RESOURCE AND PATIENT MANAGEMENT SYSTEM

# Behavioral Health System

(AMH)

## Manager Utilities and Reports Training Manual

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# 1.0 Introduction

## 1.1 Purpose

This training manual is designed for behavioral health program clinical or administrative managers using the Resource and Management System (RPMS) Behavioral Health System (BHS) application. The focus of this training manual is the Reports and Manager Utilities modules of BHS v4.0 and it is intended to provide the knowledge and skills needed to:

- Establish application site parameters.
- Generate reports for internal and external use.
- Export data to Indian Health Service (IHS) Headquarters.

## 1.2 Objectives

Upon completion of this training manual, appropriate site parameters and/or security keys will be identified, and adjusted to control:

- The type of behavioral health data passed to the Patient Care Component (PCC – PCC Link Options).
- The ability of behavioral health staff to view records.
- The ability to delete records.

Additionally, this training manual provides information to:

- Execute administrative, clinical supervision, and case management functions.
- Select and run behavioral health reports for client and program management. Export data from these reports to an Excel file.
- Routinely export behavioral health data to headquarters using the Export Utility menu.

# 2.0 Objective 1: Security Keys and Site Parameters

Identify the appropriate site parameters and/or security keys and adjust them to control:

- The type of behavioral health data passed to PCC (PCC Link Options).
- The ability of behavioral health staff to view records.
- The ability to delete records.

## 2.1 Purpose

The purpose of this lesson is to introduce the setup options and security features available in both BHS and the Graphical User Interface (GUI).

## 2.2 Overview

Regardless of the user's role, it is important to recognize the purpose of the site parameters and links to the PCC.

## 2.3 Skills

Skills acquired upon completion of this objective include:

- Identify the various fields in the BHS site parameters and purpose of the security keys and secondary menus.
- Discuss the four types of links to PCC.
- Explain the purpose of the Update Those Allowed to See all Records (formerly known as Screen Mode Data Entry or SDE) function.
- Explain the purpose of the Interactive PCC Link.
- Discuss the site parameter link to the Electronic Health Record (EHR).
- Discuss the electronic signature capability including situations that would require the addition of a provider to the Electronic Signature Exceptions list.

## 2.4 Secondary Menus

**Question**: I can log in to the classic version of BHS but cannot use the windows-type, GUI. Are there different keys for the GUI, similar to what we had for Patient Chart?

**Answer**: The Behavioral Health (BH) applications are no longer two separate entities. With the release of BHS, the same security keys control both the classic (back end or roll-and-scroll) version and the GUI. If you are able to access the classic

version but not the GUI, the problem could be related to the secondary menus that must be added to the User profile. In order to access behavioral health data through the GUI, both AMHGRPC and BMXRPC must be listed as secondary menu options.

## 2.5 Security Keys

**Question**: I can delete any unsigned note that I have entered but cannot delete anything once I have signed the note. However, my colleague is able to delete signed or unsigned notes. Is there something different in how we are set up?

**Answer**: The application itself, as well as many functions within the application, is restricted through the use of security keys. These keys should only be assigned to staff with privileged access to confidential behavioral health data. Program managers should meet with the facility's RPMS site manager when assigning security keys.

All staff will need the keys preceded by an asterisk (*) in Table 2-1. All other keys are to be assigned to supervisors, managers, or site managers. The Delete and Reports keys may be assigned to all staff at the discretion of the program manager.

Table 2-1: Security Keys and associated Permissions

| 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 can access |
| AMHZ CODING REVIEW | Review records to ensure accurate coding |

> **Note**: The AMHZ Coding Review key should **NOT** be assigned to behavioral health staff. This key is to be assigned to PCC data entry staff, who are reviewing behavioral health (BH) records that are sent to the Coding Queue. For additional information on the Coding Queue option, please see the User Manual.
>
> If Coding Review (CR) is an available option on the Data Entry menu or Update Locations a User Can See (UU) is an available option on the Manager Utilities menu, keys may have been incorrectly assigned. Please consult with the RPMS site manager.

## 2.6 Manager Utilities Menu

The Manager Utilities menu provides options for site managers and program supervisors to customize the BHS on a site-by-site basis. Options are also available for administrative functions, including exporting data to the area, resetting local flag fields, and verifying who has edited a patient record.

> **Note**: Not all users of the BHS will be given access to this menu.

### 2.6.1 Update Site Parameters (SITE)

Individual sites use the Site Parameters file to set the system to suit various site needs. Use the Update Site Parameters option to modify the parameters in this file. The most important specification in this file is the determination of the types and classification of data that passes from the BHS system to the PCC. Site Parameters need to be set-up for each division in the RPMS database using the RPMS BHS.

### 2.6.2 Export Utility Menu (EXPT)

Use the functions on the Export Utilities menu to pass data from a facility to the IHS Headquarters office for statistical reporting purposes.

### 2.6.3 Add/Edit Local Service Sites (ELSS)

Use **ELSS** to define/add local service sites. Visit data may be captured at locally identified locations (e.g. Visits at a specific Community Center). Counts of these visits can be recovered using the **GEN** option in Encounter reports or **ACT** in the Workload reports.

### 2.6.4 Reset Patient Flag Field Data (RPFF)

Use the **RPFF** option to reset the patient flag field in the patient files. Use this option to reassign a flag or all flags as needed.

### 2.6.5 Display Log of Who Edited Record (DLWE)

Use the **DLWE** option to print a list of who has edited a patient record.

### 2.6.6 Add Personal History Factors to Table (EPHX)

Use the EPHX option to add Personal History items to the four-item list initially identified for use in BHS programs. Added items are shown as items in the Personal History field in the Case Management functionality. Various reports can be run on this data element, as well.

### 2.6.7 Delete BH General Retrieval Reports Definitions (DRD)

Use the **DRD** option to delete any GEN or PGEN report definitions that were previously saved and are no longer needed.

### 2.6.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

Use the **EEPC** option to manually assign an International Classification of Diseases (ICD) code entered through the EHR to one of the behavioral health problem code groupings.

## 2.7 Update Site Parameters

In addition to assignment of security keys and secondary menus, it is recommended that administrators, managers, and the RPMS site manager review the site parameters for BHS. The options listed on the site parameters' menu may be used to customize the software to meet the needs of the staff.

### 2.7.1 Defaults

**Question**: When I am entering an encounter and select a program from the pull down list, other fields are populated too. Why does it do this?

**Answer**: The BH application contains some default settings that are designed to make data entry quicker and more consistent. These defaults are set on the site parameters option under the Manager Utilities menu.

Clinical staff should determine the most frequently used location, community, and clinic. This information should then be provided to a staff member who has the

Manager Utilities security key or should be provided to the RPMS site manager to update the default settings in the Site Parameters.

Figure 2-1 shows the Default Values for each Data Item menu screen.

```
          ****  Enter DEFAULT Values for each Data Item ****
 MH Location: DEMO INDIAN HOSPITAL
 MH Community: TAHLEQUAH                MH Clinic: MENTAL HEALTH
 SS Location: DEMO INDIAN HOSPITAL
 SS Community: TAHLEQUAH                SS Clinic: MEDICAL SOCIAL SERVI
 Chemical Dependency Location: DEMO INDIAN HOSPITAL
 Chemical Dependency Community: TAHLEQUAH
 Chemical Dependency Clinic: BEHAVIORAL H
 OTHER Location: DEMO INDIAN HOSPITAL
 OTHER Community: TAHLEQUAH             OTHER Clinic: MENTAL HEALTH

Default Type of Contact: OUTPATIENT
Default Appt/Walk In Response: APPOINTMENT
EHR Default Community: TAHLEQUAH
```

Figure 2-1: Example default values on the site parameter menu

## 2.8 DSM-5 Implementation Date

This field controls the date which the application will use to trigger the use of the DSM-5 Code Set. From the date listed forward individual visits, group visits, treatment plans, BH Problem List, and case status information will no longer use DSM-IV-TR, which includes the Multi-Axial Assessment. Appendix D: provides information about DSM copyright and trademark information.

## 2.9 Update PCC Link Features, Type of PCC Link

**Question**: The business office recently reported that there are not any billable services showing for Mental Health (Social Services, Substance Abuse, or BH). What is happening to billable contacts?

**Answer**: Many programs electronically bill using the RPMS Third Party Billing Package, which extracts data regarding billable services from the RPMS PCC. The BHS can pass data to PCC that facilitates billing. The option to pass data to PCC is included on the site parameters option under the Manager Utilities menu.

> **Note**: BHS v3.0 contained five link types including one known as MHSS Crosswalk which was removed in BHS v4.0. Sites that want to continue to mask data are encouraged to use either link 2 or link 4 listed below.

Sites may use one of the following four links to PCC. For additional details refer to Section 2.9.1 through Section 2.9.4:

- No Link Active.

- Pass Standard Code and Narrative.
- Pass All Data As Entered (No Masking).
- Pass Codes and Canned Narrative.

### 2.9.1 No Link Active

The data link between the two modules is not turned on. No data is passed to the PCC visit file from the BHS system (including the Health Summary). Therefore, since the RPMS Third Party Billing Package processes encounters in PCC, an alternative billing process needs to be established.

Other RPMS information displays in the BH applications as shown in Figure 2-2 and Figure 2-3.

```
Date                  Provider         DX        Narrative
Mar 30, 2014@16:01    Beta, Betty      F42.      HOARDING DISORDER
```

Figure 2-2: BHS display

```
No VISIT selected!
```

Figure 2-3: PCC display

No information is available for the Health Summary for this date.

### 2.9.2 Pass Standard Code and Narrative

Patient contacts in the BH application are passed to the PCC visit file using the same ICD codes and narratives, as defined by the program. This approach does not facilitate billing since all encounters the same code and narrative. In the example below all encounters have the same ICD-10 code of F42. and the same narrative of Encounter as shown in Figure 2-4 and Figure 2-5.

```
Date         POV                    Activity     Contact      Provider
09/10/2014   HOARDING DISORDER      Individual  Outpatient   Beta, Betty
```

Figure 2-4: BHS Display

```
============================POVs=====================================
         POV                                          Z71.9
ICD Narrative:                                OTHER COUNSELING OR CONSUL
Provider Narrative:                           Encounter
```

Figure 2-5: PCC Display – POV screen

### 2.9.3 Pass All Data As Entered (No Masking)

All DSM-5 and Problem Codes are passed as ICD codes as shown in the crosswalk, along with the narrative as written by the provider. This link type is preferred by most billers and coders since the actual ICD code and narrative display in PCC, as shown in Figure 2-6 and Figure 2-7.

```
Date        POV    Clinic    Activity         Contact      Provider
01/11/14    HOAR   Behav    Individual Tr    Outpatient   Beta, Betty
```

Figure 2-6: BHS screen

```
============================POVs=====================================
POV:                                          F42.
ICD Narrative                                 OBSESSIVE-COMPULSIVE DISOR
Provider Narrative:                           HOARDING DISORDER
```

Figure 2-7: PCC Display – POV screen

Appendix D: provides information about DSM copyright and trademark information.

### 2.9.4 Pass Codes and Canned Narrative

Both DSM-5 and Problem Codes are converted to ICD codes as shown in the crosswalk and passed with a single standard narrative, as defined by the program, for all contacts. This type of link facilitates billing by passing the Purpose of Visit (POV) entered in BH applications as ICD codes although the standard narrative is not passed to the Health Summary shown in Figure 2-8 and Figure 2-9.

```
Date        POV      Clinic    Activity         Contact      Provider
01/11/14   HOARDING   Be… Individual Tr…   Outpatient   Beta, Betty
```

Figure 2-8: BHS Display

```
============================POVs=====================================
POV:                                          F42.
ICD Narrative:                                OBSESSIVE-COMPULSIVE DISOR
Provider Narrative:                           Encounter
```

Figure 2-9: PCC Display – POV

Appendix D: provides information about DSM copyright and trademark information.

## 2.10 Update PCC Link features, Interactive PCC Link

**Question**: Our clinic uses the PIMS Scheduling package and enters our encounters in BHS. The billing staff is telling us that there are two records being created in PCC for each encounter. Why?

**Answer**: When clinics are set up in the Scheduling package, there is a question "Create an encounter record at Check In?" If this is answered **Yes** in the scheduling package, an PCC 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 and passed to PCC, two records have been entered for the same encounter.

To address this issue, the BHS site parameters contain a question about an interactive PCC link. In the Scheduling package, if the clinic setup response is **Yes** to the question to create an encounter at check in, then the Interactive PCC Link question in the BHS site parameters must also be answered **Yes**. If the clinic setup in the Scheduling package has a negative response, then the response to the Interactive Link question in BHS should be **No**. Figure 2-10 shows the Update PCC Link Feature Parameters popup.

```
**** Update PCC Link Feature Parameters ****
=================================================
Type of PCC Link
Type of Visit to create in PCC
Interactive PCC Link?
Allow PCC Problem List Update?
Update PCC LINK Exceptions?
```

Figure 2-10: Pop-up window for PCC Link Features on the site parameter menu

If both responses have been set to **Yes**, the clinician or data entry staff may be asked if they want to merge the BHS encounter record with one entered earlier in the day.

## 2.11 Turn off EHR to BH Link

**Question**: There seems to be an entry related to EHR on the BH site parameters. Does our facility need to do anything for this?

**Answer**: A site parameter was added in a previous version of the software to give sites the ability to "opt out" of the BH EHR visit functionality. This functionality allows BH providers to enter a visit into the EHR that passes first to PCC and then to the behavioral health database. These visits display in the EHR as well as the BHS.

The name of the site parameter is **Turn Off EHR to BH Link** and is viewed through the BHS Manager Utilities module SITE menu option. The default setting for this new site parameter is **No** and action is not required if sites are deploying the BH EHR functionality. If sites are not deploying the BH EHR visit functionality, then the site parameter should be changed to **Yes**.

## 2.12 Update Those Allowed to See All Records

**Question**: I know that clients that I see for counseling are also being seen by the psychiatrist for medication management. When I select one of the clients, only my encounters are displayed on the screen. Why?

**Answer**: In addition to security keys, there are other mechanisms built into the system to protect client information. The **Update Those Allowed to See all Records** (formerly known as the SDE List) is maintained on the Manager Utilities menu within the site parameters option. If your name is not on the list, only those encounters you entered or those where you were a provider will display.

Each site needs to determine who should have access to all information about the clients, and ensure that those names are provided to someone who can enter them on the site parameters menu option. Figure 2-11 shows the Site Parameters menu.

```
**UPDATE BH SITE PARAMETERS **  SITE NAME: DEMO HOSPITAL
=====================================================================
Update DEFAULT Values?  N
Default Health Summary Type? BEHAVIORAL HEALTH
Default response on form print? FULL Suppress Comment on Suppressed Form? YES
# of past POVs to display? 5       Exclude No Shows on last DX Display? YES
DSM-5 Implementation Date: Oct 1, 2015
Update PCC Link features? N
Turn Off EHR to BH Link? NO
Turn on PCC Coding Queue? NO        Update Provider Exceptions to E Sig? N
Update those allowed to see all records? N
Updates those allowed to override delete? N
Update those allowed to share visits? N
Update those allowed to order labs? N
If you are using the RPMS Pharmacy System, enter the Division: Test Division
```

Figure 2-11: Sample Site Parameters menu

## 2.13 Update Those Allowed to Override Delete

This option on the Site Parameters menu was created to allow sites to identify individuals who will be able to delete Intake documents regardless of who created and signed them. Because of the specific business rules attached to Intake documents, it was necessary to establish a method of deleting the intakes if an intake was entered in error or if a provider no longer worked for a site.

Users added to the **Update Those Allowed to Override Delete** list can delete any Intake document, regardless of whether or not security keys have been issued to them for deletions. If a user is not on the list, the only intakes that can be deleted are ones that the user created, as long as the appropriate security key has been assigned.

## 2.14 Update Provider Exceptions to E Sig

The electronic signature function is available on the PDE, SDE, and Group entry menus (in roll-and-scroll) and also available on the One Patient, All Patients, and Group entry menus in the GUI. Electronic signature can be applied to SOAP/Progress Notes and intake/update documents. Only those encounter records with signed SOAP/Progress Notes will pass to PCC.

Because some sites may still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a provider should be exempted from the electronic signature, those visits will pass to PCC, but show up as unsigned on the visit entry display.

See Appendix A: for more information on how to create an electronic signature.

# 3.0 Objective 2: Management Tools

Execute administrative, clinical supervision, and case management functions.

## 3.1 Purpose

The purpose of this lesson is to introduce the management tools found in in BHS, and demonstrate their usefulness in customizing data collection fields, monitoring data entry, trending client-related encounters, reviewing and assigning designated providers, etc.

## 3.2 Overview

Regardless of their roles, it is important that the user identify management tools within the application. The user should also describe how to locate encounter information in a timely manner, and produce management reports related to data entry, no show encounters or designated providers, etc.

## 3.3 Skills

Skills acquired upon completion of this objective include:

- Identify the tools located on the Manager Utilities menu and their purposes.
- Identify tools found on the primary data entry menu and be able to view and/or edit a list of designated providers, treatment plans needing reviewed, duplicate a previous encounter, etc.
- Identify the tools on the Data Entry menu and be able to view and/or display a list of visit dates, browse visits for a patient, and update the BH Problem List.
- Identify the tools on the Display Records Option (DSP) menu and view an encounter record using Display a PCC Visit (PCCV) and Display Behavioral Health Visit Record (RD) and explain the difference.

## 3.4 Management Tools located on Manager Utilities Menu

**Question**: Is there any way to individualize some of the information that is being tracked in BHS? For example, we do a lot of individual counseling sessions at the local high school; how can we track these?

**Answer**: BHS has some additional management functions on the Manager Utilities menu to help sites customize several of the fields, such as Personal History Factors or Local Service Sites shown in Figure 3-1.

```
SITE     UPDATE SITE PARAMETERS
EXPT     EXPORT UTILITY MENU…
RPFF     Re-Set Patient Flag Field Data
DLWE     Display Log of Who Edited Record
ELSS     Add/Edit Local Service Sites
DRD      Delete BH General Retrieval Report Definitions
EEPC     Edit Other EHR Clinical Problem Code Crosswalk
UU       Update Locations a User Can See
```

Figure 3-1: Sample Manager Utilities menu

### 3.4.1 Reset Patient Flag Field Data (RPFF)

Patient Flags can be numbered from 0-999; however, there must be keeper of the flags. If the narratives assigned to specific numbers become obsolete or the data is mixed up, it is possible to access this function and remove a definition or all of them. When a narrative is reset, reports generated previously, using the data will no longer be shown as valid as in Figure 3-2.

```
Select one of the following:
          A         ALL FLAGS
          O         ONE PARTICULAR FLAG
Reset which flags: A// o  ONE PARTICULAR FLAG
Which flag should be removed: 123
Are you sure you want to do this? N// y  YES
Hold on... resetting data..
All done.
```

Figure 3-2: Sample flag reset

### 3.4.2 Display Log of Who Edited Record (DLWE)

Figure 3-3 shows a list of who edited a record.

> **Note**: This option displays the names of staff using the Edit function to view an encounter record, whether or not changes were actually made to the data.

```
DATE CREATED      WHO ENTERED RECORD   LAST MOD      USER LAST UPDATE
DATE/TIME EDITED         WHO EDITED
-------------------------------------------------------------------
10/04/014           PROVIDER B          10/23/14         PROVIDER B
OCT 23, 20014 13:22      PROVIDER DE
```

Figure 3-3: Sample log

### 3.4.3 Add/Edit Local Service Site (ELSS)

Use this option to define/add local service sites in order to capture visit data at locally identified locations. Counts of these visits can be recovered using the GEN option in Encounter Reports or ACT in the Workload reports. Local Service Sites should be thought of as additional descriptors to identify where a service was provided. If data

can be captured using existing code sets it is not necessary to add a local service site. If staff routinely visits the only jail in the county, changing the type of contact to jail will produce the desired result; however, if there are multiple facilities within the service area, then a local service site may be needed shown in Figure 3-4.

```
ELSS  Add/Edit Local Service Sites
Select MHSS LOCAL SERVICE SITES: ???
       Choose from:
   CHARLESTOWN HIGH SCHOOL
   CHARLESTOWN YOUTH DETENTION CENTER
   NEWTON FALLS HEADSTART PROGRAM
      You may enter a new MHSS LOCAL SERVICE SITES, if you wish
   Select MHSS LOCAL SERVICE SITES: BARNESVILLE CO DETENTION CTR
   Are you adding 'BARNESVILLE CO DETENTION CTR' as  a new MHSS LOCAL
SERVICE SITE (the 4TH)? No// Y  (Yes)
LOCAL SERVICE SITE: BARNESVILLE CO DETENTION CTR  Replace
ABBREVIATION: BCDC
```

Figure 3-4: Adding local service site

> **Note**: Once a local service site has been added, it cannot be removed.

### 3.4.4 Add Personal History Factors to Table (EPHX)

Explanation of personal history: One or more personal history items for a patient can be documented. Personal history only needs to be documented once because it becomes a permanent part of the patient's medical record. Besides the options listed below, each facility may identify additional personal history items to track.

- Alcohol Use.
- Child Abuse (victim).
- Partner Abuse (victim).
- Substance Abuse.
- Suicide Attempt.

Facilities often find personal history factors to be useful in developing reports for tracking diagnosis associated with personal history shown in Figure 3-5.

```
Enter a PERSONAL HISTORY FACTOR: GULF WAR VETERAN
  Are you adding 'GULF WAR VETERAN' as
    A new MHSS PERSONAL HX FACTORS (the 14th)? No// Y (Yes)
FACTOR: GULF WAR VETERAN   Replace
```

Figure 3-5: Adding personal history factor

### 3.4.5 Delete BH General Retrieval Report Definitions (DRD)

This option deletes a PCC Visit or Patient General Retrieval report definition. For example, if a provider had created multiple report definitions using GEN or PGEN

and saved the logic, these reports may be deleted when the provider leaves the facility. Figure 3-6 shows the Report Name screen.

```
REPORT NAME:  ???
    Choose from:
   ALCOHOL RELATED DX 2009  STUDENT,THREE-MAY 25, 2009@13:43:45  ALCOHOL
   ST1 ALCOHOL RELATED DX  STUDENT,ONE-MAY 25, 2009@13:43:35  ALCOHOL  RELATED DX
   ST3 ELIGILITY REPORT  STUDENT,THREE-MAY 23, 2009@11:04:49  ST3 ELIGILITY REPORT
   S10 ALCOHOL RELATED DX  STUDENT,TEN-APR 25, 2010@13:12:46  S10 ALCOHOL  RELATED D
   ST8 ELIGIBILITY LIST  STUDENT,EIGHT-APR 02, 2009@11:04:48  ST8 ELIGIBILITY LIST
   MS-THIRD PARTY  STUDENT,TEN-JAN 12, 2009@11:04:53  MS-THIRD PARTY
   SKM ELIGIBILY REPORT  STUDENT,FOUR-FEB 14, 2010@11:04:49  SKM ELIGIBILITY REPORT
   VMT ELIGIBILITY LIST  STUDENT,SIX-MAY 25, 2005@11:04:48  VMT ELIGIBILITY LIST

REPORT NAME:  ST8 ELIGIBILITY LIST  STUDENT,EIGHT-APR 02, 2009@11:04:48   ST8
ELIGIBILITY LIST
Are you sure you want to delete the ST8 ELIGIBILITY LIST report definition? N// YES
Report Definition STUDENT,EIGHT-APR 02, 2009@11:04:48 deleted.
```

Figure 3-6: Deleting a report definition

### 3.4.6 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

The ICD codes that have been added to the MHSS PROBLEM/POV CODES table will not have been automatically assigned to the appropriate BH problem code group. To ensure that these ICD codes are captured in BHS reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time.

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

1. Select the Manager Utilities Menu.
2. Select EEPC Edit Other EHR Clinical Problem Code Crosswalk:
    - As each ICD code and narrative is displayed, it can be assigned to an existing Problem Code Grouping.
3. A warning prompt displays with No as the default, do one of the following:
    - If correct, type **Yes** and press Enter.
    - If incorrect, type **No** and press Enter.

After responding to the first ICD code/narrative, the application continues to present all ICD codes that have been entered since the last time this function was utilized as shown in Figure 3-7.

```
CODE: A15.0
ICD Narrative: TUBERCULOSIS OF LUNG
Enter the Problem Code Grouping: phy
 1  PHYSICAL DISABILITY/REHABILITA  4  PHYSICAL DISABILITY/REHABILITATION
 2  PHYSICAL ILLNESS, CHRONIC     6.1  PHYSICAL ILLNESS, CHRONIC
 3  PHYSICAL ILLNESS, TERMINAL    6.2  PHYSICAL ILLNESS, TERMINAL
 4  PHYSICAL ILLNESS, ACUTE         5  PHYSICAL ILLNESS, ACUTE
CHOOSE 1-4: 2   6.1  PHYSICAL ILLNESS, CHRONIC
Are you sure you want to change the MHSS Problem Code Grouping to 6.1 –
Physical Illness,
Chronic? N// y YES
CODE: 780.6
ICD Narrative: FEVER
Enter the Problem Code Grouping:
```

Figure 3-7: Sample problem code grouping edit

### 3.4.7 Update Locations a User Can See (UU)

If this option is on the Manager Utilities menu but you are not a multi-divisional site, please contact a site manager to have the security key removed.

Multi-divisional sites who want to control individual provider's access to certain locations may use this option to lock down the locations a user can see or select. For example, if Demo Hospital is listed that will be the only location that can be selected for data entry, and the only location to display most of the reports in the Reports module.

## 3.5 Case Management Tools (DE Menu)

Figure 3-8 shows and example of a DE menu.

```
PDE   Enter/Edit Patient/Visit Data – Patient Centered
SDE   Enter/Edit Visit Data – Full Screen Mode
GP    Group Form Data Entry Using Group Definition
DSP   Display Record Options…
TPU   Update BH Patient Treatment Plans…
DPL   View/Update Designated Provider List
EHRE  Edit BH Data Elements of EHR created Visit
EBAT  Listing of EHR Visits with No Activity Time
SF    Suicide Reporting Forms – Update Print…
CR    Coding Review
DSM   View DSM-5 copyright information
```

Figure 3-8: Sample DE menu

### 3.5.1 Update BH Treatment Plans (TPU)

Use the **BH** option to manage treatment plans including reports for plans that need to be reviewed or resolved shown in Figure 3-9.

```
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
```

Figure 3-9: Sample update screen

### 3.5.2 View/Update Designated Provider List (DPL)

Use the **DPL** option to update and manage a provider's patient panel. Add patients to the provider's list of patients, remove patients from the list, and review the list. Figure 3-10 shows the Designated Provider list.

```
Patients with Designated Provider: Provider S
------------------------------------------------------------------------------
# HRN     PATIENT NAME    DOB          SEX LAST VISIT      PROV TYPE
------------------------------------------------------------------------------
1  901231 PATIENT S       JAN 22, 1976  F  SEPT 20, 2014   MENTAL H
2  90745  PATIENT G       JUL 15, 1991  F  MAY 17, 2014    CD/OTH
3  90394  PATIENT R       SEP 24, 1987  M  DEC 12, 2014    MENTAL HLTH
4  900123 PATIENT Z       DEC 18, 1981  M  MAY 13, 2014    MENTAL HLTH
5  911234 PATIENT M       MAR 05, 1991  F  NOV 3, 2014     MENTAL HLTH
6  921641 PATIENT P       OCT 26, 1983  M  DEC 1, 2014     CD/OTH
7  906363 PATIENT X       FEB 14, 1984  M  JAN 2, 2014     MENTAL HLTH
8  911222 PATIENT N       JUL 23, 1987  F  DEC 14, 2014DE
    MENTAL HLTH
------------------------------------------------------------------------------
RM    Remove Patient From List          CD Change Patient's Desg Provider
AD    Add Patient to List               AV Create Contact Visit
HS    Health Summary                    Q  Quit
BV    Browse Patient's Visits
```

Figure 3-10: Sample designated provider list

## 3.6 Case Management Tools (PDE Menu)

```
AV Add Visit            LD List Visit Dates      GS GAF Scores
EV Edit Visit           TP Treatment Plan Update OI Desg Prov/Flag/Pers Hx
DR Display Record       CD Update Case Data      EH Edit EHR Visit
ES Edit SOAP            ID Intake Document       PPL Problem List Update
DE Delete Visit         AP Appointments          SN Sign Note
PF Print Encounter Form HS Health Summary        TN TIU Note Display
LV Last BH Visit        DM Display Meds          MM Send Mail Message
BV Browse Visits        LA Interim Lab Reports   FS Face Sheet
```

Figure 3-11: Sample PDE menu

### 3.6.1 Browse Visits (BV)

Use the **BV** option to browse all visits for a patient (Figure 3-12). This is similar to flipping through a paper chart. All details of the encounter, including the note display.

> **Note**: This option is now available in BHS GUI under Visit Encounters on the main menu tree.

```
Browse Behavioral Health Visits
Select one of the following:
      L      Patient's Last Visit
      N      Patient's Last N Visits
      D      Visits in a Date Range
      A      All of this Patient's Visits
      P      Visits to one Program
Browse which subset of visits for DEMO,PATIENT: N//
```

Figure 3-12: Available options for BV

### 3.6.2 List Visit Dates (LD)

Use the **LD** option to browse through a subset of visits for a patient. The date, provider, diagnosis, and POV narrative for the encounters display shown in Figure 3-13.

```
Date                 Provider         DX       Narrative
Nov 08, 2015@10:37   DEMO,DOC        F32.0     MAJOR DEPRESSIVE DIS
Nov 08, 2015@10:42   DEMO,DOC        F32.3     MAJOR DEPRESSIVE DIS
Nov 01, 2015@10:39   DEMO,DOC        F42.      HOARDING DISORDER
```

Figure 3-13: Sample record of patient visits

### 3.6.3 Problem List Update (PL)

Use the **PL** option to view the PCC problem list or view/edit the BH problem list for a patient as shown in Figure 3-14.

