

OHIO DEPT OF MENTAL HEALTH

Treatment Episode Outcomes

New Mental Health Record System in OH BH

**ODMH Office of Research & Evaluation
in collaboration with
ODADAS Office of Information Technology
12/21/2011**



Instruction manual for Treatment Episode Outcomes, the new mental health record system in the Ohio Behavioral Health (OH BH) module. The purpose of the TEO system is to collect information and outcomes required by the Substance Abuse & Mental Health Services Administration (SAMHSA) and the Ohio Department of Mental Health (ODMH).

Table of Contents

- Logging In and Logging Out..... 4
- Setup Section 6
 - SMD/SED Reporting Providers 6
 - Mental Health Special Programs: EBPs..... 7
 - Central Intake Providers and Contracting Boards 10
- Clients Section..... 13
 - Adding a Client 13
 - Finding a Client..... 15
 - Client Actions 16
- Mental Health Episodes Section 17
 - Episode Definitions..... 17
 - Episode Options..... 19
 - Adding an Admission Record 20
 - Duplicating Records for AOD Admission..... 32
 - Admission Information Specific to Clients with SMD/SED..... 33
 - Updating Records Versus an MH Update Record..... 36
 - Adding an Update Record..... 37
 - Adding Yearly Update Records 40
 - Adding a Discharge Record 41
 - Adding a Transfer Record..... 45
- SMD/SED Definitions 47
 - Serious Mental Illness, aka SMD 47
 - Adults with a Mental Illness, Disorder or Disease..... 47
 - Adults with Serious Mental Illness, aka SMD 47
 - Adults with Serious and Persistent Mental Illness 48
 - SED or Serious Emotional Disturbance 49
 - Children or Adolescents with Mental / Emotional Disorders..... 49
 - Child or Adolescent with Serious Emotional Disturbance 49
 - List of Diagnostic Codes that are Eligible for SMD/SED Definition..... 51
- Index of Definitions by Response Category 54

Table of Figures

FIGURE 1. OH BH WEB APPLICATION LOGIN	4
FIGURE 2. APPLICATION LISTING PAGE.....	4
FIGURE 3. RETURN TO PORTAL	5
FIGURE 4. SMD/SED SUPPORTING PROVIDER.....	6
FIGURE 5. START DATE OF SETUP AND MENTAL HEALTH SPECIAL PROGRAMS.....	7
FIGURE 6. SELECTING CENTRAL INTAKE PROVIDERS.....	10
FIGURE 7. CONTRACTING BOARDS.....	11
FIGURE 8. HOMEPAGE MENU -- ADDING CLIENTS	13
FIGURE 9. HOMEPAGE MENU -- FINDING AN EXISTING CLIENT	15
FIGURE 10. LIST OF CLIENTS WITH ADMISSION RECORDS.....	16
FIGURE 11. CLIENT RECORD EPISODE OPTIONS.....	18
FIGURE 12. EPISODE OPTIONS.....	19
FIGURE 13. EPISODE SCREEN FOR CLIENT WITHOUT AN ADMISSION RECORD	20
FIGURE 14. CLIENT ADMISSION RECORD (UPPER HALF).....	20
FIGURE 15. SMD/SED CRITERIA = GAF, DIAGNOSIS, SPECIAL POPULATION	28
FIGURE 16. ADMISSION RECORD (LOWER HALF).....	30
FIGURE 17. ATTENDANCE AT SELF-HELP PROGRAMS	32
FIGURE 18. PAYING BOARD AND DUPLICATING RECORDS FOR AOD ADMISSION	32
FIGURE 19. ADMISSION RECORD FOR SMD/SED CLIENT (UPPER HALF).....	33
FIGURE 20. UPDATING OR CHANGING AND EXISTING RECORD	36
FIGURE 21. EPISODE UPDATES	37
FIGURE 22. MH UPDATE RECORD (UPPER HALF).....	37
FIGURE 23. MH UPDATE RECORD (LOWER HALF).....	39
FIGURE 24. ADMISSION, UPDATE, TRANSFER & DISCHARGE STATUS.....	40
FIGURE 25. MH UPDATE	40
FIGURE 26. DISCHARGE RECORD FOR MENTAL HEALTH CLIENT (UPPER HALF).....	41
FIGURE 27. DISCHARGE RECORD FOR AN MH CLIENT (LOWER HALF).....	43
FIGURE 28. SMD/SED DISCHARGE SCREEN	44
FIGURE 29. TRANSFERRING A CLIENT WITH SED PLACED IN A TYPE 1 RESIDENTIAL FACILITY	45
FIGURE 30. SPMI/SMD DIAGRAM.....	50
FIGURE 31. SED DIAGRAM.....	50

Logging In and Logging Out

When you boot the OH BH web application login, this is the first window you will see:

Figure 1. OH BH Web Application Login

ODADAS
Application Login

Non-ODADAS Employees

Username:

Password:

[Forgot your Password?](#)

Login

ODADAS Employees

ODADAS Employees, click here

[Click here](#) if you currently do not have an account but would like to create one.

If you do not have an account, enter **Click here** to apply. Enter the Username and Password created by your application for an account. Logging in will take you to the **Application Listing** page. On the **Application Listing** page, choose the **Production** from the Environment Selection options.

Figure 2. Application Listing Page

ODADAS Application Listing

Logout

Current User Information (Editable In User Management)

Name: Dr Carol A Carstens

Title:

Email Address: CarstensC@mh.state.oh.us

ENVIRONMENT SELECTION

Select your desired environment:

Select an environment...
Production
QA
Training

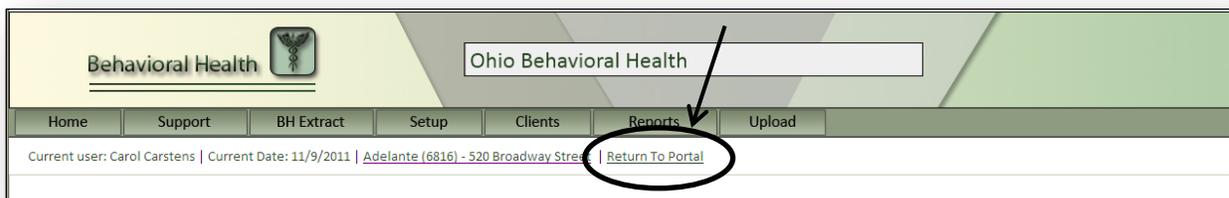
Selecting either **Training** or **Production** will bring up a list of **Current Applications**. If you're new to using the web-based application, click on **Training**; if you're ready to enter "live" data, click on **Produc-**

tion. Whether you choose **Training** or **Production**, click on **Behavioral Health**. Depending on how your account is set up, this selection may take you to the **Entity Selection** option. Click on **Provider** and indicate your organization if you boot this page. Go to next section for instructions on provider Setup. If you do not get the Entity Selection page, you are ready to begin with the provider Setup. Go to next section.

Logging Out

When you are ready to end a session, click on the **Return to Portal** link located near the banner at the top of the page as shown in Figure 2 below. This will take you back to the **Application Listing** page. There, you can log out of the web application by clicking on **Logout** in the upper right-hand corner (See Figure 2 above.)

Figure 3. Return to Portal



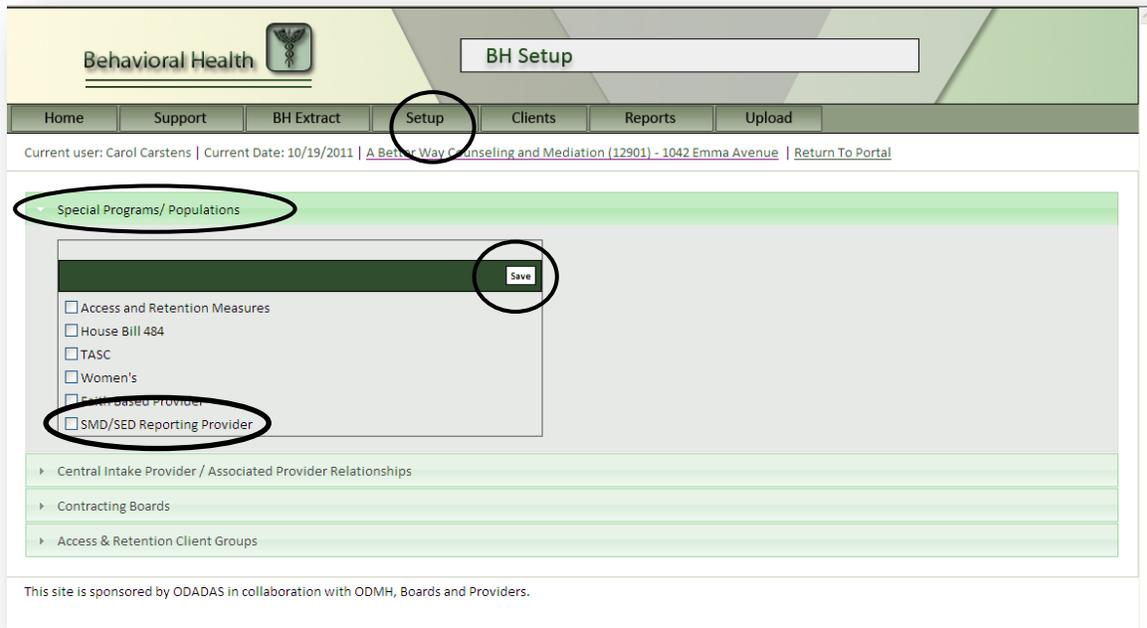
Setup Section

SMD/SED Reporting Providers

To use the new mental health templates for consumers with SMD/SED, you will need to indicate that your agency is an SMD/SED reporting provider. This is done in the **Setup Section**. In addition, if your agency provides any of the Special Mental Health Programs or evidence based practices (EPBs) listed in the Setup page, you will need to indicate their availability. Information about EPBs provided by your agency will link to the clients' admission, update and discharge records.

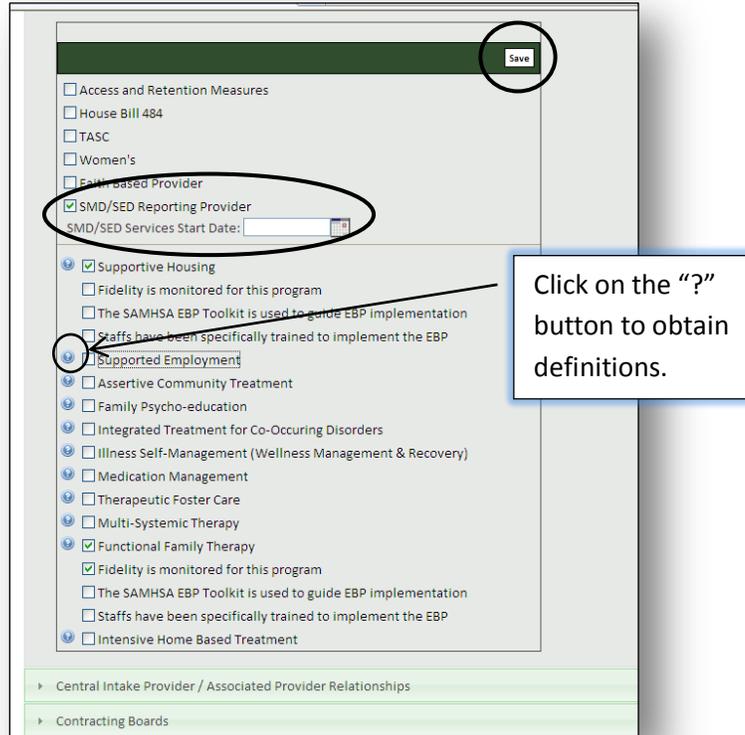
1. From the BH Homepage menu, click the **Setup** button.
2. Select the Special Programs/Populations tab. Next, select the SMD/SED Reporting Provider box (See Figure 1 below).

Figure 4. SMD/SED Supporting Provider



3. Upon selection of the SMD/SED Provider Box, a window will open asking for the **start date** for reporting on this priority population. **Start date** should be the date provider first begins submitting SMD/SED records. (See Figure 2 below.)

Figure 5. Start Date of Setup and Mental Health Special Programs



Mental Health Special Programs: EBPs

1. Clicking on SMD/SED Provider will also open up a list of **Mental Health Special Programs** or **Evidence Based Practices (EBPs)**. (See Figure 2 above.) If you do not offer any of the listed EPBs, click on **SAVE** and move on to **Central Intake Provider** section.
2. If you offer any of the **EPBs** or **Mental Health Special Programs**, select ALL those provided by your agency. Definitions of each EPB are as follows:
 - b. **Supportive Housing:** Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.
- A dropdown option displays three additional questions to determine level of program fidelity. Select all level(s) of fidelity that apply:
 1. Fidelity is monitored for this program?
 2. The SAMHSA EBP Toolkit is used to guide EBP implementation?
 3. Staffs have been specifically trained to implement the EBP?

