

# Clinical

---

## An Overview

The Clinical sub-system provides the facility to generate and maintain the various documents required as part of the clients' medical records folder. Although some of the basic demographic data is originated elsewhere in the system, all client-related information is available within the clinical sub-menu **B** for review, modification, and incorporation into the various documents produced.

The following is a brief list of these areas:

- Progress notes.
- Basic client data including billing related data and medical data.
- Assessments.
- Client related correspondence.
- Events log and shift notes.
- Treatment plans.
- Functional assessments.

```
Version:11.0          The Mental Health Workbench          03/16/98 Mon
Copyright 1997 by    IMA Mental Health - Development Area    3:05 PM
IMA, Inc.           CLINICIAN                               Option: B
Printer:Downstairs laser(WT)                               Georgeanne Biancarosa

  81 - Write progress note
  82 - Review progress notes
  83 - Print progress notes
  84 - Client data
  85 - Client medical data
  86 - Client assessments
  87 - Client related letter/memo lookup
  88 - Event log
  89 - Treatment plans
  810 - Functional assessment
  811 - Edit progress notes

Option:

                               9 men ext hlp
```

*The Clinical Menu option: B.*

---

## Description

There are two types of functions available under this menu. One provides access to the various demographics of the client database. The other provides for the actual preparation of a set of required clinical documents for the client folder in both electronic and paper modes.

Each of the following will be detailed in separate sections of this or another chapter.

### Client Demographics

- **B-4** -- Registration and Intake information collected in screens at **A-1** and **A-6** is available with options to view or update the data and add, transfer and terminate programs.
- **B-5** -- Additional medical data is entered only via this screen. It includes medications and other data related to the medical profile, distinguished from the mental health profile.
- **B-7** -- Permits access and retrieval of all client-related correspondence generated on the system by author and client, referenced for a specified date range and specified subject matter or for all subjects.
- **B-8** or **Pop-up** -- This event database is used for recording and tracking all significant client events that have occurred. This might include reportable incidents and hospitalizations, along with other trackable client events.
- **A-5** or **Pop-up** -- Maintains information about a series of collaterals associated with each client. These would include emergency contacts, significant others and primary care physician, among others.

### Clinical Documents

- **B-1, B-2, B-3, B-11** -- Progress note options include writing, reviewing, editing and printing. Various types of progress notes can be created for different service types. These include individual and group notes, periodic summary notes and restorative service notes.
- **B-6** -- This includes custom assessment forms for each group of programs within an agency and the ability to track the dates and statuses of each of these forms. Additionally, it provides for signing off on these documents after which changes are no longer permitted.
- **B-9** -- Provides for the creation of initial treatment plans as well as the review of existing plans with various levels of help from the system. These documents are also tracked in terms of due dates and status, including whether or not it is signed off.
- **B-10** -- The Treatment Formulation Summary is a special assessment form for problem areas and treatment planning. Each of the defined problem areas corresponds to specific goal definitions that are then used to create the initial and ongoing treatment plans. Further corresponding objectives and methods may also be built in for additional support in the development of the initial and ongoing treatment assessment and planning for each client.

---

# Client Information

Client information is protected by the system with restricted access. Operators can be designated access to specific options containing client information in varying levels, including generate and change client information, view only or all features. The system administrator controls this security feature.

Several locations within the system provide access to various degrees of client demographics. These screens can be found within the various options in the Reception (A), Clinical (B) and Billing (C) Menus, predominately.

## Client Data

There are sixteen screens of client demographics. These screens are in a few different locations on the system. These screens are presented in detail in the Client Data Reference Manual. The following menu options provide access to the screens where the corresponding data can be referenced and utilized.

- **A-1 CH** – Change client and program information in record.
- **A-1 CB** – Change or create client billing header.
- **A-1 CU** – Change user defined fields
- **A-1 VS** – Client managed care visits to date.
- **A-1 TD** -- Complete tickler information/Change tickler dates.
- **A-1 PH** – Monthly program hours to date for day treatment per client.

```
IMA Mental Health - Development Area Option:A1
Client data
Intake/Discharge:
IW - Full intake
QE - Quick entry intake
TR - Transfer from Pre-intake
TM - Terminate a program/Discharge
RD - Cancel a TM done in error
Changes in program data:
AP - Add a new program
QA - Quick add program
PD - Medicaid spend-downs
MD - Medicare deductibles
PH - Program hours to date
UA - Managed care authorization
US - Managed care visits to date
ER - Extension request issued
EA - Extension authorization received
Changes:
CH - Change data in record
QC - Quick change
CO - Correct data w/o history
CW - Change name and ID fields
CB - Change/create billing header
TD - Change tickler dates
CU - Change user defined fields
PC - PCS demographics
Lookup:
SH - Show full client data
HI - History lookup
BL - Billing header lookup
AL - Authorization lookup
CS - Statistics lookup
RS - Residential services lookup
CR - Central registry lookup
Option:
2 men
```

The A-1 Menu for Client Data.

- **A-5** – Client Collaterals.

```

                IMA Mental Health - Development Area  Option:A5
                Collaterals

                AD - add collaterals
                AG - add all collaterals for a program group
                CH - change collaterals
                SH - show collaterals
                DE - delete collaterals
                LS - print a list of collaterals

Option: █
                2 Men

```

The A-5 Menu for Collaterals.

- **A-9** -- Client lookup.

```

                IMA Mental Health - Development Area  Option:A9
                Client lookup

Client:      1 Unique ID:CLIEWT010185M0

Last name:Client          Billing order:MC MD
First name:Test          Client schedule:1
D.O.B.:01/01/85 Age: 13   Level:1
Sex:M                   Spend-down?W
SSN:11111111           Primary source of income:G E F G H I A C
Address:123 Some street  Medicaid ID:0943256H
                          Medicare ID:158448164A
Municipal:HMD County:40  Other insurance:AETW
Zip:11229-0000          Account/Group:138493124 ✓4389-1348
Home phone:              Holder:GIL Employer:
Work phone:              Other insurance:
                          Account/Group:
                          Holder: Employer:
Ethnic:1
Religion:
Marital:M

P(rograms).U(isits).A(ssessments).T(X plans).I(ndicators).L(edger).M(eader)? █
                1 Men ext bck req

```

The specific options available in the **B-4** menu are as follows:

- **CH** -- Change client information.
- **CO** -- Correct mistakes without history.
- **HI** -- History lookup.
- **SH** -- Show client information on the screen.
- **AP** -- Add a new program.
- **TR** -- Transfer from Pre-intake.
- **TM** -- Terminate a program/Discharge.
- **RO** -- Cancel a TM done in error.

```

IMA Mental Health - Development Area Option:04
Client data

CH - Change client information
CO - Correct mistakes w/o history
HI - History lookup
SH - Show client information on the screen
AP - Add a new program
TR - Transfer from Pre-intake
TM - Terminate a program/Discharge
RD - Cancel a TM done in error

Option: 2 men

```

*The B-4 Menu for Client Data.*

Client group maintenance is located in menu option **D-3** and **<Pop>**. Groups are added and maintained in options **AD** and **CH** for client groups provided by the agency. Clients can then be assigned and terminated from these groups within this menu. There is also the option to delete clients from groups, which is a feature determined at start-up. This delete feature is utilized when groups are reaching capacity or when it is not important that a record be kept of group enrollment and termination dates for each client. The group database can also be searched for a specific client at **FC**.

```

IMA Mental Health - Development Area Option:03
Client group maintenance

AC - add a new client to an existing group
AM - add/terminate a client to/from multiple groups
FC - search groups for a client
TC - terminate a client from all groups

AD - add client groups
CH - change client groups
SH - show client groups
DE - delete client groups
CP - copy client groups
LS - print a list of client groups

Option: 2 men

```

*The Client Group Maintenance Menu at D-3.*

### **Hard Copy**

Printed reports of demographic output from these screens are available through the following options:

- **A-8** -- Client face sheet.
- **A-6 PN/PF** -- Pre-registration worksheets for the phone narrative and face sheet.
- **G-1** -- Ad-hoc lists and detailed reports with user selected fields on the client database.

- **D-2-5** – Weekly schedule for client.
- **D-3 LS** – Group Roster and Sign-in Sheet.

---

**Note:** Before printing clinical documents from the system, the appropriate forms must be downloaded to the memory of the designated printer. Contact the System Administrator to see if this set up has been completed for your assigned printer.

---

### ***Client Registration***

Clients can be initially entered into the system in three ways, depending on agency standard procedures.

- **Pre-registration - A-6 RE** is a quick way to get a client into the system with minimal information. This can be used for telephone screening calls or when referral sources are linking the client to the agency.
- **Quick Entry** - One screen of information is at **A-1 QE**, which is a composite of client, program and billing information. This is how clients are generally loaded into the system for agencies to go live with and/or implement the system.
- **Intake** - The **A-1 IN** screen is the full intake with details about the client including alert indicators, living conditions and the DSM-IV Axes.

