



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System Part 2, AMH Data Entry

(AMH)

User Manual

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Preface

The Behavioral Health System (AMH) is a module of the Resource and Patient Management System (RPMS), designed specifically for recording and tracking patient care related to behavioral health. AMH v4.0 includes all functionality available in previous versions of the RPMS Behavioral Health software, along with multiple new features and enhancements to the Graphical User Interface (GUI) version.

1.0 Introduction

Many behavioral health providers who are co-located in a primary care setting at facilities that have implemented the RPMS Electronic Health Record (EHR) have transitioned to utilizing the EHR for documenting services and supporting integrated care. However, a number of behavioral health clinicians continue to practice at facilities where the EHR has not been adopted. For these providers, AMH v4.0 may be employed as a stand-alone, yet integrated, module within the RPMS suite of clinical and practice management applications.

AMH v4.0 offers opportunities for improving patient outcomes and continuity of care by providing:

- Standardized clinical documentation
- Tools to meet regulatory and accreditation standards
- Tools to meet reporting requirements
- Revenue enhancement
- Enable comprehensive report generation to support care management, program oversight, and use clinical data to inform prevention activities and advance both local and national health initiatives

While this package is integrated with other modules of RPMS, including the Patient Care Component (PCC), this package uses security keys and site-specific parameters to maintain the confidentiality of patient data. The AMH package is a key module within the system.

The AMH User Manual is divided into three separate documents:

- Part 1-AMH Application Set-up and Manager Utilities
- Part 2-AMH Data Entry
- Part 3-AMH Reports

This section of the AMH User Manual (Part 2) focuses on Behavioral Health Data Entry functionality. All AMH users will enter data through the GUI environment because the roll-and scroll data entry functionality has been disabled. Users are able to record all data elements related to patient care, case management, treatment planning, and follow-up services.

2.0 Orientation

The following provides information about navigating and using the **RPMS AMH GUI (BH GUI)** functionality.

2.1 Pop-Up Windows (GUI)

The application generates pop-up windows (Figure 2-1). These windows typically contain a consistent set of functional controls. In most cases, the pop-ups display Crystal Reports.

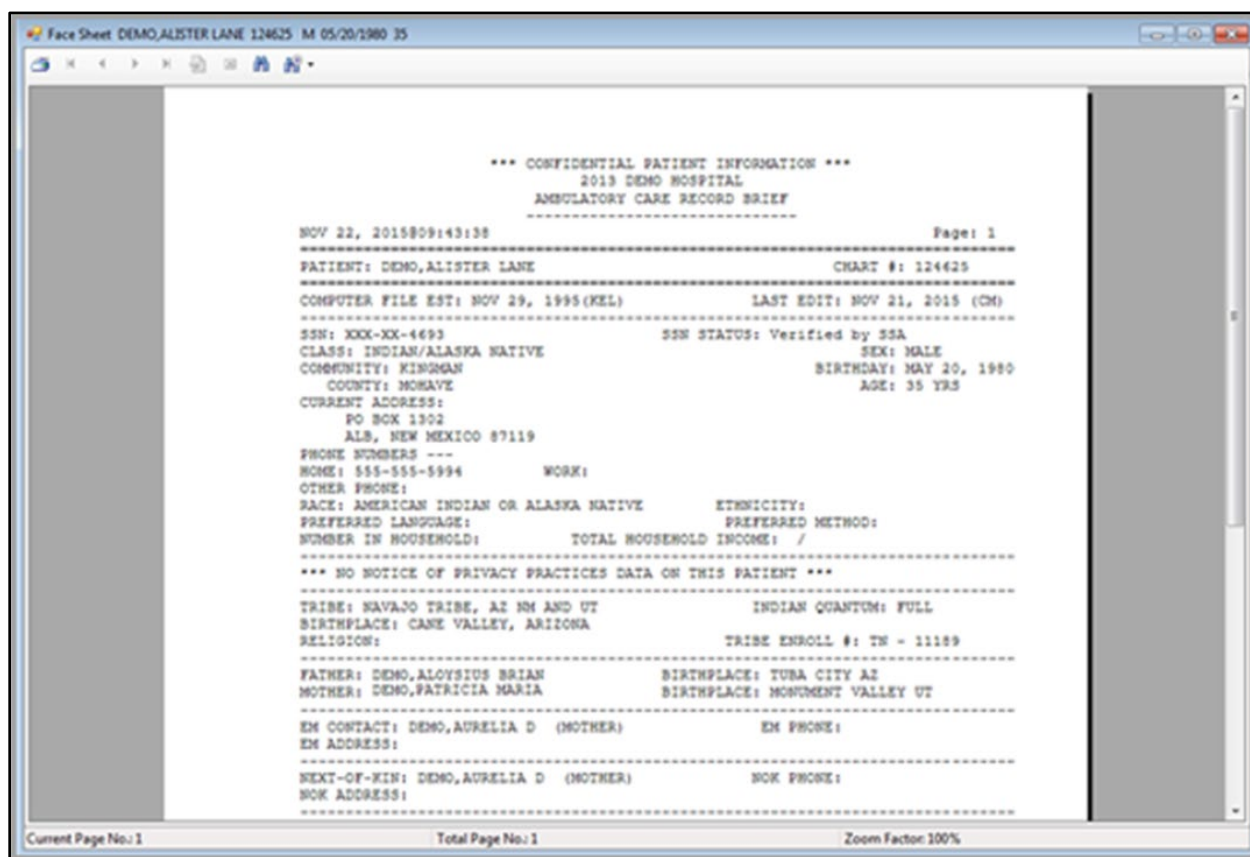


Figure 2-1: Pop-up window example

To navigate through the text on the current page, perform one of the following actions:

- Use the scroll bar to move through the content.
- Or
- Double-click any line of text then use the up-and-down arrow keys to scroll.

The bottom line of the pop-up window (Figure 2-2) displays the following information:

- The current page number being viewed
- The total number of pages
- The current zoom level applied to the text within the pop-up window



Figure 2-2: Bottom line of a pop-up window example

When the pop-up window is first opened, it displays only the first page by default.

If multiple pages are available, use the **Next Page** or **Last Page** buttons on the toolbar to navigate forward. Alternatively, you can directly enter a specific page number to jump to that page.

For detailed information about the toolbar buttons, refer to Section 2.1.2.

2.1.1 Buttons on Title Bar

The **Minimize**, **Maximize**, and **Exit Program** buttons located in the upper-right corner of the pop-up window function identically to their standard counterparts in the Windows operating system.

2.1.2 Buttons on the Toolbar

The following sub-sections describe the functions of the various buttons available on the toolbar.

Note: The **Close Current View** () button is non-functional and does not perform any action at this time.

2.1.2.1 Print Report Button

Click the **Print Report** () button to print the contents displayed in the pop-up window. The **Print** dialog appears (Figure 2-3), allowing you to configure and execute the printing process.



Figure 2-3: Print dialog example

The **Print** dialog is identical to the Windows print interface. From this dialog, you can select a printer, specify the number of copies, define the page range, and adjust other print settings to control the contents of the pop-up window that are printed.

2.1.2.2 Navigation Buttons – Move to Page

The **Move to Page** () buttons allows users to navigate between pages within the text of a pop-up window. These buttons are arranged from left to right and perform the following functions:

- **First Page:** Navigates directly to the first page.
- **Previous Page:** Navigates to the page immediately preceding the current one.
- **Next Page:** Navigates to the page immediately following the current one.
- **Last Page:** Navigates directly to the final page.

2.1.2.3 Go to Page

Click the **Go to Page** () button to navigate to a specific page. The **Go to Page** dialog (Figure 2-4) opens.

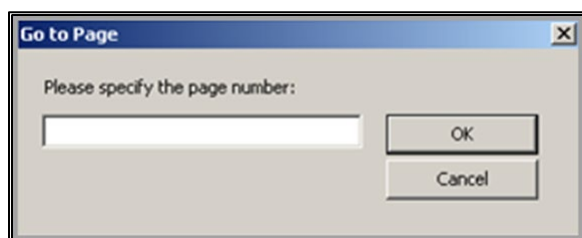


Figure 2-4: Go to Page dialog example

1. Enter the desired page number in the input field.
2. Click **OK** to display the specified page within the pop-up window; or click **Cancel** to close the dialog without making changes.

If the entered page number exceeds the range of available pages, the application will display a blank page.

2.1.2.4 Find Text

1. Click the **Find Text** () button to open the **Find Text** dialog (Figure 2-5).

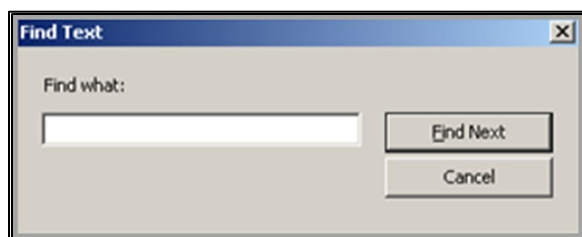


Figure 2-5: Find Text dialog

2. Enter the desired search string in the input field.
3. Click **Find Next** to initiate the search within the pop-up window. Alternatively, click **Cancel** to exit the dialog.

The **Find Next** function directs the application to locate the first occurrence of the specified text string and highlights the corresponding line.

4. Continue clicking **Find Next** to navigate through subsequent occurrences of the text string.

When no further matches are found, the system displays an informational message from the **Crystal Report Windows Forms Viewer** indicating that the search has completed.

5. Click **OK** to dismiss the information message and return to the **Find Text** dialog.

2.1.2.5 Zoom Button

Use the **Zoom** () button to adjust the text size within the pop-up window.

1. Click the **Zoom** button.
2. Select the desired **zoom level** from the drop-down list.

Note: This adjustment modifies the text size displayed within the pop-up for improved readability. It does not affect the actual output or content of the pop-up.

2.2 Using the Calendar (GUI)

Date and **Time** fields are available throughout the graphic user interface (GUI) (Figure 2-6).



Figure 2-6: Date and Time fields example

There are multiple methods for setting a date and time within these fields:

- Type a specific **value** directly into a component of the field. For example:
 - Enter **M** into the day item to set the day to Monday.
 - Enter **09** into the month item to set the month to September.
- Alternatively, place the cursor within a specific component of the field (e.g., day of week, month, hour, etc.) and use the up-and-down arrow keys to cycle through the available options.

If you prefer not to enter the date manually, follow the steps below to select a date using the calendar interface:

1. Click the **date field** drop-down to display the calendar (Figure 2-7). The current date is always highlighted by default.



Figure 2-7: Calendar for Date Field example

2. To select a different date, select the **desired day**. The selected date will automatically populate the **Date** field.
3. Use the left-or-right arrow keys to navigate by one-day, which will also update month if the boundary is crossed.
4. To change the year (Figure 2-8), click the **year label**, then use the up- and-down arrow buttons to scroll through available years.



Figure 2-8: Change Year example

5. To view the previous or next month, click the left-or-right arrow buttons located on either side of the month header.
6. To jump to a specific month, click the month label and select the desired month from the drop-down list (Figure 2-9).



Figure 2-9: List of months to select example

7. Right-click the month label and select **Go to Today** to return to the current date.
8. Press the up-and-down arrow keys to navigate the calendar week by week.
9. Press the left-or-right arrow keys to navigate the calendar day by day.

2.3 Using the Search Window (GUI)

Several fields within the application include drop-down lists that provide access to a search window. For example, selecting the **Community** field will open the **Community Search** window.



Figure 2-10: Community Search window example

This search window provides consistent functionality across various fields within the application.

1. Click **Close** to exit the search window and return to the previous screen.
2. In the **Search String** field, enter a few characters related to your search criteria.
3. Click **Search** to retrieve and display records in the **Community** list box.
4. Select the desired record, then click **OK** to populate the corresponding field on the active form. (Alternatively, click **Close** to cancel the selection.)

Note: You may also populate the field by selecting a record from the **Most Recently Selected** list box and clicking **OK**.

2.4 Using the Search Window (GUI)

Several fields in the application include lists that open a search window.

For example, clicking the **Add** button on the **Purpose of Visit (POV)** tab within the **Visit Data Entry** window opens the dialog shown in Figure 2-11.

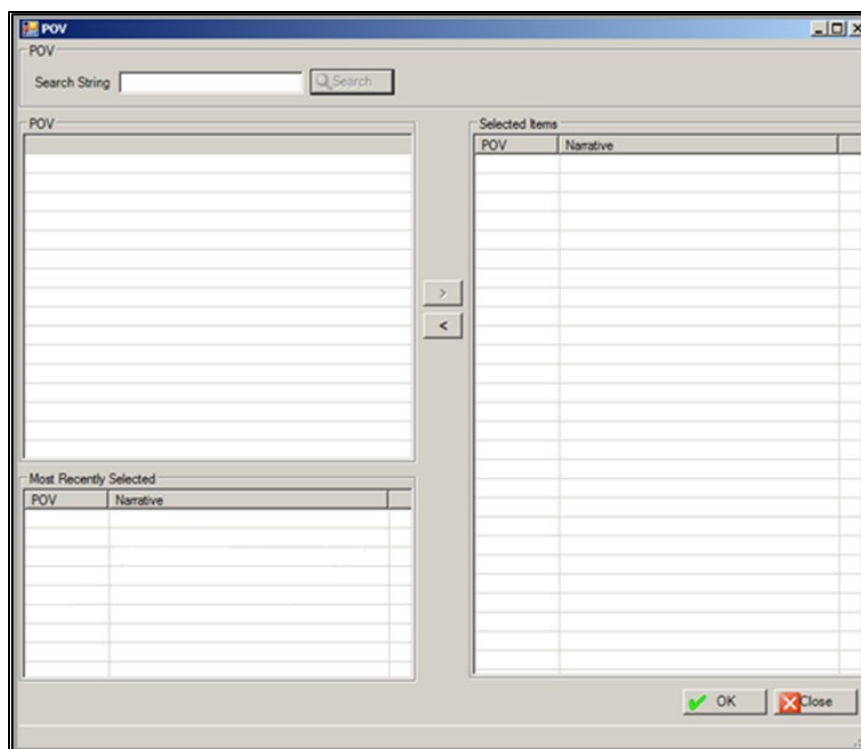


Figure 2-11: Search window example

The following instructions describe how to use a typical search window. Other windows (for example, Secondary Provider) function similarly.

1. Click **Close** to exit the window and return to the previous screen.
2. In the **Search String** field, enter a few characters of the search criteria.
3. Click **Search** to display the matching records in the **POV** list box.
4. To add one or more records from the **POV** group box to the **Selected Items** list box, click the right-arrow button.
5. To add items from the **Most Recently Selected** list box to the **Selected Items** list box, also click the arrow button.
6. To remove records from the Selected Items list box, select the item(s) and click the left-arrow button.
7. Once all desired selections have been added to the **Selected Item** list box, click **OK** to confirm the selection. (Alternatively, click **Close** to exit without saving changes.)

2.5 Using the Multiple-Select Window (GUI)

Several fields within the application provide access to a multiple-select window. For example, the **AXIS IV** field opens the multiple-select window shown in Figure 2-12.

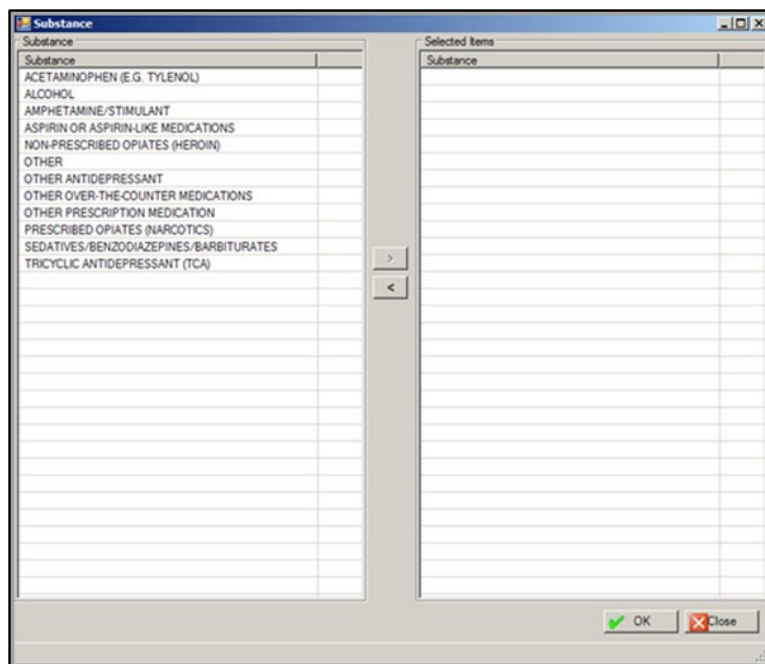


Figure 2-12: AXIS IV multiple-select window example

1. Click **Close** to exit the window and return to the previous screen.
2. To add one or more items to the **Substance** list box to the **Selected Items–Substance** list box, select the desired entries and click the right-arrow button.
 - To select multiple items, hold down the ctrl key while clicking additional codes.
3. To remove one or more items from the **Selected Items–Substance** list box and return them to the **Substance** list box, select the entries and click the left-arrow button.
4. Once all the desired items are listed in the **Selected Items–Substance** list box, click **OK** to confirm the selection.

2.6 Free-Text Fields (GUI)

Free-text fields allow users to manually enter information. These fields do not provide a predefined list of options for selection.

A context menu is available to assist with text editing (Figure 2-13).



Figure 2-13: Context menu for Text Editing example

The options in the context menu function similarly to those found in Windows applications, with the following actions:

- **Undo**—Reverses the most recent editing action.
- **Cut**—Removes the selected text from the field and copies it to the clipboard.
- **Copy**—Copies the selected text to the clipboard without removing it from the field.
- **Paste**—Inserts the clipboard contents at the current cursor position.
- **Delete**—Removes the selected text from the field without copying it.
- **Select All**—Highlights all text within the current field.

Note: For lengthy entries, users may compose and edit the text in a word processing application to leverage spelling and formatting tools. After editing, the text can be copied from the word processor and paste into the free-text field.

2.7 Selecting a Patient

This section provides instructions for selecting a patient within both the **Roll and Scroll** interface and the **RPMS AMH (GUI)**.

2.7.1 Patient Selection—Graphical User Interface (GUI)

A patient must be selected in the following scenarios:

- When no patient is currently selected and the **One Patient** option is enabled (e.g. under Visit Encounters).
- When switching to a different patient.

To select or change a patient:

- Navigate to **Patient | Select** from the menu bar

Or

- Right-click within the menu tree and click **Select Patient**.

In both cases, the **Select Patient** dialog appears (Figure 2-14).

Patient Name	Chart #	DOB	Sex	Age
DEMO.BCMATWO	147514	12/08/1971	M	53
DEMO.BEAUTIFUL DAUGHTER	999991	12/02/2018	F	6
DEMO.BENJAMIN A SR	893856	03/20/1980	M	44
DEMO.BERNADINE MARIA	140558	11/11/1992	F	32
DEMO.CDSADULT FEMALE	999998	03/25/1965	F	59
DEMO.CDSCHILD	999997	05/22/2015	F	9
DEMO.CHERYL NADINE	135548	06/24/1987	F	37
DEMO.CHILD A	T74895	08/01/2022	M	2
DEMO.COFFEE - FOLGERS*	113117	03/17/1936	M	88
DEMO.CRSCHILD	996635	03/15/2017	M	7

Figure 2-14: Select Patient dialog example

- Click the **Help** button to access context-sensitive online help for this dialog.
- Click the **Clear** button to remove all content from both the **Patient List** box and the **Patient Lookup Options** text field.

To perform a patient search:

1. In the **Patient Lookup Options** field, enter at least three characters of the **patient's last name, Health Record Number (HRN), or date of birth** (formatted as **MM/DD/YYYY**).

The application accepts either following name formats:

- **LASTNAME,FIRSTNAME**
 - **LASTNAME, FIRSTNAME** (with a space after the comma)
2. From the **Matches** drop-down list, select the desired number of matching records to display.
 - The default selection is **ALL**.
 3. Click the **Display** button to initiate the search.

Note: The system retrieves all valid matches and displays them in the **Patient List** box (reference Figure 2-14). If no matches are found, the list box will remain empty, and a message stating **0 Record(s) Found** will appear in the bottom-left corner of the dialog.

4. Use the scroll bars to browse through the list of retrieved patient records.
5. Double-click the desired patient entry in the **Patient List** box to select it. The selected patient is designated the active patient within the application.

2.8 Sensitive Patient Tracking

- To enhance patient privacy and comply with data security standards, additional safeguards have been implemented for accessing records of patients flagged as **Sensitive**.
- When a patient is marked as **Sensitive**, all access to that patient's record is monitored and logged.
- If a staff member without the appropriate security permissions attempts to access a Sensitive patient's record, the system displays a warning message indicating the restricted nature of the data.
- If the user proceeds with accessing the record despite the warning, the system automatically sends a bulletin to a designated mail group to report the access event.
- For detailed procedures and policy information regarding Sensitive Patient Tracking, refer to the *Patient Information Management System (PIMS) Sensitive Patient Tracking (BDG) User Manual*.
- If a patient is designated as **Sensitive** in the **Sensitive Patient Tracking** application, the word **SENSITIVE** appears in place of the **Social Security Number**, **Date of Birth**, and **Age** fields within the **Select Patient** dialog (Figure 2-15).

GUI Example

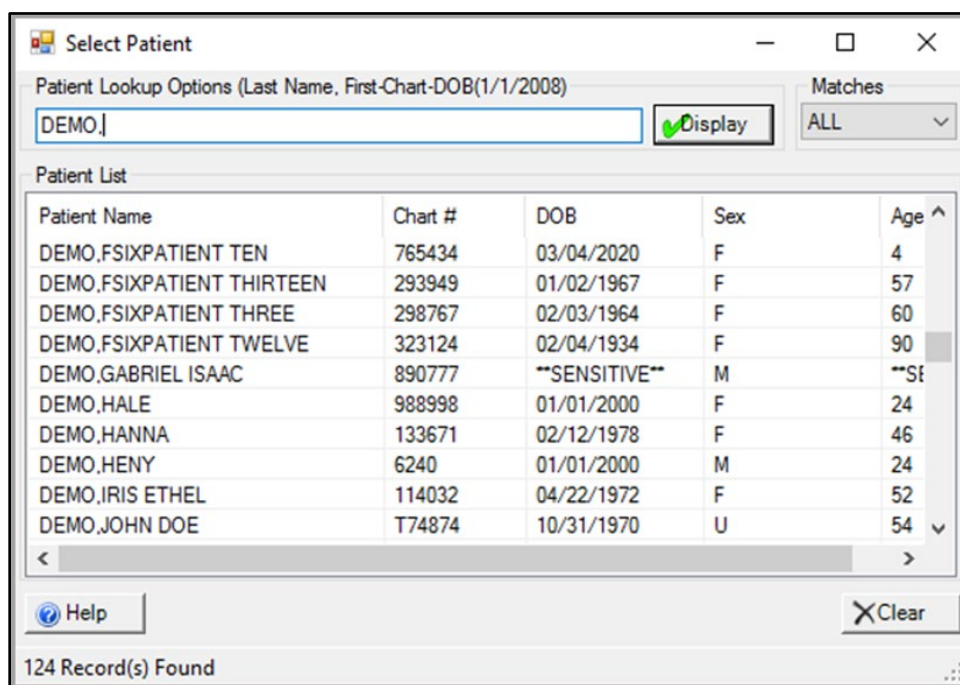


Figure 2-15: Select Patient dialog showing sensitive patient example

Figure 2-16 illustrates the warning message displayed to users within the GUI when attempting to access a **Sensitive patient** record.



Figure 2-16: Warning message displayed in GUI example

Click **Yes** to proceed with accessing the patient's record.

If **No** is selected, the user is returned to the **Select Patient** dialog without accessing the record.

2.9 Electronic Signature

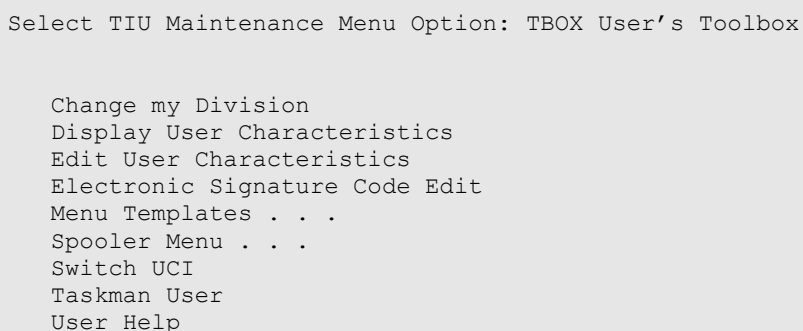
This section provides guidance on the use and configuration of the electronic signature application to both the **Roll and Scroll** interface and the **Graphical User Interface (GUI)**. The electronic signature is required to authenticate the following types of documentation:

- SOAP/Progress notes
- Intake documents
- Update documents

2.9.1 Creating Your Electronic Signature

To create or update your electronic signature:

1. At the “Select TIU Maintenance Menu Option” prompt, type **TBOX** (Figure 2-17).
2. From the **User’s Toolbox** menu, select **Electronic Signature Code Edit**.

A screenshot of a terminal window showing a menu. The prompt is "Select TIU Maintenance Menu Option: TBOX User's Toolbox". The menu options listed are: "Change my Division", "Display User Characteristics", "Edit User Characteristics", "Electronic Signature Code Edit", "Menu Templates . . .", "Spooler Menu . . .", "Switch UCI", "Taskman User", and "User Help".

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

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

Figure 2-17: Options available in the TBOX User's Toolbox example

Upon selection, prompts will guide the user through the electronic signature set-up process (Figure 2-18).

Important Notes:	When entering your Signature Block Printed Name and Title, do not include credentials (e.g., MD) in both fields. If credentials are entered in both fields, they will appear twice in the finalized signature. Ensure that: The Signature Block Printed Name contains your full name and, if desired, professional credentials. The Signature Block Title contains your official title only, without repeating credentials unnecessarily.
-------------------------	---

```

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

```

Figure 2-18: Initial Prompts Displayed During the Electronic Signature Setup Process example

When the following prompt (Figure 2-19) appears within the RPMS, it indicates that an existing electronic signature code is already associated with the user account.

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

Figure 2-19: Prompt to Enter Current Electronic Signature Code example

3. When prompted as shown in Figure 2-20, enter a new **electronic signature code** to update or replace the existing one.

```
Enter code:
```

Figure 2-20: Prompt to create a New Electronic Signature Code example

Follow the on-screen instructions to establish a new, secure code. Ensure that the code meets all system security requirements.

4. Enter a new **electronic signature code**, using **6** and **20** characters, with **Caps Lock** enabled.

Important Notes: While the code must be created using uppercase letters, **it can be entered in lower case** when signing documents (e.g., **SOAP/Progress Notes**).

Special characters are **NOT** permitted in the electronic signature code.

If the code is forgotten, it **must be reset by the Site Manager**. Once cleared, the user must create a new code.

Only the assigned user may enter or apply their electronic signature code. It is not transferable or accessible by others.

2.9.2 Electronic Signature Usage

- Each patient-related encounter can have only one electronically signed **SOAP/Progress Note**.
- Only the primary provider of service is authorized to electronically sign the **SOAP/Progress Note**, **Intake document**, or **Update document**.
 - Once electronically signed, notes containing text cannot be edited.
 - Blank **SOAP/Progress Notes** cannot be signed.
 - Signed **SOAP/Progress Notes** may only be deleted by users assigned the **AMHZ DELETE SIGNED NOTE** security key.
 - An encounter record that includes an unsigned **SOAP/Progress Note** can be edited or deleted.
 - **Electronic signatures** do not apply to **Behavioral Health (BH)** encounters created in the Electronic Health Record (EHR) system.
 - **Electronic signatures** cannot be applied to **SOAP/Progress Notes** created before the functionality was introduced in the AMH system.
 - **Electronic signatures** are not required for visits created prior to the installation of v4.0. In such cases, the following message will appear:
E Sig not required for this visit; visit is prior to Version 4.0 install date.

2.9.3 Data Entry Requirements

The **Electronic Signature** field is part of the **MH/SS RECORD** file that includes a timestamp indicating the date and time the signature was applied.

2.9.4 Assigning a PCC Visit

The application enforces the following logic when assigning a PCC visit:

- A visit **cannot** be passed to PCC if the associated **SOAP/Progress Note** has not been signed.
- Upon exiting the encounter, the application evaluates whether the current user is designated as the primary provider.
 - If the current user is the primary provider and attempts to enter or edit the record, the application permits the user to electronically sign the **SOAP/Progress Note**.
 - If the current user is not the primary provider and attempts to enter or edit the record, the application restricts the user from electronically signing the **SOAP/Progress Note**. In this scenario, the following message is displayed:
“Only the primary provider is permitted to sign the SOAP/Progress Note. The encounter will be saved as unsigned.”

Additionally, the application displays a secondary message:

“No PCC Link. Note not signed.”

2.9.5 Signing a Note (Graphical User Interface)

After a **SOAP/Progress Note** is entered, the application presents the **Sign?** dialog (Figure 2-21).



Figure 2-21: Sign? dialog example

1. Click **No** to save the encounter record without applying an electronic signature to the note.
2. Click **Yes** to proceed. The application will then display the **Electronic Signature** dialog (Figure 2-22).

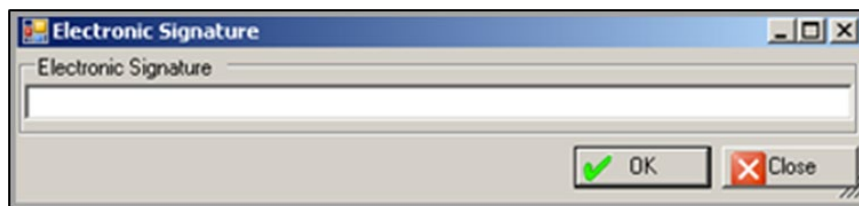


Figure 2-22: Electronic Signature dialog example

3. Enter your valid **electronic signature** and click **OK**. This action saves the encounter with the **SOAP/Progress Note** marked as signed.
 - If an invalid electronic signature is entered and **OK** is clicked, the application displays an error message:
Invalid Signature Code
 - Click **OK** on the error dialog to return focus to the **Electronic Signature** dialog for re-entry.
4. To cancel the signing process, click **Close** on the **Electronic Signature** dialog. The application will display the **Are You Sure?** confirmation dialog (Figure 2-23).

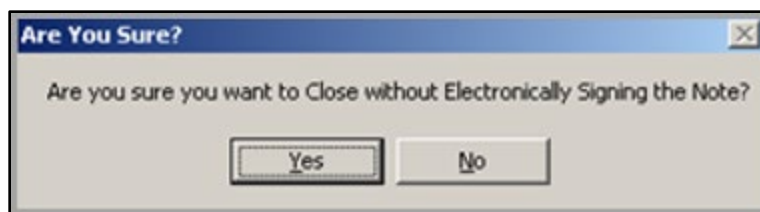


Figure 2-23: Are you Sure? Dialog example

5. Click **No** to cancel the close action. The focus will return to the **Electronic Signature** dialog.
6. Click **Yes** to confirm that you do not want to sign the note. The application will then display the **Message** dialog (Figure 2-24).

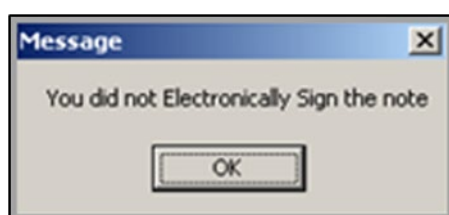


Figure 2-24: Message dialog example

7. Click **OK**. The encounter record will be saved without an electronic signature on the **SOAP/Progress Note**.

2.10 Logging Into the GUI

When accessing the graphical user interface (GUI) for the first time, the **IHS Behavior Health System Login** dialog appears (Figure 2-25).

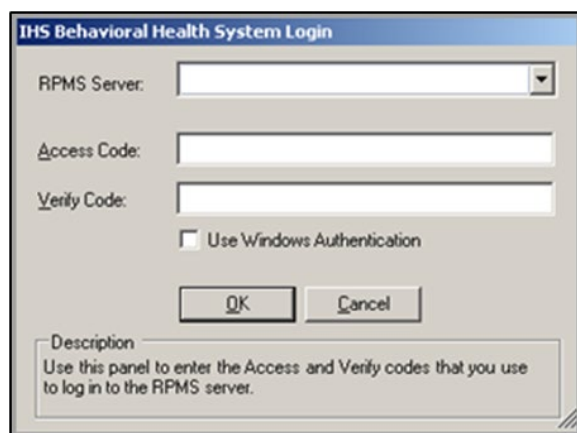


Figure 2-25: IHS AMH Login dialog example

1. In the **RPMS Server** field, click **Edit Connections**. This action opens the **RPMS Server Connection Management** dialog (Figure 2-26).

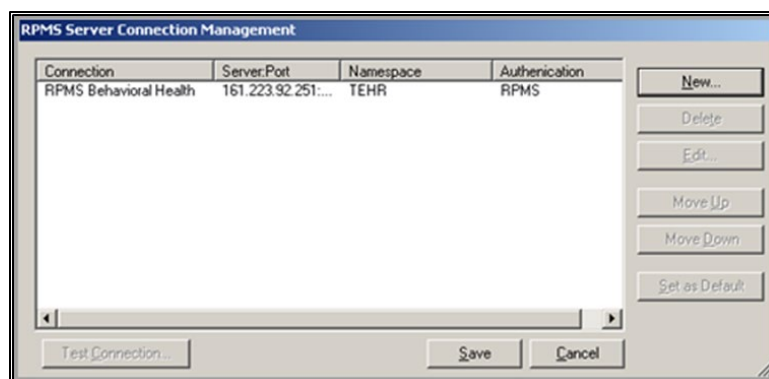


Figure 2-26: RPMS Server Connection Management dialog example

2. To configure a connection:

- Click **New** to create a new **RPMS server connection**.
- Or
- Select an existing **Connection** and click **Edit** to modify it.

The application will display the **Edit RPMS Server Connection** dialog (Figure 2-27).

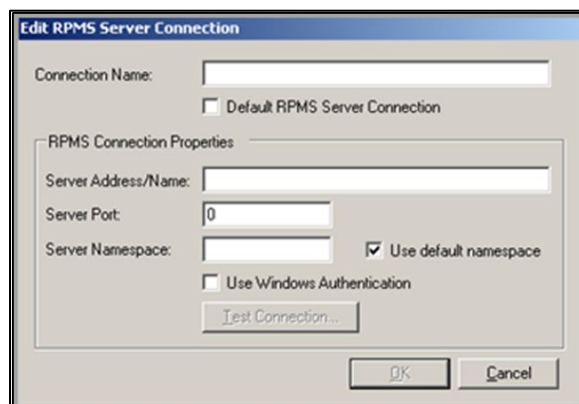


Figure 2-27: Edit RPMS Server Connection dialog example

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

3. In the **Connection Name** field, enter a name for the connection. This name can be any descriptive label of your choosing.
4. In the **Server Address/Name** field, enter the server's **IP address**, including all required punctuation.

Note: An IP address typically consists of four groups of two or three digits separated by periods (e.g., 161.223.99.999). Your Site Manager will provide the correct IP address for your configuration.

5. In the **Server Port** field, enter the designated port number for the server. This information will also be provided by your Site Manager.
6. In the **Server Namespace** field, proceed as follows:

If your site hosts multiple databases on a single server, you must specify the appropriate namespace. This is typically a text string (e.g., DEVEH).

7. In the **Use Default Namespace** field, select the **check box** only if the specified namespace is the default one used by your site.

Once all required fields are populated, the **Test Connection** button becomes active.

8. Click **Test Connection** to open the **Test Login** dialog.
 - a. Enter your **Access Code** and **Verify Code**, then click **OK**.
 - If the connection is successful, the application displays a confirmation message: **RPMS login was successful**.
 - If the connection fails, the application displays an error message. Click **OK** to return to the **Test Login** dialog and re-enter your credentials or connection information as needed.
9. Once all the required fields in the **Edit RPMS Server Connection** dialog are complete, click **OK** to save the configuration.
 - Alternatively, click **Cancel** to exit without saving.
 - Clicking **OK** will return you to the **RPMS Server Connection Management** dialog, where the new or updated connection will now be listed.
10. In the **RPMS Server Connection Management** dialog, click **Save** to confirm and store your changes.
 - Alternatively, click **Cancel** to discard any modifications.
11. After clicking **Save**, the application will return to and display the **IHS AMH Login** dialog (Figure 2-28).

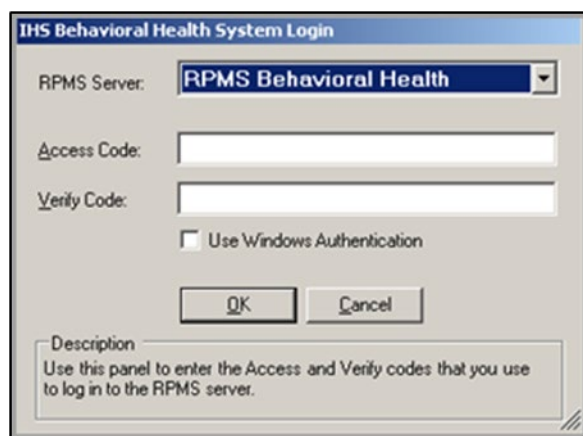


Figure 2-28: Login dialog example

- The selected server appears in the **RPMS Server** field.
12. In the appropriate fields, enter your **RPMS Access Code** and **Verify Code**.
- These credentials are the same ones used to access any RPMS session.
 - Do not enter data into the field accompanied by a check box.
13. Click **OK** to proceed and access the **RPMS AMH** tree structure.
- Alternatively, click **Cancel** to exit the login process.

2.11 RPMS AMH Tree

Figure 2-29 illustrates the default view of the RPMS AMH tree structure.

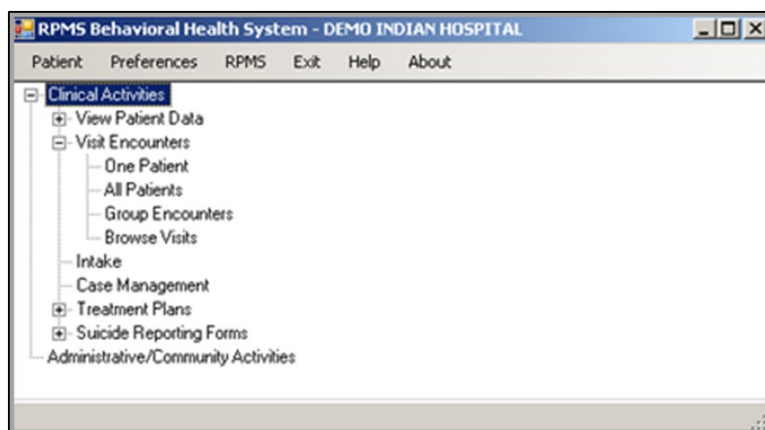


Figure 2-29: RPMS AMH Tree Structure example

The tree structure functions similarly to hierarchical trees commonly found in Microsoft Office applications.

- Click the **minus icon (-)** to collapse a section. The icon will then change to a **plus icon (+)**.

In Figure 2-29, the **View Patient Data**, **Treatment Plans**, and **Suicide Reporting Forms** sections are collapsed.

- Click the **plus icon (+)** to expand a section. The icon then changes to a **minus icon (-)**.

In the example screenshot, the **Visit Encounters** section is expanded.

Patient Menu

Use the **Patient** menu to select or change the current patient record.

Preferences Menu

Use the **Preferences** menu (Figure 2-30) to:

- Switch to a different division
- Adjust the font settings used in the main menu tree for better readability.

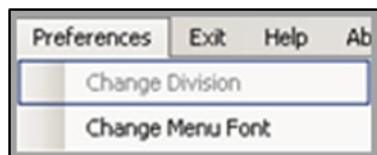


Figure 2-30: Preferences menu options example

1. In the **Change Division** field, select the appropriate **division** to use.
 - This option is accessed via the **Change Division** command, which opens the **Select Division** dialog.
 - Use this feature if your site operates with multiple RPMS databases.
2. Select **Change Menu Font** to open the **Font** dialog (Figure 2-31).
 - This option allows you to customize the appearance of the text in the tree structure.

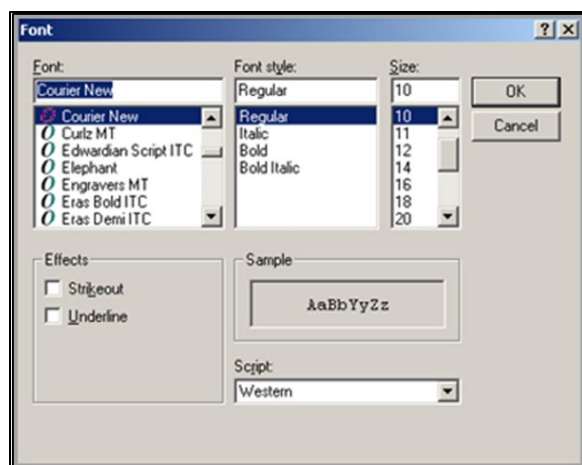


Figure 2-31: Font dialog example

- In the **Font** dialog, you can modify the following settings for the tree structure text:

- **Font Name**
- **Font Style** (e.g., Regular, Bold, Italic)
- **Font Size**

You may also apply visual effects such as **Strikeout** and **Underline**, which function similarly to those found in Microsoft Word.

- Most users adjust the font size to enhance readability.
- Use the **Script** option to change the language script of the displayed text—provided that the corresponding language pack is installed on your machine.
- If the required language pack is not installed, selecting another script will not affect the display.
- Click **OK** to apply your changes to the tree structure.
- Alternatively, click **Cancel** to exit without making changes.

RPMS Menu

Use the **RPMS** menu to access the RPMS system in roll-and-scroll mode.

After selection the **RPMS** menu, the **RPMS Terminal Emulator** window appears:

- In the **RPMS Terminal Emulator** window, select **File → Connect** to open the **Connect** dialog.
- In the **Host** field, enter the appropriate **IP address**, and then click **OK**.

Note: It is not necessary to populate any other fields.

- After clicking **OK**, the system connects to RPMS. Log in using your standard RPMS credentials.
- Once the **RPMS Terminal Emulator** fields have been populated, the application will retain these values for future logins (the required fields are pre-populated automatically).
- When you have completed your RPMS activities, select **File → Exit** to return to the graphical user interface (GUI) portion of the application.

Exit Menu

Use the **Exit** menu to close the application. When selected, the application displays the following confirmation message:

Are you sure you want to Exit?

- Click **Yes** to close the application.
- Click **No** to return to the application.

Help Menu

Use the **Help** menu to access the online help system for the application.

About Menu

Use the **About** menu to view detailed information about the application, including the version number and other relevant system details.

3.0 Data Entry

This section provides an overview of the data entry process for the **RPMS AMH Graphical User Interface–GUI (BH GUI)**.

3.1 RPMS AMH Graphical User Interface (GUI)

The data entry options for the **RPMS AMH (GUI)** are located under the **Visit Encounters** category within the application's tree structure, as illustrated in Figure 3-1.

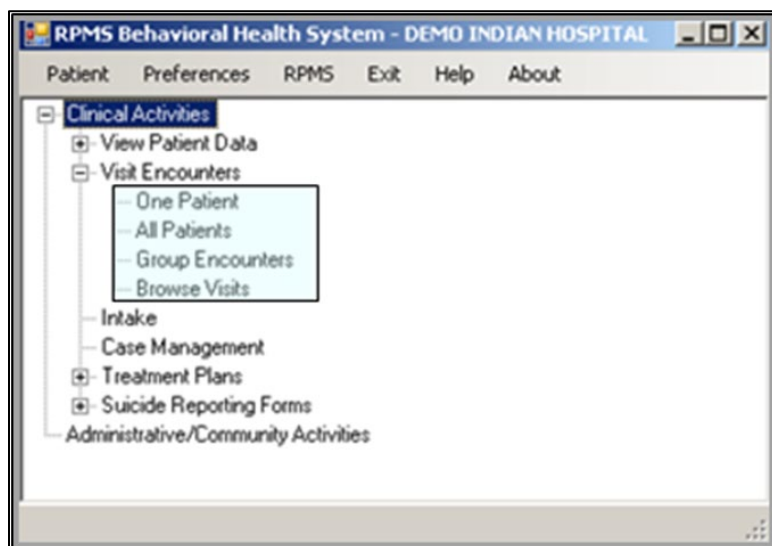


Figure 3-1: Visit Encounters Category in the RPMS AMH tree structure example

The **Visit Encounters** category provides several data entry options for managing patient and group visit information within specified date ranges:

- **One Patient**—Allows you to manage visit records for a single patient within a defined date range.
- **All Patients**—Enables you to manage visit records for all patients within a defined date range.
- **Group Encounters**—Provides access to group encounter data management for group sessions within a defined date range.
- **Browse Visits**—Display visit information for the currently selected patient within a defined date range.

4.0 One Patient Visit Data

This section describes how to manage visit data for an individual patient in the BH GUI.

4.1 Visit Window (GUI)

Within the **AMH (GUI)** tree structure, you can access the **Visit** window and manage visit data for one patient (Figure 4-1).

The screenshot shows the 'Visit' window with the following data:

C	Date	POV	Program	Clinic	Activity	Activity Time	Contact Type	Provider	Location of Encounter
*	02/26/2025	ALCOHOL WITHDRAWAL, UNCOM...	MENTAL HEALTH	MENTAL HEALTH ...	ASSESSMENT/EVALUATI...	20	OUTPATIENT		2021 DEMO HOSPITA
*	05/04/2025	MAJOR NEUROCOGNITIVE DISOR...	MENTAL HEALTH	MENTAL HEALTH ...	SCREENING-PATIENT PR...	20	OUTPATIENT		2021 DEMO HOSPITA

At the bottom left, the patient information is displayed: DEMO, DONNA SUE 137711 F 11/10/1986 39. At the bottom right, the word 'Loaded' is visible.

Figure 4-1: Visit Window for One Patient example

- **Use the Visit–One Patient** window to manage visit records within a specified date range for the currently selected patient. The patient's name is displayed in the lower-left corner of the window.
- If no current patient is selected, the system will prompt you to select one. The default date range is one year.
- Alternatively, you can access the **Visit** window for a specific patient by selecting the **All Patients** option in the **RPMS AMH (GUI)** tree structure. This displays the **Visit** window for all patients (Figure 4-2).

C	Date	Patient	Chart	Sex	DOB	POV	Program	Clinic	Activity	Activity Time	Contact
*	02/26/2026	DEMO, NIKITA	TST147194	F	08/13/1941	ANXIETY DISORDER DUE TO ANO...	MENTAL HEALTH	MENTAL HEALTH (P...	SCREENING-PATIE...	60	OUTP
*	02/26/2026	DEMO, FERN	TST142601	M	01/01/1960	MAJOR DEPRESSIVE DISORDER...	SOCIAL SERVICES	MEDICAL SOCIAL S...	INDIVIDUAL TREAT...	60	OUTP
*	02/26/2026	DEMO, DONNA SUE	TST137711	F	11/10/1986	ALCOHOL WITHDRAWAL, UNCOM...	MENTAL HEALTH	MENTAL HEALTH (P...	ASSESSMENT/EVA...	20	OUTP
	02/24/2026	DEMO, MAYLENE	TST890009	F	11/04/1949	MAJOR DEPRESSIVE DISORDER...	MENTAL HEALTH	MENTAL HEALTH (P...	INDIVIDUAL TREAT...	60	OUTP

Figure 4-2: Visit Window for All Patients example

Use the **Visit—All Patients** window to manage visit records for a selected patient. The visits displayed are limited to those within the date range specified in the **Visit Date Range** group box. The default date range is set to one day.

The features described below apply to both the **Visit—Single Patient** and **Visit—All Patients** windows.

Table 4-1 provides detailed information on the functions available in each window.

Table 4-1: Visit Window Features and Functions

Feature	Functionality
Visit Window (Single Patient)	The default Start Date is set to one year prior to the current date. To change the date range, click the list box to open the calendar, select the desired dates, and click OK to refresh the records in the Visit list box. Note: When you change the Start Date in the single-patient Visit window, the new date remains in effect for future sessions of the GUI application (until it is changed again).
Visit Window (All Patients)	The default Start Date is set to today's date. You may change this default Start Date during the session; however, the modifications remain active only until you exit the application. Upon logging in again, the Start Date automatically resets to today's date.
Visit List Box	Displays visit records within the specified Visit Date Range. An asterisk (*) in the first column indicates that the corresponding record contains an unsigned note. For additional details, refer to Signing a Note (GUI).
Add Button	Establishes the selected patient for the Add process. Click Add to create a new visit record. This opens the Visit Data Entry—Add Visit dialog.

