Children’s Mental Health Outcome Measures Reporting System
4.12.2022

User Manual
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Components of the Children’s Mental Health Outcome Measures Reporting System

1) Submission History: Allows users to check the submission history of measures reported for a client. This history includes the total score, subscale scores, and a timestamp for the measures submitted.

2) CMH Reports: Allows users to create reports summarizing data submitted to the system.

3) Client and Provider Information Entry Form

4) Strengths and Difficulties Questionnaire (SDQ) Entry Forms

5) Child and Adolescent Service Intensity Instrument (CASII) Entry Form

6) Early Childhood Service Intensity Instrument (ECSII) Entry Form

7) Summary Page: A report of scores for the measures reported during the current session.

8) Checklist: Lists completed and uncompleted tasks for the current session.

Logging into CMH Outcome Measures

1) Log in to MN–ITS.
2) Select CMH Outcome Measures from the menu on the left side of the page. This menu is populated based on the user’s MN-ITS account permissions and may change as new functions are added to MN-ITS.
Client and Provider Information

1) Field titles with an asterisk (*) indicate the information is required.
2) Enter Client Information
   a) Identification Number: There are 3 options for this number.
      i) Recipient ID: This number is also known as a Medical Assistance (MA) number or Person Master Index (PMI) number. If the client is enrolled in a Minnesota Health Care Program, use this number to enter assessments. This is a numerical field, 8 digits starting with 0. Only numbers should be entered in this field.
      ii) If client does not have a Recipient ID, check the box labeled, “Client does not have a Recipient ID,” located to the right of the field. The CMH ID field will appear.
      iii) If an error message stating, “Recipient ID not found. Please enter a valid 8-digit Recipient ID.” is displayed, please confirm that the correct Recipient ID and correct birthdate have been entered. If these two entries do not match recipient data that is currently on file with DHS, the user will receive this error message.
      iv) CMH ID: This is a system-generated number that contains 11 digits and starts with 99. If the client was previously assigned a CMH ID, use the same CMH ID for all future submissions. Do not enter internal agency case numbers or any other identification numbers that have not been assigned by the system.
      v) Generate a new CMH ID: If the child does not have a Recipient ID and has not been assigned a CMH ID, check the box labeled, “Client does not have a CMH ID, CMH ID needs to be assigned.” The system will generate a CMH ID.
         (i) Note: The system generates a CMH ID number for each client entered into the system, even if a client’s data is reported using their Recipient ID. If assessment information is entered using a Recipient ID, continue to use that number for future submissions.
   b) Sex: Select the client’s sex.
   c) Gender Identity: Select the client’s gender identity.
   d) Primary Diagnosis: Select the client’s primary ICD-10 diagnosis (dropdown menu). A list of acceptable mental health codes can be found on the Mental Health Diagnostic Codes Ranges page of the MHCP Provider Manual.
      i) Note: The menu also includes some additional diagnostic codes for conditions that may be of a focus of clinical attention, but are outside of the mental health policy scope.
   e) Race: Select the client’s race. Select all that apply.
   f) Ethnicity: Select the client’s ethnicity.
   g) Date of Birth: Enter the client’s date of birth (MM/DD/YYYY).
   h) County of Residence: Select the client’s county of residence (dropdown menu).
   i) Tribe: Select the tribe with which the client is affiliated or select “Not a tribe member” (dropdown menu).
   j) Residential Status: Select the status that best describes the client’s current living
arrangement (dropdown menu).
i) If “Other” is selected, a free text field will appear. Enter a brief description of the client’s current living arrangement. Extensive detail is not necessary. In most instances the options from the dropdown menu should sufficiently convey the residential status of the client.

3) Enter Agency Information
   a) Both the Clinic National Provider Identifier (NPI) and the Clinician NPI are required.
      i) If you do not know the appropriate clinic or clinician NPI, please use the “Lookup National Provider Identifier” link to search the NPI Registry.
   b) Providers not employed by an agency (i.e., operate a private practice) should enter their clinician NPI in both the Clinic and Clinician NPI fields.
   c) If the primary therapist is a clinical trainee, the clinician NPI number entered should be that of the clinical supervisor.
   d) If there is more than one mental health professional and/or more than one agency is treating the client, the treatment team should designate the primary treating professional or agency who will be responsible for data entry and whose clinic and clinician NPI numbers should be used.

