Clinician's Gateway

Clinical
HANDS-ON INTRODUCTION TRAINING

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CLINICIAN'S GATEWAY

What is Clinician's Gateway?

❖Clinician's Gateway is an integrated "On-line Progress Notes System".

❖The primary objective of Clinician's Gateway is to allow HIPAA-compliant electronic entry of clinical notes.

❖ Clinician's Gateway is designed to reduce audit exceptions due to missing data or missing notes, and assist management and staff in capturing all staff activity.

❖ Clinician's Gateway is a stand-alone front-end add-on to INSYST and is the first of a series of add-on packages that can be used instead of the standard built in data entry screens for INSYST.

❖ Web Based application utilizing Electronic Signatures.

❖ Allows Clinic Managers and QA/QI staff to review the work of treatment staff; a daily log report is available on demand to assist staff in capturing all staff activity.

❖ Clinician's Gateway integrates progress notes with the INSYST billing module and can be used for approximately 100% of the data entry into INSYST.

❖ HIPAA-compliant "Password Security" to keep your password unique and confidential. This is accomplished by allowing each User access to change their own Passwords whenever necessary.

New Modules

Treatment Plans - Coming Soon!

MHSA (Data Forms and Submission): installed 2008

MAA Claiming - Individual Staff Log Form: installed 2007

Have Questions? Need Help? Contact your Administrative Support Person.

v1.0
2/13/2009

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Features

❖Automated creation of direct services for individual, group and case review
❖Retrieval of notes for printing or review of work as well as for the sharing of information between colleagues. May also be used by medical records personnel who assist in the administrative work of treatment team members and by clinic managers to review the work of treatment staff
❖Fully integrated with current system (INSYST)
❖Built in timesheets to track service provider activity
❖Creation of client groups and group service notes with individual addendums
❖Multiple co-staff notes for case review
❖Medical spelling checker
❖Allows you to input correct Progress Note information into the computer and have it automatically bill the State.
❖Client information is available on any authorized computer with a few clicks no matter where the client is located.
❖Ability to track the number of completed Notes and view any Progress Notes for individual clients, or view by any given date range.
❖Ability to place uncompleted Progress Notes in Pending Mode to be completed at another time.
❖Addendums can be made to Finalized notes
❖View interval (time lapse) between date of service and date recorded.
❖View total hours accumulated per clinic, per staff, by month or day.
❖No lost Notes.
❖No more having to track down charts in order to review previous notes.
❖All Progress Notes will be readable.
❖Reduced errors in billing.
❖Be in compliance with audits (a note for each billing).
❖MORE REVENUE.

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LOGGING INTO CLINICIAN'S GATEWAY

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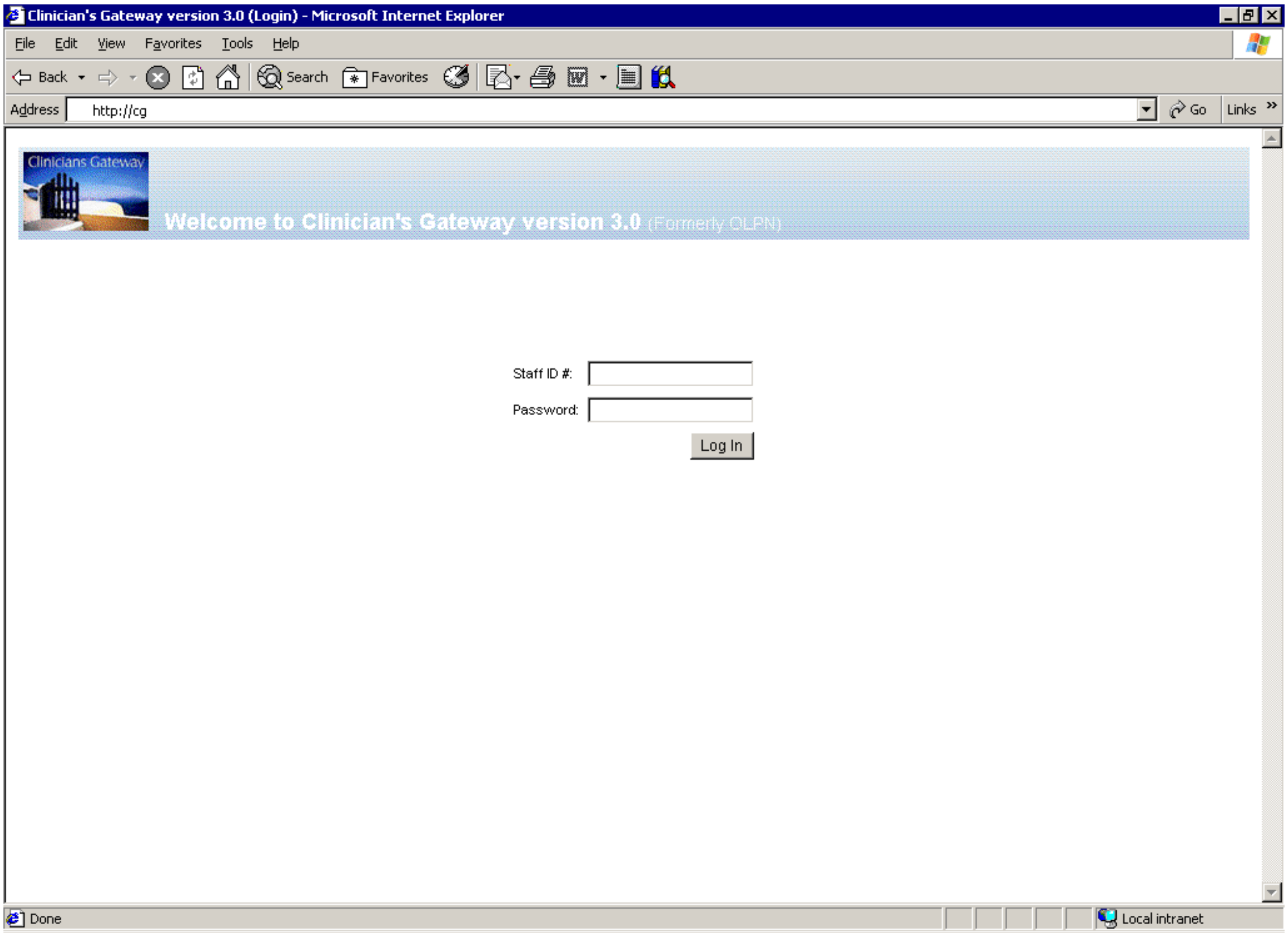
Login – Security

