MENTAL HEALTH MIS

CRISIS HOUSE ASSESSMENTS

County of San Diego
Behavioral Health Services

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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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CLINICAL STANDARD FOR ASSESSMENTS IN CCBH

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

Given that a client can have multiple historical assessments, it is helpful if the most current clinical information that prepopulates can be readily available for review when opening a new BHA, Psychiatric Assessment and/or Discharge Summary. Practically speaking, however, all information that prepopulates should not be summarily retained as portions of the assessments have become excessively long and have begun to lack clinical precision in describing the client's current needs. Since all historical information that has been final approved in these assessment types in CCBH exists for review at any time (for those who have access to the client's EHR), it is not necessary to retain all information that prepopulates in every section of an Assessment.
In 2011, the Clinical Standards Committee created standards addressing information that prepopulates into CCBH Assessments. In an effort to maintain the best clinical practice, these clinical standards have been revised by Quality Management to provide further direction on addressing information which prepopulates when adding new assessments in CCBH.

When a Client is New to Your Program

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

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

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

that the Presenting Problem information documented by you is specific to why the client is seeking services from your program at the time of the assessment.

B. Clinical Formulation: The Clinical Formulation section should be reviewed and summarized with information added to the Past Psychiatric History section, as needed. Then any prepopulated information in this section should be deleted so that the documentation in that section can refer specifically to your program, documenting clearly your assessment of medical necessity and the client's need for services at your program.

C. The following additional fields have been identified as areas in which historical information should be evaluated for inclusion, revision or deletion (when it makes clinical sense to do so):
    a. Past Psychiatric History
    b. Family History
    c. Educational/Employment History
    d. Cultural Information
    e. Social History
    f. History of Violence
    g. Trauma questions
    h. Substance Use Information
    i. Military History

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

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

<u>When Adding Information to an Assessment for a Current Client:</u>

Assessments are meant to be "living documents" in that new information may be added over the course of services as new information or clinical formulations

become available. If you have conducted the most recent assessment and are familiar with the client, it is not necessary to review each section in the entire Assessment. Rather, you may update just the sections for which you have knowledge of new information. Follow the documentation standards for labeling/dating the field you are changing as described in the paragraph above.

Concurrent Programs

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

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

Procedure: Documentation in Discharge Summaries

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

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

DIAGNOSIS PRACTICE GUIDELINES FOR THE ELECTRONIC HEALTH RECORD (EHR)

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

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

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

I. EXTERNAL PROVIDER:

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

A. When it is not within a clinician's, or programs' scope of practice to enter a diagnosis, the clinician may use a diagnosis from an "External Provider". The begin date of a diagnosis from an external provider shall be the date of the assessment or referral. A diagnosis from an External Provider is only used when there is no other active diagnosis form in the client's EHR.

B. The clinician shall complete the "External Provider" fields. The clinician shall enter the diagnostic information provided by the External Provider, the General Medical Conditions Summary Code, the diagnoses listed in order of priority, and the Trauma question.

C. When the Administrative Services Organization (ASO) authorizes services for a FFS provider and there is no active Diagnosis Form in the client's EHR, the ASO shall complete the External Provider fields. ICD-10 Other specified, Unspecified codes or Z03.89 code may be used until a specific diagnosis is received from the FFS provider. The ASO shall also complete the General

Medical Condition Summary, and answer the Trauma Question.

II. ENTERING THE DIAGNOSIS:

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

A. When an existing Diagnosis Form does not include the diagnoses for which a client is being treated at the program, that program shall add each diagnosis to the EHR with the date that the diagnosis was made.

B. When there is no existing Diagnosis Form, the Diagnosis Form must be completed with a mental health diagnosis that has a begin date on or before the first date of service.

C. There must be a SMHS reimbursable ICD-10 diagnosis listed as Priority 1 in order to claim for services.

D. Diagnoses may not be ended unless all programs concurrently serving the client agree. Multiple programs serving a client must coordinate with each other regarding diagnoses.

E. If a suspected mental health disorder is not yet diagnosed ICD-10 Other specified, Unspecified disorder codes or Z03.89 code may be entered until a specific diagnosis is determined.

F. On the Diagnosis Form, the diagnosing clinician shall assign a priority to each diagnosis. When a diagnosis is being added to an existing form, it will be given the next priority (based on Begin Date). A diagnosis with a higher priority number does **not** indicate that the diagnosis is more clinically relevant than one with a lower priority number. The client treatment is not affected by the priority number given to a diagnosis. Please note, a substance use diagnosis cannot be priority one.

III. DIAGNOSIS BEGIN AND END DATES:

A. Changing a Begin Date

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

B. Ending a Diagnosis

a. If the client has only one open assignment (only open to one program)
Staff may end a diagnosis if the client is no longer being treated for that diagnosis. The end date must be on or after the last date of service for that diagnosis.

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

C. Managing Diagnoses

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

IV. PRIORITIES FOR DIAGNOSES:

A SMHS reimbursable ICD-10 mental health diagnosis must be listed as Priority 1. The priority number in CCBH does not impact client treatment but does apply to claiming functions. When a diagnosis is added to an existing form, it is automatically given the next available priority number unless staff designate otherwise.

A. Outpatient Providers

a. When the EHR does not list the client's treatment diagnosis
The outpatient provider shall add the treatment diagnosis and make it priority 1.

b. When the EHR does list the client's treatment diagnosis
If the treatment diagnosis is listed, no action is required.

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

a. When the EHR does not include the client's treatment diagnosis
The EPU or ESU shall add the treatment diagnosis and make it Priority 1.

i. When the client leaves the EPU or ESU, the program shall end date the diagnosis that was added for that client. This will automatically return the existing diagnoses to their original priority.

b. When the EHR does list the client's treatment diagnosis as Priority 1
If the treatment diagnosis is listed as Priority 1, no action is required.

c. When the EHR does not list the existing client's treatment diagnosis as Priority 1
The EPU or ESU shall change the client's treatment diagnosis to Priority 1.

i. When the client leaves the EPU or ESU, no action is required.

V. DIAGNOSIS CLEANUP:

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

A. If client is ***not*** concurrently open to other programs, it is recommended to end the diagnosis that is no longer the focus of treatment. DO NOT DELETE THE DIAGNOSIS; ONLY END THEM. Use the final date of services with your program as the end date.

B. If the client is concurrently open to other programs, collaboration between programs **must** occur before ending any diagnosis. It is not acceptable to end any diagnosis without coordination of care if there is more than one program providing services at the same time.

VI. SUSPENSE ITEMS A & B:

A. An active diagnosis must be in place in order to claim for service. The date of diagnosis must cover all dates of service.

B. The diagnosis listed as Priority 1 must be a SMHS reimbursable ICD-10 diagnosis. A Priority 1 diagnosis may never be a neurocognitive or substance use diagnosis.

C. If there is an existing diagnosis listed that is the focus of treatment for the program, no action is required. Do not modify the existing begin date.

VII. GENERAL MEDICAL CONDITION:

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

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

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

CCBH SOFTWARE BASICS

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

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

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

- WHEN YOU GO BACK TO YOUR PROGRAM: You are learning how to enter assessments in the **"SDC Train CCBH"** environment during this training, which is for **practice purposes only**. It is important to enter all of your assessment information in the "**SDC Live CCBH**" environment when you return to your program.

- For password resets/menu issues: Call the Optum Support Desk. You may also call if you need your "SDC Live Anasazi Central" environment password or menu set up. Their contact information is:

Optum Support Desk
1-800-834-3792

Reminder:

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

CCBH SPEAK

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

PASSWORD CHANGES

Citrix (Cerner) Password

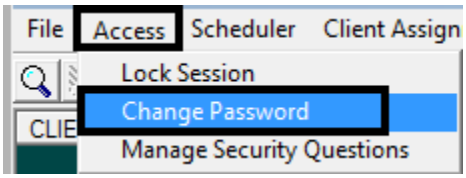
The first Citrix (Cerner) password you ever receive is considered a temporary password. For security reasons, you will be prompted to change your password on your first log in. To do so after the initial login, click “Change Password” when first logging in to Citrix (Cerner).

Next, follow the prompts to change your password.

CCBH Password

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

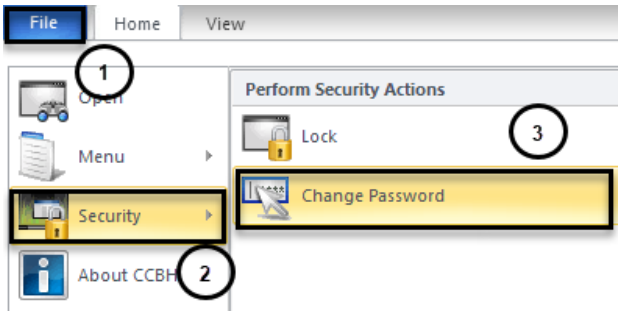
External View



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

Clinician’s Homepage

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

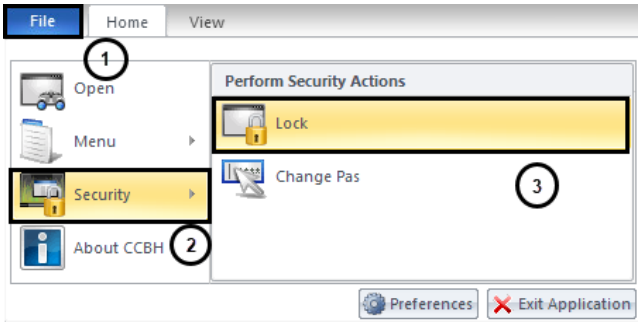


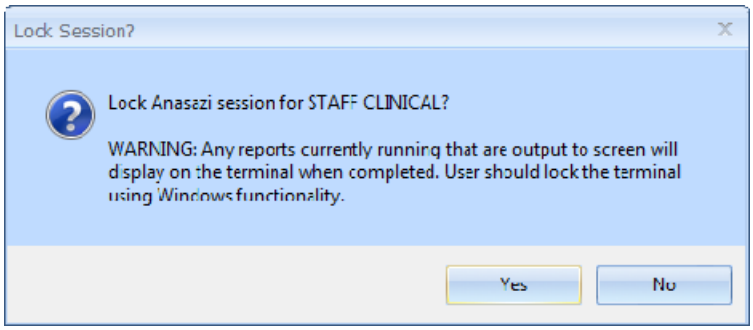
LOCK CCBH SESSION

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

Clinician's Homepage

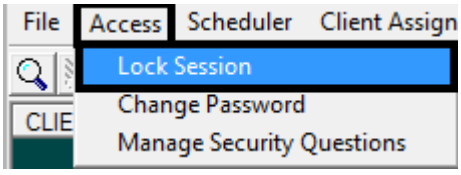
From the Clinician's Homepage, go to the "File Tab" and select the "Security" drop down menu, then select "Lock Session" button.



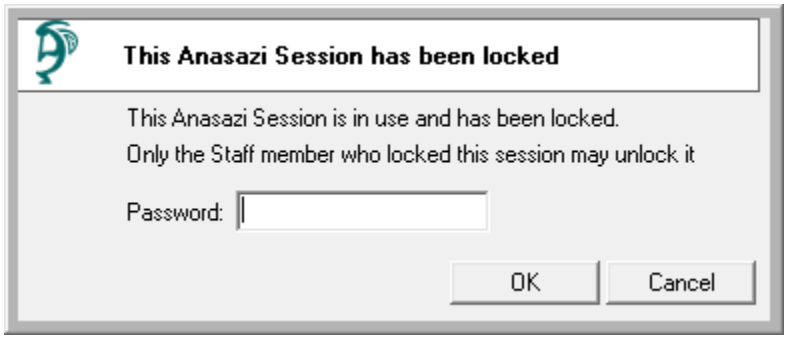


External View

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



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

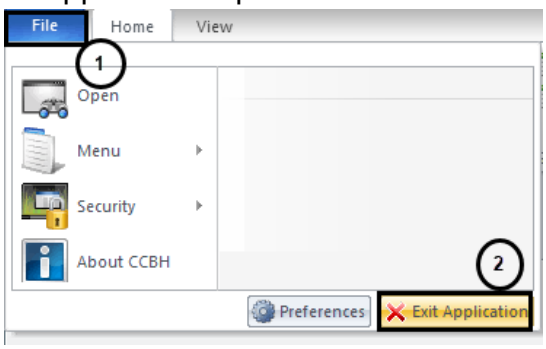


EXITING THE APPLICATION

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

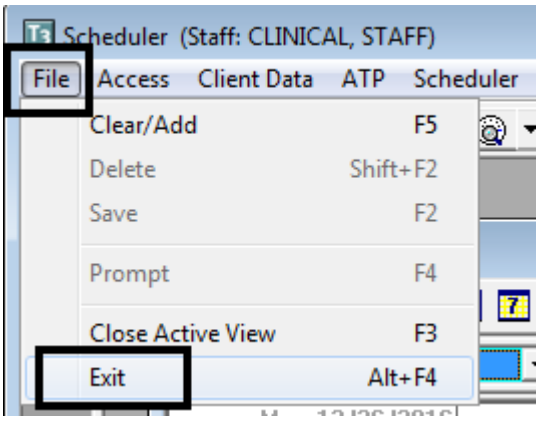
Clinician's Homepage

- Go to the "File Tab" menu in the top left-hand corner of your screen.
- Select the "Exit Application" option.



External View

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

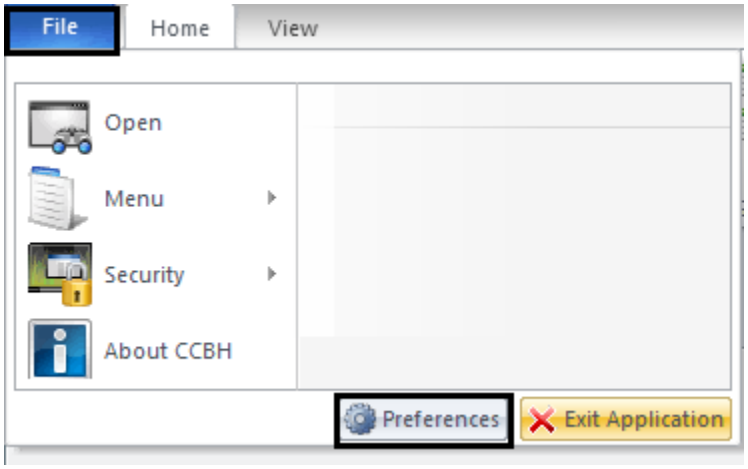


You risk being locked out of CCBH if you do not exit in the manner described above!

CLINICIAN'S HOMEPAGE PREFERENCES

How to setup and save preferences

Accessing Preferences:

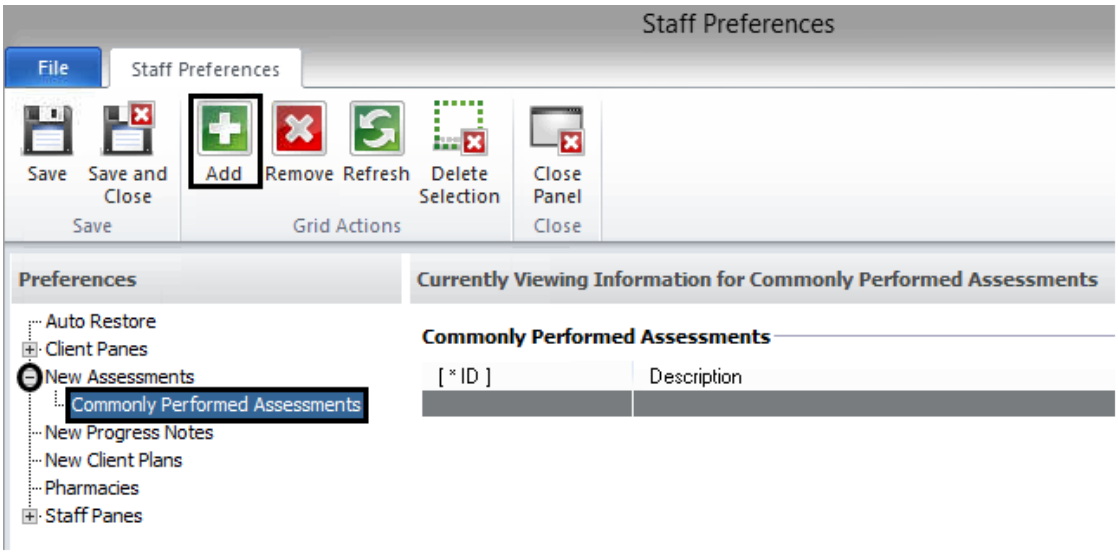


A- From the "File Tab"
B- Select the "Preferences" icon

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

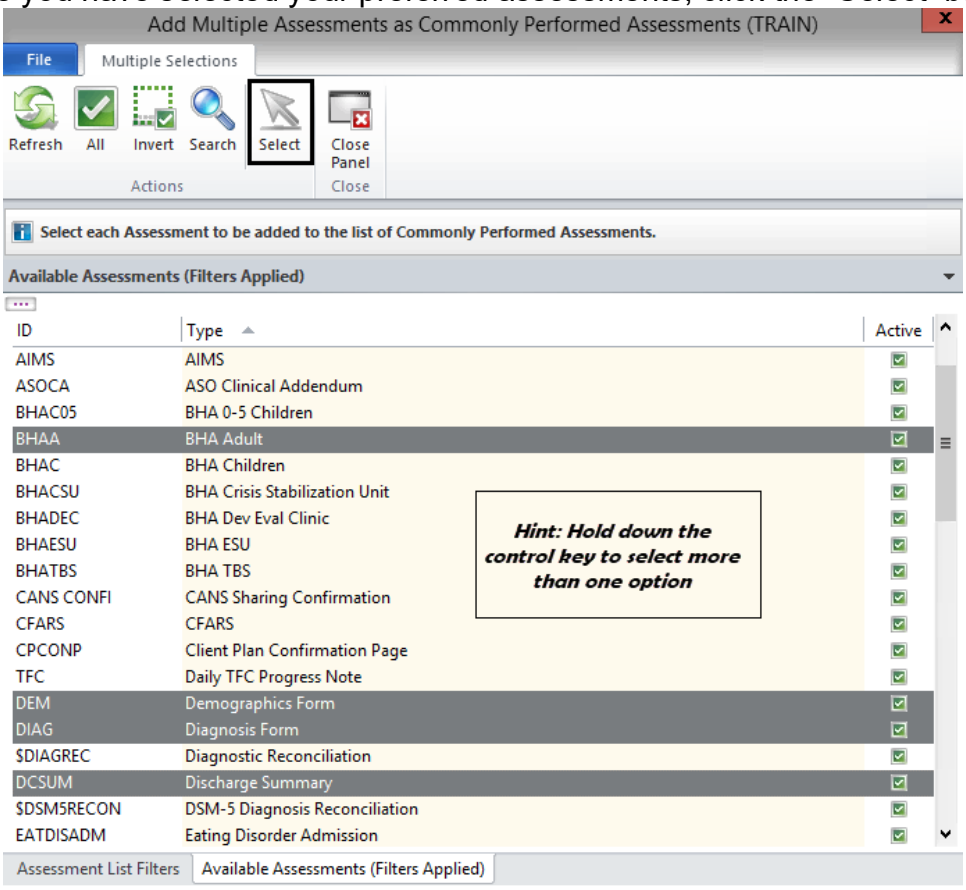
Preferences for New Assessments:

- Select the plus sign next to "New Assessments."
- Click "Commonly Performed Assessments"
- Click "Add"

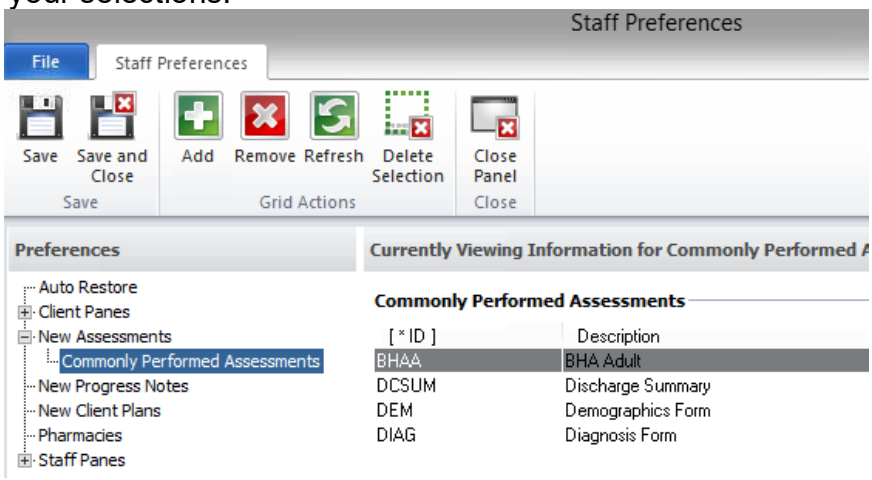


1) Select the assessment(s) *you* commonly perform. To select multiple assessments, hold down the “control” key as you click with the mouse.

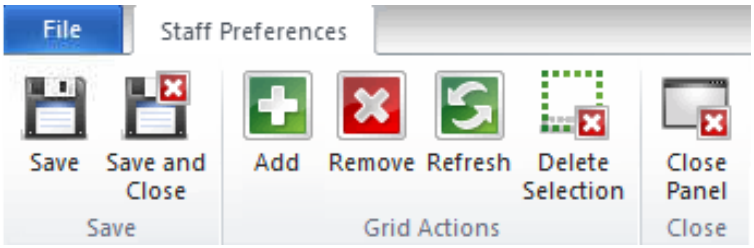
2) Once you have selected your preferred assessments, click the “Select” button.



You will see your selections.



Saving Preferences:



You have 3 options:

Save:

- Click the "Save" icon. This will save settings only.

Save and Close:

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

Close Panel:

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

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

CLINICIAN'S HOMEPAGE TERMINOLOGY

Identifying Terms Used on the Clinician's Homepage

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

File Tab:
It can be used to exit the application, set preferences, access the external view, or see recently opened views.

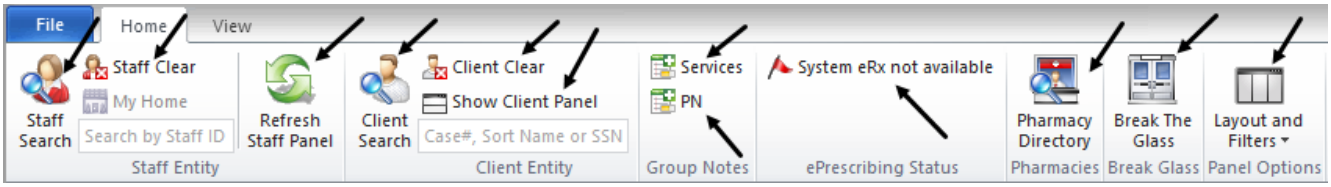
Tabs:
The "Tabs" listed below are displayed at the top of the Clinician's Homepage.

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

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

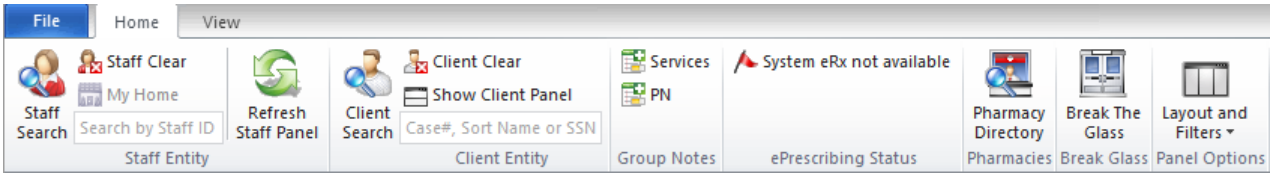
Buttons:

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



Ribbon:

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

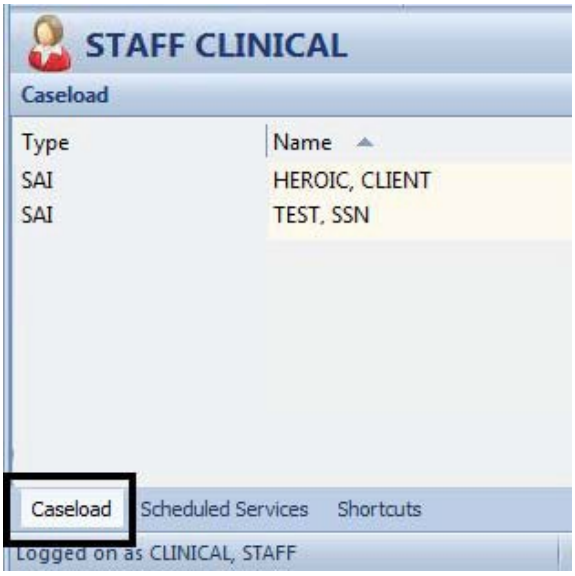


Staff Panel:
The Staff Panel automatically launches when the Clinician’s Homepage is opened.

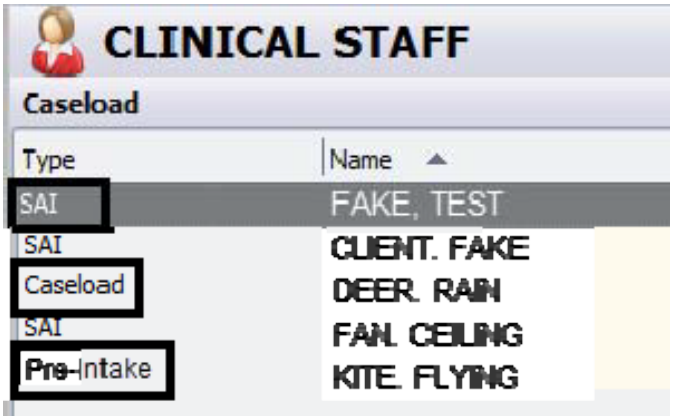
You will see your name as well as your job title listed. If you believe that the job title is incorrect, you must complete a new ARF form and submit it to the MH MIS Unit for correction.

Caseload:

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



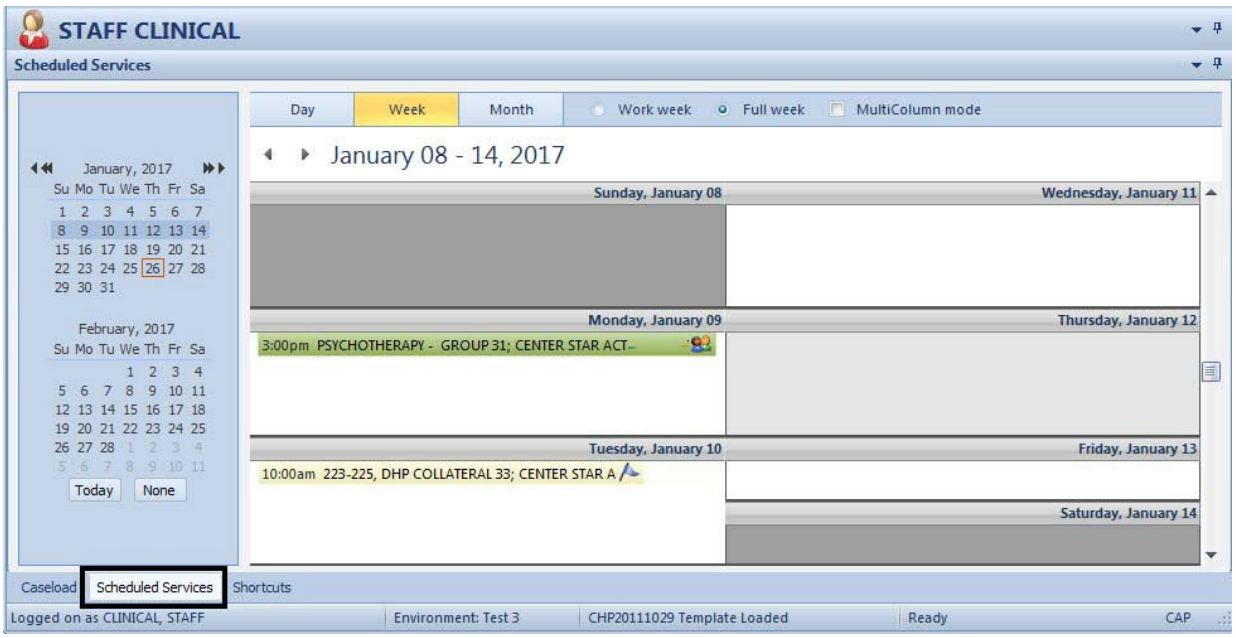
Identifying Client Type:



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

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

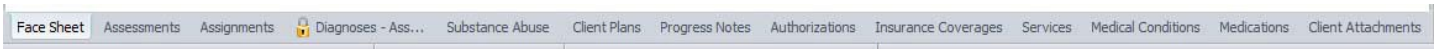
Scheduled Services:



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

Client Panel:

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

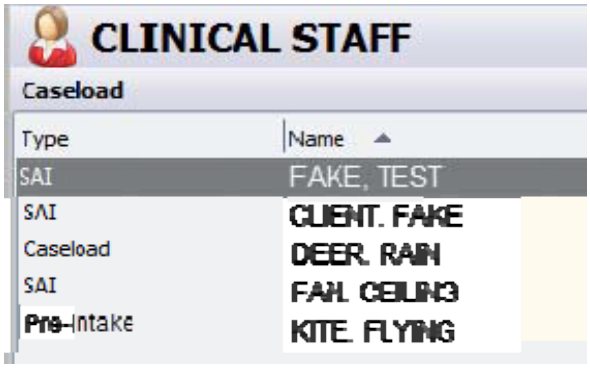


NOTES

CLIENT SEARCH

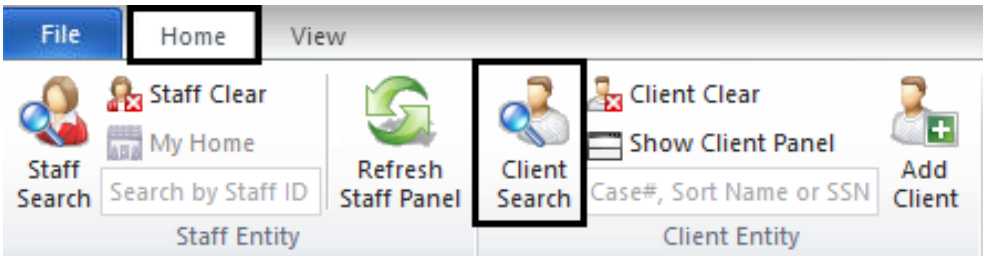
Searching for a Client Who Is In Your Caseload:

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

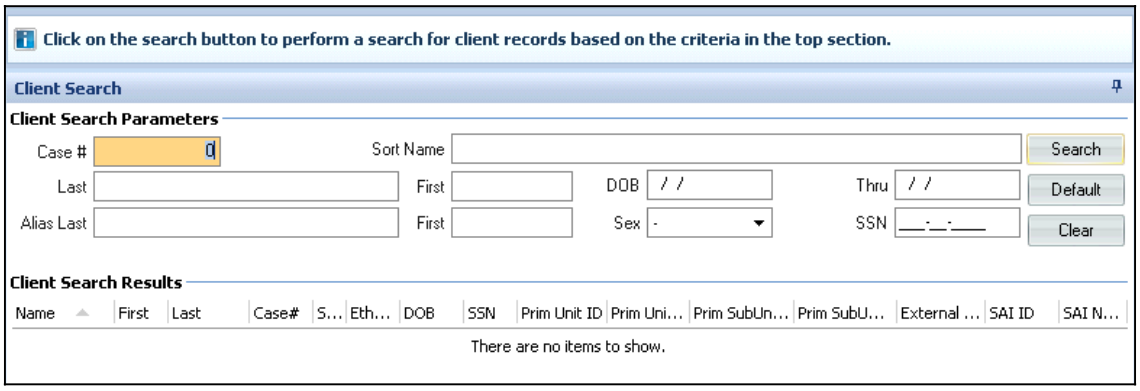


Searching for a Client Who Is Not In Your Caseload:

- Select the "Client Search" button

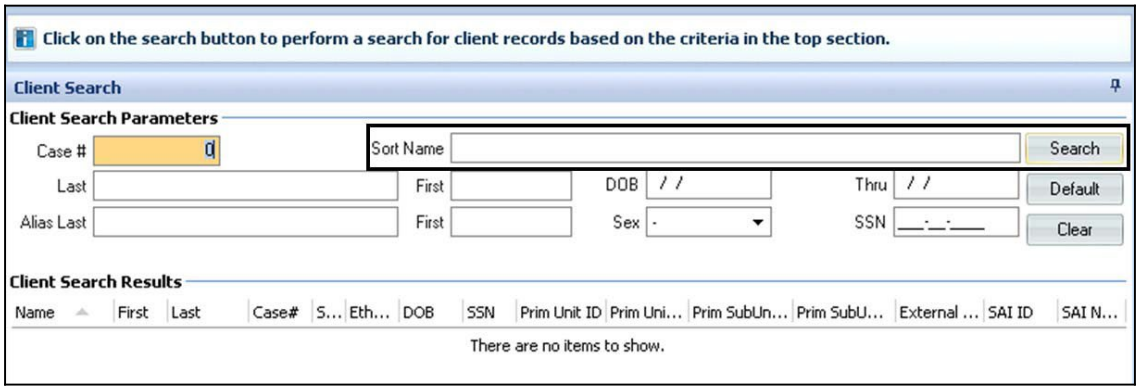


- The "Client Lookup" window will open

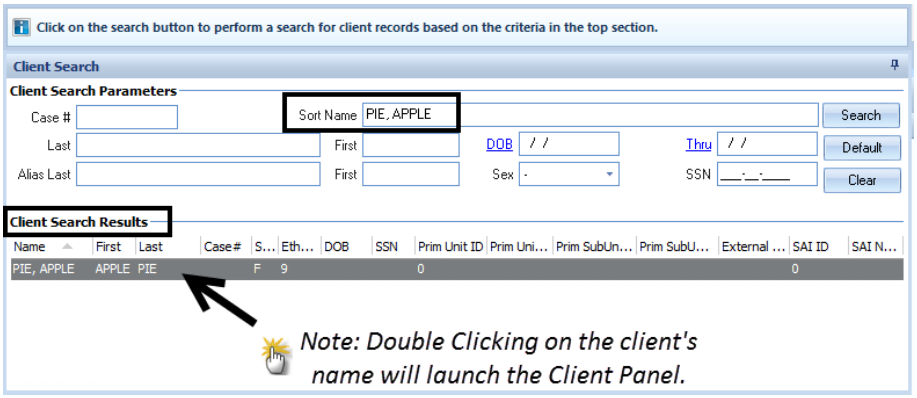


There are several different ways to search for a client from this window:

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



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



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

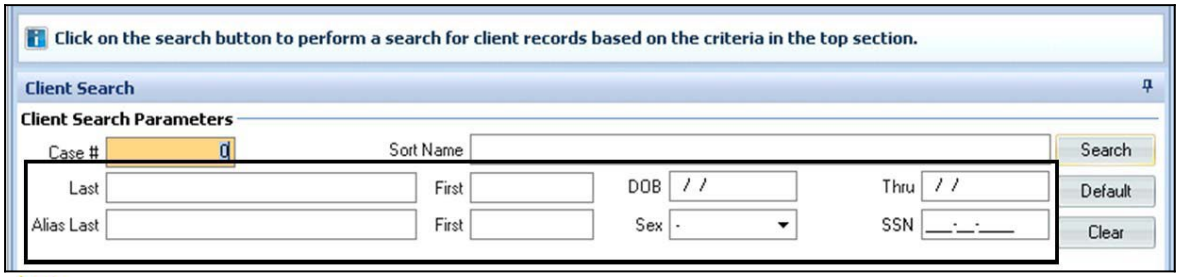
- This does not mean that the client is not in CCBH. Rather, you may not have entered the sort name exactly as it was formatted when the client’s information was first entered into the CCBH system. For this reason, you should search by other criteria such as:

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

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

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

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

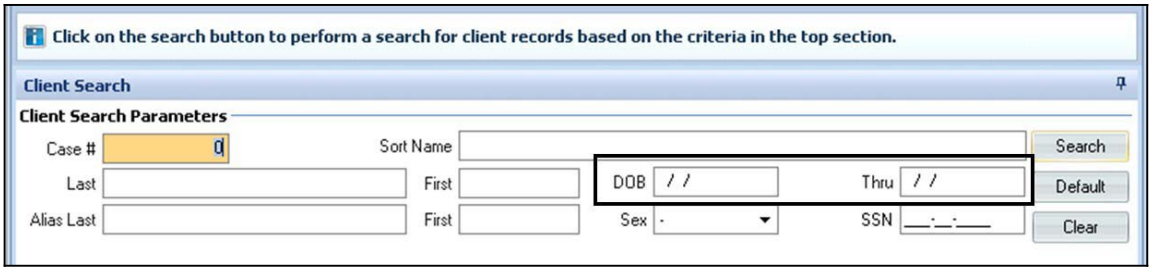


Note: If you search by data that is common in the system (such as conducting a search only by a common first name) you will receive the following warning screen. This allows you the option to either continue with or cancel the search.

