



# Clinical Guidelines for the use of CLINICOM

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## 1. Introduction

This document contains clinical recommendations that have been compiled to assist clinicians in the use of Clinicom from the clinical perspective. Clinicom assists clinicians with evaluating patients for psychiatric conditions.

Clinicom is meant to be used by self-reporting or by reporting on someone else (third party reporting). It is advisable that the clinician carefully reviews the Clinicom report and becomes familiar with it in order to expedite the assessment. We will call “user” the patient, guardian, or clinician utilizing the system.

Clinicom has been developed, tested, and refined since 2004. The application is intuitive and is designed as an interactive, time-saving tool.

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## 2. Choosing the right Clinicom Assessment

Invite Patient ▾

First choose the assessment type and then choose to send via email, text message or both. Next, fill in the appropriate fields and click send. The system will send the default invite to the patient. [Learn More](#)

Select Assessment Type

CLINICOM PRO ?

CLINICOM ?

Custom Assessment ?

It is important for Clinicians to understand the type of assessments Clinicom provides and the difference between them.

- Clinicom PRO. (Comprehensive DSM-5 Assessment)** The Clinicom Pro assessment is dynamically generated, based on a multitude of patient's variables and inputs. Clinicom PRO includes all Informational Questionnaires related to clinical and psycho-social information including, but not limited to medications, allergies, past medical history, family history, support system, educations, employment, trauma/abuse, military history, developmental history, sexual development etc. This assessment can assess for 80+ mental health conditions and includes alerts for Suicidality, PTSD, TBI, and Violent Tendencies. This Assessment includes complex psycho-social informational gathering.

The length of the Clinicom PRO assessment varies by complexity of the case. Clinicom PRO includes four gold standard assessments as a control arm, which includes the PHQ9, GAD7, DAST10 and the Audit-C. The control arm can be customized for each client to be any assessment(s) in our library. Contact [support@Clinicom.com](mailto:support@Clinicom.com) for more information on customizations.
- Clinicom. (Comprehensive DSM-5 Assessment)** The Clinicom assessment is dynamically generated based on a multitude of patient variables and inputs. This assessment can assess for 80 + mental health conditions but **does not include** all psychosocial informational questionnaires but does gather medications, allergies, and important medical Histories and other general information. Clinicom takes up to 50% less time for the patient to complete than the Clinicom Pro assessment. Clinicom includes four gold standard assessments as a control arm, which includes the PHQ9, GAD7, DAST10 and the Audit-C. The control arm can be customized for each client to be any assessment(s) in our library. Contact [support@Clinicom.com](mailto:support@Clinicom.com) for more information on customizations.
- Clinicom Custom.** The Clinician can create a customized assessment by selecting any or all of our DSM 5 based assessments, standardized tests, or any informational questionnaire. Each Custom Clinicom still includes four gold standard assessments as a control arm, which includes the PHQ9, GAD7, DAST10 and the Audit-C.

## 3. Sending the assessment to the patient

The screenshot shows the 'My Patients' section of the Clinicom interface. It includes a 'Patients List >' link, 'Invite Instructions >', and an 'Invite Patient' dropdown menu. Below the dropdown is a text box with instructions: 'First choose the assessment type and then choose to send via email, text message or both. Next, fill in the appropriate fields and click send. The system will send the default invite to the patient.' To the right is a 'Learn More' button. The 'Invite Patient:' form contains two input fields: one for an email address (pre-filled with 'patient@gmail.com') and one for a phone number (pre-filled with '5557778899'). Below these fields are two buttons: a red 'Send Invite' button and a grey 'Cancel' button. At the bottom left, there is an 'Add Patient >' link.

- **Clinicom’s assessments** can be sent to the patient quickly and easily either by email, text, or both. The patient can then complete the assessment on any digital device at their own pace. The patient can also be invited to complete a Clinicom while in the provider’s office by clicking “Add a patient”. The patient does not see or receive the completed assessment until the Clinician has reviewed the information and shares it with the patient.
- **Clinicom screens for 80+ possible psychiatric conditions** based on the DIAGNOSTICS AND STATISTICS MANUAL OF MENTAL CONDITIONS (DSM-5). Clinicom’s logic is built with hundreds of Proprietary adaptive algorithms’, based on clinical guidelines suggested by the American Psychiatric Association, (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) as well as research data results published in major clinical journals.
- **Reviewing Associated Complaints.** One of the most important features of Clinicom is the compulsory “Yes” or “No” answers that the user faces If the patient does or does not present with history of having OTHER symptoms or behaviors. In other words, the user has to answer “Yes” or “No” when facing the list of the associated complaints, which is the same as the list of chief complaints MINUS the chief complaint chosen before. This method allows for the user to negate or endorse a number of symptoms to complete the screening that ultimately drives the logic.
- **Over-rating or under-rating** are important factors that will determine the validity of the diagnoses suggested for review and the severity of the condition. Patients who have poor insight, are malingering, have secondary gains, are seeking disability, have legal issues or have cognitive limitations (i.e., low IQ or memory problems) may have reports that are not consistent with your clinical impression. Watch for symptom severity numbers that are unusually high – especially severity of 10/10 for many symptoms sets. Clinicom does not estimate “fake good” or “fake bad” users. If you notice that there are an excessive number of suggested diagnoses in the report, it is important to consider limitations on the part of the user as a factor. In these particular cases it is recommended that the clinician very closely validate the report during the clinical interview. At the top of each Clinicom report there is a time to completion section and a rating on how this time to completion compares to other patients faced with similar question sets. This indicator helps clinicians validate the quality of the assessment.