4) Enter Evaluation Period
   a) Select the Evaluation Period for the current session. The first entry for each client should be entered in the “Time 1” evaluation period. Subsequent assessments should be entered in the next available evaluation period. To determine the next available evaluation period, use the “Submission History” function.

5) Submission History
   a) The Submission History function allows users to check the submission history of outcome measures for a specific client.
   b) To use this feature:
      i) Select the “Submission History” link at the bottom of the page. A new tab will open.
      ii) Users can search by Recipient ID or CMH ID. To search by the client’s Recipient ID, enter the 8-digit number in the box labeled, “Recipient ID.” To search by the client’s CMH ID, enter the 11-digit number in the box labeled, “CMH ID.”
      iii) Select the “Search” button. The submission history, including the assessments, scores, and timestamps, for the specified ID number will be presented.
      iv) Search results can be copied, exported to Microsoft Excel, converted to a PDF, or printed using the buttons at the top of the table.
      v) Selecting the “Clear All” button will clear all of the search fields.
   c) Role-based Security: Users can view client information entered under the clinician (individual) NPI specified in their MN-ITS User Name. If a user’s MN-ITS User Name includes a clinic (organizational) NPI rather than a clinician NPI, then the user can view client information entered under the clinic NPI specified in their MN-ITS User Name.

6) Submit Client and Agency Information
   a) After completing all required fields on the client and agency information page, select the “Continue” button in the lower left corner of the page to move to the assessment entry forms or select “Cancel” to clear all data fields.

Assessment Overwrite Warning

1) Only one set of measures (SDQ and CASII/ECSII) per treating provider is allowed each evaluation period. If a SDQ, CASII, or ECSII has already been submitted for a particular evaluation period, a warning message stating, “WARNING: An undefined SDQ/CASII/ECSII has already been submitted for this evaluation period. Submitting another undefined
SDQ/CASII/ECSII will overwrite the previous submission.” will appear. Users should use the Submission History function to verify that the correct evaluation period has been selected for the current data entry session. Users should not overwrite data unless they are certain the previous entry should be deleted. Data that is overwritten cannot be recovered.

2) All measures may be entered at the same time or in several data entry sessions. The summary page only lists the scores for the assessments entered during the current data entry session.

**Completing the Strengths and Difficulties Questionnaire (SDQ)**

1) One SDQ for each category type listed below can be submitted for each evaluation period. If multiple parents/guardians, teachers, or other informants complete forms for a given evaluation period, choose the most representative form for each category. To skip SDQ entry for an evaluation period, select the “Skip SDQ to CASII” or “Skip SDQ to ECSII” link above the checklist to move on to the CASII or ECSII.

2) To enter SDQ data:
   a) Select the SDQ Category Type: Parent, Teacher, Self, or Informant
   b) Select SDQ Form Age: 2-4, 4-10, 11-17, or 18+
   c) Enter the Evaluation Date: Enter the date the SDQ was actually completed by the respondent (MM/DD/YYYY). Do not enter the date the information is entered into the Outcome Measures system.
   d) Select a response for each item (Items 1–25). If an item was not answered, select “N/A”.
   e) Select “Continue to Impact Scores for this SDQ form”.
   f) Select a response for each item (Impact Items 1-8). If an item was not answered or the Impact section of the measure was not completed, select “Not Answered” for each item.
   g) SDQ Completed by: Select the entry that best describes the respondent.
   h) Once all required items are complete, the following options are available:
      i) Select “Cancel” to clear all data entered during the current session and return to the first page of the application.
      ii) Select “+Add another SDQ form” to enter another SDQ under the current evaluation period.
      iii) Select “Continue to CASII Entry” to enter a CASII under the current evaluation period.
      iv) Select “Continue to ECSII Entry” to enter an ECSII under the current evaluation period.
      v) Select “Score, Review and Submit” if there are no additional measures to enter for the current evaluation period. The user will be directed to the Summary Page.

**Completing the Child and Adolescent Service Intensity Instrument (CASII)**
1) One CASII may be submitted per treating provider for each evaluation period.
2) To enter CASII data:
   a) Enter the Evaluation Date: Enter the date the CASII was completed by the treating professional (MM/DD/YYYY). Do not enter the date the information is entered into the Outcome Measures system.
   b) Select a response for each item (Items I - VI-B). All items are required.
   c) Select “Continue to Recommended Services.” Select “Cancel” to clear all entered data and return to the first page of the application.
3) Enter Recommended Services (Optional):
   a) Under “Services,” select the service that is currently being recommended by the treatment team.
   b) Under Hours per Month: Enter the total number of hours per month recommended for the selected service.
   c) Select “Add additional services and hours” to add additional services. Up to 10 services may be entered.
      i) If “Other” is selected from the Services menu, a text box will appear. Use this option to list services that are not included in the dropdown list. There is a 30 character limit in the text box. If more than 30 characters are entered, an error message will appear when the “Score, Review, and Submit” button is selected.

