Behavioral Health System (AMH)

User Manual

Version 4.0 Patch 2
April 2012
# Table of Contents

## 1.0 Introduction ........................................................................................................... 1
  1.1 Primary Menu ....................................................................................................... 2
  1.2 Preparations ......................................................................................................... 2
  1.3 Security Keys ..................................................................................................... 2

## 2.0 Orientation ........................................................................................................... 4
  2.1 Standard Conventions (Roll and Scroll) ............................................................ 4
    2.1.1 Caps Lock .................................................................................................... 4
    2.1.2 Default Entries .......................................................................................... 4
    2.1.3 Help .......................................................................................................... 4
    2.1.4 To Back Out .............................................................................................. 4
    2.1.5 Exit ........................................................................................................... 4
    2.1.6 Same Entries .......................................................................................... 5
    2.1.7 Lookup ...................................................................................................... 5
    2.1.8 Pause Indicator ......................................................................................... 5
    2.1.9 Dates and Times ....................................................................................... 5
    2.1.10 Stop ........................................................................................................ 6
    2.1.11 Delete .................................................................................................... 6
  2.2 ListMan (Roll and Scroll) .................................................................................... 6
  2.3 ScreenMan (Roll and Scroll) .............................................................................. 8
    2.3.1 Using the ScreenMan Window ................................................................ 8
    2.3.2 Using the Pop-Up Window ...................................................................... 9
  2.4 Full Screen Text Editor (Roll and Scroll) .......................................................... 9
  2.5 Word Processing Editors (Roll and Scroll) ....................................................... 11
  2.6 Pop-Up Windows (GUI) ................................................................................... 13
    2.6.1 Buttons on Title Bar ................................................................................. 13
    2.6.2 Buttons on the Toolbar ............................................................................ 14
  2.7 Using the Calendar (GUI) ................................................................................. 15
  2.8 Using the Search Window (GUI) ...................................................................... 16
  2.9 Using the Search/Select Window (GUI) ............................................................ 18
  2.10 Using the Multiple Select Window (GUI) ....................................................... 19
  2.11 Free Text Fields (GUI) .................................................................................. 20
  2.12 Selecting a Patient ......................................................................................... 20
    2.12.1 Patient Selection (Roll and Scroll) ......................................................... 21
    2.12.2 Patient Selection (GUI) ......................................................................... 21
  2.13 Sensitive Patient Tracking .............................................................................. 22
  2.14 Electronic Signature ....................................................................................... 24
    2.14.1 Creating Your Electronic Signature ....................................................... 24
    2.14.2 Electronic Signature Usage ................................................................... 25
    2.14.3 Data Entry Requirements (Roll and Scroll) .......................................... 25
    2.14.4 Assign PCC Visit ................................................................................... 26
    2.14.5 Signing a Note (GUI) ............................................................................ 26
    2.14.6 Signing a Note (Roll and Scroll) ............................................................ 27
### Table of Contents

#### Behavioral Health System (AMH) Version 4.0 Patch 2

**User Manual Table of Contents**

**April 2012**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.15 Login to GUI</td>
<td>28</td>
</tr>
<tr>
<td>2.16 RPMS Behavioral Health System Tree</td>
<td>30</td>
</tr>
<tr>
<td>2.16.1 Patient Menu</td>
<td>31</td>
</tr>
<tr>
<td>2.16.2 Preferences Menu</td>
<td>31</td>
</tr>
<tr>
<td>2.16.3 RPMS Menu</td>
<td>32</td>
</tr>
<tr>
<td>2.16.4 Exit Menu</td>
<td>32</td>
</tr>
<tr>
<td>2.16.5 Help Menu</td>
<td>32</td>
</tr>
<tr>
<td>2.16.6 About Menu</td>
<td>32</td>
</tr>
<tr>
<td>3.0 Data Entry</td>
<td>33</td>
</tr>
<tr>
<td>3.1 Roll and Scroll</td>
<td>33</td>
</tr>
<tr>
<td>3.2 RPMS Behavioral Health System GUI</td>
<td>34</td>
</tr>
<tr>
<td>4.0 One Patient Visit Data</td>
<td>36</td>
</tr>
<tr>
<td>4.1 Enter or Edit Patient Visit Data (Roll and Scroll)</td>
<td>36</td>
</tr>
<tr>
<td>4.1.1 Enter or Edit Patient/Visit Data—Patient Centered (PDE)</td>
<td>36</td>
</tr>
<tr>
<td>4.1.2 Add/Edit Visit Data—Full Screen Mode (SDE)</td>
<td>38</td>
</tr>
<tr>
<td>4.1.3 Using the Behavioral Health Visit Update Screen</td>
<td>39</td>
</tr>
<tr>
<td>4.1.4 Using the Behavioral Health Record Edit Window</td>
<td>49</td>
</tr>
<tr>
<td>4.1.5 Edit EHR Visit (EH)</td>
<td>63</td>
</tr>
<tr>
<td>4.1.6 Edit SOAP (ES)</td>
<td>64</td>
</tr>
<tr>
<td>4.1.7 Delete Visit (DE)</td>
<td>65</td>
</tr>
<tr>
<td>4.1.8 Sign Note (SN)</td>
<td>66</td>
</tr>
<tr>
<td>4.1.9 Print Encounter Form (PF)</td>
<td>66</td>
</tr>
<tr>
<td>4.1.10 Last BH Visit (LV)</td>
<td>68</td>
</tr>
<tr>
<td>4.1.11 Browse Visit (BV)</td>
<td>68</td>
</tr>
<tr>
<td>4.1.12 List Visit Dates (LD)</td>
<td>69</td>
</tr>
<tr>
<td>4.1.13 Display Record (DR)</td>
<td>70</td>
</tr>
<tr>
<td>4.2 Visit Window (GUI)</td>
<td>71</td>
</tr>
<tr>
<td>4.2.1 Visit Date Range Pane</td>
<td>72</td>
</tr>
<tr>
<td>4.2.2 Visit Pane</td>
<td>73</td>
</tr>
<tr>
<td>4.2.3 Add Button</td>
<td>73</td>
</tr>
<tr>
<td>4.2.4 Edit Button</td>
<td>73</td>
</tr>
<tr>
<td>4.2.5 View Button</td>
<td>73</td>
</tr>
<tr>
<td>4.2.6 Delete Button</td>
<td>73</td>
</tr>
<tr>
<td>4.2.7 Sign Note Button</td>
<td>73</td>
</tr>
<tr>
<td>4.2.8 Problem Button</td>
<td>73</td>
</tr>
<tr>
<td>4.2.9 Print Encounter Button</td>
<td>74</td>
</tr>
<tr>
<td>4.2.10 Problem Button</td>
<td>75</td>
</tr>
<tr>
<td>4.2.11 Help Button</td>
<td>75</td>
</tr>
<tr>
<td>4.2.12 Close Button</td>
<td>75</td>
</tr>
<tr>
<td>4.3 Add or Edit Visit Data Entry</td>
<td>75</td>
</tr>
<tr>
<td>4.3.1 Visit Information Pane</td>
<td>76</td>
</tr>
<tr>
<td>4.3.2 POV Tab</td>
<td>78</td>
</tr>
<tr>
<td>4.3.3 Activity Tab</td>
<td>81</td>
</tr>
<tr>
<td>4.3.4 SOAP/Progress Notes Tab</td>
<td>83</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.3.5</td>
<td>Rx Notes/Labs Tab</td>
</tr>
<tr>
<td>4.3.6</td>
<td>Wellness Tab</td>
</tr>
<tr>
<td>4.3.7</td>
<td>Measurements Tab</td>
</tr>
<tr>
<td>4.3.8</td>
<td>Intake Tab (GUI)</td>
</tr>
<tr>
<td>4.3.9</td>
<td>Suicide Form</td>
</tr>
<tr>
<td>4.3.10</td>
<td>Select PCC Visit Window</td>
</tr>
<tr>
<td>4.4</td>
<td>Browse Visits (GUI)</td>
</tr>
<tr>
<td>4.5</td>
<td>View Patient Data</td>
</tr>
<tr>
<td>4.5.1</td>
<td>Face Sheet</td>
</tr>
<tr>
<td>4.5.2</td>
<td>Health Summary</td>
</tr>
<tr>
<td>4.5.3</td>
<td>Patient Appointments</td>
</tr>
<tr>
<td>4.5.4</td>
<td>PCC Medications</td>
</tr>
<tr>
<td>4.5.5</td>
<td>PCC Labs by Visit Date</td>
</tr>
<tr>
<td>4.5.6</td>
<td>PCC Labs by Lab Test</td>
</tr>
<tr>
<td>5.0</td>
<td>Group Encounters</td>
</tr>
<tr>
<td>5.1</td>
<td>Group Form Data Entry Using Group Definition (Roll and Scroll)</td>
</tr>
<tr>
<td>5.1.1</td>
<td>Add a New Group</td>
</tr>
<tr>
<td>5.1.2</td>
<td>Edit Group Definition</td>
</tr>
<tr>
<td>5.1.3</td>
<td>Review/Edit Group Visits</td>
</tr>
<tr>
<td>5.1.4</td>
<td>Display Group Entry</td>
</tr>
<tr>
<td>5.1.5</td>
<td>Print Encounter Forms</td>
</tr>
<tr>
<td>5.1.6</td>
<td>Duplicate Group</td>
</tr>
<tr>
<td>5.1.7</td>
<td>Add No Show Visit</td>
</tr>
<tr>
<td>5.1.8</td>
<td>Sign Note</td>
</tr>
<tr>
<td>5.1.9</td>
<td>Delete Group</td>
</tr>
<tr>
<td>5.2</td>
<td>Group Entry Window (GUI)</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Group Entry Date Range Pane</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Group Entry Pane</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Add Button</td>
</tr>
<tr>
<td>5.2.4</td>
<td>Edit Button</td>
</tr>
<tr>
<td>5.2.5</td>
<td>View Button</td>
</tr>
<tr>
<td>5.2.6</td>
<td>Duplicate Button</td>
</tr>
<tr>
<td>5.2.7</td>
<td>Delete Button</td>
</tr>
<tr>
<td>5.2.8</td>
<td>Sign Note Button</td>
</tr>
<tr>
<td>5.2.9</td>
<td>Print Encounter Button</td>
</tr>
<tr>
<td>5.2.10</td>
<td>Help Button</td>
</tr>
<tr>
<td>5.2.11</td>
<td>Close Button</td>
</tr>
<tr>
<td>5.3</td>
<td>Add/Edit Group Data (GUI)</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Group Encounter Information Pane</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Activities Tab</td>
</tr>
<tr>
<td>5.3.3</td>
<td>Group Data Tab</td>
</tr>
<tr>
<td>5.3.4</td>
<td>Group Education Tab</td>
</tr>
<tr>
<td>5.3.5</td>
<td>Patients Tab</td>
</tr>
<tr>
<td>5.3.6</td>
<td>Patient Data Tab</td>
</tr>
<tr>
<td>6.0</td>
<td>Case Management</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>6.1</td>
<td>Managing Case Data (Roll and Scroll)</td>
</tr>
<tr>
<td>6.1.1</td>
<td>Open New Case (OP)</td>
</tr>
<tr>
<td>6.1.2</td>
<td>Edit Case Data (ED)</td>
</tr>
<tr>
<td>6.1.3</td>
<td>Delete Case (DC)</td>
</tr>
<tr>
<td>6.2</td>
<td>Designated Provider/Flag/Personal History (Roll and Scroll)</td>
</tr>
<tr>
<td>6.3</td>
<td>Case Management Window (GUI)</td>
</tr>
<tr>
<td>6.3.1</td>
<td>Case Management Date Range</td>
</tr>
<tr>
<td>6.3.2</td>
<td>Case Status Pane</td>
</tr>
<tr>
<td>6.3.3</td>
<td>Add Button</td>
</tr>
<tr>
<td>6.3.4</td>
<td>Edit Button</td>
</tr>
<tr>
<td>6.3.5</td>
<td>View Button</td>
</tr>
<tr>
<td>6.3.6</td>
<td>Delete Button</td>
</tr>
<tr>
<td>6.3.7</td>
<td>Help Button</td>
</tr>
<tr>
<td>6.3.8</td>
<td>Close Button</td>
</tr>
<tr>
<td>6.4</td>
<td>Add or Edit Case Management Data (GUI)</td>
</tr>
<tr>
<td></td>
<td><strong>Administrative/Community Activity</strong></td>
</tr>
<tr>
<td>7.1</td>
<td>Add Administrative/Community Activity Record (Roll and Scroll)</td>
</tr>
<tr>
<td>7.2</td>
<td>Administrative/Community Activity Window (GUI)</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Administrative/Community Activity Date Range</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Administrative/Community Activity Pane</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Add Button</td>
</tr>
<tr>
<td>7.2.4</td>
<td>Edit Button</td>
</tr>
<tr>
<td>7.2.5</td>
<td>View Button</td>
</tr>
<tr>
<td>7.2.6</td>
<td>Delete Button</td>
</tr>
<tr>
<td>7.2.7</td>
<td>Print Encounter Button</td>
</tr>
<tr>
<td>7.2.8</td>
<td>Help Button</td>
</tr>
<tr>
<td>7.2.9</td>
<td>Close Button</td>
</tr>
<tr>
<td>7.3</td>
<td>Add or Edit Administrative/Community Activity (GUI)</td>
</tr>
<tr>
<td>7.3.1</td>
<td>Administrative/Community Entry Pane</td>
</tr>
<tr>
<td>7.3.2</td>
<td>Activity Data Tab</td>
</tr>
<tr>
<td>7.3.3</td>
<td>Notes Tab</td>
</tr>
<tr>
<td></td>
<td><strong>Encounter and Treatment Plan Sharing (Roll and Scroll)</strong></td>
</tr>
<tr>
<td>9.0</td>
<td><strong>Problem List</strong></td>
</tr>
<tr>
<td>9.1</td>
<td>Patient’s Problem List (Roll and Scroll)</td>
</tr>
<tr>
<td>9.1.1</td>
<td>BH Problem Actions (Roll and Scroll)</td>
</tr>
<tr>
<td>9.1.2</td>
<td>PCC Problem List Actions (Roll and Scroll)</td>
</tr>
<tr>
<td>9.2</td>
<td>Problem List (GUI)</td>
</tr>
<tr>
<td>9.2.1</td>
<td>Behavior Health Problem List Window</td>
</tr>
<tr>
<td>9.2.2</td>
<td>PCC Problem List Window</td>
</tr>
<tr>
<td>10.0</td>
<td><strong>Treatment Plans</strong></td>
</tr>
<tr>
<td>10.1</td>
<td>Patient Treatment Plans (Roll and Scroll)</td>
</tr>
<tr>
<td>10.1.1</td>
<td>Add, Edit, Delete a Treatment Plan (UP)</td>
</tr>
<tr>
<td>10.1.2</td>
<td>Display/Print a Treatment Plan (DTP)</td>
</tr>
</tbody>
</table>
# 10.1 Treatment Plans

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1.3</td>
<td>Print List of Treatment Plans Needing Reviewed (REV)</td>
<td>197</td>
</tr>
<tr>
<td>10.1.4</td>
<td>Print List of Treatment Plans Needing Resolved (RES)</td>
<td>198</td>
</tr>
<tr>
<td>10.1.5</td>
<td>Print List of All Treatment Plans on File (ATP)</td>
<td>198</td>
</tr>
<tr>
<td>10.1.6</td>
<td>Patients w/Case Open but No Treatment Plan (NOTP)</td>
<td>200</td>
</tr>
</tbody>
</table>

## 10.2 Treatment Plan Window (GUI)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2.1</td>
<td>Treatment Plan Date Range</td>
<td>202</td>
</tr>
<tr>
<td>10.2.2</td>
<td>Treatment Plan Pane</td>
<td>203</td>
</tr>
<tr>
<td>10.2.3</td>
<td>Add Button</td>
<td>203</td>
</tr>
<tr>
<td>10.2.4</td>
<td>Edit Button</td>
<td>203</td>
</tr>
<tr>
<td>10.2.5</td>
<td>View Button</td>
<td>203</td>
</tr>
<tr>
<td>10.2.6</td>
<td>Delete Button</td>
<td>203</td>
</tr>
<tr>
<td>10.2.7</td>
<td>Print Treatment Plan Button</td>
<td>204</td>
</tr>
<tr>
<td>10.2.8</td>
<td>Help</td>
<td>205</td>
</tr>
<tr>
<td>10.2.9</td>
<td>Close Button</td>
<td>205</td>
</tr>
</tbody>
</table>

## 10.3 Add/Edit Treatment Plan Record (GUI)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.3.1</td>
<td>Treatment Plan Information Pane</td>
<td>206</td>
</tr>
<tr>
<td>10.3.2</td>
<td>Problem Tab</td>
<td>207</td>
</tr>
<tr>
<td>10.3.3</td>
<td>Plan Tab</td>
<td>209</td>
</tr>
<tr>
<td>10.3.4</td>
<td>Plan Review Tab</td>
<td>211</td>
</tr>
</tbody>
</table>

## 11.0 Suicide Forms

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Suicide Reporting Forms (Roll and Scroll)</td>
<td>214</td>
</tr>
<tr>
<td>11.1.1</td>
<td>Update Suicide Reporting Form for a Patient (SFP)</td>
<td>214</td>
</tr>
<tr>
<td>11.1.2</td>
<td>Review Suicide Forms by Date (SFD)</td>
<td>220</td>
</tr>
<tr>
<td>11.2</td>
<td>Suicide Form Window (GUI)</td>
<td>221</td>
</tr>
<tr>
<td>11.2.1</td>
<td>Suicide Form Date Range</td>
<td>222</td>
</tr>
<tr>
<td>11.2.2</td>
<td>Suicide Form Pane</td>
<td>223</td>
</tr>
<tr>
<td>11.2.3</td>
<td>Add Button</td>
<td>223</td>
</tr>
<tr>
<td>11.2.4</td>
<td>Edit Button</td>
<td>223</td>
</tr>
<tr>
<td>11.2.5</td>
<td>View Button</td>
<td>223</td>
</tr>
<tr>
<td>11.2.6</td>
<td>Delete Button</td>
<td>223</td>
</tr>
<tr>
<td>11.2.7</td>
<td>Print Button</td>
<td>224</td>
</tr>
<tr>
<td>11.2.8</td>
<td>Help Button</td>
<td>225</td>
</tr>
<tr>
<td>11.2.9</td>
<td>Close Button</td>
<td>225</td>
</tr>
<tr>
<td>11.3</td>
<td>Add/Edit Suicide Form (GUI)</td>
<td>225</td>
</tr>
<tr>
<td>11.3.1</td>
<td>Suicide Form Fields</td>
<td>226</td>
</tr>
<tr>
<td>11.3.2</td>
<td>Method Tab</td>
<td>228</td>
</tr>
<tr>
<td>11.3.3</td>
<td>Substance Use Tab</td>
<td>230</td>
</tr>
<tr>
<td>11.3.4</td>
<td>Contributing Factors Tab</td>
<td>233</td>
</tr>
<tr>
<td>11.3.5</td>
<td>Narrative Tab</td>
<td>233</td>
</tr>
</tbody>
</table>

## 12.0 Intake

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Intake Documents (Roll and Scroll)</td>
<td>234</td>
</tr>
<tr>
<td>12.1.1</td>
<td>Add Initial Intake (I)</td>
<td>235</td>
</tr>
<tr>
<td>12.1.2</td>
<td>Edit Initial Intake (E)</td>
<td>236</td>
</tr>
<tr>
<td>12.1.3</td>
<td>Add/Edit Update (U)</td>
<td>237</td>
</tr>
</tbody>
</table>
# Behavioral Health System (AMH) Version 4.0 Patch 2

## 12.1.4 Delete Intake/Update (D) ................................................................. 238

## 12.1.5 Print Intake Document ................................................................. 239

## 12.2 Intake (GUI) ................................................................................. 240

### 12.2.1 Patient Intake Documents Pane .............................................. 242

### 12.2.2 Add Initial Intake ................................................................. 243

### 12.2.3 Intake Pane ................................................................. 244

### 12.2.4 Edit Initial Intake ................................................................. 245

### 12.2.5 Add/Edit Update ................................................................. 245

### 12.2.6 Delete Intake ................................................................. 246

### 12.2.7 Display/Print Intake ................................................................. 246

## 13.0 Reports (Roll and Scroll Only) ......................................................... 248

### 13.1 Patient Listings (PAT) ................................................................. 248

#### 13.1.1 Active Client List (ACL) ................................................................. 249

#### 13.1.2 Patient General Retrieval (PGEN) ........................................... 250

#### 13.1.3 Designated Provider List (DP) .................................................. 253

#### 13.1.4 Patients with AT LEAST N Visits (GRT) ........................................ 254

#### 13.1.5 Patients Seen by Age and Sex (AGE) ......................................... 255

#### 13.1.6 Case Status Reports (CASE) .................................................. 257

#### 13.1.7 GAF Scores for Multiple Patients (GAFS) ..................................... 263

#### 13.1.8 Listing of No-Show Visits in a Date Range (NSDR) ................. 264

#### 13.1.9 Patient List for Personal Hx Items (PERS) ................................... 265

#### 13.1.10 Placements by Site/Patient (PERS) ........................................... 266

#### 13.1.11 Listing of Patients with Selected Problems (PPR) ...................... 267

#### 13.1.12 Screening Reports (SCRN) .................................................. 269

#### 13.1.13 Treatment Plans (TPR) ................................................................. 297

#### 13.1.14 Patients Seen in Groups w/Time in Group (TSG) ..................... 298

### 13.2 Behavioral Health Record/Encounter Reports (REC) ...................... 299

#### 13.2.1 List Visit Records, Standard Output (LIST) ............................. 299

#### 13.2.2 List Behavioral Hlth Records, General Retrieval (GEN) ............. 301

### 13.3 Workload/Activity Reports (WL) .................................................. 305

#### 13.3.1 Activity Report (GARS #1) (GRS1) ............................................. 305

#### 13.3.2 Activity Report by Primary Problem (GRS2) ............................. 307

#### 13.3.3 Activity Record Counts (ACT) .................................................. 307

#### 13.3.4 Program Activity Time Reports (PROG) ....................................... 309

#### 13.3.5 Frequency of Activities (FACT) .................................................. 310

#### 13.3.6 Frequency of Activities by Category (FCAT) .............................. 312

#### 13.3.7 Tally of Prevention Activities (PA) ............................................. 312

### 13.4 Problem Specific Reports (PROB) ..................................................... 314

#### 13.4.1 Abuse Report (ABU) ................................................................. 314

#### 13.4.2 Frequency of Problems (FDSM) ................................................... 315

#### 13.4.3 Frequency of Problem (Problem Code Groupings) (FPRB) ........... 317

#### 13.4.4 Frequency of Problems by Problem Category (FPRC) ................ 318

#### 13.4.5 Suicide Related Reports (SUIC) .................................................. 320

### 13.5 Print Standard Behavioral Health Tables (TABL) ......................... 325

#### 13.5.1 Print Activity Code Table (ACT) .................................................. 326
# Table of Contents

13.5.2 Print Clinic Codes (CLN) ................................................................. 326
13.5.3 Print Behavioral Health Problem/DSM IV Table (DSM) ................. 327
13.5.4 Print Behavioral Health Problem Codes (PROB) ............................ 327

## 14.0 Manager Utilities Module (Roll and Scroll) ........................................ 329

14.1 Update Site Parameters (SITE) ............................................................ 329
14.2 Export Utility Menu (EXPT) ............................................................... 338
14.2.1 Generate BH Transactions for HQ (GEN) ...................................... 338
14.2.2 Display a Log Entry (DISP) ............................................................ 339
14.2.3 Print Export Log (PRNT) ............................................................... 340
14.2.4 Regenerate Transactions (RGEN) ................................................... 340
14.2.5 Reset Data Export Log (RSET) ..................................................... 341
14.2.6 Check Records Before Export (CHK) ............................................ 341
14.2.7 Print Error List for Export (ERRS) ................................................ 342
14.2.8 Create OUTPUT File (OUTP) ........................................................ 342
14.3 Re-Set Patient Flag Field Data (RPFF) .............................................. 343
14.4 Display Log of Who Edited Record (DLWE) ....................................... 343
14.5 Add/Edit Local Service Sites (ELSS) .................................................. 344
14.6 Add Personal History Factors to Table (EPHX) .................................. 345
14.7 Delete BH General Retrieval Report Definitions (DRD) ....................... 345
14.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC) ............... 345
14.9 Update Locations a User can See (UU) .............................................. 346

## Glossary ............................................................................................................. 374

## Acronym List ....................................................................................................... 377

## Contact Information ............................................................................................ 378
1.0 **Introduction**

The Behavioral Health System (BHS) is a module of the Resource and Patient Management System (RPMS) designed specifically for recording and tracking patient care related to behavioral health. AMH v4.0 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 co-located in a primary care setting at facilities that have deployed the RPMS Electronic Health Record (EHR) have transitioned to the EHR to document their services and support integrated care. However, a large number of behavioral health clinicians are located at facilities that do not use the EHR. For these providers, AMH v4.0 can be utilized as a “stand-alone,” yet integrated module within the RPMS suite of clinical and practice management software.

AMH 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) shown in Figure 1-1:

```
**********************************************
**       IHS Behavioral Health System       **
**********************************************
Version 4.0 (Patch 2)
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 is shown in Table 1:

<table>
<thead>
<tr>
<th>Key</th>
<th>Permits Access To</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMHZMENU</td>
<td>Top-Level menu (AMHMENU)</td>
</tr>
<tr>
<td>AMHZMGR</td>
<td>Supervisory-Level/Manager options</td>
</tr>
<tr>
<td>AMHZ DATA ENTRY</td>
<td>Data Entry module</td>
</tr>
<tr>
<td>AMHZ RESET TRANS LOG</td>
<td>Reset the Export log</td>
</tr>
<tr>
<td>AMHZDECT</td>
<td>Data Entry Forms Count Menu option</td>
</tr>
<tr>
<td>AMHZHS</td>
<td>BHS Health Summary Component</td>
</tr>
<tr>
<td>AMHZRPT</td>
<td>Reports Module</td>
</tr>
<tr>
<td>AMHZ DV REPORTS</td>
<td>Screening Reports</td>
</tr>
<tr>
<td>AMHZ SUICIDE FORM ENTRY</td>
<td>Suicide Form Data Entry Menu</td>
</tr>
<tr>
<td>Key</td>
<td>Permits Access To</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>AMHZ SUICIDE FORM REPORTS</td>
<td>Suicide Form Reports Menu</td>
</tr>
<tr>
<td>AMHZ DELETE RECORD</td>
<td>Delete unsigned records</td>
</tr>
<tr>
<td>AMHZ DELETE SIGNED NOTE</td>
<td>Delete records containing signed notes</td>
</tr>
<tr>
<td>AMHZ UPDATE USER/LOCATIONS</td>
<td>Update the locations the user is permitted to access</td>
</tr>
<tr>
<td>AMHZ CODING REVIEW</td>
<td>Review records to ensure accurate coding</td>
</tr>
<tr>
<td>AMHZ PROBLEM LIST</td>
<td>Access the PCC Problem List from AMH</td>
</tr>
</tbody>
</table>

Table 1: **Security Keys**
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

When a possible answer is followed by double slashes (//) Figure 2-1, press Enter to default to the entry displayed. If you do not want to use the default response, enter 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

Press the Shift and 6 keys to generate the caret (^) symbol. This symbol terminates the current action, and backs you up one level.

2.1.5 Exit

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

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

3. Type **CONTINUE** at a menu prompt to exit RPMS, and return to the previous menu.
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 the Return key to repeat the last entry you used at the prompt.

2.1.7 Lookup

Be cautious of misspellings. To ensure the spelling of a name or entry, use only the first few letters. RPMS will display all choices that match those beginning letters as shown in Figure 2-2:

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

Figure 2-2: Patient lookup screen

2.1.8 Pause Indicator

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

1. Press Enter to go to the next page.
2. Type the caret (^) to exit the report.

2.1.9 Dates and Times

Dates and times may be entered in a number of formats. If the system prompts for a date alone, the acceptable formats are:

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

Note: If you do not enter the year, the system defaults to the current year.
If the system prompts for time, anything between 6 AM and 6 PM will be recorded correctly by entering a number or military time. Between 6 PM and 6 AM, use military time or append the number with an A or P:

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

### 2.1.10 Stop
Press C-Ctrl to stop a report or to exit the application immediately.

### 2.1.11 Delete
Type an at sign (@) in a field to delete the existing data.

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

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

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

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

1. Type a plus sign (+) in the display that fills more than one page to see the next full screen (when you are not on the last screen).

2. 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.

3. Press the up arrow key on your keyboard to move the screen display back one line at a time.

4. Press the down arrow key on your keyboard to move the screen display forward one line at a time.

5. Press the right arrow key on your keyboard to move the screen display to the right.

6. Press the left arrow key on your keyboard to move the screen display to the left.

7. Type FS in a multipage display to return to the first screen of the display.

8. Type LS in a multipage display to go to the last screen in the display.

9. Type GO and the page number of a multiscreen display to go directly to that screen.

10. Type RD to redisplay the screen.

11. Type PS to print the current screen.

12. Type PL to print an entire single or multi-screen display (called a list).

13. 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 use SL, then indicate the age, and press Enter to be moved to the Age field.
14. Type ADPL to either display or not display the list of menu options in the window at the bottom of the screen.

15. 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 Figure 2-4:

![Figure 2-4: Using ScreenMan sample screen 1](image)

If you make a change or new entry on the form, press Enter to record the change. A confirmation dialog might appear for further information. As an example, in the above example, typing Y at the “Any Secondary Providers” prompt indicates there was a secondary provider; but you must press Enter after typing Y to open the dialog and record the secondary provider information.

Type E and press Enter to close the screen, after all the required data has been entered. Type Y to save any changes.
2.3.2 Using the Pop-Up Window

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

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

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

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

---
Close     Refresh
---

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

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

Figure 2-5: Using ScreenMan, sample screen 2

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

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

Figure 2-6: Using ScreenMan, sample screen 3

2.4 Full Screen Text Editor (Roll and Scroll)

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

In many ways, the Full Screen Text Editor works just like a traditional word processor. The lines wrap automatically, the up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used. On the other hand, some of the conventions of a traditional word processing program do not apply to the RPMS full screen editor. For example, the Delete key does not work. Delete text by moving one space to the right of the error and backspacing to remove the erroneous entry.
You have the option when entering a lengthy narrative to use the narrative in a traditional word processing application like Microsoft Word or Word Perfect and paste the text into the open RPMS window.

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

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

Table 2: RPMS text Editor Commands

Figure 2-7 is a sample of the 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

1. Press F1 and type H to display all of the available commands for the RPMS Full Screen Editor (Figure 2-8). Type the 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: Insert
```

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

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

2.5 Word Processing Editors (Roll and Scroll)

The word processor editors or Roll and Scroll screens

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

![Figure 2-9: RPMS line editor default](image)

Change to the full screen editor, as follows:

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

   ![Figure 2-10: Change the Text Editor, Step 1](image)

2. At the “Select User's Toolbox Option” prompt, type “Edit User Characteristics” from TBOX and a window will be displayed.

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

4. At the “Command: prompt, type S and press Enter to save your changes. Type E and press Enter to exit the screen. The Edit User Characteristics screen and fields are shown in the Figure 2-11:
Figure 2-11: **Edit User Characteristics** 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 (Figure 2-12) with the same functional controls on them. Generally, these are Crystal Reports windows.

![Figure 2-12: Sample pop-up dialog](image)

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 press the up and down arrows on the keyboard.

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 for more information.

2.6.1 Buttons on Title Bar

The Minimize, Maximize, and Exit Program buttons on the upper right function 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. This is the same Print dialog in the Windows equivalent. Here you select the printer, number of copies, page range, and other properties used to output the contents of the pop-up dialog.

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 dialog.

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

1. Press the Go To Page button ( ) to specify a page to move to. Figure 2-13 shows the Go To Page dialog:

![Go to Page dialog](image)

Figure 2-13: Go to Page dialog

2. Type the page number and click OK to display the page. If a page outside the range of pages is entered, a blank page displays.

2.6.2.4 Find Text

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

![Find Text dialog](image)

Figure 2-14: Find Text dialog
2. Click the **Find Next** button to search for a text string. When found, the line of text is highlighted. Keep clicking the button to search for more occurrences. When the system reaches the end of the search process, the message: “information message informing you that the application has finished searching the document” displays.

3. Click **OK** to close the information message.

4. Click **Cancel** to close the dialog.

### 2.6.2.5 Zoom Button

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

### 2.7 Using the Calendar (GUI)

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

![Sample Date and Time field](image1)

**Figure 2-15: Sample Date and Time field**

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

- **Type in the field:**
  - Typing **M** in the day item sets the day to Monday.
  - Typing **09** in the month item changes the month to September.

- Place the cursor in an item (day of week, month, etc.) and press the up or down arrow keys to step through the available options.

- Click the date field’s list to display the Calendar shown in Figure 2-16:

![Sample Calendar dialog](image2)

**Figure 2-16: Sample Calendar dialog**
The calendar indicates today’s date. Set a different date by selecting it; the selected date will display in the Date field. To manipulate the calendar further:

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

![Figure 2-17: Change Year dialog](image)

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

![Figure 2-18: List of Months dialog](image)

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

## 2.8 Using the Search Window (GUI)

Several fields in the application when clicked display a search dialog. For example, the Community field displays on the **Community** search dialog shown in Figure 2-19:
Figure 2-19: **Community** search dialog

This type of dialog has similar functionality:

1. Click **Close** to exit the dialog and return to the previous window.

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

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

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

5. Right click the field and click **Clear** to remove the contents of the field.
2.9 Using the Search/Select Window (GUI)

Several fields in the application have fields that display a search or select window. For example, the Add button on the Axis I pane on the POV tab field displays the dialog shown in Figure 2-20:

![Sample search and select window](image)

Figure 2-20: Sample search and select window

The following describes how to use the window:

1. Click the Close button to exit the window.
2. Type a few characters in the Search String field and click Search button to retrieve records.
3. You can add one or more records from the Most Recently Selected pane to the Selected Items pane by clicking the right arrow button.
4. Click the right arrow button to add one or more records from the POV Axis I/II pane to the Selected Items pane.
5. Click the left arrow button to remove one or more records from the Selected Items pane.
6. When you are satisfied with the information in the Selected Item pane, click OK.
7. When 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 fields that display multiple select windows such as the **AXIS IV** window, in Figure 2-21:

![Sample AXIS IV multiple select window](image)

1. Click the **Close** button to exit the window.
2. To add one or more selected codes to the **Selected Items** pane, click the right arrow button. You can select more than one by pressing Ctrl key and selecting the next code.
3. To move one or more selected records from the **Selected Items** pane to the Axis IV pane, click the left arrow button.
4. When you have the records you want in the **Selected Item** pane, click **OK**.
5. When the field is populated on the form, you can remove its contents by right-clicking on the field and selecting **Clear**.
2.11 Free Text Fields (GUI)

Free text fields are fields where you can type information.

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

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

![Figure 2-22: Context menu to aid in editing text dialog](image)

The following options are described below:

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

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

2.12 Selecting a Patient

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

Select a patient at the “Select Patient” prompt. Type the characters of the patient’s last name, Social Security Number (SSN), Health Record Number (HRN), or date of birth (MM/DD/YYYY). The application accepts any 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)

1. Select a patient with the following rules:
   - 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.

Figure 2-23 displays the Select Patient dialog.

![Select Patient dialog](image)

2. Click Help to access the online help.

3. Click Clear to remove all data from the Patient List pane.

4. At the Patient Lookup Options (Last Name, First Chart DOB (date) field, type a few characters of the patient’s last name, SSN, HRN, or date of birth (use format MM/DD/YYYY).

5. Click Display to enter the search criteria.
• The valid candidates are retrieved as in Figure 2-24 and displayed in the Select Patient window. If candidates do not match the search criteria, results will not display.

![Select Patient window](image)

Figure 2-24: Sample Select Patient window

6. Drag the scroll bar to navigate through the names.

7. Double-click on a patient to view.

2.13 Sensitive Patient Tracking

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

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

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

1. Click Yes to access the patient’s record.
2. Click No to return to the Select Patient dialog.

Two messages can display in the roll-and-scroll application.

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

---

Figure 2-26: Continue with this Record message displayed in GUI

---

A simple warning message is shown here in Figure 2-28:
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

The User’s Toolbox in RPMS will set up the electronic signature. Use the option in bold (Electronic Signature Code Edit) shown in Figure 2-29:

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

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

Figure 2-29: Options on the TBOX User’s Toolbox

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

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

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

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

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

Figure 2-31: Prompt to enter your current electronic signature
Enter a new electronic signature code as in Figure 2-32:

| Enter code: |

Figure 2-32: Prompt for a new code

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

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

2.14.2 Electronic Signature Usage

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

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

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

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

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

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

2.14.3 Data Entry Requirements (Roll and Scroll)

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

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

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

Figure 2-33: Sample date/time stamp for electronic signature
2.14.4 Assign PCC Visit

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

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

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

2.14.5 Signing a Note (GUI)

If you have entered a SOAP/progress note, the “Sign?” dialog displays as shown in Figure 2-34:

![Sign? dialog](image)

Figure 2-34: Sign? dialog

1. Click Yes to display the Electronic Signature dialog in Figure 2-35:

![Electronic Signature dialog](image)

Figure 2-35: Electronic Signature dialog

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

3. Input a valid electronic signature and click OK. The encounter is saved with a signed note.

4. If you enter an invalid electronic signature and click OK, the application displays the Invalid notice: “Invalid Signature Code”.

5. Click OK and you return to the Electronic Signature dialog.
6. Click **Close** on the **Electronic Signature** dialog and the message: **Are You Sure?** “Are you sure you want to Close without Electronically Signing the Note?” displays as shown in Figure 2-36.

![Are you Sure? dialog](image)

Figure 2-36: Are you Sure? dialog

7. Click **No** to return to the **Electronic Signature** window.

8. Click **Yes** and the **Message** dialog in Figure 2-37 displays:

![Message dialog](image)

Figure 2-37: Text of Message dialog

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

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

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

![Prompt for current signature code dialog](image)

Figure 2-38: Prompt for current signature code dialog

- If you type **Y** with the valid electronic signature and the encounter record with a signed note is saved.
- If you use an invalid electronic signature, the encounter with a signed note will not be saved.
- If you edit a visit with a signed note and you get a message indicating that the note cannot be edited as shown in Figure 2-39:

![Message about progress note already signed](image)

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

- If you edit the note with an unsigned note and you are not the primary provider, you will receive the message shown in Figure 2-40:
Only the Primary provider is permitted to sign a note.

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

2.15 Login to GUI

If this is the first time you have logged into the GUI, the IHS Behavior Health System Login dialog displays (Figure 2-41).

Click Edit Connections on the list for the RPMS Server field. The RPMS Server Connection Management dialog displays as shown in Figure 2-42:

1. Click New to create a new connection
2. Select an existing connection and click Edit.
The **Edit RPMS Server Connection** dialog displays as shown in Figure 2-43:

![Edit RPMS Server Connection dialog](image)

Figure 2-43: Sample **Edit RPMS Server Connection** dialog

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

3. At the **Edit RPMS Server Connection** dialog, type one of the following:
   - **Connection Name**: Type the name of the connection
   - **Server Address/Name**: Type server’s IP address. An IP address is typically four groups of two or three numbers, separated by a period (.), e.g., 161.223.99.999.
   - **Server Port**: Type the server port number
   - **Server Namespace**: If your site has multiple databases on one server, you will need to type the namespace, such as a text string, e.g., DEVEH.
   - **Use default namespace**: Select checkbox if the Server Namespace is the default to be used.
   - **Test Connection**: The button becomes active when the fields have been populated. Click the **Test Connection** to display the Test Login dialog. Populate the Access Code and Verify Code fields and then click **OK**.

4. Click **OK**, to accept and the application displays the Connection Test message: “RPMS login was successful”.

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

6. Click **Save**, after the RPMS Server Connection Management dialog is complete.
Figure 2-44 displays the **IHS Behavioral Health System Login** dialog:

![IHS Behavioral Health System Login](image)

7. Type the RPMS access and verify codes. These are the same access and verify codes used to open any RPMS session.
   - Do not select the field with the checkbox.

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

### 2.16 RPMS Behavioral Health System Tree

The default display of the RPMS Behavioral Health System tree structure is shown in Figure 2-45:

![Tree structure for the RPMS Behavioral Health System](image)

The tree structure is similar to any tree structure in Microsoft® Office™.
9. Click the Minimize (-) icon to collapse the list. The icon will change to the Maximize (+) icon. The **View Patient Data, Treatment Plans, and Suicide Reporting Forms** options are collapsed in Figure 2-45.

10. Click the Maximize (+) icon to expand the list. The icon will change to the Minimize (-) icon. The Visit Encounters option is expanded in the screen capture Figure 2-45.

### 2.16.1 Patient Menu

Select the current patient from the **Patient** menu. See Section 2.12.2 for more information.

### 2.16.2 Preferences Menu

1. Select a division or change the menu default from the **Preferences** menu as shown in Figure 2-46:

   ![Preferences menu options](image)

   **Figure 2-46: Menu options on the Preferences menu**

2. Select **Change Division** to change the RPMS Division and apply to a site with more than one RPMS database.

3. Select **Change Menu Font** to change the font on the tree structure as shown in Figure 2-47:

   ![Font dialog](image)

   **Figure 2-47: Font dialog**
4. Select the **Font** dialog to change the font name, style, and size of the text on the tree structure.

5. Select **Script** to view how the text will be displayed in another language.

6. Click **OK** to apply the changes.

7. Click **Cancel** and the changes will not be applied.

### 2.16.3 RPMS Menu

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

2. On the RPMS Terminal Emulator window, select **File | Connect** to access the Connect dialog.

3. Type the IP address in the **Host** field.

4. Click **OK** to access the RPMS system and login.

5. Select **File | Exit** to return to the GUI.

### 2.16.4 Exit Menu

1. Select the **Exit** menu to leave the application. The application displays the message: “Are you sure you want to Exit?”.

2. Click **Yes** to exit.

### 2.16.5 Help Menu

Select the **Help** menu to access the online help system.

### 2.16.6 About Menu

Select the **About** menu to view information about the application.
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 (Figure 3-1). 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 shown in.

![Figure 3-1: Data Entry module screen](image)

At the “Select Behavioral Health Information System Option” prompt, type **DE** to display the Data Entry menu screen shown in Figure 3-2:

![Figure 3-2: Data Entry menu options](image)
The options on the Data Entry menu are:

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

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

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

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

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

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

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

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

- **Suicide Forms – Update/Print (SF):** 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):

![RPMS Behavioral Health System GUI](image)
• **One Patient:** manages the visits for the one patient within a date range.

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

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

• **Browse Visits:** displays visit information for the current patient within a 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 or Edit Patient Visit Data (Roll and Scroll)**

There are two ways to enter/edit patient visit data: type **PDE** or **SDE** on the IHS Behavioral Health System Data Entry Menu (Figure 4-1).

---

### IHS Behavioral Health System Data Entry Menu

Version 4.0 (patch 2)

**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]

---

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

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

Type **PDE** 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. To do this process, follow these steps:

1. At the “Select Behavioral Health Data Entry Menu Option” prompt, type **PDE**. Do the following:

2. Type a patient’s name.

   - If the patient is deceased, the application displays the patient’s date of death (Figure 4-2).

   **PATIENT'S DATE OF DEATH IS Jan 14, 2000@20:30**
Figure 4-2: Information about patient’s date of death screen

- Type **No** at the “Ok?” prompt, to return to “Enter Patient Name” prompt.
- Type **Yes** at the “Ok?” prompt, to proceed to the Patient Data Entry screen.

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

<table>
<thead>
<tr>
<th>Patient Name: DEMO, DOROTHY ROSE</th>
<th>HRN: 999999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: FEMALE</td>
<td>DOB: Oct 10, 1942</td>
</tr>
<tr>
<td>Age: 66 YRS</td>
<td>SSN: XXX-XX-1111</td>
</tr>
</tbody>
</table>

**Designated Providers:**
- Mental Health: A/SA: Other (2):
- Social Services: Other:
- Primary Care: SMITH, A

**Last Visit (excl no shows):** May 29, 2008 BETAAAA,BJ REGULAR VISIT

<table>
<thead>
<tr>
<th>Date</th>
<th>Visit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/20/2009</td>
<td>314.9 ATTENTION-DEFICIT/HYPERACTIVITY DIS. NOS</td>
</tr>
<tr>
<td>04/22/2009</td>
<td>LAST 6 AXIS V VALUES RECORDED. (GAF SCORES)</td>
</tr>
<tr>
<td>04/29/2009</td>
<td>55</td>
</tr>
<tr>
<td>05/01/2009</td>
<td>77</td>
</tr>
<tr>
<td>07/01/2009</td>
<td>65</td>
</tr>
</tbody>
</table>

**Pending Appointments:**
- Select the appropriate action Q for QUIT
- AV Add Visit
- EV Edit Visit
- DR Display Record
- ES Edit SOAP
- DE Delete Visit
- PF Print Encounter Form
- LV Last BH Visit
- BV Browse Visits

**Select Action:** Q//

Figure 4-3: Sample Patient Data Entry screen

3. At the “Select Action” prompt, type **AV** to add a visit, or **EV** to edit a visit. Do the following:

4. At the “Which set of defaults do you want to use in Data Entry?” prompt, type the program the provider is affiliated with. The predefined defaults for clinic, location, community, and program will be automatically applied to the visit. Type one of the following:
   - **M** Mental Health Defaults
   - **S** Social Services Defaults
   - **C** Chemical Dependency or Alcohol/Substance Abuse
   - **O** Other

5. Set the date at the “Enter ENCOUNTER DATE” prompt. Refer to Section 2.1.9.

6. At the “Enter PRIMARY PROVIDER” prompt, type the primary provider name.
7. Type **EV** (Edit Visit), the application displays the Behavioral Health Record Edit window. Refer to Section 4.1.4.

8. Type **AV** (Add Visit), the application displays the Behavioral Health Visit Update screen. Refer to Section 4.1.3.

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

This selection specifies 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.

1. Type **SDE** on the Data Entry Menu to enter/edit visit data for one or more patients.

2. At the “Which set of defaults do you want to use in Data Entry?” prompt, type one of the following:
   - **M** Mental Health Defaults
   - **S** Social Services Defaults
   - **C** Chemical Dependency or Alcohol/Substance Abuse
   - **O** Other

3. Set the date at the “Enter ENCOUNTER DATE” prompt.

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

![Figure 4-4: Sample Update BH Forms screen](image-url)
The asterisk (*) preceding the number of the encounter record indicates that the record contains an unsigned note. Refer to Section 2.14.

The **PPL** option is fully described below. See Section 9.1.

4. Type **EV** to edit a selected record (patient visit); refer to Section 4.1.4. Type **AV** to add a patient visit, the following prompts display:

5. At the “TYPE THE PATIENT’S HRN, NAME, SSN OR DOB” prompt, type the patient’s name.

6. At the “Enter PRIMARY PROVIDER” prompt, type the primary provider name for the visit (current logon user is default). The Behavioral Health Visit Update screen displays.

### 4.1.3 Using the Behavioral Health Visit Update Screen

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

```
* BEHAVIORAL HEALTH VISIT UPDATE * [press <F1>E when visit entry is complete]  
Encounter Date: MAR 5, 2009     User: THETA, SHIRLEY  
Patient Name: DEMO, DARRELL LEE DOB: 9/23/86    HR#: 117305  
---------------------------------------------------------------------------  
Arrival Time: 12:00  
Display/Edit Visit Information Y Any Secondary Providers?: N  
Chief Complaint/Presenting Problem: SOAP/Progress Note <press enter>: Comment/Next Appointment <press enter>: PURPOSE OF VISIT (POVS) <enter>: Any CPT Codes to enter? Y  
Activity: Activity Time: # Served: 1 Interpreter??  
Any Patient Education Done? N Any Screenings to Record? N  
Any Measurements? N Any Health Factors to enter? N  
Display Current Medications? N MEDICATIONS PRESCRIBED <enter>:  
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

When saving data on the Behavioral Health Visit Update screen 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 for more information.

1. At the “Arrival Time:” prompt, type a time, the default is 12:00.

2. At the “Display/Edit Visit Information” prompt, type **Y** to access the Visit Information screen shown in Figure 4-6:
***** Visit Information *****

Program: MENTAL HEALTH          Location of Encounter: SELLS HOSP
Clinic: MENTAL HEALTH            Appointment/Walk In: APPOINTMENT
Type of Contact: OUTPATIENT      Community of Service: TUCSON

Figure 4-6: Sample Visit Information screen

The application automatically populates the fields on the Visit information pop-up according to the 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.

3. At the “Program” prompt, type one of the following:
   - M (Mental Health), S (Social Services)
   - O (Other)
   - C (Chemical Dependency)

4. At the “Location of Encounter” prompt, type the encounter.

5. At the “Clinic:” prompt, type the clinic context. Response must be a clinic listed in the RPMS Standard Code Book table.

6. At the “Appointment/Walk-In:” prompt, type one of the following:
   - A (Appointment)
   - W (Walk In)
   - U - Unspecified (non-patient or telephone contact).

7. At the “Type of Contact:” prompt, type the contact activity setting

8. At the “Community of Service:” prompt, type the response for the community included in the RPMS community code set.

9. At the “Any Secondary Providers?” prompt, type Y to access the **Enter/Edit Providers of Service** screen (Figure 4-7):

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

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Primary/Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>THETA,STUART</td>
<td>PRIMARY/SECONDARY</td>
</tr>
<tr>
<td>PROVIDER:</td>
<td>PRIMARY/SECONDARY</td>
</tr>
<tr>
<td>PROVIDER:</td>
<td>PRIMARY/SECONDARY</td>
</tr>
<tr>
<td>PROVIDER:</td>
<td>PRIMARY/SECONDARY</td>
</tr>
<tr>
<td>PROVIDER:</td>
<td>PRIMARY/SECONDARY</td>
</tr>
</tbody>
</table>

User Manual
One Patient Visit Data
April 2012
PROVIDER:                                     PRIMARY/SECONDARY:

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

10. At the “PROVIDER:” prompt, type the secondary provider name.
11. At the “PRIMARY/SECONDARY:” prompt, type additional providers.

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

1. At the “Chief Complaint/Presenting Problem” prompt, type the chief complaint or problem.
2. At the “SOAP/Progress Note” prompt, press Enter, a secondary window displays. Type text in the field.
3. At the “Comment/Next Appointment” prompt, press Enter, a secondary window displays. Type text in the field.
4. At the “PURPOSE OF VISIT (POVS)” prompt, press Enter to access the Purpose of Visit (POV) Update dialog. Figure 4-8 displays the Purpose of Visit Update screen.

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

5. Type the caret (^) at the last prompt to exit the Purpose of Visit Update screen.
6. When you press Enter at the last prompt, the cursor jumps to the DIAGNOSIS field.
7. At the “DIAGNOSIS:” prompt, type the POV (the one- or two-digit BHS Purpose of Visit Code or the five-digit DSM-IV-TR diagnostic code).

   - After typing the POV in the Diagnosis field, the Narrative field updates. 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.

8. At the “AXIS III:” prompt, press Enter to access another window and type the general medical conditions of the patient.

9. At the “AXIS IV:” prompt, type one of the major psychosocial or environmental problem codes.

10. At the “AXIS V:” prompt, type the patient’s functional level using the GAF scale.

11. At the “GAF Scale Type:” prompt, type the acronym for the specific GAF Scale.

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

12. At the “CPT Codes” prompt, type Y to access the Add/Edit CPT Procedures pop-up window (Figure 4-9).

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

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

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

1. At the “CPT Code:” prompt, type the CPT code for Behavioral Health services.

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

   - After typing the CPT, HCPCS, or other billing code, the application confirms that you want to add the code.
2. At the “Activity” prompt, type the activity code that documents the type of service or activity performed by the Behavioral Health provider.

   These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and will affect the billing process. Refer to Appendix A: 

3. At the “Activity Time” prompt, type the activity time.

4. At the “# Served” prompt, type the number served

   - Use 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. At the “Interpreter?” prompt, type 1 (yes) or 0 (no) to indicate if an interpreter was present during the patient encounter.

5. At the “Any Patient Education Done?” prompt, type Y to access the Patient Education Enter/Edit screen (Figure 4-10).

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

   EDUCATION TOPIC:
   EDUCATION TOPIC:
   EDUCATION TOPIC:
   EDUCATION TOPIC:
   EDUCATION TOPIC:

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

6. At the “Display Patient Education History?” prompt, type Y or N to display the Behavioral Health and PCC patient education history.

7. At the “EDUCATION TOPIC:” prompt, type the education topic used for encounter.

   The application displays the following screen (Figure 4-11).

   EDUCATION TOPIC: ABD-COMPLICATIONS
   INDIVIDUAL/GROUP: INDIVIDUAL
   READINESS TO LEARN: 
   LEVEL OF UNDERSTANDING: 
   PROVIDER: THETA,MARK
   MINUTES: 
   COMMENT: 
Figure 4-11: Sample pop-up for education topic information

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

9. At the “Readiness to Learn” prompt, type one of the following:
   - Distraction - use when the patient has limited readiness to learn because the distractions cannot be minimized.
   - Eager to Learn - use when the patient is exceedingly interested in receiving education.
   - Intoxication - use when the patient has decreased cognition due to intoxication with drugs or alcohol
   - Not Ready - use when the patient is not ready to learn.
   - Pain - use when the patient has a level of pain that limits readiness to learn.
   - Receptive - use when the patient is ready or willing to receive education.
   - Severity of Illness - use when the patient has a severity of illness that limits readiness to learn.
   - Unreceptive - use when the patient is not ready or willing to receive education.
   - Level of Understanding - Specify the level of understanding. This is a required field. Type 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 - type 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): type the status of the education, if any. Type one of the following:
     - GS–goal set
• **GM**–goal met
• **GNM**–goal not met
• **GNS**–goal not set

10. At the “Any Screenings to Record?” prompt, type one of the following:

- Type **N** to accept the default response
- Type **Y** to use the displayed fields to record any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter (Figure 4-12):

```plaintext
<table>
<thead>
<tr>
<th>Intimate Partner Violence (IPV/DV)</th>
<th>Display IPV/DV screening history?</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPV Screening/Exam Result:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV Screening Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV COMMENT:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening</td>
<td>Display Alcohol Screening History?</td>
<td>N</td>
</tr>
<tr>
<td>Alcohol Screening Result:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Display Depression Screening History?</td>
<td>N</td>
</tr>
<tr>
<td>Depression Screening Result:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dep Screening Comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

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

11. At the “Display IPV/DV screening History?” prompt, type **Y** and the Intimate Partner Violence/Domestic Violence (IPV/DV) screening history displays on secondary screen.

12. At the “IPV Screening/Exam Result” prompt, type 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

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

14. At the “IPV Comment” prompt, type the text of any comment related to the IPV/DV screening.
15. At the “Display Alcohol screening History?” prompt, type Y and the alcohol screening history displays on secondary screen.

16. At the “Alcohol Screening Result” prompt, type the result of the alcohol screening. Type one of the following:
   - N–Negative
   - P–Positive
   - UAS–Unable to screen
   - REF–Patient Refused Screening

17. At the “Alcohol Screening Provider” prompt, type the provider name

18. At the “Alcohol Screening Comment” prompt, type the text of any comment related to the alcohol screening

19. At the “Display Depression screening History?” prompt, type Y and the depression screening history displays on a secondary screen.

20. At the “Depression Screening Result” prompt, type one of the following:
   - N–Negative
   - P–Positive
   - UAS–Unable to screen
   - REF–Patient Refused Screening

21. At the “Depression Screening Provider” prompt, type the provider name.

22. At the “Dep Screening Comment” prompt, type the text of any comment related to the depression screening.

23. At the “Any Measurement?” prompt, type Y to access the Measurements pop-up in Figure 4-13:

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

Figure 4-13: Sample Measurements pop-up

24. At the “Measurement” prompt, identify the type of measurement being taken on the patient. The application will populate the Description field.

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

27. At the “Any Health Factors to enter?” prompt, type one of the following:
   - **N** to end the process.
   - **Y** to access the Patient Health Factor Update dialog in Figure 4-14:

```
****** PATIENT HEALTH FACTOR UPDATE ******
Examples of health factors: Tobacco Use, Alcohol Cage, TB Status
Patient Name: DEMO, DARRELL LEE
-------------------------------------------------------------------------
Display Health Factor History?  N
After entering each factor you will be prompted for additional data items
HEALTH FACTOR
```

Figure 4-14: Sample Patient Health Factor Update dialog.

28. At the “Display Health Factor History?:” prompt, type one of the following:
   - **N** to end the process.
   - **Y** to display the health factor history for the patient on another screen

29. At the “HEALTH FACTOR” prompt, type patient’s health factor status at the encounter shown in Figure 4-15:

```
LEVEL/SEVERITY
QUANTITY
COMMENTS
```

Figure 4-15: Other fields for health factor data

30. At the “LEVEL/SEVERITY” prompt, type one of the following:
   - **M** (Minimal)
   - **MO** (Moderate)
   - **H** (Heavy/Severe).

31. At the “QUANTITY” prompt, type a number between 0 and 99999.

32. At the “COMMENTS” prompt, type comments regarding the health factor. Do the following:
The following are the fields on the Behavioral Health Visit Update screen.

33. At the “Display Current Medications?” prompt, type one of the following:
   - N to display the currently dispensed medications
   - Y to display the Output Browser screen shown in Figure 4-16:

![Output Browser]

Figure 4-16: Sample display of current medications

34. At the “MEDICATIONS PRESCRIBED” prompt, press Enter to access another screen and enter the medications prescribed.

35. At the “Any Treated Medical Problems?” prompt, type one of the following:
   - N to end the process
   - Y to access another screen as shown in Figure 4-17:

![Medical Problem]

Figure 4-17: Sample medical problem dialog

36. At the “MEDICAL PROBLEM:” prompt, type the medical problems treated by the provider.

37. At the “Placement Disposition” prompt, type the active disposition such as hospitalization or placement in a treatment facility is required. A pop-up displays as shown in Figure 4-18:

![Facility Referred]

Enter the Facility to which the patient was referred
FACILITY REFERRED TO:
38. At the “FACILITY REFERRED TO:” prompt, type the name of the facility.

39. At the “Visit Flag” prompt, type the numeric value for the flag.
   - 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. As an example, 1 might mean any visit on which a narcotic was prescribed.

40. At the “Local Service Site” prompt, type the location.

### 4.1.4 Using the Behavioral Health Record Edit Window

Figure 4-19 displays the Behavioral Health Record Edit screen used to edit an existing visit.

![Sample Behavioral Health Record Edit dialog](image)

1. At the “Date” prompt, set the date of the visit.
2. At the “Location of Service” prompt, and type the service that took place.
3. At the “Program” prompt, type, the provider name.
4. At the “Outside Location” prompt, type the name of the outside location.
5. At the “Clinic” prompt, type the response listed in the RPMS Standard Code Book table.
6. At the “Appt/Walk-in” prompt, type the appointment information.
7. At the “Visit Flag” prompt, type the numeric value for the flag.
• 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. As an example, 1 might mean any visit on which a narcotic was prescribed.

8. At the “Type of Contact” prompt, type the contact name.

9. At the “Community” prompt, type the name of the community.

10. Press Enter at the “Provider” prompt, to display the Enter/Edit Providers of Service screen as shown in Figure 4-20:

```
********** ENTER/EDIT PROVIDERS OF SERVICE **********
[prompt <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 screen

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

b. At the “PRIMARY/SECONDARY:” prompt, type of the primary or secondary provider.

c. Type Close at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplay.

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

12. At the “Activity” prompt, type the activity code that documents the type of service or activity.

• 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 Appendix A: Activity Codes and Definitions for more information.

13. At the “Activity Time” prompt, type the number of minutes spent on the activity.

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

14. At the “# Served” prompt, type the number of the encounter.
15. At the “Interpreter Utilized” prompt, type Y only if an interpreter is required to communicate with the patient.

16. At the “Chief Complaint/Presenting Problem” prompt, type the reason the patient needed services.

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

18. At the “Comment/Next Appointment” prompt, type the text regarding the next appointment.

19. At the “Medications Prescribed” prompt, press Enter to display another window to input the medications prescribed.

20. Press Y at the “Edit Purpose of Visits?” prompt, to display the Purpose of Visit Update screen shown in Figure 4-21:

```
******** 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 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 screen

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

b. At the “Narrative:” prompt, accept the narrative that is displayed or edit to clarify reason for visit.

- As an 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.
c. At the “AXIS III:” prompt, press Enter to display another window and type general medical conditions of the patient treated during the visit.

d. At the “AXIS IV:” prompt, type one or more of the nine major psychosocial or environmental problem codes.

e. At the “AXIS V:” prompt, type the patient’s functional level using the Global Assessment of Functioning (GAF) scale.

f. At the “GAF Scale Type:” prompt, type the acronym for the GAF Scale Type.

g. Type caret (^) to close the pop-up: the Behavioral Health Record Edit screen redisplays.

21. At the “Edit Treated Medical Problems?” prompt, type Y to display the Enter/Edit Treated Medical Problems screen shown in Figure 4-22, where one or more medical problems can be entered.

22. At the “Edit CPT Codes?” prompt, type Y to display the Add/Add/Edit CPT Procedures screen in Figure 4-23.
23. At the “Edit Health Factors?” prompt, type Y to display the Patient Health Factor Update screen (Figure 4-24):

```
******* PATIENT HEALTH FACTOR UPDATE *******
Examples of health factors: Tobacco Use, Alcohol Cage, TB Status
Patient Name: DEMO,DARRELL LEE
-------------------------------------------------------------------------
Display Health Factor History?  N
After entering each factor you will be prompted for additional data items
HEALTH FACTOR
```

Figure 4-24: Sample Patient Health Factor Update dialog

a. At the “Display Health Factor History?” prompt, type Y to display the Health Factor History.

b. At the “HEALTH FACTOR” prompt, type the factor to display the screen shown in Figure 4-25:

```
LEVEL/SEVERITY
QUANTITY
COMMENTS
```

Figure 4-25: Fields for health factor data

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

d. At the “Quantity” prompt, type a number.

e. At the “Comment” prompt, type health factor comment.

f. Type Close at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redispays.

24. At the “Edit Patient Education?” prompt, Type Y to display the Patient Education Enter/Edit screen in Figure 4-26:

```
PATIENT EDUCATION ENTER/EIDT* [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: 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

c. At the “Education Topic: prompt, type the education topic.
d. At the “Individual/Group:” prompt, type the education for an individual or group.
e. At the “Readiness to Learn:” prompt, type one of the following:
   • Distraction: use when the patient has limited readiness to learn because the distractions cannot be minimized.
   • Eager to Learn: use when the patient is exceedingly interested in receiving education.
   • Intoxication: use when the patient has decreased cognition due to intoxication with drugs or alcohol
   • Not Ready: use when the patient is not ready to learn.
   • Pain: use when the patient has a level of pain that limits readiness to learn.
   • Receptive: use when the patient is ready or willing to receive education.
   • Severity of Illness: use when the patient has a severity of illness that limits readiness to learn.
   • Unreceptive: use when the patient is NOT ready or willing to receive education.
f. At the “Level of Understanding:” prompt, type one of the following:
   • 1 (Poor)
2. (Fair)
3. (Good)
4. (Group No Assessment)
5. (Refused)

g. At the “Provider:” prompt, type the provider for the visit. The default is the current logon user.
h. At the “Minutes:” Prompt, type the number of minutes spent on education.
i. At the “Comment:” prompt, type any comments about the education topic.
j. At the “Status (Goal):” prompt, type one of the following:
   - GS  goal set
   - GM  goal met
   - GNM goal not met
   - GNS goal not set

k. Type Close at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

25. At the “Edit Any Screening Exams?” prompt type Y to display the pop-up screen in Figure 4-28:

```
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 dialog

a. At the “Display IPV/DV screening History?” prompt, type Y and IPV/DV Exam History screen displays.
b. At the “IPV Screening/Exam Result” prompt, type one of the following:
   - N  Negative
   - PR Present
   - PAP Past and Present
• **PA** Past
• **UAS** Unable to screen
• **REF** Patient Refused Screening

c. At the “IPV Screening Provider” prompt, type the provider name.
d. At the “IPV Comment” prompt, type a comment related to the screening.
e. At the “Display Alcohol screening History?” prompt, type **Y** and the alcohol screening history.
f. At the “Alcohol Screening Result” type one of the following:
   • **N** Negative
   • **P** Positive
   • **UAS** Unable to screen
   • **REF** Patient Refused Screening
g. At the “Alcohol Screening Provider” prompt, type the provider name.
h. At the “Alcohol Screening Comment” prompt, type the comment related to the alcohol screening.
i. At the “Display Depression screening History?” prompt, type **Y** and the depression screening history screen displays.
j. At the “Depression Screening Result” prompt, type one of the following:
   • **N** Negative
   • **P** Positive
   • **UAS** Unable to screen
   • **REF** Patient Refused Screening

k. At the “Depression Screening Provider” prompt, type the provider name.
l. At the “Dep Screening Comment” prompt, type the text of the comment related to the depression screening.
m. Type **Close** at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

26. At the “Edit Measurements?” prompt type **Y** and the Measurements pop-up in Figure 4-29 displays:

```
*** Measurements ***
Measurement Description        Value                       Provider
------------------------------------------------------------------------
Figure 4-29: Sample Measurements pop-up
```
a. At the “Measurement” prompt, type the type of measurement being taken. The Description field will populate.

b. At the “Value” prompt, type the numeric value of the measurement.

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

d. Type Close at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

e. At the “Placement Disposition” prompt type when hospitalization or placement in a treatment facility is required.

f. At the “Referred to” prompt, type the name of the facility.

g. Type Close at the “Command” prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

If the SOAP/Progress Note is unsigned and you are the primary provider, the “Enter your Current Signature Code” displays at the command prompt.

- Type your signature code and the signature is applied to the SOAP/Progress Note associated with the current visit. Refer to Section 2.14 for more information.

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

Figure 4-30 shows 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). Add/Update/Print Intake Document
8). Add/Update Suicide Forms
9). Provide List Update
10). None of the Above (Quit)

Choose one of the above: (1-10): 10/

Figure 4-30: Other Information screen

27. Do one of the following:

- Type 9 to display the BH Problem List Update screen. See Section 9.1 for more information.
- Type **10** to exit and one of the following occurs:
  - If the patient was not checked in using the scheduling package, the Other Information screen closes.
  - If the patient was checked in using the scheduling package,
  - If there was an appointment the patient was checked in for using the scheduling package, the Generating PCC Visit screen displays (Figure 4-31).

**Notes:** 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 created using the scheduling package and no other clinics saw the patient that day), then the option to link is never presented and the BH visit continues to create a new visit in PCC.

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

28. At the “Select” prompt, type the number associated with the target visit and press Enter. Figure 4-32 shows the BH screen.

<table>
<thead>
<tr>
<th>#</th>
<th>PRV</th>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>LOC</th>
<th>ACT</th>
<th>PROB</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BJB</td>
<td>BETAA, EMILY MAE</td>
<td>WW129608</td>
<td>WW</td>
<td>11</td>
<td>799.9</td>
<td>DIAGNOSIS OR CONDITION DEF</td>
</tr>
<tr>
<td>2</td>
<td>BJB</td>
<td>BETAA, EMILY MAE</td>
<td>WW129608</td>
<td>WW</td>
<td>11</td>
<td>80</td>
<td>HOUSING</td>
</tr>
<tr>
<td>3</td>
<td>BJB</td>
<td>SIGMAAA, DAVID R</td>
<td>WW145072</td>
<td>WW</td>
<td>12</td>
<td>83</td>
<td>MEDICAL TRANSPORTATION NEE</td>
</tr>
</tbody>
</table>
29. At the “Select” prompt, type **DR** and the Patient Information screen in Figure 4-33 displays.

```
Patient Name: THETA, JIMMY JOE
Chart #: 129347
Date of Birth: NOV 01, 1986
Sex: M

-------------------- [1mBH RECORD FILE]m --------------------
DATE OF SERVICE: FEB 15, 2012@09:07
PROGRAM: SOCIAL SERVICES
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE: SELLS
ACTIVITY TYPE: 13
ACTIVITY TYPE NAME: INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT
TYPE OF CONTACT: OUTPATIENT
PATIENT: FAUST, JIMMY JOE
PT AGE: 25
CLINIC: MEDICAL SOCIAL SERVICES
NUMBER SERVED: 1
APPT/WALK-IN: WALK-IN
ACTIVITY TIME: 60
AXIS V: 65
GAF SCALE TYPE: TEST
INTERPRETER UTILIZED: NO
VISIT: FEB 15, 2012@09:07
POSTING DATE: FEB 15, 2012
WHO ENTERED RECORD: GAMMA, RYAN
DATE LAST MODIFIED: FEB 15, 2012
USER LAST UPDATE: GAMMA, RYAN
DATE/TIME LAST MODIFIED: FEB 15, 2012@15:06:39
EDIT HISTORY:
  Feb 15, 2012 9:09:18 am GAMMA, RYAN
  Feb 15, 2012 1:14 pm GAMMA, RYAN
  Feb 15, 2012 3:06 pm GAMMA, RYAN
EXTRACT FLAG: ADD
CREATED BY BH?: YES
DATE/TIME NOTE SIGNED: FEB 15, 2012@09:21
SIGNATURE BLOCK: Ryan GAMMA
SIGNATURE BLOCK TITLE: TEST DOC
AXIS III:
TEST
AXIS IV:
6 - ECONOMIC PROBLEMS
SUBJECTIVE/OBJECTIVE:
THIS IS A TEST OF THE PN FIELD.
COMMENT/NEXT APPOINTMENT:
NOTE FORWARD TO:
MEDICATIONS PRESCRIBED:
```
30. At the “Press enter to continue” prompt, press Enter. Messages may display indicating that the record is or is not signed. The Other Information screen displays as shown in Figure 4-34:

Figure 4-34: Other Information screen

31. At the “Choose one of the above” prompt, type 10 to exit. The Patient Visit screen displays as shown in Figure 4-35. This screen is view only.
32. At the “Select Action” prompt, type Q and press Enter to exit. The Data Entry Menu displays as shown in Figure 4-36:

33. At the “Select Behavioral Health Data Entry Menu Option” prompt, type DSP. The Data Entry Menu Display Options screen displays as shown in Figure 4-37:
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: THETA,JIMMY JOE
M 11-01-1986 XXX-XX-3033    WW 129347

Enter VISIT date: t-1  (FEB 15, 2012)

Figure 4-37: Data Entry Menu Display Options

34. At the Enter VISIT date: prompt, type PCCV Figure 4-38 shows the PCC Visit screen.

PCC VISIT DISPLAY     Page: 1 of 3

Patient Name:          THETA,JIMMY JOE[m
Chart #:               129347
Date of Birth:         NOV 01, 1986
Sex:                   M
Visit IEN:             2570481
VISIT/ADMIT DATE&TIME: FEB 15, 2012@09:07
DATE VISIT CREATED:    FEB 15, 2012
TYPE:                  IHS
PATIENT NAME:          THETA,JIMMY JOE
LOC. OF ENCOUNTER:     DEMO INDIAN HOSPITAL
SERVICE CATEGORY:      AMBULATORY
CLINIC:                MEDICAL SOCIAL SERVICES
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:    FEB 15, 2012
WALK IN/APPT:          WALK IN
CREATED BY USER:       GAMMAA,RYAN
OPTION USED TO CREATE: AMHGRPC
USER LAST UPDATE:      GAMMAA,RYAN
OLD/UNUSED UNIQUE VIS: 5059010002570481
DATE/TIME LAST MODIFI: FEB 15, 2012@14:59:58
CHART AUDIT STATUS:    INCOMPLETE
NDW UNIQUE VISIT ID (: 102320002570481
VISIT ID:              3M6T-WWX
PROVIDER:              GAMMAA,RYAN
AFF.DISC.CODE:         1C9AAA
PRIMARY/SECONDARY:     PRIMARY
POV:                   303.02
ICD NARRATIVE:         AC ALCOH DEP INTOX-EPISOD
PROVIDER NARRATIVE:    ALCOHOL INTOXICATION, EPISODIC
4.1.5 Edit EHR Visit (EH)

1. Type **EH** to edit a 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.

2. Set the date at the “Enter ENCOUNTER DATE” prompt. The application displays the Edit Behavioral Health Specific Fields for an EHR Visit window shown in Figure 4-39:

   ![Figure 4-39: Sample information about editing a BH visit entered through the EHR.](image)

3. At the “Community of Service” prompt, type the location where the encounter took place.

4. At the “Activity Type” prompt, type the activity for the visit.

5. At the “Appt/Walk In” prompt, type the visit option: appointment, walk-in, or unspecified.

6. At the “Placement Disposition” prompt, type any active disposition (such as Alcohol/Drug Rehab) and the pop-up in Figure 4-40 displays:

   ![Figure 4-40: Sample information about editing a BH visit entered through the EHR.](image)
7. At the “Facility Referred to” prompt, type the facility to which the patient was referred.

8. At the “Interpreter Utilized” prompt, indicate if an interpreter was used in the visit.

9. At the “Comment/Next Appt” prompt, press Enter to display another window and type text about the next appointment.

10. At the “Local Service Site” prompt, type the site for the visit.

11. At the “Flag (Local Use)” prompt, type a local flag for the types of visits.
    - The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

12. At the “AXIS III” prompt:
    a. Press Enter and another window will display, type the text for the medical condition (press Enter to update or Tab to bypass)
    b. Press Tab to bypass the field.

13. At the “AXIS IV” prompt, type 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.

14. At the “AXIS V” prompt, type the patient’s functional level, using the Global Assessment of Functioning (GAF) scale.

15. At the “Scale Type” prompt, type the acronym for the GAF Scale Type.

4.1.6 Edit SOAP (ES)

1. Type ES (Figure 4-3) at the “Select Action” prompt to edit the SOAP note for a specified patient visit as well as the text for Chief Complaint, Comment/Next Appointment, and Medications Prescribed.

   **Note:** This applies only to records with unsigned notes.

2. At the “Edit which Record: (1-x)” prompt, where x is the number of the last record, select the record to edit and the screen refreshes.
3. At the “CHIEF COMPLAINT” prompt, type the chief complaint.

4. At the “SOAP/PROGRESS NOTE” prompt, type new text if necessary. Existing text displays below the prompt and can be edited.

5. At the “Edit? NO/?” prompt:
   - Type Y to display another window and edit the “SOAP/PROGRESS NOTE”.
   - Type N to continue.

6. At the “COMMENT/NEXT APPOINTMENT” prompt, type new text if necessary. Existing text displays below the prompt and can be edited.

7. At the “Edit? NO/?” prompt:
   - Type Y to edit the “COMMENT/NEXT APPOINTMENT” note.
   - Press N to continue.

8. At the “MEDICATIONS PRESCRIBED” prompt, type new text if necessary. Existing text displays below the prompt and can be edited.

9. At the “Edit? NO/?” prompt:
   - Type Y to edit the “MEDICATIONS PRESCRIBED” note.

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

   - Type N and the Other Information screen displays.

4.1.7 Delete Visit (DE)

1. Type DE to remove a 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.

2. At the “Enter Encounter Date” prompt, set the date of the encounter to be removed.

3. At the “Are you sure you want to DELETE this record?” prompt:
   - Type Y: the message “Record Deleted” displays. Press Enter to continue.
   - Press N to end the process.
4.1.8 Sign Note (SN)

Type **SN** to sign a note in a visit record (Figure 4-41). You can only sign notes where you are the primary provider.

After using SN, one or two actions happen:

1. (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. (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.

**Note:** Visits with a blank SOAP/Progress Note will not appear on the list.

---

**Behavioral Health visits for ALPHA, CHELSEA MARIE**

<table>
<thead>
<tr>
<th>#</th>
<th>PROVIDER</th>
<th>LOC</th>
<th>DATE</th>
<th>ACT</th>
<th>CONT</th>
<th>PATIENT</th>
<th>PROB</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>THETA, SHIRLE</td>
<td>WW</td>
<td>05/12/2009</td>
<td>OUTP</td>
<td>WW</td>
<td>116431</td>
<td>56</td>
<td>MARITAL PROBLEM</td>
</tr>
</tbody>
</table>

Figures 4-41: List of records that you can change

4. At the “Which record do you want to display (1-x)” prompt, where x is the number of the last record, type the record number.

   – The application displays the BH Visit Record Display screen.

5. At the “Select Action” prompt, type Q and Enter to exit the BH Visit Record

   - Type **N** to end the sign note process.
   - Type **Y**: the Edit SOAP screen displays. Save the record and the signature code prompt displays.

6. At the “Enter your Current Signature Code” prompt, type your signature code.

   - This signature applies to the SOAP/Progress Note associated with the current visit. Refer to Section 2.14.6 for more information. After entering your signature code, the OTHER INFORMATION screen displays.
   - If the electronic signature is not entered or an invalid signature is entered three times, the window closes. After the screen closes, the following message displays: “There is no electronic signature, this visit will not be passed to PCC”.

4.1.9 Print Encounter Form (PF)

1. Type **PF** to print or browse the encounter form for a specified date.

2. Set the date at the “Enter ENCOUNTER DATE” prompt.
3. At the “What type of form do you want to print” prompt, type one of the following:
   - F  Full Encounter Form
   - S  Suppressed Encounter Form
   - B  Both a Suppressed & Full
   - T  2 copies of the Suppressed
   - E  2 copies of the Full

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

4. At the “Device” prompt, type the device to print or browse. Figure 4-42 shows the data for a suppressed encounter form.
4.1.10 Last BH Visit (LV)

1. Type LV to display the last BH Visit Record (Figure 4-43) for the current patient.

2. At the “Do you want a particular provider’s last visit” prompt:
   - Type Y to continue

```
AXIS IV:   6 - ECONOMIC PROBLEMS
          8 - LEGAL INTERACTION PROBLEMS
AXIS V: 

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

Figure 4-42: Sample Suppressed Encounter Form

4.1.11 Browse Visit (BV)

1. Type BV to browse behavioral health visits.

2. Browse which subset of visits for [current patient name] and type one of the following:
   - L Patient’s Last Visit
   - N Patient’s Last N Visits

Figure 4-43: Sample BH Visit Record Display screen
• D Visits in Date Range
• A All of this Patient’s Visits
• P Visits to one Program
  – Type N, D, or P to continue

Type A on the Browse Patient’s Visits window and the screen displays as shown in Figure 4-44:

Figure 4-44: Sample Report screen

4.1.12 List Visit Dates (LD)
1. Type LD to list the current patient’s visit dates.
2. Browse which subset of visits for [current patient name] and 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
     – Type N, D, or P to continue
Figure 4-45 shows the Browse Patient’s Visit screen.

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>DX</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 26, 2009@09:00</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>testing v4.0 provide</td>
</tr>
<tr>
<td>Mar 23, 2009@11:41</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>Depressive Disorder,</td>
</tr>
<tr>
<td>Jan 22, 2009@15:03</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>Depressive Disorder,</td>
</tr>
<tr>
<td>May 06, 2008@14:23</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>Depressive Disorder,</td>
</tr>
<tr>
<td>Apr 18, 2008</td>
<td>BETAaaa,Bj</td>
<td>295.33</td>
<td>Paranoid Type Schizo</td>
</tr>
<tr>
<td>Apr 07, 2008@14:07</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>Depressive Disorder,</td>
</tr>
<tr>
<td>Feb 18, 2008@17:03</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>Depressive Disorder,</td>
</tr>
<tr>
<td>Feb 12, 2008@16:24</td>
<td>GAMMAAA,DENISE</td>
<td>311.</td>
<td>Depressive Disorder,</td>
</tr>
<tr>
<td>Jan 22, 2008@12:06</td>
<td>BETAaaa,Bj</td>
<td>295.33</td>
<td>Paranoid Type Schizo</td>
</tr>
<tr>
<td>Jan 11, 2008@12:00</td>
<td>GAMMAAA,DENISE</td>
<td>296.31</td>
<td>MAJOR DEPRESSIVE DIS</td>
</tr>
<tr>
<td>Aug 29, 2007@08:53</td>
<td>BETAaaa,Bj</td>
<td>295.33</td>
<td>Paranoid Type Schizo</td>
</tr>
<tr>
<td>Feb 02, 2006@12:00</td>
<td>BETAaaa,Bj</td>
<td>13</td>
<td>SCHIZOPHRENIC DISORD</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
+ Next Screen          - Previous Screen      Q    Quit
Select Action:+//

4.1.13 Display Record (DR)

1. Type **DR** to display the data about a specified visit.

2. At the Enter ENCOUNTER DATE” prompt, set the date of the visit. The BH Visit Record Display screen displays as shown in Figure 4-46:
3. At the “Select Action” prompt, type Q and press Enter. The OTHER INFORMATION screen displays as shown in Figure 4-47:

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

Update, add or append any of the following data

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

Choose one of the above: (1-9): 9/
```

Figure 4-47: Options on the Other Information menu

4. Type 9 to display the BH Problem List Update screen. See Section 9.1 for more information.

5. Use the options to update visit information about the patient, if needed.

6. Type 10 to exit.

### 4.2 Visit Window (GUI)

One way to access the *Visit* window is to use the One Patient option on the **RPMS Behavioral Health System** GUI tree structure. Figure 4-48 shows the Visit window for one patient:

![Visit window for one patient](image)

Use the *Visit* for one patient window to manage the visits within a 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. Default 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. Figure 4-50 shows the Visit window for all patients:

![Visit window for all patients](image)

Figure 4-49: 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 pane. The default is one day.

### 4.2.1 Visit Date Range Pane

The Visit Date Range pane shows the range of visits shown in Figure 4-49.

#### 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 pane.

**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:

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 Pane

The Visit pane shows the visit records in the visit date range.

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

4.2.3 Add Button

Select the patient to use in the add process. Click Add to add a new visit record. You will access the Visit Data Entry–Add Visit dialog. Refer to Section 4.3 for more information.

4.2.4 Edit Button

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

4.2.5 View Button

Click View (or double-click on a record) to browse a 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 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 for more information.

4.2.8 Problem Button

Select a record and click the Problem button to access either a BH Problem List or the PCC Problem list. Refer to Section Figure 9-2 for more information.
4.2.9 Print Encounter Button

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

**Note:** 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 first page of the **Print Encounter** window displays as shown in Figure 4-50:

![Sample Print Encounter window](image)

Figure 4-50: Sample **Print Encounter** window

Refer to Section 2.6 to review the features of this type of window.
4.2.10 Problem Button
Select a visit and then click the Problem button to manage the patient’s Behavioral Health and PCC problems. See Section 9.2 for more information.

4.2.11 Help Button
Click Help on the Visit window to access the online help.

4.2.12 Close Button
Click Close on the Visit window to exit the window.

4.3 Add or Edit Visit Data Entry
1. Click Add on the Visit window to add a new record. Figure 4-51 shows the Visit Data Entry–Add Visit dialog.

![Sample Visits Data Entry–Add Visit window](image-url)

Figure 4-51: Sample Visits Data Entry–Add Visit window
2. Click **Edit** to edit the selected visit for the current patient. The same fields appear on the **Visit Data Entry–Edit Visit** as on the Add Visit dialog
   - The Edit button will be inactive if the patient does not have any previous visits)
3. Click **Help** to access online help about this window.
4. Click **Save**. The changes are saved and the Add or Edit window closes.
   - If a SOAP/ Progress note was added, the user will be asked if they wish to sign the note. Refer to Section 2.14.5 for more information.
     - If the patient was not checked in for an appointment, the **Visit** window displays.
     - If the patient was checking in for an appointment using the scheduling package and it is set to create a visit at check-in, the **Select PCC Visit** window displays. Refer to Section 4.3.10 for more information.

**Note:** 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: “Unsaved Data Will Be Lost, Continue?”

- Click **Yes** to close without saving; the data entry window closes.
- Click **No** to remain on the data entry window and continue to work.

### 4.3.1 Visit Information Pane

1. Type data in the **Visit Information** pane shown in Figure 4-52:

   ![Figure 4-52: Sample Visit Information pane](image-url)
2. Select a provider from the Primary Provider field. The default is the current provider.

3. At the “Encounter Date/Time” field, set the date from the calendar.

4. At the “Program” field, type one of the following to associate the visit:
   - Mental health
   - Social services
   - Other
   - Chemical Dependency

5. Select the encounter from the Encounter Location list.

6. Select the Clinic field to display the Clinic search window.

7. At the Appointment or Walk-In list field, type one of the following:
   - Appointment
   - Walk In
   - Unspecified (for non-patient contact)

8. Select the activity setting from the Type of Contact list.

9. Select the Community of Service field to display the Community Search window.
4.3.2  **POV Tab**

Select the **POV** tab (Figure 4-53) 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 4-53: Sample POV Tab on Visit Data Entry window](image)

**4.3.2.1  Axis I/Axis II Pane**

Select the **Axis I/Axis II** pane (Figure 4-54) to manage the POV codes for Axis I or Axis II issues.

![Figure 4-54: Sample Axis I/Axis II pane](image)

1. Click **Delete** to remove a selected code from the pane. The **Are You Sure** confirmation displays
   - Click **Yes** to remove the selected code from the pane
   - Click **No** to cancel the request.
2. Click **Add** to access the POV (Axis I/II) search window.
   - You can add one or more POV codes associated with the visit.
   - You can search by code number or POV narrative.
3. Click **Edit** to edit the POV narrative of a selected record on the **Edit POV** dialog shown in Figure 4-55:
4.3.2.2 Axis III Pane
Type the client’s general medical conditions in the free text field on the Axis III pane. This field should only be used if the medical condition was treated during the visit.

4.3.2.3 Axis IV Pane
Figure 4-56 shows the Axis IV: Major Physosocial and Environmental Problems window that identify the major category of the problem in the Code field.

1. Click Add to add the codes on the Axis IV multiple select dialog.
2. Click Delete to remove a selected code. The confirmation dialog: Are You Sure? displays:
   • Click Yes to remove the selected code from the pane
   • Click No to cancel the deletion.

4.3.2.4 Axis V
Type the GAF scale value in the Axis V field shown in Figure 4-57. The field is limited to three numerical characters.

Figure 4-55: Edit POV dialog

- Click OK to accept the entry and the narrative is changed to the selected code.
- Click Close to cancel the edit.
• When the Axis V field is populated, the GAF Scale Type field becomes active. You can enter the GAF scale type - enter the acronym for the GAF Scale Type.

• If you click the link on the GAF Scale Type label, The Global Assessment of Functioning pop-up in Figure 4-58 displays. This provides information about the Global Assessment Scale of Functioning (GAF) Scale and the Children’s Global Assessment Scale (CGAS).

![Figure 4-58: Global Assessment of Functioning (GAF) scale](image-url)
4.3.3 Activity Tab

Select the Activity tab shown in Figure 4-59 to manage activity data about the visit for the current patient.

![Activity Tab on the Visit Data Entry window](image)

**Figure 4-59: Sample Activity Tab on the Visit Data Entry window**

### 4.3.3.1 Activity Pane

Figure 4-60 shows the Activity pane.

![Activity pane](image)

**Figure 4-60: Sample Activity pane**

The following fields in bold text are required.

1. Click the Activity field to select the 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 arrow on the field to display the Activity search window. Here you search for the activity name. Refer to Appendix A: Activity Codes and Definitions for more information.

2. Type the time at the Activity Time field. This required field determines how much provider time was involved in providing and documenting the service or performing the activity.
3. Type the flag at the **Visit Flag** prompt. This field is for local use in flagging various types of visits.
   - The site will define a numeric value to indicate the definition of the flag. For example, a 1 might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.

4. Click the “Local Service Site” field to select the local service site, if necessary.

5. Click the “Interpreter Utilized?” box, if an interpreter is required to communicate with the patient.

6. At the Number Served” prompt, type the number served.
   - 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 Pane

Select the **CPT Code(s)** pane to manage the codes shown in Figure 4-61:

![Sample CPT Codes pane](image)

Figure 4-61: Sample CPT Codes pane

1. Click **Add** to display the CPT Code search/select window. The Narrative field is automatically populated.

2. Click **Delete** to remove a selected record. The confirmation **Are You Sure** displays: “Are you are sure you want to delete”.
   - Click **Yes**: to remove the selected code.
   - Click **No**: the code is not removed.
4.3.3.3 **Secondary Providers for this Visit Pane**

From the **Secondary Providers For the Visit** pane (Figure 4-62) select the providers used during the encounter.

![Sample secondary providers for this Visit pane](image)

3. Click **Add** to access the Secondary Providers search/select window and search for the provider.

4. Click **Delete** to remove a selected secondary provider record. The confirmation **Are You Sure** displays: “Are you sure you want to delete?”
   - Click **Yes**: to remove the selected provider.
   - Click **No**: the provider is not removed.

4.3.4 **SOAP/Progress Notes Tab**

Select the **SOAP/Progress Notes** tab (Figure 4-63) on the **Visit Data Entry** window to manage the SOAP/progress note associated with the current visit.

![Sample SOAP/Progress Notes tab](image)

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

1. Type the problem in the **Chief Complaint/Presenting Problem** field.
2. Type notes in the **Progress Notes** field. A SOAP or progress note must be entered in the context of a visit.

3. Type additional comments in the **Comments/Next Appointment** field.

4. Select a placement type from the **Placement Disposition** field.

5. Type the name of the facility in the **Placement Name** field.

### 4.3.5 Rx Notes/Labs Tab

Select the **Rx Notes** tab to view prescription data or laboratory tests data as in Figure 4-64:

![Sample Rx Notes/Labs tab](image)

Figure 4-64: Sample **Rx Notes/Labs** tab

The Rx/Labs pane controls display on the right side of the tab.

#### 4.3.5.1 Rx Data

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

1. Select the **PCC Medications** pane to view medications prescribed for the patient.

2. Select the **Behavioral Health Medications** pane to view the visit dates when behavioral health medication was prescribed and any associated notes.

3. Select the **Prescription Entry** field to enter data 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.

4.3.5.2 PCC Labs

When PCC Labs is selected in the Rx/Labs pane, you can select: View by Visit, View by Lab Test, or Graph.

4.3.5.2.1 View by Visit Date

When View by Visit Date is selected, (Figure 4-65) displays the View Labs by Visit Date dialog.

![Sample View Labs by Visit Date dialog]

The View Labs by Visit Date and View Labs by Lab Test dialogs display 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 the dates by clicking the field on the calendar. After setting the date, click OK to accept the date, or click Close to ignore. The OK function displays a pop-up that shows the first page of the PCC labs by visit date within the range.

4.3.5.2.2 View by Lab Test

When View by Lab Test is selected, the View Labs by Lab Test dialog displays as shown in Figure 4-66:

![Sample View Labs by Lab Test dialog]
The **View Labs by Visit Date** and **View Labs by Lab Test** dialog have the following features:

- If necessary, change the **Begin Date**.
- 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.

See Section 2.7 for more information.

### 4.3.5.2.3 Graph

If you select **Graph**, the right side of the tab changes to two panels: **Lab Graph Date Range** and **Graphable Lab Tests** as in Figure 4-67:

![Figure 4-67: Sample panes for Graph option](image)

**Lab Graph Date Range**

The default date is one year. This date range determines the data displayed in the Graphable Lab Tests pane. You can edit either or both dates. Click the drop-down list and select a date from the calendar. Click Display to refresh the data in the Graphable Lab Tests pane as shown in Figure 4-68:
Graphable Lab Tests

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 laboratory test is shown in Figure 4-69:
4.3.6 Wellness Tab

Select the Wellness tab (Figure 4-70) to view the BH/PCC wellness activities, and manage the education, health factors, and screenings for the visit.

![Wellness tab screenshot](image)

Figure 4-70: 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 Patient Education on the Wellness tree structure to display the patient education panes: Patient Education History and Patient Education Data Entry panes are shown in Figure 4-71:

![Patient Education panes screenshot](image)

Figure 4-71: Sample Patient Education panes
The Patient Education History pane is read-only. You can scroll through the data using the scroll bar.

You can add/edit data in the Patient Education Data Entry pane by pressing the Add, Edit, or Delete button.

4.3.6.1.1 Add Patient Education Record
1. Click Add to display the Education Topic window and select a topic. Click OK to accept the selection shown in Figure 4-72.

2. If you clicked OK, the application displays the Patient Education dialog, and the Education Topic field is populated.

3. Click Close and the application displays the “Continue” warning: “Canceling will lose all unsaved data, Continue?”
   
   - Click Yes: to return to the Patient Education Data Entry pane.
   - Click No: to display the Patient Education dialog with no data in the fields.

