients with Personal History Items report.

XX	DEMO INDIAN HOSPITAL		
PERSONAL HISTORY LIST BY PATIENT	Jul 13, 2009@09:53:05	Page 1	
PATIENT	SEX	AGE	CHART NUMBER

ALCOHOL USE			
ALPHA A, SAUNDRA KAY	FEMALE	58	117175
BETA, BRENNA KAY	FEMALE	21	155215
BETA, HEATHER LINDA PAIGE	FEMALE	73	142321
BETA A, STEVEN	MALE	29	188444
GAMMA, JANE ELLEN	FEMALE	19	
GAMMA, TIMOTHY	MALE	29	
PHIIIIII, GREGORY SHANE	MALE	42	184929
SIGMA A A, AMY LYNN	FEMALE	65	130119
Enter ?? for more actions >>>			
+ NEXT SCREEN	- PREVIOUS SCREEN	Q	QUIT
Select Action: +//			

Figure 13-20: Sample List of Patients with Personal History Items report

The application will display a sub-count for each Personal History Item.

13.1.10 Placements by Site/Patient (PPL)

Use the PPL option to produce a report that shows a list of patients who have had a placement disposition recorded in a specified date range.

Below are the prompts.

- “Enter beginning Date”
Specify the beginning date of the date range.
- “Enter ending Date”
Specify the ending date of the date range.
- “How would you like this report sorted”
Type **P** (alphabetically by patient name) or **S** (alphabetically by site referred to).
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Placements report.

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX	DEMO INDIAN HOSPITAL PLACEMENTS				Page 1
PLACEMENT DATES: OCT 19, 2008 TO APR 17, 2009					
PATIENT NAME	HRN	DATE PLACED	POV	PLACEMENT	FACILITY REFERRED TO

ALPHA, JACOB SCOTT	102668	05/03/09	295.15	E	
APATT, CHELSEA MAR	116431	03/25/09	12	OUTPATIENT	
Placement Made by: GAMMAA, RYAN					
Designated SS Prov: BETA, BETAA					
BPATT, RUSTY LYNN	207396	04/06/09	15	OUTPATIENT	
Placement Made by: GAMMAA, RYAN					
BPATTTT, ADAM M	109943	04/07/09	311.	OUTPATIENT	
Placement Made by: GAMMAA, RYAN					
Enter ?? for more actions					
>>>					
+ NEXT SCREEN	-	PREVIOUS SCREEN	Q	QUIT	
Select Action: +/-					

Figure 13-21: Sample Placements report

Near the end of the report, the report shows subtotals by Placement Type, subtotals by Facility Referred, and the Total Number of Placements.

13.1.11 Listing of Patients with Selected Problems (PPR)

Use the PPR option to produce a report that lists all patients who have been seen for a particular diagnosis/problem in a specified date range. For example, you can enter all suicide problems codes (39, 40, and 41) and you will get a list of all patients seen for suicide and can then use this report to assist in follow up activities. The report will list the Designated Provider, the Patient Name, the date seen for this problem, and the date last seen.

Below are the prompts.

- “Which Type”

Type one of the following: **P** (Problem Code and all DSM codes grouped under it), or **D** (individual problem or DSM codes).

Below are prompts for the P type:

- “Enter Problem Code”

Enter the problem code. The next prompt allows you to enter another problem code.

- “Enter Beginning Visit Date”

Specify the beginning date of the date range.

- “Enter Ending Visit Date”

Specify the ending date of the date range.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report.

XX	Apr 17, 2009						Page 1	
PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS								
Visit Dates: Oct 19, 2008 to Apr 17, 2009								
PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS

APATQ, ABIGAIL	103952	02/25/32	F	BJB		41	12/08/08	12/29/08
BPAT, ROBERT JACOB	207365	02/06/55	M	JC		41	12/29/08	01/05/09

FPAT12,AMANDA ROSE	186121	01/10/98	F	DG	40	12/01/08	12/30/08
YPATB,ANNEMARIE LEE	105883	02/11/44	F	DG	40	04/06/09	04/06/09
Designated MH Prov: GALPHA,DENISE							
Designated SS Prov: GAMMAA,RYAN							
Enter ?? for more actions							>>>
+ NEXT SCREEN		- PREVIOUS SCREEN		Q	QUIT		
Select Action: +//							

Figure 13-22: Sample Patients Seen with Selected Diagnosis/Problems report (P type)

Below are the prompts for the D (individual problem or DSM codes) type:

- “Enter Problem/Diagnosis Code”
Specify the problem/diagnosis code. The next prompt allows you to enter another problem/diagnosis code.
- “Enter beginning Visit Date”
Specify the beginning date of the date range.
- “Enter ending Visit Date”
Specify the ending date of the date range.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen with Selected Diagnosis/Problems report.

XX	Apr 17, 2009						Page 1	
PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS								
Visit Dates: Oct 19, 2008 to Apr 17, 2009								
PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS

ALPHA,CHELSEA MARIE	116431	02/07/75	F	DG		43.3	04/06/09	04/16/09
Designated SS Prov: BDOC11,BJ								
ALPHA,MISTY DAWN	131668	04/21/46	F	rust		200.20	02/04/09	06/12/09
Designated SS Prov: DEM0,PSYCHIATRIST								
Enter ?? for more actions								>>>
+ NEXT SCREEN	-	PREVIOUS SCREEN			Q	QUIT		
Select Action: +//								

Figure 13-23: Sample Patients Seen with Selected Diagnosis/Problems report (D type)

13.1.12 Screening Reports (SCRN)

Use the SCRN option to access the Screening Reports menu.

```

*****
**          IHS Behavioral Health System          **
**                Screening Reports                **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

IPV    IPV/DV Reports ...
ALC    Alcohol Screening Reports ...
DEP    Depression Screening Reports ...
PHQ    PHQ-2 and PHQ-9 Scores for One Patient
PHQS   PHQ-2 and PHQ-9 Scores for Multiple Patients

Select Screening Reports Option:

```

Figure 13-24: Options on the Screening Reports menu

13.1.12.1 IPV/DV Reports (IPV)

Use the IPV option to access the IPV/DV Report menu.

```

*****
**          IHS Behavioral Health System          **
**                IPV/DV Reports                  **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

DVP    Tally/List Patients with IPV/DV Screening
DVS    Tally/List IPV/DV Screenings
ISSP   List all IPV/DV Screenings for Selected Patients
IPST   Tally/List Pts in Search Template w/IPV Screening
IVST   Tally List all IPV Screenings for Template of Pts

Select IPV/DV Reports Option:

```

Figure 13-25: Options on the IPV/DV Reports menu

13.1.12.1.1 Tally/List Patients with IPV/DV Screening (DVP)

This report will tally and optionally list all patients who have had IPV screening (PCC Exam Code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, provider (either exam provider, if available) or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal

Below are prompts for the DVP report:

- “Enter Beginning Date for Screening”
Enter the beginning date of the date range for the screening.
- “Enter Ending Date for Screening”
Enter the ending date of the date range for the screening.
- “Which items should be tallied: (0-11)”
Select which items you want to tally on this report:

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 Provider	11) Designated Primary Care

Figure 13-26: List of options from which to tally the report

The response must be a list or range, e.g., 1,3,5 or 2-4,8.

- “Would you like to include IPV/DV Screenings documented in the PCC clinical database?”
Type **Y** (yes) or **N** (no).
- “Would you like to include a list of patients screened?”
Type **Y** (yes) or **N** (no). If you type **Y**, the following prompt will display.
- “How would you like the list to be sorted”

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-27: List of options to sort the list

The default is H (Health Record Number).

- “Display the Patient’s Designated Providers on the list?”

Type **Y** (yes) or **N** (no).

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “DEVICE”

Specify the device to output the report.

Below is a sample report.

XX	Feb 15, 2011				Page 1
*** IPV SCREENING PATIENT TALLY AND PATIENT LISTING ***					
Screening Dates: Jan 16, 2011 to Feb 15, 2011					
This report excludes data from the PCC Clinical database					
			DATE		
PATIENT NAME	HRN	AGE	SCREENED	RESULT	CLINIC

CHI, JIMMY FRED	143023	76	M 02/09/11	NEGATIVE	BEHAVIORAL HEALTH
Comment: test in ehr					
DXs: 312.33 Pyromania					
Primary Provider on Visit: GAMMA, RYAN					
Provider who screened: GAMMA, RYAN					
DEMO, AUSTIN WAYNE	192640	25	M 02/04/11	NEGATIVE	MENTAL HEALTH
Comment: Selected score and then it defaulted as me for provider - I					
don't have a problem with this					
DXs: 296.32 MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE					
Primary Provider on Visit: BETA, BJ					
Provider who screened: BETA, BJ					
Enter RETURN to continue or '^' to exit:					

Figure 13-28: Sample output of the IPV Screening Patient Tally and Patient Listing report

13.1.12.1.2 Tally/List IPV/DV Screenings (DVS)

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

Note:

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

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

Below are prompts for the DVS report:

- Enter Beginning Date for Screening
Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
Enter the ending date of the date range for the screening.
- Which items should be tallied: (0-11)
Select which items you want to tally on this report:

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

Figure 13-29: List of options from which to tally the report

The response must be a list or range, e.g., 1,3,5 or 2-4,8.

- Would you like to include IPV/DV Screenings documented in the PCC clinical database?
Type **Y** (yes) or **N** (no).
- Would you like a list of visits w/screenings done?
Type **Y** (yes) or **N** (no). If you type **Y**, the following prompt will display.
- How would you like the list to be sorted

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-30: List of options to sort the list

The default is H (Health Record Number).

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “DEVICE”

Specify the device to output the report.

Below is a sample report.

XX	Feb 15, 2011				Page 1
*** IPV SCREENING VISIT TALLY AND VISIT LISTING ***					
Screening Dates: Nov 17, 2010 to Feb 15, 2011					
This report excludes PCC Clinics					

Sample output of the IPV Screening Visit Tally and Visit Listing report

13.1.12.1.3 List all IPV/DV Screenings for Selected Patients (ISSP)

This report will list all patients you select who have had IPV screening or a refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

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

Below are prompts for the ISSP report:

- “Enter Beginning Date for Screening”

Enter the beginning date of the date range for the screening.

- “Enter Ending Date for Screening”

Enter the ending date of the date range for the screening.

- “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?”
Type **Y** (yes) or **N** (no).
- “Include which patients in the list”
Type one of the following: **F** (FEMALES only), **M** (MALES only), **B** (Both MALE and FEMALES).
- “Would you like to restrict the report by Patient age range?”
Type **Y** (yes) or **N** (no). If you type **Y**, other prompts will display.
- “Which result value do you want included in this list: (1-7)”

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

Figure 13-31: List of options used to be included in the list

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g., to get only those patients who have had a result of Present enter **2**. To get all patients who have had a screening result of Past or Present, enter **2,3**).

- “Include visits to ALL clinics?”
Type **Y** (yes) or **N** (no).

Report should include visits whose PRIMARY PROVIDER on the visit is

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 13-32: Options for visits to be used on the report

If you type **O**, other prompts will display.

Select which providers who performed the screening should be included

Select one of the following:	
O	One Provider Only

P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 13-33: Options for providers to be used on the report

If you type **O**, other prompts will display.

- “Would you like to limit the list to just patients who have a particular designated Mental Health provider?”

Type Y (yes) or N (no). If you type Y, other prompts will display.

- “Would you like to limit the list to just patients who have a particular designated Social Services provider?”

Type Y (yes) or N (no). If you type Y, other prompts will display.

- “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?”

Type Y (yes) or N (no). If you type Y, other prompts will display.

- “Select Report Type”

Type one of the following: L (List of Patient Screenings) or S (Create a Search Template of Patients). If you type S, other prompts will display.

- “How would you like the list to be sorted”

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-34: List of options to sort the list

The default is H (Health Record Number).

- “Display the Patient’s Designated Providers on the list?”

Type Y (yes) or N (no).

The default is H (Health Record Number).

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “DEVICE”

Specify the device to output the report.

The application displays the criteria for the report. After pressing Enter, the application displays the report.

XX	Feb 15, 2011				Page 1
*** IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS ***					
Screening Dates: Nov 17, 2010 to Feb 15, 2011					
PATIENT NAME	HRN	AGE	DATE SCREENED	RESULT	CLINIC

ALPHA,WILLA BELLE	110838	44	F 01/12/11	PAST	MENTAL HEALTH
DXs: 14 MAJOR DEPRESSIVE DISORDER					
Primary Provider on Visit: THETA,WENDY					
Provider who screened: THETA,WENDY					
ALPHA,KIMBERLY ANN	166488	59	F 12/14/10	PRESENT	MENTAL HEALTH
DXs: 39 SUICIDE (IDEATION)					
Primary Provider on Visit: GAMMA,RYAN					
Provider who screened: GAMMA,RYAN					
Enter RETURN to continue or '^' to exit:					

Figure 13-35: Sample IPV Screening Visit Listing for Selected Patients report

13.1.12.1.4 Tally/List Pts in Search Template w/IPV Screening (IPST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest IPV screening (PCC Exam Code 34) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

13.1.12.1.5 Tally/List all PIV Screenings for Template of Pts (IVST)

This report will tally and optionally list all visits on which IPV screening (PCC Exam Code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. Only patients who are members of a user-defined search template are included in this report. This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

13.1.12.2 Alcohol Screening Reports (ALC)

Use the ALC option to access the ALC Report menu.

```

*****
**          IHS Behavioral Health System          **
**          Alcohol Screening Reports              **
*****
                Version 4.0 (patch 1)

                DEMO INDIAN HOSPITAL

ASP   Tally/List Patients with Alcohol Screening
ALS   Tally/List Alcohol Screenings
ASSP  List all IPV/DV Screenings for Selected Patients
APST  Tally/List Pts in Search Template w/Alcohol Screening
AVST  Tally List all Alcohol Screenings for Template of Pts

Select Alcohol Screening Reports Option:

```

Figure 13-36: Options on the ALC Reports menu

13.1.12.2.1 *Tally/List Patients with Alcohol Screening (ASP)*

This report will tally and optionally list all patients who have had an alcohol screening (Exam Code 35) or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the patients by age, gender, result, provider (either exam provider, if available) or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

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

Below are the prompts.

- “Enter Beginning Date for Screening”
Specify the beginning date of the date range.
- “Enter Ending Date for Screening”
Specify the ending date of the date range.
- “Which items should be tallied”
Specify which items you would like to have displayed in the report. The application provides a list of items. Your response must be a list (like 1,3,5) or a range (2-4, 8).
- “Would you like to include Alcohol Screenings documented in the PCC clinical database?”
Type **Y** (Yes) or **N** (No).
- “Would you like to include a list of patients screened?”
Type **Y** (Yes) or **N** (No).

If you answered Yes to this question, the next prompt will display:
- “How would you like this report sorted”
Type only one of the items in the list provided by the application.
- “Display the Patient’s Designated Providers on the list?”
Type **Y** (Yes) to display the patient’s Designated Providers or **N** (No) to bypass this option.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally/List Patients with Alcohol Screenings report.

XX	Oct 07, 2010	Page 1
*** ALCOHOL SCREENING PATIENT TALLY AND PATIENT LISTING *** Screening Dates: Sep 07, 2010 to Oct 07, 2010 This report excludes data from the PCC Clinical database		

	#	% of patients

Total Number of Patients screened	4	
By Result		
NEGATIVE	1	25.0%
POSITIVE	2	50.0%
REFUSED SCREENING	1	25.0%
By Gender		
F	3	75.0%
M	1	25.0%
By Age		
26 yrs	1	25.0%
27 yrs	1	25.0%
44 yrs	1	25.0%
48 yrs	1	25.0%

Figure 13-37: Sample Tally/List Patients with Alcohol Screenings report

13.1.12.2.2 Tally/List Alcohol Screening (ALS)

This report will tally and optionally list all visits on which an alcohol screening (Exam Code 35) or a refusal was documented in a specified time frame.

Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

This report will tally the visits by age, gender, result, 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 PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

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

Below are the prompts.

- “Enter Beginning Date for Screening”
Specify the beginning date of the date range.
- “Enter Ending Date for Screening”
Specify the ending date of the date range.
- “Which items to be tallied”
Specify which items you would like to have displayed in the report. The application provides a list. Your response must be list (like 1,3,5) or a range (2-4, 8).
- “Would you like to include ALCOHOL Screenings documented in the PCC clinical database”
Type **Y** (Yes) or **N** (No).
- “Would you like to include a list of visits w/screenings done?”
Type **Y** (Yes) or **N** (No).
- “How would you like this report sorted”
The report can be sorted by only one of the items in the list.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Tally/List Alcohol Screenings report.

*** ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING ***

Screening Dates: Sep 10, 2010 to Dec 09, 2010

This report excludes PCC Clinics

	#	% of patients
Total Number of Visits with Screening	4	
Total Number of Patients screen	4	
By Result		
NEGATIVE	1	25.0%
POSITIVE	2	50.0%
REFUSED SCREENING	1	25.0%
By Gender		
FEMALE	3	75.0%
MALE	1	25.0%
By Age		
26 yrs	1	25.0%

27 yrs	1	25.0%			
44 yrs	1	25.0%			
48 yrs	1	25.0%			
By Provider who screened					
ALPHAA, GEORGE C	1	25.0%			
BETAA, FRANK S	1	25.0%			
GAMMA, MATT	1	25.0%			
OMICRON, STEVE N	1	25.0%			
By Primary Provider of Visit					
ALPHAA, GEORGE C	1	25.0%			
BETAA,FRANK S	1	25.0%			
WEARY, MATT	1	25.0%			
OMICRON, STEVE N	1	25.0%			
By Designated Primary Care Provider					
UNKNOWN	3	75.0%			
RH00000,HELEN K	1	25.0%			
By Clinic					
ALCOHOL AND SUBSTANCE	1	25.0%			
MEDICAL SOCIAL SERVICES	1	25.0%			
MENTAL HEALTH	2	50.0%			
By Date					
Jul 25, 2006	1	25.0%			
Aug 09, 2006	1	25.0%			
Aug 17, 2006	1	25.0%			
Aug 23, 2006	1	25.0%			
By Designated Mental Health Provider					
UNKNOWN	4	100.0%			
By Designated Social Services Provider					
UNKNOWN	4	100.0%			
By Designated A/SA Provider					
UNKNOWN	4	100.0%			
PATIENT NAME	HRN	AGE	SCREENED	RESULT	CLINIC
Patient T11	4551	26 F	08/17/06	POSITIVE	
DXs: 29.1	SCREENING FOR ALCOHOLISM				
29.2	SCREENING FOR DRUG ABUSE				
995.81	ADULT ABUSE (SUSPECTED), PHYSICAL				
Primary Provider on Visit: BETA, FRANK S					
Provider who screened: DOC22, FRANK S					

Figure 13-38: Sample Tally/List Alcohol Screenings report

13.1.12.2.3 List All Alcohol Screenings for Selected Patients (ASSP)

This report will tally and optionally list all patients who have had an alcohol screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049

- Refusal of Exam Code 35

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

Below are the prompts.