3) Select “Score, Review and Submit” to score and submit the measures entered during the current data entry session. Select “Cancel” to clear all data entered during the current session and return to the first page of the application. The “Checklist” menu can also be used to navigate to other pages within the application if additional assessments or revisions need to be entered prior to submitting the data.

Completing the Early Childhood Service Intensity Instrument (ECSII)

1) One ECSII may be submitted per treating provider for each evaluation period.
2) To enter ECSII data:
   a) Enter the Evaluation Date: Enter the date the ECSII was completed by the treating professional (MM/DD/YYYY). Do not enter the date the information is entered into the Outcome Measures system.
b) Select a response for each item (Items I-VI-C). All items are required.
c) Select “Continue to Recommended Services.”
3) Enter Recommended Services (Optional):
   a) Under “Services,” select the service that is currently being recommended by the treatment team.
   b) Under Hours per Month: Enter the total number of hours per month recommended for the selected service.
   c) Select “Add Additional services and hours” to enter additional services. Up to 10 services may be entered.
      i) If “Other” is selected from the Services menu, a text box will appear. Use this option to list services that are not included in the dropdown list. There is a 30 character limit in the text box. If more than 30 characters are entered, an error message will appear when the “Score, Review, and Submit” button is selected.
4) Select “Score, Review and Submit” to score and submit the measures entered during the current data entry session. Select “Cancel” to clear all data entered during the current session and return to the first page of the application. The “Checklist” menu can also be used to navigate to other pages within the application if additional assessments or revisions need to be entered prior to submitting the data.

Summary Page

1) The summary page presents the scores for the assessments entered during the current session.
2) The following warning will be displayed in red text at the top of the summary page: **Warning:** Data entered in this session will be submitted and saved only after you select the 'SUBMIT' button. Please review and then submit this data. If you wish to edit the data, then select the 'edit' link provided in the checklist on the right panel of this page. Once you submit the data, you cannot make any changes.
3) Print this page for your records. The summary page cannot be accessed after submission. The following warning will be displayed in red text on the right side of the page as a reminder to print the summary page: **Warning:** Please print for your records. All data will be unavailable once the web browser is closed.
4) Select “Submit.” Select “Cancel” to clear all data entered during the current session and return to the first page of the application. The “Checklist” menu can also be used to navigate to other pages within the application if additional assessments or revisions need to be entered prior to submitting the data.

**SDQ Score Categorization**

1) Cut-points for SDQ scores for clients ages 4-17, including the 4-10 years old and 11-17 years old forms.

<table>
<thead>
<tr>
<th></th>
<th>Original 3-band categorization</th>
<th>Newer 4-band categorization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal</td>
<td>Borderline</td>
</tr>
<tr>
<td>Total difficulties score</td>
<td>0-13</td>
<td>14-16</td>
</tr>
<tr>
<td>Emotional problems score</td>
<td>0-3</td>
<td>4</td>
</tr>
<tr>
<td>Conduct problems score</td>
<td>0-2</td>
<td>3</td>
</tr>
<tr>
<td>Hyperactivity score</td>
<td>0-5</td>
<td>6</td>
</tr>
<tr>
<td>Peer problems score</td>
<td>0-2</td>
<td>3</td>
</tr>
<tr>
<td>Prosocial score</td>
<td>6-10</td>
<td>5</td>
</tr>
<tr>
<td>Impact score</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
2) Provisional cut-points for SDQ scores for clients ages 2-4.