FOR BHCS STAFF: Find the link to this page at http://achcsa.org/behavioral-health , click on Clinician's Gateway in the left hand column.

FOR CBO STAFF: Find the link via the web portal at https://go.bhcsportal.org .



- **Log on page – This invokes your digital signature.**
- **Keep your password secure – Important: To be kept as secure as a bank card pin number.**
- **Passwords must be at least eight characters – one uppercase and one lowercase alpha character, and one numeric character.**
- **If you have three failed attempts at entering your password, your account will be locked, and you will need to contact the helpdesk at (510) 567-8181 (tie line 38181) for assistance.**

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CLIENT INFORMATION

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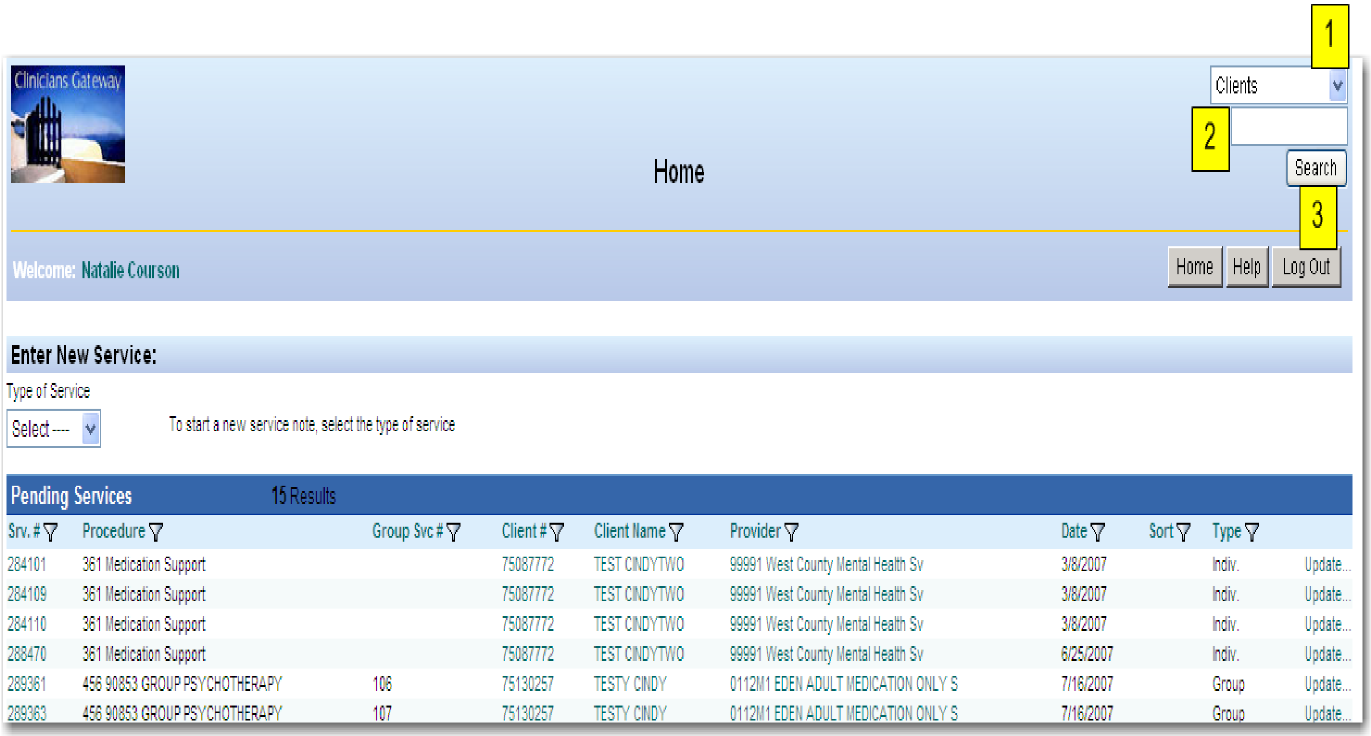
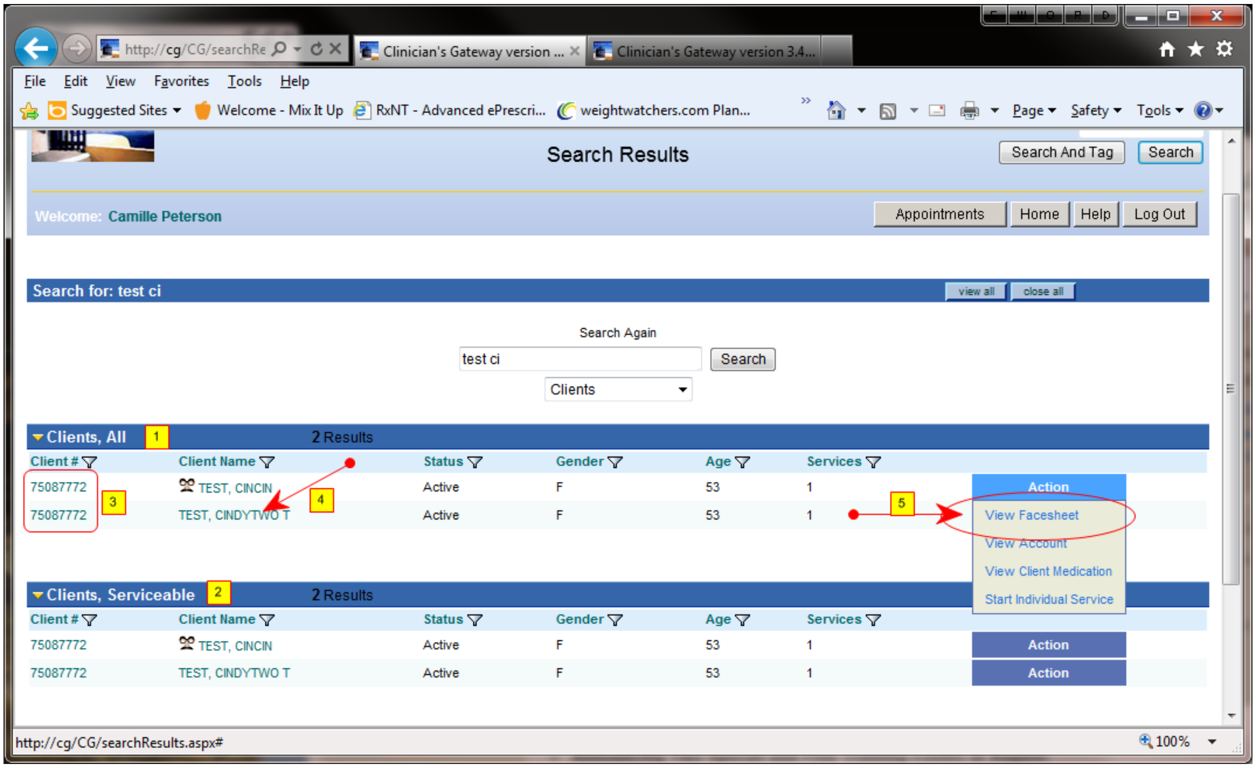
Client Face Sheet

