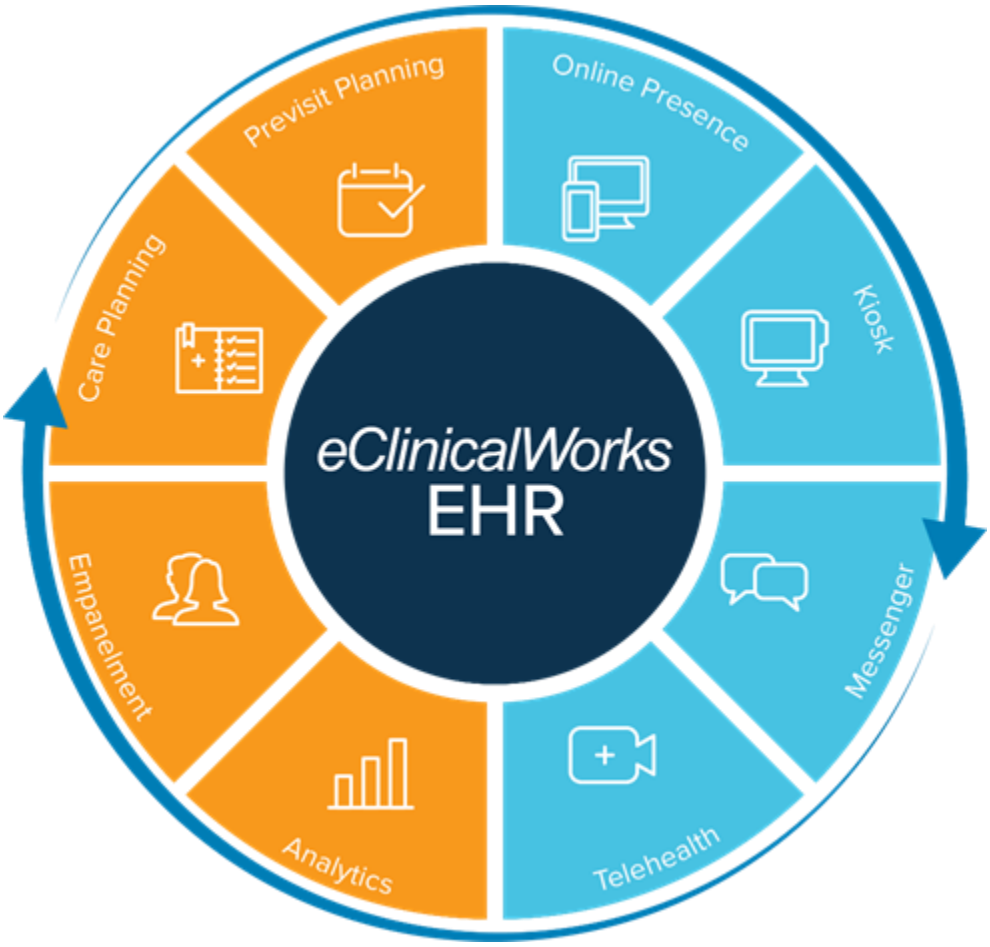
eClinicalWorks

Business Analysis Department



Workbook: PHM Care Plan- Behavioral Health

Client Name: Katy Trail Community Health Center

September 2020

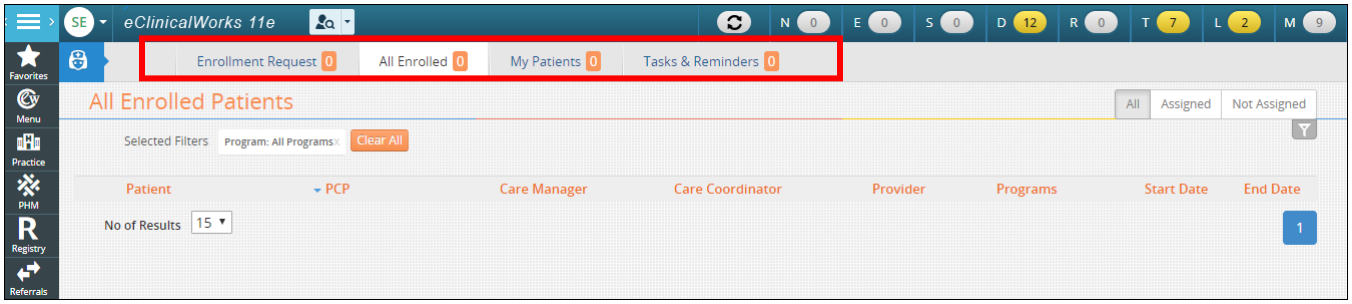
CONTENTS

PHM navigation band > Care Planning

Care Planning Dashboard

Care Planning Dashboard contains four tabs:

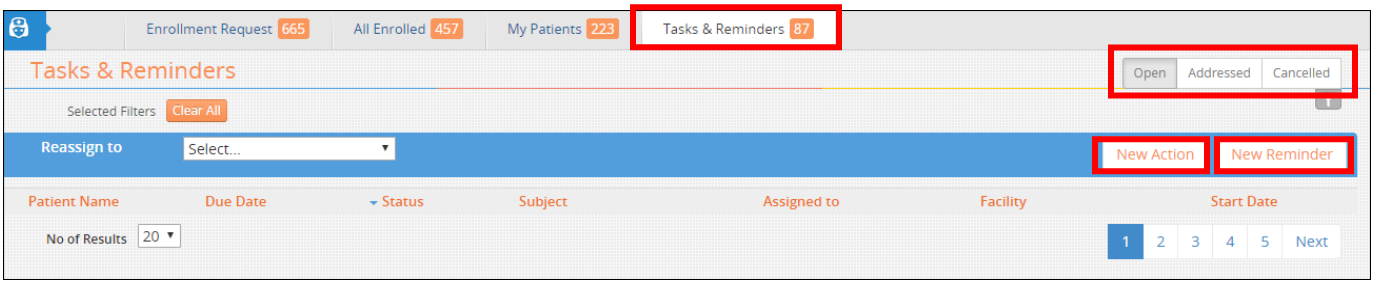
- Enrollment Request
- All Enrolled
- My Patients
- Tasks & Reminders



Tasks and Reminders

This tab has two features:

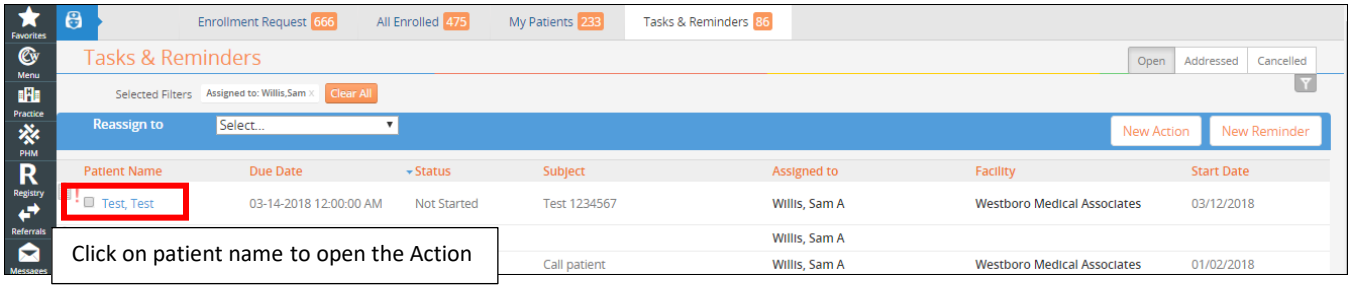
- Tasks (Actions) and Reminders.
- Both Actions and Reminders (Open, Addressed and Cancelled) can be viewed from this screen.



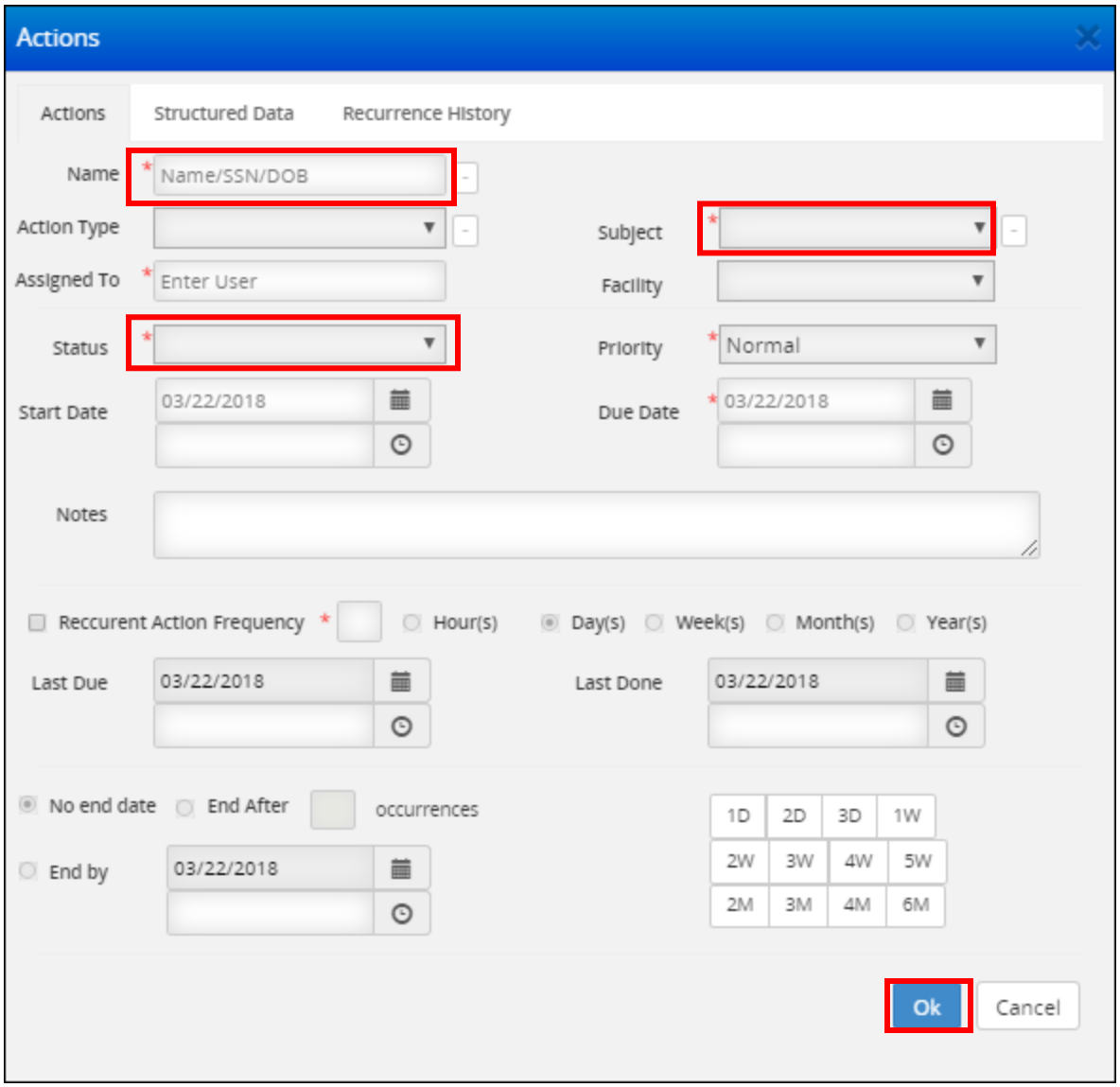
Actions

Actions enable users to create and assign patient specific tasks such as scheduling follow-up appointments or calling a PCP for referral, etc. You may assign an action to either self or any other staff member and track the progress until it is complete. Actions within the Care Planning Dashboard are the same as throughout eCW.

1. To open an Action assigned to the logged-in user:
    a) Click on the blue patient name from the 'Tasks and Reminders' page to open the Action.
    b) There are 3 tabs to this Actions window. Click on each tab to view additional details.
    c) To Address/ Close this action, change the 'Status' field to 'Completed'. This will remove this action from Open items and put it in the 'Addressed' bucket. All 'Closed' Actions can be viewed under the 'Addressed' tab.
    d) Click OK to save all changes.



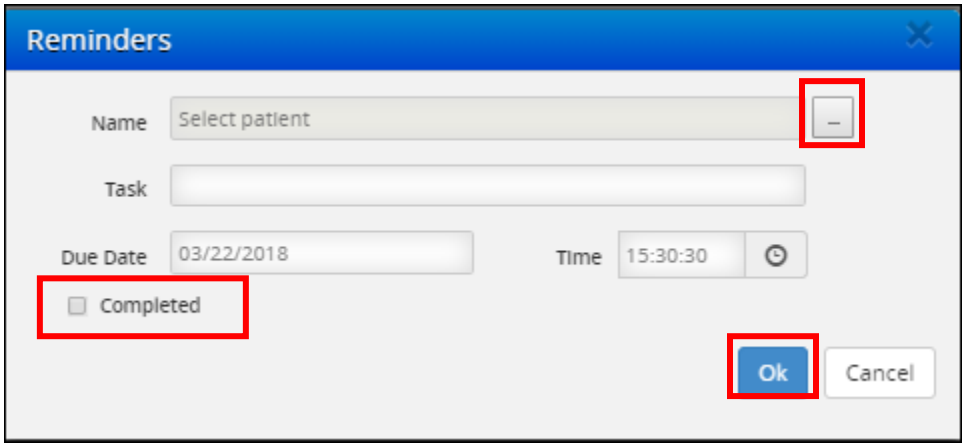
2. To Create a New Action
    a) Click on 'New Action' button, the following window will open:
    b) Fill out all appropriate details. 'Status' refers to the Action's progress. 'Assigned To' field indicates who receives the Action (the user will see it in their Tasks and Reminders window).
    c) Hit 'Ok' on the bottom of the window to save this new Action.


Actions
Actions
Structured Data
Recurrence History
Name
Name/SSN/DOB
Action Type
Subject
Assigned To
Enter User
Facility
Status
Priority
Normal
Start Date
03/22/2018
Due Date
03/22/2018
Notes
Reccurent Action Frequency
Hour(s)
Day(s)
Week(s)
Month(s)
Year(s)
Last Due
03/22/2018
Last Done
03/22/2018
No end date
End After
occurrences
End by
03/22/2018
1D
2D
3D
1W
2W
3W
4W
5W
2M
3M
4M
6M
Ok
Cancel

Reminders

Reminders are not as elaborate or detailed as Actions. These can be used to create reminder messages to your self. Note that Reminders do not sho in the 'T' jellybean or show in the patient record.

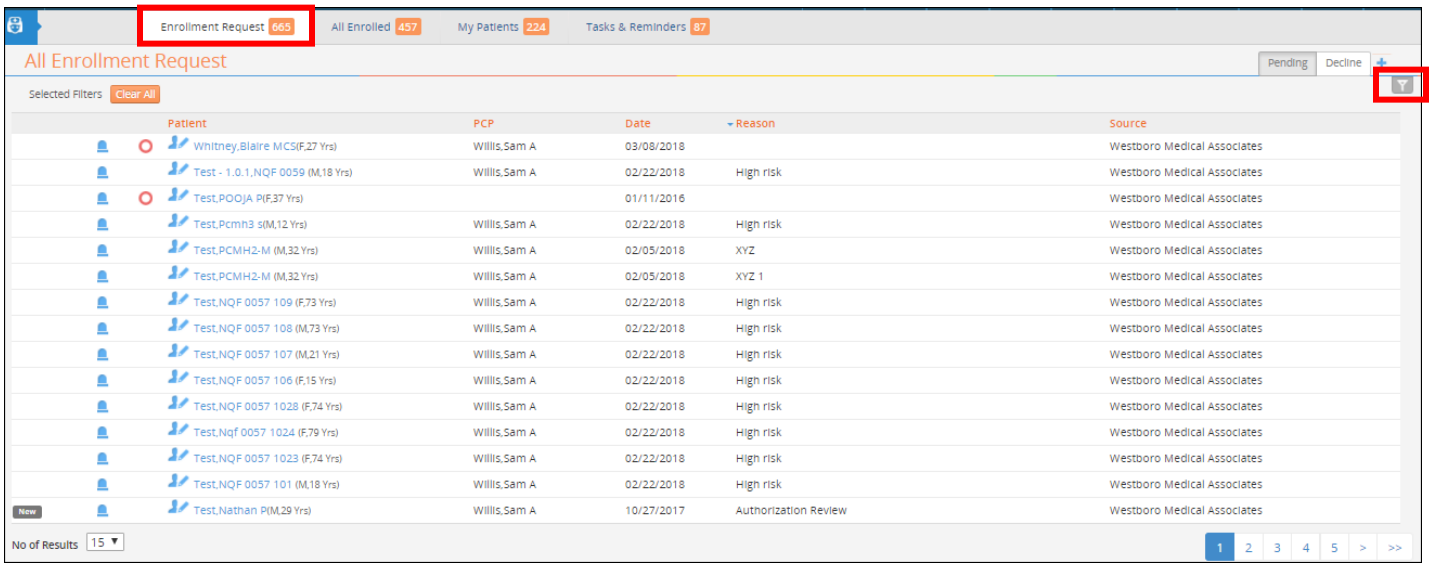
1. To open a previously created Reminder:
    a) Click on the blue patient name from the 'Tasks and Reminders' page to open the Reminder.
    b) In order to Close/ Address this action to remove it from the 'open' list, the check off the 'Completed' checkbox and hit OK to save.
2. To Create a New Reminder:
    a) Click on the blue patient name from the 'Tasks and Reminders' page to open the Reminder.
    b) New Reminder window will now open.
    c) Fill out all appropriate fiels and click "Ok" to save this new Reminder.



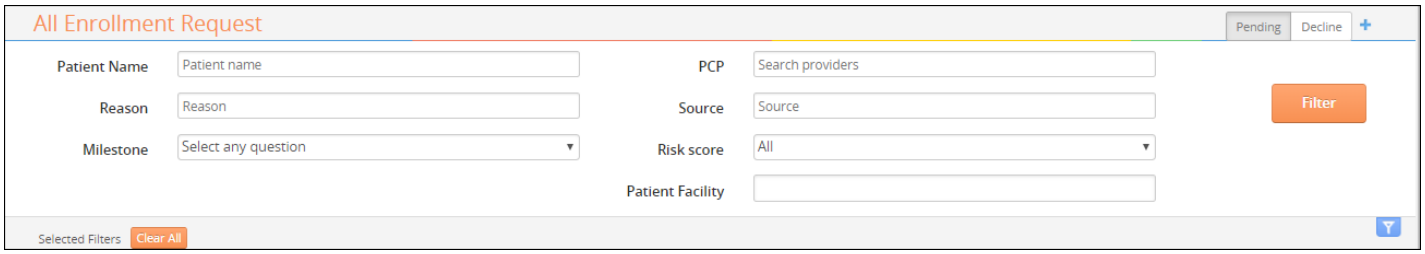
Enrollment Request

Note: Katy Trail Community Health Center will not be utilizing Enrollment Requests at this time.

The Enrollment Request tab is a list of patients who have been flagged by providers or staff that the patient is eligible for receiving care management and are pending to be enrolled to a care management and/or BH program and assigned a care team.

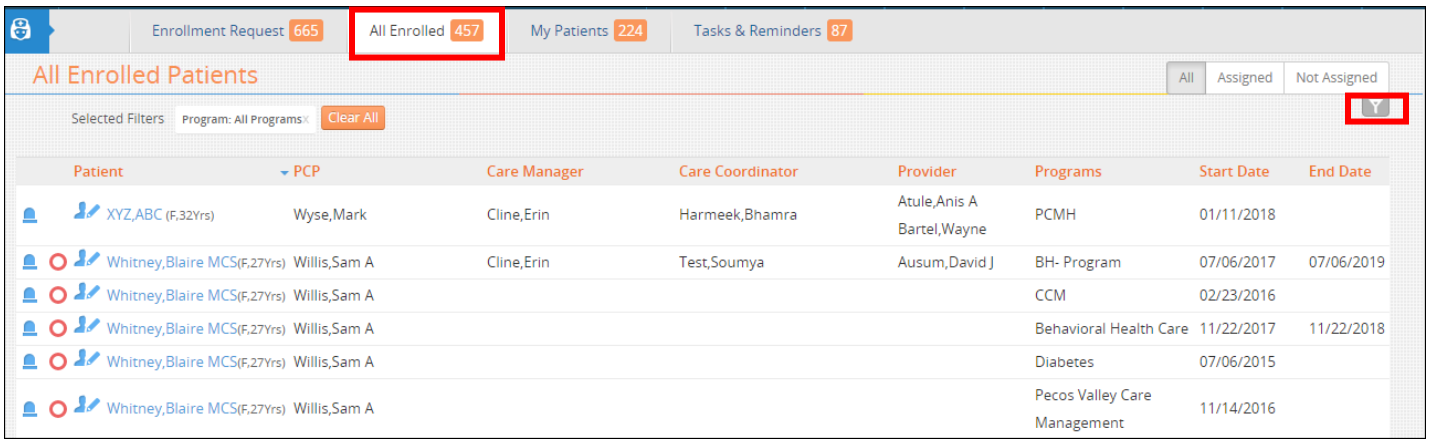


Click the 'Filter' icon to expand for additional filter options below:

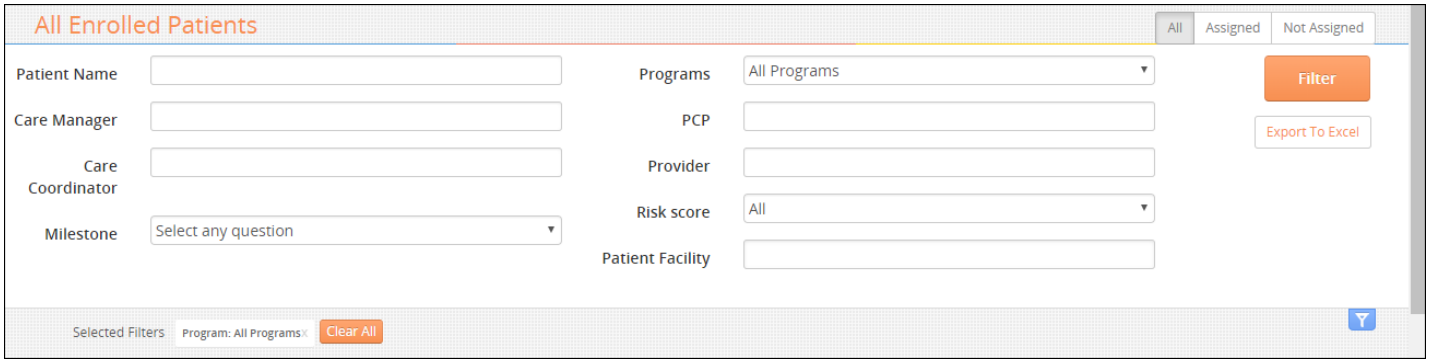


All Enrolled

The All Enrolled tab allows the Care Manager to view all patients who have been enrolled into care management and/or BH programs.

