

## Using SB-MHITS care plan

*Clinical Assessment* is the first note you will fill out for a patient in SB-MHITS. If the patient is not a new patient, you'll use the *Clinical Assessment* template for the first visit you enter into MHITS, even if that visit is technically a follow-up visit.

The screenshot shows the SB-MHITS Initial Assessment form. The 'Care Plan' section is circled in red. The form includes sections for Patient Concerns, Prior Mental Health Treatment, Alcohol/Substance Abuse, Prior Medications, Current Medications, Care Plan, and Outcome Measures. The Care Plan section has a green plus sign to add a problem/goal.

NAME	DAILY DOSE	DURATION	HOW LONG AGO	EFFICACY	SIDE EFFECTS
<input type="text"/>					
<input type="text"/>					
<input type="text"/>					
<input type="text"/>					

NAME	DOSAGE
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>

Care Plan

Add another problem/goal

Outcome Measures (select which measures should appear in this note)

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Under Care plan, click the green plus sign to enter the first problem category. You can also wait to enter Care Plan problems until the follow-up note.

The close-up shows the Care Plan section with the following fields:

**Care Plan**

**Problem:** Category:  Sub-Category:

Cancel adding last problem/goal

Add another problem/goal

**Care Plan**

**Problem:** Category:  Sub-Category:

Cancel adding last problem/goal

Add another problem/goal

Use the green + sign to enter additional problems as appropriate. In this example, we will select one problem that we will measure with the PHQ9 and one problem we will measure with a custom 0-10 scale.

**Care Plan**

**Problem:** Category:  Sub-Category:

**Problem:** Category:  Sub-Category:

Cancel adding last problem/goal

Add another problem/goal

Directly below the care plan section is the outcome measures section. The screening tools selected by default are the PHQ9, the GAD7, and the SDQ conduct and attention subscales. This is the initial battery that new patients should receive. If you suspect other issues, you'll select the appropriate tools to assess those domains. For existing patients, if you already have a diagnosis, you can just select the tool that is most appropriate for symptom monitoring. The scales you select will appear below.

**Care Plan**

**Problem:** Category:  Sub-Category:

**Problem:** Category:  Sub-Category:

Cancel adding last problem/goal

Add another problem/goal

---

**Outcome Measures (select which measures should appear in this note)**

PHQ Depression Scale  GAD-7 Anxiety Scale

SDQ Strengths and Difficulties Questionnaire  CRAFFT Drug Use Scale

Trauma Screen

**PHQ Depression Scale (PHQ-9 Score :  )** history

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0      Not difficult at all     
  1      Somewhat difficult     
  2      Very difficult     
  3      Extremely difficult

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**GAD-7 Anxiety Scale (GAD-7 Score :  )** history

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious or on edge	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Not being able to stop or control worrying	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

Fill out the tools you have selected. Complete your note and click save.

At the next visit and all subsequent visits, you'll enter a follow-up note. If you have added one or more problems in the Clinical Assessment, you will automatically be prompted to fill out a more detailed care plan in the follow-up note:

Care Plan: Which goal(s) do you want to work on today?

**Goal: Not specified yet (Emotional/Behavioral Health/Depression)**

*Last updated by: Jessica Knaster Wasse, 1/29/2013*

**General Information**

Problem Category: \* Emotional/Behavioral Health  
 Problem Subcategory: \* Depression  
 Target Outcome Measurement Tool:   
 Target Outcome Measure:   
 Timeframe: \*   
 Date Opened: \*  /  /  today   
 Date Closed:  /  /  today   
 Closed Reason:   
 Clinical Lead: \*

Problem/Need (in client's words):

Goal (in client's words): \*

Barriers (in client's words):

Strengths (in client's words):

**Interventions**

Add intervention

**Goal: Not specified yet (Family Functioning/Family Disruption)**

*Last updated by: Jessica Knaster Wasse, 1/29/2013*

**General Information**

Problem Category: \* Family Functioning  
 Problem Subcategory: \* Family Disruption  
 Target Outcome Measurement Tool:   
 Target Outcome Measure:   
 Timeframe: \*   
 Date Opened: \*  /  /  today   
 Date Closed:  /  /  today   
 Closed Reason:   
 Clinical Lead: \*

Problem/Need (in client's words):

Goal (in client's words): \*

Barriers (in client's words):

Strengths (in client's words):

For each problem, you'll fill out the measurement tool, your target # to reach, timeframe, date opened, and more detail about the problem, goal, barriers, and strengths, ideally in the client's words. For our depression problem, the target populates automatically to the cutoff score for that measure.

