Clinical Features

Progress Notes

Profile Controls

The behavior and interaction of the notes program with the user varies greatly between installations, depending upon a set of profile control files that set in motion a number of hidden options within this program. These profile control files are customized for the agency to reflect its needs and standard operating procedures. The following is a list of these files:

1. **CHKPRG.DAT** – Defines switching activity codes for clients within a group belonging to different programs.
2. **CLTMNT.ALT** – Defines custom fields for the alert indicator fields.
3. **CLTNOT.DAT –** Determines activity code pairs for collateral visits.
4. **SALMNT.DFT** – Determines default answers to billing questions at certain fields: location, type of contact, etc.
5. **B1-PGMACT.DAT** -- Lists programs that require front desk check-in for entry of billable notes.
6. **B1-PGMDIV.DAT --** Validates program division against staff division to control access across divisions
7. **SALMNT.CHD --** Checks for total hours to date this month and switch code as required for CDT programs.
8. **ACN???.CMO** – Sets the text template for notes associated with activity code ???.
9. **CN???.CMO –** Sets the text template for notes associated with program organization (**PRGORG**) code ??? when no template exists for the activity entered.
10. **LOCATE.CVT --** Location conversion chart for specified programs on certain days of the week that is used when a program meets at a different location on weekends.
11. **PCVNOTE.DAT** -- Information for scanning interface when notes are entered using an image scanner in lieu of the keyboard.
12. **BTNHLD.DAT --** Consolidation profile list.

Electronic Record Features

There are optional features within progress notes to provide extra security. These features were designed to substantiate the on-line documentation as official medical records, eliminating the need to maintain paper copies. These features include:

1. **Electronic Signature for Progress Notes** – This system setting designates whether the agency is utilizing the Electronic Signature for Progress Notes. Once initialized, when a note is signed on the system, a signature block including ESOF on <date> with the corresponding staff's Name and Corresponding Title at the Time of the Service will be appended to the text and viewable whenever displaying notes or printed.
2. **System Closed Notes** – When this feature is initialized the System will automatically close any open Progress Notes from that business day. While Progress Notes can be left in a preliminary stage or unsigned to allow further editing for a short time period, all progress notes left in a preliminary status will be closed automatically at midnight of that business day. The status of System Closed Notes will be reflected as "C"; whereas Notes Closed by the Clinician will be reflected as Status "Y", or Not Yet Closed as "N".
3. **Electronic Signature for TX Plans & Assessments –** This options works as above for TX Plans and Assessments with the ESOF signature block for signed documents when initialized. When unsigned the signature line will print without the ESOF on <date> designation.
4. **Embed Signature within Progress Note** – When initialized, this option will embed an ESOF signature block into all Progress Notes as Closed as described above. Additionally an ESOF block will be printed for Progress Notes closed prior to the designated date at the time of printing for those notes Signed and Closed prior to the availability of the ESOF feature.
5. **Supervisory Progress Note Sign-Off -** When initialized, this option will present only designated staff with the **'Sign note?'** prompt. Signing authorization is designated in the approved operator's Option list in H-3 as "SNOTE".
6. **Tracking** -Tracks who typed the note and the staff for whom it was written.
7. **Screen Security** - When a terminal has been left inactive for a given period of time, the screen is blanked out and locked until the original user password is re-entered.
8. **QA Reports** - A QA Report can be run at **G-16 UN** to list the notes that have not been signed, have been closed by the system or both. This report can be run prior to the midnight deadline for a list of those notes to be closed by the system.

   Additionally, QA Reports can be run to determine those recorded visits that don't have a corresponding progress note in **G-16 VS**.

   G-16 NB is a similar report which lists notes that do not have corresponding activities recorded.

System Level Initialization Options/Decisions

- Completing a progress note for an activity can be set to create/generate the invoice for that service.
- Alerts can always be presented for editing within client progress notes.
- Supervisory sign-off requirements can be activated for agencies who have service providers who require supervisory sign-off on activities and documentation.
- Notes left in a preliminary status can be closed automatically by the system at midnight each day.
- Electronic Signatures can be activated for Progress Notes.
- An ESOF Signature Block can be appended to the Print-Out of Progress Notes for any printed notes prior to a Designated Date.
- Electronic Signatures can be activated for Treatment Plans and Assessments.
- Treatment Plans and Assessments can be archived to a designated directory.

Medical Data

Client medical data is part of the Clinical sub-system. There are two versions of this option. The first version is for general release and the second contains options that are premium items.