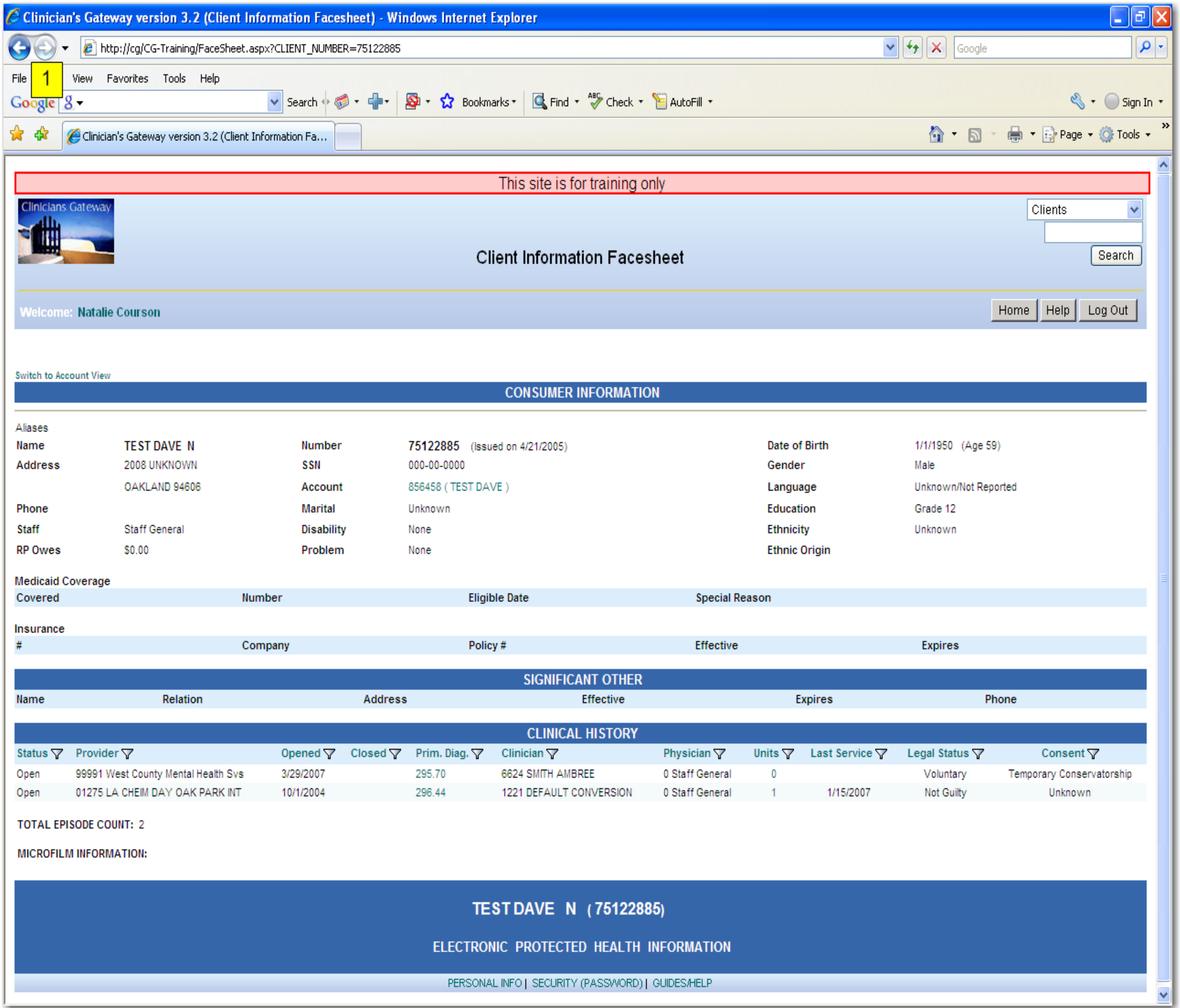


- **1** – To get to the client Face Sheet, select “clients” from the drop list.
- **2** – Type the client’s last name first, then first name. (with a space in between…do not use a comma)
    - Alternately, you could type in the client’s InSyst ID number.
    - Alternately, you could type in the client’s Social Security Number preceded by the # sign (for example #123-33-3333)
- **3**- Click on Search