Additional Client Search Feature

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

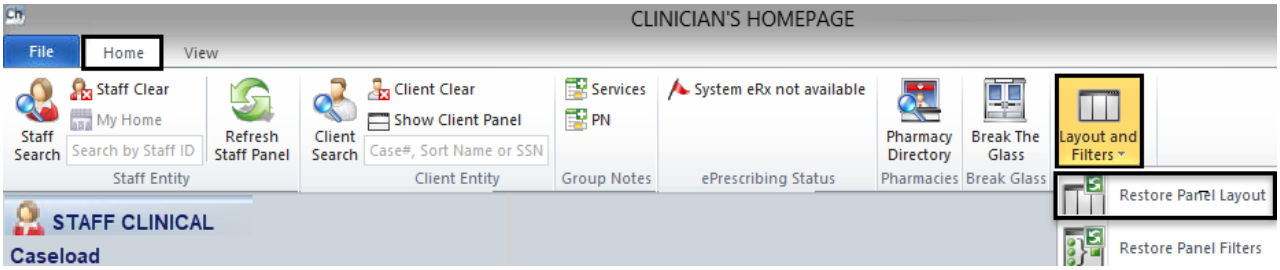
*Note: If the exact DOB is known ~ enter it in the 'DOB' **and** 'Thru' fields to find clients born only on that date.*



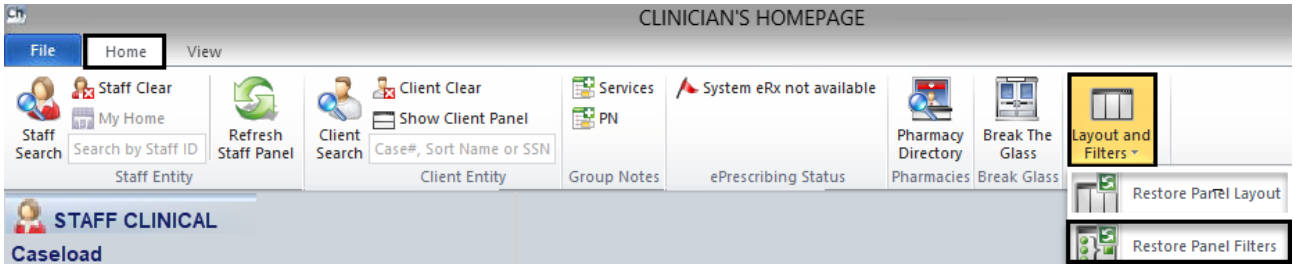
NOTES

RESTORE SYSTEM DEFAULTS

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



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

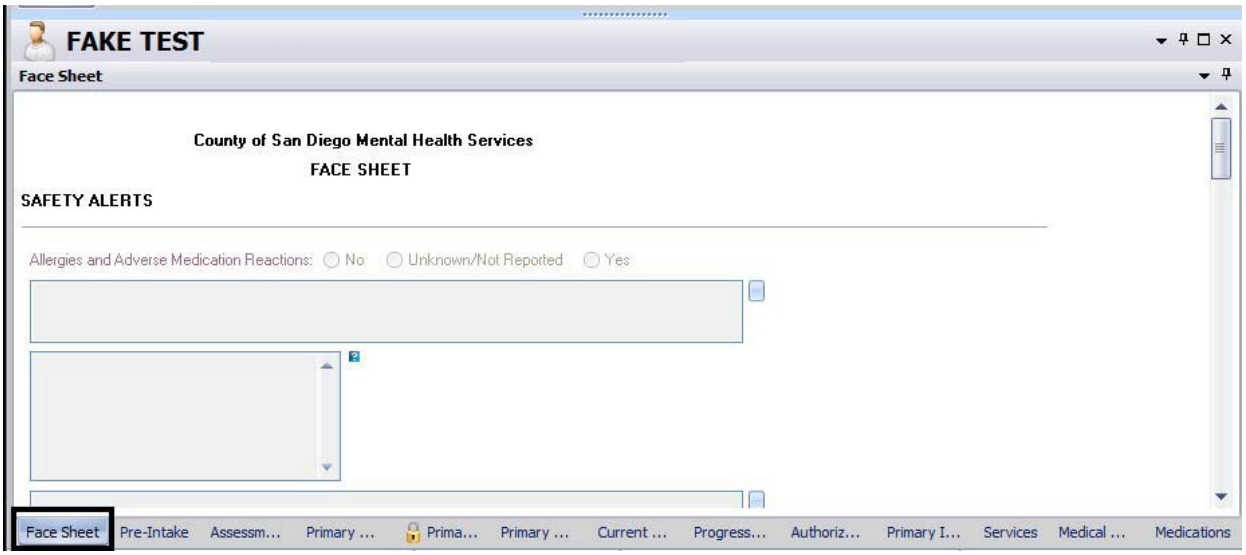


NOTES

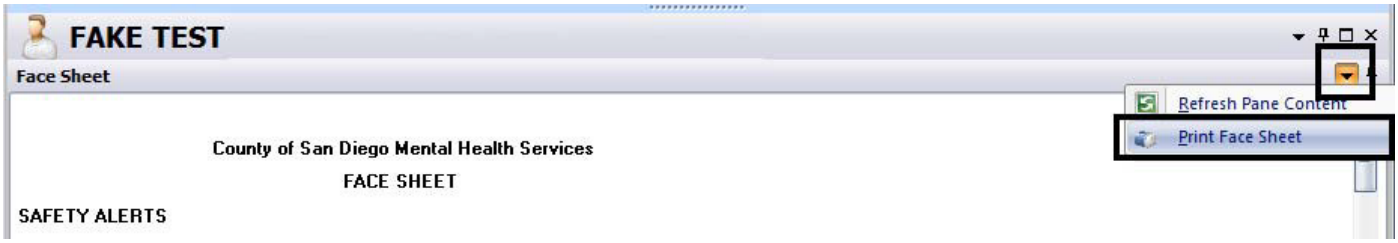
CLIENT FACE SHEET

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

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



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

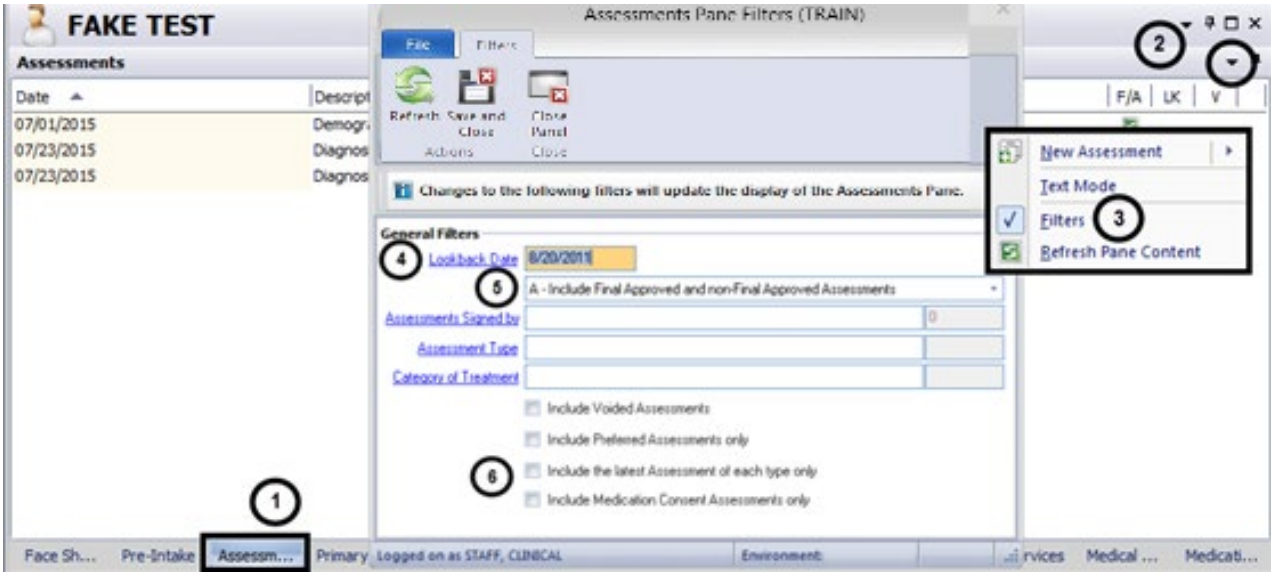


FILTER SETTINGS

Modifying filter settings to display historical assessments

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

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

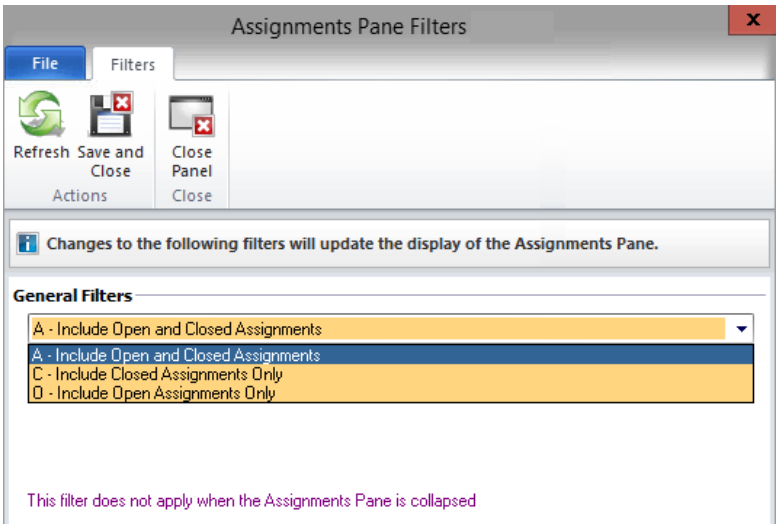


Filters in Clinician's Homepage:

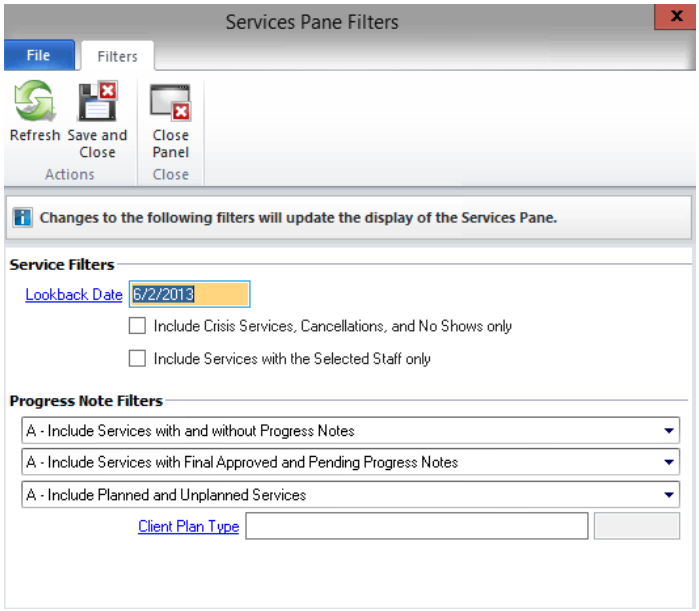
Note: Filters will vary based on which pane is selected on the client panel.

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

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



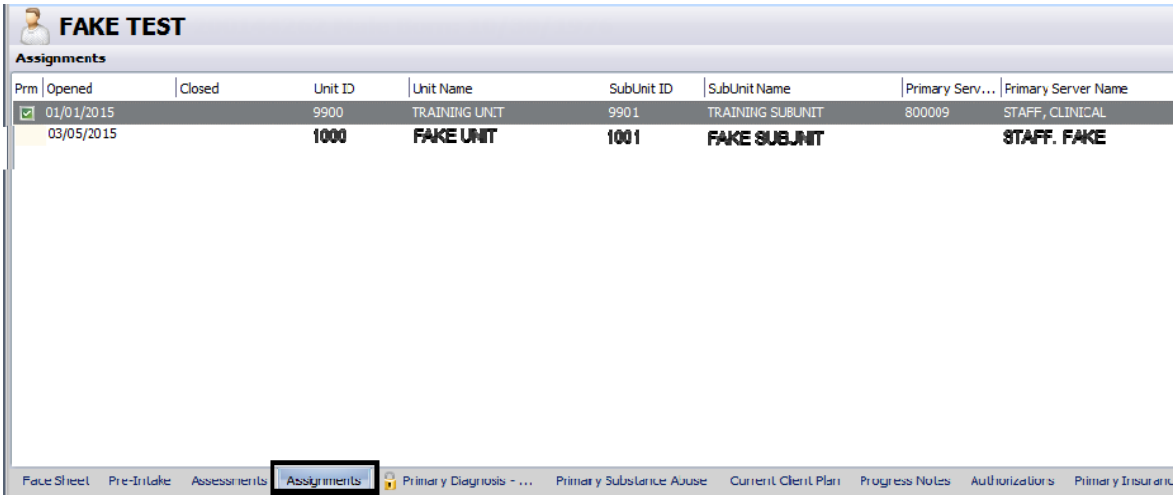
Services Pane Filter(s): updates the display of the Services Pane. The date field filters for services on or after the date entered. Check boxes further filter that data, for particular service types or services by specified staff, for example.



VIEWING CLIENT ASSIGNMENTS
Clinician's Homepage

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

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

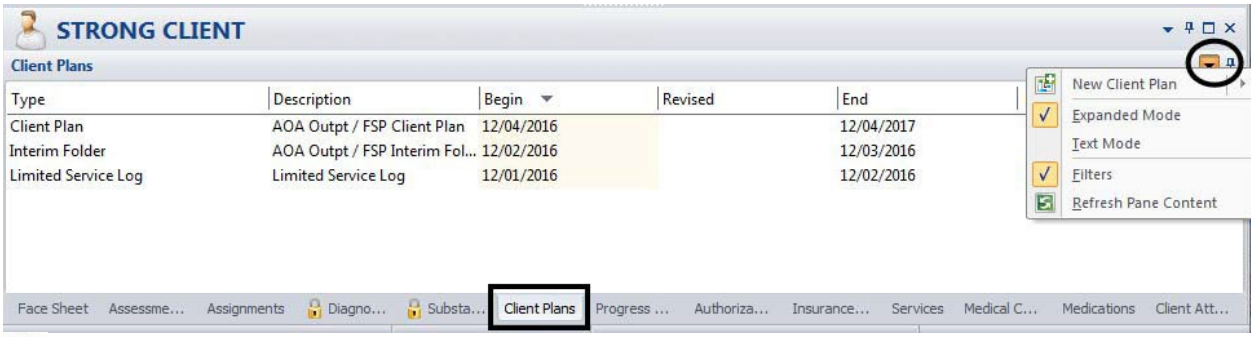


NOTES

VIEWING CLIENT PLANS

To View Existing Client Plans:

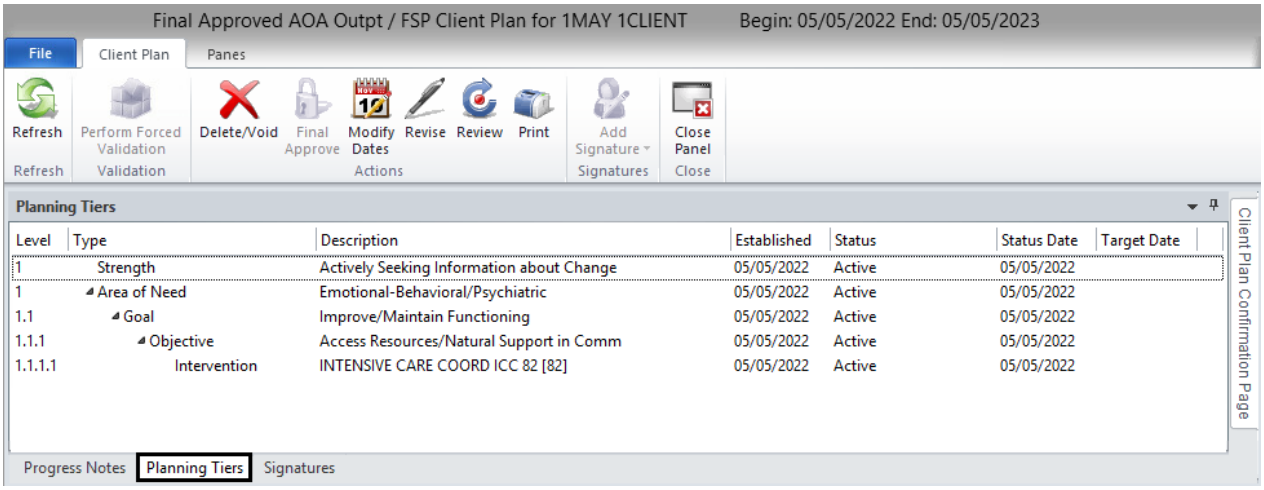
1. On the Client Panel, find the “Client Plans” pane and single click on it.



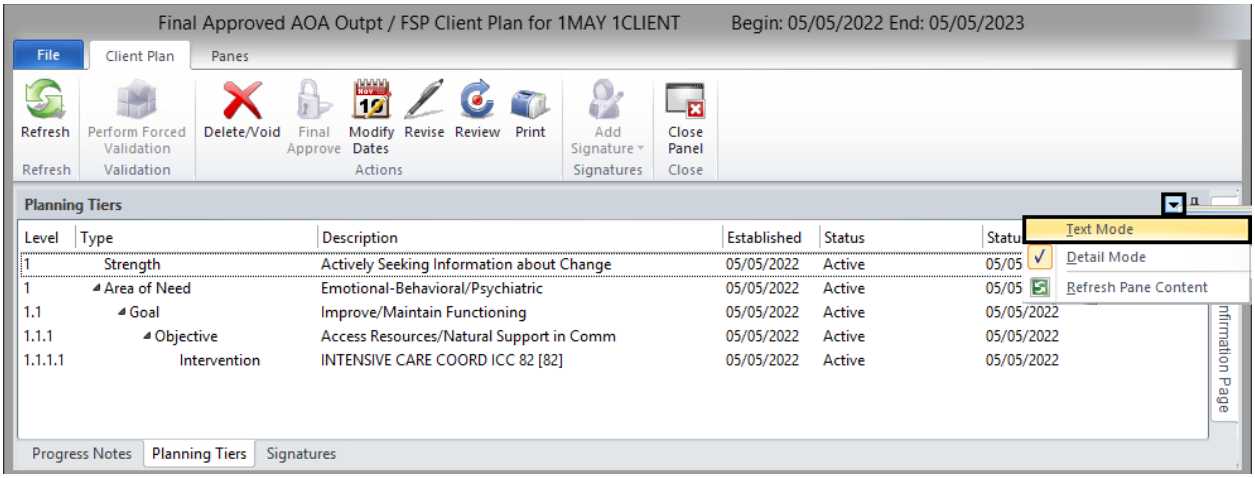
Note: “Expanded Mode”- displays all Client Plans, regardless of the plan type, or dates. “Text Mode” displays the text associated with the Plan. “Filters” will allow you to adjust the dates or types of plans that display.

2. Double click on the client plan you wish to view.

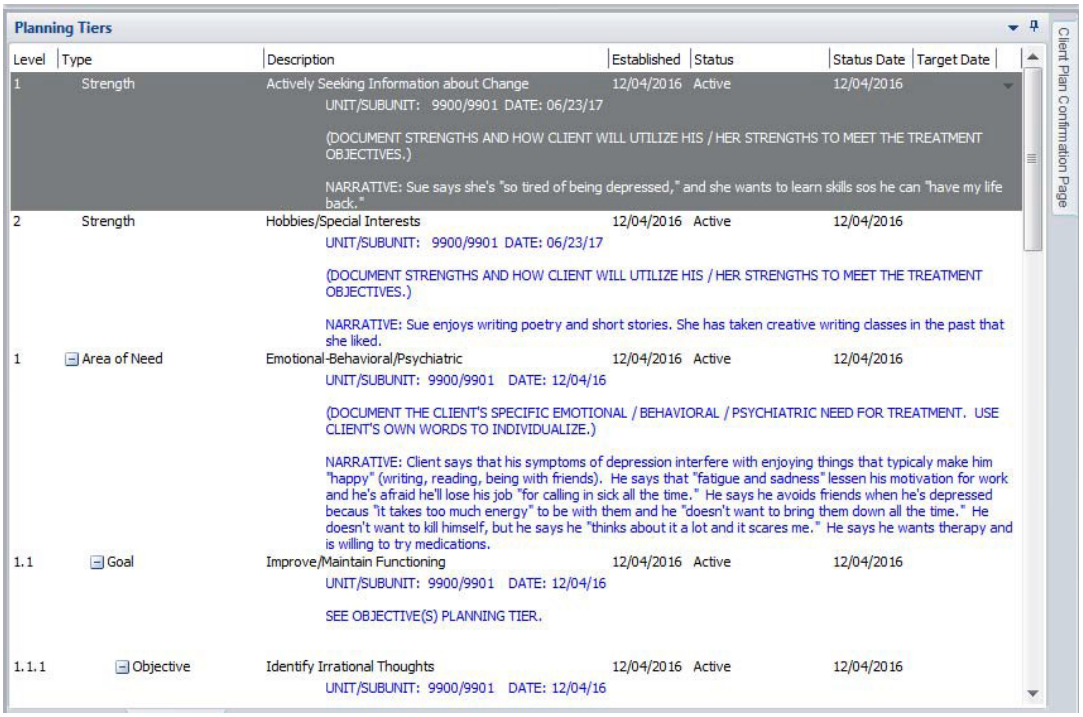
3. To view all the planning tiers, click on the “Planning Tiers” pane. The client plan will appear.



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

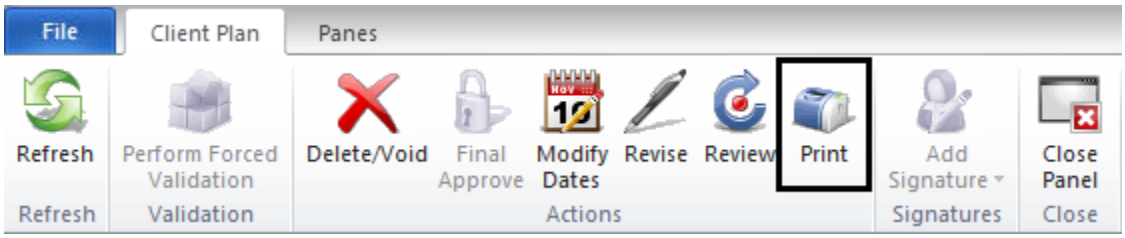


5. Planning tiers will display with the narrative portion listed below it.

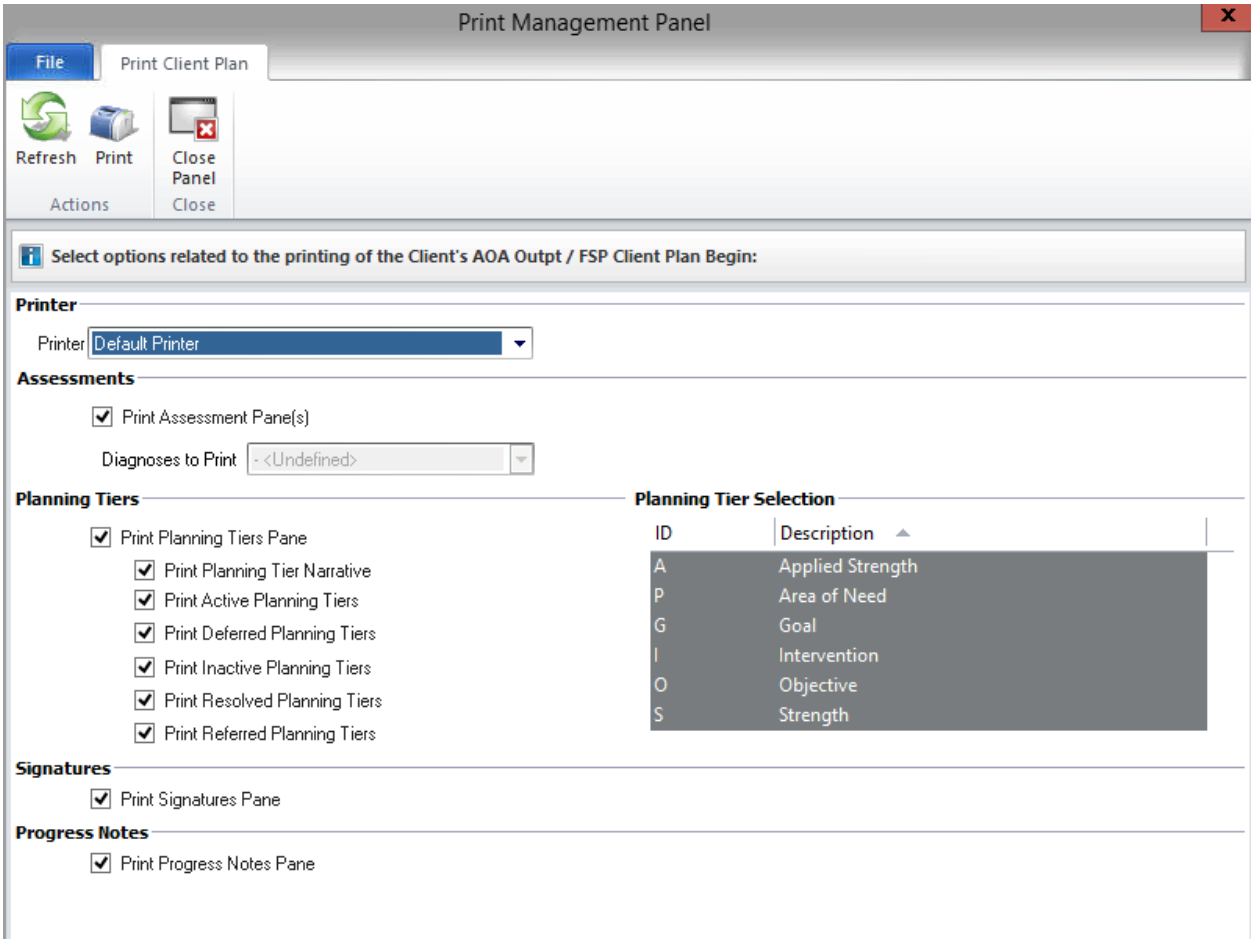


PRINTING CLIENT PLANS

1. To print the client plan, select “Print.”

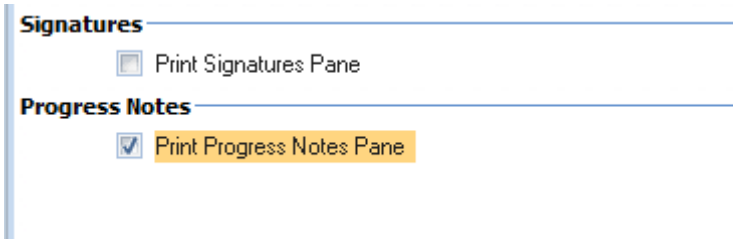


2. Adjust your Print Management Panel accordingly, and select “Print.”

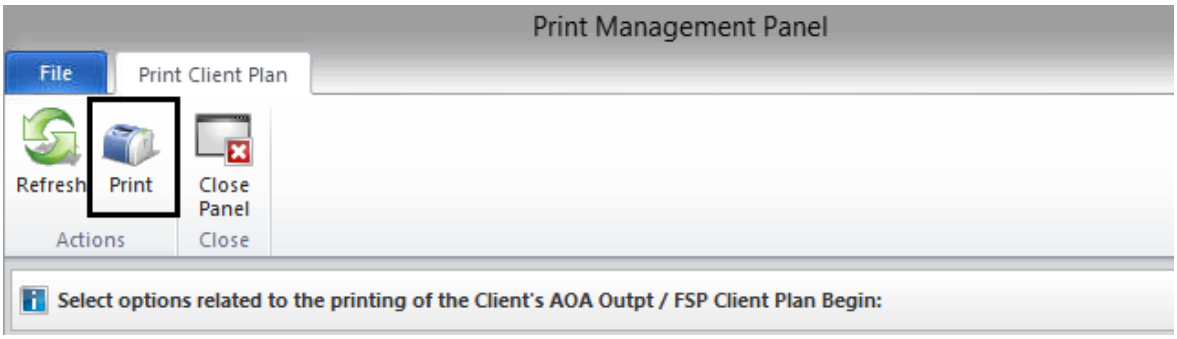


PRINTING ALL PROGRESS NOTES ASSOCIATED WITH A CLIENT PLAN

1. Follow the previous steps for printing the client plan. Be sure to uncheck all of the check boxes except for “Print Progress Notes Pane.”



