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



## CONFIDENTIALITY

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

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

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

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

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

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

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

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

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



# **CLONED DOCUMENTATION**

### From the Compliance Bulletin # 30, October 17, 2011

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

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

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

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

Bob Borntrager, CHC Chief Compliance Officer (619) 515-4246 Robert.Borntrager@sdcounty.ca.gov





## **OVERVIEW OF CLIENT PLANS**

There are different ways to hold progress notes in CCBH. You can think of them as "folders" in which to keep your progress notes:



These "folders" may or may not all be used by your program. Each is a "stand alone" folder and they are not sequential (that is to say, you do not 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 short term services by programs (i.e. ESU, walk-in clinic) where a Client Plan will never be completed. If your program does not provide these short term services, you probably won't use this "folder."

**The Interim Folder:** The standard for completing a Client Plan has not changed – you still have 30 days from the time a client comes to your program to complete a Client Plan. However, CCBH needs a place to "hold" your progress notes, and the Interim Folder performs that function. This is the "folder" where you will document all your services prior to opening the Client Plan. Can you leave this folder open indefinitely? No! The Interim folder needs to be closed:

- 1. If the client leaves the program without a Client Plan being started and you are the only provider;
- 2. If you are ready to begin the Client Plan.

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

**Day Treatment Med Folder:** The Day Treatment Med Folder is only used for children's day treatment medical staff to store their progress notes. The folder will be opened upon the first date of service with the day treatment program and will only be closed once the client discharges. If the client receives day treatment services for more than 2 years, a new "folder" will need to be opened. Only day treatment medical staff notes should be stored in this folder.

**The Client Plan** holds all the progress notes written after opening the plan. You do not need to open an Interim Folder before opening a Client Plan if that is your workflow (for example, many programs complete the BHA and Client Plan at the initial appointment). In other words, the Client Plan can be opened immediately as you start seeing your 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

This is the client's general strength(s) <u>and</u> how the client might utilize this strength(s) to help them to help achieve their objective(s).

#### Area of Need

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

#### Goal

This is the broad goal that the client wants to achieve in treatment. *No narration is required for this Planning Tier.* 

#### Objective

These are the actions/activities/steps of the client or others to help reduce the impairment. *Objective(s) narration is <u>observable &</u> <u>measurable.</u>* 

#### Intervention

Interventions are the service codes to be used to treat the client. *Frequency, duration will be specified and the individualized purpose for all service codes.* 





# **HOW PROGRESS NOTES DISPLAY IN THE CLIENT PANEL**

#### To View Existing Progress Notes:

1. On the Client Panel, find the "Progress Notes" pane and single click on it.

-								
	TEST							• ₽ □ ×
Progress Note	s							<b>▼</b> ₽
Search Progre	ess Notes							
Client Plan	Туре	F/A	Date 🔻	Thru	Primary Signer	Inte	rvention	
IF Interim F	o Individual Progress I	Note 🖪 🛛	01/04/2017	01/04/2017	CLINICAL, STAFF			
IF Interim F	o Never-Billable Progr	es 🔽 🛛	01/02/2017	01/02/2017	CLINICAL, STAFF			
Face Sh P	re-Intake Assessm	Assignm	🔓 Diag	Substan Clier	nt Pl Progres Au	thoriz Insuran	Services Medical	Medicati
Logged on as Cl	LINICAL, STAFF		Enviror	nment: Test 3	CHP20111029 Templat	e Loaded	Ready	

#### 2. Click on the black drop down arrow to open display options.

A FAKE TEST	70.000.000				<b>→</b> ₽ □ ×
Progress Notes Search Progress Notes					New Progress Note
Client Plan Type	F/A Date 🔻	Thru	Primary Signer	Interver	<u>F</u> ilters <u>R</u> efresh Pane Content
IF Interim Fo Individual Progress N IF Interim Fo Never-Billable Progres			CLINICAL, STAFF	_	1
*					

*Note: "*Filters" allows you to select how you want to view progress notes (in a particular date range, by Client Plan Type, by Progress Note Type, by a particular Intervention, Final Approved & Pending progress notes, and/or voided progress notes.)

- 3. Double click on any progress note you would like to see in its entirety.
- 4. Click on the "Client Narrative" line to read the narrative.

Final Approved Individual Progress Note from 01/04/2017	
Clinical	<b>#</b>
Section Expand Collapse Display Narrative	Standard
Current Client Information     TEST, FAKE     Case Number: Gender: Male DOB: Age: 32 yrs     Allergies: No Known Allergies     Client Narratives	No Narrative Selected
Lock Va   Type A   Date A   Owner	
7	



5. To view encounter information select the "Encounter" pane, and double click on the encounter to open details.

Encou	- Import	Display Detail				
nters	✓ E	ncounter (U)	ASSESSMENT - PSYCHOSOCIAL 10 (10)	09/25/2017	1:37	
		Staff - Lead	CLINICAL, STAFF	09/25/2017	1:37	0:13 (D)
		Client	FAKE, TEST	09/25/2017	1:37	
- <b>p</b>						
End	counters	Signatures				

# <u>NOTES</u>


# HOW CLIENT PLANS DISPLAY IN THE CLIENT PANEL

#### **To View Existing Client Plans:**

1. On the Client Panel, find the "Client Plans" pane and single click on it.

Client Plans					
Туре	Description	Begin 🔻	Revised	End	New Client Plan
Client Plan	AOA Outpt / FSP Client Plan	12/04/2016		12/04/2017	<u>Expanded Mode</u>
Interim Folder	AOA Outpt / FSP Interim Fol	12/02/2016		12/03/2016	<u>T</u> ext Mode
Limited Service Log	Limited Service Log	12/01/2016		12/02/2016	Filters
					Refresh Pane Content

Note: "Expanded Mode"- displays all Client Plans, regardless of the plan type, or dates. "Text Mode" displays the text associated with the Plan. "Filters" will allow you to adjust the dates or types of plans that display.

- 2. Double click on the client plan you wish to view.
- 3. To view all the planning tiers, click on the "Planning Tiers" pane. The client plan will appear.

	Client Plan Pa	nes		
G	-	X 1 12 2 6 1	🔉 🔮 🗔	
Refresh	Perform Forced Validation	Delete/Void Final Modify Revise Review I Approve Dates	Print Add Close Signature + Panel	
Refresh	Validation	Actions	Signatures Close	
lanning	Tiers			<b>→</b> ₽
evel   Ty	pe	Description	Established Status	Status D   Target D
	Strength	Actively Seeking Information about Change	12/04/2016 Active	12/04/2016
	Strength	Hobbies/Special Interests	12/04/2016 Active	12/04/2016
-	Area of Need	Emotional-Behavioral/Psychiatric	12/04/2016 Active	12/04/2016
1	- Goal	Improve/Maintain Functioning	12/04/2016 Active	12/04/2016
1.1	Objective	Identify Irrational Thoughts	12/04/2016 Active	12/04/2016
1	Interve	ntion PSYCHOTHERAPY - INDIVIDUAL 30 [30]	12/04/2016 Active	12/04/2016
.1	Interve	ntion REHAB-GROUP 35 [35]	12/04/2016 Active	12/04/2016