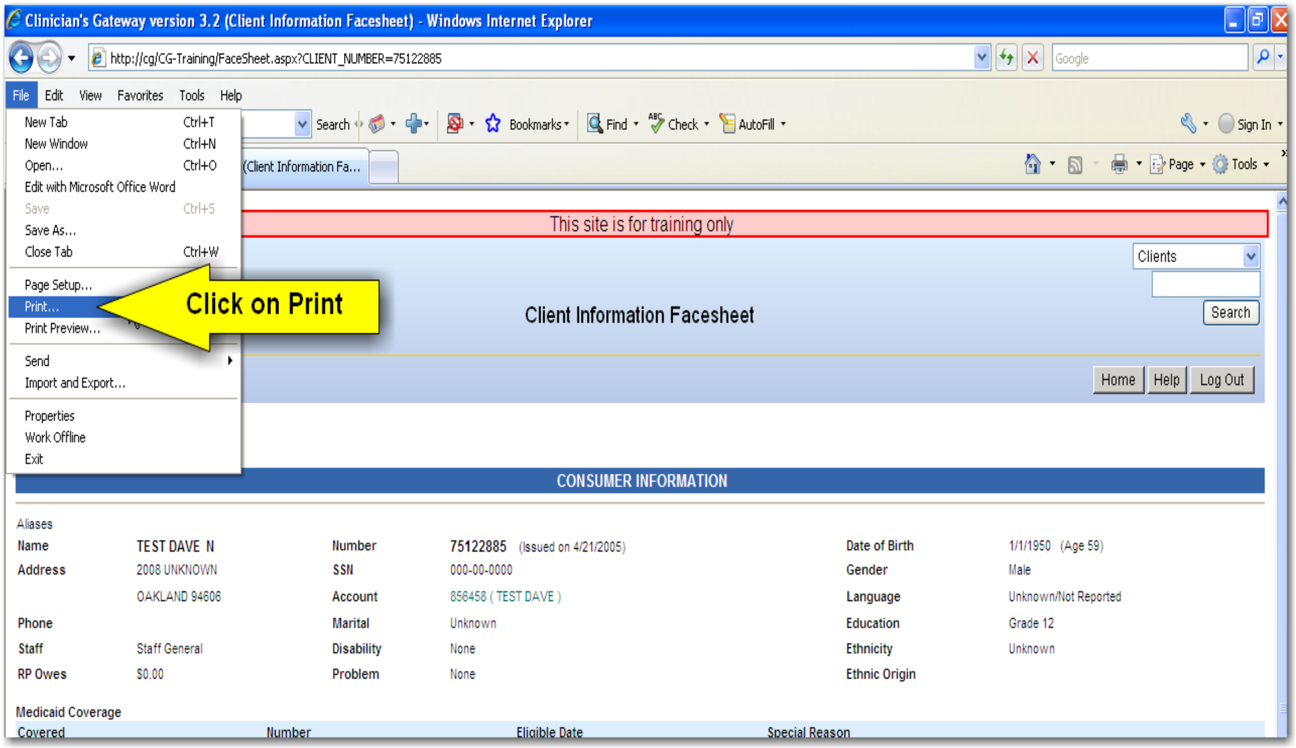


- **1-3** - The search results screen will show the list of clients.
  - **1**. The list of "All" clients are all clients in Alameda County.
  - **2**. The list of "Serviceable" clients are those clients for whom you can write a note.
  - **3.** Notice that these two clients are the same person, because they have the same client number. The one with the icon is an alias name.

