



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System Part 3, AMH Reports

(AMH)

User Manual

Version 4.0 Patch 13
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Office of Information Technology
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Preface

The Behavioral Health System (AMH) is a module of the Resource and Patient Management System (RPMS), designed specifically for recording and tracking patient care related to behavioral health. AMH v4.0 includes all functionality available in the previous versions of the RPMS behavioral health software, along with multiple new features and enhancements to the graphical user interface (GUI).

1.0 Introduction

Many behavioral health providers who are co-located in a primary care setting at facilities that have implemented the RPMS Electronic Health Record (EHR) have transitioned to utilizing the EHR for documenting services and supporting integrated care. However, a number of behavioral health clinicians continue to practice at facilities where the EHR has not been adopted. For these providers, AMH v4.0 may be employed as a standard-alone, yet integrated, module within the RPMS suite of clinical and practice management applications.

AMH v4.0 offers opportunities for improving patient outcomes and continuity of care by providing:

- Standardized clinical documentation
- Tools to meet regulatory and accreditation standards
- Tools to meet reporting requirements
- Revenue enhancement
- Enable comprehensive report generation to support care management, program oversight, and use clinical data to inform prevention activities and advance both local and national health initiatives

While this package is integrated with other modules of RPMS, including the Patient Care Component (PCC), this package uses security keys and site-specific parameters to maintain the confidentiality of patient data. The AMH package is a key module within the system.

The AMH User Manual is divided into three separate documents:

- Part 1-AMH Application Set-up and Manager Utilities
- Part 2-AMH Data Entry
- Part 3-AMH Reports

This AMH User Manual Part 3 Section focuses on the AMH reports functionality. All AMH reports reside in the Roll and Scroll Environment. Behavioral Health staff can run various types of reports for clinical, workload, and reporting purposes.

1.1 Primary Menu

The **Primary Menu** option for this package is **IHS AMH (AMHMENU)** (Figure 1-1).

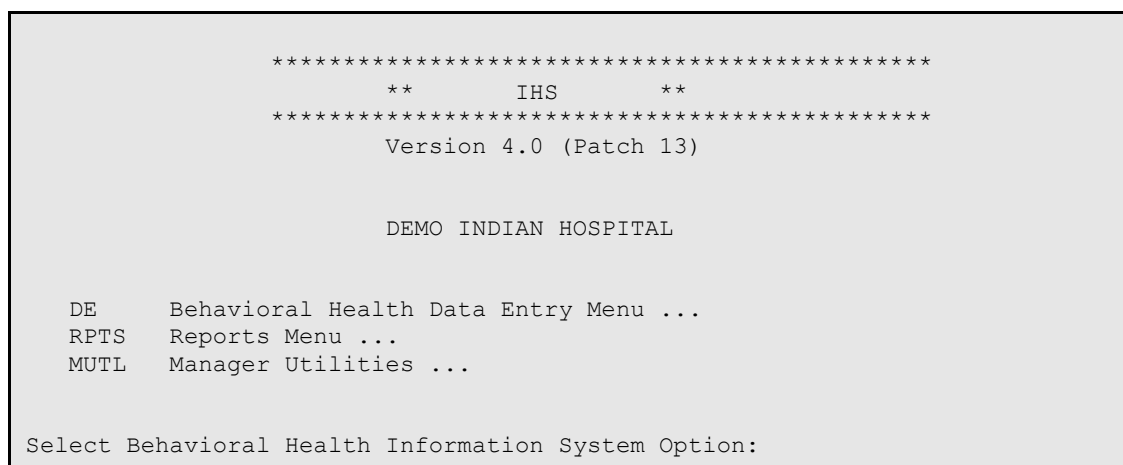


Figure 1-1: Options on the IHS AMH menu example

1.2 Security Keys

Security keys listed in Table 1-1 must only be assigned to personnel who have authorized access to confidential behavioral health data. Program Managers should collaborate with Site Managers to determine appropriate personnel for security key assignments, ensuring access is granted only those with the necessary privileges. For staff needing to run reports, one or more of the bold security keys will need to be assigned.

Table 1-1: Security Keys

Key	Permits Access To
AMHZMENU	Top-Level menu (AMHMENU)
AMHZMGR	Supervisory-Level/Manager options
AMHZ DATA ENTRY	Data Entry module
AMHZ RESET TRANS LOG	Reset the Export log
AMHZDECT	Data Entry Forms Count Menu option
AMHZHS	BHS Health Summary Component
AMHZRPT	Reports Module
AMHZ DV REPORTS	Screening Reports
AMHZ SUICIDE FORM ENTRY	Suicide Form Data Entry Menu
AMHZ SUICIDE FORM REPORTS	Suicide Form Reports Menu
AMHZ DELETE RECORD	Delete unsigned records
AMHZ DELETE SIGNED NOTE	Delete records containing signed notes
AMHZ UPDATE USER/LOCATIONS	Update the locations the user is permitted to access
AMHZ CODING REVIEW	Review records to ensure accurate coding

2.0 Orientation

The following provides information about using the **RPMS AMH Roll and Scroll**.

2.1 Standard Conventions (Roll and Scroll)

2.1.1 Caps Lock

Always work with the **Caps Lock** on.

2.1.2 Default Entries

Any time **Double Slashes** (//) follow a possible response, press **Enter** to accept the default entry displayed (Figure 2-1). If the default response is not desired, type a new response after the **Double Slashes** (//).

A screenshot of a terminal window with a light gray background. The text displayed is: "Do you want to display the health summary? N// (No Health Summary will be displayed.)". The text is in a monospaced font.

Figure 2-1: Showing acceptance of a default entry example

2.1.3 To Back Out

To generate the **Caret** (^) symbol, press the number **six (6)** key while holding down the **Shift** key. This symbol is used to terminate the current operation and navigates one level up in the interface.

2.1.4 Exit

- Type **HALT** at a menu option prompt to exit from RPMS at any time.
- Type **RESTART** at a menu option prompt to exit out to the “Access Code:” prompt.
- Type **CONTINUE** at a menu option prompt to exit from RPMS, and then at the next RPMS sign-on, continue from the same menu.

2.1.5 Same Entries

For certain types of data fields, primarily those that use lists of possible entries (such as facilities, diagnoses, communities, patients, etc.), press the **Spacebar** key, then press **Enter** to repeat the last entry used at the prompt.

2.1.6 Lookup

Avoid misspellings. If you're unsure of the spelling of a name or entry, type only the first few letters. RPMS displays all matching options (Figure 2-2) that begin with those letters.

PATIENT NAME: DEMO									
1	DEMO, BARRY	M	05-05-1989	054270542	PIMC	101623			
						SE	101624		
2	DEMO, CHRIS	Y	F	06-16-1954	001290012	PIMC	100039		
						HID	100040		
						SE	100041		

Figure 2-2: Patient lookup screen example

2.1.7 Pause Indicator

The **Angle Bracket (<>)** symbol is usually displayed when a multi-page report reaches the bottom of the display screen, indicating that additional pages are available. Press **Enter** to view the next page or type a **Caret (^)** symbol to exit the report.

2.1.8 Dates and Times

Users can enter dates and times in various formats. If the system prompts for a date only, the acceptable formats are as follows:

- T (today)
- 3/28
- 0328
- 3-28
- 3.28
- T-1 (yesterday)
- T-30 (a month ago)
- T+7 (a week from today)

Note: If the user does not enter the year, the system defaults to the current year.

If the system prompts for a time, any entry between **6:00 a.m.** and **6:00 p.m.** will be recorded correctly using either standard or military time. For times between **6:00 p.m.** and **6:00 a.m.**, use military time, or append the number with an **A** for **a.m.** or **P** for **p.m.**

Example:

- 130 (1:30 p.m.)
- 130A (1:30 a.m.)

If the system prompts for both date and time, the acceptable formats are as follows.

Example:

- T@1 (Today at 1 p.m.)
- 4/3@830

2.1.9 Stop

To terminate a report during processing, or to perform an emergency exit, press **Ctrl-C** to immediately halt program execution.

2.1.10 Delete

Entering the **At (@)** symbol in a populated field will overwrite and remove all existing data contained in that field.

2.2 ListMan (Roll and Scroll)

The **AMH Reporting** program utilizes a screen interface known as **ListMan** for data entry and review. This interface presents information in a window-style display with menu options for editing, displaying, or reviewing data located at the bottom section of the screen.

When accessing the system via a personal computer configured as an **RPMS** terminal, mouse functionality, such as pointing and clicking, is not supported for menu selection.

To access additional menu options related to data display, printing, or review, users may enter two **Question Marks (??)** at the “Select Option” prompt. Entering a corresponding symbol or letter mnemonic at the “Select Action” prompt initiates the associated action.

In the example provided in Figure 2-3, two **Question Marks (??)**, are entered at the “Select Action” prompt to display the list of secondary options available.

GROUP ENTRY		Mar 03, 2026 13:59:56				Page:		1 of 1	
Group Entry		* - Unsigned Group Note							
	Date	Group Name	Activity	Prg	Cln	Prov	TOC	POV	
1)	02/11/26	Group D	ASSESSMEN	M	MENTA	AFSHAR,M	OUT	F11.188	
2)	02/11/26	Group AKC	EDUCATION	M	MENTA	CHELICH,	OUT	A41.9 -	

```

Enter ?? for more actions

1   Add a New Group                6   Review/Edit Group Visits
2   Display Group Entry            7   Add No Show Visit
3   Duplicate Group                8   Edit Group Definition
4   Delete Group                  9   Sign Notes
5   Print Encounter Forms          Q   Quit

Select Action: +/-/?

The following actions are also available:
+   Next Screen                    FS   First Screen          SL   Search List
-   Previous Screen                LS   Last Screen            ADPL Auto Display(On/Off)
UP  Up a Line                      GO   Go to Page             QU   Quit
DN  Down a Line                    RD   Re Display Screen
>   Shift View to Right            PS   Print Screen
<   Shift View to Left            PL   Print List

```

Figure 2-3: ListMan Secondary Options screen

At the “Select Action” prompt, users can do the following:

- To navigate through multi-page displays, enter the **plus sign (+)** to advance to the subsequent full screen, provided the current screen is not the final one.
- Enter the **Dash (-)** to navigate to the preceding screen, providing the current screen is not the initial one. This command is functional only if multiple screens have been previously accessed during the current session.
- Press the **up-arrow** key to scroll the display upward by one line.
- Press the **down-arrow** key to scroll the display downward by one line.
- Press the **right-arrow** key to shift the display to the right.
- Press the **left-arrow** key to shift the display to the left.
- Enter **FS** in a multi-page display to navigate to the first screen.
- Enter **LS** in a multi-page display to navigate to the last screen.
- Enter **GO** followed by the page number to directly access the specified screen within a multi-screen display.
- Enter **RD** to redisplay the screen.
- Enter **PS** to print the current screen.
- Enter **PL** to print the entire display, whether it comprises a single screen or multiple screens (referred to as a list).
- Enter **SL** to initiate a search prompt and press **Enter** to navigate to the first occurrence of that term within the list. For example, to locate the patient’s age while viewing the **Face Sheet**, enter **SL**, type **Age**, and press **Enter** to jump to the relevant field.

- Enter **ADPL** to toggle the display of menu options window located at the bottom of the screen.
- Enter **QU** to exit the current screen and return to the menu.

2.3 ScreenMan (Roll and Scroll)

2.3.1 Utilizing the ScreenMan Interface

When entering data using the **ScreenMan** interface (Figure 2-4), press **Enter** to confirm default values or to submit manually entered data within a field. Navigation between fields may be accomplished using the **tab** or **arrow** keys. These keys also allow users to skip fields where data entry is not required. During the initial data entry process, the system automatically populates various demographic fields when patient, program, and course of action information is specified. Additionally, if program specific defaults have been configured, the corresponding data will be displayed on the screen.

```

** UPDATE BH SITE PARAMETERS **           Site Name: ABERDEEN AO
=====
Update DEFAULT Values?  N
Update Hospital Location Defaults?  N
Default Health Summary Type:

Default response on form print:           Suppress Comment on Suppressed Form?
# of past POVs to display:                Exclude No Shows on last DX Display?
DSM-5 Implementation Date:
Update PCC Link Features?  N
Turn Off EHR to BH Link?
Turn on PCC Coding Queue?  NO             Update Provider Exceptions to E Sig?  N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits?  N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:

```

Figure 2-4: Example 1 of ScreenMan

To apply modifications or add new entries within the form, press **Enter** to commit the change(s). A confirmation dialog may be displayed, prompting for additional input. In certain cases, a supplementary pop-up window may be triggered to facilitate further data entry. For instance, in some scenarios, entering **Y** and then pressing **enter** at a prompt will initiate a dialog window and input the relevant response to the prompt.

Upon completion of all required data entry, type **E**, and press **Enter** to exit the screen. To save any modifications made during the session, type **Y** when prompted.

2.3.2 Using the Pop-up Window

To navigate between input fields within the pop-up window (Figure 2-5), press **Enter**. To shift focus to the “Command” prompt, which defaults to the **Close** option, press the **Tab** key. Press **Enter** once more to execute the selected command and return to the primary data entry screen.

```

*****  ENTER/EDIT PROVIDERS OF SERVICE  *****

Encounter Date: MAR 27,2001          User: DEMO,DOROTHY K
Patient Name: DEMO,SALLY
-----

PROVIDER: DEMO,STEPHEN A      <TAB>    PRIMARY/SECONDARY: PRIMARY  <TAB>
PROVIDER: DEMO,GRETCHEN      <TAB>    PRIMARY/SECONDARY: SECONDARY <TAB>
PROVIDER:                    <TAB>    PRIMARY/SECONDARY:
PROVIDER:                    PRIMARY/SECONDARY:

Close      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: Close  [RET]          Press <PF1>H for help      Insert

```

Figure 2-5: Example 2 of ScreenMan

Press **Enter** to open a text editor screen (Figure 2-6).

```

+-----+
| *****  Enter/Edit Clinical Data Items  ***** |
| Encounter Date: MAR 27,2001          User: DEMO, STANLEY K. |
| Patient Name: DEMO,ARTHUR  DOB: 8/1/84  HR#: 101813 |
| CHIEF COMPLAINT: Alcohol Dependence |
| S/O/A/P: [RET] |
| |
+-----+

```

Figure 2-6: Example 3 of ScreenMan

2.4 Full-Screen Text Editor (Roll and Scroll)

While many data entry fields utilize coded selections from predefined tables, certain components, such as clinical documentation, treatment plans, intake forms, require extensive free-text input. The RPMS provides two text-editing interfaces to support this functionality, a line editor, and a full-screen editor. Most users prefer the **Full Screen Text Editor** due to its enhanced usability and word-processor-like features.

The **Full-Screen Text Editor** offers several familiar behaviors found in traditional word processing applications. Text wraps automatically at the end of each line, and standard navigation is supported via arrow keys (**up**, **down**, **right**, **left**). Both uppercase and lowercase characters may be entered as needed. However, it is important to note that some standard word-processor conventions do not apply. For example, the **Delete** key is not functional within the RPMS full-screen editor. To remove text, position the cursor one space to the right of the character or word to be deleted, then use the **Backspace** key to remove the unwanted content.

For extended narrative entries, users may find it more efficient to compose the text in a dedicated word processing program (e.g. Microsoft Word or WordPerfect) and then paste the content into the RPMS full-screen editor.

Refer to Table 2-1 for a list of the most commonly used RPMS text editor commands.

Table 2-1: RPMS Text Editor Commands

Action Needed	Use These Keys
Delete a line (extra blank or text)	PF1(F1) followed by D
Join two lines (broken or too short)	PF1(F1) followed by J
Save without exiting	PF1(F1) followed by S
Exit and save	PF1(F1) followed by E
Quit without saving	PF1(F1) followed by Q
Top of text	PF1(F1) followed by T

Examples of **Text Edit** screens are shown in Figure 2-7 and Figure 2-8.

```

==[ WRAP ]==[ INSERT ]=====< S/O/A/P >===== [ <PF1>H=Help ]====
This is a demonstration of how to type and use the full screen editor.
When all relevant information has been entered, press [F1]E

<===T=====T=====T=====T=====T=====T=====T=====T=====T=====T>=====T
Bottom of text                                PF1(F1) followed by B

```

Figure 2-7: Using Text Editor screen one example

To view all available commands in the **RPMS Full-Screen Editor**, press **F1** and then type **H**. To exit the help screens, type a **Caret (^)** symbol.

```

** UPDATE BH SITE PARAMETERS **           Site Name: ABERDEEN AO
=====
Update DEFAULT Values?  N
Update Hospital Location Defaults?  N
Default Health Summary Type:

Default response on form print:          Suppress Comment on Suppressed Form?
# of past POVs to display:              Exclude No Shows on last DX Display?
DSM-5 Implementation Date:

```

```

Update PCC Link Features?  N
Turn Off EHR to BH Link?
Turn on PCC Coding Queue?  NO          Update Provider Exceptions to E Sig?  N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits?  N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:

COMMAND:                                     Press <PF1>H for help      Insert

```

Figure 2-8: Using Text Editor screen two example

- If the cursor is positioned at the “COMMAND” prompt, type **E** followed by **S** to save and exit the data entry screen.
- If the cursor is not at the “COMMAND” prompt, press the **F1** key to access the **Command line**, then type **E**.

In both cases, the entered data is saved, and the data entry screen closes.

2.5 Word Processing Editors (Roll and Scroll)

If the interface shown in Figure 2-9 appears when accessing a word-processing field, this indicates that the default editor is set to the RPMS line editor.

```
1>
```

Figure 2-9: Default RPMS Line Editor interface

To access the full-screen text editor, follow these steps:

1. At any “Menu” prompt, type **TBOX** (Figure 2-10). The **ToolBox** is a secondary menu accessible to all users, though it is not typically visible by default.

```

DE      Behavioral Health Data Entry Menu ...
RPTS    Reports Menu ...
MUTL    Manager Utilities ...

Select Behavioral Health Information System Option: TBOX  User's Toolbox

Change my Division
Display User Characteristics
Edit User Characteristics
Electronic Signature code Edit
Menu Templates ...
Spooler Menu ...
Switch UCI
TaskMan User
User Help

```

Select User's Toolbox Option: Edit User Characteristics

Figure 2-10: Accessing the ToolBox to change the Text Editor (Step 1)

2. At the “Select User’s Toolbox Option” prompt, enter **Edit User Characteristics**. The **Edit User Characteristics** window displays.
3. Use the **down-arrow** key to navigate to the **Preferred Editor** field. To set the preferred editor to **Screen Editor**, type **SC**. Continue using the **down-arrow** key to move the cursor to the “Command” prompt.
4. At the “Command” prompt, type **S** and press **Enter** to save all changes. Then type **E** and press **Enter** to exit the screen. Refer to Figure 2-11 for an illustration of the **Edit User Characteristics** screen and its fields.

EDIT USER CHARACTERISTICS		PAGE 1 OF 1
NAME: DEMO, SAMANTHA A		
INITIAL: SAS	PHONE:	
NICK NAME:	OFFICE PHONE:	
	VOICE PAGER:	
	DIGITAL PAGER:	
ASK DEVICE TYPE AT SIGN-ON: DON'T ASK		
AUTO MENU: YES, MENUS GENERATED		
TYPE-AHEAD: ALLOWED		
TEXT TERMINATOR:		
PREFERRED EDITOR: SCREEN EDITOR - VA FILEMAN		
Want to edit VERIFY CODE (Y/N):		
Exit	Save	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND: S	Press <PF1>H for help	Insert
E		

Figure 2-11: Changing the Text Editor (Steps 1-4)

Note: For additional information on using the **Full-Screen Text Editor**, refer to Section 2.4.

3.0 Data Entry Menu Reports

This section provides an overview of reports located in the data entry menu in the Roll and Scroll environment. The majority of these reports are located in the **Display Record Options** menu. Begin by navigating to the **AMH** main menu (**Behavioral Health System** main menu).

Figure 3-1 and Figure 3-2 below illustrate the **Data Entry** module and demonstrate the additional functionality available for viewing patient information when necessary.

```

*****
**          IHS Behavioral Health System          **
*****
                        Version 4.0 (Patch 13)

                        DEMO INDIAN HOSPITAL

DE      Behavioral Health Data Entry Menu ...
RPTS    Reports Menu ...
MUTL    Manager Utilities ...

Select Behavioral Health Information System Option:  DE

```

Figure 3-1: Data Entry Module

The **Data Entry (DE)** option includes the menu options shown in Figure 3-2.

```

*****
**          IHS Behavioral Health System          **
**          Data Entry Menu                      **
*****
                        Version 4.0 (Patch 13)

                        DEMO INDIAN HOSPITAL

PDE      Enter/Edit Patient/Visit Data - Patient Centered
          **> Out of order:  No LONGER AVAILABLE, USE THE BH GUI
SDE      Enter/Edit Visit Data - Full Screen Mode
          **> Out of order:  No LONGER AVAILABLE, USE THE BH GUI
GP       Group Form Data Entry Using Group Definition
DSP      Display Record Options ...
TPU      Update BH Patient Treatment Plans ...
DPL      View/Update Designated Provider List
EHRE     Edit BH Data Elements of EHR created Visit
EBAT     Listing of EHR Visits with No Activity Time
INTL     Listing of Patients with Intakes
SF       Suicide Reporting Forms - Update/Print ...
CR       Coding Review
DSM      View DSM-5 copyright information

Select Behavioral Health Data Entry Menu Option:

```

Figure 3-2: Data Entry Menu

Table 3-1 provides an overview of the report options available in the **Data Entry** menu.

Table 3-1: Data Entry menu options

Option	Use
Display Record Options (DSP)	Displays visit information about particular encounters for one or more patients. See the next section for more details.
Update BH Patient Treatment Plans (TPU)	Displays lists of treatment plans needing review, resolve, or all treatment plans on file. Patients w/ Case Open but no Treatment Plan reports are also available here. All these reports are also located in the Patient Listings reports on the main Reports Menu.
View/Update Designated Provider List (DPL)	Allows a user to print their Designated Provider case load list. This report is also available in the Patient Listings reports on the main Reports Menu.
Listing of EHR Visits with No Activity Time (EBAT)	Lists the behavioral health EHR visits that have no activity time.
Listing of Patient with Intakes (INTL)	Lists Patients who have an Intake or Update on file matching the criteria you specify. This report is also available in the Patient Listings reports on the main Reports Menu.
Suicide Reporting Forms — Update/Print (SF)	Prints a list of Suicide Reporting Forms on One Patient or All Patients in a specific date range.

3.1 Display Record Options (DSP)

The **Display Record Options Menu** has various displays lists, and reports staff can utilize for clinical or administrative purposes. Majority of these reports are also available in the **Patient Listings** reports on the main **Reports Menu**. Below is an overview of these **DSP** menu options (Figure 3-3).

** IHS Behavioral Health System **	
** Data Entry Menu Display Options **	

Version 4.0 (patch 13)	
2021 DEMO HOSPITAL (INST)	
RD	Display Behavioral Health Visit Record
PCCV	Display a PCC Visit
LV	Display Patient's Last Behavioral Health Visit
LI	List Visit Records, STANDARD Output
PR	Print Encounter Form for a Visit
FC	Count Forms Processed By Data Entry
BV	Browse a Patient's Visits

GAF	GAF Scores for One Patient
GAFS	GAF Scores for Multiple Patients
PHQ	PHQ-2, PHQ-9 and PHQ-9T Scores for One Patient
PHQS	PHQ-2, PHQ-9, PHQ-9T Scores for Multiple Patients
GAD	GAD-2 and GAD-7 Scores for One Patient
GADS	GAD-2 AND GAD-7 Scores for Multiple Patients
LD	List all Visit Dates for One Patient
NS	List NO SHOW Visits for One Patient
NSDR	Listing of No-Show Visits in a Date Range
ES	Listing of Visits with Unsigned Notes
Select Behavioral Health Data Entry Menu Option:	

Figure 3-3: Overview of the DSP Menu options

3.1.1 Display Behavioral Health Record Visit Record (RD)

Display one **AMH** record for one patient. Enter an **Encounter Date**, **Location of Encounter**, and **Patient Name** for the record to display.

3.1.2 Display a PCC Visit (PCCV)

Display a **PCC visit** record for one patient. Enter a **Patient Name** and **Visit Date** for the visit to display. This can also be done within the PCC application as well.

3.1.3 Display Patient's Last Behavioral Health Visit (LV)

Display a patient's last **BH visit**. Enter a **Patient Name**. Choose a particular **provider's last visit** (optional). Select a print format of either **Encounter Form Format** or **Standard Display**. Select what type of form you want to print (**Full**, **Suppressed**, **Both**, **2 copies of Full**, or **2 copies of Suppressed**). Choose **Device** to display or print.

3.1.4 List Visit Records, Standard Output (LI)

This report produces a listing of visits in a date range selected by the user. The visits printed can be selected based on any combination of items. The user will select these criteria. The items printed on the report are also selected by the user.

3.1.5 Print Encounter Form for a Visit (PR)

This report produces hard copy computer generated encounter forms. Enter the **date range** for which forms should be printed.

3.1.6 Count Form Processed by Data Entry (FC)

This report generates a count of forms entered by a particular data entry operator or for ALL data entry operators for a date range that you specify.

3.1.7 Browse a Patient's Visits (BV)

Allows you to browse visits for one patient. This functionality also exists in the **AMH GUI (BH GUI)**.

3.1.8 GAF Scores for One Patient (GAF)

This option is used to list **GAF scores** for a patient in date order.

3.1.9 GAF Scores for Multiple Patients (GAFS)

This option is used to list **GAF scores** for multiple patients sorted by patient.

3.1.10 PHQ-2, PHQ-9, and PHQ-9T for One Patient (PHQ)

This option is used to list **PHQ2/PHQ9/PHQT Scores** for one patient within a date range specified by the user. This report is also available within the **Patient Listings Menu** on the **AMH Reports** main menu.