General Release Features

The following set-up is required by the agency for the general release.

1. Control file **B5-COMMENTS.DFT** determines the memo box pre-fill for the client medical profile in **B-5 MC/MP**. This can be a template for observations, a worksheet or a free text area.
2. Table **DRUGS** contains all of the prescription medication that the agency docs prescribe, with the drug code, description (drug name(s) and equivalents), coded type of blood work required for that drug and the frequency in weeks in which that blood work must occur. The coded type of blood work interacts with the premium options.
3. Table **MEDTYP** contains the list of medication types prescribed by the agency.
4. Table **RTEADM** contains the of routes of administration for the meds prescribed at the agency.

Premium Features

In addition to the general release features, the **B-5** medical data option has premium features that are available for purchase to generate printed prescriptions and track blood work and injection data on-line. This feature is initialized by IMA within the agency configuration and the agency completes the following set-up.

1. Control File **B5-COMPANY.DAT** is a four line file defining the agency name and address for printed prescriptions.
2. Control file **B5-BLOOD.DAT** contains the list of blood work that is required for all medication clients within the agency and the time frame in which it must occur.
3. Table **BLDWRK** contains the codes for the designated blood work types from above with a description.
4. Table **LOCINJ** contains the codes for the injection locations for the injectable medications.

Client Assessments

For the assessments in **B-6** to reflect agency customization, some set-up and definition is required. It is important to consider regulatory paper requirements and existing agency documents while planning the set-up for on-line assessments.

Assessment Setup

A folder can be defined for each type of program as defined in the program definition in the field **'Organization type:'** from table **PRGORG**. For each assessment within the folder, the following will be defined:

- **Assessment title** – This title can be up to 30 characters in length.
- **Data cluster** - A data cluster is a grouping of demographic information to include within the assessment. The available choices are listed below.

Cluster type	Description	Fields
CD-ADM **Screen 1 data**	*Chemical Dependency Admission (2 screens of data)*	Significant Other
		Religion
		# of Children & # at home
		Cultural Identity
		Living Arrangement
		Employment Status
		Problems (17)
		Marital Status
		Ethnicity
		Salary
		Referral Source
		Source of Income
		Social Security #
		Occupation
		Veteran Status
		Type of Residence
		Type of Education
		Primary Problem

		Substance abuse 3X4 matrix of substances & history
Screen 2 data		Full DSM-IV
COLL	*Client Collaterals*	Name & address of Collateral s
DIAG	*Full DSM-IV multi-axial diagnosis*	DSM-IV Axis
DISCH	*Discharge Summary Data*	Last direct contact Date of last physical Medical condition Allergies Medication
GOAL	*TX plan, goal and objectives*	Goal-Objective-Methods array (max 18 goals)
HEALTH	*Client Medical Health*	Date attached health form was completed Screening summary codes Physician Psychiatrist Medication Other medical data Allergies Past illnesses Medical diagnosis
MULTI-1	*The data below plus other data clusters as defined below interspersed with memos*	
(Data screen 1)		Religion
		# of Children & # at home
		Employment Status
		Marital Status
		Ethnicity
		Living Circumstances
	Memo #1	
(Data screen 2)	*Data screen from PSYCH*	See PSYCH
	Memo #2 *Memo #3*	
(Data screen 3)	*Data screen from DIAG*	See DIAG
PSYCH	*Psychiatric Assessment Data*	Presenting Problem
		Primary Problems
		Drug Abuse History
		Alcohol Abuse History
		Referring TX
		Referral Source
RISK	*Risk and Alert Indicators*	Alert Indicator Fields from

		CLTMNT.ALT
SDF	*County reporting Data*	Alias
		County
		Presenting Problem
		SPEMI/SED Status
		Primary & Secondary, AXIS I and AXIS II
		AXIS V GAF
		Prior Services (12)
		Disabilities(7)
SOCIAL	*Psychosocial Assessment Data*	Employment Status
		Marital Status
		Veteran Status
		Type of Education
		Living Circumstances
		Special Training
		Discharge Status
MEMO-ONLY	*Defined memos only without any data fields*	Initiated Date only

- **Topics** - A list of additional topics to be addressed within the assessment should be created. Each topic can be given a title and specific questions or forms that will be used for that topic can also be listed. Each topic can then be linked to its own memo box.
- **Memo boxes** - Each memo box is assigned a size, title, and editable text to pre-fill based on the listt of topics above.