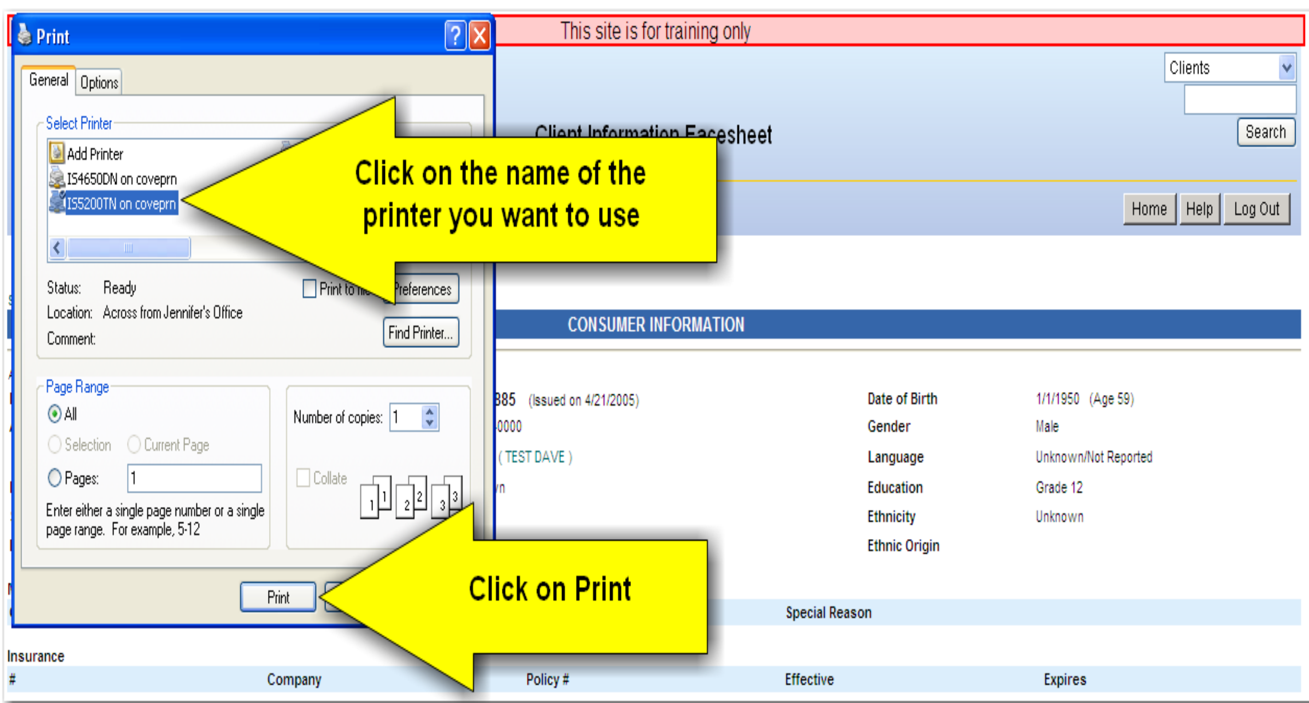
- **4-5** - To get the Face Sheet, either
  - **4** - click on the client's name or
  - **5** - hover over the "Action Bar" to bring up the menu and then click on "View Facesheet" for that client.



- To print the Face Sheet, click on file (**1**),

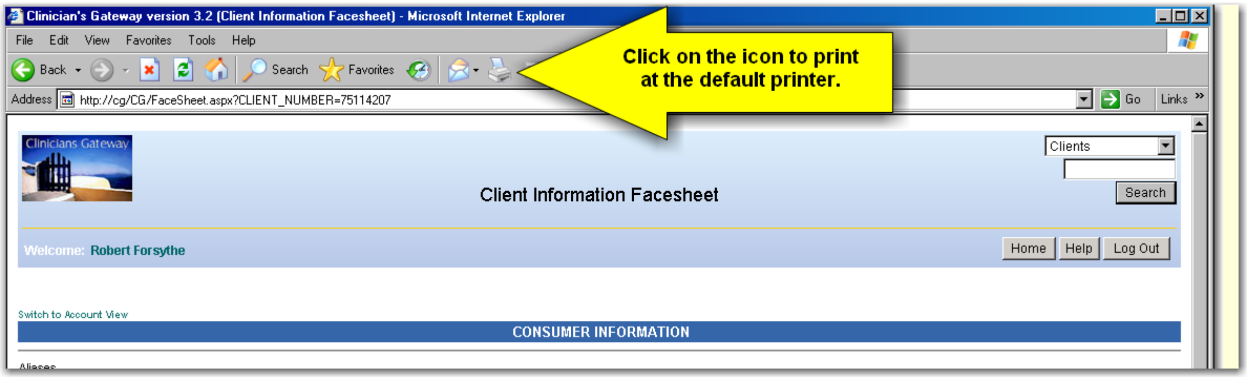


- Click on print.