2. Select “Print” once the selections have been made. All progress notes associated with it will print at one time.

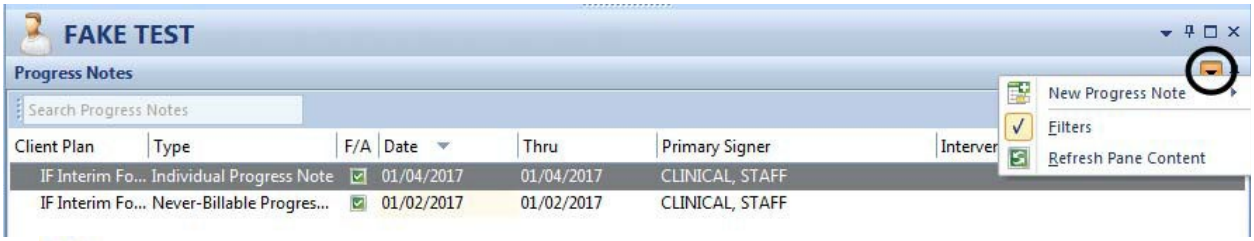


VIEWING PROGRESS NOTES

To View Existing Progress Notes:

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

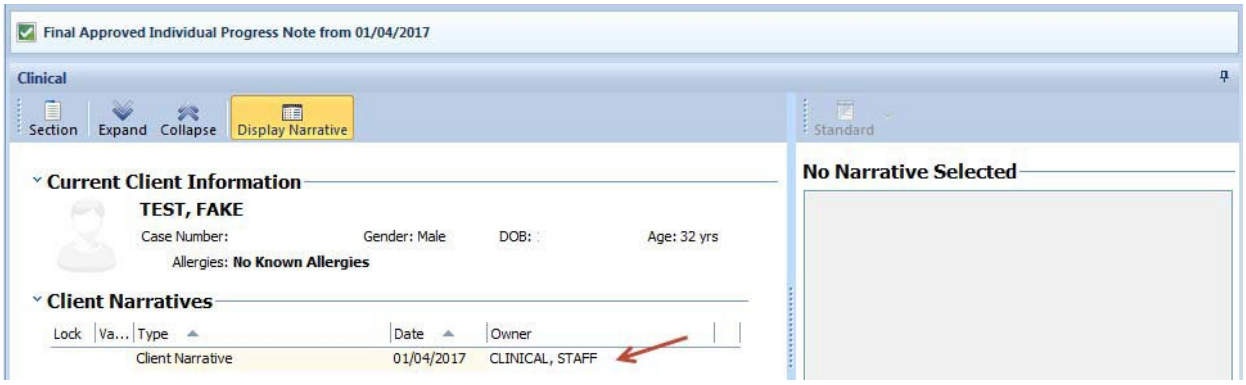
2. Click on the black drop down arrow to open display options.



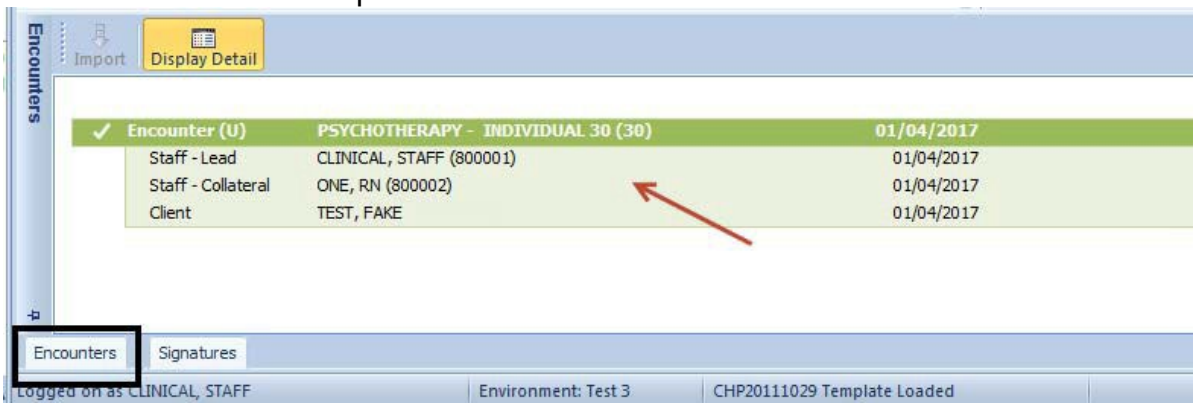
*Note: "*Filters" allows you to select how you want to view progress notes (in a particular date range, by Client Plan Type, by Progress Note Type, by a particular Intervention, Final Approved & Pending progress notes, and/or voided progress notes.)

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.



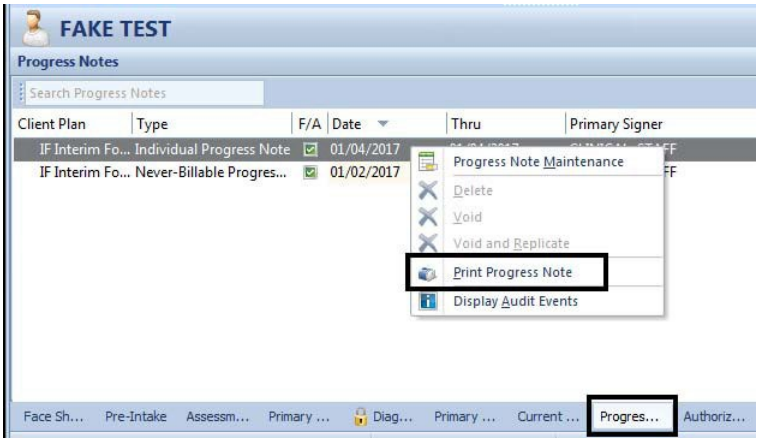
5. To view encounter information select the "Encounter" pane, and double click on the encounter to open details.



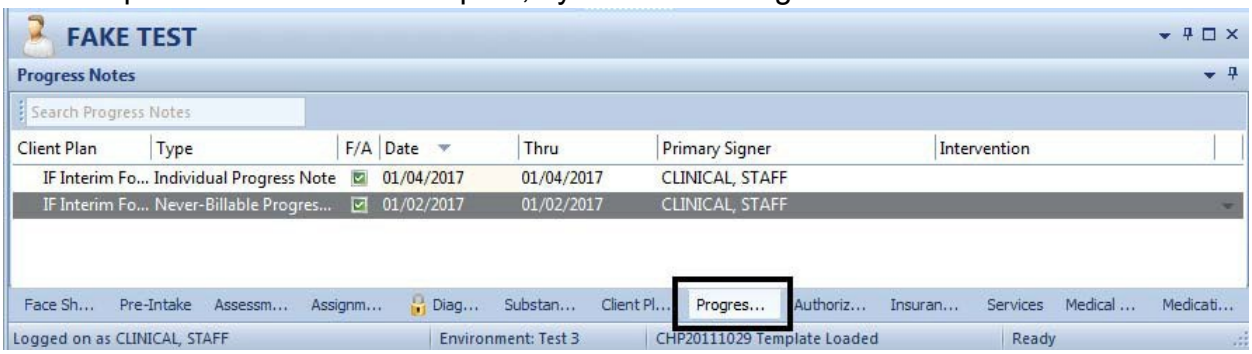
PRINTING INFORMATIONAL/INDIVIDUAL PROGRESS NOTES

There are two ways to print progress notes; the right click menu, or opening the note and selecting the print icon.

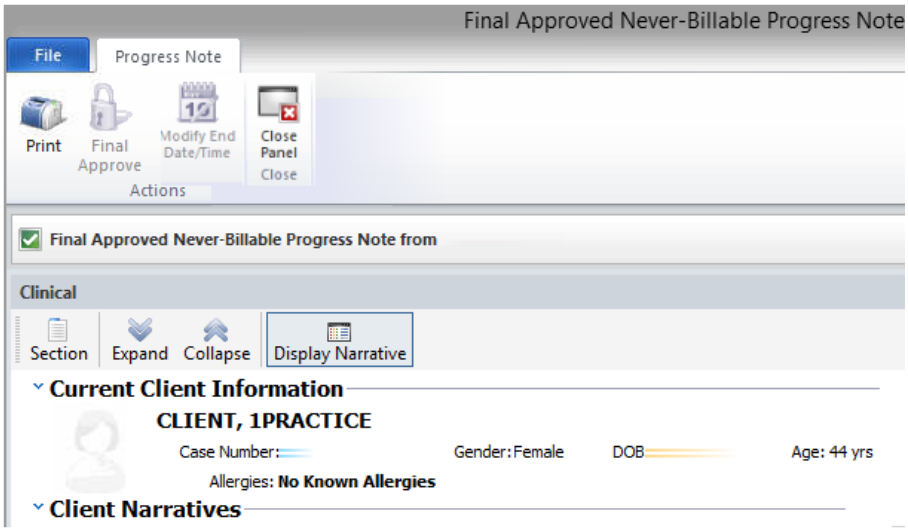
1. Right click on the desired note to print, select “Print Progress Note.”



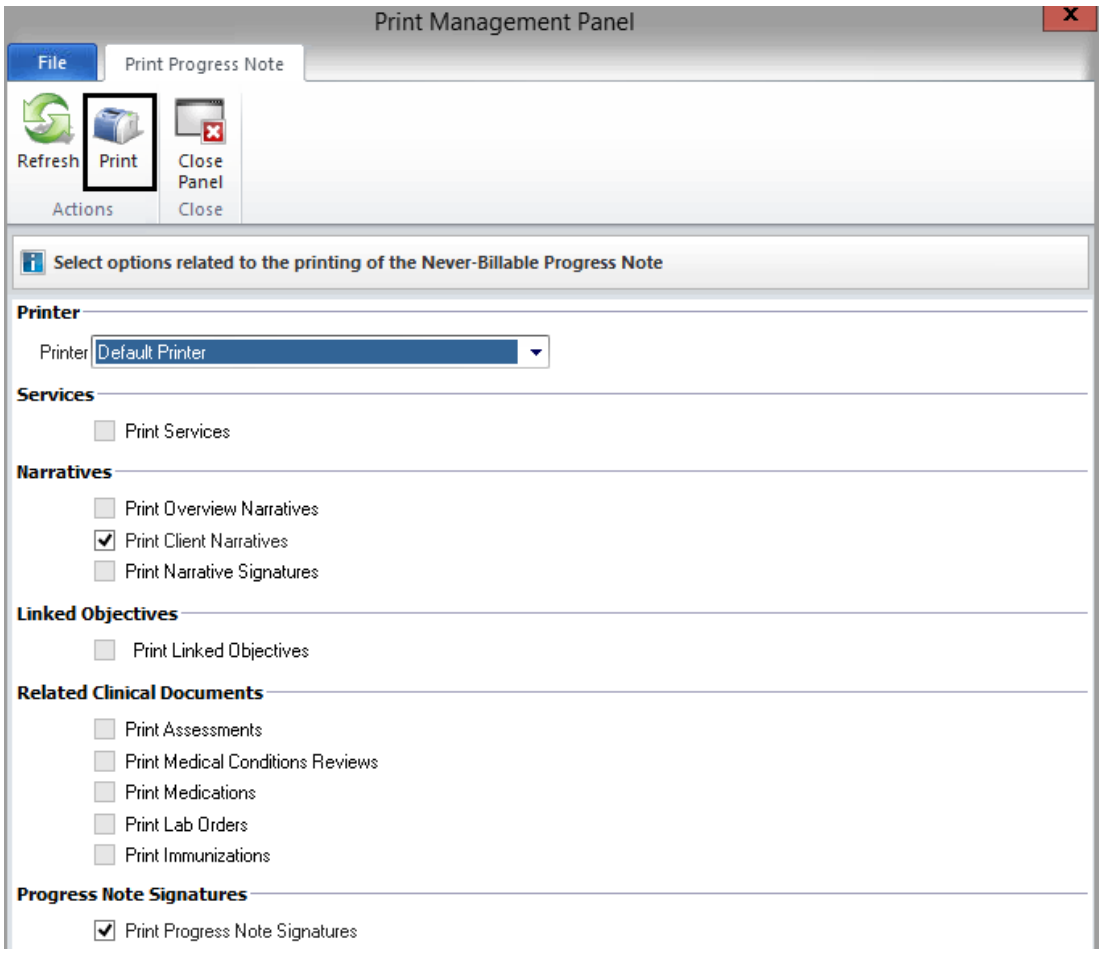
2. Open the desired note to print, by double clicking on it.



3. The progress note will display. Select “Print.”



4. Select the print destination, and which aspects of the note you would like included. Select “Print” at the top of the screen.

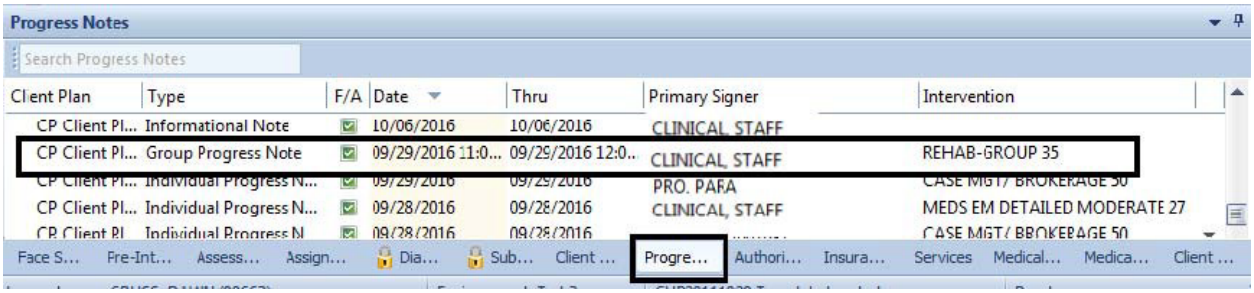


NOTE: Only aspects included in the note selected will be available for printing. For instance, users will not be able to select “Print Services” on an informational note.

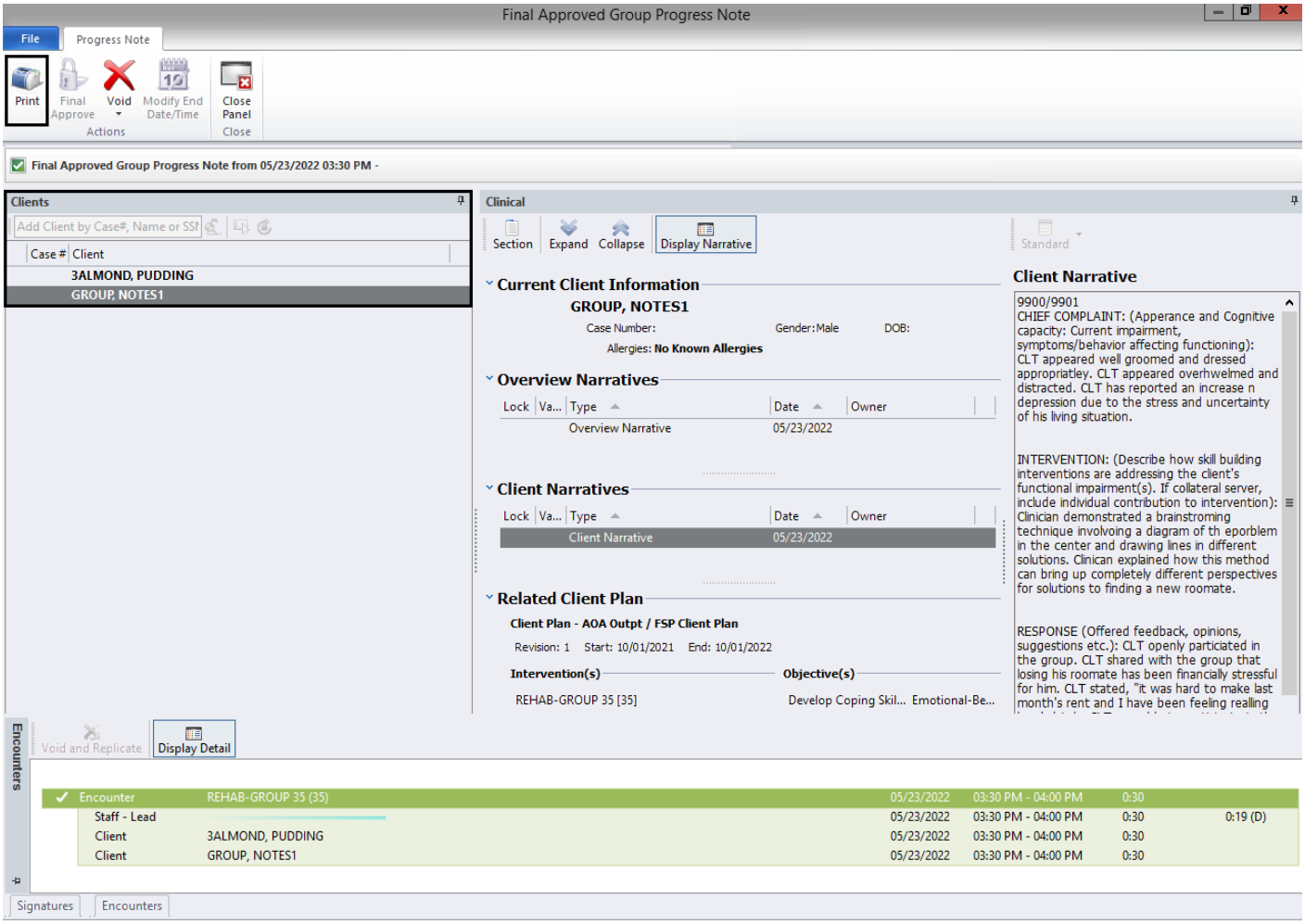
NOTES

PRINTING GROUP PROGRESS NOTES

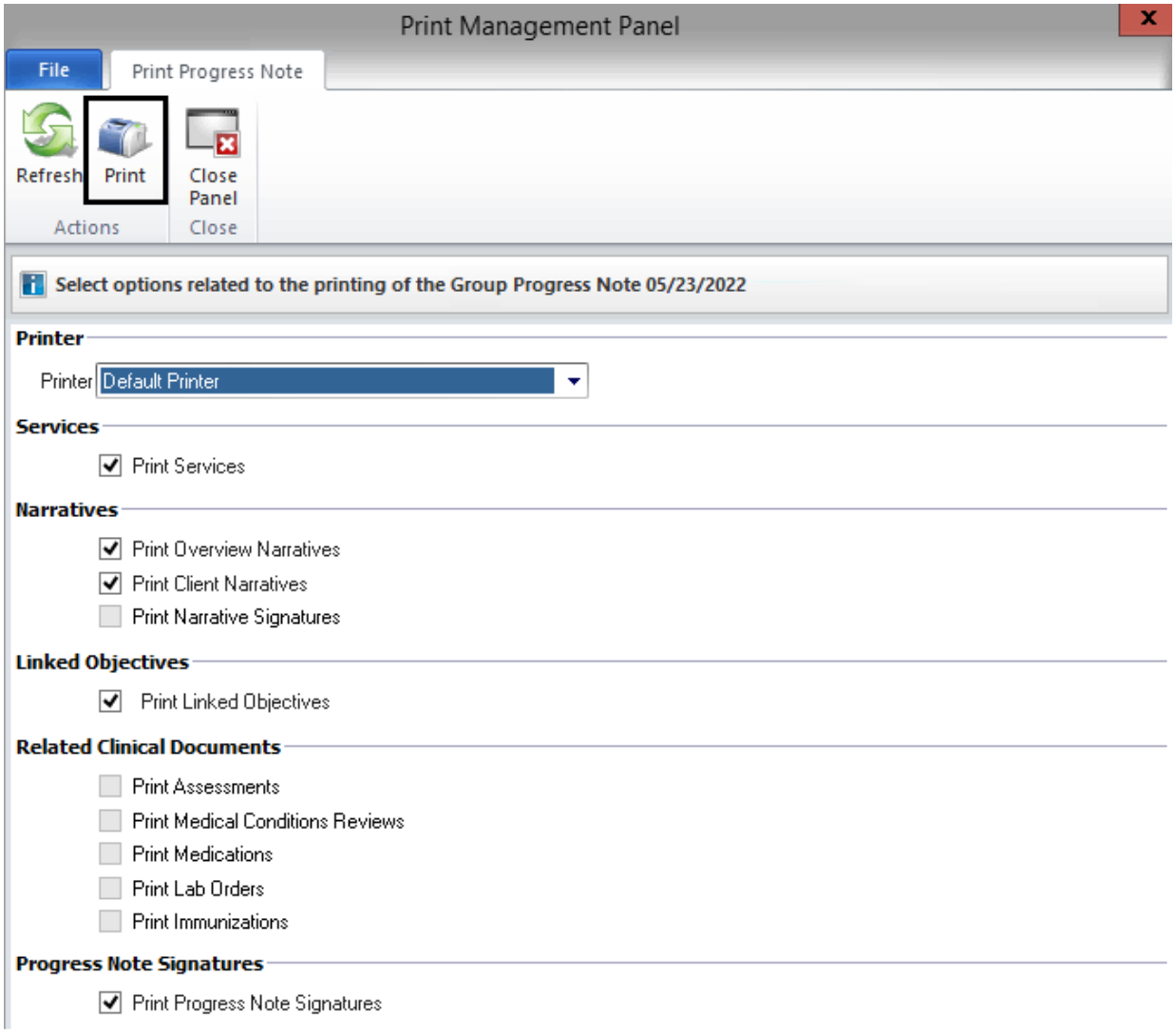
1. Open the desired note to print, by double clicking on it.



2. The Group progress note will display. Select the client for whom you wish to print a progress note. Select “Print” to print the progress note.



3. Select the print destination, and which aspects of the note you would like included. Select “Print” at the top of the screen.

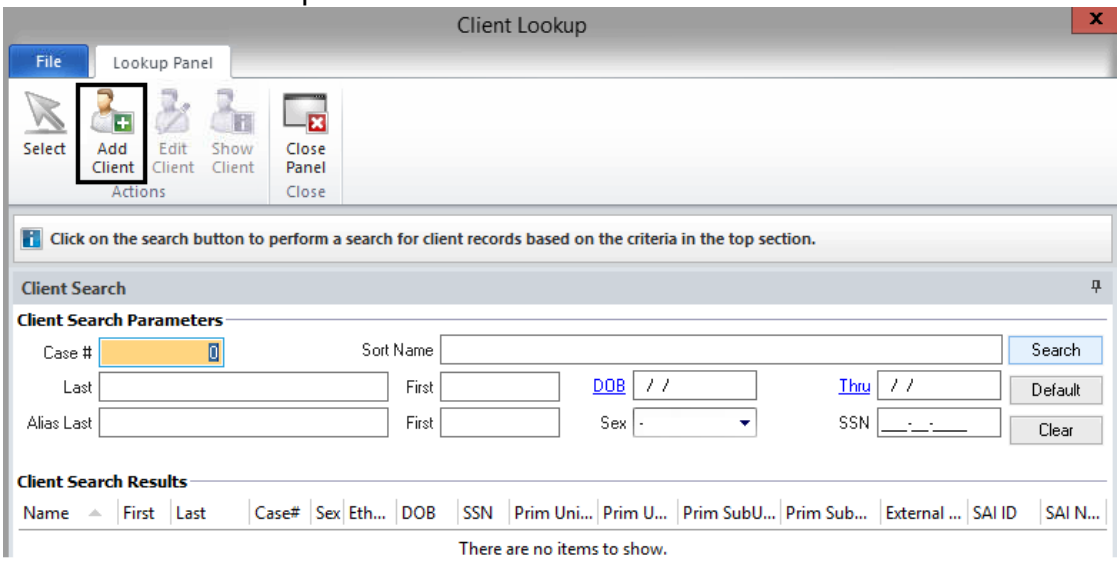


4. To print a different client’s progress note in the group, follow steps 2-3.

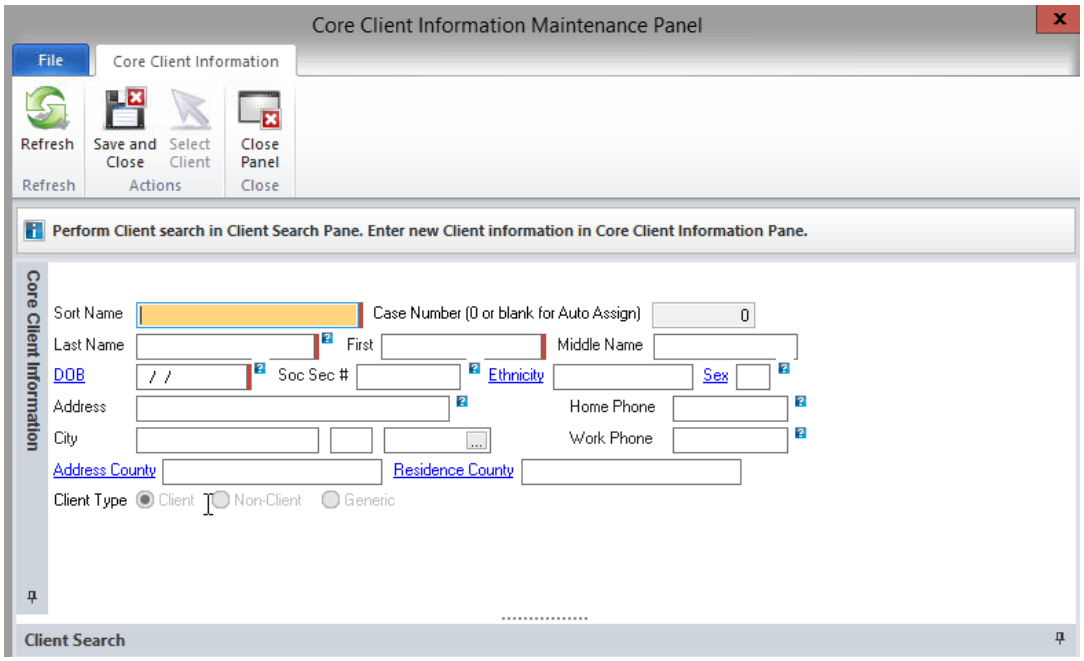
CORE CLIENT INFORMATION

Note: Before entering a new client, always search to ensure that the client is not already in the system. Refer to the "Client Search" tip sheet on the previous pages.

If you are sure that the client is not already in the system, click on the "Add Client" button in the "Client Lookup" window.

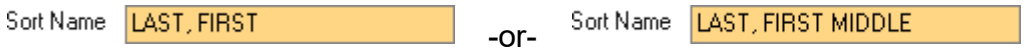


After you click on "Add Client", the "Core Client Information Maintenance Panel" window will display.



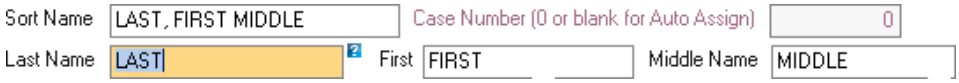
Just start typing – **DO NOT** click into the Sort Name field. Doing so could add a space at the beginning of the field. If this happens, the client will not be found if searched for by Sort Name. Enter as much client information as you have into the CCI.

In the "Sort Name" field, enter the client's name. Do not forget the comma and the space in between the last and first names. Verify that the spelling and format are correct, as this is how other staff members will be searching for the client's name in the future.

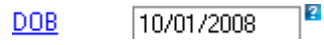


Note: If a client's name, date of birth, or social security is incorrect, fill out form BHS-025 and contact Medical Records.

- Do not enter a suffix (i.e. Jr., Sr., II, III)
- Do not enter punctuation, apostrophe (') or hyphen (-)
- Do not enter spaces (i.e. if the client has 2 last names, run them together)
  - When names are hyphenated or have another prefix such as Super-Human, it is important to enter the names into the Alias section to help facilitate future searches – e.g., Awesome Super-Human should be entered as an alias as HUMAN, AWESOME and also as SUPER, AWESOME.
- Do not use non-English letters (i.e. ñ)
- Press the Tab key and the client's Sort Name will populate the Last Name, First and Middle Name Fields

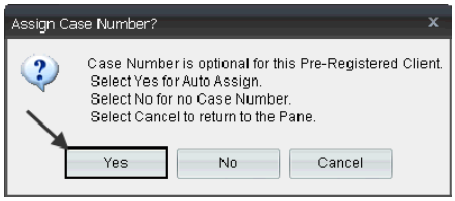


Enter the client's DOB in the following format: MM/DD/YYYY.



Note: For the remaining optional fields, enter the client's information. The information will populate to the Demographics form.

Click on the "Save and Close" button.



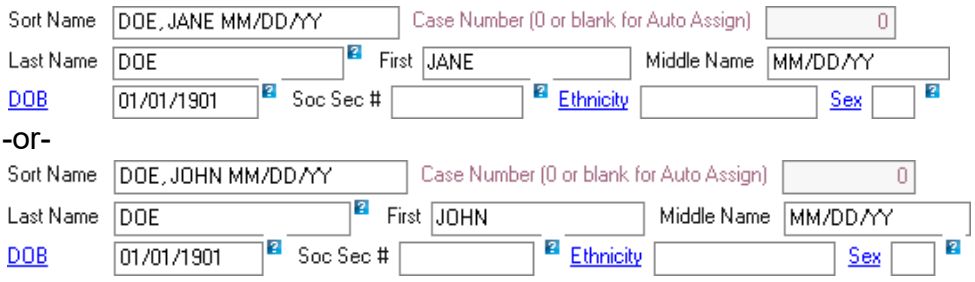
When asked about assigning a case number to this client, **Always** select "Yes."

The client is now in the system as a new client.

Entering John and Jane Doe Clients:

When an unidentified client presents, use the following guidelines for entering the client into CCBH. *Note: Once the legal name is known, submit a BHS-025 with supporting documentation to medical records. The final page in this packet contains that information.*

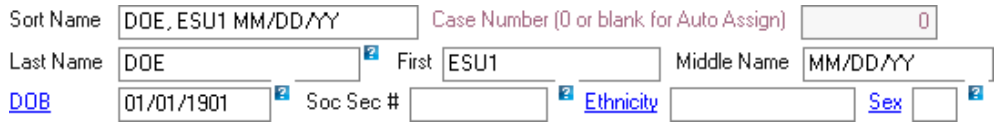
For all programs (except ESU), enter:



MM/DD/YY = date of client admission/contact. The date will default into the "Middle Name" field. **Delete the numbers in the "Middle Name" field before saving the record.**

If the client's date of birth is unknown and cannot be estimated, enter 01/01/1901.

For the ESU, enter:



ESU**1** = The first John/Jane DOE client of the day.
ESU**2** = The second John/Jane DOE client of the day.

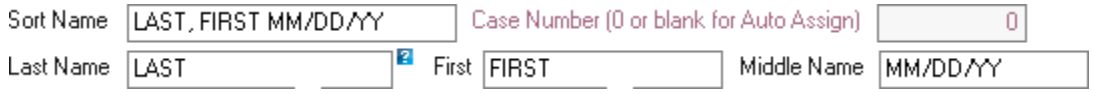
MM/DD/YY = date of client admission/contact. The date will default into the "Middle Name" field. **Delete the numbers in the "Middle Name" field before saving the record.**

If the client's date of birth is unknown and cannot be estimated, enter 01/01/1901.

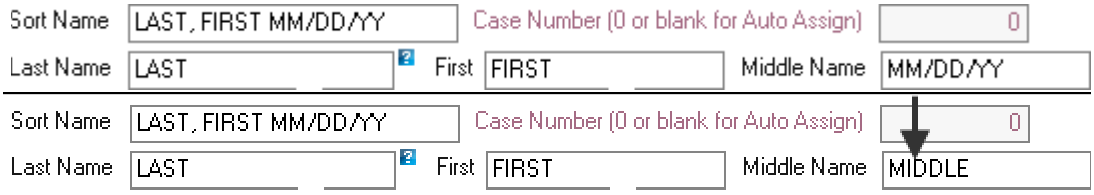
For John Doe's, enter "M" as the sex, and for Jane Doe's, enter "F" as the sex.

