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This handout contains screen shots of confidential and proprietary information for viewing only. It shall not be copied or shared for anything other than its intended purpose as a training device for the County of San Diego, Mental Health Management Information System.



CONFIDENTIALITY

HIPAA regulations mandate that <u>all</u> client information be treated confidentially.

Access to CCBH is based on your position and your job classification. You will have the access you need to complete your job duties. This can include access to clients in your Unit/SubUnit or may include full client look up. Remember – with more access comes greater responsibility regarding confidentiality!

You are <u>not</u> to share passwords with other staff. The Summary of Policy you signed before receiving your access to CCBH included your agreement to this directive. You are still responsible if someone with whom you have shared your password violates confidentiality!

The MIS unit investigates any suspicions regarding sharing of passwords. Consequences are up to, and may include termination.

Do not open any active client charts unless instructed to do so, or if it is required to complete your job duties. "Surfing" clients is a blatant breach of confidentiality.

Remember you are personally and legally responsible for maintaining confidentiality. Take it seriously.

Do not leave your computer unlocked with client data on the screen for others to access or view while you are away from your desk. Lock your CCBH session before leaving your computer.

When printing, make sure you are printing to a confidential printer, and pick up your paperwork quickly. Leaving printed Protected Health Information (PHI) out is also a confidentiality violation.

Play it safe – keep in mind how you would want your own PHI handled!



CLONED DOCUMENTATION

From the Compliance Bulletin # 30, October 17, 2011

"When documentation is worded exactly like or similar to previous entries, the documentation is referred to as cloned documentation.

"Whether the cloned documentation is handwritten, the result of pre-printed template, or use of Electronic Health Records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

"It would not be expected that every patient had the same exact problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information for each unique patient.

"Documentation exactly the same from patient to patient is considered cloned and often occurs when services have a specific set of limited or select criteria. Cloned documentation lacks the patient specific information necessary to support services rendered to each individual patient."

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OVERVIEW OF CLIENT PLANS

There are different ways to hold progress notes in CCBH. Think of them as "folders" in which to keep the progress notes:



Each folder is a "stand alone" folder and they are not sequential (that is to say, there is no need to move from one to the other in order of this listing). Each has a specific purpose, defined below:

The Limited Service Log is intended to be used for progress notes where a Client Plan will never be completed.

The Interim Folder: This is intended to be used for progress notes prior to the creation of the Client Plan. CCBH needs a place to "hold" progress notes, and the Interim Folder performs that function. This is the "folder" where clinicians will document all services prior to opening the Client Plan. Can this folder be left open indefinitely? No! The Interim folder needs to be closed:

- 1. If the client leaves the program without a Client Plan being started and the client is not open to other programs.
- 2. If the Client Plan is ready to be created.

The Interim Folder needs to be closed on a date prior to opening the Client Plan.

Note: For existing clients with a valid paper Client Plan, open the Interim Folder to store the progress notes until the Client Plan is due to be updated.

The Client Plan holds all the progress notes written after opening the plan. There is no need to open an Interim Folder before opening a Client Plan if the program's workflow is to complete the Client Plan at the initial appointment. In other words, the Client Plan can be opened as soon as direct staff start seeing the client.



STRUCTURE OF A CLIENT PLAN IN CCBH

Planning Tiers

In CCBH speak, the elements below are identified as Planning Tiers. Think of them as levels or layers in the Client Plan.

Strengths

These are the client's general strengths <u>and</u> how the clients can use these strengths to help them achieve their objective(s).

Area of Need

This is an area for the client where a level of impairment has been identified.

Goal

Enter Unit/Subunit and Date only. No narration required for this tier.

Objectives

These are the actions/activities/steps of the client or others to help reduce the client's impairments. For multiple objectives, list numerically under one Objective heading. For only one objective, delete the extra Objective Narrative standard text.

Interventions

Interventions are the services provided to the client. <u>Narration</u> for this tier can be combined with the Objective narratives.

NOTE: It's important to <u>individualize</u> the tier narratives to make the Client Plan reflect the individual client. Avoid "cloned documentation" in the Client Plans!

III

Progress Notes

CCBH SPEAK

Limited Service Log	This log is intended to be used for notes where a Client Plan will never be completed. This log is never associated with a Client Plan.
Interim Folder	The Interim Folder will be used for progress notes prior to the development of a Client Plan.
Client Plan	Plan for client treatment. Includes strengths, area of need, goals, objectives, and interventions / planned service codes. These will pull in to progress notes for planned services.
Progress Notes	Notes to capture direct services and informational services pertaining to client treatment. Encounter entry will be completed by clinicians as part of the Individual and Group Progress Notes.
Revise	Used when a client has an active Client Plan in place and a change needs to be made (adding, editing, or updating). The start date and end date of the Client Plan will remain the same and the current information will prepopulate.
Review	Used to extend the Client Plan dates. When using the Review function in CCBH, it establishes a new start and end date from the previous Client Plan and prepopulates the information for updating.
Modify Dates	Used to change the start and/or end dates of an active plan or folder. Note: Dates may not be modified to more than the set up duration. For example, a Client Plan may not be active for more than 365 days).



OVERVIEW OF THE CLINICIAN'S HOMEPAGE

The Clinician's Homepage launches with three tabs- File, Home, and View. Each tab has a ribbon of buttons. Below the buttons is the Staff panel and corresponding panes. The default pane is the Caseload, displaying the staff's assigned clients. When a client record is opened, the Client panel launches below the Staff panel.

Ch,		CLINICIAN'S HOMEPAGE (TRAIN) 235.2.0.0								
File	Home Vi	ew								
Staff Search	Staff Clear My Home Search by Staff ID Staff Entity	Refresh Staff Panel			E TH	System eRx not available ePrescribing Status	Pharmacy Directory	Break The Glass	Layout and Filters • Panel Options	
Caseloa					oroup reces			Direas Glass		
Туре		Na	ime 🔺							Case#
Caseloa	ad _	CL	ient, sample							
Caselo	bad									

Selecting a Client:

To open a client record from the Caseload pane, <u>double click</u> on the client's name.

File Home Vie									0 X
Staff Search by Staff ID	Refresh Staff Panel	Client Client Search Case#, Sort Name or SSN	Services	⚠️ System eRx not available	Pharmacy Directory	Break The Glass	Layout and Filters *		
Staff Entity		Client Entity	Group Notes	ePrescribing Status	Pharmacies	Break Glass	Panel Options		
2									↓ ‡
Caseload									↓ 4
Туре	Na	ame 🔺						Case#	
Caseload		IENT, SAMPLE							

The Client tab and ribbon of buttons, together with the Client panel with corresponding panes, are launched.

File	Home	Client	View											
Client Information	Broadca n + Alert	Note	gress	New essment •	New Client Plan • Clinical	🛃 Prospectiv	e Planning 1	New Pr	e-existing ication	Pharmacy of Choice Medical	Conditions		Refresh Client Panel Panel	Close Client Panel Options
SAN	A SAMPLE CLIENT Male Born:													
	Face Sheet County of San Diego Mental Health Services FACE SHEET													
Face Sheet	Pre-Intake	Assessments	Assignments	; 🔒 Diagn	noses 🔓	Substance Ab	Client Plans	Progress Notes	Authorizat	ions Insura	ince Cover	Services	Medical Conditi	Medications

_	
_	=

CLINICIAN'S HOMEPAGE PREFERENCES

How to Set Up and Save Preferences

Accessing Preferences:

It is best to keep a short list of the most commonly used Assessments and Client Plans for easy access. This can be set up using the Preferences feature of the application.

To set up Preferences from the Clinician's Homepage, click **File**.

Ch,	_				CLINICIAN'	S HOMEPAGE
File	Home Vie	ew				
	Staff Clear	5		🛃 Client Clear 🚍 Show Client Panel	Services	\land System eRx n
Staff Search	Search by Staff ID	Refresh Staff Panel	Client Search	Case# or Sort Name		
	Staff Entity			Client Entity	Group Notes	ePrescribing

Click Preferences.

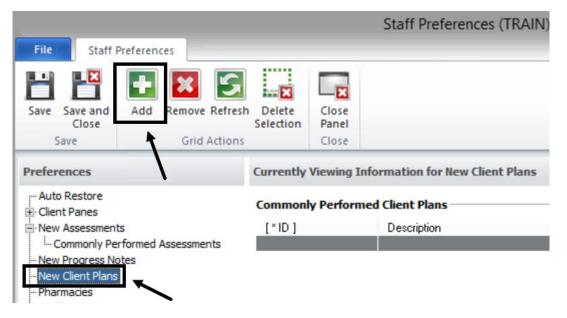
<u>Ch</u>		CLINICI
File Home	View	
Open Menu Security About CCBH	Recently Opened Views 01 Clinician's Homepage (v3.0)	
	Preferer	nces 🗙 Exit Application

The Staff Preferences menu opens. Continue to the next section for the next steps.



Staff Preferences for Limited Service Log:

1. From the Staff Preferences window, select New Client Plans and click Add.



2. The table of Available Client Plans opens. <u>Double click</u> on Limited Service Log.

Select each Client Plan to be added to the list of Commonly Performed Client Plans.							
Available Client Plans (Filters Applied)							
ID	Description 🔺						
OPCP	AOA Outpt / FSP Client Plan						
OPIF	AOA Outpt / FSP Interim Folder						
CYFCP	CYF Outpt / FSP Client Plan						
CYFIF	CYF Outpt / FSP Interim Folder						
LSL	Limited Service Log						

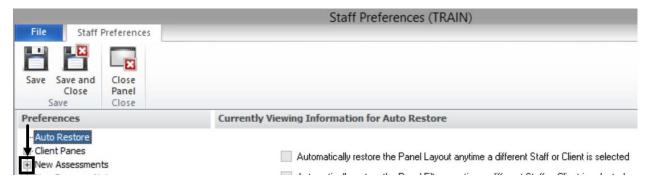
To save selection and continue setting up Staff Preferences, click Save.
 To save selection and return to the Clinician's Homepage, click Save and Close.

