RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System
(AMH)

Patch 8 Addendum

Version 3.0 Patch 8
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1.0 Introduction

Review the changes, and add a copy of them to any printed documentation your site may be using for Behavioral Health System Version 3.0, Patch 8. These changes will be integrated into future versions of the software and user manuals and will no longer be considered an addendum at the time of the next release.

This addendum only contains changes made in patches that are relevant to the user. To see a list of all changes made in a patch, please refer to the patch notes of each of these respective patches.

1.1 Summary of Changes for Patch 8

Patch 8

- New functionality to allow users to use the EHR to enter visits and have those visits pass to the BH module.
    1. Two new fields added to MHSS RECORD file:
        - EHR Created?
        - Created by BH?
    2. Modifications have been made to populate these fields for each record created.
    3. Created a routine to populate the BH module from a visit created in EHR
    4. Created an option to allow a user to edit the BH specific fields of an EHR-created visit.
    5. Modified the `Edit a Visit` and `Delete a Visit` options to not allow editing or deleting of an EHR created BH record.
    6. Modified the encounter form and record display to display the TIU note if one was created on an EHR visit.
- New functionality to allow entering measurements.
    1. Added new file to store the measurements.
    2. Updated all ScreenMan screens for Regular, Intake, and ASA type of visits to prompt for measurements.
    3. Added measurements to the form print.
    4. Added measurements to the visit display.
    5. Added measurements to the BH health summary component.
    6. Added measurements to the PCC link so they pass to PCC.
- Removed the CDMIS Staging Tool from the data entry screens and removed staging reports.
- Added Present and Past as a result choice for IPV/DV screening.

  - Modified all IPV/DV reports to recognize this new choice.
- On the suicide form and reports, changed “Self Destructive Act” to "Suicidal Behavior."
- Add the Patient Registration application item RACE to the PGEN and VGEN reports.
- Change BH Problem Code 40 Suicide Attempt ICD9 mapping from V62.84 to: 300.9 Unspecified nonpsychotic mental disorder.

Patch 7

Patch 7 provides corrections and enhancements to version 3.0 of the Behavioral Health System Patch 6 application. Patch 7 contains modifications to the following:

- Added a new report: Duration of Care Report. This report lists cases opened and the duration (time between case open and case closed dates) of the case. This report can be found under RPTS:PAT:CASE:DOC.

- Added a new report: GAF Scores for One Patient. This report lists all GAF scores for one patient in chronological order. This report can be found under the Display Record Options on the Data Entry menu (DE:DSP) and in the list of commands under PDE.

- Added a new report: GAF Scores for Multiple Patients. This report will list all GAF scores recorded for multiple patients sorted by patient. The user may select the date range of the visits and limit the list of visits/GAF scores to one program or provider. The report can be found under the Display Record Options on the Data Entry menu (DE:DSP) or under RPTS:PAT:GAFS.

- Added a new Report: Patients with Case Open but No Treatment Plan on File. This report can be found under PAT-TPR-NOTP or DE-TPU-NOTP.

- Added a new Report: Patients Seen X Number of Times w/No Case Open Date. This report lists patients who have been seen x number of times in a date range but have no case open date. This report can be found under PAT:CASE:SENO.

- ONS Report: Previously known as the SEEN Report. Patients with Case Open Date that have not been seen in x number of days: Removed prompt regarding Case Open and Admit dates from the report. Replaced the Case Admit date on the output with the provider's name. This report can be found under PAT:CASE:ONS.

- Added a new set of reports for Alcohol Screening Statistics. This set of reports can be found under RPTS-PAT-SCRN-ALC.

- Added a new set of reports for Depression Screening Statistics. This set of reports can be found under RPTS-PAT-SCRN-DEP.

- Added a new Report: Tally of Prevention Activities. This report provides a tally of Prevention Activities. This report can be found under RPTS:WL:PA.

- Added new Report: Listing of No-Show Visits in a Date Range. This report lists all No-show visits in a date range, program, and for which provider the user selects. This report can be found under RPTS-PAT-NSDR or DE-DSP-NSDR.

- Added a new Suicide Purpose of Visit report. This can be found under RPTS:PROB:SUIC:SPOV.

- IHS Aggregate Suicide Data Report (SSR) and Save of Suicide form data in Delimited format (SDEL): Added a prompt to allow selection of a specific self-injurious behavior rather than generating a report for all types. For example, you can now run the aggregate report for Suicide Ideations.

- Suicide Reports: Added a tally of the "Other" data fields to the aggregate suicide FORM reports (SSR, SAV) and to the delimited output report (SDEL).

- Modified the following reports to allow the report to be run for a selected program: ACO, ONS, TCD, SENO, ATP, REV, RES.

- Added POV to the Placements by Site/Patient report and modified order of items displayed.

Patch 6

Patch 6 provides corrections and enhancements to version 3.0 of the Behavioral Health System Patch 5 application. Patch 6 contains modifications to the following:

- Adds date printed to the following:

  a. Encounter form print

  b. Treatment plan print

  c. Intake document print

- Updated DSM-ICD mapping as appropriate for 2006 ICD codes.

  a. Added 3 new codes:

     22.2 INSOMNIA DUE TO MENTAL DISORDER - 327.02

     22.3 HYPERSOMNIA DUE TO MENTAL DISORDER - 327.15

     22.4 BEHAVIORAL INSOMNIA CHILDHOOD - V69.50

  b. Changed mapping:

     291.89 ALCOHOL INDUCED SLEEP DISORDER - 291.82

     292.89 Amphetamine-Induced Sleep Disorder - 292.85

292.89 Caffeine-Induced Sleep Disorder - 292.85

292.89 Cocaine-Induced Sleep Disorder - 292.85

292.89 Opioid-Induced Sleep Disorder - 292.85

292.89 Other (or Unknown) Substance-Induced Sleep Disorder-292.85

39 - Suicide (Ideation) - V62.84

40 - Suicide (Attempt/Gesture) - V62.84

- Added Patient Education to the Group entry.
- Added Behavior Code (stated goal) and Objective Met (goal status) to Patient Education entry.
- Added GROUP NAME to the encounter form print for suppressed form only.
- Made CLINIC a required field on all patient visits.
- Added Alcohol Screening exam to data entry screens and to form print and the health summary.
- Added Depression Screening exam to data entry screens and to form print and the health summary.
- Added a note that patient is deceased if a deceased patient is selected at any patient name prompt.

Patch 5

Patch 5 provides corrections and enhancements to version 3.0 of the Behavioral Health System Patch 4 application. Patch 5 contains modifications to the following:

- Added 2 new security keys to the system:
  1. AMHZ SUICIDE FORM ENTRY – This key must be assigned to users who enter or edit suicide forms.
  2. AMHZ SUICIDE FORM REPORTS – This key must be assigned to users who have a need to generate suicide form reports.
- Added clinic code, appt/walk-in and Visit flag to Info/Contact input screen.
- Added new defaults to site parameters for Program type OTHER.
- Updated site parameter entry to capture these new defaults.

2.0 Patch 8 General Information

This section provides detailed information regarding the modifications in Patch 8.

2.1 Behavioral Health Electronic Health Record (BH EHR) Functions within BHS v3.0

2.1.1 Overview

The IHS requires a means for Behavioral Health providers working at facilities using the RPMS Electronic Health Record (EHR) to utilize EHR, and yet have key data from the encounter populate the Behavioral Health System (namespace AMH) database. Exports from this database are important both for health statistics and workload reporting. Behavioral Health providers most interested in using the RPMS EHR are the prescribing providers, such as psychiatrists and psychiatric nurse practitioners. Experience has shown that other providers at EHR sites (psychologists, social workers, etc.) are interested in using the EHR to take advantage of other functionality such as consults, templates for clinical notes, etc.

A streamlined approach involving initial entry into EHR, with subsequent "back end" transfer of data from PCC to AMH has been developed. The primary objectives are:

- To support the entry of Behavioral Health (BH) patient encounters in the RPMS EHR that populate both the PCC and AMH databases.
- To integrate psychiatric information (particularly psychiatric medication management history) with primary care information.

2.1.2 Site Parameters

EHR to BH Link

A BHS v3.0 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 v3.0 and BH GUI/Patient Chart v1.5.

The name of the site parameter is `"Turn Off EHR to BH Link"` and it is accessed via the BHS v3.0 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."

EHR Default Community

In order to pass EHR behavioral health encounter records into the BHS v3.0 files, a Default Community of Service field was created on the BHS v3.0 site parameters' menu. If the facility has opted to pass behavioral health encounter records created in EHR to BHS v3.0, 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.

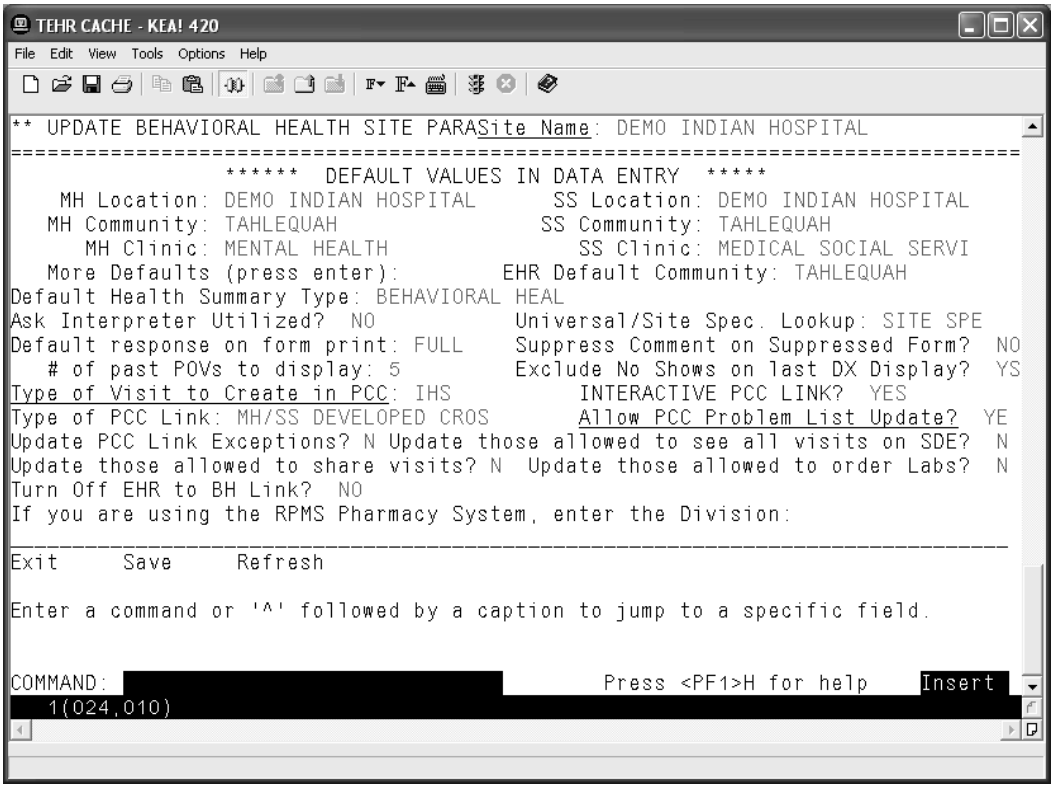

Figure 2-1: BHS v3.0 site parameters

2.1.3 Functionality and Business Rules

All BH patient encounters, whether entered in the EHR, BH GUI or BHS, will populate the AMH database.

All BH patient encounters and associated notes, whether entered via the EHR, BH GUI or BHS, will display in BH GUI and BHS.

Only those BH encounters and associated Text Integration Utility (TIU) clinical notes entered in the EHR will display in the EHR. Users will have to access BH GUI and BHS to see BH encounters entered via those applications.

Access to EHR BH TIU notes is controlled by TIU business rules determined at the facility level. Similarly, TIU behavioral health note titles are created at the facility level.

Editing and deleting of EHR BH visits will be governed by new business rules and functional requirements to support integrity of data across RPMS applications and patient safety, adherence to established RPMS BH business processes, and in accordance to HIM guidelines and professional standards.

BH providers can choose to enter BH patient encounters in the EHR, BHS, or BH GUI. Prescribing BH providers are encouraged to entered BH patient encounter information in the EHR to facilitate integration of this information with primary care.