- For instance, if the top of the Clinicom report says 30 mins 5% above average that means that this patient took 5% longer than similar patients faced with similar questions. The opposite is also true. If the report header says 15mins 50% less time than average the clinician may use this as an indicator that the patient may have rushed the assessment and therefore make their own clinical judgement on the quality of the assessment. There is no hard or fast rule on these numbers as different patients have different reading speeds and this is not intended to be definitive of the final quality of the report data. This is simply a marker or Flag for the clinician to make a clinical judgement after reviewing the information and speaking with the patient. This feature can also be used to track billable time spent on Clinicom.
- **Look for sensitive information** in the “Safety”, the “Substance Abuse” and the “Legal” sections of the Social History. This information may offer data that the patient may feel reluctant or uncomfortable to discuss verbally during the clinical interview but may feel more comfortable addressing it in within Clinicom. If that is the case, you may acknowledge to the patient that you are aware of the presence of sensitive information, but that you are willing to discuss it whenever the patient feels comfortable.
- **Each symptom is rated from 0-10 and 4 is the threshold number.** The user can choose a severity number from 0-10 where 0 = symptom not present, 10 = most severe symptom. 4 out of 10 is the threshold for any CLINICOM symptom to be accounted as “positive” into the criteria set. This is critical as the system may not prompt suggested Diagnosis if the patient under reports the severity lower than 4 on their answers. If you see many answers that are a 3 on severity it is important to dig in deeper with the client to make sure these symptoms are not more severe by their clinical impression. The clinician always retains full diagnostic control and can overwrite or add any suggested diagnosis in the diagnosis tab on each patient summary and can also do this within the report using the diagnosis button.
- Clinicom does not diagnose conditions but rather collects the data for a clinician to make the final diagnostic interpretation. Clinicom can suggest potential diagnosis for a clinician to review and also labels whether the conditions suggested meet the DSM criteria for a condition. This is not intended to be the final diagnosis. Only a trained Clinician should make the final Diagnosis.

- The following conditions are assessed by Clinicom:

	<b>CONDITION</b>	<b>ICD-10 CODES</b>
1	Acute Stress Disorder	F43.0
2	Adjustment Disorder with Anxiety	F43.22
3	Adjustment Disorder with Depressed Mood	F43.21
4	Agoraphobia	F40.00
5	Alcohol Use Disorder	(F10.10) (F10.20) 4–5 symptoms.
6	Anorexia Nervosa	(F50.01) Restricting-type. (F50.02) Binge-eating/purging type.
7	Attention-Deficit/Hyperactivity Disorder, Combined Presentation	F90.2
8	Attention-Deficit/Hyperactivity-Disorder, Predominantly Hyperactive-Impulsive Presentation	F90.1
9	Attention-Deficit/Hyperactivity-Disorder, Predominantly Inattentive Presentation	F90.0
10	Autism Spectrum Disorder	F84.0
11	Bipolar I Disorder	(F31.11) Mild with Current or most recent episode manic (F31.12) Moderate with Current or most recent episode manic (F31.13) Severe with Current or most recent episode manic (F31.31) Mild with Current or most recent episode depressed (F31.32) Moderate with Current or most recent episode depressed (F31.4) Severe with Current or most recent episode depressed (F31.2) With psychotic features with Current or most recent episode manic (F31.73) In partial remission with Current or most recent episode manic (F31.74) In full remission with Current or most recent episode manic (F31.71) In partial remission with Current or most recent episode hypomanic (F31.72) In full remission with Current or most recent episode hypomanic (F31.5) With psychotic features with Current or most recent episode depressed (F31.75) In partial remission with Current or most recent episode depressed (F31.76) In full remission with Current or most recent episode depressed
12	Bipolar II Disorder	F31.81
13	Bulimia Nervosa	F50.2
14	Cannabis Use Disorder	(F12.10) Mild: Presence of 2–3 symptoms. (F12.20) Moderate: Presence of 4–5 symptoms. (F12.20) Severe: Presence of 6 or more symptoms
15	Chronic Insomnia	F51.01
16	Chronic Motor or Vocal Tic Disorder	F95.1

17	Communication Disorder	F80.9
18	Conduct Disorder	(F91.1) Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years. (F91.2) Adolescent-onset type: Individuals show no symptom characteristic of conduct disorder prior to age 10 years. (F91.9) Unspecified onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.
19	Dissociative Disorder	F44.9
20	Encopresis	F98.1
21	Enuresis	F98.0
22	Episodic Insomnia	F51.01
23	Gambling Disorder	F63.0
24	Generalized Anxiety Disorder	F41.1
25	Hallucinogen Use Disorder	(F16.10) Mild: Presence of 2–3 symptoms. (F16.20) Moderate: Presence of 4–5 symptoms. (F16.20) Severe: Presence of 6 or more symptoms.
26	Hypomanic Episode	(F31.71) In partial remission (F31.72) In full remission (F31.9) Unspecified
27	Kleptomania	F63.2
28	Impulse Control Disorder	F91.9
29	Inhalant Use Disorder	(F18.10) Mild: Presence of 2–3 symptoms. (F18.20) Moderate: Presence of 4–5 symptoms. (F18.20) Severe: Presence of 6 or more symptoms.
30	Insomnia Disorder	F51.01
31	Learning Disorder	(F81.0) With impairment in reading (F81.81) With impairment in written expression (F81.2) With impairment in mathematics
32	Major Depressive Disorder, Recurrent	(F33.0) Mild (F33.1) Moderate (F33.2) Severe (F33.3) With psychotic features (F33.41) In partial remission (F33.42) In full remission
33	Major Depressive Disorder, Single Episode	(F32.0) Mild (F32.1) Moderate (F32.2) Severe (F32.3) With psychotic features (F32.4) In partial remission (F32.5) In full remission
34	Manic Episode	(F31.11) Mild (F31.12) Moderate (F31.13) Severe
35	Obsessive-Compulsive Disorder	F42

