



MENTAL HEALTH MIS ASSESSMENTS



Live Well San Diego

County of San Diego Behavioral Health Services



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This handout contains screen shots of confidential and proprietary information for view 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 all 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 not 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.”



CLINICAL STANDARD FOR ASSESSMENTS IN CCBH

The electronic health record (EHR) is a valuable resource for maintaining a centralized single medical record for all client clinical information. During the course of treatment, a client may accumulate multiple Behavioral Health Assessments (BHAs), Psychiatric Assessments, and/or Discharge Summaries. The system was designed to prepopulate or “pull-forward” information from certain fields in these assessment types from the most recent version into a newly opened version. This represents both an opportunity and a challenge.

Given that a client can have multiple historical assessments, it is helpful if the most current clinical information that prepopulates can be readily available for review when opening a new BHA, Psychiatric Assessment and/or Discharge Summary. Practically speaking, however, all information that prepopulates should not be summarily retained as portions of the assessments have become excessively long and have begun to lack clinical precision in describing the client’s current needs. Since all historical information that has been final approved in these assessment types in CCBH exists for review at any time (for those who have access to the client’s EHR), it is not necessary to retain all information that prepopulates in every section of an Assessment.

In 2011, the Clinical Standards Committee created standards addressing information that prepopulates into CCBH Assessments. In an effort to maintain the best clinical practice, these clinical standards have been revised by Quality Management to provide further direction on addressing information which prepopulates when adding new assessments in CCBH.

When a Client is New to Your Program

When adding a new assessment (BHA or Psychiatric Assessment) for a client that is new to your program and information has prepopulated from historical assessments, it is your responsibility to review each section in detail with the client for continued clinical relevance/accuracy. It is not required to keep all historical information in a section. Rather it is your responsibility to add, update, edit, correct, and/or retain appropriate clinical information that, in your professional opinion, is deemed relevant to the client’s current presentation/needs. You may delete information that has pre-populated for the purpose of greater accuracy in documentation of client’s current level of functioning and need. (Please note, this information will always exist in the final approved version of the Assessments previously conducted and documented in CCBH).

Standards for Specific Fields in the BHA and/or Psychiatric Assessment

- A. Presenting Problem: Information that pre-populates the Presenting Problem section should be reviewed and summarized, as appropriate, as your first entry in the Past Psychiatric History section. Once summarized, the Presenting Problem information that has prepopulated should be deleted so



- that the Presenting Problem information documented by you is specific to why the client is seeking services from your program at the time of the assessment.
- B. Clinical Formulation: The Clinical Formulation section should be reviewed and summarized with information added to the Past Psychiatric History section, as needed. Then any prepopulated information in this section should be deleted so that the documentation in that section can refer specifically to your program, documenting clearly your assessment of medical necessity and the client's need for services at your program.
- C. The following additional fields have been identified as areas in which historical information should be evaluated for inclusion, revision or deletion (when it makes clinical sense to do so):
- a. Past Psychiatric History
 - b. Family History
 - c. Educational/Employment History
 - d. Cultural Information
 - e. Social History
 - f. History of Violence
 - g. Trauma questions
 - h. Substance Use Information
 - i. Military History

Documentation Standards to Indicate Information in a Section of the BHA/Psychiatric Assessment is Being Retained or Edited

When adding to a text field, start your documentation at the beginning of the text window. Label the field with the unit/subunit number of your program to indicate which program is providing information. Additionally, add the date of your documentation. If the information that prepopulated is still current and well documented, and you are accepting the information without changes, type the heading "REVIEWED WITH NO CHANGES" at the top of the previous text. If you want to add to or edit the existing information, type the heading "REVIEWED WITH EDITS" on top of the previous text and then proceed with adding your new information. Please note: your signature on an assessment for a client that is new to your program indicates that you have reviewed all information, made the appropriate clinical revisions, additions and/or deletions, and are in agreement with the assessment.



When Adding Information to an Assessment for a Current Client:

Assessments are meant to be “living documents” in that new information may be added over the course of services as new information or clinical formulations become available. If you have conducted the most recent assessment and are familiar with the client, it is not necessary to review each section in the entire Assessment. Rather, you may update just the sections for which you have knowledge of new information. Follow the documentation standards for labeling/dating the field you are changing as described in the paragraph above.

Concurrent Programs

There are times when a client is open to two programs at the same time. In this instance, it may be appropriate to leave relevant information from the other program in the Clinical Formulation section. If a provider decides to do this (and their BHA is completed subsequent to the other program) their portion of the Clinical Formulation should be documented at the top of the text box and begun by listing their unit/subunit. To delineate the concurrent program’s Clinical Formulation information, their section should end with the following statement: “Information below is retained as the client is concurrently receiving services from another program.”

Similarly, when adding information for a current client who is being seen in another program concurrently, a program may wish to retain information throughout the BHA without making changes to it. When this is the case, the program should delineate the other program’s information by documenting “Concurrent program information reviewed with no edits.”

Procedure: Documentation in Discharge Summaries

Documentation in Discharge Summaries should always be specific to your program and the services your program provided to the client. It is not necessary to retain any information in the narrative text fields of the Discharge Summary that have prepopulated. Delete information that has prepopulated and write only information specific to your program in each narrative section.

For questions about these documentation standards or the procedures outlined above, please email the QI Unit at QIMatters.hhsa@sdcountry.ca.gov



DIAGNOSIS PRACTICE GUIDELINES **FOR THE ELECTRONIC HEALTH RECORD (EHR)**

PURPOSE:

As part of the Cerner Community Behavioral Health CCBH electronic health record, each client has a single diagnostic profile that is utilized across the System of Care (SOC). With the implementation of ICD-10, the diagnostic profile contains relevant clinical information recorded in a non-axial format. This practice guideline establishes procedures for using the diagnostic profile in the EHR.

PRACTICE GUIDELINES:

Each program is responsible for ensuring that the client they are treating has the correct diagnosis included in the client's diagnostic profile (Diagnosis Form). All programs shall verify that the active diagnoses are in the EHR as per the following guidelines.

When multiple outpatient programs are concurrently serving a client, they shall coordinate care around diagnoses. A Single Accountable Individual (SAI) is automatically assigned for each client in CCBH based on the priority level of the program. The SAI shall communicate with concurrent providers, and will facilitate updating the EHR.

I. EXTERNAL PROVIDER:

An External Provider is a licensed health care provider who has completed an assessment of the client within the past 12-months and who is outside the mental health Organizational Provider Network. Examples include a Fee-For-Service (FFS) providers or a provider outside of San Diego County.

- A. When it is not within a clinician's, or programs' scope of practice to enter a diagnosis, the clinician may use a diagnosis from an "External Provider". The begin date of a diagnosis from an external provider shall be the date of the assessment or referral. A diagnosis from an External Provider is only used when there is no other active diagnosis form in the client's EHR.
- B. The clinician shall complete the "External Provider" fields. The clinician shall enter the diagnostic information provided by the External Provider, the General Medical Conditions Summary Code, the diagnoses listed in order of priority, and the Trauma question.
- C. When the Administrative Services Organization (ASO) authorizes services for a FFS provider and there is no active Diagnosis Form in the client's EHR, the ASO shall complete the External Provider fields. ICD-10 code R69 ("Illness unspecified") may be used until a specific diagnosis is received from the FFS



provider. The ASO shall also complete the General Medical Condition Summary, and answer the Trauma Question.

II. ENTERING THE DIAGNOSIS:

When it is within their scope of practice, the clinician shall complete the Diagnosis Form. When it is not within a clinician's scope of practice to diagnose, a diagnosis may be used from an "External Provider".

- A. When an existing Diagnosis Form does not include the diagnoses for which a client is being treated at the program, that program shall add each diagnosis to the EHR with the date that the diagnosis was made.
- B. When there is no existing Diagnosis Form, the Diagnosis Form must be completed with a mental health diagnosis that has a begin date on or before the first date of service.
- C. There must be an included Title 9 diagnosis listed as Priority 1 in order to claim for services.
- D. Diagnoses may not be ended unless all programs concurrently serving the client agree. Multiple programs serving a client must coordinate with each other regarding diagnoses.
- E. ICD-10 code R69 ("Illness unspecified") may be entered for only the first 30 day assessment period. After 30 days, the clinician shall end the "Illness unspecified" diagnosis when the included diagnosis is entered.
- F. On the Diagnosis Form, the diagnosing clinician shall assign a priority to each diagnosis. When a diagnosis is being added to an existing form, it will be given the next priority (based on Begin Date). A diagnosis with a higher priority number does **not** indicate that the diagnosis is more clinically relevant than one with a lower priority number. The client treatment is not affected by the priority number given to a diagnosis. Please note, a substance use diagnosis cannot be priority one.

III. DIAGNOSIS BEGIN AND END DATES:

A. Changing a Begin Date

Staff may change the begin date of a diagnosis to an earlier date to cover services provided at the program. Never change a begin date to a later date.

B. Ending a Diagnosis

- a. If the client has only one open assignment (only open to one program)
Staff may end a diagnosis if the client is no longer being treated for that



diagnosis. The end date must be on or after the last date of service for that diagnosis.

- b. If the client has multiple open assignments (open to multiple programs)
Staff may end a diagnosis if the client is no longer being treated for that diagnosis at the program **and** all programs concurrently serving the client have been contacted **and** all agree to end the diagnosis. The end date must be on or after the last date of service for that diagnosis. Please note: never delete a diagnosis, only end if appropriate.

C. Managing Diagnoses

It is important to note that processes differ when a client is receiving services from more than one provider and by level of care (emergency services vs. outpatient). Remember that the client's record is now a single record across all providers involved in the care of that individual.

IV. PRIORITIES FOR DIAGNOSES:

An included Title 9 mental health diagnosis must be listed as Priority 1. The priority number in CCBH does not impact client treatment but does apply to claiming functions. When a diagnosis is added to an existing form, it is automatically given the next available priority number unless staff designate otherwise.

A. Outpatient Providers

- a. When the EHR does not list the client's treatment diagnosis
The outpatient provider shall add the treatment diagnosis and make it priority 1.
- b. When the EHR does list the client's treatment diagnosis
If the treatment diagnosis is listed, no action is required.

B. Emergency Psychiatric Unit (EPU) and Emergency Screening Unit (ESU)

- a. When the EHR does not include the client's treatment diagnosis
The EPU or ESU shall add the treatment diagnosis and make it Priority 1.
 - i. When the client leaves the EPU or ESU, the program shall end date the diagnosis that was added for that client. This will automatically return the existing diagnoses to their original priority.
- b. When the EHR does list the client's treatment diagnosis as Priority 1
If the treatment diagnosis is listed as Priority 1, no action is required.
- c. When the EHR does not list the existing client's treatment diagnosis as Priority 1
The EPU or ESU shall change the client's treatment diagnosis to Priority 1.
 - i. When the client leaves the EPU or ESU, no action is required.



V. DIAGNOSIS CLEANUP:

Programs are responsible for ensuring accuracy of diagnoses. Programs may “clean up” diagnoses that are no longer active.

- A.** If client is **not** concurrently open to other programs, it is recommended to end the diagnosis that is no longer the focus of treatment. **DO NOT DELETE THE DIAGNOSIS; ONLY END THEM.** Use the final date of services with your program as the end date.
- B.** If the client is concurrently open to other programs, collaboration between programs **must** occur before ending any diagnosis. It is not acceptable to end any diagnosis without coordination of care if there is more than one program providing services at the same time.

VI. SUSPENSE ITEMS A & B:

- A.** An active diagnosis must be in place in order to claim for service. The date of diagnosis must cover all dates of service.
- B.** The diagnosis listed as Priority 1 must be an included Title 9 diagnosis. A Priority 1 diagnosis may never be a substance use diagnosis.
- C.** If there is an existing diagnosis listed that is the focus of treatment for the program, no action is required. Do not modify the existing begin date.

VII. GENERAL MEDICAL CONDITION:

The “General Medical Condition Summary Code” (GMC) field is a required field on the Diagnosis form. The GMC field is part of the CSI data that is reported to the State of California. The GMC field shall reflect any general medical condition which is impacting the client’s mental health. The clinician shall complete the GMC field with any medical condition as reported by the client or obtained from another source (other medical record or report) and identify in the diagnosis “Comments” box the source of the medical condition.

If the client’s general medical condition is not listed in the GMC table, then “Other” shall be selected and the general medical condition shall be recorded in the diagnosis “Comments” box.

NOTE: When a physical health diagnosis is given, it must also match the GMC.



CCBH SOFTWARE BASICS

- CCBH IS ACCESSED THROUGH CITRIX (Cerner):
Go to <https://cosdca.cernerworks.com>
(Save this to your favorites or create a shortcut for your desktop)
- “TAB TO TRAVEL”: Get in the habit of using your “Tab” key. Using the “Tab” assures that you are directed to all required fields and that the information you input is actually captured by the system.
- RIGHT CLICK: When there is no obvious way to add information into a field, right click in the space to view your options.
- FILTERS/RADIO BUTTONS: Check these first and make sure they are on “all” when searching the database.
- MAGNIFYING GLASS/ELLIPSES “BUTTONS”: When you see these at the end of a field, it means there is a “Search Screen” that you can pull up to find information for that field. You do not have to use them, but they are there if you need them.
- REQUIRED FIELDS are in red or blue: They must be filled-in to save and final approve information.
- OPTIONAL FIELDS are in white: Information may be added, but is not required to final approve the Assessment. **Keep in mind – just because you have completed all the fields required to final approve the form, does not mean you have completed a thorough clinical assessment.** Documentation standards have not changed.
- CLOSED FIELDS are in gray: Nothing can be added in these fields.
- CASE SENSITIVE:
 - Passwords – if you receive an error message for “Invalid Password”, check to make sure you are using the appropriate upper and lower case letters when typing. After a third attempt with an invalid password, the system will lock your session and will require contacting the Optum Support Desk (1-800-834-3792) to unlock it.
 - Table Searches – when searching within a table, be aware that descriptions or IDs are case sensitive. If you do not use the correct upper or upper and lower case entry, the search will not take you to the desired table value.
- MULTIPLE WAYS TO ACCESS INFORMATION: In CCBH, it is easy to access the same information in multiple ways. We have included screenshots and directions in this document to guide you through the system.



- **LOCKING YOUR SESSION:** For security purposes, you must lock your session any time you step away from your computer. This packet explains the various ways to lock your session.



Note: Locking your session is best used for short times away from your computer. CCBH will log you out after 60 minutes. There is a chance of losing work that has not been final approved or saved if CCBH logs you off.

- **WHEN YOU GO BACK TO YOUR PROGRAM:** You are learning how to enter assessments in the “**SDC Train CCBH**” environment during this training, which is for **practice purposes only**. It is important to enter all of your assessment information in the “**SDC Live CCBH**” environment when you return to your program.
- For password resets/menu issues: Call the Optum Support Desk. You may also call if you need your “SDC Live CCBH” environment password or menu set up. Their contact information is:

Optum Support Desk
1-800-834-3792

Reminder:

Menu access is set according to job title/functions. The menus you have at your program may look different than menus shown in the screen shots in this packet.



CCBH SPEAK

Assessment	In CCBH, anything that is not a Client Plan or a Progress Note is considered an “Assessment.” So, in CCBH Speak, forms such as the Discharge Summary, Outcome Forms, and Demographic Form are considered “Assessments” as well as the actual clinical assessment forms.
Assignment	Opening/Closing a client to a specific program (Unit/SubUnit/s) and to a specific server.
Clinician’s Homepage	A “page” that provides the Clinical servers at each open assignment to view client/s and client information for the identified caseload in one screen. This includes client look up, caseload listing, appointments, task/s to do, notifications, and other client information present in the EHR.
Collateral Server	Co-Staff providing a service (i.e. co-facilitator). Used when more than one staff is providing a service to the same client, on the same date and at the same time as server.
Demographic	A client is entered into the EHR by the completion and final approval of the demographic form. A client may not be opened to assignment/program unless the demographic form is entered, completed, and final approved.
Final Approve	Locks the completed assessment. Prevents editing/deletion of assessments.
SAI – Single Accountable Individual	Primary server identified based on primary unit program set up. This staff will be listed as the primary contact for the client in the system of care for purposes of coordination of care.
Scheduler	A program within the EHR that allows for scheduling of client service events and ongoing appointment/s. This information will populate to the Clinician’s Homepage once entered into the EHR through the Scheduler menu.
Service Code	Procedure Code. The code data entered into the EHR for the purpose of claiming a service activity.
Server	Staff providing a service activity.
Unit	The Physical Location of a program, or legal entity.
Sub-Unit	The specialized set of services offered within a Unit (i.e. population, funding sources, etc.).



PASSWORD CHANGES

Citrix (Cerner) Password

The first Citrix (Cerner) password you ever receive is considered a temporary password. For security reasons, you will be prompted to change your password on your first log in. To do so after the initial login, click “Change Password” when first logging in to Citrix (Cerner).

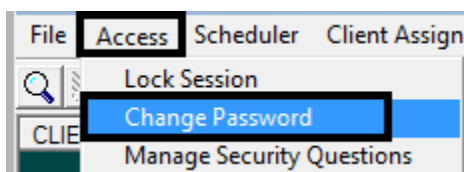


Next, follow the prompts to change your password.

CCBH Password

You are prompted by the system to change your CCBH password every 90 days. However, if you feel that someone has learned your password, for security reasons you should change it immediately. There are two ways to do this:

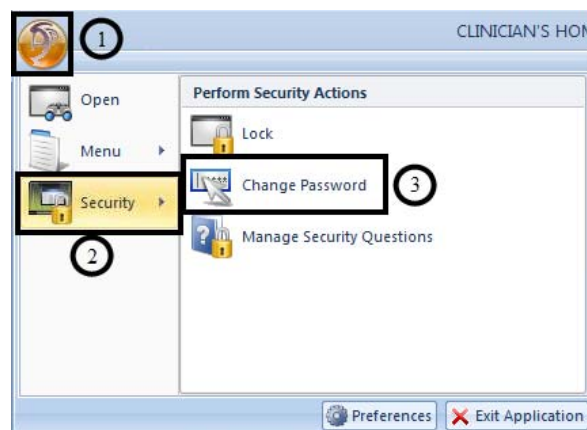
External View



From the External View, go to the “Access” tab and select the “Change Password” option. Follow the prompts to change your password.

Clinician’s Homepage

From the Clinician’s Homepage, go to the System Button. Select the “Security” menu, and then select the “Change Password” option. Follow the prompts to change your password.



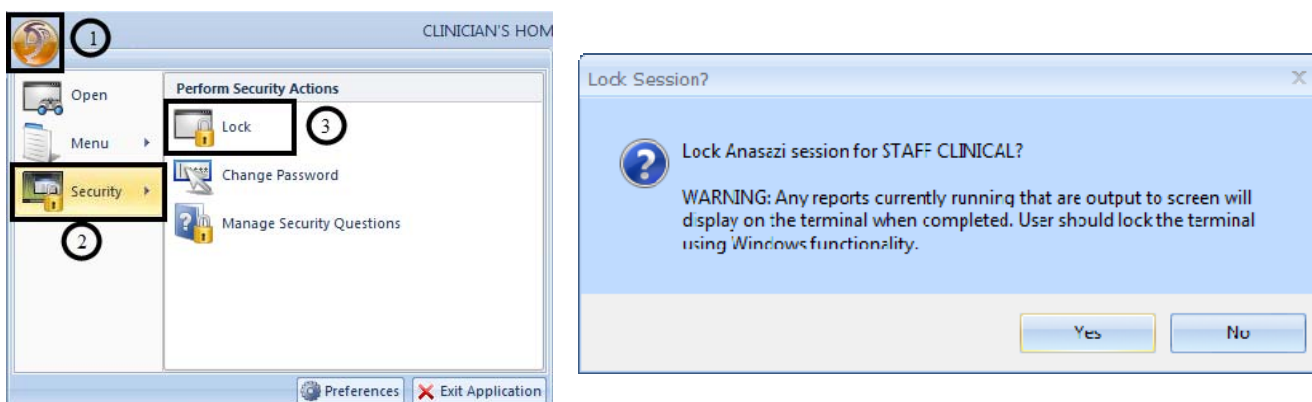


LOCK CCBH SESSION

For security reasons, the expectation is that you will lock your CCBH session any time you step away from your computer. There are two ways to do this.

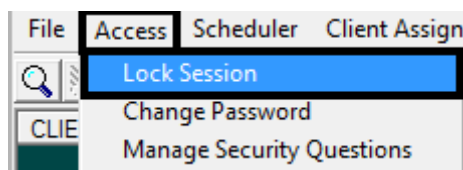
Clinician's Homepage

From the Clinician's Homepage, go to the "Systems Button" and select the "Security" drop down menu, then select "Lock Session" button.

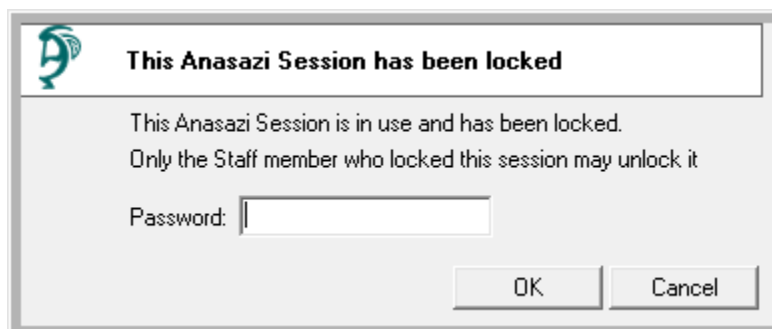


External View

From the External View, go to the "Access" tab and select the "Lock Session" option.