Entering Clients with Identical Sort Names:

If the above message appears when entering an index card, double check to ensure that the client is not already in the system. If the existing record is for a different client, adjust the client's sort name. This is accomplished by entering the second client's date of birth to the end of the client's name. Example:



The DOB will default into the "Middle Name" field. Delete the numbers in the "Middle Name" field, and enter the appropriate middle name/initial. However, **do not** change the "Sort Name" field. See the example below:



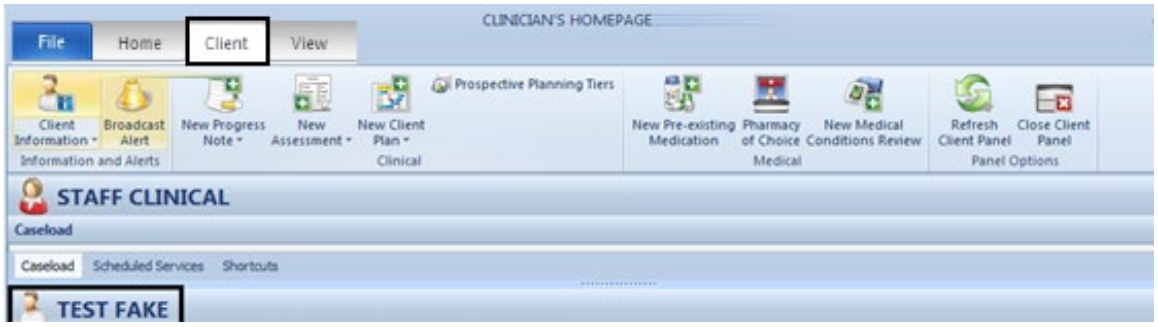
Special considerations:

- *When available, the client's middle name should always be entered.*
- *In the case of identical first and last names, the middle name may be all that is needed to differentiate among clients. If that is not enough, then the DOB is added to the end of the sort name field.*
- *When a date is added to the end of the sort name field, it appears in the middle name field. Make sure to remove it before moving forward.*

ADDING NEW ASSESSMENTS

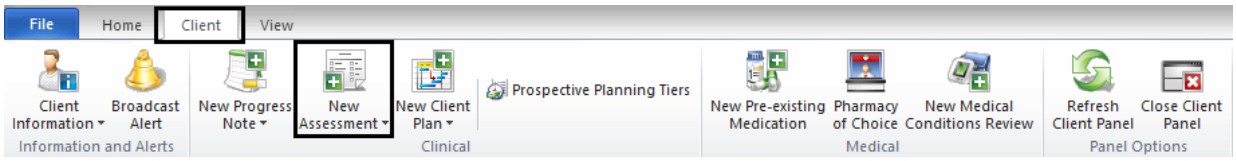
- Access the desired client.
- A “Client” tab will open with additional buttons listed within the ribbon.
- The Client Panel will launch on the bottom portion of your screen. The name of the client will display in the client name box.

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



New Assessment Button:

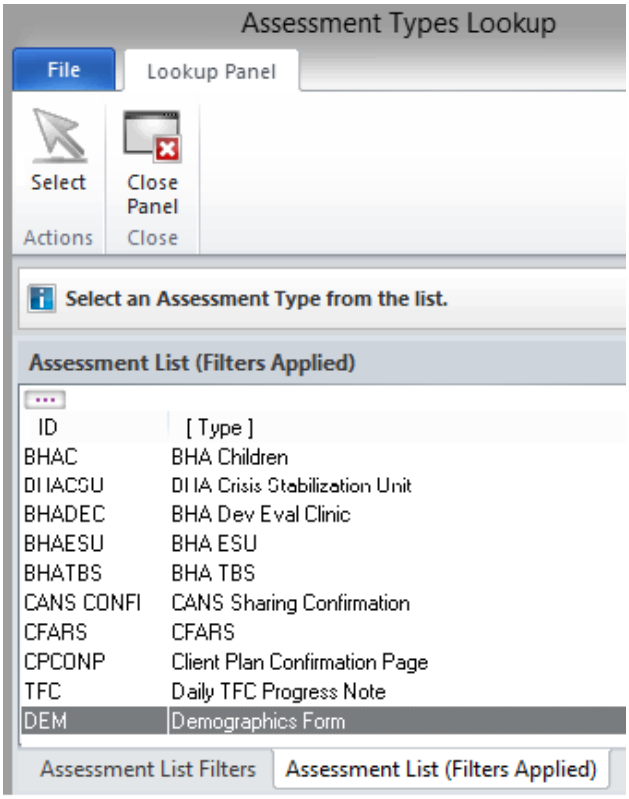
- The New Assessment button will be displayed in the “Client” tab ribbon.



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

To see a complete list of assessments:

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



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

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

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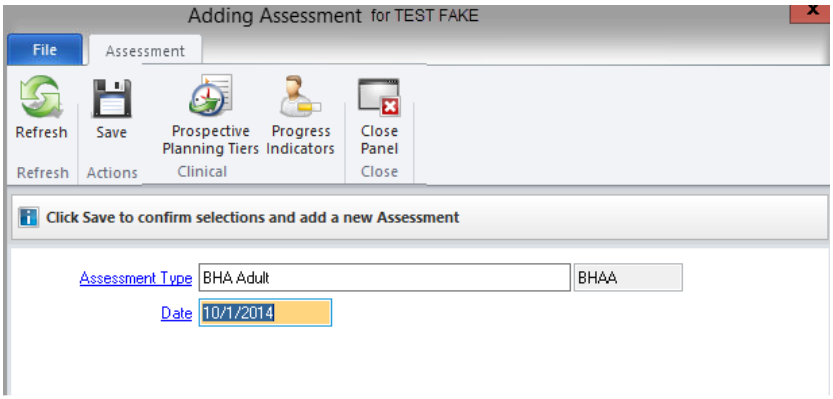
Dating the Assessment:

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



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

DEMOGRAPHICS FORM OVERVIEW

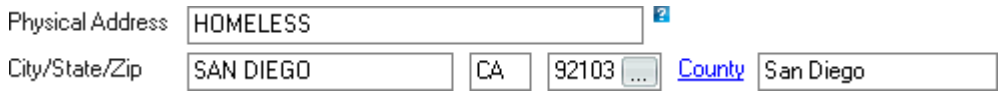
- **For any address:**

By entering the "Zip Code" and then pressing the tab key on the keyboard, the city/state/county will populate.

- **For Clients who are Homeless, Incarcerated, or Have No Reported Mailing Address:**

The physical address for a client who is **homeless** is entered with the word "homeless", and a zip code.

Note: If you have additional information (i.e.- frequents Balboa Park), type it after the word "homeless" in the Physical Address field.



In the zip code field, enter the zip code of the area where the client sleeps or frequents (if known).

If you do not know the zip code where the client frequents, enter the zip code of your program.

For individuals who are **incarcerated**, the jail's address is entered as the physical address.

For individuals who have **no reporting address**, enter the address of the client's primary subunit in both the physical and mailing address fields.

- **Phone**

If the paper demographic form does not include a home phone number, type “NONE”.

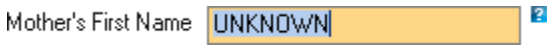
- **Religion**

If the paper demographic form lists a religion that is not included in the table, use your judgment to choose the most appropriate selection.

For example:
13 Atheist
12 No Religious Preference
98 Other
08 Other Christian
99 Unknown

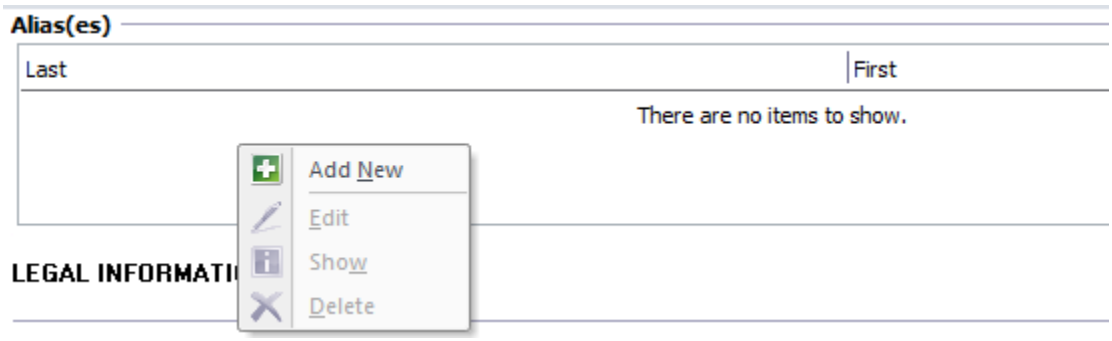
- **Mother’s First Name**

If the client’s “Mother’s First Name” is blank on the paper demographic form, type in “Unknown” instead of “None”.



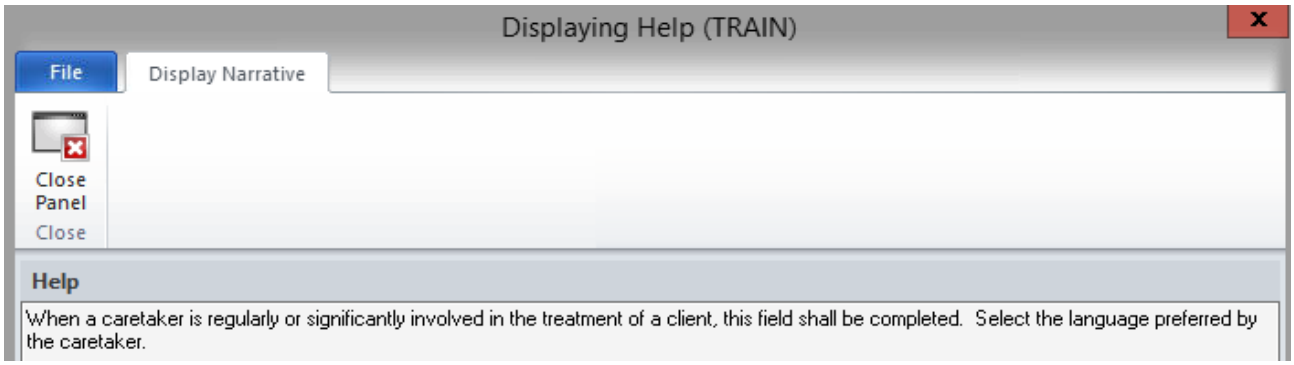
- **Alias/Contacts**

When adding/editing an Alias or Contact, right click into the box to view your menu options.



Help Text

Help Text is available for staff throughout the assessment. Help texts can be accessed by clicking on the question mark icon. For example, if you click on the “Preferred Language (Caretaker)” help text icon, the following help text appears:

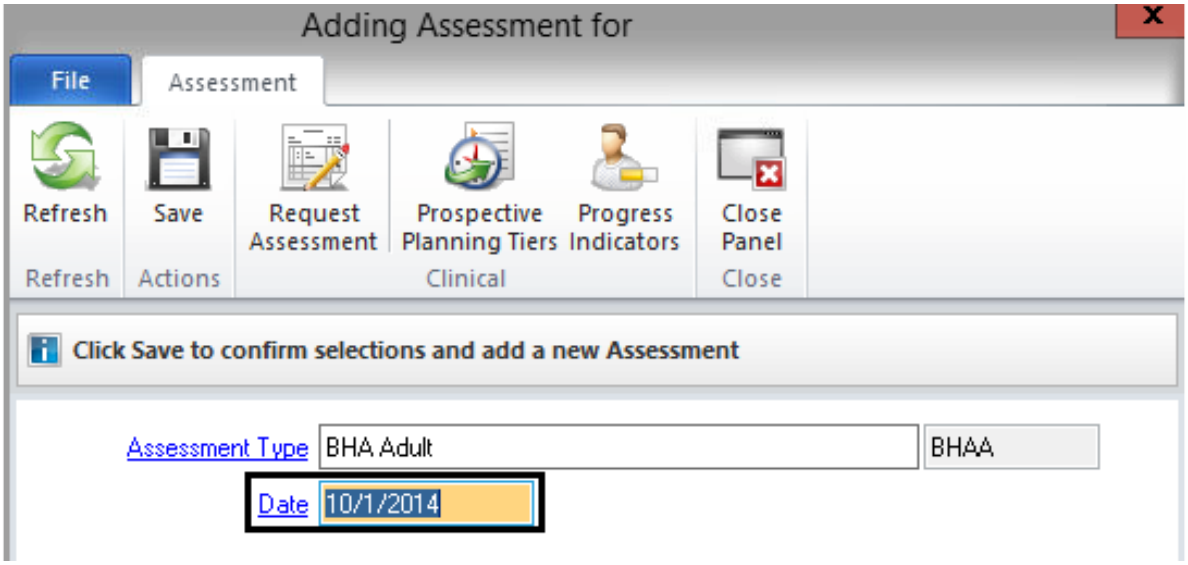


NOTES

GUIDELINES FOR DATES IN CCBH

Assessment Date:

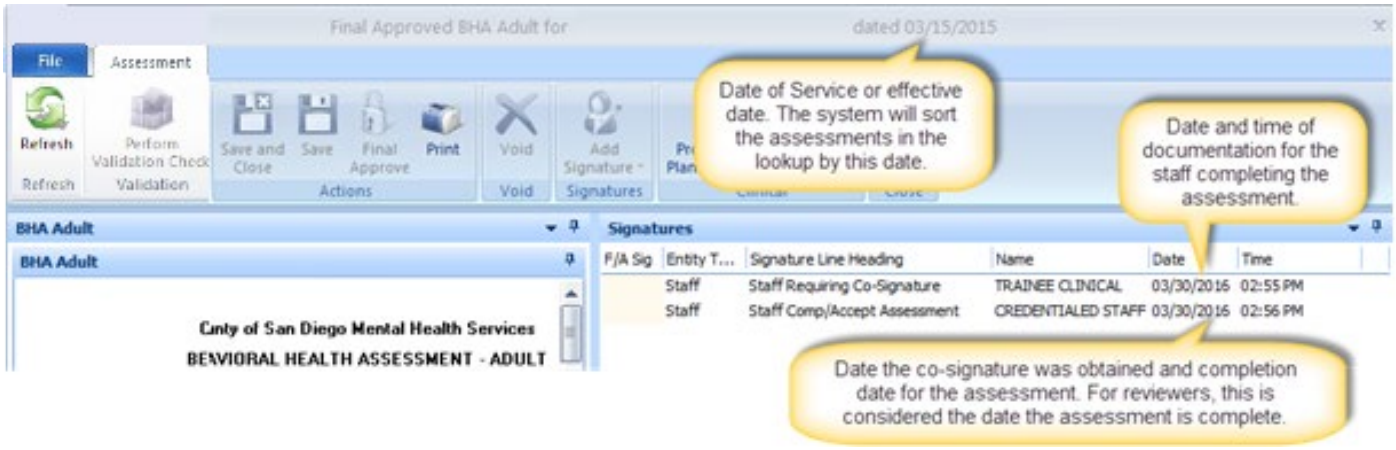
When adding an assessment, the system will require the entry of a date when opening the form for data entry. This is called the assessment date.



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

Signature Date:

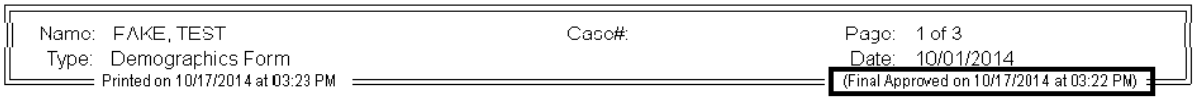
Signature dates may be different than the assessment date, which is necessary at times (i.e. when a co-signature is necessary but the staff is out of the office).



Note: Co-signatures must be completed within timelines.

Final Approve Date:

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



COUNTY OF SAN DIEGO MENTAL HEALTH SERVICES

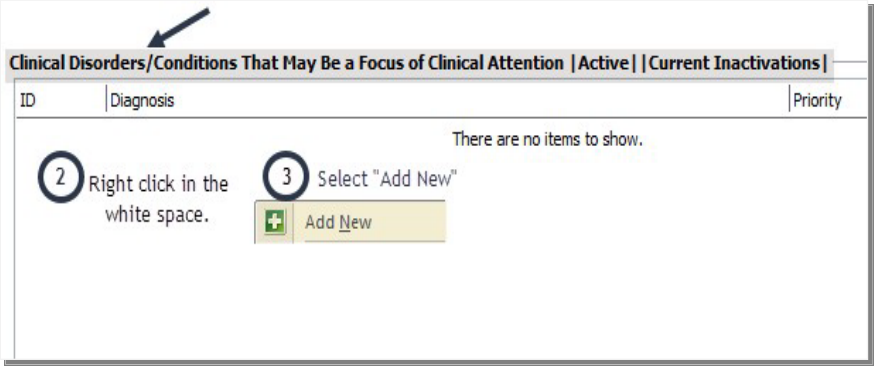
DEMOGRAPHIC FORM

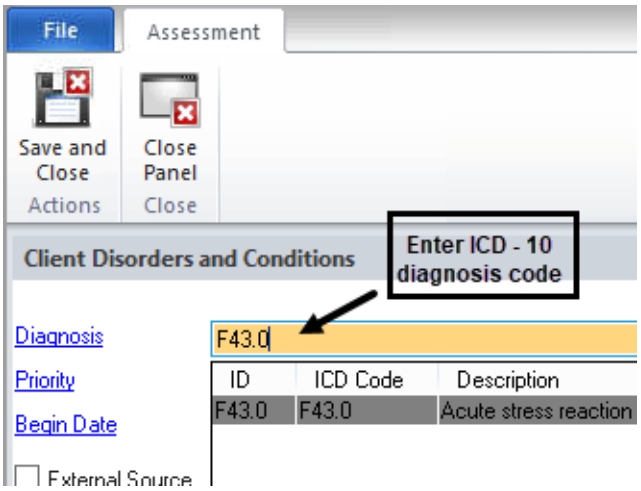
Admission Status O Pre-registered O Registered ⊙ Admit

CLIENT IDENTIFYING INFORMATION

ENTERING A DIAGNOSIS

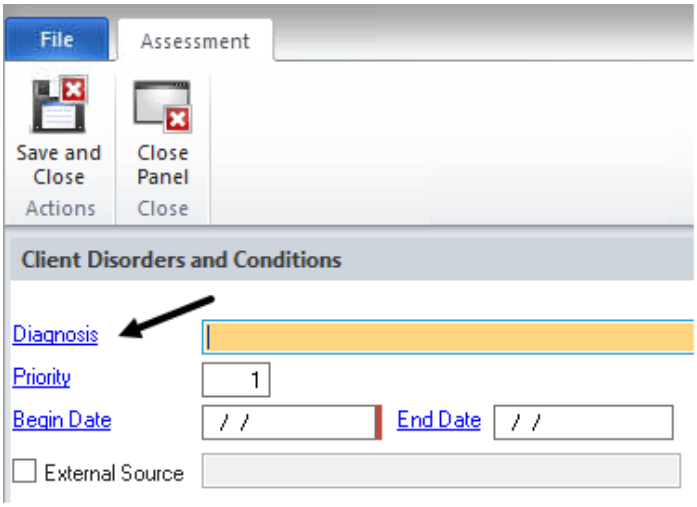
1. To enter a diagnosis, locate the “Clinical Disorders/Conditions That May be A Focus of Clinical Attention” section on the form.
2. Right click in the white space to see the option “Add New.”
3. Click on “Add New.”



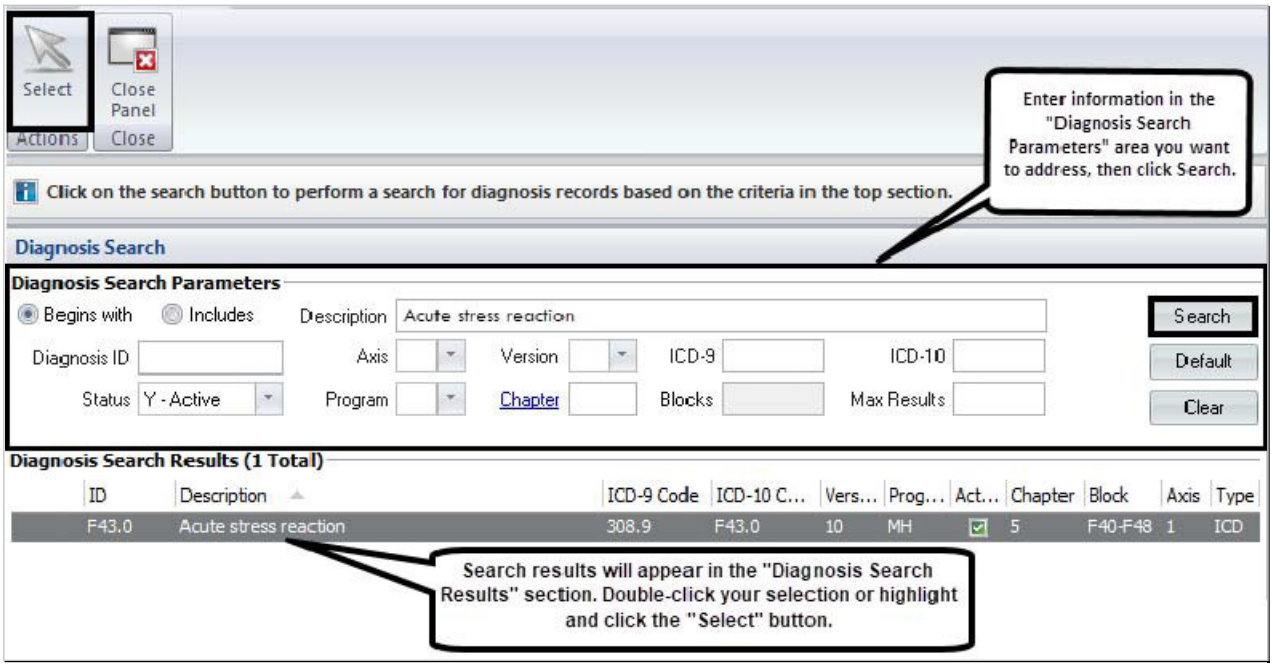


- Enter the ICD-10 diagnosis code, if known.

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

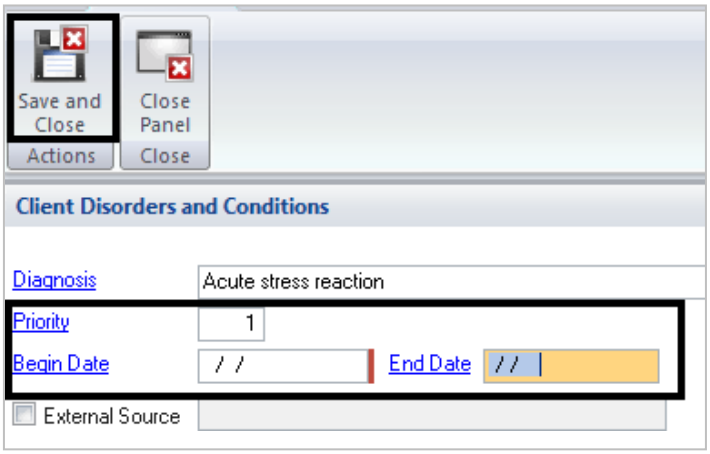


- Fill in the fields you want to address, then click the “Search” button.

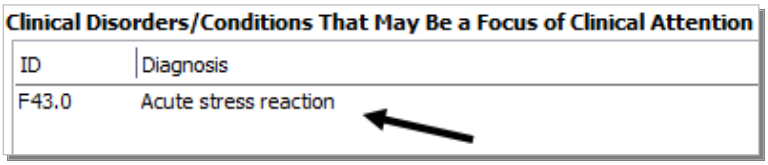


- Your selection will appear in the “Diagnosis” field. Address the following the “Priority, Begin Date, and End Date” fields. When finished, click “Save and Close” button.

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



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

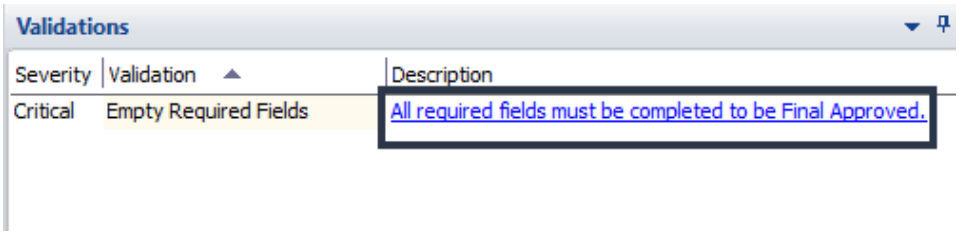


ELECTRONIC SIGNATURE GUIDELINES

- Certain assessments in CCBH can be final approved by any clinical staff who have required system access, such as the Safety Alert or the Demographic Form. Anyone can complete the assessment and final approve as themselves, without a co-signature.

- To final approve the Safety Alerts and Demographic Form

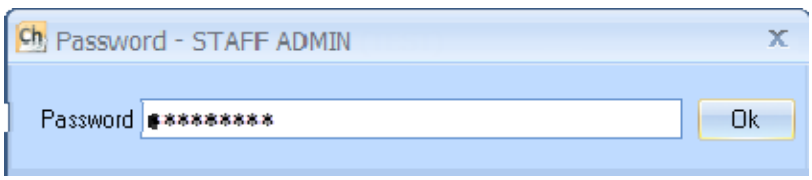
1) Make sure all software required fields have been addressed.



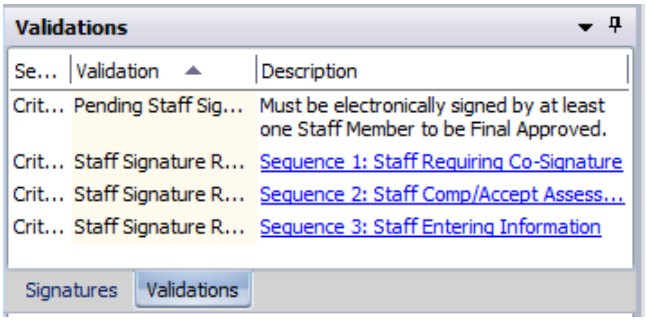
(a) To check, click the "Perform Validation Check" button at the top of the window. A screen will appear at the center of your screen with a list of fields to be addressed, if any. If all required fields have been addressed, you will not see a screen appear. When ready, proceed with the final approval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

2) Click the "Final Approve" button located at the top of the window.

3) Enter your CCBH password when prompted.



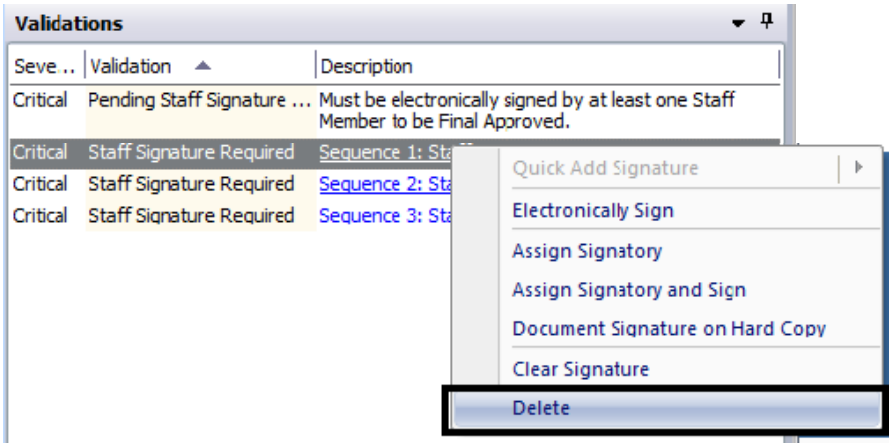
- Some assessments contain credential restricted signatures. For instance, there are three credential restricted signature lines located in the “Validations” pane of the Diagnosis Form, and two signature lines on the BHAs.



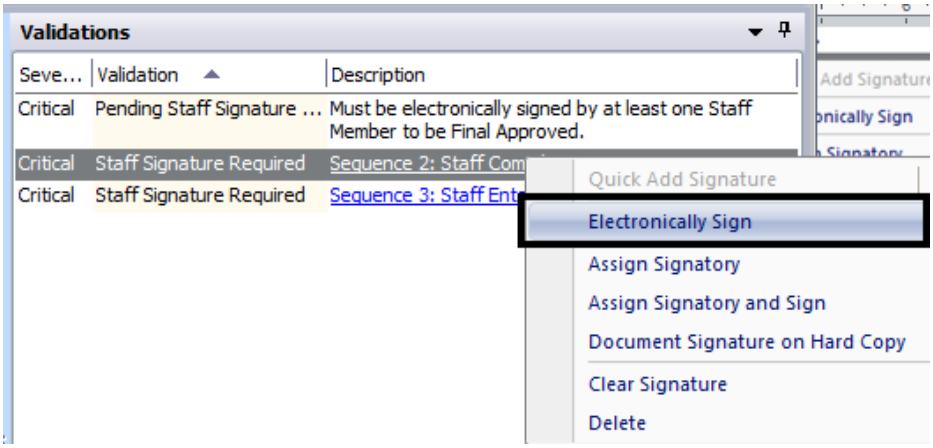
- Your license type or credential will determine how you address each signature line.

Staff Who Do Not Require a Co-Signature:

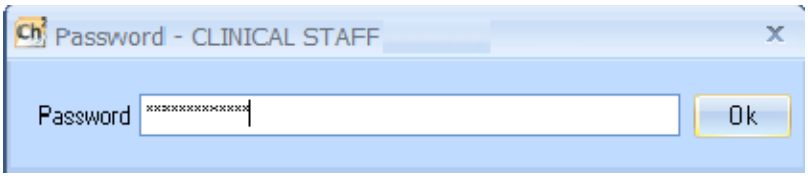
1. Sequence 1 (Staff Requiring Co-Signature) - Left click and select “Delete.”



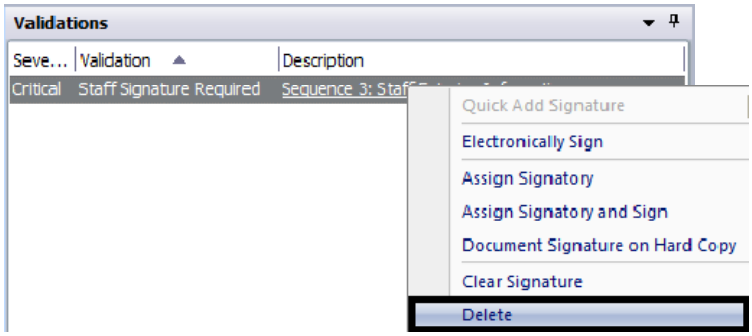
2. Sequence 2 (Staff Comp/Accept Assessment) – Left click and select “Electronically Sign.”



3. Enter your CCBH password when prompted.

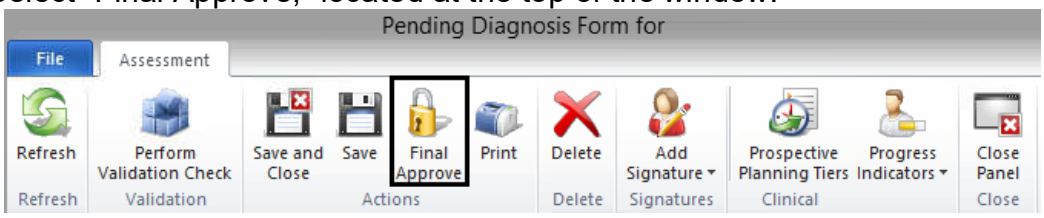


4. Sequence 3 (Staff Entering Information) – Left click and select “Delete.”



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

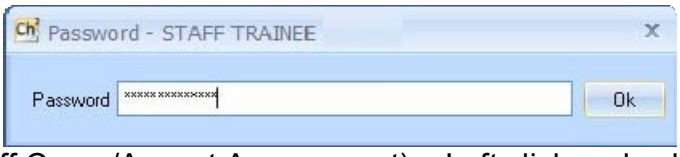
5. Select “Final Approve,” located at the top of the window.



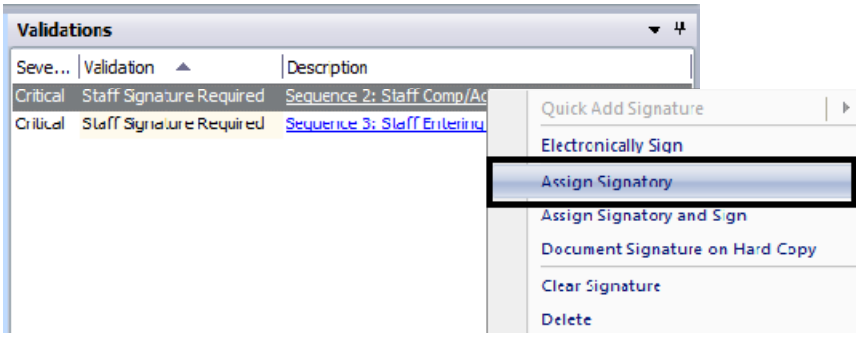
Staff Who Require a Co-Signature:

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

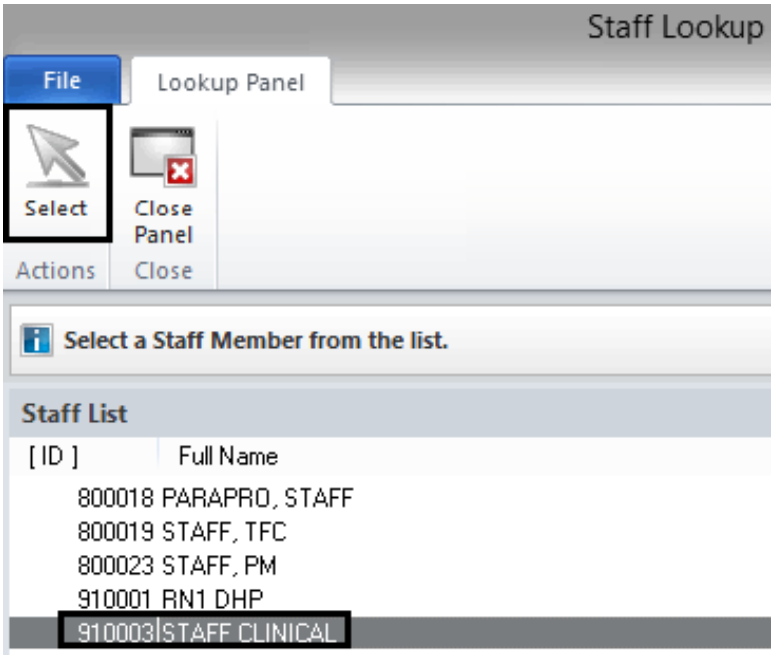
2. Enter your CCBH password when prompted.