![Figure 4-72: Sample Patient Education dialog](image)

4. Select the topic from the “Education Topic” field.

5. At the “Time” prompt, type the number of minutes spent on the topic.

6. At the “Goal” prompt, type the goal of the education.

7. Select the “Status” field and select one of the following:
   
   - Goal Set (the preparation phase defined as “patient ready to change” (patient is active)
   - Goal Met (the action phase defined as “patient actively making the change” or maintenance phase defined as “patient is sustaining the behavior change”)
   - Goal Not Met (the contemplation phase defined as “patient is unsure about the change” or relapse when the patient started making the change and did not succeed due to ambivalence or other reason)
• Goal Not Set (the precontemplation phase defined as “patient is not thinking about change”)

8. Select the “Readiness to Learn” field and select 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.

9. Select the “Level of Understanding” field and to select one of the following:

• **Poor** (does not verbalize understanding; unable to return demonstration or teach-back correctly)

• **Fair** (verbalizes need for more education; incomplete return demonstration or teach-back indicates partial understanding)

• **Good** (verbalizes understanding; able to return demonstration or teach-back correctly)

• **Group No Assessment** (education provided in group; unable to evaluate individual response)

• **Refused** (refuses education)

10. At the “Comment” prompt, type comments about the topic for the visit.

11. Click OK and the application saves the data and displays it on the **Education Topics Data Entry**.

12. Click Cancel and the “Continue?” warning: “Canceling will lose all unsaved data, Continue?”

   • Click **Yes**: to not save and leave the **Patient Education** dialog.

   • Click **No**: to return to the **Patient Education** dialog.
4.3.6.1.2 **Edit Patient Education Record**

1. Select a record in the Patient Education Data Entry.

2. Click **Edit**, the Patient Education dialog displays with the current data in the fields. Refer to Section 4.3.6.2.1 for more information about the fields.

4.3.6.1.3 **Delete Patient Education Record**

1. Select a record in the Patient Education Data Entry

2. Click **Delete**: the Are You Sure? confirmation displays: “Are you sure you want to delete?”
   - Click **Yes**: to delete the selected record
   - Click **No**: the record is not deleted.

4.3.6.2 **Health Factors**

Select the Health Factors on the Wellness tree structure to display the health factor panes (Figure 4-73): Health Factors History and Health Factors Data Entry.

![Health Factors History dialog](image)

Figure 4-73: Sample Health Factors History dialog

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** pane is read-only. You can scroll through the data using the scroll bar.
You can add/edit data in the **Health Factors Data Entry** pane by clicking **Add**, **Edit**, or **Delete**.

### 4.3.6.2.1 Add Health Factor Record

1. Click **Add** to display the **Health Factors** search window.

2. Select a health factor and click **OK** and the Health Factor window displays shown in Figure 4-74:

![Figure 4-74: Sample Health Factors dialog](image)

3. Select a factor from the Health Factor field.

4. Select the Level/Severity field and select one of the following:
   - Minimal
   - Moderate
   - Heavy/Severe

5. At the “Quantity” prompt, type a number, if necessary.

6. At the “Comment” prompt, type comments for the health factor.

7. Click **OK**: the data is saved and displays **Health Factors Data Entry** (Figure 4-73).

8. Click **Cancel**: the “Continue?” message displays: “Canceling will lose all unsaved data, Continue?”
   - Click **Yes**: entry is not saved and the Health Factors closes.
   - Click **No**: to return to the **Health Factors** window and data is saved.

### 4.3.6.2.2 Edit Health Factor Record

1. Select a record in the **Health Factors Data Entry**.

2. Click **Edit** and the **Health Factors** dialog displays with the current data. Refer to Section 4.3.6.2.1 for more information.

### 4.3.6.2.3 Delete Health Factor Record

1. Highlight a record in the **Health Factors Data Entry**.
2. Click **Delete**: the **Are You Sure** warning displays: “Are you sure you want to delete?”
   - Click **Yes**: to delete the selected record
   - Click **No**: the record is not deleted.

4.3.6.3 **Screening**

Select the Screening option on the Wellness tree structure to display the screening panes (Figure 4-75): **Screening History** and **Screening Data Entry**.

![Figure 4-75: Sample Screening History panes](image)

The **Screening History** dialog is read-only. Drag the scroll bar to navigate through the data.

1. **Add** displays when the **Screening Data Entry** is empty.

2. If the **Screening Data Entry** dialog is populated, **Edit** is enabled.
3. Click **Edit** and select a selected record. Figure 4-76 shows the Screening window.

![Screening dialog](image)

Figure 4-76: Screening dialog

4. Select the Alcohol field and select 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)

5. Select a provider from the Provider field.

6. At the “Comment” prompt, type text related to the screening.

7. Select the Depression field and select 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)

8. Select a provider from the Provider field.

9. At the “Comment” prompt, type text related to the depression screening

10. Select the IPV/DV field and select 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)
11. Select a provider from the Provider field, if necessary.
12. At the “Comment” prompt, type comments related to the IPV/DV screening
13. Click **OK**: the data is saved and displays on the **Screening Data Entry**.
14. Click **Cancel**: the “Continue?” warning displays: “Canceling will lose all unsaved data, Continue?”
   • Click **Yes**: the **Screening** dialog closes without saving changes.
   • Click **No**: to return to the **Screening** dialog.

### 4.3.7 Measurements Tab

Select the **Measurements** tab to view existing measurements as well as add, edit, or delete Measurement data for the patient visit as shown in Figure 4-77:

![Sample Measurements dialog](image)

**Figure 4-77: Sample Measurements dialog**

#### 4.3.7.1 Measurement View Pane

The pane displays the measurements for the current patient in the date range shown in the **Measurement History** pane (Figure 4-78).

1. Select the Starting Date field and set a date
2. Select the Ending Date field and set a date.
3. Click the Display button to refresh the data view pane.

![Figure 4-78: Sample Measurement View pane](image)

4. To better utilize the data collected and viewed through the Measurement View pane, click Graph (Figure 4-80).

The Measurement Type pane displays as shown in (Figure 4-79).

![Figure 4-79: Sample Measurement Type pane](image)

5. Select a measurement type to graph.
6. Click **OK** to display the MS Excel line graph in shown in Figure 4-80. A graph may be created and saved from the selected data.

Figure 4-80: Sample line graph

### 4.3.7.2 Measurement Data Entry Pane

Figure 4-81 shows the **Measurement Data Entry** pane which manages the measurements during the visit.

Figure 4-81: Sample **Measurement Data Entry** pane

1. Click **Add** to activate the measurement fields for data entry.

2. Select an option from the **Measurement Type** field. This field is inactive when editing a record.
3. Type the measurement number in the **Value** field. If the value is outside the accepted range, the **Warning** dialog shown in Figure 4-82 displays:

![Figure 4-82: Sample value outside the acceptable range warning](image)

4. Click **OK** to exit the warning and enter a valid number.

5. Select a provider from the **Provider** field.

6. Click **OK** on the **Measurement Data Entry** pane (Figure 4-81). The new record displays.

7. Click **Cancel** to end the process.

8. Click **Edit** to change a measurement or provider. The Measurement Type field is inactive when editing a record.

9. Click **OK** to change the value or provider.

10. Click **Delete** to remove a measurement record, the confirmation **Are You Sure** displays:

    - Click **Yes** to delete the record
    - Click **No** and the record will not be deleted.
4.3.8 Intake Tab (GUI)

Select the Intake tab and the Intake window displays as shown in Figure 4-83:

Figure 4-83: Initial Intake window

Refer to Section 12.2 for more information.

4.3.9 Suicide Form

Click the Suicide Form tab to display the Suicide Form window. Refer to Section Figure 11-2 for more information.
4.3.10 Select PCC Visit Window

The PCC Visit window (Figure 4-84) displays the visit has been saved and signed. The visit is entered in the scheduling package with the option to create a visit at check-in.

Figure 4-84: Sample Select PCC Visit window

1. Click **New** to create a record. The Select PCC Visit window closes. The Visit List View screen displays.

2. Highlight an entry and click OK to link one record to the PCC record.

3. Click **Refresh** to return to the GUI and view more visits.

Figure 4-85: Select PCC Visit window with more visits

4. If one has been linked, it can be viewed in PCC as shown in Figure 4-86 displays.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>BETA, EMILY MAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart #:</td>
<td>129608</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>MAR 01, 1968</td>
</tr>
<tr>
<td>Sex:</td>
<td>F</td>
</tr>
<tr>
<td>Visit IEN:</td>
<td>2565343</td>
</tr>
</tbody>
</table>

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

VISIT/ADMIT DATE&TIME: MAR 09, 2010@16:15
DATE VISIT CREATED: MAR 09, 2010
TYPE: IHS
PATIENT NAME: BETA, EMILY MAE
LOC. OF ENCOUNTER: DEMO INDIAN HOSPITAL
SERVICE CATEGORY: AMBULATORY
Figure 4-86: Information from PCC

See Section 4.1.1 for more information.

### 4.4 Browse Visits (GUI)

Figure 4-87 shows the **Browse Visits** window.

![Browse Visits Window](image)

**Figure 4-87: Sample Browse Visits dialog**
1. Select the **Browse Visits By** field and 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 the Patient’s Visits
   - **P**: Visits to One Program
   - If **L** or **A** are selected, the remaining fields will be inactive.

2. Depending on the selection in Step 1:
   - If **N** was selected, select the **Number of Records**.
   - If **D** was selected, set the **Begin Date** and **End Date**.
   - If **P** is selected, select the **Program**.
   - If **L** or **A** are selected, the remaining fields will be inactive.

3. Click **OK**: the first page of the **Browse Visits** window displays as shown in Figure 4-88:

![Figure 4-88: Sample of data in Browse window](image)
Refer to Section 2.6 for more information.

4.5 View Patient Data

When you expand View Patient Data on the tree structure (Figure 4-89) for the RPMS Behavioral Health System, select one of the following to view patient data:

- Face Sheet, Health Summary
- PCC Medications
- PCC Labs by Visit Date
- PCC Labs by Lab Test.

![RPMS Behavioral Health System tree structure for View Patient Data](image)

Figure 4-89: RPMS Behavioral Health System tree structure for View Patient Data

4.5.1 Face Sheet

The Face Sheet displays the first page of the Ambulatory Care Record Brief dialog for the current patient. Refer to Section 2.6 for more information.

- Right-click on the Face Sheet label to display Change Patient. After selecting the option, the application displays the Select Patient dialog. Refer to Section 2.12.2 for more information.
4.5.2 Health Summary

The **Health Summary** displays the selected health summary type report for the current patient. Figure 4-90 shows the **Select Health Summary Type** window.

![Select Health Summary Type window](image)

Figure 4-90: *Select Health Summary Type* window

1. Select an option from the **Select Health Summary Type** field.
2. Click **OK** to display the first page of the type of health summary. Refer to Section 2.6 for more information.

4.5.3 Patient Appointments

The **Patient Appointments** (Figure 4-91) displays the appointments of the current patient in a date range.

![Sample Patient Appointments dialog](image)

Figure 4-91: Sample *Patient Appointments* dialog

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

1. Select the **Begin Date** field and set the date.
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the appointments for the patient in the date range displays. Refer to Section 2.6 for more information.

4.5.4 PCC Medications

The **PCC Medications** displays medications for the current patient in a date range. Figure 4-92 displays the **PCC Medications** window.
1. Select the **Begin Date** field and set a date.
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the Medication Prescribed in the Behavioral Health database within the date range.

### 4.5.5 PCC Labs by Visit Date

The **PCC Labs by Visit Date** displays the PCC Labs for the current patient in a date range. Figure 4-93 displays the **View Labs by Visit Date** window.

1. Select the **Begin Date** field and set a date. The date is applied to the **View Labs by Lab Test** window as well.
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the PCC labs by visit date in the date range.
4.5.6 PCC Labs by Lab Test

The **PCC Labs by Lab Test** option displays the PCC Labs for the current patient in a date range. Figure 4-94 displays the **View Labs by Lab Test** window:

![View Labs by Lab Test window](image)

**Figure 4-94: Sample View Labs by Lab Test window**

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

1. Select the **Begin Date** field and set a date. The date is applied to the **View Labs by Visit Date** window as well

2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the **PCC labs by lab test** within the date range.
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)**

The Group Form Data Entry Using Group Definition (GP) option is used to input MH/SS data from a group form. Use if the encounter involves a group of patients. This process allows you to enter data into each participant’s record without entering an encounter record for each patient.

1. At the “Enter Beginning Date” prompt, type the date range for displaying Group definitions.

2. At the “Enter Ending Date” prompt, type the date range for displaying Group definitions. The Group Entry dialog (Figure 5-1) displays.

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

The asterisk (*) preceding the Entry Date indicates that the record contains an unsigned group note. Refer to Section 2.14 for more information.

3. At the “Select Action” prompt, type Q and press Enter to close the screen.
Note: You can edit group records only with the group screens, not on the individual data entry side (PDE, SDE).

5.1.1 Add a New Group

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-1), type 1.

2. At the “Enter Date of the Group Activity” prompt, type a date. The Group Encounter Documentation screen (Figure 5-2) displays:

```
* GROUP ENCOUNTER DOCUMENTATION *  DEMO INDIAN HOSPITAL
--------------------------------------------------------------------------
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.
Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 14,2009             Arrival Time: 12:00
Program:                                Community of Service:
Group Name:                             Clinic:
Activity:                               Activity Time:
Encounter Location:                     Type of Contact:
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N          CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
________________________________________________________________________
COMMAND:                                       Press <PF1>H for help
Insert
```

Figure 5-2: Sample Group Encounter Documentation screen

3. Type Y at the “At the “Add/View/Update Providers (Primary or Secondary)” prompt and press Enter to display the Secondary Providers screen (Figure 5-3) as an overlay to the Group Encounter Documentation screen.

```
PROVIDER:                                     PRIMARY/SECONDARY:  
PROVIDER:                                     PRIMARY/SECONDARY:  
PROVIDER:                                     PRIMARY/SECONDARY:  
```

Figure 5-3: Sample Secondary Providers screen

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

5. At the “PRIMARY/SECONDARY” prompt, type a provider name.

Note: Only one primary provider can be used, whereas, you can use multiple secondary providers.

6. At the “Command” prompt, type Close and press Enter to return to the Group Encounter Documentation screen (Figure 5-2).
7. At the “Encounter Date” prompt, set the date.
8. At the “Arrival Time” prompt, type the time of the encounter.
9. At the “Program” prompt, type one of the following:
   - M (Mental Health)
   - S (Social Services)
   - C (Chemical Dependency)
   - O (Other)
10. At the “Community of Service” prompt, type the name where the encounter took place.
11. At the “Group Name” prompt, type the name of the group encounter.
12. At the “Clinic” prompt, type the number or name of the clinic.
13. At the “Activity” prompt, type the group encounter activity.
14. At the “Activity Time” prompt, type the number of minutes spent on the activity.
   
   **Note:** 0 (zero) is not allowed as a valid entry.
15. At the “Encounter Location” prompt, type the name of the encounter location.
16. At the “Type of Contact” prompt, type the activity setting.
17. At the “POV or DSM (Primary Group Topic)” prompt, type the POV for the group topic.
18. Press Enter: to display the POV or DSM Diagnosis dialog (Figure 5-4):

   ![Figure 5-4: Sample pop-up window for POV](image)

   **POV or DSM Diagnosis (Primary Group Topic)**

<table>
<thead>
<tr>
<th>CODE</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Figure 5-4: Sample pop-up window for POV
19. At the “Code” prompt, type the MHSS Problem/DSM IV POV code. The Narrative for the code will display and can be edit.
20. At the “Chief Complaint/Presenting Problem” prompt, type the chief complaint.
21. At the “Any Patient Education Done?” prompt, type Y and the Patient Education for this Group Activity screen Figure 5-5 displays as an overaly.

```
*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

22. At the “EDUCATION TOPIC:” prompt, type the topic code. The Education Topic screen in Figure 5-6 overlays:

```
EDUCATION TOPIC: 042.-DISEASE PROCESS
LEVEL OF UNDERSTANDING: GROUP-NO ASSESSMENT
PROVIDER: THETA, SHIRLEY
MINUTES:
COMMENT:
```

Figure 5-6: Sample screen for Education Topic

- The Individual/Group field displays GROUP and is read only.
- The Level of Understanding field displays GROUP-NO ASSESSMENT and is read only.

23. At the “Provider” prompt, accept the current user name or update.

24. At the “Minutes” prompt, type the number of minutes spent on education.

25. At the “Comment:” prompt, type a comment about the education topic.

The following fields display on the Group Encounter Documentation screen (Figure 5-2).

26. At the “CPT Code(s)” prompt, press Enter to display a secondary window.

27. At the “S/O/A/P (Standard Group Note)” prompt, press Enter to display secondary window.

28. At the “Patients” prompt, press Enter to display the Patients screen shown in Figure 5-7:
Please enter all patients who participated in the group. Remove any patients who were not present

PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:

Please enter all patients who participated in the group. Remove any patients who were not present

Figure 5-7: Sample pop-up for Patients

29. At the “PATIENT:” prompt, type the patient name, HRN, DOB, or SSN. Figure 5-8 displays after you save and exit the application.

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 screen

30. Type Y: to continue editing the patient’s visit. The first patient’s record redisplay.

31. Type N: to edit the group definition.

32. Type Q and press Enter to exit. The Group Entry (Figure 5-1) screen displays.

- 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

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-1), type 8.

- If the selected group already has visits created, the following message displays: “This group already has visits created. You must use the REVIEW/EDIT GROUP VISITS to modify visits within this group”.

- The Group Entry screen redispays.

In all other cases, the Group Encounter Documentation screen displays shown in Figure 5-9:
* GROUP ENCOUNTER DOCUMENTATION *          DEMO INDIAN HOSPITAL

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

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAY 15,2009@12:00       Arrival Time: 12:00
Program: MENTAL HEALTH                  Community of Service: ABERDEEN
Group Name: meeting on thur             Clinic: EMERGENCY MEDICINE
Activity: 25                             Activity Time: 6
Encounter Location: ABERDEEN AO         Type of Contact: CONSULTATION
POV 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 for more information.

5.1.3 Review/Edit Group Visits

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-1), type 6.

2. At the “Select GROUP ENTRY” prompt, type the group entry to review or edit.

3. If the group has a signed note, the following message displays: “The notes associated with this group entry have been signed”.
   a. You can edit other items in this entry but not the notes.
   b. Press Enter to continue.

Figure 5-10 shows the Enter/Edit Patient Group Data screen after the GROUP ENTRY field is completed.

<table>
<thead>
<tr>
<th>Enter/Edit Patient Group Data Mar 27, 2009 17:33:04</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Entry</td>
<td>-------------</td>
</tr>
<tr>
<td>Patient Name</td>
<td>Sex  Age  DOB  HRN  Record Added</td>
</tr>
<tr>
<td>1) PHIIII,TERRY LYNN</td>
<td>F  40  05/10/1968  198794  yes</td>
</tr>
<tr>
<td>2) THETA,LOMIE</td>
<td>M  23  06/23/1985  115697  yes</td>
</tr>
<tr>
<td>AE Edit Patient's Group Visit</td>
<td>D  Display Patient's Group Visit</td>
</tr>
<tr>
<td>X Delete a Patient's Group Visit</td>
<td>Q  Quit</td>
</tr>
<tr>
<td>Select Action:+//</td>
<td>-------------</td>
</tr>
</tbody>
</table>

Figure 5-10: Sample Enter/Edit Patient Group Data screen

4. At the “Select Action” prompt, type Q and press Enter to exit.
5.1.3.1 Delete a Patient’s Group Visit (X)

1. At the “Select Action” prompt, type X to remove a patient’s group visit. The BH record displayed, followed by the prompt “Are you sure you want to delete this Patient’s Visit?”.
   - Type Y to delete the visit
   - Type N to cancel the deletion.

5.1.3.2 Display Patient’s Group Visit (D)

- At the “Select Action” prompt, type D to display a 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)

1. At the “Select Action” prompt type AE.

2. At the “PATIENT GROUP ENTRY (1-x)” prompt, type the group number (“x” being the number of the last group data record). The BEHAVIORAL HEALTH RECORD EDIT window displays as shown in Figure 5-11:

   ![Figure 5-11: Sample Behavioral Health Record Edit window](image)

   If the message “SOAP/PROGRESS NOTE SIGNED/UNEDITABLE” displays, the fields are not editable. Refer to Section 4.1.4 for more information.
5.1.4 Display Group Entry

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-11), type 2 and press Enter.

The group data is displayed in Figure 5-12 on the Output Browser screen.

![Figure 5-12: Sample Output Browser screen](image)

5.1.5 Print Encounter Forms

1. At the “Select Action” prompt on the Output Browser screen, type 5 and press Enter to print an encounter form for a group.

2. At the “GROUP ENTRY” prompt, type the group to use.
   a. The message “Forms will be generated for the following patient visit” displays.
   b. The names of the patients in the group displays.

3. At the “Enter response” prompt, type one of the following:
   - F: Full Encounter Form
   - S: Suppressed Encounter Form
   - B: Both a Suppressed & Full
   - T: 2 copies of the Suppressed
   - E: 2 copies of the Full
A full encounter form prints all data for a patient encounter including the S/O/A/P note and displays Chief Complaint, SOAP note, measurement data, screenings. The suppressed report does not display the information:

4. At the “Device” prompt, type the device to print/browse the encounter form.

Figure 5-13 shows a sample full encounter form report.

---

**CONFIDENTIAL PATIENT INFORMATION**

PCC BEHAVIORAL HEALTH ENCOUNTER RECORD  
Printed: Oct 01, 2009@17:38:44

*** Computer Generated Group Encounter Record ***
Group Name: Mond DV

Date: Sep 28, 2009  
Primary Provider: GAMMA, DENISE

Arrival Time: 10:00  
Flag: 

Program: SOCIAL SERVICES  
Clinic: MEDICAL SOCIAL SERVICES  
Appointment Type: UNSPECIFIED

Community: TAHELEQUAH  
Served: 1  
Time: 44 minutes

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  
PURPOSE OF VISIT (POV)

OR DSM DIAGNOSIS  
[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  
BETTTA, LORI

Enter RETURN to continue or ‘^’ to exit:

---
5.1.6 Duplicate Group

1. At the “Select Action” prompt on the Group Encounter Documentation screen (Figure 5-2), type 3. 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 reverts the SOAP/Progress Notes associated with the new group encounter to the unsigned status.

   **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.

2. At the “Select GROUP ENTRY” prompt, type the number corresponding to the group to duplicate

3. At the “Enter Date for the new group entry” prompt, type the date.

Figure 5-14 shows the Group Encounter Documentation screen as displayed:

![Sample Group Encounter Documentation screen](image)

Figure 5-14: Sample Group Encounter Documentation screen
5.1.7 Add No Show Visit

1. At the “Select Action” prompt on the Group Encounter Documentation screen (Figure 5-14), type 7 and press Enter.

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

2. At the “Select GROUP ENTRY (1-x)” prompt, type the number of the group (“x” being the number of the group).

3. At the “Select PATIENT NAME” prompt, type the name of the patient.

4. At the “Enter PRIMARY PROVIDER” prompt, type the primary provider name and the Behavioral Health Visit Update screen (Figure 2-4) displays. Refer to Section 4.1.3 for more information.

5.1.8 Sign Note

1. At the “Select Action” prompt on the Group Encounter Documentation screen, type 9 and press Enter to sign an unsigned SOAP/Progress note for a group encounter. Only the primary provider for the record can sign the note.

2. At the “Select Group Entry (1-x)” prompt, type the record number, (“x” being the number of the group).

3. If you are *not* the primary provider, the application displays the message in Figure 5-15:

   
   You are not the primary provider for this group, no electronic signature will be applied and no PCC link will occur. The primary provider will need to sign these at a later time.
   Press enter to continue....:

   Figure 5-15: Message about the primary provider

4. Press Enter to return to the Group Entry window.

If there is a record but no visits were created for this group, the following message in Figure 5-16 displays:

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

   Figure 5-16: Message about no visits created

5. Press Enter to return to the **Group Entry** screen.
If the provider opted out of E-Signature, the message in Figure 5-17 displays:

```
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 as shown in Figure 5-18:

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

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

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

Figure 5-18: Sample BH Visit Record Display screen

6. At the “Select Action: prompt, type Q and press Enter. The following message displays: “Do you wish to edit this record?”

7. Type Y: to edit the record.

8. Type N: to not edit the record.

- The application prompts: “Enter your Current Signature Code”. Refer to Section 2.14.6 for more information.

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

- At the “Select Action” prompt, type 4 and press Enter to remove a group encounter record with an unsigned note. The application verifies that you want to delete the 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)

Figure 5-19 shows the location of the Group Encounter function on the RPMS Behavioral Health System GUI tree structure.

Figure 5-19: Group Encounters location on tree structure

- Click Group Encounters to access the Group Entry window.

Figure 5-20: Sample Group Entry window

5.2.1 Group Entry Date Range Pane

The Group Entry window displays the group encounters in the date range shown in the Group Entry Date Range pane (default is one year). The default view is sorted by date +(from most recent).
1. Change the date range by accessing the calendar under the calendar list.

2. Click **OK**: the **Group Entry** pane updates.

### 5.2.2 Group Entry Pane

The Group Entry pane displays the records in the group entry date range.

The asterisk (*) in the first column indicates that the record contains an unsigned note. When you select this type of record, the **Sign Note** button becomes active. Refer to Section 2.14 for more information.

### 5.2.3 Add Button

- Click **Add** to add a new group encounter record and access the **Group Data Entry–Add Group Data** window. Refer to Section 5.3 for more information.

### 5.2.4 Edit Button

- Click **Edit** to change the highlighted group encounter record and access 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 and access the **Group Data Entry–View 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 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.

1. Select a record and click Delete. The confirmation message: Are You Sure displays.

2. Click Yes to delete the record and remove the selected group encounter record from the pane. The group definition and all individual patient records will be removed.

3. Click No and the record is not deleted.

5.2.8 Sign Note Button

1. Click Sign Note to sign a “unsigned” group encounter record (asterisk (*) in the first column). Refer to Section 2.14.5 for more information.

   • If the primary provider has opted out of E-Sig, the visit will pass to PCC, and the application displays the Message dialog displayed in Figure 5-21:

     ![Message dialog](image)

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

   • The message indicates that an electronic signature is not required.

2. 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.
Figure 5-22 shows the first page of the **Print Encounter Group** window.

![Print Encounter Group window](image)

Refer to Section 2.6 for more information.

### 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 exit the **Group Entry** window.

### 5.3 Add/Edit Group Data (GUI)

1. Do one of the following:
   - Click **Add** to add a new group data record and display the **Group Data Entry–Add Group Data** window (Figure 5-23).
   - Click **Edit** to change the group encounter record and display the **Group Data Entry–Edit Group Data** window.

**Note:** All Patient Education entries created before the installation date for BHS v4.0 will continue to display the CPT field.
Figure 5-23 displays the **Group Data Entry–Add Group Data** window. (The same fields display on the **Group Data Entry–Edit Group Data** window.)

![Group Data Entry–Add Group Data Window]

The fields in the **Group Encounter Information** pane on the **Edit Group Data** window will be active and will display the existing data (uneditable). All editing is completed in the **Group Encounter Information** pane or 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.
- Click **Help** to access online help.
- Click **Save** to save the edits and the **Add/Edit Group Data** window closes. If a SOAP/Progress note was added, the application will display the electronic signature dialog and proceed in the same manner as used for individual encounter records (**OK** or continue, etc.).
2. Click **Close** and the edits will not be saved. The **Continue?** confirmation displays: “Unsaved Data Will Be Lost, Continue?”

3. Do one of the following:
   - Click **Yes**: the record is not saved and the **Add Group Data** window closes.
   - Click **No**: to remain on the **Add Group Data** window and continue to work.

### 5.3.1 Group Encounter Information Pane

The add window shown in Figure 5-24 displays several active fields that can be changed on the **Edit Group Data** window.

![Sample Group Encounter Information pane](image)

Figure 5-24: Sample **Group Encounter Information** pane

1. Select a provider from the **Primary Provider** field.
2. Set the time and date in the **Encounter Date/Time** field.
3. Select the **Program** list and select one of the following:
   - **Mental Health**
   - **Social Services**
   - **Other**
   - **Chemical Dependency**

After a program is selected, the application automatically populates the Clinic, Community of Service, Type of Contact, and Encounter Location fields if the defaults are set in the Site Parameters menu. These fields are read only.

4. Select the encounter from the **Encounter Location** field.
5. Select the clinic context from the **Clinic** field.
6. Select the name of the group encounter from the **Group Name** field.

### 5.3.2 Activities Tab

- Select the **Activities** tab shown in Figure 5-25 to identify the community of service, type of contact, activity, and activity code.
- The information on this tab is read-only when using the **Edit Group Data** window.
5.3.2.1 Fields

1. Select a service from the **Community of Service** field.
2. Select the contact from the **Type of Contact** field.
3. Select the activity of the group encounter from the **Activity** field. Default is **Group Teatment**.
   - 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.
4. Select the number of minutes from the **Activity Time** field.

5.3.2.2 CPT Codes Pane

1. Select the **CPT Code** pane to manage the CPT codes associated with the activity.
2. Click **Add** button to display the **CPT Code** search/select window.
3. Click **OK** to add to the CPT Codes pane.
4. Click **No** to cancel the process.
5. Select a code from the **CPT Codes** pane.
6. Click **Delete** button to delete a code from the **CPT Codes** pane. The confirmation **Are You Sure?** displays: “Are you sure you want to delete?”
7. Click **Yes** to remove the selected record.

8. Click **No** to cancel the process.

### 5.3.3 Group Data Tab

Select the **Group Data** tab (Figure 5-26) to identify a chief complaint, secondary providers, POV code, and group note.

![Group Data tab](image)

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

### 5.3.3.1 Chief Complaint/Presenting Problem Pane

Type the chief complaint or presenting problem. This describes the major reason the patients in the group sought services.

### 5.3.3.2 Secondary Providers Pane

Add or delete providers on the **Secondary Providers** pane shown in Figure 5-27:

![Secondary Providers pane](image)

1. Click **Add** access the **Secondary Provider** search/select window.
2. Click Delete to remove a secondary provider. The confirmation Are You Sure? displays: “Are you are sure you want to delete?”.

3. Click Yes to remove the selected provider

4. Click No to end the process.

5.3.3.3 Purpose of Visit - POV (Primary Group Topic) Pane

Select the Purpose of Visit - POV (Primary Group Topic) pane to manage the POV codes and narratives. 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.

A minimum of one POV record is required for a group encounter (Figure 5-28):

![Figure 5-28: Sample POV pane](image)

1. Click Delete to remove a POV record. The confirmation Are You Sure? displays: “Are sure you want to delete?”
   - Click Yes to remove the selected record.
   - Click No to end the process.

2. Click Add to access the POV (Axis I/II) search and select window. The Code and Narrative is populated for the record.

3. Select a record, click Edit to change the Narrative on the Edit POV dialog (Figure 5-29):

![Figure 5-29: Edit POV dialog](image)

   - Click OK to save the changes to the narrative.
   - Click Close to end the process.
Note: Certain special characters (*,“,’,) cannot be the first character. In this case, none of these characters will populate the first character in the Narrative field (as you type).

5.3.3.4 Standard Group Note Pane
Select the Standard Group Note field to enter a group note.

- You must be on the Patient Data tab to do any editing after the group has been saved.

5.3.3.5 CPT Codes Pane
The information about this pane is covered in Section 5.3.2.2.

5.3.4 Group Education Tab
Select the Group Education tab (Figure 5-30) to add education data.

Figure 5-30: Sample Group Education tab

- The information on this tab is read-only when using the Edit Group Data window.
5.3.4.1 Add Group Education Record

1. Click **Add** on the **Group Education** tab to activate the fields on the tab (Figure 5-30).

2. Select a topic from the **Education Topic** field.

3. Select a provider from the **Provider** field.

4. Type a number in the **Time** field.

5. Select a Group-No Assessment from the **Level of Understanding** field.

6. At the **Comment** prompt, type any comments.
   - Click **Cancel** to clear the fields on the **Group Education** tab.
   - Click **OK** to add the record to the **Group Education**.

5.3.4.2 Edit Group Education Record

1. Highlight a record in the **Edit Group Education Record**.

2. Click **Edit** to display the information about the record in the fields.
   Refer to Section 5.3.4.1 for more information.

3. Click **Delete** to remove a selected record. The confirmation **Are You Sure?** displays: “Are you sure you want to delete?”

4. Click **Yes** to remove the selected record

5. Click **No** to end the process.

**Note:** The group education can be removed only prior to saving the group. Once the group has been saved, there is currently no way to remove it in the group format.
5.3.5 Patients Tab

The Patients tab (Figure 5-31) shows the patients in the group encounter.

![Sample Patients tab](image)

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

5.3.5.1 Add Patient Record

The Add button requires that the POV pane and the Standard Note Group Note (on the Group Data tab) be populated.

1. Click Add to display the Select Multiple Patients dialog shown in Figure 5-32:
Figure 5-32: Sample **Select Multiple Patients** dialog

- You can add one or more patients to the **Patients** tab
- You can search for a patient by name, HRN, DOB, or SSN.

2. Click **OK** to add the patients names to the pane and close the dialog

3. Click **Clear** to remove the names from the pane and remain on the **Select Multiple Patients** dialog.

4. Click **Close** to end the process and close the dialog.

### 5.3.5.2 Delete Patient Record

1. Click **Delete** to remove a selected patient record. The confirmation **Are You Sure?** displays: “Are sure you want to delete?”

2. Click **Yes** to remove the selected patient record.

3. Click **No** to end the process.

- Leave clients who no showed or canceled in the group since it is possible to do the “no show” within the group definition on the **Patient Data** tab in the **Time In Activity** field.

### 5.3.6 Patient Data Tab

Select the **Patient Data** tab (Figure 5-33) to add POV, group note, comment/next appointment information, and CPT codes for a patient in the group encounter.
1. Double click a patient name in the Patients pane.

2. Click Save to save the record.

3. Click Cancel to move to another part of the group data entry dialog.

5.3.6.1 Patients Pane

The Patients pane (Figure 5-34) shows the patients in the group encounter.

1. Double click a patient name to access the other panes.

2. Click OK and the cursor returns to the Patients pane. The last selected patient name is highlighted.
• If you are in ADD mode and you click OK and then attempt to go to the Group Data tab, the Continue dialog displays (Figure 5-35):

![Continue Message](image)

Figure 5-35: Continue Message

• Click Yes to overwrite any individual data. The Patients Data tab displays.
• Click No to end the process. The Patients Data tab displays.

### 5.3.6.2 Purpose of Visit - POV (DSM Diagnosis or Problem Code) Pane

Select the Purpose of Visit - POV (DSM Diagnosis or Problem Code) (Figure 5-36) pane to add, edit, or delete a POV. (You must double-click a patient name before you can add/change the data in this pane.)

![Sample POV pane](image)

Figure 5-36: Sample POV pane

1. Click Delete to remove a selected POV. The confirmation Are You Sure? displays: “Are sure you want to delete?”
2. Click Yes to remove the selected record.
3. Click No to end the process.
4. Click Add to display the Edit POV (Axis I/II) search window and select POVs.
5. Click Edit to change the narrative text of the POV record shown in Figure 5-37:

![Sample Edit POV dialog](image)

Figure 5-37: Sample Edit POV dialog

6. Click OK to accept the changes to the narrative.
7. Click Close to leave the narrative unchanged.
Note: Certain special characters (like *,”,‘) cannot be the first character. In this case, none of these characters not populate the first character in the Narrative field (as you type).

5.3.6.3 Standard Group Note

This field will contain text of the Standard Group Note on the Group Data tab. You can add text about how the patient reacted in the group (on the Patient Data tab).

This is where the user individualizes the note for the patient in focus. The standard group note should never reference the individual patient but should have information about the individual patient’s participation in the group.

- This field is available for text entry by the primary provider of the record (only).
- This field is not available for text entry if the note for the group record is signed.

5.3.6.4 Comment/Next Appointment

Type the next appointment in the Comment/Next Appointment field free text field with the text of any comments about the next appointment for the selected patient.

5.3.6.5 CPT Codes Pane

1. Select the CPT Codes pane to manage the codes for the selected patient.
2. Click Add to display the search or select window and add one or more codes.
3. Select a record and click Delete. The confirmation Are You Sure? displays: “Are sure you want to delete?”
4. Click Yes: to remove the selected record.
5. Click No: the selected record is not removed.

5.3.6.6 Time in Group

The Time-in-Group field (Figure 5-38) displays the number of minutes in the group encounter.

![Time in Group](image)

Figure 5-38: Sample Time in Group field

1. Do one of the following:
   - If the patient attended the whole group session, make no changes.
• If the patient was late or left early, change the field to reflect the actual time in
  minutes.

• Type a 0 in the field if the patient did not attend the encounter. The No Show
  message displays: “Changing Time in Group to zero removed this patient’s
  POV and Note entry. You will now be prompted for a No Show POV”.

2. Click OK to display the POV (Axis I/II) search or select window.

3. Select one or more “no show” POVs.

4. Click OK to accept the entries and the selected POVs will display in the Purpose
  of Visits – POV pane on the Patient Data tab

5. Click Cancel to end the process.

5.3.6.7 Visit Flag

Use the Visit Flag field to 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.
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 shown in Figure 6-1:

![Figure 6-1: Sample Update BH Patient Case Data screen.](image)

- At the “Select Item” prompt, the Type Q and press Enter to exit the Update BH Patient Case Data screen.

6.1.1 **Open New Case (OP)**

1. Type OP and the Update Patient Case Data screen shown in Figure 6-2 displays.

2. At the “Select Item” Enter Case Open Date” prompt, type the date to open the case. The Update Patient Case Data screen displays Figure 6-2:
3. At the “Case Open Date” prompt, type the date the case was opened.

4. At the Program Affiliation, type one of the following:
   - M  Mental Health Defaults
   - S  Social Services Defaults
   - C  Chemical Dependency or Alcohol/Substance Abuse
   - O  Other

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

6. At the “Primary Problem” prompt, type the name or code.

7. At the “Case Admit Date” prompt, set the date.

8. At the “Next Case Review Date” prompt, type the next date for the review.

9. At the “Date Case Closed” prompt, set the date.

10. At the “Disposition” prompt, type the reason for closing the case.

11. At the “Comment” prompt, type any comments about the case.

### 6.1.2 Edit Case Data (ED)

- Type **Edit Case Data (ED)** 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 for more information.
6.1.3 Delete Case (DC)

Type DC (Delete Case) to remove a case from the Update BH Patient Case Data window.

6.2 Designated Provider/Flag/Personal History (Roll and Scroll)

1. Type **OI** (Desg Prov/Flag/Pers Hx) at the **Patient Data Entry** screen Figure 6-3) to display the update Patient Information screen.

![Figure 6-3: Sample Update Patient Information screen](image)

2. At the “Designated Mental Health Provider” prompt, type the RPMS provider accepted to designate Mental Health provider status.

3. At the “Designated Social Services Provider” prompt, type the provider who accepted the designated Social Services provider.

4. At the “Designated CD A/SA Provider” prompt, type the provider who accepted the designated Chemical Dependency or Alcohol/Substance Abuse provider status.

5. At the “Designated Other Provider” prompt, type the provider who has accepted the designated Other provider status.

6. At the “Other Provider Non-RPMS” prompt, type another Behavioral Health provider not listed in RPMS.
7. At the “Patient Flag Field” prompt, type the number used to identify a specific group of patients.

8. At the “Patient Flag Narrative” prompt, type the narrative about the patient flag.

9. Type Save or Exit at the **Update Patient Information** window and the **Personal History** window.

   - If necessary, add a personal history factor. 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.

10. At the “Enter Personal History” prompt, type the personal history factor for the current patient.

   a. If you do not want to add another personal history, type the 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)

Figure 6-4 shows where the Case Management function is located on **RPMS Behavioral Health System** GUI tree structure.

![Case Management Window](image)

Figure 6-4: Case Management option on the **RPMS Behavioral Health System** GUI tree structure
Select Case Management to display the Case Management (Figure 6-5) for the current patient.

![Case Management window](image)

Figure 6-5: Sample Case Management window

### 6.3.1 Case Management Date Range

The Case Status Date Range pane displays the management records.

1. Set the date at the Start Date field.
2. Set the date at the End Date field.
3. Click OK to update the Case Status pane.

### 6.3.2 Case Status Pane

The Case Status pane displays the case management records.
6.3.3 Add Button
Click Add to insert a new record and the Case Management–Add Case window displays. Refer to Section 6.4 for more information.

6.3.4 Edit Button
Click Edit to edit a record and the Case Management–Edit Case window displays.

6.3.5 View Button
Click View (or double-click on a record) to view the data for a record and the Case Management–View Case window displays. Refer to Section 6.4 for more information.

6.3.6 Delete Button
Click Delete to remove a selected record. The confirmation: Are You Sure? displays: “Are you sure you want to delete?”
- Click Yes: to remove the record.
- Click No: the record is not removed.

6.3.7 Help Button
Click Help to access the online help system.

6.3.8 Close Button
Click Close to dismiss the Case Management window.

6.4 Add or Edit Case Management Data (GUI)
1. Click Add to display the Case Management–Add Case window (Figure 6-6).
2. Select a record and click Edit to edit the record.
3. Complete the **Case Status** pane (Figure 6-7). The **Program** and **Case Open Date** fields are required:

![Figure 6-7: Fields in Case Status pane](image)

a. Select from the options in the **Program** field.

b. Set the date at the **Case Admit Date** field and follow the instructions Section 2.7. Accept the default by clicking the box.

c. Set the **Case Open Date**.

d. Set the **Next Review Date**.

e. Select the **Provider Name** field to display the **Primary Provider** search dialog (Section 2.8).

f. Set the **Date Case Closed**.

g. Select the **Primary Problem (Axis I/II)** field to display the **Primary Problem/POV** search dialog.
h. Select the **Disposition** field to display the **Disposition** search dialog.

i. Type a comment in the **Comment** field.

4. Complete the **Patient Information** pane (Figure 6-8) to provide information about various providers and other case management information.

![Figure 6-8: Fields in the Patient Information pane](image)

**Note:** Clear the fields 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**.

a. Select the **Designated Mental Health Provider** field to display the **Designated Mental Health Provider** search dialog.

b. Type the Behavioral Health provider not listed in RPMS at the **Other Provider Non-RPMS** prompt.

c. Select the **Designated Social Work Provider** field to display **Designated Social Work Provider** search dialog.

d. Type the provider not listed in RPMS at the **Other Provider Non-RPMS** field.

e. Select the **Designated Chemical Dependency Provider** field to access the **Designated Chemical Dependency Provider** search dialog.

f. Type the defined number to identify the group in the **Patient Flag** field.

   • 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.

g. Select the **Designated Provider Other RPMS** field to display the **Designated Provider Other RPMS** search dialog.

h. Type the patient narrative in the **Patient Flag Narrative** field.

i. The **Designated Primary Care Provider** field is read only and displays the name of the designated primary care provider for the patient.
5. Complete the **Personal History** pane (Figure 6-9) by adding or deleting personal history data about the current patient.

![Sample Personal History pane](image)

Figure 6-9: Sample **Personal History** pane

- You only need to document personal history once, as it becomes a permanent part of the patient’s medical record.
  
a. Click **Add** to display the **Personal History Factors** window.
  
b. Click **Delete** to remove a selected personal history record. The confirmation **Are You Sure?** displays: “Are you sure you want to delete?”
    
    - Click **Yes** to remove the selected record.
    
    - Click **No** to end the process.

6. Click **Save** to save the case management information, the **Case Management** dialog closes.

7. Click **Close**: confirmation dialog **Continue?** displays: “Unsaved Data Will Be Lost, Continue?”
   
   - Click **Yes**, the data is not save and the **Add Case** window closes.
   
   - Click **No**, the **Add Case** window remains open.

8. Click **Help** to access the online help.
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) is found under SDE on the BH data entry window.

1. At the “Enter Primary Provider” prompt, type the primary provider for the visit. The default is the current logon user.

The application displays the Behavioral Health Record Update screen (Figure 7-1), with the following fields automatically populated: Program, Clinic, 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 7-1: Sample Behavioral Health Record Update

2. At the “Program” prompt, type the program associated with the record.

3. At the “Clinic” prompt, type the response included in the RPMS clinic code set.

4. At the “Location of Encounter” prompt, type the location of the encounter.

5. At the “Arrival Time” prompt, type the time of the encounter.

6. At the “Flag Field” prompt, type a numeric value.
• 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. Any Secondary Providers?