3.1.11 PHQ-2, PHQ-9, and PHQ-9T for Multiple Patient (PHQS)

This option is used to list **PHQ-2, PHQ-9, and PHQ-9T Scores** for multiple patients sorted by patient. This report is also available on the **Patient Listings** menu in the **AMH Reports** main menu.

3.1.12 GAD-2 and GAD-7 Scores for One Patient (GAD)

This option is used to list **GAD2 and GAD7 Scores** for one patient within a date range specified by the user. This report is also available on the **Patient Listings** menu in the **AMH Reports** main menu.

3.1.13 GAD-2 and GAD-7 Scores for Multiple Patients (GADS)

This option is used to list **GAD2 and GAD7 Scores** for multiple patients sorted by patient. This report is also available on the **Patient Listings** menu in the **AMH Reports** main menu.

3.1.14 List all Visit Dates for One Patient (LD)

This option lists all **AMH records** for one patient based on subset criteria selected in a list view screen.

3.1.15 List No Show Visits for One Patient (NS)

This option prints a list of one patient's No-Show visits using the **No-Show POV** codes not based on **Scheduling/PIMS** application information.

3.1.16 Listing of No-Show Visits in a Date Range (NSDR)

This option prints a list of visits with POVs related to **No Shows** and **Cancellations** for multiple patients. **Date range**, **program**, and **provider** can be specified by the user.

3.1.17 Listing of Visits with Unsigned Notes (ES)

This report displays a list of all encounter records containing unsigned **SOAP/Progress Notes** in a date range specified by the user (Figure 3-4). After the report is displayed, the user will have the option of affixing an electronic signature to an unsigned **SOAP/Progress Note**.

ESIG was implemented on Mar 24, 2011. Only visits after this date will be displayed in this report.

Enter a **Beginning** and **Ending Date**. Select **One** or **All Programs**. Select **One** or **All Providers**. Select how to **Sort** the report (**Patient Name**, **Date of Visit**, or **Primary Provider**). Select which **patients** you want to include in the report and click **Print** or **Browse**.

OUTPUT BROWSER	Mar 03, 2026 19:31:01	Page:	1 of	2
***** CONFIDENTIAL PATIENT INFORMATION *****				
2021 DEMO HOSPITAL (INST)			Page 1	
UNSIGNED ENCOUNTER RECORDS				
Date Range: FEB 01, 2026 and MAR 03, 2026				
PATIENT NAME	HRN	DATE/TIME	PROVIDER	PG GRP REV

DEMO,DONNA SUE	137711	Feb 26, 2026@11:40	DEMO,LORI ANN	M
DEMO,MAYLENE	890009	Feb 24, 2026@10:42	DEMO,WENDY	M Y
DEMO,NIKITA	147194	Feb 26, 2026@13:34	DEMO,WENDY	M Y
DEMO,JOHNNY	145700	Feb 20, 2026@09:22	DEMO,POOJITH	C
DEMO,P,JOHNNY	145700	Feb 20, 2026@14:14	DEMO,POOJITH	S
Total # of Unsigned Visits: 5				
Enter ?? for more actions				>>>
+ NEXT SCREEN		PREVIOUS SCREEN		Q QUIT
Select Action: +//				

Figure 3-4: Unsigned Encounter Records report example

4.0 Reports (Roll and Scroll Only)

The **Reports** menu of the AMH provides numerous options for retrieving data from the patient file. You can obtain specific patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

The **Reports** menu (Figure 4-1) contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to AMH. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options are detailed in the following sections.

```

*****
**          IHS Behavioral Health System          **
**                      Reports                      **
*****
                        Version 4.0 (Patch 13)

                        DEMO INDIAN HOSPITAL

PAT   Patient Listings ...
REC   Behavioral Health Record/Encounter Reports ...
WL    Workload/Activity Reports ...
PROB  Problem Specific Reports ...
TABL  Print Standard Behavioral Health Tables ...

Select Reports Menu Option:

```

Figure 4-1: Options on Report menu example

Use this menu for tracking and managing patients, provider, and program statistics.

Note: The location screen (UU) and the list of **Those Allowed to See All Visits** found on the site parameters menu will impact the information displayed in the reports.

For example, if your name has not been added to the list of those allowed to see all visits, the report will contain only those visits where you were a provider or completed the data entry.

4.1 Patient Listings (PAT)

The **Patient Listings** submenu (Figure 4-2) contains report options for generating lists of patients by various criteria. Also included is the **Patient General Retrieval** option, that is a custom report that allows you to select which patients to include in the report as well as the items to print and the sort criteria.

```

ACL      Active Client List
PGEN     Patient General Retrieval
DP       Designated Provider List
GRT      Patients with AT LEAST N Visits
AGE      Patients Seen by Age and Sex (132 column print)
CASE     Case Status Reports ...
GAFS     GAF Scores for Multiple Patients
NSDR     Listing of No-Show Visits in a Date Range
PERS     Patient List for Personal Hx Items
PPL      Placements by Site/Patient
PPR      Listing of Patients with Selected Problems
SB       SBIRT Report
SCRN     Screening Reports ...
TPR      Treatment Plans ...
TSG      Patients seen in groups w/Time in Group

```

Select Patient Listings Option:

Figure 4-2: Options on the Patient Listings reports example

4.1.1 Active Client List (ACL)

Use the **ACL** option to review a list of patients who have been seen in a specified date range. You can further filter the report by a particular provider, if needed.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.
- Enter Ending Date
 - Specify the ending date of the date range.

Note: The date range considered should be one in which the patient should be seen in order to be considered active.

- Limit the list to those patients who have seen a particular provider?
 - Type **Y** (Yes)
 Or
 - **N** (No)
 If you type **Y**, other prompts display.
- Demo Patient Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)

- Do you want to use:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

Browse the output on the **Output Browser** screen (Figure 4-3).

ACTIVE CLIENT LIST							
PROVIDER: PROVIDER R							
ENCOUNTER DATES: OCT 1, 2015 TO NOV 24, 2015							
PATIENT NAME	CHART NUMBER	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS
CLIENT A	106529	F	03/05/30	CHENEGA	PROVIDER R	F32.3	4
				DEMO HOSPI	STUDENT,EI	F10.24	
CLIENT B	901234	F	04/04/76	DEMO HOSPI	PROVIDER R	F42.	
CLIENT C	200042	M	03/23/83	CHENEGA	PROVIDER R	F32.1	3
				DEMO HOSPI	STUDENT,FO	F32.3	
					STUDENT,TW	F32.3	
CLIENT D	107468	M	05/20/69	DEMO HOSPI	PROVIDER R	F84.0	2
						F32.2	
CLIENT E	432098	M	04/04/75	DEMO HOSPI	PROVIDER R	F42.	1
CLIENT F	200614	F	05/17/90	CHENEGA	PROVIDER R	1.1	3
					STUDENT,TW	F10.24	
Total Number of Patients: 6							

Figure 4-3: Output Browser Data example

Near the end of the report, the application displays the total number of patients.

4.1.2 Patient General Retrieval (PGEN)

Use the **PGEN** option to produce a report that shows a listing of patients based on selected criteria. The patients used on the report can be selected based on any selected print and sort criteria.

Below are the prompts:

- Select and Print Patient List from
 - Use **S** (search template)
 Or
 - **P** (patient file)
 If you use **S**, other prompts will display.
- Do you want to use a PREVIOUSLY DEFINED REPORT?
 - Use **Y** (Yes)
 Or
 - **N** (No)

If you use **Y**, other prompts will display.

The application displays the **Patient Selection Menu** (Figure 4-4).

BH GENERAL RETRIEVAL		Dec 26, 2015 09:10:31		Page: 1 of 1	
Patient Selection Menu					
Patients can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Patients type Q.					
1) Sex	14) Medicaid Eligibility	27) Pts seen at a Locati			
2) Race	15) Priv Ins Eligibility	28) Pts Seen in a Commun			
3) Patient Age	16) Patient Flag Field	29) Pts w/Problem (DX)			
4) Patient DOB	17) Case Open Date	30) Pts w/Problem (MHSS			
5) Patient DOD	18) Case Admit Date	31) Pts seen by a Provid			
6) Living Patients	19) Case Closed Date	32) Pts w/Education Done			
7) Chart Facility	20) Case Disposition	33) Pts seen for an Acti			
8) Community of Residen	21) Next Case Review Dat	34) Pts seen w/Type of C			
9) County of Residence	22) Designated MH Prov	35) Pts seen w/Axis IV L			
10) Tribe of Membership	23) Designated SS Provid	36) Pts w/Inpatient Disp			
11) Eligibility Status	24) Designated A/SA Prov	37) Pts Last Health Fact			
12) Class/Beneficiary	25) Designated Other Pro				
13) Medicare Eligibility	26) Personal History Ite				
Enter ?? for more actions					
S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report
Select Action: S//					

Figure 4-4: Patient Selection Menu options example

Use this menu to select the patients based on various criteria. If you do not specify any criteria (immediately use the **Quit Item Selection** option), the application selects all patients.

Choose **Type of Report**.

Use one of the following:

- **T** (total count only)
- **S** (sub-counts and total count)
- **D** (detailed listing)

If you select **D** (the detailed listing), the application displays the **Print Item Selection Menu** (Figure 4-5).

BH GENERAL RETRIEVAL		Apr 16, 2015 14:46:31		Page: 1 of 1	
PRINT ITEM SELECTION MENU					
The following data items can be printed. Choose the items in the order you want them to appear on the printout. Keep in mind that you have an 80 column screen available, or a printer with either 80 or 132 column width.					
1) Patient Name	13) Class/Beneficiary	25) Case Disposition			
2) Sex	14) Medicare Eligibility	26) Next Case Review Dat			
3) Race	15) Medicaid Eligibility	27) Designated MH Prov			

4) Patient Age	16) Priv Ins Eligibility	28) Designated SS Provid
5) Patient DOB	17) Mailing Address-City	29) Designated A/SA Prov
6) Patient SSN	18) Home Phone	30) Designated Other Pro
7) Patient DOD	19) Mother's Name	31) Designated Other (2)
8) Patient Chart #	20) Patient Flag Field	32) Personal History Ite
9) Community of Residen	21) Patient Flag Narrati	33) Pts Last Health Fact
10) County of Residence	22) Case Open Date	
11) Tribe of Membership	23) Case Admit Date	
12) Eligibility Status	24) Case Closed Date	

Enter ?? for more actions

S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report

Select Action: S//

Figure 4-5: Print Item Selection Menu options example

Use this menu to determine the data items on the report. Select the items in the order that you want them to appear on the output. When finished selecting, use the **Quit Item Selection** action to dismiss the menu.

Next, the application displays the **Sort Item Selection Menu** (Figure 4-6).

BH GENERAL RETRIEVAL	Apr 16, 2009 14:49:47	Page: 1 of 1
----------------------	-----------------------	--------------

SORT ITEM SELECTION MENU

The Patients displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by patient name.

1) Patient Name	7) Community of Residen	13) Designated MH Prov
2) Sex	8) County of Residence	14) Designated SS Provid
3) Race	9) Tribe of Membership	15) Designated A/SA Prov
4) Patient DOB	10) Eligibility Status	16) Designated Other Pro
5) Patient DOD	11) Class/Beneficiary	17) Designated Other (2)
6) Patient Chart #	12) Patient Flag Field	

Enter ?? for more actions

S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report

Select Action: S//

Figure 4-6: Sort Item Selection Menu options example

Use this menu to determine how the data will be sorted on the report. If you do not select any item (immediately use the **Quit Item Selection** option), the report will be sorted by patient name.

- Do you want a separate page for each Patient Name?
 - Use Y (Yes)
- Or
 - N (No)

- Would you like a custom title for this report?
 - Use **Y** (Yes)
 Or
 - **N** (No)
 If you use **Y**, other prompts will display.
- Do you want to save this search/print/sort logic for future use?
 - Use **Y** (Yes)
 Or
 - **N** (No)
 If you use **Y**, other prompts will display.

- Demo Patient Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

The application provides a **Report Summary** that shows the criteria you selected.

- Do you want to use:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

The application first displays the **Patient Selection Criteria** for the report.

After you move onto the next screen press **Enter** (to continue), and the application displays the **Patient Listing** report (Figure 4-7).

***** CONFIDENTIAL PATIENT INFORMATION *****			
BH Patient Listing			Page 1
PATIENT NAME	SSN	COMM	RESIDENCE

A'PAT1, ALAYNA BROOKL	XXX-XX-2160	HOWE	
A'PAT1, WEBB AARON	XXX-XX-4769	PORUM	
DEMO, ALICE ROCHELLE	XXX-XX-6378	COLCORD	
DEMO, GERALDINE	XXX-XX-7097	MUSKOGEE	
Enter ?? for more actions			
+ NEXT SCREEN	- PREVIOUS SCREEN	Q	QUIT
Select Action: +//			

Figure 4-7: Patient Listing report example

4.1.3 4.1.3 Designated Provider List (DP)

Use the **DP** option to produce the designated mental health provider list report.

Below are the prompts:

- Which Designated Provider?
Use one of the following:
 - **M** (Mental health)
 - **S** (Social services)
 - **C** (Chemical, dependency or alcohol/substance abuse)
 - **O** (Other)
 - **T** (Other non-RPMS)
- Run Report for?
Use one of the following:
 - **1** (One provider)Or
 - **2** (All providers)If you use **1**, other prompts will display.
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)Or
 - **B** (Browse output on screen)

The application displays the **Designated Mental Health Provider List** report (Figure 4-8).

***** CONFIDENTIAL PATIENT INFORMATION *****					
XX					Page 1
DEMO INDIAN HOSPITAL					
DESIGNATED MENTAL HEALTH PROVIDER LIST					
PROVIDER: ALL					
PATIENT NAME	CHART #	SEX	DOB	COMMUNITY	LAST VISIT

PROVIDER: GPROVIDER,D					
DEMO,ALICE ROCHELLE	183497	F	06/25/97	COLCORD	Jan 05, 2009
DEMO,GLEN DALE	108704	M	11/10/81	TAHLEQUAH	Apr 14, 2009
DEMO,JANE ELLEN		F	01/01/90	TUCSON	Apr 15, 2009
MPAT11,SHERRY KEARNEY	197407	F	10/01/00	PEGGS	Sep 28, 2007
+ Enter ?? for more actions					>>>
+ NEXT SCREEN	-	PREVIOUS SCREEN		Q	QUIT
Select Action: +//					

Figure 4-8: Designated Mental Health Provider List report (for all providers) example

The report subtotals by provider.

4.1.4 Patients with AT LEAST N Visits (GRT)

Use the **GRT** option to produce a report that shows a list of patients who have been seen at least N number of times in a specified date range.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.
- Enter Ending Date
 - Specify the ending date of the date range.
- Enter the minimum amount of time the patient should have been seen

Use any number between **2** and **100**.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)

Or

 - **B** (Browse output on screen)

The application displays the patients seen at least N times report (Figure 4-9).

***** CONFIDENTIAL PATIENT INFORMATION *****							
XX							Page 1
DEMO INDIAN HOSPITAL							
PATIENTS SEEN AT LEAST 3 TIMES							
RECORD DATES: JAN 16, 2009 TO APR 16, 2015							
PATIENT NAME	CHART #	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS

DEMO,CHELSEA	116431	F	02/07/75	CEDAR CITY	BDOC111,BJ	1.1	67
				CHEVAK	BDOC222,LO	12	
				CHINLE CHA	CDOC1,JESS	14	
				CHINLE HOS	DEMO,DOCTO	15	
				DEMO INDIA	GDOC12,RYA	22	
+	Enter ?? for more actions						>>>
+	NEXT SCREEN	-	PREVIOUS SCREEN		Q	QUIT	
Select Action: +//							

Figure 4-9: Patients Seen at Least 3 Times report example

4.1.5 Patients Seen by Age and Sex (AGE)

Use the **AGE** option to produce a report that tallies the number of patients, who have had an encounter, by age and sex. You will choose the item you want to tally. For example, you can tally problems treated, or activities by age and sex. Any tally by **PROBLEM** only includes the **PRIMARY PROBLEM**. You will be able to define the age groups to be used.

Below are the prompts:

- Choose an item to tally by age and sex.

Use one of the following:

- 1) Program Type
- 2) POV/Problem (Problem Code)
- 3) Problem/POV (Problem Category)
- 4) Problem/POV
- 5) Location of Service
- 6) Type of Contact of Visit
- 7) Activity Code
- 8) Activity Category
- 9) Community of Service

The item you select will display down the left column of the report. Age groups will be across the top.

- Enter Beginning Visit Date for Search

- Specify the beginning date of the date range.
- Enter Ending Visit Date for Search
 - Specify the ending date of the date range.

The application displays the **Visit Selection Menu** (Figure 4-10).

BH GENERAL RETRIEVAL		Dec 26, 2015 09:20:24		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	23) Next Case Review Dat	45) Axis V			
2) Patient Sex	24) Appointment/Walk-In	46) Flag (Visit Flag)			
3) Patient Race	25) Interpreter Utilized	47) Primary Provider			
4) Patient Age	26) Program	48) Primary Prov Discipl			
5) Patient DOB	27) Visit Type	49) Primary Prov Affilia			
6) Patient DOD	28) Location of Encounte	50) Prim/Sec Providers			
7) Living Patients	29) Clinic	51) Prim/Sec Prov Discip			
8) Chart Facility	30) Outside Location	52) POV (Prim or Sec)			
9) Patient Community	31) SU of Encounter	53) POV (Prob Code Grps)			
10) Patient County Resid	32) County of Service	54) Primary POV			
11) Patient Tribe	33) Community of Service	55) POV (Problem Categor			
12) Eligibility Status	34) Activity Type	56) POV Diagnosis Catego			
13) Class/Beneficiary	35) Days in Residential	57) Procedures (CPT)			
14) Medicare Eligibility	36) Days in Aftercare	58) Education Topics Pro			
15) Medicaid Eligibility	37) Activity Category	59) Prevention Activity			
16) Priv Ins Eligibility	38) Local Service Site	60) Personal History Ite			
17) Patient Encounters O	39) Number Served	61) Designated MH Prov			
18) Patient Flag Field	40) Type of Contact	62) Designated SS Provid			
19) Case Open Date	41) Activity Time	63) Designated A/SA Prov			
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro			
21) Case Closed Date	43) PCC Visit Created				
22) Case Disposition	44) Axis IV				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 4-10: Visit Selection Menu example

Use this menu to select the visit selection criteria for the report. If you do not select any criteria (immediately use **Quit Item Selection**), all visits will be selected.

- Do you want to modify these age groups?

The application displays the currently defined age groups. Answer **Y** or **N** to this prompt. If you use **Y**, other prompts will display. Use **N** to have the defined age groups listed across the top of the report.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)

- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

The application displays the criteria for the report. After pressing **Enter**, the application displays the **Behavioral Health Record Listing** report (Figure 4-11).

```

OUTPUT BROWSER                      Apr 16, 2015 15:20:53                      Page:    1 of   23

                                     BEHAVIORAL HEALTH RECORD LISTING

REPORT REQUESTED BY: DEMO,SHIRLEY

The following visit listing contains BH visits selected based on the
following criteria:

                                     RECORD SELECTION CRITERIA

Encounter Date range:  OCT 18, 2008 to APR 16, 2015

Report Type: RECORD COUNTS BY AGE/SEX
***** CONFIDENTIAL PATIENT INFORMATION *****
                                     BEHAVIORAL HEALTH RECORD/ENCOUNTER COUNTS
                                     PROBLEM DSM-5/CODE BY AGE AND
                                     ENCOUNTER DATES:  OCT 18, 2008  TO  A

                                     SEX: BOTH
PROB DSM/CODE NARRATIVE              0-0      1-4      5-14      15-19      20-
-----
ACUTE STRESS REACTION                .        .        .        .
ADMINISTRATION                       .        .        2        .
ADULT ABUSE (SUSPECTED),UNSPEC       .        .        .        .
ALCOHOL ABUSE                        .        .        1        .
ALCOHOL ABUSE, CONTINUOUS             .        .        .        .
ALCOHOL ABUSE, EPISODIC,              .        .        .        1
ALCOHOL ABUSE, IN REMISSION           .        .        .        .
ALCOHOL ABUSE, UNSPECIFIED            .        .        1        1
+      Enter ?? for more actions                                >>>
+  NEXT SCREEN      -  PREVIOUS SCREEN      Q  QUIT
Select Action: +/-
  
```

Figure 4-11: Behavioral Health Record Listing report example

4.1.6 Case Status Reports (CASE)

Use the **CASE** option to access additional reports on the **Case Status Reports** menu (Figure 4-12).

ACO	Active Client List Using Case Open Date
ONS	Cases Opened But Patient Not Seen in N Days
TCD	Tally Cases Opened/Admitted/Closed
DOC	Duration of Care for Cases Opened and Closed
SENO	Patients Seen x number of times w/no Case Open

Select Case Status Reports Option:

Figure 4-12: Options on the Case Status Reports menu example

4.1.6.1 Active Client List Using Case Open Date (ACO)

Use the **ACO** option to produce a report that shows a list of patients who have a case open date without a case closed date.

Below are the prompts:

- Run the Report for which program
Use one of the following:
 - **O** (One program)
 Or
 - **A** (All programs)
 If you use **O**, other prompts will display.
- Include cases opened by
Use one of the following:
 - **A** (All providers)
 Or
 - **O** (One provider)
 If you use **O**, other prompts will display.
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

The application displays the active client list report (Figure 4-13).

ACTIVE CLIENT LIST								
PROVIDER: PROVIDER R								
ENCOUNTER DATES: OCT 1, 2015 TO NOV 24, 2015								
PATIENT NAME	CHART NUMBER	SEX	DOB	LOCATION SEEN	PROVIDER SEEN	PROBLEM CODES	# VISITS	
CLIENT A	106529	F	03/05/30	CHENEGA	PROVIDER R	F32.3	4	
				DEMO HOSPI	STUDENT, EI	F10.24		
CLIENT B	901234	F	04/04/76	DEMO HOSPI	PROVIDER R	F42.		
CLIENT C	200042	M	03/23/83	CHENEGA	PROVIDER R	F32.1	3	
				DEMO HOSPI	STUDENT, FO	F32.3		
					STUDENT, TW	F32.3		
CLIENT D	107468	M	05/20/69	DEMO HOSPI	PROVIDER R	F84.0	2	
						F32.2		
CLIENT E	432098	M	04/04/75	DEMO HOSPI	PROVIDER R	F42.	1	
CLIENT F	200614	F	05/17/90	CHENEGA	PROVIDER R	1.1	3	
					STUDENT, TW	F10.24		
Total Number of Patients: 6								

Figure 4-13: View of Active Client List example

4.1.6.2 Cases Opened but Patient Not Seen in N Days (ONS)

Use the **ONS** option to produce a report that shows a list of patients who have a case open date, no closed date, and have not been seen in **N** days. The user will determine the number of days to use.

Below are the prompts:

- Run the Report for which PROGRAM
Use one of the following:
 - **O** (One program)
 Or
 - **A** (All programs)
 If you use **O**, other prompts will display.
- Include cases opened by
Use one of the following:
 - **A** (Any providers)
 Or
 - **O** (One provider)
 If you use **O**, other prompts will display.
- Enter the number of days since the patient has been seen
 - Specify the number of days (**1-99999**) to be used when determining which patients should be included in the report.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

The application displays the **Cases Opened but Patient Not Seen in N Days** report (Figure 4-14).

DEMO INDIAN HOSPITAL							
ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)							
PATIENT NAME	CHART NUMBER	SEX	DOB	CASE OPEN DATE	PROVIDER	DATE LAST SEEN	# DAYS SINCE
Patient L	106299	F	11/28/85	01/01/06	GAMMAAA, DON	04/26/06	217
Patient M	102446	F	04/08/66	08/28/06	GAMMAAA, DON	03/28/06	246
Patient N	176203	M	03/04/60	10/10/05	GAMMAAA, DON	03/28/06	246
Patient O	164141	M	02/07/75	12/07/05	GAMMAAA, DON	04/25/06	218
Patient P	209591	F	04/16/62	07/25/06	ZETAAAA, MAT	07/25/06	127
Total Number of Patients: 5							
Total Number of Cases: 5							

Figure 4-14: Cases Opened But Patient Not Seen in N Days report example

4.1.6.3 Tally Cases Opened/Admitted/Closed (TCD)

Use the **TCD** option to produce a report that tallies the case open, admit, and closed dates in a specified time period.

Below are the prompts:

- Enter beginning of Time Period
 - Specify the beginning date of the date range.
- Enter ending of Time Period
 - Specify the ending date of the date range.
- Run the Report for which PROGRAM

Use one of the following:

- **O** (One program)
- Or
- **A** (All programs)

If you use **O**, other prompts will display.

- Include cases opened by

Use one of the following:

– **A** (Any provider)

Or

– **O** (One provider)

If you use **O**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- Do you want to use:

– **P** (Print output)

Or

– **B** (Browse output on screen)

The application displays the **Tally of Cases Opened/Admitted/Closed** report (Figure 4-15).