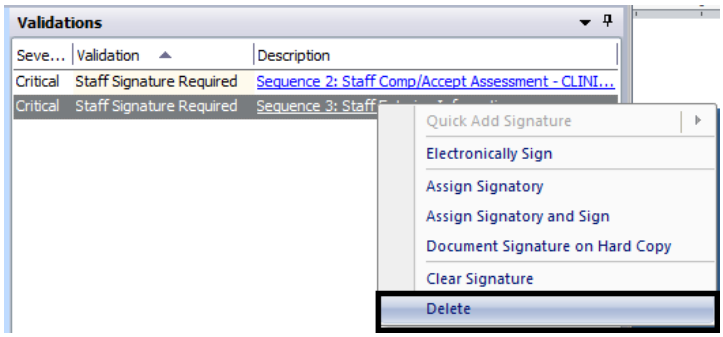
3. Sequence 2 (Staff Comp/Accept Assessment) – Left click and select "Assign Signatory."



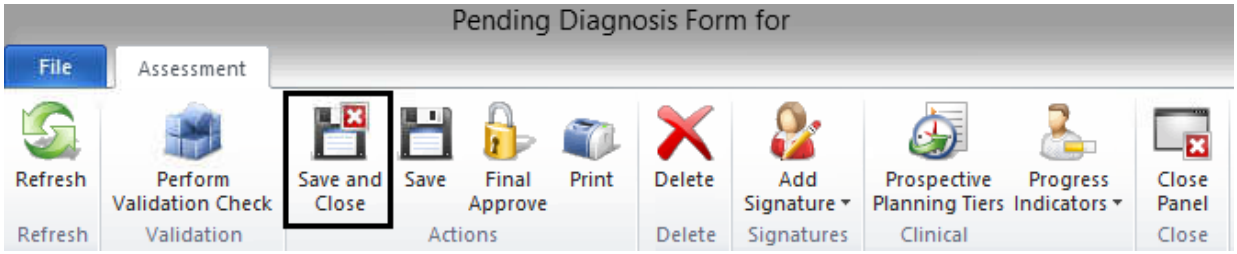
4. Find your supervisor by name or staff ID. Highlight their name and choose "Select" at the top.



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



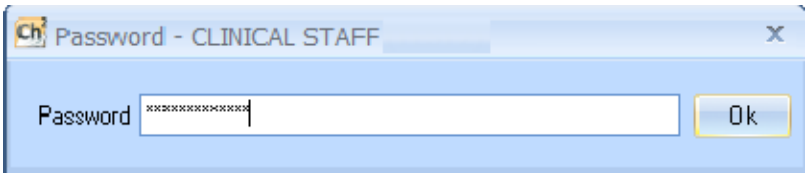
6. Click “Save and Close” located at the top of the window. After you click “Save and Close,” you return to the Clinician’s Homepage. The name of the client will display on the Notifications list on your Clinician’s Homepage and on the Homepage of the approved signer until the assessment is co-signed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



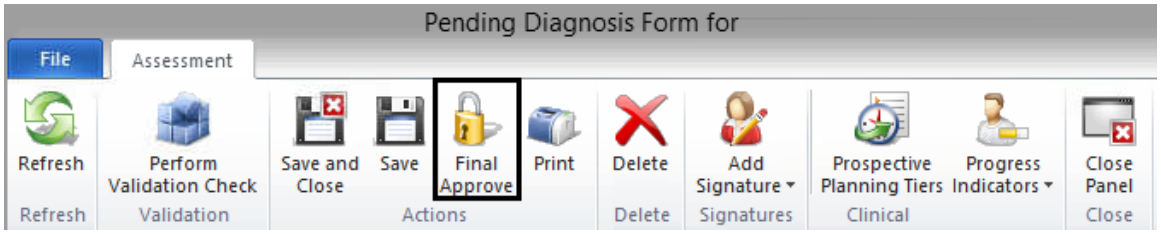
Staff Who Final Approve (or Co-Sign) Assessments For Others:

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

4. Enter your CCBH password when prompted.



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



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

PLEASE REMEMBER:

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

<u>NOTES</u>

VIEWING ASSESSMENTS

Saved forms:

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

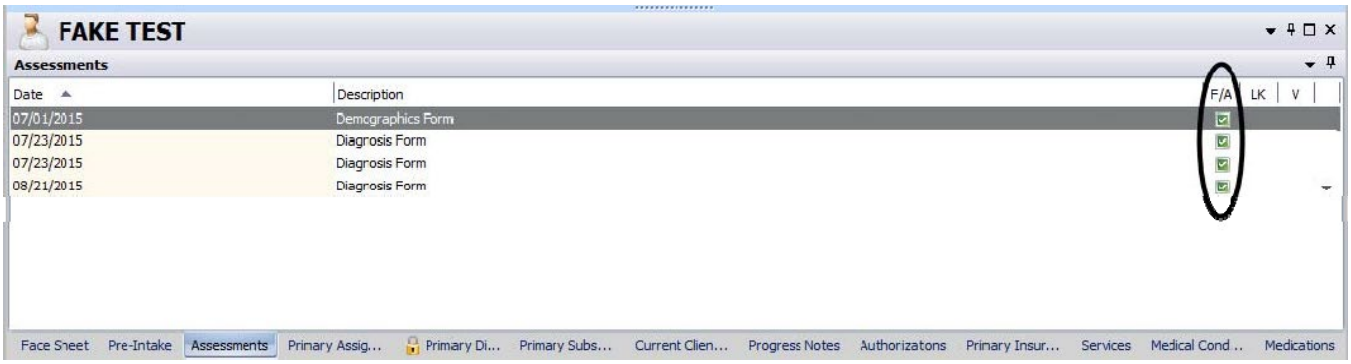
Lock it down by Final Approving to protect your work!!

How to open a saved assessment:

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

VIEWING FINAL APPROVED ASSESSMENTS

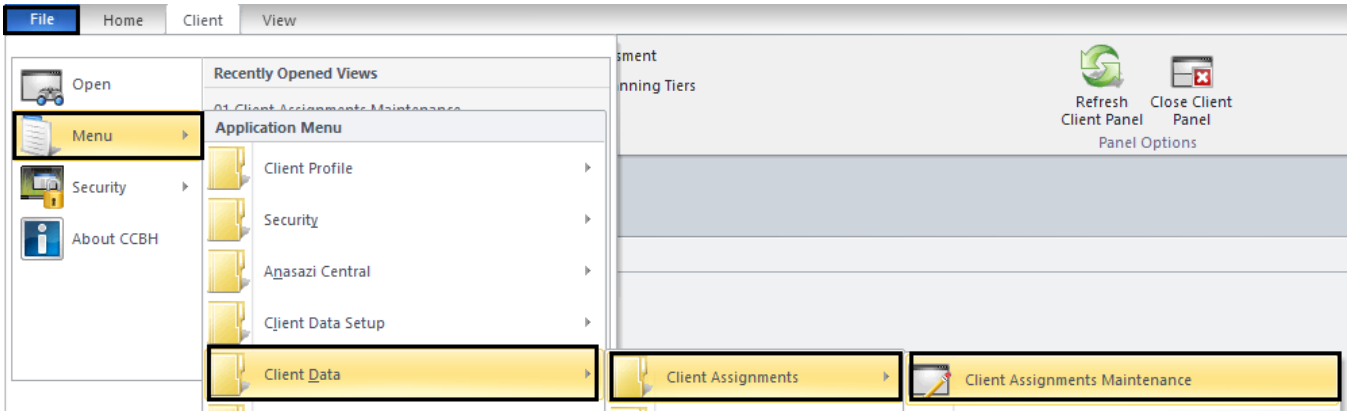
- Select a client and open the "Client Panel".
- Next, click the "Assessments" pane.
- A list of assessments will display. The assessments that are final approved will have a check under the Final approved status (F/A).
- Double click the assessment. The selected assessment will open for review.



ADDING CLIENT ASSIGNMENTS

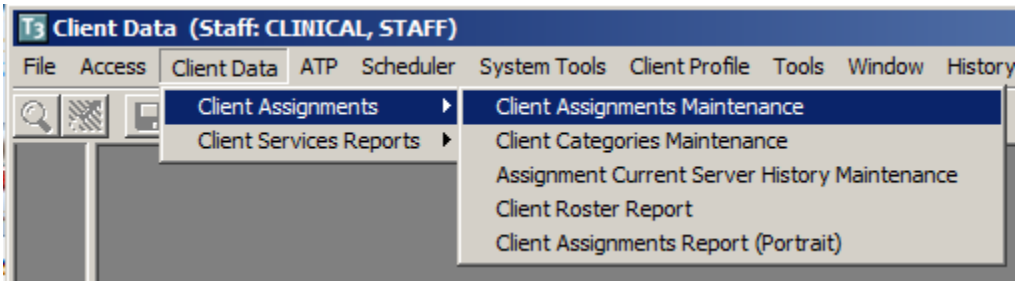
To get to the Client Assignment window:

1. Click on the File Tab
   Click "Menu" → "Client Data" → "Client Assignments" → "Client Assignments Maintenance"



To access the Client Assignment Window from the external view:

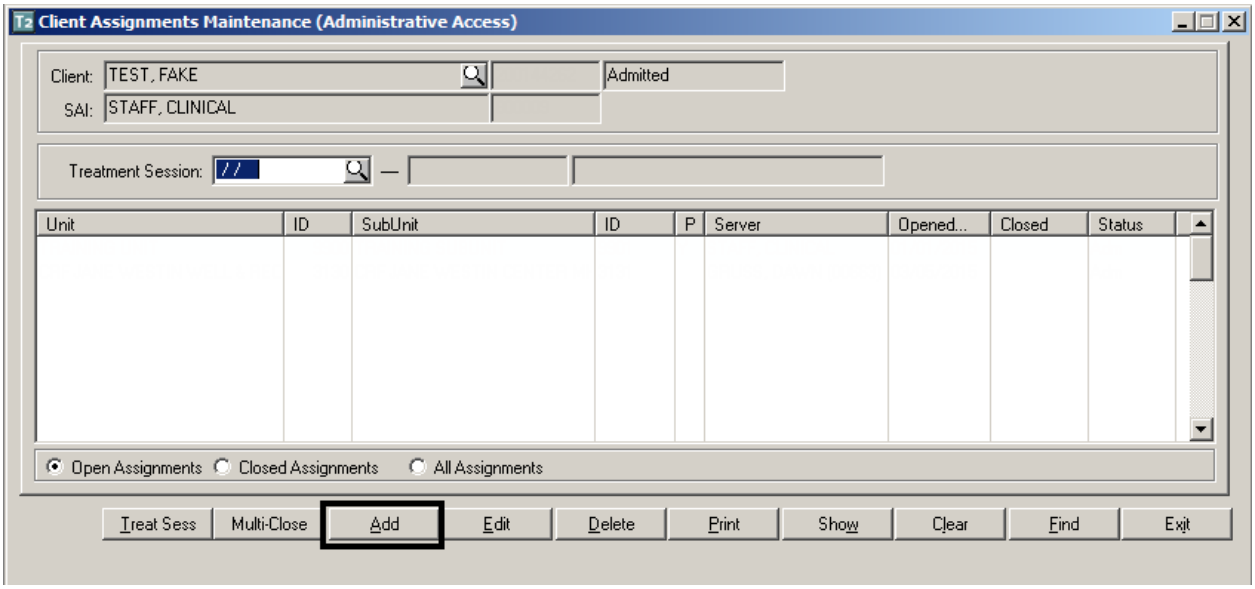
1. Click on "Client Data" → "Client Assignments" → and from the drop down menu, select "Client Assignments Maintenance."



The "Client Assignments Maintenance" window will display.

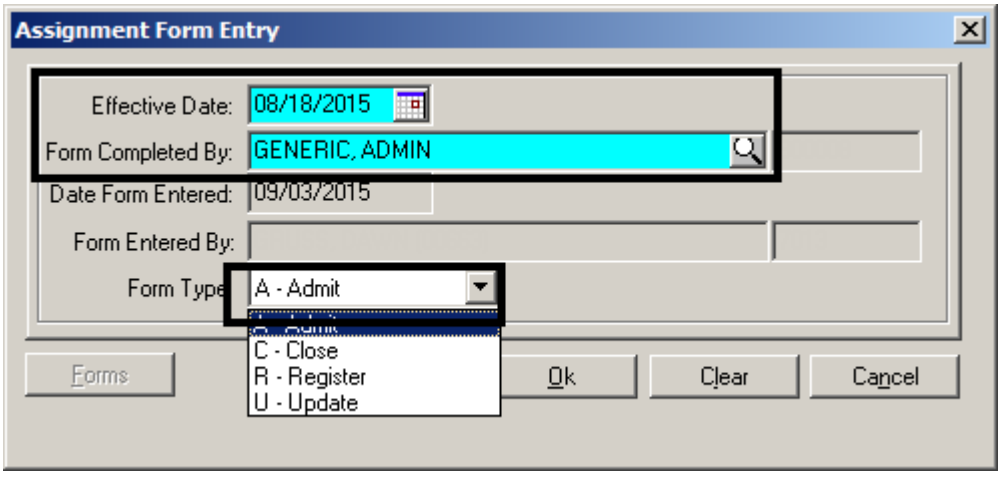
- In the blue field, enter the Client's case number or the Client's sort name (Last, First) in the "Client" and press the "Tab" key. (If the space if not blue, choose "Clear")

- Click the “Add” button to begin the opening of the assignment process.

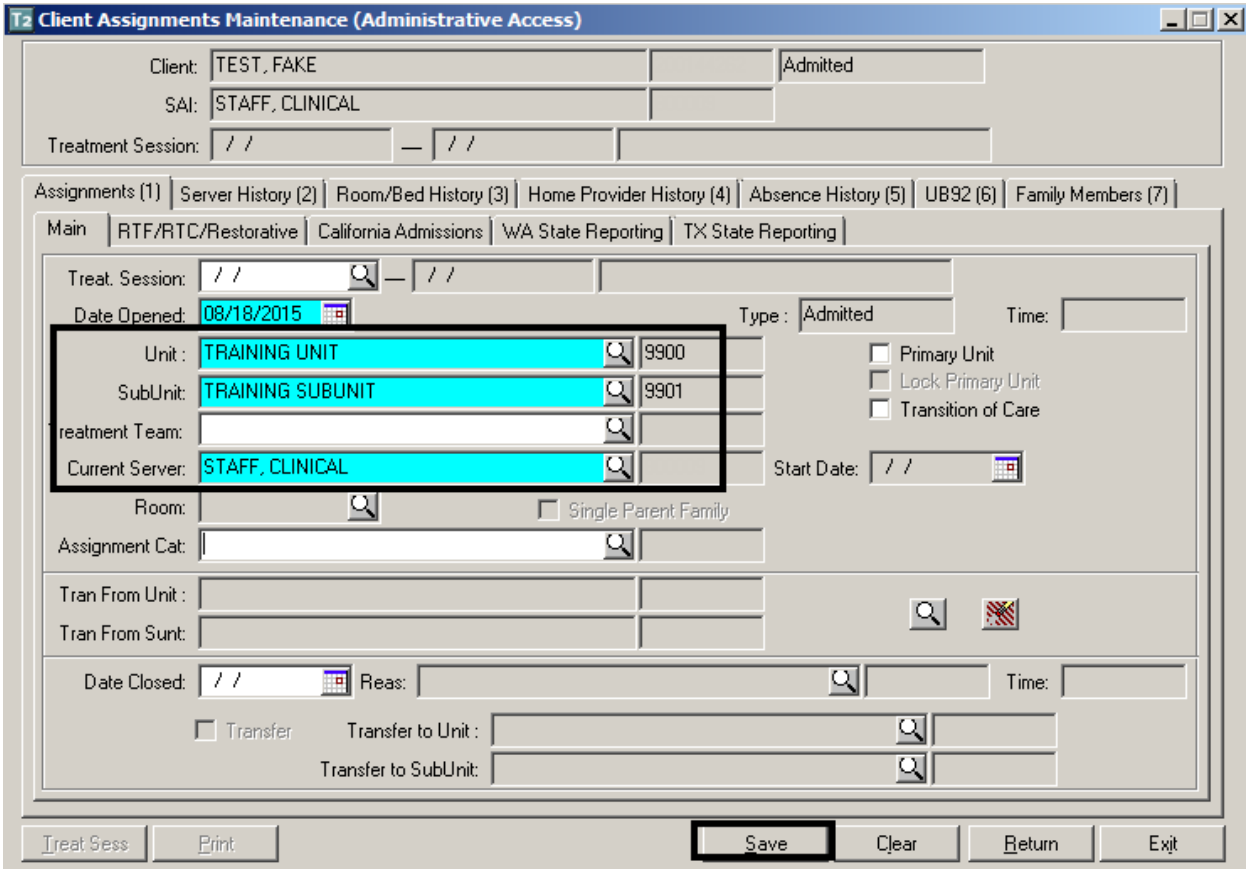


Note: If you get an error message that reads, “Assignments may not be entered for pre-registered clients” this indicates that on the demographic form, the “Admit” radio button was not checked. This requires updating the demographic form and selecting the “Admit” radio button.

- From the “Assignment Form Entry” window, enter the effective date of the Client Assignment opening and your CCBH ID number.
- From the Form Type field, click on the arrow and from the drop down menu, select, “A-Admit” and click, “Ok”.



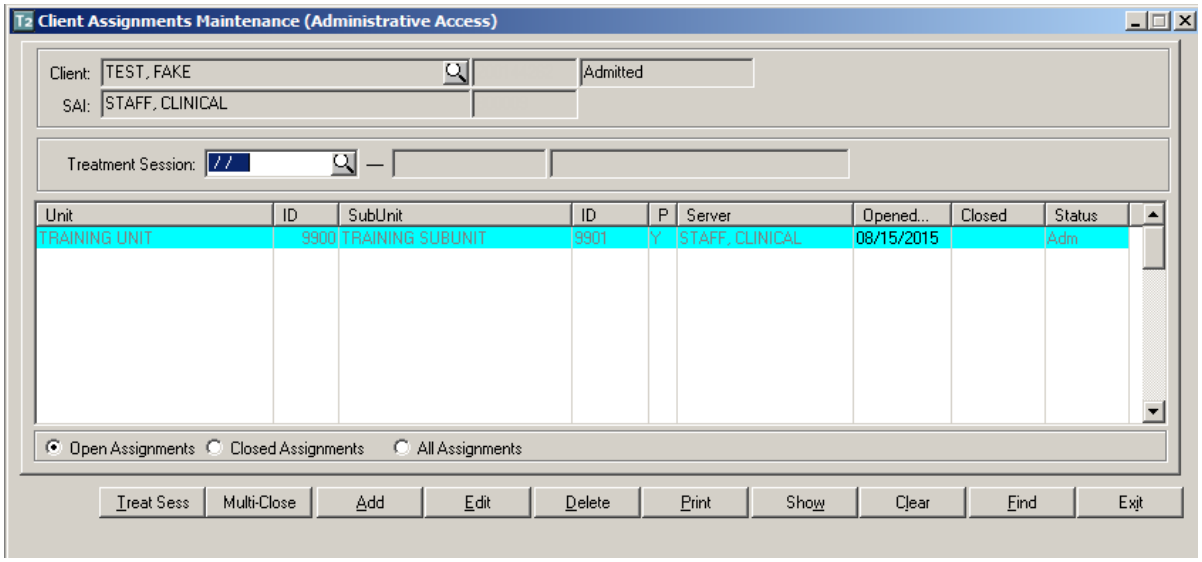
- A new Client Assignment window will appear:



Treatment Session: Leave this field blank.
Date Opened: This date pre-populates from the previous window.
Unit: Enter your program Unit in this field; hit the "Tab" key.
Sub Unit: Enter your programs SubUnit number in this field; hit the "Tab key.
Treatment Team: Leave this field blank.
Current Server: Enter the Server's CCBH ID number.
Note: The date from the "Date opened" field will auto populate from the previous window. If it's not correct, select cancel and return to previous step.

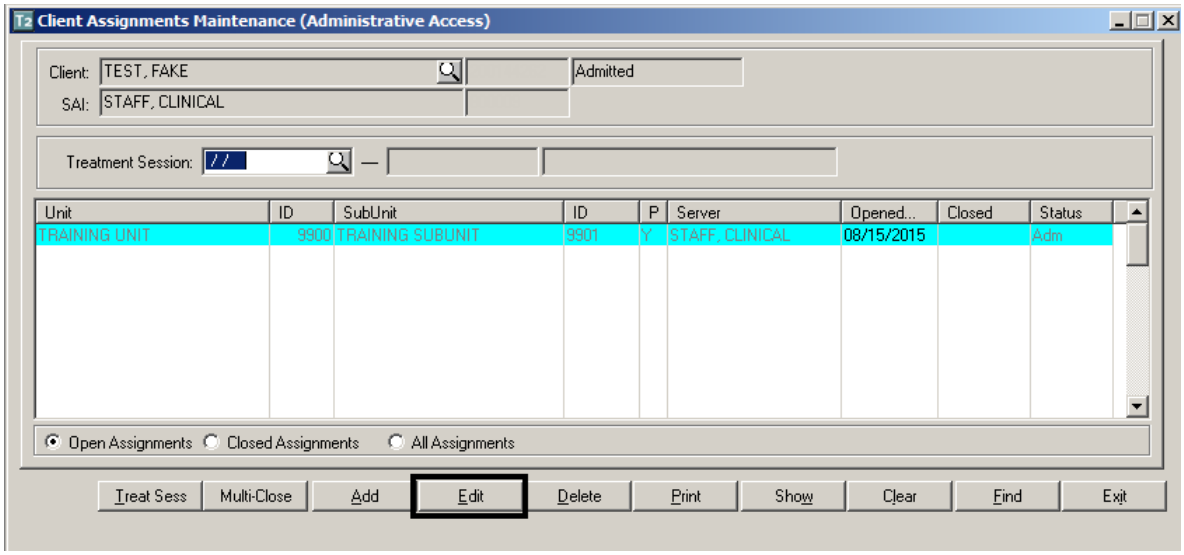
- The final step is to click the "Save**"** button.
- After you have clicked "Save", you are taken back to the "Client Assignment Maintenance" window.
- The Assignment Status for this client is now "Admitted."

- The highlighted entry below represents the completed assignment opening effective 08/15/15.

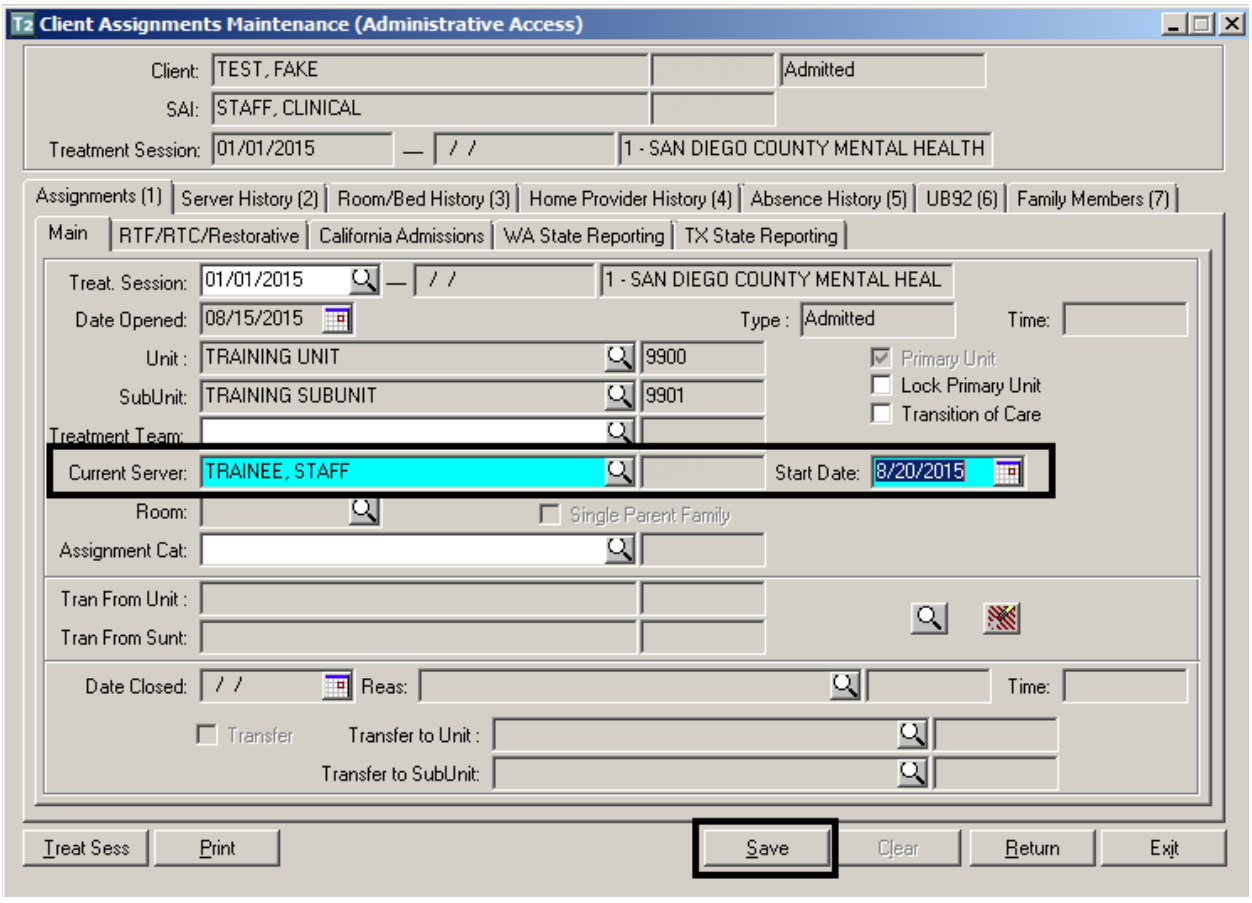


How to Update a Server

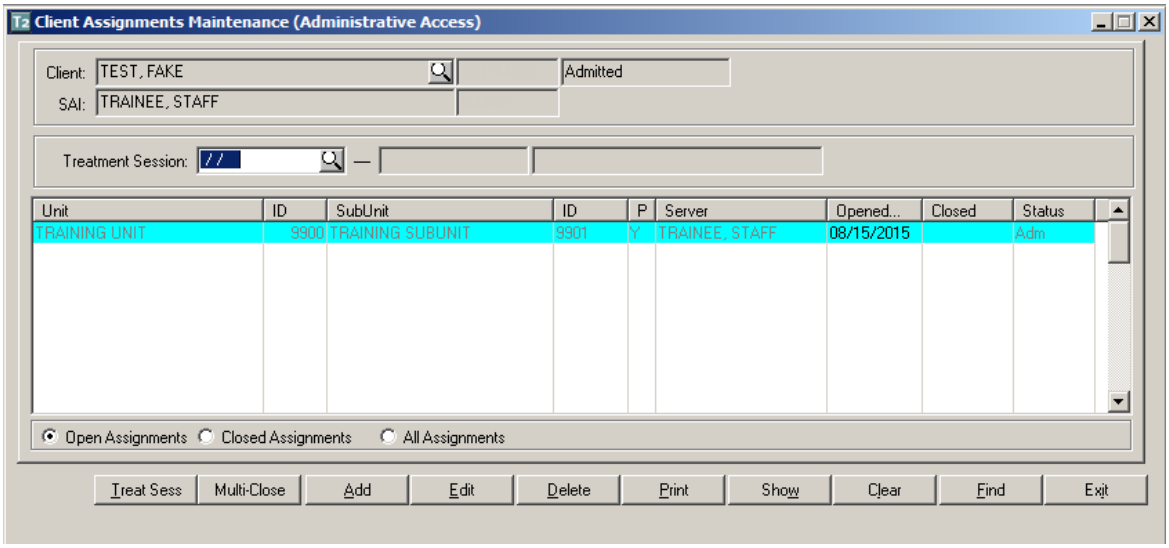
- Open the “Client Assignments Maintenance” window.
- In the “Client” field, enter the Client’s case number or the Client’s name (Last, First) and press the “Tab” key on your keyboard.
- Select the assignment you want to update by clicking on the Unit name until it’s highlighted.
- Click the “Edit” Button.



- The “Assignment Form Entry” window will display.
- Enter the effective date of the Client Assignment update and your CCBH ID number.
- In the “Form Type” field, click on the drop down arrow, select, “U-Update” and click, “OK”.
- A new Client Assignment window will appear. The following fields will auto populate from the previous window: Date Opened, Unit & Sub-Unit, and Current Server.
- Delete the Current Server and Enter the New Server’s CCBH ID number and press the “Tab” key (*the start date to the right will update).*
- The last step is to click, “Save.”



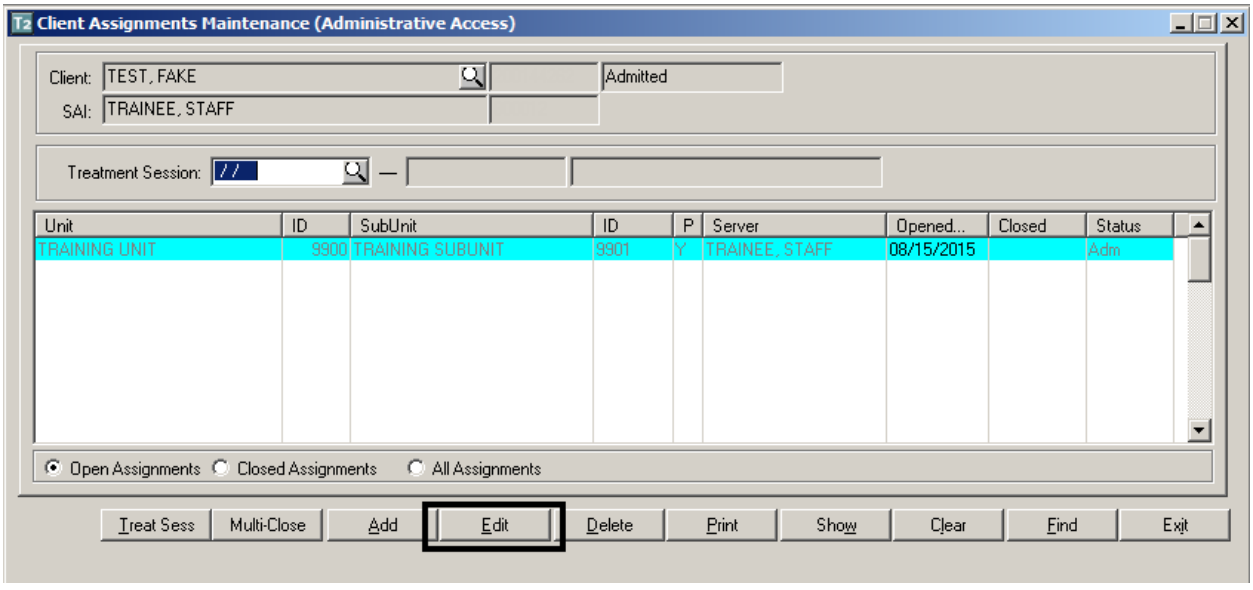
- After you have clicked “Save”, you are taken back to “Client Assignment Maintenance” window.



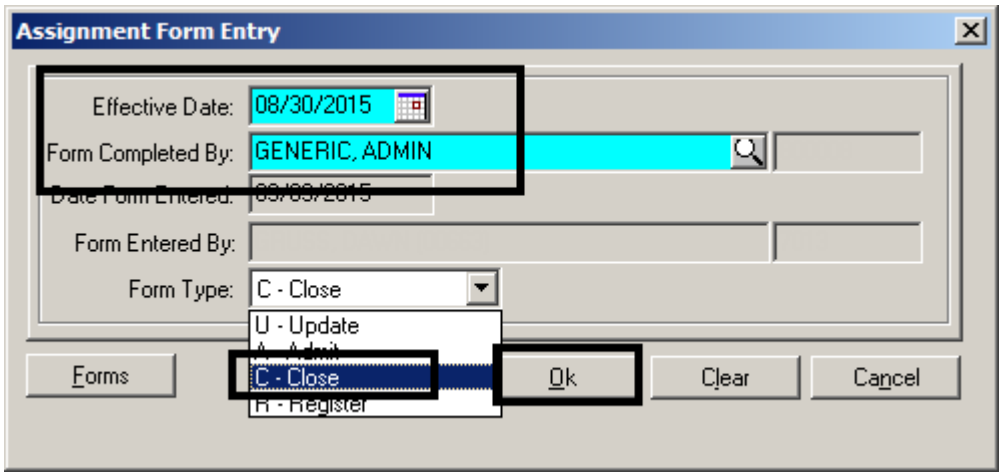
- The highlighted entry above represents the completed Server update and reflects the new Server: TRAINEE, STAFF

How to Close a Client Assignment

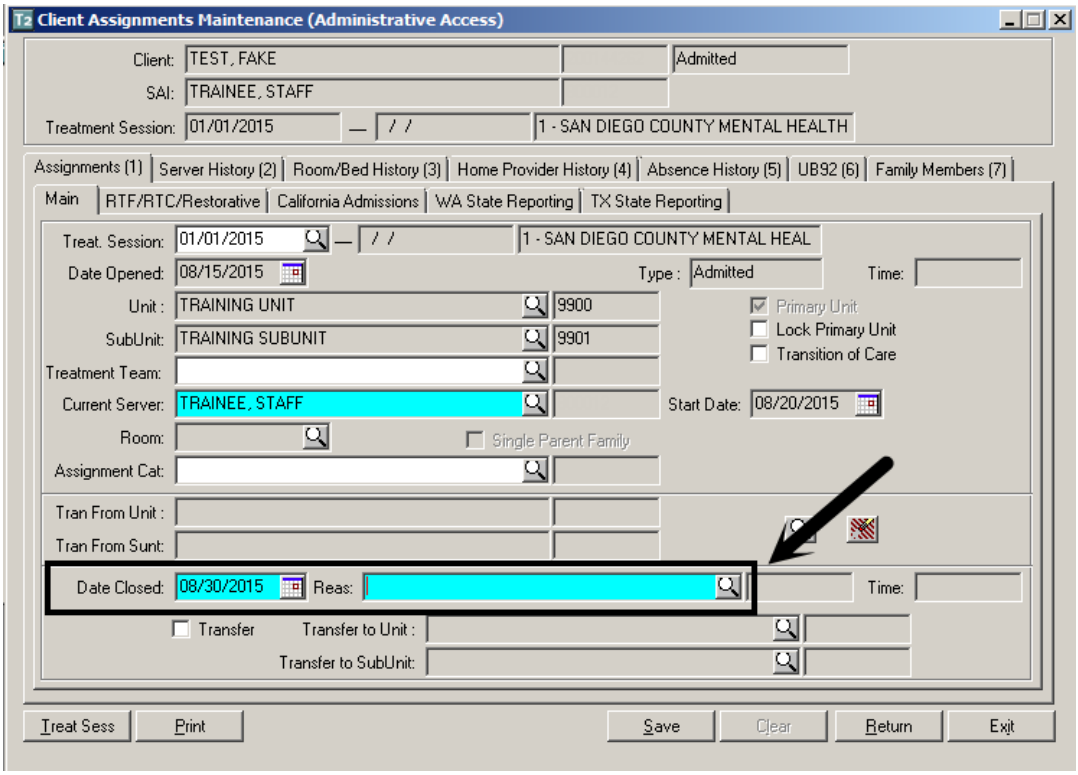
- From “Client Assignments Maintenance” window; enter the Client’s case number or the Client’s SORT name (Last, First) and press the “Tab” key.
- From the display window, select the assignment you want to close by clickingon the Unit name until it’s highlighted.
- Click the “Edit” button to begin the opening of the assignment process.



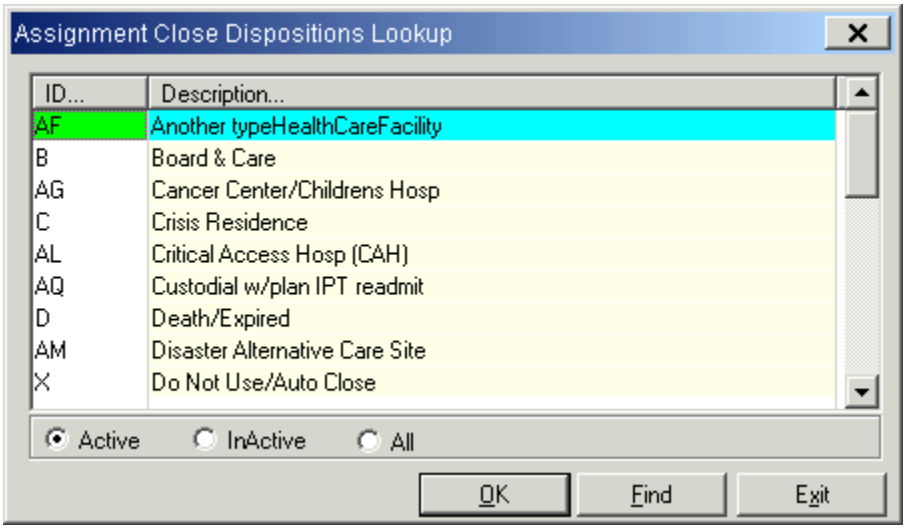
- From the “Assignment Form Entry” window, enter the effective date of the Client Assignment closing and your CCBH ID number.
- From the Form Type field, click on the arrow and select, “C-Close” and click, “OK”.



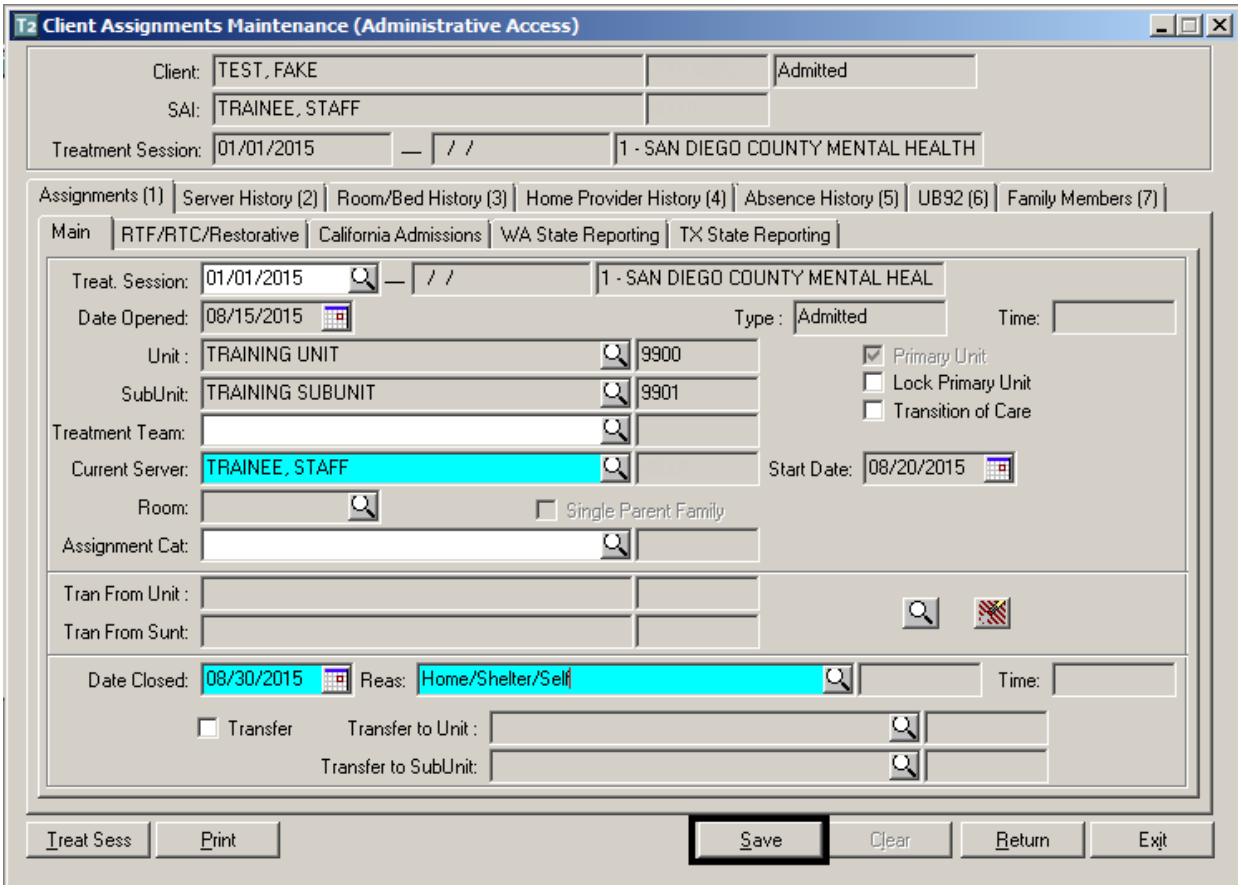
- A new Client Assignment window will appear. The following fields will auto populate from the previous window: Date Opened Unit & Sub-Unit, Current Server and Date Closed.
- Closing Reason: Click on the magnifying glass to show the closing reasons



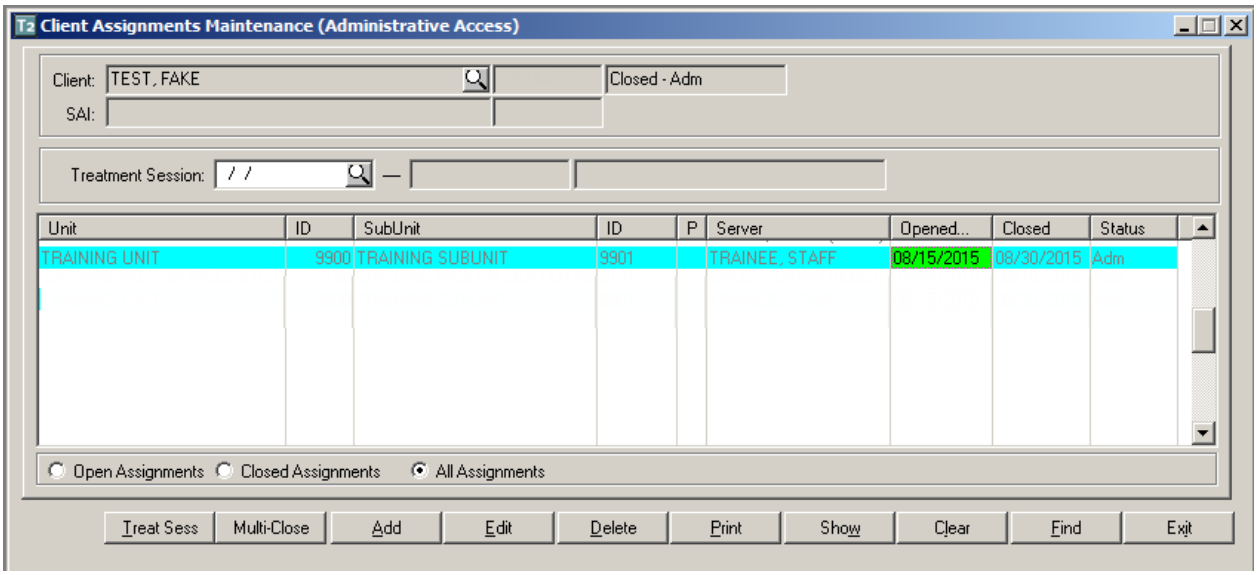
- The “Assignment Close Dispositions Lookup” window will display.
- Select the applicable code and press “OK”.



- The last step is to click, “Save.”



- After you have clicked “Save”, you are taken back to “Client Assignment Maintenance” window.
- The Assignment Status for this client is now: “Closed-Adm.”
- The highlighted entry below represents the completedassignment closing effective 08/30/2015.



Adding MD or RN Unit/Sub-Unit (If Applicable):

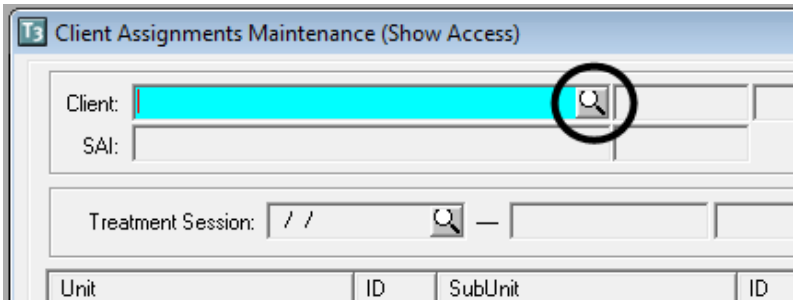
NOTE: Billing cannot be entered for an MD or RN subunit, as is not setup for billing purposes. The purpose of adding the MD and RN subunit, is so they are able to see the client on their caseload in their Clinician’s and Doctor’s Homepage.

NOTES

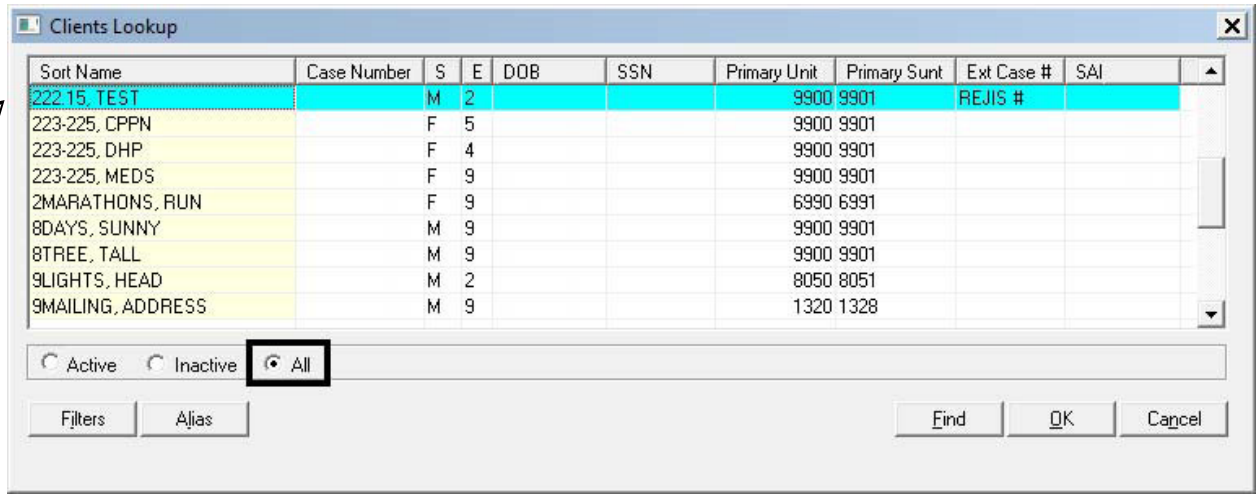
CLIENT SEARCH
External View

Client search:

- Click on the magnifying glass icon.



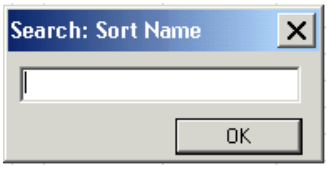
- The “Clients Lookup” window will display.



MULTIPLE WAYS TO SEARCH

Searching by Sort Name:

1. Before you begin your search, select the “All” radio button.
2. To begin the search function, place your cursor in one of the boxes under the “Sort Name” column.
3. You will see a dotted outline that appears around the box that you selected.
4. Start typing the last name of the client that you are searching for in capital letters. The “Sort Name” box appears.

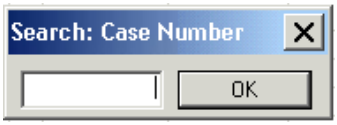


5. Type LASTNAME comma space FIRSTNAME.

6. Click “OK”.
7. After you locate your client click “OK” once more.

Searching by Case Number

1. Select the “All” radio button.
2. To begin the search function, place your cursor in one of the boxes under the “Case Number” column.
3. You will see a dotted outline that appears around the box that you selected.
4. Start typing the “Case Number” of the client you are searching for. The “Case Number” box appears.



5. Click “OK”.
6. After you locate your client click “OK” once more.

Searching by Social Security Number

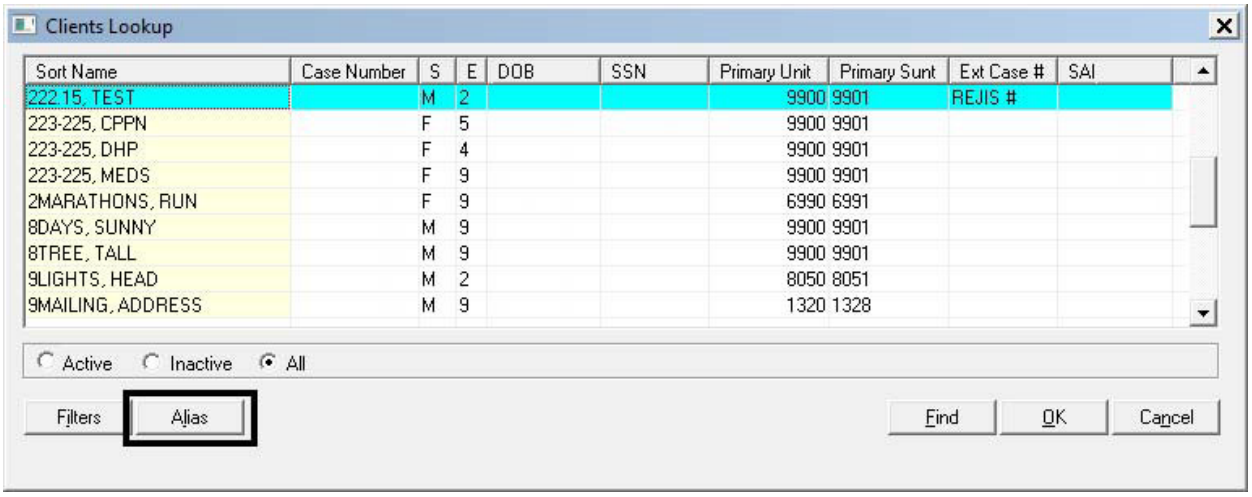
1. Select the “All” radio button.
2. To begin the search function, place your cursor in one of the boxes under the “SSN” column.
3. You will see a dotted outline that appears around the box that you selected.
4. Start typing the “SSN” with dashes of the client you are searching for. The “SSN” box appears.

5. Click “OK.”
6. After you locate your client click “OK” once more.

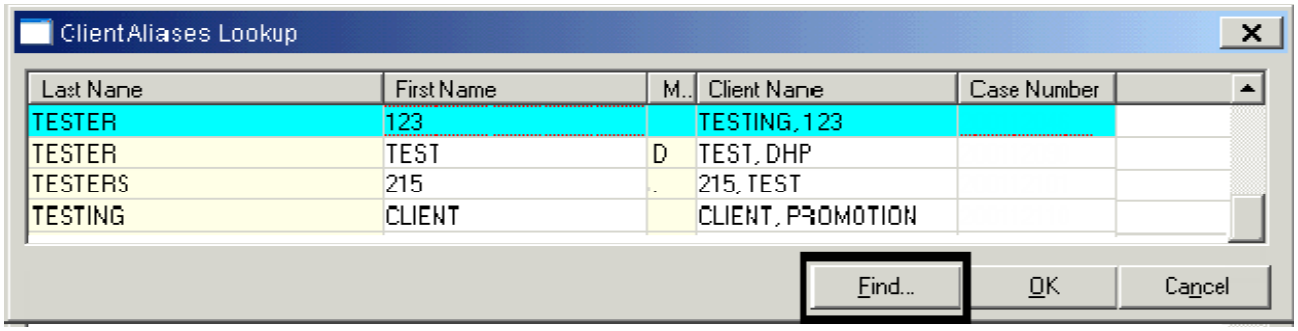
NOTES

Searching by Alias

1. On the “Clients Lookup” window, click on the “Alias” button.

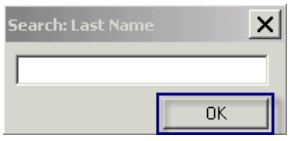


2. The “Client Aliases Lookup” window will appear.



Searching by Last Name:

1. To begin the search function, place your cursor in one of the boxes under the last name column.
2. You will see a dotted outline that appears around the box that you selected.
3. Either click “Find”, or just start typing the last name of the client that you are searching for in capital letters. The “Last Name” box appears.



4. Click “OK”.
5. After you locate your client click “OK” once more.

Searching by First Name:

1. To begin the search function, place your cursor in one of the boxes under the **"First Name"** column.
2. You will see a dotted outline that appears around the box that you selected.
3. Start typing the last name of the client that you are searching for in capital letters. The "Last Name" box appears.

4. Click "OK".
5. After you locate your client click "OK" once more.

If the client is not located after a thorough search, users may add that client to the MH MIS system (see the "Core Client Information" tip sheet).

Search reminders and things to keep in mind:

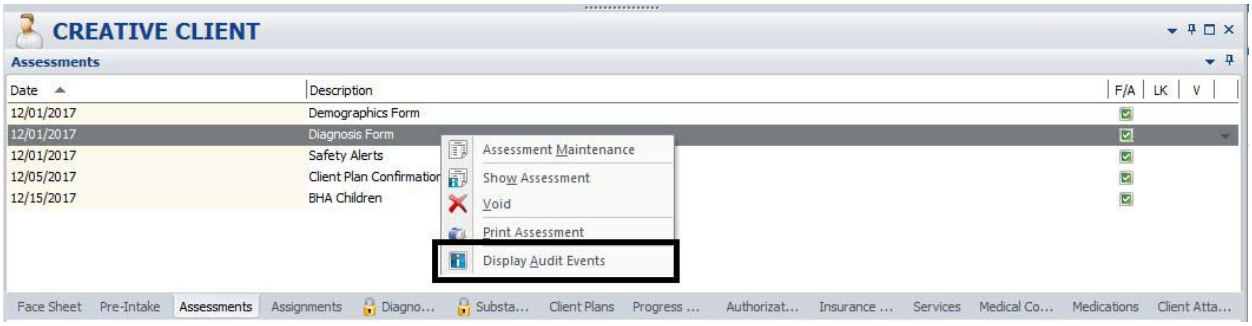
- Always select the "All" radio button when searching.
- Use CAPS when searching by name.
- Remember if you are searching by client's name, enter it in the following way: LASTNAME comma space FIRSTNAME. (e.g. CAR, BLUE). Except Alias, which you search by LAST NAME and FIRST NAME separately.
- You must complete a thorough search before adding a new client. Search by Client Name, Social Security Number (SSN), Case Number, Date of Birth (DOB) and ALIAS.

NOTES

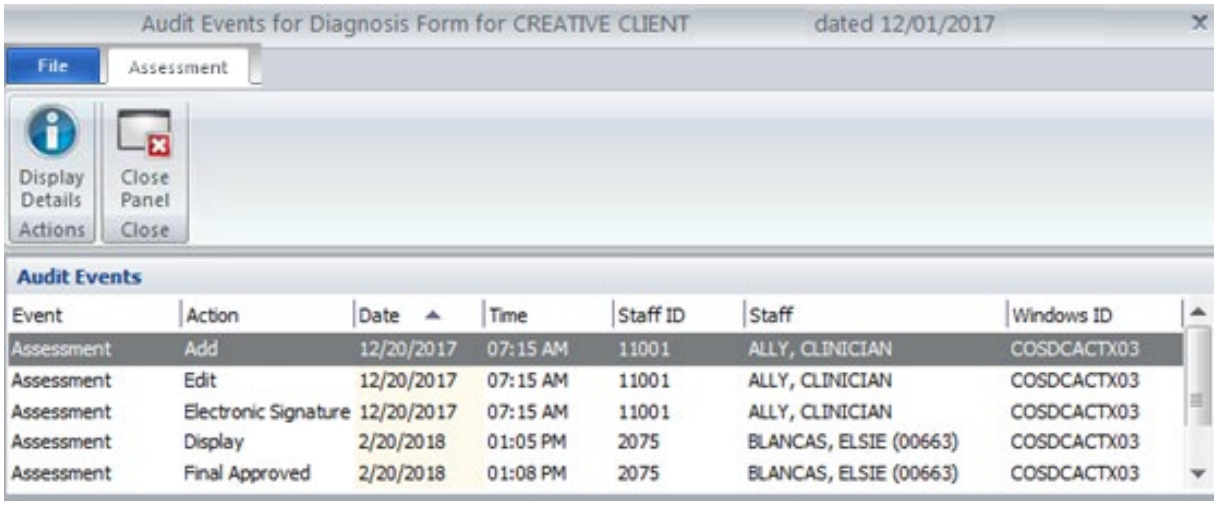
DISPLAY AUDIT EVENTS

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

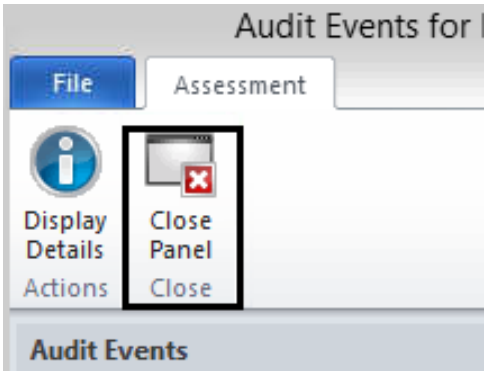
1. Right click on the assessment details you wish to view. Select “Display Audit Events.”



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

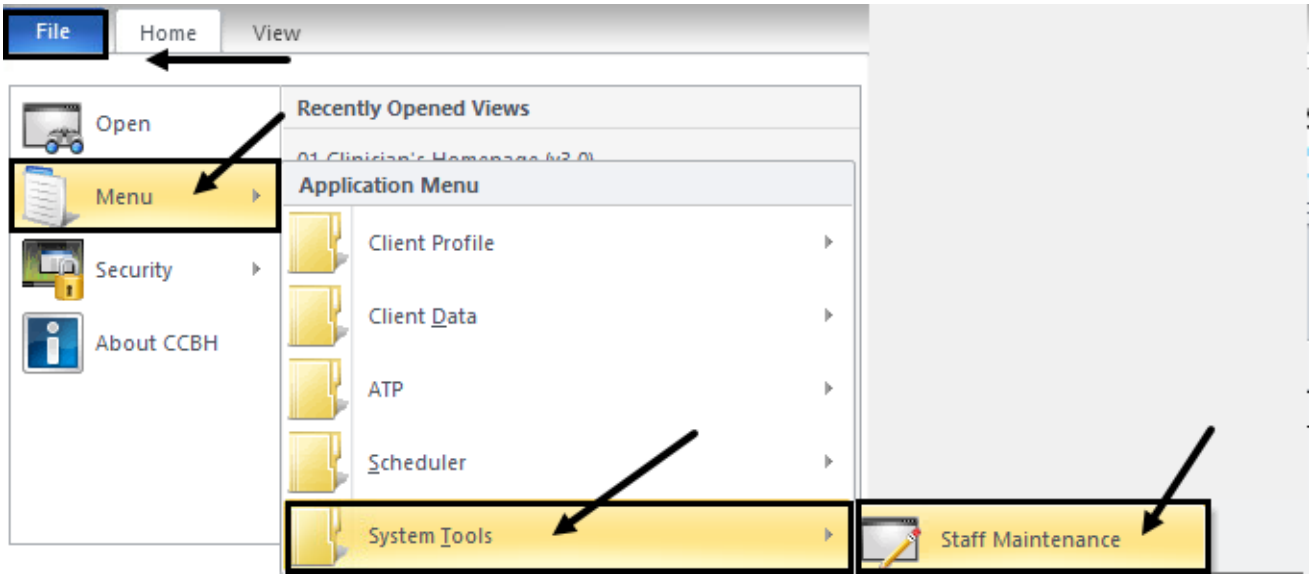


3. Select “Close Panel” to return to the Assessments Pane.

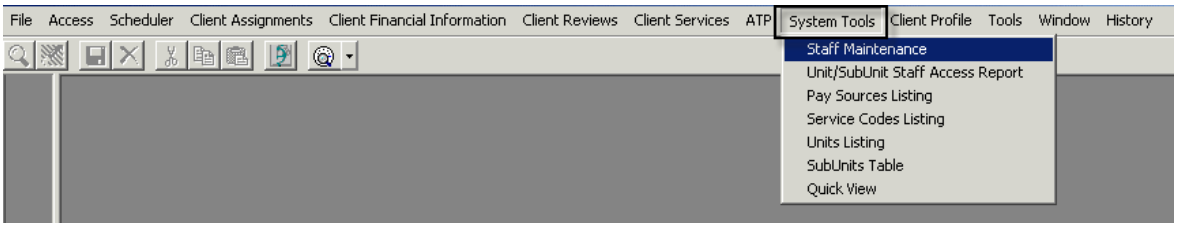


STAFF MAINTENANCE LOOKUP
How to Lookup a Staff for Contact Information

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

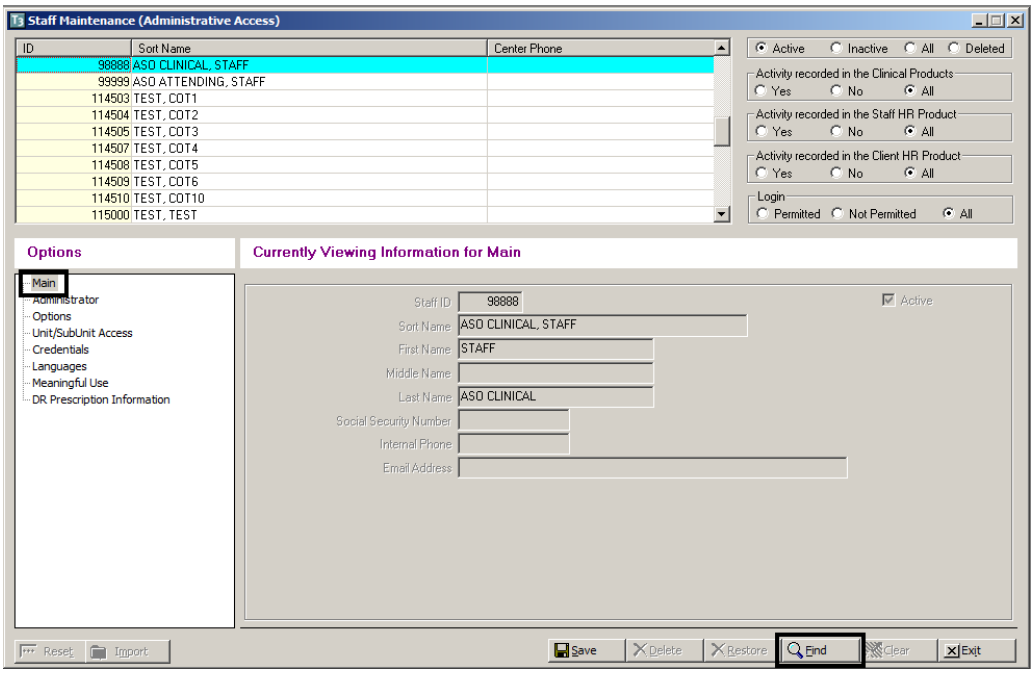


- From the EXTERNAL VIEW, locate "Staff Maintenance" under "System Tools".



"**Staff Maintenance" Menu:**

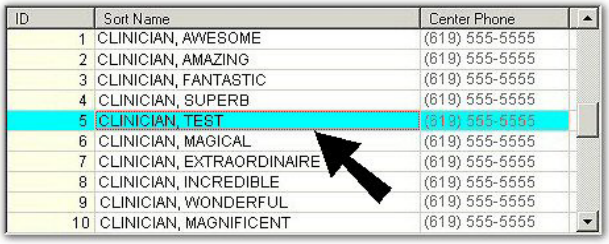
When the "Staff Maintenance" Menu launches, your staff ID and name will be highlighted in blue as a default. Your current contact information on file will be listed in the "Main (1)" tab below.