Feature	Functionality
Edit Button	Allows you to modify an existing visit record. Click Edit to open the Visit Data Entry–Edit Visit dialog.
View Button	Click View , or double-click a record, to open a visit record in browse mode. The View Visit window displays the same fields as the Add/Edit Visit dialog, except that the Intake and Suicide Form tabs are not included.
Delete Button	Click Delete to remove a specific visit record. The application prompts for confirmation before deletion. Note: Visit records containing signed SOAP/Progress Notes can only be deleted by users who possess the AMHZ DELETE SIGNED NOTE security key.
Sign Note Button	Click Sign Note to sign the note of an unsigned visit record (indicated by an asterisk (*) in the first column of the Visit list box).
Problem Button	Select a record and click Problem to open either the BH Problem List or the Patient Care Component (PCC) Problem List , depending on system configuration.
Print Encounter Button	Click Print Encounter to print encounter data for the selected visit record. The Print Encounter feature offers three options: Full , Suppressed , Both Full and Suppressed . Note: The Intake Document and Suicide Reporting Form must be printed separately and will not appear on the printed encounter form. The Suppressed Report excludes the following data elements: Chief Complaint, SOAP Note, Measurement Data, Patient Education Data, Screenings. After selecting a print option, the first page of the Print Encounter pop-up window is displayed.
Help Button	Click Help to access the online help documentation for the Visit window.
Close Button	Click Close to exit the Visit window.

4.2 Add/Edit Visit Data Entry

Use the **Add** button on the **Visit** window to create a new visit record:

1. Establish the patient to be used in the Add process.
2. Perform one of the following actions:

- Click **Add** to create a new visit for the current patient. The application displays the **Visit Data Entry–Add Visit** dialog (Figure 4-3).
- Click **Edit** to modify the selected visit for the current patient. The application displays the **Visit Data Entry–Edit Visit** dialog.

Note: The **Edit** button is inactive if the patient has no existing visit records.

3. Figure 4-3 shows a sample **Visit Data Entry–Add Visit** window. The same fields are available in the **Visit Data Entry–Edit Visit** window.

Figure 4-3: Visit Data Entry–Add Visit Window example

Table 4-2 describes the features and functions available in the **Visit Data Entry** window.

Table 4-2: Add Visit Window Features and Functions

Feature	Functionality
Help Button	Click Help to access the online help documentation for this window.
Save Button	Click Save to store any additions or modifications made in this window. See Save Process below for details.

Feature	Functionality
Close Button	Click Close to exit without saving any changes. See Close Process below for details.

Save Process

The **Save** function stores the changes and closes the **Add/Edit Visit** window.

- If a **SOAP/Progress Note** was added, the application prompts you to confirm whether you want to sign the note.

For additional information, refer to Section 2.9.

- If the patient was not checked in for an appointment through the **Scheduling** package, the system returns you to the **Visit** window.
- If the patient was checked in through the **Scheduling** package and the system is configured to create a visit at check-in, the application displays the **Select PCC Visit** window.

For more information, see Section 4.2.9.

Important Notes: If the facility does not use the **Scheduling** package and the **Interactive PCC Link** in the site parameters is disabled, the user will not be prompted to link the **BH** visit to a **PCC** visit.

If no **PCC** visit exists (e.g., the patient was never checked in, no appointment or walk-in was created, and no other clinics recorded a visit on that date), the system will not prompt to link, and the **BH** visit will automatically create a new **PCC** visit record.

Close Process

When you click **Close**, the application displays a **Continue?** confirmation dialog stating:

Unsaved Data Will Be Lost, Continue?

- Click **Yes** to discard unsaved changes and close the data entry window.
- Click **No** to cancel the close action and return to the data entry window to continue working.

4.2.1 Visit Information Group Box

Use the **Visit Information** group box (Figure 4-4) to enter details related to the patient visit.

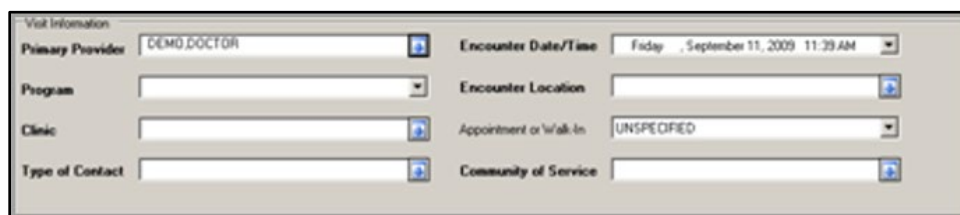
The screenshot shows a 'Visit Information' form with two columns of fields. The left column contains 'Primary Provider' (with a dropdown menu showing 'DEMO DOCTOR' and a search icon), 'Program' (with a dropdown arrow), 'Clinic' (with a dropdown arrow), and 'Type of Contact' (with a dropdown arrow). The right column contains 'Encounter Date/Time' (with a date/time picker showing 'Friday, September 11, 2009 11:39 AM'), 'Encounter Location' (with a dropdown arrow), 'Appointment or Walk-In' (with a dropdown menu showing 'UNSPECIFIED'), and 'Community of Service' (with a dropdown arrow). All field labels are in bold text.

Figure 4-4: Visit Information Group Box example

Fields displayed in bold text are required.

Primary Provider

Select the **Primary Provider** for the visit. The default value is the current provider. To change the provider, click the list to open the **Primary Provider** search window (Figure 4-5).

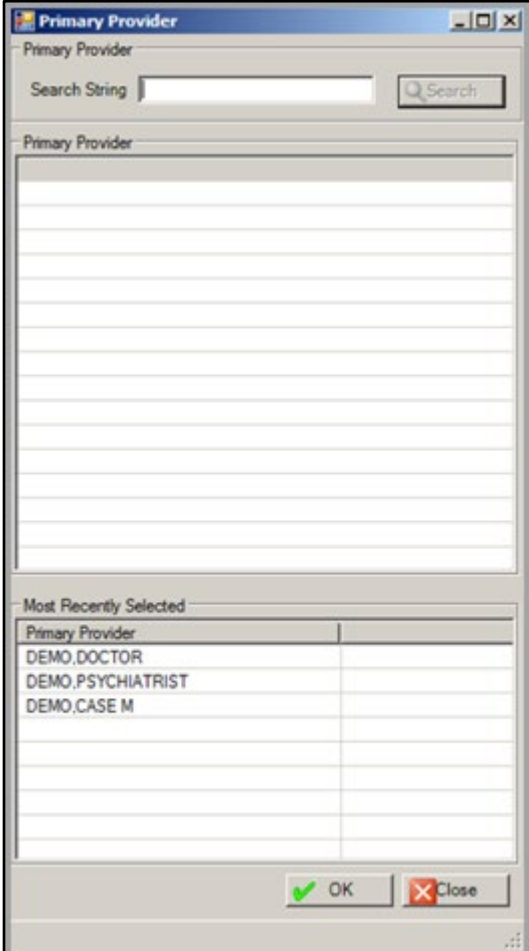
Screen Capture	What to Do
	Use this search window in one of two ways: 1. Use the Search String field by typing the provider's last name and then clicking Search. The retrieved providers will populate the Provider list box. Select a retrieved record and click OK to populate the Provider field. Otherwise, click Close. 2. Select a name in the Most Recently Selected list box and click OK to populate the Provider field. Otherwise, click Close.

Figure 4-5: Primary Provider search window example

Enter Date/Time:

Enter the **date** and **time** of the visit. The default value is the current system date and time. To change the date, click the **list** to open the calendar. The time may be edited manually. (This field can also be modified during **Edit** mode).

Program:

From the list, select the program associated with the visit. Available options include:

- **Mental health**
- **Social services**
- **Other**
- **Chemical Dependency**

After selecting a program, the application automatically populates the remaining fields, provided that default values have been configured in the **Site Parameters** menu.

1. In the **Encounter Location** field, enter the appropriate location for the encounter. This field specifies where the encounter occurs. To modify the location, click the drop-down list to open the **Location Search** window (Figure 4-6).

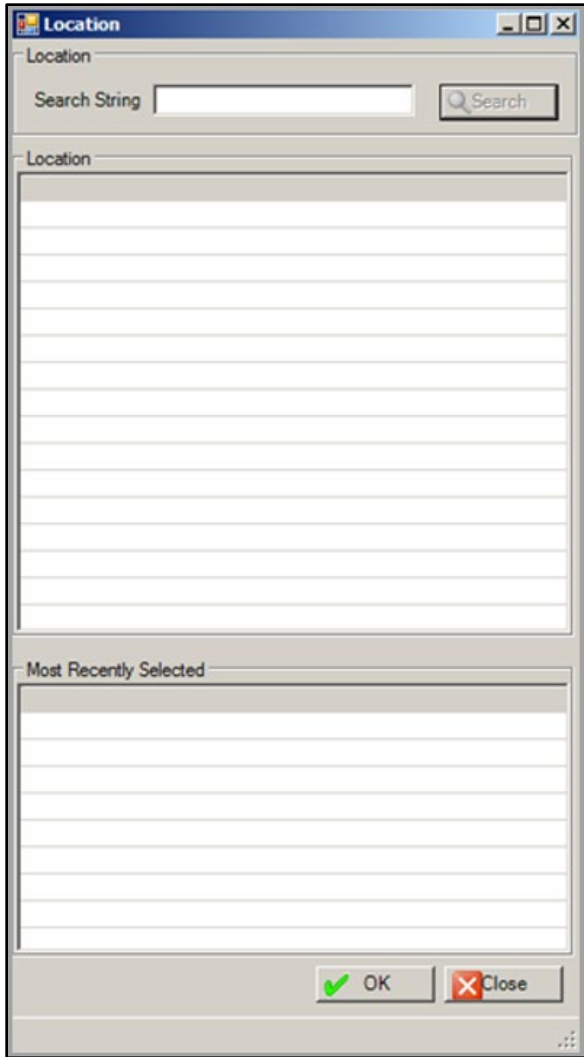
Screen Capture	What to Do
	Use the Location Search window in one of the following ways: 1. Search by Location: In the Search String field, type the location name and click Search. The system retrieves matching locations, which are displayed in the Location list box. Select the desired location and click OK to populate the Location field. To exit without making a selection, click Close. 2. Select from Recent Locations: In the Most Recently Selected list box, select a location and click OK to populate the Location field. To exit without making a selection, click Close.

Figure 4-6: Location search window example

2. In the **Clinic** field, select the appropriate clinic name. This field defines the clinic context for the encounter. The selected clinic must be listed in the **RPMS Standard Code Book** table. To change the clinic, click the drop-down list to open the **Clinic Search** window (Figure 4-7).

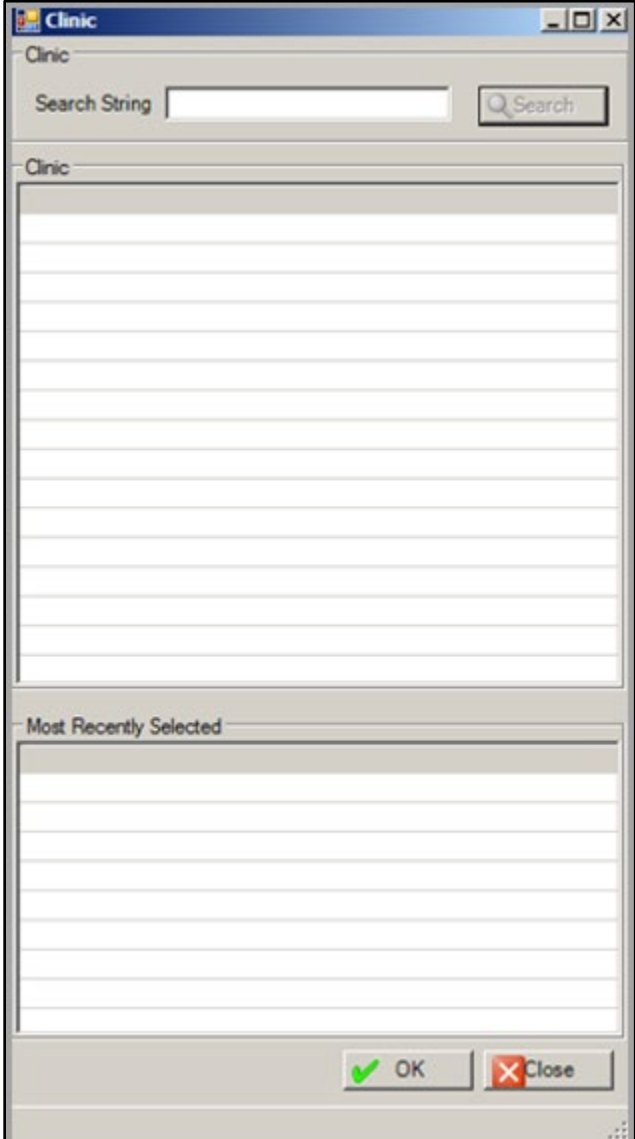
Screen Capture	What to Do
	Use the Clinic Search window in one of following ways: 1. Search by Name: In the Search String field, type the clinic name and click Search. The system retrieves matching clinics and their corresponding codes, which are displayed in the Clinic list box. Select the desired clinic and click OK to populate the Clinic field. To exit without making a selection, click Close. 2. Select from Recent Clinics: In the Most Recently Selected list box, select a clinic and click OK to populate the Clinic field. To exit without making a selection, click Close.

Figure 4-7: Clinic Search window example

Selecting an Appointment or Walk-In

In the **Appointment or Walk-In** field, select the appropriate visit type from the list. Select one of the following:

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

Specifying the Type of Contact

In the **Type of Contact** field, enter the contract type, which indicates the activity setting. To select from predefined options, click the drop-down list to open the **Type of Contact** window (Figure 4-8).

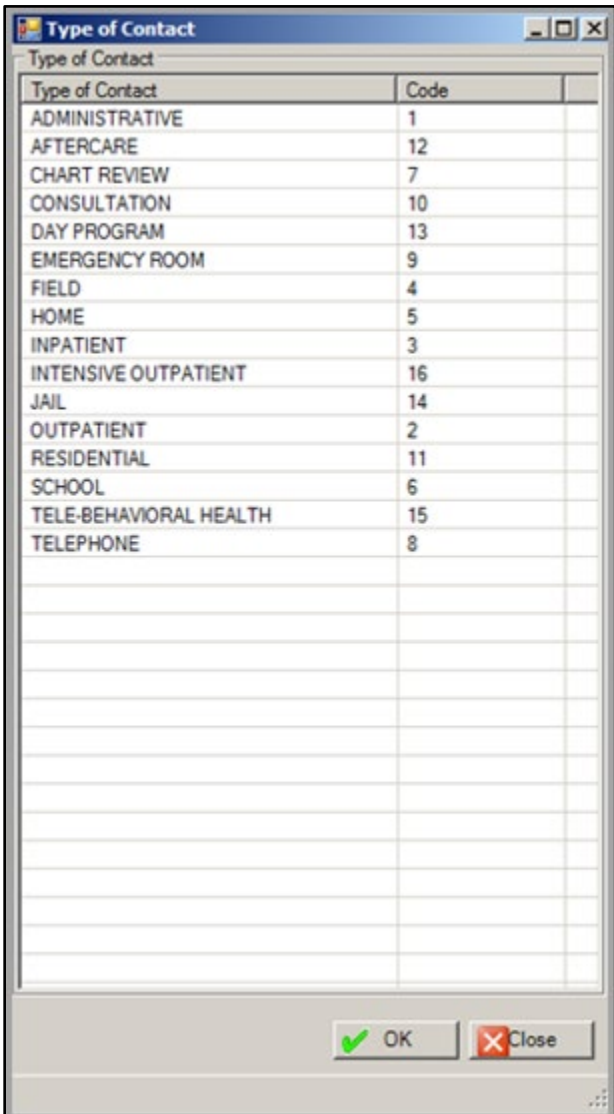
Screen Capture	What to Do
	Use the Type of Contact window as follows: 1. Select the appropriate Type of Contact from the list. 2. Click OK to populate the Type of Contact field. To exit without making a selection, click Close.

Figure 4-8: Type of Contact window example

Specifying the Community of Service

In the **Community of Service** field, enter the name of the **community** where the encounter occurred. To modify or select a community, click the drop-down list to open the **Community Search** window (Figure 4-9).

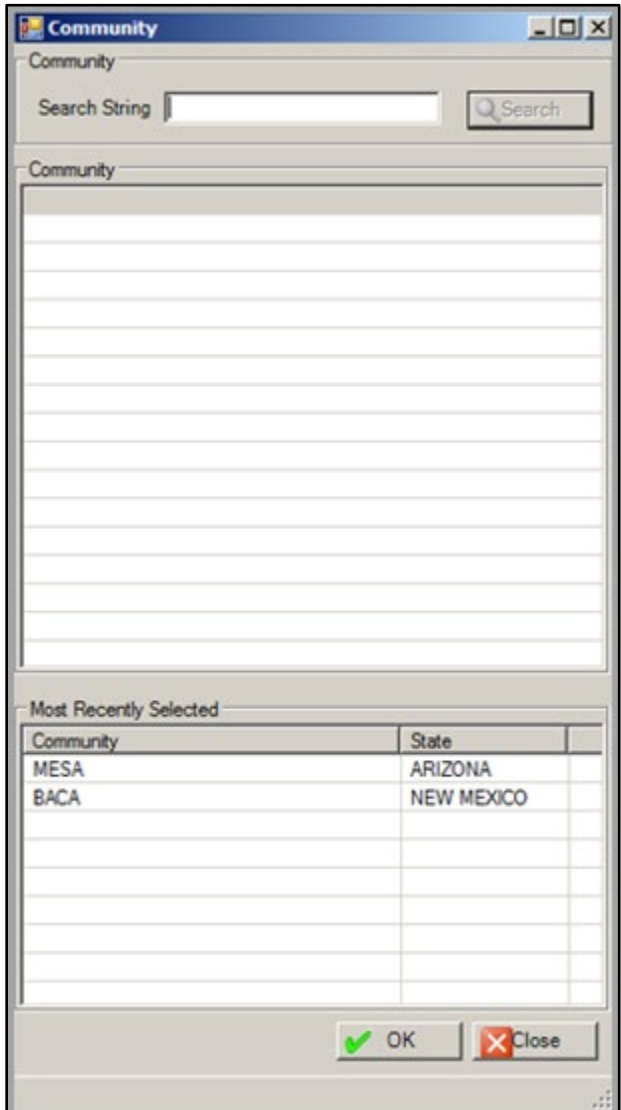
Screen Capture	What to Do
	Use the Community Search window in one of the following ways: 1. Search by Name: In the Search String field, type the community's name and click Search. The system retrieves matching community names and their corresponding states, which are displayed in the Community list box. Select the desired community and click OK to populate the Community of Service field. To exit without making a selection, click Close. 2. Select from Recent Communities: In the Most Recently Selected list box, select a community and click OK to populate the Community of Service field. To exit without making a selection, click Close.

Figure 4-9: Community search window example

4.2.2 Purpose Of Visit (POV) Tab

Use the **POV** tab (Figure 4-10) to add, edit, or delete the **Purpose of Visit (POV)** associated with the encounter.

Figure 4-10: POV Tab on Visit Data Entry window example

Users can add, edit, or delete POV records within this window.

4.2.2.1 Add Button

1. Click **Add**. The **POV** search window appears (Figure 4-11).

Figure 4-11: POV search window example

2. In the **Search String** field, enter a few characters of the search criteria.

3. Click **Search**. The system retrieves matching records, which are displayed in **POV** list box (showing the POV and its narrative).
 - To add one or more records from the **POV** list box to the **Selected Items** list box, select the desired entries and click the right-arrow button.
 - To include records from the **Most Recently Searched** list box, select one or more items and click the right-arrow button. The selected records are added to the **Selected Items** list box.
 - To remove records from the **Selected Items** list box, select the desired **entries** and click the **left-arrow** button.
4. When the **Selected Items** list box contains all desired records, click **OK** to populate the **POV** tab. To exit without saving changes, click **Close**.

4.2.2.2 Delete Button

1. Select the **POV record** to delete.
2. Click **Delete**. An “**Are You Sure**” confirmation message appears.
3. Click **Yes** to remove the selected record from the list box. To cancel the deletion, click **No**.

4.2.2.3 Edit Button

1. Select a **POV record** to edit.
2. Click **Edit**. The application displays the **Edit POV** dialog (Figure 4-12).

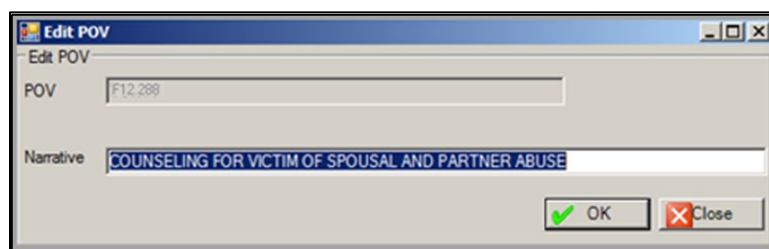


Figure 4-12: Edit POV dialog example

3. In the **Narrative** field, enter the new **POV narrative** (2–80 characters). This is a free-text field.
4. Click **OK** to save the updated narrative for the selected code on the **POV** tab. To exit without saving, click **Close**.

4.2.3 Activity Tab

Use the **Activity** tab (Figure 4-13) to manage activity data related to the visit for the current patient.

The screenshot shows the 'Activity' tab in a software window. At the top are tabs: POV, Activity, SOAP/Progress Notes, Rx Notes/Labs, Wellness, Measurements, Intake, and Suicide Form. The 'Activity' tab is selected. Below the tabs are several input fields: 'Activity' (a dropdown menu showing 'HEALTH PROMOTION'), 'Activity Time' (a text box with '10'), 'Visit Flag' (a checkbox), 'Local Service Site' (a dropdown menu), 'Interpreter Utilized?' (a checkbox), and 'Number Served' (a text box with '1'). Below these fields are two tables. The first table is titled 'CPT Code(s)' and has columns for Code, Narrative, Quant., Mod 1, and Mod 2. It has an 'Add' button (green plus icon) and a 'Delete' button (red X icon) to its right. The second table is titled 'Secondary Providers for this Visit' and has a 'Provider' column. It also has 'Add' and 'Delete' buttons to its right.

Figure 4-13: Activity tab on the Visit Data Entry window example

4.2.3.1 Activity Group Box

Figure 4-14 illustrates the **Activity** group box.

The screenshot shows a 'Activity' group box. It contains the same fields as Figure 4-13: 'Activity' (dropdown), 'Activity Time' (text box), 'Visit Flag' (checkbox), 'Local Service Site' (dropdown), 'Interpreter Utilized?' (checkbox), and 'Number Served' (text box).

Figure 4-14: Activity Group Box example

The fields displayed in **bold** text are required.

1. In the **Activity** field, select the **activity code** that identifies the type of service or activity performed by the Behavioral Health provider.

These activities may be either patient-related or administrative in nature. Use only one activity code per record, regardless of the time spent or the variety of the services provided.

Note: Certain activity codes are transmitted to PCC, which may affect the billing process.

- Click the drop-down list to open the **Activity Search** window (Figure 4-15), and search for the desired activity name. For additional information, refer to Appendix A.

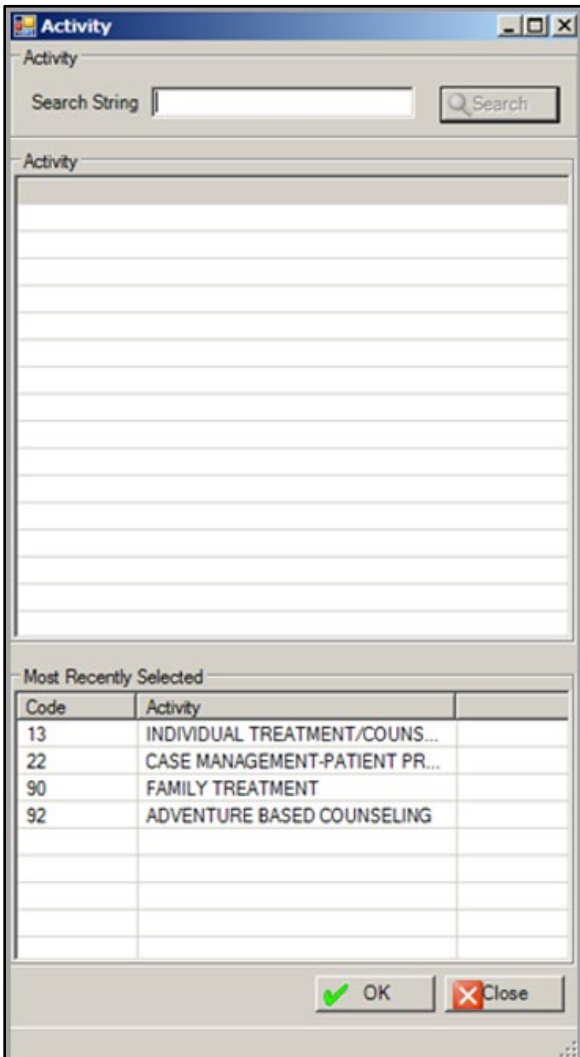
Screen Capture	What to Do
	Use the Activity Search window in one of the following ways: Search by Name: In the Search String field, type the activity name and click Search. The system retrieves matching activity codes and names, which are displayed in the Activity list box. Select the desired record and click OK to populate the Activity field. To exit without making a selection, click Close. Select from Recent Activities: In the Most Recently Selected list box, select an activity record and click OK to populate the Activity field. To exit without making a selection, click Close.

Figure 4-15: Activity Search window example

- In the **Activity Time** field, enter the amount of time spent on the activity, using any whole number between **1** and **9999** (no decimal values). The unit of measure is minutes. This required field indicates the total provider time spent performing and documenting the service activity.
- In the **Visit Flag** field, enter a numeric value between **0** and **999** (no decimal values). This field is used locally to categorize or flag specific types of visits. Each site defines its own numeric codes to represent particular visit types.

- Example: A value of **1** may indicate any visit during which a narcotic was prescribed. Later, all visits with a flag value of **1** can be retrieved to identify narcotic-related encounters.
5. In the **Local Service Site** field, select the appropriate local **service site**. Click the drop-down list to open the **Local Service Site** window (Figure 4-16).

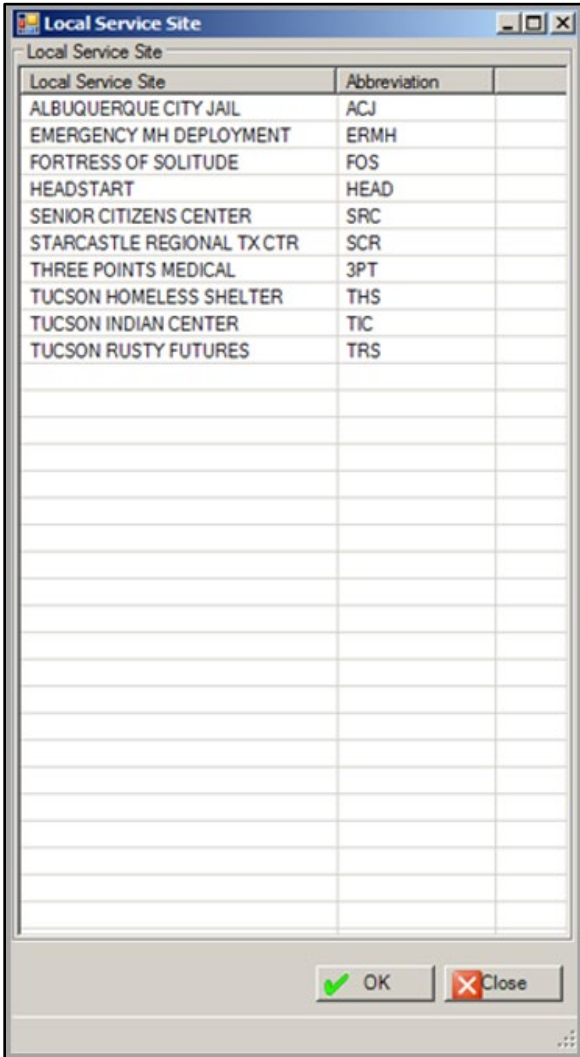
Screen Capture	What to Do
	Use this window in one of the following ways: 1. Select a local service site from the Local Service Site list. 2. Click OK to populate the Local Service Site field. To exit without making a selection, click Close.

Figure 4-16: Local Service Site Window example

6. In the **Interpreter Utilized?** field, select the check box if an interpreter was required to communicate with the patient.
7. In the **Number Served** field, enter a value between **1** and **9999** (no decimal values). The default is **1**. This required field indicates the number of individuals directly served during the activity. It applies to both direct patient care and administrative activities.

For example, group therapy sessions or family counseling may involve numbers greater than one.

4.2.3.2 CPT Code Group Box

Use the **CPT Code** group box to manage the **Current Procedural Terminology (CPT)** codes associated with the encounter. Records can be added or deleted within this group box.

4.2.3.3 Delete Button

1. Select the **CPT Code** record to delete.
2. Click **Delete**.
3. When the **Are you sure you want to delete?** confirmation message appears, click **Yes** to delete the record. To cancel the action, click **No**.

4.2.3.4 Add Button

1. Click **Add**. The **CPT Code** search window appears (Figure 4-17).

Figure 4-17: CPT Code search window example

2. In the **Search String** field, enter a keyword or partial code to search for a specific **CPT Code**.
3. Click **Search**. The system displays all **CPT Codes** matching the search criteria in the **CPT Code** field (Figure 4-18).

CPT Code

Search String 45

Search

CPT Code

CPT Code	Description
45000	DRAINAGE OF PELVK
45005	DRAINAGE OF RECTU
4500F	REF TO OUTPT CARE
45020	DRAINAGE OF RECTU
45100	BIOPSY OF RECTUM
45108	REMOVAL OF ANORE
4510F	PREV CARDREHAB C
45110	REMOVAL OF RECTU
45111	PARTIAL REMOVAL C
45112	REMOVAL OF RECTU
45113	PARTIAL PROTECTI
45114	PARTIAL REMOVAL C
45116	PARTIAL REMOVAL C
45119	REMOVE RECTUM W
45120	REMOVAL OF RECTU

Quantity 1

Modifier 1

Modifier 2

>

<

Figure 4-18: CPT Code Search Results example

4. Select the desired **CPT Code** from the list of retrieved results.
5. In the **Quantity** field, enter the number of units for the selected **CPT Code** to support accurate billing.
6. In the **Modifier** field, select the appropriate modifier for the **CPT Code**. Click the drop-down list to open the **CPT Modifier Search** window (Figure 4-19).

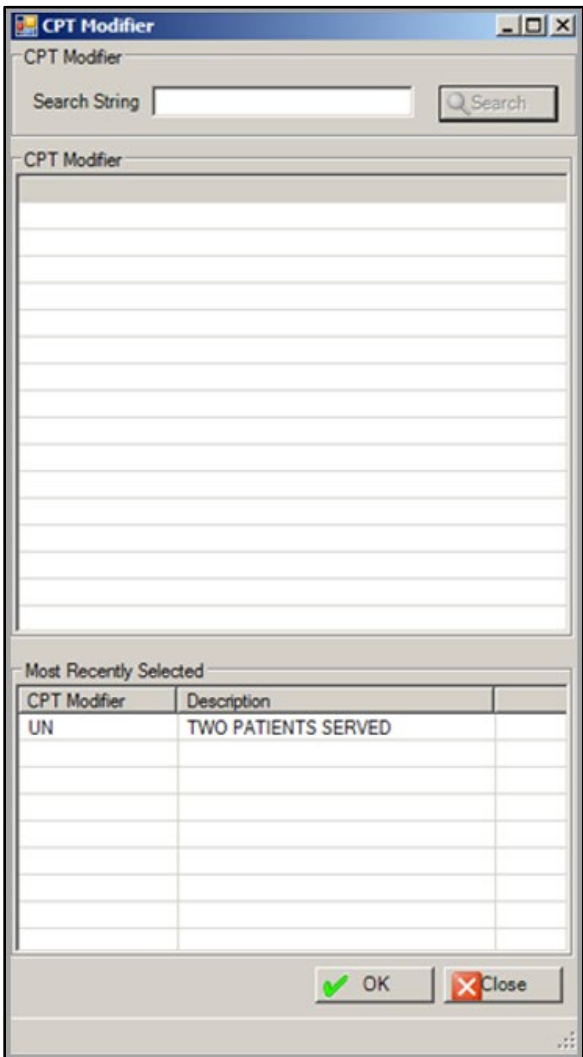
Screen Capture	What to Do
	Use the CPT Modifier Search window in one of the following ways: 1. Search by Name:In the Search String field, type the CPT Modifier name and click Search. The system retrieves matching modifier names and their descriptions, which are displayed in the CPT Modifier list box. Select the desired modifier and click OK to save the selection. To exit without making a selection, click Close. 2. Select from Recent Modifiers:In the Most Recently Selected list box, select a CPT modifier and click OK to save the selection. To exit without making a selection, click Close.

Figure 4-19 CPT Modifier Search window example

7. After completing the **Quantity** and **Modifier** fields, click the **right-arrow** button to add the selected items to the **Selected Items** list box.
 - Multiple CPT Codes may be added using this process.
 - Alternatively, you can populate the **Selected Items** list box by selecting a **CPT Code** from the **Most Recently Selected** list box and clicking the **right-arrow** button.
 - To remove a **CPT Code** from the **Selected Items** list box, select the **code** and click the **left-arrow** button.
8. When all desired codes appear in the **Selected Items** list box, click **OK** to save the data and add it to the **CPT Codes** group box. To exit without saving, click **Close**.

4.2.3.5 Secondary Providers for this Visit Group Box

Use the **Secondary Providers for this Visit** group box (Figure 4-20) to manage the secondary providers associated with the encounter.

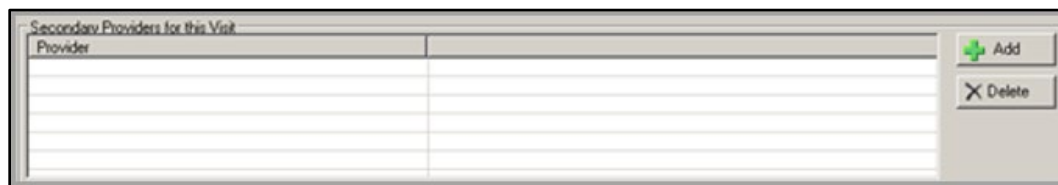


Figure 4-20: Secondary Providers for This Visit Group Box example

You can add or delete records within the **Secondary Provider** group box.

4.2.3.6 Add Button

1. Click **Add**. The **Secondary Providers Multiple** search window appears (Figure 4-21).

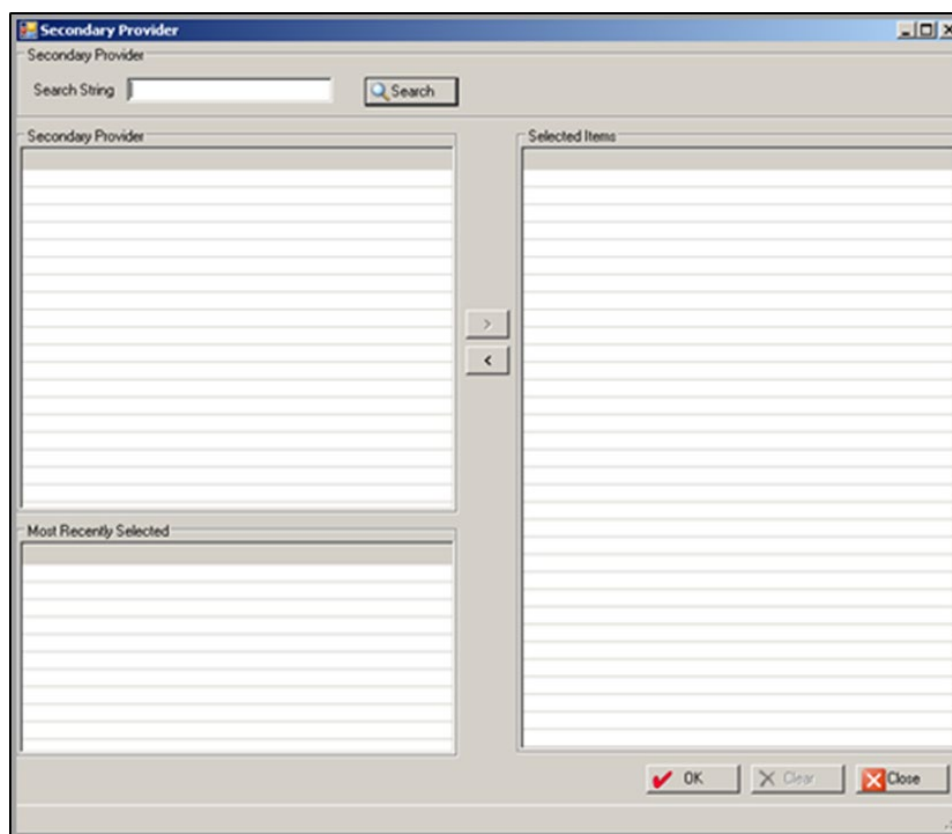


Figure 4-21: Secondary Provider Multiple search window example

2. In the **Search String** field, enter a few characters of the secondary provider's last name.

3. Click **Search**. The system retrieves matching records, which are displayed in **Secondary Provider** list box.
 - To add one or more selected records from the **Secondary Providers** list box to the **Selected Items** list box, click the **right-arrow** button.
 - To add one or more records from the **Most Recently Selected** list box to the **Selected Items** list box, click the **right-arrow** button.
 - To remove one or more records from the **Selected Items** list box, select the **records** and click the **left-arrow** button.
4. When the **Selected Items** list box contains all desired providers, click **OK** to populate the **Secondary Providers for This Visit** group box. To exit without saving, click **Close**.

4.2.3.7 Delete Button

1. Select the provider record to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to remove the selected provider from the **Secondary Providers for This Visit** group box. To cancel the action, click **No**.

4.2.4 SOAP/Progress Notes Tab

Use the **SOAP/Progress Notes** tab (Figure 4-22) on the **Visit Data Entry** window to manage the SOAP or progress note associated with the current visit, record the chief complaint or presenting problem, and to enter any comments regarding the next appointment.

Figure 4-22: SOAP/Progress Notes Tab example

If you are editing a record that contains a signed note, the **Progress Notes** field will be inactive (read-only). All other fields will be active.

1. In the **Chief Complaint/Presenting Problem** field, enter the **Chief Complaint/Presenting Problem** (2–80 characters). This is a free-text field that describes the primary reason the patient sought services.
2. In the **Progress Notes** field, enter the text of the progress note for the visit. A SOAP or progress note must be documented within the context of a visit. This is a free-text field.
3. In the **Comments/Next Appointment** field, enter any additional notes or comments regarding the client's next appointment. This is a free-text field.
4. In the **Placement Disposition** field, select the appropriate placement disposition(s).

Use this field when hospitalization, referral, or placement in another facility is required.

Click the drop-down list to open the **Disposition** dialog (Figure 4-23).

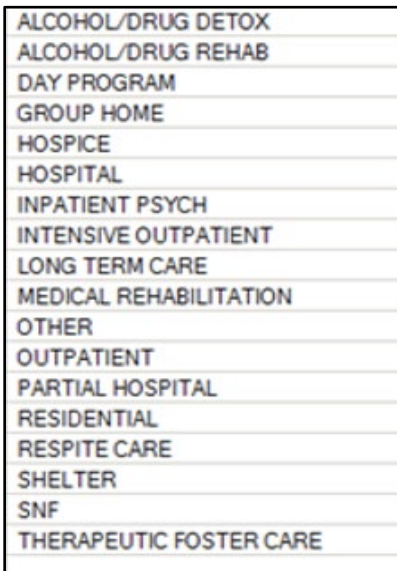
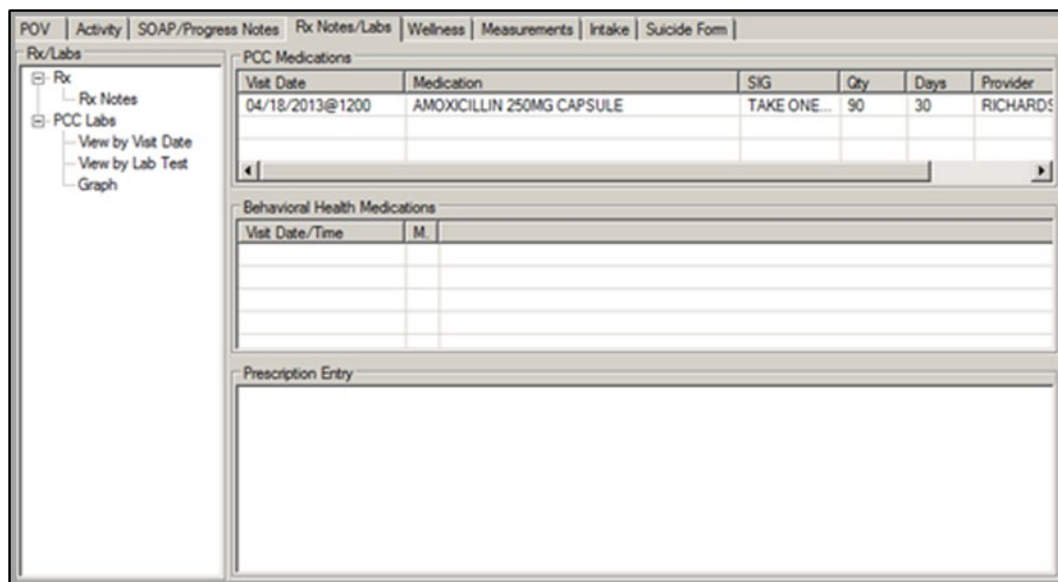
Screen Capture	What to do
	Use the Placement Disposition dialog in one of following ways: 1. Select the Placement Type. 2. Type the name of the Placement Site. 3. Click Add to populate the Placement Disposition field to the box on the right. More than one placement can be entered.

Figure 4-23: Placement Disposition example

In the **Placement Disposition** field, you can also edit or delete a placement entered by clicking on the **placement type** then clicking on the **edit** or **delete** option.

4.2.5 Rx Notes/Labs Tab

Use the **Rx Notes/Labs** tab (Figure 4-24) to view prescription data and laboratory test data associated with the encounter.



The screenshot shows the 'Rx Notes/Labs' tab selected in the top navigation bar. The left sidebar contains a tree view with 'Rx' and 'PCC Labs' expanded. The main content area is divided into three sections: 'PCC Medications' (a table with one row of data), 'Behavioral Health Medications' (an empty table), and 'Prescription Entry' (a large empty text area).

Visit Date	Medication	SIG	Qty	Days	Provider
04/18/2013@1200	AMOXICILLIN 250MG CAPSULE	TAKE ONE...	90	30	RICHARD S

Visit Date/Time	M

Figure 4-24: Rx Notes/Labs Tab example

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

4.2.5.1 **RX Data**

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

4.2.5.2 **PCC Medications List Box**

Use the **PCC Medications** list box to view medications prescribed through the **Patient Care Component (PCC)** system for the current patient.

Note: Complete medication history may not be present here.

4.2.5.3 **Behavioral Medication List Box**

Use the **Behavioral Medication** list box to view visit dates when behavioral health medication is prescribed, along with any associated notes.

4.2.5.4 **Prescription Entry Field**

Use the **Prescription Entry** field to record information about the patient's prescriptions. This is a free-text field. A context menu is available that allows you to cut, copy, or paste data, and functions similar to those found in MS Office applications.

Information entered into the **Medications** field during future visits. Items from the **Medication** field can also be copied and pasted into the **Prescription Entry** field. This feature is often used by some sites to record notes for the psychiatrist, such as documenting a pill count with the patient or noting whether the patient is compliant with medication.

4.2.5.5 **PCC Labs**

When **PCC Labs** is selected in the **Rx/Labs** group box, you can select to display the laboratory data:

- **View by Visit**
- **View by Lab Test**
- **Graph**

4.2.5.6 View by Visit Date

Select the **View by Visit Date** option to open the **View Labs by Visit Date** dialog (Figure 4-25).



Figure 4-25: View Labs by Visit Date dialog example

The **View Labs by Visit Date** dialog includes the following features:

- The default **Begin Date** is set to one year prior to the current date.
 - The application links the default dates across views so that changing date in one view updates the default date in both Lab views.
 - When the **Begin Date** is changed, the new date remains in effect until you change it again.
 - The application saves the user's default **Begin Date** upon exit. You may edit either or both date fields as needed.
1. In the **Begin Date** field, select the start date for the desired date range. Click the drop-down list to open the calendar, then select the appropriate date.
 2. In the **End Date** field, select the end date for the desired date range. Click the drop-down list to open the calendar, then select the appropriate date.
 3. Once all required fields are complete, click **OK**. The application displays the first page of the PCC labs for the selected patient, organized by visit date within the specified date range, in a pop-up window. To exit without making changes, click **Close**. For additional information about controls on the pop-up window, refer to Section 2.1.

Note: The same functionality is also available in the **RPMS AMH (GUI)** tree structure.

4.2.5.7 Graph View

When the **Graph** option (Figure 4-26) is selected, the left side of the tab updates to display two sections:

- **Lab Graph Date Range**—Allows users to define the date range for the laboratory data to be graphed

- **Graphable Lab Tests**—Lists the laboratory tests available for graphical display.

[illegible]

Figure 4-26: Graph Option Group Box example

4.2.5.8 Lab Graph Date Range

The **Lab Graph Date Range** section defines the time period used to display data in the **Graphable Lab Tests** list box.

- By default, the date range is set to one year.
- You may modify either or both dates as needed to adjust the data displayed.

Follow the steps below to define a custom date range:

1. In the **Starting Date** field, click the drop-down list to open the calendar, then select the desired start date for the graph's data range.
2. In the **Ending Date** field, click the drop-down list to open the calendar, then select the desired end date for the graph's data range.
3. Once the date range is correctly defined, click **Display**. The application will refresh the data in the **Graphable Lab Tests** list box to reflect the specified range.

Note: The selected date range remains in effect until it is modified again by the user.

4.2.5.9 Graphable Lab Tests

To generate a graph for a laboratory test (Figure 4-27), select a single lab test record from the **Graphable Lab Tests** list box, and then click **Graph**.

[illegible]

Figure 4-27: Graphable Lab Tests list box example

When the **Graph** command is executed:

- The application exports the selected lab test data to a Microsoft Excel spreadsheet.
- A graphical representation of the selected lab test data is automatically displayed (see Figure 4-28).

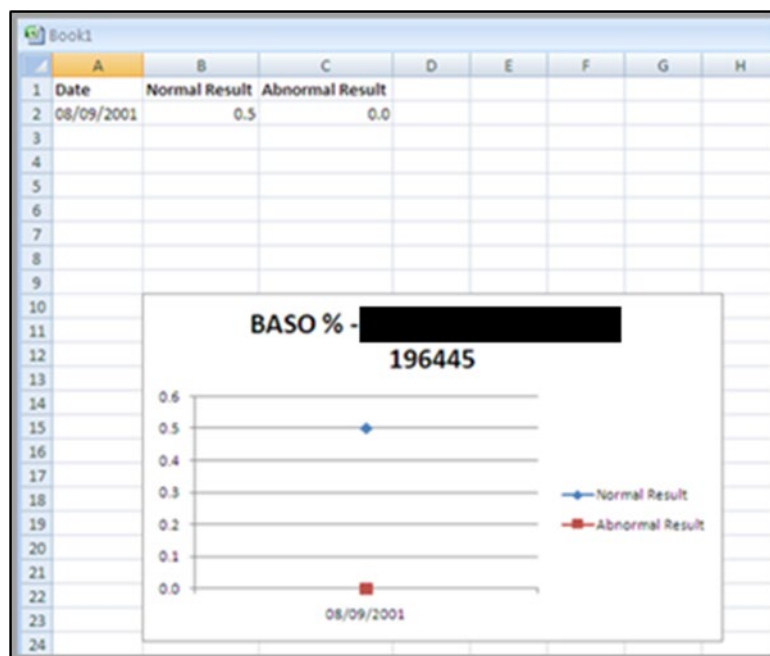


Figure 4-28: Lab Test Graph example

- If desired, you may save the generated data and graph for future reference or analysis.

4.2.6 Wellness Tab

The **Wellness** tab allows users to view and manage BH/PCC wellness activities, including patient education, health factors, and screenings associated with a visit.