4. To view the narrative for the planning tiers, click on the black drop down arrow, and select "Text mode."

	Client Plan Pa	ines			
Refresh Refresh	Validation	Delet	e/Void Final Modify Revise Review Print Dates Actions	Add Signature Signatures	$\sim$
Plannin	ig Tiers				
Level T	ype		Description	Established Status	S Text Mode
1	Strength		Actively Seeking Information about Change	12/04/2016 Active	12 Detail Mode
2	Strength		Hobbies/Special Interests	12/04/2016 Active	12 🔄 Refresh Pane Content
1 (	Area of Need		Emotional-Behavioral/Psychiatric	12/04/2016 Active	12/04/2016
1.1	🖃 Goal		Improve/Maintain Functioning	12/04/2016 Active	12/04/2016
1.1.1	.1 Objective		Identify Irrational Thoughts	12/04/2016 Active	12/04/2016
1.1	Interve	ntion	PSYCHOTHERAPY - INDIVIDUAL 30 [30]	12/04/2016 Active	12/04/2016 12/04/2016 12/04/2016 12/04/2016
1.1	Interve	ntion	REHAB-GROUP 35 [35]	12/04/2016 Active	12/04/2016 🚽

5. Planning tiers will display with the narrative portion listed below it.

Planni	ng Tiers				• 1
Level	Туре	Description	Established Status	Status Date Target Date	1
1	Strength	Actively Seeking Information about Change UNIT/SUBUNIT: 9900/9901 DATE	12/04/2016 Active : 06/23/17	12/04/2016	•
		(DOCUMENT STRENGTHS AND HOV OBJECTIVES.)	/ CLIENT WILL UTILIZE HIS / HER ST	RENGTHS TO MEET THE TREATMENT	
		NARRATIVE: Sue says she's "so tire back."	d of being depressed," and she wan	ts to learn skills sos he can "have my life	
2	Strength	Hobbies/Special Interests UNIT/SUBUNIT: 9900/9901 DATE	12/04/2016 Active : 06/23/17	12/04/2016	
		(DOCUMENT STRENGTHS AND HOV OBJECTIVES.)	/ CLIENT WILL UTILIZE HIS / HER ST	RENGTHS TO MEET THE TREATMENT	
		NARRATIVE: Sue enjoys writing po she liked.	etry and short stories. She has taker	creative writing classes in the past that	t
1	Area of Need	Emotional-Behavioral/Psychiatric UNIT/SUBUNIT: 9900/9901 DATE	12/04/2016 Active 12/04/16	12/04/2016	
		(DOCUMENT THE CLIENT'S SPECIF) CLIENT'S OWN WORDS TO INDIVID		CHIATRIC NEED FOR TREATMENT, USE	
		"happy" (writing, reading, being wi and he's afraid he'll lose his job "for becaus "it takes too much energy"	h friends). He says that "fatigue an calling in sick all the time." He says l to be with them and he "doesn't wan	enjoying things that typicaly make him d sadness" lessen his motivation for wor ne avoids friends when he's depressed t to bring them down all the time." He ares me." He says he wants therapy ar	
1.1	🖃 Goal	Improve/Maintain Functioning	12/04/2016 Active	12/04/2016	
		UNIT/SUBUNIT: 9900/9901 DATE	: 12/04/16		
		SEE OBJECTIVE(S) PLANNING TIER			
1.1.1	<ul> <li>Objective</li> </ul>	Identify Irrational Thoughts	12/04/2016 Active	12/04/2016	



# **INFORMATIONAL NOTE**

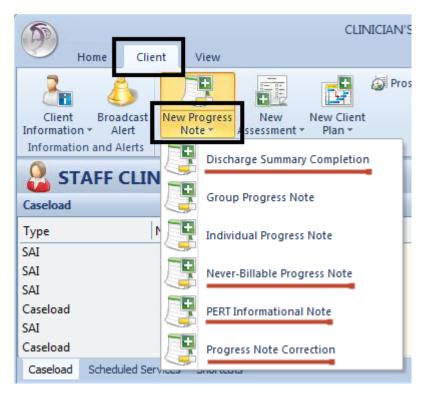
Informational notes are used when a not-billable activity is provided. The services documented in these notes are not connected to the client plan and no billing is generated. These notes are also used to record billing errors. You must select the type of informational note you wish to write.

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

*Note:* A *folder* should be in place before you create an Informational Progress Note.

#### Accessing a New Informational Progress Note:

- 1. Click on the "Client" tab.
- 2. Click on the lower portion of "New Progress Note" button.
- 3. Select one of the Informational Notes noted below, (there are 4 types).



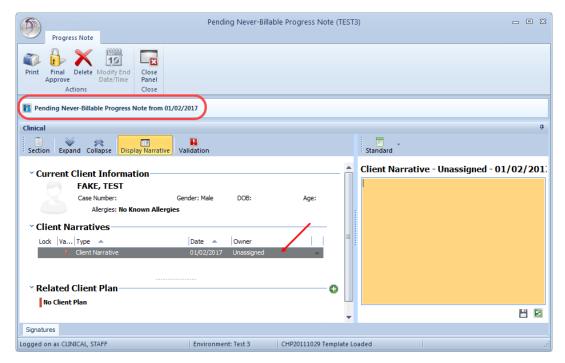
			2
	-		-
	-		
1	-	-	-

4. The begin date will automatically choose today's date. Be sure to change the date if the event took place on a different date. Be mindful when entering this date, as it cannot be changed. After selecting the appropriate date, click on the "Save" button.

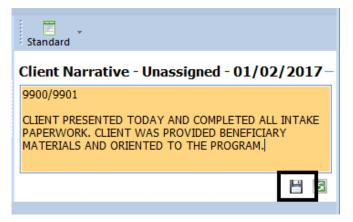
						Progre	ss No
50			Add Progr	ess Note (TEST3)			
J	Progress Note						
H							
Save	Close						
ctions	Panel Close						
Clic	k Save to confirm	selections and a	add a new Prog	gress Note			
	Decessory Marke	Never Billable E	Program Mate		02	1	
	Progress Note		rogress Note		UΖ		
	Start Date	1/2/2017					

#### Enter a Narrative in a Progress Note:

- 5. The empty note window displays ready for data entry. In the "Pending Never-Billable Progress Note" window, verify the "Date" for the Progress Note. If the date is not correct, select "Delete" and start again.
- 6. The yellow narrative section indicates you are ready to begin typing. If the section is not yellow, double click anywhere on the "Client Narrative" line to open the narrative for data entry.



7. Once you have completed the narrative entry select the save icon below the narrative.



8. Your name will now show as Owner of that narrative.

#### Client Narratives

Lock Va Type 🔺	Date 🔺	Owner	
Client Narrative	01/02/2017	CLINICAL, STAFF	

9. Select the green plus symbol, under "Related Client Plan," to indicate which *folder* you would like to store your note in. If there is only one option, it will auto select it for you.