- c. **Supported Employment:** Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illness' rehabilitation and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client to staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.
- d. **Assertive Community Treatment (ACT):** A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. A key aspect is low caseloads and the availability of the services in a range of settings.
- e. **Family Psycho-Education:** Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family Psycho-education programs may be either multi-family or single-family focused. Core characteristics of family Psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.
- f. **Integrated Dual Disorder Treatment (IDDT):** Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.
- g. **Illness Self-Management/Wellness Management & Recovery:** These are broad set of rehabilitation methods aimed at teaching individuals with a mental illness some strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping

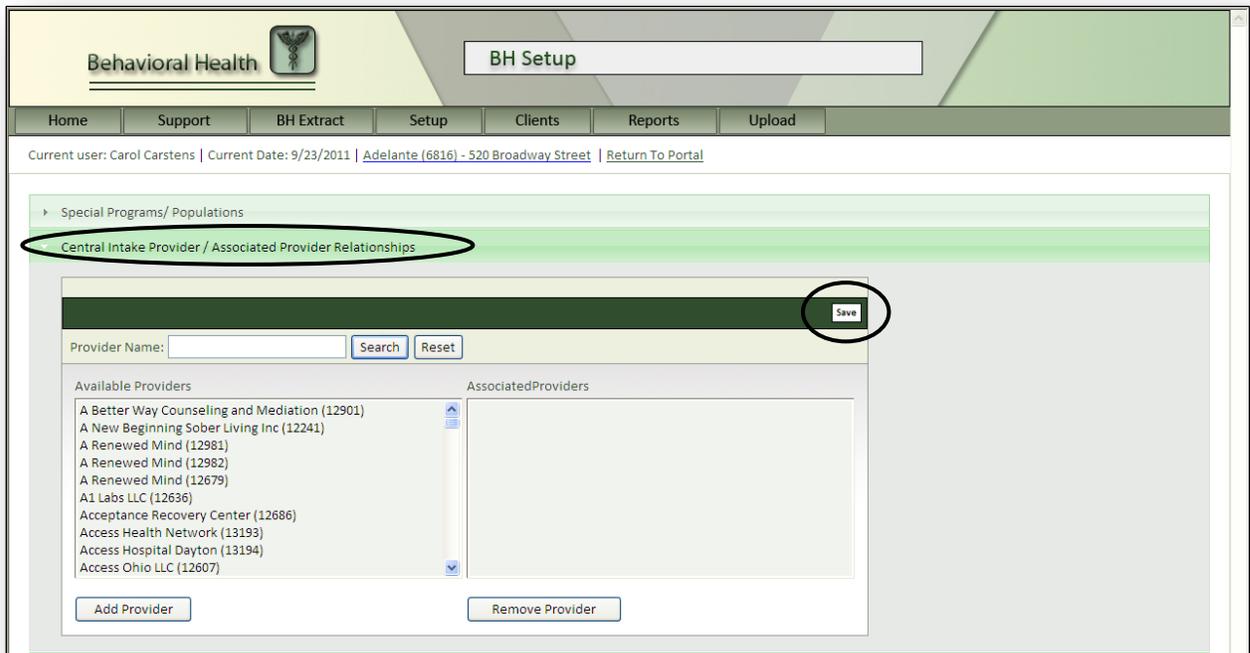
strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

- h. **Medication Management:** In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following: Utilization of a systematic plan for medication management; Objective measures of outcome are produced; Documentation is thorough and clear; Consumers and practitioners share in the decision-making..
- i. **Therapeutic Foster Care:** Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than to traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed. A key difference between TFC and traditional foster care is the TFC family receives an extensive pre-service training and in-service supervision and support.
- i. **Multi-Systemic Therapy (MST):** MST views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.
- j. **Functional Family Therapy (FFT):** FFT is a phased program where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family.
- k. **Intensive Home-based Treatment (IHBT):** Intensive Home-Based Treatment is a time-limited mental health service for youth with serious emotional disabilities and their families, provided in the home, school and community where the youth lives, with the goal of stabilizing mental health concerns, and safely maintaining the youth in the least restrictive, most normative environment. IHBT provides a comprehensive set of services (CPST, Behavioral Health Counseling and Therapy; Crisis Response; mental health assessment, supportive services) integrated by a team of providers into a seamless set of services delivered to the family. The main purposes are out-of-home placement prevention, reunification, and stabilization & safety.
- When finished, click on **Save** and move on to **Central Intake Provider**, which is located below the Special Programs box.

Central Intake Providers and Contracting Boards

1. Select the **Central Intake Provider / Associated Provider Relationships** at very bottom of screen (see Figure 2 above). This option opens a second screen (see Figure 3 below).

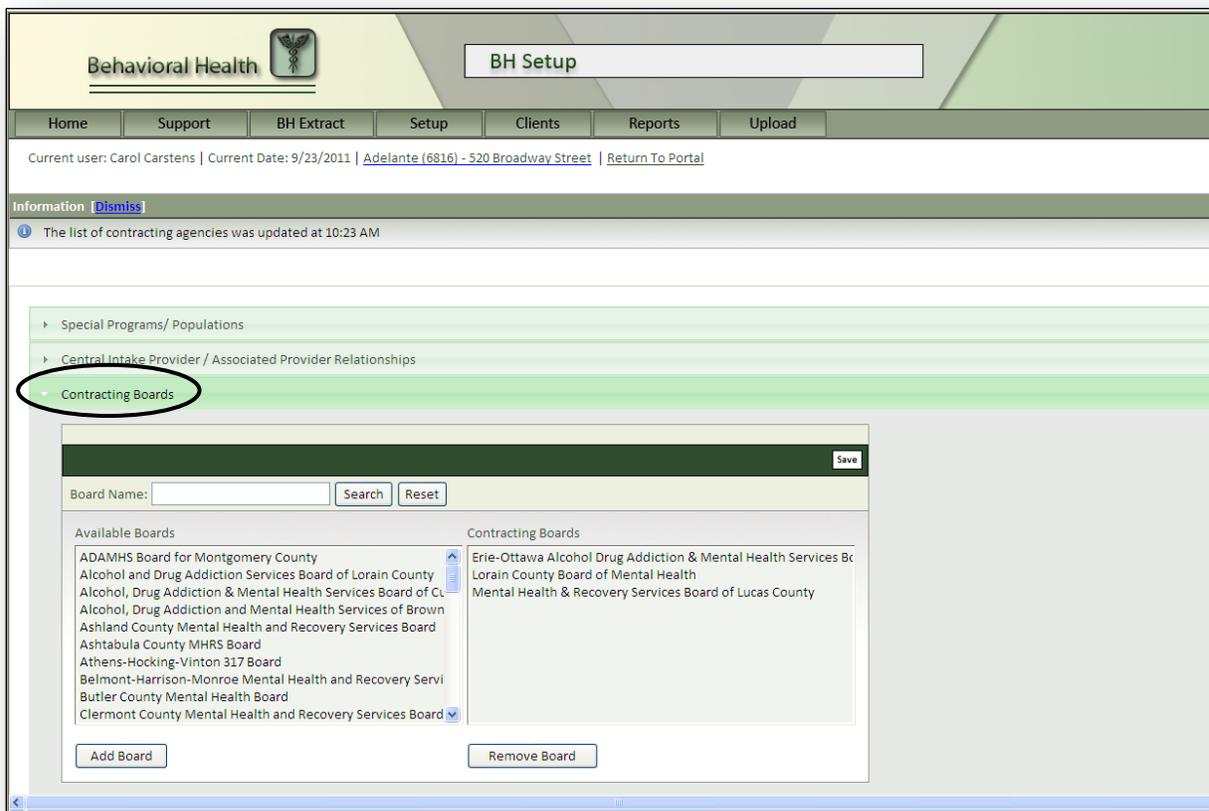
Figure 6. Selecting Central Intake Providers



- b. Adding Associated Provider(s) will assume you are a **Central Intake Provider**. If any providers are added here, you will be offered the option of forwarding an admission to another provider. The receiving provider becomes the owner of the admission.
- c. Selecting **Central Intake Provider / Associated Provider Relationships**
 - i. Adding an **Associated Provider**
 1. Select a Provider from the **Available Providers** list.
 2. Click the **Add provider >>>** button to move the selected Provider to the **Associated Providers** list.
 3. Click the **Save** button to save the changes to the list.
 - ii. Removing an **Associated Provider**
 1. Select the Provider to be removed from the **Associated Providers** list.
 2. Click the **<<< Remove Provider** button to remove the selected Provider from the **Associated Providers** list.
 3. Click the **Save** button to save the changes to the list.
 - iii. Searching for a **Provider**

1. Enter the search criteria in the **Provider Name** box.
 2. Click the **Search** button.
 3. All Providers matching the search criteria will be listed in the **Available Providers** list.
- iv. Undoing a search
1. Click the **Reset** button.
 2. All Providers will be listed in the **Available Providers** list.
2. **Contracting Boards** (see Figure 4 below)
- a. Move to **Contracting Boards**, located directly below the Central Intake Provider tab. Contracting Boards are any board that will be paying for services provided by the -- provider during the client's episode of care. The provider's home board is automatically included on the list and is the default payer.

Figure 7. Contracting Boards



- b. Selecting **Contracting Boards** will allow you to Search, Add or Remove Boards from the **Paying Board** list on the **Admission Screen**.
 - i. Adding a **Contracting Board**

1. Select a board from the **Available Boards** list.
 2. Click the **Add Board >>>** button to move the selected board to the **Contracting Boards** list.
 3. Click the **Save** button to save the changes to the list.
 - ii. Removing a **Contracting Board**
 1. Select the board to be removed from the **Contracting Boards** list.
 2. Click the **>>>Remove Board** button to remove the selected board from the **Contracting Boards** list.
 3. Click the **Save** button to save the changes to the list.
 - iii. Searching for a **Board**
 1. Enter the search criteria in the **Board Name** box.
 2. Click the **Search** button.
 3. All Boards matching the search criteria will be listed in the **Available Boards** list.
 - iv. Undoing a search
 1. Click the **Reset** button.
 2. All Boards will be listed in the **Available Boards** list.
 - c. All of the boards listed in the **Contracting Boards** list will be available for selection on the **Admission** page.
3. Access and Retention Client Groups – Applies to AOD clients.

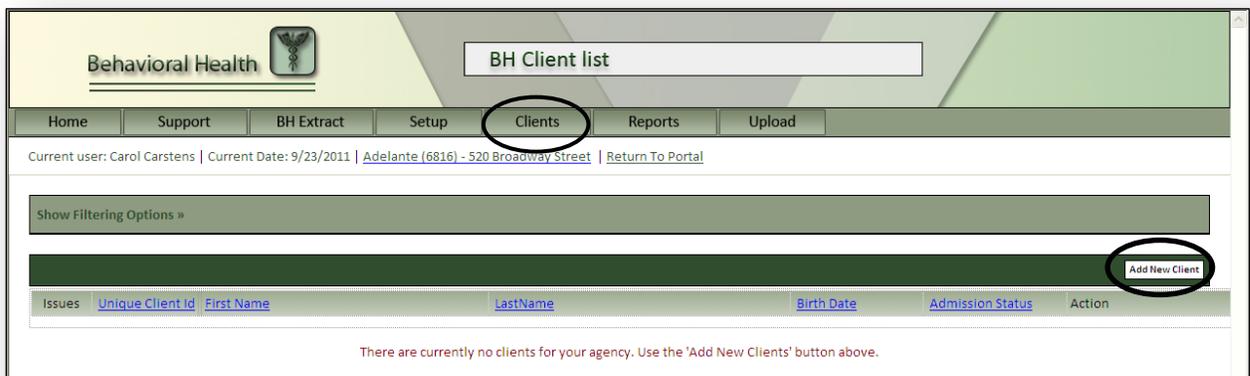
Clients Section

The client section is used to enter a client into the web-based Behavioral Health System. Selecting the **Clients** link on the left menu will take you to the Clients Page, which lists all of the Provider's clients that have been entered to date into the OH-BH.

Adding a Client

1. From the BH Homepage menu, click the **Clients** button.
2. Click the **Add a New Client** button from the **BH Client List** page.

Figure 8. Homepage Menu -- Adding Clients



3. Enter the Unique Client Identifier (UCI) in the **Specify UCI** text box; this is the same UCI used in MACSIS for billing.
 - a. If UCI is not known at this time, check the **Unknown UCI** button.
 - b. Select **Private/Non-UCI** radio button if the client will not be entered into MACSIS. This type of client and their BH data will not be available for Board or State use.
4. Enter the **Client's First Name**.
5. Enter the **Client's Last Name**.
6. Type the **Client's Date of Birth** as mm/dd/yyyy, then click on the calendar icon to enter.
7. Select the **Client's Gender** from the drop-down button:
 - a. Male
 - b. Female
 - c. Unknown

8. Select the **Client's Race** from the drop-down button:
 - a. Alaska Native
 - b. American Indian
 - c. Asian
 - d. Black/African-American
 - e. Native Hawaiian/Other Pacific Islander
 - f. White
 - g. Other Single Race
 - h. Two or more races
 - i. Unknown

9. Select the **Client's Ethnicity** from the drop-down button:
 - a. Cuban
 - b. Mexican
 - c. Puerto Rican
 - d. Other Specific Hispanic
 - e. Hispanic, Origin not Specified
 - f. Not Hispanic Origin
 - g. Unknown

10. Click the **Save** button to add the Client
 - a. Once the client is saved, you will be directed to the **Client Episodes** page to begin entering the Admission record.

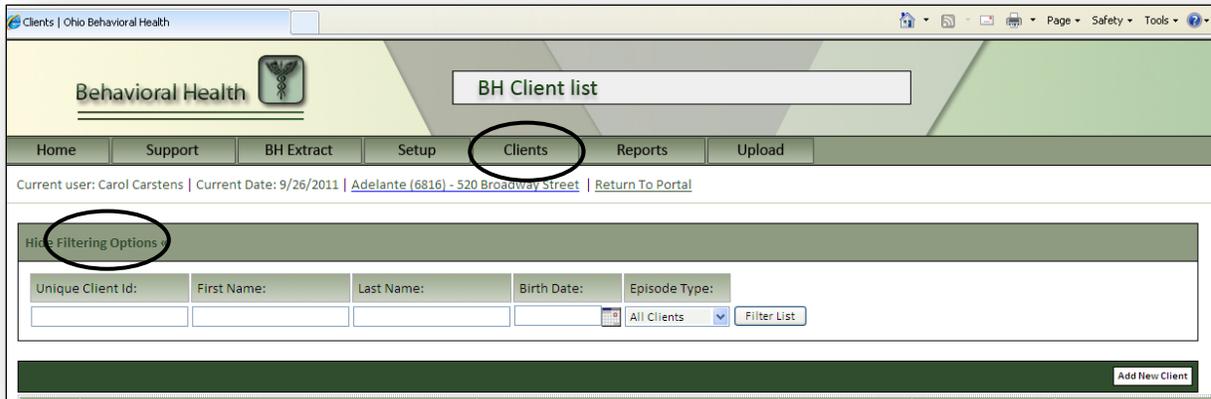
11. Clicking the **Save** button will cause the OH-BH to attempt to validate the Client's UCI against what has been entered in MACSIS.
 - a. If the UCI is found and the client's name, date of birth, gender, race and ethnicity match MACSIS values, then the client's UCI is validated.
 - b. If the UCI is found and the client's name, date of birth and gender match, but race and/or ethnicity do not match, you will be prompted to select the correct value.
 - c. If the UCI, name, date of birth or gender does not match, then the client will remain in a **Pending Validation** status.
 - d. Client/UCI information is updated weekly in the OH-BH; all **Pending Validation** clients in the OH-BH will be validated against any new UCIs from MACSIS.