Care Plan: Which goal(s) do you want to work on today?

**Goal: Not specified yet (Emotional/Behavioral Health/Depression)**

*Last updated by: Jessica Knaster Wasse, 1/29/2013*

**General Information**

Problem Category: \* Emotional/Behavioral Health  
 Problem Subcategory: \* Depression  
 Target Outcome Measurement Tool: PHQ Depression Scale  
 Target Outcome Measure: 10  
 Timeframe: \* 3 months  
 Date Opened: \* 1 / 29 / 2013 today   
 Date Closed:  /  /  today   
 Closed Reason:   
 Clinical Lead: \* Jessica Knaster Wasse

Problem/Need (in client's words):  
 feel tired and sad all the time

Goal (in client's words): \*  
 to have more days where I am happy

Barriers (in client's words):  
 easier not to leave the house

Strengths (in client's words):  
 my mom cares about me and I want to get better grades

The tool you've selected, in this case the PHQ9, will pop up directly below your problem information. Even though you entered a PHQ9 at the initial assessment, the graph will be blank at this time because the care plan only graphs results on or before the date the problem was opened.

Patient | Caseload | Tools | Logout | Search Patient: | Hello, Jessica (Jessica.Knaster)

### Measurement History

### PHQ Depression Scale (PHQ-9 Score : 17)

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all  0      Somewhat difficult  1      Very difficult  2      Extremely difficult  3

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### Interventions

Add intervention

You can then add an intervention for each problem by clicking the green plus sign in the intervention section.

### Interventions

1

Modality : \* Counseling

Activity : Cognitive behavioral therapy

Add intervention

Then fill out the details for the problem. In this example we'll use a 0-10 scale where 10 is worst and 0 is best. The scale will pop up below the problem detail and the chart will be blank, because you have not entered any scores yet.

**General Information** Last updated by: Jessica Knaster Wasse, 1/29/2013

**Problem Category:** \* Family Functioning  
**Problem Subcategory:** \* Family Disruption

**Target Outcome Measurement Tool:** Basic 0-10 Scale  
**Target Outcome Measure:** 5  
**Timeframe:** 3 months  
**Date Opened:** 1 / 29 / 2013 today  
**Date Closed:** / / today  
**Closed Reason:**   
**Clinical Lead:** \*

**Problem/Need (in client's words):**  
 i yell at my mom too much

**Goal (in client's words):** \*  
 to not lose my temper with my mom. scale 0-10 with 10= worst it can be, 0 = perfect child

**Barriers (in client's words):**  
 it's hard to control my anger

**Strengths (in client's words):**  
 i do want to change

---

**Measurement History**

---

**Basic 0-10 Scale**

PLEASE RATE YOUR NEEDS IN THIS AREA TODAY.

0	No needs in this area
5	Moderate needs in this area
10	High needs in this area

0  
  1  
  2  
  3  
  4  
  5  
  6  
  7  
  8  
  9  
  10

Add an intervention for this problem by clicking the green + sign.

**Patient** | **Caseload** | **Tools** | **Logout** | **Search Patient:** | Hello, Jessica (Jessica.Knaster)

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**Basic 0-10 Scale**

PLEASE RATE YOUR NEEDS IN THIS AREA TODAY.