Signatures

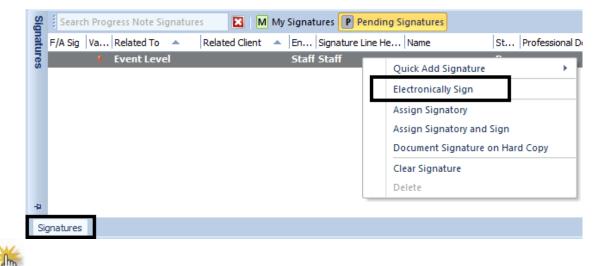
10. Once the correct client plan type is populated, click the save icon. (*It will change to a pen icon once it is successfully saved*).





#### **Progress Notes Signatures:**

- 1. Select the "Signatures" pane by single clicking at the bottom. This will automatically show all pending signatures.
- 2. Right click on the "Staff Signature" line and choose "Electronically Sign".



Note: If your program requires a co-signature on informational notes, right click  $\rightarrow$  select "Quick Add Signature"  $\rightarrow$  "Add Staff Signature," select "Supervising/Co-Signer Staff," and then assign the signature to your supervisor.

<b>()</b>	Pending Never-Billable Prog	gress Note (TEST3)	- 6
Progress Note Print Final Delete Modify End Approve Actions			
Pending Never-Billable Progress Note from	01/02/2017		
Clinical			
Section Expand Collapse Display Narrat	ive	Standard	
<ul> <li>Current Client Information — TEST, FAKE</li> </ul>		No Narrative Selecte	d
TEST, FAKE Case Number:		ge: 32 yrs	d
TEST, FAKE Case Number:	M My Signatures P Pending Signatures	ge: 32 yrs	-
TEST, FAKE Case Number:			ve Selecte
TEST, FAKE Case Number: ress Note Signatures		ge: 32 yrs	d Date Time
TEST, FAKE       Case Number:       Search Progress Note Signatures	M My Signatures P Pending Signatures	ge: 32 yrs	-
TEST, FAKE Case Number:	M My Signatures P Pending Signatures	ge: 32 yrs	-

3. Select "Final Approve."

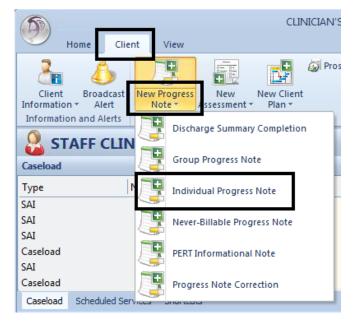


# **INDIVIDUAL PROGRESS NOTE**

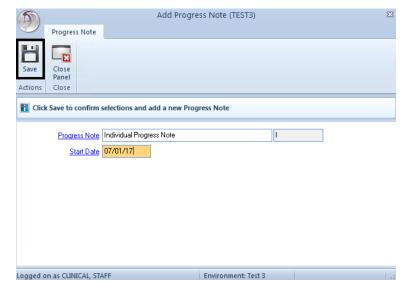
Each individual service provided to a client and/or their family must be documented using an individual progress note (one service, one note). Billing is generated from these types of notes.

#### To create An Individual Progress Note:

- 1. Click on the "Client" tab
- 2. Click on the lower portion of "New Progress Note" button.
- 3. Select "Individual Progress Note."



4. The begin date will automatically choose today's date. Be sure to change the date if the encounter took place on a different date. **Be mindful** when entering this date, as it cannot be changed. After selecting the appropriate date, click on the "Save" button.



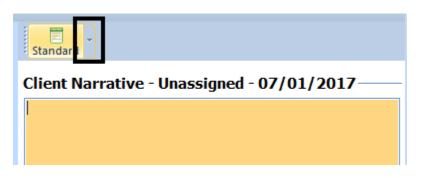


#### Enter a Narrative in a Progress Note:

- 1. The empty note window displays ready for data entry. In the "Pending Individual Progress Note" window, verify the "Date" for the Individual Progress Note. If the date is not correct, select "Delete" and start again.
- 2. The yellow narrative section indicates you are ready to begin typing. If the section is not yellow, double click anywhere on the "Client Narrative" line to open the narrative for data entry.

Progress Note	Pend	ing Individual Progress Note (TEST3)	
Final Detete ModifyEnd Date/Time Actions Close			
Pending Individual Progress Note from 07/01/20	17		
Clinical			ņ
Section Expand Collapse Display Narrative	La Validation		Standard
<ul> <li>Current Client Information         <ul> <li>TEST, FAKE</li> <li>Case Number:</li> <li>Alergies: penicilin V potassi</li> </ul> </li> <li>Client Narratives         <ul> <li>Lock   Va   Type ▲</li> <li>Clent Narrative</li> </ul> </li> <li>Related Client Plan         <ul> <li>No Client Plan</li> </ul> </li> </ul>	Sender: Male DOB: Jm, Peanut Date Owner 07/01/2017 Unassigned	Age: 32 yrs	Client Narrative - Unassigned - 07/01/2017
			88
Encounters Signatures			
Logged on as CLINICAL, STAFF	Environment: Test 3	CHP20111029 Template Loaded	NUM!

3. To import the standard text template client narrative, click on the down arrow next to the "Standard" button to launch the standard text menu.





Standard Text
Case Management Note / Case Management Note
Family Psychotherapy Note / Family Psychotherapy Note
Family Rehab Progress Note / Family Rehab Note
Group Psychotherapy Note / Group Psychotherapy
Group Rehab Note / Group Rehab Note
ICC Progress Note
Individual Psychotherapy Note / Individual Psychotherapy Note
Individual Rehab Note / Individual Rehab Note
Medication Progress Note / SOC
Nursing Progress Note
Service Code 24 / Medication Progress Note
Service Code 25 / Problem Focused Level of Exam
Service Code 26 / Expand Prob Focus Level Exam
Service Code 27 / Detailed Level of Exam
Service Code 28 / Comprehensive Level of Exam
TBS Progress Note / TBS Use Only
Telehealth Progress Note
Treatment Team Progress Note / SOC
Wraparound

5. Based on your clinical judgment,

clarify and complete all the prompts that have been populated in the narrative section. Once you have completed the narrative entry, select the save icon below.

E .

4. Select the appropriate standard text prompt that you wish to populate for the client's progress note.

1	Client Narrative - Unassigned - 07/01/2017—	
	TRAVEL TO/FROM:	
	CHIEF COMPLAINT:	
	Appearance and Cognitive capacity:	
	Current impairment: (Symptoms/behavior affecting functioning):	
	INTERVENTION: (Describe how skill building interventions are addressing the client's functional impairment(s)(s):	=
	RESPONSE:	
	PROGRESS TOWARDS OBJECTIVES:	
	PLAN OF CARE: (Changes in client plan, homework, next steps, referrals given):	
	OVERALL RISK:	
	Based on current service, including mitigating factors, evaluate and determine if the client is at an elevated risk for:	Ŧ
	8	5

6. Your name will now show as Owner of that narrative.

Client Narratives			
Lock Va Type 🔺	Date 🔺	Owner	
Client Narrative	07/01/2017	CLINICAL, STAFF	

7. Select the green plus symbol to select which *folder* you would like to store your note in. If there is only one option, it will be auto-selected it for you.

