MENTAL HEALTH MIS

PROGRESS NOTES

County of San Diego
Behavioral Health Services

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

CONFIDENTIALITY

HIPAA regulations mandate that 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."

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

OVERVIEW OF CLIENT PLANS

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

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

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

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

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

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

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

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

STRUCTURE OF A CLIENT PLAN IN CCBH

Planning Tiers

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

Strengths

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

Area of Need

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

Goal

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

Objectives

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

Interventions

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

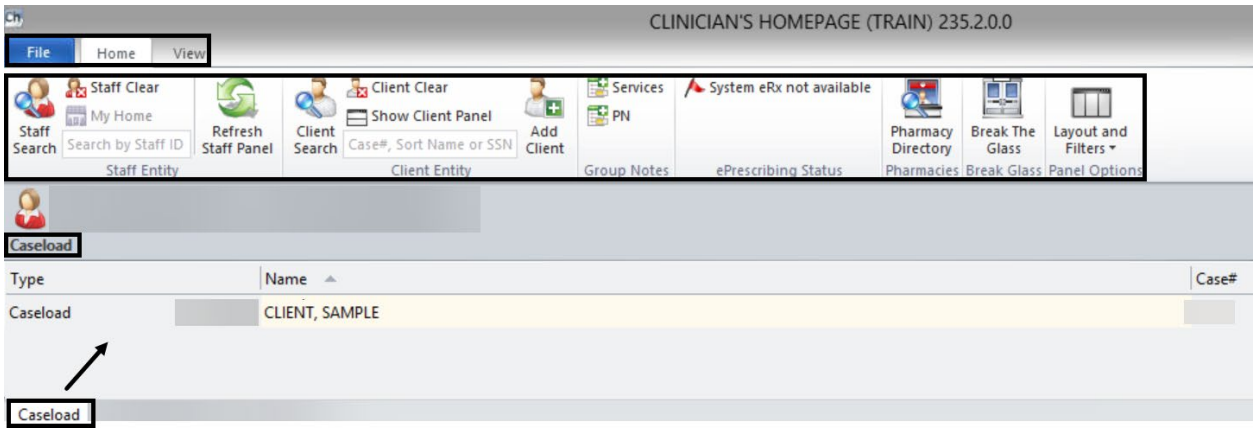
NOTE: It's important to individualize the tier narratives to make the Client Plan reflect the individual client. Avoid "cloned documentation" in the Client Plans!

CCBH SPEAK

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

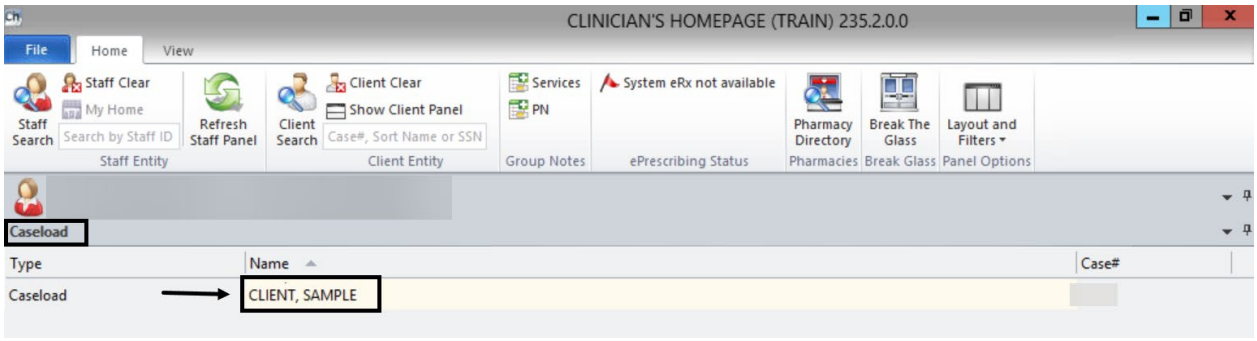
OVERVIEW OF THE CLINICIAN'S HOMEPAGE

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

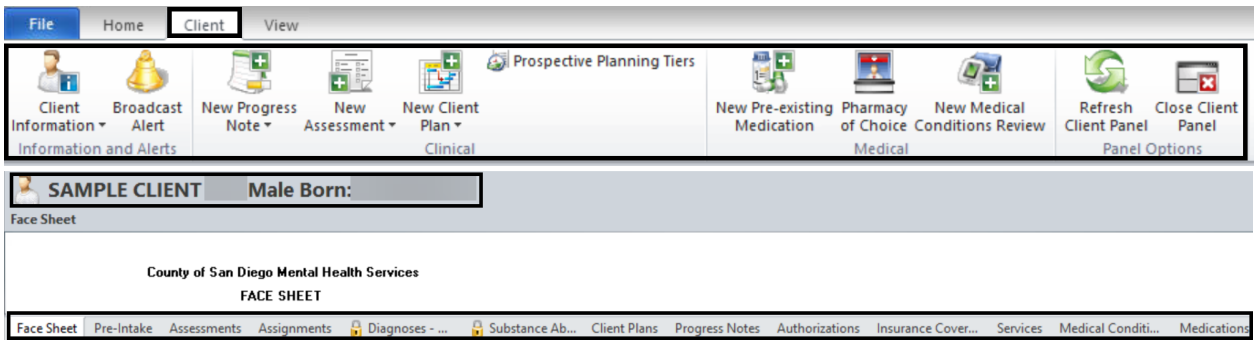


Selecting a Client:

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



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



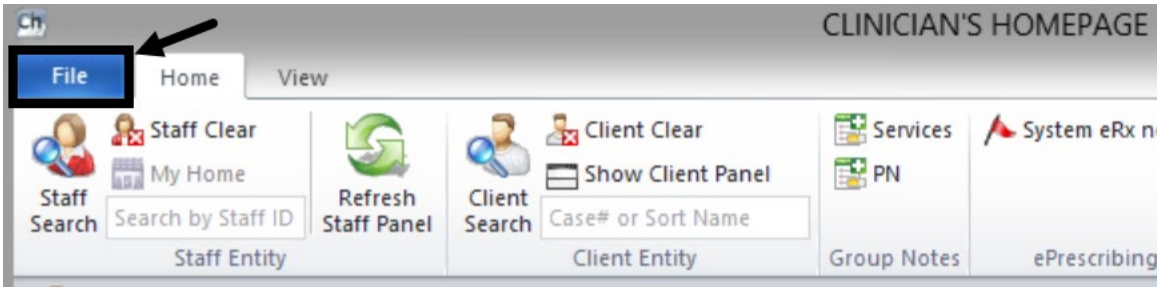
CLINICIAN'S HOMEPAGE PREFERENCES

How to Set Up and Save Preferences

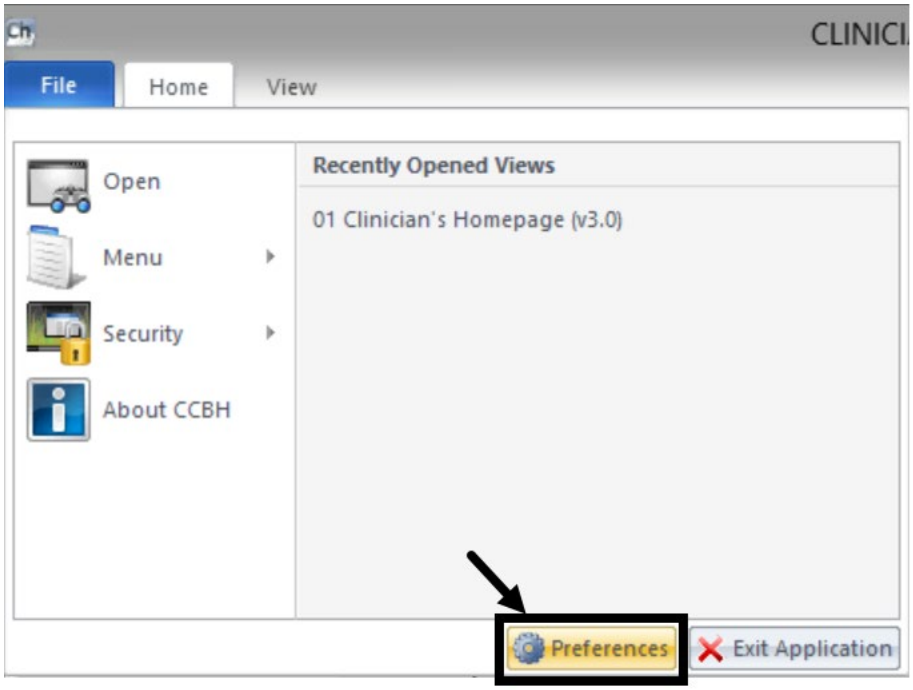
Accessing Preferences:

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

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



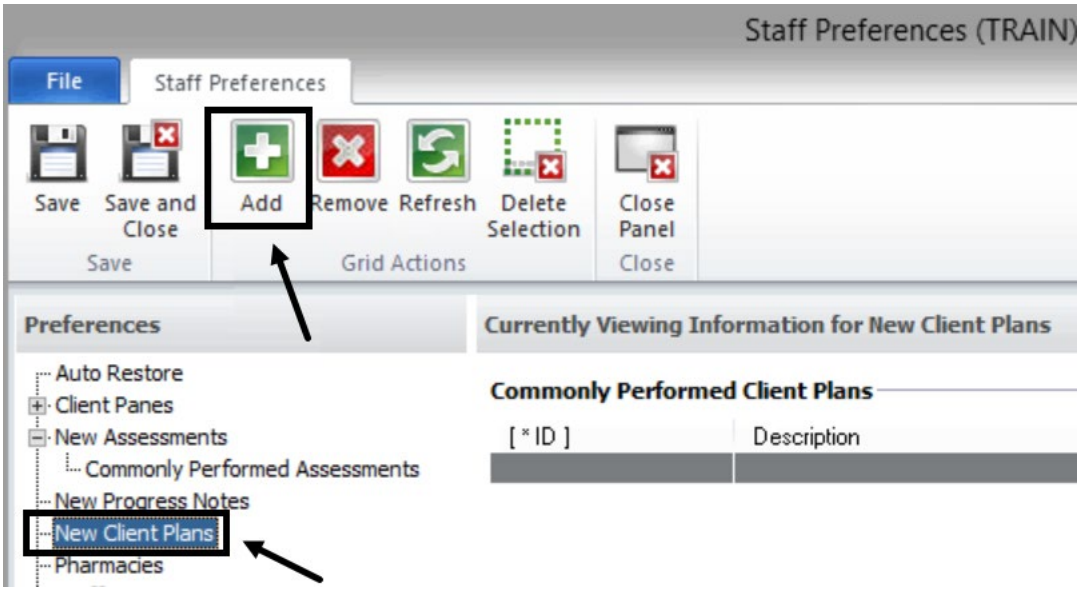
Click **Preferences**.



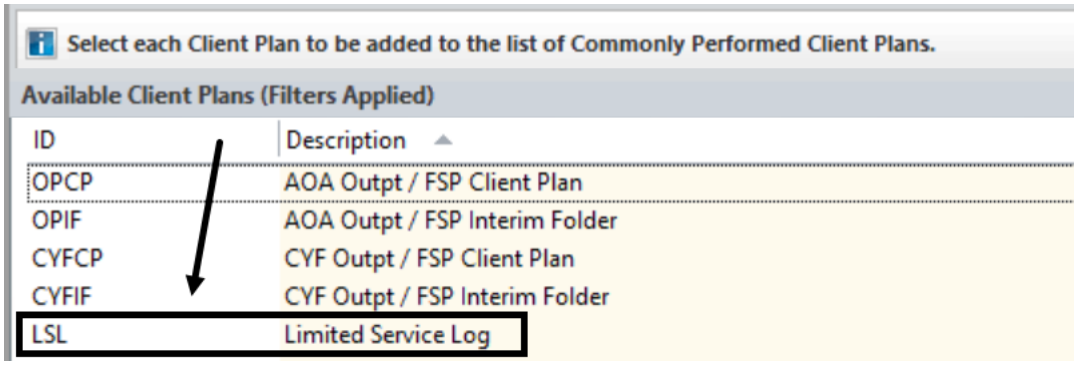
The Staff Preferences menu opens. Continue to the next section for the next steps.

Staff Preferences for Limited Service Log:

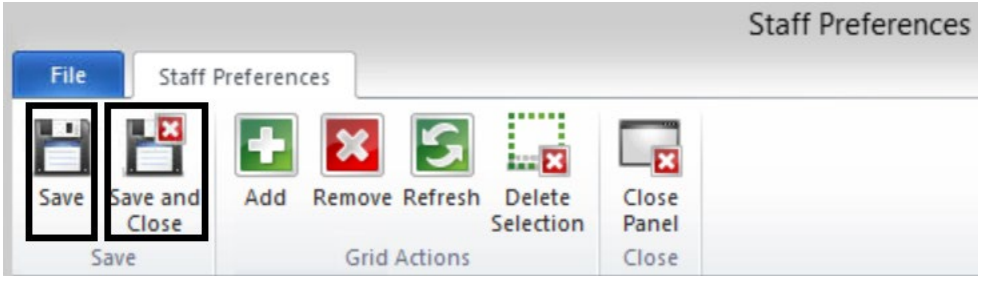
1. From the Staff Preferences window, select **New Client Plans** and click **Add**.



2. The table of Available Client Plans opens. Double click on **Limited Service Log**.

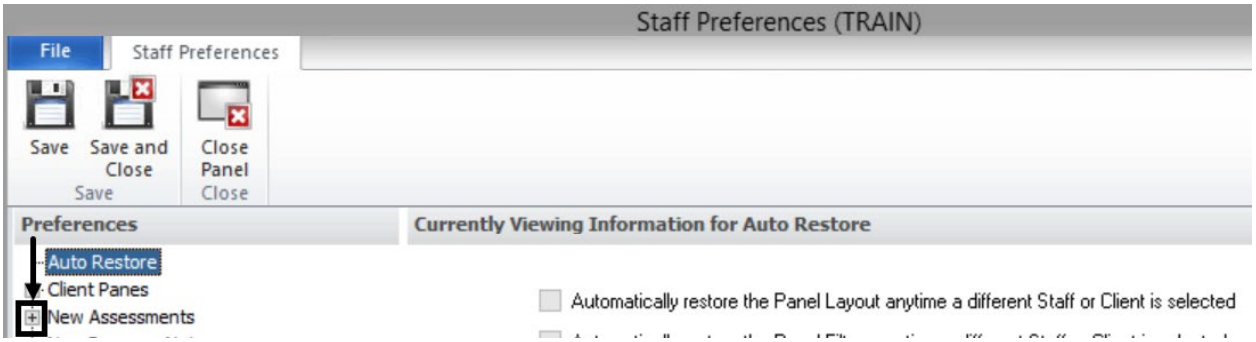


3. To save selection and continue setting up Staff Preferences, click **Save**.
   To save selection and return to the Clinician's Homepage, click **Save and Close**.

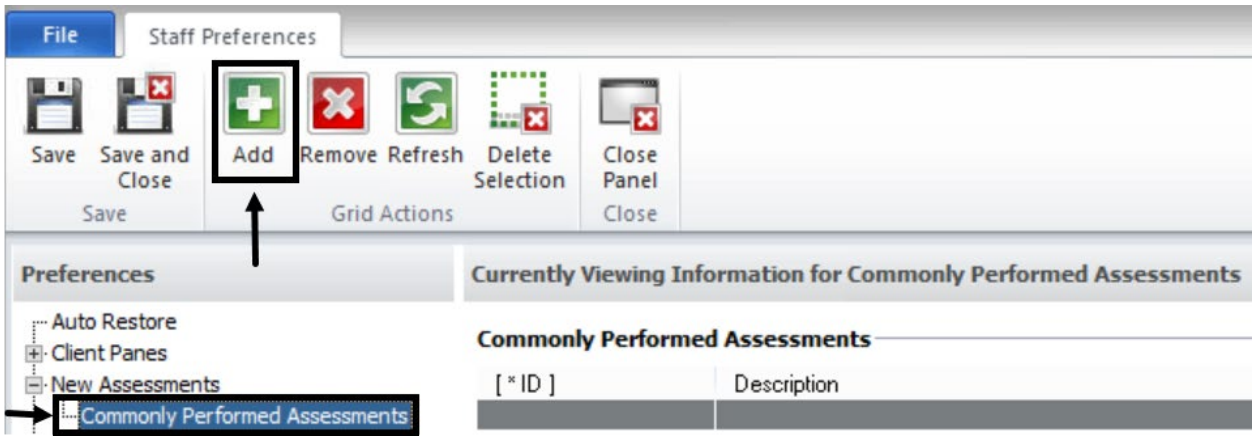


Staff Preferences for Problem List:

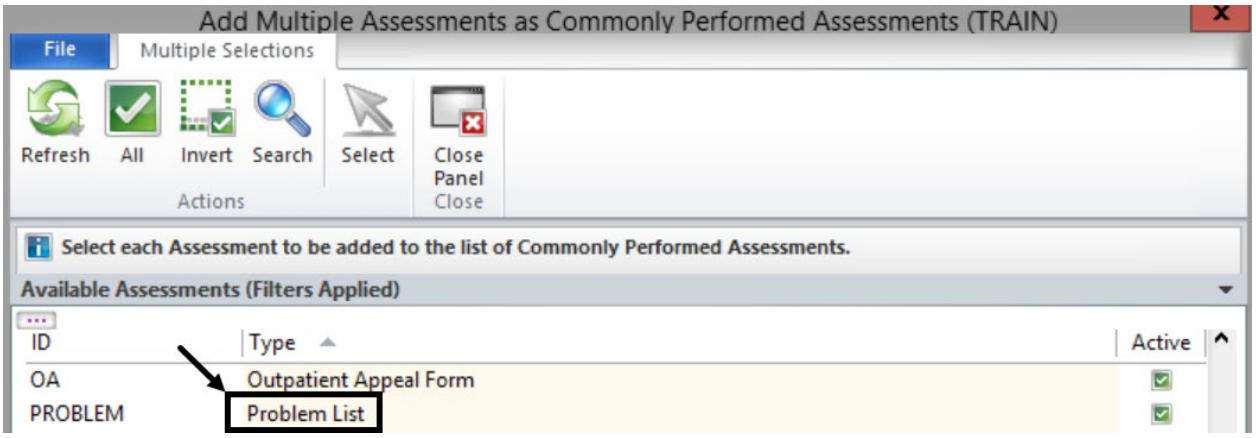
1. At the Staff Preferences window, click the **+** sign to the left of New Assessments.



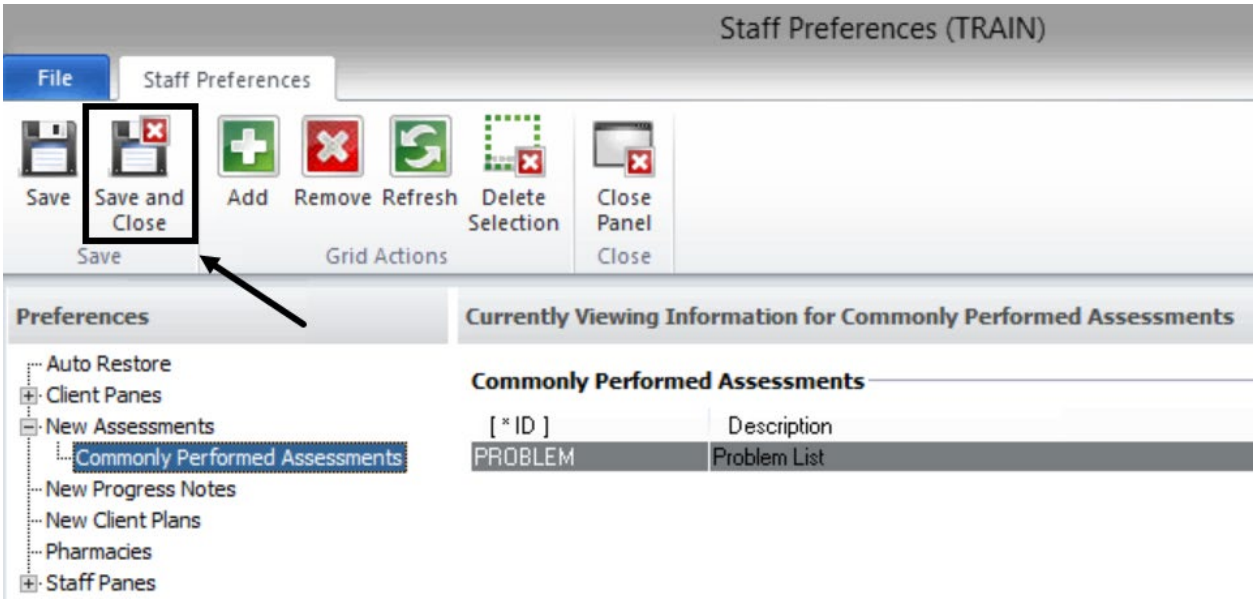
2. Click **Commonly Performed Assessments** and **Add.**



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



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



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

NOTES

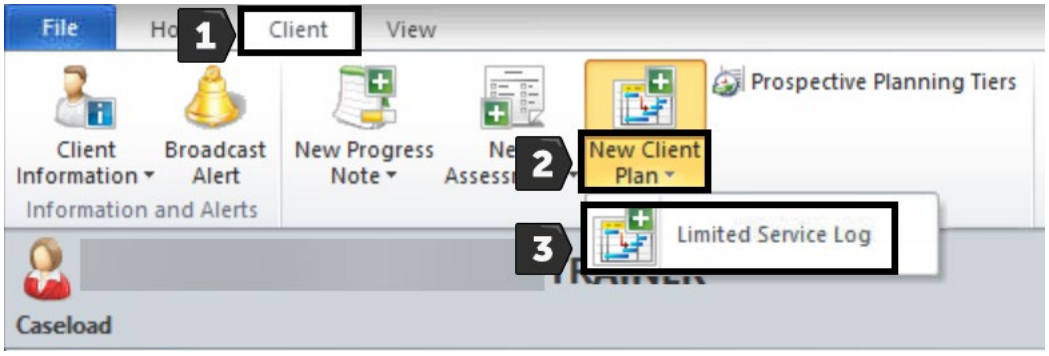
LIMITED SERVICE LOG

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

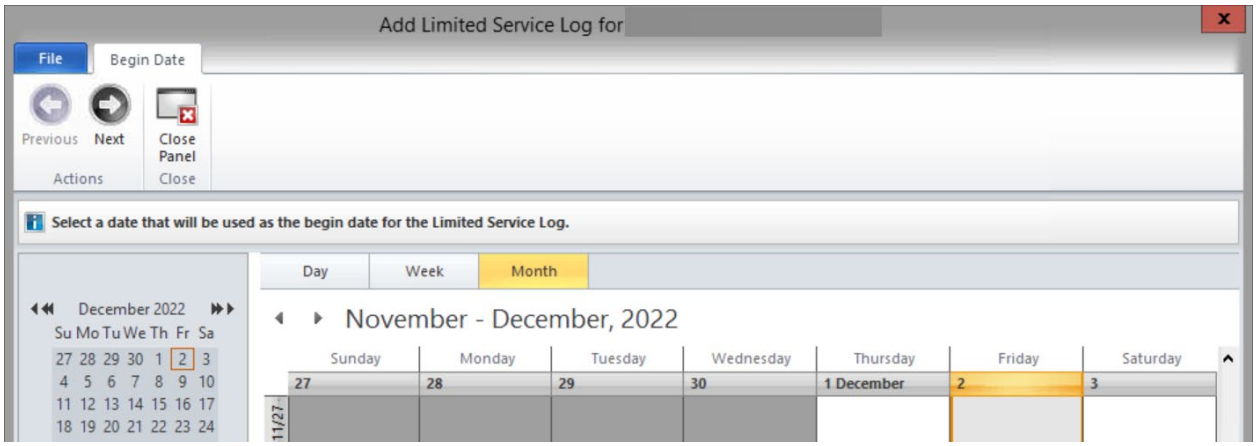
Adding a Limited Service Log:

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

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



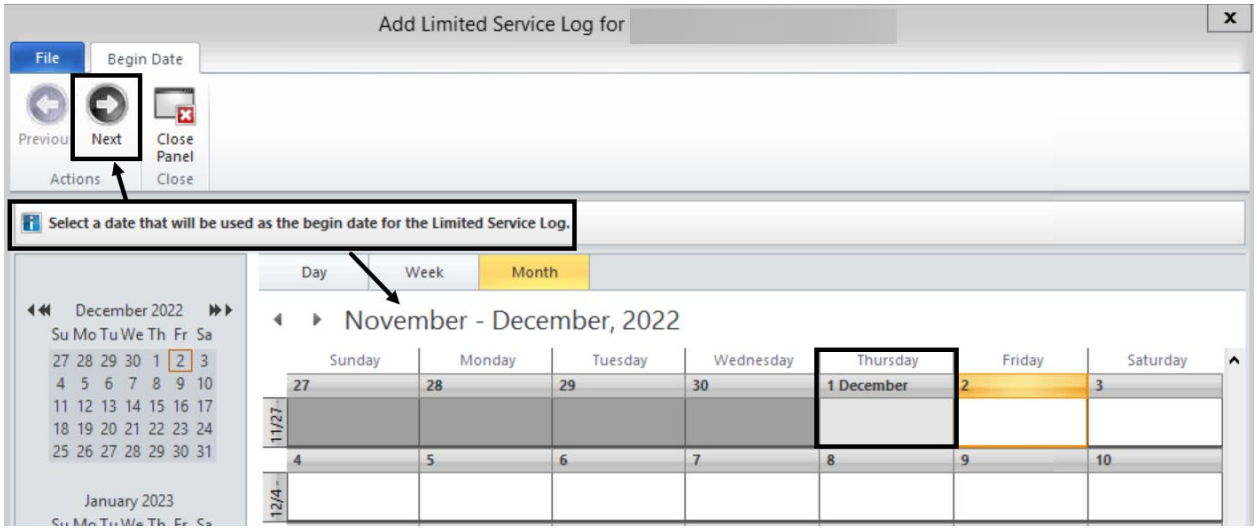
The Limited Service Log launches and opens up the calendar.



