ANASAZI

SOFTWARE®

# Assessment Product User Manual

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# THE FLYING TOUR

The Anasazi Software Assessment Product automates the clinical processes of intake, assessment, and client progress indicators as well as provides automated support for Caseload management. During the intake and assessment processes, Clinicians complete Assessments on-line to capture clinical information used for case disposition and the formulation of treatment protocols.

The completion of automated Assessments supports the development of a Client Problems List through the linkage of questions on the Assessments to the Problems List in the PGOIs Table. Additionally, responses to questions can be collected and readily viewed as Client Progress Indicators for a Client's progress during treatment. Assessments and the Client Problems List build the foundation for the automated Treatment Plan.

The Clinician's Homepage provides Caseload management support by displaying the Clinician's active Caseload with automated Notification of tasks to be completed. User definable Help Text can be incorporated into Assessments to provide on-line support to Clinicians during the completion of Assessments.

## Setup

The following Anasazi Central and Assessment Tables and Views are used throughout the Assessment process; required Tables/Views are designated as 'r' and optional views as 'o'. Field definitions for each of the Anasazi Tables can be found in the Anasazi Products Tables Manual. The Treatment Plan Setup Views can be found in the Treatment Plan Product User Manual. The Assessment Setup Views may be found in the Setup section of this manual.

### *Anasazi Central Setup Views*

- Action Schedule Templates Table (o)
- Axis IV Diagnosis Table (r)
- Categories of Treatment Table (r) - If Categories of Treatment are activated in Staff Maintenance in Anasazi Central.
- Diagnosis Classes Table (o)
- Diagnosis Codes Table (r)
- Diagnostic Impressions Table (o)
- Document Types Table (o)
- Drug Classes Table (r) - If the Medication MEW or Medication Module is implemented. This Table should be populated with broad categories of medication.

- Drug Families Table (r) - If the Medication MEW or Medication Module is implemented. This Table should be populated with Drug Families, which are defined as categories within a Drug Class.
- Drug Manufacturers Table (r) - If the Medication MEW or Medication Module is implemented. This Table is used to manage Drug Manufacturers, which can be associated to medications via the Pharmacy Drugs Table.
- Drug Use Frequencies Table (r) - If the Drug Use MEW is implemented or an Assessment question uses the Table.
- Drug Use Methods Table (r) - If the Drug Use MEW is implemented or an Assessment question uses the Table.
- Drug Use Types Table (r) - If the Drug Use MEW is implemented or an Assessment question uses the Table.
- Generic Drugs Table (r) - If the Medication MEW or Medication Module are implemented or an Assessment question uses the Table.
- Medication Forms Table (r) - If the Medication MEW or Medication Module is implemented.
- Medication Frequencies Table (r) - If the Medication MEW or Medication Module is implemented.
- Medication Products Table (r) - If the Medication MEW or Medication Module is implemented.
- Medication Units Table (r) - If the Medication MEW or Medication Module is implemented.
- Offense Types Table (r) - If the Legal MEW is implemented or an Assessment question uses the Table.
- Pharmacy Drugs Table (r) - If the Medication MEW or Medication Module is implemented. This Table is used to manage entries for medication product names and associate them to generic medication names.
- SMI/SED at Risk Statuses Table (r) - If an Assessment question uses the Table.

### *Treatment Plan Product Setup Views*

- PGOIs Table (Problem, Goals, Objectives and Interventions) (r)
- Strengths Table (o)
- Problem Groups Table (o)
- Standard Text Table (o)
- Assessment/Treatment Plan Types Table (o)

### *Assessment Product Setup Views*

- Assessment Tables (r) - Some Tables used by the Assessment and Treatment Plan Product are accessible via a Menu (e.g., Referral Source Types Table) and are referred to as 'stand alone' Tables, while other Tables are accessible via the Assessment Tables View. The Tables in the Assessment Tables View are linked to Question objects in the WYSIWYG Design View (AS059EA). When a Question object in WYSIWYG is linked to a Table not found in this View of Assessment Tables, the list of available 'stand alone' Tables should be reviewed to determine those that may need to be added to the Menu.

- Assessment System Parameters Maintenance (r) - Used to manage settings that control the behavior of the Assessment Product.

- Client Table Types Maintenance (o) - The Client Table Types Maintenance View is where restricted versions of Multiple Entry Windows (MEWs) are created and the columns that display on-screen are defined. The initial installation of the Assessment Product includes the required Client Table Types Maintenance setup. Additional setup is covered during Advanced WYSIWYG training and a detailed description is provided in the Advanced WYSIWYG Training Manual.

## Discussion

The Anasazi Assessment Product provides functionality to add Clients to the system and to capture demographic and clinical Assessments through the Client's episode of care. While the actual content of Assessments varies by customer, the Assessment Product automates the collection of information during the clinical intake and assessment processes. A common intake and assessment process could include Assessments for Screening, Clinical Eligibility, Intake, Ongoing Reviews, Quality Assurance, Chart Management, Referral/Transfer and Discharge. Assessments are completed online, electronically signed and stored in an electronic medical record format.

The Assessment Product includes the WYSIWYG View, which offers center-level functionality to create and edit Assessment pages without requiring programming knowledge. Assessments are designed using questions from the Assessment Product Questions file. Different functionality is incorporated into each question type and impacts the formulation of the Prospective Strengths and Problems List as well as Client Progress Indicators and the system's ability to control question status.

The Prospective Strengths and Problems List can be built based on responses to questions on Assessments. A response can be linked to a problem on the Problem List. Clinicians will be prompted that a Problem is attached and given the option to place the problem on the Problem List.

Questions can also be used as Client Progress Indicators. The responses to questions can be set up to capture a history of their responses through the Client's episode of care.

Some question types may be used to control the status of other questions. A particular response to a Control Question can be set to require, enable or disable other questions.

There are nine question types:

- Radio Button - A multiple choice question that allows only one response to be selected from on-screen options. A Radio Button type question can be linked to the Problems List, added to the Client Progress Indicators List and can be designated as a Control Question.
- Checklist - A multiple choice question that allows the selection of multiple responses from options displayed on screen. A Checklist type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, and cannot be designated as a Control Question.
- Selection List - A multiple choice question that allows the selection of only one response from a table-driven selection list. A Selection List type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, but can be designated as a Control Question. If used as a Control Question, the IDs for the values in the table must each be a single character.
- Multiple Selection List - A multiple choice question that allows the selection of multiple responses from a table-drive selection list. A Multiple Selection List type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, and cannot be designated as a Control Question.
- Checkbox - A single option question that allows the user to check a box indicating a response. A Checkbox type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, but can be designated as a Control Question.
- Date - A question that only permits a response in date format (mmddyyyy). A Date type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, but can be designated as a Control Question. When a Date type question is used as a control question, it controls based on ‘blank’, ‘not blank’ rather than a specific date parameter.
- Numeric - A question that only permits a numeric response. A Numeric type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, but can be designated as a Control Question if the appropriate options are available upon edit. When a Numeric type question is used as a control question, it controls based on ‘blank’, ‘not blank’ rather than a specific numeric parameter.
- Short Text - A narrative question that permits the entry of 60 alpha-numeric characters. A Short Text type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, but can be designated as a Control Question if the appropriate options are available upon edit. When a Short Text type question is used as a control question, it controls based on ‘blank’, ‘not blank’.
- Narrative Text - A narrative question that permits the entry of approximately eight pages of text. A Narrative Text type question cannot be linked to the Problems List, cannot be added to the Client Progress Indicators List, and cannot be designated as a Control Question.

In addition to collecting information by question type, questions can be combined into Multiple Entry Windows (MEWs) on an Assessment to maintain a history associated with the type of information being captured. There are nine types of Multiple Entry Windows: Alias, Diagnosis, Drug Use, Education, Family/ Relationships, Immunization, Legal, Medication, and Treatment.

## *Client Chart*

The Client Chart is the View from which a Client's Assessments and Treatment Plans are managed. Information on the Client Chart is included in the Views section of this manual.

## *Clinician's Homepage*

The Clinician's Caseload appears on the Clinician's Homepage. Additionally, the Clinician's Homepage provides Clinicians with the following Notifications for each of the Clients on their Caseload:

- Routinely scheduled Assessment due;
- One-time Assessment requested;
- Assessment or Progress Note requires signature;
- Unplanned service provided;
- Treatment Plan Target/follow-up date approaching/past;
- Client Action due.

## Notifications

If there is at least one Notification for a Client, the Client is preceded with a red bang '**!**' (Notification) or a blue bang '**!**', which indicates an Alert. (As detailed in the Security section, Foreign Clients are always preceded with a red bang '**!**'.)

Notification Types:

- '**!** Form Pending Final Approval' (red bang) - If a Client has a Form that is not yet Final Approved and the selected Staff is the Client's SAI (for Assessments, ISLs, ITPs, and TPs, this only applies if the Logged-In Staff has COT Access to the Assessment). This also displays for Staff who is a signer on the Form until such time as they enter and save their electronic signature. Displays as one of the following:
  - 'Assessment Pending Final Approval'
  - 'Interim Treatment Plan Pending Final Approval'
  - 'Treatment Plan (may be appended with 'Revision' or 'Review') Pending Final Approval'
  - 'Informational Note Pending Final Approval'
  - 'Narrative Progress Note Pending Final Approval' (if Planned, appended with the description of the service specified for the Intervention; if Unplanned, appended with 'Unplanned')
  - 'Individual Progress Note Pending Final Approval' (appended with the description of the single Client service, and if Unplanned, appended with 'UnPlanned')
  - 'Multi-Service Progress Note Pending Final Approval' (if Planned, appended with the description of the service specified for the Intervention; if UnPlanned, appended with 'UnPlanned')
  - 'Group Progress Note Pending Final Approval' (if Planned, appended with the description of the service specified for the Intervention; if UnPlanned, appended with 'UnPlanned')

- '**!** *{Name of Assessment}* has been Final Approved *{Final Approved on date}*' (red bang) - CA Customers - When an Assessment of the type entered in the 'Diagnosis Notification Assessment' field on the Main (1) Tab Page of California System Setup is Final Approved. The Notification appears on the Homepage of each Staff Member for each Assignment that is open for the Client at the time the Assessment is Final Approved. The Notification is cleared by double-clicking on the Notification from the Homepage. For example, Server A clears the Notification in his Homepage. The Notification continues to appear on Server B's Homepage until she clears it from her Homepage. In addition, the Notification appears only one. For example, if an Assessment is completed on 10/1/2008 and the Homepage Notification has not been cleared, and the Assessment is completed again on 10/3/2008, only the 10/3/2008 Notification is displayed as a Notification, as it is the most recent Final Approved Assessment.

- '**!** Assessment Requested' (red bang) - If a Client has a pending Requested Assessment and the selected Staff is the Client's SAI. This only applies if the Logged-In Staff has COT access to the Assessment.

- '**!** Target Date Approaching/Past' (red bang) - For all current Final Approved Full Treatment Plans that have a date entered in the PGO 'Target' field that is approaching/past the 'Notify of PGO Target Dates in the next ## Days' entered in Assessment System Parameters Maintenance, whose 'Status' is 'A - Active' and the selected Staff is the Client's SAI. This only applies if the Logged-In Staff has COT access to the Assessment.

- '**!** UnPlanned Progress Note' (blue bang) - A Client with a TP (not an ISL or ITP) has an UnPlanned Progress Note entered that is Final Approved, was entered by someone other than the Client's SAI, the selected Staff is the Client's SAI, and the UnPlanned Note has not yet been acknowledged.

- '**!** Glass Broken' (red bang) - The selected Staff is the Clinician who Broke the Glass; the Expiration Date is greater than or equal to the current date; and the Dialog was not canceled after having entered information into the top container (a Client was selected).

- '**!** Pre-Intake in Process' (red bang) - There are three ways in which a Pre-Intake Client can be included on a Clinician's Homepage:
  - Foreign Clients who have an Open Pre-Intake at a Unit/SubUnit to which the selected Staff is a Pre-Intake Worker.
  - Foreign Clients who have an Open Pre-Intake that was initiated by the selected Staff.
  - Foreign Clients who have an Open Pre-Intake that is referred to the selected Staff.

- **!** Client Action Notification (red bang) - displays as one of the following (details follow):
  - '1st' Client Action Due
  - '2nd' Client Action Due
  - 'Ongoing' Client Action Due
  - 'Final' Client Action Due
  - 'Action Schedule Audit Pending'

  - Assessment Due on - If the Scheduled Client Action Type is Assessment, the Notification displays as: **!** (red bang); the Sequence of the Scheduled Client Action; Assessment Due on; the Due Date of the Client Action; the name of the Assessment and the ID of the Action Schedule Template.

*Privacy Note: This Notification only displays if the Logged In Staff has COT Access to the Assessment.*

- Assessment Page Due on - If the Scheduled Client Action Type is Assessment Page, the Notification displays as: **!** (red bang); the Sequence of the Scheduled Client Action; Assessment Page Due on; the Due Date of the Client Action; the name of the Assessment Page and the ID of the Action Schedule Template.

  *Privacy Note: This Notification only displays if the Logged In Staff has COT Access to the Assessment Page.*

- ISL Due on - If the Scheduled Client Action Type is an Interim Service Log, the Notification displays as: **!** (red bang); the Sequence of the Scheduled Client Action; ISL Due on; the Due Date of the Client Action; the name of the ISL and the ID of the Action Schedule Template.

  *Privacy Note: This Notification only displays if the Logged In Staff has COT Access to the ISL.*

- ITP Due on - If the Scheduled Client Action Type is an Interim Treatment Plan, the Notification displays as: **!** (red bang); the Sequence of the Scheduled Client Action; ITP Due on; the Due Date of the Client Action; the name of the ITP and the ID of the Action Schedule Template.

  *Privacy Note: This Notification only displays if the Logged In Staff has COT Access to the ITP.*

- TP Due on - If the Scheduled Client Action Type is a Treatment Plan, the Notification displays as: **!** (red bang); the Sequence of the Scheduled Client Action; Treatment Plan Due on; the Due Date of the Client Action; the name of the Treatment Plan and the ID of the Action Schedule Template.

  *Privacy Note: This Notification only displays if the Logged In Staff has COT Access to the TP.*

- Financial Review Due on - If the Scheduled Client Action Type is a Client Financial Review, the Notification displays as: **!** (red bang); the Sequence of the Scheduled Client Action; Financial Review Due on; the Due Date of the Client Action and the ID of the Action Schedule Template.

- Action Schedule Audit Pending - This Notification displays if the Action Schedule Audit flag is active for the Client. This flag indicates that a Staff Member should audit the Client's Action Schedule to affirm that it is appropriate, or alternately, update it such that it is appropriate. This occurs when the system determines that there is no clear call as to what Client Action Schedule a completed Client Action should be linked to. The system either updates the Client's Action Schedule based on a reasonable guess as to what is appropriate or it does not update the Client's Action Schedule because the system cannot reasonable determine what is appropriate.

  When the Audit Flag is set for a Client, only the 'Action Schedule Audit Pending' Notification displays on the Clinician's Homepage; no other Client Action Notifications display. (Note: the Client Schedule Audit Flag is cleared via the Client Action Schedules Maintenance View.)

*Notes about Client Action Notifications on the Clinician's Homepage*

- When an Assessment, Assessment Page, ISL, ITP or Treatment Plan Client Action Notification is double-clicked on from the Clinician's HomePage, the Client Chart is launched for the selected Client, with the Client Chart Lookup displayed.

  *Note: launching is disabled if:*

  - *Running in Network Mode and the Client is currently Checked Out to a laptop.*
  - *If the Client Chart is already displayed and another Client is selected and not in Home Folder Mode (i.e., the Logged In Staff is in the middle of doing something with another Client).*

- When a Client Financial Review Client Action Notification is double-clicked on from the Clinician's Homepage, the Client Financial Review is launched as if it was launched from the menu.

- All Scheduled Client Action Notifications (except for the Action Schedule Audit Pending Notification - noted below) display if the Client has a Scheduled Client Action that is Pending that falls within the 'Action Notification Days Span' (as entered in Center Setup (2)) and:

  - The Selected Staff is the Client's SAI (subject to latency);
    - OR -
  - For Automatically Scheduled Client Actions, the Action Schedules Template indicates that the Client Action should be reported to All Servers at All Assignments; and
  - It is a Hand Scheduled Client Action.

## Treatment Teams

Establishing Treatment Teams is a means to indicate each of the Staff Members who are treating a Client. More specifically, a Treatment Team is a list of Staff Members who belong to a named team (e.g. Team A). Clients who are being treated by a Treatment Team appear on the Caseloads of each of the Treatment Team's Staff Members. For more information on Treatment Teams, see the Anasazi Software Client Data Assignments Manual.

## Clients Lookup Dialog

The Clients Lookup Dialog is covered in the Anasazi Products Navigation Guide. Additional functionality from the Clients Lookup Dialog that is available in the Assessment Product, and is covered in this manual, includes:

- Print Client Assessments - Allows printing Assessments in a Client's chart by date ranges.

- Add/Edit Clients - A dialog to add/edit Clients.

## Break the Glass

The Assessment and Treatment Plan Products provide a means to ‘Break the Glass’. Breaking the Glass is a means to - in a crisis situation - put a particular Client on a Staff Member's Homepage who ordinarily would not be displayed. The Break the Glass Dialog is available from the 'Break the Glass' button on the Clinician's Homepage. By clicking the ‘Break the Glass’ button on the Clinician’s Homepage and entering the required data, the Logged-In Staff who clicked the ‘Break the Glass’ button obtains access to information about the Client - the Client appears on the Logged-In Staff’s Homepage. Specifically, the Client entered in the ‘Client’ field in the Break the Glass Dialog appears on the Logged-In Staff’s Homepage. It is then expected that the Clinician will take some other action (e.g. open an Assignment) to keep the Client on the Clinician’s Homepage.

## *Security*

Navigating to another Staff’s Homepage circumvents Security, to a degree, for the Logged in Staff (the specific intent is to give a Staff Member access to Clients that he/she might not otherwise have access to). However, the only Security Level that will be circumvented is Client Access. No other Security Level (e.g. Category of Treatment) will be compromised. To this end, the only portal through which another Staff’s Clients can be accessed is through the Clinician’s Homepage - by navigating to his/her Homepage. Doing so allows the Logged-In Staff to see a list of the other Staff’s Clients, and some (but maybe not all) Notifications about those Clients. Further, double-clicking a Client launches the Client Chart View with the Client loaded. This covers two points at which Client Access is circumvented:

- On the Clinician’s Homepage, a Staff Member may see a list of another Staff Member’s Clients by navigating to his/her Homepage.
- The Assessment and Treatment Plan Products may then be launched with one of those Clients pre-loaded (bypassing the normal Client Selection controls of the Assessment and Treatment Plan Products). However, once in the Assessment and Treatment Plan Products, all Security is subject to the Logged-In Staff’s access, not the Staff for whose Homepage was selected.

When the Clinician’s Homepage is first displayed, the Logged-In Staff displays in the ‘Homepage for’ field, with their Caseload displayed in the Tree.

- Any Staff Member may be selected if the Logged-In Staff Member is a Clinical Administrator.
- Staff that are subordinate to the Logged-In Staff Member as defined in Supervisory Tree Maintenance may be selected.
- Staff to whom the Logged-In Staff Member has been provided Homepage Guest Access as defined in Home Page Guest Access Maintenance may be selected.

Clients that are on the Selected Staff’s Caseload display as follows:

- Clients who have an Open Assignment for which the Selected Staff is or was the Server at any point within the Latency Period (specified in the ‘Assignment Close Latency Days’ field in Security Parameters Maintenance, described in the Anasazi Products System Administrator Manual) or a Member of the Assignment’s indicated Treatment Team at any point within the Latency Period.

- Clients who have a Closed Assignment that was closed within the Latency Period for which the Selected Staff was the Server at any point within the Latency Period or a Member of the Assignment's indicated Treatment Team at any point within the Latency Period.

Foreign Clients (not on the selected Staff's Caseload) will always be preceded with a red bang as '**!**'. They may appear on the Clinician's Homepage for one or more of the following reasons:

- 'Form Pending Final Approval' - Foreign Clients who have a Form that is not yet Final Approved for which the selected Staff is a signer on the Form (for Assessments, ISLs, ITPs, and TPs, this only applies if the Logged-In Staff has Category of Treatment (COT) Access to the Assessment).

- 'Glass Broken' - Foreign Clients for the selected Staff for whom the Glass has been broken. These Clients display with '(glass broken)' appended.

- 'Pre-Intake' - Foreign Pre-Intake Clients for the selected Staff. (Note: Pre-Intake Clients display with 'Pre-Intake' appended without regard to whether or not they are Foreign Clients.)

- 'Client Guest Access' - Foreign Clients (who are still on the Server's Caseload - subject to latency) for which the selected Staff has active Client Guest Access. These will display with '(guest access)' appended to the end. Criteria:

    - Client Guest Access has been granted to the selected Staff via Client Guest Access Maintenance.
    - Client Guest Access has not been Voided for the Selected Staff.
    - Client Guest Access for the selected Staff is greater than or equal to the Client Guest Access Begin Date as established in Client Guest Access Maintenance.
    - The current date is less than or equal to the Client Guest Access Expiration Date as established in Client Guest Access Maintenance + the Guest Access Latency Days value specified in Security Parameters Setup.

## *Treatment Sessions and Assignments*

The Client Chart and Clinician's Homepage contain buttons to allow for adding Client Treatment Sessions and Assignments. Adding Treatment Sessions and Assignments has special considerations related to privacy and security in that Staff Members commonly cannot access Clients that are not on their Caseload, and as such cannot put Clients on their Caseload. (Note: editing Assignments and Treatment Sessions has no special considerations; this activity is controlled by the common privacy/security controls.) To accommodate this, Menu Groups allow for designating that Staff:

- May add Treatment Sessions and Assignments for all Clients;

- May not add Treatment Sessions and Assignments for Clients; or

- May only add Treatment Sessions and Assignments for Clients on the Staff Member's Caseload/ Homepage.

The buttons for 'Client Treatment Sessions Maintenance' are shadowed if the Staff Member does not have Menu Access to the Client Treatment Sessions View. The buttons for 'Client Assignments Maintenance' are shadowed if the Staff Member does not have Menu Access to the Client Assignments View.

If the Staff Member has rights to add Assignments and Treatment Sessions for all Clients, then the Staff member's normal Client Access is overridden when adding Treatment Sessions and Assignments. That is, a Client's Name or Case Number may be entered directly into the 'Client' field on the Client Chart to access a Client who is not on the Staff Member's Caseload. However, the Clients Lookup Dialog still only displays Clients according to the Staff Member's Client Access.

Once a Client is selected in the Client Assignments Maintenance View, only Assignments to Unit/SubUnits to which the Staff Member has access are displayed.

## Client Assignments Maintenance

When accessing Client Assignments Maintenance from the Client Chart View or the Clinician's Homepage, the following applies:

- The 'Add' button is shadowed if the selection to the 'Except the Staff' field in Menu Group Maintenance is 'N - May not add Treatment Sessions and Assignments for Clients'.
- The 'Add' button is shadowed if the selection to the 'Except the Staff' field in Menu Group Maintenance is 'O - May only add Treatment Sessions and Assignments for Clients on the Staff Member's Caseload/ Homepage' if the selected Client is not on the Staff's Caseload (subject to latency) nor would appear as a Foreign Client on the Staff's Homepage.
- If the selection to the 'Except the Staff' field in Menu Group Maintenance is 'A - May add Treatment Sessions and Assignments for all Clients', any Client may be selected (but the Client Lookup will nonetheless be constrained as normal).
- If the selection to the 'Except the Staff' field in Menu Group Maintenance is 'O - May only add Treatment Sessions and Assignments for Clients on the Staff Member's Caseload/Homepage', Clients may be selected (that would not ordinarily be allowed to be selected) that are on the Staff's Caseload (subject to latency) or that would appear as a Foreign Client on the Staff's Homepage.
- When launched from the Client Chart View or the Clinician's Homepage View without a passed Client, the Client Assignments View is launched in the normal fashion, according to access rights. However, if a Client is passed, the Client Assignments View is launched with that Client displayed. This circumvents the normal Client Access control.
- In all cases, if a Client is selected that would not normally be allowed to be selected, the list of Assignments will display in the normal fashion and the degree of access to those Assignments will be as normal, but the 'Edit' and 'Delete' buttons will be shadowed.
- Launching Treatment Sessions from this view will pass the Client without regard to how the Client was selected.

## Client Treatment Sessions Maintenance

When accessing Client Treatment Sessions Maintenance from the Client Chart View or the Clinician's Homepage, the following applies:

- The 'Add' button is shadowed if the selection to the 'Except the Staff' field in Menu Group Maintenance is 'N - May not add Treatment Sessions and Assignments for Clients'.
- The 'Add' button is shadowed if the selection to the 'Except the Staff' field in Menu Group Maintenance is 'O' - May only add Treatment Sessions and Assignments for Clients on the Staff Member's Caseload/Homepage' if the selected Client is not on the Staff's Caseload (subject to latency) nor would appear as a Foreign Client on the Staff's Homepage.
- If the selection to the 'Except the Staff' field in Menu Group Maintenance is 'A - May add Treatment Sessions and Assignments for all Clients', any Client may be selected (but the Client Lookup will nonetheless be constrained as normal).
- If the selection to the 'Except the Staff' field in Menu Group Maintenance is 'O - May only add Treatment Sessions and Assignments for Clients on the Staff Member's Caseload/Homepage', Clients may be selected (that would not ordinarily be allowed to be selected) that are on the Staff's Caseload (subject to latency) or that would appear as a Foreign Client on the Staff's Homepage.
- When launched from the Client Chart View or the Clinician's Homepage View without a passed Client, the Client Treatment Sessions View is launched in the normal fashion. If a Client is passed, the Client Treatment Sessions View is launched with that Client displayed. This circumvents the normal Client Access control.
- In all cases, if a Client is selected that would not normally be allowed to be selected, the list of Treatment Sessions will display, but the 'Edit' and 'Delete' buttons will be shadowed.

### *Pre-Intake*

Before an Assignment is opened for a new Client (or for a Client that was previously closed), the Client is not displayed on any Clinician’s Homepage. Clients are generally initially entered into the product through a Pre-Intake Process, which is typically performed by a defined set of Pre-Intake Workers - potentially at a defined set of Units/SubUnits. Staff Members who are considered to be Pre-Intake Workers are designated as such in Staff Maintenance. Staff Members may be designated as a Pre-Intake Worker at all Units/SubUnits, or only for specific Units/SubUnits. Staff Members who are designated as Pre-Intake Workers have the ability to initiate a ‘Pre-Intake’ for a Client, which:

- Indicates that a chosen Client is in the Pre-Intake process;
- Allows for optionally designating a Pre-Intake Unit/SubUnit; and
- Allows for optionally designating a Refer to Pre-Intake Staff Member.

Clients who are in the Pre-Intake process display on the Homepage of:

- The Staff Member who initiated the Pre-Intake;
- Staff who are designated as Pre-Intake Workers at a Unit/SubUnit to which the Client was (optionally) referred; and
- The Staff Member to whom the Client was (optionally) referred.

Having the Client on a Homepage generally grants rights to that Staff Member to open an Assignment for the Client (and as such to permanently place the Client on a Caseload/Homepage). Opening an Assignment for a Client that is in the Pre-Intake process will then automatically close the Client's Pre-Intake. Pre-Intakes may also be manually closed (e.g. because the Client no-shows).

Note: The Intake Worker designation does not control if the Staff Member can add new Clients, nor add Treatment Sessions and Assignments for Clients, nor does it override any other Privacy/Security controls that are established for the Staff Member.

### *Assessment Signatures*

A signature group is included on at least one page in each Assessment as a means of electronically signing an Assessment. Two types of signature groups are available: standard and professional. Credentials may be attached to any signature group to restrict the electronic signature by credential. Signature groups can be set to clear if changes are made to an Assessment after electronic signature, but before final approval. Signature groups can be set to be required. At least one Signature Line ‘Name’ must be entered in order to save a record.

### *Client Signatures*

Assessment and Treatment Plan pages may include a Client Signature Group. When these pages are completed through the Client Chart View, the Client’s name is automatically displayed to the Client Signature Line (and may not be changed). Clicking the ‘Yes’ radio button next to the Client Name indicates that the Staff is attesting that the Client (or Parent/Guardian) signed the page on paper. Doing so displays the Password Dialog, at which the Staff enters their password. At that time, the Signature Line is date and time stamped, and the Client Signature Line is considered to be complete.

## Client Signature Pad Functionality

Electronic Client Signatures can be obtained through a Signature Pad device that is connected to the system. Signatures obtained in this manner are displayed to the Client Signature Dialog the way they were entered by the Client (or Parent/Guardian). Details pertaining to Signature Pad Devices and instructions for installation are covered in detail in the Anasazi Signature Pad Approved Devices and Installation Instructions document.

### *Document Management*

The Document Management Functionality provides the means for Staff to securely capture, retain and present Client specific foreign (i.e., paper, non-Anasazi) documents within the Client Chart. Specifically, it provides a means to electronically store paper records that would normally be a part of the Client's paper chart such that a comprehensive Electronic Health Record can be attained. Examples of foreign documents include (but are not limited to) lab results, referral documents, clinical documents from external doctors and hospitals (e.g., discharge summaries), legal documents (e.g., court orders), documents from schools, and paper forms that are completed/signed at the Center (e.g., consent for treatment).

Foreign documents can come into the Center in paper form, or electronically (such as through e-mail). The Anasazi Document Management functionality accommodates attaching both paper and electronic documents.

## Client Attachments Dialog

The Client Attachments Dialog allows for listing, displaying, printing and exporting existing Attachments, as well as scanning, importing and routing new Attachments.

Attachments can optionally be associated to a specific Assessment or Treatment Plan. For example, a hospital discharge summary might be linked to an Intake Assessment.

## Scanning Documents

### *Local Scanning*

Local scanning is when a document is immediately scanned into the system when it arrives at the Center by Staff who has first-hand (or near first-hand) knowledge of the document. In this case, 'Tagging Information' relative to the document is entered (e.g., document type, document date, etc.). After scanning, the document immediately appears within the Client Chart.

> *Note: Local (real time) scanning does not require a scanner on every Staff Member's desk, nor that Clinicians personally scan the documents. It may be that only certain Staff, such as Intake Staff, have a scanner on their desk, or that there are one or more shared scanners at a location. With a shared scanner approach, documents are still considered to be scanned 'locally', or 'real time' (i.e., they are not 'routed' to a central location to be scanned after-the-fact). In this case, scanning could be performed by Administrative Staff who has (near) first-hand knowledge of the document.*

### *Centralized Scanning*

Centralized scanning is done after-the-fact, meaning that the document will be routed to and scanned by an individual who does not have first-hand knowledge of the document. As with Local Scanning, the 'Tagging Information' relative to the document is keyed prior to routing by the individual who has first-hand knowledge of the document. Tagging results in a unique Control Number that will be associated with the document once it is scanned into the system. The document is then routed to a central location to be scanned. At the central location, the document's 'Tag' is retrieved in the Client Attachments Dialog, and then the document is scanned.

*Note: Centralized (after-the-fact) scanning does not imply that considerable time will pass before the document is scanned. Rather, the centralized scanning concept addresses the scenario where the individual who does the scanning does not have first-hand knowledge of the document. Tagging information is immediately entered by a Staff Member who has the first-hand knowledge of the document (e.g., a Clinician). The document is subsequently scanned and linked (via the 'Tag' number) to the appropriate Tag information by another Staff Member, which could potentially be completed (almost) immediately.*

### *Bulk Scanning*

Bulk scanning is when multiple documents (multiple documents for multiple Clients) are scanned concurrently. That is, a large stack of documents are placed in the scanner document feeder. Bulk scanning is applicable to two scenarios: 1) a Center that has a large volume of centralized scanning, and 2) scanning historical documents (i.e., converting all paper charts to electronic media). Further, bulk scanning implies that the documents to be scanned have Tagging information affixed (preferably bar codes). With this approach, the scanner, and the related software, can automatically detect, separate and appropriately file the various documents.

## Importing Documents

Documents that have been received via electronic media (e.g., e-mail) can be imported. As with scanning, Tagging information is captured and retained with the resulting Attachment.

Following are the supported formats for importing:

- Animated GIF - Graphics Interchange Format
- BMP - Standard Windows Bitmap Format
- CUR - Microsoft Windows Cursor
- CUT - Dr. Halo/Dr. Genius Clipboard Format
- DDS - Microsoft Direct Draw Surface Format
- DIB - Standard Windows Bitmap Format
- EMF - Enhanced Windows Metaformat
- EXIF - Exchangeable Image Format
- EXR - OpenEXR Format
- FAX G3 RAW - Group 3 Fax Format
- GIF, Interlaced GIF - Graphics Interchange Format
- HDR - High Dynamic-Range Format
- IFF - Interchange Format
- ICO - Icone Format
- J2K, J2C - PPEG-2000 Codestream
- JBG, JBIG - Joint Bi-level Image Experts Group
- JIF, JFIF - JPEG File Interchange Format
- JNG - JPEG Network Graphics

- JP2 - JPEG-2000 Format
- JPEG, JPG, JPE - Joint Photographic Expert Group
- KOA - KOALA Format
- LBM - Interchange File Format-Interleaved Bitmap
- MNG - Multiple-image Network Graphics
- PBM - Portable Bitmap File
- PBM RAW - Portable Bitmap BINARY
- PCD - Kodak Photo-CD File
- PCX - PC Paintbrush Format
- PDF - Portable Document Format
- PDF/A - Document Format for Long Term Preservation
- PDF Multipage - Portable Document Format
- PGM - Portable Graymap File
- PGM RAW - Portable Graymap BINARY
- PSD - Photoshop File
- PNG - Portable Network Graphics Format
- PNM - Portable Any Map
- PPM - Portable Pixmap File
- PPM RAW - Portable Pixmap BINARY
- RAS - Sun Raster Format
- RAW Memory Bits - RAW Bitmap
- RLE - Standard Windows Bitmap Format
- SGI - Silicon Graphics Image Format
- TGA - TARGA Image Format
- TIFF - Tagged-Image Format
- TIFF Multipage - Multipage Tagged-Image Format
- WBMP - Wireless Bitmap
- WMF - Standard Windows Metaformat
- XBM - X-Bitmap Format
- XPM - X Pixmap Format

## Exporting Documents

Documents that have been scanned or imported can also be exported. The file name is created by the system, as follows: Tag # + Client ID + week exported + year exported. Scanned documents that are exported are created as PDF files; imported documents are created in the format that they were originally imported as.

## Routing Attachments

The Routing Attachments functionality accommodates the routing of paper documents to a central location to be scanned. As with scanning, Tagging Information is captured, but the document is not immediately scanned. Rather, a unique Control Number is affixed to the document, and when the document is (centrally) scanned, the Control Number is used to link the document to the appropriate Tag.

There are two methods for obtaining a unique Control Number for documents that are accommodated:

- Automatically generate a unique Control Number (from a system counter). The Control Number would then be affixed to the document to be scanned in one of two fashions:
    - Hand written on the document (or on a label to be affixed to the document); or
    - Printed on a cover sheet to be affixed to the document. With this approach, the cover sheet will include the unique Control Number as well as the Tagging Information to aid in confirmation when the document is centrally scanned. In addition, a bar code could be used to support bulk scanning requirements.

- Using pre-printed labels with unique Control Numbers. In this case, the Control Number from the pre-printed label is entered at the time the Tagging Information is entered (rather than being automatically generated). The label could be inclusive of a bar code, which could then be used to support bulk scanning requirements.

## Privacy/Security

Attachments are only displayed to Staff who have the appropriate Category of Treatment (COT) Access. If a Tag record is associated with an Assessment/Treatment Plan, COT Access is based upon the COT associated with that Assessment/Treatment Plan Type record. Otherwise, COT Access is based upon the COT associated with the Tag's Document Type. For details on Categories of Treatment, refer to the Anasazi Products System Administrator Manual.

## Access to Document Management Functionality

Attachments functionality can be exposed or hidden in the system, and the documentation path managed, within Assessment System Parameters Maintenance.

The ability to view, add/edit or delete Attachments is controlled by the selection in the 'Attachments' field in the Assessment and Treatment Planning Access Dialog. (Refer to the Anasazi Software System Administrator Manual for details on the Assessment and Treatment Planning access Dialog.) Access can be set to one of the following:

- '1 - Show' - allows for viewing Tags via the Client Attachments Dialog (i.e., Staff cannot add new Tags, edit or delete existing Tags, scan or import documents or void Tags with attached documents). Tags are the labels that identify the document.

- '2 - Add/Edit' - allows for adding and editing Tags as well as scanning, importing and exporting documents via the Client Attachments Dialog.

- '3 - Delete' - allows for adding and deleting Tags, deleting Tags without attached documents, as well as scanning, importing and exporting documents via the Client Attachments Dialog.

- ‘4 - Admin’ - allows for adding and editing Tags, deleting Tags without attached documents, voiding Tags with attached documents, as well as scanning, importing and exporting documents via the Client Attachments Dialog.

## *Help Text*

Help Text that is user definable can be entered and displayed for all questions as well as text lines on an Assessment page.

## *Diary of Changes*

Diary of Changes pages may be added to Assessments to capture a history of on-line access to an Assessment. Each entry on the Diary of Changes Page displays the following information: the date and time for which the entry was made, the Staff Member associated with the entry, the action that triggered the entry, and any comments that were recorded regarding the Diary entry.

Following are the actions that cause an entry to be made to the Diary of Changes:

- Editing, Voiding, Revising, Final Approving an Assessment - A comments field is required if changes are made to the Assessment. If no changes are made, the comments are optional and the system automatically includes the text ‘no changes’.

- Electronic Signature - Whenever an Assessment is electronically signed, the system automatically records an entry in the Diary. If the Date, Time or Server are not the current date and time and Logged-In Server, the system also records this information.

- If an electronic signature is cleared during a session, either manually or for a clearable signature when a response is changed, information about the clear is automatically appended to the text message for the session.

- Viewing a Final Approved Assessment - An Assessment can be set up so that an entry is made in the Diary automatically each time it is viewed after it has been Final Approved. Along with date, time and Logged-In Staff Member, the Diary states whether the operator is currently on the Client's Treatment Team.

- Printing an Assessment - If an Assessment is set up so that a Diary entry is made each time the Assessment is viewed, an entry will also be made each time the Assessment is auto-printed.

- Checking Out and Checking in to Laptop - When an Assessment that contains a Diary of Changes Page is downloaded to a laptop, an entry is made in the Diary. When an Assessment is uploaded to a laptop, all Diary entries made on the laptop are appended to the Diary entries currently found on the server.

- Add a Page to an Assessment - When a page is added to an Assessment, an entry is made in the Diary that includes the name of the page added.

- Combine Clients - When Client records are combined via the Anasazi Central Combine Clients utility.

## *Assessments and Billing*

Certain Assessments contain information that affects billing. In particular, at least one diagnosis within the Diagnosis Review has to match up with the restrictions that are set in the ‘Diagnosis Types’ field and/or the ‘Diagnosis Billing Types’ field the Claim Diagnosis Tab Page of the Benefit Plans Table. Checkbox fields that define what diagnoses will be *printed* on the Claim are on the Claim Diagnosis Tab Page of the Benefit Plans Table.