ALBUQUERQUE HOSPITAL		
TALLY OF CASES OPENED/ADMITTED/CLOSED		

Number of Cases Opened:	6	
Number of Cases Admitted:	2	
Number of Cases Closed:	2	
Tally of Dispositions:		
PATIENT DIED		1
PATIENT DMOVED		1
RUN TIME (H.M.S): 0.0.0		
End of report. PRESS ENTER:		

Figure 4-15: Tally of Cases Opened/Admitted/Closed report example

4.1.6.4 Duration of Care for Cases Opened and Closed (DOC)

Use the **DOC** option to produce a report that shows a list of all closed cases in a specified date range. In order to be included in this report, the case must have both a case open and a case closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases can be selected based on Open date, Closed date, or both. Only those cases falling within the specified time frame will be counted.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.
- Enter Ending Date
 - Specify the ending date of the date range.
- Select which Dates should be Used

Use one of the following:

 - **O** (Cases opened in that Date Range)
 - **C** (Cases closed in that Date Range)
 - **B** (Cases either opened or closed in that Date Range)
- Run the Report for which PROGRAM

Use one of the following:

 - **O** (One program)

Or

 - **A** (All programs)

If you use **O**, other prompts will display.
- Include cases opened by

Use one of the following:

 - **A** (Any provider)

Or

 - **O** (One provider)

If you use **O**, other prompts will display.
- Do you want each Provider on a separate page?

Use one of the following:

 - **Y** (for yes)

Or

 - **N** (for no).

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the **Duration of Care** report (Figure 4-16).

***** CONFIDENTIAL PATIENT INFORMATION *****						
DEMO HOSPITAL						
Case Dates: May 24, 2008 to May 24, 2010						
DURATION OF CARE REPORT						
PATIENT NAME	CHART NUMBER	CASE OPEN DATE	CASE CLOSED DATE	DURATION	POV	PROVIDER
Patient A	148367	05/22/08	08/22/08	92 days		BETA,B
Patient B	114077	06/27/08	08/28/08	62 days		BETA,B
Patient B	114077	07/25/08	08/21/08	27 days		BETA,B
Total Number of Cases for DEMO,B: 3						
Average Duration of Care: 60.33 days						
Patient C	211053	04/19/08	08/16/08	119 days	72.1	DEMO,ROBER
Total Number of Cases for DEMO,ROBERTA: 1						
Average Duration of Care: 119.00 days						
Patient D	146565	08/01/08	08/16/08	15 days	305.62	DEMO,MAUDE
Total Number of Cases for DEMO,MAUDE: 1						
Average Duration of Care: 15.00 days						
Patient E	148256	07/25/08	09/01/08	38 days		DEMO,VICTOR
Total Number of Cases for DEMO,VICTOR L: 1						
Average Duration of Care: 38.00 days						
Patient F	106030	05/22/08	08/30/08	100 days		DEMO,GEO
Total Number of Cases for DEMO,GEORGE G: 1						
Average Duration of Care: 100.00 days						
Total Number of Cases: 7						
Average Duration of Care: 64.71 days						

Figure 4-16: Duration of Care report example

At the end of the report, the application provides the total number of cases for the provider and the average duration of care.

4.1.6.5 Patient Seen X Number of Times with No Case Open (SENO)

Use the **SENO** option to produce a report that shows a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. The user, based on the program's standards of care, specifies when a case is to be opened. For example, a case will be opened if a patient has been seen at least three times.

Below are the prompts:

- Enter Beginning Visit Date
 - Specify the beginning date of the date range.
- Enter Ending Visit Date
 - Specify the ending date of the date range.
- Run Report for which PROGRAM
Use one of the following:
 - **M** (Mental Health)
 - **S** (Social Services)
 - **O** (Other)
 - **C** (Chemical Dependency)
- Include visits to
Use one of the following:
 - **A** (All providers)Or
 - **O** (One provider)If you use **O**, other prompts will display.
- Enter number of visits
 - Specify the number of visits with no case opened.
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)Or
 - **B** (Browse output on screen)

The application displays the **Patients Seen at least N times with no Case Open Date** report (Figure 4-17).

PATIENTS SEEN AT LEAST 3 TIMES WITH NO CASE OPEN DATE							
VISIT DATE RANGE: Oct 01, 2015 to Jan 01, 2016							
VISITS TO PROGRAM: MENTAL HEALTH							
PATIENT NAME	CHART NUMBER	SEX	DOB	# VISITS	LAST VISIT	LAST DX	PROVIDER

CLIENT SR	116431	F	02/07/75	14	10/10/15	F02.80	PROVIDER B
CLIENT BA	188444	M	10/14/79	22	10/28/15	F19.181	PROVIDER B
CLIENT BK	113419	M	07/18/85	5	10/02/15	T74.31XD	PROVIDER B
CLIENT AB	201295	M	05/14/41	4	11/22/15	Z59.5	PROVIDER F
CLIENT CA	171659	F	12/07/94	4	12/09/15	F64.1	PROVIDER B
CLIENT SM	152608	M	02/25/86	4	12/19/15	F54	PROVIDER B
CLIENT YE	194181	M	08/21/98	7	11/19/15	F15.24	PROVIDER Y
Total Number of Patients: 3							

Figure 4-17: Patients Seen at Least N Times with No Case Open Date report example

4.1.7 GAF Scores for Multiple Patients (GAFS)

Use the **GAFS** option to produce a report that lists the **GAF** scores for multiple patients, sorted by patient. Only visits with **GAF** scores recorded will display on this list.

Below are the prompts:

- Enter Beginning Date of Visit
 - Specify the beginning date of the date range.
- Enter Ending Date of Visit
 - Specify the ending date of the date range.
- List visits/GAF Scores for which program

Use one of the following:

- **O** (One program)

Or

- **A** (All programs)

If you use **O**, other prompts will display.

- Include visits to

Use one of the following:

- **A** (All providers)

Or

- **O** (One provider)

If you use **O**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the **GAF Scores for Multiple Patients** report (Figure 4-18).

XX	Apr 17, 2009					Page 1
GAF SCORES FOR MULTIPLE PATIENTS						
Visit Dates: Oct 19, 2008 to Apr 17, 2009						
Program: ALL						
Provider: ALL						
PATIENT NAME	HRN	Date	GAF TYPE	Provider	PG Diagnosis/POV	

DEMO,MINNIE	145318	09/17/10 99	DEMO,RY M	296.40-BIPOLAR I	DISOR	
DEMO,JAMES WILL	192636	07/19/10 75		DEMO,D M	300.02-GENERALIZED ANX	
DEMO,ROBERT MITC	186585	09/16/10 66	test	DEMO,RY M	293.82-PSYCHOTIC DISOR	
+ Enter ?? for more actions				>>>		
+ NEXT SCREEN		PREVIOUS SCREEN		Q	QUIT	
Select Action: +//						

Figure 4-18: GAF Scores for Multiple Patients report example

4.1.8 Listing of No-Show Visits in a Date Range (NSDR)

Use the **NSDR** option to print a list of visits with POVs related to No Shows and Cancellations for multiple patients. The user will specify the date range, program, and provider.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.

- Enter Ending Date
 - Specify the ending date of the date range.
- Run the Report for which PROGRAM

Use one of the following:

 - **O** (One program)

Or

 - **A** (All programs)

If you use **O**, other prompts will display.
- Include visits for

Use one of the following:

 - **A** (All providers)

Or

 - **O** (One provider)

If you use **O**, other prompts will display.
- How would you like the report sorted
 - Use **P** (Patient name)

Or

 - **D** (Date of visit)
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)

Or

 - **B** (Browse output on screen)

The application displays the **Behavioral Health No Show Appointment Listing** report (Figure 4-19).

***** CONFIDENTIAL PATIENT INFORMATION *****					
DEMO INDIAN HOSPITAL					
Page 1					
BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING					
Appointment Dates: OCT 19, 2014 and APR 17, 2015					
PATIENT NAME	HRN	DATE/TIME	PROVIDER	PG	POV

```

-----
DEMO,ROBERT JACOB  207365 Jan 05, 2009@12:00 DEMO,JESSIC M  8-FAILED APPOI
DEMO,CHARLES R    112383 Dec 30, 2008          DEMO,BJ    M  8.1-PATIENT CANC
DEMO,BEULAH       140325 Feb 12, 2009@12:00 DEMO,RYAN   S  8-FAILED APPOI
DEMO,RACHEL MAE   201836 Jan 06, 2009@12:00 DEMO,MIC O  8.3-DID NOT WAIT

Total # of Patients: 4      Total # of No Show Visits: 4

      Enter ?? for more actions                                >>>
+   NEXT SCREEN      -   PREVIOUS SCREEN      Q   QUIT
Select Action: +/-

```

Figure 4-19: Behavioral Health No Show Appointment Listing report example

At the end of the report, the application shows the total number of patients and the total number of No-Show visits.

4.1.9 Patient List for Personal Hx Items (PERS)

Use the **PERS** option to produce the **List of Patients with Personal History Items** report.

Below are the prompts:

- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

Figure 4-20 shows the List of Patients with Personal History Items report.

```

XX                                DEMO INDIAN HOSPITAL
PERSONAL HISTORY LIST BY PATIENT   Jul 13, 2015@09:53:05   Page 1
  PATIENT                        SEX    AGE  CHART NUMBER
-----
                                ALCOHOL USE
DEMO, SAUNDRA KAY                FEMALE    58    117175
DEMO, BRENN A KAY                FEMALE    21    155215
DEMO, HEATHER LINDA PAIGE        FEMALE    73    142321
DEMO, STEVEN                     MALE      29    188444
DEMO, JANE ELLEN                 FEMALE    19
DEMO, TIMOTHY                    MALE      29
DEMO, GREGORY SHANE              MALE      42    184929
DEMO, AMY LYNN                   FEMALE    65    130119

```

```

Enter ?? for more actions
+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT
Select Action: +//
  
```

Figure 4-20: List of Patients with Personal History Items report example

The application will display a sub-count for each Personal History Item.

4.1.10 Placements by Site/Patient (PPL)

Use the **PPL** option to produce a report that shows a list of patients who have had a placement disposition recorded in a specified date range.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.
- Enter Ending Date
 - Specify the ending date of the date range.
- How would you like this report sorted?
 - **P** (alphabetically by patient name)
 Or
 - **S** (alphabetically by site referred to)
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

The application displays the **Placements** report (Figure 4-21).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX                                                     Page 1
                DEMO INDIAN HOSPITAL
                PLACEMENTS
        PLACEMENT DATES:  SEP 03, 2025  TO  MAR 03, 2026
PATIENT NAME      HRN      DATE      POV      REFERRAL      FACILITY REFERRED TO
                        PLACED
-----
  
```

DEMO, ANGELA	456123	01/09/26	F33.1	OTHER	Test
Placement Made by: DEMO, THERESA					
DEMO, ANGELA	456123	01/09/26	F33.1	HOSPITAL	Test 2
Placement Made by: DEMO, THERESA					
DEMO, ANGELA	456123	01/09/26	F33.1	ALCOHOL/DRUG D	Test Name 1
Placement Made by: DEMO, THERESA					
DEMO, CHERYL NADINE	135548	01/15/26	F10.14	ALCOHOL/DRUG R	AI FRIENDSHIP HOUSE
Placement Made by: DEMO, WENDY					
DEMO, CHERYL NADINE	135548	01/15/26	F10.14	OTHER	PHOENIX INDIAN CENTE
Enter ?? for more actions					>>>
+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT					
Select Action: +//					

Figure 4-21: Placements report example

Near the end of the report, it shows subtotals by **Placement Type**, subtotals by **Facility Referred**, and the **Total Number of Placements**.

4.1.11 Listing of Patients with Selected Problems (PPR)

Use the **PPR** option to produce a report that lists all patients who have been seen for a particular diagnosis/problem in a specified date range. For example, you can enter all suicide problems codes (**39**, **40**, and **41**) and you will get a list of all patients seen for suicide and can then use this report to assist in follow up activities. The report will list the Designated Provider, the Patient Name, the date seen for this problem, and the date last seen.

Below are the prompts.

- Which Type

Use one of the following:

- **P** (Problem Code and all DSM Codes grouped under it)
- **D** (Individual Problem or DSM Codes)

Below are prompts for the **P** type:

- Enter Problem Code
 - Enter the problem code. The application lists the problem/diagnosis codes that will be included. The next prompt allows you to enter another problem code.
- Enter Beginning Visit Date
 - Specify the beginning date of the date range.
- Enter Ending Visit Date
 - Specify the ending date of the date range.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)

- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

The application displays the **Patients Seen with Selected Diagnosis/Problems** report (Figure 4-22).

XX	Apr 17, 2015						Page 1	
PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS								
Visit Dates: Oct 19, 2008 to Apr 17, 2009								
PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS

DEMO,ABIGAIL	103952	02/25/32	F	BJB	41		12/08/08	12/29/08
DEMO,ROBERT JACOB	207365	02/06/55	M	JC	41		12/29/08	01/05/09
DEMO,AMANDA ROSE	186121	01/10/98	F	DG	40		12/01/08	12/30/08
DEMO,ANNEMARIE LEE	105883	02/11/44	F	DG	40		04/06/09	04/06/09
Designated MH Prov: DEMO,DENISE								
Designated SS Prov: DEMO,RYAN								
Enter ?? for more actions								>>>
+ NEXT SCREEN	-	PREVIOUS SCREEN			Q	QUIT		
Select Action: +/-								

Figure 4-22: Patients Seen with Selected Diagnoses/Problems report (P type) example

Below are the prompts for the **D (individual problem or DSM codes)** type:

- Enter Problem/Diagnosis Code
 - Specify the problem/diagnosis code. The next prompt allows you to enter another problem/diagnosis code.
- Enter Beginning Visit Date
 - Specify the beginning date of the date range.
- Enter Ending Visit Date
 - Specify the ending date of the date range.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the **Patients Seen with Selected Diagnosis/Problems** report (Figure 4-23).

XX	Oct 17, 2015						Page 1	
PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS								
Visit Dates: Oct 19, 2008 to Apr 17, 2009								
PATIENT NAME	HRN	DOB	SEX	PROV	DX	DX	DATE SEEN	LAST VIS

DEMO,CHELSEA MARIE	116431	02/07/75	F	DG		F33.1	10/06/15	10/16/15
Designated SS Prov: BDOC11,BJ								
DEMO,MISTY DAWN	131668	04/21/46	F	rust		200.20	02/04/09	06/12/09
Designated SS Prov: DEMO,PSYCHIATRIST								
Enter ?? for more actions								>>>
+ NEXT SCREEN		- PREVIOUS SCREEN			Q	QUIT		
Select Action: +//								

Figure 4-23: Patients Seen with Selected Diagnoses/Problems report (D Type) example

4.1.12 SBIRT Report (SB)

Use the **SB** option to produce a report that will tally and optionally list all patients who have had a positive screening result for risky or harmful alcohol use in an Ambulatory Care setting in the time frame specified by the user. These tallies will also be further defined to show if the patient received a **Brief Negotiated Interview (BNI)**, **Brief Intervention (BI)**, and/or **Referral to Treatment (RT)** within seven days of the positive screen result. Visits from PCC and AMH will be included.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.
- Enter Ending Date
 - Specify the ending date of the date range.
- Include which patients in the list

Use one of the following:

 - **F** (FEMALES only)
 - **M** (MALES only)
 - **B** (Both MALE and FEMALES)
- Would you like to restrict the report by **Patient age range**?

- Use **Y** (Yes)
- Or
- **N** (No). If you use **Y**, other prompts will display.
- Include patients who were seen by which providers during the report period
Select one of the following:
 - **O** (One Provider Only)
 - **P** (Any/All Providers)
- Patient Lists
Select one of the following:
 - **1** (Those with a Positive Alcohol Screening)
 - **2** (Those with at least 1 Positive Alcohol Screening with BNI/BI or RT)
 - **3** (Those with all Positive Alcohol Screenings without BNI/BI or RT)
 - **0** (No Lists)
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
- **B** (Prowse output on screen)

The application displays the SBIRT report (Figure 4-24).

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)		
Screening Dates: Jul 10, 2015 to Jul 10, 2017		
	Number	Percent
	-----	-----
Patients screened for alcohol use	28	
Patients screened Positive (at least once)	9	32.1%
Patients Screened Positive w/ BNI/BI on same day as screen	5	55.6%
Patients Screened Positive w/ BNI/BI 1-3 days after screen	1	11.1%
Patients Screened Positive w/		

BNI/BI 4-7 days after screen	0	0.0%
Patients Screened Positive referred for treatment w/in 7 days	0	0.0%
Enter ?? for more actions		>>>
+ NEXT SCREEN	- PREVIOUS SCREEN	Q QUIT

Figure 4-24: SBIRT report example

4.1.13 Screening Reports (SCRN)

Use the **SCRN** option to access the **Screening Reports** menu (Figure 4-25).

**	IHS Behavioral Health System **
**	Screening Reports **

Version 4.0 (Patch 13)	
DEMO INDIAN HOSPITAL	
IPV	IPV/DV Reports ...
ALC	Alcohol Screening Reports ...
DEP	Depression Screening Reports ...
SOC	Social Determinants of Health Scrn (SDOH) Rpts ...
DRU	Drug Use Screening Reports ...
SRA	Suicide Risk Assessment Reports ...
SSR	Suicide Screening Reports ...
TAPS	TAPS Screening Report
TAPP	TAPS - Positive Screening Results Report
PHQ	PHQ-2, PHQ-9 and PHQ-T Scores for One Patient
PHQS	PHQ-2 PHQ-9, PHQ-9T Scores for Multiple Patients
GAD	GAD-2 and GAD-7 Scores for One Patient
GADS	GAD-2 AND GAD-7 Scores for Multiple Patients
Select Screening Reports Option:	

Figure 4-25: Options on the Screening Reports menu example

4.1.13.1 IPV/DV Reports (IPV)

Use the **IPV** option to access the **IPV/DV Reports** menu (Figure 4-26).

**	IHS Behavioral Health System **
**	IPV/DV Reports **

Version 4.0 (Patch 13)	
DEMO INDIAN HOSPITAL	
DVP	Tally/List Patients with IPV/DV Screening

DVS	Tally/List IPV/DV Screenings
ISSP	List all IPV/DV Screenings for Selected Patients
IPST	Tally/List Pts in Search Template w/IPV Screening
IVST	Tally List all IPV Screenings for Template of Pts
Select IPV/DV Reports Option:	

Figure 4-26: Options on the IPV/DV Reports menu example

4.1.13.1.1 Tally/List Patients with IPV/DV Screening (DVP)

This report will tally and optionally list all patients who have had **IPV** screening (**PCC Exam code 34**), or a refusal documented in a specified time frame. This report will tally the patients by age, sex, result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

Below are prompts for the **DVP** report:

- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-11)**
 - Select which items you want to tally on this report (Figure 4-27):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Sex	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider
Which items should be tallied: (0-11)://	

Figure 4-27: List of Options From Which to Tally the report example

The response must be a list or range, e.g., **1, 3, 5**, or **2–4, 8**.

- Would you like to include **IPV/DV** screenings documented in the **PCC** clinical database?
 - Use **Y** (Yes)

Or

– N (No)

- Would you like to include a list of patients screened?

– Use Y (Yes)

Or

– N (No)

If you use Y, the following prompt will display.

- How would you like the list to be sorted

Figure 4-28 lists the possibilities.

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

How would you like the list to be sorted: H//

Figure 4-28: List of Options to sort the list example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

– Use Y (Yes)

Or

– N (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- DEVICE

Specify the device to output the report.

Figure 4-29 shows a sample report.

XXX	May 18, 2016					Page 1
IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS						
Screening Dates: May 18, 2009 to May 18, 2016						
Patient Name	HRN	AGE	DATE	RESULT	CLINIC	

DEMO,CECILE	103465	42 F	07/09/16	NEGATIVE	TELEBEHAVIORAL HE	
Comment: Exposure to violence as a child						
DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER						
Primary Provider on Visit: DEMO,RYAN						
Provider who screened: DEMO,RYAN						
DEMO,CANDI LYNN	115655	40 F	12/19/15	NEGATIVE	MENTAL HEALTH	
Comment: Patient says she wouldn't tolerate DV since she was a child abuse victim and spent years in counseling to deal with her issues.						
DXs: F42. HOARDING DISORDER						
Primary Provider on Visit: DEMO,DENNY						
Provider who screened: DEMO,CHARLENE						
EPSILON, JANICE	116431	18 F	01/15/15	NEGATIVE	MEDICAL SOCIAL SERVI	
Comment: Patient denies any current domestic violence.						
DXs: F84.0 AUTISM SPECTRUM DISORDER						
Primary Provider on Visit: DEMO,GLORIA						
Provider who screened: DEMO,GLORIA:						

Figure 4-29: Output of the IPV Screening Patient Tally and Patient Listing report example

4.1.13.1.2 Tally/List IPV/DV Screenings (DVS)

This report will tally and optionally list all visits on which **IPV** screening (**Exam Code 34**) or a refusal was documented in a specified time frame. This report will tally the visits by age, sex, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

This report will optionally look at both the **Behavioral Health** and **PCC** clinical databases for evidence of screening/refusal. Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are prompts for the **DVS** report:

- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-11)**
 - Select which items (Figure 4-30) you want to tally on this report:

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Sex	8) Designated MH Provider

```

3) Age of Patient          9) Designated SS Provider
4) Provider who Screened  10) Designated ASA/CD Provider
5) Clinic                 11) Designated Primary Care
Provider
Which items should be tallied? (0-11)://

```

Figure 4-30: List of Options From Which to Tally the report example

The response must be a list or range, e.g., **1,3,5** or **2–4,8**.

- Would you like to include **IPV/DV** screenings documented in the **PCC** clinical database?
 - Use **Y** (Yes)
 - Or
 - **N** (No)
- Would you like a list of visits w/screenings done?
 - Use **Y** (Yes)
 - Or
 - **N** (No)

If you use **Y**, the following prompt will display.

- How would you like the list to be sorted?

Figure 4-31 lists the options.

```

Select one of the following:

      H      Health Record Number
      N      Patient Name
      P      Provider who screened
      C      Clinic
      R      Result of Exam
      D      Date Screened
      A      Age of Patient at Screening
      G      Sex of Patient
      T      Terminal Digit HRN

How would you like the list to be sorted? H//

```

Figure 4-31: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)

- **DEVICE**

Specify the device to output the report (Figure 4-32).

*** IPV SCREENING VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Oct. 31, 2013 to Dec. 30, 2013		
This report excludes PCC Clinics		

Total Number of Visits with Screening	#	% of patients
Total Number of Patients screened	2	
By Result		
NEGATIVE	1	50.0%
PRESENT	1	50.0%
By Provider who screened		
DEMO, RYAN	1	50.0%
DEMO, WENDY	1	50.0%
By Date		

Figure 4-32: Output of the IPV Screening Visit Tally and Visit Listing report example

4.1.13.1.3 List All IPV/DV Screenings for Selected Patients (ISSP)

This report will list all patients you select who have had **IPV** screening or a refusal documented in a specified time frame. You will select the patients based on age, sex, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

- Below are prompts for the **ISSP** report:
 - Enter Beginning Date for Screening
Enter the beginning date of the date range for the screening.
 - Enter Ending Date for Screening
Enter the ending date of the date range for the screening.
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?
Use one of the following:
 - **Y** (Yes)
 - Or
 - **N** (No)

- Include which patients in the list
Use one of the following:
 - **F** (Females only)
 - **M** (Males only)
 - **B** (Both Males and Females)
- Would you like to restrict the report by **patient age range**?
 - Use **Y** (Yes)

Or

- **N** (No)

If you use **Y**, other prompts will display.

- Which result value (Figure 4-33) do you want included in this list: **(1-7)**

```

1) Normal/Negative
2) Present
3) Past
4) Present and Past
5) Refused
6) Unable to Screen
7) Screenings done with no result entered
8) Referral Needed
  
```

Figure 4-33: List of Options to Include in the List example

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g., to get only those patients who have had a result of **Present**, enter **2** to get all patients who have had a screening result of **Past** or **Present**, enter **2,3**).

- Include visits to ALL clinics?

Use one of the following:

- **Y** (Yes)

Or

- **N** (No)

Report should include visits whose **PRIMARY PROVIDER** on the visit is one of the possible options on Figure 4-34. If you use **O**, other prompts will display.

```

Select one of the following:
O (One Provider Only)
P (Any/All Providers, including unknown)
U (Unknown Provider Only)
  
```

Figure 4-34: Options for Visits to Include on the report example

Select which providers who performed the screening should be included.

Figure 4-35 shows the possible options. If you use **O**, other prompts will display.

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 4-35: Options for Providers to Include on the report example

- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?

– Use **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?

– Use **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?

– Use **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Select a Report type.

Use one of the following:

– **L** (List of Patient Screenings)

– **S** (Create a Search Template of Patients)

If you use **S**, other prompts will display.

- How would you like the list to be sorted?

Figure 4-36 shows the possible selections.

Select one of the following:	
H	Health Record Number

N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

Figure 4-36: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

- Use **Y** (Yes)

Or

- **N** (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)

- **E** (Exclude demo patients)

- **O** (Include only demo patients)

- DEVICE

Specify the device to output the report.

The application displays the criteria for the report. After pressing **Enter**, the application displays the report (Figure 4-37).

XXX	May 18, 2016					Page 1
IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS						
Screening Dates: May 18, 2009 to May 18, 2016						
Patient Name	HRN	AGE	DATE	RESULT	CLINIC	

DEMO,CECILE	103465	42	F 10/09/15	NEGATIVE	TELEBEHAVIORAL HE	
Comment: Exposure to violence as a child						
DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER						
Primary Provider on Visit: DEMO,RYAN						
Provider who screened: DEMO,RYAN						
DEMO,CANDI LYNN	115655	40	F 12/19/15	NEGATIVE	MENTAL HEALTH	
Comment: Patient says she wouldn't tolerate DV since she was a child abuse victim and spent years in counseling to deal with her issues.						
DXs: F42. HOARDING DISORDER						
Primary Provider on Visit: DEMO,DENNY						
Provider who screened: DEMO,CHARLENE						
DEMO,JANICE	116431	18	F 01/15/16	NEGATIVE	MEDICAL SOCIAL SERVI	
Comment: Patient denies any current domestic violence.						
DXs: F84.0 AUTISM SPECTRUM DISORDER						

Primary Provider on Visit: DEMO, GLORIA
 Provider who screened: DEMO, GLORIA

Figure 4-37: IPV Screening Visit Listing for Selected Patients report example

4.1.13.1.4 Tally/List Pts in Search Template w/IPV Screening (IPST)

Note: This **IPV/DV** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of patients receiving screening, including refusals only patients who are members of a user-defined search template are included in this report.

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **IPV** screening (**Exam Code 34**), or a refusal documented in a specified time frame. This report will tally the patients by age, sex, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

4.1.13.1.5 Tally List All PIV Screenings for Template of Pts (IVST)

Note: This **IPV/DV** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of all visits **w/IPV** screening, including only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which **IPV** screening (**Exam Code 34**), or a refusal was documented in a specified time frame. This report will tally the visits by age, sex, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. This report will optionally look at both **Behavioral Health** and **PCC** databases for evidence of screening/refusal.

4.1.13.2 Alcohol Screening Reports (ALC)

Use the **ALC** option to access the **ALC Report** menu (Figure 4-38).