* Related Client Plan No Client Plan	0	
	*****	
Signatures		

- If this is a planned encounter, also select the Intervention and the linked Objective from the Client Plan. The green check box will indicate which are selected. Once the correct Client Plan type, Intervention, and Objective are populated, click the save icon. (*It will change to a pen icon once it is successfully saved*).
- 9. If this is an unplanned encounter, select the Client Plan and click the save icon. (*It will change to a pen icon once it is successfully saved*). The Interventions and Objectives shall be left blank.

Y Related Client Plan		H	)
<u> Client Plan - AOA Outpt / FSP Client Plan</u>		5	
Revision: 1.01 Start: 06/08/2017 End: 07/03/20	17		
Intervention(s)	Objective(s)		
PSYCHOTHERARY - INDIVIDUAL 30 [30]	Develop Coping Skills to Manage Emotional-Behavioral/		
REHAB-INDIVIDUAL 34 [34]			
CASE MGT/ DROKERAGE SU [SU]			
MEDS EM EXPANDED LOW 26 [26]			

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



#### Enter/Edit a Client Encounter:

1. Select the "Encounter" pane at the bottom. Double click on the red line to add a client encounter.

Encounters	- Import	Display Detail			
inters	I F	mpty Time Slot	Double Click to Add	07/01/2017	
		inpey time slot	DOUBLE CIECK TO AUG	0701/2017	
-12	4			Ш	
En	counters	Signatures			
Logg	ied on as C	LINICAL, STAFF	En	vironment: Test 3	CHP20111029 Template Loaded

2. Click on the green arrow to populate yourself as the server. If you selected an Intervention as a planned encounter in the client plan, it will also populate the service code. If it was an unplanned encounter, enter in the service code. Enter the Service time, Travel time, and Documentation time (as applicable). Then select "Save."

5			Progres	s Note I	Encounter	s (TEST3)				23
	Progress	s Note Encounters								
Refresh Refresh	Close Panel Close									
		r Information								д
Server/S	Service –				Date	/Time				-
		ead Server 🛛 🖊	,		/	Date	07/01/2017			
					K		Start	Duration	Stop	
5	Staff CLIN	ICAL, STAFF	/	80000	411	Service		0:58 📕		
Ser	vice REH/	AB-INDIVIDUAL 34 📕	-	34		Travel				
Superv	/isor				Doc	umentation		0:15		
								Save	Cancel	



3. Select the blue hyperlink to select the client's assignment. This will link the encounter to your program's Unit and Sub-Unit.

Saturday	July 1, 2017	0 day(s) ago
58 minutes 15 minutes (D)	REHAB-INDIVIDUAL 34 (34) CLINICAL, STAFF (800001)	
is minutes (D)	CLINICAL, STAFF (800001)	

Im

Note: Loaded Assignment for Unit/ Sub-Unit should appear; if not, check the client's assignment to ensure the client is open to your program during the date of service.

- 4. Check the service indicators to ensure proper documentation, and adjust service indicators accordingly.
  - a. In "Billing Type," select the language utilized for the service delivery.
  - b. In "Intensity Type," select the type of interpreter utilized for service delivery.

Billing					
Lab			Pa	rticipants	
Provided To	Client	C		Days	
Provided At	Office	Α		Quantity	
Outside Facility				Fee	
Contact Type	Face to Face	F			
Appointment Type	Scheduled	1			
Billing Type					
Intensity Type					



5. Click on "Diagnoses." In the top portion, all of the client's active diagnoses on that date of service will pull from the most recent final approved diagnosis assessment. Select the green arrow next to the diagnosis that was the focus of the treatment. The diagnosis will now display in bright green at the top and move to show in the lower portion of the screen. This indicates it is linked to the service.

*Note:* If a desired diagnosis is not on the list, a new Diagnosis Assessment must be entered. Only diagnoses that were active on the date of service will show.

Diagnoses E0F/30 Collateral Server(s) F39 ✓ F31 F13 F60	39 Un 31.31 Bip 13.10 Se 60.9 Pe	lient's Chart scription specified mood [affective] disorde olar disorder, current episode dep Jative, hypnotic or anxiolytic abus sonality disorder, unspecified rroiditis, unspecified	press I (Primary	/) 2 /) 3	Begin 01/01/201 01/01/201 10/15/201 10/15/201	.7 Active .6 Active	
			I (Primary	/) 5	01/01/201		400 \$00 \$
							<b>*</b>
Diagnos	oses for Service						
ICD	Desc	iption		Axis	/ Priority	Begin	
F31.31	1 Bipola	r disorder, current episode depre	ssed, mild	I (Primary)	1	01/01/2017	×

*Note:* To remove an attached diagnosis, click on the red "X" in the lower portion.

6. If homework was assigned or completed in the course of a mental health service, OR if a Child Family Team meeting was conducted for Pathways to Well Being clients, it must be indicated in the EBP (Evidence Based Practice). You may enter the selection on lines 2 or 3. If all 3 lines are already filled you may remove what populated on default in lines 2 or 3. Selection 1 should always remain what populated. If these 3 options do not apply, staff will skip this step.

Encounter Information for Client: TEST	FAKE
Encounter	Currently Viewing Information for EBP/SS
Assignment and Billing Parameters	Evidence Based Practice/Service Strategy
EBP/SS Collateral Berver(s)	EBP/SS 1 Age-Specific Svc Strategy 61
	EBP/SS 2 Medication Management 07
	EBP/SS 3 Homework Assignment Given 90



Note: If there was a collateral server- a separate service will be entered to bill for their unique contribution for the specialty mental health service. Do not input their service information in the individual progress note.

7. When all the encounter information is entered and correct, select "Save".

5		Enco	ounter for	TEST FAKE			23
	Progress Note Encounters						
G Refresh	Delete Remove Void and	Add Collateral	Close Panel				
Refresh	Replicate Delete	Collateral(s)					
Encount	er Information for Client: 1	EST FAKE					д
Encount	er	Curre	ntly Viewi	ng Information for EBP/SS			
Assign Diagno	ment and Billing Parameters uses	Evide	nce Base	d Practice/Service Strategy			
EBP/SS Collate	s rral Server(s)		EBP/SS	Age-Specific Svc Strategy	61		
			EBP/SS	2 Medication Management	07		
			EBP/SS	3 Homework Assignment Given	90		
						Save	Cancel

Note: The "Cancel" button will eliminate all entry for re-entry.

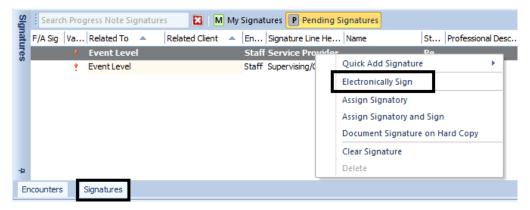
8. After you click on the "Save," the window closes and the services are displayed on the Encounter pane of the "Individual Progress Note" window. Ensure they are correct as they cannot be edited after the note is final approved.