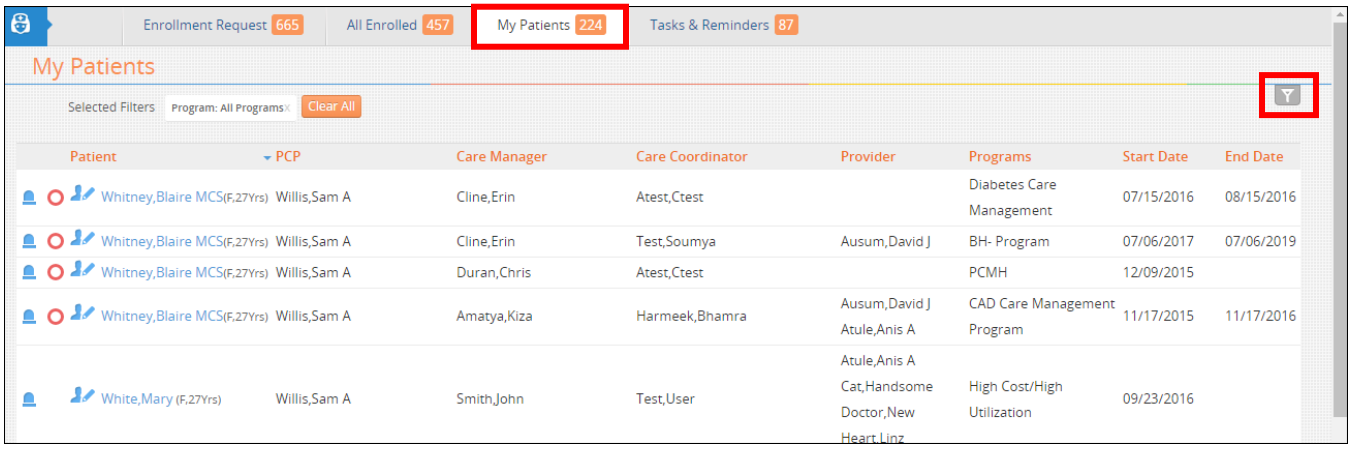


Click the 'Filter' icon to expand for additional filter options below:

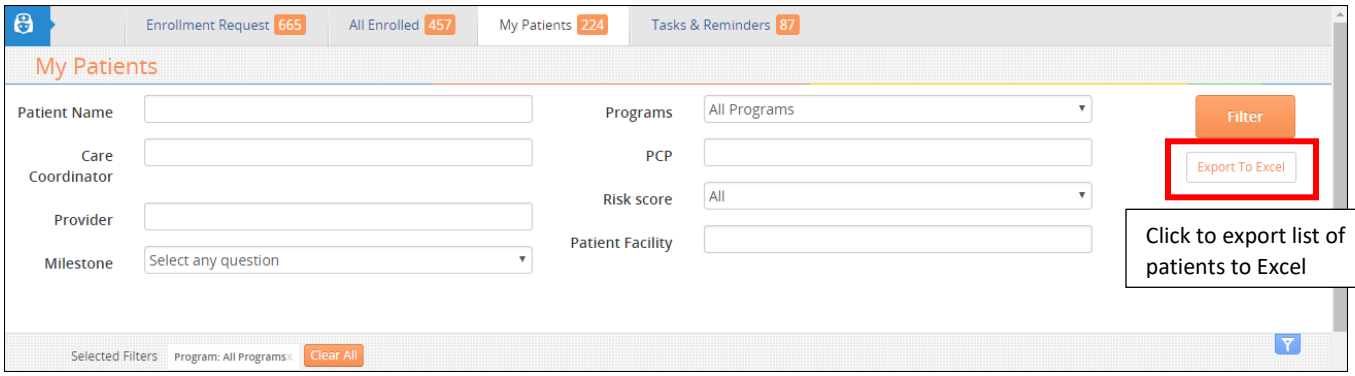


My Patients

The My Patients tab allows the care manager/care coordinator to see the patients assigned to them.



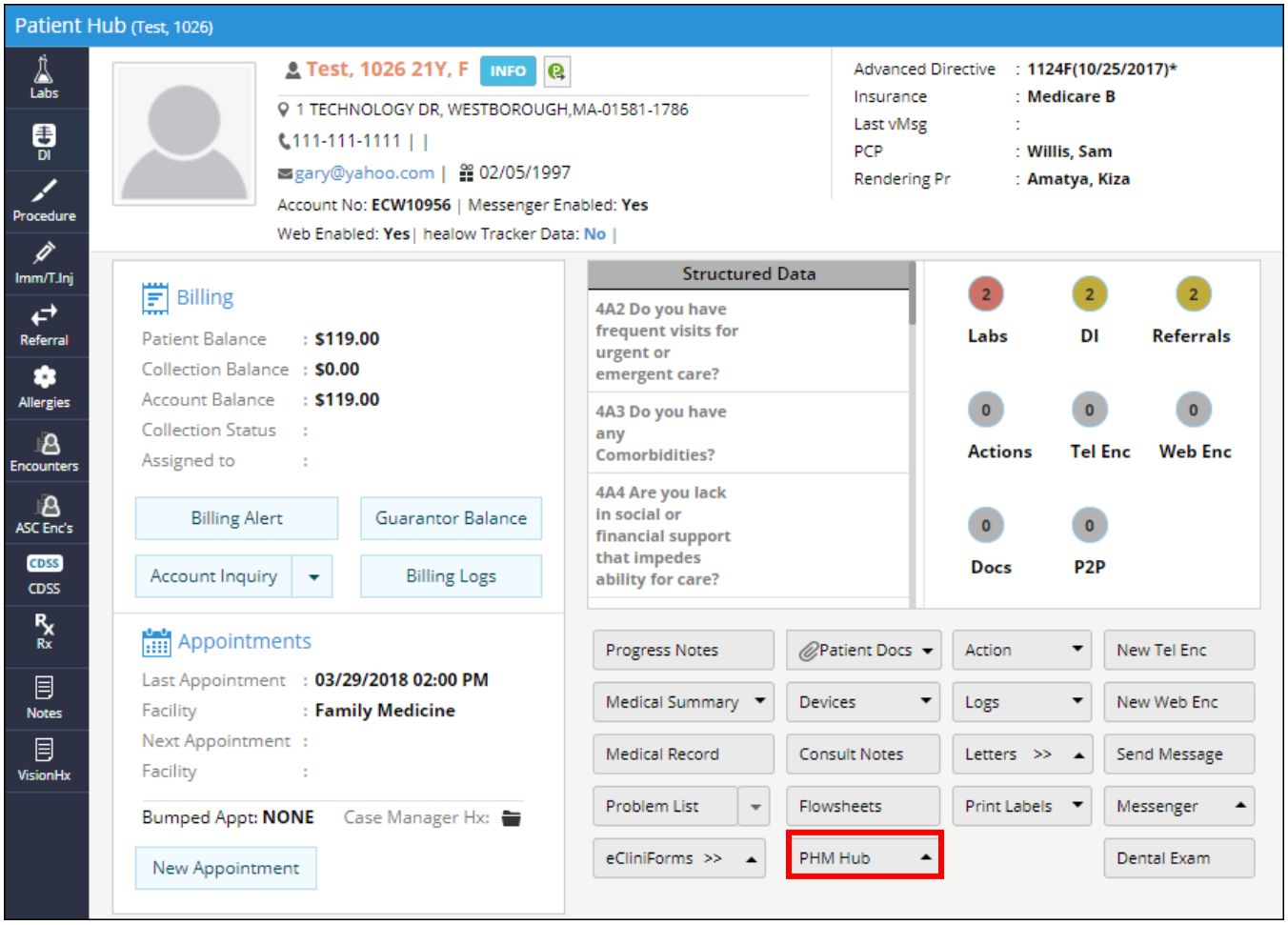
Click the ‘Filter’ icon to expand for additional filter options below:



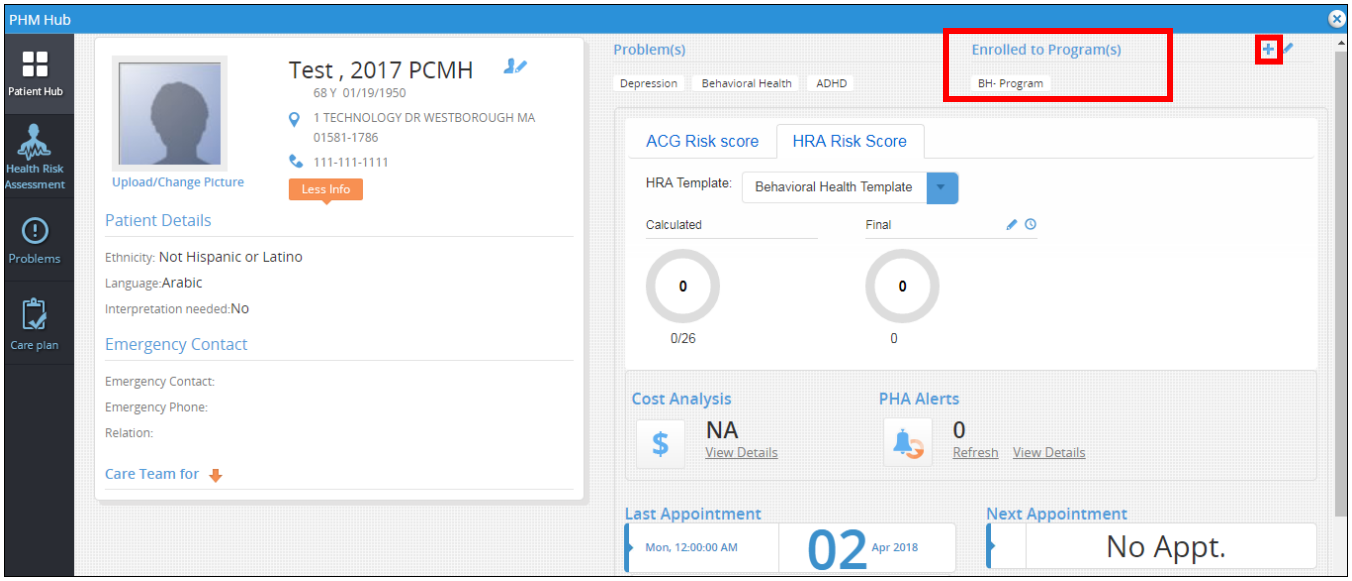
Patient Enrollment

Enrolling Patients from Patient PHM Hub

To access the PHM Hub, go to the patient's hub, find the PHM icon and click on it. You will be presented with several options; PHM Hub, Create Virtual Visit, and Enroll. Clicking 'Enroll' will allow you to directly enroll a patient or send an enrollment request to the Care Planning dashboard.



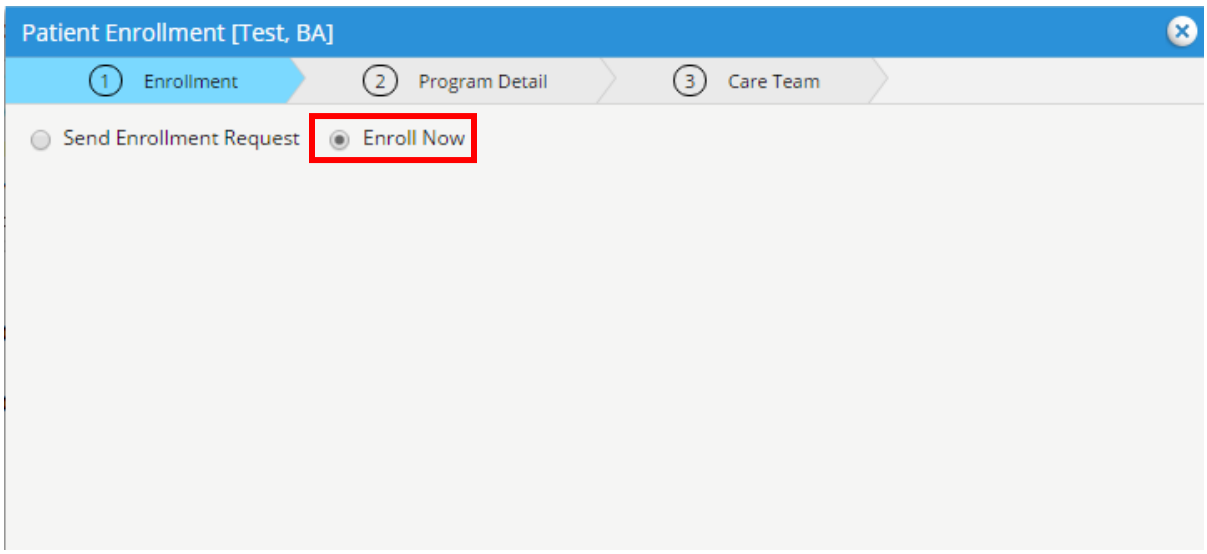
If you want to verify if a patient is already in a program, select PHM Hub from the patient hub. You can view the list of current programs under 'Enrolled to Programs'. When accessing the PHM patient hub, click on the blue '+' sign on the top right corner to initiate enrollment:



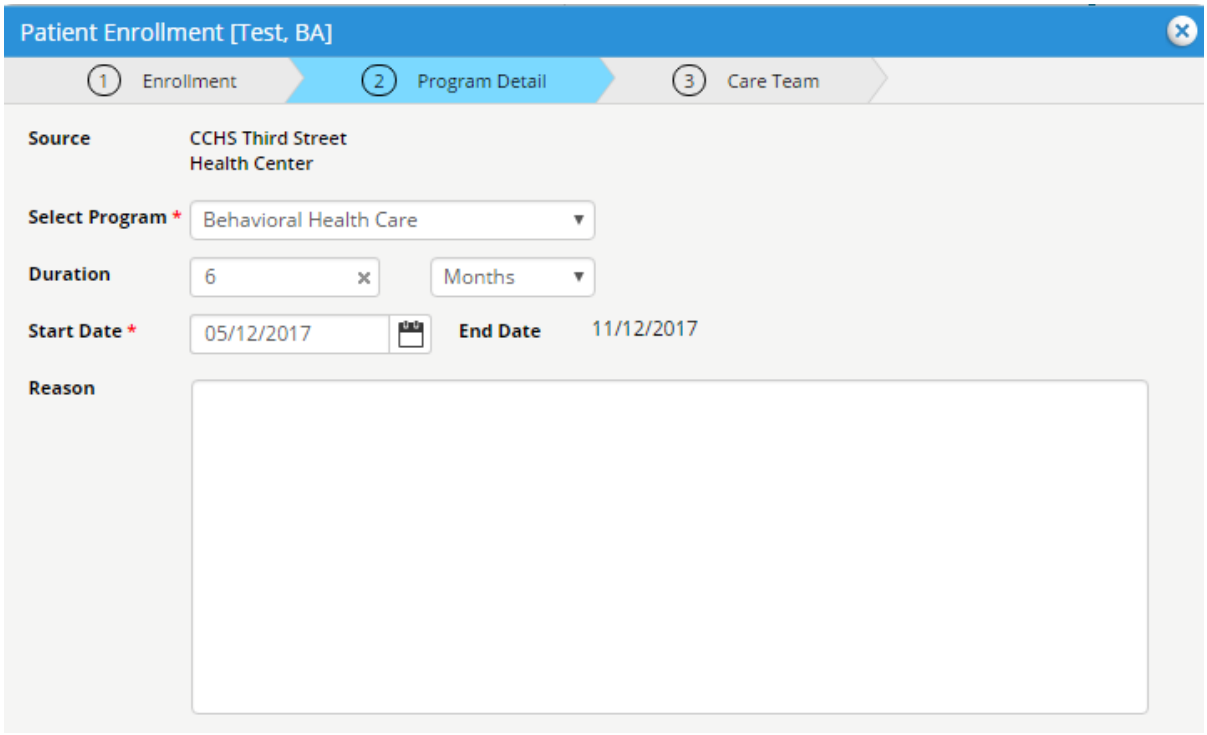
Program and Care Team Assignment

Note: Katy Trail Community Health Center will not be utilizing Enrollment Requests at this time.

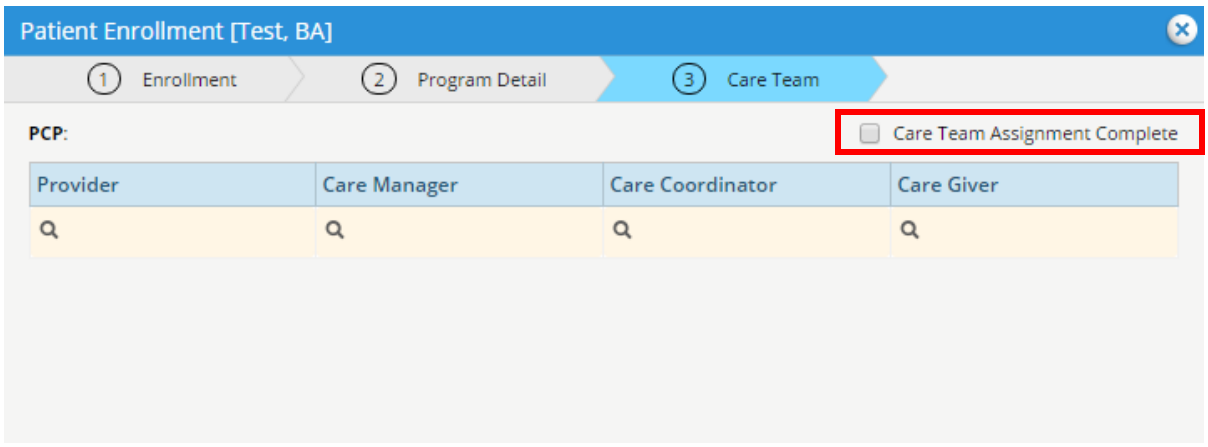
1. After initiating enrollment from the HUB or PHM HUB, you will see an option to choose 'Send Enrollment Request' or 'Enroll Now'. Choose Enroll Now and click Next.



2. In next screen, select the patient's program. The duration and reason fields are optional. Entering a duration will calculate an end date based off the start date and duration. Click Next when finished.



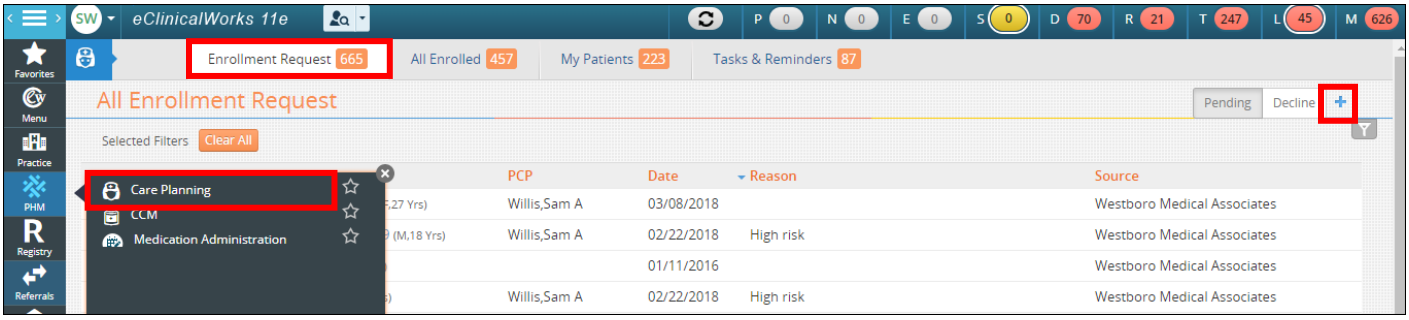
3. After selecting a program, you will be prompted to assign the patient's care team. The PCP and care giver fields pulls from the patients demographics screen. The provider field lists all practicing and referring providers. You may select multiple care coordinators but only one care manager. If care team assignment is completed, check the box 'Care Team Assignment Complete'. Leave unchecked if the the care team is pending. When finished, click 'I'm Done'.