```
*****
**          IHS Behavioral Health System          **
**          Alcohol Screening Reports              **
*****
Version 4.0 (Patch 13)
```

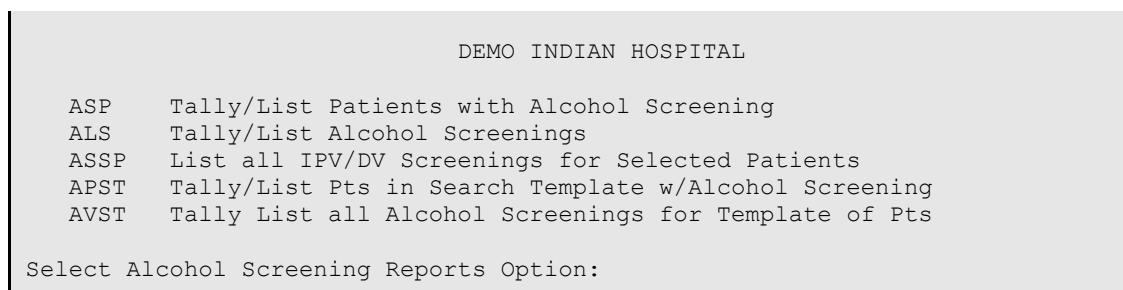


Figure 4-38: Options on the ALC reports menu example

4.1.13.2.1 Tally/List Patients with Alcohol Screening (ASP)

This report will tally and optionally list all patients who have had **ALCOHOL Screening** or a refusal documented in a specified time frame. **Alcohol Screening** is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Any CAGE [F018-F022] or CAGE-AID [F210-F214] Health Factor
- Any TAPS-Alcohol Health Factor [F175-F179]
- Diagnoses 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050, 3016F [BGP ALCOHOL SCREENING CPTS]
- Refusal of Exam Code 35

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are the prompts:

- Enter Beginning Date for Screening.
Specify the beginning date of the date range.
- Enter Ending Date for Screening.
Specify the ending date of the date range.
- Which items should be tallied?
Specify which items you would like to have displayed in the report. The application provides a list of items. Your response must be a list (like **1,3,5**) or a range (**2-4, 8**).
- Would you like to include **ALCOHOL** screenings documented in the **PCC** clinical database?
 - Use **Y** (Yes)Or
 - **N** (No)
- Would you like to include a list of patients screened?
 - Use **Y** (Yes)Or
 - **N** (No)
- If you answered **Yes** to this question, the next prompt displays:
 - How would you like this report sorted?
 - Use only one of the items in the list provided by the application.
- Display the **Patient's Designated Providers** on the list?
 - Use **Y** (Yes) to display the patient's Designated Providers or **N** (No) to bypass this option.
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)Do you want to use:
 - **P** (Print output)Or
 - **B** (Browse output on screen)

The application displays the **Tally/List Patients with Alcohol Screenings** report (Figure 4-39).

XX	Oct 07, 2010	Page 1
*** ALCOHOL SCREENING PATIENT TALLY AND PATIENT LISTING ***		
Screening Dates: Sep 07, 2010 to Oct 07, 2010		
This report excludes data from the PCC Clinical database		

	#	% of patients
Total Number of Patients screened	4	
By Result		
NEGATIVE	1	25.0%
POSITIVE	2	50.0%
REFUSED SCREENING	1	25.0%
By Sex		
F	3	75.0%
M	1	25.0%
By Age		
26 yrs	1	25.0%
27 yrs	1	25.0%
44 yrs	1	25.0%
48 yrs	1	25.0%

Figure 4-39: Tally/List Patients with Alcohol Screenings report example

4.1.13.2.2 Tally/List Alcohol Screening (ALS)

This report will tally and optionally list all visits on which **ALCOHOL** screening or a refusal was documented in a specified time frame.

Alcohol screening is defined as any of the following documented:

- Alcohol screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Any CAGE [F018-F022] or CAGE-AID [F210-F214] Health Factor
- Any TAPS-Alcohol Health Factor [F175-F179]
- Diagnoses 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050, 3016F [BGP ALCOHOL SCREENING CPTS]
- Refusal of Exam Code 35

This report will tally the visits by age, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Enter the **date range** during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are the prompts:

- Enter Beginning Date for Screening
 - Specify the beginning date of the date range.
- Enter Ending Date for Screening
 - Specify the ending date of the date range.

Note: This date range indicates when the screening was done.

- Which items to be tallied?
Specify which items you would like to have displayed in the report. The application provides a list. Your response must be a list (like **1,3,5**) or a range (**2-4, 8**).
- Would you like to include **ALCOHOL** screenings documented in the **PCC** clinical database?
 - Use **Y** (Yes)Or
 - **N** (No)
- Would you like to include a list of visits w/screenings done?
 - Use **Y** (Yes)Or
 - **N** (No)
- How would you like this report sorted?
The report can be sorted by only one of the items in the list.
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)

- Do you want to use:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

The application displays the **Tally/List Alcohol Screenings** report (Figure 4-40).

*** ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING ***					
Screening Dates: Sep 10, 2010 to Dec 09, 2010					
This report excludes PCC Clinics					

Total Number of Visits with Screening	#	% of patients			
Total Number of Patients screen	4				
By Result					
NEGATIVE	1	25.0%			
POSITIVE	2	50.0%			
REFUSED SCREENING	1	25.0%			
By Sex					
FEMALE	3	75.0%			
MALE	1	25.0%			
By Age					
26 yrs	1	25.0%			
27 yrs	1	25.0%			
44 yrs	1	25.0%			
48 yrs	1	25.0%			
By Provider who screened					
DEMO, GEORGE C	1	25.0%			
DEMO, FRANK S	1	25.0%			
DEMO, MATT	1	25.0%			
DEMO, STEVE N	1	25.0%			
By Primary Provider of Visit					
DEMO, GEORGE C	1	25.0%			
DEMO, FRANK S	1	25.0%			
DEMO, MATT	1	25.0%			
DEMO, STEVE N	1	25.0%			
By Designated Primary Care Provider					
UNKNOWN	3	75.0%			
DEMO, HELEN K	1	25.0%			
By Clinic					
ALCOHOL AND SUBSTANCE	1	25.0%			
MEDICAL SOCIAL SERVICES	1	25.0%			
MENTAL HEALTH	2	50.0%			
By Date					
Jul 25, 2006	1	25.0%			
Aug 09, 2006	1	25.0%			
Aug 17, 2006	1	25.0%			
Aug 23, 2006	1	25.0%			
By Designated Mental Health Provider					
UNKNOWN	4	100.0%			
By Designated Social Services Provider					
UNKNOWN	4	100.0%			
By Designated A/SA Provider					
UNKNOWN	4	100.0%			
PATIENT NAME	HRN	AGE	SCREENED	RESULT	CLINIC

Patient H	114551	26 F	08/17/09	POSITIVE	

```

DXs: T43.205A ANTIDEPRESSANT DISCONTINUATION SYNDROME, INITIAL ENCOUNTER
Primary Provider on Visit: Provider B
Provider who screened: Provider B

Patient J 116475 27 F 08/23/09 REFUSED SCREENIN
DXs: F84.0 AUTISM SPECTRUM DISORDER
Primary Provider on Visit: Provider A
Provider who screened: Provider A

```

Figure 4-40: Tally/List Alcohol Screenings report example

4.1.13.2.3 List All Alcohol Screenings for Selected Patients (ASSP)

This report will tally and optionally list all patients who have had an **Alcohol** screening, or a refusal documented in a specified time frame. **Alcohol** screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Any CAGE [F018-F022] or CAGE-AID [F210-F214] Health Factor
- Any TAPS-Alcohol Health Factor [F175-F179]
- Diagnoses 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050, 3016F [BGP ALCOHOL SCREENING CPTS]
- Refusal of Exam Code 35

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

Below are the prompts:

- Enter Beginning Date for Screening
Specify the beginning date of the date range.
- Enter Ending Date for Screening

Specify the ending date of the date range.

- Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?

- Use **Y** (Yes)

Or

- **N** (No)

- Include which patients in the list?

- **F** (Females Only)

- **M** (Males Only)

- **B** (Both Male and Females)

- Would you like to restrict the report by **Patient age range**?

- Type **Y** (Yes)

Or

- **N** (No)

If you want to include visits from ALL age ranges, answer **No**. If you want to list visits for only patients with a particular age range, enter **Yes**. If you use **Yes**, other prompts will display.

- Which result values do you want included on this list?

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (for example, to get only those patients who have had a result of **Positive**, enter **2**; to get all patients who have had a screening result of **Positive** or **Refused**, enter **2,3**).

- You can choose from the following:

- **1** Normal/Negative

- **2** Positive

- **3** Refused

- **4** Unable to Screen

- **5** Screenings done with no result entered

- **6** Referral Needed

- Include visits to ALL clinics?

- Use **Y** (Yes)

Or

- **N** (No)

If **No** is used, additional prompts will display.

- Report should include visits whose PRIMARY PROVIDER on the visit is:

- **O** (One Provider Only)
- **P** (Any/All Providers including Unknown)
- **U** (Unknown Provider Only)

If you use **O**, other prompts will display.

- Select which providers who performed the screening should be included:
 - **O** (One Provider Only),
 - **P** (Any/All Providers including Unknown), or
 - **U** (Unknown Provider Only).
- If you use **O**, other prompts will display.
- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?
 - Use **Y** (Yes)

Or

- **N** (No)

If **Yes** is used, additional prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?
 - Use **Y** (Yes) or **N** (No). If **Yes** is used, additional prompts will display.
- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?

- Use **Y** (Yes)

Or

- **N** (No)

If **Yes** is used, additional prompts will display.

- Select a Report type.
 - **L** (List of Patient Screenings)
 - **S** (Create a Search Template of Patients)
 - How would you like this report sorted?

The report can be sorted by only one of the items in the list.
 - Display the **Patient's Designated Providers** on the list?
 - Use **Y** (Yes)
- Or
- **N** (No)
- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

The application displays the criteria you selected for the report.

Then, the application displays the **Tally/List Alcohol Screenings** report (Figure 4-41).

XX	Oct 07, 2010			Page 1
*** ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS ***				
Screening Dates: Jul 09, 2010 to Oct 07, 2010				
DATE				
PATIENT NAME	HRN	AGE	SCREENED	CLINIC

SIGMAAAAA,BRITTANY LYN	129079	41	F 08/03/10	BEHAVIORAL HEALTH
Type/Result: ALCOHOL SCREENING NEGATIVE				
Primary Provider on Visit: BETA,BETAA				
Provider who screened: BETA,BETAA				
SIGSIG,ALICIA MARIE	169379	58	F 09/08/10	ALCOHOL AND SUBSTANC
Type/Result: AUDT 21				
Primary Provider on Visit: BETA,BETAA				
Provider who screened: UNKNOWN				
Enter RETURN to continue or '^' to exit:				

Figure 4-41: Alcohol Screenings Visit Listing for Selected Patients report example

4.1.13.2.4 Tally/List Pts in Search Template with Alcohol Screenings (APST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Alcohol** screening or a refusal documented in a specified time frame. **Alcohol** screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Any CAGE [F018-F022] or CAGE-AID [F210-F214] Health Factor
- Any TAPS-Alcohol Health Factor [F175-F179]
- Diagnoses 29.1

- CPT 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050, 3016F [BGP ALCOHOL SCREENING CPTS]
- Refusal of Exam Code 35

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available, or primary provider on the visit) clinic, date of screen, designed PCP, MH Provider, SS Provider, and A/SA/ Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of **Patients** not visits or screenings.

4.1.13.2.5 Tally/List All Alcohol Screenings for Template of Pts (AVST)

This **ALCOHOL** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Note: Tally and listing of all visits w/alcohol screening only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which **Alcohol** screening or a refusal was documented in a specified time frame specified. **Alcohol** screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Any CAGE [F018-F022] or CAGE-AID [F210-F214] Health Factor
- Any TAPS-Alcohol Health Factor [F175-F179]
- Diagnoses 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT 99408, 99409, G0396, G0397, G0442, G0443, G2011, G2196, G2197, H0049, H0050, 3016F [BGP ALCOHOL SCREENING CPTS]
- Refusal of Exam Code 35

This report will tally the visits by age, sex, result, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A.SA Provider.

- This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.
- This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

4.1.13.3 Depression Screening Reports (DEP)

Use the **DEP** option to access the **Depression Screening Reports** menu (Figure 4-42).

```

*****
**      IHS Behavioral Health System      **
**      Depression Screening Reports      **
*****
                        Version 4.0 (Patch 13)

                        DEMO INDIAN HOSPITAL

DSP    Tally/List Patients with Depression Screening
DLS    Tally/List Depression Screenings
DSSP   List all Depression Screenings / Selected Patients
DPST   Tally/List Pts in Search Temp w/Depression Scrn
DVST   Tally List all Depression Scrn for Template of Pts

Select Depression Screening Reports Option:

```

Figure 4-42: Options on the Depression Screening reports menu example

4.1.13.3.1 Tally/List Patient with Depression Screening (DSP)

This report will tally and optionally list all patients who have had **Depression** screening or a refusal documented in the specified time frame. **Depression** screening is defined as any of the following documented:

- Depression Screening Exam (Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusals.

This is a tally of patients, not visits or screening.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are the prompts:

- Enter Beginning Date for Screening
Specify the beginning date of the date range.
- Enter Ending Date for Screening
Specify the ending date of the date range.
- Which items should be tallied: **(0-11)**

Select which items you want to tally on this report (Figure 4-43):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Sex	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 4-43: List of Options From Which to Tally the Report example

- Would you like to include **Depression** screenings documents in the **PCC clinic** database?
 - Use **Y** (Yes)
 - Or
 - **N** (No)
- Would you like to include a list of patients screened?
 - Use **Y** (Yes)
 - Or
 - **N** (No)

If you use **Y**, the following will display (Figure 4-44).

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

How would you like the list to be sorted: H//

Figure 4-44: List of Options to Sort the List example

- Display the **Patient's Designated Providers** on the list?

Use one of the following:

– Y (Yes)

Or

– N (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– I (Include all patients)

– E (Exclude demo patients)

– O (Include only demo patients)

- DEVICE

Specify the device to output the report.

Below is a sample report (Figure 4-45).

	By Age	#	% of patients
	4 yrs	1	0.5%
	5 yrs	1	0.5%
	6 yrs	3	1.4%
	7 yrs	2	0.9%
	8 yrs	4	1.9%
	9 yrs	1	0.5%
	10 yrs	2	0.9%
	11 yrs	6	2.8%
	12 yrs	3	1.4%
	13 yrs	1	0.5%
XX	Feb 15, 2011		Page 1
*** DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING ***			
Screening Dates: Nov 17, 2010 to Feb 15, 2011			
This report excludes data from the PCC Clinical database			

PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

			#	% of patients
		89 yrs	1	0.5%
		92 yrs	1	0.5%
By Provider who screened				
		DEMO,BJ	53	24.9%
		DEMO,LORI	5	2.3%
		DEMO,JESSICA	7	3.3%
		DEMO,DOCTOR	1	0.5%
		DEMO,RYAN	53	24.9%
		DEMO,DENISE	16	7.5%
		DEMO,HOWARD	1	0.5%
		DEMO,STEVE C	1	0.5%
BETA,MISTY DAWN	106371	28 F	01/12/11	TELEBEHAVIORAL HEALT
Type/Result: DEPRESSION SCREENING POSITIVE				
Comment: TESTING EHR				
Primary Provider on Visit: DEMO,RYAN				
Provider who screened: DEMO,RYAN				
DEMO,WILLA BELLE	110838	44 F	01/12/11	MENTAL HEALTH
Type/Result: DEPRESSION SCREENING NEGATIVE				
Primary Provider on Visit: DEMO,WENDY				
Provider who screened: DEMO,WENDY				
DEMO,JIMMY JOE	129347	24 M	01/31/11	MENTAL HEALTH
Type/Result: PHQ2 6				
Primary Provider on Visit: DEMO,RYAN				
Provider who screened: DEMO,RYAN				
Enter RETURN to continue or '^' to exit:				

Figure 4-45: Tally/List Patients with Depression Screening report example

4.1.13.3.2 Tally/List Depression Screenings (DLS)

This report will tally and optionally list all visits on which **Depression** screening or a **refusal** was documented in a specified time frame. **Depression** screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses 14.1
- Education Topics: DEP-SCR
- Refusal of Exam Code 36

This report will tally the visits by age, sex, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are the prompts:

- Enter Beginning Date for Screening
 - Specify the beginning date of the date range.
- Enter Ending Date for Screening
 - Specify the ending date of the date range.
- Which items should be tallied: **(0-11)**
 - Select which items you want to tally on this report (Figure 4-46):

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Sex	8) Designated MH Provider
3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 4-46: List of Options From Which to Tally the report example

- Would you like to include **Depression** screenings documents in the **PCC** clinic database?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Would you like to include a list of visits w/screening done?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

If you use **Y**, the following prompt will display.

- How would you like the list to be sorted (Figure 4-47)?

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

Figure 4-47: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- DEVICE

Specify the device to output the report (Figure 4-48).

XX	Dec 26, 2013	Page 1
*** DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Jan 01, 1980 to Dec 26, 2013		
This report excludes PCC Clinics		

	#	% of patients
Total Number of Visits with Screening	450	
Total Number of Patients screened	229	
By Result		
	14.1	35
DEPRESSION SCREENING NEGATIVE	115	7.8%
DEPRESSION SCREENING PATIENT REFUSED SCREENING		143.1%
DEPRESSION SCREENING POSITIVE	129	28.7%
DEPRESSION SCREENING UNABLE TO SCREEN	15	3.3%
REFERRAL NEEDED	15	3.3%
PHQ2	1	0.2%
PHQ2 0	2	0.4%

PHQ2	1	5	1.1%
PHQ2	2	8	1.8%
PHQ2	3	16	3.6%
PHQ2	4	11	2.4%
PHQ2	5	13	2.9%
PHQ2	6	2	0.4%
PHQ2	7	1	0.2%
PHQ2	COMPLETE BREECH	1	0.2%
PHQ9	1	1	0.2%
PHQ9	10	3	0.7%
PHQ9	10.5	1	0.2%
PHQ9	12	2	0.4%
PHQ9	13	3	0.7%
PHQ9	14	2	0.4%
PHQ9	15	5	1.1%
PHQ9	16	2	0.4%
PHQ9	17	7	1.6%
PHQ9	18	2	0.4%
PHQ9	19	3	0.7%
PHQ9	20	8	1.8%
PHQ9	21	7	1.6%
PHQ9	22	4	0.9%
PHQ9	24	1	0.2%
PHQ9	25	3	0.7%
PHQ9	27	2	0.4%
PHQ9	3	1	0.2%
PHQ9	5	5	1.1%
PHQ9	5.5	1	0.2%
PHQ9	6	2	0.4%
PHQ9	7	5	1.1%
PHQ9	8	5	1.1%
PHQ9	9	4	0.9%
PHQT	12	2	0.4%
PHQT	13	3	0.7%
PHQT	14	2	0.4%
PHQT	15	5	1.1%
PHQT	16	2	0.4%
PHQT	17	7	1.6%
PHQT	18	2	0.4%
PHQT	19	3	0.7%
PHQT	20	8	1.8%
PHQT	21	7	1.6%
PHQT	22	4	0.9%
PHQT	24	1	0.2%
PHQT	25	3	0.7%
PHQT	27	2	0.4%
V79.0		2	0.4%

PATIENT NAME	HRN	AGE	DATE SCREENED	CLINIC

DEMO,KASSANDRA DA	101349	30	F 04/06/10	MEDICAL SOCIAL SERVI
Type/Result:	PHQ9	17		
DXs:	88		OTHER SOCIOLEGAL PROBLEMS	
Primary Provider on Visit:	DEMO,DOCTOR			
Provider who screened:	UNKNOWN			
DURANT,COURTNEY NICO	101351	34	F 04/05/10	MENTAL HEALTH
Type/Result:	PHQ2	2		
DXs:	43.1		PARTNER ABUSE (SUSPECTED), PHYSICAL	
	27		ALCOHOL DEPENDENCE	

```

304.22    COCAINE DEPENDENCE, EPISODIC
Primary Provider on Visit:  DEMO,DOCTOR
Provider who screened:    UNKNOWN
Enter RETURN to continue or '^' to exit:

```

Figure 4-48: Depression Screening Visit Tally and Visit Listing report example

4.1.13.3.3 List All Depression Screenings/Selected Patients (DSSP)

This report will tally and optionally list all patients who have had **Depression** screening or a **refusal** documented in the time frame specified by the user.

Depression screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses 14.1
- Education Topics: DEP-SCR
- Refusal of Exam Code 36

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

You will be able to choose the patients by age, sex, clinic, primary provider, or result of the screening.

Below are the prompts:

- Enter Beginning Date for Screening
 - Specify the beginning date of the date range.
- Enter Ending Date for Screening
 - Specify the ending date of the date range.
- Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Include which patients in the list.

Use one of the following:

– **F** (Females only)

– **M** (Males only)

– **B** (Both Male and Females)

- Would you like to restrict the report by Patient age range?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Which result values do you want included on this list? (Figure 4-49)

```
1) Normal/Negative
2) Positive
3) Refused
4) Unable to Screen
5) Screenings done with no result entered
6) Referral Needed
```

Figure 4-49: List of Options From Which to Select example

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (for example, to get only those patients who have had a result of **Positive**, enter **2** to get all patients who have had a screening result of **Positive** or **Refused**, enter **2,3**).

- Include visits to ALL clinics.

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Report should include visits whose **PRIMARY PROVIDER** on the visit is.

If you use **O**, other prompts will display (Figure 4-50).

Select one of the following:

O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 4-50: Options for Visits to Include on the report example

- Select which providers who performed the screening should be included.

If you use **O**, other prompts will display (Figure 4-51).

Select one of the following:

O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 4-51: Options for Providers to Include on the report example

- Would you like to limit the list to just patients who have a particular, designated **Mental Health** provider?

– Use **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?

– Use **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?

– Use **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Select a Report type.

Use one of the following:

– **L** (List of Patient Screenings)

Or

– **S** (Create a Search Template of Patients)

If you use **S**, other prompts will display.

- How would you like the list to be sorted?

Select one of the following (Figure 4-52):

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

Figure 4-52: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- DEVICE

Specify the device to output the report.

After pressing **Enter**, the application displays the report (Figure 4-53).

XX	Feb 15, 2011	Page 1
*** DEPRESSION SCREENING VISIT LISTING FOR SELECTED PATIENTS ***		
Screening Dates: Nov 17, 2010 to Feb 15, 2011		
PATIENT NAME	HRN	DATE
	AGE	SCREENED
		CLINIC

BETA,MISTY DAWN	106371 28 F	01/07/11
Type/Result:	DEPRESSION SCREENING	POSITIVE
Comment:	testing ehr	
Primary Provider on Visit:	DEMO,RYAN	
Provider who screened:	DEMO,RYAN	
		BEHAVIORAL HEALTH

```

DEMO,WILLA BELLE      110838 44  F 01/12/11      MENTAL HEALTH
Type/Result: DEPRESSION SCREENING  POSITIVE
Primary Provider on Visit:  DEMO,WENDY
Provider who screened:  DEMO,WENDY

Enter RETURN to continue or '^' to exit:

```

Figure 4-53: Depression Screening Visit Listing for Selected Patients report example

4.1.13.3.4 Tally/List Pts in Search Temp with Depression Screening (DPST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Depression** screening or a refusal documented in the time frame specified by the user. **Depression** screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses 14.1
- Education Topics: DEP-SCR
- Refusal of Exam Code 36

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

4.1.13.3.5 Tally/List All Depression Screenings for Templates of Pts (DVST)

This report will tally and optionally list all visits on which **Depression** screening or a refusal was documented in the time frame specified by the user. **Depression** screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9, PHQT
- Diagnoses 14.1
- Education Topics: DEP-SCR

- Refusal of PCC Exam Code 36

This report will tally the visits by age, sex, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: This report will, optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of visits with a screening done; if a patient had multiple screenings during the time period, all will be counted.

4.1.13.4 Social Determinants of Health Screening (SDOH) Reports (SOC)

From the **Screening Reports** (Figure 4-54), use the **SOC** option to access the **SDOH Reports** menu.