36	Opioid Use Disorder	(F11.10) Mild: Presence of 2–3 symptoms. (F11.20) Moderate: Presence of 4–5 symptoms. (F11.20) Severe: Presence of 6 or more symptoms.
37	Oppositional Defiant Disorder	F91.3
38	Other Substances Use Disorder	(F19.10) Mild: Presence of 2–3 symptoms. (F19.20) Moderate: Presence of 4–5 symptoms. (F19.20) Severe: Presence of 6 or more symptoms.
39	Panic Disorder	F41.0
40	Persistent or Chronic Insomnia Disorder	F51.01
41	Persistent Depressive Disorder	F34.1
42	Persistent Motor or Vocal Tic Disorder	F95.1
43	Pica	(F98.3) in children and (F50.8) in adults
44	Posttraumatic Stress Disorder	F43.10
45	Posttraumatic Stress Disorder with Delayed Symptoms	F43.10
46	Posttraumatic Stress Disorder with Dissociative and Delayed Symptoms	F43.10
47	Posttraumatic Stress Disorder with Dissociative Symptoms	F43.10
48	Pyromania	F63.1
49	Reactive Attachment Disorder	F94.1
50	Recurrent Insomnia	F51.01
51	Schizophrenia	F20.9
52	Schizophreniform Disorder	F20.81
53	Sedative Use Disorder	F13.99
54	Selective Mutism	F94.0
55	Sensory Processing Disorder	F88
56	Separation Anxiety Disorder	F93.0
57	Sleep Disorder	G47.20
58	Social Anxiety Disorder (Social Phobia)	F40.10
59	Specific Phobia	(F40.218) Animal (e.g., spiders, insects, dogs). (F40.228) Natural environment (e.g., heights, storms, water). (F40.23x) Blood-injection-injury (e.g., needles, invasive medical procedures). Coding note: Select specific ICD-10-CM code as follows: F40.230 fear of blood; F40.231 fear of injections and transfusions; F40.232 fear of other medical care; or F40.233 fear of injury. (F40.248) Situational (e.g., airplanes, elevators, enclosed places). (F40.298) Other (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).



60	Stimulant Use Disorder	Mild: Presence of 2–3 symptoms. (F15.10) Amphetamine-type substance (F14.10) Cocaine (F15.10) Other or unspecified stimulant Moderate: Presence of 4–5 symptoms. (F15.20) Amphetamine-type substance (F14.20) Cocaine (F15.20) Other or unspecified stimulant Severe: Presence of 6 or more symptoms. (F15.20) Amphetamine-type substance (F14.20) Cocaine (F15.20) Other or unspecified stimulant
61	Substance Use Disorder	F19.10 Mild F19.20 Moderate F19.20 Severe
62	Substance Abuse - Amphetamines	(F15.10) Mild: Presence of 2–3 symptoms. (F15.20) Moderate: Presence of 4–5 symptoms. (F15.20) Severe: Presence of 6 or more symptoms.
63	Substance Abuse - Barbiturates/Benzodiazepines	(F13.10) Mild: Presence of 2–3 symptoms. (F13.20) Moderate: Presence of 4–5 symptoms. (F13.20) Severe: Presence of 6 or more symptoms.
64	Substance Abuse - Cocaine	(F14.10) Mild: Presence of 2–3 symptoms. (F14.20) Moderate: Presence of 4–5 symptoms. (F14.20) Severe: Presence of 6 or more symptoms.
65	Substance Use Disorder - Heroin/Fentanyl	(F11.10) Mild: Presence of 2–3 symptoms. (F11.20) Moderate: Presence of 4–5 symptoms. (F11.20) Severe: Presence of 6 or more symptoms.
66	Substance Abuse - Methadone/Suboxone	(F11.10) Mild: Presence of 2–3 symptoms. (F11.20) Moderate: Presence of 4–5 symptoms. (F11.20) Severe: Presence of 6 or more symptoms.
67	Substance Abuse - Other Opiates	(F11.10) Mild: Presence of 2–3 symptoms. (F11.20) Moderate: Presence of 4–5 symptoms. (F11.20) Severe: Presence of 6 or more symptoms.
68	Substance Abuse - Other Sedatives	(F13.10) Mild: Presence of 2–3 symptoms. (F13.20) Moderate: Presence of 4–5 symptoms. (F13.20) Severe: Presence of 6 or more symptoms.
69	Substance Use Disorder - Synthetics	(F19.10) Mild: Presence of 2–3 symptoms. (F19.20) Moderate: Presence of 4–5 symptoms. (F19.20) Severe: Presence of 6 or more symptoms.
70	Suicide Warning	R45.81

71	Tobacco Use Disorder	305.1 (Z72.0) Mild: Presence of 2–3 symptoms. 305.1 (F17.200) Moderate: Presence of 4–5 symptoms. 305.1 (F17.200) Severe: Presence of 6 or more symptoms.
72	Tourett's Disorder	F95.2
73	Transient Tic Disorder	F95.8
74	Traumatic Brain Injury	S06.2X9S
75	Unspecified Attention-Deficit/Hyperactivity Disorder	F90.9
76	Unspecified Bipolar Disorder	F31.9
77	Unspecified Depressive Disorder	(F32.9) Single Episode and (F33.9) Recurrent episode
78	Unspecified Disruptive, Impulse-Control, and Conduct Disorder	F91.9
79	Unspecified Feeding or Eating Disorder (Anorexia)	F50.9
80	Unspecified Feeding or Eating Disorder (Bulimia)	F50.9
81	Unspecified Traumatic Brain Injury	F02.80