Only individual BH patient encounter information can be entered into the EHR. BH users will have to access BH GUI or BHS to enter group encounters, document treatment plans, case status, and administrative entries.

The Suicide Reporting Form remains available and accessible to BH providers via the EHR, BH GUI, or BHS. All Suicide Reporting Form entries populate the RPMS BHS (AMH namespace) database.

2.1.4 Editing a BH EHR Encounter Record Using BHS v3.0

BHS v3.0 users are restricted from editing the BH EHR visit except to enter additional BHS data. This includes fields that are not stored in PCC such as Axis IV, Axis V, Placement Disposition, etc. This will permit the capture of these items for BHS local and national reports. Patch 8 includes the ability to edit the BH EHR via a new BHS edit option, "EDIT EHR BH RECORD."

To edit the BH EHR visit from the main DE Menu:

- Select EHR, Edit BH Data Elements of EHR Created Visit
- Select the patient
- Enter the date for the BH EHR visit

```
          Edit Behavioral Health Specific Fields for an EHR Visit
Patient: DEMO, W                    HRN: 114319
Visit Date: SEP 17, 2007@15:15      Provider: B
------------------------------------------------------------------------------
Community of Service: TA
Activity Type: 99 INDIVIDUAL BH EHR VI
Appt/Walk In: UNSPECIFIED
Placement Disposition:
 Interpreter Utilized:  Comment/Next Appt (press Enter)
   Local Service Site:
     Flag (Local Use):
     AXIS III (press Enter to update or TAB to bypass):
              AXIS IV:
              AXIS IV:
              AXIS IV:

               AXIS V:
```

Figure 2-2: BH EHR edit screen in BHS v3.0

The specific fields that can be edited in BHS v3.0 (or BH GUI) are displayed on the Edit Behavioral Health Specific Fields for an EHR Visit screen. Community of Service and Activity Type are required fields and will display defaults but may be edited as needed.

- Appt/Walk In is shown as Unspecified for all EHR visits prior to editing. This may be changed to either Walk In or Appointment, or left as Unspecified when appropriate.

- Placement Disposition should be added if the patient was referred elsewhere for care. To enter and save placement information, select one of the following nineteen placement types:

  Alcohol/Drug Detox
  Alcohol/Drug Rehab
  Day Program
  Group Home
  Hospice
  IHS Hospital
  Inpatient Medical
  Inpatient Psych
  Intensive Outpatient
  Long Term Care
  Medical Rehabilitation
  Other
  Outpatient
  Partial Hospital

Residential
Respite Care
Shelter
SNF (Skilled Nursing Facility)
Therapeutic Foster Care

After the placement type is entered, a dialog box is displayed for entering the name of the facility. Type in the exact name of the facility and press [Enter] to return to the main data entry screen.

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

Figure 2-3: Facility dialogue box

- The remaining optional fields on the data entry screen function exactly as the corresponding fields in BHS v3.0 data entry. Instructions for those fields can be found in the BHS v3.0 User Manual or in the BHS v3.0 Training Manual.

- After all editing is completed the changes should be saved.

To edit the BH EHR visit from either the PDE, SDE, or RDE menu options:

- Select EH, Edit EHR Visit

- Select patient and date of the EHR visit

- Continue with editing as described above

2.1.5 Editing Other EHR Problem Code on the BHS v3.0 Manager Utilities Menu

In the RPMS behavioral health applications the Purpose of Visit (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.

In order to add an ICD-9 code to a Problem Code Grouping, follow these steps:

- Select the Manager Utilities Menu.
- Select EEPC Edit Other EHR Clinical Problem Code Crosswalk.
- As each ICD code and narrative is displayed, the user is given an opportunity to assign it to an existing Problem Code Grouping.
- A warning prompt displays and the user must type in [YES] to accept the entry. If the entry is incorrect, press [Enter] to accept the default [NO].
- After responding to the first ICD code/narrative, the application will continue to present all ICD codes that have been entered since the last time this function was utilized.

```
CODE: 011.41
ICD Narrative: TB LUNG FIBROSIS-NO EXAM
Enter the Problem Code Grouping: phy
     1  PHYSICAL DISABILITY/REHABILITA  4  PHYSICAL DISABILITY/REHABILITATION
     2  PHYSICAL ILLNESS, CHRONIC     6.1  PHYSICAL ILLNESS, CHRONIC
     3  PHYSICAL ILLNESS, TERMINAL    6.2  PHYSICAL ILLNESS, TERMINAL
     4  PHYSICAL ILLNESS, ACUTE         5  PHYSICAL ILLNESS, ACUTE
CHOOSE 1-4: 2   6.1  PHYSICAL ILLNESS, CHRONIC
Are you sure you want to change the MHSS Problem Code Grouping to
      6.1 – Physical Illness, Chronic? N// y YES

CODE: 780.6
ICD Narrative: FEVER
Enter the Problem Code Grouping:
```

Figure 2-4: Sample problem code grouping edit

2.2 MS Measurements in the Regular, Intake and A/SA Visit Types

2.2.1 Entering Measurements

Measurements such as height, weight, blood pressure, pain, etc. that are recorded in the context of a visit can be stored in RPMS. In support of Agency health initiatives, including the Chronic Care and Behavioral Health Initiatives, the capability to record the results of four standardized, widely deployed brief screening and assessment tools

will be incorporated into RPMS. These are CRAFFT, AUDIT, PHQ2, and PHQ9. The tools for inclusion were identified by primary and behavioral health care subject matter experts. In preparation for the addition of the BH measurements to the RPMS measurements table, the ability to add measurements to an encounter record has been incorporated into the Intake, Regular, and A/SA visit types.

To add a measurement to the encounter record:

- Select a Regular, Intake, or A/SA visit type and complete all required fields.
- At the `Any Measurements?` prompt, type [Y] and press [Enter].
- When the dialog box displays, type the two-letter code or the first three letters of the measurement type to be entered, or type [?] to see the list of options.
- After selecting the type of measurement, type in the value or type [?] for Help.
- The provider field defaults to the provider for the encounter. This field may be edited.
- The user is presented with an opportunity to enter additional measurements. If no additional measurements need to be recorded, exit the text box.

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

```
         ***Measurements ***

Measurement       Description       Value                    Provider
-------------------------------------------------------------------------
PU                PULSE             70                       B
```

Figure 2-5: Measurements dialogue box

To edit a measurement, the visit must be selected using EV Edit Record. Once the visit is displayed, tab down to the `Edit Measurements?` prompt and type [Y]. Make any corrections or additions in the dialog box.

To remove a measurement, return to the EV Edit Record function, select the visit to be edited and then tab down to the `Edit Measurement?` prompt. When the dialog box appears, find the entry to be deleted and use the standard RPMS convention to delete an entry [@]. A verification message will be displayed before the deletion is accepted.

2.3 CD Staging Tool

The CD Staging Tool has been removed from the data entry screens and from staging reports. Historical CD Staging Tool data is retained. CD Staging Tool data in encounter records created prior to the release of Patch 8 will be viewed only when the encounter record is accessed.

2.4 IPV/DV Screening Exam Code

The new intimate partner/domestic violence (IPV/DV) screening result of PAST AND PRESENT has been added to the IPV/DV screening exam code. All IPV/DV screening reports have been modified to recognize this new screening result. Allowable results now include Negative, Present, Present and Past, Past, Patient Refused Screening, and Unable to Screen.

2.5 Suicide Reporting Form and Related Reports

The label "Self Destructive Act" has been changed to "Suicidal Behavior." There has been no change to the list associated with this label.

2.6 PGEN and GEN Reports

The Patient Registration item RACE has been added to both reports on the Selection, Print, and Sort menus.

2.7 Suicide Attempt mapping to ICD

Based on changes made in ICD-9, the mapping for Problem Code 40 Suicide Attempt has been changed from v62.84 Suicide Ideation to 300.9 Unspecified Non-psychotic Mental Disorder.

3.0 Patch 7 General Information

This section provides detailed information regarding the modifications in Patch 7.

3.1 Behavioral Health Reports

3.1.1 Patient Listings

3.1.1.1 Case Status Reports

DOC Duration of Care for Cases Opened and Closed

This report will produce a list of all closed cases in a date range that you specify. In order to be included in this report the case must have both a case open and a case closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date.

1. Type [PAT] to select Patient Listings Reports and press [Enter].
2. Type [CASE] for Case Status Reports and press [Enter].
3. Type [DOC] for the Duration of Care Report and press [Enter].
4. Type a Beginning Date and press [Enter].
5. Type an Ending Date and press [Enter].
6. Select one of the following and press [Enter]:
   - O Cases Opened in that Date Range
   - C Cases Closed in that Date Range
   - B Cases either opened or closed in that Date Range
7. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
8. To select a particular provider's caseload, type [O] and press [Enter] when prompted. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all providers, type [A] at the prompt and press [Enter].
9. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
10. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                        DURATION OF CARE REPORT
PATIENT NAME   CHART    CASE OPEN   CASE CLOSED   DURATION    POV   PROVIDER
               NUMBER   DATE        DATE
  Patient A    148367   05/22/06    08/22/06      92 days           BRUNER,B
  Patient B    114077   06/27/06    08/28/06      62 days           BRUNER,B
  Patient B    114077   07/25/06    08/21/06      27 days           BRUNER,B
  Total Number of Cases for BRUNER,B: 3
  Average Duration of Care: 60.33 days

  Patient C    211053   04/19/06    08/16/06     119 days    72.1   SCHIFAN,RO
  Total Number of Cases for SCHIFAN,ROBERTA: 1
  Average Duration of Care: 119.00 days

  Patient D    146565   08/01/06    08/16/06     15 days    305.62  VICTORY,MAUDE
  Total Number of Cases for VICTORY,MAUDE: 1
  Average Duration of Care: 15.00 days

  Patient E    148256   07/25/06    09/01/06    38 days           YOUNG,VICTOR L
  Total Number of Cases for YOUNG,VICTOR L: 1
  Average Duration of Care: 38.00 days

  Patient F    106030   05/22/06    08/30/06    100 days        ZIESLER,GEORGE G
  Total Number of Cases for ZIESLER,GEORGE G: 1
  Average Duration of Care: 100.00 days

  Total Number of Cases: 7
  Average Duration of Care: 64.71 days
```

Figure 3-1: Sample duration of care report

SENO Patients Seen X Number of Times with No Case Open

This report will produce a list of patients, in a date range specified by the user, who have been seen a certain number of times but do not have open cases. The user, based on their program's standards of care, specifies when a case is to be opened. For example, a case will be opened if a patient has been seen at least three (3) times.

1. Type [PAT] to select Patient Listings Reports and press [Enter].
2. Type [CASE] for Case Status Reports and press [Enter].
3. Type [SENO] for the Patient Seen X Number of Times with No Case Open Report and press [Enter].
4. Type a Beginning Date and press [Enter].
5. Type an Ending Date and press [Enter].
6. Run `Report for Which Program` prompt. Type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter].
7. To select a particular provider's caseload, type [O] and press [Enter] at the `Include cases opened by` prompt. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all

providers, type [A] at the `Include cases opened by` prompt and press [Enter].

8. Enter the number of visits that may occur before a case should be opened (for example, three visits) and press [Enter].
9. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
10. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                          DEMO INDIAN HOSPITAL
            PATIENTS SEEN AT LEAST 2 TIMES WITH NO CASE OPEN DATE
                VISIT DATE RANGE: Jun 02, 2006 to Nov 29, 2006

                      VISITS TO PROGRAM: MENTAL HEALTH
PATIENT NAME  CHART   SEX   DOB     #     LAST VISIT  LAST     PROVIDER
              NUMBER              VISITS               DX
Patient G     116431  F 02/07/75   3     11/14/06    43.1     BRUNER,B
Patient H     142538  F 10/10/42   3     11/27/06    27       BRUNER,B
Patient I     113419  M 07/18/85   3     08/16/06    296.33   BAKER,KEITH N
Patient J     201295  M 05/14/41   4     08/22/06    296.40   FAIRCHILD, THO
Patient K     194181  M 08/21/98   2      06/19/06   314.9    YARBROW,JOH

    Total Number of Patients: 5
```

Figure 3-2: Sample patients seen at least x number of times with no case open date

ONS Cases Opened but Patient Not Seen in N Days

This was formerly known as the SEEN Report. Report display has been changed to include the provider's name.

```
                          DEMO INDIAN HOSPITAL
              ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)
PATIENT NAME  CHART   SEX  DOB      CASE OPEN   PROVIDER   DATE LAST   # DAYS
              NUMBER                DATE                   SEEN        SINCE
Patient L     106299  F  11/28/85  01/01/06  GRENWAY,DON  04/26/06    217
Patient M     102446  F  04/08/66  08/28/06  GRENWAY,DON  03/28/06    246
Patient N     176203  M  03/04/60  10/10/05  GRENWAY,DON  03/28/06    246
Patient O     164141  M  02/07/75  12/07/05  GRENWAY,DON  04/25/06    218
Patient P     209591  F  04/16/62  07/25/06  WEARY,MAT    07/25/06    127

    Total Number of Patients: 5
    Total Number of Cases: 5
```

Figure 3-3: Sample cases opened but patient not seen in n days

3.1.1.2 Screening Reports

The RPMS screening exam codes for IPV/DV, Depression, and Alcohol are available in BHS v3.0 and the graphical user interface to BHS v3.0 which is known as BH GUI v1.5 (Patient Chart). The exam codes allow the provider to document the results of the domestic violence, alcohol, or depression screenings.