12. A successful **Save** will provide an extended screen with an **Episodes** box requesting "Add New Admission" button to add an episode.

13. Click the **Clients** button once you are done adding a client. This will get you back to the Clients page.

Finding a Client

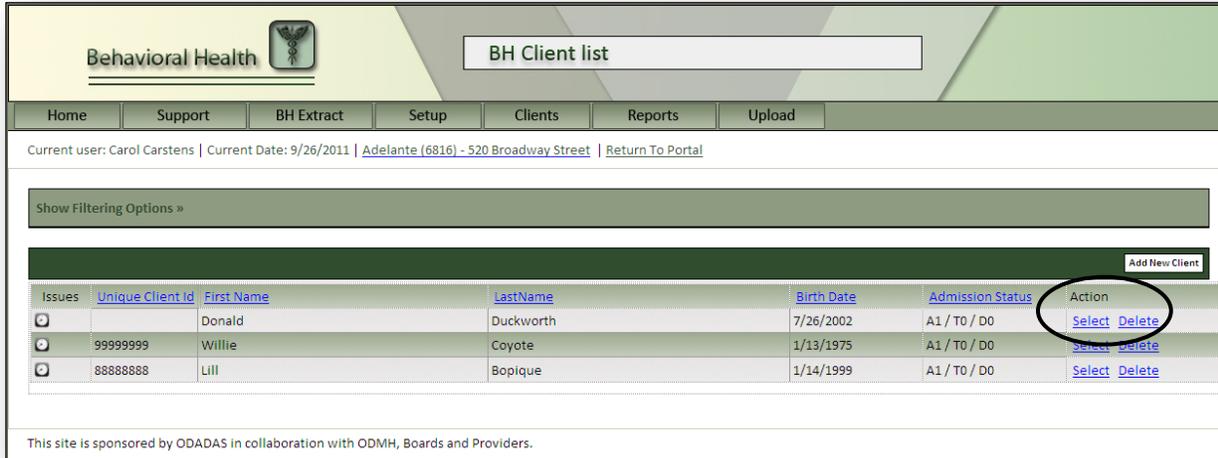
Figure 9. Homepage Menu -- Finding an Existing Client



1. From the BH Homepage menu, click the **Client** button.
2. On the top left of the Clients Page, click **Show Filtering Options** (see Figure 6 above).
3. Enter Search Criteria
 - a. Unique Client ID
 - b. First Name
 - c. Last Name
 - d. Birth Date
 - e. Episode Type
 - i. All clients
 - ii. Open Episodes – clients who have at least one admission record without a corresponding discharge record. This will include MH clients with update records.
 - iii. No Episodes – clients who do not have at least one admission record.
4. Clicking the **Filter List** button will return a list of contacts that only meet the search criteria.
5. Select **Remove Filter** to remove search criteria. This will take you back to the **Clients Page**.

Client Actions

Figure 10. List of Clients with Admission Records



Issues	Unique Client Id	First Name	LastName	Birth Date	Admission Status	Action
<input type="checkbox"/>		Donald	Duckworth	7/26/2002	A1 / T0 / D0	Select Delete
<input type="checkbox"/>	99999999	Willie	Coyote	1/13/1975	A1 / T0 / D0	Select Delete
<input type="checkbox"/>	88888888	Lill	Bopique	1/14/1999	A1 / T0 / D0	Select Delete

Select – The Select action will take you to the Client Episodes page where you can edit the selected client information and view existing episodes for the client. This is where the client’s mental health episode can be entered.

Delete – The Delete action will remove the client from the client list. You will be unable to delete a client if any episodes exist for the client.

Mental Health Episodes Section

Episode Definitions

A **mental health treatment episode** is defined as the period of services between the beginning of a treatment services (admission) and an update or termination of services for the prescribed treatment plan. Mental health treatment episodes are created with an annual update record if the client is still receiving services or with a termination (discharge) record if the client is no longer receiving services.

A **mental health admission** is defined as the formal acceptance of a client with serious mental disturbance (SMD) or severe emotional disturbance (SED) into treatment. Therefore, events such as initial screening, referral, and wait-listing are considered to take place before creation of the admission record.

The Department of Mental Health requires an admission record ONLY for clients with SMI or SED who are admitted for mental health treatment paid for in whole or part by public funds. An SMD and SED determination are based on diagnosis, the global assessment of functioning (GAF), and the special population field SMD/SED. Criteria for SMD/SED determination are found in Appendix A. Many mental health clients have an SMI or SED diagnosis and GAF determination upon referral from a hospital or other treatment provider. These prior diagnostic and GAF assessments can be used at intake to create an admission record; otherwise, creation of an admission record should be delayed until an SMD or SED diagnosis and GAF have been determined through a diagnostic assessment or physician interview.

An **update** is defined as the yearly update of information about active clients. A yearly post-admission update is required for all active clients. An active client is defined as someone receiving services within the six month period prior to the yearly update. A client admitted on July 13, 2010, who last received services on February 14, 2011, would be considered active on an annual update occurring July 13, 2011. However, if no update or discharge record were submitted, the client would be flagged for discharge after August 14 because of a six month (180 day) lapse in service receipt.

A **discharge** is defined as the termination of services regardless of the reason. In cases where a client with SMD/SED has a 180-day lapse in service receipt, ODMH will issue a notice of administrative closure. Providers may choose to create either a discharge or an update record upon notice of administrative closure.

A **transfer** is used only with consumers placed in a Type1 Residential Treatment Facility. The purpose of transfer records is to provide the State with information about length of stay in the Type 1 Residential level of care. Therefore, Transfer Records are created to track the client's movement out of or into the Type 1 Residential placement level of care within the agency providing the residential treatment. When client is admitted to a Type 1 Residential Treatment Facility, the admission record is used to indicate that living situation. If the client is moved from the Type 1 Residential Facility to a different living situation such as foster care or a group home within the same agency or to another agency, a transfer record should be created so that length of stay in the Type 1 Residential placement level of care can be calculated. If the client is changing providers when discharged directly from a Type 1 Residential placement level of care, the discharge record will be populated with the living situation entered into the transfer record. An outpatient provider may choose to leave a client's record open because the client has been

temporarily placed at a Type 1 Residential Facility for stabilization and is expected to return to the outpatient agency. In such a case, the outpatient provider should not change the client's living situation *unless at the time of annual update* the client is still residing at the Type 1 Residential Facility.

An outpatient provider may choose to leave a client's record open because the client has been temporarily placed at a Type 1 Residential Facility for stabilization and is expected to return to the outpatient agency. In such a case, the outpatient provider should not change the client's living situation *unless at the time of annual update* the client is still residing at the Type 1 Residential Facility

Figure 11. Client Record Episode Options

Behavioral Health  BH Client Episodes

Home Support BH Extract Setup Clients Reports Upload

Current user: Carol Carstens | Current Date: 9/27/2011 | Adelante (6816) - 520 Broadway Street | [Return To Portal](#)

Save Cancel

Unique Client Identifier (UCI): Unknown UCI Private/Non-UCI Specify UCI

First Name: Last Name:

Date of Birth: Gender:

Race: Ethnicity:

Episodes

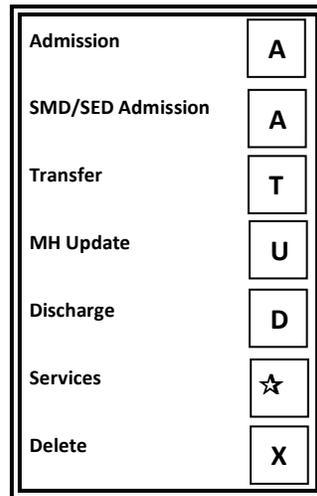
Add New Admission

Admission Date	Current Level Of Care	Primary Diagnosis Code	Discharge Date	Options
9/26/2011	Not Applicable (MH Only)	311 Depressive Disorder NOS		<input type="button" value="Options"/> 

Episode Options

After selecting a client with an existing record (see Figure 8 above), the **Options** button produces the following pop-up:

Figure 12. Episode Options



Admission [A] – The **Admission** option takes you to the general MH Client Admission record to make corrections to the first admission page.

SMD/SED Adm [A] – The **SMD/SED Admission** option takes you to the SMD/SED Admission record to make corrections to the second admission page.

Update [U] – The **Update** option takes you to the Update page where you can enter or edit the annual update record for the SMD/SED client.

Discharge [D] – The **Discharge** option will take you to the Discharge page where you can enter or edit the episode's discharge record for clients with an SMD/SED Admission.

Transfer [T] – The **Transfer** option takes you to the Transfer page where you can add or delete Transfer records for consumers placed in Type 1 Residential Treatment Facilities.

Services [☆] – The Services option links to MACSIS services information.

Delete [X] – The **Delete** option will remove the Episode from the Episodes list. You will be prompted to confirm the deletion of the Episode.

Admission, SMD/SED Admission, Update, Discharge and Transfer records can be amended or "updated" after the record is completed and saved.

Adding an Admission Record

Figure 13. Episode Screen for Client without an Admission Record

Home Support BH Extract Setup Clients Reports Upload

Current user: Carol Carstens | Current Date: 9/27/2011 | Adelante (6816) - 520 Broadway Street | Return To Portal

Unique Client Identifier (UCI): Unknown UCI Private/Non-UCI Specify UCI

First Name: Parker Last Name: Lott

Date of Birth: 8/11/1965 Gender: Male

Race: Other Single Race Ethnicity: Other Specific Hispanic

Episodes

Admission Date	Current Level Of Care	Primary Diagnosis Code	Discharge Date	Options
There are no episodes for this client. Click the 'Add New Admission' button to add an episode.				

Save Cancel

Add New Admission

1. From the BH home page menu, click the **Clients** button.
2. Click the **Select** button under **Action** from the existing client. This will take you to the **Client Episodes** page.
3. Click the **Add New Admission** button (see Figure 10 above). This will take you to the **BH Admission** page (see Figure 11 below).

Figure 14. Client Admission Record (Upper Half)

Currently Selected Client: Parker Lott (No UCI--Private Client)

Client Sections: Admission

Other Actions: Print, Return to List

Save Return To Episodes

Date of First Contact: []

Admission Date: []

Level Of Care: Not Applicable (MH Only)

Provider Episode Number: []

Referred By: <Select An Item>

Marital Status: <Select An Item>

Education Level Completed: <Select An Item>

Education Enrollment: <You Must Select A Level Of Education Before You Choose This Item>

Employment Status: <Select An Item>

Primary Source of Income/Support: <Select An Item>

Living Arrangements: <You Must Select The Client Employment Status Before You Choose This Item>

Prior AOD Treatment Episodes: <Select An Item>

Diagnosis Type: <Select An Item>

Opioid Replacement Therapy: <Select An Item>

Number of Children in Household Under 18: []

Global Assessment of Functioning (GAF): []

Click on the "?" button for definitions

- a. Enter or select from the calendar the **Date of First Contact** (see Figure 11 above). This is the date the client first contacted the provider with a request for services.
- b. Enter or select from the calendar the **Admission Date**. This is the day when the client received his or her first direct treatment service.
- c. **Level of Care**: You must select **Not Applicable – MH Only**. This selection opens up the record for an SMD/SED admission.
- d. Enter the **Provider Episode Number** – this field is for the Provider to uniquely identify the episode.
- e. Select **Referred by** from the following options:
 - i. **Individual** – includes self-referral/family/friend. Includes the client, a family member, friend or any other individual, who would not be included in any of the following categories.
 - ii. **AOD Care Provider** – Any program, clinic, or other health care provider whose principal object is treatment of clients with substance abuse problems, or a program whose activities are related to alcohol or other drug abuse prevention, education, or treatment.
 - iii. **Mental Health Provider** – a psychiatrist, psychiatric hospital, or mental health program.
 - iv. **Other Health Care Provider** – a physician or other licensed health care professional; or general hospital, clinic, or nursing home.
 - v. **School** – a school principal, counselor, or teacher; or student assistance program, the school system, or an educational agency.
 - vi. **Employer/EAP** – a supervisor or an employee counselor.
 - vii. **Child Welfare Agency** (i.e., County Department of Job and Family Services, Child Service Board) – federal, state, or county child welfare agencies.
 - viii. **Other Community Referral** – community or religious organization; a non-child welfare state or county agency; self-help groups (AA, NA).
 - ix. **Prison** – state correctional facility.
 - x. **Courts/Other Criminal Justice** – Federal, municipal, common pleas, juvenile court, domestic relations, drug court, mental health court, probation, parole, diversionary program, defense attorneys.
 - xi. **Forensic Hospital** – State hospital forensic unit.
 - xii. **Jail** – county or municipal correctional facility.
 - xiii. **Families and Children First Council** – OFCF
 - xiv. **Unknown**
- f. Select **Marital Status** from the following:
 - i. Single/Never Married – includes clients whose only marriage was annulled.
 - ii. Married/Living Together as Married – includes those cohabiting as a couple.
 - iii. Divorced – includes those who are legally divorced, but are not currently married or cohabiting.