Note: Katy Trail Community Health Center will not be utilizing Care Coordinators at this time.

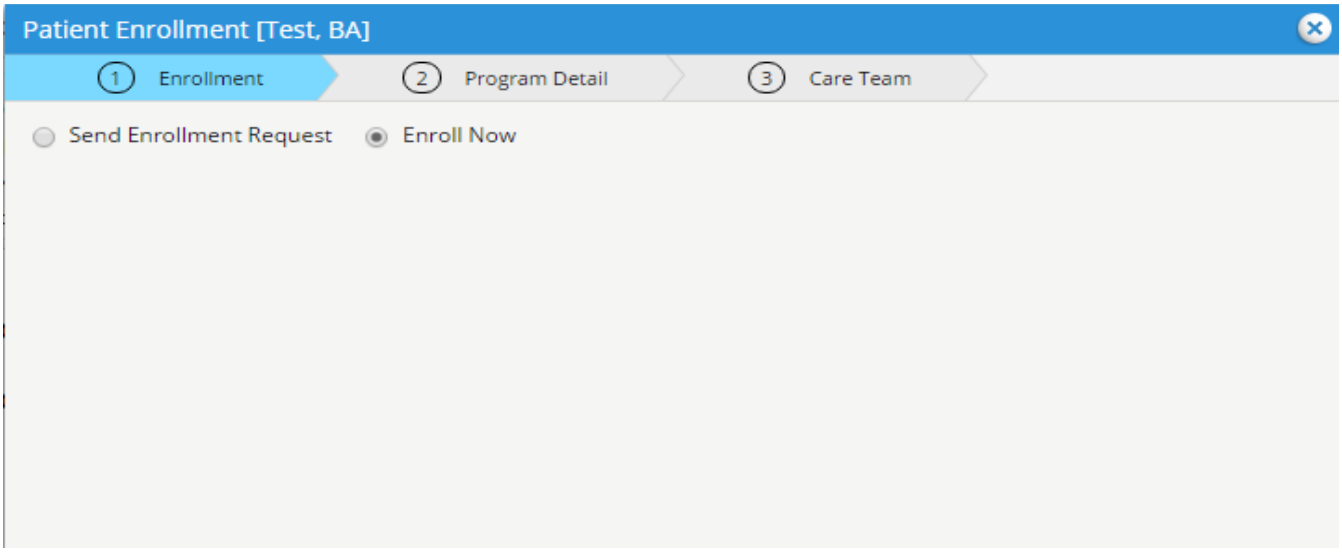
Enrolling Patients from the Care Planning 'Dashboard'

From the PHM navigation band, click on Care Planning 'Dashboard' and then click on the Enrollment Request tab. The patients listed are pending enrollment. To add a new enrollment request, click on the blue "+" icon at the top right of the screen.



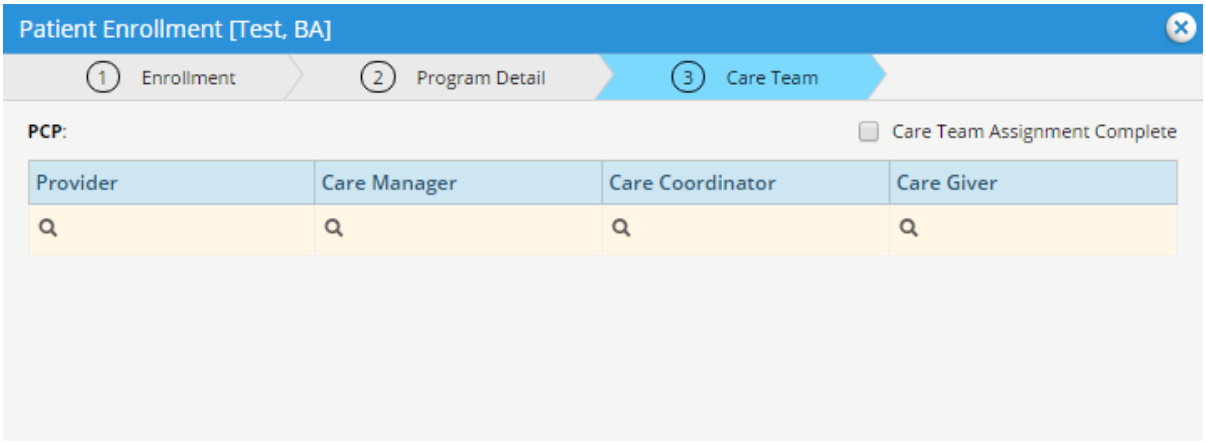
Using the 'Enroll Now" process, follow the steps below to complete the Enrollment process:

1. This will open the Patient Enrollment window, select Enroll Now, click "Next".



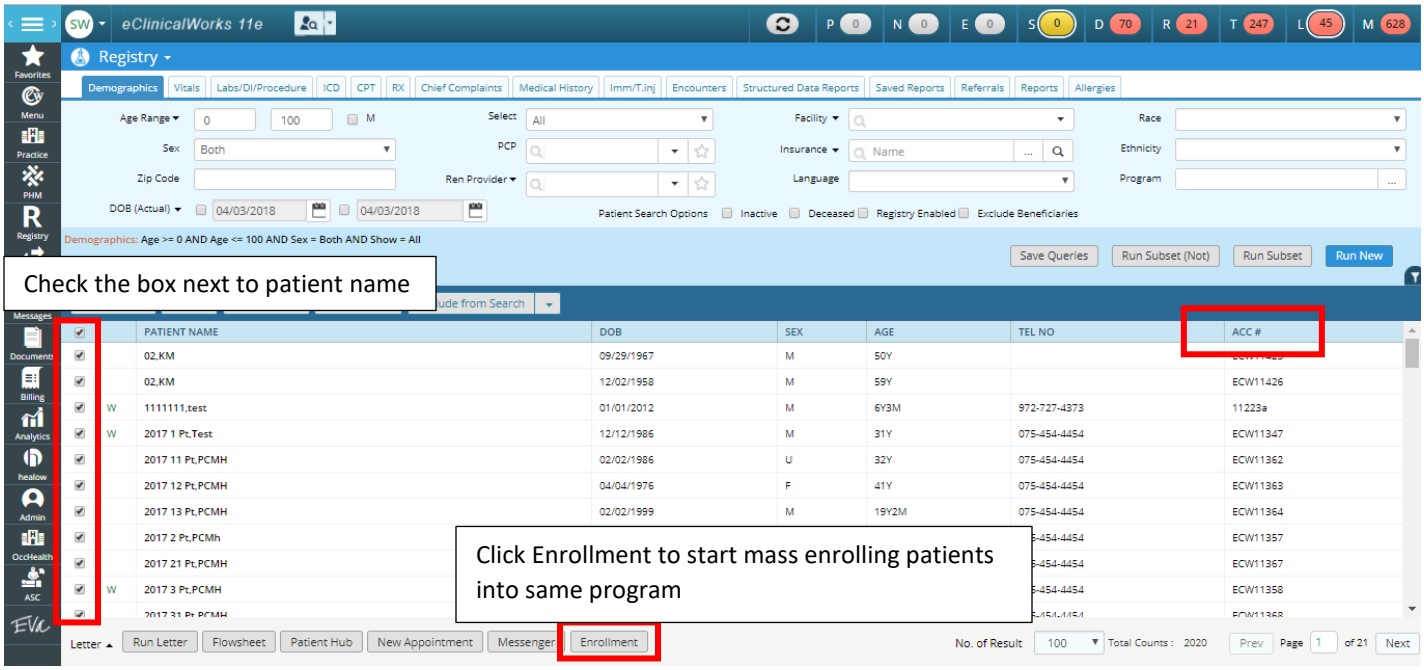
2. Click the "…" button to search for a patient and click "Next".

3. Complet the Care Team Assignment, select Care Team Assignment Complete.

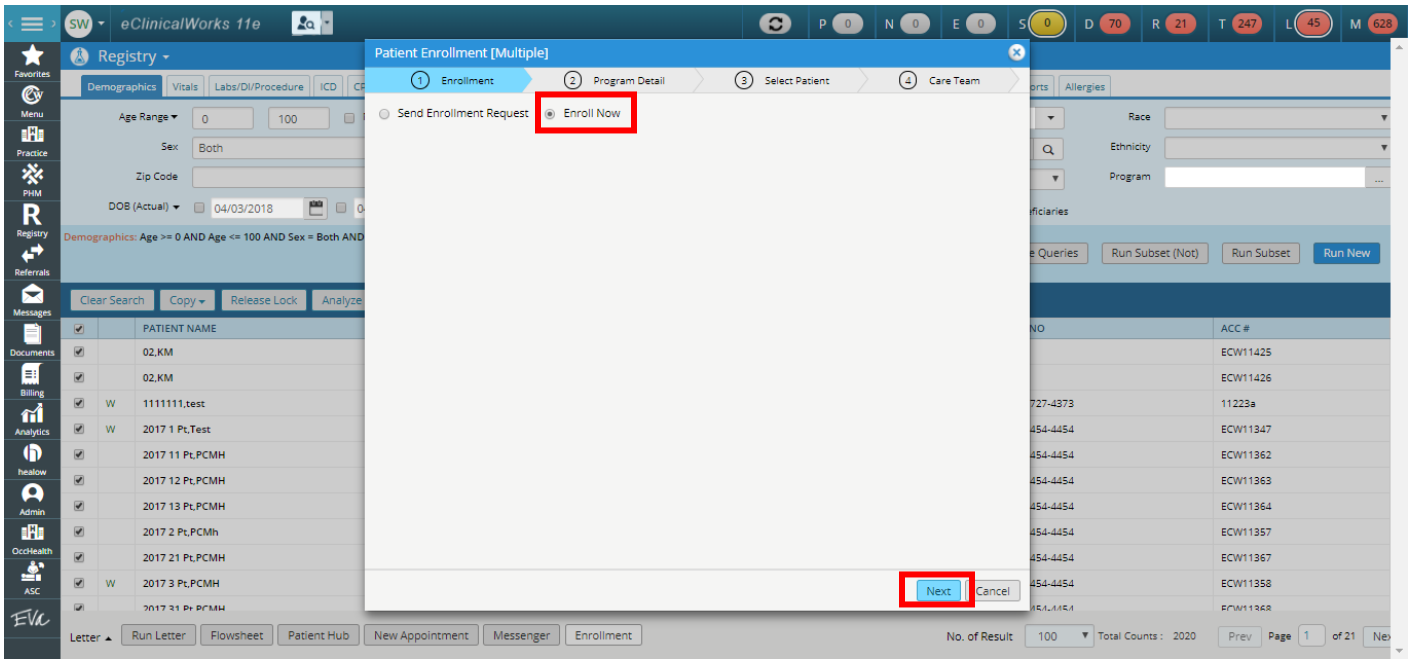


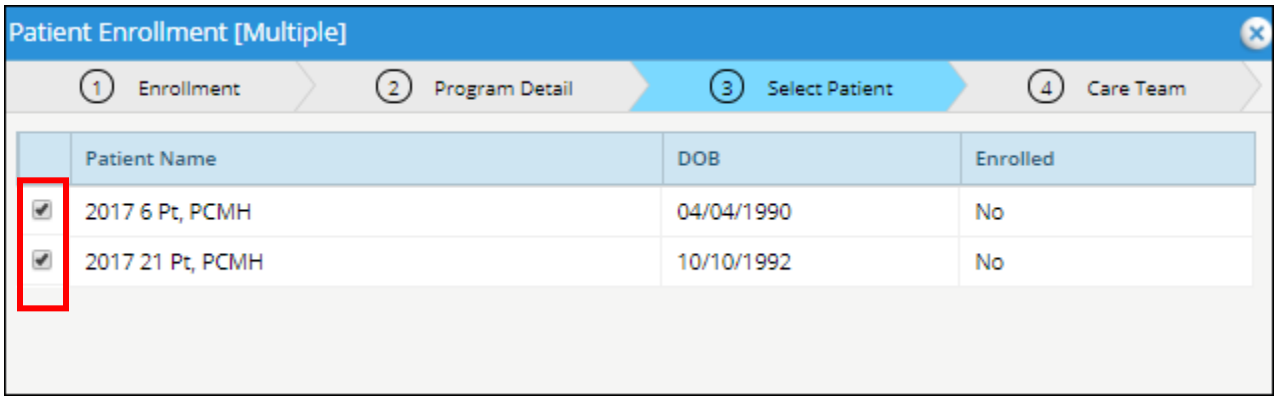
Enrolling Patients from the Registry

From the Registry, you can filter by specific criteria and enroll individual patients into a program or mass enroll multiple patients into the same program.



1. To start enrollment, check the box next to the patient(s) name and click ‘Enrollment’.
2. Select ‘Enroll Now’ and click Next.



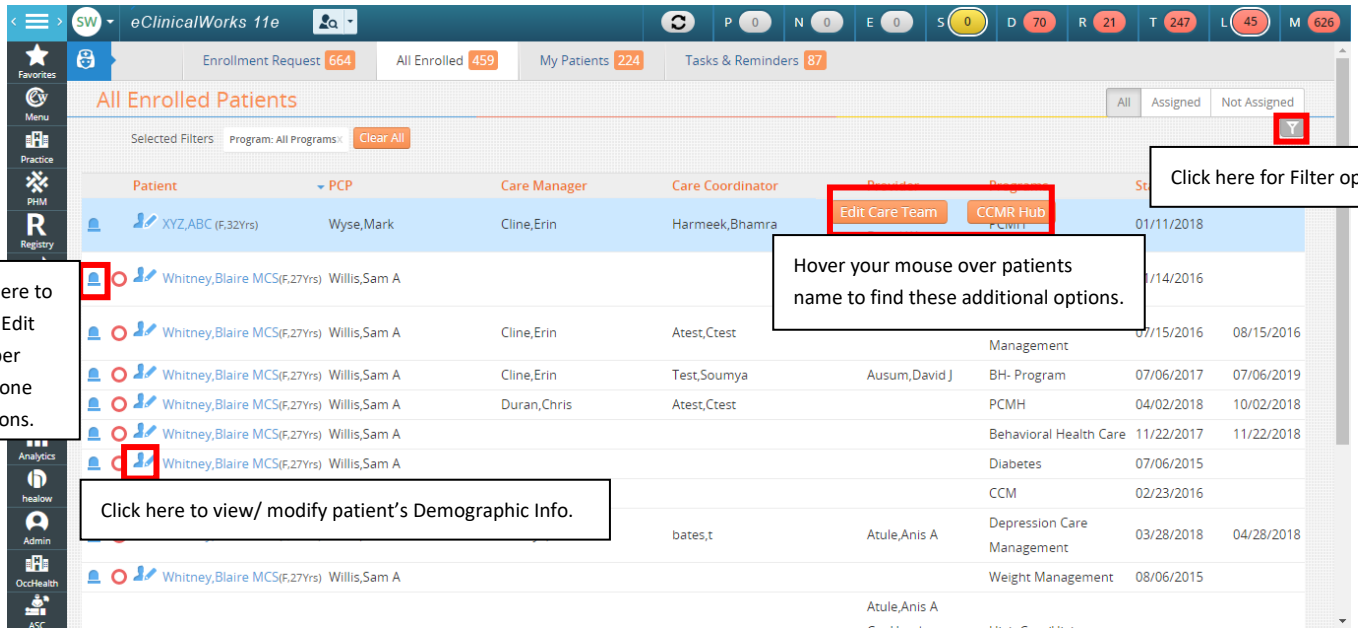


3. After selecting a program, you will be prompted to confirm patient(s) to be enrolled in same program and assign the care team. The PCP and care giver fields pull from the patient's demographics screen. The provider field lists all practicing and referring providers. If care team assignment is completed, check the box 'Care Team Assignment Complete'. Leave unchecked if the care team is pending. When finished, click 'I'm Done'.

Care Planning 'Dashboard'

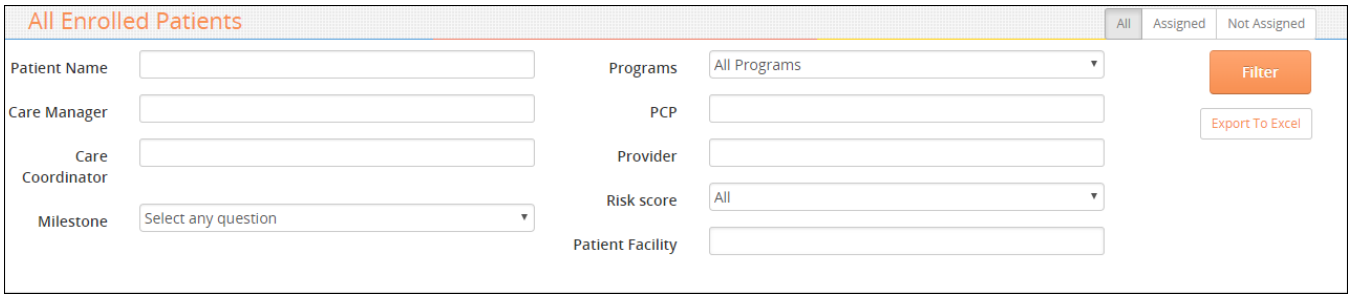
The Care Planning 'Dashboard' can be used by Care Managers or Care Coordinators to view and manage their patients. Using this window, the logged in user can view and answer 'Member Milestone' questions, edit a patient's Care Team assignment, view a patient's PHM Hub and view all patients Enrolled into specific or all programs.

To access Care Planning 'Dashboard', click on 'Care Planning' on the top of the window as shown below:



Care Planning Filters

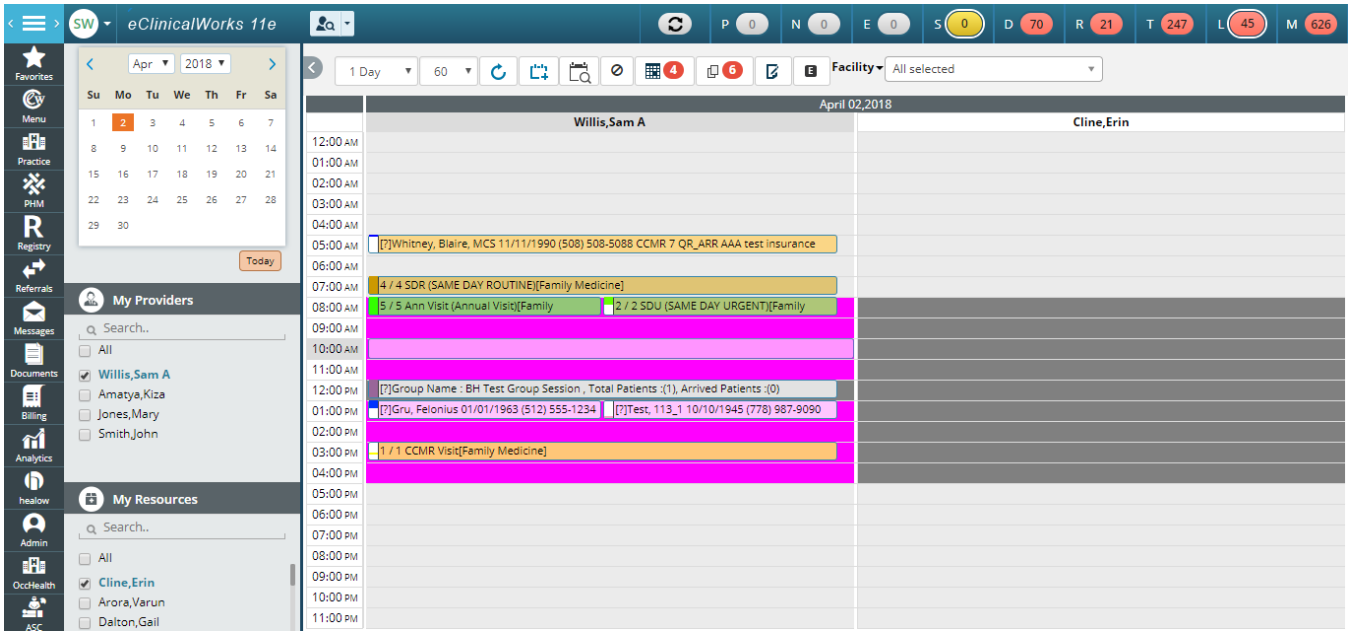
Filter options are available in the Care Planning 'Dashboard' as well as the Enrollments tab. They offer a way to organize or filter patients based on the attributes listed below.