IPV/DV, Depression, and Alcohol Screening report functionality is available in BHS v3.0, Reports Menu. There are five reports total for each of the types of screening. This document describes the three most commonly used reports: ASP, ALS, and ASSP. These reports can be used by a behavioral health program at the local level to generate data on screenings administered by behavioral health providers. National GPRA IPV/DV, Alcohol, and Depression Screening reports are done using the Clinical Reporting System (CRS) application. CRS will look at the data available in the Patient Care Component (PCC) of RPMS as well as data in BHS v3.0 if the link to PCC is on in BHS v3.0.

The user can navigate to the screening reports from BHS v3.0 by following the menus listed below (using Alcohol Screening as the example):

DE	Behavioral Health Data Entry Menu ...
RPTS	**Reports Menu ...**
MUTL	Manager Utilit
PAT	**Patient Listings ...**
REC	Behavioral Health Record/Encounter Reports ...
WL	Workload/Activity Reports ...
PROB	Problem Specific Reports ...
TABL	Print Standard Behavioral Health Tables ..
ACL	Active Client List
PGEN	Patient General Retrieval
DP	Designated Provider List
GRT	Patients with AT LEAST N Visits
AGE	Patients Seen by Age and Sex
CASE	Case Status Reports…
GAFS	GAF Scores for Multiple Patients
NSDR	Listing of No Show Visits in a Date Range
PERS	Patient List for Personal Hx Items
PPL	Placements by Site/Patient
PPR	Listing of Patients with Selected Problems
SCRN	**Screening Reports…**
TPR	Treatment Plans…
TSG	Patient seen in groups w/Time in Group
IPV	IPV/DV Reports…
ALC	**Alcohol Screening Reports**
DEP	Depression Screening Reports
ASP	Tally/List Patients with Alcohol Screening
ALS	Tally/List Alcohol Screenings
ASSP	List all Alcohol Screenings for Selected Patients
APST	Tally/List Pts in Search Template wAlcohol Screening
AVST	Tally List all Alcohol Screenings for Template of Pts

ASP Tally and Listing Of Patient's Receiving Alcohol Screening, Including Refusals

This report will tally and optionally list all patients who have had Alcohol screening (Exam code 35) or a refusal documented in the time frame specified by the user. This report will tally the patients by age, gender, result, provider (either exam provider, if

available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

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.

To run the Tally/List Patients with Alcohol Screening report, follow these steps:

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

```
Total Number of Patients screened          4
                By Result
                NEGATIVE                1              25.0%
                POSITIVE                2              50.0%
                REFUSED SCREENING       1              25.0%

                 By Gender
                 FEMALE         3       75.0%
                 MALE           1       25.0%

                 By Age
                 26 yrs         1       25.0%
                 27 yrs         1       25.0%
                 44 yrs         1       25.0%
                 48 yrs         1       25.0%

                 By Provider who screened
                 IMHOFF, GEORGE  C        1       25.0%
                 UNGER, FRANK S           1       25.0%
                 WEARY, MATT              1       25.0%
                 WESTERN, STEVE N         1       25.0%

                 By Primary Provider of Visit
                 UNGER, FRANK S           1       25.0%
                 WEARY, MATT              1       25.0%
                 WESTERN, STEVE N         1       25.0%

                 By Clinic
                 ALCOHOL AND SUBSTANCE         1       25.0%
                 MEDICAL SOCIAL SERVICES       1       25.0%
                 MENTAL HEALTH                 2       50.0%

                 By Date
                 Jul 25, 2006         1       25.0%
                 Aug 09, 2006         1       25.0%
                 Aug 17, 2006         1       25.0%
                 Aug 23, 2006         1       25.0%
     PATIENT NAME   HRN     AGE   SCREENED    RESULT         CLINIC
     Patient Q      114551  26 F  08/17/06    POSITIVE     ALCOHOL AND SUBST
     DXs: 29.1     SCREENING FOR ALCOHOLISM
          29.2     SCREENING FOR DRUG ABUSE
          995.81   ADULT ABUSE (SUSPECTED), PHYSICAL
     Primary Provider on Visit:  UNGER, FRANK  S
     Provider who screened:  UNGER, FRANK S

     Patient R     116475  27 F  08/23/06   REFUSED SCREENIN  MENTAL HEALTH
     DXs: 14.1     SCREENING FOR DEPRESSION
     Primary Provider on Visit:  IMHOFF, GEORGE C
     Provider who screened:  IMHOFF, GEORGE C

     Patient S     206936  48 M   08/09/06   NEGATIVE      MEDICAL SOCIAL SE
     DXs: 14.1     SCREENING FOR DEPRESSION
          995.82   ADULT ABUSE (SUSPECTED), EMOTIONAL
     Primary Provider on Visit:  WESTERN, STEVE N
     Provider who screened:  WESTERN, STEVE N
```

Figure 3-4: Sample tally/list patients with alcohol screening report

ALS Tally and Listing of All Visits W/Alcohol Screening

This report will tally and optionally list all visits on which Alcohol screening (Exam code 35) or a refusal was documented in the time frame specified by the user. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

> **Note:** This report will optionally look at both the Behavioral Health and PCC clinical databases for evidence of screening/refusal.

1. Type ALS at the "Select Alcohol Reports Option" prompt.
2. A description of the report displays.
3. Type a beginning date for your listing at the "Enter Beginning Date for Screening" prompt.
4. Type an ending date for your listing at the "Enter Ending Date for Screening" prompt.
5. Type the number of the items which you would like tallied at the "Which items should be tallied" prompt.
6. Type YES or NO at the "Would you like to include Alcohol Screenings documented in the PCC clinical database?" prompt.
7. Type YES or NO at the "Would you like to include a list of visits w/screening done?" prompt.
8. Select how you would like the list to be sorted by typing the character of the option at the "How would you like the list to be sorted" prompt.
9. Type the name of an output device at the "Device" prompt.

```
      Total Number of Visits with Screening    4
      Total Number of Patients screened     4
           By Result
                 NEGATIVE                1     25.0%
                 POSITIVE                2     50.0%
                 REFUSED SCREENING       1     25.0%
           By Gender
                 FEMALE                  3     75.0%
                 MALE                    1     25.0%
           By Age
                 26 yrs                  1      25.0%
                 27 yrs                  1      25.0%
                 44 yrs                  1      25.0%
                 48 yrs                  1      25.0%
         By Provider who screened
            IMHOFF, GEORGE C             1      25.0%
            UNGER, FRANK S               1      25.0%
            WEARY, MATT                  1      25.0%
            WESTERN, STEVE N             1      25.0%
        By Primary Provider of Visit
            IMHOFF, GEORGE C             1           25.0%
            UNGER,FRANK S                1           25.0%
            WEARY, MATT                  1           25.0%
            WESTERN, STEVE N             1           25.0%
      By Designated Primary Care Provider
            UNKNOWN                      3           75.0%
            WHEATON,HELEN K              1           25.0%
      By Clinic
             ALCOHOL AND SUBSTANCE       1           25.0%
             MEDICAL SOCIAL SERVICES     1           25.0%
             MENTAL HEALTH               2           50.0%
      By Date
             Jul 25, 2006                1           25.0%
             Aug 09, 2006                1           25.0%
             Aug 17, 2006                1           25.0%
             Aug 23, 2006                1           25.0%
      By Designated Mental Health Provider
             UNKNOWN                     4           100.0%
      By Designated Social Services Provider
             UNKNOWN                     4           100.0%
      By Designated A/SA Provider
             UNKNOWN                     4           100.0%
PATIENT NAME      HRN         AGE         SCREENED   RESULT        CLINIC
   Patient T      114551      26  F       08/17/06   POSITIVE
   DXs: 29.1     SCREENING FOR ALCOHOLISM
        29.2     SCREENING FOR DRUG ABUSE
        995.81   ADULT ABUSE (SUSPECTED), PHYSICAL
Primary Provider on Visit:  UNGER, FRANK S
Provider who screened: UNGER, FRANK S

   Patient U      116475      27  F       08/23/06    REFUSED SCREENIN
   DXs: 14.1     SCREENING FOR DEPRESSION
   Primary Provider on Visit:  IMHOFF, GEORGE C
   Provider who screened: IMHOFF, GEORGE C
```

Figure 3-5: Sample tally and listing of all visits w/alcohol screening report

ASSP List all ALCOHOL Screenings for Selected Patients

This report lists all patients you select who have had an alcohol screening or a refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done.

To run the List all Alcohol Screenings for Selected Patients report, follow these steps:

1. Type SSP at the "Select Alcohol Reports Option" prompt.
2. A description of the report displays.
3. Type a beginning date for your listing at the "Enter Beginning Date for Screening:" prompt.
4. Type an ending date for your listing at the "Enter Ending Date for Screening" prompt.
5. Type YES or NO at the "Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?" prompt.
6. Type F (Females Only), M (Males Only), or B (Both Male and Females) at the "Include which patients in the list:" prompt.
7. Type YES or NO at the "Would you like to restrict the report by Patient age range?" prompt.
8. Type an age range at the "Enter an Age Range (e.g. 5-12,1-1):" prompt.
9. Type the number of the value you would like included on your report at the "Which result values do you want included on this list:" prompt.
10. Type YES or NO at the "Include visits to ALL clinics?" prompt.
11. Type O (One Provider Only), P (Any/All Providers (including unknown)), or U (Unknown Provider Only) at the "Report should include visits whose Primary Provider on the visit is:" prompt.
12. Type O (One Provider Only), P (Any/All Providers (including unknown)), or U (Unknown Provider Only) at the "Select which providers who performed the screening should be included:" prompt.
13. Type YES or NO at the "Would you like to limit the list to just patients who have a particular designated Mental Health provider?" prompt.
14. Type YES or NO at the "Would you like to limit the list to just patients who have a particular designated Social Services provider?" prompt.

15. Type YES or NO at the "Would you like to limit the list to just patients who have a particular designated ASA/CD provider?" prompt.
16. Type L (List of Patient Screenings) or S (Create a Search Template of Patients) at the "Select Report Type:" prompt.
17. Select how you would like the list to be sorted by typing the character of the option at the "How would you like the list to be sorted:" prompt.
18. Type the name of an output device at the "Device:" prompt.
19. The report is then displayed onscreen or printed.

```
***ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS ***
Screening Dates: Jan 01, 2000 to Jan 31, 2005

PATIENT NAME HRN AGE SCREENED RESULT CLINIC
--------------------------------------------------------------------------------
No data to report.
```

Figure 3-6: Sample list all alcohol screenings for selected patients report

3.1.1.3 Treatment Plan Reports

NOTP Patients with Case Open but no Treatment Plan
This report will list all patients who have a case open date, no case closed date, and no treatment plan in place.

