RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System (AMH)

Patch 4 Addendum

Version 3.0 Patch 4
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Office of Information Technology
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1.0 Introduction

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

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

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

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

- A new group data entry option has been added, allowing you to define a group and repeatedly re-use that group definition, if appropriate. (Section5.0)

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

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

- The Treatment Plan menu and reports have been modified.
    - The Treatment Plan menu has been rearranged. 8.1
    - A new prompt has been added when running the Treatment Plan reports.

- The Treatment Plan reports have been modified to display patient name, DOB, chart, date established, date next review, date resolved, responsible provider, and program. 8.2
- A new Treatment Plan Report has been added that will list all treatment plans on file.8.3

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

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

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

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

- Administrative Entry now prompts for Number Served.

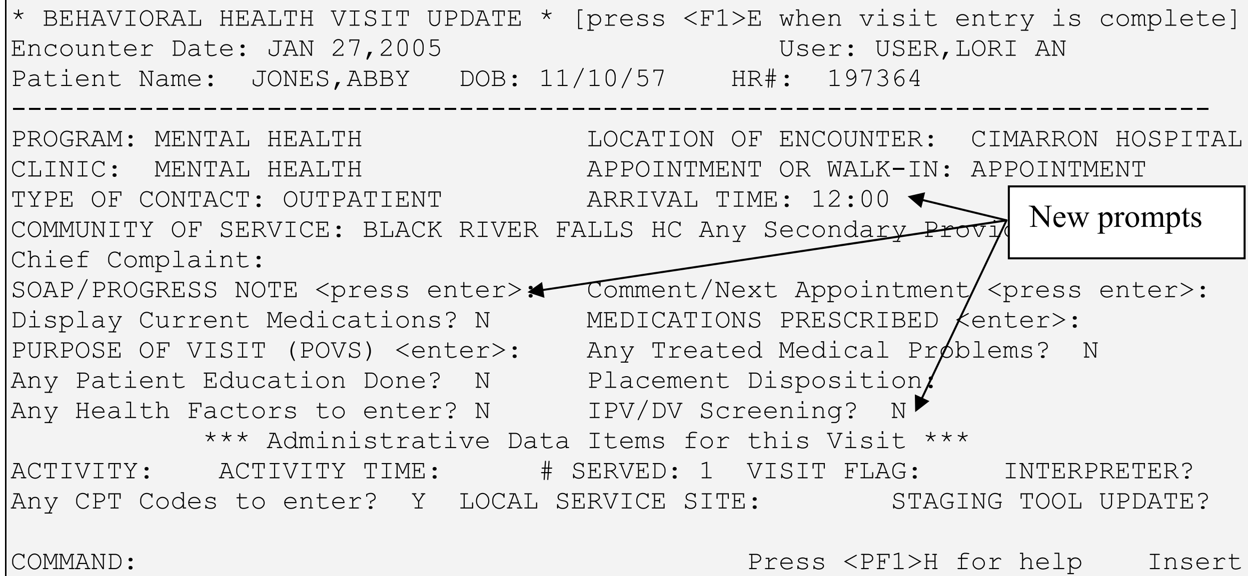
Patch 3
No patch addendum for patch 3. Please refer to the patch 3 note file for details of the changes included in patch 3.

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

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

2.0 Regular Visit Screen

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



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

COMMAND:                                   Press <PF1>H for help    Insert
```


Figure 2-1: Modified Regular Visit Screen

3.0 Patient Education Entry Screen

3.1 New Display Patient Education History Option

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

```
*PATIENT EDUCATION ENTER/EDIT*   [press <F1>C to return to main screen]
 Patient Name: JONES,ABBY

 ---------------------------------------------------------------------------
 After entering each topic you will be prompted for additional fields

 Display Patient Education History?  N  <-------------- New prompt

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

Figure 3-1: New "Display Patient Education History:" prompt.

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

```
OUTPUT BROWSER              Jan 28, 2005 08:54:25          Page:    1 of    2
Patient Education List for GUMP,FOREST



*** All education provided in past 2 years by BH programs ***
DATE      TOPIC                            LEVEL OF UND    MIN IND/GRP   PROVIDER
----      -----                            ------------    --- -------   --------
07/13/04  MEDS-INFORMATION                   GOOD            5   IND       S04

*** All education documented in PCC in past 2 years ***
DATE      TOPIC                            LEVEL OF UND    MIN IND/GRP   PROVIDER
----      -----                            ------------    --- -------   --------
03/30/04  DM-NUTRITION
03/30/04  DM-COMPLICATIONS
10/15/03  M-FOLLOW-UP                                            IND
10/15/03  M-MEDICATION DISPENSE TO PROXY                         IND
10/14/03  M-INFORMATION                      GOOD                IND
10/14/03  M-DRUG INTERACTION                 GOOD                IND
08/31/03  M-INFORMATION                      GOOD                IND
08/06/03  M-INFORMATION                      GOOD                IND
+         Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 3-2: Historical listing of Patient Education

3.2 New Fields

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

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

```
EDUCATION TOPIC: CD-MEDICATIONS

INDIVIDUAL/GROUP:
MINUTES:
LEVEL OF UNDERSTANDING
PROVIDER:
COMMENT:
```

Figure 3-3: Modified Patient Education entry screen

4.0 Modified Health Factor Entry Screen

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

```
               ******* PATIENT HEALTH FACTOR UPDATE *******
Examples of health factors:  Tobacco Use, Alcohol Cage, TB Status
Patient Name: GUMP,FOREST
----------------------------------------------------------------------------
 Display Health Factor History?  N <------ New prompt

 HEALTH FACTOR                  LEVEL/SEVERITY PROVIDER             QUANTITY
```

Figure 4-1: New "Display Health Factor History" prompt.

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

```
OUTPUT BROWSER            Jan 28, 2005 09:01:14          Page:    1 of    2
Health Factors List for GUMP,FOREST



*** All health factors provided in past 2 years by BH programs ***
DATE      FACTOR                           SEVERITY     QUANTITY   PROVIDER
----      ------                           --------     --------   --------
07/13/04  CAGE 2/4                         MODERATE     1          S04
04/18/04  CURRENT SMOKER                                           S20

*** All health factors documented in PCC in past 2 years ***
DATE      FACTOR                           SEVERITY     QUANTITY   PROVIDER
----      ------                           --------     --------   --------
01/10/05  LEARNING PREFERENCE-DO/PRACTIC
01/10/05  LEARNING PREFERENCE-DO/PRACTIC
01/10/05  LEARNING PREFERENCE-DO/PRACTIC
12/31/04  CAGE 0/4
11/15/03  CURRENT SMOKER
10/15/03  CURRENT SMOKER
09/03/03  NON-TOBACCO USER
+         Enter ?? for more actions                                     >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 4-2: Historical listing of the client's health factors

5.0 Group Form Data Entry Using Group Definition (GP)

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

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

```
GROUP ENTRY                  Jan 28, 2005 09:45:13          Page:    1 of    1
Group Entry
      Date     Group Name           Activity   Prg Cln    Prov       TOC POV

1) 01/28/05 MARITAL SESSION, TUE GROUP TRE  M   MENTA  JONES,PA  OUT 56 - MAR





          Enter ?? for more actions
1    Add a New Group                        5    Print Encounter Forms
2    Display Group Entry                    6    Review/Edit Group Visits
3    Duplicate Group                        7    Add No Show Visit
4    Delete Group                           Q    Quit
Select Action:+//
```

Figure 5-1: Group Entry Screen

5.1 Add a New Group (1)

Use this option to add a new group entry.