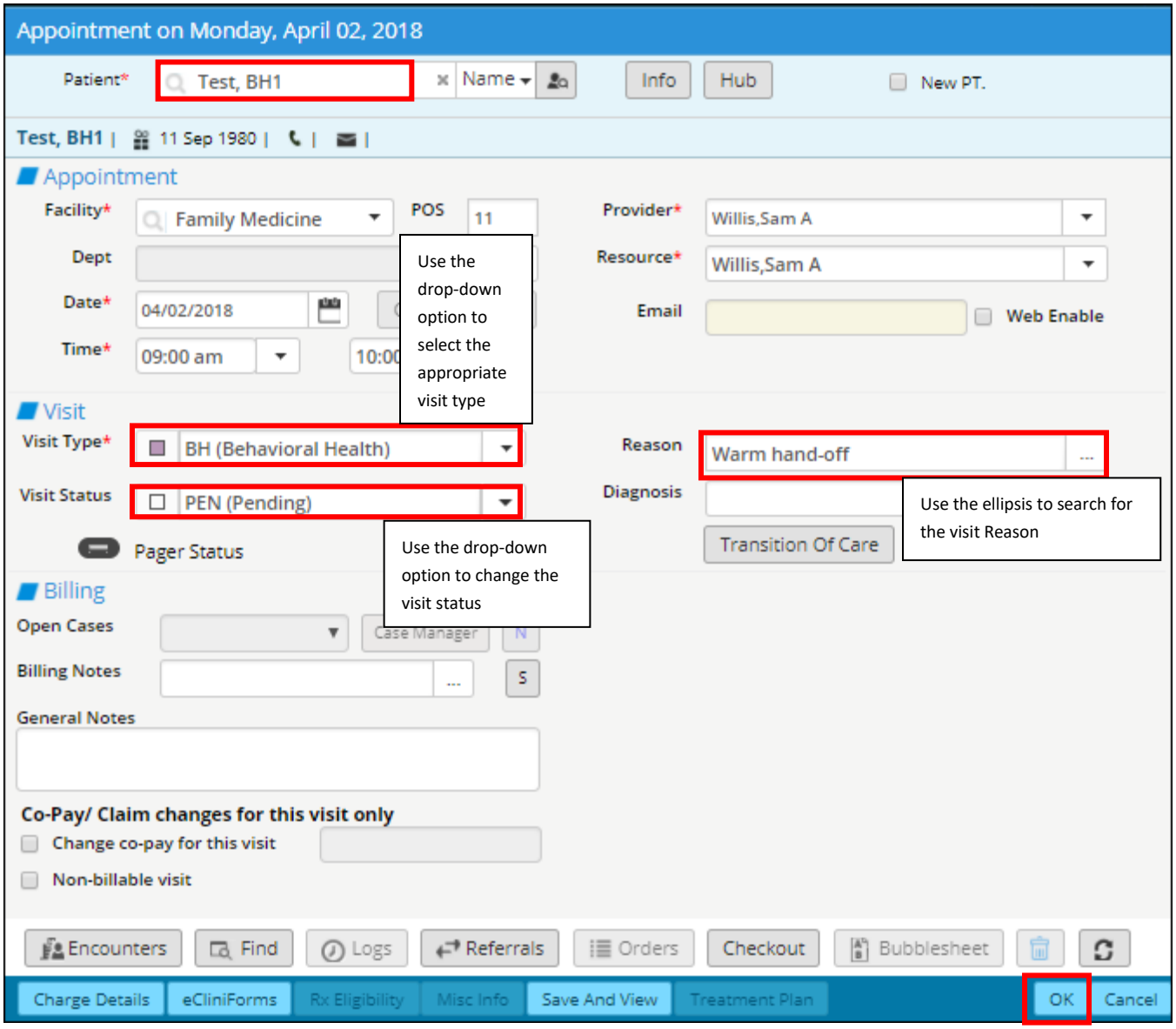
Behavioral Health and Care Plan Visits

Create an Appointment

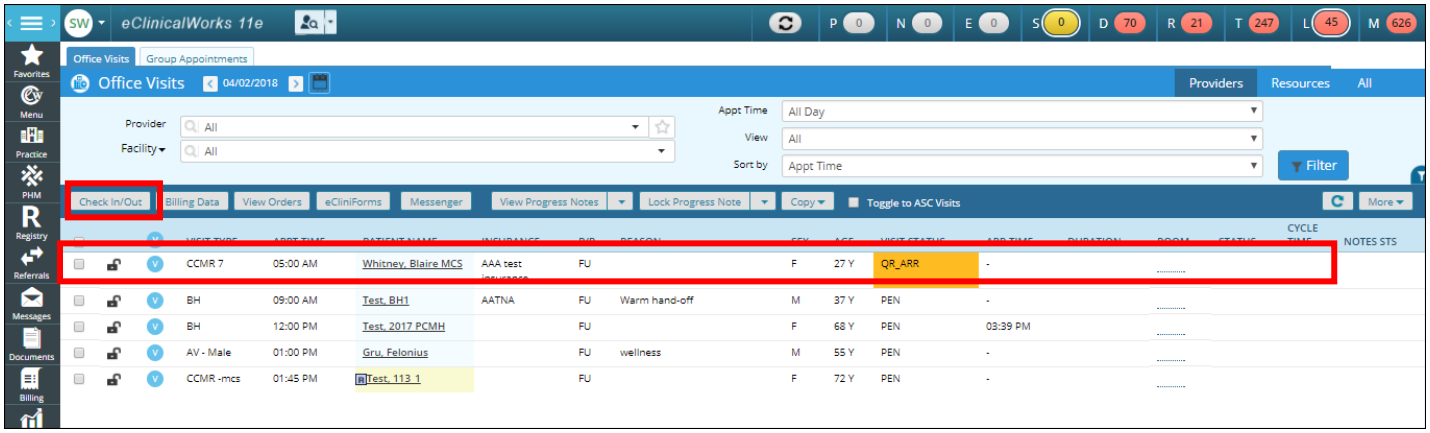
1. If front office staff have not already scheduled the appointment, or if you are seeing a walk-in patient, you will need to create an appointment/encounter before you can document a progress note or care plan. For advanced options, please refer to the Front Office workbooks.
2. Open the resource schedule and double click on the time slot that reflects the desired time and provider for the encounter. This will open a new appointment window.

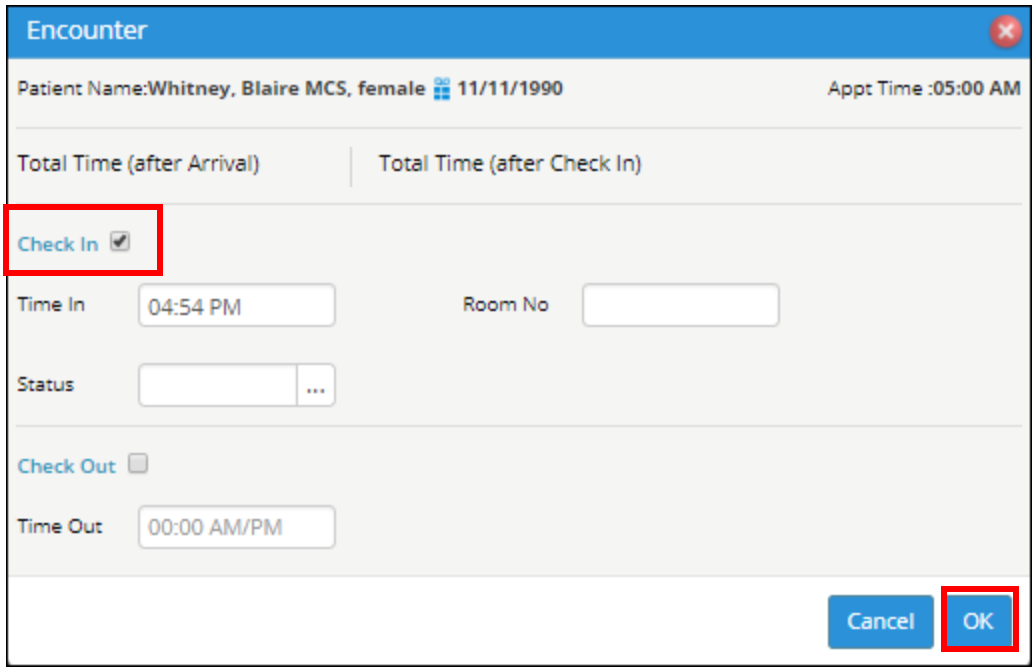


3. Select the patient and the appropriate visit type. Make sure to document the reason for the appointment. If the patient has arrived, change the visit status to ARR (Check-In). Refer to the Front Office workbooks for additional appointment functionalities. When you are finished, click “OK”.

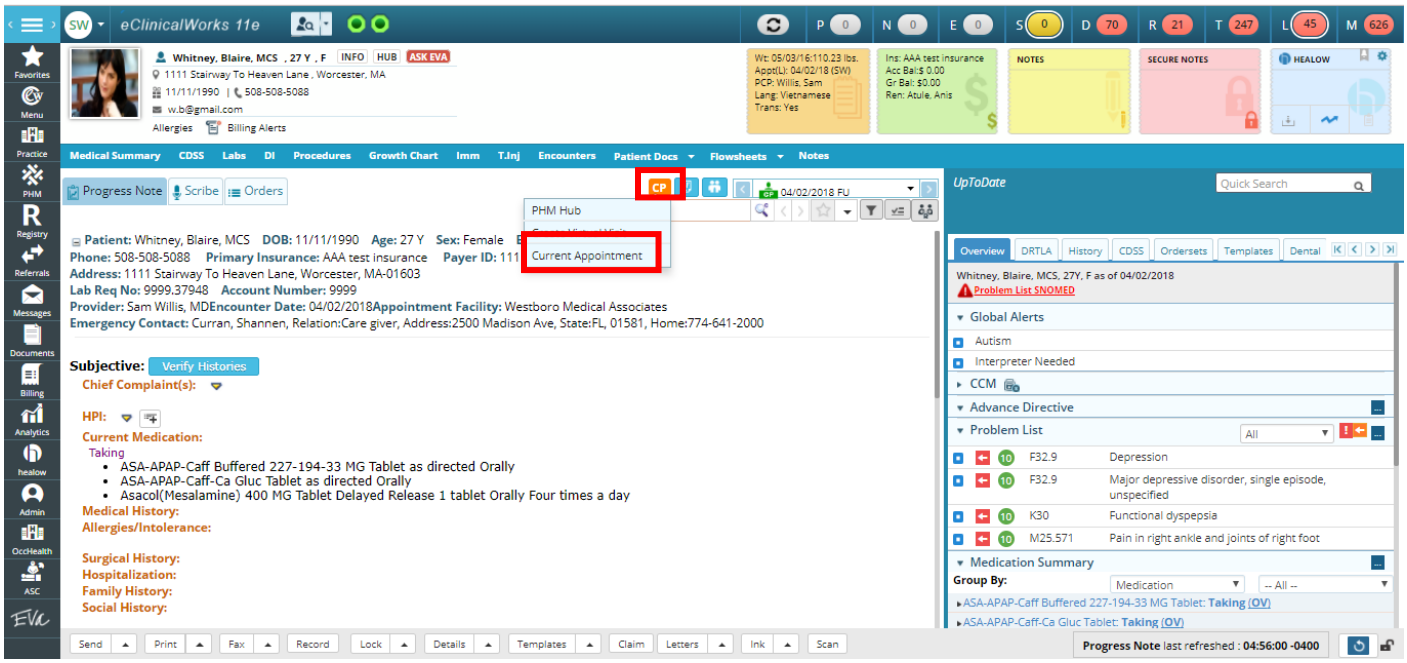


4. From the 'Office Visit' screen/ 'S' jellybean, check in the patient by clicking on the "Check In/Out" button on the top of the screen. You can edit the "Visit Status" to indicate the current stage of the encounter. Once the patient is checked in, double click on appointment to open the Progress note.





5. Double clicking on the patient will open the SOAP Notes/Progress Note for the patient. To open the Care Plan from the progress note, click the orange "CP" button at the top of the progress note and select "Current Appointment" or Care Plan heading under Treatment section of progress note.

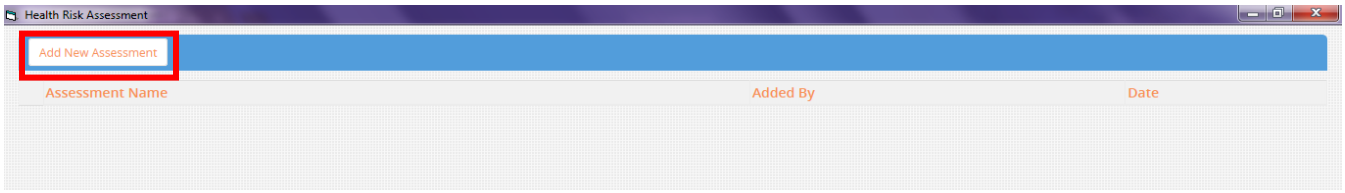


Documenting Health Risk Assessments

Enter assessments in the HRA section of the Progress Note or HRA section in the PHM Hub.

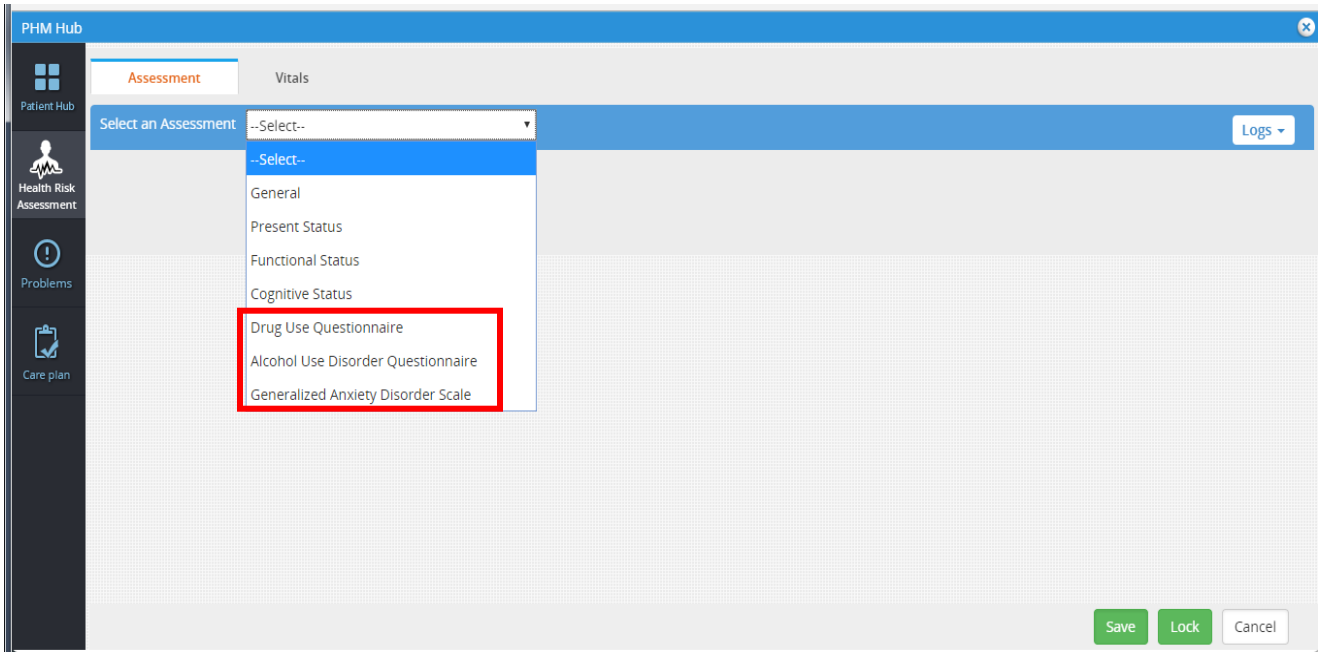
1. On the Progress Notes window, click on Health Risk Assessment.

The Assessment window opens:

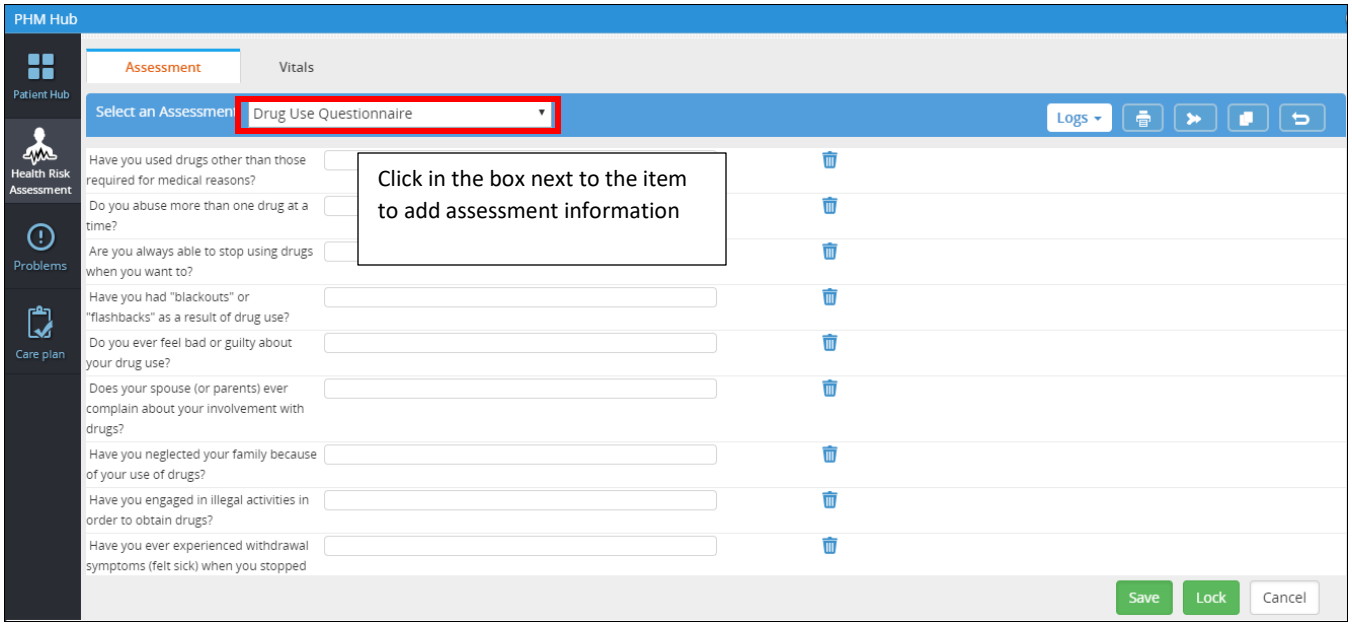


2. Click on Add New Assessment.

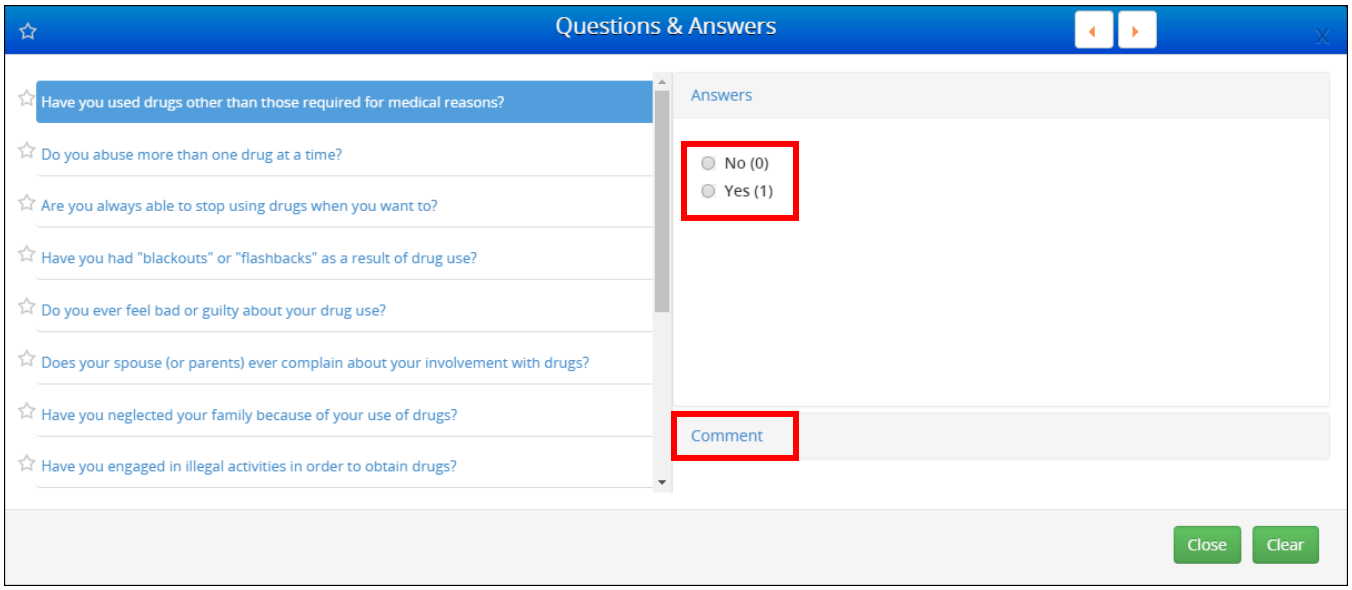
From the Select an Assessment drop-down list, select the appropriate screening/assessment.