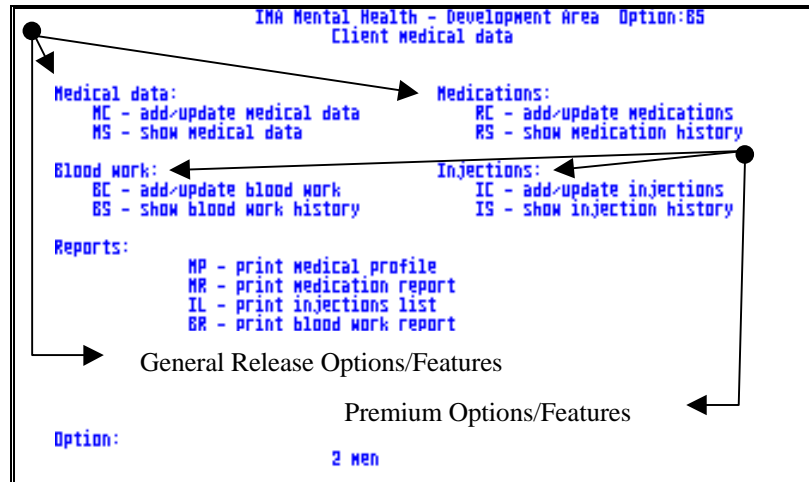
### **Client Medical Data**

**B-5** contains all of the data relating to the client's general and clinical medical status. There are data and memo screens with information ranging from identifying physical attributes to medical diagnoses and observations in the medical data section. A Medical Profile Report can be printed for each client, including prescription medications and the previously mentioned data with a physician signature line for the client hard copy record.

Additionally, medication options include adding new prescriptions, updating prescriptions with changes or stop dates and documenting medication monitoring. Progress notes are linked directly to the prescription medication option for streamlined documentation access. A Medication Report can also be selected by client, physician and medication/medication type to improve medication monitoring capabilities.

Additional premium options are available within the **B-5** Menu. Prescriptions can be written from the system, complying with FDA standard formatting and requirements. A blood work reminder screen also opens the medication option for each client when these premium options are initialized. Blood work and injections can be updated and monitored on-line, as well. Tickler type reports are also possible for these features.

For a full description of this option, see the corresponding chapter of this Guide.



The B-5 Menu for Client Medical Data.

## Client Related Letter/Memo Lookup

All letter correspondence generated within the system related to a specific client is accessible in **B-7**. Users can select correspondence by author or all, a specific client or all, a date range and the type of letter or all. Once a specific letter is selected, it can be displayed on the screen or reprinted.

```

IMA Mental Health - Development Area Option: B7
Client related letter/memo lookup

Author:all
Client:  1 Test      Client
Starting date:first
Ending date:last
Type of letters:all

Ready to lookup letters? (Y.N)
1 Men ext bck req
  
```

Selection criteria for lookup screen.

## Client Assessment

For each program enrollment of a client, an assessment folder can be created. Assessment folders contain sets of forms that can be filled out and attached to the client record. A different folder can be designed for each program type within the agency. A folder can consist of up to ten different assessment forms. The program organization type determines the specific folder that is created. When the folder is created, the first assessment in that folder is initiated and the user is asked to complete the various sections as specified by the design of the folder. All the other assessments in that folder

are listed as not initiated. Client assessment folders are created and maintained in sub-menu option **B-6** with the following options.

- **CR** – Create folder and Initial Assessment.
- **IN** – Initiate the other assessments.
- **CH** – Change an assessment.
- **SH** – Show an assessment on the screen.
- **RA** – Reassign an assessment.
- **CP** – Copy an assessment.
- **DE** – Delete an assessment.
- **PR** – Print assessments.
- **DS** – Display a list of assessments.
- **LS** – Print a list of assessments.
- **VS** – View or print signed off assessments.

```
IMA Mental Health - Development Area  Option:66
Client assessments

CR - create folder and the first assessment
IM - initiate the other assessments
CH - Change an assessment
SH - show an assessment on the screen
RA - reassign an assessment
CP - copy an assessment
DE - delete an assessment

PR - print assessments
DS - display a list of assessments
LS - print a list of assessments
VS - view or print signed off assessments

Option: 2 Men
```

The B-6: Client Assessment Sub-menu.

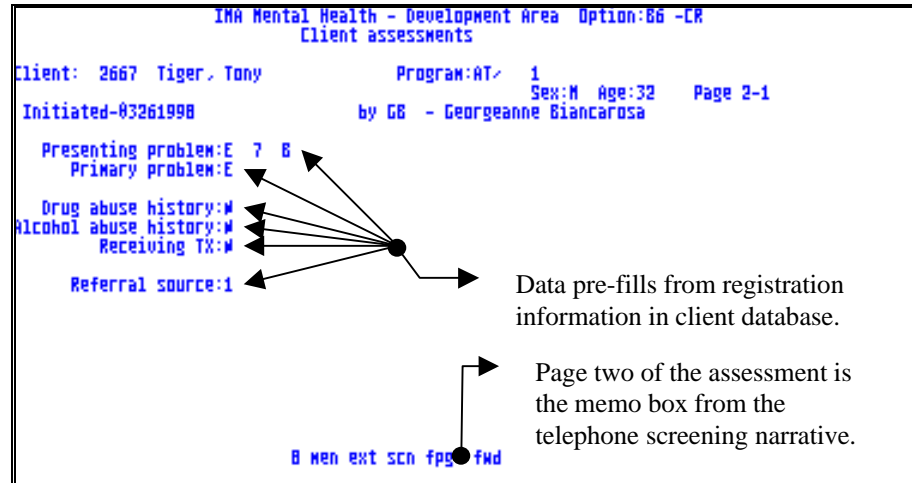
**B-6 CR** creates the assessment folder for the program enrollment and initiates the first assessment. For agencies using the **A-6 RE** option, this assessment is the first in the folder for the designated program. **B-6 IN** initiates the other assessments in the folder. When an assessment is completed, either through **B-6 CR** or **IN**, the operator has an option to sign-off on it or to leave it open. Once it is signed-off, it may no longer be edited. Data archiving is also available for signed off assessments.

Typically, an assessment folder may be started while the client is still in a screening program. Later when the client is transferred to a designated treatment program, it is not desirable to start a new folder but to continue within the same one. This may be accomplished by reassigning the original assessment folder from the screening program to the new treatment program. This is done through option **B-6 RA**. There is also a feature to copy an assessment from one client to another with option **CP**.

When the **B-6 CR** option is requested for a client and program that already has an existing folder, the system will alert the user that an assessment has already been created and give the option to create a new assessment. If the user answers **Yes** at this prompt, a

second assessment folder will be created as a sequence 2 assessment folder. This is used by some agencies that create periodic, annual or quarterly, assessment review documents similar to treatment plans. It is important to insure that this feature is not accidentally applied when trying to complete open assessments within an existing folder.

Depending on the thoroughness of the information collected at pre-registration, the initial assessment will be completely or partially completed when it is presented to the staff for creation. The first screen pulls data fields from the pre-registration screens and the second page is the memo box from the telephone screening narrative.



The first page of the initial assessment at B-6 CR.

**B-6 VS** provides the option to view or print signed-off assessments. This is available only if assessment archiving is activated. Under this option, the assessment as last edited is saved in a new document database when the assessment is signed off. Also, when this is activated, the **LS** option can no longer be used for signed-off items. These items can only be reprinted from the archived or signed off documents by selecting the **B-6 VS** option.

## Assessments within a Folder

Navigation within the assessment is made easy while in the **CH** and **SH** options through a drop-down selection window. Choosing an option will go to that corresponding, specific place within the document.

```

IMA Mental Health - Development Area Option:66 -IW
Client assessments
Client: 2667 Tiger, Tony
Assessments to be initiated:
1) PSYCH initiated on 03/26/1998 by GB
2) COLL initiated on 03/26/1998 by GB
3) GOAL initiated on 03/26/1998 by GB
4) RISK initiated on 03/26/1998 by GB
5) DIAG initiated on 03/26/1998 by GB
6) HEALTH not yet initiated
7) SDF not yet initiated
8) CD-ADM not yet initiated
9) MULTI-1 not yet initiated
10) DISCH not yet initiated

Choose the assessment to be initiated:
      2 men ext bck num req

```

Contents of an Assessment folder.

```

IMA Mental Health - Development Area Option:66 -SH
Client assessments
Client: 2667 Tiger, Tony          Program:AT/ 1 I-03261998
Assessment: 1/3 - GOAL           Sex:M Age:32 Page 4-1

```

Code	Status	Date	Staff
1	001	0	03/26/98 GB
2			

```

2 Redu Choose screen to start with
      Description
      1) Data Screen - 1
      2) MEMO AREA GOAL #1
      3) MEMO AREA GOAL #2

```

Go to specific area within assessment.

Assessment: Goal is in first folder sequence, third assessment.

```

Section to start with, E to select another assessment: 1
      2 men ext bck fwd req

```

A drop down selection window within a selected assessment in B-6 SH.

Each assessment consists of the following sections:

1. **Header** - Each assessment has a header that includes a date, staff person, and status code.
2. **Data cluster** - A data section with selected fields from the client database. There are 10 pre-defined data clusters that can be used for this section.
3. **Memo boxes** - A series of memo boxes can be defined for each assessment. The definition includes a title, size, and three different ways to pre-fill the memo area:
  - a. **Template** - A template can be specified to fill the memo area.
  - b. **Previous memo** - A memo can be pre-filled with the contents of a previously filled memo box from any other assessment in this folder. When the text sections are imported they will automatically get stamped with the date and author of the original text.

- c. **Linked memo** - A memo can be linked to any other memo area in the folder so that the contents always remain the same where edits to one automatically carry through to the other.

These assessments and the assessment folders are set up for the agency in file **CLTASM.DFT**. Specifics pertaining to the contents and construction of this file are found in the Administrator's Guide.

---

## Functional Assessment

The Functional Assessment is another type of client assessment, outlining the specific problem areas for the focus of treatment for a client. This is created and maintained in **B-10**, but can be referenced within the other clinical components, most notably, treatment plans.

There are five parts to a functional assessment.

1. **Header** – This contains some basic information such as the initiation date and name of the staff person.
2. **Problem areas** – Up to 30 problem areas can be focused on for any particular program type. These problem areas cover the broad range of issues that this program type generally encounters. This list is defined using the treatment areas from table **TXAREA** in the setup file **B10-ORG.DAT**.
3. **Memo** – There are 2 general memo files for which default templates can be defined in files **B10-MEMO1.ARE** and **B10-MEMO2.ARE**.
4. **Diagnosis** – This screen will show the client's full DSM V multi-axis diagnosis.
5. **Finished** – The assessment can be signed off on by the staff person.

These areas are presented as a prompt line at the bottom of the screen upon entering any of the problem assessment options. Typing the corresponding initial and pressing **<enter>** will take the user to that part of the assessment for creation, editing or viewing, depending on the option selected.

### Set Up for Functional Assessments

The **B-10** setup file (**B10-ORG.DAT**) determines the list of problem areas presented for editing within the assessment for a specific client program. The description of these areas comes from table **TXAREA**.

There are two possible set-ups for any organization type. The first is more traditional, where goals and objectives are linked to areas and problems. This set-up is designated with a "G" at the end line for that organization type in the set-up file and within the corresponding tables. The other is where goals only are linked to problems only, and is designated by an "O" at the end of the line for that organization type in the set-up file and within the corresponding tables.

### Creating a Functional Assessment

Upon entering the **B-10 CR** menu and choosing a client and program for which to create the assessment, the screen below is shown. The user can edit any of the five parts of the functional assessment.

```

IMA Mental Health - Development Area Option:610-CR
Functional assessment

Client: 2667 Tiger, Tony          Program:AT/ 1
Initiated-03251998              by GB - Georgeanne Biancarosa

Problem Area      Rating  Problem  Goals for 90
I Anger Management      1      3      3
J Mania or Hypomania    1      0      0
K Depression             0      3      3
L Paranoid ideation     1      0      0

```

**Ratings, Problems and Goals for B-9**  
from editing Problem areas.

List of problem areas (from table **TXAREA**) pre-filled from areas linked to treatment problems associated with client program enrollment.

Change H(eaders), P(robblem areas), M(emos), D(iagnosis), F(inished)?  
1 Men ext req

Prompt line for selecting the area of the problem assessment to go to.

The Functional Assessment creation screen in B-10 CR.

```

IMA Mental Health - Development Area Option:610-CR
Functional assessment

Client: 2667 Tiger, Tony          Program:AT/ 1
Problem area:I Anger Management

```

Rating	Code	Problem
1	I 1	Explosive outburst
2	I 1	Overreaction to small irr
3	I 1	Challenge authority

Code indicating treatment rating, low, moderate, severe, etc. from table **TXRATE**.

Code describing treatment action: initial for **B-9**, monitor, etc. from table **TXACT**.

Overall rating: Rating:1

Problem area COMMENTS:  
Ct. requires extensive work on anger management and accepting authority. Ct. will participate in insight oriented individual counseling.

Comments on problem area.

Problem descriptors from table **TXPROB** for specified problem area.

Describing a Problem Area from the previous screen.

```

IMA Mental Health - Development Area Option:610-CR
Functional assessment

Client: 2667 Tiger, Tony          Program:AT/ 1

```

ASSETS: Ct. is skilled verbally and financially stable. Ct. has supportive family and home environment. Ct. is likeable and able to establish rapport with staff. Ct. hopeful about treatment and already engaged by process.

Deficits: Ct. has mood swings and anger outbursts, indicating poor impulse control and probable affective disorder. Ct. has limited coping skills and feels entitled to speak his thoughts, no matter the circumstance.

78 x 40 Men ext scn bpg fpg bck fwd del

One of two agency-defined memo boxes for the functional assessment.

The functional assessment can also be used to help create a treatment plan for this client in this program. The first code requested in the problem area description, which comes from table **TXACT**, can select this problem to become associated to a treatment goal on the treatment plan. Items selected and rated for this are shown on the initial summary page of the problem assessment in a dedicated column, as shown above.

## Editing Functional Assessments

When an area is chosen for editing, up to ten problems associated with the area can be added. Once the problems have been added, a specific action code is assigned to each of these problems. These actions are defined in table **TXACT**. This action code controls whether or not the problem will be associated with a treatment plan goal or objective. The user must also assign a rating to each problem. Rating codes are defined in table **TXRATE** and can be changed as the client progresses in treatment. Once each specific problem has been rated, a more general rating is assigned to each area. The rating ranges from 0-5. Default memos can be setup for each of these five ratings, which can be further edited and individualized per client.

---

## Treatment Plans

Treatment plans contain important clinical information about each client and serve as a guide for the course of treatment for a client. Treatment plans are created and maintained in the **B-9** menu option. There are four basic parts to a treatment plan.

1. **Header** – The header contains information such as staff member and team assignments, treatment plan issue date, and ratings for treatment progress.
2. **Goal** – The goal is constructed to coincide with the three-step process of approaching a client's clinical treatment.
  - a) Specific long-term *goals* are determined with the client as a focus for clinical treatment. These goals will reflect the client's desired treatment outcomes.
  - b) *Objectives* are then selected for the client to accomplish in order to bring him to a larger goal. These objectives should be flexible, measurable and attainable throughout the course of treatment. These objectives will also be the yardstick for measuring treatment success at the conclusion of treatment.
  - c) Finally, precise *methods* or interventions by which to accomplish the different objectives are determined. Each single objective can have a group of methods associated with it.
3. **Diagnosis** - contains the DSM-IV diagnosis data on all five axes.
4. **Memo** - A series of agency-defined memo boxes are presented where free form text can be entered.

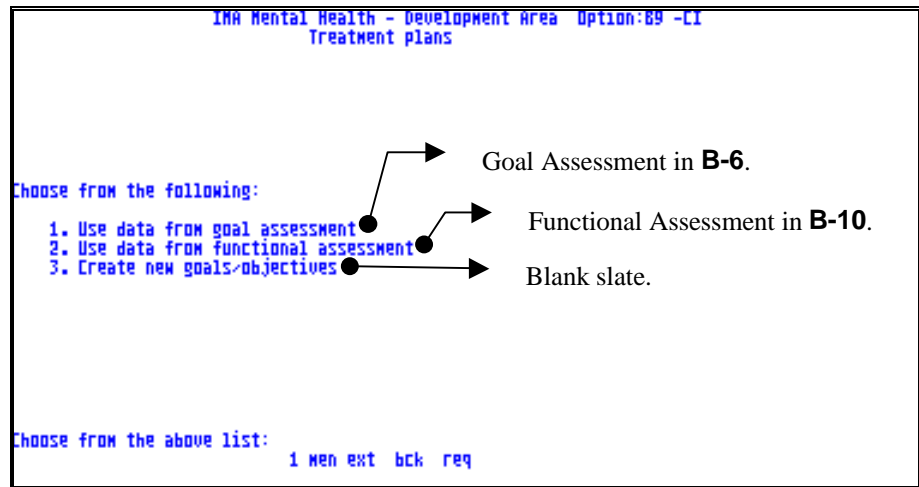
## Creating a Treatment Plan

**B-9 CI** is where an initial treatment plan is created. Once a client and program are chosen, the system checks if the client has any previous plans or assessments. If so, the next prompt addresses the way in which the goals of the treatment plan will be constructed. These options include:

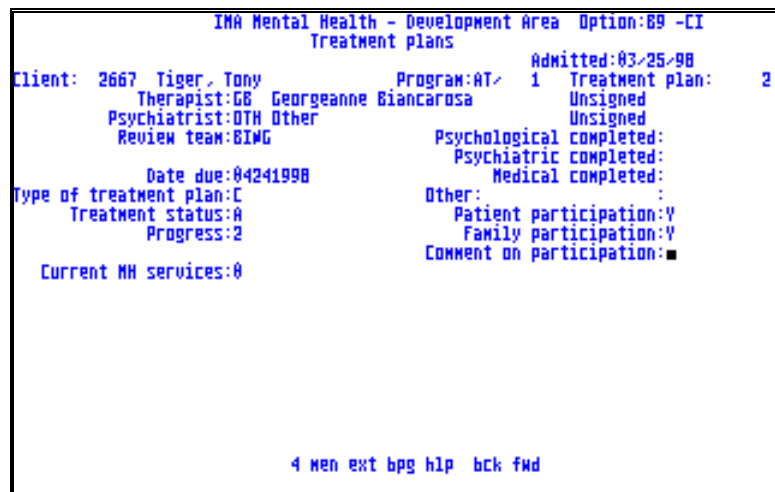
- Use the data from the goal assessment outline as created in option **B-6**.
- Use data from the problem list in the Treatment Formulation Summary in option **B-10**.
- Create new goals/objectives.

Choose an option by typing the corresponding number and pressing <enter>. The header screen will then be shown. There are some required fields that address the status of the plan and patient/family participation in the therapy.

**Note:** If neither the goal assessment or problem assessment have been completed, a selection screen will not appear and the system will go directly into the plan header.



The selection screen for options on levels of system assistance in creating a client treatment plan for B-9 CI.



The Treatment Plan Header Screen at B-9 CI.

After the header information is completed, the goal summary section is presented. Goals from the goal assessment or the problem assessment will be automatically listed if one of those options was selected. If not, a blank goal summary is presented.

```

      IMA Mental Health - Development Area  Option:89 -CI
      Treatment plans
Client: 2667 Tiger, Tony      Program:AT/ 1 Treatment plan: 2
      Therapist:GB Georgeanne Biancarosa      Unsigned      Page 2
      Admitted:03/25/98
# Goal          Code Status Date Staff
1 Employment    U01  0  03/26/98 GB
2 Increase Coping Skills:  --  0  03/26/98 GB
3 Increase pro-social interactio  --  2  03/26/98 GB
4 Reduce depression 00      0  03/26/98 GB
# Goal          Code Status Date Staff

<return> for detail. E to edit U01. A to add. <del> to delete:
      1 Men ext bpg fpg bck fwd del

```

Summary Goal Screen for B-9 CI.

For all of those options new goals can be added. Goals can also be edited or deleted. A new goal is added by typing <A> and pressing <enter>. This will cause a special goal window to pop open. Goals are then entered either by pressing <hlp> and selecting a specific goal or selecting **code --** for a free form entry. A goal status is then entered, reflecting the level or treatment phase of the problem. These treatment statuses are defined in table **TXSTAT**. A comment box is then available for entering any additional details that pertain to this goal. For free form goals, the first thirty characters become the goal statement. Once a goal is added to the plan it can be further edited by typing <E> and pressing <enter>. This will allow any of the goal description mentioned fields to be changed, including the comment box.

```

      IMA Mental Health - Development Area  Option:89 -CI
      Treatment plans
Client: 2667 Tiger, Tony      Program:AT/ 1 Treatment plan: 2
      Therapist:GB Georgeanne Biancarosa      Unsigned      Page 2
      Admitted:03/25/98
# Goal          Code Status Date Staff
1 Employment    U01  2  03/26/98 GB
-- Increase coping skills:      0  03261998 GB
Comments
Increase coping skills:
to withstand annoyances and handle daily routine.
Drop down Goal window within
previous Goal Summary screen.
60 x 24 Men ext scn bck fwd del
# Goal          Status Date Staff
Comments for free form Goal entry.

```

The Goal detail screen in B-9 CI for adding a free form goal.

An objective or method can be added by highlighting the corresponding goal and pressing <enter> within the summary screen. This will present the detail screen for the selected goal. Type <A> and press <enter> and then enter the corresponding code for either **Objective** or **Method/Intervention**. Select the desired objective or method from <hlp> or choose **code --** to enter free form, as with adding goals. Status will also be



```

IMA Mental Health - Development Area Option:89 -CN
Treatment plans
Client: 2667 Tiger, Tony Admitted:03/25/98
Therapist:GG Georgeanne Biancarosa Program:AT/ 1 Treatment plan: 2
Unsigned Page 2

Goal -- Increase coping skills:
Objective -- Explore cognitive messages tha

Method Status Stat Date Target Start Staff
-- Keep journal of daily events t 0 03261998 07231998 03261998 GG

Comments
Keep journal of daily events that cause outbursts:
Monitor event precursors, ct. actions and responses to ct.
from others.

3 men ext scn hlp bck fwd req
Method Status Status Target Start Staff
Date Date Date
Comments for free form Method.

```

The Method/Intervention detail screen in B-9 CI.

The diagnosis screen contains the DSM-IV diagnosis data on all five axes.

```

IMA Mental Health - Development Area Option:89 -CI
Treatment plans
Client: 2667 Tiger, Tony Admitted:03/25/98
Therapist:GG Georgeanne Biancarosa Program:AT/ 1 Treatment plan: 2
Primary diagnosis:099.28 Adj.D-D w/Mixed Emot. Unsigned Page 4

Axis DSM-IV Spec Description Specifier
I:309.28 Adj.D-D w/Mixed Emot.
:301.13 R-D Cyclothymia Rule Out
II:071.09 No diagnosis
III:None None
IV:3 Moderate Prob:02 06
V:2
High:05

7 men ext scn bpg fpg hlp bck fwd del
Axis DSM IV Code Spec Code Description of code Specifier Detail

```

The Diagnosis screen of the treatment plan.

Next, agency defined memo boxes are presented for additional information as defined in the treatment plan setup file for the program type. The actual size and default texts for each of these memo boxes are also defined in the treatment plan setup file.

If the client program is setup as a skills-rating program in file **B9-SKILLS.DAT**, there will be an additional option to view the client's skill ratings.

Finally, there are two sign-off functions available in treatment plans, one for the therapist and another for the psychiatrist. In residential programs, the second sign-off is assigned to the supervisor instead of the psychiatrist. The system will recognize when the therapist

and psychiatrist is the same person and allow for a single sign-off. Signing-off on a plan will close any pending ticklers related to this treatment plan. Data archiving is available for signed-off plans.

## Other Options

- **CR** - After the initial treatment plan is created there is a special option to create a treatment plan review. This creates a new plan using the data from the last plan for the client within the designated program.
- **CH, SH** and **DE** are for editing, showing and deleting the plan, respectively.
- **RE** - This will move a client's treatment plan to or from one program to another.
- **CP** - This will copy one client's treatment plan to another client for the program specified.
- **RV** - This option is to be for revising a signed-off plan prior to issuing a new plan review.

## Hard Copy & Viewing

- **PR** - This will produce a printout of the treatment plan. Some of these printouts are shown below.
- **PS** - This will create a printout of the problems/functional skills survey ratings from the **B-10** problem assessment attached to the treatment plan.
- **DS** - This will display on the screen all clients and their treatment plans according to status, date and the staff member who created the plan.
- **LS** - A printout of the above **DS** listing.
- **VS** - This provides an option to view or print signed-off treatment plans. This is available only if treatment plan archiving is turned on. Under this option, the treatment plan as last edited is saved in a new document database when the treatment plan is signed off. When this is activated, the **LS** option can no longer be used to view or print signed-off items. These can only be reprinted from the archived documents using **B-9 VS**.

## Sample Treatment Plan Printouts

**Patient:** Phillip Banks 5000 **Sex:** M **D.O.B.:** 03/05/49

**Primary Therapist:** Michael Samel **Prepared by:**

### ASSESSMENT DATES

Psychosocial: 11/01/1995	1. Mike Samel
Psychiatric: 11/02/1995	2. Barry Samel
Medical: 11/02/1995	3. Denis P. Quinn

### DIAGNOSTIC INFORMATION:

I : 290.00 Senile Dementia  
: 291.00 Alcohol withdrwl delirium  
: 292.00 Withdrawal  
II : 296.36 MajDepres,Recur,FulRe  
III : 0090 Gastroenteritis  
IV : Separation Loss of job  
: Phase of Life Cycle Arrested  
V : Current GAF:10 Highest GAF past year:

Primary diagnosis: 290.00 Senile Dementia

### Memo Boxes:

#### TREATMENT

Expectations include:

Regular attendance and participation in education and group sessions

Confidentiality (what happens in group stays among group members)

Completion of self-report assignments as instructed by counselor

Relate family of origin/relationship story to group

Invite significant others to participate in treatment

Complete a relapse prevention assignment

Physical examination, if not yet completed, or follow through with physician's care

Individual and family sessions will be scheduled in addition to group session

#### CRITERIA

The criteria for discharge of this client is a total cure on at least 75% of the diagnosed problems.

### ALERT INDICATORS

Suicide attempt: 3	Med. compliance: 3	Support system: 1
Suicide ideation: 1	MH service compliance: 3	Substance abuse: 1
Aggressive behavior: 1	Emergency sys use: 2	Runaway behavior: 0
Basic non-MH use: 1	Placement/Hospital: 1	Abuse/neglect issues: 5

Alerts are rated from 1 to 5 (1 being none and 5 severe)

**Goal A:**

IMPROVE COGNITIVE FUNCTIONING

Status:A

Staff:MS

Patient will improve to a level where he is able to maintain employment for a period of 2 months and will not demonstrate symptoms of psychotic thought processes for 1 year.

**Objective 1:**

DECREASE DELUSIONAL THINKING

Target: 12/12/95

Staff:MS

Status:A

Patient will not demonstrate delusional thinking during group and social activities for a period of one month.

**Method/Task 1:**

PRESCRIBE ANTIPSYCHOTIC

11/12/95 - 12/12/95

Staff:MS

Status: A

Psychiatrist will prescribe and monitor anti-psychotic medication per team psychiatrist.

**Objective 2:**

TOLERATE STRUCTURED ACTIVITY

Target: 12/12/95

Staff:MS

Status: A

Patient will demonstrate the ability to tolerate structured daily activity as evidenced by successful completion of the occupational training program.

**Method/Task 1:**

REFER TO TRAINING RESOURCE

11/12/95 - 12/12/95

Staff:MS

Staff will refer patient to training resource and provide support to help patient negotiate transition.

**Goal B:**

INCREASE COPING SKILLS

Status: A

Staff: MS

Develop skills to manage anxiety as evidenced by discontinuing unnecessary emergency room visits within 2 months.

**Objective 1:**

ALTERNATIVE COPING METHOD

Target: 01/12/96

Staff:MS

Status: A

Identify 2 appropriate alternative methods of coping which result in significant decrease of anxiety level as reported by patient within two months.

**Method/Task 1:**

MEET WEEKLY

11/12/95 - 01/12/96

Staff: MS

Status: A

Therapist will meet with client once weekly for half-hour.

**Objective 2:**

INC. SOCIAL SUPPORT NETWORK

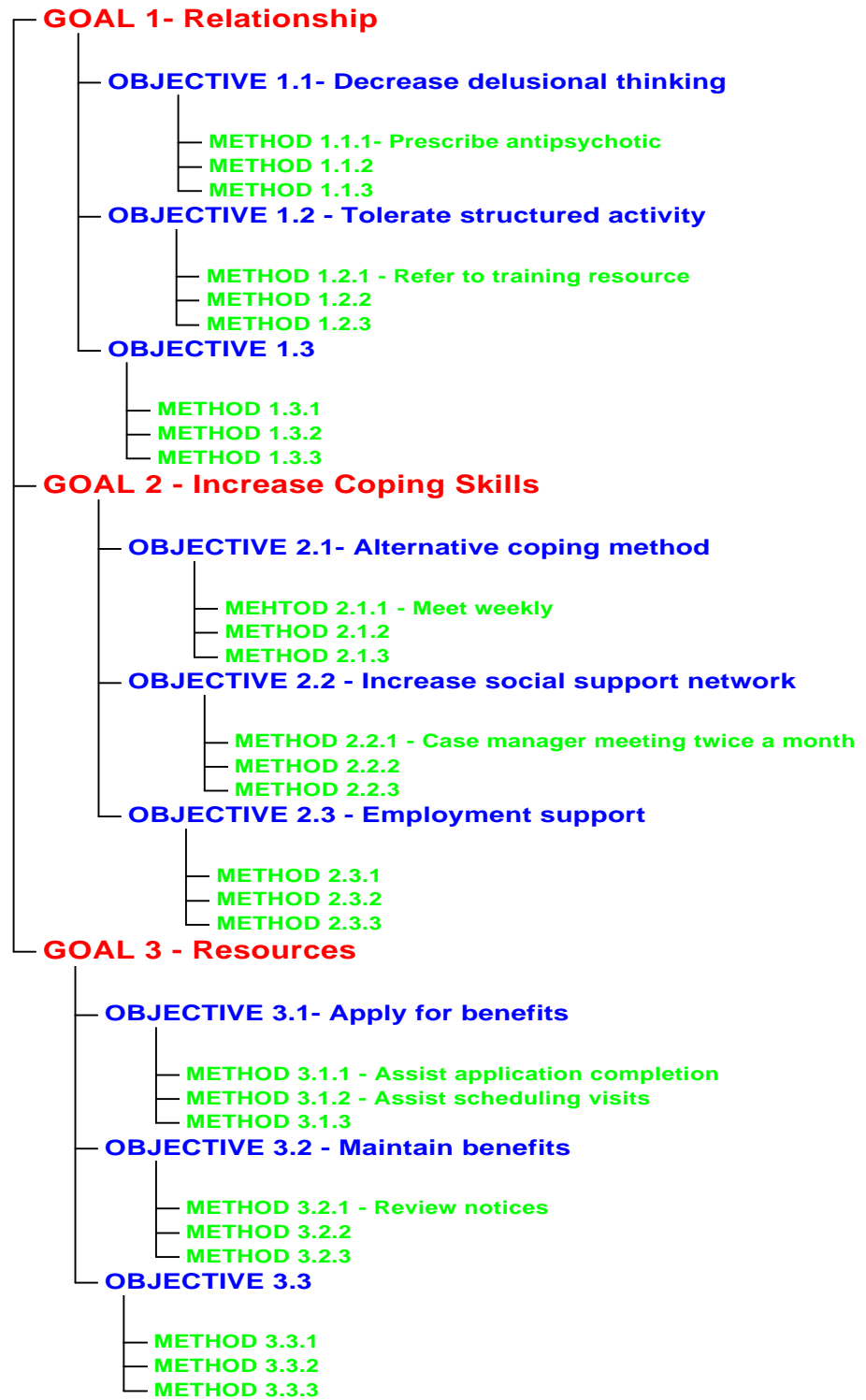
Target: 01/12/96

Staff: MS

Status: A

Identify and connect with individuals that support healthy lifestyle and pro-social activities within two months. Include support group participation.

# The Hierarchy



---

# Progress Notes

Progress Note maintenance is divided into four menu options.

- **B-1** is where the progress note is originally prepared. There are also options for changing, displaying and printing notes as well.

---

**Note:** Changes can only be made for progress notes that have not yet been signed off on.

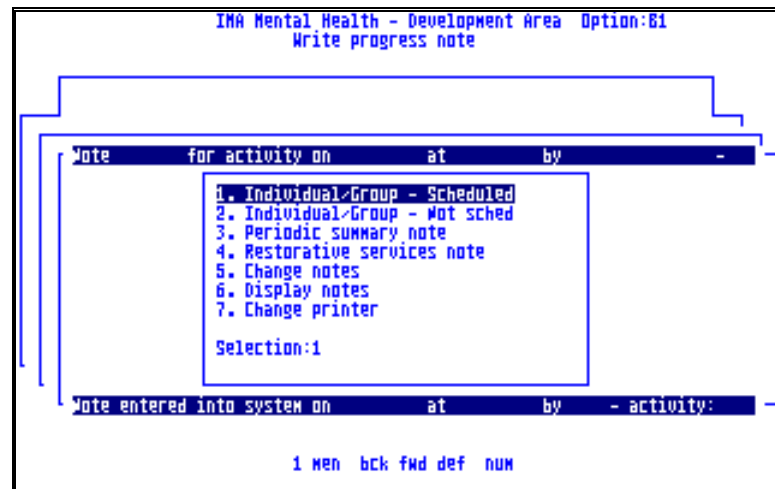
---

- **B-2** permits existing progress notes to be reviewed by client. This option is useful for providing 'read only' access to select users.
- **B-3** is used to print the progress notes. Selection for an individual client or range of clients can be made. The printout can be of the actual text of the note or an index to the note.
- **B-11** is used to edit the header fields of a progress note, such as activity code, date and time. Access should be restricted for use of this option.

General comments relating to the writing of progress notes can be found at the end of this section.

## Write Progress Note

The **B-1** sub-menu presents options for the management of progress notes. These options include writing, changing, displaying or routing progress notes to a different printer. Notes for individual and group sessions can be generated for scheduled events or not scheduled. Additionally, periodic summary notes and restorative services notes can be generated. Based on this selection, a specific screen unique to the specified note type will be displayed.



*The Progress Note Type selection screen.*

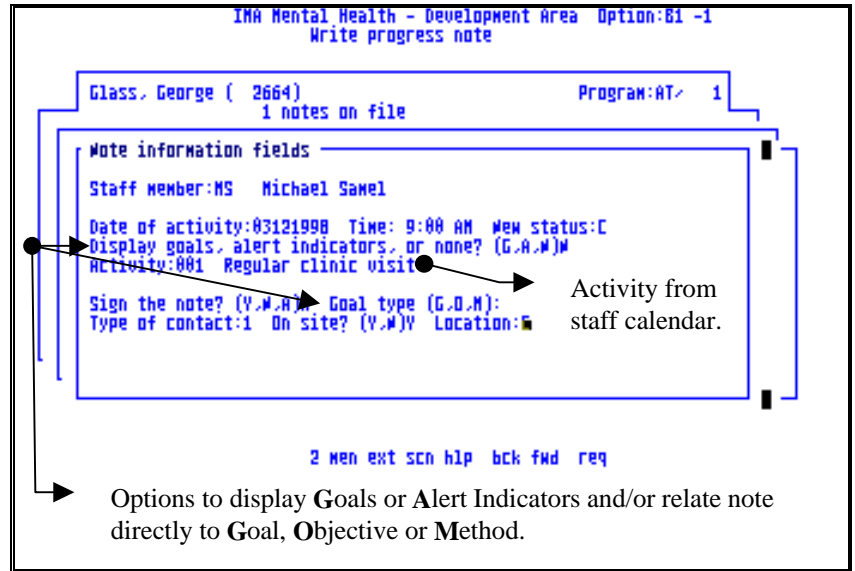
### **Individual/Group - Scheduled**

This note type is used for client sessions that have been scheduled on the staff calendar. After the date and staff members are specified, all the visits on the staff schedule for that staff and day are shown. When a visit is selected, the system will mark the visit in the

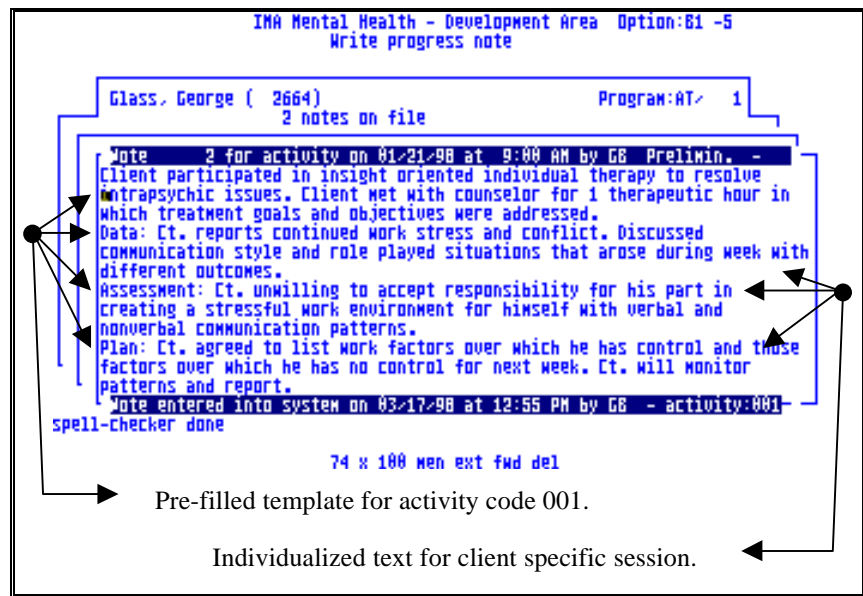
schedule as complete. The two visit types that can be chosen for this option are individual and group.

1. In the case of individual client visits, a box will display the client's programs. This is necessary because clients can be enrolled in multiple programs simultaneously and can have different sets of notes for each program.

Next, the data that is required for this note, is presented in a single screen. If the pre-filled data items from the staff schedule on this screen are correct, they can be accepted by pressing <scn> and the user can proceed directly to the text of the note. A memo box will open in which a pre-filled template is inserted based on the activity type. This memo can be edited and individualized for the specific issues related to each individual session.



The data fields for an individual appointment note.



The memo box for an individual note.

- For a group visit, a box will show the members of the group. The actual group can be changed by either deleting clients who were no shows for this particular session or by adding clients that participated but are not members of the group. These are only temporary adjustments and will not effect the group definition.

The user then has the option of writing individual or batch memos. In the case of batch memos, the user writes one single text that is posted in each group member's file. For individual notes the user begins by writing general text and cutting it to the clipboard by pressing <Pst/Cut> and then <Esc>. The system then pastes this text into each client's note. The user is then presented each client's note one at a time and given the opportunity of adding additional text specific to each individual client for this group visit.

The next prompt refers to client programs. When a note is written for a group with its members enrolled in different programs, the program field should be left blank, by pressing <enter> and the system will file the note in the first active program of each client. Administrative control file **CHKPRG.DAT** contains information for activity code switching needed depending on the program type.

Next, the data that is required for this note, is presented in a single screen. If the pre-filled data items from the staff schedule on this screen are correct, they can be accepted by pressing <scn> and the user can proceed directly to the text of the note. A memo box will open in which a pre-fill is inserted based on the group activity type. This memo can be edited and individualized for group specific information.

```
INA Mental Health - Development Area Option: E1 -2
Write progress note

Group: Adult Chem Abuse Prg (ACAP)

Note information fields
Staff member: GB  Georgeanne Biancarosa
Date of activity: 03161998 Time: 11:00 AM
Activity: 002 Group visit
Sign the note? (Y,N,A)A Goal type (G,D,N):
Type of contact: 1 On site? (Y,N)Y Location: 5

2 men ext scn hlp bck fwd req
```

*The data fields for the group note.*

```

IMA Mental Health - Development Area Option:61 -2
Write progress note

Enter text for common group note for ACAP session
When finished do a CUT (file out to clipboard) and Esc

Note for activity on 03/16/98 at 11:00 AM by GB -
[This group is a therapeutic group designed to address intrapsychic and
interpersonal issues with members.

Group Goal:Relate patterns of emotional responses and risk factors for
using alcohol and recognize these patterns prior to relapse events.

Assessment:Members took comfort in shared experiences of isolation,
despair and hopelessness. Members at initial phase of trust in group
building. More trust needed for safe confrontation on blame assignment.

Plan:Continue to promote group development through stages. Permit members
to grow through conflict and confrontation with one another.
Note entered into system on 03/23/98 at 12:02 PM by GB - activity:002

Print this note? (Y,N)          1 men ext rpg
  
```

Template pre-fill for activity code 002.

Common group text for individual group notes.

*Individual memo for group note.*

```

IMA Mental Health - Development Area Option:61 -2
Write progress note

Enter text specific to this client within group ACAP
Client 2651 - Test Client

Note for activity on 03/16/98 at 11:00 AM by GB -
Ct. shared how his patterns of use usually coincided with patterns of
increasing stress at work and pressure from his spouse. Ct. shared that
his response was then to use and become increasingly verbally and
physically abusive.

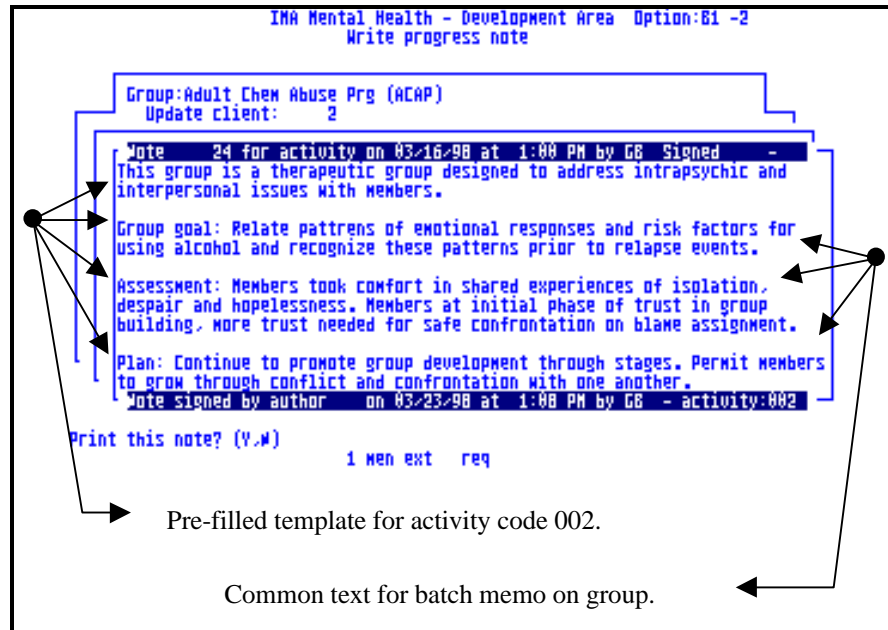
Ct. showed little insight into his responsibility in the use of alcohol or
the abuse of his spouse. He was aware only of external control factors
for which he was not responsible. ■

Note entered into system on 03/23/98 at 12:02 PM by GB - activity:002

74 x 100 men ext bck fwd del
  
```

Individual memo attached to pre-filled group template for individual group notes.

*The specific individual client note attached to a common group note.*



*A batch group note.*

Progress notes are linked to the staff schedule in two ways. Progress notes are typed based on activity code and the status of the appointment in the calendar. The activity code is an important indicator, because it is linked to client billing and reporting indices, in addition to the coded pre-filled template. As a result, it is very important that the activity code match the service provided. Additionally, the completion of a note can cause the status of an activity to Close, if the agency selects this option.

Events such as no-shows and cancellations can also be assigned an activity code and linked to a pre-filled memo text, based on standard agency operating procedures for those event types. This text would document that those procedures were initiated and would be useful in utilizing a batch memo for those events.

### ***Individual/Group – Not Scheduled***

This is to be used when writing a note for an unscheduled visit. The entire process is the same as above except that the date and the fields specifying the client, program and visit information are not pre-filled on the data screen and must be entered by the user.

### ***Periodic Summary Note***

This is used for doing the weekly or biweekly staff notes on a day treatment program or other group activities for a specified time period. The template type to attach to the end of a client note is designated as one of three types. The three types available are activity, treatment plan and events. Activity type provides a list of staff activities for this client. Treatment plan type provides an outline of the goals in the current plan. The events type provides a list of events from the event log posted in **B-8**.

The system searches the database, retrieves all the appropriate template type items that this client participated in within this period and attaches the listing to the text of the note. The clinician can then edit the text of the note as necessary.

```

IMA Mental Health - Development Area Option:81 -3
Write progress note

Note information fields
Staff Member:GB Georgeanne Biancarosa
Template type (A,T,E):A Period covered:11031997 to 11071997
Date of note:11101997 Time: 1:31 PM
Display goals, alert indicators, or none? (G,A,W)W
Activity:002 Group visit

Sign the note? (Y,N,A)A Goal type (G,D,M):
Type of contact:1 On site? (Y,N)Y Location:03

Answer must be A(ctivities), T(x plan), or E(vents)

1 men ext scn hlp bck fwd def req

```

The data fields for the periodic summary note.

```

IMA Mental Health - Development Area Option:81 -3
Write progress note

Ticklerbergerman, Testirolahan ( 2566) Program:AA/ 1
5 notes on file

Note 5 for activity on 11-10-97 at 2:25 PM by GB Signed -
Ct. participated in the following activities this week. These individual
sessions focused on controlling impulses and improving the quality of
social interactions with peers and family members. Ct. has made marked
imprpovement with decreasing negative verbalizations to others and will
continue to work toward goals in this format.

Services provided as follows:
11-03-97 001 - Regular clinic visit 1:00 hours
11-04-97 001 - Regular clinic visit 1:00 hours
11-05-97 001 - Regular clinic visit 1:00 hours
11-06-97 001 - Regular clinic visit 1:00 hours

Note signed by author on 03-23-98 at 2:37 PM by GB - activity:002

Print this note? (Y,N)N
1 men ext req

```

An activity template attachment to a periodic summary note.

```

IMA Mental Health - Development Area Option:81 -3
Write progress note

Test , Client ( 3000) Program:AT/ 1
31 notes on file

Note for activity on 09-27-97 at 2:30 PM by GB -
Ct. has completed orientation goals and is working on increasing positive
social interactions and positive peer relations, while decreasing
aggressive outbursts. Ct. has maintained consistent behavior, requiring
support and prompts from staff at least twice per hour.

Tx plan as follows:
A. Orient Living Area 1.1 A MS
B. ADL Behavior 001 A MS
C. ADL Behavior 001 A MS
D. Aggressive Behavior 001 A MS

Note signed by author on 03-23-98 at 2:30 PM by GB - activity:002

74 x 100 men ext bck fwd del

```

A treatment plan template attachment to a periodic summary note.

```

IMA Mental Health - Development Area Option:81 -3
Write progress note

Chaimson - PI, Mike ( 3) Program:RS/ 1
      8 notes on file

Note for activity on 09/18/97 at 2:47 PM by GB -
Ct. has had difficult period. The motor vehicle accident precipitated a
fishback which resulted in psychiatric hospitalization for three days.
Meds were changed as a result. Upon reentry, Ct. had outburst of verbal
aggression toward resident. During final hours of loss of privileges, Ct.
engaged in attention seeking self abusive behavior, resulting in more
sanctions and 1:1 supervision until med stabilization and functional
improvement.
Events as follows:
09/10/97 RS CM MV Motor vehicle accident JSM
09/10/97 RS CM PS Psychiatric hospitalization JSM
09/14/97 RS CM PS Verbal abuse of residents JSM
09/15/97 RS CM PS Cut finger with kitchen knife JSM
Note signed by author on 03/23/98 at 2:47 PM by GB - activity:011
74 x 100 wren ext bck fwd del

```

An event template attachment to a periodic summary note.

### Restorative Services Note

Upon selecting the restorative services note, the system prompts for a residential program to be selected. The system then displays all the clients currently enrolled in the designated residential program so one client can be selected for the note. When a client is chosen, the header screen is displayed. As the user passes through the data screen, the residential services completed to date for the current month are displayed in a window. The user can then proceed through the note as above.

```

IMA Mental Health - Development Area Option:81 -4
Write progress note

Clients of program Residential ICL
Client # Name # srvc Date of last srvc
37 Simmons, Darryl 3 03/04/1998
175 Gregoire, Ian 0
239 Clark, Dennis 1 03/04/1998
2566 Ticklerbergerman, Testirolahan 0

Client # &Name # of Date of
Services Last Srvc

Type <return> to exit, <bck>,<fwd> to select
1 wren ext bck fwd

```

A listing of clients enrolled in the residential program.

```

IMA Mental Health - Development Area Option:61 -4
Write progress note

Samuelson, Jeannette ( 103)          Program:AA/ 2
26 notes on file

Note information fields
Residential services completed
Service                                Type  Date
ASA - Assertiveness/Self advocacy Tr   1    03/04/98
Date of                                1    03/04/98
Display HS - Health services           1    03/04/98
Activit MM - Medication Management     1    03/04/98
+ 1 others
Sign th 4 of type 1 services
Type of are required this month. The above have been
        completed to date.

Type <return> when done with the display
        1 Men ext bck fwd

```

The residential services completed are displayed.

```

IMA Mental Health - Development Area Option:61 -4
Write progress note

Samuelson, Jeannette ( 103)          Program:AA/ 2
27 notes on file

Note 27 for activity on 03/23/98 at 3:38 PM by GG Signed -
Pt. participated in activities as listed for today. ASA, DLS, HS and MM
were Completed with little support from staff. Some prompting was
required by staff for reporting medication side effects. Additionally,
motivation was minimal during DLS.

Staff will monitor med changes and support pro-social activities.

Note signed by author on 03/23/98 at 3:48 PM by GG - activity:002

Print this note? (Y.N)
        1 Men ext req

```

The restorative services note for the residential services completed.

## General Comments Relating to Notes

- Progress Notes can only be written for appointments/activities that have a status of Scheduled, In, Rescheduled, No Show and Cancelled (U). Appointments/activities that have a status of Completed/closed will not permit that a note be written in coordination with schedule. Note may be written through Individual/Group Not Scheduled in **B-1**.
- Before the text of the note is written the user has the option to view the goals of the treatment plan or to see and change the client's alert indicators.
- The individual or group progress note can be associated with a specific goal, objective or method of the client's treatment plan.
- The memo area of the note can be blank or it can be set to pre-fill with a template associated with an activity code or program type. These pre-filled templates are written in **H-12 NT**.

This memo box is presented in word processing mode and can obtain up to 100 lines. All the features of the text editor, such as spell check and reformatting, are available. When the body of the note is completed it is exited and saved by pressing the <Esc> key. These memos are automatically imported based on the activity code selected. The notes are then editable by the user within the progress note option screens.

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

File /u/mh/dev/sco/notemplate/ACW001.CMD
Client participated in insight oriented individual therapy to resolve and
explore intrapsychic issues. Client met with counselor for 1 therapeutic
hour in which treatment goals and objectives were addressed.

Data:
Assessment:
Plan:

120 x 1000 mem ext
```

The default memo for activity code 001: individual session.

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

File /u/mh/dev/sco/notemplate/ACW002.CMD
Group is a therapeutic group designed to address intrapsychic
and interpersonal issues with members.

Group goal:
Assessment:
Plan:

120 x 1000 mem ext
```

The default memo for code 002: group session.

- To document a group activity in which not all members were present, select the group and delete the actual group participants. This will leave a list of the group members who did not participate in this session. At the '**Activity:**' prompt, enter the designated no show or cancellation code. This will enter this activity in the client's record and keep the event open. Once that is completed, go back to this same group and delete the members who were not present. This will leave the group participants for which individual or batch notes may be entered for this activity described previously.

---

**Note:** If the participation note is written first, the event will be closed and the no show or cancellation notes will have to be done individually without the schedule.

---

- Upon completion of the note, it may be signed off, which means that it is sealed and is available only for viewing, but not changing. Staff members, who are unauthorized to sign-off on notes, will not be presented with the option of doing so. The note can also be left unsigned. This is useful if a supervisor must first review it. In this case, the initials of the author of the note will not be changed, but the supervisor will be designated as closing the note by day and time. An additional security feature is available where the system will close all notes left in unsigned for more than 24 hours.
- A hard copy of the progress note can be printed immediately or batch printed at another time.
- Progress notes can also be periodically archived in menu option **H-46 CN**. Archiving is advantageous because it cuts down on processing time. Once a note has been archived it is available for review in option **H-15**.

---

## Event Log

**B-8** is a module for recording, monitoring and tracking significant events related to a client. Some typical events include reportable incidents, client movements out of the residence, psychiatric or medical diversions/interventions and social interactions. These event types are defined in table **REFMVM**. Specific events can also be setup with automatic notification of designated supervisory staff through e-mail features. This is controlled by file **B8-EMAIL.INI**.

```

IMA Mental Health - Development Area  Option:88
Event log

LE - log an event
PS - post a shift note
CH - change an event
SH - show an event on the screen
SS - show a shift note
DE - delete an event

PR - print a report of the event log
DS - display a list of the events
LS - print a list of the events
PE - print a single event

Option:■                               2 men

```

*The Event Log Sub-menu at B-8.*

Each event consists of a starting event, as defined in table **REFSCD**, and an event type that is a link to **REFMVM**. Events can be set to automatically close and have a change status designated or left blank. Ending events come from table **REFECD** and can have event types that are linked to **REFMVM**.

Additional information included relating to the event are referring provider, referring services and an event comment. This comment can be an editable pre-fill template based on the specific event or a free form memo.

```

IMA Mental Health - Development Area Option:BB -LE
Event log
Client: 3000 Test          . Client Program:AT/ 1
Logged:
  Staff:GB   Georgeanne Biancarosa
  Type of event:CE      Event:F
  Date:03271998        Time: 3:19 PM
Services provider:IN      Services:I F

Event comments
Who responded:local EMS
Other people involved:no other clients, site supervisor and PD
Any injuries:unknown at this time
Property damage:none

70 x 200 men ext scn bck fwd

```

The event information screen at B-8 LE.