7. Type Y to display the Enter/Edit Providers of Service screen shown in Figure 7-2:

```
******* 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 7-2: Sample Enter/Edit Providers of Service screen

8. At the “PROVIDER:” prompt, type the name of the providers.

9. At the “PRIMARY/SECONDARY: Use SECONDARY:” prompt, type any secondary providers. The BEHAVIORAL HEALTH RECORD UPDATE screen in Figure 7-1 displays.

10. At the “Community of Service” prompt, type the location of the encounter.

11. At the “Activity Code” prompt, type the activity code associated with the encounter. Refer to Appendix A: Activity Codes and Definitions for more information.

12. At the “# Served” prompt, type the number of people served in the activity.

13. At the “Activity Time” prompt, type the number of minutes spent on the activity.

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

14. At the “Type of Contact” prompt, type the activity setting.

15. At the “Local Service Site” prompt, type the site for the encounter.
16. At the “Any Prevention Activities to Record?” prompt, type Y and the Prevention Activities screen shown in Figure 7-3 displays:

![Figure 7-3: Prevention Activities screen]

- 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.

17. At the “PREVENTION ACTIVITY” prompt, type the code for the prevention activity. These activities are recorded when recording non-patient activities.

18. At the “TARGET” prompt: type the population the prevention activity is designed for:

- A (Adult)
- Y (Youth)
- F (Family)
- M (Mixed Adult & Youth)
- S (Staff)
- E (Elderly Only)
- W (Women)

19. At the “Purpose of Visits (POVS)” prompt, press Enter. The BH Record Entry–Purpose of Visit Update screen in Figure 7-4 displays.
20. At the “PROBLEM CODE” prompt: type the problem code defines either the Behavioral Health Purpose of Visit or the more specific DSM IV diagnostic code.

21. At the “NARRATIVE” prompt, type the narrative for the problem code.

The prompts for the Behavioral Health Record Update screen (Figure 7-1) continue.

22. At the “COMMENT (press enter) prompt, press Enter to display a secondary window and enter comments about the Administrative/Community Activity.

7.2 Administrative/Community Activity Window (GUI)

Figure 7-5 shows where the Administrative/Community Activities function is located on RPMS Behavioral Health System GUI tree structure.

Select Administrative/Community Activities from the RPMS Behavioral Health System GUI tree structure (Figure 7-5), the Administrative/Community Activity in Figure 7-6 displays.

Figure 7-6: Sample Administrative/Community Activity window
The Administrative/Community Activity window shows the administrative and community activities records.

### 7.2.1 Administrative/Community Activity Date Range

The **Administrative/Community Activity Date Range** pane shows the date range for the records in the Administrative/Community Activity pane.

1. Select the Start Date field and set a date, if necessary.
2. Select the End Date field and set a date, if necessary.
   - Click **OK** and the records in the pane display

### 7.2.2 Administrative/Community Activity Pane

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 for more information.

### 7.2.4 Edit Button

Click **Edit** to edit a 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 exit the window.

### 7.2.6 Delete Button

Click **Delete** to delete a record. The deletion is confirmed.
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 as shown in (Figure 7-7).

![Sample output for a selected Administrative/Community Activity record](image)

Refer to Section 2.6 for more information.

7.2.8 Help Button

Click **Help** to access the online help system.

7.2.9 Close Button

Click **Close** to exit the Administrative/Community Activity window.

7.3 Add or Edit Administrative/Community Activity (GUI)

1. Click **Add** on the Administrative/Community Activity window (Figure 7-5) to add new administrative/community activity data. This function displays the Administrative/Community Activity Data Entry–Add Administrative/Community Data window shown in Figure 7-8.
2. Highlight a record (on the Administrative/Community Activity window) and click **Edit** to change the administrative/community activity data. This function displays the Administrative/Community Activity Data Entry–Edit Administrative/Community Data window.

- This window has the same fields as the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**.

![Figure 7-8: Sample Community Activity Data Entry–Add Community Data window](image)

3. Click **Help** to access the online help.

4. Click **Save** to add the record.

5. Click **Close** and the record is not saved.

### 7.3.1 Administrative/Community Entry Pane

Figure 7-9 shows the **Administrative/Community Entry** pane.
1. Select a provider for the administrative/community activity from the **Primary Provider** field.

2. Set a date in the **Encounter Date/Time** field, if necessary.

3. Select the **Program** field and type one of the following:
   - Mental Health
   - Social Services
   - Other
   - Chemical Dependency to continue

4. Select a location where the administrative/community activity took place in the **Encounter Location** field.

5. Select an activity setting in the **Contact field** field.

6. Select a location from the **Community of Service** field.

7. Select a clinic from the **Clinic** field.

8. Select a code associated with the administrative/community from the **Activity Code** field.

9. Type the number of minutes in the **Activity Time** field.

10. Type the number of people served in the activity in the **# Served** field.

11. Type a numeric value in the **Flag** field.
   - 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. As an example, 1 might mean any visit on which a narcotic was prescribed.

12. Select the site associated with the administrative/community activity from the **Local Service Site** field.
7.3.2 Activity Data Tab

Select the Activity Data tab (Figure 7-10) to specify the POV, prevention activities, and secondary providers data.

![Sample Activity Data tab](image1)

**Figure 7-10: Sample Activity Data tab**

### 7.3.2.1 Purpose of Visit–POV Pane

The POV pane in Figure 7-11 displays the POVs associated with the administrative/community activity:

![Sample POV pane](image2)

**Figure 7-11: Sample POV pane**

- 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 to display the search/select window. Here you select one or more POVs.

7.3.2.1.2 Edit Button
Click Edit Figure 7-11 to change the Narrative field of a POV record in the pane. The Edit POV pane shown in Figure 7-12 displays.

![Edit POV dialog]

1. Type text in the Narrative field.
   - Click OK to update the record.
   - Click Close to end the process and the Edit POV pane closes.

7.3.2.1.3 Delete Button
Select a POV record and click Delete to remove a record. The confirmation: Are You Sure? displays: “Are you sure you want to delete?”
   - Click Yes to remove the selected group encounter record from the pane.
   - Click No to end the process.

7.3.2.2 Prevention Activities Pane
The Prevention Activities pane (Figure 7-13) lists the prevention activities associated with the administrative/community activity.

![Sample Prevention Activities pane]

- 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.

1. At the Target field, type one of the following:
- Adult
- Youth
- Family
- Mixed (Adult & Youth)
- Staff
- Elderly Only
- Women

### 7.3.2.2.1 Add Button
Click **Add** to insert a prevention activity record to the pane. Click **Add** to access the **Prevention Activity** search/select window.

- If you use **OTHER** on the Prevention Activity search window, Figure 7-14 displays

![Figure 7-14: Other dialog](image)

- Type text in the **Other** field.
  - Click **OK** to display the text in the **Other** field.
  - Click **Close** to end the operation.

### 7.3.2.2 Delete Button
1. Highlight a prevention activity record.
2. Click **Delete**. The confirmation **Are You Sure?** displays: “Are you sure you want to delete?”

- Click **Yes** to remove the selected record from the pane.
- Click **No** to end the process.

### 7.3.2.3 Secondary Providers Pane
The **Secondary Providers** pane (Figure 7-15) lists the secondary providers associated with the administrative/community activity.

![Figure 7-15: Sample Secondary Providers pane](image)
7.3.2.3.1 *Add*

Click **Add** on the Secondary Providers pane to display the Secondary Providers search or select window.

7.3.2.3.2 *Delete*

1. Highlight the secondary provider record.

2. Click **Delete**. The confirmation **Are You Sure?** displays: “Are you sure you want to delete?”
   - Click **Yes** to remove the selected record from the pane.
   - Click **No** to end the process.

7.3.3 *Notes Tab*

Type administrative/community activity notes in the **Notes** field (Figure 7-16):

![Sample Notes field](image)

*Figure 7-16: Sample Notes field*
8.0 **Encounter and Treatment Plan Sharing (Roll and Scroll)**

After the entry of a Visit or a Treatment plan, you will have the option to share it with a colleague through MailMan. In order to do this, you must be properly set up through Site Parameters as a provider who can share information.

Make sure that the provider being sent the plan should actually be using this function.

After the entry of a Visit or Treatment plan, the following message displays as shown in Figure 8-1:

| Do you want to share this visit information with other providers? N// |

Figure 8-1: Question after entry of a visit or treatment plan

- At the “Do you want to share this visit information with other providers?” prompt, type **Y**. The process of sending the information via a MailMan message is shown in Figure 8-2:

<table>
<thead>
<tr>
<th>Send to: NUUUU,BILL WBM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Send to:</td>
</tr>
<tr>
<td>Message will be sent to: THETA,BILL</td>
</tr>
<tr>
<td>Do you want to attach a note to this mail message? N// YES</td>
</tr>
<tr>
<td>Enter the text of your note.</td>
</tr>
<tr>
<td>NOTE APPENDED TO MAIL MSG:</td>
</tr>
<tr>
<td>No existing text</td>
</tr>
<tr>
<td>Edit? NO//Y</td>
</tr>
<tr>
<td>- Here the provider can append a note to his/her colleague.</td>
</tr>
<tr>
<td>Ready to send mail message?? Y// ES</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Sending Mailman message to distribution list</td>
</tr>
<tr>
<td>Message Sent</td>
</tr>
<tr>
<td>Press enter to continue....:</td>
</tr>
</tbody>
</table>

Figure 8-2: Sending a treatment plan through MailMan
9.0 Problem List
This section addresses the Problem List management for Roll and Scroll and the GUI.

9.1 Patient’s Problem List (Roll and Scroll)
The PPL appears on the Patient Data Entry and Update BH Forms screens.

1. Select PPL to display the patient’s problem list and the following message displays as shown in Figure 9-1:

   Problem List updates must be attached to a visit. If you are updating the Problem List in the context of a patient visit select the appropriate existing visit and then update the Problem List. If you are updating the Problem List outside of the context of a patient visit, first create a chart review visit and then update the Problem List.

   Select record to associate the Problem List update to: (1-5):

   Figure 9-1: Message displayed by the application

2. At the “Select record to associate the Problem List update to “ prompt, select a visit and the following screen (Figure 9-2) displays:

   BH Problem List Update        Aug 23, 2011 14:05:45          Page:    1 of    1
   --------------------------------------------------------------------------------
   Patient Name: DEMO,DUCK    DOB: FEB 05, 1975   Sex: M   HRN: 36219
   --------------------------------------------------------------------------------
   BH Problem List Updated On: Aug 22, 2011  By: SIGMA,DARLA
   1)   DX: 301.0   Status: ACTIVE   Last Modified: 08/22/2011  
        DSM Narrative: PARANOID PERSONALITY DISORDER  
        Provider Narrative: PARANOID PERSONALITY DISORDER  
        Date of Onset: 02/10/2009   Facility: DEMO INDIAN HOSPITAL

   Enter ?? for more actions                                          >>>
   AP   Add BH Problem       NO   Add Note             FA   Face Sheet
   EP   Edit BH Problem      MN   Edit Note            BP   Add BH Prob to PCC PL
   DE   Delete BH Problem    RN   Remove Note          PC   PCC Problem List Update
   AC   Activate BH Problem  NP   No Active BH ProblemsQ    Quit
   IP   Inactivate BH Prob   LR   Problem List Reviewed  
   DD   Detail Display       HS   Health Summary
   Select Action: +//

   Figure 9-2: Sample BH Problem List update screen

3. At the “Select Action” prompt, type Q and press Enter to close the screen.
9.1.1 BH Problem Actions (Roll and Scroll)

**Note**: BH Problem List information does not cross to PCC.

9.1.1.1 Add BH Problem (AP)

1. Type AP to add a new BH problem for the current patient’s visit (Figure 9-2). Figure 9-3 shows the current patient’s problem list:

   ![Figure 9-3: Example of options from which to choose screen](image)

   - Purpose of Visit Diagnoses assigned to this patient in the past 90 days:
     1) 304.22 COCAINE DEPENDENCE, EPISODIC
     2) 304.82 POLYSUBSTANCE DEPENDENCE, EPISODIC
     3) 079.81 HANTAVIRUS INFECTION
     4) 301.0 PARANOID PERSONALITY DISORDER
     5) 301.10 AFFECTIV PERSONALITY NOS
     6) 304.00 OPIOID DEPENDENCE, UNSPECIFIED
     7) 304.30 CANNABIS DEPENDENCE, UNSPECIFIED
     8) Any Other Diagnosis

2. At the “Choose a Diagnosis: (1-8):” prompt, type one of the following:
   - Type 1-7 and the PROVIDER NARRATIVE prompt displays.
   - Type 8 to continue

3. At the “Enter Diagnosis to Add to the Problem List” prompt, type the diagnosis to be added to the BH Problem List.

4. At the “STATUS” prompt, type the status of the diagnosis, either A (active) or I (inactive). The default for a new problem is A.

5. At the “DATE OF ONSET” prompt, type the date of the diagnosis.

6. At the “Add TREATMENT Note?” prompt:
   - Type N: the focus will go to the “Enter the Date the Problem List was Updated by the Provider” prompt.
   - Type Y to add a treatment note.

7. At the “PROVIDER NARRATIVE” prompt, type the treatment note.

8. At the “AUTHOR” prompt, type an author name.

9. At the “LONG/SHORT TERM TREATMENT” prompt:
   - Type 1 for Short Term
   - Type 2 for Long Term. This refers to the treatment described in the Treatment note.
• After completing the last prompt, focus returns to the “Add TREATMENT Note?” prompt.

10. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

11. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).

• If you are transcribing an update from a BHS provider, then enter the name of the provider.

• If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.2 Edit BH Problem (EP)

1. At the “Select Problem” prompt, type **EP** to edit a specified BH problem.

2. At the “Select Problem” prompt, type the number of the problem to edit.

3. At the “PROBLEM CODE” prompt, type the problem code.

4. At the “PROVIDER NARRATIVE” prompt, type the provider narrative.

5. At the “DATE OF ONSET” prompt, type the date of onset, when the problem was first diagnosed. (This can be left blank.)

6. At the “STATUS” prompt, type the status, **A** (active) or **I** (inactive), if needed.

7. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

8. At the “Enter the individual that updated the Problem List” prompt, type the name of individual who updated the BH Problem List.

• If you are transcribing an update from a BHS provider, then enter the name of the provider.

• If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.3 Delete BH Problem (DE)

1. At the “Select Problem” prompt, type **DE** to delete a specified BH problem.

2. At the “Select Action” prompt, type the action to execute, **1** (Delete BH Problem) or **2** (Detail display)

• In this case, type **1**.
3. At the “Select Problem” prompt, type the number of the problem to delete. After specifying a valid problem number, the information about the problem displays as shown in Figure 9-4:

Deleting the following BH Problem from DUCK DEMO's BH Problem List.

PROBLEM CODE: 9.1 PATIENT NAME: DEMO, DUCK
DATE LAST MODIFIED: SEP 07, 2011@14:07:46
PROVIDER NARRATIVE: PRE-SENILE CONDITION
FACILITY: DEMO INDIAN HOSPITAL NMBER: 3
DATE ENTERED: SEP 07, 2011@13:54:16 STATUS: ACTIVE
USER LAST UPDATE: THETA, SHIRLEY

Please Note: You are NOT permitted to delete a BH Problem without entering a reason for the deletion.

Figure 9-4: Example of information displayed about the problem code

4. At the “Are you sure you want to delete this BH Problem?” prompt, type one of the following:
   - Type N: the focus will return to the BH Problem List Update screen.
   - Type Y and the following prompts display:

5. At the “Enter the Provider who deleted the Problem” prompt, type the name of the provider who deleted the problem.

6. At the “REASON PROBLEM DELETED” prompt, type one of the following:
   - D (Duplicate)
   - E (Entered in Error)
   - O (Other)
     - Type O at the prompt.

7. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

8. At the “Enter the individual that updated the Problem List” prompt, type a name.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.4 Activate BH Problem (AC)

1. At the “Select Problem” prompt, type AC to cause the status of a inactive BH problem to be active.
2. At the “Select Problem” prompt, type the number of the problem to activate.

If the problem is already active, the following message in Figure 9-5 displays:

That problem is already ACTIVE!!
Press return to continue....:

Figure 9-5: Message displayed when the problem is already active

3. At the “Press return to continue” prompt, press Enter and the focus returns to the BH Problem List Update screen (Figure 9-2). If the problem is not active, the following prompts continue:

4. Set a date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

5. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

### 9.1.1.5 Inactivate BH Problem (IP)

1. At the “Select Problem” prompt, type **IP** to cause the status of a active BH problem to become inactive.

2. At the “Select Problem” prompt, type the number of the problem to inactivate.
   - If the problem is already inactive, the following message in Figure 9-6 displays:

That problem is already INACTIVE!!
Press return to continue....:

Figure 9-6: Message displayed when the problem is already inactive

3. At the “Press return to continue” prompt, press Enter and the focus returns to the BH Problem List Update window.
   - If the problem is not inactive, the prompts continue:

4. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

5. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the Problem List.
9.1.1.6 **Detail Display (DD)**

1. At the “Select Problem” prompt, type **DD** to display detail information about a selected BH problem.

2. At the “Select Problem” prompt, type the problem to use.

Behavioral Health Problem List information on the **Output Browser** screen displays as shown in Figure 9-7:

![OUTPUT BROWSER](image)

Figure 9-7: Sample Problem Detail

9.1.1.7 **Add Note (NO)**

1. At the “Select Problem” prompt, type **NO** to add a note to a selected BH problem.

2. At the “Select Action” prompt, type one of the following:
   - 1 Add Note
   - 2 No Active BH Problems
     - Type 1 in this case.

3. At the “Select Problem” prompt, type the problem to which to add a note.

   The application displays information about the selected problem and information about any existing notes.

4. At the “Add a new Problem Note for this Problem?” prompt, type one of the following:
   - Type N: to return to the BH Problem List Update window.
   - Type Y: and the following prompts continue:
5. At the “NARRATIVE” prompt, type the text of the narrative of the note.

6. At the “AUTHOR” prompt, type a name.

7. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following: 1 (for short) or 2 (for long).

The application will refresh with the information about the problem and information about the notes as shown in Figure 9-8:

Adding a Note to the following problem on DOROTHY ROSE DEMO's BH Problem List.

<table>
<thead>
<tr>
<th>PROBLEM CODE: 304.22</th>
<th>PATIENT NAME: DEMO, DOROTHY ROSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE LAST MODIFIED: OCT 05, 2011@11:18:18</td>
<td></td>
</tr>
<tr>
<td>PROVIDER NARRATIVE: COCAINE DEPENDENCE, EPISODIC</td>
<td></td>
</tr>
<tr>
<td>FACILITY: DEMO INDIAN HOSPITAL</td>
<td>NMBR: 2</td>
</tr>
<tr>
<td>DATE ENTERED: OCT 05, 2011@11:18:18</td>
<td>STATUS: ACTIVE</td>
</tr>
<tr>
<td>USER LAST UPDATE: DEMO, DOCTOR</td>
<td></td>
</tr>
</tbody>
</table>

Notes:

1) Date Added: 12/01/2011 Author: DEMO, CASE M
   Note Narrative: Pt has problems with illegal drugs
   SHORT TERM TREATMENT

2) Date Added: 12/05/2011 Author: DEMO, DOCTOR
   Note Narrative: Pt has resolved some of the problems with illegal drugs
   SHORT TERM TREATMENT

Figure 9-8: Example of information about the problem and information about the notes

8. At the “Add a new Problem Note for this Problem?” prompt type one of the following:
   - Type Y: the prompts will repeat, starting with NARRATIVE.
   - Type N to continue

9. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

10. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.8 Edit Note (MN)

1. At the “Select Problem” prompt, type MN to edit the text of a selected note.

2. At the “Select Problem” prompt, type the problem having the note to be edited.
3. At the “Edit which one” prompt, type the note to edit.

4. At the “NARRATIVE: <text of the problem> Replace” prompt, type the replacement text for the NARRATIVE.

5. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following:
   - 1 (for short)
   - 2 (for long)

6. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
   Use the default date or specify another one.

7. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.9 Remove Note (RN)

1. At the “Select Problem” prompt, type RN to delete a selected note.

2. At the “Select Problem” prompt, type the problem having the note to be removed.

3. At the “Remove which one” prompt, type the note to remove.

4. At the “Are you sure you want to delete this NOTE?” prompt, type one of the following:
   - Type N: to return to the BH Problem List Updated window.
   - Type Y: to continue.

5. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

6. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the BH Problem List (for instance, correcting the DSM code) then enter your own name.
9.1.1.10 No Active BH Problems (NP)

Type NP to specify the date when a provider indicates that the patient has no active BH problems. This action requires that there are no ACTIVE problems on the patient’s BH problem list (otherwise, the application will display an error message).

1. At the “Did the Provider indicate that the patient has No Active BH Problems” prompt, type one of the following:
   - Type N: the focus will return to the BH Problem List Update window.
   - Type Y to continue
2. Set the date at the “Enter the Date the Provider documented ‘No Active BH Problems: prompt.
3. At the “Enter the PROVIDER who documented ‘No Active BH Problems” prompt, type the provider name who documented that there are no active BH problems.

9.1.1.11 Problem List Reviewed (LR)

1. At the “Select Problem” prompt, type LR to indicate who and when the current patient’s BH Problem List was reviewed.
2. At the “Did the Provider indicate that he/she reviewed the Problem List?” prompt, type one of the following:
   - Type N: the message: ‘No Action Take” displays and focus returns to the BH Problem List Update window.
   - Type Y: and the prompts continue.
3. Set the date at the “Enter the Date the Provider Reviewed the Problem List” prompt.
4. At the “Enter the PROVIDER who Reviewed the Problem List” prompt, type the name of the provider who reviewed the BH Problem List.

9.1.1.12 ADD BH Prob to PCC PL (BP)

1. At the “Select Problem” prompt, type BP to add a BH problem to the PCC problem list. This action requires security access (the security key is AMHZ PCC PROBLEM LIST).
2. At the “Select Problem” prompt, type the problem to be added to the PCC problem list.

The application displays the PCC Problem list for the patient as shown in Figure 9-9:

PCC Problem List for DEMO, DOROTHY ROSE.
Figure 9-9: Example of information about the PCC Problem List

3. At the “Are you sure you want to add diagnosis XXX to PCC?” prompt type one of the following
   - Type N: the focus will return to the BH Problem List Update window.
   - Type Y and the message in Figure 9-10 displays:

   This is the only narrative the rest of the medical community will see on the Health Summary for this problem. You may change it now if desired.

Figure 9-10: Example of message displayed by the application

4. At the “PROVIDER NARRATIVE: <words of the narrative>” prompt, edit the narrative, if necessary.

9.1.1.13 PCC Problem List Update (PC)

1. Type PC to update the PCC problem list. This action requires security access (the security key is AMHZ PCC PROBLEM LIST). The following message displays as shown in Figure 9-11:

   You are now leaving the Behavioral Health Problem List and will be taken into the PCC Problem List for updating.

   Do you wish to continue? Y/

Figure 9-11: Information displayed by the application

2. At the “Do you wish to continue?” prompt, type one of the following:
   - Type N: the focus will return to the BH Problem List Update window.
   - Type Y to continue

3. At the “Location where Problem List update occurred” prompt, type the location where the Problem List update occurred.
4. At the “Date Problem List Updated” prompt, type the date the problem list was updated. The Problem List Update screen displays as shown in Figure 9-12:

```plaintext
--------------------------------------------------------------------------------
Patient Name: DEMO, DOROTHY ROSE   DOB: OCT 10, 1942   Sex: F   HRN: 99999
--------------------------------------------------------------------------------
1) Problem ID:   WW1    DX: 995.2   Status: ACTIVE   Onset: ADE: PCN, SULFA
   Provider Narrative: Asthma, Unspecified
   Classification: 2-MILD PERSISTENT
3) Problem ID:   WW7    DX: V15.89 Status: ACTIVE Onset: +
   Enter ?? for more actions                                          >>>
   AP   Add Problem          DD   Detail Display       LR   Problem List Reviewed
   EP   Edit Problem         NO   Add Note             HS   Health Summary
   DE   Delete Problem       MN   Edit Note            FA   Face Sheet
   AC   Activate Problem     RN   Remove Note
   IP   Inactivate Problem   NP   No Active Problems
Select Action: +//
```

Figure 9-12: Example of Problem List Update screen

See Section 9.1.2 for more information.

9.1.2 PCC Problem List Actions (Roll and Scroll)

**Note:** PCC Problem List information crosses to PCC.

The following section provides information about the various PCC Problem List actions that you can use.

9.1.2.1 Add Problem (AP)

1. At the “Select Problem” prompt, type AP to add a new PCC problem for the current patient’s visit.
2. At the “Enter Problem Diagnosis” prompt, type the problem diagnosis for the PCC problem.
3. At the “Provider Narrative” prompt, type the narrative for the PCC problem.
4. At the “E CODE (CAUSE OF INJURY)” prompt, type the E code for the cause of injury.
5. At the “E CODE 2” prompt, add another E Code, if necessary.
6. At the “E CODE 3” prompt, add another E Code, if necessary.
7. At the “DATE OF ONSET” prompt, type the date of when the problem was diagnosed.

8. At the “NMBR” prompt, type the number of the PCC problem.
   - This is a number which, together with the Patient (#.02) and Facility (#.06) fields, serves as a unique identifier for this problem. Up to 2 decimal places may be used to indicate that a problem is a result of, or related to, another problem.

9. At the “CLASS” prompt, indicate if this problem is documented for historical purposes. Type P (for PERSONAL HISTORY) or leave it blank.

10. At the “STATUS” prompt, type the status of the problem, either A (Active) or I (Inactive). The default is for a new problem is ACTIVE.

11. At the “Add a new Problem Note for this Problem?” prompt, type one of the following:
   - Type N: the focus will return to the “Enter the Date the Problem List was Updated by the Provider” prompt.
   - Type Y: the following prompts will display:

12. At the “NOTE NARRATIVE” prompt, type the text of the narrative for the note.

13. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

14. At the “Enter the INDIVIDUAL who Updated the Problem List” prompt, type the name of individual who updated the PCC Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.2.2 Edit Problem (EP)
1. At the “Select Problem” prompt, type EP to edit a specified PCC problem.
2. At the “Select Problem” prompt, type the number of the problem to edit.

The prompts are the same as adding a PCC problem. See Section 9.1.2.1 for more information.

9.1.2.3 Delete Problem (DE)
1. At the “Select Problem” prompt, type DE to delete a PCC problem.
2. At the “Select Action” prompt, type one of the following:
   - 1 (Delete Problem)
   - 2 (Detail Display)
     – Type 1 in this case.
3. At the “Select Problem” prompt, type the number of the problem to delete.

The screen will update as shown in Figure 9-13:

Deleting the following Problem from DOROTHY ROSE DEMO's Problem List.

DIAGNOSIS: 678.10          PATIENT NAME: DEMO, DOROTHY ROSE
DATE LAST MODIFIED: DEC 05, 2011  PROVIDER NARRATIVE: Pt has problems
FACILITY: DEMO INDIAN HOSPITAL NMBR: 13
DATE ENTERED: DEC 05, 2011     STATUS: ACTIVE
USER LAST MODIFIED: THETA, SHIRLEY ENTERED BY: THETA, SHIRLEY

Please Note: You are NOT permitted to delete a problem without
entering a reason for the deletion.

Figure 9-13: Example of information displayed about the problem code

4. At the “Are you sure you want to delete this PROBLEM?” prompt, do one of the following:
   - Type N to end this process and redisplay the Problem List Update screen.
   - Type Y to continue.
5. At the “Provider who deleted the Problem” prompt, enter the name of the provider
   who deleted the problem.
6. At the “REASON PROBLEM DELETED”, type one of the following reasons:
   - D – Duplicate
   - E – Entered in Error
   - O Other (Other prompts will display)
7. Set the date at the "Enter the Date the Problem List was Updated by the Provider”
   prompt.
8. At the “Enter the INDIVIDUAL who Updated the Problem List” prompt, type the
   name of the individual who updated the PCC Problem List

Type the name of individual who updated the **PCC Problem List**.
   - If transcribing an update from a BHS provider, type the name of the
     provider.
9.1.2.4 **Activate Problem (AC)**

1. At the “Select Problem” prompt, type **AC** to activate the status of the displayed PCC problem.
2. At the “Select Problem” prompt, type the number of the problem to activate.
   - If the problem is already active, the application displays the message in Figure 9-14:

```
That problem is already ACTIVE!!
Press return to continue.....:
```

Figure 9-14: Message displayed when problem is already active

   - Press Enter, to return to the Problem List Update screen.
   - If the problem is not active, the following prompts continue:
3. Set the date at the "Enter the Date the Problem List was Updated by the Provider” prompt.
4. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the PCC Problem List.
   - If transcribing an update from a BHS provider, type the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.5 **Inactivate Problem (IP)**

1. At the “Select Problem” prompt, type **IP** to cause the status of a active PCC problem to become inactive.
2. At the “Select Problem” prompt, type the number of the problem to inactive.
   - If the problem is already inactive, a message displays as shown in Figure 9-15:

```
That problem is already INACTIVE!!
Press return to continue.....:
```

Figure 9-15: Message that displays when the problem is already inactive

   - Press Enter to return to the Problem List Update screen.
   - If the problem is not inactive, the prompts continue:
3. Set the date at the "Enter the Date the Problem List was Updated by the Provider" prompt.

4. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the PCC Problem List.
   - If transcribing an update from a BHS provider, type the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.6 Detail Display (DD)

1. At the “Select Problem” prompt, type **DD** to display the detail information about a selected problem.

2. At the “Select Problem” prompt, type the problem to use.

The application will display detail information about the problem on the Output Browser screen as shown in Figure 9-16:

```
OUTPUT BROWSER  Dec 05, 2011 12:25:37  Page: 1 of 1

DIAGNOSIS: 998.0  PATIENT NAME: DEMO,DOROTHY ROSE
DATE LAST MODIFIED: JAN 12, 2011  CLASS: PERSONAL HISTORY
PROVIDER NARRATIVE: Postoperative Shock, Not Elsewhere Classified
FACILITY: DEMO INDIAN HOSPITAL  NMBR: 4
DATE ENTERED: JAN 12, 2011  STATUS: INACTIVE
RECORDING PROVIDER: THETA,SHIRLEY
NOTE FACILITY: DEMO INDIAN HOSPITAL
Note Narrative: physical ill
```

Figure 9-16: Sample Problem Detail

9.1.2.7 Add Note (NO)

1. At the “Select Problem” prompt, type **NO** to add a note to a selected problem.

2. At the “Select Action” prompt,
   - Type 1 - Add Note
   - Type 2 - No Active Problems
     - Type 1 in this case.

3. At the “Select Problem” prompt, type the problem to add a note. The application will display the information regarding the selected problem and any existing notes.
4. At the “Add a new Problem Note for this Problem?” prompt, type one of the following:
   - Type N to end this process and redisplay the Problem List Update screen.
   - Type Y to continue.

5. At the “NOTE NARRATIVE” prompt, type the text of the narrative of the note. The application displays the problem notes and continues.

6. At the “Add a new Problem Note for this Problem?” prompt, do one of the following:
   - Type Y to return to the NOTE NARRATIVE prompt.
   - Type N to continue.

7. Set the date at the "Enter the Date the Problem List was Updated by the Provider” prompt.

8. At the “Enter the INDIVIDUAL who Updated the Problem List” prompt, type the name of the person who updated the PCC problem list.
   - If transcribing an update from a BHS provider, type the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.8 Edit Note (MN)

1. At the “Select Problem” prompt, type MN to edit the text of a selected note.
   - If there are no notes, the following message displays: “No note on file for this problem”.

2. Press Enter to return to the Problem List Update window, type the problem containing the note to edit.

3. At the “Edit which one” prompt, type the note to edit.

4. At the “NOTE NMBR” prompt, type the number of the note to be edited.

5. At the “NOTE NARRATIVE: <text of the problem> Replace” prompt, type the replacement text of the note.

6. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

7. At the “Enter the individual that updated the Problem List” prompt, type the name of individual who updated the PCC Problem List.
   - If transcribing an update from a BHS provider, type the name of the provider.
• If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.9 Remove Note (RN)
1. Type RN to delete a selected note.
2. At the Select Problem” prompt, type the problem containing the note to remove.
3. At the “Remove which one” prompt, type the note to remove.
4. At the “Are you sure you want to delete this NOTE?” prompt, type one of the following:
   • Type N to return to the Problem List Updated window.
   • Type Y to continue.
5. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
6. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the PCC Problem List.

9.1.2.10 No Active Problems (NP)
Select NP to specify the date when a provider indicates that the patient has no active PCC problems. This action requires that there are no ACTIVE problems on the patient’s PCC problem list.

1. At the “Did the Provider indicate that the patient has No Active Problems” prompt, type one of the following:
   • Type N and the focus will return to the Problem List Update window.
   • Type Y to continue.
2. Set the date at the “Enter the Date the Provider documented ‘No Active Problems”.
3. At the “Enter the PROVIDER who documented ‘No Active Problems” prompt, type the name of the provider name who documented the activity.

9.1.2.11 Problem List Reviewed (LR)
Select LR to indicate who and when the current patient’s PCC Problem List was reviewed.

1. At the “Did the Provider indicate that he/she reviewed the Problem List?” prompt type one of the following:
• Type N and the message: ‘No Action Take” displays and focus will return to the Problem List Update window.
• Type Y to continue.

2. Set the date at the “Enter the Date the Provider Reviewed the Problem List” prompt.

3. At the “Enter the PROVIDER who Reviewed the Problem List” prompt, type the name of the provider who reviewed the problem list.

9.2 Problem List (GUI)

This section addresses how to manage the problems for the selected patient on the Visit window.

After selecting a record and clicking the Problem button, select one of the following options:

• BH Problem List
• PCC Problem List

9.2.1 Behavior Health Problem List Window

1. Select the BH Problem List and the Behavioral Health Problem List window displays as shown in Figure 9-17. The current patient’s problems displays in the Problem List including associated notes.

![Figure 9-17: Sample Behavioral Health Problem List window](image)
2. Click **Save** to execute the current action will execute and remain on the window.

3. Click **Close** to exit the window.

4. Click **Cancel** to remain on the window and no action is taken.

9.2.1.1 **Add Problem**

1. Select **Add Problem** from the **Problems** menu to activate the fields in the Problem List Data Entry pane shown in Figure 9-18:

![Figure 9-18: Sample Problem List Data Entry pane](image)

2. Click the **Diagnosis** field to display the **POV (Axis I/II)** window and select a POV.

3. Click **Active** or **Inactive** to identify the diagnosis.

4. Set the **Date of Onset**.
   - To have no Date of Onset, remove the check from the box.

5. Select **Add Note?** box to display the **Note** pane shown in Figure 9-19:

![Figure 9-19: Note pane](image)

   - If necessary, uncheck **Note** to close the pane.

6. Type the text in the **Note** field.

7. Select a name from the **Author** field.

8. Select **Long Term** or **Short Term**.

9. Set **Date Updated**.

10. Select the primary provider from the **Person Who Updated** field.
11. Click **Save** to add the problem.

12. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.2 Edit Problem

1. Select **Edit Problem** from the **Problems** menu. The fields in the **Problem List Data Entry** pane become active.

2. Click **Save** to update the record in the **Problem List**.

3. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.3 Delete Problem

1. Highlight a problem in the **Problem List**.

2. Select **Delete Problem** from the **Problems** menu. The **Problem List Reason for Delete** dialog displays as shown in Figure 9-20:

   ![Figure 9-20: Problem List Reason for Delete dialog](image)

   **Figure 9-20:** Problem List Reason for Delete dialog

3. Select an option from the **Reason** field as shown in Figure 9-21.

   - If you select **OTHER**, the dialog changes. Type the reason for deleting the problem in the **Other** field.

   ![Figure 9-21: Problem List Reason for Delete when using OTHER dialog](image)

   **Figure 9-21:** Problem List Reason for Delete when using OTHER dialog

4. Click **OK** to activate the **Date Updated** and **Person Who Updated** fields (Figure 9-22)

   - Click **Close** to close the operation.
5. Set **Date Updated**.

6. Select the primary provider from the **Person Who Updated** field.

7. Click **Save** to update the **Problem List**.

8. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.4 Activate/Inactivate Problem

1. Select an existing problem in the **Problem List**.

2. Select **Activate (or Inactive)** from the **Problems** menu. The **Date Updated** and **Person Who Updated** fields activate. See Figure 9-23:

![Figure 9-23: Sample active fields for Inactivate (or Activate) process](image)

3. Set the **Date Updated**.

4. Select the Primary Provider from the **Person Who Updated** field.

5. Click **Save** to update the **Problem List**.

6. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.5 Add Note

1. Highlight a problem in the **Problem List**.

2. Select **Add Note** from the **Notes** menu to activate the fields shown in Figure 9-24:

![Figure 9-24: Active fields for adding a note](image)

3. Set the **Date Updated**.
4. Select the primary provider from the **Person Who Updated** field.

5. Type the text in the **Note** field.

6. Select an author from the **Author** field.

7. Select **Long Term or Short Term**.

8. Click **Save** to update the **Problem List**.

9. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.6 Edit Note

1. Select a note in the **Problem List**.

2. Select **Edit Note** from the **Notes** menu to activate the fields.

   See Section 9.2.1.5 for more information.

3. Click **Save** to update the **Problem List**.

4. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.7 Remove Note

1. Select a note in the **Problem List**.

2. Select **Remove Note** from the **Notes** menu to activate the **Date Updated** and **Person Who Updated** fields (Figure 9-25)

![Figure 9-25: Active Date Updated and Person Who Updated fields](image)

3. Set the **Date Updated**.

4. Select the primary provider from the **Person Who Updated** field.

5. Click **Save** to update the **Problem List**.

6. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.8 Detail Display

1. Highlight a problem in the **Problem List**.

2. Click **Detail Display**. Figure 9-26 displays the **BH Problem List Detail** pop-up for the patient.
9.2.1.9 No Active Problems

1. Click the **No Active Problems** button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.
   - Click the button and if there are active problems, the message displays: “There are ACTIVE Problems on this patient’s BH problem list. You cannot use this action item.”

2. Click **OK** to close the message and the focus returns to the Behavioral Health Problem List window.
   - Click the button and there are no active problems, the following message displays: “Did the Provider indicate that the patient has No Active BH Problem?”

3. Click **Yes** and the **Date Documented** and **Provider Who Documented** fields become active (Figure 9-27).

4. Click **No** and the fields remain inactive.

Figure 9-26: Sample BH Problem List Detail for a patient
5. Set **Date Documented**

6. Select the primary provider from the **Person Who Documented** field.

7. Click **Save** to update the **Problem List**.

8. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.10 Problem List Reviewed

1. Click **Problem List Reviewed** to indicate that the current patient’s problem list was reviewed. The **Date Reviewed** and **Provider Who Reviewed** fields become active as shown in Figure 9-28:

![Figure 9-28: Sample Problem List Reviewed and Provider Who Reviewed fields](image)

2. Set the **Date Reviewed**.

3. Select a Primary Provider from the **Person Who Reviewed** field.

4. Click **Save** to update the **Problem List**.

5. Click **Cancel** to remain on the window and no action is taken.

### 9.2.1.11 Add BH Problem to PCC Problem

1. Highlight a BH problem in the **Problem List** (Figure 9-17) and click **Add BH Problem to PCC Problem**.

   **Note:** This function requires the AMHZ PCC Problem List key. If you do not have this key, this button will be inactive.

   - If the problem already exists on the **PCC Problem List**, the **Exists** dialog displays (Figure 9-29).
   - Click **Yes** to add the problem
   - Click **No** to end this process.
• If the problem does not exist on the **PCC Problem List**, the **Success** dialog displays (Figure 9-30).

2. Click **OK** to display the **Problem List Data Entry** pane, with the Narrative field active. Type text in the Narrative field.

3. Click **Save** and the problem displays on the **PCC Problem List**.

4. Click **Cancel** to end the process.

5. Diagnosis Does Exist on PCC Problem List

   • If the problem already exists on the **PCC Problem List**, the **Exists** dialog displays (Figure 9-29).
   
   • Click **Yes** to add the problem
   
   • Click **No** to end the process.

9.2.1.12 **PCC Problem List Update**

   • Click **PCC Problem List Update** to display the **PCC Problem List** window.
9.2.2 PCC Problem List Window

1. Select **PCC Problem List** from the Problem list on the (on the **Visit** window Figure 4-48) the **PCC Problem List** window (Figure 9-32) displays.

![Figure 9-32: Sample PCC Problem List window](image)

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

2. Click **Save** to execute and remain on the window.

3. Click **Close** to exit the window.

4. Click **Cancel** to remain on the window and no action will be taken.

Refer to Section 2.0 for the instructions for these fields.

9.2.2.1 Add Problem

1. Select **Add Problem** from the **Problems** menu to display the **Problem List Data Entry** pane shown in Figure 9-33:

![Figure 9-33: Problem List Data Entry fields for Add Problem](image)
2. Click the **Diagnosis** field to display the **POV (Axis I/II)** window and select a POV.

3. Click **Active** or **Inactive**.

4. Set the **Date of Onset**.
   - To have no Date of Onset, remove the check mark.

5. Select **PERSONAL HISTORY** from the **Class** field. The **Number** field is automatically updated.
   - This is the ID number for the problem. For example, if the field is populated with 11, then the ID will be WW11.

If the Diagnosis Code was injury related, the application will display the E Codes pane shown in Figure 9-34.

![Figure 9-34: Fields in E Codes pane](image)

6. Select the **E Code (Cause of Injury)** to display the **Diagnosis** search dialog.

7. Find the E Code and select it. The **E Code 2** field will become active.

8. If necessary, select the **E Code 2** to display the **Diagnosis** search dialog.

9. Find the E Code and select it. The **E Code 3** field will become active.
   - If you do not populate this field, the **E Code 3** field will remain inactive.

10. If necessary, select the **E Code 3** to display the Diagnosis search dialog.

11. Find the E-code and select it.

12. Select **Add Note?** to display the **Note** pane shown in Figure 9-35:

![Figure 9-35: Note pane](image)

13. Type the text in the **Note** field.

14. Select an author from the **Author** field.

15. Select **Long Term or Short Term**.
16. Set Date Updated.

17. Select the primary provider from the Person Who Updated field.
   - Click Save to add to the Problem List.
   - Click Cancel to remain on the window and no action is taken.

### 9.2.2.2 Edit Problem

1. Highlight a problem in the Problem List
2. Select Edit Problem from the Problems menu

All of the fields in the Problem List Data Entry pane become active. See Section 9.2.2.1 for more information about how to edit the fields.

   - Click Save to update the Problem List.
   - Click Cancel to end the process.

### 9.2.2.3 Delete Problem

1. Highlight a problem in the Problem List.
2. Select Delete Problem from the Problems menu. The Problem List Reason for Delete dialog (Figure 9-20) displays. Refer to Section 9.2.1.3 for more information about this dialog.

### 9.2.2.4 Activate/Inactivate Problem

1. Highlight a problem in the Problem List.
2. Select Activate (or Inactive) from the Problems menu.

See Section 9.2.1.4 for more information.

### 9.2.2.5 Add Note

1. Highlight a problem in the Problem List.
2. Select Notes from the Add Note menu.

Refer to Section 9.2.1.5 for more information.

### 9.2.2.6 Edit Note

1. Highlight a note in the Problem List.
2. Select Notes from the Edit Note menu.
Refer to Section 9.2.1.6 for more information.

9.2.2.7 Remove Note
1. Highlight a note in the Problem List.
2. Select Notes from the Remove Note menu.
Refer to Section 9.2.1.7 for more information.

9.2.2.8 Detail Display
1. Highlight a problem in the Problem List.
2. Click Detail Display button. The PCC Problem List Detail pop-up (Figure 9-36) displays:

![Figure 9-36: Sample PCC Problem List Detail pop-up window](image)

9.2.2.9 No Active Problems
1. Click the No Active Problems button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.
• Click the button and if there are active problems, the following message displays: “There are ACTIVE Problems on this patient’s BH problem list. You cannot use this action item.”

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

• Click the button and there are no active problems, the following message displays: “Did the Provider indicate that the patient has No Active BH Problem?”

3. Click Yes and the Date Documented and Provider Who Documented fields become active (Figure 9-37).

4. Click No and the fields remain inactive.

![Date Documented and Provider Who Documented fields](Figure 9-37)

Figure 9-37: Active fields for the No Active Problems process

5. Set the Date Updated.

6. Select the Primary Provider from the Provider Who Documented.

7. Click Save to update the Problem List.

8. Click Cancel to remain on the window and no action is taken

9.2.2.10 Problem List Reviewed

This function works like the Problem List Reviewed for BH Problem list. See Section 9.2.1.10 for more information,

9.2.2.11 BH Problem List Update

• Click BH Problem List Update to display the Behavioral Health Problem List window.
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)
- Select **Update BH Patient Treatment Plans** (TPU) on the Data Entry Menu to display the Patient Treatment Plans menu shown on Figure 10-1:

```
**********************************************
**       IHS Behavioral Health System       **
**          Patient Treatment Plans         **
**********************************************
Version 4.0 (patch 2)
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)
1. At the “Select Update BH Patient Treatment Plans Option” prompt, type **UP** (Add, Edit, Delete a Treatment Plan) to display the Update Patient Treatment Plan (Figure 10-2) screen:

```
Update Patient Treatment Plan Apr 13, 2009 17:11:07          Page:    1 of    9
Patient Name:  ALPHAA,CHELSEA MARIE     DOB:  FEB 07, 1975   Sex:  F
TREATMENT PLANS CURRENTLY ON FILE

1) Program: SOCIAL SERVICES     Responsible Provider:  GAMMAA,RYAN
   Date Established:  MAR 27, 2009     Next Review Date:  APR 01, 2009
   Status:                             Date Resolved:  
   Problem: eating                    

2) Program: MENTAL HEALTH          Responsible Provider:  GAMMAA,RYAN
   Date Established:  MAR 24, 2009     Next Review Date:  APR 15, 2009
   Status:                             Date Resolved:  
   Problem: testing functionality of editing tip

3) Program: MENTAL HEALTH          Responsible Provider:  BETAAAA,BJ
   Date Established:  MAR 24, 2009     Next Review Date:  JUN 22, 2009
   Status:                             Date Resolved:  
   Problem: TESTING BASED ON RYAN'S FINDINGS
```
2. At the “Select Action” prompt, type Q and press Enter to close the screen.

**10.1.1.1 Add Treatment Plan (AD)**

- At the “Select Update BH Patient Treatment Plans Option” prompt, type AD to add a new treatment plan for the current patient.

Refer to Section 10.1.1.2 for more information.

**10.1.1.2 Edit a Plan (ED)**

1. At the “Select Update BH Patient Treatment Plans Option” prompt, type ED to change a selected treatment plan for the current patient.
   - The “Enter Date Established” prompt is read only.
2. At the “Program:” prompt, type one of the following:
   - M (Mental Health), S (Social Services)
   - O (Other)
   - C (Chemical Dependency)
3. At the “Designated Provider” prompt, type the name of the provider.
4. At the “Case Admit Date” prompt, set the date.
   - The “AXIS I” field is read only
5. At the “Edit?” prompt, type one of the following:
   - Type Y to access another window and change the AXIS I text.
   - Type N to cancel the operation.
   - The “AXIS II” field is read only
6. At the “Edit?” prompt, type one of the following:
   - Type Y to access another window and change the AXIS II text.
   - Type N to cancel the operation.

**AXIS III**

- The “AXIS III” field is read only.
7. At the “Edit?” prompt, type one of the following:
   • Type Y to access another window and change the AXIS III text.
   • Type N to cancel the operation.

8. At the “Select AXIS IV” prompt, 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).

9. At the “AXIS V” prompt, type the functional level.

10. At the “GAF Scale Type” prompt, type the acronym GAF Scale Type.

11. At the “Problem List” prompt, type a description.

12. At the “Treatment Plan Narrative (Problems/Goals/Objectives/Methods)” prompt, type the narrative of the problem.

13. At the “Edit?” prompt, type one of the following:
   • Type Y to display another window and change the narrative.
   • Type N to cancel the operation.

14. At the “Anticipated Completion Date” prompt, set the date.
   • Review Date field is read only.

15. At the “Concurring Supervisor” prompt, type the name of the supervisor.

16. At the “Date Concurred” prompt, set the date. A list of “Participants in the development of this plan” displays (Figure 10-3). If there are no participants, the “None recorded” message displays.

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.

17. Do one of the following at the “Which action” prompt:

- Type A to add a participant.  
  - At the “Enter the Participant Name” prompt, type the name of the participant.  
  - At the “Enter the Relationship to the Client” prompt, type the relationship.
- Type E to edit an existing participant. After you indicate the participant name, the prompts are the same as the add option.
- Type D to delete an existing participant. The application asks to specify the one you want to delete.  
  No confirmation message displays.  
- Type N to continue onto the next prompt.
- The “Date Closed” prompt is read only.

10.1.1.3 Delete Tx Plan (DE)  
1. Type DE to delete a treatment plan, do one of the following  
2. At the “Select BH Treatment Plan” prompt, type the treatment plan to be removed.  
3. At the “Are you sure you want to DELETE this Treatment Plan?” prompt, do one of the following:  
   - Type Y to remove the treatment plan from Update Patient Treatment Plan screen.