1	Encounter	REHAB-INDIVIDUAL	34 (34) 07/01/2017	0:58	
_	Staff - Lead	CLINICAL, STAFF	07/01/2017	0:58	0:15 (D)
	Client	FAKE, TEST	07/01/2017	0:58	



#### **Progress Notes Signatures:**

- 1. Select the "Signatures" pane at the bottom. This will automatically show all pending signatures.
- 2. Right click on the first line, "Service Provider," and choose "Electronically Sign".



- 3. On the second signature line:
  - a. If you do not need a co signature, right click and select "Delete."

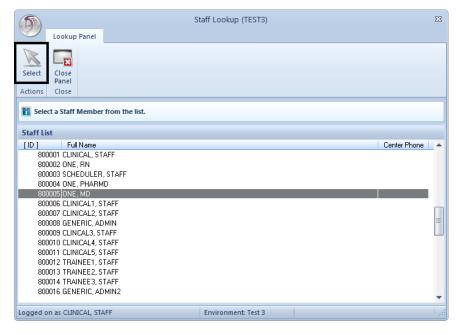
Sig	Search Progress Note Signatures 🛛 🔀 🛛 My Signatures 📭 Pending Signat	tures
Signatures	F/A Sig 🛛 Va   Related To 🔺 🛛   Related Client 🔺   En   Signature Line He   Nam	e St Professional Desc Si Rel
res	f Event Level Staff Supervising/Co-Si	Quick Add Signature
		Electronically Sign
		Assign Signatory
		Assign Signatory and Sign
		Document Signature on Hard Copy
		Clear Signature
-10		Delete
Б	ncounters Signatures	

b. If you do need a co-signature, right click and select "Assign Signatory"

Sig	Search	Prog	ress Note Sig	gnature	es 🔣 🕅	Му	Signatur	es P Pe	ending Si	ignatu	ires			
Signatures	F/A Sig	Va	Related To	*	Related Client	٠	En Si	gnature L	ine He	Name	2	St	Professional De	esc Si
res 4		*	Event Level				Staff Su	upervising	/Co-Si		Quick Add Electronical Assign Sign Document Clear Signa Delete	ly Sign atory atory ar signatu	]	> 
	counters	5	Signatures											
Logg	ied on as	CLIN	ICAL, STAFF				Environ	ment: Tes	t 3	C	HP20111029	Templat	e Loaded	

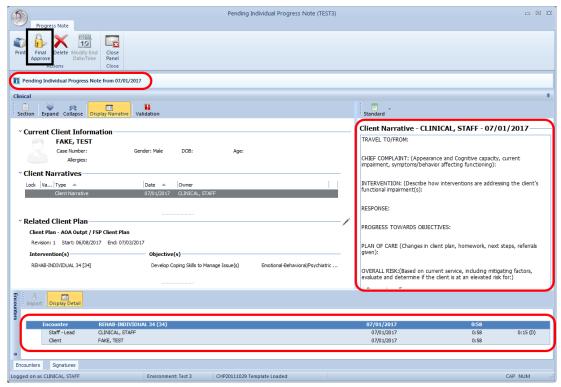


The Staff Lookup" window opens. If you know the CCBH number of the co-signer, begin typing it to search for the staff. If you do not know the number, single click in the "Full Name" column and begin typing, last name first. The "Search: [Full Name]" window appears. Select "OK" when you've completed typing the co-signer's name/staff ID. Click "Select" at the top once vour desired staff is selected. The staff's name will populate. Close the panel so the cosigner may review the note.



#### Final Approve the Progress Note:

1. Once all signatures are complete, verify the date, encounter information, and narrative are **complete and correct**, select "Final Approve."





# **GROUP PROGRESS NOTES**

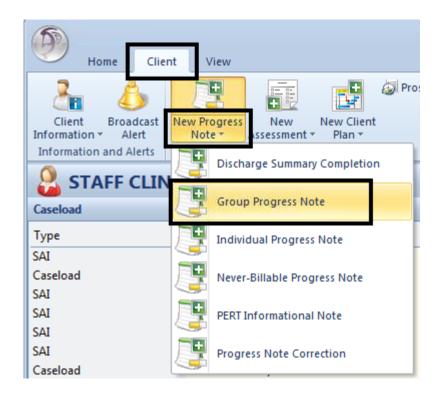
### **Group Progress Note:**

Group progress notes are used for services that include multiple clients such as group psychotherapy, group rehab, collateral group, etc. Billing is generated from these types of notes.

*Note:* A client plan type should be in place for **all** clients attending the group before you create a group progress note.

### Accessing New Group Note

- 1. Click on the "Client" tab.
- 2. Click on the lower portion of "New Progress Note" button.
- 3. Select "Group Progress Note."





4. The begin date will automatically choose today's date. Be sure to change the date if the encounter took place on a different date. Be mindful when entering this date, as it cannot be changed. Enter in the start and end time of the group. The system defaults to the A.M., so add a "P" for P.M. time. Be mindful when entering the time, as it cannot be changed. After selecting the appropriate date and time, click on the "Save" button.

9		Add Progress Note (TEST3)	23
	Progress Note		
H Save	Close Panel		
Actions	Close		
E Click	c Save to confirm s	selections and add a new Progress Note	
	Progress Note	Group Progress Note	
	Start Date	06/28/2017 Start Time 04:00 PM	
		End Time 05:00 PM	
Logged o	on as CLINICAL, STA	FF Environment: Test 3	

5. The empty note window displays ready for data entry.

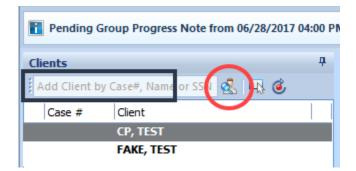
again.

. . . Pending Group Progress Note (TEST3) 5 🗙 📅 🗔 0 te from 06/28/2017 04:00 PM - 06/28/2017 05:00 PM 6. In the "Pending SSN & 48 @ Group Progress Expand Collapse Case # Clent Note" window, verify There are no items to show No Narrative Selected ~ Current Client Information No Client Selected the date and time Case Number: DOB Allergies: No Kn An All are correct. If the **Overview Narratives** date and or time are not correct, select **Client Narratives** "Delete" and start Lock Va... Type ... Date -There are no items to show Related Client Plan No Client Plan Encounters Signatures ged on as CUNICAL STAFF



#### **Adding Clients:**

- 1. Add clients by entering the client's case number, and selecting "Enter" on your keyboard. If you do not have the case number(s) utilize the client search icon. When the client is successfully added to the group, their name will display.
- 2. Repeat this step for each client in the group.



#### Adding Clinical Narratives:

There are two narrative sections in the Group Progress note. The Overview Narrative is for the overview of the group. The Client Narrative details the specific client's mood, safety issues, participation in group, progress towards individual goals, etc.

- 1. The client selected in gray on the list to the left indicates which client chart you are documenting in. The client's name will also be listed in the center of the note.
- 2. The "Overview Progress Note" section is where you provide a general description of the overall focus of the group for all participants. In this section, you would include the objective(s) for the group and the anticipated outcome(s). Double click anywhere on the "Overview Narrative" line to open the narrative for data entry. The yellow narrative section indicates you are ready to begin typing.