When the **Wellness** tab is first accessed, the application displays a tree structure (Figure 4-29).



Figure 4-29: Wellness tab example

From the Wellness tree structure, you can select any of the following options:

- **Patient Education**
- **Health Factors**
- **Screening**

4.2.6.1 Patient Education

Select **Patient Education** from the **Wellness** tree structure to display the **Patient Education** group boxes (Figure 4-30):

- **Patient Education History**

The **Patient Education History** list box is read only. Use the scroll bar to review historical patient education entries.

- **Patient Education Data Entry**

The **Patient Education Data Entry** list box allows you to add, edit, or delete data using the corresponding buttons (**Add**, **Edit**, **Delete**).

The screenshot shows two overlapping windows from a software application. The top window is titled 'Patient Education History' and contains a table with five columns: 'Date', 'Education Topic', 'Time Spent', 'Level Of Understanding', and 'Comment'. The table is currently empty. Below the table is a horizontal scrollbar. The bottom window is titled 'Patient Education Data Entry' and contains a table with four columns: 'Education Topic', 'Time Spent', 'Level Of Understanding', and 'Comment'. This table is also empty. It has a horizontal scrollbar at the bottom.

Figure 4-30: Patient Education Group Boxes example

4.2.6.2 Add/Edit Patient Education Record

The **Add** and **Edit** functions share the same set of data entry fields.

To create or modify a patient education record, use one of the following methods:

- Click **Add** to create a new education record.
- Select an existing **education record**, then click **Edit** to modify it.

The **Education Topic** search window appears (Figure 4-31).

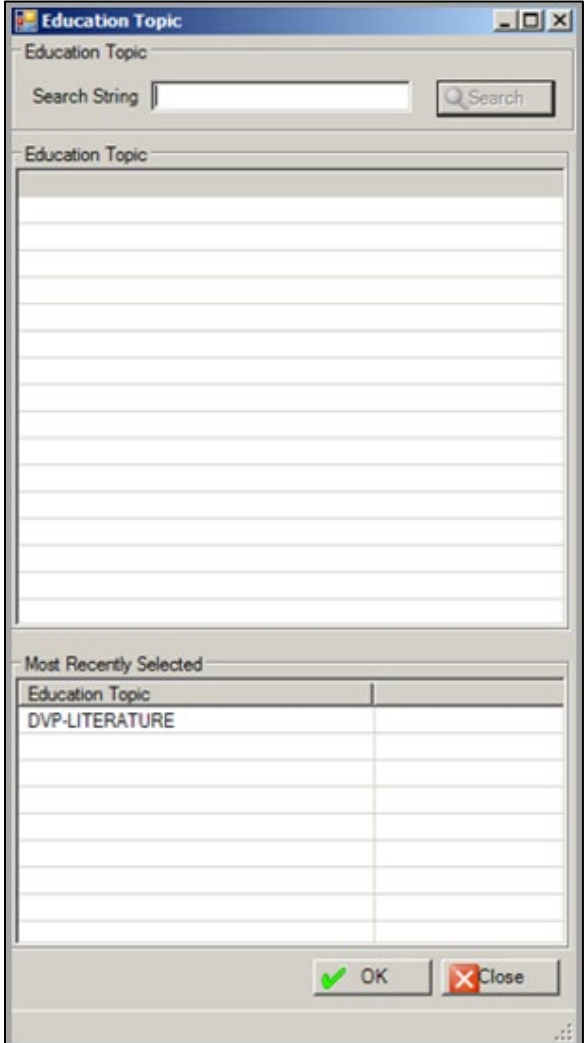
Screen Capture	What to Do
	Use the Education Topic Selection window in one of two ways: 1. Search for a Topic: In the Search String field, type part or all of the education topic name, then click Search. The matching topics will appear in the Education Topic list box. Select the desired topic and click OK. To exit without making a selection, click Close. 2. Select from Recent Topics: In the Most Recently Selected list box, select a previously used education topic and click OK. To exit without a selection, click Close.

Figure 4-31: Education Topic search window example

If the user clicks **Close**, the system displays the following confirmation message:

Warning: Canceling will result in the loss of all unsaved data, Continue?

- Click **Yes** to discard changes and return to the **Patient Education Data Entry** group box.
- Click **No** to remain in the current dialog with unsaved data.

If the user clicks **OK**, the **Patient Education** dialog appears (Figure 4-32) with the **Education Topic** field automatically populated.

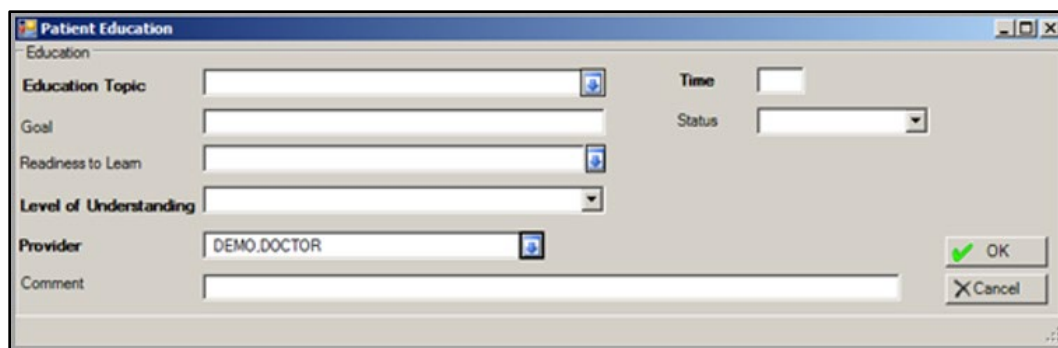


Figure 4-32: Patient Education dialog example

The **Patient Education** dialog includes several fields. Fields displayed in bold text are required:

- **Education Topic**
- **Level of Understanding**
- **Provider**

Education Topic

Review the **Education Topic** field to confirm or change the selected topic. This field is populated automatically based on the selection made in the **Education Topic** search window.

To change the topic, click the list icon to reopen the **Education Topic** search window (Figure 4-33) and proceed using one of the following methods:

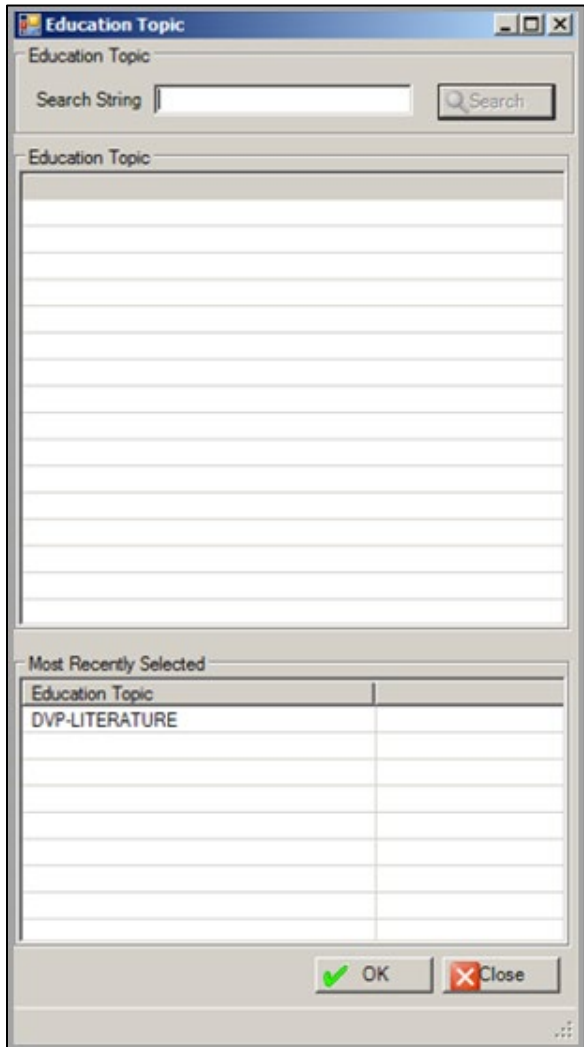
Screen Capture	What to Do
	Use the Education Topic search window in one of the following ways: 1. Search for a Topic: Enter a keyword in the Search String field and click Search. The Education Topic list box will display the search results. Select a topic and click OK to populate the field. To exit without making a selection, click Close. 2. Select from Recent Topics: Select a topic from the Most Recently Selected list box and click OK to populate the field. To exit without making a selection, click Close.

Figure 4-33: Education Topic search window example

- 1. Time Field:** Enter the total number of minutes spent on the education topic in the **Time** field. Input any whole number between **1–9999**.
- 2. Goal Field:** Enter the stated goal of the education session. Example, Patient plans to walk six times a week.
- 3. Status Field:** Select the appropriate **status** for the education goal. Select one of the following options:
 - Goal Set–Preparation phase:** The patient is ready to change and is actively engaged in the planning process.
 - Goal Met–Action or maintenance phase:** The patient is actively implementing and maintaining the behavior change

- **Goal Not Met–Contemplation or relapse phase:** The patient is uncertain about the change or has attempted but not succeeded in maintaining it due to ambivalence or other factors.
 - **Goal Not Set–Pre-contemplation phase:** The patient is not currently considering a behavior change.
4. **Readiness to Learn Field:** In the **Readiness to Learn** field, select the appropriate **option** that reflects the patient’s readiness level. Click the list icon to open the **Readiness to Learn** search window (Figure 4-34).

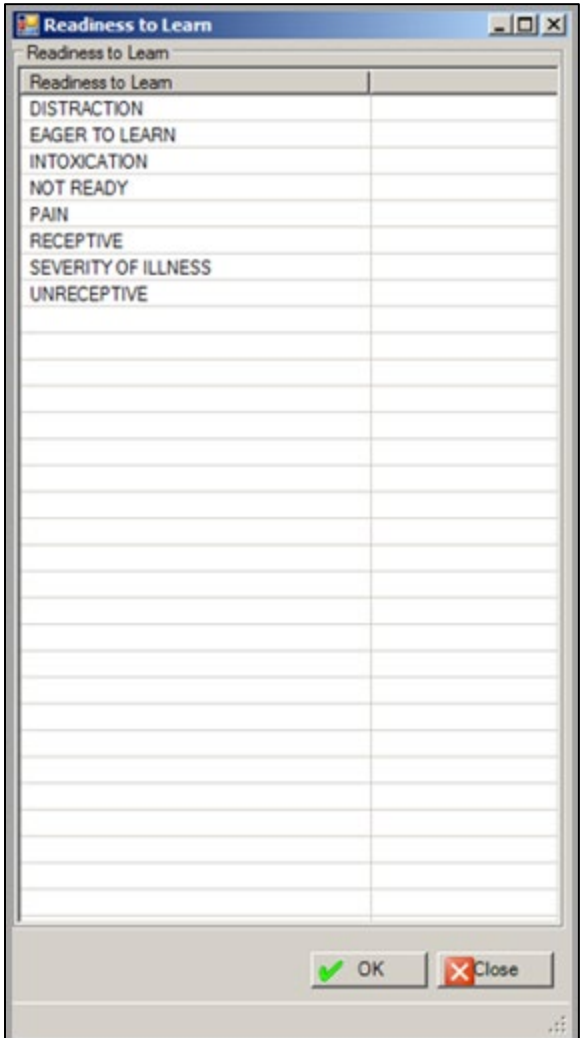
Screen Capture	What to Do
	Using the Readiness to Learn Window: 1. Select a Readiness to Learn option from the list. 2. Click OK to confirm your selection and populate the Readiness to Learn field. To exit without making a selection, click Close.

Figure 4-34: Readiness to Learn search window example

Level of Understanding

In the **Level of Understanding** field, select the option that best represents the patient's demonstrated level of understanding. Select one of the following:

- **Poor**—The patient does not verbalize understanding and is unable to perform a return demonstration or teach-back correctly.
- **Fair**—The patient acknowledges the need for additional education; a partial return demonstration or teach-back indicates incomplete understanding.
- **Good**—The patient verbalizes understanding and successfully performs a return demonstration or teach-back.
- **Group No Assessment**—Education was delivered in a group setting; individual comprehension could not be evaluated.
- **Refused**—The patient declined education.

Provider Field

In the **Provider** field, select the provider responsible for delivering the patient education. Click the list icon to display the **Education Provider** search window (Figure 4-35).

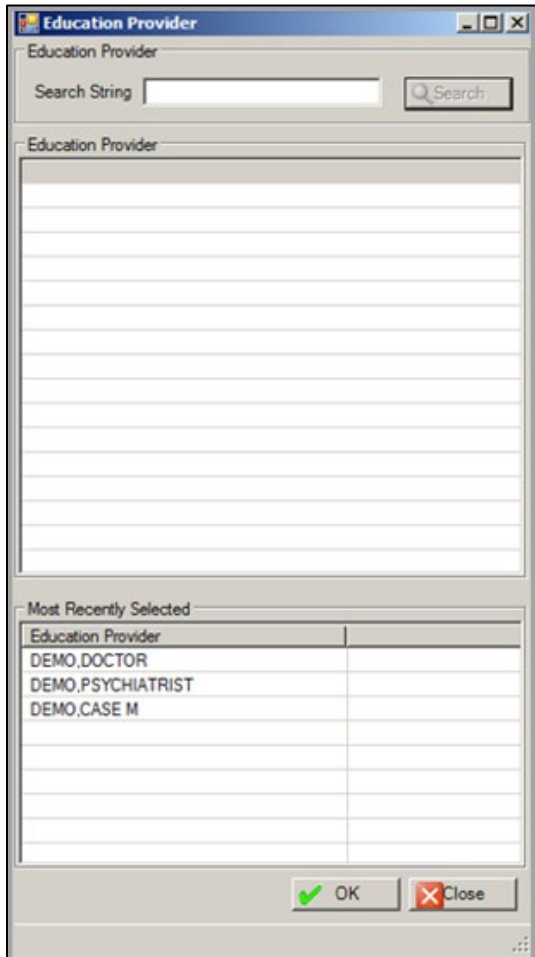
Screen Capture	What to Do
	Use the Education Provider search window in either of the following ways: 1. Search by Provider Name: Enter the education provider's last name in the Search String field, then click Search. The system will display matching provider names in the Education Provider list box. Select the desired provider and click OK to populate the Provider field. To exit without making a selection, click Close. 2. Select from Recent Providers: Select a provider name from the Most Recently Selected list box and click OK to populate the Provider field. To exit without making a selection, click Close.

Figure 4-35: Education Provider search window example

1. In the **Comment** field, enter any remarks or notes related to the education topic for the visit. This is a free-text field.
2. When you have finished entering information, click **OK** to complete the dialog, or click **Cancel** to exit.
 - If you click **OK**, the application saves the entered data and displays it on the **Education Topics Data Entry** grid.
 - If you click **Cancel**, the system displays a confirmation message **Continue? warning:**

Canceling will lose all unsaved data, Continue?

 - Click **Yes** to exit without saving and close the **Patient Education** dialog.
 - Click **No** to return focus to the **Patient Education** dialog.

- If you are using the **Edit** function, click **OK** after completing the dialog to update the fields. (Otherwise, click **Cancel** to exit without making changes.)

If the record was originally saved prior to the installation date of **BHS v4.0**, the **CPT** field will continue to be displayed. You may edit an education record only if the associated visit has a signed note.

4.2.6.3 Delete Patient Education Record

1. In the **Patient Education Data Entry** grid, select the **record** you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to remove the selected record. (Otherwise, click **No** to cancel and retain the record.)

4.2.6.4 Health Factors

Select **Health Factors** from the **Wellness** tree structure to display the available list boxes (Figure 4-36):

- **Health Factors History**
- **Health Factors Data Entry**

Figure 4-36: Health Factors list boxes example

Health Factors represent components of a patient's overall health and wellness that are not documented as **ICD** or **CPT Codes**, nor recorded elsewhere. They are not visit-specific and pertain to the patient's general health status. Health Factors are displayed on both the **Adult Regular** and **Behavioral Health** summary reports.

Health Factors can influence a person's overall health status and response to treatment. Certain patient education assessments, such as barriers to learning and learning preferences, may also be categorized as Health Factors.

The **Health Factors History** list box is read-only. You can review the information by scrolling through the list using the scroll bar.

You can add or modify information in the **Health Factors Data Entry** list box by using the **Add**, **Edit**, or **Delete** buttons.

4.2.6.5 Add/Edit Health Factor Record

The **Add** and **Edit** utilize the same fields.

- To add a new record, click **Add**.
- Or
- To modify an existing record, select the record and click **Edit**.

The **Health Factors** window appears (Figure 4-37).

HealthFactor	Level/Severity	Quantity	Provider	Comment
CAGE 1/4	MINIMAL	0	WISDOM	

Figure 4-37: Health Factors window example

Fields displayed in **bold** text are required.

1. To select a **Health Factor**, click the drop-down list to open the **Health Factor** list and select one.

2. In the **Level/Severity** field, select the appropriate option from the list (if applicable):
 - **Minimal**
 - **Moderate**
 - **Heavy/Severe**
3. In the **Quantity** field, enter the quantity associated with the health factor, if applicable.
4. In the **Comment** field, enter any additional remarks or clarifying information regarding the documented health factor. This is a free-text field.
5. When all information is entered, click **OK** to complete the dialog. (Otherwise, click **Cancel**.)
 - If you click **OK**, the application saves the data and displays it in the **Health Factors Data Entry**.
 - If you click **Cancel**, the system displays the following confirmation message:

Continue?

Canceling will result in the loss of all unsaved data, Continue?
 - Click **Yes** to exit without saving and close the **Health Factors** dialog.
 - Click **No** to return the **Health Factors** dialog without losing data.
6. After editing a record and completing the dialog, click **SAVE** to save the changes and close the window.

4.2.6.6 Delete Health Factor Record

1. In the **Health Factors Data Entry** grid, select the **record** you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** message appears, click **Yes** to delete the selected record. Click **No** to cancel and retain the record.

4.2.6.7 Screening

Select **Screening** from the **Wellness** tree structure to display the screening list boxes (Figure 4-38):

- **Screening History**
- **Screening Data Entry**

The screenshot shows two list boxes. The top list box, titled 'Screening History', has columns: Date, Alcohol, Alcohol Provider, Alcohol Comment, and Depres. The bottom list box, titled 'Screening Data Entry', has columns: Alcohol, Alcohol Comment, Depression, and Depression Comment. Both list boxes are currently empty.

Figure 4-38: Screening List Boxes example

The **Screening History** list box is read-only. Use the scroll bar to navigate through the data.

- If the **Screening Data Entry** list box is empty, the **Add** button is displayed.
- If the **Screening Data Entry** list box contains existing records, the **Edit** button is displayed. You can modify a selected record by clicking **Edit**.

In either case, the **Screening** dialog appears (Figure 4-39).

The screenshot shows the 'Screening' dialog box. It has a 'Screening Type' dropdown set to 'Suicide Risk'. Below it is a 'Suicide Risk' dropdown with a list of options: LOW, MODERATE, HIGH, REFERRAL NEEDED, PATIENT REFUSED SCREENING, and UNABLE TO SCREEN. To the right of the 'Suicide Risk' dropdown is a 'Comment' text box. Below the 'Suicide Risk' dropdown is a 'Provider' dropdown. To the right of the 'Provider' dropdown is a 'Save' button. At the bottom right are 'OK' and 'Cancel' buttons. Below the 'Screening' section is a 'Screening Data Entry' table with columns: Screening Type, Result, Provider, and Comment. The table contains five rows of data. At the bottom right of the table are 'Edit' and 'Delete' buttons. At the bottom of the dialog are 'Save' and 'Close' buttons.

Screening Type	Result	Provider	Comment
SDOH Transportation	NEGATIVE	PATIENT, WENDY	
SDOH Utilities	NEGATIVE	PATIENT, WENDY	
SDOH Housing	NEGATIVE	PATIENT, WENDY	
SDOH Food	NEGATIVE	PATIENT, WENDY	
SDOH Interpersonal	POSITIVE	PATIENT, WENDY	

Figure 4-39: Screening dialog example

4.2.7 Measurements Tab

Use the **Measurements** tab (Figure 4-40) to view existing measurements, as well as to add, edit, or delete **V Measurement** data for the current patient visit.

The screenshot shows the 'Measurements' tab in a software application. At the top, there are tabs for 'POV', 'Activity', 'SOAP/Progress Notes', 'Rx Notes/Labs', 'Wellness', 'Measurements', 'Intake', and 'Suicide Form'. The 'Measurements' tab is selected.

Below the tabs, there is a 'Measurement View' section. It includes a 'Measurement History' group box with 'Starting Date' (Tuesday, November 09, 2010) and 'Ending Date' (Wednesday, January 19, 2011). There are 'Display' and 'Graph' buttons.

Below this is a table with the following data:

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

Below the table is a 'Measurement Data Entry' section. It includes a table for adding new measurements:

Measurement	Description	Value	Provider
AUDIT	AUDIT	25	DEMO.DOCTOR

There are 'Add', 'Edit', and 'Delete' buttons next to the table. Below the table, there are fields for 'Measurement Type' and 'Provider', and a 'Value' field. There are also 'OK' and 'Cancel' buttons.

Figure 4-40: Measurements tab example

4.2.7.1 Measurement View Group Box

The **Measurement View** group box (Figure 4-41) displays the measurements for the current patient within the date range specified in the **Measurement History** group box.

The screenshot shows the 'Measurement View' group box. It includes a 'Measurement History' group box with 'Starting Date' (Tuesday, November 09, 2010) and 'Ending Date' (Wednesday, January 19, 2011). There are 'Display' and 'Graph' buttons.

Below this is a table with the following data:

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

Figure 4-41: Measurement View group box example

4.2.7.2 Change Date Range

1. In the **Starting Date** field, select a new date. Click the drop-down list to open the calendar, then select the desired start date.
2. In the **Ending Date** field, select a new date. Click the drop-down list to open the calendar, then select the desired end date.
3. Click **Display** to refresh and update the records shown in the group box.

4.2.7.3 Graph

To further analyze the data displayed in the **Measurement View** group box, you can generate a graph of a selected measurement.

1. Click **Graph**. The **Measurement Type** dialog appears (Figure 4-42).

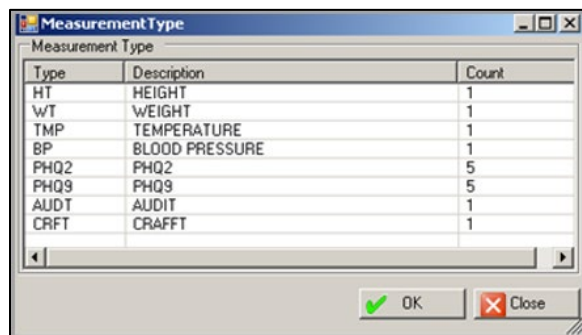


Figure 4-42: Measurement Type dialog example

2. Select the measurement type you want to graph.
3. Click **OK** to generate the graph.

The application automatically exports the data to Microsoft Excel, where it is displayed as a line graph (Figure 4-43).

Click **Close** to exit without generating a graph.

The focus shifts to Microsoft Excel, displaying the data as a line graph by default. You may modify or change the graph type as desired using Excel's charting tools.

4. Save the data and graph in Excel if needed.

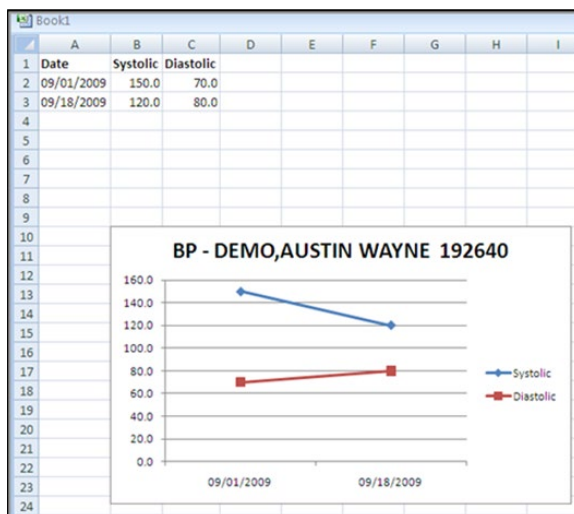


Figure 4-43: Line Graph example

5. Save the data, if needed.

4.2.7.4 Measurement Data Entry Group Box

Use the **Measurement Data Entry** group box (Figure 4-44) to manage patient measurements during the current visit.

Figure 4-44: Measurement Data Entry group box example

The **Measurement Data Entry Group Box** includes the options to **Add**, **Edit**, or **Delete** measurement data entry records as needed.

4.2.7.5 Delete Button

1. Select the measurement you want to delete.

Note: Measurements can only be deleted from the encounter record in which they were originally entered.

2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to remove the selected measurement record from the **Measurement Data Entry** group box. Click **No** to cancel and retain the record.

4.2.7.6 Add/Edit Button

The **Add** and **Edit** functions use the same fields.

- Click **Add** to activate the measurement fields for data entry. The fields displayed in bold text are required.
 - To modify an existing record, select the **record** and click **Edit**. The fields will be populated with the existing data.
1. In the **Measurement Type** field, select a **V Measurement** type. Click the drop-down list to open the **Measurement Type Search** window (Figure 4-45) and select the appropriate type.
 - This field is inactive when editing an existing record.

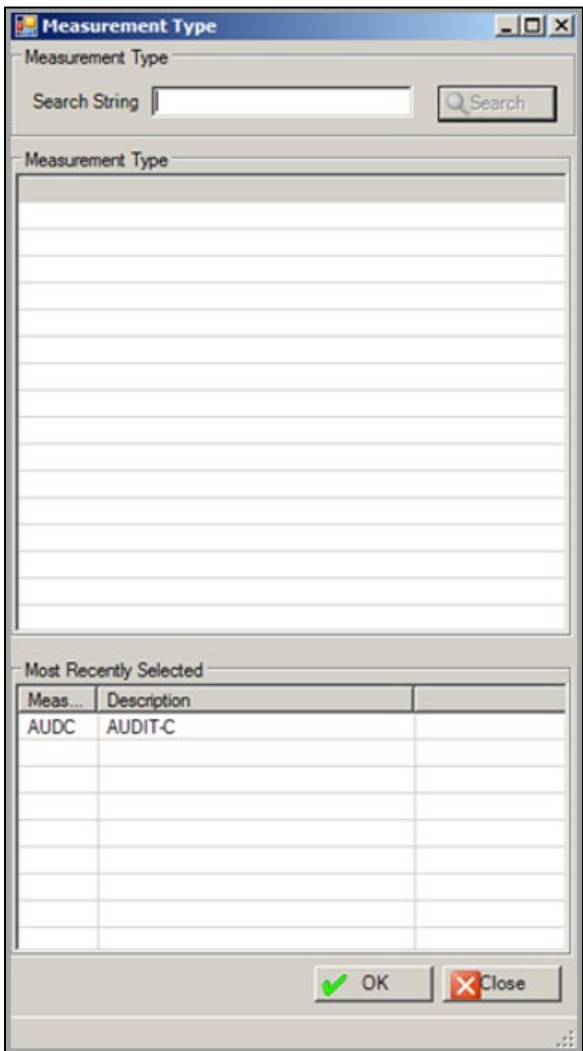
Screen Capture	What to Do
	Use the Measurement Type Search window in one of the following ways: 1. Search by Keyword: In the Search String field, type the name of the measurement type, then click Search. The system retrieves matching measurement types and displays them in the Measurement Type list box. Select the desired record and click OK to populate the Measurement Type field. Click Close to exit without making a selection. 2. Select from Most Recently Selected List: In the Most Recently Selected list box, select a previously used measurement type. Click OK to populate the Measurement Type field. Click Close to exit without making a selection.

Figure 4-45: Measurement Type Search window example

2. In the **Value** field, enter the numeric value of the measurement.
 - If the entered value falls outside the accepted range, a **Warning** message appears (Figure 4-46).
 - Click **OK** to dismiss the warning and re-enter a valid numeric value.

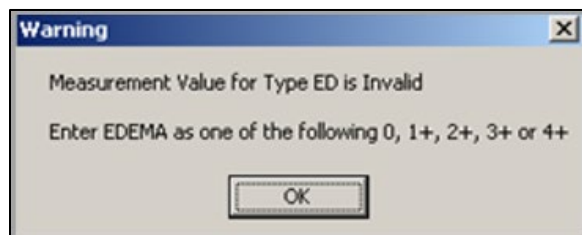


Figure 4-46: Warning dialog–Invalid Measurement Value example

3. In the **Provider** field, select the provider who entered the measurement data. The default is the **Primary Provider**. Click the list to access the **Measurement Provider Search String** window (Figure 4-47) to change this field.

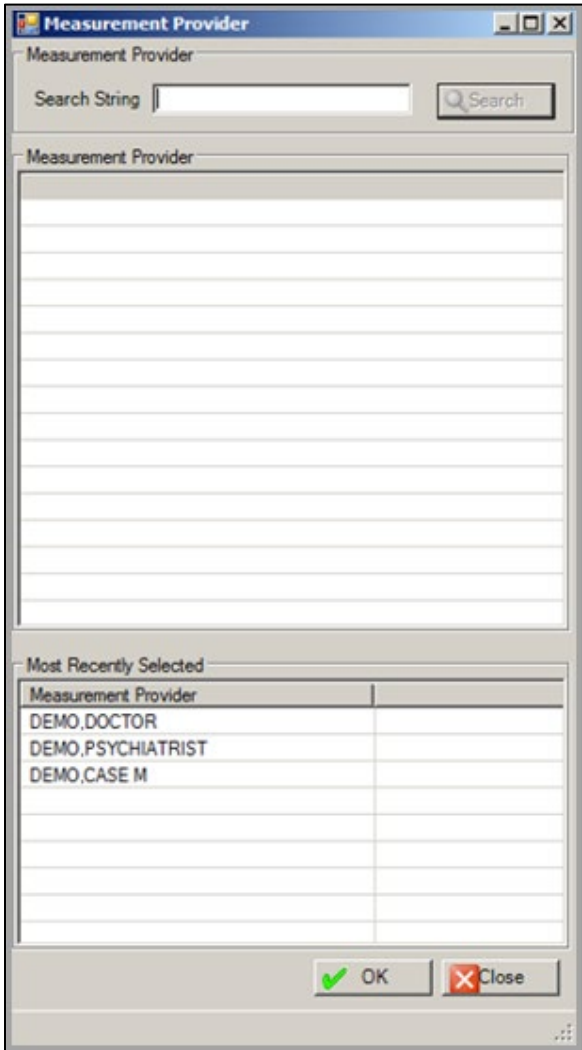
Screen Capture	What to Do
	Use the Measurement Provider Search window in one of the following ways: 1. Search by Provider Name: In the Search String field, type the provider's last name, then click Search. The retrieved provider names will appear in the Measurement Provider list box. Select the desired record and click OK to populate the Provider field. Click Close to exit without making a selection. 2. Search from Most Recently Selected: In the Most Recently Selected list box, select a previously used provider. Click OK to populate the Provider field. Click Close to exit without making a selection.

Figure 4-47: Measurement Provider Search window example

4. When all data fields are complete, click **OK** in the **Measurement Data Entry** group box to save the record.
 - A new record will appear in the grid showing the **Measurement type, description, value, and provider**.

Note: Measurements and Patient Education entries print on the **Full Encounter** form only; they do not appear on the **Suppressed Encounter** form.

5. When editing a record, click **OK** to save changes to the **Value** and/or **Provider** fields. Click **Cancel** to discard any changes.

4.2.8 Intake Tab (GUI)

When you click the **Intake** tab, the **Intake** window appears (Figure 4-48).

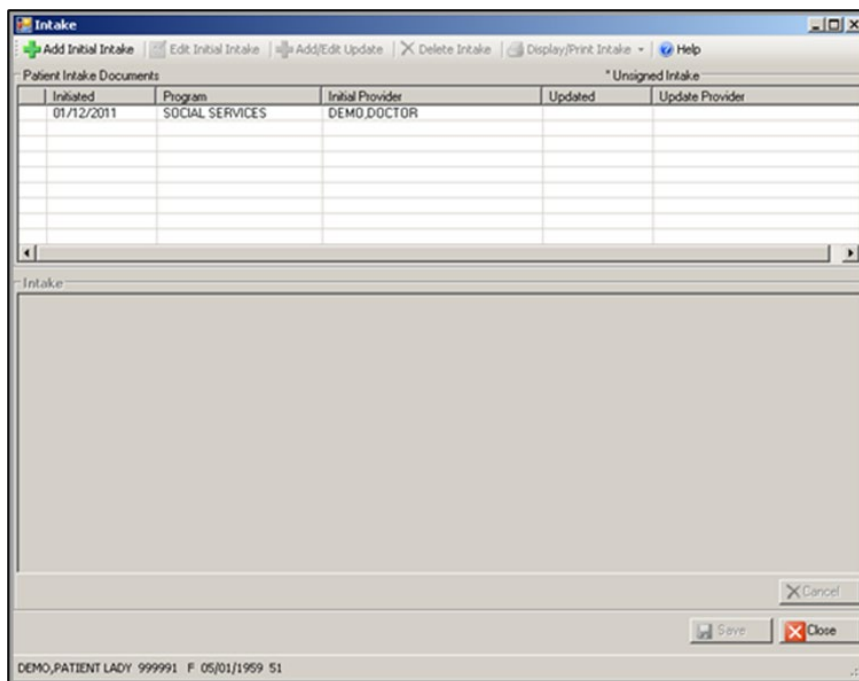


Figure 4-48: Initial Intake window example

For additional information about the Intake (GUI), refer to Section 11.1.

4.2.9 Suicide Form

Click the **Suicide Form** tab to open the **Suicide Form** window. For additional information about the **Suicide Form (GUI)**, refer to Section 10.1.

4.2.10 Select PCC Visit Window

Access the **Select PCC Visit** window (Figure 4-49) after saving and signing a visit that was entered in the **Scheduling** package with the option to create a visit at check-in.

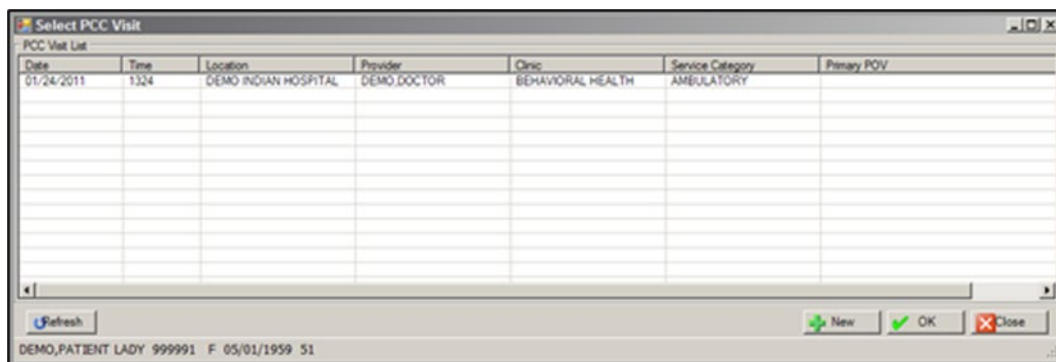


Figure 4-49: Select PCC Visit Window with One Visit example

Users can perform one of the following actions:

- Create a new record.
- Or
- Link the entry to the record created by the **Scheduling** package (a **PCC Incomplete Visit** record).

If the visits displayed do not include the one you need to link to, you may either:

- Select another visit.
- Or
- Wait until the patient has been checked in through the **Scheduling** package.

After checking-in the patient in the **Scheduling** package, return to the GUI and click **Refresh** to load and display the updated list of available visits (Figure 4-50).

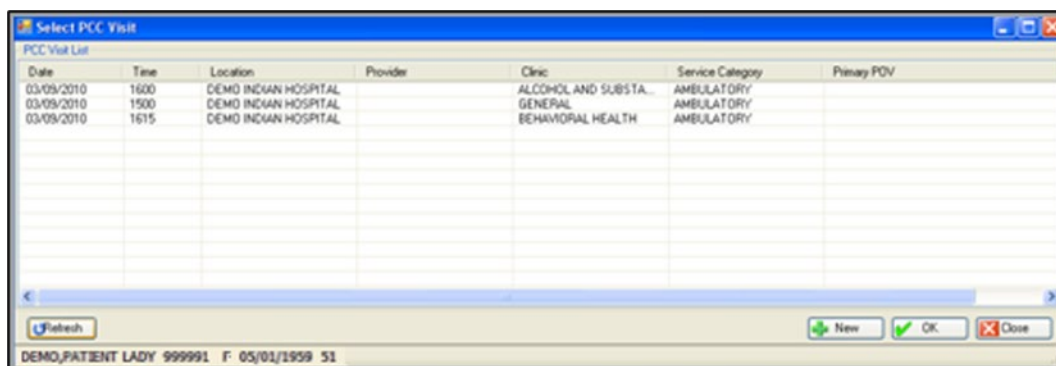


Figure 4-50: Select PCC Visit Window with Multiple Visits example

Then, select the entry you just created and click **OK**. This action links the two records in PCC.

When you access PCC (Figure 4-51), the linked records will appear as shown below.

Patient Name: DEMO, EMILY MAE

```

Chart #:          129608
Date of Birth:    MAR 01, 1968
Sex:              F
Visit IEN:        2565343

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: MAR 09, 2010@16:15
DATE VISIT CREATED:   MAR 09, 2010
TYPE:                 IHS
PATIENT NAME:         DEMO,EMILY MAE
LOC. OF ENCOUNTER:    DEMO INDIAN HOSPITAL
SERVICE CATEGORY:    AMBULATORY
CLINIC:               BEHAVIORAL HEALTH
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:   MAR 09, 2010
WALK IN/APPT:        WALK IN
HOSPITAL LOCATION:    BJB BH
CREATED BY USER:     BETA,BETAS
OPTION USED TO CREATE: SD IHS PCC LINK - << When it has been linked, it will
                                always show this option

APPT DATE&TIME:       MAR 09, 2010@16:15
USER LAST UPDATE:     BETA,BETAA
VCN:                  47887.3A
OLD/UNUSED UNIQUE VIS: 5059010002565343
DATE/TIME LAST MODIFI: MAR 09, 2010@16:57:35
CHART AUDIT STATUS:    REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (: 102320002565343
VISIT ID:              3C5N-WWX

===== PROVIDER =====
PROVIDER:             DEMO,DOCTOR
AFF.DISC.CODE:         3A513
PRIMARY/SECONDARY:     PRIMARY
V FILE IEN:            4873643

===== POV =====
POV:                  F10.24
ICD NARRATIVE:         Alcohol dependence with alcohol-induced mood disorder
PROVIDER NARRATIVE:    ALCOHOL-INDUCED BIPOLAR AND RELATED DISORDER WITH MODERAT
DATE/TIME ENTERED:     NOV 16, 2015@10:43:44
ENTERED BY:            DEMO,DOCTOR
DATE/TIME LAST MODIFI: NOV 16, 2015@10:43:44
LAST MODIFIED BY:      DEMO,DOCTOR
V FILE IEN:            3211018

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

```

Figure 4-51: PCC Linked Records example

4.3 Browse Visits (GUI)

Use the **Browse Visits** option in the **RPMS AMH (GUI)** tree structure to access the **Browse Visits** dialog. This dialog applies to the current patient.

1. In the **RPMS AMH (GUI)** tree structure, select **Browse Visits**.
2. The **Browse Visits** dialog appears (Figure 4-52).

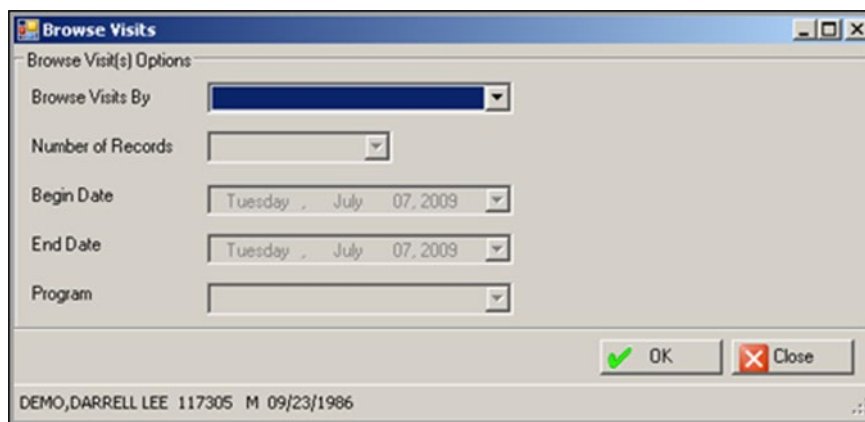


Figure 4-52: Browse Visits dialog example

3. In the **Browse Visits By** field, select one of the following options:
 - **L–Patient’s Last Visit**
 - **N–Patient’s Last N Visits**
 - **D–Visits in a Date Range**
 - **A–All of the Patient’s Visits**
 - **P–Visits to One Program**
 - If you select **A** or **L**, the remaining fields will be inactive.
 - If you select **N**, the **Number of Records** field becomes active.
4. In the **Number of Records** field, select the desired number of visits to display.
 - If you select **D** in the **Browse Visits** field, the **Begin Date** and **End Date** fields become active.
5. In the **Begin Date** field, select the starting date from the list.
6. In the **End Date** field, select the ending date from the list.
 - If you select **P** in the **Browse Visits** field, the **Program** field becomes active.
7. In the **Program** field, select one of the following program options:
 - **M–Mental Health**
 - **S–Social Services**
 - **O–Other**
 - **C–Chemical Dependence**

8. Click **OK** to continue. (Otherwise, click **Close** to exit.)

After clicking **OK**, the first page of the **Browse Visits** window appears (Figure 4-53).

Browser Visits DEMO,DOROTHY ROSE 999999 18/10/1942 71

Patient Name: DEMO,DOROTHY ROSE DOB: Oct 10, 1942
HRN: 999999

***** Suicide Forms on File *****
Date of Act: DEC 06, 2012 Suicidal Behavior: IDEATION W/ PLAN AND INTENT
Previous Attempts: UNKNOWN Method: STABBING/LACERATION
Date of Act: SEP 30, 2009 Suicidal Behavior: ATTEMPT
Previous Attempts: 0 Method: *****

Visit Date: Jan 17, 2014 Provider: DEMO, SHIRLEY
Activity Type: Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:
5

SUBJECTIVE/OBJECTIVE:
COMMENT/NEXT APPOINTMENT:
Medications Prescribed: *****

Visit Date: Jan 17, 2014 Provider: DEMO SHIRLEY
Activity Type: Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:
SUBJECTIVE/OBJECTIVE:
COMMENT/NEXT APPOINTMENT:
Medications Prescribed:

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

Figure 4-53: Data in browse window example

For additional information on using the controls within this type of window, refer to Section 2.0.

4.4 View Patient Data

When you expand the **View Patient Data** option in the **RPMS AMH (GUI)** tree structure (Figure 4-54), you can select any of the available sub-options to view specific patient information:

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

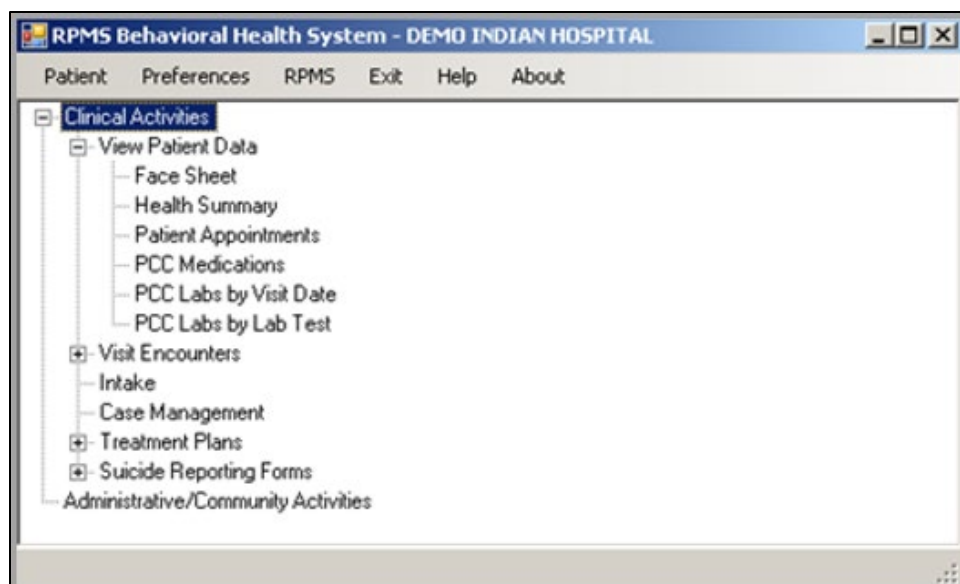


Figure 4-54: RPMS AMH Tree Structure for View Patient Data example

All displayed data pertains to the current patient.

4.4.1 Face Sheet

Use the **Face Sheet** option to view the first page of the **Ambulatory Care Record Brief** pop-up window for the current patient. For additional information about this type of window, refer to Section 2.0.

4.4.2 Health Summary

Use the **Health Summary** option to view the selected health summary report for the current patient.

When selected, the **Select Health Summary Type** dialog appears (Figure 4-55).

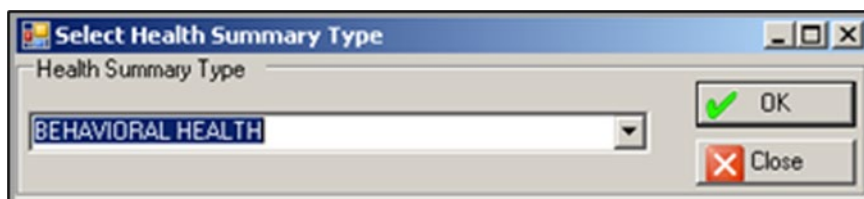


Figure 4-55: Select Health Summary Type dialog example

1. In the **Health Summary Type** field, select the desired summary type from the list.
2. Click **OK** to continue. (Otherwise, click **Close** to exit.)

- After clicking **OK**, a pop-up window appears displaying the first page of the selected health summary (Figure 4-56).

Health Summary DEMO,DOROTHY ROSE 999999 F 10/10/1942 71

***** CONFIDENTIAL PATIENT INFORMATION -- 7/29/2014 12:27 PM [ST] *****
 ***** DEMO,DOROTHY ROSE #999999 <A> (BEHAVIORAL HEALTH SUMMARY) pg 1 *****

----- DEMOGRAPHIC DATA -----

DEMO,DOROTHY ROSE DOB: OCT 10,1942 71 YRS FEMALE no blood type
 CHEROKEE NATION, OK SSN: XXX-XX-1111
 MOTHER'S MAIDEN NAME: DEMO,CRYSTAL MARCHELLE
 (H) 555-444-3333 (W) 555-222-6666 FATHER'S NAME: DEMO,MARTIN
 MOAB (1234 ROAD STREET,ANYTOWN,VA,99999)

LAST UPDATED: DEC 23,2011 ELIGIBILITY: CHS & DIRECT
 VETERAN

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT? YES
 DATE RECEIVED BY PATIENT: Jun 30, 2003
 WAS ACKNOWLEDGEMENT SIGNED? YES

HEALTH RECORD NUMBERS: 999999 DEMO INDIAN HOSPITAL
 DESIGNATED PROVIDERS
 DESIGNATED PRIMARY CARE PROVIDER: SMITH,A
 CASE MANAGER:
 MENTAL HEALTH: DEMO,DEWAYNE

REMARKS:
 CDIB ON FILE
 UPDATE/NO 3RD PARTY/10-07-99/PG
 [more]

----- INSURANCE INFORMATION -----

INSURANCE	NUMBER	SUFF COV	EL DATE	SIG DATE	END DATE
----- ALLERGIES (FROM PROBLEM LIST) -----					

***** ADE: PCN, SULFA *****

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

Figure 4-56: Health Summary pop-up window example

If the report contains multiple pages, use the **Next Page** and **Last Page** buttons to navigate between pages or enter a specific page number to move directly to that page. For additional information about the controls available in this type of window, refer to Section 2.0.

4.4.3 Patient Appointments

Use the **Patient Appointments** option to view the scheduled appointments for the current patient within a specified date range. When selected, the **Patient Appointments** dialog appears (Figure 4-57).

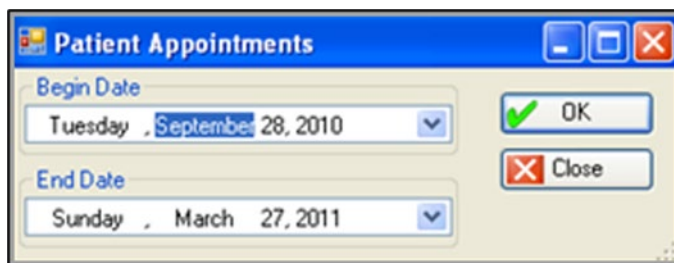


Figure 4-57: Patient Appointments dialog example

By default, the **Begin Date** is set to three months prior to the current date, and the **End Date** is set to three months in the future.