- iv. Widowed – includes those whose spouse is deceased, but are not currently married or cohabiting.
 - v. Separated – includes those separated legally or otherwise absent from spouse because of marital discord.
- g. Select **Education Level** from the following. Chose the highest degree/grade completed.
- i. Less than one grade completed.
 - ii. First grade
 - iii. Second grade
 - iv. Third grade
 - v. Fourth grade
 - vi. Fifth grade
 - vii. Sixth grade
 - viii. Seventh grade
 - ix. Eighth grade
 - x. Ninth grade
 - xi. Tenth grade
 - xii. Eleventh grade
 - xiii. High School Diploma/GED
 - xiv. Trade/Technical School
 - xv. Some college
 - xvi. 2 year college/Associate’s degree
 - xvii. 4 year college / Bachelor’s degree
 - xviii. Grad degree: Masters/Doctorate/Other professional degree
 - xix. Unknown
- h. Select **Education Enrollment** from the following:
- i. Early Childhood Education Setting (e.g., Head Start, Pre-School or Childcare)
 - ii. K through 12th grade: Includes private, public, alternative. home schools
 - iii. GED classes
 - iv. College
 - v. Other School: Adult basic education, literacy
 - vi. Vocational/Job Training
 - vii. Not Enrolled
 - viii. Unknown

If **K through 12** is indicated, select **Education Type** from the following:

- i. **Not currently enrolled in school**
- ii. **Not Behaviorally Handicapped** – Use this to indicate that the client does not have an Individual Education Plan (IEP).
- iii. **Behaviorally Handicapped** – Use this to indicate the client HAS an Individual Education Plan (IEP).

In the new MH record, “behaviorally handicapped” can be used to indicate the client has an IEP. “Not behaviorally handicapped” would be used to indicate the client does not have an IEP.

- i. Select **Employment Status** from the following. NOTE: If client is employed AND enrolled as a student, report his/her work status and ignore option **Not in Labor Force – Student**. Report student status ONLY if client is not employed, but enrolled as a student.
 - i. **Full Time Employed** – 35 + hours/weekly; legal employment including self-employment or exchanging work for housing, schooling, or care. If a client would have been working, but is on approved leave this should be counted as employed if the clients intends to work after leave ends.
 - ii. **Part Time Employed** – same as full time except less than 35 hours/weekly
 - iii. **Sheltered Employment** – Transitional or extended employment programs intended to provide training and experience to individuals in segregated settings to acquire the skills necessary to succeed in subsequent competitive employment or to use their existing abilities to earn less than minimum wage in a segregated workshop setting
 - iv. **Unemployed but Actively Looking for Work** – actively seeking work, but not yet working

Not In Labor Force:

- v. **Homemaker** – client is primarily responsible for managing a household and is not responsible for earning the income for that household
 - vi. **Student** – client is actively enrolled in and attending school and not employed-- if a student is employed check employment status (part/full time) and NOT student
 - vii. **Volunteer Worker** – client is actively engaged in volunteer work on a regular basis in lieu of employment
 - viii. **Retired** – client is retired from working
 - ix. **Disabled** – client is unable to work because of disability
 - x. **Inmate of Jail/Prison/Corrections** – client is unable to work due to incarceration
 - xi. **Engaged in Residential/Hospital (Institutionalized)** – client is unable to work due to hospitalization/residential treatment
 - xii. **Other not in Labor Force** – Unemployed not looking/discouraged worker/Other reason: client is not in the labor force due to barriers such as inadequate transportation, lack of childcare, poor health that does not qualify for disability, needed at home to care for others, lack of job skills, client is not in the labor force and has not been actively seeking work
 - xiii. **Unknown**
- j. Select the **Primary Source of Income/Support** from the following, for a child under 18, select source of parental income:
 - i. **Wages/Salary Income** - income generated by employment
 - ii. **Family/Relative** - spousal alimony, income received from family or relative
 - iii. **Public Assistance** - Examples: TANF, Unemployment insurance
 - iv. **Retirement/Pension** –Social Security, 401K, etc.

- v. **Disability** - Examples: SSI, SSDI, Worker's Compensation
 - vi. **Other** - Any other source of income including when client has income, but does not disclose source of income.
 - vii. **Unknown**
 - viii. **None**
- k. Select **Living Arrangement** from one of the following:
- i. **Independent Living (Own Home)** – a house, apartment, or a home that the client rents or owns, which is not sponsored, licensed, supervised, or otherwise connected to mental health or AOD providers. Includes children living with parents, adult living with parent, or an adult who has a roommate where they share household expenses.
 - ii. **Homeless** – Refers to those who have no fixed address and/or those who reside in shelters that provide overnight lodging for homeless persons. Examples: Homeless shelter; Mission; Street or Outdoors.
 - iii. **Other's Home** – House, apt, or other living situation in which the client lives with a relative or friend who is head of the household. Includes Kinship Care: Children living with a relative who is also the legal foster parent should be reported in this category.
 - iv. **Residential Care** – short-term living environment (or longer term for some adults), it may or may not be 24 hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services, and accommodations. Treatment services are billed separately. This category includes:
 - Child Residential Care / Group Home** – a congregate living environment licensed by a county or state department to provide care to children or adolescents. Reasons for this placement level of care are more environmental in nature than psychiatric. Child residential Care / Group Home may provide supervision, social services, and accommodations, but treatment services are provided separately and service intensity will vary from client to client. **Adult Residential Care/ ACF/Adult Care Facility (Adult Group Home/Adult Family Home)** - a congregate living environment licensed by a state department to provide care to adults. Reasons for this placement level of care are more environmental in nature than psychiatric. Home may provide supervision, social services, and accommodations, but treatment services are provided separately and service intensity will vary from client to client. **Adult Residential Care (Type 2, 3)** – licensed by the state, includes room & board and may or may not include personal care or mental health services. May be called Residential Support, Next-Step Housing, or Supervised Group Living.
 - v. **Respite Care** – short-term living environment, it may or may not be 24 hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately.

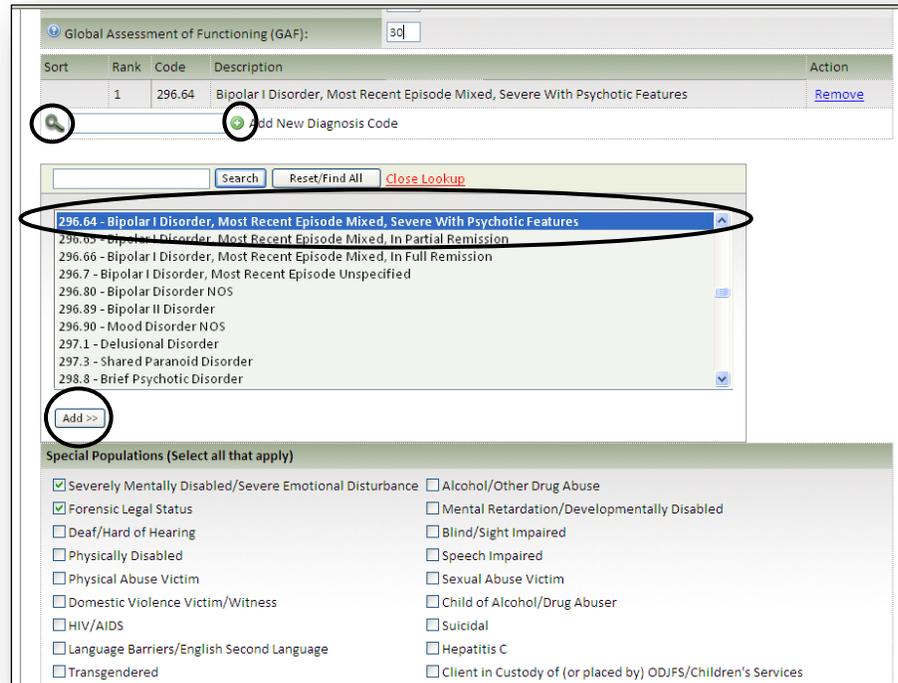
- vi. **Foster Care** – Living situations in which the client resides with a non-related family or person in that person’s home for purpose of receiving care, supervision, assistance, and accommodations. Treatment services are billed separately. Licensed through the state.
- vii. **Crisis Care** – Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 24 hours per day/7 days a week. Treatment services are billed separately.
- viii. **Temporary Housing** – Non-hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately.
- ix. **Community Residence** – Person living in an apt where they entered into an agreement that is not covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of onsite supervision for residents.
- x. **Nursing Facility** – Refers to a nursing facility licensed by the Ohio Department of Health for the provision of various levels of nursing care. Examples: Skilled Nursing Facility; Intermediate Care Facility; Nursing Home.
- xi. **Licensed MR Facility** – Refers to any ODMR-DD licensed group home or community facility (that is not an ICF-MR) where supervision, services and/or accommodations are provided. Examples: Group Home for persons with MR; Residential Facility for persons with MR.
- xii. **State MH/MR Institution** – Refers to any state-operated institution under the jurisdiction of the ODMH or ODMR-DD. Examples: State Psychiatric Hospital; State Developmental Center; Behavioral Healthcare Organization.
- xiii. **Hospital** – Refers to any non-state operated hospital, including a private psychiatric hospital or the psychiatric division of a general medical facility. Examples: General Hospital; Community Hospital; Private Psychiatric Hospital.
- xiv. **Correctional Facility** – Refers to any facility operated by city, county, state or federal law enforcement providers. Examples: Jail, Workhouse, Prison.
- xv. **Other** – Refers to any living arrangements that are not listed above.
- xvi. **Unknown**
- xvii. **Type 1 Residential Treatment** – Provides room and board, personal care, and certified mental health services to one or more adults, or children or adolescents. Provider is licensed and certified by ODMH as a Type 1 Residential facility. Reasons for this placement level of care are more psychiatric or behavioral in nature than environmental.

- I. Select the number of **Prior AOD Treatment Episodes** from the following:
 - i. 0 Previous Episodes
 - ii. 1 Previous Episode
 - iii. 2 Previous Episodes
 - iv. 3 Previous Episodes

- v. 4 Previous Episodes
 - vi. 5 or More Previous Episodes
 - vii. Unknown
- m. Select **Diagnosis Type** from the following:
- i. DSM IV
 - ii. ICD9
- n. Is the Client in **Opioid Replacement Therapy**? Select from the following:
- i. Yes – if the client’s use of methadone or buprenorphine is part of the client’s treatment plan
 - ii. No
 - iii. Unknown
- o. Enter the **Number of Children in Household Under 18**:
- i. Count all children in the home even if they are not directly dependent upon the client. If client is in foster care, count number of children in foster home.
- p. Enter the client’s **Global Assessment of Functioning (GAF)**. Clicking on the “?” button will provide a description of the following ranges:
- i. **100-91** Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his/her many positive qualities. No symptoms.
 - ii. **90-81** Absent of 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).
 - iii. **80-71** If symptoms are present, they are transient and expectable reactions to psycho-social 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).
 - iv. **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 relationships.
 - v. **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).
 - vi. **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).
 - vii. **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).

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

Figure 15. SMD/SED Criteria = GAF, Diagnosis, Special Population



- q. Enter a **Diagnosis Code** (see Figure 12 above).
 - i. Select the **magnifying glass** to search for a Diagnosis Code
 1. select **Diagnosis Code** from list
 2. select **Add >>** to add to Diagnosis List
 - ii. Use Sort Arrows to change Rank of Diagnosis Codes
 - iii. Select “+” button to save
 - iv. There is no limit to the number of Diagnosis codes, only diagnosis codes ranked 1 and 2 will be used for federal reporting. **If you manually enter a five-digit diagnosis code like 296.4 into the window, you must enter the fifth digit (xxx.xx) or you will get an error message when you try to save the record.**

Diagnostic codes that are not eligible for an SMD classification—e.g., the 301 series for personality disorders—cannot be entered as a first diagnosis. These diagnoses can be entered as second or third, however. See listing in back of manual for SMD eligible diagnostic codes.

- r. **Special Populations** (Select all that apply) from the following: (see Figure 12 above)
 - i. **Severely Mentally Disabled (SMD)** or **Seriously Emotionally Disturbed (SED)** – **Adults:** The client has a long-standing, persistent disability due to a psychiatric condition. The client will have a history of multiple psychiatric hospitalizations and/or placements as well as substantial engagement with community mental health providers. **Child/Adolescent:** The client has substantial behavioral or emotional problems at school, home, or in the community that have a negative

impact on development and functioning. The client has a history of disrupted living environment, school suspensions/expulsions, and or juvenile justice involvement.

When the GAF is 61 or higher, the SMD/SED box can be checked to indicate the client meets criteria for the priority population. E.g., A client could be functioning well at admission, but has a history of substantial service engagement or disrupted living environments. Checking SMD/SED will override the GAF threshold for SMD/SED classification and open the record for additional information specific to the priority population.

- ii. **Alcohol/Other Drug Abuse** – Can be used to indicate a substance abusing / mentally ill (SAMI) client.
- iii. **Forensic Legal Status** – Adult client is involved in the criminal or juvenile justice system and is also served or eligible to be served by the mental health system. Forensic clients can be **adults** who get arrested, detained, or diverted who have a mental illness. They can also be individuals in the hospital or on conditional release who have a forensic legal status or people coming out of prison/jail who have serious mental illness.
- iv. **Mental Retardation/Developmental Disability** – Can be used to indicate client has a DD diagnosis without entering a specific Axis II diagnosis.
- v. Deaf/Hearing Impaired
- vi. Blind/Sight Impaired
- vii. Physically Disabled
- viii. Speech Impaired
- ix. Physical Abuse Victim
- x. Sexual Abuse Victim
- xi. Domestic Violence Victim/Witness
- xii. Child of Alcohol/Drug Abuser
- xiii. HIV/AIDS
- xiv. **Suicidal** – Includes clients with a history of multiple episodes of suicidality or low lethality suicidal behavior. Also refers to history of intentional self-injury (e.g., cutting).
- xv. Language Barriers/English Second Language
- xvi. Hepatitis C
- xvii. **Transgendered** – Client expresses a gender identity that differs from the one corresponding to his/her sex at birth.
- xviii. Client is in Custody of (or placed by) ODJFS/Children’s Services
- xix. **Multiple Service System Involvement** – Refers to children and adolescents involved in two or more service systems. Such clients may receive service coordination or services funded through a Families and Children First Council.
- xx. **Early Childhood: At Risk for SED** – Client is age 0 to 6 and presents with symptoms and behaviors that suggest risk of serious emotional disturbance.

- xxi. **Sexual Offender** – Client is a registered offender and/or someone with a history of referral and treatment for sexual aggression.
 - xxii. **Bisexual/Gay/Lesbian** – Client identifies as a sexual minority.
 - xxiii. **Military Family** – Client is the child, spouse or other dependent of active or inactive soldier. Military includes National Guard, Army, Navy, Marines, Coast Guard.
 - xxiv. None of the Above
- s. Select **Military Status** from the following: (see Figure 13 below)
- i. None
 - ii. Active Duty
 - iii. Discharged
 - iv. Disabled Veteran
- If Military Status is **NOT** None then answer the following:
- v. Served in Afghanistan? Yes or No
 - vi. Served in Iraq? Yes or No

Figure 16. Admission Record (Lower Half)

The screenshot shows the lower half of an admission record form. It includes several sections:

- Military Status:** A dropdown menu set to "Disabled Veteran".
- Served In Afghanistan?** Radio buttons for "Yes" and "No", with "No" selected.
- Served In Iraq?** Radio buttons for "Yes" and "No", with "No" selected.
- Drug Of Choice:** Radio buttons for "Yes" and "No", with "Yes" selected.
- Table:** A table with columns: Rank, Drug Of Choice, Frequency Of Use, Route of Administration, and Age Of First Use. The first row shows "1st Choice", "Nicotine", "Daily", "Smoking", and "12". Below the table is an "Add Item" row with dropdown menus for Rank, Drug Of Choice, Frequency Of Use, and Route of Administration.
- Number of Arrests in the Past 30 Days:** A text input field containing the number "2".
- Primary Reimbursement:** A dropdown menu set to "Medicaid".
- Frequency of attendance at self-help programs in the 30 days prior to admission:** A dropdown menu set to "No attendance in the past month".
- Board:** A table with two rows. The first row is "Lorain County Board of Mental Health (47)" with a red minus icon. The second row is "Mental Health & Recovery Services Board of Lucas County" with a green plus icon.
- Buttons:** "Update", "Duplicate for AOD Admission", and "Return To Episodes" at the bottom right.

 A black oval highlights the "Drug Of Choice" section and the table below it.

- t. If there is a Drug of Choice—**including nicotine use**—select primary **Drug of Choice** from the following (see Figure 13 above). This is not a diagnosis; this is a way to indicate what substances a mental health client may be using or abusing on a regular basis.
- i. Alcohol
 - ii. Cocaine/Crack
 - iii. Marijuana/Hashish
 - iv. Heroin
 - v. Non-prescription Methadone
 - vi. Other Opiates and Synthetics

- vii. PCP
- viii. Other Hallucinogens
- ix. Methamphetamines
- x. Other Amphetamines
- xi. Other Stimulants
- xii. Benzodiazepines
- xiii. Other Non-Benzodiazepine Tranquilizers
- xiv. Barbiturates
- xv. Other Non-Barbiturate Sedatives or Hypnotics
- xvi. Inhalants
- xvii. Over-the-Counter Medications
- xviii. Nicotine
- xix. Other Medications
- xx. Unknown

Select **Frequency of Use** from the following:

- i. No Use in the Past Month
- ii. 1 - 3 Times in the Past Month
- iii. 1 – 2 Times in the Past Week
- iv. 3 – 6 Times in the Past Week
- v. Daily
- vi. Unknown

Select **Route of Administration** from the following:

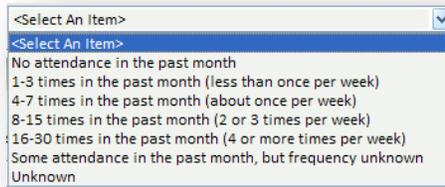
- i. Oral
- vii. Smoking
- viii. Inhalation
- ix. Injection
- x. Other
- xi. Not Applicable
- xii. Unknown

Enter **Age of First Intoxication** when Drug of Choice is Alcohol, otherwise enter **Age of First Use**

Select **“+”** button to save Drug of Choice

- u. Enter **Number of Arrests in the Past 30 Days** (AOD NOM).
- v. Select the expected **Primary Reimbursement** from the following: (see figure 8g)
 - i. Self-Pay
 - ii. Blue Cross/Blue Shield
 - iii. Medicare
 - iv. Medicaid
 - v. Other Government Payments (Includes Board funded)
 - vi. Worker’s Compensation
 - vii. Other Health Insurance Companies
 - viii. No Charge
 - ix. Other Payment Source
- w. Select the frequency of attendance at self-help programs in the 30 days prior to admission from the following:

Figure 17. Attendance at Self-Help Programs



- x. Select the board that is paying for the client's services during this episode of care (see Figure 15 below).

Figure 18. Paying Board and Duplicating Records for AOD Admission



Duplicating Records for AOD Admission

Click on the **Save** button. This will bring up a window that says **Duplicate for AOD Admission**. To enter the record for a client receiving treatment for both mental health and AOD problems, click on **Duplicate for AOD Admission** (see Figure 15 above).

When a client meets criteria for SMD or SED, a second admission screen is used to collect additional information for the focus population. Required fields in the additional admission form depend on whether the client admission is for an adult with SMD or a child/adolescent with SED.

Admission Information Specific to Clients with SMD/SED

- Click on **Update** to go to the additional admission screen for clients who meet SMD/SED criteria.

Figure 19. Admission Record for SMD/SED Client (Upper Half)

Currently Selected Client: Tinker Belle (89898989) - Admission date: 11/1/2011, Latest Level of care: Not Applicable (MH Only)

Update **Return To Episodes**

CGAS (Children's Global Assessment Scale): 45

Does the client use any tobacco products? Yes No Don't Know

AOD Involvement? Yes No Don't Know

Dual eligible (Medicaid/Medicare)? Yes No Don't Know

Type: **Bio Markers**

Height: 4 feet 6 inches **BMI** 20

Weight: 85 lbs

Does the client report or provide evidence of having any of the following conditions over the past year? (Select all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease/Failure
<input type="checkbox"/> Cardiovascular Disease (e.g., heart attack, stroke)	<input type="checkbox"/> Bowel Obstruction (e.g., constipation)
<input type="checkbox"/> High Blood Pressure	<input checked="" type="checkbox"/> Respiratory Disease (e.g., COPD, asthma)

How frequently has the client used the following since admission or last update? Admissions/visits may be for primary and/or psychiatric care. (99=Unknown)

Hospital:	2
Emergency Room Admissions/Visits:	4
Outpatient visits to the physician, nurse practitioner, or clinic:	3
Dental Visits:	1

The client will receive *Multi-Systemic Therapy*:

The client will receive *Intensive Home Based Treatment*:

Update **Return To Episodes**

Client Sections

- Admission
- SMD/SED Admission
- Transfer
- Discharge
- Services

Special Categories

Other Actions

- Print
- Return to List

Admission Records for clients with SED differ from those for adults with SMD because they allow for voluntary entry of a CGAS value. In all other respects, the SMD/SED Admission Record is the same.

- Children's Global Assessment of Scale (CGAS)** is optional and can be left blank. Choose CGAS from one of the following ranges:

100-91: Superior functioning in all areas (at home, at school and with peers); involved in a wide range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.); likeable, confident; 'everyday' worries never get out of hand; doing well in school; no symptoms.

90-81: Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and 'everyday' worries that occasionally get out of hand (e.g.,

mild anxiety associated with an important exam, occasional 'blowups' with siblings, parents or peers).

80-71: No more than slight impairments in functioning at home, at school, or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sibling), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61: Some difficulty in a single area but generally functioning well (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60-51: Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50-41: Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

40-31: Major impairment of functioning in several areas and unable to function in one of these areas i.e., disturbed at home, at school, with peers, or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21: Unable to function in almost all areas e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20-11: Needs considerable supervision to prevent hurting others or self (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1: Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect or personal hygiene.

- c. Does the client use **tobacco products**?
 - i. Yes ii. No iii. Unknown
- d. Click the box if the client has any **AOD involvement**. If the client takes psychotropic medications and drinks any alcohol or uses any illicit substance, check this box.
- e. Click the box if the client is eligible for both **Medicaid and Medicare**.

BIOMARKERS

- f. Indicate the **Type** of information source for height and weight: (See Figure 16 above)
 - i. **Self Reported** – the client or a family member provided the information.
 - ii. **Measured** – a staff measured the client’s height and weight.
- g. What is the **Client’s Height** (feet and inches)? (Enter 9 in Feet box if unknown)
- h. What is the **Client’s Weight** (pounds)? (Enter 9 in Weight box if unknown)

The client’s **Body Mass Index (BMI)** will be automatically calculated.

- i. **Physical Health Conditions:** Does the client report or provide evidence of having any of the following conditions over the past year? (Select all that apply.)
 - i. Diabetes
 - ii. High Cholesterol
 - iii. Cardiovascular Disease (e.g., heart attack, stroke)
 - iv. High Blood Pressure
 - v. Cancer
 - vi. Kidney Disease/Failure
 - vii. Bowel Obstruction (e.g., constipation)
 - viii. Respiratory Disease (e.g., COPD, asthma)
- j. How frequently has the client used the following **health care services** in the last six months? Admissions/visits may be for primary and/or psychiatric care. (See Figure 16 above. Enter 99 if unknown.)
 - i. Hospital:
 - ii. Emergency Room:
 - iii. Outpatient Visits:
 - iv. Dental Visits:

Mental Health Programs/EBPs

- k. Select any Mental Health Programs/EBPs that the client is expected to receive. In the example shown in Figure 16 above, only those Mental Health EBPs selected on the Setup page appear on the bottom of the SMD/SED Admission page. Admission, Update, and Discharge records will list only those EBPs selected by the provider in the Setup.

- Click **Save** button to save the complete SMD/SED Admission Record.

Updating Records Versus an MH Update Record

Admission, SMD/SED Admission, Update, Transfer and Discharge records can all be changed (updated) by clicking on the **square update button** at the bottom or top of the data entry form. (See Figure 17 below.) This update option becomes available as soon as you've saved a new record of any kind. The **Update Record**, however, is comparable to an Admission, SMD/SED Admission, Transfer or Discharge—it is a Client Selection record required on a yearly basis for active SMD/SED clients

Figure 20. Updating or Changing an Existing Record

Currently Selected Client: Jemima Puddleduck (No UCI--Private Client)

[Update](#) [Duplicate for AOD Admission](#) [Return To Episodes](#)

Client Sections

- [Admission](#)
- [SMD/SED Admission](#)
- [Transfer](#)
- [Update](#)
- [Discharge](#)
- [Services](#)

Special Categories

Other Actions

- [Print](#)
- [Return to List](#)

Change an existing record

Navigate to a yearly Update record for SMD/SED client.

Sort	Rank	Code	Description	Action
	1	296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified	Remove

[Add New Diagnosis Code](#)

Adding an Update Record

1. From the BH Homepage menu, click the **Clients** button.
2. Click the **Select** button under **Action** from the existing client. The pop-up window will provide a list of options. Select **MH Update**. This will take you to the **Client Episodes** page.

Refer to Admission Record section for detail on re-response categories and definitions. See Index in back of manual for page location of definitions by response category.

Figure 21. Episode Updates

The screenshot shows the Ohio Behavioral Health web application interface. At the top, there is a navigation bar with 'Home', 'Support', 'BH Extract', 'Setup', 'Clients', 'Reports', and 'Upload'. Below this, a status bar indicates the current user is Carol Carstens and the current date is 10/21/2011. The main content area shows the 'Currently Selected Client: Jemima Puddleduck (No UCI--Private)' with an admission date of 10/20/2011. A 'New MH Update' button is circled in red. To the right, a 'Client Sections' menu is visible, listing options like Admission, SMD/SED Admission, Transfer, Update, Discharge, and Services.

3. Click the **Options** button then move your mouse and select Update. This will take you to the Episode's Update page (see Figure 18 above). Click on **New MH Update** to go to **Update Record** page (see Figure 19 below).

Figure 22. MH Update Record (Upper Half)

The screenshot displays the 'MH Update Record' page for Alice Wonderland. The form contains several fields for data entry: 'Date of Update' (calendar icon), 'Education Level Completed' (dropdown), 'Education Enrollment' (dropdown with a warning message), 'CGAS (Children's Global Assessment Scale)' (text input), 'Number of arrests in the last 30 days (99 = Unknown)' (text input), 'Does the client use any tobacco products?' (radio buttons for Yes, No, Don't Know), 'Employment Status' (dropdown), 'Living Arrangements' (dropdown), 'AOD Involvement' (radio buttons for Yes, No, Don't Know), and 'Diagnosis Type' (dropdown). Below these fields is a table with columns for 'Sort', 'Rank', 'Code', 'Description', and 'Action', and a search bar with a magnifying glass icon and a '+ Add New Diagnosis Code' button. On the right side, there are two additional sections: 'Client Sections' with links for Admission, SMD/SED Admission, Transfer, Update, Discharge, and Services; and 'Special Categories' with links for HB484, TASC, Women's, and A&R. At the bottom right, there is an 'Other Actions' section with 'Print' and 'Return to List' options.

- a. Indicate **Date of Yearly Update**.
- b. Select **Highest Education Level Completed**. Choose the highest degree/grade completed. Choices will be limited based on admission selection. E.g., if admission has a Tenth Grade Education Level, the update choice would be limited to Tenth Grade and above.

Select **Education Enrollment**. If **K through 12** is indicated, select **Education Type**.

In the new MH record, “behaviorally handicapped” can be used to indicate the client has an IEP. “Not behaviorally handicapped” would be used to indicate the client does not have an IEP.

- c. Enter CGAS – Optional
- d. Enter **Number of Arrests** in the last 30 days. If unknown, enter 99.
- e. Indicate whether the client uses tobacco products **at time of update**.
- f. Select current **Employment Status**.

If client is employed AND enrolled as a student, report his/her work status and ignore option **Not in Labor Force – Student**. Report student status ONLY if client is not employed, but enrolled as a student.

- g. Select **Living Arrangement**.
- h. Check **AOD Involvement** if the client shown evidence of an alcohol or drug problem in addition to a mental health problem.
- i. Select **Diagnosis Type** if there are additional or new diagnoses at time of update
- j. Enter **any new diagnoses** if there are additional or new diagnoses at time of update.
- k. Enter the client’s **Global Assessment of Functioning (GAF)** at time of update.

When the GAF is 61 or higher, the SMD/SED box can be checked to indicate the client meets criteria for the priority population. Checking SMD/SED will override the GAF threshold for SMD/SED classification.

Figure 23. MH Update Record (Lower Half)

Special Populations (Select all that apply)

Severely Mentally Disabled/Severe Emotional Disturbance Alcohol/Other Drug Abuse
 Forensic Legal Status Mental Retardation/Developmentally Disabled
 Deaf/Hard of Hearing Blind/Sight Impaired
 Physically Disabled Speech Impaired
 Physical Abuse Victim Sexual Abuse Victim
 Domestic Violence Victim/Witness Child of Alcohol/Drug Abuser
 HIV/AIDS Suicidal
 Language Barriers/English Second Language Hepatitis C
 Transgendered Client in Custody of (or placed by) ODJFS/Children's Services
 Sexual Offender Multiple Service System Involvement
 Early Childhood at Risk for SED Gay, Lesbian, Bisexual
 Military Family/Dependent

Bio Markers

Type:

Height: feet inches **BMI**

Weight: lbs

Does the client report or provide evidence of having any of the following conditions over the past year? (Select all that apply)

Diabetes Cancer
 High Cholesterol Kidney Disease/Failure
 Cardiovascular Disease (e.g., heart attack, stroke) Bowel Obstruction (e.g., constipation)
 High Blood Pressure Respiratory Disease (e.g., COPD, asthma)

- l. Special Populations indicated at Admission will appear checked on the Update form. Add or correct any **Special Populations** that were not indicated on admission or since last update.
 - m. Enter **height and weight** (feet and inches) if this information was not indicated at admission or has changed since admission or last update. Enter 9 if unknown.
 - n. Does the client report or provide evidence of having any of the listed **physical health conditions** since admission or last update? Select any that were not indicated at admission or have changed since admission or last update.
 - o. How frequently has the client used **medical services** since admission or last update? Admissions/visits may be for primary and/or psychiatric care. Enter 99 if unknown.
 - p. Select **Primary Reimbursement** if it has changed since admission or last update. When you select either Medicaid or Medicare, you will get a drop-down box asking whether the client is dual eligible. (See Figure 21 below)
 - q. Select the **Primary Source of Income/Support** from the following (for a child under 18, select source of parental income) if this has changed since admission or last update.
 - r. Select any **Mental Health Programs/EBPs** the client received since admission or last update.
- Click **Save** button to save the Update Record.

Adding Yearly Update Records

1. From the BH Homepage menu, click on **Clients** button.
2. In Figure X below, note under the Admission Status column that Bob Evan’s status is A1/U1/T1/D0. This means she has one admission record, one update record, one transfer record, and no discharge records. Click the **Select** button under **Action** from the existing client. This will take you to the **Client Episodes** page.

Figure 24. Admission, Update, Transfer & Discharge Status

Issues	Unique Client Id	First Name	LastName	Birth Date	Admission Status	Action
		Maggie	Moo	10/1/1986	A1 / U1 / T0 / D1	Select Delete
	1008646	7C14331	F27F95727CE5	10/29/2012	A2 / U0 / T0 / D0	Select Delete
	123987	Bob	Evans	7/13/2000	A1 / U1 / T1 / D0	Select Delete
	1123581321	A-9749-20434303582E	EE	6/29/1998	A1 / U0 / T0 / D0	Select Delete
	244688	A11CA74E9	D-AB7D-2CB5F5D45991	3/8/1903	A1 / T0 / D0	Select Delete

3. On the Client Episodes page click on the **Options** button and select **MH Update** from the pop up box that appears. This will take you to the **MH Update** page (See Figure 22 below).

Figure 25. MH Update

Behavioral Health Ohio Behavioral Health

Home Support BH Extract Setup Clients Reports Upload

Current user: Carol Carstens | Current Date: 11/8/2011 | A Better Way Counseling and Mediation (12901) - 1042 Emma Avenue | Return To Portal

Currently Selected Client: Bob Evans (123987) - Admission date: 11/8/2011, Latest Level of care: Not Applicable (MH Only)

Client Sections: Admission, SMD/SED Admission, Transfer, Update, Discharge, Services

Update Date	Action
11/8/2011	Delete

4. If you choose “Select” under “Action”-- indicated with  -- you will boot an existing Update Record created on 11/8/2011. To create a new yearly update, select **New MH Update** button. This will open a blank update screen.

Adding a Discharge Record

1. From the BH Homepage menu, click the **Clients** button.
2. Click the **Select** button under **Action** from the existing client. This will take you to the **Client Episodes** page.
3. Click the **Options** button, then move your mouse and select **Discharge**. This will take you to the Episode's Discharge page (see Figure 21 below).

Refer to Admission Record section for detail on response categories and definitions. See Index in back of manual for page location of definitions by response category.

Figure 26. Discharge Record for Mental Health Client (Upper Half)

The screenshot shows the 'BH Discharge' form in a web application. The header includes the 'Behavioral Health' logo and a search bar. A navigation menu contains 'Home', 'Support', 'BH Extract', 'Setup', 'Clients', 'Reports', and 'Upload'. The user information bar shows 'Current user: Carol Carstens | Current Date: 9/28/2011 | Adelante (6816) - 520 Broadway Street | Return To Portal'. The client information bar states 'Currently Selected Client: E0D3257AA 012 (No UCI--Unknown UCI) - Admission date: 9/13/2011, Latest Level of care: Not Applicable (MH Only)'. The form fields include: 'Last Date of Service' (9/26/2011), 'Closure Date' (9/28/2011), 'Discharge Reason' (Left on Own, Against Staff Advice WITH Satisfactory Progress), 'Did client choose another provider due to religious preference?' (No), 'Education Level Completed' (Unknown), 'Education Enrollment' (GED Classes), 'Employment Status' (Part Time Employed), 'Primary Source of Income/Support' (Wages/Salary Income), 'Living Arrangements' (Independent Living (Own Home)), and 'Global Assessment of Functioning (GAF)' (55). At the bottom, there is a table with columns for 'Sort', 'Rank', 'Code', 'Description', and 'Action', and an 'Add New Diagnosis Code' button.

In cases where a client with SMD/SED has a 180-day lapse in service receipt, ODMH will issue a notice of administrative closure. Providers may choose to create either a discharge or an update record with notice of administrative closure.

- a. Enter or select the **Last Date of Service**.
- b. Enter or select the **Closure Date**.
- c. Select the **Discharge Reason** from the following:
 - i. Successful Completion/Graduation

- ii. Assessment & Evaluation Only, Successfully Completed no Further Services Recommended
 - iii. Assessment & Evaluation Only, Client Rejected Recommendations
 - iv. Left on Own, Against Staff Advice WITH Satisfactory Progress
 - v. Left on Own, Against Staff Advice WITHOUT Satisfactory Progress
 - vi. Involuntarily Discharged Due to Non-Participation
 - vii. Involuntarily Discharged Due to Violation of Rules
 - viii. Referred to Another Program or Service with SATISFACTORY Progress
 - ix. Referred to Another Program or Service with UNSATISFACTORY Progress
 - x. Incarcerated Due to Offense Committed while in Treatment/Recovery with SATISFACTORY Progress
 - xi. Incarcerated Due to Offense Committed while in Treatment/Recovery with UNSATISFACTORY Progress
 - xii. Incarcerated Due to Old Warrant/Charged from Before Entering Treatment/Recovery with SATISFACTORY Progress
 - xiii. Incarcerated Due to Old Warrant/Charged from Before Entering Treatment/Recovery with UNSATISFACTORY Progress
 - xiv. Transferred to Another Facility for Health Reasons
 - xv. Death
 - xvi. Client Moved
 - xvii. Needed Services Not Available
 - xviii. Other
- d. [Religious Affiliated Providers Only] Did client choose another Provider due to Religious Preference?
- i. Select **YES** if the client has chosen to leave provider due to a religious choice. This choice can be to another religious denomination or secular provider.
- e. Select **Education Level**. Choose the highest degree/grade completed. Choices will be limited based on admission selection. E.g., if admission has a Tenth Grade Education Level, then discharge choice would be limited to Tenth Grade and above.
- Select **Education Enrollment**. Indicate client's current educational enrollment status. If **K through 12** is indicated, select **Education Type**.

In the new MH record, "behaviorally handicapped" can be used to indicate the client has an IEP. "Not behaviorally handicapped" would be used to indicate the client does not have an IEP.

- f. Select **Employment Status** at time of discharge.
- g. Select the **Primary Source of Income/Support** at time of discharge. For a child under 18, select source of parental income.
- h. Select **Living Arrangement** at time of discharge.
- i. Select **Diagnosis Type** if an additional or new diagnosis has been made at time of discharge.

- j. Enter the client's **Global Assessment of Functioning (GAF)**.
- k. Enter **Discharge Diagnosis** if different from diagnosis at admission or last update.
- l. Add any **Special Populations** that were not indicated on admission or last update.
- m. If there is a Drug of Choice—*including nicotine use*—select primary **Drug of Choice**.
- n. Enter **Number of Arrests in the Past 30 Days**.
- o. Enter **Primary Reimbursement**.
- p. If arrests occurred in past 30 days, **Was the client charged with a criminal offense for which the incident was alleged to have happened after the client was admitted to treatment?**
- q. Select the **Frequency of Attendance at self-help programs** in the 30 days prior to discharge.

Figure 27. Discharge Record for an MH Client (Lower Half)

Special Populations (Select all that apply)

<input checked="" type="checkbox"/> Severely Mentally Disabled/Severe Emotional Disturbance	<input type="checkbox"/> Alcohol/Other Drug Abuse
<input checked="" type="checkbox"/> Forensic Legal Status	<input type="checkbox"/> Mental Retardation/Developmentally Disabled
<input type="checkbox"/> Deaf/Hard of Hearing	<input type="checkbox"/> Blind/Sight Impaired
<input type="checkbox"/> Physically Disabled	<input type="checkbox"/> Speech Impaired
<input type="checkbox"/> Physical Abuse Victim	<input type="checkbox"/> Sexual Abuse Victim
<input type="checkbox"/> Domestic Violence Victim/Witness	<input type="checkbox"/> Child of Alcohol/Drug Abuser
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Suicidal
<input type="checkbox"/> Language Barriers/English Second Language	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Transgendered	<input type="checkbox"/> Client in Custody of (or placed by) ODJFS/Children's Services
<input type="checkbox"/> Sexual Offender	<input type="checkbox"/> Multiple Service System Involvement
<input type="checkbox"/> Early Childhood at Risk for SED	<input checked="" type="checkbox"/> Gay, Lesbian, Bisexual
<input type="checkbox"/> Military Family/Dependent	

Is There A Drug Of Choice? Yes No

Number of Arrests in the Past 30 Days: (enter 99 for Unknown) Primary Reimbursement

Was the client charged with a criminal offense for which the incident was alleged to have happened after the client was admitted to this program?
 Yes No

Frequency of attendance at self-help programs in the 30 days prior to discharge:

Figure 28. SMD/SED Discharge Screen

Currently Selected Client: John Wayne Gacey (345634562) - Admission date: 10/31/2011, Latest Level of care: Not Applicable (MH Only)

Update Delete Return To Episodes

Client Sections
 Admission
 SMD/SED Admission
 Transfer
 Update
 Discharge
 SMD/SED Discharge
 Services

Special Categories
 HB484
 TASC
 A&R

Other Actions
 Print
 Return to List

Does the client use any tobacco products?: Yes No Don't Know

Bio Markers

Type: Self Reported

Height: 5 feet 6 inches **BMI 36**
 Weight: 220 lbs

Does the client report or provide evidence of having any of the following conditions over the past year? (Select all that apply)

Diabetes Cancer
 High Cholesterol Kidney Disease/Failure
 Cardiovascular Disease (e.g., heart attack, stroke) Bowel Obstruction (e.g., constipation)
 High Blood Pressure Respiratory Disease (e.g., COPD, asthma)

How frequently has the client used the following since admission or last update? Admissions/visits may be for primary and/or psychiatric care. (99=Unknown)

Hospital: 99
 Emergency Room Admissions/Visits: 99
 Outpatient visits to the physician, nurse practitioner, or clinic: 99
 Dental Visits: 99

AOD Involvement: Yes No Don't Know

The client received *Supportive Housing*:
 The client received *Family Psycho-education*:
 The client received *Illness Self-Management (Wellness Management & Recovery)*:

Update Return To Episodes

- r. Does the client use **any tobacco products**?
- s. Is the client **dual eligible** for Medicaid and Medicare?
- t. Are height and weight information **self reported or measured**?
- u. Enter **height and weight** (feet and inches) if this information was not indicated at admission or has changed since admission or last update.
- v. Does the client report or provide evidence of having any of the listed **physical health conditions** since admission or last update? Select any that were not indicated at admission or have changed since admission or last update.
- q. How frequently has the client used **medical services** since admission or last update? Admissions/visits may be for primary and/or psychiatric care. Enter 99 if unknown.
- r. Does the client have an **AOD involvement**?
- s. Enter any of the **Mental Health Programs/EBPs** the client received since admission or last update.
- Click **Save** button to save the Discharge Record.

Adding a Transfer Record

The purpose of the Transfer Record is to keep track of a client's length of stay in Type 1 Residential Treatment. Transfer records are used **ONLY** for tracking movement of consumers into and out of Type 1 Residential settings. When client is admitted to a Type 1 Residential Facility, the client's admission record is used to indicate that placement level of care in the Living Arrangement field. If the client is moved from the Type 1 Residential setting to a different Living Arrangement such as foster care or a group home within the same agency or to another agency, a transfer record should be created so that length of stay in the Type 1 Residential placement level of care can be calculated. If the client is changing providers when discharged from a Type 1 Residential placement level of care, the discharge record will be populated with the living situation entered into the transfer record.

An outpatient provider may choose to leave a client's record open because the client has been temporarily placed at a Type 1 Residential Facility for stabilization and is expected to return to the outpatient agency. In such a case, the outpatient provider should not change the client's living situation *unless* the client is still residing at the Type1 Residential Facility *at the time of annual update*.

1. From BH Homepage menu, click the **Clients** button.
2. Click the **Select** button under **Action** from the existing client. This will take you to the **Client Episodes** page.
3. Click the **Options** button (see Figure 8) then move your mouse and select **Transfer** (see Figure 9). This will take you to the Episode's Transfer page (see Figure 24 below).

Figure 29. Transferring a Client with SED Placed in a Type 1 Residential Facility

The screenshot displays the 'BH Transfer' interface. At the top, there's a navigation bar with 'Home', 'Support', 'BH Extract', 'Setup', 'Clients', 'Reports', and 'Upload'. Below this is a user information bar: 'Current user: Carol Carstens | Current Date: 9/28/2011 | Adelante (6816) - 520 Broadway Street | Return To Portal'. A message box states 'The transfer was successfully added'. Below that, it says 'Currently Selected Client: E0D3257AA 012 (No UCI--Unknown UCI) - Admission date: 9/13/2011, Level of care: Not Applicable (MH Only)'. A 'Return To Episodes' button is visible. The main content area features a table with the following data:

Transfer Date	Living Arrangement	Action
9/30/2011	Residential Treatment Center	Delete
10/17/2011	Foster Care	Delete
10/17/2011	Residential Treatment Center	Save

In the example shown in Figure 24, the client has transferred from “independent living/own home” into Type 1 residential treatment on 9/30/2011. On 10/17/2011, the client transferred from Type 1 residential treatment to “foster care.” The transfer out of Type 1 residential treatment to a different Living Arrangement should be noted whether or not the “foster care” provider is the same agency as the Type 1 Residential Facility or not.

- a. Enter or Select the Transfer Date.
- b. If the client is transferring into Residential Treatment, this will be the default Living Arrangement. If the client is transferring from Residential Treatment, provider must indicate new Living Arrangement. Always select the Living Arrangements **to which client has been transferred**.
- c. The form will not permit re-admission to residential treatment prior to the date of transfer from that treatment setting.

SMD/SED Definitions

Serious Mental Illness, aka SMD

Adults with a Mental Illness, Disorder or Disease

- I. Must be 18 years of age or older; and
- II. Individuals with any DSM-IV-TR diagnosis, with the exception of the following exclusionary diagnoses:
 - developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders)
 - substance-related disorders
 - conditions or problems classified in DSM-IV-TR as other conditions that may be a focus of clinical attention (V codes)
 - Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium
 - sleep disorders; and
- III. Individuals with Global Assessment of Functioning Scale (GAF) ratings between 60 and 100 (lowest level of care need, tier 3).

Adults with Serious Mental Illness, aka SMD

- I. Must be 18 years of age or older; and
- II. Individuals with any DSM-IV-TR diagnosis, with the exception of the following exclusionary diagnoses:
 - developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders)
 - substance-related disorders
 - conditions or problems classified in DSM-IV-TR as other conditions that may be a focus of clinical attention (V codes)
 - Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and
- III. Treatment history covers the client's lifetime treatment for the DSM IV-TR diagnoses other than those listed as exclusionary diagnoses specified in section II and meets one of the following criteria:
 - a. Continuous treatment of 6 months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
 - b. Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period; or
 - c. A history of using two or more of the following services over the most recent 12 month period continuously or intermittently (this includes consideration of a person who received care in a correctional setting): psychotropic medication management, behavioral health counseling, CPST, crisis intervention; or

- d. Previous treatment in an outpatient service for at least six months, and a history of at least two mental health psychiatric hospitalizations; or
 - e. In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 6 months.
- IV. Individuals with Global Assessment of Functioning Scale (GAF) ratings between 40 and 60 (mid-range level of care need, tier 2). Clinician discretion may be used in determining into which tier an individual with a GAF rating of 40-50 (either tier 1 or tier 2) should be placed.

Adults with Serious and Persistent Mental Illness

- I. Must be 18 years of age or older; and
- II. Individuals with any DSM-IV-TR diagnosis, with the exception of the following exclusionary diagnoses:
 - developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders)
 - substance-related disorders
 - conditions or problems classified in DSM-IV-TR as other conditions that may be a focus of clinical attention (V codes)
 - Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium and sleep disorders; and
- III. Treatment history covers the client's lifetime treatment for the DSM IV-TR diagnoses other than those listed as exclusionary diagnoses specified in section II and meets one of the following criteria:
 - a. Continuous treatment of 12 months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or 12 months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
 - b. Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period; or
 - c. A history of using two or more of the following services over the most recent 12 month period continuously or intermittently (this includes consideration of a person who might have received care in a correctional setting): psychotropic medication management, behavioral health counseling, CPST, crisis intervention.
 - d. Previous treatment in an outpatient service for at least 12 months, and a history of at least two mental health psychiatric hospitalizations; or
 - e. In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 12 months.
- IV. Individuals with Global Assessment of Functioning Scale (GAF) ratings of 50 or below (highest level of care need, tier 1). Clinician discretion may be used in determining into which tier an individual with a GAF rating of 40-50 (either tier 1 or tier 2) should be placed.

SED or Serious Emotional Disturbance

Children or Adolescents with Mental / Emotional Disorders

- I. 0 years of age through 17 years of age (youth aged 18-21 years who are enrolled in high school, in Department of Youth Services or Children Services custody or when it is otherwise developmentally/clinically indicated may be served to assist with transitioning to adult services), and
- II. Individuals with any DSM-IV-TR diagnosis, except developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders), substance-related disorders, or conditions or problems classified in DSM-IV-TR as other conditions that may be a focus of clinical attention (V codes) unless these conditions co-occur with another diagnosable mental or emotional disorder, and
- III. Assessment of impaired functioning at age appropriate levels and difficulty with age appropriate role performance with a Global Assessment of Functioning Scale (GAF score between 50 and 90. Clinical discretion may be used to place individuals with GAF scores between 50 and 60 in a higher intensity (Serious Emotional Disturbance)

Child or Adolescent with Serious Emotional Disturbance

- I. 0 years of age through 17 years of age (youth aged 18-21 years who are enrolled in high school, in Department of Youth Services or Children Services custody or when it is otherwise developmentally/clinically indicated may be served to assist with transitioning to adult services), and
- II. Individuals with any DSM-IV-TR diagnosis, except developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders), substance-related disorders, or conditions or problems classified in DSM-IV-TR as other conditions that may be a focus of clinical attention (V codes), unless these conditions co-occur with another diagnosable mental or emotional disorder, and
- III. Assessment of impaired functioning at age appropriate levels and difficulty with age appropriate role performance with a Global Assessment of Functioning Scale (GAF score below 60. Clinical discretion may be used to place individuals with GAF scores between 50 and 60 in a lower intensity of services (Mental/Emotional Disorder), and
- IV. Duration of the mental health disorder has persisted or is expected to be present for six months or longer.

Figure 30. SPMI/SMD Diagram

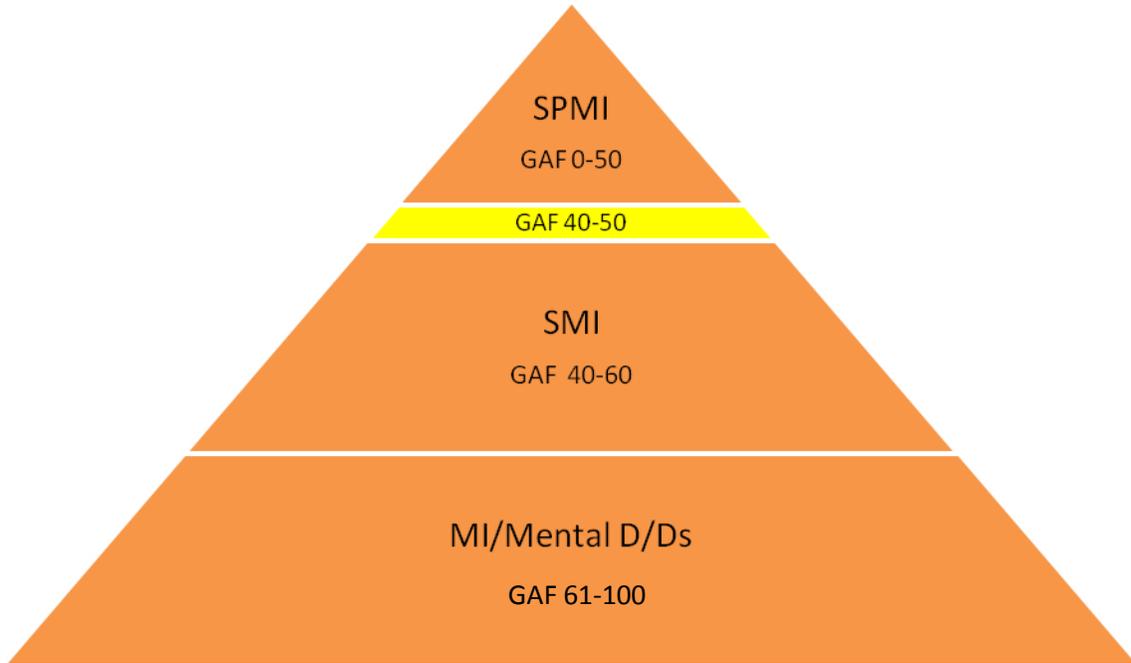
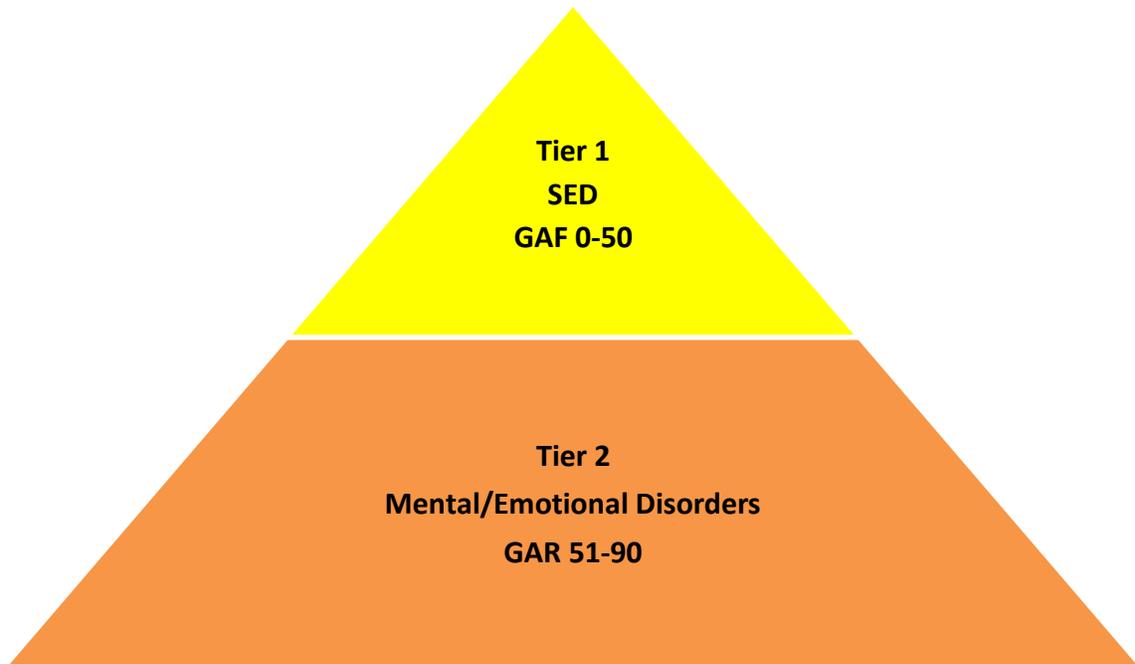