- “Enter Beginning Date for Screening”
Specify the beginning date of the date range.
- “Enter Ending Date for Screening”
Specify the ending date of the date range.
- “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?”
Type **Y** (Yes) or **N** (No).
- “Include which patients in the list”
Type **F** (Females Only), **M** (Males Only), or **B** (Both Male and Females).
- “Would you like to restrict the report by Patient age range?”
Type **Y** (Yes) or **N** (no). If you wish to include visits from *all* age ranges, answer **No**. If you wish to list visits for only patients with a particular age range, enter **Yes**. If you type **Yes**, other prompts will display.
- “Which result values do you want included on this list”
You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter **2** to get all patients who have had a screening result of Positive or Refused, enter **2,3**).

You can choose from the following:

- 1) Normal/Negative
- 2) Positive

- 3) Refused
- 4) Unable to Screen
- 5) Screenings done with no result entered
- “Include visits to ALL clinics”
Type **Y** (Yes) or **N** (No). If No is used, additional prompts will display.
- “Report should include visits whose PRIMARY PROVIDER on the visit is”
Type **O** (One Provider Only), **P** (Any/All Providers including Unknown), or **U** (Unknown Provider Only). If you type **O**, other prompts will display.
- “Select which providers who performed the screening should be included”
Type **O** (One Provider Only), **P** (Any/All Providers including Unknown), or **U** (Unknown Provider Only). If you type **O**, other prompts will display.
- “Would you like to limit the list to just patients who have a particular designated Mental Health provider?”
Type **Y** (Yes) or **N** (No). If Yes is used, additional prompts will display.
- “Would you like to limit the list to just patients who have a particular designated Social Services provider?”
Type **Y** (Yes) or **N** (No). If Yes is used, additional prompts will display.
- “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?”
Type **Y** (Yes) or **N** (No). If Yes is used, additional prompts will display.
- “Select Report Type”
Type **L** (List of Patient Screenings) or **S** (Create a Search Template of Patients).
- “How would you like this report sorted”
The report can be sorted by only one of the items in the list.
- “Display the Patient’s Designated Providers on the list?”
Type **Y** (Yes) or **N** (no).
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- Do you wish to

Type **P** (print output) or **B** (browse output on screen).

The application displays the criteria you selected for the report.

Then, the application displays the Tally/List Alcohol Screenings report.

XX	Oct 07, 2010			Page 1
*** ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS ***				
Screening Dates: Jul 09, 2010 to Oct 07, 2010				
PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

SIGMAAAA,BRITTANY LYN	129079	41	F 08/03/10	BEHAVIORAL HEALTH
Type/Result: ALCOHOL SCREENING NEGATIVE				
Primary Provider on Visit: BETA,BETAA				
Provider who screened: BETA,BETAA				
SIGSIG,ALICIA MARIE	169379	58	F 09/08/10	ALCOHOL AND SUBSTANC
Type/Result: AUDT 21				
Primary Provider on Visit: BETA,BETAA				
Provider who screened: UNKNOWN				
Enter RETURN to continue or '^' to exit:				

Figure 13-39: Sample Alcohol Screenings Visit Listing for Selected Patients report

13.1.12.2.4 Tally/List Pts in Search Template w/Alcohol Screenings (APST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest alcohol screening (Exam Code 35) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

13.1.12.2.5 Tally list all Alcohol Screenings for Template of Pts (AVST)

This report will tally and optionally list all visits on which an alcohol screening (Exam Code 35) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. Only patients who are members of a user-defined search template are included in this report. This alcohol screening report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

13.1.12.3 Depression Screening Reports (DEP)

Use the DEP option to access the Depression Screening Reports menu.

**	IHS Behavioral Health System	**

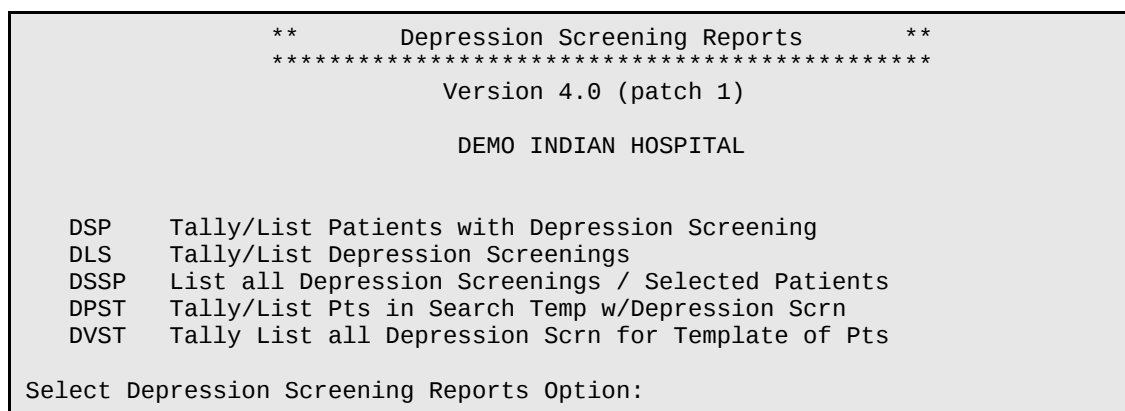


Figure 13-40: Options on the Depressing Screening Reports menu

13.1.12.3.1 *Tally/List Patient with Depression Screening (DSP)*

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusals.
- This is a tally of patients, not visits, or screening.

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

Below are the prompts:

- “Enter Beginning Date for Screening”
Specify the beginning date of the date range.

- “Enter Ending Date for Screening”

Specify the ending date of the date range.

- “Which items should be tallied: (0–11)”

Select which items you want to tally on this report:

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	

Figure 13-41: List of options from which to tally the report

- “Would you like to include DEPRESSION Screenings documented in the PCC clinic database?”

Type **Y** (yes) or **N** (no).

- “Would you like to include a list of patients screened.”

Type **Y** (yes) or **N** (no). If you type **Y**, the following will display.

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-42: List of options to sort the list

The default is H (Health Record Number).

- “Display the Patient’s Designated Providers on the list?”

Type **Y** (yes) or **N** (no).

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “DEVICE”

Specify the device to output the report.

Below is a sample report.

XX	Feb 15, 2011			Page 1
*** DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING ***				
Screening Dates: Nov 17, 2010 to Feb 15, 2011				
This report excludes data from the PCC Clinical database				
PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

BETA, MISTY DAWN	106371	28 F	01/12/11	TELEBEHAVIORAL HEALT
Type/Result: DEPRESSION SCREENING POSITIVE				
Comment: TESTING EHR				
Primary Provider on Visit: GAMMA, RYAN				
Provider who screened: GAMMA, RYAN				
PI, WILLA BELLE	110838	44 F	01/12/11	MENTAL HEALTH
Type/Result: DEPRESSION SCREENING NEGATIVE				
Primary Provider on Visit: IOTA, WENDY				
Provider who screened: IOTA, WENDY				
THETA, JIMMY JOE	129347	24 M	01/31/11	MENTAL HEALTH
Type/Result: PHQ2 6				
Primary Provider on Visit: GAMMA, RYAN				
Provider who screened: GAMMA, RYAN				
Enter RETURN to continue or '^' to exit:				

13.1.12.3.2 Tally/List Depression Screenings (DLS)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done.

Enter the date range during which the screening was done. To obtain all screenings ever, put in a long date range like 01/01/1980 to the present date.

Below are the prompts:

- “Enter Beginning Date for Screening”
Specify the beginning date of the date range.
- “Enter Ending Date for Screening”
Specify the ending date of the date range.
- “Which items should be tallied: (0-11)”
Select which items you want to tally on this report:

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 Provider	11) Designated Primary Care

Figure 13-43: List of options from which to tally the report

- “Would you like to include DEPRESSION Screenings documented in the PCC clinic database?”
Type **Y** (yes) or **N** (no).
- “Would you like to include a list of visits w/screening done?”
Type **Y** (yes) or **N** (no). If you type **Y**, the following prompt will display.
- “How would you like to the list to be sorted.”
The following will display.

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Gender of Patient
T	Terminal Digit HRN

Figure 13-44: List of options to sort the list

The default is H (Health Record Number).

- “Display the Patient’s Designated Providers on the list?”
Type **Y** (yes) or **N** (no).
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “DEVICE”
Specify the device to output the report.

Below is a sample report

XX	Feb 15, 2011			Page 1
*** DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING ***				
Screening Dates: Nov 17, 2010 to Feb 15, 2011				
This report excludes PCC Clinics				
PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

GAMMA, FREDRICK COD	100306	33 M	01/13/11	ALCOHOL AND SUBSTANC
Type/Result: DEPRESSION SCREENING POSITIVE				
Comment: referring to inpatient treatment				
DXs: 82.1 UNEMPLOYMENT				
Primary Provider on Visit: BETA, BJ				
Provider who screened: BETA, BJ				
BETA, MISTY DAWN	106371	28 F	01/07/11	BEHAVIORAL HEALTH
Type/Result: DEPRESSION SCREENING POSITIVE				
Comment: testing ehr				
Primary Provider on Visit: GAMMA, RYAN				
Provider who screened: GARCIA, RYAN				
BETA, MISTY DAWN	106371	28 F	01/10/11	BEHAVIORAL HEALTH
Type/Result: DEPRESSION SCREENING NEGATIVE				
Primary Provider on Visit: GAMMA, RYAN				
Provider who screened: GAMMA, RYAN				
Enter RETURN to continue or '^' to exit:				

Figure 13-45: Sample Depression Screening Visit Tally and Vlist Listing report

13.1.12.3.3 List all Depression Screenings / Selected Patients (DSSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1

- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

You will be able to choose the patients by age, gender, clinic, primary provider, or result of the screening.

Below are the prompts:

- “Enter Beginning Date for Screening”
Specify the beginning date of the date range.
- “Enter Ending Date for Screening”
Specify the ending date of the date range.
- “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?”
Type **Y** (yes) or **N** (no).
- “Include which patients in the list”
Type one of the following: **F** (FEMALES only), **M** (MALES Only), or **B** (Both MALE and FEMALES).
- “Would you like to restrict the report by Patient age range?”
Type **Y** (yes) or **N** (no). If you type **Y**, other prompts will display.
- “Which result values do you want included on this list”
Below is a list from which to select.

- | |
|---|
| <ul style="list-style-type: none">1) Normal/Negative2) Positive3) Refused |
|---|

- | |
|--|
| 4) Unable to Screen
5) Screenings done with no result entered |
|--|

Figure 13-46: List of options from which to select

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

- “Include visits to ALL clinics”

Type **Y** (yes) or **N** (no).

- “Report should include visits whose PRIMARY PROVIDER on the visit is”

Select one of the following:						
<table> <tr> <td>O</td> <td>One Provider Only</td> </tr> <tr> <td>P</td> <td>Any/All Providers (including unknown)</td> </tr> <tr> <td>U</td> <td>Unknown Provider Only</td> </tr> </table>	O	One Provider Only	P	Any/All Providers (including unknown)	U	Unknown Provider Only
O	One Provider Only					
P	Any/All Providers (including unknown)					
U	Unknown Provider Only					

Figure 13-47: Options for visits to be used on the report

If you type **O**, other prompts will display.

- “Select which providers who performed the screening should be included”

Select one of the following:						
<table> <tr> <td>O</td> <td>One Provider Only</td> </tr> <tr> <td>P</td> <td>Any/All Providers (including unknown)</td> </tr> <tr> <td>U</td> <td>Unknown Provider Only</td> </tr> </table>	O	One Provider Only	P	Any/All Providers (including unknown)	U	Unknown Provider Only
O	One Provider Only					
P	Any/All Providers (including unknown)					
U	Unknown Provider Only					

Figure 13-48: Options for providers to be used on the report

If you type **O**, other prompts will display.

- “Would you like to limit the list to just patients who have a particular designated Mental Health provider?”

Type **Y** (yes) or **N** (no). If you type **Y**, other prompts will display.

- “Would you like to limit the list to just patients who have a particular designated Social Services provider?”

Type **Y** (yes) or **N** (no). If you type **Y**, other prompts will display.

- “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?”

Type **Y** (yes) or **N** (no). If you type **Y**, other prompts will display.

- “Select Report Type”
Type one of the following: **L** (List of Patient Screenings) or **S** (Create a Search Template of Patients). If you type S, other prompts will display.
- “How would you like the list to be sorted”
The following will display.

```

Select one of the following:

      H      Health Record Number
      N      Patient Name
      P      Provider who screened
      C      Clinic
      R      Result of Exam
      D      Date Screened
      A      Age of Patient at Screening
      G      Gender of Patient
      T      Terminal Digit HRN
  
```

Figure 13-49: List of options to sort the list

The default is H (Health Record Number).

- “Display the Patient’s Designated Providers on the list?”
Type **Y** (yes) or **N** (no).
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “DEVICE”
Specify the device to output the report.

The application displays the criteria for the report. After pressing Enter, the application displays the report.

```

XX                               Feb 15, 2011                               Page 1

***  DEPRESSION SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
      Screening Dates: Nov 17, 2010 to Feb 15, 2011

PATIENT NAME      HRN      AGE      DATE      CLINIC
-----
BETA,MISTY DAWN    106371 28  F 01/07/11    BEHAVIORAL HEALTH
Type/Result: DEPRESSION SCREENING POSITIVE
Comment: testing ehr
Primary Provider on Visit:  GAMMA,RYAN
Provider who screened:  GAMMA,RYAN
  
```

```

CHI,WILLA BELLE      110838 44  F 01/12/11      MENTAL HEALTH
Type/Result: DEPRESSION SCREENING  POSITIVE
Primary Provider on Visit:  IOTA,WENDY
Provider who screened:  IOTA,WENDY

Enter RETURN to continue or '^' to exit:

```

Figure 13-50: Sample Depression Screening Visit Listing for Selected Patients report

13.1.12.3.4 *Tally/List Pts in Search Temp w/Depression Scrn (DPST)*

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of patients, not visits or screenings.

13.1.12.3.5 *Tally List all Depression Scrn for Template of Pts (DVST)*

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR

- Refusal of PCC Exam Code 36

This report will tally the visits by age, gender, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes:

- This report will, optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
- This is a tally of visits with a screening done; if a patient had multiple screenings during the time period, all will be counted.

13.1.12.4 PHQ-2 and PHQ-9 Scores for One Patient (PHQ)

Use the PHQ option to produce a report that lists PHQ2 and PHQ9 Scores for one patient within a specified date range.

Below are the prompts:

- “Select PATIENT NAME”
Specify the name of the patient whose scores are to be displayed.
- “Browse which subset of visits for <name of patient>”
Type **N** (Patient’s Last N Visits), **D** (Visits in a Date Range), or **A** (All of this patient’s Visits). If you type **N** or **D**, other prompts will display.
- “Limit by Clinic/Provider”
Type **C** (Visits to Selected Clinics), **P** (Visits to Selected Providers), or **A** (Include All Visits regardless of Clinic/Provider).

The application displays the PHQ-2/PHQ-9 Scores for One Patient report.

PHQ-2/PHQ-9 Scores		Oct. 03, 2008 18:37			Page 1 of 1	
Patient Name: Doe, Jane		DOB: Dec 11, 1976				
HRN: 123942						

Date	PHQ-2	PHQ-9	PROVIDER	CLINIC	Diagnosis/POV	

10/01/08	5	21	GAMMA, JOHN	MENT	311. - Depressive Disorder, Not Els	
09/30/08	1		GAMMA, JOHN	MENT	311. - Depressive Disorder, Not Els	
09/19/08	3	24	GAMMA, JOHN	MENT	311. - Depressive Disorder, Not Els	
09/19/08	0		GAMMA, JOHN	ALCO	305.02 - ALCOHOL ABUSE,	
09/12/08		14	KAPPA, ADAM	MEDSS	305.02 - ALCOHOL ABUSE,	
07/18/06	4	19	DELTA, JAMES	BH	13 - SCHIZOPHRENIC DISORDER	
06/01/05	2		GAMMA, DON	PC	311 - DEPRESSIVE DISOCER,NOS	
Enter ?? for more actions						

+	Next Screen	-	Previous Screen	Q	Quit
Select Action: +//					

Figure 13-51: Sample PHQ-2 and PHQ-9 Scores for One Patient report

13.1.12.5 PHQ-2 and PHQ-9 Scores for Multiple Patients (PHQS)

Use the PHQS option to produce a report that lists PHQ-2 and PHQ-9 Scores for multiple patients, sorted by patient. Only visits with PHQ-2/PHQ-9 scores recorded will display on this list.

Below are the prompts.