1. Type [PAT] to select Patient Listings Reports and press [Enter].
2. Type [TPR] to select Treatment Plan Reports and press [Enter].
3. Type [NOTP] for Patients with Case Open but no Treatment Plan Report and press [Enter].
4. Type a Beginning Date and press [Enter].
5. Type an Ending Date and press [Enter].
6. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
7. To select a particular provider's caseload, type [O] and press [Enter] when prompted. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all providers, type [A] at the prompt and press [Enter].
8. Select the category that should be used to sort the list – Responsible Provider, Patient Name, or Case Open Date – and press [Enter].
9. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.

10. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                        DEMO INDIAN HOSPITAL
         LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE
         Case Open Dates: JUN 02, 2006 to NOV 29, 2006
                   Program: OTHER
PATIENT NAME     HRN     CASE OPEN   PROGRAM     PROVIDER          LAST VISIT
                         DATE
Patient AF      187413   08/07/06    OTHER       BRUNER,B          10/09/06
```

Figure 3-7: Sample patients with case open but no treatment plan report

3.1.1.4 Other New Patient Listing Reports

GAFS GAF Scores for Multiple Patients

This option is used to list GAF scores for multiple patients sorted by patient.

1. Type [PAT] to select Patient Listings Reports and press [Enter].
2. Type [GAFS] for GAF Scores for Multiple Patients Report and press [Enter].
3. Type a Beginning Date and press [Enter].
4. Type an Ending Date and press [Enter].
5. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
6. To select a particular provider's caseload, type [O] and press [Enter] when prompted. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all providers, type [A] at the prompt and press [Enter].
7. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
8. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                    GAF SCORES FOR MULTIPLE PATIENTS
                    Visit Dates: Jun 02, 2006 to Nov 29, 2006
                    Program: MENTAL HEALTH
                          Provider: ALL

PATIENT NAME  HRN    Date     GAF  Provider    PG  Diagnosis/POV
PATIENT V     183497 08/22/06 48   GRENWAY,DON M  295.10-SCHIZOPHRENIA, DISOR

PATIENT W     141621 11/20/06 45   BRUNER,B    M  43.1-PARTNER ABUSE (SUSPE

PATIENT X     113419 06/16/06 45   BARNETT,LIN M  296.33-MAJOR DEPRESSIVE DIS
PATIENT X     113419 07/18/06 50   BACKER,KEN  M  296.33-MAJOR DEPRESSIVE DIS
PATIENT X     113419 08/16/06 55   BACKER,KEN  M  296.33-MAJOR DEPRESSIVE DIS

PATIENT Y     201295 06/26/06 50   GASTON,PAM  M  38.1-DIAGNOSIS DEFERRED O
PATIENT Y     201295 07/10/06 40   CHILDRESS,H M  296.40-BIPOLAR I DISORDER,
PATIENT Y     201295 07/17/06 45   CHILDRESS,H M  296.40-BIPOLAR I DISORDER,
PATIENT Y     201295 08/22/06 52   CHILDRESS,H M  296.40-BIPOLAR I DISORDER,
```

Figure 3-8: Sample GAFs scores for multiple patients report

NSDR Listing of No Show Visits in a Date Range

This option will print a list of visits with POVs related to No Shows and Cancellations for multiple patients. Date range, program, and provider can be specified by the user.

1. Type [PAT] to select Patient Listings Reports and press [Enter].
2. Type [NSDR] for Listing of No Show Visits in a Date Range Report and press [Enter].
3. Type a Beginning Date and press [Enter].
4. Type an Ending Date and press [Enter].
5. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
6. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all providers, type [A] at the prompt and press [Enter].
7. Indicate whether you would like the report sorted by Patient Name or Date of Visit and press [Enter].
8. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
9. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
              BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
             Appointment Dates:  JUN 02, 2006 and NOV 29, 2006

PATIENT NAME  HRN      DATE/TIME           PROVIDER     PG  POV

PATIENT Z     188444   Sep 14, 2006@12:00  GRENWAY,DON  M   8-FAILED APPOI
PATIENT AA    103182   Aug 30, 2006@09:00  BRUNER, B    O   8-FAILED APPOI
PATIENT AB    112451   Aug 30, 2006@12:00  VAUGHN,JI    M   8.11-PATIENT CANC
PATIENT AC    190866   Jul 27, 2006@11:00  DAVIS,PAM    S   8.1-PATIENT CANC
PATIENT AD    138796   Aug 09, 2006@10:30  ENSLOW, N    M   8.11-PATIENT CANC
PATIENT AE    112160   Jul 19, 2006@09:30  ELLIS, WADE  C   8.3-DID NOT WAIT
Total # of Patients: 6    Total # of No Show Visits: 6
```

Figure 3-9: Sample listing of no show visits in a date range report

PPL Placements by Site/Patient

This report has been changed to include all placements recorded in the encounter record's Placement Disposition field.

This report will produce a list of patients who had had a placement disposition recorded in the past year.

1. Type [PAT] to select Patient Listings Reports and press [Enter].
2. Type [PPL] for Placements by Site/Patient Report and press [Enter].
3. Type a Beginning Date and press [Enter].
4. Type an Ending Date and press [Enter].
5. Indicate whether you would like the report sorted Alphabetically by Patient Name or Alphabetically by Site Referred to and press [Enter].
6. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
7. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                          DEMO INDIAN HOSPITAL
                               PLACEMENTS
                  PLACEMENT DATES:  NOV 29, 2005  TO  NOV 29, 2006

PATIENT NAME   HRN      DATE    POV      PLACEMENT       FACILITY REFERRED TO
                        PLACED
Patient A      183497  02/03/06 90       RESIDENTIAL      Chief Gall
  Placement Made by: BRUNER, B
  Designated MH Prov: GRENWAY, DON
  Designated SS Prov: BRUNER, B
  Designated A/SA/CD Prov: LOMAND, MICHAEL
Patient A      183497  08/22/06 295.10   INPATIENT PSYC   tucson psychiatric
  Placement Made by: GRENWAY, DON
  Designated MH Prov: GRENWAY, DON
  Designated SS Prov: BRUNER, B
  Designated A/SA/CD Prov: LOMAND, MICHAEL
Patient B      198858  02/28/06 311.    INPATIENT PSYC    palo verde psych. h
  Placement Made by: BRUNER, B
Patient C      188444  09/18/06 305.1   INPATIENT PSYC    GOOD SHEPHERD
  Placement Made by: BRUNER, B
Patient D      135004  04/11/06 312.31  PARTIAL HOSPIT    OKC Good Samaritan
  Placement Made by: BRUNER, B

Subtotal by Placement Type:
     INPATIENT PSYCH                    3
     PARTIAL HOSPITAL                   1
     RESIDENTIAL                        1

Subtotal by Facility Referred to:
     Chief Gall                         1
     GOOD SHEPHERD                      1
     OKC Good Samaritan Hospital        1
     palo verde psych. hosp.            1
     tucson psychiatric institute       1

Total Number of Placements: 5
```

Figure 3-10: Sample placement by site/patient report

3.2 Workload/Activity Reports

PA Tally of Prevention Activities

This report will produce 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.

1. Type [WL] to select Workload/Activity Reports and press [Enter].
2. Type [PA] for the Tally of Prevention Activities Report and press [Enter].
3. Type a Beginning Date and press [Enter].
4. Type an Ending Date and press [Enter].
5. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for

Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].

6. At the next prompt, choose the prevention activities to be tallied: All providers, Selected set or taxonomy of providers, or One provider, and press [Enter]. If you selected a Selected set of providers or One provider, enter the last name of the provider at the next prompt and press [Enter]. If you selected the set or taxonomy option, continue to enter providers until all have been listed. If you want to see the information for all providers, type [A] at the "Include cases opened by:" prompt and press [Enter].
7. If you selected a set of providers and wish to save the group for future use, type [Y] and press [Enter] at the next prompt. Assign a group name at the next prompt and press [Enter], then type a brief description for the taxonomy and press [Enter]. The next prompt, "Extended Description," allows for a more in depth explanation of the taxonomy and is optional. Press [Enter] to continue.
8. Press [Enter] at Device: Home, and Right Margin to display the report. To print the report, type in the location of your printer at the "Device" prompt and press [Enter].
9. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
              *   TALLY OF PREVENTION ACTIVITIES  *
             VISIT Date Range: AUG 31, 2006 through NOV 29, 2006
PREVENTION ACTIVITY    # of visits    % of visits

Total # Visits w/Prevention Activity:          3
Total # of Prevention Activities recorded:     3

DOMESTIC VIOLENCE       1               33.3
      YOUTH             1               100.0

PUBLIC AWARENESS        1               33.3
      ADULT             1               100.0

SMOKING/TOBACCO         1               33.3
     MIXED(ADULT & YTH) 1               100.0

TARGET TOTALS
ADULT                   1        33.3
MIXED(ADULT & YTH)      1        33.3
YOUTH                   1        33.3
```

Figure 3-11: Sample tally of prevention activities report

3.3 Problem Specific Reports

3.3.1 Suicide Related Reports

Many of the suicide related reports have been modified to allow for the selection or printing of information in the "Other" data entry fields. Some minor changes were made to report titles and the descriptive paragraphs. SSR, SDEL, and SGR have been modified to include the ability to select a particular suicidal behavior or all activity.

SSR Aggregate Suicide Form Data - Standard
This report will tally the data items specific to the Suicide Form for a date range, community, and type of self-destructive act as specified by the user.

1. Type [PROB] to select Problem Specific Reports and press [Enter].
2. Type [SUIC] to select the Suicide Related Reports and press [Enter].
3. Type [SSR] for the Aggregate Suicide Form Data - Standard Report and press [Enter].
4. Type a Beginning Date and press [Enter].
5. Type an Ending Date and press [Enter].
6. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
7. At the next prompt, choose the self-destructive act to be tallied and press [Enter]:
    - Ideation with Plan and Intent
    - Attempt
    - Completed Suicide
    - Attempted Suicide with Homicide
    - Completed Suicide with Homicide
    - All of the Above (Also Includes Blanks)
8. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
9. Follow the onscreen instructions to return to the Report Menu after completing this activity.

******* AGGREGATE SUICIDE FORM DATA - STANDARD*******
Act Occurred: Aug 31, 2006 - Nov 29, 2006
Community where Act Occurred: ALL Communities

Age Range: 25-44 years Total # of Suicide Forms: 3

		REPORT	TOTALS
Self Destructive Act:	ATTEMPT	3	100%
Event logged by Discipline:	MEDICAL SOCIAL WORKER	3	100%
Event logged by Provider:	GRENWAY, DON	3	100%
Sex:	FEMALE	1	33%
	MALE	2	67%
Employed:	UNEMPLOYED	3	100%
Tribe of Enrollment:	CHEROKEE NATION OF OKLAHOMA	3	100%
Community of Residence:	MUSKOGEE	2	67%
	TAHLEQUAH	1	33%
Relationship:	SINGLE	3	100%
Education:	HIGH SCHOOL GRADUATE/GED	1	33%
	SOME COLLEGE/TECHNICAL SCHOOL	2	67%
Method:	HANGING	3	100%
	OTHER	3	100%
Method if Other:	Drowning	1	33%
	Suicide by Cop	1	33%
	MVA	1	33%
Previous Attempts:	0	1	33%
	2	1	33%
	3 OR MORE	1	33%
Substance Use Involved:	ALCOHOL AND OTHER DRUGS	3	100%
Location of Act:	OTHER	3	100%
Other location of Act:	Cabin in the woods	1	33%
	Grandparent’s Farm	1	33%
Lethality:	MEDIUM	3	100%
Disposition:	OTHER	3	100%
Disposition if OTHER:	County Psychiatric Facility	1	33%
	Juvenile Treatment Facility	1	33%
	Foster Care	1	33%
Contributing Factors:	LEGAL	1	33%
	OTHER	3	100%
Contributing Factor if OTHER:	Test Results	1	33%
	cont fact 8	1	33%
Substance Drugs:	OTHER	3	100%
	Other Substance Test	1	33%
	Other substance	1	33%
	other alcohol and drugs	1	33%

Age Range: 45-64 years Total # of Suicide Forms: 1

		REPORT	TOTALS
Self Destructive Act:	ATTEMPT	1	100%
Event logged by Discipline:	MEDICAL SOCIAL WORKER	1	100%
Event logged by Provider:	BRUNER,B	1	100%
Sex:	FEMALE	1	100%
Employed:	DATA NOT ENTERED	1	100%
Tribe of Enrollment:	CHEROKEE NATION OF OKLAHOMA	1	100%
Community of Residence:	TAHLEQUAH	1	100%

Relationship:	SAME SEX PARTNERSHIP	1	100%
Education:	COLLEGE GRADUATE	1	100%
Method:	OTHER	1	100%
Method if Other:	drowning	1	100%
Previous Attempts:	UNKNOWN	1	100%
Substance Use Involved:	NONE	1	100%
Location of Act:	OTHER	1	100%
Other location of Act:	Lake Bemidji	1	100%
Lethality:	MEDIUM	1	100%
Disposition:	MENTAL HEALTH FOLLOW-UP	1	100%
Contributing Factors:	UNKNOWN	1	100%

Age Range: 65-125 years **Total # of Suicide Forms: 1**

		REPORT	TOTALS
Self Destructive Act:	ATTEMPT	1	100%
Event logged by Discipline:	MEDICAL SOCIAL WORKER	1	100%
Event logged by Provider:	BRUNER,B	1	100%
Sex:	FEMALE	1	100%
Employed:	RETIRED	1	100%
Tribe of Enrollment:	CHOCTAW NATION OF OKLAHOMA	1	100%
Community of Residence:	SAWYER	1	100%
Relationship:	SINGLE	1	100%
Education:	LESS THAN 12 YEARS	1	100%
Method:	GUNSHOT	1	100%
	OVERDOSE	1	100%
Previous Attempts:	UNKNOWN	1	100%
Substance Use Involved:	NONE	1	100%
Location of Act:	OTHER	1	100%
Other location of Act:	Adult Day Care Center	1	100%
Lethality:	HIGH	1	100%
Disposition:	IN-PATIENT MENTAL HEALTH TREAT	1	100%
Contributing Factors:	FINANCIAL STRESS	1	100%
	HISTORY OF PHYSICAL ILLNESS	1	100%

Age Range: ALL AGES **Total # of Suicide Forms: 5**

		REPORT	TOTALS
Self Destructive Act:	ATTEMPT	5	100%
Event logged by Discipline:	MEDICAL SOCIAL WORKER	5	100%
Event logged by Provider:	GRENWAY, DON	3	60%
	BRUNER, B	2	40%
Sex:	FEMALE	3	60%
	MALE	2	40%
Employed:	RETIRED	1	20%
	UNEMPLOYED	3	60%
	DATA NOT ENTERED	1	20%
Tribe of Enrollment:	CHEROKEE NATION OF OKLAHOMA	4	80%
	CHOCTAW NATION OF OKLAHOMA	1	20%
Community of Residence:	MUSKOGEE	2	40%
	SAWYER	1	20%
	TAHLEQUAH	2	40%
Relationship:	SINGLE	4	80%

```
                        SAME SEX PARTNERSHIP              1                 20%
Education:          LESS THAN 12 YEARS                    1                 20%
                    HIGH SCHOOL GRADUATE/GED              1                 20%
                    SOME COLLEGE/TECHNICAL SCHOOL         2                 40%
                    COLLEGE GRADUATE                      1                 20%
Method:                   GUNSHOT                         1                 20%
                          HANGING                         3                 60%
                          OVERDOSE                        1                 20%
                          OTHER                           4                 80%
Method if Other:            drowning                      2                 40%
                            Suicide by cop                1                 20%
                            MVA                           1                 20%
Previous Attempts:  0                                     1                 20%
                    2                                     1                 20%
                    3 OR MORE                             1                 20%
                    UNKNOWN                               2                 40%
Substance Use Involved:  NONE                             2                 40%
                          ALCOHOL AND OTHER DRUGS         3                 60%
Location of Act:  OTHER                                   5                100%
Other location of Act:  Adult Day Care Center             1                 20%
                        Lake Bemidji                      1                 20%
                        Grandparent's Farm                1                 20%
                        Cabin in Woods                    1                 20%
Lethality:          HIGH                                  1                 20%
                    MEDIUM                                4                 80%
Disposition:        MENTAL HEALTH FOLLOW-UP               1                 20%
                    IN-PATIENT MENTAL HEALTH TREAT        1                 20%
                    OTHER                                 3                 60%
Disposition if OTHER:   County Psychiatric Facility      1                 20%
                        Juvenile Treatment Facility       1                 20%
                        Foster Care                       1                 20%
Contributing Factors:   FINANCIAL STRESS                  1                 20%
                        HISTORY OF PHYSICAL ILLNESS       1                 20%
                        LEGAL                             1                 20%
                        UNKNOWN                           1                 20%
                        OTHER                             3                 60%
Contributing Factor if OTHER:       Test Results          1                 20%
                              cont fact 8                 1                 20%
Substance Drugs:                  OTHER                   3                 60%
                                  Other Substance Test    1                 20%
                                  Other substance         1                 20%
                                  other alcohol and drugs 1                 20%
```

Figure 3-12: Sample aggregate suicide form data – standard report

SPOV Suicide Purpose of Visit Report

This report will display the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Enc). A display by age and gender is also included.

1. Type [PROB] to select Problem Specific Reports and press [Enter].
2. Type [SUIC] to select the Suicide Related Reports and press [Enter].
3. Type [SPOV] for the Suicide Purpose of Visit Report and press [Enter].
4. Type a Beginning Date and press [Enter].

5. Type an Ending Date and press [Enter].
6. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
7. Press [Enter] at Device: Home, and Right Margin to display the report. To print the report, type in the location of your printer at the `"Device"` prompt and press [Enter].
8. Follow the onscreen instructions to return to the Report Menu after completing this activity.

*** SUICIDE PURPOSE OF VISIT REPORT ***
VISIT Date Range: OCT 31, 2006 through NOV 30, 2006
BOTH MALE AND FEMALE PATIENTS' VISITS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	7	35.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	6	30.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	5.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	20	100.0	0	0.0	0	0.0	0	0.0	0	0.0

MALE PATIENTS VISITS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	6	66.7	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

FEMALE PATIENTS VISITS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	4	36.4	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0

65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	5	38.5	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - MALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	50.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	3	33.3	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

55-64 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Figure 3-13: Sample suicide purpose of visit report

3.4 Reports on Data Entry Menu

GAFS GAF Scores for Multiple Patients

This report can also be found on the Reports Menu (RPTS:PAT;GAFS). This option is used to list GAF scores for multiple patients sorted by patient.

1. Type [DE] to select Behavioral Health Data Entry Menu and press [Enter].
2. Type [DSP] for the Display Record Options and press [Enter].
3. Type [GAFS] for GAF Scores for Multiple Patients Report and press [Enter].
4. Type a Beginning Date and press [Enter].
5. Type an Ending Date and press [Enter].
6. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
7. To select a particular provider's caseload, type [O] and press [Enter] when prompted. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all providers, type [A] at the prompt and press [Enter].
8. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
9. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                    GAF SCORES FOR MULTIPLE PATIENTS
                Visit Dates: Jun 02, 2006 to Nov 29, 2006
                        Program: MENTAL HEALTH
                            Provider: ALL

PATIENT NAME  HRN    Date     GAF Provider     PG  Diagnosis/POV
PATIENT V     183497 08/22/06 48  GRENWAY,DON  M  295.10-SCHIZOPHRENIA, DISOR

PATIENT W     141621 11/20/06 45  BRUNER,B     M  43.1-PARTNER ABUSE (SUSPE

PATIENT X     113419 06/16/06 45  BARNETT,LIN  M  296.33-MAJOR DEPRESSIVE DIS
PATIENT X     113419 07/18/06 50  BACKER,KEN   M  296.33-MAJOR DEPRESSIVE DIS
PATIENT X     113419 08/16/06 55  BACKER,KEN   M  296.33-MAJOR DEPRESSIVE DIS

PATIENT Y     201295 06/26/06 50  GASTON,PAM   M  38.1-DIAGNOSIS DEFERRED O
PATIENT Y     201295 07/10/06 40  CHILDRESS,H  M  296.40-BIPOLAR I DISORDER,
PATIENT Y     201295 07/17/06 45  CHILDRESS,H  M  296.40-BIPOLAR I DISORDER,
PATIENT Y     201295 08/22/06 52  CHILDRESS,H  M  296.40-BIPOLAR I DISORDER,
```

Figure 3-14: Sample GAF scores for multiple patients report

GAF GAF Scores for One Patient

This option is used to list GAF scores for a patient in date order.

1. Type [DE] to select Behavioral Health Data Entry Menu and press [Enter].
2. Type [DSP] for the Display Record Options and press [Enter].
3. Type [GAF] for GAF Scores for One Patient Report and press [Enter].
4. Type the first three letters of the patient's last name, the full last name, medical record number, or Social Security Number and press [Enter]. If presented with a list, type the number of the patient and press [Enter].
5. Select the subset of visits to be displayed and press [Enter]:
   - Patient's Last N Visits
   - Visits in a Date Range
   - All of this Patient's Visits
   - Visits to One Program
   - Visits to One Provider
6. Follow the instructions (Enter date range, select number of visits, etc.) if you selected any subset other than All of this Patient's Visits.
7. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
Patient Name:  PATIENT A        DOB: Feb 07, 1975
HRN: 116431

Date        GAF PROVIDER       PROGRAM    Diagnosis/POV
04/07/06    65  GRENWAY,DON    MENTAL H   296.32 - MAJOR DEPRESSIVE DISORDER,
04/07/06    65  GRENWAY,DON    MENTAL H   296.32 - MAJOR DEPRESSIVE DISORDER,
04/19/06     0  GRENWAY,DON    SOCIAL S   43.1 - PARTNER ABUSE (SUSPECTED),PH
10/17/06    65  GRENWAY,DON    SOCIAL S   296.21 - AT RISK FOR HOMELESSNESS
```

Figure 3-15: Sample GAF scores for one patient report

This report is also available on the PDE, Patient Data Entry menu (DE:PDE:GS).

NOTP Patients with Case Open but no Treatment Plan

This report will list all patients who have a case open date, no case closed date, and no treatment plan in place.

1. Type [DE] to select Behavioral Health Data Entry menu and press [Enter].
2. Type [TPU] to select Update BH Patient Treatment Plans menu and press [Enter].
3. Type [NOTP] for Patients with Case Open but no Treatment Plan Report and press [Enter].
4. Type a Beginning Date and press [Enter].
5. Type an Ending Date and press [Enter].
6. To select one particular program, type [O] at the next prompt and press [Enter]; then type [M] for Mental Health, [S] for Social Services, [C] for Chemical Dependency or alcohol/substance abuse, or [O] for Other and press [Enter]. To select all programs, type [A] at the prompt and press [Enter].
7. To select a particular provider's caseload, type [O] and press [Enter] when prompted. Then enter the last name of the provider at the next prompt and press [Enter]. To view the information for all providers, type [A] at the prompt and press [Enter].
8. Select the category that should be used to sort the list – Responsible Provider, Patient Name or Case Open Date – and press [Enter].
9. Type [P] and press [Enter] to generate a hard copy of the report, or type [B] and press [Enter] to view the report onscreen.
10. Follow the onscreen instructions to return to the Report Menu after completing this activity.