- Clinicom Can also trigger warnings for Suicide, TBI, Violent Tendencies, and Aggression. This feature is already set up in your account and will only show if triggered.**
- Conditions NOT assessed by Clinicom:**
  1. Factitious Disorders
  2. Somatoform Disorders
  3. Amnesic Disorders
  4. Delirium
  5. Dementia
  6. Mental Retardation
  7. Sexual and Gender Identity Disorders
  8. Adjustment Disorders
  9. Psychiatric Disorders due to Medical Conditions
  10. Personality Disorders \* Clinicom does have a screener for PD called the UBQ found in the standardized test section that can be added to the control arm
- CLINICOM automatically calculates a Severity Index for each condition (CGI) suggested for the clinician's review and they run from 1 to 7 where 1 is "not ill", 2 is "very mildly ill", 3 is "mildly ill", 4 is moderately ill", 5 is "markedly ill", 6 "is seriously ill" and 7 is "extremely ill".**
- The Suicide Risk Score.** One of the most powerful tools that CLINICOM offers is the suicide risk assessment, "Suicidality", which is not considered a condition, but rather "a state". Here the logic calculates "the risk" for somebody to attempt or commit suicide, but it does not "predict" somebody's risk to commit suicide. The suicide logic is extremely complex as it pulls and weighs risk factor from multiple areas (i.e., history of previous suicidal attempts, stressors, history of abuse, family history, diagnoses, hospitalizations, multiple diagnoses, etc. in Clinicom Pro). We recommend that patients with suicide risk severity of 3 be seen by a psychiatrist within the next 48 hours; risk of 4 in 24 hours at the latest. A psychiatrist should see patients with a severity risk of 5, the same day. Patients with a suicide severity of 6 and 7 should be sent to the emergency room.



Before the patient or guardian start answering clinical questions, they have to acknowledge that the patient is not actively suicidal, i.e. has a suicide intent or plan. If they are actively suicidal, they are recommended to call the suicide hotline and go to any emergency room. If the patient is not actively suicidal while Clinicom is completed but becomes suicidal in the days after completing Clinicom but before the initial visit with the clinician, then they should be instructed to go to the ER for an evaluation.

*These are general guidelines and may not prevent a patient from committing suicide, thus ultimately are the clinician's responsibility and judgment that will determine the patient's disposition for safety. Consequently, please use these guidelines with extreme caution. Acutely suicidal patients are directed to go immediately to the ER, to call 911, or to call a suicide hotline and will not be able to start the assessment.*

## 4. Seeing your patient

- **The patient/guardian** should have fully completed CLINICOM *before* the initial clinical interview.
- **CLINICOM can be used for children aged 6 and above, adolescents, and adults.**
- Adults self-report
- Children & Adolescents
  - **For Children and Adolescents take into consideration the following:**
    - Guardians are supposed to use Clinicom for the assessment of persons under legal age.
    - Guardians can always ask relevant questions to the minor while taking the assessment if needed.
    - **360 assessments** for 13- 19 year-olds, Clinicom offers a special feature called our 360 assessment feature, that allows parents or guardians to opt in or out of sending the teenager their own Clinicom assessment at no extra charge. Parents or guardians are prompted by the system to select this option without the clinician having to do anything. The system calculates the patient's age and then determines if this option should be presented to the parent or guardian as they do their assessment. The parent or guardian can always opt out of this option, or they can say yes and enter the patient's cell phone number or email to send a separate Clinicom to the teenager. When opted IN this feature allows clinicians to gain two perspectives and valuable insight into the lives of their patients and family. Both reports will be in the patient's Clinicom file.

Note: 360 Assessments can also be sent as a follow up to any age reporter to gain insight on any age, person from the viewpoint of multiple reporters. This is found in the "Add follow up" section once you select the follow up, Click "Create Follow up" and in the "Send to box" select Third party.

Send Invite
✕

Please be sure to schedule this invite at least one week before the next appointment.

Send To:

Send On:

Repeat:

CLINICOM can only send communications to the patient. You may add a note to your patient to have them forward this message to any third party they choose.

Please forward this invite to

Create Follow Up
Cancel

CLINICOM should **not** be used for adults *self-report* who have;

- Very serious memory problems i.e. “Alzheimer’s Disease”.
  - Psychotic symptoms where reality testing is seriously compromised.
  - Mental retardation.
  - Geriatric patients with neurodegenerative disease.
- **Severity scores *before* treatment.** The patient or guardian who starts CLINICOM is instructed to mark the severity of the questions representing the patient’s functioning at baseline before treatment and not counting the effect of treatment which is asked in a different question set. For instance, if they felt very depressed before treatment the answer could be 9/10 and 5/10 after they got “a little better” with treatment.
  - **Review the Initial Assessment Report**, which is presented in a standard H&P format in Clinicom Pro. This process takes a few very valuable minutes and allows for enhanced face-to-face time with the patient. Reviewing the information prior to the clinical assessment allows you to begin working on the patient’s bio-psycho-social formulation and possible differential diagnoses. The report does not allow for changes made by the patient/guardian once the user ends the assessment in the computer. This guarantees compliance with strict rules associated with confidentiality-Health Information and Portability Act (HIPAA) and FDA CRF 21 Part 11. It is very important to understand that the questions that the patients see on the screen are very detailed and have several examples of the case in point. On the report, the same questions –now symptoms- presented to the clinician, are spelled out based on usual clinical verbiage in an abbreviated manner.
  - **Text boxes** are available for users to report freely on questions which do not have an answer that has to be responded to in a programmed format (i.e. yes/no, severity or multiple-choice questions). You can assess grammar, syntax, detail, and coherence of the information provided by the user in text boxes and displayed in italic letters. These are very valuable indicators of the overall patient’s (if self-reported) cognitive functioning and may guide you to decide how to approach the interview. These text boxes are also valuable when the user is reporting on a child/adolescent, because it allows the user to provide detailed sensitive information.