You may modify either or both dates as needed.

1. In the **Begin Date** field, click the drop-down list and select a date from the calendar. This defines the start of the date range.
2. In the **End Date** field, click the drop-down list and select a date from the calendar. This defines the end of the date range.
3. When all fields are complete, click **OK** to proceed. (Otherwise, click **Close** to exit without saving changes).
4. If **OK** is selected, a pop-up window displays the first page of the patient's appointments within the specified date range.

The application retains both default dates when you exit the program.

For additional information on using the controls in this type of window, refer to Section 2.0.

4.4.4 PCC Medications

Use the **PCC Medications** option to view the patient's medication records from the PCC system within a specified date range. When selected, the **PCC Medications** dialog appears (Figure 4-58).

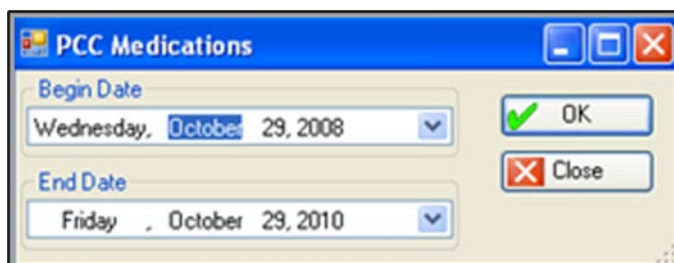


Figure 4-58: PCC Medications dialog example

By default, the **Start Date** is set to one year prior to the current date.

You may modify either or both date fields as needed.

1. In the **Begin Date** field, click the drop-down list and select a date from the calendar. This defines the start of the date range.
2. In the **End Date** field, click the drop-down list and select a date from the calendar. This defines the end of the date range.
3. When all fields are complete, click **OK** to proceed. (Otherwise, click **Close** to exit.)

After clicking **OK**, a pop-up window appears displaying the first page of **Medication Prescribed** from the **Behavioral Health** database within the selected date range.

4.4.5 PCC Labs by Visit Date

Use the **PCC Labs by Visit Date** option to view laboratory results from the **PCC** system for the current patient within a specified visit date range. When selected, the **View Labs by Visit Date** dialog appears (Figure 4-59).



Figure 4-59: View Labs by Visit Date dialog example

By default, the **Begin Date** is set to one year prior to the current date.

You may modify either or both date fields as needed.

1. In the **Begin Date** field, click the drop-down list and select a date from the calendar. This defines the start of the date range.
2. In the **End Date** field, click the drop-down list and select a date from the calendar. This defines the end of the date range.
3. When all fields are complete, click **OK** to continue. (Otherwise, click **Close** to exit.)

After clicking **OK**, the first page of the **PCC Labs by Visit Date** report is displayed for the selected date range.

This same function is also available when entering or modifying visit encounter data for a patient on the **Rx Notes/Labs** tab.

4.4.5.1 PCC Labs by Lab Test

Use the **PCC Labs by Lab Test** option to view laboratory results from the PCC system for the current patient within a specified lab test date range. When selected, the **View Labs by Lab Test** dialog appears (Figure 4-60).



Figure 4-60: View Labs by Lab Test dialog example

By default, the **Begin Date** is set to one year prior to the current date.

You may modify either or both date fields as needed.

1. In the **Begin Date** field, click the drop-down list and select a date from the calendar. This defines the start of the date range.

Note: If you change the **Begin Date** in **View Labs by Lab Test** dialog, the application automatically applies this change to the **Begin Date** in **View Labs by Visit Date** dialog. The application saves your default **Begin Date** when you exit the program.

2. In the **End Date** field, click the drop-down list and select a date from the calendar. This defines the end of the date range.
3. When all fields are complete, click **OK** to continue. (Otherwise, click **Close** to exit.)

After clicking **OK**, a pop-up window displays the first page of the **PCC Labs by Lab Test** within the specified date range.

This same function is also available when entering or editing visit encounter data for a patient on the **Rx Notes/Labs** tab.

5.0 Group Encounters

This section provides detailed instructions for entering and editing group encounter data within the **RPMS AMH (GUI)** (Graphical User Interface).

5.1 Group Entry Window (GUI)

The **Group Encounter** function can be accessed through the **RPMS AMH (GUI)** tree structure, as illustrated in Figure 5-1.

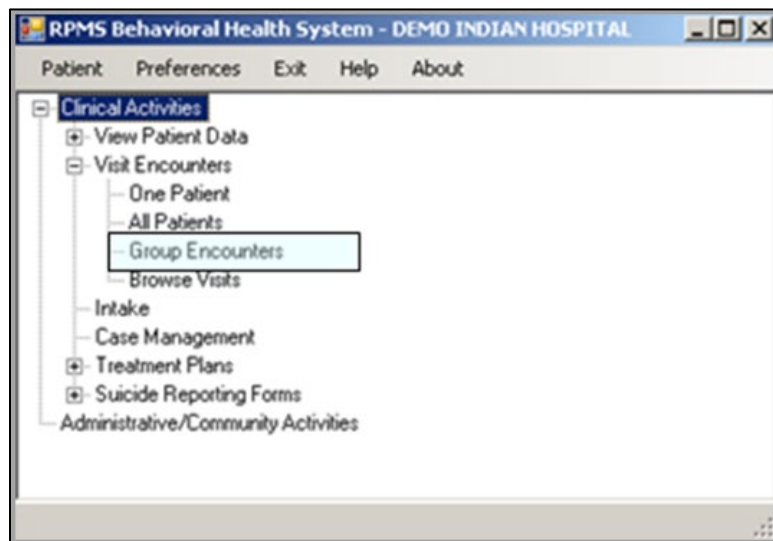


Figure 5-1: Location of Group Encounters option in Tree Structure example

Select the **Group Encounters** option to open the **Group Entry** window, as shown in Figure 5-2.

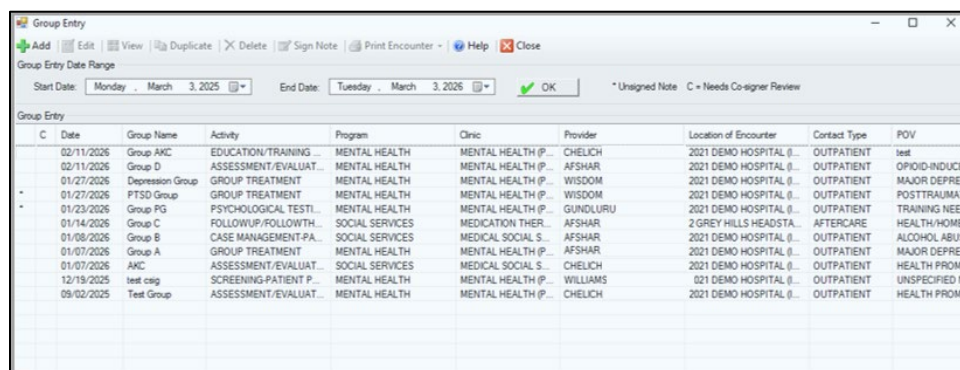


Figure 5-2: Group Entry window example

Table 5-1 provides descriptions of the features and functions available in the **Group Entry** window.

Table 5-1: Group Entry Window Features and Functions

Feature	Description and Functionality
Group Entry Date Range Group Box	Displays all group encounters within the specified date range (default: one year). The list is sorted by date, with the most recent encounters appearing first. To modify the date range, use the calendar control associated with the date fields, then click OK to refresh the display.
Group Entry List Box	Lists all group encounter records within the selected date range. An asterisk (*) in the first column indicates that the record contains an unsigned note. When an unsigned note is selected, the Sign Note button becomes active.
Add Button	Click Add to create a new group encounter record. The Group Data Entry-Add Group Data window will open for data entry.
Edit Button	Click Edit to modify the selected group encounter record. The Group Data Entry-Edit Group Data window will open for editing.
View Button	Click View , or double-click a record, to open the Group Data Entry-View Group Data window. This window displays all fields present in the Add/Edit view but in read-only format.
Duplicate Button	Click Duplicate to create a new group encounter based on an existing record. Edit any fields necessary to reflect differences in the new group encounter. The system automatically checks the RPMS Patient Registration files for a Date of Death to prevent inclusion of deceased patients. If the source group contains signed SOAP/Progress Notes , these notes are duplicated in unsigned status for the new group encounter. Only the standard group note is duplicated - individual patient notes are not. Selecting a record and clicking Duplicate opens the Group Data Entry – Duplicate Group Data window, which contains the same fields as the Add Group Data window. The duplicated record defaults to the current date and time .
Delete Button	To remove a group encounter, select the record and click Delete . A confirmation message will appear: Are You Sure? Click Yes to confirm or No to cancel. Clicking Yes permanently removes the group definition and all associated individual patient records. Only users with the AMHZ DELETE SIGNED NOTE security key can delete group encounters that contain signed SOAP/Progress Notes .
Print Encounter Button	Select a group encounter record and click Print Encounter to print one of the following report types: Full , Suppressed , Both Full and Suppressed . Full : Prints all data for the group encounter, including the SOAP note. Suppressed : Omits the Chief Complaint, SOAP note, measurement data, and screening information. The application will display the first page of the Print Encounter Group pop-up window.
Help Button	Click Help to open the online help documentation for the Group Entry window.
Close Button	Click Close to exit the Group Entry window.
Sign Note Button	Click Sign Note to sign an unsigned group encounter record (indicated by an asterisk (*) in the first column).

Sign Note Button

Click the **Sign Note** button to open the **Sign?** dialog, where you will enter your electronic signature. Additional details about this process are provided in Section 2.9.5.

If the primary provider has opted out of using the electronic signature (E Sig) feature, the signature process will be routed to the **Patient Care Component (PCC)**. In this case, the application displays a message, as shown in Figure 5-3.

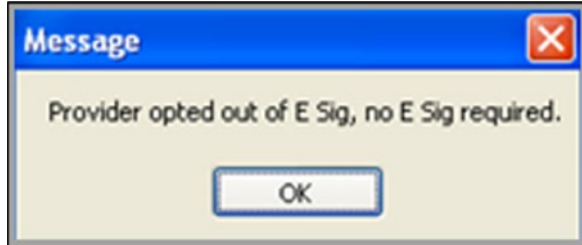


Figure 5-3: Message indicating provider opted out of Electronic Signature example

This message indicates that no electronic signature is required for the selected record. Click **OK** to acknowledge the message and leave the **Sign Note** process.

5.2 Add/Edit Group Data (GUI)

Use the **Group Data Entry** window to add new group data records or edit existing group encounter records.

- Click the **Add** button to create a new group data record. This opens the **Group Data Entry–Add Group Data** window.
- Alternatively, click the **Edit** button to modify the selected group encounter record. This opens the **Group Data Entry–Edit Group Data** window.

Note: All **Patient Education** entries created prior to the installation date of **Behavioral Health System (BHS)** version 4.0 will continue to display the **CPT** field.

The **Group Data Entry–Add Group Data** window is shown in Figure 5-4. The **Edit Group Data** window contains the same data fields.

Figure 5-4: Group Data Entry–Add Group Data window example

Table 5-2 describes the features and functionality available in the **Group Data Entry–Add Group Data** window.

Table 5-2: Group Data Entry–Add Group Data Window Features and Functionality

Feature	Description and Functionality
Group Encounter Information Group Box	Displays existing data for the selected group encounter. Data in these fields cannot be modified directly. All editing must be performed within the Group Encounter Information group box or on the Patient Data tab if the group record has already been saved. - If the group encounter has been signed, other fields may still be edited; however, the Note section cannot be modified. - If you open an unsigned group encounter record, the Note field remains editable.
Help Button	Click Help to open the online help system for this window.
Save Button	Click Save to apply changes and close the window.

Save Process

When you save a record, the following actions occur:

- If a **SOAP/Progress Note** was added, the system displays a **Sign?** confirmation message asking whether you would like to sign the note immediately.
- Click **No** to leave the note unsigned.
- Click **Yes** to open the **Electronic Signature** dialog.

For more information about electronic signatures, refer to Section 2.9

Close Process

When closing a record, the system displays the **Continue?** dialog with the message:
Unsaved Data Will Be Lost, Continue?

Choose from one of the following options:

- Click **Yes** to close without saving. This dismisses the **Add Group Data** window.
- Click **No** to remain on the **Add Group Data** window and continue working.

Additional Features:

- If you access an unsigned group data record, you can edit the individual note (not the group note) and other visit elements only on the **Patient Data** tab.
- The **Patient Data** tab is the only area editing is allowed after a group has been saved but not signed.
- If you access a signed group data record, you may edit all fields on the **Patient Data** tab except the note.

5.2.1 Group Encounter Information Group Box

The **Add** window (Figure 5-5) contains the following active fields within the **Group Encounter Information** group box.

Figure 5-5: Group Encounter Information group box example

Important: These fields are inactive (read-only) and cannot be modified in the **Edit Group Data** window.

Note: Fields in bold are required.

Primary Provider

At the **Primary Provider** field, select the primary provider for the group encounter. The default value is the current provider.

- To change the provider, click the list icon to open the **Primary Provider** search window (Figure 5-6).

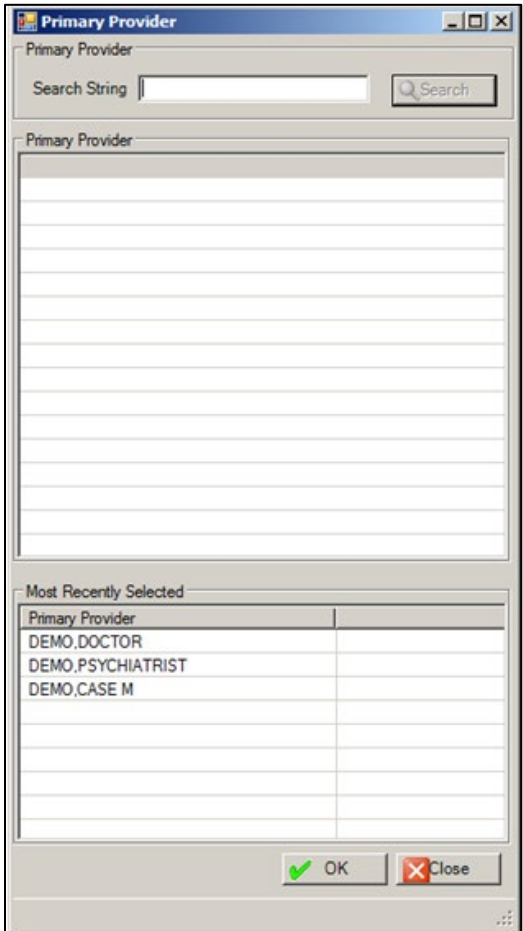
Screen Capture	What to Do
	Use the Primary Provider Search window in one of the following ways: 1. Search by Name: In the Search String field, type the provider's last name and click Search. The results will populate the Primary Provider list box. Select a name and click OK to populate the Primary Provider field. Click Close to exit without making a selection. 2. Select from Most Recently Selected: Select a name from the Most Recently Selected list box. Click OK to populate the Primary Provider field. Click Close to exit without making a selection.

Figure 5-6: Primary Provider search window example

Encounter Date/Time

At the **Encounter Date/Time** field, select the date and time of the encounter. The default value is the current date and time.

- To change the date, click the **List** icon to access the calendar.
- You may select the **hour**, **minutes**, and **AM/PM**.
- If you enter a time using **24-hour format** (for example, 13:25), the application automatically converts it to **1:25 PM**.

- You can adjust the time manually.

Program

At the **Program** field, select the **program** associated with the visit. Click the **List** icon and select one of the following options:

- **Mental Health**
- **Social Services**
- **Chemical Dependency**
- **Other**

After selecting a program, the system automatically populates the **Clinic** and **Encounter Location** fields if the defaults were set in the **Site Parameters** menu. These fields are inactive on the **Edit Group Data** window.

Encounter Location

At the **Encounter Location** field, select the **location** of the group encounter. Click the **List** icon to open the **Location Search** window (Figure 5-7).

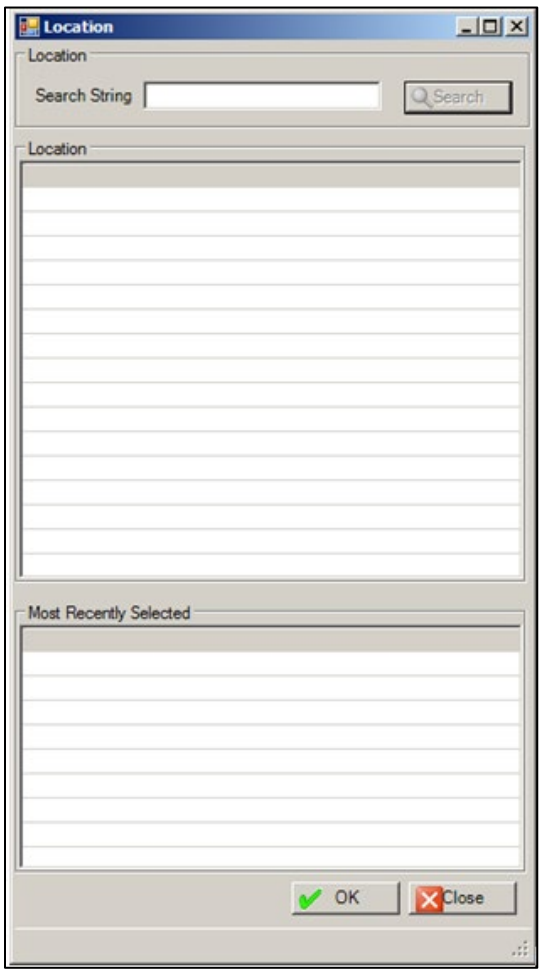
Screen Capture	What to Do
	Use the Location Search window in one of the following ways: 1. Search by Name: In the Search String field, type the location name and click Search. The results will populate the Location list box. Select a location and click OK to populate the Encounter Location field. Click Close to exit without selecting a location. 2. Select from Most Recently Selected: Select a location name in the Most Recently Selected list box. Click OK to populate the Encounter Location field. Click Close to exit without selecting a location.

Figure 5-7: Location Search window example

Clinic

At the **Clinic** field, select the **clinic context**. The selected clinic must appear in the **RPMS Standard Code Book** table. Click the **List** icon to open the **Clinic Search** window (Figure 5-8).

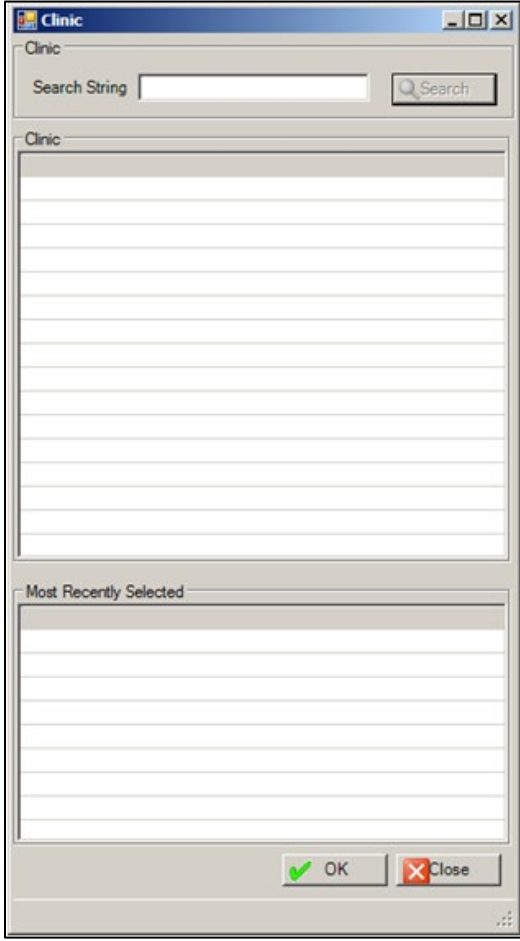
Screen Capture	What to Do
	Use the Clinic Search window in one of the following ways: 1. Search by Name: In the Search String field, type the clinic name and click Search. The results will populate the Clinic list box with clinic names and codes. Select a clinic and click OK to populate the Clinic field. Click Close to exit without making a selection. 2. Select from Most Recently Selected: Select a clinic name from the Most Recently Selected list box. Click OK to populate the Clinic field. Click Close to exit without making a selection.

Figure 5-8: Clinic Search window example

Group Name

At the **Group Name** field, enter the name of the group encounter. This is a free-text field that allows between 1 and 30 characters.

5.2.2 Activities Tab

Use the **Activities** tab (Figure 5-9) to specify the **Community of Service**, **Type of Contact**, **Activity**, and **Activity** code. In addition, you can add **CPT Codes** in the lower group box.

Note: All information on this tab is read-only when accessed through the **Edit Group Data** window.

[illegible]

Figure 5-9: Activities tab example

5.2.2.1 Fields

The following fields are available on the **Activities** tab.

Community of Service

At the **Community of Service** field, select the community of service where the group encounter took place. To change this field, click the **List** icon to open the **Community Search** window (Figure 5-10).

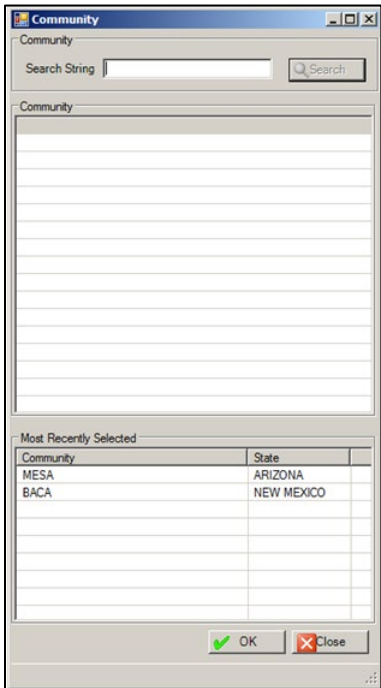
Screen Capture	What to Do
	Use the Community Search window in one of the following ways: 1. Search by Name: In the Search String field, type the community's name and click Search. The retrieved community's names and their associated states will populate the Community list box. Select a community and click OK to populate the Community of Service field. Click Close to exit without making a selection. 2. Select from Most Recently Selected List: Select a community from the Most Recently Selected list box. Click OK to populate the Community of Service field. Click Close to exit without making a selection.

Figure 5-10: Community Search window example

Type of Contact

At the **Type of Contact** field, select the **activity setting** for the group encounter. To change this field, click the **List** icon to open the **Type of Contact** window (Figure 5-11).

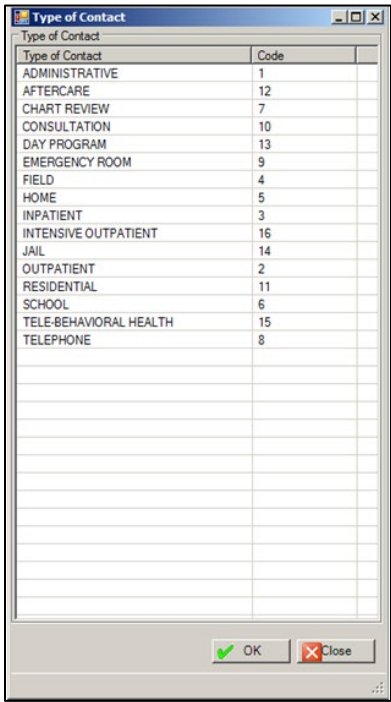
Screen Capture	What to Do
	Use the Type of Contact window as follows: 1. Select a Type of Contact from the list. 2. Click OK to populate the Type of Contact field. Click Close to exit without making a selection.

Figure 5-11: Type of Contact window example

Activity

At the **Activity** field, select the activity associated with the group encounter. The default is **Group Treatment**.

To change this field, click the **List** icon to open the **Activity Search** window (Figure 5-12).

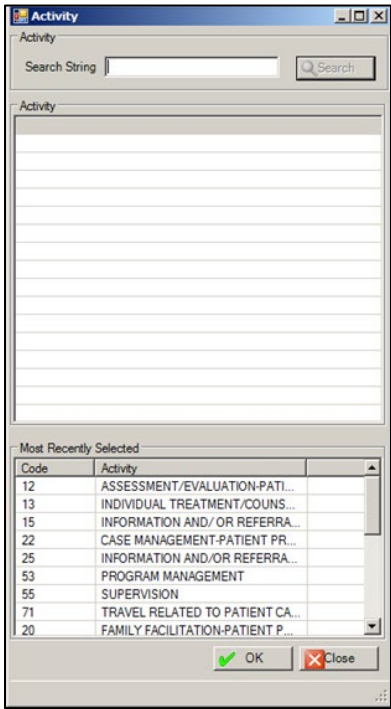
Screen Capture	What to Do
	Use the Activity Search window in one of the following ways: 1. Search by Name or Code: In the Search String field, type the activity name or code and click Search. The retrieved activities will populate the Activity list box. Select an activity and click OK to populate the Activity field. Click Close to exit without making a selection. 2. Select from Most Recently Selected List: Select a record from the Most Recently Selected list box. Click OK to populate the Activity field. Click Close to exit without making a selection.

Figure 5-12: Activity search window example

Activity Time

At the **Activity Time** field, enter the total number of minutes spent on group activity. Enter an integer value between **1** and **9999**.

Note: A value of **zero (0)** is not valid.

5.2.2.2 CPT Codes Group Box

Use the **CPT Codes** group box to manage the **Current Procedural Terminology (CPT)** codes associated with a group activity.

5.2.2.2.1 Add Button

1. Click **Add**.

The **CPT Code** search window displays (Figure 5-13).

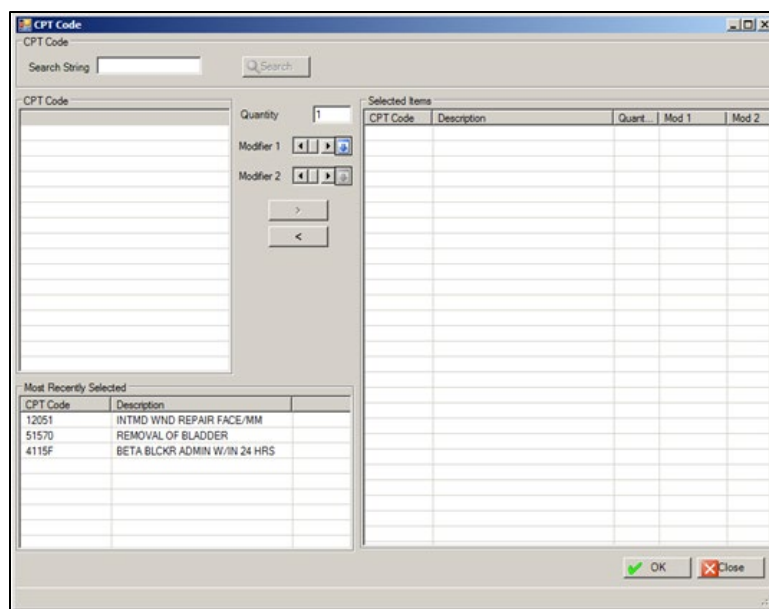


Figure 5-13: CPT Code search window example

2. In the **Search String** field, enter a keyword or code number to search for a specific **CPT Code**.
3. Click **Search**. Matching **CPT Codes** will display in the **CPT Code List** field (Figure 5-14).

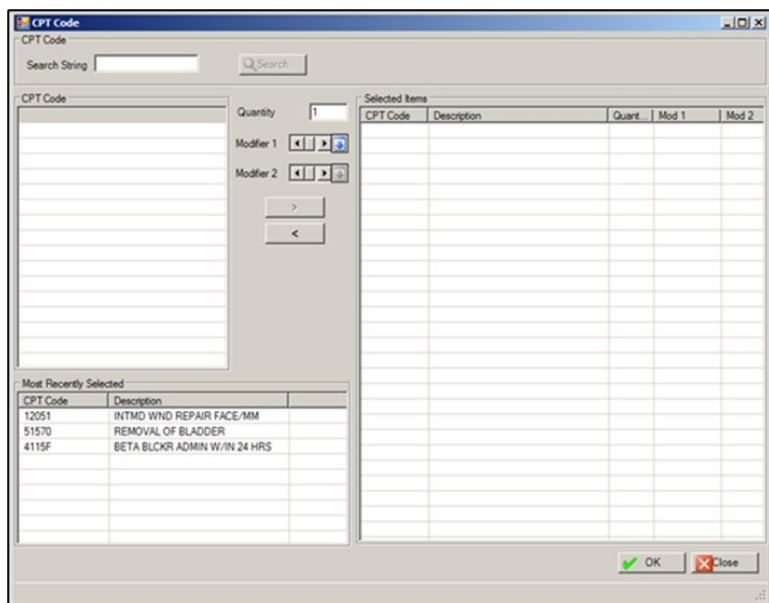


Figure 5-14: CPT Code search results example

4. Select a **CPT Code** from the results.

- In the **Quantity** field, enter the number of **CPT Codes** to apply for billing purposes.
- In the **Modifier** field, select a modifier for the **CPT Code**.
- Click the list arrow to open the **CPT Modifier Search** window (Figure 5-15).

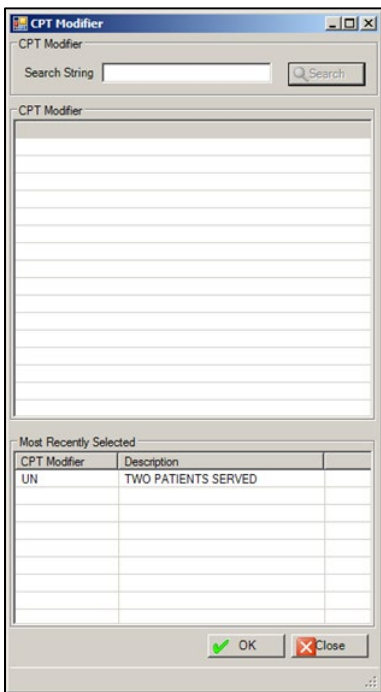
Screen Capture	What to Do
	Use the CPT Modifier Search window in one of the following ways: 1. Search String: In the Search String field, type all or part of the CPT Modifier name and click Search. The retrieved CPT Modifier names and their descriptions will appear in the CPT Modifier List box. Select a modifier and click OK to save. (Click Close to cancel.) 2. Most Recently Selected list: Select a CPT modifier from the Most Recently Selected list box. Click OK to save. Click Close to cancel.

Figure 5-15: Modifier Search window example

5. After completing the **Quantity** and **Modifier** fields, click the **right-arrow** button to add the **CPT Code(s)** to the **Selected Items** list box.

You may add multiple **CPT Codes** using this process.

6. Alternatively, you can add a **CPT Code** by selecting it from the **Most Recently Selected** list box and clicking the **right-arrow** button.
7. To remove a **CPT Code** from the **Selected Items** list box, click the **left-arrow** button.
8. When all desired codes have been added, click **OK** to save the data and update the **CPT Codes** group box. Click **Close** to exit without saving.

5.2.2.2.2 Delete Button

Use the **Delete** button to remove a **CPT Code** record from the **CPT Codes** group box.

To delete a **CPT Code**:

1. Select the **CPT Code** record you want to delete.
2. Click **Delete**.
3. When the confirmation message **Are You Sure?** appears, click **Yes** to confirm and remove the selected record from the **CPT Codes** group box. Click **No** to cancel the deletion and retain the record.

5.2.3 Group Data Tab

Use the **Group Data** tab (Figure 5-16) to specify information related to a group encounter, including **Secondary Providers**, **Purpose of Visit (POV) code**, **group notes**, and **CPT Codes** for the group encounter.

The screenshot shows the 'Group Data' tab selected in a software interface. The interface includes several sections:

- Chief Complaint/Presenting Problem:** A text input field.
- Secondary Providers:** A table with columns for 'Provider' and an empty column. To the right are 'Add' (with a green plus icon) and 'Delete' (with a red X icon) buttons.
- Purpose of Visit - POV (Primary Group Topic):** A table with columns for 'Code', 'Narrative', and an empty column. To the right are 'Add' (with a green plus icon), 'Edit' (with a pencil icon), and 'Delete' (with a red X icon) buttons.
- Standard Group Note:** A large text area for notes.

Figure 5-16: Group Data tab example

Note: Only the primary provider can modify information on the **Group Data** tab. The individual performing the data entry may edit the information on this tab only until the group has been saved. Once the group record is saved, the fields on this tab become read-only. Any further edits must be made on the **Patient Data** tab. Group box names displayed in bold text indicate required fields.

5.2.3.1 Chief Complaint/Presenting Problem Field

In the **Chief Complaint/Presenting Problem** field, enter a brief description of the primary reason the patient or group is seeking services. The entry must contain between 2 and 80 characters.

5.2.3.2 Secondary Providers Group Box

Use the **Secondary Providers** group box (Figure 5-17) to add or remove secondary providers for the group encounter.

Figure 5-17: Secondary Providers group box example

5.2.3.2.1 Add Button

Click **Add**. The **Secondary Provider Multiple** search window (Figure 5-18) appears.

Figure 5-18: Secondary Providers search window example

Use the **Secondary Provider Multiple** search window in the following manner:

1. In the **Search String** field, enter a few characters of the desired search criteria.

2. Click **Search**. The matching records appear in the **Secondary Provider** list box.
3. To add one or more records from the **Secondary Provider** list box to the **Selected Items–Secondary Provider** list box, click the **right-arrow** button.
 - Alternatively, you can select one or more records from the **Most Recently Selected** list box and click the **right-arrow** button to add them to the **Selected Items–Secondary Provider** list box.
4. To remove one or more records from the **Selected Items–Secondary Provider** list box, select the desired records and click the **left-arrow** button.
5. When the **Selected Items–Secondary Provider** list box contains all the desired records, click **OK**. The selected records will populate the **Secondary Providers** group box.
 - To cancel without saving your selections, click **Close**.

5.2.3.2.2 Delete Button

1. Select the **Secondary Provider** record you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message displays, click **Yes** to remove the selected secondary provider. To cancel the action, click **Close**.

5.2.3.3 Purpose of Visit (POV)–Primary Group Topic Group Box

Use the **Purpose of Visit–POV (Primary Group Topic)** group box (Figure 5-19) to add, edit, or delete **POV** codes and their associated narratives for the group encounter. These POVs apply to all group members and will appear on both the **Patient Data** tab and the printed encounter record, unless they are edited or deleted on the **Patient Data** tab.

Note: At least one **POV** record is required for each group encounter.

Purpose of Visit - POV (Primary Group Topic)	
Code	Narrative

+ Add
✎ Edit
✖ Delete

Figure 5-19: POV group box example

Users can add, edit, or delete **POV** records directly within this group box.

5.2.3.3.1 Delete Button

1. Select the **POV** record you want to delete.
2. Click **Delete**.

- When the **Are You Sure** confirmation message appears, click **Yes** to remove the selected **POV** record. To cancel the deletion, click **No**.

5.2.3.3.2 Add Button

Click **Add**. The **POV Multiple** search window (Figure 5-20) appears.

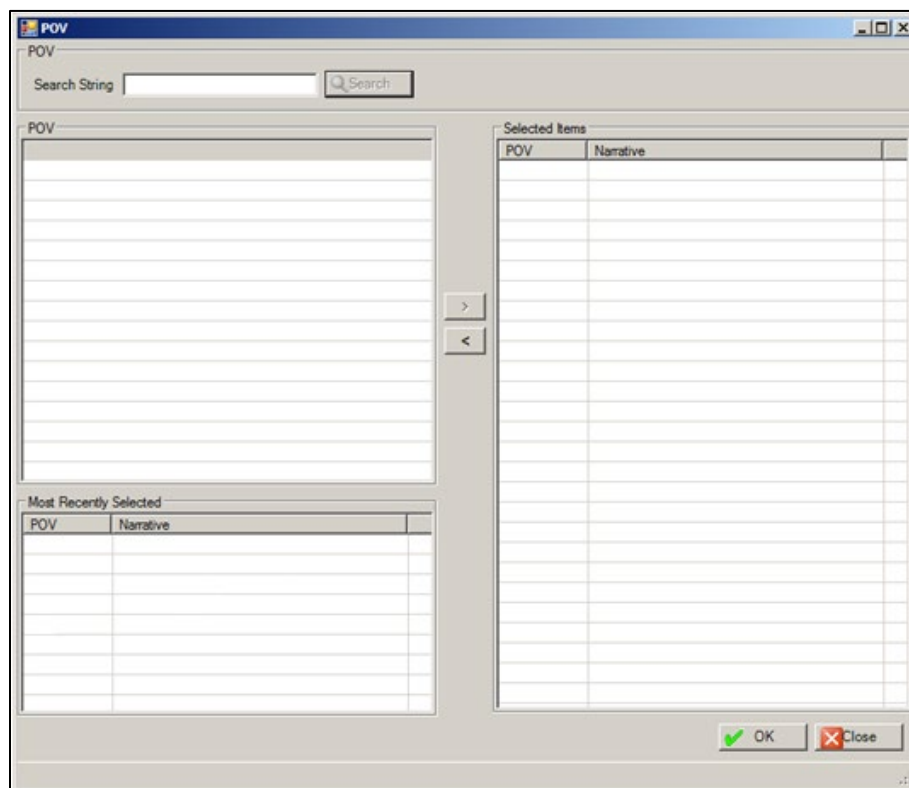


Figure 5-20: POV Multiple Select/Search window example

Use the **POV Multiple** search window as follows:

- In the **Search String** field, enter a few characters of the desired search criteria.
- Click **Search**. The matching records including the POV and narrative appear in the **POV** list box.
- To add one or more selected records from the **POV** list box to the **Selected Items** list box, click the **right-arrow** button.
- Alternatively, select one or more records in the **Most Recently Selected** list box and click the **right-arrow** button to add them to the **Selected Items** list box.
- To remove one or more records from the **Selected Items** list box, select the **records** and click the **left-arrow** button.

- When the **Selected Items** list box contains all desired records, click **OK**. The selected POVs will populate the **Purpose of Visit (POV)** group box. To cancel without saving your selections, click **Close**.

5.2.3.3 Edit Button

Use the **Edit** button to modify the Narrative part of a **POV record** displayed in the group box.

- Select the **POV record** you want to edit.
- Click **Edit**.
- The **Edit POV** dialog appears (Figure 5-21).

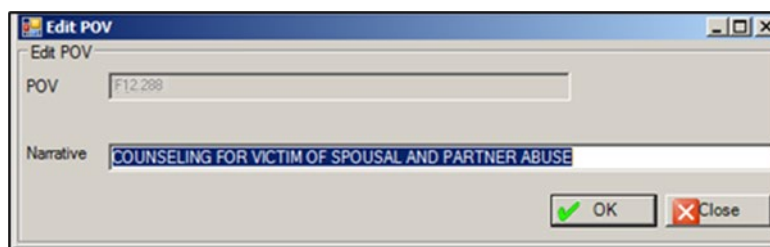


Figure 5-21: Edit POV dialog example

- In the **Narrative** field, enter the updated **POV narrative** (2–80 characters).

Note: The **Narrative** field is free-text. The first character cannot be a single or double quotation mark (‘ or ’).

- Click **OK** to save the updated narrative for the selected **POV** code. To cancel without making changes, click **Close**.

5.2.3.4 Standard Group Note Field

Use **Standard Group Note** field to enter the narrative text for a group encounter. This field is free-text and allows you to document the content of the group session.

After the group record has been saved, you must return to the **Patient Data** tab to make any further edits.

5.2.4 Group Education Tab

Use the **Group Education** tab (Figure 5-22) to add, modify, or delete education-related data for the group encounter.

Figure 5-22: Group Education tab example

When accessing this tab through the **Edit Group Data** window, all information is read-only.

5.2.4.1 Add/Edit Group Education Record

The **Add** and **Edit** functions use the same fields.

Group Education entries created prior to the installation date for **BHS v4.0** will continue to display the **Goal** and **CPT** fields.

- Click **Add** to activate the fields below the education grid.
Or
- Select an existing record and click **Edit**.
 1. In the **Education Topic** field, select the education topic for the group encounter. Click the drop-down list to open the **Education Topic Search** window (Figure 5-23), where you can search for an education code.

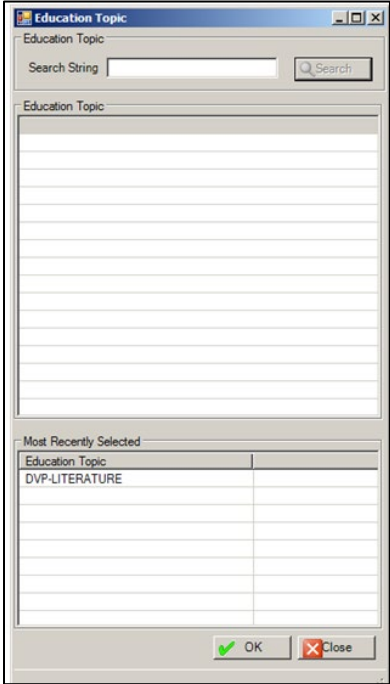
Screen Capture	What to Do
	Use the Education Topic search window in one of the following ways: 1. Search by Text: Type the education topic in the Search String field and click Search. Select a result from the Education Topic list and click OK to populate the field. Click Close to exit without selecting a topic. 2. Select from Most Recently Selected: Select an item from the Most Recently Selected list. Click OK to populate the field. Click Close to exit without selecting a topic.

Figure 5-23: Education Topic search window example

2. In the **Provider** field, select the provider conducting the group education. Click the drop-down list to open the **Education Provider Search** window (Figure 5-24).

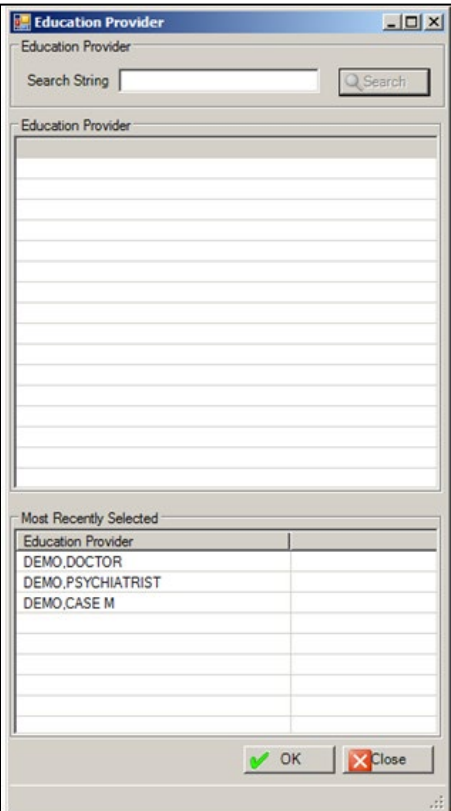
Screen Capture	What to Do
	Use the Education Provider Search window in one of the following ways: 1. Search by Provider Name: Type the provider's last name in the Search String field and click Search. Select a result from the Education Provider list and click OK to populate the field. Click Close to exit without selecting a provider. 2. Select from Most Recently Selected: Select a provider from the Most Recently Selected list. Click OK to populate the field. Click Close to exit without selecting a provider.

Figure 5-24: Education Provider Search window example

3. In the **Time** field, enter the number of minutes spent on the education topic. Valid values are any integer from 1–9999.
4. In the **Level of Understanding** field, select the **assessed level** of understanding for the education topic. The default and only available option for group encounters is **Group-No Assessment**.
5. Use the **Comment** field to enter any relevant notes or additional information about the education topic for the group encounter.
6. Click **Cancel** to clear all fields on the **Group Education** tab.
7. Click **OK** to save the entry. The new or updated record is added to the **Education** grid.

5.2.4.2 Delete Group Education Record

1. Select the **Group Education** record you want to delete.
2. Click **Delete**.

- When the **Are You Sure** confirmation message displays, click **Yes** to remove the selected education record from the group box. Click **No** to cancel the deletion.

Note: Group Education records can be deleted only before the group encounter is saved. After the group has been saved, there is currently no method to remove Group Education within the group format.

5.2.5 Patients Tab

The **Patients** tab (Figure 5-25) displays the list of patients included in the group encounter.

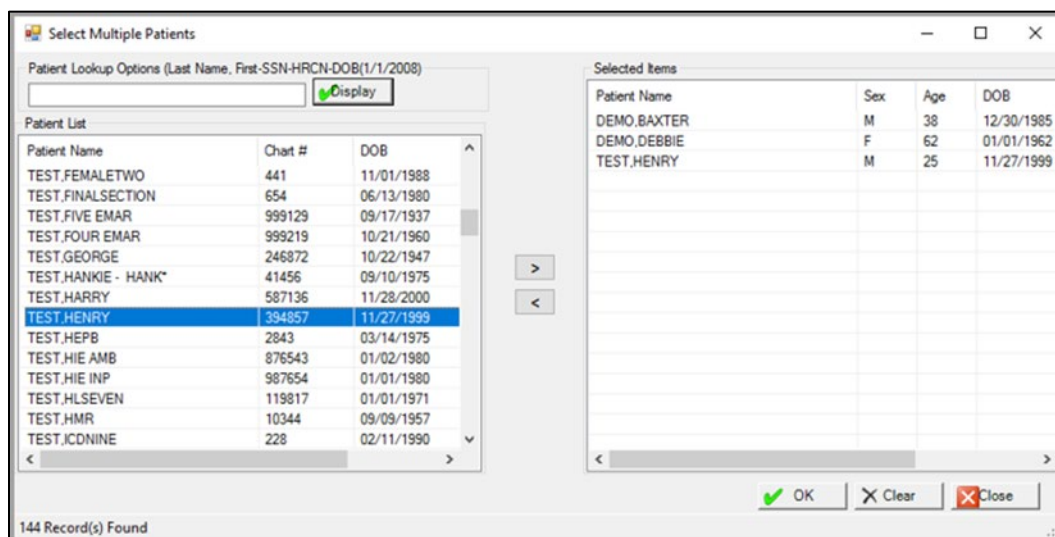


Figure 5-25: Patients tab example

When accessed through the **Edit Group Data** window, all information on this tab is read only.

Patient records can be added or deleted from this tab only when using the **Add Group** window.

5.2.5.1 Add Patient Record

The **Add** button is enabled only when both the **POV** group box and the **Standard Group Note** field (on the **Group Data** tab) have been completed.

- Click **Add** to open the **Select Multiple Patients** dialog (Figure 5-26).

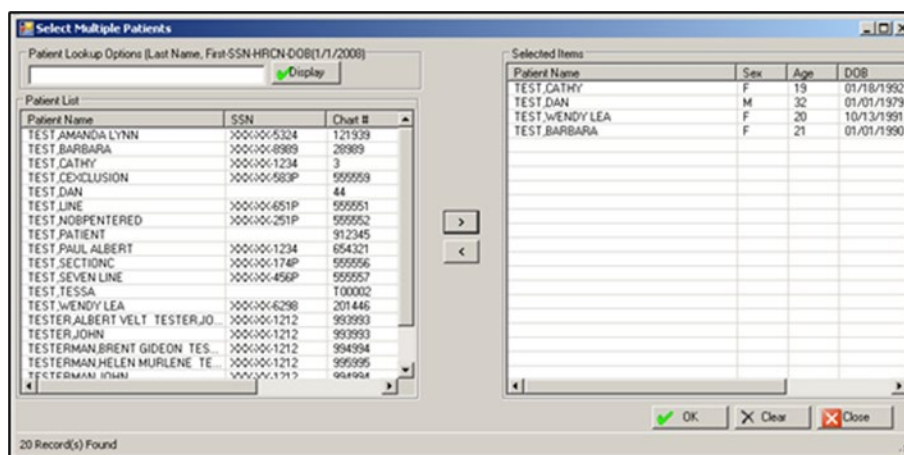


Figure 5-26: Select Multiple Patients dialog example

Use this dialog to add one or more patients to the **Patients** tab.

2. In the **Patient Lookup** field, enter the **patient's name**, **health record number (HRN)**, **date of birth (DOB)**, or **Social Security Number (SSN)**.
3. Click **Display**.

The matching patients will appear in the **Patient List** box.

4. Select one or more patients from the **Patient List** group box and click the **right-arrow** button to move them to the **Selected Items** list box.
 - To remove a patient's name from the **Selected Items** list box, select the **patient** and click the **left-arrow** button to return the name to the **Patient List** box.
5. When the **Selected Items** list is complete, select one of the following options:
 - Click **OK** to populate the **Patients** group box on the **Patients** tab with the selected names. The dialog will close.
 - Click **Clear** to remove all names from the **Selected Items** box while keeping the dialog open.
 - Click **Close** to close the dialog without adding any patients to the **Patients** group box.

5.2.5.2 Delete Patient Record

1. Select the patient record you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to remove the selected patient from the **Patient** group box. Click **No** to cancel the deletion.

Note: Do not remove patients who were no-shows or cancellations. These individuals must remain in the group because their attendance status can be recorded in the **Time In/Activity** field on the **Patient Data** tab.

5.2.6 Patient Data Tab

Use the **Patient Data** tab (Figure 5-27) to enter or update **Purpose of Visit—POV**, **Standard Group Notes**, and **Comments/Next Appointment** details for an individual patient within the group encounter.

The screenshot displays the 'Patient Data' tab within a software interface. At the top, there are tabs for 'Activities', 'Group Data', 'Group Education', 'Patients', and 'Patient Data'. The 'Patient Data' tab is active, showing a list of patients with columns: Patient Name, Sex, Age, DOB, and Chart. The list includes MITCHELL (M, 15, 02/19/1998, 186585), JIMMY JOE (M, 27, 11/01/1986, 129347), RAYDEAN (M, 43, 07/23/1970, 107900), and a partially visible entry (M, 47, 09/16/1971, 186476). Below the list, there are sections for 'Purpose of Visit - POV (Diagnosis or Problem Code)' with 'Code' and 'Narrative' columns and 'Add', 'Edit', and 'Delete' buttons; 'Standard Group Note' with a text area; 'Comment/Next Appointment' with a text area; and 'CPT Code(s)' with 'Code', 'Narrative', 'Quant.', 'Mod 1', and 'Mod 2' columns and 'Add' and 'Delete' buttons. At the bottom, there are checkboxes for 'Time In Group' and 'Visit Flag', and 'OK' and 'Cancel' buttons.

Figure 5-27: Patient Data tab example

Table 5-3 describes the features and functionality available on this window.

Table 5-3: Patient Data Features and Functionality

Features	Description and Functionality
Patients List Field	Double-click a patient's name in the Patients list box to activate the remaining group boxes.
OK Button	Click OK after selecting a patient and entering or modifying patient data to save the information.
Cancel Button	Click Cancel to discard any changes and to close the Patient Data tab.

5.2.6.1 Patients List Box

The **Patients** list box (Figure 5-28) displays all patients included in the group encounter.

Patients					
Patient Name	Sex	Age	DOB	Chart	
DEMO,TIMMIE	M	9	06/18/1999	192144	
DEMO,DOROTHY ROSE	F	66	10/10/1942	999999	
DEMO,COLTON MAXWELL	M	31	05/18/1977	100678	

Figure 5-28: Patients list box example

1. Double-click a **patient's name** to activate the corresponding group boxes and fields.
2. After entering all required information for the selected patient, click **OK**. Focus will return to the **Patients** list box.
3. Double-click the next **patient** and repeat the process. Continue until data entry is complete for all patients in the group.
4. Click **Save** to save all patient-specific information.

If you are in **ADD** mode, clicked **OK** for a patient, and then attempt to navigate to the **Group Data** tab, the system will display the **Continue** warning message (Figure 5-29).

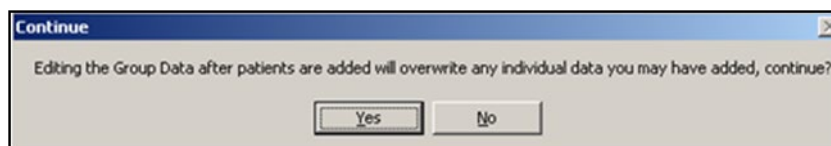


Figure 5-29: Continue warning message example

- Click **Yes** to overwrite any newly added individual patient data. Focus will remain on the **Group Data** tab.
- Click **No** to keep the individual patient data intact. Focus will remain on the **Patients Data** tab.

5.2.6.2 Purpose of Visit–POV (Diagnosis or Problem Code) Group Box

Use the **Purpose of Visit–POV (Diagnosis or Problem Code)** group box (Figure 5-30) to add, edit, or delete a POV entry for the selected patient. Important: You must double-click a patient's name in the **Patients** list box before entering or modifying any data in this group box.

Code	Narrative
Z65.1	IMPRISONMENT OR OTHER INCARCERATION
Z65.4	VICTIM OF CRIME
T74.31XD	SPOUSE OR PARTNER ABUSE, PSYCHOLOGICAL, CON...

Figure 5-30: POV group box example

A **POV** entry is required for each patient in the group encounter record.

Within this group box, you may add new **POV** codes, edit existing entries, or delete **POV** records as needed.

5.2.6.2.1 Delete Button

1. Select the **POV record** you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to remove the selected **POV record** from the **POV** group box. Click **No** to cancel the deletion.

5.2.6.2.2 Add Button

1. Click **Add**. The **POV Multiple** search window appears (Figure 5-31).

Figure 5-31: POV Multiple search window example

2. Use the **POV Multiple** search window, as follows:
 - a. In the **Search String** field, enter a few characters related to the **POV** you are looking for.

- b. Click **Search**. The retrieved **POV** codes and their narratives will display in the **POV** list box.
 - c. To add one or more **POV** codes from the **POV** list box to the **Selected Items** list box, select the desired entries and click the **right-arrow button**.
 - To remove **POV** codes from the **Selected Items** list box, select them and click the **left-arrow button**.
 - You may also add codes by selecting one or more items from the **Most Recently Selected** list box and clicking the **right-arrow button**.
3. When the **Selected Items** list is complete, click **OK** to populate the **Purpose of Visit (POV)** group box with the selected codes. Click **Close** to exit without adding any **POV** records.

5.2.6.2.3 Edit Button

1. Select a **POV** record you want to edit.
2. Click **Edit** to open the **Edit POV** dialog (Figure 5-32).

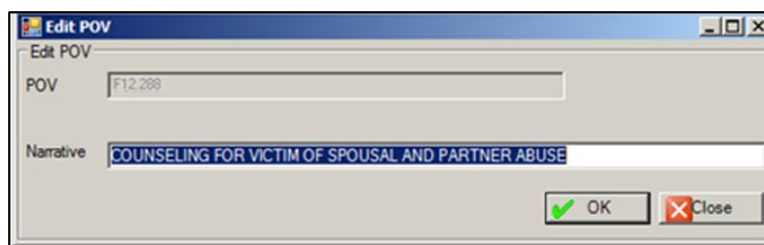


Figure 5-32: Edit POV dialog example

3. In the **Narrative** field, update the narrative text (2–80 characters).

Note: The **Narrative** field is free-text. However, the first character cannot be a single quotation mark (‘), double quotation mark (“), or asterisk (*).

4. Click **OK** to save the updated narrative to the selected **POV** record in the **POV** group box on the **Patient Data** tab.
5. Click **Close** to exit without saving changes.

5.2.6.3 Standard Group Note Field

Enter the text of the **Standard Group Note** in this free-text field. This section may include general observations relevant to all group participants. Individualized information about the patient in focus including their response, engagement, or participation in the group session (as documented on the **Patient Data** tab) should be added here.

The **Standard Group Note** itself must not reference any specific patient. Instead, it should contain content that can be applied consistently across all participants, while this field is used to tailor the note to the individual patient's experience.

- This field is available for text entry only to the primary provider associated with the record.
- This field becomes read-only and cannot be edited once the group record note has been signed.

5.2.6.4 Comment/Next Appointment Field

Use this free-text field to document comments related to the selected patient's next appointment, including scheduling notes, follow-up instructions, or other relevant information.

Note: This field is available for text entry only to the primary provider associated with the record.

5.2.6.5 CPT Codes Group Box

Use the **CPT Codes** group box (Figure 5-33) to add, view, or delete **CPT Code** entries for the selected patient within the group encounter.

CPT Code(s)				
Code	Narrative	Quant...	Mod 1	Mod 2

Figure 5-33: CPT Codes group box example

Users may manage **CPT Code** records here, including adding new codes or removing existing ones as appropriate.

5.2.6.5.1 Delete Button

1. Select a **CPT Code** record you want to delete.
2. Click **Delete**.
3. When the **Are You Sure?** confirmation dialog appears, click **Yes** to permanently remove the selected record from the **CPT Codes** group box. Click **No** to cancel the deletion.

5.2.6.5.2 Add Button

1. Click **Add**. The **CPT Code** search window opens (Figure 5-34).

Figure 5-34 shows the CPT Code search window. It includes a search bar, a list of CPT codes, and a table for selected items. The 'Most Recently Selected' table contains the following data:

CPT Code	Description
12051	INTMD WND REPAIR FACE/MM
51570	REMOVAL OF BLADDER
4115F	BETA BLCKR ADMIN W/IN 24 HRS

Figure 5-34: CPT Code search window example

2. In the **Search String** field (Figure 5-35), enter text to search for a **CPT Code**. Matching **CPT Codes** appear in the **CPT Code** list.

Figure 5-35 shows the CPT Code search results dialog. The search string is '45'. The results list is as follows:

CPT Code	Description
45000	DRAINAGE OF PELVK
45005	DRAINAGE OF RECTU
4500F	REF TO OUTPT CARL
45020	DRAINAGE OF RECTU
45100	BIOPSY OF RECTUM
45108	REMOVAL OF ANORE
4510F	PREV CARDREHAB C
45110	REMOVAL OF RECTU
45111	PARTIAL REMOVAL C
45112	REMOVAL OF RECTU
45113	PARTIAL PROTECTO
45114	PARTIAL REMOVAL C
45116	PARTIAL REMOVAL C
45119	REMOVE RECTUM W
45120	REMOVAL OF RECTU

Figure 5-35: CPT Code search results dialog example

3. In the **Quantity** field, enter the number of units to support billing requirements.

4. In the **Modifier** field, select the appropriate modifier for the **CPT Code**. Click the drop-down list to open the **CPT Modifier Search** window (Figure 5-36).

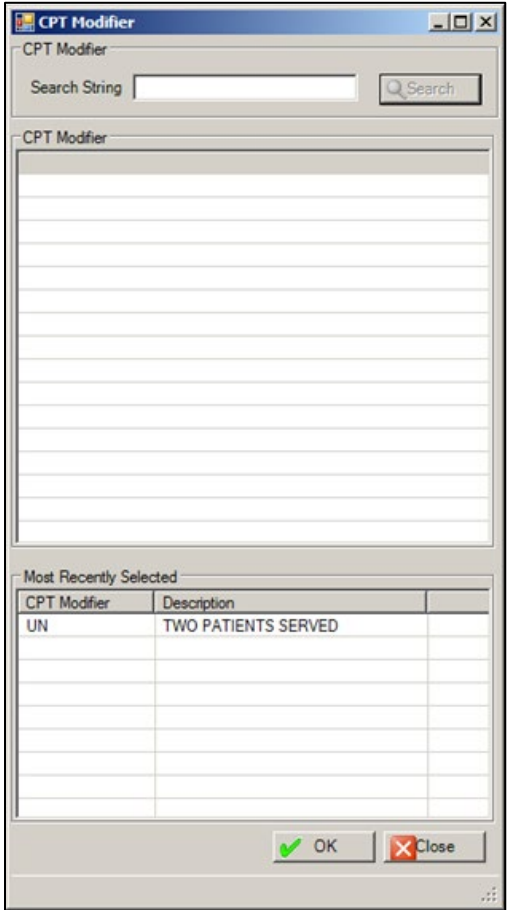
Screen Capture	What to Do
	Use the CPT Modifier Search window in one of the following ways: 1. Search Method: In the Search String field, type all or part of the CPT Modifier name and click Search. The retrieved CPT Modifier names and their descriptions will appear in the CPT Modifier List box. Select a modifier and click OK to save. Click Close to cancel. 2. Recent Selection Method: Select a CPT modifier from the Most Recently Selected list box. Click OK to save. Click Close to cancel.

Figure 5-36: CPT Modifier Search window example

5. To remove a **CPT Code** from the **Selected Items** list, click the **left-arrow** button.
6. After completing the **Quantity** and **Modifier** fields, click the **right-arrow** button to add the **CPT Code** to the **Selected Items** list.
7. When the **Selected Items** list box is complete, click **OK** to save the data and add the **CPT Code(s)** to the **CPT Code(s)** group box. Click **Close** to exit without saving.

5.2.6.6 Time in Group

1. In the **Time in Group** field (Figure 5-37), enter the number of minutes the patient participated in the group encounter (up to six digits).

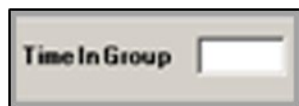
A screenshot of a software interface showing a label 'Time In Group' followed by a small rectangular input field.

Figure 5-37: Time in Group field example

The **Time in Group** value is required for all group encounter records.

Consider the following guidelines:

- **Full Attendance:**

If the patient attended the entire group session, no changes are necessary; the field will default to the full session duration.

- **Partial Attendance:**

If the patient arrived late or left early, update the **Time in Group** field to reflect the actual number of minutes the patient participated.

- **No Attendance:**

If the patient did not attend at all, enter a **0** in the **Time in Group** field and click **OK**. The application will display a **No-Show** message indicating:

Changing Time in Group to zero removed this patient's POV and Note entry.

Next:

- You will be prompted to enter a **No Show POV**. Click **OK** to continue.
- The **POV** search window appears, allowing you to select one or more no-show POVs.
- Click **OK** to save your selections (or **Cancel** to exit without saving.)
- After clicking **OK**, the selected POVs will appear in the **Purpose of Visits–POV** group box on the **Patient Data** tab. Any existing POVs will be replaced by the new selections.

5.2.6.7 Visit Flag

Use the **Visit Flag** field (Figure 5-38) to assign a visit flag for the group encounter.

A screenshot of a software interface showing a label 'Visit Flag' followed by a small rectangular input field.

Figure 5-38: Visit Flag field example

- Enter a whole number between 0 and 999 (no decimal values) in the **Visit Flag** field.

- This field is used locally to classify or track specific types of visits based on site-defined criteria.
 - For example, a site may designate the value **1** to indicate any visit in which a narcotic was prescribed.
 - Users can later retrieve all visits with a **Visit Flag** of **1** to generate a list of all encounters involving narcotics prescriptions.

6.0 Case Management

This section provides guidance on using the **Case Management** option within the **RPMS AMH (GUI)** navigation tree.

6.1 Case Management Window (GUI)

Figure 6-1 shows the location of the **Case Management** option within the **RPMS AMH (GUI)** navigation tree.

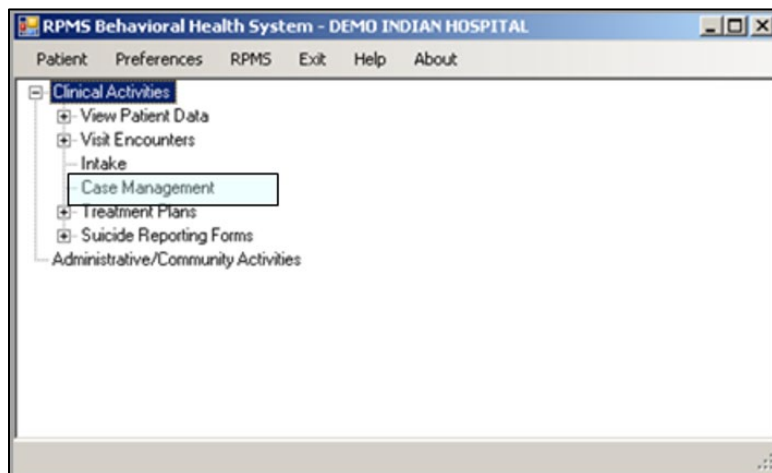


Figure 6-1: Case Management option in the RPMS AMH (GUI) tree structure example

Select the **Case Management** option to open the **Case Management** window (Figure 6-2) for the current patient.

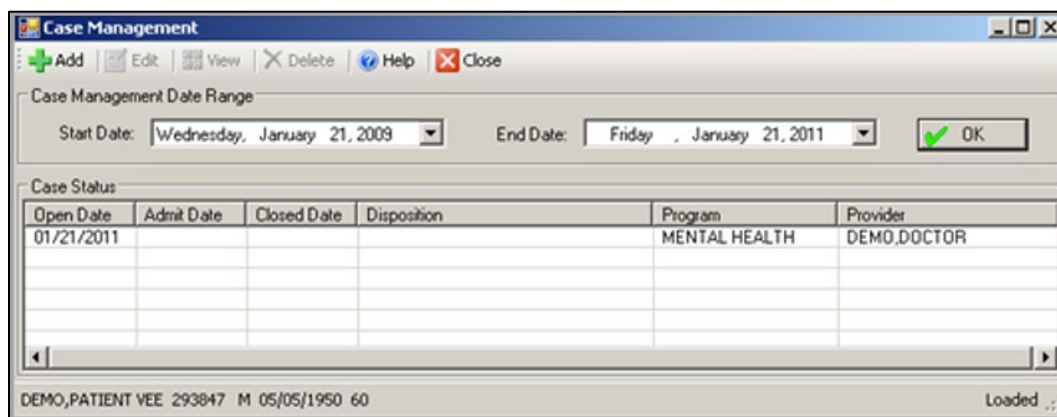


Figure 6-2: Case Management window example

Use the **Case Management** window to view and manage the case management records for the current patient within a specified date range. The patient's name appears in the lower-left corner of the window for reference.

Table 6-1 describes the features and functionality available in the **Case Management** window.

Table 6-1: Case Management window features and functionality

Feature	Functionality
Case Management Date Range Group Box	Displays the date range for the case management records shown. To change the date range, select new dates using the calendar controls. Click OK to refresh the list in the Case Status group box.
Case Status Group Box	Displays all case management records that fall in the selected date range.
Add Button	Click Add to create a new case management record. The Case Management–Add Case window appears.
Edit Button	Click Edit to modify the selected case management record. The Case Management–Edit Case window appears.
View Button	Click View , or double-click a record, to open the Case Management–View Case window. The displayed fields match those in the add/edit windows but are read-only.
Delete Button	Click Delete to remove the selected case status record. When the Are You Sure? confirmation message appears, click Yes to proceed or No to cancel.
Help Button	Click Help to open the online help system for the Case Management window.
Close Button	Click Close to exit the Case Management window.

6.2 Add/Edit Case Management Data (GUI)

Use this function to create or update case management records for the current patient.

- To add a new case management record, click **Add**. The **Case Management–Add Case** window opens (Figure 6-3).
- To edit an existing record, select the **record** and click **Edit**. The **Case Management–Edit Case** window appears. This window contains the same fields as the **Add Case** window.

Figure 6-3: Case Management–Add Case window example

Table 6-2 describes the functions of each button on the **Add Case** window.

Table 6-2: Case Management–Add Case window buttons and functions

Button	Functionality
Save	Saves the case management information entered on the window and closes the form.
Close	Opens the Continue? dialog, which states: “ <i>Unsaved Data Will Be Lost, Continue?</i> ” Click Yes to close the window without saving. Click No to return to the Add Case window and continue working.
Help	Opens the online help system for this window.

6.2.1 Case Status Group Box

Figure 6-4: Fields in Case Status group box example

Note: The fields in bold text are required.
--

1. In the **Program** field, select the program associated with the new case. Options include:
 - **Mental Health**
 - **Social Services**
 - **Chemical Dependency**
 - **Other**
2. In the **Case Admit Date** field, select the **date** the case was admitted. This is the date the case management plan was developed and treatment began. To accept the default (today's date), select the **check box** next to the displayed date. To change the date, open the calendar by selecting the drop-down list.
3. In the **Case Open Date** field, select the **date** the case was opened. This represents the first contact for the episode of care. The default is the current date. To change the date, use the calendar accessible from the drop-down list.
4. In the **Next Review Date** field, select the date of the next scheduled case review. The default is today's date. To accept the default, select the **check box** next to the date. To change the date, open the calendar via the drop-down list.
5. In the **Provider Name** field, select the **Primary Provider** for the case. The default is the currently logged-in user. Select the drop-down list to open the **Primary Provider** search window (Figure 6-5).

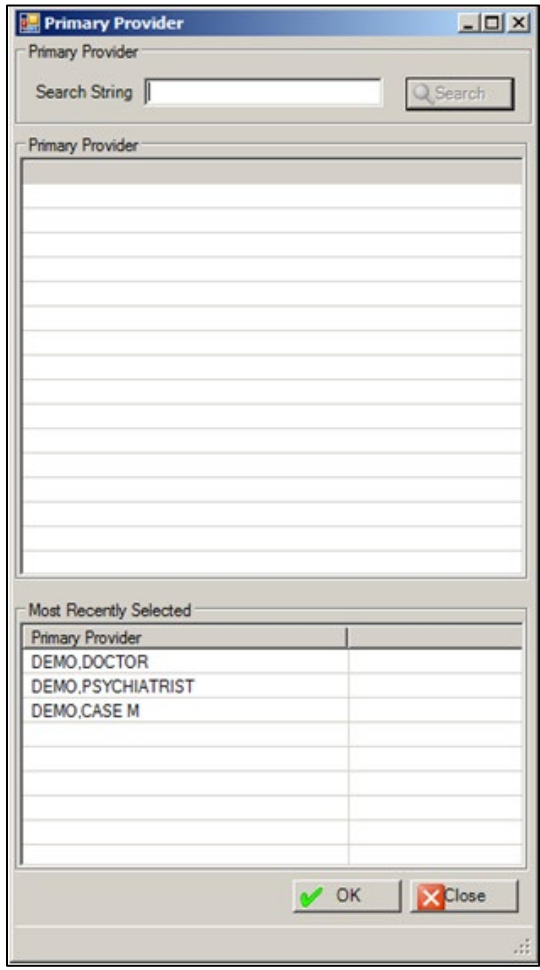
Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Provider Name -: Enter the provider's last name in the Search String field and select Search. The resulting list appears in the Primary Provider list box. Select a provider and click OK to populate the field. Click Close to exit without making a selection. 2. Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 6-5: Primary Provider search window example

1. In the **Date Case Closed** field, select the date the case was closed. This is the date treatment was discontinued.
 - a. To accept the default (today's date), select the **check box** next to the date.
 - b. To change the date, open the **calendar** via the drop-down list.
2. In the **Primary Problem** field, select the **primary problem (POV)** associated with the case.
 - Select the drop-down list to open the **Primary Provider (POV) Search** window (Figure 6-6).

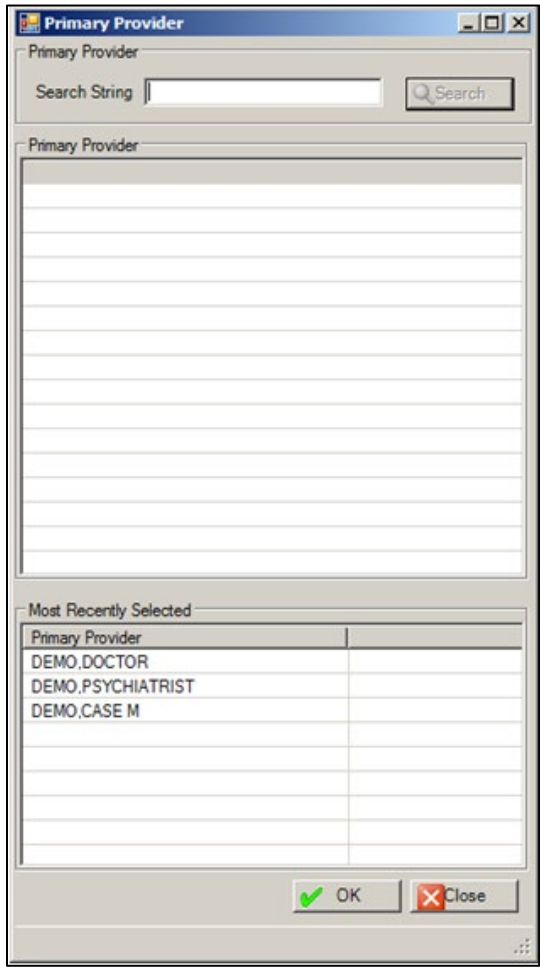
Screen Capture	What to Do
	Use the Primary Provider Search window in one of the following ways: 1. Search by Provider Name: Enter the provider's last name in the Search String field and select Search. The resulting list appears in the Primary Provider list box. Select a provider and click OK to populate the field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 6-6: Primary Problem/POV Search window example

3. In the **Disposition** field, select the reason the case is being closed. This field is required when a date is entered in the **Date Case Closed** field. Select the drop-down list to open the **Disposition** search window (Figure 6-7).

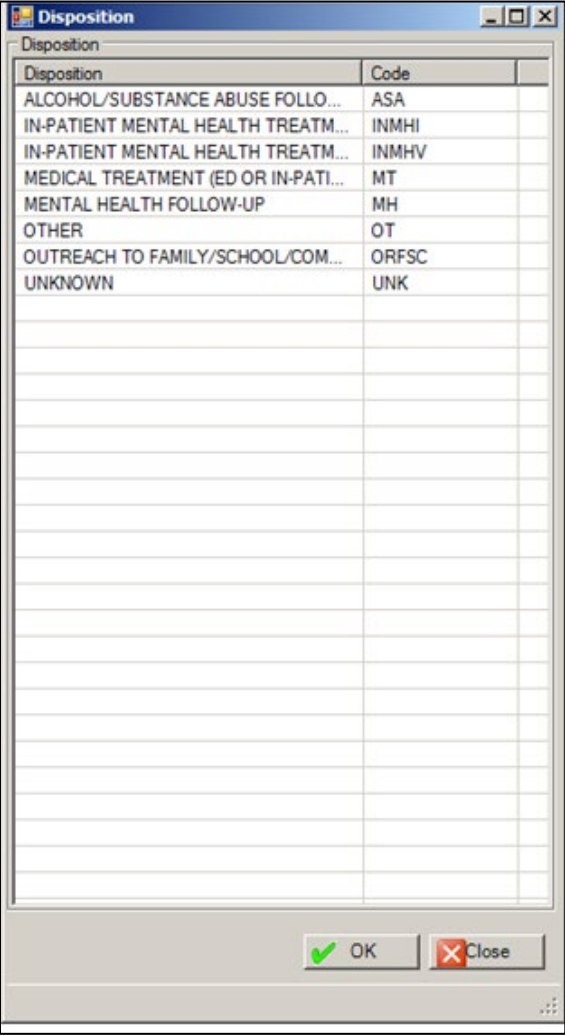
Screen Capture	What to Do
	Use the Disposition search window in one of the following ways: 1. Search by Disposition: Select a Disposition option and click OK (or select Cancel to exit without a selection). 2. After selecting OK, the chosen option is populated in the Disposition field.

Figure 6-7: Disposition search window example

In the **Comment** field, enter any comments relevant to the case. This free-text field accepts 1–240 characters.

6.2.2 Patient Information Group Box

Use the **Patient Information** group box (Figure 6-8) to enter information about designated providers and other case management details.

Figure 6-8: Patient Information group box fields example

Note: All fields in this group box are optional. These fields must be cleared when the case is closed; otherwise, the patient will continue to appear on the provider's case list. To clear a field, right-click the field and select **Clear**.

1. In the **Designated Mental Health Provider** field, select the RPMS provider who has agreed to serve as the designated mental health provider for the patient. Select the drop-down list to open the **Designated Mental Health Provider Search** window (Figure 6-9).

Screen Capture	What to Do
	Use the Designated Mental Health Provider search window in one of the following ways: 1. Search by Provider Name: Enter the provider's last name in the Search String field and click Search. The resulting list appears in the Designated Mental Health Provider list box. Select a provider and click OK. Click Close to exit without selecting a provider. 2. Search by Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK. Click Close to exit without selecting a provider.

Figure 6-9: Designated Mental Health Provider search window example

2. In the **Other Provider Non-RPMS** field, enter the name of a **Behavioral Health** provider not listed in RPMS. This free-text field accepts 2–40 characters.
3. In the **Designated Social Work Provider** field, select the RPMS provider who has accepted designated social work provider status for the patient. Select the drop-down list to open the **Designated Social Work Provider Search** window (Figure 6-10).

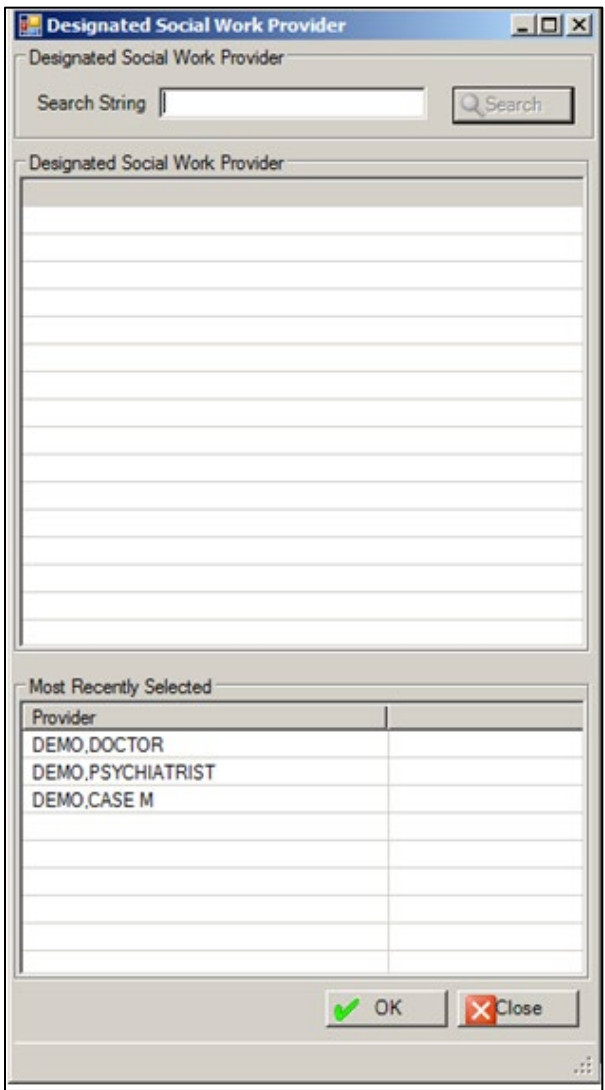
Screen Capture	What to Do
	Use the Designated Social Work Provider search window in one of the following ways: 1. Search by Designated Social Work Provider: Enter the provider's last name in the Search String field and click Search. The results will populate in the Designated Social Work Provider list box. Select a provider and click OK. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 6-10: Designated Social Work Provider search window example

4. In the corresponding **Other Provider Non-RPMS** field, enter the name of a non-RPMS social work provider, using 2–40 characters.

5. In the **Designated Chemical Dependency Provider** field, select the **RPMS provider** who has accepted designated chemical dependency provider status for the patient. Click the drop-down list to open the **Designated Chemical Dependency Provider** search window (Figure 6-11).

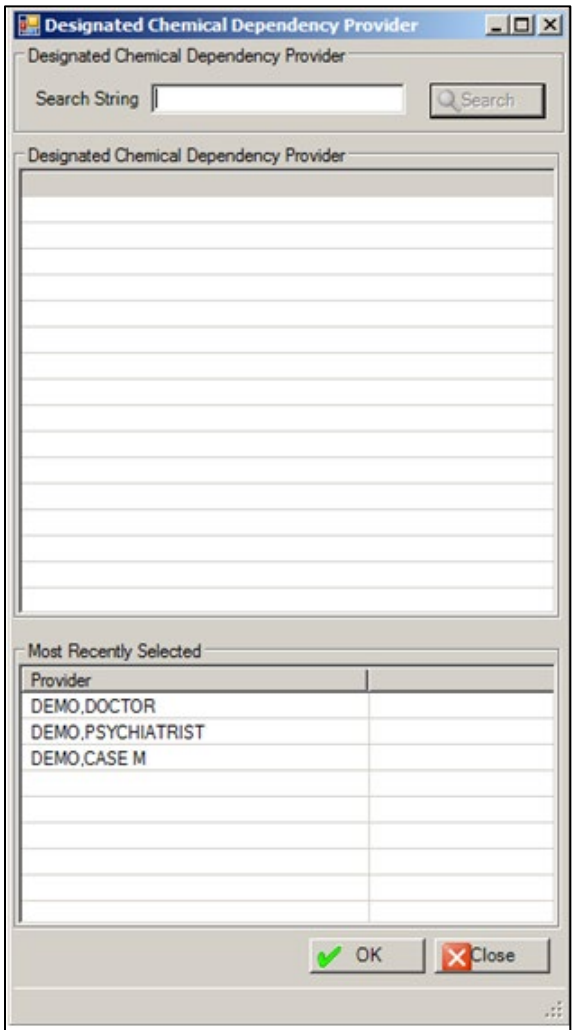
Screen Capture	What to Do
	Use the Designated Chemical Dependency Provider search window in one of the following ways: Search by Name: Enter the provider's last name in the Search String field and click Search. The results populate the Designated Chemical Dependency Provider list box. Select a provider and click OK. Click Close to exit without making a selection. Search by Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 6-11: Designated Chemical Dependency Provider search window example

6. In the **Patient Flag** field, enter a locally defined number code (0–999) used to identify a specific group of patients. Examples include:
- **1**—Patients with a family history of substance abuse
 - **2**—Patients enrolled in a special social services program
 - **3**—Patients enrolled in a special drug trial

Important: Programs with multiple service components (e.g. Social Services and Mental Health) must coordinate the meaning of patient flags to prevent multiple uses of the same flag.

7. In the **Designated Provider Other RPMS** field, select the RPMS provider designated for another role not covered above. Select the drop-down list to open the **Designated Other RPMS Provider Search** window (Figure 6-12).

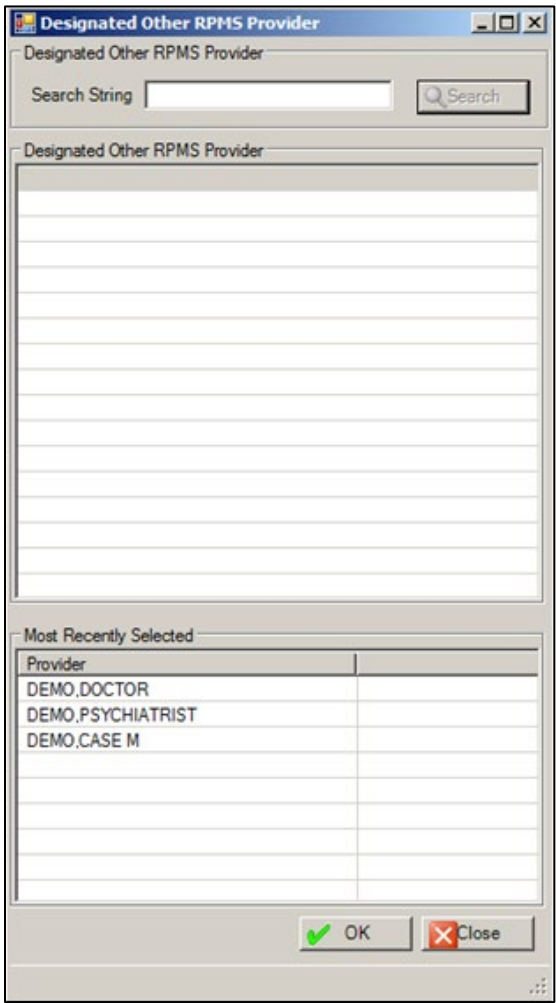
Screen Capture	What to Do
	Use the Designated Other RPMS Provider search window in one of the following ways: 1. Search by Name: Enter the provider's last name in the Search String field and click Search. The results populate the Designated Other RPMS Provider list box. Select a provider and click OK. (Click Close to exit without making a selection.) 2. Search by Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 6-12: Designated Other RPMS Provider search window example

8. In the **Patient Flag Narrative** field, enter a description of the patient flag (2–60 characters).
9. The **Designated Primary Care Provider** field displays the patient's primary care provider, if one is assigned. This information is view-only and is pulled from the **Primary Care Provider** application.

6.2.3 Personal History Group Box

Use the **Personal History** group box (Figure 6-13) to add or remove personal history information for the current patient.

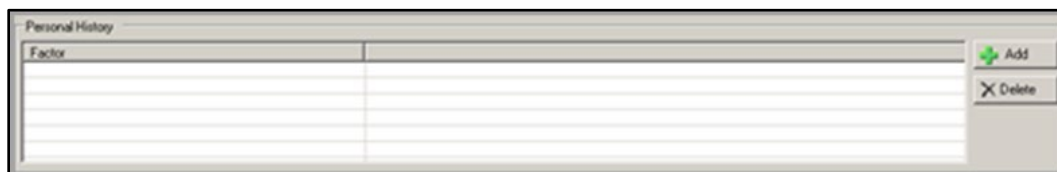


Figure 6-13: Personal History group box example

Personal history information only needs to be documented once, as it becomes a permanent component of the patient's medical record. Many facilities use personal history data to support reporting needs, including the identification and tracking of diagnosis associated with personal history factors.

6.2.3.1 Add Button

Click **Add**. The **Personal History Factors** multiple search window (Figure 6-14) opens, allowing users to add one or more personal history factors.

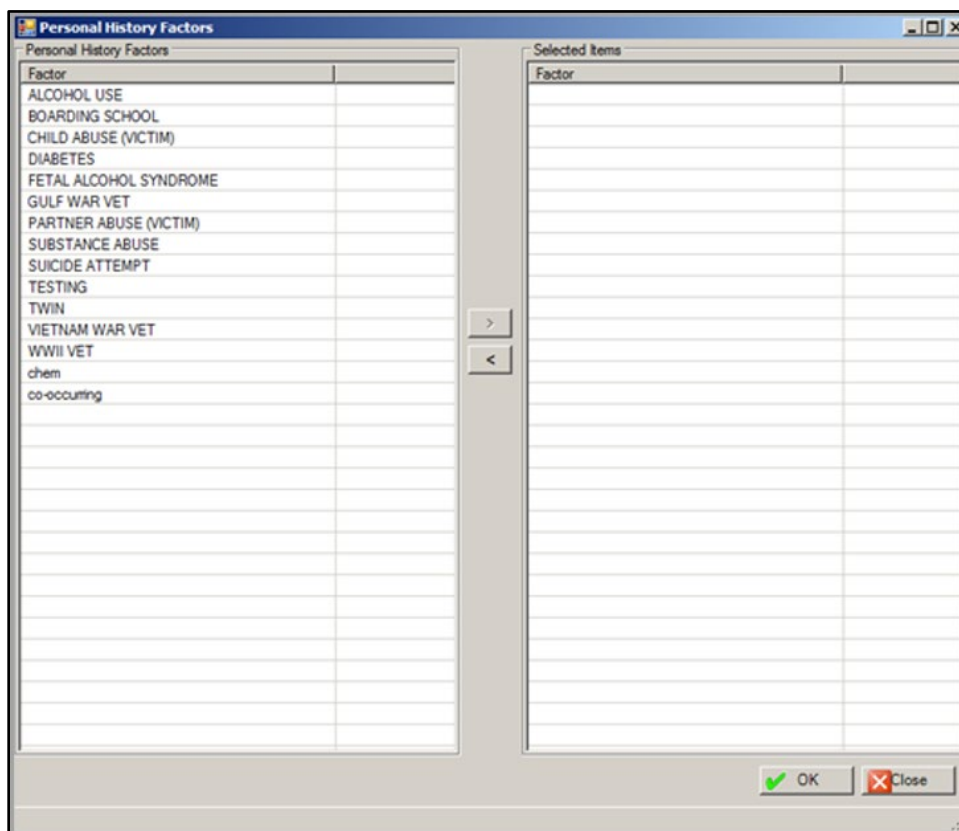


Figure 6-14: Personal History Factors multiple search window example

Use this multiple search window as follows:

1. To add one or more selected items from the **Personal History Factors** list box to the **Selected Items Factor** list box, click the **right-arrow** button.
2. To remove one or more selected records from the **Selected Items–Factor** list box, click the **left-arrow** button.
3. When the **Selected Items–Factor** list box contains all desired items, click **OK** to populate the **Personal History** group box. If you do not want to save the selections, click **Close** instead.

6.2.3.2 Delete Button

1. Select the personal history record you want to delete.
2. Click **Delete**.
3. When the **Are You Sure?** confirmation message appears, type **Y** (Yes) to delete the record or **N** (No) to cancel the action.

7.0 Administrative/Community Activity

The **Administrative/Community Activity** option gives support to community organizations, planning groups, and local stakeholders engaged in developing solutions for community issues.

7.1 Administrative/Community Activity Window (GUI)

The image below illustrates the location of the **Administrative/Community Activities** function within the **RPMS AMH (GUI)** tree structure (Figure 7-1).

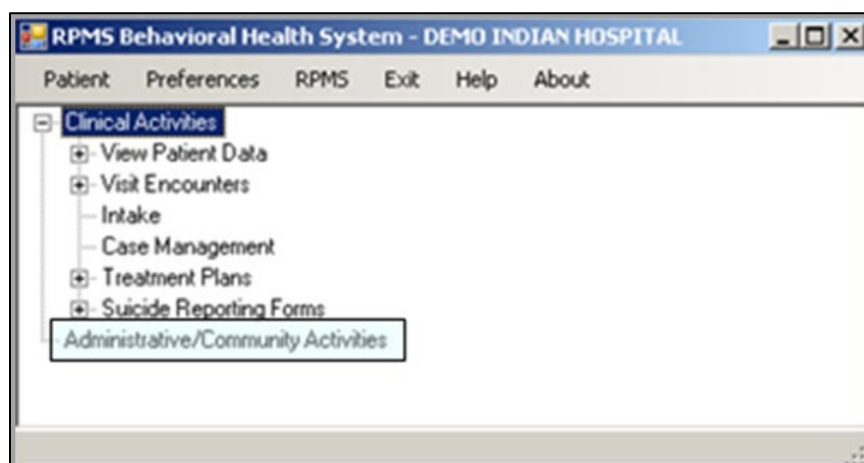


Figure 7-1: Administrative/Community Activities option on the RPMS AMH (GUI) tree structure example

After selecting the **Administrative/Community Activities** option from the **RPMS AMH (GUI)** tree structure, the **Administrative/Community Activity** window opens.

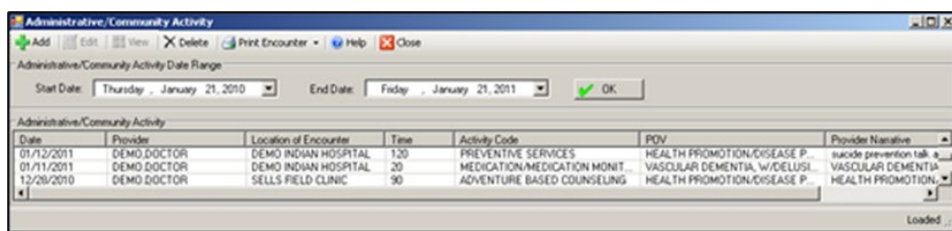


Figure 7-2: Administrative/Community Activity window example

The **Administrative/Community Activity** window displays existing administrative and community activity records.

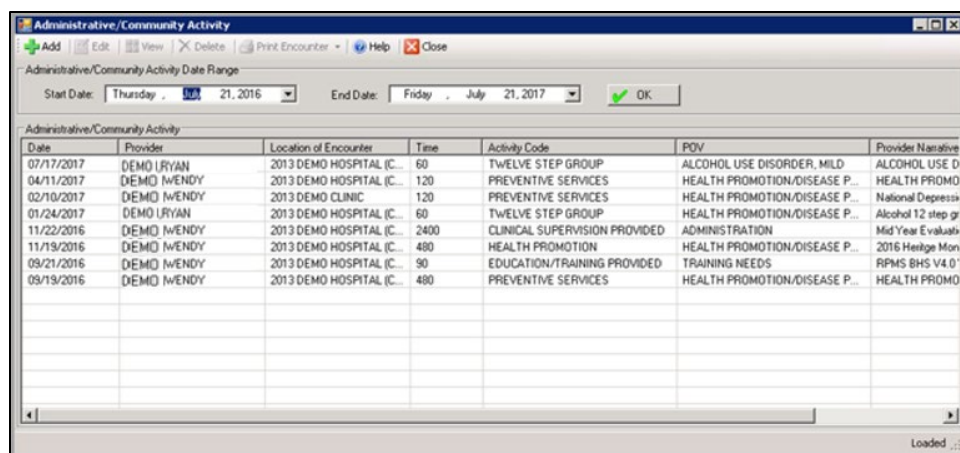
Table 7-1 describes the features and functionality in this window.

Table 7-1: Administrative/Community Activity window features and functions

Features	Functionality
Administrative/Community Activity Date Range	Displays the date range for records in the Administrative/Community Activity list box. You may adjust either date by clicking the corresponding field and selecting a new date from the calendar. After modifying the date range, click OK to refresh the records displayed.
Administrative/Community Activity List Box	Lists activity records in chronological order based on the defined date range.
Add Button	Click Add to create a new administrative/community activity record. This opens the Administrative/Community Activity Data Entry–Add Administrative/Community Data window.
Edit Button	Select a record and click Edit to modify it. This opens the Administrative/Community Activity Data Entry–Edit Administrative/Community Data window, which contains the same fields as the Add window.
View Button	Highlight a record and click View (or double-click the record) to open the Community Activity Data Entry–View Community Data window. This is a read-only view containing the same fields as the Add/Edit) windows. Click Close to exit.
Delete Button	Click Delete to remove a selected record. The system displays a confirmation prompt before deletion.
Help Button	Click Help to open the online help system for the Administrative/Community Activity window.
Close Button	Click Close to exit the Administrative/Community Activity window.
Print Encounter Button	Select a record and click Print Encounter to print or preview the encounter. Select one of the following options: Full , Suppressed , or Both Full and Suppressed . The <i>Suppressed</i> option omits chief complaint/presenting problem information for confidentiality. The application then displays the Print Encounter pop-up window.

7.2 Add/Edit Administrative/Community Activity (GUI)

1. Click **Add** on the **Administrative/Community Activity** window (Figure 7-3) to create a new administrative or community activity record. This opens the **Administrative/Community Activity Data Entry–Add Administrative/Community Data** window (Figure 7-3).



Administrative/Community Activity

Administrative/Community Activity Date Range

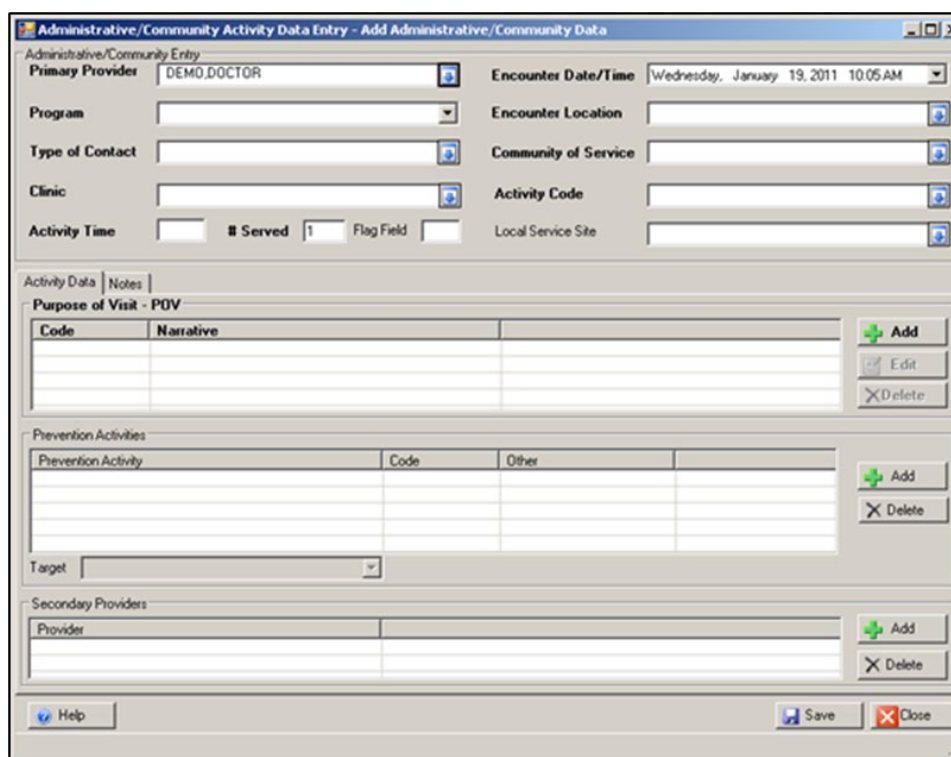
Start Date: Thursday, July 21, 2016 End Date: Friday, July 21, 2017 OK

Date	Provider	Location of Encounter	Time	Activity Code	POV	Provider Narrative
07/17/2017	DEMO I RYAN	2013 DEMO HOSPITAL (C...	60	TWELVE STEP GROUP	ALCOHOL USE DISORDER, MILD	ALCOHOL USE D
04/11/2017	DEMO I WENDY	2013 DEMO HOSPITAL (C...	120	PREVENTIVE SERVICES	HEALTH PROMOTION/DISEASE P...	HEALTH PROMO
02/10/2017	DEMO I WENDY	2013 DEMO CLINIC	120	PREVENTIVE SERVICES	HEALTH PROMOTION/DISEASE P...	National Depressi
01/24/2017	DEMO I RYAN	2013 DEMO HOSPITAL (C...	60	TWELVE STEP GROUP	HEALTH PROMOTION/DISEASE P...	Alcohol 12 step gr
11/22/2016	DEMO I WENDY	2013 DEMO HOSPITAL (C...	2400	CLINICAL SUPERVISION PROVIDED	ADMINISTRATION	Mid Year Evaluati
11/19/2016	DEMO I WENDY	2013 DEMO HOSPITAL (C...	480	HEALTH PROMOTION	HEALTH PROMOTION/DISEASE P...	2016 Hedge Mon
09/21/2016	DEMO I WENDY	2013 DEMO HOSPITAL (C...	90	EDUCATION/TRAINING PROVIDED	TRAINING NEEDS	RPMS BHS V4.0
09/19/2016	DEMO I WENDY	2013 DEMO HOSPITAL (C...	480	PREVENTIVE SERVICES	HEALTH PROMOTION/DISEASE P...	HEALTH PROMO

Loaded

Figure 7-3: Community Activity data entry list view example

- To edit an existing record, highlight the desired entry on the **Administrative/Community Activity** window and click **Edit**. This opens the **Administrative/Community Activity Data Entry–Edit Administrative/Community Data** window (Figure 7-4). This **Edit** window contains the same fields as the **Add** window.



Administrative/Community Activity Data Entry - Add Administrative/Community Data

Administrative/Community Entry

Primary Provider: DEMO.DOCTOR Encounter Date/Time: Wednesday, January 19, 2011 10:05 AM

Program: Encounter Location:

Type of Contact: Community of Service:

Clinic: Activity Code:

Activity Time: # Served: 1 Flag Field: Local Service Site:

Activity Data | Notes

Purpose of Visit - POV

Code	Narrative

Prevention Activities

Prevention Activity	Code	Other

Target:

Secondary Providers

Provider

Help Save Close

Figure 7-4: Community Activity Data Entry–Add Administrative/Community Data window example

- Click **Help** to access the online help resources for this window.

- After completing all required fields, click **Save** to store the record. If you do not want to save changes, click **Close**. Clicking **Save** adds the new or updated record to the **Administrative/Community Activity** window.

7.2.1 Administrative/Community Entry Group Box

The **Administrative/Community Entry** group box is shown in Figure 7-5.

Figure 7-5: Administrative/Community Entry group box example

Fields shown in **bold** are required.

- In the **Primary Provider** field, select the provider responsible for the administrative/community activity. Click the drop-down list to open the **Primary Provider** search window (Figure 7-6).

Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: Search by Name: Type the provider's last name in the Search String field and click Search. Select a name from the displayed list in the Primary Provider list box and click OK to populate the field. Click Close to exit without making a selection. Search by Most Recently Selected: Select a name in the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 7-6: Primary Provider search window example

2. In the **Encounter Date/Time** field, enter the date and time of the activity. The current date and time populate this field by default. Click the drop-down list to select a date from the calendar. Modify the time manually by selecting the hour, minutes, and AM/PM. If time is entered in 24-hour format (e.g. 13:25), the system automatically converts it to 1:25 PM.
3. In the **Program** field, enter the program associated with the activity. Options include:
 - **Mental Health**
 - **Social Services**
 - **Chemical Dependency**
 - **Other**

If **Site Parameter** defaults are configured, completing this field for a new record may automatically populate the remaining required fields.

4. In the **Encounter Location** field, select the location where the activity occurred. Click the list to open the **Location Search** window (Figure 7-7).

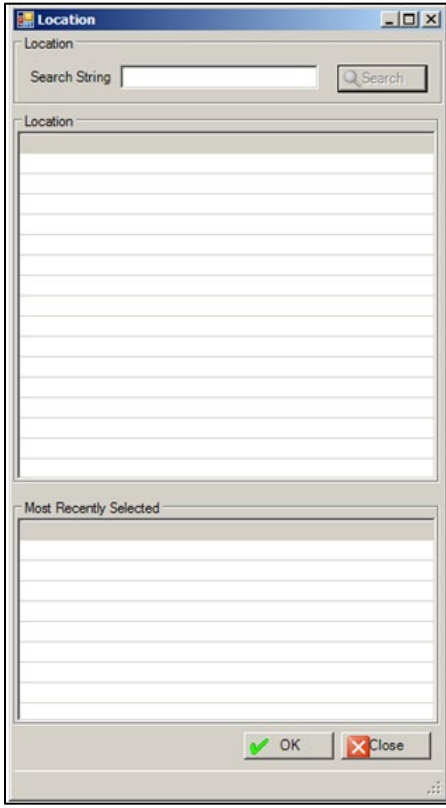
Screen Capture	What to Do
	Use the Location search window in one of the following ways: 1. Search by Location: Type the location in the Search String field and click Search. The resulting locations will populate the Location list box. Select a location and click OK to populate the field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK to populate the field. (Click Close to exit without making a selection.)

Figure 7-7: Location search window example

5. In the **Type of Contact** field, select the setting in which the activity occurred. Click the list to open the **Type of Contact** selection window (Figure 7-8).

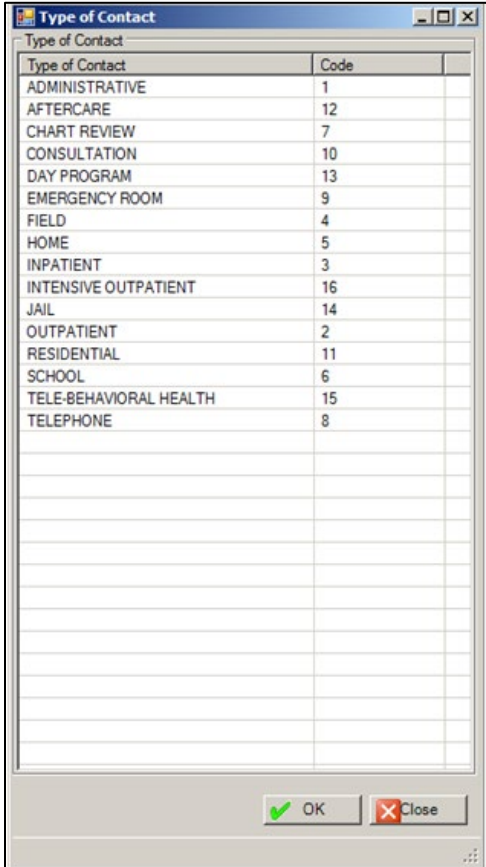
Screen Capture	What to Do
	Use the Type of Contact search window in the following way: 1. Select a type of contact from the list. 2. Click OK to populate the field. Click Close to exit without making a selection.

Figure 7-8: Type of Contact search window example

6. In the **Community of Service** field, select the community where the encounter occurred. Click the list to open the **Community** search window (Figure 7-9).

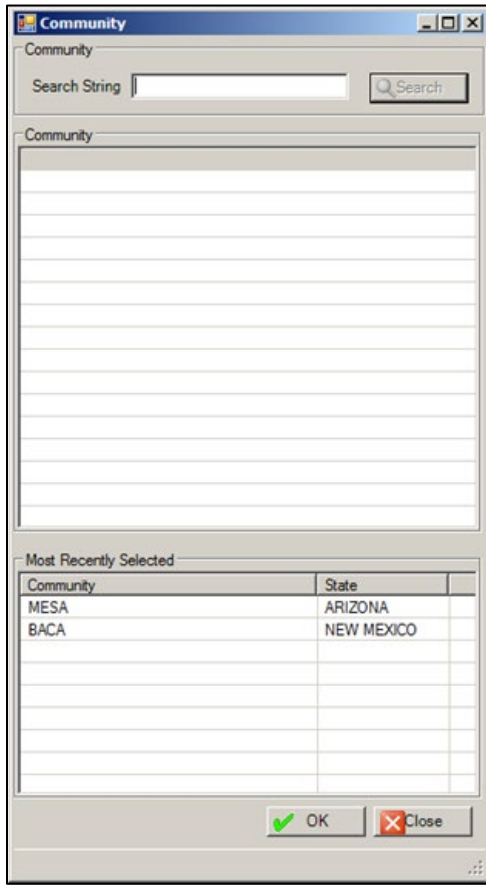
Screen Capture	What to Do
	Use the Community search window in one of two ways: 1. Use the Search String field by typing the community's name and then clicking Search. The retrieved names will populate the Community list box. Select a retrieved record and click OK to populate the Community of Service field. Otherwise, click Close. 2. Select a name in the Most Recently Selected list box and click OK to populate the Community of Service field. Otherwise, click Close.

Figure 7-9: Community search window example

7. In the **Clinic** field, select the clinic associated with the activity. Click the list to open the **Clinic** search window (Figure 7-10).

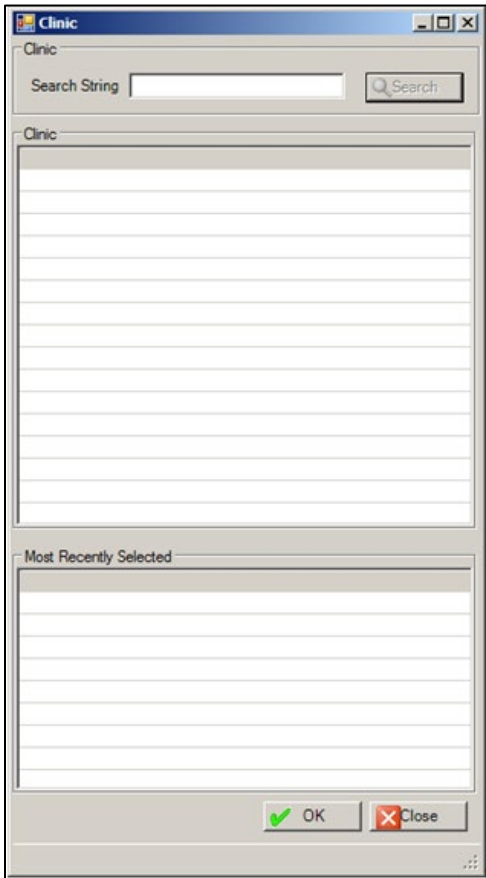
Screen Capture	What to Do
	Use the Clinic search window in one of the following ways: 1. Search by Name: Type the clinic name or code in the Search String field and click Search. The results will populate the Clinic list box. Select a clinic and click OK to populate the field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK to populate the field. Click Close to exit without making a selection.

Figure 7-10: Clinic search window example

8. In the **Activity Code** field, select the code corresponding to the administrative/community activity. Click the list to open the **Activity** search window (Figure 7-11).

For additional definitions, see Appendix A.

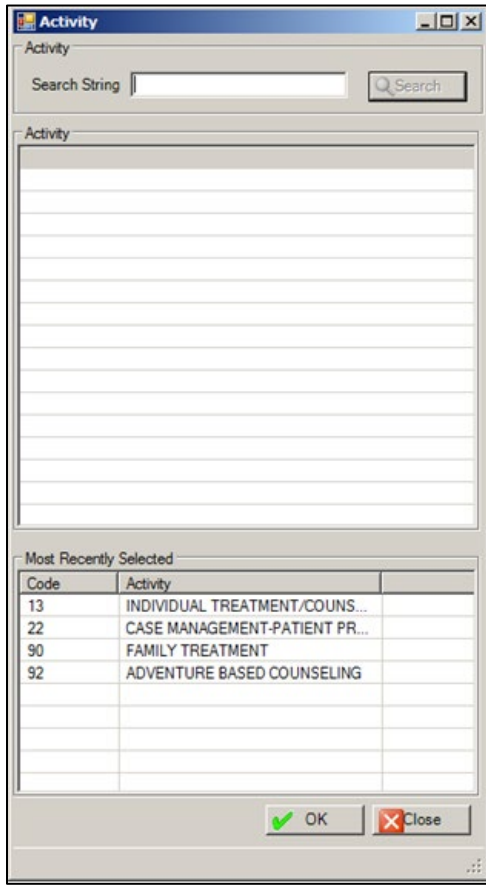
Screen Capture	What to Do
	Use the Activity Code search window in one of the following ways: 1. Search by Name: Type the activity name or code into the Search String field and click Search. The results will populate the Activity list box. Select an item and click OK to populate the Activity Code field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK to populate the Activity Code field. Click Close to exit without making a selection.

Figure 7-11: Activity search window example

9. In the **Activity Time** field, enter the number of minutes spent on the activity. Use any whole number between **1 and 9999**.
10. In the **# Served** field, enter the number of individuals served during the activity. Use any whole number between **0 and 999**.
11. In the **Flag** field, enter a local flag value (**0 to 999**) used to categorize specific types of visits. Flag definitions are determined by each site. For example, a flag of **1** might represent visits where a narcotic was prescribed, enabling later retrieval of all such encounters.
12. In the **Local Service Site** field (Figure 7-12), select the local service site associated with the activity, if applicable. Click the **list** to open the **Local Service Site** window.

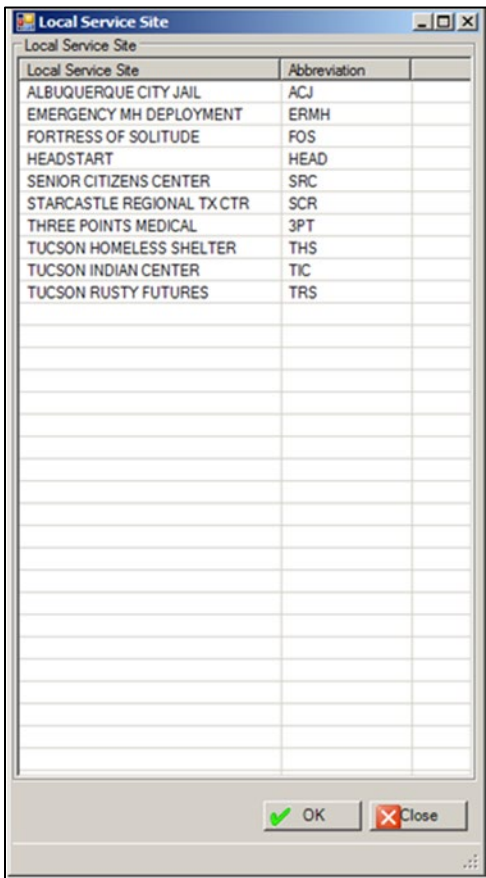
Screen Capture	What to Do
	Use the Local Service Site search window in the following ways: 1. Select a Local Service Site from the list. 2. Click OK to populate the field. (Click Close to exit without making a selection.)

Figure 7-12: Local Service Site search window example

7.2.2 Activity Data Tab

Use the **Activity Data** tab (Figure 7-13) to enter information related to the **Purpose of Visit (POV)**, **Prevention Activities**, and **Secondary Providers**.

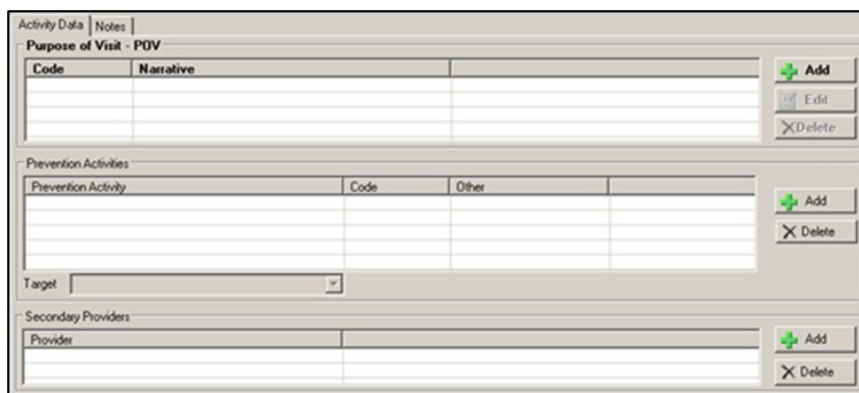


Figure 7-13: Activity Data tab example

7.2.2.1 Purpose of Visit–POV Group Box

The **Purpose of Visit–POV Group Box** (Figure 7-14) lists the POVs associated with the administrative/community activity.

Code	Narrative
97	ADMINISTRATION

Figure 7-14: POV Group Box example

Every administration/community activity record must contain at least one POV. Users may add, edit, or delete POV entries as needed.

7.2.2.1.1 Add Button

Click **Add**. The **POV** search window (Figure 7-15) opens, allowing you to select one or more POVs.

Figure 7-15: POV search window example

Use the search window as follows:

1. In the **Search String** field, type part of the POV description or code.
2. Click **Search**. Retrieved records appear in the **POV** list box, showing both the POV and its narrative.

- To add one or more selected POVs to the **Selected Items** list box, click the **right-arrow** button.
 - To remove one or more selected items from the **Selected Items** list box, click the **left-arrow** button.
3. When the **Selected Item** list box contains all desired entries, click **OK** to populate the **POV** group box. (Otherwise, click **Close**.)

7.2.2.1.2 Edit Button

1. Select the **POV** record you want to edit.
2. Click **Edit**. The **Edit POV** window appears (Figure 7-16).

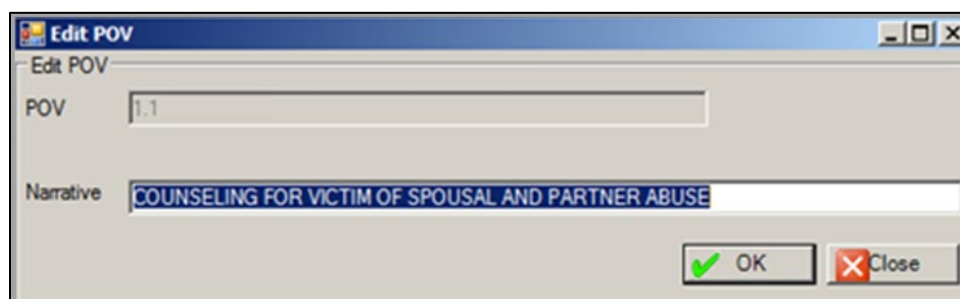


Figure 7-16: Edit POV window example

3. In the **Narrative** field, enter the updated **POV narrative** using **2–80** characters.

Note: The POV narrative cannot begin with a single (‘) or double (“) quotation mark. This is a free-text field.

4. Click **OK** to save the revised narrative. (Otherwise, click **Close**.)

7.2.2.1.3 Delete Button

1. Select a **POV record** you want to delete.
2. Click **Delete**.

The **Are You Sure?** confirmation message appears.

3. Click **Yes** to remove the selected **POV** from the group box. Otherwise, click **No** to cancel the deletion.

7.2.2.2 Prevention Activities Group Box

The **Prevention Activities** group box (Figure 7-17) displays all prevention activities associated with the administrative/community activity.

Figure 7-17: Prevention Activities group box example

The **Target** field remains disabled until at least one **Prevention Activity** is entered. If all prevention activities are removed, the **Target** field becomes disabled again.

Use this group box to add or delete prevention activities and to specify the corresponding target population.

1. In the **Target** field, select the population for whom the prevention activity is intended. The selected target applies to all prevention activities recorded for the encounter. Available options include:

- **Adult**
- **Youth**
- **Family**
- **Mixed (Adult & Youth)**
- **Staff**
- **Elderly Only**
- **Women**
- **Men**

7.2.2.2.1 Add Button

1. Click **Add**. The **Prevention Activity Multiple-Select** window opens.
2. Select one or more **prevention activities** (Figure 7-18).

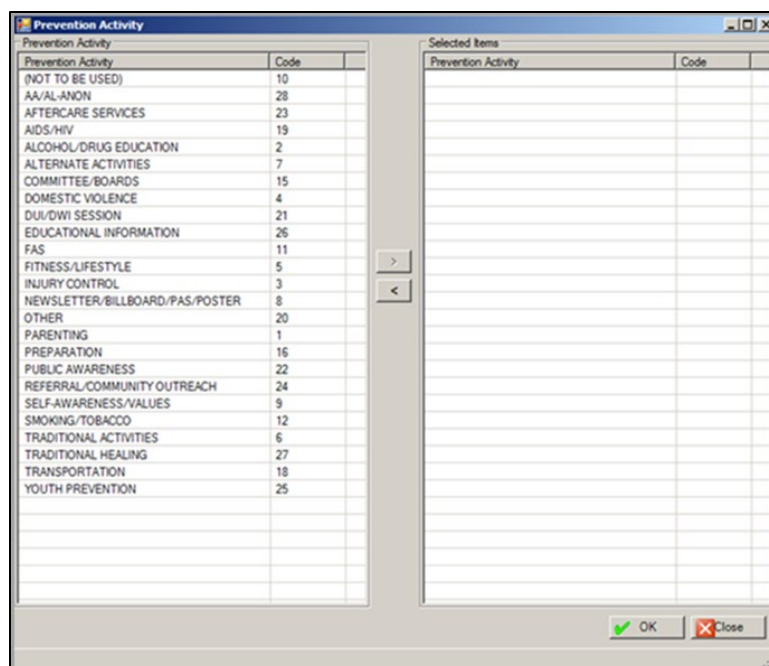


Figure 7-18: Prevention Activity multiple-select window example

3. Use the multiple-select window as follows:

- To add one or more selected items from the **Prevention Activity** list box to the **Selected Items–Prevention Activity** list box, click the **right-arrow** button.
 - a. To remove one or more selected records from the **Selected Items–Prevention Activity** list box, click the **left-arrow** button.
 - b. When the **Selected Items–Prevention Activity** list is complete, click **OK** to populate the **Prevention Activity** group box. (Otherwise, click **Close**.)
 - c. If you select **OTHER (Code 20)** in the **Prevention Activity** list, the **Other** window appears (Figure 7-19).



Figure 7-19: Other window example

- d. In the **Other** field, type the description of the prevention activity (up to **80** characters).
- e. Click **OK** to populate the **Other** column in the grid.

If the **Other** window is closed without entering text, the **Other** cell in the grid remains blank.

7.2.2.2.2 Delete Button

1. Select the prevention activity record you want to delete.
2. Click **Delete**.
3. When the **Are You Sure?** confirmation message appears, click **Yes** to remove the selected prevention activity record from the group box. (Otherwise, click **No** to cancel the deletion.)

7.2.2.3 Secondary Providers Group Box

The **Secondary Providers** group box (Figure 7-20) displays all secondary providers associated with the administrative/community activity.

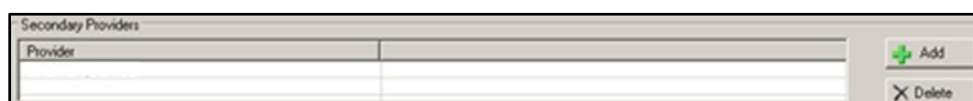


Figure 7-20: Secondary Providers group box example

Users may add or delete secondary provider records as needed.

7.2.2.3.1 Add Process

Click **Add** to open the **Secondary Provider** search window (Figure 7-21). From this window, select one or more secondary provider names.

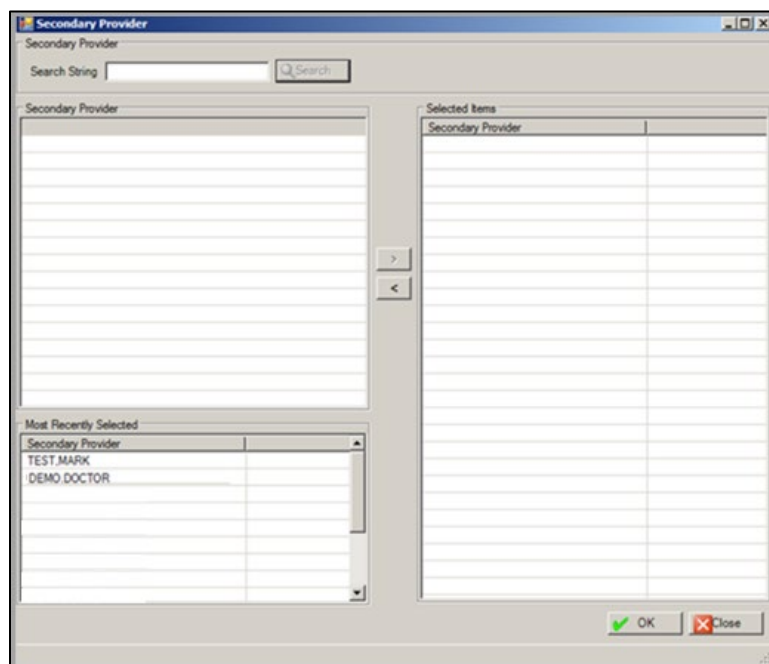


Figure 7-21: Secondary Provider search window example

1. Use the **Secondary Providers Multiple** search window as follows:

- In the **Search String** field, enter a few characters of the provider's name or other search criteria.
- Click **Search**. The retrieved records appear in the **Secondary Provider** list box.
- To add one or more selected providers from the **Secondary Provider** list box to the **Selected Items–Secondary Provider** list box, click the **right-arrow** button.
 - Alternatively, you may select one or more providers from the **Most Recently Selected** list box and click the **right-arrow** button to add them.
 - To remove one or more providers from the **Selected Items–Secondary Provider** list box, click the **left-arrow** button.
- a. When the **Selected Items–Secondary Provider** list box contains all desired selections, click **OK** to populate the **Secondary Providers** group box. (Otherwise, click **Close**.)

7.2.2.3.2 Delete Process

1. Select the **secondary provider** record you want to remove.
2. Click **Delete**.
3. When the **Are You Sure?** confirmation message appears, click **Yes** to delete the selected **secondary provider record** from the group box. (Otherwise, click **No** to cancel.)

7.2.3 Notes Tab

Use the **Notes** tab (Figure 7-22) to enter any additional information or comments relevant to the administrative/community activity.

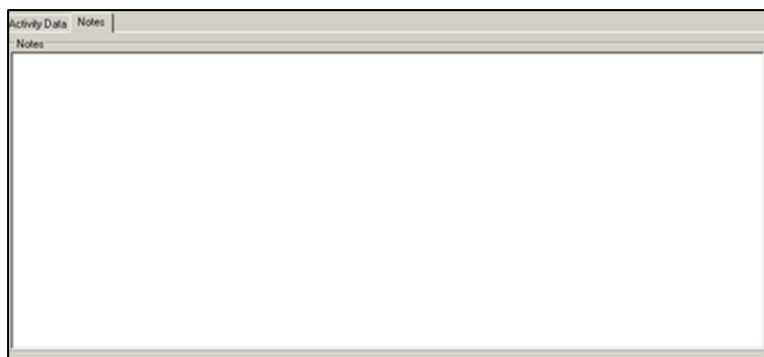
The image shows a screenshot of a software window with two tabs: 'Activity Data' and 'Notes'. The 'Notes' tab is selected and active. Below the tab header is a large, empty rectangular text area for entering notes.

Figure 7-22: Notes tab example

This field is a free-text box.

8.0 Problem List

This section describes how to manage the **Problem List** using the Graphical User Interface (GUI).

8.1 Problem List (GUI)

This section explains how to manage problems for a selected patient from the **Visit** window.

After selecting a patient encounter and clicking the **Problem** button, select one of the following options:

- **BH Problem List**
- **PCC Problem List (display only)**

8.1.1 Behavior Health Problem List Window

When you select **BH Problem List**, the **Behavioral Health Problem List** window opens (Figure 8-1).

Figure 8-1: Behavioral Health Problem List window example

The patient's current problems appear in the **Problem List** grid, including any associated notes. Notes display directly beneath the corresponding problem.

Table 8-1 describes the window's features.

Table 8-1: Behavioral Health Problem List Window Features and Functionality

Feature	Functionality
Help Button	Opens online help for this window.
Close Button	Exits the window.
Cancel Button	Cancels the current action (such as Add Problem) and remains on the window.

8.1.1.1 Add/Edit Problem

The **Add** and **Edit** functions use the same fields.

1. To add a new **problem**, select **Problems | Add Problem** to display the **Problem List Data Entry** group box.
2. To edit an existing problem, select the **problem**, then select **Problems | Edit Problem**. The **Problem List Data Entry** group box (see Figure 8 2) opens with fields populated. The fields shown in bold are required.

Figure 8-2: Problem List Data Entry group box example

3. Click the list for the **Diagnosis** field to open the **POV** search window (Figure 8-3). Select a **POV** to populate both the **Diagnosis** and **Narrative** fields.
4. Use the **Active/Inactive** option buttons to indicate the current status of the diagnosis. Active is the default for new problems.
5. Select the date the problems is first diagnosed using the **Date of Onset** field. For new problems, today's date is the default.

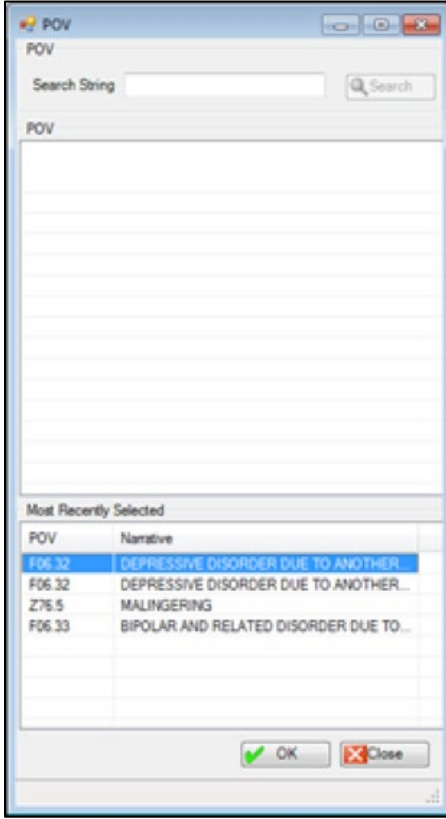
Screen Capture	What to Do										
 <table border="1" data-bbox="365 745 771 976"> <thead> <tr> <th>POV</th><th>Narrative</th></tr> </thead> <tbody> <tr> <td>F06.32</td><td>DEPRESSIVE DISORDER DUE TO ANOTHER...</td></tr> <tr> <td>F06.32</td><td>DEPRESSIVE DISORDER DUE TO ANOTHER...</td></tr> <tr> <td>Z76.5</td><td>MALINGERING</td></tr> <tr> <td>F06.33</td><td>BIPOLAR AND RELATED DISORDER DUE TO...</td></tr> </tbody> </table>	POV	Narrative	F06.32	DEPRESSIVE DISORDER DUE TO ANOTHER...	F06.32	DEPRESSIVE DISORDER DUE TO ANOTHER...	Z76.5	MALINGERING	F06.33	BIPOLAR AND RELATED DISORDER DUE TO...	Use the POV search window in one of the following ways: 1. Search by POV: In the Search String field, type all or part of the POV description click Search. Retrieved POVs populate the list box. Select a POV and click OK to populate the Diagnosis and Narrative fields. Click Close to exit without making a selection. 2. Search from Most Recently Selected: Select a POV from the Most Recently Selected list box and click OK to populate the Diagnosis and Narrative fields. Click Close to exit without making a selection.
POV	Narrative										
F06.32	DEPRESSIVE DISORDER DUE TO ANOTHER...										
F06.32	DEPRESSIVE DISORDER DUE TO ANOTHER...										
Z76.5	MALINGERING										
F06.33	BIPOLAR AND RELATED DISORDER DUE TO...										

Figure 8-3: POV search window example

- Clear the check box to remove the **Date of Onset**.
 - To change the **Date of Onset**, click the list and select a date from the calendar.
6. Review the **Narrative** field populated from the selected diagnosis. Modify the text in this free-text field if needed.
 7. Select the **Add Note?** check box to display the **Note** group box (Figure 8-4).

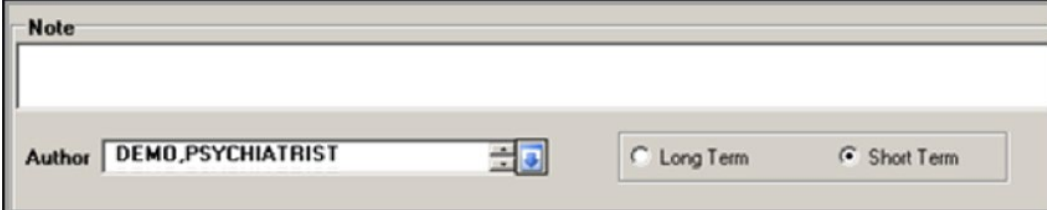


Figure 8-4: Note group box example

- If needed, clear the **Note** field to hide the group box.
- Within the **Note** group box:

Note: Enter the note text, typically describing treatment, or relevant details.

- a. **Author:** Enter the author's name. The system defaults to the current user. To change the name, click the list to open the **Primary Provider** search window (Figure 8-5).

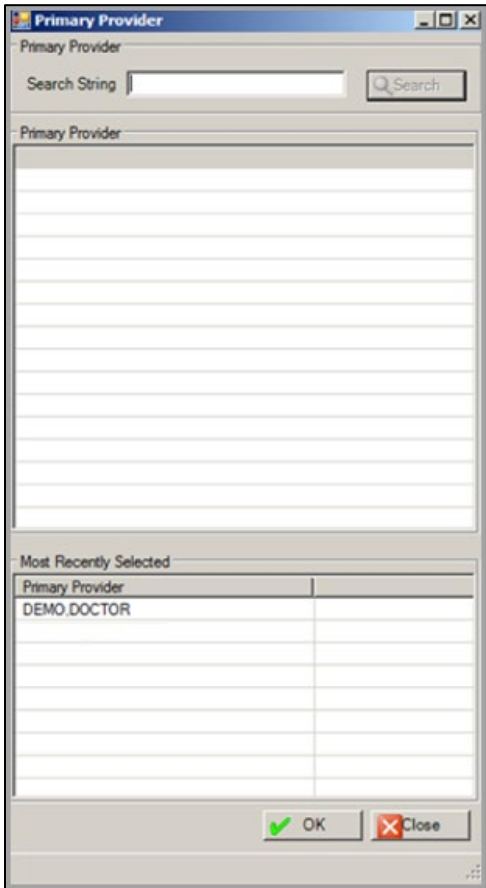
Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Name: Type the provider's last name into the Search String field and click Search. Select a name from the results and click OK. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 8-5: Primary Provider search window example

- b. **Long-Term/Short-Term:** Select either **Long-Term** or **Short-Term**, depending on the treatment type described in the note.
8. **Date Updated:** This field defaults to today's date. To modify it, click the list and select another date from the calendar.
9. **Person Who Updated:** This field displays the default provider (typically the visit provider associated with the **Problem List** entry). To change the provider, click the list to open the **Primary Provider** search window (Figure 8-6) and select a different name.

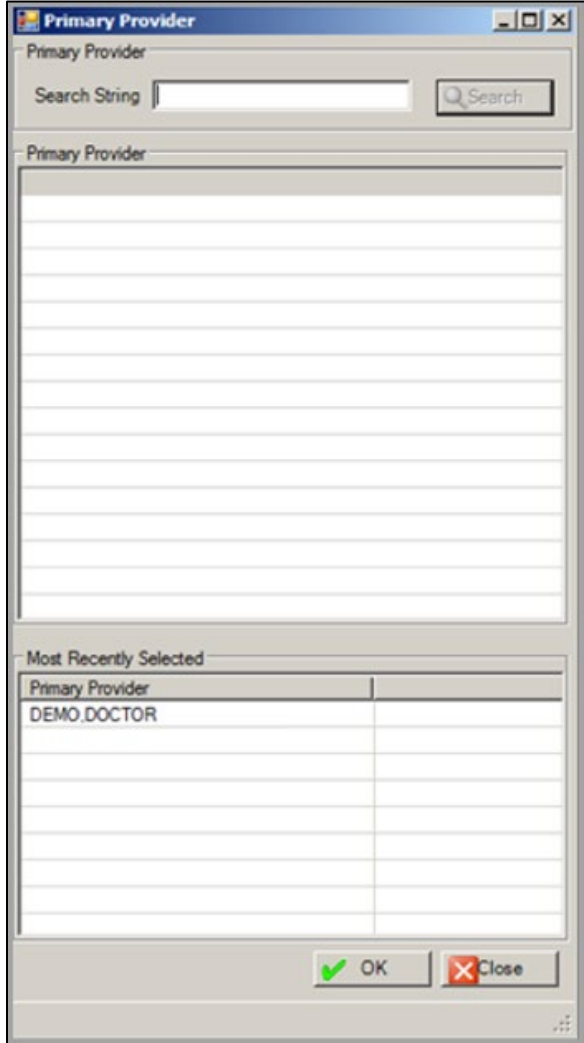
Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Name: Type the primary provider's last name into the Search String field and click Search. The resulted names will populate the Primary Provider list box. Select a name and click OK to populate the Person Who Updated field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a provider name in the Most Recently Selected list box and click OK to populate the Person Who Updated field. Click Close to exit without making a selection.

Figure 8-6: Primary Provider search window example

10. If using **Add**, click **Save** after completing all fields to add the new problem to the **Problem List** grid. (Otherwise, click **Cancel**).
11. If using **Edit**, click **Save** to update the selected problem on the **Problem List** grid. (Otherwise, click **Cancel**).

8.1.1.2 Delete Problem

1. In the **Problem List** grid, select the problem you want to delete.
2. From the menu, select **Problems | Delete Problem**.

The **Problem List–Reason for Delete** dialog appears (Figure 8-7).

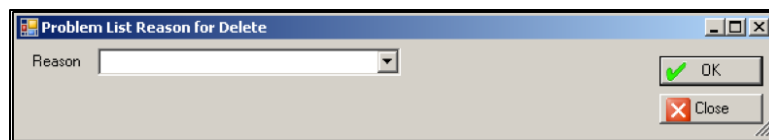


Figure 8-7: Problem List Reason for Delete dialog example

3. In the **Reason** field (see Figure 88), click the **down-arrow** and select one of the required options.

- **DUPLICATE**
- **ENTERED IN ERROR**
- **OTHER**

If you select **OTHER**, an additional text field appears (see Figure 8-8). Enter the required explanation in the **Other** field.

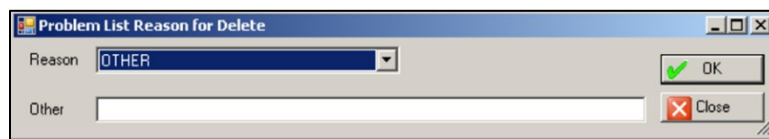


Figure 8-8: Problem List Reason for Delete dialog with OTHER selected example

4. After completing the **Reason for Delete** dialog, click **OK** to proceed. To exit without making changes, click **Close**.
5. After clicking **OK**, the **Date Updated** and **Person Who Updated** fields become active (Figure 8-9).

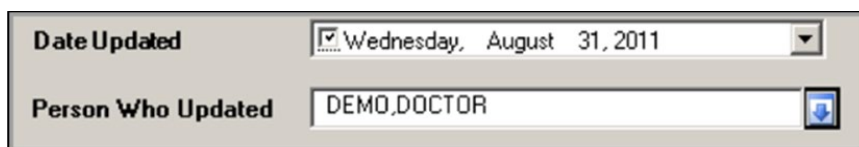


Figure 8-9: Active Date Updated and Person Who Updated fields example

6. In the **Date Updated** field, select the date of the update. The default is the current date. To change the date, open the calendar and select a different date.
7. In the **Person Who Updated** field, select the provider who performed the updated. The default is the provider associated with the visit linked to the **Problem List** entry. The **Primary Provider** window opens (Figure 8-10).

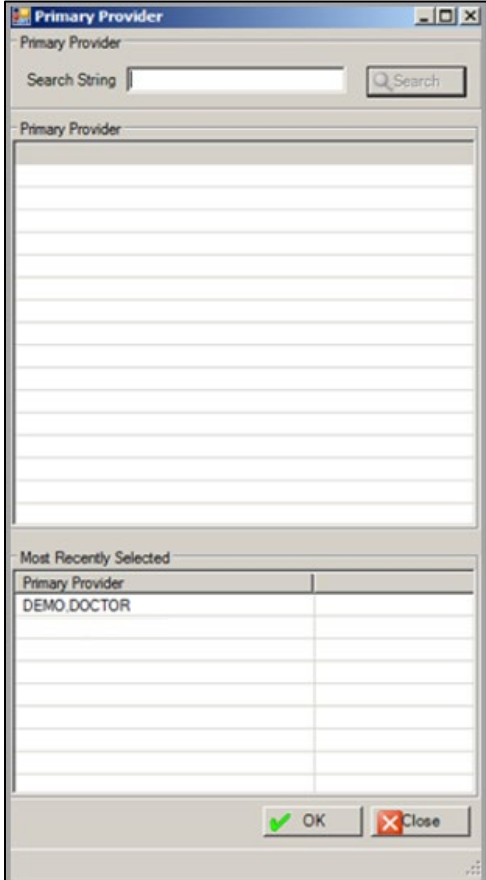
Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Name –: Enter the primary provider's last name into the Search String and click Search. Select the appropriate provider from the Primary Provider list and click OK. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a provider from the Most Recently Selected list and click OK. Click Close to exit without making a selection.

Figure 8-10: Primary Provider search window example

8. After completing all active fields, click **Save** to remove the problem from the **Problem List** grid. To cancel the deletion, click **Cancel**.

8.1.1.3 Activate/Inactivate Problem

1. In the **Problem List** grid, select an existing problem you want to activate or inactivate.
2. From the menu, select **Problems | Activate** or **Problems | Inactivate**.

The **Date Updated** and **Person Who Updated** fields appear (see Figure 8-11).

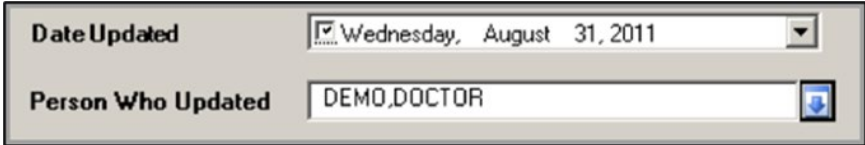


Figure 8-11: Date Updated and Person Who Updated fields example

3. In the **Date Updated** field, select the date of the update. The default is today's date. To change the date, open the calendar and select another date.

Note: The **Activate** action requires that the **Date Updated** check box is selected.

4. In the **Person Who Updated** field, select the **individual** responsible for updating the **Problem List**. To change the name, open the drop-down list to access the **Primary Provider** search window and select the appropriate **provider**.
5. After completing all required fields, click **Save** to update the status of the selected problem in the **Problem List** grid. (To exit without making changes, click **Cancel**.)

8.1.1.4 Add/Edit Note

The **Add Note** and **Edit Note** functions use the same fields.

- To add a note: Select an existing problem in the **Problem List** grid, then select **Notes | Add Note**.
- To edit a note: Select an existing note in the **Problem List** grid, then select **Notes | Edit Note**.

When editing, the fields are populated with the note's existing data.

Figure 8-12 illustrates the fields available in the lower group box.

The screenshot shows a form with the following fields:

- Date Updated:** A date picker showing 'Friday, July 15, 2011'.
- Person Who Updated:** A dropdown menu showing 'GARCIA,RYAN'.
- Note:** A large text area for entering the note.
- Author:** A dropdown menu showing 'GARCIA,RYAN'.
- Long Term / Short Term:** Two radio buttons for selecting the note type.

Figure 8-12: Active fields for editing a note example

1. **Date Updated:** Select the date of the update. The default is today's date. To change the date, open the calendar and select a different date.

Note: The **Add Note** action requires that the **Date Updated** check box is selected.

2. **Person Who Updated:** Select the **individual** who updated the problem list. To select a different name, open the drop-down list to access the **Primary Provider** search window and select the appropriate **provider**.
3. **Note:** Enter the note text in this free-text field. This narrative typically includes information relevant to the treatment.
4. **Author:** Select the author of the note. To select a different provider, open the drop-down list to access the **Primary Provider** search window (see Figure 8-5).

5. **Long Term/Short Term:** Select either **Long Term** or **Short Term**, depending on the type of treatment described in the note.
6. When all fields in the lower group box are complete, click **Save**.
 - For **Add Note**, the system assigns a note number, displays the date added, and shows the note narrative in the **Problem List** grid.
 - For **Edit Note**, clicking **Save** updates the existing note in the **Problem List** grid. (To exit without saving changes, click **Cancel**).

8.1.1.5 Remove Note

1. In the **Problem List** grid, select the note you want to remove.
2. From the menu, select **Notes | Remove Note**.

The **Date Updated** and **Person Who Updated** fields become active (see Figure 8-9).

3. In the **Date Updated** field, select the **date** of the update. The default is today's date. To change the date, open the calendar and select another date.

Note: The **Remove Note** action requires that the **Date Updated** check box is selected.

4. In the **Person Who Updated** field, select the individual who performed the update. To select a different provider, open the drop-down list to access the **Primary Provider** search window (see Figure 8-10) and select the appropriate name.
5. After completing the required fields, click **Save**. (To cancel and exit without changes, click **Cancel**.) If **Save** was selected, the system proceeds to a confirmation prompt.
6. At the **Are You Sure?** confirmation message, click **Yes** to remove the note. The note will then be removed from the **Problem List** grid. (To abort the removal, click **No**.)

8.1.1.6 Detail Display

1. In the **Problem List** grid, select the problem for which you want to view additional details.
2. Click the **Detail Display** button.

The **BH Problem List Detail** pop-up window appears for the selected patient (Figure 8-13).

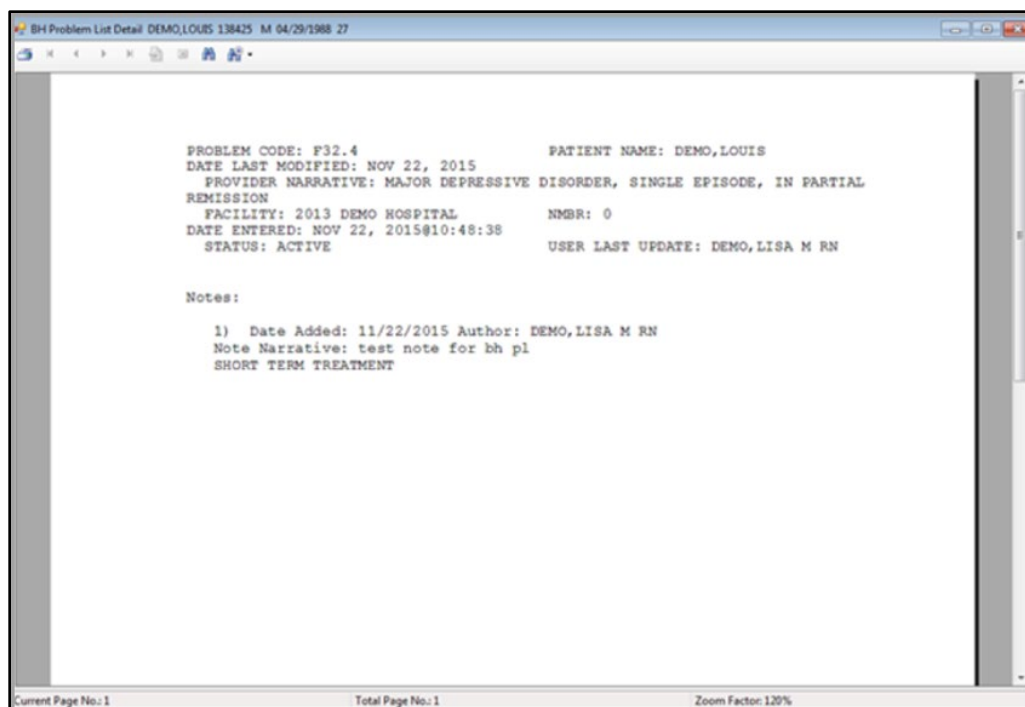


Figure 8-13: BH Problem List Detail for a selected demo patient example

For information about using the controls in the pop-up window, refer to Section 2.1.

8.1.1.7 No Active Problems

Use the **No Active Problems** button to indicate that the patient has no active **Behavioral Health (BH)** problems. The application automatically determines whether any active BH problems exist.

1. After clicking **No Active Problems** button, if the patient does have active problems, the following message appears:

There are ACTIVE Problems on this patient's BH problem list. You cannot use this action item.

2. Click **OK** to dismiss the message. The system returns to the **Behavioral Health Problem List** window.

If the patient does not have any active problems, the system displays the following:

Did the Provider indicate that the patient has No Active BH Problem?

3. Click **Yes** to continue. (To cancel the action, click **No**.)

When **Yes** is selected, the **Date Documented** and **Provider Who Documented** fields become active (Figure 8-14).

Date Documented ☒ Monday, January 30, 2012

Provider Who Documented DEMO, CASE M

Figure 8-14: Date Documented and Provider Who Documented fields example

4. In the **Date Documented** field, select the date the provider documented that the patient has no active BH problems. The default is today's date. To select a different date, use the calendar.

Note: The **No Active Problems** action requires that the **Date Documented** check box is selected.

5. In the **Provider Who Documented** field, select the provider who documented the information. To change the provider, open the drop-down list to access the **Primary Provider** search window (Figure 8-15) and select a different name.

Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Name: Type the primary provider's last name into the Search String field and click Search. The resulted names will populate the Primary Provider list box. Select a name and click OK to populate the field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a provider name in the Most Recently Selected list box and click OK to populate the field. Click Close to exit without making a selection.

Figure 8-15: Primary Provider search window example

6. After completing all required fields, click **Save**. (To exit without saving, click **Cancel**.)

After saving, status information is displayed below the action buttons. Examples include:

No Active BH Problem Documented on Dec 01, 2011 by DEMO,DOCTOR

BH Problem List Reviewed on Dec 01, 2011 by DEMO,DOCTOR

8.1.1.8 Problem List Reviewed

1. Click the **Problem List Reviewed** button to document that the provider has reviewed the patient's **BH problem list**.

The **Date Reviewed** and **Provider Who Reviewed** fields become active (see Figure 8 16).

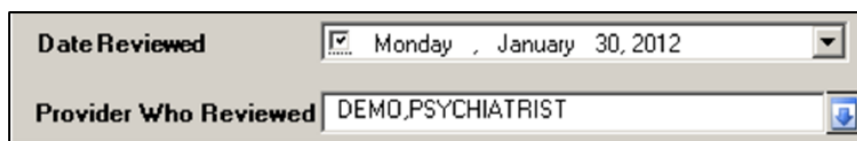
The image shows a software interface with two fields. The first field is labeled "Date Reviewed" and contains a date picker showing "Monday, January 30, 2012". The second field is labeled "Provider Who Reviewed" and contains the text "DEMO,PSYCHIATRIST".

Figure 8-16: Date Reviewed and Provider Who Reviewed fields example

2. In the **Date Reviewed** field, select the date the provider reviewed the problem list. The default value is today's date. To select a different date, open the calendar and select a new date.

Note: The **Problem List Reviewed** action requires that the **Date Reviewed** check box is selected.

3. In the **Person Who Reviewed** field, select the reviewing provider. To change the name, click the drop-down list to open the **Primary Provider** search window (Figure 8-17) and select the appropriate provider.

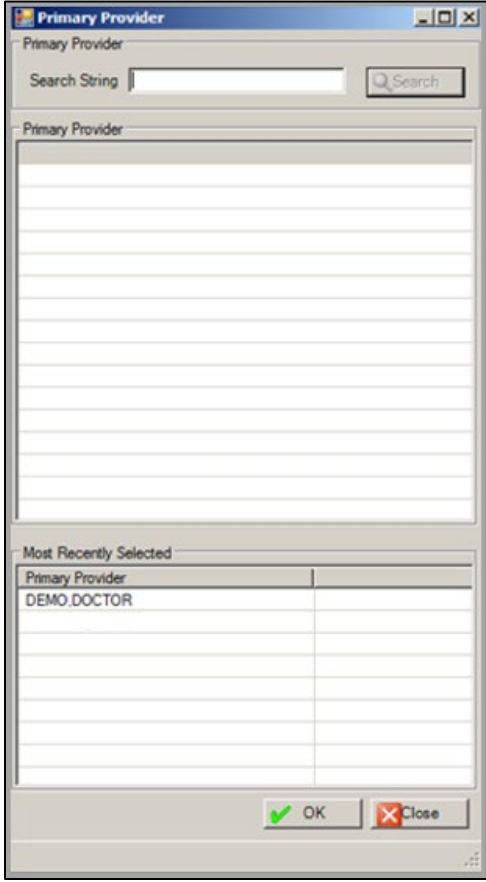
Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Name: Type the primary provider's last name into the Search String field and click Search. The resulted names will populate the Primary Provider list box. Select a name and click OK to populate the field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a provider name in the Most Recently Selected list box and click OK to populate the field. Click Close to exit without making a selection.

Figure 8-17: Primary Provider search window example

4. After completing all required fields, click **Save**. (To exit without saving, click **Cancel**.)

After saving, the system displays a confirmation message below the action buttons on the **Behavioral Health Problem List** window. For example:

BH Problem List Reviewed on December 1, 2011 by DEMO,DOCTOR

8.1.1.9 PCC Problem List Display

Click the **PCC Problem List Display** button to navigate to the **PCC Problem List** window (Figure 8-18).

8.1.1.10 PCC Problem List Window

1. After selecting the **PCC Problem List** option from the **Visit** window, the **PCC Problem List** window opens (Figure 8-18).

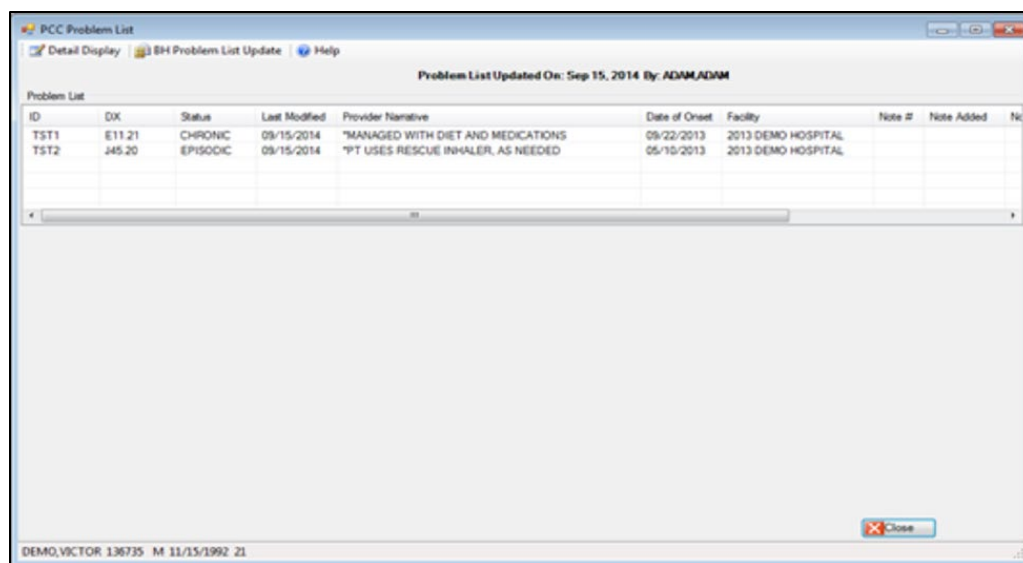


Figure 8-18: PCC Problem List window example

The patient's current PCC problems appear in the **Problem List** grid, along with any associated notes. Notes are displayed on the row directly beneath the corresponding problem.

2. Click **Close** to exit the window.
3. Click **Help** to access the online help for this window.

8.1.1.11 Detail Display

1. In the **Problem List** grid, select the problem for which you want to view detailed information.
2. Click the **Detail Display** button.

The **PCC Problem List Detail** window for the selected patient appears (Figure 8-19).

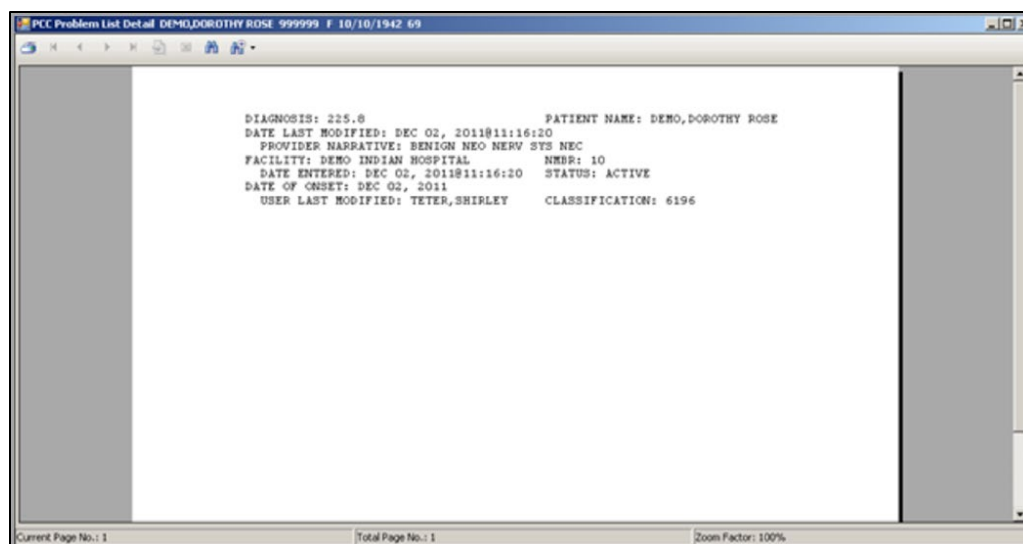


Figure 8-19: PCC Problem List detail display example

9.0 Treatment Plans

Use the **Treatment Plans** feature to add or update treatment plans in the **RPMS AMH Graphical User Interface (GUI)**.

9.1 Treatment Plan Window (GUI)

The RPMS AMH (GUI) application provides functionality for managing treatment plans for individual patients.

Figure 9-1 illustrates where the treatment plan functions appear within the **Clinical Activities** tree structure.

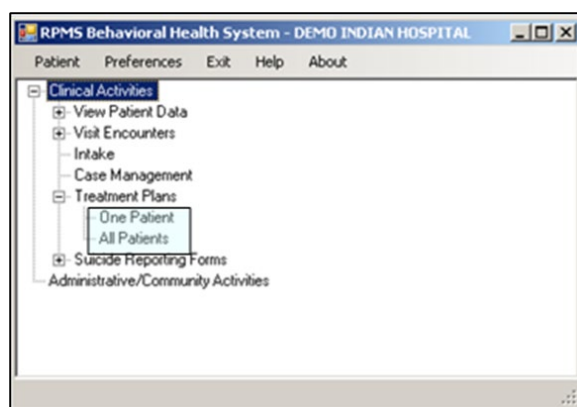


Figure 9-1: Location of Treatment Plans Functions on tree structure

You can access the **Treatment Plan** window in two ways:

- Using the **One Patient** option opens the **Treatment Plan** window for the current patient (Figure 9-2).

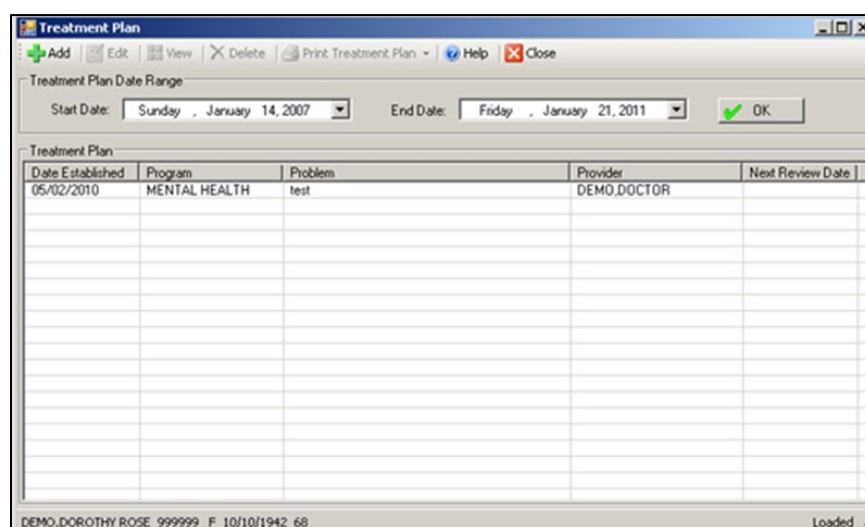


Figure 9-2: Treatment Plan group box for current patient example

- Using the **All Patients** option opens the **Treatment Plan** window for All Patients (Figure 9-3).

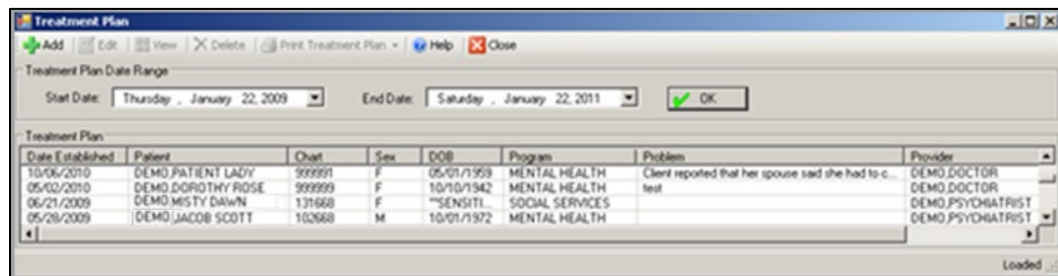


Figure 9-3: Treatment Plan window for all patients example

Table 9-1 provides a summary of features and functionality available in both windows.

Table 9-1: Treatment Plan window Features and Functionality

Feature	Functionality
Treatment Plan Window for One Patient	The default Start Date is one year prior to today. Changes to the Start Date persists in future sessions until modified again.
Treatment Plan Window for All Patients	The default Start Date is one year prior to today. Changes to the Start Date remain in effect until you exit the application; upon next login, the Start Date returns to one year prior.
Treatment Plan Group Box	Displays the treatment plan records within the selected Treatment Plan Date Range , sorted in date order.
Add Button	Establishes the patient context and opens the Treatment Plan – Add Treatment Plan window to create a new treatment plan record.
Edit Button	Opens the Treatment Plan—Edit Treatment Plan window to modify the selected treatment plan record.
View Button	Opens the Treatment Plan—View Treatment Plan window in view-only mode. (Double-clicking a record also opens this window.) The displayed fields are identical to those in the Add/Edit dialogs.
Help Button	Opens the online Help system for the Treatment Plan window.
Close Button	Closes the Treatment Plan window.
Delete Button	Deletes the selected treatment plan record. The application prompts for confirmation before deletion.
Print Treatment Plan Button	Prints the selected Treatment Plan record. Three print options are available: 1. Treatment Plan Only 2. Review Data Only 3. Treatment Plan and Review Data. Highlight a record, select a print option, and the application determines which options are currently available.

Additional behavior for the **Print Treatment Plan** button:

If you select **Review Data Only** or **Treatment Plan and Review Data**, and review records exist, the application displays the **Treatment Plan Reviews** dialog (Figure 9-4).

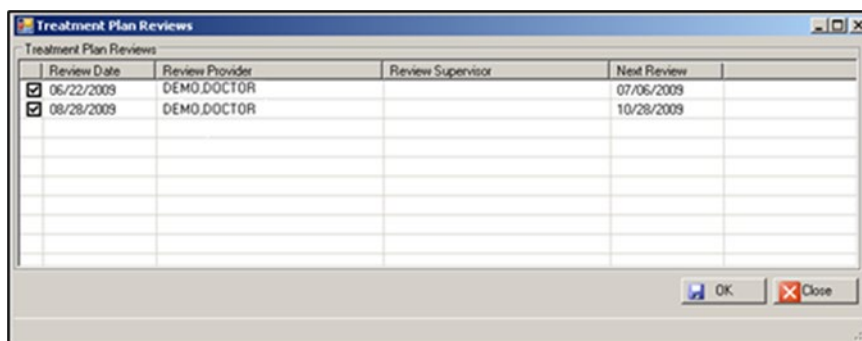


Figure 9-4: Treatment Plan Reviews dialog example

Select the review records to include and click **OK**. To exit the print process without printing, click **Close**.

The first page of the printed **Treatment Plan** appears similar to the example in Figure 9-5.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
*
* TREATMENT PLAN                                Printed: Dec 27, 2013@12:17:21
* Name: DEMO,DUCK                                Page 1
* DEMO INDIAN HOSPITAL    DOB: 2/5/75    Sex: M    Chart #: WW36219
*
*-----*
Date Established:      Dec 27, 2013
Admit Date:
Anticipated Completion Date:
Date Closed:
Provider:              DEMO,SHIRLEY
Supervisor:            <not recorded>
Date Concurred:
Review Date:           Dec 31, 2013

DIAGNOSIS

PROBLEM LIST

TREATMENT PLAN (Problems/Goals/Objectives/Methods)

____
Client's Signature      Designated Provider's Signature

____
Supervisor's Signature  Physician's Signature

____
Other                  Other

____
Other                  Other
  
```

Current Page No.: 1 Total Page No.: 2 Zoom Factor: 100%

Figure 9-5: Treatment Plan printout example

9.2 Add/Edit Treatment Plan Record (GUI)

1. Click **Add** on the **Treatment Plan** window to open the **Treatment Plan–Add Treatment Plan** dialog.
2. Click **Edit** on the **Treatment Plan** window to display the **Treatment Plan–Edit Treatment Plan** dialog.

Note: Both dialogs contain the same fields.

Figure 9-6 shows the **Add Treatment Plan** window. Table 9-2 describes the **Add Treatment Plan** window's buttons and functionality.

Figure 9-6: Add Treatment Plan window example

Table 9-2: Add Treatment Plan Window Buttons and Functionality

Button	Functionality
Help Button	Opens the online help system for this window.
Save Button	Saves the information in the window. When saved, the system adds or updates the treatment plan record on the Treatment Plan window.
Close Button	Displays a Continue? dialog with the message: <i>Unsaved Data Will Be Lost, Continue?</i> Click Yes to close the window without saving. Click No to return to the Add/Edit Treatment Plan window.

9.2.1 Treatment Plan Information Group Box

Use the **Treatment Plan Information** group box (Figure 9-7) to manage the core details associated with a treatment plan.

Figure 9-7: Treatment Plan Information group box example

Fields shown in **bold** are required: **Date Established**, **Program**, and **Designated Provider**.

1. **Date Established:** Select the **date** on which the treatment plan was created. For a new record, the default is the current date. Click the drop-down list to open the calendar and select a different date.
2. **Next Review Date:** Select the **date** the treatment plan is scheduled for review. Click the drop-down list to open the calendar.

Note: This field becomes inactive if **Date Completed/Closed** has been populated,.

3. **Program:** Select the program associated with the treatment plan. Click the drop-down list to select one of the following options:
 - **Mental Health**
 - **Social Services**
 - **Other**
 - **Chemical Dependency**
4. **Date Completed/Closed:** Select the date the treatment plan was completed or closed. Click the drop-down list to open the calendar.
5. **Case Admit Date:** Select the date the patient was admitted for services. Click the drop-down list to open the calendar.
6. **Anticipated Completion Date:** Select the projected completion date for the treatment plan. Click the drop-down list to open the calendar.
7. **Designated Provider:** Select the name of the designated provider responsible for the treatment plan. Click the drop-down list to open the **Designated Provider** Search window (Figure 9-8).

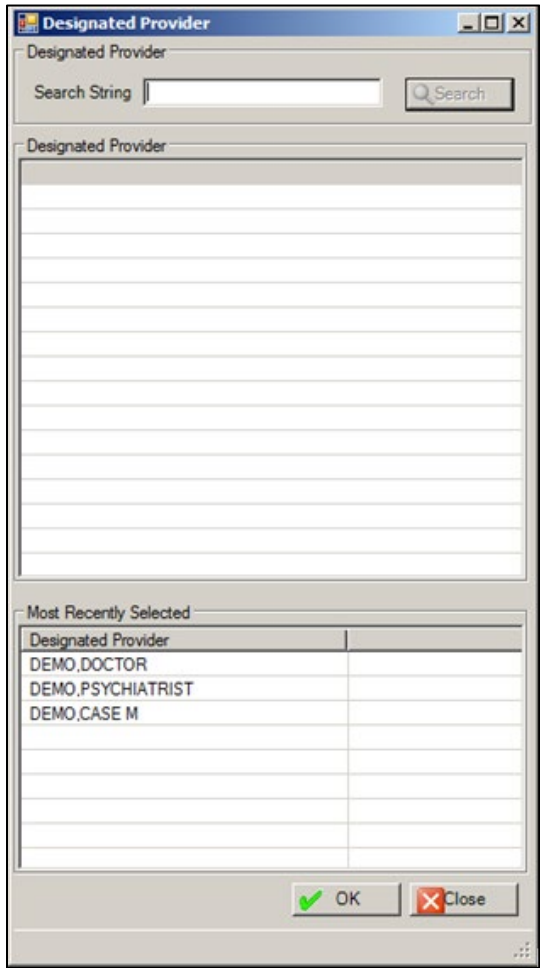
Screen Capture	What to Do
	Use the Designated Provider search window in one of the following ways: 1. Search by Name: Type the designated provider's last name in the Search String field and click Search. Matching records will appear in the Designated Provider list box. Select a record and click OK to populate the field. (Click Close to exit without making a selection.) 2. Search by Most Recently Selected: Choose a name from the Most Recently Selected list box and click OK to populate the field. (Click Close to exit without making a selection.)

Figure 9-8: Designated Provider search window example

8. **Concurring Supervisor:** Select the name of the concurring supervisor for the treatment plan. Click the drop-down list to open the **Concurring Supervisor** search window (Figure 9-9).

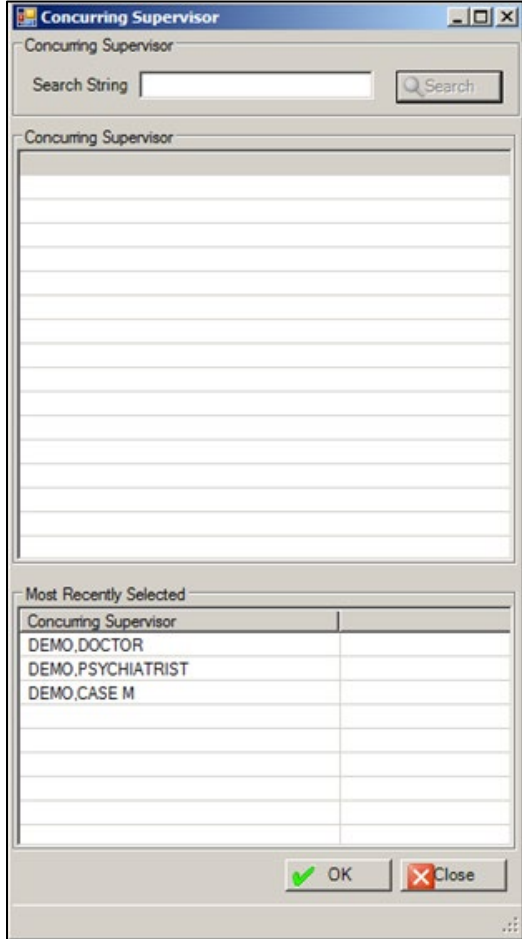
Screen Capture	What to Do
	Use the Concurring Supervisor search window in one of the following ways: 1. Search by Name: Type the concurring supervisor's last name in the Search String field and click Search. Matching records will appear in the Concurring Supervisor list box. Select a record and click OK to populate the field. (Click Close to exit without making a selection.) 2. Search from Most Recently Selected: Choose a name from the Most Recently Selected list box and click OK to populate the field. (Click Close to exit without making a selection.)

Figure 9-9: Concurring Supervisor search window example

9. **Date Concurred:** Select the **date** on which the concurring supervisor formally approved the treatment plan. This date cannot precede the **Date Established**. Click the drop-down list to open the calendar and adjust the date as needed.

9.2.2 Diagnosis Tab

Use the **Diagnosis** tab (Figure 9-10) to enter diagnosis information related to the treatment plan. This section includes:

- **Problem List**—The narrative description of the patient's identified problems.
- **Diagnosis**—The narrative description of the diagnosis associated with the treatment plan.

The screenshot shows a software window with three tabs: 'Diagnosis', 'Plan', and 'Plan Review'. The 'Diagnosis' tab is active. Below the tabs, there is a 'Problem List' section and a large, empty text area labeled 'Diagnosis' for entering clinical information.

Figure 9-10: Diagnosis tab example

Both fields are free-text fields, allowing users to enter detailed clinical information as needed.

9.2.3 Plan Tab

Use the **Plan** tab (Figure 9-11) to document the components of the treatment plan. This includes adding plan participants and detailing the plan's **Problems, Goals, Objectives, and Methods**.

The screenshot shows a software window with three tabs: 'Diagnosis', 'Plan', and 'Plan Review'. The 'Plan' tab is active. It contains a 'Participants' section with a table that has two columns: 'Participant' and 'Relationship'. To the right of the table are three buttons: 'Add' (with a green plus icon), 'Edit' (with a pencil icon), and 'Delete' (with a red X icon). Below the participants section is a large, empty text area labeled 'Problems/Goals/Objectives/Methods'.

Figure 9-11: Plan tab example

9.2.3.1 Participants Group Box

Use the **Participants** group box to manage the individuals involved in the treatment plan.

Delete Button

Use the **Delete** button to remove an existing participant record.

1. Select the **participant record** you want to delete.
2. Click **Delete**.
3. When prompted, confirm the deletion by entering **Y** (Yes) or **N** (No).

Add/Edit Button

The **Add** and **Edit** buttons use the same entry fields.

- Click **Add** to create a new participant record.
- Or
- Select an existing record and click **Edit** to update it.

Treatment Plan Participants Dialog

Clicking **Add** or **Edit** opens the **Treatment Plan Participants** dialog (Figure 9-12).

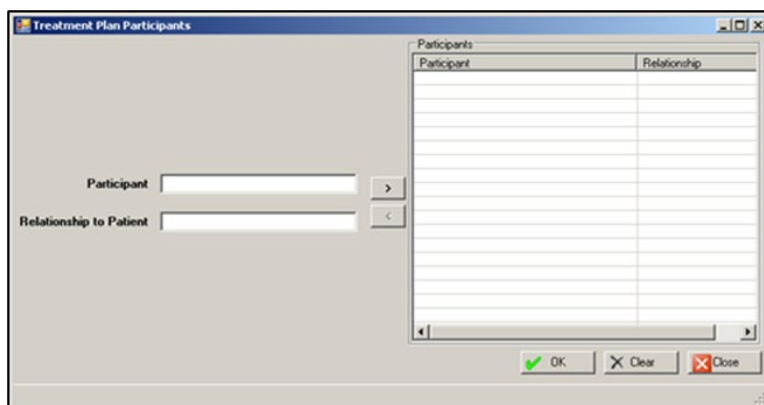


Figure 9-12: Treatment Plan Participants dialog example

1. **Participant:** Enter the **participant's name**. This is a free-text field.
2. **Relationship to Patient:** Enter the **participant's relationship** to the patient. This is a free-text field.
3. After completing the **Participant** and **Relationship to Patient** fields, select one of the following actions:
 - Click the **right-arrow** button to add the entry to the **Participants** list box. Multiple entries may be added.
 - Click **Clear** to remove the information entered in the fields.
4. To remove a **highlighted entry** from the **Participants** list box, click the **left-arrow** button.

5. When finished:

- If you access the dialog using **Add**, click **OK** to save the new entries. The items in the **Participants** list box will populate the **Participants** group box on the **Plan Review** tab of the add/edit treatment plan window. Otherwise, click **Close** to exit without saving.
- If you accessed the dialog using **Edit**, click **OK** to save your changes. The updated values replace the existing participant information.

9.2.3.2 Problems/Goals/Objectives/Methods

Use this field to document the problems, goals, objective, and methods associated with the treatment plan. This is a free-text field, allowing you to enter detailed narrative information as needed.

9.2.4 Plan Review Tab

Use the **Plan Review** tab to document the review of the treatment plan. When a record is selected in the **plan review** grid, you may do the following:

- Complete the **plan review** fields located below the grid.
- Update the participants for the plan review in the **Participants** group box.
- Enter the **Progress Summary** for the review in the provided free-text field.

After completing all applicable fields and group box entries, click **OK** to save the plan review record. To exit without saving, click **Cancel**.

9.2.4.1 Review Group Box

Use the **Review** group box to document the treatment plan's review information, including the **Review Date**, **Review Provider**, **Review Supervisor**, and **Next Review Date**.

Delete Button

Use the **Delete** button to delete a selected plan review record.

1. Select the **plan review record** you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, type **Y** (Yes) to delete the record. Type **N** (No) to cancel the deletion.

Edit Button

Use the **Edit** button to modify an existing plan review record.

1. Select the plan review record you want to change.

2. Click **Edit**.
3. The fields associated with the selected review become active and editable. These fields are described under the **Add** button instructions below.

Add Button

Use the **Add** button to create a new plan review record. To complete the process, populate the fields below the review grid, update the **Participants** group box, and complete the **Progress Summary** field.

Fields shown in **bold** are required.

1. Click **Add**. The fields below the review grid become active.
2. **Review Date**: Select the date of the review. For a new record, the default is the current date. Click the drop-down list to open the calendar and select another date.
3. **Next Review Date**: Select the date of the next scheduled review. For a new record, the default is the current date. Click the drop-down list to open the calendar.
4. **Note**: Changing the **Next Review Date** here will also be updated the **Next Review Date** on the **Treatment Plan Information** group box.
5. **Review Provider**: Select the name of the provider conducting the review. The default is the current user. Click the drop-down list to open the **Reviewing Provider** search window (Figure 9-13).

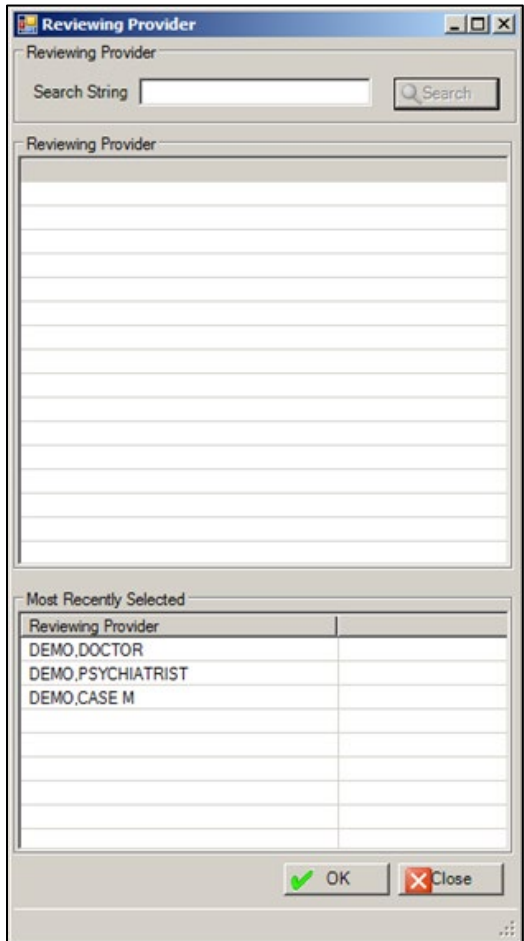
Screen Capture	What to Do
	Use the Reviewing Provider search window in one of the following ways: 1. Search by Name: Type the reviewing provider's last name in the Search String field, then click Search. Matching results will appear in the Reviewing Provider list box. Select a record and click OK to populate the Review Provider field. (Click Close to exit without making a selection.) 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK to populate the Review Provider field. (Click Close to exit without making a selection.)

Figure 9-13: Reviewing Provider search window example

6. **Review Supervisor:** Select the supervisor responsible for reviewing the treatment plan. Click the drop-down list to open the **Reviewing Supervisor** search window (Figure 9-14).

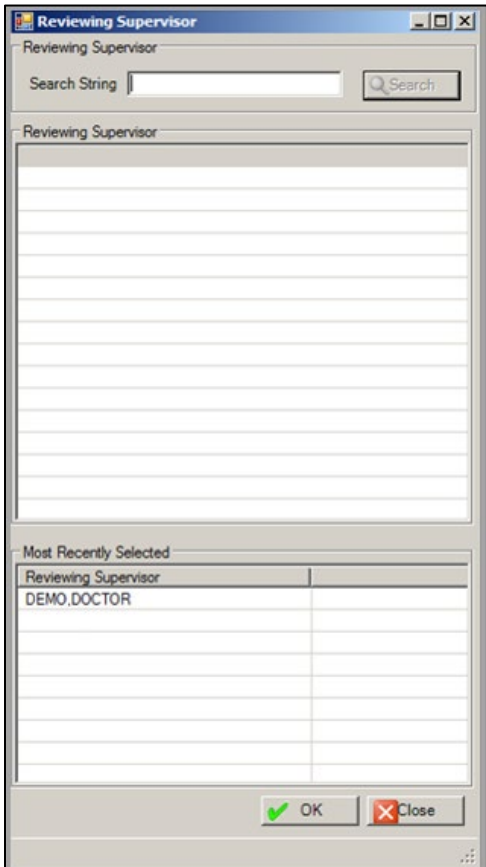
Screen Capture	What to Do
	Use the Reviewing Supervisor search window in one of the following ways: 1. Search by Name: Type the reviewing supervisor's last name in the Search String field, then click Search. Matching results appear in the Reviewing Supervisor list box. Select a record and click OK to populate the Review Supervisor field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a name in the Most Recently Selected list box and click OK to populate the Review Supervisor field. Click Close to exit without making a selection.

Figure 9-14: Reviewing Supervisor search window example

9.2.4.2 Participants Group Box (Plan Review)

Use the **Participants** group box to view and manage the participants associated with the plan review.

Add/Edit Button

The **Add** and **Edit** buttons use the same dialogs and fields.

- Click **Add** to open the **Treatment Plan Participants** dialog.
- Or
- Select an existing participant record and click **Edit** to open the same dialog (Figure 9-15).

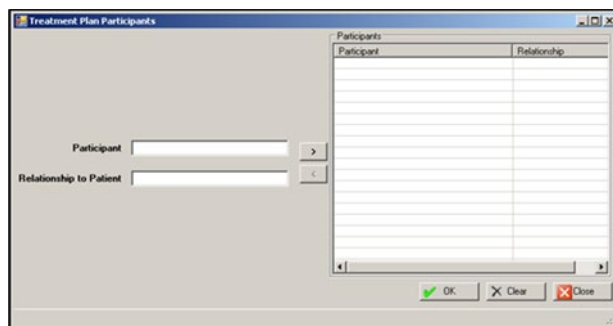


Figure 9-15: Treatment Plan Participants dialog example

1. **Participant:** Enter the participant's name. This is a free-text field.
2. **Relationship to Patient:** Enter the participant's relationship to the patient. This is a free-text field.
3. After completing the **Participant** and **Relationship to Patient** fields, select one of the following:
 - Click the **right-arrow** button to add the entry to the **Participants** list box. Multiple entries may be added.
 - Click **Clear** to remove the information entered in the fields.
4. To remove a selected record in the **Participants** list box, click the **left-arrow** button.
5. When finished:
 - If you accessed the dialog using **Add**, click **OK** to save the entries. The items in the **Participants** list box will populate the **Participants** group box on the **Plan Review** tab of the **Add/Edit Treatment Plan** window. Click **Close** to exit without saving.
 - If you accessed the dialog using **Edit**, click **OK** to save your changes. The updated values will replace the existing participant information.

Delete Button

Use the **Delete** button to remove a selected participant record.

1. Select the **participant record** you want to delete.
2. Click **Delete**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to delete the record, or click **No** to cancel the action.

9.2.4.3 Progress Summary

Use the **Progress Summary** field to document the progress of the plan review. This is a free-text field, allowing entry of detailed narrative information regarding the review outcomes and observations.

10.0 Suicide Forms

Users can manage suicide forms within the RPMS AMH (GUI) application.

Note: All fields on the suicide form are mandatory. However, this requirement is not enforced by the system. If all fields are completed, the suicide form is marked Complete. If any field is left blank, the form is marked Incomplete, although it can still be saved.

10.1 Suicide Form Window (GUI)

Suicide form options are located under the **Suicide Reporting Forms** category in the **RPMS AMH (GUI)** tree structure (Figure 10-1).

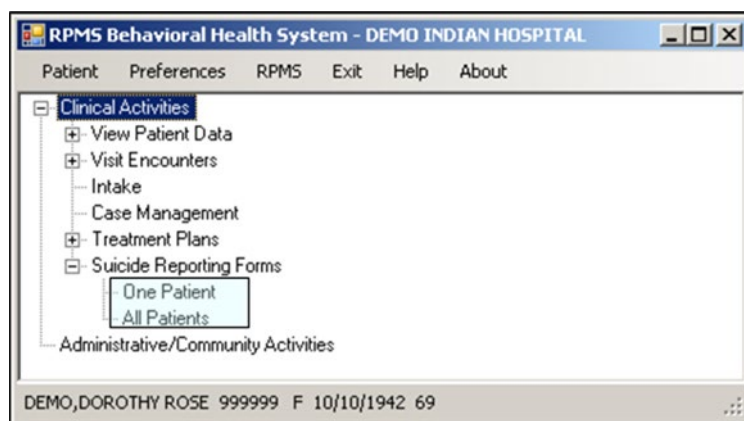


Figure 10-1: Location of Suicide Forms on the Tree Structure example

One method to access the **Suicide Form** window is to select the **One Patient** option.

Note: You may also open this window by clicking the **Suicide Form** tab on the **Visit Data Entry–Add/Edit** window.

If you access the **Suicide Form** for one patient window (Figure 10-2) and no patient has been selected, the system will prompt you to select one.

Date	Local Case #	Provider	Suicidal Behavior
11/23/2010		DEMO DOCTOR	
09/25/2010		DEMO CASE M	
09/30/2009			ATTEMPT

Figure 10-2: Suicide Form Window for One Patient example

You can also access the **Suicide Form** window by selecting the **All Patients** option (Figure 10-3). The system will then display the Suicide Form window for All Patients.

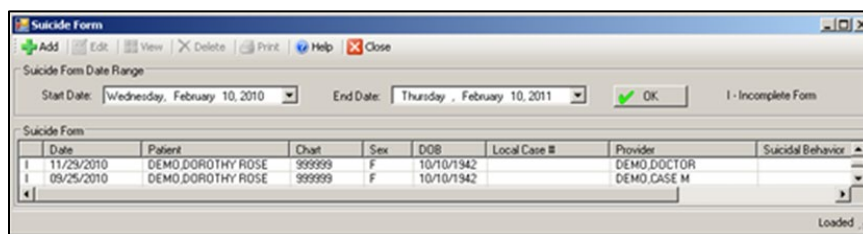


Figure 10-3: Suicide Form window for All Patients example

Both **Suicide Form** windows function in the same manner.

Table 10-1 explains the **Suicide Form** window features and functionality.

Table 10-1: Suicide Form window Features and Functionality

Feature	Functionality
Suicide Form Window for One Patient	The default Start Date is one year prior. If you change the Start Date for the Suicide Form window for One Patient, the new date persists across future sessions for the following areas: • Visit window for One Patient • Suicide Form window for One Patient • Treatment Plan window for One Patient
Suicide Form Window for All Patients	The default Start Date is one year prior. If you change the Start Date, the new date remains in effect only until you exit the application. The Start Date resets to one year prior at the next login. Changes to the Start Date for All Patients also affects the Visit , Suicide Form , and Treatment Plan windows for All Patients.
Suicide Form Group Box	Displays suicide form records within the selected date range, listed chronologically. An "I" in the first column indicates an Incomplete suicide form.
Add Button	Use this button to create a new suicide form record. First, ensure a patient is selected. Clicking Add opens the Visit Data Entry–Add Suicide Entry dialog.
Edit Button	Opens the Visit Data Entry–Edit Suicide Entry dialog to modify the highlighted suicide form for the current patient. This button is inactive if the patient has no previous visits.
View Button	Opens the Suicide Form Data Entry–View Suicide Form window, either by clicking View or by double-click a form in the list. This read-only window displays same fields as the add/edit suicide form window.
Delete Button	Removes the highlighted suicide form. When the Are You Sure confirmation message appears, click Yes to delete the record or No to cancel.

Feature	Functionality
Help Button	Opens the online help system for the Suicide Forms window.
Close Button	Closes the Suicide Form window.
Print Button	Prints the highlighted suicide form. After clicking Print , the first page of the Suicide Reporting Form pop-up window appears.

Figure 10-4 is an example of a **Suicide Reporting Form**.

Figure 10-4: Suicide Reporting Form example

This window displays the following:

- Data entered on the suicide form.
- Patient data (e.g. sex, date of birth, age).
- Edit history, which includes **Date and time** of last modification, **User** who made the update, **List** of all updates with timestamp and modifying user.

10.2 Add/Edit Suicide Form (GUI)

- Click **Add** to create a new suicide form record. The **Suicide Form Data Entry–Add Suicide Form** window will open.

Or

- Select an existing record and click **Edit**. The **Suicide Form Data Entry–Edit Suicide Form** window will open.

The fields described below appear on both the **Add** and **Edit** suicide form windows (Figure 10-5).

Figure 10-5: Suicide Form Data Entry--Add Suicide Form window example

All fields, except **Local Case Number** and **Narrative**, are required to save the form. If you attempt to save without completing required fields, the system displays the **Required Information** message (Figure 10-6).

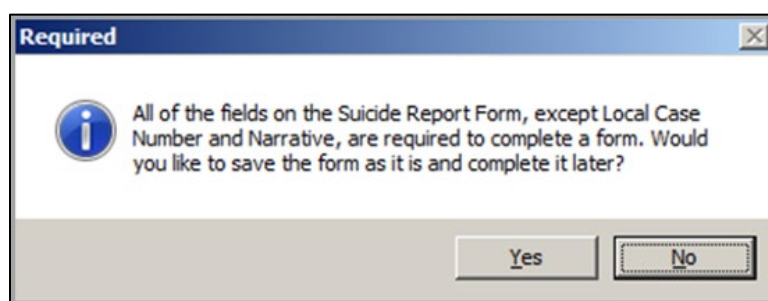


Figure 10-6: Required Information message example

- Click **Yes** to **save** the form in its current (incomplete) state and return to the **Suicide Form** window.
- Click **No** to **cancel** the save and remain on the data entry form.

Table 10-2 describes the **Suicide Form** window buttons and functionality.

Table 10-2: Suicide Form buttons and functionality

Button	Functionality
Save	Saves the data entered on the form.
Help	Opens the online help system for the Suicide Form window.
Close	Opens the Continue? dialog, which states: <i>Unsaved Data Will Be Lost, Continue?</i> Click Yes to exit without saving. Click No to return to the Suicide Form and continue working.

10.2.1 Suicide Form Fields

Required fields on the Suicide Form (Figure 10-7) are in **bold**.

Figure 10-7: Fields on Suicide Form example

1. **Local Case Number:** Enter the local case number or health record number, if applicable (up to **20** characters). This is a free-text field.
2. **Provider:** Select the provider completing the form. For new records, the application automatically populates this field with the currently logged-in provider. To change the provider, click the drop-down list to open the **Provider** search window (Figure 10-8).

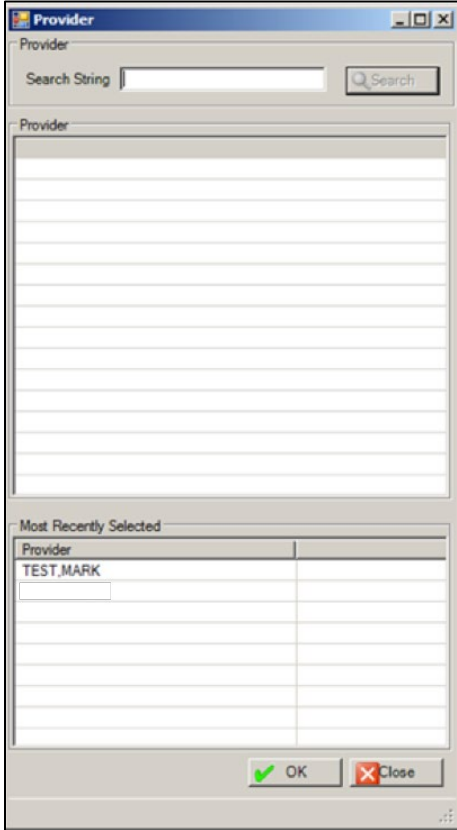
Screen Capture	What to Do
	Use the Provider search window in one of the following ways: 1. Search by Name: Type the provider's last name in the Search String field and click Search. The retrieved names will appear in the Provider list box. Select a record and click OK to populate the Provider field. Otherwise, click Close. 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK. Otherwise, click Close.

Figure 10-8: Provider search window example

3. **Date of Act:** Select the date on which the suicidal act occurred. For new records, the current date is used by default. Click the drop-down list to open a **calendar** and select another **date**.
4. **Community Where Act Occurred:** Select the community where the act occurred. Click the drop-down list to open the **Community** search window (Figure 10-9).

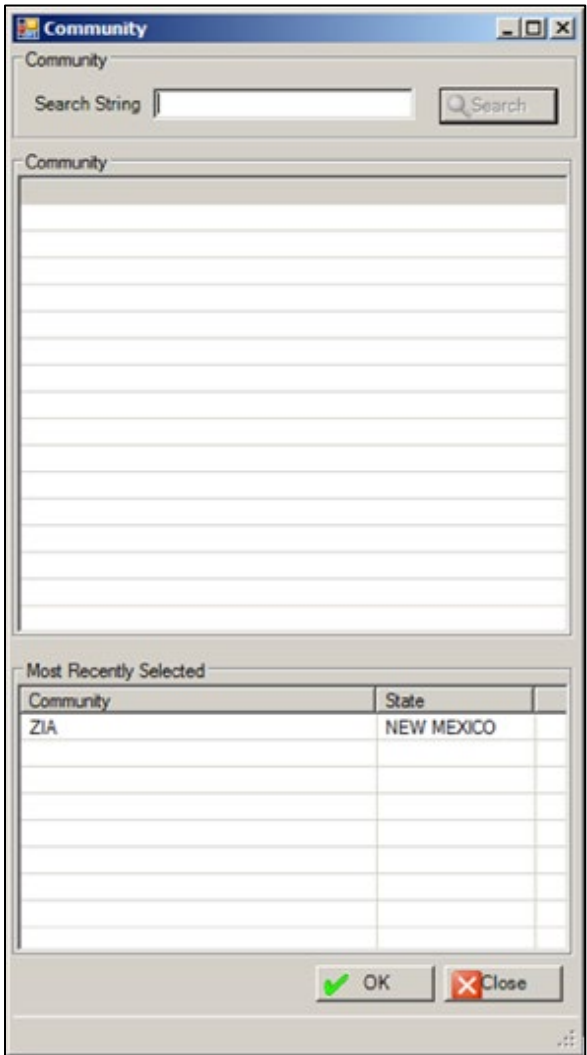
Screen Capture	What to Do
	Use the Community search window in one of the following ways: 1. Search by Community Name: Type the community name in the Search String field and click Search. The resulted names will populate the Community list box. Select a record and click OK to populate the Community Where Act Occurred field. Click Close to exit without making a selection. 2. Search by Most Recently Selected: Select a name from the Most Recently Selected list box and click OK. Click Close to exit without making a selection.

Figure 10-9: Community search window example

5. **Relationship Status:** Select the patient's **relationship status** from one of the following options:
 - **Single**
 - **Married**
 - **Divorced/Separated**
 - **Widowed**
 - **Cohabiting/Common Law**
 - **Same Sex Partnership**
 - **Unknown**

6. **Education:** Select the patient's highest level of education from one of the following options:
 - **Less than 12 years**
 - **High School Graduate/GED**
 - **Some College/Technical School**
 - **Collage Graduate**
 - **Post-Graduate**
 - **Unknown**
7. **Employment Status:** Select the patient's employment status from one of the following options:
 - **PART TIME**
 - **FULL TIME**
 - **UNEMPLOYED**
 - **RETIRED**
 - **STUDENT**
 - **STUDENT AND EMPLOYED**
 - **UNKNOWN**
8. **If less than 12 years, highest grade completed:** Enter the highest grade completed by the patient (0–11). This field becomes active only when **Education** is set to **Less than 12 years**.
9. **Suicidal Behavior:** Select the type of suicidal activity from one of the following options:
 - **IDEATION W/ PLAN AND INTENT**
 - **ATTEMPT**
 - **COMPLETED SUICIDE**
 - **ATT'D SUICIDE W/ATT'D HOMICIDE**
 - **ATT'D SUICIDE W/COMPL HOMICIDE**
 - **COMPL SUICIDE W/ATT'D HOMICIDE**
 - **COMPL SUICIDE W/COMP'L HOMICIDE**
10. **Location of Act:** Select where the suicidal act did occur from one of the following options:
 - **HOME OR VICINITY**

- **SCHOOL**
- **WORK**
- **JAIL/PRISON/DETENTION**
- **TREATMENT FACILITY**
- **MEDICAL FACILITY**
- **OTHER**
- **UNKNOWN**

11. **Previous Attempts:** Select the number of previous suicide attempts from one of the following options:

- **0**
- **1**
- **2**
- **3 OR MORE**
- **UNKNOWN**

12. **Other:** If selected in **Location of Act**, enter a description of the location (up to **80** characters). This is a free-text field.

13. **Disposition:** Select the disposition of the suicide act. Click the drop-down list to open the **Disposition** search window (Figure 10-10).

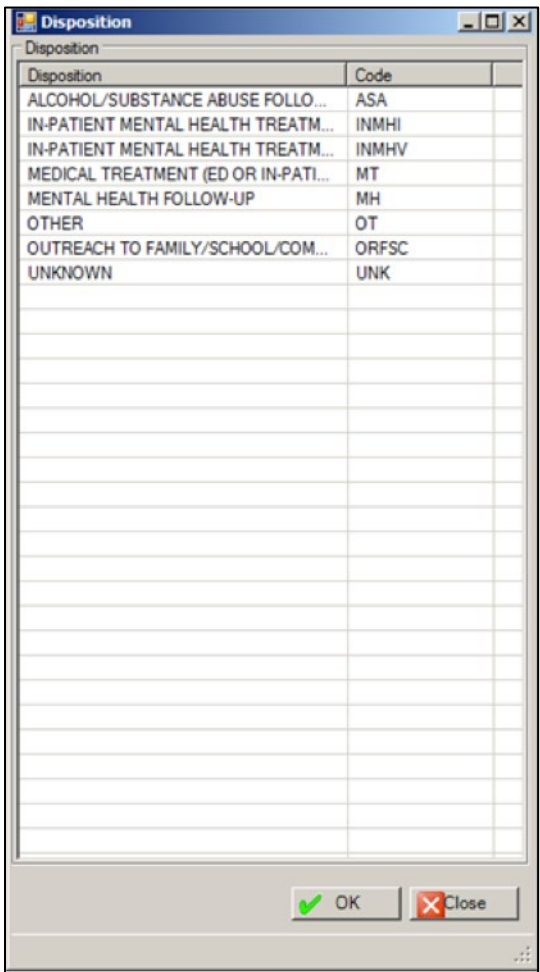
Screen Capture	What to Do
	Use the Disposition search window as follows: Search by Disposition Name: Select a Disposition option and click OK. The selected option will populate the Disposition field. - If Other is selected, an additional free-text field becomes active. Enter a description of the disposition (up to 80 characters).

Figure 10-10: Disposition search window example

10.2.2 Method Tab

Use the **Method** tab (Figure 10-11) to document the method used in the suicide act and, when applicable, to record any substances involved in overdose incidents.

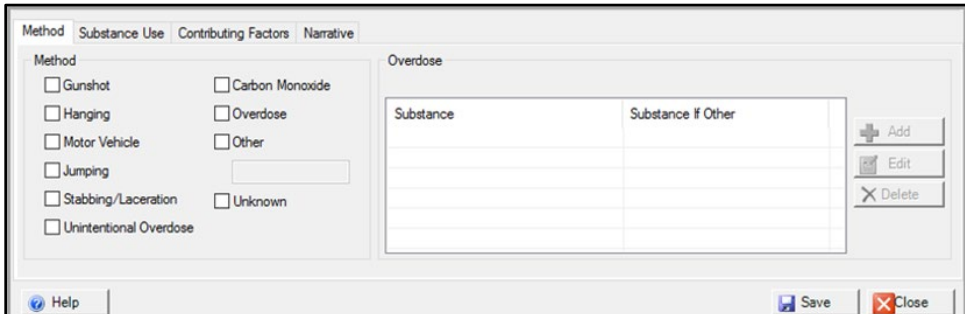


Figure 10-11: Method tab example

10.2.2.1 Method Group Box

1. Select one or more methods. Choose all check boxes that apply to the method used in the suicide act. At least one method is required.
2. If **Overdose** is selected: Selecting the **Overdose** check box opens the **Substance Multiple** search window (Figure 10-12), where you can specify one or more categories involved in the overdose event.

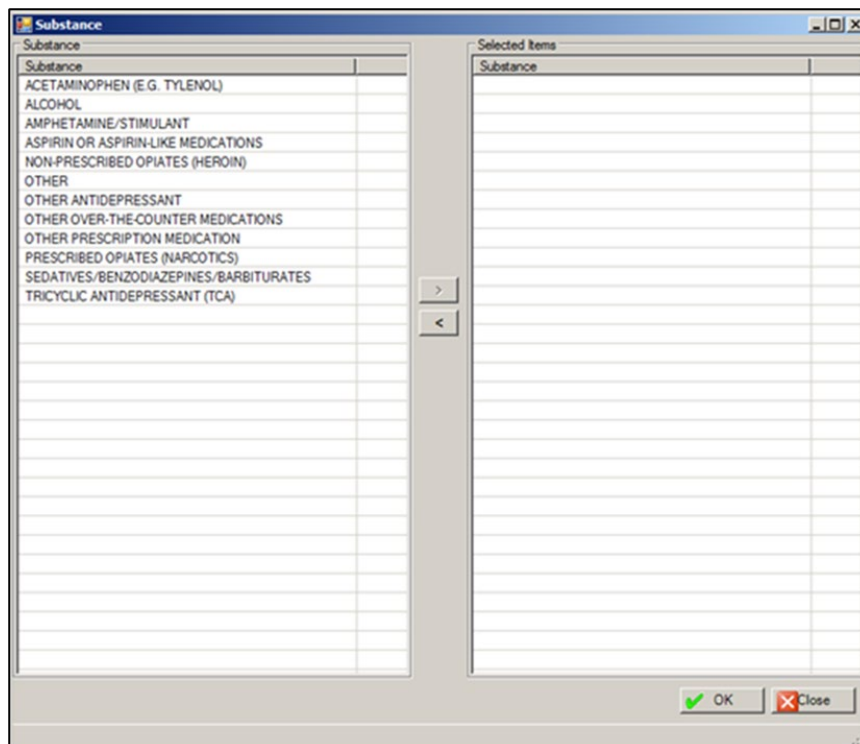


Figure 10-12: Substance multiple search window

Use the selection window as follows:

- a. Select a substance category in the **Substance** list box.
 - b. Click the **right-arrow** button to add the selection to the **Selected Item Substance** list box.
 - c. To remove an item, highlight it in the **Selected Item Substance** list box and click the **left-arrow** button.
 - d. When the list is complete, click **OK** to populate the **Overdose** group box with the selected substances.
3. If substance containing **OTHER** is selected: After clicking **OK**, the **Other** dialog appears (Figure 10-13).
 - Enter a description of the **Other** substance in the free-text field (up to **80** characters).

- Click **OK** to add the description to the **Substances If the Other** field in the **Overdose** group box.

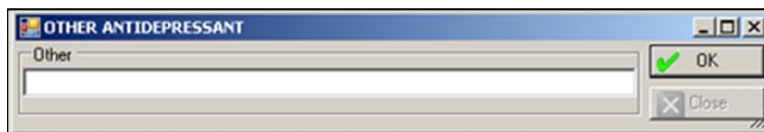


Figure 10-13: Other dialog example

- If the **Other** method check box is selected: The free-text field beneath the check box becomes active. Enter the description of the method used (up to **80** characters).
- If **Overdose** is selected from the **Method** options, the **Overdose** group box becomes available, and the **Substance Multiple** search window displays (Figure 10-14).

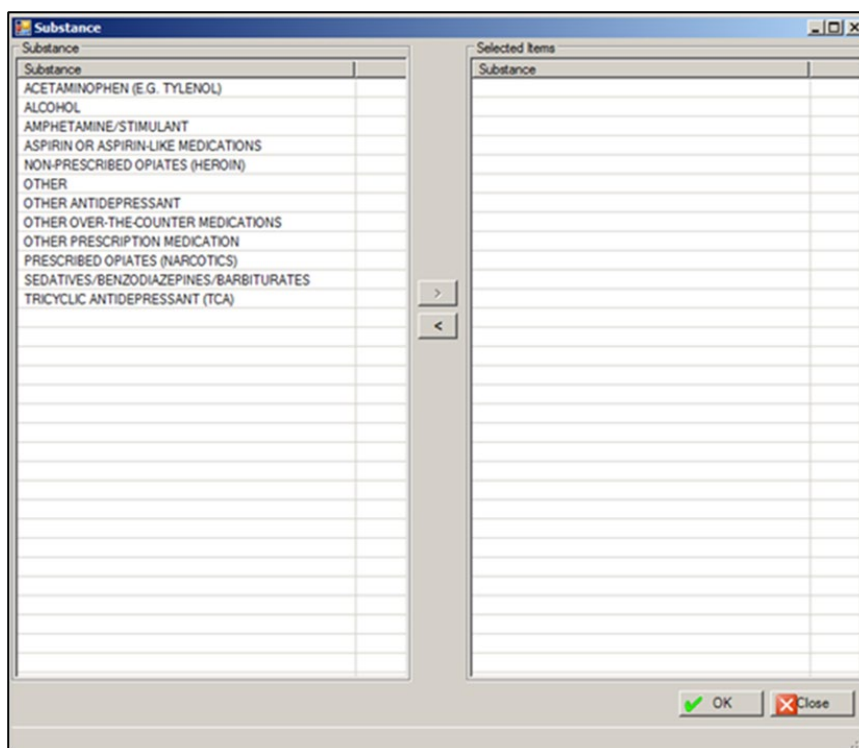


Figure 10-14: Substance multiple search window example

Use this window in the same manner described above:

- Select a substance from the **Substance** list box.
- Use the **right-arrow** button to add it to the **Selected Item Substance** list box.
- Use the **left-arrow** button to remove items.

7. Click **OK** to populate the **Overdose** list box or click **Cancel** to exit without saving selections.

10.2.2.2 Overdose Group Box

The **Overdose** group box displays the categories of substances involved in an overdose-related suicide act. After this group box is populated, the **Add**, **Edit**, and **Delete** buttons become active, allowing you to manage the listed substances.

10.2.2.2.1 Delete Button

Use the **Delete** button to remove a substance from the **Overdose** list.

1. Select the **substance** you want to delete.
2. Click **Delete**.
3. When the **Are you sure?** confirmation message appears, click **Yes** to delete the record. (Otherwise, click **No**.)

10.2.2.2.2 Edit Button

Use the **Edit** button to modify a substance entry, including the **Substance If Other** value.

1. Highlight the **record** that contains data in the **Substance If Other** column.
2. Click **Edit**. The **Other Antidepressant** dialog appears (Figure 10-15).

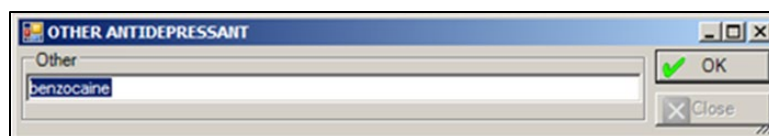


Figure 10-15: Other Antidepressant dialog example

- Update the text in the **Other** field.
 - Click **OK** to save the changes.
3. Click **OK** to close the dialog.

10.2.2.2.3 Add Button

Use the **Add** button to add one or more substances to the **Overdose** group box.

1. Click **Add**. The **Substance Multiple** search window opens (Figure 10-16).

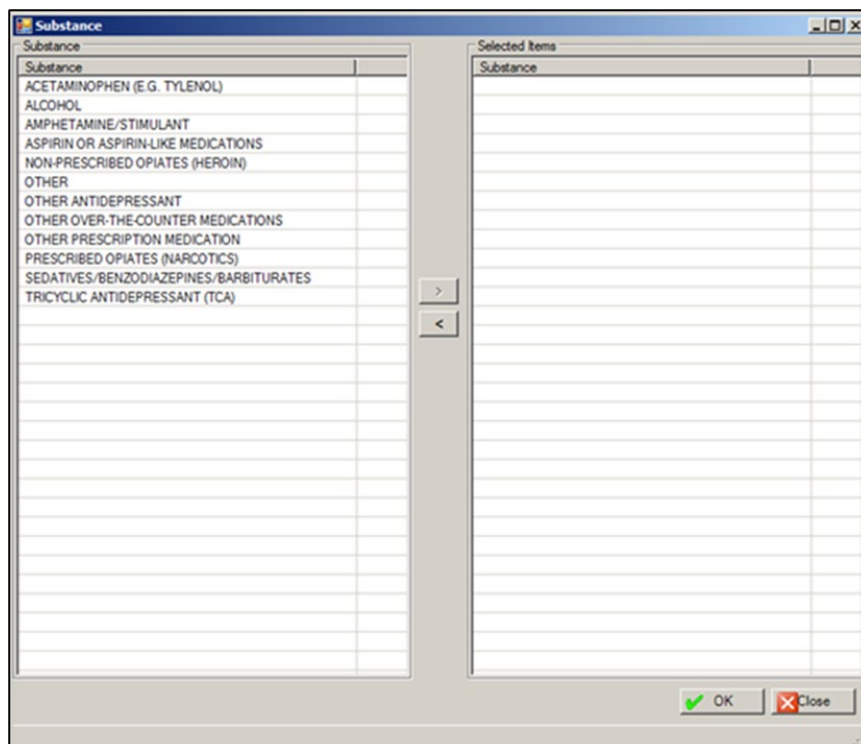


Figure 10-16: Substance multiple search window example

Use this search window as follows:

- Select one or more substances in the **Substance** list box.
 - Click the **right-arrow** button to move the selected items to the **Selected Item Substance** list box.
 - To remove an item, select it in the **Selected Item Substance** list box and click the **left-arrow** button.
 - When the **Selected Item Substance** list is complete, click **OK** to populate the **Overdose** group box. (Otherwise, click **Close**.)
2. If you select a substance that includes **Other** in its title, the **Other** dialog displays (Figure 10-17).

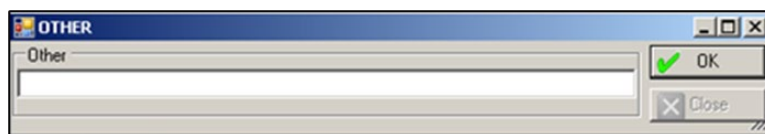


Figure 10-17: Other dialog example

- a. Type the specific **substance** used (up to **80** characters). This is a free-text field.
- b. Click **OK** to populate the **Substance If Other** column in the **Overdose** grid.

10.2.3 Substance Use Tab

Use the **Substance Use** tab (Figure 10-18) to document any substances involved in the suicide incident, including the specific substances and their corresponding categories.

Substance	Substance If Other
ALCOHOL	beer and drugs
OTHER	

Figure 10-18: Substance Use tab example

10.2.3.1 Substances Involved This Incident Group Box

1. Select one or more check boxes in this group box to indicate the substance involved in the suicide incident (Figure 10-19). At least one selection is required.

Figure 10-19: Substances Involved This Incident group box example

2. If you select the **Alcohol and Other Drugs** check box, the **Substance Multiple** search window opens (Figure 10-20), allowing you to add one or more specific substances.

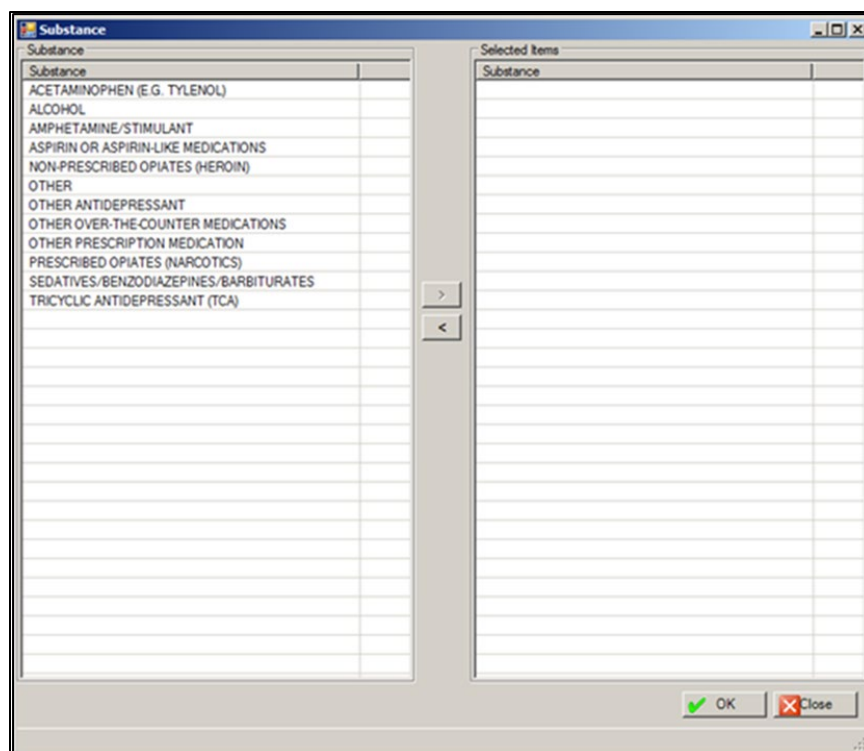


Figure 10-20: Substance multiple search window example

Use this window as follows:

- Select one or more **substances** in the **Substance** list box.
 - Click the **right-arrow** button to add them to the **Selected Item Substance** list box.
 - To remove a substance, select it in the **Selected Item Substance** list box and click the **left-arrow** button.
 - When the **Selected Item Substance** list is complete, click **OK** to populate the **Substances Involved** list box. (Otherwise, click **Close**.)
3. If you select the **Other** option in the **Substance Multiple** search window, the **Other** dialog appears (Figure 10-21).

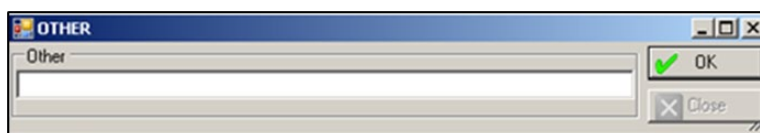


Figure 10-21: Other dialog example

- Type the name of the substance (up to **80** characters).
- Click **OK** to add the entry to the **Substances Involved** list box. The text entered appears in the **Substance If Other** column.

If you clear the **Alcohol and Other Drugs** check box, all substance entries in the **Substances Involved** list box are removed automatically.

10.2.3.2 Substances Involved Group Box

The **Substances Involved** group box (Figure 10-22) displays the substances used immediately before or during the suicide incident.

Substance	Substance If Other
HALLUCINOGENS	
OTHER	Other vapors

Figure 10-22: Substances Involved group box example

When the **Alcohol and Other Drugs** check box is selected, the **Add**, **Edit**, and **Delete** buttons become active, allowing you to manage the list of substances involved.

10.2.3.2.1 Add Button

Use the **Add** button to enter one or more new substance records.

1. Click **Add**. The **Substance Multiple** search window opens (Figure 10-23), allowing you to select one or more substances.

Figure 10-23: Substance multiple search window example

Use this window as follows:

- Select one or more **substances** in the **Substance** list box.

- Click the **right-arrow** button to select items to the **Selected Item Substance** list box.
 - To remove an item, select it in the **Selected Item Substance** list box and click the **left-arrow** button.
 - When the **Selected Item Substance** list box is complete, click **OK** to populate the **Substances Involved** group box. (Otherwise, click **Close**.)
2. If you select an item labeled **Other** in the **Substance Multiple** search window, the **Other** dialog appears (Figure 10-24).

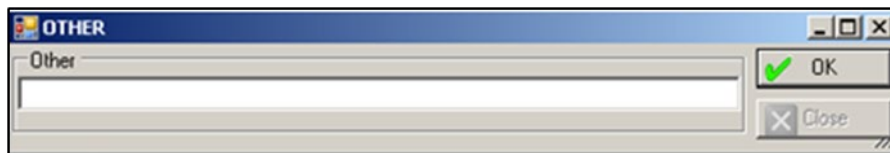


Figure 10-24: Other dialog example

- Type the **name** of the substance (up to **80** characters).
- Click **OK** to add the entry to the **Substances Involved** list box. The value entered appears in the **Substance If Other** column.

10.2.3.2.2 Edit Button

Use the **Edit** button to modify records that populate the **Substance If Other** column.

1. Highlight the record you want to edit.
2. Click **Edit**.
3. The **Other** dialog appears. Update the text in the **Other** field as needed, then click **OK** to save the changes (otherwise, click **Close**).

Clicking **OK** updates the value in the **Substance If Other** column.

10.2.3.2.3 Delete Button

Use the **Delete** button to remove a selected substance record.

1. Select the record you want to delete.
2. Click **Delete**.
3. When the **Are You Sure?** confirmation message appears, click **Yes** to delete the record. (Otherwise, click **No**.)

10.2.4 Contributing Factors Tab

Use the **Contributing Factors** tab (see Figure 10 25) to document one or more factors that contributed to the suicide act.

Figure 10-25: Contributing Factors tab example

1. Select one or more check boxes that identify the contributing factors. At least one selection is required.
2. If you select the **Other** check box, the free-text field below it becomes active. Enter a description of the additional contributing factor (up to **80** characters).

10.2.5 Narrative Tab

Use the **Narrative** tab to enter information in the **Other Relevant Information** free-text field (Figure 10-26). This field is optional.

Figure 10-26: Other Relevant Information field example

Use this field to document additional details that are not captured elsewhere in the form.

Note: This is not intended for SOAP notes or progress notes.

11.0 Intake

This section describes how to manage intake and update documents in the GUI.

11.1 Intake (GUI)

There are two ways to access and work with the **Patient Intake** documents in the GUI:

- Select the **Intake** option in the **GUI tree** structure.
- Select the **Intake** tab on the **Add/Edit Visit Data Entry** window.

Both methods open the same **Intake** window.

The following instructions describe how to use the **Intake** option on the **GUI tree** structure. After selecting **Intake**, the **Select Program** dialog appears (Figure 11-1).

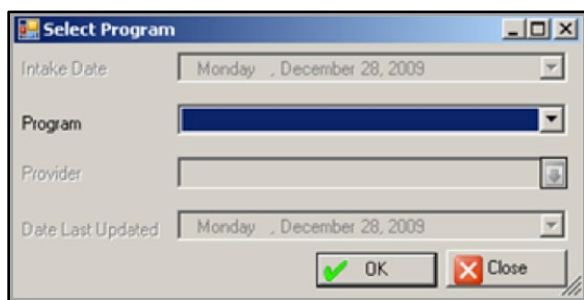


Figure 11-1: Select Program dialog example

1. In the **Program** field, select a program from the list.
2. Click **OK** (or click **Close** to cancel).

Clicking **OK** opens the **Intake** window (Figure 11-2), which lists the intake documents for the selected program for the current patient. The patient's name appears in the lower-left corner of the window.

Note: This is the same window displayed when you click the **Intake** tab on the **Add/Edit Visit Data Entry** window.

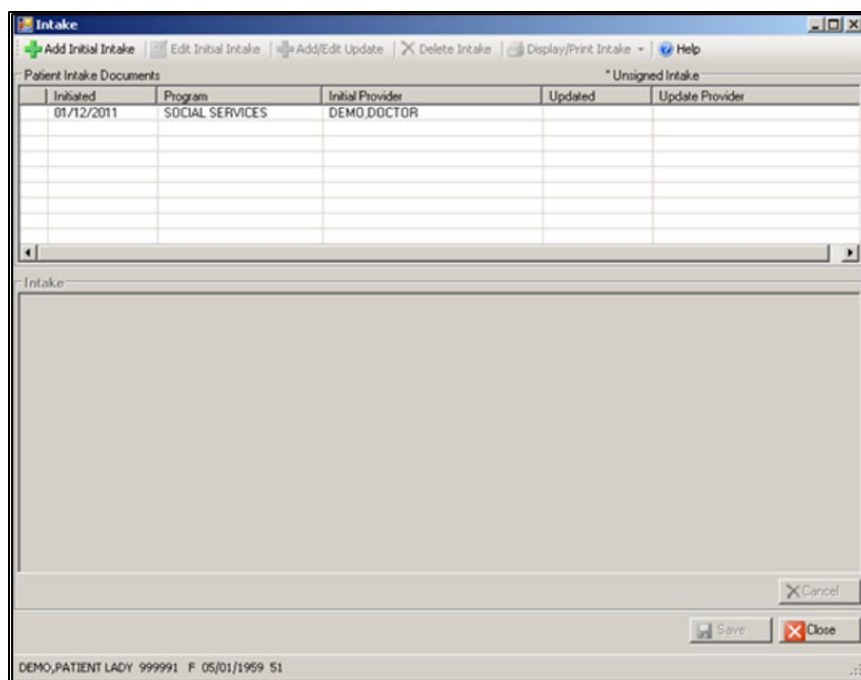


Figure 11-2: Intake window example

An asterisk (*) in the first column indicates that the record contains an unsigned intake or update document.

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

11.1.1 Patient Intake Documents List Box

The **Patient Intake Documents** list box (Figure 11-3) displays all intake and update documents associated with the current patient. Intake documents are editable; update documents are view-only.

Patient Intake Documents			* Unsigned Intake	
Initiated	Program	Initial Provider	Updated	Update Provider
* 01/14/2010	MENTAL HEALTH	DEMO.DOCTOR	01/14/2010	DEMO.DOCTOR
* 07/09/2009		DEMO.DOCTOR	01/28/2010	DEMO.DOCTOR

Figure 11-3: Patient Intake Documents list box example

You can distinguish document types as follows:

- Intake documents appear on the left side of the grid, under the **Date Initiated**, **Program**, and **Initial Provider** columns.
- Update documents appear on the right side of the grid, under the **Date Updated** and **Update Provider** columns.

When you highlight a record in the list box, the contents of the selected document appear in the **Intake** group box.

All initial documents and updates created before the installation of BHS v4.0 remain unsigned and editable. The initial provider associated with the intake will continue to be recorded as the provider for the intake document. Any edits or updates made after the installation date will follow all business rules introduced in BHS v4.0.

11.1.2 Add Initial Intake

Use the **Add Initial Intake** button to create a new initial intake document.

1. Click **Add Initial Intake** to open the **Select Intake Parameters** dialog (Figure 11-4).

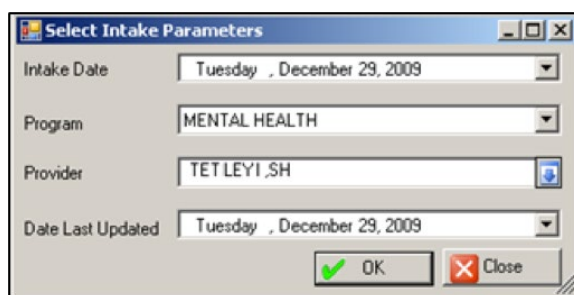


Figure 11-4: Select Intake Parameters dialog example

2. **Intake Date:** The current date displays by default. To change it, click the list and select a different date from the calendar.

Note: Future dates cannot be selected.

3. **Program:** The default program displays based on the program selected when you first accessed the **Intake** menu. To change it, click the list and select another option.

Note: Changing the program will prevent the new document from immediately appearing in the list view. To view the newly added document, you must return to the program selection screen and select the program associated with the document. It is recommended to select the correct program initially to avoid this step.

4. **Provider:** The current login provider displays by default. To change the provider, click the list to open the **Primary Provider** search window (Figure 11-5).

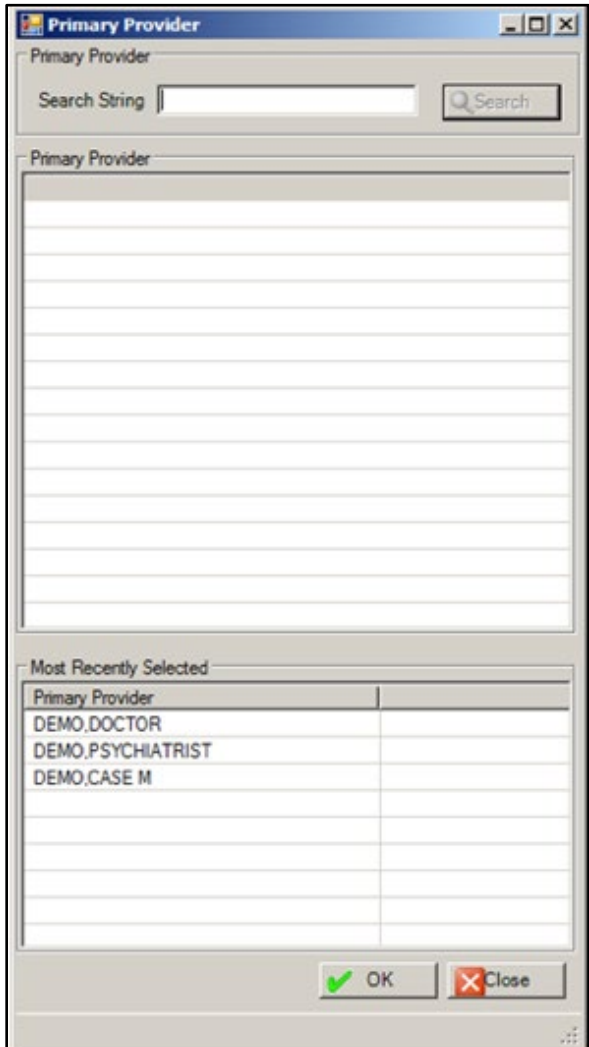
Screen Capture	What to Do
	Use the Primary Provider search window in one of the following ways: 1. Search by Name: Type the provider's last name in the Search String field and click Search. The retrieved names populate the Primary Provider list box. Select a name and click OK to populate the Provider field. Otherwise, click Close. 2. Search by Most Recently Selected: Select a provider from the Most Recently Selected list box and click OK to populate the Provider field. Otherwise, click Close.

Figure 11-5: Primary Provider search window example

5. **Date Last Updated:** The current date displays by default. To change it, click the list and select another date from the calendar. (Future dates are not allowed).

After completing all fields in the **Select Intake Parameters** dialog, click **OK** to activate the **Intake** group box. Otherwise, click **Close** to cancel the operation.

Section 11.1.3 provides additional information about the **Intake** group box.

11.1.3 Intake Group Box

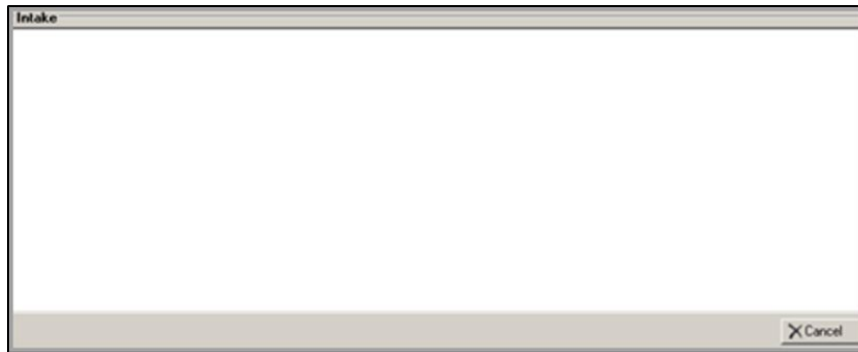


Figure 11-6: Active Intake group box example

When the **Intake** group box is active, use it to enter the narrative text for the intake or update document. This narrative constitutes the body of the intake document.

To exit the **Intake** group box without saving, click **Cancel**. This action deactivates the group box.

After completing the narrative, click **Save** to proceed, or click **Close** to exit.

- **If the user clicks Close:** A confirmation message appears *Unsaved Data Will Be Lost, Continue?*. Click **Yes** to discard any unsaved data and return to the GUI tree structure. Click **No** to return to the **Intake** group box.
- **If the user clicks Save:** The **Intake Electronic Signature** dialog displays (Figure 11-7). The **Save** process requires that the narrative field contains text.

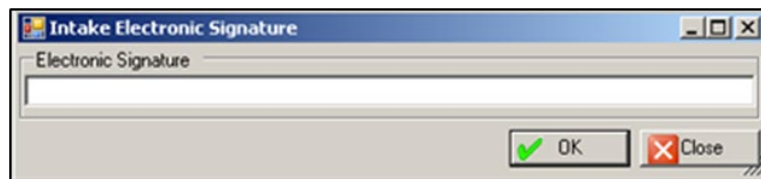


Figure 11-7: Intake Electronic Signature dialog

To Electronically Sign the Document:

- In the **Electronic Signature** field, enter your electronic signature.
- Click **OK**. The system saves the document and marks it as signed. Once signed, the document is locked and cannot be edited.

To Save the Document Without Signing:

1. Leave the **Electronic Signature** field blank.
2. Click **Close**.
3. Respond to the confirmation dialog, which states: **Are you sure you want to Close without Electronically Signing the Intake?**

- Click **Yes** to save the document marked as unsigned. A message displays: **You did not Electronically Sign the Intake**. Click **OK** to dismiss the message. Unsigned documents remain editable.
- Click **No** to return to the **Intake Electronic Signature** dialog.

11.1.4 Edit Initial Intake

Use the **Edit Initial Intake** button to revise an existing initial intake document.

- If the selected document has been signed: The application displays the following message: **This Initial Intake document has been signed. You cannot edit it**. Click **OK** to dismiss the message. The edit process is terminated because signed documents are locked from further modification.
- If the user is not the provider or the individual who originally created the intake: The application displays the following message: **You are not the provider or the person who entered the Intake, you cannot edit it**. Click **OK** to dismiss the message and exit the edit process.

If you are authorized (i.e., you are the provider or the original document creator), the application displays the **Select Intake Parameters** dialog. For details on completing this dialog, see Section 11.1.2.

After completing the **Select Intake Parameters** dialog, the system displays the existing intake narrative in the **Intake** group box. For additional information about entering or modifying narrative text, see Section 11.1.3.

11.1.5 Add/Edit Update

The **Add/Edit Update** button displays one of two labels: **Add Update** or **Edit Update** depending on the type and status of the selected document.

Note: If a signed **Update** document is selected: The button label is **Edit Update**. After clicking the button, the application displays the message: **This Intake Update document has been signed. You cannot edit it**. Click **OK** to dismiss the message and exit the editing process.

Locked Documents: Once the **Provider** electronically signs an update document, it becomes locked and cannot be edited or deleted unless: the user has the required security key, or the user is listed in the **Delete Override Site Parameter**.

Button Behavior

- If an **Initial Intake** document (signed or unsigned) is selected, the button label is **Add Update**.

- If an unsigned **Update** document is selected, the button label is **Edit Update**.
- Regardless of which label appears, selecting the button opens the **Select Intake Parameters** dialog.
- For detailed instructions on completing this dialog, see Section 11.1.2.
- After completing the **Select Intake Parameters** dialog, the **Intake** group box becomes active, allowing you to enter or edit update narrative text. See Section 11.1.3 for more information on using the **Intake** group box.

11.1.6 Delete Intake

Use the **Delete Intake** button to remove a selected unsigned intake document from the **Patient Intake Documents** list.

1. Select an **unsigned intake document** you want to delete.
2. Click **Delete Intake**.
3. When the **Are You Sure** confirmation message appears, click **Yes** to delete the document (otherwise, click **No**).

Permissions and Restrictions

- Only the **Intake Provider** or the user who originally entered the intake may delete the document.
- Users listed in the **Delete Override** section of the **Site Parameters** menu in RPMS may also delete the intake, even if they are not the original provider or author.

If the selected intake document has one or more associated update documents, the application displays the following message:

This intake document has updates associated with it. It cannot be deleted at this time.

- Click **OK** to dismiss the message and exit the delete process.

11.1.7 Display/Print Intake

Use the **Display/ Print Intake** button to access the available display and print options (Figure 11-8).

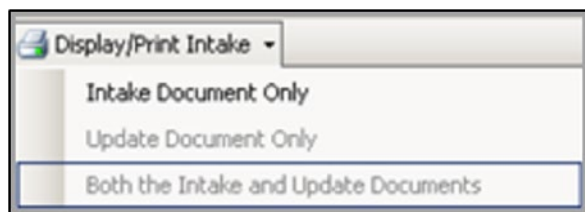


Figure 11-8: Display/Print Intake options example

1. Highlight an **intake record**, then select one of the available options (only valid options will be enabled).

If you select **Update Document Only** or **Both the Intake and Update Documents**, the application displays the **Intake Updates** dialog (Figure 11-9).

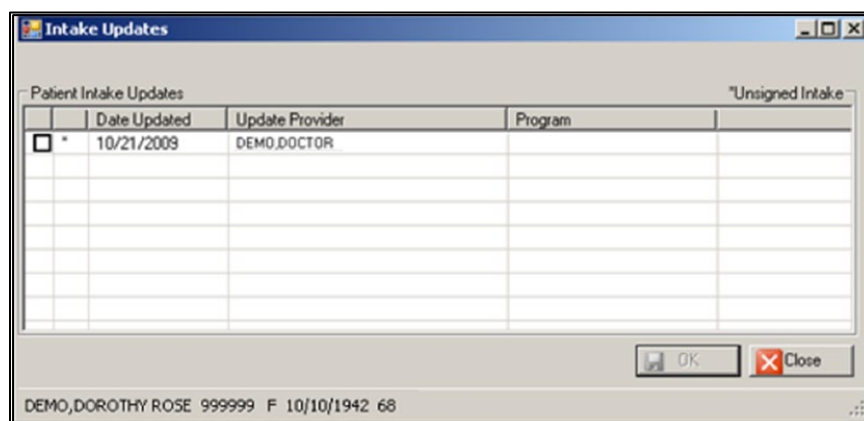


Figure 11-9: Intake Updates dialog example

2. In the **Intake Updates** dialog, select the update records you want to include in the output by checking the corresponding boxes, and then click **OK** (otherwise, click **Close**).

The first page of the **Intake** pop-up window (for the current patient) then appears (Figure 11-10).

The screenshot shows a window titled "Intake DEMO,DOROTHY ROSE 999999 F 10/10/1942 68". The window contains the following text:

```

***** CONFIDENTIAL PATIENT INFORMATION *****
*
* INTAKE DOCUMENT                               Printed: Nov 02, 2010@12:32:01
* Name: DEMO,DOROTHY ROSE                        Page 1
* DEMO INDIAN HOSPITAL      DOB: 10/10/42  Sex: F  Chart #: WU999999
*
*****

Date Established:  JAN 14, 2010
Provider:          DEMO,KAREN
Program:          MENTAL HEALTH
Type of Document:  INITIAL

Intake Documentation/Narratives:
!8#%& 4 ()_+{} : "<>?'-~=[\]:;'. ,./
Documenting Prevention Activities

Non-Patient Record - Adding
1. Log on to BHS v3.0 and select DE for data entry.
2. Select [SDE] for the Full Screen Mode and press [Enter].
3. Select the default - Mental Health, Social Services, or Chemical
   Dependency.
4. Enter the date of the activity.
5. At the List View, select [AN] to add a non-patient record and press
   [Enter].
6. Enter the Primary Provider and press [Enter].
7. Enter the required information (underlined items) and optional
   items as desired. Number served may be 0 through 999.
8. Prevention Activities - if the activity needs to be recorded as
   a prevention service, type [V] and press [Enter]. A text box for entering
   the Prevention Activity will be displayed. Identify the type of activity
   and the target audience.

Type of Activity
  
```

At the bottom of the window, it says "Current Page No.: 1", "Total Page No.: 1+", and "Zoom Factor: 100%".

Figure 11-10: Intake pop-up window example

For more information about the controls available in this type of pop-up window, see Section 2.0.

Appendix A Activity Codes and Definitions

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

All the Activity Codes shown with a three-letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

A.1 Patient Services—Patient Always Present (P)

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

01—Twelve Step Work—Group (TSG)

Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem—alcoholism, drug dependence, overeating, etc.—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).

04-Re-assessment, Patient Present (RAS)

Formal assessment activities intended to reevaluate the patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

11-Screening (SCN)

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

12-Assessment/Evaluation (EVL)

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

13-Individual Treatment/Counseling/Education (IND)

Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

15-Information and/or Referral (REF)

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

16-Medication/Medication Monitoring (MED)

Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

17-Psychological Testing (TST)

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

18-Forensic Activities (FOR)

Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

19-Discharge Planning (DSG)

Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

20-Family Facilitation (FAC)

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

21-Follow-through/Follow-up (FOL)

Periodic evaluative review of a specific client/patient's progress after discharge.

22-Case Management (CAS)

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

23-Other Patient Services not identified here (OTH)

Any other patient services not identified in this list of codes.

47-Couples Treatment (CT)

Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.

48-Crisis Intervention (CIP)

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

67-Opiate Treatment/Maintenance (OPI)

Services related to opioid treatment and/or maintenance when the patient is present.

85-Art Therapy (ART)

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

86-Recreation Activities (REC)

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

88-Acupuncture (ACU)

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

89-Methadone Maintenance (MET)

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

90–Family Treatment (FAM)

Family-centered therapy with an emphasis on the client/patient’s functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences. Often brief and solution focused.

91–Group Treatment (GRP)

This form of therapy involves groups of patients/clients who have similar problems that are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

92–Adventure Based Counseling (ABC)

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

93–Relapse Prevention (REL)

Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

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

94–Life Skills Training (LST)

Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

95–Cultural Activities–Pt. Present (CUL)

Participation in educational, social, or recreational activities for the purpose of supporting a client/patient’s involvement, connection, and contribution to the patient’s cultural background.

96–Academic Services (ACA)

Provision of alternative schooling under the guidelines of the state education program.

97–Health Promotion (HPR)

Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

A.2 Support Services–Patient Not Present (S)

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

05-Re-assessment, Patient Not Present

Reassessment or reevaluation activities when patient is not present at time-of-service delivery.

24-Material/Basic Support (SUP)

Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

25-Information and/or Referral (INF)

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

26-Medication/Medication Monitoring (MEA)

Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time-of-service delivery.

27-Forensic Activities (FOA)

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

28-Discharge Planning (DSA)

Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

29-Family Facilitation (FAA)

Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

30-Follow-up/Follow-through (FUA)

Periodic evaluative review of a specific client/patient's progress after discharge.

31-Case Management (CAA)

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

33-Technical Assistance

Task-specific assistance to achieve an identified end.

34-Other Support Services

Any other ancillary, adjunctive, or collateral services not identified here.

44-Screening

Activities associated with patient/client screening where no information is added to the patient/client's file.

45-Assessment/Evaluation

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

49-Crisis Intervention (CIA)

Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

68-Opiate Treatment/Maintenance (OPI)

Services related to opioid treatment and/or maintenance when the patient is not present.

A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes the following:

35-Collaboration

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

36-Community Development

Planning and development efforts focused on identifying community issues and methods of addressing these needs.

37-Preventive Services

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

38-Patient Transport

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

39-Other Community Services

Any other form of community services not identified here.

40-Referral

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

87-Outreach

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

A.4 Education Training (E)

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job related knowledge, attitudes, and skills. Includes:

41-Education/Training Provided**42-Education/Training Received****43-Other Education/Training****A.5 Administration (A)**

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

32-Clinical Supervision Provided

Clinical supervision is a process based upon a clinically focused, professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

50-Medical Rounds (General)

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

51-Committee Work

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

52-Surveys/Research

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

53-Program Management

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

54-Quality Improvement

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

55-Supervision

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

56-Records/Documentation

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

57-Child Protective Team Activities

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

58-Special Projects

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

59-Other Administrative

Any other administrative activities not identified in this section.

60-Case Staffing (General)

A regular or ad-hoc forum for the exchange of clinical experience, ideas and recommendations.

66-Clinical Supervision Received

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

A.6 Consultation (L)

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

61-Provider Consultation (PRO)

Focus is a specific patient, and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

62-Patient Consultation (Chart Review Only) (CHT)

Focus is a specific patient, and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

63-Program Consultation

Focus is a programmatic effort to address specific needs.

64-Staff Consultation

Focus is a provider or group of providers addressing a type or class of problems.

65-Community Consultation

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

A.7 Travel (T)

71-Travel Related to Patient Care

Staff travel to patient's home or other locations—related to provision of care. Patient is not in the vehicle.

72-Travel Not Related to Patient Care

Staff travel to meetings, community events, etc.

A.8 Placements (PL)

75-Placement (Patient Present) (OHP)

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

76-Placement (Patient Not Present) (OHA)

Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences. This activity might include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

A.9 Cultural Issues (O)

81-Traditional Specialist Consult (Patient Not Present) (TRA)

Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

82-Traditional Specialist Consult (Patient Not Present) (TRA)

Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

83-Tribal Functions

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

84-Cultural Education to Non-Tribal Agency/Personnel

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

Appendix B DSM-5-TR Copyright and Trademark Information

B.1 Copyright

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Appendix C Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (ROB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS website:

<https://home.ihs.gov/security/index.cfm><http://security.ihs.gov/>.

Note: Users must be logged on to the IHS D1 Intranet to access these documents.

The ROB listed in the following sections are specific to RPMS.

C.1 All RPMS Users

In addition to these rules, each application may include additional ROB that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

C.1.1 Access

RPMS users shall:

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

C.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall:

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

C.1.3 Accountability

RPMS users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

C.1.4 Confidentiality

RPMS users shall:

- Be aware of the sensitivity of electronic and hard copy information and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not:

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

C.1.5 Integrity

RPMS users shall:

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not:

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

C.1.6 System Logon

RPMS users shall:

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

C.1.7 Passwords

RPMS users shall:

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not:

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

C.1.8 Backups

RPMS users shall:

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

C.1.9 Reporting

RPMS users shall:

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not:

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

C.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall:

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

C.1.11 Hardware

RPMS users shall:

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

C.1.12 Awareness

RPMS users shall:

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

C.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall:

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not:

- Disable any encryption established for network, internet, and Web browser communications.

C.2 RPMS Developers

RPMS developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not:

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

C.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not:

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Caret

The caret (^) symbol is obtained by pressing Shift-6.

Command

The instructions you give the computer to record a certain transaction. For example, selecting Payment or P at the command prompt tells the computer you are applying a payment to a chosen bill.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user's paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Data Elements

Data fields that are used in filling out forms in BHS.

Default Response

Many of the prompts in the BHS program contain responses that can be activated simply by pressing the Enter key. For example: Do you really want to quit? No//. Pressing the Enter key tells the system you do not want to quit. No// is considered the default response.

Device

The name of the printer to use when printing information. Home means the computer screen.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

FileMan

The database management system for RPMS.

Free-Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

Frequency

The number of times a particular situation occurs in a given amount of time.

Full Screen Editor

A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper- and lower-case letters can be used.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

Menu

The menu is a list of different options from which to select at a given time. To select a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a tree structure because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the root at the top and the leaves at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical user interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI—Character User Interface.

Security Keys

Tools used to grant/restrict access to certain applications, application features, and menus.

Site Manager

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu

A menu that is accessed through another menu.

Suicide

The act of causing one's own death.

- Ideation with Intent and Plan – Serious thoughts of suicide or of taking action to take one's life with means and a specific plan
- Attempt – A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.
- Completion – A fatal self-inflicted destructive act with explicit or inferred intent to die.

Terminal Emulator

A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor

A word processing program that entering and editing text.

Word Processing Field

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

Acronym	Term Meaning
A/SA	Alcohol and Substance Abuse
BH	Behavioral Health
AMH	Behavioral Health System
CAC	Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading of BHS and other software programs for the end users. The CAC is sometimes referred to as the application coordinator or a “super-user.”
CD	Chemical Dependency
EHR	Electronic Health Record
eSig	Electronic Signature
GPRA	Government Performance and Results Act; a federal law requiring federal agencies to demonstrate through annual reporting that they are using appropriated funds effectively to meet their Agency’s missions.
GUI	Graphic User Interface, a Windows-like interface with drop-down menus, text boxes icons, and other controls that supports data entry using a combination of the computer mouse and keyboard.
HIPAA	Health Insurance Portability and Accountability Act
HHS	Department of Health and Human Services
HRCN	Health Record Chart Number
ID	Identification
IHS	Indian Health Service
IT	Information Technology
MH	Mental Health
OIT	Office of Information Technology
PC	Personal Computer
PCC	Patient Care Component
PHI	Protected Health Information
PHR	Personal Health Record
PII	Personally Identifiable Information
PPN	Patient Preferred Name
ROB	Rules of Behavior
RPMS	Resource and Patient Management System
QA	Quality Assurance

Acronym	Term Meaning
SAC	Standards and Conventions
SOP	Standard Operating Procedure
VPN	Virtual Private Network

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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