> **Note**: This functionality is now available in the GUI.

```
BH Problem List Update       NOV 09, 2015 16:21:16      Page:    1 of   2
------------------------------------------------------------------------------
Patient Name: ALPHAA,CHELSEA MARIE   DOB: FEB 07, 1975   Sex: F   HRN: 11
------------------------------------------------------------------------------
1)   DX: F42.      Status: ACTIVE         Last Modified: 11/08/2015
     DSM Narrative: HOARDING DISORDER
     Provider Narrative: HOARDING DISORDER
     Date of Onset:    Facility: 2013 DEMO HOSPITAL
        Notes:
           STP Note #1 Added: 11/8/2015
           Narrative:  TESTING

2)   DX: F32.0     Status: ACTIVE         Last Modified: 11/08/2015
     DSM Narrative: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD
```

```
     Provider Narrative: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD +
Enter ?? for more actions                                      >>>
AP  Add BH Problem       NO  Add Note           FA  Face Sheet
EP  Edit BH Problem      MN  Edit Note          BP  Add BH Prob to PCC PL
DE  Delete BH Problem    RN  Remove Note        PC  PCC Problem List Update
AC  Activate BH Problem  NP  No Active BH Probl Q   Quit
IP  Inactivate BH Prob   LR  Problem List Reviewed
DD  Detail Display       HS  Health Summary
Select Action: +//
```

Figure 3-14: Sample BH Problem List Update 2.4 Management Tools (DSP)

The DSP menu (Figure 3-15) allows an encounter record either in BHS or in PCC to be reviewed.

```
RD       Display a Behavioral Health Visit Record
PCCV     Display a PCC Visit
LV       Display Patient's Last Behavioral Health Visit
LI       List Visit Records, Standard Output
PR       Print Encounter Form for a Visit
FC       Count Forms Processed by Data Entry
BV       Browse a Patient's Visits
GAF      GAF Scores for One Patient
GAFS     GAF Scores for Multiple Patients
PHQ      PHQ-2, PHQ-9, and PHQ-T Scores for One Patient
PHQS     PHQ-2, PHQ-9, and PHQ-T Scores for Multiple Patients
LD       List All Visit Dates for One Patient
NS       Listing of No Show Visits for One Patient
NSDR     Listing of No-Show Visits in a Date Range
ES       Listing of Visits with Unsigned Notes
```

Figure 3-15: Sample DSP menu

### 3.6.4 Display Behavioral Health Visit Record (RD)

The RD option shows encounter information in a format similar to PCC; however, it also includes the SOAP note and comments as shown in Figure 3-16.

```
Patient Name:          CLIENT D
Chart #:               907468
Date of Birth:         MAY 20, 1969
Sex:                   M
=============== BH RECORD FILE ===============
DATE OF SERVICE:       OCT 23, 2014@10:00
PROGRAM:               MENTAL HEALTH
POSTING DATE:          OCT 23, 2014
LOCATION OF ENCOUNTER: DEMO HOSPITAL
COMMUNITY OF SERVICE:  BARNESVILLE
ACTIVITY TYPE:         12
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               CLIENT D
PT AGE:                37
NUMBER SERVED:         1
APPT/WALK-IN:          APPOINTMENT
ACTIVITY TIME:         60
INTERPRETER UTILIZED:  NO
VISIT:                 OCT 23, 2014@10:00
```

```
WHO ENTERED RECORD:    CLERK W
DATE LAST MODIFIED:    OCT 23, 2014
EXTRACT FLAG:          ADD
CLINIC:                MENTAL HEALTH
USER LAST UPDATE:      CLERK W
AXIS IV:
SUBJECTIVE/OBJECTIVE:
COMMENT/NEXT APPOINTMENT:
NOTE FORWARDED TO:
MEDICATIONS PRESCRIBED:
=============== MHSS RECORD PROBLEMS (POVS) ===============
PROBLEM CODE:          F32.0
PROBLEM CODE NARRATIV: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD
PROVIDER NARRATIVE:    MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD
=============== MHSS RECORD PROVIDER ===============
PROVIDER:              PROVIDER Z
PROVIDER DISCIPLINE:   LICENSED MEDICAL SOCIAL WORKER
PRIMARY/SECONDARY:     PRIMARY
```

Figure 3-16: Sample Behavioral Health Visit Record Display

## 3.6.5 Display a PCC Visit (PCCV)

The PCCV option (Figure 3-17) shows encounter information as it displays when passed to PCC. If the PCC Link is set to pass no data, the encounter will not be available in this format.

```
Patient Name:          CLIENT D
Chart #:               107468
Date of Birth:         MAY 20, 1969
Sex:                   M
Visit IEN:             165735
=============== VISIT FILE ===============
VISIT/ADMIT DATE&TIME: OCT 23, 2014@10:00
DATE VISIT CREATED:    OCT 23, 2014
TYPE:                  IHS
PATIENT NAME:          CLIENT D
LOC. OF ENCOUNTER:     DEMO HOSPITAL
SERVICE CATEGORY:      AMBULATORY
CLINIC:                MENTAL HEALTH
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:    OCT 23, 2014
WALK IN/APPT:          APPOINTMENT
CREATED BY USER:       CLERK W
USER LAST UPDATE:      CLERK W
UNIQUE VISIT ID:       5055300000165735
DATE/TIME LAST MODIFI: NOV 08, 2015@12:45:42
VISIT ID:              14DR-CGX
=============== PROVIDER ===============
PROVIDER:              PROVIDER Z
AFF.DISC.CODE:         1621
PRIMARY/SECONDARY:     PRIMARY
=============== POV ===============
POV:                   F32.0
ICD NARRATIVE:         Major depressive disorder, single episode, mild
PROVIDER NARRATIVE:    MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD
PRIMARY SNOMED:        63161005
PRIMARY SNOMED PREFER: Principal
```

```
DATE/TIME ENTERED:     NOV 08, 2015@12:45:42
ENTERED BY:            DEMO,DOC
DATE/TIME LAST MODIFI: NOV 08, 2015@12:45:42
LAST MODIFIED BY:      DEMO,DOC
V FILE IEN:            3210969 ================ ACTIVITY TIME
================
ACTIVITY TIME:         60
TOTAL TIME:            60
UNIQUE VISIT ID:       5055300000165735
DATE/TIME LAST MODIFI: NOV 08, 2015@12:45:42
VISIT ID:              14DR-CGX
```

Figure 3-17: Sample PCCV display

## 3.6.6 List No-Show Visits for One Patient (NS)

Use the NS option to view no-shows for a client within a time frame shown as in Figure 3-18.

```
BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
Appointment Dates: JUL 25, 2009 and OCT 23, 2009
CLIENT A
DATE/TIME              PROVIDER        PG     POV
Sep 14, 2014@18:00     PROVIDER P      M      8.1
OCT 04, 2014@12:00     PROVIDER Q      S      8
```

Figure 3-18: Sample no-show report for one patient

## 3.6.7 Listing of Visits with Unsigned Notes (ES)

Use the **ES** option to display a list of all encounter records (Figure 3-19) containing unsigned SOAP/progress notes in a specific date range. Encounter records created before the date of installation of BHS do not display and cannot be signed.

```
UNSIGNED ENCOUNTER RECORDS
Date Range: Nov 1, 2009 and May 1, 2010
PATIENT NAME          HRN DATE/TIME               PROVIDER      PG   GRP
------------------------------------------------------------------------
ALPHAA,MISTY DAWN     131668 DEC 02,2014@11:00    BETA,BETTY     M     Y
GAMMA,CARMELITA SUSAN 102668 DEC 02,2014@11:00    BETA,BETTY     M     Y
EPSILON,JAMES EDWARD  116431 DEC 02,2014@11:00    BETA,BETTY     M     Y
DELTA,CHELSEA MARIE   182497 DEC 02,2014@11:00    BETA,BETTY     M     Y
ALPHAA,ROBERT LOWE    103147 DEC 01,2014@10:00    THETA,SHIRLEY  S
TOTAL # OF UNSIGNED VISITS: 5
```

Figure 3-19: Sample Listing of Visits with Unsigned Notes report

**Case Management Exercises**

Use the same client for the first five exercises.

**A.** Browse all the encounter records since January 1st for the client designated by the trainer. (DE-DSP-BV)

**B.** List the visit dates for the client since January 1st, 2014. How would you print this simple report of the visit record? (DE-DSP-LV)

**C.** Your program has a policy of refusing to see a client with more than three no-shows in six months. Run the No-Show Report for the client. (DE-DSP-NS)

**D.** You would like to see the last visit of all the clients for whom you are the designated provider. When was the client's last visit? (DE-DPL)

**E.** Run a report showing all the encounter records with unsigned SOAP/progress notes for the last six months. (DE-DSP-ES)

# 4.0 Objective 3: BHS Reports

Select and run behavioral health reports for client and program management. Export data from these reports to an Excel file.

## 4.1 Purpose

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

## 4.2 Overview

It is important that all users of BHS be able to generate a report showing client contacts, treatment plans needing revised, problem specific reports, or workload reports. Generating reports enables the provider to monitor encounter data for accuracy, manage resources efficiently, and provide encounter data to governing bodies, funding sources, etc.

## 4.3 Skills

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 active client list, treatment plans needing revised, IPV/DV screenings completed, and aggregated suicide data.
- Convert BHS report data to an Excel spreadsheet or Word document.
- Generate reports using the BH General Retrieval (GEN) or Patient General Retrieval (PGEN) options.

## 4.4 Reports Menu

The Reports menu of the BHS provides numerous options for retrieving data from the patient's file. Specific client information and tabulations of records and visits can be obtained from the database. This manual will provide information about some of the most frequently used BHS reports, for information on all available reports see the User Manual. Options are provided for both predefined and custom reports shown in Table 4-1.

Table 4-1: Table of report menu options and definitions

| Report Menu Options | Definition | Description |
|---|---|---|
| PAT | Patient Listings | The Patient Listings submenu contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, which is a custom report that allows you to select which clients to include in the report, which items to print, and how you wish the clients to be sorted. |
| REC | Behavioral Health Record/Encounter Reports | Report options for listing various records from the BHS patient file are available on the Behavioral Health Record/Reports Menu. Select from a standard output list, a custom retrieval tool, or a list of potentially billable visits. |
| WL | Workload/Activity Reports | The Workload/Activity Reports Menu presents options to generate reports related specifically to the activities of Behavioral Health providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring Behavioral Health care. |
| PROB | Problem Specific Reports | The Problem Specific Report options concern particular problem areas of interest to IHS Behavioral Health providers. In addition, reports that tabulate problems by frequency are provided. |

**Note**: All reports have been updated to prompt users to include or exclude a site's Demo/Test patients. To use this feature, the site's demo and test patients must be included in the Demo Patient Search Template. This option is found in PCC Management Reports and is controlled by the security key APCLZ UPDATE DEMO TEMPLATE. If you do not have this key and need to add a new demo or test patient to the list, please contact the PCC supervisor. 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.

### 4.4.1 Patient Listings (PAT)

The Patient Listings submenu contains report options for generating lists of patients by various criteria.

### 4.4.2 Active Client List (ACL)

The ACL report (Figure 4-1) produces a list of clients who have been seen within a specified date range. This report looks for encounter records, displaying the provider, problem code or diagnosis, and the number of visits at each location within the time period. (It should not be mistaken for a list of cases assigned to a clinician – that would be the Designated Provider List).

```
                          ACTIVE CLIENT LIST
                          PROVIDER: PROVIDER R
                 ENCOUNTER DATES:  OCT 1, 2015 TO NOV 24, 2015
PATIENT NAME CHART  SEX   DOB    LOCATION     PROVIDER  PROBLEM      #
             NUMBER              SEEN         SEEN     CODES   VISITS
-------------------------------------------------------------------------
CLIENT A    106529  F   03/05/30  CHENEGA     PROVIDER R   F32.3     4
                                  DEMO HOSPI   STUDENT,EI   F10.24
CLIENT B    901234  F  04/04/76  DEMO HOSPI   PROVIDER R   F42.
CLIENT C    200042  M  03/23/83  CHENEGA      PROVIDER R   F32.1     3
                                  DEMO HOSPI   STUDENT,FO   F32.3
                                               STUDENT,TW   F32.3
CLIENT D   107468   M  05/20/69  DEMO HOSPI   PROVIDER R   F84.0     2
                                               F32.2
CLIENT E   432098   M  04/04/75  DEMO HOSPI   PROVIDER R   F42.      1
CLIENT F   200614   F  05/17/90  CHENEGA      PROVIDER R    1.1      3
                                               STUDENT,TW   F10.24
Total Number of Patients: 6
```

Figure 4-1: Sample Active Client List

### 4.4.3 Designated Provider List (DP)

The Designated Provider List looks at information entered on the Patient Information tab in BHS GUI or through OI, Desg Prov/Flag/Pers HX on the PDE menu in BHS. This format requires selection of the type of Designated Provider (mental health, chemical dependency, etc.) and then either one provider or all providers. Figure 4-2 shows the Designated Provider List.

```
PATIENT NAME CHART #    SEX      DOB      COMMUNITY        LAST VISIT
-------------------------------------------------------------------------
PROVIDER: STUDENT,ONE
CLIENT Z     200833     F       08/09/92  CARNEGIE         May 02, 2014
CLIENT Y     200130     M       04/09/92  VERDEN           Sep 14, 2009
CLIENT X     200328     M       04/17/84  APACHE           Mar 10, 2012
CLIENT W     106093     F       07/16/84  MOUNTAIN VI      Mar 10, 2010
CLIENT V     201185     F       10/29/43  ANADARKO         Jan 26, 2010
SUB-TOTAL:  5
PROVIDER:  STUDENT,TWO
CLIENT A     100318     F       09/15/92  MOUNTAIN VI      May 05, 2014
CLIENT B     200011     M       04/08/91  FORT COBB        Sep 14, 2009
```

```
CLIENT C     102170     M       10/26/83  CARNEGIE         May 02, 2010
CLIENT D     107007     F       04/29/84  HOBART           Apr 24, 2014
SUB-TOTAL:  4
PROVIDER:  STUDENT,FOUR
CLIENT L     200609     M       03/28/81  CARNEGIE         Apr 24, 2014
CLIENT M     104225     F       09/17/84  EAKLY            Apr 24, 2010
CLIENT N     107780     M       06/25/51  CARNEGIE         Jan 25, 2014
SUB-TOTAL:  3
PROVIDER:  STUDENT,SIX
CLIENT R     200471     F       08/23/92  MOUNTAIN VI      Jan 09, 2014
CLIENT S     106989     M       02/20/79  CARNEGIE         Mar 06, 2014
CLIENT T     106352     F       09/09/84  CARNEGIE         Apr 24, 2014
SUB-TOTAL:  3
```

Figure 4-2: Sample Designated Provider List

## 4.4.4 Duration of Care Report (DOC)

The DOC report (Figure 4-3) produces a list of all closed cases in a specified date range. To be included in this report, the case must have both a case open and a case closed date. Duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases may be selected based on open date, closed date, or both. Only cases falling within the specified time frame are counted.

```
********** CONFIDENTIAL PATIENT INFORMATION **********
DEMO HOSPITAL
Case Dates: May 24, 2008 to May 24, 2010
DURATION OF CARE REPORT
PATIENT NAME CHART     CASE OPEN   CASE CLOSED  DURATION  POV  PROVIDER
             NUMBER    DATE        DATE
------------------------------------------------------------------------
Patient A    148367    05/22/08    08/22/08     92 days         BETA,B
Patient B    114077    06/27/08    08/28/08     62 days         BETA,B
Patient B    114077    07/25/08    08/21/08     27 days         BETA,B
Total Number of Cases for BETAA,B: 3
Average Duration of Care: 60.33 days

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

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

Patient E    148256    07/25/08    09/01/08     38 days         THA,VICTOR
Total Number of Cases for THA,VICTOR L: 1
Average Duration of Care: 38.00 days

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

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

Figure 4-3: Sample Duration of Care report

### 4.4.5 Patient Seen X Number of Times with No Case Open (SENO)

The SENO report (Figure 4-4) produces a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. Based upon a program's standard of care, a user may specify when a case may be opened. For example, a case can be opened if a patient has been seen at least three times.

```
      PATIENTS SEEN AT LEAST 3 TIMES WITH NO CASE OPEN DATE
               VISIT DATE RANGE: Oct 01, 2015 to Jan 01, 2016
                      VISITS TO PROGRAM: MENTAL HEALTH
PATIENT NAME  CHART   SEX   DOB        #     LAST VISIT   LAST    PROVIDER
              NUMBER               VISITS                DX
-------------------------------------------------------------------------
CLIENT SR     116431   F   02/07/75   14    10/10/15     F02.80  PROVIDER B
CLIENT BA     188444   M   10/14/79   22    10/28/15     F19.181 PROVIDER B
CLIENT BK     113419   M   07/18/85    5    10/02/15    T74.31XD PROVIDER B
CLIENT AB     201295   M   05/14/41    4    11/22/15     Z59.5   PROVIDER F
CLIENT CA      171659   F   12/07/94    4    12/09/15     F64.1   PROVIDER B
CLIENT SM     152608   M   02/25/86    4    12/19/15     F54     PROVIDER B
CLIENT YE     194181   M   08/21/98    7    11/19/15     F15.24  PROVIDER Y

Total Number of Patients: 7
```

Figure 4-4: Sample SENO report

### 4.4.6 Listing of No-Show Visits in a Date Range (NSDR)

Use the **NSDR** option to print a list of visits (Figure 4-5) with purpose of visit (POV) related to no shows and cancellations for multiple patients. Specify the date range, program, and provider.