You will be prompted to enter your password to unlock the session.





EXITING THE APPLICATION

EXITING CCBH: To make sure you do not accidentally create a “ghost session” and lock yourself out of accessing CCBH, you must exit in the following manner:

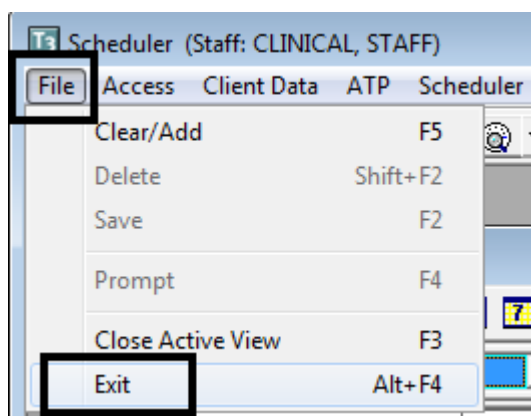
Clinician’s Homepage

- o Go to the “Systems Button” menu in the top left-hand corner of your screen.
- o Select the “Exit Application” option.



External View

- o Go to the “File” menu in the top left-hand corner of your screen.
- o Select the “Exit” option.
- o Repeat this step for any open external view window.



You risk being locked out of CCBH if you do not exit in the manner described above!



CLINICIAN'S HOMEPAGE PREFERENCES

How to setup and save preferences

Accessing Preferences:

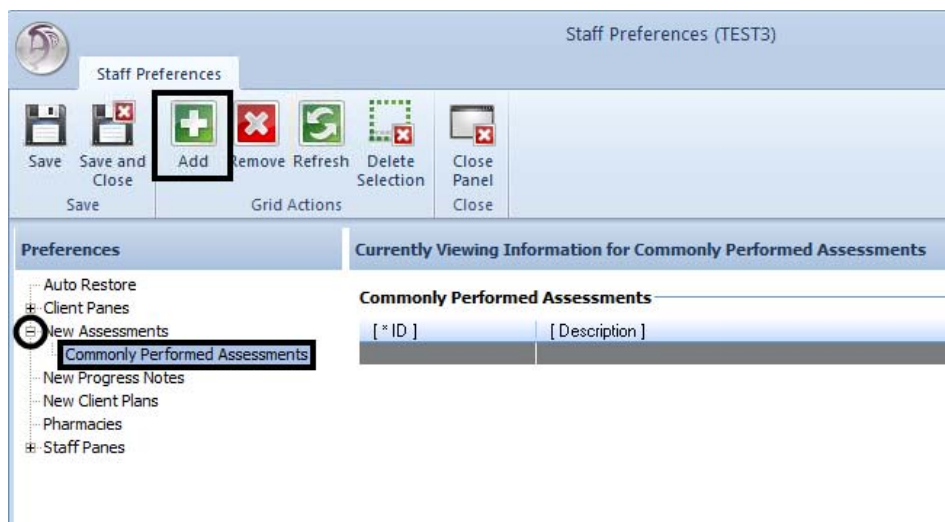


- A- From the “Systems Button”
- B- Select the “Preferences” icon

This feature allows you to set the Assessments that you use most frequently as preferences for easy access.

Preferences for New Assessments:

- o Select the plus sign next to “New Assessments.”
- o Click “Commonly Performed Assessments”
- o Click “Add”





Assessments

- 1) Select the assessment(s) *you* commonly perform. To select multiple assessments, hold down the “control” key as you click with the mouse.
- 2) Once you have selected your preferred assessments, click the “Select” button.

Add Multiple Assessments as Commonly Performed Assessments (TEST3)

Multiple Selections

Refresh All Invert Search **Select** Close Panel Close

Actions

Select each Assessment to be added to the list of Commonly Performed Assessments.

Available Assessments (Filters Applied)

ID	Type	Active
AB109DISCH	AB109 Discharge	<input checked="" type="checkbox"/>
AB109LOC	AB109 Level of Care	<input checked="" type="checkbox"/>
AB109SCRN	AB109 Screening	<input checked="" type="checkbox"/>
AIMS	AIMS	<input checked="" type="checkbox"/>
ASOCA	ASO Clinical Addendum	<input checked="" type="checkbox"/>
BHAA	BHA Adult	<input checked="" type="checkbox"/>
BHACJFS	BHA Child JFS STAT	<input checked="" type="checkbox"/>
BHAC	BHA Children	<input checked="" type="checkbox"/>
BHAESU	BHA ESU	<input checked="" type="checkbox"/>
BHAST	BHA START	<input checked="" type="checkbox"/>
BHATBS	BHA TBS	<input checked="" type="checkbox"/>
CFARS	CFARS	<input checked="" type="checkbox"/>
DEM	Demographics Form	<input checked="" type="checkbox"/>
DIAG	Diagnosis Form	<input checked="" type="checkbox"/>
\$DIAGREC	Diagnostic Reconciliation	<input checked="" type="checkbox"/>
DCSUM	Discharge Summary	<input checked="" type="checkbox"/>
DCCAPS	Discharge Summary CAPS	<input checked="" type="checkbox"/>
DCSDCPH	Discharge Summary SDCPH	<input checked="" type="checkbox"/>
DCSHERF	Discharge Summary Sheriff	<input checked="" type="checkbox"/>

Hint: Hold down the control key to select more than one option

Assessment List Filters Available Assessments (Filters Applied)

You will see your selections.

Staff Preferences (TEST3)

Staff Preferences

Save Save and Close Add Remove Refresh Delete Selection Close Panel Close

Save Grid Actions Close

Preferences

- Auto Restore
- Client Panes
- New Assessments
 - Commonly Performed Assessments**
- New Progress Notes
- New Client Plans
- Pharmacies
- Staff Panes

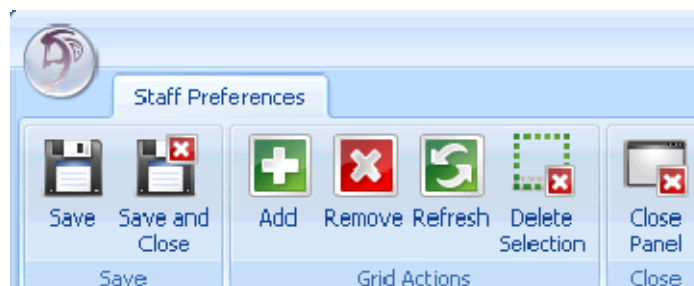
Currently Viewing Information for Commonly Perform

Commonly Performed Assessments

[* ID]	[Description]
BHAA	BHA Adult
DCSUM	Discharge Summary
DEM	Demographics Form
DIAG	Diagnosis Form



Saving Preferences:



You have 3 options:

Save:

- Click the “Save” icon. This will save settings only.

Save and Close:

- Click the “Save and Close” icon. This will save your selections and take you back to the Clinician’s Homepage.

Close Panel:

- **WARNING:** If you click the “Close Panel” icon without saving, all of your preferences will need to be reset.



Note: These preferences will not transfer from your TRAIN account to LIVE. They must be setup in LIVE too.



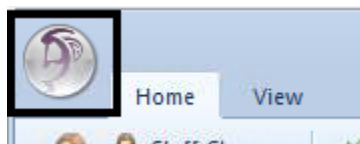
CLINICIAN'S HOMEPAGE TERMINOLOGY Identifying Terms Used on the Clinician's Homepage

Clinician's Homepage:

The Clinician's Homepage is a real-time tool that provides up-to-the-minute client status at a glance.

Systems Button:

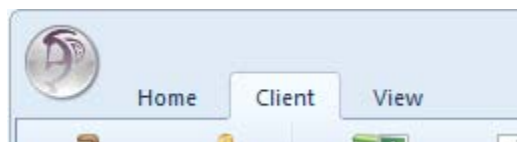
The "Systems Button" acts as the "file" menu. It can be used to exit the application, set preferences, access the external view, or see recently opened views.



Tabs:

The "Tabs" listed below are displayed at the top of the Clinician's Homepage.

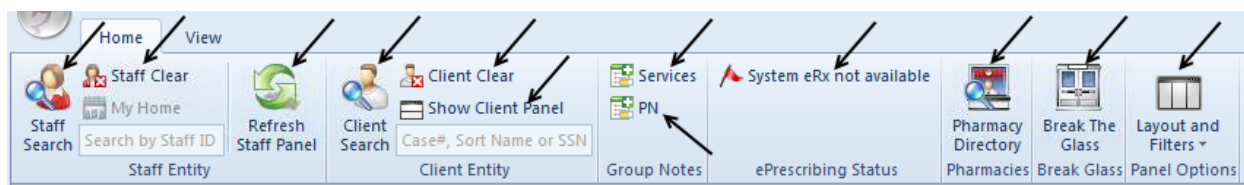
- There are three tabs: "Home", "Client", and "View."



Note: The "Client" tab will only be available if a client has been selected.

Buttons:

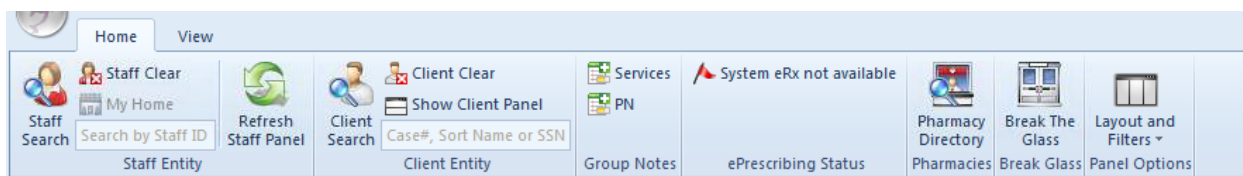
- The "Buttons" are individual selections that can be clicked on to perform various functions.





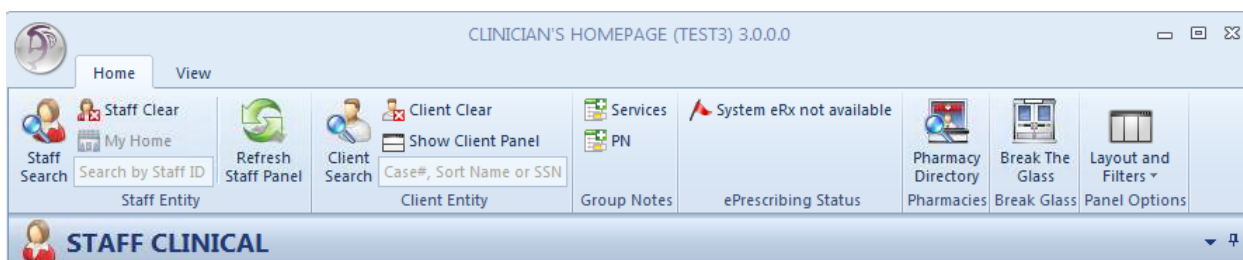
Ribbon:

- The “Ribbon” is an object that is comprised of various buttons.



Staff Panel:

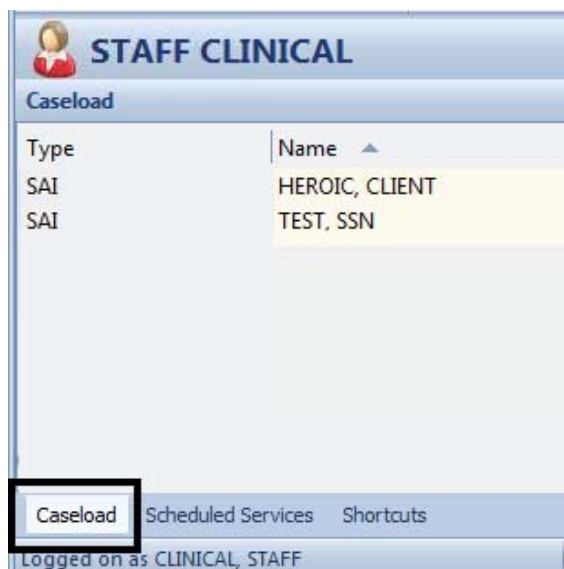
The Staff Panel automatically launches when the Clinician’s Homepage is opened.



You will see your name as well as your job title listed. If you believe that the job title is incorrect, you must complete a new ARF form and submit it to the MH MIS Unit for correction.

Caseload:

The Staff Panel defaults to show your caseload. These are the clients who have been assigned to you. You can always return to your caseload by selecting the Caseload pane at the bottom of the screen:





Identifying Client Type:

You can find the client designation under the “Type” heading on the “Caseload” pane of the staff panel. There are three client types that may appear on your caseload:

Type	Name
SAI	FAKE, TEST
SAI	CLIENT. FAKE
Caseload	DEER. RAIN
SAI	FAN. CEILING

- **SAI:** this signifies that you are the Single Accountable Individual for the client listed.
- **Caseload:** this indicates that, in addition to your program, the client is being seen at another program. You are not the SAI for this client type – the other program staff would be the SAI.
- **Pre-Intake:** this indicates that the client is temporarily on your caseload as a pre-intake client. Pre-intake is intended for the purpose of allowing brief access by a clinician to the Client Chart for the process of screening before the client is assigned to a Unit/SubUnit.



Scheduled Services:

The screenshot displays the 'STAFF CLINICAL' software interface. At the top, there's a header with a user profile icon and the text 'STAFF CLINICAL'. Below this is a 'Scheduled Services' section with a dropdown arrow. The main area features a calendar on the left for January 2017, with the 26th highlighted. The right side shows a grid of services for the week of January 08-14, 2017. The grid is organized by day: Sunday (Jan 08), Monday (Jan 09), Tuesday (Jan 10), Wednesday (Jan 11), Thursday (Jan 12), Friday (Jan 13), and Saturday (Jan 14). Services are listed in rows: '3:00pm PSYCHOTHERAPY - GROUP 31; CENTER STAR ACT...' on Monday and '10:00am 223-225, DHP COLLATERAL 33; CENTER STAR A...' on Tuesday. At the bottom, there's a navigation bar with tabs for 'Caseload', 'Scheduled Services' (which is selected and highlighted with a red box), and 'Shortcuts'. The status bar at the very bottom shows 'Logged on as CLINICAL, STAFF', 'Environment: Test 3', 'CHP20111029 Template Loaded', 'Ready', and 'CAP'.

Any clients displayed in this pane are scheduled for service events that calendar day. You can always return to this pane by selecting the Scheduled Services pane tab at the bottom of the window.

Client Panel:

- The “Client Panel” displays information about the client that you selected. The “Client Panel” consists of “Client Panes”. You may access the information contained in those panes by clicking on each pane.

The screenshot shows the top navigation bar of the software. It contains a series of tabs: 'Face Sheet', 'Assessments', 'Assignments', 'Diagnoses - Ass...', 'Substance Abuse', 'Client Plans', 'Progress Notes', 'Authorizations', 'Insurance Coverages', 'Services', 'Medical Conditions', 'Medications', and 'Client Attachments'. The 'Assessments' tab is currently selected and highlighted.



CLIENT SEARCH

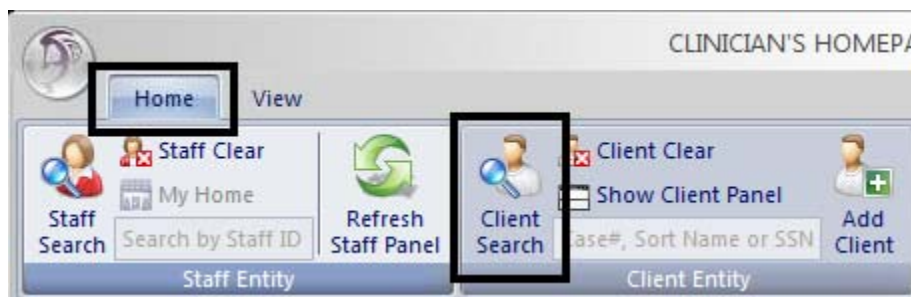
Searching for a Client Who Is In Your Caseload:

- On the Clinician’s Homepage “Home” tab, under “Caseload”, double click on the name of the client.
- This action opens up the “Client Panel” where you can find information about your client.



Searching a Client Who Is Not In Your Caseload:

- Select the “Client Search” button



- The “Client Lookup” window will open

Click on the search button to perform a search for client records based on the criteria in the top section.

Client Search

Client Search Parameters

Case # Sort Name

Last First DOB Thru

Alias Last First Sex SSN

Client Search Results

Name	First	Last	Case#	S...	Eth...	DOB	SSN	Prim Unit ID	Prim Uni...	Prim SubUn...	Prim SubU...	External ...	SAI ID	SAI N...
There are no items to show.														



There are several different ways to search for a client from this window:

- By “Sort Name”: Enter the client’s sort name in the LAST NAME, FIRST NAME format, then select the “Search” button. (The “Sort Name” is the client’s name as formatted when first entered into the CCBH system):

Click on the search button to perform a search for client records based on the criteria in the top section.

Client Search

Client Search Parameters

Case # Sort Name Search

Last First DOB Thru Default

Alias Last First Sex SSN Clear

Client Search Results

Name	First	Last	Case#	S...	Eth...	DOB	SSN	Prim Unit ID	Prim Uni...	Prim SubUn...	Prim SubU...	External ...	SAI ID	SAI N...
There are no items to show.														

- If the Sort Name you’ve entered is in the system, it will be displayed in the “Client Search Results” area, as in this screen shot which exemplifies a search done for fictional client sort name, “PIE, APPLE”:

Click on the search button to perform a search for client records based on the criteria in the top section.

Client Search

Client Search Parameters

Case # Sort Name Search

Last First DOB Thru Default

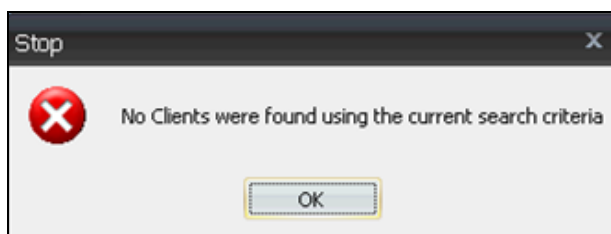
Alias Last First Sex SSN Clear

Client Search Results

Name	First	Last	Case#	S...	Eth...	DOB	SSN	Prim Unit ID	Prim Uni...	Prim SubUn...	Prim SubU...	External ...	SAI ID	SAI N...
PIE, APPLE	APPLE	PIE		F	9		0						0	

Note: Double Clicking on the client's name will launch the Client Panel.

- If the Sort Name you entered is not in the system, you will receive the following stop message:



- This does not mean that the client is not in CCBH. Rather, you may not have entered the sort name exactly as it was formatted when the client’s information was first entered into the CCBH system. For this reason, you should search by other criteria such as:



Note: Before beginning another type of search, select the “Clear” button to reset the search criteria.



- In client search, enter LAST NAME, FIRST NAME, date of birth (check spelling and in ALL CAPS).
 - If client is found with that name, double check SSN.
- Search by SSN.
- Search by Alias.
 - If match found, open the Demographic form on client and double check DOB, address, SSN.
 - Check 3rd Party information to see if client has the same Medi-Cal (BIC, CIN) number.
- If it is unclear which is the first name or the last name, enter the other position of names in Alias – e.g., Bubble Gum entered into CCI as GUM, BUBBLE may be entered into Alias as BUBBLE, GUM.



Note: When searching use all capital letters, these fields are case sensitive.

- You can now search by one or more of the other criteria fields (Last, First, DOB, Alias Last, First, Sex, Case Number). Select the “Search” button.



Note: If you search by data that is common in the system (such as conducting a search only by a common first name) you will receive the following warning screen. This allows you the option to either continue with or cancel the search.



Additional Client Search Feature

- The “Thru” field, in conjunction with the “DOB” field allows you to search for clients within a particular date range. For example, if the DOB is approximately 3/10/1964 and you enter 3/08/1964 in the “DOB” field and 3/12/1964 in the “Thru” field, all clients in the system who have that dates of birth in that date range will be displayed in the “Client Search Results” window.



*Note: If the exact DOB is known ~ enter it in the ‘DOB’ **and** ‘Thru’ fields to find clients born only on that date.*

The screenshot shows a web-based search interface. At the top, a blue banner contains the text: "Click on the search button to perform a search for client records based on the criteria in the top section." Below this is a section titled "Client Search" with a search icon. Underneath is "Client Search Parameters" with several input fields: "Case #" (with a dropdown arrow), "Sort Name", "Last", "First", "Alias Last", "First", "DOB / /", "Thru / /", "Sex" (with a dropdown arrow), and "SSN -.-". There are three buttons: "Search", "Default", and "Clear". A black rectangular box highlights the "DOB / /" and "Thru / /" fields.

NOTES



RESTORE SYSTEM DEFAULTS

If the layout becomes distorted, or the panes have *disappeared*, select “Restore Panel Layout” (under the Layout and Filters button on the Home tab). This will restore the layout to what it was when you first logged in.



Select “Restore Panel Filters” (under the Layout and Filters button on the Home tab) to bring all the Filters back to their default settings, if desired.




NOTES



CLIENT FACE SHEET

The Client Face Sheet will allow users to view any entered information from the client's most recent final approved Safety Alert, Demographic Form, and Diagnosis Form. The Client Face Sheet displays the Primary Unit, SubUnit and SAI for the client. If the client information has not been entered on one of these forms, the corresponding information fields on the Face Sheet will be blank.

- After accessing a client, the Client Face Sheet can be viewed by clicking the “Face Sheet” pane in the client panel.