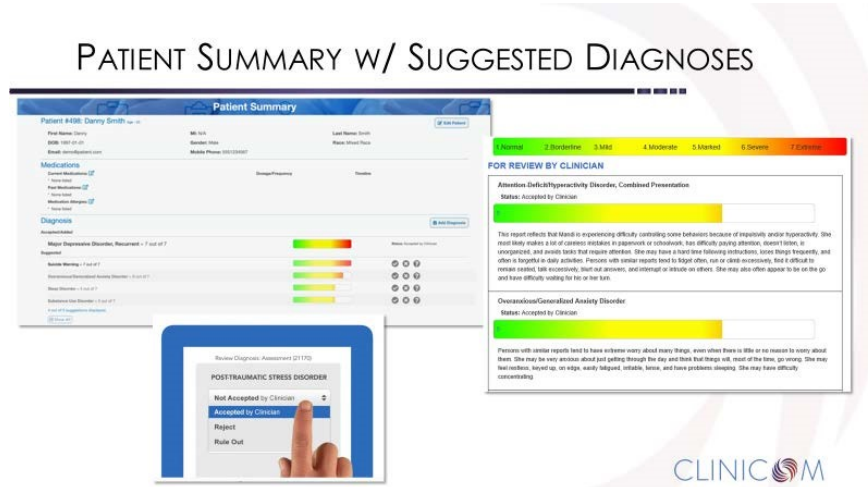
- **Focus on the Chief Complaint** and try to understand how it relates to the information in the report because this may be a way to look for the reliability and consistency of the reporter and address the reason why the patient or guardian is seeking help. Each Clinicom comprehensive assessment begins by asking the subject to define their chief complaint. This is the starting point for the algorithm and lets the clinician focus and prioritize conditions. The subject is also given a second opportunity to define as many other secondary complaints as needed but is only allowed to choose ONE chief complaint.
- **Secondary Complaints.** The patient/subject is also given a second opportunity to define as many other secondary complaints as needed but is only allowed to choose ONE chief complaint. Once the chief complaint is selected then the subject is prompted to choose as many secondary complaints as they would like. Each selected complaint can add to the length of the assessment. Algorithms for Suicide Alerts, PTSD, TBI, & Violent tendencies are not dependent on patient selecting the appropriate chief complaints but rather based on answers to certain questions in the algorithm. Additionally, other algorithms for conditions are triggered by certain answers and severity of answers within the system. **This system was designed to maximize sensitivity, accuracy, and to minimize the length of the assessment.**

## Chief and Secondary complaint options

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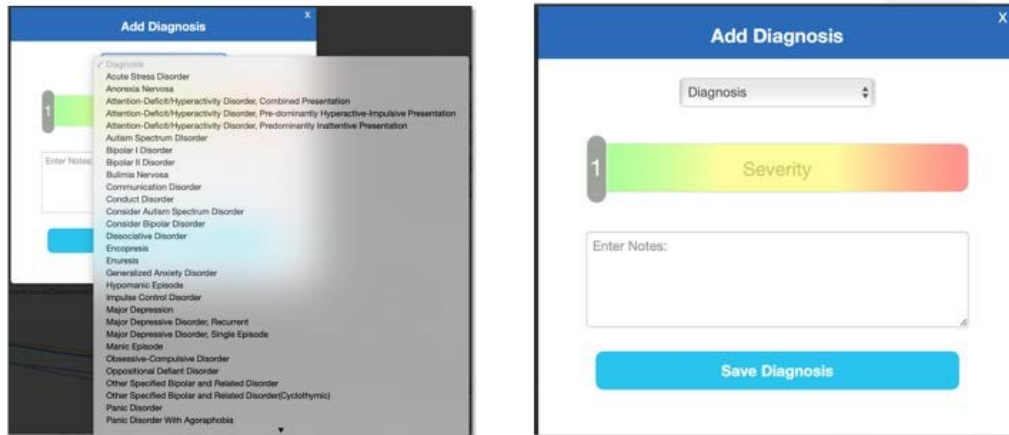
1. Suicide thoughts or behavior	15. Failed to develop age-appropriate relationships
2. Depression or being withdrawn	16. Eating difficulties or likes to eat unusual things
3. Anxiety or excessive worries	17. Academic/School-related problems
4. Odd, strange or unusual behavior	18. Not talking or not communicating as expected for his/her age
5. Hearing voices that others cannot hear	19. Legal problems
6. Abuses nicotine, and/or alcohol, and/or drugs and/or pills, and/or inhalants	20. (Child only) Bonding problems with caregivers due to history of neglect
7. Obsessed, stubborn, rigid, "set in their ways", "picky", doing things "over and over"	21. (Child only) Wets bed or underwear or soils underwear
8. Difficulty paying attention	22. Abnormal movements
9. Hyperactivity	23. Lack of ability to genuine bond with caregivers and/or excessively friendly with strangers
10. Irritability, anger, rages	24. Very scared about certain things, people, animals, places, weather, blood, heights, enclosed places, choking, illness, etc'
11. Violent behavior	25. Difficulty remembering familiar people or events, not feeling like his/herself, time loss, like in trance
12. Mood instability, "moody", or crying spells, or "giggly"	26. Very uncomfortable in social situations, public engagements, or refusing to go to school
13. Sleep difficulties	27. Severe problems controlling urges (pulling hair, setting fires, gambling, stealing, fighting, playing video or computer games)
14. Experienced traumatic event or victim of abuse	