10.1.1.4 Enter TP Review (RV)  
1. Type RV to display the Treatment Plan Update screen for the current patient.  
2. At the “Select BH Treatment Plan” prompt, type the treatment plan to review, do one of the following:  
   - At the “Select REVIEW DATE” prompt, change the review date. If a date is not entered, you exit the RV process.
4. At the “Review Provider” prompt, type the name of the review provider.

5. At the “Review Supervisor” prompt, type the name of the review supervisor.

6. At the “Progress Summary”, the progress summary displays if applicable.

7. At the “Edit?” prompt, do one of the following:
   - Type Y: to edit the text of the progress summary, a secondary screen displays.
   - Type N: to continue.

8. At the “Select TX REVIEW PARTICIPANT NAME”, type a new treatment review participant name.

9. At the “Relationship to Client” prompt, type the relationship to the client.
   This prompt does not appear unless you added a name in the previous prompt.

10. At the “Next Review Date” prompt, the next review date displays

**10.1.1.5 Disp/Print Plan (DS)**

1. Type DS to display/print a specified treatment plan for the current patient, do one of the following:

2. At the “Select BH Treatment Plan” type the treatment plan to browse or print.

3. At the “What would do like to print” prompt, do one of the following:
   - Type T (Treatment Plan Only)
   - R (Treatment Plan REVIEWS Only)
   - B (both Treatment Plan and Reviews)

4. At the “Do you wish to” prompt, do one of the following:
   - Type P (print output on paper)
   - Type B (browse output on screen) shown in Figure 10-4:

---

**CONFIDENTIAL PATIENT INFORMATION**

TREATMENT PLAN                          Printed: Oct 27, 2009@09:49:14
Name: ALPHAA, CHELSEA MARIE          Page 1
DOB: 2/7/75    Sex: F    Chart #: WW116431

Date Established:          Oct 01, 2009
Admit Date:                Oct 01, 2009
Anticipated Completion Date: Oct 01, 2009
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)

- Type HS to display/print the health summary for the patient.
10.1.1.7 Browse Visits (BV)

1. Type **BV** to browse the behavioral health visits for the current patient.

2. At the “Browse which subset of visits for [patient name]” prompt, do 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)
   - **P** (visits to one program). If you type **N**, **D**, or **P** to continue. The BROWSE PATIENT’S VISITS screen displays as shown in Figure 10-5:

   ![Figure 10-5: Sample patient's behavioral health visits screen](image_url)

10.1.1.8 Share a TP (SP)

**Note:** 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)**

1. Type **DTP** (at the Patient Treatment Plans menu) to display/print the treatment plan for a patient, do one of the following:

2. At the “Select PATIENT NAME” prompt, type the patient name to be used, do one of the following:

   If the patient does not have a treatment plan, a message displays.

   If the patient has at least one treatment plan, the **Display/Print Treatment Plan** screen will display as shown in Figure 10-6:

   ![Sample Display/Print Treatment Plan screen](image)

   - Type **Q** (Quit) to exit
   - Type **NS** (Next Screen) to display the next screen of information
   - Type **PS** (Previous Screen) to display the previous screen of information
   - Type **DN** (Down a Line) to display the next line of information (does not work when you are on the last screen).
   - Type **UP** (Up a Line) to display the line previous line of information (does not work when you are on the first screen).
10.1.2.1 Display/Print Plan (DS)

- Type DS to browse/print a treatment plan. Refer to Section 10.1.1.5 for more information.

10.1.2.2 Health Summary (HS)

1. Type HS to display a type of health summary for the current patient

2. At the “Select Health Summary Type Name” prompt, type the health summary needed. The Health Summary for the current patient on the Output Browser screen.

10.1.2.3 Print List (PL)

1. Type PL to display/print the treatment plans for the current patient.

2. At the “Device” prompt, type the device to print/browse the list of treatment plans.

The application displays the Display/Print Treatment Plan for the current patient as shown in Figure 10-7:

```
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                                          |
| Date Established: APR 02, 2009 Next Review Date: APR 12, 2009        |
| Status: Problem: testing functionality                               |
| Responsible Provider: GAMMAA,RYAN                                   |
| Date Resolved:                                                      |
+------------------------------------------------------------------------+

+------------------------------------------------------------------------+
| 2) Program: MENTAL HEALTH                                             |
| Date Established: APR 02, 2009 Next Review Date: APR 02, 2009        |
| Status: Problem:                                                      |
| Responsible Provider: GAMMAA,RYAN                                     |
| Date Resolved:                                                       |
+------------------------------------------------------------------------+

+------------------------------------------------------------------------+
| 3) Program: MENTAL HEALTH                                             |
| Date Established: APR 02, 2009 Next Review Date: APR 02, 2009        |
| Status: Problem:                                                      |
| Responsible Provider: GAMMAA,RYAN                                     |
| Date Resolved:                                                       |
+------------------------------------------------------------------------+

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

Figure 10-7: Sample Display/Print Treatment Plan window

10.1.2.4 Search List (SL)

1. Type SL to search the text of the treatment plans.

2. At the “Search for” prompt, type the search text string.
If the application finds the first occurrence of the text string, the text is highlighted, do one of the following:

3. At the Stop Here?” prompt do one of the following:
   - Type N to leave the search sequence.
   - Type Y to search for the next occurrence of the text string.
     - If the text string is found, it will be highlighted.
     - If the text string is not found, the message “Text not found. Text not found. Do you want to start at the beginning of the list?” displays.

10.1.3 Print List of Treatment Plans Needing Reviewed (REV)

1. Type REV to print all patients who have a treatment plan which is due to be reviewed in a date range.
2. At the “Enter Beginning Date” prompt, type the beginning date of the range.
3. At the “Enter Ending Date” prompt, type the ending date of the range.
4. At the “Run the Report for which Program” prompt, type one of the following:
   - A (All Programs)
   - O (One Program) to continue
5. At the “List Treatment Plans for” prompt, type one of the following:
   - A (All Programs)
   - O (One Program) to continue
6. At the “Demo Patient Inclusion/Exclusion” prompt, do one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)
7. At the “Device” prompt, type the device to print/browse the output.

Figure 10-8 shows a sample Listing of Treatment Plans Due to be Reviewed screen:
10.1.4 Print List of Treatment Plans Needing Resolved (RES)

- Type RES to print a list of all patients who have treatment plans in an anticipated completion date within a date range that need to be resolved.

- The prompts are the same as those for the Print List of Treatment Plans Needing Reviewed (REV).

Figure 10-9 shows a sample of Listing of Treatment Plans Due to be Resolved is displayed:

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

** DEMO INDIAN HOSPITAL
** LISTING OF TREATMENT PLANS DUE TO BE RESOLVED
** Date Range: APR 07, 2008 to APR 07, 2009

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DOB</th>
<th>CHART # DATE</th>
<th>REVIEW DATE</th>
<th>ANTICIPATED ESTABLISHED</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Program: MENTAL HEALTH</td>
<td>Responsible Provider: BETAA, BJ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALPHAA, CHELSEA MARIE</td>
<td>2/7/75</td>
<td>116431</td>
<td>Mar 21, 2006</td>
<td>Sep 30, 2008</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program: CHEMICAL DEPENDENCY</td>
<td>Responsible Provider: GAMMA, DENISE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALPHAA, GLEN DALE</td>
<td>11/10/81</td>
<td>108704</td>
<td>Dec 10, 2007</td>
<td>May 06, 2008</td>
<td>Dec 10, 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program: MENTAL HEALTH</td>
<td>Responsible Provider: BETAA, BJ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

1. Type ATP to print/browse a list of all patients who have a treatment plan on file in a specified date range.

2. At the “Enter BEGINNING Date” prompt, type the beginning date.
3. At the “Enter ENDING Date” prompt, type the ending date.

4. At the “Run the Report for which PROGRAM” prompt, type one of the following:
   - A (All Programs)
   - O (One Program), other prompts will display

5. At the “List treatment plans for” prompt, type one of the following:
   - A (All Programs)
   - O (One Program), other prompts will display

6. At the “Sort list by” prompt, type one of the following
   - P (Responsible Provider)
   - N (Patient Name)
   - D (Date Established)

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients).

8. At the “Device” prompt, type the device to browse/print the information. The Listing of Treatment Plans screen will display as shown in Figure 10-10:

   ![](image)

Figure 10-10: Sample list of treatment plans
10.1.6 Patients w/Case Open but No Treatment Plan (NOTP)

1. Type **NOTP** to produce a report that lists all patients who have a case open date, no case closed date, and no treatment plan in place of a specified date range.

2. At the “Enter BEGINNING Date” prompt, type the beginning date.

3. At the “Enter ENDING Date” prompt, type the ending date.

4. At the “List cases opened by” prompt, type one of the following:
   - A (All Programs)
   - O (One Program) to continue
   
   This allows you to limit the report output to cases opened by one or all Programs.

5. At the “List cases opened by” prompt, type one of the following:
   - A (All Providers)
   - O (One Provider) to continue

6. At the “Sort list by” prompt, type one of the following:
   - P (Responsible Provider)
   - N (Patient Name)
   - C (Case Open Date).

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients).

8. At the “Do you wish to” prompt, type one of the following:
   - P (Print output)
   - B (Browse output on screen).

The application displays the **LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE** report shown in Figure 10-11:

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>CASE OPEN PROGRAM</th>
<th>PROVIDER</th>
<th>LAST VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>THETAA, ROLAND</td>
<td>258852</td>
<td>10/01/10</td>
<td>MENTAL HEA</td>
<td>12/07/10</td>
</tr>
<tr>
<td>BETAAA, MONTY</td>
<td>741147</td>
<td>11/03/10</td>
<td>MENTAL HEA</td>
<td>12/07/10</td>
</tr>
<tr>
<td>DEMO, DOROTHY ROSE</td>
<td>999999</td>
<td>12/07/10</td>
<td>MENTAL HEA</td>
<td>07/08/10</td>
</tr>
</tbody>
</table>
10.2 Treatment Plan Window (GUI)

The RPMS Behavioral Health System GUI application provides ways to manage treatment plans for one patient.

The treatment plan functions display as shown in Figure 10-12:

![Location of Treatment Plan functions on tree structure](image)

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 selection shown in Figure 10-13:

![Sample Treatment Plan window for current patient](image)

**Figure 10-13: Sample Treatment Plan window for current patient**

Another way to access the **Treatment Plan** window is to use the All Patients option shown in Figure 10-14. The features for both windows follow.

![Sample Treatment Plan window for all patients](image)

**Figure 10-14: Sample Treatment Plan window for all patients**

### 10.2.1 Treatment Plan Date Range

The treatment plan records are within the date range shown in the **Treatment Plan Date Range** pane.

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** pane.
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 Pane

The Treatment Plan pane shows the records within the treatment plan date range.

10.2.3 Add Button

Click **Add** to add a new treatment record for the patient. The **Treatment Plan–Add Treatment Plan** window displays. Refer to Section 10.3 for more information.

10.2.4 Edit Button

Click **Edit** to edit a treatment plan record. The Treatment Plan–Edit Treatment Plan screen displays.

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. Refer to Section 10.3 for more information.

10.2.6 Delete Button

Click **Delete** to delete a treatment plan record. The deletion is confirmed.
10.2.7 Print Treatment Plan Button

1. Highlight a record and click **Print Treatment Plan** to print a Treatment Plan record. Three options will be displayed:

   - **Treatment Plan Only**
   - **Review Data Only**
   - **Treatment Plan and Review Data**

   If **Review Data Only** or **Treatment Plan and Review Data** is selected and if there are one or more reviews, the **Treatment Plan Reviews** dialog (Figure 10-15) displays.

   ![Sample Treatment Plan Reviews dialog](image)

   Figure 10-15: Sample **Treatment Plan Reviews** dialog

2. Select one or more **Treatment Plan Review records** and click **OK**.

3. Click **Close** to exit the print routine.
The first page of the **Treatment Plan** pop-up window displays as shown in Figure 10-16:

![Sample Treatment Plan pop-up window](image)

Figure 10-16: Sample **Treatment Plan** pop-up window

Refer to Section 2.6 for more information.

### 10.2.8 Help

Click **Help** to access the online help system.

### 10.2.9 Close Button

Click **Close** to close the **Treatment Plan** window.

### 10.3 Add/Edit Treatment Plan Record (GUI)

1. Do one of the following:

   - 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.
Figure 10-17 shows the Treatment Plan - Add Treatment Plan window:

- Click Help to access the online help system.

2. Click Save to save the data or changes.

10.3.1 Treatment Plan Information Pane

Select the Treatment Plan Information pane (Figure 10-18) to manage the basic information about the treatment plan. Do the following:
1. Set the **Date Established**.
2. Set the **Next Review Date**.
3. Select the **Program** field and type one of the following:
   - Mental Health
   - Social Services
   - Other
   - Chemical Dependency
4. Set the **Date Completed/Closed**.
5. Set the **Case Admit Date**.
6. Set the **Anticipated Completion Date**.
7. Select a provider name from the **Designated Provider** field.
8. Select a name from the **Concurring Supervisor** field.
9. Set the **Date Conurred**.

### 10.3.2 Problem Tab

Select the **Problem** tab to manage the Axis I through V data and the problem list (Figure 10-19):

![Sample Problem Tab](image)

*Figure 10-19: Sample Problem tab*
10.3.2.1 **Problem List Pane**
Type up to 240 characters to list and briefly describe multiple problems.

10.3.2.2 **Axis I Pane**
Type the text of the clinical disorders or other conditions that might be a focus of clinical attention for the treatment plan.

10.3.2.3 **Axis II Pane**
Type the text of the personality disorders or mental retardation to be used in the treatment plan.

10.3.2.4 **Axis III Pane**
Type the text of a general medical condition to be used in the treatment plan.

10.3.2.5 **Axis IV Pane**
1. Type one or more of the psychosocial or environmental codes (Figure 10-20) that identifies the major category of the problem.

![Figure 10-20: Sample Axis IV pane](image)

2. Click **Add** to add the codes on the **Axis IV** multiple select window.
3. Click **Delete** to remove a highlighted code. The **Are You Sure?** confirmation displays: “Are you are sure you want to delete?”
   - Click **Yes** to remove the selected code from the pane.
   - Click **No** to retain the code.

10.3.2.6 **Axis V**
1. Type three characters in the **Axis V** field to enter the GAF scale value.
2. Type an acronym using up to 20 characters in the **GAF Scale Type** field.
If you click the link on the GAF Scale Type label, the application displays the Global Assessment of Functioning pop-up (Figure 10-21) window.

Figure 10-21: Global Assessment of Functioning (GAF) Scale

10.3.3 Plan Tab

Select the Plan tab to add participants to the plan as well as describing the Problems/Goals/Objectives/Methods of the plan. Figure 10-22 shows the Plan tab.
To manage the participants in the treatment plan:

- Select a patient in the Patient pane and click **Edit** to change the record. The **Treatment Plan Participants** window displays (Figure 10-23).
- Select a patient in the Patient pane and click **Delete** to delete the record. A confirmation message displays.
- Click **Add** to add a new participant record. The **Treatment Plan Participants** window displays (Figure 10-23).

### 10.3.3.1 Treatment Plan Participants Dialog
To update the Treatment Plan Participants window:
1. Type the participant name in the Participant field.
2. Type the relationship in the Relationship to Patient field.
3. Click the right-pointing arrow to add the information to the Participants pane.
   - Click the left-pointing arrow to remove a highlighted record in the Participants pane.
   - Click Clear to remove the data in the Participant and Relationship to Patient fields.
4. Click OK to save the data to update the Participants pane of the Plan Review tab.
5. Click Close to exit the window.

10.3.3.2 Problems/Goals/Objectives/Methods
Type the text of the problems, goals, objective, or methods for the treatment plan in the Plan tab as shown in Figure 10-22.

10.3.4 Plan Review Tab
Select the Plan Review tab (Figure 10-24) to document the review of the treatment plan.

![Plan Review Tab](image)

Figure 10-24: Sample Plan Review tab

When a record is highlighted, do the following:
1. Complete the fields for the plan review (below the grid). See Section 10.3.4.1.

2. Complete the participants in the plan review (in the Participants pane). See Section 10.3.4.2.

3. Complete the progress summary for the plan review (in the Progress Summary pane). See Section 10.3.4.2.

4. Click **OK** to save the plan review record.
   - Click **Cancel** and the record is not saved.

### 10.3.4.1 Review Pane

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

1. Do one of the following:
   - Select a record and click **Delete** to remove the record. A confirmation message displays.
     - Click **Yes** to delete the record.
     - Click **No** to end the process.
   - Select a record and click **Edit** to update the record.
   - Click **Add** to add a new review record.

2. Set the **Review Date**.

3. Set the **Next Review Date**.

   **Note:** Changing the next review date will also change the next review date on the Treatment Plan Information pane.

4. Select a provider from the Review Provider field.

5. Select a name from the Review Supervisor field.

### 10.3.4.2 Participants Pane (Plan Review)

Use the Participants pane (Figure 10-24) to show the participants in the plan review.

Do one of the following:

- Select a record and click **Add** to access the Treatment Plan Participants window. Refer to Section 10.3.3.1 for more information.
• Select a record and click **Edit** to edit a record. The **Treatment Plan Participants** window displays with the current data. Refer to Section 10.3.3.1 for more information.

• Select a record and click **Delete** to remove the record. A confirmation message displays
  – Click Yes to delete the record.
  – Click No to end the process.

**10.3.4.3 Progress Summary**

Type text in the Progress Summary field to add to the progress of the plan review.
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.

**Note:** All 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)

At the “Suicide Reporting Forms–Update/Print” prompt, type **SF** on the IHS Behavioral Health System Data Entry Menu to manage suicide forms in the roll-and-scroll application. Figure 11-1 shows the options available.

<table>
<thead>
<tr>
<th>SFD</th>
<th>Review Suicide Reporting Forms by Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFP</td>
<td>Update Suicide Reporting Form for a Patient</td>
</tr>
</tbody>
</table>

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)

1. Type **SFP** at the “Select Suicide Reporting Forms - Update/Print Option” prompt, do the following to complete:

2. At the “Select Patient Name field” prompt, type the name of the patient. The View/Update Suicide Form screen displays as shown in Figure 11-2:
**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)**

1. Type **AF** at the “Select Item(s)” prompt, to add a suicide form to the patient. Do the following:

   2. At the “Provider Completing the form” prompt, type the name of the provider.

   3. At the “Enter the Date of the Suicide Act” prompt, set the date of the act. The Updating IHS Suicide Form screen (Figure 11-3) displays.

**11.1.1.1.2 Edit a Suicide Form (EF)**

1. Type **EF** at the “Select Suicide Reporting Forms - Update/Print Option” prompt, to change the suicide form. The Updating IHS Suicide Form screen shown in Figure 11-3 displays:

   **Figure 11-2: Sample View/Update Suicide Form screen for the current patient**

   - If the suicide forms are incomplete, a message displays.

   3. Type **Q** and press Enter to close the window.

   **Figure 11-3: Sample Updating IHS Suicide Form window**
2. At the “Local Case #” prompt, type the case number generated by the site (1–20 characters).

3. At the “Provider” prompt, type the provider completing the form.

4. At the “Employment Status” prompt, 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)

5. At the “Date of Act” prompt, type the date.

6. At the “Community where Act Occurred” prompt, type the community name.

7. At the “Relationship Status” prompt, type one of the following:
   - 1 (single)
   - 2 (married)
   - 3 (divorced/separated)
   - 4 (widowed)
   - 5 (cohabiting/common law)
   - 6 (same sex partnership)
   - 9 (unknown)

8. At the “Education” prompt, 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
9. If 1 is entered, the following prompt displays: “If less than 12 years, highest grade completed”, type between 0 and 12.

10. At the “Suicidal Behavior” prompt, type the behavior for the suicide act.

11. At the “Method (press enter)” prompt, press Enter to display the pop-up in Figure 11-4:

*** If you need help type ?, not ?? ***

METHOD:
METHOD:
METHOD:

Figure 11-4: Sample fields on the pop-up

12. At the “Method:” prompt, type one or more suicide methods.

13. Type Other at the “Method” prompt, the message “Please describe the “OTHER” Method” displays. Type between 1 and 40 characters.

14. At the “Previous Attempts” prompt, type one of the following:
   - 0 0
   - 1 1
   - 2 2
   - 3 3 or more
   - U Unknown

15. At the “Substance Use Involved” prompt, type one of the following:
   - 1 (none)
   - 2 (alcohol and other drugs)
   - U (unknown)

16. At the “METHOD” prompt, type 2. The list of drug choices type screen displays as shown in Figure 11-5:

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

17. At the “SUBSTANCE DRUG USED” prompt, type “OTHER”. The message: Drug if other. Type between 1 and 40 characters.

18. At the “Location of Act” prompt, type the location.
19. If you type **Other** in the Location of Act field, a message prompts”, Location of Act If Other. Type between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

20. At the “Contributing Factors (press enter) prompt, press Enter to displays the Contributing Factors pop-up in Figure 11-6:

```
ENTER all Contributing Factors. To see a list of choices type '?
FACTOR:
FACTOR:
FACTOR:
```

Figure 11-6: Fields on the pop-up

21. At the “FACTOR:” prompt, type one or more contributing factors.

**Note:** You cannot use UNKNOWN if other legitimate values have already been entered. If you want to use UNKNOWN you must first delete (type ‘@’) all other entries and deletion confirmations will display.

22. If you type **OTHER** at the prompt, the following message prompts: “Enter a brief description of the “Other” Contributing Factor.” Type between 1 and 40 characters.

23. At the “Disposition” prompt, type the disposition of the suicide act.

24. If you type **OTHER** at the prompt, the following message prompts: “Disposition If Other. Type between 1 and 80 characters.

25. At the “Other Relevant Information” prompt, press Enter to display another window and type the relevant text about the suicide act.

26. Type **Exit** or **Save** to leave the form. If there is any missing data, Figure 11-7 displays and lists the actions to 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
```

Figure 11-7: List of actions you can take

27. Type **E** to return to the form, edit and complete.

28. Type **D** to delete the form. There is no confirmation message.
29. Type L to leave the form incomplete. The form can be completed at a later time.

11.1.1.2 Display a Suicide Form (DF)

1. Type DF to display a specified suicide form. Do the following:

2. At the “Select Suicide Reporting Form List (1-x) (where x is the number of last form)” prompt, type the name of the suicide form to display.

3. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - B (browse output on screen)

Figure 11-8 shows the Output Browser screen where you can browse the Suicide Reporting Form on the screen.

11.1.1.3 Delete a Suicide Form (XF)

1. Type XF to remove a selected suicide form record. Do the following:

2. At the “Select Suicide Reporting Form List (1-x) (where x is the number of last form)” prompt, type the form name to be removed.

3. At the “Are you sure you want to delete this suicide form?” prompt, type one of the following:
   - Type Y to accept the form selection.
   - Type N to end the process.
11.1.1.4 **Browse Visits for this Patient (BV)**

Type **BV** to browse the BH visits for the current patient. 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)
- **P** (visits to one program).

  – Type **N**, **D**, or **P** to continue

11.1.1.5 **Health Summary for this Patient (HS)**

Type **HS** to display or print a health summary for the current patient. The health summary for the patient displays on the Output Browser screen (Figure 11-8).

11.1.2 **Review Suicide Forms by Date (SFD)**

1. Type **SFD** to review the suicide forms in a date range. Do the following:

2. At the “Enter Beginning Suicide form date” prompt, set the beginning date.

3. At the “Enter Ending Suicide form date” prompt, set the ending date. The Review Suicide Reporting Forms screen shown in Figure 11-9 displays:

   ![Sample Review Suicide Report Forms window](image)

   **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 for more information.

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, shown in Figure 11-10:

![Figure 11-10: Location of Suicide Forms on the tree structure](image)

One way to display 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 (Figure 11-11). If you access the Suicide Form for one patient window and there is no current patient, you will be asked to select one.

![Figure 11-11: Suicide Form window for one patient](image)
Another way to access the Suicide Form window is to select the All Patients option (Figure 11-10). The **Suicide Form** window for all patients is displayed in Figure 11-12:

![Suicide Form Window](image)

Figure 11-12: Sample Suicide Form window for all patients

### 11.2.1 Suicide Form Date Range

The suicide form records are in the suicide form date range. To change the date range:

1. Click the **Start Date** field and set the date.
2. Click the **End Date** field and set the date.
3. Click **OK**, the window refreshes.

#### 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.

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.

11.2.2 Suicide Form Pane

The Suicide Form pane displays the suicide form records in the date range. The records are listed by date. The I in the first column of the pane indicates the suicide form is incomplete.

11.2.3 Add Button

1. Select a patient (Figure 11-12) to use in the add process
2. Click Add to insert a new suicide record. The Data Entry–Add Suicide Entry window in Figure 11-14 displays. Refer to Section 11.3 for more information.

11.2.4 Edit Button

1. Select a patient to edit in the pane.
2. Click Edit and the Data Entry–Edit Suicide Entry window displays.
   - 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 for more information.

11.2.5 View Button

Click View (or double-click on a form) to browse the highlighted suicide form record. The Suicide Form Data Entry–View Suicide Form window displays.

11.2.6 Delete Button

1. Select a patient to delete in the pane.
2. Click Delete to remove the highlighted suicide form record. A confirmation displays.
• Click Yes to remove the selected suicide record.
• Click No to leave the record.

11.2.7 Print Button

Click Print on the Suicide Form window to output the highlighted suicide form record. The first page of the Suicide Form pop-up window displays as shown in 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 for more information.
11.2.8 Help Button
Click **Help** to access the online help system.

11.2.9 Close Button
Click **Close** to close the **Suicide Form** window.

11.3 Add/Edit Suicide Form (GUI)
Figure 11-14 shows the fields on the **Suicide Form Data Entry–Add Suicide Form** window.

![Suicide Form Data Entry–Add Suicide Form window](image)

Figure 11-14: Sample **Suicide Form Data Entry–Add Suicide Form** window

1. Click Save to save the information on this window.
   - All fields except the **Local Case Number** and **Narrative** are required. If the fields are not completed, Figure 11-15 displays:
2. Click Yes to save the form and complete at a later time. You return to the Suicide Form window
   - Click No, the form is not saved and you remain on the data entry form.
3. Click Help to access the online help system.
4. Click Close, the Continue? dialog displays:
   - Click Yes to not save; the Add window closes.
   - Click No to remain on the Add window and continue.
Refer to Section 2.11 for more information.

11.3.1 Suicide Form Fields
1. Type the case number or health record number in the Local Case Number field.
2. Select the provider from the Provider field.
3. Set the Date of Act.
4. Select the name from the Community Where Act Occurred field.
5. Select the Relationship Status field and type one of the following:
   - 1 (single)
   - 2 (married)
   - 3 (divorced/separated)
   - 4 (widowed)
   - 5 (cohabiting/common law)
   - 6 (same sex partnership)
   - 9 (unknown)
6. Select the **Education** field and 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

7. Select the **Employment Status** field and 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)

8. Select the type of activity from the **Suicidal Behavior** field.

9. Select the location of the act from the **Location of Act** field.
   - If **Other** is selected in the **Location of Act** field and the **if other** field become active. Type a description.

10. Select the number of attempts from the **Previous Attempts** field.

11. Select the disposition of the suicide act in the **Disposition** field.
   - If **Other** is selected in the **Disposition** field and the field to the right becomes active. Type a description.
11.3.2 Method Tab

Figure 11-16 shows the Method tab used to indicate the suicide act and the substance used in overdose cases.

![Sample Method tab](image)

Figure 11-16: Sample Method tab

11.3.2.1 Method Pane

1. On the Method Pane, do one of the following:

2. Click one or more boxes. One box is required.

3. Select the Overdose box and the Substance window displays as shown in Figure 11-17:

![Substance window](image)

Figure 11-17: Substance window
4. Highlight one or more items in the Substance column and click the right arrow button to add to the Selected Items column.

5. Click OK to update the Overdose pane.

- If you select a substance with OTHER in its description and click OK, the OTHER ANTIDEPRESSANT dialog displays shown in Figure 11-18:

![Figure 11-18: Sample OTHER ANTIDEPRESSANT dialog](image)

- Type text in the Other field (limited to 80 characters). You can not exit without typing text in the dialog.
- Click OK to populate the Substance If Other column on the Overdose pane.
- Click Close if text was not entered in the Other field.

6. Select the Other box, the field below becomes active, type text in the field.

11.3.2.2 Overdose Pane

The Overdose pane contains the categories of substances used in the overdose suicidal act. Once it is populated, the Add, Edit, and Delete buttons become active.

If you select the Overdose box under Method (Figure 11-16), the Substance window (Figure 11-17) displays.

Highlight one or more items in the Substance column and click the right arrow button to add to the Selected Items column.

Click OK to update the Overdose pane.

Click Add to add one or more new records. The Substance window displays.

Highlight one or more items in the Substance column and click the right arrow button to add to the Selected Items column.

Click OK to update the Overdose pane.

If you select a substance with OTHER in its description and click OK, the OTHER Figure 11-19 dialog displays:
Figure 11-19: OTHER dialog

Type text in the Other field (limited to 80 characters). You can not exit without typing text in the dialog.

Click OK to populate the Substance If Other column on the Overdose pane.

Click Close if text was not entered in the Other field.

Highlight the record in the Substance if Other column and click Edit to display the Other dialog (Figure 11-19). The data in the Substance If Other field displays in the Other field.

Click OK to exit the Other window.

Click Delete to remove a selected substance record in the Overdose pane. The deletion is confirmed.

11.3.3 Substance Use Tab

Select the Substance Use tab to identify the substances involved in the suicide incident and the categories of the substances involved as shown in Figure 11-20:

Figure 11-20: Sample Substance Use tab

11.3.3.1 Substances Involved in This Incident Pane

Select one of the boxes in this pane that describes the substance used in the suicide act. At least one is required.
If you select the Alcohol and Other Drugs box, the Substance window in Figure 11-22 displays.

Highlight one or more items in the Substance column and click the right arrow button to add to the Selected Items column.

Click OK to populate the Substance If Other column on the Substances Involved pane.

Select Other in Figure 11-22 and the Other dialog in Figure 11-19 displays.

Type in the Other field (limited to 80 characters). You can not exit without typing text in the dialog.

Click OK to populate the Substance Involved column.

Click Close if text was not entered in the Other field.

Uncheck the Alcohol and Other Drugs boxes and the Substances Involved pane clears.
11.3.3.2 Substances Involved Pane

![Figure 11-23: Sample Substances Involved pane](image)

This pane contains the substances used immediately before or during the suicidal act. When the Alcohol and Other Drugs boxes are checked, Add, Edit, and Delete become active.

Click Add to add one or more new records. The Substance (Figure 11-22) window displays.

Highlight one or more items in the Substance column and click the right arrow button to add to the Selected Items column.

Click OK to update the Substances Involved pane.

If you select a substance with OTHER in its description and click OK, the OTHER Figure 11-19 dialog displays:

Type text in the Other field (limited to 80 characters). You can not exit without typing text in the dialog.

Click OK to populate the Substance If Other column on the Substances Involved pane.

Click Close if text was not entered in the Other field.

Highlight a record (with Other) in the Substance If Other column and click Edit. The Other (Figure 11-19) dialog displays.

Click OK to populate the Substance If Other column on the Overdose pane.

Click Close if text was not entered in the Other field.

Click Delete to remove a selected substance record in the Substances Involved pane.
11.3.4 Contributing Factors Tab

Select the **Contributing Factors** tab to identify the contributing factors associated with the suicide act as shown in Figure 11-24.

![Sample Contributing Factors tab](image)

Select one or more of the boxes that describe the contributing factors for the suicide act. At least one is required.

If you select **Other**, the field below the box becomes active. Type a description in the field.

11.3.5 Narrative Tab

Select the **Narrative** tab and type text in the **Other Relevant Information** field Figure 11-25.

![Sample Other Relevant Information field](image)

**Note:** 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 OTHER INFORMATION screen displays as shown in Figure 12-1:

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

Update, add or append any of the following data

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

Choose one of the above: (1-9): 9/
```

Figure 12-1: Options on the Other Information menu

The other place you can add/change/remove an intake document is the Intake Document (ID) option on the Patient Data Entry (Figure 4-3) screen. You will be prompted for a Program (you are associated with). After specifying the program, the Update BH Intake Document screen displays as shown in Figure 12-2:

```
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
*2  12/29/09  MENTAL H GAMMAA, RYAN
*3  12/29/09  MENTAL H GAMMAA, RYAN
*4  12/29/09  MENTAL H THETA, SHIRLEY
*5  12/29/09  MENTAL H THETA, SHIRLEY
*6  12/29/09  MENTAL H GAMMAA, RYAN
*7  10/07/09  GAMMAA, RYAN
*8  04/21/09  GAMMAA, RYAN

Enter ?? for more actions
```
Type Q and press Enter to exit the Update BH Intake Document screen.

The asterisk (*) in the first column indicates that the record contains an unsigned intake/update document.

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)

1. Type I to create an initial intake document for the visit. A message displays stating the application is adding the Intake document. Do the following:

2. At the “Do you wish to continue to add the Intake Document?” prompt, type one of the following:
   - Type N to end the create process.
   - Type Y to add the Intake document and continue:
3. At the “DATE” prompt, set the date (cannot be a future date).
4. At the “PROGRAM:” prompt, type the health information.
5. At the “PROVIDER” prompt, type the provider name.
6. At the “DATE LAST UPDATED” prompt, set the date (cannot be future date).
7. At the “NARRATIVE/No Existing Text/Edit?” prompt, type one of the following:
   - Type N to end the edit process
     - The Intake document is created.
     - The Update BH Intake Document screen displays.
   - Type Y to edit the narrative on another screen.
   - Click Save and complete the following:
8. At the “Enter your Current Signature Code” prompt, do one of the following:
   - Type the electronic signature to sign the document. This action marks the document as signed. It cannot be edited.
   - Press Enter and the document will not be signed and can be edited.

12.1.2 Edit Initial Intake (E)

1. Type E to change the selected initial intake document and do the following:

   **Note:** 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.

2. At the “CHOOSE” prompt, type one of the following:
   - Type 2 (Quit) – to return to the Update BH Intake Document
   - Type 1 (Edit Initial Intake Document) – to continue

3. At the Select Intake (1 of x) where x is the number of the last intake document” prompt, select the intake document to edit.
   - If the intake document is signed, it cannot be edited.
   - If you are not the original author or the person who entered this document, you cannot edit it.

4. At the “DATE” prompt, set the date (cannot be a future date).

5. At the “PROGRAM:” prompt, type the health information.

6. At the “PROVIDER” prompt, type the provider name.

7. At the “DATE LAST UPDATED” prompt, set the date (cannot be future date).

8. At the “NARRATIVE/No Existing Text/Edit?” prompt, type one of the following:
   - Type N to end the edit process
     - The applications indicates the Intake document was created
     - An intake narrative must be created before an electronic signature can be applied.
   - A message displays verifying the Intake Narrative, type one of the following:
     - Type Y to return to the Narrative prompts
     - Type N to return to the Update BH Intake Document screen.
• Type **Y** to edit the narrative on another screen.
• Click Save and complete the following:

9. At the “Enter your Current Signature Code” prompt, do one of the following:
  
  • Type the electronic signature to sign the document. This action marks the document as signed. It cannot be edited.
  
  • Press Enter and the document will not be signed and can be edited.

### 12.1.3 Add/Edit Update (U)

Type **U** to create a new update to a intake document or edit an existing, unsigned document where you are the provider. Do the following:

**Note:** Only the person who originally entered the intake document or the intake document provider can edit the document.
Other providers can only view or print the document.

1. At the “Select Intake: (1-**x**) where **x** is the document number” prompt, select the intake document. A message displays after the document is selected (Figure 12-3):

   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.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Quit/Exit Update</td>
</tr>
<tr>
<td>1</td>
<td>Date Updated: 01/26/10 Provider: THETA, SHIRLEY MENTAL HEALTH</td>
</tr>
<tr>
<td>2</td>
<td>Add new Update document</td>
</tr>
</tbody>
</table>

   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.

2. At the “Select Action” prompt and do one of the following:
• Add a new update to the intake document.
• 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, the process ends.
• If you select the Add new Update document option (2 in Figure 12-3), do the following:

3. At the “DATE” prompt, set the date (cannot be a future date).
4. At the “PROVIDER” prompt, type the provider name.
5. At the “DATE LAST UPDATED” prompt, set the date (cannot be future date).
   • The text of the narrative or “no existing text displays” in the “NARRATIVE”
6. At the “Edit?” prompt, type one of the following:
   • Type N to end the process.
   • Type Y to display another window and edit the text of the narrative.
   • Click Save and complete the following:

7. At the “Enter your Current Signature Code” prompt, do one of the following:
   • Type the electronic signature to sign the document.
   • Press Enter to do one of the following:
     – Add a new update to the intake document:
     – Edit an existing, unsigned where you are the provider or entered the document. Do one of the following:

8. At the “Select Action” prompt, type one of the following (Figure 12-4):

   | 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

• Type 0 to Quit and return to the Update BH Intake Document screen.
• Type 1, to revise the Date Updated and Provider..
• Type 2 to Add new Update Document.

Refer to Section for more information

12.1.4 Delete Intake/Update (D)

Type D to do one of the following:
• Delete Intake/Update
• Display/Print Intake/Update

12.1.4.1 Delete Intake/Update

You can delete only unsigned Intake documents you entered or on which you are the provider, unless you possess a special key or are listed on the Delete Override list. Do one of the following:

1. At the “Select Intake” prompt, do one of the following:
   • Select the Initial Intake to delete
   • Select the Initial Intake with the Update to delete. Figure 12-5 displays the choices:

<table>
<thead>
<tr>
<th>0</th>
<th>Quit/Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Date MM/DD/YY Provider: &lt;provider name&gt;</td>
</tr>
</tbody>
</table>

   Figure 12-5: Actions to take

2. Type 0 to return to the Update BH Intake Document screen.

3. Type 1 if you are the intake provider or the person who entered this Initial Intake document.
   • If you meet one of the criteria, a message displays indicating to select which Intake or Update document to delete.
   • Initial Intake documents that have Updates associated with them cannot be deleted.

4. Select a document to delete, the message: “Are you sure you want to delete this <name> document?”
   • Type Y to delete.
   • Type N to not delete.

12.1.4.2 Display/Print Intake/Update

This action is the same as Type P on the Update BH Intake Document window. Refer to Section 12.1.5 for more information.

12.1.5 Print Intake Document

1. Type P to print or /browse a intake document. Do the following:

2. At the “Select Intake Update (1-x) where x is the number of the last intake record” prompt, type the document to display or print.
3. At the “What would you like to print?” prompt, do one of the following
   - Type I (Intake document only)
   - Type U (Update document only) another menu is displayed listing each of the
     updates and an option to print all updates
   - Type Q (quit/exit) to return to the previous menu.
   - Type B (both the Intake and Update documents), do the following:

4. At the “Do you wish to” prompt, type one of the following:
   - Type B browse output on screen.
   - Type P to print output on paper as shown in Figure 12-6:

```
********** 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. Either
method accesses the same Intake window.

   - 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.

The following provides information about using the Intake option on the GUI tree
structure.
The Intake option applies to the current patient. After selecting the Intake option, the application displays the **Select Program** dialog displayed in Figure 12-7:

![Select Program dialog](image)

**Figure 12-7: Select Program dialog**

1. Select an option from the **Program** field.
2. Click **OK** to display **Intake** (Figure 12-8) window listing the intake documents for the program for the current patient
3. Click **Close** to end the process.

**Note:** The following window is the window that displays when you click the Intake tab on the Add/Edit Visit Data Entry window.
An asterisk (*) in the first column indicates that the record contains an unsigned intake/update document.

4. Click **Help** to access the online help.

### 12.2.1 Patient Intake Documents Pane

The Patient Intake Documents (Figure 12-9) pane 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 pane (under the Date Initiated, Program, and Initial Provider columns).
The update documents are listed on the right side of the pane (under the Date Updated and Update Provider columns).

When you highlight a record in the Patient Intake Documents pane, the text of the document displays in the Intake pane.

**Note:** 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

1. Click Add Initial Intake (Figure 12-8) to add a new initial intake document. The Select Intake Parameters dialog displays as shown in Figure 12-10:

![](image)

**Figure 12-10: Sample Select Intake Parameters dialog**

2. Set the Intake Date (cannot be a future date).

3. Select the program from the Program field.

**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.

4. Select a name from the Provider field.

5. Set the Date Last Updated (cannot be a future date).
   - Click OK to active the Intake pane.
   - Click Close to end the process.
Refer to Section 12.2.3 for more information.

12.2.3 Intake Pane

Figure 12-11: Sample of active **Intake** pane

1. Type text in the **Intake** pane (Figure 12-11).
2. Click **Cancel** to cause the pane to become inactive.
3. Click **Close** and the **Continue?** dialog: “Unsaved Data Will Be Lost, Continue?”
   - Click **Yes** to cancel the input and return to the GUI tree structure.
   - Click **No** to return to the **Intake** pane.
4. Click **Save** to save the input. The **Intake Electronic Signature** dialog displays as shown in Figure 12-12:

![Intake Electronic Signature dialog](image)

Figure 12-12: Intake Electronic Signature dialog

5. Type the signature in the **Electronic Signature** field.
6. Click **OK** to save the document and make it as signed.
7. Click **Close** and the **Are You Sure?** dialog displays: “Are you sure you want to Close without Electronically Signing the Intake?”
8. Click **Yes** to not sign it and to save the document marked as not signed.
   - Click **OK** to exit 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 close the message and end the 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.

- **OK** to close the message and end the process.

If you are the provider or the person who entered the intake, the application displays the **Select Intake Parameters** dialog.

After completing this dialog, the text of the initial intake document will display in the **Intake** area of the **Intake** window.

Refer to Section 12.2.2 and Section 12.2.3 for more information.

12.2.5 Add/Edit Update

This button has two different labels, depending on the action you take:

- 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.

**Note:** If you select a signed update document, the button reads **Edit Update**. After you click **Edit Update**, the application displays the message: “This intake update document has been signed. You cannot edit it.” Click **OK** to dismiss the message and exit the edit process.

After the provider locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the delete override site parameter.

After completing this dialog, the Intake pane will become active.
12.2.6 Delete Intake

Click **Delete Intake** to delete a selected unsigned intake document (in the Patient Intake Documents pane).

- The **Are You Sure** dialog displays
- Click Yes to delete the document.
- Click No to leave the document.

- 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

1. Click **Display/Print Intake** (Figure 12-13) to displays display/print options.

![Figure 12-13: Options for the Display/Print Intake button](image)

2. Highlight a record and select a highlighted option from the list.

3. Select either **Update Document Only** or **Both the Intake and Update Documents**, the Intake Updates window displays as shown in Figure 12-14:
4. Select the records to include in the output.
   - Click **OK** to display the first page of the Intake (for the current patient) pop-up window (Figure 12-15):

Refer to Section 2.6 for more information.
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 (Figure 13-1) are detailed in the following sections. Use this menu for tracking and managing patient, provider, and program statistics.

13.1 Patient Listings (PAT)

shows the Patient Listings submenu that contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, a custom report that allows selection of which patients to include in the report and items to print and the sort criteria.
13.1.1 Active Client List (ACL)

1. At the “Select Patient Listings Option” prompt type **ACL** to review a list of patients who have been seen in a date range. To filter the report, do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. At the “Limit the list to those patients who have seen a particular provider?” prompt, type one of the following:
   - Type **N** to end the process.
   - Type **Y** to continue.

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

6. At the “Do you wish to:” prompt, type one of the following:
   - **P** (print output)
   - **B** (browse output on screen)

7. Type **B** to browse the output on the Output Browser window displayed in Figure 13-2:

********** CONFIDENTIAL PATIENT INFORMATION **********
13.1.2 Patient General Retrieval (PGEN)

1. At the “Select Patient Listings Option” prompt, type PGEN to produce a report showing a listing of patients based on selected criteria. Do one of the following:

2. At the “Select and Print Patient List from” prompt, Type one of the following:
   - P (patient file)
   - S to continue

3. At the “Do you want to use a PREVIOUSLY DEFINED REPORT?” prompt type one of the following:
   - N to end the process
   - Y to display the Patient Selection Menu displayed as shown in Figure 13-3:
9) County of Residence    22) Designated MH Prov    35) Pts seen w/Axis IV L
10) Tribe of Membership   23) Designated SS Provid 36) Pts w/Inpatient Disp
11) Eligibility Status    24) Designated A/SA Prov 37) Pts Last Health Fact
12) Class/Beneficiary     25) Designated Other Pro
13) Medicare Eligibility  26) Personal History Ite

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

Figure 13-4: Sample Patient Selection Menu options

If you do not specify any criteria, type Q and press Enter to exit the menu.

4. At the “Choose Type of Report” prompt, type one of the following:
   • T (total count only)
   • S (subcounts and total count)
   • D (detailed listing).

5. Select D to display the Print Item Selection Menu in Figure 13-4:

   BH GENERAL RETRIEVAL          Apr 16, 2009 14:46:31          Page:    1 of    1
   PRINT ITEM SELECTION MENU
   The following data items can be printed. Choose the items in the order you
   want them to appear on the printout. Keep in mind that you have an 80
   column screen available, or a printer with either 80 or 132 column width.
   1)  Patient Name           13)  Class/Beneficiary     25)  Case Disposition
   2)  Sex                    14)  Medicare Eligibility  26)  Next Case Review Dat
   3)  Race                   15)  Medicaid Eligibility  27)  Designated MH Prov
   4)  Patient Age            16)  Priv Ins Eligibility  28)  Designated SS Provid
   5)  Patient DOB            17)  Mailing Address-City 29)  Designated A/SA Prov
   6)  Patient SSN            18)  Home Phone            30)  Designated Other Pro
   7)  Patient DOD            19)  Mother's Name         31)  Designated Other (2)
   8)  Patient Chart #        20)  Patient Flag Field 32)  Personal History Ite
   9)  Community of Residen   21)  Patient Flag Narrati 33)  Pts Last Health Fact
  10)  County of Residence   22)  Case Open Date
  11)  Tribe of Membership   23)  Case Admit Date
  12)  Eligibility Status    24)  Case Closed Date

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

Figure 13-5: Sample Print Item Selection Menu options

   • This menu determines the data items on the report. Select the items in the order
   that you want them to appear on the output.

6. At the “Select Action” prompt, type Q to exit the menu. The Sort Item Selection
   Menu displays as shown in Figure 13-5:
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 Residence  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 Prov
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

- This menu determines how the data will be sorted.