```

*****
**  IHS Behavioral Health System          **
**    SDOH Screening Reports              **
*****
                        Version 4.0 (patch 13)

                        2021 DEMO HOSPITAL (INST)

SDP    Tally Patients with SDOH Screenings
ISD    Inpatient SDOH Report

Select Social Determinants of Health Scrn (SDOH) Rpts Option:

```

Figure 4-54: SDOH Screening Reports menu example

4.1.13.4.1 Tally Patients with SDOH Screenings (SDP)

This report will tally all patients who have had an **SDOH** screening or a **refusal** documented in the time frame specified by the user. **SDOH** screening is defined as any of the following documented:

- SDOH Food Screening Exam (Exam code 46)
- SDOH Housing Screening Exam (Exam code 47)
- SDOH Transportation Screening Exam (Exam code 48)
- SDOH Utilities Screening Exam (Exam code 49)
- SDOH Interpersonal Safety Screening Exam (Exam code 50)

Refusal of exam code 46, 47, 48, 49 50

This report will tally the patients by age groups, sex, screening exam, result, clinic, Patient Community, Race, and Ethnicity.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are the prompts for this report.

- Enter Beginning Date for Screening
Specify the beginning date of the date range.
- Enter Ending Date for Screening
Specify the ending date of the date range.
- Include all Screenings done at ALL locations?
 - Use **Y** (Yes)Or
 - **N** (No)
- Include all Screenings done at ALL clinics?
 - Use **Y** (Yes)Or
 - **N** (No)
- Which Exam type(s) should be tallied?
 - 1) All
 - 2) SDOH Food
 - 3) SDOH Housing
 - 4) SDOH Transportation
 - 5) SDOH Utilities
 - 6) SDOH Interpersonal Safety
- Which items should be tallied?
 - 0) Do Not Include any Tallies

- 1) Sex
- 2) Age Groupings
- 3) Clinic
- 4) Ethnicity
- 5) Race
- 6) Patient Community
- Would like to include **SDOH** screenings documented in the **PCC Clinical** database?
 - Use **Y** (Yes)
- Or
- **N** (No)
- Demo Patient/Inclusion/Exclusion.

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- **DEVICE**

Specify the device to output the report (Figure 4-55).

*** SDOH SCREENINGS PATIENT TALLY ***		
Screening Dates: Sep 27, 2023 to Sep 27, 2024		
This report includes data from the PCC Clinical database		

Total Number of Patients screened	14	
SDOH Exam FOOD	Total number screened (denominator): 12	
	#	%
POSITIVE	5	41.7%
NEGATIVE	5	41.7%
PATIENT REFUSED SCREENING	0	0.0%
UNABLE TO SCREEN	0	0.0%
REFERRAL NEEDED	2	16.7%
SDOH Exam HOUSING	Total number screened (denominator): 12	
#	%	
POSITIVE	2	16.7%
NEGATIVE	8	66.7%
PATIENT REFUSED SCREENING	0	0.0%

UNABLE TO SCREEN	0	0.0%
REFERRAL NEEDED	2	16.7%
SDOH Exam TRANSPORTATION		
Total number screened (denominator): 11		
	#	%
POSITIVE	3	27.3%

Figure 4-55: SDOH Screenings Patient Tally example

4.1.13.4.2 Inpatient SDOH Report (ISD)

This report will tally inpatients who had all five (5) **SDOH** screenings (**Food, Housing, Transportation, Utilities, and Interpersonal Safety**) documented by their discharge date.

Note: If a patient has multiple admissions, the last admission is used in this report. You may also request a list of those patients who were not screened for all five (5).

Enter the discharge date range. The following are the prompts for this report.

- Enter Beginning Discharge Date
Specify the beginning date of the date range.
- Enter Ending Discharge Date
Specify the ending date of the date range.
- Would you like to include a list of patients not screened?
 - Use **Y** (Yes)
 Or
 - **N** (No)
- Demo Patient/Inclusion/Exclusion.
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- DEVICE
Specify the device to output the report (Figure 4-56).

***** CONFIDENTIAL PATIENT INFORMATION *****
 2021 DEMO HOSPITAL (INST)
 SDOH Inpatient Screening Population Reports
 Screening Dates: Sep 27, 2023 to Sep 27, 2024
 This report includes data from the PCC clinical database

SDOH 1: Population-Inpatient Screening			
Measure Name	# Patients w/Admission	# Patients Screened	% Screened
SDOH 1: Population-Inpatient Screening	29	1	3.45%
SDOH-2: Population-Inpatient Positive Screening			
Measure Name	# Patients w/Admission	# Patients Screened	% Positive
SDOH-2-SDOH Food	29	1	100.00%
SDOH-2-SDOH Housing	29	1	0.00%
SDOH-2-SDOH Transportation	29	1	0.00%
SDOH-2-SDOH Utilities	29	1	0.00%
SDOH-2-SDOH Interpersonal Safety	29	1	100.00%
***** CONFIDENTIAL PATIENT INFORMATION ***** 2021 DEMO HOSPITAL (INST) Patients Admitted to the Hospital without SDOH Screening Screening Dates: Sep 27, 2023 to Sep 27, 2024 This report includes data from the PCC clinical database			
PATIENT NAME	HRN	ADMISSION DATE	
DEMO,ALLISON	101266	MAR 28, 2024@12:11	
DEMO,JOSEPH	104976	OCT 23, 2023@14:00	
DEMO,STEPHANIE MARYSSA	105268	DEC 12, 2023@14:33	
DEMO,GABRIELA CLARICE	890488	DEC 03, 2023@14:00	
DEMO,EARLENA	890630	DEC 01, 2023@09:00	
DEMO,AGNES	891100	OCT 12, 2023@15:00	

Figure 4-56: SDOH Inpatient Screening Population report example

4.1.13.5 Drug Use Risk Screening Reports (DRU)

Use the **DRU** option to access the **Drug Use Risk Screening Reports** menu (Figure 4-57).

```

*****
**      IHS Behavioral Health System      **
**      Drug Use Risk Screening Reports    **
*****
                        Version 4.0 (patch 13)

                        2021 DEMO HOSPITAL (INST)

```

```

DUPTally/List Patients with Drug Use Risk Screening
DUSTally/List Drug Use Risk Screenings
DUSP   List all Drug Use Risk Screenings for Selected Pts

```

Figure 4-57: Options on the Drug Use Risk Screening reports menu example

4.1.13.5.1 Tally/List Patients with Drug Use Risk Screening (DUP)

This report will tally all patients (not number of screenings) who have had a **Drug Use Risk** screening or a **refusal** documented in the time frame specified by the user. **Drug Use Risk** screening is defined as any of the following documented:

- Unhealthy Drug Screening Exam (Exam code 45)
- Measurements: DAST-10
- Health Factor categories 4PS, CAGE, CAGE-AID, or NIDA Quick Screen
- Any TAPS-Sedative, TAPS-Cannabis, TAPS-Stimulant, TAPS-Opioid,
- TAPS-Heroin Health Factor
- POV ICD-10: Z02.83 (Encounter for blood-alcohol and blood-drug test)
- Refusal of exam code 45

This report will tally the patients by age groups, sex, screening exam result, clinic, Patient Community, Race, Ethnicity.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of Patients, not visits or screenings.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are prompts for the **DUP** report:

- Enter Beginning Date for Screening.
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening.
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-7)**

Select which items you want to tally on this report (Figure 4-58):

0) Do not include any Tallies	4) Clinic
1) Result	5) Ethnicity
2) Sex	6) Race
3) Primary Provider	7) Patient Community

Figure 4-58: List of Options From Which to Tally the report example

The response must be a list or range, for example, **1,3,5** or **2-4,7**.

- The Age Groups to be used are currently defined as:

- 0–12
- 13–17
- 18–64
- 65–125

Do you want to modify these age groups? **NO//**

If you choose to modify these age groups, type **Yes** and press **Enter**.

It will then ask you for the starting age of each age group and then the oldest age you want to include. Then it will display the new age group format.

- Would you like to include **Drug Use Risk** screenings (Figure 4-59) documented in the **PCC** clinical database? Use one of the following:

- **Y** (Yes)

Or

- **N** (No)

- Demo Patient/Inclusion/Exclusion.

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

```

*** DRUG USE RISK SCREENING PATIENT TALLY ***
Screening Dates: Nov 27, 2022 to Nov 27, 2024
This report includes data from the PCC Clinical database

```

% of patients

Total Number of Patients screened	10	By Result
4PS I HAD DIFFICULTIES DUE TO AOD USE	1	10.0%
4PS I HAVE USED AOD IN PAST MONTH	1	10.0%
4PS SCREENING NEGATIVE	3	30.0%
CAGE 0/4	1	10.0%
CAGE 1/4	2	20.0%
DAST-10 (Score: 5) POSITIVE	1	10.0%
UNHEALTHY DRUG SCREENING EXAM POSITIVE	1	10.0%
By Sex		
FEMALE	8	80.0%
MALE	2	20.0%
By Age Group		
13-17 yrs	1	10.0%
18-64 yrs	9	90.0%
By Clinic		
GENERAL	4	40.0%
GENERAL PREVENTIVE	2	20.0%
MENTAL HEALTH (PSYCHIATRY)	2	20.0%
UNKNOWN	2	20.0%

Figure 4-59: Tally/List Patients with Drug Use Risk Screening example

4.1.13.5.2 Tally/List Drug Use Risk Screening (DUS)

This report will tally all **Drug Use Risk** screenings (not number of patients) or a refusal that was documented in the time frame specified by the user. **Drug Use Risk** screening is defined as any of the following documented:

- Unhealthy Drug Screening Exam (Exam code 45)
- Measurements: DAST-10
- Health Factor categories 4PS, CAGE, CAGE-AID, or NIDA Quick Screen
- Any TAPS-Sedative, TAPS-Cannabis, TAPS-Stimulant, TAPS-Opioid,
- TAPS-Heroin Health Factor
- POV ICD-10: Z02.83 (Encounter for blood-alcohol and blood-drug test)
- Refusal of exam code 45

This report will tally the screenings by age groups, sex, screening exam result, clinic, patient community, race, and ethnicity.

Notes: This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is tally screenings done, if a patient had multiple screenings during the time period, all will be counted.

Enter the date range during which the screening was done. To get all screenings ever done, put in a long date range like **01/01/1980** to the **present date**.

- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-7)** (Figure 4-60)

0) Do not include any Tallies	4) Clinic
1) Result	5) Ethnicity
2) Sex	6) Race
3) Primary Provider	7) Patient Community

Figure 4-60: List of Options to Tally the report example

The response must be a list or range, for example, **1,3,5** or **2-4,7**.

- The Age Groups to be used are currently defined as:
 - 0 – 12
 - 13 – 17
 - 18 – 64
 - 65 – 125

Do you want to modify these age groups? **NO//**

If you choose to modify these age groups, type **Yes** and press **Enter**.

It will then ask you for the **starting age** of each age group and then the **oldest age** you want to include. Then it will display the new age group format.

- Would you like to include **Drug Use Risk** screenings documented in the **PCC** clinical database?

Use one of the following:

 - **Y** (Yes)

Or

 - **N** (No)
- Demo Patient/Inclusion/Exclusion – Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

Figure 4-61 shows a sample report.

*** DRUG USE RISK SCREENING VISIT TALLY ***		
Screening Dates: Nov 27, 2022 to Nov 27, 2024		
This report includes PCC Clinics		
	% of patients	
Total Number of Screenings	25	
Total Number of Patients screened	10	
By Result		
4PS I HAD DIFFICULTIES DUE TO AOD USE	3	12.0%
4PS I HAVE USED AOD IN PAST MONTH	3	12.0%
4PS PARENT HAS PROBLEM WITH AOD USE	2	8.0%
4PS PARTNER HAS PROBLEM WITH AOD USE	2	8.0%
4PS SCREENING NEGATIVE	3	12.0%
CAGE 0/4	1	4.0%
CAGE 1/4	2	8.0%
CAGE 2/4	2	8.0%
CANNABIS-MINIMAL RISK	1	4.0%
DAST-10 (Score: 5) POSITIVE	1	4.0%
HEROIN-MINIMAL RISK	1	4.0%
OPIOID-PROBLEM USE	1	4.0%
STIMULANT-MINIMAL RISK	1	4.0%
UNHEALTHY DRUG SCREENING EXAM POSITIVE	1	4.0%
By Sex		
FEMALE	22	88.0%
MALE	3	12.0%
By Age Group		
13-17 yrs	5	20.0%
18-64 yrs	20	80.0%

Figure 4-61: Tally/List Patients with Drug Use Screening example

4.1.13.5.3 List all Drug Use Risk Screenings for Selected Pts (DUSP)

This report lists all patients who have had a **Drug Use** screening or a refusal documented in the time frame specified by the user. **Drug Use** screening is defined as any of the following documented:

- Unhealthy Drug Screening Exam (Exam code 45)

- Measurements: DAST-10
- Health Factor categories 4PS, CAGE, CAGE-AID, or NIDA Quick Screen
- Any TAPS-Sedative, TAPS-Cannabis, TAPS-Stimulant, TAPS-Opioid
- TAPS-Heroin Health Factor
- POV ICD-10: Z02.83 (Encounter for blood-alcohol and blood-drug test)
- Refusal of exam code 45 (unhealthy drug screen exam)

Notes: This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a list of patients with all of their screenings You will be able to choose the patients by result, age, sex, or those screened in a certain clinic.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are prompts for the **DUSP** report:

- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)? Use one of the following:
 - **Y** (Yes)Or
 - **N** (No)
- Include which patients in the list. Use one of the following:
 - **F** (Females only)
 - **M** (Males Only)
 - **B** (Both Males and Females)
- Would you like to restrict the report by Patient age range? Use one of the following:
 - **Y** (Yes)Or
 - **N** (No)

If you use **Y**, other prompts will display.

- Which set of patients (Figure 4-62) do you want to list?

- 1) Patients with any **NEGATIVE** Screening
- 2) Patients with any **POSITIVE** Screening
- 3) Patients who Refused a Screening
- 4) Patients with an Unable to Screen Screening
- 5) Patients with a Referral Needed Screening Result
- 6) Patients with **ANY** Screening result (any of the above)

Figure 4-62: List of Options From Which to Select example

- Include visits to **ALL** clinics. Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Demo Patient/Inclusion/Exclusion.

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- Do you want to use:

– **P** (Print output)

Or

– **B** (Browse output on screen)

Figure 4-63 shows a sample report.

*** DRUG USE SCREENING LISTING FOR SELECTED PATIENTS ***					
Screening Dates: Nov 27, 2022 to Nov 27, 2024					
PATIENT NAME	DATE	SCREENING	HRN RESULT	DATE OF BIRTH AGE	COMMUNITY PROVIDER
DEMO, BECKY	07/18/23	4PS SCREENING	444 NEGATIVE	May 01, 1980 43	BEAVERTON DEMO, AMANDA
DEMO, BAXTER	07/12/23	CAGE 2/4	3215	Dec 30, 1985	11-MILE CO
	07/12/23	DAST-10 (Score: 5)		POSITIVE 37	DEMO, WENDY
				POSITIVE 37	DEMO, WENDY
DEMO, MELANIE	09/05/23	4PS I HAD DIFFICULTIES DUE TO	122446	Apr 23, 1992	PARKER
	09/05/23	4PS I HAVE USED AOD IN PAST M		POSITIVE 31	DEMO, MELINDA
	09/05/23	4PS PARENT HAS PROBLEM WITH A		POSITIVE 31	DEMO, MELINDA

Figure 4-63: Drug Use Screening Listing for Selected Patients example

4.1.13.6 Suicide Risk Assessment Reports (SRA)

Use the **SRA** option to access the **Suicide Risk Assessment Report** menu (Figure 4-64).

```

*****
**      IHS Behavioral Health System      **
**      Suicide Risk Assessment Reports    **
*****
                        Version 4.0 (Patch 13)

                        DEMO INDIAN HOSPITAL

SRP    Tally/List Patients with Suicide Risk Assessment
SRS    Tally/List Suicide Risk Assessments
SRSP   List all Suicide Risk Assess for Selected Patients
SRST   Tally/List Pts in Srch Temp w/ Suic Risk Assess
STST   Tally/List all Suic Risk Assess for Template pts

Select Suicide Risk Assessment Reports Option:

```

Figure 4-64: Options on the Suicide Risk Assessments Reports menu example

4.1.13.6.1 Tally/List Patients with Suicide Risk Assessment (SRP)

This report will tally and optionally list all patients who have had a **Suicide Risk Assessment (PCC Exam code 43)** or a **Refusal** documented in a specified time frame. This report will tally the patients by age, sex, result, provider (either exam provider, if available or primary provider on the visits), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

Below are prompts for the **SRP** report:

- Enter Beginning Date for Screening.
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening.
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-11)** (Figure 4-65)

0) Do not include any Tallies	6) Date of Screening
1) Result of Screening	7) Primary Provider on Visit
2) Sex	8) Designated MH Provider

3) Age of Patient	9) Designated SS Provider
4) Provider who Screened	10) Designated ASA/CD Provider
5) Clinic	11) Designated Primary Care Provider

Which items should be tallied: (0-11)://

Figure 4-65: List of options from which to tally the report example

The response must be a list or range, for example, **1,3,5** or **2-4,8**.

- Would you like to include Suicide Risk Assessments documented in the **PCC** clinical database?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Would you like to include a list of patients screened?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

If you use **Y**, the following prompt will display.

- How would you like the list to be sorted?

Select one of the following (Figure 4-66):

```
Select one of the following:

      H      Health Record Number
      N      Patient Name
      P      Provider who screened
      C      Clinic
      R      Result of Exam
      D      Date Screened
      A      Age of Patient at Screening
      G      Sex of Patient
      T      Terminal Digit HRN

How would you like the list to be sorted: H//
```

Figure 4-66: List of options to sort the list example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

– Use **Y** (Yes)

Or

– **N** (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

Figure 4-67 shows a sample report.

*** SUICIDE RISK ASSESSMENT PATIENT TALLY AND PATIENT LISTING ***					
Screening Dates: Jun 29, 2015 to Jun 29, 2017					
This report includes data from the PCC Clinical database					
PATIENT NAME	HRN	AGE	DATE SCREENED	RESULT	CLINIC

DEMO,ANNSENETTE	107104	56	F 04/08/16	LOW	MEDICAL SOCIAL SE
DXs: F10.10 ALCOHOL USE DISORDER, MILD					
Primary Provider on Visit: DEMO,RYAN					
Provider who screened: DEMO,RYAN					
DEMO,SHAYNE LYNN	113441	46	F 02/08/16	REFERRAL NEEDED	MENTAL HEALTH (PS
DXs: F43.10 TESTING					
Primary Provider on Visit: DEMO,LORI					
Provider who screened: DEMO,LORI					

Figure 4-67: Output of the Suicide Risk Assessment Patient Tally and Patient Listing report example

4.1.13.6.2 Tally/List Suicide Risk Assessments (SRS)

This report will tally and optionally list all visits on which a **Suicide Risk Assessment (Exam Code 43)** or a **Refusal** was documented in a specified time frame. This report will tally the visits by age, sex, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report will optionally look at both the **PCC** and the **Behavioral Health** clinical databases for evidence of screening/refusal.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are prompts for the **SRS** report:

- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-11)** (Figure 4-68)

```

0) Do not include any Tallies          6) Date of Screening
1) Result of Screening                 7) Primary Provider on Visit
2) Sex                                8) Designated MH Provider
3) Age of Patient                     9) Designated SS Provider
4) Provider who Screened              10) Designated ASA/CD Provider
5) Clinic                             11) Designated Primary Care Provider
Which items should be tallied? (0-11)://

```

Figure 4-68: List of Options From Which to Tally the report example

The response must be a list or range, for example, **1,3,5** or **2–4,8**.

- Would you like to include **Suicide Risk Assessment** screenings documented in the **PCC** clinical database?

Use one of the following:

- **Y** (Yes)
- Or

- **N** (No)

- Would you like a list of visits w/screenings done?

Use one of the following:

- **Y** (Yes)

Or

- **N** (No)

If you use **Y**, the following prompt will display.

- How would you like the list to be sorted? (Figure 4-69)

```

Select one of the following:

H      Health Record Number
N      Patient Name
P      Provider who screened
C      Clinic
R      Result of Exam
D      Date Screened
A      Age of Patient at Screening
G      Sex of Patient
T      Terminal Digit HRN

```

How would you like the list to be sorted? H//

Figure 4-69: List of options to sort the list example

The default is **H** (Health Record Number).

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen) (Figure 4-70)

*** SUICIDE RISK ASSESSMENT VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Jun 29, 2016 to Jun 29, 2017		
This report includes PCC Clinics		

	#	% of patients
Total Number of Visits with Screening	11	
Total Number of Patients screened	9	
RG	Jun 29, 2017	Page 1
*** SUICIDE RISK ASSESSMENT VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Jun 29, 2016 to Jun 29, 2017		
This report includes PCC Clinics		

PATIENT NAME	HRN	AGE DATE SCREENED RESULT CLINIC

DEMO,CARL JR	118338	23 M 11/16/16 MODERATE
DXs: F33.2 MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, SEVERE		
F10.20 ALCOHOL DEPENDENCE, UNCOMPLICATED due to diabetes		
Primary Provider on Visit: DEMO,RYAN		
Provider who screened: DEMO,RYAN		
DEMO,CARL JR	118338	23 M 11/20/16 MODERATE
DXs: F33.3 MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE WITH PSYCHOTIC		
F10.20 ALCOHOL DEPENDENCE, UNCOMPLICATED due to NEUROCOGNITIVE DAMA		
Primary Provider on Visit: DEMO,RYAN		
Provider who screened: DEMO,RYAN		
DEMO,CARL JR	118338	23 M 12/14/16 LOW
DXs: F33.3 MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE WITH PSYCHOTIC		

Figure 4-70: Output of the Suicide Risk Assessment Screening Visit Tally and Visit Listing report example

4.1.13.6.3 List All Suicide Risk Assess for Selected Patients (SRSP)

This report will list all patients you select who have had a **Suicide Risk Assessment** or a **Refusal** documented in a specified time frame. You will select the patients based on age, sex, result, provider, or clinic where the screening was done. You will enter a date range during which the screening was done.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

Below are prompts for the **SRSP** report:

- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Include which patients in the list.

Use one of the following:

– **F** (Females only)

– **M** (Males only)

– **B** (Both Males and Females)

- Would you like to restrict the report by Patient age range?

– **Y** (Yes)

Or

– **N** (No)

If you use **Y**, other prompts will display.

- Which result value (Figure 4-71) do you want included in this list: **(1-7)**

- | | |
|----|--|
| 1) | Low |
| 2) | Moderate |
| 3) | High |
| 4) | Refused |
| 5) | Unable to Screen |
| 6) | Referral Needed |
| 7) | Screenings done with no result entered |

Figure 4-71: List of options used to include in the list example

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (for example, to get only those patients who have had a result of **Present**, enter **2** to get all patients who have had a screening result of **Past** or **Present**, enter **2,3**).

- Include visits to ALL clinics?
 - Y (Yes)
 Or
 - N (No)
- Report should include visits whose PRIMARY PROVIDER on the visit is.

Figure 4-72 shows the possible options. If you use **O**, other prompts will display.

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 4-72: Options for visits to include on the report example

Select which providers who performed the screening should be included.

Figure 4-73 shows the possible options. If you use **O**, other prompts will display.

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 4-73: Options for providers to include on the report example

- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?
 - Use Y (Yes)
 Or
 - N (No)
 If you use **Y**, other prompts will display.
- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?
 - Use Y (Yes)

Or

– N (No)

If you use **Y**, other prompts will display.

- Would you like to limit the list to just patients who have a particular designated **ASA/CD provider**?

– Use **Y** (Yes)

Or

– N (No)

If you use **Y**, other prompts will display.

- Select Report type.

Use one of the following:

– **L** (List of Patient Screenings)

Or

– **S** (Create a Search Template of Patients)

If you use **S**, other prompts will display.

- How would you like the list to be sorted?

Figure 4-74 shows the possible selections.

Select one of the following:	
H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Exam
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

Figure 4-74: List of options to sort the list example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

– Use **Y** (Yes)

Or

– N (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- **DEVICE**

Specify the device to output the report.

The application displays the criteria for the report. After pressing **Enter**, the application displays the report (Figure 4-75).

*** SUICIDE RISK ASSESSMENT VISIT LISTING FOR SELECTED PATIENTS ***						
Screening Dates: Jun 30, 2015 to Jun 30, 2017						
PATIENT NAME	HRN	AGE	DATE	SCREENED	RESULT	CLINIC

DEMO,CECILE	103465	42	F 04/08/16	LOW		MEDICAL SOCIAL SE
DXs: F10.10 ALCOHOL USE DISORDER, MILD						
Primary Provider on Visit: DEMO,RYAN						
Provider who screened: DEMO,RYAN						
DEMO,CANDI LYNN	115655	55	F 10/02/15	LOW		GENERAL
DXs: F10.10 Alcohol abuse TESTING						
Primary Provider on Visit: DEMO,RYAN						
Provider who screened: DEMO,RYAN						

Figure 4-75: Suicide Risk Assessment Visit Listing for Selected Patients report example

4.1.13.6.4 Tally/List Pts in Search Temp with Suicide Risk Assess (SRST)

Note: This **Suicide Risk Assessment** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of patients receiving suicide risk assessment, including refusals, only patients who are members of a user-defined search template are included in this report.

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Suicide Risk Assessment (Exam code 34)** or a **Refusal** documented in a specified time frame. This report will tally the patients by age, sex, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

- The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
- This report will, optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

4.1.13.6.5 Tally/List All Suicide Risk Assess for Template Pts (STST)

Note: This **Suicide Risk Assessment** report is intended for advanced RPMS users who are experienced in building search templates and using **Q-MAN**.

Tally and listing of all visits w/suicide risk assessment, only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which a **Suicide Risk Assessment (Exam code 43)** or a **Refusal** was documented in a specified time frame. This report will tally the visits by age, sex, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. This report will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

4.1.13.7 Suicide Screening Reports (SSR)

Use the **SSR** option to access the **Suicide Screening Reports** menu (Figure 4-76).