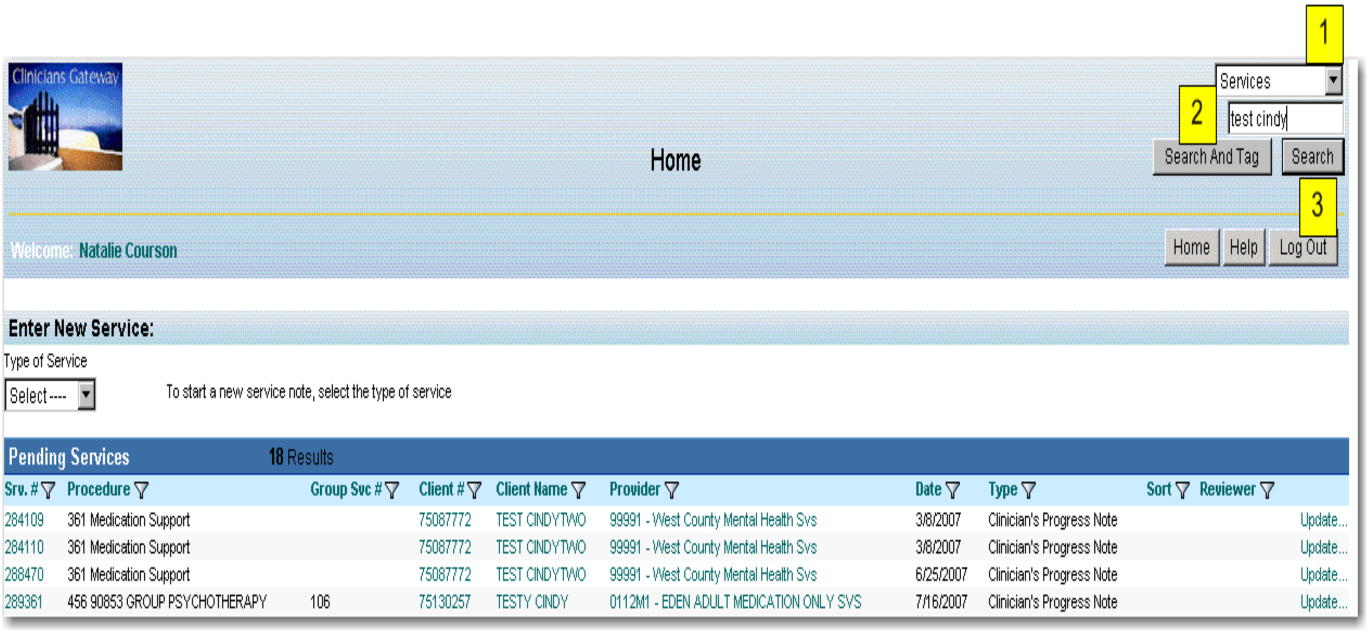


- Then select the printer you want to send the form to, and click on "Print."

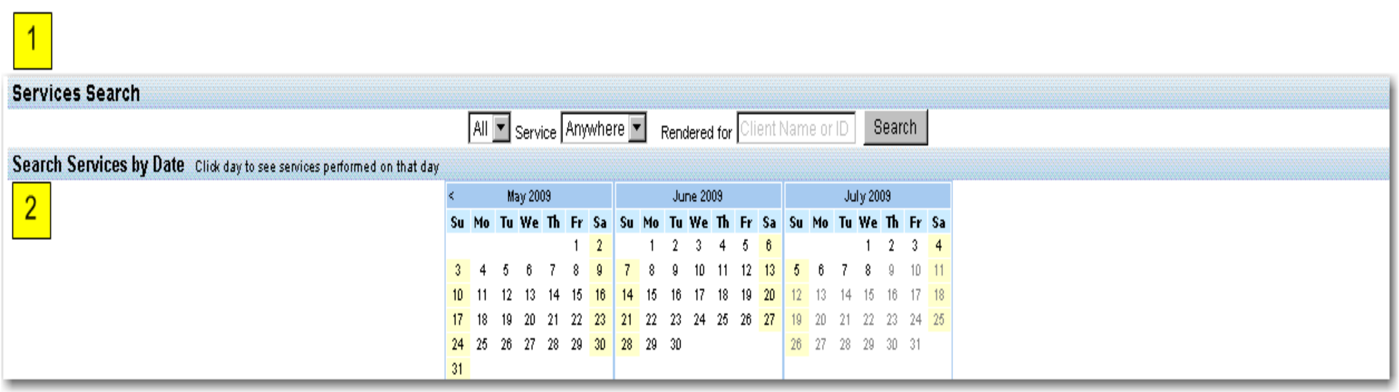
Alternately, you can use the printer icon and the Face Sheet will print at your default printer….



Client Services Search

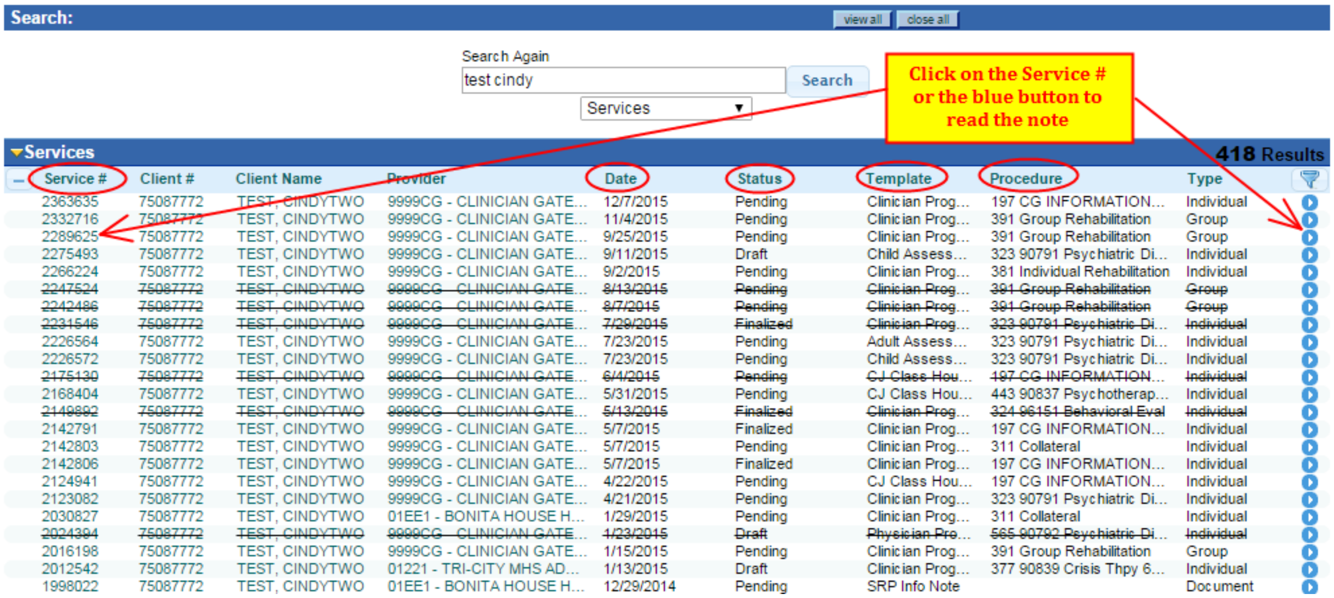


- **1** – To create a list of Services for a client, select "Services" from the drop list.
- **2** - Type the client's last name first, then the first name, (with a space in between… do not use a comma) or the client's InSyst ID #.
- **3** – Click on Search.