To add a new group, follow these steps:

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

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

   - Providers (Primary or Secondary) who facilitated the group
   - Encounter Date
   - Arrival Time
   - Program
   - Group Name
   - Community of Service
   - Clinic
   - Activity code

- Encounter Location
- Activity Time (total time the group session lasted)
- Type of Contact
- POV or DSM (Primary Group Topic)
- CPT Code(s) (if relevant)
- S/O/A/P (Standard Group Note)
- Patients attending the group session

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

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

Figure 5-2: Screen used for entering group definition

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

4. Type Y at the “Do you wish to continue on to add patient visits for this group:” prompt to confirm that the values entered are correct.

```
You have added the following group definition, please review it carefully
before you proceed.

DATE OF SERVICE: JAN 28, 2005@12:00     PROGRAM: MENTAL HEALTH
  GROUP NAME: MARITAL SESSION, TUESDAY'S
  LOCATION OF ENCOUNTER: CIMARRON HOSPITAL
  COMMUNITY OF SERVICE: LAKE CITY       ACTIVITY TYPE: 91
  TYPE OF CONTACT: OUTPATIENT           ACTIVITY TIME: 60
  CLINIC: MENTAL HEALTH
PROVIDER: JONES,PATSY                   PRIMARY/SECONDARY: PRIMARY
POV: 56
 SUBJECTIVE/OBJECTIVE:   Tuesday Evening group session on marital issues.
PATIENT: GUMP,FOREST
PATIENT: JONES,ABBY
PATIENT: SMITH,AARON


     Select one of the following:

          Y   Yes, group definition is accurate, continue on to add visits
          N   No, I wish to edit the group definition

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

Figure 5-3: Group definition confirmation screen

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

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

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

8. Type Y at the “Edit?” prompt to add any additional comments to the standard SOAP note. Otherwise type N.

```
Adding records for each individual patient in this group.


Now adding record for GUMP,FOREST

Creating new record for GUMP,FOREST.

Time this patient spent in group: 60//

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


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

  Edit? NO//

Generating PCC Visit.
```

Figure 5-4: Adding patient specific information

5.2 Display Group Entry (2)

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

To display a group entry, follow these steps:

1. Type 2 at the “Select Action:” prompt.
2. Select the group to display.
3. The data for the selected group will display.

```
OUTPUT BROWSER              Jan 28, 2005 09:50:14         Page:    1 of    1

DATE OF SERVICE: DEC 28, 2004@12:00     PROGRAM: MENTAL HEALTH
  GROUP NAME: MARITAL SESSION, TUESDAY'S
  LOCATION OF ENCOUNTER: CIMARRON HOSPITAL
  COMMUNITY OF SERVICE: LAKE CITY       ACTIVITY TYPE: 91
  TYPE OF CONTACT: OUTPATIENT           ACTIVITY TIME: 60
  CLINIC: MENTAL HEALTH
PROVIDER: JONES,PATSY                   PRIMARY/SECONDARY: PRIMARY
POV: 56
 SUBJECTIVE/OBJECTIVE:   Tuesday Evening group session on marital issues.
PATIENT: GUMP,FOREST
PATIENT: JONES,ABBY
PATIENT: SMITH,AARON
MHSS RECORD: DEC 28, 2004@12:00
MHSS RECORD: DEC 28, 2004@12:00
MHSS RECORD: DEC 28, 2004@12:00


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

Figure 5-5: Displaying a group entry

5.3 Duplicate Group (3)

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

To duplicate a group, follow these steps:

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

```
Select GROUP ENTRY:  (1-2): 1

Enter Date for the new group entry:  1/2/2005
```

Figure 5-6: Duplicating a group entry

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

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: JAN 2,2005              Arrival Time: 12:00
Program: MENTAL HEALTH
Group Name: MARITAL SESSION, TUESDAY'   Community of Service: LAKE CITY
Clinic: MENTAL HEALTH                   Activity: 91
Encounter Location: CIMARRON HOSPITAL   Activity Time: 60
Type of Contact: OUTPATIENT
POV or DSM (Primary Group Topic) <press enter>:
CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
```

Figure 5-7: Group Encounter Documentation screen

5. Review the information to confirm it is accurate for this instance of the group session. Be sure to press enter at the prompts that request the user to press enter to display the data for those items.

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

5.4 Delete Group (4)

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

5.5 Print Encounter Forms (5)

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

To print encounter forms, follow these steps:

1. Type 5 at the “Select Action:” prompt.

2. Type the number of the group at the “Select Group Entry:” prompt.

3. Select the type of encounter form(s) you want printed by typing the character of the option at the “Enter response:” prompt.

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

```
Select Action:+// 5   Print Encounter Forms
Select GROUP ENTRY:  (1-2): 1

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



     Select one of the following:

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

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

Figure 5-8: Printing encounter forms

5.6 Review/Edit Group Visits (6)

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

To review/edit group visits, follow these steps:

1. Type 6 at the "Select Action:" prompt.

2. Type the number of the group at the "Select Group Entry:" prompt.

```
Select Action:+// 6   Review/Edit Group Visits
Select GROUP ENTRY:  (1-2): 1
```

Figure 5-9: Selecting the Review/Edit Group Visits option

3. The Enter/Edit Patient Group Data screen displays (Figure 5-10).

4. Select the option you want to use by typing the appropriate character at the "Select Action:" prompt. These options are explained below.

```
Enter/Edit Patient Group Data Jan 31, 2005 08:33:40        Page:    1 of    1
Group Entry
     Patient Name                        Sex Age    DOB       HRN   Record Added

1)   GUMP,FOREST                          M  65   01/01/1940  989898    yes
2)   JONES,ABBY                           F  38   04/27/1966  155600    yes
3)   SMITH,AARON                          M  57   11/25/1947  148311    yes






          Enter ?? for more actions                                        >>>
AE   Add/Edit Patient's Group Visit     D    Display Patient's Group Visit
X    Delete a Patient's Group Visit     Q    Quit
Select Action:+//
```

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

Add/Edit Patient's Group Visit (AE)
If you select this option, you will be asked to select the patient visit and then the Edit a Record screen will display. This screen is described in the Behavioral Health System User Manual.

Delete a Patient's Group Visit (X)
Use this option to delete a patient's visit record.

Display Patient's Group Visit (D)
Use this option to display a patient's visit record.