- “Enter Beginning Date of Visit”
Specify the beginning date of the date range.
- “Enter Ending Date of Visit”
Specify the ending date of the date range.
- “Clinic Selection”
Type one of the following: **C** (Visits at Selected Clinic) or **A** (Visit to All Clinics). If you type **C**, other prompts will display.
- “Provider Selection”
Type one of the following: **A** (Visits to All Providers) or **C** (Visits to Selected Providers) or. If you type **C**, other prompts will display.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the PHQ-2 and PHQ-9 Scores for Multiple Patients report.

XX	Jul 13, 2009					Page 1
PHQ-2 and PHQ-9 SCORES FOR MULTIPLE PATIENTS						
Visit Dates: Jan 04, 2009 to Jul 13, 2009						
Clinic: ALL Clinics						
Providers: ALL Providers						
PATIENT NAME	HRN	Date	PHQ-2	PHQ-9	Provider	CLINIC Diagnosis/POV

ALPHAA, JACOB SCO	102668	02/07/09	3		GAMMA, RYA	MENTA

ALPHAB, CHELSEA	116431	07/11/09	3		BETAAAA, LO	MENTA	22-SLEEP DIS
ALPHAB, CHELSEA	116431	07/02/09		17	DEMO, PSYCH	MENTA	296.31-MAJOR DEP
ALPHAB, CHELSEA	116431	05/19/09	3		GAMMAAA, DE	MENTA	311.-DEPRESSIV
ALPHAB, CHELSEA	116431	03/17/09	4		BETA, BETAA	MEDIC	305.02-ALCOHOL A
ALPHAB, CHELSEA	116431	03/12/09		17	BETA, BETAA	BEHAV	V11.0-PERSONAL
ALPHAB, CHELSEA	116431	03/10/09		19	GAMMAAA, DE	MENTA	296.32-MAJOR DEP
ALPHAB, GLEN DAL	108704	04/11/09	4		BETA, BETAA	MENTA	296.32-DEPRESSED
ALPHAB, GLEN DAL	108704	03/27/09		21	GAMMAAA, DE	MENTA	311.-testing v
ALPHAB, GLEN DAL	108704	03/18/09	4		BETA, BETAA	MEDIC	300.6-DEPERSONA

Enter RETURN to continue or '^' to exit:

Figure 13-52: Sample PHQ-2 and PHQ-9 Scores for Multiple Patients report

13.1.13 Treatment Plans (TPR)

Use the TPR option to access the Treatment Plans menu.

ATP	Print List of All Treatment Plans on File
REV	Print List of Treatment Plans Needing Reviewed
RES	Print List of Treatment Plans Needing Resolved
NOTP	Patients w/Case Open but no Treatment Plan

Select Treatment Plans Option:

Figure 13-53: Options on the Treatment Plans menu

Print List of All Treatment Plans on File (ATP): refer to Section 10.1.5.

Print List of Treatment Plans Needing Reviewed (REV): refer to Section 10.1.3.

Print List of Treatment Plans Needing Resolved (RES): refer to Section 10.1.4.

Patients w/Case Open but no Treatment Plan (NOTP): refer to Section 10.1.6.

13.1.14 Patients Seen in Groups w/Time in Group (TSG)

Use the TSG option to produce a report that shows a list of patients who have spent time in a group in a specified date range. It will list the patient, the primary provider, diagnosis, and time spent in the group.

Below are the prompts.

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

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the Patients Seen in Groups with Time Spent in Group report.

***** CONFIDENTIAL PATIENT INFORMATION *****								
XX								Page 1
DEMO INDIAN HOSPITAL								
PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP								
DATES: JAN 17, 2009 TO APR 17, 2009								
PATIENT NAME	HRN	SEX	DOB	DATE	PROVIDER	PROBLEM	TIME	

APHAAA,CHRYSTAL	106299	F	11/28/85	04/20/09	BETA,BETAS	13	0	
Total with provider				BETAAAA,BJ	0			
Total for patient				ALPHAA,CHRYSTAL GAYL	0			
APHAAA,DIANA LE	192745	F	09/15/54	03/05/09	GAMMAA,DENISE	92	60	
				03/25/09	Not Recorded	307.50	15	
				04/21/09	THETAAAA,MARK	8.3	0	
					THETAAAA,MARK	311.	60	
Enter ?? for more actions								
+	Next Screen		-	Previous Screen		Q	Quit	

Figure 13-54: Sample Patients Seen in Groups with Time Spent in Group report

13.2 Behavioral Health Record/Encounter Reports (REC)

Use the REC option to list various records from the Behavioral Health patient file that are available on the BHS Encounter/Record Reports menu.

**	IHS Behavioral Health System
**	Encounter/Record Reports

Version 4.0 (patch 1)	
DEMO INDIAN HOSPITAL	
LIST	List Visit Records, STANDARD Output
GEN	List Behavioral Hlth Records, GENERAL RETRIEVAL
Select Behavioral Health Record/Encounter Reports Option:	

Figure 13-55: Options on the Encounter/Record Reports menu

13.2.1 List Visit Records, Standard Output (LIST)

Use the LIST option to produce a report that shows a listing of visits in a specified date range. The visits can be selected based on any combination of selected criteria. The user will select the sort criteria for the report.

Be sure to have a printer available that has 132-column print capability.

Below are the prompts.

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

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 16, 2009 15:16:17		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient Age	32) County of Service	60) Education Topics Pro			
5) Patient DOB	33) Community of Service	61) Prevention Activity			
6) Patient DOD	34) Activity Type	62) Days Used Alcohol			
7) Living Patients	35) A/SA Component	63) Days Used Drugs			
8) Chart Facility	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Community	37) Days in Residential	65) Drug/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History It			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			

Select Action: S//

Figure 13-56: Sample Visit Selection Menu

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

- “Type of Report to Print”

Type one of the following: **D** (detailed using 132 column print) or **B** (brief (using 80 column print)).

The application displays the Sort Item Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:21:06		Page: 1 of 2	
SORT ITEM SELECTION MENU					
The Visits displayed can be SORTED by ONLY ONE of the following items.					
If you don't select a sort item, the report will be sorted by visit date.					
1) Patient Name	22) County of Service	43) Days Hospitalized			
2) Patient Sex	23) Community of Service	44) Drug/Alc Related Arr			
3) Patient Race	24) Activity Type	45) Staging Average			
4) Patient DOB	25) A/SA Component	46) Alcohol/Sub Stage			
5) Patient DOD	26) A/SA Type of Contact	47) Physical Stage			
6) Patient Chart #	27) Days in Residential	48) Emotional Stage			
7) Patient Community	28) Days in Aftercare	49) Social Stage			
8) Patient County Resid	29) Activity Category	50) Cul/Spirit Stage			
9) Patient Tribe	30) Local Service Site	51) Behavioral Stage			
10) Eligibility Status	31) Number Served	52) Voc/Educ Stage			
11) Class/Beneficiary	32) Type of Contact	53) A/SA Recommended Pla			
12) Patient Flag Field	33) Inpatient Dispositio	54) A/SA Actual Placemen			
13) Encounter Date	34) PCC Visit Created	55) A/SA Difference Reas			
14) Appointment/Walk-In	35) Axis V	56) Designated MH Prov			
15) Interpreter Utilized	36) Flag (Visit Flag)	57) Designated SS Provid			
16) Program	37) Primary Provider	58) Designated A/SA Prov			
17) Visit Type	38) Primary Prov Discipl	59) Designated Other Pro			
18) Location of Encounte	39) Primary Prov Affilia	60) Designated Other (2)			
19) Clinic	40) Primary POV				
20) Outside Location	41) Days Used Alcohol				
21) SU of Encounter	42) Days Used Drugs				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-57: Sample Sort Item Selection Menu options

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

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the criteria for the report. Then, the application displays the Behavioral Health Record Listing report.

***** CONFIDENTIAL PATIENT INFORMATION *****									
DEMO INDIAN HOSPITAL									
Page 1									
BEHAVIORAL HEALTH RECORD LISTING									
Visit Dates: OCT 19, 2008 and APR 17, 2009									
=====									
DATE	PROV	LOC	PATIENT NAME	ACT	CONT	AT	HRN	PROB	NARRATIVE

10/20/08	DG	WW	ALPHA1,CHELS	12	OUTP	30	WW116431	311.	DEPRESSIVE DISO
10/22/08	DG	WW	ALPHA1,CHELS	12	OUTP	90	WW116431	311.	DEPRESSIVE DISO
10/22/08	DG	WW	ALPHA1,CHELS	12	OUTP	88	WW116431	311.	Mask Narrative
11/03/08	GHH	WW	ALPHA,ALTHEA	99	OUTP		WW123942	300.00	Situational Anx
11/06/08	GHH	WW	ALPHA,ALTHEA	99	OUTP		WW123942	311.	Depression
								300.00	Anxiety
11/11/08	BJB	1202	FPAT11,AMAND	12	OUTP	120	WW186121	V71.01	OBSERVATION OF
11/12/08	DGC	WW	SIGMA,MACEY	05	OUTP	20	WW104376	V61.01	FAMILY DISRUPTI
Enter ?? for more actions									
+ Next Screen			- Previous Screen			Q Quit			
Select Action:+//									

Figure 13-58: Sample Behavioral Health Record Listing report

13.2.2 List Behavioral Hlth Records, General Retrieval (GEN)

Use the GEN option to produce a report that shows a listing of visits selected by visit criteria. The visits printed can be selected based on any combination of selected items and the selected sort criteria.

If the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Below are the prompts.

- “Select and Print Encounter List from”

Type one of the following: **S** (search template) or **D** (date range). The next prompts vary according to the option selected.

- “Do you want to use a PREVIOUSLY DEFINED REPORT?”

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

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:21:06		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based on any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visit type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient DOB	32) County of Service	60) Education Topics Pro			
5) Patient DOD	33) Community of Service	61) Prevention Activity			
6) Patient Chart #	34) Activity Type	62) Days Used Alcohol			
7) Patient Community	35) A/SA Component	63) Days Used Drugs			
8) Patient County Resid	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Tribe	37) Days in Residential	65) Durg/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History It			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-59: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The following prompts continue in the process

- “Choose Type of Report”

Type one of the following: **T** (Total Count Only), **S** (Subcounts and Total Count), **D** (Detailed Listing), **F** (Flag ASCII file (predefined record format)).

The application displays the Print Item Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:59:50		Page: 1 of 3	
PRINT ITEM SELECTION MENU					

The following data items can be printed. Choose the items in the order you want them to appear on the printout. Keep in mind that you have an 80 column screen available, or a printer with either 80 or 132 column width.

1) Patient Name	32) Outside Location	63) Primary POV
2) Patient Sex	33) SU of Encounter	64) POV Problem Code Nar
3) Patient Race	34) County of Service	65) POV (Problem Categor
4) Patient Age	35) Community of Service	66) POV Diagnosis Catego
5) Patient DOB	36) Chief Complaint/Pres	67) POV Prov Narrative
6) Patient SSN	37) Activity Type	68) Procedures (CPT)
7) Patient DOD	38) Activity Type Narrat	69) Education Topics Pro
8) Patient Chart #	39) A/SA Component	70) Prevention Activity
9) Patient Community	40) A/SA Type of Contact	71) Treated Medical Prob
10) Patient County Resid	41) Days in Residential	72) Days Used Alcohol
11) Patient Tribe	42) Days in Aftercare	73) Days Used Drugs
12) Eligibility Status	43) Activity Category	74) Days Hospitalized
13) Class/Beneficiary	44) Local Service Site	75) Drug/Alc Related Arr
14) Medicare Eligibility	45) Number Served	76) Staging Average
15) Medicaid Eligibility	46) Type of Contact	77) Alcohol/Sub Stage
16) Priv Ins Eligibility	47) Activity Time	78) Physical Stage
17) Patient Flag Field	48) Inpatient Dispositio	79) Emotional Stage
18) Patient Flag Narrati	49) Place Referred To	80) Social Stage
19) Case Open Date	50) PCC Visit Created	81) Cul/Spirit Stage
20) Case Admit Date	51) Axis IV	82) Behavioral Stage
21) Case Closed Date	52) Axis V	83) Voc/Educ Stage
22) Case Disposition	53) Comment	84) A/SA Recommended Pla
23) Next Case Review Dat	54) Flag (Visit Flag)	85) A/SA Actual Placemen
24) Encounter Date	55) Primary Provider	86) A/SA Difference Reas
25) Encounter Date&Time	56) Primary Prov Discipl	87) Personal History It
26) Appointment/Walk-In	57) Primary Prov Affilia	88) Designated MH Prov
27) Interpreter Utilized	58) Prim/Sec Providers	89) Designated SS Provid
28) Program	59) Prim/Sec Prov Discip	90) Designated A/SA Prov
29) Visit Type	60) POV (Prim or Sec)	91) Designated Other Pro
30) Location of Encounte	61) DSM/Problem Code Nar	92) Designated Other (2)
31) Clinic	62) POV (Prob Code Grps)	

+ Enter ?? for more actions

S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report

Select Action: S//

Figure 13-60: Print Item Selection Menu options

Use this menu to select the data items to be used on the report. Use the Q option when you have completed your selections.

After selecting the items and then typing **Q**, the application displays the Sort Item Selection Menu.

BH GENERAL RETRIEVAL	Apr 17, 2009 16:02:04	Page: 1 of 2
SORT ITEM SELECTION MENU		
The Visits displayed can be SORTED by ONLY ONE of the following items.		
If you don't select a sort item, the report will be sorted by visit date.		
1) Patient Name	22) County of Service	43) Days Hospitalized
2) Patient Sex	23) Community of Service	44) Drug/Alc Related Arr
3) Patient Race	24) Activity Type	45) Staging Average
4) Patient DOB	25) A/SA Component	46) Alcohol/Sub Stage

5) Patient DOD	26) A/SA Type of Contact	47) Physical Stage
6) Patient Chart #	27) Days in Residential	48) Emotional Stage
7) Patient Community	28) Days in Aftercare	49) Social Stage
8) Patient County Resid	29) Activity Category	50) Cul/Spirit Stage
9) Patient Tribe	30) Local Service Site	51) Behavioral Stage
10) Eligibility Status	31) Number Served	52) Voc/Educ Stage
11) Class/Beneficiary	32) Type of Contact	53) A/SA Recommended Pla
12) Patient Flag Field	33) Inpatient Dispositio	54) A/SA Actual Placemen
13) Encounter Date	34) PCC Visit Created	55) A/SA Difference Reas
14) Appointment/Walk-In	35) Axis V	56) Designated MH Prov
15) Interpreter Utilized	36) Flag (Visit Flag)	57) Designated SS Provid
16) Program	37) Primary Provider	58) Designated A/SA Prov
17) Visit Type	38) Primary Prov Discipl	59) Designated Other Pro
18) Location of Encounte	39) Primary Prov Affilia	60) Designated Other (2)
19) Clinic	40) Primary POV	
20) Outside Location	41) Days Used Alcohol	
21) SU of Encounter	42) Days Used Drugs	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-61: Options on the Sort Item Selection Menu

Use this menu to determine the sort criteria for the report. If you don't select any criteria (use Quit Item Selection) immediately, the report will be sorted by visit date.

- “Do you want a separate page for each Visit Date?”

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

- “Would you like a custom title for this report?”

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

- “Do you wish to save this search/print/sort logic for future use?”

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

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

The application displays the criteria for the report.

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the visit report.

***** CONFIDENTIAL PATIENT INFORMATION *****

BH Visit Listing				Page 1
Record Dates: JAN 14, 2009 and JUL 13, 2009				
PATIENT NAME	DOB	HRN	PROGRAM	

ALPHAA, CHELSEA MARIE	02/07/1975	WW116431	MENTAL	
SIGMA, ALBERT TILLMAN	02/07/1975	WW164141	OTHER	
SIGMA, ALBERT TILLMAN	02/07/1975	WW164141	MENTAL	
SIGMA, ALBERT TILLMAN	02/07/1975	WW164141	SOCIAL	
Enter ?? for more actions				
+ Next Screen	-	Previous Screen	Q	Quit
Select Action: +//				

Figure 13-62: Sample visit report

13.3 Workload/Activity Reports (WL)

Use the WL option to view the Activity Workload Reports menu.

**	IHS Behavioral Health System
**	Activity Workload Reports

Version 4.0 (patch 1)	
DEMO INDIAN HOSPITAL	
GRS1	Activity Report
GRS2	Activity Report by Primary Problem
ACT	Activity Record Counts
PROG	Program Activity Time Reports (132 COLUMN PRINT)
FACT	Frequency of Activities
FCAT	Frequency of Activities by Category
PA	Tally of Prevention Activities
Select Workload/Activity Reports Option:	

Figure 13-63: Options on the Activity Workload Reports menu

The Workload/Activity Reports menu has options to generate reports related specifically to the activities of Behavioral Health providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring Behavioral Health care.

13.3.1 Activity Report (GARS #1) (GRS1)

Use the GRS1 option to produce a report that will tally activities by service unit, facility, and provider. The report is patterned after GARS Report #1.

Below are the prompts.

- “Enter beginning Encounter Date”
Specify the beginning encounter date for the date range.
- “Enter ending Encounter Date”
Specify the ending encounter date for the date range.
- “Run Report for which Program”
Type one the following:
 - **M**–MENTAL HEALTH
 - **S**–SOCIAL SERVICES
 - **C**–CHEMICAL DEPENDENCY or ALCOHOL/SUBSTANCE ABUSE
 - **O**–OTHER
 - **A**–ALL
- Run Report for
Type one of the following: **1** (ONE PROVIDER) or **2** (ALL PROVIDERS). If you type **1**, other prompts will display.
- Include which providers
Type one of the following: **P** (Primary Provider Only) or **S** (Both Primary and Secondary Providers).
- Demo Patient/Inclusion/Exclusion
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- Do you wish to
Type **P** (print output) or **B** (browse output on screen).

The application displays the Activity Report.