		Staff Preferences
File Staff F	Preferences	
	🛨 🔀 🔙	×
Save Save and Close	Add Remove Refresh Delete Selection	Close Panel
Save	Grid Actions	Close



Staff Preferences for Problem List:

1. At the Staff Preferences window, click the + sign to the left of New Assessments.



2. Click Commonly Performed Assessments and Add.

	Auto Restore P Client Panes			
Preferences	1	Currently	Viewing In	formation for Commonly Performed Assessment
Save	Grid Actions		Close	
Save Save and Close	Add Remove Refresh	Delete Selection	Close Panel	
	Preferences		_	

3. The table of Available Assessments, in alphabetical order, opens. Scroll down to letter P and <u>double click</u> on **Problem List**.

Add Multiple Asse	essments as Commonly Performed Assessments (TRAIN)		x			
File Multiple Selections						
Refresh All Invert Search Actions	Close Panel Close					
Select each Assessment to be added to the list of Commonly Performed Assessments.						
Available Assessments (Filters Applied)			•			
по ID Туре 🔺		Active	^			
OA Outpatient Appea	al Form					
PROBLEM Problem List						



4. To save selection and return to the Clinician's Homepage, click **Save and Close**.

File Staff Preferences	-	Staff Preferences (TRAIN)
Save and Close Save Grid Actions		Close Panel Close
Preferences		v Viewing Information for Commonly Performed Assessme
Client Panes New Assessments Commonly Performed Assessments New Progress Notes	[*ID] PROBLEM	Description
New Client Plans Pharmacies Staff Panes		

The Preferences that were set up can be accessed when a client record is launched and the Client tab is open.

NOTES



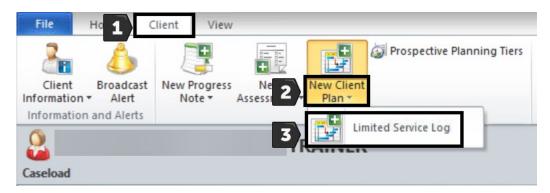
LIMITED SERVICE LOG

Limited Service Logs (LSLs) are used by programs to store clients' progress notes when Client Plans will never be completed.

Adding a Limited Service Log:

To add a Limited Service Log from the Clinician's Homepage, select the client from the staff's Caseload first to launch the Client tab and the Client panel.

- 1. After selecting the client from the clinician's Caseload, click on the Client tab.
- Find the New Client Plan button on the ribbon. The button is segmented in two parts. The upper portion of the button is a list of all Client Plans available for entry. The lower portion of the button consists of Client Plans that have been established in Staff Preferences for Limited Service Log. Click the down arrow or the words New Client Plan.
- 3. Select Limited Service Log.



The Limited Service Log launches and opens up the calendar.

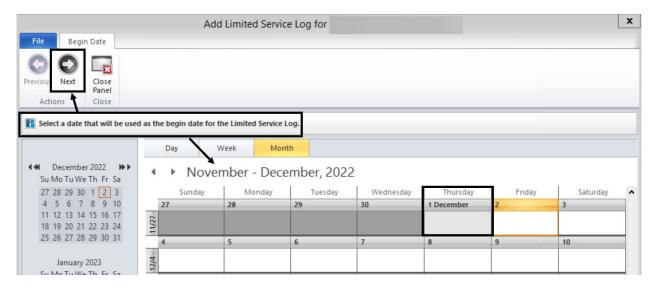
		Ado	Limited Servic	e Log for					x
File Begi	n Date								
00									
Previous Next	Close Panel								
Actions	Close								
		Day V	Veek Mont	th					
▲ December Su Mo Tu We		▲ ► Nover	mber - Dece	mber, 2022	2				
27 28 29 30		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	^
And the second s	8 9 10	27	28	29	30	1 December	2	3	
11 12 13 14 18 19 20 21		11/27							



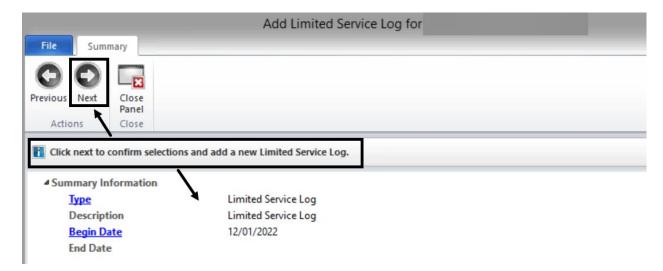
Selecting a Begin Date:

The current calendar date is automatically selected as the Begin Date.

- 1. On the large calendar, single click on the appropriate Begin Date.
- 2. Click Next.



3. Confirm that the selections made are accurate and click Next.



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Note: The Limited Service Log has no required time limit; hence the End Date is blank until the Limited Service Log is Closed.



The Pending Limited Service Log (LSL) folder opens and is in a pending status until it is Closed. The window defaults to the Limited Service Log tab displaying a ribbon of buttons at the top, and a list of progress notes, if there are any.

	Pending Limited S	ervice Log for	Beg	gin: 12/01/2022 (TRAIN)	X
File	Limited Service Log Panes				
5	X 📴 🖬 🗐				
Refresh Refresh	Delete/Void Modify Close Reopen Dates Actions	Print Close Panel Close			
Progres	s Notes				• 4
Туре	F/A Date 💌	Thru	Primary Signer	Intervention	
	X	There	are no items to show.		

Refresh clears the information being displayed in the LSL folder.

Delete/Void option works only when there are no notes entered in the folder.

Modify Dates is used to change the Begin Date of the LSL folder.

Close is used to add an End Date to the LSL folder.

Print is not used by the System of Care.

Close Panel is to close out of the LSL window.

Note: Once a Progress Note is entered, the Limited Service Log cannot be deleted or voided. Contact the Support Desk to delete or void the folder.

NOTES

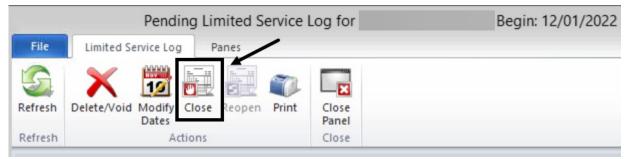
Closing a Limited Service Log:

The Limited Service Log (LSL) can be closed (end dated) when all client services are complete or if the client leaves the program.

To close the LSL, launch it first by double clicking on it in the Client Plans pane.

2	Born:				
Client Plans					
Туре	Description	Begin 💌	Revised	End	
Limited Service Log	Limited Service Log	12/01/2022			
		N			
Face Sheet Pre-Intake Assessments Assign	nments 🛛 🔓 Diagnoses 🛛 🔓 Substanc	e Ab Client Plans Progress Note	es Authorizations	Insurance Cover	Services

Once the pending LSL folder is launched, click **Close**.

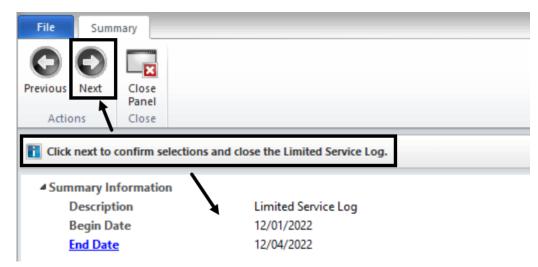


Single click the appropriate close date on the large calendar, and click Next.

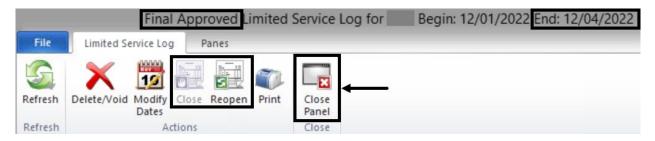
File Close Date	Clo	se Limited Servi	ce Log for SAN	1PLE CLIENT 283	(TRAIN)		
Previous Next Actions Close Panel Close Select a date that will be used	t ar the close data for	the Limited Centice					
Select a date that will be used							
	Day	Week Mo	nth				
♦ December 2022 ▶► Su Mo Tu We Th Fr Sa	 Image: Nove 	ember - Dec	ember, 202	2			
27 28 29 30 1 2 3	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
4 5 6 7 8 9 10	27	28	29	30	1 December	2	3
11 12 13 14 15 16 17 18 19 20 21 22 23 24	11/27					Limited Service L	.og
25 26 27 28 29 30 31	÷ 4	5	6	7	8	9	10
January 2023	2/4 -			Limited Service Lo	g		
Su Ma Tu Wa Th Er Ca	12,						



Verify the accuracy of the selected close date. If the close date selected is incorrect, click Previous or the End Date link. To confirm selection, click **Next**.



Several things occur when an LSL is closed. The pending LSL becomes final approved; the End Date is displayed at the top; the Close button is grayed out; and the Reopen button becomes active. To return to the Clinician's Homepage, click **Close Panel**.



The Clients Plans pane also displays the LSL's End Date and a green checkmark to indicate the folder is final approved.

2	Born:				
Client Plans					_
Туре	Description	Begin 💌	Revised	End	F/A
Limited Service Log	Limited Service Log	12/01/2022		12/04/2022	
Face Sheet Pre-Intake Assessments Assig	nments 🛛 🔒 Diagnoses 🛛 🔒 Substance	e Ab Client Plans Progress Note	es Authorizations Insurance Co	ver Services	Medical Conditi Me

Note: The **Close** button allows a close date to be added to the Limited Service Log. The **Close Panel** button closes the screen and returns user to the Clinician's Homepage.

CLIENT PLANS DISPLAY

To view existing client plans, a client must be selected first in order to launch the Client panel.