In addition, Suspense Codes ‘A - No Valid Diagnosis’ and ‘B - No Diagnosis of Billing Type’ on the Suspense (A-M) Tab Page will suspend services from claiming if at least one Diagnosis does not match up, and they also respect the Diagnosis Types and/or Diagnosis Billing Types settings on the Claim Diagnosis Tab Page. If Suspense Code A or B has the ‘On Date of Service’ field active, then the ‘qualifying diagnosis’ (based on the settings on the Claim Diagnosis Tab Page) in the Diagnosis Assessment must be dated in effect (i.e., within the Begin and End dates) on the date of service, and the system will look for historic Diagnosis Review records up to the most recent to try to find a match based on the Service Date. If the ‘On Date of Service’ field is inactive, the system looks to the most recent Diagnosis Review and the diagnoses that are active there.

Diagnosis Reviews are designed to be cumulative, historical records in the sense that typically once a diagnosis code is included in a Review, it continues to ‘roll forward’ into the next new, added Review in either an active status, or with an end date (an inactive status). For purposes of billing, the system always looks to the most recent Diagnosis Review record, and takes into consideration all of the Diagnosis Codes included as well as their date ranges. As noted above, this can vary slightly based on whether the Benefit Plan has Suspense Code A or B active, and whether the associated ‘On Date of Service’ fields are active.

In light of this, care must be taken when deleting or ‘back dating’ an Assessment, as doing so can affect billing. Assessments (Diagnosis Assessments in particular) need to be entered in chronological order. If an Assessment was incomplete or incorrect when it was first entered, it must be voided and re-entered in order to maintain the integrity of the data to ensure that all of the appropriate information ‘rolls forward’ as new Assessments are entered. For example: a Diagnosis Assessment was entered in February with Diagnosis A active. On October another Diagnosis Assessment is entered where Diagnosis A is ended and Diagnosis B is added. In December, a Diagnosis Assessment *dated June* with Diagnosis A is active and Diagnosis C active. Because Diagnosis B was added in October, it does not appear (did not ‘roll forward) on the Assessment entered in December because it was ‘back dated’ as June (before Diagnosis B was made active).

## *Diagnosis Reviews*

Diagnosis Reviews are typically entered in order, as information defaulted on subsequently entered Assessments/Treatment Plans is based upon information that has most recently been Final Approved - not based upon information from Assessments/Treatment Plans with the most recent Review Date. A system flag, ‘Warn if Diagnosis Review is added out of order’, is available in Assessment System Parameters Maintenance to optionally warn Staff in situations where Assessments/Treatment Plans that contain Diagnosis Review Pages are added out of order (e.g., the Review Date of the Assessment/Treatment Plan being added is on the same date as the Review date of an existing Assessment/Treatment Plan).

## Client Chart

### Add Assessment/Treatment Plan Algorithm

The test below occurs after the test for existing Non-Final Approved Pages when the 'Multi Open OK' field for the Page is inactive in the Enter/Edit Page Dialog accessed via WYSIWYG (where multiple pages with the same Page ID cannot co-exist in a Non-Final Approved status at the same time):

- When adding an Assessment/Treatment Plan, if the 'Warn if Diagnosis Review is added out of order' field is active in Assessment System Parameters Maintenance:
  - If the Assessment record being added contains a Diagnosis Review Page and a non-Final Approved Assessment record already exists that contains a Diagnosis Review Page, the following Confirmation Dialog presents:
    - '<*Client*> has a non-Final Approved <Assessment> dated <*Assessment Date*> that contains a Diagnosis Review Page. Continue with potential out of sequence addition of <*Assessment*> dated <*Assessment Date*>?'
      - If 'Yes' is selected, the Add process continues.
      - Otherwise, focus is returned to the Client Chart (after closing the Client Lookup, if open).
  - Otherwise, if the Assessment being added contains a Diagnosis Review Page and a non-Voided Final Approved Assessment record already exists that contains a Diagnosis Review Page with an Assessment date that is greater than the date specified for the record being added, the following Confirmation presents:
    - '<*Client*> has a more recent <*Assessment*> dated <*Assessment Date*> that contains a Diagnosis Review Page. Continue with out of sequence addition of <Assessment> dated <Assessment Date>?'
      - If 'Yes' is selected, the Add process continues.
      - Otherwise, focus is returned to the Client Chart (after closing the Client Chart Lookup, if open).
  - Otherwise, the Add Assessment/Treatment Plan Algorithm continues.
- Otherwise, the Add Assessment/Treatment Plan Algorithm continues.

### Add Page Algorithm

The test below occurs after the test for existing Non-Final Approved Pages when the 'Multi Open OK' field for the Page is inactive in the Enter/Edit Page Dialog accessed via WYSIWYG (where multiple pages with the same Page ID cannot co-exist in a Non-Final Approved status at the same time).

- When adding a Page, if the 'Warn if Diagnosis Review is added out of order' field is active in Assessment System Parameters Maintenance:

- If the Page record being added is a Diagnosis Review Page and a Non-Final Approved Assessment record already exists that contains a Diagnosis Review Page, the following Confirmation Dialog presents:
  - '<*Client*> has a Non-Final Approved <*Assessment*> dated <*Assessment Date*> that contains a Diagnosis Review Page. Continue with potential out of sequence addition of <*Assessment*> Page?'
    - If 'Yes' is selected, the Add process continues.
    - Otherwise, focus is returned to the Assessment/Treatment Plan (without adding the Page).
- Otherwise, if the Page record being added is a Diagnosis Review Page and a Non-Voided Final Approved Assessment record already exists that contains a Diagnosis Review Page with an Assessment date that is greater than the date specified for the record being added, the following Confirmation Dialog presents:
  - '<*Client*> has a more recent <*Assessment*> dated <*Assessment Date*> that contains a Diagnosis Review Page. Continue with out of sequence addition of <*Assessment*> Page?'
    - If 'Yes' is selected, the Add process continues.
    - Otherwise, focus is returned to the Assessment/Treatment Plan (without adding the Page).
- Otherwise, the Add Page Algorithm continues.

◆ Otherwise, the Add Page Algorithm continues.

## *Client Profile Views*

### Show Client Medications

The Show Client Medications View displays Final Approved medications for a selected Client.

*Note that the Client Medications Listing is also available, which reports on data entered in the Doctor's Homepage Product related to Client Medications. Refer to the Doctor's Homepage Product User Manual for information on this report.*

## *Utilities*

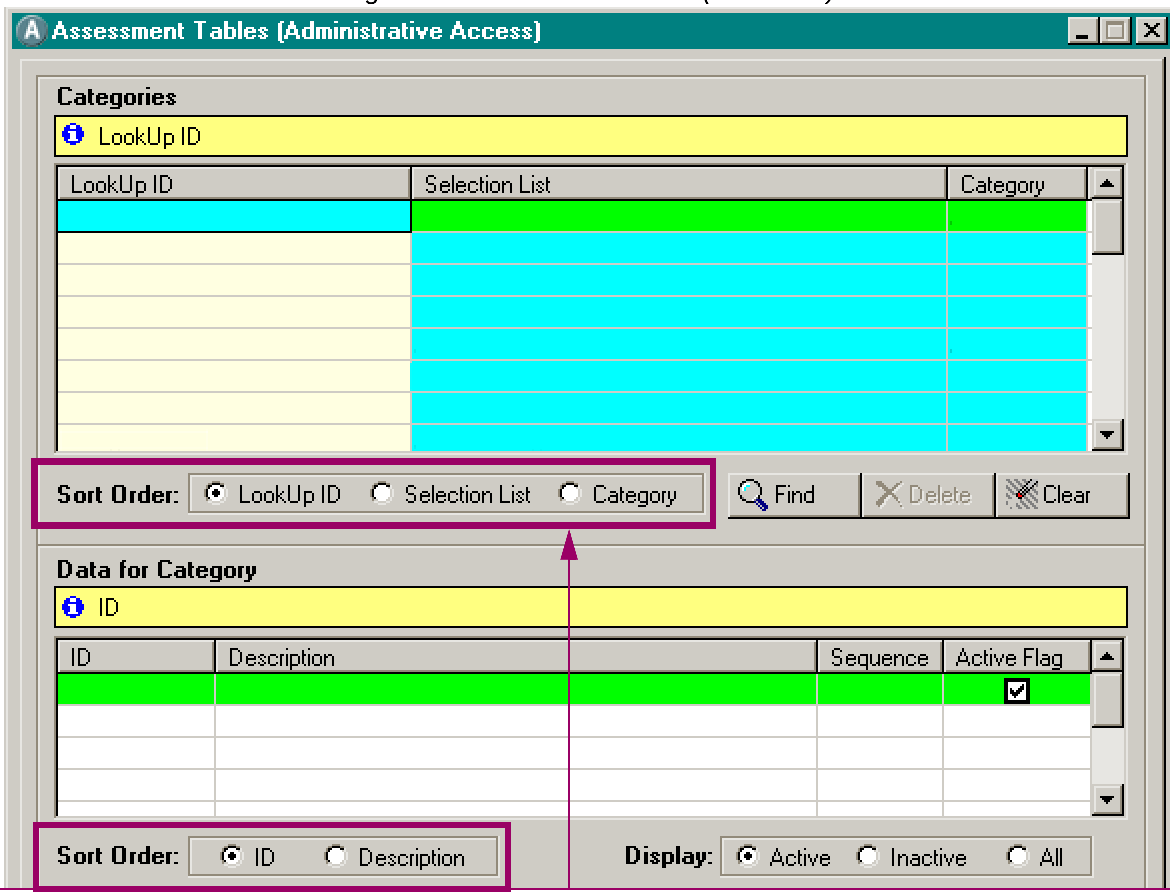
### Reset Assessments

The Reset Assessments View allows Staff to remove red locks created when the Assessment and Treatment Plan Products are shut down with an Assessment open.

# SETUP

## Assessment Tables

*Figure 1 - Assessment Tables (AS026EA)*



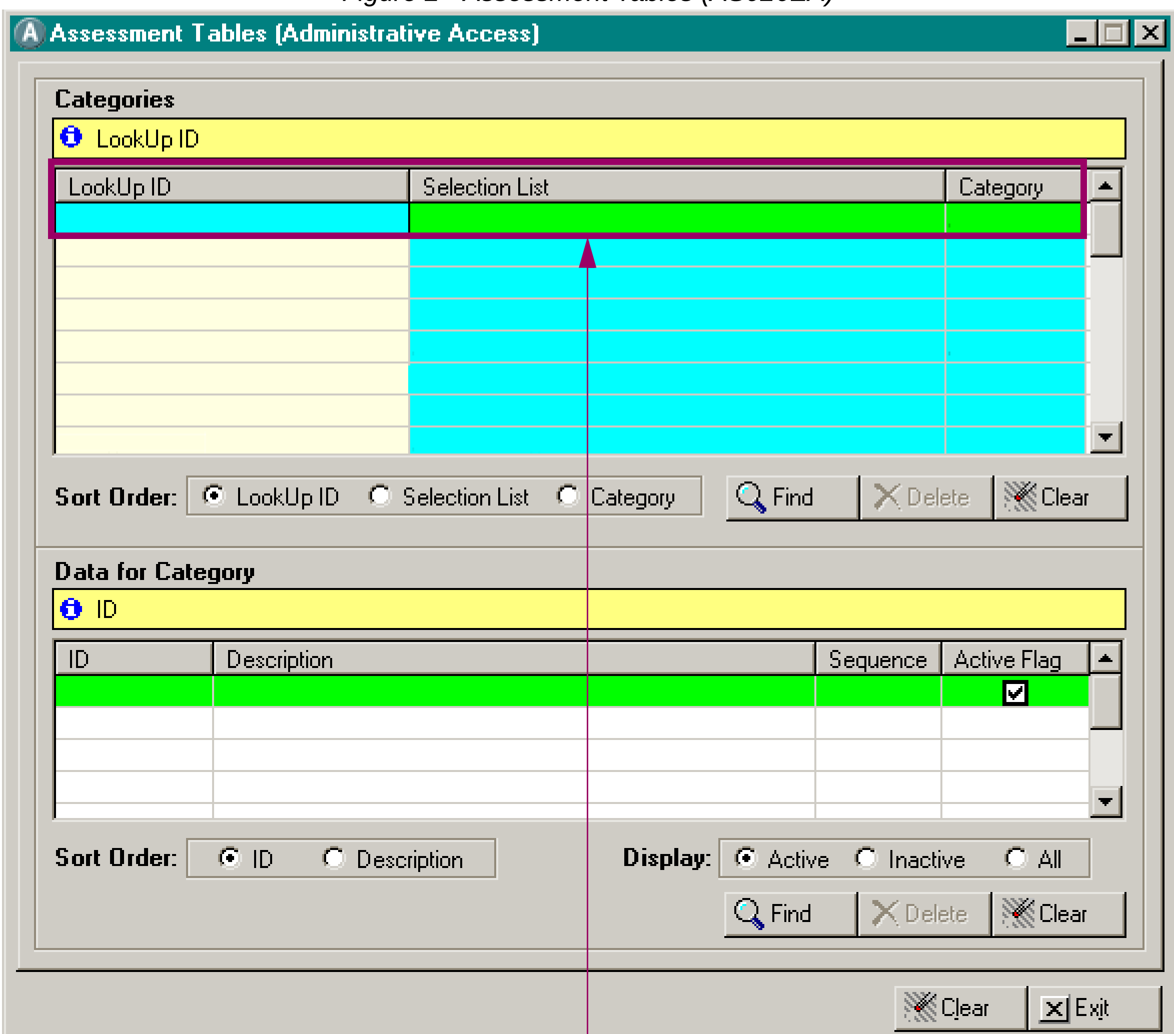

- Immediately after launching this View, a 'Sort Order' should be selected so as to avoid the accidental editing of data in the field where focus defaults. Sort Order options for the Categories container at the top of the View are by 'LookUp ID', 'Selection List' or 'Category'. Sort Order options for the Data for Category container at the bottom of the View are by 'ID' or 'Description'.

- A new entry can be created (in both the upper Categories container and the lower Data for Category container of the View) by placing focus in the next available empty row. It is recommended that Staff practice with Assessment Tables in an alternate environment (Test, Train, Test2, Test3) prior to completing work in the Live environment to become familiar with the entry process.

- Entries in this Table (in both the upper Categories container and the lower Data for Category container of this View) are saved by tabbing completely through the line, since each selection is a Grid entry type.

# Assessment Tables - Cont'd

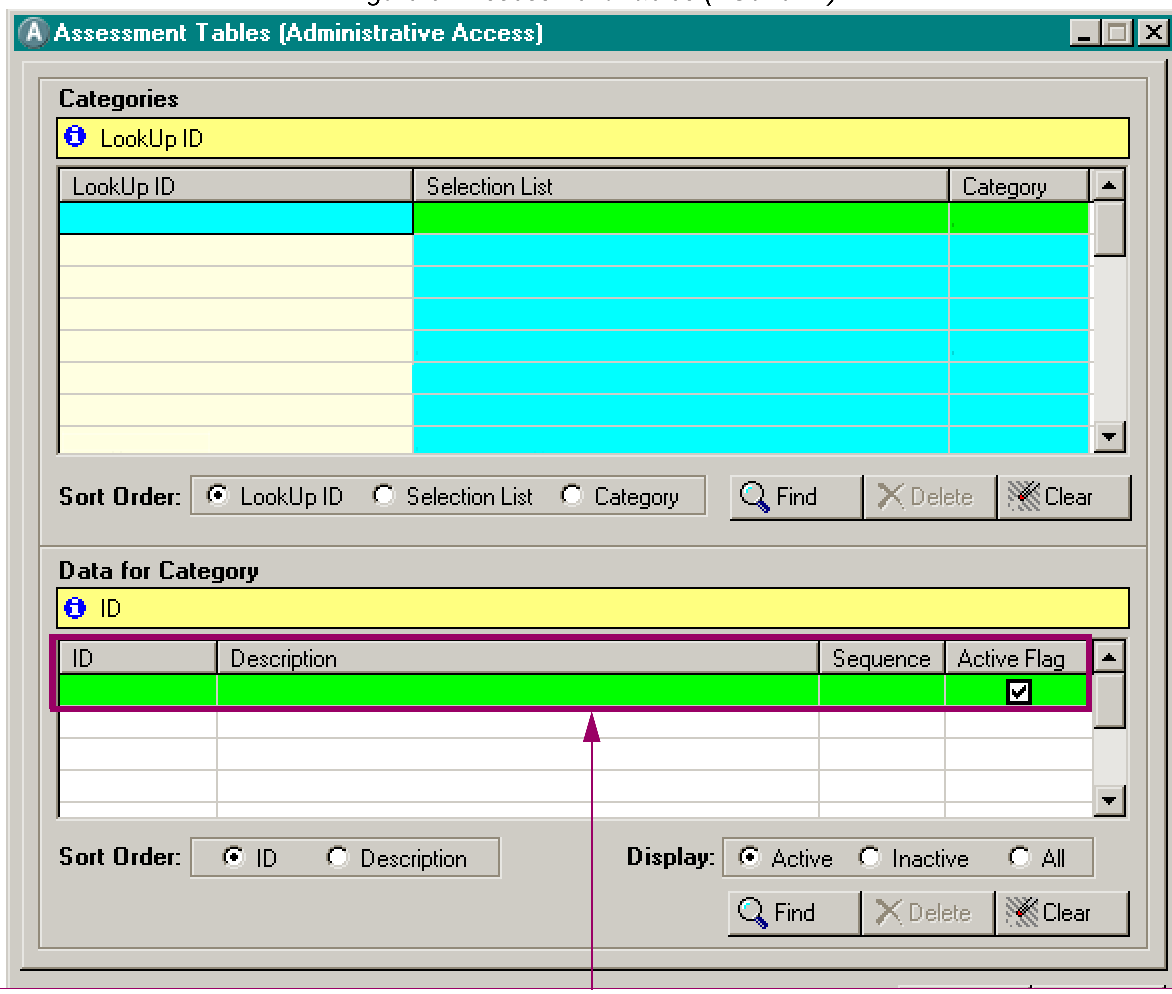
*Figure 2 - Assessment Tables (AS026EA)*




- The 'LookUp ID' should be limited to no more than 11 characters in length, is required, and is the ID of the Table. The LookUp ID should be all lowercase letters with no spaces and always ends in '_lk'. (Note: These ending characters are not displayed when working in the ATP.)
- The 'Selection List' can be a maximum of 30 characters in length, is required, and is the description of the Table as it will appear in the Title Bar of selection lists in the ATP.
- The 'Category' can be 1 to 8 characters in length, is required, and is the Category of the Table. It should be upper case with no spaces. (Note: The Category is not visible when working in the ATP.)

## Assessment Tables - Cont'd

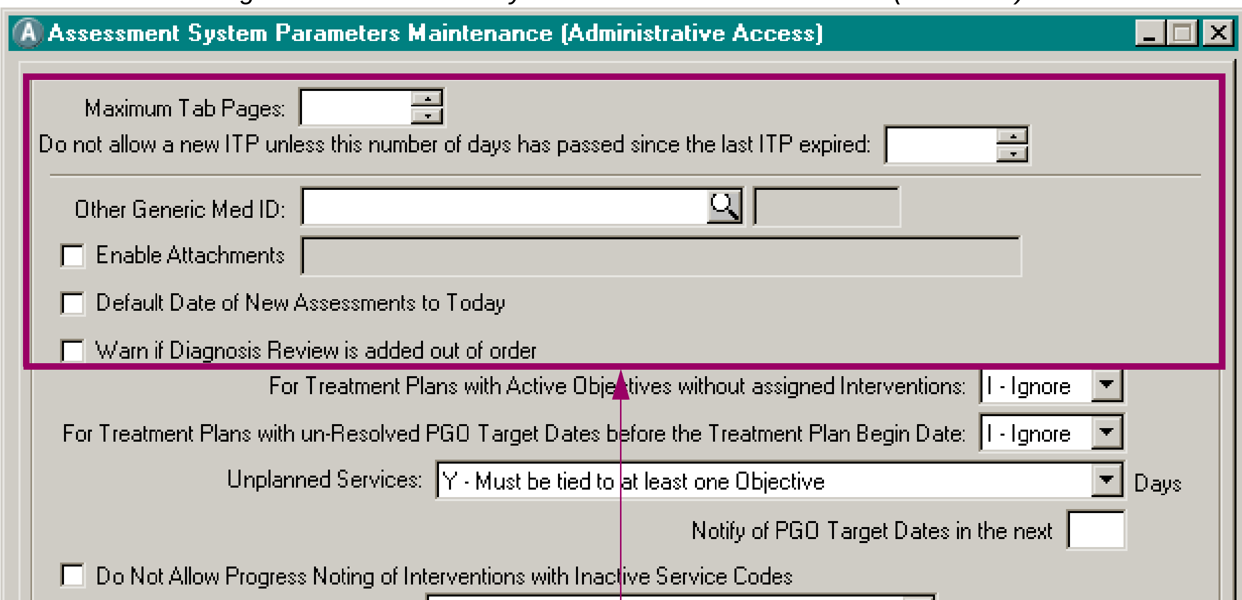
*Figure 3 - Assessment Tables (AS026EA)*




- The 'ID' can be 1 to 10 characters in length, is required, and is the ID of the data for the selected Category. Single Alpha IDs are recommended because if a selection list is used as a control question, the IDs can only be a single character. Also, if the response is displayed in a tabular format, an intuitive, single Alpha ID is useful.
- The 'Description' is required, can be a maximum of 40 characters in length, and is the description of the data for the selected Category.
- The 'Sequence' can be 1 to 4 digits in length, and is used to enter a sequence of the data in the Category. If a sequence is not entered, responses automatically sort alphabetically by ID. To use a sequence other than Alpha, numeric sequencing can be defined in this field (e.g., enter '4' to have the data sorted as the 4th item in the list).

## Assessment System Parameters Maintenance

*Figure 4 - Assessment System Parameters Maintenance (AS011EA)*




- The 'Maximum Tab Pages' can be 1 to 4 digits in length and is the maximum number of Tab Pages that can be non-final approved for all Clients at one time.

- The 'Do not allow a new ITP unless this number of days has passed since the last ITP expired' entry specifies the number of days that must have passed since an Interim Treatment Plan has expired before a new Interim Treatment Plan can be entered.

- The 'Other Generic Med ID' is selected from the Generic Drugs Lookup (from the Anasazi Central Generic Drugs Table) and is the ID of the 'Other' Generic Drug. This is used when the necessary medication is not found from the Client Data Generic Drugs Table.

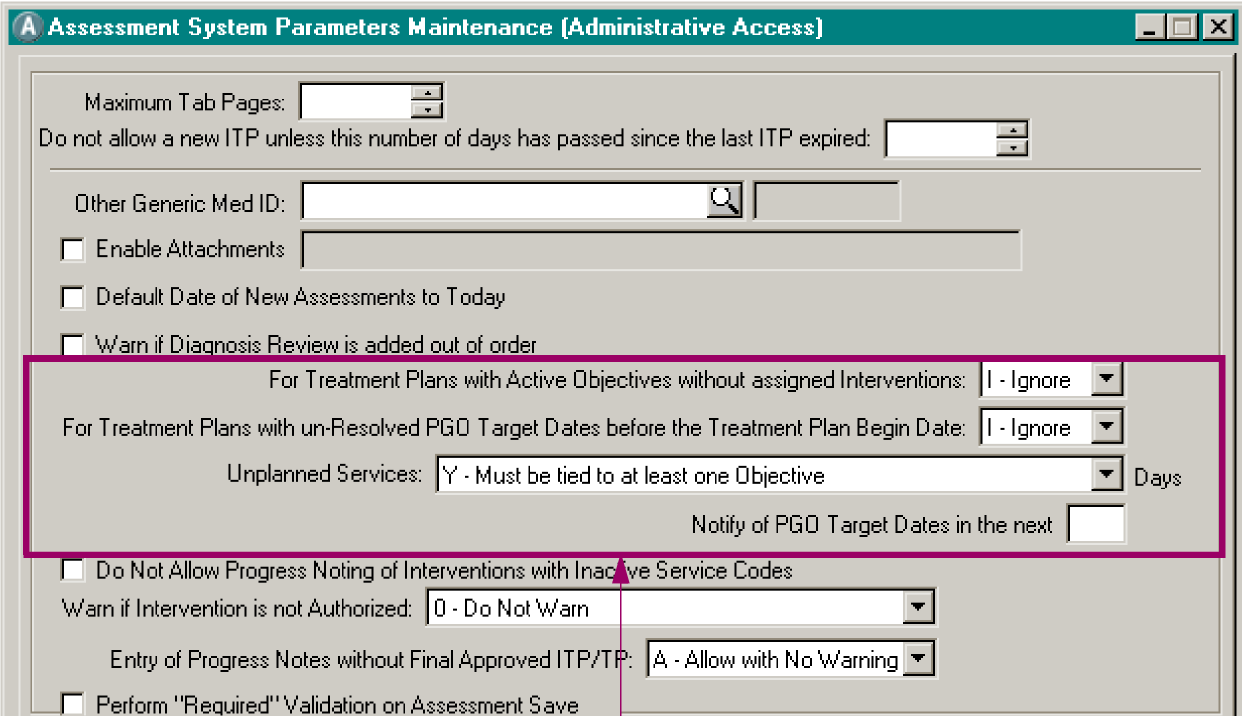
- The 'Enable Attachments' field is available if the Center has purchased ATP3, and indicates that Document Management functionality will be used. This field is always shadowed for ATP Customers, who must contact Anasazi Support prior to implementation of the Document Management functionality for activation of this field. The Path is the network directory and file path to which the attached documents are saved. The Path field is managed by Anasazi Support for ASP customers, and as such is not displayed.

- If the 'Default Date of New Assessments to Today' field is active, the date of new Assessments/ Treatment Plans defaults to the current date.

- If the 'Warn if Diagnosis Review is added out of order' field is active, Staff are presented with a warning message if Assessments/Treatment Plans containing Diagnosis Review Pages are added out of order.

## Assessment System Parameters Maintenance - Cont'd

*Figure 5 - Assessment System Parameters Maintenance (AS011EA)*




- The 'For Treatment Plans with Active Objectives without assigned Interventions' field can be set to 'I - Ignore', 'P - Prevent' or 'W - Warn'. This selection indicates whether Treatment Plans that have active Objectives to which no assigned Interventions are tied can be saved ('I - Ignore'), prevented from being saved until an Intervention has been tied to the Objective ('P - Prevent') or can have Staff be warned of the situation and can choose whether to tie an Intervention to the Objective or to save the Treatment Plan without one.

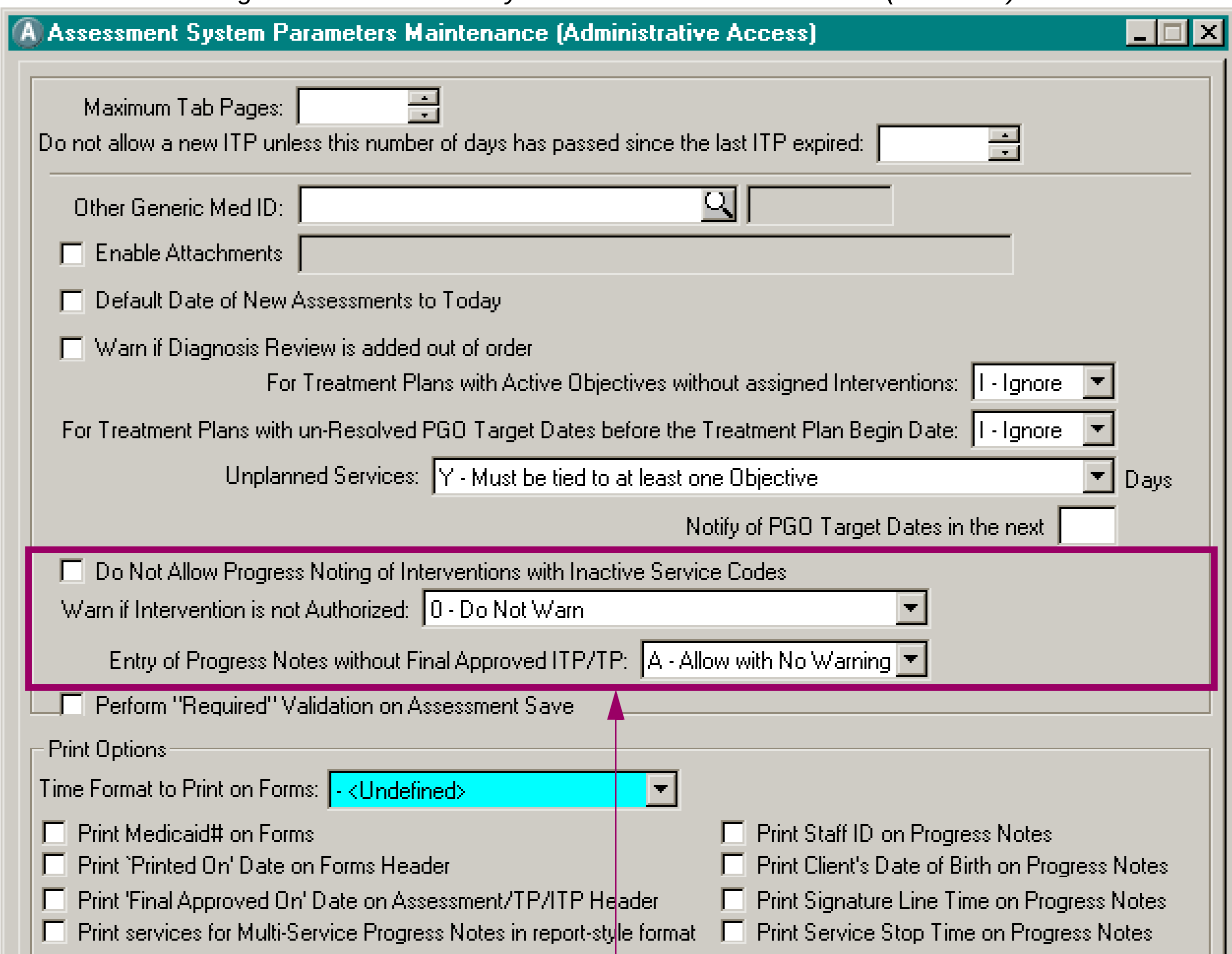
- The 'For Treatment Plans with un-Resolved PGO Target Dates before the Treatment Plan Begin Date' field can be set to 'I - Ignore', 'P - Prevent' or 'W - Warn'. This selection indicates whether Treatment Plans that have unresolved PGO Target Dates that are before the beginning date of the Treatment Plan can be saved ('I - Ignore'), prevented from being saved ('P - Prevent') or can have Staff be warned of the situation and can choose whether to save the Treatment Plan or make changes.

- The 'Unplanned Services' selection indicates the association Unplanned Services must have to Objectives and can be one of the following: 'C - Must be tied to at least one Objective except if it's a Crisis Service', 'N - Optionally Tied to Objectives' or 'Y - Must be tied to at least one Objective'.

- The 'Notify of PGO Target Dates in the next ## Days' field indicates how far ahead of time Clinicians will be notified before PGO Target Dates on their HomePage, and may be 1 to 2 digits in length.

## Assessment System Parameters Maintenance - Cont'd

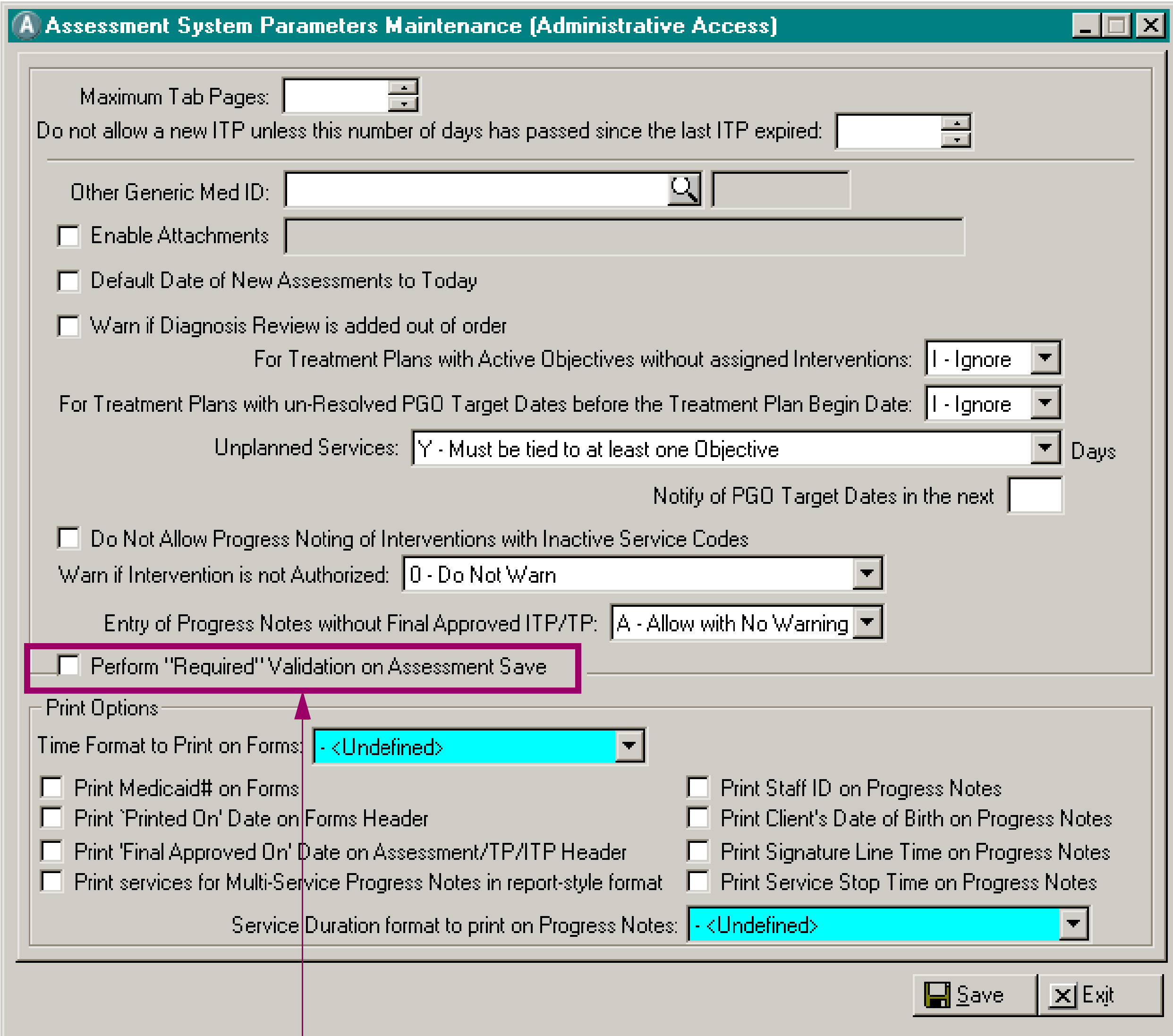
*Figure 6 - Assessment System Parameters Maintenance (AS011EA)*




- If the 'Do Not Allow Progress Noting of Interventions with Inactive Service Codes' field is active, Progress Notes cannot be entered for Interventions that contain any Inactive Service Codes.
- The 'Warn if Intervention is not Authorized' field can be set to '0 - Do Not Warn', '1 - Progress Notes Only', '2 - Interventions/TP's Only' or '3 - Progress Notes and Interventions/TP's'. If 1, 2 or 3 is selected, Staff are warned if an appropriate Authorization does not exist for the Service being Progress Noted.
- The 'Entry of Progress Notes without Final Approved ITP/TP' field designates whether or not Progress Notes can be entered if the associated Interim Treatment Plan (ITP) or Treatment Plan (TP) is not Final Approved, and can be one of the following: 'A - Allow with No Warning', 'P - Prevent' or 'W - Allow with Warning'.

## Assessment System Parameters Maintenance - Cont'd

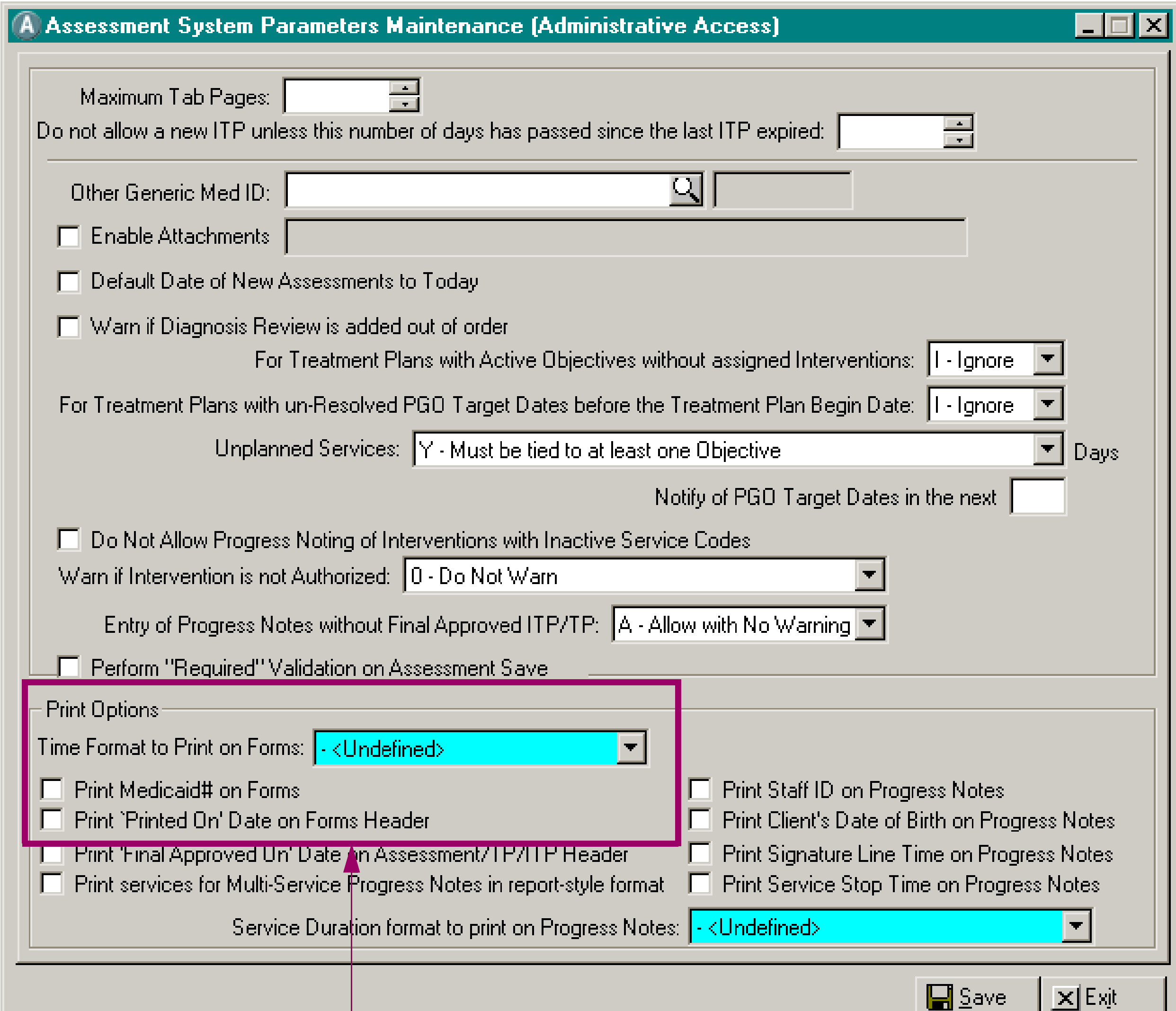
*Figure 7 - Assessment System Parameters Maintenance (AS011EA)*




- If the 'Perform "Required" Validation on Assessment Save' field is active, the system will verify that all required fields have been entered upon saving an Assessment. If any required fields have not been entered, a 'Required Entries Found!' Dialog appears listing the fields that need to have values entered. See the Perform Required Validation icon description in the Client Chart section later in this manual for more information.

## Assessment System Parameters Maintenance - Cont'd

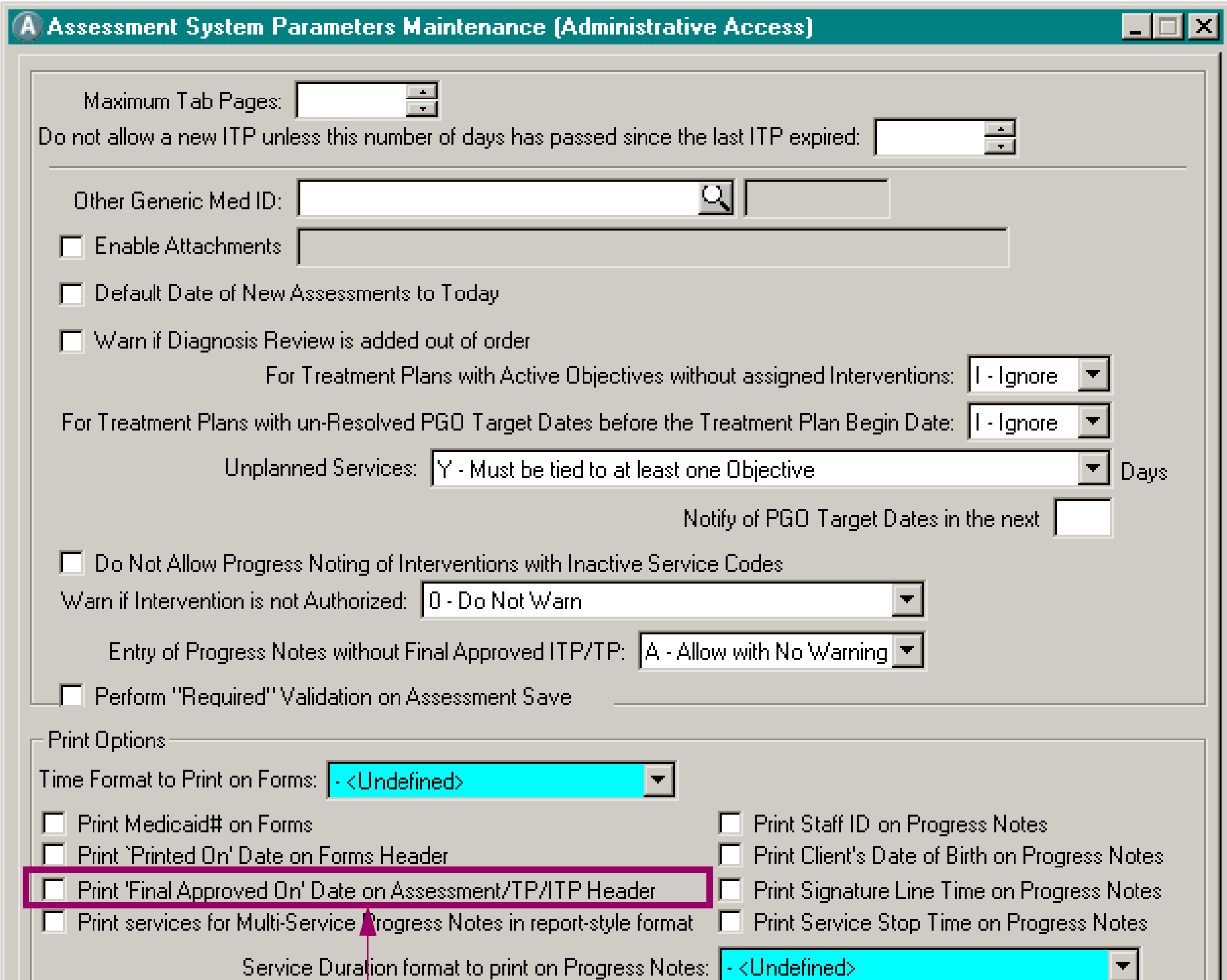
*Figure 8 - Assessment System Parameters Maintenance (AS011EA)*




- The 'Time Format to Print on Forms' field is required, can be set to 'M - 24-hour format' or 'S - 12-hour format', and indicates the manner in which the time prints on forms.
- If the 'Print Medicaid# on Forms' field is active, the Staff's Medicare Number prints on forms.
- If the 'Print 'Printed On' Date on Forms Header' field is active, the phrase 'Printed on <*Date*> at <*Time*>' appears in the left side of the header on printed forms (forms include any Client-specific form printed from the Client Chart - i.e., Progress Notes, ISLs, ITPs, TPs and Assessments. If this field is inactive, the date and time do not print.

## Assessment System Parameters Maintenance - Cont'd

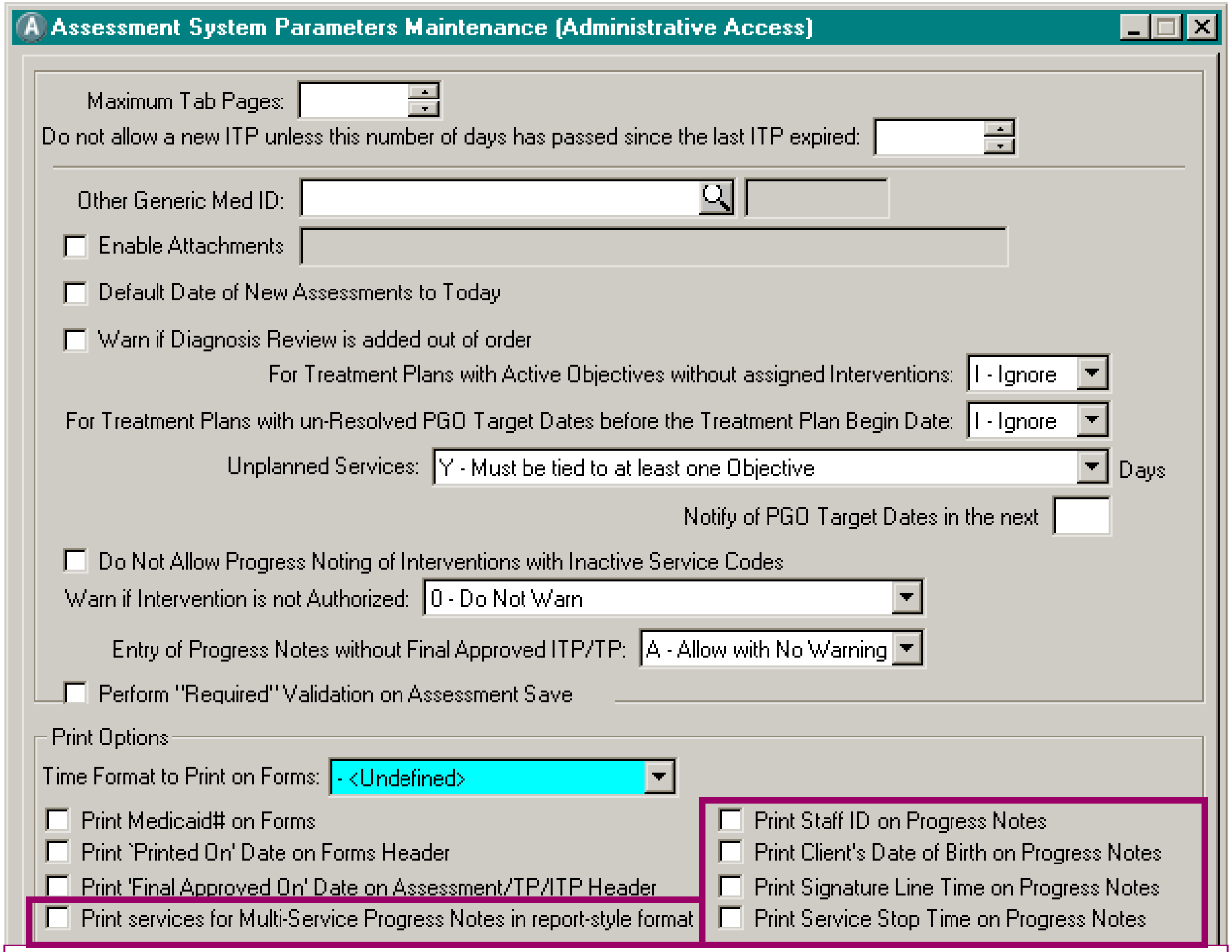
*Figure 9 - Assessment System Parameters Maintenance (AS011EA)*




- The 'Print 'Final Approved On' Date on Assessment/TP/ITP Header' field affects printing of the Final Approved Date as follows:
  - If the document has been Voided, 'Voided' prints on the right side of the header.
  - Otherwise, if the record has not been Final Approved, '(Draft)' prints on the right side of the header.
  - Otherwise, if the 'Print 'Final Approved On' Date on Header' field is active, '(Final Approved on <*Date*> at <*Time*>)' prints on the right side of the header. *(Note: this does not apply to Progress Notes and ISLs, as the Final Approval Date and Time are not saved.)*
  - Otherwise, if the 'Print 'Final Approved On' Date on Header' field is inactive, '(Final Approved)' prints on the right side of the header.

## Assessment System Parameters Maintenance - Cont'd

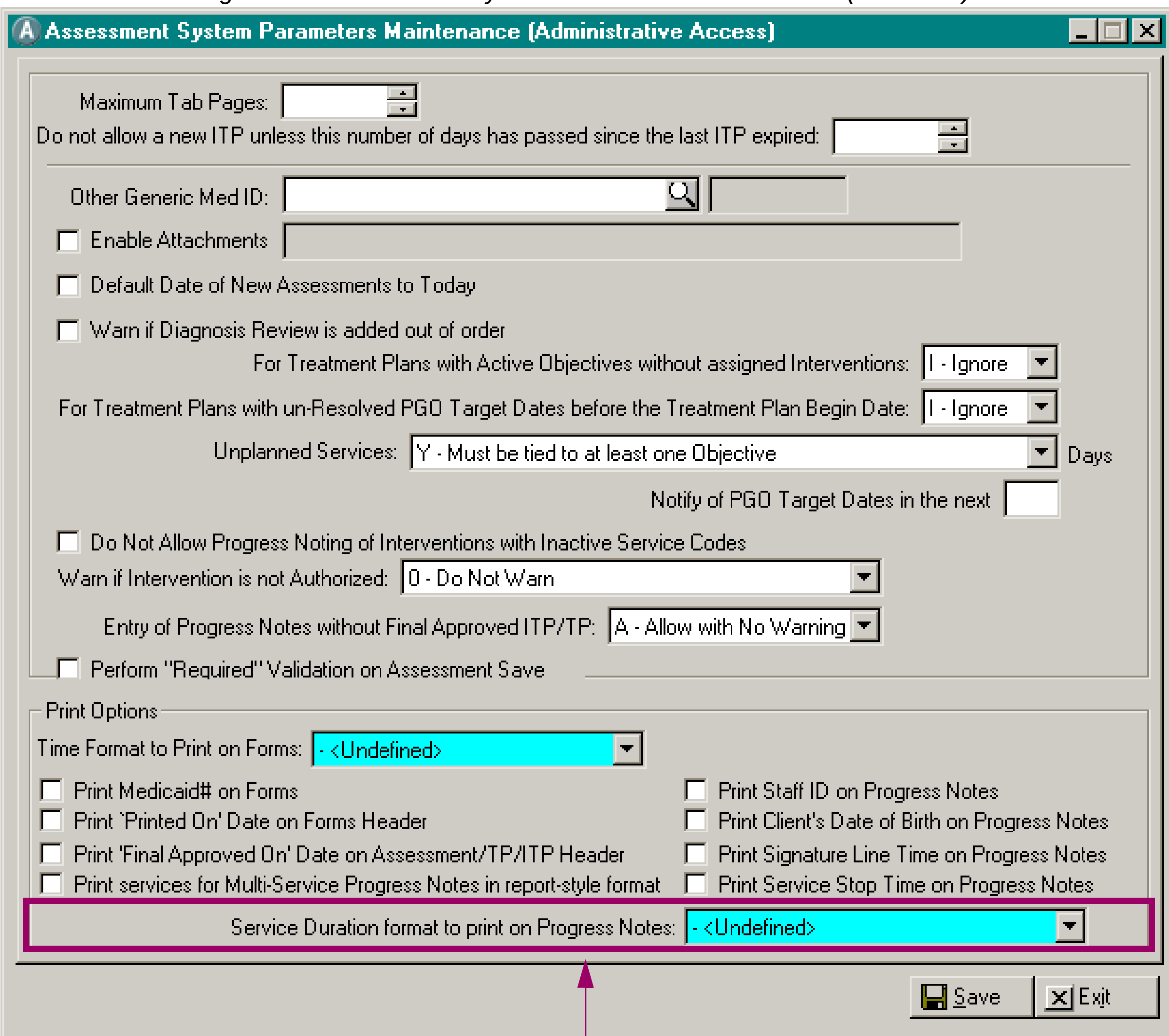
*Figure 10 - Assessment System Parameters Maintenance (AS011EA)*




- If the 'Print services for Multi-Service Progress Notes in report-style format' field is active, the details of each Service print on a single line instead of within individual boxes.
- If the 'Print Staff ID on Progress Notes' field is active, the Staff's ID from Staff Maintenance prints next to their name on the Signature Line on Progress Notes.
- If the 'Print Client's Date of Birth on Progress Notes' field is active, the Client's date of birth prints on forms beside the Client's name in the header as '(*MM/DD/YYYY*)'.
- If the 'Signature Line Time on Progress Notes' field is active, the 'Time' from the Signature Lines print on forms. If this field is inactive, the 'Time' does not print.
- If the 'Print Service Stop Time on Progress Notes' field is active, the Service's Stop Time prints on forms. If this field is inactive, the Stop Time does not print.

## Assessment System Parameters Maintenance - Cont'd

*Figure 11 - Assessment System Parameters Maintenance (AS011EA)*

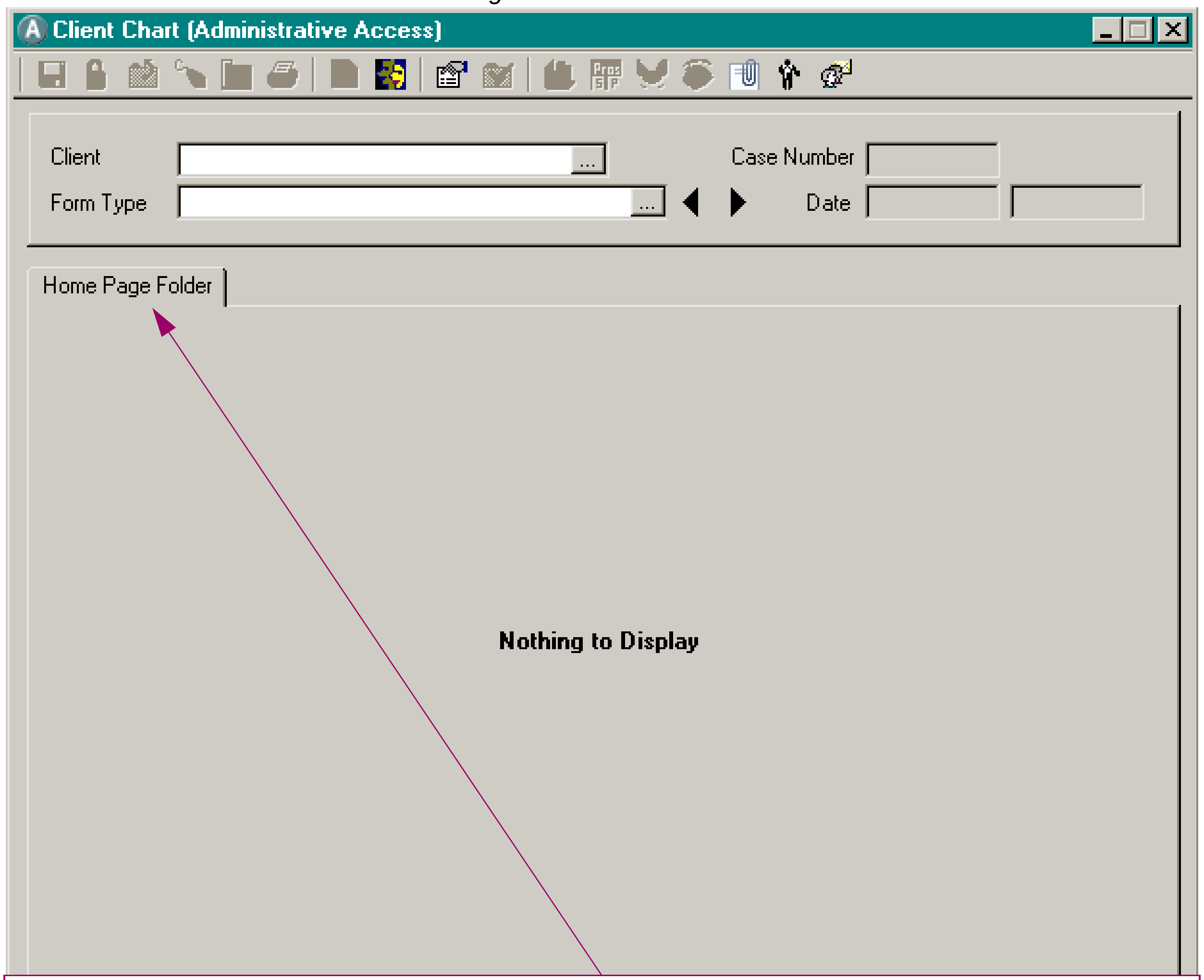



- The 'Service Duration format to print on Progress Notes' field is required and can be set to 'H - Hours and Minutes' (e.g., for a service that is 1 hour and 15 minutes, prints as '1:15' in the 'Duration' column and '1 Hour, 15 Minutes' prints to the 'Total Server Time' field) or 'M - Total Minutes' (e.g., for a for a service that is 1 hour and 15 minutes, '75' prints in the 'Duration' column and '75 Minutes' prints in the 'Total Server Time' field).

# VIEWS

## Client Chart

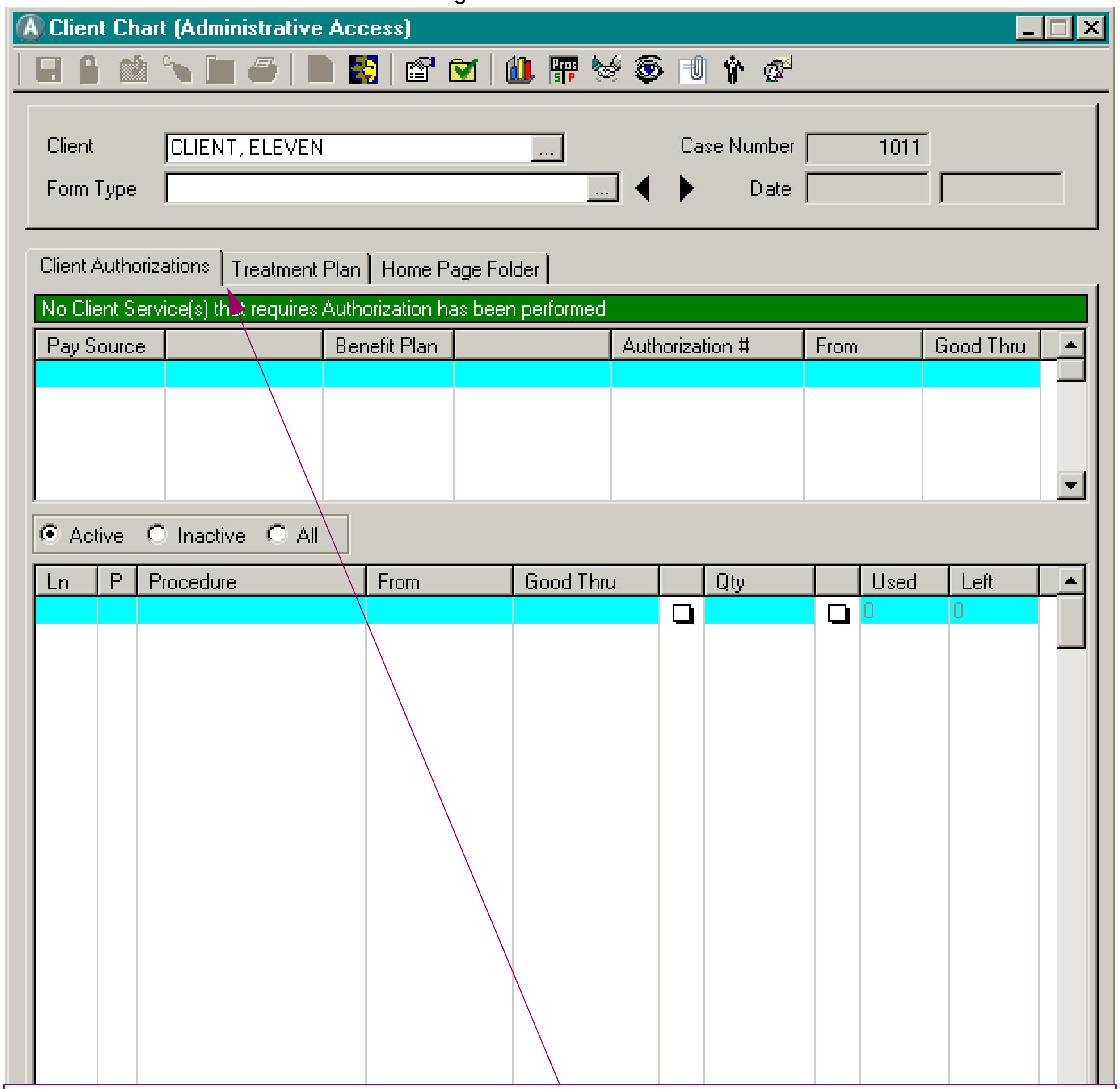
*Figure 12 - Client Chart*




- When the Client Chart is launched, if no Client is selected or a Client is selected who does not yet have a Treatment Plan, Interim Treatment Plan or Interim Service Log, a single Tab Page displays as ‘Home Page Folder’. This Tab Page acts as a placeholder until the Client has a TP, ITP or ISL created. In addition a ‘Client Authorizations’ Tab Page is displayed that shows any Client Authorizations that exist for the selected Client. The Client Authorizations Tab Page is display only. For Clients who have a TP, ITP or ISL, their TP, ITP or ISL record displays in place of the Home Page Folder Tab Page. If a ‘Face Sheet’ is specified in the Preferences Dialog (shown later in this section) it appears as an additional Tab Page.

## Client Chart - Cont'd

*Figure 13 - Client Chart*




- The above picture demonstrates how the Client Chart appears when a Client is selected who does not have a TP, ITP or ISL. The Treatment Plan Tab Page displays with the words 'No current Treatment Plan in Client Chart', in addition to the Client Authorizations and Home Page Folder Tab Pages. (If a Face Sheet has been selected in the Preferences Dialog, that will display as a Tab Page as well.)

## Client Chart - Cont'd

*Figure 14 - Tool Bar*


- Tool Bar icons become available or are shadowed depending on whether a Client is selected and which View or Dialog is currently displayed. From left to right, the Tool Bar icons are:

  - Save - saves the current Assessment or Treatment Plan.
  - Final Approve Assessment or Treatment Plan - Final Approves the Assessment or Treatment Plan.
  - Close Assessment or Treatment Plan - closes the current Assessment or Treatment Plan.
  - Signature Pad - this icon is only visible if the Agency is licensed for AS version 3, the 'Enable Signature Pads' field is active in Assessment System Parameters Maintenance, and the Page that has the focus has been signed by the Client. Clicking this button initiates the capture of an electronic Client Signature.
  - Perform Required Validation - checks all required fields to ensure that they have been completed prior to saving an Assessment. If required entries are found, a Required Entries Found! Message Box displays (shown on the next page) indicating the name of the Assessment and which fields are not populated that are required. Each empty required field that is listed in the Message Box also appear in red on the Assessment. An Assessment can still be saved, however, if all required fields are not populated, but it may not be Final Approved. If all of the required fields are populated, the Required Validation Successful Message Box appears (shown later in this section). (Note: the Validate Assessment functionality is not applicable to Texas RDM Assessments.)
  - Print - allows for printing the current form. Displays the Print Assessment/Treatment Plan Dialog (shown later in this section).
  - Add Page - displays the Select Page to Add Dialog, from which a Page can be selected to be added to the current Assessment or Treatment Plan (shown later in this section).
  - Add/Edit Group Service - allows for the addition or editing of a Group Service. See the Treatment Plan Product User Manual for information on Group Services and Progress Notes.
  - Set Preferences - displays the Preferences Dialog (shown later in this section), which allows for customizing the workspace.
  - Request an Assessment - displays the Select Requested Assessment Dialog, from which Assessments can be ordered (shown later in this section).

## Client Chart - Cont'd

*Figure 15 - Tool Bar*


- Client Progress Indicators - displays the Client Progress Indicators Dialog for the current Client (shown later in this section).
- Client Prospective Strengths and Problems - displays the Prospective Strength and Problem Dialog (shown later in this section).
- Pre-Intake - displays the Client Pre-Intake Dialog.
- HIPAA Privacy - launches the HIPAA Privacy Dialog, which displays HIPAA PHI Practices, Authorizations, Disclosures and Disclosure Revocations.
- Client Attachments - this icon is visible if the 'Enable Attachments' field is active in Assessment System Parameters Maintenance, and is available as follows:
  -  If the 'Client' field is populated and the selected Client has one or more non-Voided/ Non-Deleted Tag records to which the Staff has appropriate Category of Treatment (COT) Access, this icon appears green.
  -  If an Assessment/TP/ITP is loaded that has a non-Voided/non-Deleted Tag record with a matching Assessment/TP/ITP record, this icon appears red and indicates that the Assessment/TP/ITP has an associated Attachment. Note: COT Access to the Assessment/ TP/ITP overrides the Document Type COT Access associated with the Attachment record.
  -  Otherwise, this icon appears black.
- Client Assignments - launches the Client Data Product Client Assignments Maintenance View (see the Client Data Assignments Manual for information on this view).
- Client Treatment Sessions - launches the Client Data Product Client Treatment Sessions Maintenance View (see the Client Data Assignments Manual for information on this View).

## Client Chart - Cont'd

*Required Validation Message Boxes*

*Figure 16 - Required Entries Found! Message Box*

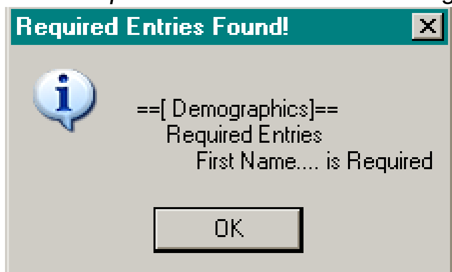
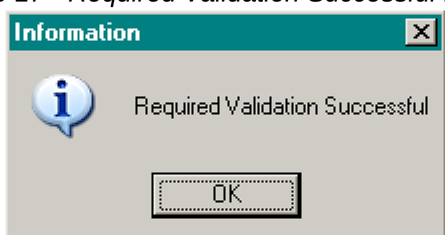
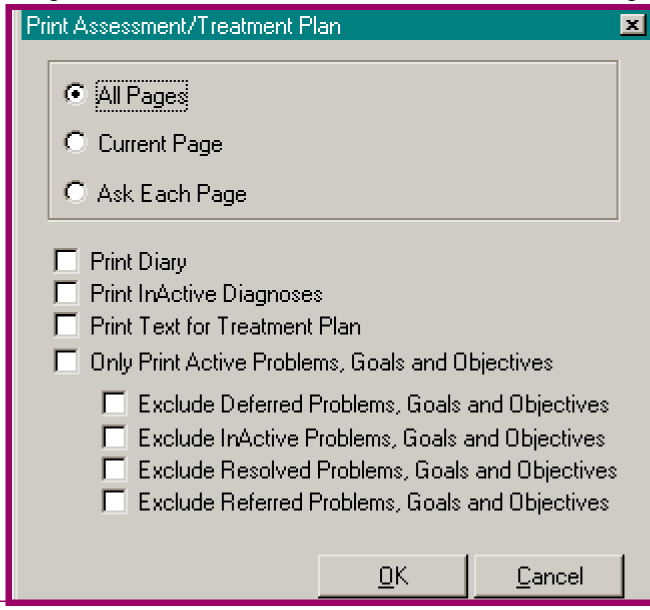



*Figure 17 - Required Validation Successful Dialog*



*Print Assessment/Treatment Plan*

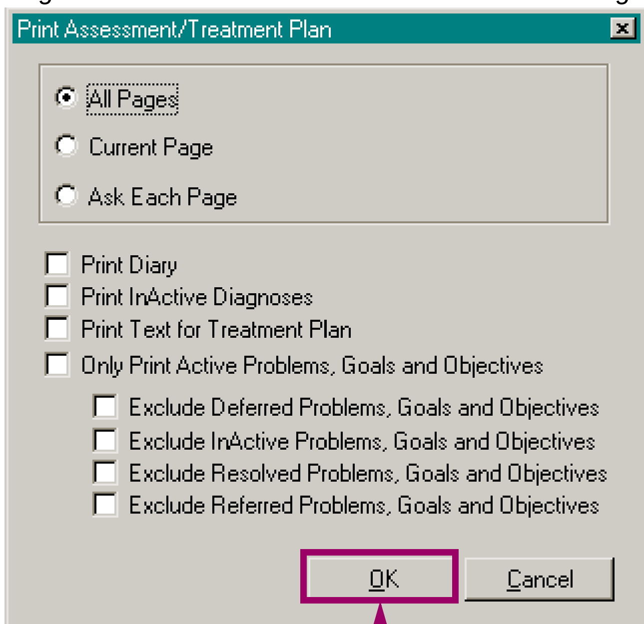
*Figure 18 - Print Assessment/Treatment Plan Dialog*




- The pages to be printed are specified by selecting the appropriate radio button: ‘All Pages’, ‘Current Page’ or ‘Ask Each Page’, which displays a Confirmation Dialog for each page that prompts whether or not it is desired to print that page.
- If the ‘Print Diary’ field is active, the Diary Page for the Assessment or Treatment Plan (if one exists) is printed.
- If the ‘Print InActive Diagnoses’ field is active, all Client Diagnoses are printed, and ‘(All Diagnoses)’ prints after the Assessment Type in the header of the form. If this field is inactive, only Client Diagnoses with no expiration date print, and ‘(Active Diagnoses)’ prints after the Assessment Type in the header of the form to indicate that the form only includes Active Diagnoses.
- If the ‘Print Text for Treatment Plan’ field is active, the detail text on the current Treatment Plan prints.
- If the ‘Only Print Active Problems, Goals and Objectives’ field is active, only the Active Problems, Goals and Objectives print; items with any other Status do not print.
- If the ‘Exclude Deferred Problems, Goals and Objectives’ field is active, the Problems, Goals and Objectives with a ‘D - Deferred’ Status as defined in the Treatment Plan are excluded from printing.
- If the ‘Exclude InActive Problems, Goals and Objectives’ field is active, the Problems, Goals and Objectives with an ‘I - Inactive’ Status as defined in the Treatment Plan are excluded from printing.
- If the ‘Exclude Resolved Problems, Goals and Objectives’ field is active, the Problems, Goals and Objectives with a ‘R - Resolved’ Status as defined in the Treatment Plan are excluded from printing.
- If the ‘Exclude Referred Problems, Goals and Objectives’ field is active, the Problems, Goals and Objectives with a ‘X - Referred’ Status as defined in the Treatment Plan are excluded from printing.

*Print Assessment/Treatment Plan - Cont'd*

*Figure 19 - Print Assessment/Treatment Plan Dialog*




- If the 'Print on Billings' field is active in Staff Maintenance, Staff Credentials print on Progress Notes and Assessment Forms.

- If the 'Print Staff ID on Progress Notes' field is active in Assessment System Parameters Maintenance, the Staff Member's ID prints next to the Staff Member's name on Progress Note signature lines (Individual, Group, Multi-Service, Narrative, and Informational Progress Notes).

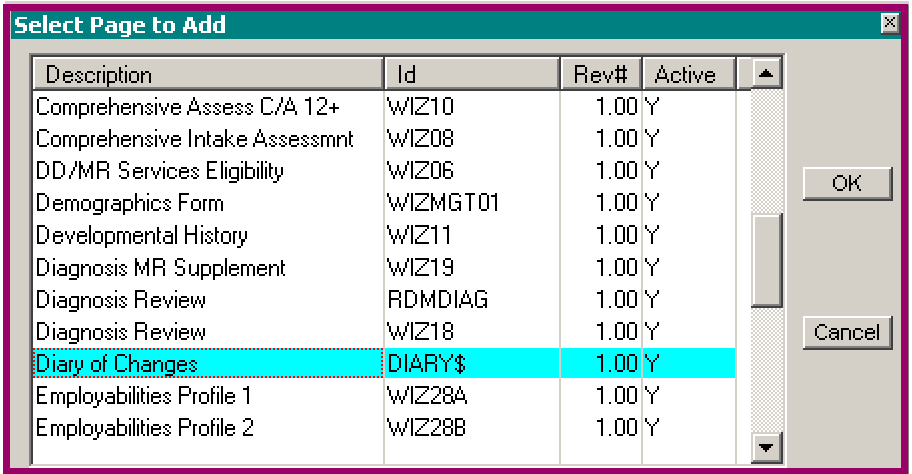
- If the 'Print services for Multi-Service Progress Notes in report style-format' field is active in Assessment System Parameters Maintenance, the details of each Service print on a single line rather than within individual boxes.

- Assessment Forms printing is sensitive to the Staff's Access Level to the Assessment Product. If the Staff's Access Level is not Clinical, responses to Questions marked as Clinical will not print, nor will any Client MEWs. For field responses that are not checkboxes or radio groups, a string of characters that look like arrows will print. For checkbox fields, a completely filled-in checkbox will print instead of an empty one or one with an 'X' in it. Radio button fields will print with all choices completely filled in.

- Once selections have been made and the 'OK' button clicked, the standard Anasazi Products Print Destination Dialog appears. For information on the Print Destination Dialog, see the Anasazi Products Navigation Guide.

*Select Page to Add*

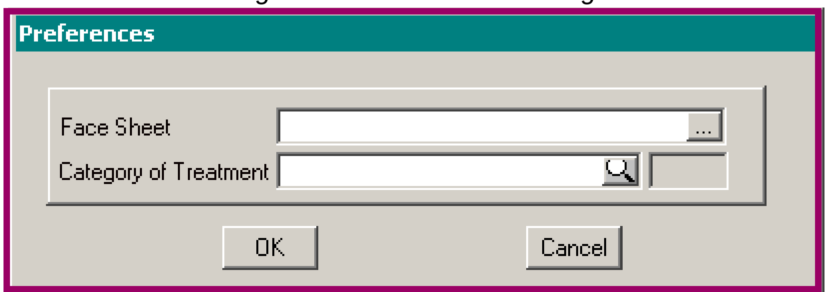
*Figure 20 - Select Page to Add Dialog*




- The Select Page to Add Dialog appears when the Add Page icon is clicked from the Tool Bar, which is available when working with an Assessment or Treatment Plan.
- To select a Page to add, click to highlight the Page and then click the ‘OK’ button.

## *Preferences*

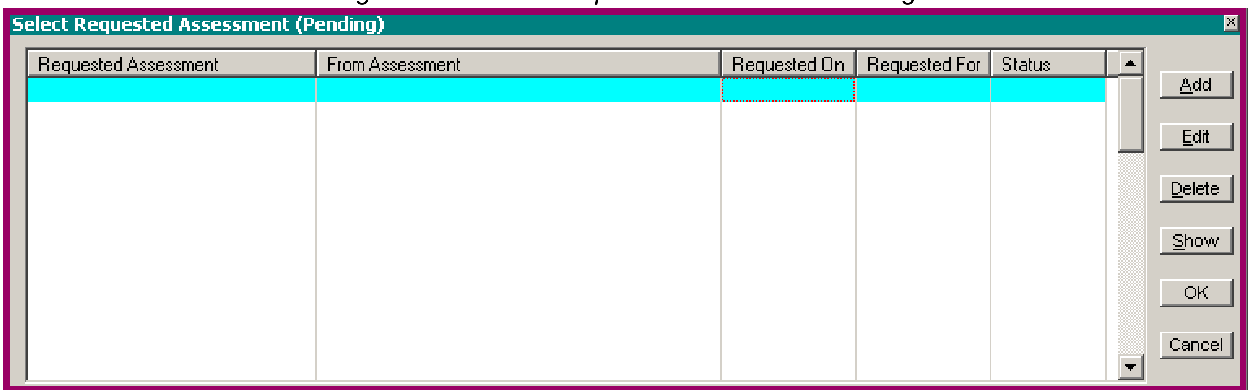
*Figure 21 - Preferences Dialog*




- The Preferences Dialog appears when the Set Preferences icon is clicked from the Tool Bar.
- The 'Face Sheet' is selected from the Select Face Sheet Lookup. If a Face Sheet is selected here, an additional Tab Page appears in the Clinician's Home Folder that displays the selected Face Sheet.
- The 'Category of Treatment' is selected from the Categories of Treatment Lookup and filters the information displayed on the Assessment Types Lookup based on the Category of Treatment selected.

*Select Requested Assessment*

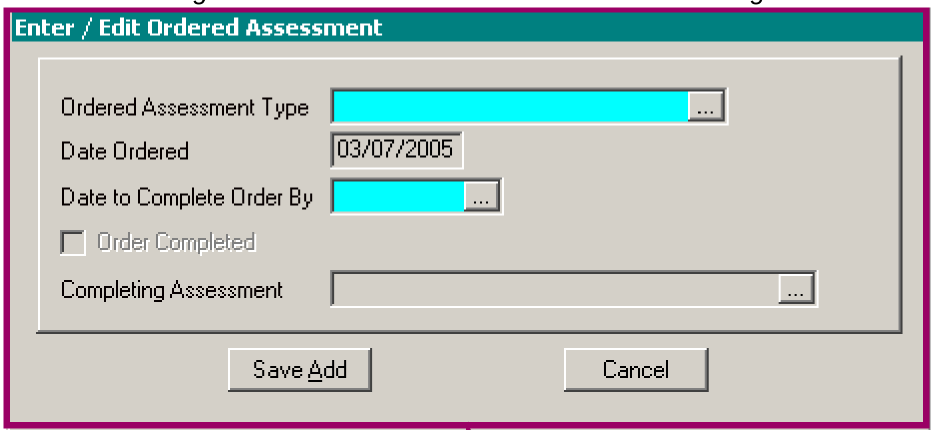
*Figure 22 - Select Requested Assessment Dialog*




- The Select Requested Assessment Dialog appears when the Request an Assessment icon is clicked from the Tool Bar.
- The 'Requested Assessment' field displays the name of the Assessment that has been requested.
- The 'From Assessment' field displays the name of the Assessment from which the new Assessment was requested.
- The 'Requested On' field displays the date on which the Assessment was ordered.
- The 'Requested For' field displays the date on which the Assessment is to be completed.
- The 'Status' field displays the status of the request (e.g. 'Pending').
- The 'Add' button displays the Enter/Edit Ordered Assessment Dialog (shown on the next page), from which an Assessment can be requested.

*Select Requested Assessment - Cont'd*

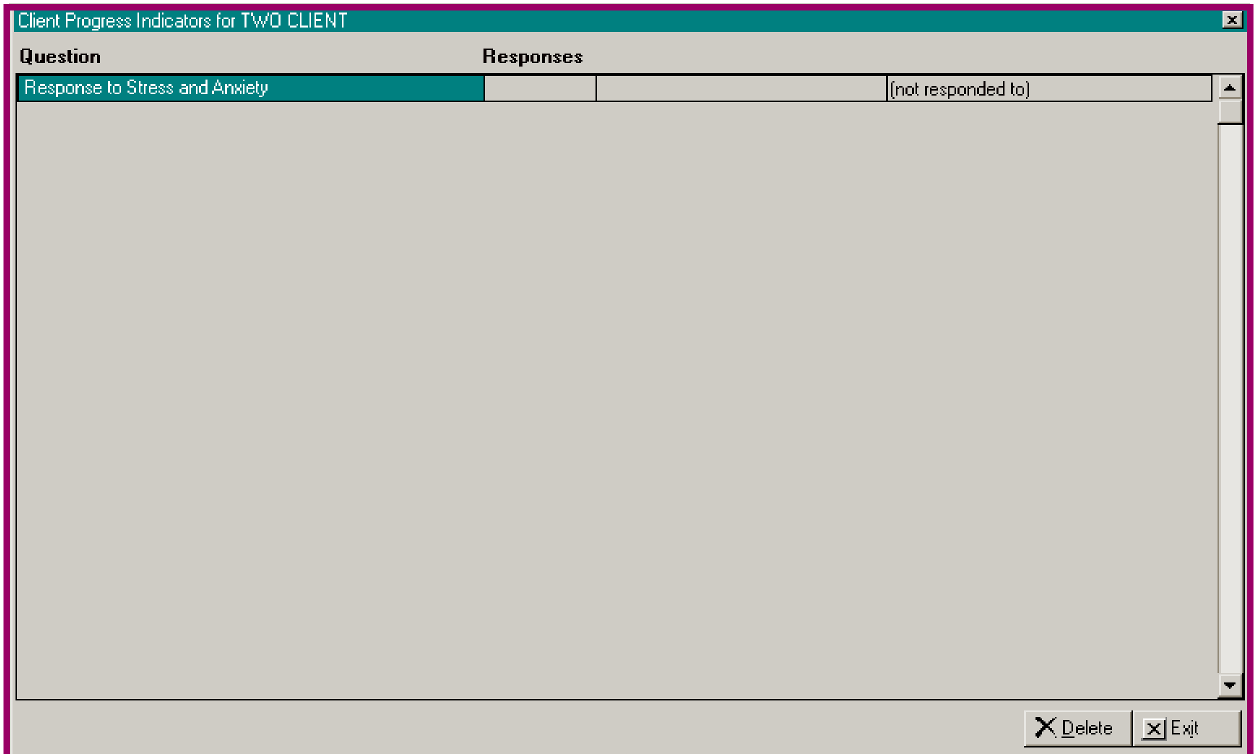
*Figure 23 - Enter/Edit Ordered Assessment Dialog*




- The 'Ordered Assessment Type' is required, is selected from the Assessment / Treatment Plan Types Lookup, and is the Assessment to be ordered/requested.
- The 'Date Ordered' defaults to the current date.
- The 'Date to Complete Order By' is required and is the date by which the Assessment order is to be completed.
- The 'Order Completed' field becomes available once a 'Date to Complete Order By' is specified. If this field is active, the Assessment order has been fulfilled.
- The 'Completing Assessment' field becomes available and is required once the 'Order Completed' field is active, and is selected from the Client Chart Lookup.

*Client Progress Indicators*

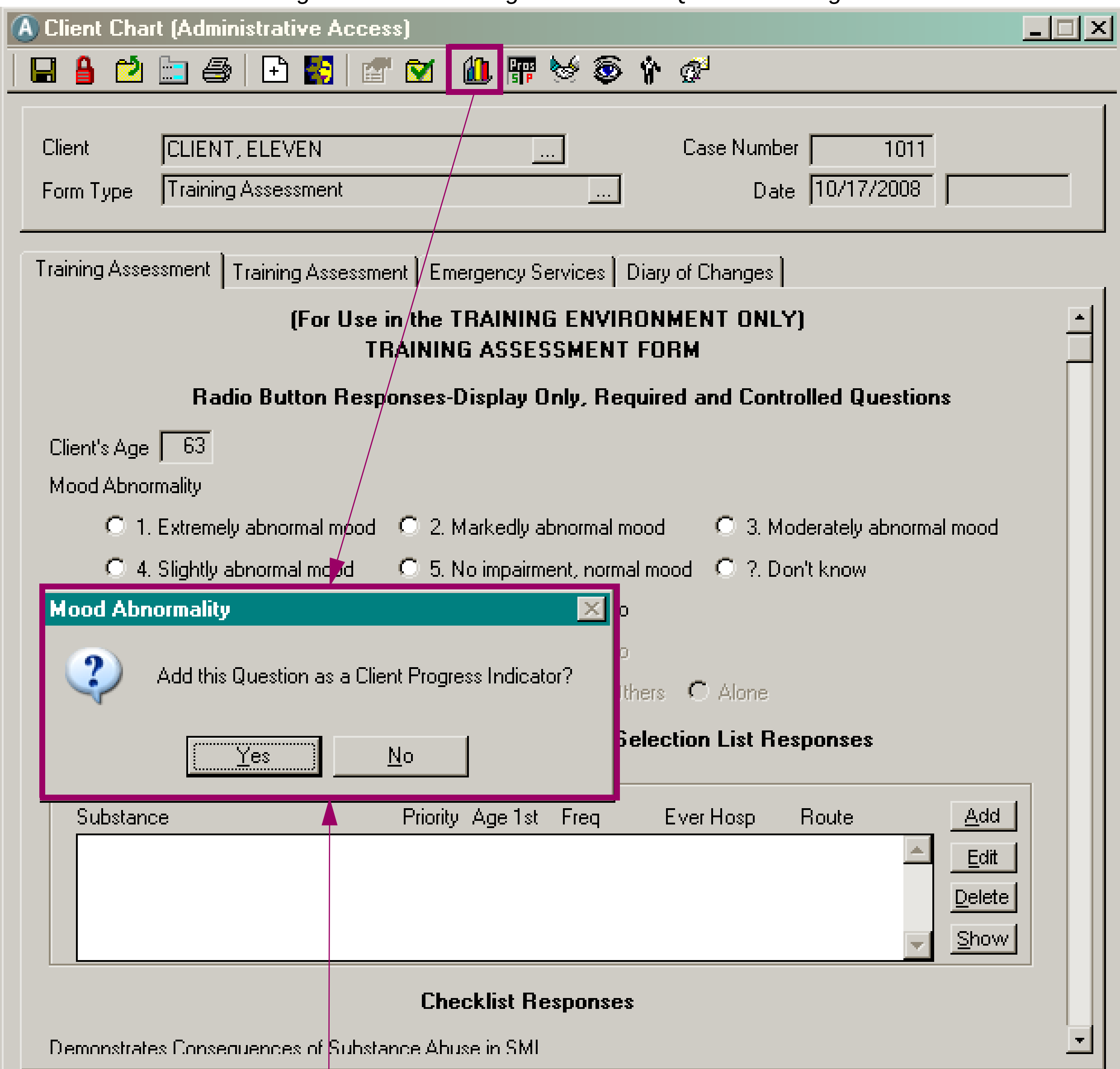
*Figure 24 - Client Progress Indicators Dialog*




- While completing an Assessment, the Clinician can add Questions to the list of Client Progress Indicators by clicking the Client Progress Indicators icon from the Tool Bar while a Question is highlighted. A Dialog appears as ‘Add this Question as a Client Progress Indicator?’ (shown on the next page). If ‘Yes’ is selected, the Question is added to the list. The Client Progress Indicators icon can also be used to simply launch the Dialog itself.
- Questions that have been added to the list of Client Progress Indicators are displayed in the Client Progress Indicators Dialog, including their associated Responses.
- The ‘Delete’ button deletes the selected Question from the list of Client Progress Indicators.

*Client Progress Indicators - Cont'd*

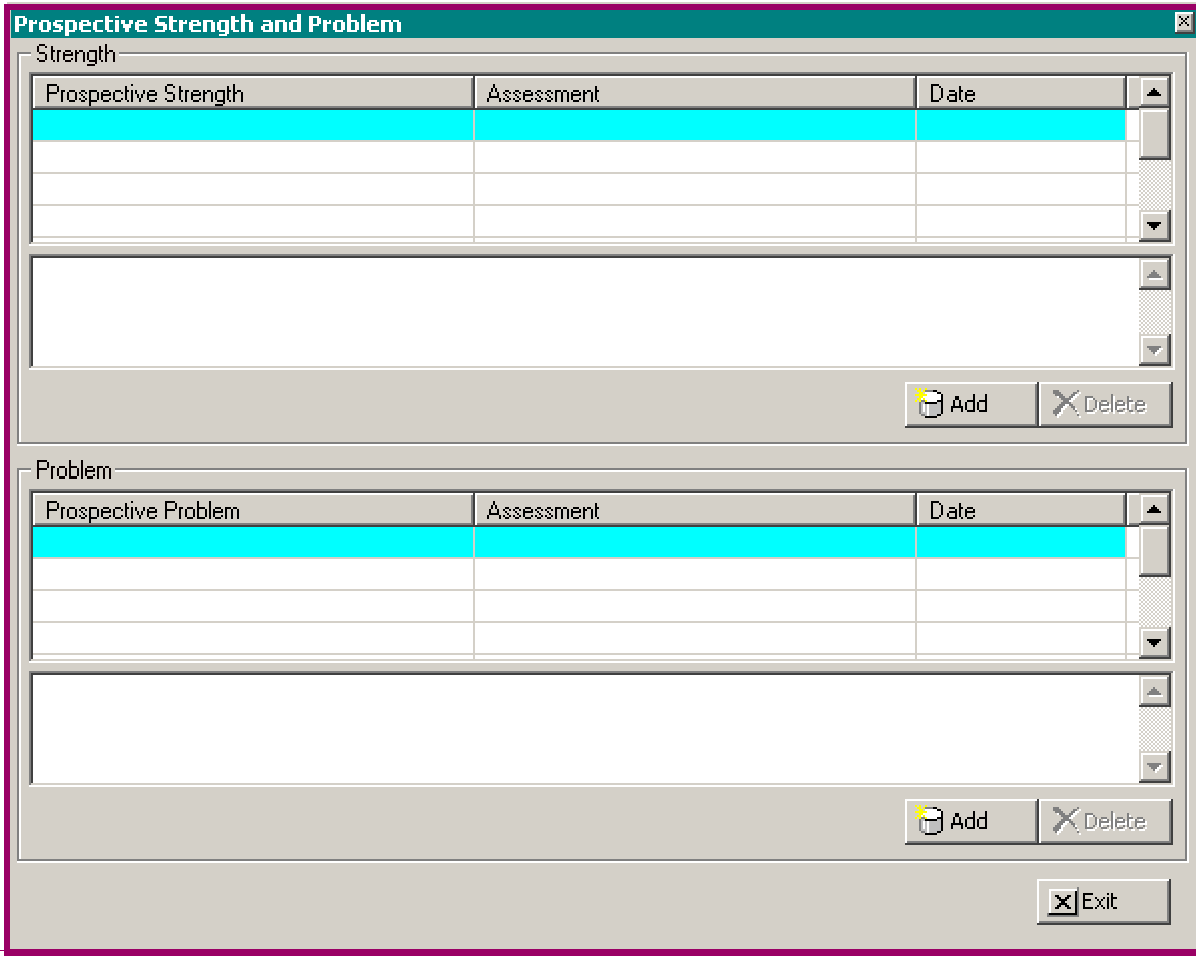
*Figure 25 - Client Progress Indicator Question Dialog*




- If 'Yes' is selected, the Question is added to the list of Client Progress Indicators.

## *Prospective Strength and Problem Dialog*

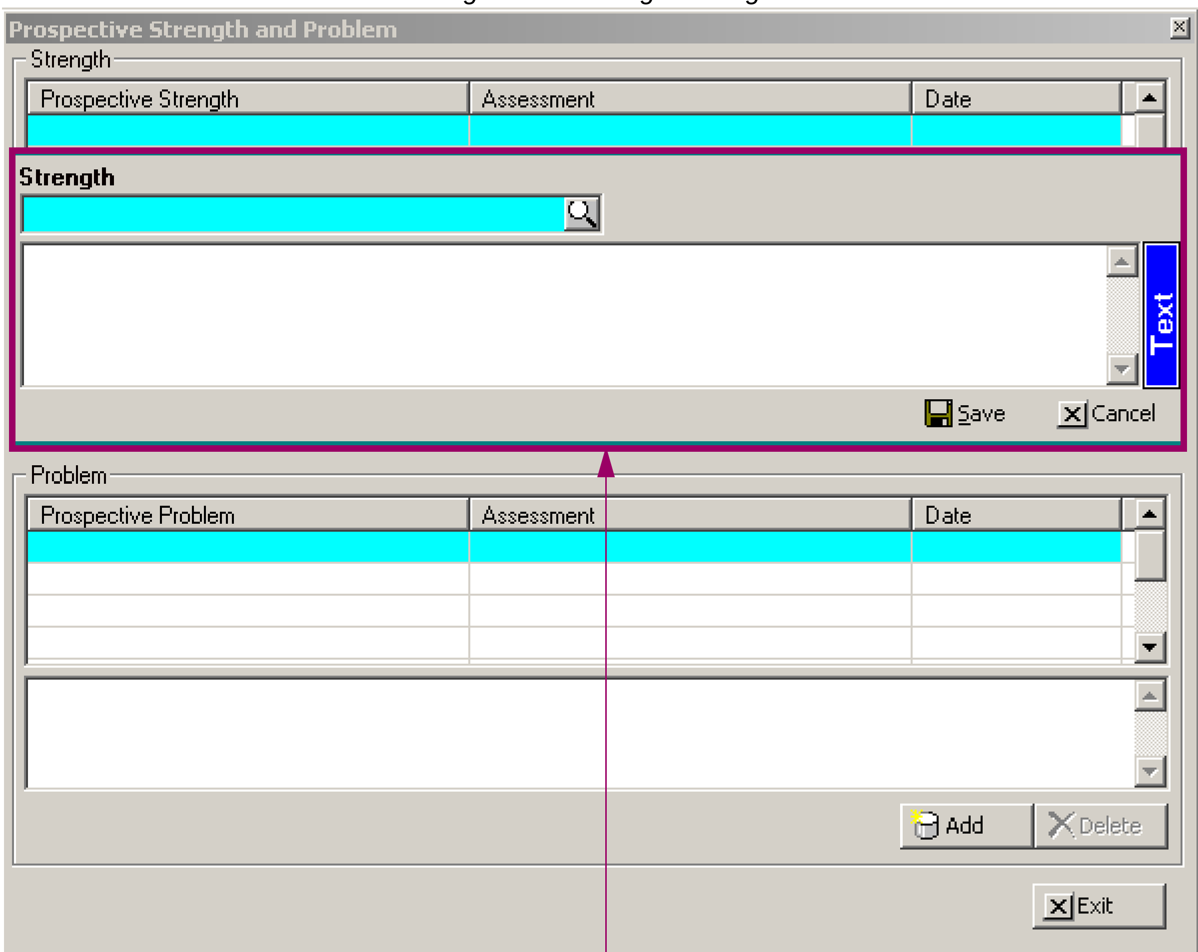
*Figure 26 - Prospective Strength and Problem Dialog*




- Prospective Strengths and Problems for the active Client are defined in the Prospective Strength and Problem Dialog. This Dialog respects Categories of Treatment (COT) access. Staff can only view Prospective Strengths/Problems that are triggered from the Assessments that are associated with their COT(s).
- The ‘Add’ button in the Strength container launches the Strength Dialog (shown on the next page).
- The ‘Delete’ button in the Strength container deletes the highlighted Strength.
- The ‘Add’ button in the Problem container launches the Problem Dialog (shown later in this section).
- The ‘Delete’ button in the Problem container deletes the highlighted Problem.

*Prospective Strength and Problem Dialog - Cont'd*

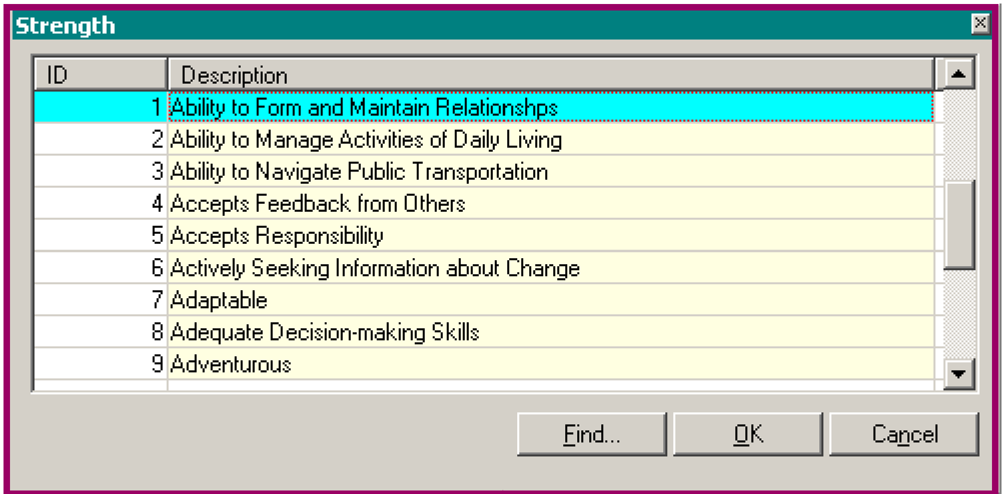
*Figure 27 - Strength Dialog*




- The 'Strength' is required and is selected from the Strength Lookup (shown on the next page).
- Once a Strength has been selected, default text for the Strength as defined in the PGOIs Table displays in the 'Text' field, but may be edited.
- The 'Text' button displays the Client Prospective Strength Standard Text Lookup, from which default text that has been established in the Standard Text Table for Strengths can be selected to be added

*Prospective Strength and Problem Dialog - Cont'd*

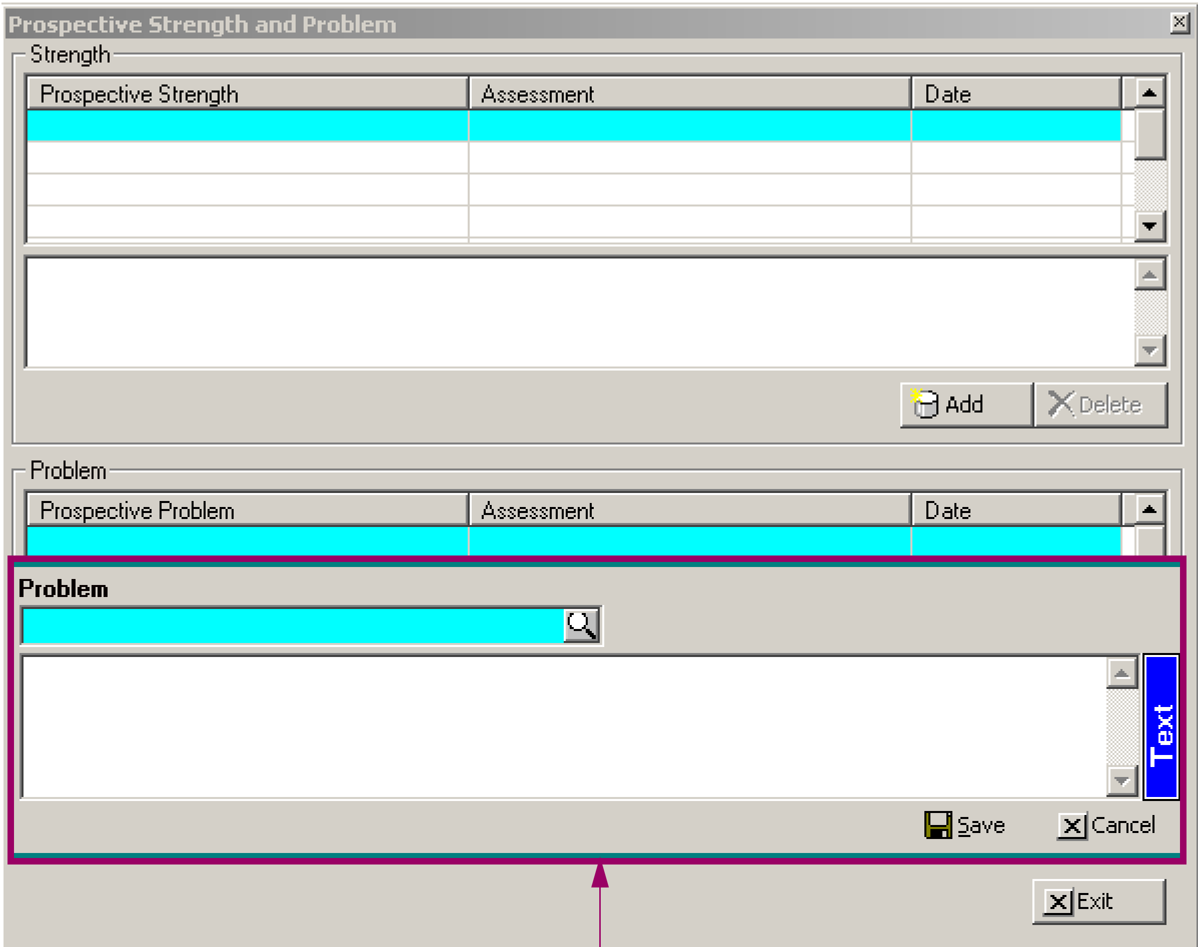
*Figure 28 - Strength Lookup*




- *Note that the Clinical Staff at your Center have developed the Strength List to reflect the clinical philosophy of your Center.*

*Prospective Strength and Problem Dialog - Cont'd*

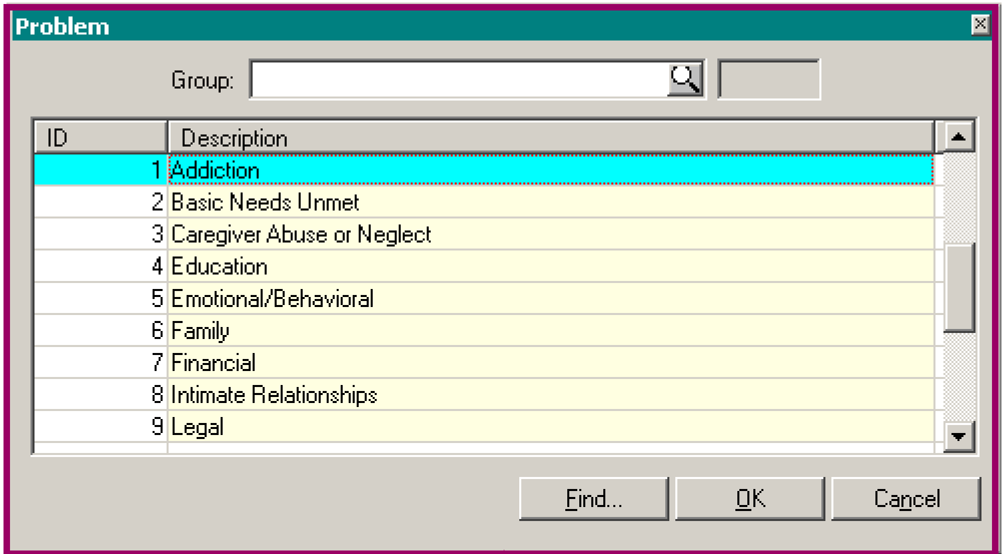
*Figure 29 - Problem Dialog*




- The 'Problem' is required and is selected from the Problem Lookup (shown on the next page).
- Once a Problem has been selected, default Text for the Problem as defined in the PGOIs Table displays, but may be edited.
- The 'Text' button displays the Client Prospective Problem Standard Text Lookup, from which default text that has been established in the Standard Text Table for Problems can be selected to be added to the text field to aid in completing the narrative.

*Prospective Strength and Problem Dialog - Cont'd*

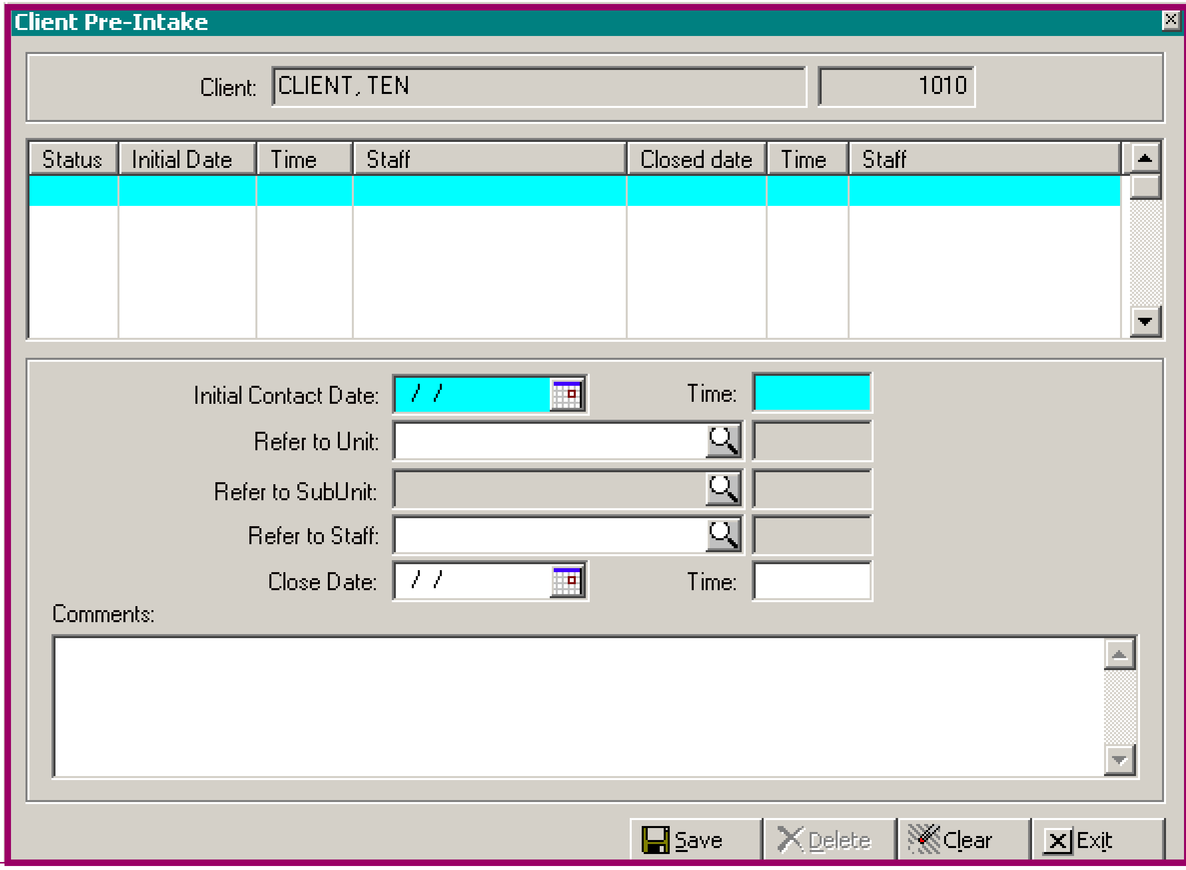
*Figure 30 - Problem Lookup*




- The Problem Lookup displays active Problems.
- The Problem list can be filtered by Problem Group by selecting an option in the 'Group' field.
- *Note that the Clinical Staff at your Center have developed the Problem List to reflect the clinical philosophy of your Center.*

*Client Pre-Intake Dialog*

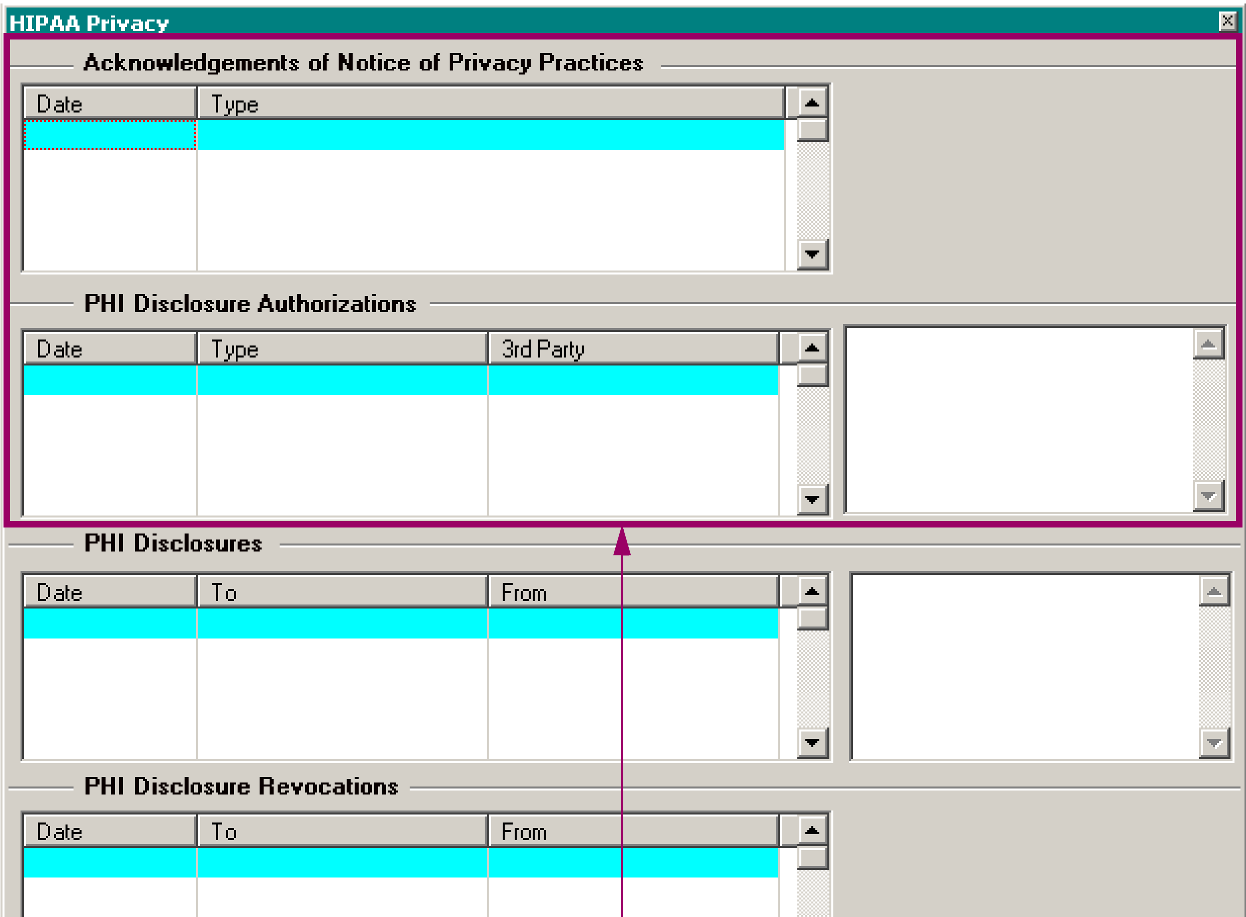
*Figure 31 - Client Pre-Intake Dialog*




- The 'Initial Contact Date' is required and defaults with the current date, but may be changed. The date entered may not be in the future.
- The 'Time' is required and defaults with the current time, but may be changed. The time entered may not be in the future.
- The 'Refer to Unit' is selected from the Units Lookup, and is the Unit to which the Client is referred.
- The 'Refer to SubUnit' field becomes available when a 'Refer to Unit' is specified, and is selected from the SubUnits Lookup.
- The 'Refer to Staff' is selected from the Staff Lookup, and is the Staff to whom the Client is referred.
- The 'Close Date' and 'Time' can be manually entered, but if the Client Pre-Intake is automatically closed (by opening an Assignment), these fields are automatically populated and are shadowed. If one of the fields is populated, they both must be populated.
- The 'Comments' field is used to enter comments regarding the Client's Pre-Intake.

*HIPAA Privacy Dialog*

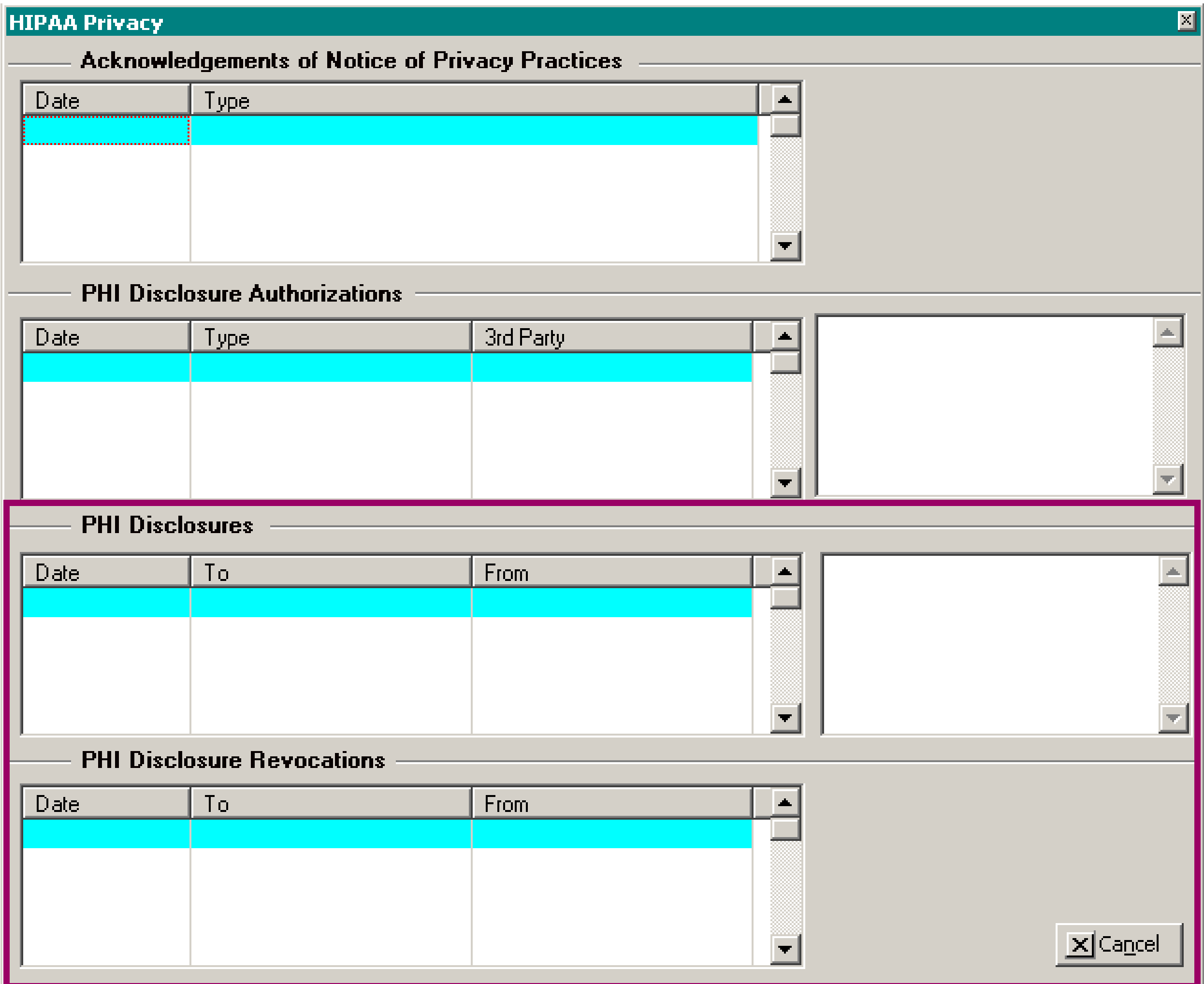
*Figure 32 - HIPAA Privacy Dialog*




- The HIPAA Privacy Dialog displays HIPAA Acknowledgements of Privacy Practices, PHI Disclosure Authorizations, PHI Disclosures and PHI Disclosure Revocations for the selected Client.
- The ‘Acknowledgements of Notice of Privacy Practices’ container displays the listing of Assessment/ Treatment Plan records that include the HIPAA Acknowledgement Notice Page (Page ID ‘HIPACKNOTICE’), including the date of the Assessment/Treatment Plan and the Assessment/ Treatment Plan Type.
- The ‘PHI Disclosure Authorizations’ container displays the listing of Assessment/Treatment Plan records that include the HIPAA Disclosure to 3rd Party Page (Page ID ‘HIPAUTHNONRT’) or HIPAA Disclosure from 3rd Party (Page ID ‘ HIPAUTHREQ), including the date of the Assessment/Treatment Plan, the Disclosure Authorization Type, the name of the 3rd Party who made the request (if requested by a 3rd Party), and the information that was requested for the disclosure (displays in the box on the right side of the container).

*HIPAA Privacy Dialog - Cont'd*

*Figure 33 - HIPAA Privacy Dialog*

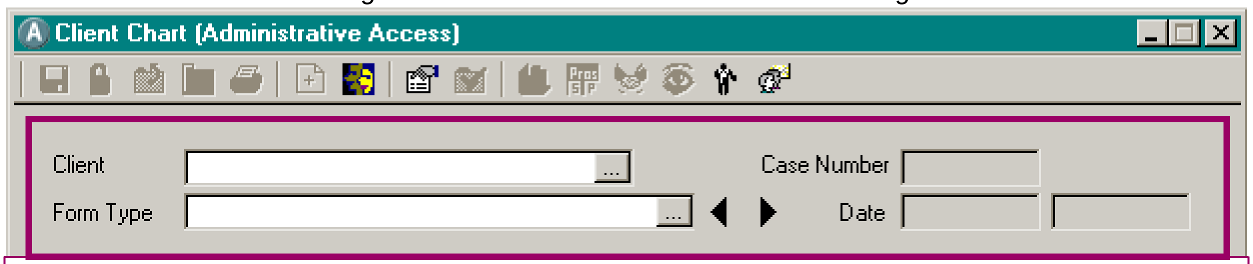



- The 'PHI Disclosures' container displays the listing of Assessment/Treatment Plan records that include the HIPAA Record of Disclosure Page (Page ID 'HIPRECDIS'), including the date of the Assessment/Treatment Plan, the 'To Name' and 'From Name', and the information that was requested for the disclosure (displays on the box on the right side of the container).

- The 'PHI Disclosure Revocations' container displays the listing of Assessment/Treatment Plan records that include the 'HIPAA Authorization Revocation' Page (Page ID 'HIPREVAUTH), including the date of the Assessment/Treatment Plan and the 'To Name' and 'From Name'.

## Selecting a Client and Assessment/Treatment Plan

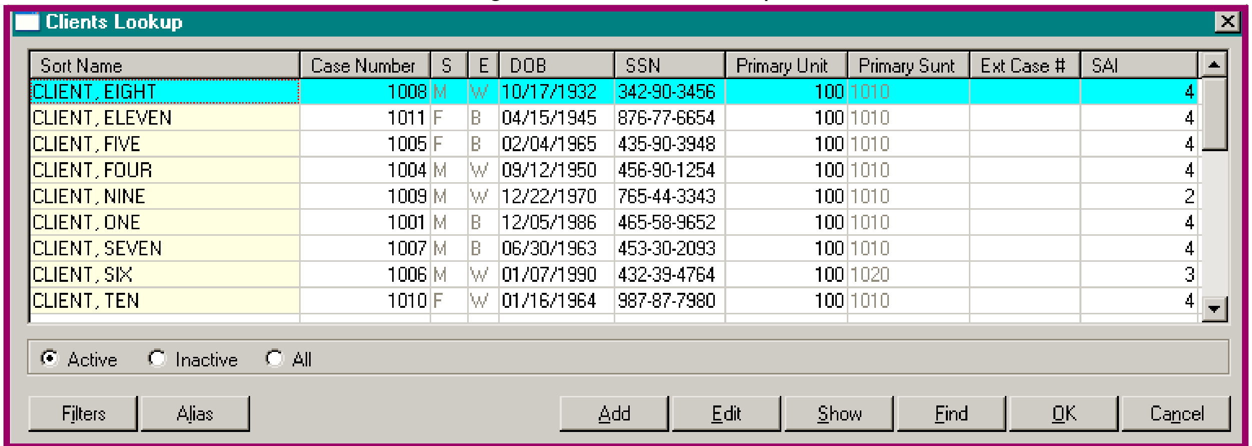
*Figure 34 - Assessment and Treatment Planning*




- A Client can be selected by clicking on a Client name on the Clinician's Homepage.
- Alternately, a Client can be selected in the 'Client' field, which displays the Clients Lookup.
- Once a Client has been selected, the Client name is displayed in the 'Client' field, and the Client's Case Number is displayed in the 'Case Number' field.
- The 'Form Type' field and the Home Page Folder pre-populate with the Client's Interim Service Log, Treatment Plan or Interim Treatment Plan that has a date span that overlaps the current date if the Logged-In Staff has Add rights to the Category of Treatment Access (COT) of the Client's Plan (as defined on the Categories of Treatment (7) Tab Page of Staff Maintenance). If the Client has more than one Treatment Plan with date spans that overlap the current date, the Treatment Plan with a start date closest to the current date defaults. An Assessment or Treatment Plan can be selected or created by clicking the ellipsis button in the 'Form Type' field, which displays the Client Chart Lookup. Plans that the Logged-In Staff has Show COT Access for can be displayed via the 'Show' button in the Client Chart Lookup. Staff may Add/Edit/Delete/Void Progress Notes when a Client Plan is accessed in Show Mode via the Client Chart Lookup if the 'Activate Category of Treatment control' field is active in Security Parameters Setup and the Logged-In Staff has Add COT Access to the COT of the Client Plan, or if the 'Activate Category of Treatment Control' field is inactive in Security Parameters Setup.
- The left and right Arrow buttons display the 'Previous Treatment Plan' or 'Next Treatment Plan'.
- A checkmark appears next to the 'Next Treatment Plan' icon when an Interim Service Log, Interim Treatment Plan or Treatment Plan that has a date span that overlaps the current date is selected.
- The 'Date' fields display the beginning and ending dates of the selected Assessment or Treatment Plan.
- Once a Client is selected, the Client's Home Page Folder displays. The most recent Treatment Plan displays for the selected Client (regardless of the Client that has focus on the Clinician's Homepage.
- If a Face Sheet has been specified in the Preferences Dialog, an additional Tab Page titled 'Face Sheet' appears with information regarding the selected Client.

# Clients Lookup

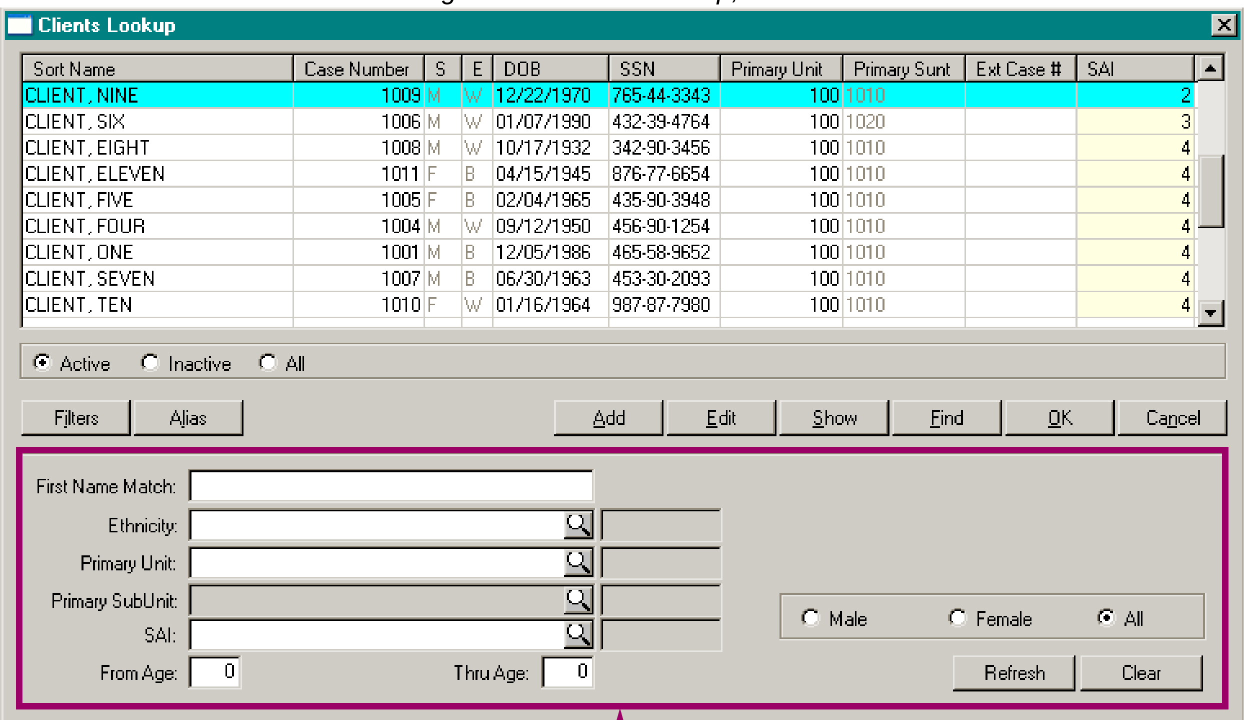
*Figure 35 - Clients Lookup*




- The 'Filters' button toggles the View to display or hide the filter container of the Dialog to allow for filtering the Client list (shown on the next page).
- The 'Alias' button displays the Client Aliases Lookup.
- The 'Add' button displays the Enter/Edit Client Dialog, from which Clients can be added (shown later in this section).
- The 'Edit' button displays the Enter/Edit Client Dialog, from which the selected Client's information can be edited.
- The 'Show' button displays the Enter/Edit Client Dialog, from which the selected Client's information is displayed in read-only mode.
- The 'Find' button allows for searching the Client list by 'Sort Name', 'Case Number', 'DOB', 'SSN', 'Primary Unit', 'Ext Case #' or 'SAI'.

## Clients Lookup - Cont'd

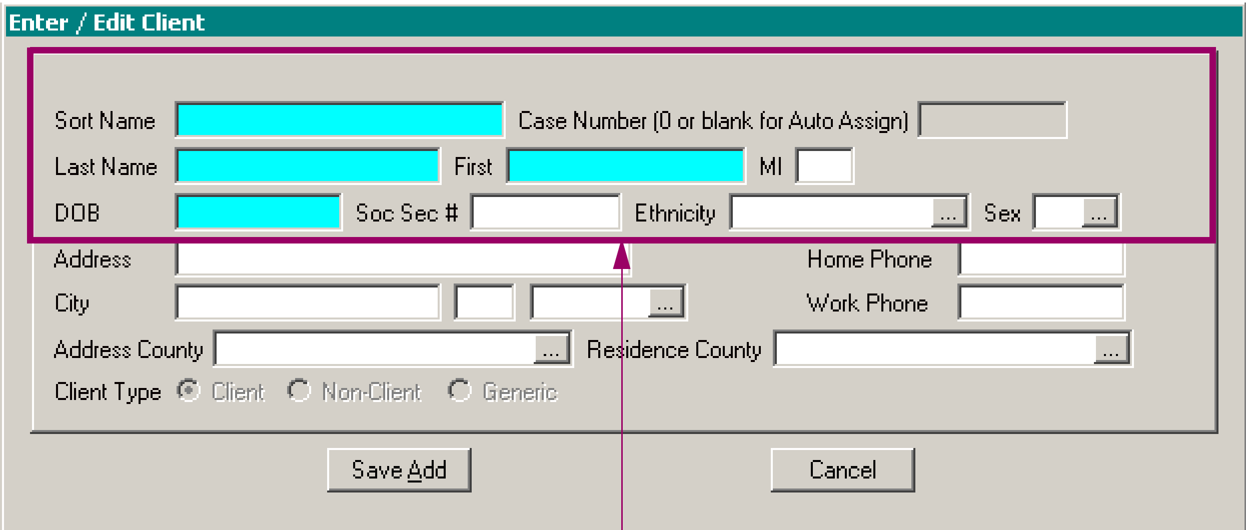
*Figure 36 - Clients Lookup, Filters*




- The 'First Name Match' field can be a maximum of 166 characters in length and is used to enter a first name on which to filter the Client list.
- The 'Ethnicity' is selected from the Ethnicities Lookup.
- The 'Primary Unit' is selected from the Units Lookup.
- The 'Primary SubUnit' field becomes available once a 'Unit' has been selected and is selected from the SubUnits Lookup.
- The 'SAI' (Single Accountable Individual, or 'Primary Server') is selected from the Staff Lookup.
- The 'From Age' can be 1 to 2 digits in length and is used with the 'Thru Age' field to filter the list based upon an age range.
- The 'Thru Age' can be 1 to 2 digits in length and is used with the 'From Age' field to filter the list based upon an age range.
- The list can be filtered by gender by selecting the appropriate radio button: 'Male', 'Female' or 'All'.

*Enter/Edit Client*

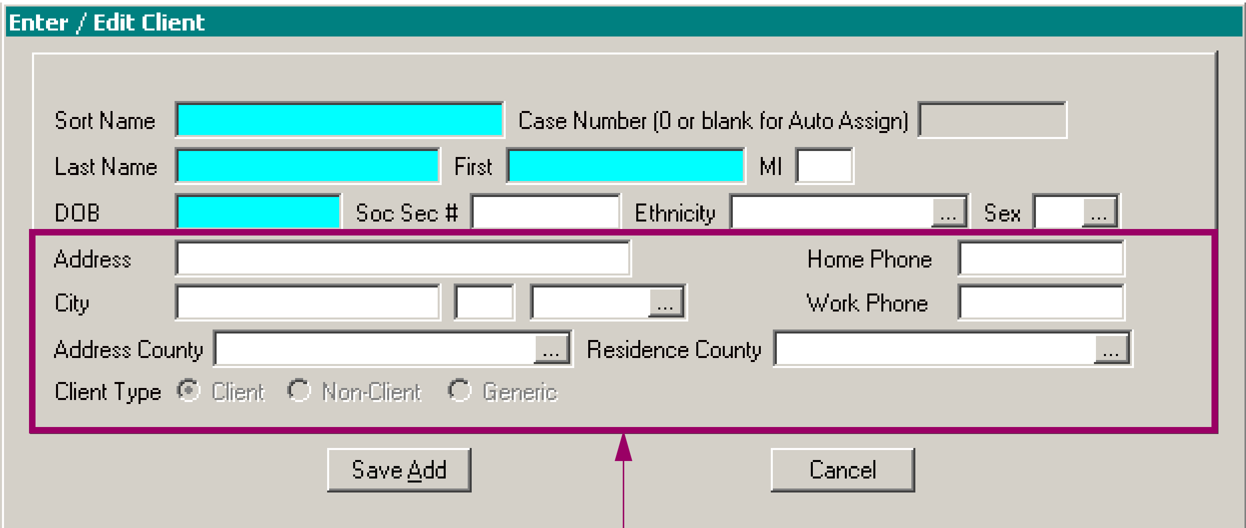
*Figure 37 - Enter/Edit Client Dialog*




- The ‘Sort Name’ is required, can be a maximum of 30 characters in length, and is the way in which the Client’s name will appear in lookups.
- The ‘Case Number’ is automatically assigned by the system using the next number in the sequence.
- The ‘Last Name’ is required, can be a maximum of 30 characters in length, and is the Client’s last name.
- The ‘First Name’ is required, can be a maximum of 15 characters in length, and is the Client’s first name.
- The ‘MI’ can be 1 character in length, and is the Client’s middle initial.
- The ‘DOB’ is required and is the Client’s date of birth in MM/DD/YYYY format.
- The ‘Soc Sec #’ can be a maximum of 11 characters in length and is the Client’s Social Security Number.
- The ‘Ethnicity’ is selected from the Select Ethnicity Dialog and is the ethnicity of the Client.
- The ‘Sex’ is selected from the Select Sex Dialog and is the gender of the Client.

*Enter/Edit Client - Cont'd*

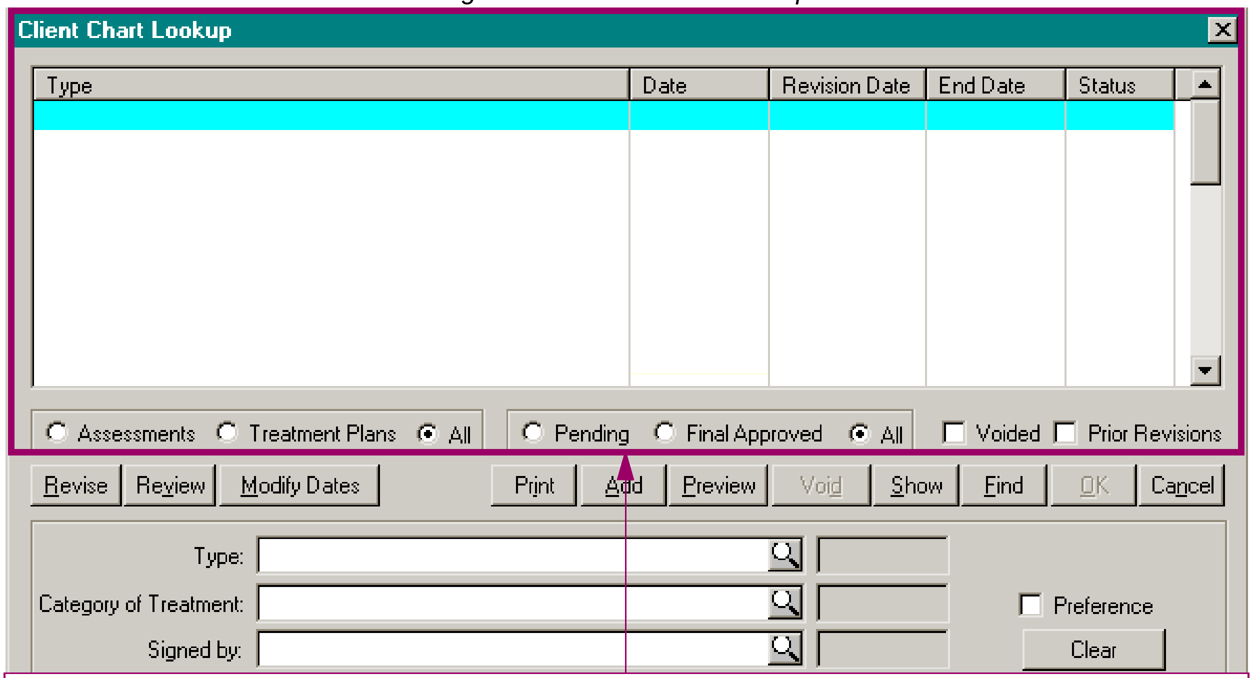
*Figure 38 - Enter/Edit Client Dialog*




- The 'Address' can be a maximum of 30 characters in length and is the Client's street address.
- The 'City' can be a maximum of 20 characters in length and is the Client's city. The adjacent field can be 1 to 2 characters in length and is the Client's state of residence. The next field is selected from the Select Zip Code Dialog and is the Client's Zip Code.
- The 'Home Phone' can be a maximum of 12 characters in length, in the format 'XXX XXX-XXXX' or 'XXX-XXXX' and is the Client's home phone number.
- The 'Work Phone' can be a maximum of 12 characters in length, in the format 'XXX XXX-XXXX' or 'XXX-XXXX' and is the Client's home phone number.
- The 'Address County' is selected from the Select County Dialog and is the Client's address county.
- The 'Residence County' is selected from the Select County Dialog and is the Client's county of residence.
- The 'Client Type' selection can be 'Client', 'Non-Client' or 'Generic'.

## Client Chart

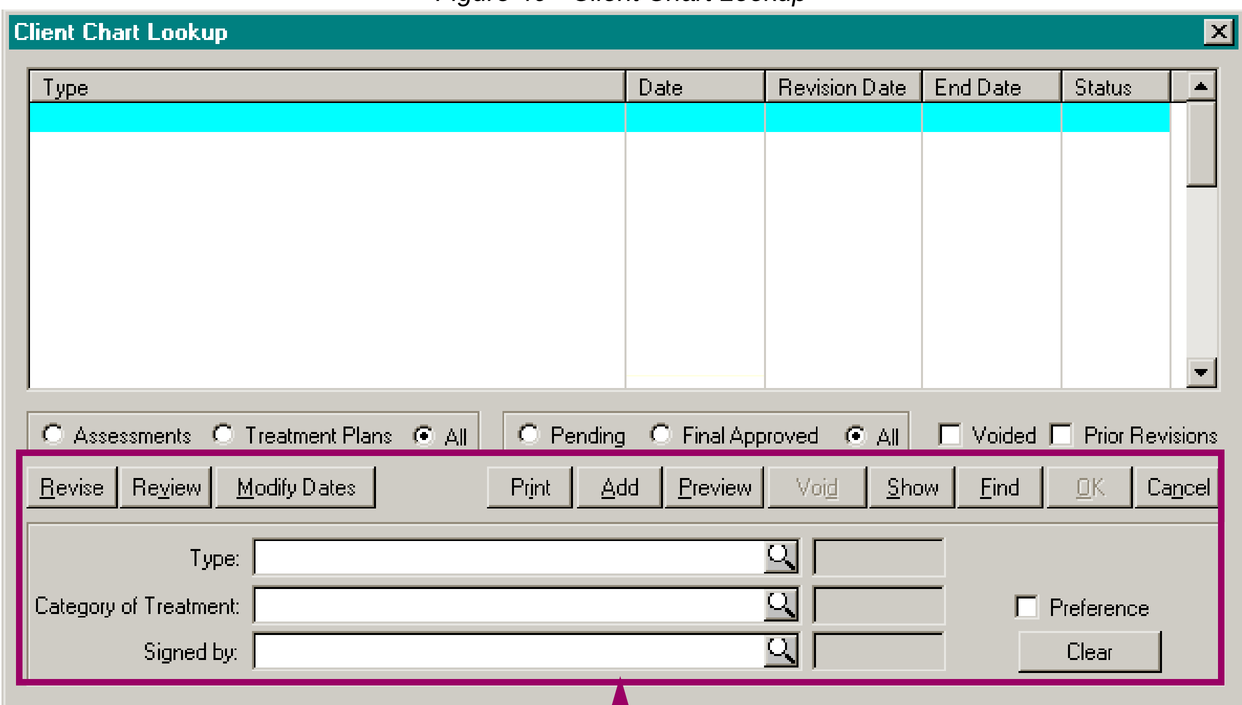
*Figure 39 - Client Chart Lookup*




- The Client Chart Dialog displays the Assessments and/or Treatment Plans that have been developed for the selected Client, including the following information:
  - 'Type' - the Assessment or Treatment Plan Type.
  - 'Date' - the Assessment or Treatment Plan Date. Clicking the Date column heading reverses the sort order. The sort order is persistent within the session.
  - 'Revision Date' - the Revision Date of Treatment Plans (only).
  - 'End Date' - the End Date of Interim Service Logs, Interim Treatment Plans and Treatment Plans.
  - 'Status' - the Assessment or Treatment Plan Status.
- Only Assessments, only Treatment Plans or both Assessments and Treatment Plans can be displayed by selecting the 'Assessments', 'Treatment Plans' or 'All' radio buttons.
- Only Pending, only Final Approved or both Pending and Final Approved Assessments and/or Treatment Plans can be displayed by clicking the 'Pending', 'Final Approved' or 'All' radio button.
- Assessments and/or Treatment Plans that have been voided can be displayed by clicking the 'Voided' field so that it is active.
- Prior Revisions of Assessments and/or Treatment Plans can be displayed by clicking the 'Prior Revisions' field so that it is active.

## Client Chart - Cont'd

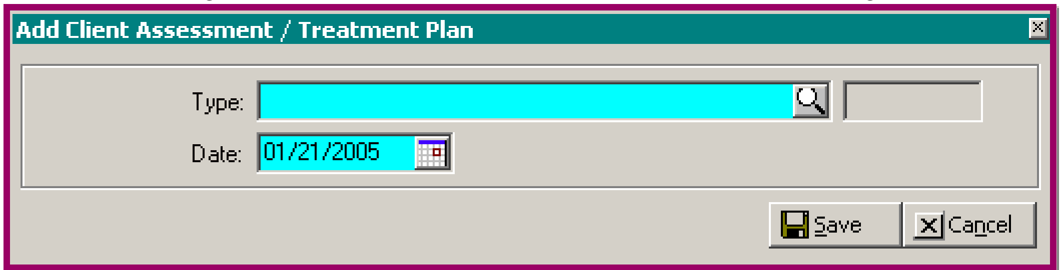
*Figure 40 - Client Chart Lookup*




- Treatment Plans can be revised, reviewed, have their dates modified, added, previewed, deleted or shown from the Client Chart Dialog. Information on how to perform each task is included later in this manual.
- The list that displays in the Client Chart Dialog can be constrained by Type, Category of Treatment or the Staff who signed the Treatment Plan.
  - The 'Type' is selected from the Assessment / Treatment Plan Types Lookup (shown later in this section).
  - The 'Category of Treatment' is selected from the Categories of Treatment Lookup, which is populated from the Anasazi Central Categories of Treatment Table.
  - The 'Signed by' Staff is selected from the Staff Lookup.
- If the 'Preference' field is active, the constraint selections made in the 'Type', 'Category of Treatment' and/or 'Signed by' fields are retained for the logged in Staff.

## *Add Client Assessment / Treatment Plan*

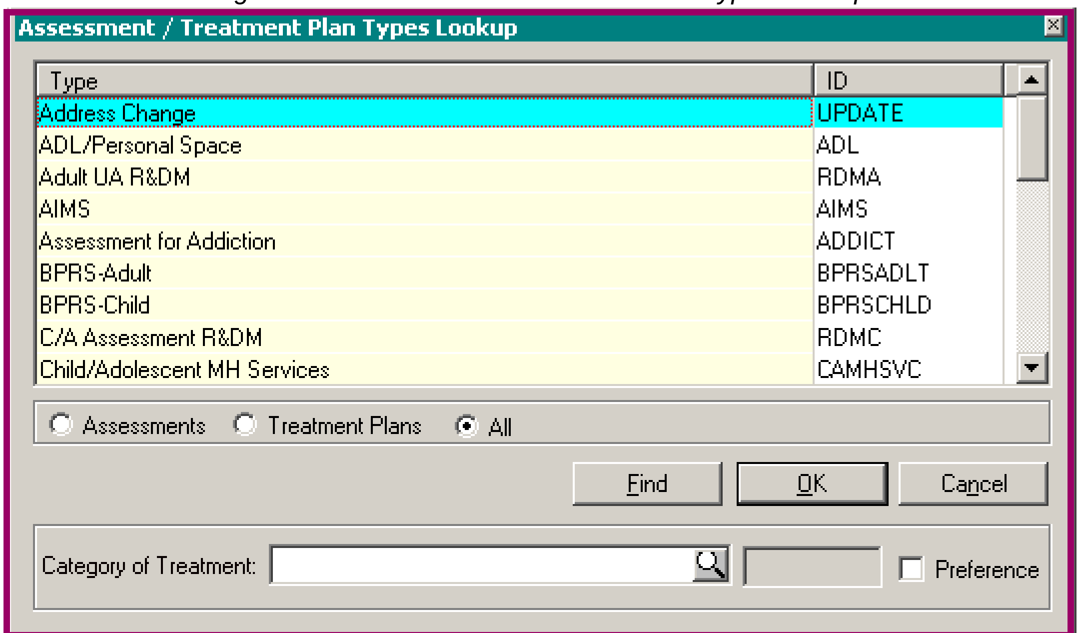
*Figure 41 - Add Client Assessment / Treatment Plan Dialog*




- The ‘Type’ is required and is selected from the Assessment / Treatment Plan Types Lookup (shown on the next page).
- The ‘Date’ is required and defaults to the current date provided the ‘Default Date of New Assessments to Today’ field is active in Assessment System Parameters Maintenance, but can be changed.

*Assessment / Treatment Plan Types Lookup*

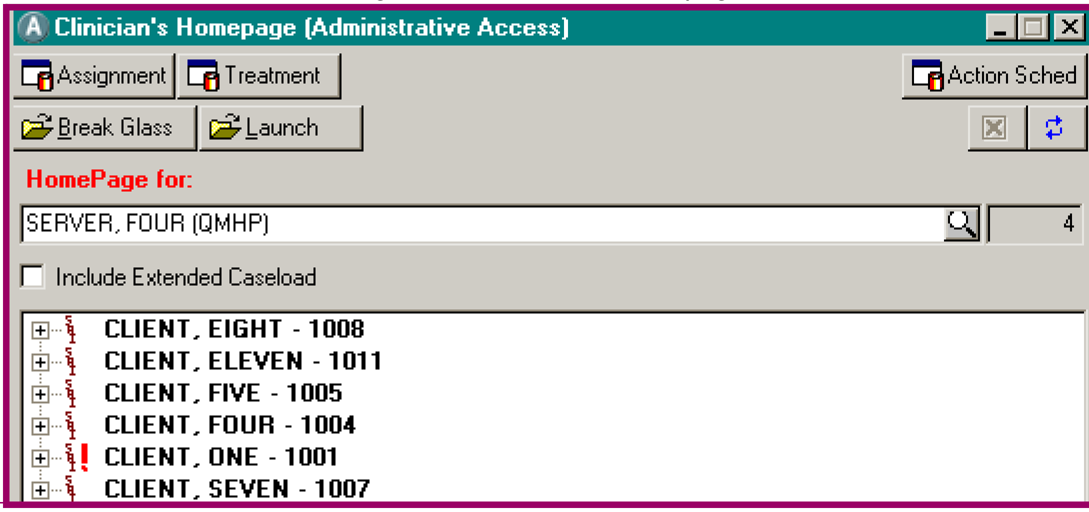
*Figure 42 - Assessment / Treatment Plan Types Lookup*




- The list displays active ‘Assessments’, ‘Treatment Plans’, or ‘All’, based on the radio button selection.
- The ‘Category of Treatment’ is selected from the Categories of Treatment Lookup (populated from the Anasazi Central Categories of Treatment Table). If a Category of Treatment is selected, the list filters to display Assessment and/or Treatment Plans that have been assigned the selected Category of Treatment.
- If the ‘Preference’ field is active, the selected Category of Treatment filter will be recalled the next time the Dialog is opened.

## Clinician's Homepage

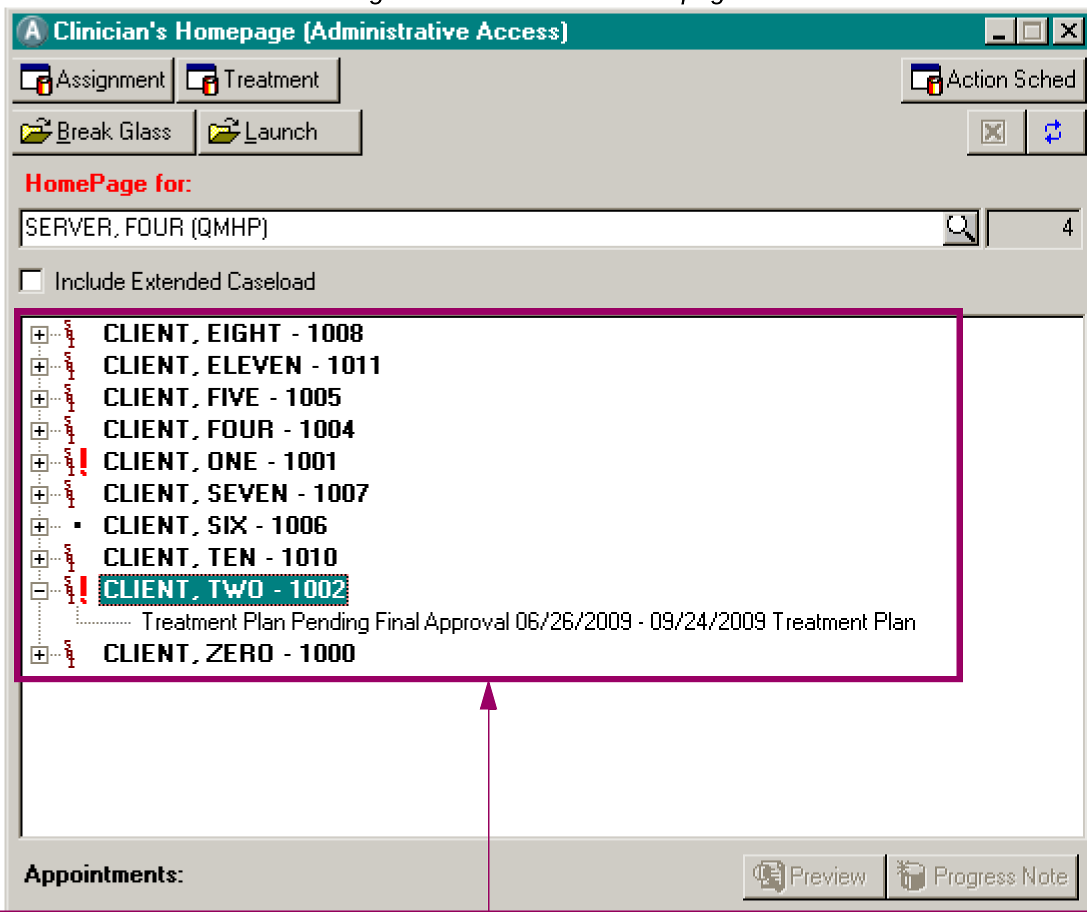
*Figure 43 - Clinician's Homepage*




- The Clinician's Homepage displays the Caseload and Notifications for the logged in Clinician (Staff Member) in a Tree format by Client.
- The 'Assignment' button launches the Client Data Client Assignments Maintenance View.
- The 'Treatment' button launches the Client Data Client Treatment Sessions Maintenance View.
- The 'Break Glass' button launches the Staff Login to Break Glass Dialog, in which the Staff Member's password must be entered in order to launch the Break the Glass Dialog.
- The 'Launch' button launches the selected Assessment or Treatment Plan.
- The 'Action Sched' button launches the Client Action Schedules Maintenance View.
- The 'Refresh' button refreshes the Tree. The Clinician's Homepage is not automatically refreshed after having performed data entry that affects the information on the Client Chart. The 'Refresh' button must be clicked or the View closed & re-launched. There is one exception: when an Appointment is selected from the Homepage to be Progress Noted, the Homepage is automatically refreshed once the Progress Note is saved and the Progress Note Dialog is closed.
- The 'Homepage for' field defaults with the currently logged in Staff, but may be changed. The Staff is selected from the Staff Lookup.
- The 'Include Extended Caseload' field is only available if the 'Enable Treatment Team Functionality' field is active in Center Setup (2). When this field is active, the Clients that display on the Homepage are those for which the Staff Member is not the SAI, but who are assigned to a Treatment Team to which the Staff Member belongs.

## Clinician's Homepage - Cont'd

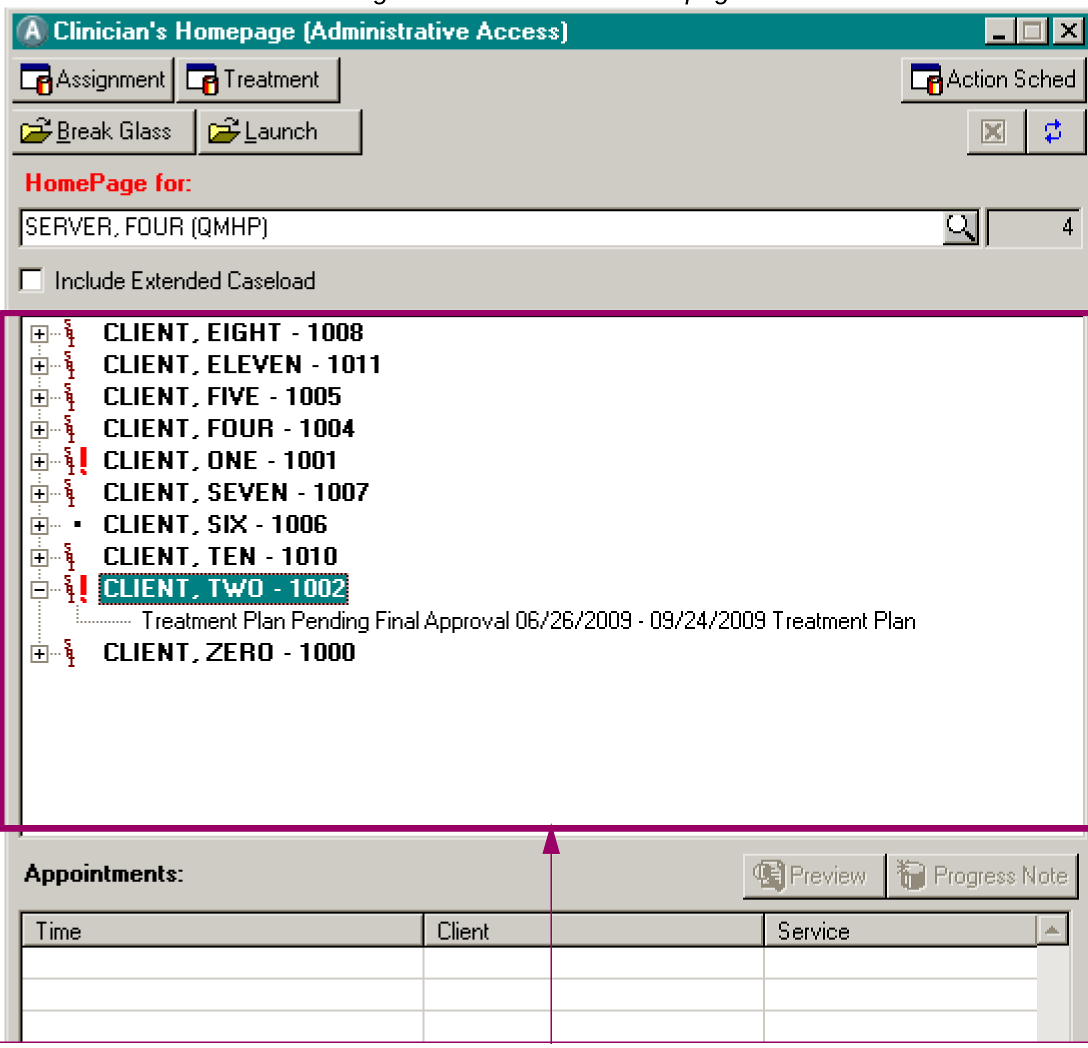
*Figure 44 - Clinician's Homepage*




- The Tree displays the Staff's Client caseload sorted by the 'Sort Name', followed by the Case Number. If the Staff selected in the 'Homepage for' field is the Client's SAI (as defined in Client Assignments Maintenance in the Client Data Product), a bitmap 'SAI' appears next to the Client's name. The Clients who are displayed on the selected Staff's caseload include:
  - Clients that have an Open Assignment for which the selected Staff is the Server.
  - Clients that have a Closed Assignment that was closed within the latency period for which the selected Staff is the Server.
  - Foreign Clients (Clients not on the selected Staff's caseload) are preceded with a red '!'. The only applicable condition is 'Form Pending Final Approval': Foreign Clients who have a form that is not yet Final Approved for which the selected Staff is a Signer on the form (for Assessments, ISLs, ITPs, TPs). This only applies if the logged-in Staff has COT access to the Assessment.
  - If there is at least one Notification for a Client, the Client is preceded with a red '!' (Notification) or a blue '!' (Alert).

## Clinician's Homepage - Cont'd

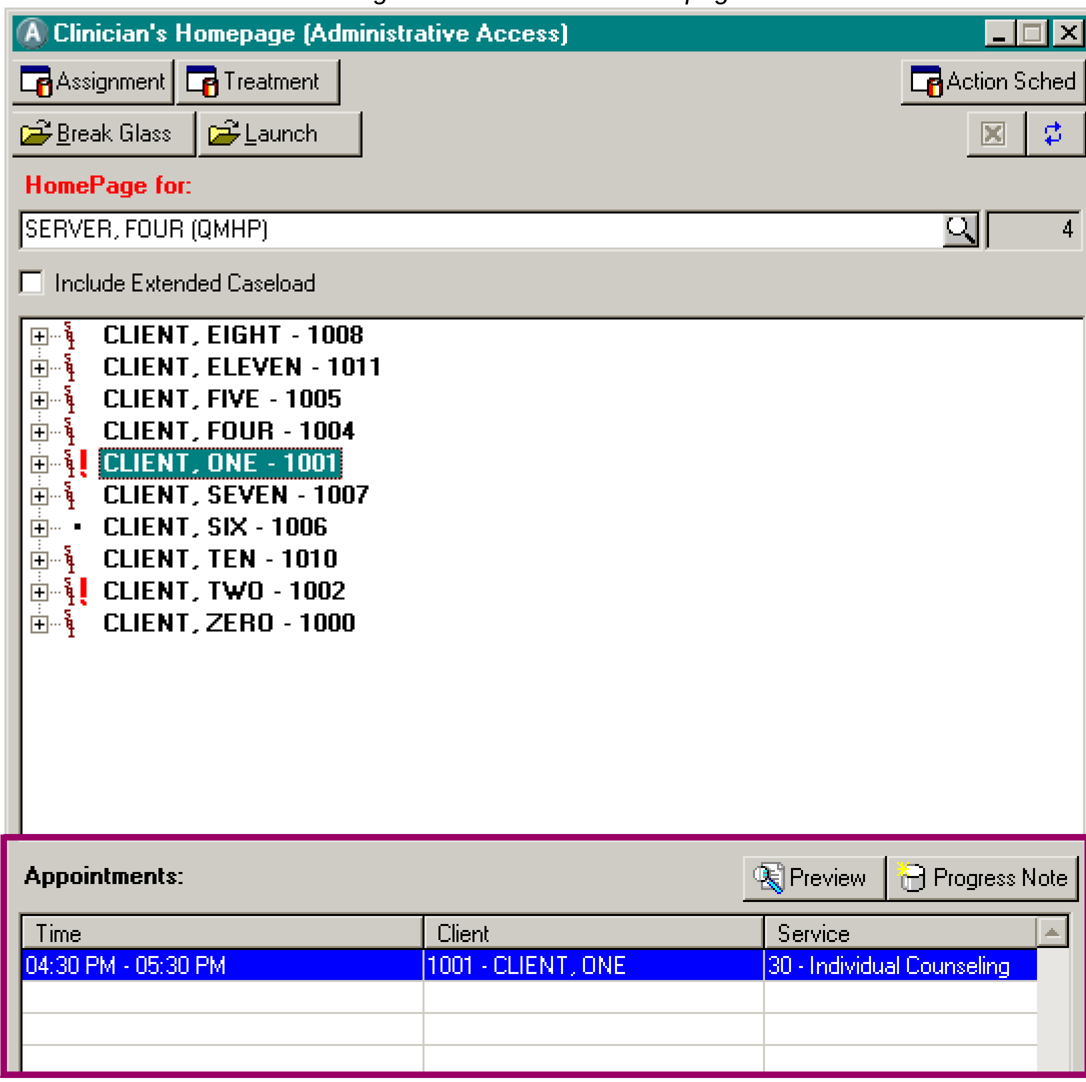
*Figure 45 - Clinician's Homepage*




- Double-clicking a Client branch launches the Client Chart View with that Client selected and his/her Home Folder displayed. An exception to this is if the Client Chart View is already launched and another Client is selected and not in Home Folder mode (i.e., the Staff Member is in the middle of working on a record for another Client). In this case a message appears indicating that the selected Client will not be displayed.
- Expanding a Client branch displays child Notification branches. See '<u>Notifications</u>' in The Flying Tour for information on Notifications.
- Clicking an item on the Notification branch will launch the item.

## Clinician's Homepage - Cont'd

*Figure 46 - Clinician's Homepage*

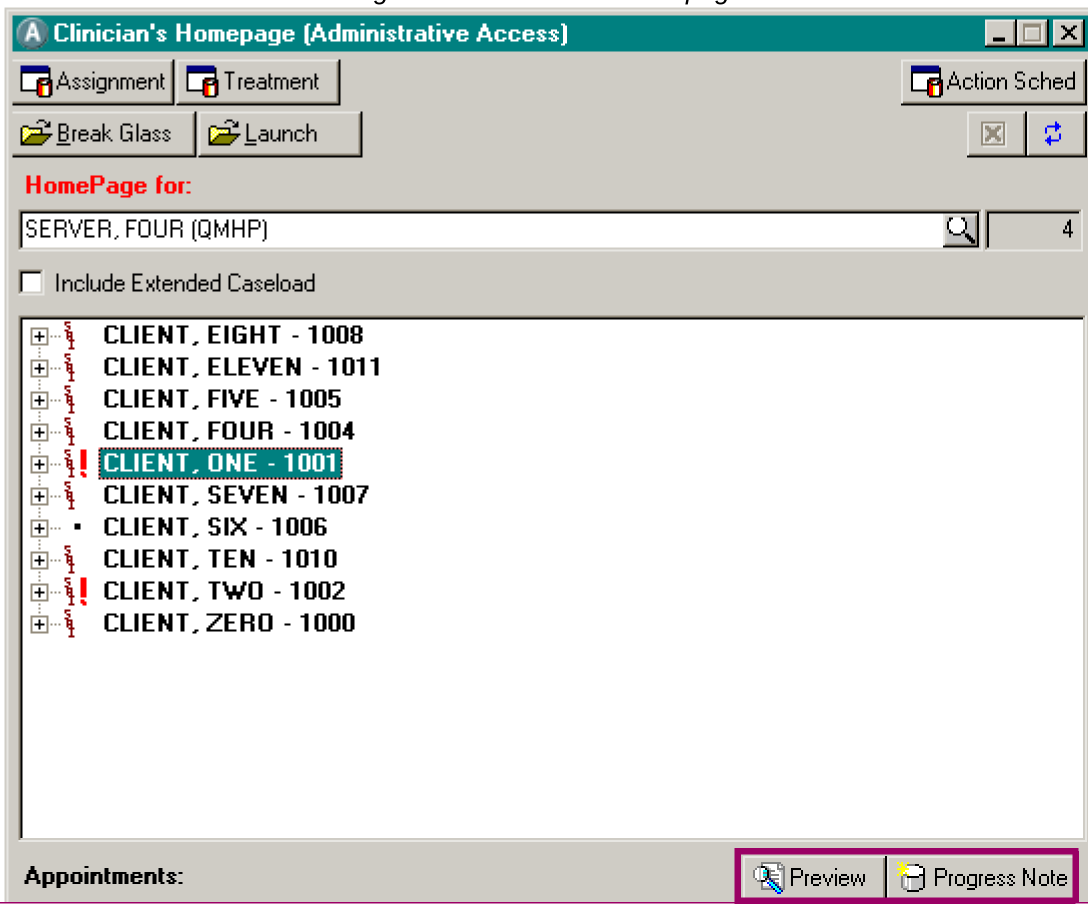



- The Appointments container displays a list of scheduled appointments for the Staff, which can be selected in order to preview Treatment Plan information or enter Progress Notes for the appointment. This information is displayed only for Customers who have purchased the Scheduler Product. Note: scheduled Services for future dates cannot be selected.

- When an Appointment is selected to be Progress Noted, the system checks for any Resolved Services for the Scheduled Event. If there are any Resolved Services, the Appointment is considered to be partially Resolved and cannot be Progress Noted from the Clinician's Homepage. The Import option in the Progress Note must be used instead (see the Treatment Plan Product User Manual for information on importing).

## Clinician's Homepage - Cont'd

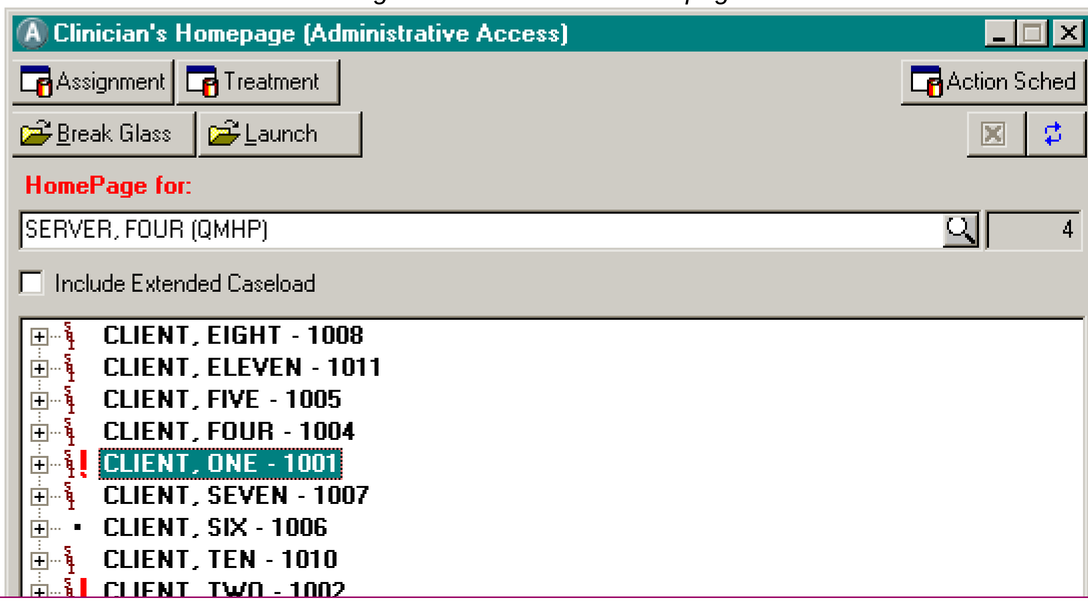
*Figure 47 - Clinician's Homepage*




- The 'Preview' button is accessible when an appointment is selected and launches the Client Chart for the selected Client. This allows Staff to review information about the Client before the Client presents for the appointment in order to determine if the Client has a Treatment Plan and/or to review recent Progress Notes, etc. The right-click shortcut menu can also be used to select 'Preview' for the selected appointment. For Individual and Multi Service appointments (the 'Preview' button is not accessible for Group Services):
  - If the Client has a Treatment Plan but no Interventions, the Treatment Plan Tab Page is displayed.
  - If the Client has a Treatment Plan but no Intervention that matches the scheduled service, the Treatment Plan Tab displays with the focus on the first Intervention.
  - If the Client has a Treatment Plan and an Intervention that matches the scheduled service, the Treatment Plan Tab Page displays with the focus on the target Intervention.
- The 'Progress Note' button is accessible when an appointment is selected. See the Treatment Plan Product User Manual for information on Progress Noting functionality.

## Clinician's Homepage - Cont'd

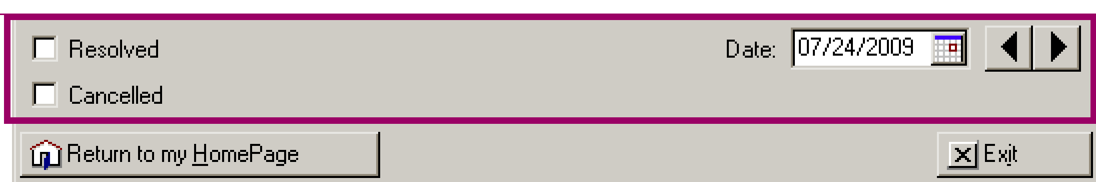
*Figure 48 - Clinician's Homepage*




- If the 'Resolved' field is active, the list of appointments includes Resolved appointments. If this field is inactive, the list of appointments does not include Resolved appointments.

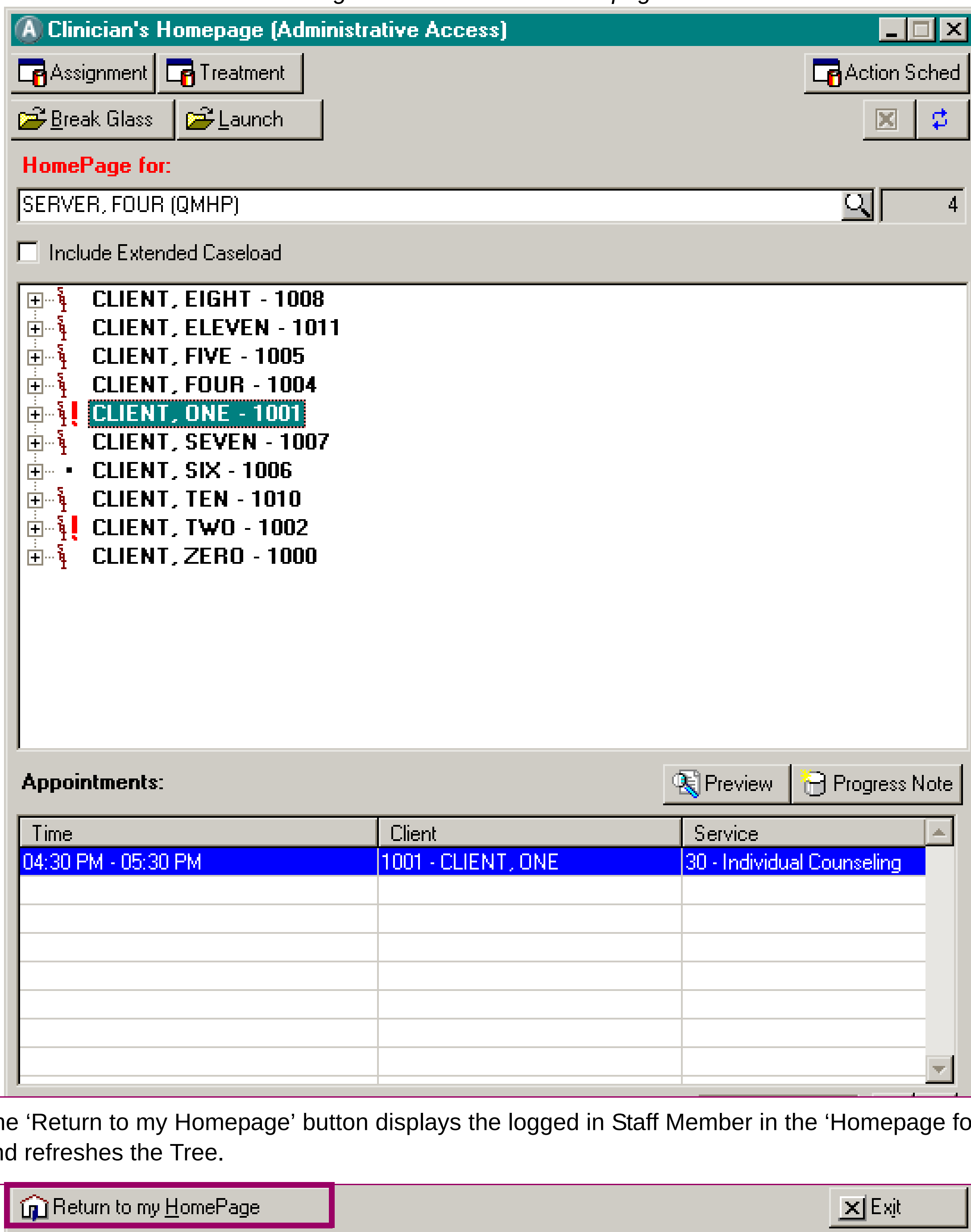
- The 'Date' field defaults to the current date but can be changed. The left and right arrows move to the previous day and next day, respectively.

- Individual Events display with the 'Cancelled' field active if the scheduled Service is in a Cancelled status. The 'Progress Note' button and the right-click 'Progress Note' menu option are shadowed if an Individual Event is selected that is Cancelled. Group Events display with the 'Cancelled' field active when all scheduled Services for an Event are in a Cancelled status. The 'Progress Note' button and the right-click 'Progress Note' menu option are shadowed for a Group Event that is displayed as Cancelled. For Group Events available to Progress Note, all scheduled Services (in a Cancelled Status or not) are imported into the Note.
  - *For Groups that include scheduled Services with a Cancelled status, Services are always created, regardless of the 'Create Svc' flag(s) in the Cancellation Reasons Table (e.g., Services are always created for both Resolved and Cancelled Services when Progress Noting). This is different from Cancelling through the Scheduler Product, where the 'Create Svc' flag for the selected Cancellation Reason is respected.*



## Clinician's Homepage - Cont'd

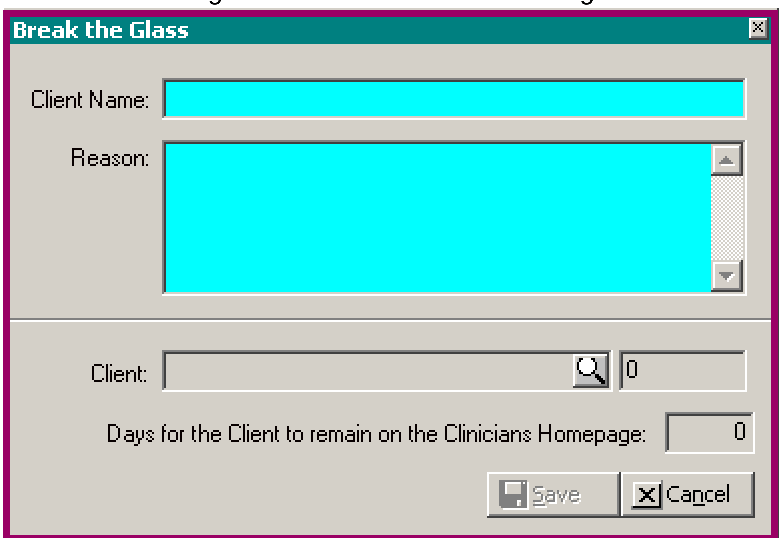
*Figure 49 - Clinician's Homepage*




- The 'Return to my Homepage' button displays the logged in Staff Member in the 'Homepage for' field and refreshes the Tree.

## Clinician's Homepage - Cont'd

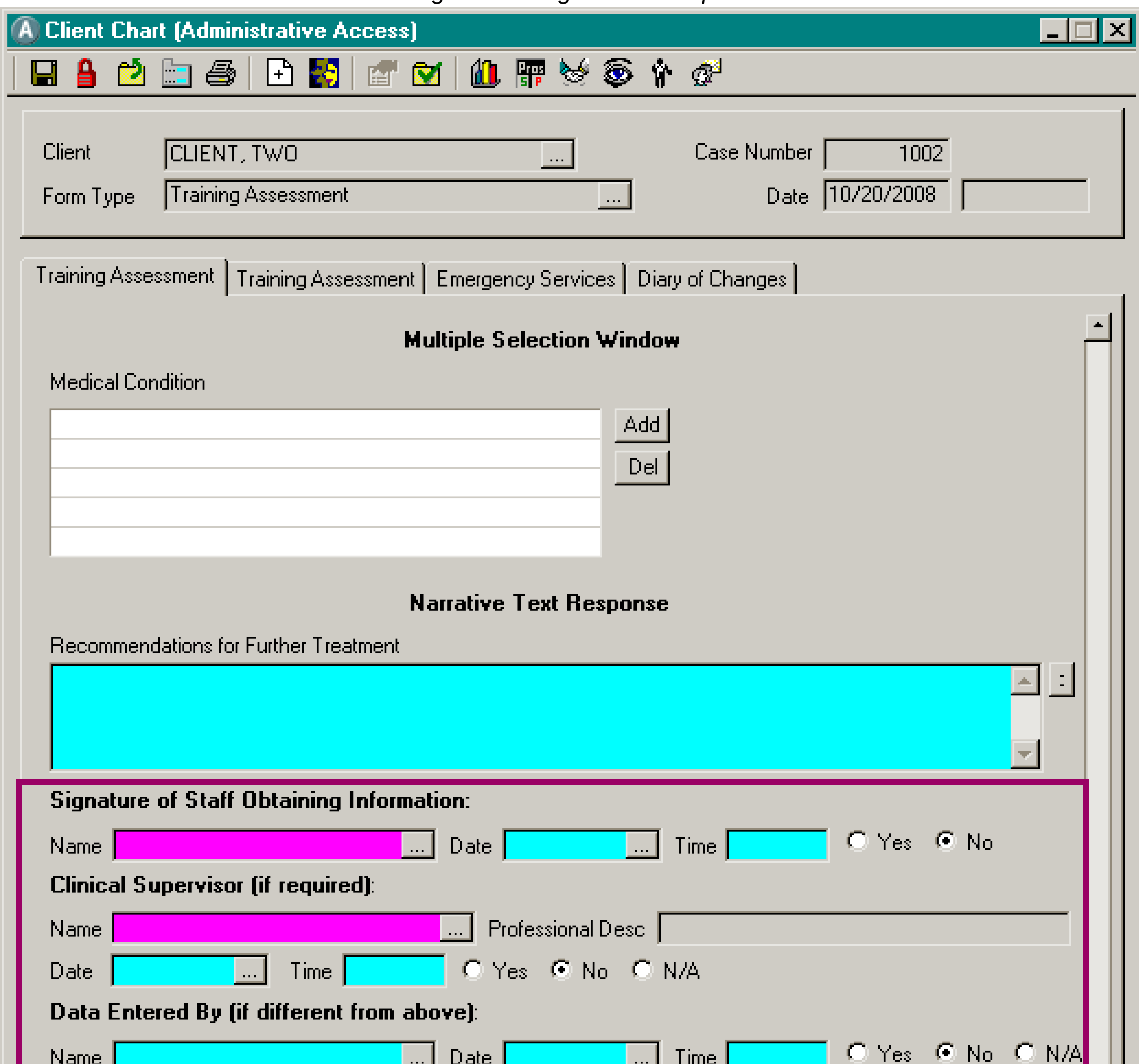
*Figure 50 - Break the Glass Dialog*




- The 'Client Name' is required and can be a maximum of 30 characters in length, and is the name of the Client as provided by the Client.
- The 'Reason' is required and is and explanation of why the Glass is being Broken.
- Once a 'Client Name' and 'Reason' have been entered, the 'Client' field becomes available and is required. The Client is selected from the Clients Lookup, which displays the entire database of Clients without any security restrictions. If a Client is not found in the database, the Staff can exit the Break the Glass Dialog; however, a Break the Glass record is still saved that includes the Staff Member's ID, Date, Time, Client Name and Reason.
- Once a 'Client Name' and 'Reason' have been entered, the 'Days for the Client to remain on the Clinician's Homepage' field becomes available, is required and can be 1 to 2 digits in length. The amount that is permitted in this field depends on the setting in the 'Max. days to keep Client on Homepage when Breaking the Glass' field in Security Parameters Setup (for information on this view, see the Anasazi Products System Administrator Manual).

## Assessment Signatures

*Figure 51 - Signature Groups*

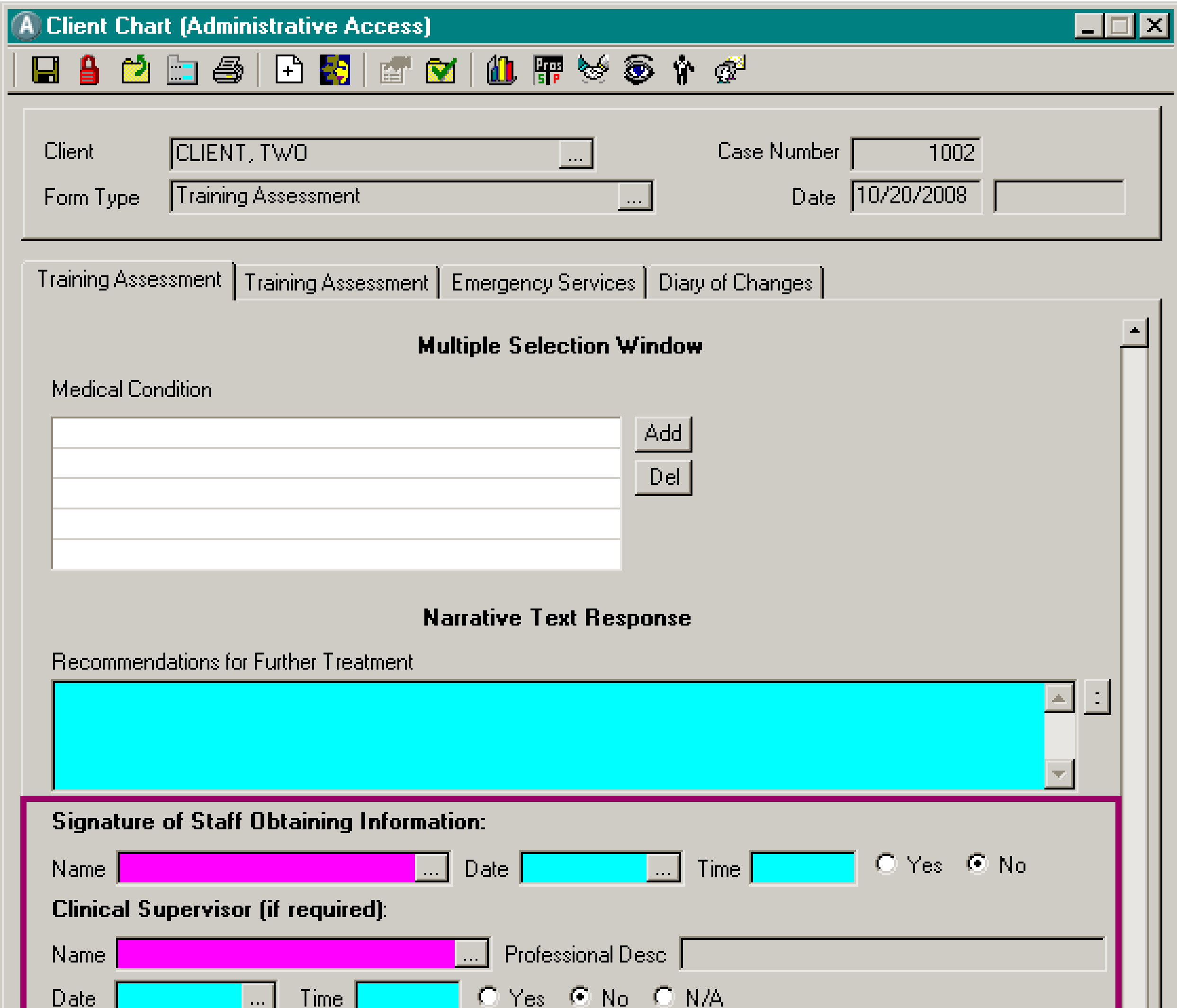



- To consider an Assessment completed, it must have an appropriately Credentialed or Non-Credentialed signature and Final Approval. A required signature will have a 'Yes' and 'No' option, whereas a non-required signature will also have 'N/A'. Signatures that require Credentials are displayed in dark pink. At least one Signature Line 'Name' must be entered in order to save a record.

- After an Assessment is finalized, it cannot be changed. Information from an approved Assessment will automatically default to the next Assessment initiated for the Client. It will not default until the Assessment is Final Approved. The defaulted information can be edited for future Assessments.

## Assessment Signatures - Cont'd

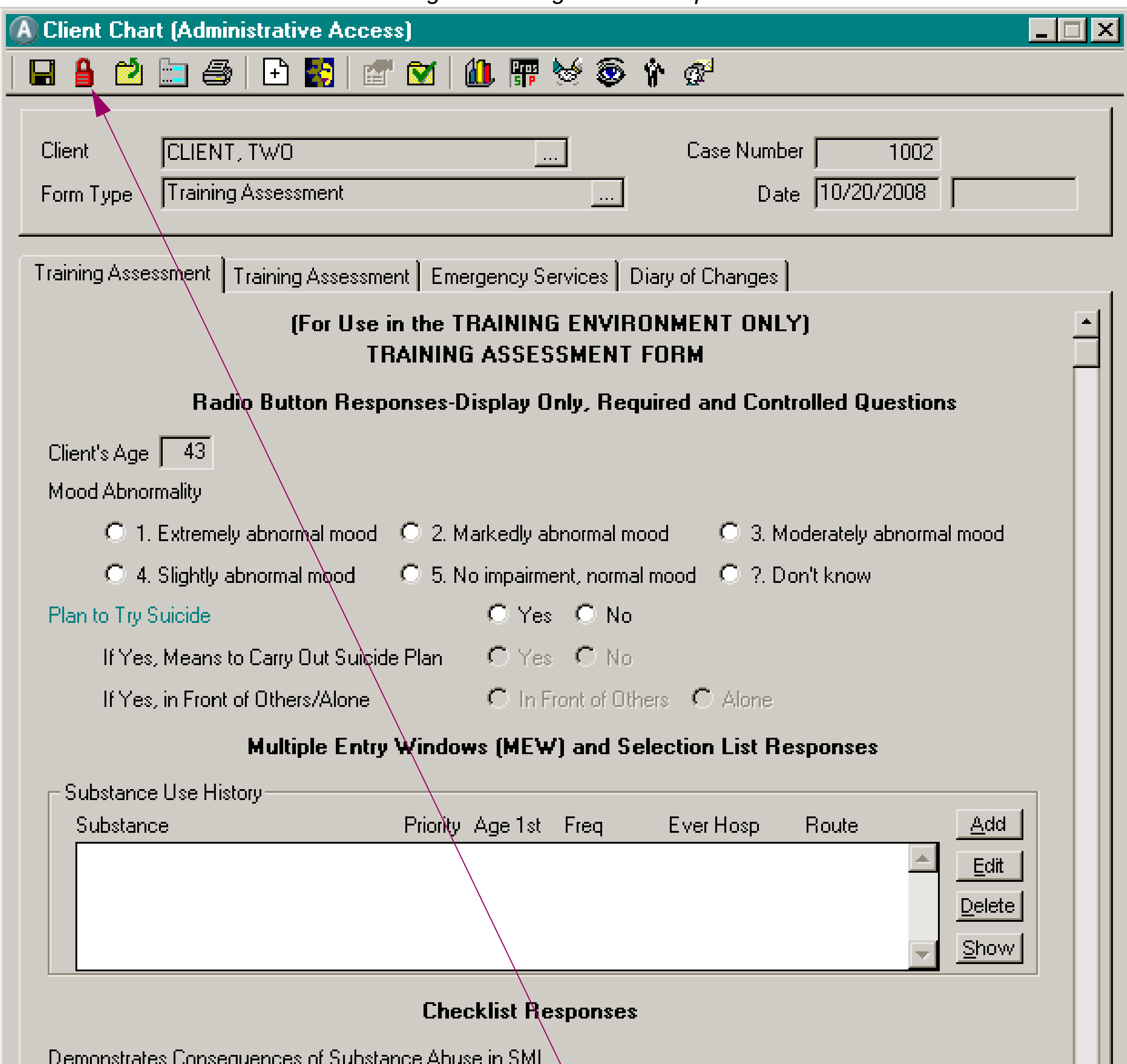
*Figure 52 - Signature Groups*




- The system defaults the current date and time if 'Yes' is selected to acknowledge that the selected signature is the electronic signature for this Assessment. A date and time other than today's can be entered when appropriate.
- If a signature other than the Staff logged into the system is selected and 'Yes' is indicated, the Assessment cannot be Final Approved. The Assessment can be Saved, and the selected Staff will be notified to sign on the Clinician's Homepage.
- If a signature other than the Staff logged into the system is selected and 'N/A' is indicated, 'N/A' signifies that the signature is not an electronic signature. An 'N/A' beside the signature indicates that a signed paper form carries the official signature for the Assessment.

## Assessment Signatures - Cont'd

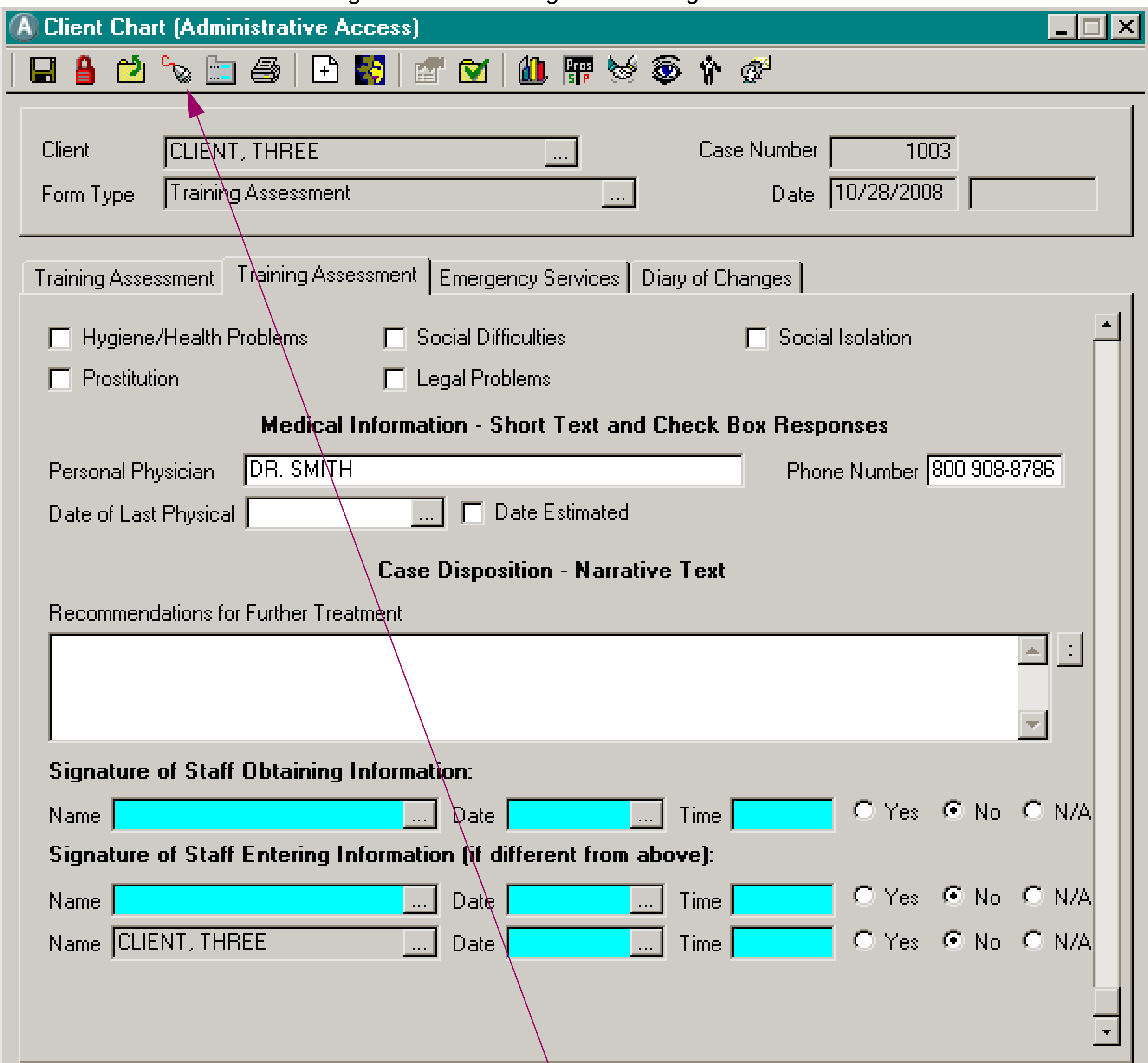
*Figure 53 - Signature Groups*




- The 'Final Approve Assessment or Treatment Plan' icon on the Tool Bar Final Approves the Assessment.
  - Note: Diagnosis Assessments (any Assessment Page in which the 'DIAG' Review Type has been linked via WYSIWYG) may not be Final Approved unless all Diagnoses (Axis I-IV) are active at the time of Final Approval.

## Assessment Signatures - Cont'd

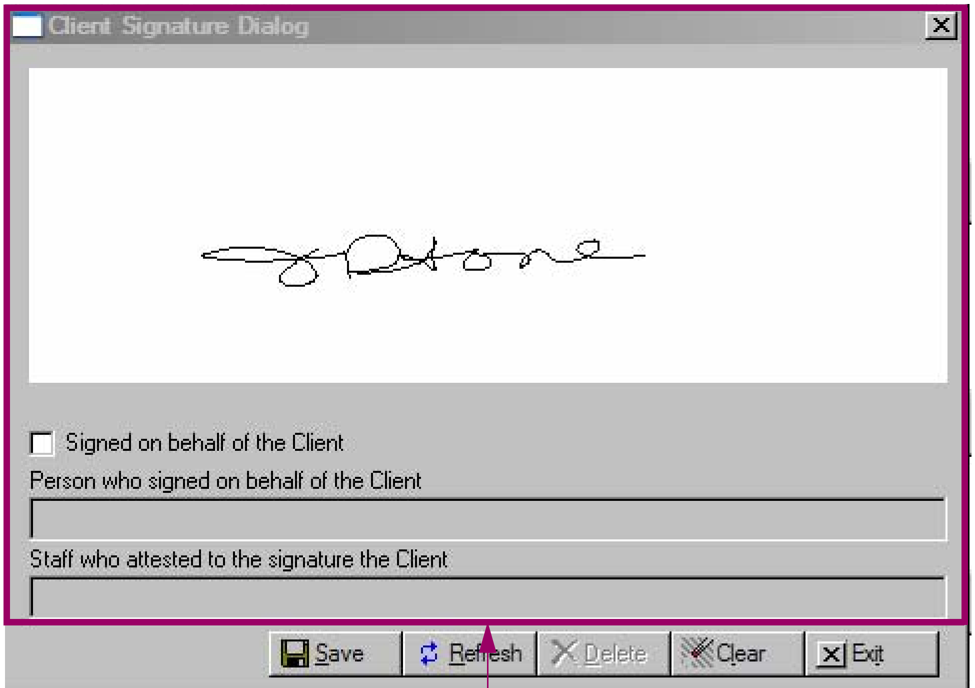
*Figure 54 - Client Signatures - Signature Pad*




- When the 'Signature Pad' icon is clicked, the Client Signature Dialog appears, provided a Signature Pad Device is attached to the computer. If a Signature Pad Device is not attached, the Dialog appears, but indicates 'Signature display unavailable'. Staff who do not have a Signature Pad Device connected to their computer may still view and print a saved Client Signature.

## Assessment Signatures - Cont'd

*Figure 55 - Client Signature Dialog*




- When the 'Signature Pad' icon is clicked, a blank Client Signature Dialog appears. As the Client enters their signature on the Signature Pad, it is displayed to the Dialog. Once the Client (or Parent/ Guardian) has completed the signature and has deemed it acceptable, Staff will click the 'Save' button and enter their password at the prompt. This saves the signature and serves to attest to the signature. The Client Signature Line on the Assessment Page is date and time stamped and the radio button is set to 'Yes'.

- *Note: a previously signed Page can be 'un-signed' by changing the Client Signature Line radio button from 'Yes' to 'No' or 'N/A'. This deletes a saved Client signature.*

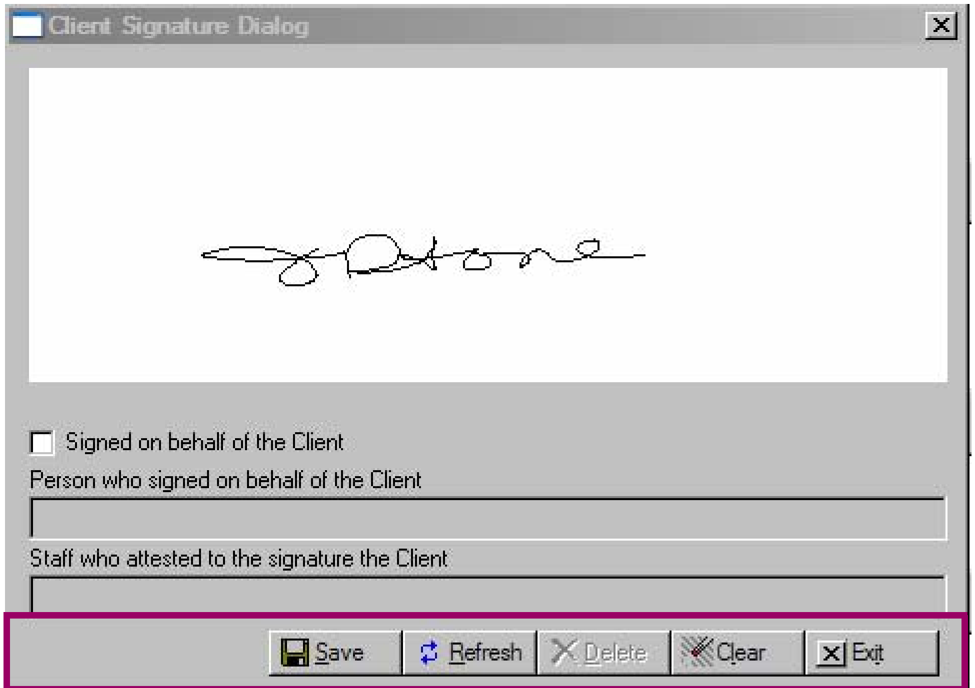
- In cases where a Parent or Guardian signs on behalf of a Client, the Client Signature Dialog includes a field for indicating that the Assessment Page was 'Signed on behalf of the Client', as well as a free text field that allows for entering the name (and relationship, if desired) of the signer (ASCII 60).

- The 'Staff who attested to the signature of the Client' field displays the name of the Staff who saved the Client Signature.

- Clicking the 'Signature Pad' button on a Page that has been signed through a Signature Pad Device displays the Signature Pad Dialog.

## Assessment Signatures - Cont'd

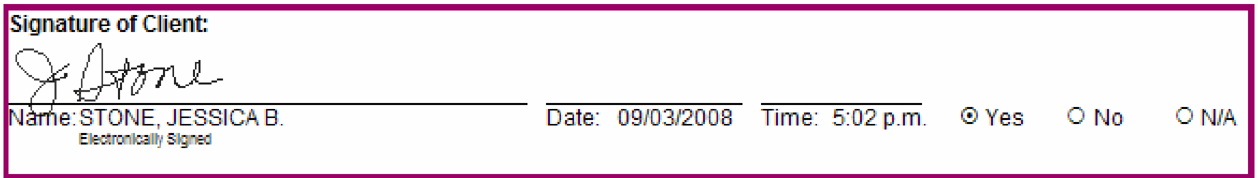
*Figure 56 - Client Signature Dialog*




- The 'Save' button prompts for the Staff password and then saves the Client signature.
- The 'Refresh' button refreshes the client information on the Signature Pad Device, clears any entries in the Client Signature Dialog and clears the signature from both locations, if present.
- The 'Delete' button deletes a saved Client signature.
- The 'Clear' button clears all Client and signature information from the Signature Pad Device.
- The 'Exit' button returns focus to the Assessment Page and no signature data is saved.

## Assessment Signatures - Cont'd

*Figure 57 - Printing Client Signatures*


**Signature of Client:**

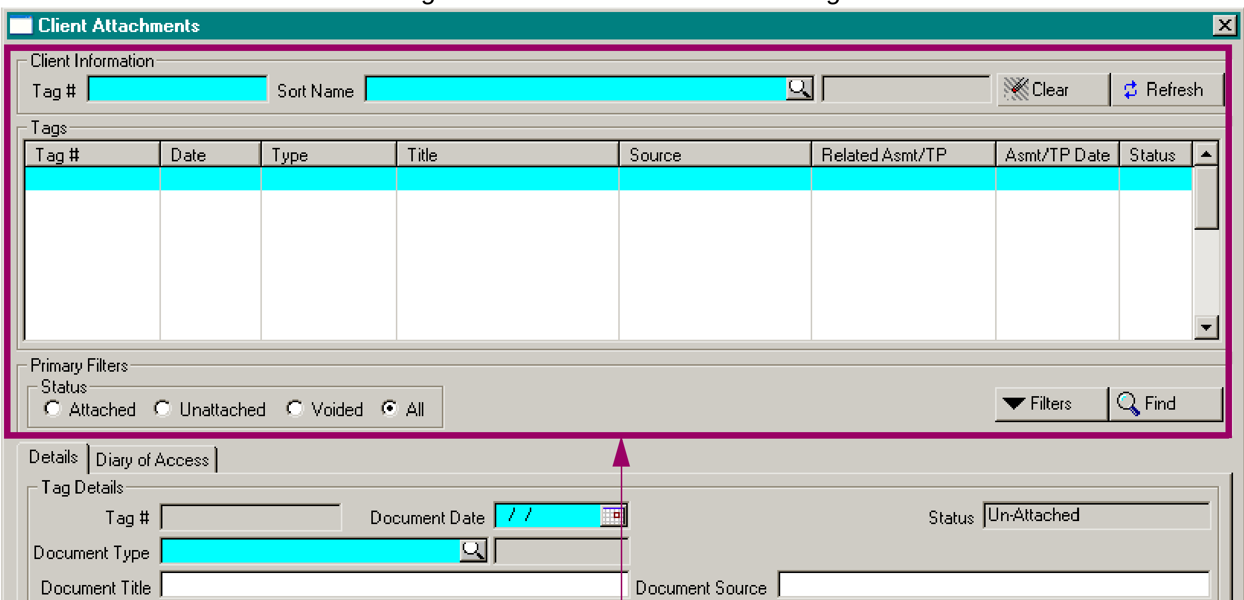
Name: STONE, JESSICA B.
Electronically Signed

Date: 09/03/2008 Time: 5:02 p.m. ⊙ Yes ○ No ○ N/A

- Pages that have been signed using a Signature Pad Device print an image of the Client Signature. When someone has signed on behalf of the Client, their Signature prints above the information entered into the 'Person who signed on behalf of the Client' field in the Client Signature Dialog.

## Document Management

*Figure 58 - Client Attachments Dialog*




- The 'Tag #' can be a maximum of 90 characters in length and is the Tag number that is associated with the attached document. Either a 'Tag #' or 'Client' must be entered.

- The 'Client' is required, is selected from the Clients Lookup, and is the Client for whom the document is associated. Either a 'Tag #' or 'Client' must be entered. If a Global Client is specified, that Client's information is populated in the Client Information container.

- The 'Clear' button clears the fields in the Client Information Container.

- The 'Refresh' button refreshes the information in the Client Information container.

- The Tags container displays a list of the Client's Tag records (to which the Staff has COT Access), including the 'Tag #', 'Date' 'Type', 'Title', 'Source', 'Related Asmt/TP', 'Asmt/TP Date' and 'Status'. The 'Status' column displays as blank when there is no attachment associated with the Tag, a blue box when the Tag has a document attached, and as a box with a blue dash in it when the Tag record is Void.

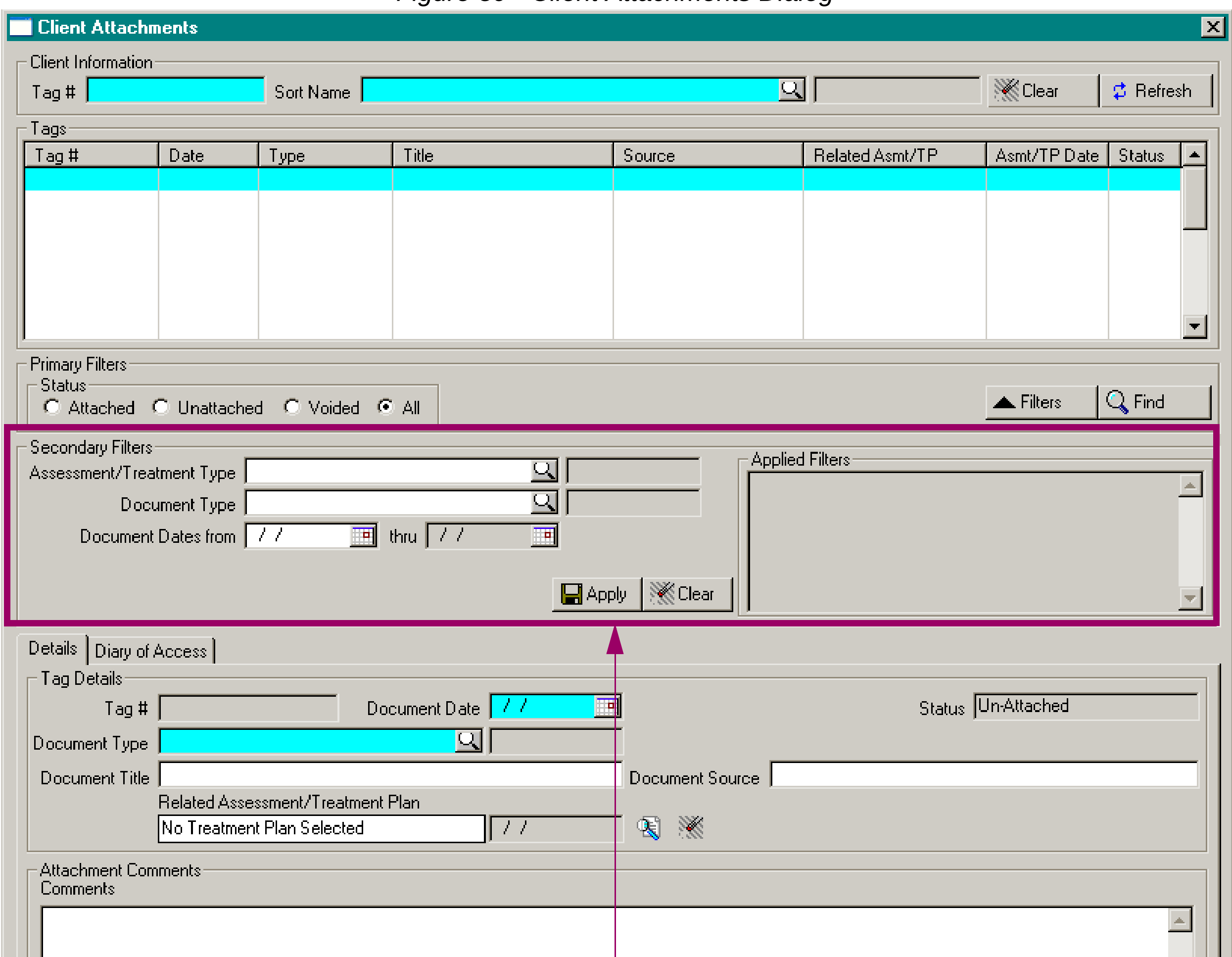
- The 'Primary Filters' container allows for filtering the list to display Tags that are 'Attached', 'Unattached', 'Voided' or 'All'.

- The 'Filters' button displays a Secondary Filters container, shown on the next page.

- The 'Find' button displays a Search Dialog that allows for searching the list by the 'Tag #'.

## Document Management - Cont'd

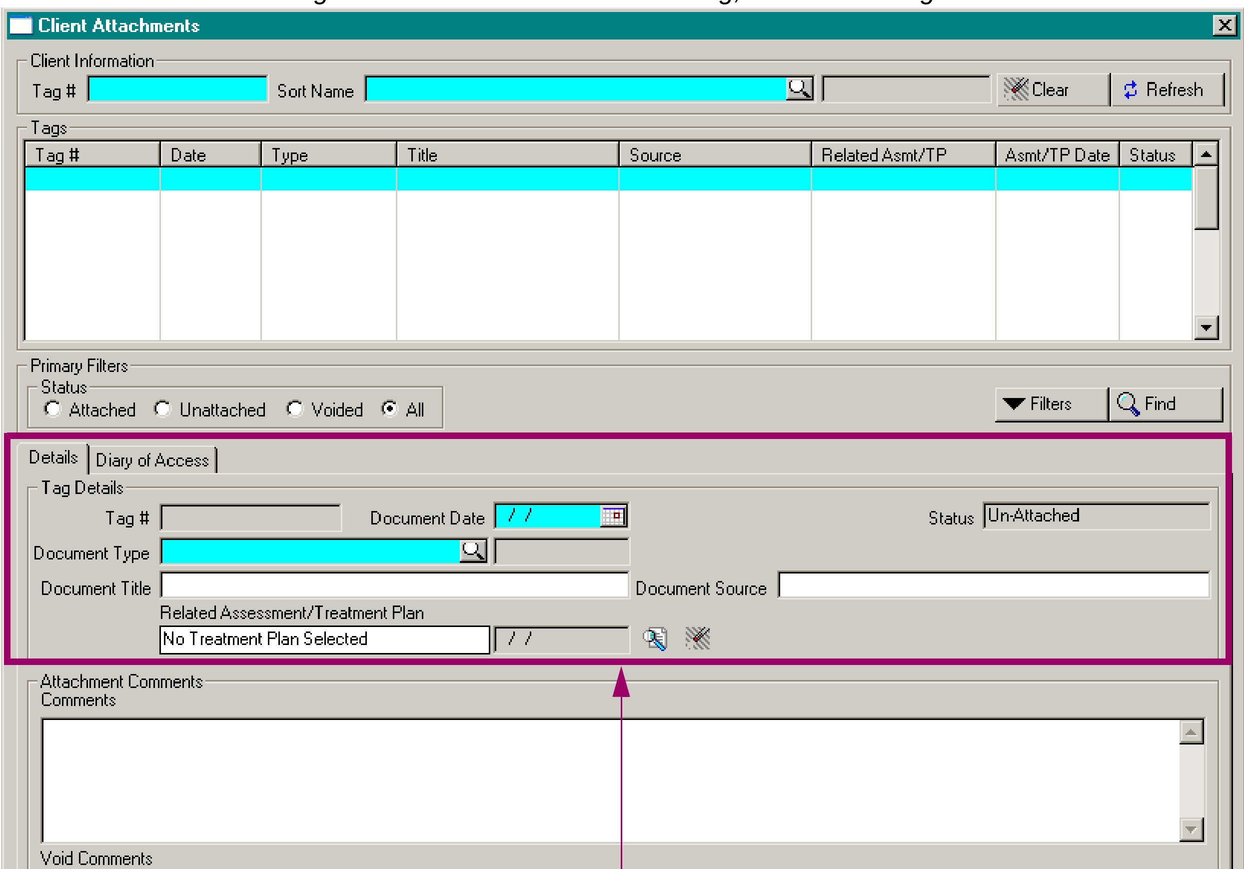
*Figure 59 - Client Attachments Dialog*




- The Secondary Filters container is displayed or hidden via the 'Filters' button.
- The Tags list can be filtered by 'Assessment/Treatment Type', which is selected from the Assessment/Treatment Plan Types Lookup.
- The Tags list can be filtered by 'Document Type', which is selected from the Document Types Lookup.
- The Tags LIst can be filtered by date via the 'Document Dates from' and 'thru' fields.
- The 'Apply' button applies the selected filters and displays them in the Applied Filters container.
- The 'Clear' button clears the selected filters from the Secondary Filters container.

## Document Management - Cont'd

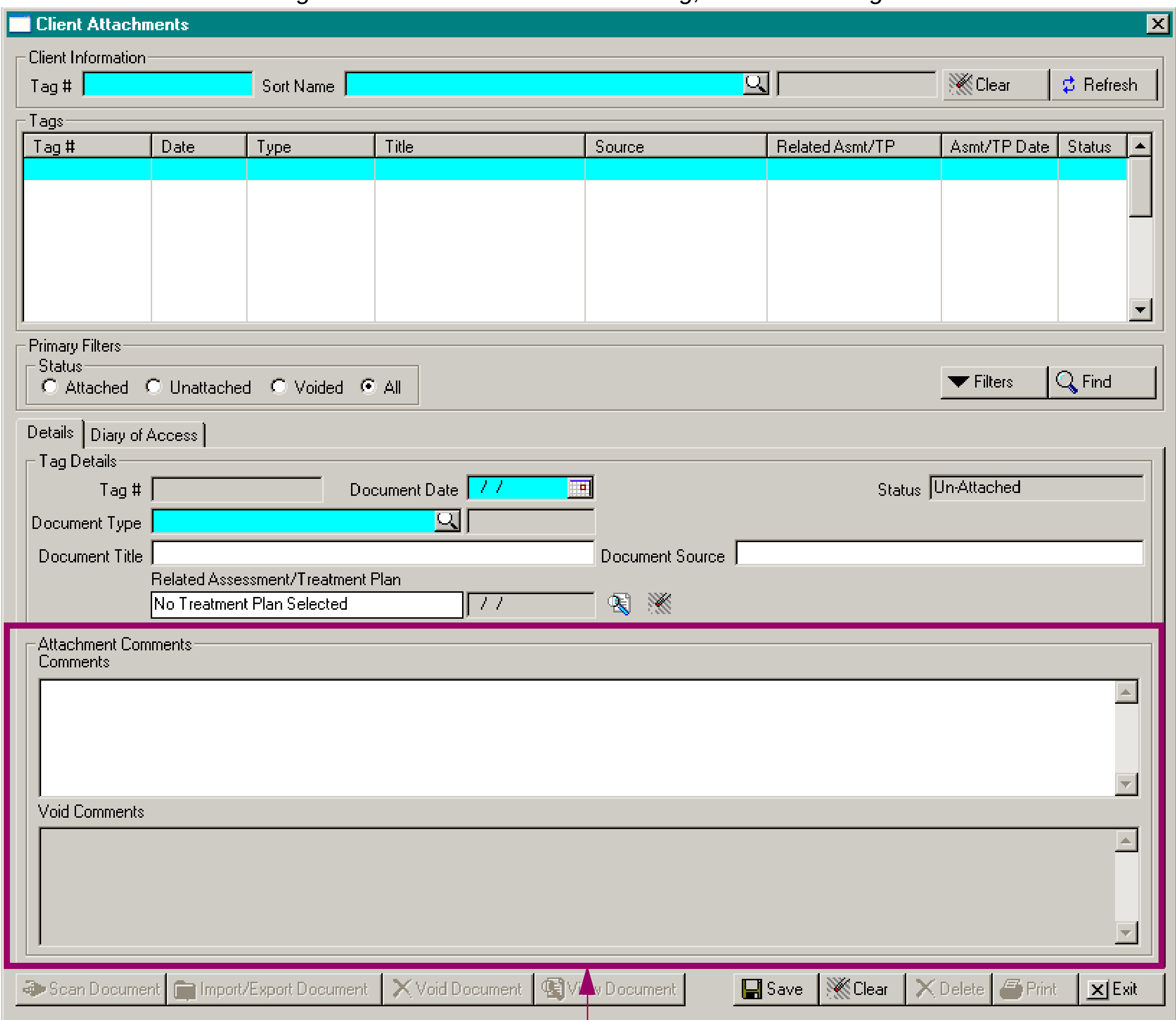
*Figure 60 - Client Attachments Dialog, Details Tab Page*




- The 'Tag #' field displays the Tag number of the record selected in the Tags container.
- The 'Document Date' is required, and is the date on which the document was scanned.
- The 'Status' field displays the Status of the selected record: 'Un-Attached' or 'Attached'.
- The 'Document Type' is required and is selected from the Document Types Lookup.
- The 'Document Title' can be a maximum of 40 characters in length.
- The 'Document Source' can be a maximum of 50 characters in length.
- The 'Related Assessment/Treatment Plan' is optional, and is selected from the Assessment/ Treatment Plan Lookup via the magnifying glass icon on paper icon. It can be cleared via the eraser icon.

## Document Management - Cont'd

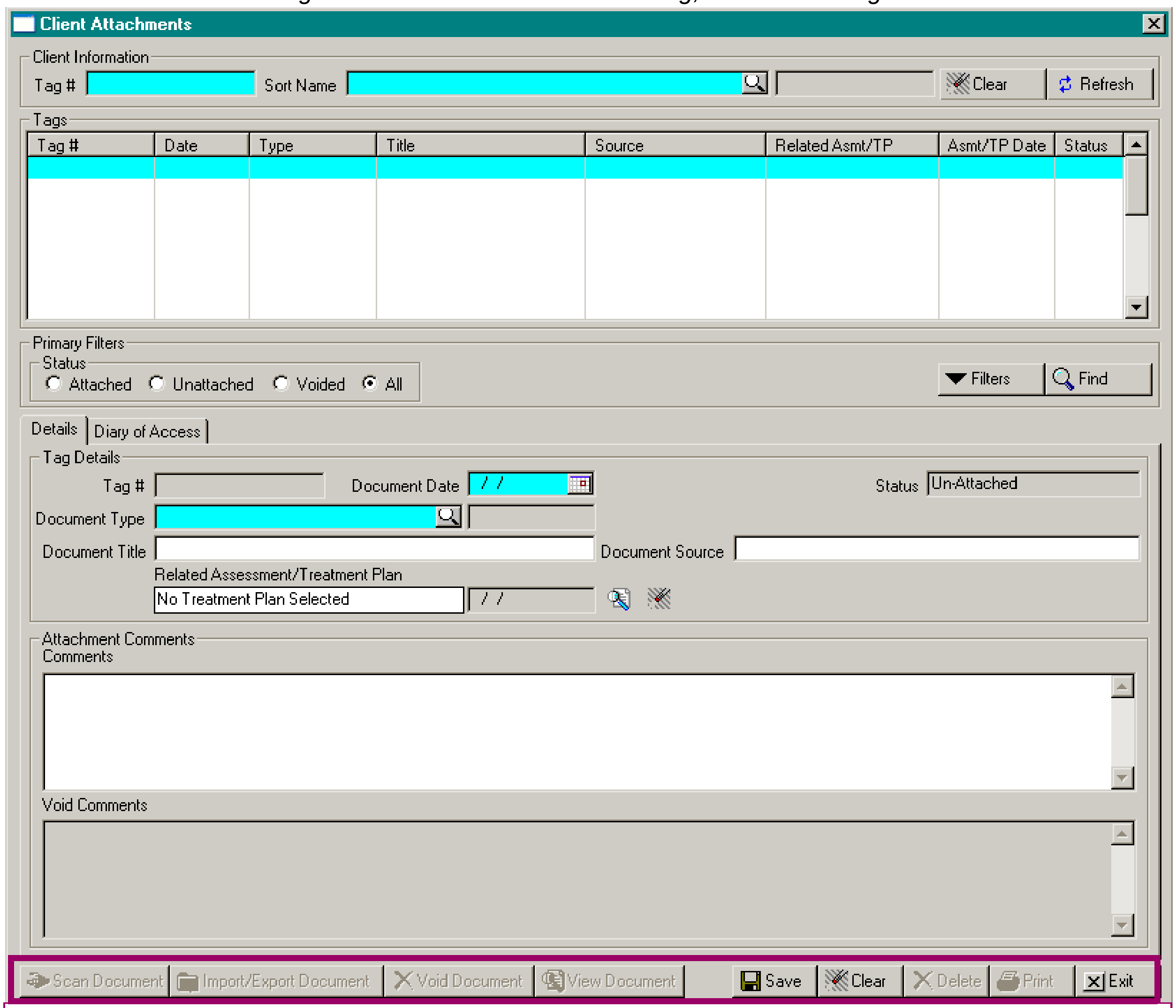
*Figure 61 - Client Attachments Dialog, Details Tab Page*




- 'Comments' can be entered regarding the Attachment.
- The 'Void Comments' field is available when voiding an attachment, and is used to enter comments regarding the void Attachment.

## Document Management - Cont'd

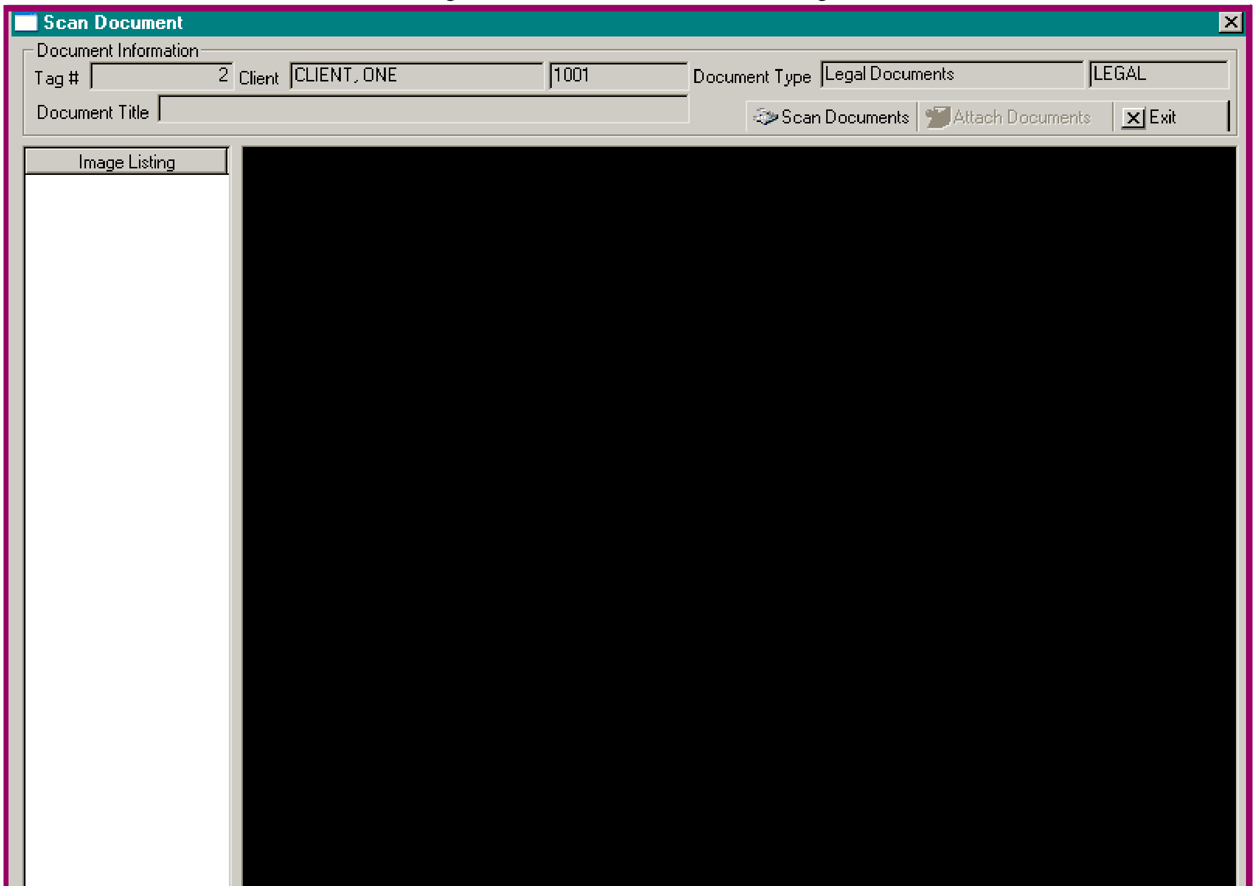
*Figure 62 - Client Attachments Dialog, Details Tab Page*




- The 'Scan Document' button displays the Scan Document Dialog, shown on the next page.
- The 'Import/Export Document' button displays the Import Document Dialog or the Export Document Dialog, shown later in this section.
- The 'Void Document' button displays the Voiding Tag Record Dialog, shown later in this section.
- The 'View Document' button displays the selected document in the Viewing Document Dialog, shown later in this section.

## Document Management - Cont'd

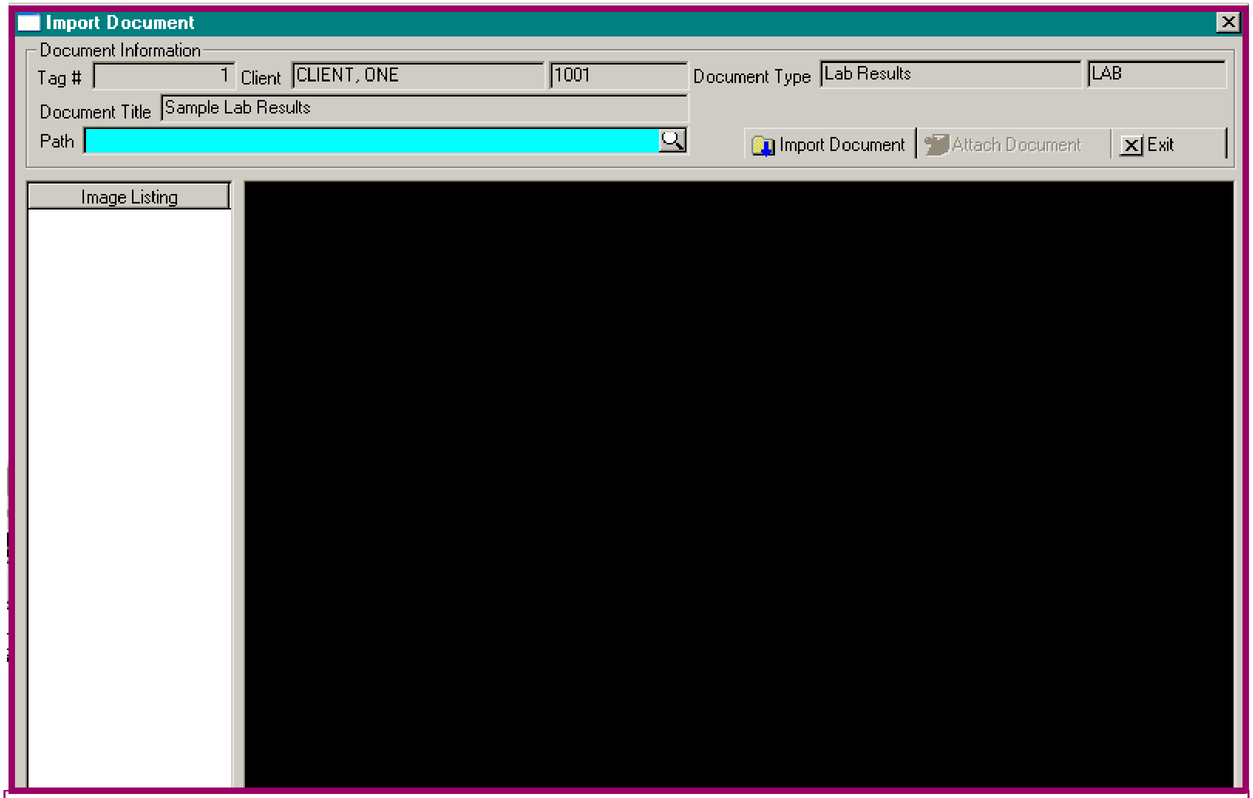
*Figure 63 - Scan Document Dialog*




- The 'Tag #' is show only and displays the Tag number to which the scanned document will be attached.
- The 'Client' is show only and displays the Client (and the Client's ID) that the Tag and document is for.
- The 'Document Type' is show only and displays the Tag's Document Type and Document Type ID.
- The 'Document Title' is show only and displays the title of the document's Tag.
- The 'Scan Documents' button initiates the scanning process. After the document has been scanned, its image appears in this Dialog.
- The 'Attach Documents' displays the Access Password Dialog. After the Staff has entered his/her password, the scanned document is attached to the Tag noted in the Document Information container.

## Document Management - Cont'd

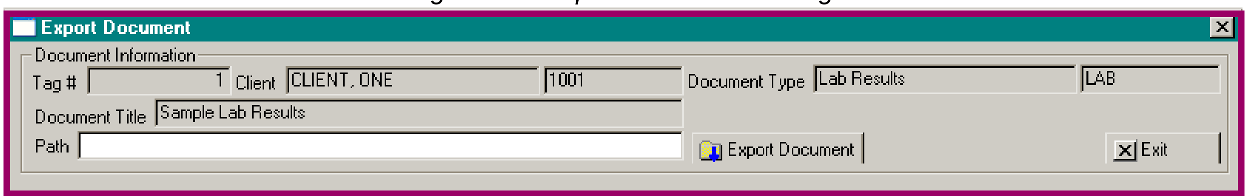
*Figure 64 - Import Document Dialog*




- The 'Tag #' is show only and displays the Tag number to which the document will be attached.
- The 'Client' is show only and displays the Client (and the Client's ID) that the Tag and document is for.
- The 'Document Type' is show only and displays the Tag's Document Type and Document Type ID.
- The 'Document Title' is show only and displays the title of the document's Tag.
- The 'Path' is required, and is the path and file name of the document to import. Once a directory has been entered into the field, the magnifying glass icon can be used to display the files in the specified path.
- The 'Import Document' button initiates the import process. After the document has been imported, its image appears in this Dialog.
- The 'Attach Document' displays the Access Password Dialog. After the Staff has entered his/her password, the imported document is attached to the Tag noted in the Document Information container.

## Document Management - Cont'd

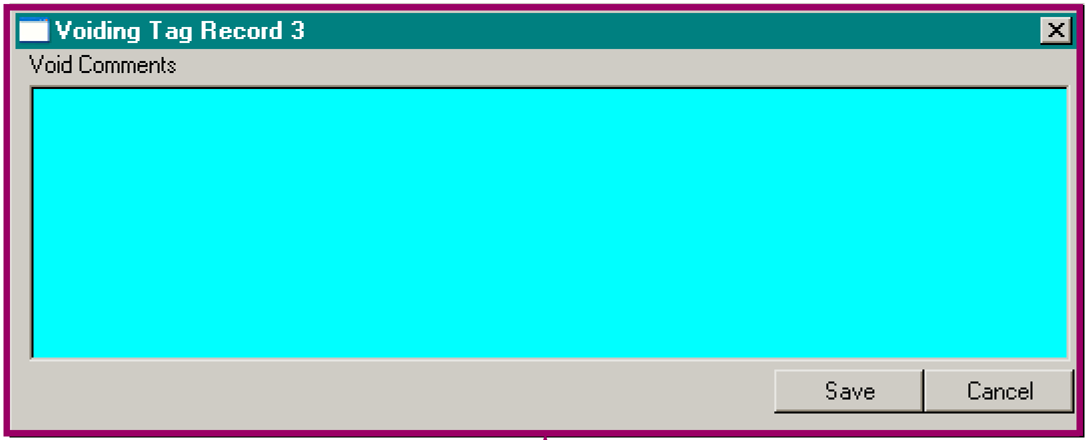
*Figure 65 - Export Document Dialog*




- The 'Tag #' is show only and displays the Tag number to which the document will be attached.
- The 'Client' is show only and displays the Client (and the Client's ID) that the Tag and document is for.
- The 'Document Type' is show only and displays the Tag's Document Type and Document Type ID.
- The 'Document Title' is show only and displays the title of the document's Tag.
- The 'Path' is the path to which the document will be exported. The file name is created by the system, as follows: Tag # + Client ID + week exported + year exported. For example, document Tag #2 for Client One exported on March 15, 2010 would be named '0000000002-00000000002-010-2010.
- The 'Export Document' button exports the selected document to the specified path.

## Document Management - Cont'd

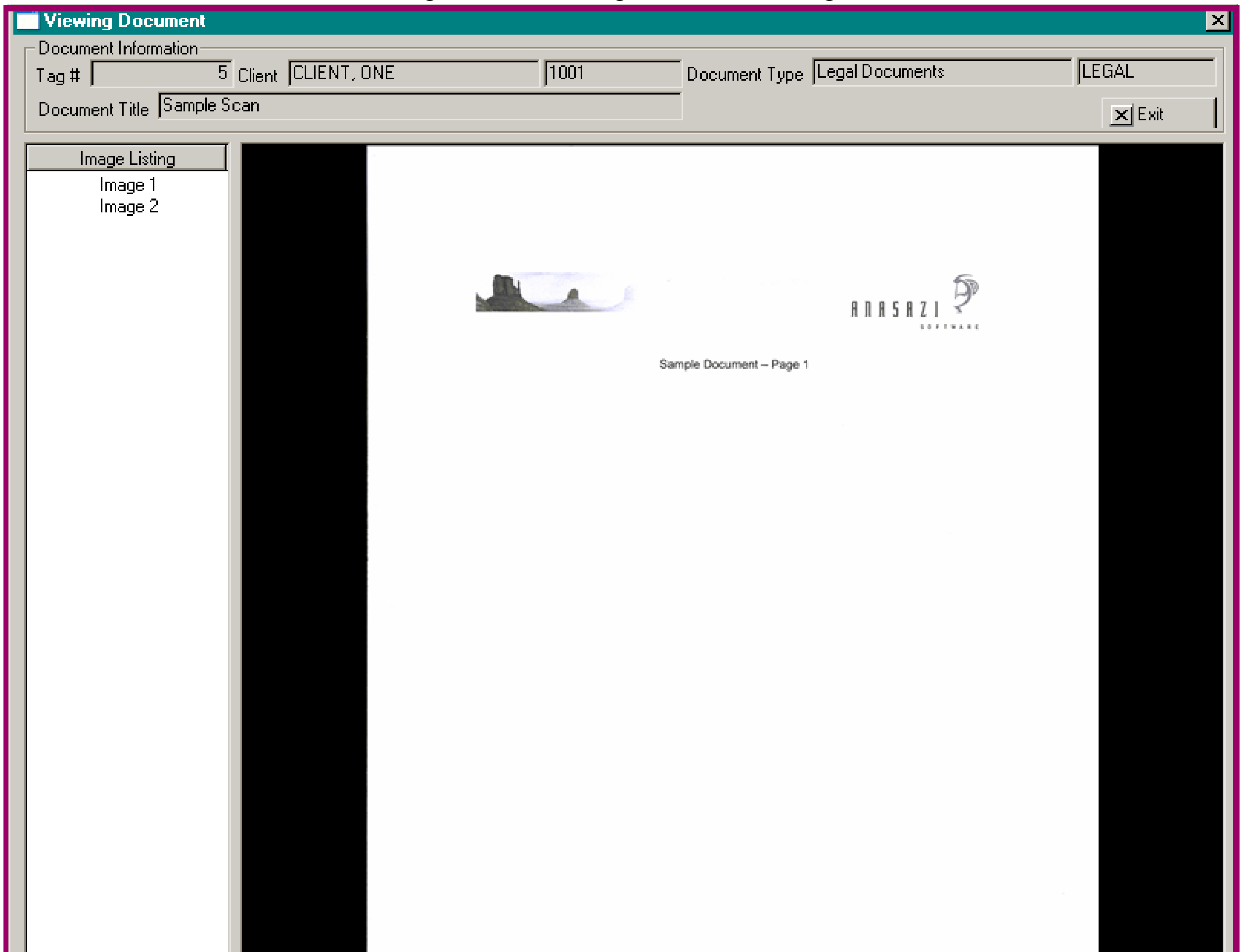
*Figure 66 - Voiding Tag Record Dialog*




- The Title Bar of the Dialog displays the Tag record ID that has been selected to be Voided.
- The 'Void Comments' are required.

## Document Management - Cont'd

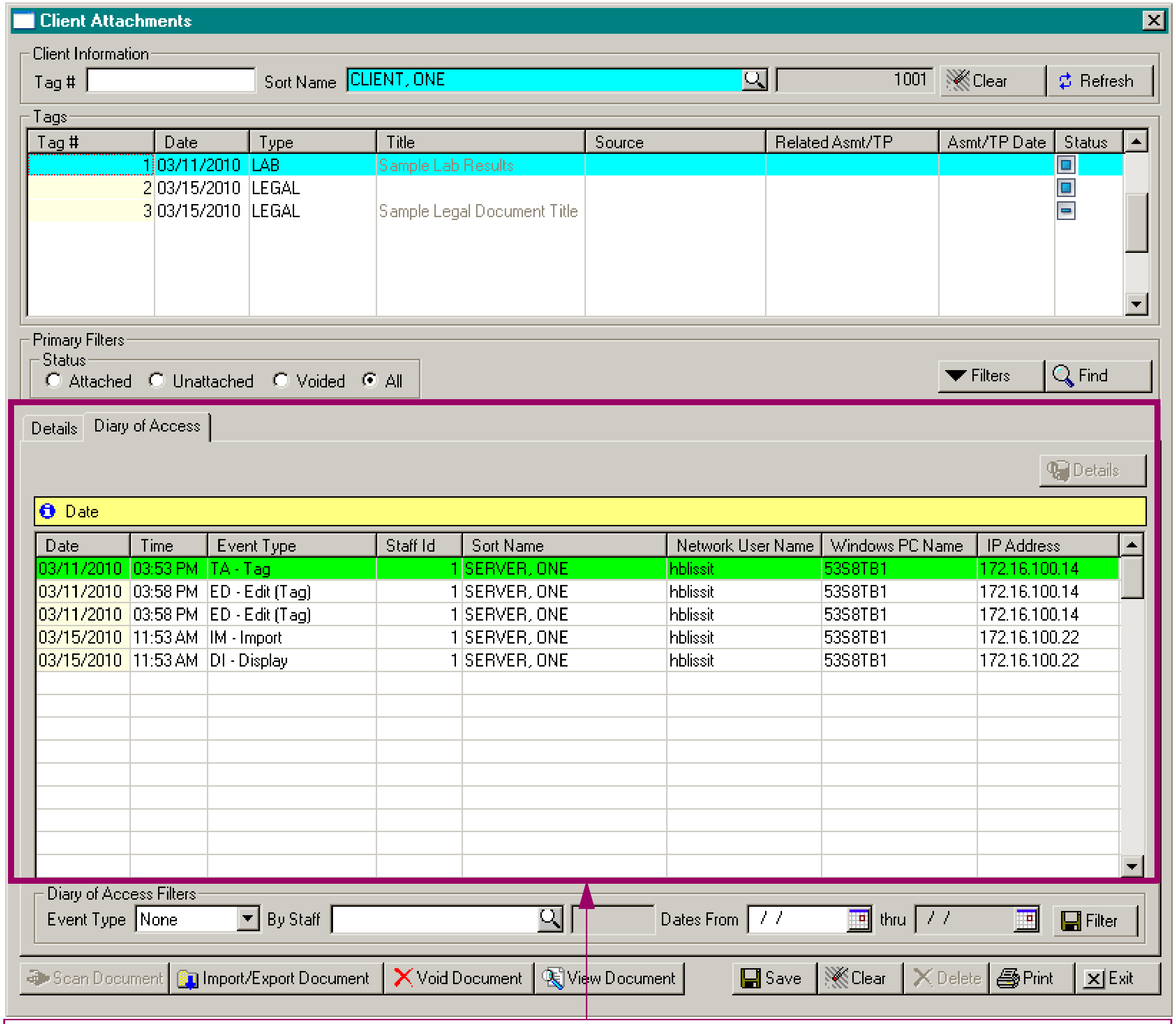
*Figure 67 - Viewing Document Dialog*




- The 'Tag #' is show only and displays the Tag number to which the document is attached.
- The 'Client' is show only and displays the Client (and the Client's ID) that the Tag and document is for.
- The 'Document Type' is show only and displays the Tag's Document Type and Document Type ID.
- The 'Document Title' is show only and displays the title of the document's Tag.
- The images associated with the attachment are listed on the left side of the Dialog in the Image Listing container. Clicking on an Image in the list displays the associated document.
- An image of the document is displayed in the center of the Dialog.

## Document Management - Cont'd

*Figure 68 - Client Attachments Dialog, Diary of Access Tab Page*

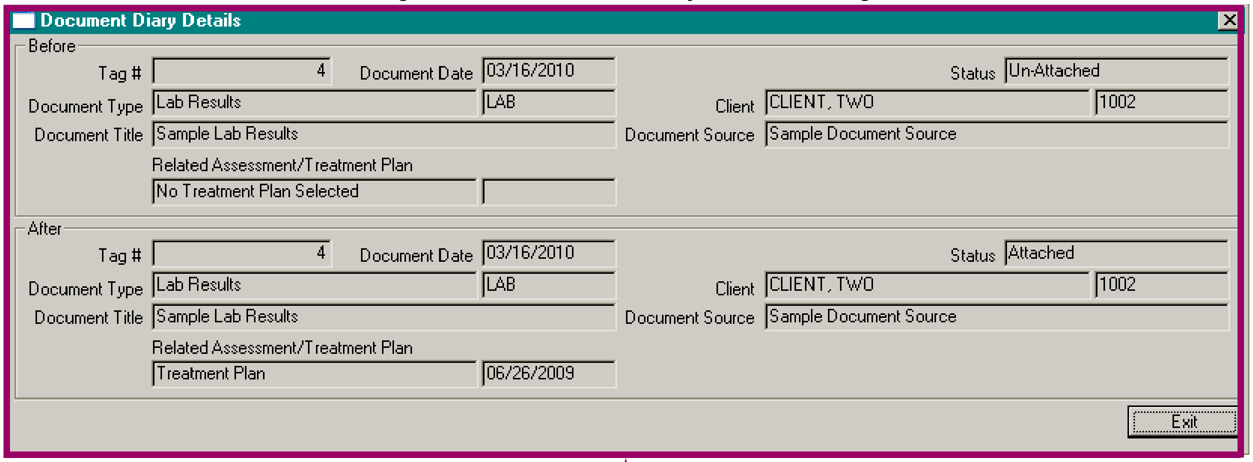



- The Diary of Access Tab Page contains information about who accessed the selected record, and includes the Date, Time, Event Type, Staff ID, Sort Name, Network User Name, Windows PC Name and IP Address.

- The 'Details' button is available if the selected Event Type for the event selected in the Diary of Access container is 'ED - Edit (Tag)', and displays the Document Diary Details Dialog. Otherwise, this button is shadowed. The 'Details' button displays the Document Diary Details Dialog (shown on the next page).

## Document Management - Cont'd

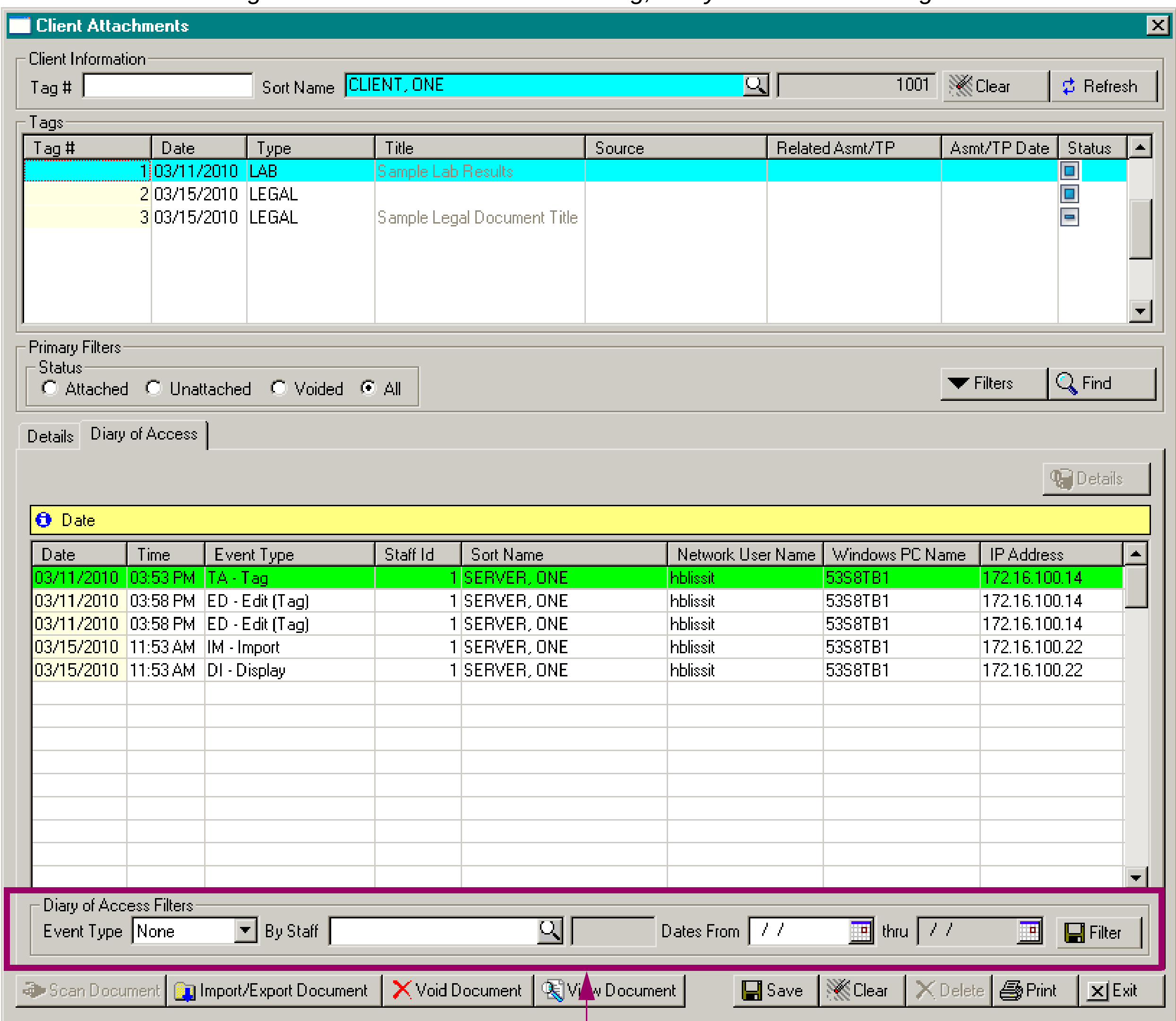
*Figure 69 - Document Diary Details Dialog*




- The Before container displays the values of the following fields as they appeared prior to editing:
  - 'Tag #'
  - 'Document Date'
  - 'Status'
  - 'Document Type'
  - 'Client'
  - 'Document Title'
  - 'Document Source'
  - 'Related Assessment/Treatment Plan'
- The After container displays the values of the following fields as they appeared after editing:
  - 'Tag #'
  - 'Document Date'
  - 'Status'
  - 'Document Type'
  - 'Client'
  - 'Document Title'
  - 'Document Source'
  - 'Related Assessment/Treatment Plan'

## Document Management - Cont'd

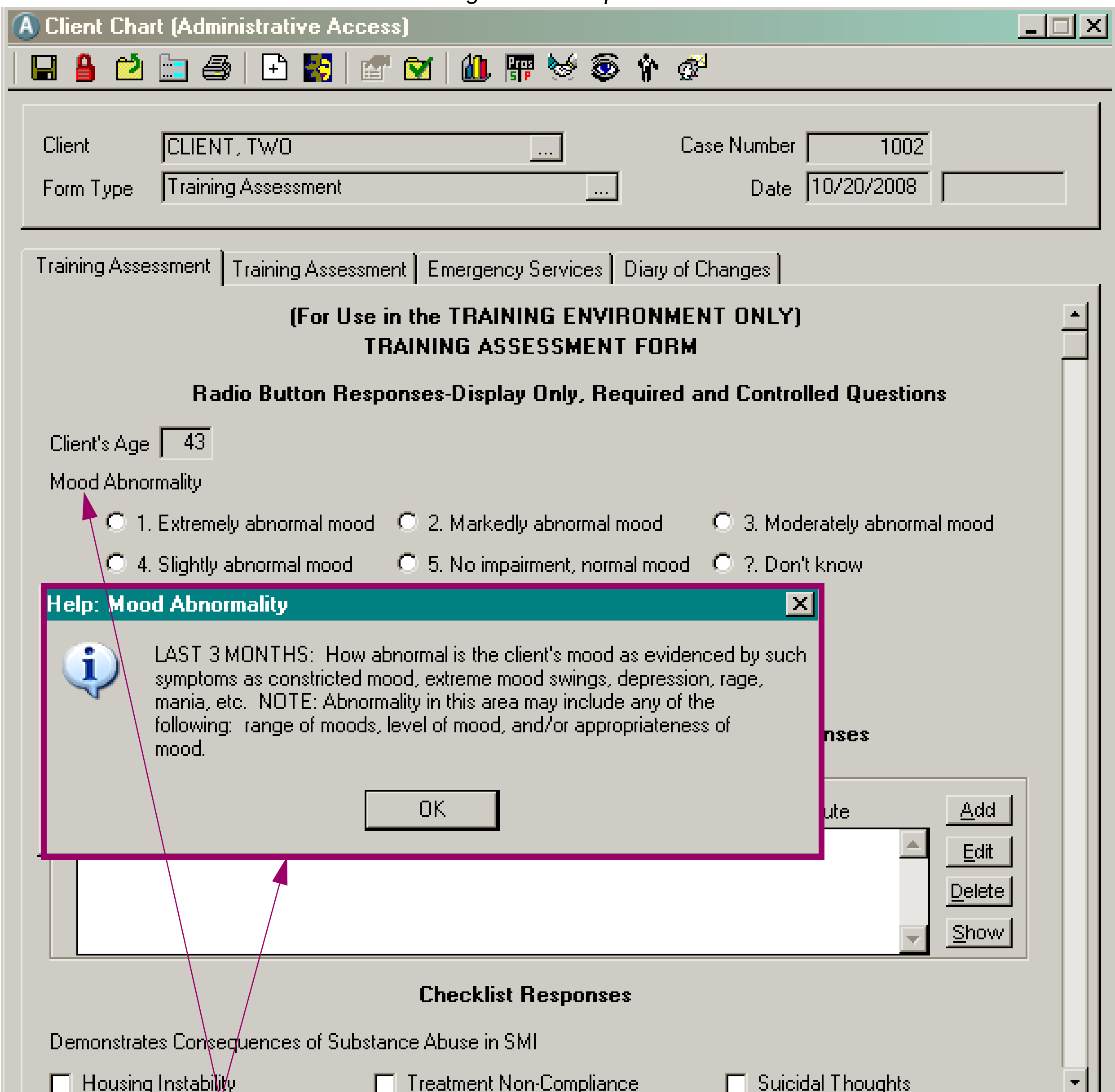
*Figure 70 - Client Attachments Dialog, Diary of Access Tab Page*




- The fields in the Diary of Access Filters container can be used to filter the Diary of Access records that are displayed by:
  - 'Event Type'
  - 'By Staff'
  - 'Dates From'
  - Dates 'thru'

## Help Text

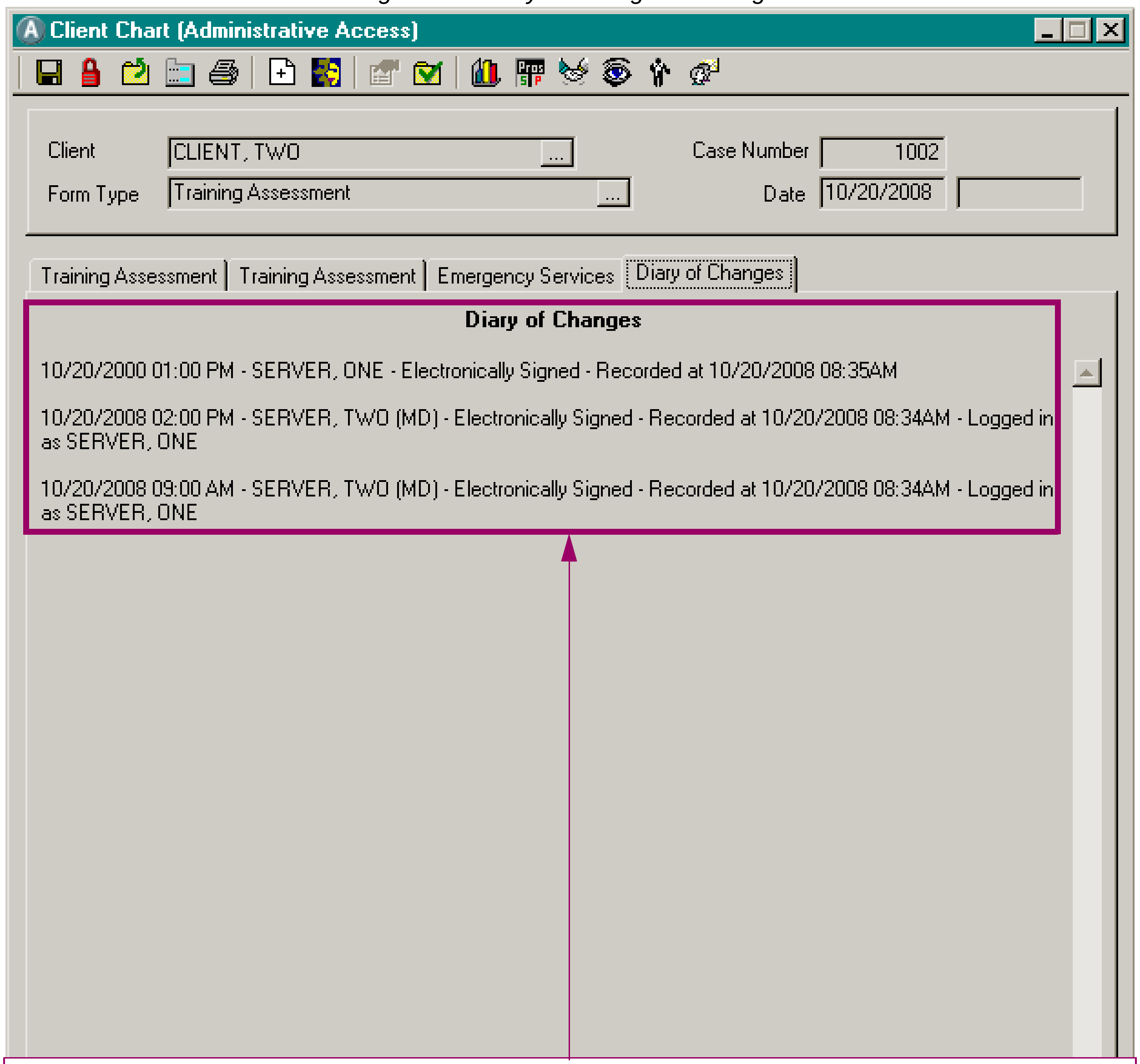
*Figure 71 - Help Text*




- Help text can be created and displayed behind all text lines and behind all question labels.
- To see Help Text, click on a label. If Help Text has been created, it displays in a Help Dialog. If there is no Help Text, a Help Dialog appears indicating ‘No help available at this time’.

## Diary of Changes Page

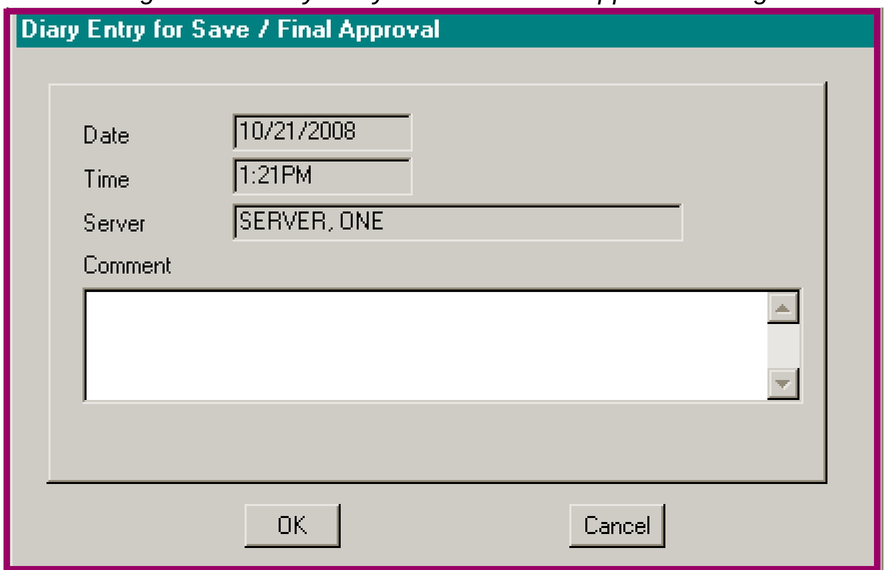
*Figure 72 - Diary of Changes Tab Page*




- The Diary of Changes Page Records an Assessment's history of being updated, viewed or printed.
- Each entry displays the date and time for which the entry was made, the Staff associated with the entry, the action that triggered the entry, and the Comments recorded in the Diary Entry for Save / Final Approval Dialog that appears when an Assessment is saved (shown on the next page).

*Diary Entry for Save / Final Approval Dialog*

*Figure 73 - Diary Entry for Save / Final Approval Dialog*

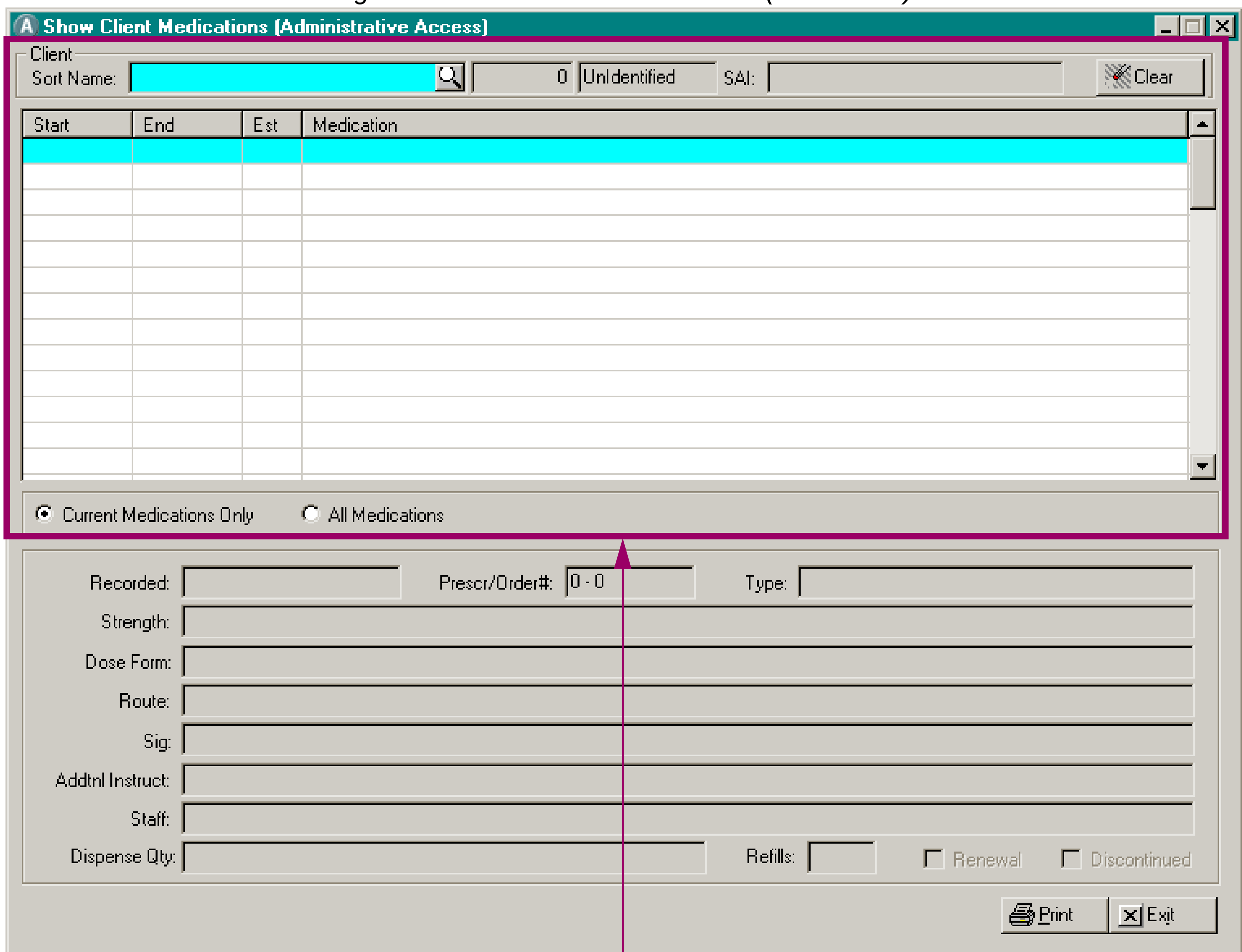



- The ‘Date’ field displays the current date.
- The ‘Time’ field displays the current date.
- The ‘Server’ field displays the name of the Logged-in Staff.
- The ‘Comments’ may be required (as detailed in the Diary of Changes section of The Flying Tour of this manual) and display on the Diary of Changes Tab Page.

# CLIENT PROFILE VIEWS

## Show Client Medications

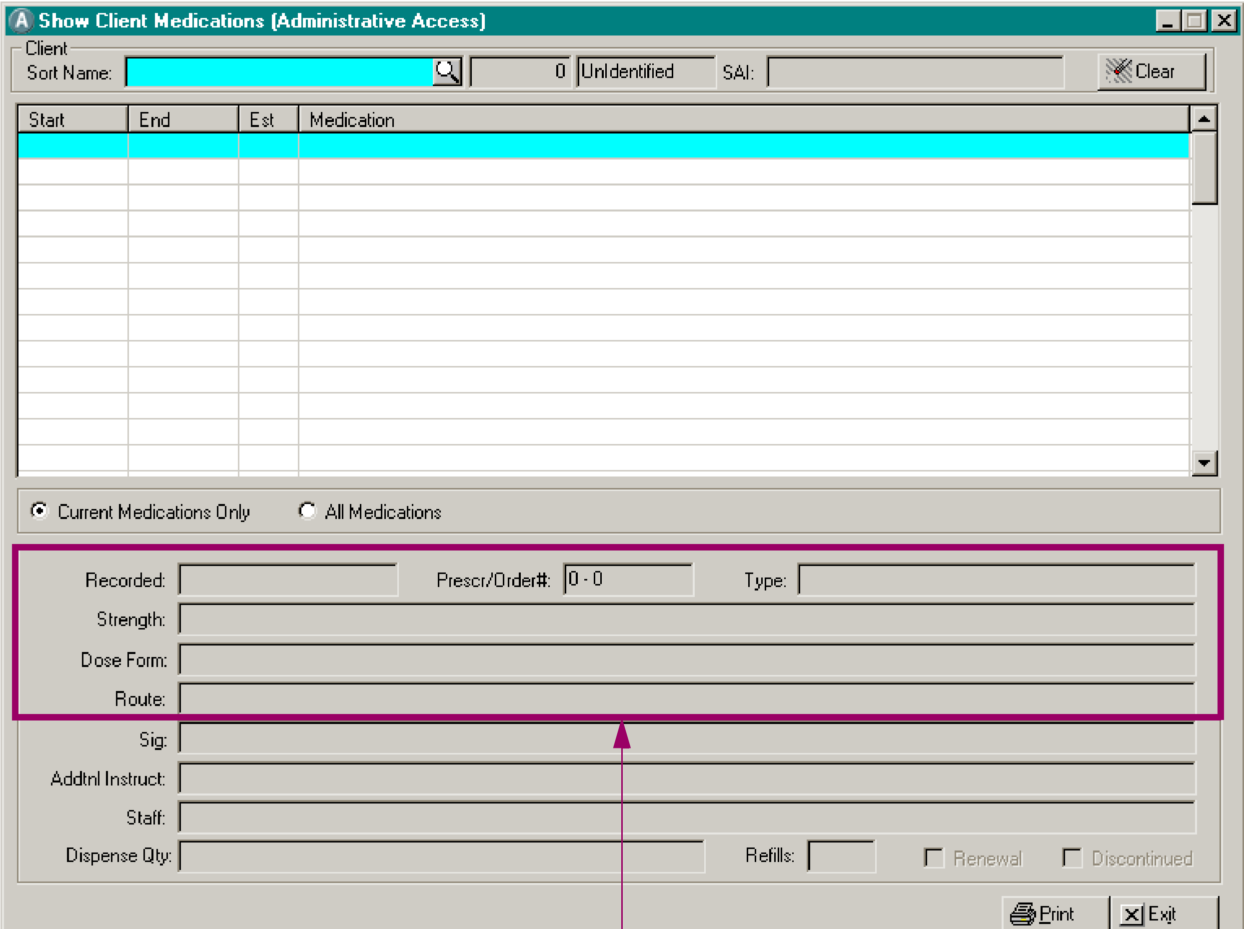
*Figure 74 - Show Client Medications (AS2134EA)*




- The Client 'Sort Name' is required and is selected from the Clients Lookup.
- The Client Medications list displays the selected Client's medications, including the 'Start' date, 'End' date, 'Est' flag (Estimated start/stop date) and medication name.
- The 'Clear' button clears the information in the view, allowing for another Client to be selected.
- The list of Client Medications can be filtered to display 'Current Medications Only' or 'All Medications' by selecting the appropriate radio button.

## Show Client Medications - Cont'd

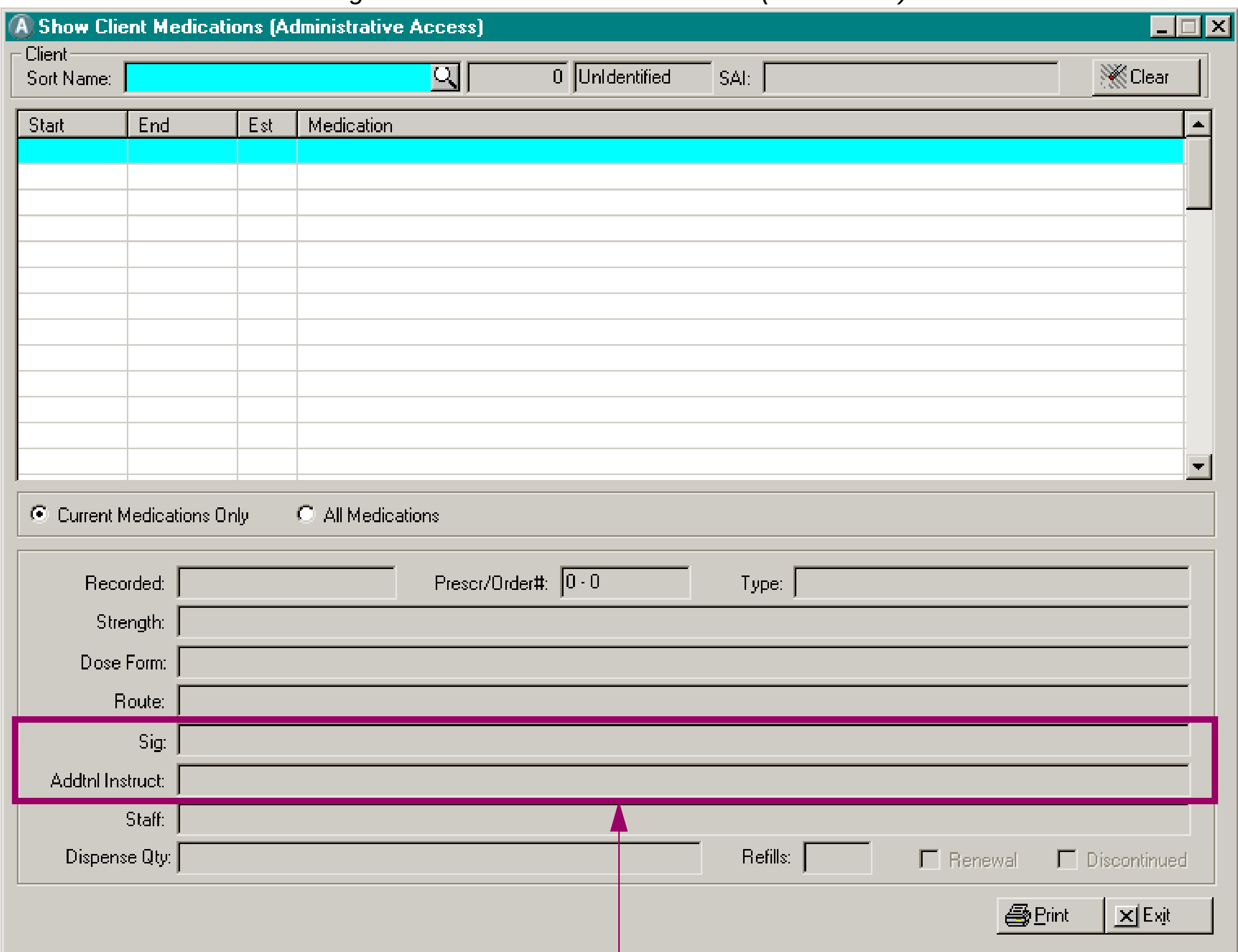
*Figure 75 - Show Client Medications (AS2134EA)*




- The 'Recorded' date is the date on which the medication record was recorded in the Doctor's Homepage.
- The 'Presc/Order #' is the Prescription/Order number of the medication record.
- The 'Type' field displays the medication record type: 'Prescription', 'Med Order', 'Pre-Exist Med' or 'Client Instruct'.
- The 'Strength' field displays the medication strength.
- The 'Dose Form' field displays the dose form of the medication.
- The 'Route' field displays the medication route.

## Show Client Medications - Cont'd

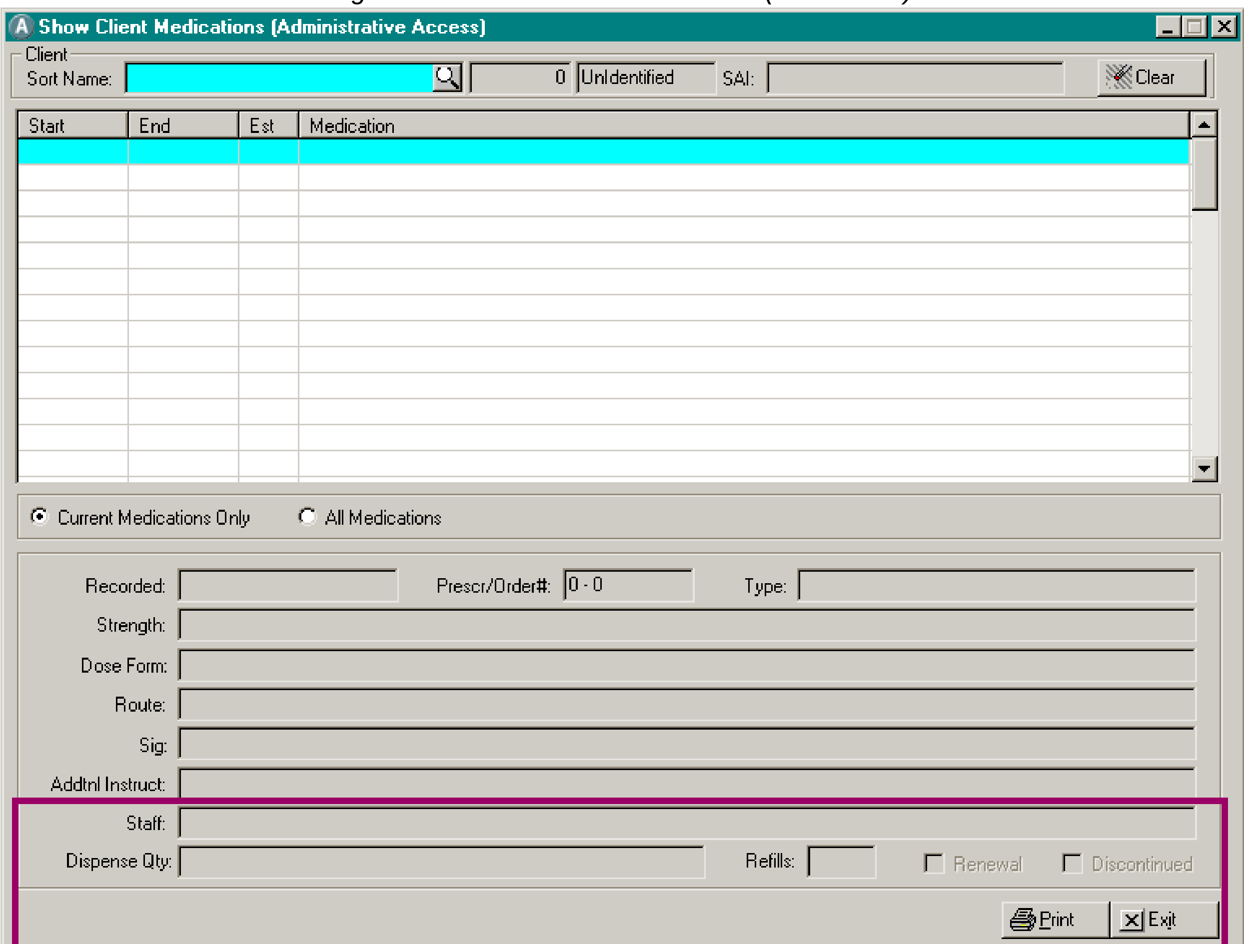
*Figure 76 - Show Client Medications (AS2134EA)*




- The 'Sig' displays the Sig for the medication. (Note: the view can be re-sized in order to display all 140 characters of the Sig. When printed to a .csv file, only the first 88 characters of the Sig print.)
- The 'Addtnl Instruct' field displays any Additional Instructions or Notes to Pharmacy that were entered for the medication in the Doctor's Homepage. (Note: the view can be re-sized in order to display all 210 characters of the Additional Instructions. When printed to a .csv file, only the first 88 characters of the Additional Instructions print.)

## Show Client Medications - Cont'd

*Figure 77 - Show Client Medications (AS2134EA)*




- The 'Staff' field displays the Sort Name of the Staff who entered the medication into the Doctor's Homepage.
- The 'Dispense Qty' field displays the quantity and dose form of the medication.
- The 'Refills' field displays the number of refills for the medication.
- If the 'Renewal' field is active, the record is a medication renewal.
- If the 'Discontinued' field is active, the medication has been discontinued.
- The 'Print' button displays the standard Anasazi Print Destination Dialog, from which the selected medication can be printed to the Screen, Default Printer, Other Printer, VPE File or Text File.

## Show Client Medications - Cont'd

*Figure 78 - Show Client Medications - Print Sample (AS2134EA)*

**CLIENT MEDICATIONS** **PAGE:** 1

**Client Name:** CLIENT, ONE 1001 Admitted **SAI:** SERVER, FOUR (QMHP)
**Print Date:** 03/02/2010 Time 14 : 27 **INCLUDED:** ALL MEDICATIONS

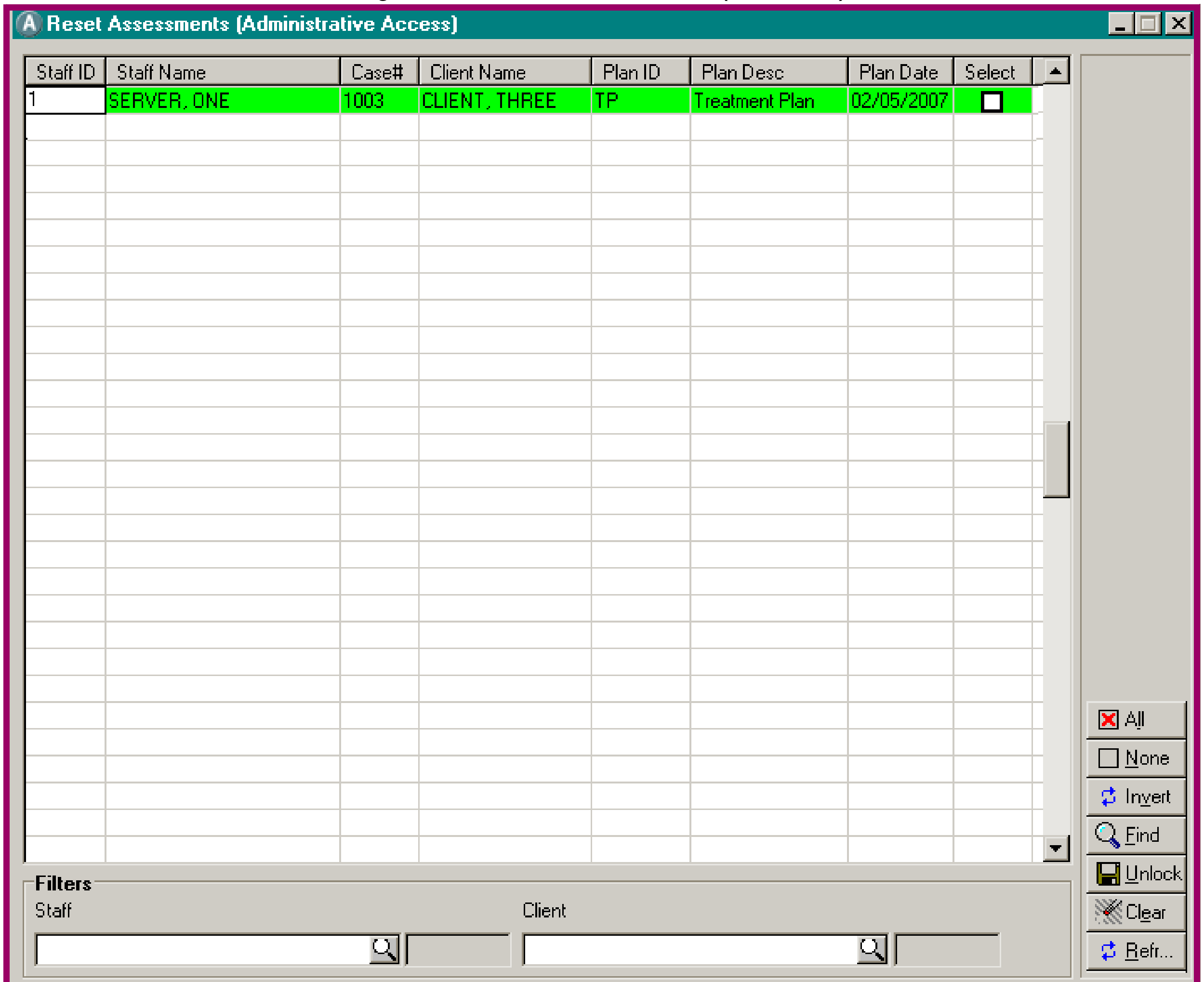
**Start Date:** 06/01/2009 **End Date:** 08/29/2009 **Est.** N **Medication:** Prozac
**Recorded:** 06/01/2009 **Prescr/Order#:** 8 - 2 **Type:** Prescription
**Strength:** 10 mg
**Dose Form:** capsule
**Route:** oral
**Sig:** Take 1 capsule(s) by mouth 1 time a day
**Addtnl Instruct:**
**Staff:** SERVER, TWO (MD)
**Dispense Qty:** 30 / Capsule(s) **Refills:** 2 ☐ **Renewal** ☐ **Discontinued**

**Start Date:** 12/16/2009 **End Date:** 02/13/2010 **Est.** N **Medication:** Wellbutrin
**Recorded:** 01/07/2010 **Prescr/Order#:** 16 - 5 **Type:** Prescription
**Strength:** 100 mg
**Dose Form:** tablet
**Route:** oral
**Sig:** Take 1 tablet(s) by mouth 1 time a day
**Addtnl Instruct:**
**Staff:** SERVER, FOUR (QMHP)
**Dispense Qty:** 30 / Tablet(s) **Refills:** 1 ☐ **Renewal** ☐ **Discontinued**

# UTILITIES

## Reset Assessments

*Figure 79 - Reset Assessments (AS001EB)*




- The list defaults to the Client and Assessment that are currently selected in the Assessment and Treatment Planning View.
- The list can be filtered by Staff, who is selected from the Staff Lookup.
- The list can be filtered by Client, who is selected from the Clients Lookup.
- The 'Unlock' button clears the red locks for the selected Assessments.

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