0	No needs in this area
5	Moderate needs in this area
10	High needs in this area

0  
  1  
  2  
  3  
  4  
  5  
  6  
  7  
  8  
  9  
  10

---

**Interventions**

**1** - **Modality:** \* Social  
**Activity:** journaling moods, sleep and meals

Add intervention +

Add another problem/goal +

---

**Outcome Measures (select which measures should appear in this note)**

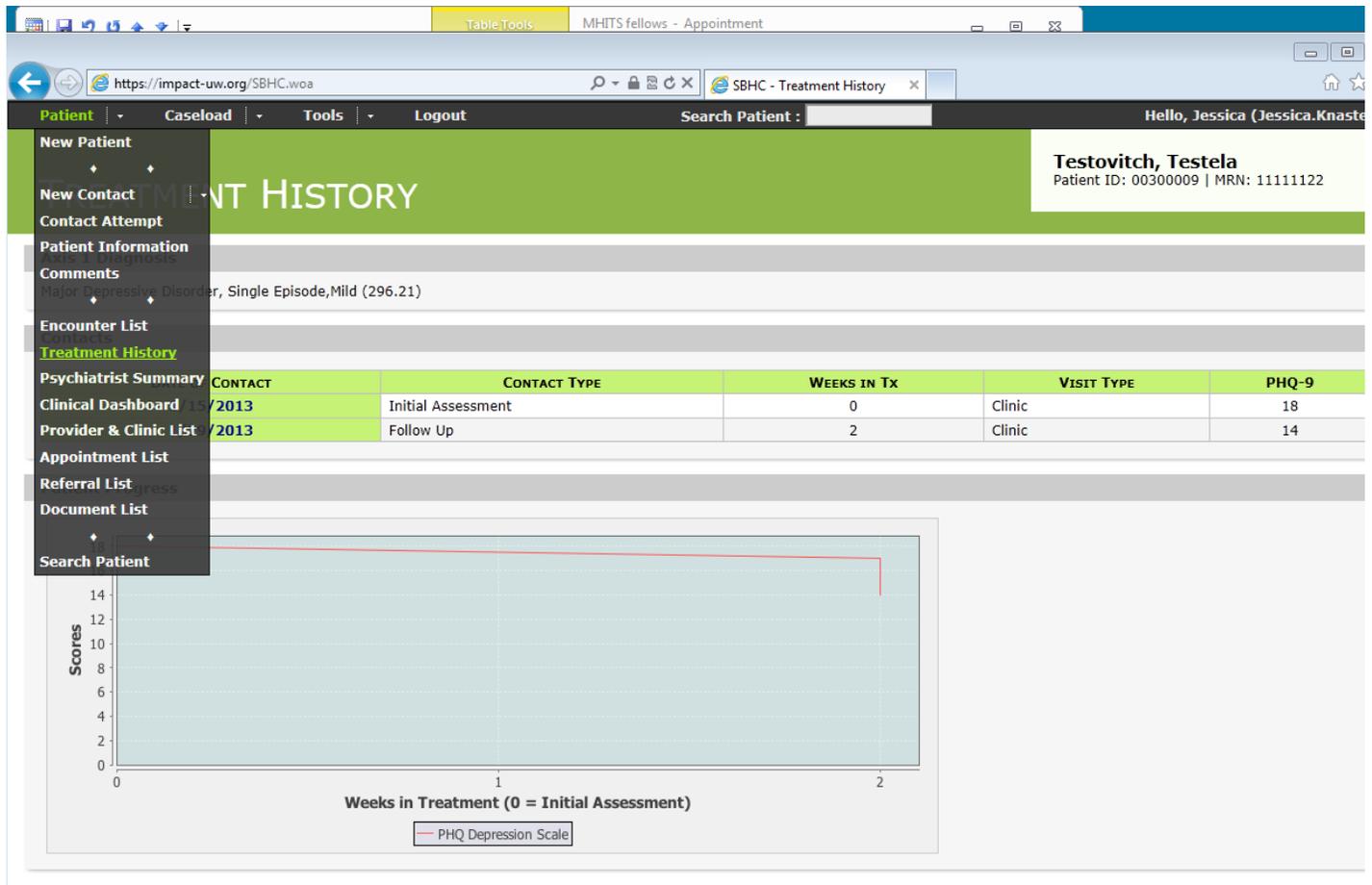
PHQ Depression Scale  
  GAD-7 Anxiety Scale  
 SDQ Strengths and Difficulties Questionnaire  
  CRAFFT Drug Use Scale  
 Trauma Screen

In the outcome measures box, the PHQ9 is automatically checked because we chose it as our outcome measure in the care plan. You can check additional tools if you'd like and they will appear below.

Finish your note and click add.

Over the course of your 2 sessions you have now entered 2 PHQ9s and 1 custom scale. We'll need 2 data points on the custom scale before we can see it on the care plan graph, but you can now see PHQ9 progress in the treatment history view. (You can't see the first Phq9 in the care plan view because the PHq9 you did at the initial assessment predates the problem opening date)

On the patient menu, select treatment history.



At your 3<sup>rd</sup> visit, you'll enter another follow-up note. The care plan is minimized by default, you'll want to expand both problems and enter your scores for that day.