1. On the Client panel, single click on the Client Plans pane.

Туре	Description	Begin 💌	Revised	End
Limited Service Log	Limited Service Log	12/01/2022		
Client Plan	AOA Outpt / FSP Client Plan	08/31/2022		08/31/2023
Client Plan	AOA Outpt / FSP Client Plan	08/31/2022	09/12/2022	08/27/2023
Interim Folder	AOA Outpt / FSP Interim Folder	08/29/2022		08/30/2022
		00, 23, 2022		00,00,202

2. To open and view the selected client plan, double click on it.

Limited Service Log				
	Limited Service Log	12/01/2022		
Client Plan	AOA Outpt / FSP Client Plan	08/31/2022		08/31/2023
Client Plan	AOA Outpt / FSP Client Plan	08/31/2022	09/12/2022	08/27/2023
nterim Folder	AOA Outpt / FSP Interim Folder	08/29/2022		08/30/2022

3. To view all the planning tiers, click the **Planning Tiers** pane.

File	Client Plan	Panes										
S		×		12	L	<u></u>	0 8		×			
Refresh	Perform Forced Validation	Delete/Void	Final Approve		Revise F	Review Pr		dd Clo ature * Pa				
Refresh	Validation		inpprote.	Action	s			atures Clo				
Planning	g Tiers											
1	T									E to b C about	CL	Children Data
Level	Туре				escription		0.1			Established	Status	Status Date
Level	Strength	0		A	ccepts Fe	edback fro	om Others			08/31/2022	Active	08/31/2022
Level 1 1	Strength Area of New	ed		A	ccepts Fe motional-	edback fro Behaviora	al/Psychiatric	c		08/31/2022 08/31/2022	Active Active	08/31/2022 08/31/2022
1 1 1.1	Strength	ed		A	ccepts Fe motional-	edback fro Behaviora		c		08/31/2022	Active	08/31/2022
1 1	Strength Area of New A Goal	ed		A Er In	ccepts Fe motional- nprove/N	edback fro Behaviora Maintain Fu	al/Psychiatric			08/31/2022 08/31/2022	Active Active	08/31/2022 08/31/2022



4. To view the narrative for the planning tiers, click on the drop down menu and select Text Mode.

Established	Status	Status Date		Text Mode
08/31/2022	Active	08/31/2022	\checkmark	Detail Mode
08/31/2022	Active	08/31/2022	5	Refresh Pane Content
08/31/2022	Active	08/31/2022		

5. The Planning Tiers will display with the narrative portion below each listed tier. To return to the previous screen, click **Close Panel**.

	Final A	pproved AOA Outpt / FSP Client Plan Revision 1.01 for CLIENT	Begin: 08/31/2022 Revised:	09/12/2022 End: 08/27/2023 (TR
File	Client Plan	Panes		
Refresh	Perform Forced Validation	Delete/Void Final Modify Revise Review Print Add Signature Panel	~	
Refresh	Validation	Actions Signatures Close		
Planning	g Tiers			•
Level	Туре	Description	Established Status	Status Date Target Date
1	Strength	Accepts Feedback from Others UNIT/SUBUNIT: 99 DATE:	08/31/2022 Active	08/31/2022
		(IDENTIFY CLIENT STRENGTH(S) FROM THE STRENGTHS T FOR THE CLIENT. IDENTIFY STRENGTH AND INDIVIDUALIZ TREATMENT OBJECTIVE(S) IN THE NARRATIVE AREAS BEL NARRATIVE:	E. DOCUMENT STRENGTH(S) AND HOW THE CLIENT	
1	Area of Nee	d Emotional-Behavioral/Psychiatric SEE PROBLEMS LIST FOR IDENTIFIED AREAS OF NEED.	08/31/2022 Active	08/31/2022

NOTES



PROGRESS NOTES DISPLAY

To view existing progress notes, a client must be selected first in order to launch the Client panel.

1. On the Client panel, single click on the **Progress Notes** pane.

Search Progress Notes					
Client Plan	Туре	F/A V	Date	Thru	Primary Signer 🔺
LSL Limited Service	Never-Billable Progress Note		12/01/2022	12/01/2022	ALLY, CLINICIAN
LSL Limited Service	Individual Progress Note		12/02/2022	12/02/2022	ALLY, CLINICIAN
LSL Limited Service	Individual Progress Note		12/02/2022	12/02/2022	ALLY, CLINICIAN
LSL Limited Service	Group Progress Note		12/04/2022 01:00:00 PM	12/04/2022 02:00:00 PM	ALLY, CLINICIAN

2. Double click on the progress note to be viewed.

Progress Notes							
Search Progress Notes							
Client Plan	Туре	F/A V	Date	Thru	Primary Signer 🔺		
LSL Limited Service	Never-Billable Progress Note		12/01/2022	12/01/2022	ALLY, CLINICIAN		
LSL Limited Service	Individual Progress Note		12/02/2022	12/02/2022	ALLY, CLINICIAN		
LSL Limited Service	Individual Progress Note		12/02/2022	12/02/2022	ALLY, CLINICIAN		
LSL Limited Service	Group Progress Note		12/04/2022 01:00:00 PM	12/04/2022 02:00:00 PM	ALLY, CLINICIAN		

3. Click on the Client Narrative line to read the narrative.

Final Approved Individual Progress Note from 12/02/2	022				
Clinical					
Section Expand Collapse Display Narrative					Standard
Current Client Information					No Narrative Selected
CLIENT, SAMPLE					
Case Number: Ge	ender:	DOB:	Age:		
Allergies: sulfamethoxazole, Late	ex				
Client Narratives					
Lock Va Type 🔺	Date 🔺	Owner			
Client Narrative	12/02/2022	ALLY, CLINICIAN		-	



4. Click **Encounters** and double click on the encounter to view the service details.

	✓	Encounter (U)	CRISIS INTERVENTION 70 (70)	12/02/2022
		Staff - Lead	ALLY, CLINICIAN (11001)	12/02/2022
		Client	CLIENT, SAMPLE	12/02/2022
-12	7			
En	counters	Signatures		

Progress Note Filters:

Filters will update the display of the Progress Notes pane. To change filters, click the <u>down arrow</u> in the top right of the Progress Notes pane, and click **Filters**.

	CLIENT							▼ ₽ □ ×
Progress Notes								
Search Progress No	tes							New Progress Note
Client Plan	Туре	F/A V	Date	Thru	Primary Signer 🔺	Intervention	\checkmark	<u>Filters</u>
LSL Limited Servi	ce Never-Billable Progress Note	1 . 1	12/01/2022	1	ALLY, CLINICIAN	1	5	Refresh Pane Content

Update the **General Filters** parameters and click **Save and Close** to save the changes.

	Progress Notes Pane Filters (TRAIN)
File Filters	
Refrest Save and Close Panel Actions Close	
Changes to the follow	ing filters will update the display of the Progress Notes Pane.
General Filters	
Date Range	12/9/2021 thru 12/09/2022
Client Plan Type	
Progress Note Type	
Category of Treatment	
Intervention	
	A - Include Final Approved and Pending Progress Notes
Γ	Include Voided Progress Notes
-	Include Preferred Progress Notes only
Logged on as ALLY, CLINIC	CIAN Environment: Training



INFORMATIONAL PROGRESS NOTES

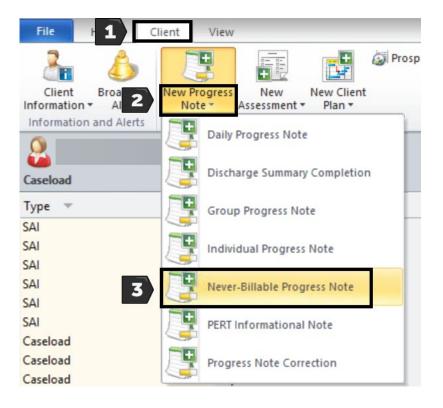
Informational Progress Notes are used when a not-billable activity is provided. The services documented in these notes are not connected to the client plan and no billing is generated. These notes are also used to record billing errors. Below are the types of Informational Progress Notes:

- Daily Progress Notes
- Discharge Summary Completion
- Never-Billable Progress Note
- PERT Informational Note
- Progress Note Correction

Adding an Informational Progress Note:

To add an Informational Progress Note from the Clinician's Homepage, select the client from the staff's Caseload first to launch the Client tab and the Client panel.

- 1. After selecting the client from the clinician's Caseload, click on the Client tab.
- 2. Find the **New Progress Note** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the available notes. Click the words **New Progress Note**.
- 3. Select the note type. For training purposes, click Never-Billable Progress Note.





4. The Progress Note type and the Start Date automatically populate once the Add Progress Note window opens. Select the **Start Date** and click **Save**.

		Add Pr	ogress Note (TRAIN)	x
File	Progress Note			
H Save	Close Panel			
Actions	Close			
Click	Save to confirm sel	ections and add a ne	w Progress Note	
	Progress Note No	ever-Billable Progress I	lote	06
-	Start Date	2/1/2022		
Logged or	n as ALLY, CLINICIA	N	Environment: Trainin	ig .:i

The Pending Never-Billable Progress Note launches. Verify the date for the progress note. If the date is not correct, select Delete and start again.

	Pending Never-Bi	llable Progress Note (1	(RAIN)	_ D X
File Progress Note				
Print Final Delete Modify End Approve Delete Modify End Actions Close Panel Close				
Pending Never-Billable Progress Note from 12/	01/2022			
Clinical				д
Section Expand Collapse Display Narrative	Validation		Standard	
Current Client Information Case Number: Allergies: sulfamethoxazo	Gender: DOB:	Age: yrs	Client Narrative -	Unassigned - 12/01/2022-
✓ Client Narratives Lock Va Type ▲	Date 🔺 Owner		=	
? Client Narrative ~ Related Client Plan No Client Plan	12/01/2022 Unassigned	¢		
			~	8
Signatures				
Logged on as ALLY, CLINICIAN	Environment: Training	CHP20111029 Template L	oaded	

Note: The **Start Date** <u>cannot be changed</u> once Save is selected. If the date is not correct and the note is still pending, delete the note and start all over. If the date is not correct and the note has been final approved, contact the Support Desk for assistance.

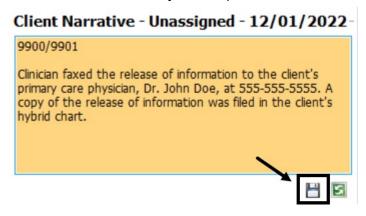
Client Narratives:

The Client Narrative box opens in yellow. This means the section is active, and narratives can be entered. If the section is not yellow, activate it by <u>double clicking</u> anywhere on the Client Narratives line located to the left of the Client Narrative box.

1. Enter the narrative, starting with the program's <u>unit/subunit</u> identification number.

Section Expand Collapse Display Narrative	Validation		Standard •
Current Client Information		^ ^	Client Narrative - Unassigned - 12/01/2022-
Case Number:	Gender: DOB: 0	Age: /rs	
Client Narratives	Date 🔺 Owner	≡	
Client Narrative Client Plan No Client Plan	12/01/2022 Unassigned	•	•
-		~	8

2. Once the narrative entry is complete, click Save.



The staff will appear as Owner of the note, and the Client Narrative box is grayed out. To update the narrative, <u>double click</u> anywhere on the Client Narrative line.