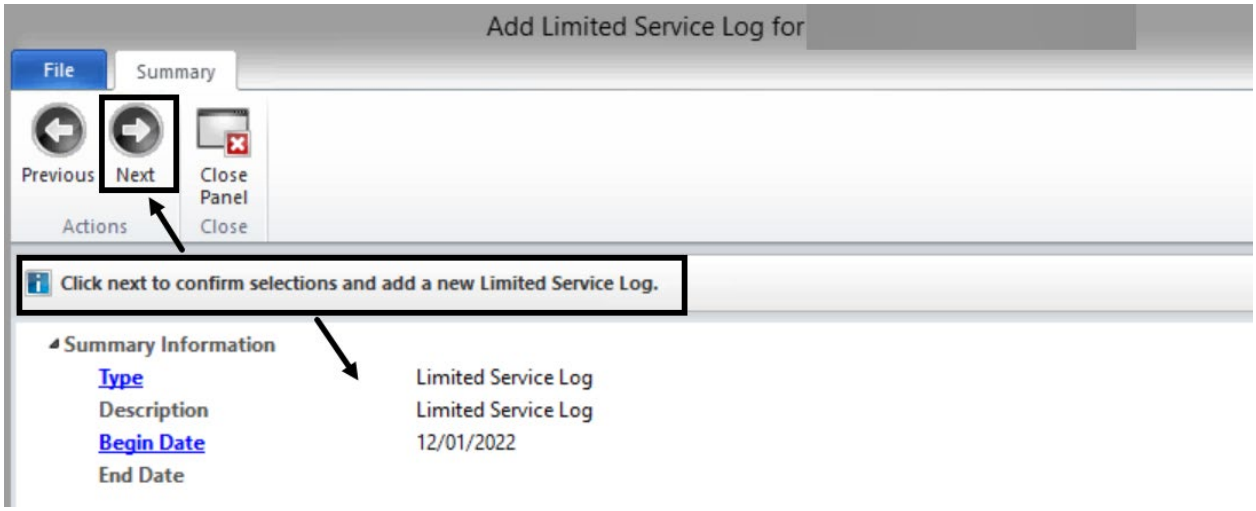
Selecting a Begin Date:

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

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

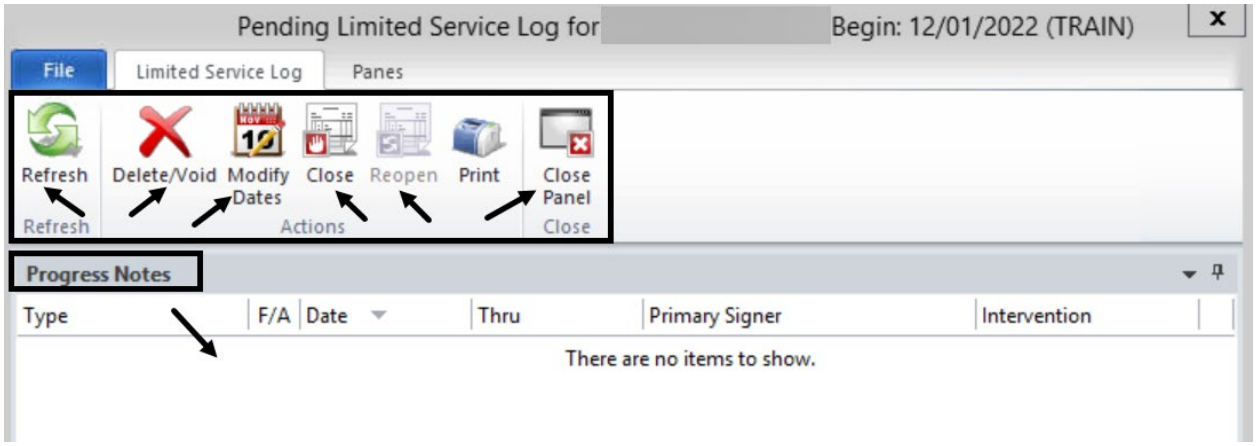


3. Confirm that the selections made are accurate and click **Next**.



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

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



Refresh clears the information being displayed in the LSL folder.

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

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

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

Print is not used by the System of Care.

Close Panel is to close out of the LSL window.

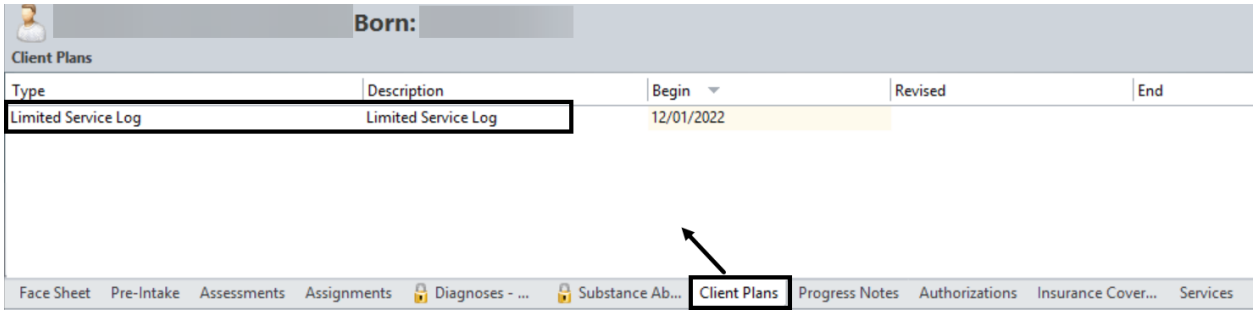
Note: Once a Progress Note is entered, the Limited Service Log cannot be deleted or voided. Contact the Support Desk to delete or void the folder.

NOTES

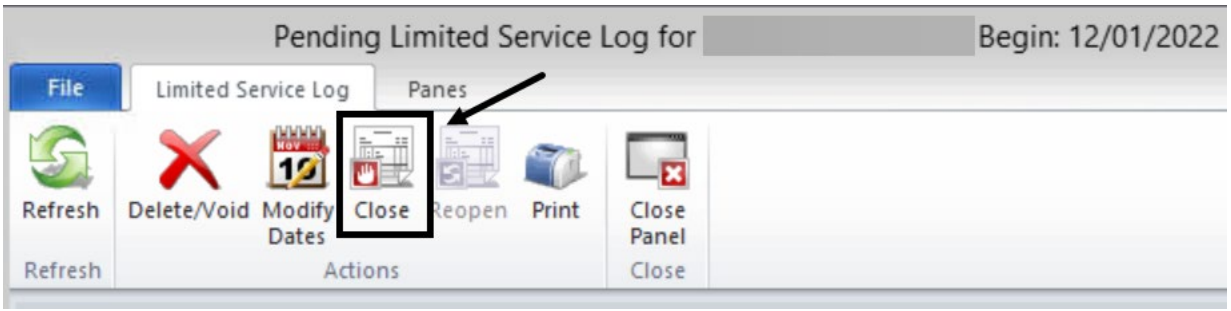
Closing a Limited Service Log:

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

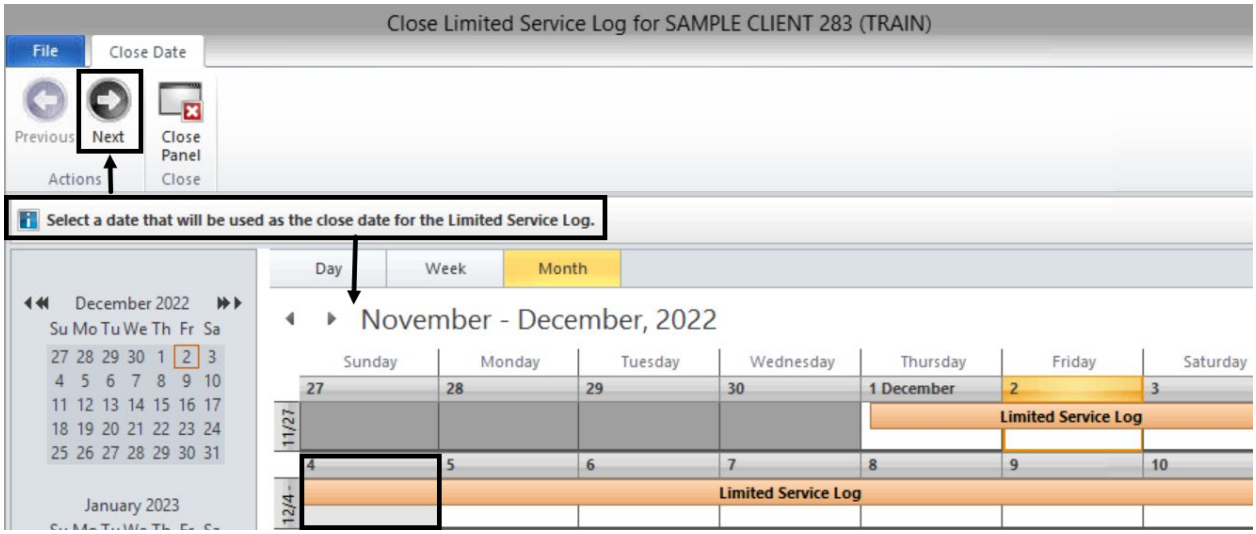
To close the LSL, launch it first by double clicking on it in the Client Plans pane.



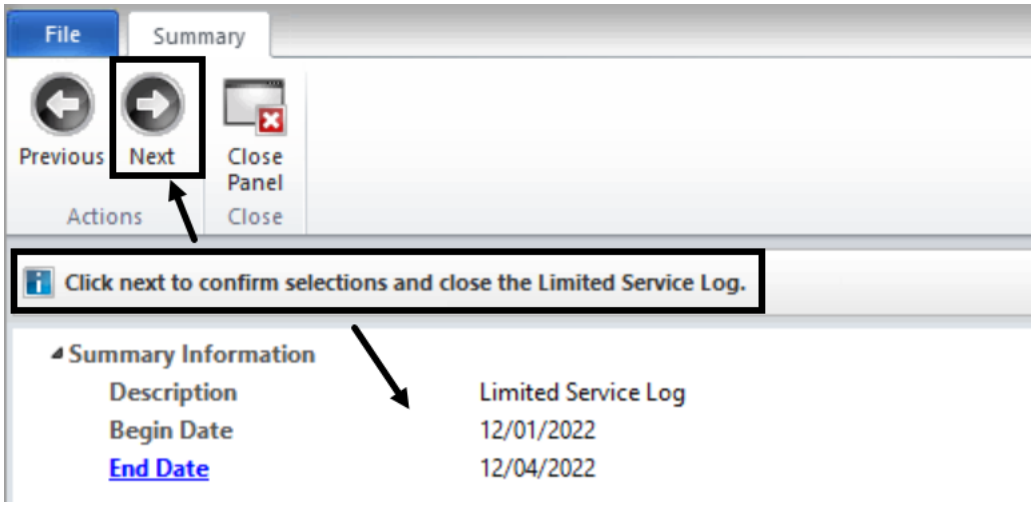
Once the pending LSL folder is launched, click **Close**.



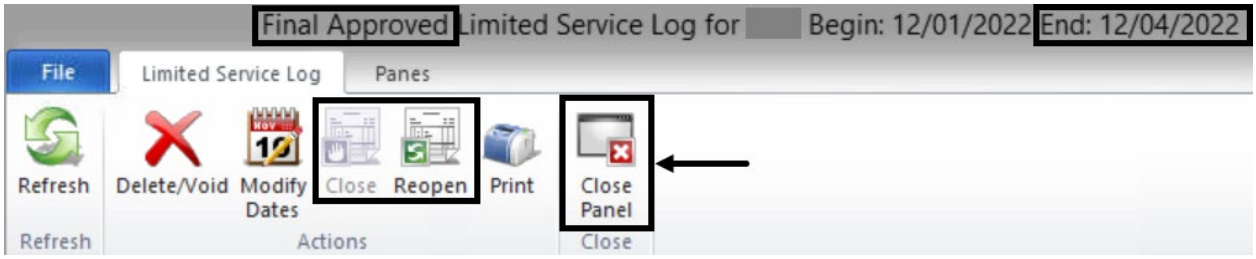
Single click the appropriate close date on the large calendar, and click **Next**.



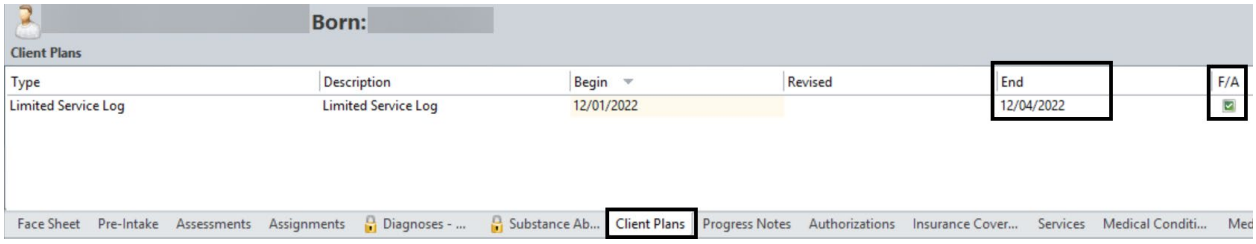
Verify the accuracy of the selected close date. If the close date selected is incorrect, click Previous or the End Date link. To confirm selection, click **Next**.



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



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

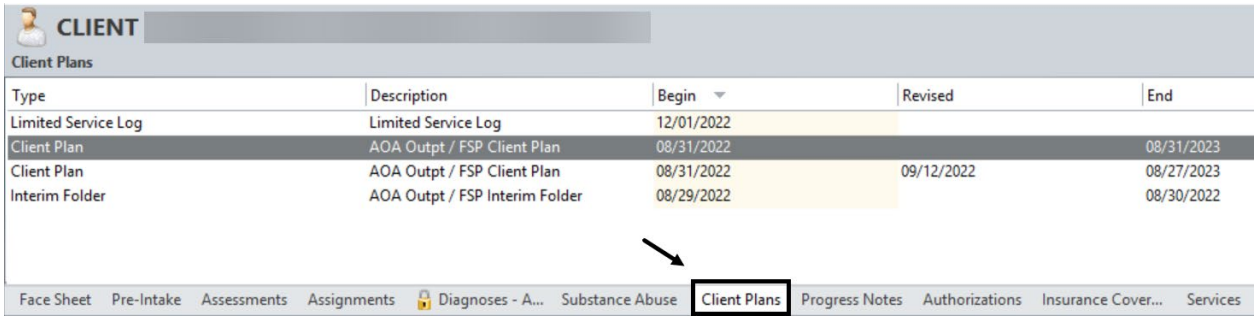


*Note: The **Close** button allows a close date to be added to the Limited Service Log. The **Close Panel** button closes the screen and returns user to the Clinician's Homepage.*

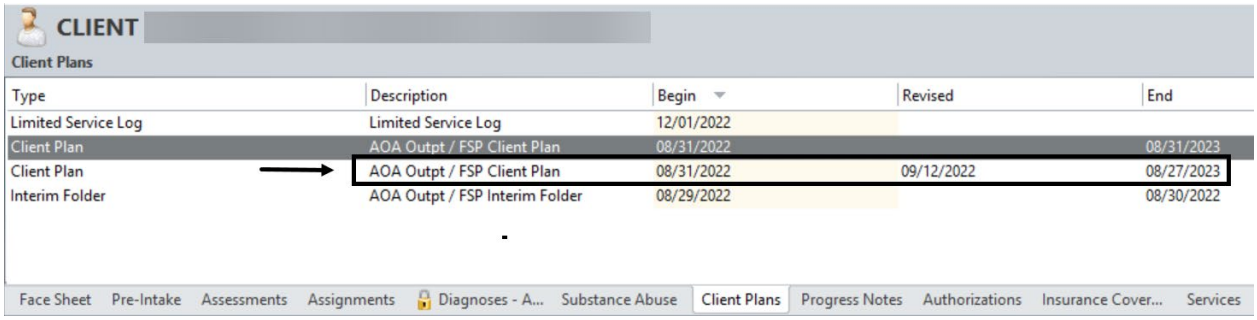
CLIENT PLANS DISPLAY

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

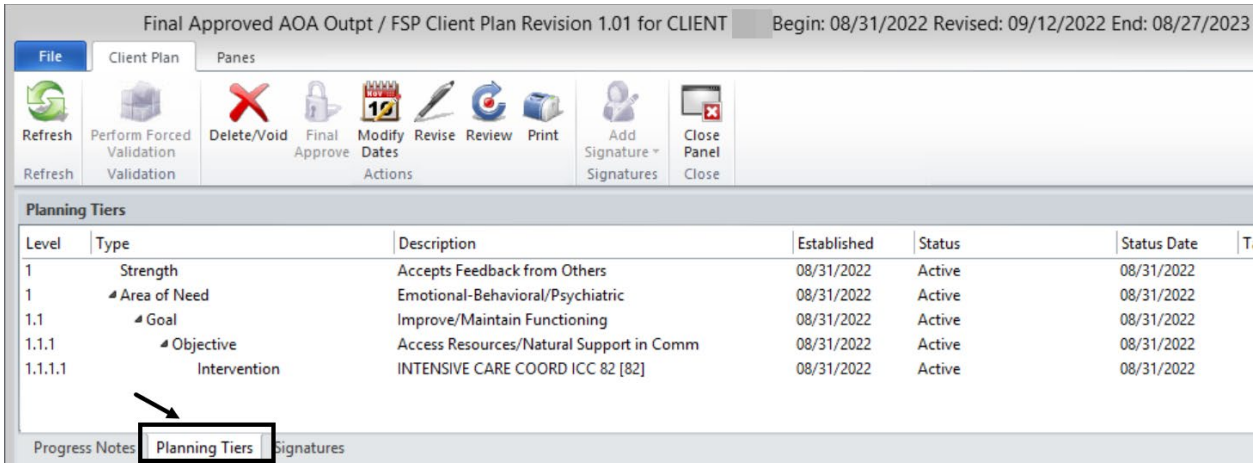
1. On the Client panel, single click on the **Client Plans** pane.



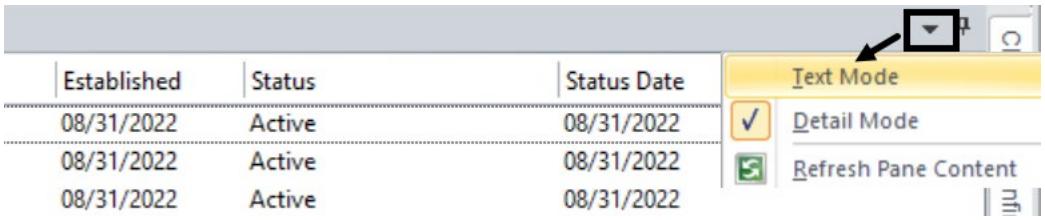
2. To open and view the selected client plan, double click on it.



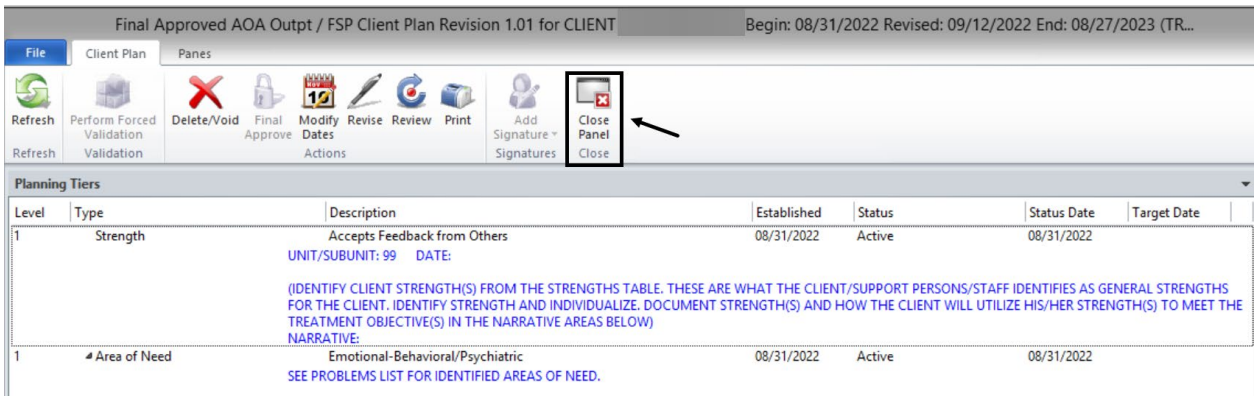
3. To view all the planning tiers, click the **Planning Tiers** pane.



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



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

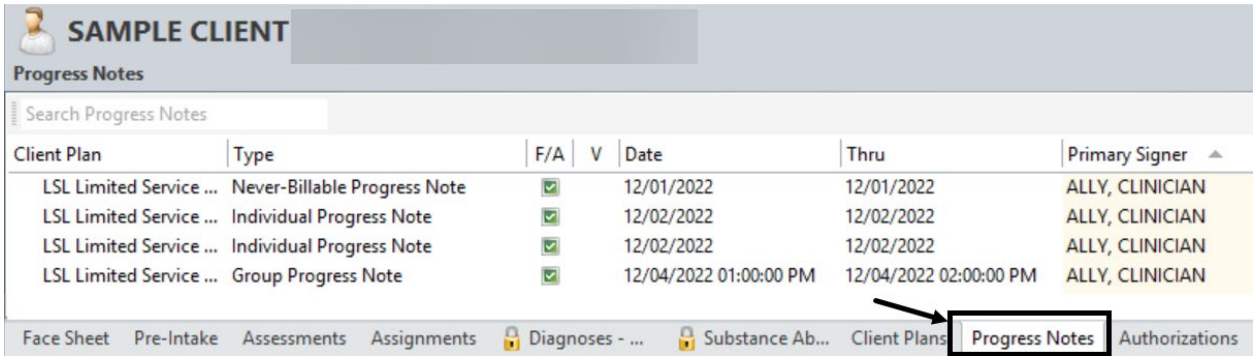


NOTES

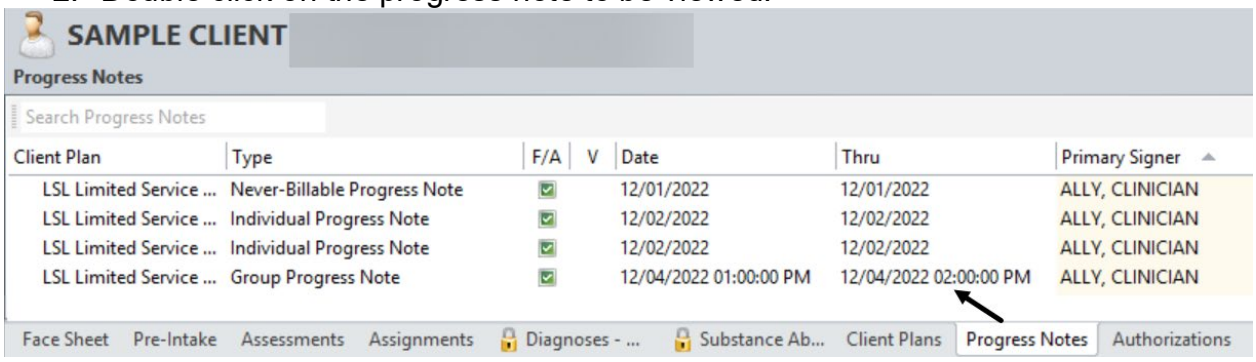
PROGRESS NOTES DISPLAY

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

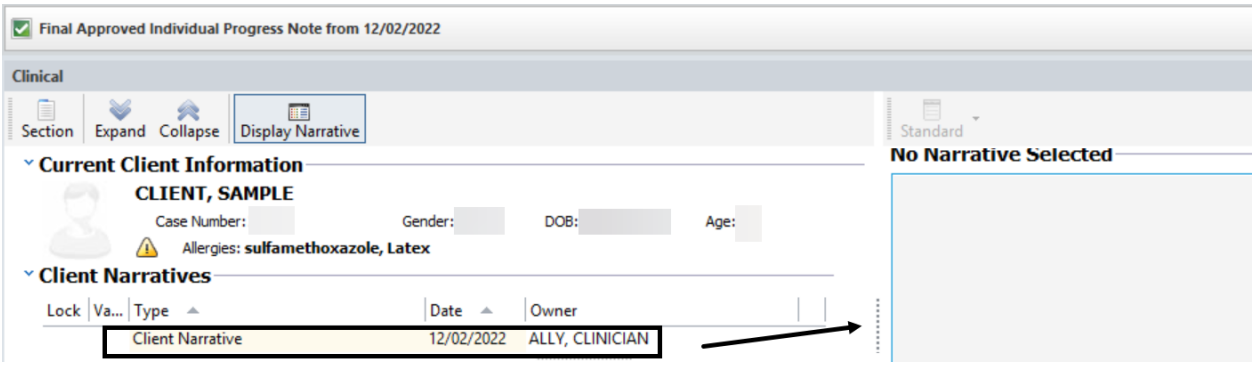
1. On the Client panel, single click on the **Progress Notes** pane.



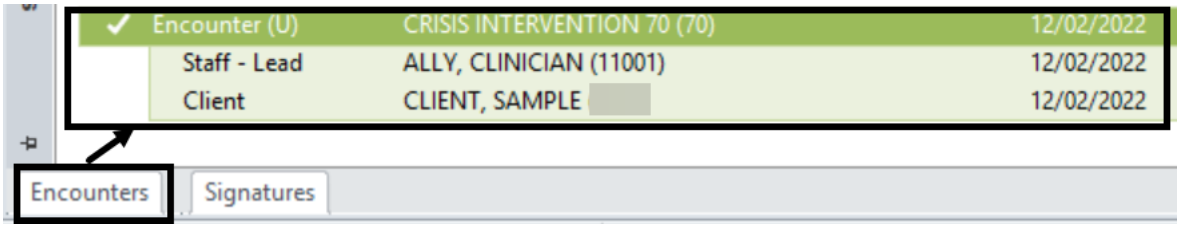
2. Double click on the progress note to be viewed.



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

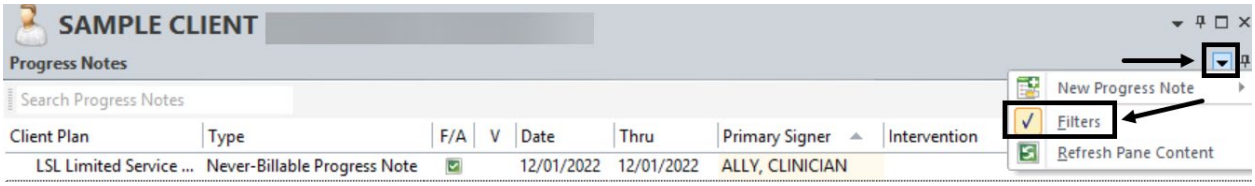


4. Click **Encounters** and double click on the encounter to view the service details.

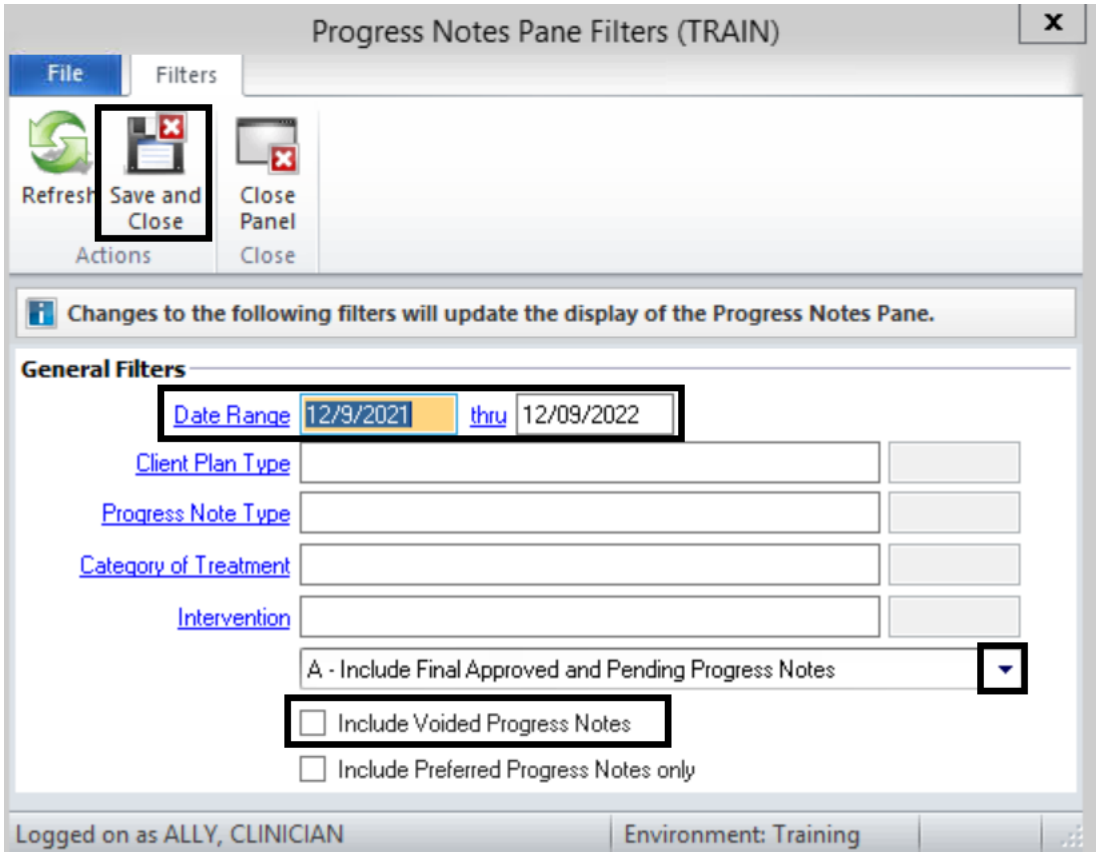


Progress Note Filters:

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



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



INFORMATIONAL PROGRESS NOTES

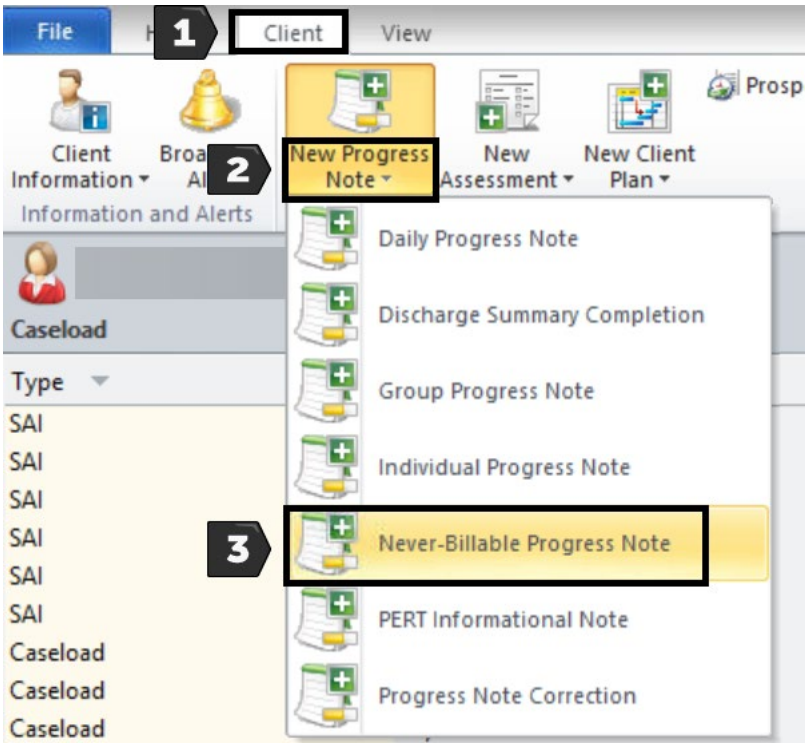
Informational Progress Notes are used when a not-billable activity is provided. The services documented in these notes are not connected to the client plan and no billing is generated. These notes are also used to record billing errors. Below are the types of Informational Progress Notes:

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

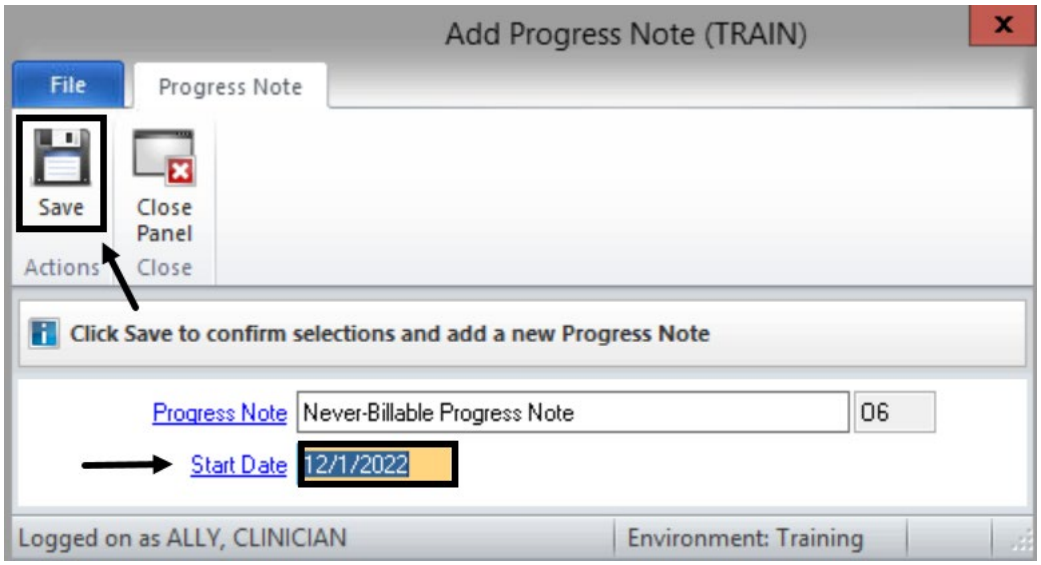
Adding an Informational Progress Note:

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

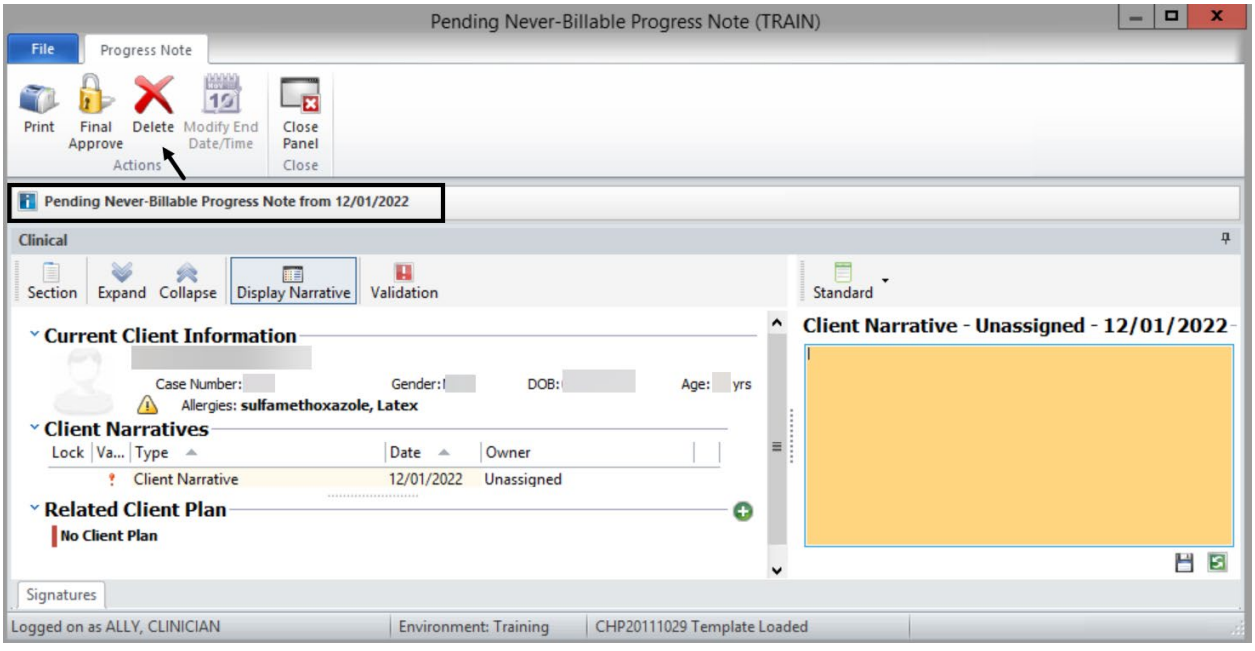
1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
2. Find the **New Progress Note** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the available notes. Click the words **New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



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



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

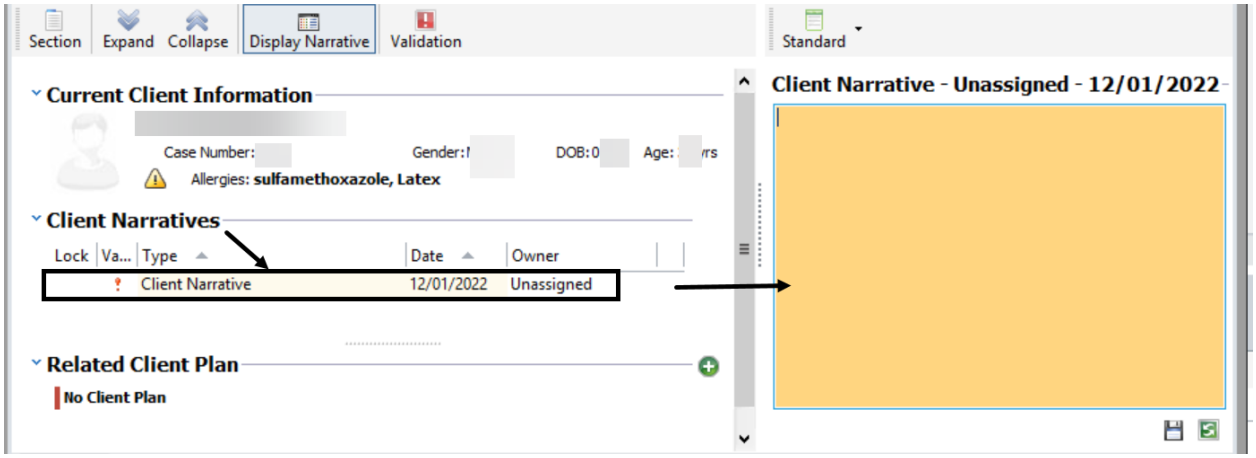


*Note: The **Start Date** cannot be changed once Save is selected. If the date is not correct and the note is still pending, delete the note and start all over. If the date is not correct and the note has been final approved, contact the Support Desk for assistance.*

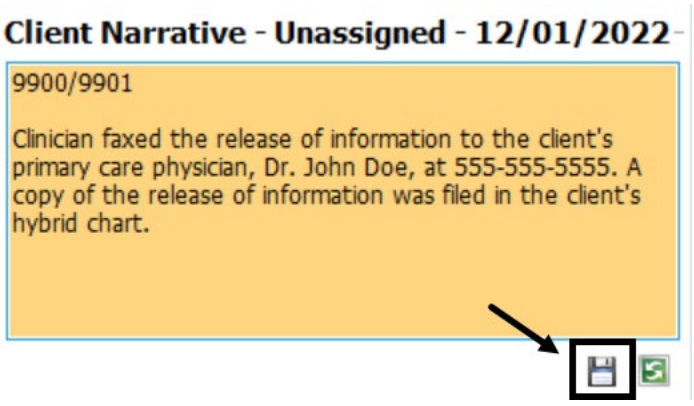
Client Narratives:

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

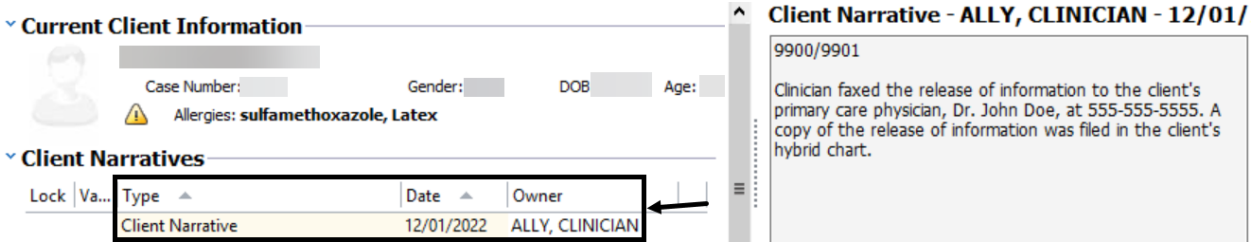
1. Enter the narrative, starting with the program's unit/subunit identification number.



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



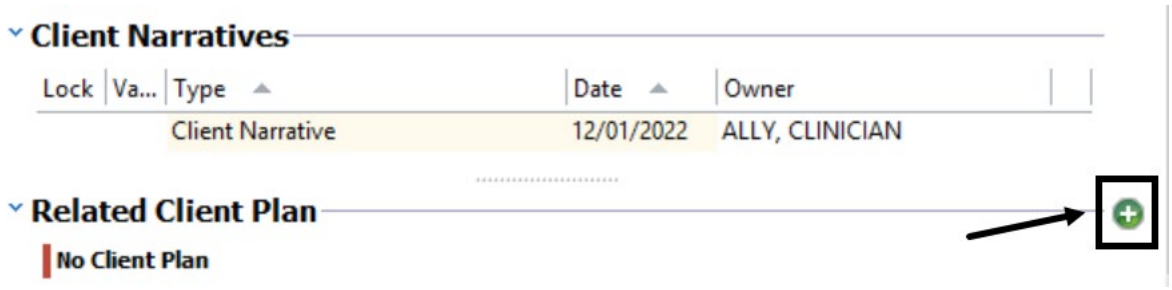
The staff will appear as Owner of the note, and the Client Narrative box is grayed out. To update the narrative, double click anywhere on the Client Narrative line.



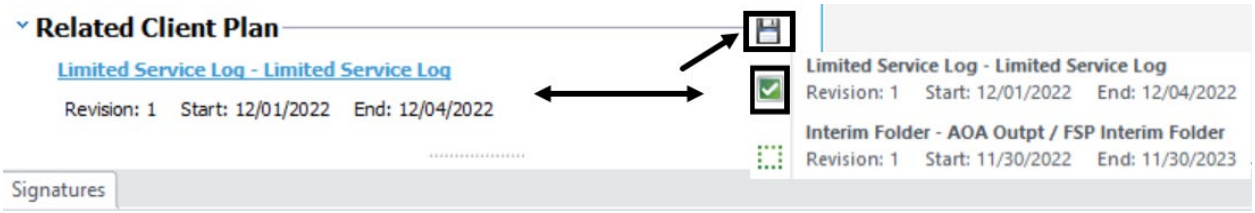
Related Client Plan:

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

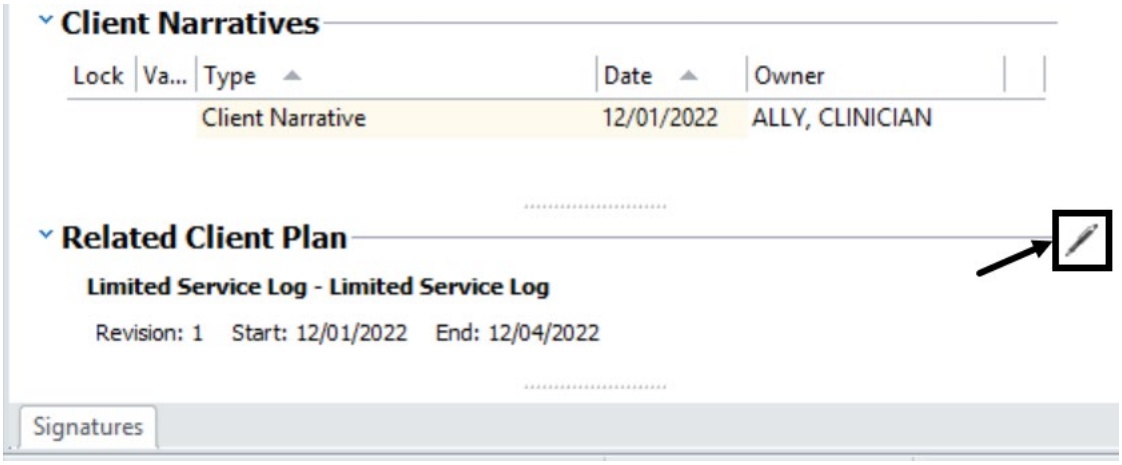
1. To link a client plan to the note, click the green plus sign .



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



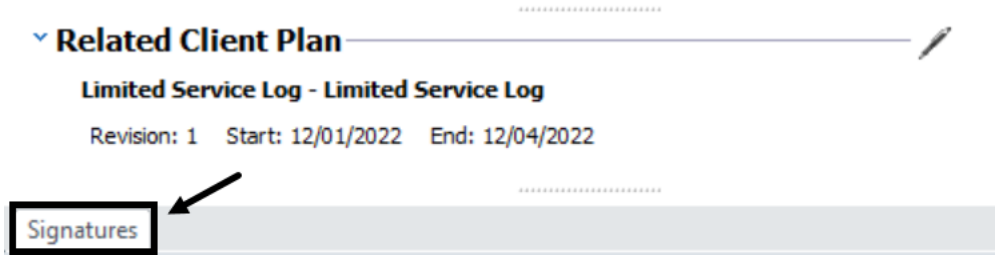
Once the selection is saved, the selected related client plan is grayed out and the Save icon is replaced by a Pen icon. If the plan selected is not correct, click on the **Pen**, then click the client plan link. Start the selection again.



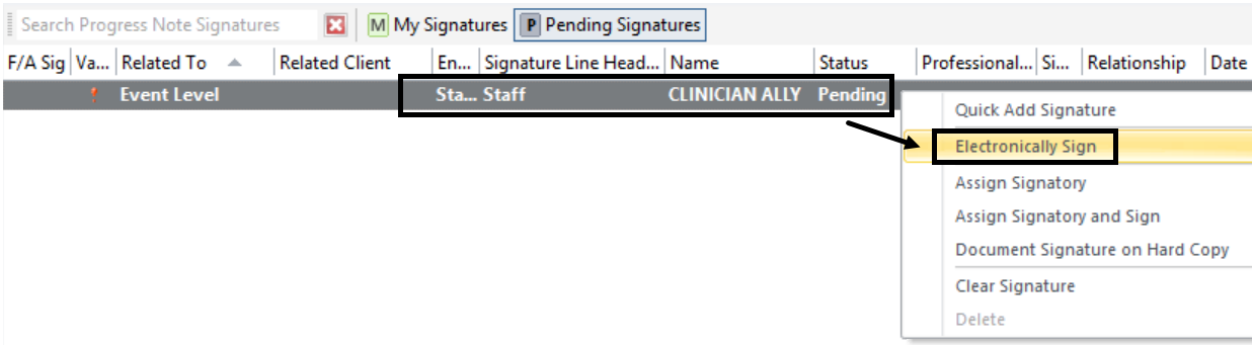
Signatures:

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

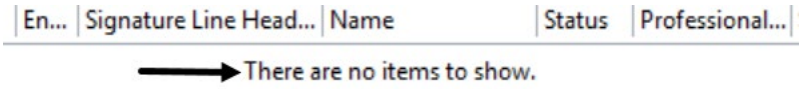
1. At the bottom left of the note, click **Signatures**.



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

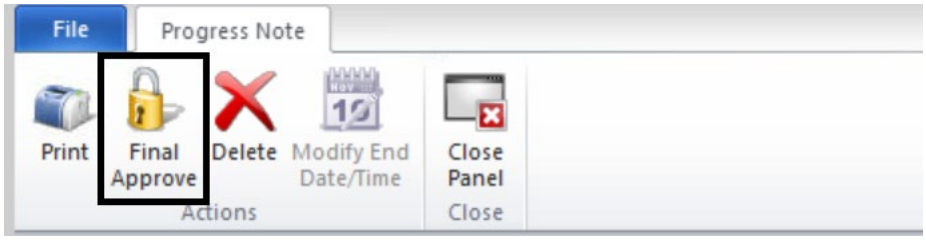


The 'There are no items to show' message will appear once the note is signed.



Final Approve:

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



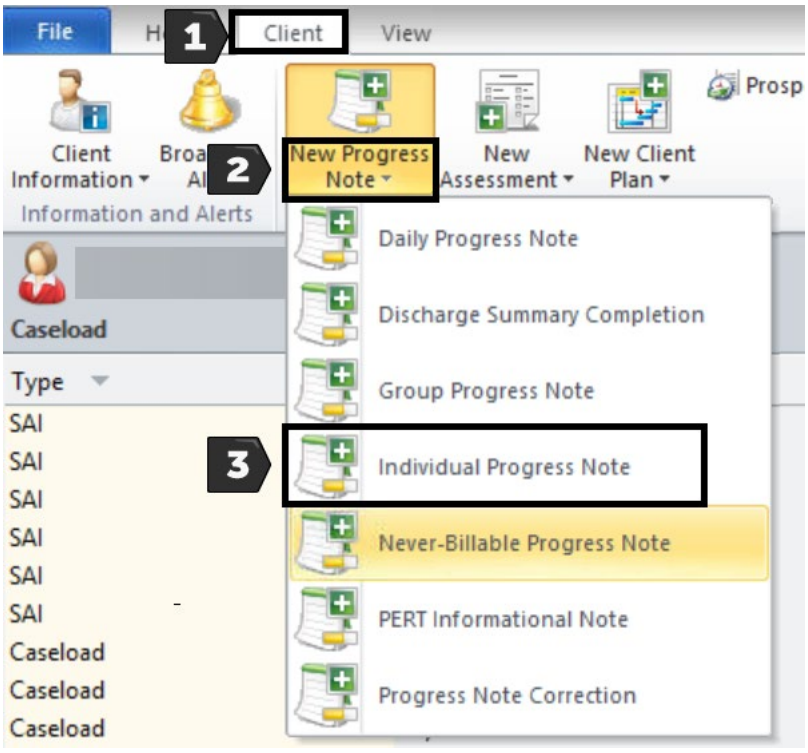
INDIVIDUAL PROGRESS NOTES

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

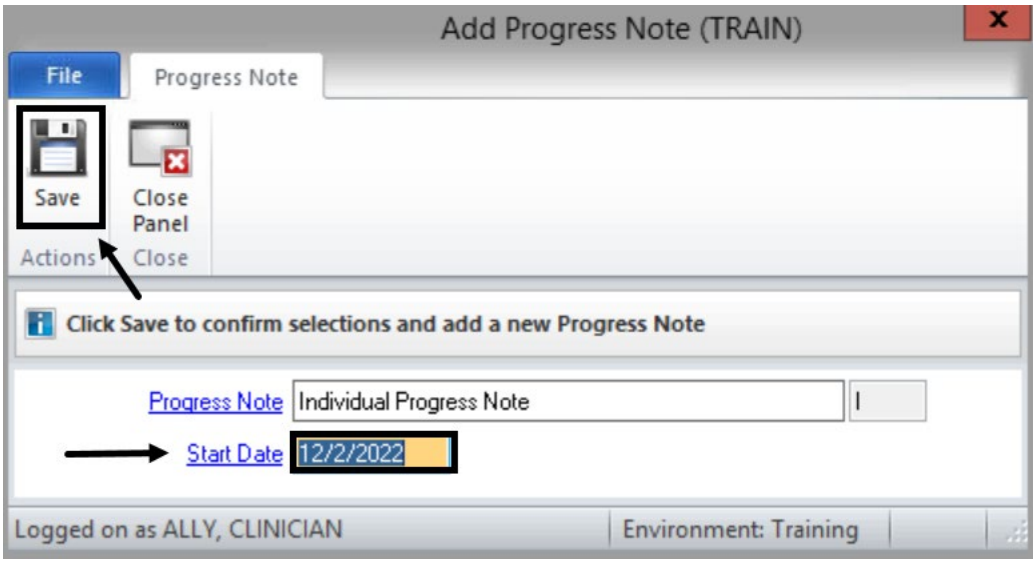
Adding an Individual Progress Note:

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

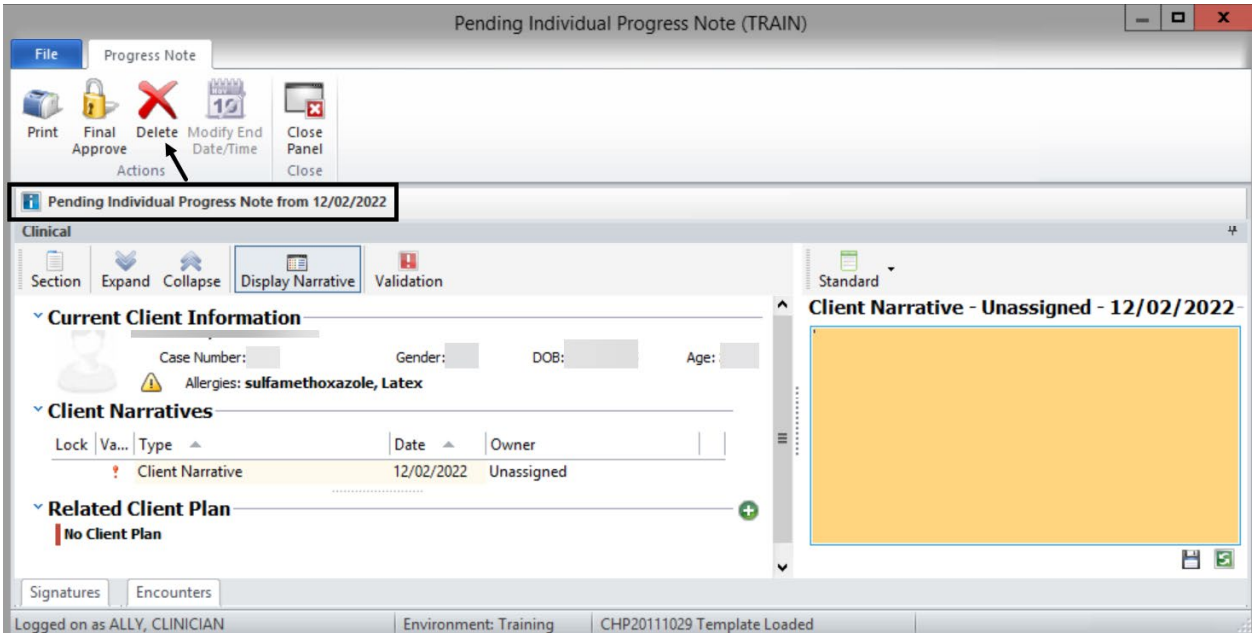
1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
2. Find the **New Progress Note** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the available notes. Click the words **New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



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



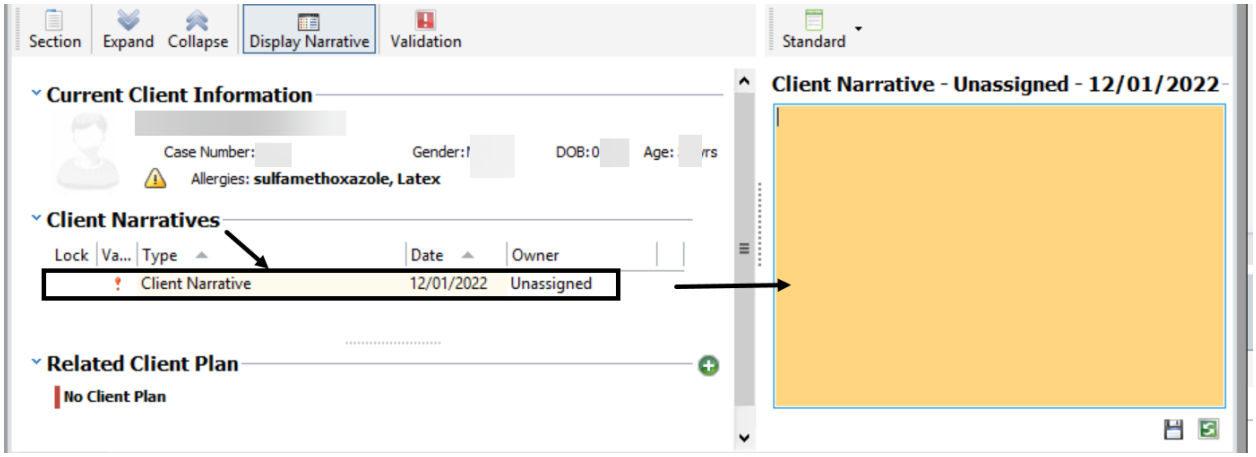
The Pending Individual Progress Note launches. Verify the date for the progress note. If the date is not correct, select Delete and start again.



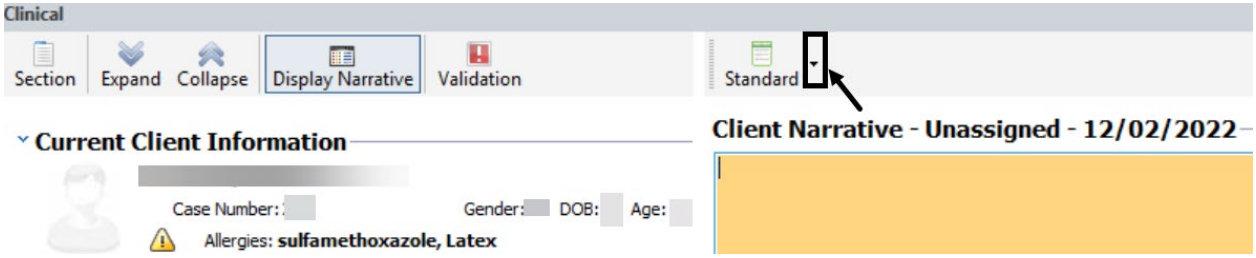
*Note: The **Start Date** cannot be changed once Save is selected. If the date is not correct and the note is still pending, delete the note and start all over. If the date is not correct and the note has been final approved, contact the Support Desk for assistance.*

Client Narratives:

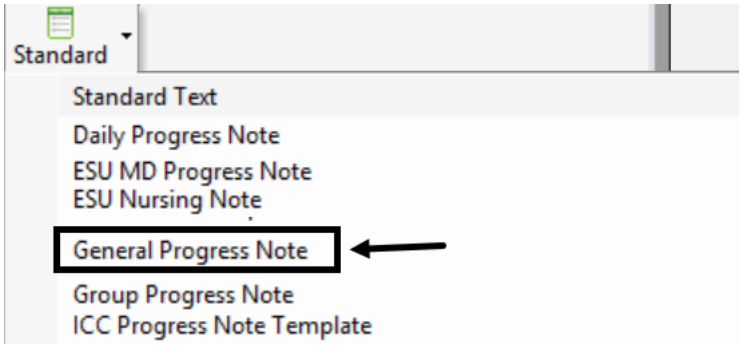
The Client Narrative box opens in yellow. This means the section is active, and narratives can be entered. If the section is not yellow, **double click** anywhere on the Client Narratives line located to the left of the Client Narrative box.



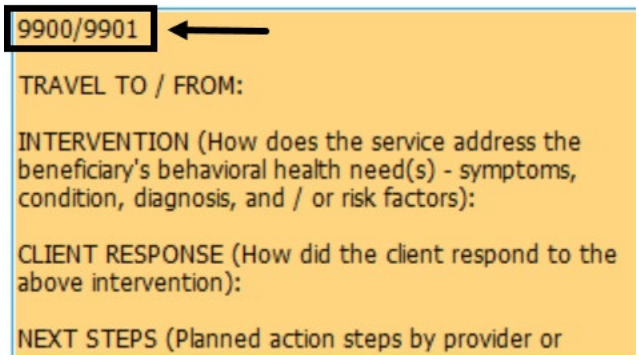
1. To use a standard text template client narrative, click on the down arrow next to the Standard button, which is right above the Client Narrative box.



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

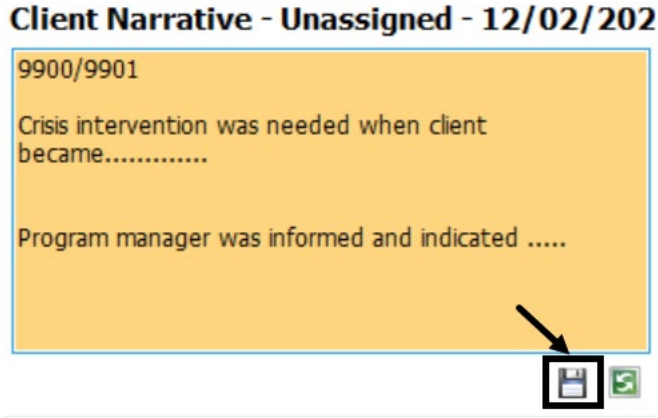


3. The standard text template is loaded into the Client Narrative box. Follow the prompts and apply clinical judgment in completing the narrative. Always start the narrative with the program's unit/subunit identification number.

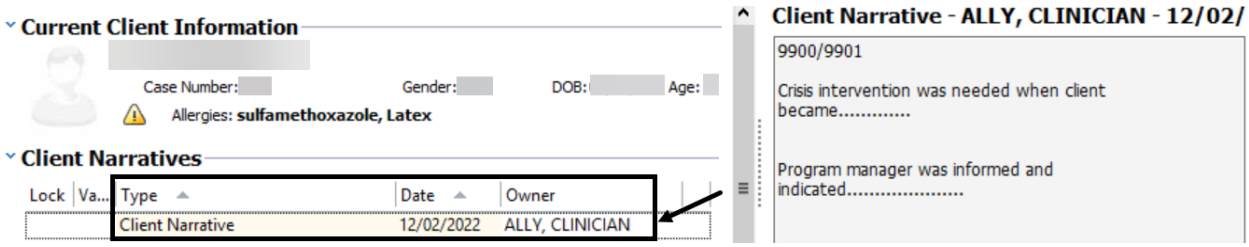


Skip Steps 1 and 2 above if a ***free flowing text***, instead of a standard text template, will be entered. Applying the same sound clinical principles, start the narrative with the program's unit/subunit identification number.

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



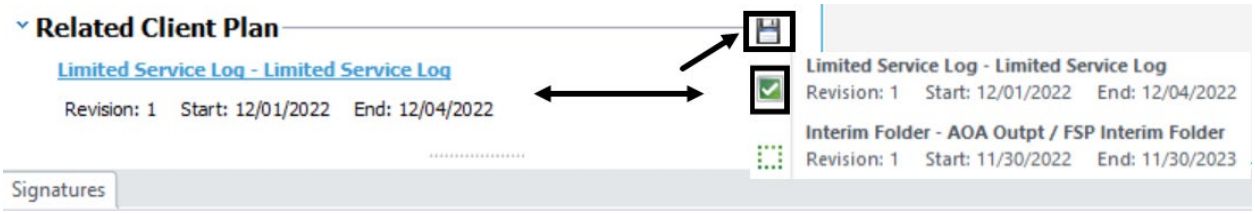
The staff will appear as the Owner of the note, and the Client Narrative is grayed out. To update the narrative, double click anywhere on the Client Narrative line.



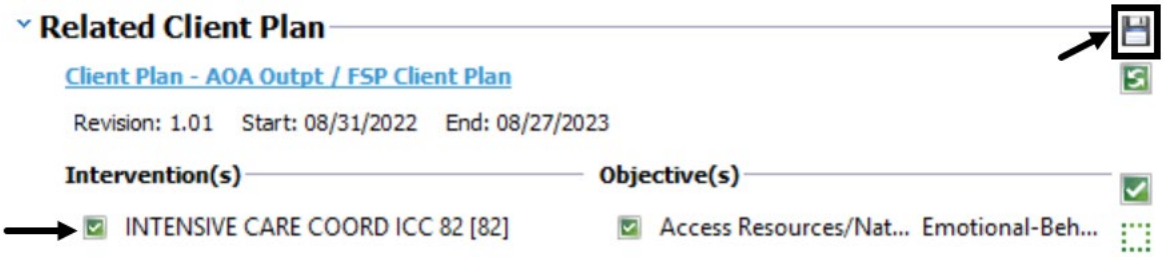
Related Client Plan:

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

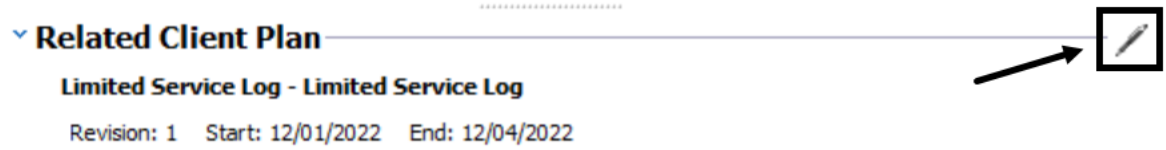
2. If there is only one client plan available, it will autopopulate. Click **Save**.
   If there are multiple plans, select the appropriate plan from the list and click **Save**.



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



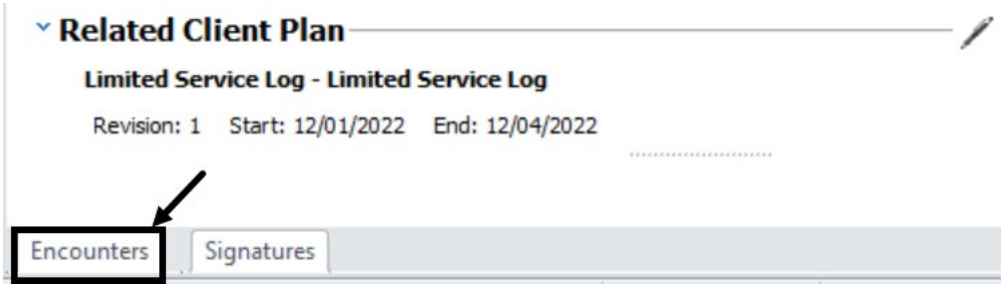
Once the selection is saved, the selected related client plan is grayed out and the Save icon is replaced by a Pen icon. If the plan selected is not correct, click on the **Pen**. Click the blue link to the Client Plan, and start the selection again.



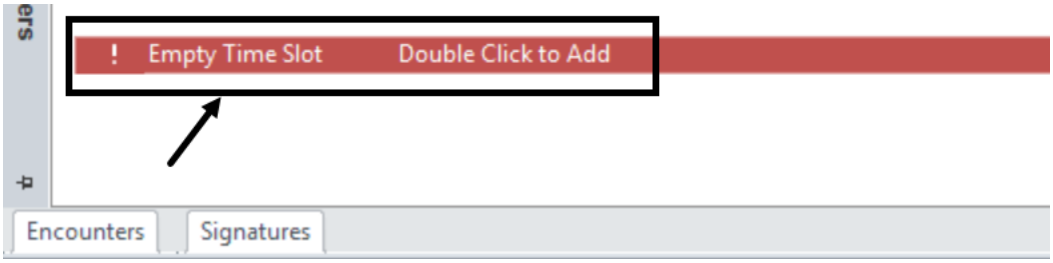
*Note: If the Intervention is on the Client Plan but is not selected in the Progress Note, the encounter will be considered **Unplanned**.*

Encounters:

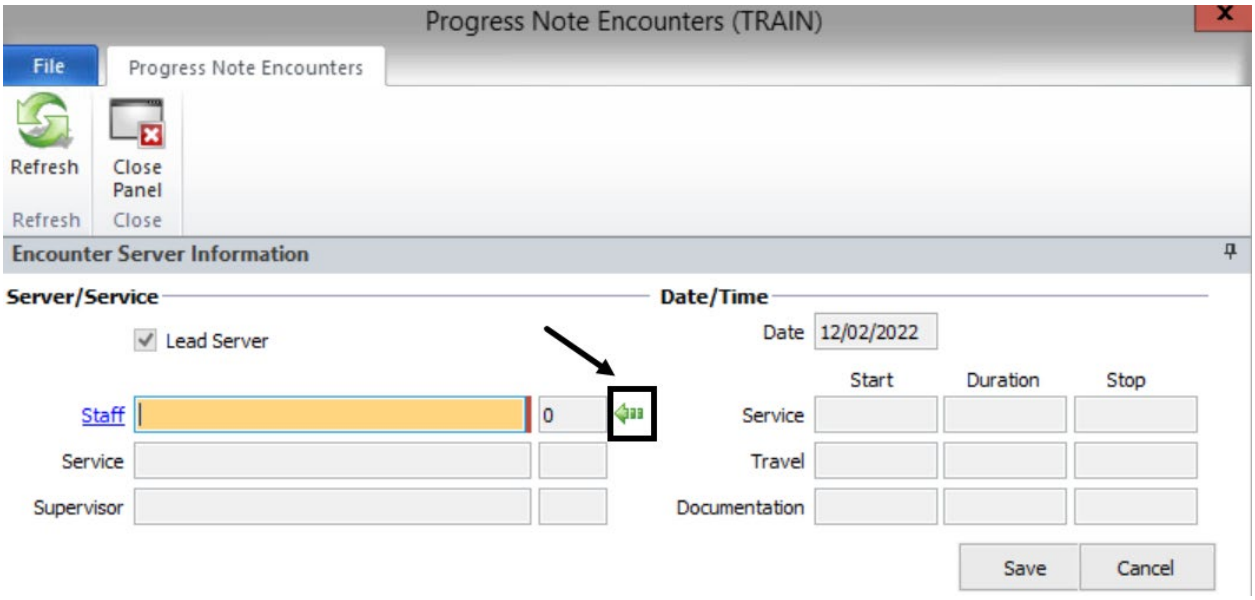
1. To enter the service encounter for this note, click **Encounters**.



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

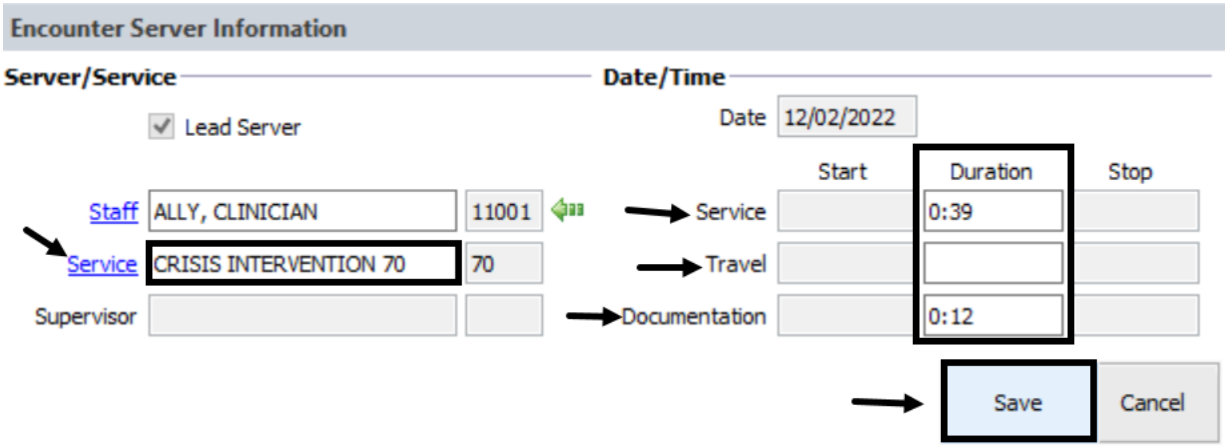


3. In the Server/Service section, click the green left arrow to autopopulate the Staff name. The Staff name can be manually entered as well.

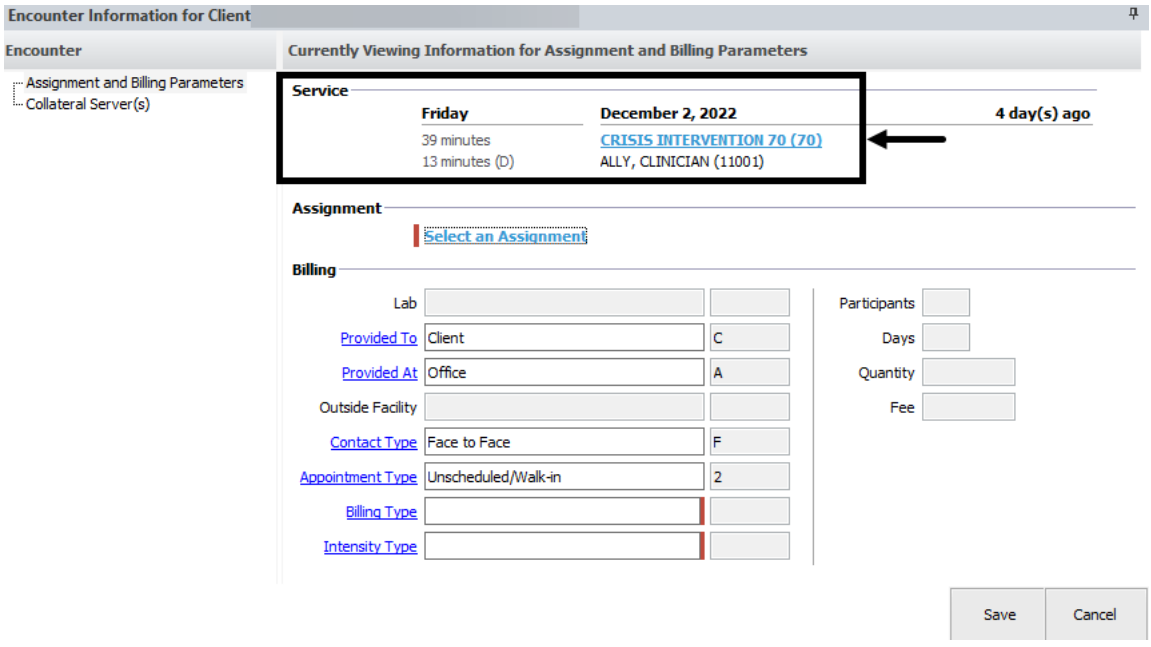


After the server is selected, the Service fields are activated for data entry. The populated Date and Lead Server fields are both grayed out and read only.

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



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

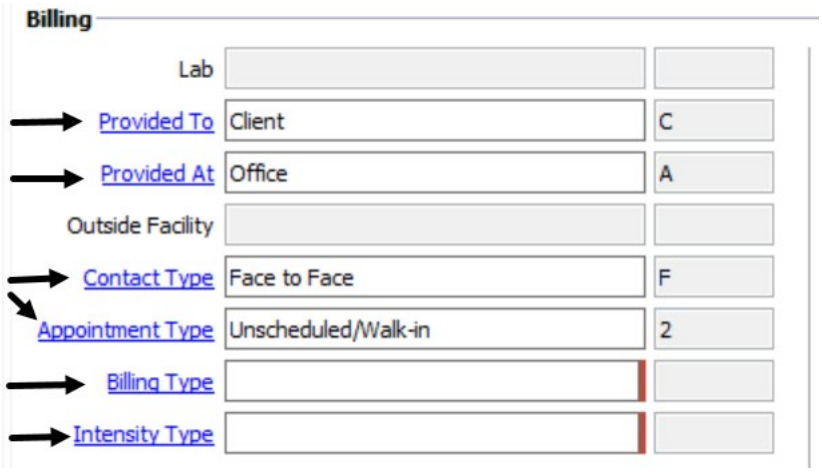


Continue with completing the Assignment and Billing Parameters section.

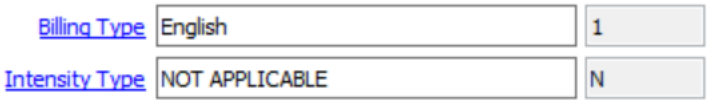
5. To select a client assignment, click the blue **Select an Assignment** hyperlink.

The program unit/subunit will be loaded. If not, check the client assignment to ensure the client is open to the program on the date of service.

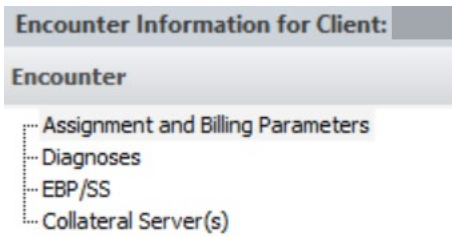
6. Review the service indicators and adjust accordingly to ensure the documentation and service indicators match.



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



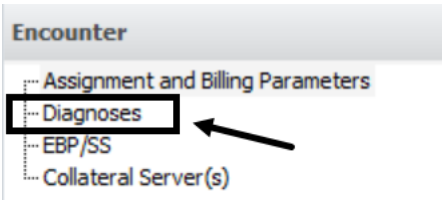
After successfully completing the Assignment and Billing Parameters, do not click Save yet. The Save button is for all Encounter Information. Go to the left side of the Encounter screen to continue completing the Encounter.



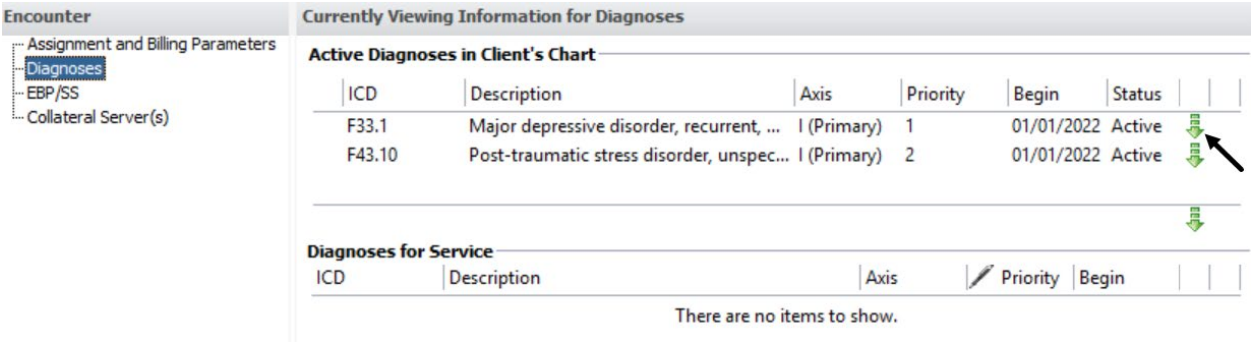
Diagnosis:

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

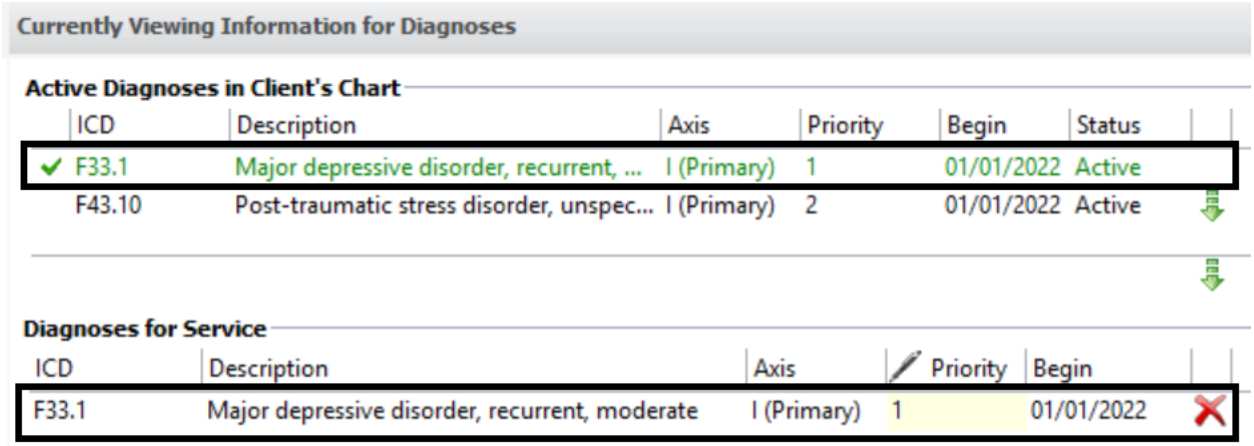
1. To link a diagnosis, click **Diagnoses**.



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



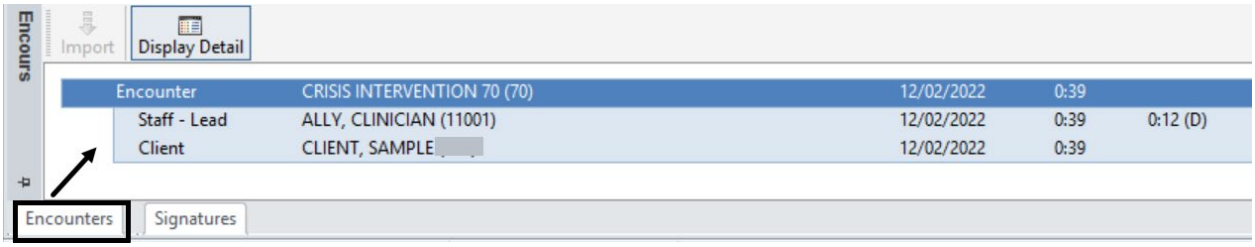
The selected diagnosis will display in bright green at the top and will display in the lower portion of the section. This indicates the diagnosis is now linked to the service. If a diagnosis was selected in error, click the red x to remove it and then select again.



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

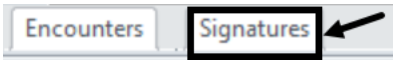
If Cancel is clicked instead of Save, all service information disappears and must be entered again.

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

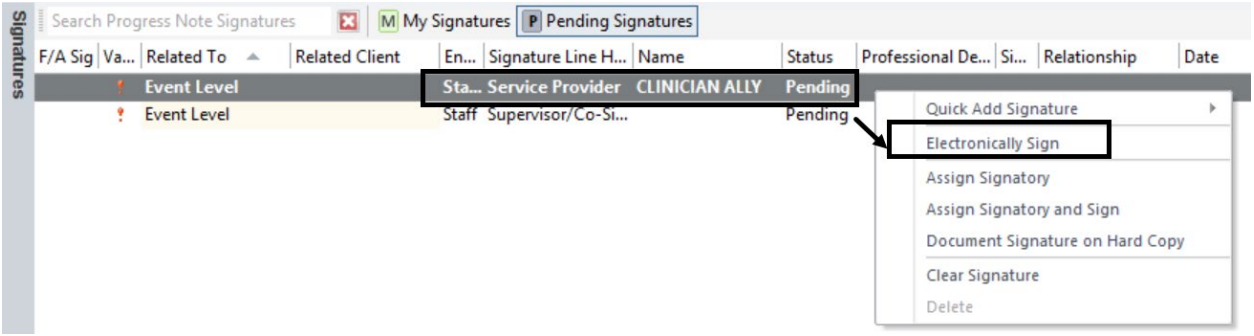


Signatures:

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

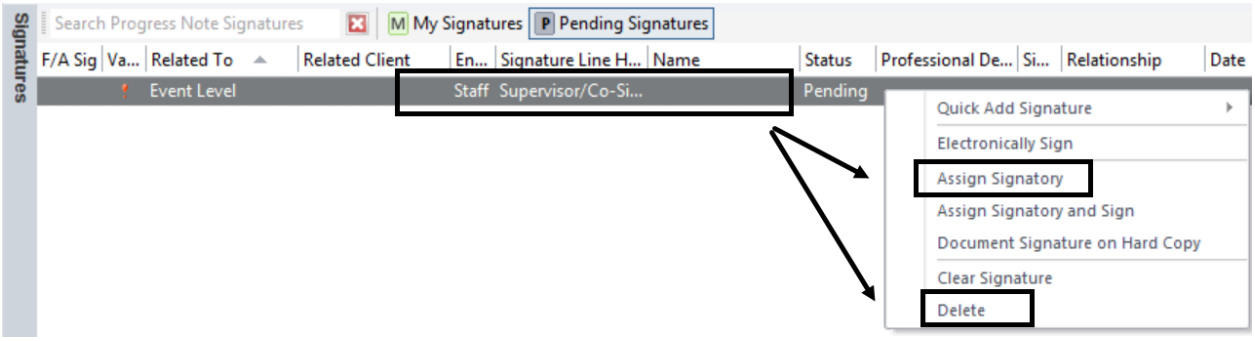


1. **Service Provider**: Right click anywhere on the Service Provider signature line where the service provider's name is displayed, and select **Electronically Sign**.



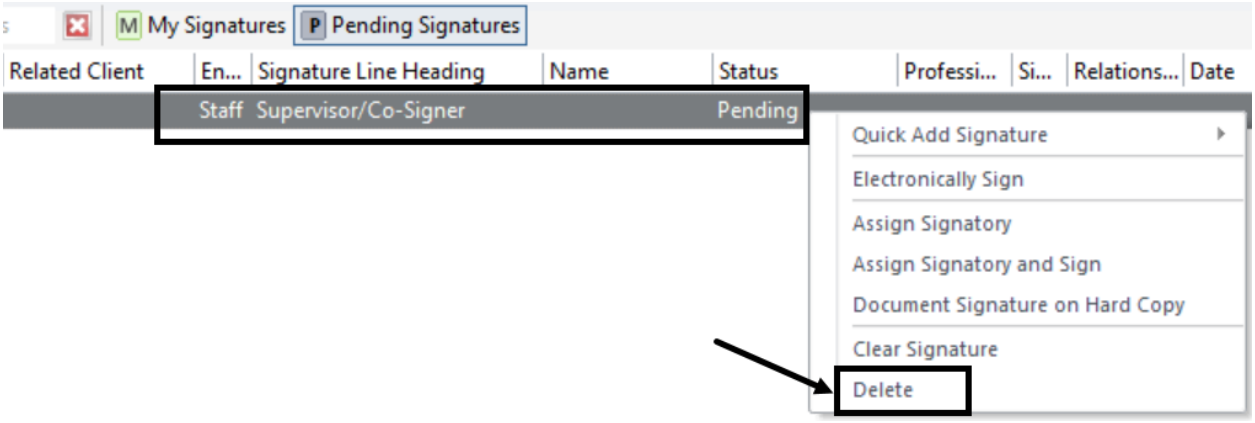
CO-SIGNATURES:

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

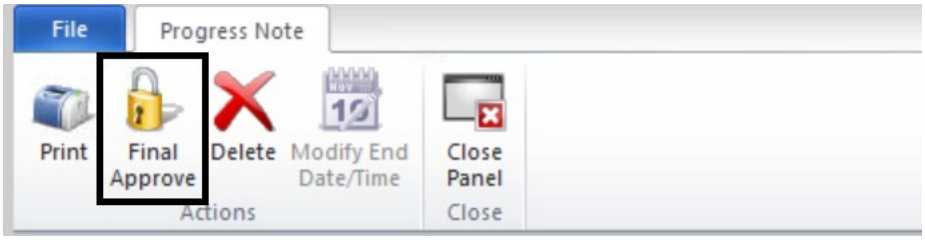


a. **Co-signature is not needed**:

i. Right click on the signature line and select **Delete.**

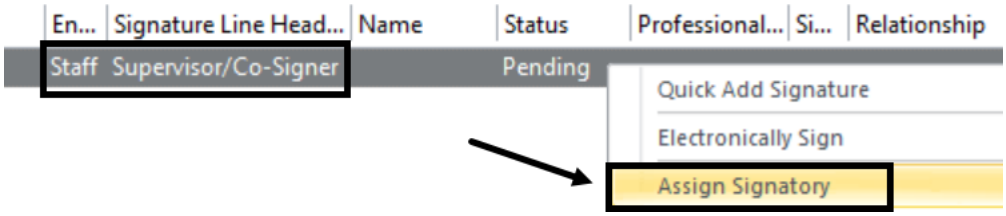


ii. Click **Final approve**.

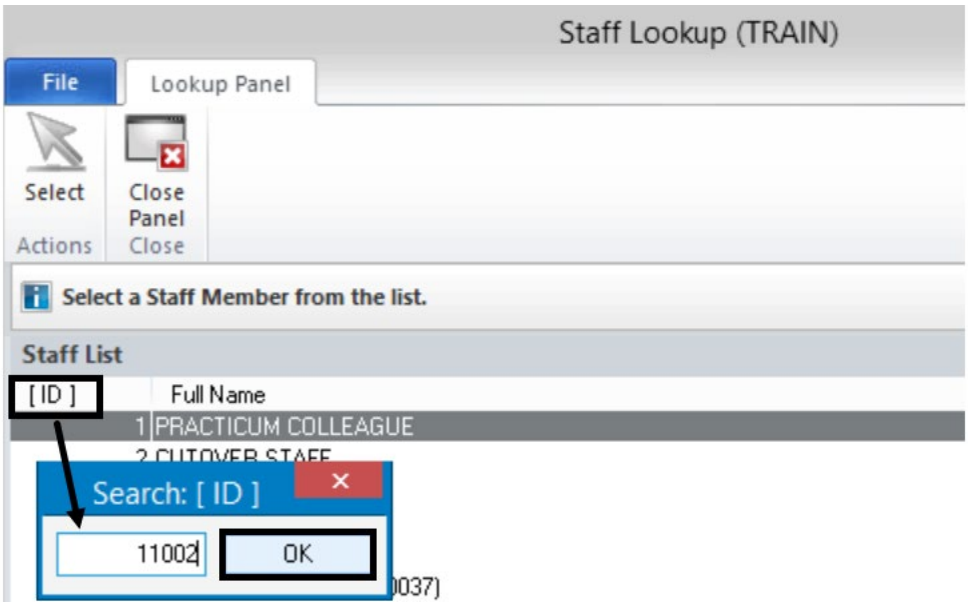


b. **Co-signature <u>is</u> needed:**

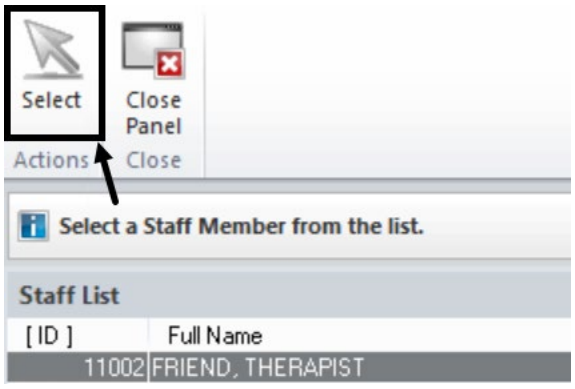
i. <u>Right click</u> on the signature line and select **Assign Signatory.**



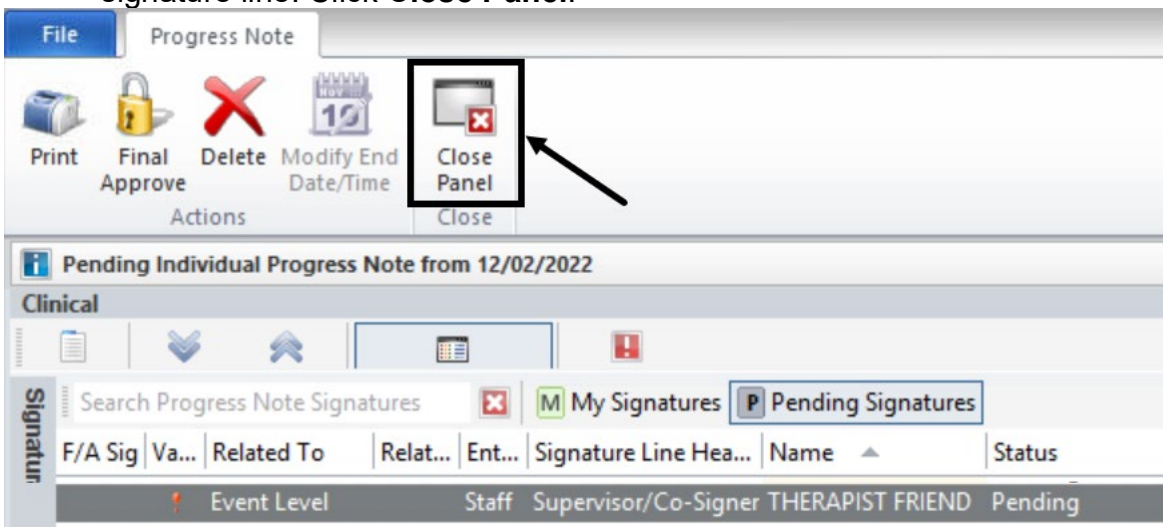
ii. The Staff Lookup table opens. Click in the **ID** column and <u>start typing</u> the <u>co-signer's CCBH ID number</u>. A Search box appears. Click **Ok**.



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



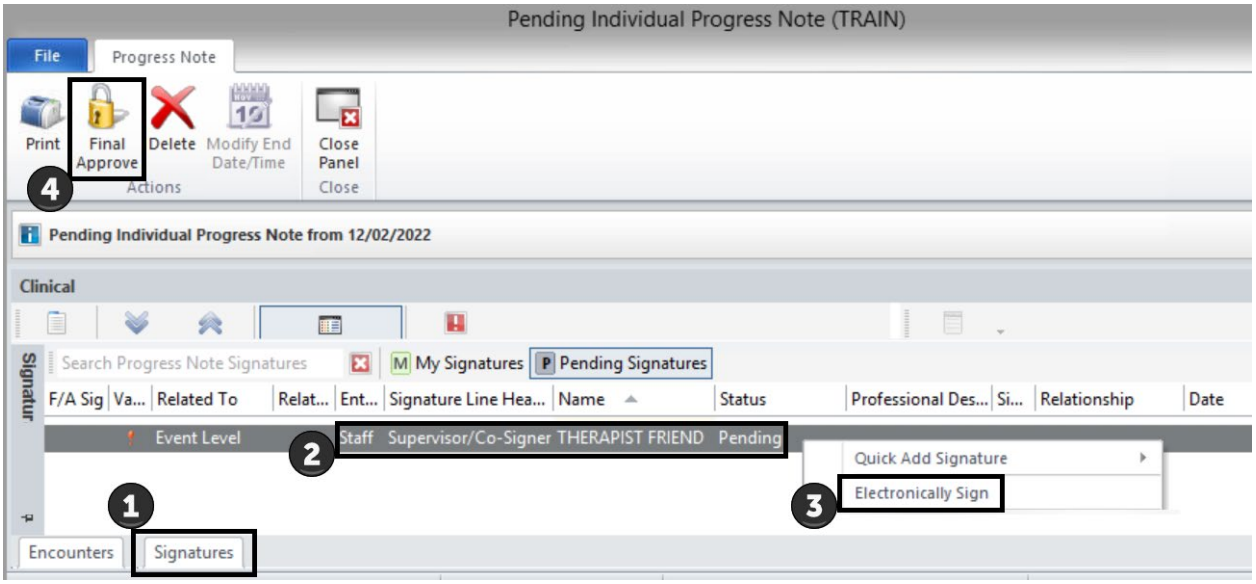
iv. The selected co-signer's name will display in the Supervisor/Co-Signer signature line. Click **Close Panel**.



Co-Signer Approving a Progress Note:

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

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



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

GROUP PROGRESS NOTES

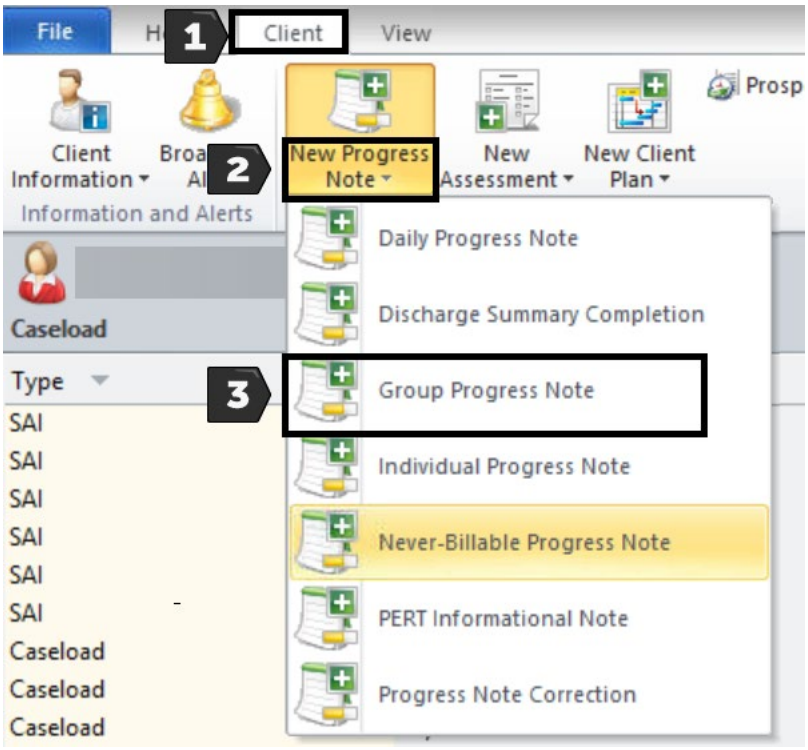
Group progress notes are used for services that include multiple clients. Billing is generated from these types of notes.

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

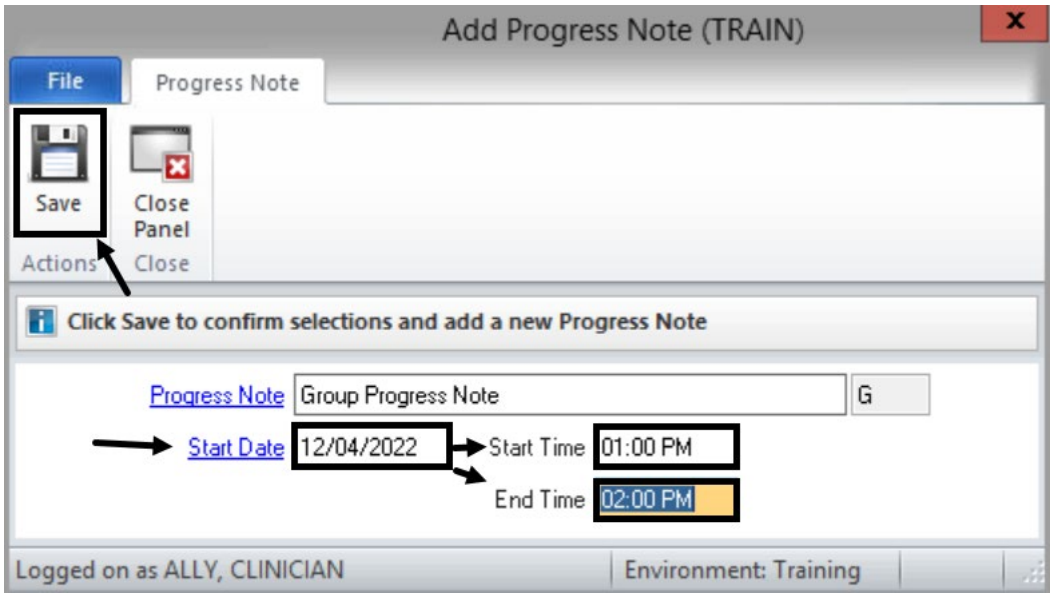
Adding a Group Progress Note:

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

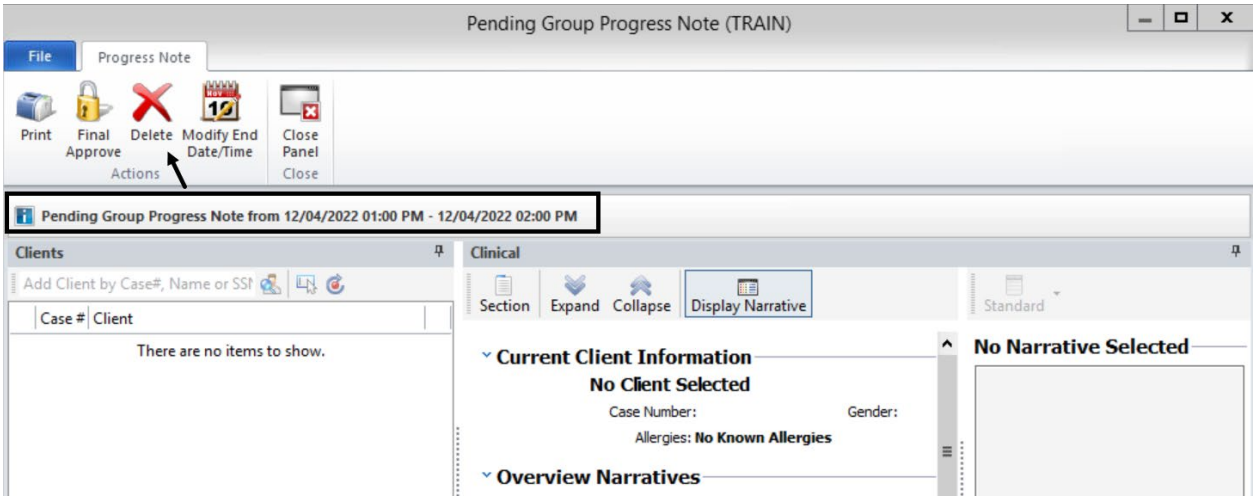
1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
2. Find the **New Progress Note** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the available notes. Click the words **New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



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

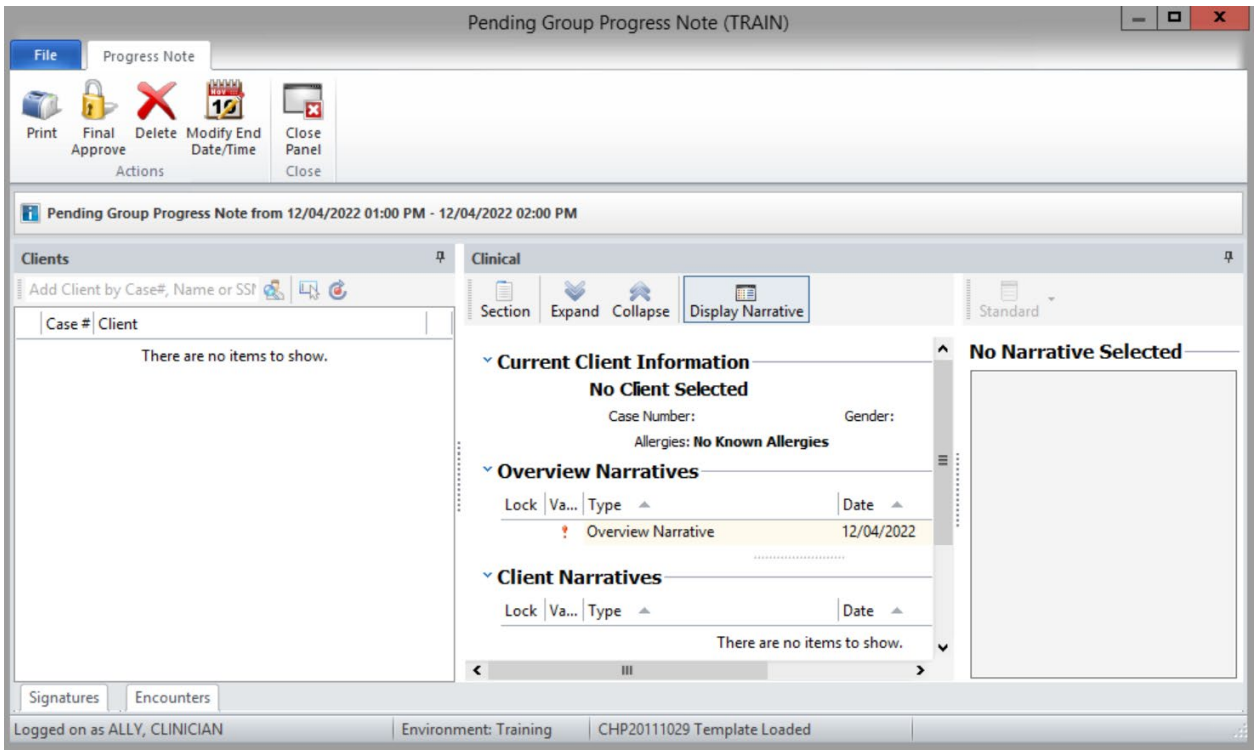


The Pending Group Progress Note launches. Verify the date and times for the progress note. If the date and/or times are not correct, select Delete and start again.



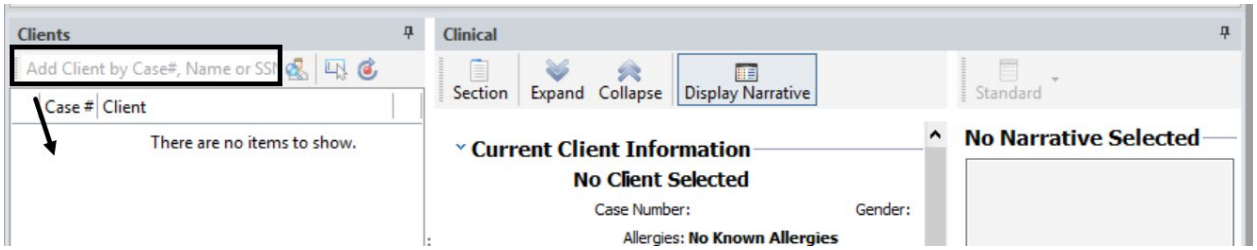
*Note: The **Start Date, Start Time, and End Time** cannot be changed once Save is selected. If the date and/or times are not correct and the note is still pending, delete the note and start all over. If the date and/or times are not correct and the note has been final approved, contact the Support Desk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

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



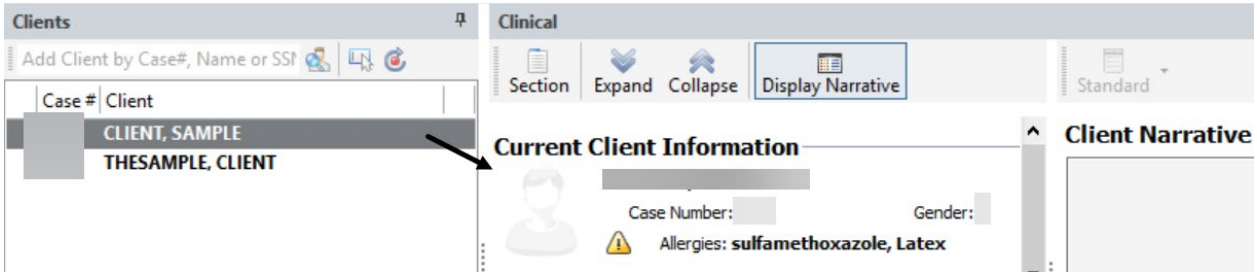
Adding Clients:

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



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

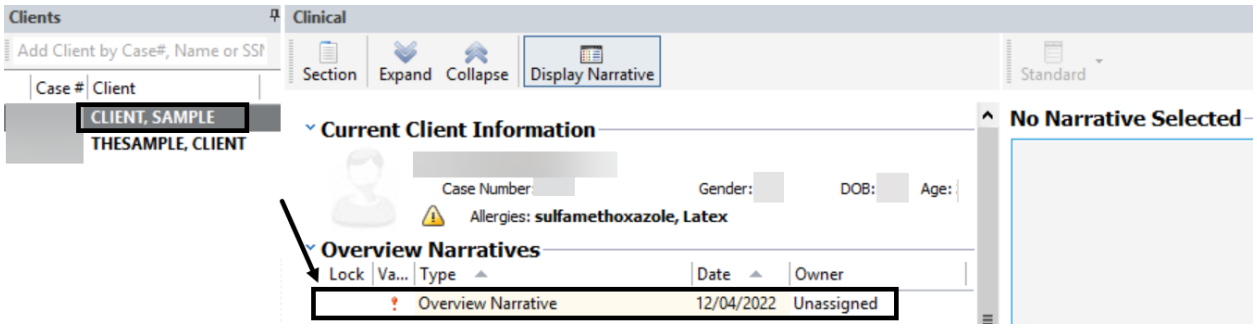
After all clients have been added, single click on the first client to continue completing the notes. Each client's identifiable information and allergies will display in the Current Client Information.



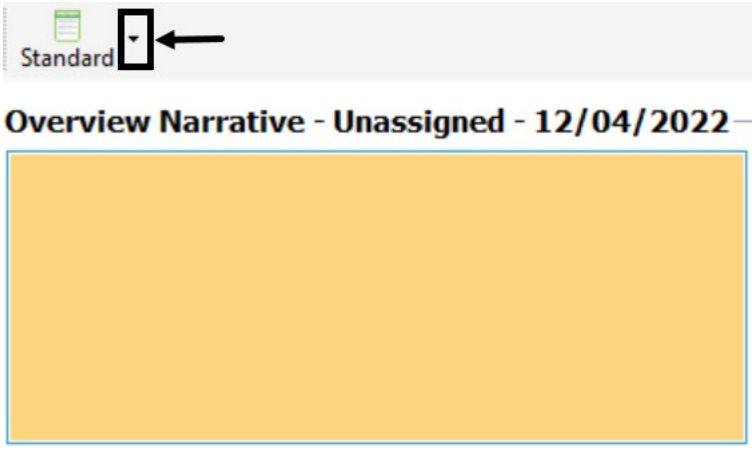
Overview Narratives:

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

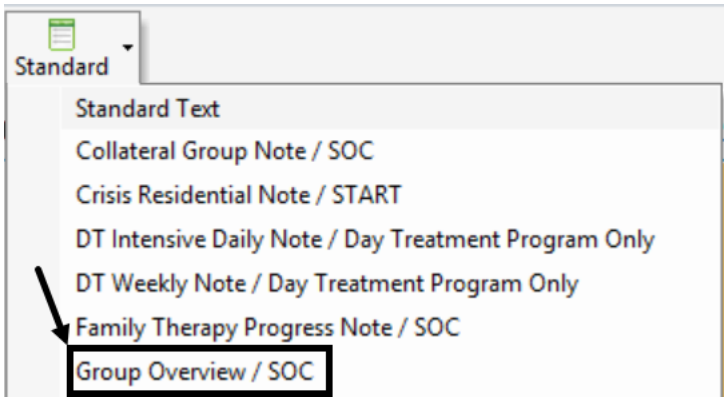
1. Double click anywhere on the **Overview Narrative** line to activate the Overview Narrative to the right.



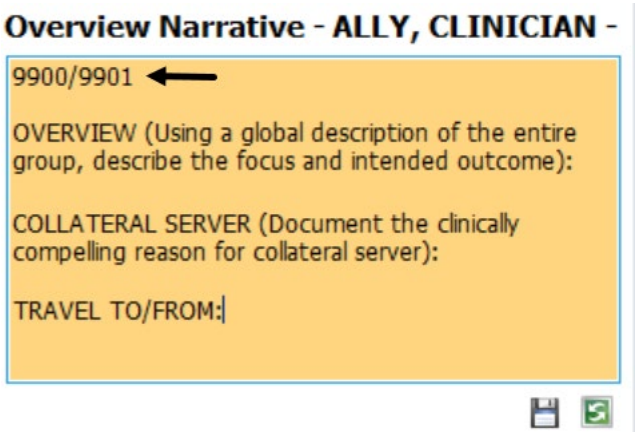
2. To use the standard text for group overview, click on the down arrow next to the Standard button.



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

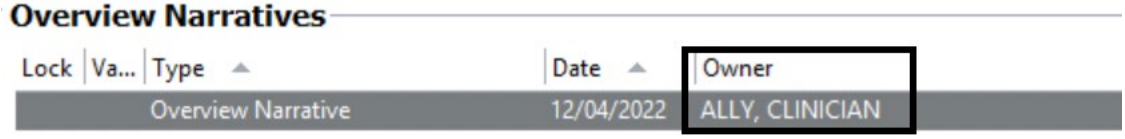


4. The group overview text template is loaded into the Overview Narrative box. Follow the prompts in completing the narrative. Always start the narrative with the program's unit/subunit identification number.



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

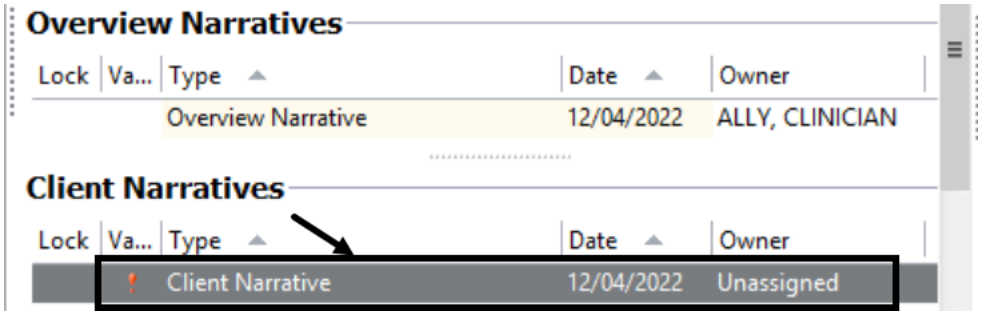
The staff will appear as the Owner of the note, and the Overview Narrative box is grayed out. To update the narrative, double click anywhere on the Overview Narrative line. The saved Overview Narrative will populate for all other clients in the group.



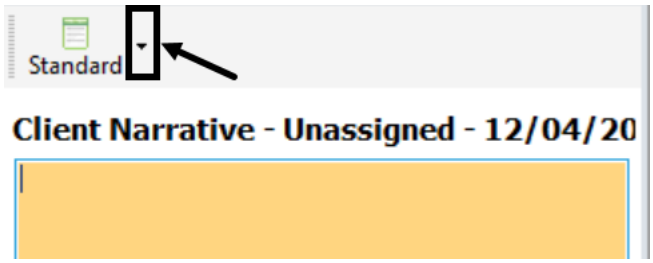
Client Narratives:

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

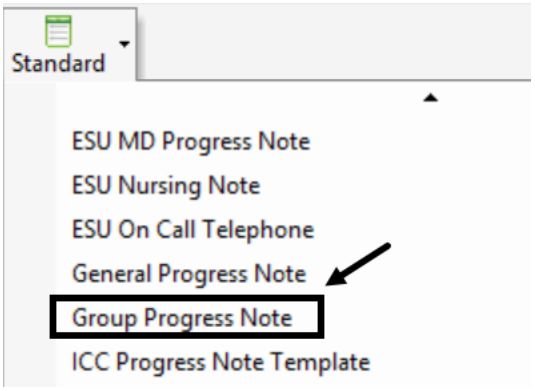
1. Double click anywhere on the Client Narratives line to activate the Client Narrative.



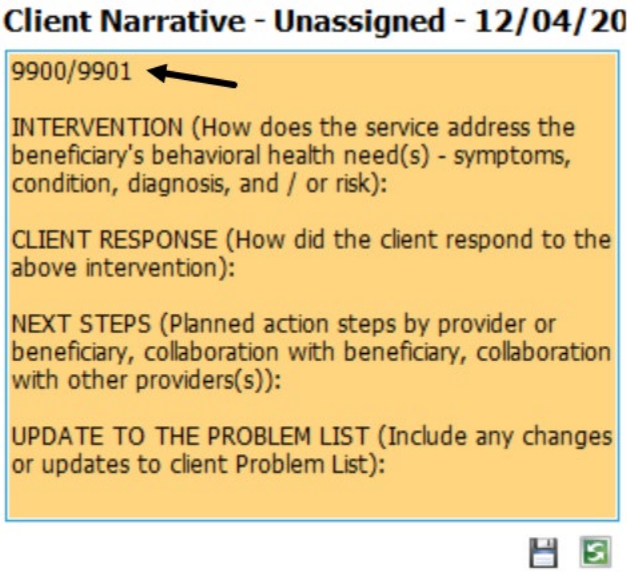
2. Once the Client Narrative box is yellow, click on the down arrow next to the Standard button. This will display the list of standard text templates.



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

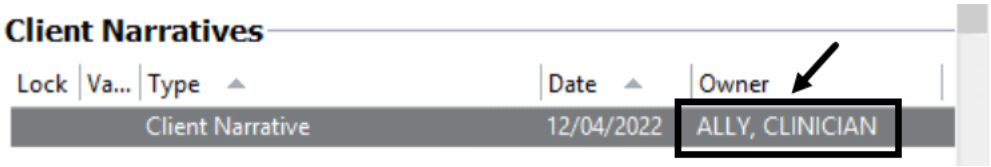


4. The standard text template is loaded into the Client Narrative box. Follow the prompts and apply clinical judgment in completing the narrative. Always start the narrative with the program's unit/subunit identification number.



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

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

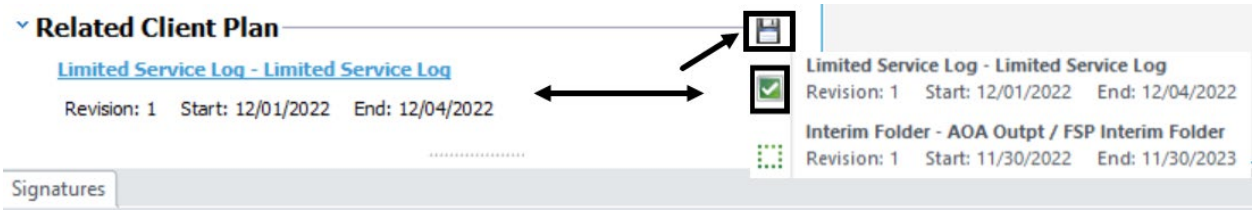


Related Client Plan:

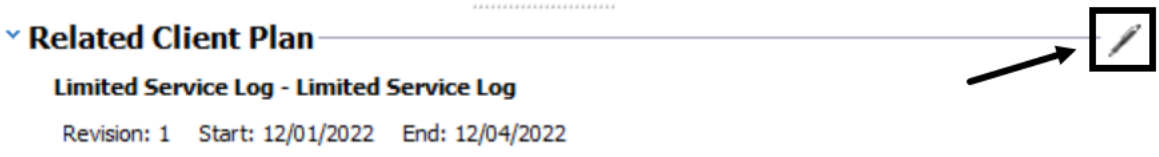
A client plan folder must be selected to indicate where the individual progress note will be stored.

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

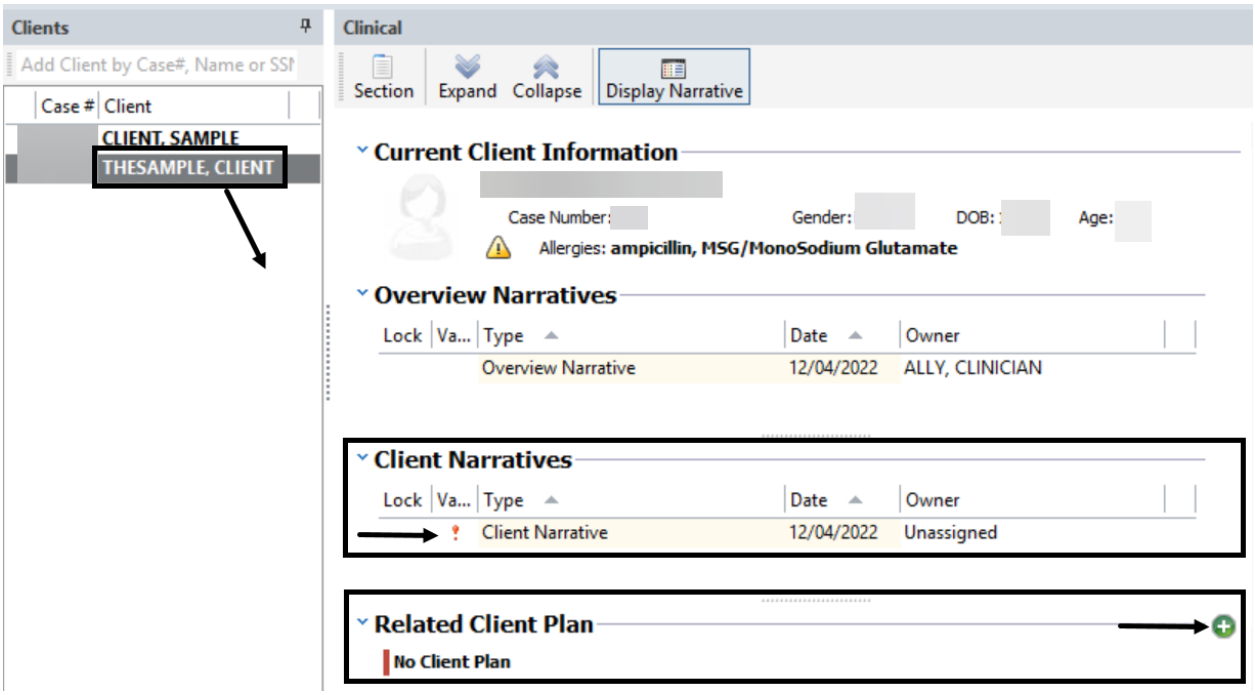
2. If there is only one client plan available, it will autopopulate. Click **Save**.
   If there are multiple plans, select the appropriate plan from the list and click **Save**.



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

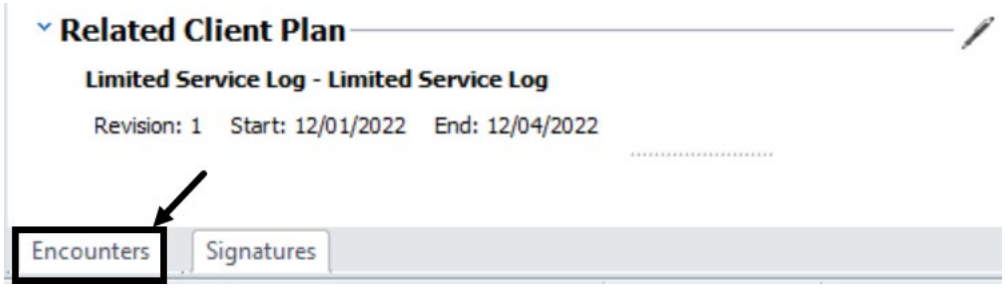


Select the next client, and repeat the same steps. Complete the **Client Narratives** and **Related Client Plan** for the remaining clients in the group before moving to the Encounters and Signatures panes.

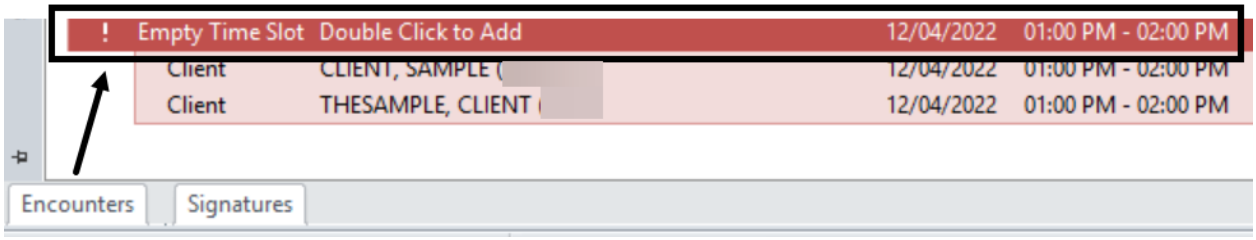


Encounters:

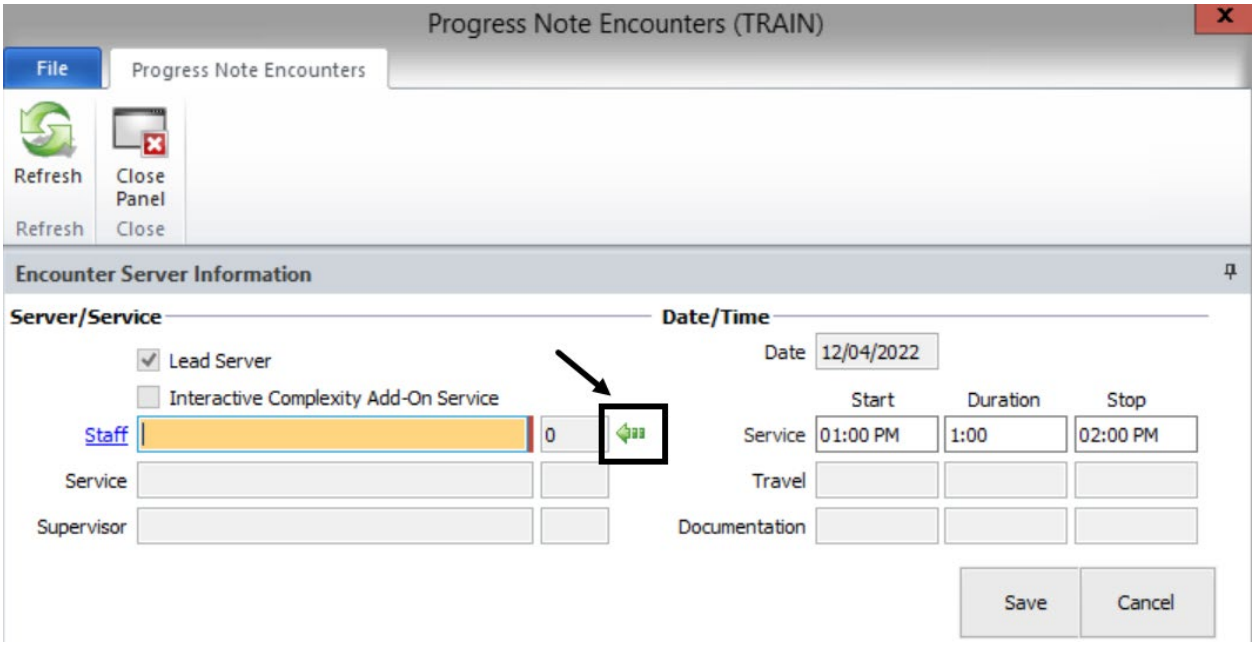
1. To enter the encounters for this note, click **Encounters**.



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

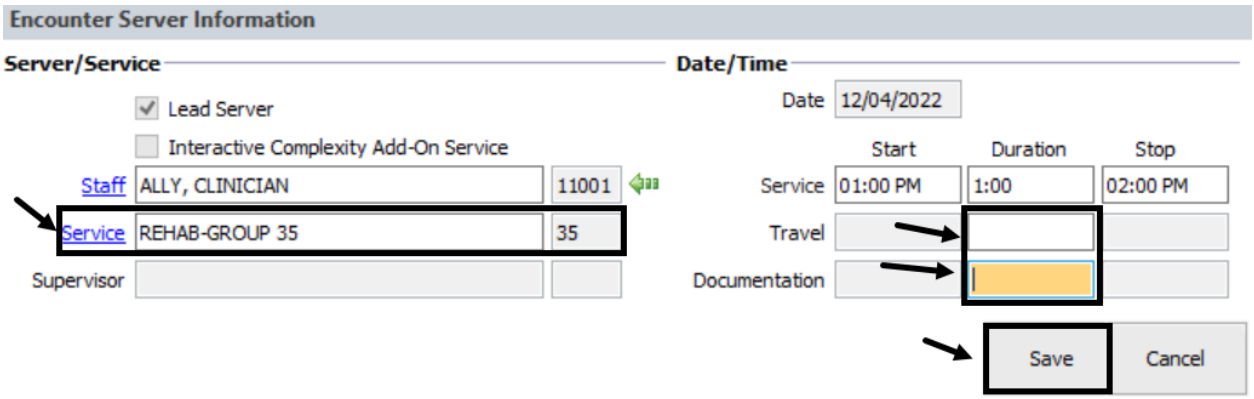


3. In the Server/Service section, click the green left arrow to autopopulate the Staff name. The Staff name can be manually entered as well.

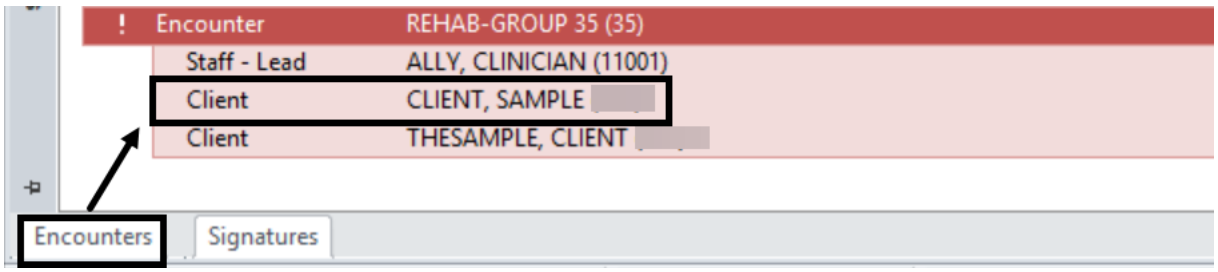


After the Server is selected, the Service fields are activated for data entry. The populated Date and Lead Server fields are both grayed out and read only.

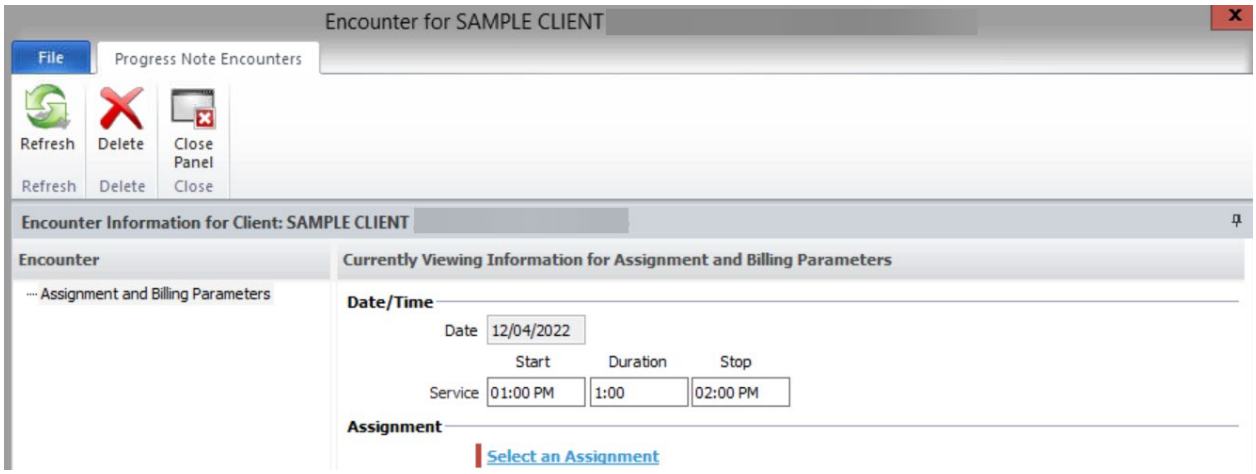
4. Enter the group service code in the **Service** field. Enter the **Travel** (if applicable) and **Documentation** times in their respective **Duration** fields. Click **Save**.



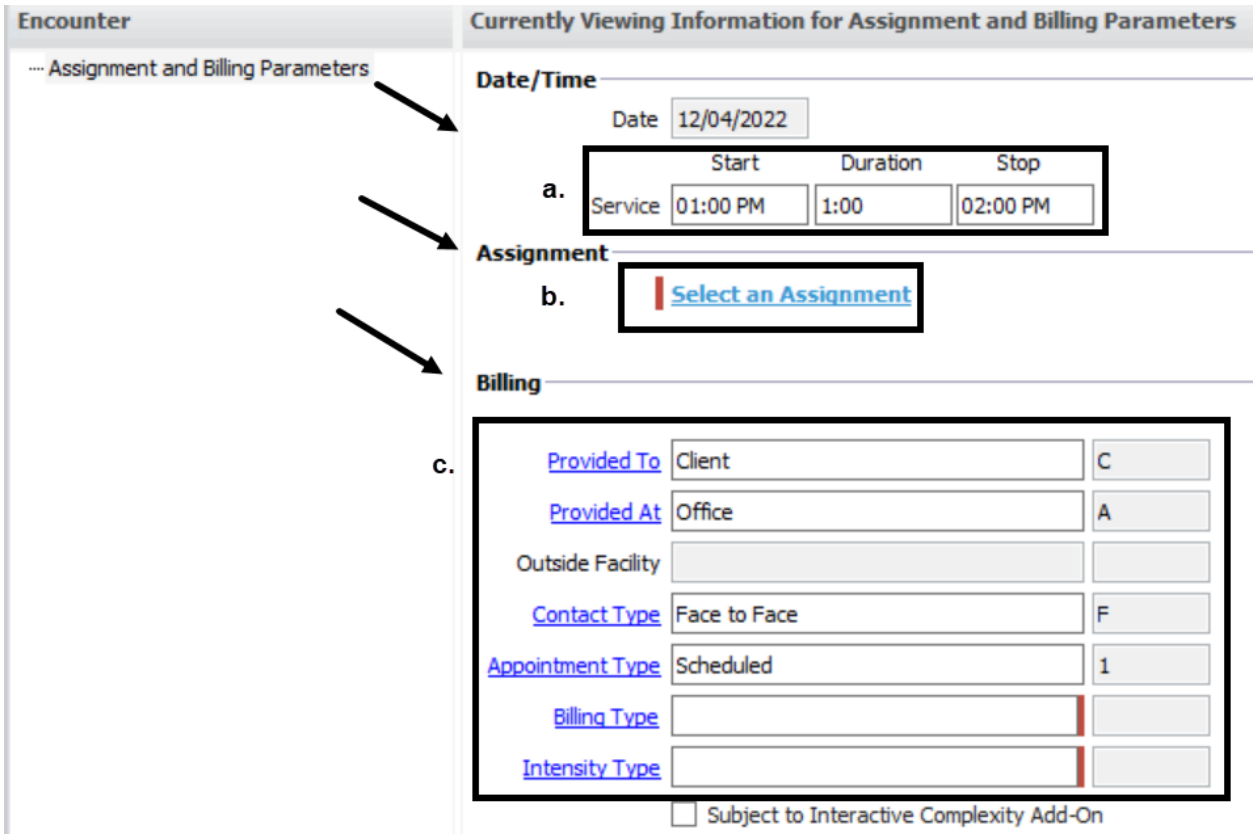
5. To enter the Assignment and Billing Parameters for each client, click **Encounters** again and **double click** anywhere on the line displaying **Client** and the name of the client. It is best to start from the top.



6. The Encounter screen for the selected client launches.

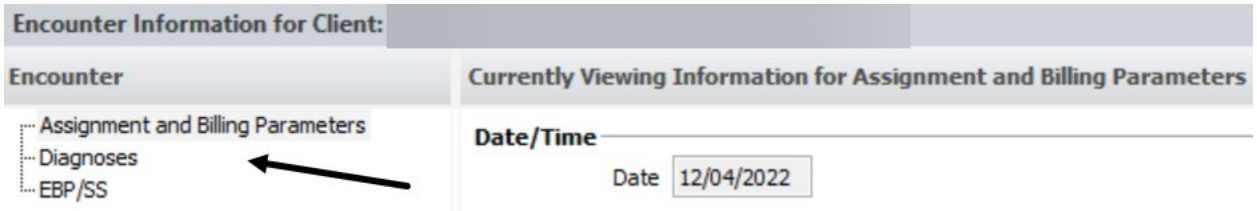


a. Review and edit the **Time** that the client participated in the group.
b. Click the **Select an Assignment** hyperlink to load the client assignment. If the program unit/subunit does not load, check the client assignment to ensure the client is open to the program on the date of service.
c. Complete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



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

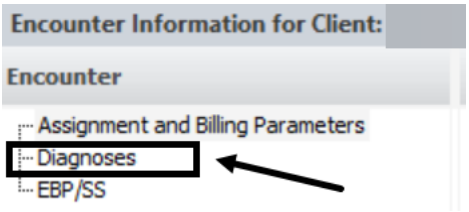
After successfully completing the Assignment and Billing Parameters, <u>do not click Save</u> yet. The Save button is for all Encounter Information. Go to the left side of the Encounter screen to continue completing the Encounter.



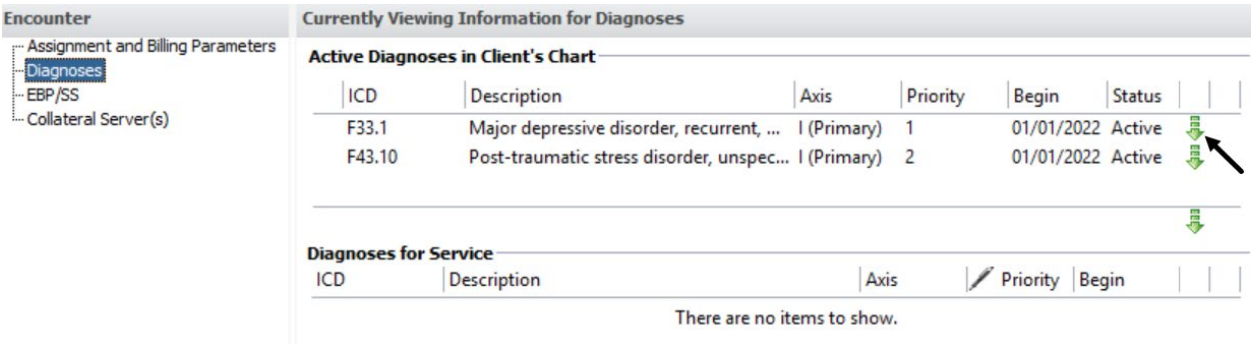
Diagnosis:

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

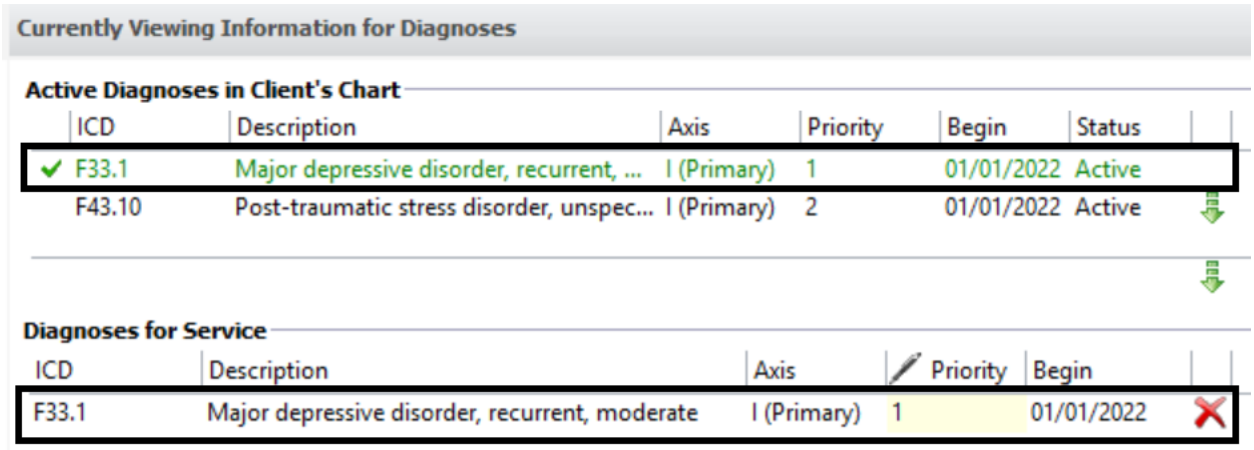
7. To link a diagnosis, click **Diagnoses**.



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

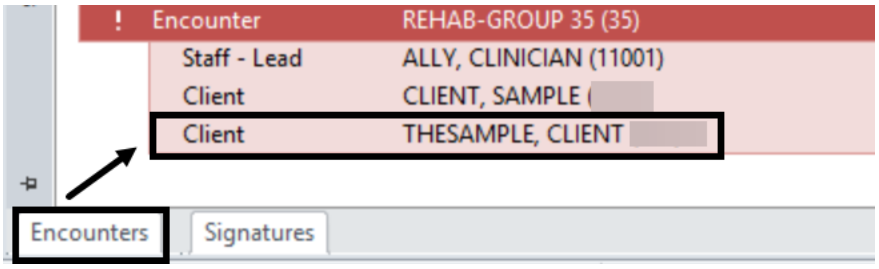


The selected diagnosis will display in bright green at the top and will display in the lower portion of the section. This indicates the diagnosis is now linked to the service. If a diagnosis was selected in error, click the red x to remove it and then select again.

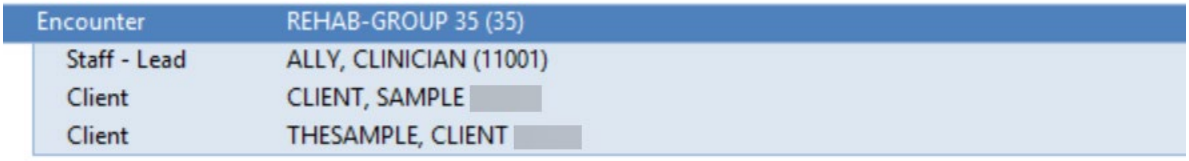


9. To save the service details that were entered and close the Encounter screen at the same time, click **Save**. If Cancel is clicked instead of Save, all service information disappears and must be entered again.

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



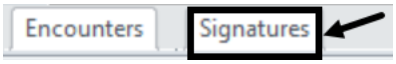
To verify that encounters were entered for all clients, click **Encounters** again. A quick view of the information entered will display in blue. To review or edit any of the service information, double click on any of the blue lines. Once the note is final approved, the display will turn green and cannot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



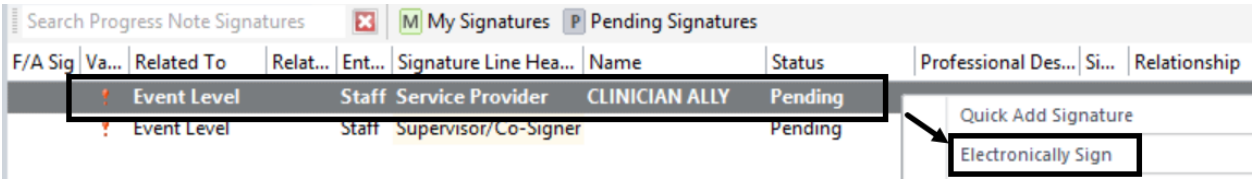
NOTES

Signatures:

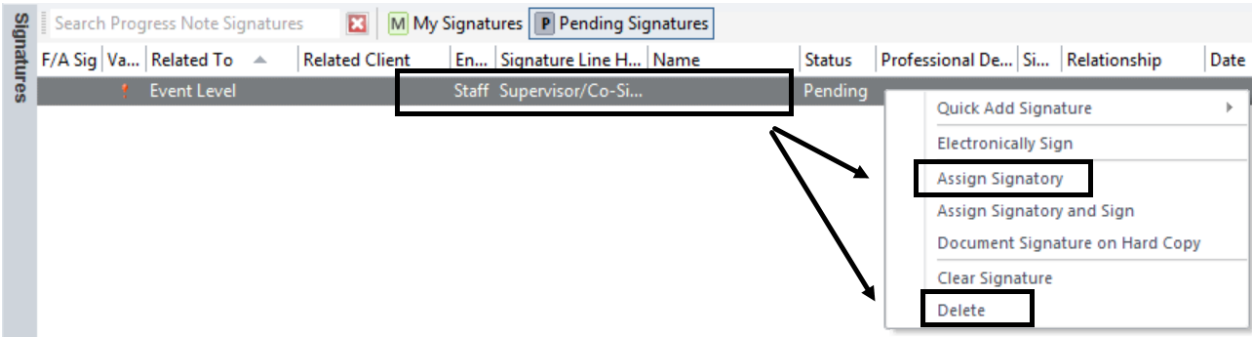
A note must be signed before it can be final approved. At the bottom of the note, click on **Signatures**.



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

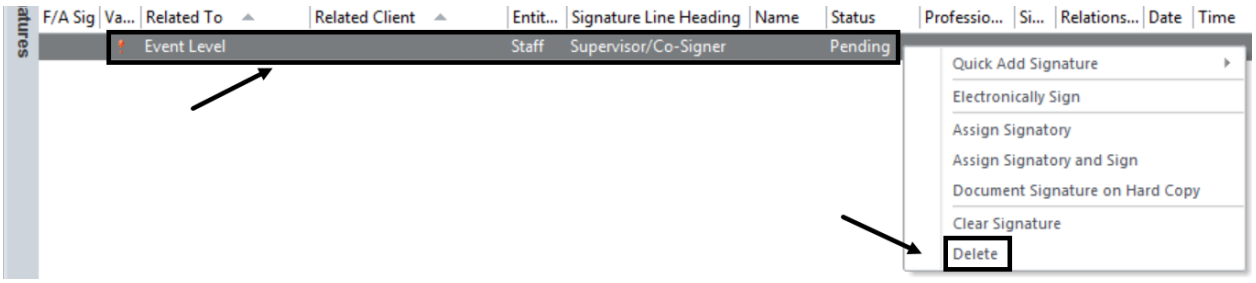


2. **Supervisor/Co-Signer**: Completing the Supervisor/Co-Signer signature line will depend on whether the staff needs a co-signature or not. Follow either the Co-signature is not needed steps or the Co-signature is needed steps below.

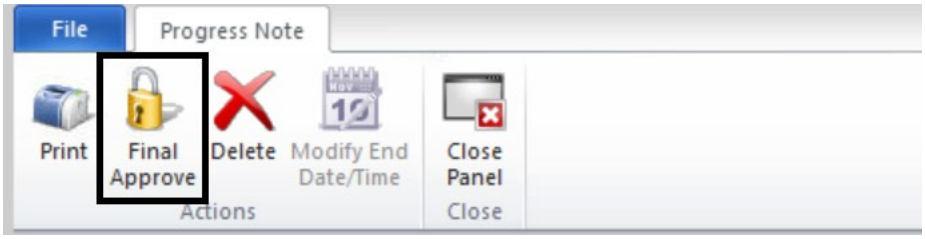


a. **Co-signature is not needed**:

i) Right click on the signature line and select **Delete.**

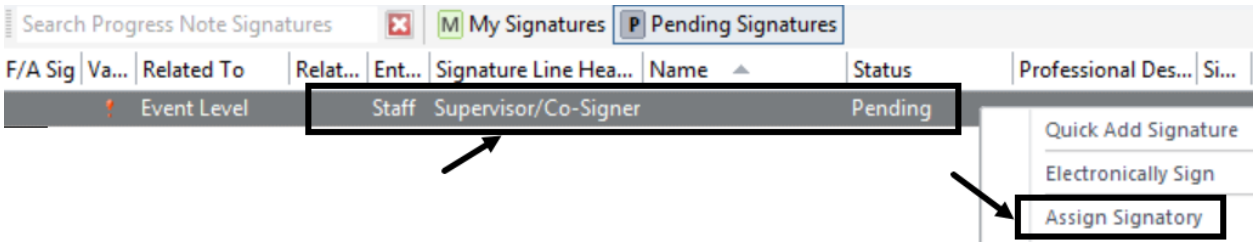


ii) Click **Final approve.**

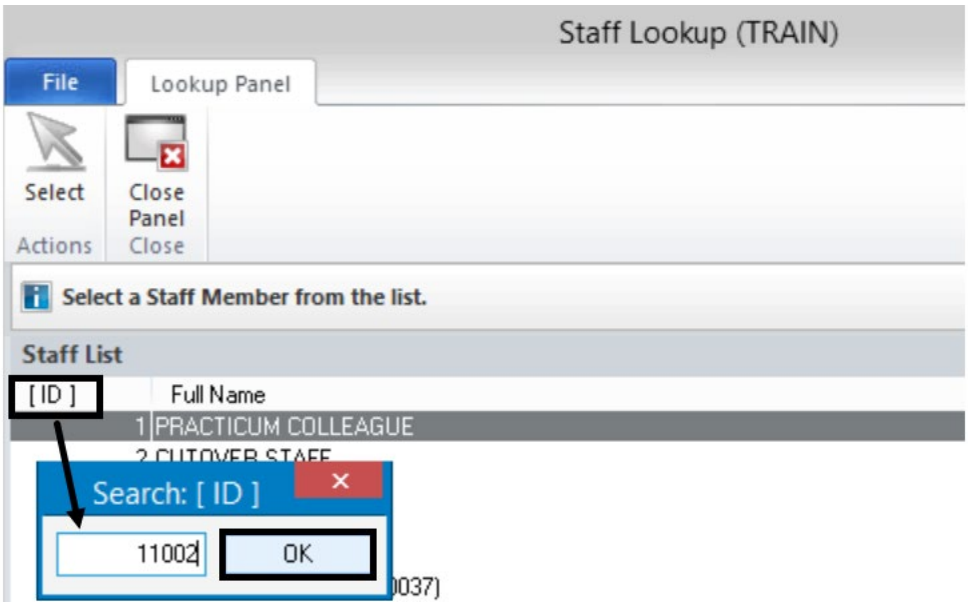


b. **Co-signature <u>is</u> needed**:

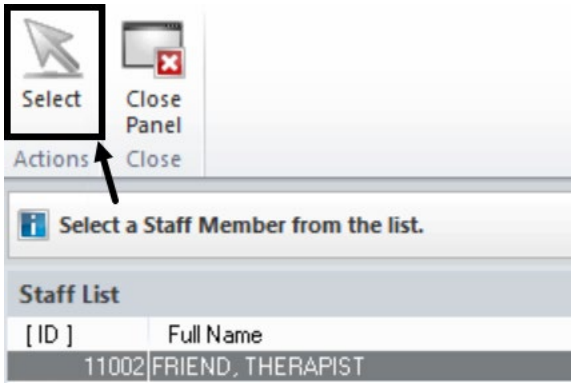
i) <u>Right click</u> on the signature line and select **Assign Signatory**.



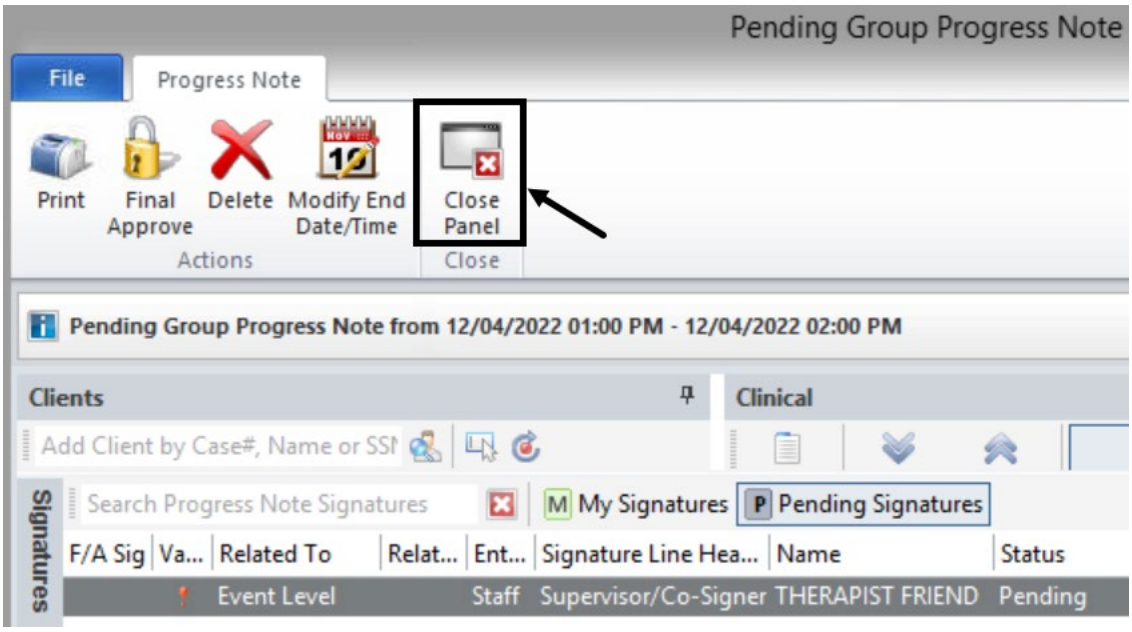
ii. The Staff Lookup table opens. Click in the **ID** column and <u>start typing</u> the <u>co-signer's CCBH ID number</u>. A Search box appears. Click **Ok**.



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



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



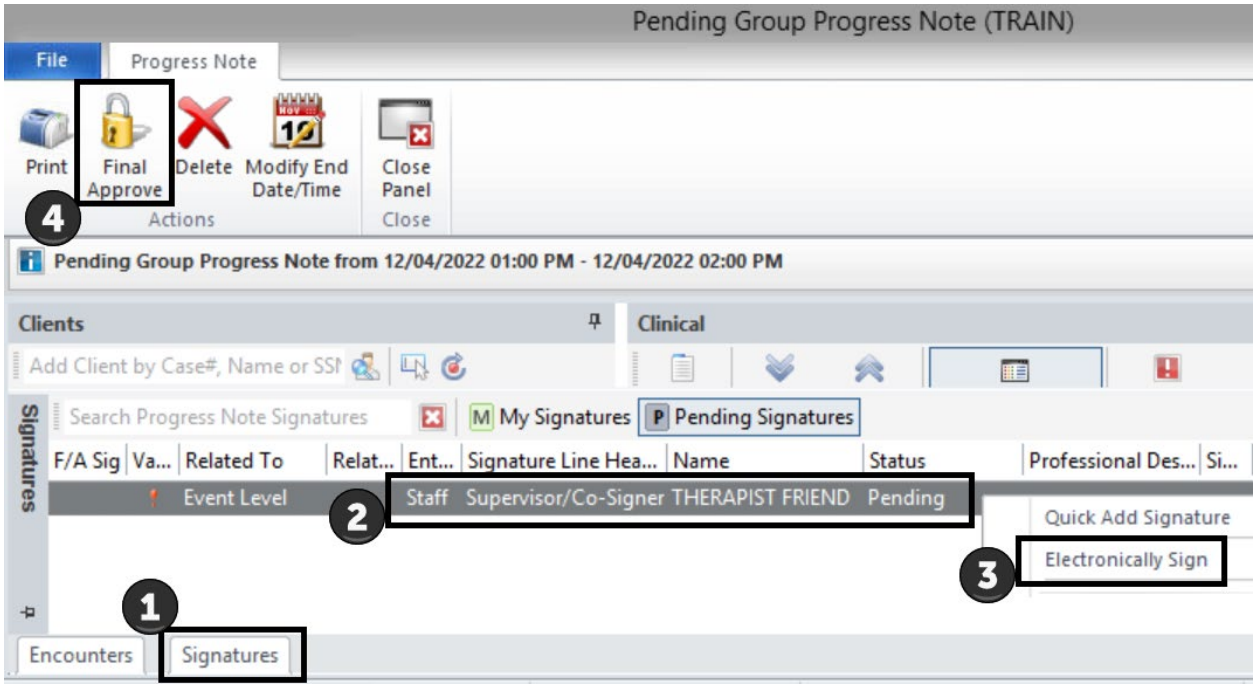
Closing the Progress Note window will allow the co-signer to open the note since only one staff can actively work on a pending note.

NOTES

Co-Signer Approving a Group Progress Note:

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

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



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

NOTES

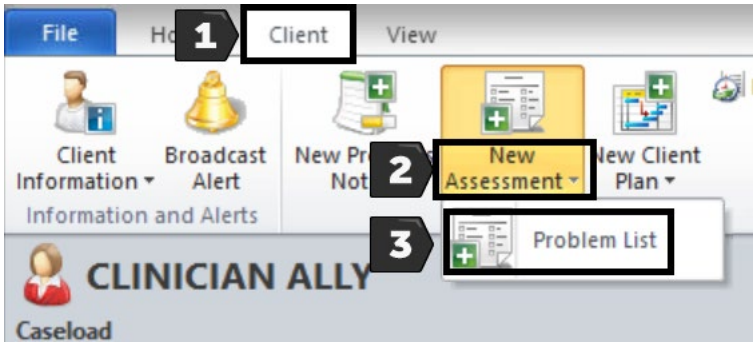
PROBLEM LIST

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

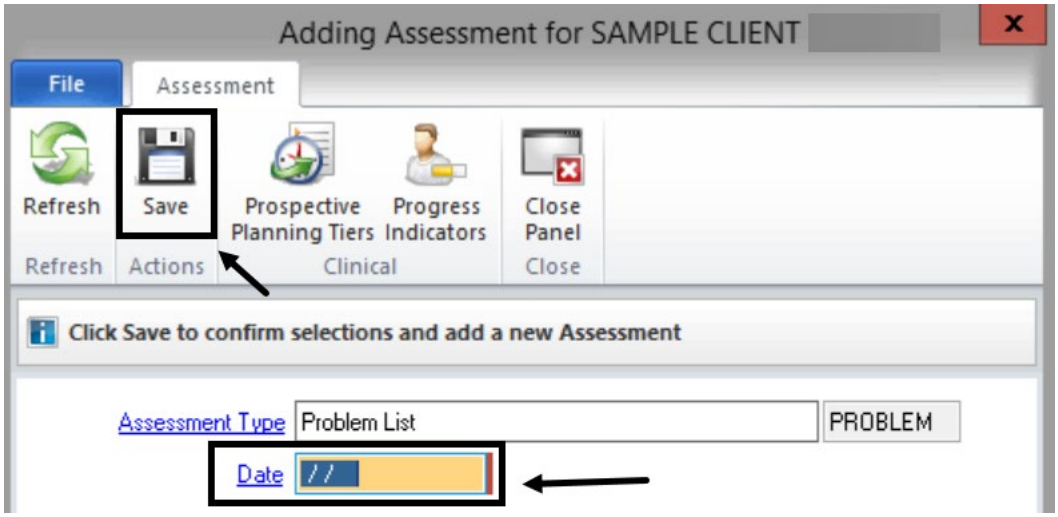
Adding a Problem List:

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

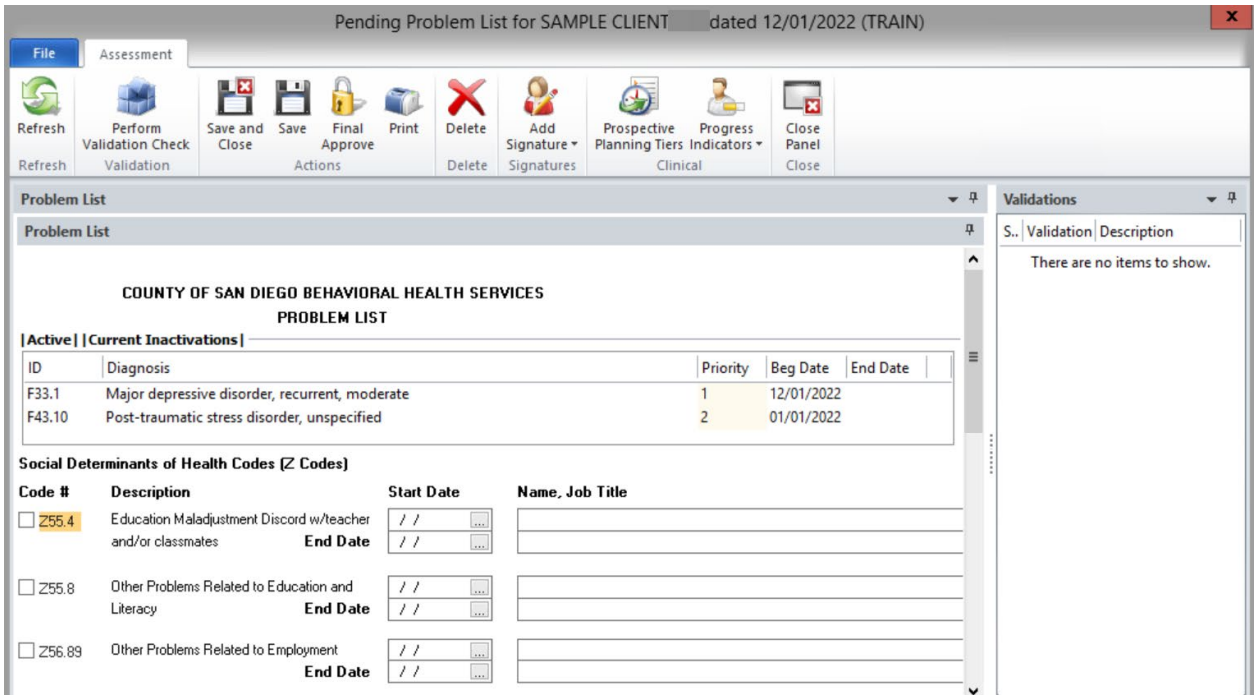
1. After selecting the client from the clinician's Caseload, click on the **Client** tab.
2. Find the **New Assessment** button on the ribbon. The button is segmented in two parts. It is best to click the lower portion of the button because it displays all the preferred assessments. Click the words **New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



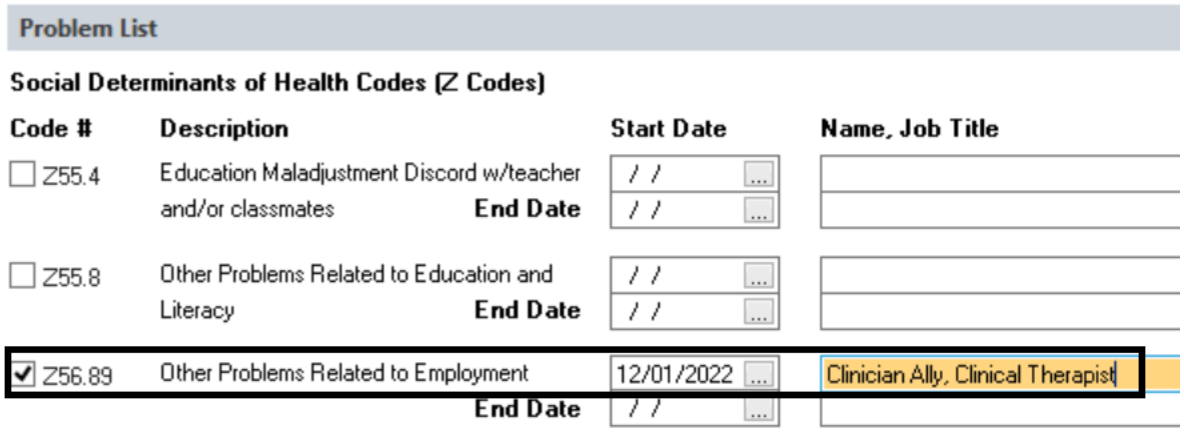
The Adding Assessment window launches automatically populating **Problem List** as the Assessment Type. Select the assessment **Date** and click **Save**.



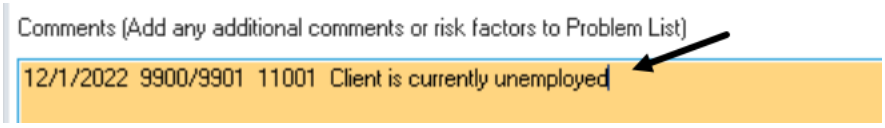
The Pending Problem List opens.



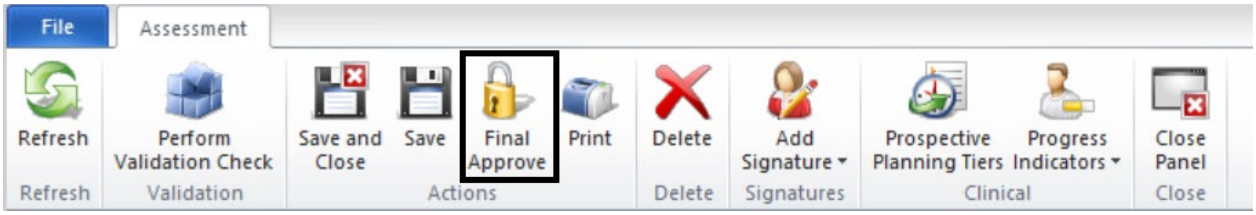
To add Social Determinants of Health Codes (Z Codes), check the box to the left of the **Z Code**. Enter **Start Date**, **Name**, and **Job Title**.



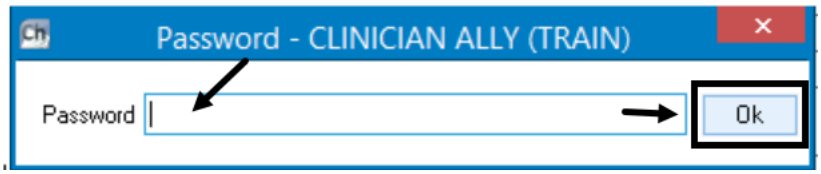
Scroll down to the **Comments** section, and enter the date, program unit/subunit, Staff ID, and an applicable Comment.



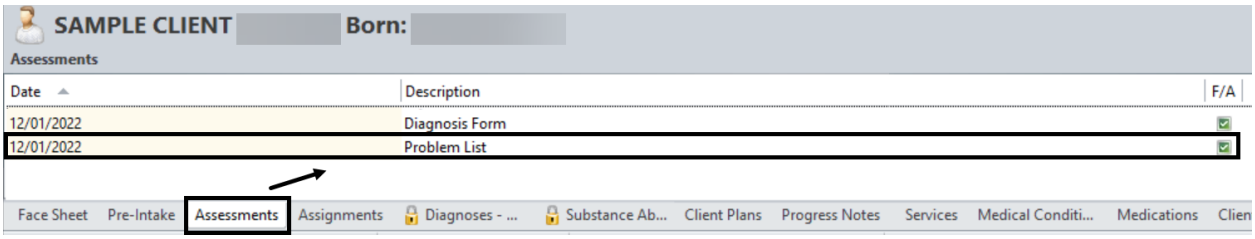
Click **Final Approve**.



Enter password, and click **Ok**.



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



NOTES

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