



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

Pre-Implementation Manual

Version 4.0
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Office of Information Technology
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1.0 Why Use BHS v4.0?

The Resource and Patient Management System (RPMS) Behavioral Health (BH) applications were designed to meet the unique documentation and reporting needs of direct Indian/Tribal/Urban (I/T/U) behavioral health providers from all disciplines, allowing users to record and report on both clinical and program activities. The BH applications interface with other RPMS applications, support third-party billing, and assist sites in meeting various accreditations and reporting requirements, including the Government Performance and Results Act (GPRA) standards. Graphical user interfaces (GUIs) are generally more intuitive and acceptable to those users familiar with Windows and Mac applications, and the BHS v4.0 GUI provides a readily accessible and user-friendly alternative to the roll-and-scroll data entry option. Many facilities currently using RPMS will already have the software and desktop requirements necessary to run BHS v4.0. This new version was developed with input from I/T/U BH providers in the field. A user-centric approach was critical in developing an application that facilitates direct provider entry of clinical information with the goal of improving quality of care, practice and program management, data collection, and data reporting to the Indian Health Service (IHS) Division of Behavioral Health.

1.1 Behavioral Health and the Electronic Health Record

In support of the integration of BH into primary care, the behavioral health system (BHS) components are incorporated in the IHS Electronic Health Record (EHR). Integrated care enhances patient safety, care coordination, and the effective use of resources, all of which contribute to improved patient outcomes. In addition to the current functionality found in BHS v4.0, the EHR offers BH providers advanced functionality, including order entry of medications, labs and radiology, enhanced note-taking capability, consults, and clinical reminders. Many training materials and tools have been developed and are available on the EHR website and EHR FTP website.

2.0 Business Processes

2.1 Workflow Analysis

Workflow at its simplest is the movement of projects and/or tasks through a work process. More specifically, workflow is the operational aspect of a work procedure: how tasks are structured, who performs them, what their relative order is, how they are synchronized, how information flows to support the tasks (work flow), and how tasks are being tracked (see Wikipedia).

A workflow approach to analyzing and managing a business process can be combined with an object-oriented approach, which tends to focus on documents and data. In general, workflow management focuses on processes rather than documents (refer to WhatIs.com).

When moving from a paper-based medical record to an electronic record or changing from one electronic record to another, a workflow analysis is recommended. This can be as simple as graphing the flow of patients and data on a piece of paper or as complicated as hiring one of the specialized firms to complete the analysis and make recommendations.

At a minimum, the workflow analysis should include:

- Detailed descriptions of current office work flow
- Detailed work flow maps of key office processes
- An analysis that identifies current inefficiencies, bottlenecks, and opportunities for improvements
- A high-level outline of desired future workflow redesigns (how the office will work when BHS v4.0 is operational)
- A list of changes that could be made now...even before installation of BHS v4.0.

2.2 BHS v4.0 GUI–Business Practices

Is there a policy and procedure in place for use of a BH EHR, e.g. the RPMS BHS v4.0 GUI?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Is the Medical Records department aware that the RPMS BHS v4.0 GUI will be deployed? If so, are they familiar with the electronically generated BH encounter forms?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Will the BH encounters be sent to the Coding Queue for review?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
How are client contacts currently documented?	
Documentation status at this time (current, backlogged by # of days or months)?	

Internal standards regarding documentation (All client contacts documented within 24 hrs, 2 days, etc.)?	
Will providers be doing direct data entry?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Do providers have adequate keyboarding skills?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Do providers have RPMS electronic signatures set up?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Are BH clients checked in using an electronic check-in process (e.g. GUI Scheduling)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
If Yes to above, is a visit created at check in (site parameter within Patient Information Management System [PIMS])?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Is the program billing for BH services?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Are providers expected to enter CPT codes?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:

3.0 PIMS Scheduling and BH Encounters

Note: This is not training on how to use the Scheduling package. This section is intended to provide an overview of how to set up BH clinics in the package and how to identify issues at sites using both Scheduling and BHS.

Question: Our clinic uses the PIMS Scheduling package and enters our encounters using BHS v4.0 or the BHS v4.0 GUI. The billing staff is telling us that two records are being created in Patient Care Component (PCC) for each encounter. Why?

Answer: When the clinics are set up in the Scheduling package, there is a “Create an encounter record at Check In?” prompt. If this is answered **YES** in the scheduling package, an encounter record is started as soon as the patient’s status is changed to Checked In. Thus, when an encounter record is created in BHS v4.0 or the BHS v4.0 GUI and passed to PCC, two records are entered for the same encounter.

To address this issue, the BHS v4.0 site parameters contain an option to turn on an interactive PCC link. If the link is turned on, users will be provided with an opportunity to merge the two encounter records, thus creating one PCC record for the visit.

3.1 Reviewing the Clinic Profile in PIMS Scheduling

The first step in the process involves accessing the Scheduling package. This step may be performed by the scheduling supervisor, PCC supervisor, or a BH staff member who has access to the supervisor’s menu in PIMS.

- Log into the Scheduling module and select the SCS option.
- Select the CPF (Clinic Profile) to view the current availability pattern.

CLINIC PROFILE	Jan 11, 2010 10:00:00	Page: 1 of 3

Clinic:	AA MENTAL HEALTH	abbrv: AA MH
Facility:	DEMO HOSPITAL	Service: MEDICINE
Location:	4th FLOOR WEST	Clinic Code: 14-MENTAL HEALTH
Telephone:	777 555-1212	Principal Clinic: MENTAL HEALTH
Non-Count:	NO	File Room List: YES
Clinic Meets:		Sched Holidays:
Appt. Display:	Begins at 10 AM	Appt. Length: 15 min.
Increments:	15-MIN	Variable Length: YES, VARIABLE LENGTH
Overbooks/Day:	2	Future Booking: 14 days max.
Auto-Rebook:	Start at 2 PM	Max. Auto-Rebook: 14 days
No-Shows:	3 allowed	Wait Period: 15
		Pull Prev x-rays: NO
Appointment List Statement:		
Special Instructions: None		

```

Pre-Apppt:                               Clinic Cancel:
Appt. Cancel:                             No-Show:

Documents Printed with Routing Slips -
Health Summary: NO                         AIU Form: NO
Rx Profile: NO

PCC Visit Link: *** TURNED ON ***
Checkin Time: ASK USER                     Visit Category: AMBULATORY
Multiple Codes: NO                          PYXIS Location: NOT USED
                                           Require Provider: YES

Clinic's Provider(s): ALPHAA,THOMAS

Clinic's Owners: ALPHAA,THOMAS

Prohibit Access to Make Appts: NO

```

Figure 3-1: Sample Clinic Profile

3.2 Interactive PCC Link in BHS v4.0 Site Parameters

In the Scheduling package, if the clinic set-up response is **YES** to the prompt about creating an encounter at check in, then the Interactive PCC Link question in the BHS site parameters must also be answered **YES**. If the clinic set up in the Scheduling package has a negative response, then the Interactive Link question in BHS should have **NO** as the response. *There should never be a mismatched response where one package has **YES** and the other **NO**.*

```

**** Update PCC Link Feature Parameters ****
=====
Type of PCC Link: PASS STND CODE AND NARRATIVE
Type of Visit to Create in PCC: IHS
Interactive PCC Link? YES
Allow PCC Problem List Update? YES
Update PCC Link Exceptions? N

```

Figure 3-2: Sample Update PCC Link Features in the Site Parameters menu

If both responses have been set to **YES** and the progress note for the encounter record has been signed, the primary provider may be asked if he/she wants to merge the BHS v4.0 or BHS v4.0 GUI encounter record with one entered earlier in the day.

```

Generating PCC Visit.

PATIENT: BROWN,EDNA MAY has one or more VISITs on Mar 09, 2010@12:00.
If one of these is your visit, please select it

1 TIME: 16:00 LOC: WW TYPE: I CAT: A CLINIC: ALCOHOL DEC: 0
VCN:47887.1A
Hospital Location: BJB AOD
Primary POV: Narrative:

```



```
2  TIME: 15:00 LOC: WW   TYPE: I CAT: A CLINIC: GENERAL  DEC: 0
VCN:47887.2A
   Hospital Location: ADULT WALKIN
   Primary POV:      Narrative:
3  TIME: 16:15 LOC: WW   TYPE: I CAT: A CLINIC: BEHAVIOR DEC: 3
VCN:47887.3A
   Hospital Location: BJB BH
   Provider on Visit: BRUNING,BJ
   Primary POV: 799.9 Narrative: DIAGNOSIS OR CONDITION DEFERRED ON AXIS
4  Create New Visit

Select: (1-4): 3
```

Figure 3-3: Sample Potential PCC Visits to merge with BHS encounter

4.0 Technical Pre-Implementation Guide

4.1 General Site Questions

Types of Services Provided <i>(check all that apply)</i>	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Medical Social Services <input type="checkbox"/> Combined Behavioral Health	<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Residential
Satellite Clinics—location and types of services provided.		
Is the RPMS server on site? If not, where is it located?		
Will there be multiple BH programs (e.g. Tribal and IHS) using a shared server?		
Does each location have Internet/Intranet access?		
Can each location connect to IHS e-mail?		
Which RPMS applications is your site currently running?		
Does your facility use the IHS EHR?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:	
Does your facility use RPMS PIMS or GUI Scheduling?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:	
Does your facility use the RPMS billing application or a commercial, off-the-shelf (COTS) billing application for BH services?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:	

4.2 Network Access and IT Support

Do all potential users have access to the system? If no, please document current plans to improve accessibility.	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Does your facility have on-site IT support? If yes, how many staff?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
Is there a designated BH superuser or Clinical Application Coordinator (CAC)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:

4.3 Hardware/Software (BH Program)

Does each BH provider have their own Personal Computer (PC)? Are they IBM compatible?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comment:
---	---

Pentium III or greater with 128 MB or more of RAM? (Preferred)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
Gigabyte or larger hard drive? (Preferred)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
17" VGA or SVGA monitor? (Preferred)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
Microsoft Windows Suite 2000 or later, Windows XP Service Pack 2 or higher, and .NET Framework version 2.0?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:

4.4 Data Security

Are computers in secure locations? If no, what plans are there to move the equipment or to ensure safety of data?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
Are computer screens visible to clients or other staff? If yes, will the computers be relocated, or monitor filters emplaced, to protect accidental disclosure of client-specific information?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
Is your program or facility using the RPMS PIMS Sensitive Patient Tracking module?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
Where are network printers located? Will documents print to a particular machine in a secure location or in each clinician's office?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:
Does your program have policies and procedures in place that specifically address the use of an EHR (RPMS)?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Comment:

5.0 PIMS Sensitive Patient Tracking

As part of the effort to ensure patient privacy, additional security measures have been added to the patient access function. Any patient flagged as Sensitive will have access to his/her record tracked. In addition, warning messages will be displayed when staff (not holding special keys) accesses these records. If an individual chooses to continue accessing the record, a bulletin is sent to a designated mail group

```
***WARNING***  
***RESTRICTED RECORD***  
*****  
This Record is protected by the Privacy Act of 1974 & Health Insurance  
Portability & Accountability Act of 1996. If you elect to proceed, you must  
prove you have a need to know. Access to this record is tracked and your  
Security Office will contact you for your justification.
```

Figure 5-1: Sample Long Warning Message displayed for a patient listed as Sensitive

For additional information on Sensitive Patient Tracking, contact your facility's information security officer.

6.0 Secondary Menus and Security Keys

6.1 Secondary Menu Required for GUI

All providers who will be using the BHS v4.0 GUI must have these two additional secondary menus added to their profile in User Management:

- AMHGRPC
- BMXRPC

6.2 Key Assignments for BH Staff

The security keys for BHS v4.0 apply to both the roll-and-scroll version and the GUI.

Security keys should only be assigned to personnel with privileged access to confidential BH data. Program managers should meet with the site manager when assigning these keys.

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

Those keys identified with an * are those which all staff will need, at a minimum, to use the application. All other keys are supervisors, managers, or site manager keys. The Delete and Reports keys may be assigned to all staff at the discretion of the program manager.

The AMHZ Coding Review key should *not* be assigned to BH staff. This key is designed for PCC data entry staff who will be reviewing BH records that are sent to the Coding Queue. For additional information on the Coding Queue option, refer to the User Manual.

7.0 BH Application Functions

Patient Information –Will the Designated Provider, Personal History Factors, and Patient Flag fields be used for case management?	Yes	No	Comment:
Intake –Are providers required to do an intake? Does the BH program have a standard paper-based intake document?	Yes	No	Comment:
Case Status –Are providers required to open, admit, and close cases for each client?	Yes	No	Comment:
Treatment Planning –Are providers required to develop treatment plans for each client? Does the BH program use a paper-based treatment planning tool?	Yes	No	Comment:
Group Entry –Are group and/or family sessions conducted? Are there any support staff that need to record nonclinical group activities, e.g. recreation or transportation?	Yes	No	Comment:
Administrative Entry –Are providers required to record nondirect client activities, such as education/training received committee work, prevention activities, etc?	Yes	No	Comment:
Suicide Reporting Form –Is data collected on acute incidents of suicide only or is historical information also captured?	Comment:		

7.1 Behavioral Health System v4.0 (BHS)

All BH data, regardless of where entered, is stored in the BHS v4.0 roll-and-scroll version.

7.1.1 Roll-and-Scroll Version

The roll-and-scroll version is divided into three major modules:

- **Behavioral Health Data Entry Menu**–Use this menu for all aspects of recording data items related to patient care, case management, treatment planning, and follow-up.
- **Reports Menu**–Use this menu for tracking and managing patient, provider, and program statistics.
- **Manager Utilities Menu**–This menu may be restricted to the site manager and the program manager or his/her designee. It is used for setting site-specific parameters related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and IHS headquarters for mandated federal reporting and funding.

7.1.2 GUI

The GUI contains the data entry menu only. Reports that providers find beneficial for patient care may be included in a subsequent patch.

8.0 Sample Documentation Guide

8.1 Outpatient Services

Referral/Screening

Type of Contact: OUTPATIENT or SCHOOL or JAIL, etc.

Activity Code:

- 11-SCREENING (patient present)
- 44-SCREENING (patient not present)

Document: Purpose of Visit (POV)

Case Status: CASE OPEN

Assessment/Initial Visit

Activity Code: 12-ASSESSMENT

Type of Contact: OUTPATIENT or SCHOOL or JAIL, etc.

Document: POV, Patient Education, Medications, Health Factors, Screenings, Summary of Intake

*Personal History Factors need to be entered, if any

**Case Staffing—assign to a Designated Provider at weekly meeting

**Within three visits with assigned provider, create an initial treatment plan

Ongoing Treatment

A. INDIVIDUAL COUNSELING SESSION

Activity: 13-INDIVIDUAL COUNSELING

Document: POV, Case Notes

B. GROUP SESSION

Type of Contact: OUTPATIENT

Activity:

- 91-GROUP COUNSELING

- Other codes as appropriate

Document: POV, Case Notes

*Need to use same POV descriptions to identify the type of group

C. CASE MANAGEMENT

Activity:

- 22-CASE MANAGEMENT (PATIENT PRESENT)
- 31-CASE MANAGEMENT (PATIENT NOT PRESENT)

D. NO-SHOWS

Activity: 31-CASE MANAGEMENT (PATIENT NOT PRESENT)

Document: POV, Case Notes

E. MEDICATION MANAGEMENT

Activity:

- 16-MEDICATION MANAGEMENT (PATIENT PRESENT)
- 26-MEDICATION MANAGEMENT (PATIENT NOT PRESENT)

Document: POV, Case Notes, Rx Notes, Patient Education (BH-MEDS)

F. CRISIS INTERVENTION

Activity:

- 48-CRISIS INTERVENTION (PATIENT PRESENT)
- 49-CRISIS INTERVENTION (PATIENT NOT PRESENT)

Document: POV, Case Notes, Rx Notes

G. REASSESSMENT

Activity:

- 04-RE-ASSESSMENT (PATIENT PRESENT)
- 05-RE-ASSESSMENT (PATIENT NOT PRESENT)

Document: POV, Patient Education, Medications, Health Factors, Summary of Intake/Update

* Treatment plans are documented on the Treatment Plan tab or menu option. An individual encounter form should also be completed to document the treatment planning activity. Follow local standards and policies on time frames for establishing and reviewing treatment plans.

Discharge/Final Visit

Activity Code:

- 19–DISCHARGE PLANNING (PATIENT PRESENT)
- 28–DISCHARGE PLANNING (PATIENT NOT PRESENT)

Document: POV, Patient Education, Medications, Health Factors, Placement Disposition

Case Status: CLOSED

*Resolve/close out treatment plan; close out Case Status

**Remove designated providers from patient information

Administrative Documentation

Type of entry: ADMINISTRATIVE/COMMUNITY ACTIVITY

Activity Codes: Any

Document: Administrative Problem Codes (95–99), Comments

Prevention Activity Documentation

Type of entry: ADMINISTRATIVE/COMMUNITY ACTIVITY

Activity Codes:

- 37–Preventive Services
- 97–Health Promotion

Document: POV, Prevention Activity, Target Audience

8.2 Youth Residential Treatment Center

Referral/Screening

Activity Code:

- 11–SCREENING (patient present)

- 44–SCREENING (patient not present)

Type of Contact: RESIDENTIAL

Document: POV

Case Status: CASE OPEN

*Primary Provider needs to be established (document in Patient Information)

Assessment/Initial Visit

Activity Code: 12-ASSESSMENT

Document: POV, Patient Education, Medications, Health Factors, Screenings, Summary of Intake

Case Status: CASE ADMIT

*Personal History Factors need to be entered, if any

**Within five working days, create an initial treatment plan (record in Treatment Plan tab with corresponding Individual Counseling Session encounter entry).

Ongoing Treatment

A. INDIVIDUAL COUNSELING SESSION

Activity: 13-INDIVIDUAL COUNSELING

Document: POV, Case Notes

B. GROUP SESSION

Activity: 91–GROUP or 90–FAMILY TREATMENT

Document:

- POV, Case Notes
- Other codes as appropriate

*Need to use same POV descriptions to identify the type of group

C. CASE MANAGEMENT

Activity:

- 22–CASE MANAGEMENT (PATIENT PRESENT)
- 31–CASE MANAGEMENT (PATIENT NOT PRESENT)

D. NO-SHOWS

Activity: 31–CASE MANAGEMENT (PATIENT NOT PRESENT)

Document: POV, Case Notes

E. EDUCATION/SCHOOL WORK

Activity: 96–ACADEMIC SERVICES

POV: 89.1–ALTERNATIVE EDUCATION SERVICES

Document: Notes as required

* May be completed as a group entry; Activity and POV would be the same as listed above

F. RECREATION GROUP

Activity: 86–RECREATION ACTIVITIES

Document: POV, Notes

G. CULTURAL/TRADITIONAL ACTIVITIES

Activity: 95–CULTURAL ACTIVITIES

Document: POV, Notes

H. SHIFT NOTES

Activity: 56–RECORDS/DOCUMENTATION

Document: POV (may use 99–OTHER ADMINISTRATIVE), Notes (consider keeping one ongoing note open for the duration of the shift)

* Treatment plans are documented on the Treatment Plan tab or menu option. An individual encounter form should also be completed to document the treatment planning activity. Follow local standards and policies on time frames for establishing and reviewing treatment plans.

I. REASSESSMENT

Activity:

- 04–RE-ASSESSMENT (PATIENT PRESENT)
- 05–RE-ASSESSMENT (PATIENT NOT PRESENT)

Document: POV, Patient Education, Medications, Health Factors, Screenings, Summary of Intake/Update

Discharge/Final Visit

Activity Code: 19–DISCHARGE PLANNING

Document: POV, Patient Education, Medications, Health Factors, Staging Tool, Placement Disposition

Case Status: CLOSED

* Resolve/close out treatment plan; close out Case Status

Administrative Documentation

Type of entry: ADMINISTRATIVE/COMMUNITY ACTIVITY

Activity Codes: Any

Document: Administrative Problem Codes (95–99), Comments

Prevention Activity Documentation

Type of entry: ADMINISTRATIVE/COMMUNITY ACTIVITY

Activity Codes:

- 37–Preventive Services
- 97–Health Promotion

Document: POV, Prevention Activity, Target Audience

8.3 Inpatient/Residential

Referral/Screening

Activity Code:

- 11–SCREENING (patient present)
- 44–SCREENING (patient not present)

Document: POV

Case Status: CASE OPEN

*Primary Provider needs to be established

Assessment/Initial Visit

Activity Code: 12–ASSESSMENT

Document: POV, Patient Education, Medications, Health Factors, Screenings, Summary of Intake, or, on Intake Tab, add a note indicating Assessment is in Medical Record

Case Status CASE ADMIT

*Personal History Factors need to be entered, if any

**Within xx hours or days, treatment plan must be established

Ongoing Treatment

These recommendations are based on the amount of documentation that needs to be completed.

A. INDIVIDUAL COUNSELING SESSION

Activity: 13–INDIVIDUAL COUNSELING

Document: POV, Case Notes

*Record treatment plan in Treatment Plan tab and complete corresponding individual encounter to capture the treatment planning development session

B. GROUP COUNSELING SESSION (PSYCHOTHERAPY)

Group Name: Actual name of the group or one specific to therapist

Activity: 91–GROUP COUNSELING (or 90–FAMILY TREATMENT)

Document: POV, Case Notes

*Need to use same POV descriptions to identify the type of group.

*Groups may be set up once and then duplicated for subsequent sessions.

C. CASE MANAGEMENT

Activity:

- 22–CASE MANAGEMENT (PATIENT PRESENT)
- 31–CASE MANAGEMENT (PATIENT NOT PRESENT)

D. MEDICATION/NURSING SERVICES

Activity:

- 16–MEDICATION/MEDICATION MONITORING (PATIENT PRESENT)

- 26–MEDICATION/MEDICATION MONITORING (PATIENT NOT PRESENT)
- 7–HEALTH PROMOTION

Document: POV, Case Notes

*May be completed as a group entry; Activity Code would be the same.

E. EDUCATION/SCHOOL WORK

Activity: 96–ACADEMIC SERVICES

POV: 89.1–ALTERNATIVE EDUCATION SERVICES

Document: Notes as required

*May be completed as a group entry; Activity and POV would be the same as listed above

F. RECREATION GROUP

Activity: 86–RECREATION ACTIVITIES

Document: POV, Notes

*Same coding may be used for individual recreation notes; type of visit would be BRIEF.

G. CULTURAL/TRADITIONAL ACTIVITIES

Activity: 95–CULTURAL ACTIVITIES

Document: POV, Notes

* May be completed as a group entry; Activity would be the same as listed.

H. OTHER GROUP ACTIVITIES

Activity:

- 85–ART THERAPY
- 92–ADVENTURE BASED COUNSELING
- 94–LIFE SKILLS TRAINING
- 97–HEALTH PROMOTION
- 23–OTHER PATIENT SERVICES NOT IDENTIFIED
- 90–FAMILY TREATMENT

* Treatment plans are documented on the Treatment Plan tab or menu option. An individual encounter form should also be completed to document the treatment planning activity. Follow local standards and policies on time frames for establishing and reviewing treatment plans.

Discharge/Final Visit

Type of Visit: REGULAR

Activity Code: 19–DISCHARGE PLANNING Document: POV, Patient Education, Medications, Health Factors, Placement Disposition

Case Status: CLOSED

* Resolve/close out treatment plan; close out Case Status.

**Change designated providers in Patient Information to reflect Aftercare or Outpatient Providers, if known.

Administrative Documentation

Type of entry: ADMINISTRATIVE/COMMUNITY ACTIVITIES

Activity Codes: Any

Document: Administrative Problem Codes (95–99), Comments

Appendix A: Activity Codes and Definitions

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

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

Appendix B: Activity Codes That Pass to PCC

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

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

Appendix C: ICD-9CM v Codes

ICD Code	Description
v11.0	Personal history of Schizophrenia
v11.1	Personal history of affective disorders
v11.2	Personal history of neurosis
v11.3	Personal history of alcoholism
v11.8	Personal history of other mental disorders
v11.9	Personal history of unspecified mental disorder
v13.21	Personal history of preterm labor
v13.7	Personal history of perinatal problems
v15.41	History of physical abuse (includes rape)
v15.42	History of emotional abuse or neglect
v15.49	Psychological trauma, not elsewhere classified
v15.52	Personal History of Traumatic Brain Injury (TBI)
v15.81	History of noncompliance with medical treatment
v15.82	History of tobacco use
v15.89	Other personal history presenting hazards to health
v15.9	Unspecified personal history presenting hazards to health
v17.0	Family history of psychiatric condition
v18.4	Family history of mental retardation
v23.9	Supervision of unspecified high risk pregnancy
v25.09	General counseling and advice on contraceptive management; family planning advice
v26.33	Genetic counseling
v26.41	Procreative counseling and advice using natural family planning
v26.49	Other procreative management counseling and advice
v40.0	Mental and behavioral problems with learning
v40.1	Mental and behavioral problems with communication including speech
v40.2	Other mental problems
v40.3	Other behavioral problems
v40.9	Unspecified mental or behavioral problem
v57.9	Care involving unspecified rehabilitation procedure
v60.0	Lack of housing
v60.1	Inadequate housing
v60.2	Inadequate material resources
v60.3	Person living alone
v60.4	No other household member able to render care
v60.5	Holiday relief care
v60.6	Person living in a residential institution
v60.8	Other specified housing or economic circumstances
v60.81	Foster care (status)
v60.89	Unspecified housing or economic circumstances
v61.01	Family disruption due to family member on military deployment

ICD Code	Description
v61.02	Family disruption due to return of family member from military deployment
v61.03	Family disruption due to divorce or legal separation
v61.04	Family disruption due to parent-child estrangement
v61.05	Family disruption due to child in welfare custody
v61.06	Family disruption due to child in foster care or in care of nonparental family member
v61.07	Family disruption due to death of family member
v61.08	Family disruption due to other extended absence of family member
v61.09	Other family disruption
v61.10	Counseling for marital and partner problems, unspecified
v61.11	Counseling for victim of spousal and partner abuse
v61.12	Counseling for perpetrator of spousal and partner abuse
v61.20	Counseling for parent-child problem, unspecified
v61.21	Counseling for victim of child abuse
v61.22	Counseling for perpetrator of parental child abuse
v61.23	Counseling for parent-biological child problem
v61.24	Counseling for parent-adopted child problem
v61.25	Counseling for parent (guardian)-foster child problem
v61.3	Problems with aged parents or in-laws
v61.41	Alcoholism in family
v61.49	Other health problems within family
v61.5	Multiparity
v61.6	Illegitimacy or illegitimate pregnancy
v61.7	Other unwanted pregnancy
v61.8	Other specified family circumstances
v61.9	Unspecified family circumstances
v62.0	Unemployment
v62.1	Adverse effects of work environment
v62.21	Personal current military deployment status
v62.22	Personal history of return from military deployment
v62.29	Other occupational circumstances or maladjustment
v62.3	Educational circumstances
v62.4	Social maladjustment
v62.5	Legal circumstances
v62.6	Refusal of treatment for reasons of religion or conscience
v62.81	Interpersonal problems, not elsewhere classified
v62.82	Bereavement, uncomplicated
v62.83	Counseling for perpetrator of physical/sexual abuse
v62.84	Suicidal ideation
v62.89	Other psychological or physical stress, not elsewhere classified (life circumstance problems; phase of life problems, borderline intellectual functioning; religious or spiritual problem)
v62.9	Unspecified psychosocial circumstance

ICD Code	Description
v63.0	Residence remote from hospital or other healthcare facility
v63.1	Medical services in home not available
v63.2	Person awaiting admission to adequate facility elsewhere
v63.8	Other specified reasons for unavailability of medical facilities
v63.9	Unspecified reason for unavailability of medical facilities
v65.0	Healthy person accompanying a sick person
v65.11	Pediatric prebirth visit for expectant mother
v65.19	Other person consulting on behalf of another person
v65.2	Person feigning illness
v65.3	Dietary surveillance and counseling
v65.40	Other unspecified counseling
v65.41	Exercise counseling
v65.42	Counseling on substance use and abuse
v65.43	Counseling on injury prevention
v65.44	HIV Counseling
v65.45	Counseling on other sexually transmitted diseases
v65.49	Other specified counseling
v65.5	Person with feared complaint in whom no diagnosis was made
v65.8	Other reasons for seeking consultation
v65.9	Unspecified reason for consultation
v66.3	Convalescence following psychotherapy and other treatment for mental disorder
v66.7	Encounter for palliative care (end of life care)
v67.3	Follow-up examination following psychotherapy and other treatment for mental disorder
v68.1	Issue of repeat prescriptions
v68.2	Request for expert evidence
v68.81	Referral of patient without examination or treatment
v68.89	Encounter for other specified administrative purpose
v68.9	Encounters for unspecified administrative purpose
v69.0	Problems related to lifestyle—lack of exercise
v69.1	Problems related to lifestyle—Inappropriate diet and eating habits
v69.2	Problems related to lifestyle—High risk sexual behavior
v69.3	Problems related to lifestyle—gambling and betting
v69.4	Problems related to lifestyle—lack of adequate sleep
v69.5	Problems related to lifestyle—behavioral insomnia of childhood
v69.8	Other problems related to lifestyle; self-damaging behavior
v69.9	Unspecified problem related to lifestyle
v70.1	General psychiatric examination, requested by the authority
v70.2	General psychiatric examination, other and unspecified
v71.01	Observation of adult antisocial behavior
v71.02	Observation of childhood or adolescent antisocial behavior
v71.09	Observation of other suspected mental condition

ICD Code	Description
v71.81	Observation and evaluation for other specified suspected conditions, abuse and neglect
v71.89	Observation and evaluation for other specified suspected conditions not found
v79.0	Special screening for depression
v79.1	Special screening for alcoholism
v79.2	Special screening for mental retardation
v79.3	Special screening for developmental handicaps in early childhood
v79.8	Special screening for other specified mental disorders and developmental handicaps
v79.9	Special screening for unspecified mental disorder and developmental handicap
v80.01	Special Screening for Traumatic Brain Injury (TBI)

Appendix D: Electronic Signature

The following provides information about the electronic signature. This signature applies to roll-and-scroll and the graphical user interface (GUI), as well as the electronic health record (EHR). You use the electronic signature to sign a note or an intake document.

D.1 Creating Your Electronic Signature

Use the User's Toolbox option in the Resource and Patient Management System (RPMS) to set up your own electronic signature. Use the option in bold (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 12-1: Options on the TBOX User's Toolbox

Prompts will appear for the electronic signature on Subjective/Objective/Assessment/Plan (S/O/A/P)/progress notes. You should not enter your initials (such as MD) under both the block name and title or it will display twice. Make sure your signature block printed name contains your name and (optionally) your credential.

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

Figure 12-2: Prompts that display at the beginning of the process

If the "Enter your Current Signature Code" prompt displays in RPMS, it means you already have an electronic signature code.

When the "Enter Code" prompt displays in RPMS, enter a new signature code.

Enter a new code (using between 6 and 20 characters) with Caps Lock *on*. However, when you enter the electronic signature (on a note, for example), it can be in lower case. (No special characters are allowed in the code.)

D.2 Resetting Your Electronic Signature

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

Appendix E: Multidivisional Sites

E.1 Manager Utilities Menu

BHS v4.0 added new options on this menu and removed some that were no longer needed. Fields that have been added include UU Update Locations a User Can See; Turn on PCC Coding Queue; and Update Those Allowed to Override Delete on the Site Parameters menu. Items that have been removed include Option 3 on the Type of PCC Link; Universal/Site Specific Lookup; and the option to Ask Interpreter Utilized.

E.2 Patient Screen (Site-Specific Look Up)

With the removal of the Universal/Site-Specific option on the Site Parameters menu, users will only be able to select a patient from the division they are currently logged into.

Scenarios:

If Jane Doe has a record at Facility A where the user is logged in, the user will be allowed to select the patient.

If Jane Doe is a patient at Facility A but the user is logged in to Facility B, Jane Doe's record will not be available.

E.3 Encounter Location Screen (UU, Update Locations a User Can See)

BHS v4.0 contains a new field called the BH User that will permit a site to screen the locations that a user may access to view or enter information. If a site wants to limit the visits by location that a Behavioral Health (BH) user can access, then it will enter that user into this file and list all the facilities/encounter locations that that user is allowed to see or access. The following will be true if an entry is made in this file:

The user will only be able to select patients with a health record at those facilities.

List views and reports will only contain patients with health records at those facilities.

The user will only be able to view/access records containing those specific encounter locations.

If a user is not entered into this file, that person will be able to see visits to all locations. This file should only be updated if a site is multidivisional and there is a need to restrict the viewing of data between sites.

Scenarios:

Jane Doe is a patient at Facility A that has been entered on the BH User's UU list (Update Locations a User Can See). When the user looks at the records for this patient, only those with the location listed as Facility A will be seen. Records entered using a different encounter location such as home, field, or a different facility will not display. *This is the most restrictive option.*

If the user does not have any entries on the UU list, the user will see records from all locations including those that may have been entered in a different division. *This is the least restrictive option.*

The Encounter Location screen does not apply to Case Status, Intake, or Treatment Plan since location is not included in those forms. It also does not apply to the Suicide Reporting Form.

E.4 Records Screen (Update Those Allowed to See All Records)

The Site Parameter option called Update Those Allowed to See All Records has now been applied to all menu options except the Suicide Reporting Form.

Scenarios:

Jane Doe's name is not on the Update Those Allowed to See All Records list. The user will only see those records that they created or those for which they were listed as a provider. *This is the most restrictive option.*

Jane Doe's name is on the Update Those Allowed to See All Records list: The user will be able to see all records even if they were not the ones who entered the record or included on the record as a provider. *This is the least restrictive option.*

The Records Screen is applied to Treatment Plan but not to Case Status or the Suicide Reporting Form.

Examples: For the purpose of this explanation, the RPMS computer has two different divisions set up rather than using separate namespaces for each facility. Division A is Demo Hospital and Division B is Locust Grove. (All entries displayed in the screen shots are from a testing database and do not include actual patient information).

The screen shots are from the BHS v4.0 Graphical User Interface (GUI); however, the same process is in place in the roll-and-scroll, back end version of the software. The screen shots reference visits only. For information on display of other functions in the application such as Treatment Plan, Case Status, or Suicide Reporting Form, please see the explanation above and/or the accompanying flow chart document.

1. For Demo Hospital, user has no entries on the **Visit** window and is not included on the Records Screen site parameter (Update Those Allowed to See All Records). Patient selected is registered at Demo Hospital.

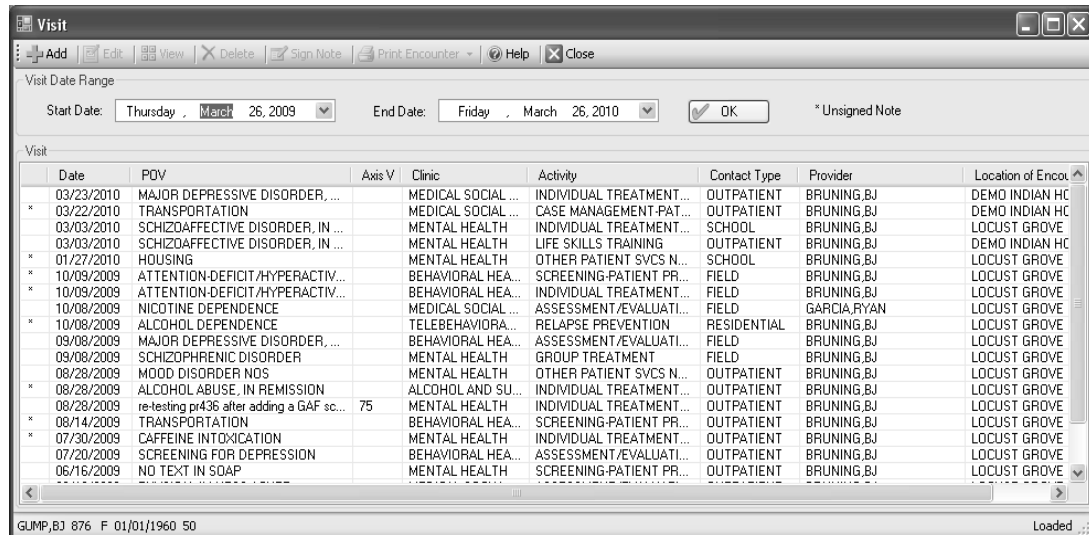


Figure E-1: User has no entries on the Visit window

2. For Demo Hospital, user has no entries on the **Visit** window and is included on the Records Screen site parameter (Update Those Allowed to See All Records). Patient selected is registered at Demo Hospital. Note that the list view now contains additional visits, specifically one entered on 10/12/2009.

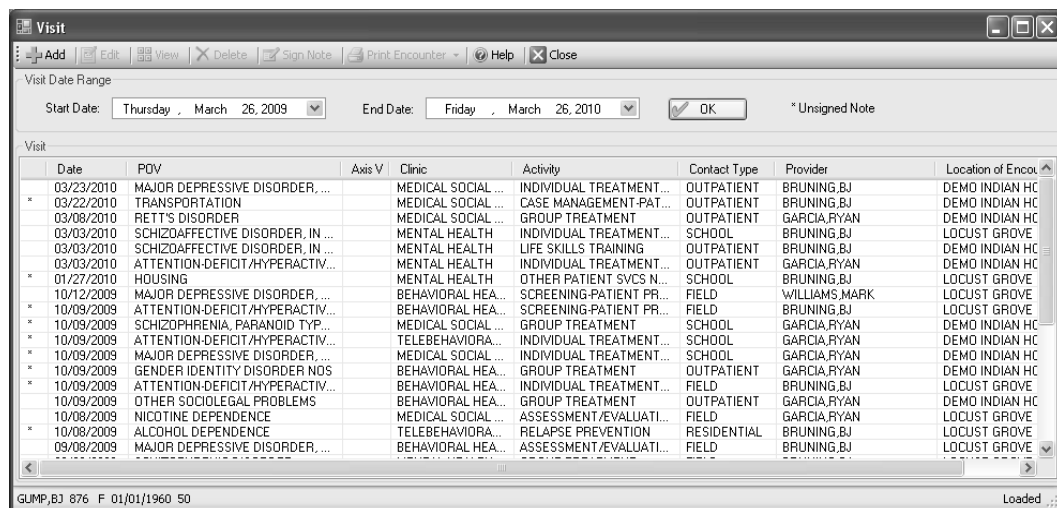


Figure E-2: List view contains additional visits

3. For Demo Hospital, user is restricted to the encounter location Demo Hospital on the **Visit** window and is not included on the Records Screen site parameter (Update Those Allowed to See All Records). Patient selected is registered at Demo Hospital.

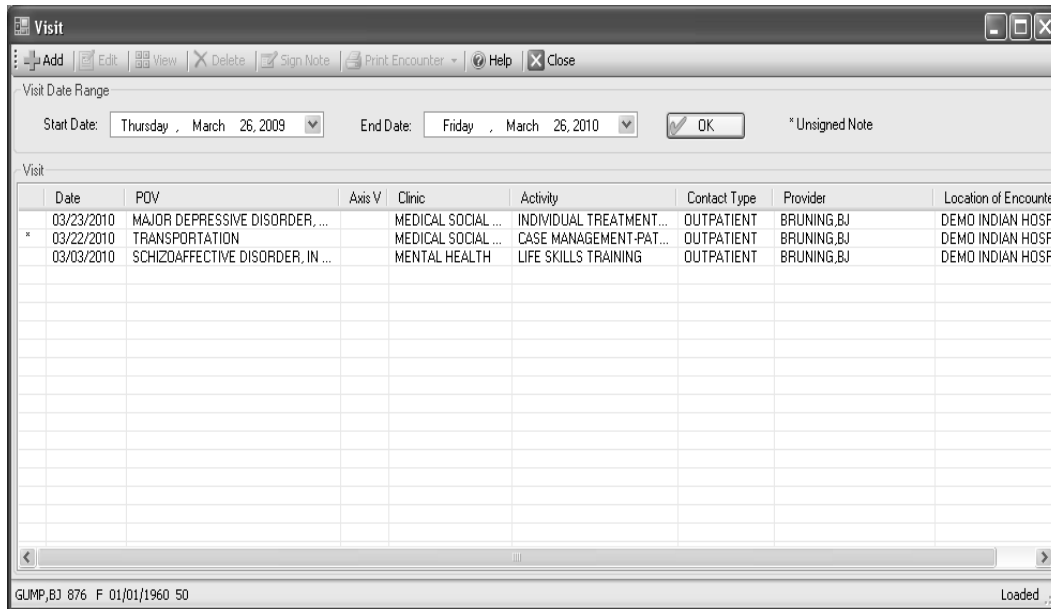


Figure E-3: User is not included on the Records Screen site parameter

- For Demo Hospital, user is restricted to the encounter location Demo Hospital on the **Visit** window and is included on the Records Screen site parameter (Update Those Allowed to See All Records). Patient selected is registered at Demo Hospital.

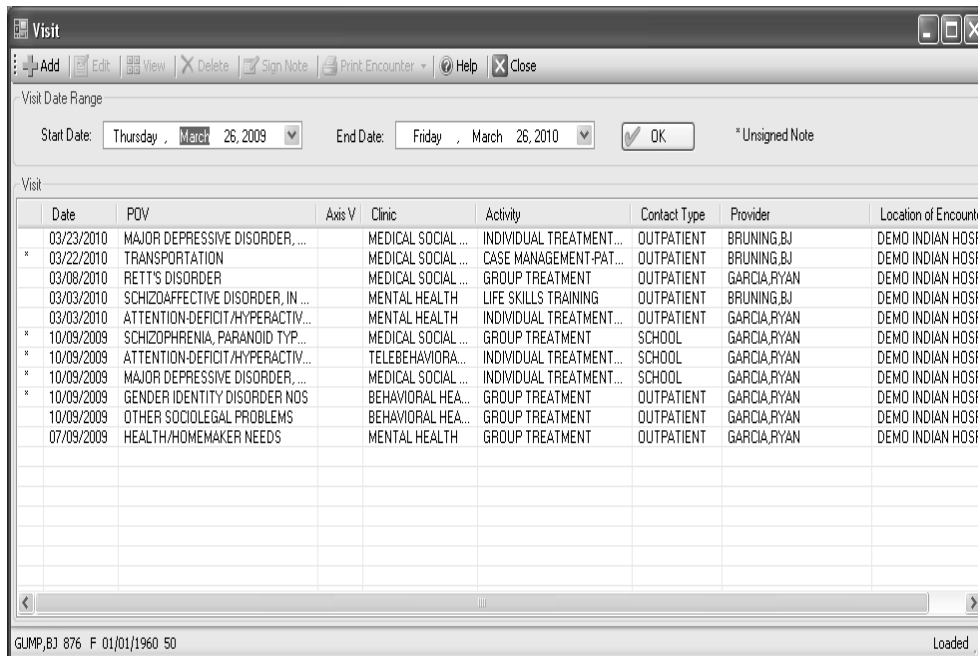


Figure E-4: User is included on the Records Screen site parameter

- For Locust Grove, user has no entries on **Visit** window and is included on the Records Screen site parameter (Update Those Allowed to See All Records). Patient selected is registered at Locust Grove. Note that the patient information at the bottom left of the screen now displays the Locust Grove chart number rather than that for Demo Hospital.

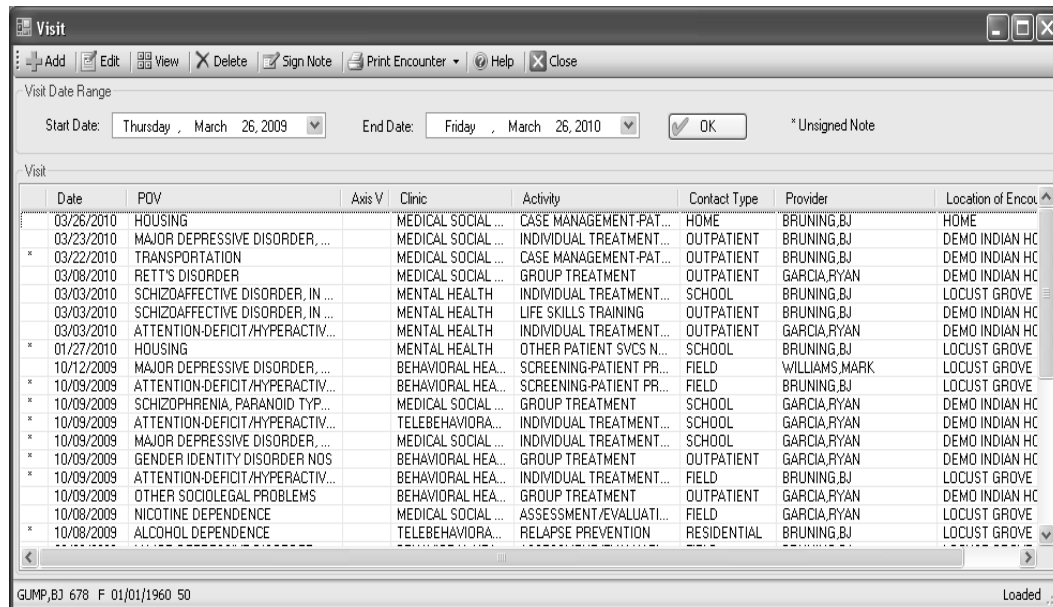


Figure E-5: Patient information now displays the chart number for Locust Grove

- For Locust Grove, user has no entries on **Visit** window and is included on the Records Screen site parameter (Update Those Allowed to See All Records). Patient selected is not registered at Locust Grove. Note that the user is informed that 0 records were found and remains on the patient select screen.

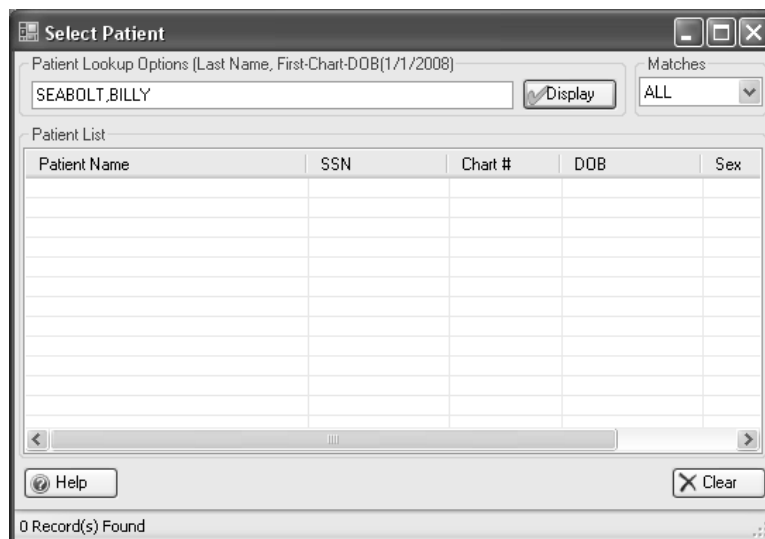


Figure E-6: User is informed that 0 records were found

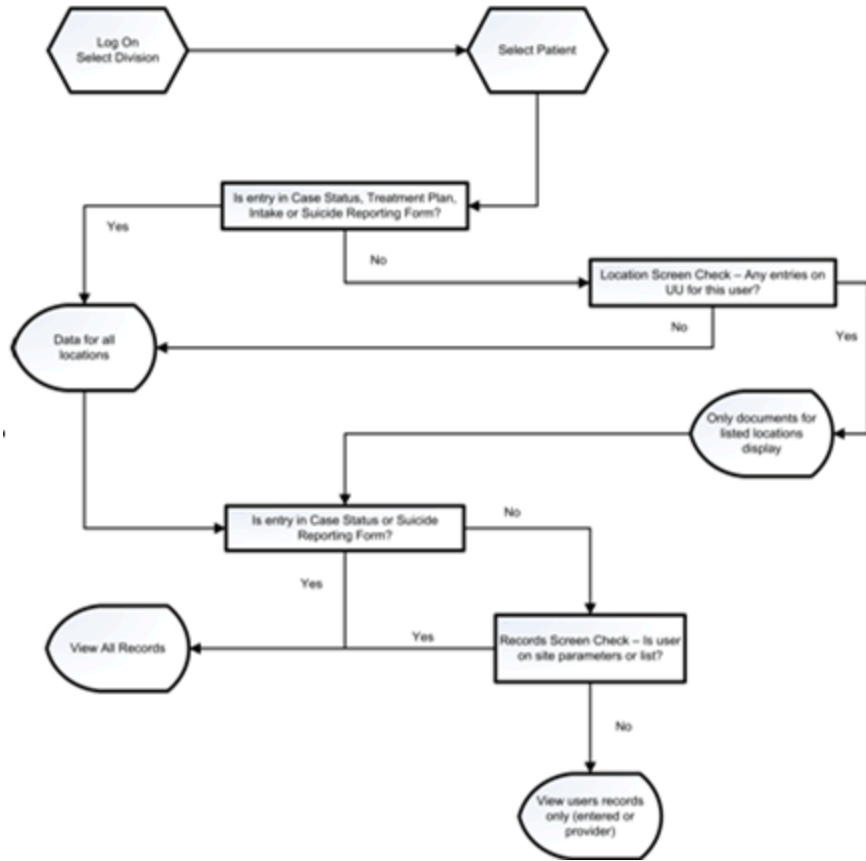


Figure E-7: UU and Those Allowed to View All Visits flowchart

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/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov