PIP MANUAL

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CHAPTER 1

INTRODUCTION
TO
P. I. P.

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

INTRODUCTION AND BACKGROUND OF PIP Revised - 9/7/00

I. INTRODUCTION TO THE PATIENT INFORMATION PROGRAM

The Patient Information Program(PIP) is a micro-computer based data system that records and processes basic patient/client census and financial information and automates several management reporting and patient tracking functions for inpatient services. The PIP system incorporates a wide range of data relevant to inpatient episodes of care, including the full client-patient data set recommended by the Mental Health Statistics Improvement Program (MHSIP) of the Center for Mental Health Services (CMHS).

The PIP system includes a Patient Information Financial (PIF) module which supports accounting transactions, such as accounts receivable activities, patient billing and general ledger, Medicaid application tracking, and other functions of the Fiscal Office.

The PIP system has been designed to maximize access and use of patient data and basic statistical information (e.g., bed occupancy, length of stay). In addition to a number of standard reports that can be executed by a menu selection, PIP incorporates use of the Relational Report Writer (R&R) produced by Concentric Data Systems which enables users to develop ad hoc and customized reports of data useful to address management and evaluation concerns. Reports can be generated at any time on an "as needed" basis.

To provide a means for future development of the system, PIP is programmed in a database management system language (Clipper) using modular programming techniques which make the program easy to use and easy to modify, expand, and maintain. The system will continue to develop with input from users. Plans are being drawn to add modules for Quality Assurance, patient incident reporting, and other areas of patient care at a later date.

The original version of the PIP system was funded in part by a National Institute of Mental Health (NIMH) MHSIP grant and by the State of Louisiana, Department of Health and Hospitals. The system was implemented in all Louisiana state psychiatric hospitals and acute units in the Fall of 1992. The system operates in either a multi-user (network) or single-user micro-computer environment.

PIP provides a comprehensive, uniform data base of relevant patient information that is useful in managing patient care across the continuum of mental health services within the facility and statewide.

II. HISTORY OF PIP SYSTEM DEVELOPMENT

The need for a computerized data base in the state inpatient units has long been recognized. Inpatient services comprise a significant proportion of the care provided by the Office of Mental Health and data is needed to manage programs effectively and to address the service needs of clients. Hospital and acute unit staff must process large amounts of patient data manually each day and are regularly required to report summary statistical data to various regulatory authorities. Most of the current methods for collecting information are not automated and they are cumbersome and cause unnecessary duplication.

An inpatient Management Information System (MIS) was originally planned to be developed soon after implementation of the MIS for the state Community Mental Health Centers in 1981. However, resources and funds for this development were not actually available until 1989 with the availability of MIS development grants from the NIMH. Louisiana applied for and was awarded a MHSIP grant and the development of a data system for inpatient services was identified as the number one goal of the grant.

The original version of the Patient Information Program was developed at the New Orleans Adolescent Hospital under the direction of Mr. Bob Bales, associate administrator, to meet the information management needs of the facility. The initial version was implemented in July 1990, and a revised version including a fiscal module was installed a few months later. At NOAH, PIP replaced the Patient Data System (PDS), a single-user micro-computer data system used to manage the Regional Hospital Bed Allocation process which was implemented in 1989 in each state psychiatric hospital participating in the allocation process.

In December 1990, the Office of Mental Health MIS Committee and Division of Program Support staff reviewed the operation of PIP at NOAH and decided it could serve as the basis for a statewide system to be used in all state psychiatric hospitals and acute units. A project team consisting of representatives of each hospital, the state Office of Mental Health, Program Support staff, DHH Information Services staff, and representatives of the OHS Division of Fiscal Services was commissioned to coordinate development and implementation of the system. DHH Information Services staff were instrumental in purchasing the necessary equipment and in setting-up networks in each state hospital facility. The contractor who originally programmed PIP was hired to further develop the system. However, due to unforeseen circumstances, the contractor could not complete the project. In 1991, RGA Computer Systems, Inc. was hired by an RFP to review the PIP system and to complete the project. Their development of the program ended in June 1993.

In the late spring and early summer of 1992, the PIP system was piloted and further developed at Southeast Louisiana Hospital under the direction of Mr. Mike Ziemba, Computer Services, and at W.O. Moss Acute Unit under the direction of Ms. Michelle Parsons. Mr. Ziemba also programmed a number of the basic PIP reports. Continued programming services have been provided through an independent contractor, Mr. Fred Martinez. Full implementation of the PIP system occurred in the inpatient facilities in Fall 1992.

In September of 1995, the PIP project team, recognizing the need to address a more extensive range of patient information issues, became CHoPIN, the Computerized Hospital Patient Information Network.

PIP Version 7.1 was implemented in the Spring 1999. While the system has been extensively reviewed and tested, it is by no means finalized, and it is expected that it will be continuously improved through the feedback and input of its users and the OMH facilities.

III. OVERVIEW OF PIP REPORTING EVENTS AND INPUT REQUIREMENTS

PIP captures patient data at each of five intervals in the episode of inpatient care:

1. PRE-ADMISSION

   Pre-admission information on a patient can be entered and retrieved if and when the patient is admitted. This provides a data base of patients waiting to be admitted to the facility which can aid management of records and patient flow. Information management and communication can increase efficiency of services to potential clients and the flow of care into the hospital by region in coordination with community services.

2. ADMISSION

   PIP records a wide-range of characteristics of patients at admission, including socio-demographic and contact information, clinical features and criminal charges, fiscal information and benefits eligibility, and program-relevant data (such as date, time, and ward of admission). Clinical data include diagnoses (provisional and treating), presenting problems at admission, substance abuse patterns, handicaps and impairments, and other relevant functional data. Fiscal data collected through Patient Information-Fiscal (PIF) support accounting functions of the facility.

3. STAFFING OR TREATMENT REVIEW

PIP records data at each staffing (e.g. 30 day, 60 day staffing and treatment review) including updates in diagnosis, discharge planning needs and barriers, and the expected length of stay.

4. STATUS CHANGE
   PIP records and tracks inter-unit transfers, leaves and passes, elopements, and other patient status changes during the course of the hospital stay and maintains a history of these changes for tracking and reporting purposes.

5. DISCHARGE
   PIP records patient discharge data, such as the date and type of discharge, the discharge diagnosis, patient's circumstance at discharge, discharge housing arrangements, and discharge referral information.

IV. GOALS AND PHILOSOPHY OF PIP SYSTEM DEVELOPMENT

The goals and philosophy of PIP system development are to make use of the rapidly advancing micro-computer technology to create a data system that will maximize the access and use of service-relevant patient information at the facility level while also providing a uniform data base for management and evaluation of inpatient services on a statewide basis. Micro-computer and network technology can put a wealth of patient data literally "at the finger tips" of program staff within each department of the hospital and service program.

A basic design philosophy guiding PIP development is that the system will be only as good as its UTILITY to its primary users and that the users of the system should be active participants in planning the advancement and enhancement of the system. The users of PIP are primarily the facility staff, but also community treatment staff in need of patient information as well as state office and federal personnel who are charged with review of state inpatient services. PIP improvement and implementation is managed through a statewide PIP project team, CHoPIN, composed of facility representatives and others to assure that the system will be responsive to the needs of managing patient care and program operations. In addition, it is expected that each user facility will maintain an active "user's group" to provide ongoing support and feedback to the CHoPIN committee on system improvements and to develop useful reports.

V. CONFIDENTIALITY OF PATIENT DATA

Although human service professionals are generally well informed about the

importance of maintaining confidentiality of case information, with the use of personal computers, networks, modems, and other electronic media for storage and transmission of data, the issue of maintaining client confidentiality takes on new dimensions and obligations. When using computers, remember:

1. The information contained on a computer disk, whether a hard disk or floppy disk, is governed by the same principles of confidentiality as paper records.

2. Printouts and drafts containing patient information should be handled in a manner so as not to breach client confidentiality. It is recommended that each document shared be stamped "confidential".

3. Exercise the same caution when handling and storing disks and printouts. These should be carefully labeled, organized, and kept secure.

4. Information left displayed on the monitor may be viewed by any passer-by. Keep the monitor facing away from public viewing when working at the computer. When not at the computer, either turn the monitor off, or better yet, save and close the file.

5. Stand alone computers have little or no built in security. For this reason, the machine itself must be kept secure and preferably dedicated to the storage of confidential information with access limited to authorized personnel.

6. Network machines have a high degree of built-in security. Access to confidential information is the primary responsibility of the network supervisor and the librarian. Tape back-ups are generally stored on and off-site and should also be carefully labeled, organized, and kept secure.

VI. LAYOUT AND USE OF MANUAL

This manual has been developed by the OMH and PIP Development Staff in conjunction and cooperation with the CHoPIN Committee. The manual is structured for instructional purposes and will serve as a primary reference source for PIP users. The manual includes an introduction, three main sections that reflect the PIP Main Menu, and one appendix as follows:

Section 1 INTRODUCTION - Includes an Introduction and Overview of PIP.

Section 2 USING PIP - INPUT/MODIFY - Covers the many functions of the program, the keystrokes to navigating the program, entering and retrieving data, and patient flow.

Section 3 USING PIP - BROWSE/REPORTS - Introduces the PIP reporting system available through the menu, and hard coded reports. Generating Reports through R&R. Introduces R&R writer, understanding databases, generating ad hoc reports with external programs, and R&R Report Writer.

Section 4 USING PIP - MAINTENANCE - Reviews the functions available for PIP Maintenance.

Appendix A DATA DICTIONARY - Provides a cross reference guide to screen descriptions, data fields, pop-up databases, codes, instructions, and definitions contained in PIP.

This manual and the appendix are designed as both a training guide and as a quick reference to the many features of PIP. The features are cross-referenced and are designed to simplify and speed your mastery of PIP. It covers both free-standing and network applications. The manual includes detailed keystroke information providing navigation through the program. Users are encouraged to obtain users manuals for MS DOS, Novell and R&R Report Writer.

VII. USER REQUEST FOR CORRECTION OR MODIFICATION

PIP is expected to be continuously improved. Your comments regarding corrections and enhancements are welcomed and appreciated. User comments and participation are needed to facilitate future program development.

Comments should be submitted, in writing or via the PIP F6 function/upload, and include as much detail as possible including:

1. Examples - Provide examples and a description of the problem or comment.

2. Print Screen - Use the DOS Print Screen command (shift\PRT SC) or a screen capture utility to illustrate a specific concern in the program whenever possible and fax to the development team.

3. Precise Terms - Use exact language as it appears on the computer

screen, manual or as defined in the Glossary, Appendix D. Information such as: screen text, field name, Pop-up name, page numbers, and screen identifying information are helpful.

4. Source Materials - Include copies of source documents that the comments reference.

5. "Wants" versus "Needs" - An attempt should be made to distinguish "Wants" ("it would be nice if ...") and "Needs" ("in order to do my job function the following changes are needed.")

6. Urgency - Indicate if the problem is considered urgent (critical to collection of data, affects operating systems and or provides inaccurate outputs or reports.)

7. Comment Form - Please file an individual report on the form provided for each comment or suggestion when possible.

To submit an enhancement request via the PIP F6 Function/Upload the user will select the F6 key and a pop-up screen will be presented to the user. The user's name and current date will automatically be entered by PIP. The user should enter the Screen Name as listed in the upper left hand corner of each screen, if applicable. The user will then discern between a "Need" or "Want" as well as establish the level of priority of this request. A very brief caption for the correction/enhancement should also be entered. The user will then select "Problem" and/or "Proposal" as well as "Action Thus Far" and enter as much information as possible following the guidelines listed above .

The PIP Facility Coordinator will then review these requests through PIP's Maintenance Menu. "Browse Enhancement List" is located under the "Update Control Databases" menu selection. At this time, the Facility Coordinator may select those approved requests for upload.

The user may also present any comments he/she might have on the form provided and submit them to their PIP Facility Coordinator. The Facility Coordinators should review comments and forward the information to the CHoPIN Committee.

ACUTE UNITS: Acute unit staff that are under the direction of the Office of Mental Health should forward all information to the OMH State Office Acute Unit Coordinator.

HOSPITALS: Hospital staff will forward comments and suggestions their Supervisor. Supervisors will then forward information to the OMH State Office, CHoPIN Chairperson.

PIP REQUEST FOR CORRECTION OR MODIFICATION

Complete one report per correction/modification requested. Please PRINT or TYPE. Use the back of the page, as needed.

FACILITY:_____ **DATE:**__/__/__ **PIP VERSION:**_____

Staff person completing report:_____ **Phone#:**_____

Is request A: (please check one)

- G need
- G want

Rate urgency of request: (please check one)

- G high priority, desperate need
- G medium priority
- G low priority

Title of screen(s) involved (Attach screen prints if possible):

Title of function involved:

Title of report involved (Attach copy of report if possible):

State the problem, question, concern, or request (Be as Specific as possible):

Solutions attempted/proposed (If Relevant):

Facility Coordinator Action Taken Thus Far:

Forward this form to your PIP Facility Coordinator. For Adult Acute Units, forward this form to the OMH State Office Acute Unit Coordinator. Facility Coordinators send original to the PIP Project Team and retain a copy for your files.

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CHAPTER 2

GETTING STARTED

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. ENTERING THE PIP PROGRAM

PIP will run on both stand alone (single user systems) and networks (multi-user systems). Explanations for both types of systems are provided below.

A. Stand Alone Systems

To enter the program type "PIP" at the drive prompt. The program will then start and take you through the opening screen to the main menu.

B. Networks

Some of the sites will have PIP running on a network. This process should be automated by your local Network supervisor. Consult local policies for logging-in to the network. Once you are attached you must 'Login.' This is a process that allows the system to identify the user and grant access rights to the user. To login you enter the word 'LOGIN' and press ENTER. You will be prompted to 'Enter your password.' You will then type your password and press ENTER. As you type your password, the cursor will not move and no characters will be displayed. This is to provide security by not allowing anyone to see your password as you type it. This password is yours and you should protect it and keep it private. After pressing ENTER, the system will process your information and display data concerning your relation to the network.

This relationship is controlled by your local network supervisor. In most cases you will be placed in a menu system with PIP as one of your options. Select PIP and you will be taken through the opening screen to the main menu.

WHAT'S NEW WITH PIP - FALL ‘00

(To be updated shortly!)

CONVENTIONS USED IN PIP

PIP uses a number of standard conventions. Information is displayed at the bottom of the screen indicating which functions are active for that screen. Additionally, function (F) keys have been assigned for certain functions. The following is an alphabetical list of the allowable functions in PIP. Hot keys, which allow selection of the function by a single keystroke, are underlined.

Alert boxes — These boxes alert the user to a specific condition in the PIP program. Examples are "An error has occurred", "Finished", etc.

Bed activity — This selection presents the bed activity history for the selected client.

Change data — This selection is used to gain access to the screen to edit or add data. In networked systems, the user must have access assigned by the PIP facility coordinator or the network administrator to be allowed to edit data. If the user does not have access to edit data, the user will be able to see the screens in the Modify menu selection, but will not be able to edit the data.

Ctrl, Page up — These two keys, when pressed together, will take the user to the first item in a pop-up.

Ctrl, Page down — These two keys, when pressed together, will take the user to the last item in a pop-up.

Decision boxes — These boxes allow the user to make a decision regarding the continuation of the current PIP process.

Delete — This key will delete the record if the user has access to delete.

Delete record — This selection deletes the record permanently. Access to this function may be limited by the PIP facility coordinator or network administrator in networked applications.

Down arrow — This key will move the cursor down from one data entry field to the following data entry field. This key also allows

moving from field to field without entering data.

End This key will highlight the last selection on the menu.

Enter In a menu, this key will select the item that is highlighted. In a field, following data entry, pressing this key will cause data to be validated, if applicable.

Esc Escapes out of a screen that shows "esc" as a selection as well as exits a pop-up. For screens with no "esc" selection, page down will exit the screen or will go to the bottom of the screen for other function selection.

Exit to main This selection returns the user to the previous menu selection.

Face sheet This selection will print a current face sheet on the selected client.

Function Keys

F1	No assigned function.
F2	No assigned function.
F3	No assigned function.
F4	No assigned function.
F5	No assigned function.
F6	Pops up the enhancement request screen.
F7	No assigned function.
F8	No assigned function.
F9	Pops up the military time crosswalk.
F10	Screen blanker.
F11	No assigned function.
F12	No assigned function.

Home This key will highlight the first selection on the menu.

Jump to page This menu option is used to gain access to a pop-up which allows the user the ability to move directly to the screen selected.

Left arrow This key will allow the cursor to move one key to the left within a data entry field.

Legal status expires For clients who are on a legal certified commitment status (PEC, CEC, etc.) the date of expiration of that legal status will appear in the upper left hand corner of the screen. It will be in a green box until 1 day prior to the expiration of the legal status, when the box will turn red and will begin blinking.

Legal history This selection presents the legal status history for the selected client.

+ Page Allows paging forward through the screens.

- Page Allows paging backward through the screens.

Page down This key will exit from the screen. If the user is in a pop-up page down will go to the last item on that pop-up screen, then "esc" will exit the pop-up.

Patient Selection Screen This red screen allows the selection of a specific client for data entry or data viewing. Clients can be selected by using the search function to identify the hospital number, name or social security number of the client whose record is being retrieved. Selection can also be made by moving the highlight bar over the specific client and pressing enter.

Right arrow This key will allow the cursor to move one key to the right within a data entry field.

Search On screens where this is identified as a function, selecting search will search for a specific client by hospital number, name, or social security number.

Submenu This selection is available in Modify, Admit, Staffing, Discharge Summary, and View. This option currently allows the user to view and edit (in all but View) physical, Medicaid certification, diagnostic or seclusion/restraint information on a client. Physical information is limited to height, weight, and allergies.

Toggle pop-ups Allows users to toggle (set on or off) whether pop-ups will automatically appear for each field or will only appear for

diagnoses or improper code entries.

Up arrow This key will move the cursor up from one data entry field to the preceding data entry field. This key also allows moving from field to field without entering data.

CHAPTER 3

MODIFY PATIENT RECORD

TRAINING MANUAL
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I. MODIFY PATIENT RECORD

This function allows the user to view and edit, depending upon access rights, a particular client's record. Select this option from the Main Menu under Input/Modify. Once in Modify, the Patient Selection Screen will appear. As instructed at the bottom of the screen, press "S" to search. The user will be prompted to search by name, hospital number or social security number. Highlight the desired method and press ENTER. The user will then be asked to enter the desired information and the search will begin. The user can also highlight a selected client on the Patient Selection Screen and press ENTER and that client record will be selected.

After locating the client record, the user is automatically taken to the first of the screens in the modify section. The user can view each screen. On networked systems, if the user has specific access, they can edit the data on most screens. Access can be given for individual screens, so the user may be able to edit some, but not all of the screens. The user can select their next function from the bottom of the screen. These functions are described in the "Conventions Used in PIP" section at the beginning of the manual.

The following lists the screens, the screen name (from the upper left corner of the screen), and the screen title.

PAGE	SCREEN NAME	SCREEN TITLE
1	**GETS1**	**Patient Admit/Face Sheet**
	For information on this screen see "Admit A Patient", Chapter 5 - Page 3.	
2	**GETS2**	**Status Information Screen**
	For information on this screen see "Admit A Patient", Chapter 5 - Page 9.	
3	**GETS4**	**Parent/Guardian Data**
	For information on this screen see "Admit A Patient", Chapter 5 - Page 21	
4	**GETS6**	**Patient Diagnosis Information**
	For information on this screen see "Complete Patient Staffing", Chapter 7 - Page 22.	
5	**REV_FGETS1**	**Client Treatment Review Form**
	For information on this screen see "Complete Patient Staffing",	

Chapter 7 - Page 9. This screen may be edited only through ”Complete Patient Staffing.“ Select this option from the Main Menu under Input/Modify.

6 **REV_FGETS2** **Drug Abuse Patterns At Admission**

For information on this screen see "Complete Patient Staffing", Chapter 7 - Page 17. This screen may be edited only through ”Complete Patient Staffing.“ Select this option from the Main Menu under Input/Modify.

7 **GETS7** **Supplementary Patient Information**

The fields displayed on this screen are user defined fields which can be modified by each facility to meet the specific needs of that facility.

8 **GETS8** **Patient Financial Information**

For information on this screen see "Admit A Patient", Chapter 5 - Page 24.

9 **DISC_GET** **Discharge Tracking Screen**

For information on this screen see "Edit Discharge Tracking", Chapter 8 - Page 2. This screen may not be edited while the patient is still active.

10 **DC_SUMGET2** **Patient Discharge Summary**

For information on this screen see "Discharge Summary", Chapter 9 - Page 4.

11 **ADMIT2_GET** **Legal Charges**

For information on this screen see "Admit A Patient", Chapter 5 - Page 23.

Upon completion of viewing or editing the screens, the user can exit to the main menu.

CHAPTER 4

PRE-ADMIT
A PATIENT

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I. PRE-ADMIT A PATIENT

This function allows collection of pre-admission data about an individual. Select this option from the Main Menu under Input/Modify. If the person has previously been a client, a selection can be made allowing the user to retrieve the admission information from the client's last stay. After selecting this option, the user is automatically taken to the Patient Interview Screens.

When the user highlights this selection and presses ENTER, a decision box appears which calls for a Y/N answer. A "Y" answer takes the user to a search screen containing the names of discharged clients. After selecting a name, the user is taken to page one of the Patient Pre-Admit Sheet. Information previously recorded about the client is automatically copied to the newly created record. This record is flagged as an interview and may be edited. An "N" response takes the user directly to page one of the Patient Pre-Admit Sheet. This record is flagged as an interview and may be edited.

***** PRE-ADMIT A PATIENT - (Mandatory Fields are preceded by ***)**

When completing a patient pre-admission interview, the only mandatory fields are NAME and DISPOSITION. If a valid name is not available, the use of Jane or John Doe (John Doe I, John Doe II, etc...) is the suggested entry. Although PIP will accept multiple entries of the same name, the user should add as much descriptive information as possible. The computer will not accept a blank entry in this field.

A. Pre-Admit a Patient - Page 1
PATIENT PRE-ADMIT SHEET (ADMIT1_GET)

SCREEN LABEL	DATABASE->FIELD NAME
INTERVIEW DATE	(INTERVU->ADM_DATE)

Enter the numeric equivalent of the month, day, and year of the date of the client's interview for possible admission to the hospital.

INTERVIEW TIME (INTERVU- > ADM_TIME)

Using the 24-hour clock ("military time"), enter the four-digit time the client was interviewed. For example, 7:30 a.m. would be entered as 0730, while 7:30 p.m. would be entered as 1930. An on-screen military time conversion chart is available by pressing F-9.

HOSPITAL NUMBER (INTERVU- > HOSP_NUM)

This is a display field automatically set to "0" or to the assigned hospital number if the client has had a previous admission in this facility.

*** **FIRST** (INTERVU- > FNAME)

Enter, in 15 characters or less, the client's first name. This field may not be left blank.

MID INITIAL (INTERVU- > MID_INIT)

Enter the client's middle initial.

*** **LAST** (INTERVU- > LNAME)

Enter, in 20 characters or less, the client's last name. This field may not be left blank.

STREET ADDRESS (INTERVU- > STADDRESS)

Enter, in 25 characters or less, the client's street address.

CITY (INTERVU- > CITY)

Enter, in 20 characters or less, the client's city of residence.

STATE (INTERVU- > STATE)

Enter the two letter abbreviation for client's state of residence.

ZIP (INTERVU- > ZIP)

Enter the client's zip code number. Nine digits are available for extended zip codes.

TELEPHONE (INTERVU- > TELEPHONE)

Enter the client's home telephone number including the area code.

RACE (INTERVU- > RACE)

Select the appropriate code for the client's race. For individuals with parents of different races or for individuals unsure of their race, the race of the client's mother should be used.

CODES & DEFINITIONS:

? **Unknown**

01 **White** - An individual having origins in any of the original peoples of Europe (including Portugal), North Africa, or the Middle East.

02 **Black/African American** - An individual having origins in any of the original black racial groups of Africa.

03 **Asian or Pacific Islander** - An individual having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands (e.g., Japan, China, Samoa, India, Korea, the Philippine Islands, Vietnam, Thailand, etc.).

04 **American Indian** - An individual having origins in any of the original peoples of North America and who maintains cultural identity through tribal affiliation or community recognition.

05 **Alaskan (Aleut, Eskimo, Indian)** - An individual having origins in any of the original peoples of Alaska and who maintains cultural identity through tribal affiliation or community recognition.

06 **Other** - A default category for use in instances in which the client is not classified above or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories.

ETHNICITY (INTERVU->ETHNIC)

Select the appropriate code which represents the ethnic heritage of the client.

CODES & DEFINITIONS:

? **Unknown**

01 **Non-Hispanic** - The client is an individual not of Spanish heritage or culture, regardless of race.

02 **Puerto Rican** - The client is an individual of Puerto Rican heritage or culture, regardless of race.

03 **Mexican/Mexican American** - The client is an individual of Mexican heritage or culture, regardless of race.

04 **Cuban** - The client is an individual of Cuban heritage or culture, regardless of race.

05 **Other Hispanic** - The client is an individual from Central or South America and all other Spanish cultures or origins (including Spain), regardless of race.

SEX (INTERVU->SEX)

Specify, by "M" or "F", the sex of the client.

SSN (INTERVU->SSN)

If the client has a valid SSN and (s)he or the parent/guardian signs the official consent form for the use of that SSN, the SSN should be entered in the nine-digit space provided.

DOB (INTERVU- > BIRTHDATE)

Enter the numeric equivalent of the month, day, and year for the date of the client's birth. If the actual date of birth isn't known, code the month and day as "01" and code the year with your estimate. Update when accurate information is obtained.

AGE (INTERVU- > AGE)

The age of the client at the time of interview is automatically calculated and entered when you insert the birth date of the client.

PLACE OF BIRTH (INTERVU- > BIRTHPLACE)

Enter the city and state of the client's place of birth. If client was born outside of the USA, add the country of birth. If unknown, leave item blank.

SPECIAL POPULATION CODES

ACUTE (INTERVU- > ADM_ACUTE)

Select the code that indicates whether or not the client meets criteria for acute mental disturbance.

CODES & DEFINITIONS:

? Unknown

00 Not Applicable

01 Applicable

Select applicable if client is of any age and mental disorder who is acutely disturbed and meets the criteria below:

a. Abrupt and serious disruption in level of functioning in the direction of severe impairment and marked personal distress.

b. Urgent/immediate need for clinical intervention to stabilize condition and prevent further, serious disabling effects.

c. Severity of current impairment tends to be short-term and intermittent rather than persistent and enduring.

1. For coding purposes, the maximum duration of an acute mental state is six months, at which time client is reclassified.

SMI/EBD (INTERVU- > ADM_CHRONI)

Select the code that indicates whether or not the client meets criteria for a seriously mentally ill adult or a child/youth who has an emotional/behavioral disorder. PIP will only allow you to select the proper code for either SERIOUSLY MENTALLY ILL ADULT (18 years and older), or EMOTIONAL/BEHAVIORAL DISORDER -- CHILD/YOUTH (Under age 18).

CODES & DEFINITIONS

? **Unknown**

00 **Not Applicable**

01 **Seriously Mentally Ill Adult** - An individual age 18 or older who meets all the criteria below:

1. Age - 18 years or older
2. Diagnosis - Severe non-organic mental illnesses including, but not limited to, schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships at work or school.
3. Disability - Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:
   a. Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
   b. Employed in a sheltered setting.
   c. Requires public financial assistance for out-of-hospital maintenance (e.g. SSI) and/or is unable to procure such without help. Does not apply to routine retirement benefits.
   d. Severely lacks social support systems in the natural environment (e.g., no close friends or group affiliations, lives alone, or is highly transient).
   e. Requires assistance in basic life skills (e.g. must be reminded to take medicine, must have transportation arranged for them, needs assistance in household management tasks).
   f. Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.
4. Duration - Must meet at least one of the following indicators of duration:
   a. Psychiatric hospitalizations of at least six months (cumulative total) in the last five years.
   b. Two or more hospitalizations for mental disorders in the last 12 month period.
   c. A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.
   d. A previous psychiatric evaluation indicating a history of

treatment for severe psychiatric disability of at least six months duration.

02 **Emotional/Behavioral Disorder -- Child/Youth** - A child or youth (age zero through 17) who has behavioral or emotional responses so different from appropriate age, cultural, or ethnic norm that they adversely affect performance. Performance includes academic, social, vocational or personal skills. Such a disability is more than a temporary, expected response to stressful events in the environment; is consistently exhibited in two different settings; and persists despite individualized intervention within general education and other settings. Emotional and behavioral disorders can co-exist with other disabilities.

Criteria (All criteria must be met):

1. Age - Under age 18.
2. Meets one of the following criteria which operationalize the above definition:
   a. Exhibits seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; **or,**
   b. Manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; **or,**
   c. Experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; **or,**
   d. Have a DSM-III-R (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive) or severe conduct disorder. This category does not include children/youth who are

socially maladjusted unless it is determines that they also meet the criteria for emotional/behavior disorders; **and,**

3. Disability: There is evidence of severe, disruptive and/or incapacitating functional imitations of behavior characterized by at least two of the following:
   a. Inability to routinely exhibit appropriate behavior under normal circumstances.
   b. Tendency to develop physical symptoms or fears associated with personal or school problems.
   c. Inability to learn or work that cannot be explained by intellectual, sensory, or health factors.
   d. Inability to build or maintain satisfactory interpersonal relationships with peers and adults.
   e. A general pervasive mood of unhappiness or depression.
   f. Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then "conduct disorders" are eligible.
4. Duration:
   a. The impairment or pattern of inappropriate behavior(s) has persisted for at least one year, **or**
   b. There is substantial risk that the impairment or pattern of inappropriate behavior(s) will persist for an extended period, **or**
   c. There is a pattern of inappropriate behaviors that are severe and of short duration.

JUDICIAL (INTERVU-> ADM_COURT)

Select the code which describes the primary criminal justice designation that is appropriate for the client at the time of admission if the client meets criteria for a current legal mandate for mental health evaluation and/or treatment.

CODES & DEFINITIONS:

? **Unknown**

00 **Not Applicable**

10 **Criteria for GW Class members** - This individual is a member of the Gary W. class action suit which is verifiable through a DHH Office.

Forensic client - This individual is mandated to receive services by the Settlement Agreement (consent decree) in Forensic class action suits. Client types 20-24 below or emergency certificate (citation in parentheses):

20 **NGBRI; Not Guilty/Insane** - Those adjudicated Not Guilty by Reason of Insanity (NGBRI) (C.Cr.Pr., Art. 654).

21 **Not competent for trial** - Pretrial clients adjudged not competent to proceed to trial (C.Cr.Pr., Art. 648, et seq.)

22 **Not to regain competency** - Pretrial clients adjudged unlikely to regain competency in the foreseeable future and may be civilly committed (C.Cr.Pr., Art 648 or La. R.S. 28:54, et seq.); Commonly known as "Lockharts".

23 **Transfer from Dept. Corr.** - Transfers from the Department of Public Safety and Corrections (La. R.S. 28:59 and/or 28:54 or by emergency certificate).

24 **Transfers from DMH Hosp.** - Transfer from other DMH hospitals who are dangerous to others and cannot be controlled at the civil hospital. (This may be done administratively and does not require court approval.)

30 **Other court-ordered client** - These clients are mandated to receive evaluation or treatment as evidenced by a current civil or juvenile court order.

JUV. CUSTODY (INTERVU- > ADM_JUVCUS)

Select the code that indicates whether or not the client meets the criteria for a juvenile in state custody. If the client is over the age of 18, PIP will not access this field.

Criteria (All criteria must be met):

1. Under age 18 years
2. Adjudicated in need of care, in need of supervision, or delinquent
3. In custody through either (at least one):
   a. Court Order
   b. Minute Entry
   c. Surrender proceedings
4. Verification by verbal confirmation of OCS worker or administrator **or** verbal confirmation of DPSC juvenile services officer or administrator **and** a copy of court order or OCS surrender form #445 within 30 days.

CODES & DEFINITIONS:

? **Unknown**

00 **Not Applicable**

01 **DSS-Office of Community Service** - In the custody of the Department of Social Services - Office of Community Services.

02 **DPSC-Office of Juv. Service** - In the custody of the Department of Public Safety and Corrections - Office of Juvenile Services

03 **DSS-OCS & DPSC-OJS** - In the custody of both DSS-OCS **and** DPSC-OJS.

04 **DSS-OCS or DPSC-OJS & DMH** - In the custody of DSS-OCS **or** DPSC-OJS **and** DMH.

ADMIT REFERRAL CODE (INTERVU- > ADMREF_COD)

Select the code that indicates the person, provider type or agency which was primarily responsible for referring and arranging for this admission. [The intent of this data element is to capture where the client actually "came from". For example, in some systems a necessary prerequisite for admission is assessment and/or administrative processing at or by another agency (e.g. a "Screening Center").]

Please note that of the following referral sources indicated as "Private", those persons, provider types or agencies are located within Louisiana. All "Private" sources located outside of the State of Louisiana are to be coded "09 Other".

CODES & DEFINITIONS

? **Unknown**

00 **None**

01 **Self** - The client decided on his/her own volition to come to this facility.

02 **Family/friend/individual** - The client decided to come to this facility based on the advice or recommendation of family and/or friends or any other individual that is not listed in any other category.

03 **School/education program** - The client was referred to this facility by a school or education agency or program (e.g., school system psychologist, a principal, counselor, teacher, etc.)

04 **Private psychiatrist** - The client was referred to this facility be a licensed psychiatrist who is in private practice.

05 **Other private mental health practitioner** - The client was referred to this facility by a mental health practitioner, such as psychologist or social worker, who is in private practice.

06 **Private inpatient psychiatric facility** - The client was referred to this facility by an inpatient psychiatric facility that is not a public mental health hospital.

07 **Private mental health clinic/organization** - The client was referred to this facility by a private organization that provides primarily outpatient mental health services.

08 **Clergy** - The client decided to come to this facility based upon the advice and/or recommendation of a member of the clergy.

09 **Other source of referral** - A source of referral not covered by the other

categories.

10 **DWI referral** - The client was referred to this facility by the courts subsequent to being charged with Driving While Intoxicated or Driving Under the Influence.

11 **Coroner** - The client was referred to this facility by a duly appointed Parish Coroner or his Deputy.

12 **Other private physician** - The client was referred to this facility by a licensed medical doctor (other than a psychiatrist) who is in private practice.

13 **Private general hospital** - The client was referred to this facility by a private general hospital.

14 **Court or local corrections** - The client was referred to this facility by an agency within the courts or a local correctional system (below the level of the Department of Corrections) including judge, prosecutor, probation officer; referred for deferred prosecution, pretrial release, pre-parole, pre-release, work release, civil commitment, or a parish prison program. Does not include DWI or DUI referrals.

15 **Private inpatient substance abuse treatment facility** - The client was referred to this facility by a private inpatient substance abuse rehabilitation organization.

16 **Private outpatient substance abuse treatment facility** - The client was referred to this facility by a private outpatient substance abuse rehabilitation organization.

17 **Private nursing home/extended care facility** - The client was referred to this facility by a private nursing home or an extended care facility.

18 **Other for Protective Custody** - The client was transported to this facility under an Order for Protective Custody issued by a Parish Coroner or his Deputy.

19 **Law enforcement agency** - The client was referred to this facility by a law enforcement agency for reasons other than a court order.

20 **Employer/EAP** - The client was referred to this facility by his/her employer or employee assistance plan, whether formal or informal. Includes supervisor or an employee counselor.

21 **Shelter for homeless/abused** - The client was referred to this facility by a shelter for the homeless and/or abused.

22 **Other DMH facility** - The client was referred to this facility by another OMH facility, including a public psychiatric hospital, an OMH Acute Treatment Unit, or a CMHC.

23 **Other State agency** - The client was referred to this facility by another State agency or facility.

24 **Patient deceased** - Not applicable upon admission.

REFERRING UNIT (INTERVU- > REFER_UNIT)

Select the appropriate code that represents the public psychiatric hospital, OMH Acute Treatment Unit, or CMHC that referred the client to this hospital. If the referral was not from one of these referral sources, the field will be automatically set to "00". The facility codes are available in the pop-up.

REFERRED BY (INTERVU- > REFER_ORG)

Enter the name of the person who referred the client to the facility, i.e. doctor's name, judge's name, etc.

*** **DISPOSITION** (INTERVU- > DISPOSITN)

Select the appropriate code that best describes the outcome of the initial contact with respect to what subsequent services, if any, are planned for the client. User cannot select 01 admit.

CODES & DEFINITIONS

01 **Admission** - This code cannot be selected during the patient interview.

02 **Placed on waiting list** - The individual is not formally admitted on the date of the initial interview, but the client's name is placed on a waiting list to be scheduled for timely admission to the hospital.

03 **Referred to CMHC** - The individual is not formally admitted to the hospital on the date of the initial interview, but rather is referred to a community mental health center/clinic.

04 **Referred to DMH acute unit** - The individual is not formally admitted to the hospital on the date of the initial interview, but rather is referred to the appropriate Office of Mental Health Acute Treatment Unit.

05 **Referred to substance abuse facility** - The individual is not formally admitted to the hospital on the date of the initial interview, but is referred to a substance abuse facility, whether public or private.

06 **Referred elsewhere** - The individual is not formally admitted to the hospital on the date of the initial interview, but the client is referred by the therapeutic staff to another agency or resource for service provision.

07 **No referral** - The individual is not formally admitted to the hospital on the date of the initial interview and is not referred elsewhere.

UNIT REFERRED TO (INTERVU->UNITREF_TO

Select the appropriate code that represents the public psychiatric hospital or community mental health center/clinic to which this client has been referred. If there was no referral, the item will be automatically set to "00". Codes are available in the pop-up.

CLINICAL STAFF ID (INTERVU->ATTD_PHYS)

Select the numeric code to identify the member of the facility's Clinical Staff who conducted the initial interview/contact with the client. Staff codes are available in the pop-up.

ADMITTING STAFF ID (INTERVU->ADM_STAFF)

Select the numeric code to identify the member of the facility's Admissions Staff who conducted the initial interview/contact with the client. Staff codes are available in the pop-up.

B. Pre-Admit a Patient - Page 2
PRE-ADMIT SCREEN (ADMIT2_GET)

I N F O R M A T I O N A L
DISPLAY ONLY
Name, Interview Date

SCREEN LABEL — DATABASE->FIELD NAME

CRIMINAL CHARGES RELATING TO ADMISSION

CODES (INTERVU->CRIMINAL1 - CRIMINAL4)

Select the code which best represents those legal charges against the client which ultimately resulted in the client being referred to this hospital. Up to four sets of charges may be included for each client. Codes are available in the pop-up.

COUNTS (INTERVU->L_CNTS1 - L_CNTS4)

Enter the number of counts of each legal charge.

JUDGE (INTERVU->COM_JUDGE)

Enter the name of the Judge issuing the criminal commitment on the client.

IS PATIENT'S PAPERWORK PREPARED FOR ADMISSION (INTERVU->READY_ADM)

Enter a "Y" or a "N" for this field to indicate whether or not all paperwork has been completed for the admission.

C. Pre-Admit a Patient - Page 3
PARENT/GUARDIAN DATA (GETS4)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date

SCREEN LABEL — DATABASE->FIELD NAME

EMERGENCY CONTACT NAME (INTERVU->EMR_NAME)
Enter the name of the emergency contact person. If this information is unknown, leave the item blank.

RELATION (INTERVU->EMR_RELATE)
Enter the emergency contact's relationship to the client.

ADDRESS (INTERVU->EMR_ADDRES)
Enter, in 25 characters or less, the emergency contact's address.

CITY (INTERVU->EMR_CITY)
Enter, in 20 characters or less, the emergency contact's city of residence.

STATE (INTERVU->EMR_STATE)
Enter the two letter abbreviation for the emergency contact's state of residence.

ZIP (INTERVU->EMR_ZIP)
Enter the emergency contact's zip code.

PHONE (INTERVU->EMR_TELE)
Enter the emergency contact's phone number including the area code.

LEGAL GUARDIAN (INTERVU->GUARDIAN)
Enter the name of the person having LEGAL custody of the client. If this information is unknown, or not applicable leave the item blank.

RELATION (INTERVU->GRD_RELATE)
Enter the guardian's relationship to the client.

ADDRESS (INTERVU->GRD_ADDRES)
Enter, in 25 characters or less, the guardian's address.

CITY (INTERVU- > GRD_CITY)
Enter, in 20 characters or less, the guardian's city of residence.

STATE (INTERVU- > GRD_STATE)
Enter the two-letter abbreviation for the guardian's state of residence.

ZIP (INTERVU- > GRD_ZIP)
Enter the guardian's zip code.

PHONE (INTERVU- > GRD_TELE)
Enter the guardian's telephone number including area code.

FATHER'S NAME (INTERVU- > FATHER)
Enter, in 25 characters or less, the father's name.

ADDRESS (INTERVU- > FATHER_ADD)
Enter, in 35 characters or less, the father's address.

OCCUPATION (INTERVU- > FATHER_OCC)
Enter, in 15 characters or less, the father's occupation.

PHONE (INTERVU- > FATHR_PHON)
Enter the father's telephone number including the area code.

CITY (INTERVU- > FATHERCITY)
Enter, in 20 characters or less, the father's city of residence.

STATE (INTERVU- > FATHER_ST)
Enter the two letter abbreviation for the father's state of residence.

ZIP (INTERVU- > FATHER-ZIP)
Enter the father's zip code.

MOTHER'S NAME (INTERVU- > MOTHER)
Enter, in 25 characters or less, the mother's name.

ADDRESS (INTERVU- > MOTHER_ADD)
Enter, in 35 characters or less, the mother's address.

OCCUPATION (INTERVU- > MOTHER_OCC)
Enter, in 15 characters or less, the mother's occupation.

PHONE (INTERVU- > MOTHR_PHON)
Enter the mother's telephone number including area code.

CITY (INTERVU- > MOTHERCITY)
Enter, in 20 characters or less, the mother's city of residence.

STATE (INTERVU- > MOTHER_ST)

Enter the two letter abbreviation for the mother's state of residence.

ZIP (INTERVU- > MOTHER_ZIP)

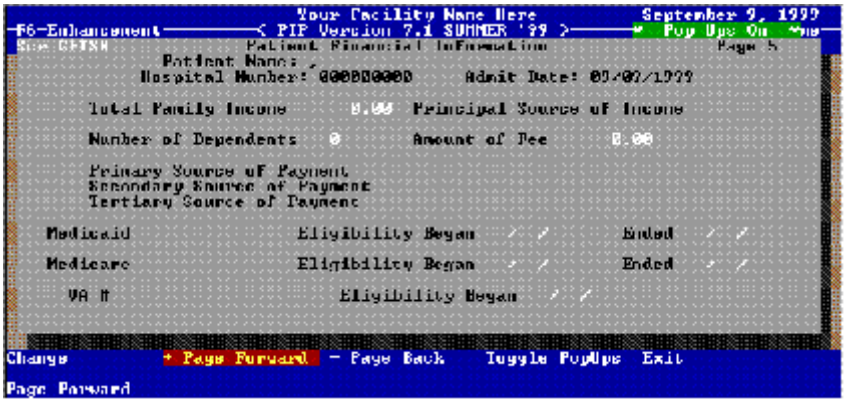
Enter the mother's zip code.

D. Pre-Admit a Patient - Page 4
SUPPLEMENTARY PATIENT INFORMATION (GETS7)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date

The fields displayed on this screen are user defined fields which can be modified by each facility to meet the needs of the facility. There are three of each of the following types of fields: Numeric, Date and Character.

SCREEN LABEL	DATABASE- > FIELD NAME
DATE FIELDS 1-3	(INTERVU- > MZD1 - MZD3)
NUMERIC FIELDS 1-3	(INTERVU- > MZN1 - MZN3)
CHARACTER FIELDS 1-3	(INTERVU- > MZC1 - MZC3)



E. Pre-Admit a Patient - Page 5
PATIENT FINANCIAL INFORMATION (GETS8)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date

SCREEN LABEL	DATABASE- > FIELD NAME
TOTAL FAMILY INCOME	(INTERVU- > TOTINCOME)

Type in the total family income as reported before deductions for taxes, bonds, dues or other items.

PRINCIPAL SOURCE OF INCOME (INTERVU- > INC_SOURCE)

Select the code for the primary source of the client's income.

CODES & DEFINITIONS

? **Unknown**

01 **Employment/Wages** - The majority of the family's income is derived through employment. The money is earned as:

a. salary, wages, tips, commissions, and/or bonuses;

b. farm self-employment (after deductions for operating expenses) or tenant farmer or sharecropper

c. non-farmer self-employment, partnerships, or professional practices

Also included are retirement incomes/pensions from private or governmental sources (such as Social Security, Railroad Retirement, State Employees' Retirement, Teachers' Retirement, military retirement, etc.) and payments from the military for National Guard or Reserve duty.

02 **Public Assistance** - The majority of the family's income is derived from some form of public assistance, including Aid to Families with Dependent Children, Supplemental Security Income, and Social Security Disability Insurance.

03 **Other** - The majority of the family's income is derived from other sources, such as interest, dividends, royalties, net rentals, alimony, child support, or any other source of income regularly received. (Do not include one-time or lump-sum payments such as inheritance or sale of a house.)

NUMBER OF DEPENDENTS (INTERVU- > NOFAMILY)

Type in the number of persons in the client's family dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes.

AMOUNT OF FEE

This field is not completed at this time.

PRIMARY SOURCE OF PAYMENT (INTERVU- > FISSTAT)

Enter the code that represents the first type of account payment.

CODES & DEFINITIONS

00 **None**

01 **No fee payment** - Based on the DHH Liability Limitation Schedule, no fee is to be charged to the client.

02 **Private/personal funds** - The fee (in total or in part) will be paid from the client's personal income or that of the client's household.

03 **Private health insurance** - The fee (in total or in part) will be paid by the

client's personal insurance carrier in accordance with the specifications of the policy.

04 **Medicare** - The fee (in total or in part) will be paid by insurance provided through Social Security or Railroad Retirement.

05 **Medicaid** - The fee (in total or in part) will be paid by the Title XIX program.

06 **VA** - The fee (in total or in part) will be paid by the Veteran's Administration.

07 **CHAMPUS** - The fee (in total or in part) will be paid by insurance provided by the Civilian Health and Military Personnel Uniformed Services.

08 **Other public sources** - The fee (in total or in part) will be paid by another organization, including Workman's Compensation.

SECONDARY SOURCE OF PAYMENT (INTERVU->FISSTAT2)

Enter the code which represents the client's secondary source of payment. See primary source of payment for codes and definitions.

TERTIARY SOURCE OF PAYMENT (INTERVU->FISSTAT3)

Enter the code which represents the client's tertiary source of payment. See primary source of payment for codes and definitions.

MEDICAID NUMBER (INTERVU->MEDCAID)

Type in the client's Medicaid number, if appropriate. If there is no eligibility, this item may be left blank.

ELIGIBILITY BEGAN (INTERVU->CAIDBEG)
ENDED (INTERVU->CAIDEND)

Enter the date(s) that Medicaid eligibility began and/or ended.

MEDICARE NUMBER (INTERVU->MEDICARE)

Type in the client's Medicare number, if appropriate. If there is no eligibility, this item may be left blank.

ELIGIBILITY BEGAN (INTERVU->CAREBEG)
ENDED (INTERVU->CAREEND)

Enter the date(s) that Medicare eligibility began and/or ended.

VA # (INTERVU->VANUMBER)

Type in the client's Veteran's Administration number, if appropriate. If there is no eligibility, this item may be left blank.

ELIGIBILITY BEGAN (INTERVU- > VABEG)

Enter the date(s) that VA eligibility began.

When editing is complete, the user will be asked whether or not the data is correct. If the response is "NO" the user will be taken back through the screens to allow for corrections of the entered data.

If the response is "YES" the user will be asked if they would like to save the record. If the user response is "YES" the record will be saved. If the response is "NO" the record will be deleted.

II. EDIT/DELETE PATIENT INTERVIEW INFORMATION

This function allows the authorized user to edit the pre-admission data of a particular individual on the Waiting List. Select this option from the Main Menu under Input/Modify. When the user highlights the Browse Waiting List function and presses ENTER, a Patient Selection Screen containing patients who have had a pre-admission interview will appear.

The format of the Patient Selection Screen for the Waiting List is identical to that of the Patient Selection Screen used for other functions. However, for this menu option, it should be noted that a date listed under “Admit Date” is actually the date of the interview. Additionally, “Discharge Date” and “Status” are not applicable to this function.

CHAPTER 5

ADMIT A PATIENT

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

ADMIT A PATIENT Revised - 9/7/00

I. ADMIT A PATIENT

This function is used to collect and record information necessary to admit a client. Select this option from the Main Menu under Input/Modify. Clients may be admitted from the Interview list, from previous stays, or directly as a new admission.

An *'Inpatient Admission'* is the formal acceptance by a hospital of a patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients generally stay at least overnight. This date and time is supported by a physician's admit order.

*** SPECIAL NOTES AND POLICIES ***

The primary responsibility of the admissions office is to enter reliable data. Certain procedures regarding the entry of data must be followed to insure consistent operation of the software. They are as follows:

1. OVERNIGHT ADMISSIONS - All overnight admissions must be entered immediately the next morning. Other departments cannot produce accurate reports until the admissions office has entered any outstanding data.
2. ADMISSION vs. RE-ADMISSIONS - When a client comes to the facility for the first time, the next available hospital number should be given to the client. When a re-admission occurs at a facility, the admit clerk must use the original Hospital Number given to the client. We suggest a single log book be retained for the purpose of maintaining hospital numbers. This is especially helpful for overnight admissions when admit staff are not available.
3. CORRECTNESS OF DATA - The admissions clerk must insure the data entered is correct. Should any errors surface during the course of the client's stay, the clerk has the responsibility to correct the error. However, if the client has been discharged, the admit clerk should inform the Medical Records Department and they are responsible for correcting the data.
4. BED ALLOCATION REPORTS - The admissions clerk is responsible for producing the Bed Allocation Reports for OMH Headquarters. These reports are available through the "BROWSE/REPORTS" option of the main menu.
5. NAME - John or Jane Doe may be entered as names for unknown clients. However this information must be updated as soon as the true identity of a client is known.

When the user highlights the Admit a Patient function and presses ENTER, a decision box appears asking "Admit this patient from the Interview List? Y/N". "Y" will present the Patient Selection Screen to select a patient who has had a pre-admission

interview. If there are no patients who have had a pre-admission interview an alert box will appear notifying the user that "There are no names on the interview list, press any key to continue". The user will then need to select Admit a Patient and enter "N" at the "Admit this patient from the Interview List? Y/N" box. When "N" is selected another decision box appears asking "Has this person been a patient before and can he/she be correctly identified? Y/N". If "Y" is selected the user is presented with a Patient Selection Screen containing patients who have been previously admitted and discharged from the facility. The user can then select the client by highlighting or searching. If "N" is selected the user is taken directly to the first screen in the Admit a Patient function.

***** ADMIT A PATIENT - (Mandatory Fields are preceded by ***)**
When completing an admission, there must be entries for ADMIT DATE, UNIT, HOSPITAL NUMBER, SOCIAL SECURITY NUMBER, PATIENT'S NAME, RESIDENT PARISH, and ADMIT LEGAL STATUS. If the user tries to exit the program with one or more of these fields blank, the program informs the user that the fields are not complete and will not perform a correct exit.

A. Admit a Patient - Page 1
PATIENT ADMIT/FACE SHEET (FACE_GET1)

SCREEN LABEL — DATABASE->FIELD NAME

***** ADMIT DATE** (MAIN->ADM_DATE)

Enter the numeric equivalent of the month, day, and year of the date of the client's formal admission to the hospital. It may not be earlier than the Date of the Interview, if an interview has occurred.

ADMIT TIME (MAIN->ADM_TIME)

Using the 24-hour clock ("military time"), enter the four digit time the client was admitted. For example, 7:30 a.m. would be entered as 0730, while 7:30 p.m. would be entered as 1930. An on-screen military time conversion chart is available by pressing F-9.

*** **UNIT** (MAIN->UNIT)

Select the appropriate unit from the pop-up menu.

*** **HOSPITAL NUMBER** (MAIN->HOSP_NUM)

Enter the unique case number assigned by this hospital when admitting the client for this episode of treatment. The case number must be at least 6 digits and is the primary client identifier upon admission.

 # OF PREV. ADMITS (MAIN->PREV_ADM)

This field is automatically updated when a client is readmitted.

LAST DC DATE (MAIN->LAST_DC)

Using the MM/DD/YYYY format, enter the date of the last discharge for this client. This field is automatically updated when a client is readmitted.

*** **SSN** (MAIN->SSN)

If the client has a valid SSN and (s)he or the parent/guardian signs the official consent form for the use of that SSN, the SSN should be entered in the nine-digit space provided. If the client does not have a valid SSN or the client refuses consent for use of the SSN, a DHH State Identifier is to be assigned to that client for identification purposes in the DHH data system.

PATIENT'S CURRENT LOS

This field is automatically calculated and displayed.

*** **FIRST** (MAIN->FNAME)

Enter, in 15 characters or less, the client's first name.

MID INITIAL (MAIN->MID_INIT)

Enter the client's middle initial.

*** **LAST** (MAIN->LNAME)

Enter, in 20 characters or less, the client's last name.

STREET ADDRESS (MAIN->STADDRESS)

Enter, in 25 characters or less, the client's street address.

CITY (MAIN->CITY)

Enter, in 20 characters or less, the client's city of residence.

STATE (MAIN->STATE)

Enter the two letter abbreviation for client's state of residence.

ZIP (MAIN->ZIP)

Enter the client's five or nine-digit zip code number.

TELEPHONE (MAIN->TELEPHONE)

Enter the client's home telephone number including the area code.

RACE (MAIN->RACE)

Select the appropriate code for the race of the client. For individuals with parents of different races or for individual unsure of their race, the race of the client's mother should be used.

CODES & DEFINITIONS:

? **Unknown**

01 **White** - An individual having origins in any of the original peoples of Europe (including Portugal), North Africa, or the Middle East.

02 **Black/African American** - An individual having origins in any of the original black racial groups of Africa.

03 **Asian or Pacific Islander** - An individual having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands (e.g., Japan, China, Samoa, India, Korea, the Philippine Islands, Vietnam, Thailand, etc.).

04 **American Indian** - An individual having origins in any of the original peoples of North America and who maintains cultural identity through tribal affiliation or community recognition.

05 **Alaskan (Aleut, Eskimo, Indian)** - An individual having origins in any of the original peoples of Alaska and who maintains cultural identity through tribal affiliation or community recognition.

06 **Other** - A default category for use in instances in which the client is not classified above or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories.

ETHNICITY (MAIN->ETHNIC)

Select the appropriate code which represents the ethnic heritage of the client.

CODES & DEFINITIONS:

? **Unknown**

01 **Non-Hispanic** - The client is an individual not of Spanish heritage or culture, regardless of race.

02 **Puerto Rican** - The client is an individual of Puerto Rican heritage or culture, regardless of race.

03 **Mexican/Mexican American** - The client is an individual of Mexican heritage or culture, regardless of race.

04 **Cuban** - The client is an individual of Cuban heritage or culture, regardless of race.

05 **Other Hispanic** - The client is an individual from Central or South America and all other Spanish cultures or origins (including Spain), regardless of race.

SEX (MAIN->SEX)

Specify, by "M" or "F", the sex of the client.

PREGNANT (MAIN->PREGNANT)

Specify, by "Y" or "N", if the client believes she is pregnant at the time of admission. If the client is male, this field automatically is set to "N".

RELIGION (MAIN->RELIGION)

Insert the code that best indicates the current religious preference of the client.

CODES & DEFINITIONS

? **Unknown**

01 **Catholic** - The client is a member of the Roman Catholic faith.

02 **Baptist** - The client is a member of the Baptist faith.

03 **Jewish** - The client is a member of the Jewish faith.

04 **Episcopalian** - The client is a member of the Episcopalian faith.

05 **Methodist** - The client is a member of the Methodist faith.

06 **Other Protestant** - The client is a member of another Protestant faith, including Lutheran, Pentecostal, Seventh Day Adventist, Assembly of God, Church of God, Spiritual Church, and the Church of God in Christ.

07 **Other Christian** - The client is a member of another Christian church, including Jehovah's Witness, Mormon, Unitarian, Quaker, or Mennonite.

08 **Christian Non-Denom** - The client is a member of a "Non-denominational Christian Church".

09 **Other** - The client is a member some religion other than those indicated above, including Muslim, Buddhist, or Hindu.

10 **None** - The client practices no organized religion or is an agnostic or an atheist.

DOB (MAIN->BIRTHDATE)

Enter the numeric equivalent of the month, day, and year for the date of the client's birth. If the actual date of birth isn't known, code the month and day as "01" and code the year with your estimate. Update when accurate information is obtained.

AGE (MAIN->AGE)

The age of the client upon admission is automatically calculated and entered when you insert the birth date of the client.

PLACE OF BIRTH (MAIN->BIRTHPLACE)

Enter the city and state of the client's place of birth. If client was born outside of the USA, add the country of birth. If unknown, leave item blank.

EDUCATION (MAIN->EDUCATION)

Record the educational level of the client by entering the number of school years completed. For example, if the client has completed high school, but has

not had any college education, educational attainment would be recorded as "12". If the client has completed school through grade 9, educational attainment would be coded as "09". All levels should be recorded in two digit, whole year numbers that reflect typical levels (e.g., completion of college = "16"; master's degree = "18"). Record only the highest grade completed. If the individual never attended school, record this as "00". If the client is currently participating in special education or another ungraded classroom situation, or if the highest level achieved was in an ungraded situation, then code this as "99".

LAST SCHOOL ATTENDED (MAIN- > LASTSCHOOL)

If the client is a child or youth under the age of 18, in 30 characters or less, enter the name of the last school attended by the client.

SPOE PROCESS UTILIZED (MAIN- > SPOE)

Specify, by "Y" or "N", if the SPOE, "Single Point Of Entry" process was utilized in the referral of the client for admission to this facility.

ADMIT REFERRAL CODE (MAIN- > ADMREF_COD)

Select the code that indicates the person, provider type or agency which was primarily responsible for referring and arranging this admission. [The intent of this data element is to capture where the client actually "came from". For example, in some systems a necessary prerequisite for admission is assessment and/or administrative processing at or by another agency (e.g. a "Screening Center").]

Please note that of the following referral sources indicated as "Private", those persons, provider types or agencies are located within Louisiana. All "Private" sources located outside of the State of Louisiana are to be coded "09 Other".

CODES & DEFINITIONS

? **Unknown**
00 **None**
01 **Self** - The client decided on his/her own volition to come to this facility (walk-in).
02 **Family/friend** - The client decided to come to this facility based on the advice or recommendation of family and/or friends or any other individual that is not listed in any other category.
03 **School/educational program** - The client was referred to this facility by a school or education agency or program (e.g., school system psychologist, a principal, counselor, teacher, etc.)
04 **Private psychiatrist** - The client was referred to this facility by a licensed

psychiatrist who is in private practice.

05 **Other pvt MH practitioner** - The client was referred to this facility by a mental health practitioner, such as psychologist or social worker, who is in private practice.

06 **Pvt inpatient psych facility** - The client was referred to this facility by an inpatient psychiatric facility that is not a public mental health hospital.

07 **Pvt MH clinic organization** - The client was referred to this facility by a private organization that provides primarily outpatient mental health services.

08 **Clergy** - The client decided to come to this facility based upon the advice and/or recommendation of a member of the clergy.

09 **Other source of referral** - A source of referral not covered by the other categories.

10 **DWI referral** - The client was referred to this facility by the courts subsequent to being charged with Driving While Intoxicated or Driving Under the Influence.

11 **Coroner** - The client was referred to this facility by a duly appointed Parish Coroner or his Deputy.

12 **Other private physician** - The client was referred to this facility by a licensed medical doctor (other than a psychiatrist) who is in private practice.

13 **Private general hospital** - The client was referred to this facility by a private general hospital.

14 **Court local corrections** - The client was referred to this facility by an agency within the courts or a local correctional system (below the level of the Department of Corrections) including judge, prosecutor, probation officer; referred for deferred prosecution, pretrial release, pre-parole, pre-release, work release, civil commitment, or a parish prison program. Does not include DWI or DUI referrals.

15 **Pvt inpatient SA tx facility** - The client was referred to this facility by a private inpatient substance abuse rehabilitation organization.

16 **Pvt outpatient SA tx facility** - The client was referred to this facility by a private outpatient substance abuse rehabilitation organization.

17 **Pvt nursing home/ext care** - The client was referred to this facility by a private nursing home or an extended care facility.

18 **Order for Protective Custody** - The client was transported to this facility under an Order for Protective Custody issued by a Parish Coroner or his Deputy.

19 **Law enforcement agency** - The client was referred to this facility by a law enforcement agency for reasons other than a court order.

20 **Employer/EAP** - The client was referred to this facility by his/her

employer or employee assistance plan, whether formal or informal. Includes supervisor or an employee counselor.

21 **Shelter for homeless abused** - The client was referred to this facility by a shelter for the homeless and/or abused.

22 **Other OMH facility** - The client was referred to this facility by another OMH facility, including a public psychiatric hospital, an OMH Acute Treatment Unit, or a CMHC.

23 **Other State agency** - The client was referred to this facility by another State agency or facility.

24 **Patient deceased** - Not applicable upon admission.

REF. UNIT (MAIN->REFER_UNIT)

Select the appropriate code that represents the public psychiatric hospital, OMH Acute Treatment Unit, or CMHC that referred the client to this hospital. If there was no referral, leave the item blank. Codes are available in the pop-up.

REFERRED BY (MAIN->REFER_ORG)

Enter the name of the person/facility by whom the client was referred to this facility, i.e. doctor or judge's name, private hospital, treatment program, etc. If referral is by SPOE, enter the name of the person/facility who made the referral to SPOE.

ADMITTING STAFF (MAIN->ADM_STAFF)

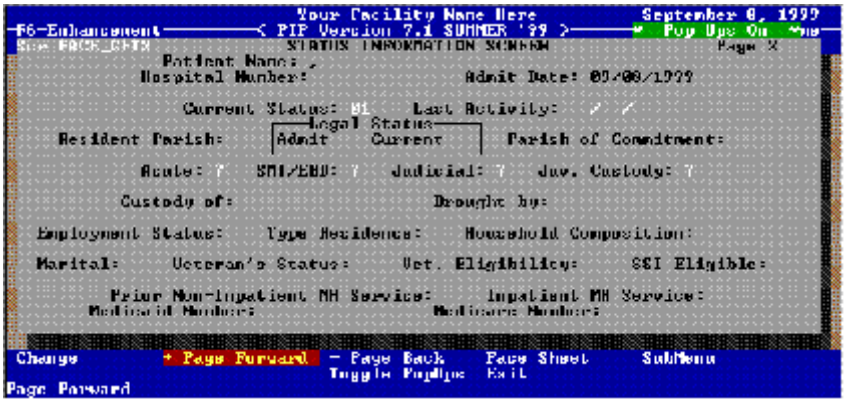
Select the numeric code to identify the member of the facility's Admissions Staff who conducted the admission with the client.

ADMITTING PHYSICIAN (MAIN->ATTD_PHYS)

Enter the provider code of the admitting physician. Codes are available in the pop-up.

RELEASE SIGNED (MAIN->RELSIGN)

For use in Acute Units only, enter the corresponding letter, (Y)es, (N)o, or (R)efused, indicating if a client has signed a Release of Confidential Information. If "yes" is selected, enter the date the release was signed.



B. Admit a Patient - Page 2
STATUS INFORMATION (FACE_GET2)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date, Current Status, Last Activity Date

SCREEN LABEL — DATABASE->FIELD NAME

***** RESIDENT PARISH** (MAIN->ORGPARISH)

Select the appropriate two-digit code for the parish of the client's residence. For clients whose residence is out-of-state, list the Parish of Origin. Note: This will be used to identify region for the bed allocation process. Codes are available in the pop-up.

***** LEGAL STATUS AT ADMISSION** (MAIN->ADMLEGSTAT)
CURRENT (MAIN->ADM_TYPE)

Select the code which describes the legal status of the client upon admission for services. This code may describe the primary criminal justice designation that is appropriate for the client at the time of admission if the client meets criteria for a current legal mandate for mental health evaluation and/or treatment.

A popup will appear to allow entry of date and time of legal status. **Only allowed choices will be lit in the popup.** For all legal status codes, the date and time the execution of the document authorizing admission should be entered. In the case of PEC/CECs, the date and time of execution of the earliest document completed should be entered. The cursor will skip the current legal status field.

CODES & DEFINITIONS

01 **Voluntary-Informal** - Admission for service by consent of the client or the parent/guardian/curator of the client. Admission may be made upon the client's request without a formal application.

02 **Voluntary-Formal** - Admission for service by consent of the client or the parent/guardian/curator of the client. Admission may be made upon the client's request with a formal application.

03 **Formal Voluntary with Notice** - Client on formal voluntary status has made a valid written request for discharge.

04 **Noncontested** - Admission for service of a client who does not have the ability to make a knowing or voluntary consent, but who does not object to admission.

05 **Physician's Emergency Certificate** - Admission for service of a client by an emergency certificate executed after an examination by a physician.

06 **Psychologist's Emergency Certificate** - Admission for service of a client by an emergency certificate executed after an examination by a psychologist.

07 **Coroner's Emergency Certificate** - Admission for service of a client by an emergency certificate executed after an examination by a coroner or his deputy.

08 **PEC/CEC** - An emergency certificate for the client has been executed by a physician or psychologist, and by a coroner or his deputy.

09 **Judicial Petition** - A petition is pending for judicial commitment of a client on a PEC/CEC or Voluntary status with 72 hour notice.

10 **Judicial Civil** - The client has been ordered into the state mental health system by a civil court.

11 **Judicial-Lockhart vs. Armistead** - The client has been ordered into the state mental health system by a criminal court after being found incompetent to proceed to trial in the foreseeable future.

12 **Judicial-Not Competent to Proceed** - The client has been ordered into the state mental health system as incompetent to proceed to trial pursuant to recommendation of a Sanity Commission.

13 **Judicial-NGBRI** - The client has been ordered into the state mental health system after having been found not guilty by reason of insanity.

14 **Judicial-Juvenile** - The client is legally a juvenile and has been ordered into the state mental health system.

PARISH OF COMMITMENT (MAIN->COM_PARISH)

Select the appropriate 2-digit code for the parish that is the legal domicile of the court which committed the client to this hospital. The user will be prompted for entry only if the client's LEGAL STATUS identifies him/her as being admitted under circumstances other than voluntary. Codes are available in the pop-up.

SPECIAL POPULATION CODES

ACUTE, AT ADMISSION (MAIN->ADM_ACUTE)

Select the code that indicates whether or not the client meets criteria for acute mental disturbance.

CODES & DEFINITIONS:

? Unknown

00 Not Applicable

01 Applicable

Select applicable if client is of any age and mental disorder who is acutely disturbed and meets the criteria below:

a. Abrupt and serious disruption in level of functioning in the direction of severe impairment and marked personal distress.

b. Urgent/immediate need for clinical intervention to stabilize condition and prevent further, serious disabling effects.

c. Severity of current impairment tends to be short-term and intermittent rather than persistent and enduring.

1. For coding purposes, the maximum duration of an acute mental state is six months, at which time client is reclassified.

SMI/EBD, AT ADMISSION (MAIN- > ADM_CHRONI)

Select the code that indicates the whether or not the client meets criteria for a seriously mentally ill adult or a child/youth who has an emotional/behavioral disorder. PIP will only allow you to select the proper code for either SERIOUSLY MENTALLY ILL ADULT (18 years and older), or EMOTIONAL/BEHAVIORAL DISORDER -- CHILD/YOUTH (Under age 18).

CODES & DEFINITIONS

? Unknown

00 Not Applicable

01 Seriously Mentally Ill Adult - An individual age 18 or older who meets all the criteria below:

1. Age - 18 years or older

2. Diagnosis - Severe non-organic mental illnesses including, but not limited to, schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships at work or school.

3. Disability - Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:

a. Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.

b. Employed in a sheltered setting.

c. Requires public financial assistance for out-of-hospital

maintenance (e.g. SSI) and/or is unable to procure such without help. Does not apply to routine retirement benefits.

d. Severely lacks social support systems in the natural environment (e.g., no close friends or group affiliations, lives alone, or is highly transient).

e. Requires assistance in basic life skills (e.g. must be reminded to take medicine, must have transportation arranged for them, needs assistance in household management tasks).

f. Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

4. Duration - Must meet at least one of the following indicators of duration:

a. Psychiatric hospitalizations of at least six months (cumulative total) in the last five years.

b. Two or more hospitalizations for mental disorders in the last 12 month period.

c. A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.

d. A previous psychiatric evaluation indicating a history of treatment for severe psychiatric disability of at least six months duration.

02 Emotional/Behavioral Disorder -- Child/Youth - A child or youth (age zero through 17) who has behavioral or emotional responses so different from appropriate age, cultural, or ethnic norm that they adversely affect performance. Performance includes academic, social, vocational or personal skills. Such a disability is more than a temporary, expected response to stressful events in the environment; is consistently exhibited in two different settings; and persists despite individualized intervention within general education and other settings. Emotional and behavioral disorders can co-exist with other disabilities.

Criteria (All criteria must be met):

1. Age - Under age 18.
2. Meets one of the following criteria which operationalizes the above definition:

a. Exhibits seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning whose thinking is frequently confused, whose

behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; **or,**

b. Manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; **or,**

c. Experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; **or,**

d. Have a DSM-III-R (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive) or severe conduct disorder. This category does not include children/youth who are socially maladjusted unless it is determines that they also meet the criteria for emotional/behavior disorders; **and,**

3. Disability: There is evidence of severe, disruptive and/or incapacitating functional imitations of behavior characterized by at least two of the following:

   a. Inability to routinely exhibit appropriate behavior under normal circumstances.

   b. Tendency to develop physical symptoms or fears associated with personal or school problems.

   c. Inability to learn or work that cannot be explained by intellectual, sensory, or health factors.

   d. Inability to build or maintain satisfactory interpersonal relationships with peers and adults.

   e. A general pervasive mood of unhappiness or depression.

   f. Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then "conduct disorders" are eligible.

4. Duration:

   a. The impairment or pattern of inappropriate behavior(s) has

persisted for at least one year, **or**

b. There is substantial risk that the impairment or pattern of inappropriate behavior(s) will persist for an extended period, **or**

c. There is a pattern of inappropriate behaviors that are severe and of short duration.

JUDICIAL, AT ADMISSION (MAIN-> ADM_COURT)

Select the code which describes the primary criminal justice designation that is appropriate for the client at the time of admission if the client meets criteria for a current legal mandate for mental health evaluation and/or treatment.

CODES & DEFINITIONS:

? **Unknown**

00 **Not Applicable**

10 **Criteria for GW Class members** - This individual is a member of the Gary W. class action suit which is verifiable through a DHH Office.

Forensic client - This individual is mandated to receive services by the Settlement Agreement (consent decree) in Forensic class action suits. Client types 20-24 below or emergency certificate (citation in parentheses):

20 **NGBRI; Not Guilty/Insane** - Those adjudicated Not Guilty by Reason of Insanity (NGBRI) (C.Cr.Pr., Art. 654).

21 **Not competent for trial** - Pretrial clients adjudged not competent to proceed to trial (C.Cr.Pr., Art. 648, et seq.)

22 **Not to regain competency** - Pretrial clients adjudged unlikely to regain competency in the foreseeable future and may be civilly committed (C.Cr.Pr., Art 648 or La. R.S. 28:54, et seq.); Commonly known as "Lockharts".

23 **Transfer from Dept. Corr.** - Transfers from the Department of Public Safety and Corrections (La. R.S. 28:59 and/or 28:54 or by emergency certificate).

24 **Transfers from OMH Hosp.** - Transfer from other OMH Hospitals who are dangerous to others and cannot be controlled at the civil hospital. (This may be done administratively and does not require court approval.)

30 **Other court-ordered client** - These clients are mandated to receive evaluation or treatment as evidenced by a current civil or juvenile court order.

JUV. CUSTODY, AT ADMISSION (MAIN-> JUV_CUS)

Select the code that indicates whether or not the client meets the criteria for

a juvenile in state custody. If the client is over the age of 18, PIP will not access this field.

CRITERIA (All criteria must be met):

1. Under age 18 years
2. Adjudicated in need of care, in need of supervision, or delinquent
3. In custody through either (at least one):
   a. Court Order
   b. Minute Entry
   c. Surrender proceedings
4. Verification by verbal confirmation of OCS worker or administrator **or** verbal confirmation of DPSC juvenile services officer or administrator **and** a copy of court order or OCS surrender form #445 within 30 days.

CODES & DEFINITIONS:

? **Unknown**

00 **Not Applicable**

01 **DSS-Office of Community Service** - In the custody of the Department of Social Services - Office of Community Services.

02 **DPSC-Office of Juv. Service** - In the custody of the Department of Public Safety and Corrections - Office of Juvenile Services

03 **DSS-OCS & DPSC-OJS** - In the custody of both DSS-OCS **and** DPSC-OJS.

04 **DSS-OCS or DPSC-OJS & OMH** - In the custody of DSS-OCS **or** DPSC-OJS **and** OMH.

CUSTODY OF (MAIN->CUSTODY)

Enter, in fifteen characters or less, the person or persons who have legal custody over client. If none, leave blank.

BROUGHT BY (MAIN->BROUGHT_BY)

Enter the name of the person who brought the client to the facility, i.e. police, parents, etc.

EMPLOYMENT STATUS (MAIN->EMPLOY_STA)

Select the code that best represents the current employment status of the client.

CODES & DEFINITIONS

? **Unknown**

01 **Employed, full time** - The client is regularly employed at least 35 hours per week.

02 **Employed, part-time** - The client is employed, but for less than 35 hours per week.

03 **Unemployed, on layoff** - The client is currently laid off, but is awaiting recall by a previous employer.

04 **Unemployed; looking for job** - The client is currently unemployed, and looking for a job.

05 **Unemployed; not looking for job** - The client is currently unemployed and is not seeking employment.

06 **Homemaker** - The client's primary responsibility is maintaining a household.

07 **Student/preschool child** - The client is a child/youth attending school (college, high school, elementary) or (s)he is not yet of school age.

08 **In Armed Forces** - The client is a member of the Army, Navy, Marines, etc.

09 **Retired worker** - The client has retired from active work.

10 **Disabled** - The client is unable to pursue an occupation because of physical or mental impairment and has been certified as "disabled" by a public agency, retirement program, or a branch of the military services. This code is not to be used if the client is certified as disabled, but holds down another full-time job.

11 **Supported Employment** - The client is engaged in non-competitive employment (not on the open market) provided in a controlled work environment with long-term support from a community support program. Examples include sheltered workshops, job coaches, "friendship clubs", or mobile work crews.

12 **Jail/prison/training institute** - The client is out of the work force because of incarceration in a jail, prison, or training institution.

13 **In hospital** - The client is out of the work force because (s)he has been in a hospital prior to admission to this facility.

14 **Other** - For use if none of the other categories is appropriate.

TYPE RESIDENCE (MAIN- > TYPE_RES)

Select the code which indicates the type of residential arrangement in which the client spent most of the day during the past 30 days preceding the current admission. When an individual spends equal time in two residences during the 30 days prior to admission, the last residence should be the one selected.

CODES & DEFINITIONS

? **Unknown**

01 **Single-family dwelling** - The client lives in a dwelling which houses only a single family. May include mobile homes.

02 **Apartment** - The client lives in a multiple-family dwelling, including duplexes, triplexes, and apartment buildings.

03 **Nursing home/care facility** - The client lives in a nursing home, convalescent home, etc.

04 **Residential hotel** - The client lives in a residential hotel or other type of boarding house arrangement, or rents a single room in someone's house.

05 **No permanent residence** - The client's residence is primarily transient (for example, a camper trailer or motor home), or the client may live "on the street". This includes clients living in a shelter, mission, or temporary living quarters or in a place that is limited/short-term stay.

06 **Group home/halfway house** - The client lives in a group home or halfway house as part of a supervised residential program designed to meet special needs.

07 **Supervised apartment** - The client lives in a supervised apartment as part of a supervised residential program designed to meet special needs.

08 **Board and care** - The client lives in a licensed, supervised "board and care" 24-hour residence as part of a supervised residential program designed to meet special needs.

09 **Jail/prison/training institute** - The client is incarcerated in a jail, prison, or training institution.

10 **Hospital** - The client has been in a medical or psychiatric hospital prior to admission.

11 **Other quarters** - For use if none of the other categories is appropriate (for example, military barracks, dormitory, fraternity, sorority, etc.).

HOUSEHOLD COMPOSITION (MAIN->HOUSE_COMP)

Select the code that best indicates the current household composition or living arrangements of the client.

CODES & DEFINITIONS

? **Unknown**

01 **Adult only** - The client is an adult and lives alone.

02 **Adult; relatives** - The client is an adult and lives with other family members (e.g., spouse, children, etc.).

03 **Adult; non-relatives** - The client is an adult and does not live with family members (e.g., lives with friends, in an institutional environment, etc.).

04 **Child; both parents** - The client is a child, lives with both parents.

05 **Child; one parent** - The client is a child and lives with only one of his/her parents.

06 **Child; relatives, not parents** - The client is a child and lives with family members other than his/her parents (e.g., lives with an uncle, sister, etc.).

07 **Child; foster family** - The client is a child, lives in a foster care family.

08 **Child; non-relative** - The client is a child and doesn't live with family

members (e.g., lives with friends, an institutional setting, etc.).

NOTE: The following definitions apply to "parents" and "relatives":

Parent: A natural parent or an adult who is occupying a parental role to the client, such as an adoptive parent or an individual married to a natural parent (e.g., step-parent).

Relative: An individual who is related to the client by kinship, marriage, or legal action (e.g., spouse, sibling, etc.).

MARITAL (MAIN-> MARITAL)

Select the code that best indicates the current marital status of the client.

CODES & DEFINITIONS

? **Unknown**

01 **Never married** - The client has never married (either legal or "common law") or the client's only marriage(s) ended in annulment.

02 **Married** - The client has been married only once and is still married to the same spouse (includes "common law" marriages and those living together as a married couple).

03 **Remarried** - The client has been married more than once and is now currently married (includes "common law" marriages and those living together as a married couple).

04 **Separated** - The client is married, but is currently living apart from (or has been deserted by) his/her spouse because of marital discord (includes informal as well as legal separations).

05 **Divorced** - The client is currently legally divorced.

06 **Widowed** - The client's spouse is deceased and the client has not remarried.

VETERAN'S STATUS (MAIN-> VETERAN)

Select the code that indicates the client's veteran status.

CODES & DEFINITIONS

? **Unknown**

01 **No** - The client is not a veteran.

02 **Yes, but no active duty** - The client served in the Reserves or the National Guard, but did not serve on active duty for more than 180 consecutive days, or (s)he served in the Merchant Marines.

03 **Yes, had active duty** - The client has served on active duty for more than 180 consecutive days in the Armed Forces (including the Coast Guard).

VET. ELIGIBILITY (MAIN->VET_ELIG)

Select the code which best represents the client's Veterans' Administration eligibility.

CODES & DEFINITIONS

? **Unknown**

01 **Is qualified** - The client has a VA file number based on his/her active military service.

02 **Is not qualified** - The client does not have a VA benefits file number based on active military service.

03 **Is a qualified dependent** - The client is listed as a qualified dependent under someone's VA file number.

SSI ELIGIBLE (MAIN->SSI_ELIG)

Select the code which represents the client's current status with respect to the SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance) programs of the Social Security Administration.

CODES & DEFINITIONS

? **Unknown**

00 **Not Applicable**

01 **Eligible & receiving payments** - The client is eligible for, and is currently receiving SSI or SSDI benefits.

02 **Eligible, not receiving payments** - The client is eligible for, but is not currently receiving SSI or SSDI payments.

03 **Potentially eligible/has applied** - The client's claim for SSI or SSDI has been submitted or is in the process of determination.

04 **Potentially eligible/has not applied** - No claim for SSI or SSDI has been filed although the client is believed to be eligible.

05 **Determined ineligible** - The client's claim for SSI or SSDI has been submitted and reviewed, and a decision of ineligible was returned.

PRIOR NON-INPATIENT MH SERVICE (MAIN->NI_MH_PAT)

Select the code that represents the client's previous history of non-inpatient mental health service(s). Non-inpatient services are defined as either outpatient or day treatment/partial hospitalization, and the provision of such services (if any) could have been by any mental health agency, organization, or practitioner.

CODES & DEFINITIONS

? **Unknown**

00 **None** - The client never received non-inpatient mental health services.

01 **Within last day** - The client has received some type of non-inpatient

mental health service(s), the most recent service occurring on this date.

02 **Within last 7 days** - The client has received some type of non-inpatient mental health service(s), the most recent service occurring within the last 7 days.

03 **Within last 30 days** - The client has received some type of non-inpatient mental health service(s), the most recent service occurring within the last 30 days.

04 **Within last 6 months** - The client has received some type of non-inpatient mental health service(s), the most recent service occurring within the last 6 months.

05 **Within last year** - The client has received some type of non-inpatient mental health service(s), the most recent service occurring within the last year.

06 **Over one year ago** - The client has received some type of non-inpatient mental health service(s), the most recent service occurring over a year ago.

INPATIENT MH SERVICE (MAIN->IN_MH_PAT)

Select the code that represents the client's previous history of inpatient mental health service(s). Inpatient service is defined as 24-hour hospitalization, and the provisions of such service (if any) could have been by any mental health agency, organization, or practitioner.

CODES & DEFINITIONS

? **Unknown**

00 **None** - The client has never received inpatient mental health services.

01 **Within last day** - The client has received some type of inpatient mental health service(s), the most recent service occurring on this date.

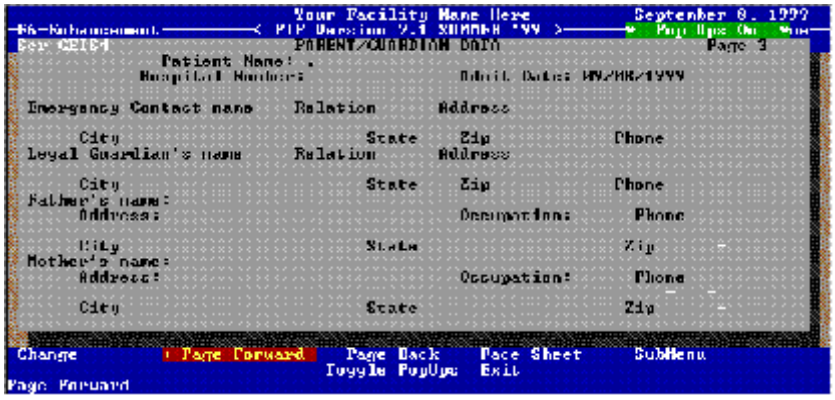
02 **Within last 7 days** - The client has received some type of inpatient mental health service(s), the most recent service occurring within the last 7 days.

03 **Within last 30 days** - The client has received some type of inpatient mental health service(s), the most recent service occurring within the last 30 days.

04 **Within last 6 months** - The client has received some type of inpatient mental health service(s), the most recent service occurring within the last 6 months.

05 **Within last year** - The client has received some type of inpatient mental health service(s), the most recent service occurring within the last year.

06 **Over one year ago** - The client has received some type of inpatient mental health service(s), the most recent service occurring over a year ago.



C. Admit a Patient - Page 3 PARENT/GUARDIAN DATA (GETS4)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date

SCREEN LABEL — DATABASE->FIELD NAME

EMERGENCY CONTACT NAME (MAIN->EMR_NAME)
Enter the information for the emergency contact person. If this information is unknown, leave the item blank.

RELATION (MAIN->EMR_RELATE)
Enter the emergency contact's relationship to the client.

ADDRESS (MAIN->EMR_ADDRESS)
Enter, in 25 characters or less, the emergency contact's street address.

CITY (MAIN->EMR_CITY)
Enter, in 20 characters or less, the emergency contact's city of residence

STATE (MAIN->EMR_STATE)
Enter the two letter abbreviation for the emergency contact's state of residence.

ZIP (MAIN->EMR_ZIP)
Enter the emergency contact's zip code.

PHONE (MAIN->EMR_TELE)
Enter the emergency contact's phone number including the area code.

LEGAL GUARDIAN (MAIN->GUARDIAN)
Enter the name of the person having LEGAL custody of the client. If this information is unknown, or not applicable, leave the item blank.

RELATION (MAIN->GRD_RELATE)
Enter the guardian's relationship to the client.

ADDRESS (MAIN->GRD_ADDRES)
Enter, in 25 characters or less, the guardian's street address.

CITY (MAIN->GRD_CITY)
Enter, in 20 characters or less, the guardian's city of residence.

STATE (MAIN->GRD_STATE)
Enter the two-letter abbreviation for the guardian's state of residence.

ZIP (MAIN->GRD_ZIP)
Enter the guardian's zip code.

PHONE (MAIN->GRD_TELE)
Enter the guardian's telephone number including the area code.

FATHER'S NAME (MAIN->FATHER)
Enter, in 25 characters or less, the father's full name.

ADDRESS (MAIN->FATHER_ADD)
Enter, in 35 characters or less, the father's street address.

OCCUPATION (MAIN->FATHER_OCC)
Enter, in 15 characters or less, the father's occupation.

PHONE (MAIN->FATHR_PHON)
Enter the father's telephone number including the area code.

CITY (MAIN->FATHERCITY)
Enter, in 20 characters or less, the father's city of residence.

STATE (MAIN->FATHER_ST)
Enter the two letter abbreviation for the father's state of residence.

ZIP (MAIN->FATHER_ZIP)
Enter the father's zip code.

MOTHER'S NAME (MAIN->MOTHER)
Enter, in 25 characters or less, the mother's full name.

ADDRESS (MAIN->MOTHER_ADD)
Enter, in 35 characters or less, the mother's street address.

OCCUPATION (MAIN->MOTHER_OCC)
Enter, in 15 characters or less, the mother's occupation.

PHONE (MAIN->MOTHR_PHON)
Enter the mother's telephone number including area code.

CITY (MAIN- > MOTHERCITY)

Enter, in 20 characters or less, the mother's city of residence.

STATE (MAIN- > MOTHER_ST)

Enter the two letter abbreviation for the mother's state of residence.

ZIP (MAIN- > MOTHER_ZIP)

Enter the mother's zip code.

D. Admit a Patient - Page 4
LEGAL CHARGES (ADMIT2_GET)

INFORMATIONAL DISPLAY ONLY
Patient Name, Admit Date

SCREEN LABEL — DATABASE- > FIELD NAME

CRIMINAL CHARGES

CODES (MAIN- > CRIMINAL1 - CRIMINAL4)

Select the code which best represents those legal charges against the client which ultimately resulted in the client being committed to this hospital. Enter the number of counts of each legal charge. Up to four sets of charges may be included for each client. Codes are available in the pop-up.

COUNTS (MAIN- > L_CNTS1 - L_CNTS4)

Enter the number of counts of each legal charge.

JUDGE (MAIN- > COM_JUDGE)

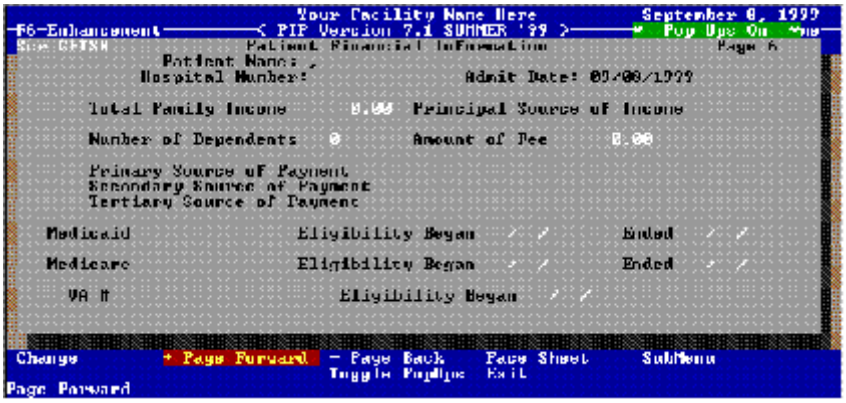
Enter the name of the Judge issuing the criminal commitment on the client.

E. Admit a Patient - Page 5
SUPPLEMENTARY PATIENT INFORMATION (GETS7)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date

The fields displayed on this screen are user defined fields which can be modified by each facility to meet the needs of that facility. There are three of each of the following types of fields: Date, Numeric and Character.

SCREEN LABEL	DATABASE->FIELD NAME
DATE FIELDS 1-3	(MAIN->MZD1 - MZD3)
NUMERIC FIELDS 1-3	(MAIN->MZN1 - MZN3)
CHARACTER FIELDS 1-3	(MAIN->MZC1 - MZC3)



F. Admit a Patient - Page 6
PATIENT FINANCIAL INFORMATION (GETS8)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date

SCREEN LABEL	DATABASE->FIELD NAME
TOTAL FAMILY INCOME	(MAIN->TOTINCOME)

Type in the total family income as reported before deductions for taxes, bonds, dues or other items.

PRINCIPAL SOURCE OF INCOME (MAIN->INC_SOURCE)

Select the code for the primary source of the client's income.

CODES & DEFINITIONS

? Unknown

01 Employment/Wages - The majority of the family's income is derived through employment. The money is earned as:

a. salary, wages, tips, commissions, and/or bonuses;
b. farm self-employment (after deductions for operating expenses) or tenant farmer or sharecropper
c. non-farmer self-employment, partnerships, or professional practices

Also included are retirement incomes/pensions from private or governmental sources (such as Social Security, Railroad Retirement, State Employees' Retirement, Teachers' Retirement, military retirement, etc.) and payments from the military for National Guard or Reserve duty.

02 Public Assistance - The majority of the family's income is derived from some form of public assistance, including Aid to Families with Dependent Children, Supplemental Security Income, and Social Security Disability Insurance.

03 Other - The majority of the family's income is derived from other sources, such as interest, dividends, royalties, net rentals, alimony, child support, or any other source of income regularly received. (Do not include one-time or lump-sum payments such as inheritance or sale of a house.)

NUMBER OF DEPENDENTS (MAIN->NOFAMILY)

Type in the number of persons in the client's family dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes.

AMOUNT OF FEE

This field is not completed at this time.

PRIMARY SOURCE OF PAYMENT (MAIN->FISSTAT)

Enter the code that represents the first type of account payment.

CODES & DEFINITIONS

00 None

01 No fee payment - Based on the DHH Liability Limitation Schedule, no fee is to be charged to the client.

02 Private/personal funds - The fee (in total or in part) will be paid from the client's personal income or that of the client's household.

03 Private health insurance - The fee (in total or in part) will be paid by the client's personal insurance carrier in accordance with the specifications of the policy.

04 Medicare - The fee (in total or in part) will be paid by insurance provided through Social Security or Railroad Retirement.

05 Medicaid - The fee (in total or in part) will be paid by the Title XIX

program.

06 **VA** - The fee (in total or in part) will be paid by the Veteran's Administration.

07 **CHAMPUS** - The fee (in total or in part) will be paid by insurance provided by the Civilian Health and Military Personnel Uniformed Services.

08 **Other public sources** - The fee (in total or in part) will be paid by another organization, including Workman's Compensation.

SECONDARY SOURCE OF PAYMENT (MAIN->FISSTAT2)

Enter the code which represents the client's secondary source of payment. See primary source of payment for codes and definitions.

TERTIARY SOURCE OF PAYMENT (MAIN->FISSTAT3)

Enter the code which represents the client's tertiary source of payment. See primary source of payment for codes and definitions.

MEDICAID NUMBER (MAIN->MEDCAID)

Type in the client's Medicaid number, if appropriate. If there is no eligibility, this item may be left blank.

ELIGIBILITY BEGAN (MAIN->CAIDBEG)
ENDED (MAIN->CAIDEND)

Enter the date(s) that Medicaid eligibility began and/or ended.

MEDICARE NUMBER (MAIN->MEDICARE)

Type in the client's Medicare number, if appropriate. If there is no eligibility, this item may be left blank.

ELIGIBILITY BEGAN (MAIN->CAREBEG)
ENDED (MAIN->CAREEND)

Enter the date(s) that Medicare eligibility began and/or ended.

VA # (MAIN->VANUMBER)

Type in the client's Veteran's Administration number, if appropriate. If there is no eligibility, this item may be left blank.

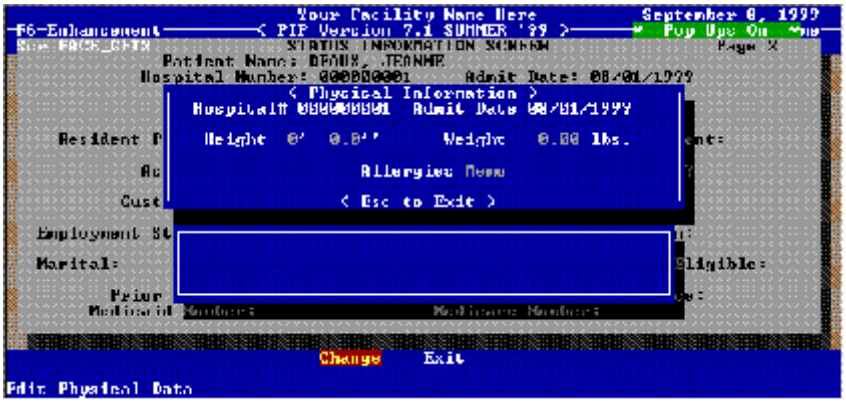
ELIGIBILITY BEGAN (MAIN->VABEG)

Enter the date(s) that VA eligibility began.

When data entry is completed the user will be asked if they would like to save the record. If the user's response is "YES" the record will be saved. If the response is "NO" the record will be deleted.

II. ADDITIONAL PATIENT INFORMATION

This function is used to collect and record additional information regarding a client. Select this option from the Page Menu by highlighting the "Submenu" function and pressing ENTER.



A. Patient Physical Information

INFORMATIONAL DISPLAY ONLY
Hospital Number, Admit Date

SCREEN LABEL	DATABASE->FIELD NAME
PHYSICAL INFORMATION	
HOSPITAL NUMBER	(PHYSICAL->HOSP_NUM)
DATE OF ADMISSION	(PHYSICAL->ADM_DATE)
HEIGHT, FEET	(PHYSICAL->HEIGHT_FT)
HEIGHT, INCHES	(PHYSICAL->HEIGHT_IN)
WEIGHT	(PHYSICAL->WEIGHT)
ALLERGIES	(PHYSICAL->ALLERGIES)

The fields displayed on this screen are used by the Pharmacy System. This information is limited to height, weight, and allergies. Height should be entered in feet and fractional inches. Weight should be entered in whole pounds. The user may now exit by pressing ESC or may select Allergies - Memo and a pop-up will appear to allow entry of any known allergies the client may have. The memo field will allow up to four lines of comments. Following the entry of a client's allergies, the user may save or abort the entry by using the function keys as listed. The user will then highlight EXIT and press ENTER to exit the screen.

B. Medicaid Certification Information

I N F O R M A T I O N A L
DISPLAY ONLY
Patient Name

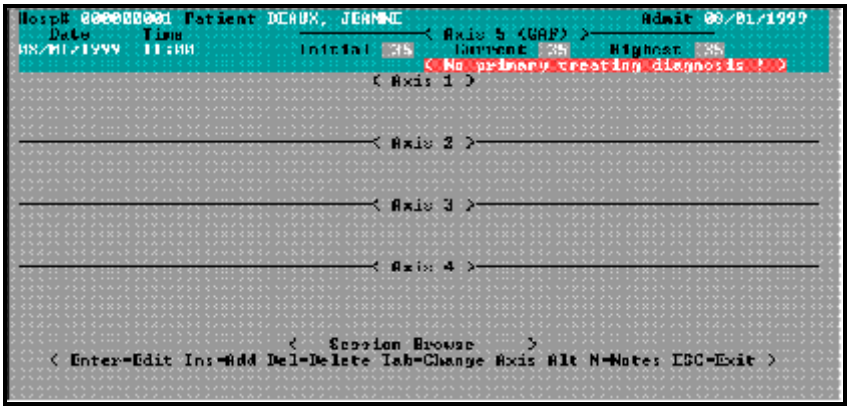
SCREEN LABEL	DATABASE->FIELD NAME
MEDICAID CERTIFICATION INFORMATION	
MEDICAID CASE #	(MED_CERT->CASE_NUM)
MEDICAID #	(MAIN->MEDCAID)
MEDICAID START	(MED_CERT->UNISYSBEG)
END	*** *CALCULATED FIELD*
MEDICARE EXP.	(MED_CERT->MEDICAREEX)
IS CASE ACTIVE?	(MED_CERT->ACTIVE)
REQUEST DATE	(CERTRESP->REQ_DATE)
REQUEST TIME	(CERTRESP->REQ_TIME)
RESPONSE	(CERTRESP->RESPONSE)
REVIEWER ID	(CERTRESP->REV_INIT)
DAYS APPROVED	(CERTRESP->DAYS_APP)
RESPONSE DATE	(CERTRESP->RESP_DATE)
MEMO	(CERTRESP->REQ_NOTES)

The fields displayed on this screen are used by various administrative departments to facilitate billing. Press INSERT to add information regarding Medicaid certification for the selected client. If there are no previous entries, the program asks if you would like to add one. The user may now exit by pressing "N" or may press "Y" or ENTER for yes. A pop-up will then appear to allow entry of Medicaid certification information the client may have. Following the entry of a client's information, the user will highlight EXIT and press ENTER to exit the screen. Press ESC to exit the pop-up.

C. DIAGNOSTIC SESSION - Admission, Most Current or Updated, and Discharge
This function is used to collect and record information regarding a client's diagnosis. Choose the Diagnostic Session option from the Page Menu by highlighting the "Submenu" function and pressing ENTER.

It should be assumed that the diagnosis appropriate to the type of record or report is provided. Specifically, for a recently admitted patient, the admission diagnosis; for a census report, the most current or admission diagnosis; and for a discharged patient, the discharge diagnosis. For these purposes, the first diagnostic session will be considered the Admission Diagnosis. Similarly, the last diagnostic session will be considered the Discharge Diagnosis.

All admitting, treating and discharge diagnoses entered prior to July 1, 1996 will be coded and tracked according to the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-III-R. After this date all diagnoses entered will be tracked according to the fourth edition, or DSM-IV.



C. Diagnostic Session

INFORMATIONAL DISPLAY ONLY
Hospital Number, Patient Name, Admit Date
*****Primary Treating Diagnosis must be indicated at each diagnostic session.**

IF THERE ARE NO PREVIOUS ENTRIES, a Diagnostic Session pop-up will appear to allow entry of this session date and time as well as the current GAF score. The user will press ENTER upon completion of this screen and PIP will then take the user to the Diagnostic Session Browse screen.

TO ADD A NEW DIAGNOSTIC SESSION, with the colored bar highlighting the top of the screen, press INSERT. A pop-up for the NEW DIAGNOSTIC SESSION will appear to allow entry of this new session date and time and current GAF score. Upon completion, the user will press Enter to save this information before returning to the Diagnostic Session Browse screen.

TO VIEW OR EDIT A PREVIOUS DIAGNOSTIC SESSION, with the colored bar highlighting the top of the screen, the user may scroll up and down the list of session dates and times using the corresponding arrow keys. Select the desired diagnostic session by highlighting the desired session date. To edit the GAF score, press Enter.

As instructed at the bottom of the screen, press TAB to browse or move through the axes. A colored bar will highlight the selected axis. The axis title will appear within the < BROWSE > at the bottom of the screen. To view or edit existing entries in the list, the user may scroll up and down using the corresponding arrow keys.

TO ENTER A CODE/DIAGNOSIS, highlight the desired axis, press the INSERT key and a diagnostic code pop-up will appear. The user may browse through the pop-up by using the arrow keys or page-up/down keys. Press ENTER to select a diagnosis.

Alternately, the user may search for a particular diagnosis by typing the code number, if known. To search for a diagnosis by name, use the arrow keys to move the highlighting bar to the diagnosis description and begin typing the desired diagnosis. In both searches, code or description, a "search string" box will appear at the top of the pop-up. Upon completion of the search press ENTER and that diagnostic code will be selected.

TO DELETE A SELECTED CODE/DIAGNOSIS, highlight the code/diagnosis to be deleted and press the DELETE key.

TO CHANGE A PREVIOUSLY SELECTED CODE/DIAGNOSIS, highlight the code/diagnosis to be changed and press ENTER. A diagnosis pop-up will appear. Highlight the new code/diagnosis and press ENTER.

Press ALT-T to toggle selection where the diagnosis is (P) Provisional or (RO) Rule Out.

Press ALT-R to raise, or ALT-L to lower, a highlighted diagnosis by one line increments on a selected axis.

Press ALT-N to open a text editor pop-up which allows for further clarification of the Diagnostic Session, as well as the diagnoses on all four axes.

Press ALT-F to view the full text description of the highlighted diagnosis as well as additional notes, if available.

Press ALT-1 to select the highlighted diagnosis as the Primary Treating Diagnosis represented to the right of the line by " < - PRI".

Press ALT-2 to select the highlighted diagnosis as the Secondary Treating Diagnosis represented to the right of the line by " < - SEC".

DSM-III-R Multiaxial System
(To be used for those diagnoses recorded prior to July 1, 1996.)

AXIS 1

Select the appropriate diagnostic code according to the DSM-III-R classification (Clinical Syndromes and V Codes). When an individual has more than one Axis 1 disorder, all of the disorders should be reported, with the reason for this episode of care being listed first. When an individual has both an Axis 1 and an Axis 2 disorder, and the Axis 1 diagnosis is the primary treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 1 diagnosis. If no Axis 1 diagnosis or condition is present, this should be coded as V71.09. If an Axis 1 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.90.

AXIS 2

Select the appropriate diagnostic code according to the DSM-III-R classification (Developmental Disorders and Personality Disorders). When an individual has both an Axis 1 and an Axis 2 diagnosis and the Axis 2 diagnosis is the principal treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 2 diagnosis. If no Axis 2 disorder is present, this should be coded as V71.09. If an Axis 2 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

AXIS 3

Select the appropriate diagnostic code according to the ICD-9-CM classification (Physical Disorders and Conditions). Axis 3 permits the clinician to indicate any current physical disorders or conditions that are potentially relevant to the understanding or management of the individual's mental disorder. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis 1 and the general medical condition should be recorded on both Axis 1 and Axis 3. In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis 1 diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder should be listed and coded on Axis 1; the general medical condition should only be coded on Axis 3. When an individual has more than one clinically relevant Axis 3 diagnosis, all should be reported.

AXIS 4

Select the appropriate code which represents the scale according to the DSM-III-R classification (Severity of Psychosocial Stressors) that may have contributed to the disorder responsible for causing this episode of the client's clinical care.

CODES & DEFINITIONS

0 Inadequate Information, Or No Change In Condition
1 None
2 Mild
3 Moderate
4 Severe
5 Extreme
6 Catastrophic

AXIS 5

Initial Current Highest

Axis 5 is for reporting the clinician's judgement of the individual's overall level of psychological, social and occupational functioning. This is done using the Global Assessment of Functioning (GAF) Scale.

In most instances, ratings on the GAF Scale should be for the Current Period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. However, PIP also tracks the GAF Scale rating at the time of admission (Initial) as well as the client's highest level of functioning during the current episode of care.

DSM-IV Multiaxial System
(To be used for those diagnoses recorded after July 1, 1996.)

AXIS 1:

Select the appropriate diagnostic code according to the DSM-IV classification (Clinical Disorders and/or Other Conditions That May Be a Focus of Clinical Attention). When an individual has more than one Axis 1 disorder, all of the disorders should be reported, with the principal diagnosis or the reason for this episode of care being listed first. When an individual has both an Axis 1 and an Axis 2 disorder, and the Axis 1 diagnosis is the primary treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 1 diagnosis. If no Axis 1 disorder is present, this should be coded as V71.09. If an Axis 1 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention:

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence *(excluding Mental Retardation, which is diagnosed on Axis 2)*
Delirium, Dementia, and Amnestic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention

AXIS 2:

Select the appropriate diagnostic code according to the DSM-IV classification (Personality Disorders and/or Mental Retardation). When an individual has both an Axis 1 and an Axis 2 diagnosis and the Axis 2 diagnosis is the principal treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 2 diagnosis. If no Axis 2 disorder is present, this should be coded as V71.09. If an Axis 2 diagnosis is deferred,

pending the gathering of additional information, this should be coded as 799.9.

Personality Disorders; Mental Retardation:

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise Specified
Mental Retardation

AXIS 3:

Select the appropriate diagnostic code according to the ICD-9-CM classification (General Medical Conditions). These are current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis 1 and the general medical condition should be recorded on both Axis 1 and Axis 3. In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis 1 diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder should be listed and coded on Axis 1; the general medical condition should only be coded on Axis 3. When an individual has more than one clinically relevant Axis 3 diagnosis all should be reported.

General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001-139)
Neoplasms (140-239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Diseases of the Blood and Blood-Forming Organs (280-289)
Diseases of the Nervous System and Sense Organs (320-389)
Diseases of the Circulatory System (390-459)
Diseases of the Respiratory System (460-519)
Diseases of the Digestive System (520-579)

Diseases of the Genitourinary System (580-629)
Complications of Pregnancy, Childbirth, and the Puerperium (630-679)
Diseases of the Skin and Subcutaneous Tissue (680-709)
Diseases of the Musculoskeletal System and Connective Tissue (710-739)
Congenital Abnormalities (740-759)
Certain Conditions Originating in the Perinatal Period (760-779)
Symptoms, Signs, and Ill-defined Conditions (780-799)
Injury and Poisoning (800-999)

AXIS 4:

Select the appropriate code which represents the scale according to the DSM-IV classification (Psychosocial and Environmental Problems). Axis 4 is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axis 1 and 2). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment.

In practice, most psychosocial and environmental problems will be indicated on Axis 4. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis 1, with a code derived from the section "Other Conditions That May Be A Focus of Clinical Attention".

The clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved.

Categories of Psychosocial and Environmental Problems:

Problems with primary support group - e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling.

Problems related to the social environment - e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)

Educational problems - e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment

Occupational problems - e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions, job dissatisfaction; job change; discord with boss or co-workers

Housing problems - e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord

Economic problems - e.g., extreme poverty; inadequate finances; insufficient welfare support

Problems with access to health care services - e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

Problems related to interaction with the legal system/crime - e.g., arrest; incarceration; litigation; victim of crime

Other psychosocial and environmental problems - e.g., exposure to disasters, war, other hostilities; discord with non-family caregivers such as counselor, social worker, or physician; unavailability of social service agencies

AXIS 5 (GAF):

Initial Current Highest

Axis 5 is for reporting the clinician's judgement of the individual's overall level of functioning. This information is useful in planning treatment, measuring its impact, and in predicting outcome. The reporting of the overall functioning on

Axis 5 is done using the **Global Assessment of Functioning (GAF) Scale**. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

In most instances, ratings on the GAF Scale should be for the Current Period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. However, PIP also tracks the GAF Scale rating at the time of admission (Initial) as well as the client's highest level of functioning during the current episode of care.

CODES & DEFINITIONS
(Use intermediate codes when appropriate, e.g., 45, 68, 72)

100 - 91 **No symptoms. Superior functioning in an wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.**

90 - 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 - 71 **If symptoms are present, they are transient and expectable reactions to psychological stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 - 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy or theft within the household)**, but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 - 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social,**

occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

50 - 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

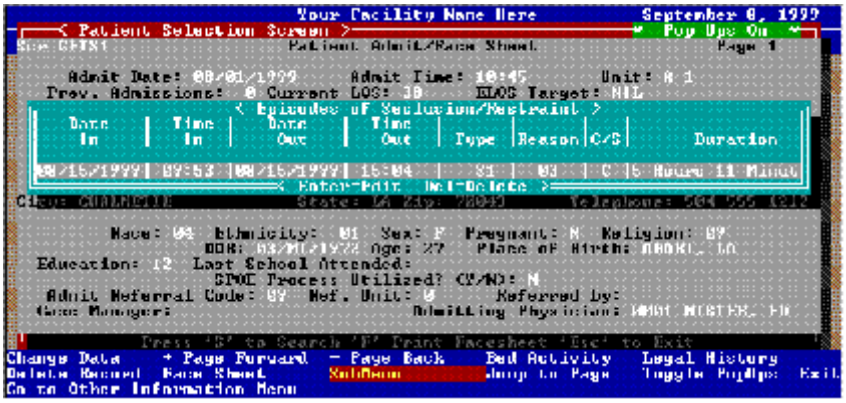
40 - 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 - 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 - 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incontinent or mute).

10 - 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 **Inadequate information.**



D. Episodes of Seclusion/Restraint

SCREEN LABEL		DATABASE->FIELD NAME
EPISODES OF SECLUSION/RESTRAINT		
DATE IN		(SECRAINT->DATEIN)
TIME IN		(SECRAINT->TIMEIN)
DATE OUT		(SECRAINT->DATEIN)
TIME OUT		(SECRAINT->TIMEIN)
TYPE		(SECRAINT->TYPE)
REASON		(SECRAINT->REASON)
C/S		(SECRAINT->CS)
DURATION	**HOURS**	(SECRAINT->ORDER_HR)
	MINUTES	(SECRAINT->ORDER_MIN)

To edit an existing entry in the list, the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press Enter and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields.

When editing is complete, the user will be asked “Do you wish to save this entry? Y/N”. If the user responds “N” the cursor will return to the edit screen to allow further editing. If the user responds “Y” the record will be updated to the database and the cursor will return to the list of entries.

Although deletion is allowed, the authorized user should proceed with extreme caution when deleting Seclusion/Restraint records.

“Esc” allows the user to return to the previous screen.

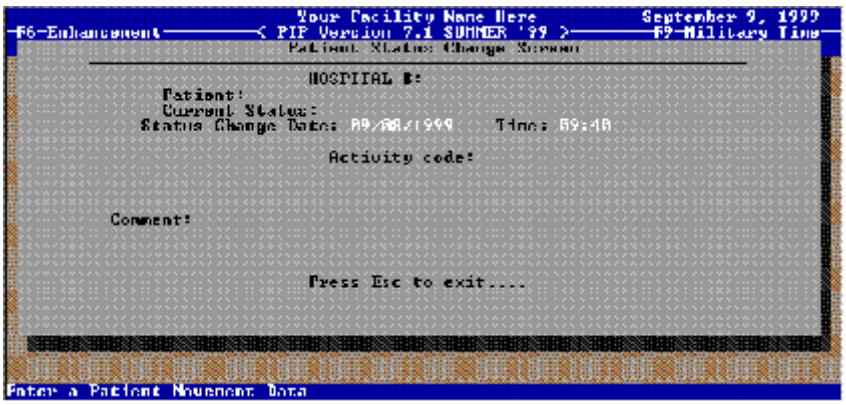
CHAPTER 6

PATIENT STATUS CHANGES

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. PATIENT STATUS CHANGES

This function allows the authorized user to change the status of a particular client. Select this option from the Main Menu under Input/Modify. Enter the hospital number of the client. This will bring up a screen with the client's name and current status.



A. Patient Status Changes - Page 1
PATIENT STATUS CHANGE SCREEN

INFORMATIONAL DISPLAY ONLY
Hospital Number, Patient, Current Status

SCREEN LABEL	DATABASE->FIELD NAME
STATUS CHANGE DATE	(BED_ACT->ACT_DATE)
TIME	(BED_ACT->TIME)

Enter the date and time of the status change. This should be available from the 24 hour report.

ACTIVITY CODE (BED_ACT->STATUS)

Select the appropriate status activity code that indicates the most recent activity of the client as supplied by the 24-hour report performed in each facility.

CODES & DEFINITIONS

01 **Admission** - The formal acceptance by a hospital of a client who is to be provided with room, board, and continuous nursing service in an area of the hospital where clients generally stay at least overnight. An admission may be first time admission to this facility or a readmission to this facility. Admission to other OMH inpatient facilities are not counted by this facility. The decision to admit requires that the client (or legal representative) authorize such services, for the hospital's therapeutic staff to plan for a timely interdisciplinary staffing of the client, and for the development of a documented course of treatment.

03 **Status Change** - Utilized to allow comments to be added.

10 **Inter-Unit Transfer** - The client is reassigned from one distinct hospital (service) unit to another distinct hospital (service) unit (for continuation of treatment). Transfers are recorded by time and date. For **statistical purposes**, the inpatient day on which the transfer occurs is allocated to the new unit only.

11 **On Leave/Pass - Trial Discharge** - Client goes on trial pass, which will result in discharge if successful. Client may or may not physically return to facility. Bed is held for client until client is formally discharged. Maximum length of a trial discharge is 14 days.

12 **On Leave/Pass - Therapeutic Pass/Home Visit** - The client has formal, authorized absence for a time-limited period. Client is expected to return to the facility, and a bed is held for the client.

13 **On Leave/Pass - Trans. to Hospital for Med. Care** - Client is transferred to a general medical hospital for medical treatment with prior knowledge that client will return to the facility (a bed is held for the client the entire time the client is on leave).

14 **On Leave/Pass - Court Pass** - (For Feliciana Forensic Facility only) Client has been transferred to the custody of law enforcement officials for court action. Bed is held for client the entire time client is on court pass.

15 **On Leave/Pass - Failure to Return from Leave/Pass** - Client (or legal representative) has notified the facility that there will be a delay in the client's return to the facility. The client is willing to return to the facility. The bed is held for the client.

19 **On Elopement** - Client is on unauthorized leave from the hospital or other location authorized by the hospital for leave/pass. Clients are placed on elopement the day of the reported elopement, regardless of the time remaining in any other leave/pass situation. The day the elopement is reported is counted as the first elopement day. A bed is held for the client during the time the client is on elopement. Client days are counted after the day the elopement was reported and are then discharged from elopement.

20 **Returned from Leave/Pass/Elopement** - The return to regular inpatient status from leave/pass or elopement. The return is recorded by date and time, but, for statistical purposes, the 24 hour period ending at midnight during which the client returns is counted as a regular inpatient day.

23 **Returned from Transfer for Med. Care** - The return to regular inpatient status from temporary transfer for medical treatment. The return is recorded by date and time, but for statistical purposes, the 24 hour period ending at midnight during which the client returns is counted as

a regular inpatient day.

29 **Returned from Elopement** - The return to regular inpatient status from elopement. The return is recorded by date and time, but for statistical purposes, the 24 hour period ending at midnight during which the client returns is counted as a regular inpatient day.

31 **Discharged - No Referral** -Formal, signed release of a client from this facility completing this episode of care. No referral applies to the following conditions:

1) No further treatment is needed, so client is not referred to another facility or agency.
2) No further treatment is needed at this facility, but there is further treatment needed. However, client is not referred to another facility or agency as the appropriate referral is not available.

32 **Discharged - Transfer to Another La. Psych Hospital** - Formal, signed release of a client from this facility completing this episode of care. Client is then "transferred" to and admitted by another OMH inpatient facility for additional treatment. This may be done because the appropriate treatment is not available at this facility or for other reasons.

33 **Discharged - Referred to CMHC** - Formal, signed release of a client from the hospital completing this episode of care. Client is referred to a CMHC for additional treatment. Further treatment may be rejected by client and/or guardian.

34 **Discharged - Referred Elsewhere** - Formal, signed released of a client from the hospital completing this episode of care. Client is referred elsewhere for additional treatment (such as drug treatment facility/program, alcohol treatment facility/program, community residential program, nursing home/extended care, or other). Admission to appropriate referral may not be available. Further treatment may be rejected by client.

35 **Discharged - Against Medical Advice** - Formal, signed release of a client from the facility following a request in writing from the client and/or guardian with 72 hours prior notification. The hospital has determined that the client needs further hospitalization at this facility/there has been no consensus that the client is stable for discharge, but the client does not meet the criteria to be legally committed to the hospital.

36 **Discharged - From Elopement** - Administrative release of a client due to prior unauthorized leave from the hospital. There is no consensus by the treatment team that the client is stable for discharge. A bed is held for the client and the client is included in the daily census - for up to 7 days following the partial day of elopement. This includes clients "lost from

contact" as well as those gone for more than 7 days after the elopement is reported.

37 **Discharged - While On Leave/Pass** - Discharge of a client who is currently on any type of leave/pass. Client does not have to physically return to the facility before discharge.

38 **Discharged - Client Died** - Discharge of any "active" client who dies, whether or not the client was on leave/pass/elopement at the time of death.

39 **Discharged - Disciplinary** - Client has been discharged from this facility for disciplinary reasons. Client may or may not need additional treatment, and may or may not be referred elsewhere for additional treatment.

40 **Discharged - Conditional** - Client has been conditionally discharged from this facility; final/complete discharge is dependent on the client meeting certain legal requirements.

41 **Discharged - Conditional - While On Leave/Pass** - **Released by Court** - Discharge of a client who is currently on any type of leave/pass and who has been conditionally discharged from this facility. Client does not have to physically return to the facility before discharge. Final/complete discharge is dependent on the client meeting certain legal requirements.

42 **Discharged - Conditional - by Physician** - Client has been conditionally discharge from this facility; upon physician's order, final/complete discharge is dependent on the client meeting certain legal requirements.

43 **Discharged - Conditional - While on Leave/Pass - by Physician** - Discharge of a client who is currently on any type of leave/pass and who has been conditionally discharged from this facility upon physician's order. Client does not have to physically return to the facility before discharge. Final/complete discharge is dependent on the client meeting certain legal requirements.

44 **Discharged - Transferred to Acute Medical Facility** - Discharge for the purpose of admission to an acute medical facility.

50 **Discharged - Other** - Client has been discharged for any reason not listed above.

OLD UNIT (BED_ACT->OLDUNIT)

If the client is currently assigned to a unit, that unit will automatically be entered.

NEW UNIT (BED_ACT->UNIT)

Enter a new unit, or if client is remaining on the old unit, press Enter to retain the old unit.

COMMENT (BED_ACT->COMMENT1)

This field allows one line of comment.

Upon completion of this field the user is asked "Is this correct? Y/N". If the user's response is "Y", the record will be saved as is. If the response is "N" the user is returned to the top of the screen for correction of the data. Following a response of "Y" for correct data entry, the user is then asked "Do you want to save this entry? Y/N". If the response is "Y" the entry will be saved and the client will be discharged from the Bed Activity database. If the response is "N", the data is erased and the user may start over. Upon completion of the screen, the user should escape back to the Main Menu.

II. EDIT/DELETE PATIENT STATUS CHANGES

This function will allow the authorized user to modify the Bed Activity record of a particular client. Select this option, while in "Modify Patient", from the Page Menu by highlighting "Bed Activity" and pressing Enter.

A. Bed Activity

I N F O R M A T I O N A L
DISPLAY ONLY
Hospital Number

SCREEN LABEL	DATABASE->FIELD NAME
BED ACTIVITY	
HOSPITAL NUMBER	(BED_ACT->HOSP_NUM**)**
DATE OF ACTIVITY	(BED_ACT->ACT_DATE)
TIME OF ACTIVITY	(BED_ACT->TIME)
STATUS	(BED_ACT-> STATUS)
CURRENT UNIT	(BED_ACT->UNIT)
OLD UNIT	(BED_ACT->OLDUNIT)
COMMENTS	(BED_ACT**->**COMMENT1 - COMMENT2)

To edit an existing entry in the list, the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press Enter and a box will appear in the lower part of the screen. The data my be edited by typing the new data in the desired fields. A pop-up is provided for the "unit" database.

When editing is complete, the user will be asked "Do you wish to save this entry? Y/N". If the user responds "N" the cursor will return to the edit screen to allow further editing. If the user responds "Y" the record will be updated to the database and the cursor will return to the list of entries.

Although deletion is allowed, the authorized user should proceed with extreme caution when deleting Bed Activity records.

“Esc” allows the user to return to the previous screen.

CHAPTER 7

COMPLETE PATIENT STAFFING

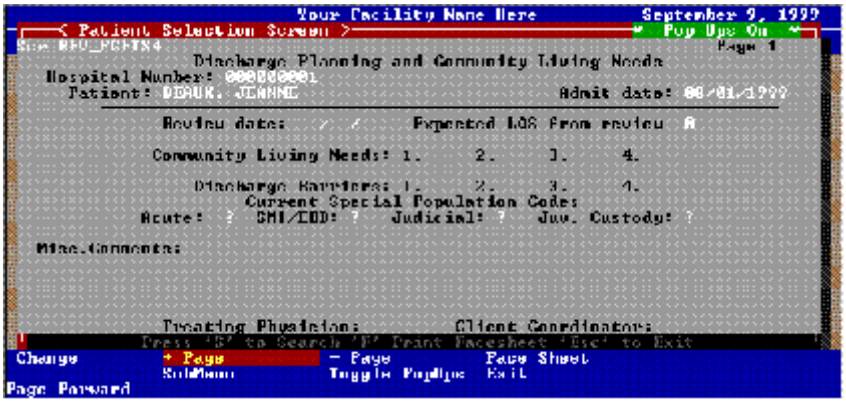
TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. COMPLETE PATIENT STAFFING

This function is used to enter Patient Staffing Information. Select this option from the Main Menu under Input/Modify. Once in Patient Staffing, the Patient Selection Screen will appear. As instructed at the bottom of the screen, press "S" to search. The user will be prompted to search by name, hospital number or social security number. Highlight the desired method and press ENTER. The user will then be asked to enter the desired information and the search will begin. The user can also highlight a selected client on the Patient Selection Screen and press ENTER and that client record will be selected.

At this point the user will be presented with the first of four Patient Information Screens. The first two screens represent data collected at the most recent client treatment review meeting. The last two pages represent the client's status at the time of admission as determined at the master treatment plan meeting. Some of the admission information will automatically be entered into these screens and that information can be edited or updated if necessary.

(Mandatory Fields are preceded by *)**



A. Complete Patient Staffing - Page 1 DISCHARGE PLANNING & COMMUNITY LIVING NEEDS (REV_FGETS4)

INFORMATIONAL DISPLAY ONLY
Patient, Hospital Number, Admit Date

SCREEN LABEL — DATABASE->FIELD NAME

REVIEW DATE (MAIN->REV_DATE)

Enter the numeric equivalent of the month, day and year of the date of the treatment review or staffing.

*** **EXPECTED LOS FROM REVIEW** (MAIN->ELOS)

Enter the number of days from last client treatment team review date until

expected discharge date. This item MAY NOT be left blank after the first treatment team review.

COMMUNITY LIVING NEEDS (MAIN- > READYNEED1 - READYNEED4)

1. 2. 3. 4.

Select the appropriate codes (up to 4 fields) for the needs of the client to live outside the hospital environment. Community living needs are client needs which must be met in order to achieve successful community placement.

CODES & DEFINITIONS

? **Unknown**

01 **Housing** - No housing is available to this client upon discharge.

02 **Entitlements/Benefits** - Successful community living will require this client to receive entitlements/benefits.

03 **Employment/Pre-employment** - The client will require employment or pre-employment services upon discharge.

04 **Education/Special Education** - The client will require educational and/or special education referral upon discharge.

05 **Money Management** - The client will require assistance with money management upon discharge.

06 **Social/Recreational** - The client will require services through a structured social and recreational program upon discharge.

07 **Family Living** - The client will require a family living environment upon discharge.

08 **Mental Health** - The client will require continued mental health services upon discharge.

09 **Physical Health** - The client will require general medical care services upon discharge.

10 **Other Community Living Needs** - The client will require other community living needs not listed above.

11 **Assessment/Service Plan** - The client requires a special assessment and/or service plan for a successful discharge.

12 **Court Order** - The client has been mandated to received evaluation and/or treatment as evidenced by a current civil or juvenile court order.

DISCHARGE BARRIERS (MAIN- > BARRIER1 - BARRIER4)

1. 2. 3. 4.

Select the appropriate codes, (up to 4 fields) which best describe the items preventing the discharge of the client. For every community living need noted,

the case manager should note under Discharge Barriers whether there is an absence of arrangements for those needs, which constitutes a barrier to discharge.

CODES & DEFINITIONS

? **Unknown**

01 **Housing** - No housing is available to this client upon discharge.

02 **Entitlements/Benefits** - Successful community living will require this client to receive entitlements/benefits.

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12 **Court Order** - The client has been mandated to received evaluation and/or treatment as evidenced by a current civil or juvenile court order.

CURRENT SPECIAL POPULATION CODES

Enter or update the current special population codes.

ACUTE (MAIN- > ACUTE)

Select the code that indicates whether or not the client meets criteria for acute mental disturbance.

CODES & DEFINITIONS:

? **Unknown**

00 Not Applicable

01 Applicable

Select applicable if client is of any age and mental disorder who is acutely disturbed and meets the criteria below:

a. Abrupt and serious disruption in level of functioning in the direction of severe impairment and marked personal distress.

b. Urgent/immediate need for clinical intervention to stabilize condition and prevent further, serious disabling effects.

c. Severity of current impairment tends to be short-term and intermittent rather than persistent and enduring.

1. For coding purposes, the maximum duration of an acute mental state is six months, at which time the client is reclassified.

SMI/EBD (MAIN- > CHRONIC)

Select the code that indicates the whether or not the client meets criteria for a seriously mentally ill adult or a child/youth who has an emotional/behavioral disorder. PIP will only allow you to select the proper code for either SERIOUSLY MENTALLY ILL ADULT (18 years and older), or EMOTIONAL/BEHAVIORAL DISORDER -- CHILD/YOUTH (Under age 18).

CODES & DEFINITIONS

? Unknown

00 Not Applicable

01 Seriously Mentally Ill Adult - An individual age 18 or older who meets all the criteria below:

1. Age - 18 years or older
2. Diagnosis - Severe non-organic mental illnesses including, but not limited to, schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships at work or school.
3. Disability - Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:
   a. Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
   b. Employed in a sheltered setting.
   c. Requires public financial assistance for out-of-hospital

maintenance (e.g. SSI) and/or is unable to procure such without help. Does not apply to routine retirement benefits.

d. Severely lacks social support systems in the natural environment (e.g., no close friends or group affiliations, lives alone, or is highly transient).

e. Requires assistance in basic life skills (e.g. must be reminded to take medicine, must have transportation arranged for them, needs assistance in household management tasks).

f. Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

4. Duration - Must meet at least one of the following indicators of duration:

a. Psychiatric hospitalizations of at least six months (cumulative total) in the last five years.

b. Two or more hospitalizations for mental disorders in the last 12 month period.

c. A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.

d. A previous psychiatric evaluation indicating a history of treatment for severe psychiatric disability of at least six months duration.

02 **Emotional/Behavioral Disorder -- Child/Youth** - A child or youth (age zero through 17) who has behavioral or emotional responses so different from appropriate age, cultural, or ethnic norm that they adversely affect performance. Performance includes academic, social, vocational or personal skills. Such a disability is more than a temporary, expected response to stressful events in the environment; is consistently exhibited in two different settings; and persists despite individualized intervention within general education and other settings. Emotional and behavioral disorders can co-exist with other disabilities.

Criteria (All criteria must be met):

1. Age - Under age 18.
2. Meets one of the following criteria which operationalizes the above definition:

a. Exhibits seriously impaired contact with reality, and

severely impaired social, academic, and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; **or,**

b. Manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; **or,**

c. Experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; **or,**

d. Have a DSM-III-R (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive) or severe conduct disorder. This category does not include children/youth who are socially maladjusted unless it is determines that they also meet the criteria for emotional/behavior disorders; **and,**

3. Disability: There is evidence of severe, disruptive and/or incapacitating functional imitations of behavior characterized by at least two of the following:

a. Inability to routinely exhibit appropriate behavior under normal circumstances.

b. Tendency to develop physical symptoms or fears associated with personal or school problems.

c. Inability to learn or work that cannot be explained by intellectual, sensory, or health factors.

d. Inability to build or maintain satisfactory interpersonal relationships with peers and adults.

e. A general pervasive mood of unhappiness or depression.

f. Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then "conduct disorders" are eligible.

4. Duration:
   a. The impairment or pattern of inappropriate behavior(s) has persisted for at least one year, **or**
   b. There is substantial risk that the impairment or pattern of inappropriate behavior(s) will persist for an extended period, **or**
   c. There is a pattern of inappropriate behaviors that are severe and of short duration.

JUDICIAL (MAIN- > COURT)

Select the code that indicates whether or not the client meets criteria for a current legal mandate for mental health evaluation and/or treatment, including Gary W. Class members, Forensic clients, and other court-ordered clients.

CODES & DEFINITIONS:

? **Unknown**

00 **Not Applicable**

10 **Criteria for GW Class members** - This individual is a member of the Gary W. class action suit which is verifiable through a DHH Office.

Forensic patient - This individual is mandated to receive services by the Settlement Agreement (consent decree) in Forensic class action suits. Client types 20-24 below or emergency certificate (citation in parentheses):

20 **NGBRI; Not Guilty/Insane** - Those adjudicated Not Guilty by Reason of Insanity (NGBRI) (C.Cr.Pr., Art. 654).

21 **Not competent for trial** - Pretrial clients adjudged not competent to proceed to trial (C.Cr.Pr., Art. 648, et seq.)

22 **Not to regain competency** - Pretrial clients adjudged unlikely to regain competency in the foreseeable future and may be civilly committed (C.Cr.Pr., Art 648 or La. R.S. 28:54, et seq.); Commonly known as "Lockharts".

23 **Transfer from Dept. Corr.** - Transfers from the Department of Public Safety and Corrections (La. R.S. 28:59 and/or 28:54 or by emergency certificate).

24 **Transfers from DMH Hosp.** - Transfer from other DMH Hospitals who are dangerous to others and cannot be controlled at the civil hospital. (This may be done administratively and does not require court approval.)

30 **Other court-ordered client** - These clients are mandated to receive evaluation or treatment as evidenced by a current civil or juvenile court order.

JUV. CUSTODY (MAIN- > JUV_CUSTDY)

Select the code that indicates whether or not the client meets the criteria for a juvenile in state custody. If the client is over the age of 18, PIP will not access this field.

CRITERIA (All must be met):

1. Under age 18 years
2. Adjudicated in need of care, in need of supervision, or delinquent
3. In custody through either (at least one):
   a. Court Order
   b. Minute Entry
   c. Surrender proceedings
4. Verification by verbal confirmation of OCS worker or administrator **or** verbal confirmation of DPSC juvenile services officer or administrator **and** a copy of court order or OCS surrender form #445 within 30 days.

CODES & DEFINITIONS:

? **Unknown**

00 **Not Applicable**

01 **DSS-Office of Community Service** - In the custody of the Department of Social Services - Office of Community Services.

02 **DPSC-Office of Juv. Service** - In the custody of the Department of Public Safety and Corrections - Office of Juvenile Services

03 **DSS-OCS & DPSC-OJS** - In the custody of both DSS-OCS **and** DPSC-OJS.

04 **DSS-OCS or DPSC-OJS & DMH** - In the custody of DSS-OCS **or** DPSC-OJS **and** DMH.

MISC. COMMENTS (up to four) (MAIN- > COMMENT1- COMMENT4)

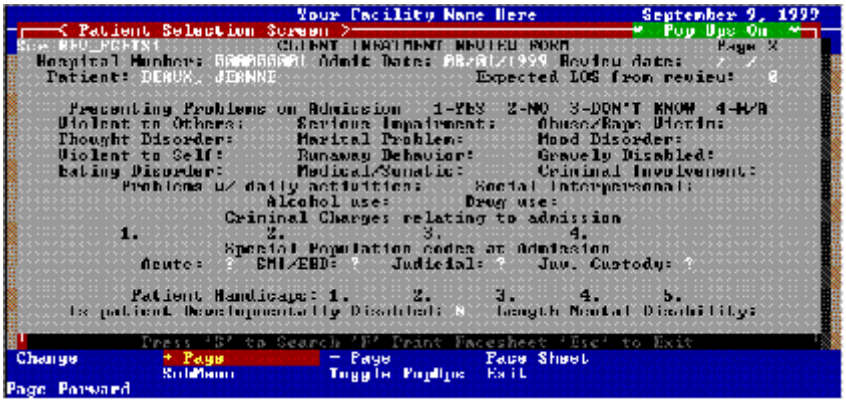
Enter (up to four lines of 55 characters or less) any miscellaneous comments about the community living needs and the discharge barriers facing the client.

TREATING PHYSICIAN (MAIN- > ATTD_PHYS2)

Select the numeric code of the treating physician. Codes are available in the pop-up.

CLIENT COORDINATOR (MAIN- > CASEMANGR1)

Select the code to identify the Case Coordinator to whom this client's case is assigned. Codes are available in the pop-up.



B. Complete Patient Staffing - Page 2
CLIENT TREATMENT REVIEW FORM (REV_FGETS1)

INFORMATIONAL DISPLAY ONLY
Hospital Number, Admit Date, Review Date, Patient Name, Expected LOS From Review

SCREEN LABEL DATABASE->FIELD NAME

PRESENTING PROBLEMS ON ADMISSION
1 = YES 2 = NO 3 = DON'T KNOW 4 = N/A

Enter 1, 2, 3, or 4 to indicate whether or not this client shows any of these presenting problems at admission. There must be at least one presenting problem. All fields must be completed.

DEFINITIONS

Violent to Others (MAIN->VIOLENT)
In association with mental health/substance abuse problems, the client shows potential for assaultiveness, homicide, or other acts of violence directed toward other people.

Serious Impairment (MAIN->S_IMPAIR)
Impairment of functioning (compared to others of the same age) in one or more major roles (e.g., school, family, interpersonal relations, self care, etc.). Immediate intervention is necessary to prevent further disabling effects on the individual.

Abuse/Rape Victim (MAIN->RAPE)
Client was physically assaulted or sexually abused, contributing to current psychological difficulties.

Thought Disorder (MAIN->THOUGHT)
Client exhibits conditions such as the following:

a. Has loss of recent or remote memory, forgetfulness (e.g., amnesia, "blackouts"); difficulty concentrating, focusing, or sustaining attention.
b. Has difficulty in conceptualizing or understanding; limited intellectual capacity.
c. Uses words, phrases, ideas that perseverate; has obsessive thoughts.

d. Is overly wary, lacks confidence in others, questions their motives, doubts their reasons (e.g., guarded, secretive, hypervigilant).
e. Thinks actions or thoughts by others have reference to self in the absence of clear evidence.
f. Has perceptions which appear real to the client but are not supported by objective stimuli or social consensus; basis may be organic or functional.
g. Unshakable, false belief(s) held in the face of evidence normally sufficient to destroy that belief (e.g., delusions of grandiosity or persecution, religious or somatic delusions).
h. Persistent, pervasive, or frequently repeated actions (e.g., compulsive acts, ritualistic behaviors).

Marital Problem (MAIN- > FAMILY)

Client exhibits conditions such as the following:

a. Physically assaultive or destructive behavior among family members.
b. Adult: An interpersonal difficulty of the client involving spouse, mate, primary partner (legal or common-law), children, parents, siblings, and/or close family members.
Child: An interpersonal difficulty of the child involving the parent(s) or guardian(s), siblings, and/or close family members.

Mood Disorder (MAIN- > MOOD)

Client exhibits conditions such as the following:

a. Lowered initiative, inaccessible to stimulation; gloomy, bleak outlook.
b. Distress or agitation resulting from concern about something impending or anticipated.
c. Unpleasant sensations associated with anticipation or awareness of danger. A phobia is an exaggerated, usually inexplicable and illogical, fear of a particular object or class of objects.
d. Feels of no use or value to self or others; low self-esteem.
e. Jumpy, jittery, taut; easily excited or irritated.
f. Wide or dramatic shifts or swings from elated/euphoric to depressed/sad.
g. A deep and pervasive sense of insecurity and dissatisfaction arising from unresolved problems.
h. Intense displeasure; rage, fury; irate, wrathful.
i. A sense of having committed some breach of conduct; recrimination, blaming, fault-finding with self.
j. Feelings of isolation, solitary desolation.
k. A sense of lack of challenge, stimulation or change; unmotivated.
l. Lack of responsiveness, especially in social relations; removal of self from daily experiences and conflicts (e.g., distant, aloof, or cold).
m. Actively hostile, quarrelsome, contentious.
n. Excessive movement, animation, (e.g., pacing, incessant talking, excessive running, difficulty in keeping seated).

Violent to Self (MAIN- > SUICIDE)

In association with mental health/substance abuse problems, client shows the potential to display suicidal or self-mutilating behavior.

Runaway Behavior (MAIN- > RUNAWAY)

Unauthorized physical departure or elopement, possibly being a status offense (e.g., runaway from home, elope from facility).

Gravely Disabled (MAIN- > DISABLED)

A condition in which the client cannot survive independently as the result of mental or combined mental and physical problems.

Eating Disorder (MAIN- > EATING)

Client's nutrition (dietary balance, vitamin intake, etc.) or weight (gain or loss) are in need of correction. May include anorexia nervosa or bulimia.

Medical/Somatic (MAIN- > MEDICAL)

Includes conditions such as the following:

a. Any non-psychiatric illness/injury (e.g., broken bones, flu, mumps) of short duration, current, or during past three (3) weeks.
b. Any non-psychiatric illness/injury (e.g., diabetes, glaucoma) of long or potentially long duration which needs to be controlled or contained.
c. A physical condition (e.g., loss of limb or sensory ability) which produces a permanent loss of normal functioning.
d. Disturbance in frequency, amount, or patterning of sleep (e.g., insomnia, nightmares, sleep-walking).

Criminal Involvement (MAIN- > CRIMINAL)

Includes conditions such as the following:

a. Legal action is pending involving the client. This does not include mental health/substance abuse treatment commitment.
b. Illegal and/or anti-social acts by the client involving property (e.g., vandalism, breaking and entering, fire-setting), or other persons (e.g., rape, mugging, assault, robbery).

Problems w/daily activities (MAIN- > DAY_ACT)

Client exhibits conditions such as the following:

a. Frequent/extended/unexplained/unapproved absence from the job, school, or training program.
b. Fails to meet expectations for job, school, or training program.
c. Presently unable to/won't perform duties on job, in school, or in training program due to illness, lack of skills, lack of motivation, or for other personal reasons.
d. Suspended/terminated from job or suspended/expelled from school or training program.

e. Disruptive behavior on the job, in school, or in training program.
f. Problem in maintaining hygiene, diet, or clothing according to age appropriate expectations, given the financial support available.
g. Problem in finding satisfying leisure time activities.
h. Problems in performance of general household duties, such as housekeeping or home maintenance, budgeting finances or paying bills, shopping for groceries or supplies, or preparation of meals for self and/or family.
i. Problems in performance of child care and/or child management, such as caring for child's physical, social, and emotional well being, and providing for appropriate discipline of behavior.
j. Unable to obtain sufficient and health-sustaining food, adequate clothing, public or private transportation, or decent shelter in an age appropriate manner and independent of finances.
k. Unable to obtain sufficient money for living expenses.
l. Behavior strikingly out of the ordinary for age, sex, culture (e.g., odd, eccentric).
m. Counteracting, opposing, withstanding the force or effect of something or someone; can be either active or passive (e.g., provocative resistance or opposition to authority, temper tantrums, stubbornness, passive aggressive behavior).

Social Interpersonal (MAIN- > SOCIAL)

Includes conditions such as the following:

a. The client does not consider ordinary societal controls as personally applicable (e.g., traffic signs, violation of school rules, truancy, etc.).
b. Deliberate lying, cheating, and/or fraud, even though not always criminal.
c. An interpersonal problem of the client's involving other than close family.
d. Lack of or difficulty mastering dress, presentation, manners, verbal expression, and any factors associated with successful interactions with other people.
e. Has difficulty making friends, developing close relationships or is so unselective in making friends that client is taken advantage of.
f. Difficulty keeping desired friends or relationships.
g. Any problem connected in some way with sex or sexuality.
h. Illegal and/or anti-social acts by the client involving property (e.g., vandalism, breaking and entering, fire-setting).
i. Illegal and/or anti-social acts by the client involving other people (e.g., rape, mugging, assault, robbery).
j. Deliberately plays upon or controls others by deceptive or unfair means, usually to the client's own advantage; manipulative.
k. Behavior strikingly out of the ordinary for age, sex, culture (e.g., odd, eccentric).
l. Counteracting, opposing, withstanding the force or effect of something or someone; can be either active or passive (e.g., provocative resistance or opposition to authority, temper tantrums, stubbornness, passive aggressive behavior).

Alcohol use (MAIN- > ALCOHOL)

Includes conditions such as the following:

a. Problem in the control of use of alcohol as indicated by: A need for the use of alcohol to escape stress or maintain adequate functioning; occasional consumption of excessive amounts of alcohol (e.g., fifth of liquor or its equivalent in wine or beer); binges (remaining intoxicated throughout the day for at least two days); inability to stop or reduce drinking despite consequences to physical health, or to social or occupational functioning.

b. Tolerance - A need for markedly increased amounts of the substance to achieve the desired effect, or markedly diminished effect with regular use of the same amount
and/or
Withdrawal - Development of withdrawal symptoms (e.g., "shakes", nausea and vomiting, malaise, or weakness) after cessation of or reduction in substance use.

Drug use (MAIN- > DRUGS)

Includes conditions such as the following:

a. Problem in the control of use of alcohol as indicated by: A need for the use of substance to escape stress or maintain adequate functioning; occasional consumption of excessive amounts of substance; binges (remaining intoxicated throughout the day for at least two days); inability to stop or reduce substance use despite consequences to physical health, or to social or occupational functioning.

b. Tolerance - A need for markedly increased amounts of the substance to achieve the desired effect, or markedly diminished effect with regular use of the same amount
and/or
Withdrawal - Development of withdrawal symptoms (e.g., "shakes", nausea and vomiting, malaise, or weakness) after cessation of or reduction in substance use.

CRIMINAL CHARGES RELATING TO ADMISSION

CODES (MAIN- > CRIMINAL1 - CRIMINAL4)

The codes that were entered on admission will automatically be entered here. Up to four sets of charges may be included for each client. Codes are available in the pop-up.

SPECIAL POPULATION CODES AT ADMISSION

Acute (MAIN- > ADM_ACUTE)
SMI/EBD (MAIN- > ADM_CHRONI)
Judicial (MAIN- > ADM_COURT)
Juv. Custody (MAIN- > ADM_JUVCUS)

The codes that were entered on admission will automatically be entered here.

PATIENT HANDICAPS (MAIN- > HANDI_1- HANDI_5)

Select the code(s) that describes up to 5 physical or mental impairments or disabilities observed in the client.

CODES & DEFINITIONS

? **Unknown**

00 **No impairments**

01 **Autism** - Autism is a severe developmental disability that is behaviorally defined. The essential features are typically manifested prior to 30 months of age and include:

a. Disturbance of developmental rates and sequences
b. Disturbances of responses to sensory stimuli
c. Disturbances of speech, language, cognition, and nonverbal communication
d. Disturbance of the capacity to appropriately relate to people, events, or objects

02 **Hearing impaired** - Hearing impaired includes both deaf and hard-of-hearing persons.

a. Deaf: A hearing impairment that is so severe that the person is impaired in processing linguistic information through hearing, with or without amplification.
b. Hard-of-hearing: A hearing loss that may range from mild to severe unaided, but does not significantly impede the learning of speech and language through normal channels.

03 **Attention deficit disorder**

a. With hyperactivity: Displays for his/her mental and chronological age, signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. Onset occurs before the age of seven, with a duration of at least six months. Condition is not due to schizophrenia, affective disorder, or severe or profound mental retardation.
b. Without hyperactivity: Same as (a) above except that the individual never had signs of hyperactivity.
c. Residual type: Signs of hyperactivity are no longer present, but other signs of the illness have persisted without periods of remission, as evidenced by signs of both attention deficits and impulsivity which result in some impairment in social or occupational functioning. Not due to schizophrenia, affective disorder, or severe or profound mental retardation.

04 **Mental retardation** - Characterized by:

a. Significantly subaverage general intellectual functioning: an IQ of 70 or below on an individually administered IQ test. (Since available intelligence tests do not yield numeric values for infants, this would be a clinical judgement of significant subaverage intellectual functioning).
b. Concurrent deficits or impairments in adaptive behavior, the person's age being taken into consideration.
c. Onset before the age of 18.

05 **Orthopedically handicapped** - Includes impairments caused by congenital anomaly (e.g.,clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and amputations and fractures or burns that cause contracture.

06 **Language disorder** - Speech impairment resulting from any physical or psychological condition that seriously interferes with the development, formation, or expression of language.

07 **Visually impaired** - Includes both blind and partial-sight persons:
a. Blind: Persons who have so little remaining vision that they must use non-sight methods as their medium.
b. Partial-sight: Persons who have experienced significant loss of vision.

08 **Epilepsy** - A nervous disorder characterized by recurring attacks of motor, sensory, or psychic malfunctions with or without unconsciousness or convulsive movements.

09 **Cerebral palsy** - Impaired muscle power and coordination from brain damage usually occurring at or before birth.

10 **Other health impairment** - Examples include limited strength, vitality, or alertness; chronic or acute health problems; or any other physical impairment to a major body system.

IS PATIENT DEVELOPMENTALLY DISABLED (MAIN->DEV_DABLED)

Enter a "Y" or an "N" in this space to indicate whether or not client is developmentally disabled.

Y **Yes** - the client is developmentally disabled. The term "developmental disability" refers to a severe, chronic disability that:
a. is attributable to a mental or physical impairment or combination of mental and physical impairments;
b. is manifested before the person reaches age 22;
c. is likely to continue indefinitely;
d. results in substantial limitations in three or more of the following area of major life activity: self-care; receptive and expressive

language; learning; mobility; self-direction; capacity for independent living; and economic sufficiency; and

e. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

N **No** - Client is not developmentally disabled as (s)he does not have the above characteristics.

LENGTH MENTAL DISABILITY (MAIN->LEN_DABLED)

For clients who are disabled by their psychiatric condition, indicate the code for the length of time for which the disability has existed.

CODES AND DEFINITIONS

? **Unknown**

01 **A year or longer** - client has been disabled by their psychiatric condition for at least one year.

02 **Less than one year** - client has been disabled by their psychiatric condition for less than one year.

03 **Not Applicable**

C. Complete Patient Staffing - Page 3
DRUG ABUSE PATTERNS AT ADMISSION (REV_FGETS2)

INFORMATIONAL DISPLAY ONLY
Patient, Hospital Number, Admit Date

SCREEN LABEL
PRIMARY DRUG

DATABASE->FIELD NAME
(MAIN->DRUG1)

Select the 2-digit code which most nearly represents the client's primary reported drug of use. The primary drug is that drug which is causing the client to seek help and for which (s)he is being admitted.

CODES & DEFINITIONS

? **Unknown**
00 **None**
01 **Heroin** - Heroin (horse, smack).
02 **Non-Rx Methadone** - Non-prescribed methadone, Dolophine.
03 **Other opiates and synthetics** - Opiate and synthetic narcotics including codeine, morphine and opium derivatives other than heroin. Demerol, Dilaudid, Hydromorphone, Mepergan, Meperidine HCL, Morphine Sulphate, Numorphan, Percodan, Pectpral Syrup, Paregoric Pantophen (chloride of opium alkaloids), Pentazocine (Talwin), Lomotil, Darvon, Fentanyl. SLANG NAMES: dover powder, cube dreamer, junkie, snow, stuff, junk, chinese red, boy, schoolboy, lords, "T's and Blues", etc.
04 **Alcohol** - Beer, wine, whiskey, liqueurs, including both ethyl and methyl alcohol. SLANG NAMES: moonshine, shine, stumpjuice, booze, etc.
05 **Barbiturates** - Amobarbital, Butisol, Phenobarbital, Secobarbital, Tuinal. SLANG NAMES: yellow jackets, nimbles, reds, pinks, red devil, pink lady, blues, blue devil, double trouble, Christmas trees, barbs, downers, block busters, green dragons, goofballs, peanuts, rainbows, Mexican reds. TRADE NAMES: Nembutal, Seconal, Amytal, Luminal, Butisol.
06 **Other sedatives and hypnotics** - Sedative or hypnotic acting non-barbiturate drugs; gluthemide (Doriden), methaqualone (Quaalude, Sopor, Optimil), chloral hydrate (Noctec, Somuos) and trade names, Noludor, Placidyl, Phenergan, Restaril, Halcion and Mandrox. SLANG NAMES: doors and fours, quads, ludes, soapers, sopes.
07 **Amphetamines** - Stimulants other than cocaine, biphetamine, dexedrine, methamphetamine, dextroamphetamine, phenmetrazine (Preludin), and

methylphenidate (Ritalin). SLANG NAMES: pop pills, bennies, uppers, black mollies, copilots, pocket rockets, truck drivers, speed, black beauties, crank, meth, jelly beans, black cadillacs, browns, greenies, b-bomb, oranges, etc. TRADE NAMES: Desoxin, Dexedrine, Mediatric, Preludin, Delcobese.

08 **Cocaine** - The stimulant cocaine. SLANG NAMES: coke, flake, snow, speed-ball, gold dust, toot, nose heaven, paradise, lady snow, girl, frisky powder, uptown.

09 **Marijuana/hashish** - Cannabis and cannabis derivatives, THC.

10 **Hallucinogens** - Hallucinatory agents other than PCP, including LSD-25, Mescaline and Peyote, certain amphetamine variants (2, 5 DMA, PMA, STP, MDMA, TMA, DOM, and DOB), Bufotenine, Ibogaine, Psilocybin and Psilocin. SLANG NAMES: acid, cubes, royal blue, wedding bells, big d, sugar lump, microdots, windowpane, purple haze, mushrooms, mesc, buttons, cactus, mercel, chocolate chips, etc.

11 **Inhalants** - Volatile organic solvents such as spray paint, glue, toluene, amylnitrate, lighter fluid, gasoline, liquid paper thinner, freon, polish remover, nitrous oxide, cleaning fluid, sealer, shoe polish.

12 **Over-the-counter drugs** - Legal over-the-counter preparations exclusive of items listed elsewhere. Include analgesics, diet preparations, relaxants, cold and sleep preparations (Nyquil, Sominex, aspirin, etc.).

13 **Tranquilizers** - Depressants not otherwise listed as barbiturates, benzodiazepines or sedative-hypnotics. Anti-anxiety drugs, muscle relaxants. Includes chlordiazepoxides, reserpine, lithium compounds, phenothiazines. TRADE NAMES: Equanil, Miltown, Mellaril, Serentil, Triavil, Valmid.

14 **Methamphetamine** - Stimulant closely related to amphetamine and ephedrine. SLANG NAMES: speed, crystal.

15 **PCP** - Phencyclidine and/or phencyclidine analogs (PCE, PCP, TCP). SLANG NAMES: angel dust, hog, peace hill, cyclone, rocket fuel, killer week, super grass, bad grass, elephant.

16 **Other stimulants** - Includes such trade names as Adipex, Bacarate, Cylert, Didrex, Ionamin, Plegine, Pre-Sate, Sanorex, Tenuate, Tepanil, Voranil.

17 **Benzodiazepine** - Includes tranquilizers such as Ativan, Azene, Clonopin, Dalmane, Diazepam, Librium, Serax, Tranxene, Valium, Verstran.

18 **Other** - Any other drugs or chemical, singular or in combination not otherwise classified as narcotics, hallucinogens, barbiturates or stimulants, including over-the-counter or "street" drugs not classified herein.

PRIMARY METHOD (MAIN- > DRUG_RTE1)

Select the method of administration the client has used for the primary drug.

CODES & DEFINITIONS

? **Unknown**

01 **Oral** - Used in or administered through the mouth.

02 **Intravenous** - Administered with an injection into the vein(s).
03 **Smoking** - Administered/inhaled in the form of smoke.
04 **Inhalation** - Administered through the nasal passages.
05 **Other** - Not covered in above choices.
06 **None reported** - This code is to be used by prevention programs and collateral contacts only.

PRIMARY FREQUENCY (MAIN->DRUG__FREQ1)

Select the frequency of use of the primary drug during the month prior to admission.

CODES & DEFINITIONS

00 **No past month use** - Client or credible collateral reports client has not used this drug during the 30 days immediately preceding admission to this hospital.
01 **1 to 3 time use in past month** - Regardless of the amount of intake, client or credible collateral reports usage pattern of one to three episodes of use per week during the 30 days immediately preceding admission.
02 **1 to 2 times per week** - The client or credible collateral reports one or two episodes of use per week during the 30 days immediately preceding admission.
03 **3 to 6 times per week** - The client or credible collateral reports three to six episodes per week during the 30 days immediately preceding admission.
04 **Daily use** - The client or credible collateral reports the client used alcohol/drugs on a daily, or almost daily basis during the month prior to admission.
05 **Unknown** - Neither the client nor any credible witness can state or estimate the frequency of use during the past 30 days.

NOTE: Use Modify Patient Record to update or correct frequency when more reliable data is obtained, but relate this data only to the month prior to admission. Do not update changing patterns during treatment of use/abuse.

PRIMARY AGE @ 1ST USE (MAIN->DRUG_AGE1)

Enter the 2-digit number representing the age of the client at first use of the primary drug.

SECONDARY DRUG (MAIN->DRUG2)

Select the 2-digit code which most nearly represents the client's secondary

reported drug of use. Secondary drug is that drug which is also causing the client to seek help and for which (s)he is being admitted. See primary drug codes and definitions.

SECONDARY METHOD (MAIN- > DRUG_RTE2)

Select the method of administration the client has used for the secondary drug. See primary method codes and definitions.

SECONDARY FREQUENCY (MAIN- > DRUGFREQ2)

Select the frequency of use of the secondary drug during the month prior to admission. See primary frequency codes and definitions.

SECONDARY AGE @ 1ST USE (MAIN- > DRUG_AGE2)

Enter the 2-digit number representing the age of the client at first use of the secondary drug.

TERTIARY DRUG (MAIN- > DRUG3)

Select the 2-digit code which most nearly represents the client's tertiary reported drug of use. Tertiary drug is that drug which is also causing the client to seek help and for which (s)he is being admitted. See primary drug codes and definitions.

TERTIARY METHOD (MAIN- > DRUG_RTE3)

Select the method of administration the client has used for the tertiary drug. See primary method codes and definitions.

TERTIARY FREQUENCY (MAIN- > DRUG_FREQ3)

Select the frequency of use of the tertiary drug during the month prior to admission. See primary frequency codes and definitions.

TERTIARY AGE @ 1ST USE (MAIN- > DRUG_AGE3)

Enter the 2-digit number representing the age of the client at first use of the tertiary drug.

NUMBER OF DRUG TREATMENT EPISODES (MAIN- > DRUG_EPISO)

Enter the code which represents the category for the number of prior treatment episodes in any drug or alcohol treatment program. If the client has ever been treated in another chemical dependency or substance abuse program, including those in mental hospitals, general hospitals, or VA hospitals, the user should enter the number of times the client has received prior treatment. NOTE: If it is known that the client has been through treatment before, but the exact number of times is not known, give the best estimate.

CODES & DEFINITIONS

0 **None/zero times** - The client or a credible collateral reports no previous treatment services for this substance.

1 **One time** - The client or a credible collateral reports one previous episode of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

2 **Two times** - The client or a credible collateral reports two previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

3 **Three times** - The client or a credible collateral reports three previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

4 **Four times** - The client or a credible collateral reports four previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

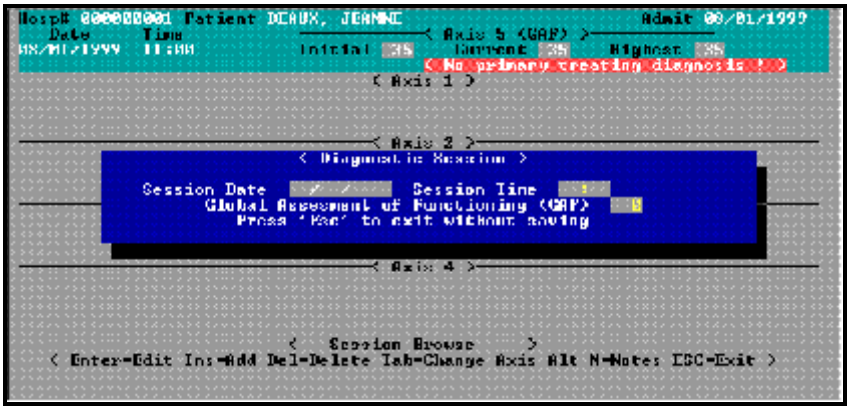
5 **Five or more times** - The client or a credible collateral reports five or more previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

II. DIAGNOSTIC SESSION - Most Current or Updated, and Discharge

This function is used to collect and record additional information regarding a client's diagnosis. Choose the Diagnostic Session option from the Page Menu by highlighting the "Submenu" function and pressing ENTER.

It should be assumed that the diagnosis appropriate to the type of record or report is provided. Specifically, for a recently admitted patient, the admission diagnosis; for a staffing review, the most current or admission diagnosis; and for a discharged patient, the discharge diagnosis. For these purposes, the first diagnostic session entered will be considered the Admission Diagnosis. Similarly, the last diagnostic session will be considered the Current and/or Discharge Diagnosis.

All admitting, treating and discharge diagnoses entered prior to July 1, 1996 will be coded and tracked according to the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-III-R After this date all diagnoses entered will be tracked according to the fourth edition, or DSM-IV.



Diagnostic Session

INFORMATIONAL DISPLAY ONLY **Hospital Number, Patient Name, Admit Date**

***** Primary Treating Diagnosis must be indicated at each diagnostic session.**

IF THERE ARE NO PREVIOUS ENTRIES, a Diagnostic Session pop-up will appear to allow entry of this session date and time as well as the current GAF score. The user will press ENTER upon completion of this screen and PIP will then take the user to the Diagnostic Session Browse screen.

TO ADD A NEW DIAGNOSTIC SESSION, with the colored bar highlighting the top of the screen, press INSERT. PIP will ask “Would you like to duplicate the most recent session?”. Press Y to duplicate the last diagnostic session or N to create new session. A pop-up for the NEW DIAGNOSTIC SESSION will appear to allow entry of this new session date and time and current GAF score. Upon completion, the user

will exit and save this information before returning to the Diagnostic Session Browse screen.

TO VIEW OR EDIT A PREVIOUS DIAGNOSTIC SESSION, with the colored bar highlighting the top of the screen, the user may scroll up and down the list of session dates and times using the corresponding arrow keys. Select the desired diagnostic session by highlighting the desired session date. To edit the GAF score, press Enter

As instructed at the bottom of the screen, press TAB to browse or move through the axes. A colored bar will highlight the selected axis. The axis title will appear within the < BROWSE > at the bottom of the screen. To view or edit existing entries in the list, the user may scroll up and down using the corresponding arrow keys.

TO ENTER A CODE/DIAGNOSIS, highlight the desired axis, press the INSERT key and a diagnostic code pop-up will appear. The user may browse through the pop-up by using the arrow keys or page-up/down keys. Press ENTER to select a diagnosis.

Alternately, the user may search for a particular diagnosis by typing the code number, if known. To search for a diagnosis by name, use the arrow keys to move the highlighting bar to the diagnosis description and begin typing the desired diagnosis. In both searches, code or description, a "search string" box will appear at the top of the pop-up. Upon completion of the search press ENTER and that diagnostic code will be selected.

TO DELETE A SELECTED CODE/DIAGNOSIS, highlight the code/diagnosis to be deleted and press the DELETE key.

TO CHANGE A PREVIOUSLY SELECTED CODE/DIAGNOSIS, highlight the code/diagnosis to be changed and press ENTER. A diagnosis pop-up will appear. Highlight the new code/diagnosis and press ENTER.

- # Press ALT-T to toggle selection where the diagnosis is (P) Provisional or (RO) Rule Out.
- # Press ALT-R to raise, or ALT-L to lower, a highlighted diagnosis by one line increments on a selected axis.
- # Press ALT-N to open a text editor pop-up which allows for further clarification of the Diagnostic Session, as well as the diagnoses on all four axes.
- # Press ALT-F to view the full text description of the highlighted diagnosis as well as additional notes, if available.

Press ALT-1 to select the highlighted diagnosis as the Primary Treating Diagnosis represented to the right of the line by " < - PRI".

Press ALT-2 to select the highlighted diagnosis as the Secondary Treating Diagnosis represented to the right of the line by " < - SEC".

DSM-III-R Multiaxial System

(To be used for those diagnoses recorded prior to July 1, 1996.)

AXIS 1

Select the appropriate diagnostic code according to the DSM-III-R classification (Clinical Syndromes and V Codes). When an individual has more than one Axis 1 disorder, all of the disorders should be reported, with the reason for this episode of care being listed first. When an individual has both an Axis 1 and an Axis 2 disorder, and the Axis 1 diagnosis is the primary treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 1 diagnosis. If no Axis 1 diagnosis or condition is present, this should be coded as V71.09. If an Axis 1 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.90.

AXIS 2

Select the appropriate diagnostic code according to the DSM-III-R classification (Developmental Disorders and Personality Disorders). When an individual has both an Axis 1 and an Axis 2 diagnosis and the Axis 2 diagnosis is the principal treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 2 diagnosis. If no Axis 2 disorder is present, this should be coded as V71.09. If an Axis 2 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

AXIS 3

Select the appropriate diagnostic code according to the ICD-9-CM classification (Physical Disorders and Conditions). Axis 3 permits the clinician to indicate any current physical disorders or conditions that are potentially relevant to the understanding or management of the individual's mental disorder. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis 1 and the general medical condition should be recorded on both Axis 1 and Axis 3. In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis 1 diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder should be listed and coded on Axis 1; the general medical condition should only

be coded on Axis 3. When an individual has more than one clinically relevant Axis 3 diagnosis, all should be reported.

AXIS 4

Select the appropriate code which represents the scale according to the DSM-III-R classification (Severity of Psychosocial Stressors) that may have contributed to the disorder responsible for causing this episode of the client's clinical care.

CODES & DEFINITIONS

0 Inadequate Information, Or No Change In Condition
1 None
2 Mild
3 Moderate
4 Severe
5 Extreme
6 Catastrophic

AXIS 5

Initial Current Highest

Axis 5 is for reporting the clinician's judgement of the individual's overall level of psychological, social and occupational functioning. This is done using the Global Assessment of Functioning (GAF) Scale.

In most instances, ratings on the GAF Scale should be for the Current Period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. However, PIP also tracks the GAF Scale rating at the time of admission (Initial) as well as the client's highest level of functioning during the current episode of care.

DSM-IV Multiaxial System
(To be used for those diagnoses recorded after July 1, 1996.)

AXIS 1:

Select the appropriate diagnostic code according to the DSM-IV classification (Clinical Disorders and/or Other Conditions That May Be a Focus of Clinical Attention). When an individual has more than one Axis 1 disorder, all of the disorders should be reported, with the principal diagnosis or the reason for this episode of care being listed first. When an individual has both an Axis 1 and an Axis 2 disorder, and the Axis 1 diagnosis is the primary treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 1 diagnosis. If no Axis 1 disorder is present, this should be coded as V71.09. If an Axis 1 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention:

- # Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence *(excluding Mental Retardation, which is diagnosed on Axis 2)*
- # Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- # Mental Disorders Due to a General Medical Condition
- # Substance-Related Disorders
- # Schizophrenia and Other Psychotic Disorders
- # Mood Disorders
- # Anxiety Disorders
- # Somatoform Disorders
- # Factitious Disorders
- # Dissociative Disorders
- # Sexual and Gender Identity Disorders
- # Eating Disorders
- # Sleep Disorders
- # Impulse-Control Disorders Not Elsewhere Classified
- # Adjustment Disorders
- # Other Conditions That May Be a Focus of Clinical Attention

AXIS 2:

Select the appropriate diagnostic code according to the DSM-IV classification (Personality Disorders and/or Mental Retardation). When an individual has both an Axis 1 and an Axis 2 diagnosis and the Axis 2 diagnosis is the principal treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 2 diagnosis. If no Axis 2 disorder is present, this should be coded as V71.09. If an Axis 2 diagnosis is deferred,

pending the gathering of additional information, this should be coded as 799.9.

Personality Disorders; Mental Retardation:

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise Specified
Mental Retardation

AXIS 3:

Select the appropriate diagnostic code according to the ICD-9-CM classification (General Medical Conditions). These are current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis 1 and the general medical condition should be recorded on both Axis 1 and Axis 3. In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis 1 diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder should be listed and coded on Axis 1; the general medical condition should only be coded on Axis 3. When an individual has more than one clinically relevant Axis 3 diagnosis all should be reported.

General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001-139)
Neoplasms (140-239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Diseases of the Blood and Blood-Forming Organs (280-289)
Diseases of the Nervous System and Sense Organs (320-389)
Diseases of the Circulatory System (390-459)
Diseases of the Respiratory System (460-519)
Diseases of the Digestive System (520-579)

- # Diseases of the Genitourinary System (580-629)
- # Complications of Pregnancy, Childbirth, and the Puerperium (630-679)
- # Diseases of the Skin and Subcutaneous Tissue (680-709)
- # Diseases of the Musculoskeletal System and Connective Tissue (710-739)
- # Congenital Abnormalities (740-759)
- # Certain Conditions Originating in the Perinatal Period (760-779)
- # Symptoms, Signs, and Ill-defined Conditions (780-799)
- # Injury and Poisoning (800-999)

AXIS 4:

Select the appropriate code which represents the scale according to the DSM-IV classification (Psychosocial and Environmental Problems). Axis 4 is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axis 1 and 2). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment.

In practice, most psychosocial and environmental problems will be indicated on Axis 4. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis 1, with a code derived from the section "Other Conditions That May Be A Focus of Clinical Attention".

The clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved.

Categories of Psychosocial and Environmental Problems:

Problems with primary support group - e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling.

Problems related to the social environment - e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)

Educational problems - e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment

Occupational problems - e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions, job dissatisfaction; job change; discord with boss or co-workers

Housing problems - e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord

Economic problems - e.g., extreme poverty; inadequate finances; insufficient welfare support

Problems with access to health care services - e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

Problems related to interaction with the legal system/crime - e.g., arrest; incarceration; litigation; victim of crime

Other psychosocial and environmental problems - e.g., exposure to disasters, war, other hostilities; discord with non-family caregivers such as counselor, social worker, or physician; unavailability of social service agencies

AXIS 5 (GAF):

Initial Current Highest

Axis 5 is for reporting the clinician's judgement of the individual's overall level of functioning. This information is useful in planning treatment, measuring its impact, and in predicting outcome. The reporting of the overall functioning on Axis 5 is done using the **Global Assessment of Functioning (GAF) Scale**. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

In most instances, ratings on the GAF Scale should be for the Current Period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. However, PIP also tracks the GAF Scale rating at the time of admission (Initial) as well as the client's highest level of functioning during the current episode of care.

CODES & DEFINITIONS
(Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 - 91 **No symptoms. Superior functioning in an wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.**

90 - 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 - 71 **If symptoms are present, they are transient and expectable reactions to psychological stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 - 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy or theft within the household)**, but**

generally functioning pretty well, has some meaningful interpersonal relationships.

60 - 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 - 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 - 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 - 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 - 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incontinent or mute).

10 - 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 **Inadequate information.**

CHAPTER 8

EDIT
DISCHARGE
TRACKING

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. EDIT DISCHARGE TRACKING

This function allows entry of information which is utilized by the Medical Records Department to track the charts of discharged patients. Select this option from the Main Menu under Input/Modify. Once in Edit Discharge Tracking, the Patient Selection Screen will appear, listing only discharged clients at this time. As instructed at the bottom of the screen, press "S" to search. The user will be prompted to search by name, hospital number or social security number. Highlight the desired method and press ENTER. The user will then be asked to enter the desired information and the search will begin. The user can also highlight a selected client on the Patient Selection Screen and press ENTER and that client record will be selected. This will bring up a screen with the client's name, hospital number, admit date, last status, and last activity date. Select "Change" to enter data. In each field the user is prompted to enter the date as each item occurs.

A. Edit Discharge Tracking - Page 1 DISCHARGE TRACKING SCREEN (DISC_GET)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date, Last Status, Last Activity

SCREEN LABEL — DATABASE->FIELD NAME

RECEIVED BY MEDICAL RECORDS (MAIN->DCRECVD)

Enter the numeric equivalent of the month, day and year of the date the chart was received fromthe unit by the Medical Records Department.

DATE ASSEMBLED (MAIN->DCASSEMBLE)

Enter the numeric equivalent of the month, day and year of the date the chart was assembled into a discharge record by the Medical Records Department.

DATE ANALYZED (MAIN->DCANALYSED)

Enter the numeric equivalent of the month, day and year of the date indicating completion of chart review for deficiencies.

DATE PLACED IN DOCTOR FILES (MAIN- > DCDOCFILES)

Enter the numeric equivalent of the month, day and year of the date the chart was placed in the Doctor's files for review/correction/completion.

DATE DICTATED (MAIN- > DCDICTATED)

Enter the numeric equivalent of the month, day and year of the date the discharge summary was dictated.

DATE TYPED (MAIN- > DCTYPED)

Enter the numeric equivalent of the month, day and year of the date the discharge summary was typed.

DATE RECEIVED (MAIN- > SUMRECVD)

Enter the numeric equivalent of the month, day and year of the date the typed discharge summary was placed on the record for signature by Medical Records.

DATE SUMMARY SIGNED (MAIN- > DC_SIGN)

Enter the numeric equivalent of the month, day and year of the date the discharge summary was signed by the doctor.

DISCHARGING PHYSICIAN (MAIN- > ATTD_PHYS3)

Enter the staff code of the discharging physician. Refer to the pop-up for staff codes.

DATE CODED (MAIN- > DCCODED)

Enter the numeric equivalent of the month, day and year of the date the final diagnoses were coded by Medical Records.

DATE CHART COMPLETE (MAIN- > DCPERMFILE)

Enter the numeric equivalent of the month, day and year of the date the chart was completed and put into permanent file by Medical Records.

PERSON HANDLING CHART (MAIN- > DCHANDLED)

Enter the name of the person handling the chart.

Upon completion of this screen, the user selects 'Exit' and the information is automatically saved.

Following data entry, the user may return to the Main Menu.

CHAPTER 9

DISCHARGE SUMMARY

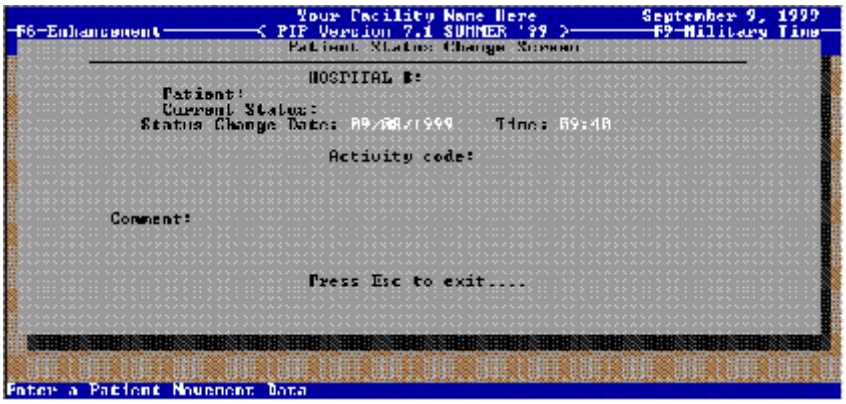
TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

DISCHARGE SUMMARY Revised - 9/7/00

I. PATIENT STATUS CHANGES

This function allows the authorized user to change a patient's status to discharged. Select this option from the Main Menu under Input/Modify. Enter the hospital number of the client to be discharged. This will bring up the client's name and current status.

An '*Inpatient Discharge*' is the termination of a period of inpatient hospitalization through the formal release of the inpatient by the hospital. This is supported by the date and time of the discharge from the unit usually identified by a discharge order, a progress note and a nursing note which describes the method of discharge, date and time. When these three do not agree, the actual date and time of the patient's departure as described by the nursing personnel will be the determining factor.



A. Patient Status Changes - Page 1
PATIENT STATUS CHANGE SCREEN

INFORMATIONAL DISPLAY ONLY
Hospital Number, Patient, Current Status

SCREEN LABEL	DATABASE->FIELD NAME
STATUS CHANGE DATE	(BED_ACT->ACT_DATE)
TIME	(BED_ACT->TIME)

Enter the date and time of the status change (discharge).

ACTIVITY CODE (BED_ACT->STATUS)

Select the code which indicates the primary reason for discharge i.e. program/service/agency the client is referred upon discharge. Only codes greater than "30" indicate a discharge.

CODES & DEFINITIONS

01 - 29 - These codes are not used for discharging a client.

31 Discharged - No Referral - Formal, signed release of a client from this facility completing this episode of care. No referral applies to the following conditions:

1) No further treatment is needed, so client is not referred to another facility or agency.
2) No further treatment is needed at this facility, but there is further treatment needed. However, client is not referred to another facility or agency as the appropriate referral is not available.

32 **Discharged - Transfer to Another La. Psych Hospital** - Formal, signed release of a client from this facility completing this episode of care. Client is then "transferred" to and admitted by another OMH inpatient facility for additional treatment. This may be done because the appropriate treatment is not available at this facility or for other reasons.

33 **Discharged - Referred to CMHC** - Formal, signed release of a client from the hospital completing this episode of care. Client is referred to a CMHC for additional treatment. Further treatment may be rejected by client and/or guardian.

34 **Discharged - Referred Elsewhere** - Formal, signed released of a client from the hospital completing this episode of care. Client is referred elsewhere for additional treatment (such as drug treatment facility/program, alcohol treatment facility/program, community residential program, nursing home/extended care, or other). Admission to appropriate referral may not be available. Further treatment may be rejected by client.

35 **Discharged - Against Medical Advice** - Formal, signed release of a client from the facility following a request in writing from the client and/or guardian with 72 hours prior notification. The hospital has determined that the client needs further hospitalization at this facility/there has been no consensus that the client is stable for discharge, but the client does not meet the criteria to be legally committed to the hospital.

36 **Discharged - From Elopement** - Administrative release of a client due to prior unauthorized leave from the hospital. There is no consensus by the treatment team that the client is stable for discharge. A bed is held for the client and the client is included in the daily census - for up to 7 days following the partial day of elopement. This includes clients "lost from contact" as well as those gone for more than 7 days after the elopement is reported.

37 **Discharged - While On Leave/Pass** - Discharge of a client who is currently on any type of leave/pass and who has completed treatment at this facility. Client does not have to physically return to the facility before discharge.

38 **Discharged - Client Died** - Discharge of any "active" client who dies, whether or not client was on leave/pass/elopement at the time of death.

39 **Discharged - Disciplinary** - Client has been discharged from this facility for disciplinary reasons. Client may or may not need additional treatment, and may or may not be referred elsewhere for additional treatment.

40 **Discharged - Conditional** - Client has been conditionally discharged from this facility; final/complete discharge is dependent on the client meeting certain legal requirements.

41 **Discharged - Conditional - While On Leave/Pass** - **Released by Court** - Discharge of a client who is currently on any type of leave/pass and who has been conditionally discharged from this facility. Client does not have to physically return to the facility before discharge. Final/complete discharge is dependent on the client meeting certain legal requirements.

42 **Discharged - Conditional - by Physician** - Client has been conditionally discharge from this facility; upon physician's order, final/complete discharge is dependent on the client meeting certain legal requirements.

43 **Discharged - Conditional - While on Leave/Pass - by Physician** - Discharge of a client who is currently on any type of leave/pass and who has been conditionally discharged from this facility upon physician's order. Client does not have to physically return to the facility before discharge. Final/complete discharge is dependent on the client meeting certain legal requirements.

44 **Discharged - Transferred to Acute Medical Facility** - Discharge for the purpose of admission to an acute medical facility.

50 **Discharged - Other** - Client has been discharged for any reason not listed above.

The user can then confirm the unit that the client is being discharged from and add any additional comments, as space permits, regarding the client. Upon completion of this field the user is asked "Is this correct? Y/N". If the user's response is "Y", the record will be saved as is. If the response is "N" the user is returned to the top of the screen for correction of the data. Following a response of "Y" for correct data entry, the user is then asked "Do you want to save this entry? Y/N". If the response is "Y" the entry will be saved and the client will be discharged from the Bed Activity database. If the response is "N", the data is erased and the user may start over. Upon completion of the screen, the user should escape back to the Main Menu.

II. DISCHARGE SUMMARY

This function allows the authorized user access to the Patient Discharge Summary Screen, which provides for the collection of data concerning discharge diagnosis, referral, date, physician, etc., as well as a another screen, the Discharge Tracking

Screen. Choose this option from the Main Menu under Input/Modify. Once in Discharge Summary, the Patient Selection Screen will appear. As instructed at the bottom of the screen, press "S" to search. The user will be prompted to search by name, hospital number or social security number. Highlight the desired method and press ENTER. The user will then be asked to enter the desired information and the search will begin. The user can also highlight a selected client on the Patient Selection Screen and press ENTER and that client record will be selected.

A. Patient Discharge Summary - Page 1 PATIENT DISCHARGE SUMMARY (DC_SUMGET2)

INFORMATIONAL DISPLAY ONLY
Patient Name, Hospital Number, Admit Date, Last Status, Last Activity

SCREEN LABEL — DATABASE->FIELD NAME

TREATING PHYSICIAN (MAIN->ATTD_PHYS2)

Select the provider code to identify the attending Physician who provided the treating diagnosis. Codes are available in the pop-up.

DISCHARGING PHYSICIAN (MAIN->ATTD_PHYS3)

Select the provider code to identify the Physician who discharged the client. Codes are available in the pop-up.

DISCHARGE DATE (MAIN->DC_DATE)

The date of last status change is stored in this field. Once a client is discharged, this field reflects the discharge date.

DISCHARGE TIME (MAIN->DC_TIME)

The time of last status change is stored in this field. Once a client is discharged, this field reflects the discharge time.

D/C REFERRAL CODE (MAIN->DCREFCODE)

Select the code which indicates the primary program/service/agency to which the client is referred for receipt of care or other services upon discharge.

Please note that of the following referral sources indicated as “Private”, those persons, provider types or agencies are located within Louisiana. All “Private” sources located outside of the State of Louisiana are to be coded “09 Other”.

CODES & DEFINITIONS

? **Unknown**

00 **None**

01 **Self** - Not applicable for discharge.

02 **Family/friend/individual** - Not applicable for discharge.

03 **School/education program** - The client was referred to a school or education agency or program (e.g., school system psychologist, a principal, counselor, teacher, etc.)

04 **Private psychiatrist** - The client was referred to a licensed psychiatrist who is in private practice.

05 **Other private mental health practitioner** - The client was referred to a mental health practitioner, such as psychologist or social worker, who is in private practice.

06 **Private inpatient psychiatric facility** - The client was referred to an inpatient psychiatric facility that is not a public mental health hospital.

07 **Private mental health clinic/organization** - The client was referred to a private organization that provides primarily outpatient mental health services.

08 **Clergy** - The client was referred to consult with a member of the clergy.

09 **Other source of referral** - A source of referral not covered by the other categories.

10 **DWI referral** - The client was returned to the court for adjudication.

11 **Coroner** - The client was referred to a duly appointed Parish Coroner or his Deputy.

12 **Other private physician** - The client was referred to a licensed medical doctor (other than a psychiatrist) who is in private practice.

13 **Private general hospital** - The client was referred to a private general hospital.

14 **Court or local corrections** - The client was referred to an agency within the courts or a local correctional system (below the level of the Department of Corrections) including judge, prosecutor, probation officer; referred for deferred prosecution, pretrial release, pre-parole, pre-release, work release, civil commitment, or a parish prison program.

15 **Private inpatient substance abuse treatment facility** - The client was referred to a private inpatient substance abuse rehabilitation organization.

16 **Private outpatient substance abuse treatment facility** - The client was

referred to a private outpatient substance abuse rehabilitation organization.

17 **Private nursing home/extended care facility** - The client was referred to a private nursing home or an extended care facility.

18 **Order for Protective Custody** - The client was transported to another facility under an Order for Protective Custody issued by a Parish Coroner or his Deputy.

19 **Law enforcement agency** - The client was referred to a law enforcement agency for reasons other than a court order.

20 **Employer/EAP** - The client was referred to his/her employer or employee assistance plan, whether formal or informal. Includes supervisor or an employee counselor.

21 **Shelter for homeless/abused** - The client was referred to a shelter for the homeless and/or abused.

22 **Other DMH facility** - The client was referred to another OMH facility, including a public psychiatric hospital, an OMH Acute Treatment Unit, or a CMHC.

23 **Other State agency** - The client was referred to another State agency or facility.

24 **Patient deceased** - The client died, no referral.

REFERRED TO (MAIN->DC_REFERAL)

Enter the name of the person/facility to whom the client was referred, i.e. doctor's name, judge's name, private hospital, treatment program, etc.

FACILITY CODE (MAIN->REFER_UNIT)

Select the appropriate code that represents the public psychiatric hospital or community mental health center/clinic to which this client has been referred. If there was no referral, leave the item blank. Codes are available in the pop-up.

OTHER REFERRAL UPON DISCHARGE (MAIN->OUNITREFTO)

Select the appropriate code to indicate to what other program service agency client is referred upon discharge.

CODES & DEFINITIONS

? **Unknown**

00 **None**

01 **Drug Treatment Facility/Program** - The client has been referred to a drug treatment facility or program upon discharge from this hospital.

02 **Alcohol Treatment Facility/Program** - The client has been referred to an alcohol treatment facility or program upon discharge from this hospital.

03 **Community Residential Program** - The client has been referred to a

community residential program upon discharge from this hospital.

04 **Nursing Home/Extended Care** - The client has been referred to a nursing home or extended care facility upon discharge from this facility.

05 **Other** - The client has been referred to a facility or program not included above upon discharge from this hospital.

AFTER CARE APPOINTMENT (MAIN- > AFT_APP)

Enter the numeric equivalent of the month, day and year of the date of the first scheduled mental health follow-up aftercare appointment.

TYPE TERMINATION (MAIN- > TYPE_TERM)

Select the appropriate code to describe the circumstances at time of service termination.

CODES & DEFINITIONS

01 **No further treatment/no referral** - The client requires no further service(s) and is not referred to any other organization for treatment continuation.

02 **No further treatment needed/referred elsewhere** - The client requires no further service(s) at this hospital and is referred to another organization or treatment continuation.

03 **No further treatment/Appropriate referral not available** - The client requires no further service(s) at this hospital, but further treatment is needed elsewhere, however, referral(s) to another organization for appropriate treatment or continuation are not possible/available.

04 **Appropriate treatment not available within facility** - The client requires service(s) that cannot be provided by this hospital. If possible, the client is referred to an appropriate organization for treatment.

05 **Further treatment needed - client refused** - The client requires further service(s), but declines to continue with further treatment.

06 **Discharged to other public psychiatric facility** - The client has been discharged from this hospital and referred to another public psychiatric hospital.

07 **Client died** - Client died while an active client of this hospital.

08 **Client lost to contact** - The client is no longer available for treatment.

09 **Discharged-court order** - The client is discharged pursuant to orders of the court.

10 **Discharged-correctional facility** - Client is discharged to a Department of Corrections facility.

HOUSING (MAIN- > DC_RESID)

Select the code which indicates the type of residential arrangement the client will have immediately following discharge.

CODES & DEFINITIONS

? **Unknown**

01 **Single-family dwelling** - The client will live in a dwelling which houses only a single family. May include mobile homes.

02 **Apartment** - The client will live in a multiple-family dwelling, including duplexes, triplexes, and apartment buildings.

03 **Nursing home or intermediate care facility** - The client will live in a nursing home, convalescent home, etc.

04 **Residential hotel** - The client will live in a residential hotel or other type of boarding house arrangement, or rents a single room in someone's house.

05 **No permanent residence** - The client's residence is primarily transient (for example, a camper trailer or motor home), or the client may live "on the street". This includes clients living in a shelter, mission, or temporary living quarters or in a place that is limited/short-term stay.

06 **Group home/halfway house** - The client will live in a group home or halfway house as part of a supervised residential program designed to meet special needs.

07 **Supervised apartment** - The client will live in a supervised apartment as part of a supervised residential program designed to meet special needs.

08 **Board and care** - The client will live in a licensed, supervised "board and care" 24-hour residence as part of a supervised residential program designed to meet special needs.

09 **Jail/prison/training institution** - The client will be incarcerated in a jail, prison, or training institution.

10 **Hospital** - The client will be in a medical or psychiatric hospital subsequent to discharge from this facility.

11 **Other quarters** - For use if none of the other categories is appropriate (for example, military barracks, dormitory, fraternity, sorority, etc.).

LIVING ARRANGEMENT (MAIN- > DC_LIVING)

Select the code that best indicates the household composition or living arrangements of the client upon discharge.

CODES & DEFINITIONS

? **Unknown**

01 **Adult only** - The client is an adult and will live alone.

02 **Adult; relatives** - The client is an adult and will live with other family members (e.g., spouse, children, etc.).

03 **Adult; non-relatives** - The client is an adult and will not live with family members (e.g.,will live with friends, in an institutional environment, etc.).

04 **Child; both parents** - The client is a child and will live with both parents.

05 **Child; one parent** - The client is a child and will live with only one of his/her parents.

06 **Child; relative other than parents** - The client is a child and will live with

family members other than his/her parents (e.g., lives with an uncle, sister, etc.).

07 **Child; foster family** - The client is a child and will live in a foster care family.

08 **Child; non-relative** - The client is a child and will not live with family members (e.g., will live with friends, in an institutional setting, etc.).

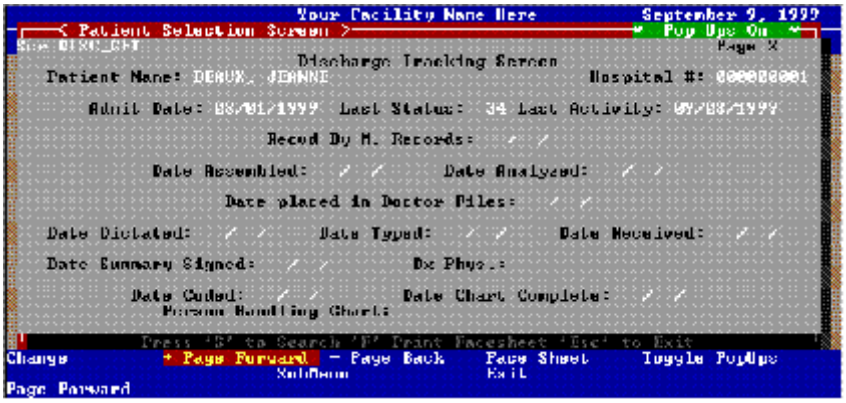
NOTE: The following definitions apply to "parents" and "relatives":

Parent: A natural parent or an adult who is occupying a parental role to the client, such as an adoptive parent or an individual married to a natural parent (e.g., step-parent).

Relative: An individual who is related to the client by kinship, marriage, or legal action (e.g., spouse, sibling, etc.).

DATE COMPLETED

Enter the numeric equivalent of the month, day and year of the date the summary was completed.



B. Patient Discharge Summary - Page 2
DISCHARGE TRACKING SCREEN (DISC_GET)

I N F O R M A T I O N A L DISPLAY ONLY
Patient Name, Hospital Number, Admit Date, Last Status, Last Activity

SCREEN LABEL — DATABASE->FIELD NAME

RECEIVED BY MEDICAL RECORDS (MAIN->DCRECVD)

Enter the numeric equivalent of the month, day and year of thedate the chart was received from the unit by the Medical Records Department.

DATE ASSEMBLED (MAIN->DCASSEMBLE)

Enter the numeric equivalent of the month, day and year of the date the chart was assembled into a discharge record by the Medical Records Department.

DATE ANALYZED (MAIN->DCANALYSED)

Enter the numeric equivalent of the month, day and year of the date indicating completion of chart review for deficiencies.

DATE PLACED IN DOCTOR FILES (MAIN->DCDOCFILES)

Enter the numeric equivalent of the month, day and year of the date the chart was placed in the Doctor's files for review/correction/completion.

DATE DICTATED (MAIN->DCDICTATED)

Enter the numeric equivalent of the month, day and year of the date the discharge summary was dictated.

DATE TYPED (MAIN->DCTYPED)

Enter the numeric equivalent of the month, day and year of the date the discharge summary was typed.

DATE RECEIVED (MAIN->SUMRECVD)

Enter the numeric equivalent of the month, day and year of the date the typed discharge summary was placed on the record for signature by Medical Records.

DATE SUMMARY SIGNED (MAIN- > DC_SIGN)

Enter the numeric equivalent of the month, day and year of the date the discharge summary was signed by the doctor.

DISCHARGING PHYSICIAN (MAIN- > ATTD_PHYS3)

Enter the staff code of the discharging physician. Refer to the pop-up for staff codes.

DATE CODED (MAIN- > DCCODED)

Enter the numeric equivalent of the month, day and year of the date the final diagnoses were coded by Medical Records.

DATE CHART COMPLETE (MAIN- > DCPERMFILE)

Enter the numeric equivalent of the month, day and year of the date the chart was completed and put into permanent file by Medical Records.

PERSON HANDLING CHART (MAIN- > DCHANDLED)

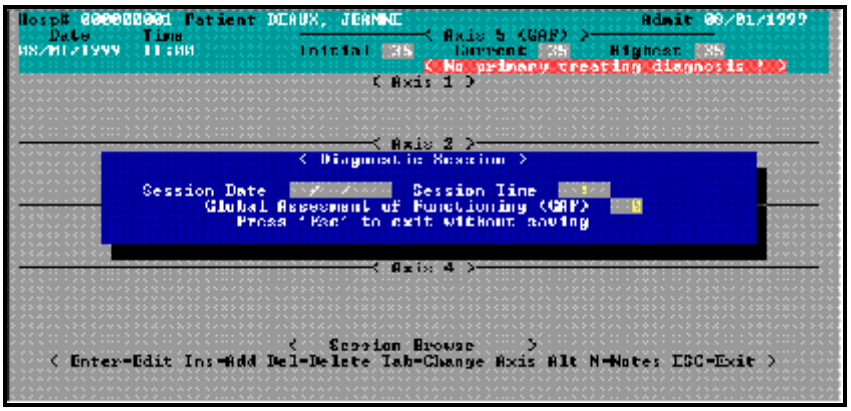
Enter the name of the person handling the chart.

III. DIAGNOSTIC SESSION - Discharge

This function is used to collect and record additional information regarding a client's diagnosis. Choose the Diagnostic Session option from the Page Menu by highlighting the "Submenu" function and pressing ENTER.

It should be assumed that the diagnosis appropriate to the type of record or report is provided. Specifically, for a recently admitted patient, the admission diagnosis; for a staffing review, the most current or admission diagnosis; and for a discharged patient, the discharge diagnosis. For these purposes, the first diagnostic session entered will be considered the Admission Diagnosis. Similarly, the last diagnostic session will be considered the Current and/or Discharge Diagnosis.

All admitting, treating and discharge diagnoses entered prior to July 1, 1996 will be coded and tracked according to the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-III-R After this date, all diagnoses entered will be tracked according to the fourth edition, or DSM-IV.



Diagnostic Session

INFORMATIONAL DISPLAY ONLY
Hospital Number, Patient Name, Admit Date

***** Primary Treating Diagnosis must be indicated at each diagnostic session.**

IF THERE ARE NO PREVIOUS ENTRIES, a Diagnostic Session pop-up will appear to allow entry of this session date and time as well as the current GAF Score. The user will press ENTER upon completion of this screen and PIP will then take the user to the Diagnostic Session Browse screen.

TO ADD A NEW DIAGNOSTIC SESSION, with the colored bar highlighting the top of the screen, press INSERT. PIP will ask "Would you like to duplicate the most recent session?". Press Y to duplicate the last diagnostic session or N to create new session. A pop-up for the NEW DIAGNOSTIC SESSION will appear to allow entry of this new session date and time and current GAF score. Upon completion, the user will exit and save this information before returning to the Diagnostic Session Browse screen.

TO VIEW OR EDIT A PREVIOUS DIAGNOSTIC SESSION, with the colored bar highlighting the top of the screen, the user may scroll up and down the list of session dates and times using the corresponding arrow keys. Select the desired diagnostic session by highlighting the desired session date. To edit the GAF score, press Enter

As instructed at the bottom of the screen, press TAB to browse or move through the axes. A colored bar will highlight the selected axis. The axis title will appear within the < BROWSE > at the bottom of the screen. To view or edit existing entries in the list, the user may scroll up and down using the corresponding arrow keys.

TO ENTER A CODE/DIAGNOSIS, highlight the desired axis, press the INSERT key and a diagnostic code pop-up will appear. The user may browse through the pop-up by using the arrow keys or page-up/down keys. Press ENTER to select a diagnosis.

Alternately, the user may search for a particular diagnosis by typing the code number,

if known. To search for a diagnosis by name, use the arrow keys to move the highlighting bar to the diagnosis description and begin typing the desired diagnosis. In both searches, code or description, a "search string" box will appear at the top of the pop-up. Upon completion of the search press ENTER and that diagnostic code will be selected.

TO DELETE A SELECTED CODE/DIAGNOSIS, highlight the code/diagnosis to be deleted and press the DELETE key.

TO CHANGE A PREVIOUSLY SELECTED CODE/DIAGNOSIS, highlight the code/diagnosis to be changed and press ENTER. A diagnosis pop-up will appear. Highlight the new code/diagnosis and press ENTER.

Press ALT-T to toggle selection where the diagnosis is (P) Provisional or (RO) Rule Out.

Press ALT-R to raise, or ALT-L to lower, a highlighted diagnosis by one line increments on a selected axis.

Press ALT-N to open a text editor pop-up which allows for further clarification of the Diagnostic Session, as well as the diagnoses on all four axes.

Press ALT-F to view the full text description of the highlighted diagnosis as well as additional notes, if available.

Press ALT-1 to select the highlighted diagnosis as the Primary Treating Diagnosis represented to the right of the line by " <- PRI".

Press ALT-2 to select the highlighted diagnosis as the Secondary Treating Diagnosis represented to the right of the line by " <- SEC".

DSM-III-R Multiaxial System
(To be used for those diagnoses recorded prior to July 1, 1996.)

AXIS 1

Select the appropriate diagnostic code according to the DSM-III-R classification (Clinical Syndromes and V Codes). When an individual has more than one Axis 1 disorder, all of the disorders should be reported, with the reason for this episode of care being listed first. When an individual has both an Axis 1 and an Axis 2 disorder, and the Axis 1 diagnosis is the primary treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " <- PRI" after the Axis 1 diagnosis. If no Axis 1 diagnosis or condition is present, this should be coded as V71.09. If an Axis 1 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.90.

AXIS 2

Select the appropriate diagnostic code according to the DSM-III-R classification (Developmental Disorders and Personality Disorders). When an individual has both an Axis 1 and an Axis 2 diagnosis and the Axis 2 diagnosis is the principal treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " <- PRI" after the Axis 2 diagnosis. If no Axis 2 disorder is present, this should be coded as V71.09. If an Axis 2 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

AXIS 3

Select the appropriate diagnostic code according to the ICD-9-CM classification (Physical Disorders and Conditions). Axis 3 permits the clinician to indicate any current physical disorders or conditions that are potentially relevant to the understanding or management of the individual's mental disorder. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis 1 and the general medical condition should be recorded on both Axis 1 and Axis 3. In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis 1 diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder should be listed and coded on Axis 1; the general medical condition should only be coded on Axis 3. When an individual has more than one clinically relevant Axis 3 diagnosis, all should be reported.

AXIS 4

Select the appropriate code which represents the scale according to the DSM-III-R classification (Severity of Psychosocial Stressors) that may have contributed to the disorder responsible for causing this episode of the client's clinical care.

CODES & DEFINITIONS

0 Inadequate Information, Or No Change In Condition
1 None
2 Mild
3 Moderate
4 Severe
5 Extreme
6 Catastrophic

AXIS 5

Initial Current Highest

Axis 5 is for reporting the clinician's judgement of the individual's overall level of psychological, social and occupational functioning. This is done using the Global Assessment of Functioning (GAF) Scale.

In most instances, ratings on the GAF Scale should be for the Current Period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. However, PIP also tracks the GAF Scale rating at the time of admission (Initial) as well as the client's highest level of functioning during the current episode

of care.

DSM-IV Multiaxial System
(To be used for those diagnoses recorded after July 1, 1996.)

AXIS 1:

Select the appropriate diagnostic code according to the DSM-IV classification (Clinical Disorders and/or Other Conditions That May Be a Focus of Clinical Attention). When an individual has more than one Axis 1 disorder, all of the disorders should be reported, with the principal diagnosis or the reason for this episode of care being listed first. When an individual has both an Axis 1 and an Axis 2 disorder, and the Axis 1 diagnosis is the primary treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 1 diagnosis. If no Axis 1 disorder is present, this should be coded as V71.09. If an Axis 1 diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention:

- # Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence *(excluding Mental Retardation, which is diagnosed on Axis 2)*
- # Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- # Mental Disorders Due to a General Medical Condition
- # Substance-Related Disorders
- # Schizophrenia and Other Psychotic Disorders
- # Mood Disorders
- # Anxiety Disorders
- # Somatoform Disorders
- # Factitious Disorders
- # Dissociative Disorders
- # Sexual and Gender Identity Disorders
- # Eating Disorders
- # Sleep Disorders
- # Impulse-Control Disorders Not Elsewhere Classified
- # Adjustment Disorders
- # Other Conditions That May Be a Focus of Clinical Attention

AXIS 2:

Select the appropriate diagnostic code according to the DSM-IV classification (Personality Disorders and/or Mental Retardation). When an individual has both an Axis 1 and an Axis 2 diagnosis and the Axis 2 diagnosis is the principal treating diagnosis for this diagnostic session, this should be indicated by adding the qualifying phrase " < - PRI" after the Axis 2 diagnosis. If no Axis 2 disorder is present, this should be coded as V71.09. If an Axis 2 diagnosis is deferred,

pending the gathering of additional information, this should be coded as 799.9.

Personality Disorders; Mental Retardation:

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise Specified
Mental Retardation

AXIS 3:

Select the appropriate diagnostic code according to the ICD-9-CM classification (General Medical Conditions). These are current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis 1 and the general medical condition should be recorded on both Axis 1 and Axis 3. In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis 1 diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder should be listed and coded on Axis 1; the general medical condition should only be coded on Axis 3. When an individual has more than one clinically relevant Axis 3 diagnosis all should be reported.

General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001-139)
Neoplasms (140-239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Diseases of the Blood and Blood-Forming Organs (280-289)
Diseases of the Nervous System and Sense Organs (320-389)
Diseases of the Circulatory System (390-459)
Diseases of the Respiratory System (460-519)
Diseases of the Digestive System (520-579)

- # Diseases of the Genitourinary System (580-629)
- # Complications of Pregnancy, Childbirth, and the Puerperium (630-679)
- # Diseases of the Skin and Subcutaneous Tissue (680-709)
- # Diseases of the Musculoskeletal System and Connective Tissue (710-739)
- # Congenital Abnormalities (740-759)
- # Certain Conditions Originating in the Perinatal Period (760-779)
- # Symptoms, Signs, and Ill-defined Conditions (780-799)
- # Injury and Poisoning (800-999)

AXIS 4:

Select the appropriate code which represents the scale according to the DSM-IV classification (Psychosocial and Environmental Problems). Axis 4 is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axis 1 and 2). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment.

In practice, most psychosocial and environmental problems will be indicated on Axis 4. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis 1, with a code derived from the section "Other Conditions That May Be A Focus of Clinical Attention".

The clinician should identify the relevant categories of psychosocial and

environmental problems and indicate the specific factors involved.

Categories of Psychosocial and Environmental Problems:

Problems with primary support group - e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling.

Problems related to the social environment - e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)

Educational problems - e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment

Occupational problems - e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions, job dissatisfaction; job change; discord with boss or co-workers

Housing problems - e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord

Economic problems - e.g., extreme poverty; inadequate finances; insufficient welfare support

Problems with access to health care services - e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

Problems related to interaction with the legal system/crime - e.g., arrest; incarceration; litigation; victim of crime

Other psychosocial and environmental problems - e.g., exposure to disasters, war, other hostilities; discord with non-family caregivers such as counselor, social worker, or physician; unavailability of social service agencies

AXIS 5 (GAF):

Initial Current Highest

Axis 5 is for reporting the clinician's judgement of the individual's overall level

of functioning. This information is useful in planning treatment, measuring its impact, and in predicting outcome. The reporting of the overall functioning on Axis 5 is done using the **Global Assessment of Functioning (GAF) Scale**. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

In most instances, ratings on the GAF Scale should be for the Current Period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. However, PIP also tracks the GAF Scale rating at the time of admission (Initial) as well as the client's highest level of functioning during the current episode of care.

CODES & DEFINITIONS
(Use intermediate codes when appropriate, e.g., 45, 68, 72)

100 - 91 **No symptoms. Superior functioning in an wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.**

90 - 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 - 71 **If symptoms are present, they are transient and expectable reactions to psychological stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 - 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy or theft within the household)**, but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 - 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 - 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 - 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 - 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 - 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incontinent or mute).

10 - 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 **Inadequate information.**

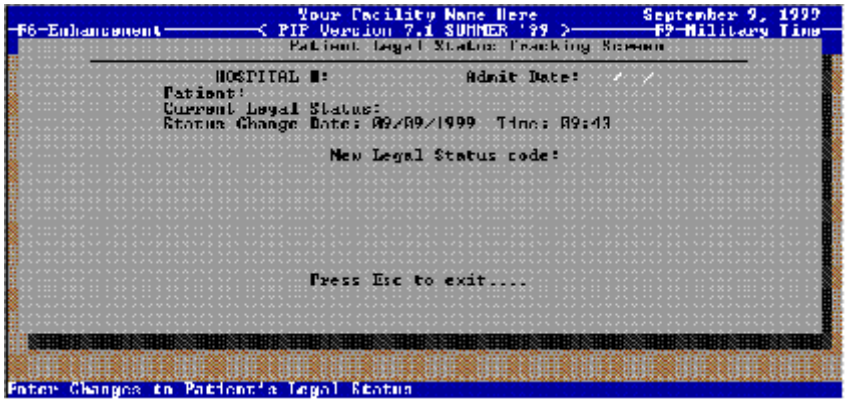
CHAPTER 10

LEGAL STATUS CHANGES

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. LEGAL STATUS CHANGES

This function allows the authorized user to change the legal status of the client. Select this option from the Main Menu under Input/Modify. Enter the hospital number of the client. The admit date, patient name, and current legal status will appear.



A. Legal Status Changes - Page 1 PATIENT LEGAL STATUS TRACKING SCREEN

I N F O R M A T I O N A L DISPLAY ONLY
Hospital Number, Admit Date, Name, Current Legal Status

SCREEN LABEL	DATABASE->FIELD NAME
STATUS CHANGE DATE	(LEGHIST->DATE)
TIME	(LEGHIST->TIME)

Enter the date and time the legal status changed. This may or may not be today's date. As an example, for PEC/CECs, the date and time of execution of the PEC/CEC should be entered.

NEW LEGAL STATUS CODE (LEGHIST->STATUS)

Select the code that indicates the new legal authorization by which the client is receiving service. **Only allowed choices will be lit in the pop-up.**

CODES & DEFINITIONS

? **Unknown**

01 **Voluntary-Informal** - Admission for service by consent of the client or the parent/guardian/curator of the client. Admission may be made upon the client's request without a formal application.

02 **Voluntary-Formal** - Admission for service by consent of the client or the parent/guardian/curator of the client. Admission may be made upon the client's request with a formal application.

03 **Formal Voluntary with Notice** - Client on formal voluntary status has made a valid written request for discharge.

04 **Noncontested** - Admission for service of a client who does not have the

ability to make a knowing or voluntary consent, but who does not object to admission.

05 **Physician's Emergency Certificate** - Admission for service of a client by an emergency certificate executed after an examination by a physician.

06 **Psychologist's Emergency Certificate** - Admission for service of a client by an emergency certificate executed after an examination by a psychologist.

07 **Coroner's Emergency Certificate** - Admission for service of a client by an emergency certificate executed after an examination by a coroner or his deputy.

08 **PEC/CEC** - An emergency certificate for the client has been executed by a physician or psychologist, and by a coroner or his deputy.

09 **Judicial-Petition** - A petition is pending for judicial commitment of a client on a PEC/CEC or Voluntary status with 72 hour notice.

10 **Judicial-Civil** - The client has been ordered into the state mental health system by a civil court.

11 **Judicial-Lockhart vs. Armistead (LVA)** - The client has been ordered into the state mental health system by a criminal court after being found incompetent to proceed to trial in the foreseeable future.

12 **Judicial-Criminal-Not Competent to Proceed (NCP)** - The client has been ordered into the state mental health system as incompetent to proceed to trial pursuant to recommendation of a Sanity Commission.

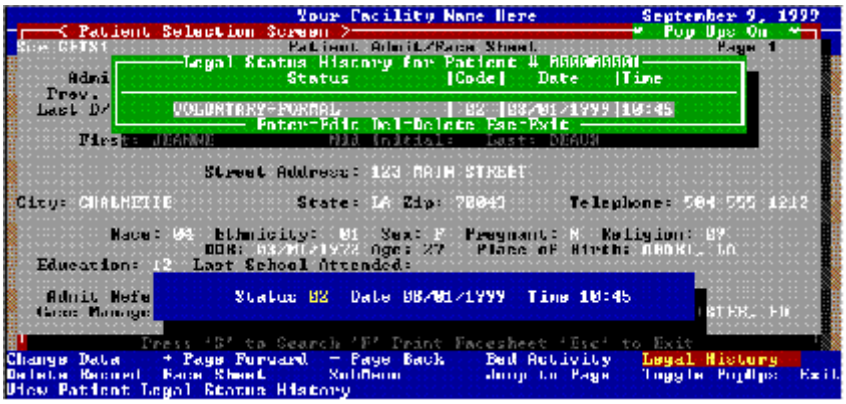
13 **Judicial-Criminal-Not Guilty by Reason of Insanity (NGBRI)** - The client has been ordered into the state mental health system after having been found not guilty by reason of insanity.

14 **Judicial-Juvenile** - The client is legally a juvenile and has been ordered into the state mental health system.

Upon completion, a decision box will appear asking "Is this correct? Y/N". An "N" answer will return the user to the hospital number field for re-entry. A "Y" answer will lead to the next decision box which asks "Do you want to save this entry?" An "N" answer will return the user to the hospital number field for re-entry. A "Y" answer will save the legal status change and the cursor will move to the blank hospital number field for entry of the next hospital number. If no other legal status changes are to be made the user can press "Esc" to return to the Main Menu - Input/Modify.

II. EDIT/DELETE LEGAL STATUS CHANGES

This function will allow the authorized user to modify the Legal Status History record of a particular client. Select this option, while in "Modify Patient", from the Page Menu by highlighting "Legal History" and pressing Enter.



A. Legal Status History

INFORMATIONAL DISPLAY ONLY

Hospital Number

SCREEN LABEL	DATABASE->FIELD NAME
LEGAL STATUS HISTORY	
CURRENT LEGAL STATUS	(LEGHIST->STATUS)
DATE OF STATUS CHANGE	(LEGHIST->DATE)
TIME OF STATUS CHANGE	(LEGHIST->TIME)

To edit an existing entry in the list, the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press Enter and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields. A pop-up is provided for the "unit" database.

When editing is complete, the user will be asked "Do you wish to save this entry? Y/N". If the user responds "N" the cursor will return to the edit screen to allow further editing. If the user responds "Y" the record will be updated to the database and the cursor will return to the list of entries.

Although deletion is allowed, the authorized user should proceed with extreme caution when deleting Legal Status History records.

"Esc" allows the user to return to the previous screen.

CHAPTER 11

SECLUSION/RESTRAINT

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. Enter Seclusion/ Restraint

This function allows the authorized user to enter information regarding each episode of use of seclusion/restraint for the client. Select this option from the Main Menu under Input/Modify. Enter the hospital number of the client. The admit date and patient name will appear.

A. Enter Seclusion/Restraint - Page 1

I N F O R M A T I O N A L DISPLAY ONLY
Hospital Number, Name, Admit Date

SCREEN LABEL — DATABASE->FIELD NAME

DATE IN (SECRAINT->DATEIN)

Enter the numeric equivalent of the month, day and year of the date this episode of use of seclusion/restraint for the client began.

TIME IN (SECRAINT->TIMEIN)

Using the 24-hour clock ("military time"), enter the four-digit time this episode of use of seclusion/restraint for the client began. For example, 7:30 a.m. would be entered as 0730, while 7:30 p.m. would be entered as 1930. An on-screen military time conversion chart is available by pressing F-9.

DATE OUT (SECRAINT->DATEOUT)

Enter the numeric equivalent of the month, day and year of the date this episode of use of seclusion/restraint for the client ended.

TIME OUT (SECRAINT->TIMEOUT)

Using the 24-hour clock ("military time"), enter the four-digit time this episode of use of seclusion/restraint for the client ended.

LOCATION (SECRAINT->LOCATION)

Select the appropriate unit, where this episode of seclusion/restraint occurred,

from the pop-up menu.

CLINICAL/SECURITY (SECRAINT->CS)

Specify, by "C" or "S", if the purpose for this episode of use of seclusion/restraint for the client was “Clinical” or “Security.”

TYPE (SECRAINT->TYPE)

Select the code that represents the type of seclusion/restraint utilized.

CODES & DEFINITIONS

S1 Seclusion, Locked, No restraints used
S2 Seclusion, Locked with restraints, Ambulatory (waist & wrist)
S3 Seclusion, Locked with restraints, Non-Ambulatory, Chair restraints
S4 Seclusion, Locked with restraints, Non-Ambulatory, 4 Point restraints
S5 Seclusion, Locked with restraints, Non-Ambulatory, 5 Point restraints
S6 Seclusion, Locked with restraints, Manual Hold (exceeds 5 minutes)
S7 Seclusion, Unlocked, No restraints used
S8 Seclusion, Unlocked with restraints, Ambulatory (waist & wrist)
S9 Seclusion, Unlocked with restraints, Non-Ambulatory, Chair restraints
S10 Seclusion, Unlocked with restraints, Non-Ambulatory, 4 Point restraints
S11 Seclusion, Unlocked with restraints, Non-Ambulatory, 5 Point restraints
S12 Seclusion, Unlocked with restraints, Manual hold (exceeds 5 minutes)
R13 Restraint, Ambulatory (waist & wrist)
R14 Restraints, Non-Ambulatory, Chair restraints
R15 Restraints, Non-Ambulatory, 4 Point restraints
R16 Restraints, Non-Ambulatory, 5 Point restraints
R17 Restraints, Manual Hold (exceeds 5 minutes)
V18 Other, Eye-to-Eye or One-to-One Visual (within 25 feet)
D19 Other, One-to-One Direct (within arm’s length)
O20 Other, Close Observation
FC21 Security Imposed Confinement
FR22 Security Imposed Restraint

REASON (SECRAINT->REASON)

Select the code that indicates the reason for which the client is in seclusion/restraint. Selection of choice “03” will cause a pop-up to appear to allow entry of the information regarding other reason(s) why the use of seclusion/restraint has been ordered.

CODES & DEFINITIONS

01 DS - Danger to Self

02 **DO** - Danger to Others
03 **Other** - POPUP TEXT (SECRAINT->REASON_TXT)

SHIFT (SECRAINT->SHIFT)

Enter the number that indicates the daily work period, or shift, e.g. “1”, “2”, or “3”, during which the client was placed in seclusion/restraint.

INITIAL/ASSESSING PHYSICIAN (SECRAINT->ASSESS_MD)

Enter the provider code of the initial/assessing physician who ordered the use of seclusion/restraint for this client. Codes are available in the pop-up.

REASSESSING/REORDERING PHYSICIAN (SECRAINT->ASSESS_MD2)

Enter the provider code of the reassessing/reordering physician who reassessed and/or reordered the use of seclusion/restraint for this client. Codes are available in the pop-up.

ORDER DURATION HOURS (SECRAINT->ORDER_HR)
MINUTES (SECRAINT->ORDER_MIN)

Enter the length of time, in whole hours and number of minutes exceeding whole hours, for which the use of seclusion/restraint has been ordered.

CURRENT PSYCHOTROPIC MEDS (SECRAINT->CURRENTMD)

A pop-up will appear to allow entry of the current psychotropic medications ordered for the client. Following the entry of a client's meds, the user may save or abort the entry by using the function keys as listed. The user will then highlight EXIT and press ENTER to exit the screen.

PRN MEDS GIVEN (SECRAINT->PRNMEDS)

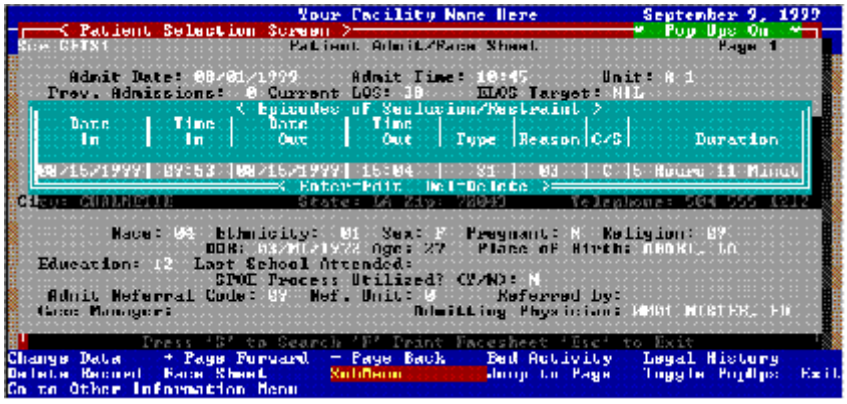
A pop-up will appear to allow entry of the PRN medications given to the client during this episode of seclusion/restraint. Following the entry of a client's PRN meds, the user may save or abort the entry by using the function keys as listed. The user will then highlight EXIT and press ENTER to exit the screen.

INITIALED BY (SECRAINT->INIT_BY)

Enter the initials of the person entering the data.

II. EDIT/DELETE SECLUSION/RESTRAINT

This function will allow the authorized user to modify the Seclusion/Restraint record of a particular client. Select this option, while in "Modify Patient", from the Page Menu by selecting "Submenu" and highlighting "Seclusion/Restraint" and pressing Enter.



A. Episodes of Seclusion/Restraint

SCREEN LABEL		DATABASE->FIELD NAME
EPISODES OF SECLUSION/RESTRAINT		
DATE IN		(SECRAINT->DATEIN)
TIME IN		(SECRAINT->TIMEIN)
DATE OUT		(SECRAINT->DATEIN)
TIME OUT		(SECRAINT->TIMEIN)
TYPE		(SECRAINT->TYPE)
REASON		(SECRAINT->REASON)
C/S		(SECRAINT->CS)
DURATION	HOURS	(SECRAINT->ORDER_HR)
	MINUTES	(SECRAINT->ORDER_MIN)

To edit an existing entry in the list, the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press Enter and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields. When editing is complete, the record will be updated to the database and the cursor will return to the previous screen.

Although deletion is allowed, the authorized user should proceed with extreme caution when deleting Seclusion/Restraint records.

CHAPTER 12

VIEW
PATIENTS

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. VIEW PATIENTS

This function allows the user to view a particular client's record. Select this option from the Main Menu under Browse/Reports. Once in View, the Patient Selection Screen will appear. As instructed at the bottom of the screen, press "S" to search. The user will be prompted to search by name, hospital number or social security number. Highlight the desired method and press ENTER. The user will then be asked to enter the desired information and the search will begin. The user can also highlight a selected client on the Patient Selection Screen and press ENTER and that client record will be selected.

After locating the client record, the user is automatically taken to the first of the screens in the View section. The user can examine each screen. Functions available to the user are at the bottom of the screen. These functions are described in the "Conventions Used in PIP" section at the beginning of the manual.

The following lists the screens, the screen name (from the upper left corner of the screen), and the screen title.

PAGE	SCREEN NAME	SCREEN TITLE
1	**GETS1**	**Patient Admit/Face Sheet**
	For information on this screen see "Admit A Patient", Chapter 5 - Page 3.	
2	**GETS2**	**Status Information Screen**
	For information on this screen see "Admit A Patient", Chapter 5 - Page 9.	
3	**GETS4**	**Parent/Guardian Data**
	For information on this screen see "Admit A Patient", Chapter 5 - Page 21	
4	**GETS6**	**Patient Diagnosis Information**
	For information on this screen see "Complete Patient Staffing", Chapter 7 - Page 22.	
5	**REV_FGETS1**	**Client Treatment Review Form**
	For information on this screen see "Complete Patient Staffing",	

Chapter 7 - Page 9.

6 **REV_FGETS2** **Drug Abuse Patterns At Admission**
For information on this screen see "Complete Patient Staffing", Chapter 7 - Page 17.

7 **GETS7** **Supplementary Patient Information**
The fields displayed on this screen are user defined fields which can be modified by each facility to meet the needs of the facility.

8 **GETS8** **Patient Financial Information**
For information on this screen see "Admit A Patient", Chapter 5 - Page 24.

9 **DISC_GET** **Discharge Tracking Screen**
For information on this screen see "Edit Discharge Tracking", Chapter 8 - Page 2.

10 **DC_SUMGET2** **Patient Discharge Summary**
For information on this screen see "Discharge Summary", Chapter 9 - Page 4.

11 **ADMIT2_GET** **Legal Charges**
For information on this screen see "Admit A Patient", Chapter 5 - Page 23.

Upon completion of viewing the screens, the user can exit to the main menu.

CHAPTER 13

SPECIAL REPORTS

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. PIP SPECIAL REPORTS

This function is used to create reports which are utilized for management decision support. They are generated at each facility and submitted to the OMH State Office and/or the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services. Select this option from the Main Menu under Browse/Reports.

Each of these reports will display the collected information on the screen when completed. By pressing "Escape", the user will then be given the option of printing the report to a local printer or to a file on the hard drive. When selecting the option to print, the user should insure that the printer is on and is loaded with paper. If the user chooses to print the report to a file, a default filename will be presented for the user's approval. The user may edit the name or accept the default and press ENTER to proceed. If the selected file name already exists the user will be prompted "That file already exists. Overwrite it? Y/N". If the user selects "Y", the existing file will be overwritten with the new report. If the user selects "N", the cursor will return to the file name, allowing that name to be changed to a new name. A report in progress may be halted by pressing "Esc".

1. ACUTE UNIT SUMMARY REPORT

This report is designed for the Office of Mental Health staffed and managed Distinct Part Adult Acute Psychiatric Units. The report can be issued for any time period. The data in the report is utilized to produce the Fiscal Year Summary Report for the Acute Units.

When this report is selected the user will enter the date for the beginning of the period to be tabulated, and the date for the end of the period to be tabulated. Progress on the report is noted on the screen. The report will appear on the screen and the user is given a choice of printing the report or saving the report to a file.

DATA ELEMENTS AND DEFINITIONS

Total Served - This field is calculated by taking the number of clients at the beginning of the month plus total admissions.

<u>PATIENT MOVEMENT</u>

In Hospital Beginning of Month - The number of clients on the unit at the beginning of the reporting month, or the beginning of the time period.

End of Month - The number of clients on the unit at the end of the reporting month, or the end of the reporting period. This is calculated by taking the number of clients on the unit at the beginning of the month (or period) plus admissions minus discharges.

New Admissions - Number of clients admitted during the reporting month for whom this was the first admission to the facility.

Readmissions - Number of clients admitted during the reporting month who had at least one previous admission to the facility.

Readmissions < 1 year - Number of clients admitted during the reporting month who had at least one previous admission to the facility within the 12 months prior to the current admission.

Total Admissions - This field is calculated by taking the first admissions plus readmissions.

Discharges - Number of clients discharged during the reporting month.

Inpatient Days - Days of stay during the month for clients on the unit during the reporting month.

Discharge Care Days - Total days of stay for clients discharged during the reporting month.

ADMISSION COMMITMENT STATUS

Formal Voluntary - Number of clients admitted on a Formal Voluntary or Non-contested during the reporting month.

PEC - Number of clients admitted on a PEC during the reporting month.

CEC - Number of clients admitted on a CEC during the reporting month.

PEC/CEC - Number of clients admitted on a PEC/CEC during the reporting month.

Civil Judicial - Number of clients admitted on a Civil Judicial during the reporting month.

Criminal Judicial-Not Competent - Number of clients admitted on a Criminal Judicial-

Not Competent during the reporting month.

Criminal Judicial-NGBRI - Number of clients admitted on a Criminal Judicial-Not Guilty by Reason of Insanity during the reporting month.

Juvenile Judicial - Number of clients admitted on a Juvenile Judicial during the reporting month.

Other - Number of clients admitted on an Unknown or Transfer from Corrections during the reporting month.

ADMISSION SOURCE OF REFERRAL

Self/Family/Friend - Number of admissions whose source of referral was Self, Family/Friend/Individual, or Order for Protective Custody.

Private Outpatient MH Provider - Number of admissions whose source of referral was Private Psychiatrist, Other Private MH Practitioner, Private MH Clinic/ Organization, or Other Private Physician.

Private Inpatient MH Provider - Number of admissions whose source of referral was Private Inpatient Psychiatric Facility.

OMH Outpatient MH Tx. Provider - Number of admissions whose source of referral was a CMHC (SPOE Process).

OMH Inpatient MH Tx. Provider - Number of admissions whose source of referral was a OMH Acute Unit or OMH Hospital.

Court/Law Enforcement - Number of admissions whose source of referral was a Court/Local Correction Facility, or Law Enforcement Agency.

Private Substance Abuse Tx. Facility - Number of admissions whose source of referral was a Private Inpatient or Outpatient Substance Abuse Facility.

Private General Hospital - Number of admissions whose source of referral was a Private General Hospital.

Coroner - Number of admissions whose source of referral was a Coroner.

Nursing Home - Number of admissions whose source of referral was a Private Nursing Home/Extended Care Facility.

Other State Agency - Number of admissions whose source of referral was an Other State Agency/Facility.

Other - Number of admissions whose source of referral was School/Educational Program, Clergy, DWI Referral, Employer/EAP, Shelter for Homeless/Abused, Other Source of Referral, or Unknown.

DISCHARGES BY SEX

Male Discharges - Number of males discharged during the reporting month.

Female Discharges - Number of females discharged during the reporting month.

DISCHARGES BY AGE

Ages 0-21 - Number of discharged clients ages 0-21.

Ages 22-64 - Number of discharged clients ages 22-64.

Age 65 -> - Number of discharged clients ages 65 and over.

DISCHARGES BY PRIMARY DIAGNOSIS

Child/Adolescent Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 299, 307.00-307.3, 307.5-307.7, 307.9, 309.21, 312.0-312.2, 312.9-315.

Schizophrenia & Other Psychotic Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 295, 297, 298.3, 298.8, 298.9.

Major Affective Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 296, 301.13, 311.

Dysthymia - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 300.4.

Anxiety Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 300.0-300.02, 300.2, 300.3, 308.3, 309.21.

Personality & Other Impulse Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 300.16, 300.19, 301.00, 301.2-301.9, 312.3.

Adjustment Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 309.00, 309.23-309.4, 309.82-309.9.

Organic Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 290, 293, 294, 310.

Mental Retardation - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 317- 319.

Alcohol/Drug Related Disorders - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 291, 292, 303.0, 303.9, 304, 305.

V-Codes (Social Conditions) - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: All V-codes other than V71.09.

Other - Number of discharges with the following Diagnostic Codes as Primary Discharge Diagnosis: 300.11-300.15, 300.6-300.9, 302, 306.51, 307.4, 307.8, 316, 780.5, 799.9, V71.09. Also includes Unknown Diagnoses.

DISCHARGE DISPOSITION

To Outpatient/Self Care Environment - Includes residential arrangement at discharge to Single Family Dwelling, or Apartment.

To Hospital - Includes residential arrangement at discharge to a Hospital.

To Nursing Home - Includes residential arrangement at discharge to a Nursing Home or Intermediate Care Facility.

To Residential Facility - Includes residential arrangement at discharge to a Residential Hotel, Group Home/Halfway House, Supervised Apartment, or Board and Care.

To Jail/Prison/Corrections - Includes residential arrangement at discharge to a Jail/Prison/Training Institute.

To Other - Includes residential arrangement at discharge to Other Quarters, No Permanent Residence, or Unknown.

2. PATIENT POPULATION MOVEMENT REPORT

This PIP report is prepared and submitted to State Office monthly. The report will show all basic patient population statistics by hospital unit, ward, and for the total hospital. Below is the list of the statistical items the report will display. The user will be able to select a begin and end date for the report (so that the report may reflect a day, month, quarter, or year period of time). After the report has been generated, the user will also be able to select the destination of the report: screen, printer, or a disk file (the user will be prompted for a file name and extension).

In the event of discrepancies, the Patient Movement Report Troubleshooter may used for more in-depth information and verification. To print the report and troubleshooter, select "Output Report to Printer with Troubleshooter."

DATA ELEMENTS AND DEFINITIONS

Licensed Beds - This is the total number of beds on the unit which the hospital has been licensed to operate on the last day of the reporting period.

Staffed Beds - This is the total number of licensed beds on the unit that are staffed and open for service on the last day of the reporting period.

Total Bed Days - This is the total number of days of hospital/facility care, from beginning of the reporting period to the end of the reporting period, a unit may provide based on the number of staffed beds. Calculated as the sum of staffed beds multiplied by the total number of days in the reporting period.

Average Daily Census - The average number of clients in the unit per day for the reporting period, including those on leave/pass/elopement for whom beds are held. This is calculated by taking the total inpatient days in the reporting period divided by number of days in the reporting period.

Bed Occupancy Rate for Staffed Beds - The average percent of beds occupied out of the total possible beds available to be occupied (staffed beds) during the reporting period. [Can be calculated as the total inpatient days divided by (the number of staffed beds in the unit times the number of days in the reporting period)] or [the average daily census divided by the number of staffed beds]. The number of staffed beds may change over the course of the reporting period, in which case it is the average number of staffed beds that is used.

> Bed Occupancy Rate Definition: The ratio of actual inpatient days to available beds for a given unit/facility during a specified period of time. Expressed as a percentage. May be for all staffed beds or licensed beds.

Bed Occupancy Rate Calculation: Average Daily Census divided by Beds

Total Clients Served - The total number of clients served in the hospital during the reporting period, which includes those that were being served on the begin date and all those admitted through the end date.

Number of Clients Served Definition: The count of persons served by the facility/unit during a given period of time.

Number of Clients Served Calculation: (Duplicated) count of number of clients in the facility/unit on the first day of a given time period plus all those admitted during that time period, includes readmissions. Unit calculations also include transfers into the unit during that time period.

Average Length of Stay for Discharged Patients - The average number of discharge days for all persons discharged during the reporting period as counted from their date of admission to their date of discharge. Calculated as the sum of the discharge days for all discharged clients divided by the total number discharges.

Average Length of Stay - Discharge Patients Definition: The average length of hospitalization of those clients who are discharged from a given unit/facility during a specified period of time.

Average Length of Stay Calculation: The sum of the discharge days of all in period divided by the total number of discharges in the period

Average Days of Care Provided - The average number of inpatient days counted from the beginning of the reporting period to the end of the reporting period for currently active clients. Calculated by the sum of inpatient days for all active clients divided by the number of clients on record at beginning of period plus admissions during reporting period (Total Clients Served).

Average Length of Stay - Active Patients Definition: The average length of stay of all clients served including those on leave/pass/elopement for whom beds are being held in a given unit/facility during a specified period of time.

Average Length of Stay - Active Patients Calculation: The sum of inpatient days in reporting period divided by the total number of clients served in reporting period

On Service, Beginning of Period - This is the unit census (total number of patients on

the ward) at the beginning of the reporting period not including the number that are on leave at this time. It includes all those clients who have an active status codes on this day excluding those who are on leave/pass or elopement that day (i.e., all with status codes less than or equal to 20 (Return from leave/pass/elopement), except 13 (Transfer to Hospital for medical care), 14 (Court Pass), and 19 (On Elopement)).

On Leave, Beginning of Period - This is the number of clients on leave/pass at the beginning of the reporting period (i.e., all with status codes 13 (Transfer to Hospital for medical care), 14 (Court Pass), and 19 (On Elopement)).

On Record, Beginning of Period - This is the sum total of all active clients at the beginning of the period (begin date), both on-service or on-leave (i.e., all status codes less than or equal to 20 (codes 01 thru 20)). It is also the sum of "On Service, Beginning of Period" and "On Leave, Beginning of Period".

First Admissions - This is the number of person directly admitted (not transferred) to the unit during the reporting period for the first time (no prior admission to the facility).

Re-Admissions - This is the number of persons directly admitted (not transferred) to the unit during the reporting period who had at least one previous admission to this hospital.

Re-Admissions W/in 30 days - This is the number of persons directly admitted (not transferred) to the unit during the reporting period who had at least one previous admission to this hospital within 30 days prior to the current admission.

Total Direct Admissions - This is the total number of all direct admissions to the unit, both first admissions and re-admissions, that occurred during the reporting period (from the begin date to the end date).

Re-Admission Rate (Percent) - This is the percent or rate of total direct re-admissions during the reporting period who had at least one previous admission to this hospital within 30 days prior to the current admission. It is calculated by dividing re-admissions by total direct admissions and converting to a percent by multiplying by 100.

Transfers from Other Units:

In - This is the total number of clients who have been transferred to the unit from another unit within the hospital (i.e., status code 10 - Inter-unit transfer).

Out - The number of clients transferred out to another unit within the hospital (status code of 10 - Inter-unit transfer).

Discharges/Deaths while:

In Hospital - The total number of clients discharged (including those who died while in the hospital) of those on service in hospital (i.e., status codes 31 - 50, excluding codes 37 (Discharged while on Leave/Pass) and 38 if client was previously on status 11 thru 19.

On Leave - Total number of discharges and deaths while on leave (i.e., status codes 37 (Discharge while on leave) and 38 (Client Died if client was previously on status 11 thru 19)).

Total Patient Days:

In-Patient - The total number of days in the hospital from beginning of the reporting period to the end of the reporting period for all <u>active clients</u> (including those on leave/pass/elopement for whom a bed is held).

Inpatient Day/Length of Stay Definition: A day of hospital/facility care, including pass days and elopement days during which a bed is held for the client. May be calculated for a particular individual or for all active clients during a particular period of time.

Inpatient Day/Length of Stay Calculation: For statistical purposes, the first partial 24-hour period ending at midnight is counted a full day. The last partial day beginning after midnight is <u>not</u> counted. Changes in inpatient status (to or from leave/pass/elopement) are counted similarly, i.e., status at midnight governs classification on the 24-hour period ending at midnight.

** * *Please note: When using the Patient Movement Report Troubleshooter, inpatient days for some patients may be separated, and the patients may have multiple entries, depending on the Bed Activity of those patients during the reporting period.*

Discharged - The total number of days in the hospital from admission to the date of discharge during the reporting period for all <u>discharged clients.</u>

Discharge Days Definition: The total number of inpatient days (for this admission) for clients who have been discharged. May be calculated for a particular individual or for all clients discharged during a particular period of time.

Discharge Days Calculation: Count all inpatient days of care provided to this client at this facility for this admission.

Placed on Leave for:

Medical Care - The number of clients with a status code 13 during the period.

Court Pass - The number of clients with a status code 14 (Court Pass) during the period.

Total Leaves - The sum total of all clients with a status code 13 - 19 during the period. This is the sum of all "Placed on Leave" clients.

Elopements - The number of clients with a status code 19 (On Elopement) during the period.

Trial Discharge - The number of clients with a status code 11 (Trial Discharge) during the period.

Home Visit - The number of clients with a status code 12 (Therapeutic Pass/Home Visit) during the period.

Failure to Return - The number of clients with a status code 15 (Failure to Return from Leave/Pass) during the period.

Total Pass Days -This is the total number of days on pass, counted from the beginning of the reporting period to the end of the reporting period, for all clients.

Returns from Leave - This is the total number of clients who have returned from a leave during this reporting period (i.e., Status code 20 (Return from leave/pass/elopement), if they were previously on status 13 (Transfer to Hospital for medical care), 14 (Court Pass), or 19 (On Elopement)).

Elopements - Total number of clients placed on elopement status during the reporting period (i.e., status code 19). An elopement is defined as a client who is on unauthorized leave from the hospital or other location unauthorized by the hospital for leave/pass. Clients are placed on elopement the day of the reported elopement, regardless of the time remaining in any other leave/pass situation. The day the elopement is reported is counted as the first elopement day. A bed is held for the client during the time the client is on elopement. Patient days are counted after the day the elopement was reported until the client is discharged.

On Service, End of Period - All clients on the unit (not on leave) at the end of the reporting period (all those with a status code of 01, 10 to this unit, or 20). This is the number of clients on service on the beginning of the period, plus those admitted, transferred in, or returned from leave to the unit since that time, not counting those who have since been discharged, transferred out to another unit, or placed on leave. This is the sum of "On Service, Beginning of Period", "Total Direct Admissions", "Transfers in from Other Units", and "Returns from Leave" minus "Discharges/Deaths While in Hospital", "Transfers out to Other Units", and "Place on Leave - Total All Leaves".

On Leave, End of Period - This is the number of clients on leave/pass at the end of the reporting period. This is the sum of "On Leave, Beginning of Period" and "Placed on Leave - Total All Leaves" minus "Returns from Leave" and "Discharges/Deaths While on Leave".

On Record, End of Period - This is the total of all active clients at the end of the period, both on-service or on-leave. This is the sum of "On Service, End of Period" and "On Leave, End of Period".

3. RESIDENT PATIENTS AT END OF PERIOD REPORT

This PIP report is prepared and submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services on a yearly basis. The report details the active cases for the end of the reporting period by psychiatric diagnosis categories, by sex, and by age group as required by SAMHSA.

4. HOSPITAL ADMISSIONS DURING PERIOD REPORT

This PIP report is prepared and submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services on a yearly basis. This is a report of the hospital admissions by psychiatric diagnosis categories, by sex and age group as required by SAMHSA.

CHAPTER 14

REPORT WRITER ACCESS

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. DATABASE MANAGEMENT SYSTEM

Database Management is a computer term that refers to the way in which information, or **data**, is sorted, stored and used. Any collection of related data grouped together as a single item is a database. A cardfile of customer names, addresses and phone numbers may be considered a database. However, it is not the cardfile itself but the way the data on each card is organized that makes it a database.

Information in a database file (.DBF) is usually arranged and stored in the form of **tables**, with rows and columns in each table. Rows in a table are called **records** and columns are called **fields**. In our previous example, the cardfile is our table. Every card in the file represents a record and each section of information the card contains is separated into fields.

In theory, every table is organized in such a way that data is easy to find. Again using our example of a cardfile, if you want to locate a customer's phone number, you simply find the card listed in their name and read across to the corresponding phone number. However, if you only have the address and not the name, it becomes difficult and tedious to locate the correct card. The card file is not very effective for finding that customer's telephone number in this instance.

When a table is computerized, problems such as this can be eliminated as the computer has the ability to quickly search for information from several different perspectives. The computerized table performing in this manner is known as a **database management system**.

II. INDEXING A DATABASE

Most records are added to tables in a random manner and the tables store these records in the actual order in which they are entered. Upon entry in a table, each record is consecutively numbered, therefore **identity order**, also known as "entry order", corresponds to the sequence in which the records were created. This is <u>not</u> the customer number, but simply a reference to the physical position the record occupies within the list of records in a database. Each record has a unique record number and this unique value is known as the record's **identity**.

Again, let's refer to our cardfile example. Suppose cards are added to the file in the following pattern: B. Jones, H. Smith, L. Andrews, P. West, T. Matthews. The record number, or identity order, would then be #1 for Jones, #2 for Smith and so on.

However, when you want a report on the data in a table, you usually want it in a specific order. Tables can be arranged several ways and in a computer program, the ability to look up data quickly is as important as the arrangement of that data within the **work area**. A work area is simply a section in the computer's memory in which we manage tables and their associated indexes. These operations may be handled through the use of **indexing** which is a way of logically arranging the tables according to the data they contain.

When reading a book, you would use a separate section known as the "index" as a guide to find where particular information is located within that book. Similarly, an **index file** is a separate file that contains information regarding the location of individual records in the *parent* table. Every index file consists of at least one field from a table and the file is organized according to that field. This field, or the combination of one or more fields, is known as a **key expression** and will sort the index file alphabetically, numerically or chronologically.

The key expression is stored in the index file in such a way that the parent table can be quickly rearranged to appear in a specific order. This is due to the relationship between each entry in this field and the corresponding record number, or identity, used to reference the position of a record in the parent table. The association between a key expression and an identity is known as a **keyed-pair**.

However, indexing does not affect the actual arrangement of the parent table. Instead, it builds a file that only appears to be a sorted file. When the parent table is in use, along with the associated index file, the first record to be retrieved is not necessarily the first record listed in the parent table; instead, it is the first record listed in the index file. The next record retrieved will be the second record listed in the index file, and so on.

If we were to create an index on our sample cardfile according to the field, or key expression, "last name", the entries would be sorted alphabetically. The first card, or record, retrieved into our index file would be record #3 - L. Andrews, followed by #1 - B. Jones, and then record #5 - T. Matthews, #2 - H. Smith and finally, #4 - P. West. The parent table, however, still maintains the original identity order.

III. ORDER MANAGEMENT SYSTEM

One effective and flexible method of indexing data is through an Order Management System. An **Order** is an index which gives the appearance that data is arranged by something other than its identity order without actually changing the physical arrangement of records in the parent table. In other words, an order never physically changes the data that it is applied against, but creates a different view of that data.

Several orders may be utilized for a single parent table so the data can be organized and accessed in many different ways. This group of orders in use, or **open**, in a work area is called the **Order Bag**. However, data can only be sorted one way at a time. For instance, you may not have the records in a cardfile in both name and ZIP code order, although you can sort them by ZIP code and then have all the records with the same ZIP code sorted alphabetically.

At any one time, only a single order can control the logical organization of the records in a work area. The active order is termed the **Controlling Order.** You may access specific orders by referencing a particular order by name as, in an order bag, each order must have a distinctive name to distinguish one order from another. This is called the order's **Tag** and is similar to an alias or nick name.

IV. SETTING RELATIONS

Once tables and indexes are opened and in use, setting up relations between them is important. The concept of a relation is simple - it ties two (or more) work areas together by means of a field or key expression, called a **linking field** that both/all have in common. In other words, the first table must contain fields that can construct a key to the data in the second table. The second table must be ordered by an index that contains the same key information.

For example, consider our sample table, the cardfile which contains the names of customers, and another table of invoices which does not contain their names. Rather than copying customer information for each invoice, only a common field, such as a customer number, is added to the invoice table. This field ties each invoice record to the original customer record that the invoice is made out against.

It is important to note that without a linking field that contains matching data in each of the tables, it is not possible to set a relation.

V. USING R&R REPORT WRITER

R&R produces reports using information stored in database files (.DBF), or as we refer to them, tables. Each report must use at least one table. The table selected as the primary source of data for the report is called a **Master File** or **Master Database**. **Related files** are additional tables from which more information may be drawn.

In order to generate a report that draws information from more than one table, you must define the relation that links the tables you want by using linking fields and indexes, or orders. R&R uses the orders to locate the appropriate records in the related tables.

It is only after you have created a database relation that R&R is able to access data in the related table. For example, you might define a database relation that links a customer cardfile and an invoice table using a customer number field present in both tables as a linking field. As long as the invoice table is indexed on the customer number field, R&R can find information about each customer's account by matching the customer numbers in the cardfile with the customer numbers on the invoices.

VI. DIAGNOSTIC DATA STRUCTURES

The following sections are intended to help users learn to retrieve diagnostic patient information from the new PIP data structures using R&R Report Writer. The new data structures were made necessary by the needs to track diagnostic data across a patient's stay, and remove the limitations on the number of diagnoses that could be tracked for a particular axis and the requirement to track Axes 4 and 5. These goals have been accomplished as well as the adding the capability of tracking the level of certainty of a diagnosis, i.e., provisional or rule-out. While the data collection flexibility of PIP has been enhanced, the use of R&R to retrieve data has become slightly more complex.

VII. DIAGNOSTIC SESSIONS

Formerly, when data was entered into PIP, information was recorded at the times of admission, staffing and discharge. Except for the "primary" admit, treating, and discharge diagnoses, some of the diagnostic data was overwritten by subsequent entries. Additionally, PIP lacked the ability to track more than three diagnoses at the time of admission. As a solution to this problem, PIP now tracks "Diagnostic Sessions." A Diagnostic Session is a snapshot of the patient's diagnostic information at a given time. A patient may have an unlimited number of sessions.

For each session, PIP tracks the Time and Date of the session, pointers to the Primary and Secondary Treating Diagnoses, and the Global Assessment of Functioning (Axis 5). This data is stored in a table named DxSn (Dx for Diagnostic, Sn for Session). Below is the structure of DxSn.dbf:

Field Name	Type	Len	Dec
UI	C	5	
FKSTAY	C	5	
DSDATE	D	8	
DSTIME	C	5	
GAF	N	3	0
TXDX1	C	7	
TXDX2	C	7	

In writing a report using a Diagnostic Session, it was thought that the most common scenarios included diagnostic information from the admitting session, the most recent or last session, or a list of the contents of all sessions. With that in mind, the sessions are ordered in several different ways as outlined in the list at the end of this chapter.

VIII. DIAGNOSIS INFORMATION

The actual PIP diagnosis information is stored is stored in a table named 'Dx.dbf'. The connecting information for the diagnosis for a particular session is stored in "SnDx1_3.dbf" for Axis 1 through Axis 3 and in "SnDx4.dbf" for Axis 4.

SnDx1_3.DBF

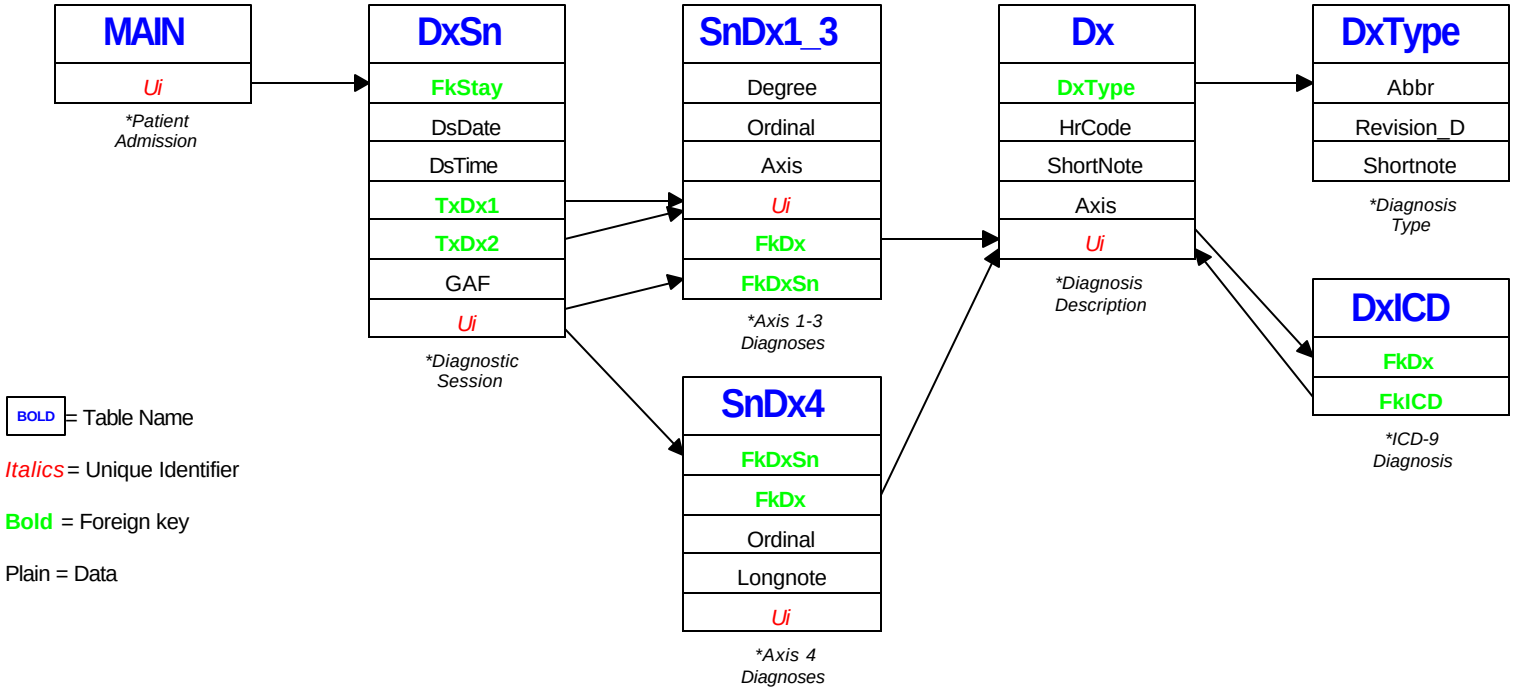
Field Name	Type	Len	Dec
UI	C	5	
FKDXSN	C	5	
DEGREE	N	6	0
ORDINAL	N	4	0
AXIS	C	1	
FKDX		C	5

SnDx4.DBF

Field Name	Type	Len	Dec
UI	C	5	
FKDXSN	C	5	
FKDX		C	5
ORDINAL	N	4	0
LONGNOTE	M	10	

IX. DATA STRUCTURE RELATIONS

The diagram on the next page demonstrates the relations between the diagnostic databases. Additionally, the arrows indicate the linking fields. Again, more information on the orders and tag names used in PIP is included at the end of this chapter.



*Each *Patient Admission* may have many *Diagnostic Sessions*

*Each *Diagnostic Session* may have many *Axis Diagnosis*

*Each *Axis Diagnosis* will have one *Diagnostic Session*

*Each *Axis Diagnosis* will have only one *Diagnosis Description.*

*Each *Diagnosis Description* may have many *Axis Diagnoses.*

*Each *ICD 9 Diagnosis* will have one *Diagnosis Description.*

*Each *Diagnosis Description* will have one *ICD 9 Diagnosis.*

*Each *Diagnosis Description* will have one *Diagnosis Type.*

*Each *Diagnosis Type* may have many *Diagnosis Descriptions.*

Patient Admission: An episode of care for a particular patient with defining characteristics of Admit Date and Discharge Date.
Diagnostic Session: An episode of diagnosis determination for a patient with identifying characteristics of Date and Time.
Axis Diagnoses: An instance of a diagnosis with identifying characteristics of Axis, Order and Degree of Certainty.
Diagnosis Description: Has identifying characteristics of Code, Description and Type.
ICD-9 Diagnosis: A connection of two diagnoses from the Dx table.

X. R&R REPORT WRITER ACCESS

This function will shell out to access Concentric Data Systems R&R Report Writer. Select this option from the Main Menu under Browse/Reports. At that time the user can generate a previously written report to view and/or print or can design a new report. Upon entering R&R, the user must select the previously designed report to use or database file(s) to design a new report. If a previously designed report is selected the user can print the report, preview the report on the screen, modify the report or save the output from the report to a file.

For information on designing new reports, the user should refer to the R&R manual.

The Office of Mental Health is developing an R & R Report Library. This library will contain facility developed R & R reports that can be accessed and used by all facilities. Based upon this, the following documentation standards are required for submission of reports to this library.

XI. DOCUMENTATION STANDARDS FOR PIP/PIF R&R REPORTS

1. To be able to use R&R reports contained in the report library, it will be necessary for all facilities to have PIP/PIF in a standard directory path. The current recommendation is: **DRIVE:\APPS\PIP**

2. Each report is to be submitted to the CHoPIN committee on a 3-1/2" diskette. More than one report can be included on the diskette.

3. If a report utilizes any user defined functions, a copy of the user defined function library should be included on the disk.

4. The R&R Documentation Form is to be completed and submitted for each report.

5. A copy of the printed specification and test-pattern for the report shall be submitted with each report. The specification and test-pattern are generated and printed by R&R by entering the Print menu selection and choosing specification and/or test pattern.

6. The following conventions should be used, as much as possible, for each report developed:
   A. The report title should be descriptive of the function of the report;
   B. The header on each page should contain the following:
      Title of Report
      Facility (should be retrieved from the chkvlmem.dbf)

Reporting Period
Date of Run Time of Run

C. The report should be paginated.

7. All reports submitted to the CHoPIN committee will be tested and then released to the facilities. After a report has been in the field for a period of 6 months, facilities will be contacted regarding the usefulness of the report. If a majority of the facilities are frequently using the report, the committee will consider having the report hard-coded into PIP/PIF.

8. Requests for special reports should be made to the CHoPIN committee in a format similar to that used for enhancement requests. As time and staff allow, attempts will be made to create requested reports.

9. All submitted reports will be kept in a report library which will automatically be sent to the facilities as part of the Upload Process. The reports will be accompanied by an introductory note which will briefly describe what information the report generates and which version of R&R is required to run the report. Additional information, such as samples of user-definable queries, may be included.

Following the report documentation form is a list of the tables, orders, order tags and key expressions used in PIP and PIF to assist in your report writing efforts. For more information on designing R&R reports, please refer to your R&R manual.

PIP/PIF R&R REPORT DOCUMENTATION FORM

Complete one form for each report submitted. Submit the R&R report on a 3-1/2" diskette to the CHoPIN Committee along with this form, a copy of the R&R specification, and a copy of the test-pattern for the report.

Person(s) designing the report:		**Date:**	
Facility:		**Phone Number:**	
Report Name:		**R&R Version:**	
Brief description of what information the report generates and intended users:			
Description of how to use the report (i.e., any special instructions, suggestions for changing the user-definable query or edits needed for facility specific data):			
Who has requested the information contained in this report, if known and how often is this information requested?			
Are there any user-defined functions used in this report? If yes, include a copy of the user defined function library on the diskette.			
Suggested key words (i.e., what words would help locate this report and what it does, such as occupancy, LOS, staffing, etc.):			

TABLE/ .DBF	ORDER TAG BAG	KEY EXPRESSION	
Bed Information Tables			
bed_act	bed_act	bed_act1	hosp_num + DtoS(act_date) + time
		bed_act2	DtoS(act_date)
		bed_act3	hosp_num
		bed_act4	hosp_num + DtoS(act_date)
		bed_act5	ui
		bed_act6	fkmain
		current	hosp_num + DtoS(adm_date) + Descend(DtoS(act_date) + Descend(time)
Diagnostic Information Tables			
codegrp	codegrp	fkdx	fkdx
		fkdxgrp	fkdxgroup
dx	dx	axis	axis
		dxtype	dxtype
		hrcode	dxtype + hrcode + shortnote
		shortnote	dxtype + shortnote
		typeaxiscd	dxtype + axis + hrcode + shortnote
		typeaxissn	dxtype + axis + shortnote + hardcode
		ui	ui
dxgroup	dxgroup	hrgroup	hrgroup
		ui	ui
dxicd	dxicd	fkdx	fkdx
		fkicd	fkicd
dxset	dxset	hrset	hrset
		ui	ui
dxsn	dxsn	dsdate	dsdate
		stay	fkstay + DtoS(dsdate) + dstime
		stay_d	fkstay + Descend(DtoS(dsdate)) + Descend(dstime)
		txdx1	txdx1
		txdx2	txdx2
		ui	ui
dxtype	dxtype	abbr	abbr
		shortnote	shortnote
groupset	groupset	fkdxgroup	fkdxgroup
		fkdxset	fkdxset
sndx1_3	sndx1_3	axisorder	fkdxsn + axis + str(ordinal)
		fkdx	fkdx
		fkdxsn	fkdxsn
		ui	ui
sndx4	sndx4	fkdx	fkdx
		fkdxsn	fkdxsn + str(ordinal)
		ui	ui
Fiscal Information Tables			
bill	bill	bill4	ui
		bill5	fkmain
		billdate	DtoS(date) + hosp_num + DtoS(adm_date)
		billnum	hosp_num + DtoS(adm_date)
		pay_bill	fisstatcod + hosp_num + DtoS(adm_date)
billdate	billdate	billdat2	Descend(DtoS(date))
fismain	fismain	fis_hnum	hosp_num + Descend(DtoS(adm_date))
		fislink	hosp_num + DtoS(adm_date)
		fismain3	ui
		fismain4	fkmain
payment	payment	paydate	DtoS(date) + hosp_num
		pmnt_beg	beg_date
		pmnt5	ui
		pmnt6	fkmain
		pmnthnum	hosp_num + DtoS(adm_date)
		pmntpabl	fisstatcod + hosp_num + DtoS(adm_date)

TABLE/ .DBF	ORDER TAG BAG	KEY EXPRESSION	
Lookup Tables			
acute	acute	acute	code
adm_type	adm_type	adm_type	code
admprob	admprob	admprob	code
barriers	barriers	barriers	code
chronic	chronic	chronic	code
cmised	cmised	cmised	code
codes	codes	codereg	region
		codes	codes
country	country	country1	ui
		country2	country
court	court	court	code
discplin	discplin	discplin	code
dispost	dispost	dispost	code
drugs	drugs	drugs	code
dsm3_r	dsm3_r	dsm3_r	code + descrimin
employ	employ	employ	code
ethnic	ethnic	ethnic	code
fiscode	fiscode	fiscode	code
fisdeny	fisdeny	fisdeny	code
frequent	frequent	frequent	code
handicap	handicap	handicap	code
holiday	holiday	holiday1	holiday
		holiday2	celebrated
		holiday3	fk_country
hospunit	hospunit	hosp2	ui
		hospunit	hrcode
househol	househol	househol	code
juv_cust	juv_cust	juv_cust	code
legalcg	legalcg	legalcg	code
length	length	length	code
marital	marital	marital	code
mhserv	mhserv	mhserv	code
needs	needs	needs	code
o_refer	o_refer	o_refer	code
paybill	paybill	paybill	code
race	race	race	code
referral	referral	referral	code
region	region	region	region
religion	religion	religion	code
resident	resident	resident	code
response	response	respons1	code
		respons2	response
route	route	route	code
source	source	source	code
ssi_elig	ssi_elig	ssi_elig	code
status	status	status	code
termin	termin	termin	code
vet_elig	vet_elig	vet_elig	code
veteran	veteran	veteran	code
Patient Information Tables			
main	main	main11	ui
		mn_disp	dispositn + lname + fname + mid_initial
		mn_hnum	val(hosp_num)
		mn_jvcst	hosp_num + DtoS(adm_date)
		mn_lname	lname + fname + mid_initial + Descend(DtoS(adm_date))
		mn_orpar	orgparish
		mn_ssi	ssn + Descend(DtoS(adm_date))
		mn_stat	status + hosp_num + Descend(DtoS(adm_date))
		mn_stat2	dispositn + hosp_num + Descend(DtoS(adm_date))
		mn_unit	unit
		mnadmdate	DtoS(adm_date)

TABLE/ .DBF	ORDER TAG BAG	KEY EXPRESSION	
		mnhnum_d	hosp_num + Descend(DtoS(adm_date))
Patient Legal Information Tables			
leghist	leghist	leghist	patid + DtoS(date)
		leghist2	ui
		leghist3	fkmain
Patient Medicaid Certification Tables			
certresp	certresp	certres2	ui
		certresp	fkmed_cert + DtoS(req_date) + req_time
med_cert	med_cert	medcert1	fkmain
		medcert2	ui
Patient Physical Information Tables			
physical	physical	phys2	ui
		phys3	fkmain
		physical	hosp_num + DtoS(adm_date)
Potential Patient Information Tables			
intervu	intervu	i_disp	dispositn + lname + fname
		i_hnum	VAL(hosp_num)
		i_jvcst	hosp_num + DtoS(adm_date)
		i_lname	lname + fname + Descend(DtoS(adm_date))
		i_orpar	orgparish
		i_ssi	ssn + Descend(DtoS(adm_date))
		i_stat	status + hosp_num + Descend(DtoS(adm_date))
		i_stat2	dispositn + hosp_num + Descend(DtoS(adm_date))
		i_unit	unit
		ihnum_d	hosp_num + Descend(DtoS(adm_date))
		int11	ui
SSI Tracking Information Tables			
ssitrack	ssitrack	ssiorder	hosp_num + DtoS(adm_date)
Staff Information Tables			
staff	staff	staff	code
		staffdis	discipline
System Tables			
nextkey	nextkey	nextkey	table
prntlst	prntlst	prntlst	name
qrylst	qrylst	qrylst	ui + trim(str(order))
rptlst	rptlst	rptlst1	ui
		rptlst2	ri_report
rpt_qry	rpt_qry	rpt_qry1	fkreport
		rpt_qry2	fkquery
Unit Information Tables			
unit	unit	unit	unit
unithist	unithist	current unit + Descend(DtoS(date))	
		unithist unit + DtoS(date)	

DESCEND: the index is in reverse order. Character fields are sorted from "Z" to "A", numeric fields from highest to lowest and date fields in reverse chronological order.

DtoS: takes the date expression (normally viewed as DD/MM/YYYY) and changes it into another format so that proper chronological order is maintained.

VAL: converts a field with "character code" format type into a "numeric code" format so that mathematical computations may be employed.

CHAPTER 15

LEGAL STATUS REPORT

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. LEGAL STATUS REPORT

This function is utilized for identifying legal commitments that are due to expire. This report is useful for clinical staff on each unit to alert them of the need for a commitment status re-evaluation. Select this option from the Main Menu under Browse/Reports.

This report will display the collected information on the screen when completed. The user will also have the option of printing the report to a local printer or to a file on the hard drive. When selecting the option to print, the user should insure that the printer is on and is loaded with paper. If the user chooses to print the report to a file, a default filename will be presented for the user's approval. The user may edit the name or accept the default and press ENTER to proceed. If the selected file name already exists the user will be prompted "That file already exists. Overwrite it? Y/N". If the user selects "Y", the existing file will be overwritten with the new report. If the user selects "N", the cursor will return to the file name, allowing that name to be changed to a new name. A report in progress may be halted by pressing "Esc".

The Legal Status Report specifies the Hospital Number, Patient Name, Unit, Current Status, and Expiration Date and Expiration Time, as appropriate. The report is sorted by Unit, and then by Hospital Number.

CHAPTER 16

STANDARD REPORTS

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. STANDARD REPORTS

This function will allow the user to run previously developed R&R Reports from within PIP. Select this option from the Main Menu under Browse/Reports. These reports are generally used by the facility for management decision support. Some of the reports are submitted to the Office of Mental Health - State Office.

Upon selection of the specific report from the report library, the user is asked to indicate the method through which the report is to be viewed. The user may choose to generate and **DISPLAY** the report, save the report to a **FILE**, send the report to a **PRINTER**, or **GRAPHIC PREVIEW BEFORE PRINTING**. The user will be then be prompted to enter the filename or specify what printer the report is to be printed on. PIP may also require the user to select a date or range of dates for the period to be tabulated. Progress on the report is noted on the screen. The user may abort the generation of a report by pressing ESC.

ADMISSIONS REPORT - NO ADMIT TYPE

This report prints a list of all patients with no admit type.

ADMISSIONS REPORT - BY AGE

This report prints a list of all patients admitted sorted by age for the date(s) designated.

ADMISSIONS REPORT - BY STATUS

This report prints a summary of admits sorted by legal status for the date(s) designated.

ADMISSIONS REPORT - TO UNIT (SPECIFY)

This report prints a list of all patients admitted to the unit specified and their length of stay.

ADMITS BY PARISH REPORT - MONTHLY

This report prints a summary of admits sorted by parish and sex for the date(s) designated.

ADMITS BY PARISH REPORT - BY RACE & SEX

This report prints a summary of admits sorted by parish, race and sex for the date(s) designated.

ADMITS FROM OTHER STATE HOSPITALS REPORT

This report prints a summary of admits from other state hospitals sorted by sex for the date(s) designated.

ADMITS REPORT - PARISH, RACE & AGE

This report prints summary of admits sorted by parish, race & age for the date(s) designated.

ADULT ADMITS BY LEGAL STATUS REPORT

This report prints a summary of adult admits sorted by legal status.

DISCHARGES BY MONTH & TYPE REPORT

This report prints a list of all patients discharged sorted by discharge type for the date(s) designated.

DAILY CENSUS SUMMARY REPORT

This report prints a summary of all active patients by unit for the date designated.

DAILY LEAVES & PASSES REPORT

This report prints a listing of all patients on leave status by unit for the date(s) designated.

DAILY REGION CENSUS REPORT

This report prints a list of all active patients sorted by region and unit for the date designated.

DAILY STATUS CHANGE REPORT

This report prints the daily status change activity sorted by status code for the date(s) designated.

DAILY UNIT CENSUS REPORT

This report prints the daily census of active patients on each unit for the date designated.

DAILY UNIT CENSUS REPORT - SINGLE UNIT

This report prints the daily census of active patients for a specified unit for the date designated.

DISCHARGE READINESS BY REGION REPORT

This report prints a list of all active patients with the estimated length of continued stay for each and sorted by region.

JUDICIAL COMMITMENT DISCHARGES REPORT

This report prints a list of all patients discharged from judicial commitment for the date(s) designated.

PATIENTS DISCHARGED BY DEATH REPORT

This report prints a list of all patients discharged by death for the date(s) selected.

PATIENTS OVER AGE 65 REPORT

This report prints a list of all active patients over the age specified sorted by unit.

PATIENT SUMMARY OF ABSENT DATA REPORT

This report prints the hospital number and patient name of records missing mandatory information.

PENDING ENHANCEMENTS REPORT

This report prints a list of PIP enhancement requests and their status.

REGIONAL BED ALLOCATION REPORT

This report prints the current number and percentage of patients in each region's allocated beds.

TOTAL ADMITS BY PARISH & RACE REPORT

This report prints a summary of admits sorted by parish and race for the date(s) designated.

CHAPTER 17

MAINTENANCE

TRAINING MANUAL
FOR THE
PATIENT INFORMATION PROGRAM
FOR THE
LOUISIANA OFFICE OF MENTAL HEALTH

I. MAINTENANCE

These options allow authorized users to reindex databases; change hospital numbers and status on patients in the PIP system; make adjustments to the control databases, user defined fields, and PIP configuration; modify users' access; and utilize external applications. Select these options from the Main Menu under Maintenance.

A. REINDEX DATABASES

This function reindexes and removes records marked for deletion in all databases used by the PIP program. Reindexing requires the exclusive use of the PIP program. During reindexing in network environments, other users in the PIP program or attempting to enter the PIP program are advised that a maintenance process is underway and that they should try to enter PIP again, at a later time.

Upon selection of this menu option by the authorized user, a message box appears which displays: "Do you want to reindex all files? Y/N". If the user selects "Y", the program will begin reindexing. If the user selects "N", the user will be presented with a pop-up menu of data tables. The up and down arrow keys are used to move the cursor to highlight the data tables to be selected for reindexing. The selections may then be marked by using the following methods:

Space Bar This key will allow the user to toggle (set on or off) data tables individually.

Function Keys

F7 Move the highlight bar to the first item in a group of data tables to be selected for reindexing and press **F7**. Now, move the highlight bar to the last item in the group to be reindexed. Press the **F7** key again to toggle and mark for reindexing.

F8 Selects all data tables for reindexing.

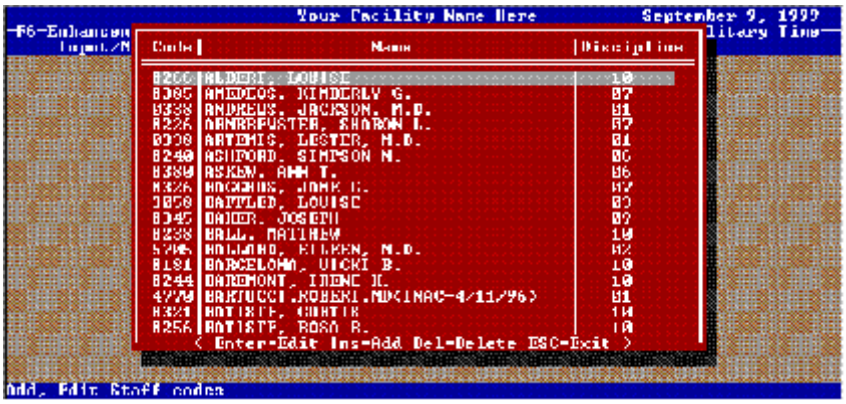
F9 Clears all data table selections.

Press ENTER to begin the reindexing process. While the program is reindexing, progress through each database is noted on the screen. During reindexing the computer is permanently deleting all records marked for deletion and recreating the indexes. This process allows faster access of data. Reindexing should be done on a regular basis. In a network environment the reindexing process should generally occur after-hours, and/or, when no other users are on the network. Completion of the reindexing process is signaled by a beeping sound and the screen message "Finished".

Once reindexing has been completed, the user is returned to the Maintenance menu.

B. UPDATE CONTROL DATABASES

This function is used to edit seven user definable Pop-up menus. It should be noted that while deletion of codes and descriptions is allowable, when codes are deleted from these databases, historical data reports and queries will contain inaccurate or missing data. It is recommended that whenever possible a code/description not be deleted.



1. Staff Codes

When selecting this menu option, the authorized user will be presented with a list of the codes, names, and discipline for each entry in the staff database.

To edit an existing entry in the list the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press ENTER and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields. A pop-up is provided for the discipline database.

To add a new entry press INSERT and a box will appear in the lower part of the screen. The user will enter the new data into the proper fields.

The OMH MIS code is issued directly from the Louisiana Office of Mental Health for each staff member. Please contact the state OMH MIS systems administrator for this code number.

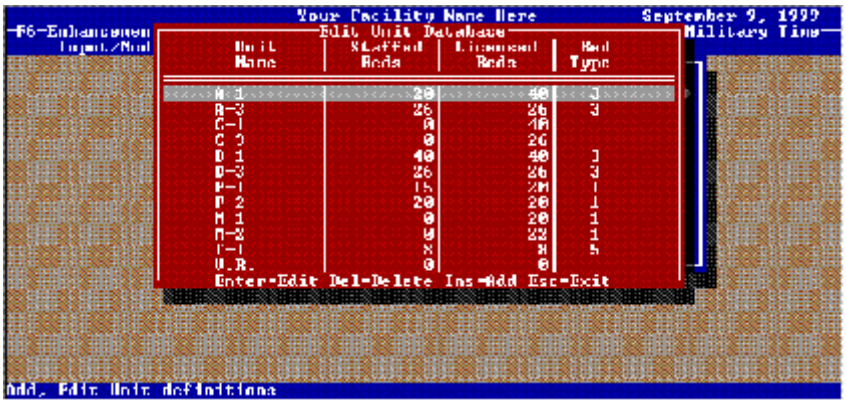
*** Enter the name in the following format: Last Name, First Name, Title (if applicable).

As mandated by the legislature for the Office of Public Health, a ”License Number“ for each clinician must be entered. This number may be obtained from either the credentialing department or Nursing Services of the individual facility.

When editing is complete the user will be asked "Is this correct? Y/N" If the user responds "N" the cursor will return to the edit screen to allow further editing. If the user responds "Y" the record will be updated to the database and the cursor will

return to the list of entries.

Although deletion is allowed, no clinical staff codes or name should be deleted as all past records that contained that staff code/name will be unable to access the proper code/name. An existing entry may be marked for deletion by pressing the DELETE key. The user will be prompted to verify the intention to delete the record. If the user responds "Y" the record will be marked to be deleted during the next re-indexing cycle. Also, whenever the highlight bar is positioned on the record a " < Deleted > " indicator will appear in the upper right corner of the box. The record may be recalled from this deleted status as long as it is visible on the screen, by pressing DELETE again. The " < Deleted > " tag will be removed.



2. Unit Definitions
When selecting this menu option, the authorized user will be presented with a list of the unit names, number of staffed beds, number of licensed beds and bed type for each entry in the unit database.

To edit an existing entry in the list the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press ENTER and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields.

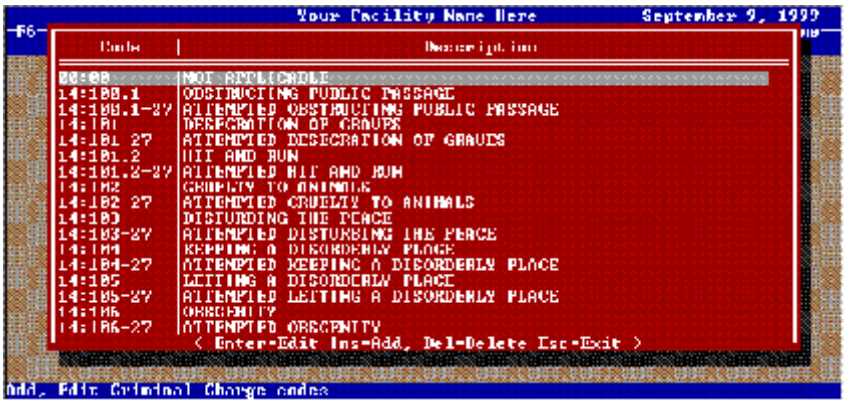
To add a new entry press INSERT and a box will appear in the lower part of the screen. The user will enter the new data into the proper fields.

When editing is complete the user will be asked "Is this correct? Y/N" If the user responds "N" the cursor will return to the edit screen to allow further editing. If the user responds "Y" the user will be asked "Do you want to save these changes?" If the response to this is "N" the cursor will return to the list of entries and no changes will be recorded. If the response is "Y" the record will be updated to the database and the Unithist.dbf, which records all changes to a particular unit, will also be updated, and the cursor will return to the list of entries.

Although deletion is allowed, no unit should be permanently deleted as all past

records that contained that unit will be unable to access the proper code/name. This will cause problems with past records that are queried or used for reports. An existing entry may be marked for deletion by pressing the DELETE key. The user will be prompted to verify the intention to delete the record. If the user responds "Y" the record will be marked to be deleted during the next re-indexing cycle. Also, whenever the highlight bar is positioned on the record a " < Deleted > " indicator will appear in the upper right corner of the box. The record may be recalled from this deleted status as long as it is visible on the screen, by pressing DELETE again. The " < Deleted > " tag will be removed.

"Esc" allows the user to return to the previous menu.



3. Criminal Charges

When selecting this menu option, the authorized user will be presented with a list of the codes and description for each entry in the criminal charge database.

To edit an existing entry in the list the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press ENTER and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields.

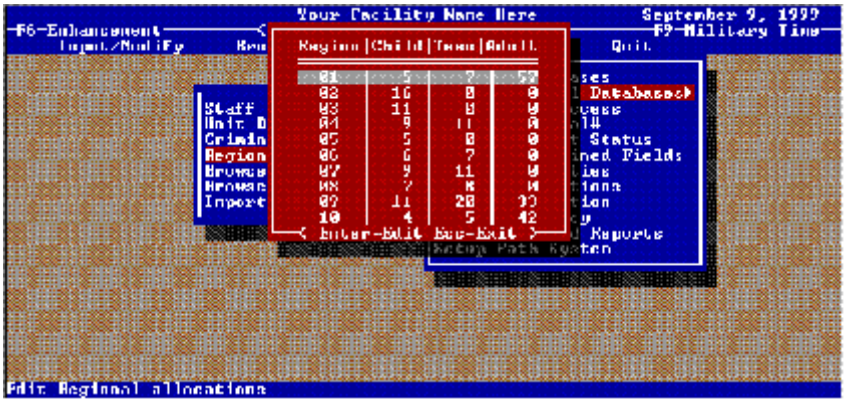
To add a new entry press INSERT and a box will appear in the lower part of the screen. The user will enter the new data into the proper fields.

When editing is complete, press ESC to return to the list of entries.

Although deletion is allowed, no charge should be permanently deleted as all past records that contained that charge will be unable to access the proper code/name. This will cause problems with past records that are queried or used for reports. An existing entry may be marked for deletion by pressing the DELETE key. The user will be prompted to verify the intention to delete the record. If the user responds "Y" the record will be marked to be deleted during the next re-indexing cycle. Also, whenever the highlight bar is positioned on the record a " < Deleted > " indicator will appear in the upper right corner of the box. The record may be recalled from this

deleted status as long as it is visible on the screen, by pressing DELETE again. The " < Deleted > " tag will be removed.

"Esc" allows the user to return to the previous menu.



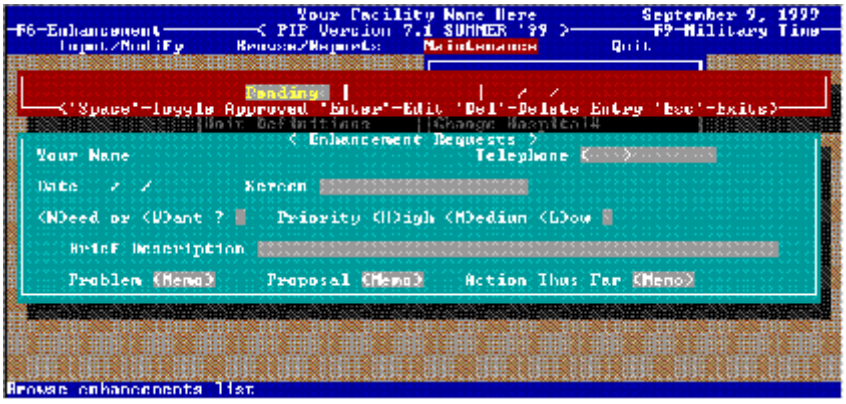
4. Regional Allocations

When selecting this menu option, the authorized user will be presented with a list of the region numbers, number of child beds, youth beds, and adult beds allocated for each entry in the region database.

To edit an existing entry in the list the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press ENTER and a box will appear in the lower part of the screen. The data may be edited by typing the new data in the desired fields.

When editing is complete the user will be asked "Is this correct? Y/N" If the user responds "N" the cursor will return to the edit screen to allow further editing. If the user responds "Y" the record will be updated to the database and the Unithist.dbf, which records all changes to a particular unit, will also be updated, and the cursor will return to the list of entries.

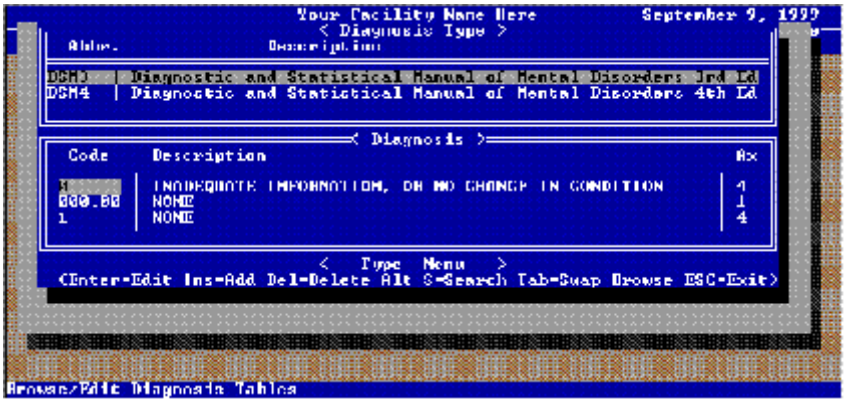
"Esc" allows the user to return to the previous menu.



5. Browse Enhancements

When selecting this menu option, the authorized user will be presented with a list of the enhancement requests that have been entered by other facility PIP users.

The user will then select requests to be assessed. When these have been reviewed and approved locally, they will be transmitted to the development team via the nightly upload.



6. Browse Diagnosis

When selecting this menu option, the authorized user will be presented with a list of the diagnostic sources and codes for each.

The user may then select a diagnostic source by scrolling up and down, using the corresponding arrow keys. When the highlight is positioned on the desired entry press TAB to move to the code list for the diagnostic source selected.

To edit an existing entry in the list the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press ENTER and a box will appear on the screen. The data may be edited by typing the new data in the desired fields.

Alternately, the user may press ALT-S to search for a particular diagnosis. At the bottom of the screen, the user will be prompted to enter the diagnostic code and press ENTER. Upon completion of the search press ENTER and that diagnostic code will be selected.

Although deletion is allowed, no diagnosis should be deleted as all past records that contained that diagnosis will be unable to access the proper code/name. This will cause problems with past records that are queried or used for reports. An existing entry may be deleted by pressing the DELETE key.

7. Import New Diagnosis

This menu option is for use by PIP technical support staff only.

C. MODIFY USER ACCESS

This function is applicable for networks only. The PIP facility coordinator and/or network administrator will set the specific access for all menu selections, editing, deletion, and toggles in PIP for each user of the program.

Upon selection of this menu option, the authorized user will be presented with a list of the user names as listed in the access database.

To edit an existing person in the list, the user may scroll up and down by using the corresponding arrow keys. When the highlight is positioned on the desired entry, press ENTER and a box will appear on the screen. The data may be edited by typing a "Y" or "N" in the desired fields. Entering a "Y" will give the selected user access to the menus for that group. Selecting "N" will exclude the selected user from the group.

To add a new user press INSERT and the authorized user will be asked "Do you want to copy another User's Access Record? Y/N" Entering "N" will cause a box to appear on the screen. Enter the full name of the new user. The data may be edited by typing a "Y" or "N" in the desired fields. Typing a "Y" will give the selected user access to the menus for that group. Typing "N" will exclude the selected user from the group. When editing is complete the user will be returned to the previous pop-up box. If the authorized user responds to the question with "Y", a list of current users will appear. When the highlight is positioned on the desired user whose access record is to be copied, press ENTER and the pop-up box will appear on the screen. The authorized user may edit this screen to customize access or press the PAGE DOWN key to save and exit this screen.

When an employee who had access to PIP terminates employment at the facility they can be deleted from access to the PIP system. An existing entry may be marked for deletion by pressing the DELETE key. The user will be prompted to verify the intention to delete the record. If the user responds "Y" the record will be marked to be deleted during the next re-indexing cycle.

"Esc" allows the user to return to the previous menu.

D. CHANGE HOSPITAL #

Upon selection of this menu option, the authorized user will be taken to the Patient Selection Screen where they can highlight the client or search for a client to change their patient hospital number.

Upon selection of a patient, a message box appears that allows the user to view the "old" hospital number and admit date. The user can then enter the updated/corrected hospital number and admit date. Upon completion the user will be returned to the Maintenance Menu.

E. CHANGE PATIENT STATUS

Upon selection of this menu option, the authorized user will be taken to the Patient Selection Screen, where they can highlight the client or search for a client to change their patient status.

Upon selection of a patient, a message box appears that identifies the hospital number and the current status code. The user can then enter the updated/corrected status code. A pop-up menu of available status codes appears. Only allowable codes will be lit. Upon completion the user can press "Esc" to return to the Maintenance Menu.

F. EDIT USER DEFINED FIELDS

Upon selection of this menu option, the authorized user will be presented with a screen allowing editing of the screen labels for the user defined fields. These labels appear on page 7 of the "Modify Patient" screens. The first three labels are for date fields, the second three are for numeric fields, and the third group of three labels are for character fields. The user may enter a label up to 25 characters long. When the user reaches the bottom of the page the program will ask "Do you wish to save this entry? Y/N". If the user responds by selecting "N" the cursor will return to the top field and allow further editing. If the user responds "Y" the program will save the field labels and return to the menu.

G. BACK UP UTILITIES

This feature is not yet available. The authorized user will be able to set up access to the backup utilities in the "Other Applications" menu selection.

H. OTHER APPLICATIONS

Upon selection of this option, the authorized user will be able to shell out of PIP to external programs.

To set up access to an external program, press INSERT. The user will be presented

with a pop-up. Enter the "Title" of the external application, the "Description", and the "Command". The command is what will be issued to start the external application.

NOTE: The program must be in the path to be able to be accessed from within PIP. Users will be asked "Is this correct? Y/N". A "N" will return the user to the Title field for changes. If "Y" is selected the user will then be asked "Do you want to save this entry? Y/N". "Y" will save the entry. "N" will return the user to the green external application menu screen.

To change the "Title", "Description" or "Command" of a program, press ENTER to edit and make the change. The user will then be asked "Have you finished editing this record? Y/N". Selecting "Y" will save the changes, "N" will return the cursor to the "Title" field for continued editing.

To delete an application from internal PIP access, highlight the program to delete, press DELETE. The screen message will say "WARNING! This record will be deleted. Shall I continue? Y/N" Selecting "Y" will remove the program from internal PIP access. "N" will cancel the deletion.

"Esc" will exit the External Application Setup.

I. PIP CONFIGURATION

Upon selection of this menu option by the authorized user, facility specific items may be set. This configuration should be set by the PIP facility coordinator/network administrator.

Specify the correct facility name, phone number, address, city, state and zip code. If available, the facility tax ID, Medicare, and Medicaid numbers can be specified. Specify the current facility administrator. Specify the Hospital ID number, and the NIMH number. NOTE: The acute units will not have NIMH numbers.

For Medical Center of Louisiana, the selection can be made to display the (T)ulane or (L)SU prefixes of the hospital numbers. All other facilities should set this to "N".

For the Earl K. Long Acute Unit, the selection can be made to use the Billing number. This is needed due to having a Greenwell Springs Hospital number and an Earl K. Long Hospital number. All other facilities should set this to "N".

If the facility is an Acute Unit Installation, selecting "Y" will allow a field indicating

whether or not a client has signed a "Release of Confidential Information" to appear on Screen GETS1 of the client's record.

Those hospitals who are currently using the HCS Pharmacy System should select "Y" to use the HCS Pharmacy System Interface. All other facilities should set this to "N".

The Pharmacy Transfer Files Path contains the location of the pharmacy update files for the HCS Pharmacy System ADT Transfer.

For increased security, the authorized user has the option to allow PIP to automatically turn on the screen blanker after a pre-determined time period. Additionally, PIP may be set up to check for the user's Novell password while in screen blanker mode.

The changes are automatically saved upon completion of this screen.

J. UPDATE PHARMACY

Upon selection of this menu option by the authorized user, this feature will send admits and updates to Active Patient data to the HCS Pharmacy system.

PIP tracks the height, weight and allergies of patients. These entries may be accessed by selecting ”Physical Information” from the SUBMENU of the “Modify Patient” Menu Selection.

K. SETUP STANDARD REPORTS

This feature is not yet available. The authorized user will be allowed to set up control filed, queries and reports for the report interface.

L. SETUP PATH SYSTEM

Authorized users may select this function.