```

*****
**          IHS Behavioral Health System          **
**          Suicide Screening Reports              **
*****
                        Version 4.0 (patch 13)

                        2021 DEMO HOSPITAL (INST)

SRPTally/List Patients with Suicide Screening
SRSTally/List Suicide Screenings
SRSP   List all Suicide Screenings for Selected Patients
SRST   Tally/List Pts in Srch Temp w/ Suic Screening
STST   Tally/List all Suic Screenings for Template pts

Select Suicide Screening Reports Option:

```

Figure 4-76: Suicide Screening Reports menu example

4.1.13.7.1 Tally/List Patients with Suicide Screening (SRP)

This report will tally and optionally list all patients who have had a **Suicide** screening or a **refusal** documented in the time frame specified by the user. **Suicide** screening is defined as any of the following documented:

- Suicide Screening (Exam code 44)
- Refusal of exam code 44

This report will tally the patients by age, sex, screening exam result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider.

Notes: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

This report will optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal.

This is a tally of patients, not visits or screenings.

Below are prompts for the **SRP** report (Figure 4-77):

- Enter Beginning Date for Screening.
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening.
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-11)**
 - Select which items you want to tally on this report:

0) Do not include any Tallies	7) Primary Provider on Visit
1) Result of Screening	8) Designated MH Provider
2) Sex	9) Designated SS Provider
3) Age of Patient	10) Designated ASA/CD Provider
4) Provider who Screened	11) Designated Primary Care Provider
5) Clinic	12) Race
6) Date of Screening	13) Ethnicity

Figure 4-77: SRP Report Tallied Items

The response must be a list or range, for example, **1,3,5** or **2-4,8**.

- Would you like to include **Suicide** screening documented in the **PCC** clinical database?

Use one of the following:

 - **Y** (Yes)

Or

 - **N** (No)
- Would you like to include a list of patients screened? Use one of the following:
 - **Y** (Yes)

Or

 - **N** (No)

If you use **Y**, the following prompt will display.
- How would you like the list to be sorted (Figure 4-78)?

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Screening
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN
Q	Race

How would you like the list to be sorted: H//

Figure 4-78: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

- Use **Y** (Yes)

Or

- **N** (No)

- Demo Patient/Inclusion/Exclusion.

Use one of the following:

- **I** (Include all patients)

- **E** (Exclude demo patients)

- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

Figure 4-79 displays the **Suicide Screening Patient Tally** report.

*** SUICIDE SCREENING PATIENT TALLY ***		
Screening Dates: Dec 10, 2023 to Dec 10, 2024		
This report includes data from the PCC Clinical database		

Total Number of Patients screened	#	% of patients
By Result		
ACUTE POSITIVE	2	66.7%
NON-ACUTE POSITIVE	1	33.3%
By Sex		
FEMALE	1	33.3%
MALE	2	66.7%
By Age		

33 yrs	1	33.3%
54 yrs	1	33.3%
88 yrs	1	33.3%
By Provider who screened		
DEMO, ARLIS	1	33.3%
DEMO, ALEXIS	1	33.3%
DEMO, WENDY	1	33.3%
By Clinic		
GENERAL PREVENTIVE	1	33.3%
MENTAL HEALTH (PSYCHIATRY)	2	66.7%

Figure 4-79: Suicide Screening Patient Tally example

4.1.13.7.2 Tally/List Suicide Screenings (SRS)

This report will tally and optionally list all visits on which **Suicide** screening or a **refusal** was documented in the time frame specified by the user. **Suicide** screening is defined as:

- Suicide Screening (exam code 44)
- Refusal of exam code 44

This report will tally the visits by age, sex, screening result, provider (either exam provider, if available, or primary provider on the visit), clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA provider.

Notes: This report will optionally look at both **PCC** and the **Behavioral Health** clinical databases for evidence of screening/refusal.

This is a tally visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

Below are prompts for the **SRS** report:

- Enter Beginning Date for Screening.
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Which items should be tallied: **(0-11)**

Select which items (Figure 4-80) you want to tally on this report:

- | | |
|-------------------------------|--------------------------------|
| 0) Do not include any Tallies | 6) Date of Screening |
| 1) Result of Screening | 7) Primary Provider on Visit |
| 2) Sex | 8) Designated MH Provider |
| 3) Age of Patient | 9) Designated SS Provider |
| 4) Provider who Screened | 10) Designated ASA/CD Provider |

5) Clinic

11) Designated Primary Care Provider

Figure 4-80: List of Options From Which to Tally the Report example

The response must be a list or range, for example, **1,3,5** or **2–4,8**.

- Would you like to include **Suicide** screenings documented in the **PCC** clinical database?

Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

- Would you like a list of visits w/screenings done? Use one of the following:

– **Y** (Yes)

Or

– **N** (No)

If you use **Y**, the following prompt will display.

- How would you like the list to be sorted (Figure 4-81)?

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Screening
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN
Q	Race

How would you like the list to be sorted: H//

Figure 4-81: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Demo Patient/Inclusion/Exclusion.

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- Do you want to use:

– **P** (Print output)

Or

- **B** (Browse output on screen)

Figure 4-82 displays the **Suicide Screening Visit Tally and Visit Listing**.

*** SUICIDE SCREENING VISIT TALLY AND VISIT LISTING ***		
Screening Dates: Nov 27, 2022 to Nov 27, 2024		
This report includes PCC Clinics		

Total Number of Visits with Screening	#	% of patients
Total Number of Patients screened	4	
By Result		
ACUTE POSITIVE	2	50.0%
NON-ACUTE POSITIVE	2	50.0%
By Sex		
FEMALE	2	50.0%
MALE	2	50.0%
By Age		
33 yrs	1	25.0%
38 yrs	1	25.0%
54 yrs	1	25.0%
88 yrs	1	25.0%
By Provider who screened		
DEMO, ARLIS	1	25.0%
DEMO, ALEXIS	1	25.0%
DEMO, WENDY	2	50.0%

Figure 4-82: Suicide Screening Visit Tally and Visit Listing example

4.1.13.7.3 List All Suicide Screenings for Selected Patients (SRSP)

This report will tally and optionally list all patients who have had a **Suicide** screening or a **Refusal** documented in a time frame specified by the user. **Suicide** screening is defined as any of the following documented:

- Suicide Screening (Exam Code 44)
- Refusal of Exam Code 44

You will select the patients based on age, sex, screening exam result, provider, clinic, date of screening, designated PCP, MH Provider, SS Provider, and A/SA Provider. You will enter a date range during which the screening was done.

Below are prompts for the **ISSP** report:

- Enter Beginning Date for Screening

- Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening.
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?
 - Use **Y** (Yes)
 Or
 - **N** (No)
- Include which patients in the list. Use one of the following:
 - **F** (Females only)
 - **M** (Males only)
 - **B** (Both Males and Females)
- Type the correct **Letter** and press **Enter**.
- Would you like to restrict the report by Patient age range?
 - Use **Y** (Yes)
 Or
 - **N** (No)
- Which result value (Figure 4-83) do you want included in this list: **(1-7)**

```

1)  Negative
2)  Acute Positive
3)  Non-Acute Positive
4)  Refused
5)  Unable to Screen
6)  Referral Needed
7)  Screenings done with no result entered
  
```

Figure 4-83: Result Values example

- Include visits from ALL Clinics?
- Enter **Yes** or **No** and press **Enter**.
 - Use **Y** (Yes)
 Or
 - **N** (No)
- Report should include visits whose **PRIMARY PROVIDER** on the visit is.
Figure 4-84 shows the possible options. If you use **O**, other prompts will display.

```

Select one of the following:

O  One Provider Only
P  Any/All Providers (including unknown)
  
```

U	Unknown Provider Only
---	-----------------------

Figure 4-84: Options for Visits to Include on the Report example

Select which providers who performed the screening should be included.

Figure 4-85 shows the possible options. If you use **O**, other prompts will display.

Select one of the following:	
O	One Provider Only
P	Any/All Providers (including unknown)
U	Unknown Provider Only

Figure 4-85: Options for providers to Include on the report example

- Would you like to limit the list to just patients who have a particular designated **Mental Health** provider?
 - Use **Y** (Yes)
 - Or
 - **N** (No)

If you use **Y**, other prompts will display.
- Would you like to limit the list to just patients who have a particular designated **Social Services** provider?
 - Use **Y** (Yes)
 - Or
 - **N** (No)

If you use **Y**, other prompts will display.
- Would you like to limit the list to just patients who have a particular designated **ASA/CD** provider?
 - Use **Y** (Yes)
 - Or
 - **N** (No)

If you use **Y**, other prompts will display.
- Select Report type.

Use one of the following:

 - **L** (List of Patient Screenings)
 - Or
 - **S** (Create a Search Template of Patients) If you use **S**, other prompts will display.

- How would you like the list to be sorted (Figure 4-86)?

Select one of the following:

H	Health Record Number
N	Patient Name
P	Provider who screened
C	Clinic
R	Result of Screening
D	Date Screened
A	Age of Patient at Screening
G	Sex of Patient
T	Terminal Digit HRN

Figure 4-86: List of Options to Sort the List example

The default is **H** (Health Record Number).

- Display the Patient's Designated Providers on the list?

– Use **Y** (Yes)

Or

– **N** (No)

- Demo Patient/Inclusion/Exclusion.

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- DEVICE

Specify the device to output the report.

The application displays the criteria for the report. After pressing **Enter**, the application displays the report (Figure 4-87).

```

*** SUICIDE SCREENING VISIT LISTING FOR SELECTED PATIENTS ***
      Screening Dates: May 27, 2024 to Nov 27, 2024

PATIENT NAME      HRN      AGE      DATE      SCREENED RESULT      CLINIC
-----
Total Number of Visits with Screening      2
Total Number of Patients Screened          2

DEMO,TERRENCE      147300 88  M 10/17/24 ACUTE POSITIVE      GENERAL PREV
Primary Provider on Visit: DEMO,ARLIS
Provider who screened: DEMO,ARLIS
Race: AMERICAN INDIAN OR ALASKA NATIVE
Ethnicity: NOT HISPANIC OR LATINO

DEMO,JOHN DOE      748740 54  M 11/25/24 ACUTE POSITIVE      MENTAL HEALTH
DXs: T14.91XA CURRENT SUICIDAL BEHAVIOR, INITIAL ENCOUNTER

```

Figure 4-87: Suicide Screening Visit Listing for Selected Patients

4.1.13.7.4 Tally/List Pts in a Search Template w/ Suicide Screenings (SRST)

Note: Tally and listing of patients receiving suicide screening, including refusals, only patients who are members of a user-defined search template are included in this report.

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest **Suicide Screening (Exam code 44)** or a **Refusal** documented in a specified time frame.

This report will tally the patients by age, sex, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal. It will, optionally, look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal. The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.

4.1.13.7.5 Tally/List all Suicide Screenings for Template Patients (STST)

Note: Tally and listing of all visits w/suicide screening, only patients who are members of a user-defined search template are included in this report.

This report will tally and optionally list all visits on which a **Suicide Screening (Exam code 44)** or a **Refusal** was documented in a specified time frame.

This report will tally the visits by age, sex, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. It will optionally look at both **PCC** and the **Behavioral Health** databases for evidence of screening/refusal. This is a tally of visits with a screening done. If a patient had multiple screenings during the time period, all will be counted.

4.1.13.8 TAPS Screening Report (TAPS)

This report (Figure 4-90) will tally and optionally list all patients who have had **TAPS Screening** documented in the time frame specified by the user. **TAPS Screening** is defined as ALL 8 of the following documented on the SAME DATE:

- TAPS-ALCOHOL
- TAPS-CANNABIS
- TAPS-HEROIN
- TAPS-OPIOID
- TAPS-OTHER SUBSTANCES

- TAPS-SEDATIVE
- TAPS-STIMULANT
- TAPS-TOBACCO

This report will tally the patients by **age groups, sex, clinic, race**, and result of the **screen**.

- If a patient had all **8** screenings more than once in the time period, only the latest date where all **8 TAPS** health factors were documented is used in this report.
- All **TAPS** health factors results must be completed.
- This report will optionally, look at both **PCC** and the **Behavioral Health** databases, for evidence of screening.
- A positive screening result is defined as **Problem Use, High Risk, and In Early Remission** for each specific substance.

Enter the date range during which the screening was done. To get all screenings ever put in a long date range like **01/01/1980** to the **present date**.

The following are the prompts for this report.

- Enter Beginning Date for Screening
Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
Enter the ending date of the date range for the screening.
- Do you want to modify the Age Categories (Figure 4-88) for this report?
 - Enter **Y** (Yes)
 - Or
 - **N** (No)
- Select one of the following:

1	Those with a Positive Screening in any substance
2	Those with a Positive Screening in a specific substance
0	No Lists

Figure 4-88: Age Categories example

- At the “Patient Lists” prompt, enter a **number** and press **Enter**.
- How would you like the list to be sorted (Figure 4-89)?

H	Health Record Number
N	Patient Name
C	Clinic
D	Date Screened
A	Age of Patient at Screening

T	Terminal Digit HRN
---	--------------------

Figure 4-89: Patient Lists example

- At the prompt to sort, type the **letter** and press **Enter**.
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?
 - Enter **Y** (Yes)
 - Or
 - N** (No)
- Demo Patient/Inclusion/Exclusion.

Use one of the following:

 - I** (Include all patients)
 - E** (Exclude demo patients)
 - O** (Include only demo patients)
- Do you want to use:
 - P** (Print output)
 - Or
 - B** (Browse output on screen)

TOBACCO, ALCOHOL, PRESCRIPTION MEDICATION, AND OTHER SUBSTANCES						
*** PATIENT TALLY AND PATIENT LISTING ***						
Screening Dates: Nov 27, 2022 to Nov 27, 2024						
This report includes data from the PCC Clinical database						

PATIENT NAME	HRN	AGE	SEX	DATE	CLINIC	SCREENED

Total Number of Patients screened:						1
Total Number of Patients with at least one positive screening:						1 100.0%
By Sex						
FEMALE						1 100.0%
By Age						
13-17 yrs old						1 100.0%
By Clinic						
MEDICAL SOCIAL SERVICES						1 100.0%
By Race						
AMERICAN INDIAN OR ALASKA NATIVE						1 100.0%

By Ethnicity		
NOT HISPANIC OR LATINO	1	100.0%
Tobacco		
HIGH RISK	1	100.0%
IN EARLY REMISSION	0	0.0%
MINIMAL USE	0	0.0%
PROBLEM USE	0	0.0%
UNDETERMINED RISK	0	0.0%
Positive Tobacco Tally	1	100.0%
Alcohol		
HIGH RISK	0	0.0%
IN EARLY REMISSION	0	0.0%
MINIMAL USE	0	0.0%
PROBLEM USE	1	100.0%
UNDETERMINED RISK	0	0.0%
Positive Alcohol Tally	1	100.0%

Figure 4-90: TAPS Screening Report (TAPS) example

4.1.13.9 TAPS-Positive Screening Results Report (TAPP)

This report (Figure 4-92) will tally and optionally list all patients who have had a **POSITIVE TAPS** screening documented in the time frame specified by the user. Indicate which of these substances to report on.

- TAPS-ALCOHOL
- TAPS-CANNABIS
- TAPS-HEROIN
- TAPS-OPIOID
- TAPS-OTHER SUBSTANCES
- TAPS-SEDATIVE
- TAPS-STIMULANT
- TAPS-TOBACCO

This report will tally the patients by age groups, sex, clinic, race, and result of the screen.

- If a patient had a **Positive** screening more than once in the time period, only the latest date will be used in this report.
- This report will optionally look at both **PCC** and the **Behavioral Health** databases, for evidence of **Positive** screening.
- A **Positive** screening result is defined as **Problem Use**, **High Risk**, and **In Early Remission** for each specific substance.

Below are the prompts in this report.

- Which Substance do you want to report on (Figure 4-91)?

1	TAPS-ALCOHOL
2	TAPS-CANNABIS
3	TAPS-HEROIN
4	TAPS-OPIOID
5	TAPS-OTHER SUBSTANCES
6	TAPS-SEDATIVE
7	TAPS-STIMULANT
8	TAPS-TOBACCO

Figure 4-91: Substances to report

- Enter the number selected and press Enter.
- Enter Beginning Date for Screening
 - Enter the beginning date of the date range for the screening.
- Enter Ending Date for Screening
 - Enter the ending date of the date range for the screening
- Do you want to modify the Age Categories for this report?
 - Enter **Yes**
 - Or
 - **No**
- Would you like to include screenings documents in non-behavioral health clinics (those documented in PCC)?
 - Enter **Yes**
 - Or
 - **No**
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
 - Or
 - **B** (Browse output on screen)

PATIENTS SCREENED POSITIVE FOR TAPS-ALCOHOL *** PATIENT TALLY AND PATIENT LISTING *** Screening Dates: Nov 27, 2021 to Nov 27, 2024

This report includes data from the PCC Clinical database.		

Total Number of Patients screened positive for ALCOHOL:	1	
By Sex		
FEMALE	1	100.0%
By Age		
13-17 yrs old	1	100.0%
By Clinic		
MEDICAL SOCIAL SERVICES	1	100.0%
By Race		
AMERICAN INDIAN OR ALASKA NATIVE	1	100.0%
By Ethnicity		
NOT HISPANIC OR LATINO	1	100.0%
ALCOHOL		
PROBLEM USE	1	100.0%

Figure 4-92: TAPS-Positive Screening Results report (TAPP)

4.1.13.10 PHQ-2 and PHQ-9 Scores for One Patient (PHQ)

Use the **PHQ** option to produce a report that lists **PHQ2**, **PHQ9**, and **PHQT Scores** for one patient within a specified date range.

Below are the prompts:

- Select **PATIENT NAME**
 - Specify the **name** of the patient whose scores are to be displayed.
- Browse which **subset** of visits for **<name of patient>**

Use one of the following:

 - **N** (Patient's Last N Visits)
 - **D** (Visits in a Date Range)
 - **A** (All of this patient's Visits)

If you use **N** or **D**, other prompts will display.
- Limit by Clinic/Provider.

Use one of the following:

 - **C** (Visits to Selected Clinics)

- **P** (Visits to Selected Providers)
- **A** (Include All Visits regardless of Clinic/Provider)

The application displays the **PHQ-2/PHQ-9/PHQT Scores for One Patient** report (Figure 4-93).

PHQ-2, PHQ-9 and PHQ-9T SCORES FOR MULTIPLE PATIENTS							
Visit Dates: Mar 09, 2015 to Mar 09, 2016							
Clinic: ALL Clinics							
Providers: ALL Providers							
PATIENT NAME	HRN	Date	PHQ2	PHQ9	PHQT	Provider	CLINIC Diagnosis/POV

DEMO,JOSEPH	147423	03/03/16			23	DEMO,RY BEHAV	F43.11-POST-T
DEMO,AMBER DA	118957	03/05/16			5	DEMO,WE BEHAV	R45.851-Suicid
Enter ?? for more actions							>>>
+ NEXT SCREEN		PREVIOUS SCREEN			Q	QUIT	
Select Action: +//							

Figure 4-93: PHQ-2 and PHQ-9 Scores for One Patient Report example

4.1.13.11 PHQ-2 and PHQ-9 (PHQS) Scores for Multiple Patients

Use the **PHQS** option to produce a report that lists **PHQ-2** and **PHQ-9 Scores** for multiple patients, sorted by patient. Only visits with **PHQ-2/PHQ-9** scores recorded will display on this list.

Below are the prompts:

- Enter Beginning Date of Visit
 - Specify the beginning date of the date range.
- Enter Ending Date of Visit
 - Specify the ending date of the date range.
- Clinic Selection

Use one of the following:

 - **C** (Visits at Selected Clinic)

Or

 - **A** (Visit to All Clinics)

If you use **C**, other prompts will display.
- Provider Selection.

Use one of the following:

 - **A** (Visits to All Providers)

Or

- **C** (Visits to Selected Providers)

If you use **C**, other prompts will display.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the **PHQ-2 and PHQ-9 Scores for Multiple Patients** report (Figure 4-94).

XX	Jul 13, 2016					Page 1	
PHQ-2 and PHQ-9 SCORES FOR MULTIPLE PATIENTS							
Visit Dates: Jan 04, 2009 to Jul 13, 2009							
Clinic: ALL Clinics							
Providers: ALL Providers							
PATIENT NAME	HRN	Date	PHQ-2	PHQ-9	Provider	CLINIC Diagnosis/POV	

DEMO,JACOB SCO	102668	02/07/16		3	DEMO,RYA	MENTA	
DEMO,CHELSEA	116431	05/19/16	3	3	DEMO,DE	MENTA F32.0-MAJOR DEPRESS	
DEMO,CHELSEA	116431	03/17/16	4		DEMO,BETAA	MEDIC F32.3-MAJOR DEPRESS	
DEMO,CHELSEA	116431	03/10/16		19	DEMO,DE	MENTA F42.-HOARDING DISOR	
Enter RETURN to continue or '^' to exit:							

Figure 4-94: PHQ-2 and PHQ-9 Scores for Multiple Patients report example

4.1.13.12 GAD-2 and GAD-7 Scores for One Patient (GAD)

Use the **GAD** option to produce a report that lists **GAD2** and **GAD7 Scores** for one patient within a specified date range.

Below are the prompts:

- Select **PATIENT NAME**
 - Specify the **name** of the patient whose scores are to be displayed.
- Browse which subset of visits for **<name of patient>**

Use one of the following:

- **N** (Patient's Last N Visits)
- **D** (Visits in a Date Range)
- **A** (All of this patient's Visits)

If you use **N** or **D**, other prompts will display.

- Limit by Clinic/Provider

Use one of the following:

- **C** (Visits to Selected Clinics)
- **P** (Visits to Selected Providers)
- **A** (Include All Visits regardless of Clinic/Provider)

The application displays the **GAD-2/GAD-7 Scores for One Patient** report (Figure 4-95).

GAD2/GAD7		Jul 05, 2017 11:00:33		Page: 1 of 1	
Patient Name: TEST,DONNA		DOB: Feb 17, 1954			
HRN: 13976					

Date	GAD2	GAD7	PROVIDER	CLINIC	Diagnosis/POV

04/24/17	2	20	DEMO,DONNA	GENERAL	R51. - headache
11/18/16	2	2	20	DEMO,DONNA	GENERAL
06/01/16	2			GENERAL	Z00.00 - routine exam
03/10/16			DEMO,DONNA	GENERAL	R05. - TEST
03/07/16	2	4	15	2	DEMO,DONNA
			GENERAL		J45.991 - COUGH ASTHMA REL
Enter ?? for more actions					
+	Next Screen		-	Previous Screen	
				Q	Quit

Figure 4-95: GAD-2 and GAD-7 Scores for One Patient Report example

4.1.13.13 GAD-2 and GAD-7 Scores for Multiple Patients (GADS)

Use the **GADS** option to produce a report that lists **GAD-2** and **GAD-7 Scores** for multiple patients, sorted by patient. Only visits with **GAD-2/GAD-7** scores recorded will display on this list.

Below are the prompts:

- Enter Beginning Date of Visit
 - Specify the beginning date of the date range.
- Enter Ending Date of Visit
 - Specify the ending date of the date range.
- Clinic Selection

Use one of the following:

- C (Visits at Selected Clinic)

Or

- A (Visit to All Clinics)

If you use C, other prompts will display.

- Provider Selection

Use one of the following:

- A (Visits to All Providers)

Or

- C (Visits to Selected Providers)

If you use C, other prompts will display.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- I (Include all patients)
- E (Exclude demo patients)
- O (Include only demo patients)

- Do you want to use:

- Use P (Print output)

Or

- B (Browse output on screen)

The application displays the **GAD-2 and GAD-7 Scores for Multiple Patients** report (Figure 4-96).

XX	Jul 05, 2017					Page 1	
GAD-2 and GAD-7 SCORES FOR MULTIPLE PATIENTS							
Visit Dates: Jul 05, 2015 to Jul 05, 2017							
Clinic: ALL Clinics							
Providers: ALL Providers							
PATIENT NAME	HRN	Date	GAD2	GAD7	Provider	CLINIC	Diagnosis/POV

DEMO,JACOB SCO	102668	02/07/16		3	DEMO,RYA	MENTA	
DEMO,CHELSEA	116431	05/19/16	3	3	DEMO,DE	MENTA	F32.0-MAJOR DEPRESS
DEMO,CHELSEA	116431	03/17/16	4		DEMO,BETAA	MEDIC	F32.3-MAJOR DEPRESS
DEMO,CHELSEA	116431	03/10/16		14	DEMO,DE	MENTA	F42.-HOARDING DISOR

```
Enter RETURN to continue or '^' to exit:
```

Figure 4-96: GAD-2 and GAD-7 Scores for Multiple Patients report example

4.1.14 Treatment Plans (TPR)

Use the **TPR** option to access the **Treatment Plans** menu (Figure 4-97).

```
ATP      Print List of All Treatment Plans on File
REV      Print List of Treatment Plans Needing Reviewed
RES      Print List of Treatment Plans Needing Resolved
NOTP     Patients w/Case Open but no Treatment Plan
```

```
Select Treatment Plans Option:
```

Figure 4-97: Options on the Treatment Plans menu example

4.1.14.1 Patients Seen in Groups with Time in Group (TSG)

Use the **TSG** option to produce a report that shows a list of patients who have spent time in a group in a specified date range. It will list the patient, the primary provider, diagnosis, and time spent in the group.

Below are the prompts:

- Enter Beginning Date
 - Specify the beginning date of the date range.
- Enter Ending Date
 - Specify the ending date of the date range.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)

Or

 - **B** (Browse output on screen)

The application displays the **Patients Seen in Groups with Time Spent in Group** report (Figure 4-98).