***** CONFIDENTIAL PATIENT INFORMATION *****				
XX	MAY 04, 2009Page 1			
ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM				
RECORD DATES: FEB 03, 2009 TO MAY 04, 2009				
# PATS is the total number of unique, identifiable patients when a patient name was entered on the record. # served is a tally of the number served data value.				
	# RECS	ACT TIME (hrs)	# PATS	# SERVED

AREA: TUCSON				
SERVICE UNIT: SELLS				

FACILITY: SELLS HOSP				
PROVIDER: BETAA,BJ (PSYCHIATRIST)				
13-INDIVIDUAL TREATMENT/COUNS	3	2.8	3	3
16-MEDICATION/MEDICATION MONI	1	1.0	1	1
91-GROUP TREATMENT	2	1.5	2	2
	=====	=====	=====	=====
PROVIDER TOTAL:	6	5.3	6	6
PROVIDER: BETABB,LORI (PHYSICIAN)				
11-SCREENING-PATIENT PRESENT	1	0.3	1	1
13-INDIVIDUAL TREATMENT/COUNS	1	0.2	1	1
22-CASE MANAGEMENT-PATIENT PR	2	0.7	1	2
	=====	=====	=====	=====
PROVIDER TOTAL:	4	1.3	3	4
PROVIDER: DEMO,DOCTOR (PHYSICIAN)				
85-ART THERAPY	4	0.7	4	4
	=====	=====	=====	=====
PROVIDER TOTAL:	4	0.7	4	4
Enter RETURN to continue or '^' to exit:				

Figure 13-64: Sample Activity Report

Near the end of the report, there will be a Facility Total, SU Total, and Area Total.

13.3.2 Activity Report by Primary Problem (GRS2)

Use the GRS2 option to produce a report that will tally primary problems by service unit, facility, and by provider and activity.

The prompts are the same as those for the GRS1 report. Refer to Section 13.3.1 Activity Report for more information.

The application displays the Activity Report by Primary Purpose report.

***** CONFIDENTIAL PATIENT INFORMATION *****				
xx	MAY 04, 2009Page 1			
ACTIVITY REPORT BY PRIMARY PURPOSE				
ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM				
RECORD DATES: FEB 03, 2009 TO MAY 04, 2009				
# PATS is the total number of unique, identified patients when a patient name was entered on the record. # served is a tally of the number served data value.				
	# RECS	ACT TIME	# PATS	# SERVED

AREA: TUCSON				
SERVICE UNIT: SELLS				
FACILITY: SELLS HOSP				
PROVIDER: BETAAAA,BJ (PSYCHIATRIST)				
ACTIVITY: 13-INDIVIDUAL TREATMENT/C				
311.-DEPRESSIVE DISORDER NOS	1	1.0	1	1
	=====	=====	=====	=====
ACTIVITY TOTAL:	1	1.0	1	1
ACTIVITY: 16-MEDICATION/MEDICATION				

295.15-SCHIZOPHRENIA, DISORGAN	1	1.0	1	1
	=====	=====	=====	=====
ACTIVITY TOTAL:	1	1.0	1	1
	=====	=====	=====	=====
PROVIDER TOTAL:	2	2.0	2	2
Enter ?? for more actions				
+ Next Screen	- Previous Screen	Q	Quit	
Select Action:+//				

Figure 13-65: Sample Activity Report by Primary Purpose report

13.3.3 Activity Record Counts (ACT)

Use the ACT option to produce a report that will generate a count of activity records for a selected item in a specified date range. You will be given the opportunity to select which visits will be included in the tabulation. For example, you can choose to tally activity time by Problem Code for only those with a discipline of Psychiatrist.

Below are the prompts.

- “Choose an item for calculating activity time and records counts”

The application displays a list of items from which to choose.

- “Enter beginning Visit Date for Search”

Specify the beginning visit date for the date range.

- “Enter ending Visit Date for Search”

Specify the ending visit date for the date range.

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL

Apr 17, 2009 15:21:06

Page: 1 of 2

Visit Selection Menu

Visits can be selected based on any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visit type Q.

1) Patient Name	29) Clinic	57) POV (Problem Categor
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)
4) Patient DOB	32) County of Service	60) Education Topics Pro
5) Patient DOD	33) Community of Service	61) Prevention Activity
6) Patient Chart #	34) Activity Type	62) Days Used Alcohol
7) Patient Community	35) A/SA Component	63) Days Used Drugs
8) Patient County Resid	36) A/SA Type of Contact	64) Days Hospitalized
9) Patient Tribe	37) Days in Residential	65) Durg/Alc Related Arr
10) Patient County Resid	38) Days in Aftercare	66) Staging Average
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage
12) Eligibility Status	40) Local Service Site	68) Physical Stage

13) Class/Beneficiary	41) Number Served	69) Emotional Stage
14) Medicare Eligibility	42) Type of Contact	70) Social Stage
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas
21) Case Closed Date	49) Primary Provider	77) Personal History It
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro
26) Program	54) POV (Prim or Sec)	
27) Visit Type	55) POV (Prob Code Grps)	
28) Location of Encounte	56) Primary POV	
Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 13-66: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the Activity Record Counts report.

							MAY 04, 2009 Page 1
RECORD DATES: FEB 03, 2009 TO MAY 04, 2009							
NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM IV TR/CODE							
PROB	DSM/CODE	NARRATIVE	CODE	# RECS	# PATS	ACTIVITY TIME	# SERVED

ADMINISTRATION			97	4	4	0.1	4
ALCOHOL ABUSE			29	4	4	1.2	4
ALCOHOL ABUSE, EPISODIC			305.02	5	2	4.1	5
ALCOHOL ABUSE, UNSPECIF			305.00	4	2	2.0	4
ALCOHOL DEPENDENCE			27	3	3	2.0	3
ALCOHOL DEPENDENCE, IN			303.93	2	2	1.5	2
ALCOHOLISM IN FAMILY			V61.41	4	4	0.7	4
AMPHETAMINE DEPENDENCE,			304.40	1	1	0.0	1
Enter ?? for more actions							

+	Next Screen	-	Previous Screen	Q	Quit
Select Action: +//					

Figure 13-67: Sample Activity Record Counts report

13.3.4 Program Activity Time Reports (PROG)

Use the PROG option to produce a report that will generate a count of activity records, total activity time, and number of patient visits by program and by a selected item within a specified date range. You will be given the opportunity to select which visits will be included on the report. For example, you might want to only report on those records on which the type of visits was Field.

Note: If you choose to report on Problems, *only the primary problem* is included.

The prompts are the same as those for the ACT report. Refer to Section 13.3.3 Activity Record Counts for more information.

The application displays the record selection criteria. After pressing Enter, the application displays the Program Activity Time report.

Encounter Date range: FEB 03, 2009 to MAY 04, 2009					
MENTAL HEALTH AND SOCIAL SERVI ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGR RECORD DATES: FEB 03, 2009 TO MA					
SOCIAL SERVICES AND MENTAL HEALTH COMB					
PROVIDER	NO. OF RECORDS	NO. OF PATIENTS	TOTAL ACTIV TIME	NO. OF RECORDS	NO. OF PATIENT

ALPHA, AAA	15	7	3.6	2	2
BETA, BETAA	33	18	22.6	8	4
BETAAAA, LORI	16	6	5.0	.	.
CAAAA, JESSICA	9	2	6.3	.	.
DEMO, CASE M	1	1	0.0	.	.
DEMO, DOCTOR	1	1	0.2	1	1
NUUUUUUU, AMY J	3	3	2.0	.	.
GAMMA, RYAN	106	30	66.3	24	5
**** Patient Count TOAL is not an unduplicated count.					
Enter ?? for more actions					
+	Next Screen	-	Previous Screen	Q	Quit
Select Action: +//					

Figure 13-68: Sample Program Activity Time report

13.3.5 Frequency of Activities (FACT)

Use the FACT option to produce a report that will generate a list of the top N Activity Codes for selected visits.

Below are the prompts.

- “Enter beginning Visit Date for Search”
Specify the beginning visit date for the date range.
- “Enter ending Visit Date for Search”
Specify the ending visit date for the date range.

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:21:06		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based on any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visit type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient DOB	32) County of Service	60) Education Topics Pro			
5) Patient DOD	33) Community of Service	61) Prevention Activity			
6) Patient Chart #	34) Activity Type	62) Days Used Alcohol			
7) Patient Community	35) A/SA Component	63) Days Used Drugs			
8) Patient County Resid	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Tribe	37) Days in Residential	65) Durg/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History Ite			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-69: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- “Select Type of Report”

Type one of the following: **L** (list of items with counts) or **B** (Bar Chart, requires 132 column printer).

- “How many entries do you want to list (5–100)”

Specify the number of entries (any number 5–100).

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the criteria for the report. After pressing Enter, the application displays the Frequency of Activities report.

MAY 04, 2009			Page 1	
DEMO INDIAN HOSPITAL				
TOP 10 Activity Code's.				
DATES: FEB 03, 2009 TO MAY 04, 2009				
No.	ACTIVITY TYPE	ACTIVITY CODE	# RECS	ACT TIME (HRS)

1.	SCREENING-PATIENT PRESENT	11	55	34.8
2.	INFORMATION AND/ OR REFERRAL-P	15	32	12.3
3.	GROUP TREATMENT	91	30	17.1
4.	INDIVIDUAL TREATMENT/COUNSEL/E	13	22	17.0
5.	ASSESSMENT/EVALUATION-PATIENT	12	19	15.5
6.	INDIVIDUAL BH EHR VISIT	99	19	0.6
7.	ACADEMIC SERVICES	96	16	8.1
8.	ART THERAPY	85	15	6.7
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 13-70: Sample Frequency of Activities report

13.3.6 Frequency of Activities by Category (FCAT)

Use the FCAT option to produce a report that generates a list of the top N Activity Category for selected visits.

The prompts are the same as for the Frequency of Activities report. Refer to Section 13.3.5 Frequency of Activities report.

Below is a sample Frequency of Activities by Category report.

MAY 04, 2009			Page 1	
DEMO INDIAN HOSPITAL				
TOP 10 Activity Category's.				
DATES: FEB 03, 2009 TO MAY 04, 2009				
No.	ACTIVITY CATEGORY	CATEGORY CODE	# RECS	ACT TIME (HRS)

1.	PATIENT SERVICES	P	943	556778.2
2.	SUPPORT SERVICES	S	56	52.9
3.	ADMINISTRATION	A	21	26.6
4.	PLACEMENTS	PL	6	2.8
5.	COMMUNITY SERVICES	C	2	9.0
6.	EDUCATION/TRAINING	E	2	1.5
7.	CULTURALLY ORIENTED	O	1	0.5
8.	TRAVEL	T	1	0.3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 13-71: Sample Frequency of Activities by Category report

13.3.7 Tally of Prevention Activities (PA)

Use the PA option to produce a report that will show a count of all visits with a prevention activity entered. It will also produce a tally/count of those prevention activities with Target Audience subtotals.

Below are the prompts.

- “Enter Beginning Visit Date”
Specify the beginning visit date for the date range.
- “Enter Ending Visit Date”
Specify the ending visit date for the date range.
- “Run the Report for which PROGRAM”
Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.
- “Enter a code indicating which providers are of interest”
Specify the Providers whose Prevention activities you want to tally. Type one of the following: **A** (all providers), **S** (Select set or Taxonomy of Providers), or **O** (one provider). If you type **S** or **O**, other prompts will display.
- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Device”

Specify the device to browse/print the report.

The application displays the Tally of Prevention Activities report.

May 04, 2009			Page: 1	
Behavioral Health				

* TALLY OF PREVENTION ACTIVITIES *				

VISIT Date Range: FEB 03, 2009 through MAY 04, 2009				
PREVENTION ACTIVITY			# of visits	% of visits

Total # Visits w/Prevention Activity:			3	
Total # of Prevention Activities recorded:			5	
AIDS/HIV			1	33.3
YOUTH 1 100.0				
OTHER			1	33.3
NOT RECORDED 1 100.0				
PUBLIC AWARENESS			1	33.3
NOT RECORDED 1 100.0				
SELF-AWARENESS/VALUES			1	33.3
ADULT 1 100.0				
SMOKING/TOBACCO			1	33.3
YOUTH 1 100.0				
TARGET TOTALS				
ADULT 1 33.3				
NOT RECORDED 1 33.3				
YOUTH 1 33.3				
RUN TIME (H.M.S): 0.0.0				
Enter RETURN to continue or '^' to exit:				

Figure 13-72: Sample Tally of Prevention Activities report

13.4 Problem Specific Reports (PROB)

Use the PROB option to produce a list of BH issues of particular concern to providers, managers, and administrators from a clinical and public health perspective.

**	IHS Behavioral Health System	**
**	Problem Specific Reports	**

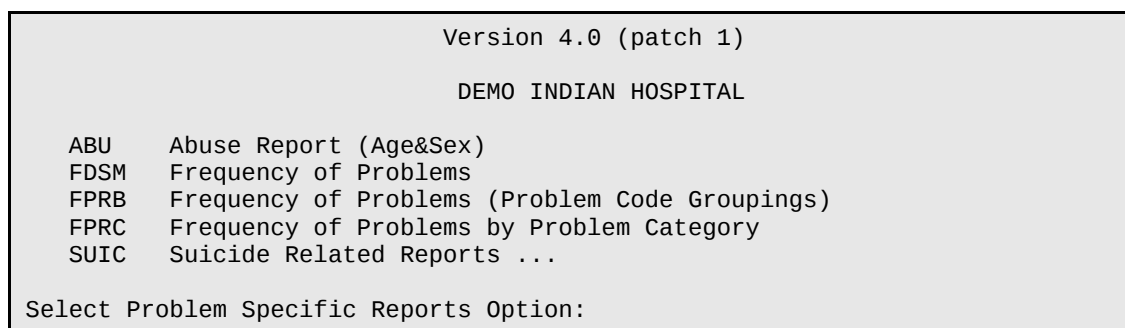


Figure 13-73: Options on the Problem Specific Reports menu

13.4.1 Abuse Report (ABU)

Use the ABU option to produce a report that focuses on patients who might have been victims of abuse or neglect. It will present, by age and sex, the number of individual patients who were seen for the following Purpose of Visit (POV)—the application displays the POVs.

Below are the prompts.

- “Enter Beginning Visit Date”
Specify the beginning visit date for the date range (during which the patient should have been seen with one of the above problems).
- “Enter the Ending Visit Date”
Specify the ending visit date for the date range.

The application displays the current Age Groups.
- “Do you wish to modify these age groups?”
Type **Y** or **N** at this prompt. If you type **Y**, other prompts will display. Type **N** to not modify the age groups.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).
- “Do you wish to”
Type **P** (print output) or **B** (browse output on screen).

The application displays the Abuse by Age and Sex report. You need a 132-column printer to print the report.

13.4.2 Frequency of Problems (FDSM)

Use the FDSM option to produce a report that shows a list of the top N Problem/POV for selected visits.

Below are the prompts.

- “Enter beginning Visit Date for Search”
Specify the beginning visit date for the date range.
- “Enter ending Visit Date for Search”
Specify the ending visit date for the date range.

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:21:06		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based on any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visit type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient DOB	32) County of Service	60) Education Topics Pro			
5) Patient DOD	33) Community of Service	61) Prevention Activity			
6) Patient Chart #	34) Activity Type	62) Days Used Alcohol			
7) Patient Community	35) A/SA Component	63) Days Used Drugs			
8) Patient County Resid	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Tribe	37) Days in Residential	65) Durg/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History It			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-74: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- “Include which POVs”

Type one of the following: **P** (primary POV only) or **S** (primary and secondary POVs).

- “Select Type of Report”

Type one of the following: **L** (List of items with counts) or **B** (Bar Chart, requires 132-column printer).

- “How many entries do you want to list (5–100)”

Specify the number of entries.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type **P** (print output) or **B** (browse output on screen).

The application displays the Frequency of Problems report.

JUN 09, 2009

Page 1

DEMO INDIAN HOSPITAL

TOP 10 Problem/POV's.

PRIMARY POV Only

DATES: MAR 11, 2009 TO JUN 09, 2009

No.	PROB DSM/CODE	NARRATIVE	CODE	# RECS	ACT TIME (HRS)
1.	DEPRESSIVE DISORDER NOS		311.	150	114.8
2.	ANXIETY DISORDER NOS		300.00	52	28.8
3.	CROSS-CULTURAL CONFLICT		2	48	35.5
4.	SCHIZOPHRENIA, DISORGANIZED TY		295.15	33	26.1
5.	PARANOID PERSONALITY DISORDER		301.0	32	21.1
6.	PHYSICAL ILLNESS,ACUTE		5	32	22.9
7.	DEMENTIA OF THE ALZHEIMER'S TY		290.0	31	27.4
8.	MARITAL PROBLEM		56	25	7.9
9.	HEALTH/HOMEMAKER NEEDS		1	21	17.6
10.	MAJOR DEPRESSIVE DISORDER, REC		296.32	20	32.3

RUN TIME (H.M.S): 0.0.0

End of report. PRESS ENTER:

Figure 13-75: Sample Frequency of Problems report

13.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

Use the FPRB option to produce a report that shows a list of the top N Problem/POV for visits that you select.

Below are the prompts.

- “Enter beginning Visit Date for Search”
Specify the beginning visit date for the date range.
- “Enter ending Visit Date for Search”
Specify the ending visit date for the date range.

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:21:06		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based on any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visit type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient DOB	32) County of Service	60) Education Topics Pro			
5) Patient DOD	33) Community of Service	61) Prevention Activity			
6) Patient Chart #	34) Activity Type	62) Days Used Alcohol			
7) Patient Community	35) A/SA Component	63) Days Used Drugs			
8) Patient County Resid	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Tribe	37) Days in Residential	65) Durg/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History Ite			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-76: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

The prompts continue.

- “Include which POVs”

Type one of the following: **P** (Primary POV only) or **S** (Primary and Secondary POVs).

- “Select Type of Report”

Type one of the following: **L** (List of items with counts) or **B** (Bar Chart, required 132 column printer).

- “How many entries do you want in the list (5–100)”

Specify the number of entries, using any whole number 5–100.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do You wish to”

Type one of the following: **P** (print output) or **B** (browse output on screen).