- The Client's Face Sheet cannot be edited from this view. To print click on the drop down arrow  at the top right, and click “Print Face Sheet”.

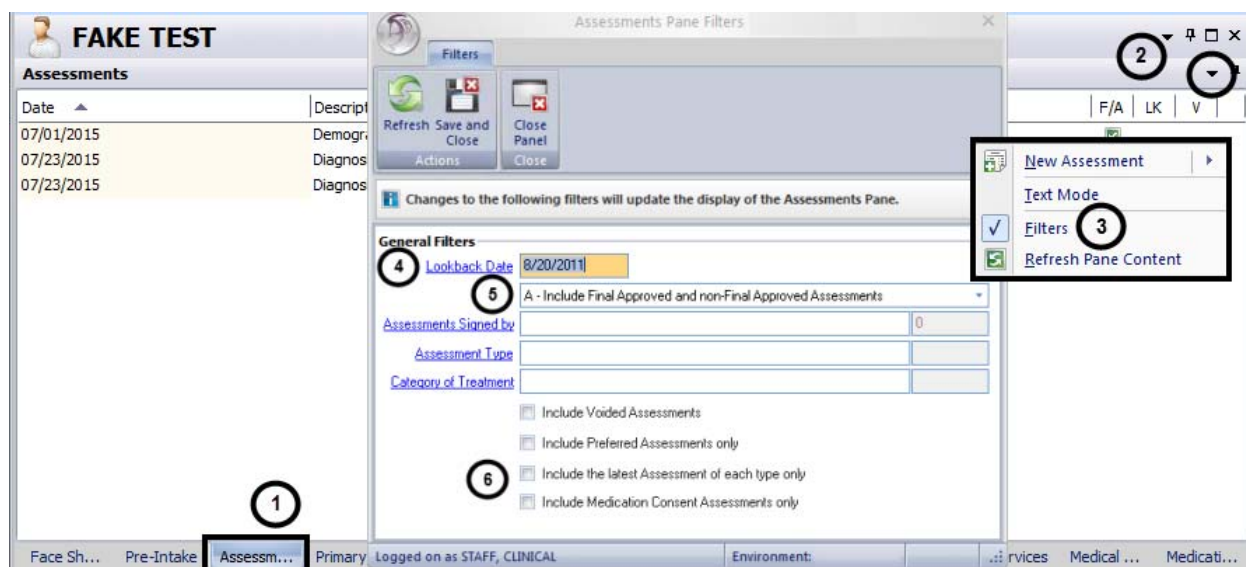


FILTER SETTINGS

Modifying filter settings to display historical assessments

Each user may personalize the way filters display information in his or her Clinician's Homepage. Any time you do not see the desired information, the first step is to check the filters to assure the correct parameters are selected for your search.

1. On the "Client Panel", click on the "Assessments" pane. The "Assessments" pane will open an expanded window.
2. Click the drop down arrow  on the "Assessments" bar that displays on the right.
3. A new window will display. Click on the check mark  or on the word "Filters".
4. The "Filters" window will display. There are three areas where you can make changes: Lookback Date: This date pre-populates back 48 months from the date you open the filter. If a desired assessment is before the date listed, and is not displaying on the "Assessments" tab; you can adjust the date manually.
5. From the drop down menu, you may choose A: "Include Final Approved and non-Final Approved Assessments", F: "Include Final Approved Assessments only" or N-"Include non-Final Approved Assessments only".
6. You may also place a checkmark by the "Include the latest Assessment of each type only" choice given.





Filters in Clinician's Homepage:



Note: Filters will vary based on which pane is selected on the client panel.

Several panes located within the Client Panel contain "Filters". Below are some examples:

Assignments Pane Filters: *updates the Assignments Pane to display Opened and Closed Assignments.*

Assignments Pane Filters

Filters

Refresh Save and Close Close Panel
Actions Close

Changes to the following filters will update the display of the Assignments Pane.

General Filters

A - Include Open and Closed Assignments
A - Include Open and Closed Assignments
C - Include Closed Assignments Only
D - Include Open Assignments Only

This filter does not apply when the Assignments Pane is collapsed

Services Pane Filter(s): updates the display of the Services Pane. The date field filters for services on or after the date entered. Check boxes further filter that data, for particular service types or services by specified staff, for example.

Service Pane Filters

Filters

Refresh Save and Close Close Panel
Actions Close

Changes to the following filters will update the display of the Services Pane.

Service Filters

Lookback Date 6/2/2013

Include Crisis Services, Cancellations, and No Shows only
 Include Services with the Selected Staff only

Progress Note Filters

A - Include Services with and without Progress Notes
A - Include Services with Final Approved and Pending Progress Notes
A - Include Services with Planned and Unplanned Progress Notes

Client Plan Type



VIEWING CLIENT ASSIGNMENTS Clinician's Homepage

Client "Assignments" refer to where the client has received, or is currently receiving, services. In the "Clinician's Homepage" you can view the Opening/Closing dates when a client was assigned to a specific program (Unit/SubUnit/s) and to a specific server.

- A. In the "Client Panel" click on the "Assignments" pane.
- B. It displays all the assignments attached to the client.

FAKE TEST								
Assignments								
Prm	Opened	Closed	Unit ID	Unit Name	SubUnit ID	SubUnit Name	Primary Serv...	Primary Server Name
<input checked="" type="checkbox"/>	01/01/2015		9900	TRAINING UNIT	9901	TRAINING SUBUNIT	800009	STAFF, CLINICAL
	03/05/2015		1000	FAKE UNIT	1001	FAKE SUBUNIT		STAFF. FAKE

Face Sheet Pre-Intake Assessments **Assignments** Primary Diagnosis - ... Primary Substance Abuse Current Client Plan Progress Notes Authorizations Primary Insurance

NOTES

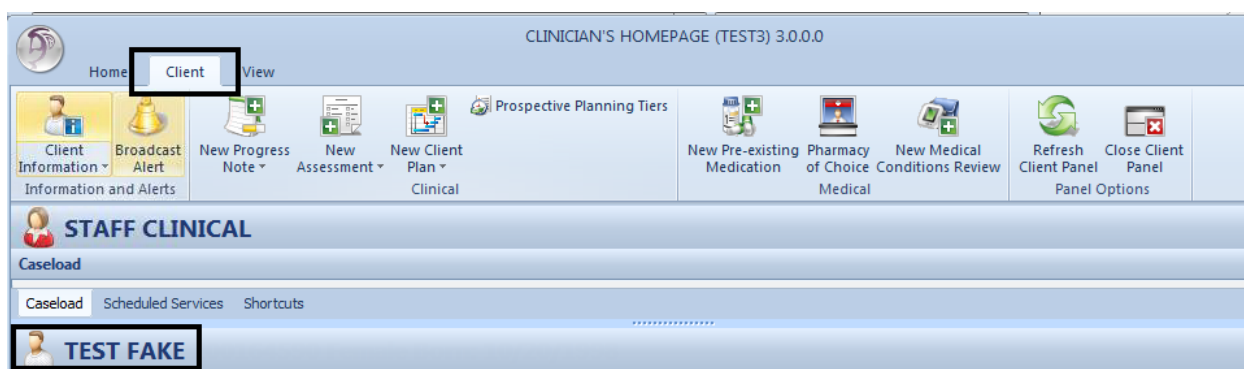


ADDING NEW ASSESSMENTS

- Access the desired client.
- A “Client” tab will open with additional buttons listed within the ribbon.
- The Client Panel will launch on the bottom portion of your screen. The name of the client will display in the client name box.

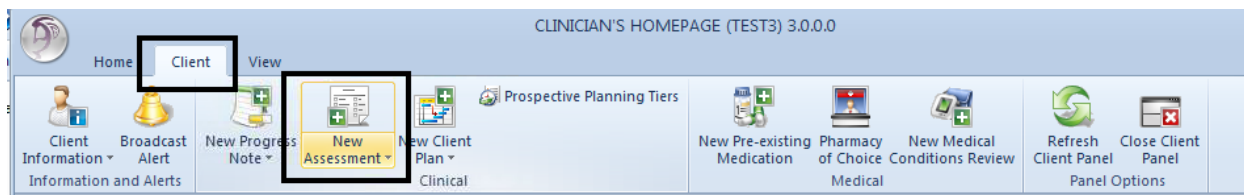


Note: A client name must be displayed in the “Client Panel” to have the “Client” tab accessible.



New Assessment Button:

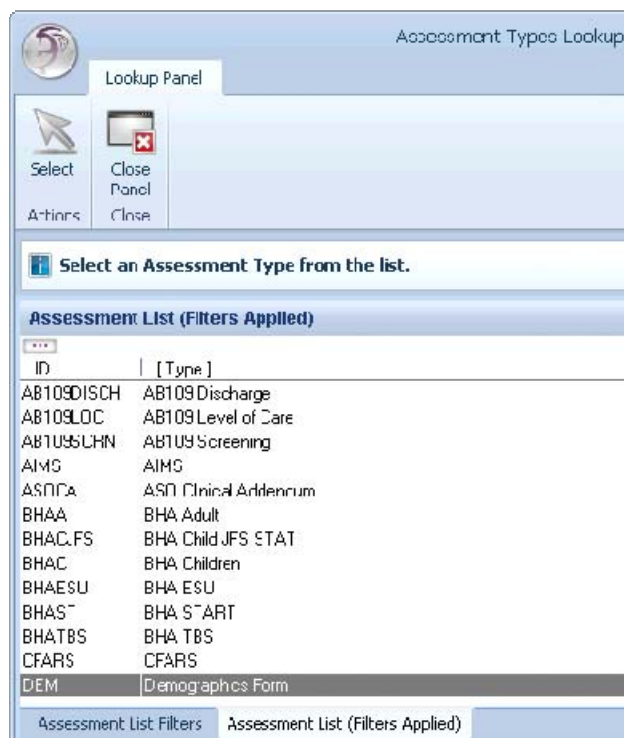
- The New Assessment button will be displayed in the “Client” tab ribbon.



Note: The new assessment button is segmented in two parts. The upper portion of the button is a list of all assessments available for entry. The lower portion consists of assessments that have been established as “New Assessments” in your “Preferences”.

To see a complete list of assessments:

- Click on the top portion of the “New Assessments” button.
- The “New Assessment Lookup” window displays.



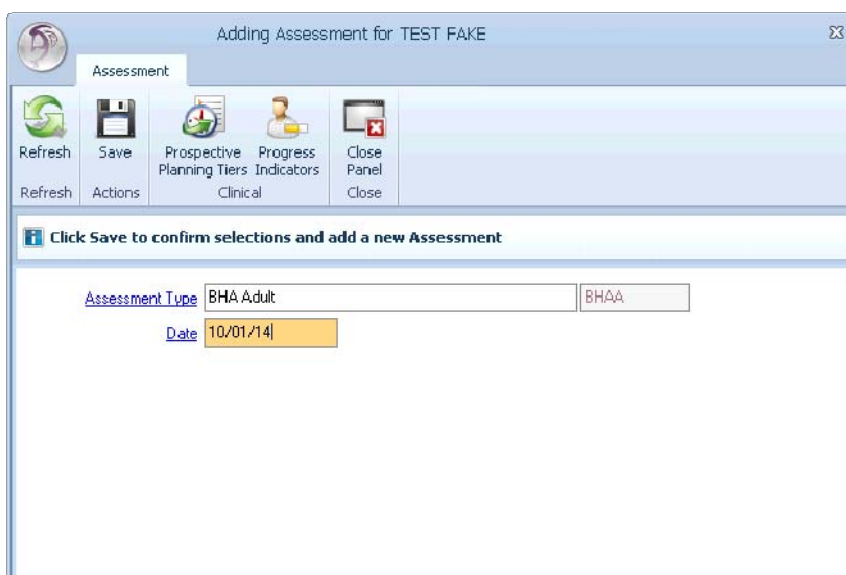
- Search for the desired assessment by using the scroll bar on the right side of the list.
- Highlight the assessment you wish to launch.
- Click “Select”.
- The system will open the external view and the selected assessment to begin data entry.



Note: Double clicking on the assessment will also launch the desired assessment.

Dating the Assessment:

- Place the desired date in the date field.
- Refer to the **“GUIDELINES FOR DATES IN CCBH”**.
- Press the “Save” button. This will launch the assessment for data entry.



Note: Correct entry of the date is essential. Once the date is entered in the above field, it cannot be altered.



GUIDELINES FOR DATES IN CCBH

Assessment Date:

When adding an assessment, the system will require the entry of a date when opening the form for data entry. This is called the assessment date.

Adding Assessment for TEST FAKE

Assessment

Refresh Save Prospective Planning Tiers Progress Indicators Close Panel

Refresh Actions Clinical Close

Click Save to confirm selections and add a new Assessment

Assessment Type BHA Adult BHAA

Date 10/01/14

The assessment date determines the date the assessment is sorted in the look up window. The assessment date must match the service date that is claimed in the system. Progress note documentation will need to support the service claimed. When an assessment service takes more than one session to complete, multiple service dates claimed must be indicated in each progress note for each service date. However, the assessment date entered in the MIS will remain the initial assessment service date.





Signature Date:

Signature dates may be different than the assessment date, which is necessary at times (i.e. when a co-signature is necessary but the staff is out of the office).

Final Approved BHA Adult for: dated 03/15/2015

Assessment

Refresh Validation Actions Void Signatures

Date of Service or effective date. The system will sort the assessments in the lookup by this date.

Date and time of documentation for the staff completing the assessment.

F/A Sig	Entity T...	Signature Line Heading	Name	Date	Time
	Staff	Staff Requiring Co-Signature	TRAINEE CLINICAL	03/30/2016	02:55 PM
	Staff	Staff Comp/Accept Assessment	CREDENTIALLED STAFF	03/30/2016	02:56 PM

County of San Diego Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - ADULT

Date the co-signature was obtained and completion date for the assessment. For reviewers, this is considered the date the assessment is complete.



Note: Co-signatures must be completed within timelines.

Final Approve Date:

The final approval date may be different than the assessment date and/or signature dates. The final approval date is the date that the assessment is considered active and complete. This date will also drive the timelines for documentation reviews.

Name: FAKE, TEST	Case#:	Page: 1 of 3
Type: Demographics Form		Date: 10/01/2014
Printed on 10/17/2014 at 03:23 PM		(Final Approved on 10/17/2014 at 03:22 PM)

COUNTY OF SAN DIEGO MENTAL HEALTH SERVICES DEMOGRAPHIC FORM

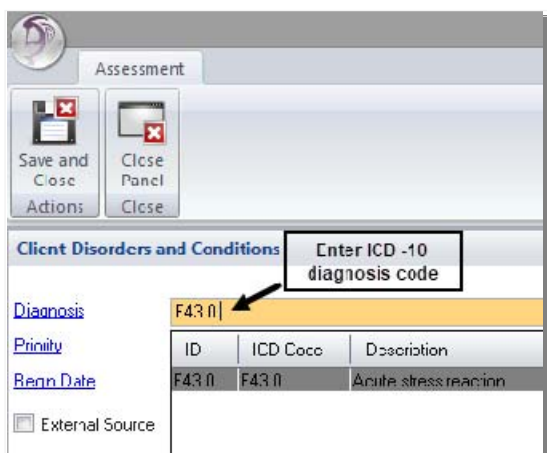
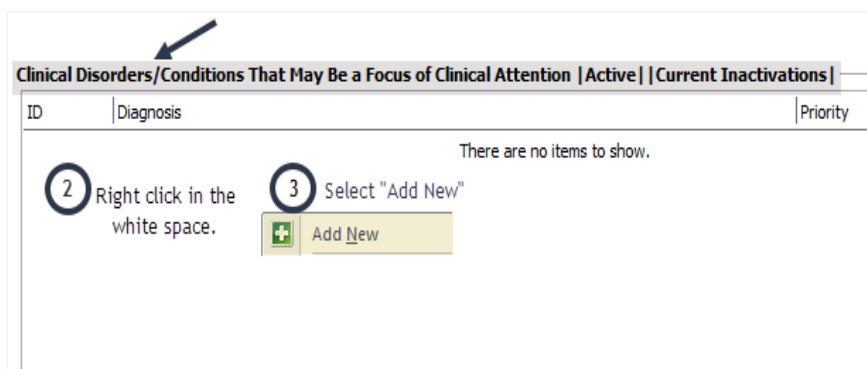
Admission Status Pre-registered Registered Admit

CLIENT IDENTIFYING INFORMATION



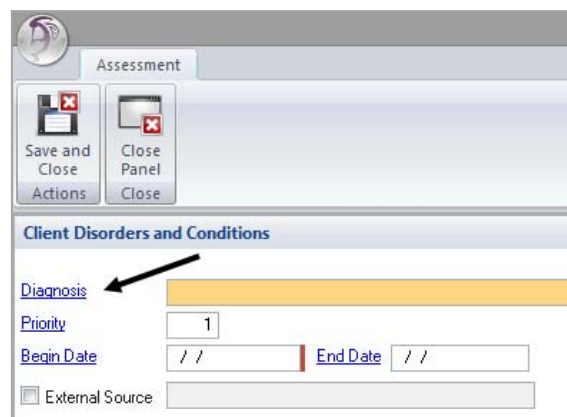
ENTERING A DIAGNOSIS

1. To enter a diagnosis, locate the “Clinical Disorders/Conditions That May be A Focus of Clinical Attention” section on the form.
2. Right click in the white space to see the option “Add New.”
3. Click on “Add New.”



- Enter the ICD-10 diagnosis code, if known.

- If the ICD-10 diagnosis code is not known, click on the “Diagnosis” link and search for the diagnosis by entering a description.





- Fill in the fields you want to address, then click the “Search” button.

Diagnosis Search Parameters

Begins with Includes Description:
 Diagnosis ID: Axis: Version: ICD-9: ICD-10:
 Status: Program: Chapter: Blocks: Max Results:

Diagnosis Search Results (1 Total)

ID	Description	ICD-9 Code	ICD-10 C...	Vers...	Prog...	Act...	Chapter	Block	Axis	Type
F43.0	Acute stress reaction	308.9	F43.0	10	MH	<input checked="" type="checkbox"/>	5	F40-F48	1	ICD

- Your selection will appear in the “Diagnosis” field. Address the following the “Priority, Begin Date, and End Date” fields. When finished, click “Save and Close” button.

Note: Refer to the *Diagnosis Practice Guidelines* section of this manual for important information regarding the “Priority, Begin Date, and End Date” fields.

Client Disorders and Conditions

Diagnosis:
 Priority:
 Begin Date: End Date:
 External Source

- The diagnosis entered will now appear in the “Clinical Disorders/Conditions That May be A Focus of Clinical Attention” section.

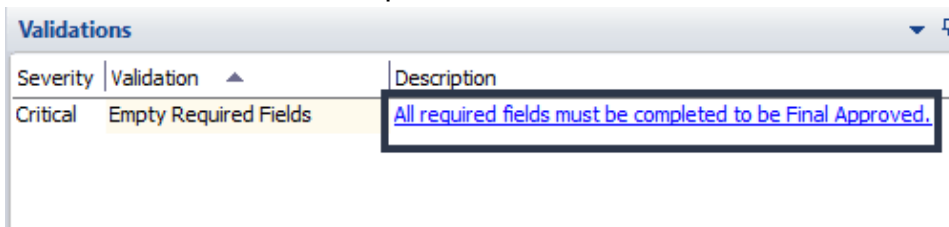
Clinical Disorders/Conditions That May be A Focus of Clinical Attention

ID	Diagnosis
F43.0	Acute stress reaction

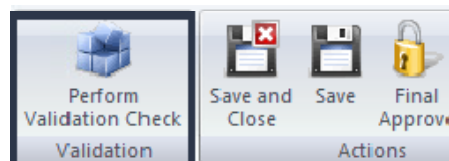


ELECTRONIC SIGNATURE GUIDELINES

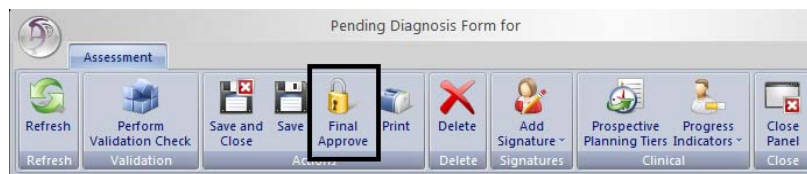
- Certain assessments in CCBH can be final approved by any clinical staff who have required system access, such as the Safety Alert or the Demographic Form. Anyone can complete the assessment and final approve as themselves, without a co-signature.
- To final approve the Safety Alerts and Demographic Form
 - 1) Make sure all software required fields have been addressed.



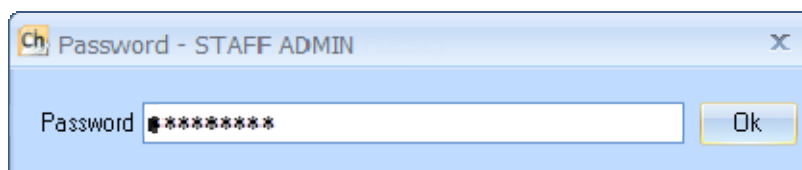
- (a) To check, click the “Perform Validation Check” button at the top of the window. A screen will appear at the center of your screen with a list of fields to be addressed, if any. If all required fields have been addressed, you will not see a screen appear. When ready, proceed with the final approval step for the assessment.



- 2) Click the “Final Approve” button located at the top of the window.

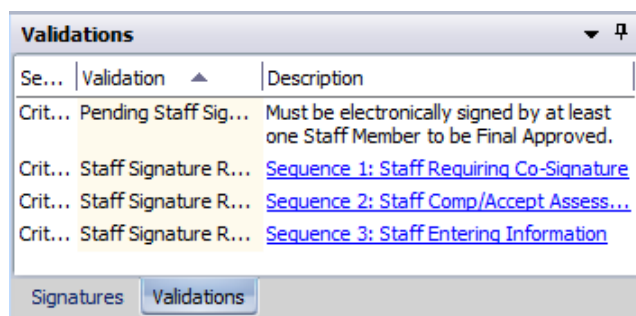


- 3) Enter your CCBH password when prompted.





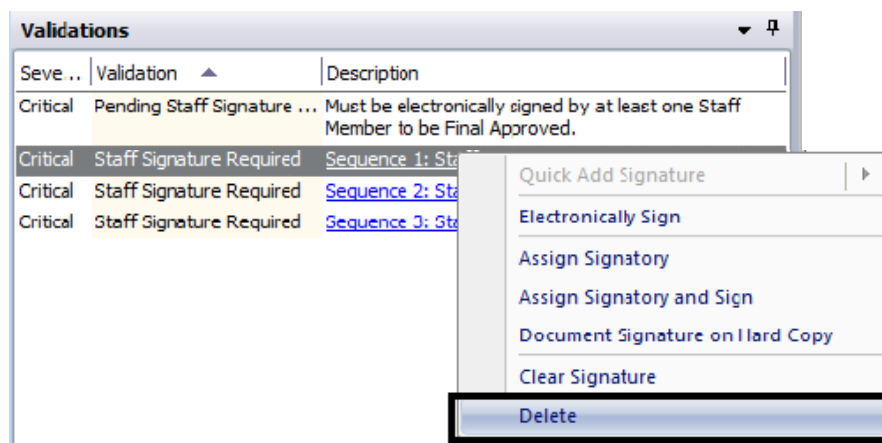
- Some assessments contain credential restricted signatures. For instance, there are three credential restricted signature lines located in the “Validations” pane of the Diagnosis Form, and two signature lines on the BHAs.



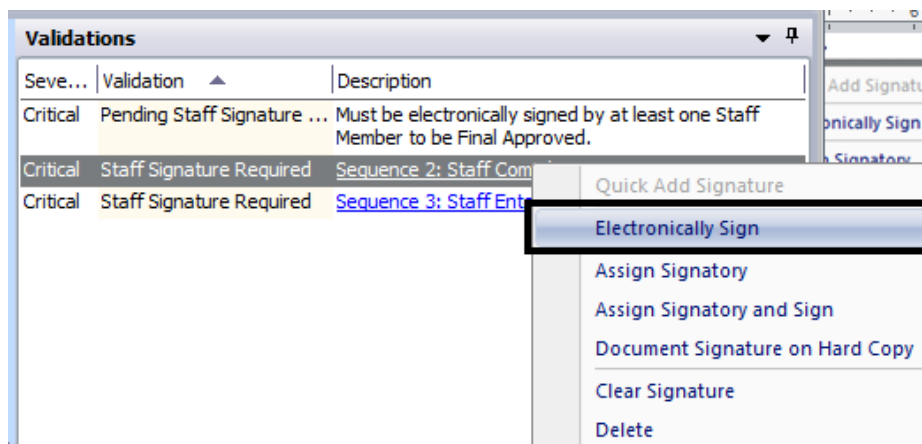
- Your license type or credential will determine how you address each signature line.

Staff Who Do Not Require a Co-Signature:

1. Sequence 1 (Staff Requiring Co-Signature) - Left click and select “Delete.”

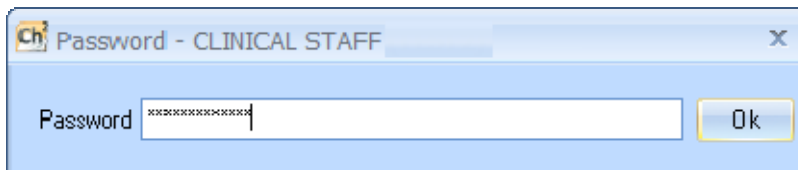


2. Sequence 2 (Staff Comp/Accept Assessment) – Left click and select “Electronically Sign.”

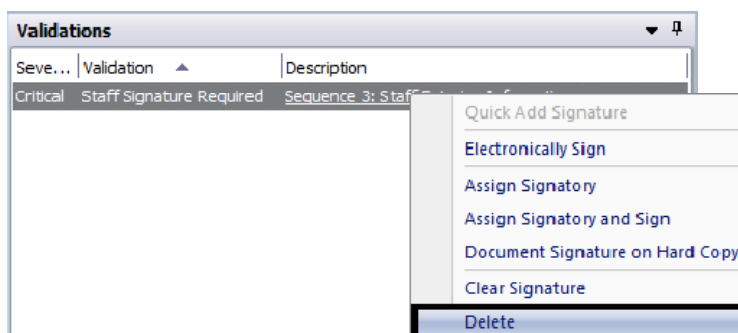




3. Enter your CCBH password when prompted.



4. Sequence 3 (Staff Entering Information) – Left click and select “Delete.”



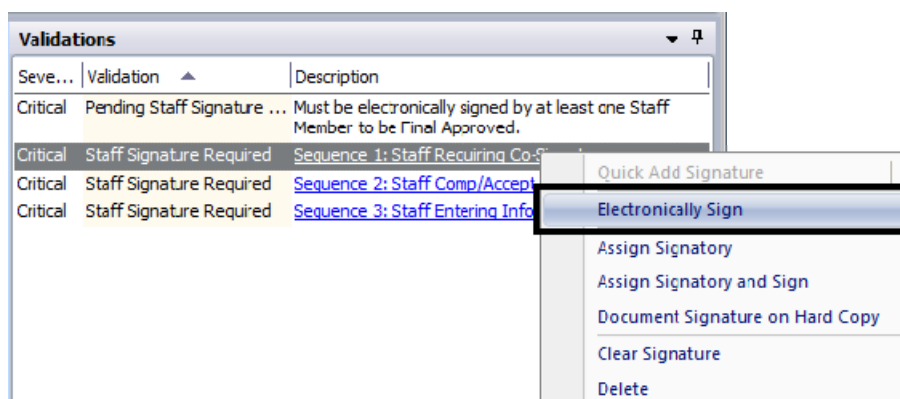
NOTE: Sequence 3 is for administrative staff, entering on your behalf. Most assessments will have only Sequence 1 and Sequence 2. Follow the same procedure as mentioned above.

5. Select “Final Approve,” located at the top of the window.



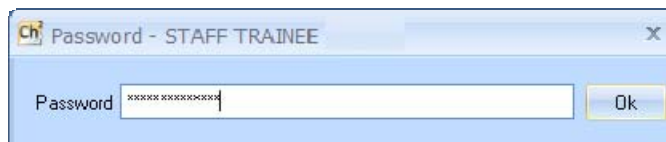
Staff Who Require a Co-Signature:

1. Sequence 1 (Staff Requiring Co-Signature) - Left click and select “Electronically Sign.”

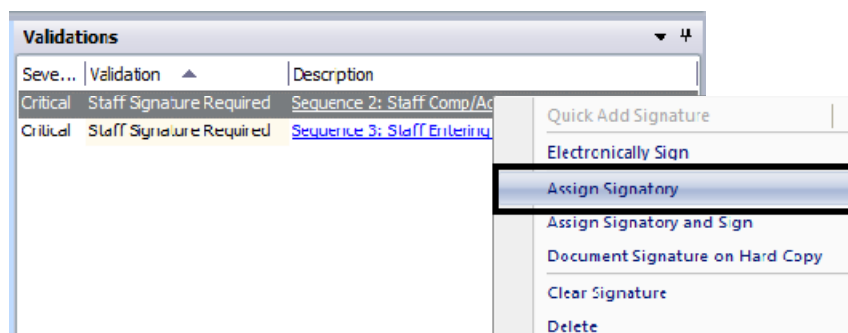




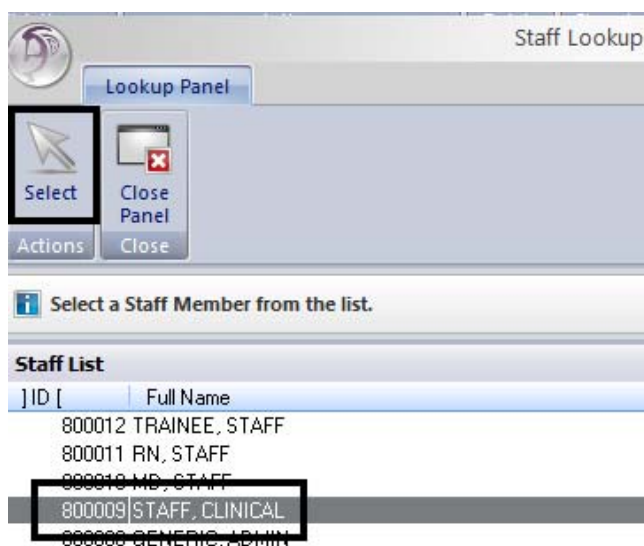
2. Enter your CCBH password when prompted.



3. Sequence 2 (Staff Comp/Accept Assessment) – Left click and select “Assign Signatory.”

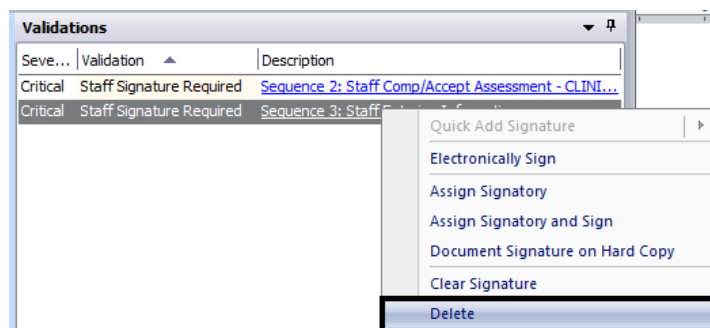


4. Find your supervisor by name or staff ID. Highlight their name and choose “Select” at the top.





5. Sequence 3 (Staff Entering Information) – Left click and select “Delete.”

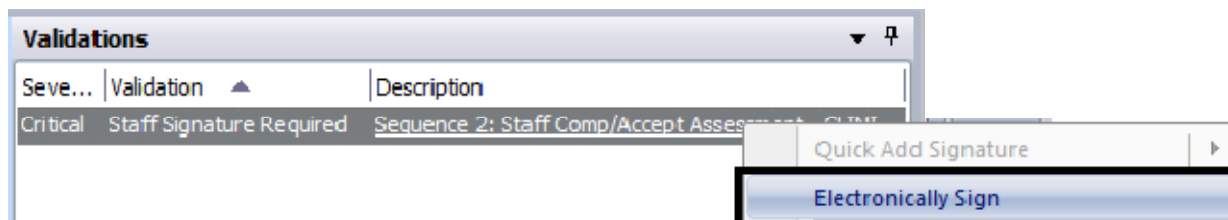


6. Click “Save and Close” located at the top of the window. After you click “Save and Close,” you return to the Clinician’s Homepage. The name of the client will display on the Notifications list on your Clinician’s Homepage and on the Homepage of the approved signer until the assessment is co-signed and final approved.



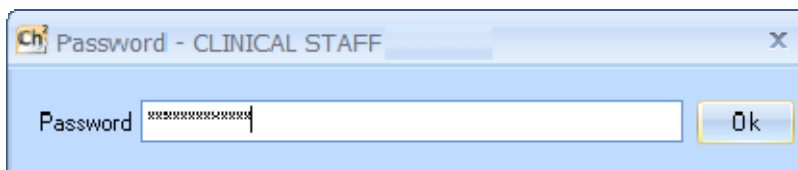
Staff Who Final Approve (or Co-Sign) Assessments For Others:

1. Find the client on your Notifications list on the Clinician’s Homepage.
2. Access the assessment and review. The person for whom you are co-signing should have already completed Sequence 1 signature line and deleted Sequence 3.
3. Sequence 2 (Staff Comp/Accept Assessment) – Left click and select “Electronically Sign.”

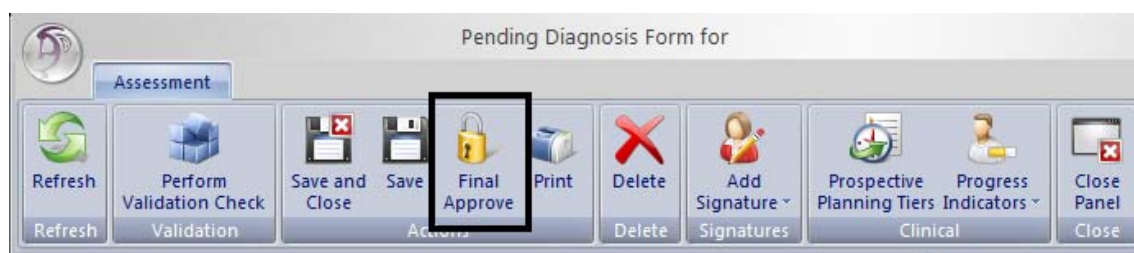




4. Enter your CCBH password when prompted.



5. Click "Final Approve" located at the top of the window.



REMINDER: Co-signatures and final approval of assessments should be done as soon as possible.

PLEASE REMEMBER:



Passwords may NEVER be shared as this constitutes a breach of security and HIPAA violation.

NOTES



VIEWING ASSESSMENTS

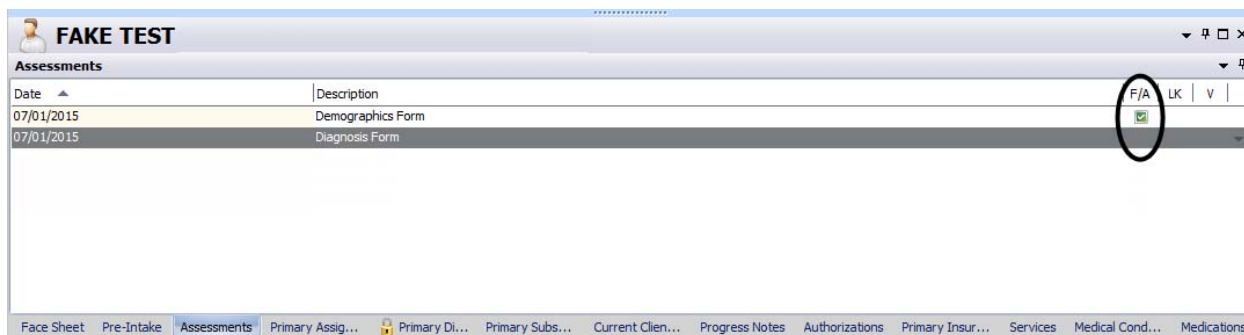
Saved forms:

- Are “saved” but not final approved.
- Can be edited or deleted by anyone who has access to that client’s forms.
- Will hold up the work flow as they prevent adding another form in which any fields are shared.

Lock it down by Final Approving to protect your work!!

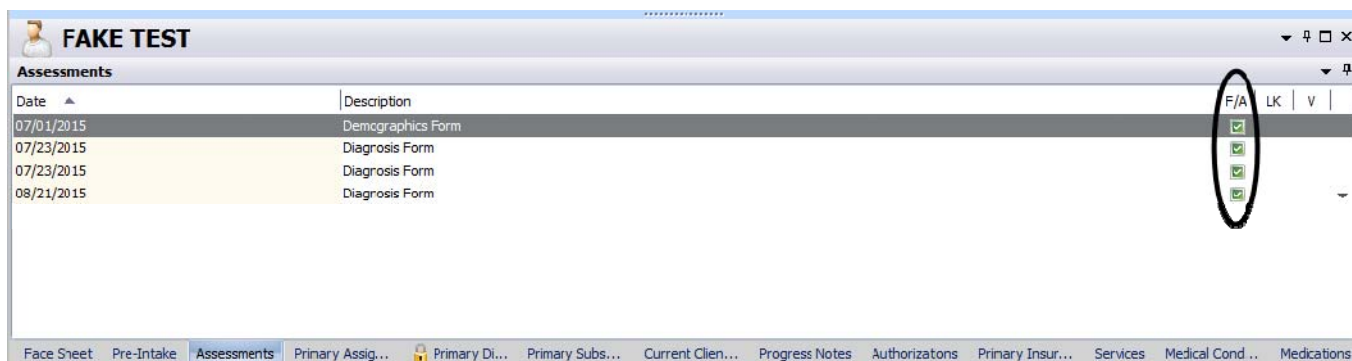
How to open a saved assessment:

- Select a client and open the “Client Panel”. Next, click the “Assessments” pane.
- A list of assessments will display. The assessment that is not final approved will not have a check under the Final Approved status (F/A).
- Double click the assessment. The selected assessment will open for data entry and completion.



VIEWING FINAL APPROVED ASSESSMENTS

- Select a client and open the “Client Panel”.
- Next, click the “Assessments” pane.
- A list of assessments will display. The assessments that are final approved will have a check under the Final approved status (F/A).
- Double click the assessment. The selected assessment will open for review.



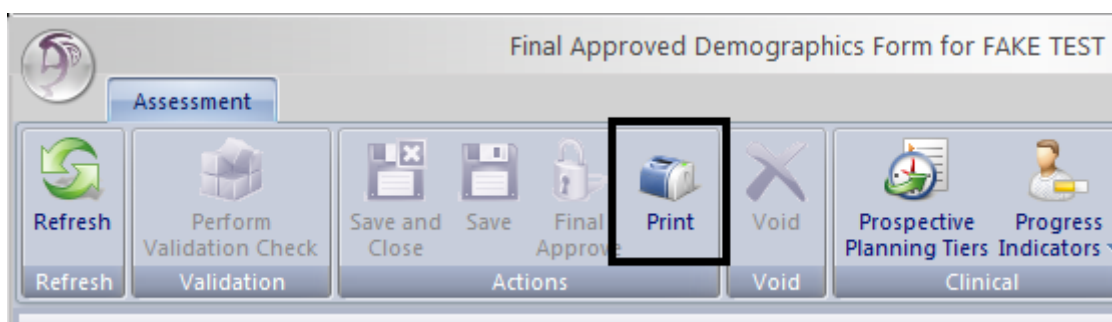


PRINT TO SCREEN

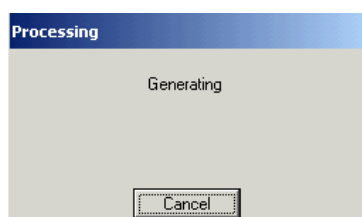
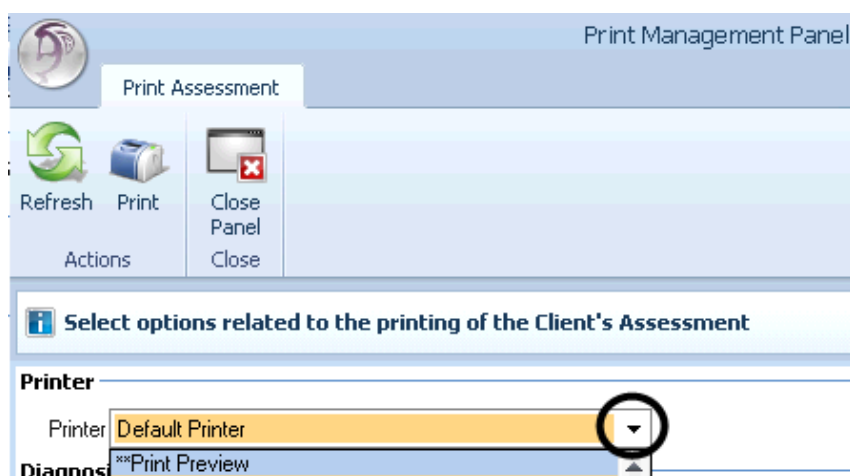


Note: Before printing a hard copy, always print to screen first to verify whether printing is truly necessary.

- Click the “Print” button.



- Click on the down arrow to the right of the “Printer” field, click “Print Preview”, and click the “Print” button.



It will take a few moments to process the command. Wait until the following message disappears.

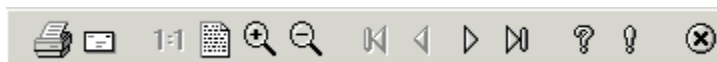


A copy displays on the screen. Pay attention to the total number of pages before deciding to print a physical copy.

Name: LAST, FIRST MIDDLE	Case#:	Page: 1 of 2
Type:		Date:
Printed on 09/01/2010 at 9:13 am		(Tray)

Icons

You will find icons across the top of the print screen which will allow navigation through the copy.



Prints a physical copy.



Emails a copy. **DO NOT** use this feature, as it is a breach in confidentiality.



Displays the default size of the copy.



Shrinks the copy down to 25% of the default size.



Zooms in by 50% each time the icon is clicked.



Zooms out by 25% each time the icon is clicked.



Navigates directly to the first page.



Navigates back one page.



Navigates forward one page.



Navigates directly to the last page.



Displays keyboard commands for navigating through the copy.



Displays the details of the software product.