5.7 Add No Show Visit (7)

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

6.0 Intake Document Modifications

6.1 New Date Value Fields

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

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

```
PATIENT DATA ENTRY          Jan 31, 2005 08:59:45          Page:    1 of    1
Patient: USER,ABRAHAM   HRN: 169386
         MALE  DOB: Jan 28, 1991   AGE: 14 YRS   SSN: 555066179
Designated Providers:
 Mental Health:                        Social Services:
          A/SA:                                  Other:
     Other (2):                           Primary Care:

No BH Visits on File

Pending Appointments:




                  Select the appropriate action   Q for QUIT
AV Add Visit              BV Browse Visits          DM Display Meds
EV Edit Visit             LD List Visit Dates       LA Interim Lab Reports
DV Display Visit          TP Treatment Plan Update  SR Staging Report
ES Edit SOAP              CD Update Case Data       OI Desg Prov/Flag/Pers Hx
DE Delete Visit           ID Update Intake Document PL Problem List Update
PF Print Encounter Form   AP Appointments           MM Send Mail Message
LV Last BH Visit          HS Health Summary         FS Face Sheet

Select Action: Q// ID   Update Intake Document

DATE OF INITIAL INTAKE: Jan 31, 2005//   (JAN 31, 2005)
INITIAL PROVIDER: JONES,MARY//        AA     119     100ZZZ     PSYCHIATRIST
DATE UPDATED: Jan 31, 2005//
PROVIDER LAST UPDATE: JONES,MARY//
```

Figure 6-1: New Intake document date fields

6.2 New Print Intake Document Option (PI)

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

To print an intake document, select the PI option and then enter the device on which to print the document.

```
Update Intake Document      Jan 31, 2005 09:04:15          Page:    1 of    1
Patient Name:  USER,ABRAHAM     DOB:  JAN 28, 1991   Sex:  M


Designated MH Provider:
Designated SS Provider:
Desg CD A/SA Provider:
Desg Other Provider:
Desg Other (2) Provider:
=============== BH INTAKE DOCUMENT ===============
Initial Intake:          JAN 31, 2005
      Provider:          SMITH,AMY LYNN
   Last Update:          JAN 31, 2005
      Provider:          SMITH,AMY LYNN

INTAKE DOCUMENTATION/NARRATIVE:


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

New Option

Figure 6-2: New Print Intake Document option

7.0 Suicide Form Modifications

7.1 New and Deleted Fields

The following fields have been REMOVED from the suicide form:

- Intervention (Suicide Ideation/Attempt)

- Intervention (Completed Suicide)

The following fields have been ADDED to the suicide form:

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

```
***  UPDATING IHS SUICIDE FORM  ***  F1 E to exit ***
Patient: USER,ABRAHAM                   MALE          HRN: 123386
DOB: Jan 28, 1900          Community Res: Unspecified
Tribe: CHOCTAW NATION OF OKLAHOMA
Computer Generated Case #: 5052010131200500000661
Provider: JONES,PATSY                Initials:     Discipline:
-----------------------------------------------------------------------------
 1. Local Case #:             Provider: JONES,PATSY
 7. Employment Status:
 8. Date of Act: JAN 31,2005  11. Community where act Occurred:
12. Relationship Status:                    13. Education:
14. Self Destructive Act:
15. Method (press enter):                   16. Previous Attempts:
17. Substance Use Involved:                 18. Location of Act:
19. Contributing Factors (press enter):     20. Lethality:
21. Disposition:
22. Other Relevant Information:
```

Figure 7-1: Updated Suicide form

7.2 Suicide Form Fields and Allowable Entries

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

Employment Status

Code	Value
P	PART-TIME
F	FULL-TIME
S	SELF-EMPLOYED
UE	UNEMPLOYED
ST	STUDENT
SE	STUDENT AND EMPLOYED
UNK	UNKNOWN

Relationship Status

Code	Value
1	SINGLE
2	MARRIED
3	DIVORCED/SEPARATED
4	WIDOWED
5	COHABITING/COMMON LAW
6	SAME SEX PARTNERSHIP
9	UNKNOWN

Education

Code	Value
1	LESS THAN 12 YEARS
2	HIGH SCHOOL GRADUATE/GED
3	SOME COLLEGE/TECHNICAL SCHOOL
4	COLLEGE GRADUATE
5	POST GRADUATE
6	UNKNOWN

Self Destructive Act

Code	Value
1	IDEATION WITH PLAN AND INTENT
2	ATTEMPT
3	COMPLETED SUICIDE
4	ATTEMPTED SUICIDE WITH HOMICIDE
5	COMPLETED SUICIDE WITH HOMICIDE

Method

Code	Value
1	GUNSHOT
2	HANGING
3	MOTOR VEHICLE
4	JUMPING
5	STABBING/LACERATION
6	CARBON MONOXIDE
7	OVERDOSE
U	UNKNOWN
8	OTHER

Note: If the method used is Overdose the user will be asked to enter the type of drug used from the following list:

ACETAMINOPHEN (E.G. TYLENOL)
ALCOHOL
AMPHETAMINE/STIMULANT
ASPIRIN OR ASPIRIN-LIKE MEDICATIONS
NON-PRESCRIBED OPIATES (HEROIN)
OTHER
OTHER ANTIDEPRESSANT
OTHER OVER-THE-COUNTER MEDICATIONS
OTHER PRESCRIPTION MEDICATION
PRESCRIBED OPIATES (NARCOTICS)
SEDATIVES/BENZODIAZEPINES/BARBITURATES
TRICYCLIC ANTIDEPRESSANT (TCA)

Previous Attempts

Code	Value
0	0
1	1
2	2
3	3 OR MORE
U	UNKNOWN

Location of Act

Code	Value
1	HOME OR VICINITY
2	SCHOOL
3	WORK
4	JAIL/PRISON/DETENTION
5	TREATMENT FACILITY
6	MEDICAL FACILITY
7	OTHER
8	UNKNOWN

Lethality

Code	Value
L	LOW
M	MEDIUM
H	HIGH

Substance Used Involved

Code	Value
1	NONE
2	ALCOHOL AND OTHER DRUGS
U	UNKNOWN

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

ALCOHOL
AMPHETAMINE/STIMULANT

Contributing Factors

DEATH OF FRIEND OR RELATIVE
DIVORCE/SEPARATION/BREAKUP OF RELATIONSHIP
FINANCIAL STRESS
HISTORY OF MENTAL ILLNESS
HISTORY OF PHYSICAL ILLNESS
HISTORY OF SUBSTANCE ABUSE/DEPENDENCE
LEGAL

CANNABIS (MARIJUANA) COCAINE HALLUCINOGENS INHALANTS NON-PRESCRIBED OPIATES (HEROIN) OTHER PRESCRIBED OPIATES (NARCOTICS) SEDATIVES/BENZODIAZEPINES/BARBITURATES	OCCUPATIONAL/EDUCATIONAL PROBLEM OTHER SUICIDE OF FRIEND OR RELATIVE UNKNOWN VICTIM OF ABUSE (CURRENT) VICTIM OF ABUSE (PAST)
Disposition ASA ALCOHOL/SUBSTANCE ABUSE FOLLOW-UP INMHI IN-PATIENT MENTAL HEALTH TREATMENT (INVOLUNTARY) INMHV IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY) MT MEDICAL TREATMENT (ED OR IN-PATIENT) MH MENTAL HEALTH FOLLOW-UP OT OTHER ORFSC OUTREACH TO FAMILY/SCHOOL/COMMUNITY UNK UNKNOWN	

8.0 Treatment Plan Menu and Report Modifications

8.1 Updated Treatment Plan Menu

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