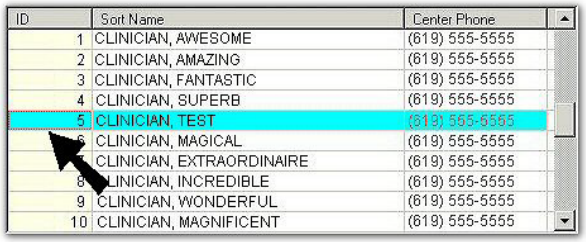


To begin your search:

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

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

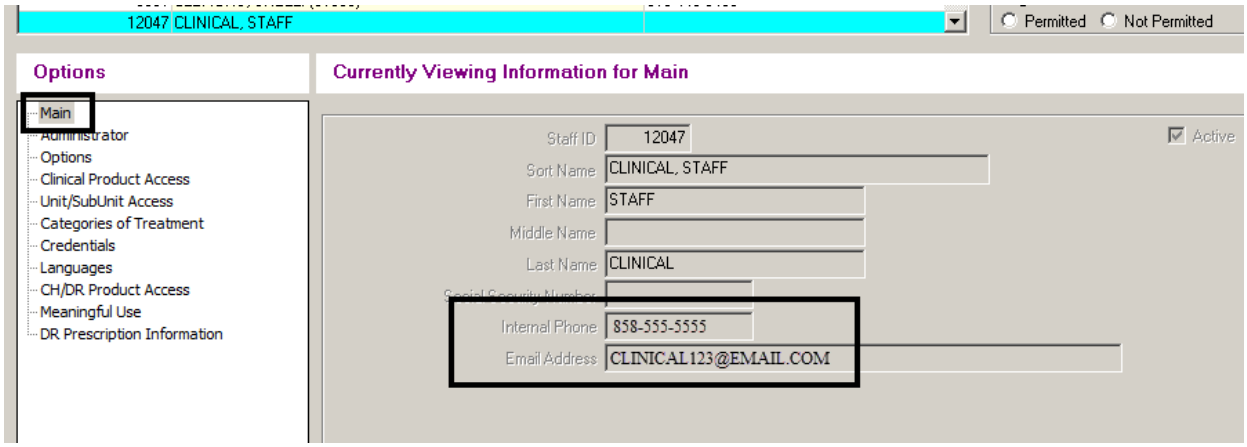




Search Window:

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

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



- The contact information of the staff for which you have entered will display under "Main".

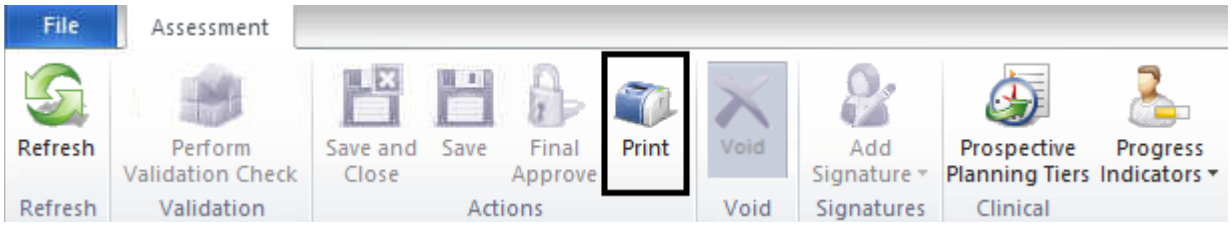
- The "Internal Phone" number as well as the "Email Address" will be listed when it is available.

NOTES

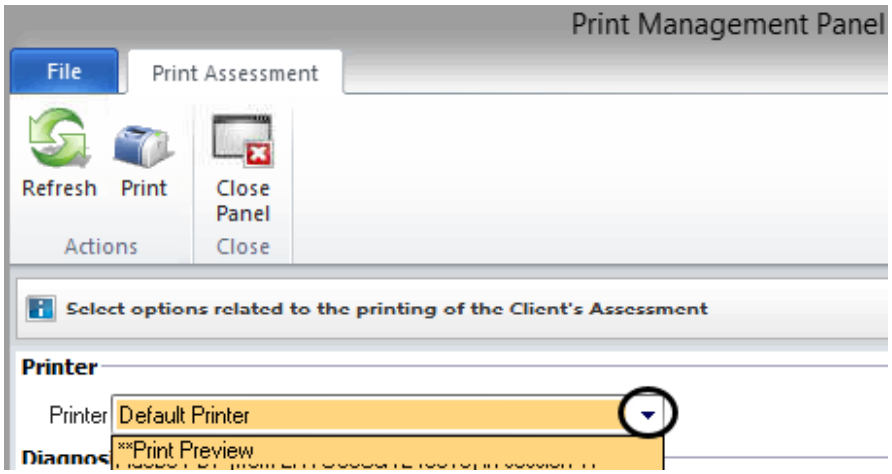
PRINT TO SCREEN

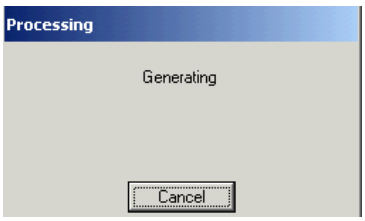
Note: Before printing a hard copy, always print to screen first to verify whether printing is truly necessary.

- Click the “Print” button.



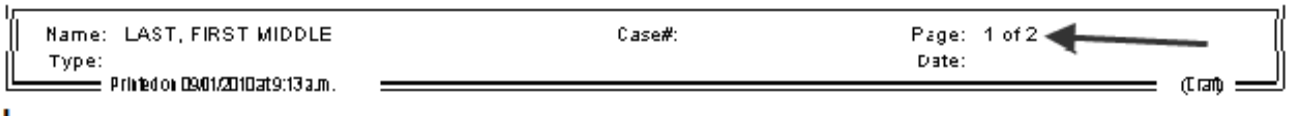
- Click on the down arrow to the right of the “Printer” field, click “Print Preview”, and click the “Print” button.





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

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



Icons

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

Prints a physical copy.

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

Displays the default size of the copy.

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

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

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

Navigates directly to the first page.

Navigates back one page.

Navigates forward one page.

Navigates directly to the last page.

Displays keyboard commands for navigating through the copy.

Displays the details of the software product.

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

CLINICIAN'S HOMEPAGE NOTIFICATIONS PANE

Managing Notifications and Timelines

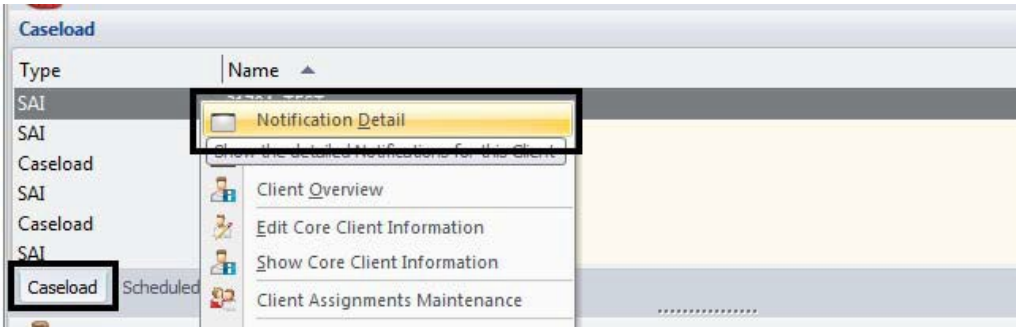
Client Action Schedules are notifications in the system which indicates when an assessment is due based on client activity in the County system of care. These notifications are intended to assist in managing tasks related to quality and coordination of care for each client. The primary server at each program continues to be responsible to manage and track all necessary actions required by the County system of care for each client.

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

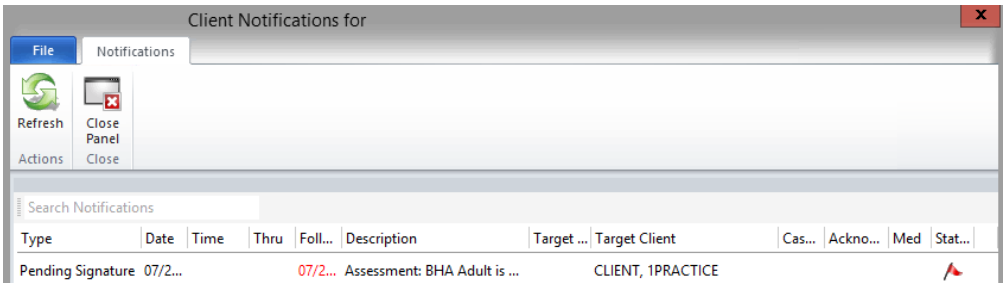
There are two ways to see the details of a "Notification":

1st Way

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

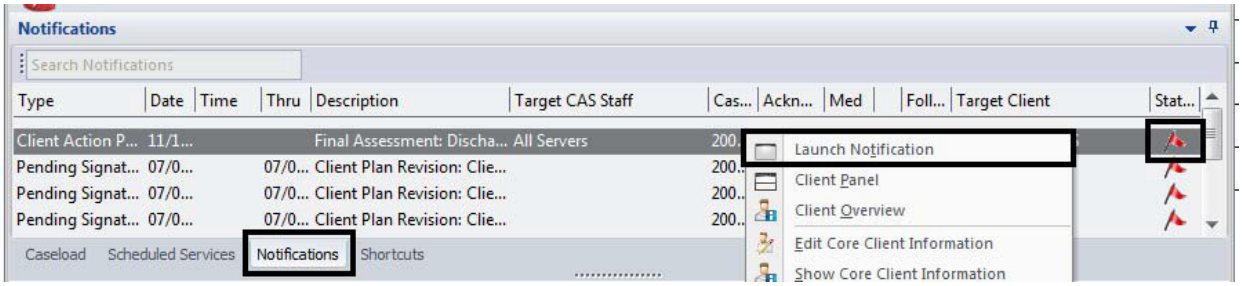


- When the "Notification Detail" option is selected, the "Client Notifications" window activates, displaying what action is required for the client. Double click on the line to open up the Assessment.



2nd Way

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



Timelines to Keep in Mind:

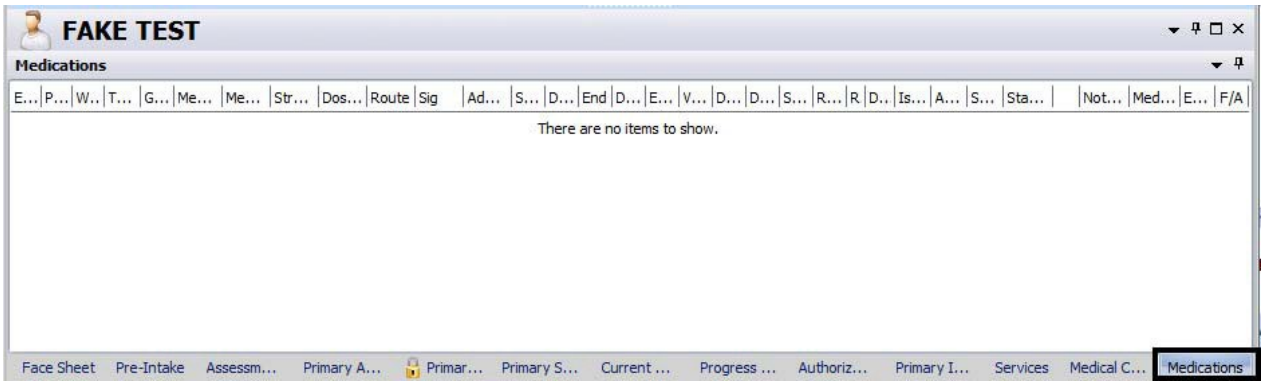
- A Behavioral Health Assessment (BHA) must be completed within sixty days after the opening of a client assignment.
- A notification for a BHA will be listed and will remain on the Homepage for sixty days from the due date. Sixty days after the due date, the notification will ‘drop off’ of the Caseload “Notifications”.
- Note: just because a notification has ‘dropped off’ does not mean it is no longer required – the notification is intended as a reminder only. Remember, assessments not completed within the sixty day required time-frame are considered out of compliance per County QM documentation standards.
- A client’s annual review date is established by most recent final approved BHA (check the notification dates for details).
- A Discharge Summary must be completed within 7 days after a client’s assignment to your program is closed.

Example:

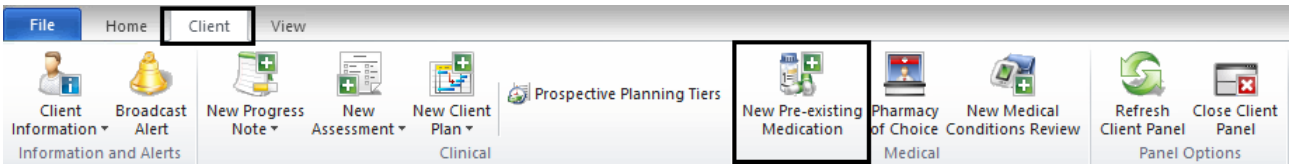
	Open Date	BHA Completed	BHA Update Due
Program A			
Program B			
Program A			

ENTERING A NEW PRE-EXISTING MEDICATION

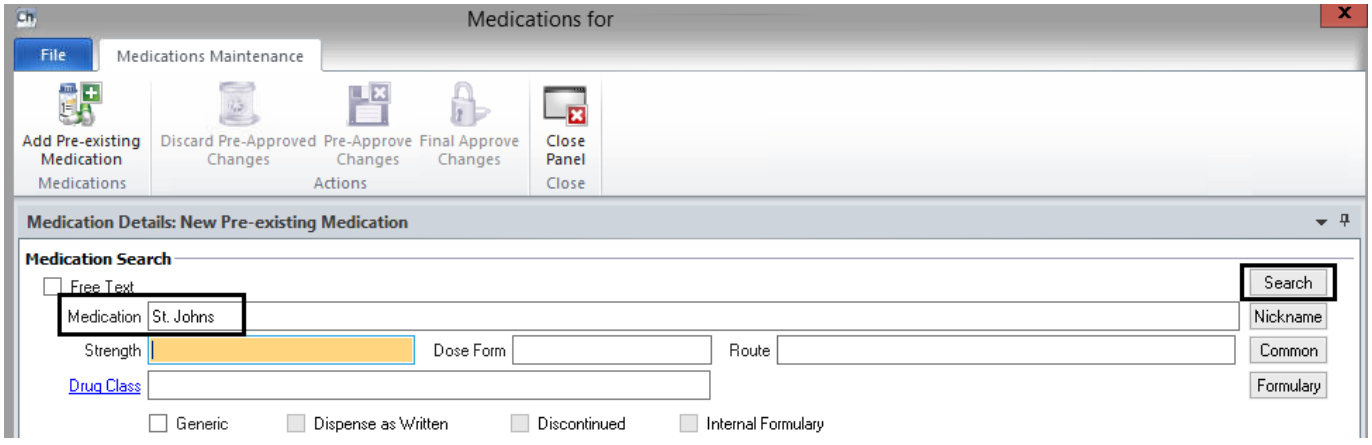
- View the medications listed in the “Medications” pane.



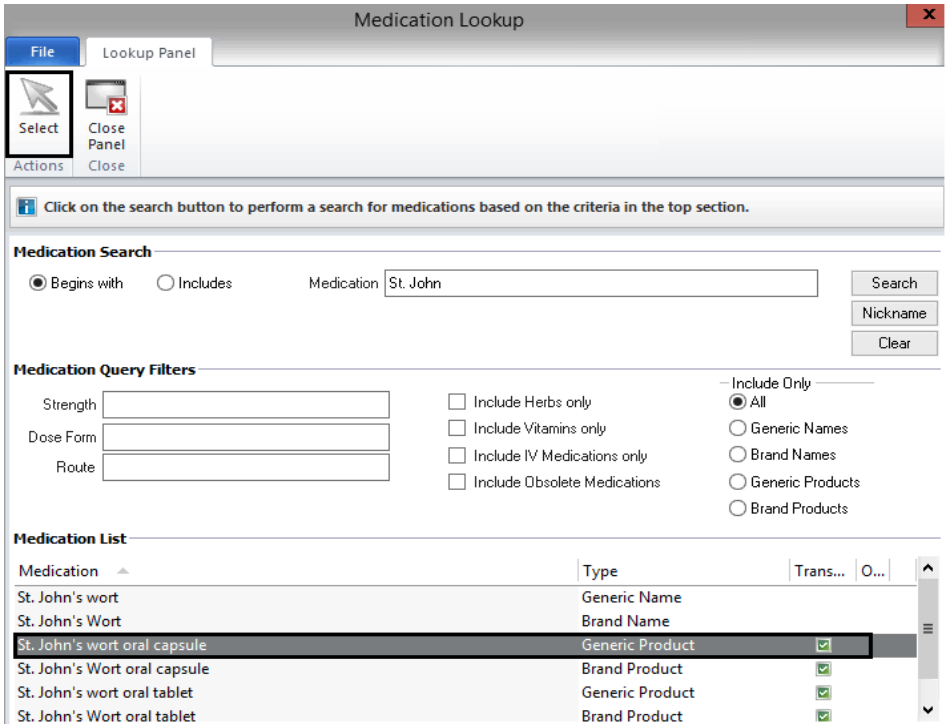
- If the client reports taking a medication that is not listed, click the “New Pre-existing Medication” button.



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

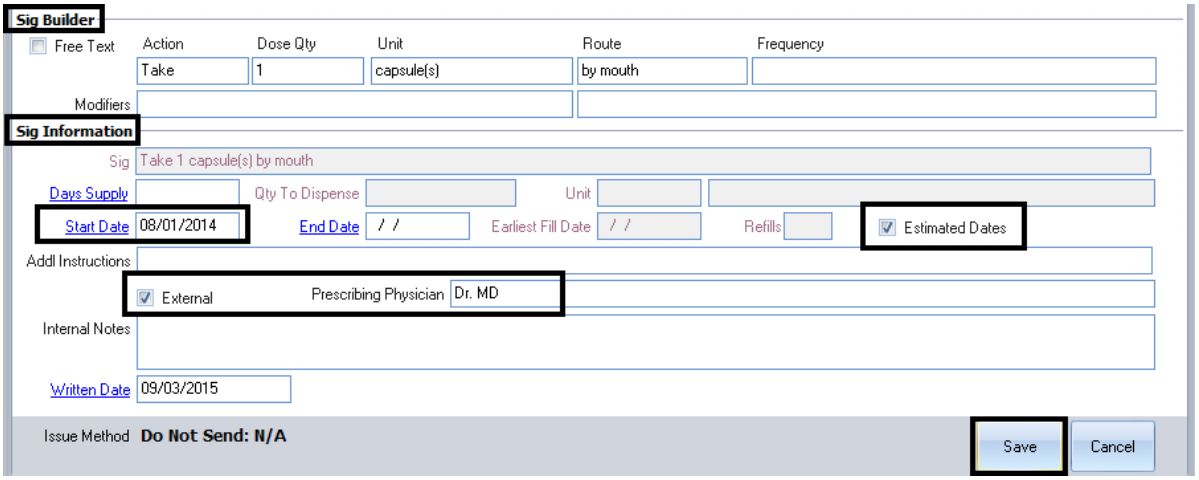


- Locate the appropriate medication from the list, and double click on it, or click once and choose “Select” at the top.

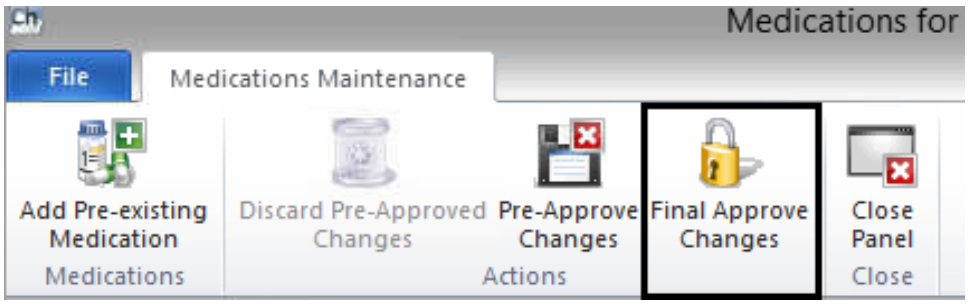


- Once you’ve chosen the medication of your choice, a new window launches. The only other “software required” field is “Start Date”; however, clinically, if you have additional information, enter it into the “Sig Builder” and “Sig Information” fields. If prescribed by an external provider, select the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

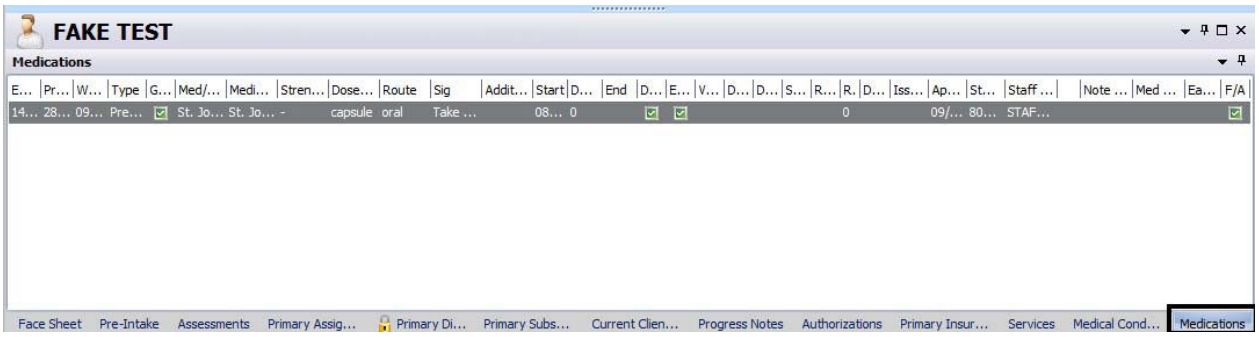
Note: If you do not have the exact start date, select the “Estimated Dates” box.



- Click the “Final Approve Changes” button.



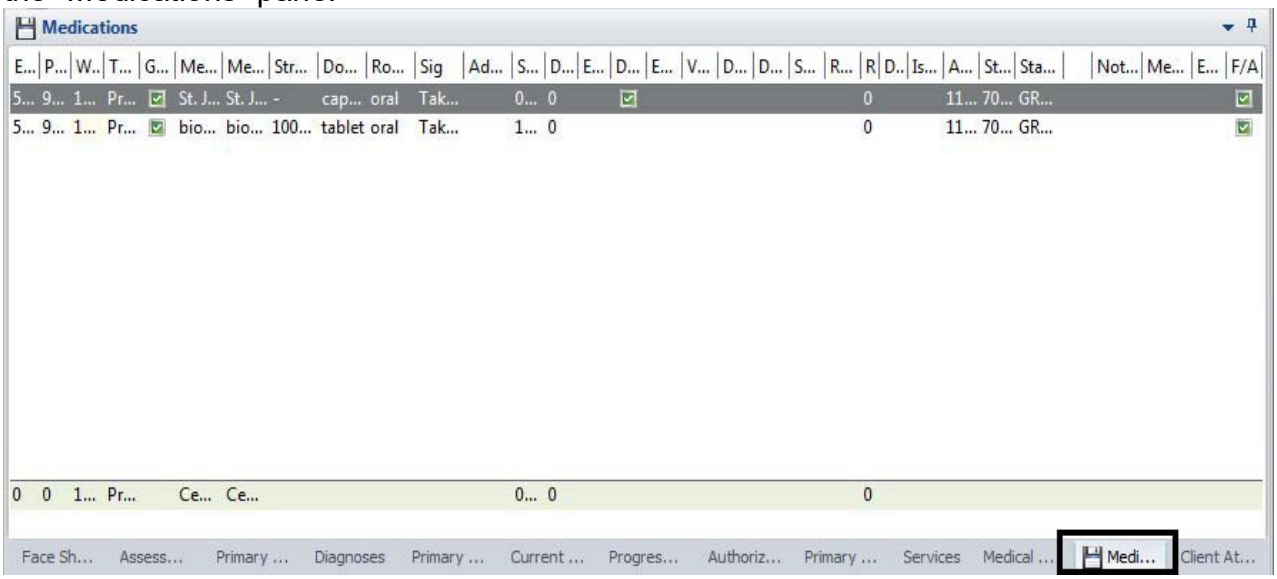
- The medication then displays in the “Medications” pane of the client panel.



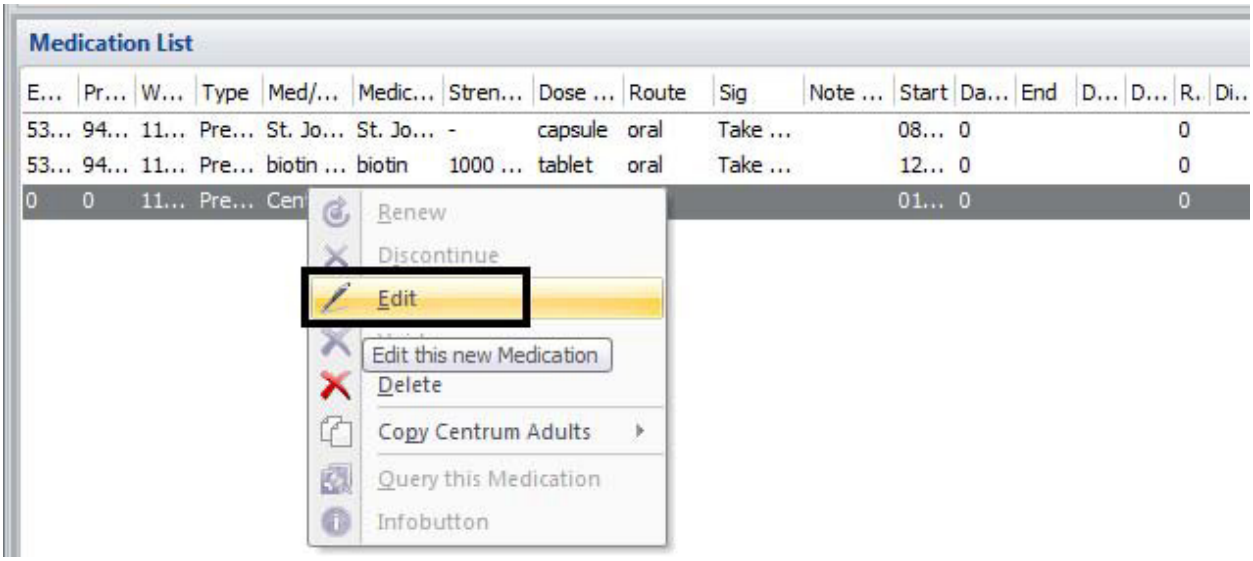
EDITING A PRE-EXISTING MEDICATION

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

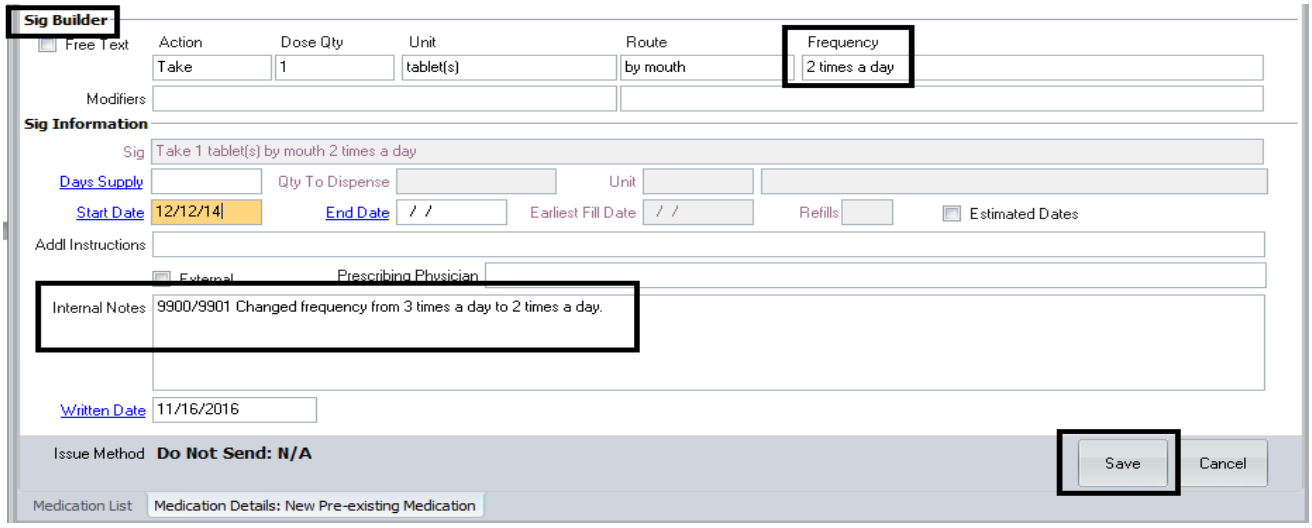
1. Select the appropriate client, and double click on the medication you wish to edit in the “Medications” pane.



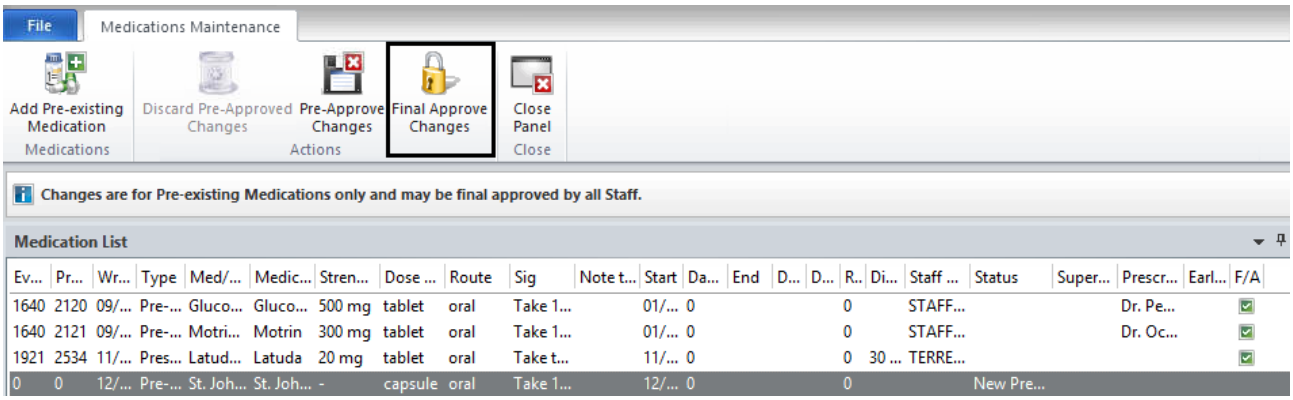
2. The client's medications appear in a new window. Right click on the medication you wish to edit. A drop down menu appears. Select "Edit".



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



4. Click the “Final Approve Changes” button.

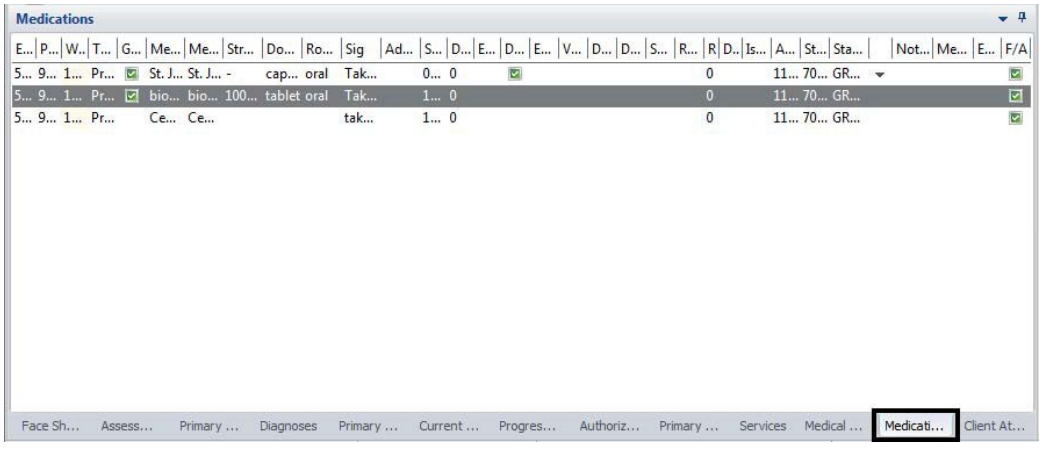


5. The edited prescription then displays in the “Medications” pane of the client panel. The change that was just made can now be observed in the “Sig” column.