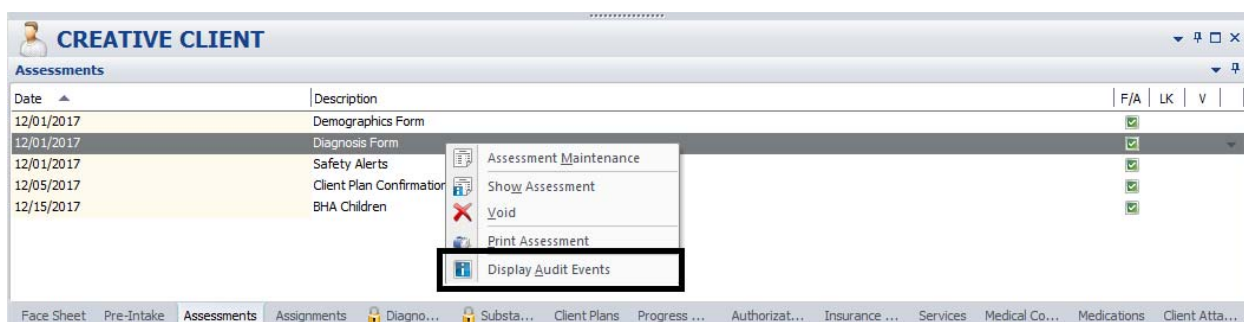
- Closes out of "Print to Screen" and returns to the original view.



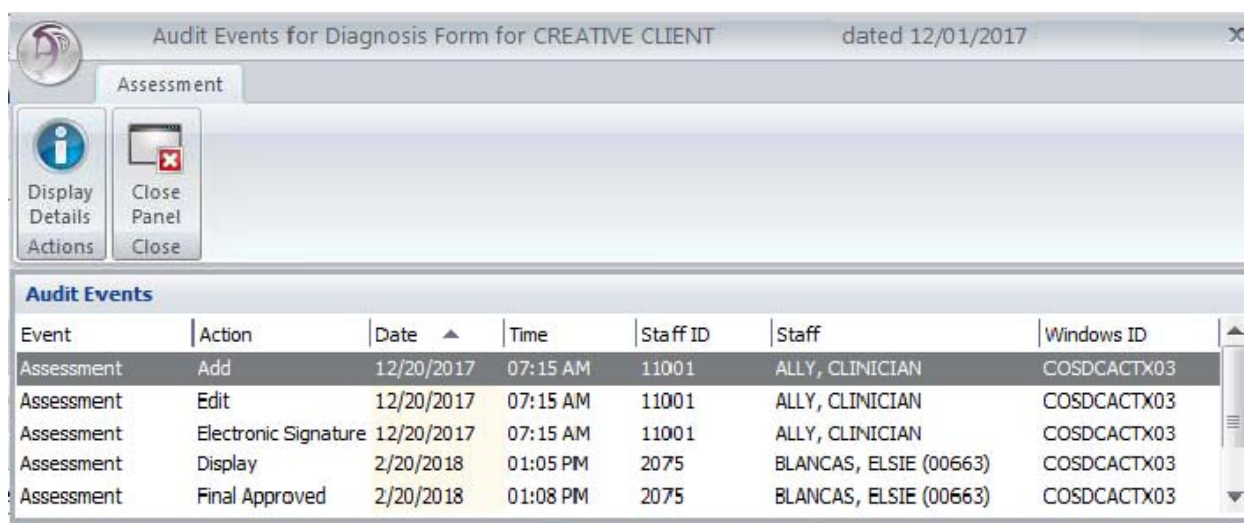
DISPLAY AUDIT EVENTS

To see when an assessment was added, edited, final approved, viewed, or printed, utilize Display Audit Events. Display Audit Events will display who touched the assessment, when, and what action was completed.

1. Right click on the assessment details you wish to view. Select “Display Audit Events.”



2. Each column in the window that appears can be sorted by clicking on the column header. The window will display a line for each separate action a staff takes (add, edit, sign, final approve, display, and print).



3. Select “Close Panel” to return to the Assessments Pane.

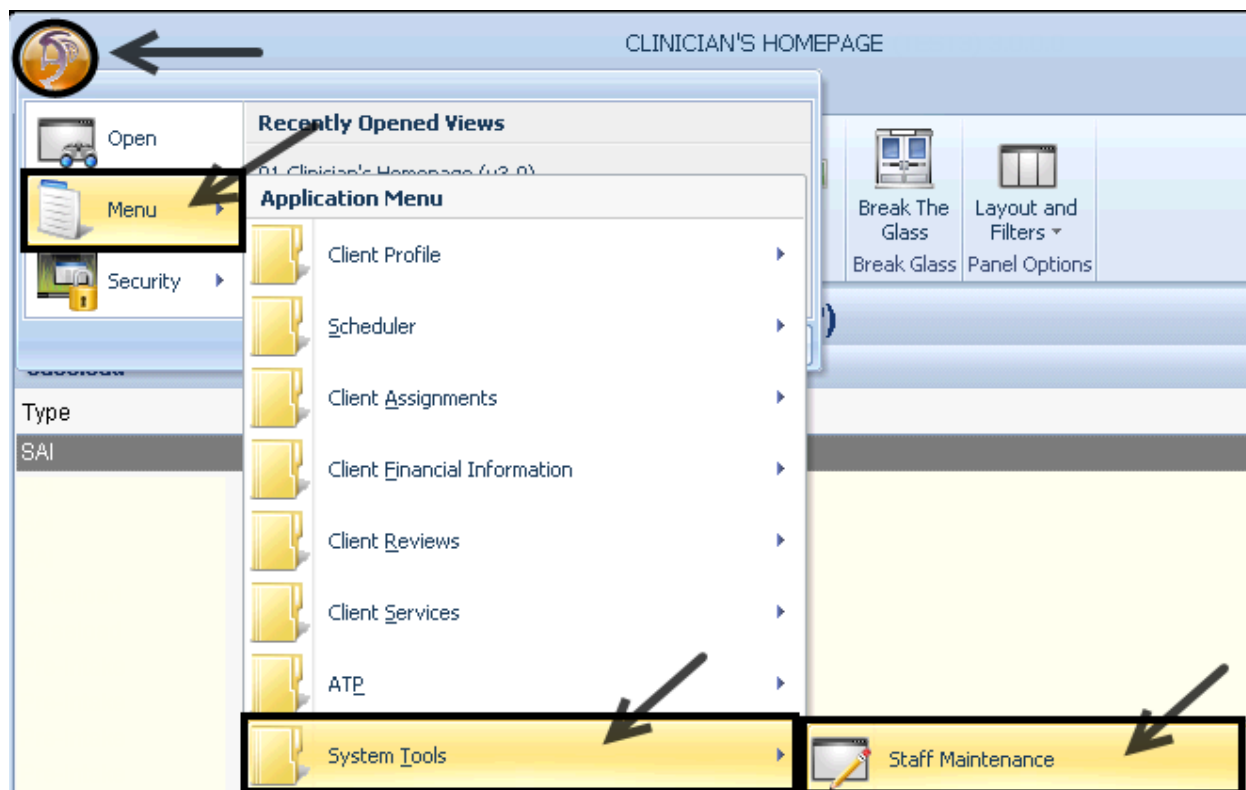




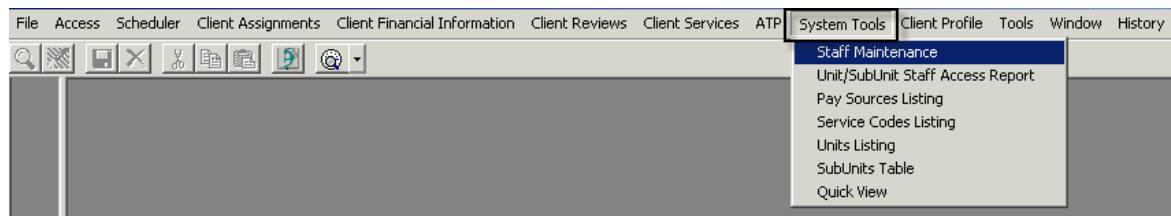
STAFF MAINTENANCE LOOKUP

How to Lookup a Staff for Contact Information

- From the CLINICIAN'S HOMEPAGE, click the Systems Button, click "Menu", click "System Tools", and click "Staff Maintenance".



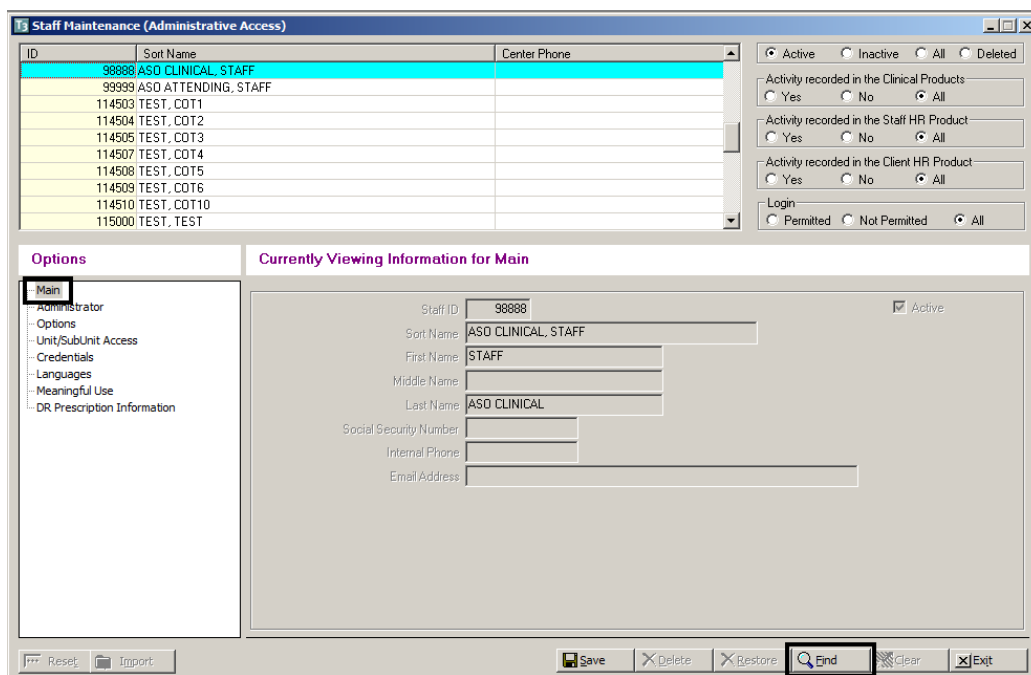
- From the EXTERNAL VIEW, locate "Staff Maintenance" under "System Tools".





“Staff Maintenance” Menu:

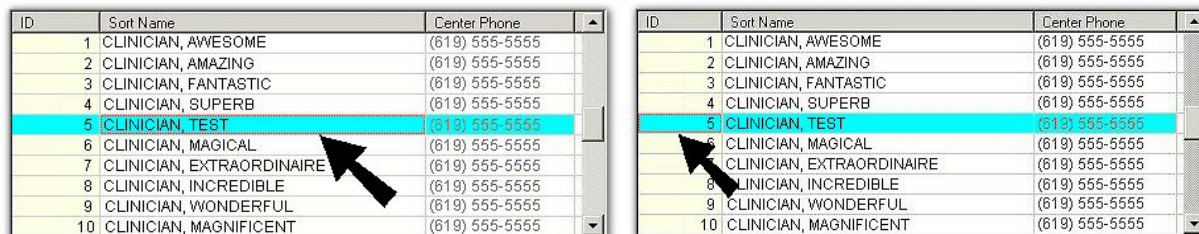
When the “Staff Maintenance” Menu launches, your staff ID and name will be highlighted in blue as a default. Your current contact information on file will be listed in the “Main (1)” tab below.



To begin your search:

- Press the “Find” button at the bottom of the window.
- The “Search: Sort Name” box will launch.

NOTE: You may search by “ID” or “Sort Name” by clicking under the desired column before pressing “Find”. A red dotted box will display under the field you are searching.





Search Window:

Search: Sort Name

CLINICAL, STAFF

OK

- Type in the desired name of the staff you wish to find.

NOTE: The format must be last name, comma, then SPACE, and first name. For example, "CLINICAL, STAFF" would be the proper format.

12047 CLINICAL, STAFF

Permitted Not Permitted

Options

- Main
- Administrator
- Options
- Clinical Product Access
- Unit/SubUnit Access
- Categories of Treatment
- Credentials
- Languages
- CH/DR Product Access
- Meaningful Use
- DR Prescription Information

Currently Viewing Information for Main

Staff ID 12047 Active

Sort Name CLINICAL, STAFF

First Name STAFF

Middle Name

Last Name CLINICAL

Internal Phone 858-555-5555

Email Address CLINICAL123@EMAIL.COM

- The contact information of the staff for which you have entered will display under "Main".
- The "Internal Phone" number as well as the "Email Address" will be listed when it is available.

NOTES



CLINICIAN'S HOMEPAGE NOTIFICATIONS PANE Managing Notifications and Timelines

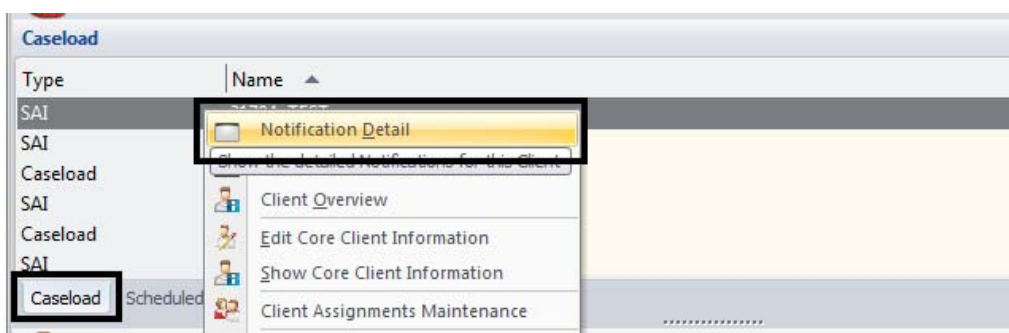
Notifications are intended to assist in managing tasks related to quality and coordination of care for each client. The primary server at each program continues to be responsible to manage and track all necessary actions required by the County system of care for each client.

Due to a shared electronic health record for each client, a complete and up-to-date behavioral health assessment must be present in each client record. There will no longer be multiple assessments for each program. Timelines for due dates may be impacted when a client is open to more than one program at one time (due dates will be driven by the most recent final approved BHA). The primary server at each program is responsible to coordinate due dates and clinical information between programs when this does occur.

There are two ways to see the details of a “Notification”:

1st Way

- To display the action required for the client, right click anywhere on the line where the client's name displays. This will activate a drop down menu with several options. Select the “Notification Detail” option.



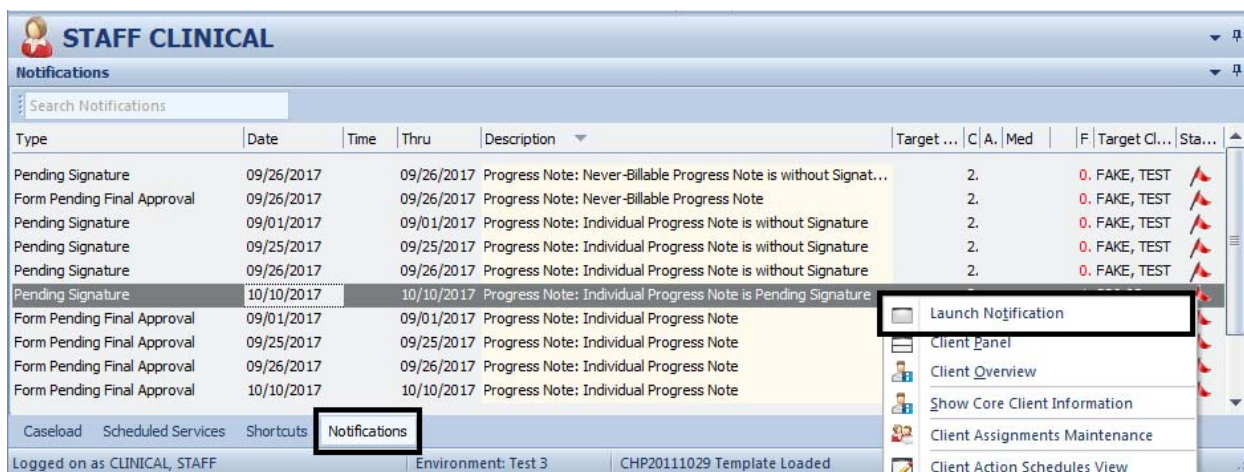
- When the “Notification Detail” option is selected, the “Client Notifications” window activates, displaying what action is required for the client. Double click on the line to open.

Type	Date	Time	Thru	Follo...	Description	Target ...	Target Client	C...	Acknowledge	Med	Sta...
Form Pending Final A...	10/10...		10/10...	10/10...	Progress Note: Individual Progres...		226.03, CPPN	2...			
Pending Signature	10/10...		10/10...	10/10...	Progress Note: Individual Progres...		226.03, CPPN	2...			



2nd Way


- In the staff panel on the notifications pane, either right click on the line and choose “Launch Notification” or double click anywhere on the line.



Timelines to Keep in Mind:

- A Behavioral Health Assessment (BHA) must be completed within thirty days after the opening of a client assignment.
- A client’s annual review date is established by most recent final approved BHA (check the notification dates for details).
- A Discharge Summary must be completed within 7 days after a client’s assignment to your program is closed.

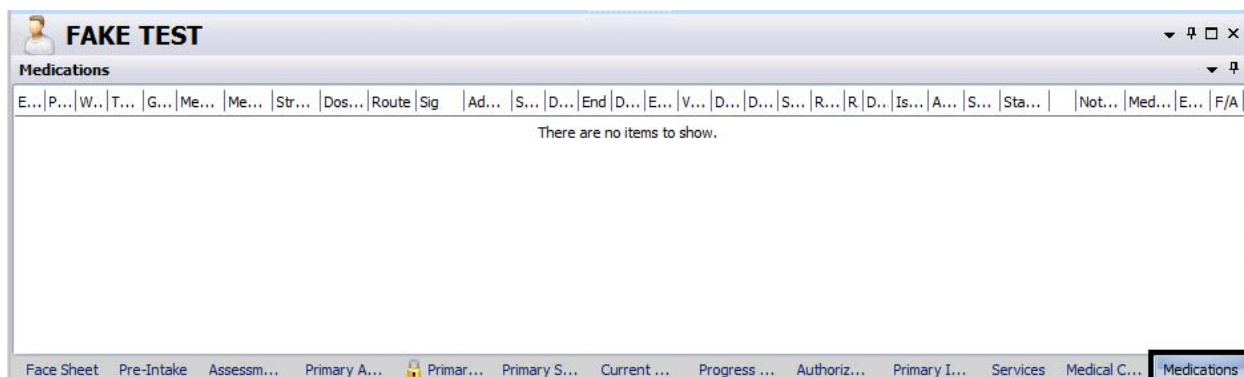
Example:

	Open Date	BHA Completed	BHA Update Due
Program A			
Program B			
Program A			

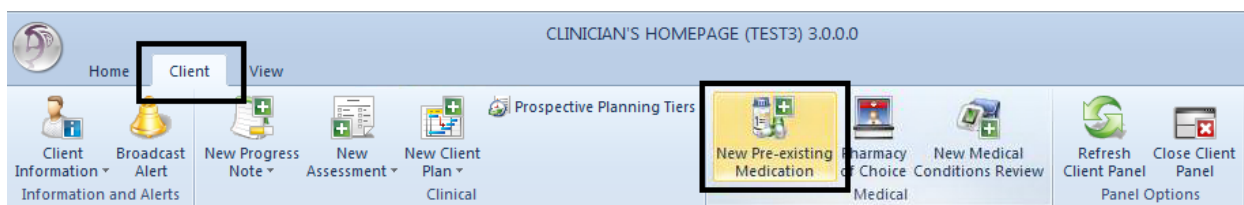


ENTERING A NEW PRE-EXISTING MEDICATION

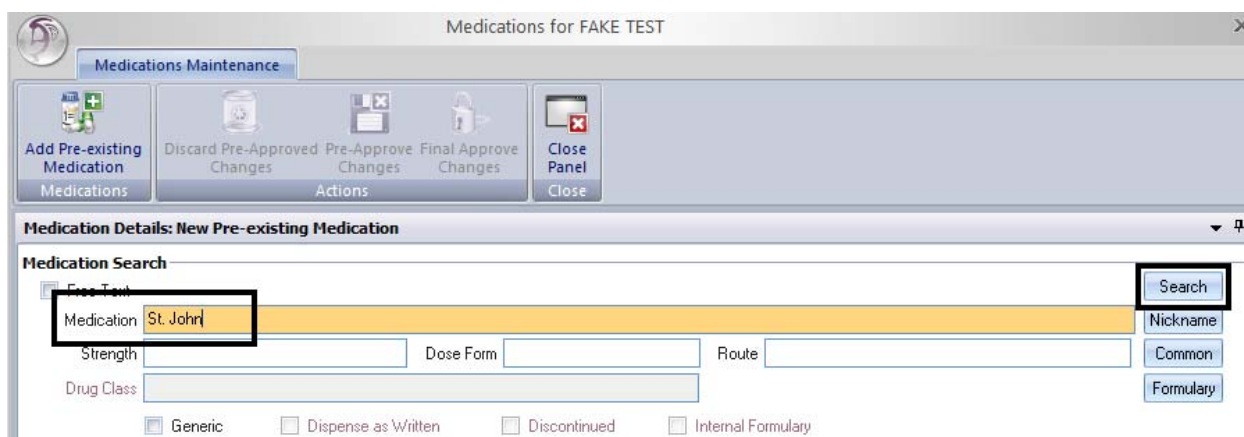
- View the medications listed in the “Medications” pane.



- If the client reports taking a medication that is not listed, click the “New Pre-existing Medication” button.



- A new window launches. In the “Medication” field, type in the first few letters (at least three) of the medication, and click “Search”.





- Locate the appropriate medication from the list, and double click on it, or click once and choose “Select” at the top.

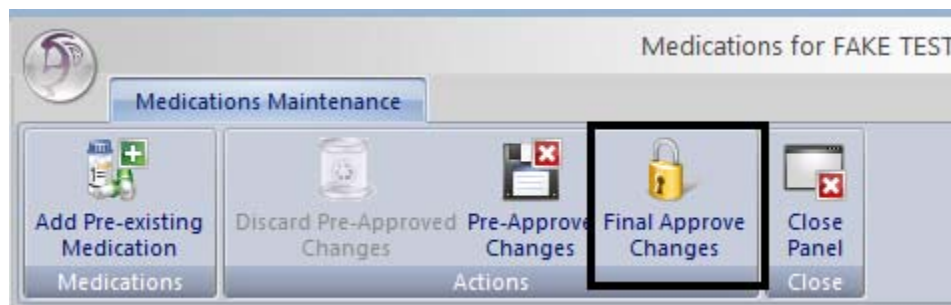
- Once you’ve chosen the medication of your choice, a new window launches. The only other “software required” field is “Start Date”; however, clinically, if you have additional information, enter it into the “Sig Builder” and “Sig Information” fields. If prescribed by an external provider, select the name of the physician in the “Prescribing Physician” field. When finished, select “Save”.



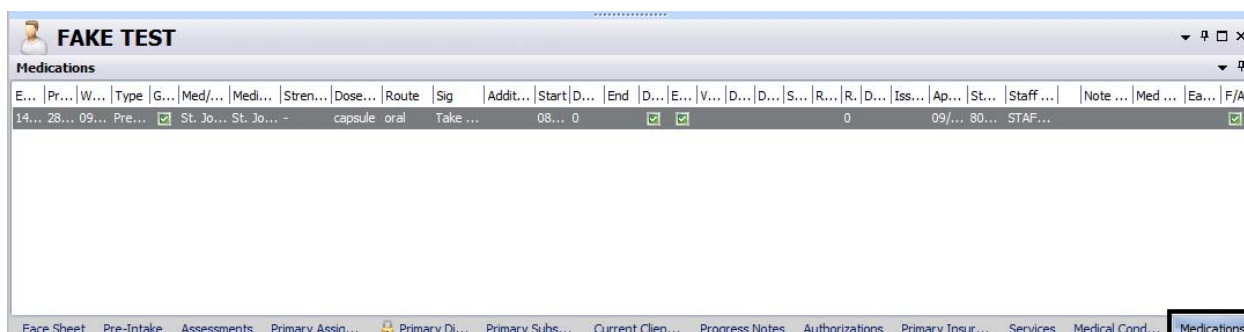
Note: If you do not have the exact start date, select the “Estimated Dates” box.



- Click the “Final Approve Changes” button.



- The medication then displays in the “Medications” pane of the client panel.



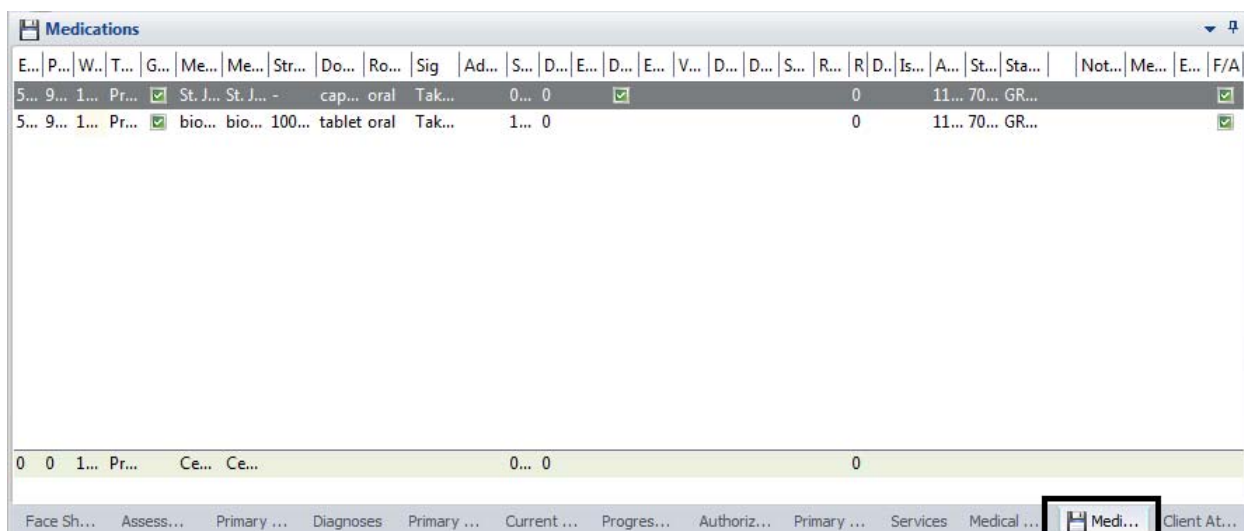


EDITING A PRE-EXISTING MEDICATION

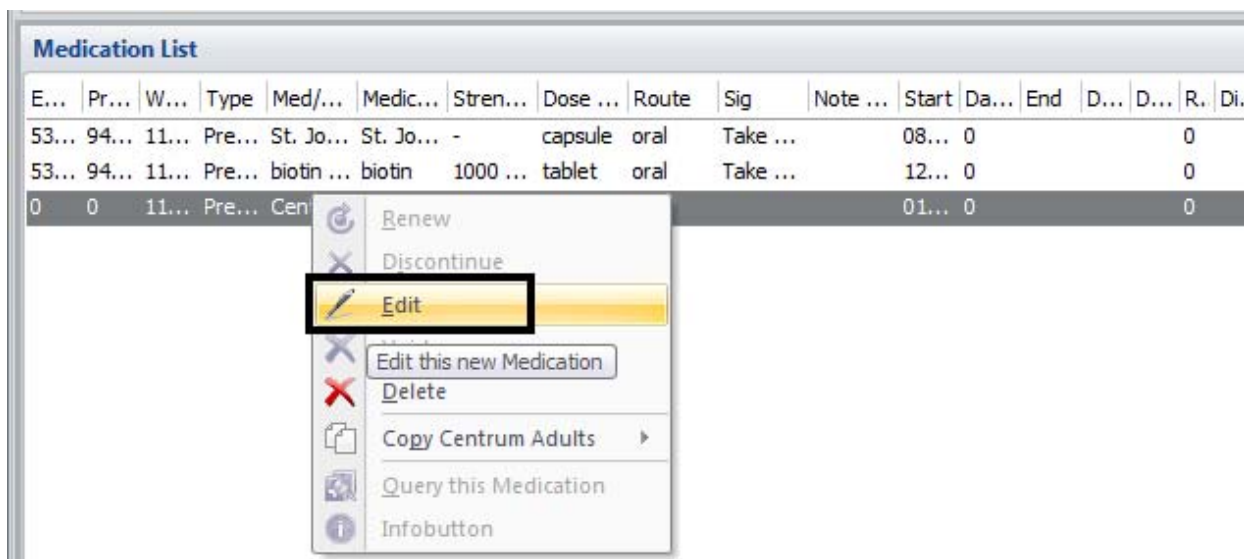


*Note: The “Edit” option will only show for **Non-Final Approved Pre-Existing Medications**. Otherwise, the menu will be greyed out.*

1. Select the appropriate client, and double click on the medication you wish to edit in the “Medications” pane.



2. The client’s medications appear in a new window. Right click on the medication you wish to edit. A drop down menu appears. Select “Edit”.





3. The “Medication Details: Edit Prescription” window launches. Make the appropriate change in the “Sig Builder” portion of the window. In this example we will change the frequency from 3 times a day to 2 times a day. In the “Internal Notes” section, enter what change was made and when it was made. Then, select the “Save Medication”.

Sig Builder

Free Text

Action: Take Dose Qty: 1 Unit: tablet(s) Route: by mouth Frequency: 2 times a day

Modifiers: _____

Sig Information

Sig: Take 1 tablet(s) by mouth 2 times a day

Days Supply: _____ Qty To Dispense: _____ Unit: _____

Start Date: 12/12/14 End Date: / / Earliest Fill Date: / / Refills: _____ Estimated Dates

Add Instructions: _____

External Prescribing Physician: _____

Internal Notes: 9900/9901 Changed frequency from 3 times a day to 2 times a day.

Written Date: 11/16/2016

Issue Method: **Do Not Send: N/A**

Save Cancel

Medication List: Medication Details: New Pre-existing Medication

4. Click the “Final Approve Changes” button.

Medications Maintenance

Add Pre-existing Medication Discard Pre-Approved Changes Pre-Approve Changes **Final Approve Changes** Close Panel

Medications Actions Close

Medication List (Pre-Approved)

E...	Pr...	W...	Type	Med/...	Medic...	Stren...	Dose ...	Route	Sig	Note ...	Start	Da...	End	D...	D...	R.	Di...	Staff ...	Status	Super...	Presc...	Ea...	F/A
53...	94...	11...	Pre...	St. Jo...	St. Jo...	-	capsule	oral	Take ...		08...	0				0		GRUS...					<input checked="" type="checkbox"/>
53...	94...	11...	Pre...	biotin ...	biotin	1000 ...	tablet	oral	Take ...		12...	0				0		GRUS...					<input checked="" type="checkbox"/>
0	0	11...	Pre...	Centr...	Centr...				take 1...		12...	0				0						New Pre...	

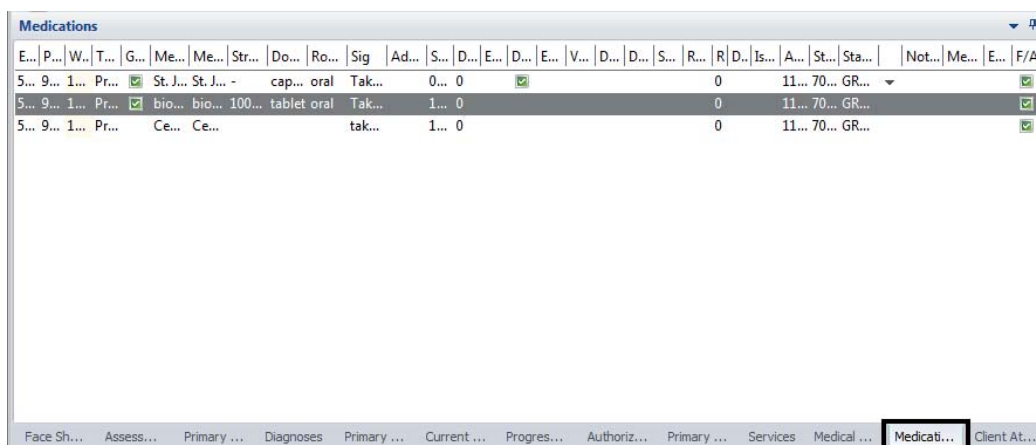
5. The edited prescription then displays in the “Medications” pane of the client panel. The change that was just made can now be observed in the “Sig” column.



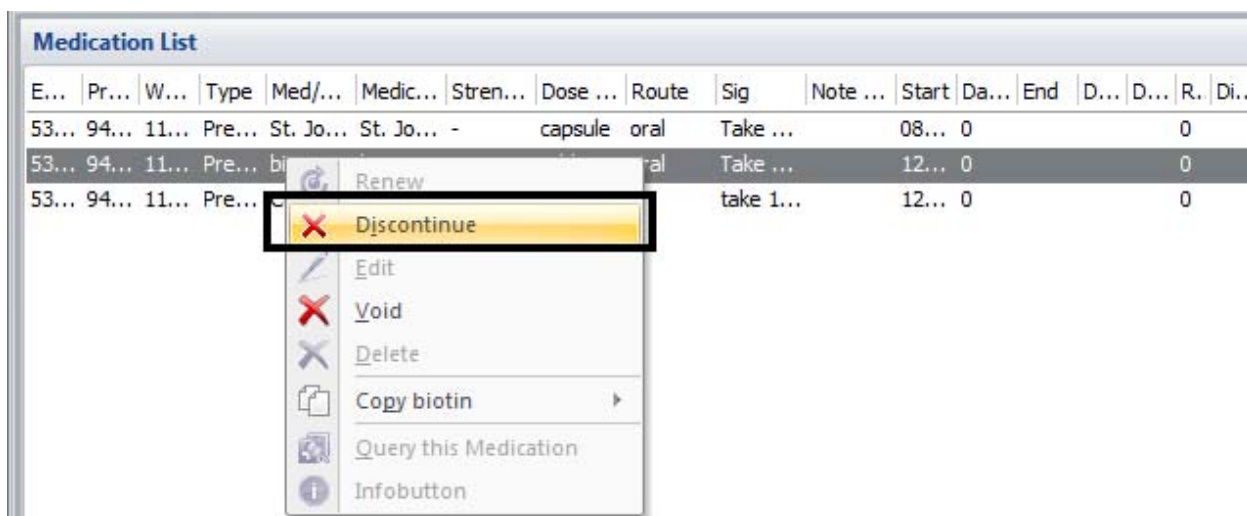
DISCONTINUING A PRE-EXISTING MEDICATION

Prescriptions are automatically discontinued in DHP if there is an end date in the Sig Builder and the end date has passed. However, there may be time when you want to discontinue a medication in the client's record (for example, you find out that the pre-existing medication that was prescribed by another Prescriber has been terminated, or you learn the client has stopped taking a medication). Discontinuing a medication does NOT alert the pharmacy- you must contact the pharmacy directly to let them know. Unless you are a medical staff with access to Doctor's Homepage you will only have access to discontinue pre-existing medications, not prescriptions.

1. Select the appropriate client, and double click on the medication you wish to discontinue in the "Medications" pane.



2. The "Medications List" for that client will launch. Right click on the medication you wish you discontinue. A drop down menu will launch. Click on "discontinue".





3. The “Medication Details: Discontinue Prescription” window launches. The end date will default to the current date (but may be changed). Click “Save Medication”.

Sig Information

Sig: Take 1 capsule(s) by mouth

Days Supply: [] Qty To Dispense: [] Unit: []

Start Date: 08/01/2014 **End Date: 11/16/2016** Earliest Fill Date: / / Refills: [] Estimated Dates

Add Instructions: []

External Prescribing Physician: []

Internal Notes: []

Written Date: 11/16/2016

Issue Method: [Select Issue Method](#) **Save** Cancel

Medication List: Medication Details: Discontinue Pre-existing Medication

4. You are returned to the “Medications Maintenance” window. A green check now appears in the “Discontinued” column for this medication. Click the “Final Approve Changes” button.

Medications Maintenance

Add Pre-existing Medication Medications Discard Pre-Approved Changes Pre-Approve Changes Actions **Final Approve Changes** Close Panel Close

Changes are for Pre-existing Medications only and may be final approved by all Staff.

E...	Pr...	W...	Type	Med/...	Medic...	Stren...	Dose ...	Route	Sig	Note ...	Start Da...	End	Discontinued	D...	R...	S...	Status	Sup...	Presc...	Ea...	F/A
53...	94...	11...	Pre...	St. Jo...	St. Jo...	-	capsule	oral	Take ...		08... 0	11...	<input checked="" type="checkbox"/>	0	G..	Discont...					<input checked="" type="checkbox"/>
53...	94...	11...	Pre...	biotin ...	biotin	1000 ...	tablet	oral	Take ...		12... 0			0	G..						<input checked="" type="checkbox"/>
53...	94...	11...	Pre...	Centr...	Centr...				take 1...		12... 0			0	G..						<input checked="" type="checkbox"/>

5. The discontinued prescription then displays in the “Medications” pane of the client panel with a green check-mark in the “Discontinued” column.

E...	P...	W...	T...	G...	Me...	Me...	Str...	Do...	Ro...	Sig	Ad...	S...	D...	E...	D...	E...	V...	Discontinued	S...	R...	F	D	I...	A...	S...	St...	N...	M...	E...	F/A
5...	9...	1...	Pr...	<input checked="" type="checkbox"/>	St. J...	St. J...	-	cap...	oral	Tak...		0...	0	1...	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	0	1...	7...	G...							<input checked="" type="checkbox"/>	
5...	9...	1...	Pr...	<input checked="" type="checkbox"/>	bio...	bio...	100...	tablet	oral	Tak...		1...	0						0	1...	7...	G...						<input checked="" type="checkbox"/>		
5...	9...	1...	Pr...		Ce...	Ce...				tak...		1...	0						0	1...	7...	G...						<input checked="" type="checkbox"/>		



VOIDING A PRE-EXISTING MEDICATION

The use of “Void” is only completed on medications that have been Final Approved in error (such as accidentally entering a medication for the wrong client). Unless you are a medical staff with access to Doctor’s Homepage you will only have access to void pre-existing medications, not prescriptions.

1. Select the appropriate client, and double click on the medication you wish to void in the “Medications” pane.

E...	P...	W...	T...	G...	Me...	Me...	Str...	Do...	Ro...	Sig	Ad...	S...	D...	E...	D...	E...	V...	D...	D...	S...	R...	R	D...	Is...	A...	St...	Sta...	Not...	Me...	E...	F/A
5...	9...	1...	Pr...	St J...	St J...	-	cap...	oral	Tak...	0...	0										0			11...	70...	GR...					
5...	9...	1...	Pr...	bio...	bio...	100...	tablet	oral	Tak...	1...	0										0			11...	70...	GR...					
5...	9...	1...	Pr...	Ce...	Ce...				tak...	1...	0										0			11...	70...	GR...					

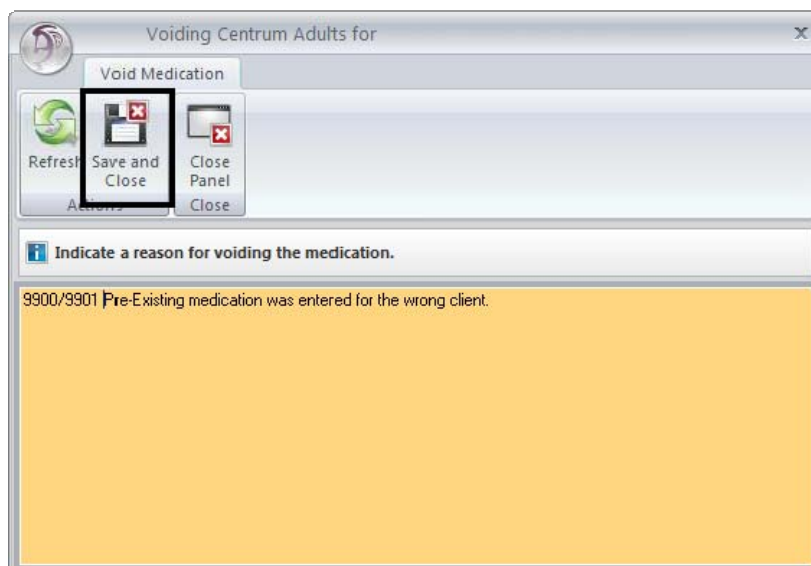
2. The “Medication List” for the client launches. Right click on the medication you wish to void and click, “Void”.

E...	Pr...	W...	Type	Med/...	Medic...	Stren...	Dose ...	Route	Sig	Note ...	Start	Da...	End	Discontinued	D...	R
53...	94...	11...	Pre...	biotin ...	biotin	1000 ...	tablet	oral	Take ...		12...	0				0
53...	94...	11...	Pre...	Centr...	Centr...				take 1...		12...	0				0

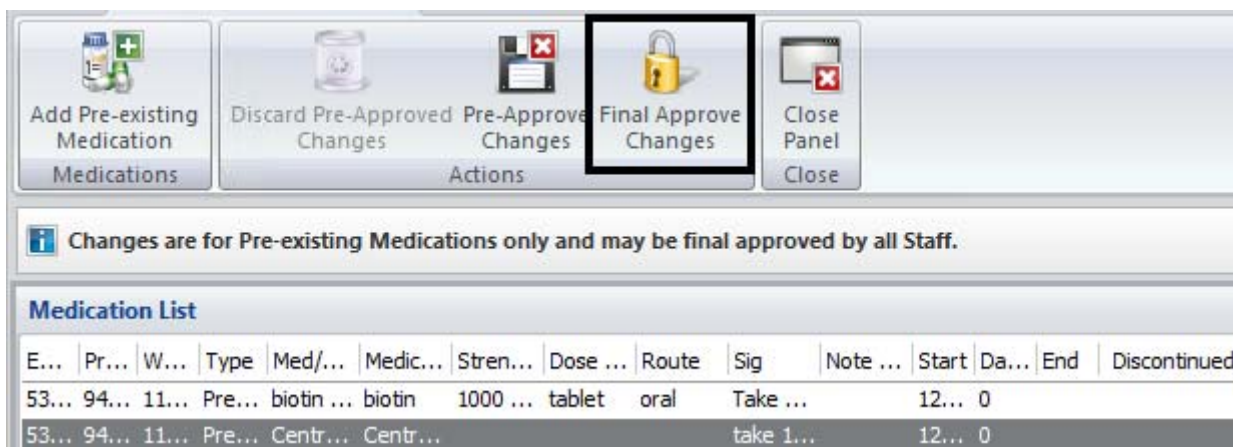
- Renew
- Discontinue
- Edit
- Void**



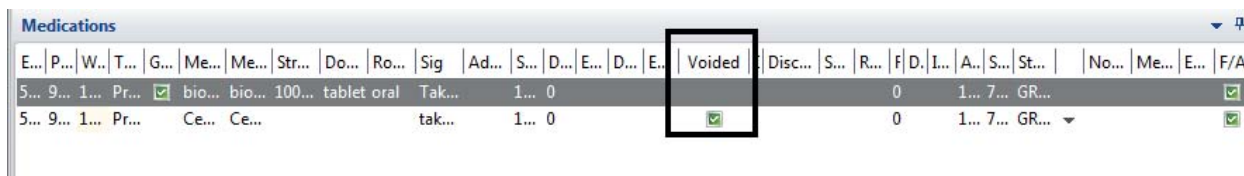
3. A new window launches which allows narrative text to be entered. Document the reason for voiding, and click “Save and Close”.