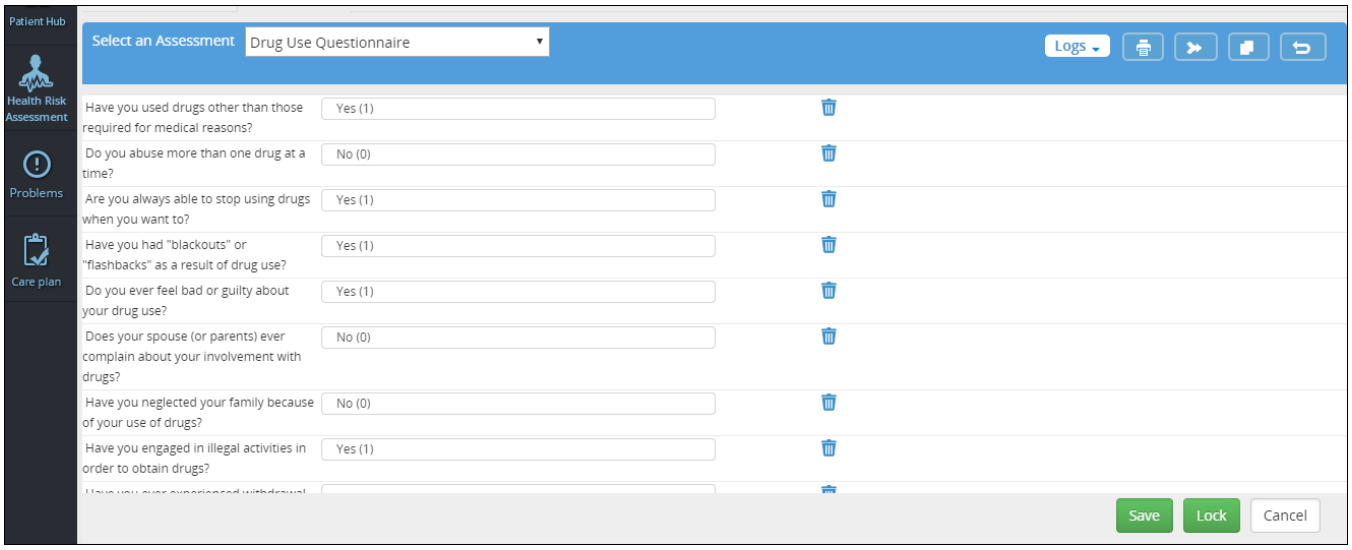


The assessment questions display:



3. Click in the box next to the item to add assessment information.
4. Click each question to display answers on the right-hand side. Select the options from the available list. A green check mark next to a question indicates that a question has been answered. Comments can also be entered in the Comment box. When done, click Close.



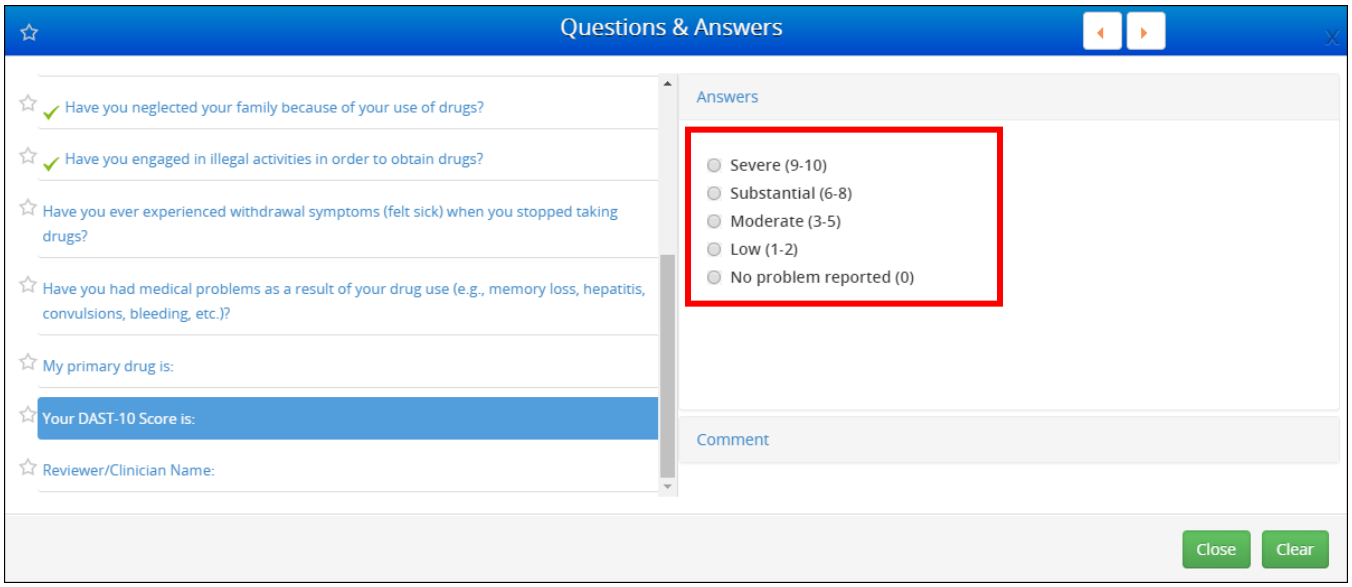


5. After clicking Close, manually calculate the score and document in the Scoring Field

See example:

Click into the blank space to document the score

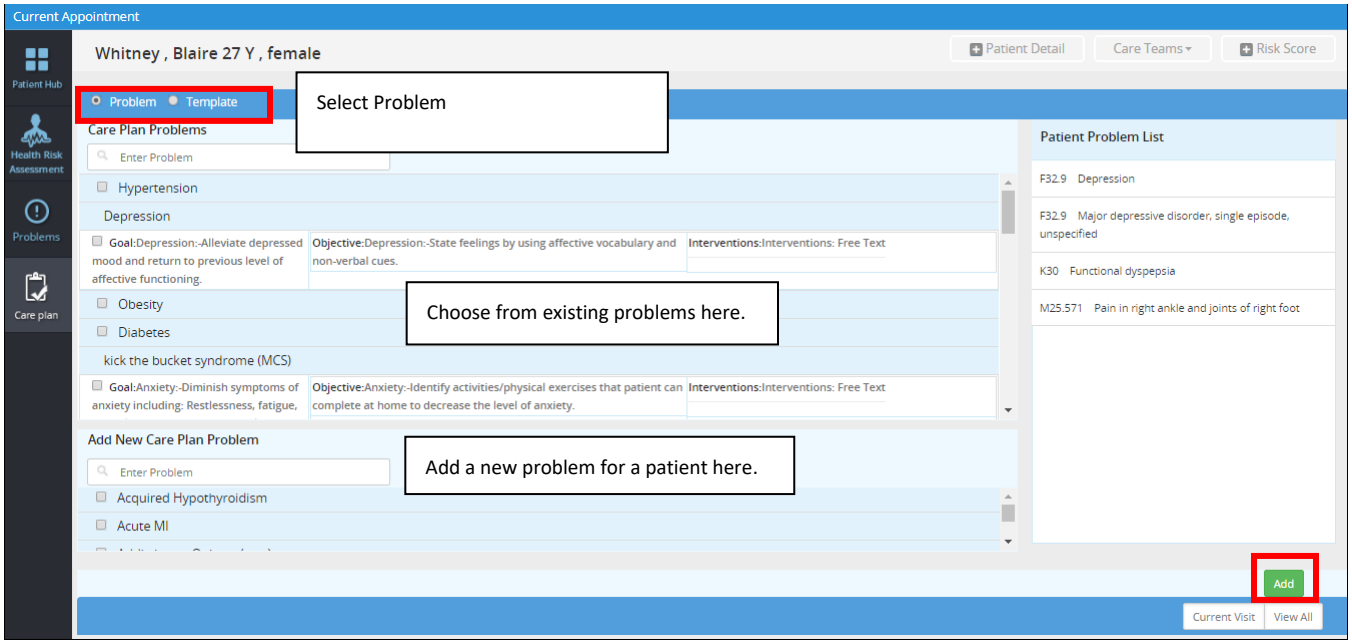
Your DAST-10 Score is:



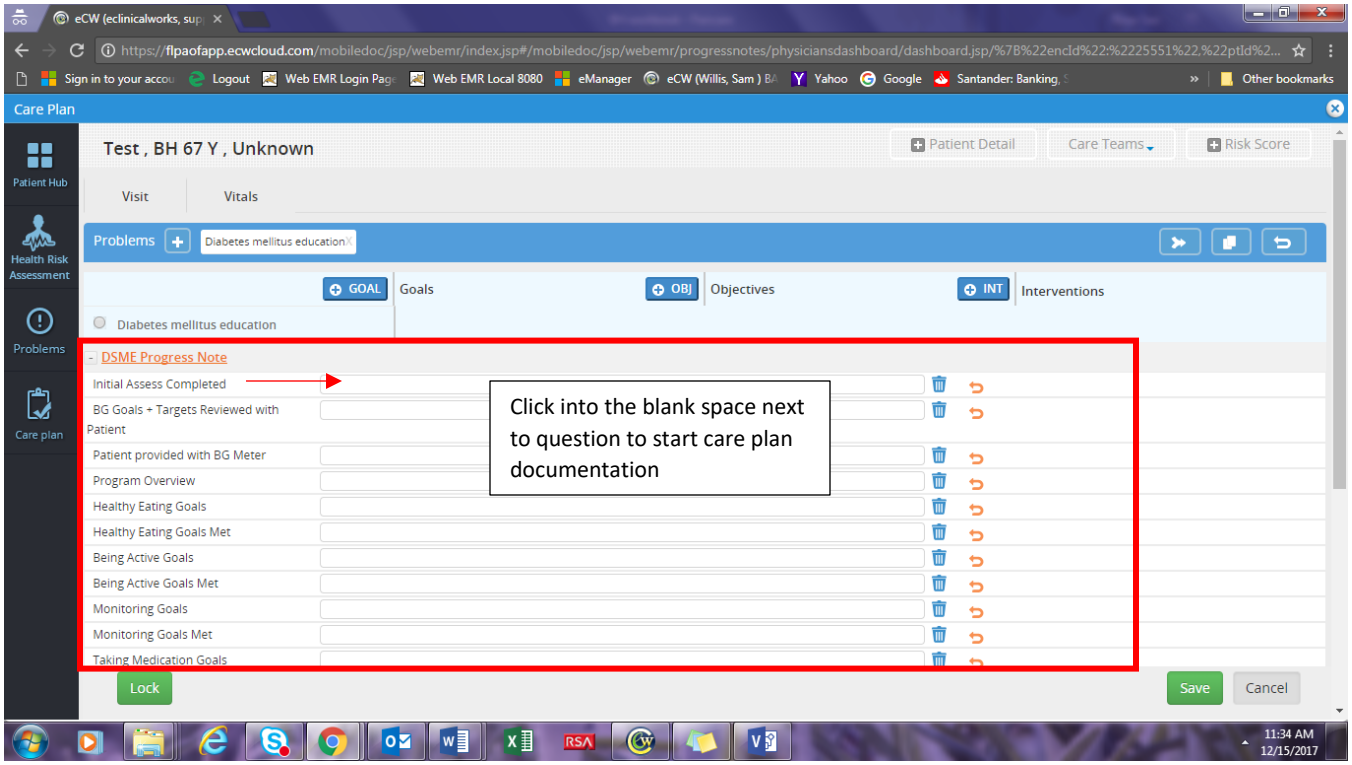
1. To save, click Save.
2. To lock, click Lock.
3. To cancel, click Cancel.
4. Once assessment is saved, user may click on Add New Assessment to document any additional health screenings
5. Click 'X' to return to the Progress Notes Window.

Documenting the Care Plan

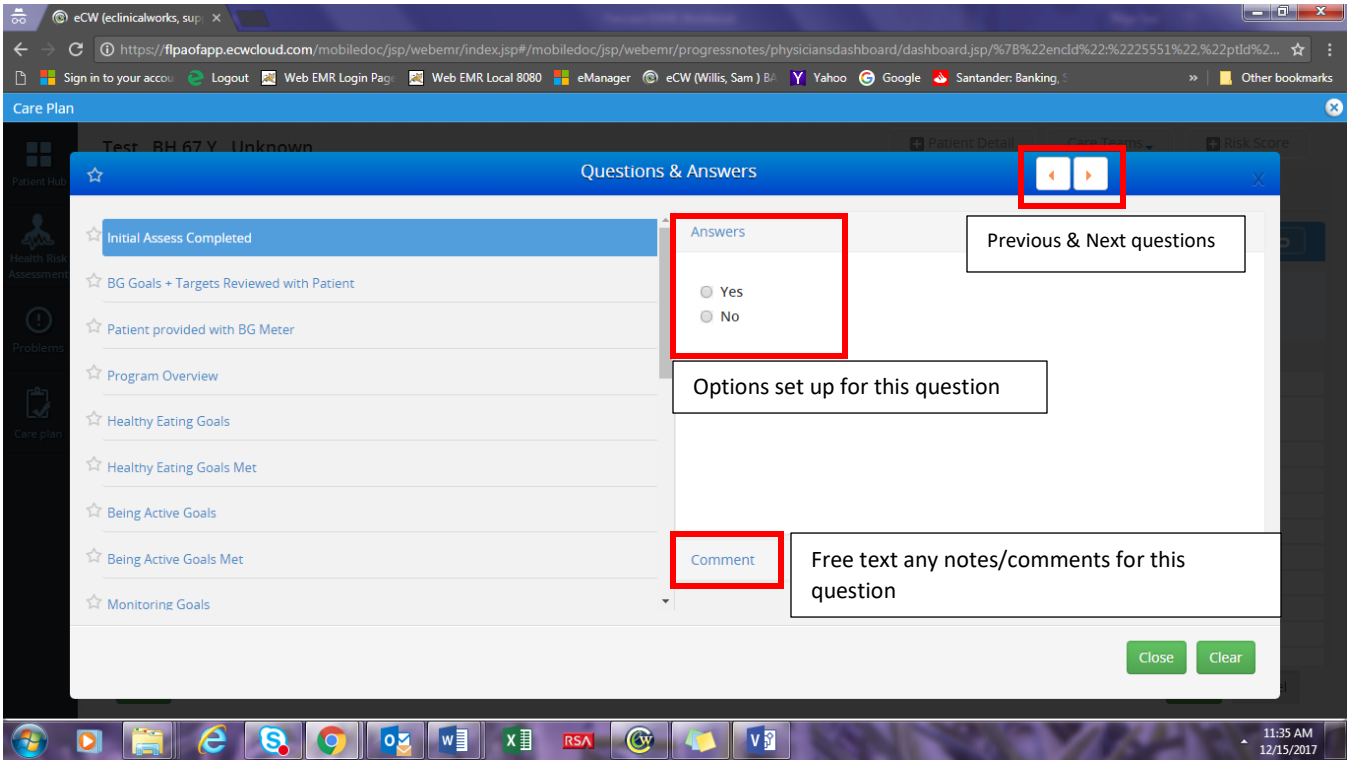
1. To access and fill out the Care Plan, click the Care Plan Link or or orange CP button on the progress note (select “Current Appointment”). This will open the window page:



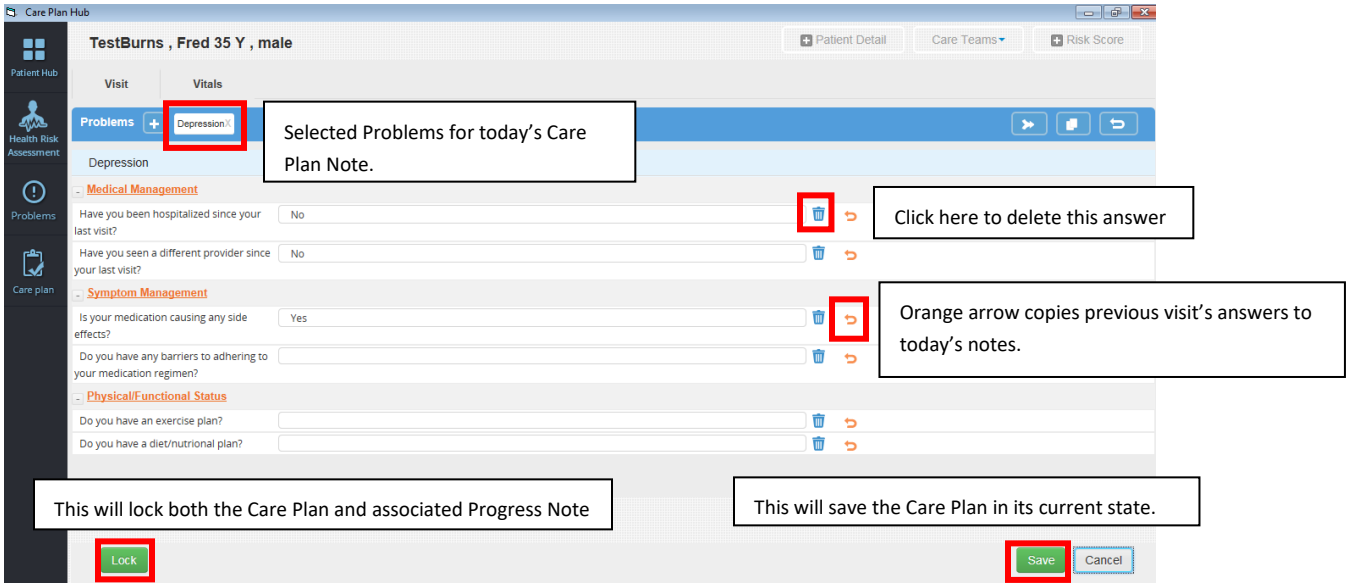
2. Check off the box next to the problem(s) that are to be addressed during the visit. If the problem is new or has yet to be documented, you can add it by selecting an option from the bottom half of the screen. If you are documenting a Care Plan based off of a template, select the Template radio button at the top of the screen.
3. After documenting the patients problem, you may be responsible for answering additional items that appear below the goals, objectives and interventions (if applicable). These items are linked to the templates or problems that were selected for this care plan. If these questions were documented on the previous care plan, it is possible to copy the responses.



4. Click into the blank space of a question to open the questions and answers page. The left side of the page displays the questions contained in the care plan while the right displays potential options. There is a comment box available to additional details. Navigate through questions either by clicking on them or using the orange arrow at the top of the screen.

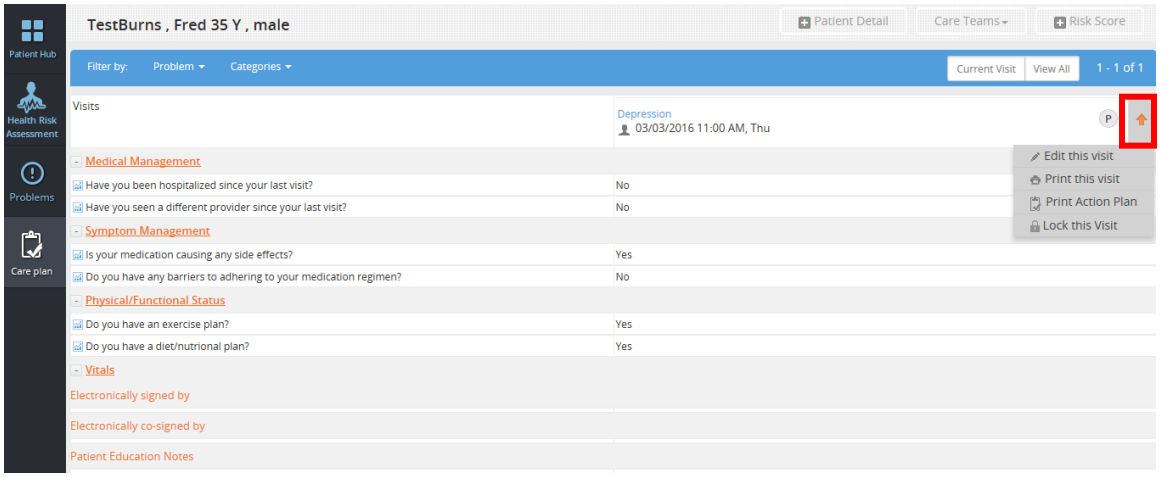


5. Once the reponses are completed, click Close.

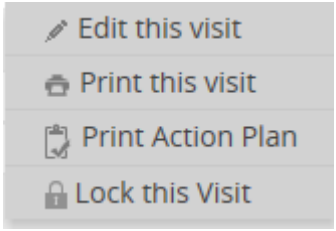


6. You can update the goals, objectives and interventions for the Problems selected for this progress note during the visit (if applicable).

7. Once care plan documentation is completed, click Save. A summarized view with further options then appear as below:



8. Once you have saved your care plan it will change slightly in appearance. Click the orange arrow at the top right of the screen for a list of care plan options.

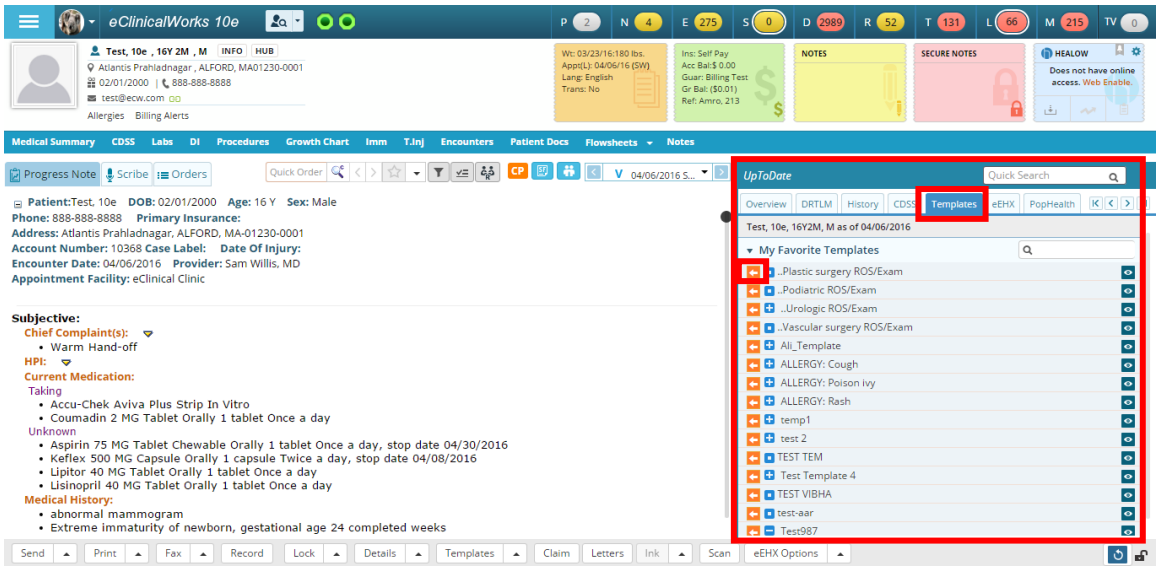


To print all questions that were answered during this visit.
To go back to the Care Plan note and make any changes.
To print an Action Plan.
Click here to lock both Progress Note as well as Care Plan Note associated with this visit.