Current (Client Information				^	Client Narrative - ALLY, CLINICIAN - 12/01/
						9900/9901
	Case Number:	Gender:	DOB	Age:		Clinician faxed the release of information to the client's
	Allergies: sulfamethoxazole,	Latex				primary care physician, Dr. John Doe, at 555-555-5555. A copy of the release of information was filed in the client's
* Client Na	arratives					hybrid chart.
Lock Va	Туре 🔺	Date 🔺	Owner		=	
	Client Narrative	12/01/2022	ALLY, CLINICIAN	-		

Related Client Plan:

A client plan must be linked to the progress note before it can be final approved. The Related Client Plan section displays the No Client Plan message when a client plan is not linked to the note.

1. To link a client plan to the note, click the green plus sign 😳.

.ock Va Type 🔺	Date 🔺	Owner	
Client Narrative	12/01/2022	ALLY, CLINICIAN	
Related Client Plan—			

2. The client plan will autopopulate, if there is only one available. Click **Save**. If there are multiple plans, select the appropriate plan from the list and click **Save**.

* Related Client Plan		₩ 💾	S		
Limited Service Log - Limited Service	<u>ce Log</u>	-		ice Log - Limited Se	
Revision: 1 Start: 12/01/2022 End:	12/04/2022		Revision: 1	Start: 12/01/2022	End: 12/04/2022
			Interim Fold	er - AOA Outpt / FSI	P Interim Folder
			Revision: 1	Start: 11/30/2022	End: 11/30/2023
Signatures					

Once the selection is saved, the selected related client plan is grayed out and the Save icon is replaced by a Pen icon. If the plan selected is not correct, click on the **Pen**, then click the client plan link. Start the selection again.

Lock Va Type 🔺	Date 🔺	Owner	11
Client Narrative	12/01/20	22 ALLY, CLINICIAN	
Related Client Plan Limited Service Log - Limited	Service Log		
	End: 12/04/2022		

Signatures:

After verifying the accuracy of the narrative and the linked client plan, a note must be signed before it can final approved.

1. At the bottom left of the note, click **Signatures**.

* Related Cl	ient Plan		/
Limited Ser	vice Log - Limited	Service Log	
Revision: 1	Start: 12/01/2022	End: 12/04/2022	
	/		
Signatures			

2. <u>Right click</u> anywhere on the Staff Signature line, where it shows the staff name and Pending, and select **Electronically Sign**.

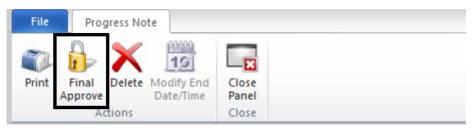
Search Progress Note Signatures	M My Signatures Pending Signa	tures		
F/A Sig Va Related To 🔺 Related Cli	nt En Signature Line Head	Name	Status	Professional Si Relationship Date
f Event Level	Sta Staff	CLINICIAN ALLY	Pending	Quick Add Signature
				Electronically Sign
				Assign Signatory
				Assign Signatory and Sign
				Document Signature on Hard Copy
				Clear Signature
				Delete

The 'There are no items to show' message will appear once the note is signed.



Final Approve:

In order for a note to be considered completed, it must be final approved. In the upper left side of the Progress Note, click **Final Approve**.





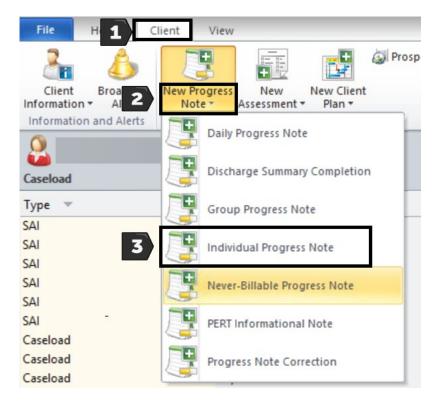
INDIVIDUAL PROGRESS NOTES

Each individual service provided to a client and/or their family must be documented using an individual progress note (one service, one note). Billing is generated from these types of notes.

Adding an Individual Progress Note:

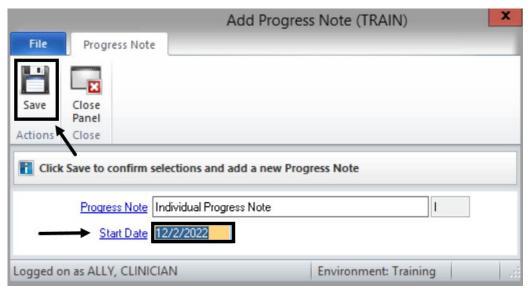
To add an Individual Progress Note from the Clinician's Homepage, select the client from the staff's Caseload first to launch the Client tab and the Client panel.

- 1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
- 2. Find the **New Progress Note** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the available notes. Click the words **New Progress Note**.
- 3. Click Individual Progress Note.





4. The Progress Note type and the Start Date automatically populate once the Add Progress Note window opens. Select the **Start Date** and click **Save**.



The Pending Individual Progress Note launches. Verify the date for the progress note. If the date is not correct, select Delete and start again.

	Pending	Individual Progress Not	e (TRAIN)		_ D X
File Progress Note					
Print Final Delete Modify End Date/Time Approve Close					
Pending Individual Progress Note from 12/02/202	2				
Clinical					4
Section Expand Collapse Display Narrative	Ualidation			Standard	
Current Client Information Case Number: Allergies: sulfamethoxazole,		DOB: Age:		Client Narrative - I	Unassigned - 12/02/2022
Client Narratives			-		
Lock Va Type	Date 🔺 Owne	er	=		
? Client Narrative	12/02/2022 Unass	igned			
✓ Related Client Plan No Client Plan			0		
• • • • • • • • • • • • • • • • • • • •			~		8
Signatures Encounters					
Logged on as ALLY, CLINICIAN	Environment: Train	ning CHP20111029 Tem	plate Loaded		

Note: The **Start Date** <u>cannot be changed</u> once Save is selected. If the date is not correct and the note is still pending, delete the note and start all over. If the date is not correct and the note has been final approved, contact the Support Desk for assistance.

Client Narratives:

The Client Narrative box opens in yellow. This means the section is active, and narratives can be entered. If the section is not yellow, **<u>double click</u>** anywhere on the Client Narratives line located to the left of the Client Narrative box.

Section Expand Collapse Display Narrativ	e Validation		Standard
Current Client Information		^	Client Narrative - Unassigned - 12/01/2022-
\sim			
Case Number:	Gender:1 DOB:0	Age: //rs	
Client Narratives Lock Va Type	Date 🔺 Owner		
? Client Narrative	12/01/2022 Unassigned		→
✓ Related Client Plan No Client Plan		-0	
-		•	88

1. To use a standard text template client narrative, click on the <u>down arrow</u> next to the Standard button, which is right above the Client Narrative box.

Clinical	
Section Expand Collapse Display Narrative Validation	Standard
Current Client Information	Client Narrative - Unassigned - 12/02/2022-
Case Number: Gender: DOB: Age: Allergies: sulfamethoxazole, Latex	

2. Select the appropriate standard text prompt to use for the client's progress note.

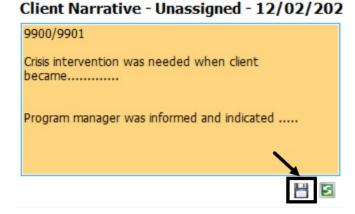
Stan	dard	
	Standard Text	
	Daily Progress Note ESU MD Progress Note ESU Nursing Note	
	General Progress Note	
	Group Progress Note ICC Progress Note Template	

3. The standard text template is loaded into the Client Narrative box. Follow the prompts and apply clinical judgment in completing the narrative. Always start the narrative with the program's <u>unit/subunit</u> identification number.

9900/9901	
TRAVEL TO / FROM:	
INTERVENTION (How does the serv beneficiary's behavioral health need(condition, diagnosis, and / or risk fac	s) - symptoms,
CLIENT RESPONSE (How did the clie above intervention):	ent respond to the
NEXT STEPS (Planned action steps l	by provider or

<u>Skip Steps 1 and 2 above</u> if a *free flowing text*, instead of a standard text template, will be entered. Applying the same sound clinical principles, start the narrative with the program's <u>unit/subunit</u> identification number.

4. Once the narrative entry is complete, click **Save**.



The staff will appear as the Owner of the note, and the Client Narrative is grayed out. To update the narrative, <u>double click</u> anywhere on the Client Narrative line.

Current Client Inform	nation		^	Client Narrative - ALLY, CLINICIAN - 12/02/ 9900/9901
Case Number	Gender: Sulfamethoxazole, Latex	DOB: Age:		Crisis intervention was needed when client became
Client Narratives				Program manager was informed and
Lock Va Type 🔺	Date 🔺	Owner	• =	indicated
Client Narrative	12/02/2022	ALLY, CLINICIAN		

Related Client Plan:

1. A client plan folder must be selected to indicate where the individual progress note will be stored. To link a client plan to the note, click the green plus sign ①.

V Related Client Plan

2. If there is only one client plan available, it will autopopulate. Click **Save**. If there are multiple plans, select the appropriate plan from the list and click **Save**.

* Related Client Plan			
Limited Service Log - Limited Service Log		ice Log - Limited Se	
Revision: 1 Start: 12/01/2022 End: 12/04/2022	Revision: 1	Start: 12/01/2022	End: 12/04/2022
		er - AOA Outpt / FS	
	 Revision: 1	Start: 11/30/2022	End: 11/30/2023
Signatures			

If this service is a <u>planned encounter</u>, also select the Intervention and the linked Objective from the Client Plan before clicking Save. The green check box will indicate which ones are selected. If it is an unplanned encounter, do not make any selections. Click **Save**.