```
DEMO INDIAN HOSPITAL
PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP
DATES:  JAN 17, 2009  TO  APR 17, 2009
```

PATIENT NAME	HRN	SEX	DOB	DATE	PROVIDER	PROBLEM	TIME
DEMO, CRYSTAL	106299	F	11/28/85	04/20/09	DEMO, BETAS	F42	0
Total with provider				DEMO, BJ	0		
Total for patient				DEMO, CRYSTAL	GAYL	0	
DEMO, DIANA LE	192745	F	09/15/54	03/05/09	DEMO, DENISE	F33.0	60
				03/25/09	Not Recorded	F31.3	15
				04/21/09	DEMO, MARK	F42.	0
					DEMO, MARK	F33.0	60

Figure 4-98: Patients Seen in Groups with Time Spent in Group report example

4.2 Behavioral Health Record/Encounter Reports (REC)

Use the **REC** option to list various records from the **Behavioral Health** patient file that are available on the **BHS Encounter/Record Reports** menu (Figure 4-99).

**	IHS Behavioral Health System
**	Encounter/Record Reports

Version 4.0 (Patch 13)	
DEMO INDIAN HOSPITAL	
LIST	List Visit Records, STANDARD Output
GEN	List Behavioral Hlth Records, GENERAL RETRIEVAL
Select Behavioral Health Record/Encounter Reports Option:	

Figure 4-99: Options on the Encounter/Record Reports menu example

4.2.1 List Visit Records, Standard Output (LIST)

Use the **LIST** option to produce a report that shows a listing of visits in a specified date range. The visits can be selected based on any combination of selected criteria. The user will select the sort criteria for the report.

Be sure to have a printer available that has 132-column print capability.

Below are the prompts:

- Enter Beginning Visit Date for Search
 - Specify the beginning date of the date range.
- Enter Ending Visit Date for Search
 - Specify the ending date of the date range.

The application displays the **Visit Selection Menu** (Figure 4-100).

BH GENERAL RETRIEVAL		Dec 26, 2013 09:47:03		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEEENIN			
17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM			
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History It			
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov			
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid			
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov			
22) Case Admit Date	46) Axis IV	70) Designated Other Pro			
23) Case Closed Date	47) Axis V				
24) Case Disposition	48) Flag (Visit Flag)				
20) Case Admit Date	42) Inpatient Dispositio	64) Designated Other Pro			
21) Case Closed Date	43) PCC Visit Created				
22) Case Disposition	44) Axis IV				
+ Enter ?? for more actions					
S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report
Select Action: S//					

Figure 4-100: Visit Selection Menu example

Use this menu to select the visit criteria for the report. If you do not select any criteria (immediately use the **Quit Item Selection**), all visits will be selected.

- Type of Report to Print

Use one of the following:

- **D** (detailed using 132-column print)

Or

- **B** (brief (using 80-column print)

The application displays the Sort Item Selection Menu (Figure 4-101).

BH GENERAL RETRIEVAL		Dec 26, 2013 09:55:56		Page: 1 of 2	
SORT ITEM SELECTION MENU					
The Visits displayed can be SORTED by ONLY ONE of the following items. If you don't select a sort item, the report will be sorted by visit date.					

1) Patient Name	18) Visit Type	35) Flag (Visit Flag)
2) Patient Sex	19) Location of Encounte	36) Primary Provider
3) Patient DOB	20) Clinic	37) Primary Prov Discipl
4) Patient DOD	21) Outside Location	38) Primary Prov Affilia
5) Patient Chart #	22) SU of Encounter	39) Primary POV
6) Ethnicity	23) County of Service	40) IPV SCREENING
7) Veteran Status Y/N	24) Community of Service	41) ALCOHOL SCREENING
8) Patient Community	25) Activity Type	42) DEPRESSION SCRFEEENIN
9) Patient County Resid	26) Days in Residential	43) SUICIDE RISK ASSESSM
10) Patient Tribe	27) Days in Aftercare	44) Designated MH Prov
11) Eligibility Status	28) Activity Category	45) Designated SS Provid
12) Class/Beneficiary	29) Local Service Site	46) Designated A/SA Prov
13) Patient Flag Field	30) Number Served	47) Designated Other Pro
14) Encounter Date	31) Type of Contact	48) Designated Other (2)
15) Appointment/Walk-In	32) Inpatient Dispositio	
16) Interpreter Utilized	33) PCC Visit Created	
17) Program	34) Axis V	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 4-101: Sort Item Selection Menu options example

Use this menu to determine how the visit data will be sorted on the report. If you do not select any item (immediately use the **Quit Item Selection** option), the report will be sorted by visit date.

- Do you want a separate page for each Visit Date?

– Use **Y** (Yes)

Or

– **N** (No)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- Do you want to use:

– **P** (Print output)

Or

– **B** (Browse output on screen)

The application displays the criteria for the report. Then, the application displays the **Behavioral Health Record Listing** report (Figure 4-102), which is the brief type.

BEHAVIORAL HEALTH RECORD LISTING	
Visit Dates: DEC 23, 2011 and JAN 23, 2012	
=====	

DATE	PROV	LOC	PATIENT NAME	ACT	CONT	AT	HRN	PROB	NARRATIVE
12/23/11	WW	WW	DEMO, CHARLES	13	OUTP	88	WW109767	F84.0	AUTISM SPEC
								F10.24	ALCOHOL DEP
12/23/11	VA	WW	DEMO, JIMM	13	OUTP	60	WW129347	F42.	HOARDING DI
12/27/11	DJS	1337	DEMO, DANNY	91	OUTP	10	WW176178	F42.	HOARDING DI
12/27/11	DJS	1337	DEMO, ALISO	91	OUTP	10	WW193661	F32.3	MAJOR DEPRE
12/27/11	DJS	1337	DEMO, ROBERT	91	OUTP	10	WW186585	F32.1	MAJOR DEPRE
12/27/11	DJS	1337	DEMO, CLAUDIA	91	OUTP	10	WW177791	F32.3	MAJOR DEPRE
12/28/11	RJG	WW	DEMO, RYAN J	13	OUTP	90	WW163449	F84.0	AUTISM SPEC
12/28/11	RJG	WW	DEMO, JADA KAR	13	OUTP	90	WW173042	F10.25	ALCOHOL DEP
12/28/11	GB	WW	DEMO, REBECC	11	OUTP	50	WW113487	T43.205A	ANTIDEPRESS
RUN TIME (H.M.S): 0.0.0									
End of report. PRESS ENTER									

Figure 4-102: Behavioral Health Record Listing report example

4.2.2 List Behavioral Health Records, General Retrieval (GEN)

Use the **GEN** option to produce a report that shows a listing of visits selected by visit criteria. The visits printed can be selected based on any combination of selected items and the selected sort criteria.

Note: If the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

Below are the prompts:

- Select and Print Encounter List from
Use one of the following:
 - S (search template)
 Or
 - D (date range)
 The next prompts vary according to the option selected.
- Enter Beginning Encounter Date for search
 - Define the beginning encounter date.
- Enter Ending Encounter Date for search
 - Define the ending encounter date.
- Do you want to use a PREVIOUSLY DEFINED REPORT?
Use one of the following:
 - Y (Yes)
 Or
 - N (No)

If you use **Y**, other prompts display.

The application displays the **Visit Selection Menu** (Figure 4-103).

BH GENERAL RETRIEVAL		June 26, 2017 10:02:48		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEEENIN			
17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM			
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History Ite			
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov			
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid			
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov			
22) Case Admit Date	46) Axis IV	70) Designated Other Pro			
23) Case Closed Date	47) Axis V				
24) Case Disposition	48) Flag (Visit Flag)				
+ Enter ?? for more actions					
S	Select Item(s)	+	Next Screen	Q	Quit Item Selection
R	Remove Item(s)	-	Previous Screen	E	Exit Report
Select Action: S//					

Figure 4-103: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

The following prompts continue in the process:

- Select Type of Report. Use one of the following:
 - **T** (Total Count Only)
 - **S** (Sub-counts and Total Count)
 - **D** (Detailed Listing)
 - **F** (Flag ASCII file) (pre-defined record format)

The application displays the **Print Item Selection Menu** (Figure 4-104).

BH GENERAL RETRIEVAL		June 26, 2017 10:06		Page: 1 of 2	
PRINT ITEM SELECTION MENU					
The following data items can be printed. Choose the items in the order you want them to appear on the printout. Keep in mind that you have an 80 column screen available, or a printer with either 80 or 132 column width.					
1) Patient Name	29) Interpreter Utilized	57) Primary Prov Affilia			
2) Patient Sex	30) Program	58) Prim/Sec Providers			
3) Patient Race	31) Visit Type	59) Prim/Sec Prov Discip			
4) Patient Age	32) Location of Encounte	60) POV (Prim or Sec)			
5) Patient DOB	33) Clinic	61) DX/Problem Code Narr			
6) Patient SSN	34) Outside Location	62) POV (Prob Code Grps)			
7) Patient DOD	35) SU of Encounter	63) Primary POV			
8) Patient Chart #	36) County of Service	64) POV Problem Code Nar			
9) Ethnicity	37) Community of Service	65) POV (Problem Categor			
10) Veteran Status Y/N	38) Chief Complaint/Pres	66) POV Diagnosis Catego			
11) Patient Community	39) Activity Type	67) POV Prov Narrative			
12) Patient County Resid	40) Activity Type Narrat	68) Procedures (CPT)			
13) Patient Tribe	41) Days in Residential	69) Education Topics Pro			
14) Eligibility Status	42) Days in Aftercare	70) Prevention Activity			
15) Class/Beneficiary	43) Activity Category	71) Treated Medical Prob			
16) Medicare Eligibility	44) Local Service Site	72) IPV SCREENING			
17) Medicaid Eligibility	45) Number Served	73) ALCOHOL SCREENING			
18) Priv Ins Eligibility	46) Type of Contact	74) DEPRESSION SCRFEENIN			
19) Patient Flag Field	47) Activity Time	75) SUICIDE RISK ASSESSM			
20) Patient Flag Narrati	48) Inpatient Dispositio	76) Personal History It			
21) Case Open Date	49) Place Referred To	77) Designated MH Prov			
22) Case Admit Date	50) PCC Visit Created	78) Designated SS Provid			
23) Case Closed Date	51) Axis IV	79) Designated A/SA Prov			
24) Case Disposition	52) Axis V	80) Designated Other Pro			
25) Next Case Review Dat	53) Comment	81) Designated Other (2)			
26) Encounter Date	54) Flag (Visit Flag)				
27) Encounter Date&Time	55) Primary Provider				
28) Appointment/Walk-In	56) Primary Prov Discipl				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 4-104: Print Item Selection Menu options example

Use the **Sort Item Selection Menu** (Figure 4-105) to select the data items to be used on the report. Use option **Q** when you have completed your selections.

BH GENERAL RETRIEVAL		June 26, 2017 09:55:56		Page: 1 of 2	
SORT ITEM SELECTION MENU					
The Visits displayed can be SORTED by ONLY ONE of the following items.					
If you don't select a sort item, the report will be sorted by visit date.					
1) Patient Name	18) Visit Type	35) Flag (Visit Flag)			
2) Patient Sex	19) Location of Encounte	36) Primary Provider			
3) Patient DOB	20) Clinic	37) Primary Prov Discipl			
4) Patient DOD	21) Outside Location	38) Primary Prov Affilia			
5) Patient Chart #	22) SU of Encounter	39) Primary POV			
6) Ethnicity	23) County of Service	40) IPV SCREENING			
7) Veteran Status Y/N	24) Community of Service	41) ALCOHOL SCREENING			
8) Patient Community	25) Activity Type	42) DEPRESSION SCRFEENIN			

9) Patient County Resid	26) Days in Residential	43) SUICIDE RISK ASSESSM
10) Patient Tribe	27) Days in Aftercare	44) Designated MH Prov
11) Eligibility Status	28) Activity Category	45) Designated SS Provid
12) Class/Beneficiary	29) Local Service Site	46) Designated A/SA Prov
13) Patient Flag Field	30) Number Served	47) Designated Other Pro
14) Encounter Date	31) Type of Contact	48) Designated Other (2)
15) Appointment/Walk-In	32) Inpatient Dispositio	
16) Interpreter Utilized	33) PCC Visit Created	
17) Program	34) Axis V	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 4-105: Options on the Sort Item Selection Menu example

Use this menu to determine the sort criteria for the report. If you do not select any criteria (immediately use the **Quit Item Selection** option), the report will be sorted by visit date.

- Do you want a separate page for each Visit Date?

Use one of the following:

– Y (Yes)

Or

– N (No)

- Would you like a custom title for this report?

Use one of the following:

– Y (Yes)

Or

– N (No)

If you use Y, other prompts will display.

- Do you want to save this SEARCH/PRINT/SORT logic for future use?

Use one of the following:

– Y (Yes)

Or

– N (No)

If you use Y, other prompts will display.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– I (Include all patients)

– E (Exclude demo patients)

- **O** (Include only demo patients)
The application displays the criteria for the report.

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the criteria for the report. After pressing **Enter**, the application displays the visit report (Figure 4-106).

***** CONFIDENTIAL PATIENT INFORMATION *****				
BH Visit Listing				Page 1
Record Dates: JAN 14, 2009 and JUL 13, 2009				
PATIENT NAME	DOB	HRN	PROGRAM	

--			MENTAL	
DEMO,CHELSEA MARIE	02/07/1975	WW116431	MENTAL	
DEMO,ALBERT TILLMAN	02/07/1975	WW164141	OTHER	
DEMO,ALBERT TILLMAN	02/07/1975	WW164141	MENTAL	
DEMO,ALBERT TILLMAN	02/07/1975	WW164141	SOCIAL	
Enter ?? for more actions				
+ Next Screen	- Previous Screen	Q	Quit	
Select Action:+//				

Figure 4-106: Visit report example

4.3 Workload/Activity Reports (WL)

Use the **WL** option to view the **Activity Workload Reports** menu (Figure 4-107).

**	IHS Behavioral Health System **
**	Activity Workload Reports **

Version 4.0 (Patch 13)	
DEMO INDIAN HOSPITAL	
GRS1	Activity Report
GRS2	Activity Report by Primary Problem
ACT	Activity Record Counts
PROG	Program Activity Time Reports (132 COLUMN PRINT)
FACT	Frequency of Activities
FCAT	Frequency of Activities by Category
PA	Tally of Prevention Activities
Select Workload/Activity Reports Option:	

Figure 4-107: Options on the Activity Workload Reports menu example

The **Workload/Activity Reports** menu has options to generate reports related specifically to the activities of **Behavioral Health** providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring **Behavioral Health** care.

4.3.1 Activity Report (GRS1)

Use the **GRS1** option to produce a report that will tally activities by service unit, facility, and provider.

Below are the prompts:

- Enter Beginning Encounter Date.
 - Specify the beginning encounter date for the date range.
- Enter Ending Encounter Date.
 - Specify the ending encounter date for the date range.
- Run Report for which Program.

Use one the following:

- **M**–Mental Health
- **S**–Social Services
- **C**–Chemical Dependency or Alcohol/Substance Abuse
- **O**–Other
- **A**–All

- Run Report for Provider(s).

Use one of the following:

- **1** (One Provider)

Or

- **2** (All Providers)

If you use **1**, other prompts will display.

- Include which providers.

Use one of the following:

- **P** (Primary Provider Only)

Or

- **S** (Both Primary and Secondary Providers)

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)

- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

The application displays the **Activity Report** (Figure 4-108).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XX                                     MAY 04, 2009Page 1
      ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM
      RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

                                     # RECS    ACT TIME    # PATS    # SERVED
                                     (hrs)
-----
AREA:  TUCSON
SERVICE UNIT:  SELLS
FACILITY:  SELLS HOSP
PROVIDER:  DEMO,BJ (PSYCHIATRIST)
      13-INDIVIDUAL TREATMENT/COUNS                3         2.8         3         3
      16-MEDICATION/MEDICATION MONI                1         1.0         1         1
      91-GROUP TREATMENT                          2         1.5         2         2
      =====
PROVIDER TOTAL:                6         5.3         6         6

PROVIDER:  DEMO,LORI (PHYSICIAN)
      11-SCREENING-PATIENT PRESENT                 1         0.3         1         1
      13-INDIVIDUAL TREATMENT/COUNS                1         0.2         1         1
      22-CASE MANAGEMENT-PATIENT PR                2         0.7         1         2
      =====
PROVIDER TOTAL:                4         1.3         3         4

PROVIDER:  DEMO,DOCTOR (PHYSICIAN)
      85-ART THERAPY                              4         0.7         4         4
      =====
PROVIDER TOTAL:                4         0.7         4         4
Enter RETURN to continue or '^' to exit:

```

Figure 4-108: Activity Report example

Near the end of the report, there will be a **Facility Total**, **SU Total**, and **Area Total**.

4.3.2 Activity Report by Primary Problem (GRS2)

Use the **GRS2** option to produce a report that will tally PRIMARY problems by service unit, facility, and by provider and activity.

The prompts are the same as those for the **GRS1** report. Section 4.3.1 provides more information about the **Activity Report**.

The application displays the **Activity Report by Primary Problem** report (Figure 4-109).

```

***** CONFIDENTIAL PATIENT INFORMATION *****
xx                                     MAY 04, 2009Page 1
      ACTIVITY REPORT BY PRIMARY PURPOSE[AC8.1]
      ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM
      RECORD DATES:  FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identified patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

                                     # RECS    ACT TIME # PATS    # SERVED
                                     (hrs)
-----
AREA:  TUCSON
SERVICE UNIT:  SELLS
FACILITY:  SELLS HOSP
PROVIDER:  DEMO,BJ (PSYCHIATRIST)
ACTIVITY:  13-INDIVIDUAL TREATMENT/C
           F32.0-MAJOR DEPRESS                1        1.0        1        1
           =====
ACTIVITY TOTAL:                1        1.0        1        1

ACTIVITY:  16-MEDICATION/MEDICATION
           F42.-HOARDING DISOR                1        1.0        1        1
           =====
ACTIVITY TOTAL:                1        1.0        1        1

           =====
PROVIDER TOTAL:                2        2.0        2        2

Enter ?? for more actions
+   Next Screen      -   Previous Screen      Q   Quit
Select Action :+//

```

Figure 4-109: Activity Report by Primary Purpose report example

4.3.3 Activity Record Counts (ACT)

Use the **ACT** option to produce a report that will generate a count of activity records for a selected item in a specified date range. You will be given the opportunity to select which visits will be included in the tabulation. For example, you can choose to tally activity time by **Problem Code** for only those with a discipline of Psychiatrist.

Below are the prompts:

- Choose an item for calculating activity time and records counts.
 - The application displays a list of items from which to choose.
- Enter Beginning Visit Date for Search
 - Specify the beginning visit date for the date range.

- Enter Ending Visit Date for Search
 - Specify the ending visit date for the date range.

The application displays the **Visit Selection Menu** (Figure 4-110).

BH GENERAL RETRIEVAL		Dec 26, 2013 10:21:08		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEEENIN			
17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM			
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History It			
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov			
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid			
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov			
22) Case Admit Date	46) Axis IV	70) Designated Other Pro			
23) Case Closed Date	47) Axis V				
24) Case Disposition	48) Flag (Visit Flag)				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 4-110: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the **Activity Record Counts** report (Figure 4-111).

RECORD DATES: FEB 03, 2009 TO MAY 04, 2009						
NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM-5/CODE						
PROB	DSM/CODE	NARRATIVE	CODE	# RECS	# PATS	ACTIVITY TIME

	GENERALIZED ANXIETY DIS		F41.1	1	1	1.0
	MAJOR DEPRESSIVE DISORD		F32.9	1	1	0.0
	SUICIDE (ATTEMPT/GESTUR		40	1	1	0.9
	Suicidal ideations		R45.851	1	1	0.0
	Suicide attempt		T14.91	1	1	0.0
Enter ?? for more actions						
+	Next Screen	-	Previous Screen	Q	Quit	
Select Action:+//						

Figure 4-111: Activity Record Counts report example

4.3.4 Program Activity Time Reports (PROG)

Use the **PROG** option to produce a report that will generate a count of activity records, total activity time, and number of patient visits by Program and by a selected item within a specified date range. You will be given the opportunity to select which visits will be included on the report. For example, you might want to only report on those records on which the type of visits was Field.

Note: If you choose to report on Problems, **ONLY THE PRIMARY PROBLEM** is included.

The prompts are the same as those for the **ACT** report. Section 4.3.3 provides more information about **Activity Record Counts**.

The application displays the record selection criteria. After pressing **Enter**, the application displays the **Program Activity Time** report (Figure 4-112).

Encounter Date range: FEB 03, 2009 to MAY 04, 2009					
MENTAL HEALTH AND SOCIAL SERVI					
ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGR					
RECORD DATES: FEB 03, 2009 TO MA					
SOCIAL SERVICES AND MENTAL HEALTH COMB					
SOCIAL SERV					
PROVIDER	NO. OF RECORDS	NO. OF PATIENTS	TOTAL ACTIV TIME	NO. OF RECORDS	NO. OF PATIENT

```

-----
DEMO,AAA                15          7          3.6                2          2
DEMO,BETAA              33         18         22.6                8          4
DEMO,LORI                16          6          5.0                .          .
DEMO,JESSICA             9          2          6.3                .          .
DEMO,CASE M              1          1          0.0                .          .
DEMO,DOCTOR              1          1          0.2                1          1
DEMO,AMY J               3          3          2.0                .          .
DEMO,RYAN               106         30         66.3               24          5
**** Patient Count TOAL is not an unduplicated count.

Enter ?? for more actions
+   Next Screen          Previous Screen      Q   Quit
Select Action:+//

```

Figure 4-112: Program Activity Time report example

4.3.5 Frequency of Activities (FACT)

Use the **FACT** option to produce a report that will generate a list of the top **N Activity Codes** for selected visits.

Below are the prompts:

- Enter Beginning Visit Date for Search
 - Specify the beginning visit date for the date range.
- Enter Ending Visit Date for Search
 - Specify the ending visit date for the date range.

The application displays the **Visit Selection Menu** (Figure 4-113).

BH GENERAL RETRIEVAL		Dec 26, 2013 10:23:22		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEENIN			

17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History Ite
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov
22) Case Admit Date	46) Axis IV	70) Designated Other Pro
23) Case Closed Date	47) Axis V	
24) Case Disposition	48) Flag (Visit Flag)	
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 4-113: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

- Select Type of Report
 - Use one of the following:
 - **L** (list of items with counts)
 - Or
 - **B** (Bar Chart, requires 132 column printer)
- How many entries do you want to list (**5–100**)
 - Specify the number of entries (any number **5–100**).
- Demo Patient/Inclusion/Exclusion
 - Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
- Or
 - **B** (Browse output on screen)

The application displays the criteria for the report. After pressing **Enter**, the application displays the **Frequency of Activities** report (Figure 4-114).

MAY 04, 2009		Page 1	
DEMO INDIAN HOSPITAL			
TOP 10 Activity Code's.			
DATES: FEB 03, 2009 TO MAY 04, 2009			
No.	ACTIVITY TYPE	ACTIVITY CODE	# RECS ACT TIME (HRS)

1.	SCREENING-PATIENT PRESENT	11	55	34.8
2.	INFORMATION AND/ OR REFERRAL-P	15	32	12.3
3.	GROUP TREATMENT	91	30	17.1
4.	INDIVIDUAL TREATMENT/COUNSEL/E	13	22	17.0
5.	ASSESSMENT/EVALUATION-PATIENT	12	19	15.5
6.	INDIVIDUAL BH EHR VISIT	99	19	0.6
7.	ACADEMIC SERVICES	96	16	8.1
8.	ART THERAPY	85	15	6.7

RUN TIME (H.M.S): 0.0.0
End of report. PRESS ENTER:

Figure 4-114: Frequency of Activities report example

4.3.6 Frequency of Activities by Category (FCAT)

Use the **FCAT** option to produce a report that generates a list of the top **N Activity Category** for selected visits.

The prompts are the same as for the **Frequency of Activities** report. Section 4.3.5 **Frequency of Activities** report.

Below is a sample **Frequency of Activities by Category** report (Figure 4-115).

MAY 04, 2009			Page 1	
DEMO INDIAN HOSPITAL				
TOP 10 Activity Category's.				
DATES: FEB 03, 2009 TO MAY 04, 2009				
No.	ACTIVITY CATEGORY	CATEGORY CODE	# RECS	ACT TIME (HRS)

1.	PATIENT SERVICES	P	943	556778.2
2.	SUPPORT SERVICES	S	56	52.9
3.	ADMINISTRATION	A	21	26.6
4.	PLACEMENTS	PL	6	2.8
5.	COMMUNITY SERVICES	C	2	9.0
6.	EDUCATION/TRAINING	E	2	1.5
7.	CULTURALLY ORIENTED	O	1	0.5
8.	TRAVEL	T	1	0.3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 4-115: Frequency of Activities by Category report example

4.3.7 Tally of Prevention Activities (PA)

Use the **PA** option to produce a report that will show a count of all visits with a prevention activity entered. It will also produce a tally/count of those prevention activities with Target Audience subtotals.

Below are the prompts:

- Enter Beginning Visit Date

- Specify the beginning visit date for the date range.
- Enter Ending Visit Date
 - Specify the ending visit date for the date range.
- Run the Report for which PROGRAM.

Use one of the following:

 - **O** (one program)

Or

 - **A** (all programs)

If you use **O**, other prompts will display.
- Enter a code indicating which providers are of interest.

Specify the **Providers** whose **Prevention** activities you want to tally.

Use one of the following:

 - **A** (all providers)
 - **S** (Select set or Taxonomy of Providers)
 - **O** (one provider)

If you use **S** or **O**, other prompts will display.
- Demo Patient/Inclusion/Exclusion

Use one of the following:

 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- DEVICE

Specify the device to browse/print the report.

The application displays the Tally of Prevention Activities report (Figure 4-116).