```
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  112383 Dec 30,2008       BETAAAA,BJ   M   8.1-PATIENT CAN
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 WAI

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

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

Figure 4-5: Sample Behavioral Health No Show Appointment Listing report (NSDR)

## 4.4.7 Placements by Site/Patient (PPL)

Use the **PPL** option to produce a report that shows a list of patients who have had a placement disposition recorded in the past year. Specify the date range during which the patient had a placement. Figure 4-6 shows the placement dates are from October 19, 2008 to April 17, 2009.

```
OUTPUT BROWSER              Apr 17, 2009 13:11:50        Page:    1 of   15

                                                                    Page 1
DEMO INDIAN HOSPITAL
PLACEMENTS
PLACEMENT DATES:  OCT 19, 2008  TO  APR 17, 2009

PATIENT NAME         HRN    DATE     POV   PLACEMENT  FACILITY REFERRED TO
                       PLACED
------------------------------------------------------------------------------
ALPHA,JACOB SCOTT  102668 05/03/09 295.15 SHELTER    MY TREATMENT HOUSE
APATT,CHELSEA MAR  116431 03/25/09 12    OUTPATIENT  ST JOSEPH'S HEALTHCARE
   Placement Made by: GAMMAA,RYAN
   Designated SS Prov: BETA,BJ

BPATT,RUSTY LYNN   207396 04/06/09 15    OUTPATIENT  ST JOSEPH'S HEALTHCARE
   Placement Made by: GAMMAA,RYAN

BPATTTT,ADAM M     109943 04/07/09 311.0 OUTPATIENT  BETA COUNSELING
   Placement Made by: GAMMA,RYAN

Subtotal by Placement Type:
OUTPATIENT                  3
SHELTER                     1

Subtotal by Facility Referred to:
  MY TREATMENT HOUSE             1
  ST. JOESPH'S HEALTHCARE        2
  BETA COUNSELING                1

Total Number of Placements: 4

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

Figure 4-6: Sample Placements report

## 4.4.8 List All IPV/DV Screenings for Selected Patients (ISSP)

The **ISSP** report (Figure 4-7) lists all patients that have been selected who have had IPV screening or a refusal documented in a specified time frame. Select patients based on age, gender, result, provider, or clinic where the screening was done.

```
XXX                          May 18, 2010                              Page 1

***IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS***
Screening Dates: May 18, 2009 to May 18, 2010

Patient Name       HRN    AGE    DATE      RESULT      CLINIC
-------------------------------------------------------------------------
BETAA,CECILE      103465  42  F 07/09/09   NEGATIVE    TELEBEHAVIORAL HE
      Comment: Exposure to violence as a child
  DXs:   T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL
ENCOUNTER
  Primary Provider on Visit:  GAMMAA, RYAN
    Provider who screened:    GAMMAA,RYAN

DELTA,CANDI LYNN  115655  40  F 12/19/09   NEGATIVE    MENTAL HEALTH
   Comment: Patient says she wouldn't tolerate DV since she was a child
abuse victim and spent years in counseling to deal with her issues.
   DXs:  F42. HOARDING DISORDER
   Primary Provider on Visit: ALPHAA,DENNY
    Provider who screened:    BETA,CHARLENE

EPSILON, JANICE   116431  18  F 01/15/10   NEGATIVE    MEDICAL SOCIAL SERVI
  Comment: Patient denies any current domestic violence.
  DXs:  F84.0 AUTISM SPECTRUM DISORDER
  Primary Provider on Visit: DELTA,GLORIA
    Provider who screened:   DELTA,GLORIA
```

Figure 4-7: IPV/DV Screening for Selected Patients report (ISSP)

## 4.4.9 Tally/List Alcohol Screening (ALS)

The **ALS** report tallies and optionally lists all visits on which an alcohol screening (Exam code 35) or a refusal was documented in a specified time frame. The report (Figure 4-8) tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

```
Total Number of Visits with Screening         4
    Total Number of Patients screened         4

By Result
   NEGATIVE           1       25.0%
   POSITIVE           2       50.0%
   REFUSED            1       25.0%

By Gender
   FEMALE             3       75.0%
   MALE               1       25.0%

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

By Provider who screened
   Provider A         1       25.0%
   Provider B         1       25.0%
   Provider C         1       25.0%
```

```
   Provider D         1       25.0%

By Primary Provider of Visit
   Provider A         1       25.0%
   Provider B         1       25.0%
   Provider C         1       25.0%
   Provider D         1       25.0%

By Designated Primary Care Provider
   UNKNOWN            3       75.0%
   Provider X         1       25.0%

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

By Date
   Jul 25, 2009        1       25.0%
   Aug 09, 2009        1       25.0%
   Aug 17, 2009        1       25.0%
   Aug 23, 2009        1       25.0%

By Designated Mental Health Provider
   UNKNOWN            4       100.0%

By Designated Social Services Provider
   UNKNOWN            4       100.0%

By Designated A/SA Provider
   UNKNOWN            4       100.0%

PATIENT NAME   HRN      AGE     SCREENED RESULT      CLINIC
--------------------------------------------------------------------------------
Patient H      114551   26 F    08/17/09 POSITIVE
   DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER
Primary Provider on Visit:  Provider B
       Provider who screened:  Provider B

Patient J   116475    27 F        08/23/09 REFUSED SCREENIN
   DXs: F84.0    AUTISM SPECTRUM DISORDER
   Primary Provider on Visit:  Provider A
        Provider who screened: Provider A
```

Figure 4-8: Sample Tally/List Alcohol Screening report (ALS)

## 4.4.10 Tally/List Patient with Depression Screening (DSP)

The **DSP** report tallies and lists all patients who have had depression screening or a refusal documented in a specified time frame. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR

– Refusal of PCC exam code 36

The report tallies patients by age, gender, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider. The DSP report is displayed in Figure 4-9 and Figure 4-10.

> **Notes:** The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report. This report optionally looks at both PCC and the Behavioral Health databases for evidence of screening/refusals. This is a tally of **patients**, not visits, or screening.

```
XXX                          MAY 10, 2010                        PAGE 1
***DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING***
Screening Dates: May 18, 2009 to May 18, 2010
This report excludes data from the PCC Clinical database
-------------------------------------------------------------------------
                                        #      % of patients
               By Gender
                     F                  48     54.5%
                     M                  40     45.5%
               By Age
               12 Yrs                    1      1.1 %
               17 Yrs                    1      1.1 %
               18 yrs                    1      1.1%
               21 yrs                    3      3.4%
               22 yrs                    3      3.4%
```

Figure 4-9: Tally by gender and age (DSP)

> **Note**: The DSP report displays tallies for various items selected; then shows individual patient data the user opted to include.

```
PATIENT NAME    HRN    AGE    DATE  SCREEND    CLINIC
-------------------------------------------------------------------------
CODA,ANNE      100656  46 F   12/11/09         MEDICAL SOCIAL SE
   Type/Result: DEPRESSION SCREENING PATIENT REFUSED SCREENING
   Comment: Patient refused screening and wouldn't discuss decision
   Primary Provider on Visit: GAMMA,RYAN
      Provider who screened:  GAMMA,RYAN

EPSILON,JAMES  101349  30 M   04/06/10         MENTAL HEALTH
   Type/Result:  PHQ2   3
   DXs:   T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL
   Primary Provider on Visit: DELTA,DANNY
      Provider who screened:  DELTA,DANNY

THETA,RONALD   101438  25 M   12/14/09         MEDICAL SOCIAL SERV
   Type/Result:  DEPRESSION SCREENING       NEGATIVE
   DXs:   F84.0 AUTISM SPECTRUM DISORDER
   Primary Provider on Visit: ALPHAA,LAURA
      Provider who screened:  ALPHAA,LAURA
```

Figure 4-10: Sample Tally/List Patients with Depression Screening report

## 4.4.11 BHS Encounter Reports (REC)

Report options for listing various records from the BHS patient file are available on the BHS Encounter/Record Reports Menu. There are two options to select from: LIST and GEN.

## 4.4.12 List Visit Records, Standard Output (LIST)

The LIST report (Figure 4-11) produces either a detailed or brief listing of Mental Health, Chemical Dependency, or Social Services visits. The list of visits are for a specified date range, and visits can be selected based on any of the following items: provider, program, provider discipline, problem code, activity type, type of contact, patient age, patient sex, patient tribe, patient community, community of service, or location of encounter.

```
                    BEHAVIORAL HEALTH RECORD LISTING
                 Visit Dates:  DEC 23, 2011 and JAN 23, 2012
================================================================================
 DATE     PROV LOC  PATIENT NAME ACT CONT AT  HRN      PROB    NARRATIVE
--------------------------------------------------------------------------------
12/23/11  WW   WW   BETA,CHARLES  13 OUTP 88  WW109767 F84.0    AUTISM SPEC
                                                   F10.24   ALCOHOL DEP
12/23/11  VA   WW   UPSILON,JIMM  13 OUTP 60  WW129347 F42.     HOARDING DI
12/27/11  DJS  1337 ETA,DANNY LU  91 OUTP 10  WW176178 F42.     HOARDING DI
12/27/11  DJS  1337 LAMBDA,ALISO  91 OUTP 10  WW193661 F32.3    MAJOR DEPRE
12/27/11  DJS  1337 SIGMA,ROBERT  91 OUTP 10  WW186585 F32.1    MAJOR DEPRE
12/27/11  DJS  1337 XI,CLAUDIA M  91 OUTP 10  WW177791 F32.3    MAJOR DEPRE
12/27/11  DJS  1337 RHO,JADA KAR  91 OUTP 10  WW173042 F32.3    MAJOR DEPRE
12/27/11  DJS  WW   ETA,DANNY LU  13 OUTP 55  WW176178 F10.24   ALCOHOL DEP
12/27/11  DJS  1086 OMICRON,BOB   91 OUTP 10  WW198993 T43.205A ANTIDEPRESS
12/28/11  RJG  1150 SIGMA,ROBERT  16 OUTP 60  WW186585 T43.205A ANTIDEPRESS
12/28/11  RJG  WW   IOTA,MISTY R  13 OUTP 60  WW106371 F32.3    MAJOR DEPRE
12/28/11  RJG  WW   ZETA,RYAN J   13 OUTP 90  WW163449 F84.0    AUTISM SPEC
12/28/11  RJG  WW   RHO,JADA KAR  13 OUTP 90  WW173042 F10.25   ALCOHOL DEP
12/28/11  GB   WW   KAPPA,REBECC  11 OUTP 50  WW113487 T43.205A ANTIDEPRESS

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 4-11: Sample LIST report

## 4.4.13 Workload/Activity Reports (WL)

- **GRS1**. This report tallies activities (such as Individual Treatment, Case Management, etc.) by service unit, facility and by provider.
- **GRS2**. This report tallies primary problems by service unit, facility, provider, and activity.
- **ACT**. This report generates a count of records for selected items (such as Provider of Service, Activity Code, etc.) in a specific date range.

- **PROG**. This report generates a count of records, total activity time, and number of patient visits by program and by selected items in a specific date range.
- **FACT**. This report generates a list of the top N activity codes for selected visits.
- **FCAT**. This report generates a list of the top N activity categories (Patient Services, Support Services, etc.) for selected visits.

FACT and FCAT are Top Ten Reports and do not include all Activity Codes or Categories.

Table 4-2 shows how various reports tally or generate a record count.

Table 4-2: Report Tally logic

| | One/All Programs | One/All Providers | Activity | # of Records | Activity Time | # of Patients | POV | Select Contact Type | 132 Column |
|---|---|---|---|---|---|---|---|---|---|
| GARS1 | X | X | X | X | X | X | | | |
| GARS2 | X | X | X | X | X | X | X | | X |
| ACT | | | | X | X | X | | X | |
| PROG | | | | X | X | X | | X | X |
| FACT | | | X | X | X | | | | $ |
| FCAT | | | X | X | X | | | | $ |

- **ACT** and **PROG**. Only one of the following items may be selected for these reports.
  - ACT Selection Menu:
    - Provider of Service.
    - Appointment/Walk-In.
    - Interpreter Utilized.
    - Discipline of Provider.
    - Program Type.
    - Date of Visit.
    - POV/Problem (Problem Code).
    - Problem/POV (Problem Category).
    - Problem/POV.
    - Location of Service.
    - Service Unit of Service.
    - Type of Contact of Visit.
    - Activity Code.

- Activity Category.
- Community of Service.
- Local Service Site.
- Age.
- Gender.
- Clinic Type.

– PROG Selection Menu:

- Provider of Service.
- Discipline of Provider.
- Program Type.
- Date of Visit.
- POV/Problem (Problem Code).
- Problem/POV (Problem Category).
- Problem/POV.
- Location of Service.
- Service Unit of Service.
- Type of Contact of Visit.
- Activity Code.
- Activity Category.
- Community of Service.

FACT and FCAT: Select one or more variables from the Visit Selection Menu or type Q (Quit) to quit item selection and include all visits. The more variables selected, the narrower the report specifications are as shown in Figure 4-12.

```
                              Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk
indicates items already selected.  To bypass screens and select all Visits
type Q.

------------------------------------------------------------------------------
1) Patient Name           23) Next Case Review Dat  45) Axis V
2) Patient Sex            24) Appointment/Walk-In   46) Flag (Visit Flag)
3) Patient Race           25) Interpreter Utilized  47) Primary Provider
4) Patient Age            26) Program               48) Primary Prov Discip
5) Patient DOB            27) Visit Type            49) Primary Prov Affili
6) Patient DOD            28) Location of Encounte  50) Prim/Sec Providers
7) Living Patients        29) Clinic                51) Prim/Sec Prov Disci
8) Chart Facility         30) Outside Location      52) POV (Prim or Sec)
9) Patient Community      31) SU of Encounter       53) POV (Prob Code Grps
```

```
10) Patient County Resid  32) County of Service     54) Primary POV
11) Patient Tribe         33) Community of Service  55) POV (Problem Catego
12) Eligibility Status    34) Activity Type         56) POV Diagnosis Categ
13) Class/Beneficiary     35) Days in Residential   57) Procedures (CPT)
14) Medicare Eligibility  36) Days in Aftercare     58) Education Topics Pr
15) Medicaid Eligibility  37) Activity Category     59) Prevention Activity
16) Priv Ins Eligibility  38) Local Service Site    60) Personal History It
17) Patient Encounters O  39) Number Served         61) Designated MH Prov
18) Patient Flag Field    40) Type of Contact       62) Designated SS Provi
19) Case Open Date        41) Activity Time         63) Designated A/SA Pro
20) Case Admit Date       42) Inpatient Dispositio  64) Designated Other Pr
21) Case Closed Date      43) PCC Visit Created
22) Case Disposition      44) Axis IV
```

Figure 4-12: Visit Selection Menu items.

- If the bar chart option is selected when printing, 132-column paper will be needed.

## 4.4.14 Activity Report (GRS1)

Use the **GRS1** option to produce a report that tallies activities by service unit, facility, and provider as shown in Figure 4-13.

```
ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM
         RECORD DATES:  JUL 26, 2009  TO  OCT 24, 2009
# PATS is the total number of unique, identifiable patients when a patient
name was entered on the record.  # served is a tally of the number served
data value.
                                        #RECS    ACT TIME  # PATS   # SERVED
                                                    (hrs)
-------------------------------------------------------------------------------
AREA:  OKLAHOMA
  SERVICE UNIT:  LAWTON
     FACILITY:  DEMO HOSPITAL
        PROVIDER:  PROVIDER BR (LICENSED MEDICAL SOCIAL WORKER)
        12-ASSESSMENT/EVALUATION-PATI       3        5.0       2         3
           13-INDIVIDUAL TREATMENT/COUNS    1        1.0       1         1
           41-EDUCATION/TRAINING PROVIDE    1       12.0      18
           48-CRISIS INTERVENTION-PATIEN    1        0.5       1         1
           49-CRISIS INTERVENTION-PATIEN    1        1.5       1         1
           97-HEALTH PROMOTION              6        4.0       3         6
                                         =======   =======   =======  =====
        PROVIDER TOTAL:                    13      24.0       8         30
```

Figure 4-13: Sample Activity Report

## 4.4.15 Frequency of Activities by Category (FACT)

Use the **FACT** option to produce a report (Figure 4-14) that generates a list of the top *N* Activity Category for selected visits.

```
  MAY 04, 2009                                                    Page 1
                            DEMO INDIAN HOSPITAL
TOP 10 Activity Category's.
```

```
DATES:  FEB 03, 2009  TO  MAY 04, 2009
No.   ACTIVITY TYPE                ACTIVITY CODE    # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------
1.    GROUP TREATMENT                  91             158           71.3
2.    INDIVIDUAL TREATMENT/COUNSEL/E   13             103           99.3
3.    SCREENING-PATIENT PRESENT        11              18           12.0
4.    ASSESSMENT/EVALUATION-PATIENT    12              17           12.7
5.    INDIVIDUAL BH EHR VISIT          99              11            7.0
6.    ADVENTURE BASED COUNSELING       92              10            7.5
7.    PREVENTIVE SERVICES              37              10           24.3
8.    CASE MANAGEMENT-PATIENT PRESEN   22               4            2.3
9.    LIFE SKILLS TRAINING             94               4            1.5

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 4-14: Sample Frequency of Activities by Category report

## 4.4.16 Tally of Prevention Activities (PA)

Use the **PA** option to produce a report that shows a count of all visits with a prevention activity entered as shown in Figure 4-15. This option also produces a tally/count of those prevention activities with Target Audience subtotals.

```
May 04, 2009                                                    Page: 1
                         BEHAVIORAL HEALTH
                      ************************************
                      *   TALLY OF PREVENTION ACTIVITIES *
                      ************************************
                 VISIT Date Range: FEB 03, 2009 through MAY 04, 2009
PREVENTION ACTIVITY                          # of visits     % of visits
-------------------------------------------------------------------------
Total # Visits w/Prevention Activity:      3
Total # of Prevention Activities recorded: 5

AIDS/HIV                                     1               33.3
    YOUTH             1        100.0

OTHER                                        1               33.3
    NOT RECORDED      1        100.0

PUBLIC AWARENESS                             1               33.3
    NOT RECORDED      1        100.0

SELF-AWARENESS/VALUES                        1               33.3
    ADULT             1        100.0

SMOKING/TOBACCO                              1               33.3
    YOUTH             1        100.0

TARGET TOTALS

    ADULT             1         33.3
    NOT RECORDED      1         33.3
    YOUTH             1         33.3

RUN TIME (H.M.S): 0.0.0
```

Figure 4-15: Sample Tally of Prevention Activities report (PA)

## 4.4.17 Problem-Specific Reports (PROB)

Use these reports to produce lists of BH issues of particular concern to providers, managers, and administrators from a clinical and public health perspective.

## 4.4.18 Frequency of Problems Report (FDX)

Use the **FDX** option to produce a report showing a list of the top N Problem/POV for selected visits shown in Figure 4-16.

```
JUN 09, 2009                                                        Page 1
DEMO INDIAN HOSPITAL

TOP 10 Problem/POV's.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009
No.   PROB DX/CODE NARRATIVE          CODE         # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------
1.    MAJOR DEPRESSIVE DISORDER,RECU  F33.9          150      114.8
2.    GENERALIZED ANXIETY DISORDER    F41.1           52       28.8
3.    UNSPECIFIED ATTENTIONN-DEFICIT  F90.9           48       35.5
4.    BIPOLAR DISORDER, UNSPECIFIED   F31.9           33       26.1
5.    OBSESSIVE-COMPULSIVE DISORDER   F42             32       21.1
6.    PANIC DISORDER                  F41.0           32       72.9
7.    ANOREXIA NERVOSA, RESTRICTING   F50.01          31       27.4
8.    ALCOHOL USE DISORDER, MODERAT   F10.20          25        7.9
9.    HEALTH/HOMEMAKER NEEDS            1             21       17.6
10.   INSOMNIA DISORDER               G47.00          20       32.3

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 4-16: Sample Frequency of Problems report (FDX)

## 4.4.19 Listing of Suicide Forms by Selected Variables (SGR)

The **SGR** report is a "general retrieval" type report (Figure 4-17) and lists selected data items for Suicide Reporting Forms in a date range. The user can specify how to display items in the printed report.

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
BH Suicide Form Listing                                          Page 1

PATIENT NAME    SEX    DOB        DATE OF ACT    SUCIDAL BEHAVIOR
-------------------------------------------------------------------------
PATIENT,CRSQL   F    05/05/1955   10/15/2008    ATTEMPT
BETA,JANE ELLEN F    01/01/1990   11/01/2008    IDEATION WITH PLAN
BETA,JANE ELLEN F    01/01/1990   05/18/2009    ATTEMPT
CHIIIIII,SARINA F    05/18/1983   03/29/2009    - -
CHIIIIII,SARINA F    05/18/1983   06/21/2009    COMPLETED SUICIDE
BETA,ABBY GAIL  F    06/14/1975   06/13/2009    ATTEMPTED SUICIDE WITH HOMI
SIGMA,SERGIO    M    09/08/1965   09/01/2009    COMPLETED SUICIDE WITH HOMI
RHOO,EDWIN RAY  M    06/07/1978   10/27/2008    IDEATION WITH PLAN
```

```
RHOO,EDWIN RAY  M    06/07/1978   12/20/2008    IDEATION WITH PLAN
RHOO,EDWIN RAY  M    06/07/1978   01/01/2009    IDEATION WITH PLAN
RHOO,EDWIN RAY  M    06/07/1978   02/16/2009    ATTEMPT
RHOO,EDWIN RAY  M    06/07/1978   04/30/2009    IDEATION WITH PLAN
RHOO,EDWIN RAY  M    06/07/1978   06/01/2009    IDEATION WITH PLAN
Enter RETURN to continue or '^' to exit:
```

Figure 4-17: Sample BH Suicide Form Listing report (SGR)

## 4.4.20 Suicide Purpose of Visit Report (SPOV)

The **SPOV** report displays the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Enc). A list by age and gender is also included. The report shown in Figure 4-18 is generated with both duplicated and unduplicated patient counts.

```
                *   SUICIDE PURPOSE OF VISIT REPORT  *
              VISIT Date Range: OCT 31, 2009 through NOV 30, 2009

                    BOTH MALE AND FEMALE PATIENTS' VISITS
39 & v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
                      & v62.84                              & v62.84
            #     %    #       %    #      %    #      %    #      %
 1-4 yrs    0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 5-9 yrs    2  10.0    0     0.0    0    0.0    0    0.0    0    0.0
 10-14 yrs  7  35.0    0     0.0    0    0.0    0    0.0    0    0.0
 15-19 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 20-24 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 25-34 yrs  6  30.0    0     0.0    0    0.0    0    0.0    0    0.0
 35-44 yrs  2  10.0    0     0.0    0    0.0    0    0.0    0    0.0
 45-54 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 55-64 yrs  1   5.0    0     0.0    0    0.0    0    0.0    0    0.0
 65-74 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 75-84 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 85+ yrs    2  10.0    0     0.0    0    0.0    0    0.0    0    0.0

TOTAL       20 100.0   0     0.0    0    0.0    0    0.0    0    0.0

                        MALE PATIENTS VISITS
39 & v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
                      & v62.84                              & v62.84
     #    %    #      %     #      %    #      %    #      %
 1-4 yrs    0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 5-9 yrs    0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 10-14 yrs  6  66.7    0     0.0      0     0.0    0    0.0     0    0.0
 15-19 yrs  0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 20-24 yrs  0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 25-34 yrs  2  22.2    0     0.0      0     0.0    0    0.0     0    0.0
 35-44 yrs  1  11.1    0     0.0      0     0.0    0    0.0     0    0.0
 45-54 yrs  0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 55-64 yrs  0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 65-74 yrs  0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 75-84 yrs  0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
 85+ yrs    0   0.0    0     0.0      0     0.0    0    0.0     0    0.0
```

```
TOTAL       9   100.0 0    0.0      0     0.0   0    0.0     0    0.0

                          FEMALE PATIENTS VISITS
39 & v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
                      & v62.84                              & v62.84
             #    %    #     %      #      %     #      %    #      %
1-4 yrs      0   0.0   0    0.0     0     0.0    0    0.0    0    0.0
5-9 yrs      2  18.2   0    0.0     0     0.0    0    0.0    0    0.0
10-14 yrs    1   9.1   0    0.0     0     0.0    0    0.0    0    0.0
15-19 yrs    0   0.0   0    0.0     0     0.0    0    0.0    0    0.0
20-24 yrs    0   0.0   0    0.0     0     0.0    0    0.0    0    0.0
25-34 yrs    4  36.4   0    0.0     0     0.0    0    0.0    0    0.0
35-44 yrs    1   9.1   0    0.0     0     0.0    0    0.0    0    0.0
45-54 yrs    0   0.0   0    0.0     0     0.0    0    0.0    0    0.0
55-64 yrs    1   9.1   0    0.0     0     0.0    0    0.0    0    0.0

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

TOTAL       11 100.0   0    0.0     0     0.0    0    0.0    0    0.0

        UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS
39 & v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
                      & v62.84                              & v62.84
             #      %    #      %     #      %     #      %     #      %
1-4 yrs      0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
5-9 yrs      1    7.7     0    0.0     0    0.0     0    0.0     0    0.0
10-14 yrs    2   15.4     0    0.0     0    0.0     0    0.0     0    0.0
15-19 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
20-24 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
25-34 yrs    5   38.5     0    0.0     0    0.0     0    0.0     0    0.0
35-44 yrs    2   15.4     0    0.0     0    0.0     0    0.0     0    0.0
45-54 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
55-64 yrs    1    7.7     0    0.0     0    0.0     0    0.0     0    0.0
65-74 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
75-84 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
 85+ yrs     2   15.4     0    0.0     0    0.0     0    0.0     0    0.0

TOTAL       13  100.0     0    0.0     0    0.0     0    0.0     0    0.0
                UNDUPLICATED PATIENT COUNT - MALE PATIENTS
39 & v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
                      & v62.84                              & v62.84
             #      %    #      %     #      %     #      %     #      %
1-4 yrs      0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
5-9 yrs      0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
10-14 yrs    1   25.0     0    0.0     0    0.0     0    0.0     0    0.0
15-19 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
20-24 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
25-34 yrs    2   50.0     0    0.0     0    0.0     0    0.0     0    0.0
35-44 yrs    1   25.0     0    0.0     0    0.0     0    0.0     0    0.0
45-54 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
55-64 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
65-74 yrs    0    0.0     0    0.0     0    0.0     0    0.0     0    0.0
```

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 75-84 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 85+ yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| **TOTAL** | 4 | 100.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

**UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS**
**39 & v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed**

| **AGE GROUP** | **# Encs** | | **# w POV 39 & v62.84** | | **w/ POV 40** | | **w/ POV 41** | | **w/ 39/40/41 & v62.84** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % |
| 1-4 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 5-9 yrs | 1 | 11.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 10-14 yrs | 1 | 11.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 15-19 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 20-24 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 25-34 yrs | 3 | 33.3 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 35-44 yrs | 1 | 11.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 45-54 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 55-64 yrs | 1 | 11.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 65-74 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 75-84 yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 85+ yrs | 2 | 22.2 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| **TOTAL** | 9 | 100.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |

Figure 4-18: Sample SPOV report

**Basic Reports Exercises**

1. Enter an encounter record for prevention using the Administrative/Community Activities entry format in BHS. Use the Prevention Activity Code (37) and select the type of prevention activity and target audience.

2. Generate a Prevention Activities Report for the fiscal year. (WL-PA)

3. Generate at least one report from each of the categories: Patient Listings, Encounter Records, Workload, and Problem.

4. Compare the FDX to the FPRB for the past 90 days. (PROB – FDX & FPRB). What differences are there? Which report would you find most helpful?

5. Find the number of cases Opened/Admitted/Closed for all providers during the current year. (PAT – TCD)

6. Browse the active client list for the current year. (PAT-ACL)

7. Run a report tallying and listing clients who have received an alcohol screening from January 1, 20012 to present. Tally by result, gender, age, provider who screened, and date of screen. Include a list of all patients screened. (PAT – SCRN – ALC – ASP). What is the total number of clients screened during this date range? How many of the clients had a positive alcohol screening? Why would it be helpful to include a list of all clients screened?

8. Run a report listing the results of alcohol screenings for female clients between the ages of 15 and 44. (PAT-SCRN-ALC-ASSP)

9. Run the listing of Suicide Forms by Selected Variables report (SGR) using the Sub-count and Total Count option and sort by the Suicidal Behavior. (PROB-SUIC-SGR ) What was the total count of forms? Total count of patients?

10. Run the SPOV Report using a one year date range and all communities. (PROB-SUIC-SPOV) How does this information differ from that produced in the SGR?

# 5.0 Converting Reports to Excel or Word

## 5.1 Telnet Help

The following sections use the text from **TNVTPlus Help** to describe how to open and close an output file.

### 5.1.1 Open an Output File

1. On the Session menu, point to **Capture To File** and click **Start Capture** to record session output in a file on your PC.
2. Do one of the following:
   - Type the file name for the output file.
   - Browse through your folders and click a file name.

Additional notes:

- If the file you specify already exists, TNVTPlus prompts you to verify that you want to overwrite it.
  - To overwrite the contents of the file with output from the current session, click **Yes**.
  - Otherwise, if you do not want to overwrite the file, click **No**.
- The default file name extension is **.cte**.
- To display the results of the recorded session file, click **Playback**.
- To change the default settings, click **Settings**.
- In addition to writing network system output to the file, TNVTPlus records the session name and the name of the network host to which you are connected. If a connection closes, is reset, or reopens, the file also included that information.
- The **Capture To File** command records escape sequences, providing a useful feature for diagnosing problems and troubleshooting.

### 5.1.2 Close an Output File

1. Do one of the following:
   - On the Session menu, point to **Capture to File** and click **Stop Capture**.
   - Let the output file close automatically when you close the session.
2. To display the results of the recorded session file, click **Play Back**.

## 5.2 Capturing Reports in BHS

Capturing the information in the reports process is the first step in transferring data to Microsoft® Word or Excel®. Start the capture after logging in and selecting the report type to run:

1. Select **Print** at the Browse or Print prompt.
2. Click **Session**.

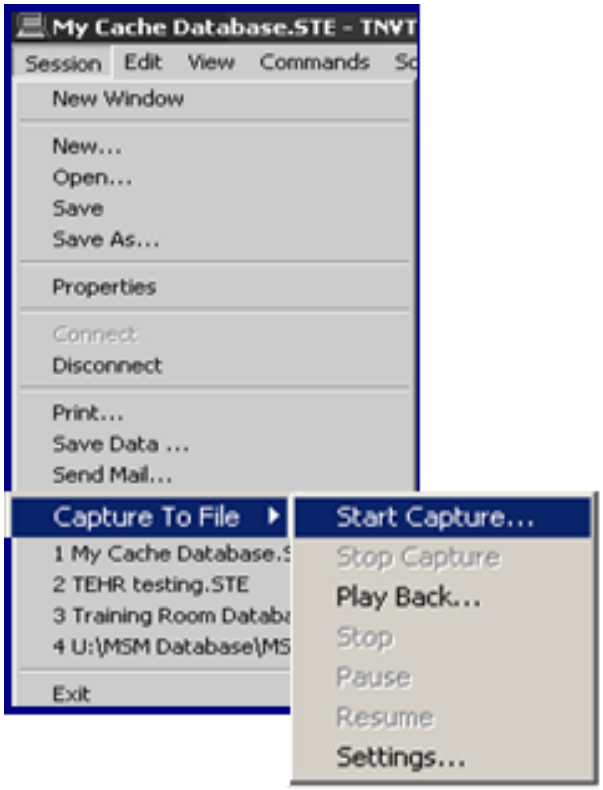



Figure 5-1: Start capture window

3. Click **Capture to File** and select **Start Capture**. The **Save As** dialog (Figure 5-2) opens.

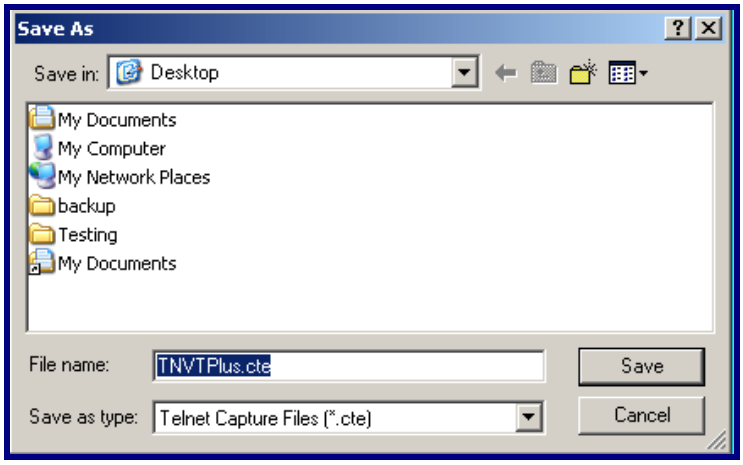



Figure 5-2: Save As dialog

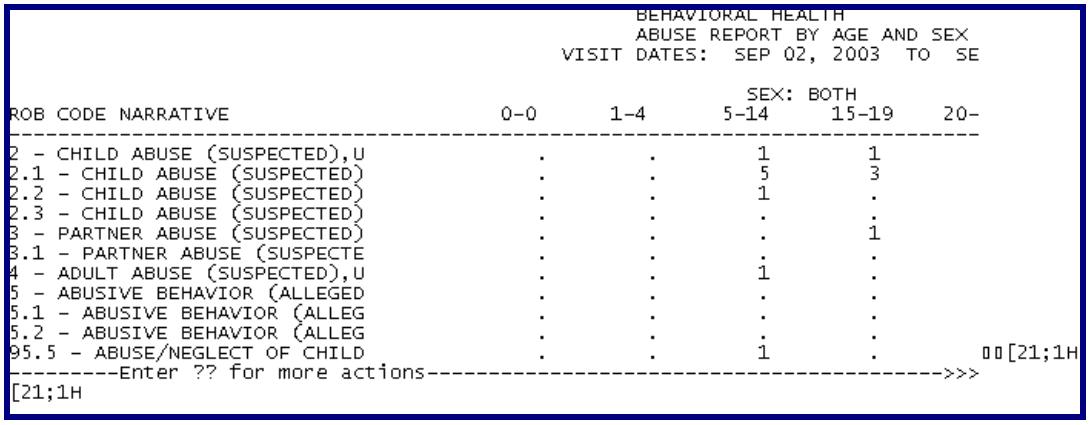
4. Type a name for the document in the **File name** field as shown in. If necessary, navigate to a location to save the file.
5. Click **Save**.
6. At the Device prompt type **;;9999** and press **Enter**.
7. Click **Session**.
8. Click **Capture to File**, and **Stop Capture**. The document is available for review and editing.

## 5.3 Importing Data from the Screen Capture into Microsoft Excel or Word

> **Note**: The following instructions pertain to Microsoft Excel and Word, Version 2013. Users of other versions must adapt the instructions to particular version being used.

### 5.3.1 Microsoft Excel

1. Navigate to the file that was created from the report screen capture.
2. Remove extraneous data before saving and reopening in Excel or Word. Figure 5-3 shows the before the extraneous data was removed example. Figure 5-4 shows the after the extraneous data was removed example.

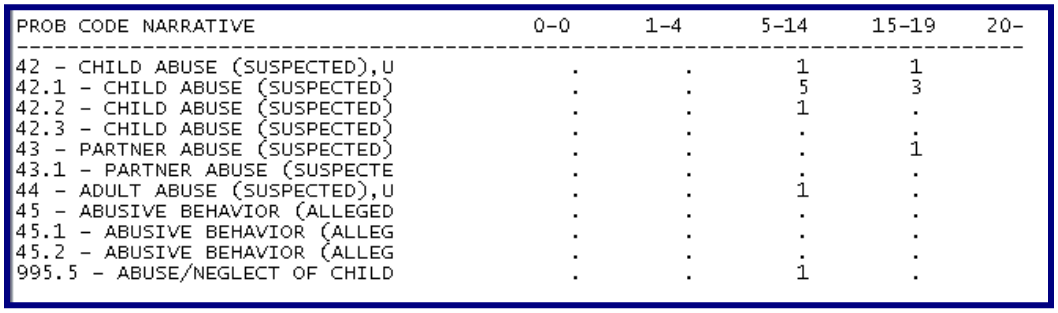


```
                                                BEHAVIORAL HEALTH
                                                ABUSE REPORT BY AGE AND SEX
                                          VISIT DATES:  SEP 02, 2003  TO  SE

                                                          SEX: BOTH
ROB CODE NARRATIVE                        0-0      1-4      5-14     15-19    20-
-------------------------------------------------------------------------------
2 - CHILD ABUSE (SUSPECTED),U               .        .        1        1
2.1 - CHILD ABUSE (SUSPECTED)               .        .        5        3
2.2 - CHILD ABUSE (SUSPECTED)               .        .        1        .
2.3 - CHILD ABUSE (SUSPECTED)               .        .        .        .
3 - PARTNER ABUSE (SUSPECTED)               .        .        .        1
3.1 - PARTNER ABUSE (SUSPECTE               .        .        .        .
4 - ADULT ABUSE (SUSPECTED),U               .        .        1        .
5 - ABUSIVE BEHAVIOR (ALLEGED               .        .        .        .
5.1 - ABUSIVE BEHAVIOR (ALLEG               .        .        .        .
5.2 - ABUSIVE BEHAVIOR (ALLEG               .        .        .        .
95.5 - ABUSE/NEGLECT OF CHILD               .        .        1        .        [21;1H
---------Enter ?? for more actions-----------------------------------------------
[21;1H
```

Figure 5-3: Before removing extraneous data

In Figure 5-3, the report header, time the report ran and prompt need to be removed. In Figure 5-4, the basic data from the report is imported into Excel or Word.



```
PROB CODE NARRATIVE                       0-0      1-4      5-14     15-19    20-
-------------------------------------------------------------------------------
42 - CHILD ABUSE (SUSPECTED),U              .        .        1        1
42.1 - CHILD ABUSE (SUSPECTED)              .        .        5        3
42.2 - CHILD ABUSE (SUSPECTED)              .        .        1        .
42.3 - CHILD ABUSE (SUSPECTED)              .        .        .        .
43 - PARTNER ABUSE (SUSPECTED)              .        .        .        1
43.1 - PARTNER ABUSE (SUSPECTE              .        .        .        .
44 - ADULT ABUSE (SUSPECTED),U              .        .        1        .
45 - ABUSIVE BEHAVIOR (ALLEGED              .        .        .        .
45.1 - ABUSIVE BEHAVIOR (ALLEG              .        .        .        .
45.2 - ABUSIVE BEHAVIOR (ALLEG              .        .        .        .
995.5 - ABUSE/NEGLECT OF CHILD              .        .        1        .
```

Figure 5-4: After removing extra data

3. Save and close Notepad.
4. Open the Excel application.
5. Click the **File** menu on the left.
6. Click **Open** from the menu shown in Figure 5-5.

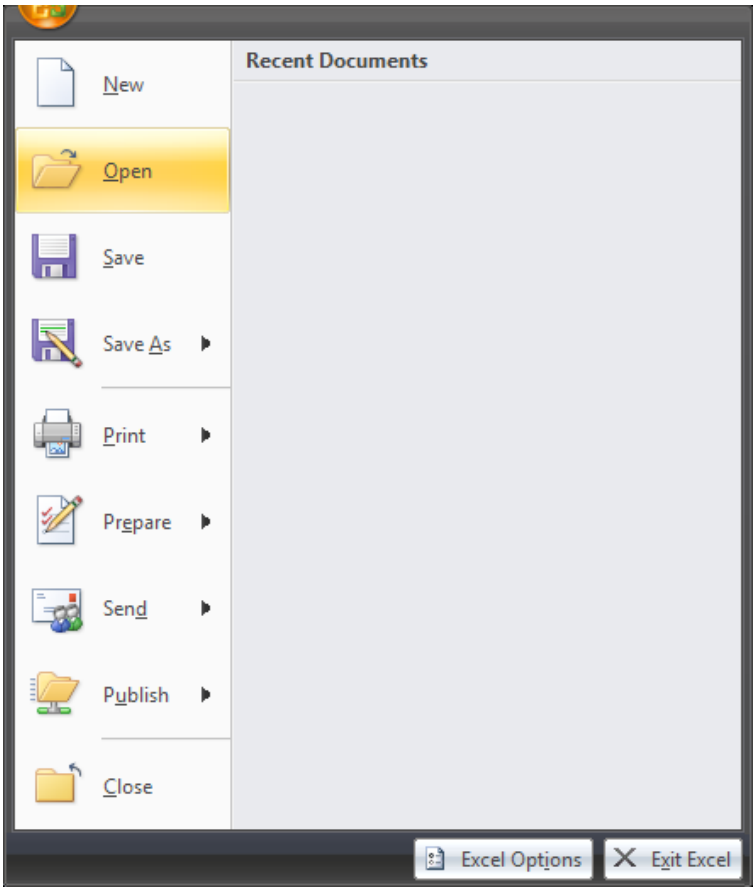



Figure 5-5: Screen 1 of opening a new document

7. Click the file type and change to **All Files** and change the **Look in** location if necessary as shown in Figure 5-6. Select the spreadsheet.

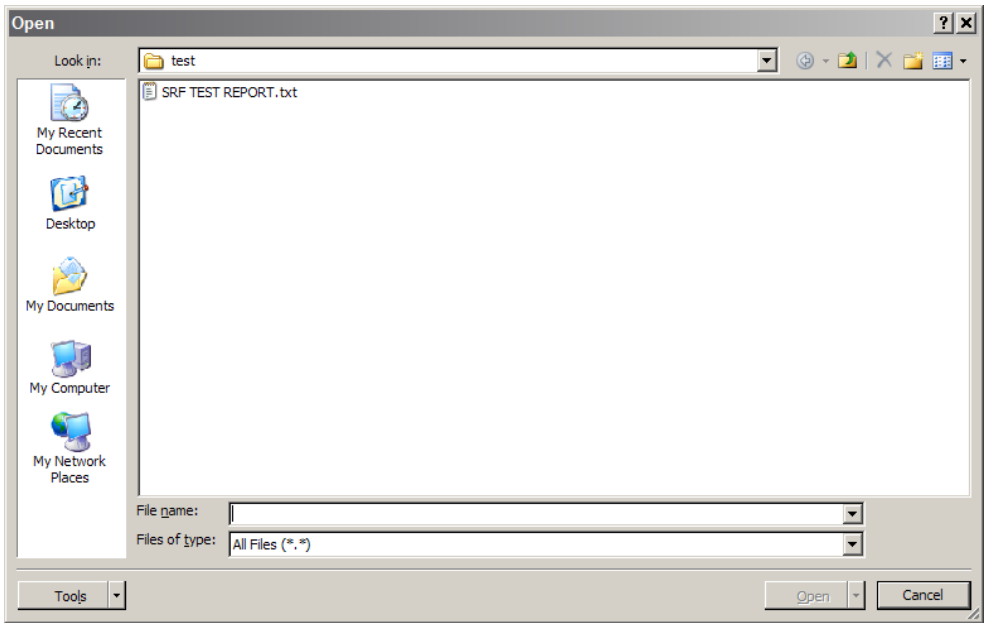



Figure 5-6: Screen 2 of opening a new document

The Text Import Wizard converts imported data in a three step process:

1. Determine the file type and the line to start importing data:

    a. Figure 5-7 shows the user must change the **Start import at row** field to line 2 as there is no data on line 1.

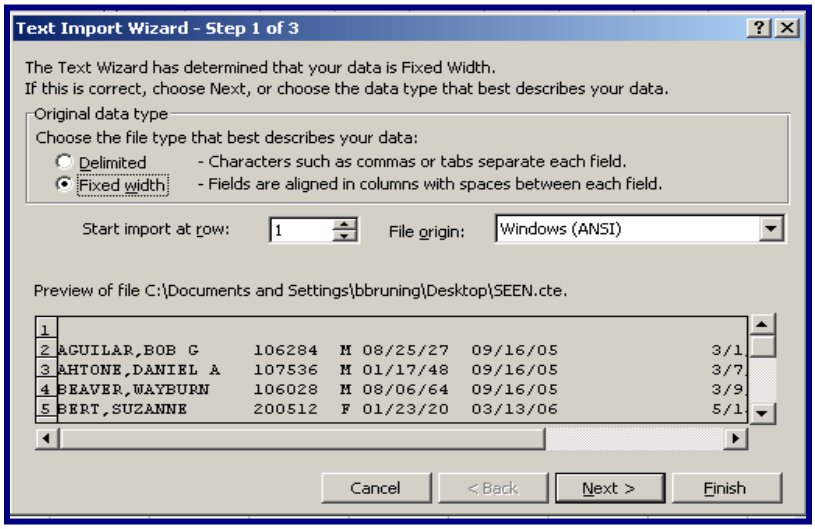



Figure 5-7: Text Import Wizard, Screen 1

    b. When done, click **Next**. Screen 2 (Figure 5-8) displays.

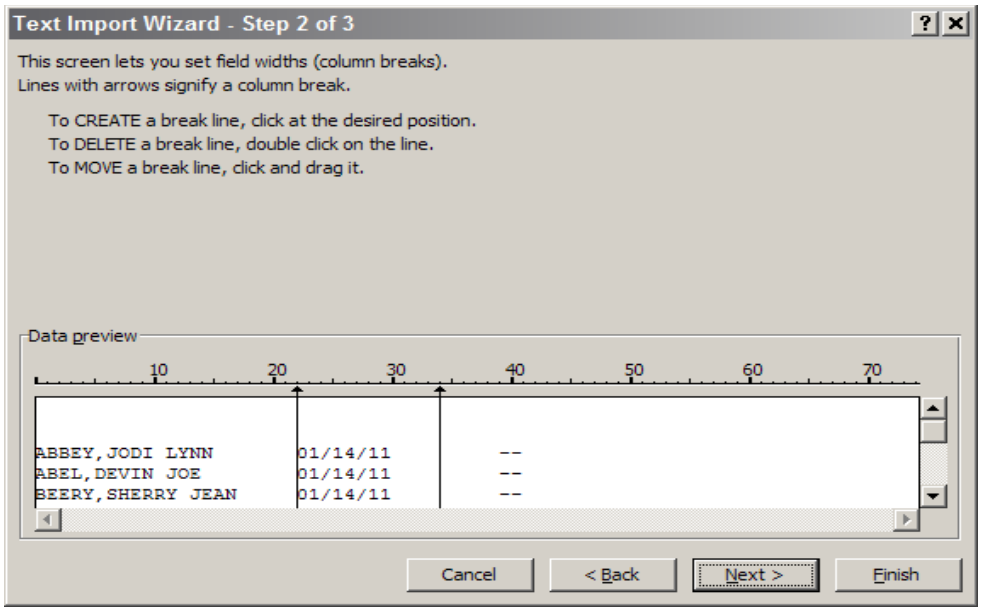



Figure 5-8: Text Import Wizard, Screen 2

2. Adjust the column widths and check the data preview as shown in. When done, click **Next**. Screen 3 (Figure 5-9) displays.

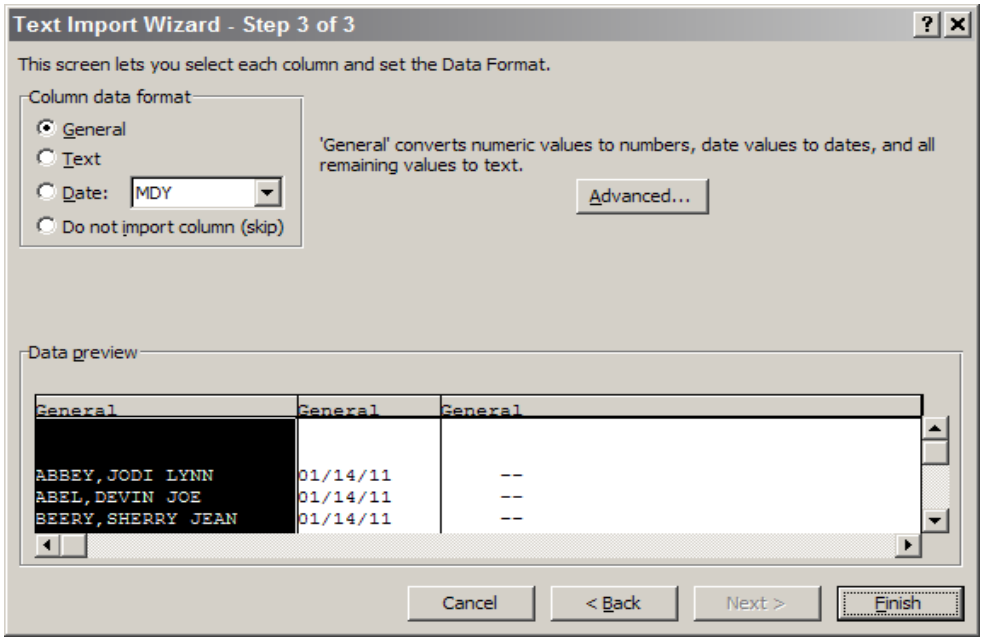



Figure 5-9: Text Import Wizard, Screen 3

3. Select the format for the columns and remove unnecessary fields.

| | |
|---|---|
| **Note**: | In this example, the data fields have been changed from General to Date. |

4. Click **Finish** to display the data in Microsoft Excel.

**Warning:**Data has **not** been saved in Microsoft Excel at this point.

5. Adjust the column widths or make other changes as desired. If ######## is showing in a field, the column is too narrow for the data to display. To correct this, widen the column:

   - To remove all the data in a column, click the letter representing that column and click **Delete** (either right-click or go to the **Edit** menu). The same process may be used to delete rows.
   - Click **View**, and click **Header/Footer** to add labels and print the report.

**Note**: Save the data before exiting.

6. To make a chart out of the data, highlight the data fields to be included.

| | A | B |
|---|---|---|
| 1 | PATIENT SERVICES | 2488.6 |
| 2 | ADMINISTRATION | 275.8 |
| 3 | COMMUNITY SERVICES | 135.8 |
| 4 | EDUCATION/TRAINING | 489.4 |
| 5 | SUPPORT SERVICES | 15.5 |
| 6 | TRAVEL | 6.5 |
| 7 | CULTURALLY ORIENTED | 6 |

Figure 5-10: Chart data

7. Click the **Insert** tab on the toolbar and select a type of graph to be created as shown in Figure 5-11.

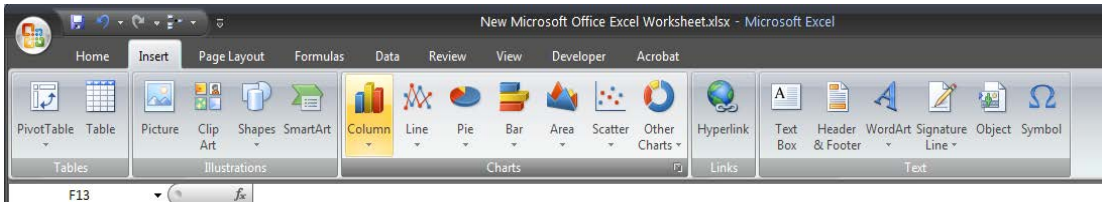



Figure 5-11: Chart Options on the **Insert** Tab

8. The Chart will display on the current worksheet as shown in Figure 5-12.

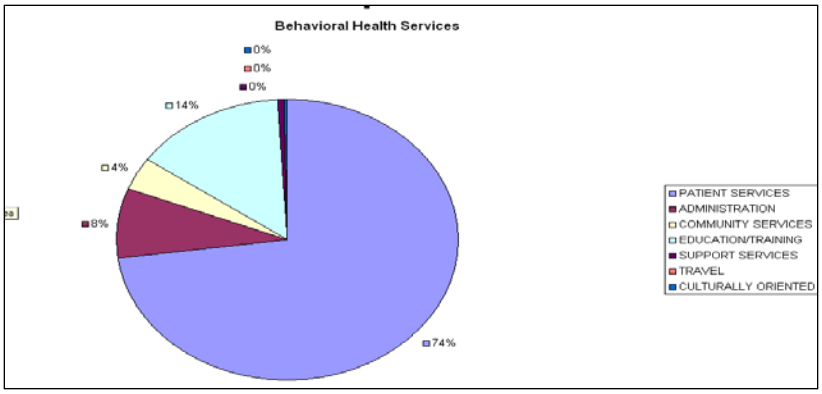



Figure 5-12: Sample completed chart

### 5.3.1.1 Microsoft Word

Remove the extraneous information before saving and re-opening in Word. Figure 5-13 and Figure 5-14 display the before and after examples.