```
                        DEMO INDIAN HOSPITAL
          LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE
          Case Open Dates: JUN 02, 2006 to NOV 29, 2006
                         Program: OTHER
PATIENT NAME    HRN       CASE OPEN    PROGRAM     PROVIDER        LAST VISIT
                          DATE
Patient AF      187413    08/07/06     OTHER       BRUNER,B        10/09/06
```

Figure 3-16: Sample patients with case open but no treatment plan report.

This report is also available on the Reports Menu (RPTS:TPR:NOTP).

4.0 Appendix A: Activity Codes and Definitions

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

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.

Patient Services – Patient Always Present (P)
Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem, and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

01 – Twelve Step Work – Group (TSG)
Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. – is a disease of the mind, body, and spirit.

02 – Twelve Step Work – Individual (TSI)
Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. – is a disease of the mind, body, and spirit.

03 – Twelve Step Group (TSG)
Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, CoDA (Co-dependents Anonymous), and OA (Overeaters Anonymous).

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

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

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

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

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

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

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

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

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

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

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

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

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

48 – Crisis Intervention (CIP)
Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

85 – Art Therapy (ART)
The application of a variety of art modalities (drawing, painting, clay and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.

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

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

89 – Methadone Maintenance (MET)
Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed, 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 which are especially amenable to the benefits of peer interaction and support, and who meet regularly with a group therapist or facilitator.

92 – Adventure Based Counseling (ABC)
The use of adventure-based practice to effect a change in behaviors (both increasing function and positive action and decreasing dysfunction and negative action) as it relates to health and/or mental health.

93 – Relapse Prevention (REL)
Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

- Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
- Strategies for avoiding high-risk situations
- Strategies for coping with high-risk situations when encountered
- Strategies for coping with alcohol/drug cravings
- Strategies for coping with lapses to drug use to prevent full-blown relapses

94 – Life Skills Training (LST)
Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

95 – Cultural Activities – Pt. Present (CUL)
Participation in educational, social, or recreational activities for the purpose of supporting a client/patient's involvement, connection and contribution to his/her cultural background.

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

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

99 – Individual BH EHR Visit (EHR)
Behavioral Health visits entered into RPMS via the Electronic Health Record (EHR); 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.

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

24 – Material/Basic Support (SUP)
Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

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

26 – Medication/Medication Monitoring (MEA)
Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

27 – Forensic Activities (FOA)
Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

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

29 – Family Facilitation (FAA)
Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

30 – Follow-up/Follow-through (FUA)
Periodic evaluative review of a specific client/patient's progress after discharge.

31 – Case Management (CAA)
Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

33 – Technical Assistance
Task-specific assistance to achieve an identified end.

34 – Other Support Services
Any other ancillary, adjunctive, or collateral services not identified here.

44 – Screening
Activities associated with patient/client screening when the patient is not present.

45 – Assessment/Evaluation
Assessment or evaluation activities when patient is not present at time of service delivery.

49 – Crisis Intervention (CIA)
Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

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

35 – Collaboration
Collaborative effort with other agency or agencies to address a community request.

36 – Community Development
Planning and development efforts focused on identifying community issues and methods of addressing these needs.

37 – Preventive Services
Activity, class, project, public service announcement, or other activity whose primary purpose is to prevent the use/abuse of alcohol or other substances and/or improve lifestyles, health, image, etc.

38 – Patient Transport
Transportation of a client to or from an activity or placement, such as a medical appointment, program activity, or from home.

39 – Other Community Services
Any other form of community services not identified here.

40 – Referral
Referral of a client to another agency, counselor, or resource for services not available or provided by the referring agency/program. Referral is limited to providing the client with information and may extend to calling and setting up appointments for the client.

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

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

- 41 – Education/Training Provided
- 42 – Education/Training Received
- 43 – Other Education/Training

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

32 – Clinical Supervision Provided
Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

50 – Medical Rounds (General)
On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

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

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

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

54 – Quality Improvement
Participation in activities focused on improving the quality and appropriateness of medical or behavioral health care and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

55 – Supervision
Participation in activities to ensure that personnel perform their duties effectively. This code does not include clinical supervision.

56 – Records/Documentation
Review of clinical information in the medical record/chart or documentation of services provided to or on behalf of the client. This does not include the time spent in service delivery.

57 – Child Protective Team Activities
Participation in a multi-disciplinary child protective team to evaluate alleged maltreatments of child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance their caregiver's capacity to provide a safer environment when possible.

58 – Special Projects
A specifically-assigned task or activity which is completed over a period of time and intended to achieve a particular aim.

59 – Other Administrative
Any other administrative activities not identified in this section.

60 – Case Staffing (General)
A regular or ad-hoc forum for the exchange of clinical experience, ideas, and recommendations.

66 – Clinical Supervision Received
Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

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

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

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

63 – Program Consultation
Focus is a programmatic effort to address specific needs.

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

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

Travel (T)

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

72 – Travel Not Related to Patient Care
Staff travel to meetings, community events, etc.

Placements (PL)

75 – Placement (Patient Present) (OHP)
Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

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

Cultural Issues (O)

81 – Traditional Specialist Consult (Patient Present) (TRD)
Seeking recommendation or service from a recognized Indian spiritual leader or traditional practitioner with the patient present. Such specialists may be called in either as advisors or as direct providers, when agreed upon between client and counselor.

82 – Traditional Specialist Consult (Patient Not Present) (TRA)
Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or traditional practitioner (patient not present). Such specialists may be called in either as advisors or as direct providers, when agreed upon between client and counselor.

83 – Tribal Functions
Services offered during or in the context of a traditional tribal event, function, or affair – secular or religious. Community members gather to help and support individuals and families in need.

84 – Cultural Education to Non-Tribal Agency/Personnel
The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

5.0 Appendix B: Activity Codes that Pass to PCC

Activity Code	Description	Pass to PCC
01	Twelve Step Work – Group (TSG)	Yes
02	Twelve Step Work – Individual (TSI)	Yes
03	Twelve Step Group (TWG)	No
11	Screening – Patient Present (SCN)	Yes
12	Assessment/Evaluation – Patient Present (EVL)	Yes
13	Individual Treatment/Counsel/Education – Pt. Present (IND)	Yes
15	Information and Referral – Patient Present (REF)	Yes
16	Medication/Medication Monitoring – Pt. Present (MED)	Yes
17	Psychological Testing – Patient Present (TST)	Yes
18	Forensic Activities – Patient Present (FOR)	Yes
19	Discharge Planning – Patient Present (DSG)	Yes
20	Family Facilitation –Patient Present (FAC)	Yes
21	Follow Through/Follow Up – Patient Present (FOL)	Yes
22	Case Management – Patient Present (CAS)	Yes
23	Other Patient Services Not Identified – Patient Present (OTH)	Yes
24	Material/Basic Support – Patient Not Present (SUP)	No
25	Information and/or Referral – Patient Not Present (INF)	No
26	Medication/Medication Monitoring – Pt. Not Present (MEA)	Yes
27	Forensic Activities – Patient Not Present (FOA)	No
28	Discharge Planning – Patient Not Present (DSA)	No
29	Family Facilitation – Patient Not Present (FAA)	No
30	Follow Through/Follow Up – Patient Not Present (FUA)	No
31	Case Management – Patient Not Present (CAA)	Yes
32	Clinical Supervision Provided	No
33	Technical Assistance – Patient Not Present	No
34	Other Support Services – Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening – Patient Not Present	No
45	Assessment/Evaluation – Patient Not Present	No
47	Couples Treatment – Patient Present (CT)	Yes
48	Crisis Intervention – Patient Present (CIP)	Yes

Activity Code	Description	Pass to PCC
49	Crisis Intervention – Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes
99	Individual BH EHR Visits (EHR)	Yes

6.0 Appendix C: POV Codes

Purpose of Visit (POV) Codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to record activities; however, aggregate reports can be organized by these broad POV categories. The POV codes include DSM-IV-TR codes as well as BHS problem codes.

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

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

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

6.1 Medical/Social Problems Category

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

6.2 Psychosocial Problems Category

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

Organic Mental Disorders

9.1 Pre-Senile Dementia, Uncomplicated (290.10)
9.2 Senile Dementia, Uncomplicated (290.0)
10 Alcohol Withdrawal Delirium (291.0) •
11 Drug Withdrawal Syndrome (292.0) •
12 Other Organic Mental Disorder/NOS (294.9) •
12.1 Substance-Induced Delirium, Dementia, Amnestic and other Cognitive Disorders (294.9) •

Other Psychoses

13 Schizophrenic Disorder (295.90) •
14 Major Depressive Disorder (311) •
14.2 Alcohol or Drug Induced Mood Disorder (296.90) •
15 Bipolar Disorder (296.80) •
16 Delusional Disorder (297.1) •
17 Psychotic Disorder NOS (298.9) •
17.1 Alcohol or Drug Induced Psychotic Disorder (298.9) •

Neurotic, Personality and Other Non-psychotic Disorders

18 Anxiety Disorder (300.00) •
18.1 Alcohol or Drug Induced Anxiety Disorder (300.00) •
19 Personality Disorder (301.9) •
20 Psychosexual Disorder (302.9) •
20.1 Alcohol or Drug Induced Psychosexual Disorder (302.9) •
21 Communication Disorder NOS (307.9) •
21.1 Medication-Induced Disorder (995.2) •
22 Sleep Disorder (307.47) •
22.1 Alcohol or Drug Induced Sleep Disorder (307.47) •
22.2 Insomnia due to Mental Disorder (327.02)
22.3 Hypersomnia due to Mental Disorder (327.15)
22.4 Behavioral Insomnia Childhood (v69.50)
23 Eating Disorder (307.50) •
24 Adjustment Disorder (309.9) •
25 Disruptive Behavior Disorder (312.9) •
26 Impulse Control Disorder (312.30) •

Alcohol and Drug Abuse

27 Alcohol Dependence (303.90) •
28 Drug Dependence (304.90) •
29 Alcohol Abuse (305.00) •
30 Drug Abuse (305.90) •

Disorders First Evident in Infancy, Childhood, or Adolescence

31 Disorder of Infancy, Childhood/Adol. (313.9) •
32 Pervasive Developmental Disorder (299.80) •
35 Unspecified Mental Retardation (319) •

Other

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

Suicide

39 Suicide Ideation (v62.84)
40 Suicide Attempt/Gesture (300.9)
41 Suicide Completed (798.1) *

6.3 Abuse Category

Child Abuse (Focus of Attention is on Victim)

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

Partner Abuse (Focus of Attention is on Victim)

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

Adult Abuse (Focus of Attention is on Victim)

44 Adult Abuse (Suspected), Unspecified (995.80) *

44.1 Adult Abuse (Suspected), Physical (995.81) *
44.2 Adult Abuse (Suspected), Emotional (995.82) *
44.3 Adult Abuse (Suspected), Sexual (995.83) *
44.4 Other Partner Abuse & Neglect (multiple forms of abuse/neglect) (995.85) *

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

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

Rape

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

6.4 Neglect Category

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

6.5 Family Life Problems Category

50 Traumatic Bereavement (v62.82)
51 Alcohol Related Birth Defect (v13.7) *
51.1 Fetal Alcohol Syndrome (760.71)
52 Child Or Adolescent Antisocial Behavior (v71.02)
53 Adult/Child Relationship (v61.20)

54 Uncomplicated Grief Reaction (v62.82)
54.1 Death, Patient Expired
54.2 Dying, End of Life Care (v66.7)
55 Illness in Family (v61.49)
56 Marital Problem (v61.10)
57 Sibling Conflict (v61.8)
58 Separation/Divorce (v61.0)
59 Family Conflict (v61.8)
60 Interpersonal Relationships (v62.81)
61 Adult Antisocial Behavior (v71.01)
62 Other Family Life Problem (v61.8)

6.6 Pregnancy/Childbirth Problems Category

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

6.7 Socioeconomic Problems Category

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

6.8 Sociolegal Problems Category

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

6.9 Educational/Life Problems Category

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

6.10 Administrative Problems Category

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

6.11 Out of Home Care Category

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

6.12 Other Patient Related Problems Category

38.2 Med Refill – Issue of Repeat Prescription (v68.1)
99.9 Other EHR Clinical

6.13 Screenings Category

14.1 Screening for Depression (v79.0)
29.1 Screening for Alcoholism (v79.1)
29.2 Screening for Drug Abuse (v79.8)

7.0 Appendix D: POV Code Definitions

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

Note:

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

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

7.1 Medical/Social Problems Category

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

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

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

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

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

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

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

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

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

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

8.1 Patient Cancelled, Rescheduled

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

8.2 Provider Cancelled, Rescheduled

8.21 Provider Cancelled, Not Rescheduled

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

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

7.2 Psychosocial Problems Category

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

7.2.1 Organic Mental Disorders

9.1-	290.10	Presenile Dementia, Uncomplicated
	294.10	Dementia of the Alzheimer's Type, with early onset, without Behavioral Disturbance
	294.11	Dementia of the Alzheimer's Type, with early onset, with Behavioral Disturbance
9.2-	290.0	Senile Dementia, Uncomplicated
	294.10	Dementia of the Alzheimer's Type, with late onset, without Behavioral Disturbance
	294.10	Dementia due to … (general medical condition) without Behavioral Disturbance
	294.11	Dementia of the Alzheimer's Type, with late onset, with Behavioral Disturbance
	294.11	Dementia due to …(general medical condition) with Behavioral Disturbance

Alcoholic Withdrawal Delirium

10-	291.0•	Alcohol Intoxication Delirium
	291.0•	Alcohol Withdrawal Delirium

	291.81	Alcohol Withdrawal
	291.9	Alcohol-Related Disorder NOS

Drug Withdrawal Syndrome

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

Other Organic Mental Disorder NOS

	294.8	Amnestic Disorder NOS
	294.8	Dementia NOS
	293.0	Delirium Due to...(Indicate Med. Condition)
	293.89	Anxiety or Catatonic Disorder Due to …(Indicate Med. Condition)
	293.9	Mental Disorder NOS Due to...(Indicate Med. Condition)
	294.0	Amnestic Disorder Due to...(Indicate Med. Condition)
12-	294.9•	Cognitive Disorder NOS
	780.09	Delirium NOS
	290.40	Vascular Dementia, Uncomplicated
	290.41	Vascular Dementia, W/Delirium
	290.42	Vascular Dementia, W/Delusions
	290.43	Vascular Dementia, W/Depressed Mood

12.1-	294.9•	Substance-Induced Delirium, Dementia, Amnestic and other Cognitive Disorders
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	291.2	Alcohol-Induced Persisting Dementia
	292.81	Amphetamine Intoxication Delirium
	292.81	Cannabis Intoxication Delirium
	292.81	Cocaine Intoxication Delirium
	292.81	Hallucinogen Intoxication Delirium

292.81	Inhalant Intoxication Delirium
292.81	Opioid Intoxication Delirium
292.81	Other (or Unknown) Substance-Induced Delirium
292.81	Phencyclidine Intoxication Delirium
292.81	Sedative, Hypnotic, or Anxiolytic Intoxication Delirium
292.81	Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
292.82	Inhalant-Induced Persisting Dementia
292.82	Other (or Unknown) Substance-Induced Persisting Dementia
292.82	Sedative, Hypnotic, or Anxiolytic-Induced Persisting Dementia
292.83	Other (or Unknown) Substance-Induced Persisting Amnestic Disorder
292.83	Sedative, Hypnotic, or Anxiolytic-Induced Persisting Amnestic Disorder

7.2.2 Other Psychoses

Schizophrenic Disorder

295.10	Schizophrenia, Disorganized Type, Unspecified
295.11	Schizophrenia, Disorganized Type, Subchronic
295.12	Schizophrenia, Disorganized Type, Chronic
295.13	Schizophrenia, Disorganized Type, Subchronic W/Acute Exacerbation
295.14	Schizophrenia, Disorganized Type, Chronic W/Acute Exacerbation
295.15	Schizophrenia, Disorganized Type, In Remission
295.20	Schizophrenia, Catatonic Type
295.21	Schizophrenia, Catatonic Type, Subchronic
295.22	Schizophrenia, Catatonic Type, Chronic
295.23	Schizophrenia, Catatonic Type, Subchronic, W/Acute Exacerbation
295.24	Schizophrenia, Catatonic Type, Chronic, W/Acute Exacerbation
295.25	Schizophrenia, Catatonic Type, In Remission
295.30	Schizophrenia, Paranoid Type, Unspecified
295.31	Schizophrenia, Paranoid Type, Subchronic
295.32	Schizophrenia, Paranoid Type, Chronic
295.33	Schizophrenia, Paranoid Type, Subchronic, W/Acute Exacerbation
295.34	Schizophrenia, Paranoid Type, Chronic, W/Acute Exacerbation
295.35	Schizophrenia, Paranoid Type, In Remission
295.60	Schizophrenia, Residual Type, Unspecified
295.61	Schizophrenia, Residual Type, Subchronic
295.62	Schizophrenia, Residual Type, Chronic

	295.63	Schizophrenia, Residual Type, Subchronic, W/Acute Exacerbation
	295.64	Schizophrenia, Residual Type, Chronic, W/Acute Exacerbation
	295.65	Schizophrenia, Residual Type, In Remission
13-	295.90•	Schizophrenia, Undifferentiated Type, Unspecified
	295.91	Schizophrenia, Undifferentiated Type, Subchronic
	295.92	Schizophrenia, Undifferentiated Type, Chronic
	295.93	Schizophrenia, Undifferentiated Type, Subchronic, w/Acute Exacerbation
	295.94	Schizophrenia, Undifferentiated Type, Chronic, W/Acute Exacerbation
	295.95	Schizophrenia, Undifferentiated Type, In Remission

Major Depressive Disorder

	300.4	Dysthymic Disorder
14-	311•	Depressive Disorder NOS
	296.20	Major Depressive Disorder, Single Episode, Unspecified
	296.21	Major Depressive Disorder, Single Episode, Mild
	296.22	Major Depressive Disorder, Single Episode, Moderate
	296.23	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
	296.24	Major Depressive Disorder, Single Episode, Severe with Psychotic Features
	296.25	Major Depressive Disorder, Single Episode, In Partial Remission
	296.26	Major Depressive Disorder, Single Episode, In Full Remission
	296.30	Major Depressive Disorder, Recurrent, Unspecified
	296.31	Major Depressive Disorder, Recurrent, Mild
	296.32	Major Depressive Disorder, Recurrent, Moderate
	296.33	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features
	296.35	Major Depressive Disorder, Recurrent, In Partial Remission
	296.36	Major Depressive Disorder, Recurrent, In Full Remission
	293.83	Mood Disorder Due to...(Indicate Med. Condition)
	291.89	Alcohol-Induced Mood Disorder
14.2-	296.90•	Alcohol or Drug Induced Mood Disorder NOS
	292.84	Amphetamine-Induced Mood Disorder
	292.84	Cocaine-Induced Mood Disorder
	292.84	Hallucinogen-Induced Mood Disorder
	292.84	Inhalant-Induced Mood Disorder
	292.84	Opioid-Induced Mood Disorder

292.84	Other (or Unknown) Substance-Induced Mood Disorder
292.84	Phencyclidine-Induced Mood Disorder
292.84	Sedative-, Hypnotic- or Anxiolytic-Induced Mood Disorder

Bipolar Disorder

296.00	Bipolar I Disorder, Single Manic Episode, Unspecified
296.01	Bipolar I Disorder, Single Manic Episode, Mild
296.02	Bipolar I Disorder, Single Manic Episode, Moderate
296.03	Bipolar I Disorder, Single Manic Episode, Severe, Without Psychotic Features
296.04	Bipolar I Disorder, Single Manic Episode, Severe, with Psychotic Features
296.05	Bipolar I Disorder, Single Manic Episode, In Partial Remission
296.06	Bipolar I Disorder, Single Manic Episode, In Full Remission
296.40	Bipolar I Disorder, Most Recent Episode Manic, Unspecified Bipolar I Disorder, Most Recent Episode Hypomanic
296.41	Bipolar I Disorder, Most Recent Episode Manic, Mild
296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate
296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe without Psychotic Features
296.44	Bipolar I Disorder, Most Recent Episode manic, Severe with Psychotic Features
296.45	Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
296.46	Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
296.51	Bipolar I Disorder, Most Recent Episode Depressed, Mild
296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate
296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe, Without Psychotic Features
296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe, With Psychotic Features
296.55	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
296.56	Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.61	Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate

	296.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
	296.64	Bipolar I Disorder, Most Recent Episode Mixed, Severe, With Psychotic Features
	296.65	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
	296.66	Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
	296.7	Bipolar I Disorder, Most Recent Episode Unspecified,
15-	296.80•	Bipolar Disorder NOS
	296.89	Bipolar II Disorder
	296.90	Mood Disorder NOS
	301.13	Cyclothymic Disorder

Delusional Disorder

16-	297.1•	Delusional Disorder
	297.3	Shared Psychotic Disorder

Psychotic Disorder NOS

	295.40	Schizophreniform Disorder, Unspecified
	295.41	Schizophreniform Disorder, Subchronic
	295.42	Schizophreniform Disorder, Chronic
	295.43	Schizophreniform Disorder, Subchronic, W/Acute Exacerbation
	295.44	Schizophreniform Disorder, Chronic, With Acute Exacerbation
	295.45	Schizophreniform Disorder, In Remission
	295.70	Schizoaffective Disorder, Unspecified
	295.71	Schizoaffective Disorder, Subchronic
	295.72	Schizoaffective Disorder, Chronic
	295.73	Schizoaffective Disorder, Subchronic, W/Acute Exacerbation
	295.74	Schizoaffective Disorder, Chronic, With Acute Exacerbation
	295.75	Schizoaffective Disorder, In Remission
	298.8	Brief Psychotic Disorder
17-	298.9•	Psychotic Disorder NOS
	293.81	Psychotic Disorder Due to...(Indicate Med.Cond.), W/Delusions
	293.82	Psychotic Disorder Due to...(Indicate Med.Cond.), W/Hallucinations
17.1-	298.9•	Alcohol or Drug Induced Psychotic Disorder
	291.3	Alcohol-Induced Psychotic Disorder, With Hallucinations
	292.11	Amphetamine-Induced Psychotic Disorder, with Delusions

	292.11	Cannabis-Induced Psychotic Disorder with Delusions
	292.11	Cocaine-Induced Psychotic Disorder with Delusions
	292.11	Hallucinogen-Induced Psychotic Disorder with Delusions
	292.11	Inhalant-Induced Psychotic Disorder with Delusions
	292.11	Opioid-Induced Psychotic Disorder with Delusions
	292.11	Other (or Unknown) Substance-Induced Psychotic Disorder with Delusions
	292.11	Phencyclidine-Induced Psychotic Disorder with Delusions
	292.11	Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Delusions
	292.12	Amphetamine-Induced Psychotic Disorder with Hallucinations
	292.12	Cannabis-Induced Psychotic Disorder with Hallucinations
	292.12	Cocaine-Induced Psychotic Disorder with Hallucinations
	292.12	Hallucinogen-Induced Psychotic Disorder with Hallucinations
	292.12	Inhalant-Induced Psychotic Disorder with Hallucinations
	292.12	Opioid-Induced Psychotic Disorder with Hallucinations
	292.12	Other (or Unknown) Substance-Induced Psychotic Disorder with Hallucinations
	292.12	Phencyclidine-Induced Psychotic Disorder with Hallucinations
	292.12	Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder with Hallucinations

7.2.3 Neurotic, Personality and Other Nonpsychotic Disorders

Anxiety Disorder

18-	300.00•	Anxiety Disorder NOS
	300.01	Panic Disorder, Without Agoraphobia
	300.02	Generalized Anxiety Disorder
	300.12	Dissociative Amnesia
	300.13	Dissociative Fugue
	300.14	Dissociative Identity Disorder
	300.15	Dissociative Disorder NOS
	300.21	Panic Disorder, With Agoraphobia
	300.22	Agoraphobia Without history of Panic Disorder
	300.23	Social Phobia
	300.29	Specific Phobia
	300.3	Obsessive-Compulsive Disorder
	300.6	Depersonalization Disorder
	300.9	Unspecified Mental Disorder (Nonpsychotic)
	308.3	Acute Stress Reaction
	309.81	Post-Traumatic Stress Disorder
	293.84	Anxiety Disorder Due to...(Indicate Med. Condition)
18.1-	300.00•	Alcohol or Drug Induced Anxiety Disorder

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

Personality Disorder

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

Psychosexual Disorder

	302.2	Pedophilia
	302.3	Transvestic Fetishism
	302.4	Exhibitionism
	302.6	Gender Identity Disorder in Children
	302.6	Gender Identity Disorder NOS
	302.70	Sexual Dysfunction NOS
	302.71	Hypoactive Sexual Desire Disorder
	302.72	Female Sexual Arousal Disorder
	302.72	Male Erectile Disorder
	302.73	Female Orgasmic Disorder
	302.74	Male Orgasmic Disorder
	302.75	Premature Ejaculation
	302.76	Dyspareunia (Not Due to a General Medical Condition)
	302.79	Sexual Aversion Disorder
	302.81	Fetishism
	302.82	Voyeurism
	302.83	Sexual Masochism
	302.84	Sexual Sadism

	302.85	Gender Identity Disorder in Adolescents or Adults
	302.89	Frotteurism
	302.9	Paraphilia NOS
20-	302.9•	Sexual Disorder NOS
	306.51	Vaginismus (Not Due to a General Medical Condition)
	607.84	Male Erectile Disorder Due to;;;(Indicate General Medical Condition)
	608.89	Male Dyspareunia Due to…(Indicate General Medical Condition)
	608.89	Male Hypoactive Sexual Desire Disorder Due to…(Indicate General Medical Condition)
	608.89	Other Male Sexual Dysfunction Due to…(Indicate General Medical Condition)
	625.0	Female Dyspareunia Due to…(Indicate General Medical Condition)
	625.8	Female Hypoactive Sexual Desire Disorder Due to … (indicate General Medical Condition)
	625.8	Other Female Sexual Dysfunction Due to…(Indicate General Medical Condition)
20.1-	302.9•	Alcohol or Drug Induced Psychosexual Disorder
	291.89	Alcohol-Induced Sexual Dysfunction
	292.89	Amphetamine-Induced Sexual Dysfunction
	292.89	Cocaine-Induced Sexual Dysfunction
	292.89	Opioid-Induced Sexual Dysfunction
	292.89	Other (or Unknown) Substance-Induced Sexual Dysfunction
	292.89	Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction

Communication Disorder NOS

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

Medication Induced Disorder

	332.1	Neuroleptic-Induced Parkinsonism
	333.1	Medication-Induced Postural Tremor
	333.7	Neuroleptic-Induced Acute Dystonia
	333.82	Neuroleptic-Induced Tardive Dyskinesia
	333.90	Medication-Induced Movement Disorder NOS

	333.92	Neuroleptic Malignant Syndrome
	333.99	Neuroleptic-Induced Acute Akathisia
21.1-	995.2•	Adverse Effects of Medication, NOS

Sleep Disorder

	307.42	Primary Insomnia; Insomnia Related to.(Indicate Axis I or Axis II)
	307.44	Primary Hypersomnia
	307.45	Circadian Rhythm Sleep Disorder
	307.46	Sleep Terror Disorder
	307.46	Sleepwalking Disorder
22-	307.47•	Dyssomnia NOS
	307.47	Parasomnia NOS
	307.47	Nightmare Disorder
	347.00	Narcolepsy without Cataplexy
	347.01	Narcolepsy with Cataplexy
	347.10	Narcolepsy condition without Cataplexy
	347.11	Narcolepsy condition with Cataplexy
	780.52	Sleep Disorder Due to…(Indicate General Medical Condition), Insomnia Type
	780.54	Sleep Disorder Due to…(indicate General Medical Condition), Hypersomnia Type
	780.59	Sleep Disorder Due to…(indicate General Medical Condition), Mixed Type)
	780.59	Sleep Disorder Due to…(indicate General Medical Condition), Parasomnia type
22.1-	307.47•	Alcohol or Drug Induced Sleep Disorder
	291.82	Alcohol-Induced Sleep Disorder
	292.85	Amphetamine-Induced Sleep Disorder
	292.85	Caffeine-Induced Sleep Disorder
	292.85	Cocaine-Induced Sleep Disorder
	292.85	Opioid-Induced Sleep Disorder
	292.85	Other (or Unknown) Substance-Induced Sleep Disorder
	292.85	Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder
22.2-	327.02	Insomnia due to Mental Disorder
22.3-	327.15	Hypersomnia due to Mental Disorder
22.4-	v69.50	Behavioral Insomnia Childhood

Eating Disorder

	307.1	Anorexia Nervosa
23-	307.50•	Eating Disorder NOS
	307.51	Bulimia Nervosa

	307.52	Pica
	307.53	Rumination Disorder
	307.59	Feeding Disorder of Infancy or Early Childhood

Adjustment Disorder

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

Disruptive Behavior Disorder NOS

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

Impulse Control Disorder

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

7.2.4 Alcohol and Drug Abuse

Alcohol Dependence

27-	303.90•	Alcohol Dependence, Unspecified
	303.91	Alcohol Dependence, Continuous
	303.92	Alcohol Dependence, Episodic
	303.93	Alcohol Dependence, In Remission

Drug Dependence

	304.00	Opioid Dependence, Unspecified
	304.01	Opioid Dependence, Continuous
	304.02	Opioid Dependence, Episodic
	304.03	Opioid Dependence, In Remission
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence, Unspecified
	304.11	Sedative, Hypnotic, or Anxiolytic Dependence, Continuous
	304.12	Sedative, Hypnotic, or Anxiolytic Dependence, Episodic

	304.13	Sedative, Hypnotic, or Anxiolytic Dependence, In Remission
	304.20	Cocaine Dependence, Unspecified
	304.21	Cocaine Dependence, Continuous
	304.22	Cocaine Dependence, Episodic
	304.23	Cocaine Dependence, In Remission
	304.30	Cannabis Dependence, Unspecified
	304.31	Cannabis Dependence, Continuous
	304.32	Cannabis Dependence, Episodic
	304.33	Cannabis Dependence, In Remission
	304.40	Amphetamine Dependence, Unspecified
	304.41	Amphetamine Dependence, Continuous
	304.42	Amphetamine Dependence, Episodic
	304.43	Amphetamine Dependence, In Remission
	304.50	Hallucinogen Dependence. Unspecified
	304.51	Hallucinogen Dependence, Continuous
	304.52	Hallucinogen Dependence, Episodic
	304.53	Hallucinogen Dependence, In Remission
	304.60	Inhalant Dependence, Unspecified
	304.61	Inhalant Dependence, Continuous
	304.62	Inhalant Dependence, Episodic
	304.63	Inhalant Dependence, In Remission
	304.60	Phencyclidine Dependence
	304.61	Phencyclidine Dependence, Continuous
	304.62	Phencyclidine Dependence, Episodic
	304.63	Phencyclidine Dependence, In Remission
	304.80	Polysubstance Dependence, Unspecified
	304.81	Polysubstance Dependence, Continuous
	304.82	Polysubstance Dependence, Episodic
	304.83	Polysubstance Dependence, In Remission
28-	304.90•	Other (or Unknown) Substance, or Phencyclidine Dependence, Unspecified
	304.91	Other (or Unknown) Substance, or Phencyclidine Dependence, Continuous
	304.92	Other (or Unknown) Substance, or Phencyclidine Dependence, Episodic
	304.93	Other (or Unknown) Substance, or Phencyclidine Dependence, In Remission
	305.10	Nicotine Dependence
	292.9	Amphetamine-Related Disorder NOS
	292.9	Cannabis-Related Disorder NOS
	292.9	Cocaine-Related Disorder NOS
	292.9	Hallucinogen-Related Disorder NOS
	292.9	Inhalant-Related Disorder NOS
	292.9	Nicotine-Related Disorder NOS
	292.9	Opioid-Related Disorder NOS

	292.9	Other (or Unknown) Substance-Related Disorder NOS
	292.9	Phencyclidine-Related Disorder NOS
	292.9	Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS

Alcohol Abuse

	303.00	Alcohol Intoxication, Unspecified
	303.01	Alcohol Intoxication, Continuous
	303.02	Alcohol Intoxication, Episodic
	303.03	Alcohol Intoxication, In Remission
29-	305.00•	Alcohol Abuse, Unspecified
	305.01	Alcohol Abuse, Continuous
	305.02	Alcohol Abuse, Episodic,
	305.03	Alcohol Abuse, In Remission

Drug Abuse

	305.20	Cannabis Abuse, Unspecified
	305.21	Cannabis Abuse, Continuous
	305.22	Cannabis Abuse, Episodic
	305.23	Cannabis Abuse, In Remission
	305.30	Hallucinogen Abuse, Unspecified
	305.31	Hallucinogen Abuse, Continuous
	305.32	Hallucinogen Abuse, Episodic
	305.33	Hallucinogen Abuse, In Remission
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse, Unspecified
	305.41	Sedative, Hypnotic, or Anxiolytic Abuse, Continuous
	305.42	Sedative, Hypnotic, or Anxiolytic Abuse, Episodic
	305.43	Sedative, Hypnotic, or Anxiolytic Abuse, In Remission
	305.50	Opioid Abuse, Unspecified
	305.51	Opioid Abuse, Continuous
	305.52	Opioid Abuse, Episodic
	305.53	Opioid Abuse, In Remission
	305.60	Cocaine Abuse, Unspecified
	305.61	Cocaine Abuse, Continuous
	305.62	Cocaine Abuse, Episodic
	305.63	Cocaine Abuse, In Remission
	305.70	Amphetamine Abuse, Unspecified
	305.71	Amphetamine Abuse, Continuous
	305.72	Amphetamine Abuse, Episodic
	305.73	Amphetamine Abuse, In Remission
30-	305.90•	Other (or Unknown) Substance Abuse
	305.90	Inhalant Abuse
	305.90	Phencyclidine Abuse
	305.91	Other (or Unknown) Substance Abuse, Continuous
	305.91	Inhalant Abuse, Continuous
	305.91	Phencyclidine Abuse, Continuous
	305.92	Other (or Unknown) Substance Abuse, Episodic

	305.92	Inhalant Abuse, Episodic
	305.92	Phencyclidine Abuse, Episodic
	305.93	Other (or Unknown) Substance Abuse, In Remission
	305.93	Inhalant Abuse, In Remission
	305.93	Phencyclidine Abuse, In Remission
	305.90	Caffeine Intoxication
	305.91	Caffeine Intoxication, Continuous
	305.92	Caffeine Intoxication, Episodic
	305.93	Caffeine Intoxication, In Remission

7.2.5 Disorders First Evident in Infancy, Childhood, or Adolescence

Disorder of Infancy, Childhood and Adolescence

	313.23	Selective Mutism
	313.81	Oppositional Defiant Disorder
	313.82	Identity Problem
	313.89	Reactive Attachment Disorder of Infancy or Early Childhood
31-	313.9•	Disorders of Infancy, Childhood, or Adolescence NOS
	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	314.01	Attention-Deficit Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS

Pervasive Developmental Disorder

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

	315.9	Learning Disorder NOS
	787.6	Encopresis, With Constipation and Overflow Incontinence

Unspecified Mental Retardation

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

7.2.6 Other

Psychological Factor Affecting a Medical Condition

36-	316•	(Specified Psych. Factor) Affecting...(Indicate Med.Cond.)

Factitious Disorder

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

Somatoform Disorder

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

Other Suspected Mental Condition

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

Diagnosis Deferred

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

Suicide

39-	v62.84	Suicide (Ideation) - Thinking about, including talking about, taking one's life.
40-	300.9	Suicide (Attempt/Gesture) - Any effort directed at harming one's self.
41-	798.1•	Suicide (Completed) - Intentional self inflicted death requires follow-up to complete suicide registry information.

7.3 Abuse Category

Child Abuse (Focus of Attention is on Victim)

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

Partner Abuse (Focus of Attention is on Victim)

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

Adult Abuse (Focus of Attention is on Victim)

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

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

45.1*-	v61.12	Abusive Behavior (Alleged), Physical/Emotional; adult victim; focus on perpetrator who is also a partner
45.11*-	v62.83	Abusive Behavior (Alleged); adult victim; focus on perpetrator who is not the victim's partner
45.12*-	v61.22	Abusive Behavior (Alleged), Physical/Emotional; child victim; focus on perpetrator who is victim's parent

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

Rape

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

7.4 Neglect Category

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

7.5 Family Life Problems Category

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

7.6 Pregnancy/Childbirth Problems Category

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

7.7 Socioeconomic Problems Category

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

7.8 Sociolegal Problems Category

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

7.9 Educational/Life Problems Category

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

7.10 Administrative Problems Category

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

7.11 Out of Home Care Category

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

7.12 Other Patient Related Problems Category

38.2-	v68.1	Med Refill – Issue of Repeat Prescription
99.9		Other EHR Clinical

7.13 Screenings Category

14.1-	**(v79.0)**	Screening for Depression
29.1-	**(v79.1)**	Screening for Alcoholism
29.2-	**(v79.8)**	Screening for Drug Abuse

8.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT User Support (IHS) by:

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

Fax: (505) 248-4297

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov