RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

Data Entry Training Manual

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1.0 Objective #1: Introduction to RPMS and BHS v4.0

1.1 Purpose

The purpose of this exercise is to explain the relationship between the Resource and Patient Management System (RPMS) suite of applications and the behavioral health application.

1.2 Overview

It is important that users understand the relationship between the Behavioral Health System (BHS) v4.0 software and the RPMS suite of applications, regardless of their discipline.

1.3 Skills You Will Acquire

Upon completion of this objective, you will be able to:

- Understand how the behavioral health application relates to other RPMS applications
- Identify the various desktop links (client software) that may be used to record encounter data
- Understand how RPMS, including BHS, protects sensitive data by requiring users to have access and verify codes and to comply with specific security directives

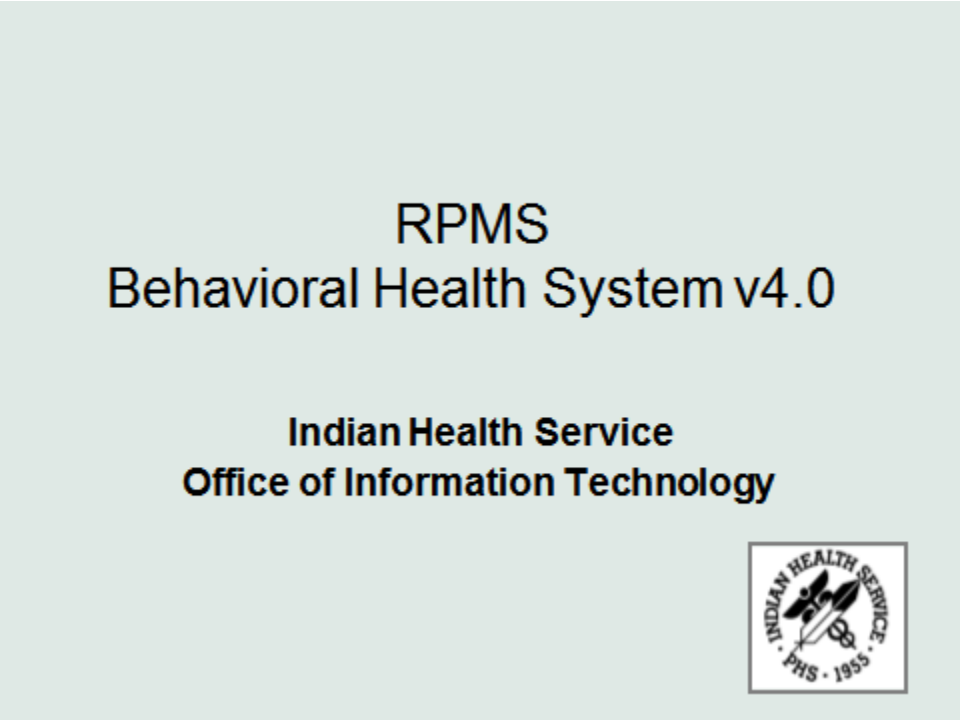

Figure 1-1: RPMS Behavioral Health System PowerPoint® presentation

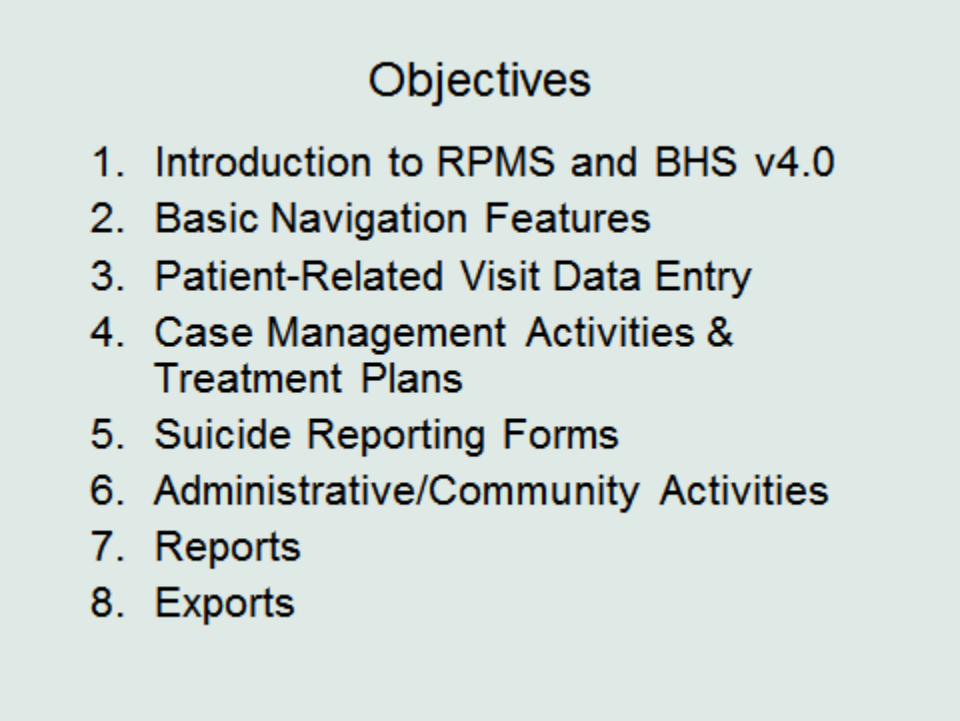

Figure 1-2: List of objectives

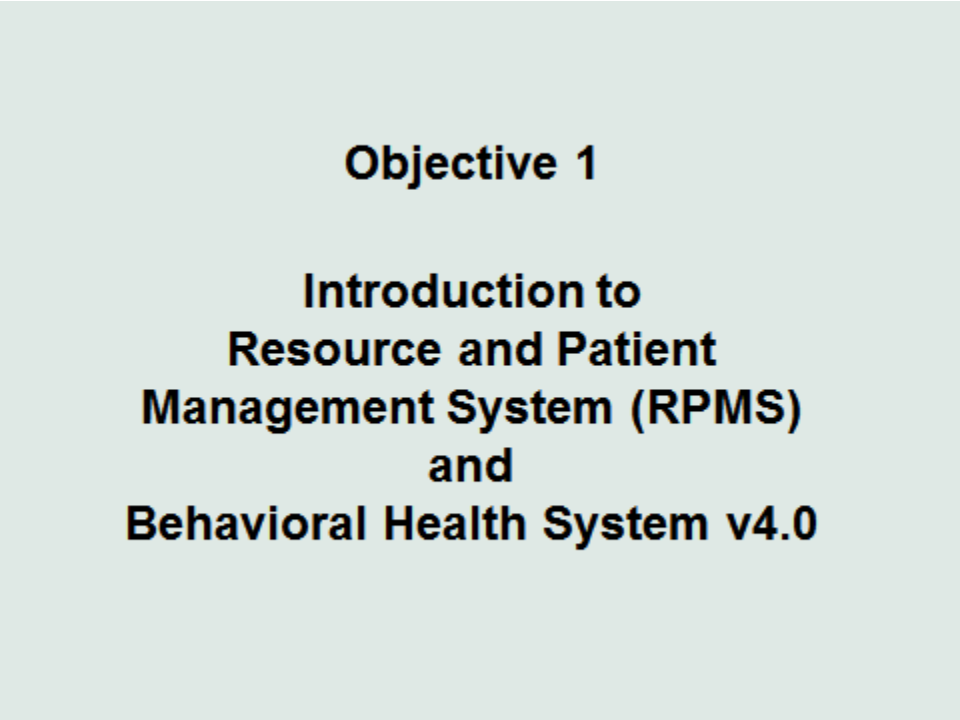

Figure 1-3: Objective 1

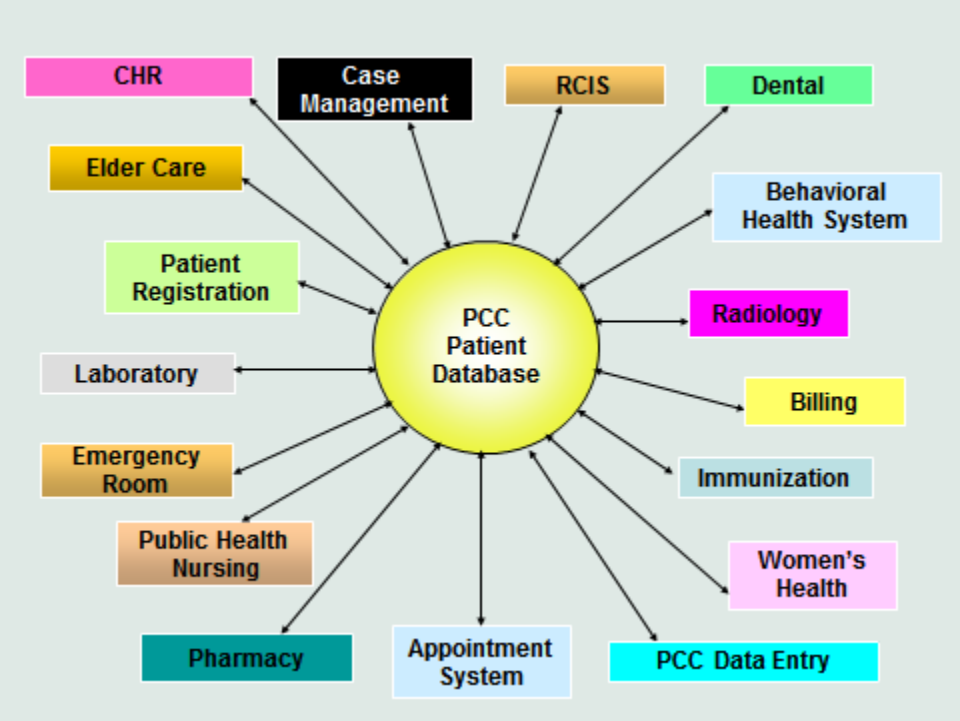

Figure 1-4: PCC Patient Database is interconnected to many different applications

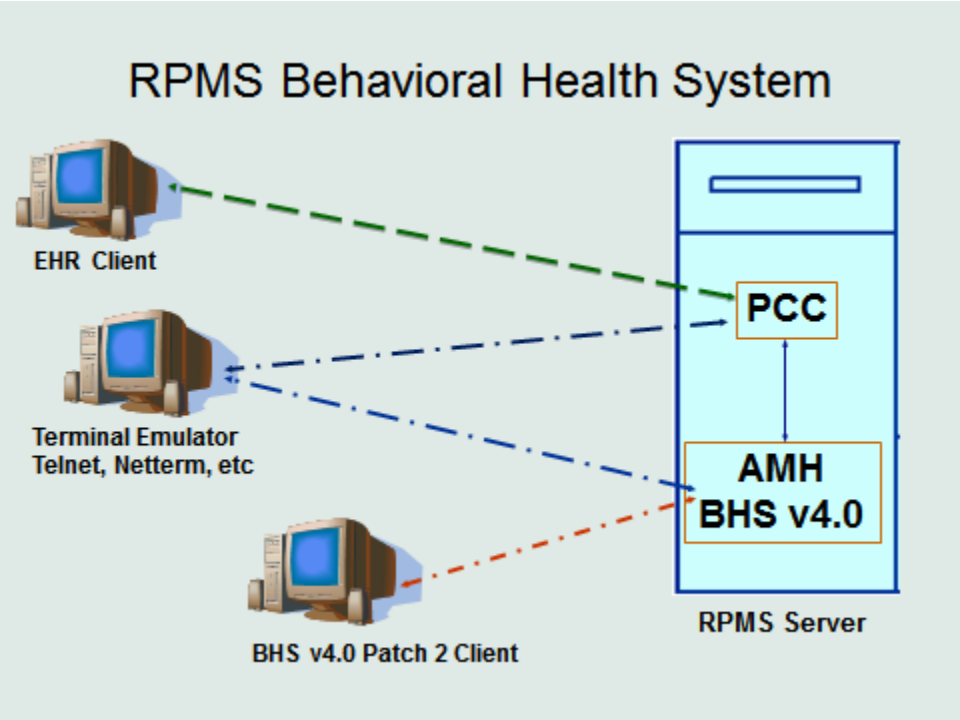

Figure 1-5: RPMS Behavioral Health System

Application Sign-On/Off

Sign on – BHS v4.0 is password protected.

Access/Verify – The site manager will issue users RPMS Access and Verify codes. The Access code is permanent; Verify codes need to be updated periodically.

Security – Access/Verify codes cannot be shared with anyone. Typically only BH providers are given access to BHS v4.0.

Sign off – Be sure to log off when leaving the terminal.

Figure 1-6: Application sign-on/off

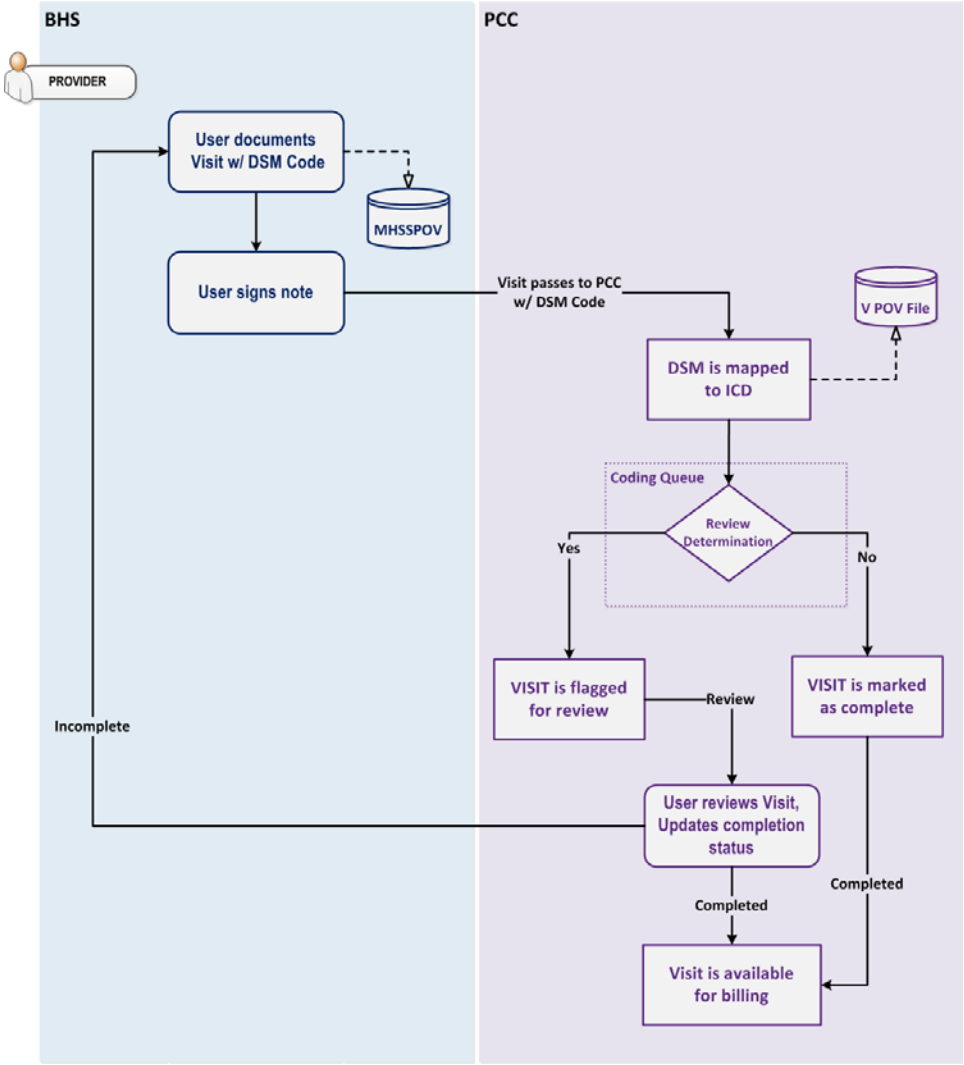

Figure 1-7: A visual representation of the data flow from BHS to PCC

2.0 Objective #2: Basic Navigation Features

2.1 Purpose

The purpose of this exercise is to introduce the various navigation features of BHS.

2.2 Overview

Regardless of their discipline, it is important that users are able to easily navigate through BHS.

2.3 Skills You Will Acquire

Upon completion of this objective, you will be able to:

- Understand how the menu tree functions.
- Understand how to access and enter data into the different data entry fields.
- Access the online Help file.
- Log-on to the BHS ***roll and scroll***.
- Understand how to use the Electronic Signature functionality.
- Understand how to use **Crystal Reports** windows and their functionality, including printing records.
- Understand the difference between **One Patient** and **All Patient** list views.
- Log-on to BHS.
- Select a patient.
- Print a Health Summary.
- Print a Face Sheet.
- View Patient Appointments.
- View Patient Care Component (PCC) Medications.
- View PCC Labs by Visit Date.
- View PCC Labs by Lab Test.

2.4 Main Menu Tree

Log onto BHS to view the menu tree shown in Figure 2-1:

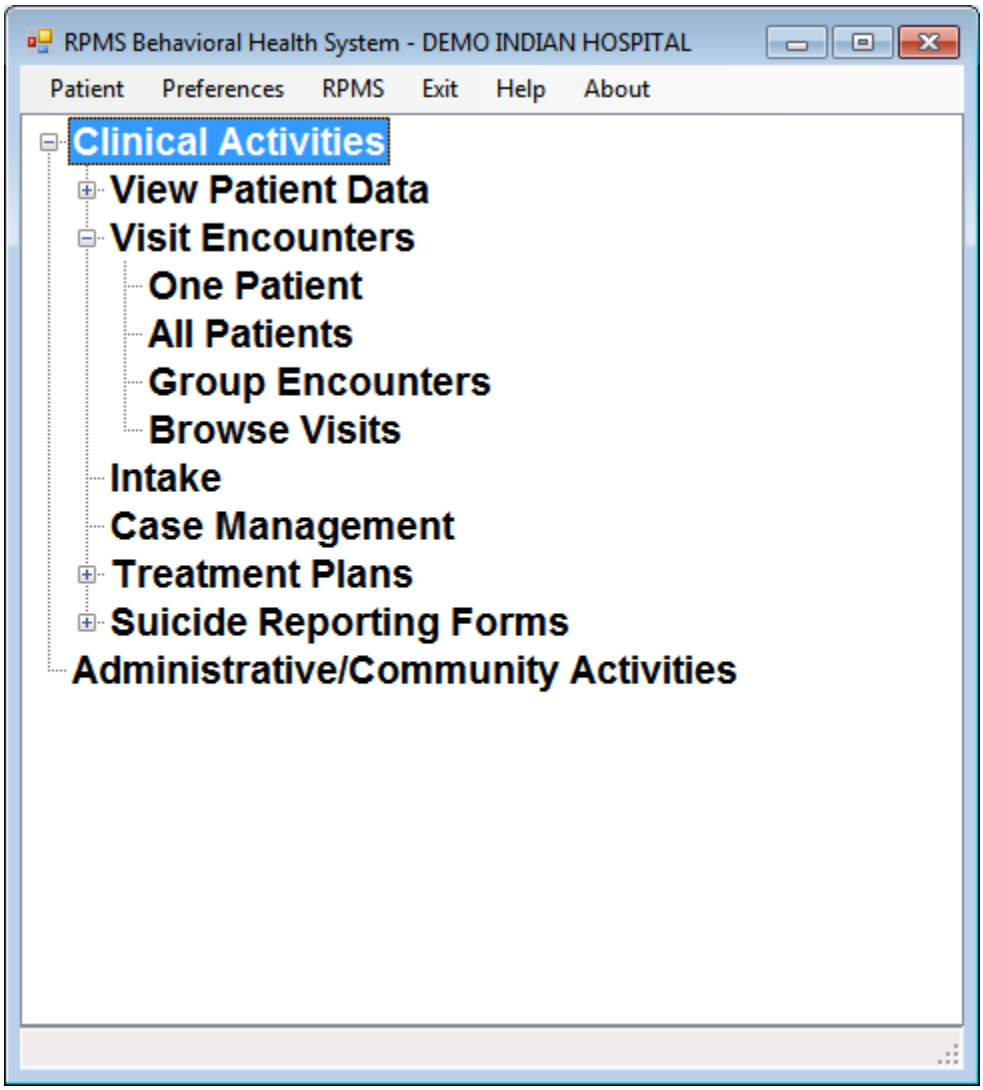

Figure 2-1: **Main Menu** tree

The menu tree functions similar to any tree structure in Microsoft® Office®. The menu tree is used to access the various data entry features of BHS. To access a data entry feature, click one of the menu items.

- Click the minus sign (-) to collapse the list. The icon will change to a plus sign (+). The **Treatment Plans** and **Suicide Reporting Forms** options are collapsed as shown in Figure 2-1.
- Click the plus sign (+) to expand the list. The icon will change to the minus sign (-). The **Visit Encounters** option is expanded as shown in Figure 2-1.
- Select the **Patient** menu to select the current patient.

- Select the **Preferences** menu to change the font or select another division. The menu is inactive if there is only one division.
- Select the **RPMS** menu to access the application.
- Select the **Exit** menu to leave the application.
- Select the **Help** menu to access the online help system.
- Select the **About** menu to view information about the application (such as its version number). If contact with the Indian Health Service (IHS) Help Desk is necessary, include a screen capture of this information.

2.5 RPMS Link

The RPMS ***roll and scroll*** is available in BHS via a terminal emulator link found on the menu. This feature allows for the use of RPMS ***roll and scroll*** functionality without having to log-in to a different application. All of the RPMS ***roll and scroll*** functionality is available. Some of the more advanced emulator features offered by emulator products such as NetTerm, TelTerm, TNVTPlus, etc. are not available. For example data cannot be captured or saved to a file for export.

Figure 2-2 shows the **RPMS Terminal Emulator** window after an RPMS link has been selected.

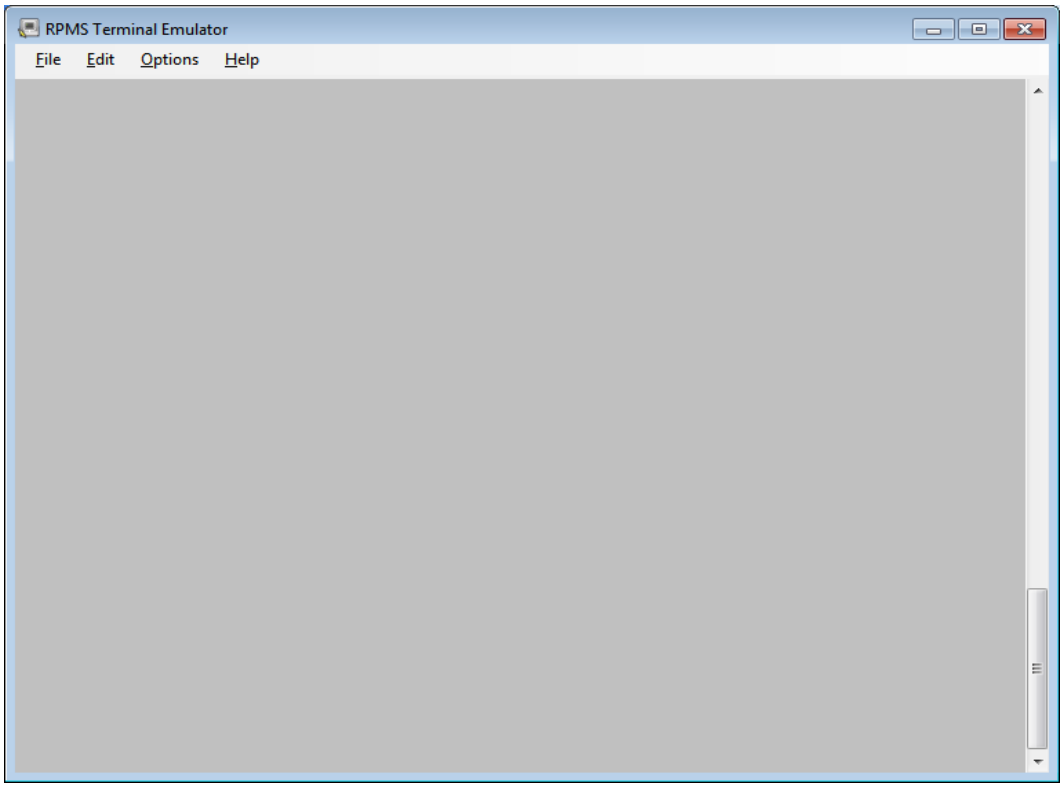

Figure 2-2: **RPMS Terminal Emulator**

1. Select **File** on the menu.
2. Select **Connect** from the list. The **Connect** (Figure 2-3) dialog displays.

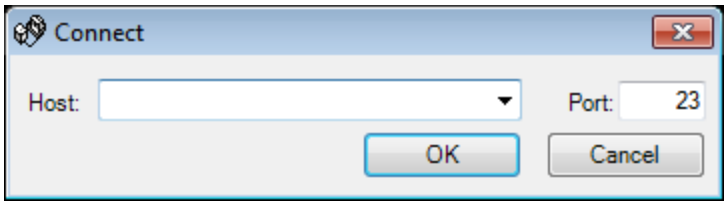

Figure 2-3: **Connect** dialog

3. Type the database IP address in the **Host** field.
   - The IP address must to be entered the first time you log on.
4. Click **OK** to display the roll and scroll log on prompts.
   - Click **Cancel** to end the process.

2.6 Online Help File

The online Help file contains detailed information about the BHS application (Figure 2-4). If you have any questions about the application, it is strongly encouraged that you to use the Help file.

The online Help file provides the ability to browse the contents using a menu tree structure, search for specific content, and print a specific section or the whole Help file.

To search for specific content in the Help file, click the **Search** tab, enter a keyword, and click **List Topics**. The results of the search displays in a list. Double-click one of the results to view that section of the Help file.

To print a section of the **Help** file, highlight the section to print and click the **Print** button. The application will ask if you would like to print just the selected topic or the selected heading and all subtopics. Select the option to print and click **OK**.

The Help file will automatically open to the section corresponding with your location in the application.

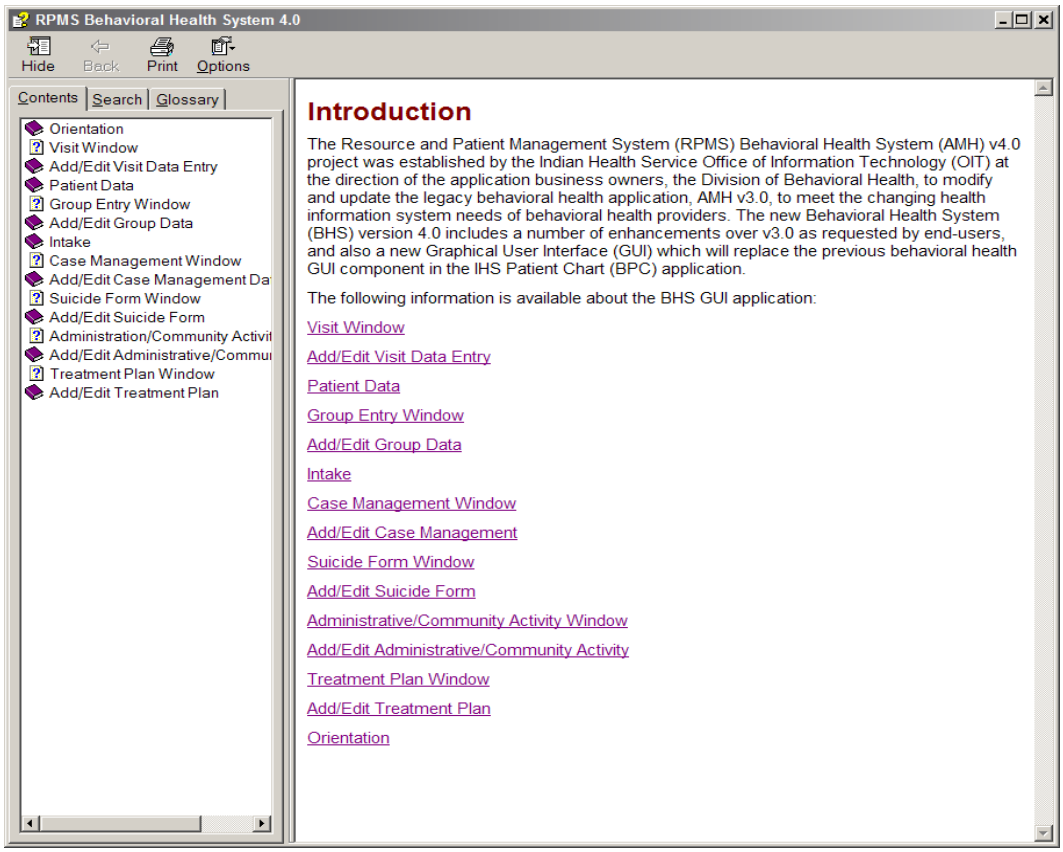

Figure 2-4: **Help** file

2.7 Patient List Views

2.7.1 One Patient List View

Features in BHS allow data to be entered via the One Patient list view. The One Patient list view (Figure 2-5) shows the record data for a single patient within a date range.

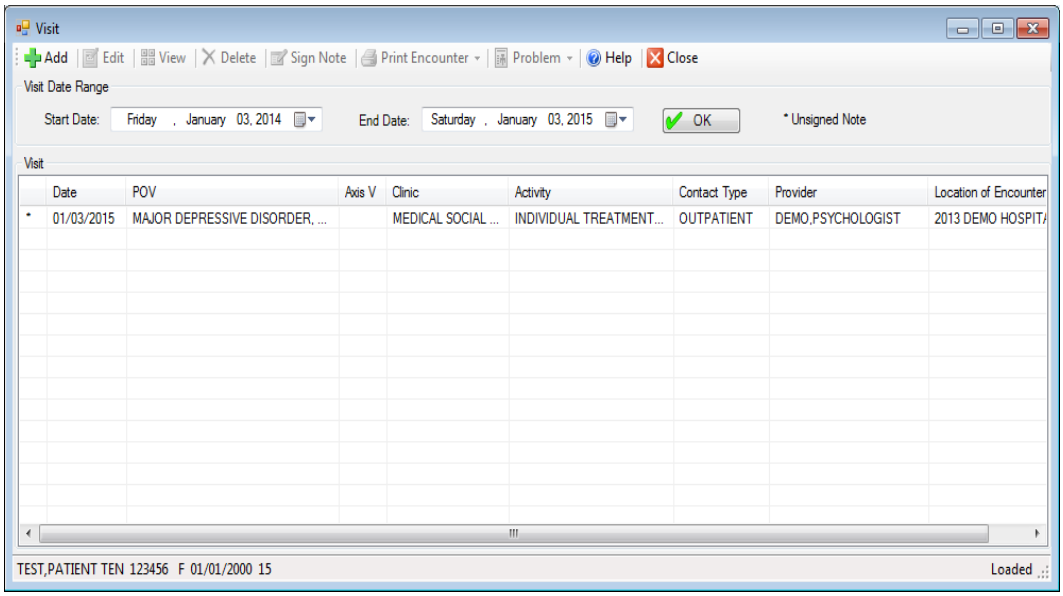

Figure 2-5: **Visit** Encounters, One Patient list view

Highlight a patient from the One Patient list view:

- If a patient record has not been selected, a prompt displays.
- The patient's name, age, sex, and date of birth (DOB) display in the status bar (the lower left-hand corner) as shown in Figure 2-5.

2.7.2 All Patient List View

The All Patient list view displays the record data for all patients within a date range.

- If you have a patient selected and you access the **All Patients** menu, the selected patient will be cleared out.
- Click **Add** to insert a new record. Figure 2-6 shows the All Patients **Visit** Encounter window.

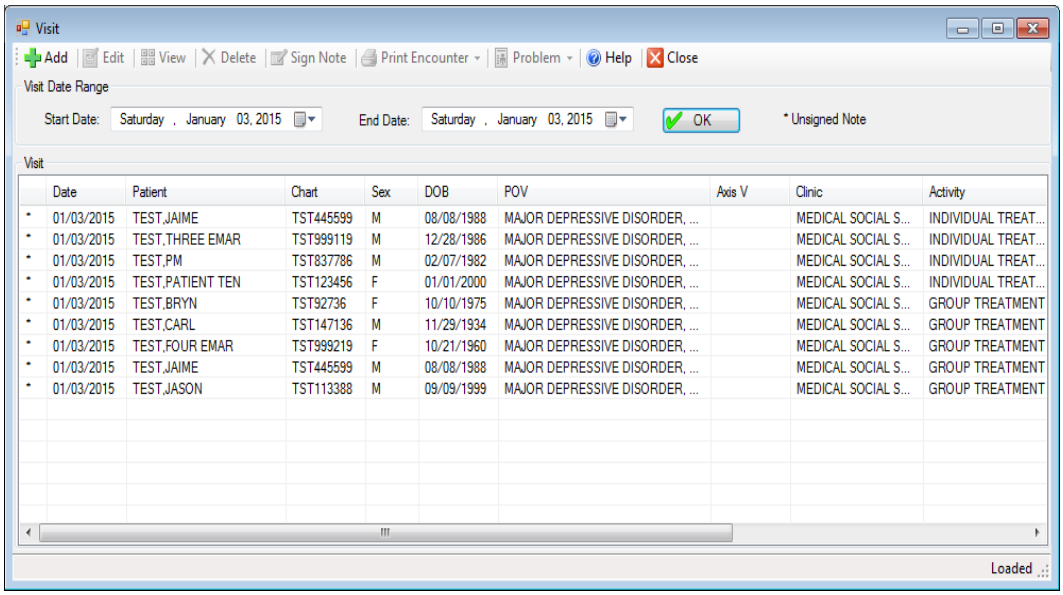

Figure 2-6: **Visit** Encounters, All Patients list view

2.8 Data Entry Fields

There are several types of data entry fields throughout BHS, including Calendar date select fields, search select windows, and multiple select windows.

2.8.1 Calendar Date Select Fields

Select the Calendar date fields to change a date. Click the arrow next to a calendar field and a calendar displays as shown in Figure 2-7:

Figure 2-7: Calendar Date Select field

The calendar defaults to the current date. To change the month:

- Click the left or right arrows.
- Click the up or down arrows, to change the year. Figure 2-8 shows the year select field.

Figure 2-8: Year Select field

- The date can be changed by typing the month/day/year into the field.
- Press the right and left arrows to navigate from month to day to year.

2.8.2 Search Select Windows

Several fields in the application have a drop-down fields that display a search dialog. For example, the **Activity** pane will access the **Activity** search dialog (Figure 2-9).

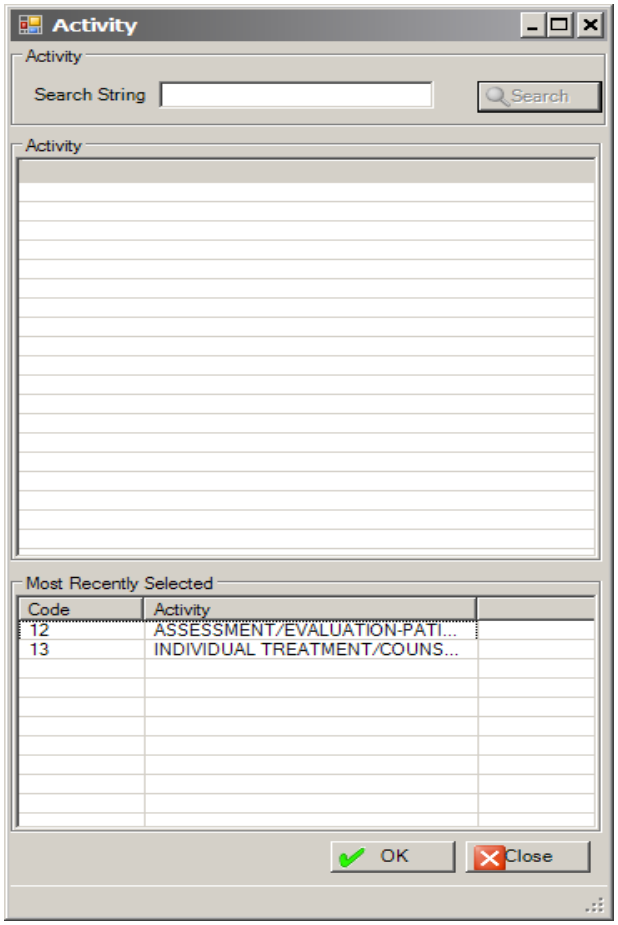

Figure 2-9: **Activity** Search Select pane

- Type a few characters into the **Search String** field and click **Search**. The results display in the **Activity** pane. Double-click a result to display.
- Activities can also be selected from the **Most Recently Selected** pane. When there is only one response for a **Search String**, the application will automatically display the result.
- Type a question mark (**?**) into the search string and click **Search**, if you are unsure of possibilities.

2.8.3 Multiple Select Windows

One or more responses can be selected by highlighting one in the list on the left and holding down the Ctrl key. Click the right arrow to move the selections to the Selected Items pane. Figure 2-10 shows the **Substance** multiple select window:

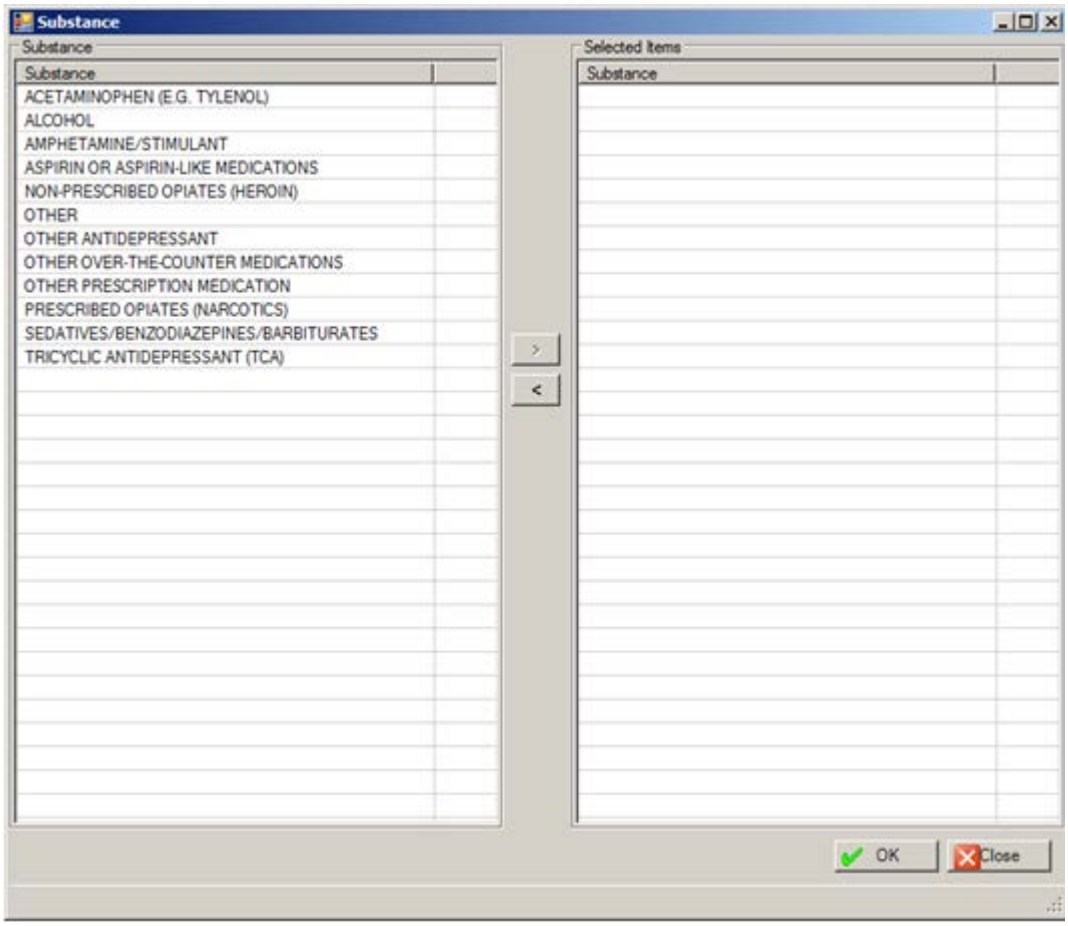

Figure 2-10: **Substance** Multiple Select window

- Click **OK** to display the previous window (Figure 2-6).
- Click **Close** to end the process.

2.8.4 Electronic Signature

BHS contains an electronic signature feature allowing patient visits and intake documents to be electronically signed. To distinguish between signed and an unsigned documents, unsigned visits, and intake documents on the list view, an asterisk (*) displays to the left. When a document is signed, the asterisk no longer displays.

- Only signed **Visit Encounters** will pass to PCC; unsigned **Visits** will not pass to PCC until they are signed. The Electronic Signature in the BHS is the same as the one used in the Electronic Health Record (EHR).
- The Electronic Signature is available in both EHR and BHS. If you do not have an Electronic Signature, your site manager will help you set one up. See Appendix A: for more information about setting up an Electronic Signature.

2.8.5 Crystal Reports Windows

The **Crystal Reports** windows are display only. They have their own features and commands. These windows display when you access the print functionality, open a Health Summary (Figure 2-11), or view a **Face Sheet**.

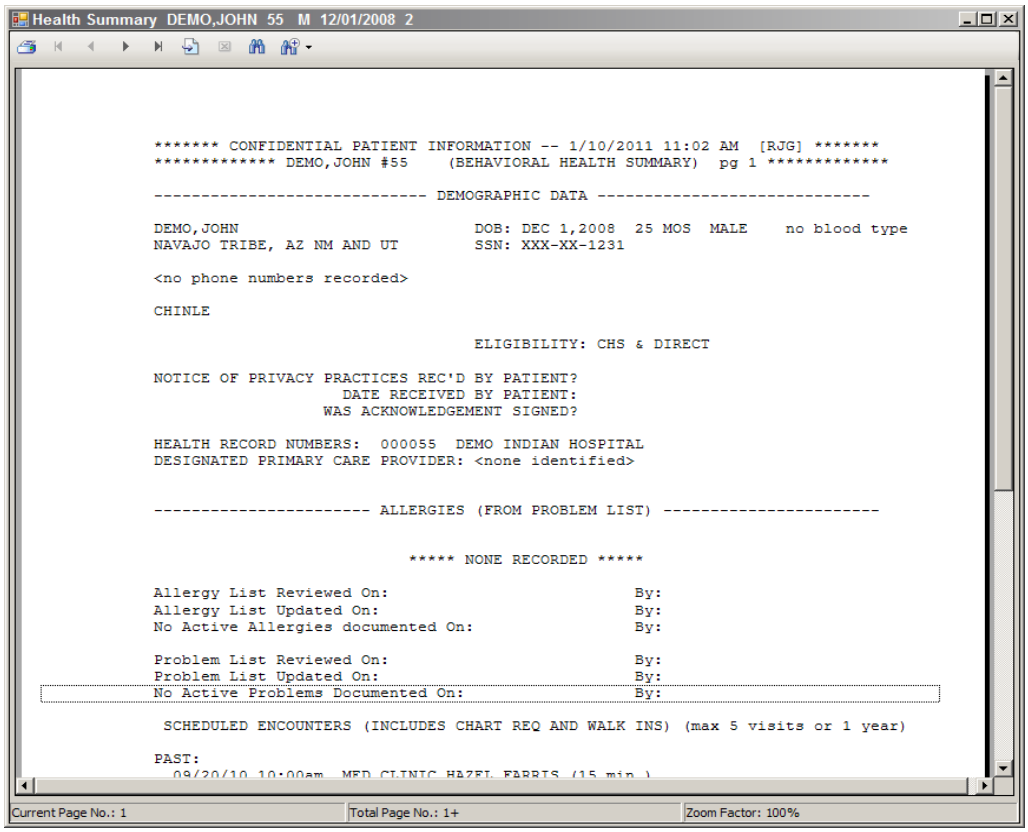

Figure 2-11: **Health Summary** Crystal Reports window

- Click the scroll bar on the right of the window to navigate through the document.
- Click the document and press the arrows on the keyboard to view the information.

2.8.5.1 Buttons on the Crystal Reports Toolbar

- Click **Print** to display the **Print** dialog. Select the printer, number of copies, page range, and other properties used to output the contents of the Crystal Reports window.

- Use the navigation buttons to move from page to page in the text of the Crystal Reports window. From left to right, the buttons have the following functions:
  - Go to the first page.
  - Go to the previous page.
  - Go to the next page.
  - Go to the last page.
- Type a page number in the **Go to Page** box and press Enter to navigate to the page.
- Click **Find Text** to display the **Find Text** box, enter the search criteria and press Enter.
- Click **Zoom** to increase the size of the text of the **Crystal Reports** window.

2.8.6 Other Navigation Information

It is recommended that you complete forms by moving from the top of the screen to the bottom as you navigate through data entry screens in BHS. Many forms feature tabs for entering information. It is recommended that you navigate through the tabs, completing the information from left to right.

All of the forms have required fields to fill out before the **Save** operation can be completed. The required fields are those in **bold** text. An error message displays if you attempt to save a form without completing the required fields.

2.9 Log On

Select **Behavioral Health System** from the **Start** menu or double click the icon (Figure 2-12) on the desktop.

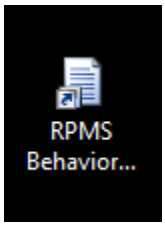

Figure 2-12: Log-on icon

- Type the **Access Code** and **Verify Code** data in the fields as shown in Figure 2-13:

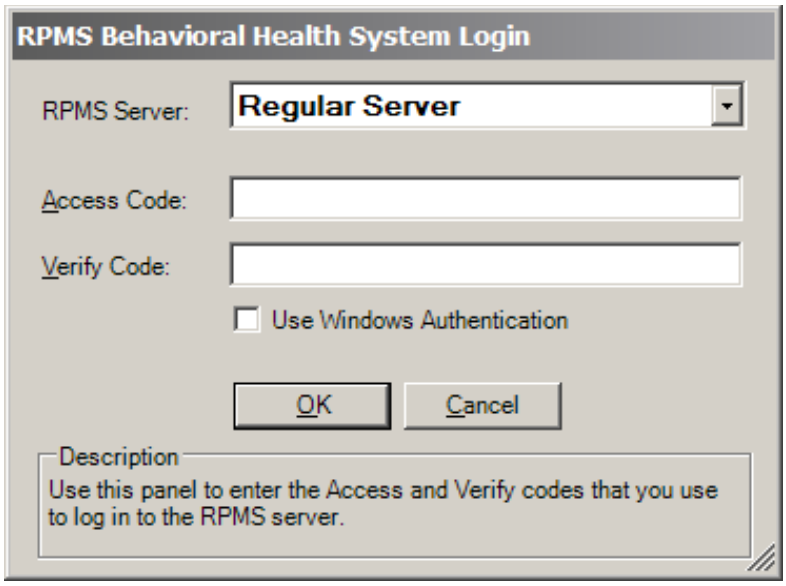

Figure 2-13: **Login** screen

2.10 Patient Select

5. Click **Patient** at the top of the main menu tree (Figure 2-1) and click **Select**. The **Patient Select** window will display as shown in Figure 2-14:

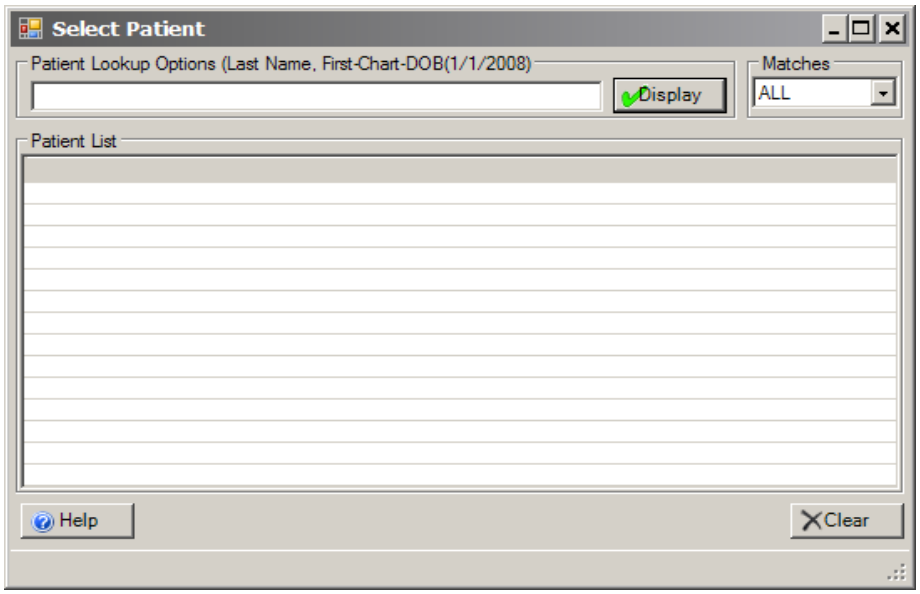

Figure 2-14: **Select Patient**

6. Type data in the **Patient Lookup Options (Last Name, First-Chart-DOB)** field.
7. Click **Search** to display the results in the **Patient List** pane.

8. Double click the patient's name to display the information in the lower left corner of the window as shown in Figure 2-5.

   - If you select the **One Patient** data entry option, **Case Management**, **View Health Summary**, or **View Face Sheet**, and a patient is not selected, the **Select Patient** window displays.

> **Note:** Right-click anywhere on the menu tree to display a "Change Patient" prompt that will display the same **Patient Select** window.

2.11 View Patient Data

The **View Patient Data** section of the main menu tree allows for the display and printing of patient data. These options display in a view only **Crystal Reports** window and cannot be edited.

2.11.1 Face Sheet

Click **View Face Sheet** on the menu tree to print or display a **Face Sheet**. The **Face Sheet** will display in a **Crystal Reports** window.

2.11.2 Health Summary

Click **View Health Summary** on the menu tree to print or display the types of Health Summary. The **Select Health Summary Type** dialog shown in Figure 2-15 will display. Select a summary type from the **Health Summary Type** menu and click **OK**.

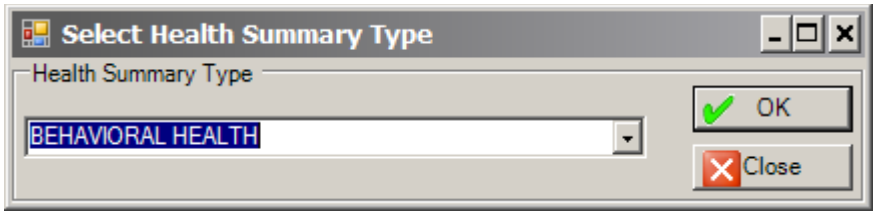

Figure 2-15: **Health Summary Type** dialog

2.11.3 Patient Appointments

Click **Patient Appointments** (Figure 2-16) to print or display appointments. The **Patient Appointments** date dialog displays.

- Select the date range and click **OK** to display the appointments. The default date range is three months in the past to three months in the future.

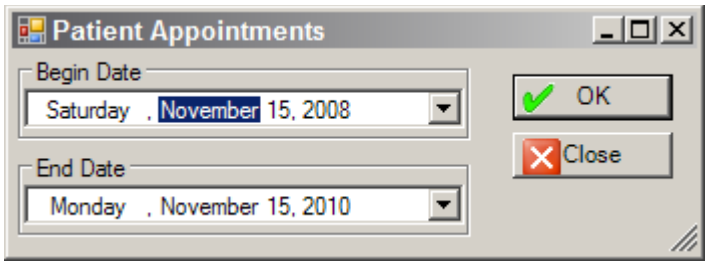

Figure 2-16: **Patient Appointments** Date Select dialog

2.11.4 PCC Medications

Click **PCC Medications** to print or display medications for a patient.

- The **PCC Medications** date dialog (Figure 2-17) displays.
- Select the date range and click **OK** to display the data. The default date range is one year in the past to the current date.

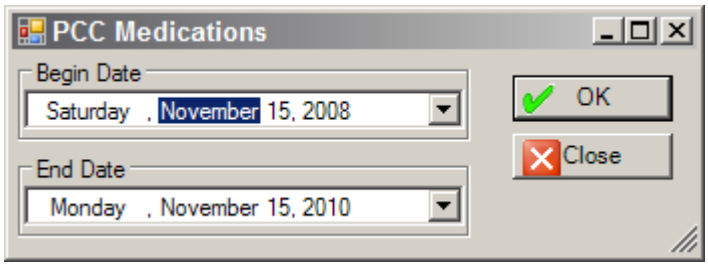

Figure 2-17: **PCC Medications** Date Select Window

2.11.5 PCC Labs by Visit Date

Click **PCC Labs by Visit Date** to print or display the lab information.

- The **PCC Labs by Visit Date** dialog (Figure 2-18) displays. Select the date range and click **OK** to display the patient information by visit date. The default date range is one year in the past through the current date.

Figure 2-18: PCC **Labs by Visit Date** Selection dialog

2.11.6 PCC Labs by Lab Test

Click **PCC Labs by Lab Test** to print or display PCC Labs listed by lab test for a patient. The **View Labs by Lab Test** dialog (Figure 2-19) displays.

- Select the date range and click **OK** to display the lab tests for the patient. The default date range is one year in the past through the current date.

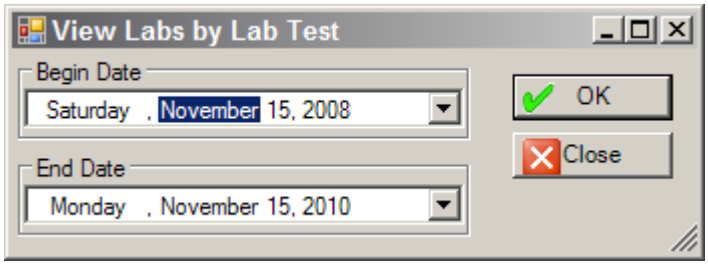

Figure 2-19: **PCC Labs by Lab Test Date** Selection dialog

3.0 Objective #3: Patient-Related Visit Data Entry

3.1 Purpose

The purpose of this exercise is to introduce you to patient-related visit documentation that can be entered through BHS.

3.2 Overview

Regardless of their discipline, it is important for users to enter accurate patient data. Complete and accurate data is critical for many reasons, most importantly for patient outcome, but also for billing purposes and program management and planning.

3.3 Skills You Will Acquire

Upon completion of this objective you will be able to:

- Identify the required fields.
- Enter an Individual Patient encounter.
- Access the Behavioral Health and PCC Problem Lists.
- Enter Intake information.
- Enter a Group encounter.
- Browse Visits.

3.4 Visit Encounters: One Patient Data Entry

Click **One Patient** under **Visit Encounters (**Figure 2-1) on the main menu tree to display the One Patient list view. You will be prompted to select a patient if one has not been selected from the One Patient view.

3.4.1 One Patient List View

The One Patient list view in Figure 3-1 displays the visits for the patient within a specified date range.

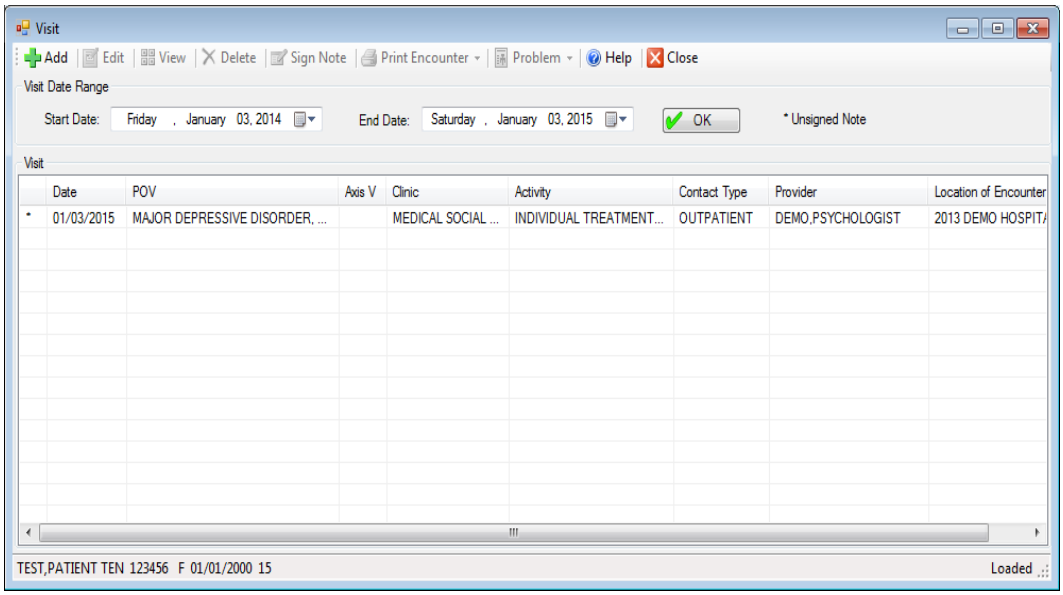

Figure 3-1: **Visit** Encounters, One Patient list view

The default date range for One Patient Visit Encounters is one year. When a new start date is selected it becomes the default until changed. Do the following:

1. Click **Add** to enter a new encounter.
2. Click **Edit** to update the selected encounter. After a note has been signed, it cannot be edited.

> **Note:** If you highlight an encounter that was entered via the **Group** functionality, the **Edit** button will be inactive.

3. Click **View** to review the encounter.
4. Click **Delete** to remove the encounter.
   - You must possess the appropriate **Delete** key to remove an encounter.
   - A confirmation will display for the deletion.
   - Visits with signed notes cannot be deleted unless you possess the **Delete Signed Note** key.
5. Click **Sign Note** to sign an unsigned note.
   - If a note is already signed, this feature is inactive. If you are not the Primary Provider and you try to sign a note, a message will display.
6. Click **Print Encounter** to print full, suppressed, or both full and suppressed copies of the encounter.

7. Click **Problem** for access to the Behavioral Health (BH) Problem List or PCC Problem List for a patient.
8. Click **Help** to display the online help.
9. Click **Close** to exit the list view.

3.4.2 Add, Edit, Sign Note Window

Click **Add**, **Edit**, or **Sign Note** on the One Patient **Visit** list view (Figure 3-1) to display the **Visit Data Entry** dialog (Figure 3-2).

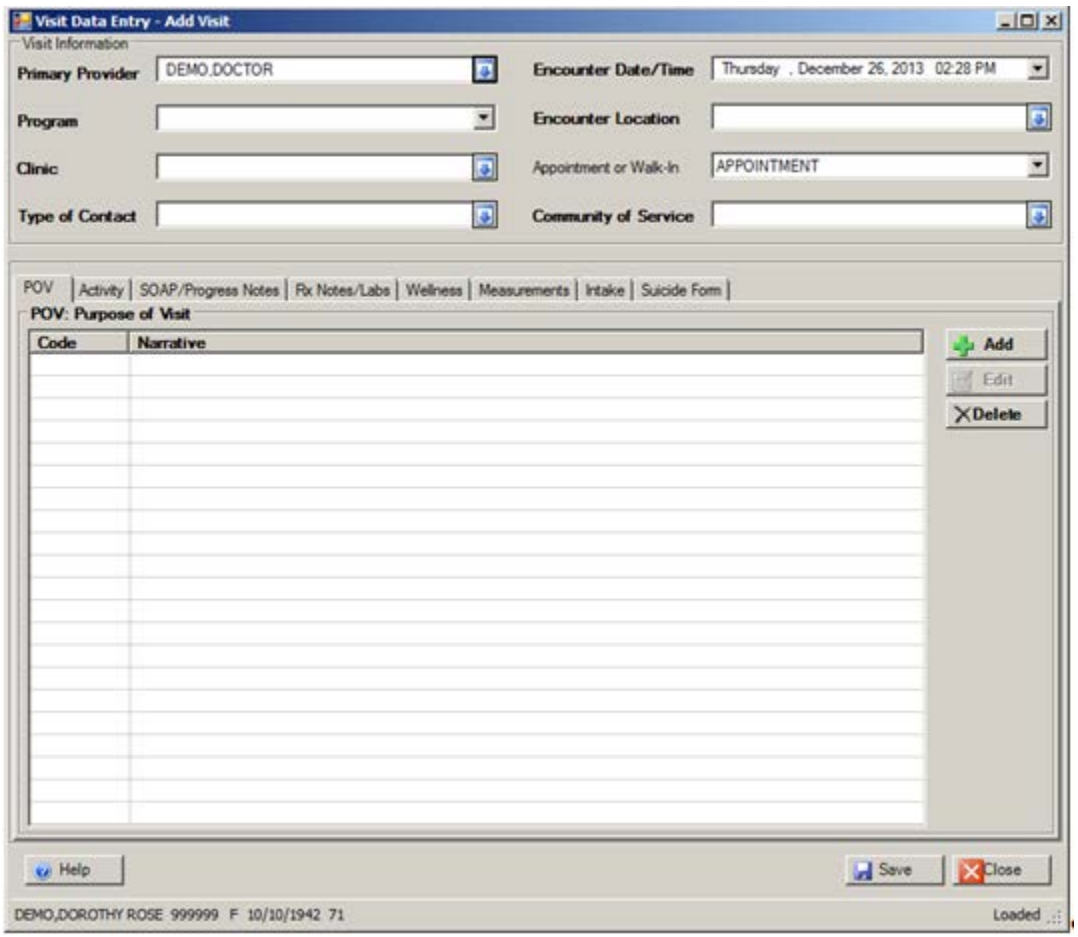

Figure 3-2: **Visit Data Entry** dialog

The required fields for One Patient Visit Data Entry are:

- **Primary Provider**
- **Encounter Date/Time**
- **Program**
- **Encounter Location**

- **Clinic**
- **Type of Contact**
- **Community of Service**
- **POV**
- **Activity**
- **Activity Time**
- **Number Served**

> **Notes**: The **Intake** tab on the **Individual Patient Visit** data entry window is the same as the window that displays when you click **Intake** on the menu tree. For further information about the Intake functionality, see Section 3.3.
>
> The **Suicide Form** tab on the **Individual Patient Visit** data entry window is the same as the window that displays when you click **One Patient** under **Suicide Reporting Forms** on the menu tree. For further information about the Suicide Reporting functionality, see Section 5.0.

If there are defaults set on the **Site Parameters** menu, selecting a program can default the **Encounter Location**, **Clinic**, **Type of Contact**, and **Community of Service**.

Select the **Rx Notes/Labs** (Figure 3-3) tab to view and graph lab data for the patient. The left side of the tab displays the **PCC Labs** features. The **View by Visit Date** and **View by Lab Test** features are the same as those found on the **View Patient Data** tree.

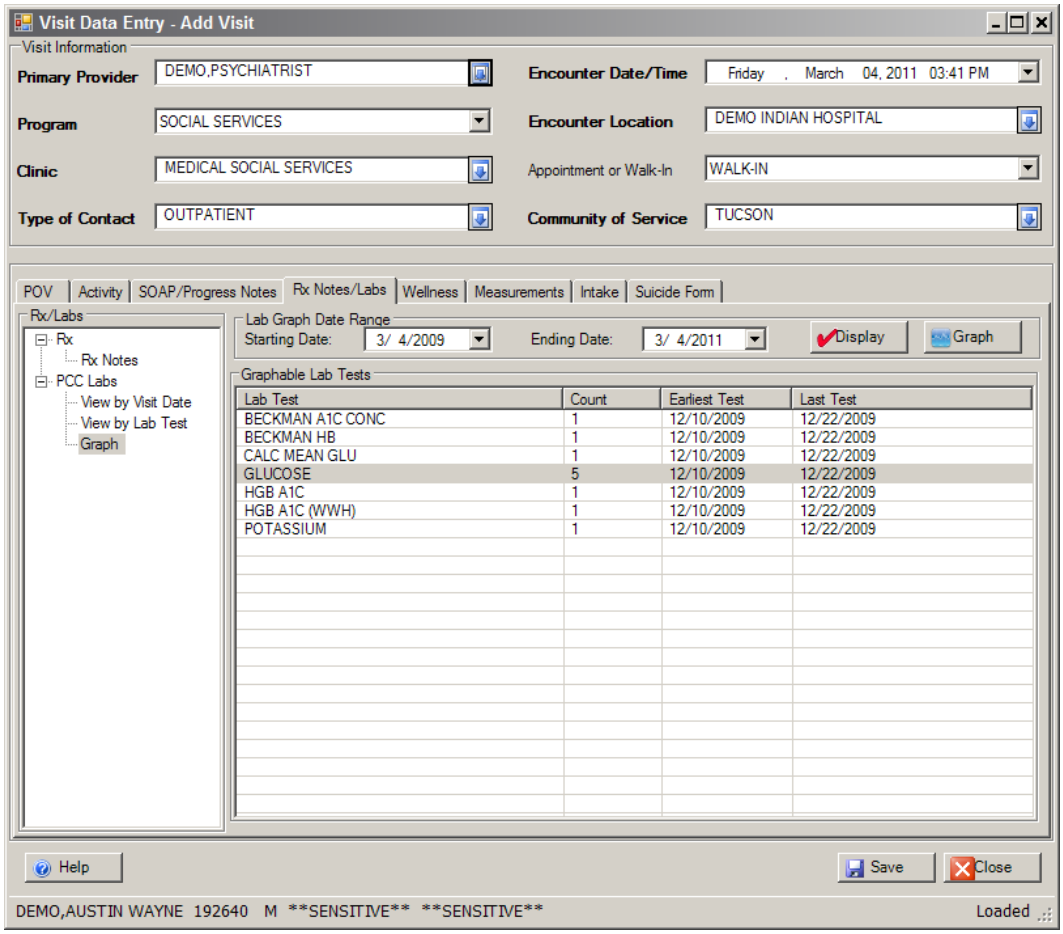

Figure 3-3: **Rx Notes/Labs** tab

1. Highlight a lab test and click **Graph** to create a lab results graph.
2. Set a date and click **Display**. Items to be graphed will display in a Microsoft® Excel® spreadsheet.
3. Complete the required and additional entry field and click **Save**. A message displays to sign the note.
   - If a SOAP/Progress Note was entered, a message displays requesting the note to be signed.
     - Click **Yes** to enter the signature code and sign the note
     - Click **No** to dismiss the prompt and leave the note unsigned.
   - If a SOAP/Progress Note is not entered, a message displays requesting a SOAP/Progress Note.
     - Click **Yes** to return to the SOAP/Progress Note field
     - Click **No** to save the visit without a note.

> **Note**: If you attempt to edit a visit with a signed SOAP/Progress Note, you will be unable to edit the note and the **Note** field will be inactive

3.5 Visit Encounters: All Patients Data Entry

Click **All Patients** under **Visit Encounters** on the main menu tree to display the **All Patients** list view shown in Figure 3-4:

3.5.1 All Patients List View

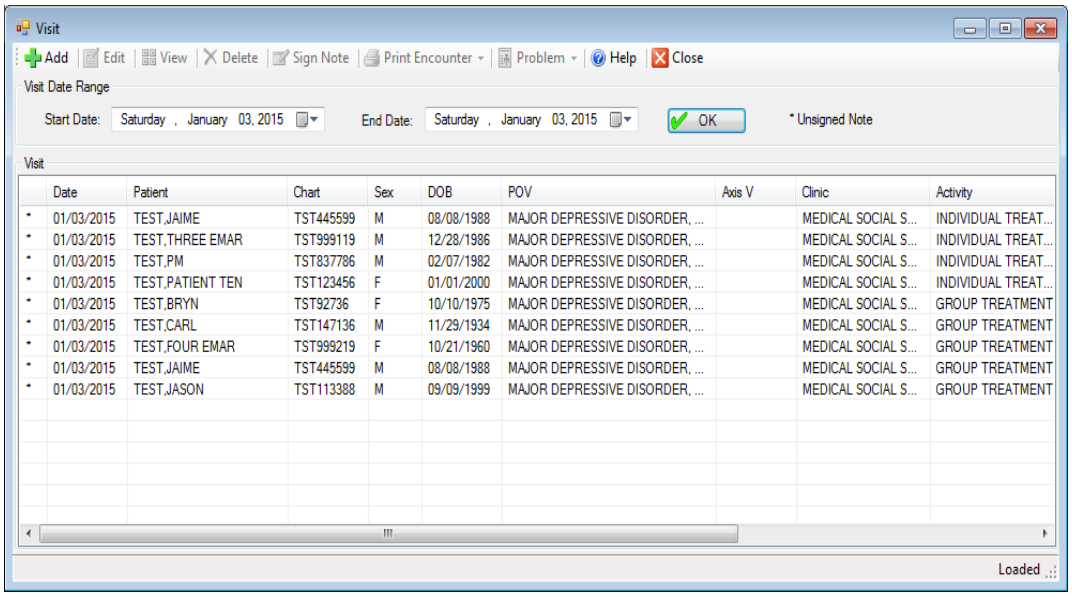

Figure 3-4: **Visit** Encounters, All Patients list view

The **All Patients** list view displays visits for all patients within a date range. The current date is the default.

The **All Patients** list view features the same functions and buttons as the **One Patient** list view (Section 3.4.1).

3.5.2 Add, Edit, Sign Note Window

The **Add**, **Edit**, and **Sign Note** window for **All Patients** is the same as **One Patient** (Section 3.4.2).

3.5.2.1 Practice Exercises

1. Enter an individual patient **Visit Encounter** by using the **One Patient** option:

    a. Complete only the required fields.

   b. Save without signing the note.

2. Enter an individual patient **Visit Encounter** by using the **All Patients** option:
   a. Complete the required fields as well as some of the non-required fields.
   b. Save and sign the note.
3. From the **All Patients** list view:
   a. Highlight the **Visit Encounter** entered earlier but left unsigned.
   b. Click **Sign Note**.
   c. Enter SOAP note text and sign the note.
4. From the **All Patients** list view, edit the **Visit Encounter** you entered with the signed note.

3.6 Visit Encounters: BH Problem List

1. Highlight a visit in the **One Patient** or **All Patients** window under **Visit Encounters**.
2. Click **Problem**. The **BH** or **PCC Problem List** for the selected patient displays

Problem List updates must be associated with a visit. The visit documentation must be completed prior to updating the **BH Problem List.**

3.6.1 Behavioral Health Problem List

1. Click **BH Problem List** to view the **Behavioral Health Problem List** window displayed in Figure 3-5.
   - The window features a list view on the top half of the window and data entry fields on the lower half.
   - **Problem List** items are listed with their associated notes below.
2. Highlight a **Problem List** item or **Note** to view an item in the **Problem List Data Entry** pane.

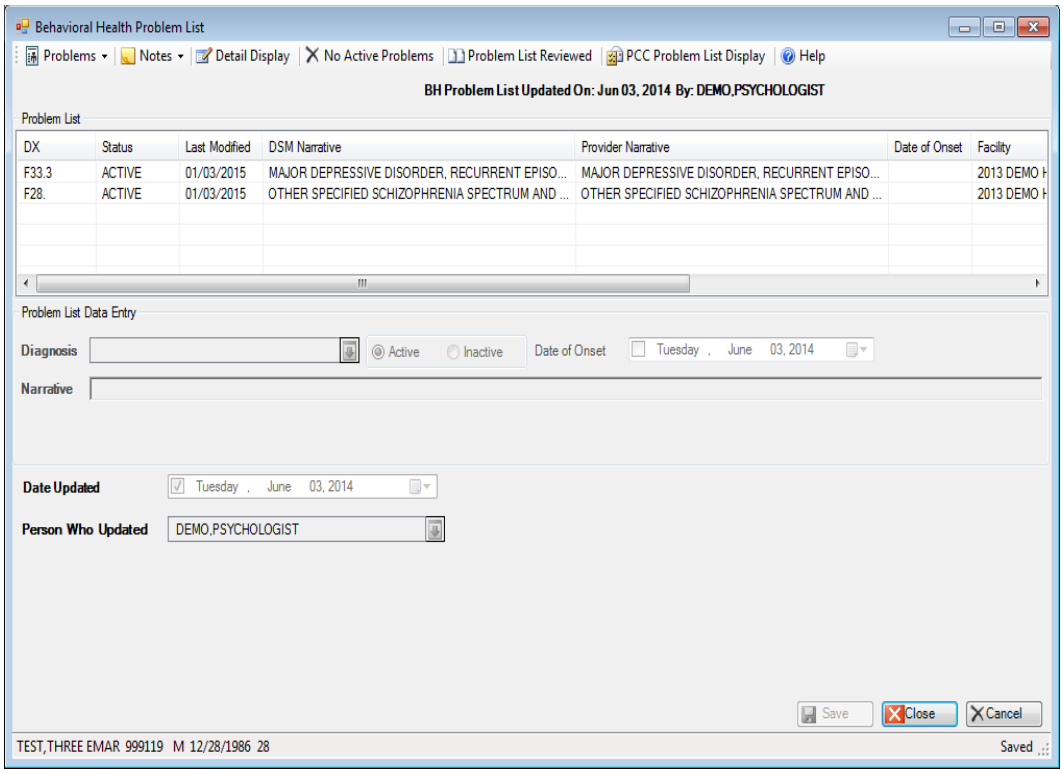

Figure 3-5: **Behavioral Health Problem List**

3. Click the **Problems** menu and do one of the following:

   - Click **Add Problem** to insert a Behavioral Health Problem List item
   - Highlight a problem and click **Edit Problem** to update the item.
   - Highlight a problem and click **Delete Problem** to remove the item.
   - Highlight an inactive problem and click **Activate Problem** to change the status of the item.
   - Highlight an active problem and click **Inactivate Problem** to change the status of the item.

4. Click the **Notes** menu and do one of the following:

   - Select an existing item and click **Add Note**.
   - Select an existing note and click **Edit Note**
   - Select an existing note and click **Remove Note**.
   - Select **Detail Display** to display the details of a Behavioral Health Problem List item and its associated notes in a Crystal Reports window. The item may also be printed.

5. Click **No Active Problems** to indicate that the patient has no Active Behavioral Health Problems.
6. Click **Problem List Reviewed** to indicate that the patient's Behavioral Health Problem List has been reviewed.
7. Click **PCC Problem List Display** to view the **PCC Problem List**.
8. Click **Help** to display the online help.
9. Click **Save** to save a record,
10. Click **Cancel** to dismiss any changes,
11. Click **Close** to exit the **BH Problem List** window.

Additional information about the Behavioral Health Problem List is displayed below the action items. The following information may be displayed in this section followed by a date:

- BH Problem List Reviewed On:
- BH Problem List Updated On:
- No Active Problems Documented On:

When a BH Problem List item is added, edited, deleted, activated, or inactivated the **Problem List Data Entry** (Figure 3-6) pane of the Behavioral Health Problem List screen becomes active.

Note:	The **Add Note?** box is used to add a note to a Problem List item and is only available on the **Problem List Data Entry** window when in **Add Problem** mode. A note may be added to a **Problem List** item after a **Problem List** is added by accessing the **Notes** menu.

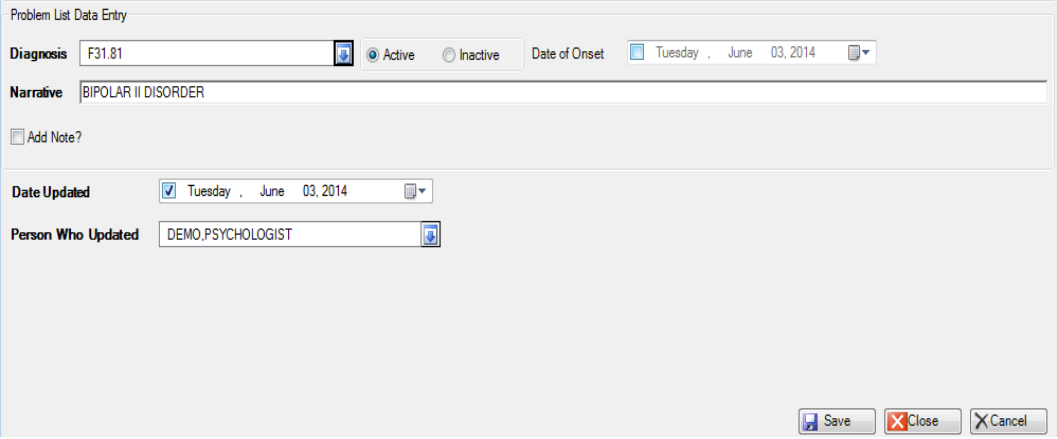

Figure 3-6: **Problem List Data Entry** dialog

The Required fields in the **Problem List Data Entry** section are:

- Diagnosis
- Narrative
- Date Updated
- Person Who Updated

> **Note**: The **Person Who Updated** field is defaulted to the **Primary Provider** of the visit to which the Problem List Update is associated.

12. Click **Notes** to add, edit, or remove a note to a **Problem List** item. Select an option on the **Notes** menu to active the **Note** area (Figure 3-7) on the **Problem List Data Entry** pane.

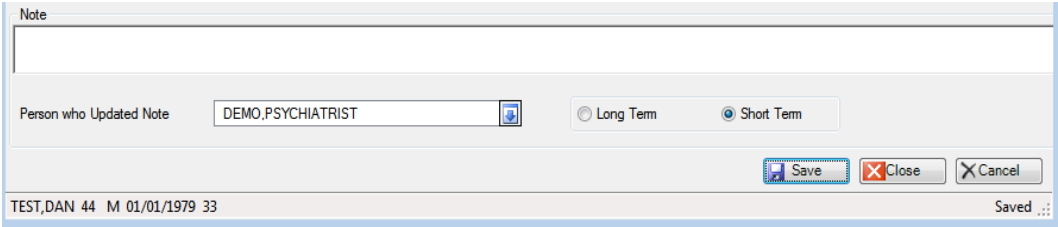

Figure 3-7: **Note** area of the **Problem List Data Entry** pane

The required fields in the **Notes** pane are:

- Note
- Author

> **Note**: The **Author** field is defaulted to the **Primary Provider** of the visit to which the Problem List Update is associated.

3.6.2 Practice Exercises

- Using a visit created while completing the exercises in Section 3.6.1.1, add an item to the patient's **Behavioral Health Problem List** and include a **Note.**
- Delete an item from the **Behavioral Health Problem List.**

3.7 Individual Patient Visit Encounters: Intake Tab

Click the **Intake** tab (Figure 3-8) in an individual patient encounter to access the **Intake** list view/data entry window. The top half of the window is a list view and the bottom half displays data entry field. Initial **Intakes** are displayed on the left side of the list view, and can be identified by a date in the **Initiated** column. **Intake** Updates are displayed on the right side of the list view and can be identified by a date in the **Updated** column.

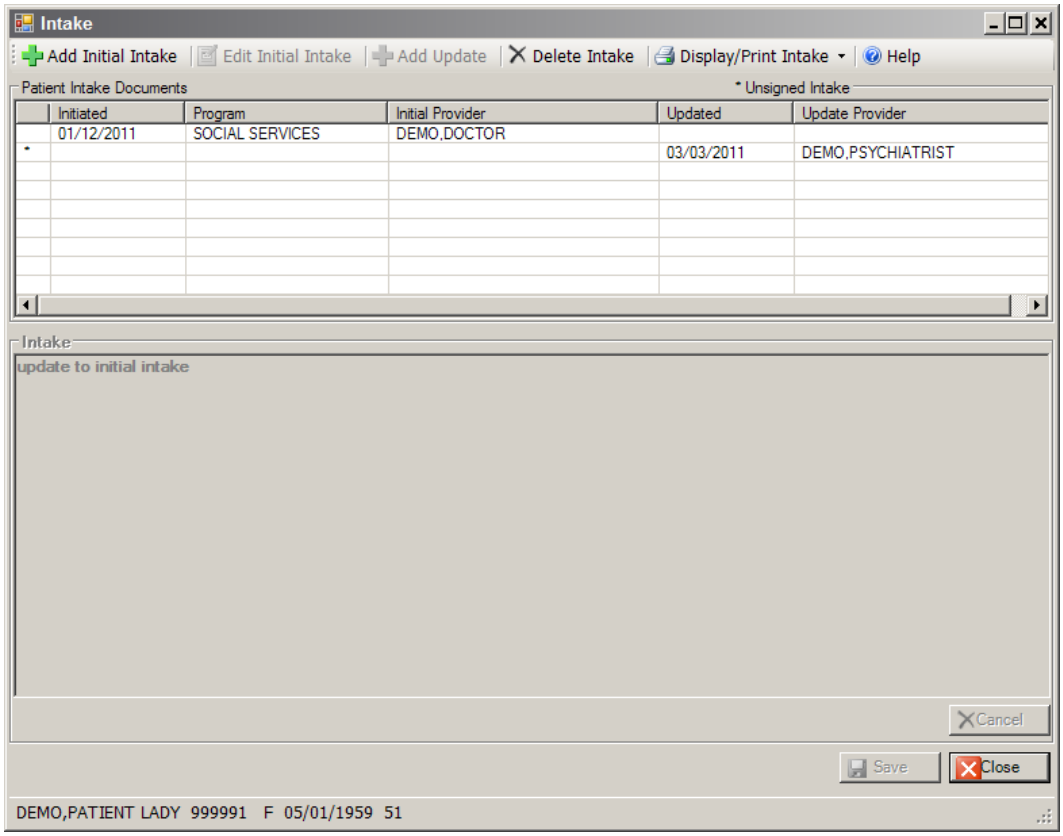

Figure 3-8: **Intake** list view

On the top of the window are the following buttons:

- **Add Initial Intake**. Add an Initial Intake.
- **Edit Initial Intake**. Edit an Initial Intake or sign an **Initial Intake** that was left unsigned. Initial Intakes can only be edited by the provider of the intake or by the person who entered the intake. In order for an intake to be edited, it must be unsigned.
- **Add/Edit Update**. Allows you to add or edit an Intake Update. This button has two options, depending on the item you have highlighted:
  - If you have an **Initial Intake** highlighted, the button will read **Add Update**.
  - If you have an update highlighted, the button will read **Edit Update**.
- **Delete Intake**. Allows you to delete the highlighted intake document:
  - You must possess the appropriate **Delete** key and you will be asked to confirm that you wish to delete the intake.
  - Only the provider of the intake or the person who entered the intake is allowed to delete the intake.

  - Signed intake documents cannot be deleted unless you are listed on the **Delete Override Site Parameter** or meet the above delete criteria to be able to delete intakes and possess the Delete Signed Note key.
  - Initial Intakes with Updates attached cannot be deleted until the attached Updates are deleted.
  - Once the attached Updates are deleted, the Initial Intake may be deleted.
- **Display/Print Intake** to display or print an initial intake, an intake update, or a combination of the two.
- Click **Help** to display the online help.
- Click **Close** to exit list view.

Add or edit an intake document to display the **Select Intake Parameters** dialog (Figure 3-9).

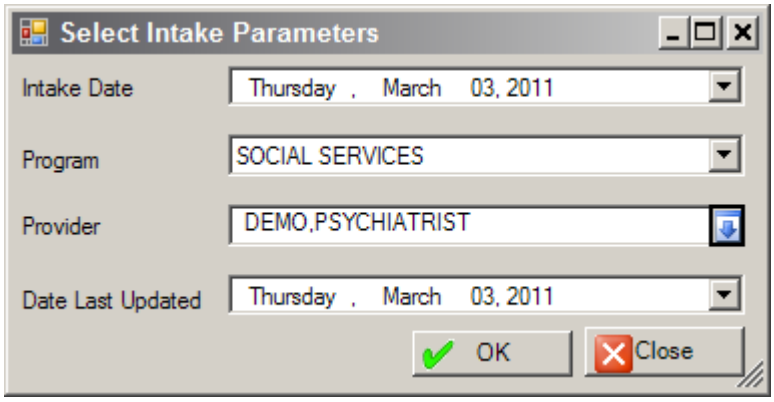

Figure 3-9: **Select Intake Parameters**

- The **Intake Date** and **Date Last Updated** fields default to the current date.
- The **Program** field defaults to the program associated with the visit.
- The **Provider** field defaults to the logged-in provider:

All these fields may be changed, but it is advised that you do not change the program at this time because it will not be visible when you return to the list view. You have to back out of the list view, access **Intake** from the menu tree, and select the appropriate program associated with the document you just entered.

> **Note**: Accessing **Intake** documents from the menu tree functions similarly, except you will be prompted to select a program before the list view displays.

Adding or editing an intake document makes the **Data Entry** field active. This is a word processing field into which you can also paste copied text. Once you have entered your intake documentation and clicked **Save**, you will be prompted to enter your electronic signature code. If you do not wish to sign the document at this time,

you can click **Cancel**, confirm that you do not want to sign the document, and the document will remain unsigned. To sign an unsigned intake document, highlight the document you wish to sign and click the appropriate **Edit** button. Once the document opens for editing, you can add additional text and click **Save**, or simply save without editing to receive the electronic signature prompt.

> **Note**: Signing the **Intake** document is separate from the signing of a SOAP/Progress Note.

Appendix A: provides more information about setting up an Electronic Signature in RPMS.

> **Note**: If you wish to quickly view an intake document, you can double-click it in the list view and it will display in the Data Entry field, but will not be editable.

For further information about the Intake functionality, access the online **Help** file.

3.7.1 Practice Exercises

1. Enter an Initial Intake, save, and sign the intake.
2. Enter an Update to the Initial Intake you entered, and save without signing it.
3. Enter an additional Update and save and sign it.
4. Display/print the Initial Intake and just the second Update.

3.8 Visit Encounters: Group Encounters

Click **Group Encounters** under **Visit Encounters** to display the **Group Encounters** list view (Figure 3-10).

3.8.1 List View

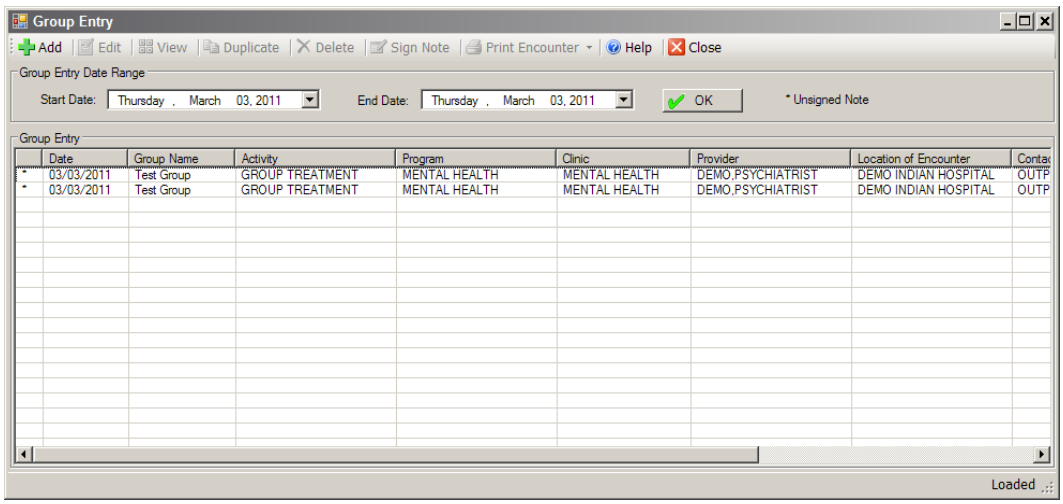

Figure 3-10: **Group Entry** list view

The Group Encounter list view displays group encounters within a date range. The default date range for group encounters is one year.

At the top of the window are the following:

- **Add**: to add a new group encounter.
- **Edit**: to edit a highlighted group encounter. Once a group has been saved, only data on the **Group Encounter Information** section and the **Patient Data** tab may be edited. If the notes have been signed, you will not be able to edit them.

> **Note**: The individual patient encounters associated with a group cannot be edited through the One Patient or All Patient list views. All editing of individual patient data should be done via the **Group Encounter Information** section of the group encounter or the **Patient Data** tab. When accessing the One Patient or All Patient list views, if you highlight an encounter that was entered via the Group functionality. The **Edit** button will be inactive.

- **View**: to view the highlighted group encounter.
- **Duplicate**: to duplicate a group encounter. This feature duplicates the Standard Group Note, the group Purpose of Visit (POV) data, and the patients in the group. It does not duplicate Group Education, or data on the **Patient Data** tab.
- **Delete**: to delete a highlighted group encounter. A **Delete** key is required in order to delete a group encounter. A confirmation message will display. Deleting a group encounter deletes the group definition and the individual patient encounters associated with the group. Signed notes cannot be deleted unless you possess the Delete Signed Note key.

- **Sign Note**: To sign the unsigned notes for all of the patients in a group. This feature is inactive if the notes have already been signed. If you are not the Primary Provider and you try to sign the group notes, you will receive a message stating that you cannot sign them.
- **Print Encounter**: to print either a full, suppressed, or both full and suppressed copy of the group encounter for all patients in the group.
- Click **Help**: to display the online help.
- Click **Close**: to exit the list view.

3.8.2 Add Group Data

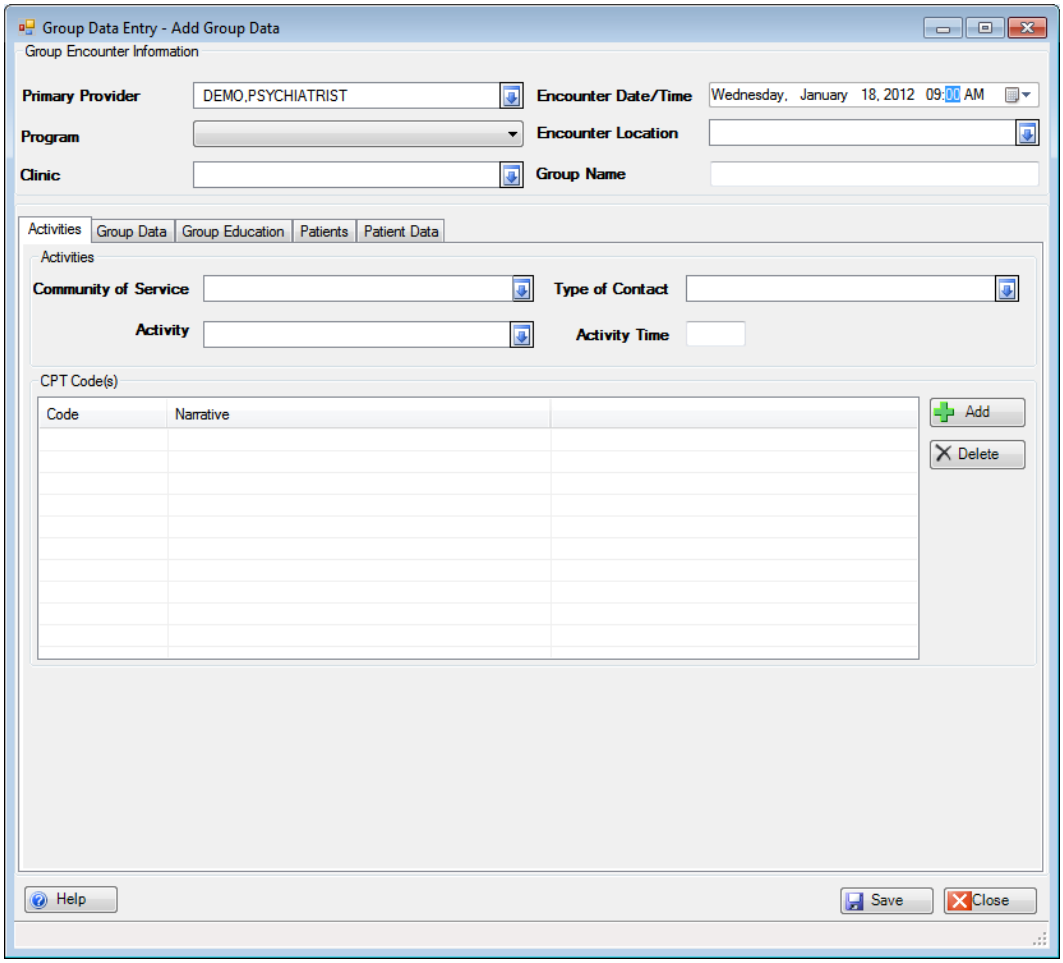

Figure 3-11: **Group Data Entry Add** window

The required fields for Group Encounters are:

- **Primary Provider**
- **Encounter Date/Time**

- **Program**
- **Group Name**
- **Clinic**
- **Community of Service**
- **Type of Contact**
- **Activity**
- **Encounter Location**
- **Activity Time**
- **POV**
- **Standard Group Note**
- **Patients**

The data entered in the **Group Data** and **Group Education** tabs will apply to all patients in the group. Select the patients and navigate to the **Patient Data** tab. You can customize the data for the individual patients in the group. For example, you can remove one of the POVs or add an additional POV for an individual patient.

Note:	Click the **Group Data** tab after you enter data into the **Patient Data** tab to clear whatever has been entered on the **Patient Data** tab. Make sure that all group information is accurate prior to navigating to the **Patient Data** tab.

Complete the required and additional fields and click **Save**. A message displays requesting the note to be signed. Signing the notes signs the notes for all patients in the group.

- Click **Yes** to enter the signature code and sign the note
- Click **No** to dismiss the prompt and leave the note unsigned.

3.8.3 Edit or Sign Note

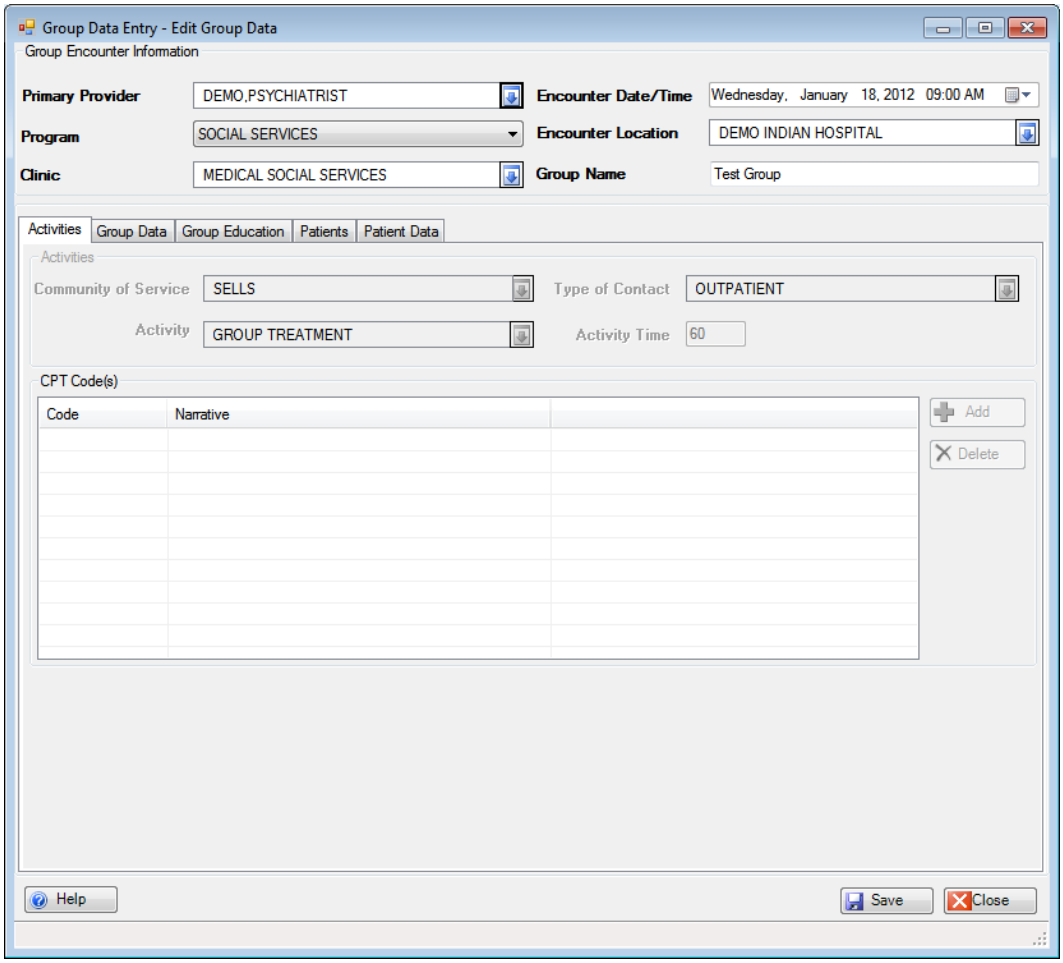

Figure 3-12: **Group Data Entry – Edit Group Data** window

Click **Edit** or **Sign Note** in the Group Encounter list view (Section 3.8.1) to open the data entry window. Only the fields in the **Group Encounter Information** and **Patient Data** tab will be active.

> **Note**: If you edit a group encounter with signed notes, the **Standard Group Note** fields will be inactive and you will be unable to edit the individual patient notes in the **Patient Data** tab.

- If edits are required or a patient needs to be deleted, the Group Encounter should be duplicated, the changes should be made, and original be deleted.

> **Note**: A duplicated group encounter does not contain the Group Education or any changes you made on the **Patient Data** tab of the original group encounter, you will need to reenter this information in the new encounter.

If the Group Notes are unsigned and you are the Primary Provider, click **Save** to prompt for your electronic signature code.

3.8.3.1 Practice Exercises

- Enter a Group Encounter by completing the required fields and patient education. Save without signing the note.
- Edit the same Group Encounter by changing data in the **Group Encounter Information** section and the **Patient Data** tab. Save and sign the note.
- Highlight the same Group Encounter again and click **Duplicate**. Change some of the data and save and sign the note.

3.9 Browse Visits

Click **Browse Visits** under **Visit Encounters** to display the window shown in Figure 3-13.

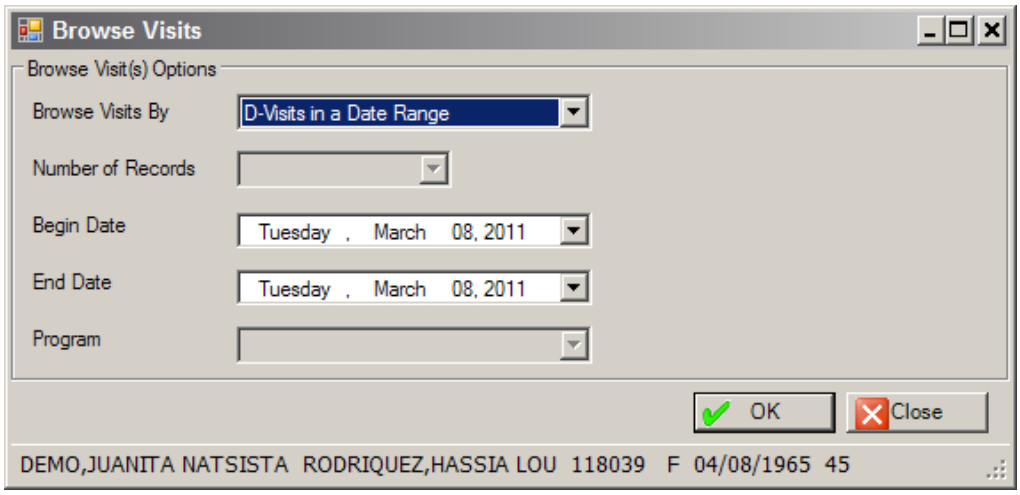

Figure 3-13: **Browse Visits**

You can browse visits by the following criteria:

- **Patients Last Visit**
- **Patients Last N Visits**
- **Visits in a Date Range**
- **All of this Patient's Visits**
- **Visits to One Program**

Other fields will become available depending on the selections made. For example, if you choose to browse by **Patients Last N Visits**, the **Number of Records** field becomes available for you to select a number.

- Click **OK** to display the visits in a **Crystal Reports** window.

4.0 Objective #4: Case Management Activities and Treatment Plans

4.1 Purpose

The purpose of this exercise is to introduce the optional **Case Management** and **Treatment Plan** features of BHS.

4.2 Overview

It is important that users of BHS, regardless of their discipline, be able to enter accurate, optional patient-related data such as case status and treatment plans and reviews. Complete and accurate data is critical for many reasons, most importantly for patient outcome, but also for billing purposes, program management, and planning.

4.3 Skills You Will Acquire

Upon completion of this objective you will be able to:

- Recognize the different types of optional data entry fields
- Add and update Case Status, Designated Provider, and Personal History information
- Complete a client-specific Treatment Plan and Review

4.4 Case Management

Select **Case Management** from the menu tree (Figure 2-1) to display the **Case Status** list view. You will be prompted to select a patient if one has not been highlighted in the list view.

4.4.1 List View

The **Case Status** list view displays Case Status records for a patient within a date range. The default date range is one year. Data entered on the **Patient Information** or **Personal History** panes of the **Case Management Add or Edit** window will not be reflected in the list view.

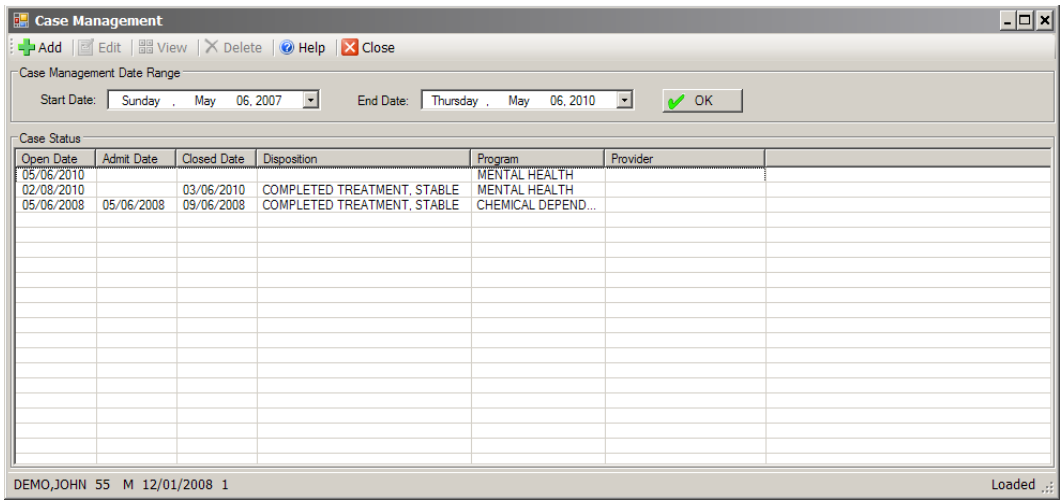

Figure 4-1: **Case Management** list view

On the top of the window are the following

- **Add**: Allows you to add Case Management information.
- **Edit**: Allows you to edit Case Management information.
- **View**: Allows you to view Case Management information.
- **Delete**: Allows you to delete a Case Status. You must possess the appropriate **Delete** key and you will be asked to confirm that you wish to delete the Case Status.
- Click **Help**: Displays the online help.
- Click **Close**: Exits the list view.

4.4.2 Add or Edit

Click **Add** or **Edit** on the list view will display the **Case Management – Add Case** window shown in Figure 4-2:

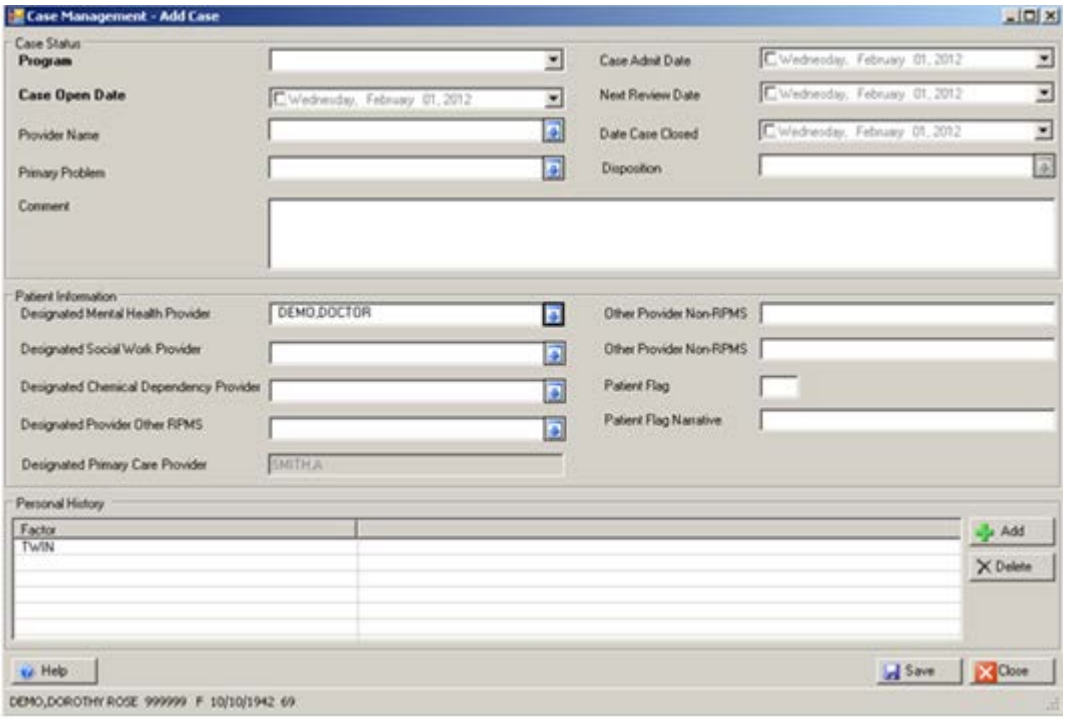

Figure 4-2: **Case Management Add Case** window

There are only two required fields on this screen and are only required if data is entered in the **Case Status** pane. Data can be entered in the **Patient Information** and **Personal History** panes of the window, without having to complete any required fields.

The required fields on the Case Status section of the Case Management screen are:

- **Program**
- **Case Open Date**

4.5 Treatment Plans: One Patient Data Entry

Click the plus sign (+) to the right of the menu item, to expand the **One Patient** and **All Patient** options. You will be prompted to select a patient, if one has not been highlighted.

4.5.1 One Patient List View

Click **One Patient** under **Treatment Plans** to display the One Patient Treatment Plan list view shown in Figure 4-3:

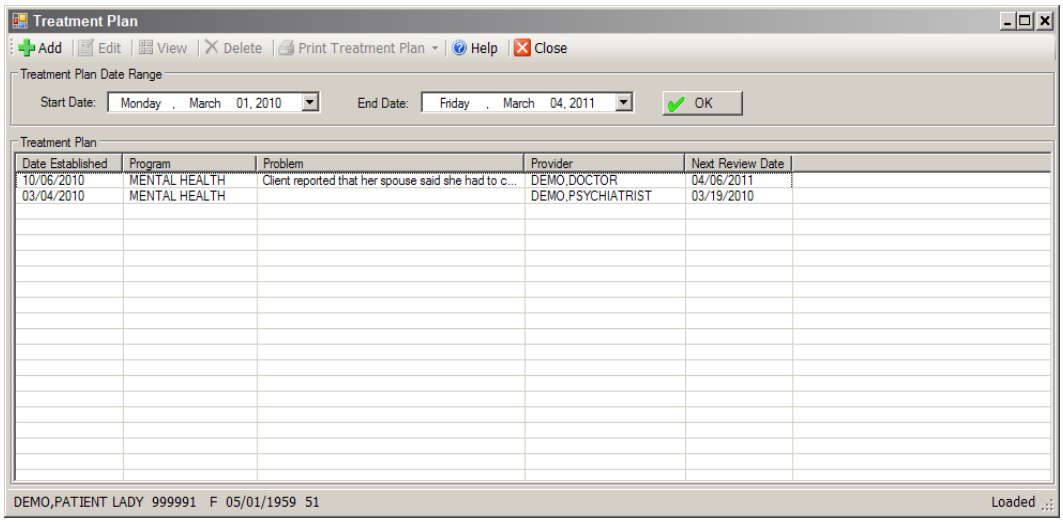

Figure 4-3: **Treatment Plan** One Patient window

The One Patient Treatment Plan list view displays treatment plans for the patient within a date range. The default date range is one year.

On the top of the window are the following:

- **Add**: Allows you to add a new Treatment Plan.
- **Edit**: Allows you to edit a Treatment Plan or add a Review.
- **View**: Allows you to view a Treatment Plan or Review.
- **Delete**: Allows you to delete a Treatment Plan and its Reviews. You must possess the appropriate **Delete** key and you will be asked to confirm that you wish to delete the Treatment Plan.
- **Print Treatment Plan**: Allows you to print a **Treatment Plan**, a review, or a combination of the Treatment Plan and Reviews.
- Click **Help**: Displays the online help.
- **Close**: Closes the window.

4.5.2 One Patient Add or Edit

Click **Add** or **Edit** on the **One Patient** list view to display the **Treatment Plan** data entry window shown in Figure 4-4:

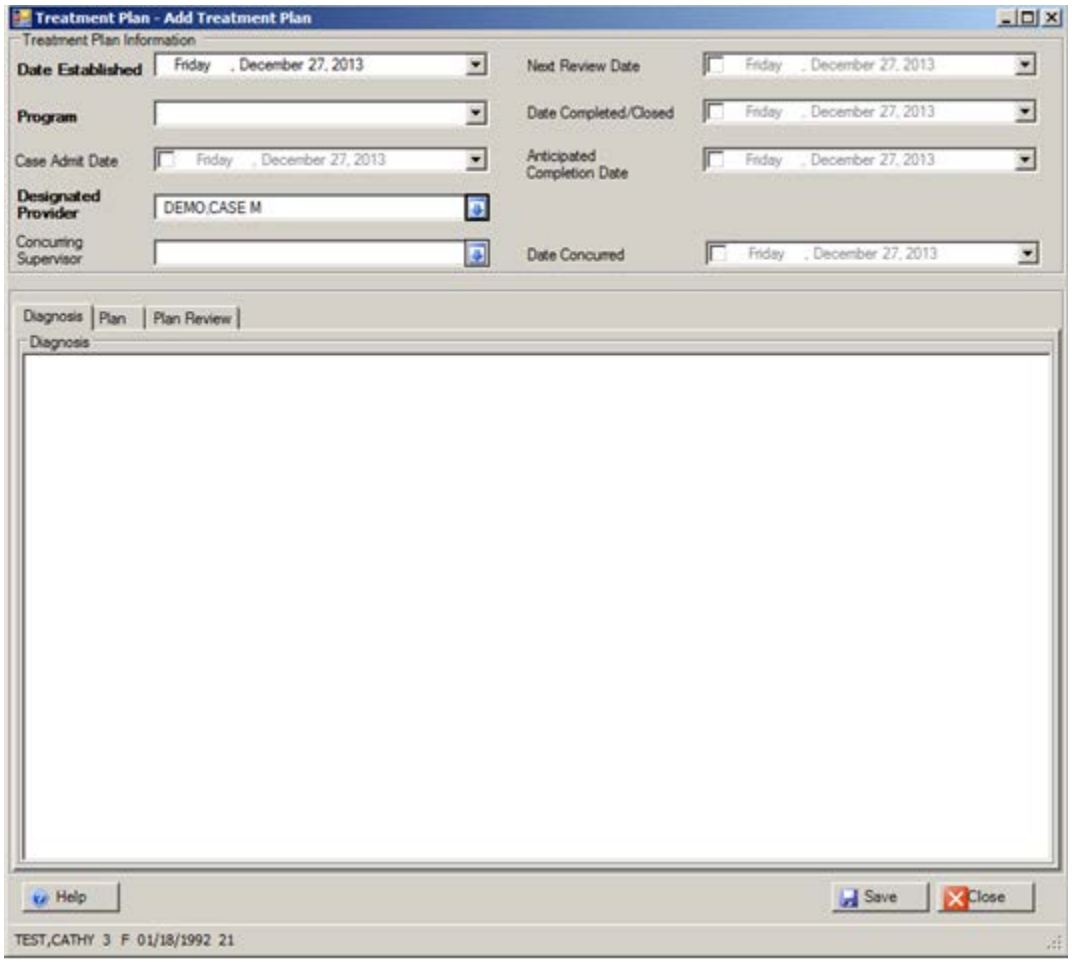

Figure 4-4: **Treatment Plan–Add Treatment Plan** window

The required fields for the **Treatment Plan** data entry screen are:

- **Date Established**
- **Program**
- **Designated Provider**

If you are entering a review in the **Plan Review** tab, the required fields are:

- **Review Date**
- **Next Review Date**
- **Review Provider**

> **Note**: When you enter a Next Review Date on the **Plan Review** tab, it will automatically change the Next Review Date on the **Treatment Plan** header.

Treatment Plan Reviews are performed by editing the original **Treatment Plan** and adding a Review in the **Plan Review** tab.

4.6 Treatment Plans: All Patients Data Entry

Click the plus sign (+) to the right of the menu item, to access the All Patients Treatment Plan functionality in BHS. The Treatment Plan will expand as shown in Figure 4-5.

4.6.1 All Patients List View

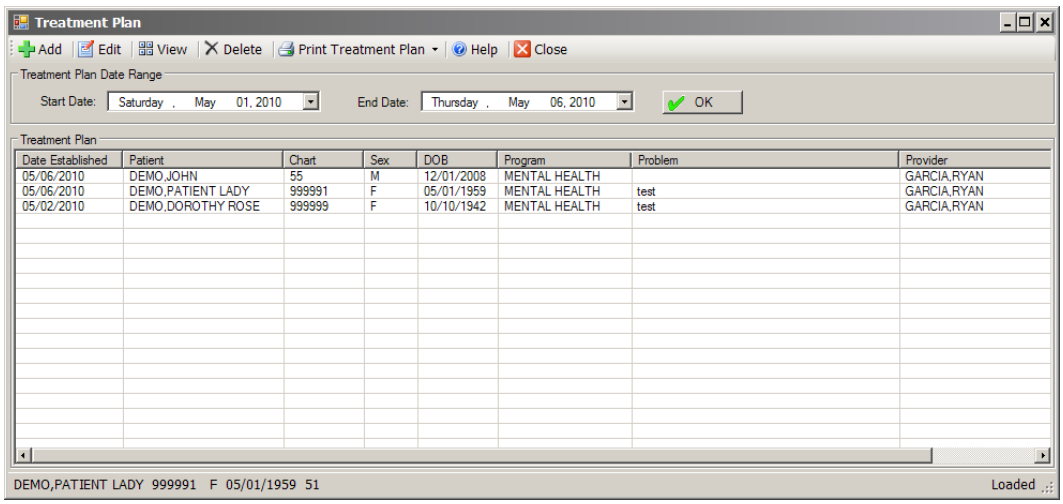

Figure 4-5: **Treatment Plan** All Patients list view

Click **All Patients** under **Treatment Plans** to open the **All Patients Treatment Plan** list view. The **All Patients Treatment Plan** list view displays treatment plans for all patients within a date range. The default date range is one year. Set a new start date.

The buttons on the top of the window are the same as those in the One Patient Treatment Plan list view (Section 4.5.1).

4.6.2 All Patients Add or Edit

The **Add and Edit** window for All Patients is the same as for One Patient (see Section 4.5.2).

4.6.2.1 Practice Exercises

- Enter a Case Status for a patient, including Designated Provider and Personal History information, and click **Save**.
- Edit the Case Status you entered and change some of the information. Click **Save**.
- Enter a Treatment Plan for a patient with a Date Established of two weeks ago, include two or three participants, and save.
- Enter a Plan Review for the same patient with a Review Date of the current date and save.

5.0 Objective #5: Suicide Reporting Forms

5.1 Purpose

The Purpose of this exercise is to introduce you to the Suicide Reporting Form feature of BHS.

5.2 Overview

It is important that users of BHS, regardless of their discipline, be able to enter accurate patient-related Suicide Reporting Form information. Complete and accurate Suicide Reporting Form data is used to generate statistical data at the point of service that can be used at the local, area, and national levels to help focus prevention efforts, identify trends, and to determine program and funding needs.

5.3 Skills You Will Acquire

Upon completion of this objective, you will be able to:

- Summarize the importance of suicide surveillance
- Recognize suicidal behaviors that should be recorded using the Suicide Reporting Form
- Understand the required fields on the Suicide Reporting Form
- Add and edit a Suicide Reporting Form

5.4 Suicide Reporting Form: One Patient Data Entry

Click the plus sign (+) to the right of the menu item, to expand the options for **One Patient** and **All Patients**. When a patient is not selected, a message prompt will display.

5.4.1 One Patient List View

The **Suicide Reporting Form One Patient** list view displays Suicide Reporting Forms for one patient within a date range shown in Figure 5-1. The default date range is one year, but this can be changed.

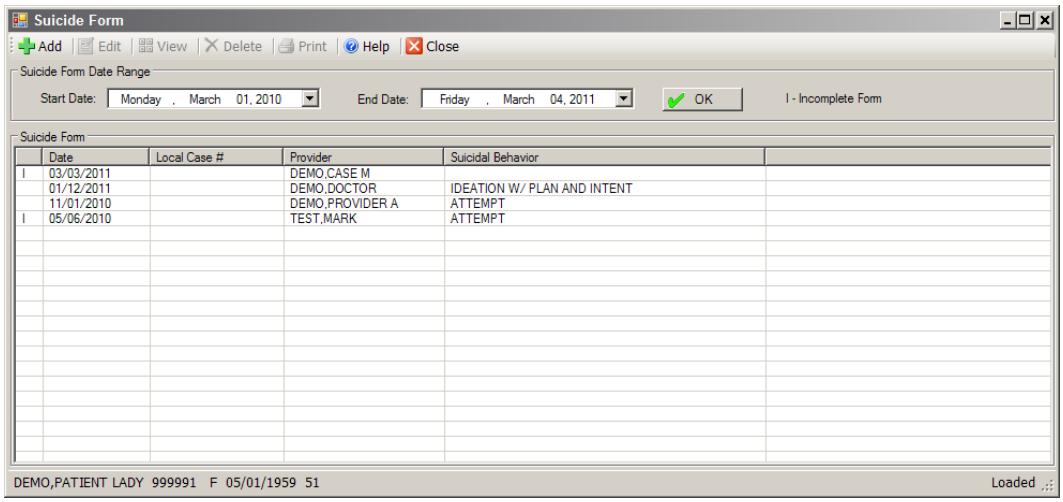

Figure 5-1: **Suicide Reporting form** One Patient list view

On the top of the window are the following:

- **Add**: To add a new Suicide Reporting Form.
- **Edit**: To edit a Suicide Reporting Form.
- **View**: To view a Suicide Reporting Form
- **Delete**: To delete a Suicide Reporting Form. You must possess the appropriate **Delete** key and you will be asked to confirm that you wish to delete the form.
- **Print**: To print a Suicide Reporting Form. When printed, Suicide Reporting Forms do not contain any identifiable patient information.
- Click **Help**: To display the online help.
- Click **Close**: To exit the list view.

> **Note:** Incomplete Suicide Reporting Forms are identified with an "I" in the first column from the left.

5.4.2 One Patient Add or Edit

Click **Add** or **Edit** on the One Patient list view will display the **Suicide Reporting Form** data entry screen shown in Figure 5-2.

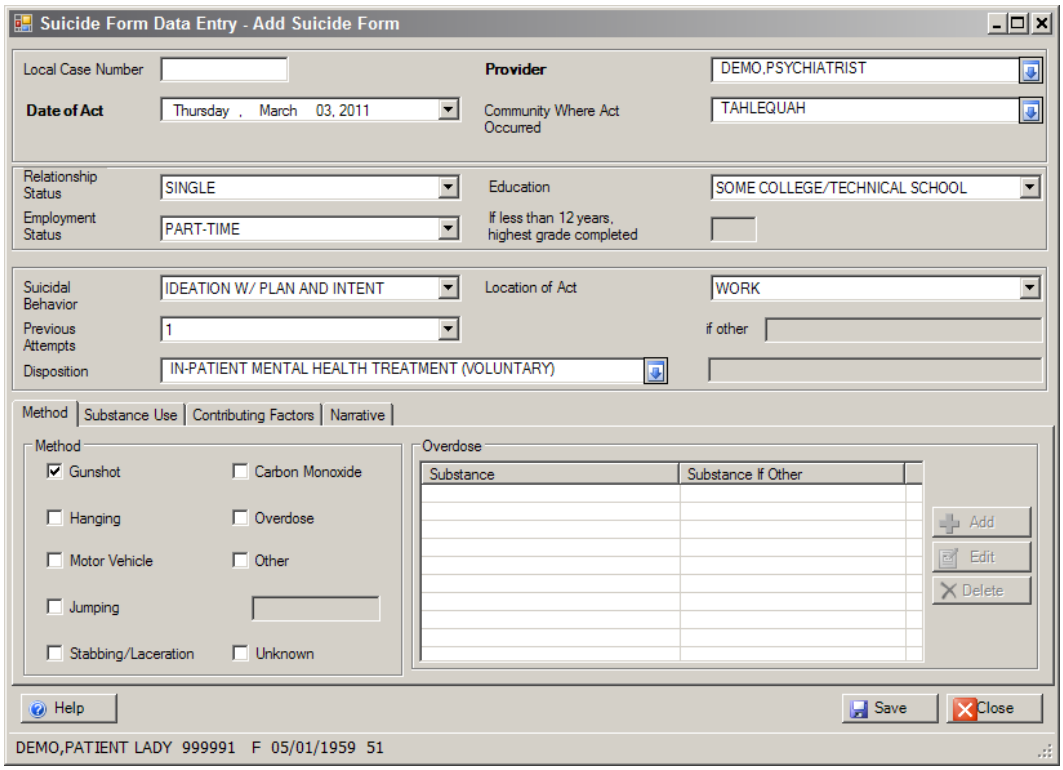

Figure 5-2: **Suicide Form Data Entry–Add Suicide Form** window

There are two required fields that are bolded on the **Suicide Reporting Form**:

- **Provider**
- **Date of Act**

These two fields are required to be able to save a Suicide Reporting Form. All the other fields, except **Local Case Number** and **Narrative**, are required, but not enforced. This means - if you are in the process of filling out the form, and have only completed some of the fields, you can click **Save** and you will be given the option to save the form as is and return to complete it later. For a Suicide Reporting Form to be considered complete, all of the fields except for **Local Case Number** and **Narrative** must contain responses.

The required fields are:

- **Community Where Act Occurred**
- **Relationship Status**
- **Education**

- **Employment Status**
- **Suicidal Behavior**
- **Location of Act**
- **Previous Attempts**
- **Disposition**
- **Method**
- **Substance Use**
- **Contributing Factors**

> **Note**: Most of the fields have the option of responding with **Unknown** to help facilitate completion of the form when not all data is known.

5.5 Suicide Reporting Form: All Patients Data Entry

Click the plus sign (+) to the right of the menu item, to expand the **One Patient Suicide Reporting Form** functionality in BHS.

5.5.1 All Patients List View

Click **All Patients** under **Suicide Reporting Forms** opens the **All Patients Suicide Reporting Form** list view shown in Figure 5-3:

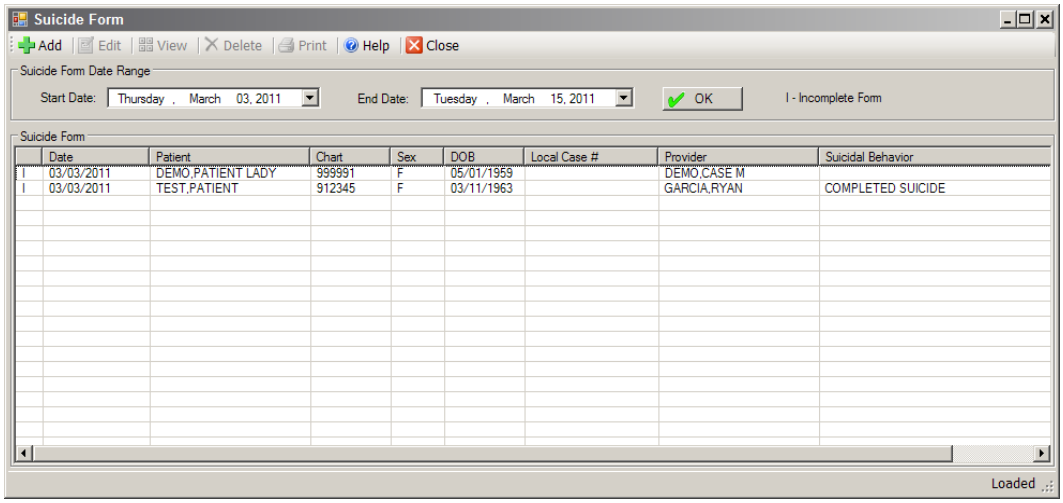

Figure 5-3: **Suicide Reporting form** All Patients list view

The **All Patients Suicide Reporting Form** list view displays **Suicide Reporting Forms** for all patients within a date range. The default date range is one year. Set a new start date.

The buttons on the top of the window are the same as those in the **One Patient Suicide Reporting Form** list view (Section 5.4.1).

> **Note**: Incomplete Suicide Reporting Forms are identified with an "**I**" in the first column from the left.

5.5.2 All Patients Add or Edit

The **Add and Edit** screen for **All Patients** is the same as **for One Patient** (Section 5.4.2).

5.5.2.1 Practice Exercises

- Enter a **Suicide Reporting Form** for a patient, but leave some of the required but not enforced fields empty and click **Save**.
- Edit the **Suicide Reporting Form** you just entered and complete the remaining fields.

6.0 Objective #6: Administrative/Community Activities

6.1 Purpose

The purpose of this exercise is to introduce you to the non-patient-related activity documentation that can be entered through BHS.

6.2 Overview

It is important that users of BHS, regardless of their discipline, be able to enter data for administrative or community activities. Complete and accurate data is critical for many reasons, most importantly for program management, but also for planning.

6.3 Skills You Will Acquire

Upon completion of this objective, you will be able to:

- Identify the required fields
- Enter an Administrative/Community Activity
- Utilize the **Prevention Activity** fields

6.4 Administrative/Community Activities Data Entry

Click **Administrative/Community Activities** in the menu tree (Figure 2-1) to display the **Administrative/Community Activities** list view Figure 6-1:

6.4.1 List View

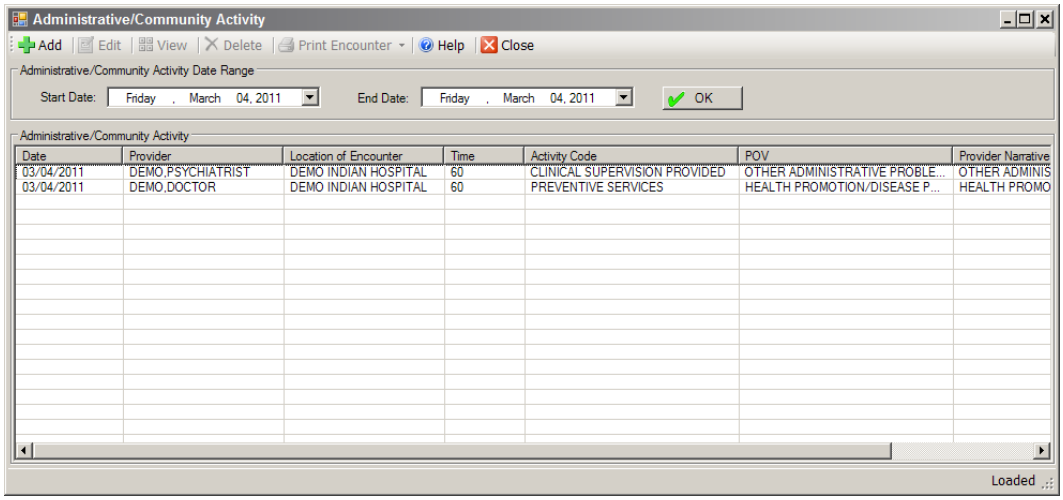

Figure 6-1: **Administrative/Community Activity** window

The **Administrative/Community Activities** list view displays Administrative/Community Activities within a date range. The default date range is one year.

On the top of the window are the following:

- **Add**: To add an Administrative/Community Activity.
- **Edit**: To edit an Administrative/Community Activity.
- **View**: To view an Administrative/Community Activity.
- **Delete**: To delete an Administrative/Community Activity. You must possess the appropriate **Delete** key. A confirmation message will display.
- **Print Encounter**: To print an Administrative/Community Activity.
- Click **Help**: To display the online help.
- Click **Close**: To exit the list view.

6.4.2 Add or Edit

Add or **Edit** on the **Administrative/Community Activities** list view displays the data entry window in Figure 6-2:

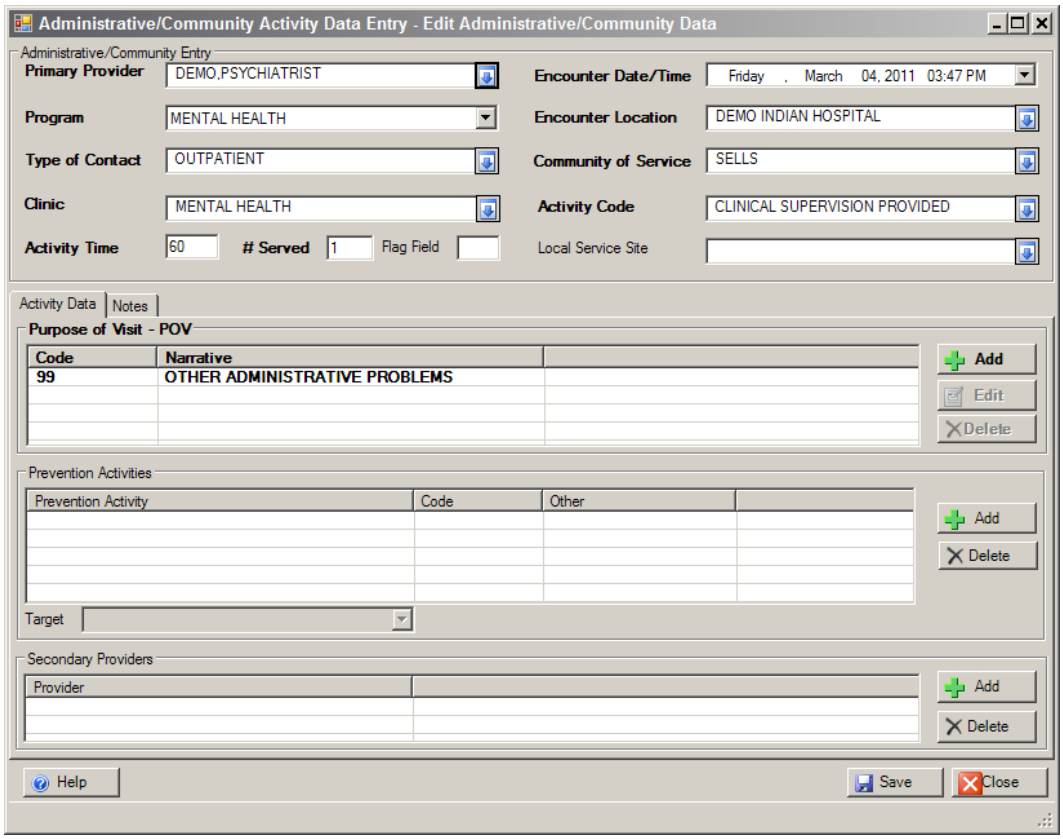

Figure 6-2: **Administrative/Community Activity Data Entry–Edit Administrative/Community Data** window

The required fields for an Administrative/Community Activity are:

- **Primary Provider**
- **Encounter Date/Time**
- **Program**
- **Encounter Location**
- **Type of Contact**
- **Community of Service**
- **Clinic**
- **Activity Code**
- **Activity Time**
- **# Served**
- **Purpose of Visit**

If there are defaults set on the **Site Parameters** menu, selecting a program can default the **Encounter Location**, **Clinic**, **Type of Contact**, and **Community of Service**.

Prevention Activities have been added to **Administrative/Community Activities**. Document Prevention Activities that were performed as well as the population to which the activities were directed.

6.4.2.1 Practice Exercises

- Enter an Administrative/Community Activity and save.
- Edit the Administrative/Community Activity you just entered and save.
- Enter an Administrative/Community Activity to document Prevention Activities and click **Save**.

7.0 Objective #7: Reports

Use the BHS roll-and-scroll application to view the Reports menu, identify reports, and run a sample report.

7.1 Purpose

The purpose of this exercise is to introduce the various types of reports that can be generated through BHS.

7.2 Overview

Regardless of the role, it is important that all users can generate a report showing, for example, a clinician's designated provider caseload, treatment plans needing revision, or No Show reports for a patient. Generating reports enables the provider to monitor encounter data for accuracy and to manage his/her case load efficiently.

7.3 Skills You Acquire

Upon completion of this objective, you will be able to:

- Identify reports that can be generated in BHS.
- Select report parameters including time frames, clinicians, types of visits, etc.
- Generate reports to display an individual clinician's case load using the Designated Provider menu, a list of no shows for a patient, and Suicide Reporting Form data sorted by date.

7.4 Selecting Report Parameters

The BHS Reports menu and other reports found in the Data Entry menu provide options for retrieving data from the RPMS database. You can obtain patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

7.4.1 System Tools

The Behavioral Health reports use two actions that allow you to select the records or visits to include in reports and to view data on the screen. The system provides detailed instructions for performing these actions.

- At the prompt, type **+** or **–** to review the items in the list.
- At the prompt, type **S**.
- At the prompt, type any combination of the data items in the list (for example: type a list or a range of numbers at the next prompt.

- Do one of the following:
  - At the prompt, type values for the items you selected, such as an age range.
  - To include all records, type **Q** at the prompt to bypass this step in the process.

After you select and define the criteria, the system will display the **Item List**. The items you selected will be marked with an asterisk (*).

- To add or remove items from the **Item List**, type **S SELECT** or **R REMOVE** at the prompt.
- Type information as requested at the prompts and press Enter to record your changes.
- When complete, type **Q** to continue creating the report.

7.4.2 Identifying Data

To maximize the effectiveness of the RPMS reports, data must be entered into the system on a regular basis. As the database begins to increase, the available number of reports and the scale of the report will increase. For example, a site using the application since 1997 may have 50,000 records, while a site using it for a year, will have a smaller number of records.

Once your facility or program begins looking at the possibility of generating regular reports from BHS, it is important to clearly delineate the criteria for each report. For example, do you want a list of patients or information about encounters? Are you looking for data regarding the past quarter or for the previous year? A particular subset of patients or all patients? Do you want to exclude Demo patients? One provider or all providers?

When considering the criteria to be included in the report, it is important to understand how the items and values are used in combination.

- And Or Logic:
  - AND is used for all items.
  - OR is used for all multiple values within one item.

  For example:

  DESG MH PROVIDER: Mary Smith
  AND
  COMMUNITY OF RESIDENCE: Tucson –OR— San Xavier

7.5 Reports–BHS DE Data Entry Menu

FAQ: I'm a clinician at a small facility where only the supervisors have the security key for the BHS reports. Is there any way that I can access some basic information, such as cases assigned to me or treatment plans coming up for review?

Answer: Many of the reports that a clinician might want access to can be found on the BHS DE Data Entry menu. If you don't have the security key for that menu, please request that these security keys be added:

- **AMHZMENU**: Permits access to top level menu
- **AMHZ DATA ENTRY**: Permits access to the data entry menu

7.5.1 View/Update Designated Provider List

Add, review, or remove patients from the list in the View/Update Designated Provider List. Do the following:

1. Log in to BHS roll-and-scroll (Figure 2-13).
2. Type the code in the Access Code field and press Enter.
3. Type the code in the Verify Code field and press Enter.
4. Press the Caps Lock key before continuing.

Note:	The mouse does not work in the RPMS BHS roll-an-scroll version (back end). After typing all relevant information, the user should press the Enter key to continue to the next field, unless otherwise instructed.

5. Type **mnemonic** at the "Behavioral Health System" prompt, and press Enter.
   - Menus may be locally defined and will generally display all the RPMS applications for which the user has security keys.
6. At the prompt, type **DE** and press Enter.
7. At the prompt, type **DPL VIEW/UPDATE DESIGNATED PROVIDER LIST** and press Enter. The Designated Provider will default to the person who is logged in (if they are a provider).
8. To accept the default, press Enter:
   - To change to a different Designated Provider, type the last name of that provider.
   - Type a question mark (**?**) to see a list of providers for the facility and press Enter.
9. Select one of the following:
   - ALL Patients
   - Exclude DEMO Patients

- Include ONLY DEMO Patients

10. At the prompt, press Enter.

> **Note**: Many of the reports in BHS allow the user to include or exclude demo patients. Demo patients must be designated as such in PCC Management Reports. A patient whose name includes Demo or Test does not necessarily mean a patient is designated as a demo patient. In order to designate a patient as a demo patient access the PCC Management Reports menu and select OTH. On the OTH menu select DPST which will take you to a list where demo patients can be added. Patients added to this list will be designated as demo patients and can be included or excluded from BHS reports.

11. Select Demo Patient Inclusion/Exclusion to display the list of patients currently assigned to that provider as shown in Figure 7-1:

```
OUTPUT BROWSER              November 16, 2015 15:02:18          Page: 1 of 5


              ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                      Page 1
                              DEMO INDIAN HOSPITAL
                      DESIGNATED MENTAL HEALTH PROVIDER LIST
                                  PROVIDER: ALL
PATIENT NAME              CHART #    SEX   DOB      COMMUNITY   LAST VISIT
-----------------------------------------------------------------------------
PROVIDER:  PROVIDER,DG

ALPHA,ALICE ROCHELLE      183497    F   06/25/97   COLCORD      Jan 05, 2014
ALPHAA,GLEN DALE          108704    M   11/10/81   TAHLEQUAH    Apr 14, 2014
GPAT,JANE ELLEN                     F   01/01/90   TUCSON       Apr 15, 2014
MPAT11,SHERRY KEARNEY     197407    F   10/01/00   PEGGS        Sep 28, 2014

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

Figure 7-1: Sample Designated Provider list

To remove a patient from the list:

1. At the prompt, type **RM REMOVE PATIENT FROM LIST** and press Enter
2. Type the number of patients to be removed at the next prompt and press Enter. A message will display indicating that the patient has been removed from the provider's DP list.
3. At the "DO YOU WANT TO UPDATE THE CASE STATUS?" prompt, type one of the following:

- **No** to return to the report.
- **Yes** to navigate to the Case Status menu.

> **Note**: When you see a prompt similar to "Do you want to update the case status?" followed by a combination of letters and slashes (//), the letter or letters indicate the default response. If you want to accept the response, press Enter; if want a different response, type the new response after the slashes (//) and press Enter when completed.

4. To add a patient to the list, do one of the following:
   - At the prompt, type **AD ADD PATIENT TO LIST** and press Enter.
   - At the prompt, type the chart number (Health Record Number or HRN), Social Security Number (SSN), DOB, or patient's name (Last name, first name) and press Enter.

   The Designated Provider screen will be displayed with the prompt in the Designated Mental Health Provider field.

5. Type the provider's name or search for the provider's name by typing the first three letters of the provider's last name or a question mark (**?**) and press Enter.
6. If the provider is not the Mental Health Provider, press Enter to move to the correct field and complete the data entry. Press Enter to move to the Command field.
7. At the "Command" prompt, type **S** to save the changes or type **E** to exit the view.

To change the patient's Designated Provider:

1. At the prompt, type CD CHANGE PATIENT'S DESG PROVIDER and presses Enter.
2. At the next prompt, type the number for the patient and press Enter.
3. When the "Designated Mental Health Provider" prompts displays, it will identify the current provider as the default response.
4. Enter the name of the new designated provider;
   - If there is no response identified, a mental health designated provider may be added.
   - The field may be left blank if there is no assigned designated provider for mental health.
5. Press Enter to continue.

6. Complete the remaining fields or press **Shift+6** to exit.

7.5.2 TPU, Update BH Treatment Plans

Type **TPU** to manage treatment plans, including reports of plans that need to be reviewed or resolved as shown in Figure 7-2:

```
                  ***********************************************
                  **       IHS Behavioral Health System       **
                  **          Patient Treatment Plans         **
                  ***********************************************
                               Version 4.0 Patch 5

                               DEMO INDIAN HOSPITAL

   UP     (Add, Edit, Delete) a Treatment Plan
   DTP    Display/Print a Treatment Plan
   REV    Print List of Treatment Plans Needing Reviewed
   RES    Print List of Treatment Plans Needing Resolved
   ATP    Print List of All Treatment Plans on File
   NOTP   Patients w/Case Open but no Treatment Plan


Select Update BH Patient Treatment Plans Option:
```

Figure 7-2: Sample Update screen

7.5.2.1 REV, Print List of Treatment Plans Needing Reviewed

The report will list all patients who have a treatment plan that is due to be reviewed in a date range specified by the user.

1. Log in to RPMS.
2. Select the BHS menu.
3. At the prompt, type **DE** and press Enter.
4. At the prompt, type **TPU** (Update BH Patients Treatment Plans) and press Enter.
5. At the prompt, type **REV** (Print List of Treatment Plans Needing Reviewed) and press Enter.
6. After verifying the report is required, set a beginning date and press Enter.
7. At the prompt, type an ending date and press Enter.
8. At the next prompt, type one of the following:
   - **Mental Health**.
   - **Chemical Dependency**.
   - **Social Services**.

- **Other**.

9. Select All or One provider(s) at the prompt and press Enter.
   - If one provider is selected, the user will be asked to enter the provider (Last name, first name).
10. Select one of the following:
    - **ALL Patients**.
    - **Exclude DEMO Patients**.
    - **Include ONLY DEMO Patients**.
11. At the prompt, press Enter.
12. At the device prompt, press Enter several times until the report appears as shown in Figure 7-3:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                  Page 1
                            DEMO INDIAN HOSPITAL
             LISTING OF TREATMENT PLANS DUE TO BE REVIEWED
                    Date Range: APR 07, 2008 to APR 07, 2009

PATIENT NAME           DOB       CHART # DATE         REVIEW DATE   ANTICIPATED
                                         ESTABLISHED                COMPLETION
                                                                    DATE
-------------------------------------------------------------------------------

ALPHA,ALICE ROCHELLE 6/25/97 183497  Dec 01, 2005 Feb 23, 2009  Feb 23, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 21, 2006 Sep 30, 2008
   Program: CHEMICAL DEPENDENCY  Responsible Provider: GAMMAA,DENISE
ALPHAA,GLEN DALE    11/10/81 108704  Dec 10, 2007 May 06, 2008  Dec 10, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAAA,BJ

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

Figure 7-3: Sample REV report for all programs, all providers

7.5.2.2 RES, Print List of Treatment Plans Needing Resolved

This report will list all patients who have a treatment plan that is due to be resolved in a date range specified by the user.

1. Log in to RPMS.
2. Select the BHS menu.
3. At the prompt, type **DE** and press Enter.
4. At the prompt, type **TPU** and press Enter.

5. At the prompt, type **RES** (Print List of Treatment Plans Needing Resolved) and press Enter.
6. After verifying the report is required, set a beginning date and press Enter.
7. At the prompt, type an ending date and press Enter.
8. At the next prompt, type one of the following:
   - **Mental Health**.
   - **Chemical Dependency**.
   - **Social Services**.
   - **Other**.
9. Type **All** or **One** provider(s) at the prompt and press Enter.
   - If one provider is selected, the user will be asked to enter the provider (Last name, first name).
10. Type one of the following:
    - **ALL Patients**.
    - **Exclude DEMO Patients**.
    - **Include ONLY DEMO Patients**.
11. At the prompt, press Enter.
12. At the device prompt, press Enter several times until the report appears as shown in Figure 7-4:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                  Page 1
                              DEMO INDIAN HOSPITAL
             LISTING OF TREATMENT PLANS DUE TO BE RESOLVED
                     Date Range: APR 07, 2008 to APR 07, 2009

PATIENT NAME          DOB      CHART # DATE        REVIEW DATE   ANTICIPATED
                                       ESTABLISHED                COMPLETION
                                                                    DATE
-----------------------------------------------------------------------------

ALPHA,ALICE ROCHELLE 6/25/97 183497  Dec 01, 2005 Feb 23, 2009  Feb 23, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,CHELSEA MARIE 2/7/75  116431  Jun 27, 2007               Jul 02, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,GLEN DALE    11/10/81 108704  Dec 10, 2007 May 06, 2008  Dec 10, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,CHELSEA MARIE 2/7/75  116431  Mar 03, 2008 Mar 18, 2008  Apr 07, 2008
   Program: MENTAL HEALTH        Responsible Provider: GAMMAA,DENISE
SIGMA,ALBERT TILLMAN 2/7/75  164141  Apr 01, 2008 Aug 01, 2008  Sep 30, 2008
   Program: MENTAL HEALTH        Responsible Provider: GAMMAA,DENISE
```

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

Figure 7-4: Sample RES for Mental Health, All Providers

> **Note**: You can also run a report listing All Treatment Plans on File by using the ATP option.

7.5.3 NS, List No Show Visits for One Patient

This option will print a list of one patient's no show visits.

1. Log in to RPMS.
2. Select the BHS menu.
3. At the prompt, type **DE** and press Enter.
4. At the prompt, type **DSP** and press Enter.
5. At the prompt, type Select **NS** and press Enter.
6. Type a patient's name (Last name, first name), Chart #, SSN, or DOB and press Enter.
7. After verifying the report is required, set a beginning date and press Enter.
8. At the prompt, type an ending date and press Enter.
9. Select one or all program(s) at the next prompt and press Enter.
10. Select **Print** or **Browse** and press Enter until the report displays on screen as shown in Figure 7-5:

```
OUTPUT BROWSER                Apr 17, 2009 13:01:58          Page: 1 of 1

             ********** CONFIDENTIAL PATIENT INFORMATION **********
                               DEMO INDIAN HOSPITAL                    Page 1

                BEHAVIORAL HEALTH NO SHOW REPORT FOR THETA,MICHELLE ROSE
               Appointment Dates:  OCT 19, 2008 and APR 17, 2009
===========================================================================
DATE                   PROVIDER     PROGRAM       POV
---------------------------------------------------------------------------
Jan 05, 2009@12:00 KAPPA,JESSIC  MENTAL HEALTH    8-FAILED APPOI
Dec 30, 2008       BETAAAA,BJ    MENTAL HEALTH    8.1-PATIENT CANC
Feb 12, 2009@12:00 GAMMAA,RYAN   SOCIAL SERVICES  8-FAILED APPOI
Jan 06, 2009@12:00 LAMBDAAA,MIC  OTHER        8.3-DID NOT WAIT

Total # of No Show Visits: 4

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

Figure 7-5: Sample no show visits for one patient report

7.5.4 NSDR, Listing of No Show Visits in a Date Range

This option will print a list of visits with POVs related to No Shows and Cancellations for multiple patients. Date range, program, and provider can be specified by the user. You can also run a report listing No Show Visits for One patient by using the NS report.

1. Log in to RPMS
2. Select the BHS menu.
3. At the prompt, type **DE**.
4. At the prompt, type **DSP** (Display Record Options) and press Enter.
5. At the prompt, type **NSDR** (Listing of No Show Visits in a Date Range) and press Enter.
   - After reading the prompt, type beginning date and press Enter.
6. At the prompt, type the ending date and press Enter.
7. At the next prompt, type one of the following:
   - **Mental Health**.
   - **Chemical Dependency**.
   - **Social Services**.
   - **Other**.
8. Type **All** or **One** provider(s) at the prompt and press Enter.
   - If one provider is selected, the user will be asked to enter the provider (Last name, first name).
9. At the prompt, select a sort method (Patient Name or Date of Visit) and press Enter.
10. Select one of the following:
    - **ALL Patients**.
    - **Exclude DEMO Patients**.
    - **Include ONLY DEMO Patients**.
11. At the prompt, press Enter.
12. Select Print or Browse and press Enter until the report displays on screen as shown in Figure 7-6:

```
OUTPUT BROWSER                Apr 17, 2009 13:01:58       Page:    1 of 1

             ********** CONFIDENTIAL PATIENT INFORMATION **********
                               DEMO INDIAN HOSPITAL                    Page 1

                 BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
               Appointment Dates:  OCT 19, 2008 and APR 17, 2009

PATIENT NAME        HRN    DATE/TIME          PROVIDER     PG  POV
-----------------------------------------------------------------------------
BPAT,ROBERT JACOB   207365 Jan 05, 2009@12:00 CBETA,JESSIC M  8-FAILED APPOI
FPAT1111,CHARLES R  112383 Dec 30, 2008       BETAAAA,BJ   M  8.1-PATIENT CA
RPAT111,BEULAH      140325 Feb 12, 2009@12:00 GAMMAA,RYAN  S  8-FAILED APPOI
VPAT1,RACHEL MAE    201836 Jan 06, 2009@12:00 LAMBDAAA,MIC O  8.3-DID NOT WA

Total # of Patients: 4     Total # of No Show Visits: 4

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

Figure 7-6: Sample no show visits in a date range report

> **Note**: You can also run a report listing the No Show visits for an individual patient by using the NS option.

7.5.5 SFD, Review Suicide Reporting Forms by Date

This option will display a list of Suicide Reporting Forms for a date range specified by the user.

1. Log in to RPMS
2. Select the BHS menu
3. At the prompt, type **DE**.
4. At the prompt, type **SF** (Suicide Reporting Forms, Update/Print) and press Enter.
5. At the prompt, type **SFD** (Review Suicide Reporting Forms by Date) and press Enter.
6. Set the beginning date and press Enter.
7. Set the ending date and press Enter.
8. Select whether you want to Include ALL Patients, Exclude DEMO Patients, or Include ONLY DEMO Patients and press Enter.
9. View the report on screen shown in Figure 7-7:

```
Suicide Form Review: Oct 17, 2010 - Nov 16, 2010
I = Incomplete Form
       Date
```

```
No.    of Act   Patient             HRN    DOB      Suicidal Behavior    PRV Loc
-----------------------------------------------------------------------------
1)     11/04/10 BETA,ROBERT JACOB   207365 02/06/55 IDEATION WITH PLAN A RJG
2)     11/03/10 ALPHA,ROBERT MITCHE 186585 02/19/98 ATTEMPT              RJG
3)     11/03/10 GAMMA,MONTY         741147 07/23/88 COMPLETED SUICIDE    RJG
4)     11/02/10 DELTA,RODNEY MICHAE 186585 02/19/98 IDEATION WITH PLAN A RJG
5)  I  11/01/10 THETA,MISTY DAWN    106371 08/31/82 ATTEMPT              RJG
6)  I  11/01/10 LAMDA,JIMMY RAY     146733 07/14/90 COMPLETED SUICIDE    RJG
7)  I  10/28/10 OMEGA,ROLAND        258852 08/08/76                      RJG
8)  I  10/28/10 OMICRON,SHANE JAC   207365 02/06/55                      RJG

+         Enter ?? for more actions                                      >>>

AF   Add Form             DE   Delete Form          Q    Quit
EF   Edit Form            +    Next Screen
DF   Display Form         -    Previous Screen
```

Figure 7-7: Sample Suicide Reporting Forms by date display

7.5.5.1 Practice Scenarios

Use the BHS Data Entry DE Menu to generate these reports:

- A report of No Shows for an individual patient within the past year.
- The Treatment Plans Needing Reviewed (REV) and the Treatment Plans Needing Resolved Reports, using the same date range. Compare the two reports.

8.0 Objective #8: Exporting

Routinely export behavioral health data to IHS using the Export Utility Menu.

8.1 Purpose

The purpose of this exercise is to present and demonstrate the routine exporting process.

8.2 Overview

It is important that all users of BHS, regardless of their role, demonstrate an understanding of the data exporting process. Behavioral Health data is exported in aggregate form without patient identifiers. The export is done via BHS. The BHS export process is similar to the RPMS PCC export, but it is a separate data transmission.

8.3 Skills You Will Acquire

Upon completion of this objective, you should be able to:

- Complete the monthly CHK in preparation for exporting data
- Correct the errors identified in the CHK report
- Understand how data is exported to IHS National Programs

FAQ: What happens to the data that is sent to IHS? Is it stored with other data sent to the data warehouse?

Answer: Behavioral Health data is sent to IHS data warehouse via File Transfer Protocol. The data doesn't contain patient-identifying information in an easily readable format and is sent via a secure connection. Once it is received at the data warehouse, it is sent immediately to the Indian Health Performance Evaluation System (IHPES) program where it is stored on a different server.

FAQ: Why is it important that the data be sent on a regular basis?

Answer: Requests from Congress, the Office of Management and Budget, and the Department of Health and Human Services (HHS) are processed using the data that has been sent to IHS. These requests may come in at any time and often have a short turn-around time. If data is not exported regularly (preferably on a monthly basis), these reports may not accurately reflect behavioral health services provided by IHS and/or Tribal facilities. For example, when the budget tables for FY 2007 were being prepared, IHPES only had data from 10 of the 12 areas.

FAQ: How is the exported data being used? What kinds of reports could the areas and/or facilities receive from the data warehouse?

Answer: At this time, the exported data is used to generate reports for Congress, OMB, HHS, etc. as referenced above. The Behavioral Health Clinical Application Coordinator has established a group of subject matter experts who will develop guidelines related to other uses of the data, such as area-wide reports, trending, etc.

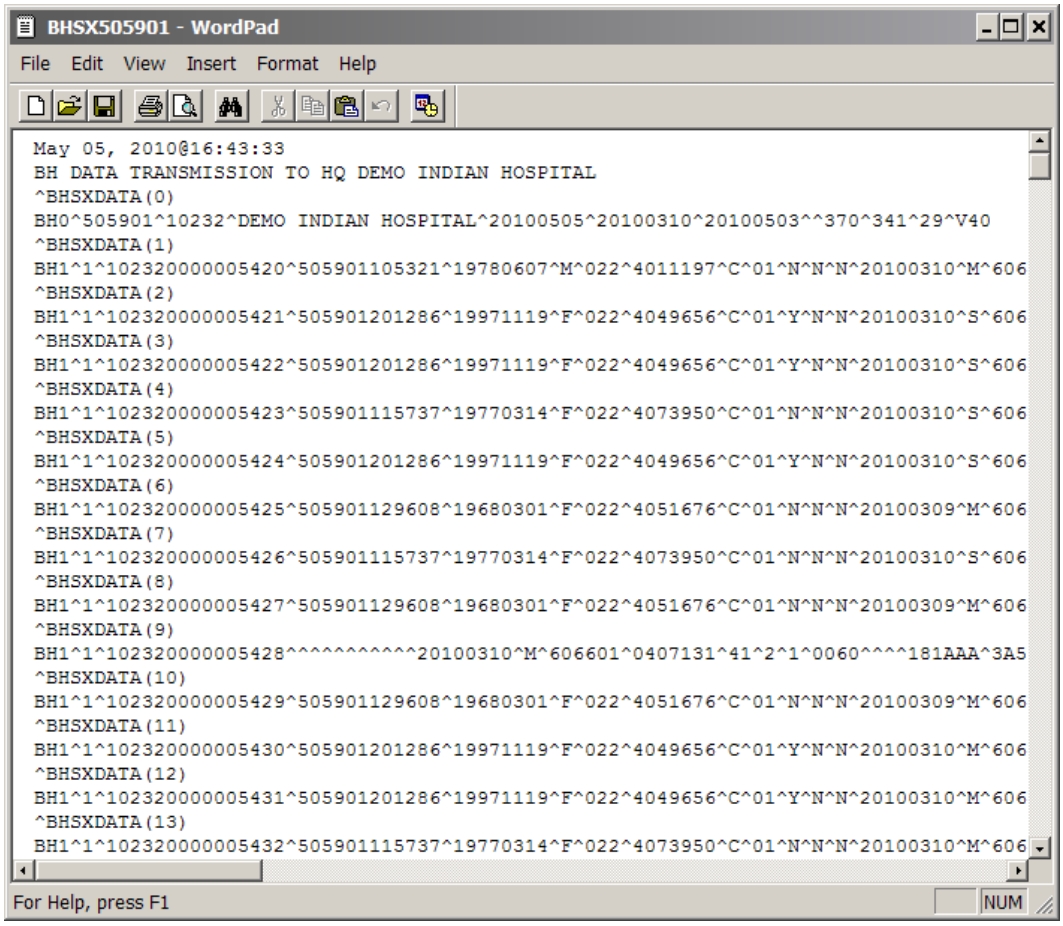

Figure 8-1: Sample **WordPad** export

8.4 Checking Data for Errors

FAQ: At training, the instructors talk about the importance of running CHK to check for errors before the export is done. Is this really necessary?

Answer: Running CHK will allow the behavioral health staff to fix errors that may also be preventing the encounter from passing to PCC and then on to the billing package.

```
                              DEMO INDIAN HOSPITAL                    Page 1
                            BH EXPORT RECORD REVIEW
                Record Posting Dates:  APR 19, 2009 and APR 20, 2009

RECORD DATE          PATIENT              HRN     PGM  TYPE         ACT TYPE
-------------------------------------------------------------------------------

APR 20, 2009@09:44   ALPHA,CHELSEA MARIE 116431   S   OUTPATIENT        16
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@09:51   BETA,EDWIN RON      105321   S   OUTPATIENT        85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:46   BETA,EDWIN RON      105321   S   OUTPATIENT        85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:56   SIGMA,SERGIO        206293   S   OUTPATIENT        15
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:00   THETA,CHRYSTAL GAYL 106299   M   OUTPATIENT        94
E023-NO AFFILIATION FOR PROVIDER

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

Figure 8-2: CHK sample

Complete these steps:

1. After generating the CHK report, access the BHS menu;
   - Type **DE** (data entry)
   - Type **SDE** (select a program)
   - Type the encounter date
2. Find the encounter on the **SDE** list view; check the encounter record to verify provider name or other information needed.

```
-------------------------------------------------------------------------------
Date of Encounter:  Saturday  JAN 03, 2015      * unsigned note
-------------------------------------------------------------------------------
 #  PRV PATIENT NAME         HRN      LOC  ACT  PROB     NARRATIVE

*  1   PD TEST,BRYN       TST92736    TST  91   F33.3 MAJOR DEPRESSIVE DISORDER,
*  2   PD TEST,CARL       TST147136   TST  91   F33.3 MAJOR DEPRESSIVE DISORDER,
*  3   PD TEST,FOUR EMAR  TST999219   TST  91   F33.3 MAJOR DEPRESSIVE DISORDER,
*  4   PD TEST,JAIME      TST445599   TST  91   F33.3 MAJOR DEPRESSIVE DISORDER,
*  5   PD TEST,JAIME      TST445599   TST  13   F33.3 MAJOR DEPRESSIVE DISORDER,
*  6   PD TEST,JASON      TST113388   TST  91   F33.3 MAJOR DEPRESSIVE DISORDER,
*  7   PD TEST,PATIENT TE TST123456   TST  13   F33.3 MAJOR DEPRESSIVE DISORDER,
*  8   PD TEST,PM         TST837786   TST  13   F33.3 MAJOR DEPRESSIVE DISORDER,
*  9   PD TEST,THREE EMAR TST999119   TST  13   F33.3 MAJOR DEPRESSIVE DISORDER,

                                          ?? for more actions

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


Enter ENCOUNTER DATE:
```

Figure 8-3: SDE list view

In this sample, (Figure 8-3) the encounter record for Demo, Dorothy was saved without the POV. The clinician will need to enter the POV and save the encounter again.

Another entry listed in this sample indicates that there is no discipline for the provider who documented an encounter for Alphaa, Lisa. When this encounter is displayed, the provider is Omega, Rick. To fix this, someone in IT or the business office (or whoever has responsibility for setting up the users/providers in AVA) will need to access the provider file and make the needed correction.

> **Note**: The first time a site runs the CHK report, they may have many pages of errors. If a provider has been entering encounters for a number of months or years but hasn't been set up properly in RPMS (AVA), all of the errors related to services by that provider will be cleared up when the Provider file is corrected. *Corrections to the Provider file should be made in AVA, not through FileMan.*

Errors related to the Provider file or to fields in Patient Registration usually need to be completed by staff members who manage those files routinely. Behavioral Health staff will need to complete any errors related to the actual data entry for the encounters, such as a missing POV, clinic code, etc.

After corrections are completed, the encounter record will be included in the next export. It isn't necessary to resolve all errors before exporting; however, it is advisable to correct all errors ASAP to avoid accumulation of additional errors related to the same problem.

Note: For a complete list of the Export Error Messages, see Appendix B: .

Appendix A: Appendix A: Electronic Signature

A.1 Electronic Signature

The following sections provide information about the electronic signature. This signature applies to roll-and-scroll, as well as the EHR. Use an electronic signature to sign a note or an intake document.

A.1.1 Creating an Electronic Signature

Use the User's Toolbox option (Figure A-1) in RPMS to setup an electronic signature. Open the Toolbox by typing **TBOX** or **USERS TOOLBOX** at any prompt where an option can be selected. Use the option Electronic Signature Code Edit.

```
Select TIU Maintenance Menu Option: TBOX User's Toolbox
   Change my Division
   Display User Characteristics
   Edit User Characteristics
   Electronic Signature Code Edit
   Menu Templates . . .
   Spooler Menu . . .
   Switch UCI
   Taskman User
   User Help
```

Figure A-1: Options on the TBOX User's Toolbox

Prompts display for the electronic signature on SOAP/progress notes. Do not enter any initials (such as MD) under both the block name and title or it will show twice. Make sure the signature block printed name contains your name and (optionally) credentials as shown in Figure A-2:

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

Figure A-2: Signature block prompts

If a user already has an electronic signature code, the "Enter your Current Signature Code" prompt will display.

- At the “Enter Code” prompt in RPMS, enter a new signature code. Enter a new code (using between 6 and 20 characters) with Caps Lock ON. When entering the electronic signature, lower case can be used. No special characters are allowed in the code.
  - If you forget the code, it must be cleared out by your Site Manager; and a new code must be created. You are the only one who can enter your electronic signature code.

Appendix B: Export Error Messages

Table B-1: Export Error Messages

Code	Short Description	Explanation	Correction Needed
E001	No Date of Service	The date of service is missing or invalid.	Use the edit function in the Data Entry menu to modify the date of service.
E002	DUZ (2) ASUFAC Missing	ASUFAC in the Location table for DUZ (2) is missing.	Notify your site manager or programmer. This location may have been deleted from the location or institution file.
E003	Program Code Missing	The program providing the service is missing.	Use the edit function in the Data Entry menu to modify the program code.
E004	Location of Service Missing	No location was entered for this visit.	Use the edit function in the Data Entry menu to enter the correct location.
E005	Location of Service ASUFAC Invalid	Location Pointer is Invalid.	The pointer to the location file is invalid. Notify your site manager or a programmer. A location may have been deleted from the location or institution file.
E006	No Community of Service	The community of service is missing or invalid.	Use the edit function in the Data Entry menu to modify the community of service.
E007	ST CTY COMM Code Invalid	The pointer to the community file is invalid.	Notify your site manager or programmer.
E008	Area SU COMM Code Invalid	The pointer to the ASUFAC file is invalid.	Notify your site manager or programmer.
E009	No Activity Code	The activity code is missing or invalid.	Use the edit function in the Data Entry menu to modify the activity code.
E010	No Type of Contact	The type of contact is missing or invalid.	Use the edit function in the Data Entry menu to modify the type of contact.
E011	# Served less than 1	Default has been changed or number deleted.	Use the edit function in the Data Entry menu to modify the number served.
E012	Activity Minutes is Missing or 0	The activity time is missing or invalid.	Use the edit function in the Data Entry menu to re-enter an appropriate activity time in minutes.
E013	No HRN's for Patient	Health Record Number/Chart Number missing or does not exist.	The patient does not have a Health Record number on file for either the location of the visit or for the facility to which you were logged into. Verify that you are logged into the appropriate facility for which information is being entered. If you are logged into the appropriate facility, a health record number must be assigned for this patient through the Patient Registration system. *A temporary chart number may have been used for the patient. A permanent health record number must be assigned.*

Code	Short Description	Explanation	Correction Needed
E014	No sex in Patient's File	No sex has been entered for this patient.	The sex of the patient must be entered through Patient Registration.
E015	Patient Missing DOB	No DOB has been entered for this patient.	Enter the patient's missing DOB through the Patient Registration system.
E016	No Community of Residence	No current community has been entered.	This patient does not have an entry in the Current Community field in Patient Registration. Enter the missing current community in the Patient Registration system.
E017	Invalid Community Pointer	Community of Residence is missing (bad pointer).	The pointer to the community file is invalid. More than likely, a Community was deleted from the Community file. The Site/PCC Manager can correct this problem through FileMan. A community entry must be made for this patient through the Patient Registration system.
E018	No Tribe of Membership	No tribe has been entered.	No tribe of membership has been entered for this patient. Enter a valid tribe through the Patient Registration system.
E019	Old Unused Tribe Code	An old tribe code is used for this patient.	The tribe of membership for this patient is one that is no longer acceptable. Change the Tribe to a valid tribe code through the Patient Registration system.
E020	No Tribe Code	This patient's Tribe Code is missing or has a bad pointer.	The pointer to the Tribe File for this patient is bad. More than likely someone deleted a Tribe from the Tribe file. The Site/PCC Manager can correct this problem through FileMan.
E021	No POV	No POV has been entered for this visit.	Use the edit function in the Data Entry menu to re-enter/modify the POV.
E022	No Provider of Service	No Primary Provider has been entered for this visit.	Use the edit function in the Data Entry menu to enter the provider.
E023	No Affiliation for Provider	A provider's affiliation is missing from the Provider file.	A provider was entered into the Provider file without a valid affiliation. Use The New User/Provider File to enter a valid affiliation for the provider. It may be necessary to contact the Site/PCC Manager.
E024	No Discipline for Provider	A provider's discipline is missing from the Provider file.	A provider was entered into the Provider file without a valid discipline. Use The New User/Provider File to enter a valid discipline for the provider. It may be necessary to contact the Site/PCC Manager.

Code	Short Description	Explanation	Correction Needed
E025	No Initials for Provider	A provider's initials are missing from the Provider file.	A provider was entered into the Provider file without initials. Use The New User/Provider File to enter the provider's initials. It may be necessary to contact the Site/PCC Manager.

Appendix C: DSM Copyright and Trademark Information

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Appendix D: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

D.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

D.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.

- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

D.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

D.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

D.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

D.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

D.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.

- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

D.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

D.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

D.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

D.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

D.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

D.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

D.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

D.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

D.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Acronym List

Acronym	Meaning
BH	Behavioral Health
BHS	Behavioral Health System
DOB	Date of Birth
EHR	Electronic Health Record
HHS	Health and Human Services
HRN	Health Record Number
IHPES	Indian Health Performance Evaluation System
IHS	Indian Health Service
PCC	Patient Care Component
POV	Purpose of Visit
RPMS	Resource and Patient Management System
SSN	Social Security Number

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

Web: http://www.ihs.gov/helpdesk/

Email: support@ihs.gov