- **1** – Alternately, you can use the Services Search, or (**2**) Search Services by Date, at the bottom of the Home Page

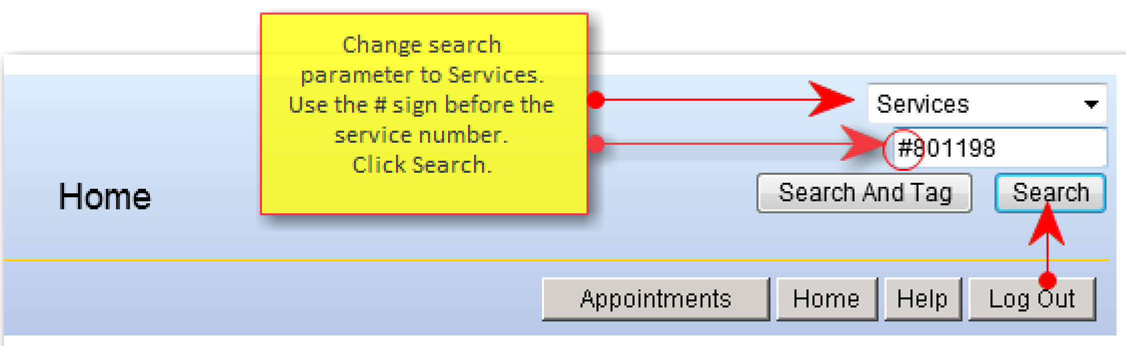
Search Results:
To read the notes, click on the Service # or click on the blue button.



Service #	Client #	Client Name	Provider	Date	Status	Template	Procedure	Type
2363635	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	12/7/2015	Pending	Clinician Prog...	197 CG INFORMATION...	Individual
2332716	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	11/4/2015	Pending	Clinician Prog...	391 Group Rehabilitation	Group
2289625	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	9/25/2015	Pending	Clinician Prog...	391 Group Rehabilitation	Group
2275493	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	9/11/2015	Draft	Child Assess...	323 90791 Psychiatric Di...	Individual
2266224	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	9/2/2015	Pending	Clinician Prog...	381 Individual Rehabilitation	Individual
~~2247524~~	~~75087772~~	~~TEST, CINDYTWO~~	~~9999CG - CLINICIAN GATE...~~	~~8/13/2015~~	~~Pending~~	~~Clinician Prog...~~	~~391 Group Rehabilitation~~	~~Group~~
~~2242486~~	~~75087772~~	~~TEST, CINDYTWO~~	~~9999CG - CLINICIAN GATE...~~	~~8/7/2015~~	~~Pending~~	~~Clinician Prog...~~	~~391 Group Rehabilitation~~	~~Group~~
~~2231546~~	~~75087772~~	~~TEST, CINDYTWO~~	~~9999CG - CLINICIAN GATE...~~	~~7/29/2015~~	~~Finalized~~	~~Clinician Prog...~~	~~323 90791 Psychiatric Di...~~	~~Individual~~
2226564	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	7/23/2015	Pending	Adult Assess...	323 90791 Psychiatric Di...	Individual
2226572	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	7/23/2015	Pending	Child Assess...	323 90791 Psychiatric Di...	Individual
~~2175130~~	~~75087772~~	~~TEST, CINDYTWO~~	~~9999CG - CLINICIAN GATE...~~	~~6/4/2015~~	~~Pending~~	~~CJ Class Hou...~~	~~197 CG INFORMATION...~~	~~Individual~~
2168404	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	5/31/2015	Pending	CJ Class Hou...	443 90837 Psychotherap...	Individual
~~2149892~~	~~75087772~~	~~TEST, CINDYTWO~~	~~9999CG - CLINICIAN GATE...~~	~~5/13/2015~~	~~Finalized~~	~~Clinician Prog...~~	~~324 96151 Behavioral Eval~~	~~Individual~~
2142791	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	5/7/2015	Finalized	Clinician Prog...	197 CG INFORMATION...	Individual
2142803	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	5/7/2015	Pending	Clinician Prog...	311 Collateral	Individual
2142806	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	5/7/2015	Finalized	Clinician Prog...	197 CG INFORMATION...	Individual
2124941	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	4/22/2015	Pending	CJ Class Hou...	197 CG INFORMATION...	Individual
2123082	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	4/21/2015	Pending	Clinician Prog...	323 90791 Psychiatric Di...	Individual
2030827	75087772	TEST, CINDYTWO	01EE1 - BONITA HOUSE H...	1/29/2015	Pending	Clinician Prog...	311 Collateral	Individual
~~2024394~~	~~75087772~~	~~TEST, CINDYTWO~~	~~9999CG - CLINICIAN GATE...~~	~~1/23/2015~~	~~Draft~~	~~Physician Pro...~~	~~565 90792 Psychiatric Di...~~	~~Individual~~
2016198	75087772	TEST, CINDYTWO	9999CG - CLINICIAN GATE...	1/15/2015	Pending	Clinician Prog...	391 Group Rehabilitation	Group
2012542	75087772	TEST, CINDYTWO	01221 - TRI-CITY MHS AD...	1/13/2015	Draft	Clinician Prog...	377 90839 Crisis Thpy 6...	Individual
1998022	75087772	TEST, CINDYTWO	01EE1 - BONITA HOUSE H...	12/29/2014	Pending	SRP Info Note		Document

Searching for a Single Service by Service Number

To look up a service by its service number, in the Global Search area, simply precede the service number by the # sign. Click Search.