7. At the “Do you want a separate page for each Patient Name?” prompt, type one of the following:
   - Y (create a separate page for each patient)
   - N (separate page is not created)

8. At the “Would you like a custom title for this report?” type one of the following:
   - N (custom title is not create)
   - Y to continue

9. At the “Do you wish to save this search/print/sort logic for future use?” prompt, type one of the following:
   - N (logic is not saved)
   - Y to continue

10. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
    - I (include all patients)
    - E (exclude demo patients)
    - O (include only demo patients).

11. At the “Do you wish to” prompt, type one of the following:
    - P (print output)
    - B (browse output on screen) The Patient Selection Criteria for the report displays.
12. Press Enter to display the BH Patient Listing report displayed in Figure 13-6:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
BH Patient Listing
Page 1
PATIENT NAME          SSN          COMM RESIDENCE
----------------------------------------------------
A'PAT1, ALAYNA BROOKL  XXX-XX-2160  HOWE
A'PAT1, WEBB AARON      XXX-XX-4769  PORUM
ALPHA, ALICE ROCHELLE  XXX-XX-6378  COLCORD
ALPHA, GERALDINE        XXX-XX-7097  MUSKOGEE
Enter ?? for more actions
+ NEXT SCREEN          - PREVIOUS SCREEN      Q QUIT
```

Figure 13-7: Sample Patient Listing report

13.1.3 Designated Provider List (DP)

1. At the “Select Patient Listings Option” prompt, type DP to produce the designated mental health provider list report. Do the following:

2. At the “Which Designated Provider?” prompt, type one of the following:

   Type one of the following:
   - M Mental Health Defaults
   - S Social Services Defaults
   - C Chemical Dependency or Alcohol/Substance Abuse
   - O Other
   - T (other non-RPMS)

3. At the “Run Report for” prompt, type one of the following:

   - 2 (all providers)
   - 1 (one provider) to continue

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

5. At the “Do you wish to” prompt, type one of the following:

   - P (print output)
• **B** (browse output on screen) The Designated Mental Health Provider List report displays as shown in Figure 13-7:

![Figure 13-7: Designated Mental Health Provider List report](image_url)

**OUTPUT BROWSER**

<table>
<thead>
<tr>
<th>PROVIDER: GPROVIDER,D</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPHA, ALICE ROCHELLE</td>
</tr>
<tr>
<td>183497</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>06/25/97</td>
</tr>
<tr>
<td>COLCORD</td>
</tr>
<tr>
<td>Jan 05, 2009</td>
</tr>
<tr>
<td>ALPHAA, GLEN DALE</td>
</tr>
<tr>
<td>108704</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>11/10/81</td>
</tr>
<tr>
<td>TAHLEQUAH</td>
</tr>
<tr>
<td>Apr 14, 2009</td>
</tr>
<tr>
<td>GPAT, JANE ELLEN</td>
</tr>
<tr>
<td>197407</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>01/01/90</td>
</tr>
<tr>
<td>TUCSON</td>
</tr>
<tr>
<td>Apr 15, 2009</td>
</tr>
<tr>
<td>MPAT11, SHERRY KEARNEY</td>
</tr>
<tr>
<td>197407</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>10/01/00</td>
</tr>
<tr>
<td>PEGGS</td>
</tr>
<tr>
<td>Sep 28, 2007</td>
</tr>
</tbody>
</table>

---

**Figure 13-8: Sample Designated Mental Health Provider List report (for all providers)**

### 13.1.4 Patients with AT LEAST N Visits (GRT)

1. At the “Select Patient Listings Option” prompt, type **GRT** to produce a report that shows a list of patients who have been seen N number of times in a date range. Do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. Type a number between 2 and 100 at the “Enter the minimum number of time the patient should have been seen” prompt.

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - B (browse output on screen) The Patient Seen N Times report displays as shown in Figure 13-8:
**Figure 13-9: Sample Patients Seen at least 3 Times report**

### 13.1.5 Patients Seen by Age and Sex (AGE)

1. At the “Select Patient Listings Option” prompt, type **AGE** to produce a report that tallies the number of patients, who have had an encounter. You will choose the item you want to tally, such as problems treated, or activities by age and sex. Tallies by PROBLEM ONLY includes the PRIMARY PROBLEM and group ages can be defined. You will be able to define the age groups to be used. Do the following:

2. At the “Choose an item to tally by age and sex” prompt, 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 selected will display down the left column of the report. Age groups display across the top of the report.

3. Set the date at the “Enter beginning Visit Date for search” prompt.
4. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-9:

<table>
<thead>
<tr>
<th>1) Patient Name</th>
<th>23) Next Case Review Dat</th>
<th>45) Axis V</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Patient Sex</td>
<td>24) Appointment/Walk-In</td>
<td>46) Flag (Visit Flag)</td>
</tr>
<tr>
<td>3) Patient Race</td>
<td>25) Interpreter Utilized</td>
<td>47) Primary Provider</td>
</tr>
<tr>
<td>4) Patient Age</td>
<td>26) Program</td>
<td>48) Primary Prov Discipl</td>
</tr>
<tr>
<td>5) Patient DOB</td>
<td>27) Visit Type</td>
<td>49) Primary Prov Affilia</td>
</tr>
<tr>
<td>6) Patient DOD</td>
<td>28) Location of Encounter</td>
<td>50) Prim/Sec Providers</td>
</tr>
<tr>
<td>7) Living Patients</td>
<td>29) Clinic</td>
<td>51) Prim/Sec Prov Discip</td>
</tr>
<tr>
<td>8) Chart Facility</td>
<td>30) Outside Location</td>
<td>52) POV (Prim or Sec)</td>
</tr>
<tr>
<td>9) Patient Community</td>
<td>31) SU of Encounter</td>
<td>53) PO (Prob Code Grps)</td>
</tr>
<tr>
<td>10) Patient County Resid</td>
<td>32) County of Service</td>
<td>54) Primary PO</td>
</tr>
<tr>
<td>11) Patient Tribe</td>
<td>33) Community of Service</td>
<td>55) PO (Problem Categor</td>
</tr>
<tr>
<td>12) Eligibility Status</td>
<td>34) Activity Type</td>
<td>56) PO Diagnosis Catego</td>
</tr>
<tr>
<td>13) Class/Beneficiary</td>
<td>35) Days in Residential</td>
<td>57) Procedures (CPT)</td>
</tr>
<tr>
<td>14) Medicare Eligibility</td>
<td>36) Days in Aftercare</td>
<td>58) Education Topics Pro</td>
</tr>
<tr>
<td>15) Medicaid Eligibility</td>
<td>37) Activity Category</td>
<td>59) Prevention Activity</td>
</tr>
<tr>
<td>16) Priv Ins Eligibility</td>
<td>38) Local Service Site</td>
<td>60) Personal History Ite</td>
</tr>
<tr>
<td>17) Patient Encounters O</td>
<td>39) Number Served</td>
<td>61) Designated MH Prov</td>
</tr>
<tr>
<td>18) Patient Flag Field</td>
<td>40) Type of Contact</td>
<td>62) Designated SS Provid</td>
</tr>
<tr>
<td>19) Case Open Date</td>
<td>41) Activity Time</td>
<td>63) Designated A/SA Prov</td>
</tr>
<tr>
<td>20) Case Admit Date</td>
<td>42) Inpatient Dispositio</td>
<td>64) Designated Other Pro</td>
</tr>
<tr>
<td>21) Case Closed Date</td>
<td>43) PCC Visit Created</td>
<td>65)</td>
</tr>
<tr>
<td>22) Case Disposition</td>
<td>44) Axis IV</td>
<td>66)</td>
</tr>
</tbody>
</table>

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

5. At the “Do you wish to modify these age groups?” prompt, type one of the following:
   - Type N to have the defined age groups listed across the top of the report.
   - Type Y to continue.

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
• Type B (browse output on screen) to display the Record Search Criteria screen.

8. At the prompt, press Enter to display the Behavioral Health Record Listing report displayed in Figure 13-10:

![Figure 13-10: Sample Behavioral Health Record Listing report]

13.1.6 Case Status Reports (CASE)

At the “Select Patient Listings Option” prompt, type CASE to display additional reports on the Case Status Reports menu shown in Figure 13-11:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO</td>
<td>Active Client List Using Case Open Date</td>
</tr>
<tr>
<td>ONS</td>
<td>Cases Opened But Patient Not Seen in N Days</td>
</tr>
<tr>
<td>TCD</td>
<td>Tally Cases Opened/Admitted/Closed</td>
</tr>
<tr>
<td>DOC</td>
<td>Duration of Care for Cases Opened and Closed</td>
</tr>
<tr>
<td>SENO</td>
<td>Patients Seen x number of times w/no Case Open</td>
</tr>
</tbody>
</table>

![Figure 13-12: Options on the Case Status Reports menu]
### 13.1.6.1 Active Client List Using Case Open Date (ACO)

1. At the “Select Case Status Reports” prompt, type **ACO** to generate a report that shows a list of patients who have a case open date without a case closed date. Do the following?

2. At the “Run the Report for which program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue

3. At the “Include cases opened by” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

5. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the CONFIDENTIAL PATIENT INFORMATION screen shown in Figure 13-12:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
WHITE EARTH HEALTH CENTER
Encounter Dates: JAN 22, 2008 to JAN 21, 2009
ACTIVE CLIENT LIST (CASE OPEN DATE WITH NO CASE CLOSED DATE)

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CHART NUMBER</th>
<th>SEX</th>
<th>DOB</th>
<th>CASE OPEN DATE</th>
<th>CASE ADMIT DATE</th>
<th>PROVIDER</th>
<th>PROBLEM CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPHA,ALICE ROC</td>
<td>183497</td>
<td>F</td>
<td>06/25/97</td>
<td>01/23/06</td>
<td></td>
<td>BETA,BETAA</td>
<td>296.31</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CHII,RONAL</td>
<td>296.32</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>GAMMAAA,RYA</td>
<td></td>
</tr>
</tbody>
</table>

Case Provider: GAMMAAA, DENISE

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CHART NUMBER</th>
<th>SEX</th>
<th>DOB</th>
<th>CASE OPEN DATE</th>
<th>CASE ADMIT DATE</th>
<th>PROVIDER</th>
<th>PROBLEM CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPHA,JACOB SCO</td>
<td>102668</td>
<td>M</td>
<td>10/01/72</td>
<td>05/06/09</td>
<td></td>
<td>GAMMAAA,RYA</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MUUUU,KARE</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>292.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>V11.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>V71.02</td>
</tr>
</tbody>
</table>

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)

1. At the “Select Case Status Reports” prompt, type ONS to generate 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. Do the following:

2. At the “Run the Report for which program” prompt, type one of the following:
   - A (all programs)
   - O (one program) to continue

3. At the “Include cases opened by” prompt, type one of the following:
   - A (all programs)
   - O (one program) to continue

4. At the “Enter the number of days since the patient has been seen” prompt, type the number of days (1–99999) to be included in the report.

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) Figure 13-13 displays the Cases Opened but Patient Not Seen in \(N\) Days report.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CHART NUMBER</th>
<th>SEX</th>
<th>DOB</th>
<th>CASE OPEN DATE</th>
<th>PROVIDER</th>
<th>DATE LAST SEEN DATE</th>
<th># DAYS Since Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient L</td>
<td>106299</td>
<td>F</td>
<td>11/28/85</td>
<td>01/01/06</td>
<td>GAMMAAA, DON</td>
<td>04/26/06</td>
<td>217</td>
</tr>
<tr>
<td>Patient M</td>
<td>102446</td>
<td>F</td>
<td>04/08/66</td>
<td>08/28/06</td>
<td>GAMMAAA, DON</td>
<td>03/28/06</td>
<td>246</td>
</tr>
<tr>
<td>Patient N</td>
<td>176203</td>
<td>M</td>
<td>03/04/60</td>
<td>10/10/05</td>
<td>GAMMAAA, DON</td>
<td>03/28/06</td>
<td>246</td>
</tr>
<tr>
<td>Patient O</td>
<td>164141</td>
<td>M</td>
<td>02/07/75</td>
<td>12/07/05</td>
<td>GAMMAAA, DON</td>
<td>04/25/06</td>
<td>218</td>
</tr>
<tr>
<td>Patient P</td>
<td>209591</td>
<td>F</td>
<td>04/16/62</td>
<td>07/25/06</td>
<td>ZETAAAA, MAT</td>
<td>07/25/06</td>
<td>127</td>
</tr>
</tbody>
</table>

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)

1. At the “Select Case Status Reports” prompt, type TCD to generate a report that tallies the case open, admit, and closed dates in a specified time period. Do the following:

2. Set the date at the “Enter beginning of Time Period” prompt.

3. Set the date at the “Enter ending of Time Period” prompt.

4. At the “Run the Report for which program” prompt, type one of the following:
   - A (all programs)
   - O (one program) to continue

5. At the “Include cases opened by” prompt, type one of the following:
   - A (all programs)
   - O (one program) to continue

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the Tally of Cases Opened/Admitted/Closed report shown in Figure 13-14:

```
DEMO INDIAN 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)

1. At the “Select Case Status Reports” prompt, type **DOC** to generate a report that shows a list of all closed cases in a date range. In order to be included in this report, the case must have both a case open 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. Do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. At the “Please Select which Dates should be Used” prompt, type one of the following:
   - **O** (cases opened in that date range)
   - **C** (cases closed in that date range)
   - **B** (cases either opened or closed in that date range).

5. At the “Run the Report for which program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue

6. At the “Include cases opened by” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue

7. At the “Do you want a separate page for each Patient Name?” prompt, type one of the following:
   - **Y** (create a separate page for each patient)
   - **N** (separate page is not created)

8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

9. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Duration of Care report shown in Figure 13-15:
The application displays the Duration of Care report.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CHART NUMBER</th>
<th>CASE OPEN DATE</th>
<th>CASE CLOSED DATE</th>
<th>DURATION</th>
<th>POV</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient A</td>
<td>148367</td>
<td>05/22/08</td>
<td>08/22/08</td>
<td>92 days</td>
<td>BETA,B</td>
<td></td>
</tr>
<tr>
<td>Patient B</td>
<td>114077</td>
<td>06/27/08</td>
<td>08/28/08</td>
<td>62 days</td>
<td>BETA,B</td>
<td></td>
</tr>
<tr>
<td>Patient B</td>
<td>114077</td>
<td>07/25/08</td>
<td>08/21/08</td>
<td>27 days</td>
<td>BETA,B</td>
<td></td>
</tr>
<tr>
<td>Patient C</td>
<td>211053</td>
<td>04/19/08</td>
<td>08/16/08</td>
<td>119 days</td>
<td>SIGMA,ROBERTA</td>
<td></td>
</tr>
<tr>
<td>Patient D</td>
<td>146565</td>
<td>08/01/08</td>
<td>08/16/08</td>
<td>15 days</td>
<td>THETA,MAUDE</td>
<td></td>
</tr>
<tr>
<td>Patient E</td>
<td>148256</td>
<td>07/25/08</td>
<td>09/01/08</td>
<td>38 days</td>
<td>CHI,VICTOR L</td>
<td></td>
</tr>
<tr>
<td>Patient F</td>
<td>106030</td>
<td>05/22/08</td>
<td>08/30/08</td>
<td>100 days</td>
<td>UPSILON,GEORGE</td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Cases for BETAA,B: 3
Average Duration of Care: 60.33 days

Total Number of Cases: 7
Average Duration of Care: 64.71 days

Figure 13-16: Sample Duration of Care report

13.1.6.5 Patient Seen x Number of Times w/no Case Open (SENO)

1. At the “Select Case Status Reports” prompt, type SENO to generate 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. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt.

4. At the “Run the Report for which program” prompt, type one of the following:
   - A (all programs)
   - O (one program) to continue

5. At the “Include visits to” prompt, type one of the following:
   - A (all providers)
   - O (one program) to continue
6. At the “Enter number of visits (X number of visits with no case opened)” prompt, type the number of visits with no case opened.

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the Patients Seen at least N times with no Case Open Date report shown in Figure 13-16

<table>
<thead>
<tr>
<th>DEMO INDIAN HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENTS SEEN AT LEAST 2 TIMES WITH NO CASE OPEN DATE</td>
</tr>
<tr>
<td>VISIT DATE RANGE: Jun 02, 2008 to Nov 29, 2008</td>
</tr>
<tr>
<td>VISITS TO PROGRAM: MENTAL HEALTH</td>
</tr>
<tr>
<td>PATIENT NAME</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Patient G</td>
</tr>
<tr>
<td>Patient H</td>
</tr>
<tr>
<td>Patient I</td>
</tr>
<tr>
<td>Patient J</td>
</tr>
<tr>
<td>Patient K</td>
</tr>
</tbody>
</table>

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)

1. At the “Select Patient Listings Option” prompt, GAFS to generate a report that lists the GAF scores for multiple patients, sorted by patient. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt.

4. At the “List visits/GAF Scores for which program” prompt type one of the following:
   - A (all programs)
   - O (one program) to continue

5. At the “Include visits to” prompt, type one of the following:
• A (all providers)
• O (one program) to continue

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:
• P (print output)
• Type B (browse output on screen) to display the GAF Scores for Multiple Patients report shown in Figure 13-17

Figure 13-18: Sample GAF Scores for Multiple Patients report

13.1.8 Listing of No-Show Visits in a Date Range (NSDR)

1. At the “Select Patient Listings Option” prompt, NSDR to print a list of visits with POVs related to no shows and cancellations for multiple patients. Do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. At the “List visits/GAF Scores for which program” prompt type one of the following
• A (all programs)
• O (one program) to continue

5. At the “Include visits to” prompt, type one of the following:
• A (all providers)
• O (one program) to continue

6. At the “How would you like the report sorted” prompt, type one of the following:
• P (patient name)
• D (date of visit).

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:
• P (print output)
• Type B (browse output on screen) to display the Behavioral Health No Show Appointment Listing report shown in Figure 13-18:

![Table](image)

**13.1.9 Patient List for Personal Hx Items (PERS)**

1. At the “Select Patient Listings Option” prompt, type **PERS** to generate the List of Patients with Personal History Items report. Do the following:

2. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

3. At the “Do you wish to” prompt, type one of the following:

• P (print output)
• Type B (browse output on screen) to display the Personal History Items report

Figure 13-19:

<table>
<thead>
<tr>
<th>XX</th>
<th>DEMO INDIAN HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONAL HISTORY LIST BY PATIENT</td>
<td>Jul 13, 2009@09:53:05</td>
</tr>
<tr>
<td>PATIENT</td>
<td>SEX</td>
</tr>
<tr>
<td>---------</td>
<td>-----</td>
</tr>
<tr>
<td>ALCOHOL USE</td>
<td></td>
</tr>
<tr>
<td>ALPHAA, SAUNDRA KAY</td>
<td>FEMALE</td>
</tr>
<tr>
<td>BETA, BRENNA KAY</td>
<td>FEMALE</td>
</tr>
<tr>
<td>BETA, HEATHER LINDA PAIGE</td>
<td>FEMALE</td>
</tr>
<tr>
<td>BETAA, STEVEN</td>
<td>MALE</td>
</tr>
<tr>
<td>GAMMA, JANE ELLEN</td>
<td>FEMALE</td>
</tr>
<tr>
<td>GAMMA, TIMOTHY</td>
<td>MALE</td>
</tr>
<tr>
<td>PHIIII, GREGORY SHANE</td>
<td>MALE</td>
</tr>
<tr>
<td>SIGMAAA, AMY LYNN</td>
<td>FEMALE</td>
</tr>
</tbody>
</table>

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

Figure 13-20: Sample List of Patients with Personal History Items report

13.1.10 Placements by Site/Patient (PPL)

1. At the “Select Patient Listings Option” prompt, type PPL option to generate a report that shows a list of patients who have had a placement disposition recorded in a date range. Do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. At the “How would you like the report sorted” prompt, type one of the following:

• P (alphabetically by patient name)
• S (alphabetically by site referred to).

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:
• P (print output)
• Type B (browse output on screen) to display the Placements report shown in Figure 13-20:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>HRN</th>
<th>Date</th>
<th>POV</th>
<th>Placement</th>
<th>Facility Referred To PLACED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPHA, JACOB SCOTT</td>
<td>102668</td>
<td>05/03/09</td>
<td>295.15</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>APATT, CHELSEA MAR</td>
<td>116431</td>
<td>03/25/09</td>
<td>12</td>
<td>OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Placement Made by: GAMMA, RYAN</td>
<td>Designated SS Prov: BETA, BETA</td>
</tr>
<tr>
<td>BPATT, RUSTY LINN</td>
<td>207396</td>
<td>04/06/09</td>
<td>15</td>
<td>OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Placement Made by: GAMMA, RYAN</td>
<td>Designated SS Prov: BETA, BETA</td>
</tr>
<tr>
<td>BPATTTT, ADAM M</td>
<td>109943</td>
<td>04/07/09</td>
<td>311</td>
<td>OUTPATIENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Placement Made by: GAMMA, RYAN</td>
<td>Designated SS Prov: BETA, BETA</td>
</tr>
<tr>
<td>Enter ?? for more actions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ NEXT SCREEN          - PREVIOUS SCREEN      Q QUIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 13-21: Sample Placements report

13.1.11 Listing of Patients with Selected Problems (PPR)

1. At the “Select Patient Listings Option” prompt, type PPR to generate a report that lists all patients who have been seen for a diagnosis/problem in a date range. Do the following:

2. At the “Which Type?” prompt, type one of the following:
   • D (individual problem or DSM codes)
   • P (Problem Code and all DSM codes grouped under it) the prompts continue:

3. At the “Enter Problem Code” prompt, type the code. The next prompt allows you to enter another problem code.

4. Set the date at the “Enter Beginning Visit Date” prompt.

5. Set the date at the “Enter Ending Visit Date” prompt.

   • At the prompt, type one of the following:
     • P (alphabetically by patient name)
     • S (alphabetically by site referred to).

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   • I (include all patients)
7. At the “Do you wish to” prompt, type one of the following:

- **P** (print output)
- **Type B** (browse output on screen) to display the Patients Seen with Selected Diagnosis/Problems report shown in Figure 13-21:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>HRN</th>
<th>DOB</th>
<th>Sex</th>
<th>Prov</th>
<th>Dx</th>
<th>Date Seen</th>
<th>Last Vis</th>
</tr>
</thead>
<tbody>
<tr>
<td>APATQ, ABIGAIL</td>
<td>103952</td>
<td>02/25/32</td>
<td>F</td>
<td>BJB</td>
<td>41</td>
<td>12/08/08</td>
<td>12/29/08</td>
</tr>
<tr>
<td>BPAT, ROBERT JACOB</td>
<td>207365</td>
<td>02/06/55</td>
<td>M</td>
<td>JC</td>
<td>41</td>
<td>12/29/08</td>
<td>01/05/09</td>
</tr>
<tr>
<td>FPAT12, AMANDA ROSE</td>
<td>186121</td>
<td>01/10/98</td>
<td>F</td>
<td>DG</td>
<td>40</td>
<td>12/01/08</td>
<td>12/30/08</td>
</tr>
<tr>
<td>YPATB, ANNEMARIE LEE</td>
<td>105883</td>
<td>02/11/44</td>
<td>F</td>
<td>DG</td>
<td>40</td>
<td>04/06/09</td>
<td>04/06/09</td>
</tr>
</tbody>
</table>

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)

- At the prompt, type the following:
  - **D** (individual problem or DSM codes) Do the following:
    1. At the “Enter Problem/Diagnosis Code” prompt, type the code. The next prompt allows you to enter another problem/diagnosis code.
    2. Set the date at the “Enter Beginning Visit Date” prompt.
    3. Set the date at the “Enter Ending Visit Date” prompt.
    4. At the “How would you like the report sorted” prompt, type one of the following:
      - **P** (alphabetically by patient name)
      - **S** (alphabetically by site referred to).
    5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
      - **I** (include all patients)
      - **E** (exclude demo patients)
      - **O** (include only demo patients)
    6. At the “Do you wish to” prompt, type one of the following:
• **P** (print output)

• Type **B** (browse output on screen) to display Patients Seen with Selected Diagnosis/Problems report shown in Figure 13-22:

<table>
<thead>
<tr>
<th>XX</th>
<th>Apr 17, 2009</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Visit Dates: Oct 19, 2008 to Apr 17, 2009</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**PATIENT NAME</td>
<td>HRN</td>
<td>DOB</td>
</tr>
<tr>
<td>----------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>ALPHA,CHELSEA MARIE</td>
<td>116431</td>
<td>02/07/75</td>
</tr>
<tr>
<td>Designated SS Prov: BDOC11,BJ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

At the “Select Patient Listings Option” prompt, type **SCRN** to access the Screening Reports menu shown in Figure 13-23:

```
**********************************************
**       IHS Behavioral Health System       **
**             Screening Reports            **
**********************************************
Version 4.0 (patch 2)
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)

At the “Select Screening Reports Option” prompt, type **IPV** to access the IPV/DV Report menu as shown in Figure 13-24:

```
**********************************************
**       IHS Behavioral Health System       **
**             IPV/DV Reports              **
**********************************************
Version 4.0 (patch 2)
```
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. Do the following:

**Note:** 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.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied: (0-11)” prompt, select the items to be tallied (Figure 13-25).

   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

4. At the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt, type one of the following:

   - Type Y to include the screenings
   - Type N to not include the screenings

5. At the “Would you like to include a list of patients screened?” prompt type one of the following:
• Type N to not include the list of patients
• Type Y to continue

6. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-26 shows the list of options to sort. The default is H (Health Record Number). Do the following:

<table>
<thead>
<tr>
<th>Selection</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Health Record Number</td>
</tr>
<tr>
<td>N</td>
<td>Patient Name</td>
</tr>
<tr>
<td>P</td>
<td>Provider who screened</td>
</tr>
<tr>
<td>C</td>
<td>Clinic</td>
</tr>
<tr>
<td>R</td>
<td>Result of Exam</td>
</tr>
<tr>
<td>D</td>
<td>Date Screened</td>
</tr>
<tr>
<td>A</td>
<td>Age of Patient at Screening</td>
</tr>
<tr>
<td>G</td>
<td>Gender of Patient</td>
</tr>
<tr>
<td>T</td>
<td>Terminal Digit HRN</td>
</tr>
</tbody>
</table>

Figure 13-27: List of options to sort the list

7. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
• Type N to not display the list
• Type Y to display the list

8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

9. At the “DEVICE” prompt, type the device to output the report.

Figure 13-27 shows the sample report:

<table>
<thead>
<tr>
<th>ST</th>
<th>Jan 18, 2012</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** IPV SCREENING PATIENT TALLY AND PATIENT LISTING ***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening Dates: Nov 19, 2011 to Jan 18, 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This report excludes data from the PCC Clinical database</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>By Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEGATIVE</td>
</tr>
<tr>
<td>PRESENT AND PAST</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE</td>
</tr>
</tbody>
</table>
13.1.12.1.2 Tally/List IPV/DV Screenings (DVS)

The 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. Do the following:

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.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied: (0-11)” prompt, select the items to be tallied (Figure 13-28).

Figure 13-29: List of options from which to tally the report

- The response must be a list or range similar to: 1,3,5 or 2-4,8.
4. At the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt, type one of the following:
   - Type Y to include the screenings
• Type N to not include the screenings

5. At the “Would you like a list of visits w/screenings done?” prompt, type one of the following:
   • Type N to not include the list of patients
   • Type Y to continue

6. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-29 shows the list of options to sort. The default is H (Health Record Number). Do the following:

```
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

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   • I (include all patients)
   • E (exclude demo patients)
   • O (include only demo patients)
   • At the “DEVICE” prompt, type the device to output the report.

Figure 13-30 shows the sample report:

```
ST                              Jan 18, 2012                       Page 1
***  IPV SCREENING VISIT TALLY AND VISIT LISTING  ***
Screening Dates: Oct 20, 2011 to Jan 18, 2012
This report excludes PCC Clinics

---------------------------------------------------------------------------------------------------------------------------------------
#      % of patients
Total Number of Visits with Screening         2
Total Number of Patients screened         2
By Result
  NEGATIVE         1       50.0%
  PRESENT AND PAST         1       50.0%
By Age
  29 yrs         1       50.0%
---------------------------------------------------------------------------------------------------------------------------------------
```
56 yrs 1 50.0%

By Provider who screened

Enter RETURN to continue or '^' to exit:

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIII, JESSICA</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>GAMMA, RYAN</td>
<td>1</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

By Primary Provider of Visit

GAMMA, RYAN 2 100.0%

By Clinic

ALCOHOL AND SUBSTANCE 1 50.0%
BEHAVIORAL HEALTH 1 50.0%

By Date

Figure 13-31: Sample output of the IPV Screening Visit Tally and Visit Listing report

13.1.12.1.3 **List all IPV/DV Screenings for Selected Patients (ISSP)**

The report lists all patients selected who have had IPV screening or a refusal documented in a specified time frame. Do the following:

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?” prompt, type one of the following:
   - Y to include screenings
   - N to not include screenings
4. At the “Include which patients in the list” prompt, type one of the following:
   - F (FEMALES only)
   - M (MALES only)
   - B (Both MALE and FEMALES)
5. At the “Would you like to restrict the report by Patient age range?” prompt, type one of the following:
   - N to not restrict the age range
   - Y to continue
6. At the “Which result value do you want included in this list: (1-7)” prompt, type one of the selections displayed in Figure 13-31:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal/Negative</td>
</tr>
<tr>
<td>2</td>
<td>Present</td>
</tr>
<tr>
<td>3</td>
<td>Past</td>
</tr>
<tr>
<td>4</td>
<td>Present and Past</td>
</tr>
<tr>
<td>5</td>
<td>Refused</td>
</tr>
<tr>
<td>6</td>
<td>Unable to Screen</td>
</tr>
<tr>
<td>7</td>
<td>Screenings done with no result entered</td>
</tr>
</tbody>
</table>

Figure 13-32: List of options used to be included in the list

You can limit the list by doing one of the following:

- To get only those patients who have had a result of Present enter 2.
- To get all patients who had a screening result of Past or Present, enter 2,3).

7. At the “Include visits to ALL clinics?” prompt, type one of the following:

- **Y** to include the visits
- **N** to not include the visits

Figure 13-32 shows the visits used on the report.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

Figure 13-33: Options for visits to be used on the report

- Type **O** other prompts display:

8. At the “Would you like to limit the list to just patients who have a particular designated Mental Health provider?” prompt, type one of the following:

- **N** to not limit the list
- **Y** to continue:

9. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:

- **N** to not limit the list
- **Y** to continue

10. At the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt, type one of the following:

- **N** to not limit the list
• Y to continue

11. At the “Select Report Type” prompt, type one of the following:

• L (List of Patient Screenings)
• S (Create a Search Template of Patients) to continue

12. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-26 shows the list of options to sort. The default is H (Health Record Number). Do the following:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>H   Health Record Number</td>
</tr>
<tr>
<td>N   Patient Name</td>
</tr>
<tr>
<td>P   Provider who screened</td>
</tr>
<tr>
<td>C   Clinic</td>
</tr>
<tr>
<td>R   Result of Exam</td>
</tr>
<tr>
<td>D   Date Screened</td>
</tr>
<tr>
<td>A   Age of Patient at Screening</td>
</tr>
<tr>
<td>G   Gender of Patient</td>
</tr>
<tr>
<td>T   Terminal Digit HRN</td>
</tr>
</tbody>
</table>

Figure 13-34: List of options to sort the list

13. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:

• Y to display the provider on the list
• N to display the provider on the list

14. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

15. At the “DEVICE” prompt, type the device to output the report. Press Enter to display the IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS report displayed in Figure 13-34:

<table>
<thead>
<tr>
<th>XX</th>
<th>Feb 15, 2011</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS ***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening Dates: Nov 17, 2010 to Feb 15, 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT NAME</td>
<td>HRN</td>
<td>AGE</td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>ALPHA,WILLA BELLE</td>
<td>110838</td>
<td>44</td>
</tr>
<tr>
<td>DXs: 14</td>
<td>MAJOR DEPRESSIVE DISORDER</td>
<td></td>
</tr>
<tr>
<td>Primary Provider on Visit: THETA, WENDY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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)**

Type **ALC** to display the ALC Report menu shown in Figure 13-35:

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:
• 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

Note: 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 entered in a long date range like 01/01/1980 to the present date.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied” prompt, type the items to be displayed on the report.
   • The response must be a list or range similar to: 1,3,5 or 2-4,8.
4. At the “Would you like to include ALCOHOL Screenings documented in the PCC clinical database?” prompt, type one of the following:
   • Type Y to include the screenings
   • Type N to not include the screenings
5. At the “Would you like to include a list of patients screened?” prompt, type one of the following
   • Type N to not include the list
   • Type Y to continue
6. At the “How would you like the report sorted” prompt, type only one of the items in the list provided by the application.
7. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
• Y to display the patient’s Designated Providers
• N (No) to bypass this option.

8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
• I (include all patients)
• E (exclude demo patients)
• O (include only demo patients)

9. At the “Do you wish to” prompt, type one of the following:
• P (print output)
• Type B (browse output on screen) to display the Tally/List Patients with Alcohol Screenings report shown in Figure 13-36:

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Patients</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>screened</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEGATIVE</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>POSITIVE</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>REFUSED SCREENING</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td>75.0%</td>
</tr>
<tr>
<td>M</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>By Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 yrs</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>27 yrs</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>44 yrs</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>48 yrs</td>
<td>1</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

Figure 13-37: Sample Tally/List Patients with Alcohol Screenings report

13.1.12.2 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 time frame.

Alcohol Screening is defined as any of the following:

• 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

Note: 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.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied” prompt, type the items to be displayed on the report.
   - The response must be a list or range similar to: 1,3,5 or 2-4,8.
4. At the “Would you like to include ALCOHOL Screenings documented in the PCC clinical database?” prompt, type one of the following:
   - Type Y to include the screenings
   - Type N to not include the screenings
5. At the “Would you like to include a list of visits w/screenings done?” prompt, type one of the following:
   - Type Y to include the list of visits w/screenings
   - Type N to not include the list of visits w/screenings
6. At the “How would you like the report sorted” prompt, type only one of the items in the list.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)
8. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
Type B (browse output on screen) to display the Duration of Care report shown in Figure 13-37:

```
*** ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING ***
Screening Dates: Sep 10, 2010 to Dec 09, 2010
This report excludes PCC Clinics

<table>
<thead>
<tr>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Visits with Screening</td>
<td>4</td>
</tr>
<tr>
<td>Total Number of Patients screen</td>
<td>4</td>
</tr>
<tr>
<td>By Result</td>
<td></td>
</tr>
<tr>
<td>NEGATIVE</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>POSITIVE</td>
<td>2 50.0%</td>
</tr>
<tr>
<td>REFUSED SCREENING</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
</tr>
<tr>
<td>FEMALE</td>
<td>3 75.0%</td>
</tr>
<tr>
<td>MALE</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Age</td>
<td></td>
</tr>
<tr>
<td>26 yrs</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>27 yrs</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>44 yrs</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>48 yrs</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Provider who screened</td>
<td></td>
</tr>
<tr>
<td>ALPHAA, GEORGE C</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>BETAA, FRANK S</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>GAMMA, MATT</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>OMICRON, STEVE N</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Primary Provider of Visit</td>
<td></td>
</tr>
<tr>
<td>ALPHAA, GEORGE C</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>BETAA, FRANK S</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>WEARY, MATT</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>OMICRON, STEVE N</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Designated Primary Care Provider</td>
<td></td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>3 75.0%</td>
</tr>
<tr>
<td>RHO00, HELEN K</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Clinic</td>
<td></td>
</tr>
<tr>
<td>ALCOHOL AND SUBSTANCE</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>MEDICAL SOCIAL SERVICES</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
<td>2 50.0%</td>
</tr>
<tr>
<td>By Date</td>
<td></td>
</tr>
<tr>
<td>Jul 25, 2006</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>Aug 09, 2006</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>Aug 17, 2006</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>Aug 23, 2006</td>
<td>1 25.0%</td>
</tr>
<tr>
<td>By Designated Mental Health Provider</td>
<td></td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>4 100.0%</td>
</tr>
<tr>
<td>By Designated Social Services Provider</td>
<td></td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>4 100.0%</td>
</tr>
<tr>
<td>By Designated A/SA Provider</td>
<td></td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>4 100.0%</td>
</tr>
<tr>
<td>PATIENT NAME</td>
<td>HRN   AGE SCREENED RESULT  CLINIC</td>
</tr>
<tr>
<td>Patient T11</td>
<td>4551   26  F 08/17/06 POSITIVE</td>
</tr>
<tr>
<td>DXs: 29.1 SCREENING FOR ALCOHOLISM</td>
<td></td>
</tr>
<tr>
<td>29.2 SCREENING FOR DRUG ABUSE</td>
<td></td>
</tr>
<tr>
<td>995.81 ADULT ABUSE (SUSPECTED), PHYSICAL</td>
<td></td>
</tr>
<tr>
<td>Primary Provider on Visit:</td>
<td>BETA, FRANK S</td>
</tr>
<tr>
<td>Provider who screened:</td>
<td>DOC22, FRANK S</td>
</tr>
</tbody>
</table>
```

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

**Note:** 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. Do the following?

Below are the prompts.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?” prompt, type one of the following:
   - Type **Y** to include the screenings
   - Type **N** to not include the screenings
4. At the “Include which patients in the list” prompt, type one of the following:
   - **F** (FEMALES only)
   - **M** (MALES only)
   - **B** (Both MALE and FEMALES)
5. At the “Would you like to restrict the report by Patient age range?” prompt, type one of the following:
   - **N** to list visits for patients in a date range
6. At the “Which result values do you want included on this list?” prompt, choose from the following:
   • 1) Normal/Negative
   • 2) Positive
   • 3) Refused
   • 4) Unable to Screen
   • 5) Screenings done with no result entered

   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).

7. At the “Include visits to ALL clinics” prompt, type one of the following:
   • Y to include visits
   • N to continue

8. At the “Report should include visits whose PRIMARY PROVIDER on the visit is” prompt, type one of the following:
   • P (Any/All Providers including Unknown)
   • U (Unknown Provider Only)
   • O (One Provider Only)

9. At the “Select which providers who performed the screening should be included” prompt, type one of the following:
   • P (Any/All Providers including Unknown)
   • U (Unknown Provider Only)
   • O (One Provider Only)

10. At the “Would you like to limit the list to just patients who have a particular designated Mental Health provider?” prompt, type one of the following:
    • N to not limit the list
    • Y to continue

11. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:
    • N to not limit the list
12. At the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt, type one of the following:
   - N to not limit the list
   - Y to continue

13. At the “Select Report Type” prompt, type one of the following:
   - L (List of Patient Screenings)
   - S (Create a Search Template of Patients).

14. At the “How would you like the report sorted” prompt, sort by only one of the items in the list.

15. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
   - Y to display the provider
   - N to not display the provider

16. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

17. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the Tally/List Alcohol Screenings report shown in Figure 13-16:

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>SCREENED</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGMAAAAA,BRITTANY LYN</td>
<td>129079</td>
<td>41</td>
<td>F 08/03/10</td>
<td>BEHAVIORAL HEALTH</td>
</tr>
<tr>
<td>Type/Result: ALCOHOL SCREENING NEGATIVE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Provider on Visit: BETA,BETAA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider who screened: BETA,BETAA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGSIG,ALICIA MARIE</th>
<th>169379</th>
<th>58</th>
<th>F 09/08/10</th>
<th>ALCOHOL AND SUBSTANC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type/Result: AUDT 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Provider on Visit: BETA,BETAA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider who screened: UNKNOWN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)

Type **DEP** to access the Depression Screening Reports menu.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSP</td>
<td>Tally/List Patients with Depression Screening</td>
</tr>
<tr>
<td>DLS</td>
<td>Tally/List Depression Screenings</td>
</tr>
<tr>
<td>DSSP</td>
<td>List all Depression Screenings / Selected Patients</td>
</tr>
<tr>
<td>DPST</td>
<td>Tally/List Pts in Search Temp w/Depression Scrn</td>
</tr>
<tr>
<td>DVST</td>
<td>Tally List all Depression Scrn for Template of Pts</td>
</tr>
</tbody>
</table>

Select Depression Screening Reports Option:

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

Note: 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. Do the following:
  1. Set the date at the “Enter Beginning Date for Screening” prompt.
  2. Set the date at the “Enter Ending Date for Screening prompt.
  3. At the “Which items should be tallied: (0-11)” prompt, select the items to be tallied (Figure 13-40).

| 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 |

Figure 13-41: List of options from which to tally the report

4. At the “Would you like to include DEPRESSION Screenings documented in the PCC clinic database?” prompt, type one of the following:
   - Y to include the screenings
   - N to not include the screenings

5. At the “Would you like to include a list of patients screened.” prompt, type one of the following:
   - N to not include the list of patients
   - Y the following screen will display Figure 13-41:

Select one of the following:

<p>| H | Health Record Number |
| N | Patient Name |
| P | Provider who screened |
| C | Clinic |</p>
<table>
<thead>
<tr>
<th>R</th>
<th>Result of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Date Screened</td>
</tr>
<tr>
<td>A</td>
<td>Age of Patient at Screening</td>
</tr>
<tr>
<td>G</td>
<td>Gender of Patient</td>
</tr>
<tr>
<td>T</td>
<td>Terminal Digit HRN</td>
</tr>
</tbody>
</table>

Figure 13-42: List of options to sort the list

- The default is H (Health Record Number).

6. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
   - Y to display the list
   - N to not display the list

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

   At the “DEVICE” prompt, type the device to output the report.