```
                  *********************************************
                  **       IHS Behavioral Health System       **
                  **          Patient Treatment Plans         **
                  *********************************************
                                   Version 3.0

                                CIMARRON HOSPITAL


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

Select Update BH Patient Treatment Plans Option:
```

Figure 8-1: Updated treatment plan menu

8.2 Treatment Plan Report Modifications

All Treatment Plan reports now display the following items:

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

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

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

PATIENT NAME        DOB       CHART # DATE         REVIEW DATE   RESOLVE DATE
                                      ESTABLISHED
```

Figure 8-2: Treatment report items

8.3 Print List of All Treatment Plans on File (ATP)

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

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

1. From the Patient Treatment Plans menu, type ATP at the "Select Update BH Patient Treatment Plans Option:" prompt.
2. A description of the report displays.
3. Type a beginning date for your listing at the "Enter Beginning Date for Screening:" prompt.
4. Type an ending date for your listing at the "Enter Ending Date for Screening:" prompt.
5. You may run the listing by one provider or by all providers. Type O (One Provider) or A (All Providers) at the "List treatment plans for:" prompt.
6. Select how you would like to sort the list by typing P (Responsible Provider), N (Patient Name), or D (Date Established) at the "Sort list by:" prompt.
7. Type the name of an output device at the "Device:" prompt.
8. The report is then displayed onscreen or printed. See Figure 8-4 a sample output.

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

Select Update BH Patient Treatment Plans Option: ATP  Print List of All
Treatment


**********  LIST TREATMENT PLANS  **********

This report will list all patients who have a treatment plan on file.
Please enter the date range during which the treatment plan was established.


Enter BEGINNING Date:  010100  (JAN 01, 2000)

Enter ENDING Date:  (1/1/2000 - 12/31/2699): T  (JAN 31, 2005)

You can limit the report output to treatment plans for one or all Providers
```

```
     Select one of the following:

          O         One Provider
          A         All Providers

List treatment plans for: O// All Providers

     Select one of the following:

          P         Responsible Provider
          N         Patient Name
          D         Date Established

Sort list by: P// P  Responsible Provider
DEVICE: HOME//   Virtual
```

Figure 8-3: Running the new ATP report

```
             **********  CONFIDENTIAL PATIENT INFORMATION  **********
AA                                                                   Page 1
                              CIMARRON HOSPITAL
                          LISTING OF TREATMENT PLANS
                    Date Established: JAN 01, 2000 to JAN 31, 2005

PATIENT NAME        DOB       CHART # DATE         REVIEW DATE   RESOLVE DATE
                                      ESTABLISHED
-----------------------------------------------------------------------------


ZZCASH,ROSEMARY     10/6/64   ???     May 03, 2004 Jun 05, 2004  Aug 05, 2004
   Program: MENTAL HEALTH        Responsible Provider: STUDENT,EIGHT
ROWE,LUCAS          6/2/52    198365  Aug 09, 2004 Aug 15, 2004  Aug 01, 2005
   Program: CHEMICAL DEPENDENCY  Responsible Provider: STUDENT,EIGHT
LINCOLN,AGATHA      3/12/93   200968  Jul 17, 2004 Sep 02, 2004
   Program: CHEMICAL DEPENDENCY  Responsible Provider: STUDENT,EIGHT
ELLISON,LIONEL      12/21/81  202358  Apr 01, 2004 Oct 01, 2004  Apr 01, 2005
   Program: CHEMICAL DEPENDENCY  Responsible Provider: STUDENT,EIGHTEEN
GEHRIG,BRENDA       2/24/62   232729  Jan 12, 2004 Jul 06, 2004  Apr 12, 2005
   Program: CHEMICAL DEPENDENCY  Responsible Provider: STUDENT,ELEVEN
SAUNDERS,JOANNE     12/28/00  232728  Mar 01, 2004 Jul 07, 2004  Mar 01, 2005
   Program: MENTAL HEALTH        Responsible Provider: STUDENT,ELEVEN
```

Figure 8-4: Sample ATP report output

9.0 New IPV/DV Options

9.1 Intimate Partner Violence/Domestic Violence Exam Screening Entry Screen

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

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

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

 Display IPV/DV screening history?

 Screening/Exam Result:

 Provider: JONES,PATSY

 COMMENT:
```

Figure 9-1: New IPV/DV screen

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

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

Comments
Enter IPV/DV screening exam results with a comment.

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

 Display IPV/DV screening history?

 Screening/Exam Result:

 Provider: JONES,PATSY

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

Figure 9-2: Adding comments

Display IPV/DV screening history?

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

```
OUTPUT BROWSER             Jan 28, 2005 09:06:47          Page:    1 of    1
IPV/DV Exam History for GUMP,FOREST



*** All IPV/DV Screening Exams documented in BH ***
DATE      SCREENING RESULT                 PROVIDER
----      ----------------                 --------
09/13/04  UNABLE TO SCREEN                 USER,HANK
          Patient's minor child was present, unable to screen.

*** All IPV/DV Screening Exams document in PCC ***
DATE      SCREENING RESULT                 PROVIDER
----      ----------------                 --------

01/01/04  PAST                           SMITH,MARY ANN





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

Figure 9-3: Historical listing of IPV/DV screening exams

9.2 New Intimate Partner Violence/Domestic Violence Reports

Five new reports have been added to the Behavioral Health System v3.0 to report on IPV/DV screening. In order to access the IPV/DV reports the user must be assigned the AMHZ DV REPORTS security key. Due to the confidential nature of these reports this security key should only be assigned to providers who have a specific need for this information.

These reports can be found under the Patient Listings menu option under the Reports menu. RPTS > PAT >DVR.

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

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

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

```
                 ********************************************
                 **       IHS Behavioral Health System       **
                 **             Patient Listings             **
                 ********************************************
                               Version 3.0

                            CIMARRON HOSPITAL


   ACL    Active Client List
   PGEN   Patient General Retrieval
   DP     Designated Provider List
   GRT    Patients with AT LEAST N Visits
   ACO    Active Client List Using Case Open Date
   AGE    Patients Seen by Age and Sex (132 column print)
   DVR    IPV/DV Reports ...  <---- New menu option
   PERS   Patient List for Personal Hx Items
   PPL    Placements by Site/Patient
   PPR    Listing of Patients with Selected Problems
   REV    Print List of Treatment Plans Needing Reviewed
   RTR    Residential Treatment Aftercare Report
   SEEN   Cases Opened But Patient Not Seen in N Days
   TCD    Tally Cases Opened/Admitted/Closed
   TPR    Print List of Treatment Plans Needing Resolved
   TSG    Patients seen in groups w/Time in Group

Select Patient Listings Option:
```

Figure 9-4: Patient Listings menu

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

```
                 ********************************************
                 **       IHS Behavioral Health System       **
                 **             IPV/DV Reports               **
                 ********************************************
                               Version 3.0

                            CIMARRON HOSPITAL


   DVP    Tally/List Patients with IPV/DV Screening
   DVS    Tally/List IPV/DV Screenings
   SSP    List all IPV/DV Screenings for Selected Patients
   PST    Tally/List Pts in Search Template w/IPV Screening
```