After defining the folders that will be created for each program organization type, the information can be entered in the assessment set up file. The definitions of assessment folders are made in the **CLTASM.DFT** file. This file uses a form layout language that creates a unique set of forms grouped in folders. Each folder is then assigned to a specific program type. The following is an outline of the file.

1. Number of assessment folders - The number of folders that are being defined. Each **PRGORG** can have its own assessment folder.
2. Organization type from **PRGORG** for the first folder.
3. Titles and number of default goals and objectives - If the GOAL type data cluster is used, this line defines the title and pre-fill to the goal section.
4. Number of assessments - The number of assessments within this folder for this **PRGORG**.
5. Section to define each individual assessment.
    - Title for assessment and data cluster to use.
    - Number of memo boxes.
    - Definition for each memo box - The definition of each box contains 5 pieces of information.
        - Memo box number

- Title
- Length
- Width
- Memo content - This may be one of three things:
    a) Name of template file.
    b) Copy of previous memo - Use # and then the memo box number from which to copy. Memos can only be copied within the same folder.
    c) Link to previous memo - Use memo box number of link.

```
                    IMA Mental Health - Development Area  Option:H12-MS
                             Edit control files

 File /u/mh_dev/sco/admindata/CLTASM.MS
!Number of assessments, Date of last change:12-27-95
3
! Program group found in Table PRGORG
MH
! Goal, Objective, Method titles (stay away from plurals)
Goal,Objective,Method
! Default goal,objective,method
0
! Number of assessments
10
! Title for assessment 1, data cluster
PSYCH,PSYCH
! Define memo boxes for assessment 1
1
1,Telephone screening,300,70,PSYCH.ASM

                          120 x 1000 men ext
```

Control file CLTASM.DFT.

System Level Options/Decisions

The agency also needs to determine some system settings for agency **B-6** preferences. These options are initialized and subsequently changed by IMA at the system level.

- Allow **B-6** to copy across **PRGORG** types at option **CP**
- Print signature on assessments

Functional Assessments

Functional assessments measure functional skills and behaviors for clients in long term treatment environments. Treatment areas are identified with corresponding and related treatment problems from which to build client treatment and habilitation plans.

Functional assessments are not only stand alone measurements of functional skills and behaviors, but are tied to the treatment planning feature, as well. That relationship will be discussed in the following section.

Construction Elements:

1. Areas are defined to point to goals and link to problems, which point to objectives.
2. Problems are defined to point to goals.

Required definitions:

Several tables and control files require definition for functional assessments.

Areas and Problems:

- **TXAREA** table including cross-reference to treatment goal.
- **TXPROB** table including cross-reference to treatment area and sort key by treatment goal/objective.
- **H-11 CH P** for 12 line expanded problem statement.
- **TXACT** table describes the treatment action for areas defined per **PRGORG** and each's required action as it relates to the treatment plan.

Control Files

- **B10-HEADER.ARE** – defines the header for the printed Functional Assessment.
- **B10-MEMO1.ARE** – defines the template and/or pre-fill for the first Functional Assessment memo box.
- **B10-MEMO2.ARE** – defines the template and/or pre-fill for the second Functional Assessment memo box.
- **B10-ORG.DAT** – defines the set of problem areas that are assigned and/or available for each **PRGORG** type and how the treatment plan program will interpret treatment areas and problems.
- **B10-RATING.xx** – are the files defining each **B-10** rating, where xx is the rating code.

System Level Options

- A default action code from **TXACT** can be designated.

Treatment Plans

Treatment plans can be an independent tool or interact with the previous assessments. The Functional Assessment from B-10 can automate treatment planning based upon its results per client. Also, if a goal assessment is defined in B-6, its results can also automate the treatment planning function per client. A treatment plan can also be created from the goal, objective and method libraries, free form or a in a combination of any of the above.

Goal bank definition

Goals:

- **TXGOAL** table including cross-reference to program type and sort key by treatment area.
- **H-11 CH G** for 12 line expanded goal statement.
- Free form goal statements may also be entered while creating a plan for a client.

Objectives:

- **TXOBJ** table including cross-reference to a goal code
- **H-11 CH O** for expanded objective definition statement.
- Free form objective statements may also be entered while creating a plan for a client.

Methods:

- **TXMETH** table with cross-reference to an objective
- **H-11 CH M** for expanded method definition statement
- Free form method statements may also be entered while creating a plan for a client.

Definition of treatment areas, problems and goals are instrumental in the development of effective assessments in addition to treatment plans. Definition of goals, objectives and methods are instrumental in the development of effective treatment plans.