```
                                                BEHAVIORAL HEALTH
                                                ABUSE REPORT BY AGE AND SEX
                                          VISIT DATES:  SEP 02, 2003  TO  SE

                                                          SEX: BOTH
ROB CODE NARRATIVE                          0-0      1-4      5-14     15-19    20-
-------------------------------------------------------------------------------
2 - CHILD ABUSE (SUSPECTED),U                 .        .        1        1
2.1 - CHILD ABUSE (SUSPECTED)                 .        .        5        3
2.2 - CHILD ABUSE (SUSPECTED)                 .        .        1        .
2.3 - CHILD ABUSE (SUSPECTED)                 .        .        .        .
3 - PARTNER ABUSE (SUSPECTED)                 .        .        .        1
3.1 - PARTNER ABUSE (SUSPECTE                 .        .        .        .
4 - ADULT ABUSE (SUSPECTED),U                 .        .        1        .
5 - ABUSIVE BEHAVIOR (ALLEGED                 .        .        .        .
5.1 - ABUSIVE BEHAVIOR (ALLEG                 .        .        .        .
5.2 - ABUSIVE BEHAVIOR (ALLEG                 .        .        .        .
995.5 - ABUSE/NEGLECT OF CHILD                .        .        1        .        [21;1H
---------Enter ?? for more actions-------------------------------------------->>>
[21;1H
```

Figure 5-13: Before removing data

```
PROB CODE NARRATIVE                         0-0      1-4      5-14     15-19    20-
-------------------------------------------------------------------------------
42 - CHILD ABUSE (SUSPECTED),U                .        .        1        1
42.1 - CHILD ABUSE (SUSPECTED)                .        .        5        3
42.2 - CHILD ABUSE (SUSPECTED)                .        .        1        .
42.3 - CHILD ABUSE (SUSPECTED)                .        .        .        .
43 - PARTNER ABUSE (SUSPECTED)                .        .        .        1
43.1 - PARTNER ABUSE (SUSPECTE                .        .        .        .
44 - ADULT ABUSE (SUSPECTED),U                .        .        1        .
45 - ABUSIVE BEHAVIOR (ALLEGED                .        .        .        .
45.1 - ABUSIVE BEHAVIOR (ALLEG                .        .        .        .
45.2 - ABUSIVE BEHAVIOR (ALLEG                .        .        .        .
995.5 - ABUSE/NEGLECT OF CHILD                .        .        1        .
```

Figure 5-14: After removing extra data

1. Save and close **Notepad**.
2. Open the Word application.

3. Click the File menu on the left.
4. Click Open from the menu shown in Figure 5-15.

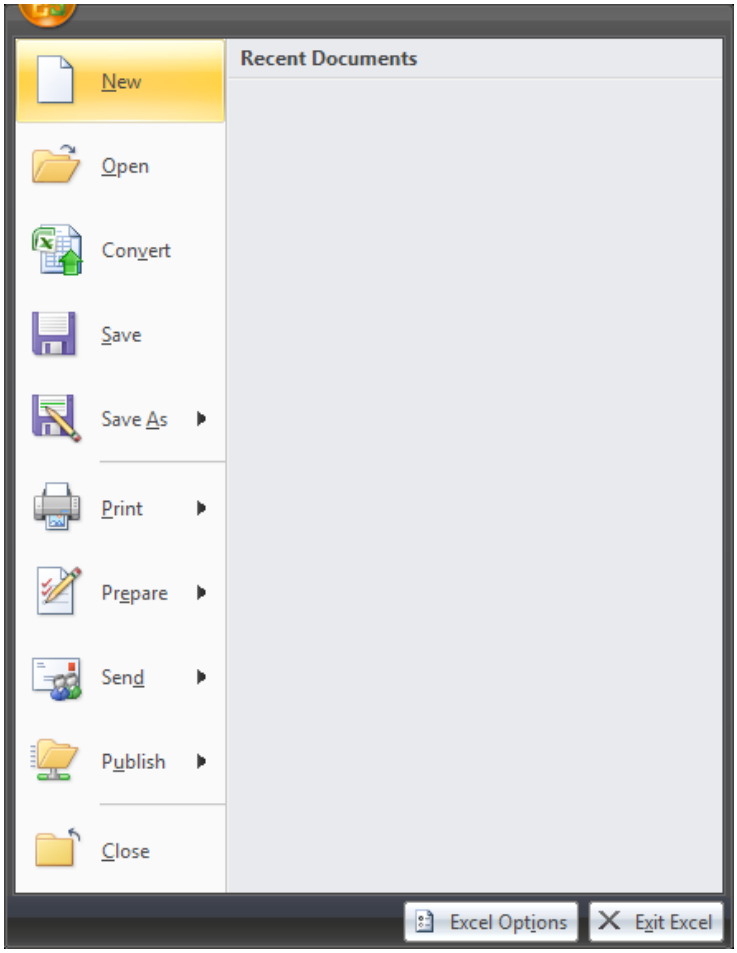



Figure 5-15: Open a new document in Microsoft Word

5. Click the file type and change to **All Files** and change the **Look in** location if necessary as shown in Figure 5-16. Select the document.

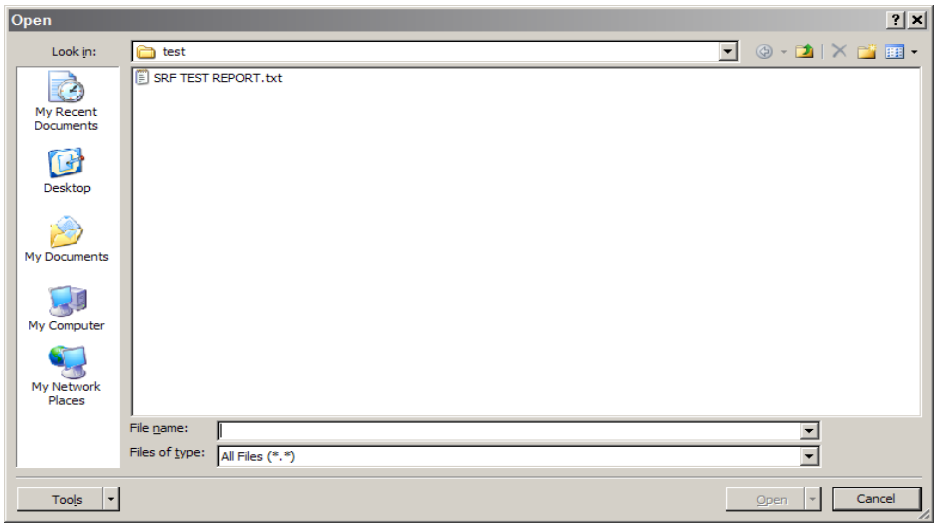



Figure 5-16: **Open** window

- To insert the data as a table (Figure 5-17), convert it to Excel and then import it into Word. If the data is not large, go to the Insert tab, click **Table**, and **Insert Table** to create a table with as many rows and columns as necessary.
- Copy and paste line-by-line from the Excel spreadsheet to the Word table. Advanced users may use other options to create a new document with this data.

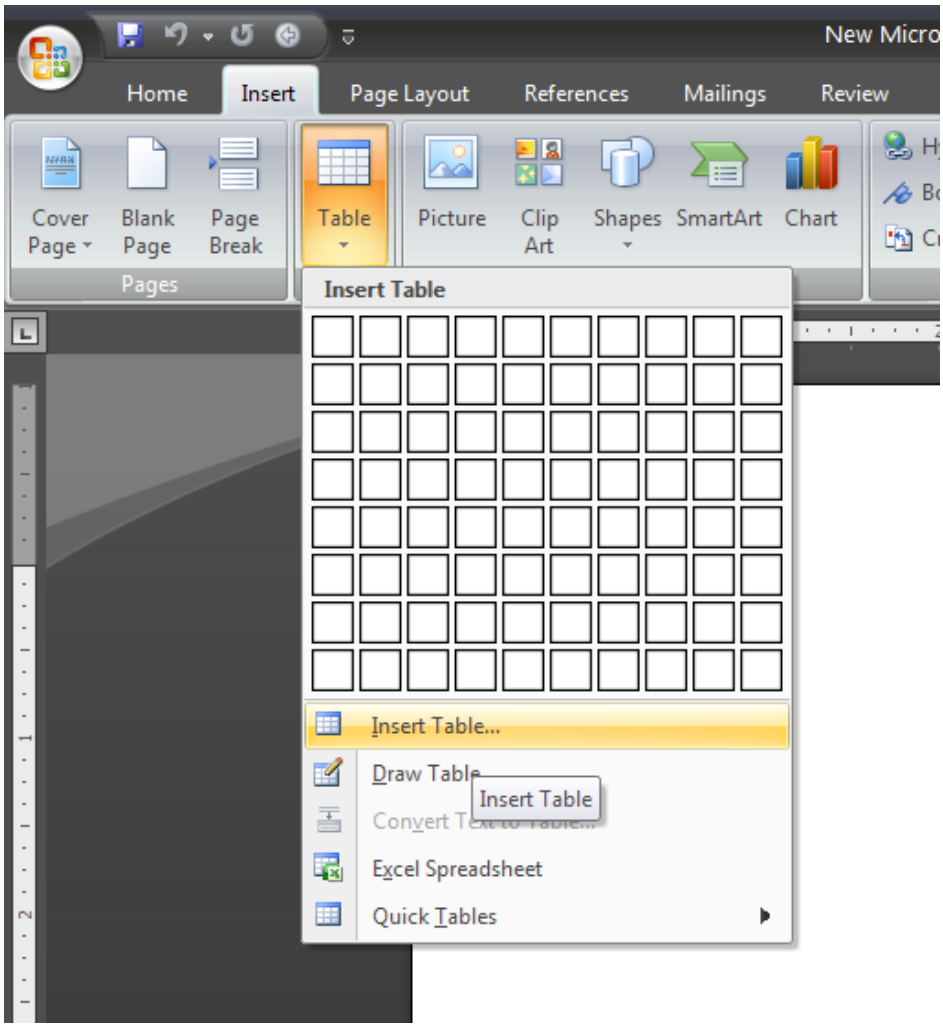



Figure 5-17: **Table** menu

**RPMS Data to Excel Exercises**

**A.** Using the FPRB report capture the data and convert it to an Excel spreadsheet. After converting the data, select a type of graph to use and save it as an object within a spreadsheet.

**B.** Using the ACT report, capture the data related to the discipline of the provider. Select a chart that displays the data effectively.

**C.** Identify other report formats that might be appropriate for conversion to graphs or charts.

## 5.4 Patient General Retrieval (PGEN)

This report produces a listing of selected patients. The patients printed can be selected based on any combination of items. The selection menus look similar to those for the GEN report, but reference patient data rather than encounter data.

## 5.5 Examples

- Select patient for whom Provider is the primary provider.
- Select all patients in Community X who are female and have been seen for diagnosis code 311 (or a different one provided by the trainer).
- Select all patients under 10 who have been seen by Provider Y.

### 5.5.1 Patient Selection Menu

Patients can be selected based upon any of the items in the following list:

1. Sex
2. Race
3. Patient Age
4. Patient DOB
5. Patient DOD
6. Living Patients
7. Chart Facility
8. Community of Residence
9. County Residence
10. Tribe of membership
11. Eligibility Status
12. Class/Beneficiary
13. Medicare Eligibility
14. Medicaid Eligibility
15. Priv Ins Eligibility
16. Patient Flag Field
17. Case Open Date

18. Case Admit Date
19. Case Closed Date
20. Case Disposition
21. Next Case Review Date
22. Designated MH Provider
23. Designated SS Provider
24. Designated A/SA Provider
25. Designated Other Provider
26. Personal History Item
27. Patients seen at a location
28. Patients seen in a community
29. Patients w/Problem (DX)
30. Patients w/Problem (MHSS )
31. Patients seen by a provider
32. Patients w/Education done
33. Patients seen for an Activity
34. Patients seen w/Type of Contact
35. Patients seen w/Axis IV
36. Patients w/Inpatient Disposition
37. Patients Last Health Factor

Select as many or as few items as necessary, in any order or combination.

- An asterisk (*) indicates already selected items.
- To bypass screens and select all Patients, type **Q** (Quit).

### 5.5.2 Print Selection Menu

Choose items in the order they should appear on the printout:

1. Patient Name
2. Sex

3. Race
4. Patient Age
5. Patient DOB
6. Patient SSN
7. Patient DOD
8. Patient Chart #
9. Community of Residence
10. County of Residence
11. Tribe of membership
12. Eligibility Status
13. Class/Beneficiary
14. Medicare Eligibility
15. Medicaid Eligibility
16. Private Insurance Eligibility
17. Mailing Address
18. Home Phone
19. Mother's Name
20. Patient Flag Field
21. Patient Flag Narrative
22. Case Open Date
23. Case Admit Date
24. Case Closed Date
25. Case Disposition
26. Next Case Review Date
27. Designated MH Provider
28. Designated SS Provider
29. Designated A/SA Provider

30. Designated Other Provider
31. Designated Other (2)
32. Personal History Item
33. Patients Last Health Factor

An 80-column screen is available, however you may have to print to a printer with either 80 or 132-column width.

### 5.5.3 Sort Selection Menu

Patients can be sorted by one of the following items:

1. Patient Name
2. Sex
3. Race
4. Patient DOB
5. Patient DOD
6. Patient Chart #
7. Community of Residence
8. County of Residence
9. Tribe of Membership
10. Eligibility Status
11. Class/Beneficiary
12. Patient Flag Field
13. Designated MH Provider
14. Designated SS Provider
15. Designated A/SA Provider
16. Designated Other Provider
17. Designated Other (2)

If a sort item is not selected, the report sorts by patient name.

**GEN and/or PGEN Report Exercises**

**A.** Using GEN, run a report to identify all services provided by a provider discipline (class) of psychiatrist (or a different one assigned by the trainer) within the past 90 days. For the print selection menu, what options might be used to identify the patient and the diagnosis for the encounter?

**B.** Using PGEN, run a report to identify all female patients who have a problem code of 80, Housing (or a different one assigned by the trainer), within the past year.

**C.** Would you use GEN or PGEN to create a list of encounters with Provider X? Is there an alternative to using GEN or PGEN to get this information, such as a different "canned" report?

**D.** Generate reports of all female patients with a Personal History Factor of Child Abuse (Victim). Generate a total count, a sub-count, a total (use community of residence as one of the print selections), and then a detailed report. Which report is most helpful?

# 6.0 Objective 4: Exporting

Routinely export behavioral health data to headquarters using the Export Utility menu.

## 6.1 Purpose

The purpose of this lesson is to discuss and demonstrate the Exporting process.

## 6.2 Overview

Regardless of their role, it is important that all users of BHS and the GUI, demonstrate an understanding of the data exporting process.

## 6.3 Goals

Skills acquired upon completion of this objective include:

- Identify the location of the Export Utility menu and explain the process involved in successfully transmitting records to headquarters.
- Explain the error corrections process.
- Identify local, area, and national contacts for assistance, if needed.

## 6.4 Export Utility Menu

Use this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes.

> **Note**: This set of utilities should only be accessed and used by the site manager or a designated BH staff member.

### 6.4.1 Generate Transactions for HQ (GEN)

This routine generates BHS transactions to HQ. The transactions are for records posted between specified ranges of dates. If a caret (^) is typed at any prompt, the system displays a message asking for confirmation of entries prior to generating transactions.

1. At the "Select Export Utility Menu Option" prompt, type **GEN** to generate BHS transactions to Headquarters.
2. Type data at the prompts, and press Enter to record each entry.

### 6.4.2 Display a Log Entry (DISP)

1. At the "Select Export Utility Option" prompt, type **DISP** and press Enter.
2. Type data at the prompts, and press Enter to record each entry.

### 6.4.3 Print Export Log PRNT

1. At the "Select Export Utility Menu Option" prompt, type **PRNT** and press Enter to print the Export log.
2. Type data at the prompts, and press Enter to record each entry.

### 6.4.4 Check Records Before Export (CHK)

To review all records that have been posted to the BHS database since the last export was performed:

1. At the "Select Export Utility Menu Option" prompt, type **CHK** and press Enter.
2. Type data at the prompts, and press Enter to record each entry.

> **Note**: This option reviews all records that were posted from the day after the last date of that run up until two days ago.

### 6.4.5 Print Error List for Export (ERRS)

Use this report (Figure 6-1) to review all records that have been posted to the database and are still in error after the latest Export/Generation:

1. At the "Select Export Utility Menu Option" prompt, type **ERRS** and press Enter.
2. Type data at the prompts, and press Enter to record each entry.

> **Note**: The "Check Records Before Export" option should be used to determine all errors **before** running the generation. Then correct errors before the next export/generation.