Related Client Plan		-4
Client Plan - AOA Outpt / FSP Client Plan		S
Revision: 1.01 Start: 08/31/2022 End: 08/27/20	23	
Intervention(s)	Objective(s)	~
INTENSIVE CARE COORD ICC 82 [82]	Access Resources/Nat Emotional-Beh	

Once the selection is saved, the selected related client plan is grayed out and the Save icon is replaced by a Pen icon. If the plan selected is not correct, click on the **Pen**. Click the blue link to the Client Plan, and start the selection again.

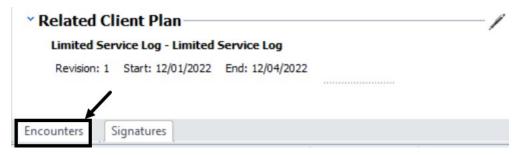
* Related Cl	iont Dian		A
* Related Cl	ient Plan		
Limited Ser	vice Log - Limited	Service Log	
Revision: 1	Start: 12/01/2022	End: 12/04/2022	

Note: If the Intervention is on the Client Plan but is not selected in the Progress Note, the encounter will be considered **Unplanned**.



Encounters:

1. To enter the service encounter for this note, click **Encounters**.



2. <u>Double click</u> on the red line where it states- Empty Time Slot Double Click to Add.

ers	1	Empty Time Slot	Double Click to Add	
		1		
-12				
	counte	rs Signatures		

3. In the Server/Service section, click the <u>green left arrow</u> to autopopulate the Staff name. The Staff name can be manually entered as well.

1			Progres	ss Note Er	ncounters (TRAIN)			X
File	Progr	ess Note Encounters							
S									
Refresh	Close Panel								
Refresh	Close								
Encount	er Serve	r Information							Ф
Server/S	ervice				Date/Time				
	√ Le	ead Server			Date	12/02/2022			
				X	—	Start	Duration	Stop	
<u>S</u>	taff			0	Service				
Ser	vice				Travel				
Superv	isor				Documentation				
							Save	Cancel	

After the server is selected, the Service fields are activated for data entry. The populated Date and Lead Server fields are both grayed out and read only.

4. Enter the **Service** code, if unplanned. The Service autopopulated if the service is planned and the Intervention was selected when the client plan was linked to the note. Enter the **Service**, **Travel** (if applicable), and **Documentation** times in their respective **Duration** fields. Click **Save**.

Encounter Server Information				
Server/Service	Date/Time			
Lead Server	Date	12/02/2022		
		Start	Duration	Stop
Staff ALLY, CLINICIAN	11001		0:39	
Service CRISIS INTERVENTION 70	70 Travel			
Supervisor	>Documentation		0:12	
		\rightarrow	Save	Cancel

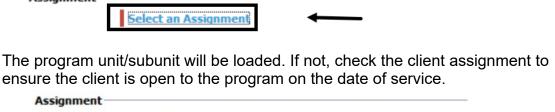
After clicking Save, the Server/Service screen closes and is replaced by the Assignment and Billing Parameters window. If the selected unplanned service is not correct, click the service link to change it.

Encounter Information for Client							
Encounter	Currently Viewing	Information for As	signment and Billi	ng Parameter	s		
– Assignment and Billing Parameters – Collateral Server(s)		Friday 39 minutes 13 minutes (D)	December 2, CRISIS INTER ALLY, CLINICIA	RVENTION 70 (7	70)	4 day(:	s) ago
	-	Select an Assignm	ent				
	Billing						
	Lab				Participants		
	Provided To	Client		С	Days		
	Provided At	Office		Α	Quantity		
	Outside Facility				Fee		
	Contact Type	Face to Face		F			
	Appointment Type	Unscheduled/Walk-in		2			
	Billing Type						
	Intensity Type						
					I		
						Save	Cance

Continue with completing the Assignment and Billing Parameters section.

-	
=	

5. To select a client assignment, click the blue **Select an Assignment** hyperlink.





6. Review the service indicators and adjust accordingly to ensure the documentation and service indicators match.

Billing		
Lab		
Provided To	Client	с
Provided At	Office	A
Outside Facility		
Contact Type	Face to Face	F
Appointment Type	Unscheduled/Walk-in	2
Billing Type		
Intensity Type		

Billing Type is the language utilized during service.

Intensity Type indicates the type of interpreter utilized during service, if any. If no interpreter is utilized, select Not Applicable.

Billing Type	English	1
Intensity Type	NOT APPLICABLE	Ν

After successfully completing the Assignment and Billing Parameters, do not click Save yet. The Save button is for all Encounter Information. Go to the left side of the Encounter screen to continue completing the Encounter.

Encounter Information for Client:
Encounter
Assignment and Billing Parameters Diagnoses EBP/SS Collateral Server(s)

Diagnosis:

A diagnosis must be linked to the service note. All the client's active diagnoses, including effective dates, will pull from the most recent final approved diagnosis assessment and will display in the Diagnoses section.

1. To link a diagnosis, click **Diagnoses**.

Encounter					
··· Assignment and Billing Parameters					
··· Diagnoses					
EBP/SS					
Collateral Server(s)					

2. In the top part of the Diagnoses section, click the green down arrow next to the diagnosis that was the focus of the treatment.

Encounter	Currently View	ing Information for Diagnoses					
- Assignment and Billing Parameters	Active Diagno	ses in Client's Chart					
EBP/SS	ICD	Description	Axis	Priority	Begin	Status	
Collateral Server(s)	F33.1	Major depressive disorder, recurrent,	I (Primary)	1	01/01/2022	Active	
	F43.10	Post-traumatic stress disorder, unspec	I (Primary)	2	01/01/2022	Active	-
							-
	Diagnoses for	Service					
	ICD	Description	Axi	s 🖊	Priority Beg	gin	
		There are no it	ems to show	,			

There are no items to show.

The selected diagnosis will display in bright green at the top and will display in the lower portion of the section. This indicates the diagnosis is now linked to the service. If a diagnosis was selected in error, click the red x to remove it and then select again.

Currently Viev	ving Information for Diagnoses					
Active Diagno	oses in Client's Chart					
ICD	Description	Axis	Priority	Begin	Status	
✓ F33.1	Major depressive disorder, recurrent,	l (Primary)	1	01/01/2	2022 Active	
F43.10	Post-traumatic stress disorder, unspec	l (Primary)	2	01/01/2	2022 Active	4
						-
Diagnoses for	Service					
ICD	Description	Axis	5	/ Priority	Begin	
F33.1	Major depressive disorder, recurrent, moder	rate I (Pi	rimary)	1	01/01/2022	×

To save the service details that were entered and close the Encounter screen at the same time, click **Save**.



If Cancel is clicked instead of Save, all service information disappears and must be entered again.

To verify the accuracy of the service information entered, click **Encounters**. A quick view of the information entered will display in blue. To edit the service information, <u>double click</u> on the top blue line. Once the note is final approved, the display will turn green and cannot be edited.

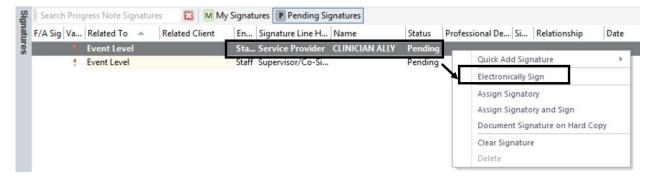
Encour	Import Display Detail				
ú	Encounter	CRISIS INTERVENTION 70 (70)	12/02/2022	0:39	
	Staff - Lead	ALLY, CLINICIAN (11001)	12/02/2022	0:39	0:12 (D)
	Client	CLIENT, SAMPLE	12/02/2022	0:39	
-12					
En	counters Signatures				

Signatures:

After verifying the accuracy of the narrative, the linked client plan, and the encounter, a note must be signed before it can be final approved. At the bottom of the note, click on **Signatures**.

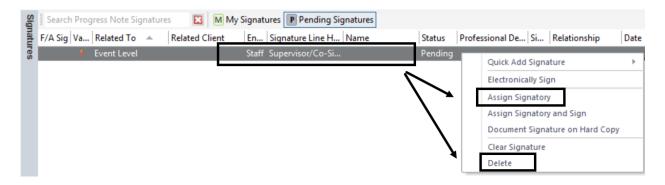


1. <u>Service Provider</u>: <u>Right click</u> anywhere on the Service Provider signature line where the service provider's name is displayed, and select **Electronically Sign**.



CO-SIGNATURES:

2. <u>Supervisor/Co-Signer</u>: Completing the Supervisor/Co-Signer signature line will depend on whether the staff needs a co-signature or not. Follow either the Co-signature <u>is not</u> needed steps or the Co-signature <u>is</u> needed steps below.



a. Co-signature is not needed:

i. <u>Right click</u> on the signature line and select **Delete.**

5 🔣 MM	ly Signatures P Pending Signatures			
Related Client	En Signature Line Heading	Name	Status	Professi Si Relations Date
	Staff Supervisor/Co-Signer		Pending	Quick Add Signature
				Electronically Sign
				Assign Signatory Assign Signatory and Sign Document Signature on Hard Copy
			\searrow	Clear Signature Delete

ii. Click Final approve.

File	Prog	ress Note		
		× 19	3	
Print	Approve	Delete Modify End Date/Time tions	Close Panel Close	



b. Co-signature is needed:

i. <u>Right click</u> on the signature line and select **Assign Signatory.**

En Signature Line Head	Name Statu	s Professional Si Relationship
Staff Supervisor/Co-Signer	Pend	Quick Add Signature
		Electronically Sign
		Assign Signatory

ii. The Staff Lookup table opens. Click in the **ID** column and <u>start typing</u> the <u>co-signer's CCBH ID number</u>. A Search box appears. Click **Ok**.

		Staff Lookup (TRAIN)				
File	Lookup Panel					
N	×					
Select	Close Panel					
Actions	Close					
Staff Lis	ct a Staff Member fr	om the list.				
[ID]	Full Name					
	1 PRACTICUM CC	LLEAGUE				
	2 CUTOVER STAT					
S	Search: [ID]					
	11002 ОК	1 037)				

iii. To confirm the selected co-signer, click **Select**.



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iv. The selected co-signer's name will display in the Supervisor/Co-Signer signature line. Click **Close Panel**.