4. The “Medication Maintenance” window is launched. Click the “Final Approve Changes” button.



5. The voided prescription then displays in the “Medications” pane of the client panel with a check mark in the “Voided” column.

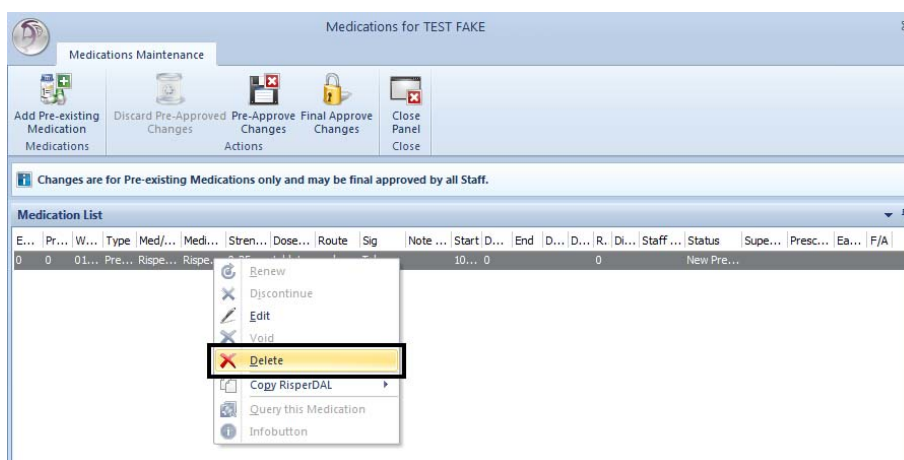




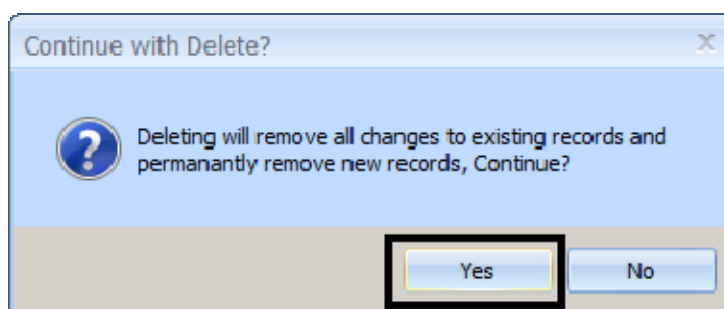
DELETING A PRE-EXISTING MEDICATION

A medication can only be deleted BEFORE it has been final approved. You would do this, for example, if you are in the middle of a prescription and realize you've made an error. Unless you are a medical staff with access to Doctor's Homepage you will only have access to delete pre-existing medications, not prescriptions.

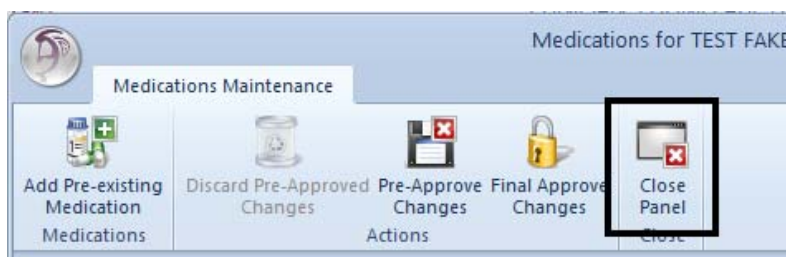
1. In the "Medication Maintenance" window, right click on the medication you wish to delete, and click "Delete."



2. The following message will appear. Click "Yes."



3. The medication is removed from the "Medication Maintenance" window. Click "Close Panel."

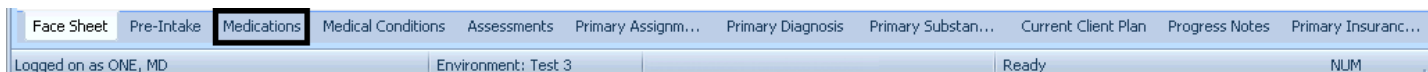




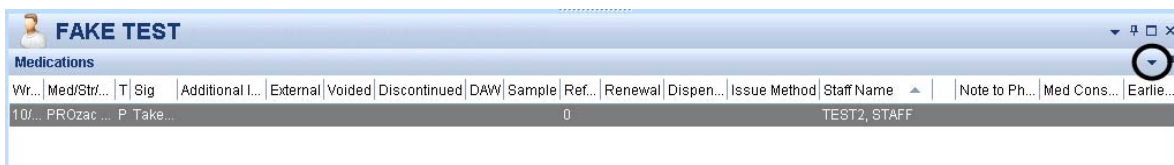
PRINTING CLIENT MEDICATIONS

A list of the client’s medications can be printed from the Medications Pane.

1. With the Client panel open, select the “Medications” pane at the bottom of the screen.



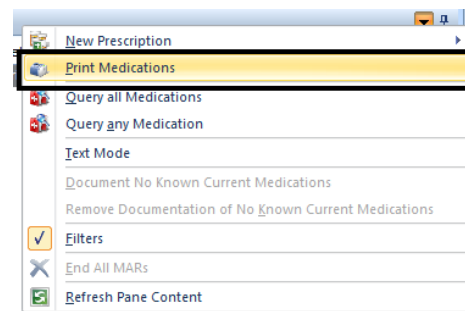
2. On the right top portion of the Client panel, select the down arrow.



3. A drop down menu will launch. Select the “Print Medications” option.

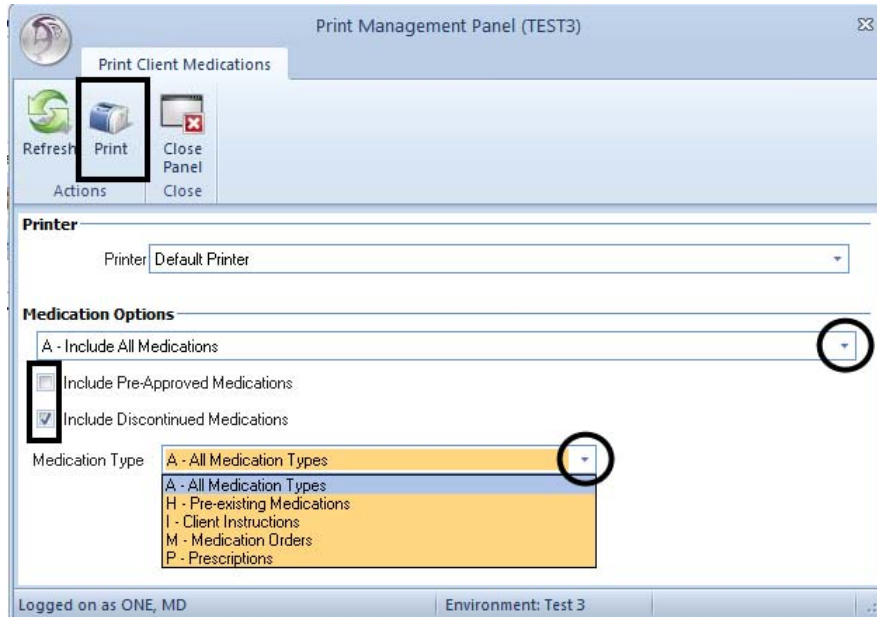


Note: This menu will also appear when right clicking in the white space within the client panel.



4. Adjust the printing options to what is needed. Users can choose to print only a certain medication type, to include pre-approved or discontinued medications, and/or to include all medications or only current medications.

5. When finished adjusting the filters, select “Print.”





SCHEDULER

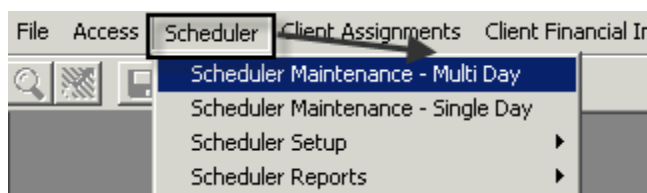
Scheduler is a comprehensive support system that helps clinicians to manage their clients' treatment plans. With the Scheduling System, you have the flexibility to define schedules for clients and clinicians. You can view a schedule over one day, two days, a week, or a month.

The portion contained in this packet is a limited version of how you can use Scheduler. Several Administrative staff have been trained in this part of the software in depth.

There are multiple ways to access Scheduler in CCBH.

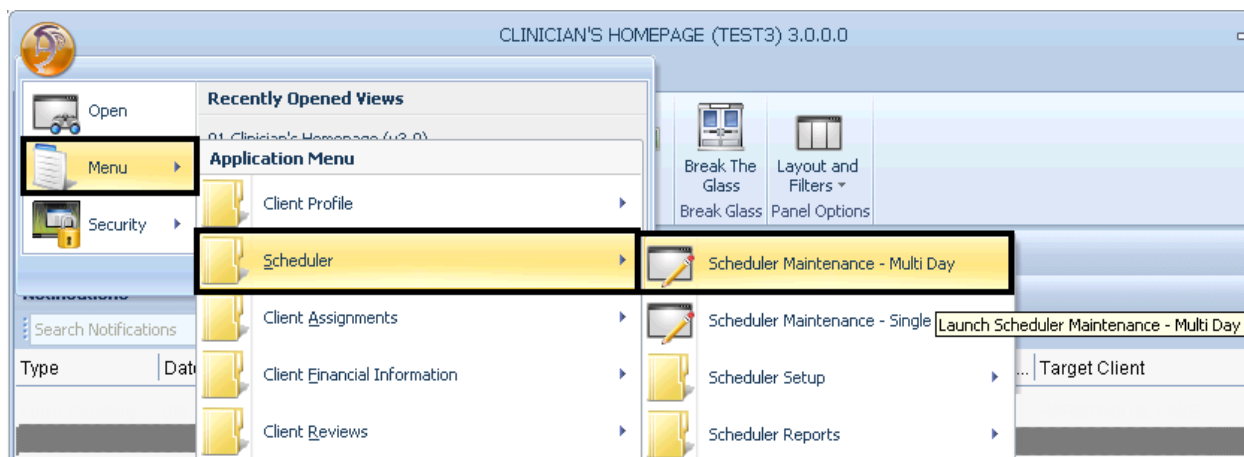
From the External View:

- Click on the "Scheduler" menu.
- A drop down menu will display, select "Scheduler Maintenance- Multi Day".



From the Clinician's Homepage

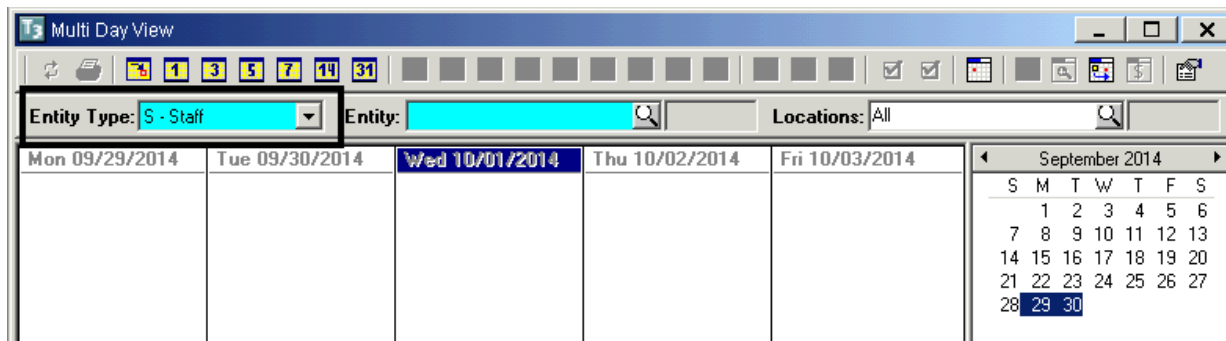
- From the "Systems Button", select "Menu", then "Scheduler", then "Scheduler Maintenance - Multi Day".





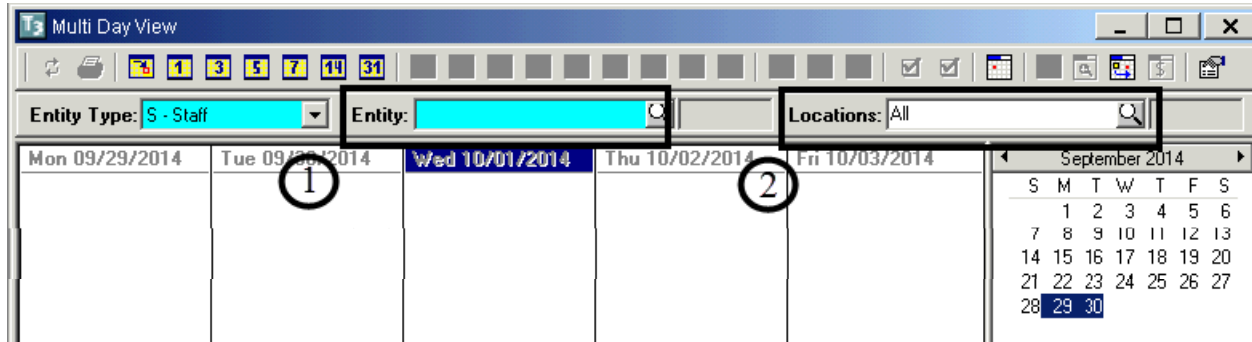
The Multi-Day screen will display.

- “Entity Type” will default to Staff.



To view a schedule

1. Enter the CCBH ID number in the “Entity” field and press the tab key on the keyboard. NOTE: If you wish to view a schedule for a client instead of staff, change the “Entity Type” to “Client”, and enter a client case number in the “Entity” field
2. Leave the “Location” field on “All”

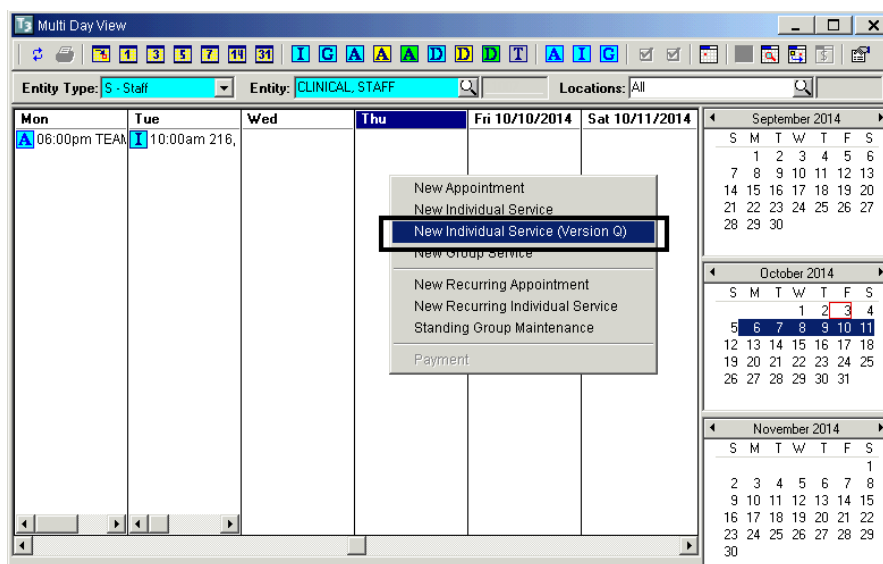


NOTES

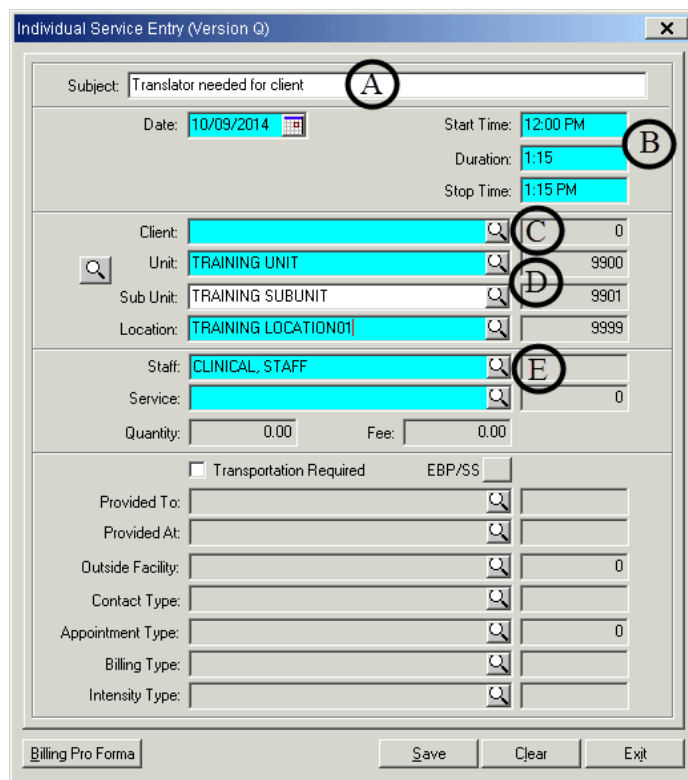


To schedule a service event

- Right click into the actual day the event is to take place (Ex: 10/9/14).
- A floating menu appears.
- From Floating menu: Select “New Individual Service (Version Q)”.



- The “Subject” can be manually entered, or it can be left blank. If it is left blank, it will default to the service code description after selecting the service code
- Enter the “Start Time”. The system will default to “am.” Either enter military time, or the letter “p” for pm. For duration, enter as H:MM (i.e. forty-five minutes is :45 and one hour and fifteen minutes is 1:15).The system will calculate the “End Time” automatically
- Select the client from the “Client Look Up” screen
- When the “Unit” is entered, the “Location” field automatically fills. Enter the Sub Unit





E. The “Staff” field defaults to the entity selected when you originally right clicked on the Multi Day View; however, the staff person can be changed

ID	Desc
5	SCREENING 5
9	ASSESSMNT PSYCHSOC INTERACT 9
10	ASSESSMENT - PSYCHOSOCIAL 10
11	MEDICATION EVALUATION 11
12	PSYCHOLOGICAL TESTING 12
13	PLAN DEVELOPMENT 13
14	EVAL OF RECRD FOR ASSESSMNT 14
15	EXTERNAL REPORT PREPARATION 15
16	PSYCH TEST-TECHNICIAN 16

- From the drop down menu, select the intended Service Code for the service event

- Once a service code is selected, the service indicators auto fill

Staff: CLINICAL_STAFF
Service: ASSESSMENT - PSYCHOSOCIAL 10
Quantity: 0.00 Fee: 0.00
 Transportation Required EBP/SS
Provided To: Client
Provided At: Office
Outside Facility: 0
Contact Type: Face to Face
Appointment Type: Scheduled
Billing Type: Not Applicable
Intensity Type: NOT APPLICABLE

ID	Description	Alternate ID
J	Client Job Site	7
C	Correctional Facility	8
L	Crisis Residential	1
F	Faith Based (church)	f
G	Health Care - Primary Care	g
H	Home	2
E	Homeless/Emerg Shelter	5
K	IP Free Stdnng Hosp/IMD/SH	6
D	IP Full Scale Hosp/SNF	9

- If the place of service is different than the default for “Prov. At”, enter the correct “Provided At” from the “Place of Service” look-up



Assessments

- Enter an “Outside Facility” if “K”, “D”, or an “S” is selected as the place of service

ID	Description
325	ABRAXAS CONTINUATION HIGH-PO
794	ACADEMY FOR LEARNING-BU
99	ADA W. HARRIS ELEMENTARY-CA
437	ADAMS ELEMENTARY-SD
347	ADDBE-BLUFFS ELEMENTARY-PO
706	ALAMOSA PARK ELEMENTARY-VU
421	ALBA-SD
405	ALBERT EINSTEIN ACA CHARTER-SD
589	ALBERT EINSTEIN ACAD CHARTE-SD
438	ALCOTT ELEMENTARY-SD
791	ALL TRIBES AMER INDIAN CHAR-VP
106	ALLEN (ELLA B.)CH
59	ALPINE COMMUNITY DAY-AU
53	ALPINE ELEMENTARY-AU
653	ALTA VISTA ACADEMY-SW
693	ALTA VISTA HIGH-VU
766	ALVIN M. DUNN ELEMENTARY-SM
168	AM HERITAGE K-8 CHARTER-EE
439	ANGIER ELEMENTARY-SD
101	ANNE AND WM HEDENKAMP ELEME-CH
71	ANZA ELEMENTARY-CV

Transportation Required EBP/SS

Provided To: Client C

Provided At: School S

Outside Facility: COMMUNITY SCHOOLS - CENTRAL-OE 33

Contact Type: Face to Face F

Appointment Type: Scheduled 1

Billing Type: Not Applicable X

Intensity Type: NOT APPLICABLE N

- The other indicators can be changed if desired. Click “Save”

- Select “Save” and the service will now appear on your schedule.