Clients P	Clinical	φ.
Add Client by Case#, Name or SSN 🛃 🖳 💰	Section Expand Collapse Display Narrative Validation	Standard
FAKE, TEST	Current Client Information FAKE, TEST Case Number: Gender: DOB: 10/11/1999 Age: Allergies: No Known Allergies	Overview Narrative - Unassigned - 06/2
	✓ Overview Narratives         Date ▲         Owner         Image: Control of the state of the sta	



 Import the standard text template for the Overview Narrative, by selecting the arrow. Based on your clinical judgment, clarify and complete all the prompts that have been populated in the narrative section. Select the save icon at the bottom of the narrative.

Progress Notes
Standari
Overview Narrative - Unassigned - 06/28/2017–
9900/9901
OVERVIEW (Using a global description of the entire
group, describe the focus and intended outcome):
COLLATERAL SERVER
TRAVEL TO/FROM:
8

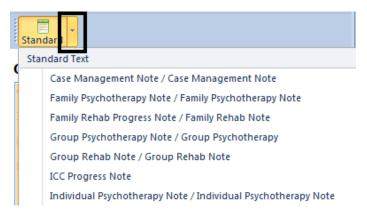
4. Your name will now show as Owner of the narrative.

Overview Narratives			
Lock Va Type 🔺	Date 🔺 Owr	her	
Overview Narrative	06/28/2017 CLIN	NICAL, STAFF	-

- 5. When the Group Overview has been written for one client and saved, it will prepopulate in the progress notes for all other clients in the group.
- 6. The "Client Narratives" section is where you document the specifics of the individual client's participation in the group. Double click anywhere on the "Client Narrative" line to open the narrative for data entry. The yellow narrative section indicates you are ready to begin typing.

nical			
ection Expand Collapse Display Nam	ative Validation	Standard	
Current Client Information –		Client Narrative - Unassigned - 06/28	8/2017
Case Number: Allergies: No Known A	Gender: DOB: Illergies	Age: ·	
Coverview Narratives	Date 🔺 Owner		
Overview Narrative	06/28/2017 CLINICAL, STAFF		
Client Narratives			

7. Import the "Standard Text" by selecting the arrow. Select the most appropriate option for help text on the type of information to include in your documentation.



 Based on your clinical judgment, clarify and complete all the prompts that have been populated in the text window. Select the save icon at the bottom of the narrative.

ľ	CHIEF COMPLAINT:
1	Appearance and Cognitive capacity:
	Current impairment: (Symptoms/behavior affecting functioning):
	INTERVENTIONS: (Describe how skill building interventions are addressing the client's functio impairment(s). If collateral server, include individual contribution to intervention):
1	RESPONSE (Offered feedback, opinions, suggestions etc.):
	PROGRESS TOWARDS OBJECTIVES:
	PLAN OF CARE (Next group, homework, action items):
1	OVERALL RISK:
	Based on current service, including mitigating factors, evaluate and determine if the client is an elevated risk for:
1	Danger to self:
	Danger to others:

9. Your name will show as Owner of the narrative.

Client Narratives												
Lock Va Type 🔺	Date 🔺 Owner											
Client Narrative	06/28/2017 CLINICAL, STAFF											



10. Select the green plus symbol, under "Related Client Plan" to select which *folder* you would like to store your note in. If there is only one option, it will be auto-selected it for you.

* Related Client Plan	( <b>0</b> )
No Client Plan	$\mathbf{\nabla}$

- 10. If this is a planned encounter, also select the Intervention and the linked Objective from the Client Plan. The green check box will indicate which are selected. Once the correct Client Plan type, Intervention, and Objective are populated, click the save icon. (*It will change to a pen icon once it is successfully saved*).
- 11. If this is an unplanned encounter, select the Client Plan and click the save icon. (*It will change to a pen icon once it is successfully saved*). The Interventions and Objectives shall be left blank.

× Related Client Plan		
<u>Client Plan - AOA Outpt / FSP Client Plan</u>	5	
Revision: 1.01 Start: 06/08/2017 End: 07/03/2017		
Intervention(s) Objective(s)		
REHAB-GROUP 35 [35] Develop Coping Skil Emotional-Be		

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

11. Select the next client in the group and repeat steps 6-10. Complete the documentation for each client in the group.

#### Enter/Edit the Client Encounter:

1. Select the "Encounter" pane at the bottom. Double click on the red line to add the server information.



Encounters	Voida		y Detail			_	
Ś	. !	Empty Time Slot	Double Click to Add	06/28/20	17 04:00 PM - 05:00 PM		
		Client	223-225, CPPN	06/28/2	01/ 04:00 PM - 05:00 PM	1:00	
		Client	TEST, FAKE	06/28/2	017 04:00 PM - 05:00 PM	1:00	
<b>4</b>		-					
En	counters	Signatures					
Logo	ged on a	s CLINICAL, STAFF	E	Environment: Test 3	CHP20111029 Template Loaded	đ	

2. Click on the green arrow to populate yourself as the server. Enter in the service code. The Service time will prepopulate from the group start and stop time. Enter the Travel time and Documentation time (as applicable). Then select "Save."

5			Progres	s Note	Encou	unters (TEST3)				23
	Progress	s Note Encounters								
G										
Refresh	Close									
Refresh	Close									
Encount	er Serve	r Information								д
Server/S	Service -					Date/Time				_
						Date	06/28/2017			
	V 1	ead Server			K		Start	Duration	Stop	
<u>s</u>	taff CLIN	ICAL, STAFF	/	80000	4m	Service	04:00 PM	1:00	05:00 PM	]
Ser	vice REH/	AB-GROUP 35 🖌		35		Travel				
Superv	visor					Documentation		0:23 🖌		
								Save	Cancel	
Logged o	n as CLINI	ICAL, STAFF		Enviror	nment:	Test 3				

Note: If a collateral server was utilized, make sure there is a valid reason to have a collateral server and it is documented well. The billing information for the collateral server should be entered as an 815 service code, by the administrative staff.

- Xi Void and Replicate Display Detail Encounters REHAB-GROUP 35 (35) 06/28/2017 04:00 PM - 05:00 PM 1:00 Encounter CLINICAL, STAFF 04:00 PM - 05:00 PM Staff - Lead 1:00 0:23 (D) 06/28/2017 CP, TEST 06/28/2017 04:00 PM - 05:00 PM 1:00 Client FAKE, TEST 04:00 PM - 05:00 PM Client 06/28/2017 1:00 -12 Encounters Signatures
- 3. Double click on a client to add the client encounter.