## 5. Consider your differential diagnoses.



- It is very important to point out that, “Clinicom’s suggested diagnoses are NOT supposed to be used as final diagnoses without a comprehensive evaluation, interview, formulation, and consideration of a differential logic by a qualified clinician.” Clinicom allows the clinician to Accept, Reject, or to rule out any suggested diagnosis. This important step keeps the final diagnostic decisions in the clinicians’ trained hands. These responses also help feed the Clinicom Data Bank which is used to refine the sensitivity and specificity of Clinicom. It is important to accept, reject, or rule out all Clinicom suggested diagnosis for this purpose. **This feature is also a patented feature of Clinicom.**
- If you are not qualified to consider a differential diagnosis, make sure you refer the patient with those concerns to a qualified clinician. Many non-psychiatric physicians, who treat adults, feel comfortable treating depression in adults, but many pediatricians feel very uncomfortable doing so in children. The reverse is true for ADHD. Some pediatricians and adult psychiatrists feel uncomfortable diagnosing children or adults with Autism Spectrum Disorder, then they can refer the patient to a specialist for further evaluation based on the CLINICOM’s data. This highlights the importance of careful validation of the CLINICOM report by a qualified clinician.
- **WARNING: CLINICOM IS NOT A “DIAGNOSTIC TEST”,** but it is used as an assessment tool that facilitates the organized collection and use of information on an artificial intelligence platform that in turn transforms information, based on certain rules (i.e., DSM-5, APA Guidelines, evidence-based research, etc.) into knowledge. **“ONLY a qualified clinician can validate the information.”**
- Clinicom is a powerful clinical decision support tool **“Augmented Intelligence”** that allows the clinician more time to focus on the patient’s conditions and create a treatment plan. It is ultimately up to the clinician and only the clinician to Accept, Reject, Rule Out or Add a Diagnosis.
- **Add a Diagnosis.** In the rare event that the clinician would like to add an additional diagnosis, the system allows the flexibility for clinicians to add their own diagnosis.

## ADD PATIENT DIAGNOSIS



### Differential diagnosis utilizing CLINICOM:

- **Autism Spectrum Disorder (ASD) versus Obsessive Compulsive Disorder (OCD).** In some cases, the questions related to the repetitive behavioral aspects of ASD may overlap with compulsions associated with OCD. Some ASD patients may also have comorbid OCD. ASD patient's repetitive behaviors may be purposeless.
- **Autism Spectrum Disorder (ASD) versus Schizophrenia.** The odd or bizarre behavior observed in ASD may overlap with bizarre behavior that is seen in schizophrenia.
- **OCD versus no-OCD.** CLINICOM's question's set for OCD are very detailed and have many examples, but many patients or guardians who truly suffer from OCD do not have insight into the condition and perceive it as "normal", thus the condition is not suggested by CLINICOM because the symptoms are minimized by the user.
- **OCD versus schizophrenia.** Some ritualistic behavior of OCD may be bizarre and needs further assessment. **OCD in some cases can exacerbate into very bizarre behavior many times seen in schizophrenia. They also can be co-morbid conditions.**
- **Schizophrenia versus Communication Disorders.** Some negative symptoms associated with unproductive language reflecting schizophrenia may be associated or overlap with expressive language disorder/communication disorder or selective mutism.
- **Schizophrenia versus Social Phobia.** Lack in social interaction reflecting schizophrenia may be associated or overlap with social phobia or selective mutism.

- **Schizophrenia versus no-schizophrenia.** The CLINICOM's logic for schizophrenia is very detailed and follows the exact guidelines of the DSM-5 in terms of number of symptoms and timeframes and can suggest this diagnosis with several subcategories. Some clinicians may feel that the diagnosis of schizophrenia suggested by CLINICOM is not accurate because of the preconceived notion that the patients with schizophrenia "have to hear voices and/or be delusional". It is important to remember that the DSM-5 requires at least 2 of **any** of the 5 criteria (1. Delusions; 2. Hallucinations; 3. Disorganized speech; 4. Grossly disorganized **or** catatonic behavior; 5. Negative symptoms: flat affect, less interest in activities, etc.) from section A. plus at least two or more of these symptoms must be (1), (2), (3) and present for a significant portion of time during a one- month period and continuous signs of the disturbance persisting for at least 6 months, with functional impairment in order to consider schizophrenia. Lack of Hallucinations for example does not exclude Schizophrenia.
- **Schizophrenia versus Major Depression.** Some of the negative symptoms reflecting schizophrenia may be associated or overlap with may mayor depression. **Schizophrenic patients may look chronically depressed, but they may tell you they are not depressed. This is important to understand specially when a third party is reporting on the patient thinking the patient is depressed.**
- **ADHD versus Bipolar disorder.** Some of the distractibility, hyperactivity and impulsivity symptoms reflecting ADHD may be associated or overlap with Bipolar Disorder. The fluctuations of these symptoms may be very important in determining the correct diagnosis because ADHD symptoms do not fluctuate as Bipolar symptoms do.
- **ADHD versus Communication disorders.** Some symptoms associated with inattention may be associated or overlap with Receptive Communication Disorder. In some of these cases the patient's guardian may for example complain about the patient not following verbal instructions, and this may be due to Receptive Language difficulties.
- **Bipolar versus no-Bipolar.** Very frequently the user "does not remember" the duration of the manic episodes or they mark that the manic episode lasted 3 days or less. This does not formally qualify a manic episode, which requires at least 4 days in duration. These are the difficulties of operating with rules that need to be concrete or "all or nothing" like in the DSM-5.

**Important:** You can Call Clinicom Healthcare Inc. at 1-833-271-1325 or email [support@clinicom.com](mailto:support@clinicom.com) if you have clinical questions that you need to discuss, and a team member will contact you to address your questions or concerns.