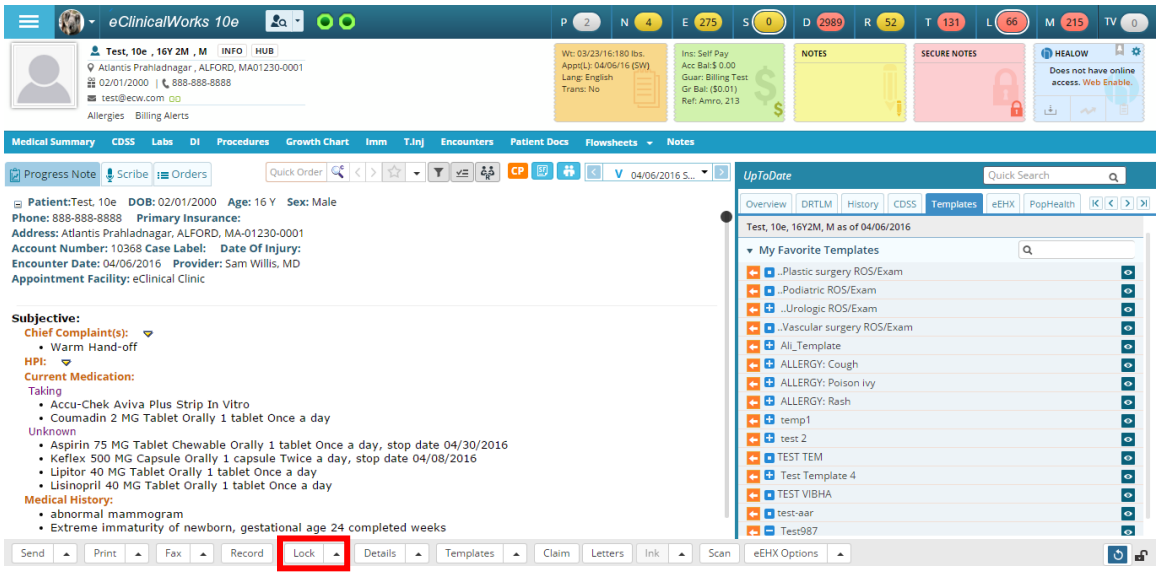
Progress Note Documentation

Note: Katy Trail Community Health Center Care Management and Behavioral Health will document Chief Complaints, Assessments, Visit Codes, and Next Visit within the progress note.

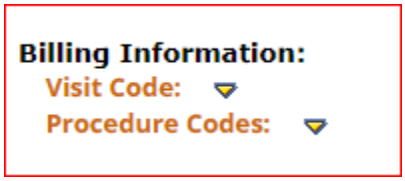
1. Many visits will require documentation both in the Care Plan as well as the Progress Note. To return to the progress note view after Care Plan documentation, simply save your care plan and exit the screen by clicking on the [X] in the top-right corner of the screen.
2. Most of your relevant Progress Note content can be pulled into a new note by merging a template. If a template has been added as a favorite, it will be listed in the right chart panel under the Templates tab. Click on the orange arrow to merge the template to your existing Progress Note (if applicable).



3. Once the template is merged into your note, you can begin to click on the items that carried over to start documentation.
4. If the note is complete and no other providers will be working from it, you may proceed to locking the note. Click the lock button at the bottom of the progress note. Please note that locking the Care Plan will lock the Progress Note and vice versa.



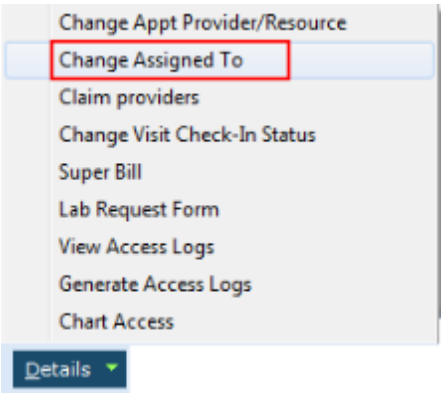
5. To enter billing information, go to Billing section of the Progress Note (refer to billing workflow for more information).



6. Follow same documentation workflow for subsequent care planning and BH visits.
7. If another provider will be reviewing/co-signing the Progress Note, refer to the Assigning, Reviewing and Co-Signing Progress Note Workflow.

Care Managers Assigning Progress Notes to Supervising Physicians

Path: *Progress Notes > arrow next to Details > Change Assigned To*



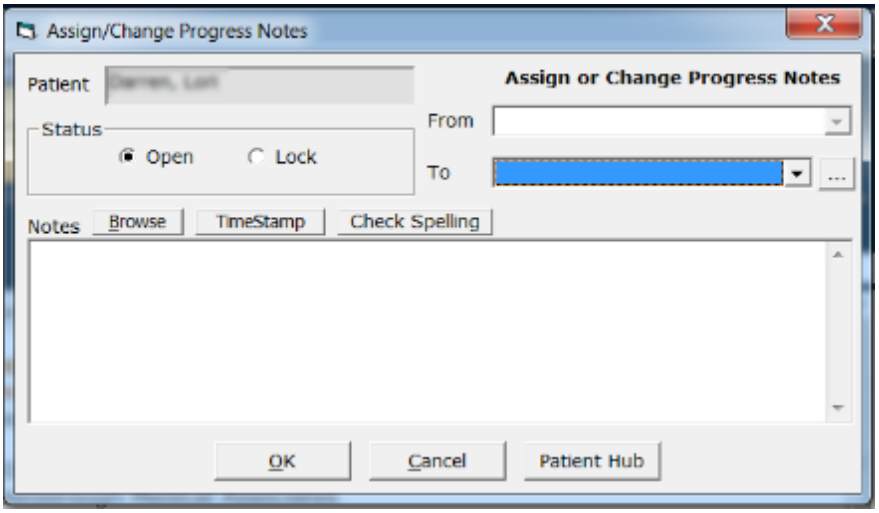
The care manager can assign the Progress Notes to the supervising physician after the documentation is complete.

To assign to supervising physician:

1. In the Notes section, enter additional notes. This note does not become part of the Progress Notes.
1. To sign off on the note and assign the supervising physician to co-sign, select the *Lock* radio button.

   OR

   To have supervising physician sign-off, select the *Open* radio button.
2. From the *To* drop-down list, select the name of the supervising physician:



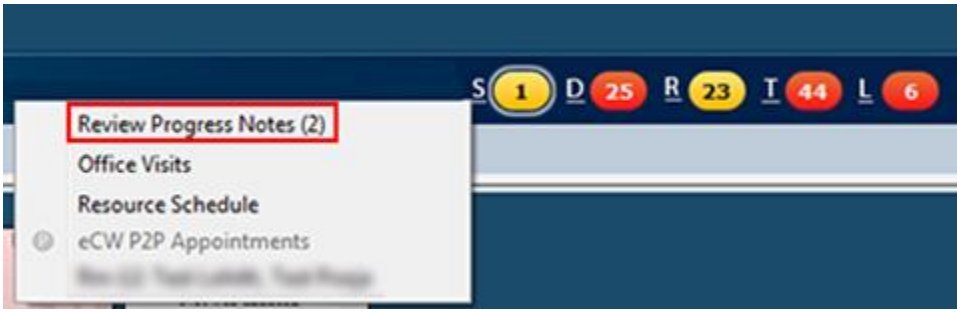
The Progress Notes are assigned to the supervising physician.

Reviewing and Approving Assigned Progress Notes

A lock sign displays next to Progress Notes that require a co-sign. An open lock sign displays next to Progress Notes that require a sign off.

To review and sign off on the assigned Progress Notes:

1. Click the *S* next to the Quick-Launch button.
2. Click *Review Progress Notes*:



The Review Progress Notes window opens.

3. In the Status column, click the *More (…)* button.
4. For Progress Notes that were previously locked, select the *Co-sign* radio button.
5. Lock the Progress Notes that require a sign off.

Care Plan Reviews

A Care Plan Review is where the BH provider (Care Manager) along with a clinical staff member (care coordinator) can certify that the treatment plan was discussed with the client during the face-to-face encounter, and that the client agrees to the treatment plan. Referring providers and non-BH providers can also review this care plan once they have logged on to eCW using their own credentials.

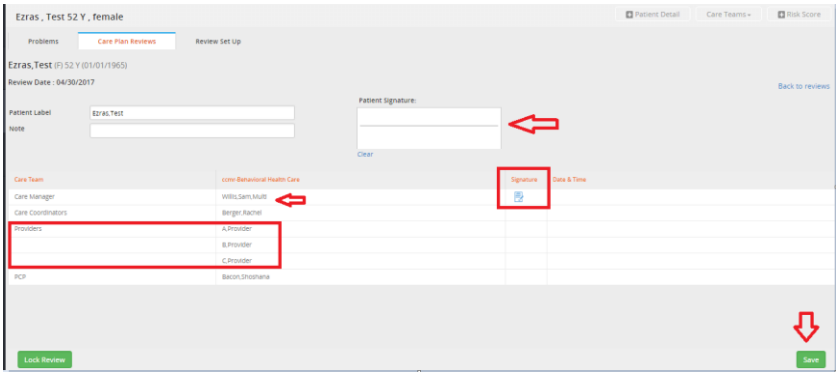
For a care plan review to be completed on a client, there are two requirements:

1) The client must be enrolled into the 'Behavioral Health Care' program.
2) The client must be assigned a Care Team.

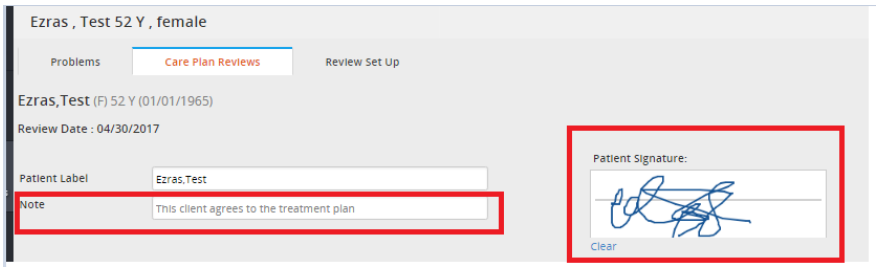
Completing the Care Plan Review

After the goals, objectives, interventions have been added on to the client's chart and a treatment plan has been completed, the final step is to go to the 'Problems' tab and click on 'Care Plan Reviews.' This will show you the encounter for the day that the client had a BH visit.

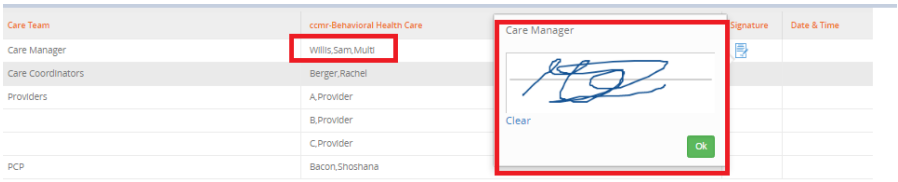
Click on the encounter date marked by the red arrow above and it will open this screen below. The BH provider will be under care manager. In this case, Dr. Willis is the BH provider and can click on the signature section highlighted to document his/her signature. The highlighted providers section where you see Providers A, B, C are where non-BH providers will go in and sign. They will be unable to sign this right now as you must be logged on to eCW under your credentials to see the signature pad icon.



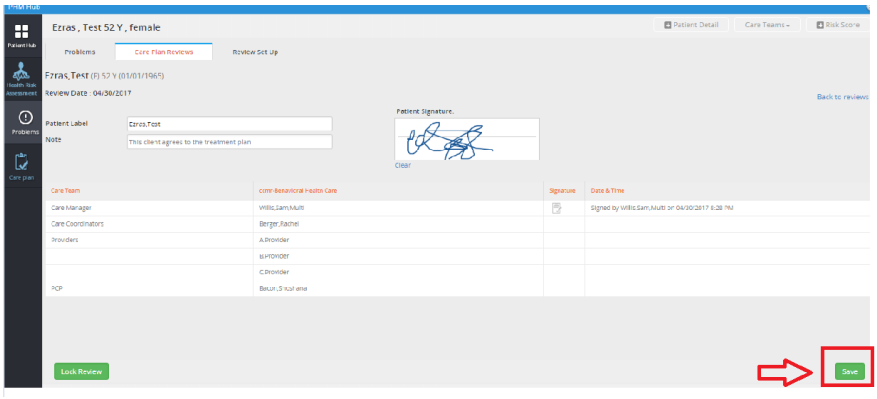
Now, put in your comments under notes and use the mouse or signature pad (if used) to document the patient's signature.



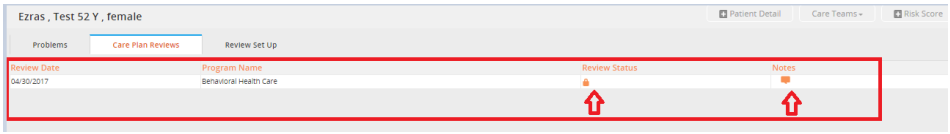
Now, the BH provider will document their signature by clicking on the signature pad icon next to her name as seen in the screen shot below.



You can save your review or lock your review.

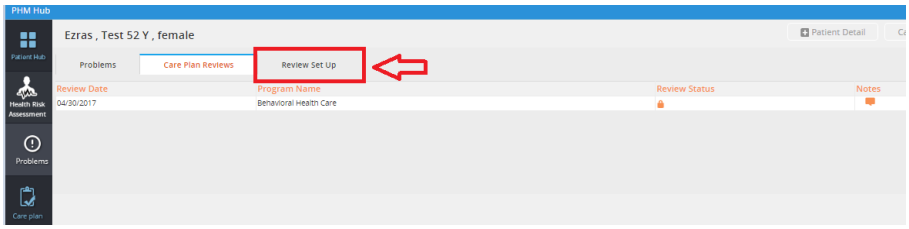


Locking your review will turn your screen in to this screenshot below where your notes will show up in the orange cloud icon. While this review is part of the client's BH note, it will not go inside the client's progress note. It will always be associated to the client's chart and meets all state regulations in terms of documenting multiple signatures on the care plan review.

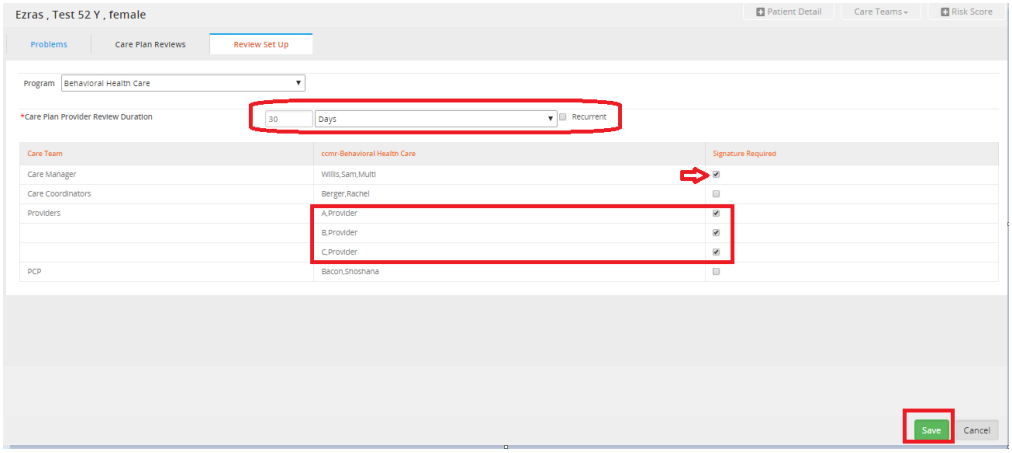


Creating a Care Plan Review alert

A care plan review alert is a reminder you can put on the client if you want to complete a care plan review in 30/60/90 days. In this scenario, if you want Amanda to come back in 30 days and want to make sure you complete a review on her chart, click on the 'Review Set Up' tab seen below.

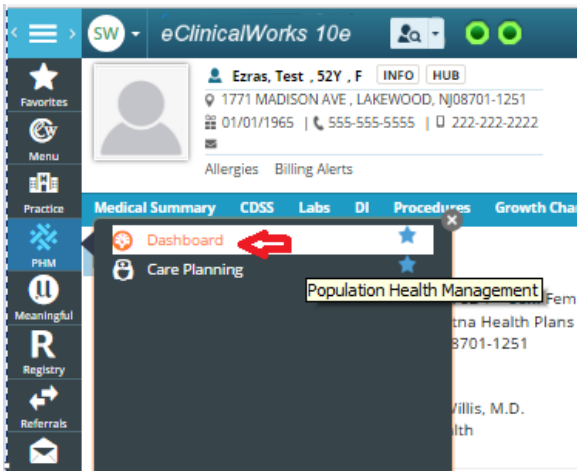


Make sure you select Providers A, B, and C if you want non-BH providers to complete a care plan review on the client. If these boxes next to the providers are not checked, non-BH providers will not be able to do a care plan review on the client. Click on 'Save' to save this care plan review alert.

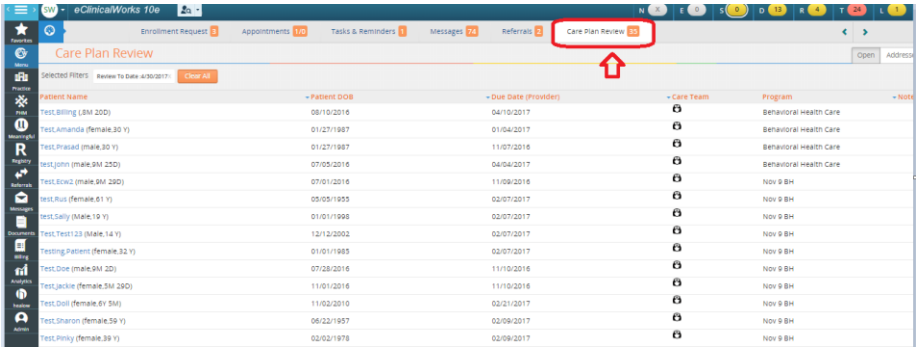


Viewing Care Plan Review Alerts

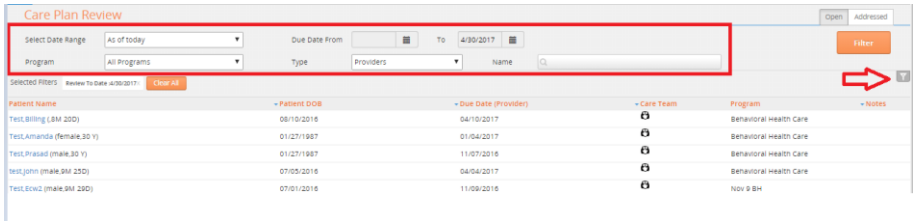
Go to the PHM Band → Dashboard



The ‘Care Plan Review’ tab shows you all care plan reviews which are due. The Care Plan review tab lists patients who are currently due for a new Care Plan Review. Hovering over a client’s name will display options for completing either a patient review, provider review, or both. Clicking on any of the options will open the Care Plan Hub on the reviews tab.