4. You can verify which client chart you are working in by looking at the top of the encounter:

5	5		Encou	nter for FA	KE TEST	0164600 Refe Rome 11/15/1994 (18513)		
	Progress	Note Enc	ounters					
5	X	<b>×</b>						
Refresh	Delete	Close Panel						
Refresh	Delete	Close						
Encount	er Inform	nation for	Client: FA	KE TEST				

	Currently Viewing	Information	for Assignme	ent and Billin	g Param	eters	
mation will	Date/Time						
eck the service	Date	06/28/2017	<u> </u>	/	/	-	
nment, and		Start 🛩	Duration	Stop 4			
ators to ensure	Service	04:00 PM	1:00	05:00 PM			
umentation, and	Assignment						
rdingly.	А	TRAINING UN	IIT (9900) / 1	RAINING SU	BUNIT (	<u>9901)</u> 🥢	
illing Type,"		Opened: 01/01	/2017				
t the language	Billing						
ed for the						_	
ce delivery.	Provided To	Client			С		
ntensity Type,"	Provided At	Office			A	~	
ct the type of							
preter utilized	Outside Facility						1
ervice delivery.	Contact Type	Face to Face			F	4	
	Appointment Type	Scheduled			1	~	
	Billing Type	English			1		
	Intensity Type	NOT APPLICA	BLE		Ν		

- 5. Billing inform appear. Che time, assign billing indica proper docu adjust accor
  - a. In "B selec utilize servi
  - b. In "In selec inter for se

6. Click on "Diagnoses." In the top portion, all of the client's active diagnoses on that date of service will pull from the most recent final approved diagnosis assessment. Select the green arrow next to the diagnosis that was the focus of the treatment. The diagnosis will now display in green at the top and move to show in the lower portion of the screen. This indicates it is linked to the service.

*Note:* If a desired diagnosis is not on the list, a new Diagnosis Assessment must be entered. Only diagnoses that were active on the date of service will show.

incounter	Currently View	ving Information for Diagnoses									
Assignment and Billing Parameters	Active Diagn	Active Diagnoses in Client's Chart									
EBP/SS	ICD	Description	Axis	Priority	Begin	Status					
	F39	Unspecified mood [affective] disorder	I (Primary)	1	01/01/2	017 Active	-				
	✓ F31.31	Bipolar disorder, current episode depress	I (Primary)	2	01/01/2	017 Active	K				
	F13.10	Sedative, hypnotic or anxiolytic abuse, u	I (Primary)	3	10/15/2	016 Active	-				
	F60.9	Personality disorder, unspecified	I (Primary)	4	10/15/2	016 Active	dan dan dan				
	E06.9	Thyroiditis, unspecified	I (Primary)	5	01/01/2	017 Active	-				
	Diagnoses fo	r Service									
	ICD	Description		Axis	🖉 Priority	Begin					
	F31.31	Bipolar disorder, current episode depressed, m	nild i	I (Primary)	1	01/01/2017	×				

*Wote:* To remove an attached diagnosis, click on the red "X" in the lower portion.

7. If homework was assigned or completed in the course of a mental health service, OR if a Child Family Team meeting was conducted for Pathways to Well Being clients, it must be indicated in the EBP (Evidence Based Practice). You may enter the selection on lines 2 or 3. If all 3 lines are already filled you may remove what populated on default in lines 2 or 3. Selection 1 should always remain what populated. If these 3 options do not apply, staff will skip this step.

Encounter Information for Client: TEST	Encounter Information for Client: TEST FAKE								
Encounter	Currently Viewing Information for EBP/SS								
Assignment and Billing Parameters	Evidence Based Practice/Service Strategy								
EBP/SS Collateral Berver(s)	EBP/SS 1 Age-Specific Svc Strategy	61							
	EBP/SS 2 Medication Management	07							
	EBP/SS 3 Homework Assignment Given	90							

Note: Pay attention to the following things: A) Time for each client auto populates. "Start", "Duration", and "Stop" times can be changed as necessary. B) Each client can have an individual start and end time. C) Verify billing indicators (Prov. To, Prov. At, etc.) D) Verify the correct diagnosis is linked to the service.

8. When all the encounter information is added, select "Save".

(5)		Enc	ounter for Ti	EST FAKE			23
	Progress Note Encounters						
G Refresh	Delete Remove Void and Replicate	Add Collateral	Close Panel				
Refresh	Delete	Collateral(s)					
Encount	er Information for Client: 1	EST FAKE					<b>4</b>
Encount	er	Curre	ently Viewing	Information for EBP/SS			
Diagno		Evide	ence Based P	ractice/Service Strategy			
EBP/SS Collate	aral Server(s)		EBP/SS 1	Age-Specific Svc Strategy	61		
			EBP/SS 2	Medication Management	07		
			EBP/SS 3	Homework Assignment Given	90		
						Save	Cancel

Note: The "Cancel" button will eliminate all entry for re-entry.

9. Repeat steps 3-8 until encounter information is added for each client. When all information has been added the encounter will display in blue.

Encounters	Void a	Nd Replicate Disp	lay Detail				
~		Encounter	REHAB-GROUP 35 (35)	06/28/2017	04:00 PM - 05:00 PM	1:00	
		Staff - Lead	CLINICAL, STAFF	06/28/2017	04:00 PM - 05:00 PM	1:00	0:23 (D)
		Client	CP, TEST	06/28/2017	04:00 PM - 05:00 PM	1:00	
		Client	FAKE, TEST	06/28/2017	04:00 PM - 05:00 PM	1:00	
÷							
En	counters	Signatures					

### **Progress Notes Signatures:**

- 1. Select the "Signatures" pane at the bottom. This will automatically show all pending signatures.
- 2. Right click on the first line, "Service Provider" and choose "Electronically Sign".

Sign	Search Progress Note Signatur	es M My Signatures P Pending Signatures	
뮽	F/A Sig 🛛 Va Related To 🛛 🔺	Related Client E Signature Line H Name	St Professional Des Si Relationship
res	🕴 Event Level	St Service Provider STAFF CLINIC	Quick Add Signature
	? Event Level	Staff Supervising/Co-S	
			Electronically Sign
			Assign Signatory
			Assign Signatory and Sign
			Document Signature on Hard Copy
-10			Clear Signature
E	incounters Signatures		Delete

### 3. On the second signature line:

a. If you do not need a co signature, right click and select "Delete."

Sig	Search Progress Note Signatures 🛛 🔀 🛛 M My Signatures 🕑 Pending Signatures							
nature	F/A Sig Va Related To	🔺 Relat	ed Client E	Signature Line H	Name	St	t Professional Des	.  Si  Re
res	f Event Level		Staff	f Supervising/Co-S		Quick Add S Electronically Assign Signa Assign Signa	iignature y Sign	•
						Document S	ignature on Hard Co	ру
-12						Clear Signat	ure	L
E	ncounters Signatures					Delete		
Log	ged on as CLINICAL, STAFF		En	vironment: Test 3	C	HP20111029	Template Loaded	

b. If you do need a co-signature, right click and select "Assign Signatory."

Sig	Searc	Search Progress Note Signatures 🛛 🕅 My Signatures 📭 Pending Signatures							
latu	F/A Sig	Va Relat	ed To	▲  F	Related Client	E Si	gnature Line H	Name	St Professional Des Si R
res		∮ Event	: Level			Staff Su	pervising/Co-S		Quick Add Signature     >       Electronically Sign     >       Assign Signatory     >       Assign Signatory and Sign     >       Document Signature on Hard Copy     >
E	ncounter	s Signat	ures						Clear Signature Delete
Log	ged on a	as CLINICAL,	STAFF			Enviro	onment: Test 3		CHP20111029 Template Loaded



 The Staff Lookup" window opens. If you know the CCBH number of the co-signer, begin typing it to search for the staff. If you do not know the number, single click in the "Full Name" column and begin typing, last name first. The "Search: [Full Name]" window appears. Select "OK" when you've completed typing the co-signer's name/staff ID. Click "Select" at the top once your desired staff is selected. The staff's name will populate. Close the panel so the co-signer may review the note.

	5	Staff Lookup (TEST3)	Σ
Lookup Panel			
Select Close			
Panel			
ctions Close			
Select a Staff Member	from the list.		
Staff List			
[ID] Full Name			Center Phone
800001 CLINICAL, STA			Center Frione
800002 ONE, RN			
800003 SCHEDULER.	STAFE		
800004 ONE, PHARMI			
800005 ONE, MD			
800006 CLINICAL1, ST	AFE		
800007 CLINICAL2, ST			ſ
800008 GENERIC, AD	ИN		1
800009 CLINCAL3, ST			
800010 CLINICAL4, ST	AFF		
800011 CLINICAL5, ST	AFF		
800012 TRAINEE1, ST	AFF		
800013 TRAINEE2, ST	AFF		
800014 TRAINEE3, ST	AFF		
	dIN2		
800016 GENERIC, AD			

#### Final Approve the Progress Note:

1. Once all signatures are complete, verify the date, encounter information, and narratives are **complete and correct**, select "Final Approve."

Pending Group Progress Note (TEST3)						
Progress Note						
Print Final Delete Modify End Close						
Approve Date/Time Panel						
Actions Close						
T Pending Group Progress Note from 06/28/2017 04:00 PM - 06/28/2017 05:00 PM						
Clients <sup>1</sup> Clinical	<b>4</b>					
Add Client by Case#, Name or SSN 🕴 📄 💊 🙊 🔳						
Case # Client Section Expand Collapse Display Narrative Validation	Standard					
CP, TEST	Client Narrative - CLINICAL, STAFF - 06/28					
FAKE, TEST	9900/9901					
Case Number: Gender: DOB: Age:	CHIEF COMPLAINT: (Appearance and Cognitive capacity, Current impairment, symptoms/behavior affecting					
Allergies: No Known Allergies	functioning):					
Overview Narratives	INTERVENTION: (Describe how skill building interventions					
Lock Va Type 🔺 Date 🔺 Owner	are addressing the client's functional impairment(s). If collateral server, include individual contribution to the					
Overview Narrative 06/28/2017 CLINICAL, STAFF	intervention):					
Client Narratives	RESPONSE: (Offered feedback, opinions, suggestions, etc):					
	etc).					
Lock Va Type A Date A Owner Client Narrative 06/28/2017 CLINICAL, STAFF	PROGRESS TOWARDS OBJECTIVES:					
Cilent Narrauve 06/28/2017 CLINICAL, STAFF						
	PLAN OF CARE (Next group, homework, action items):					
× Related Client Plan	·					
Client Plan - AOA Outpt / FSP Client Plan	OVERALL RISK: (Based on current service, including					
	mitination factors evaluate and determine if the client is					
Void and Replicate Display Detail						
ā         Encounter         REHAB-GROUP 35 (35)         06/28/20	17 04:00 PM - 05:00 PM 1:00					
Staff - Lead CLINICAL, STAFF 06/28/20						
Client CP, TEST 06/28/20	017 04:00 PM - 05:00 PM 1:00					
Client FAKE, TEST 06/28/20	017 04:00 PM - 05:00 PM 1:00					
*						
Encounters Signatures						
Logged on as CLINICAL, STAFF Environment: Test 3 CHP20111029 Template Loaded	CAP NUM:					



# **Report for Services**

The report listed below may be utilized for monitoring and maintenance of and Services. 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.

#### SERVICES REPORT

CLINICIAN'S HOMEPAGE	- 8
Client Profile	armacy rectory rmacies Break Glass Break Glass Break Glass Panel Options
Security Client Data	·
Type ATP Client Services Reports	Client Services Report
<u>S</u> cheduler	Client Services Listing
System <u>T</u> ools	Services Exceptions Report
	Timeliness of Service Entry Report
	Client Diagnosis Report
	Length of Stay Report Discharge Report
	CaseLoad Performance Report

### Productivity By Service Code And Server

This report captures the number of services and service hours listed by service codes and subtotaled by Server for a specific date range. It is run by the SubUnit and sorted by Server with a page break between Servers.

- 1. Locate Client Services Report on the menu toolbar.
- 2. Select "Load" on the Client Services Report screen.
- 3. Highlight "Productivity by Service Code and Server" from the template list and select "Load."
- 4. On Selections 3 tab, enter Unit and SubUnit.
- 5. On Selections 5 tab, enter Unit and SubUnit.
- 6. On Selections 8 tab, enter a date range in the "Date Range" and "Thru" fields for the period of productivity desired.
- 7. Other tabs and fields are pre-set for the template.
- 8. Select "Print" to print the report.



### **PROGRESS NOTE REPORTS**

<b>()</b>		CLINICIAN'S HOMEPAGE (TEST3) 3.0.0.0
Open Menu	Recently Opened Views D. Client Schlore Depart Application Menu Client Profile	ces     System eRx not available     Image: Constraint of the system and the
About CCBH	Client Data	
	ATP >	Clinician's Homepage (v3.0)
	System Tools	Client Action Schedules Maintenance
	System Loois	Client Categories Maintenance
		An Assessment and Treatment Plan Listing Assessment and Treatment Plan Listing Client Action Notifications Report
		Diagnosis Code Listing
		UnDuplicated Client Assignments Matrix Report
		Client Action Schedules Report
		Missing Progress Notes Report
		Show Client Medical Conditions
		Progress Notes Report

### **Progress Notes Report**

The Progress Note Report is a simple but effective way to identify progress notes that have not been final approved. All types of progress notes that are not final approved will populate on this report.

- 1. Locate Progress Notes Report on the menu toolbar.
- 2. Select "Load".
- 3. Highlight "Non-Final Approved Progress Notes Report" from the template list and select "Load."
- 4. On Selections 1 tab, enter a date range in the "Progress Note Start Dates" and "Thru" fields for the period desired. Enter in your staff ID in the "Staff Signature" field.
- 5. On Selections 2 tab, enter Unit and SubUnit.
- 6. Select "Print" to print the report.



## **EXPECTATIONS AFTER TRAINING**

- Progress notes will be entered in CCBH immediately after training (per staff and not by program).
- Plan for the transition
  - When staff return from training, they need to have a lower number of client contacts initially so that they can begin using CCBH right away.
  - Review caseloads.
  - o Allow time for clinicians to practice and receive needed technical support.
  - Use monitoring tools to support staff.

### PROGRESS NOTE CORRECTION RESOURCES ON THE OPTUM WEBSITE

- The Progress Note Correction Request Form(s).
- The Progress Note Correction Materials for individual notes and group notes for both clinical staff and administrative staff.
- The matrix of the full correction process for both individual and group notes.
- Video tutorials of common correction processes from start to finish.
- Billing Correction Tutorials

If you have questions on progress note corrections, or need assistance in the correction process, call the Optum Support Desk

### 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)				

vveekends (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.

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				

#### **Additional Contacts**