Event printouts or displays are available in the event log at **B- 8 PR, DS** and **PE** for a number of selection criteria including event type, client, disposition and date range, among others. B-8 PR is an ad-hoc report of the event database and has event detail on numerous factors.

```

IMA Mental Health - Development Area Option:BB -PR
Event log

Event date range - start:first   end:last
Disposition date range - start:first   end:last

Type of event:all
Provider:all
Event:all
Program:all
Source: Medicare?Y Medicaid?Y 3rd party?Y Company:all
      No coverage:Y
Client range - start:first   end:last
Log/disposition staff:L Staff member:all
Include open, completed, or both? (0,C,B)B

Sort criteria:
Program:1 Provider:2 Type of event:3 Client:4
Dates:5 Event-disposition:E Insurance plan:6

Use <def> for first date

8 men ext scn fpg fwd def req

```

The B-8 PR selection screen for a detailed report on the Event Log.

```

IMA Mental Health - Development Area Option:BB -DS
Event log

Logged                                     Disposition
Client Pgm Ev # Staff Date Event          Status Staff Date
1 AA      1 MS  11-03-97 MV Motor vehicle accid
160 RS    1 JSM 11-14-97 MV Motor vehicle accid
160 RS    2 JSM 11-14-97 ER Emergency room visi CLOSED JSM 11-14-97
160 RS    3 JSM 11-14-97 ER Emergency room visi CLOSED JSM 11-14-97
160 RS    4 JSM 11-14-97 ER Emergency room visi CLOSED JSM 11-14-97
STAFF     1 DSF 11-10-97 SM Shift note

Ct. Pgm Ev # Staff Date Event          Status Staff Date

D to display, <bck>,<fwd> to select, <return> to continue, C for criteria:
1 men ext bck fwd

```

A list of events for a specified time period in B-8 DS.

**B-8 PS** is a staff communication entry to quickly post a shift note. The events comments memo box can automatically pre-fill with enrollees of the designated residential program. Those present can be indicated with an [X] and a general note can be written with information pertaining to any unusual events or noted pre-cursors to possible events on a later shift.

```

IMA Mental Health - Development Area Option:BB -PS
Event log

Client:STAFF MEMBER, STAFF          Program:AT/ 1
Logged:
  Staff:GB Georgeanne Biancarosa
  Type of event:COM Event:SM
  Date:03271998 Time: 3:31 PM
Services provider: Services:

Event comments
All clients attended designated group activities. Ct. 3000 passed out
after physicia activity, returned from ER, no restrictions, but
monitor. Ct. 2271 & B antagonistic all day.
B - test Chaimson B (X)
2271 - Jane Doe (X)
2566 - Testrolahan Ticklerbergerman (X)
2651 - Test Client (X)
3000 - Client Test (X)

Code does not exist in table RESDSP

70 x 200 men ext scn fwd

```

A shift note posted in B-8 PS.

System settings include a list of appropriate events for each event type from file **B8-ACT.DAT** and a list of default programs for each operator from file **B8-OPR.DAT**. This file is also a security feature, which includes only those operators who have access to the **B-8** log.

---

# Tickler System

The tickler system will generate staff e-mail reminders automatically based on a set of client related events. The tickler system will also print status reports indicating tickler due dates and completion dates.

## Description

The client related events that trigger the ticklers can be related to fields in the client database, specific to stages within client treatment, or part of the client medical review. An example of a tickler relating to client treatment would be a reminder for a client in a specific program 30 days after admission. This tickler would be sent to the client's program therapist indicating that an initial treatment plan is due. This tickler would do three things:

1. Generate e-mail to the primary staff person assigned to the client.
2. Appear on a report as an item that needs attention.
3. Be recorded in the client database upon completion.

The features involved in using the tickler system are:

- Setup tickler definitions.
- Generate reports on ticklers due.
- Mark ticklers completed.
- Look up records of completed ticklers.

## Tickler definitions

### *Choosing trigger points*

The first thing to do in setting up the tickler system is to decide which ticklers the agency is interested in tracking. There are many different trigger points that can be used from various sections of the client and staff activity databases. Using these variables, the agency can determine a set of ticklers that should apply to each type of program. After defining the ticklers and trigger points for each type of program the actual definitions can then be setup. The following is a list of those variables.

1. **Screening date** (SCN-DATE)- The client screening date in a program or any fixed number of days, months, or years from that date.
2. **Admission date** (ADM-DATE)- The client admission date to a program or any fixed number of days, months, or years from that date.
3. **Termination date** (TRM-DATE)- The termination date of a client from any program or any fixed number of days, months, and years from that termination date.
4. **Date of birth** (DOB) - The client's date of birth or any fixed number of days, months, or years from that DOB.
5. **Financial review** (FIN-REV)- The '**Last evaluation:**' date in the client's billing header or any fixed number of days, months, or years from that date.

6. **RX date** (RX-DATE)- Date of any active prescription in the client's medical data (**B-5**) or any fixed number of days, months, or years from the date of that prescription.
7. **RX date for a specific medication** (RX-DATE: <MED>)- Date of a specific drug prescription in the client's medical data (**B-5**) or any fixed number of days, months, or years from that date.
8. **Physical evaluation** (PHYSICAL)- The '**Last physical:**' date from the client's medical data (**B-5**) or any fixed number of days, months, or years from that date.
9. **Blood work** (BLOOD)- The '**Blood work:**' date from the client's medical data (**B-5**) or any fixed number of days, months, or years from date of that blood work.
10. **Medical review** (MED-REV)- The '**Last review:**' date from the client's medical data (**B-5**) or any fixed number of days, months, or years from that date.
11. **Visits** (VISITS)- A specific number of staff activity visits for a client in a given program.
12. **Nth visit** (NTH-VIS)- Every given number of visits (e.g. every 10<sup>th</sup> visit.).
13. **Calendar year visits** (CAL-VISITS)- Number of visits in present calendar year.
14. **Admission year visits** (ADM-VISITS)- Number of visits in year from admission month and day using the staff activity database.
15. **Admission year billable visits** (BILL-ADM-VISITS)- Same as above using the billing database only.
16. **Medicaid benefit year visits** (MD-VISITS)- Number of visits in the most recent Medicaid benefit year, as determined by the '**Date received:**' field in the Medicaid section of the client's billing header.
17. **Medicaid authorized visits** (AUT-VIS)- This is related to the number in the '**Medicaid authorized visits:**' field of the client's billing header.
18. **Program hours** (PRG-HOURS)- For CDT programs, the cumulated monthly hours for a specific client within that program.
19. **Next TX plan due** (NXT-TX)- This works off the '**Date of next review:**' field in the treatment plan database for each client.
20. **Treatment Plan review** (INITIATED-TX) – Projects review date from the date from the '**Initiated:**' field in the client treatment plan data (**B-9**) for any fixed number of days, months, or years from the date of the initiation of that treatment plan.
21. **Treatment Plan Review** (SIGNOFF1-TX) – Projects review date from the date in the '**Signed Therapist:**' field in the client treatment plan data (**B-9**) for any fixed number of days, months or years from the date of the therapist sign-off of that treatment plan.
22. **Treatment Plan Review** (SIGNOFF2-TX) – Projects review date from the date in the '**Signed Psychiatrist:**' field in the client treatment plan data (**B-9**) for any fixed number of days, months or years from the date of the psychiatrist sign-off of that treatment plan.

23. **Previous ticklers** - The completion date of any of the above completed ticklers can be used as a source to generate a new tickler.

### Definitions

1. **Program groups** - Programs can be grouped together for ticklers using the 'Tickler type:' field in the program definition (**H-13**). The table **TCKTYP** in **H-2** controls this field.
2. **Tickler type codes** - Once deciding on the ticklers that are to be created, each tickler type should be given a unique character identification code. These codes should then be added to the table **MALCAT** in **H-2**. (E.g. treatment plan tickler can be **TP**, Treatment plan reviews can be **TPR**, etc.).
3. **Tickler control file** - The file that controls the ticklers can be edited in **H-12 TK**. The file is in the admindata directory and is called **TCKRPT.DT2**.

### Tickler Reports

The tickler reports are run in **D-8**. The selection criteria include:

- **Subject** – Tickler subjects from Table **MALCAT**.
- **Recipient** – List of Operators.
- **Client** – a specific client or all clients.
- **Program** – a specific program or all programs.
- **Dates** – Report date and Tickler creation date.
- **Alert Level** -- **Overdue**, **Current**, **1 month** in the future or **2 months** in the future.

The report can then be sorted by program, subject, recipient, name and due date by placing numbers next to each of these fields or accepting the defaulted order by pressing <enter> at each field.

```

IMA Mental Health - Development Area Option:DB
Tickler reports

Subject:ITP      Initial TX Plan
Recipient:MS     Mike Samel

Client:all
Program:all
Report date:04021998
Earliest tickler to create:03031998
Alert level (O,C,1,2):1
Generate report? (Y,N)W
Sort sequence - program:1 subject:2 recipient:3 name:4 due date:5

1 men ext scn bck fwd num req

```

*Tickler Report selection screen.*

## Marking ticklers completed

1. **Using e-mail** - In e-mail (**D-1**) there is a section that deals with completing ticklers. **CT** will show open ticklers and close completed ticklers. The **DT** option can be used to delete a tickler.
2. **Using on line assessments and treatment plans** - The system can be setup so that if assessments and treatment plan are completed on line, their completion will automatically close the ticklers and create completion entries in **A-1 TD**. The file controlling this is **CLTASM.TCK**.

---

**Note:** Tickler messages are detailed in the corresponding section of the E-Mail Chapter.

---

## Looking up completed ticklers

**A1-TD** allows you to both lookup completed ticklers and add completed ticklers to the database. This records the completed event and can serve as the trigger for a new tickler.