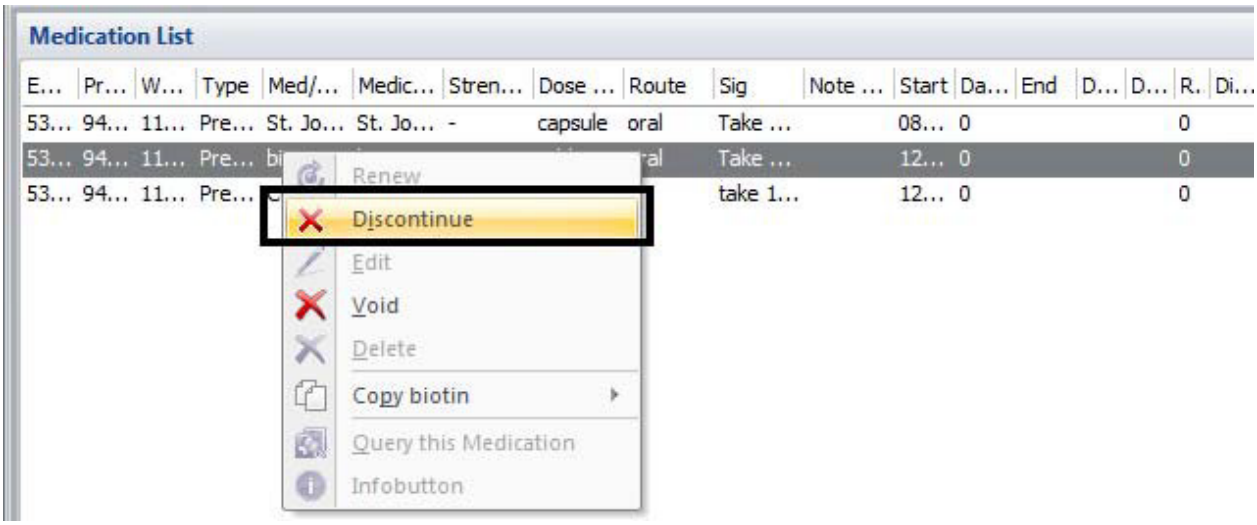
DISCONTINUING A PRE-EXISTING MEDICATION

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

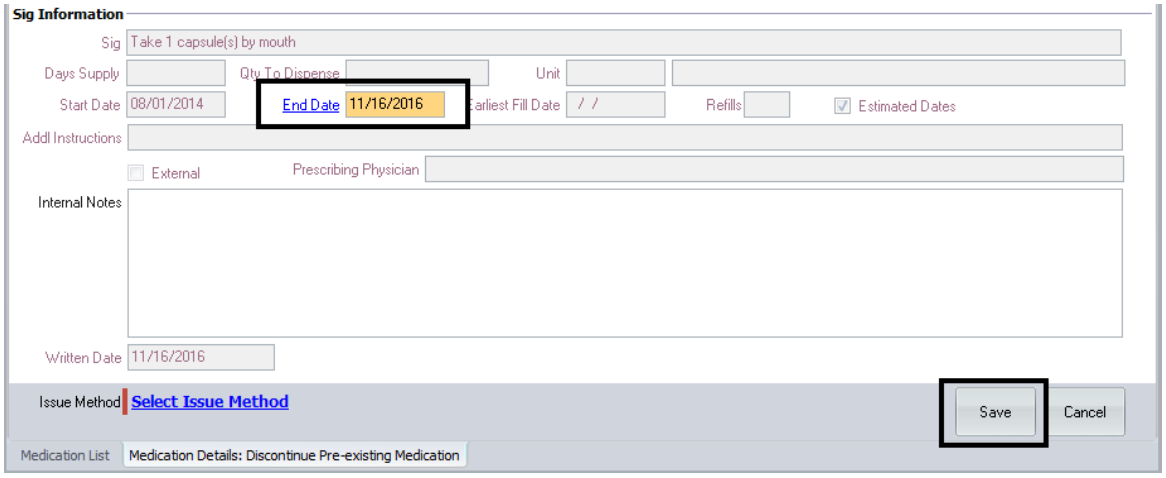
1. Select the appropriate client, and double click on the medication you wish to discontinue in the “Medications” pane.



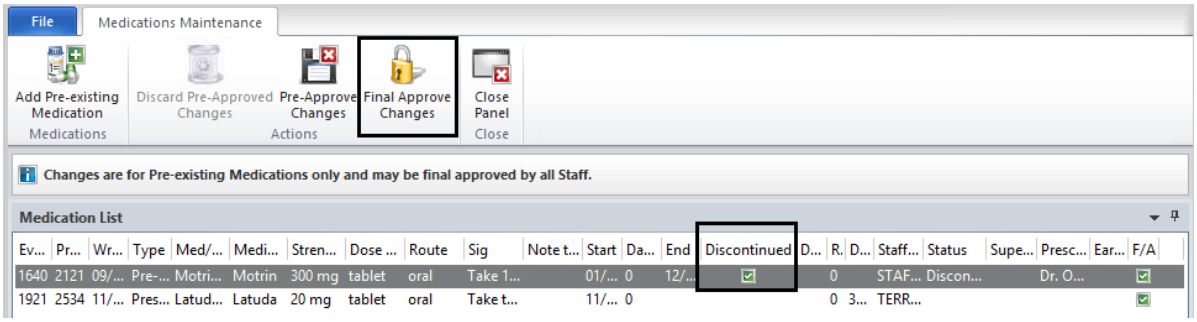
2. The “Medications List” for that client will launch. Right click on the medication you wish you discontinue. A drop down menu will launch. Click on “discontinue”.



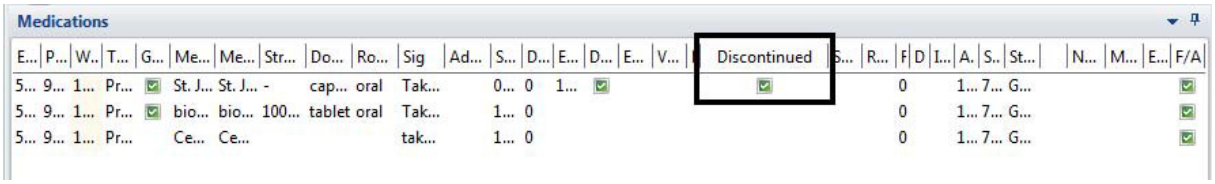
3. The “Medication Details: Discontinue Prescription” window launches. The end date will default to the current date (but may be changed). Click “Save Medication”.



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



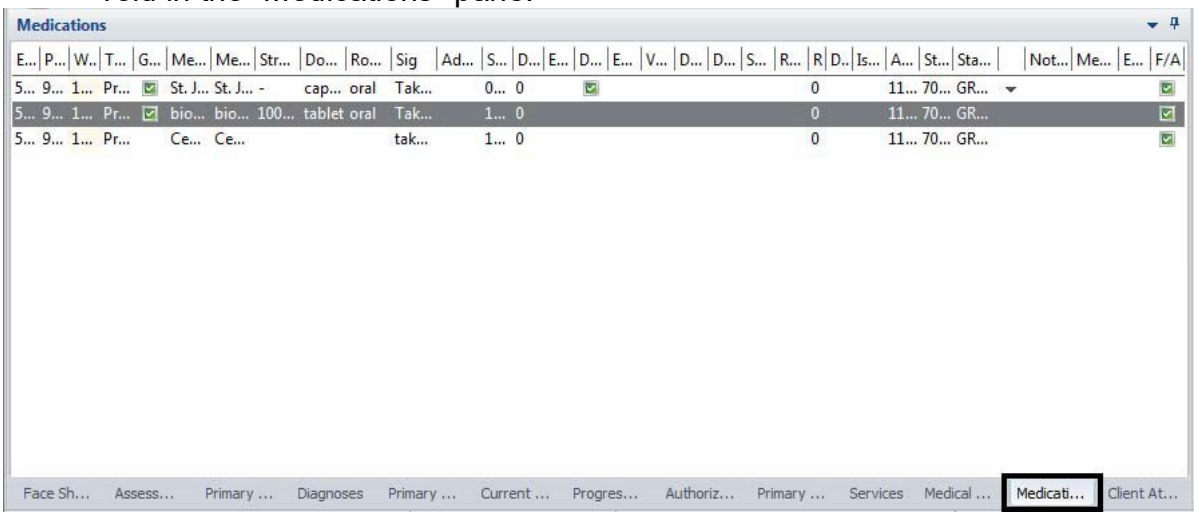
5. The discontinued prescription then displays in the “Medications” pane of the client panel with a green check-mark in the “Discontinued” column.



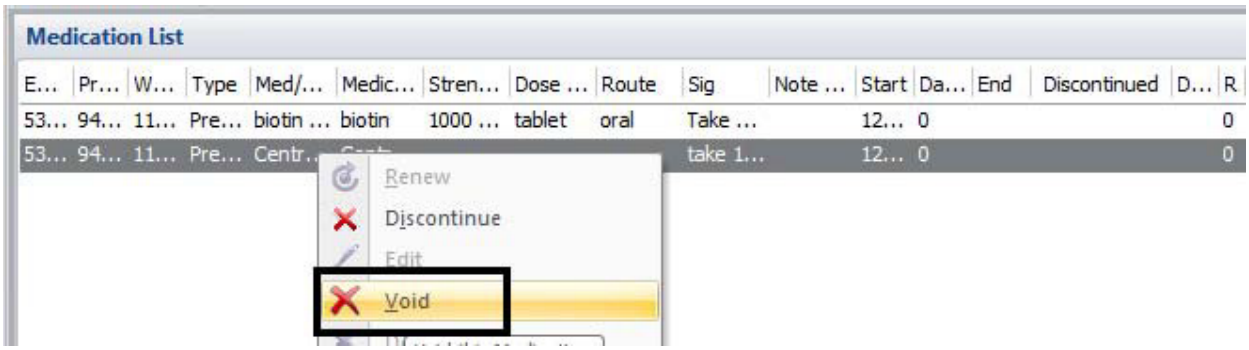
VOIDING A PRE-EXISTING MEDICATION

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

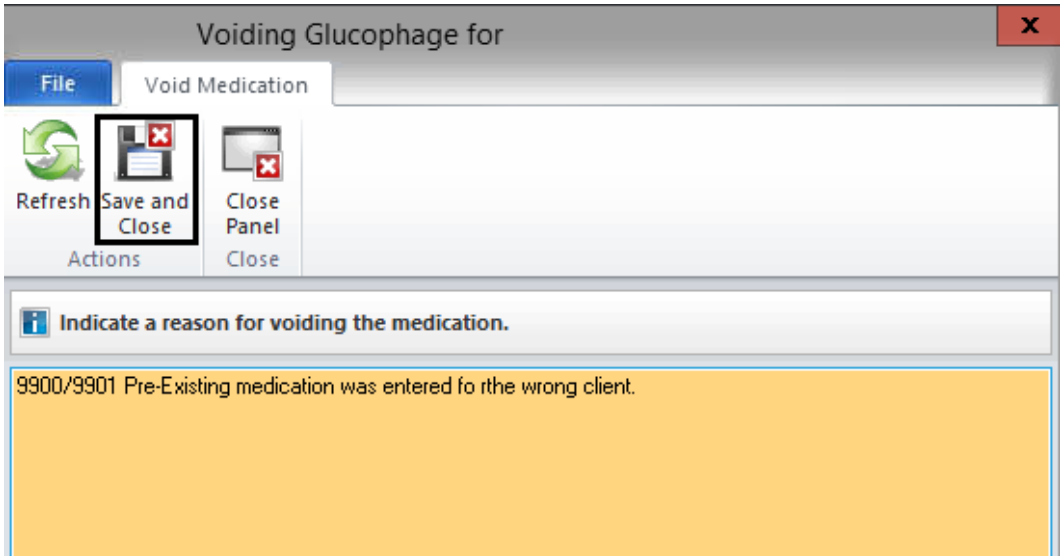
1. Select the appropriate client, and double click on the medication you wish to void in the “Medications” pane.



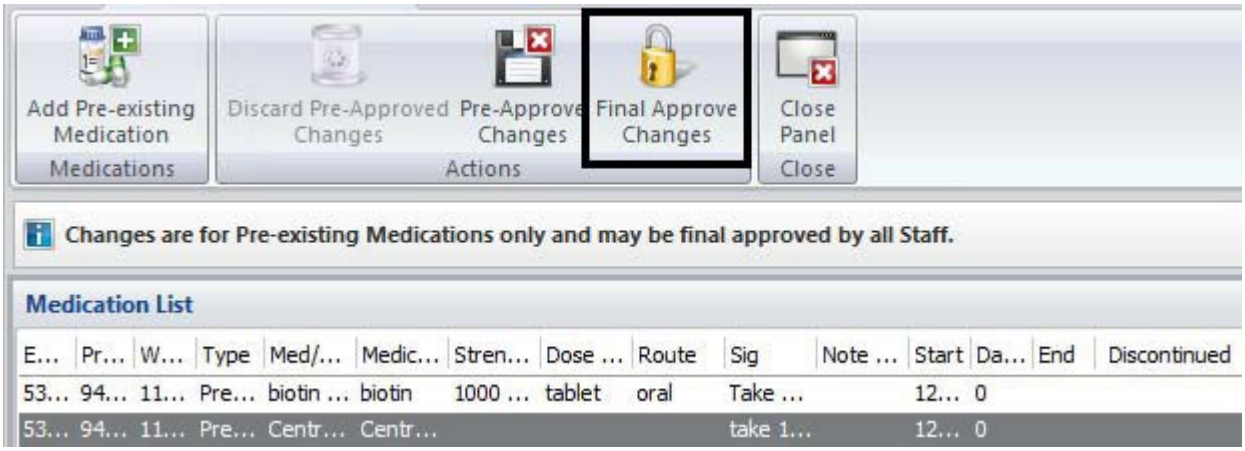
2. The “Medication List” for the client launches. Right click on the medication you wish to void and click, “Void”.



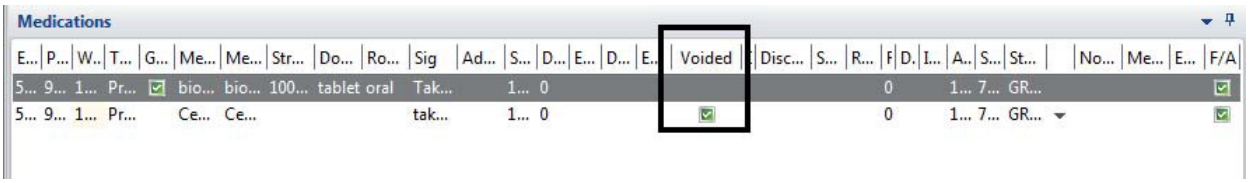
3. A new window launches which allows narrative text to be entered. Document the reason for voiding, and click “Save and Close”.



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



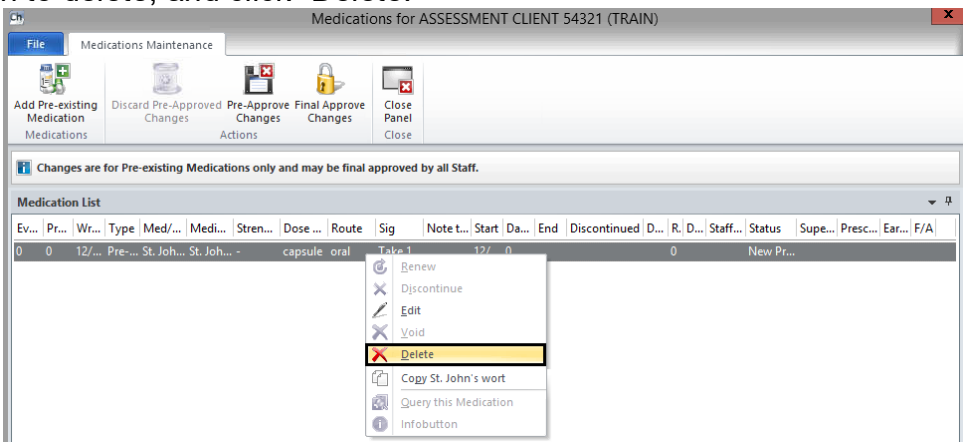
5. The voided prescription then displays in the “Medications” pane of the client panel with a check mark in the “Voided” column.



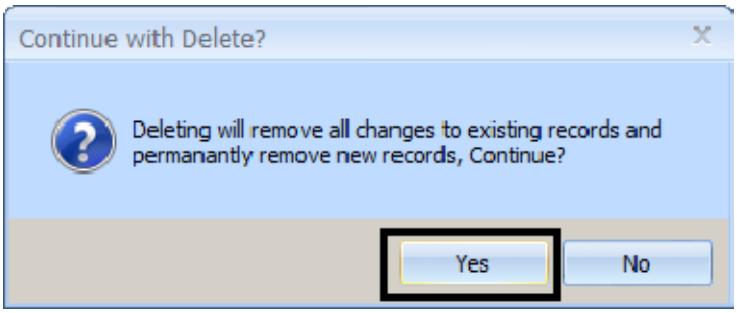
DELETING A PRE-EXISTING MEDICATION

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

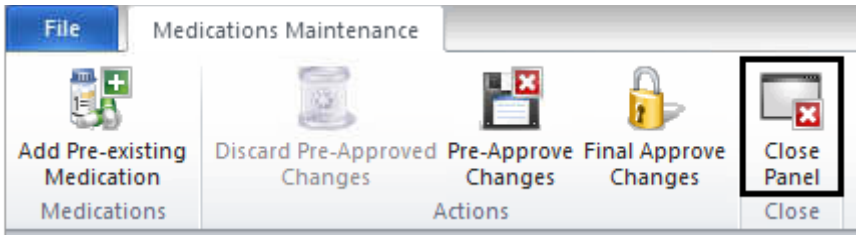
1. In the “Medication Maintenance” window, right click on the medication you wish to delete, and click “Delete.”



2. The following message will appear. Click “Yes.”



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



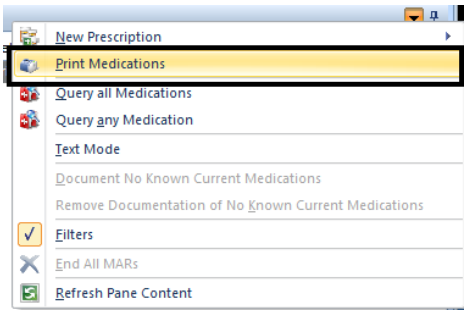
PRINTING CLIENT MEDICATIONS

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

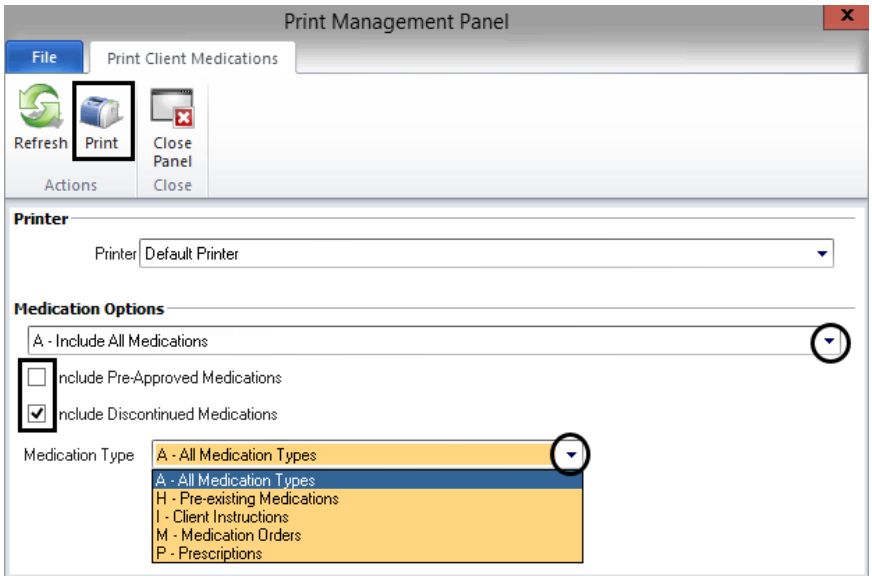
1. With the Client panel open, select the “Medications” pane at the bottom of the screen.

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

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



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



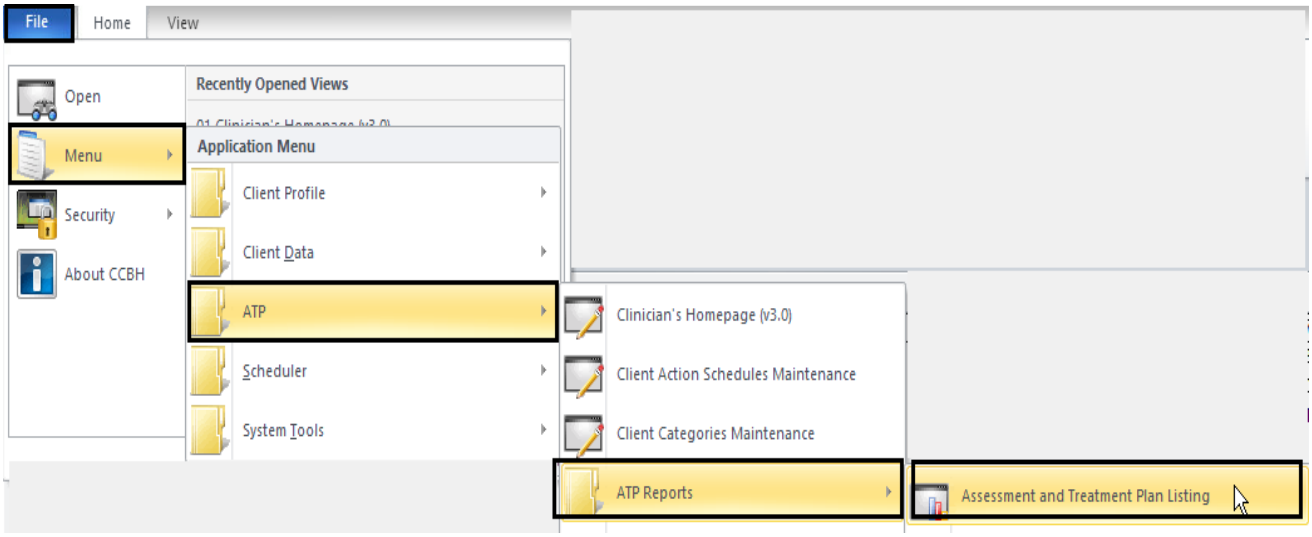
4. Adjust the printing options to what is needed. Users can choose to print only a certain medication type, to include pre-approved or discontinued medications, and/or to include all medications or only current medications.

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

SUPPLEMENTAL REPORTS

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

ASSESSMENT REPORTS



Assessments Final Approved by Primary Signer:

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

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

Assessments Not Final Approved:

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

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

NOTES

BHS-025 CLIENT CHANGE REQUESTS

- Login to the Optum website with your username and password
- Click on BHS Provider Resources → MHP Provider Documents → Forms
- Download the form fills needed

**Please note these forms MUST be typed.*

BHS-025 FORM A AND B JOB AID

Form A- to be used to request changes to the following*:

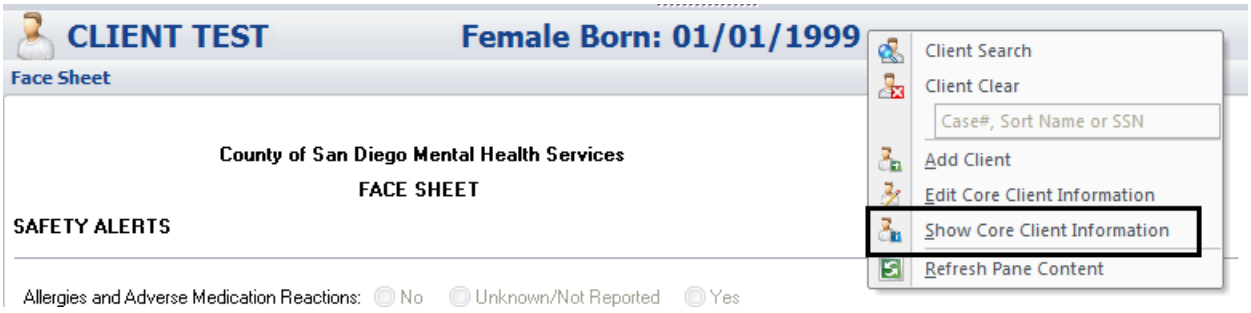
1. ***Name*** (Sort name, Last Name, First, Middle Name)
2. ***DOB*** (date-of-birth)
3. ***SSN*** (social security number)
4. ***Sex*** (Gender)
5. ***Medi-Cal Policy Number /Effective Date***

*Users should **NOT** make changes to Name, DOB, SSN, and Sex when creating a Demographic Form.

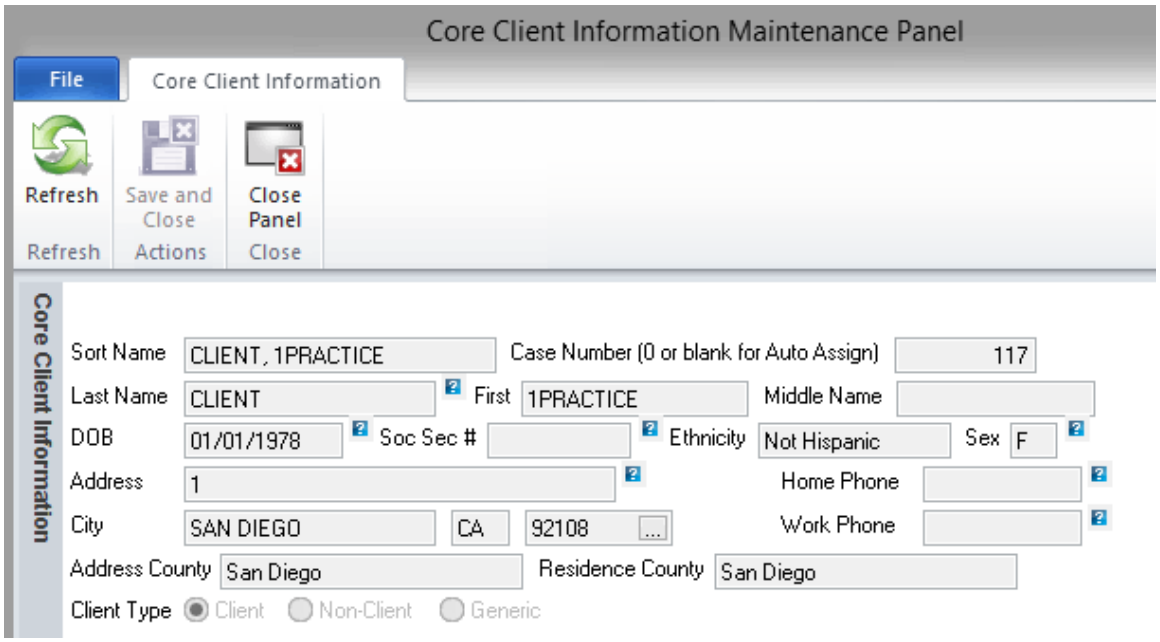
Form B- to be used to request two medical record numbers, for the same person, to be combined.

How to Find Core Client Information (CCI):

1. Search for desired client in CCBH.
2. Once in the client's chart RIGHT click on clients DOB, a small window will pop up.
3. Select "Show Core Client Information."



4. The CCI will display.



How to Complete BHS-025 Forms:

1. **Section #1-Requester Information**: Should be completed for BOTH forms. All sections should be completed. The Requester is the person completing the form.

2. **Section #2-Client Information**:
   For **Form A** "Client Record" column should be completed as data appears in Core Client Information (CCI). In "Change Client Record TO" column ONLY fill in the sections that need to be changed.
   For **Form B** "Client Record A" and "Client Record B" columns should both be completed as data appears in CCI.

To find Medi-Cal Policy # and effective date click on "Insurance Coverages" tab on bottom of page.

Columns should be completed using the CCI (See How to Find CCI instructions above). Columns are completed from TOP to BOTTOM. **DO NOT USE DEMOGRAPHIC FORM OR FACE SHEET**.

Live Well, San Diego!

County of San Diego-HHSA-Behavioral Health Services

CHANGE/ADDITION of Client Information Form

Form **A**

Fax Form to Health Information Management Services (HIMS) @ (619) 399-3503

For assistance call: Optum Help Desk (800) 834-3792 or HIMS (619) 692-5700 x3

REQUESTER:

- Use Form A to request CHANGES/CORRECTIONS to the Core Client Information (CCI), DEMOGRAPHIC FORM, and/or CLIENTS 3RD PARTY COVERAGES only.
- Only TYPED Forms will be accepted effective 05/15/2019.
- Complete fields in each column as instructed.
- Fax this form along with any supporting documents e.g. ID, Medi-Cal card, Immigration, Adoption.

*Medical Policy & Effective date can be found in *Clinicians Homepage "Insurance Coverage"* Tab

Section #1 - REQUESTER INFORMATION

Date of **Request**	/ /	**Form completed by:**		
Program Name		**Your Phone #**	( ) -	Ext #
Unit/SubUnit #	/	**Your Fax #**	( ) -	

Section #2 - CLIENT INFORMATION

CCI Data Fields- To find CCI - Right click on patient name, select "Show Core Client Information"	Client Record As Data CURRENTLY APPEARS in the Core Client Information (CCI) window Leave field blank if data not available	Change Client Record TO: Complete ONLY fields that need to be changed (Exactly as it should be entered in CCI)
Case Number		
Sort Name		
Client Name		
Date of Birth (mm/dd/yyyy)	/ /	/ /
Sex/Gender	☐ Female ☐ Male ☐ Other ☐ Unknown	☐ Female ☐ Male
Social Security #	- -	- -
***Medi-Cal Policy #/eff date (mm/dd/yyyy)**	/ /	/ /
Remarks / Additional Information		

STOP – DO NOT ENTER INFORMATION BELOW THIS LINE. HIMS USE ONLY.

☐ NOTICE TO REQUESTER: Unable to confirm change should be made	**Reason:**

CLIENT INFORMATION TO BE KEPT IN CCBH

Case Number		**Date of Birth** (mm/dd/yyyy)	/ /
CCBH Sort Name		**Social Security #**	- -
Client Name		**Medi-Cal Policy # /eff date**	/ /

Date completed by HIMS	/ /	**HIMS Staff CCBH ID # and Name**	

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Live Well, San Diego!

HHSA

County of San Diego-HHSA-Behavioral Health Services
DUPLICATE CLIENT CASE NUMBER
Fax Form to Health Information Management Services (HIMS) @ (619) 399-3503
For assistance call: Help Desk (800) 834-3792 or HIMS (619) 692-5700 x3

Form **B**

REQUESTER:

- Use Form B to request duplicate client case numbers to be combined.
- Only TYPED Forms will be accepted effective 05/15/2019.
- Complete fields in each column as instructed.
- Fax this form along with any supporting documents e.g. ID, Medi-Cal card, Immigration, Adoption.

*Medical Policy & Effective date can be found in *Clinicians Homepage "Insurance Coverage"* Tab

Section #1 - REQUESTER INFORMATION

Date of Request	/ /	Form completed by:		
Program Name		Your Phone #	( ) -	Ext #
Unit/SubUnit #	/	Your Fax #	( ) -	

Section #2 - CLIENT INFORMATION

CCI Data Fields- To find CCI - Right click on patient name, select "Show Core Client Information")	Client Record A As Data CURRENTLY APPEARS in the Core Client Information (CCI) window Leave field blank if data not available	Client Record B As Data CURRENTLY APPEARS in the Core Client Information (CCI) window Leave field blank if data not available
Case Number		
Sort Name		
Client Name		
Date of Birth (mm/dd/yyyy)	/ /	/ /
Social Security #	- -	- -
*Medi-Cal Policy #/eff date (mm/dd/yyyy)	/ /	/ /
Remarks/ Add'l Information		

STOP – DO NOT ENTER INFORMATION BELOW THIS LINE. HIMS USE ONLY.

☐ NOTICE TO REQUESTER: Unable to Combine Clients	Reason:

CLIENT INFORMATION TO BE KEPT IN CCBH

Case Number		Date of Birth	/ /
Sort Name		Social Security #	- -
Client Name		Medi-Cal Policy # /eff date	/ /
Date completed by HIMS	/ /	HIMS Staff CCBH ID # and Name	

☐ Sent to ASO ☐ Sent to MHBU ☐ N/A

The section below to be completed by the Administrative Services Organization (ASO) staff only.

Date ASO Combined Clients	/ /	ASO Staff who Combined Clients	

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TRAINING TIP SHEET

1. **WHEN YOU GO BACK TO YOUR PROGRAM**:
   You are learning how to enter assessments in the "**SDC Train CCBH**" environment during this training, which is for **practice purposes only**. It is important to enter all of your assessment information in the **"SDC Live CCBH"** environment when you return to your program.

2. **SUPPORT DESK – IMPORTANT!:**
   Please do not try to solve issues by "working around" the system. You are to enter data as required and you must call the Support Desk for any questions.

   The Support Desk contact information is:

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

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

   https://www.optumsandiego.com

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

4. **TO REGISTER FOR ADDITIONAL TRAINING:**

   www.regpack.com/reg/optum

5. **HIPAA REGULATIONS FOR TRAINING:** There is actual client data (names, etc.) in the training environment. HIPAA regulations mandate this information be treated confidentially.

6. **NON-USE OF CCBH ACCOUNT**: Inactive accounts pose a security risk by allowing an opportunity for unauthorized access. Therefore, in order to safeguard protected health information, inactive accounts will be closely monitored. Users who have not used CCBH in 90 days will have their account deactivated.

Support Desk Contact Information

sdhelpdesk@optum.com
1-800-834-3792

Monday through Friday (E-mail)

Hours	Services
6:00 am to 6:00 pm	All services except password resets or any service involving PHI

Monday through Friday (Telephone)

Hours	Services
4:30 am to 6:00 am	Resetting passwords (24 hour programs) and reporting system outages*
6:00 am to 6:00 pm	All services
6:00 pm to 11:00 pm	Resetting passwords (24 hour programs) and reporting system outages*
11:00 pm to 4:30 am	Reporting system outages*

Weekends (Telephone)

Hours	Services
4:30 am to 11:00 pm	Resetting passwords (24 hour programs) and reporting system outages*
11:00 pm to 4:30 am	Reporting system outages*

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

Support Desk Suggestions

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

Additional Contacts

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