Tue 10/07/2014	Wed 10/08/2014	Thu 10/09/2014	Fri 10/10/2014	Sat 10/11/2014
		I 12:00pm TEST, FA		



SCHEDULER INSTRUCTIONS FOR CLINICIANS

Multi-Day View

The Multi-Day View allows the user to enter appointments on behalf of an individual staff and to view one staff person's daily, weekly, monthly or multi-day schedule. Client services may also be entered and viewed in the Multi-Day View.

To access, select Scheduler from menu, select Scheduler Maintenance-Multi-Day from the Scheduler menu drop down.

The "Multi-Day View" screen will open.

Entity Type

Entity Type defaults to "Staff". To change Entity Type, From the Entity Type drop down menu, select "Staff" or "Client" to view either staff or client's schedule. The "Entity" field selection list is dependent on the selection in the Entity Type Field.

Entity

Select the magnifying glass to view lookup. Select the desired staff or client. If "Staff" was selected in the Entity Type field, the "Staff Lookup" screen will appear. If "Client" was selected in the Entity Type field, the "Client Lookup" screen will appear. The staff member's schedule will display. Services can be added or edited, but may only be deleted by the Help Desk.

The selected client's services will be displayed and can be edited or canceled. Since staff schedules cannot be viewed from the "Client Screen", do not add client appointments from this view. Adding client appointments from this view may result in double booking staff. Once the staff or client has been selected the event icons will activate.

Locations

Locations default to "All". A "Location Code" if entered will filter the selected staff person's schedule for that site. In most cases, leaving it on "All" has the same result. When client is selected as the "Entity Type" and a specific client is selected as the "Entity", leaving the "Location Code" set to "All" allows staff to view all of that specific client's appointments that have been scheduled at any site.

To return the default "All", clear the location code in the field and tab out.

Version Q

Version Q is a screen used for scheduling with fewer fields to complete than the individual client service screen. Version Q does not allow for the scheduling of a collateral server or editing of a scheduled individual service event, or for comments to be added. However, once a service is scheduled with Version Q, it may be edited to include collateral server and comments by editing the Individual Service event.



Select “New Individual Service (Version Q)” in the drop down menu to schedule a client service event.

Complete the “Subject” line. Enter a subject or a comment that may provide additional information (i.e. Translator needed for client). If no information is entered into the subject line, it will default to the service code description after selecting the service code.

For a “Normal” appointment event enter the “Start Time” followed by an “A” (or “a”) for a.m. or “P” (or “p”) for p.m. and the duration of the event. (i.e. If the length of the event is 1 hour and 45 minutes, enter 1:45 or military time). This will populate the “End Time”.



Note: In Scheduler the period (.) is not recognized in all start /stop time fields.

Select the client from the “Client Look Up” screen.

Enter the “Unit” and the “Location” field will automatically fill. Enter the “SubUnit” (required although this appears optional).

The “Staff” field defaults to the entity selected; however, the staff person can be changed.

Select the intended Service Code for the scheduled event from the drop down menu. Once a service code is selected, the service code indicators will autofill. (Note: case management service codes do not autofill) If the “Prov. At” (Place of Service) is different than the default, enter the correct “Provided At” from the “Place of Service” look-up. Enter an “Outside Facility” if “K”, “D”, or an “S” is selected as a Place of Service. Other indicators can be changed. Select “Save”.



Client Categories Maintenance

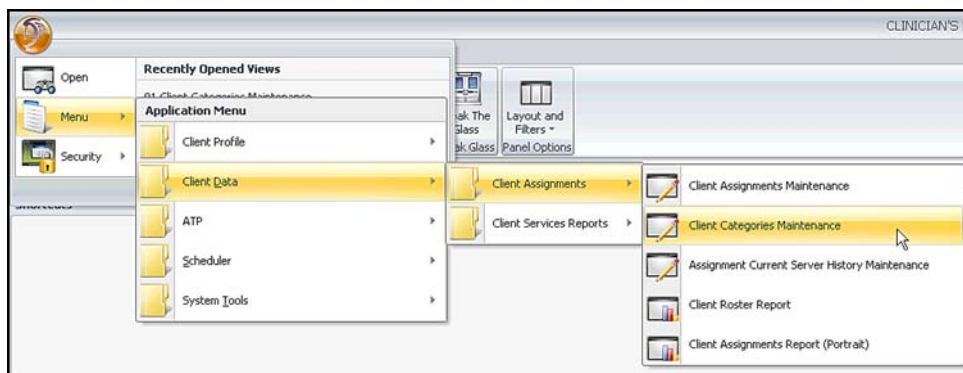
Entering Client Categories Maintenance:

Once the program has confirmed that a client belongs in one of the client categories in CCBH, programs must make the appropriate designation. There is a brief glossary attached about each category.

This is done through the “Client Categories Maintenance” screen.

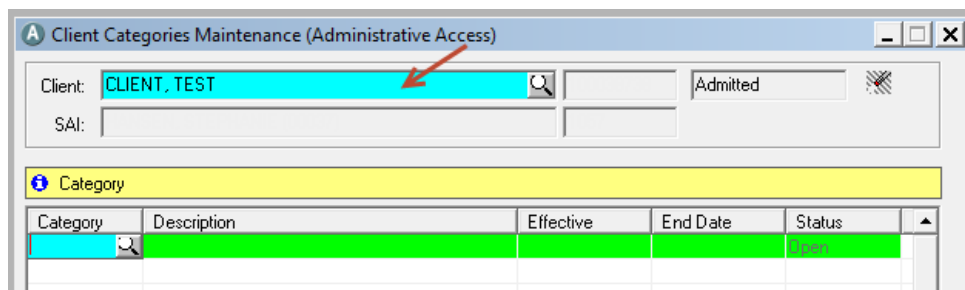
Once the client’s name has been selected from the CHP (and the Client Panel is open), follow these steps:

1. From the Clinician’s Homepage (CHP), go to the Systems button in the top left-hand corner.

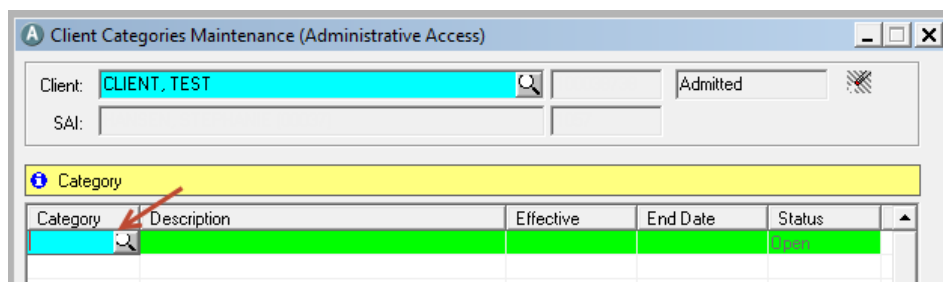


Select Menu → Client Data → Client Assignments → Client Categories Maintenance

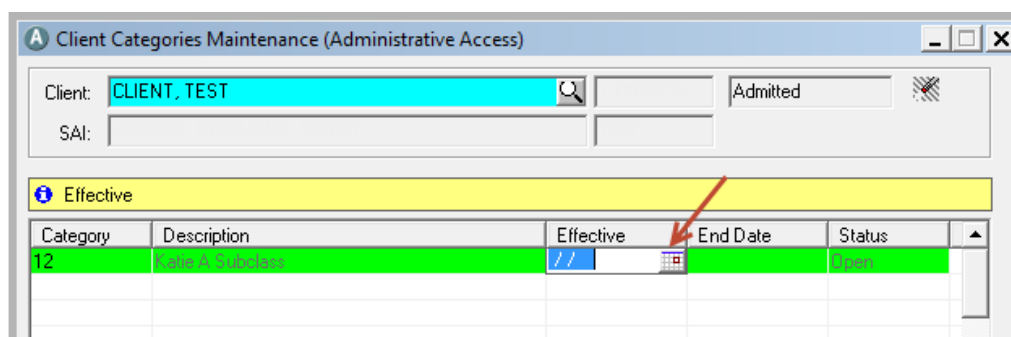
2. The “Client Categories Maintenance” window will launch, with the name of client you selected on your CHP pre-populated in the “Client” field. (If you did not select a client prior to this step, simply enter the client number in this field and select “Tab” to populate the client’s name).



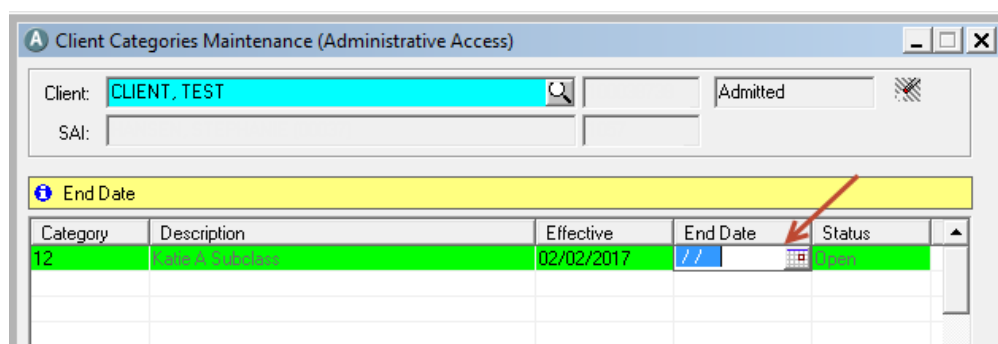
3. Click in the “Category” column. This will activate the field for data entry. Use the magnifying glass icon at the end of that field to launch the “Client Categories Lookup” table. Select the appropriate option for your client.



4. Your selection will now populate the “Client Categories Maintenance” window tab. Using your mouse, click in the “Effective” column to add the date it was determined the client was eligible. Once the date has been entered, make sure to tab out of the field, and **tab until you are taken to the line below your entered information**. This saves the information just entered. If you do not tab until you reach the line below the line of your entered information, your entry will not be saved. Then, select the “Exit” button at the bottom of the screen.



6. When the program has confirmed that the client is no longer eligible, the program must return to the “Client Categories Maintenance” screen to enter an end date. It is the same steps as 1-2 & 4, except the program is entering information into the “End Date” instead of the “Start Date” column. Once the end date is entered, make sure to TAB out of the field and **tab until you are taken to the line below your entered information**. This saves the information just entered. If you do not tab until you reach the line below the line of your entered information, your entry will be lost!



7. Then, select the “Exit” button at the bottom of the screen



Client Category Maintenance Glossary

AB109

A funding source for clients that are low risk offenders released from State custody to the County of San Diego for supervision and services. Alcohol, Drug & Mental Health services at various programs are provided to those that qualify for them. The goal is to provide supportive and rehabilitative services to these individuals to help them meet their needs and stay out of the justice system.

“AB109 Funded” are those programs that have a contract with the County to provide services to this population, and the “AB109 Non-Funded” are programs that an AB109 designated client may go to if the funded programs are full and impacted, but the program is not receiving contract funding for the services. The “Funded” programs are: CRF HEARTLAND CENTER, CRF MARIA SARDINAS WELLNESS & RECOVERY, EXODUS CENTRAL, and TELECARE PROPS.

Assertive Community Treatment (ACT)

ACT Services are provided in a multi-disciplinary team-based model of service that uses a comprehensive team approach and provides treatment 24 hours a day, 7 days a week, 365-days a year. The services are targeted for **homeless** persons with a severe mental illness who may have a co-occurring disorder, are unconnected to outpatient services, may be referred by the justice system, have multiple major areas of impairment, have more than one long term care episode, and multiple ER and acute care hospitalizations and justice related episodes.

The ACT program provides **integrated** mental health and medication services, rehabilitation and recovery services, intensive case management and have a staff-to-client ratio of approximately 1:10. Clients are typically provided services in person at a minimum of four (4) times per week to meet with the client’s clinical needs and meet ACT fidelity rating. Services may be provided on a much more frequent basis, depending on client need.

ACT Strength-Based Case Management (SBCM)

Strengths-Based Case Management services are delivered through BHS contracted service. Programs assist clients with severe mental illness who may have a co-occurring disorder to **access** needed mental health, medical, educational, social, prevocational, vocational, housing supports and rehabilitative or other community services. The service activities may include, but are not limited to case management, care coordination, referral and linkage to needed services; monitoring services delivery to ensure beneficiary access to services and the services delivery system, monitoring of the client’s progress, and plan development



AOT Court Ordered

Assisted Outpatient Treatment, also known as Laura’s Law, is a process by which the court, after a thorough investigation, orders an individual into an appropriate level of treatment. Individuals who are ordered into treatment are required to meet 9 criteria under Laura’s Law with the primary deciding clinical factor being client is “substantially deteriorating.” As part of the petition process, the licensed mental health clinician must prove to the court via an AOT evaluation that this level of treatment is the least restrictive level of treatment and, if not ordered, may result in the decompensation of the individual. The treatment offered in this category is the same level of treatment as an Assertive Community Treatment model.

AOT Voluntary

Similar to AOT Court Ordered, the individual is required to meet nine criteria under Laura’s law with the primary deciding clinical factor being client is “substantially deteriorating.” In this category, however, the client has not been court ordered into treatment. Though the client has met the definition for Laura’s Law and a licensed mental health clinician has conducted an AOT evaluation, the client has willingly agreed to participate in the AOT program and avoid the court process. The treatment offered in this category is the same level of treatment, an Assertive Community Treatment model, offered to individuals in the AOT Court Ordered category.

Augmented Services Programs (ASP)

Strive to enhance and improve client functioning through augmentation of basic Board and Care (B & C) services to specific individuals living in specific B & C facilities with which the County has an ASP contract. Emphasis is on developing client strengths, symptom management, and client self-sufficiency. Priority for ASP services is given to those people in most need of additional services. Any BHS funded case management services program may refer to ASPs.

Emergency/Transitional Shelter Bed

The goal of ETSB is to provide short term housing assistance to individuals connected to the respective clinic while stable income is sought. Emphasis is on securing stable income, symptom management, and client self-sufficiency. Priority for ETSB services is given to those people with a pending SSI claim.

BHS Regional Clinics (North Central, East County, North Inland, and North Coastal) are the designated locations for referrals to the Emergency & Transitional Shelter Bed (ETSB), through the respective clinic Homeless Outreach Worker (HOW).

Katie A.

A shorthand way of referring to the settlement agreement for a class action lawsuit brought against the County of Los Angeles and the State of California. The result is that specific collaboration between County Behavioral Health Systems and Children’s Welfare Services is mandated so that certain children in both systems of care are



guaranteed to receive intensive services to address their needs of safety, permanency and well-being. It is for Children’s programs only. In San Diego County, we refer to Katie A. as Pathways to Well-Being or the acronym **PWB**, so you may hear this language in your program. The class action lawsuit settlement defined members of the class and members of the subclass. These are legal terms that spell out what criteria need to be met in order to receive the specialty mental health services that the settlement defines.

A clinician in your program will give you a form that says if the client meets criteria for Katie A Class or Subclass. This is the information you will put into Client Categories Maintenance. There have been several trainings on PWB, so if you are unfamiliar with this and the services provided (and you work in the Children’s System of Care) talk to your program manager for more specific information.

Parolee

On a regular basis, individuals are discharged on parole from California State penal institutions. In many instances, these persons are in need of mental health services. Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Health Care Services and the County of San Diego. Parolees who are Medi-Cal beneficiaries and who meet specialty mental health medical necessity requirements, as specified in CCR, Title 9, Section 1830.205, will be provided appropriate Medi-Cal covered mental health services. Due to the passage of SB 389, MHSA funds may be used to provide services to persons who meet existing eligibility criteria for MHSA-funded programs and who are participating in a pre-sentencing or post-sentencing diversion program, to provide services to persons who are on parole, probation, PRCS, or mandatory supervision.

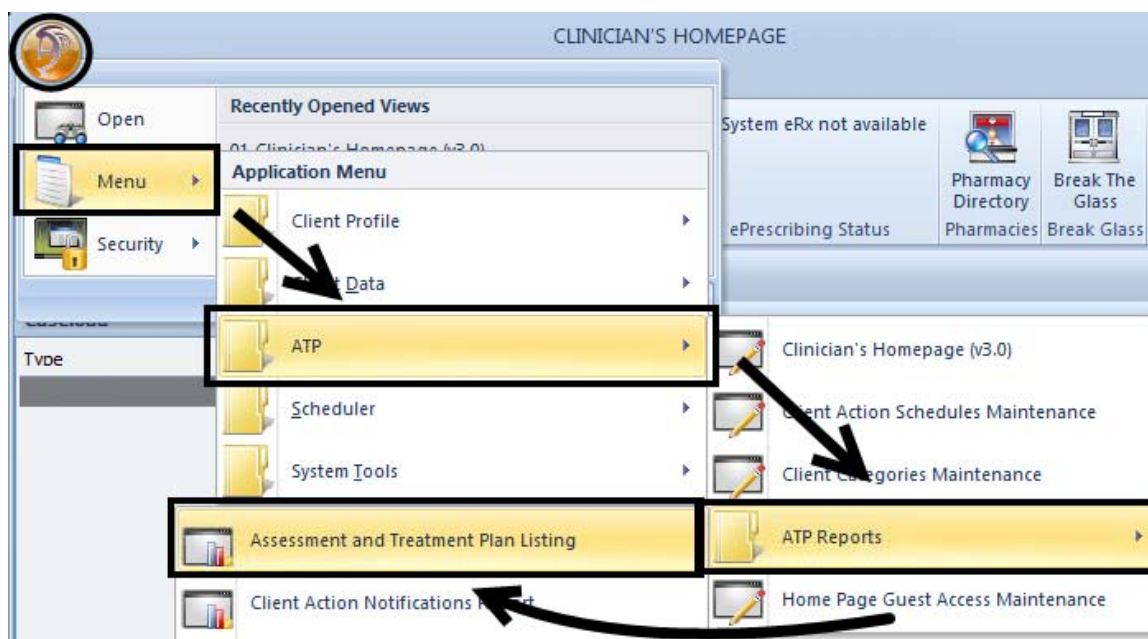
NOTES



SUPPLEMENTAL REPORTS

The reports listed below may be utilized for monitoring and maintenance of Assessments. Only designated staff in each program will have access to the reports that they are authorized to use. For additional assistance with approved template reports, please contact the Optum Support Desk at 1-800-834-3792.

ASSESSMENT REPORTS



Assessments Final Approved by Primary Signer:

Used to determine who has entered Assessments in to CCBH during a specified timeframe. Can be used to determine who is actively entering in Assessments based on the timeframe entered and can indicate if a staff needs a re-training prior to registration for the Client Plan and Progress Notes training.

1. Click on the "ATP" menu
2. Click on "ATP Reports" submenu
3. Select "Assessment and Treatment Plan Listing"
4. Select "Load" and click on "Assessments Final Approved by Primary Server" and select "Load" again
5. On "Selections1" enter in your Primary Unit
6. On "Selections2" enter in the "Final Approved Dates" and "thru" (recommendation is to run for a two to four week duration)
7. Select "Print"



Assessments Not Final Approved:

Used to determine who has entered and not final approved Assessments in to CCBH during a specified timeframe. Can be used to assure co-signatures are occurring within timelines, to determine if staff is completing assessments correctly, and determine if assessment/s are outstanding in the client chart.

1. Click on the “ATP” menu
2. Click on “ATP Reports” submenu
3. Select “Assessment and Treatment Plan Listing”
4. Select “Load” and click on “Assessments Not Final Approved” and select “Load” again
5. On “Selections1” enter in your Primary Unit
6. On “Selections2” enter in the “Final Approved Dates” and “thru” (recommendation is to run for a two to four week duration)
7. Select “Print”

NOTES



TRAINING TIP SHEET

1. WHEN YOU GO BACK TO YOUR PROGRAM:

- You are learning how to enter assessments in the “SDC Train CCBH” environment during this training, which is for **practice purposes only**. It is important to enter all of your assessment information in the “SDC Live CCBH” environment when you return to your program.

2. SUPPORT DESK – IMPORTANT!:

- Please do not try to solve issues by “working around” the system. You are to enter data as required and you must call the Support Desk for any questions.
- The Support Desk contact information is:

Optum Support Desk Contact Information

800-834-3792

sdhelpdesk@optum.com

3. FOR ONLINE USER MANUALS AND FORMS: (including forms and form-fill versions of assessments for “emergency” situations) go to the Optum website below and follow these instructions:

<https://www.optumsandiego.com>

- Click "Register" to get an on-line form for your personal login.
- Confirm your email address.
- When you have access, click “Login”.
- Login with your User Name and Password.
- Go to "Secure Documents".
- Select CCBH (formerly Anasazi) Secure Documents
- Click "Forms" or "Manuals".

4. TO REGISTER FOR ADDITIONAL TRAINING:

www.reqpacks.com/Optum

- ### **5. HIPAA REGULATIONS FOR TRAINING:** There is actual client data (names, etc.) in the training environment. HIPAA regulations mandate this information be treated confidentially.
- ### **6. NON-USE OF CCBH ACCOUNT:** Inactive accounts pose a security risk by allowing an opportunity for unauthorized access. Therefore, in order to safeguard protected health information, inactive accounts will be closely monitored. Users who have not used CCBH in 90 days will have their account deactivated.



Support Desk Contact Information

sdhelpdesk@optum.com

1-800-834-3792

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

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.

Additional Contacts

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