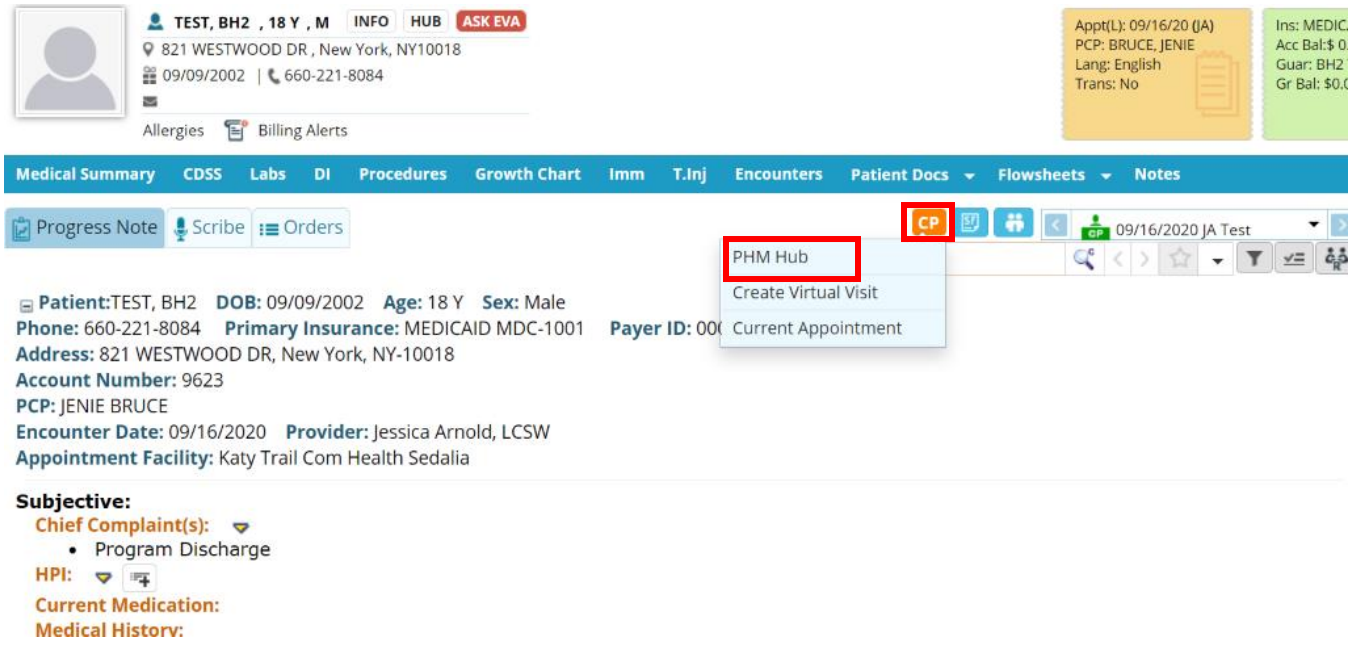
You can use different filters to search for care plan reviews based on date range, program name, or BH providers.



End Program Enrollment

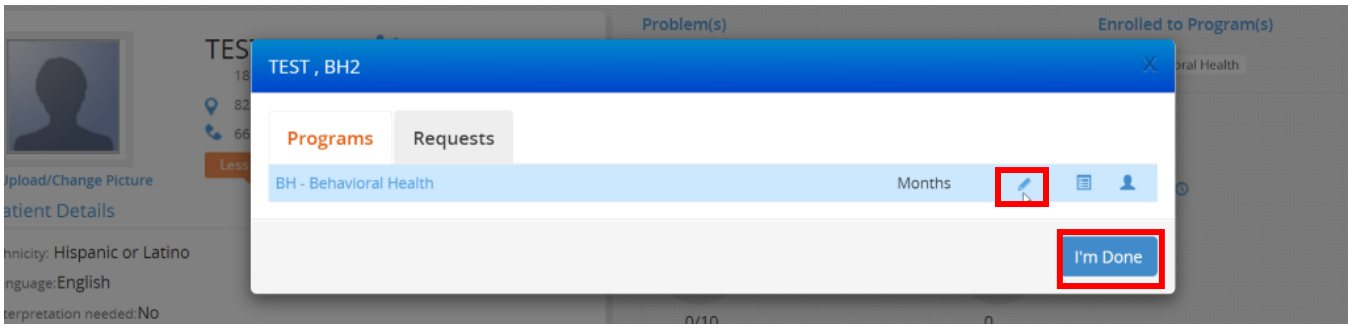
When a patient has completed their treatment, is discharged, or needs to be dis-enrolled from a program for any other reason, they are removed from a program by following the "End Enrollment" workflow below.

1. Click the orange CP button on the upper right of the note.
2. Select PHM Hub.

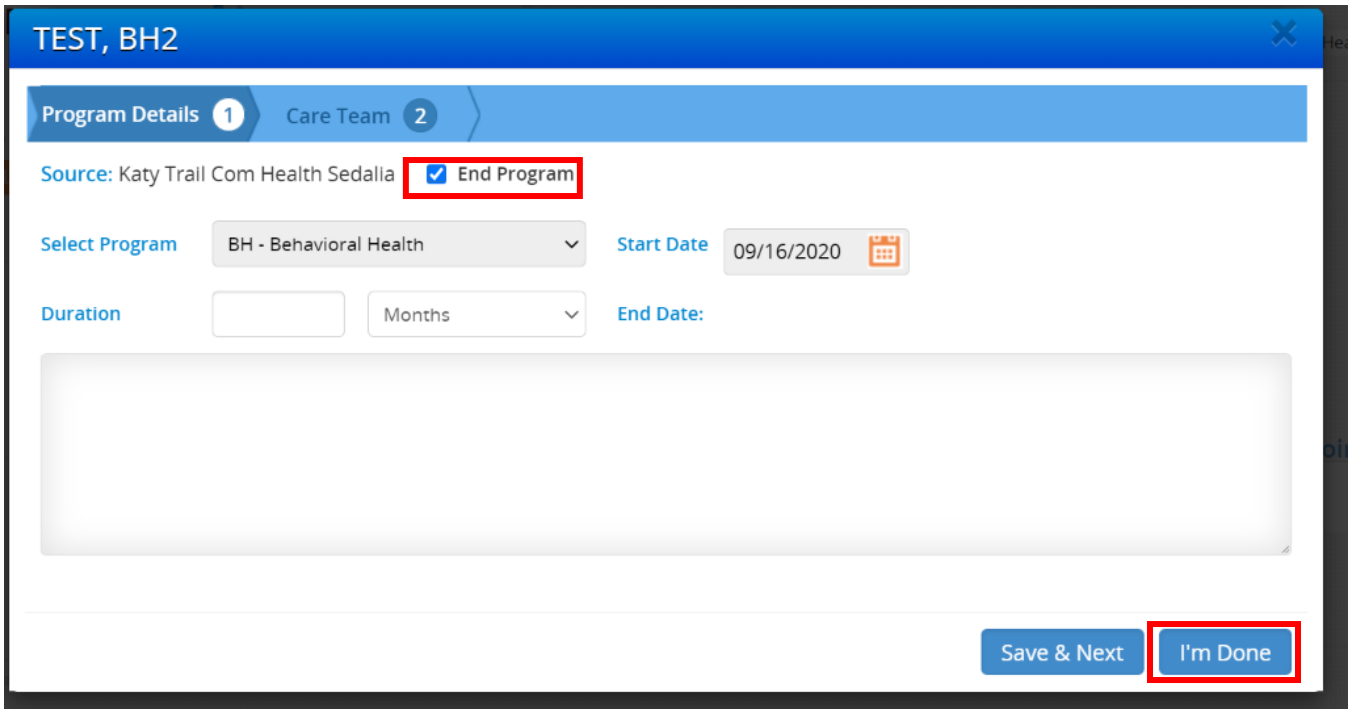


3. In the PHM Hub, select the pencil icon next to Enrolled in Programs

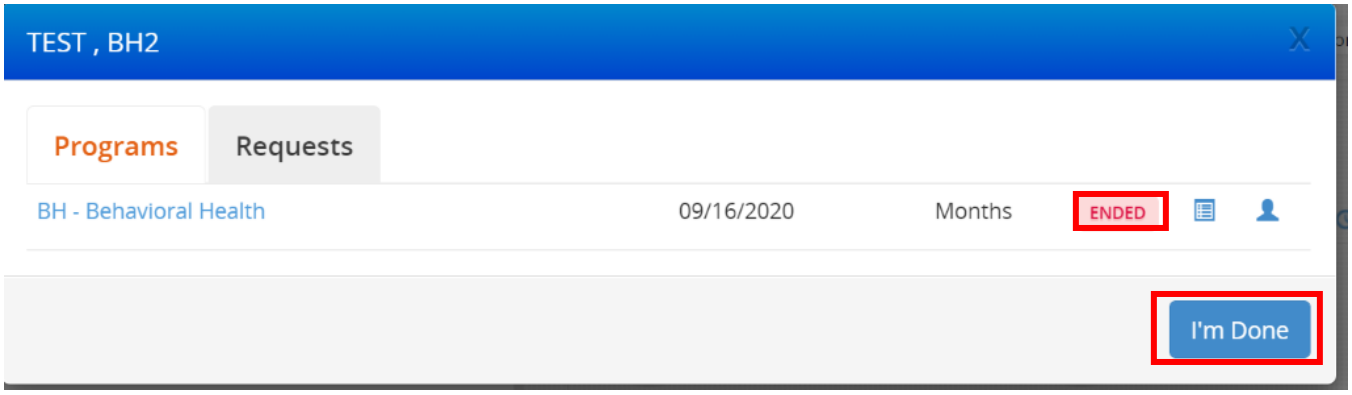
4. Hover your mouse over the program name, it will highlight blue, and select the pencil.



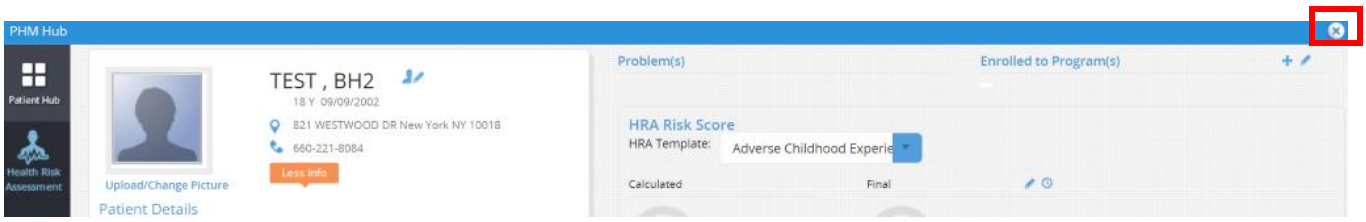
5. Check ‘End Program,’, then select ‘I’m Done.’



6. The program will show ‘Ended.’ Select ‘I’m Done.’



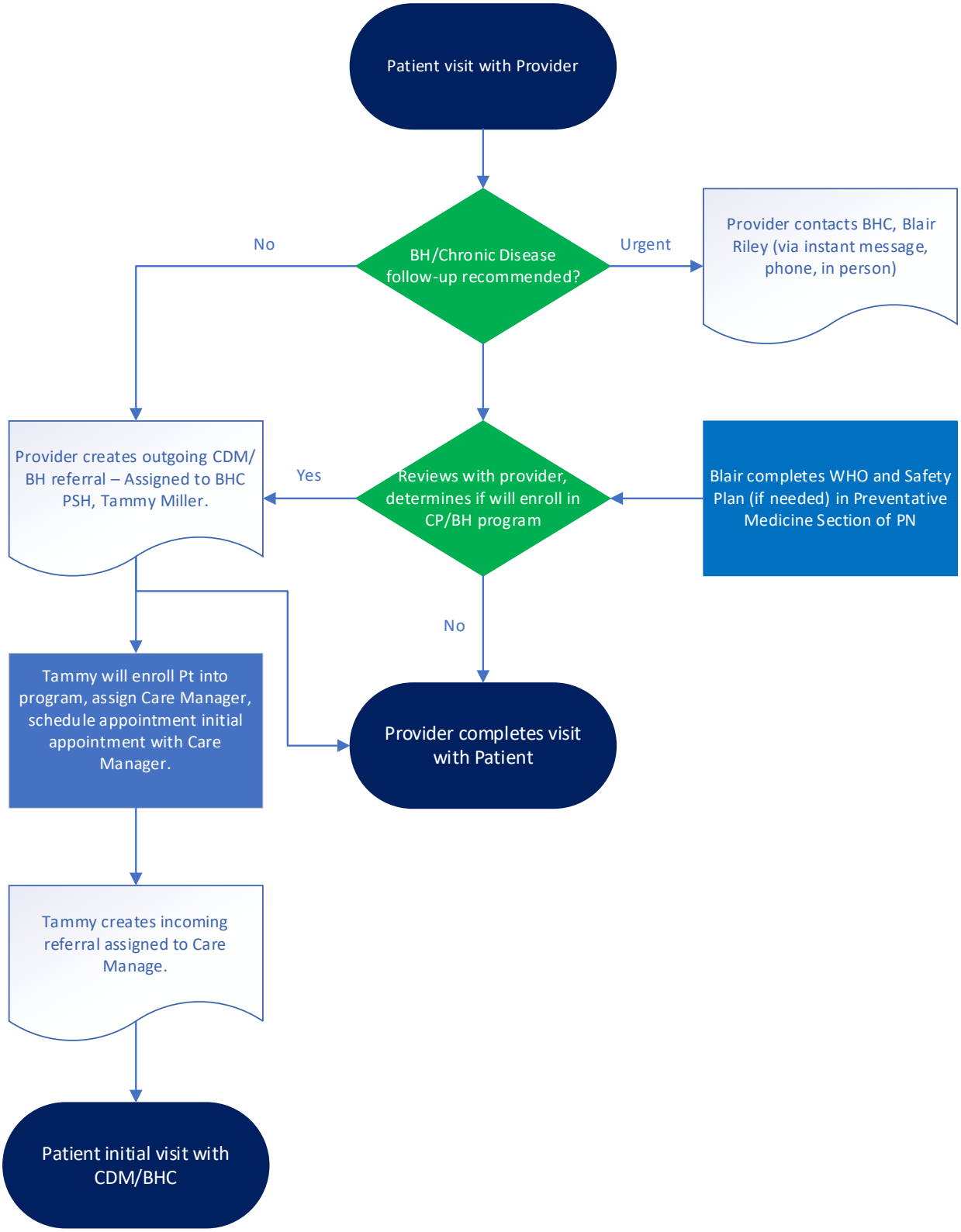
7. Click ‘X’ in the upper right of the hub to go back to the progress note.



Note, you can also access the PHM Hub directly from the Patient Hub or Care Planning Dashboard.

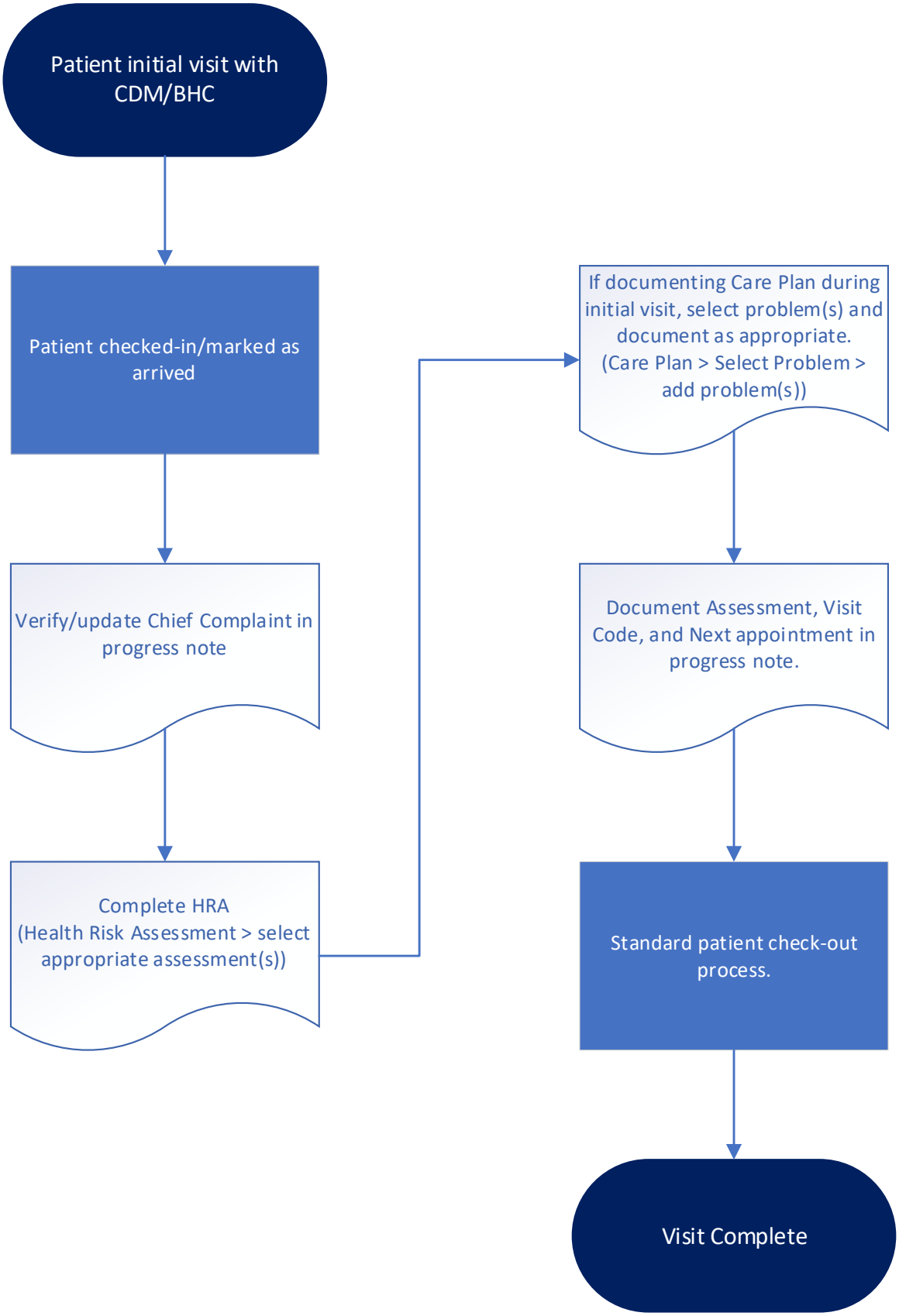
Katy Trail CHC Care Planning and Behavioral Health Workflows

Enrollment and Care Team Selection – Katy Trail CHC Patient

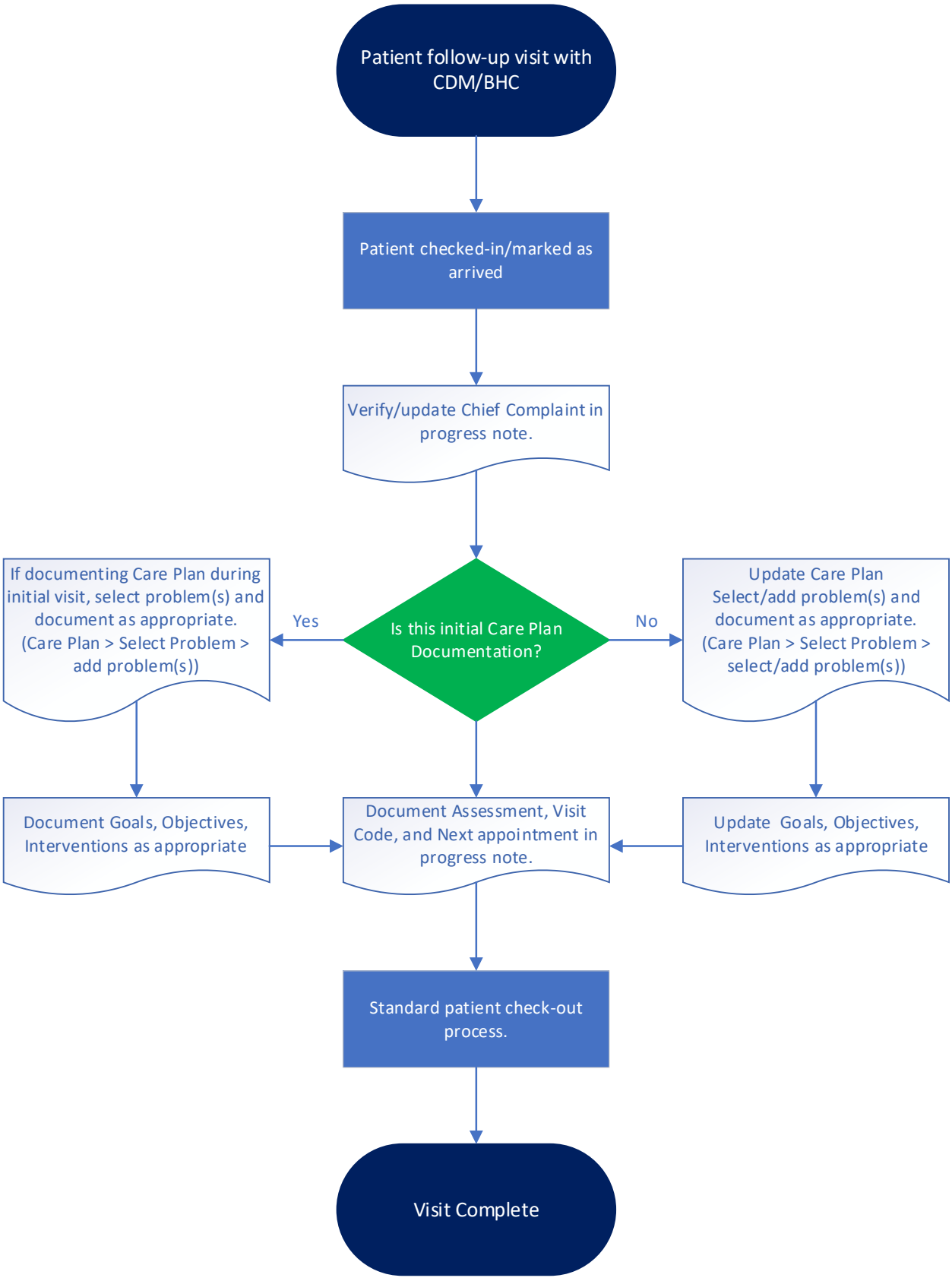


Enrollment and Care Team Selection – School Based

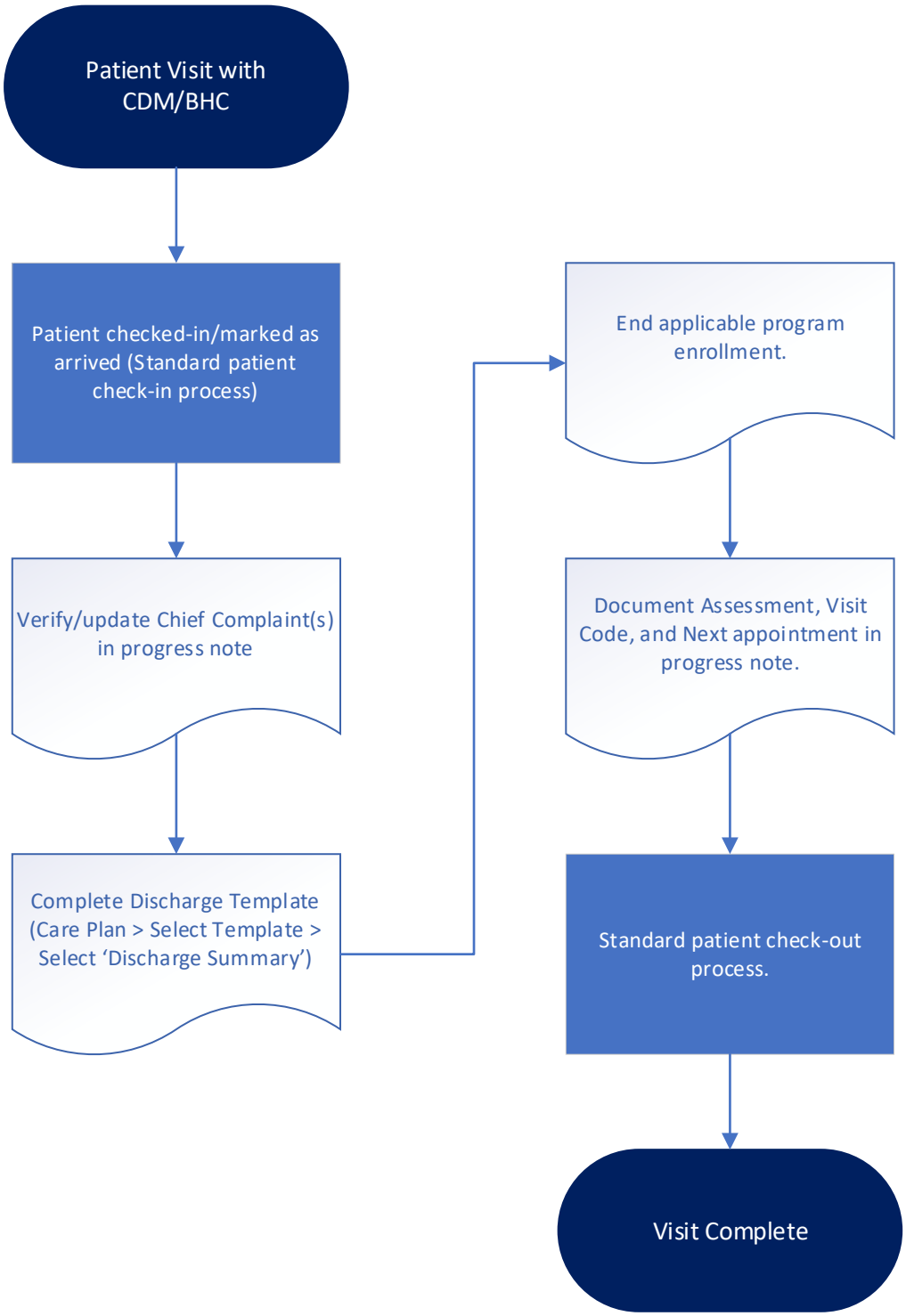
Chronic Disease Management/Behavioral Health - Initial Visit



Chronic Disease Management/Behavioral Health – Follow up Visit



Chronic Disease Management/Behavioral Health – End Program Enrollment



Katy Trail Community Health Center - CP/BH Documentation

Programs

- BH - Behavioral Health
- BH - Chronic Disease Management
- BH - Medicaid Initiative
- BH - Chronic Pain/MAT/IBHS
- BH - Zero Suicide
- BH - Community Connections

Problems

- ADHD
- Alcohol Drug Use
- Anger
- Anxiety
- Behavior
- Communication/Social Skills
- Depression
- Emotions
- Grief
- Manic Behaviors
- OCD
- ODD
- Psychosis
- School related
- Sucidality
- Trauma
- Asthma
- Chronic Pain
- Diabetes
- Hyperlipidemia
- Hypertension
- Tobacco Use
- Weight

Templates

- Discharge Summary

Goals

Anxiety Disorder:

- Anxiety - GAD-7: Reduce negative symptoms of anxiety. Progress will be measured on the assessment/screening tool, GAD-7, seeing a reduction for baseline to identified target.
- Anxiety - Avoidance: Gain skills to work through negative feelings and reduce avoidance behaviors and will gradually increase involvement in the listed behavior/activity.
- Anxiety - Panic Reduction: Reduce the frequency of panic attacks from baseline to identified target
- Anxiety - SUD – Reduce SUD (Subjective Units of Disturbance) related to anxiety symptoms from baseline to target.
- Anxiety – Additional goal 1
- Anxiety – Additional goal 2

Depression Disorder:

- Depression - PHQ-9: Reduce negative symptoms of depression. Progress will be measured on the assessment/screening tool, PHQ-9, seeing a reduction for baseline to identified target.
- Depression - Self 1 to 10: Decrease depression, based on self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing a decrease from baseline to identified target.
- Depression - Self -Esteem 1 to 10: Increase self-value, based on a self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing an increase from baseline to identified target.
- Depression - Self-harm: Reduce self-harm urges and/or behavior based on self-report. Progress will be measured by:
- Depression - SUD – Reduce SUD (Subjective Units of Disturbance) related to depression symptoms from baseline to target.
- Depression – Additional goal 1
- Depression – Additional goal 2

Suicidality

- Sucidality - Columbia (C-SSRS): Reduce thoughts of suicidality. Progress will be measured on the assessment/screening tool, C-SSRS, seeing a reduction from baseline to identified target.
- Sucidality - 1 to 10: Suicidal ideation will improve based on self-report. Progress will be measured on a scale of 1 (less frequent) to 10 (more frequent), seeing a reduction from baseline to identified target.
- Sucidality - Reduction: Experience a reduction of suicidal thoughts, noticing a decline withing designated time period, from baseline to target.
- Sucidality - Self Harm: Reduce negative self-harm urges and/or behavior based on self-report. Progress will be measured by:
- Sucidality - SUD – Reduce SUD (Subjective Units of Disturbance) related to suicidal ideation and or self-harm from baseline to target
- Sucidality - Safety Plan: Complete and utilize a Safety Plan to identify triggers, coping skills, contact information and local resources, prior to engaging in self harm or suicidal behaviors. This will be measured through patient report.
- Sucidality – Additional goal 1
- Sucidality – Additional goal 2

ADHD

- ADHD - Vanderbilt: Reduce inattention and or hyperactivity symptoms. Progress will be measured on the assessment/screening tool, Vanderbilt, seeing a reduction from baseline to identified target.
- ADHD - 1 to 10: Reduce inattention and or hyperactive symptoms, based on self-report. Progress will be measured on a scale of 1 (reduced behaviors) to 10 (more behaviors), seeing a reduction from baseline to identified target.
- ADHD - Demonstrate increased ability to focus on tasks as evidence by:
- ADHD - SUD – (Name) will reduce SUD (Subjective Units of Disturbance) related to inattention and or hyperactivity symptoms from baseline to target.
- ADHD – Additional goal 1
- ADHD – Additional goal 2

ODD

- ODD - Vanderbilt: Reduce inattention and or hyperactivity symptoms. Progress will be measured on the assessment/screening tool, Vanderbilt, seeing a reduction from baseline to identified target.
- ODD - 1 to 10: Reduce defiant symptoms, based on self-report. Progress will be measured on a scale of 1 (reduced behaviors) to 10 (more behaviors), seeing a reduction from baseline to identified target.
- ODD - Neg Interactions: Reduce negative interactions with adults/authority figures as evidence by:
- ODD - SUD – Reduce SUD (Subjective Units of Disturbance) related to oppositional and defiant behaviors from baseline to target.
- ODD – Additional goal 1
- ODD – Additional goal 2

Anger

- Anger - 1 to 10: Reduce negative anger symptoms based on self-report. Progress will be measured on a scale of 1 (less behaviors) to 10 (more behaviors), seeing a reduction from baseline to identified target.
- Anger - Increase ability to manage anger effectively as evidence by:
- Anger - Reduce intensity and frequency of verbal and physical aggression as evidence by:
- Anger - SUD – Reduce SUD (Subjective Units of Disturbance) related to anger and aggression from baseline to target.
- Anger – Additional goal
- Anger – Additional goal

Trauma

- Trauma - 1 to 10: Trauma related symptoms severity will improve, based on a self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing an improvement from baseline to identified target.
- Trauma - Self 1 to 10: Nightmare severity will decrease, based on a self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing a reduction from baseline to identified target.
- Trauma - Explore and resolve issues related to trauma as evidence by:
- Trauma - SUD – Reduce SUD (Subjective Units of Disturbance) related to trauma response symptoms from baseline to target.
- Trauma – Additional goal 1

- Trauma – Additional goal 2

Manic Behaviors

- MB - Self 1 to 10: Manic behavior severity will improve, based on self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing and reduction from baseline to identified target.
- MB - Self 1 to 10: Reduce impulsive behaviors, based on self-report. Progress will be measured on a scale of 1 (less behaviors) to 10 (more behaviors), seeing a reduction from baseline to identified target.
- MB - SUD – Reduce SUD (Subjective Units of Disturbance) related to manic symptoms from baseline to target.
- MB – Additional goal 1
- MB – Additional goal 2

OCD

- OCD - 1 to 10 Obsessions: Reduce obsessive thinking, based on self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing a reduction from baseline to identified target.
- OCD - 1 to 10 Compulsions: Reduce compulsive behaviors, based on self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing a reduction from baseline to identified target.
- OCD - SUD – Reduce SUD (Subjective Units of Disturbance) related to obsessive and or compulsive symptoms from baseline to target.
- OCD – Additional goal 1
- OCD – Additional goal 2

Grief

- Grief - SUD: Reduce SUD (Subjective Units of Disturbance) related to grief and loss from baseline to target.
- Grief - Additional goal 1
- Grief - Additional goal 2

Psychosis

- Psychosis - 1 to 10: Reduce severity of psychosis, based on self-report. Progress will be measured on a scale of 1 (negative) to 10 (positive), seeing a decrease from baseline to identified target.
- Psychosis - SUD – Reduce SUD (Subjective Units of Disturbance) related to Psychosis symptoms from baseline to target.
- Psychosis – Additional goal 1
- Psychosis – Additional goal 2

School Related

- School Related - Improve classroom functioning as evidence by:
- School Related - Improve school attendance as evidence by:
- School Related - SUD: Reduce SUD (Subjective Units of Disturbance) related to school stressors from baseline to target.
- School Related - Additional goal 1
- School Related - Additional goal 2

Emotions

- Emotions - Learn appropriate ways to express different feelings as evidence by:
- Emotions - SUD – (Name) Reduce SUD (Subjective Units of Disturbance) related to negative emotional responses from baseline to target.
- Emotions – Additional goal 1
- Emotions – Additional goal 2

Behavior

- Behavior - Improve overall behavior (and attitude/mood) as evidence by:
- Behavior - Demonstrate ability to process thoughts and feelings before acting as evidence by:
- Behavior - SUD – Reduce SUD (Subjective Units of Disturbance) related to negative behaviors from baseline to target.
- Behavior - Additional goal 1
- Behavior - Additional goal 2

Diabetes

- Diabetes - A1C: Reduce barriers to health and wellness resulting in lower A1C score. Progress will be measured by routine A1C lab work.
- Diabetes - Glucose: Reduce barriers to health and wellness resulting in lower glucose. Progress will be measured by routine sugar level checks.
- Diabetes - Carbohydrates: Reduce barriers to health and wellness by reducing daily carbohydrates.
- Diabetes – Additional goal 1
- Diabetes – Additional goal 2

Hypertension

- Hypertension - Blood pressure: Reduce barriers to health and wellness by reaching and maintaining a healthy blood pressure reading.
- Hypertension – Additional goal 1
- Hypertension – Additional goal 2

Weight

- Weight - Total pounds: Reduce barriers to health and wellness to reach a healthy weight.
- Weight - Per pound: Reduce barriers to health and wellness to reach a healthy weight goal.
- Weight - Calories: Reduce barriers to health and wellness to reach a healthy weight goal, by focusing on calorie intake.
- Weight – Additional goal 1
- Weight – Additional goal 2

Hyperlipidemia

- Hyperlipidemia - Total Cholesterol: Reduce barriers to health and wellness as evident by reducing total Cholesterol.
- Hyperlipidemia - LDL: Reduce barriers to health and wellness as evident by reducing LDL cholesterol.
- Hyperlipidemia – Additional goal 1

- Hyperlipidemia – Additional goal 2

Asthma

- Asthma - Frequency: Reduce barriers to health and wellness as evident by improved maintenance of asthma with reduction in asthma attacks. Progress will be measured by tracking number of attacks from baseline to identified target.
- Asthma – Additional goal 1
- Asthma – Additional goal 2

Tobacco Use

- Tobacco Use - Taper down: Reduce barriers to the cessation of tobacco use by tapering down with the intent to eventually quit.
- Tobacco Use - Stop: Reduce barriers to the cessation of tobacco use and will no longer use tobacco products by the target date.
- Tobacco Use - Additional goal 1
- Tobacco Use - Additional goal 2

Alcohol/Drug Use

- Alcohol/Drug Use - Alcohol: Reduce barriers to reduce / stop the use of alcohol and maintain sobriety.
- Alcohol/Drug Use - Drugs: Reduce barriers to reduce / stop drug usage and maintain sobriety.
- Alcohol/Drug Use - Alcohol and drug use: Reduce barriers to reduce / stop alcohol and drug usage and maintain sobriety.
- Alcohol/Drug Use – Additional goal 1
- Alcohol/Drug Use – additional goal 2

Chronic Pain

- Chronic Pain - Rating scale: Reduce barriers and utilize strategies and treatments to better manage chronic pain.
- Chronic Pain - Behavior change: Reduce barriers and utilize strategies and treatments to better manage chronic pain.
- Chronic Pain - Additional goal 1
- Chronic Pain - Additional goal 2

Objectives

- Adherence: Pt will maintain medication adherence for symptom management.
- Self-care: Patient will explore and implement self-care practices to improve overall health and wellness.
- Sleep: Patient will improve sleep quality, utilizing good Sleep hygiene.
- Hygiene: Patient will maintain personal hygiene / grooming.
- Specialists: Pt will work with treatment team and specialist to improve health and wellness, as well as utilize community supports appropriately.

- Education of dx: Patient will gain understanding of the diagnosis and symptoms related to diagnosis, and impact on overall health and wellness.
- Ed Cycle of Behaviors / ABC Model: Pt will understand the cycle of behaviors, recognizing precipitating event, that triggers thoughts, and feelings, which translate into behaviors and can reinforce negative thinking patters and actions.
- F-F-F: Patient will understand and be able to identify the warning signs / triggers of the Fight-Flight-Freeze response, to allow the use of coping skills to counter the physical impacts. Pt will report noticed changes with Fight, Flight, or Freeze response.
- Coping: Patient will use healthy coping strategies to improve negative symptom management.
- Deep Breathing: Patient will learn, practice, and utilize Deep Breathing for coping and calming.
- Mindfulness: Patient will learn, practice, and utilize mindfulness for coping.
- Tension Reduction: Patient will learn, practice, and utilize tension reduction strategies for wellness.
- Behavioral Activation: Patient will gain understanding of the benefits of and utilize behavioral activation.
- Cognitive Distraction: Patient will learn, practice, and utilize cognitive distraction for coping.
- Activity/Exercise: Patient will increase physical activity.
- Triggers: Patient will be able to recognize triggers for negative symptoms and utilize strategies to cope with emotional reactions.
- Behaviors: Patient will be able to identify behaviors, patterns and functional impact connected to symptoms and identify behavior changes to assist with negative symptoms reduction.
- Communication: Patient gain understanding of the difference between passive, aggressive, and assertive communication and increase the use of and confidence in assertive communication.
- Emotions: Patient will gain understanding in the purpose of emotions, reduce the urge to avoid and gain skills to work through uncomfortable / overwhelming emotions.
- Core Beliefs: Patient will increase awareness and of negative thing patterns, cognitive distortions, and core beliefs, to evaluate facts from judgements.
- Socratic Questions: Patient will analyze and thoughts through Socratic questions, to identify evidence of, or lack of, evidence to support thoughts.
- Exposure: Patient will utilize strategies, such as imagery and progressive exposure to reduce the intensity of negative symptoms, giving the ability to have more control over emotions, and focus on successes, versus the what ifs. Pt will report exposure exercises and the impact within sessions.
- Self-Worth: Patient will utilize strategies to develop a positive self-worth, identify strengths, learn to care for and like self and to reduce self-judgment to improve self-esteem.
- Problem solving Skills: Patient will learn and utilize problem solving skills to evaluate situations and identify healthy solutions.
- Interpersonal Relationships: Patient will evaluate relationships, examine healthy versus unhealthy interactions, and set appropriate boundaries.
- Safety Plan: Patient will complete and follow safety plan to reduce risk.
- Additional objective 1
- Additional objective 2
- Additional objective 3
- Additional objective 4
- Additional objective 5

Interventions

Risk

- Risk - BH Provider assessed safety and risk.
- Risk - BH Provider completed safety plan.
- Risk - BH Provider reviewed safety plan.
- Risk - BH Provider educated and provided crisis line phone numbers and phone applications.
- Risk - other

Adherence

- Adherence - BH Provider reviewed adherence to attending scheduled appointments and taking mediations as prescribed.
- Adherence - BH Provider educated on the benefits of medication adherence.
- Adherence - BH Provider encouraged scheduling appointment with prescribing provider for medication review.
- Adherence - BH Provider reviewed adherence to behavioral activation plan.
- Adherence - BH Provider reviewed adherence to diet and lifestyle changes for wellness.
- Adherence - Other

Assessment

- Assessment - BH Provider assessed current mood and symptoms.
- Assessment - BH Provider explored changes in mood and symptoms.
- Assessment - BH Provider assessed functioning and Behaviors.
- Assessment - BH Provider assessed functional limitations caused by presenting problem.
- Assessment - BH Provider assessed functional limitations caused by mobility.
- Assessment - BH Provider assessed functional limitations caused by work.
- Assessment - BH Provider assessed functional limitations caused by school.
- Assessment - BH Provider assessed functional limitations caused by Interpersonal interactions.
- Assessment - BH Provider assessed functional limitations caused by Activities of Interest.
- Assessment - BH Provider assessed readiness for change.
- Assessment - BH Provider assessed progress toward goals.
- Assessment - other

Educate

- Educate - BH Provider provided education on BH services within the clinic and community.
- Educate - BH Provider provided education on the therapeutic process and treatment modality.
- Educate - BH Provider provided education on symptoms and / or diagnosis.
- Educate - BH Provider provided education on relaxation, coping skills, and / or distress tolerance.
- Educate - BH Provider provided education on deep breathing
- Educate - BH Provider provided education on mindfulness
- Educate - BH Provider provided education on tension reduction
- Educate - BH Provider provided education on imagery
- Educate - BH Provider provided education on other:

- BH Provider provided education on intervention strategies.
- BH Provider provided education on health risks connected to unmanaged symptoms.
- BH Provider provided education on diet changes and modifications.
- BH Provider provided education on benefits of behavioral activation and or change.
- Educate - Other

Goal Setting

- Goal Setting - BH Provider explored goals and expectations for services.
- Goal Setting - BH Provider assisted in the identification of long term and short-term smart goals.
- Goal Setting - BH Provider connected objectives to reach and / obtain goals.
- Goal Setting - BH Provider facilitated in the development of Treatment Plan.
- Goal Setting - BH Provider evaluated progress toward objectives and goals.

Strategies

- Strategies - BH Provider utilized and reinforced Relaxation, Coping Skills, and / or Distress Tolerance strategies.
- Strategies - BH Provider evaluated and reinforced behavioral activation.
- Strategies - BH Provider utilized strategies to expand emotional understanding.
- Strategies - BH Provider analyzed and identified maladaptive thoughts.
- Strategies - BH Provider utilized and reinforced strategies to challenge and alter thoughts.
- Strategies - BH Provider utilized and reinforced strategies for building confidence in self.
- Strategies - BH Provider encouraged and reinforced assertive communication skills.
- Strategies - BH Provider evaluated and reinforced healthy relationships and boundaries.
- Strategies - BH Provider utilized and reinforced impulse control strategies.
- Strategies - BH Provider utilized and reinforced inattention and focus strategies.
- Strategies - BH Provider encouraged and reinforced behavior modification strategies.
- Strategies - BH Provider evaluated and identified healthy parental skills.
- Strategies - Other

Termination

- Termination - BH Provider educated and discussed the termination process, assessing continued need for current level of services and the need for follow up services.
- Termination - Other

APPENDIX A: NOTICES

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