## 6. The Clinicom Report

**Assessment Results**

**Assessment #1** CLINICOM Pro (#44771) **Completed:** 2021-11-12 **View Report**

**Complaints:** Irritability, Anger, Rages, Difficulty Paying Attention, Violent Behavior, Obsessed, Stubborn, Rigid, Set In Their Ways, Picky, Doing Things Over And Over, Abuses Nicotine, And/or Alcohol, And/or Drugs, And/or Pills, And/or Inhalants, Very Scared About Certain Things, People, Animals, Places, Weather, Blood, Heights, Enclosed Places, Choking, Illness, Etc  
Communication Disorder = 7 out of 7

Completed by: **Patient**

Attention-Deficit/Hyperactivity Disorder, Combined Presentation = 6 out of 7

Social Phobia (Social Anxiety Disorder) = 6 out of 7

Panic Disorder = 5 out of 7

- **CLINICOM’S reports** can be accessed by clicking the report chart icon or View Report button.
- **CLINICOM** also offers a “Report Narrative Summary”. What the summary (narrative) does, is collects the important symptoms from the conditions that the report suggests for review by the clinician and automatically generates a narrative that is written to reflect specifically the patient’s symptoms and condition. The clinician can then use the narrative to include it in the History of Present Illness of the H&P and/or to include findings in a letter to a referral source. Please make sure you edit the summary after you copy and paste it.
- **Many clinicians** use the CLINICOM Report to share with the patient/family the reason why they are coming to certain diagnostic conclusions. The CLINICOM Report can also be used as a great educational tool which allows the clinician to “*show how and why*” diagnostic decisions are being made and institute the appropriate level of care and treatment planning.
- **“Why am I bipolar”?** Now you can bring the user’s answers into play to respond to this and many similar questions utilizing the CLINICOM Report.
- **“Why are you going to treat me with that medication”?** or **“I did not know I had OCD, don’t they have to wash their hands a lot”?** These are going to be questions that will culminate with very appropriate answers that have concrete evidence as long as you feel that the user is reliable.
- You can use the report to also educate the patient or guardian about **what symptoms can she or he expect to get better** and mark them on the CLINICOM report.

## SEVERITY HEATMAP W/EDITING CAPABILITIES



### 7. Update the CLINICOM Report

- Once the patient has been seen by the clinician, the report and information contained within should be carefully validated by:
  - Accepting Diagnoses
  - Adding Diagnoses
  - Ruling Out Diagnoses
  - Rejecting Diagnoses
  - Accepting Severity Scale
  - Changing Severity Scale
  - Updating Current Medications with the new treatment plan if any.
  - Utilizing the TEXT BOX in the Dx section to make comments reflecting,
    - Your formulation
    - User's reliability
    - Diagnostic challenges
    - Further testing needed
    - Treatment recommendations
    - Referrals

- Storing the Clinicom Report
- Printing a Final Report to hand to your patient (without the diagnoses page) or send to your referral source.
- Clinicom reports are printed to PDFs for security purposes and can be stored as PDFs within EMRs/EHRs. Clinicom can be integrated with some EHR platforms via APIs. Contact [support@clinicom.com](mailto:support@clinicom.com) for more info and ask about our EMR/HER integrations.
- **It is imperative that clinicians Accept or Reject Diagnosis in the system prior to printing or filing the final Clinicom Report. Reports will denote if the clinician took the time to accept, reject, or rule out a Diagnosis. If a Clinician is uncertain of the diagnosis the clinician is recommended to label the diagnosis as “Rule Out”. This not only helps improve the systems accuracy over time but also ensures that patients are not misdiagnosed.**

## PATIENT SUMMARY W/ SUGGESTED DIAGNOSES

The screenshot displays the 'Patient Summary' page for Patient #498, Darvy Smith. It includes fields for First Name, Last Name, SSN, Gender, Race, Ethnicity, and Mobile Phone. Below this are sections for Medications and Diagnosis. A 'FOR REVIEW BY CLINICIAN' section highlights two suggested diagnoses: 'Attention Deficit/Hyperactivity Disorder, Combined Presentation' and 'Overanxious/Generalized Anxiety Disorder'. Each diagnosis has a 'Status: Accepted by Clinician' and a corresponding progress bar. A separate inset shows a 'Review Diagnosis' dialog box for 'POST-TRAUMATIC STRESS DISORDER' with options: 'Not Accepted by Clinician', 'Accepted by Clinician', 'Reject', and 'Rule Out'. A legend at the top right of the interface shows a color scale from 1 (Normal) to 7 (Extreme).

## 8. Sending a Follow up assessment

The screenshot shows the 'Assessment Results' page. At the top, there are tabs for 'All Results', 'Progress', 'Diagnoses', 'Reports', 'Medications', 'Demographics', and 'Graph'. The main content area is titled 'Assessment Results' and shows 'Completed by Patient'. Below this, it lists 'Assessment #1 CLINICOM (#97831)' completed on 2023-05-21. A list of 'Complaints' includes: Alcohol Misuse (4 out of 7), Chronic Insomnia (4 out of 7), Audit-C (5 out of 12), PHQ-9 (8 out of 27), GAD7 (6 out of 21), and DAST-10 (0 out of 10). To the right of these metrics are horizontal progress bars. On the far right, there is a vertical stack of buttons: 'View Report', 'Add Follow Up', 'Narrative', 'Delete Assessment', 'Share Report', and 'Edit Flag'.



- An important aspect of a good mental health treatment plan is accurate metric based follow up assessment using standardized tools to track and measure progress. Clinicom allows a clinician to create custom follow up assessment for each patient.
- Simply click on the “Add Follow Up” link on the patient summary page and this will take you to the follow up generator page. You can select from suggested scales. These suggestions are autogenerated by the system based on the Accepted Diagnosis the clinician has chosen for that particular patient. The clinician can decide how comprehensive or “light” of a follow up to create based on the medical necessity. Clinicians can choose from any one or more of our Standardized Scales, DSM-5 based scales, or anyone one or more of our Informational Questionnaires.

### Example 1.

If the clinician gave the patient a Clinicom Pro for the first Visit and found Depression to be an issue, the follow up assessment can be given to track depression using the HAMD. The system will automatically suggest this scale from the drop down and the clinician can add it or any other scale they wish to add as a follow up given at a schedule the clinician defines.

### Example 2.

If the clinician gave the patient a Clinicom for the first visit because the patient did not have time to complete a Clinicom PRO that includes the informational questionnaires, during the follow up the clinician can add any of the informational questionnaires they wish to give to the patient at that time as a follow up.

- Self vs Third person reporting

It is important to note that Clinicom assessments and follow ups can be given to a patient or to a third-party reporter such as a parent, grandparent, guardian, teacher etc. To maintain HIPAA compliance, all third-party assessments are still shared directly with the adult patient/guardian who can forward the “Third party link” to whomever the clinician would like to gain feedback from. This maintains the private health information control with the patient/guardian.

**Please be sure to communicate the need for the patient/guardian to forward this invite to whomever the third part is.** That is not done through our system as it would violate HIPAA, it is up to the patient/guardian to execute sharing the link with the third party.

- Follow up Graphing.

It is important to point out that the graphing feature within Clinicom is automated and is only present once two or more of the same assessments are completed. For example, two HAMD assessments or Two PHQ9's. One needs two data points in order to graph a line, and so on all new patients with only one assessment/one data set the graph will not show until two or more follow up assessments are complete.

- Timing of Follow up Assessments through the Calendar Feature.

Once a follow up assessment has been designed by the clinician to fit the patient’s needs, the clinician will answer when they would like to schedule the follow up assessment.

This is a critical step in treatment planning that should be evaluated based on medical necessity. After the initial visit the clinician can schedule one or more follow-ups (based on necessity).

This will allow the clinician to have ample metric-based data to review for the next meeting with a patient.

- Follow ups can be scheduled in a repeat cadence in the follow up dialog box. Click on “Repeat” and select the number of times you wish to send this follow up and then click on “Every” to determine the frequency of this follow up.

Follow ups can also be customized to your location to be preset and designed by you and our team through customization in any frequency or cadence for any assessment. Contact [Support@Clinicom.com](mailto:Support@Clinicom.com) for more information on automatic follow up cadences.

Send Invite
✕

Please be sure to schedule this invite at least one week before the next appointment.

Send To:

Send On:

Repeat:

Every:

CLINICOM can only send communications to the patient. You may add a note to your patient to have them forward this message to any third party they choose.

Please forward this invite to

Create Follow Up
Cancel



## Metric-Based Treatment Tracking

## 9. Gold Standard Assessments

Clinicom includes many gold standard assessments commonly used in clinical practice to be used with custom assessments and follow-up assessments. The below list of assessments is for reference only and is incomplete as we are constantly adding new standardized assessments each month.

### Standardized Scales

#### Standardized Scales

ADHD Rating Scale - Child  
 Adult ADHD Self-Report Scale (ASRS-v1.1)  
 Adverse Childhood Experiences International  
 Questionnaire (ACE-IQ)  
 Antidepressant Treatment Response Questionnaire  
 (ATRQ)  
 Applied Cognition-Abilities-Short Form  
 Audit-C  
 Brief Psychiatric Rating Scale - Positive (BPRS)  
 Clinically Useful Anxiety Outcome Scale  
 Clinically Useful Depression Outcome Scale  
 Clinician Administered PTSD Scale - 5 (CAPS-5)  
 Compassion Satisfaction and Compassion Fatigue  
 (PROQOL)  
 Dimensional Obsessive-Compulsive Scale (DOCS)  
 Drug Abuse Screening Test (DAST-10)  
 DSM-5 Self-Rated Level 1 Cross-Cutting Symptom  
 Measure  
 Epworth Sleepiness Scale  
 Frequency, Intensity, and Burden of Side Effects  
 Ratings (FIBSER)  
 Hamilton Anxiety Rating Scale (HAM-A)  
 Hamilton Rating Scale for Depression (17-Items)  
 (HAM-D)  
 McGill Pain Questionnaire  
 Montgomery-Asberg Depression Rating Scale  
 (MADRS)

NICHQ Vanderbilt Assessment - Parent  
 NICHQ Vanderbilt Assessment - Teacher  
 NICHQ Vanderbilt Follow-up - Parent  
 NICHQ Vanderbilt Follow-up - Teacher  
 NIDA - Assist  
 Patient Health Questionnaire-9 (PHQ-9)  
 Pediatric Anxiety Rating Scale  
 Pediatric Anxiety Rating Scale Symptoms Follow-  
 Up  
 PROMIS - Global Health Mental  
 PROMIS - Pain Behavior  
 PROMIS - Pain Intensity  
 PROMIS - Pain Interference  
 PROMIS - Self-Efficacy for Managing Emotions  
 PROMIS - Sleep Disturbance  
 Psychosis Symptom Severity  
 PTSD Checklist for DSM-5 (PCL-5)  
 Scale of Suicidal Ideation (SSI)  
 Severity Measure for Social Anxiety Disorder  
 Social Interaction Anxiety Scale (SIAS)  
 The Generalized Anxiety Disorder 7 Item Scale  
 (GAD-7)

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