<table>
<thead>
<tr>
<th>Parent completed SDQ</th>
<th>Original 3-band categorization</th>
<th>Newer 4-band categorization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal</td>
<td>Borderline</td>
</tr>
<tr>
<td>Total difficulties score</td>
<td>0-12</td>
<td>13-15</td>
</tr>
<tr>
<td>Emotional problems score</td>
<td>0-2</td>
<td>3</td>
</tr>
<tr>
<td>Conduct problems score</td>
<td>0-2</td>
<td>3</td>
</tr>
<tr>
<td>Hyperactivity score</td>
<td>0-5</td>
<td>6</td>
</tr>
<tr>
<td>Peer problems score</td>
<td>0-3</td>
<td>4</td>
</tr>
<tr>
<td>Prosocial score</td>
<td>6-10</td>
<td>5</td>
</tr>
<tr>
<td>Impact score</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teacher completed SDQ</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total difficulties score</td>
<td>0-10</td>
<td>11-14</td>
<td>15-40</td>
</tr>
<tr>
<td>Emotional problems score</td>
<td>0-2</td>
<td>3</td>
<td>4-10</td>
</tr>
<tr>
<td>Conduct problems score</td>
<td>0-2</td>
<td>3</td>
<td>4-10</td>
</tr>
<tr>
<td>Hyperactivity score</td>
<td>0-4</td>
<td>5-6</td>
<td>7-10</td>
</tr>
<tr>
<td>Peer problems score</td>
<td>0-2</td>
<td>3-4</td>
<td>5-10</td>
</tr>
<tr>
<td>Prosocial score</td>
<td>5-10</td>
<td>4</td>
<td>0-3</td>
</tr>
<tr>
<td>Impact score</td>
<td>0</td>
<td>1</td>
<td>2-10</td>
</tr>
</tbody>
</table>

**Submission Notification Page**

1) Users will receive a message stating, “You’ve successfully submitted the outcome measures for your client! Thank you for your submission!” as confirmation of successful submission of the current data entry session.

**Children’s Mental Health Outcome Measures Reports**

1) This function allows users to create reports based on data submitted to the CMH Outcome Measures System. To access this function, select the “CMH Report” link in the upper right hand corner of the page. A new tab will open.
2) Role-based Security: The report options available to each user are determined by the user’s MN-ITS account. Users with a clinic (organizational) NPI in their MN-ITS User Name, can create Clinic and Provider reports based on client information entered under the clinic NPI specified in their MN-ITS User Name. Users with a clinician (individual) NPI can create Provider and Individual reports based on client information entered under the clinician (individual) NPI specified in their MN-ITS User Name.

3) To Create a Report:
   a) Field titles with an asterisk (*) indicate the information is required.
   b) Select the Report Type:
      i) Clinic Reports: These reports display averages of the data submitted under the specified clinic (organizational) NPI.
         - (1) Clinic SDQ Total Score Report
         - (2) Clinic SDQ Subscales Report
         - (3) Clinic CASII Report
         - (4) Clinic ECSII Report
      ii) Provider Reports: These reports displays averages of the data submitted under the specified clinic (organizational) and clinician (individual) NPI.
         - (5) Provider SDQ Total Score Report
         - (6) Provider SDQ Subscales Report
         - (7) Provider CASII Report
         - (8) Provider ECSII Report
      iii) Individual Reports: These reports display data submitted for a specific client under the specified clinician (individual) NPI.
         - (9) Individual SDQ Total Score Report
         - (10) Individual SDQ Subscales Report
         - (11) Individual CASII Report
         - (12) Individual ECSII Report
   c) Report Filters:
      i) Clinic NPI and Clinician NPI: The NPI from the user’s MN-ITS User Name will default to the appropriate field. If applicable, enter the appropriate Clinician NPI to create a Provider report.
      ii) Evaluation Start Date: Enter the start date of the report (MM/DD/YYYY).
      iii) Evaluation End Date: Enter the end of the report (MM/DD/YYYY).
      iv) SDQ Category Type: Select the SDQ Category Type.
      v) Completed By (Optional): Select the SDQ respondent type from the dropdown menu.
         1) If “Self” is selected in the SDQ Category Type field, the Completed By field will default to “Self.”
   d) Select the “Run Report” button. To clear all of the filter fields, select the “Clear All” button.
      i) The report graph and table can be printed or converted to a PDF file using the
“Print/PDF” button to the left of the graph.

1) Select a data point on the graph to display the Evaluation Period and data point value.

2) Select a scale in the legend to highlight a data series in the graph.

ii) The report table can be exported to Microsoft Excel using the “Excel” button to the left of the table.

1) A Search field is located to the right of the report table.

4) Users can access the Submission History function from the CMH Reports page by selecting the “Submission History” link in the upper right hand corner of the page or can return to the main Client Information page of the application by selecting the “Enter Data for Client” link.

Technical Assistance

- For technical assistance, contact the MHCP Provider Resource Center.