G-16 FF is a quality assurance report of free-form treatment plan items. Running this report can help determine frequently repeated themes that may warrant definition in the appropriate corresponding tables.

Tables

The tables that need to be defined for the header sections of the assessments and treatment plans are:

1. **NOPART** - Reasons for no-participation
2. **SPPROG** - Plan Progress
3. **SPTYPE** - Type of Plan
4. **TXGOAL**- Goals are a three character code with a thirty character description, four character program type cross-reference, four character TXAREA sorting string and twelve line memo box defined in **H-11 CH G**.
5. **TXMETH** – Methods are a three character code with a thirty character description, TXOBJ cross-reference and a twelve line memo box defined in **H-11 CH M**.
6. **TXOBJ** – Objectives are a three character code with a thirty character description, TXGOAL cross-reference and a twelve line memo box defined in **H-11 CH O**.

7. **TXSTAT** -- Treatment statuses are a one character code with a thirty character description which reflects the status of treatment for a specific goal, objective or method.
8. **TXRATE** – Treatment ratings are one character codes with a thirty-character description which reflect the rating for a specific goal, objective or method and the overall treatment problem. **B10-RATING.xx** defines the auto-fill for the linked memo box.

Memo Boxes

In **H-11**, stock memos can be created to be associated with each problem area, goal, objective and method used in a treatment plan. A set of memo boxes can be attached to each treatment plan. The title, size, and contents of each one is designed separately for each program type within the agency in control file **SRVPLN.DFT** which can be accessed through **H-12 TP**.

```
IMA Mental Health - Development Area  Option:H11-CH
Treatment plan memos

Tx code type (P,G,O,M):G

TX goal code:OF4          Legal Issues

TX goal code text
Ct. will accept responsibility and respond responsibly to
the mandates of court.

TX goal OF4 text ok? (Y,N)Y
60 x 24 men ext bck del
```

The goal statement memo for a TXGOAL in H-11

System Level Options

- Free-form goals, objectives and methods can be defined for use with a designated code or not allowed.
- The initiated date can be presented as an editable data field and printed on the hard copy document or the initiated date can be neither presented for editing or printed in the document.
- The sign-off date can be printed on the treatment on the treatment plan or not printed on the hard copy document.

Residential Features

Two premium packages are available for agencies with residential programs. One has a special statistics reporting feature, discussed in the Reports Chapter of this Guide, and an Event Log. The other manages client entitlement data. These options are initialized for the agency at the system level if these features are purchased by the agency.

Event Log

The Event Log at **B-8** requires some special set-up with control files and tables.

Tables

1. **REFMVM** for **'Type of event:'** in logging new event
2. **REFSCD** is **'Event:'** logged
3. **REFPRV** is list of providers for **'Services provider:'**
4. **REFSRV** is list of services that would be provided for **'Services:'**
5. **REFECD** is list of closing events for **'Event:'** to close

Files

1. **B8-ACT.DAT** is a matrix of event movement types from **REFMVM** and valid activity codes
2. **B8-EMAIL.INI** lists the e-mail recipients based on event type
3. **B8-OPR.DAT** lists the operators with authorized access to this feature and the corresponding programs
4. **B8-SHIFT.HEAD** is the shift note memo header

System Level Options

1. A default event type (**REFMVM**) can be specified for posting shift notes at **PS**
2. A default event (**REFSCD**) can be specified for posting shift notes in **PS**

Entitlements

A-11 is a menu of options for managing and maintaining client entitlement data. This includes entitlement set-up, receipt recording and disbursements.

Tables

- **SSISRC** for **'Source:'** of entitlement
- **SSIDEP** is the **'Type:'** of deposit from the source
- **FINSUM** list the possible **'Sources of income:'** for the client

Files

- **A1-SSI.DFT** lists the default values of SSI expected agency and client amounts per program

Termination/Discharge Options

Clients can be enrolled in programs and in groups within programs. Client terminations and discharges are handled differently for each and have special initialization features at the system level.

Client Groups

D-3 TC is the option by which clients can be added to and remove from group rosters. This option has three possible ways of handling these records.

- Clients will be deleted from the group without maintaining a record of their group enrollment data.
- Clients will be terminated from the group, maintaining group enrollment data for enrollment and discharge dates and a discharge reason.
- The user can also be prompted to determine which option will be employed at the time of **D-3 TC**.

Client Programs

Inactive clients can be terminated in a batch through option **C-10**. This option can also be configured to delete the associated scheduled appointments for those specific clients and program enrollments.