```
   VST    Tally List all IPV Screenings for Template of Pts

Select IPV/DV Reports Option:
```

Figure 9-5: IPV/DV reports menu

9.2.1 Tally/List Patients with IPV/DV Screening (DVP)

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

This report tallies the clients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider and A/SA Provider.

> **Notes**:
>
> The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
>
> This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal

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

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

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

```
Select IPV/DV Reports Option: DVP  Tally/List Patients with IPV/DV Screening

                                USER,MARY ANN
CIMARRON HOSPITAL

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

This report will tally and optionally list all patients who have had
IPV screening (Exam code 34) or a refusal documented in the time frame
specified by the user.
This report will tally the patients by age, gender, result, provider (either
exam provider, if available, or primary provider on the visit), clinic,
date of screening, designated PCP, MH Provider, SS Provider and A/SA
Provider.
  Notes:
         - the last screening/refusal for each patient is used.  If a
patient was screened more than once in the time period, only the latest is
used in this report.
         - this report will optionally, look at both PCC and the Behavioral
Health databases for evidence of screening/refusal

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

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

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

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

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

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

     Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

```
How would you like the list to be sorted: H// H Health Record Number

Display the Patient's Designated Providers on the list? N// YES
DEVICE: HOME//
```

Figure 9-6: Running the DVP report

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

```
   AA                              Jan 31, 2005                       Page 1

        ***  IPV SCREENING PATIENT TALLY AND PATIENT LISTING  ***
             Screening Dates: Jan 01, 2000 to Jan 31, 2005
            This report includes data from the PCC Clinical database

----------------------------------------------------------------------------
                                              #      % of patients
     Total Number of Patients screened         3

                              By Result

                NO RESULT RECORDED             1       33.3%
                           PRESENT             1       33.3%
                  UNABLE TO SCREEN             1       33.3%

                              By Gender

                            FEMALE             1       33.3%
                              MALE             2       66.7%

                                By Age

                             2 yrs             1       33.3%
                            37 yrs             1       33.3%
                            64 yrs             1       33.3%

              By Provider who screened

                      BUTCHER,HANK             1       33.3%
                  STUDENT,THIRTEEN             1       33.3%
                           UNKNOWN             1       33.3%

           By Primary Provider of Visit

                      BUTCHER,HANK             1       33.3%
                  CURTIS,A CLAYTON             1       33.3%
                  STUDENT,THIRTEEN             1       33.3%

     By Designated Primary Care Provider

                       STUDENT,ONE             1       33.3%
                           UNKNOWN             2       66.7%
```

```
                              By Clinic

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

                               By Date

   AA                             Jan 31, 2005                       Page 2

           ***  IPV SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Jan 01, 2000 to Jan 31, 2005
            This report includes data from the PCC Clinical database

----------------------------------------------------------------------------
                                              #      % of patients
                          Apr 01, 2004         1       33.3%
                          Jul 26, 2004         1       33.3%
                          Sep 13, 2004         1       33.3%

     By Designated Mental Health Provider

                          NYE,PATRICIA         1       33.3%
                               UNKNOWN         2       66.7%

    By Designated Social Services Provider

                       MEARS,PRISCILLA         1       33.3%
                               UNKNOWN         2       66.7%

     By Designated A/SA Provider

                        ALLISON,ARNOLD         1       33.3%



   AA                             Jan 31, 2005                       Page 1

           ***  IPV SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Jan 01, 2000 to Jan 31, 2005
            This report includes data from the PCC Clinical database

                                   DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
-----------------------------------------------------------------------------

SNOW,WILLIAM          202024 37  M 07/26/04 PRESENT          ALCOHOL AND
SUBST
   DXs: 27       ALCOHOL DEPENDENCE
   Primary Provider on Visit:  STUDENT,THIRTEEN
       Provider who screened:  STUDENT,THIRTEEN

RATHER,MIRIAM         225255 2   F 04/01/04                  GENERAL
   DXs: 250.00   DM TYPE 2
        486.     PNEUMONIA
   Primary Provider on Visit:  CURTIS,A CLAYTON
```

```
       Provider who screened:  UNKNOWN

GUMP,FOREST           989898 64  M 09/13/04 UNABLE TO SCREEN MENTAL HEALTH
   Comment: COMMENT
   DXs: 44       ADULT ABUSE (SUSPECTED),UNSPECIFIED
   Primary Provider on Visit:  BUTCHER,HANK
       Provider who screened:  BUTCHER,HANK
        Designated Providers:  CHEMICAL DEPENDENCY: ALLISON,ARNOLD
                               PRIMARY CARE: STUDENT,ONE
                               MENTAL HEALTH: NYE,PATRICIA
```

Figure 9-7: Sample DVP report

9.2.2 Tally/List IPV/DV Screenings (DVS)

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

Notes:

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

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

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

1. Type DVS at the “Select IPV/DV Reports Option:” prompt.
2. A description of the report displays.
3. Type a beginning date for your listing at the “Enter Beginning Date for Screening:” prompt.
4. Type an ending date for your listing at the “Enter Ending Date for Screening:” prompt.
5. Type the number of the items which you would like tallied at the “Which items should be tallied:” prompt.
6. Type YES or NO at the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt.
7. Type YES or NO at the “Would you like to include a list of visits w/screening done?” prompt.

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

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

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

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

                                SMITH,AMY LYNN
CIMARRON HOSPITAL

                TALLY AND LISTING OF ALL VISITS W/IPV SCREENING

This report will tally and optionally list all visits on which
IPV screening (Exam code 34) or a refusal was documented in the
time frame specified by the user.
This report will tally the visits by age, gender, result, provider (either
exam provider, if available, or primary provider on the visit), and date of
screening/refusal.
  Note:
          - this report will optionally, look at both the Behavioral Health
             and PCC clinical databases for evidence of screening/refusal

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

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

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

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

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

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


     Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
```

```
         D         Date Screened
         A         Age of Patient at Screening
         G         Gender of Patient
         T         Terminal Digit HRN

How would you like the list to be sorted: H// N  Patient Name
DEVICE: HOME
```

Figure 9-8: Running the DVS report

```
   AA                            Jan 31, 2005                       Page 1

                ***  IPV SCREENING VISIT TALLY AND VISIT LISTING  ***
                    Screening Dates: Jan 01, 2000 to Jan 31, 2005
                           This report excludes PCC Clinics

-----------------------------------------------------------------------------
                                                 #      % of patients
 Total Number of Visits with Screening         2
     Total Number of Patients screened         2

                                  By Result

                                   PRESENT      1       50.0%
                           UNABLE TO SCREEN      1       50.0%

                                  By Gender

                                      MALE      2       100.0%

                                    By Age

                                    37 yrs      1       50.0%
                                    64 yrs      1       50.0%

                  By Provider who screened

                              BUTCHER,HANK      1       50.0%
                          STUDENT,THIRTEEN      1       50.0%

               By Primary Provider of Visit

                              BUTCHER,HANK      1       50.0%
                          STUDENT,THIRTEEN      1       50.0%

         By Designated Primary Care Provider

                               STUDENT,ONE      1       50.0%
                                   UNKNOWN      1       50.0%

                                  By Clinic

                     ALCOHOL AND SUBSTANCE      1       50.0%
                             MENTAL HEALTH      1       50.0%

                                   By Date
```

```
                          Jul 26, 2004         1       50.0%
                          Sep 13, 2004         1       50.0%