Patient Caseload Tools Logout Search Patient:

Hello, Jessica (Jessica.Knaster)

# FOLLOW UP

Iestovitch, Iestela  
Patient ID: 00300009 | MRN: 11111122

Date of Contact : 1 / 29 / 2013 today

**Patient Concerns** history

**Current Medications** history

NAME	DOSAGE	ADHERENCE
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> of <input type="text"/> or Daily Dose: <input type="text"/>	<input type="text"/>

**Care Plan: Which goal(s) do you want to work on today?**

Goal: to have more days where I am happy (Emotional/Behavioral Health/Depression) expand

Goal: to not lose my temper with my mom. scale 0-10 with 10= worst it can be, 0 = perf... (Family Functioning/Family Disruption) expand

Add another problem/goal

**Outcome Measures (select which measures should appear in this note)**

PHQ Depression Scale  GAD-7 Anxiety Scale

SDQ Strengths and Difficulties Questionnaire  CRAFFT Drug Use Scale

Trauma Screen

**Safety Concerns** history

Flag as Safety Risk? :

**Mental Status Examination** history

In our example, we enter a PHQ9 for the depression problem and a 0-10 for the family functioning problem.

my mom cares about me and I want to get better grades

Measurement History



PHQ Depression Scale (PHQ-9 Score : )

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy	<input checked="" type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
10. If you checked off <u>any</u> problems on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	
<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3	

Patient | Caseload | Tools | Logout | Search Patient: | Hello, Jessica (Jessica.Kna

**Problem Category:** \* Family Functioning  
**Problem Subcategory:** \* Family Disruption  
**Target Outcome Measurement Tool:** Basic 0-10 Scale  
**Target Outcome Measure:** 5  
**Timeframe:** \* 3 months  
**Date Opened:** \* 1 / 29 / 2013   
**Date Closed:** / /   
**Closed Reason:**   
**Clinical Lead:** \* Jessica Knaster Wasse

**Problem/Need (in client's words):**  
 i yell at my mom too much

**Goal (in client's words):** \*  
 to not lose my temper with my mom. scale 0-10 with 10= worst it can be, 0 = perfect child

**Barriers (in client's words):**  
 it's hard to control my anger

**Strengths (in client's words):**  
 i do want to change

**Measurement History**

**Basic 0-10 Scale**

PLEASE RATE YOUR NEEDS IN THIS AREA TODAY.

0	No needs in this area
5	Moderate needs in this area
10	High needs in this area

0     1     2     3     4     5     6     7     8     9     10

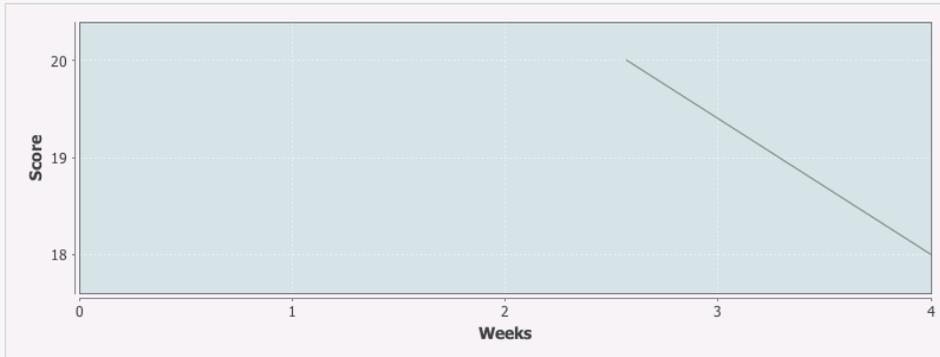
**Interventions** Last updated by: Jessica Knaster Wasse. 1/29/2013

Finish your note (or finish the required fields) and click save.

Voila- your progress is now mapped on your care plan graphs. You can view the care plan graphs in two places- the dashboard, or in the most recent follow up note.

Clinical Lead : Jessica Knaster Wasse

Measurement History



PHQ Depression Scale (PHQ-9 Score : 18, Severe depressive symptoms)

Last updated by: Jessica Knaster Wasse, 1/30/2013

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3
4. Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input checked="" type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
10. If you checked off <u>any</u> problems on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	
<input type="radio"/> 0	<input type="radio"/> 1	<input checked="" type="radio"/> 2	<input type="radio"/> 3	

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Interventions