Figure 13-42 shows the sample report:

```
XXX                              Jan 18, 2012                       Page 1
***  DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING  ***
Screening Dates: Dec 19, 2011 to Jan 18, 2012
This report excludes data from the PCC Clinical database

<table>
<thead>
<tr>
<th>Total Number of Patients screened</th>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ2</td>
<td>2</td>
<td>20.0%</td>
</tr>
<tr>
<td>PHQ9</td>
<td>13</td>
<td>20.0%</td>
</tr>
<tr>
<td>PHQ9</td>
<td>16</td>
<td>20.0%</td>
</tr>
<tr>
<td>PHQ9</td>
<td>18</td>
<td>20.0%</td>
</tr>
<tr>
<td>PHQ9</td>
<td>22</td>
<td>20.0%</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Number of Patients screened</th>
<th>#</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 yrs</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td>29 yrs</td>
<td>1</td>
<td>20.0%</td>
</tr>
</tbody>
</table>
```
45 yrs  1  20.0%
62 yrs  1  20.0%
68 yrs  1  20.0%

By Provider who screened
GARCIA,RYAN  1  20.0%

PATIENT NAME          HRN    AGE    SCREENED           CLINIC
--------------------------------------------------------------------------------
BETAAAAA,MISTY DAWN  106371  29  F  12/28/11          BEHAVIORAL HEALTH
    Type/Result: PHQ9   22
    Primary Provider on Visit: GARCIA,RYAN
    Provider who screened: GARCIA,RYAN

THETAAAA,REBECCA LEE 113487  45  F  12/30/11            MENTAL HEALTH
    Type/Result: PHQ9   16
    Primary Provider on Visit: SIMGEN,DARLA
    Provider who screened: SIMGEN,DARLA

Enter RETURN to continue or '^' to exit:

Figure 13-43: Sample Tally/List Patients with Depression Screening report

13.1.12.3.2 **Tally/List Depression Screenings (DLS)**

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following:

- 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

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. Do the following:
  The application displays the following prompts:
  1. Set the date at the “Enter Beginning Date for Screening” prompt.
  2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied: (0-11)” prompt, select the items to be tallied (Figure 13-43).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not include any Tallies</td>
</tr>
<tr>
<td>1</td>
<td>Result of Screening</td>
</tr>
<tr>
<td>2</td>
<td>Gender</td>
</tr>
<tr>
<td>3</td>
<td>Age of Patient</td>
</tr>
<tr>
<td>4</td>
<td>Provider who Screened</td>
</tr>
<tr>
<td>5</td>
<td>Clinic</td>
</tr>
<tr>
<td>6</td>
<td>Date of Screening</td>
</tr>
<tr>
<td>7</td>
<td>Primary Provider on Visit</td>
</tr>
<tr>
<td>8</td>
<td>Designated MH Provider</td>
</tr>
<tr>
<td>9</td>
<td>Designated SS Provider</td>
</tr>
<tr>
<td>10</td>
<td>Designated ASA/CD Provider</td>
</tr>
<tr>
<td>11</td>
<td>Designated Primary Care Provider</td>
</tr>
</tbody>
</table>

Figure 13-44: List of options from which to tally the report

4. At the “Would you like to include DEPRESSION Screenings documented in the PCC clinic database?” prompt, type one of the following:

- **Y** to include the screenings
- **N** to not include the screenings

5. At the “Would you like a list of visits w/screenings done?” prompt, type one of the following:

- **Type N** to not include the list of patients
- **Type Y** to continue

6. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-29 shows the list of options to sort. The default is **H** (Health Record Number). Do the following:

```
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 13-45: List of options to sort the list

7. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:

- **Type N** to not display the list
- **Type Y** to display the list

8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

9. At the “DEVICE” prompt, type the device to output the report.

Figure 13-45 shows the sample report:

![Sample Report Image]

**Behavioral Health System (AMH) Version 4.0 Patch 2**

**User Manual Activity Codes and Definitions**

**April 2012**

- E (exclude demo patients)
- O (include only demo patients)

9. At the “DEVICE” prompt, type the device to output the report.

Figure 13-45 shows the sample report:

<table>
<thead>
<tr>
<th>XX</th>
<th>Jan 18, 2012</th>
<th>Page 1</th>
</tr>
</thead>
</table>

### *** DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING ***

Screening Dates: Dec 19, 2011 to Jan 18, 2012
This report excludes PCC Clinics

<table>
<thead>
<tr>
<th>Total Number of Visits with Screening</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Patients screened</td>
<td>6</td>
</tr>
</tbody>
</table>

#### By Result

| PHQ2  | 2 | 14.3% |
| PHQ9  | 13| 14.3% |
| PHQ9  | 15| 14.3% |
| PHQ9  | 16| 28.6% |
| PHQ9  | 18| 14.3% |
| PHQ9  | 22| 14.3% |

#### By Gender

| F     | 4 | 57.1% |
| M     | 3 | 42.9% |

#### By Age

| 11 yrs | 1 | 14.3% |
| 29 yrs | 1 | 14.3% |
| 45 yrs | 2 | 28.6% |
| 61 yrs | 1 | 14.3% |
| 62 yrs | 1 | 14.3% |
| 68 yrs | 1 | 14.3% |

#### By Provider who screened

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>AGE</th>
<th>SCREENED</th>
<th>CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>BETAAAAA,MISTY DAWN</td>
<td>106371</td>
<td>29</td>
<td>F 12/28/11</td>
<td>BEHAVIORAL HEALTH</td>
</tr>
<tr>
<td>Type/Result: PHQ9 22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Provider on Visit: GARCIA,RYAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider who screened: GARCIA,RYAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THETAAAA,REBECCA LEE</td>
<td>113487</td>
<td>45</td>
<td>F 12/30/11</td>
<td>MENTAL HEALTH</td>
</tr>
<tr>
<td>Type/Result: PHQ9 16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Provider on Visit: SIMGEN,DARLA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider who screened: SIMGEN,DARLA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

- 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

**Note:** 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. Do the following:

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening prompt.
3. At the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)” prompt, type one of the following:
   - Y to include screenings
   - N to not include screenings
4. At the “Include which patients in the list” prompt, type one of the following:
   - F (FEMALES only)
   - M (MALES only)
   - B (Both MALE and FEMALES)
5. At the “Would you like to restrict the report by Patient age range?” prompt, type one of the following:
6. At the “Which result values do you want included on this list” prompt, choose one of the following:

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

Figure 13-47: 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).

7. At the “Include visits to ALL clinics” prompt, type one of the following:

- Y to include visits
- N to continue

8. At the “Report should include visits whose PRIMARY PROVIDER (Figure 13-47 on the visit), type one of the following:

- P (Any/All Providers including Unknown)
- U (Unknown Provider Only)
- O (One Provider Only) to continue.

Figure 13-48: Options for visits to be used on the report

9. At the “Select which providers who performed the screening should be included” (Figure 13-48) prompt, type one of the following:

- P (Any/All Providers including Unknown)
- U (Unknown Provider Only)
- O (One Provider Only) to continue
10. At the “Would you like to limit the list to just patients who have a particular designated Mental Health provider?” prompt, type one of the following:
   - N to not limit the list
   - Y to continue:

11. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:
   - N to not limit the list
   - Y to continue

12. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:
   - N to not limit the list
   - Y to continue

13. At the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt, type one of the following:
   - N to not limit the list
   - Y to continue

14. At the “Select Report Type” prompt, type one of the following:
   - L (List of Patient Screenings)
   - S (Create a Search Template of Patients) to continue

15. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-49 shows the list of options to sort. The default is H (Health Record Number). Do the following:

Select one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Health Record Number</td>
</tr>
<tr>
<td>N</td>
<td>Patient Name</td>
</tr>
<tr>
<td>P</td>
<td>Provider who screened</td>
</tr>
<tr>
<td>C</td>
<td>Clinic</td>
</tr>
<tr>
<td>R</td>
<td>Result of Exam</td>
</tr>
<tr>
<td>D</td>
<td>Date Screened</td>
</tr>
<tr>
<td>A</td>
<td>Age of Patient at Screening</td>
</tr>
<tr>
<td>G</td>
<td>Gender of Patient</td>
</tr>
<tr>
<td>T</td>
<td>Terminal Digit HRN</td>
</tr>
</tbody>
</table>

Figure 13-50: List of options to sort the list
16. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
   - Type N to not display the list
   - Type Y to display the list

17. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)
   - At the “DEVICE” prompt, type the device to output the report. Press Enter.

Figure 13-50 shows the sample report:

![Sample Depression Screening Visit Listing for Selected Patients report](image)

Figure 13-51: 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

**Note:** 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 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

**Note:** This report will 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)
1. Type PHQ option to generate a report that lists PHQ2 and PHQ9 Scores for one patient within a date range. Do the following:

2. At the “Select PATIENT NAME” prompt, type the name of the patient.

3. Browse which subset of visits for [current patient name] and 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
a. Type N, D, or P to continue

4. At the “Limit by Clinic/Provider” prompt, type one of the following:
   - C (Visits to Selected Clinics)
   - P (Visits to Selected Providers)
   - A (Include All Visits regardless of Clinic/Provider)

Figure 13-51 displays the PHQ-2/PHQ-9 Scores for One Patient report.

<table>
<thead>
<tr>
<th>Date</th>
<th>PHQ-2</th>
<th>PHQ-9</th>
<th>PROVIDER</th>
<th>CLINIC</th>
<th>Diagnosis/POV</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/08</td>
<td>5</td>
<td>21</td>
<td>GAMMA, JOHN</td>
<td>MENT</td>
<td>311. – Depressive Disorder, Not Els</td>
</tr>
<tr>
<td>09/30/08</td>
<td>1</td>
<td></td>
<td>GAMMA, JOHN</td>
<td>MENT</td>
<td>311. – Depressive Disorder, Not Els</td>
</tr>
<tr>
<td>09/19/08</td>
<td>3</td>
<td>24</td>
<td>GAMMA, JOHN</td>
<td>MENT</td>
<td>311. – Depressive Disorder, Not Els</td>
</tr>
<tr>
<td>09/12/08</td>
<td>0</td>
<td></td>
<td>GAMMA, JOHN</td>
<td>ALCO</td>
<td>305.02 – ALCOHOL ABUSE,</td>
</tr>
<tr>
<td>07/18/06</td>
<td>4</td>
<td>19</td>
<td>DELTA, JAMES</td>
<td>BH</td>
<td>13 – SCHIZOPHRENIC DISORDER</td>
</tr>
<tr>
<td>06/01/05</td>
<td>2</td>
<td></td>
<td>GAMMA, DON</td>
<td>PC</td>
<td>311 – DEPRESSIVE DISORDER, NOS</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit

Select Action:+//

Figure 13-52: 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)

1. At the “Select Action” prompt, type 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. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt.

4. At the “Clinic Selection” prompt, type one of the following:
   - A (Visit to All Clinics)
   - C (Visits at Selected Clinic) to continue

5. At the “Provider Selection” prompt, type one of the following:
   - A (Visits to All Providers)
   - C (Visits to Selected Providers) to continue
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the PHQ-2 and PHQ-9 Scores for Multiple Patients report shown in Figure 13-52:

   ![Sample PHQ-2 and PHQ-9 Scores for Multiple Patients report]

   **Figure 13-53: Sample PHQ-2 and PHQ-9 Scores for Multiple Patients report**

### 13.1.13 Treatment Plans (TPR)

At the “Select Patient Listings Option” prompt, type **TPR** to access the Treatment Plans menu displayed in Figure 13-53

<table>
<thead>
<tr>
<th>ATP</th>
<th>Print List of All Treatment Plans on File</th>
</tr>
</thead>
<tbody>
<tr>
<td>REV</td>
<td>Print List of Treatment Plans Needing Reviewed</td>
</tr>
<tr>
<td>RES</td>
<td>Print List of Treatment Plans Needing Resolved</td>
</tr>
<tr>
<td>NOTP</td>
<td>Patients w/Case Open but no Treatment Plan</td>
</tr>
</tbody>
</table>

**Select Treatment Plans Option:**

![Options on the Treatment Plans menu]

**Figure 13-54: 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)

1. At the “Select Patient Listings Option” prompt, type TSG option to generate 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. Do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

5. At the “Do you wish to” prompt, type one of the following:
   - P (print output)

Type B (browse output on screen) to display the Patients Seen in Groups with Time Spent in Group report shown in Figure 13-54:

```
********** 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,CHRYSLE 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
```
13.2 Behavioral Health Record/Encounter Reports (REC)

Type REC to list various records from the Behavioral Health patient file that are available on the BHS Encounter/Record Reports menu (Figure 13-55).

---

**IHS Behavioral Health System**
**Encounter/Record Reports**

Version 4.0 (patch 2)

 DEMO INDIAN HOSPITAL

LIST  List Visit Records, STANDARD Output
GEN  List Behavioral Hlth Records, GENERAL RETRIEVAL

Select Behavioral Health Record/Encounter Reports Option:

---

13.2.1 List Visit Records, Standard Output (LIST)

At the Select Behavioral Health Record/Encounter Reports Option” prompt, type LIST option to generate 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. Do the following:

1. Set the date at the “Enter Beginning Date for Search” prompt.
2. Set the date at the “Enter Ending Date for Search” prompt.

Be sure to have a printer available that has 132-column print capability.

1. Set the date at the “Enter Beginning Date for Search” prompt.
2. Set the date at the “Enter Ending Date for Search” prompt.

Figure 13-56 displays the Visit Selection Menu.

---

| Patient Name | 23) Next Case Review Dat | 45) Axis V |
| Patient Sex  | 24) Appointment/Walk-In | 46) Flag (Visit Flag) |
| Patient Race | 25) Interpreter Utilized | 47) Primary Provider |
| Patient Age  | 26) Program             | 48) Primary Prov Discipl |
| Patient DOB  | 27) Visit Type          | 49) Primary Prov Affilia |
| Patient DOD  | 28) Location of Encounte| 50) Prim/Sec Providers |
| Living Patients | 29) Clinic             | 51) Prim/Sec Prov Discip |
| Chart Facility | 30) Outside Location   | 52) POV (Prim or Sec) |
| Patient Community | 31) SU of Encounter   | 53) POV (Prob Code Grps) |
| Patient County Resid | 32) County of Service | 54) Primary POV |
| Patient Tribe | 33) Community of Service| 55) POV (Problem Categor |
| Eligibility Status | 34) Activity Type     | 56) POV Diagnosis Catego |
| Class/Beneficiary | 35) Days in Residential| 57) Procedures (CPT) |
300

14) Medicare Eligibility  36) Days in Aftercare  58) Education Topics Pro
15) Medicaid Eligibility  37) Activity Category  59) Prevention Activity
16) Priv Ins Eligibility  38) Local Service Site  60) Personal History Item
17) Patient Encounters  39) Number Served  61) Designated MH Prov
18) Patient Flag Field  40) Type of Contact  62) Designated SS Prov
19) Case Open Date  41) Activity Time  63) Designated A/SA Prov
20) Case Admit Date  42) Inpatient Disposition  64) Designated Other Prov
21) Case Closed Date  43) PCC Visit Created
22) Case Disposition  44) Axis IV

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

Figure 13-57: Sample Visit Selection Menu

Use the menu in Figure 13-56 to select the visit criteria for the report.

3. At the “Type of Report to Print” prompt, type one of the following:
   • D (detailed using 132 column print)
   • B (brief (using 80 column print))

The Sort Item Selection Menu as shown in Figure 13-57:

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

Figure 13-58: Sample Sort Item Selection Menu options
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)
5. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the criteria for the report and the Behavioral Health Record Listing report shown in Figure 13-58:

   4.

<table>
<thead>
<tr>
<th>DATE</th>
<th>PROV LOC</th>
<th>PATIENT NAME</th>
<th>ACT CONT AT</th>
<th>HRN</th>
<th>PROB</th>
<th>NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/20/08</td>
<td>DG</td>
<td>WW</td>
<td>12 OUTP 30</td>
<td>WW116431</td>
<td>311.</td>
<td>DEPRESSIVE DISO</td>
</tr>
<tr>
<td>10/22/08</td>
<td>DG</td>
<td>WW</td>
<td>12 OUTP 90</td>
<td>WW116431</td>
<td>311.</td>
<td>DEPRESSIVE DISO</td>
</tr>
<tr>
<td>11/03/08</td>
<td>GHH</td>
<td>WW</td>
<td>12 OUTP 120</td>
<td>WW186121</td>
<td>V71.01</td>
<td>OBSERVATION OF</td>
</tr>
<tr>
<td>11/12/08</td>
<td>DGC</td>
<td>WW</td>
<td>05 OUTP 20</td>
<td>WW104376</td>
<td>V61.01</td>
<td>FAMILY DISRUPTI</td>
</tr>
</tbody>
</table>

   Figure 13-59: Sample Behavioral Health Record Listing report

---

13.2.2 List Behavioral Hlth Records, General Retrieval (GEN)

1. At the “Select Action” prompt, type GEN to generate 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. Do the following

   When the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

2. At the “Select and Print Encounter List from” prompt, type one of the following:
   - S (search template)
   - D (date range)
3. At the “Do you want to use a PREVIOUSLY DEFINED REPORT?” prompt, type one of the following:
- N to not use the report
- Y to continue

Figure 13-59 displays the Visit Selection Menu.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Patient Name</td>
<td>23) Next Case Review Date</td>
</tr>
<tr>
<td>2)</td>
<td>Patient Sex</td>
<td>24) Appointment/Walk-In</td>
</tr>
<tr>
<td>3)</td>
<td>Patient Race</td>
<td>25) Interpreter Utilized</td>
</tr>
<tr>
<td>4)</td>
<td>Patient Age</td>
<td>26) Program</td>
</tr>
<tr>
<td>5)</td>
<td>Patient DOB</td>
<td>27) Visit Type</td>
</tr>
<tr>
<td>6)</td>
<td>Patient DOD</td>
<td>28) Location of Encounter</td>
</tr>
<tr>
<td>7)</td>
<td>Living Patients</td>
<td>29) Clinic</td>
</tr>
<tr>
<td>8)</td>
<td>Chart Facility</td>
<td>30) Outside Location</td>
</tr>
<tr>
<td>9)</td>
<td>Patient Community</td>
<td>31) SU of Encounter</td>
</tr>
<tr>
<td>10)</td>
<td>Patient County Resid</td>
<td>32) County of Service</td>
</tr>
<tr>
<td>11)</td>
<td>Patient Tribe</td>
<td>33) Community of Service</td>
</tr>
<tr>
<td>12)</td>
<td>Eligibility Status</td>
<td>34) Activity Type</td>
</tr>
<tr>
<td>13)</td>
<td>Class/Beneficiary</td>
<td>35) Days in Residential</td>
</tr>
<tr>
<td>14)</td>
<td>Medicare Eligibility</td>
<td>36) Days in Aftercare</td>
</tr>
<tr>
<td>15)</td>
<td>Medicaid Eligibility</td>
<td>37) Activity Category</td>
</tr>
<tr>
<td>16)</td>
<td>Priv Ins Eligibility</td>
<td>38) Local Service Site</td>
</tr>
<tr>
<td>17)</td>
<td>Patient Encounters</td>
<td>39) Number Served</td>
</tr>
<tr>
<td>18)</td>
<td>Patient Flag Field</td>
<td>40) Type of Contact</td>
</tr>
<tr>
<td>19)</td>
<td>Case Open Date</td>
<td>41) Activity Time</td>
</tr>
<tr>
<td>20)</td>
<td>Case Admit Date</td>
<td>42) Inpatient Disposition</td>
</tr>
<tr>
<td>21)</td>
<td>Case Closed Date</td>
<td>43) PCC Visit Created</td>
</tr>
<tr>
<td>22)</td>
<td>Case Disposition</td>
<td>44) Axis IV</td>
</tr>
</tbody>
</table>

+ 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: Sample Visit Selection Menu options

4. At the “Choose Type of Report” prompt, type one of the following:
   - T (Total Count Only), S (Subcounts and Total Count)
   - D (Detailed Listing)
   - F (Flag ASCII file (predefined record format)).

Figure 13-60 displays the Print Item Selection Menu.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
5. Select the data items to be used on the report and type Q at the Select Actions” prompt. Use the Q option when you have completed your selections. The Sort Item Selection Menu displays as shown in Figure 13-61:

Figure 13-61: Print Item Selection Menu options
6. At the “Do you want a separate page for each Visit Date?” prompt, type one of the following:
   - Y to create a separate page
   - N to not create a separate page

7. At the “Would you like a custom title for this report?” prompt, type one of the following:
   - N to not create a custom title
   - Y to continue

8. At the “Do you wish to save this search/print/sort logic for future use?” prompt, type one of the following:
   - N (logic is not saved)
   - Y to continue

9. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

10. At the “Do you wish to” prompt, type one of the following:
    - P (print output)
    - Type B (browse output on screen) to display the criteria for the report.

11. Press Enter to display the BH Visit Listing report shown in Figure 13-62:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
BH Visit Listing                                       Page 1
Record Dates: JAN 14, 2009 and JUL 13, 2009

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DOB</th>
<th>HRN</th>
<th>PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALPHAA, CHELSEA MARIE</td>
<td>02/07/1975</td>
<td>WW116431</td>
<td>MENTAL</td>
</tr>
<tr>
<td>SIGMA, ALBERT TILLMAN</td>
<td>02/07/1975</td>
<td>WW164141</td>
<td>OTHER</td>
</tr>
<tr>
<td>SIGMA, ALBERT TILLMAN</td>
<td>02/07/1975</td>
<td>WW164141</td>
<td>MENTAL</td>
</tr>
</tbody>
</table>
```
13.3 Workload/Activity Reports (WL)

Type **WL** to view the Activity Workload Reports menu displayed in Figure 13-63:

```
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
```

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)

1. At the “Select Workload/Activity Reports Option” prompt, type **GRS1** option to generate a report that will tally activities by service unit, facility, and provider. The report is patterned after GARS Report #1. Do the following:

2. Set the date at the “Enter Beginning Encounter Date” prompt.

3. Set the date at the “Enter Ending Encounter Date” prompt.

4. At the “Run Report for which Program” prompt, type one of the following:
   - **M**–MENTAL HEALTH
   - **S**–SOCIAL SERVICES
5. At the “Run Report for” prompt, type one of the following:
   - 2 (all providers)
   - 1 (one provider) to continue

6. At the “Include which providers” prompt, type one of the following:
   - P (Primary Provider Only)
   - S (Both Primary and Secondary Providers).

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the Activity report shown in Figure 13-64:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
XX    MAY 04, 2009Page 1
ACTIVITY REPORT FOR ALL PROGRAMS (MH, SS, CD, OTHER) PROGRAM
RECORD DATES:  FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

# RECS ACT TIME # PATS # SERVED
(hrs) ----------------------------

AREA:  TUCSON
SERVICE UNIT:  SELLS
FACILITY:  SELLS HOSP
PROVIDER:  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

Enter RETURN to continue or '^' to exit:

Figure 13-65: Sample Activity Report
```
13.3.2 Activity Report by Primary Problem (GRS2)

At the “Select Workload/Activity Reports Option” prompt, type **GRS2** to generate 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 for more information.

The Activity Report by Primary Purpose report displays as shown in Figure 13-65:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
xx                                                        MAY 04, 2009
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:  BTTAAAA,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
```

Figure 13-66: Sample Activity Report by Primary Purpose report

13.3.3 Activity Record Counts (ACT)

1. At the “Select Workload/Activity Reports Option” prompt, type **ACT** to generate 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. Do the following:

2. At the “Choose an item for calculating activity time and records counts” prompt, do the following:
3. Set the date at the “Enter beginning Visit Date for search” prompt.

4. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-66:

```
Visit Selection Menu
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.
1) Patient Name           23) Next Case Review Dat  45) Axis V
2) Patient Sex            24) Appointment/Walk-In 46) Flag (Visit Flag)
3) Patient Race           25) Interpreter Utilized 47) Primary Provider
4) Patient Age            26) Program               48) Primary Prov Discipl
5) Patient DOB            27) Visit Type            49) Primary Prov Affilia
6) Patient DOD            28) Location of Encounter 50) Prim/Sec Providers
7) Living Patients        29) Clinic                51) Prim/Sec Prov Discip
8) Chart Facility         30) Outside Location      52) POV (Prim or Sec)
9) Patient Community      31) SU of Encounter       53) POV (Prob Code Grps)
10) Patient County Resid   32) County of Service   54) Primary POV
11) Patient Tribe         33) Community of Service 55) POV (Problem Categor
12) Eligibility Status     34) Activity Type        56) POV Diagnosis Catego
13) Class/Beneficiary     35) Days in Residential  57) Procedures (CPT)
14) Medicare Eligibility   36) Days in Aftercare   58) Education Topics Pro
15) Medicaid Eligibility   37) Activity Category    59) Prevention Activity
16) Priv Ins Eligibility   38) Local Service Site   60) Personal History Ite
17) Patient Encounters O  39) Number Served         61) Designated MH Prov
18) Patient Flag Field    40) Type of Contact       62) Designated SS Provid
19) Case Open Date        41) Activity Time         63) Designated A/SA Prov
20) Case Admit Date       42) Inpatient Dispositio 64) Designated Other Pro
21) Case Closed Date      43) FCC Visit Created     65) Designated Recent
22) Case Disposition     44) Axis IV                  66) Purpose

+         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//
```

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display report criteria.
Figure 13-67 shows the Activity Record Counts report.

<table>
<thead>
<tr>
<th>PROB DSM/CODE NARRATIVE</th>
<th>CODE</th>
<th># RECS</th>
<th># PATS</th>
<th>ACTIVITY TIME</th>
<th># SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMINISTRATION</td>
<td>97</td>
<td>4</td>
<td>4</td>
<td>0.1</td>
<td>4</td>
</tr>
<tr>
<td>ALCOHOL ABUSE</td>
<td>29</td>
<td>4</td>
<td>4</td>
<td>1.2</td>
<td>4</td>
</tr>
<tr>
<td>ALCOHOL ABUSE, EPISODIC</td>
<td>305.02</td>
<td>5</td>
<td>2</td>
<td>4.1</td>
<td>5</td>
</tr>
<tr>
<td>ALCOHOL ABUSE, UNSPECIF</td>
<td>305.00</td>
<td>4</td>
<td>2</td>
<td>2.0</td>
<td>4</td>
</tr>
<tr>
<td>ALCOHOL DEPENDENCE</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>2.0</td>
<td>3</td>
</tr>
<tr>
<td>ALCOHOL DEPENDENCE, IN</td>
<td>303.93</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>2</td>
</tr>
<tr>
<td>ALCOHOLISM IN FAMILY</td>
<td>V61.41</td>
<td>4</td>
<td>4</td>
<td>0.7</td>
<td>4</td>
</tr>
<tr>
<td>AMPHETAMINE DEPENDENCE,</td>
<td>304.40</td>
<td>1</td>
<td>1</td>
<td>0.0</td>
<td>1</td>
</tr>
</tbody>
</table>

Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit

Select Action:+//

Figure 13-68: Sample Activity Record Counts report

13.3.4 Program Activity Time Reports (PROG)

At the “Select Workload/Activity Reports Option” prompt, type PROG to create 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.

**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 for more information.

The application displays the record selection criteria. Press Enter to display the Program Activity Time report shown in Figure 13-68:

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>NO. OF RECORDS</th>
<th>NO. OF PATIENTS</th>
<th>ACTIV TIME</th>
<th>NO. OF RECORDS</th>
<th>NO. OF PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH AND SOCIAL SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL SERVICES AND MENTAL HEALTH COMBINED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Activity Codes and Definitions

**Behavioral Health System (AMH) Version 4.0 Patch 2**

**User Manual Activity Codes and Definitions**

April 2012

<table>
<thead>
<tr>
<th>ALPHA,AAA</th>
<th>15</th>
<th>7</th>
<th>3.6</th>
<th>2</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>BETA,BETAA</td>
<td>33</td>
<td>18</td>
<td>22.6</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>BETAAAA,LORI</td>
<td>16</td>
<td>6</td>
<td>5.0</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>CAAAA,JESSICA</td>
<td>9</td>
<td>2</td>
<td>6.3</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>DEMO,CASE M</td>
<td>1</td>
<td>1</td>
<td>0.0</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>DEMO,DOCTOR</td>
<td>1</td>
<td>1</td>
<td>0.2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>NUUUUUU,AMY J</td>
<td>3</td>
<td>3</td>
<td>2.0</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>GAMMMA,RYAN</td>
<td>106</td>
<td>30</td>
<td>66.3</td>
<td>24</td>
<td>5</td>
</tr>
</tbody>
</table>

**** Patient Count TOAL is not an unduplicated count.

Enter ?? for more actions

+    Next Screen          -    Previous Screen      Q    Quit

Select Action:+//

---

**Figure 13-69: Sample Program Activity Time report**

#### 13.3.5 Frequency of Activities (FACT)

1. At the “Select Workload/Activity Reports Option” prompt, type FACT option to generate a report that will generate a list of the top \( N \) Activity Codes for selected visits. Do the following:

   Below are the prompts.

2. Set the date at the “Enter beginning Visit Date for search” prompt.

3. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-69:

---

**Figure 13-69: Sample Program Activity Time report**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Patient Name</td>
<td>23) Next Case Review Dat</td>
<td>45) Axis V</td>
</tr>
<tr>
<td>2) Patient Sex</td>
<td>24) Appointment/Walk-In</td>
<td>46) Flag (Visit Flag)</td>
</tr>
<tr>
<td>3) Patient Race</td>
<td>25) Interpreter Utilized</td>
<td>47) Primary Provider</td>
</tr>
<tr>
<td>4) Patient Age</td>
<td>26) Program</td>
<td>48) Primary Prov Discipl</td>
</tr>
<tr>
<td>5) Patient DOB</td>
<td>27) Visit Type</td>
<td>49) Primary Prov Affilia</td>
</tr>
<tr>
<td>6) Patient DOD</td>
<td>28) Location of Encounter</td>
<td>50) Prim/Sec Providers</td>
</tr>
<tr>
<td>7) Living Patients</td>
<td>29) Clinic</td>
<td>51) Prim/Sec Prov Discip</td>
</tr>
<tr>
<td>8) Chart Facility</td>
<td>30) Outside Location</td>
<td>52) POV (Prim or Sec)</td>
</tr>
<tr>
<td>9) Patient Community</td>
<td>31) SU of Encounter</td>
<td>53) POV (Prob Code Grps)</td>
</tr>
<tr>
<td>10) Patient County Resid</td>
<td>32) County of Service</td>
<td>54) Primary POV</td>
</tr>
<tr>
<td>11) Patient Tribe</td>
<td>33) Community of Service</td>
<td>55) POV (Problem Categ</td>
</tr>
<tr>
<td>12) Eligibility Status</td>
<td>34) Activity Type</td>
<td>56) POV Diagnosis Categ</td>
</tr>
<tr>
<td>13) Class/Beneficiary</td>
<td>35) Days in Residential</td>
<td>57) Procedures (CPT)</td>
</tr>
<tr>
<td>14) Medicare Eligibility</td>
<td>36) Days in Aftercare</td>
<td>58) Education Topics Pro</td>
</tr>
<tr>
<td>15) Medicaid Eligibility</td>
<td>37) Activity Category</td>
<td>59) Prevention Activity</td>
</tr>
<tr>
<td>16) Priv Ins Eligibility</td>
<td>38) Local Service Site</td>
<td>60) Personal History Ite</td>
</tr>
<tr>
<td>17) Patient Encounters O</td>
<td>39) Number Served</td>
<td>61) Designated MH Prov</td>
</tr>
<tr>
<td>18) Patient Flag Field</td>
<td>40) Type of Contact</td>
<td>62) Designated SS Provid</td>
</tr>
<tr>
<td>19) Case Open Date</td>
<td>41) Activity Time</td>
<td>63) Designated A/SA Prov</td>
</tr>
<tr>
<td>20) Case Admit Date</td>
<td>42) Inpatient Dispositio</td>
<td>64) Designated Other Pro</td>
</tr>
<tr>
<td>21) Case Closed Date</td>
<td>43) PCC Visit Created</td>
<td></td>
</tr>
</tbody>
</table>
4. At the “Select Type of Report” prompt, type one of the following:
   • L (list of items with counts)
   • B (Bar Chart, requires 132 column printer)
5. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   • I (include all patients)
   • E (exclude demo patients)
   • O (include only demo patients)
7. At the “Do you wish to” prompt, type one of the following:
   • P (print output)
   • Type B (browse output on screen) to display the criteria for the report.
8. Press Enter to display the Frequency of Activities report shown in Figure 13-70:
13.3.6 Frequency of Activities by Category (FCAT)

At the “Select Workload/Activity Reports Option” prompt, type FCAT to create 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 for more information.

Figure 13-71 displays the Frequency of Activities by Category report.

<table>
<thead>
<tr>
<th>No.</th>
<th>ACTIVITY CATEGORY</th>
<th>CATEGORY CODE</th>
<th># RECS</th>
<th>ACT TIME (HRS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>PATIENT SERVICES</td>
<td>P</td>
<td>943</td>
<td>556778.2</td>
</tr>
<tr>
<td>2.</td>
<td>SUPPORT SERVICES</td>
<td>S</td>
<td>56</td>
<td>52.9</td>
</tr>
<tr>
<td>3.</td>
<td>ADMINISTRATION</td>
<td>A</td>
<td>21</td>
<td>26.6</td>
</tr>
<tr>
<td>4.</td>
<td>PLACEMENTS</td>
<td>PL</td>
<td>6</td>
<td>2.8</td>
</tr>
<tr>
<td>5.</td>
<td>COMMUNITY SERVICES</td>
<td>C</td>
<td>2</td>
<td>9.0</td>
</tr>
<tr>
<td>6.</td>
<td>EDUCATION/TRAINING</td>
<td>E</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>7.</td>
<td>CULTURALLY ORIENTED</td>
<td>O</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>8.</td>
<td>TRAVEL</td>
<td>T</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0
End of report. PRESS ENTER:

Figure 13-72: Sample Frequency of Activities by Category report

13.3.7 Tally of Prevention Activities (PA)

1. At the “Select Workload/Activity Reports Option” prompt, type 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. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt.

4. At the “Run the Report for which Program” prompt, type one of the following:
   - A (All Programs)
   - O (One Program) to continue

5. At the “Enter a code indicating which providers are of interest” prompt, type one of the following:
   - A (all providers)
O (one provider) to continue

S (Select set or Taxonomy of Providers) to continue

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

7. At the “DEVICE” prompt, type the device to output the report.

Figure 13-72 shows the Tally of Prevention Activities report:

<table>
<thead>
<tr>
<th>VISIT Date Range: FEB 03, 2009 through MAY 04, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENTION ACTIVITY</td>
</tr>
<tr>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Total # Visits w/Prevention Activity:</td>
</tr>
<tr>
<td>Total # of Prevention Activities recorded:</td>
</tr>
<tr>
<td>AIDS/HIV</td>
</tr>
<tr>
<td>YOUTH</td>
</tr>
<tr>
<td>OTHER</td>
</tr>
<tr>
<td>NOT RECORDED</td>
</tr>
<tr>
<td>PUBLIC AWARENESS</td>
</tr>
<tr>
<td>NOT RECORDED</td>
</tr>
<tr>
<td>SELF-AWARENESS/VALUES</td>
</tr>
<tr>
<td>ADULT</td>
</tr>
<tr>
<td>SMOKING/TOBACCO</td>
</tr>
<tr>
<td>YOUTH</td>
</tr>
</tbody>
</table>

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 13-73: Sample Tally of Prevention Activities report
13.4 Problem Specific Reports (PROB)

At the “Select Workload/Activity Reports Option” prompt, type **PROB** to create a list of BH issues of concern to providers, managers, and administrators from a clinical and public health perspective. Figure 13-73 shows the Problem Specific Reports menu.

```
**********************************************
**       IHS Behavioral Health System       **
**         Problem Specific Reports         **
**********************************************
Version 4.0 (patch 2)
DEMO INDIAN HOSPITAL

ABU    Abuse Report (Age&Sex)
FDSM   Frequency of Problems
FPRB   Frequency of Problems (Problem Code Groupings)
FPRC   Frequency of Problems by Problem Category
SUIC   Suicide Related Reports ...
```

Figure 13-74: Options on the Problem Specific Reports menu

13.4.1 Abuse Report (ABU)

1. At the “Select Problem Specific Reports Option” prompt, type **ABU** to create a report that focuses on patients who might have been victims of abuse or neglect. The report will include: by age and sex, the number of individual patients who were seen for the following Purpose of Visit (POV)—the application displays the POVs. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt to display the Age Groups prompt.

4. At the “Do you wish to modify these age groups? Prompt, type one of the following:
   - **N** to not modify the age groups
   - **Y** to continue

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:
315

• **P** (print output)
• Type **B** (browse output on screen) to display the Abuse by Age and Sex report.
  – A 132-column printer is needed to print the report.

### 13.4.2 Frequency of Problems (FDSM)

1. At the “Select Problem Specific Reports Option” prompt, type **FDSM** to create a report that shows a list of the top \( N \) Problem/POV for selected visits. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt.

Figure 13-74 shows the Visit Selection Menu.

![Visit Selection Menu](image_url)

**Figure 13-75: Sample Visit Selection Menu options**

4. At the “Include which POVs” prompt, type one of the following:
- **P** (Primary POV only)
- **S** (Primary and Secondary POVs)

5. At the “Select Type of Report” prompt, type one of the following:
   - **L** (list of items with counts)
   - **B** (Bar Chart, requires 132 column printer)

6. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Frequency of Problems report shown in Figure 13-75:

```
JUN 09, 2009                                                      Page 1
DEMO INDIAN HOSPITAL

TOP 10 Problem/POV's.
PRIMARY POV Only
DATES: MAR 11, 2009 TO JUN 09, 2009

<table>
<thead>
<tr>
<th>No.</th>
<th>PROB DSM/CODE NARRATIVE</th>
<th>CODE</th>
<th># RECS</th>
<th>ACT TIME (HRS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>DEPRESSIVE DISORDER NOS</td>
<td>311.</td>
<td>150</td>
<td>114.8</td>
</tr>
<tr>
<td>2.</td>
<td>ANXIETY DISORDER NOS</td>
<td>300.00</td>
<td>52</td>
<td>28.8</td>
</tr>
<tr>
<td>3.</td>
<td>CROSS-CULTURAL CONFLICT</td>
<td>2</td>
<td>48</td>
<td>35.5</td>
</tr>
<tr>
<td>4.</td>
<td>SCHIZOPHRENIA, DISORGANIZED TY</td>
<td>295.15</td>
<td>33</td>
<td>26.1</td>
</tr>
<tr>
<td>5.</td>
<td>PARANOID PERSONALITY DISORDER</td>
<td>301.0</td>
<td>32</td>
<td>21.1</td>
</tr>
<tr>
<td>6.</td>
<td>PHYSICAL ILLNESS,ACUTE</td>
<td>5</td>
<td>32</td>
<td>22.9</td>
</tr>
<tr>
<td>7.</td>
<td>DEMENTIA OF THE ALZHEIMER'S TY</td>
<td>290.0</td>
<td>31</td>
<td>27.4</td>
</tr>
<tr>
<td>8.</td>
<td>MARITAL PROBLEM</td>
<td>56</td>
<td>25</td>
<td>7.9</td>
</tr>
<tr>
<td>9.</td>
<td>HEALTH/HOMEMAKER NEEDS</td>
<td>1</td>
<td>21</td>
<td>17.6</td>
</tr>
<tr>
<td>10.</td>
<td>MAJOR DEPRESSIVE DISORDER, REC</td>
<td>296.32</td>
<td>20</td>
<td>32.3</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0
End of report. PRESS ENTER:
```

Figure 13-76: Sample Frequency of Problems report
13.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

1. At the “Select Problem Specific Reports Option” prompt, type **FPRB** to create a report that shows a list of the top \( N \) Problem/POV for visits that you select. Do the following:

2. Set the date at the “Enter beginning Visit Date for search” prompt.

3. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-76:

```
Visit Selection Menu
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type           49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounter 50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic               51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location     52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter      53)  POV (Prob Code Grps)
10) Patient County Resid    32)  County of Service    54)  Primary POV
11) Patient Tribe          33)  Community of Service 55)  POV (Problem Categor
12) Eligibility Status      34)  Activity Type        56)  POV Diagnosis Catego
13) Class/Beneficiary      35)  Days in Residential  57)  Procedures (CPT)
14) Medicare Eligibility    36)  Days in Aftercare    58)  Education Topics Pro
15) Medicaid Eligibility    37)  Activity Category    59)  Prevention Activity
16) Priv Ins Eligibility    38)  Local Service Site   60)  Personal History Ite
17) Patient Encounters O    39)  Number Served       61)  Designated MH Prov
18) Patient Flag Field      40)  Type of Contact     62)  Designated SS Provid
19) Case Open Date         41)  Activity Time        63)  Designated A/SA Prov
20) Case Admit Date        42)  PCC Visit Created   64)  Designated Other Pro
21) Case Closed Date        43)  Inpatient Dispositio 65)  Designated Other Pro
22) Case Disposition       44)  Axis IV

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

Figure 13-77: Sample Visit Selection Menu options

4. At the “Include which POVs” prompt, type one of the following:
   - **P** (Primary POV only)
   - **S** (Primary and Secondary POVs)

5. At the “Select Type of Report” prompt, type one of the following:
   - **L** (list of items with counts)
• **B** (Bar Chart, requires 132 column printer)

6. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Frequency of Problems by Category report shown in Figure 13-77:

```
JUN 09, 2009                                                     Page 1
DEMO INDIAN HOSPITAL
TOP 10 POV/Problem (Problem Code)'s.
PRIMARY POV Only
DATES: MAR 11, 2009 TO JUN 09, 2009

<table>
<thead>
<tr>
<th>No.</th>
<th>PROB CODE</th>
<th>NARRATIVE</th>
<th>PROBLEM (POV) CODE#</th>
<th>RECS</th>
<th>ACT TIME (HRS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>MAJOR DEPRESSIVE DISORDERS</td>
<td>14</td>
<td>123</td>
<td>94.2</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>ANXIETY DISORDER</td>
<td>18</td>
<td>30</td>
<td>14.2</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>SCHIZOPHRENIC DISORDER</td>
<td>13</td>
<td>29</td>
<td>25.8</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>CROSS-CULTURAL CONFLICT</td>
<td>2</td>
<td>19</td>
<td>15.0</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>MARITAL PROBLEM</td>
<td>56</td>
<td>18</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>ALCOHOL ABUSE</td>
<td>29</td>
<td>16</td>
<td>14.1</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>ILLNESS IN FAMILY</td>
<td>55</td>
<td>16</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>HOUSING</td>
<td>80</td>
<td>15</td>
<td>8.0</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>SENILE OR PRE-SENILE CONDITION</td>
<td>9</td>
<td>14</td>
<td>9.7</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>BIPOLAR DISORDER</td>
<td>15</td>
<td>13</td>
<td>5.2</td>
<td></td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0
End of report. PRESS ENTER:
```

Figure 13-78: Sample Frequency of Problem by groupings report

### 13.4.4 Frequency of Problems by Problem Category (FPRC)

1. At the “Select Problem Specific Reports Option” prompt, type **FPRC** to create a report that generates a list of the top N Problem/POV (Problem Category) for selected visits. Do the following:

2. Set the date at the “Enter beginning Visit Date for search” prompt.

3. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-78:
Visit Selection Menu

Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.

1) Patient Name  23) Next Case Review Date  45) Axis V
2) Patient Sex  24) Appointment/Walk-In  46) Flag (Visit Flag)
3) Patient Race  25) Interpreter Utilized  47) Primary Provider
4) Patient Age  26) Program  48) Primary Prov Discipl
5) Patient DOB  27) Visit Type  49) Primary Prov Affiliation
6) Patient DOD  28) Location of Encounter  50) Prim/Sec Providers
7) Living Patients  29) Clinic  51) Prim/Sec Prov Discipl
8) Chart Facility  30) Outside Location  52) POV (Prim or Sec)
9) Patient Community  31) SU of Encounter  53) POV (Prob Code Grps)
10) Patient County Resid  32) County of Service  54) Primary POV
11) Patient Tribe  33) Community of Service  55) POV (Problem Categor
12) Eligibility Status  34) Activity Type  56) POV Diagnosis Categor
13) Class/Beneficiary  35) Days in Residential  57) Procedures (CPT)
14) Medicare Eligibility  36) Days in Aftercare  58) Education Topics Pro
15) Medicaid Eligibility  37) Activity Category  59) Prevention Activity
16) Priv Ins Eligibility  38) Local Service Site  60) Personal History Item
17) Patient Encounters O  39) Number Served  61) Designated MH Prov
18) Patient Flag Field  40) Type of Contact  62) Designated SS Provider
19) Case Open Date  41) Activity Time  63) Designated A/SA Prov
20) Case Admit Date  42) Discharge Date  64) Designated Other Prov
21) Case Closed Date  43) PCC Visit Created
22) Case Disposition  44) Axis IV

+ Enter ?? for more actions
S Select Item(s) + Next Screen  Q Quit Item Selection
R Remove Item(s) - Previous Screen  E Exit Report
Select Action: S/
8. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display record selection criteria.

9. Press Enter to display the Frequency of Problems by Category report shown in Figure 13-79:

```
JUN 09, 2009
DEMO INDIAN HOSPITAL

TOP 10 Problem/POV (Problem Category)'s.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

<table>
<thead>
<tr>
<th>No.</th>
<th>CATEGORY NARRATIVE</th>
<th>CATEGORY CODE</th>
<th># RECS</th>
<th>ACT TIME (HRS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>PSYCHOSOCIAL PROBLEMS</td>
<td>2</td>
<td>294</td>
<td>220.6</td>
</tr>
<tr>
<td>2.</td>
<td>MEDICAL/SOCIAL PROBLEMS</td>
<td>1</td>
<td>73</td>
<td>598.6</td>
</tr>
<tr>
<td>3.</td>
<td>FAMILY LIFE PROBLEMS</td>
<td>5</td>
<td>37</td>
<td>11.5</td>
</tr>
<tr>
<td>4.</td>
<td>SOCIOECONOMIC PROBLEMS</td>
<td>8</td>
<td>27</td>
<td>12.4</td>
</tr>
<tr>
<td>5.</td>
<td>ADMINISTRATIVE PROBLEM</td>
<td>11</td>
<td>14</td>
<td>11.5</td>
</tr>
<tr>
<td>6.</td>
<td>ABUSE</td>
<td>3</td>
<td>10</td>
<td>5.1</td>
</tr>
<tr>
<td>7.</td>
<td>OTHER PATIENT RELATED</td>
<td>13</td>
<td>6</td>
<td>12.3</td>
</tr>
<tr>
<td>8.</td>
<td>EDUCATIONAL/LIFE PROBLEMS</td>
<td>10</td>
<td>8</td>
<td>5.9</td>
</tr>
<tr>
<td>9.</td>
<td>SCREENING</td>
<td>12</td>
<td>7</td>
<td>4.9</td>
</tr>
<tr>
<td>10.</td>
<td>PREGNANCY/CHILDBIRTH PROBLEMS</td>
<td>6</td>
<td>6</td>
<td>1.8</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.1
End of report. PRESS ENTER:
```

Figure 13-80: Sample Frequency of Problems by Problem Category report

13.4.5 Suicide Related Reports (SUIC)

Type SUIC to access the Suicide Reports menu shown in Figure 13-80:

```
***********************************************************************
** 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 13-81: Options on Suicide Report menu
13.4.5.1 Aggregate Suicide Form Data–Standard (SSR)

1. At the “Select Problem Specific Reports Option” prompt, type SSR to create a report that tallies the data items to the Suicide Form for a date range, community, and type of suicidal behavior (specified by the user). Do the following:

2. Set the date at the “Enter Beginning Date of Suicide Act prompt.

3. Set the date at the “Enter Ending Date of Suicide Act prompt.

4. At the “Report on Suicide Forms for Suicide Acts that occurred in” prompt, type one of the following:
   - O (One particular Community)
   - A (All Communities).

5. At the “Include which Suicidal Behaviors (0–9)” prompt, type the associated number.

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the Aggregate Suicide Form Data–Standard report shown in Figure 13-81:

---

### DEMO INDIAN HOSPITAL  
Jul 13, 2009

***** AGGREGATE SUICIDE FORM DATA - STANDARD*****

**Act Occurred: Jan 14, 2009 - Jul 13, 2009**

**Community where Act Occurred: ALL Communities**

---

**Age Range: 20-24 years**

**Total # of Suicide Forms: 1**

**REPORT TOTALS**

- **Suicidal Behavior:** ATT SUICIDE W/ ATT HOMICIDE  1  100%
- **Event logged by Discipline:** PSYCHIATRIST  1  100%
- **Event logged by Provider:** GAMMAA, RYAN  1  100%
- **Sex:** MALE  1  100%
- **Employed:** PART-TIME  1  100%
- **Tribe of Enrollment:** CHEROKEE NATION OF OKLAHOMA  1  100%
- **Community of Residence:** WELLLING  1  100%
- **Relationship:** MARRIED  1  100%
- **Education:** COLLEGE GRADUATE  1  100%
- **Method:** GUNSHOT 1  100%
- **HANGING** 1  100%
- **Previous Attempts:** 1  100%
- **Substance Use Involved:** NONE  1  100%
13.4.5.2 Aggregate Suicide Form Data - Selected Variables (SAV)
This report will tally the selected data items for Suicide Forms in a 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 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.

1. At the “Enter Beginning Visit Date” prompt, type the beginning visit date.
2. At the “Enter Ending Visit Date” prompt, type the ending visit date.

3. At the “Run the Report for which Program” prompt, type one of the following:
   - A (all programs)
   - O (one program) to continue

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - I (include all patients)
   - E (exclude demo patients)
   - O (include only demo patients)

5. At the “Do you wish to” prompt, type one of the following:
   - P (print output)
   - Type B (browse output on screen) to display the Suicide Purpose of Visit report shown in Figure 13-82:

   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

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th># Encs</th>
<th># w POV 39</th>
<th>w/ POV 40</th>
<th>w/ POV 41</th>
<th>w/ 39/40/41</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>1-4 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>5-9 yrs</td>
<td>2</td>
<td>10.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>10-14 yrs</td>
<td>7</td>
<td>35.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>15-19 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>20-24 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>25-34 yrs</td>
<td>6</td>
<td>30.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>35-44 yrs</td>
<td>2</td>
<td>10.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>45-54 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>55-64 yrs</td>
<td>1</td>
<td>5.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>75-84 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>85+ yrs</td>
<td>2</td>
<td>10.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
</tbody>
</table>

   MALE PATIENTS VISITS

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th># Encs</th>
<th># w POV 39</th>
<th>w/ POV 40</th>
<th>w/ POV 41</th>
<th>w/ 39/40/41</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>1-4 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>5-9 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>10-14 yrs</td>
<td>6</td>
<td>66.7</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>15-19 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>20-24 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>25-34 yrs</td>
<td>2</td>
<td>22.2</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
<tr>
<td>35-44 yrs</td>
<td>1</td>
<td>11.1</td>
<td>0</td>
<td>0.0</td>
<td>0/0/0</td>
</tr>
</tbody>
</table>
### FEMALE PATIENTS VISITS

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th># Encs</th>
<th>w POV 39</th>
<th>w/ POV 40</th>
<th>w/ POV 41</th>
<th>w/ 39/40/41</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-54 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>55-64 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>75-84 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>85+ yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
</tbody>
</table>

### UNDUPPLICATE PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th># Encs</th>
<th>w POV 39</th>
<th>w/ POV 40</th>
<th>w/ POV 41</th>
<th>w/ 39/40/41</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-54 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>55-64 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>75-84 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>85+ yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
</tbody>
</table>

### UNDUPPLICATE PATIENT COUNT - MALE PATIENTS

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th># Encs</th>
<th>w POV 39</th>
<th>w/ POV 40</th>
<th>w/ POV 41</th>
<th>w/ 39/40/41</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-54 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>55-64 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>75-84 yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>85+ yrs</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>13</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
</tbody>
</table>
13.5 Print Standard Behavioral Health Tables (TABL)

Type **TABL** to print the various BH tables (activity code, clinical codes, BH Problem/DSM IV, and BH Problem Codes).

The TABL (Figure 13-83) displays the Print BH Standard Tables menu.

```
ACT   Print Activity Code Table
CLN   Print Clinic Codes
DSM   Print Behavioral Health Problem/DSM IV Table
PROB  Print Behavioral Health Problem Codes
```

**Figure 13-84: Options on the Print BH Standard Tables menu**
13.5.1 Print Activity Code Table (ACT)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type ACT. This report will print either to a printer or screen (Figure 13-84), a list of all activity codes. It will list the code, short description, the category, and whether the code passes to PCC.

```
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CATEGORY</th>
<th>PCC</th>
<th>MNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>TWELVE STEP WORK - GROUP</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>TSG</td>
</tr>
<tr>
<td>02</td>
<td>TWELVE STEP WORK - INDIVIDUAL</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>TSI</td>
</tr>
<tr>
<td>03</td>
<td>TWELVE STEP GROUP</td>
<td>PATIENT SERV</td>
<td>NO</td>
<td>TWG</td>
</tr>
<tr>
<td>04</td>
<td>RE-ASSESSMENT, PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>RAS</td>
</tr>
<tr>
<td>05</td>
<td>RE-ASSESSMENT, PATIENT NOT PRESENT</td>
<td>SUPPORT SERV</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>SCREENING-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>SCN</td>
</tr>
<tr>
<td>12</td>
<td>ASSESSMENT/EVALUATION-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>EVL</td>
</tr>
<tr>
<td>13</td>
<td>INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>IND</td>
</tr>
<tr>
<td>14</td>
<td>FAMILY/GROUP TREATMENT-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>FAM</td>
</tr>
<tr>
<td>15</td>
<td>INFORMATION AND/ OR REFERRAL-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>REF</td>
</tr>
<tr>
<td>16</td>
<td>MEDICATION/MEDICATION MONITORING-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>MED</td>
</tr>
<tr>
<td>17</td>
<td>PSYCHOLOGICAL TESTING-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>TST</td>
</tr>
<tr>
<td>18</td>
<td>FORENSIC ACTIVITIES-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>FOR</td>
</tr>
<tr>
<td>19</td>
<td>DISCHARGE PLANNING-PATIENT PRESENT</td>
<td>PATIENT SERV</td>
<td>YES</td>
<td>DSG</td>
</tr>
</tbody>
</table>

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

Figure 13-85: Sample Behavioral Health Activity Codes report

13.5.2 Print Clinic Codes (CLN)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type CLN to print the activity code table displayed in Figure 13-85:

```
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>ALCOHOL AND SUBSTANCE</td>
<td>A3</td>
</tr>
<tr>
<td>35</td>
<td>AMBULANCE</td>
<td>D1</td>
</tr>
<tr>
<td>35</td>
<td>ANTICOAGULATION THERAPY</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>AUDIOLOGY</td>
<td></td>
</tr>
</tbody>
</table>
```

Enter RETURN to continue or '^' to exit:
### 13.5.3 Print Behavioral Health Problem/DSM IV Table (DSM)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type **DSM**. This report will print either to a printer or the screen, a list of all active Problem/DSM codes. It will list the code, narrative, the 2-digit problem code it is mapped to and the ICD9-Diagnosis code it is mapped to, as shown in Figure 13-86:

```
XX                                      May 04, 2009                Page 1

********** BEHAVIORAL HEALTH PROBLEM/DSM CODES **********

<table>
<thead>
<tr>
<th>CODE</th>
<th>NARRATIVE</th>
<th>PROBLEM CODE</th>
<th>ICD-9 CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>.9999</td>
<td>UNCODED DIAGNOSIS</td>
<td>99.9</td>
<td>.9999</td>
</tr>
<tr>
<td>010.00</td>
<td>PRIM TB COMPLEX-UNSPEC</td>
<td>99.9</td>
<td>010.00</td>
</tr>
<tr>
<td>011.41</td>
<td>TB LUNG FIBROSIS-NO EXAM</td>
<td>6.1</td>
<td>011.41</td>
</tr>
<tr>
<td>030.9</td>
<td>LEPROSY NOS</td>
<td>99.9</td>
<td>030.9</td>
</tr>
<tr>
<td>034.0</td>
<td>STREP SORE THROAT</td>
<td>5</td>
<td>034.0</td>
</tr>
<tr>
<td>054.10</td>
<td>GENITAL HERPES NOS</td>
<td>99.9</td>
<td>054.10</td>
</tr>
<tr>
<td>1</td>
<td>HEALTH/HOMEMAKER NEEDS</td>
<td>1</td>
<td>V60.4</td>
</tr>
</tbody>
</table>
```

Enter RETURN to continue or '^' to exit:

Figure 13-87: Sample Behavioral Health Problem/DSM Codes report

### 13.5.4 Print Behavioral Health Problem Codes (PROB)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type **PROB**. This report will print either to a printer or the screen, a list of all active Problem codes. It will list the code, narrative, and the problem category. The report displays in Figure 13-87:

```
XX                                      May 04, 2009                Page 1

Figure 13-87: Sample Behavioral Health Problem/DSM Codes report

********** BEHAVIORAL HEALTH PROBLEM/DSM CODES **********

<table>
<thead>
<tr>
<th>CODE</th>
<th>NARRATIVE</th>
<th>PROBLEM CODE</th>
<th>ICD-9 CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>.9999</td>
<td>UNCODED DIAGNOSIS</td>
<td>99.9</td>
<td>.9999</td>
</tr>
<tr>
<td>010.00</td>
<td>PRIM TB COMPLEX-UNSPEC</td>
<td>99.9</td>
<td>010.00</td>
</tr>
<tr>
<td>011.41</td>
<td>TB LUNG FIBROSIS-NO EXAM</td>
<td>6.1</td>
<td>011.41</td>
</tr>
<tr>
<td>030.9</td>
<td>LEPROSY NOS</td>
<td>99.9</td>
<td>030.9</td>
</tr>
<tr>
<td>034.0</td>
<td>STREP SORE THROAT</td>
<td>5</td>
<td>034.0</td>
</tr>
<tr>
<td>054.10</td>
<td>GENITAL HERPES NOS</td>
<td>99.9</td>
<td>054.10</td>
</tr>
<tr>
<td>1</td>
<td>HEALTH/HOMEMAKER NEEDS</td>
<td>1</td>
<td>V60.4</td>
</tr>
</tbody>
</table>
```

Enter RETURN to continue or '^' to exit:
<table>
<thead>
<tr>
<th>CODE</th>
<th>NARRATIVE</th>
<th>PROBLEM CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HEALTH/HOMEMAKER NEEDS</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>1.1</td>
<td>HEALTH PROMOTION/DISEASE PREVENTION</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>2</td>
<td>CROSS-CULTURAL CONFLICT</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>3</td>
<td>UNSPECIFIED MENTAL DISORDER (NON-PSYCHOTIC)</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>4</td>
<td>PHYSICAL DISABILITY/REHABILITATION</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>5</td>
<td>PHYSICAL ILLNESS, ACUTE</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>6.1</td>
<td>PHYSICAL ILLNESS, CHRONIC</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
<tr>
<td>6.2</td>
<td>PHYSICAL ILLNESS, TERMINAL</td>
<td>MEDICAL/SOCIAL PROBL</td>
</tr>
</tbody>
</table>

Figure 13-88: Sample Behavioral Health Problem Codes report
14.0 Manager Utilities Module (Roll and Scroll)

The Manager Utilities module shown in Figure 14-1, provides options for Site Managers and program supervisors to customize BHS to suit their site’s needs. Options are also available for administrative functions, including the export of data to the Area, resetting local flag fields, and verifying users who have edited patient records.

---

**IHS Behavioral Health System**
**Manager Utilities**
**Version 4.0 (patch 2)**

DEMO INDIAN HOSPITAL

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITE</td>
<td>Update Site Parameters</td>
</tr>
<tr>
<td>EXPT</td>
<td>Export Utility Menu</td>
</tr>
<tr>
<td>RPFF</td>
<td>Re-Set Patient Flag Field Data</td>
</tr>
<tr>
<td>DLWE</td>
<td>Display Log of Who Edited Record</td>
</tr>
<tr>
<td>ELSS</td>
<td>Add/Edit Local Service Sites</td>
</tr>
<tr>
<td>EPHX</td>
<td>Add Personal History Factors to Table</td>
</tr>
<tr>
<td>DRD</td>
<td>Delete BH General Retrieval Report Definitions</td>
</tr>
<tr>
<td>EEPC</td>
<td>Edit Other EHR Clinical Problem Code Crosswalk</td>
</tr>
<tr>
<td>UU</td>
<td>Update Locations a User can See</td>
</tr>
</tbody>
</table>

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)

1. At the “Select Manager Utilities Option” prompt, type SITE to modify the parameters in the Behavioral Health file. Individual sites use the Site Parameters file to set BHS to suit their program needs. Do the following:

2. At the “Select MHSS SITE PARAMETERS” prompt, type the location where the program visits take place. You will be prompted if a new location is being used.

The application displays the Update BH Site Parameters screen (Figure 14-2):

---

**UPDATE BH SITE PARAMETERS**
Site Name: SITEXXX

Update DEFAULT Values? N
Default Health Summary Type: BEHAOVIRAL 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: Insert

Press <PF1>H for help

Figure 14-2: Sample Update BH Site Parameters window

3. At the “Update DEFAULT Values?” prompt, type Y and the application displays Figure 14-3. All default settings are moved to this separate pop-up window. Do the following:

**** 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

4. At the “MH/SS/CD/OTHER Location” prompt, type the name of the location where the program visits take place.

5. At the “MH/SS/CD/OTHER Community” prompt, type the name of the community where the program visits occur.

6. At the “MH/SS/CD/OTHER Clinic” prompt, type the name of the clinic where the program visits occur.
7. At the “Default Type of Contact” prompt, indicate the type of contact setting or code.

8. At the “Default Appt/Walk in Response” prompt, indicate Specify the type of visit that occurred.

9. At the “EHR Default Community” prompt, type 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.

10. At the “Default HEALTH Summary Type” prompt, indicate the type of health summary printed from within the BH package.

   - The default value is the Mental Health/Social Services summary type. Refer to the Health Summary System Manuals for further information.

11. At the “Default response on form print” prompt, the response applies to when to 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.
12. At the “Suppress Comment on Suppressed Form?” prompt, type one of the following:
   • Y to suppress the comments
   • N to not suppress the comments

13. At the “# of past POVs to display” prompt, type the number of the past POVs to be displayed on the Patient Data Entry screen.

14. At the “Exclude No Shows on last DX Display?” prompt, type one of the following:
   • Y to exclude no shows
   • N to include no shows

15. At the “Update PCC Link Features?” prompt, type Y to display the Update PCC Link Feature Parameters pop-up window (Figure 14-4).

   Figure 14-4: Fields on the Update PCC Link Feature Parameters pop-up

16. At the “Type of PCC Link: prompt, determine the type of data that passes from BHS to the PCC, select one of the following:
   • No Link Active – Use 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).
   • Pass STND Code and Narrative – Use type 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.
   • Pass All Data as Entered (No Masking) - Use 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.
   • Pass Codes and Canned Narrative - Use 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.
For “Pass STND Code and Narrative” and “Pass Codes and Canned Narrative” options, the application displays the Standard Code to Use pop-up shown in Figure 14-5:

<table>
<thead>
<tr>
<th>Standard Code to Use (Option 2 ONLY): V65.40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative for MH Program: MH/SS/SA COUNSELING</td>
</tr>
<tr>
<td>Narrative for SS Program: SS VISIT</td>
</tr>
</tbody>
</table>

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.

17. At the “Type of Visit to create in PCC” prompt, is dependent upon type of visit created from the encounter record you enter into BHS. Depending on the classification of the BHS programs at your facility. Type one of the following

- I (IHS)
- C (Contract)
- 6 (638 Program)
- T (Tribal)
- O (Other)
- V (VA)
- P (Compacted Program)
- U (Urban Program)

18. At the “Interactive PCC Link?” prompt, 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.

19. At the “Allow PCC Problem List Update?:” prompt, type one of the following:
   - Y to allow the ability to update a patient’s PCC problem list
   - N to not allow the ability to update a patient’s PCC problem list

20. At the “Update PCC LINK Exceptions?:” (Figure 14-6) prompt, type one of the following:
   - Y to determine if you want to set data passing parameters for individuals that are different from the program default.
   - N – not to set data passing parameters for individuals that are different from the program default.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Type of PCC Link for this Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGMA, LORRAINE</td>
<td>NO LINK ACTIVE</td>
</tr>
<tr>
<td>CZZ, BILL</td>
<td>PASS CODE AND STND NARRATIVE</td>
</tr>
<tr>
<td>DELTA, GREG</td>
<td>PASS STND CODE AND NARRATIVE</td>
</tr>
<tr>
<td>MBETAA, MARY</td>
<td>PASS ALL DATA AS ENTERED</td>
</tr>
</tbody>
</table>

Figure 14-6: Setting up PCC link exceptions

21. At the “Turn Off EHR to BH Link?” prompt, 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.

22. At the “Turn on PCC Coding Queue?” prompt, type one of the following:
   - 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.
   - 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 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:

23. Log into BHS v4.0 and select the Manager Utilities menu.
24. Select Site Parameters and type the name of the site to update.
25. On the site parameters entry window, scroll down to the Turn on PCC Coding Queue field.
26. Type Y at this field.
27. 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.

28. At the “Update Provider Exceptions to E Sig?” prompt type one of the following:

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.

- N to not update the provider exceptions.
- Type Y the following pop-up displays as shown in Figure 14-7:

```
Electronic Signature will not be activated for providers added to
```
29. At the “PROVIDER” prompt, type the name of the provider with exception to electronic signature.

Some sites may 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 provider should be exempted from the electronic signature, those visits will pass to PCC but show up as unsigned on the visit entry display.

30. At the “Update those allowed to see all records?” prompt, type one of the following:

- Type N, 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.
- Type Y, (Figure 14-8) 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.

31. At the “Update those allowed to override delete?” prompt, type one of the following:

- N to not allow override delete
- Y to determine if you want to update those allowed to override delete. Figure 14-9 shows the screen.
32. At the “Update those allowed to share visits?” prompt, type one of the following:

- N to not update those allowed to share visit information via RPMS mail message
- Type Y, the pop-up in Figure 14-10 displays.

A new name can be added 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.

33. At the “Update those allowed to order Labs?” prompt type one of the following:

- N to not update those allowed to order labs.
- Type Y to display the pop-up in Figure 14-11.

A new name can be added at the “User Permitted to Order Labs” prompt. All users permitted to order lab tests should be entered here.
At the “If you are using the RPMS Pharmacy System, enter the Division” prompt, type the name of the division for the RPMS Pharmacy System.

14.2 Export Utility Menu (EXPT)

1. At the “Select Manager Utilities Option” prompt, type **EXPT** to access the Export Utility Menu shown in Figure 14-12:

![Export Utility Menu](image)

Use the options on this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes.

**Note:** 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-CHECK, 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)

1. At the “Select Export Utility Menu Option” prompt, type **GEN** to generate BH transactions to be sent to HQ.

The transactions are for records posted since the last time you did an export up until yesterday. Both BH visit records and Suicide forms will be exported.
2. Type the caret (^) at any prompt to exit and the application will display a confirmation prior to generating transactions as shown in Figure 14-13:

```
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

3. At the “Do you want to continue?” prompt, type one of the following:
   - N to return to the Export Utility menu
   - Y to continue.

4. At the “Do you want to QUEUE this to run at a later time?” prompt, type N and the generation will be put in the queue and the generate process continues as shown in Figure 14-14:

```
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)

1. At the “Select Manager Utilities Option” prompt, type DISP to display the extract log information in a date range.

2. At the “Select MHSS EXTRACT LOG BEGINNING DATE” prompt, type the extract log beginning date. (You can view the extract date by typing two question marks (??) at this prompt.)

3. At the “DEVICE” prompt, type the device for viewing the data.

Figure 14-15 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:  _____________
```

User Manual  Activity Codes and Definitions
April 2012

339
## 14.2.3 Print Export Log (PRNT)

1. At the “Select Export Utility Menu Option” prompt, type `PRNT` to display the export extract log report. The application displays the previous selection’s beginning date.

2. Set the date at the “START WITH BEGINNING DATE” prompt.

3. Set the date at the “GO TO BEGINNING DATE” prompt.

4. At the “DEVICE” prompt, type the device to print/browse the log.

Figure 14-16 displays the Mental Health/Social Service Export Extract Log.

### 14.2.4 Regenerate Transactions (RGEN)

1. At the “Select Export Utility Menu Option” prompt, type `RGEN` to regenerate transactions between two dates. Do the following:

   **Warning:** Do not use this option if you are not an expert user.

2. Set the date at the “Select MHSS EXTRACT LOG BEGINNING DATE” prompt, Figure 14-17 displays.
Log entry 6 was for date range MAR 2, 2007 through JUN 16, 2007
And generated 44 transactions from 67 records.
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)

This routine will reset the BH Data Transmission Log. You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place!

The BH Data Transmission log entry you choose will be removed from the log file and all Utility and Data globals associated with that run will be killed.

You must now select the Log Entry to be reset. <Select carefully>

The BH Data Transmission log entry you choose will be removed from the log file and all Utility and Data globals associated with that run will be killed.

14.2.6 Check Records Before Export (CHK)

1. At the “Select Export Utility Menu Option” prompt, type CHK to review all records that were posted to the BH database since that last export was done. It will review all records that were posted from the day after the last date of that run up until 2 days ago.

The application displays the two dates, such as APR 19, 2009 and APR 20, 2009 inclusive. If the entries are displaying on this list, they are not passing to PCC and the billing package. Do the following:

2. At the “Do you want to continue?” prompt, type one of the following:
   - N to end the process
   - Y to continue

3. At the “DEVICE” prompt, type the device to review the report.

Figure 14-18 displays the BH Export Record Review report.
Figure 14-18: Sample report about records before export

14.2.7 Print Error List for Export (ERRS)

1. At the “Select Export Utility Menu Option” prompt, type ERRS 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. Do the following:

2. Set the date at the “Select MHSS EXTRACT LOG BEGINNING DATE” prompt. You can view the extract date list by typing two question marks (??) at the 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.

3. At the “DEVICE” prompt, type the device to print/browse the report.

   Figure 14-19 displays the MHSS Extract Log Error Report.

Figure 14-19: Sample MHSS Extract Log Error Report

14.2.8 Create OUTPUT File (OUTP)

At the “Select Export Utility Menu Option” prompt, type OUTP 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)

1. At the “Select Manager Utilities Option” prompt, type **RPFF** 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 flag or all flags. You may use this reset option to reassign a flag or all flags as needed. Do the following:

2. At the “Reset which flags” prompt, type one of the following:
   - **A**  (all flags)
   - **O**  (one flag) to continue

3. At the “Are you sure you want to do this?” prompt, type **Y**, Figure 14-20 displays:

   ![Hold on... resetting data..](image)

   All done.

   Figure 14-20: Sample information from the application about the reset process

14.4 Display Log of Who Edited Record (DLWE)

1. At the “Select Manager Utilities Option“ prompt, type **DLWE** to display a list of who edited BH records of a specified patient. Do the following:

2. Set the date at the “Enter ENCOUNTER DATE” prompt.

3. At the “Enter LOCATION OF ENCOUNTER” prompt, type the location.

4. At the “Enter PATIENT” prompt, type the name of the patient.

   Figure 14-21 displays the visits with no location or patient.

   ![Behavioral Health visits for APR 10, 2009](image)
You can display the visit data for a record by responding the “Which record do you want to display?” prompt. The application displays the visit data as shown in Figure 14-22:

**Figure 14-22: Sample report about visit data of a particular record**

### 14.5 Add/Edit Local Service Sites (ELSS)

1. At the “Select Manager Utilities Option” prompt, type `ELSS` to add/edit location service sites. If a new location is added, a name and abbreviation should be provided. Counts of these visits can be recovered using the GEN option in Encounter Reports or ACT in the Workload reports. Do the following:

   - Type Y to confirm the new site
   - Type new service site and a confirmation displays.
   - Type N and the “Select MHSS LOCAL SERVICE SITES” prompt displays.

2. Type an existing factor, for example, HEADSTART, do the following:

   - At the “LOCAL SERVICE SITE: HEADSTART Replace” prompt, press Enter to accept the existing service site.

3. At the “ABBREVIATION: HEAD” prompt, press Enter to accept the abbreviation of the existing service site.
14.6 Add Personal History Factors to Table (EPHX)

1. At the “Select Manager Utilities Option” prompt, type **EPHX** 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. Do the following:

2. At the “Enter a PERSONAL HISTORY FACTOR” prompt, type a personal history factor.
   - Type **Y** to confirm the factor entry.
   - Type **N** and the “Enter a PERSONAL HISTORY FACTOR” prompt repeats.

3. Type an existing factor, such as, FAS, the application displays a similar message: At the “FACTOR: FAS//” prompt, press Enter to accept the existing factor.

14.7 Delete BH General Retrieval Report Definitions (DRD)

1. At the “Select Manager Utilities Option” prompt, type **DRD** to delete a PCC Visit or Patient General Retrieval report definition. This enables the user to delete a PCC Visit or Patient General Retrieval report definition. Do the following:

2. At the “REPORT NAME” prompt, type the name of the report to be removed.
   - Type a question mark (?) at this prompt to view a list of existing definitions.

3. At the “Are you sure you want to delete the [report name] definition?” prompt, identify the name of the report.
   - Type **Y** to confirm the deletion
   - Type **N** to not delete

14.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

At the “Select Manager Utilities Option” prompt, type **EEPC** 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. The following sample prompts display:

- **CODE:** V72.3
- **ICD Narrative:** GYNECOLOGIC EXAMINATION

1. At the “Enter the Problem Code Grouping” prompt, type 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)

1. At the “Select Manager Utilities Option” prompt, type **UU** to identify 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.

2. At the “Select BH USER NAME” prompt, type the user name to be added to the BH User file. A ScreenMan screen will pop-up permitting the manager to enter all of the locations that the user is able to access or “see” on the screen.
Figure 14-23 displays the Update Visit Locations a User can See screen.

```
**** Update Visit Locations a User can See ****
USER: BETA,LORI

Location: DEMO INDIAN HOSPITAL
Location: SELLS HOSP
Location:
Location:
Location:

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

Figure 14-23: Sample Update Visit Locations a User can See screen

3. At the “Location” prompt, type the location that the user can view.

   - You can specify more than one location.

   In the example, the provider will only be able to access visits to the designated Hospitals. If a patient being treated, has to visit another, the provider would not see that visit information. For example, if the user chooses “Browse Visits” they 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

<table>
<thead>
<tr>
<th>Activity Code</th>
<th>Description</th>
<th>Pass to PCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Twelve Step Work – Group (TSG)</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>Twelve Step Work – Individual (TSI)</td>
<td>Yes</td>
</tr>
<tr>
<td>03</td>
<td>Twelve Step Group (TWG)</td>
<td>No</td>
</tr>
<tr>
<td>04</td>
<td>Re-Assessment, Patient Present</td>
<td>Yes</td>
</tr>
<tr>
<td>05</td>
<td>Re-Assessment, Patient Not Present</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Screening – Patient Present (SCN)</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>Assessment/Evaluation – Patient Present (EVL)</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Individual Treatment/Counsel/Education – Pt. Present (IND)</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Information and Referral – Patient Present (REF)</td>
<td>Yes</td>
</tr>
<tr>
<td>16</td>
<td>Medication/Medication Monitoring – Pt. Present (MED)</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>Psychological Testing – Patient Present (TST)</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>Forensic Activities – Patient Present (FOR)</td>
<td>Yes</td>
</tr>
<tr>
<td>19</td>
<td>Discharge Planning – Patient Present (DSG)</td>
<td>Yes</td>
</tr>
<tr>
<td>20</td>
<td>Family Facilitation – Patient Present (FAC)</td>
<td>Yes</td>
</tr>
<tr>
<td>21</td>
<td>Follow Through/Follow Up – Patient Present (FOL)</td>
<td>Yes</td>
</tr>
<tr>
<td>22</td>
<td>Case Management – Patient Present (CAS)</td>
<td>Yes</td>
</tr>
<tr>
<td>23</td>
<td>Other Patient Services Not Identified – Patient Present (OTH)</td>
<td>Yes</td>
</tr>
<tr>
<td>24</td>
<td>Material/Basic Support – Patient Not Present (SUP)</td>
<td>No</td>
</tr>
<tr>
<td>25</td>
<td>Information and/or Referral – Patient Not Present (INF)</td>
<td>No</td>
</tr>
<tr>
<td>26</td>
<td>Medication/Medication Monitoring – Pt. Not Present (MEA)</td>
<td>Yes</td>
</tr>
<tr>
<td>27</td>
<td>Forensic Activities – Patient Not Present (FOA)</td>
<td>No</td>
</tr>
<tr>
<td>28</td>
<td>Discharge Planning – Patient Not Present (DSA)</td>
<td>No</td>
</tr>
<tr>
<td>29</td>
<td>Family Facilitation – Patient Not Present (FAA)</td>
<td>No</td>
</tr>
<tr>
<td>30</td>
<td>Follow Through/Follow Up – Patient Not Present (FUA)</td>
<td>No</td>
</tr>
<tr>
<td>31</td>
<td>Case Management – Patient Not Present (CAA)</td>
<td>Yes</td>
</tr>
<tr>
<td>32</td>
<td>Clinical Supervision Provided</td>
<td>No</td>
</tr>
<tr>
<td>33</td>
<td>Technical Assistance – Patient Not Present</td>
<td>No</td>
</tr>
<tr>
<td>34</td>
<td>Other Support Services – Patient Not Present</td>
<td>No</td>
</tr>
<tr>
<td>35</td>
<td>Collaboration</td>
<td>No</td>
</tr>
<tr>
<td>36</td>
<td>Community Development</td>
<td>No</td>
</tr>
<tr>
<td>37</td>
<td>Preventive Services</td>
<td>No</td>
</tr>
<tr>
<td>38</td>
<td>Patient Transport</td>
<td>No</td>
</tr>
<tr>
<td>39</td>
<td>Community Services</td>
<td>No</td>
</tr>
<tr>
<td>40</td>
<td>Referral</td>
<td>No</td>
</tr>
<tr>
<td>41</td>
<td>Education/Training Provided</td>
<td>No</td>
</tr>
<tr>
<td>42</td>
<td>Education/Training Received</td>
<td>No</td>
</tr>
<tr>
<td>43</td>
<td>Other Education/Training</td>
<td>No</td>
</tr>
<tr>
<td>44</td>
<td>Screening – Patient Not Present</td>
<td>No</td>
</tr>
<tr>
<td>45</td>
<td>Assessment/Evaluation – Patient Not Present</td>
<td>No</td>
</tr>
<tr>
<td>47</td>
<td>Couples Treatment – Patient Present (CT)</td>
<td>Yes</td>
</tr>
<tr>
<td>Activity Code</td>
<td>Description</td>
<td>Pass to PCC</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>48</td>
<td>Crisis Intervention – Patient Present (CIP)</td>
<td>Yes</td>
</tr>
<tr>
<td>49</td>
<td>Crisis Intervention – Patient Not Present (CIA)</td>
<td>No</td>
</tr>
<tr>
<td>50</td>
<td>Medical Rounds (General)</td>
<td>No</td>
</tr>
<tr>
<td>51</td>
<td>Committee Work</td>
<td>No</td>
</tr>
<tr>
<td>52</td>
<td>Surveys/Research</td>
<td>No</td>
</tr>
<tr>
<td>53</td>
<td>Program Management</td>
<td>No</td>
</tr>
<tr>
<td>54</td>
<td>Quality Improvement</td>
<td>No</td>
</tr>
<tr>
<td>55</td>
<td>Supervision</td>
<td>No</td>
</tr>
<tr>
<td>56</td>
<td>Records/Documentation</td>
<td>No</td>
</tr>
<tr>
<td>57</td>
<td>Child Protective Team Activities</td>
<td>No</td>
</tr>
<tr>
<td>58</td>
<td>Special Projects</td>
<td>No</td>
</tr>
<tr>
<td>59</td>
<td>Other Administrative</td>
<td>No</td>
</tr>
<tr>
<td>60</td>
<td>Case Staffing (General)</td>
<td>No</td>
</tr>
<tr>
<td>61</td>
<td>Provider Consultation (PRO)</td>
<td>Yes</td>
</tr>
<tr>
<td>62</td>
<td>Patient Consultation (Chart Review) (CHT)</td>
<td>Yes</td>
</tr>
<tr>
<td>63</td>
<td>Program Consultation</td>
<td>No</td>
</tr>
<tr>
<td>64</td>
<td>Staff Consultation</td>
<td>No</td>
</tr>
<tr>
<td>65</td>
<td>Community Consultation</td>
<td>No</td>
</tr>
<tr>
<td>66</td>
<td>Clinical Supervision Received</td>
<td>No</td>
</tr>
<tr>
<td>71</td>
<td>Travel Related to Patient Care</td>
<td>No</td>
</tr>
<tr>
<td>72</td>
<td>Travel Not Related to Patient Care</td>
<td>No</td>
</tr>
<tr>
<td>75</td>
<td>Placement – Patient Present (OHP)</td>
<td>Yes</td>
</tr>
<tr>
<td>76</td>
<td>Placement – Patient Not Present (OHA)</td>
<td>No</td>
</tr>
<tr>
<td>81</td>
<td>Traditional Specialist Consult – Patient Present (TRD)</td>
<td>Yes</td>
</tr>
<tr>
<td>82</td>
<td>Traditional Specialist Consult – Patient Not Present (TRA)</td>
<td>No</td>
</tr>
<tr>
<td>83</td>
<td>Tribal Functions</td>
<td>No</td>
</tr>
<tr>
<td>84</td>
<td>Cultural Education to Non-Tribal Agency/Personnel</td>
<td>No</td>
</tr>
<tr>
<td>85</td>
<td>Art Therapy (ART)</td>
<td>Yes</td>
</tr>
<tr>
<td>86</td>
<td>Recreation Activities (REC)</td>
<td>No</td>
</tr>
<tr>
<td>87</td>
<td>Outreach</td>
<td>No</td>
</tr>
<tr>
<td>88</td>
<td>Acupuncture (ACU)</td>
<td>Yes</td>
</tr>
<tr>
<td>89</td>
<td>Methadone Maintenance (MET)</td>
<td>Yes</td>
</tr>
<tr>
<td>90</td>
<td>Family Treatment (FAM)</td>
<td>Yes</td>
</tr>
<tr>
<td>91</td>
<td>Group Treatment (GRP)</td>
<td>Yes</td>
</tr>
<tr>
<td>92</td>
<td>Adventure Based Counseling (ABC)</td>
<td>Yes</td>
</tr>
<tr>
<td>93</td>
<td>Relapse Prevention (REL)</td>
<td>Yes</td>
</tr>
<tr>
<td>94</td>
<td>Life Skills Training (LST)</td>
<td>Yes</td>
</tr>
<tr>
<td>95</td>
<td>Cultural Activities (CUL)</td>
<td>No</td>
</tr>
<tr>
<td>96</td>
<td>Academic Services (ACA)</td>
<td>No</td>
</tr>
<tr>
<td>97</td>
<td>Health Promotion (HPR)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Appendix C: ICD-9CM v Codes

<table>
<thead>
<tr>
<th>ICD Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>v11.0</td>
<td>Personal history of Schizophrenia</td>
</tr>
<tr>
<td>v11.1</td>
<td>Personal history of affective disorders</td>
</tr>
<tr>
<td>v11.2</td>
<td>Personal history of neurosis</td>
</tr>
<tr>
<td>v11.3</td>
<td>Personal history of alcoholism</td>
</tr>
<tr>
<td>v11.8</td>
<td>Personal history of other mental disorders</td>
</tr>
<tr>
<td>v11.9</td>
<td>Personal history of unspecified mental disorder</td>
</tr>
<tr>
<td>v13.21</td>
<td>Personal history of pre-term labor</td>
</tr>
<tr>
<td>v13.7</td>
<td>Personal history of perinatal problems</td>
</tr>
<tr>
<td>v15.41</td>
<td>History of physical abuse (includes rape)</td>
</tr>
<tr>
<td>v15.42</td>
<td>History of emotional abuse or neglect</td>
</tr>
<tr>
<td>v15.49</td>
<td>Psychological trauma, not elsewhere classified</td>
</tr>
<tr>
<td>v15.52</td>
<td>Personal History of Traumatic Brain Injury (TBI)</td>
</tr>
<tr>
<td>v15.81</td>
<td>History of noncompliance with medical treatment</td>
</tr>
<tr>
<td>v15.82</td>
<td>History of tobacco use</td>
</tr>
<tr>
<td>v15.89</td>
<td>Other personal history presenting hazards to health</td>
</tr>
<tr>
<td>v15.9</td>
<td>Unspecified personal history presenting hazards to health</td>
</tr>
<tr>
<td>v17.0</td>
<td>Family history of psychiatric condition</td>
</tr>
<tr>
<td>v18.4</td>
<td>Family history of mental retardation</td>
</tr>
<tr>
<td>v23.9</td>
<td>Supervision of unspecified high risk pregnancy</td>
</tr>
<tr>
<td>v25.09</td>
<td>General counseling and advice on contraceptive management; family planning advice</td>
</tr>
<tr>
<td>v26.33</td>
<td>Genetic counseling</td>
</tr>
<tr>
<td>v26.41</td>
<td>Procreative counseling and advice using natural family planning</td>
</tr>
<tr>
<td>v26.49</td>
<td>Other procreative management counseling and advice</td>
</tr>
<tr>
<td>v40.0</td>
<td>Mental and behavioral problems with learning</td>
</tr>
<tr>
<td>v40.1</td>
<td>Mental and behavioral problems with communication including speech</td>
</tr>
<tr>
<td>v40.2</td>
<td>Other mental problems</td>
</tr>
<tr>
<td>v40.9</td>
<td>Unspecified mental or behavioral problem</td>
</tr>
<tr>
<td>v57.9</td>
<td>Care involving unspecified rehabilitation procedure</td>
</tr>
<tr>
<td>v60.0</td>
<td>Lack of housing</td>
</tr>
<tr>
<td>v60.1</td>
<td>Inadequate housing</td>
</tr>
<tr>
<td>v60.2</td>
<td>Inadequate material resources</td>
</tr>
<tr>
<td>v60.3</td>
<td>Person living alone</td>
</tr>
<tr>
<td>v60.4</td>
<td>No other household member able to render care</td>
</tr>
<tr>
<td>v60.5</td>
<td>Holiday relief care</td>
</tr>
<tr>
<td>v60.6</td>
<td>Person living in a residential institution</td>
</tr>
<tr>
<td>v60.8</td>
<td>Other specified housing or economic circumstances</td>
</tr>
<tr>
<td>v60.81</td>
<td>Foster care (status)</td>
</tr>
<tr>
<td>v60.89</td>
<td>Unspecified housing or economic circumstances</td>
</tr>
<tr>
<td>v61.01</td>
<td>Family disruption due to family member on military deployment</td>
</tr>
<tr>
<td>v61.02</td>
<td>Family disruption due to return of family member from military deployment</td>
</tr>
<tr>
<td>v61.03</td>
<td>Family disruption due to divorce or legal separation</td>
</tr>
<tr>
<td>ICD Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>v61.04</td>
<td>Family disruption due to parent-child estrangement</td>
</tr>
<tr>
<td>v61.05</td>
<td>Family disruption due to child in welfare custody</td>
</tr>
<tr>
<td>v61.06</td>
<td>Family disruption due to child in foster care or in care of non-parental family member</td>
</tr>
<tr>
<td>v61.07</td>
<td>Family disruption due to death of family member</td>
</tr>
<tr>
<td>v61.08</td>
<td>Family disruption due to other extended absence of family member</td>
</tr>
<tr>
<td>v61.09</td>
<td>Other family disruption</td>
</tr>
<tr>
<td>v61.10</td>
<td>Counseling for marital and partner problems, unspecified</td>
</tr>
<tr>
<td>v61.11</td>
<td>Counseling for victim of spousal and partner abuse</td>
</tr>
<tr>
<td>v61.12</td>
<td>Counseling for perpetrator of spousal and partner abuse</td>
</tr>
<tr>
<td>v61.20</td>
<td>Counseling for parent-child problem, unspecified</td>
</tr>
<tr>
<td>v61.21</td>
<td>Counseling for victim of child abuse</td>
</tr>
<tr>
<td>v61.22</td>
<td>Counseling for perpetrator of parental child abuse</td>
</tr>
<tr>
<td>v61.23</td>
<td>Counseling for parent-biological child problem</td>
</tr>
<tr>
<td>v61.24</td>
<td>Counseling for parent-adopted child problem</td>
</tr>
<tr>
<td>v61.25</td>
<td>Counseling for parent (guardian)-foster child problem</td>
</tr>
<tr>
<td>v61.3</td>
<td>Problems with aged parents or in-laws</td>
</tr>
<tr>
<td>v61.41</td>
<td>Alcoholism in family</td>
</tr>
<tr>
<td>v61.49</td>
<td>Other health problems within family</td>
</tr>
<tr>
<td>v61.5</td>
<td>Multiparity</td>
</tr>
<tr>
<td>v61.6</td>
<td>Illegitimacy or illegitimate pregnancy</td>
</tr>
<tr>
<td>v61.7</td>
<td>Other unwanted pregnancy</td>
</tr>
<tr>
<td>v61.8</td>
<td>Other specified family circumstances</td>
</tr>
<tr>
<td>v61.9</td>
<td>Unspecified family circumstances</td>
</tr>
<tr>
<td>v62.0</td>
<td>Unemployment</td>
</tr>
<tr>
<td>v62.1</td>
<td>Adverse effects of work environment</td>
</tr>
<tr>
<td>v62.21</td>
<td>Personal current military deployment status</td>
</tr>
<tr>
<td>v62.22</td>
<td>Personal history of return from military deployment</td>
</tr>
<tr>
<td>v62.29</td>
<td>Other occupational circumstances or maladjustment</td>
</tr>
<tr>
<td>v62.3</td>
<td>Educational circumstances</td>
</tr>
<tr>
<td>v62.4</td>
<td>Social maladjustment</td>
</tr>
<tr>
<td>v62.5</td>
<td>Legal circumstances</td>
</tr>
<tr>
<td>v62.6</td>
<td>Refusal of treatment for reasons of religion or conscience</td>
</tr>
<tr>
<td>v62.81</td>
<td>Interpersonal problems, not elsewhere classified</td>
</tr>
<tr>
<td>v62.82</td>
<td>Bereavement, uncomplicated</td>
</tr>
<tr>
<td>v62.83</td>
<td>Counseling for perpetrator of physical/sexual abuse</td>
</tr>
<tr>
<td>v62.84</td>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>v62.89</td>
<td>Other psychological or physical stress, not elsewhere classified (life circumstance problems; phase of life problems, borderline intellectual functioning; religious or spiritual problem)</td>
</tr>
<tr>
<td>v62.9</td>
<td>Unspecified psychosocial circumstance</td>
</tr>
<tr>
<td>v63.0</td>
<td>Residence remote from hospital or other health care facility</td>
</tr>
<tr>
<td>v63.1</td>
<td>Medical services in home not available</td>
</tr>
<tr>
<td>v63.2</td>
<td>Person awaiting admission to adequate facility elsewhere</td>
</tr>
<tr>
<td>ICD Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>v63.8</td>
<td>Other specified reasons for unavailability of medical facilities</td>
</tr>
<tr>
<td>v63.9</td>
<td>Unspecified reason for unavailability of medical facilities</td>
</tr>
<tr>
<td>v65.0</td>
<td>Healthy person accompanying a sick person</td>
</tr>
<tr>
<td>v65.11</td>
<td>Pediatric pre-birth visit for expectant mother</td>
</tr>
<tr>
<td>v65.19</td>
<td>Other person consulting on behalf of another person</td>
</tr>
<tr>
<td>v65.2</td>
<td>Person feigning illness</td>
</tr>
<tr>
<td>v65.3</td>
<td>Dietary surveillance and counseling</td>
</tr>
<tr>
<td>v65.40</td>
<td>Other unspecified counseling</td>
</tr>
<tr>
<td>v65.41</td>
<td>Exercise counseling</td>
</tr>
<tr>
<td>v65.42</td>
<td>Counseling on substance use and abuse</td>
</tr>
<tr>
<td>v65.43</td>
<td>Counseling on injury prevention</td>
</tr>
<tr>
<td>v65.44</td>
<td>HIV Counseling</td>
</tr>
<tr>
<td>v65.45</td>
<td>Counseling on other sexually transmitted diseases</td>
</tr>
<tr>
<td>v65.49</td>
<td>Other specified counseling</td>
</tr>
<tr>
<td>v65.5</td>
<td>Person with feared complaint in whom no diagnosis was made</td>
</tr>
<tr>
<td>v65.8</td>
<td>Other reasons for seeking consultation</td>
</tr>
<tr>
<td>v65.9</td>
<td>Unspecified reason for consultation</td>
</tr>
<tr>
<td>v66.3</td>
<td>Convalescence following psychotherapy and other treatment for mental disorder</td>
</tr>
<tr>
<td>v66.7</td>
<td>Encounter for palliative care (end of life care)</td>
</tr>
<tr>
<td>v67.3</td>
<td>Follow-up examination following psychotherapy and other treatment for mental disorder</td>
</tr>
<tr>
<td>v68.1</td>
<td>Issue of repeat prescriptions</td>
</tr>
<tr>
<td>v68.2</td>
<td>Request for expert evidence</td>
</tr>
<tr>
<td>v68.81</td>
<td>Referral of patient without examination or treatment</td>
</tr>
<tr>
<td>v68.89</td>
<td>Encounter for other specified administrative purpose</td>
</tr>
<tr>
<td>v68.9</td>
<td>Encounters for unspecified administrative purpose</td>
</tr>
<tr>
<td>v69.0</td>
<td>Problems related to lifestyle – lack of exercise</td>
</tr>
<tr>
<td>v69.1</td>
<td>Problems related to lifestyle – Inappropriate diet and eating habits</td>
</tr>
<tr>
<td>v69.2</td>
<td>Problems related to lifestyle – High risk sexual behavior</td>
</tr>
<tr>
<td>v69.3</td>
<td>Problems related to lifestyle – gambling and betting</td>
</tr>
<tr>
<td>v69.4</td>
<td>Problems related to lifestyle – lack of adequate sleep</td>
</tr>
<tr>
<td>v69.5</td>
<td>Problems related to lifestyle – behavioral insomnia of childhood</td>
</tr>
<tr>
<td>v69.8</td>
<td>Other problems related to lifestyle; self-damaging behavior</td>
</tr>
<tr>
<td>v69.9</td>
<td>Unspecified problem related to lifestyle</td>
</tr>
<tr>
<td>v70.1</td>
<td>General psychiatric examination, requested by the authority</td>
</tr>
<tr>
<td>v70.2</td>
<td>General psychiatric examination, other and unspecified</td>
</tr>
<tr>
<td>v71.01</td>
<td>Observation of adult antisocial behavior</td>
</tr>
<tr>
<td>v71.02</td>
<td>Observation of childhood or adolescent antisocial behavior</td>
</tr>
<tr>
<td>v71.09</td>
<td>Observation of other suspected mental condition</td>
</tr>
<tr>
<td>v71.81</td>
<td>Observation and evaluation for other specified suspected conditions, abuse and neglect</td>
</tr>
<tr>
<td>v71.89</td>
<td>Observation and evaluation for other specified suspected conditions not found</td>
</tr>
<tr>
<td>v79.0</td>
<td>Special screening for depression</td>
</tr>
<tr>
<td>ICD Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>v79.1</td>
<td>Special screening for alcoholism</td>
</tr>
<tr>
<td>v79.2</td>
<td>Special screening for mental retardation</td>
</tr>
<tr>
<td>v79.3</td>
<td>Special screening for developmental handicaps in early childhood</td>
</tr>
<tr>
<td>v79.8</td>
<td>Special screening for other specified mental disorders and developmental handicaps</td>
</tr>
<tr>
<td>v79.9</td>
<td>Special screening for unspecified mental disorder and developmental handicap</td>
</tr>
<tr>
<td>v80.01</td>
<td>Special Screening for Traumatic Brain Injury (TBI)</td>
</tr>
</tbody>
</table>
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/](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 Enter. For example: “Do you really want to quit? No//.” Pressing the Enter key tells the system you do not want to quit. “No//” is considered the default response.

Device
The name of the printer to use when printing information. Home means the computer screen.

Fields
Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

FileMan
The database management system for RPMS.

Free Text Field
This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

Frequency
The number of times a particular situation occurs in a given amount of time.
**Full Screen Editor**
A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

**Interface**
A boundary where two systems can communicate.

**Line Editor**
A word-processing editor that allows editing text line-by-line.

**Menu**
The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

**Menu Tree/Tree Structure**
A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

**Prompt**
A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

**Roll-and-Scroll**
The roll-and-scroll data entry format captures the same information as the graphical user interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

**Security Keys**
Tools used to grant/restrict access to certain applications, application features, and menus.

**Site Manager**
The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.
Submenu
A menu that is accessed through another menu.

Suicide
The act of causing one’s own death.

Ideation with Intent and Plan–Serious thoughts of suicide or of taking action to take one’s life with means and a specific plan

Attempt–A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

Completion–Fatal self-inflicted destructive act with explicit or inferred intent to die.

Terminal Emulator
A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor
A word processing program that entering and editing text.

Word Processing Field
This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.
## Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/SA</td>
<td>Alcohol and Substance Abuse</td>
</tr>
<tr>
<td>BH</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>BHS</td>
<td>Behavioral Health System</td>
</tr>
<tr>
<td>CAC</td>
<td>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.”</td>
</tr>
<tr>
<td>CD</td>
<td>Chemical Dependency</td>
</tr>
<tr>
<td>EHR</td>
<td>Indian Health Service RPMS Electronic Health Record</td>
</tr>
<tr>
<td>GPRA</td>
<td>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.</td>
</tr>
<tr>
<td>GUI</td>
<td>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.</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>RPMS</td>
<td>Resource and Patient Management System</td>
</tr>
<tr>
<td>TIU</td>
<td>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.</td>
</tr>
</tbody>
</table>
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