     By Designated Mental Health Provider

                                                 #      % of patients
                          NYE,PATRICIA         1       50.0%
                               UNKNOWN         1       50.0%

    By Designated Social Services Provider

                       MEARS,PRISCILLA         1       50.0%
                               UNKNOWN         1       50.0%

     By Designated A/SA Provider

                        ALLISON,ARNOLD         1       50.0%


   AA                             Jan 31, 2005                      Page 1

             ***  IPV SCREENING VISIT TALLY AND VISIT LISTING  ***
                 Screening Dates: Jan 01, 2000 to Jan 31, 2005
                        This report excludes PCC Clinics

                               DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
-----------------------------------------------------------------------------
GUMP,FOREST           989898 64  M 09/13/04 UNABLE TO SCREEN
   Comment: COMMENT
   DXs: 44       ADULT ABUSE (SUSPECTED),UNSPECIFIED
   Primary Provider on Visit:  BUTCHER,HANK
        Provider who screened:  BUTCHER,HANK
SNOW,WILLIAM          202024 37  M 07/26/04 PRESENT
   DXs: 27       ALCOHOL DEPENDENCE
   Primary Provider on Visit:  STUDENT,THIRTEEN
```

Figure 9-9: Sample DVS outputs

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

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

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

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

2. A description of the report displays.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19. The report is then displayed onscreen or printed. See Figure 9-11 for a sample output.

```
Select IPV/DV Reports Option: SSP  List all IPV/DV Screenings for Selected
Patients
```

```
                                SMITH,AMY LYNN
CIMARRON HOSPITAL

         LISTING OF PATIENTS RECEIVING IPV SCREENING,INCLUDING REFUSALS

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


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


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

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

     Select one of the following:

          F         FEMALES Only
          M         MALES Only
          B         Both MALE and FEMALES

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

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

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

You can limit the list to only patients who have had a screening
in the time period on which the result was any combination of the
following: (e.g. to get only those patients who have had a result of
Present enter 2 to get all patients who have had a screening result of
Past or Present, enter 2,3)

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

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

Include visits to ALL clinics? Yes// YES

     Select one of the following:
```

```
          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only

Report should include visits whose PRIMARY PROVIDER on the visit is: P
Any/All Providers (including unknown)

     Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only

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

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

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

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

     Select one of the following:

          L         List of Patient Screenings
          S         Create a Search Template of Patients

Select Report Type: L// List of Patient Screenings


     Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted: H// R Result of Exam

Display the Patient's Designated Providers on the list? N// YES
DEVICE: HOME// 0;P-OTHER80  Virtual
```

Figure 9-10: Running the SSP report

```
   AA                              Jan 31, 2005                       Page 1

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

```
                                   DATE
PATIENT NAME          HRN     AGE   SCREENED RESULT           CLINIC
-------------------------------------------------------------------------------

No data to report.
```

Figure 9-11: Sample SSP output

9.2.4 Tally/List Pts in Search Template w/IPV Screening (PST)

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

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

This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

> **Notes**:
>
> The last screening/refusal for each patient is used. If a Patient was screened more than once in the time period, only the latest is used in this report.
>
> This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal

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

1. Type PST at the "Select IPV/DV Reports Option:" prompt.
2. A description of the report displays.
3. Press the Enter key at the "Press enter to continue:" prompt.
4. Type a beginning date for your listing at the "Enter Beginning Date for Screening:" prompt.
5. Type an ending date for your listing at the "Enter Ending Date for Screening:" prompt.
6. Type the name of the search template at the "Enter Patient Search Template name:" prompt.
7. Type the number of the items which you would like tallied at the "Which items should be tallied:" prompt.

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

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

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

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

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

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

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


                                USER,LORI ANN
CIMARRON HOSPITAL

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

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

This report will tally and list all patients who are members of
of a user defined search template.  It will tally and list their latest
IPV screening (Exam code 34) or a refusal documented in the time frame
specified by the user.
This report will tally the patients by age, gender, result, screening
provider, primary provider of the visit, designated primary care
provider, and date of screening/refusal.
  Notes:
          - the last screening/refusal for each patient is used.  If a
            patient was screened more than once in the time period, only the
            latest is used in this report.
          - this report will optionally, look at both PCC and the Behavioral
            Health databases for evidence of screening/refusal



Press enter to continue: [ENT]


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

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

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

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

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

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

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


     Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted: H// D Date Screened

Display the Patient's Designated Providers on the list? N// YES
DEVICE: HOME// [ENT]
```

Figure 9-12: Running the PST report

```
   AA                             Jan 31, 2005                      Page 1

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

-----------------------------------------------------------------------------
                                              #      % of patients
 Total Number of Patients in TEMPLATE:     3,465

    Total Number of Patients screened         2       0.1%

                                              #      % of patients screened
```

```
                             By Result

                   NO RESULT RECORDED         1       50.0%
                     UNABLE TO SCREEN         1       50.0%

                             By Gender

                               FEMALE         1       50.0%
                                 MALE         1       50.0%

                               By Age

                                2 yrs         1       50.0%
                               64 yrs         1       50.0%

              By Provider who screened

                              UNKNOWN         2       100.0%

           By Primary Provider of Visit

                     CURTIS,A CLAYTON         1       50.0%
                              UNKNOWN         1       50.0%

     By Designated Primary Care Provider

                          STUDENT,ONE         1       50.0%
                              UNKNOWN         1       50.0%

                             By Clinic

                              GENERAL         1       50.0%
                              UNKNOWN         1       50.0%

                              By Date
                         Sep 13, 2004         1       50.0%

     By Designated Mental Health Provider


    By Designated Social Services Provider

     By Designated A/SA Provider

 AA                             Jan 31, 2005                       Page 1

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

                                   DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
-----------------------------------------------------------------------------
RATHER,MIRIAM         225255 2   F 04/01/04                  GENERAL
```

```
   DXs: 250.00   DM TYPE 2
        486.     PNEUMONIA
   Primary Provider on Visit:  CURTIS,A CLAYTON
        Primary who screened:  UNKNOWN

GUMP,FOREST           989898 64  M 09/13/04 UNABLE TO SCREEN
   Comment: COMMENT
   Primary Provider on Visit:  UNKNOWN
        Primary who screened:  UNKNOWN
        Designated Providers:  CHEMICAL DEPENDENCY: ALLISON,ARNOLD
                               PRIMARY CARE: STUDENT,ONE
                               MENTAL HEALTH: NYE,PATRICIA

   AA                              Jan 31, 2005                     Page 2

           ***  IPV SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Jan 01, 2000 to Jan 31, 2005
            This report includes data from the PCC Clinical database
                   SEARCH TEMPLATE OF PATIENTS: LORI DM PATS
                         Listing of those NOT Screened

                                   DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
----------------------------------------------------------------------------
ELLIOTT,MARIE         100015 80  F
MAYS,KAIA             100016 71  F
CARSON,KRISTIN        100018 49  F
DARROUGH,MARCIE       100020 52  F
SNOW,SHAWN            100027 70  F
JEFFERSON,ARNOLD      100029 76  M
COBB,PATRICK          100030 59  M
THOME,HILDA           100040 72  F
THOMS,DAISY           100052 47  F
PALMER,CINDY          100053 59  F
MORENO,ABE            100055 69  M
```

Figure 9-13: Sample PST output

9.2.5 Tally List all IPV Screenings for Template of Patients (VST)

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

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

This report tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

To run the Tally List all IPV Screenings for Template of Patients report, follow these steps:

1. Type VST at the "Select IPV/DV Reports Option:" prompt.
2. A description of the report displays.
3. Type a beginning date for your listing at the "Enter Beginning Date for Screening:" prompt.
4. Type an ending date for your listing at the "Enter Ending Date for Screening:" prompt.
5. Type the name of the search template at the "Enter Patient Search Template name:" prompt.
6. Type the number of the items which you would like tallied at the "Which items should be tallied:" prompt.
7. Type YES or NO at the "Would you like to include IPV/DV Screenings documented in the PCC clinical database?" prompt.
8. Type YES or NO at the "Would you like to include a list of patients screened?" prompt.
9. Select how you would like the list to be sorted by typing the character of the option at the "How would you like the list to be sorted:" prompt.
10. Type the name of an output device at the "Device:" prompt.
11. The report is then displayed onscreen or printed. See Figure 9-15 for some sample outputs.

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

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

This report will tally and optionally list all visits on which IPV screening
(Exam code 34) or a refusal was documented in the time frame specified by the
user.
This report will tally the visits by age, gender, result, provider (either
exam provider, if available, or primary provider on the visit), and date of
screening/refusal.
  Note:
         -  this report will optionally, look at both the Behavioral Health
and PCC databases for evidence of screening/refusal



Please enter the date range during which the screening was done.
```

```
To get all screenings ever put in a long date range like 01/01/1980
to the present date.


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

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

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

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

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

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


     Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN

How would you like the list to be sorted: H// Age of Patient at Screening
DEVICE: HOME// 0;P-OTHER80  Virtual
```

Figure 9-14: Running the VST Report

```
   AA                              Jan 31, 2005                        Page 1

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

-----------------------------------------------------------------------------
                                                 #      % of patients
 Total Number of Visits with Screening            4
     Total Number of Patients screened            2
  Total Number of Patients in Template        3,465

                                                 #      % of patients screened
```

```
                        By Result

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

                        By Gender

                          FEMALE       1       25.0%
                            MALE       3       75.0%

                          By Age

                           2 yrs       1       25.0%
                          64 yrs       3       75.0%

        By Provider who screened

                    BUTCHER,HANK       1       25.0%
                         UNKNOWN       3       75.0%

     By Primary Provider of Visit

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

 By Designated Primary Care Provider

                     STUDENT,ONE       3       75.0%
                         UNKNOWN       1       25.0%

                        By Clinic

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

                         By Date

AA                             Jan 31, 2005                       Page 2

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

-----------------------------------------------------------------------------
                                      #      % of patients screened
                    Apr 01, 2004       1       25.0%
                    Sep 05, 2004       1       25.0%
                    Sep 13, 2004       2       50.0%

 By Designated Mental Health Provider

 By Designated Social Services Provider
```

```
     By Designated A/SA Provider

   AA                             Jan 31, 2005                      Page 1

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

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

   AA                             Jan 31, 2005                      Page 2

             ***  IPV SCREENING VISIT TALLY AND VISIT LISTING  ***
                 Screening Dates: Jan 01, 2000 to Jan 31, 2005
            This report includes data from the PCC Clinical database
                   SEARCH TEMPLATE OF PATIENTS: LORI DM PATS
                         Listing of those NOT Screened

                                   DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
----------------------------------------------------------------------------
ELLIOTT,MARIE         100015 80  F
MAYS,KAIA             100016 71  F
CARSON,KRISTIN        100018 49  F
DARROUGH,MARCIE       100020 52  F
SNOW,SHAWN            100027 70  F
JEFFERSON,ARNOLD      100029 76  M
```

Figure 9-15: Sample VST ouput

10.0 Appendix A: Activity Codes and Definitions

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

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

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

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

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

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

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

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

- **15-Information and/or Referral (REF)**
  Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are

those that direct or guide a client/patient to appropriate services provided outside of your organization.

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

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

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

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

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

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

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

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

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

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

- **85 – Art Therapy (ART)**

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

- **86 – Recreation Activities (REC)**

  Recreation and leisure activities with the purpose of improving and maintaining clients'/patients' general health and well-being.

- **88 – Acupuncture (ACU)**

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

- **89 – Methadone Maintenance (MET)**

  Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed ,ethadone maintenance agency under the supervision of a physician. Services include methadone dosing, medical care, counseling and support and disease prevention and health promotion.

- **90 – Family Treatment (FAM)**
  Family-centered therapy with an emphasis on the client/patient's functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences; often brief and solution focused .

- **91 – Group Treatment (GRP)**
  This form of therapy involves groups of patients/clients who have similar problems which are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

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

- **93 – Relapse Prevention (REL)**
  Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:
    - Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
    - Strategies for avoiding high-risk situations
    - Strategies for coping with high-risk situations when encountered
    - Strategies for coping with alcohol/drug cravings

- Strategies for coping with lapses to drug use to prevent full-blown relapses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **43- Other Education/Training**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Travel (T)

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

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

Placements (PL)

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

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

Cultural Issues (O)

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

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

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

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

11.0 Appendix B: POV Codes

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

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

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

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

11.1 Medical/Social Problems Category

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

11.2 Psychosocial Problems Category

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

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

11.3 Abuse Category

Child Abuse (Focus of Attention is on Victim)

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

Partner Abuse (Focus of Attention is on Victim)

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

Adult Abuse (Focus of Attention is on Victim)

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

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

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

Rape

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

11.4 Neglect Category

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

11.5 Family Life Problems Category

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

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)

11.6 Pregnancy/Childbirth Problems Category

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

11.7 Socioeconomic Problems Category

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

11.8 Sociolegal Problems Category

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

11.9 Educational/Life Problems Category

89 Academic Problem (v62.3)
89.1 Alternative Education Services
90 School Behavior Problem (v62.3)
91 School Dropout (v62.3)
92 Vocational Rehabilitation Services (v57.22)
93 Peer Conflict (v62.81)

94 Phase of Life Problems (v62.89)
94.1 Religious or Spiritual Problem (v62.89)
94.2 Borderline Intellectual Functioning (v62.89)

11.10 Administrative Problems Category

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

11.11 Out of Home Care Category

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

11.12 Other Patient Related Problems Category

38.2 Med Refill – Issue of Repeat Prescription (v68.1)

11.13 Screenings Category

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

12.0 Appendix C: POV Code Definitions

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

> **Note**:
>
> * v-Codes marked with an asterisk will have this additional narrative: "SEE PROVIDER FOR DETAILS OF THIS PROBLEM."
>
> • ICD-9-CM Codes marked with a bullet will have: "DIAGNOSTIC IMPRESSION," prefixed to the narrative

12.1 Medical/Social Problems Category

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

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

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

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

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

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

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

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

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

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

8.1- Patient Cancelled, Rescheduled

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

8.2- Provider Cancelled, Rescheduled

8.21- Provider Cancelled, Not Rescheduled

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

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

12.2 Psychosocial Problems Category

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

12.2.1 Organic Mental Disorders

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

	294.11	Dementia due to …(general medical condition) with Behavioral Disturbance

Alcoholic Withdrawal Delirium

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

Drug Withdrawal Syndrome

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

Other Organic Mental Disorder NOS

	294.8	Amnestic Disorder NOS
	294.8	Dementia NOS
	293.0	Delirium Due to...(Indicate Med. Condition)
	293.89	Anxiety or Catatonic Disorder Due to …(Indicate Med. Condition)
	293.9	Mental Disorder NOS Due to...(Indicate Med. Condition)
	294.0	Amnestic Disorder Due to...(Indicate Med. Condition)
12-	294.9•	Cognitive Disorder NOS
	780.09	Delirium NOS
	290.40	Vascular Dementia, Uncomplicated
	290.41	Vascular Dementia, W/Delirium
	290.42	Vascular Dementia, W/Delusions
	290.43	Vascular Dementia, W/Depressed Mood
12.1-	294.9•	Substance-Induced Delirium, Dementia, Amnestic and other Cognitive Disorders

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

12.2.2 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

	Code	Description
	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

	Code	Description
	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

	Code	Description
	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

	Code	Description
16-	297.1•	Delusional Disorder
	297.3	Shared Psychotic Disorder

Psychotic Disorder NOS

Code	Description
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

12.2.3 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

	Code	Description
	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

	Code	Description
	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

	Code	Description
	302.2	Pedophilia
	302.3	Transvestic Fetishism
	302.4	Exhibitionism
	302.6	Gender Identity Disorder in Children
	302.6	Gender Identity Disorder NOS

	302.70	Sexual Dysfunction NOS
	302.71	Hypoactive Sexual Desire Disorder
	302.72	Female Sexual Arousal Disorder
	302.72	Male Erectile Disorder
	302.73	Female Orgasmic Disorder
	302.74	Male Orgasmic Disorder
	302.75	Premature Ejaculation
	302.76	Dyspareunia (Not Due to a General Medical Condition)
	302.79	Sexual Aversion Disorder
	302.81	Fetishism
	302.82	Voyeurism
	302.83	Sexual Masochism
	302.84	Sexual Sadism
	302.85	Gender Identity Disorder in Adolescents or Adults
	302.89	Frotteurism
	302.9	Paraphilia NOS
20-	302.9•	Sexual Disorder NOS
	306.51	Vaginismus (Not Due to a General Medical Condition)
	607.84	Male Erectile Disorder Due to;;;(Indicate General Medical Condition)
	608.89	Male Dyspareunia Due to…(Indicate General Medical Condition)
	608.89	Male Hypoactive Sexual Desire Disorder Due to…(Indicate General Medical Condition)
	608.89	Other Male Sexual Dysfunction Due to…(Indicate General Medical Condition)
	625.0	Female Dyspareunia Due to…(Indicate General Medical Condition)
	625.8	Female Hypoactive Sexual Desire Disorder Due to … (indicate General Medical Condition)
	625.8	Other Female Sexual Dysfunction Due to…(Indicate General Medical Condition)

20.1-	302.9•	Alcohol or Drug Induced Psychosexual Disorder
	291.89	Alcohol-Induced Sexual Dysfunction
	292.89	Amphetamine-Induced Sexual Dysfunction
	292.89	Cocaine-Induced Sexual Dysfunction
	292.89	Opioid-Induced Sexual Dysfunction
	292.89	Other (or Unknown) Substance-Induced Sexual Dysfunction
	292.89	Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction

Communication Disorder NOS

307.0	Stuttering
307.20	Tic Disorder NOS

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

Medication Induced Disorder

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

Sleep Disorder

	307.42	Primary Insomnia; Insomnia Related to.(Indicate Axis I or Axis II)
	307.44	Hypersomnia Related to...(Indicate Axis I or Axis II)
	307.44	Primary Hypersomnia
	307.45	Circadian Rhythm Sleep Disorder
	307.46	Sleep Terror Disorder
	307.46	Sleepwalking Disorder
22-	307.47•	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
	291.89	Alcohol-Induced Sleep Disorder
	292.89	Amphetamine-Induced Sleep Disorder
	292.89	Caffeine-Induced Sleep Disorder
	292.89	Cocaine-Induced Sleep Disorder

	292.89	Opioid-Induced Sleep Disorder
	292.89	Other (or Unknown) Substance-Induced Sleep Disorder
	292.89	Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder

Eating Disorder

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

Adjustment Disorder

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

Disruptive Behavior Disorder NOS

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

Impulse Control Disorder

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

12.2.4 Alcohol and Drug Abuse

Alcohol Dependence

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

	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

12.2.5 Disorders First Evident in Infancy, Childhood, or Adolescence

Disorder of Infancy, Childhood and Adolescence

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

12.2.6 Other

Psychological Factor Affecting a Medical Condition

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

Factitious Disorder

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

Somatoform Disorder

	300.7	Body Dysmorphic Disorder
	300.7	Hypochondriasis
	300.81	Somatization Disorder
37.1-	300.82•	Somatoform Disorder NOS
	300.82	Undifferentiated Somatoform Disorder

	300.11	Conversion Disorder
	307.80	Pain Disorder Associated With Psychological Features
	307.89	Pain Disorder Associated With Both Psych. and Med. Condition

Other Suspected Mental Condition

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

Diagnosis Deferred

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

Suicide

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

12.3 Abuse Category

Child Abuse (Focus of Attention is on Victim)

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

Partner Abuse (Focus of Attention is on Victim)

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

Adult Abuse (Focus of Attention is on Victim)

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

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

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

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

Rape

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

12.4 Neglect Category

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

12.5 Family Life Problems Category

50- v62.82 Traumatic Bereavement
51*- v13.7 Alcohol Related Birth Defect (ARBD)
51.1*- 760.71 Fetal Alcohol Syndrome (FAS)
52- v71.02 Child or Adolescent Antisocial Behavior

53-	v61.20	Adult/Child Relationship
54-	v62.82	Uncomplicated Grief Reaction
54.1-		Death, Patient Expired
54.2-	v66.7	Dying, End of Life Care
55-	v61.49	Illness in Family
56-	v61.10	Marital Problem
57-	v61.8	Sibling Conflict
58-	v61.0	Separation/Divorce
59-	v61.8	Family Conflict
60-	v62.81	Interpersonal Relationships
61-	v71.01	Adult Antisocial Behavior
62-	v61.8	Other Family Life Problems

12.6 Pregnancy/Childbirth Problems Category

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

12.7 Socioeconomic Problems Category

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

12.8 Sociolegal Problems Category

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

12.9 Educational/Life Problems Category

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

12.10 Administrative Problems Category

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

12.11 Out of Home Care Category

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

12.12 Other Patient Related Problems Category

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

12.13 Screenings Category

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

13.0 Appendix D: Activity Codes that Pass to PCC

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 (COU)	Yes

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

14.0 Contact Information

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

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