The application displays the Frequency of Problems by Category report.

JUN 09, 2009		DEMO INDIAN HOSPITAL		Page 1	
TOP 10 POV/Problem (Problem Code)'s.					
PRIMARY POV Only					
DATES: MAR 11, 2009 TO JUN 09, 2009					
No.	PROB CODE NARRATIVE	PROBLEM (POV) CODE#	RECS	ACT TIME (HRS)	
1.	MAJOR DEPRESSIVE DISORDERS	14	123	94.2	
2.	ANXIETY DISORDER	18	30	14.2	
3.	SCHIZOPHRENIC DISORDER	13	29	25.8	
4.	CROSS-CULTURAL CONFLICT	2	19	15.0	
5.	MARITAL PROBLEM	56	18	5.4	
6.	ALCOHOL ABUSE	29	16	14.1	
7.	ILLNESS IN FAMILY	55	16	4.3	
8.	HOUSING	80	15	8.0	
9.	SENILE OR PRE-SENILE CONDITION	9	14	9.7	
10.	BIPOLAR DISORDER	15	13	5.2	
RUN TIME (H.M.S): 0.0.0					
End of report. PRESS ENTER:					

Figure 13-77: Sample Frequency of Problem by groupings report

13.4.4 Frequency of Problems by Problem Category (FPRC)

Use the FPRC option to produce a report that generates a list of the top N Problem/POV (Problem Category) for selected visits.

Below are the prompts

- “Enter beginning Visit Date for Search”
Specify the beginning visit date for the date range.
- “Enter ending Visit Date for Search”
Specify the ending visit date for the date range.

The application displays the Visit Selection Menu.

BH GENERAL RETRIEVAL		Apr 17, 2009 15:21:06		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based on any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visit type Q.					
1) Patient Name	29) Clinic	57) POV (Problem Categor			
2) Patient Sex	30) Outside Location	58) POV Diagnosis Catego			
3) Patient Race	31) SU of Encounter	59) Procedures (CPT)			
4) Patient DOB	32) County of Service	60) Education Topics Pro			
5) Patient DOD	33) Community of Service	61) Prevention Activity			
6) Patient Chart #	34) Activity Type	62) Days Used Alcohol			
7) Patient Community	35) A/SA Component	63) Days Used Drugs			
8) Patient County Resid	36) A/SA Type of Contact	64) Days Hospitalized			
9) Patient Tribe	37) Days in Residential	65) Durg/Alc Related Arr			
10) Patient County Resid	38) Days in Aftercare	66) Staging Average			
11) Patient Tribe	39) Activity Category	67) Alcohol/Sub Stage			
12) Eligibility Status	40) Local Service Site	68) Physical Stage			
13) Class/Beneficiary	41) Number Served	69) Emotional Stage			
14) Medicare Eligibility	42) Type of Contact	70) Social Stage			
15) Medicaid Eligibility	43) Activity Time	71) Cul/Spirit Stage			
16) Priv Ins Eligibility	44) Inpatient Dispositio	72) Behavioral Stage			
17) Patient Encounters 0	45) PCC Visit Created	73) Voc/Educ Stage			
18) Patient Flag Field	46) Axis IV	74) A/SA Recommended Pla			
19) Case Open Date	47) Axis V	75) A/SA Actual Placemen			
20) Case Admit Date	48) Flag (Visit Flag)	76) A/SA Difference Reas			
21) Case Closed Date	49) Primary Provider	77) Personal History It			
22) Case Disposition	50) Primary Prov Discipl	78) Designated MH Prov			
23) Next Case Review Dat	51) Primary Prov Affilia	79) Designated SS Provid			
24) Appointment/Walk-In	52) Prim/Sec Providers	80) Designated A/SA Prov			
25) Interpreter Utilized	53) Prim/Sec Prov Discip	81) Designated Other Pro			
26) Program	54) POV (Prim or Sec)				
27) Visit Type	55) POV (Prob Code Grps)				
28) Location of Encounte	56) Primary POV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 13-78: Sample Sort Item Selection Menu options

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the Quit Item Selection option), all visits will be used.

- “Include which POVs”

Type one of the following: **P** (Primary POV only) or **S** (Primary and Secondary POVs).

- “Select Type of Report”

Type one of the following: **L** (List of items with counts) or **B** (Bar Chart, requires 132 column printer).

- “How many entries do you want in the list (5–100)”

Specify the number of entries, using any whole number 5–100.

- “Demo Patient/Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do You wish to”

Type one of the following: **P** (print output) or **B** (browse output on screen).

The application displays the record selection criteria. After pressing Enter, the application displays the Frequency of Problems by Problem Category report.

JUN 09, 2009		DEMO INDIAN HOSPITAL		Page 1	
TOP 10 Problem/POV (Problem Category)'s.					
PRIMARY POV Only					
DATES: MAR 11, 2009 TO JUN 09, 2009					
No.	CATEGORY NARRATIVE	CATEGORY CODE	# RECS	ACT TIME (HRS)	
1.	PSYCHOSOCIAL PROBLEMS	2	294	220.6	
2.	MEDICAL/SOCIAL PROBLEMS	1	73	598.6	
3.	FAMILY LIFE PROBLEMS	5	37	11.5	
4.	SOCIOECONOMIC PROBLEMS	8	27	12.4	
5.	ADMINISTRATIVE PROBLEM	11	14	11.5	
6.	ABUSE	3	10	5.1	
7.	OTHER PATIENT RELATED	13	6	12.3	
8.	EDUCATIONAL/LIFE PROBLEMS	10	8	5.9	
9.	SCREENING	12	7	4.9	
10.	PREGNANCY/CHILDBIRTH PROBLEMS	6	6	1.8	
RUN TIME (H.M.S): 0.0.1					
End of report. PRESS ENTER:					

Figure 13-79: Sample Frequency of Problems by Problem Category report

13.4.5 Suicide Related Reports (SUIC)

Use the SUIC option to access the Suicide Reports menu.

```

*****
**          IHS Behavioral Health System          **
**                Suicide Reports                **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

SSR   Aggregate Suicide Form Data - Standard
SAV   Aggregate Suicide Data Report - Selected Variables
SDEL  Output Suicide Data in Delimited Format
SGR   Listing of Suicide forms by Selected Variables
SUIC  Suicide Report (Age&Sex)
SPOV  Suicide Purpose of Visit Report

Select Suicide Related Reports Option:

```

Figure 13-80: Options on Suicide Report menu

13.4.5.1 Aggregate Suicide Form Data–Standard (SSR)

This report will tally the data items to the Suicide Form for a date range, community, and type of suicidal behavior (specified by the user).

Below are the prompts.

- “Enter Beginning Date of Suicide Act”
Specify the beginning date for the date range.
- “Enter Ending Date of Suicide Act”
Specify the ending date for the date range.
- “Report on Suicide Forms for Suicide Acts that occurred in”
Type one of the following: **O** (One particular Community) or **A** (All Communities).
- “Include which Suicidal Behaviors (0–9)”
The application displays the suicide behaviors. You can respond with a list or a range.
- “Demo Patient/Inclusion/Exclusion”
Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

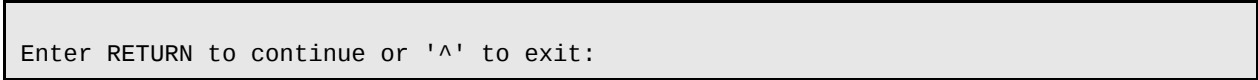
- “Do You wish to”

Type one of the following: **P** (print output) or **B** (browse output on screen).

The application displays the Aggregate Suicide Form Data–Standard report.

DEMO INDIAN HOSPITAL	Jul 13, 2009	Page 1
***** AGGREGATE SUICIDE FORM DATA - STANDARD*****		
Act Occurred: Jan 14, 2009 - Jul 13, 2009		
Community where Act Occurred: ALL Communities		

Age Range: 20-24 years	Total # of Suicide Forms: 1	
Suicidal Behavior:	ATT SUICIDE W/ ATT HOMICIDE	REPORT TOTALS 1 100%
Event logged by Discipline:	PSYCHIATRIST	1 100%
Event logged by Provider:	GAMMAA, RYAN	1 100%
Sex:	MALE	1 100%
Employed:	PART-TIME	1 100%
Tribe of Enrollment:	CHEROKEE NATION OF OKLAHOMA	1 100%
Community of Residence:	WELLING	1 100%
Relationship:	MARRIED	1 100%
Education:	COLLEGE GRADUATE	1 100%
Method:	GUNSHOT	1 100%
	HANGING	1 100%
Previous Attempts:	1	1 100%
Substance Use Involved:	NONE	1 100%
Location of Act:	WORK	1 100%
Disposition:	IN-PATIENT MENTAL HEALTH TREAT	1 100%
Contributing Factors:	DEATH OF FRIEND OR RELATIVE	1 100%
Age Range: 45-64 years	Total # of Suicide Forms: 13	
Suicidal Behavior:	IDEATION WITH PLAN AND INTENT	REPORT TOTALS 4 31%
	ATTEMPT	3 23%
	ATT SUICIDE W/ ATT HOMICIDE	3 23%
	ATT SUICIDE W/ COMP HOMICIDE	2 15%
	COMP SUICIDE W/ ATT HOMICIDE	1 8%
Event logged by Discipline:	ACUPUNCTURIST	7 54%
	PSYCHIATRIST	6 46%
Event logged by Provider:	GAMMAAA, DENISE	1 8%
	BETAAAA, BJ	7 54%
	THETAA, RYAN	5 38%



Enter RETURN to continue or '^' to exit:

Figure 13-81: Sample Aggregate Suicide Form Data - Standard report

13.4.5.2 Aggregate Suicide Form Data - Selected Variables (SAV)

This report will tally the selected data items for Suicide Forms in a particular date range.

13.4.5.3 Output Suicide Data in Delimited Format (SDEL)

This report will extract all data elements on the Suicide form in a delimited form for a specified date range.

13.4.5.4 Listing of Suicide forms by Selected Variables (SGR)

This report is a 'general retrieval' type report that will list the selected data items for Suicide Forms in a particular date range. You can also specify how to display the items in the printed report.

13.4.5.5 Suicide Report (Age & Sex) (SUIC)

This report will present, by age and sex, the number of individual patients who were seen for the following POVs: 39, 40, and 41 as well as V62.84 (Suicidal Ideation).

13.4.5.6 Suicide Purpose of Visit Report (SPOV)

This report will display the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Encs). Any records containing the International Classification of Diseases, Ninth Revision (ICD-9) Code v62, 84, Suicidal Ideation will be included in the tallies for Problem Code 39. A display by age and gender is also included.

Below are the prompts.

- “Enter Beginning Visit Date”
Specify the beginning visit date for the date range.
- “Enter Ending Visit Date”
Specify the ending visit date for the date range.
- “Run the Report for which Program”
Type one of the following: **O** (one program) or **A** (all programs). If you type **O**, other prompts will display.

- “Demo Patient Inclusion/Exclusion”

Type one of the following: **I** (include all patients), **E** (exclude demo patients), **O** (include only demo patients).

- “Do you wish to”

Type one of the following: **P** (print output) or **B** (browse output on screen)

The application displays the Suicide Purpose of Visit report.

* SUICIDE PURPOSE OF VISIT REPORT *														
VISIT Date Range: OCT 31, 2006 through NOV 30, 2006														
BOTH MALE AND FEMALE PATIENTS' VISITS														
39& v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed														
AGE GROUP	#	Encs	#	w	POV	39	w/	POV	40	w/	POV	41	w/	39/40/41
	#	%	#		%		#		%	#		%	#	%
1-4 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
5-9 yrs	2	10.0	0		0.0		0		0.0	0		0.0	0	0.0
10-14 yrs	7	35.0	0		0.0		0		0.0	0		0.0	0	0.0
15-19 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
20-24 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
25-34 yrs	6	30.0	0		0.0		0		0.0	0		0.0	0	0.0
35-44 yrs	2	10.0	0		0.0		0		0.0	0		0.0	0	0.0
45-54 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
55-64 yrs	1	5.0	0		0.0		0		0.0	0		0.0	0	0.0
65-74 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
75-84 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
85+ yrs	2	10.0	0		0.0		0		0.0	0		0.0	0	0.0
TOTAL	20	100.0	0		0.0		0		0.0	0		0.0	0	0.0
MALE PATIENTS VISITS														
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed														
AGE GROUP	#	Encs	#	w	POV	39	w/	POV	40	w/	POV	41	w/	39/40/41
	#	%	#		%		#		%	#		%	#	%
1-4 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
5-9 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
10-14 yrs	6	66.7	0		0.0		0		0.0	0		0.0	0	0.0
15-19 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
20-24 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
25-34 yrs	2	22.2	0		0.0		0		0.0	0		0.0	0	0.0
35-44 yrs	1	11.1	0		0.0		0		0.0	0		0.0	0	0.0
45-54 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
55-64 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
65-74 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
75-84 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
85+ yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0
TOTAL	9	100.0	0		0.0		0		0.0	0		0.0	0	0.0
FEMALE PATIENTS VISITS														
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed														
AGE GROUP	#	Encs	#	w	POV	39	w/	POV	40	w/	POV	41	w/	39/40/41
	#	%	#		%		#		%	#		%	#	%
1-4 yrs	0	0.0	0		0.0		0		0.0	0		0.0	0	0.0

5-9 yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	4	36.4	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS										
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	#	Encs	#	w POV 39	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	5	38.5	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - MALE PATIENTS										
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	#	Encs	#	w POV 39	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	50.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS										
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	#	Encs	#	w POV 39	#	w/ POV 40	#	w/ POV 41	#	w/ 39/40/41
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

25-34 yrs	3	33.3	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Figure 13-82: Sample Suicide Purpose of Visit report

13.5 Print Standard Behavioral Health Tables (TABL)

Use the TABL option to print the various BH tables (activity code, clinical codes, BH Problem/DSM IV, and BH Problem Codes).

The TABL option accesses the Print BH Standard Tables menu.

**	IHS Behavioral Health System
**	Print BH Standard Tables

Version 4.0 (patch 1)	
DEMO INDIAN HOSPITAL	
ACT	Print Activity Code Table
CLN	Print Clinic Codes
DSM	Print Behavioral Health Problem/DSM IV Table
PROB	Print Behavioral Health Problem Codes
Select Print Standard Behavioral Health Tables Option:	

Figure 13-83: Options on the Print BH Standard Tables menu

13.5.1 Print Activity Code Table (ACT)

Use the ACT option to print the activity code table.

XX	May 04, 2009		Page 1	
***** BEHAVIORAL HEALTH ACTIVITY CODES *****				
CODE	DESCRIPTION	CATEGORY	PCC	MNE
01	TWELVE STEP WORK - GROUP	PATIENT SERV	YES	TSG
02	TWELVE STEP WORK - INDIVIDUAL	PATIENT SERV	YES	TSI
03	TWELVE STEP GROUP	PATIENT SERV	NO	TWG
04	RE-ASSESSMENT, PATIENT PRESENT	PATIENT SERV	YES	RAS
05	RE-ASSESSMENT, PATIENT NOT PRESENT	SUPPORT SERV	NO	

11	SCREENING-PATIENT PRESENT	PATIENT SERV	YES	SCN
12	ASSESSMENT/EVALUATION-PATIENT PRESENT	PATIENT SERV	YES	EVL
13	INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT	PATIENT SERV	YES	IND
14	FAMILY/GROUP TREATMENT-PATIENT PRESENT	PATIENT SERV	YES	FAM
15	INFORMATION AND/ OR REFERRAL-PATIENT PRESENT	PATIENT SERV	YES	REF
16	MEDICATION/MEDICATION MONITORING-PATIENT PRESENT	PATIENT SERV	YES	MED
17	PSYCHOLOGICAL TESTING-PATIENT PRESENT	PATIENT SERV	YES	TST
18	FORENSIC ACTIVITIES-PATIENT PRESENT	PATIENT SERV	YES	FOR
19	DISCHARGE PLANNING-PATIENT PRESENT	PATIENT SERV	YES	DSG
Enter RETURN to continue or '^' to exit:				

Figure 13-84: Sample Behavioral Health Activity Codes report

13.5.2 Print Clinic Codes (CLN)

Use the CLN option to print the activity code table.

CLINIC STOP LIST		APR 16, 2009	14:22	PAGE 1
NAME	CODE			

ALCOHOL AND SUBSTANCE	43			
AMBULANCE	A3			
ANTICOAGULATION THERAPY	D1			
AUDIOLOGY	35			
BEHAVIORAL HEALTH	C4			
CANCER CHEMOTHERAPY	62			
CANCER SCREENING	58			
CARDIOLOGY	02			
CASE MANAGEMENT SERVICES	77			
CAST ROOM	55			
CHART REV/REC MOD	52			
CHEST AND TB	03			
CHIROPRACTIC	A6			
CHRONIC DISEASE	50			
COLPOSCOPY	C3			
COMPLEMENTARY MEDICINE	A5			

Figure 13-85: Sample Clinic Stop List codes

13.5.3 Print Behavioral Health Problem/DSM IV Table (DSM)

Use the DSM option to print the BH Problem/DSM IV Table codes.

XX	May 04, 2009	Page 1
***** BEHAVIORAL HEALTH PROBLEM/DSM CODES *****		

CODE	NARRATIVE	PROBLEM CODE	ICD-9 CODE
.9999	UNCODED DIAGNOSIS	99.9	.9999
010.00	PRIM TB COMPLEX-UNSPEC	99.9	010.00
011.41	TB LUNG FIBROSIS-NO EXAM	6.1	011.41
030.9	LEPROSY NOS	99.9	030.9
034.0	STREP SORE THROAT	5	034.0
054.10	GENITAL HERPES NOS	99.9	054.10
1	HEALTH/HOMEMAKER NEEDS	1	V60.4
Enter RETURN to continue or '^' to exit:			

Figure 13-86: Sample Behavioral Health Problem/DSM Codes report

13.5.4 Print Behavioral Health Problem Codes (PROB)

Use the PROB option to print the BH problem codes.

XX	May 04, 2009	Page 1
***** BEHAVIORAL HEALTH PROBLEM CODES *****		
CODE	NARRATIVE	PROBLEM CATEGORY
1	HEALTH/HOMEMAKER NEEDS	MEDICAL/SOCIAL PROBL
1.1	HEALTH PROMOTION/DISEASE PREVENTION	MEDICAL/SOCIAL PROBL
2	CROSS-CULTURAL CONFLICT	MEDICAL/SOCIAL PROBL
3	UNSPECIFIED MENTAL DISORDER(NON-PSYCHOTIC)	MEDICAL/SOCIAL PROBL
4	PHYSICAL DISABILITY/REHABILITATION	MEDICAL/SOCIAL PROBL
5	PHYSICAL ILLNESS, ACUTE	MEDICAL/SOCIAL PROBL
6.1	PHYSICAL ILLNESS, CHRONIC	MEDICAL/SOCIAL PROBL
6.2	PHYSICAL ILLNESS, TERMINAL	MEDICAL/SOCIAL PROBL
Enter RETURN to continue or '^' to exit:		

Figure 13-87: Sample Behavioral Health Problem Codes report

14.0 Manager Utilities Module (Roll and Scroll)

The Manager Utilities module provides options for Site Managers and program supervisors to customize BHS to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, resetting local flag fields, and verifying users who have edited particular patient records.

```

*****
**          IHS Behavioral Health System          **
**          Manager Utilities                     **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

SITE  Update Site Parameters
EXPT  Export Utility Menu ...
RPFF  Re-Set Patient Flag Field Data
DLWE  Display Log of Who Edited Record
ELSS  Add/Edit Local Service Sites
EPHX  Add Personal History Factors to Table
DRD   Delete BH General Retrieval Report Definitions
EEPC  Edit Other EHR Clinical Problem Code Crosswalk
UU    Update Locations a User can See

Select Manager Utilities Option:

```

Figure 14-1: Options on the Manager Utilities menu

This menu might be restricted to the site manager and the program manager or the designee. Use this menu for setting site-specific options related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and IHS Headquarters for mandated federal reporting and funding.

14.1 Update Site Parameters (SITE)

Use the SITE option to modify the parameters in the Behavioral Health file. Individual sites use the Site Parameters file to set BHS to suit their program needs.

Below are the prompts.

- “Select MHSS SITE PARAMETERS”

Specify the location where the program visits take place. If you use a new one, the application confirms that you are using the new one (type **Y** or **N**).

The application displays the Update BH Site Parameters window.

```

** UPDATE BH SITE PARAMETERS **      Site Name: SITEXXX
=====
Update DEFAULT Values?  N

Default Health Summary Type: BEHA0VIRAL HEALTH

Default response on form print: FULL      Suppress Comment on Suppressed
Form? NO

# of past POVs to display: 1              Exclude No Shows on last DX
Display? N

Update PCC Link Features?  N
Turn Off EHR to BH Link?  NO
Turn on PCC Coding Queue? YES              Update Provider Exception to E
Sig? N

Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits? N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:

COMMAND:                                Press <PF1>H for help
Insert

```

Figure 14-2: Sample Update BH Site Parameters window

Below are the fields on the window.

- Update DEFAULT Values?

Type **Y** or **N**. If you type **Y**, the application displays the following pop-up. All default settings are moved to this separate pop-up window.

```

**** Enter DEFAULT Values for each Data Item ****
MH Location: DEMO INDIAN HOSPITAL
MH Community: TAHLEQUAH              MH Clinic: MENTAL HEALTH
SS Location: DEMO INDIAN HOSPITAL
SS Community: TAHLEQUAH              SS Clinic: MEDICAL SOCIAL SERVI
Chemical Dependency Location: DEMO INDIAN HOSPITAL
Chemical Dependency Community: TAHLEQUAH
Chemical Dependency Clinic: BEHAVIORAL H
OTHER Location: DEMO INDIAN HOSPITAL
OTHER Community: TAHLEQUAH          OTHER Clinic: MENTAL HEAL

Default Type of Contact: OUTPATIENT
Default Appt/Walk In Response: APPOINTMENT
EHR Default Community: TAHLEQUAH

```

Figure 14-3: Pop-up for default values of BH site

Below are the prompts on the pop-up.

- “MH/SS/CD/OTHER Location”: Specify the name of the location where the program visits take place.

- “MH/SS/CD/OTHER Community”: Specify the name of the community where the program visits occur.
- “MH/SS/CD/OTHER Clinic”: Specify the name of the clinic where the program visits occur.
- “Default Type of Contact”: Specify the type of contact setting or code (e.g., Administrative, Chart Review, etc.).
- “Default Appt/Walk in Response”: Specify the type of visit that occurred (e.g., appointment, walk in, or unspecified).
- “EHR Default Community”: Specify the name of the default community used in the EHR. In order to pass EHR behavioral health encounter records into the BHS v4.0 files, a Default Community of Service field was created on the BHS v4.0 site parameters’ menu. If the facility has opted to pass behavioral health encounter records created in EHR to BHS v4.0, the application will populate the Community of Service field with the value entered in the site parameter EHR Default Community or, if that field is blank, with the default Mental Health community value. If the default Mental Health community value is blank, the field will be populated with the default Social Services community value; if that field is also blank, the field will be populated with the default Chemical Dependency value; and if that field is blank, the default Other Community value will be used. If none of the default community fields contains a value, no behavioral health record will be created.

Below are the fields on the update window.

- Default HEALTH Summary Type
Specify the type of health summary printed from within the BH package. Typically, the default value is the Mental Health/Social Services summary type. Refer to the Health Summary System Manuals for further information on the available types.
- Default response on form print
Your response applies to when you print a Mental Health/Social Services record. Type one of the following: **B** (both), **F** (full), **S** (suppressed form), **T** (Suppressed–two copies), **E** (Full–two copies). The suppressed report does *not* display the following information: Chief Complaint, SOAP note, measurement data, screenings.

A full encounter form prints all data for a patient encounter including the S/O/A/P note. The suppressed version of the encounter form will not display the S/O/A/P note for confidentiality reasons. It is important to note that the S/O/A/P and chief complaint will be suppressed, but the comment/next appt, activity code, and POV will still appear on the printed encounter.
- Suppress Comment on Suppressed Form?

Type **Y** or **N** to suppress the provider's comments.

- # of past POVs to display

Specify the number of the past POVs to be displayed on the Patient Data Entry screen. This response must be a whole number between 0 and 5.

- Exclude No Shows on last DX Display?

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

- Update PCC Link Features?

Type **Y** or **N**. If you type **Y**, the application displays the Update PCC Link Feature Parameters pop-up window.

```

**** Update PCC Link Feature Parameters ****
=====
Type of PCC Link
Type of Visit to create in PCC
Interactive PCC Link?
Allow PCC Problem List Update?
Update PCC LINK Exceptions?

```

Figure 14-4: Fields on the Update PCC Link Feature Parameters pop-up

The underlined fields are required on the pop-up window.

- Type of PCC Link: What you use determines the type of data that passes from BHS to the PCC. Use one of the following:
 - No Link Active. Use this option to have the data link between the two modules turned off. No data is passed to the PCC visit file from the BHS system (including the Health Summary). Therefore, because the RPMS Third Party Billing Package processes encounters in PCC, an alternative billing process will need to be established. If you leave this field blank, it is the same as choosing this option and no data will pass to PCC.
 - Pass STND Code and Narrative. Use this option to have all patient contacts in the Behavioral Health programs passed to the PCC visit file using the same ICD-9 code and narrative, as defined by the program. This approach does not facilitate billing because all encounters will appear the same. For example, if the code and narrative are entered in the site parameters as v65.40, Encounter, all encounters will have the ICD code of v65.40 and narrative of Encounter.

- Pass All Data as Entered (No Masking). Use this option to have all DSM IV and Problem Codes passed as ICD-9 codes as shown in the crosswalk along with the narrative as written by the provider. This link type is the one most preferred by billers and coders since the actual ICD code and narrative display in PCC.
- Pass Codes and Canned Narrative. Use this option to have both DSM IV and Problem Codes converted to ICD-9 codes as shown in the crosswalk and passed with a single standard narrative, as defined by the program, for all contacts. This type of link facilitates billing by passing the POV entered in BH applications as ICD codes although the standard narrative is not passed to the Health Summary.

For “Pass STND Code and Narrative” and “Pass Codes and Canned Narrative” options, the application displays the Standard Code to Use pop-up.

Standard Code to Use (Option 2 ONLY): V65.40 Narrative for MH Program: MH/SS/SA COUNSELING Narrative for SS Program: SS VISIT
--

Figure 14-5: Standard code to use screen

With each of these link types, standard data is passed to the PCC. You can specify those standards using the Standard Code to Use screen. The standard code, shown in the first line, will be passed if using Pass STND Code and Narrative. The narrative entered will be the only narrative passed if you have selected Pass STND Code and Narrative and Pass Codes and Canned Narrative options.

- Type of Visit to create in PCC: what you use determines the type of visit created from the encounter record you enter into BHS. Type one of the following, depending on the classification of the BHS programs at your facility.
 - **I** (IHS)
 - **C** (Contract)
 - **6** (638 Program)
 - **T** (Tribal)
 - **O** (Other)
 - **V** (VA)
 - **P** (Compacted Program)
 - **U** (Urban Program)

- Interactive PCC Link?: Type **Y** or **N**. The BHS site parameters contain a question about an interactive PCC link to address an issue with the PIMS Scheduling package. Because it is possible to set up a clinic in the Scheduling package that initiates a PCC record at check in, some sites were creating two separate records for each individual patient encounter in the behavioral health clinics. If you leave the field blank, this is the same as using N (for this prompt) and the interactive link will not be turned on.

In the Scheduling package, if the clinic set-up response is YES to the question about creating an encounter at check in, then the Interactive PCC Link question in the BHS site parameters must also be answered YES. If the clinic set up in the Scheduling package has a negative response, then the Interactive Link question in BHS should be set to NO.

Note: There should never be a mismatched response where one package has YES and the other NO.

- Allow PCC Problem List Update?: Type **Y** or **N** to allow the ability to update a patient's PCC problem list from within BHS.
- Update PCC LINK Exceptions?: Type **Y** or **N** to determine if you want to set data passing parameters for individuals that are different from the program default.

Provider Name	Type of PCC Link for this Provider
SIGMA, LORRAINE	NO LINK ACTIVE
CZZ, BILL	PASS CODE AND STND NARRATIVE
DELTA, GREG	PASS STND CODE AND NARRATIVE
MBETAA, MARY	PASS ALL DATA AS ENTERED

Figure 14-6: Setting up PCC link exceptions

Below are the fields on the update window.

- Turn Off EHR to BH Link?

Type **Y** or **N**. A site parameter was created to give sites the ability to “opt out” of the new behavioral health (BH) Electronic Health Record (EHR) visit functionality. This functionality allows BH providers to enter a visit into the EHR that passes first to PCC and then to the behavioral health database (AMH). These visits display in the EHR as well as the BH applications, BHS v4.0 and the RPMS Behavioral Health System v4.0 GUI.

The name of the site parameter is Turn Off EHR to BH Link and it is accessed via the BHS v4.0 Manager Utilities module SITE menu option. The default setting on this new site parameter is NO and no action is required if sites will be deploying the BH EHR functionality. If sites will not be deploying the BH EHR visit functionality, then the site parameter should be changed to YES.

- Turn on PCC Coding Queue?

Type **Y** (yes) or **N** (no).

- If you type **Y**, the visits will not be passed directly to the billing package. The visits will be marked as incomplete and must be reviewed by local data entry staff, billers, or coders.
- If you type **N**, all visits will continue to pass to PCC as complete.

Because the visits entered in the behavioral health system have always been marked as complete, the visits were going through PCC to the claims generator without review. With this version of the software, sites are given the option of transmission to the Coding Queue or continuing to send visits to PCC marked as complete.

In addition to establishing an option on the site parameters' menu to turn on the Coding Queue, an option that can be placed on data entry staff's RPMS menu has been created. Because the SOAP/Progress Notes related to visits created in BHS do not pass to PCC, the data entry staff, billers, and/or coders needed some method to access the notes for review. The option will allow them to review the specifics for a particular visit but will not give them full access to BHS. For example, they will not be able to view treatment plans, case status information, or the Suicide Reporting Forms.

Turning on the link to the Coding Queue in the Behavioral Health System should not be done if the PCC Coding Queue has not been activated. However, if the PCC Coding Queue has been activated and the site wants the BHS-generated visits to be reviewed, complete the following steps:

1. Log in to BHS v4.0 and select the Manager Utilities menu.
2. Select the Site Parameters option and enter the name of the site you want to update.
3. On the site parameters entry window, scroll down to the Turn on PCC Coding Queue field.
4. Type **Y** at this field.
5. Save the changes to the site parameters.

Once the coding queue option has been turned on and the changes to the site parameters are saved, any visits documented in BHS v4.0 will be flagged as incomplete. Visits created the same day but before the site parameters were changed will still be marked as complete. The date and time the visit was entered in RPMS determines the flag to be applied, not the date and time of service.

- Update Provider Exceptions to E Sig?

Type **Y** (yes) or **N** (no). The electronic signature function is available on the PDE, SDE, Intake, and Group entry menus (in roll and scroll) and also available on the One Patient, All Patients, Intake, and Group entry menus (in the GUI). Only those encounter records with signed SOAP/Progress Notes will pass to PCC.

If you type **Y**, the application displays the following pop-up.

Electronic Signature will not be activated for providers added to this list.

PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:

Figure 14-7: Place to list provider exceptions to electronic signature

Populate the PROVIDER field with the name of the provider with exception to electronic signature.

Because some sites might still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a particular provider should be exempted from the electronic signature, those visits will pass to PCC but show up as unsigned on the visit entry display.

- Update those allowed to see all records?

Type **Y** or **N** to determine if you want to update those allowed to see all records.

- If the user's name is added to this list, the user will be able to see all records entered into the system, whether the user was the provider of the visit or not, or whether the provider created the record or not.
- If the user's name is not added to this list, only those encounter records the user created or those on which the user was a provider will be visible to that user.

The Help prompt has been updated and provides the following information when the user types in a question mark (?): "If users need to see records other than their own, their names should be added to this list. Type a **Y** to update the list."

If you type **Y**, the following pop-up displays. You can add another user to the list. This new user will be able to see all visits when using the SDE or PDE options.

Enter only those users who should be permitted to see all Visit and Intake records for all patients whether they were the provider of record or the user who entered the record or not. Users not entered on this list will see only those Visits or Intake records that they entered or for which they were the provider of record. This parameter applies to the SDE menu option and all other options that display Visit and Intake information.

```

-----
+THETA, SHIRLEY
PHI, LISA M
RHO, SUSAN P
ALPHA, WENDY

```

Figure 14-8: List of names allowed to see all records

- Update those allowed to override delete?

Type **Y** or **N** to determine if you want to update those allowed to override delete.

If you type **Y**, the following pop-up displays. You can add another name to the list.

```

Enter only those users who should be permitted to delete any Intake
document, signed or unsigned, whether they are the user who
entered the Intake document or the provider of record.
-----

```

```

THETA, MARK
CHI, RONALD D SR
NU, KAREN

```

Figure 14-9: List of names allowed to delete any Intake document

- Update those allowed to share visits?

Type **Y** or **N** to update those allowed to share visit information via RPMS mail message.

If you type **Y**, the application displays the following pop-up. Here you can add a new name at the “User allowed to share visits via mail” prompt. All users permitted to share visit information via RPMS mail messages should be entered here.

```

Entering users into this field will give them access to send a copy of
a completed encounter form (either full or suppressed) to other
RPMS users. Keep confidentiality issues in mind when deciding on
who should be given this access.

```

```

User allowed to share visits via mail: BETA, BJ
User allowed to share visits via mail: ALPHA, WENDY
User allowed to share visits via mail: GAMMA, RYAN
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:
User allowed to share visits via mail:

```

Figure 14-10: Sample pop-up to enter user names allowed to share visits via mail

- Update those allowed to order Labs?

Type **Y** or **N** to permit those allowed to order laboratory tests.

If you type **Y**, the application displays the following pop-up. Here you can add a new name at the “User Permitted to Order Labs” prompt. All users permitted to order lab tests should be entered here.

```

The users that you enter into this field will be given access to
order LAB tests through the SEND PATIENT option.
If a user is not entered here he/she will not be granted access to the
LAB SEND PATIENT option.

User Permitted to Order Labs:
User Permitted to Order Labs:
User Permitted to Order Labs:

```

Figure 14-11: Pop-up to enter user names allowed to order labs

- If you are using the RPMS Pharmacy System, enter the Division
Specify the name of the division for the RPMS Pharmacy System.

14.2 Export Utility Menu (EXPT)

Use the EXPT option to access the options on the Export Utility Menu.

```

*****
**          IHS Behavioral Health System          **
**              Export Utility                    **
*****
                        Version 4.0 (patch 1)

                        DEMO INDIAN HOSPITAL

GEN    Generate BH Transactions for HQ
DISP   Display a Log Entry
PRNT   Print Export Log
RGEN   Re-generate Transactions
RSET   Re-set Data Export Log
CHK    Check Records Before Export
EDR    Re-Export BH Data in a Date Range
ERRS   Print Error List for Export
OUTP   Create OUTPUT File

Select Export Utility Menu Option:

```

Figure 14-12: Options on the Export Utility Menu

Use the options on this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes.

Important: This set of utilities should only be accessed and used by the site manager, the BH program manager, or designee.

These options should be familiar to site managers and other RPMS staff who generate exports. The recommended sequence for their use follows those from PCC-CHK, clean, GEN, DISP, ERRS, transmit. RGEN, RSET, and OUTP should be reserved for expert use as required.

14.2.1 Generate BH Transactions for HQ (GEN)

Use the GEN option to generate BHS transactions to be sent to HQ. The transactions are for records posted between a specified date range.

The transactions are for records posted since the last time you did an export up until the previous day. Both BH visit records and Suicide forms will be exported.

You can type a caret (^) at any prompt to exit and the application will ask you to confirm your entries prior to generating transactions.

The application displays the following information:

```
The inclusive dates for this run are DEC 28,2008 through APR 18,2009.
The location for this run is DEMO INDIAN HOSPITAL.
Do you want to continue? N//
```

Figure 14-13: Sample information before continuing

- Do you want to continue?

Type **Y** or **N**. If you type **N**, you return to the Export Utility menu. If you type **Y**, the prompts continue.

- Do you want to QUEUE this to run at a later time?

Type **Y** or **N**. If you type **Y**, the generation will be put in the queue. If you type **N**, the generate process continues. The BH export generally takes less than five minutes to generate. It will still tie up your computer while doing the export (but it is quick).

```
Enter beginning date for this run:  SEP 1, 2008

The inclusive dates for this run are  SEP 1, 2008  THROUGH  SEP 30,
2008
The location for this run is the _____HOSPITAL/CLINIC.

Do you want to continue (Y/N)  N// Y

Generating transactions.      Counting records      (  * 100*  )
```

```
*100* Transactions were generated.
Updating log entry.
Deleting cross reference entries (100)

RUN TIME (H.M.S): 0.3.56
```

Figure 14-14: Sample information for generating the new log entry

14.2.2 Display a Log Entry (DISP)

Use the DISP option to display the extract log information in a specified date range.

- **Select MHSS EXTRACT LOG BEGINNING DATE**
Specify the extract log beginning date. (You can view the extract date by typing a question mark (?) at this prompt.)
- **Select MHSS EXTRACT LOG ENDING DATE**
Specify the extract log ending date.

The application displays the extract log information.

```
NUMBER: 2                      BEGINNING DATE: SEP 1, 2008
ENDING DATE: SEP 30, 2008@10:26:49
RUN STOP DATE/TIME: OCT 2, 1994@10:30:51
COUNT OF ERRORS: 2           COUNT OF TRANSACTIONS: 98
COUNT OF RECORDS PROCESSED: 100    RUN LOCATION: _____
# ADDS: 97                     # MODS: 1
# DELETES: 0
TRANSMISSION STATUS: SUCCESSFULLY COMPLETED
```

Figure 14-15: Sample extract log information

14.2.3 Print Export Log (PRNT)

Use the PRNT option to display the export extract log report.

The application displays the previous selection beginning date.

- **START WITH BEGINNING DATE**
Press Enter to accept the default date. Otherwise, specify the first beginning date of the date range.
- **GO TO BEGINNING DATE**
Press Enter to accept to default date. Otherwise, specify the next beginning date.
- **DEVICE**
Specify the device to print/browse the log.

The application displays the Mental Health/Social Service Export Extract Log.

*****MENTAL HEALTH/SOCIAL SERVICES*****						
EXPORT EXTRACT LOG						
			PAGE: 1			
			REPORT DATE: 04/20/09			
	ADDS	DEL	MODS	TRANS	ERROR	RECORD
=====						
3	10/24/06	12/21/06		39	10	45
	10/24/06	12/21/06				
4	12/20/06	05/14/07		256	34	278
	12/20/06	05/14/07				
5	05/13/07	08/22/07		128	55	181
	05/13/07	08/22/07				
6	08/21/07	10/03/08		537	77	595
	08/21/07	10/03/08				
7	10/02/08	11/17/08		21	4	17
	10/02/08	11/17/08				
8	11/16/08	12/10/08		185	12	180
	11/16/08	12/10/08				
9	12/09/08	12/29/08		33	0	33
	12/09/08	12/29/08				

TOTAL	0	0	0	1199	192	1329

Figure 14-16: Sample export extract log

14.2.4 Regenerate Transactions (RGEN)

Use the RGEN option to regenerate transactions between two dates.

Warning: Do not use this option if you are not an expert user.

Below are the prompts.

- “Select MHSS EXTRACT LOG BEGINNING DATE”

Specify the beginning date.

If you specified an existing date, the application displays the following information (example uses Log Entry 3).

Log entry 6 was for date range MAR 2, 2007 through JUN 16, 2007
And generated 44 transactions from 67 records.

This routine will generate transactions.

Do you want to regenerate the transactions for this run? N//

Figure 14-17: Sample information about regenerate transactions

14.2.5 Reset Data Export Log (RSET)

Use the RSET option to reset the BH Data Transmission Log. You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place!

The BH Data Transmission log entry you choose will be *removed* from the log file and all Utility and Data globals associated with that run will be killed.

14.2.6 Check Records Before Export (CHK)

Use the CHK option to review records that were posted between two dates. The application displays the two dates, such as APR 19, 2009 and APR 20, 2009 inclusive. If the entries are hitting this list, they aren't passing to PCC and the billing package.

Note: This option will review all records that were posted from the day after the last date of that run up until two days previous.

The application displays the BH Export Record Review report.

DEMO INDIAN HOSPITAL						Page 1
BH EXPORT RECORD REVIEW						
Record Posting Dates: APR 19, 2009 and APR 20, 2009						
RECORD DATE	PATIENT	HRN	PGM	TYPE	ACT TYPE	

APR 20, 2009@09:44 E023-NO AFFILIATION FOR PROVIDER	ALPHA,CHELSEA MARIE	116431	S	OUTPATIENT	16	
APR 20, 2009@09:51 E023-NO AFFILIATION FOR PROVIDER	DELTA,EDWIN RAY	105321	S	OUTPATIENT	85	
APR 20, 2009@10:46 E023-NO AFFILIATION FOR PROVIDER	DELTA,EDWIN RAY	105321	S	OUTPATIENT	85	
APR 20, 2009@10:56 E023-NO AFFILIATION FOR PROVIDER	SIGMA,SERGIO	206293	S	OUTPATIENT	15	
APR 20, 2009@10:00 E023-NO AFFILIATION FOR PROVIDER	ALPHA,CHRYSTAL GAYL	106299	M	OUTPATIENT	94	
RUN TIME (H.M.S): 0.0.0						
End of report: PRESS ENTER:						

Figure 14-18: Sample report about records before export

14.2.7 Print Error List for Export (ERRS)

Use the ERRS option to print/browse the report that shows all records that have been posted to the database and are still in error AFTER the latest Export/Generation.

If the records are listed here, they aren't passing to PCC and the billing package.

Below are the prompts.

- “Select MHSS EXTRACT LOG BEGINNING DATE”

Specify the extract log beginning date. (You can view the extract date by typing a question mark (?) at this prompt.)

Note: The Check Records before Export option should have been used to determine all errors before running the generation. You can now correct these remaining errors before the next export/generation.

- “Device”

Specify the device to print/browse the report.

The application displays the MHSS Extract Log Error Report.

MHSS EXTRACT LOG ERROR REPORT					APR 20, 2009 13:15	PAGE 1
VISIT DATE	PATIENT	HRN	PGM	TYPE		ACT TYPE

AUG 21, 2006 17:44	ALPHAAA, STEVEN ALLAN	165583	S	OUTPATIENT		31
ERROR: E021-NO PURPOSE OF VISIT						
JUNE 8, 2006						
ERROR: E023-NO AFFILIATION FOR PROVIDER						
Press ENTER to Continue:						

Figure 14-19: Sample MHSS Extract Log Error Report

14.2.8 Create OUTPUT File (OUTP)

Use the OUTP option to create an output file. Consult with the site manager on how to create an RPMS export.

14.3 Re-Set Patient Flag Field Data (RPFF)

Use the RPFF option to reset all patient flag fields to null. This should be done each time you want to flag patients for a different reason. You can reset one particular flag or all flags. You may use this reset option to reassign a particular flag or all flags as needed.

Below are the prompts.

- “Reset which flags”

Type one of the following: **A** (all flags) or **O** (one particular flag). If you type **O**, other prompts will display.

- “Are you sure you want to do this?”

Type **Y** or **N**. If you type **Y**, the application shows the following information:

```
Hold on... resetting data..
All done.
```

Figure 14-20: Information from the application about the reset process

14.4 Display Log of Who Edited Record (DLWE)

Use the DLWE option to display a list of who edited BH records of a specified patient.

Below are the prompts.

- “Enter ENCOUNTER DATE”

Specify the date of the encounter.

- “Enter LOCATION OF ENCOUNTER”

If known, specify the location. Otherwise press Enter.

- “Enter PATIENT”

Specify the name of the patient.

The application displays the Behavioral Health Visits for the date specified. The following examples were visits with no location and no patient.

Behavioral Health visits for APR 10, 2009							
#	PROVIDER	LOC	COMMUNITY	ACT	CONT	PATIENT	PROB NARRATIVE
1	GAMMAA, RYAN	WW	TAHLEQUAH		OUTP	WW 116431	14

2	BETAAAA, BJ	WW	TAHLEQUAH	99	OUTP	WW	108704	296.32	DEPRESSED
3	GAMMAA, RYAN	WW	TAHLEQUAH	13	ADMI	-----		14.1	SCHIZOPHRENIA
4	GAMMAA, RYAN	LC	ABIQUIU	76	INTE	WW	105321	15	BIPOLAR DISORDE
5	GAMMAA, RYAN	WW	TAHLEQUAH	16	OUTP	WW	116431	311.	DEPRESSIVE DISO
6	GAMMAA, RYAN	WW	TAHLEQUAH	19	OUTP	WW	116431	314.9	ATTENTION-DEFIC
7	GAMMAA, RYAN	WW	TAHLEQUAH	16	OUTP	WW	116431	295.15	SCHIZOPHRENIA,

Which record do you want to display: (1-7):

Figure 14-21: Sample Behavioral Health Visits window

You can display the visit data for a particular record by responding the “Which record do you want to display?” prompt. The application displays the visit data.

MHSS RECORD LIST				APR 20, 2009 11:31		PAGE 1
DATE						
CREATED	WHO ENTERED	RECORD	LAST MOD	USER	LAST	UPDATE
	DATE/TIME	EDITED	WHO EDITED			

04/10/09	BETAAAA, BJ		04/10/09	BETAAAA, BJ		
	APR 10, 2009	12:01	BETAAAA, BJ			
	APR 10, 2009	12:04	BETAAAA, BJ			
	APR 10, 2009	12:05	BETAAAA, BJ			
	APR 10, 2009	12:06	BETAAAA, BJ			

End of report. Press enter:

Figure 14-22: Sample report about visit data of a particular record

14.5 Add/Edit Local Service Sites (ELSS)

Use the ELSS option to add/edit location service sites. If you add a new location service site, you give it a name and abbreviation. Counts of these visits can be recovered using the GEN option in Encounter Reports or ACT in the Workload reports.

Below are the prompts.

- “Select MHSS LOCAL SERVICE SITES”

Specify a new or existing local service site. Specify a new service site using 3–30 characters.

If you specify a new service site, the application confirms that you are adding this new service site (type **Y** or **N**); if you type **N**, the above prompt repeats.

If you specify an existing factor, for example, HEADSTART, the application displays the following prompt:

- “LOCAL SERVICE SITE: HEADSTART//”

You can accept the existing service site by pressing Enter. Otherwise, you can give it a new service site name.

- “ABBREVIATION: HEAD”

You can accept the abbreviation of the existing service site by pressing Enter. Otherwise, you can give it another abbreviation.

14.6 Add Personal History Factors to Table (EPHX)

Use the EPHX option to add personal history factors to the four-item list initially identified for use in BHS programs. Added items will be shown as items in the Personal History field any place this option exists in a Select or Print field in the GEN reports.

Below are the prompts.

- “Enter a PERSONAL HISTORY FACTOR”

Specify a new or existing personal history factor. If you use a new factor, using 3–30 characters, with no numeric or starting with punctuation.

If you specify a new factor, the application confirms that you are adding this new factor (type **Y** or **N**); if you type **N**, the above prompt repeats.

If you specify an existing factor, for example, **FAS**, the application displays the following prompt:

- “FACTOR: FAS//”

You can accept the existing factor by pressing Enter. Otherwise, you can give it a new factor name.

14.7 Delete BH General Retrieval Report Definitions (DRD)

Use the DRD option to delete a PCC Visit or Patient General Retrieval report definition. This option enables the user to delete a PCC Visit or Patient General Retrieval report definition. For example, if a provider had created multiple report definitions using GEN or PGEN and saved the logic, these reports may be deleted when the provider leaves the facility.

Below are the prompts.

- “REPORT NAME”

Specify the name of the report whose definition you want to remove. You can type a question mark (?) at this prompt to view a list of existing definitions.

- “Are you sure you want to delete the [report name] definition?”

The [report name] is the name of the report you specified in the previous prompt.
Type **Y** or **N** at this confirmation prompt.

14.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

Use the EEPC option to loop through all MHSS PROBLEM/DSM IV table entries created by EHR users to change the grouping from the generic 99.9 OTHER EHR CLINICAL grouping to a more specific MHSS PROBLEM CODE grouping.

In the RPMS behavioral health applications, the POV is recorded as either a BH Problem Code or DSM-IV TR code. For the purpose of reports, these codes are grouped within larger problem code groupings and then again in overarching categories. For example, DSM-IV TR code 311 Depressive Disorder NOS is also stored as problem code grouping 14 Depressive Disorders and problem category Psychosocial Problems.

In the RPMS EHR, the POV is recorded using ICD-9 codes, not DSM-IV TR codes. Many ICD and DSM numeric codes are identical. There may be instances when a provider selects an ICD code that does not have a matching DSM code. When this occurs it will be dynamically added to the MHSS PROBLEM/DSM IV table. Once the ICD-9 code is in the MHSS PROBLEM/DSM IV table, then it is accessible to users in BHS or BH GUI as well.

These ICD-9 codes that have been added to the MHSS PROBLEM/DSM IV table will not have been automatically assigned to the appropriate BH problem code group. To ensure that these ICD-9 codes are captured in BHS reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time.

Below are sample prompts for a site.

- “CODE: V72.3”
- “ICD Narrative: GYNECOLOGIC EXAMINATION”
- “Enter the Problem Code Grouping”

Specify the grouping code for the above Code and ICD Narrative.

The application provides you with the caret (^) option so that you don’t have to go all the way through the entries.

14.9 Update Locations a User can See (UU)

Use the UU option to specify the location a user can view in this application.

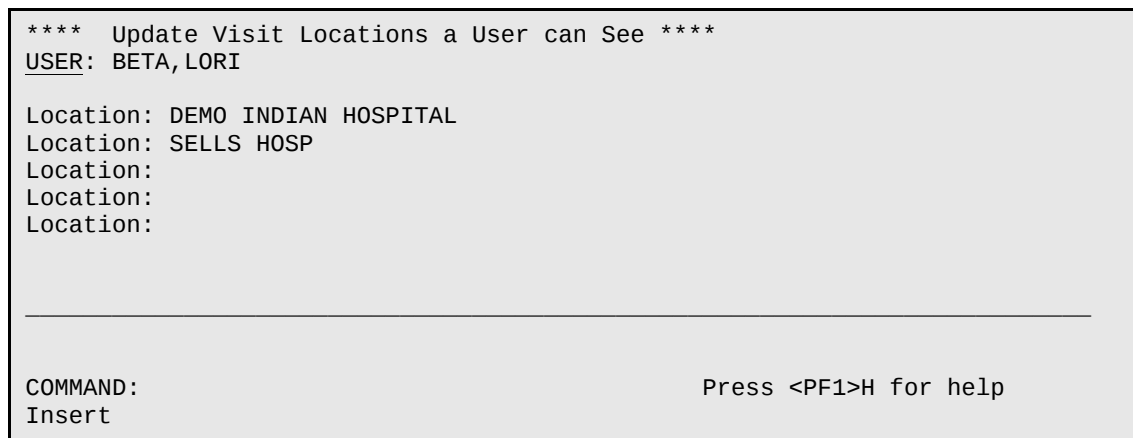
BHS v4.0 contains a new field called the BH User that will permit a site to screen the locations that a user may access to view or enter information.

If a site wants to limit the visits by location that a BH user can access then they will enter that user into this file and list all the facilities/locations that that user is allowed to “see” or access. If an entry is made in this file for a user that user will only be able to “lookup” patients with a health record at those facilities, only patients with health records at those facilities will display on patient lists and reports, and will only be able to view/access visits to those locations. If a user is not entered into this file that person will be able to see visits to all locations. This file will only be updated if a site is multidivisional and there is a need to restrict the viewing of data between sites.

- **Select BH USER NAME**

Specify the user you want to use. This will add the user to the BH User file. A ScreenMan screen will pop-up and the manager can enter all of the locations that the user is able to access or “see” on the screen.

The application displays the Update Visit Locations a User can See window.



```
**** Update Visit Locations a User can See ****
USER: BETA, LORI

Location: DEMO INDIAN HOSPITAL
Location: SELLS HOSP
Location:
Location:

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

Figure 14-23: Sample Update Visit Locations a User can See window

- **Location**

Specify the location that the user can view in this application.

You can specify more than one location. If this is the case, use the next Location field.

In the above example, the provider Lori Beta will only be able to access visits to Demo Indian Hospital and Sells Hospital. If a patient that she is treating had a visit to Phoenix Hospital, she would not see that visit information. This logic applies to any option that displays or reports on visit data. For example, Lori Beta chooses option “Browse Visits” she would not see any visit in the visit list that was to a location other than the two listed above.

Appendix A: Activity Codes and Definitions

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

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

A.1 Patient Services—Patient Always Present (P)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

- **01–Twelve Step Work – Group (TSG)**

Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

- **02–Twelve Step Work - Individual (TSI)**

Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

- **03–Twelve Step Group (TSG)**

Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, Co-dependents Anonymous (CoDA).and Overeaters Anonymous (OA).

- **04-Re-assessment, Patient Present (RAS)**

Formal assessment activities intended to reevaluate the patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

- **11-Screening (SCN)**

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

- **12-Assessment/Evaluation (EVL)**

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

- **13-Individual Treatment/Counseling/Education (IND)**

Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

- **15-Information and/or Referral (REF)**

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

- **16-Medication/Medication Monitoring (MED)**

Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

- **17-Psychological Testing (TST)**

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

- **18-Forensic Activities (FOR)**

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

- **19-Discharge Planning (DSG)**

Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

- **20-Family Facilitation (FAC)**

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

- **21-Follow-through/Follow-up (FOL)**
Periodic evaluative review of a specific client/patient's progress after discharge.
- **22-Case Management (CAS)**
Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination.
- **23-Other Patient Services not identified here (OTH)**
Any other patient services not identified in this list of codes.
- **47-Couples Treatment (CT)**
Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.
- **48-Crisis Intervention (CIP)**
Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.
- **85-Art Therapy (ART)**
The application of a variety of art modalities (drawing, painting, clay, and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.
- **86-Recreation Activities (REC)**
Recreation and leisure activities with the purpose of improving and maintaining clients'/patients' general health and well-being.
- **88-Acupuncture (ACU)**
The use of the Chinese practice of Acupuncture in the treatment of addiction disorders (including withdrawal symptoms and recovery) and other behavioral health disorders.
- **89-Methadone Maintenance (MET)**
Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed methadone maintenance agency under the supervision of a physician. Services include methadone dosing, medical care, counseling and support and disease prevention and health promotion.

- **90–Family Treatment (FAM)**

Family-centered therapy with an emphasis on the client/patient’s functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences; often brief and solution focused.

- **91–Group Treatment (GRP)**

This form of therapy involves groups of patients/clients who have similar problems that are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

- **92–Adventure Based Counseling (ABC)**

The use of adventure-based practice to effect a change in behaviors (both increasing function and positive action and decreasing dysfunction and negative action) as it relates to health and/or mental health.

- **93–Relapse Prevention (REL)**

Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

- Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
- Strategies for avoiding high-risk situations
- Strategies for coping with high-risk situations when encountered
- Strategies for coping with alcohol/drug cravings
- Strategies for coping with lapses to drug use to prevent full-blown relapses

- **94–Life Skills Training (LST)**

Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

- **95–Cultural Activities - Pt. Present (CUL)**

Participation in educational, social, or recreational activities for the purpose of supporting a client/patient’s involvement, connection, and contribution to the patient’s cultural background.

- **96–Academic Services (ACA)**

Provision of alternative schooling under the guidelines of the state education program.

- **97–Health Promotion (HPR)**

Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

A.2 Support Services—Patient Not Present (S)

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

- **05-Reassessment, Patient Not Present**

Reassessment or reevaluation activities when patient is not present at time of service delivery.

- **24-Material/Basic Support (SUP)**

Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

- **25-Information and/or Referral (INF)**

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

- **26-Medication/Medication Monitoring (MEA)**

Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

- **27-Forensic Activities (FOA)**

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

- **28-Discharge Planning (DSA)**

Collaborative service planning with other community caregivers to develop a goal oriented follow-up plan for a specific client/patient.

- **29-Family Facilitation (FAA)**

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

- **30-Follow-up/Follow-through (FUA)**

Periodic evaluative review of a specific client/patient's progress after discharge.

- **31-Case Management (CAA)**

Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

- **33-Technical Assistance**

Task-specific assistance to achieve an identified end.

- **34-Other Support Services**

Any other ancillary, adjunctive, or collateral services not identified here.

- **44-Screening**

Activities associated with patient/client screening where no information is added to the patient/client's file.

- **45-Assessment/Evaluation**

Assessment or evaluation activities when patient is not present at time of service delivery.

- **49-Crisis Intervention (CIA)**

Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes:

- **35-Collaboration**

Collaborative effort with other agency or agencies to address a community request.

- **36-Community Development**

Planning and development efforts focused on identifying community issues and methods of addressing these needs.

- **37-Preventive Services**

Activity, class, project, public service announcement, or other activity whose primary purpose is to prevent the use/abuse of alcohol or other substances and/or improve lifestyles, health, image, etc.

- **38-Patient Transport**

Transportation of a client to or from an activity or placement, such as a medical appointment, program activity, or from home.

- **39-Other Community Services**

Any other form of community services not identified here.

- **40-Referral**

Referral of a client to another agency, counselor, or resource for services not available or provided by the referring agency/program. Referral is limited to providing the client with information and might extend to calling and setting up appointments for the client.

- **87-Outreach**

Activities designed to locate and educate potential clients and motivate them to enter and accept treatment.

A.4 Education Training (E)

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job related knowledge, attitudes, and skills. Includes:

- 41-Education/Training Provided
- 42-Education/Training Received
- 43-Other Education/Training

A.5 Administration (A)

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

- **32-Clinical Supervision Provided**

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

- **50-Medical Rounds (General)**

On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

- **51-Committee Work**

Participation in the activities of a body of persons delegated to consider, investigate, take action on, or report on some matter.

- **52-Surveys/Research**

Participation in activities aimed at identification and interpretation of facts, revision of accepted theories in the light of new facts, or practical application of such new or revised theories.

- **53-Program Management**

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

- **54-Quality Improvement**

Participation in activities focused on improving the quality and appropriateness of medical or behavioral healthcare and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

- **55-Supervision**

Participation in activities to ensure that personnel perform their duties effectively. This code does not include clinical supervision.

- **56-Records/Documentation**

Review of clinical information in the medical record/chart or documentation of services provided to or on behalf of the client. This does not include the time spent in service delivery.

- **57-Child Protective Team Activities**

Participation in a multi-disciplinary child protective team to evaluate alleged maltreatments of child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance their caregiver's capacity to provide a safer environment when possible.

- **58-Special Projects**

A specifically-assigned task or activity which is completed over a period of time and intended to achieve a particular aim.

- **59-Other Administrative**

Any other administrative activities not identified in this section.

- **60-Case Staffing (General)**

A regular or ad-hoc forum for the exchange of clinical experience, ideas and recommendations.

- **66-Clinical Supervision Received**

Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

A.6 Consultation (L)

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

- **61-Provider Consultation (PRO)**

Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

- **62-Patient Consultation (Chart Review Only) (CHT)**

Focus is a specific patient and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

- **63-Program Consultation**

Focus is a programmatic effort to address specific needs.

- **64-Staff Consultation**

Focus is a provider or group of providers addressing a type or class of problems.

- **65-Community Consultation**

Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

A.7 Travel (T)

- **71-Travel Related to Patient Care**

Staff travel to patient's home or other locations – related to provision of care. Patient is not in the vehicle.

- **72 Travel Not Related to Patient Care**

Staff travel to meetings, community events, etc.

A.8 Placements (PL)

- **75-Placement (Patient Present) (OHP)**

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

- **76-Placement (Patient Not Present) (OHA)**

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences. This activity might include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

A.9 Cultural Issues (O)

- **81-Traditional Specialist Consult (Patient Not Present) (TRA)**

Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

- **82-Traditional Specialist Consult (Patient Not Present) (TRA)**

Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

- **83-Tribal Functions**

Services offered during or in the context of a traditional tribal event, function, or affair—secular or religious. Community members gather to help and support individuals and families in need.

- **84-Cultural Education to Non-Tribal Agency/Personnel**

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

Appendix B: Activity Codes that Pass to PCC

Activity Code	Description	Pass to PCC
01	Twelve Step Work – Group (TSG)	Yes
02	Twelve Step Work – Individual (TSI)	Yes
03	Twelve Step Group (TWG)	No
04	Re-Assessment, Patient Present	Yes
05	Re-Assessment, Patient Not Present	No
11	Screening – Patient Present (SCN)	Yes
12	Assessment/Evaluation – Patient Present (EVL)	Yes
13	Individual Treatment/Counsel/Education – Pt. Present (IND)	Yes
15	Information and Referral – Patient Present (REF)	Yes
16	Medication/Medication Monitoring – Pt. Present (MED)	Yes
17	Psychological Testing – Patient Present (TST)	Yes
18	Forensic Activities – Patient Present (FOR)	Yes
19	Discharge Planning – Patient Present (DSG)	Yes
20	Family Facilitation – Patient Present (FAC)	Yes
21	Follow Through/Follow Up – Patient Present (FOL)	Yes
22	Case Management – Patient Present (CAS)	Yes
23	Other Patient Services Not Identified – Patient Present (OTH)	Yes
24	Material/Basic Support – Patient Not Present (SUP)	No
25	Information and/or Referral – Patient Not Present (INF)	No
26	Medication/Medication Monitoring – Pt. Not Present (MEA)	Yes
27	Forensic Activities – Patient Not Present (FOA)	No
28	Discharge Planning – Patient Not Present (DSA)	No
29	Family Facilitation – Patient Not Present (FAA)	No
30	Follow Through/Follow Up – Patient Not Present (FUA)	No
31	Case Management – Patient Not Present (CAA)	Yes
32	Clinical Supervision Provided	No
33	Technical Assistance – Patient Not Present	No
34	Other Support Services – Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening – Patient Not Present	No
45	Assessment/Evaluation – Patient Not Present	No
47	Couples Treatment – Patient Present (CT)	Yes

Activity Code	Description	Pass to PCC
48	Crisis Intervention – Patient Present (CIP)	Yes
49	Crisis Intervention – Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes

Appendix C: ICD-9CM v Codes

ICD Code	Description
v11.0	Personal history of Schizophrenia
v11.1	Personal history of affective disorders
v11.2	Personal history of neurosis
v11.3	Personal history of alcoholism
v11.8	Personal history of other mental disorders
v11.9	Personal history of unspecified mental disorder
v13.21	Personal history of pre-term labor
v13.7	Personal history of perinatal problems
v15.41	History of physical abuse (includes rape)
v15.42	History of emotional abuse or neglect
v15.49	Psychological trauma, not elsewhere classified
v15.52	Personal History of Traumatic Brain Injury (TBI)
v15.81	History of noncompliance with medical treatment
v15.82	History of tobacco use
v15.89	Other personal history presenting hazards to health
v15.9	Unspecified personal history presenting hazards to health
v17.0	Family history of psychiatric condition
v18.4	Family history of mental retardation
v23.9	Supervision of unspecified high risk pregnancy
v25.09	General counseling and advice on contraceptive management; family planning advice
v26.33	Genetic counseling
v26.41	Procreative counseling and advice using natural family planning
v26.49	Other procreative management counseling and advice
v40.0	Mental and behavioral problems with learning
v40.1	Mental and behavioral problems with communication including speech
v40.2	Other mental problems
v40.3	Other behavioral problems
v40.9	Unspecified mental or behavioral problem
v57.9	Care involving unspecified rehabilitation procedure
v60.0	Lack of housing
v60.1	Inadequate housing
v60.2	Inadequate material resources
v60.3	Person living alone
v60.4	No other household member able to render care
v60.5	Holiday relief care
v60.6	Person living in a residential institution
v60.8	Other specified housing or economic circumstances
v60.81	Foster care (status)
v60.89	Unspecified housing or economic circumstances
v61.01	Family disruption due to family member on military deployment

ICD Code	Description
v61.02	Family disruption due to return of family member from military deployment
v61.03	Family disruption due to divorce or legal separation
v61.04	Family disruption due to parent-child estrangement
v61.05	Family disruption due to child in welfare custody
v61.06	Family disruption due to child in foster care or in care of non-parental family member
v61.07	Family disruption due to death of family member
v61.08	Family disruption due to other extended absence of family member
v61.09	Other family disruption
v61.10	Counseling for marital and partner problems, unspecified
v61.11	Counseling for victim of spousal and partner abuse
v61.12	Counseling for perpetrator of spousal and partner abuse
v61.20	Counseling for parent-child problem, unspecified
v61.21	Counseling for victim of child abuse
v61.22	Counseling for perpetrator of parental child abuse
v61.23	Counseling for parent-biological child problem
v61.24	Counseling for parent-adopted child problem
v61.25	Counseling for parent (guardian)-foster child problem
v61.3	Problems with aged parents or in-laws
v61.41	Alcoholism in family
v61.49	Other health problems within family
v61.5	Multiparity
v61.6	Illegitimacy or illegitimate pregnancy
v61.7	Other unwanted pregnancy
v61.8	Other specified family circumstances
v61.9	Unspecified family circumstances
v62.0	Unemployment
v62.1	Adverse effects of work environment
v62.21	Personal current military deployment status
v62.22	Personal history of return from military deployment
v62.29	Other occupational circumstances or maladjustment
v62.3	Educational circumstances
v62.4	Social maladjustment
v62.5	Legal circumstances
v62.6	Refusal of treatment for reasons of religion or conscience
v62.81	Interpersonal problems, not elsewhere classified
v62.82	Bereavement, uncomplicated
v62.83	Counseling for perpetrator of physical/sexual abuse
v62.84	Suicidal ideation
v62.89	Other psychological or physical stress, not elsewhere classified (life circumstance problems; phase of life problems, borderline intellectual functioning; religious or spiritual problem)
v62.9	Unspecified psychosocial circumstance
v63.0	Residence remote from hospital or other health care facility

ICD Code	Description
v63.1	Medical services in home not available
v63.2	Person awaiting admission to adequate facility elsewhere
v63.8	Other specified reasons for unavailability of medical facilities
v63.9	Unspecified reason for unavailability of medical facilities
v65.0	Healthy person accompanying a sick person
v65.11	Pediatric pre-birth visit for expectant mother
v65.19	Other person consulting on behalf of another person
v65.2	Person feigning illness
v65.3	Dietary surveillance and counseling
v65.40	Other unspecified counseling
v65.41	Exercise counseling
v65.42	Counseling on substance use and abuse
v65.43	Counseling on injury prevention
v65.44	HIV Counseling
v65.45	Counseling on other sexually transmitted diseases
v65.49	Other specified counseling
v65.5	Person with feared complaint in whom no diagnosis was made
v65.8	Other reasons for seeking consultation
v65.9	Unspecified reason for consultation
v66.3	Convalescence following psychotherapy and other treatment for mental disorder
v66.7	Encounter for palliative care (end of life care)
v67.3	Follow-up examination following psychotherapy and other treatment for mental disorder
v68.1	Issue of repeat prescriptions
v68.2	Request for expert evidence
v68.81	Referral of patient without examination or treatment
v68.89	Encounter for other specified administrative purpose
v68.9	Encounters for unspecified administrative purpose
v69.0	Problems related to lifestyle – lack of exercise
v69.1	Problems related to lifestyle – Inappropriate diet and eating habits
v69.2	Problems related to lifestyle – High risk sexual behavior
v69.3	Problems related to lifestyle – gambling and betting
v69.4	Problems related to lifestyle – lack of adequate sleep
v69.5	Problems related to lifestyle – behavioral insomnia of childhood
v69.8	Other problems related to lifestyle; self-damaging behavior
v69.9	Unspecified problem related to lifestyle
v70.1	General psychiatric examination, requested by the authority
v70.2	General psychiatric examination, other and unspecified
v71.01	Observation of adult antisocial behavior
v71.02	Observation of childhood or adolescent antisocial behavior
v71.09	Observation of other suspected mental condition
v71.81	Observation and evaluation for other specified suspected conditions, abuse and neglect

ICD Code	Description
v71.89	Observation and evaluation for other specified suspected conditions not found
v79.0	Special screening for depression
v79.1	Special screening for alcoholism
v79.2	Special screening for mental retardation
v79.3	Special screening for developmental handicaps in early childhood
v79.8	Special screening for other specified mental disorders and developmental handicaps
v79.9	Special screening for unspecified mental disorder and developmental handicap
v80.01	Special Screening for Traumatic Brain Injury (TBI)

Appendix D: RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: <http://security.ihs.gov/>.

The ROB listed in the following sections are specific to RPMS.

D.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

D.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

D.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

D.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

D.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

D.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

D.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

D.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

D.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

D.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

D.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

D.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

D.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

D.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

D.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

D.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information..

Glossary

Caret

The symbol ^ obtained by pressing Shift-6.

Command

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Data Elements

Data fields that are used in filling out forms in BHS.

Default Response

Many of the prompts in the BHS program contain responses that can be activated simply by pressing the Enter key. For example: “Do you really want to quit? No//.” Pressing the Enter key tells the system you do not want to quit. “No//” is considered the default response.

Device

The name of the printer to use when printing information. Home means the computer screen.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

Fileman

The database management system for RPMS.

Free Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

Frequency

The number of times a particular situation occurs in a given amount of time.

Full Screen Editor

A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

Menu

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical use interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

Security Keys

Tools used to grant/restrict access to certain applications, application features, and menus.

Site Manager

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu

A menu that is accessed through another menu.

Suicide

The act of causing one's own death.

Ideation with Intent and Plan—Serious thoughts of suicide or of taking action to take one's life with means and a specific plan

Attempt—A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

Completion—Fatal self-inflicted destructive act with explicit or inferred intent to die.

Terminal Emulator

A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor

A word processing program that entering and editing text.

Word Processing Field

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

A/SA	Alcohol and Substance Abuse
BH	Behavioral Health
BHS	Behavioral Health System
CAC	Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading of BHS and other software programs for the end users. The CAC is sometimes referred to as the application coordinator or a “super-user.”
CD	Chemical Dependency
EHR	Indian Health Service RPMS Electronic Health Record
GPRA	Government Performance and Results Act; a federal law requiring federal agencies to demonstrate through annual reporting that they are using appropriated funds effectively to meet their Agency’s missions.
GUI	Graphic User Interface, a Windows-like interface with drop-down menus, text boxes icons, and other controls that supports data entry using a combination of the computer mouse and keyboard.
IHS	Indian Health Service
MH	Mental Health
RPMS	Resource and Patient Management System

TIU

Text Integration Utilities, a document management application. This application is used to create and store a wide variety of clinical note templates in the RPMS Electronic Health Record.

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

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

Fax: (505) 248-4363

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

E-mail: support@ihs.gov