```
BH DATA TRANSMISSION TO HQ DEMO HOSPITAL
^BHSXDATA(0)
BH0^505530^14879^DEMO HOSPITAL^20060412^20060404^20060410^^205^195^10^V40P4
^BHSXDATA(1)
BH1^1^148790000001075^505530108665^19891202^F^231^4008141^C^01^N^N^N^20050714^M^5055
30^4016253^12^2^1^0120^^A^0^1621^^^^42.1^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^DV-
DP^^I^10^^2^^^^^^^^^^^^^BARRIERS TO LEARNING-NO BARRIERS^^^^^^^^N^^^C4
^BHSXDATA(2)
BH1^1^148790000001428^505530108665^19891202^F^231^4008141^C^01^N^N^N^20060404^M^5055
30^4067892^48^2^1^1100^1^A^0^196123^^^^295.90^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^
^^^^^^^^^^^^^^^^^^^^^^^^^^^^N^^^14
BH2^505530110320050000010947^212475^12^M^39^062^4028391^F^20051103^2704061^2^^2^^1^0
^1^L^1^20060405^1^^^^^2^^ALCOHOL^SEDATIVES/BENZODIAZEPINES/BARBITURATES^DIVORCE/SEPA
RATION/BREAKUP OF RELATIONSHIP^OTHER^^
```

```
^BHSXDATA(205)
BH2^505530110320050000010067^206432^06^F^13^062^4038500^R^20051103^2704061^2^^1^11^1
^0^1^M^1^20060405^1^^^^^2^^SEDATIVES/BENZODIAZEPINES/BARBITURATES^ALCOHOL^DIVORCE/SE
PARATION/BREAKUP OF RELATIONSHIP^OTHER^^
**
```

Figure 6-1: Sample export (ERRS)

### 6.4.6 Set Automated Export Option (SAE)

These options control the destination of the BHSX Export once it is generated. If no selection is made the application comes set with option 1, Automatically Send Export to HQ.

1. At the "Select Export Utility Menu Option" prompt, type **SAE** to set the destination for the export file.
2. At the "Auto Export Option" prompt, type one of the following.
   - Automatically Send Export to HQ
   - Automatically Send Export to Area
   - Automatically Send Export to Both Area and HQ
   - Do Not Automatically Send Exports

## 6.5 Exporting Behavioral Health Data

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

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

**Process**: After generating the CHK report, view the BHS menu. Select (DE), select a program and enter the encounter date. Figure 6-2 shows the CHK report.

```
RECORD DATE         PATIENT      HRN     PGM  TYPE            ACT TYPE
-------------------------------------------------------------------
JUL 27, 2009@10:00  CLIENT AH    911873   M   OUTPATIENT       13
E024-NO DISCIPLINE FOR PROVIDER

JUL 27, 2009@09:45  CLIENT SA    105072   M   OUTPATIENT       13
E021-NO PURPOSE OF VISIT

JUL 27, 2009@12:00  CLIENT NL    100070    M   OUTPATIENT        12
E024-NO DISCIPLINE FOR PROVIDER
```

Figure 6-2: CHK sample

Find the encounter on the List View in SDE, and look at the encounter record to verify provider name or other information needed as shown in Figure 6-3:

```
#  PRV PATIENT NAME   HRN    LOC   ACT   PROB    NARRATIVE
-------------------------------------------------------------------
1  CLA CLIENT RX    912345           30    14      DEPRESSION
2  S18 CLIENT JK    923122           13    305.1   NICOTINE DEPENDE
3  S18 CLIENT JK    923122           12    305.1   NICOTINE DEPENDE
4  S04 CLIENT HA    129125           13    14.1    SCREENING FOR DEP
5  S05 CLIENT HA    129125           12    14      DEPRESSION
6  S07 CLIENT CD    943219           12    14.1    SCREENING FOR DEP
7  S07 CLIENT EM    922334           13    305.1   NICOTINE DEPENDE
8  S06 CLIENT MA    123456           12    14      DEPRESSION
9  S06 CLIENT WH    234567           13    305.1   NICOTINE DEPENDEN
10 S03 CLIENT TO    987654           13    292.0   NICOTINE WITHDR
11 S03 CLIENT XX    905702           13          <NO PROBLEM RECORDED>
```

Figure 6-3: SDE list view

Figure 6-4 shows the encounter record for CLIENT XX was saved without the POV. The clinician needs to enter the POV and save the encounter again.

Another entry listed in the CHK sample indicates that there is no discipline for the provider who documented an encounter for CLIENT AH. When this encounter is displayed, the provider is Alphaa,Cindy. 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.

```
BH VISIT RECORD DISPLAY                                  JULY 31, 2009
-------------------------------------------------------------------
WHO ENTERED RECORD:                    ALPHAA,CINDY
DATE LAST MODIFIED:                       JULY 27,2009
EXTRACT FLAG:                             ADD
CLINIC:                                   MENTAL HEALTH
USER LAST UPDATE:                         ALPHAA,CINDY
IPV/DV SCREENING:                         PRESENT
PROVIDER WHO SCREENED:                 ALPHAA,CINDY
ALCOHOL SCREENING:                     POSITIVE
ALCOHOL SCREENING PROVIDER:            ALPHAA,CINDY
DEPRESSION SCREENING:                  POSITIVE
DEPRESSION SCREENING PROVIDER:         ALPHAA,CINDY
```

Figure 6-4: Sample patient record

> **Note**: The first time a site runs the CHK report, it may have many pages of errors. If a provider has been entering encounters for a number of months or years but has not 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.

When corrections are completed, the encounter record will be included in the next export. It is not necessary to resolve all errors before exporting; however, it is advisable to correct all errors as soon as possible to avoid accumulation of additional errors related to the same problem. A list of these errors and how to resolve them is listed in Appendix C.

## 6.6 Using TaskMan to Generate BHS Exports

In order to ensure that the export file is created monthly, a task may be set up in RPMS TaskMan. The site manager should be able to do this as long as the Option name (AMH Export Queue Export) is provided. Setting up the task does not relieve the clinic staff from checking and correcting errors on a regular basis.

> **Note**: Errors displaying in the BHS export CHK report indicate those encounter records have not been passed to PCC or to the RPMS Third Party Billing Package.
>
> Due to the short billing cycle for some insurers, it is recommended that the CHK process be completed at least monthly, preferably a week or so before the export is generated.

**Question**: What happens to the data that is sent to Headquarters? Is it stored with other data sent to the data warehouse?

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

**Question**: Why is it important that data is sent on a regular basis?

**Answer**: Requests from Congress, the Office of Management and Budget, and the Department of Health and Human Services are processed using the data that has been sent to HQ. These requests may come in at any time and often have a short turnaround 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 Fiscal Year 2007 were being prepared, IHPES only had data from 10 of the 12 areas.

**Question**: 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, DHHS, 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.

# 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, GUI 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: GEN Report Menu Screens

```
                              Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

------------------------------------------------------------------------------
1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV
```

Figure B-1: GEN Report Visit Selection Menu

```
                             ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

------------------------------------------------------------------------------
1)  Patient Name           27)  Interpreter Utilized  53)  Primary Provider
2)  Patient Sex            28)  Program               54)  Primary Prov Discipl
3)  Patient Race           29)  Visit Type            55)  Primary Prov Affilia
4)  Patient Age            30)  Location of Encounte  56)  Prim/Sec Providers
5)  Patient DOB            31)  Clinic                57)  Prim/Sec Prov Discip
6)  Patient SSN            32)  Outside Location      58)  POV (Prim or Sec)
7)  Patient DOD            33)  SU of Encounter       59)  DX/Problem Code Nar
8)  Patient Chart #        34)  County of Service     60)  POV (Prob Code Grps)
9)  Patient Community      35)  Community of Service  61)  Primary POV
10)  Patient County Resid  36)  Chief Complaint/Pres  62)  POV Problem Code Nar
11)  Patient Tribe         37)  Activity Type         63)  POV (Problem Categor
12)  Eligibility Status    38)  Activity Type Narrat  64)  POV Diagnosis Catego
13)  Class/Beneficiary     39)  Days in Residential   65)  POV Prov Narrative
14)  Medicare Eligibility  40)  Days in Aftercare     66)  Procedures (CPT)
15)  Medicaid Eligibility  41)  Activity Category     67)  Education Topics Pro
16)  Priv Ins Eligibility  42)  Local Service Site    68)  Prevention Activity
17)  Patient Flag Field    43)  Number Served         69)  Treated Medical Prob
18)  Patient Flag Narrati  44)  Type of Contact       70)  Personal History Ite
19)  Case Open Date        45)  Activity Time         71)  Designated MH Prov
```

```
20)  Case Admit Date       46)  Inpatient Dispositio  72)  Designated SS Provid
21)  Case Closed Date      47)  Place Referred To     73)  Designated A/SA Prov
22)  Case Disposition      48)  PCC Visit Created     74)  Designated Other Pro
23)  Next Case Review Dat  49)  Axis IV               75)  Designated Other (2)
24)  Encounter Date        50)  Axis V
25)  Encounter Date&Time   51)  Comment
26)  Appointment/Walk-In   52)  Flag (Visit Flag)
```

Figure B-2: GEN Report Item Selection Menu

```
                        SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

---------------------------------------------------------------------------
1)  Patient Name           16)  Program               31)  Inpatient Dispositio
2)  Patient Sex            17)  Visit Type            32)  PCC Visit Created
3)  Patient Race           18)  Location of Encounte  33)  Axis V
4)  Patient DOB            19)  Clinic                34)  Flag (Visit Flag)
5)  Patient DOD            20)  Outside Location      35)  Primary Provider
6)  Patient Chart #        21)  SU of Encounter       36)  Primary Prov Discipl
7)  Patient Community      22)  County of Service     37)  Primary Prov Affilia
8)  Patient County Resid   23)  Community of Service  38)  Primary POV
9)  Patient Tribe          24)  Activity Type         39)  Designated MH Prov
10)  Eligibility Status    25)  Days in Residential   40)  Designated SS Provid
11)  Class/Beneficiary     26)  Days in Aftercare     41)  Designated A/SA Prov
12)  Patient Flag Field    27)  Activity Category     42)  Designated Other Pro
13)  Encounter Date        28)  Local Service Site    43)  Designated Other (2)
14)  Appointment/Walk-In   29)  Number Served
15)  Interpreter Utilized  30)  Type of Contact
```

Figure B-3: GEN Report Sort Item Selection Menu

# Appendix C: Export Error Messages

Table C-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. |

| Code | Short Description | Explanation | Correction Needed |
|---|---|---|---|
| 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.* |
| 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. |

| Code | Short Description | Explanation | Correction Needed |
|---|---|---|---|
| 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. |
| 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 D: DSM Copyright and Trademark Information

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# Appendix E: 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.

## E.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).

### E.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.

### E.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.

### E.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.

### E.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.

### E.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.

### E.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).

### E.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.

### E.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.

### E.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.

### E.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.

### E.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.

### E.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.

### E.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.

## E.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.

## E.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 | Term Meaning |
|---|---|
| BH | Behavioral Health |
| BHS | Behavioral Health System |
| EHR | Electronic Health Record |
| GUI | Graphical User Interface |
| ICD | International Classification of Diseases |
| IHPES | Indian Health Performance Evaluation System |
| IHS | Indian Health Service |
| PCC | Patient Care Component |
| POV | Purpose of Visit |
| RPMS | Resource and Patient Management System |
| SPOV | Suicide Purpose of Visit |

# 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