F	ile Progress Note	
Pri	nt Final Delete Modify End Date/Time	Close Panel
	Actions	Close
E	Pending Individual Progress Note	from 12/02/2022
Clin	nical	
1	i 🛛 🖌 🙊 🔽	
Sigi	Search Progress Note Signatures	M My Signatures Pending Signatures
Signatur	F/A Sig Va Related To Rela	at Ent Signature Line Hea Name 🔺 Status
-	🕴 Event Level	Staff Supervisor/Co-Signer THERAPIST FRIEND Pending

Co-Signer Approving a Progress Note:

The co-signer of a progress note will open and review the pending note in its entirety. To approve and co-sign the note, perform the following:

- 1. Click on the **Signatures** pane.
- 2. Right click anywhere on the signature line displaying the co-signer's name.
- 3. Select Electronically Sign.
- 4. Click Final Approve.

	Pending Indi	vidual Progress Note	e (TRAIN)	
File Progress Note				
🖚 🔒 🗙 🛅				
Print Final Delete Modify End Approve Date/Time	Close Panel			
4 Actions	Close			
Clinical		e .]		
F/A Sig Va Related To Re				
F/A Sig Va Related To Re	lat Ent Signature Line Hea Name	Status	Professional Des Si Relationship	Date
f Event Level	2 Staff Supervisor/Co-Signer THERAPIS	T FRIEND Pending	Quick Add Signature	
1		3	Electronically Sign	
Encounters Signatures				
87. X 17.				

Note: After signing the progress note, a co-signer should <u>final approve</u> the note.



GROUP PROGRESS NOTES

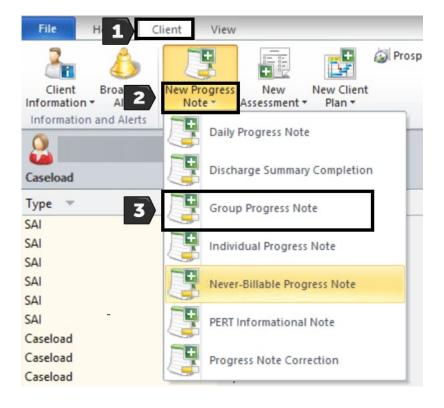
Group progress notes are used for services that include multiple clients. Billing is generated from these types of notes.

A client plan type should be in place for all clients attending the group service before creating a group progress note.

Adding a Group Progress Note:

To add a Group Progress Note from the Clinician's Homepage, select the client from the staff's Caseload first to launch the Client tab and the Client panel.

- 1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
- 2. Find the **New Progress Note** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the available notes. Click the words **New Progress Note**.
- 3. Click Group Progress Note.



Ξ	

4. The Add Progress Note window launches. The Progress Note type and the Start Date will populate, but the Start Time and End Time fields will not populate. Select the correct **Start Date**, and enter the **Start Time** and **End Time**. Click **Save**

		Add Progress	s Note (TRAIN)	 x
File	Progress Note			
Save	Close Panel Close			
_	Progress Note Gr	ections and add a new Prog roup Progress Note 2/04/2022 Start Time C End Time	G 11:00 PM 12:00 PM	
Logged or	as ALLY, CLINICIA	N	Environment: Training	

The Pending Group Progress Note launches. Verify the date and times for the progress note. If the date and/or times are not correct, select Delete and start again.

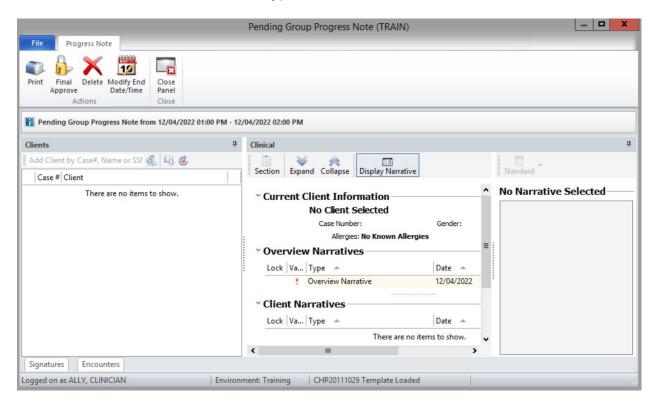
	Pending Group Progress Note (TRAIN)	_ 🗆 X
File Progress Note		
Print Approve Actions Delete Modify End Actions Date/Time Close		
Pending Group Progress Note from 12/04/2022 01:0	0 PM - 12/04/2022 02:00 PM	
Clients	[‡] Clinical	
🛿 Add Client by Case#, Name or SSI 🔬 🖳 🥝		
Case # Client	Section Expand Collapse Display Narrative Standard	
There are no items to show.	Current Client Information No Client Selected Case Number: Allergies: No Known Allergies Overview Narratives	lected
	Overview Narratives	

They be

Note: The **Start Date, Start Time, and End Time** <u>cannot be changed</u> once Save is selected. If the date and/or times are not correct and the note is still pending, delete the note and start all over. If the date and/or times are not correct and the note has been final approved, contact the Support Desk for assistance.



The Group Progress Note launches with 3 main sections of information. The Clients section will display the clients who attended the group. The Clinical section is similar to the informational and individual progress notes, with the exception of the group's Overview Narratives added for this type of note.



Adding Clients:

All clients who attended the group service must be listed in the Clients section. In the Add Client by Case#, Name or SSN field, enter the client's CCBH **Case Number**, and press the **Enter** key on the keyboard. If the client's Case Number is not readily available, the client's Sort Name may also be used.



Add the Case Number and press Enter for each client who participated in the group.



After all clients have been added, <u>single click</u> on the <u>first client</u> to continue completing the notes. Each client's identifiable information and allergies will display in the Current Client Information.

Clients		Clinical		
Add Client by Case#, Name or SSI 🛃 🖳 💰	1	Section Expand Collapse Display Narrative		Standard
CLIENT, SAMPLE THESAMPLE, CLIENT		Current Client Information	^	Client Narrative
		Case Number: Gender: Allergies: sulfamethoxazole, Latex		:

Overview Narratives:

There are two narrative sections in the Group Progress Note. The Overview Narratives is for the overview of the group.

1. <u>Double click</u> anywhere on the **Overview Narrative** line to activate the Overview Narrative to the right.

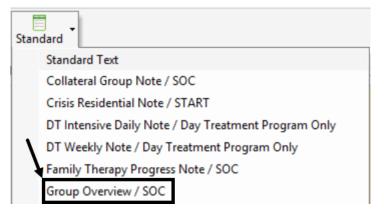
Clients [‡] Clini	cal		
Add Client by Case#, Name or SSN	tion Expand Collapse		Standard
CLIENT, SAMPLE THESAMPLE, CLIENT	Current Client Information	^	No Narrative Selected
$\mathbf{\lambda}$	Case Number Gender: DOB: Age:		
	Dverview Narratives Lock Va Type Date Owner	-	
	Overview Narrative 12/04/2022 Unassigned	-	

2. To use the standard text for group overview, click on the <u>down arrow</u> next to the Standard button.

ndard -	_			
erview Na	arrative	Unassig	ned - 12/0	4/2022-
		ndard		ndard - 12/0



3. Select Group Overview/SOC from the list of standard text templates.



4. The group overview text template is loaded into the Overview Narrative box. Follow the prompts in completing the narrative. Always start the narrative with the program's <u>unit/subunit</u> identification number.

Overview Narrative - ALL	Y, CLINICIAN -
9900/9901 🗕	
OVERVIEW (Using a global descript group, describe the focus and inte	
COLLATERAL SERVER (Document compelling reason for collateral ser	
TRAVEL TO/FROM:	

5. Once the narrative entry is complete, click **Save**.



The staff will appear as the Owner of the note, and the Overview Narrative box is grayed out. To update the narrative, <u>double click</u> anywhere on the Overview Narrative line. The saved Overview Narrative will populate for all other clients in the group.

Overview Narratives			
Lock Va Type 🔺	Date 🔺	Owner	1
Overview Narrative	12/04/2022	ALLY, CLINICIAN	

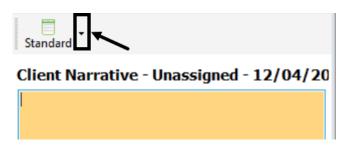
Client Narratives:

The Client Narratives section is used to document the specifics of the individual client's participation in the group.

1. <u>Double click</u> anywhere on the Client Narratives line to activate the Client Narrative.

Overvie	w Narratives			—	
Lock Va	Туре 🔺	Date 🔺	Owner		=
	Overview Narrative	12/04/2022	ALLY, CLINICIAN		
Client Na	arratives				
Lock Va	Туре 🔺 🔪	Date 🔺	Owner		
1	Client Narrative	12/04/2022	Unassigned		

2. Once the Client Narrative box is yellow, click on the <u>down arrow</u> next to the Standard button. This will display the list of standard text templates.



3. Scroll down and select the Group Progress Note standard text template.

Stan	dard
	▲
	ESU MD Progress Note
	ESU Nursing Note
	ESU On Call Telephone
	General Progress Note
	Group Progress Note
	ICC Progress Note Template



4. The standard text template is loaded into the Client Narrative box. Follow the prompts and apply clinical judgment in completing the narrative. Always start the narrative with the program's <u>unit/subunit</u> identification number.

Client Narrative - Unassigned - 12/04/20
9900/9901
INTERVENTION (How does the service address the beneficiary's behavioral health need(s) - symptoms, condition, diagnosis, and / or risk):
CLIENT RESPONSE (How did the client respond to the above intervention):
NEXT STEPS (Planned action steps by provider or beneficiary, collaboration with beneficiary, collaboration with other providers(s)):
UPDATE TO THE PROBLEM LIST (Include any changes or updates to client Problem List):

5. Once the narrative entry is complete, click **Save**.



The staff will appear as the Owner of the note, and the Client Narrative is grayed out. To update the narrative, <u>double click</u> anywhere on the Client Narrative line.

Lock Va Type Date Owner Client Narrative 12/04/2022 ALLY, CLINICIAN	Client Narratives		
Client Narrative 12/04/2022 ALLY, CLINICIAN	Lock Va Type 🔺	Date 🔺	Owner
	Client Narrative	12/04/2022	ALLY, CLINICIAN

Related Client Plan:

A client plan folder must be selected to indicate where the individual progress note will be stored.

1. To link a client plan to the note, click the green plus 😳 sign.

Y Related Client Plan	→ O
_	V
No Client Plan	



2. If there is only one client plan available, it will autopopulate. Click **Save**. If there are multiple plans, select the appropriate plan from the list and click **Save**.

Y Related Client Plan	_ ⊼ ⊟
Limited Service Log - Limited Service Log Revision: 1 Start: 12/01/2022 End: 12/04/2022	Limited Service Log - Limited Service Log Revision: 1 Start: 12/01/2022 End: 12/04/2022
	Interim Folder - AOA Outpt / FSP Interim Folder
Signatures	Revision: 1 Start: 11/30/2022 End: 11/30/2023

Once the selection is saved, the selected related client plan is grayed out and the Save icon is replaced by a Pen icon. If the plan selected is not correct, click on the **Pen**. Click the blue link to the Client Plan, and start the selection again.

	iont Dian		 a
* Related Cl	ient Plan		
Limited Ser	vice Log - Limited	Service Log	
Revision: 1	Start: 12/01/2022	End: 12/04/2022	

Select the next client, and repeat the same steps. Complete the **Client Narratives** and **Related Client Plan** for the remaining clients in the group before moving to the Encounters and Signatures panes.

Clients	д	Clinical					
Add Client by Case#, Name or SS		Section Expand Collapse D	isplay Narrative				
CLIENT, SAMPLE THESAMPLE, CLIENT		Current Client Inform	ation				
		Case Number:		Gender:	DOB: :	Age:	
A		Allergies: a	mpicillin, MSG/M	IonoSodium Glu	tamate		
		* Overview Narratives					
		Lock Va Type 🔺		Date 🔺	Owner		
		Overview Narrativ	/e	12/04/2022	ALLY, CLINICIAN		
	ľ						
		Client Narratives					
		Lock Va Type 🔺		Date 🔺	Owner		
		Client Narrative		12/04/2022	Unassigned		
							-
		* Related Client Plan—				_	\rightarrow
		No Client Plan					



Encounters:

1. To enter the encounters for this note, click **Encounters**.

* Related C	ient Plan		 /
Limited Ser	vice Log - Limited	Service Log	
Revision: 1	Start: 12/01/2022	End: 12/04/2022	
Encounters	Signatures		

2. <u>Double click</u> on the top red line to enter the provider service information. The clients are listed below the top red line.

	1	Empty Time Slot	Double Click to Add	12/04/2022	01:00 PM - 02:00 PM
		Client	CLIENT, SAMPLE (12/04/2022	01:00 PM - 02:00 PM
	Ι	Client	THESAMPLE, CLIENT	12/04/2022	01:00 PM - 02:00 PM
-12	/				
Enc	ounters	Signatures			

3. In the Server/Service section, click the <u>green left arrow</u> to autopopulate the Staff name. The Staff name can be manually entered as well.

			Progress	Note	e Enco	unters (TRAIN)			X
File	Prog	gress Note Encounters								
5										
Refresh	Close									
Refresh	Close									
Encounte	er Serv	er Information								ą
Server/S	ervice					Date/Time				-
	~	Lead Server		1		Date	12/04/2022			
		Interactive Complexity Ad	d-On Service		<u>×</u>	•	Start	Duration	Stop	
St	taff			0	400	Service	01:00 PM	1:00	02:00 PM]
Serv	vice					Travel				
Supervi	isor					Documentation]
								Save	Cancel	

After the Server is selected, the Service fields are activated for data entry. The populated Date and Lead Server fields are both grayed out and read only.

4. Enter the group service code in the **Service** field. Enter the **Travel** (if applicable) and **Documentation** times in their respective **Duration** fields. Click **Save**.

Encounter S	erver Information						
Server/Serv	ice			Date/Time			
	✓ Lead Server			Date	12/04/2022		
	Interactive Complexity Add-On Service				Start	Duration	Stop
Staff	ALLY, CLINICIAN	11001	411	Service	01:00 PM	1:00	02:00 PM
Service	REHAB-GROUP 35	35		Travel	1		
Supervisor				Documentation	1		
					7	Save	Cancel

5. To enter the Assignment and Billing Parameters for each client, click **Encounters** again and **double click** anywhere on the line displaying **Client** and the name of the client. It is best to start from the top.

	1	Encounter	REHAB-GROUP 35 (35)	
		Staff - Lead	ALLY, CLINICIAN (11001)	
		Client	CLIENT, SAMPLE	
	1	Client	THESAMPLE, CLIENT	
-Þ				
En	counters	Signatures		

6. The Encounter screen for the selected client launches.

			Encounter for SAMPLE CLIENT	X
File	Progr	ess Note Encounters		_
5	X	×		
Refresh	Delete	Close Panel		
Refresh	Delete	Close		
Encount	er Inforn	nation for Client: SAM	MPLE CLIENT	ф.
Encount	er		Currently Viewing Information for Assignment and Billing Parameters	
Assign	ment and E	Billing Parameters	Date/Time	
			Date 12/04/2022	
			Start Duration Stop	
			Service 01:00 PM 1:00 02:00 PM	
			Assignment	
			Select an Assignment	

- a. Review and edit the **Time** that the client participated in the group.
- b. Click the **Select an Assignment** hyperlink to load the client assignment. If the program unit/subunit does not load, check the client assignment to ensure the client is open to the program on the date of service.
- c. Complete the **Billing** information for the client. Review the service indicators and adjust accordingly to ensure accuracy. The documentation and billing information should match.

Encounter	Currently Viewing Information for Assignment and Billing Parameters
Assignment and Billing Parameters	Date/Time Date 12/04/2022 a. Start Duration Stop Service 01:00 PM 1:00 02:00 PM
c.	b. <u>Select an Assignment</u> Billing Provided To Client C
	Provided At Office A
	Outside Facility
	Contact Type Face to Face F
	Appointment Type Scheduled 1
	Billing Type
	Intensity Type
	Subject to Interactive Complexity Add-On

Billing Type is the language utilized during service.

Intensity Type indicates the type of interpreter utilized during service, if any. If no interpreter is utilized, select Not Applicable.

After successfully completing the Assignment and Billing Parameters, <u>do not click Save</u> yet. The Save button is for all Encounter Information. Go to the left side of the Encounter screen to continue completing the Encounter.

Encounter Information for Client:	
Encounter	Currently Viewing Information for Assignment and Billing Parameters
Assignment and Billing Parameters Diagnoses EBP/SS	Date/Time Date 12/04/2022

Diagnosis:

A diagnosis must be linked to the service note. All the client's active diagnoses, including effective dates, will pull from the most recent final approved diagnosis assessment and will display in the Diagnoses section.

7. To link a diagnosis, click **Diagnoses**.

Encounter Information for Client:	
Encounter	
··· Diagnoses	
EBP/SS	

8. In the top part of the Diagnoses section, click the green down arrow next to the diagnosis that was the focus of the treatment.

Encounter	Currently View	ing Information for Diagnoses					
- Assignment and Billing Parameters	Active Diagno	ses in Client's Chart					
EBP/SS	ICD	Description	Axis	Priority	Begin	Status	
Collateral Server(s)	F33.1	Major depressive disorder, recurrent,	I (Primary)	1	01/01/2022	Active	-
	F43.10	Post-traumatic stress disorder, unspec	I (Primary)	2	01/01/2022	Active	-
	Diagnoses for	Service					
	ICD	Description	Axi	s 🖌	Priority Beg	gin	
		There are no it	ems to show				

The selected diagnosis will display in bright green at the top and will display in the lower portion of the section. This indicates the diagnosis is now linked to the service. If a diagnosis was selected in error, click the red x to remove it and then select again.

ctive Diagno	ses in Client's Chart					
ICD	Description	Axis	Priority	Begin	Status	
✓ F33.1	Major depressive disorder, recurrent,	l (Primary)	1	01/01/2022	2 Active	
F43.10	Post-traumatic stress disorder, unspec	l (Primary)	2	01/01/2022	2 Active	
						ł
iagnoses for	Service					
CD	Description	Axis		Priority Be	egin	
F33.1	Major depressive disorder, recurrent, mode	rate I (Pr	imary) 1	01	/01/2022	>



9. To save the service details that were entered and close the Encounter screen at the same time, click **Save**. If Cancel is clicked instead of Save, all service information disappears and must be entered again.



<u>Repeat</u> the Steps 1 through 9 above for each client until all clients in the group have encounters.



To verify that encounters were entered for all clients, click **Encounters** again. A quick view of the information entered will display in blue. To review or edit any of the service information, <u>double click</u> on any of the blue lines. Once the note is final approved, the display will turn green and cannot be edited.

Encounter	REHAB-GROUP 35 (35)
Staff - Lead	ALLY, CLINICIAN (11001)
Client	CLIENT, SAMPLE
Client	THESAMPLE, CLIENT

NOTES

Signatures:

A note must be signed before it can be final approved. At the bottom of the note, click on **Signatures**.



1. <u>Service Provider</u>: <u>Right click</u> anywhere on the Service Provider signature line, where the service provider's name is displayed, and select **Electronically Sign**.

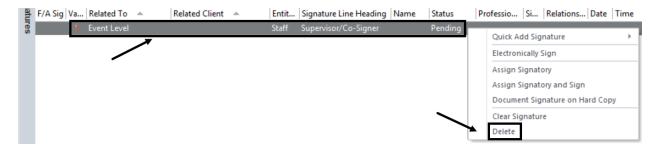
Searc	h Prog	gress Note Signa	atures 🛛 🗈	My Signatures	P Pending Signatures				
F/A Sig	Va	Related To	Relat En	Signature Line Hea	Name	Status	Pro	fessional Des Si Relationship	
	*	Event Level	Sta	off Service Provider	CLINICIAN ALLY	Pending		Quick Add Signature	
- · ·	1	Event Level	Sta	ff Supervisor/Co-Signe	er	Pending	· ` `		
								Electronically Sign	

2. <u>Supervisor/Co-Signer</u>: Completing the Supervisor/Co-Signer signature line will depend on whether the staff needs a co-signature or not. Follow either the Co-signature <u>is not</u> needed steps or the Co-signature <u>is</u> needed steps below.

Sig	Search Progress Note Signatures	My Signatures Pending Signatures	
natures	F/A Sig Va Related To 🔺 Related Clier	t En Signature Line H Name	Status Professional De Si Relationship Date
res	f Event Level	Staff Supervisor/Co-Si	Pending Quick Add Signature
		7	Electronically Sign
		· · · · · ·	Assign Signatory
			Assign Signatory and Sign
			Document Signature on Hard Copy
			Clear Signature
			Delete

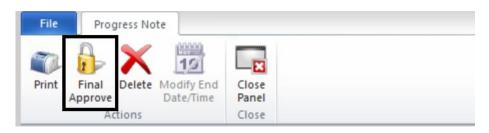
a. Co-signature is not needed:

i) <u>Right click</u> on the signature line and select **Delete.**



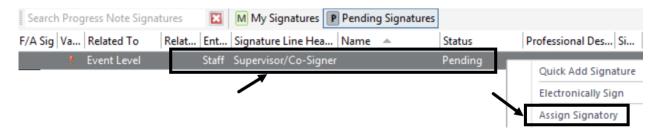


ii) Click Final approve.

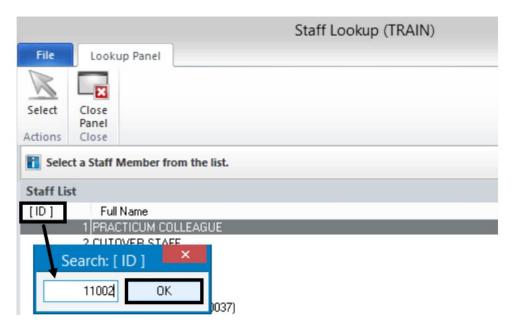


b. Co-signature is needed:

i) Right click on the signature line and select Assign Signatory.

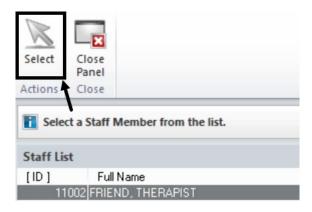


ii. The Staff Lookup table opens. Click in the **ID** column and <u>start typing</u> the <u>co-signer's CCBH ID number</u>. A Search box appears. Click **Ok**.





iii. To confirm the selected co-signer, click **Select**.



iv. The selected co-signer's name will display in the Supervisor/Co-Signer signature line. Click **Close Panel**.

_				Pending	Group Pro	gress Note
F	ile Progress Note	_				
9	D 🔒 🗙 📆					
Pr	int Final Delete Modify End Approve Date/Time	Close Panel				
	Actions	Close				
8	Pending Group Progress Note from	n 12/04/20	022 01:00 PM - 12/	04/2022 02:0	0 PM	
Cli	ents		ф.	Clinical		
∏ A	dd Client by Case#, Name or SSI 🧟		6		*	
Sigi	Search Progress Note Signatures	E	My Signature	P Pendin	g Signature	s
Signatures	F/A Sig Va Related To Rela	t Ent	Signature Line He	ea Name		Status
res	🕴 Event Level	Staff	Supervisor/Co-Si	gner THERA	PIST FRIEND	Pending

Closing the Progress Note window will allow the co-signer to open the note since only one staff can actively work on a pending note.

NOTES

Co-Signer Approving a Group Progress Note:

The co-signer of a progress note will open and review the pending note in its entirety. To approve and co-sign the note, perform the following:

- 1. Click on the **Signatures** pane.
- 2. Right click anywhere on the signature line displaying the co-signer's name.
- 3. Select Electronically Sign.
- 4. Click Final Approve.

	Pending Group Progress Note (TRAIN)
File Progress Note	
Print Final Approve Delete Modify End Date/Time	Close Panel Close
Pending Group Progress Note fro	n 12/04/2022 01:00 PM - 12/04/2022 02:00 PM
Clients	4 Clinical
Add Client by Case#, Name or SSI	
Search Progress Note Signature	M My Signatures Pending Signatures
F/A Sig Va Related To Rel	t Ent Signature Line Hea Name Status Professional Des Si
Event Level	Staff Supervisor/Co-Signer THERAPIST FRIEND Pending Quick Add Signature Electronically Sign
Encounters Signatures	

Note: After signing the progress note, a co-signer should <u>final approve</u> the note.

<u>NOTES</u>



PROBLEM LIST

A Problem List must be created for all clients open to a program. As the current Diagnosis Form will populate into the new Problem List, the program shall ensure the current Diagnosis Form is accurate and up to date before entering a Problem List.

Adding a Problem List:

To add a Problem List from the Clinician's Homepage, select the client from the staff's Caseload first to launch the Client tab and the Client panel.

- 1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
- 2. Find the **New Assessment** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the preferred assessments. Click the words **New Assessment**.
- 3. Click Problem List.



The Adding Assessment window launches automatically populating **Problem List** as the Assessment Type. Select the assessment **Date** and click **Save**.

		Adding Assessme	ent for SAN	APLE CLIENT
File	Asses	sment		
G Refresh	Save	Prospective Progress Planning Tiers Indicators	Close Panel	
Refresh	Actions	Clinical	Close	
Click	Save to c	onfirm selections and add a nt Type Problem List	new Assessm	PROBLEM



The Pending Problem List opens.

			Pend	ding Pro	blem Li	st for SAM	PLE CLIENT	dated	12/01/20	22 (TRAIN)			X
File	Assessment													
Refresh	Perform	Save and	Save Final	Print	X Delete	Add								
Kellesii	Validation Check	Close	Approv		Delete	Signature *	Planning Tiers							
Refresh	Validation		Actions		Delete	Signatures	Clin	ical	Close					
Problem	List										▼ ‡	Validatio	ons	↓ ₽
Problem	n List										Д	S Valid	lation Descriptio	n
Active	COUNTY (GO BEHAVIO PROBLEM LI		ALTH SEF	IVICES					^	The	re are no items to	o show.
ID	Diagnosis							Priority	Beg Date	End Date	=			
F33.1	Major depress	ive disorder	, recurrent, mo	derate				1	12/01/2022	2				
F43.10	Post-traumati	c stress diso	order, unspecifie	ed				2	01/01/2022	2				
Social D	eterminants of He	ealth Codes	s (Z Codes)											
Code #	Description			Start	Date	Name, Jo	b Title							
255.4	Education Mal and/or classma		iscord w/teacher End Date								_			
☐ Z55.8	Other Problem: Literacy	s Related to E	Education and End Date	11										
C 256.8	9 Other Problem:	s Related to E	Employment End Date	11							_			

To add Social Determinants of Health Codes (Z Codes), <u>check</u> the box to the left of the **Z Code**. Enter **Start Date**, **Name**, and **Job Title**.

Problem List									
Social Determinants of Health Codes (Z Codes)									
Code #	Description	Start Date	Name, Job Title						
Z55.4	Education Maladjustment Discord w/teacher and/or classmates End Date	// //							
Z55.8	Other Problems Related to Education and Literacy End Date	//							
✔ Z56.89	Other Problems Related to Employment	12/01/2022	Clinician Ally, Clinical Therapist						
	End Date	11							

<u>Scroll down</u> to the **Comments** section, and enter the date, program unit/subunit, Staff ID, and an applicable Comment.

Comments (Add any additional comments or risk factors to Problem List)
12/1/2022 9900/9901 11001 Client is currently unemployed

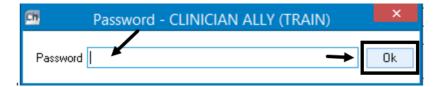
I

Progress Notes

Click Final Approve.

File	Assessment								
5		×	Н		7	X	2	🎒 🦾	×
Refresh	Perform Validation Check	Save and Close	Save	Final Approve	Print	Delete	Add Signature •	Prospective Progress Planning Tiers Indicators *	Close Panel
Refresh	Validation		Act	ions		Delete	Signatures	Clinical	Close

Enter password, and click **Ok**.



The Problem List window closes and the system returns to the Clinician's Homepage. To view the final approved Problem List, single click the Assessments pane and double click on it.

者 SAN	IPLE CLI	ENT	Borr	1:							
Assessments	;										
Date 🔺				Description							F/A
12/01/2022				Diagnosis Form							Z
12/01/2022				Problem List							
	_	_									
Face Sheet	Pre-Intake	Assessments	Assignments	🔒 Diagnoses	🔓 Substance Ab	Client Plans	Progress Notes	Services	Medical Conditi	Medications	Clien

NOTES



Support Desk Contact Information sdhelpdesk@optum.com 1-800-834-3792

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	Monday through Friday (E-mail)					
Hours	Services					
6:00 am to 6:00 pm	All services except password resets or any service involving PHI					
Monday through Friday (Telephone)						
Hours	Services					
4:30 am to 6:00 am	Resetting passwords (24 hour programs) and reporting system outages*					
6:00 am to 6:00 pm	All services					
6:00 pm to 11:00 pm	Resetting passwords (24 hour programs) and reporting system outages*					
11:00 pm to 4:30 am	Reporting system outages*					
	Weekends (Telephone)					
Hours	Services					
4:30 am to 11:00 pm	Resetting passwords (24 hour programs) and reporting system outages*					
11:00 pm to 4:30 am	Reporting system outages*					

* By definition, a system outage affects multiple users. Examples include when: -The system does not respond and appears to be frozen -No data can be entered or viewed

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Support Desk Suggestions

- Please consult with your program manager and your resource packet prior to contacting the Support Desk.
- When calling for a password reset on weekdays between 4:30-6a or 6-11p, or calling weekends between 4:30a-11p, you must leave a message. Include your name, CCBH staff ID, phone number and the reason for your call.
- You may be given a ticket/tracking number if you call between 6:00a and 6:00p Monday through Friday. Remember to keep this number for future reference.

Questions	Where To Go
Clinical Documentation Questions	Documentation Manual/Your Program Manager
Duplicate Clients and Name/DOB/Gender/SSN Changes	Complete Form BHS-025 and Call Medical Records: 619-692-5700 x 3
Financial Questions (UMDAP/Insurance)	Billing Unit: 619-338-2612 Fax- 858-467-9682
Online User Manuals and Forms	www.optumsandiego.com
Service Codes	CCBH (Anasazi) User Manual/QM Unit