Figure 31. SED Diagram



List of Diagnostic Codes that are Eligible for SMD/SED Definition

293.81	PSY DIS W DELUS OTH DIS	295.50	LATENT SCHIZOPHREN-UNSP
293.82	PSY DIS W HALLUC OTH DIS	295.51	LAT SCHIZOPHREN-SUBCHR
293.83	MOOD DISORDER OTHER DIS	295.52	LATENT SCHIZOPHREN-CHR
293.84	ANXIETY DISORDER OTH DIS	295.53	LAT SCHIZO-SUBCHR/EXACER
293.89	TRANSIENT MENTAL DIS NEC	295.54	LATENT SCHIZO-CHR/EXACER
293.9	TRANSIENT MENTAL DIS NOS	295.55	LAT SCHIZOPHREN-REMISS
295.	SCHIZOPHRENIC DISORDERS	295.6	RESIDUAL SCHIZOPHRENIA
295.0	SIMPLE SCHIZOPHRENIA	295.60	SCHIZOPHR DIS RESID NOS
295.00	SIMPL SCHIZOPHREN-UNSPEC	295.61	SCHIZOPH DIS RESID-SUBCH
295.01	SIMPL SCHIZOPHREN-SUBCHR	295.62	SCHIZOPHR DIS RESID-CHR
295.02	SIMPLE SCHIZOPHREN-CHR	295.63	SCHIZO RESID SUBCHR/EXAC
295.03	SIMP SCHIZ-SUBCHR/EXACER	295.64	SCHIZOPH RESID-CHRO/EXAC
295.04	SIMPL SCHIZO-CHR/EXACERB	295.65	SCHIZOPH DIS RESID-REMISS
295.05	SIMPL SCHIZOPHREN-REMISS	295.7	SCHIZOAFFECTIVE DISORDER
295.1	HEBEPHRENIA	295.70	SCHIZOAFFECTIVE DIS NOS
295.10	HEBEPHRENIA-UNSPEC	295.71	SCHIZOAFFECTV DIS-SUBCHR
295.11	HEBEPHRENIA-SUBCHRONIC	295.72	SCHIZOAFFECTIVE DIS-CHR
295.12	HEBEPHRENIA-CHRONIC	295.73	SCHIZOAFF DIS-SUBCH/EXAC
295.13	HEBEPHREN-SUBCHR/EXACERB	295.74	SCHIZOAFFTV DIS-CHR/EXAC
295.14	HEBEPHRENIA-CHR/EXACERB	295.75	SCHIZOAFFECTVE DIS-REMISS
295.15	HEBEPHRENIA-REMISSION	295.8	SCHIZOPHRENIA NEC
295.2	CATATONIC SCHIZOPHRENIA	295.80	SCHIZOPHRENIA NEC-UNSPEC
295.20	CATATONIA-UNSPEC	295.81	SCHIZOPHRENIA NEC-SUBCHR
295.21	CATATONIA-SUBCHRONIC	295.82	SCHIZOPHRENIA NEC-CHR
295.22	CATATONIA-CHRONIC	295.83	SCHIZO NEC-SUBCHR/EXACER
295.23	CATATONIA-SUBCHR/EXACERB	295.84	SCHIZO NEC-CHR/EXACERB
295.24	CATATONIA-CHR/EXACERB	295.85	SCHIZOPHRENIA NEC-REMISS
295.25	CATATONIA-REMISSION	295.9	SCHIZOPHRENIA NOS
295.3	PARANOID SCHIZOPHRENIA	295.90	SCHIZOPHRENIA NOS-UNSPEC
295.30	PARANOID SCHIZO-UNSPEC	295.91	SCHIZOPHRENIA NOS-SUBCHR
295.31	PARANOID SCHIZO-SUBCHR	295.92	SCHIZOPHRENIA NOS-CHR
295.32	PARANOID SCHIZO-CHRONIC	295.93	SCHIZO NOS-SUBCHR/EXACER
295.33	PARAN SCHIZO-SUBCHR/EXAC	295.94	SCHIZO NOS-CHR/EXACERB
295.34	PARAN SCHIZO-CHR/EXACERB	295.95	SCHIZOPHRENIA NOS-REMISS
295.35	PARANOID SCHIZO-REMISS	296.	EPISODIC MOOD DISORDER
295.4	SCHIZOPHRENIFORM DIS	296.0	BIPOL 1 SINGLE MANIC
295.40	SCHIZOPHRENIFORM DIS NOS	296.00	BIPOL I SINGLE MANIC NOS
295.41	SCHIZOPHRENIC DIS-SUBCHR	296.01	BIPOL I SINGLE MANC-MILD
295.42	SCHIZOPHREN DIS-CHRONIC	296.02	BIPOL I SINGLE MANIC-MOD
295.43	SCHIZO DIS-SUBCHR/EXACER	296.03	BIPOL I SING-SEV W/O PSY
295.44	SCHIZOPHR DIS-CHR/EXACER	296.04	BIPO I SIN MAN-SEV W PSY
295.45	SCHIZOPHRENIC DIS-REMISS	296.05	BIPOL I SING MAN REM NOS
295.5	LATENT SCHIZOPHRENIA	296.06	BIPOL I SINGLE MANIC REM
296.11	RECUR MANIC DIS-MILD	296.7	BIPOLOR I CURRENT NOS
296.12	RECUR MANIC DIS-MOD	296.8	BIPOLAR DISORDER NOS/NEC

296.13	RECUR MANIC DIS-SEVERE	296.80	BIPOLAR DISORDER NOS
296.14	RECUR MANIC-SEV W PSYCHO	296.81	ATYPICAL MANIC DISORDER
296.15	RECUR MANIC-PART REMISS	296.82	ATYPICAL DEPRESSIVE DIS
296.16	RECUR MANIC-FULL REMISS	296.89	BIPOLAR DISORDER NEC
296.2	DEPRESS PSYCHOSIS	296.9	EPISOD MOOD DIS NOS/NEC
296.20	DEPRESS PSYCHOSIS-UNSPEC	296.90	EPISODIC MOOD DISORD NOS
296.21	DEPRESS PSYCHOSIS-MILD	296.99	EPISODIC MOOD DISORD NEC
296.22	DEPRESSIVE PSYCHOSIS-MOD	297.	DELUSIONAL DISORDER
296.23	DEPRESS PSYCHOSIS-SEVERE	297.1	DELUSIONAL DISORDER
296.24	DEPR PSYCHOS-SEV W PSYCH	297.3	SHARED PSYCHOTIC DISORD
296.25	DEPR PSYCHOS-PART REMISS	297.8	PARANOID STATES NEC
296.26	DEPR PSYCHOS-FULL REMISS	297.9	PARANOID STATE NOS
296.3	RECURR DEPR PSYCHOS	298.8	REACT PSYCHOSIS NEC/NOS
296.30	RECURR DEPR PSYCHOS-UNSP	298.9	PSYCHOSIS NOS
296.31	RECURR DEPR PSYCHOS-MILD	300.01	PANIC DIS W/O AGORPHOBIA
296.32	RECURR DEPR PSYCHOS-MOD	300.02	GENERALIZED ANXIETY DIS
296.33	RECUR DEPR PSYCH-SEVERE	300.1	DISSOCIATIVE DISORDER
296.34	REC DEPR PSYCH-PSYCHOTIC	300.11	CONVERSION DISORDER
296.35	RECUR DEPR PSYC-PART REM	300.12	DISSOCIATIVE AMNESIA
296.36	RECUR DEPR PSYC-FULL REM	300.13	DISSOCIATIVE FUGUE
296.4	BIPOL 1 CURRENT MANIC	300.14	DISSOCIATIVE IDENTITY DIS
296.40	BIPOL I CURRNT MANIC NOS	300.15	DISSOCIATIVE REACT NOS
296.41	BIPOL I CURNT MANIC-MILD	300.16	FACTITIOUS DIS W SYMPTOM
296.42	BIPOL I CURRNT MANIC-MOD	300.19	FACTITIOUS ILL NEC/NOS
296.43	BIPOL I MANC-SEV W/O PSY	300.21	AGORAPHOBIA W PANIC DIS
296.44	BIPOL I MANIC-SEV W PSY	300.22	AGORAPHOBIA W/O PANIC
296.45	BIPOL I CUR MAN PART REM	300.23	SOCIAL PHOBIA
296.46	BIPOL I CUR MAN FULL REM	300.29	ISOLATED/SPEC PHOBIA NEC
296.5	BIPOL 1 CUR DEPRESSED	300.3	OBSESSIVE-COMPULSIVE DIS
296.50	BIPOL I CUR DEPRES NOS	300.4	DYSTHYMIC DISORDER
296.51	BIPOL I CUR DEPRESS-MILD	300.6	DEPERSONALIZATION DISORD
296.52	BIPOL I CUR DEPRESS-MOD	300.7	HYPOCHONDRIASIS
296.53	BIPOL I CURR DEP W/O PSY	300.8	SOMATOFORM DISORDER
296.54	BIPOL I CURRNT DEP W PSY	300.81	SOMATIZATION DISORDER
296.55	BIPOL I CUR DEP REM NOS	300.82	UNDIFF SOMATOFORM DISRDR
296.56	BIPOL I CURRNT DEP REMIS	300.89	SOMATOFORM DISORDERS NEC
296.6	BIPOL 1 CURRENT MIXED	300.9	NONPSYCHOTIC DISORD NOS
296.60	BIPOL I CURRNT MIXED NOS	301.13	CYCLOTHYMIC DISORDER
296.61	BIPOL I CURRNT MIX-MILD	302.	SEXUAL/GENDER ID DISORD
296.62	BIPOL I CURRNT MIXED-MOD	302.2	PEDOPHILIA
296.63	BIPOL I CUR MIX W/O PSY	302.3	TRANSVESTIC FETISHISM
296.64	BIPOL I CUR MIXED W PSY	302.4	EXHIBITIONISM
296.65	BIPOL I CUR MIX-PART REM	302.6	GENDR IDENTITY DIS-CHILD
296.66	BIPOL I CUR MIXED REMISS	302.7	PSYCHOSEXUAL DYSFUNCTION
302.70	PSYCHOSEXUAL DYSFUNC NOS	309.0	ADJUSTMNT DIS W DEPRESSN
302.71	HYPOLACTIVE SEX DESIRE	309.21	SEPARATION ANXIETY
302.72	INHIBITED SEX EXCITEMENT	309.24	ADJUSTMENT DIS W ANXIETY
302.73	FEMALE ORGASMIC DISORDER	309.28	ADJUST DIS W ANXIETY/DEP

302.74	MALE ORGASMIC DISORDER	309.3	ADJUST DISOR/DIS CONDUCT
302.75	PREMATURE EJACULATION	309.4	ADJ DIS-EMOTION/CONDUCT
302.76	DYSPAREUNIA PSYCHOGENIC	309.81	POSTTRAUMATIC STRESS DIS
302.79	PSYCHOSEXUAL DYSFUNC NEC	309.9	ADJUSTMENT REACTION NOS
302.8	PSYCHOSEXUAL DIS NEC	310.1	PERSONALITY CHG OTH DIS
302.81	FETISHISM	311.	DEPRESSIVE DISORDER NEC
302.82	VOYEURISM	312.3	IMPULSE CONTROL DIS NEC
302.83	SEXUAL MASOCHISM	312.30	IMPULSE CONTROL DIS NOS
302.84	SEXUAL SADISM	312.32	KLEPTOMANIA
302.85	GEND IDEN DIS ADOL/ADULT	312.33	PYROMANIA
302.89	PSYCHOSEXUAL DIS NEC	312.34	INTERMITT EXPLOSIVE DIS
302.9	PSYCHOSEXUAL DIS NOS	312.39	IMPULSE CONTROL DIS NEC
306.51	PSYCHOGENIC VAGINISMUS	312.8	OTHR CONDUCT DISTURB NEC
307.1	ANOREXIA NERVOSA	312.81	CNDCT DSRDR CHLDHD ONST
307.5	EATING DISORDERS NEC/NOS	312.82	CNDCT DSRDR ADLSCNT ONST
307.50	EATING DISORDER NOS	312.89	OTHER CONDUCT DISORDER
307.51	BULIMIA NERVOSA	312.9	CONDUCT DISTURBANCE NOS
307.52	PICA	313.23	SELECTIVE MUTISM
307.53	RUMINATION DISORDER	313.81	OPPOSITION DEFIANT DISOR
307.59	EATING DISORDER NEC	313.82	IDENTITY DISORDER
307.6	ENURESIS	313.89	EMOTIONAL DIS CHILD NEC
307.7	ENCOPRESIS	313.9	EMOTIONAL DIS CHILD NOS
307.8	PSYCHOGENIC PAIN DISORD	314.0	ATTENTION DEFICIT DIS
307.80	PSYCHOGENIC PAIN NOS	314.00	ATTN DEFIC NONHYPERACT
307.89	PSYCHOGENIC PAIN NEC	314.01	ATTN DEFICIT W HYPERACT
307.9	SPECIAL SYMPTOM NEC/NOS	316.	PSYCHIC FACTOR W OTH DIS

Index of Definitions by Response Category

- Employment Status, 24
 - Actively Looking for Work, 24
 - Full Time, 24
 - Not in Labor Force, Disabled, 24
 - Not in Labor Force, Homemaker, 24
 - Not in Labor Force, Jail/Prison/Corrections, 25
 - Not in Labor Force, Other, 25
 - Not in Labor Force, Residential/Hospital, 25
 - Not in Labor Force, Retired, 24
 - Not in Labor Force, Student, 24
 - Not in Labor Force, Volunteer, 24
 - Part Time, 24
 - Sheltered, 24
- Living Arrangement, 25
 - Community Residence, 26
 - Correctional Facility, 27
 - Crisis Care, 26
 - Foster Care, 26
 - Homeless, 25
 - Hospital, 27
 - Independent Living, 25
 - Licensed MR Facility, 27
 - Nursing Facility, 26
 - Other's Home, 25
 - Residential Care/Group Home/ACF, 25
 - Respite Care, 26
 - State MH/MR Institution, 27
 - Temporary Housing, 26
 - Type 1 Residential Treatment, 27
- Marital Status, 23
 - Divorced, 23
 - Living Together as Married, 23
 - Single/Never-Married, 23
 - Single/Separated, 23
 - Widowed, 23
- Mental Health Special Programs, 7
 - Assertive Community Treatment (ACT), 8
 - Family Psycho-Education, 8
 - Functional Family Therapy (FFT), 9
 - Illness Self-Management/Wellness Management & Recovery, 8
 - Integrated Dual Disorder Treatment (IDDT), 8
 - Intensive Home-based Treatment (IHBT), 9
 - Medication Management, 9
 - Multi-Systemic Therapy (MST), 9
 - Supported Employment, 8
 - Supportive Housing, 7
 - Therapeutic Foster Care, 9
- Referred by, 22
 - AOD Care Provider, 22
 - Child Welfare Agency, 22
 - Employer/EAP, 22
 - Forensic Hospital, 22
 - Individual, 22
 - Jail, 22
 - Mental Health Provider, 22
 - OFCE, 22
 - Other Community Referral, 22
 - Other Criminal Justice, 22
 - Other Health Care Provider, 22
 - Prison, 22
 - School, 22
- Special Populations, 29
 - Alcohol/Other Drug Abuse, 30
 - Bisexual/Gay/Lesbian, 31
 - Developmentally Disabled, 30
 - Early Childhood at Risk for SED, 30
 - Forensic Status, 30
 - Military Family, 31
 - Multiple Service System Involvement, 30
 - Sexual Offender, 31
 - SMD/SED, 29
 - Suicidal, 30
 - Transgendered, 30