May 04, 2009		Page: 1	
Behavioral Health			

* TALLY OF PREVENTION ACTIVITIES *			

VISIT Date Range: FEB 03, 2009 through MAY 04, 2009			
PREVENTION ACTIVITY		# of visits	% of visits

Total # Visits w/Prevention Activity:		3	
Total # of Prevention Activities recorded:		5	
AIDS/HIV		1	33.3
YOUTH	1	100.0	
OTHER		1	33.3

NOT RECORDED	1	100.0		
PUBLIC AWARENESS			1	33.3
NOT RECORDED	1	100.0		
SELF-AWARENESS/VALUES			1	33.3
ADULT	1	100.0		
SMOKING/TOBACCO			1	33.3
YOUTH	1	100.0		
TARGET TOTALS				
ADULT	1	33.3		
NOT RECORDED	1	33.3		
YOUTH	1	33.3		
RUN TIME (H.M.S): 0.0.0				
Enter RETURN to continue or '^' to exit:				

Figure 4-116: Tally of Prevention Activities report example

4.4 Problem Specific Reports (PROB)

Use the **PROB** option to produce a list of BH issues of particular concern to providers, managers, and administrators from a clinical and public health perspective. Figure 4-117 shows the **Problem Specific Report** menu.

**	IHS Behavioral Health System **
**	Problem Specific Reports **

Version 4.0 (Patch 13)	
DEMO INDIAN HOSPITAL	
ABU	Abuse Report (Age&Sex)
FDSM	Frequency of Problems
FPRB	Frequency of Problems (Problem Code Groupings)
FPRC	Frequency of Problems by Problem Category
SUIC	Suicide Related Reports ...
Select Problem Specific Reports Option:	

Figure 4-117: Options on the Problem Specific Reports menu example

4.4.1 Abuse Report (ABU)

Use the **ABU** option to produce a report that focuses on patients who might have been victims of abuse or neglect. It will present, by age and sex, the number of individual patients who were seen for the **Purpose of Visit (POV)**. The application displays the POVs.

Below are the prompts:

- Enter Beginning Visit Date

Specify the beginning visit date for the date range (during which the patient should have been seen with one of the above problems).

- Enter the Ending Visit Date

Specify the ending visit date for the date range.

The application displays the current Age Groups.

- Do you want to modify these age groups?

Use one of the following:

- **Y** (Yes)

Or

- **N** (No)

If you use **Y**, other prompts will display. Use **N** to not modify the age groups.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)

- **E** (Exclude demo patients)

- **O** (Include only demo patients)

- Do you want to use:

- **P** (Print output)

Or

- **B** (Browse output on screen)

The application displays the **Abuse Report by Age and Sex** report. You need a 132-column printer to print the report.

4.4.2 Frequency of Problems (FDX)

Use the **FDX** option to produce a report (Figure 4-119) that shows a list of the top N Problem/POV for selected visits.

Below are the prompts:

- Enter Beginning Visit Date for Search

Specify the beginning visit date for the date range.

- Enter Ending Visit Date for Search

Specify the ending visit date for the date range.

- The application displays the **Visit Selection Menu** (Figure 4-118).

BH GENERAL RETRIEVAL		Dec 26, 2013 10:26:30		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEEENIN			
17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM			
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History It			
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov			
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid			
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov			
22) Case Admit Date	46) Axis IV	70) Designated Other Pro			
23) Case Closed Date	47) Axis V				
24) Case Disposition	48) Flag (Visit Flag)				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 4-118: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

- Include which POVs.

Use one of the following:

- **P** (primary POV only)

Or

- **S** (primary and secondary POVs)

- Select Type of Report.

Use one of the following:

- **L** (List of items with counts)

Or

– **B** (Bar Chart, requires 132 column printer)

- How many entries do you want to list (**5-100**)

Specify the number of entries.

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- Do you want to use:

– **P** (Print output)

Or

– **B** (Browse output on screen)

JUN 09, 2009			Page 1	
DEMO INDIAN HOSPITAL				
TOP 10 Problem/POV's.				
PRIMARY POV Only				
DATES: MAR 11, 2009 TO JUN 09, 2009				
No.	PROB DSM/CODE NARRATIVE	CODE	# RECS	ACT TIME (HRS)
1.	MAJOR DEPRESSIVE DISORDER,RECU	F33.9	150	114.8
2.	GENERALIZED ANXIETY DISORDER	F41.1	52	28.8
3.	UNSPECIFIED ATTENTIONN-DEFICIT	F90.9	48	35.5
4.	BIPOLAR DISORDER, UNSPECIFIED	F31.9	33	26.1
5.	OBSESSIVE-COMPULSIVE DISORDER	F42	32	21.1
6.	PANIC DISORDER	F41.0	32	72.9
7.	ANOREXIA NERVOSA, RESTRICTING	F50.01	31	27.4
8.	ALCOHOL USE DISORDER, MODERAT	F10.20	25	7.9
9.	HEALTH/HOMEMAKER NEEDS	1	21	17.6
10.	INSOMNIA DISORDER	G47.00	20	32.3
RUN TIME (H.M.S): 0.0.0				
End of report. PRESS ENTER:				

Figure 4-119: Frequency of Problems report example

4.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

Use the **FPRB** option to produce a report (Figure 4-121) that shows a list of the top **N Problem/POV** for visits that you select.

Below are the prompts:

- Enter Beginning Visit Date for Search

Specify the beginning visit date for the date range.

- Enter Ending Visit Date for Search

Specify the ending visit date for the date range. (Figure 4-120)

BH GENERAL RETRIEVAL		Dec 26, 2013 10:29:11		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEEENIN			
17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM			
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History It			
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov			
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid			
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov			
22) Case Admit Date	46) Axis IV	70) Designated Other Pro			
23) Case Closed Date	47) Axis V				
24) Case Disposition	48) Flag (Visit Flag)				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 4-120: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

The prompts continue:

- Include which POV/s.

Use one of the following:

– **P** (Primary POV only)

Or

– **S** (Primary and Secondary POVs)

- Select Type of Report.

Use one of the following:

- **L** (List of items with counts)

Or

- **B** (Bar Chart, required 132 column printer)
- How many entries do you want in the list (**5-100**).
 - Specify the number of entries, using any whole number (**5-100**).
- Demo Patient/Inclusion/Exclusion

Use one of the following:

- **I** (Include all patients)
- **E** (Exclude demo patients)
- **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)

Or

- **B** (Browse output on screen)

JUN 09, 2009				Page 1	
DEMO INDIAN HOSPITAL					
TOP 10 POV/Problem (Problem Code)'s.					
PRIMARY POV Only					
DATES: MAR 11, 2009 TO JUN 09, 2009					
No.	PROB CODE NARRATIVE	PROBLEM (POV) CODE#	RECS	ACT TIME (HRS)	
1.	MAJOR DEPRESSIVE DISORDERS	14	123	94.2	
2.	ANXIETY DISORDER	18	30	14.2	
3.	SCHIZOPHRENIC DISORDER	13	29	25.8	
4.	CROSS-CULTURAL CONFLICT	2	19	15.0	
5.	MARITAL PROBLEM	56	18	5.4	
6.	ALCOHOL ABUSE	29	16	14.1	
7.	ILLNESS IN FAMILY	55	16	4.3	
8.	HOUSING	80	15	8.0	
9.	SENILE OR PRE-SENILE CONDITION	9	14	9.7	
10.	BIPOLAR DISORDER	15	13	5.2	
RUN TIME (H.M.S): 0.0.0					
End of report. PRESS ENTER:					

Figure 4-121: Frequency of Problem by groupings report example

4.4.4 Frequency of Problems by Problem Category (FPRC)

Use the **FPRC** option to produce a report that generates a list of the top **N** **Problem/POV (Problem Category)** for selected visits.

The prompts are below:

- Enter Beginning Visit Date for Search.

Specify the beginning visit date for the date range.

- Enter Ending Visit Date for Search

Specify the ending visit date for the date range.

The application displays the **Visit Selection Menu** (Figure 4-122).

BH GENERAL RETRIEVAL		Dec 26, 2013 10:29:11		Page: 1 of 2	
Visit Selection Menu					
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all Visits type Q.					
1) Patient Name	25) Next Case Review Dat	49) Primary Provider			
2) Patient Sex	26) Appointment/Walk-In	50) Primary Prov Discipl			
3) Patient Race	27) Interpreter Utilized	51) Primary Prov Affilia			
4) Patient Age	28) Program	52) Prim/Sec Providers			
5) Patient DOB	29) Visit Type	53) Prim/Sec Prov Discip			
6) Patient DOD	30) Location of Encounte	54) POV (Prim or Sec)			
7) Ethnicity	31) Clinic	55) POV (Prob Code Grps)			
8) Veteran Status Y/N	32) Outside Location	56) Primary POV			
9) Living Patients	33) SU of Encounter	57) POV (Problem Categor			
10) Chart Facility	34) County of Service	58) POV Diagnosis Catego			
11) Patient Community	35) Community of Service	59) Procedures (CPT)			
12) Patient County Resid	36) Activity Type	60) Education Topics Pro			
13) Patient Tribe	37) Days in Residential	61) Prevention Activity			
14) Eligibility Status	38) Days in Aftercare	62) IPV SCREENING			
15) Class/Beneficiary	39) Activity Category	63) ALCOHOL SCREENING			
16) Medicare Eligibility	40) Local Service Site	64) DEPRESSION SCRFEEENIN			
17) Medicaid Eligibility	41) Number Served	65) SUICIDE RISK ASSESSM			
18) Priv Ins Eligibility	42) Type of Contact	66) Personal History Ite			
19) Patient Encounters O	43) Activity Time	67) Designated MH Prov			
20) Patient Flag Field	44) Inpatient Dispositio	68) Designated SS Provid			
21) Case Open Date	45) PCC Visit Created	69) Designated A/SA Prov			
22) Case Admit Date	46) Axis IV	70) Designated Other Pro			
23) Case Closed Date	47) Axis V				
24) Case Disposition	48) Flag (Visit Flag)				
+ Enter ?? for more actions					
S Select Item(s)	+ Next Screen	Q Quit Item Selection			
R Remove Item(s)	- Previous Screen	E Exit Report			
Select Action: S//					

Figure 4-122: Visit Selection Menu options example

Use this menu to determine visit data that will be selected for the report. If you do not select any item (immediately use the **Quit Item Selection** option), all visits will be used.

- Include which POVs.

Use one of the following:

- **P** (Primary POV only)

Or

– **S** (Primary and Secondary POVs).

- Select Type of Report.

Use one of the following:

– **L** (List of items with counts)

Or

– **B** (Bar Chart, requires 132 column printer)

- How many entries do you want in the list (**5-100**)?

– Specify the number of entries, using any whole number (**5-100**).

- Demo Patient/Inclusion/Exclusion

Use one of the following:

– **I** (Include all patients)

– **E** (Exclude demo patients)

– **O** (Include only demo patients)

- Do you want to use:

– **P** (Print output)

Or

– **B** (Browse output on screen)

The application displays the record selection criteria. After pressing **Enter**, the application displays the **Frequency of Problems by Problem Category** report (Figure 4-123).

JUN 09, 2009			Page 1	
DEMO INDIAN HOSPITAL				
TOP 10 Problem/POV (Problem Category)'s.				
PRIMARY POV Only				
DATES: MAR 11, 2009 TO JUN 09, 2009				
No.	CATEGORY NARRATIVE	CATEGORY CODE	# RECS	ACT TIME (HRS)

1.	PSYCHOSOCIAL PROBLEMS	2	294	220.6
2.	MEDICAL/SOCIAL PROBLEMS	1	73	555798.6
3.	FAMILY LIFE PROBLEMS	5	37	11.5
4.	SOCIOECONOMIC PROBLEMS	8	27	12.4
5.	ADMINISTRATIVE PROBLEM	11	14	11.5
6.	ABUSE	3	10	5.1
7.	OTHER PATIENT RELATED	13	6	12.3
8.	EDUCATIONAL/LIFE PROBLEMS	10	8	5.9
9.	SCREENING	12	7	4.9
10.	PREGNANCY/CHILDBIRTH PROBLEMS	6	6	1.8
RUN TIME (H.M.S): 0.0.1				
End of report: PRESS ENTER:				

Figure 4-123: Frequency of Problems by Problem Category report example

4.4.5 Suicide Related Reports (SUIC)

Use the **SUIC** option to access the **Suicide Reports** menu (Figure 4-124).

```

*****
**      IHS Behavioral Health System      **
**              Suicide Reports              **
*****
Version 4.0 (Patch 13)

DEMO INDIAN HOSPITAL

SSR   Aggregate Suicide Form Data - Standard
SAV   Aggregate Suicide Data Report - Selected Variables
SDEL  Output Suicide Data in Delimited Format
SGR   Listing of Suicide forms by Selected Variables
SUIC  Suicide Report (Age&Sex)
SPOV  Suicide Purpose of Visit Report

Select Suicide Related Reports Option:

```

Figure 4-124: Options on Suicide Report menu example

4.4.5.1 Aggregate Suicide Form Data–Standard (SSR)

This report will tally the data items specific to the **Suicide Form** for a date range, community, and type of suicidal behavior (specified by the user).

Below are the prompts:

- Enter Beginning Date of Suicide Act
 - Specify the beginning date for the date range.
- Enter Ending Date of Suicide Act
 - Specify the ending date for the date range.
- Report on Suicide Forms for Suicide Acts that occurred in:

Use one of the following:

- **O** (One particular Community)

Or

- **A** (All Communities)

If you use **O**, other prompts will display.

- Include which Suicidal Behaviors (**0-9**).

The application displays the suicide behaviors. You can respond with a list or a range.

- Age Groups can be modified by typing **Yes** at the prompt. You then need to enter the starting age of each group until completed. Press **Enter** with it blank one time. It will then ask for the oldest age allowed. The new age groupings will then be displayed.
- Demo Patient/Inclusion/Exclusion
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to:
Use one of the following:
 - **P** (Print output)
 Or
 - **B** (Browse output on screen)

Figure 4-125 shows the **Aggregate Suicide Form Data–Standard** report.

DEMO INDIAN HOSPITAL	Jul 13, 2009	Page 1
***** AGGREGATE SUICIDE FORM DATA - STANDARD*****		
Act Occurred: Jan 14, 2009 - Jul 13, 2009		
Community where Act Occurred: ALL Communities		

Age Range: 20-24 years	Total # of Suicide Forms: 1	
Suicidal Behavior: ATT SUICIDE W/ ATT HOMICIDE		REPORT TOTALS 1 100%
Event logged by Discipline: PSYCHIATRIST		1 100%
Event logged by Provider: DEMO,RYAN		1 100%
Sex: MALE		1 100%
Employed: PART-TIME		1 100%
Tribe of Enrollment: CHEROKEE NATION OF OKLAHOMA		1 100%
Community of Residence: WELLING		1 100%
Relationship: MARRIED		1 100%
Education: COLLEGE GRADUATE		1 100%
Method: GUNSHOT		1 100%
HANGING		1 100%
Previous Attempts: 1		1 100%

Substance Use Involved:	NONE	1	100%
Location of Act:	WORK	1	100%
Disposition:	IN-PATIENT MENTAL HEALTH TREAT	1	100%
Contributing Factors:	DEATH OF FRIEND OR RELATIVE	1	100%
Age Range: 45-64 years	Total # of Suicide Forms: 13		
		REPORT TOTALS	
Suicidal Behavior:	IDEATION WITH PLAN AND INTENT	4	31%
	ATTEMPT	3	23%
	ATT SUICIDE W/ ATT HOMICIDE	3	23%
	ATT SUICIDE W/ COMP HOMICIDE	2	15%
	COMP SUICIDE W/ ATT HOMICIDE	1	8%
Event logged by Discipline:	ACUPUNCTURIST	7	54%
	PSYCHIATRIST	6	46%
Event logged by Provider:	DEMO,DENISE	1	8%
	DEMO,BJ	7	54%
	DEMO,RYAN	5	38%
Race:	AMERICAN INDIAN OR ALASKA NATIVE	1	100%
	Ethnicity: NOT HISPANIC OR LATINO	1	100%
	Veteran's Status: NO	1	100%
Enter RETURN to continue or '^' to exit:			

Figure 4-125: Aggregate Suicide Form Data—Standard report example

4.4.5.2 Aggregate Suicide Form Data—Selected Variables (SAV)

This report will tally the selected data items for **Suicide Forms** in a particular date range.

4.4.5.3 Output Suicide Data in Delimited Format (SDEL)

This report will extract all data elements on the **Suicide Form** in a delimited form for a specified date range.

4.4.5.4 Listing of Suicide Forms by Selected Variables (SGR)

This report is a general retrieval type report that will list the selected data items for **Suicide Forms** in a particular date range. The user can also specify how to display the items in the printed report.

4.4.5.5 Suicide Report (Age & Sex) (SUIC)

This report will present, by age and sex, the number of individual patients who were seen for the following **POVs: 39, 40, and 41**, as well as **V62.84 (Suicidal Ideation)**.

4.4.5.6 Suicide Purpose of Visit Report (SPOV)

This report will display the **Suicide POVs (39, 40, 41)** as a percentage of the total number of **Behavioral Health Encounter Records (Encs)**. Any records containing the **ICD-9 code v62, 84, Suicidal Ideation** will be included in the tallies for **Problem Code 39**. A display by age and sex is also included.

Below are the prompts:

- Enter Beginning Visit Date
Specify the beginning visit date for the date range.
- Enter Ending Visit Date
Specify the ending visit date for the date range.
- Run the Report for which Program?
Use one of the following:
 - **O** (one program)
 - Or
 - **A** (all programs)
 If you use **O**, other prompts will display.
- Demo Patient Inclusion/Exclusion.
Use one of the following:
 - **I** (Include all patients)
 - **E** (Exclude demo patients)
 - **O** (Include only demo patients)
- Do you want to use:
 - **P** (Print output)
 - Or
 - **B** (Browse output on screen)

Figure 4-126 shows the **Suicide Purpose of Visit** report.

Behavioral Health				

* SUICIDE PURPOSE OF VISIT REPORT *				

VISIT Date Range: OCT 31, 2006 through NOV 30, 2006				
BOTH MALE AND FEMALE PATIENTS' VISITS				
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide				
Attempt/Gesture; 41 - Suicide Completed				
AGE GROUP	# Encs	# w POV 39	w/ POV 40	w/ POV 41
		V62.84/R45.851 & T14.91		w/ 39/40/41/ V62.84/R45.8

	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	7	35.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	6	30.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	5.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	10.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	20	100.0	0	0.0	0	0.0	0	0.0	0	0.0
MALE PATIENTS VISITS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
			V62.84/R45.851 & T14.91						V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	6	66.7	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0
FEMALE PATIENTS VISITS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
			V62.84/R45.851 & T14.91						V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	4	36.4	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
			V62.84/R45.851 & T14.91						V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	5	38.5	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - MALE PATIENTS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
			V62.84/R45.851 & T14.91						V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	50.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0
UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS										
39, V62.84, R45.851 - Suicide Ideation; 40 & T14.91-Suicide Attempt/Gesture; 41 - Suicide Completed										
AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41/	
			V62.84/R45.851 & T14.91						V62.84/R45.8	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	3	33.3	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

85+ yrs	2	22.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Figure 4-126: Suicide Purpose of Visit report example

4.5 Print Standard Behavioral Health Tables (TABL)

Use the **TABL** option to print the various **BH tables (activity code, clinical codes, and BH Problem Codes)**.

The **TABL** option accesses the **Print BH Standard Tables** menu (Figure 4-127).

```

*****
**      IHS Behavioral Health System      **
**      Print BH Standard Tables          **
*****
                        Version 4.0 (Patch 13)

                        DEMO INDIAN HOSPITAL

ACT    Print Activity Code Table
CLN    Print Clinic Codes

Select Print Standard Behavioral Health Tables Option:

```

Figure 4-127: Options on the Print BH Standard Tables menu example

4.5.1 Print Activity Code Table (ACT)

Use the **ACT** option to print the **Activity Code** table (Figure 4-128).

XX	May 04, 2009	Page 1		
***** BEHAVIORAL HEALTH ACTIVITY CODES *****				
CODE	DESCRIPTION	CATEGORY	PCC	MNE
01	TWELVE STEP WORK - GROUP	PATIENT SERV	YES	TSG
02	TWELVE STEP WORK - INDIVIDUAL	PATIENT SERV	YES	TSI
03	TWELVE STEP GROUP	PATIENT SERV	NO	TWG
04	RE-ASSESSMENT, PATIENT PRESENT	PATIENT SERV	YES	RAS
05	RE-ASSESSMENT, PATIENT NOT PRESENT	SUPPORT SERV	NO	
11	SCREENING-PATIENT PRESENT	PATIENT SERV	YES	SCN
12	ASSESSMENT/EVALUATION-PATIENT PRESENT	PATIENT SERV	YES	EVL
13	INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT	PATIENT SERV	YES	IND

14	FAMILY/GROUP TREATMENT-PATIENT PRESENT	PATIENT SERV	YES	FAM
15	INFORMATION AND/ OR REFERRAL-PATIENT PRESENT	PATIENT SERV	YES	REF
16	MEDICATION/MEDICATION MONITORING-PATIENT PRESENT	PATIENT SERV	YES	MED
17	PSYCHOLOGICAL TESTING-PATIENT PRESENT	PATIENT SERV	YES	TST
18	FORENSIC ACTIVITIES-PATIENT PRESENT	PATIENT SERV	YES	FOR
19	DISCHARGE PLANNING-PATIENT PRESENT	PATIENT SERV	YES	DSG
20	FAMILY FACILITATION-PATIENT PRESENT	PATIENT SERV	YES	FAC
21	FOLLOWTHROUGH/FOLLOWUP-PATIENT PRESENT	PATIENT SERV	YES	FOL
Enter RETURN to continue or '^' to exit:				

Figure 4-128: Behavioral Health Activity Codes report example

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Appendix B Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (ROB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS website:

<https://home.ihs.gov/security/index.cfm>.

Note: Users must be logged on to the IHS D1 Intranet to access these documents.

The ROB listed in the following sections are specific to RPMS.

B.1 All RPMS Users

In addition to these rules, each application may include additional ROB that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

B.1.1 Access

RPMS users shall:

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

B.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall:

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

B.1.3 Accountability

RPMS users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

B.1.4 Confidentiality

RPMS users shall:

- Be aware of the sensitivity of electronic and hard copy information and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not:

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

B.1.5 Integrity

RPMS users shall:

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not:

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

B.1.6 System Logon

RPMS users shall:

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

B.1.7 Passwords

RPMS users shall:

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not:

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

B.1.8 Backups

RPMS users shall:

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

B.1.9 Reporting

RPMS users shall:

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not:

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

B.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall:

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

B.1.11 Hardware

RPMS users shall:

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not:

- Eat or drink near system equipment.

B.1.12 Awareness

RPMS users shall:

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

B.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall:

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not:

- Disable any encryption established for network, internet, and Web browser communications.

B.2 RPMS Developers

RPMS developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not:

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

B.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not:

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Caret

The caret (^) symbol is obtained by pressing Shift-6.

Command

The instructions you give the computer to record a certain transaction. For example, selecting Payment or P at the command prompt tells the computer you are applying a payment to a chosen bill.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user's paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Data Elements

Data fields that are used in filling out forms in BHS.

Default Response

Many of the prompts in the BHS program contain responses that can be activated simply by pressing the Enter key. For example: Do you really want to quit? No//. Pressing the Enter key tells the system you do not want to quit. No// is considered the default response.

Device

The name of the printer to use when printing information. Home means the computer screen.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

FileMan

The database management system for RPMS.

Free-Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.

Frequency

The number of times a particular situation occurs in a given amount of time.

Full Screen Editor

A word processing system used by RPMS. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up-, down-, right-, and left-arrow keys move the cursor around the screen, and a combination of upper- and lower-case letters can be used.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

Menu

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a tree structure because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the root at the top and the leaves at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical use interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI—Character User Interface.

Security Keys

Tools used to grant/restrict access to certain applications, application features, and menus.

Site Manager

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu

A menu that is accessed through another menu.

Suicide

The act of causing one's own death.

- Ideation with Intent and Plan – Serious thoughts of suicide or of taking action to take one's life with means and a specific plan
- Attempt – A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.
- Completion – A fatal self-inflicted destructive act with explicit or inferred intent to die.

Terminal Emulator

A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor

A word processing program that entering and editing text.

Word Processing Field

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

Acronym	Term Meaning
A/SA	Alcohol and Substance Abuse
BH	Behavioral Health
AMH	Behavioral Health System
CAC	Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading of BHS and other software programs for the end users. The CAC is sometimes referred to as the application coordinator or a "super-user."
CD	Chemical Dependency
EHR	Electronic Health Record
eSig	Electronic Signature
GPRA	Government Performance and Results Act; a federal law requiring federal agencies to demonstrate through annual reporting that they are using appropriated funds effectively to meet their Agency's missions.
GUI	Graphic User Interface, a Windows-like interface with drop-down menus, text boxes icons, and other controls that supports data entry using a combination of the computer mouse and keyboard.
HIPAA	Health Insurance Portability and Accountability Act
HHS	Department of Health and Human Services
HRCN	Health Record Chart Number
ID	Identification
IHS	Indian Health Service
IT	Information Technology
MH	Mental Health
OIT	Office of Information Technology
PC	Personal Computer
PCC	Patient Care Component
PHI	Protected Health Information
PHR	Personal Health Record
PII	Personally Identifiable Information
PPN	Patient Preferred Name
ROB	Rules of Behavior
RPMS	Resource and Patient Management System
QA	Quality Assurance

Acronym	Term Meaning
SAC	Standards and Conventions
SOP	Standard Operating Procedure
VPN	Virtual Private Network

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

Phone: (888) 830-7280 (toll free)

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