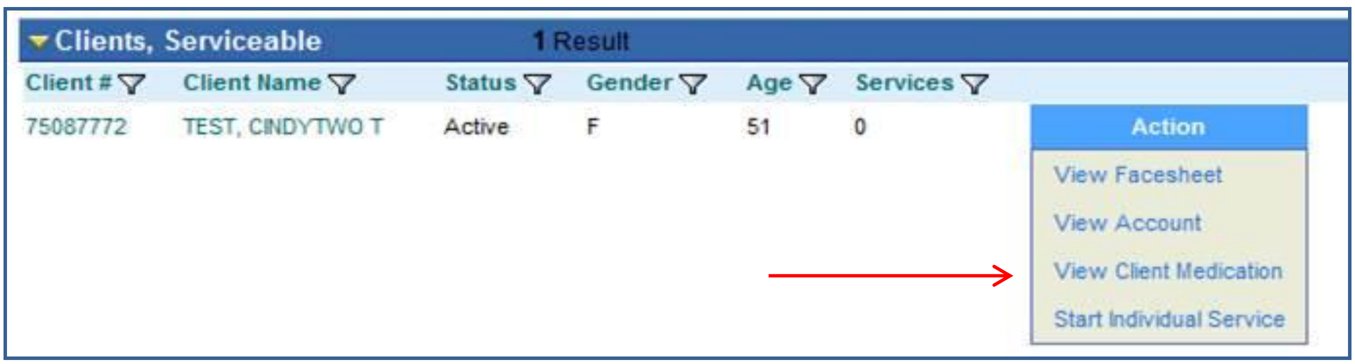
DISPLAYING THE MEDICATION LOG:

The Medication Log can be called up by two methods: either by using the Client Search/Action Bar or by using the Client Medication Search.

Method # 1: "CLIENT SEARCH/ACTION BAR" SEARCH PROCEDURE:

1. In the Global Search field, leave Clients in the drop down, and enter the **client's name**, click **Search.**

2. On the "**Action Bar**" click View Medication Log**.**



Method # 2: "CLIENT MEDICATION" SEARCH PROCEDURE:

1. In the Global Search area, choose **Client Medication**, and enter the **client's number** (their name is not specific enough), click Search. This will bring you directly to the Medication Log

MEDICATION LOG:

The Medication Log displays all of the client's medications from E-Prescribing and from the Physician's Progress Notes.

The top section of the Log will import all the medications that were e-prescribed in RxNT, an e-prescribing application that our physicians and nurses have begun using.

The bottom section imports the entries from the "Plan" section of the Physicians Progress Note. History from all Physician's Progress Notes will be displayed no matter how old.

Sample of a Client's Medication Log:

Connect to RxNT

Details	Entry Date	Drug Name	Dosage	Prescribing Doctor	Refills	Svc. Numbe
	14-Jul-2011	benztropine 1 mg Tab	take 1 tablet by oral route 2 times per day	Luisito Roxas	2	
	14-Jul-2011	haloperidol 10 mg Tab	take 1 tablet by oral route 2 times per day	Luisito Roxas	2	
	14-Jul-2011	buspirone 15 mg Tab	take 1 tablet (15 mg) by oral route 2 times per day	Luisito Roxas	2	
	14-Jul-2011	Klonopin 1 mg Tab	take 1 tablet by oral route 2 times per day	Luisito Roxas	2	

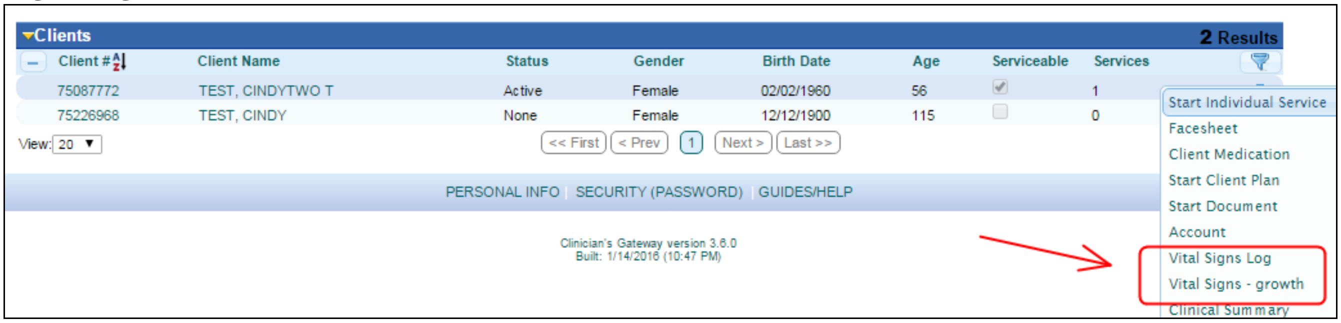
Svc. Number	Svc Date	Primary Clinician	Status	Note
803419	7/20/2011	ROXAS LUISITO	FINALIZED	n/a
800089	7/14/2011	ROXAS LUISITO	FINALIZED	Will continue present medications since they do appear to be effective. Compliance with medications was emphasized. Will check labs..Refill sent to pharmacy. Medications: Haldol 10 mg bid; Zyprexa 15 mg bid; Cogentin 1 mg bid; Depakote 500 mg q am and 1000 mg q hs; Klonopin 1 mg bid; Buspar 15 mg bid; Lactulose 15 cc bid. RTC: 9/8@4:30
799371	7/13/2011	ROXAS LUISITO	FINALIZED	n/a

The bottom section, from the physician's note, should contain the complete medication regimen for the client, if the physician has manually entered it.

Clicking on the Service Number will bring up the entire note.

Vital Signs:

<u>Find Vital Signs log using the Action Bar:</u> Search for the client first, then request the Vital Signs Log or the Growth Chart from the Action Bar.

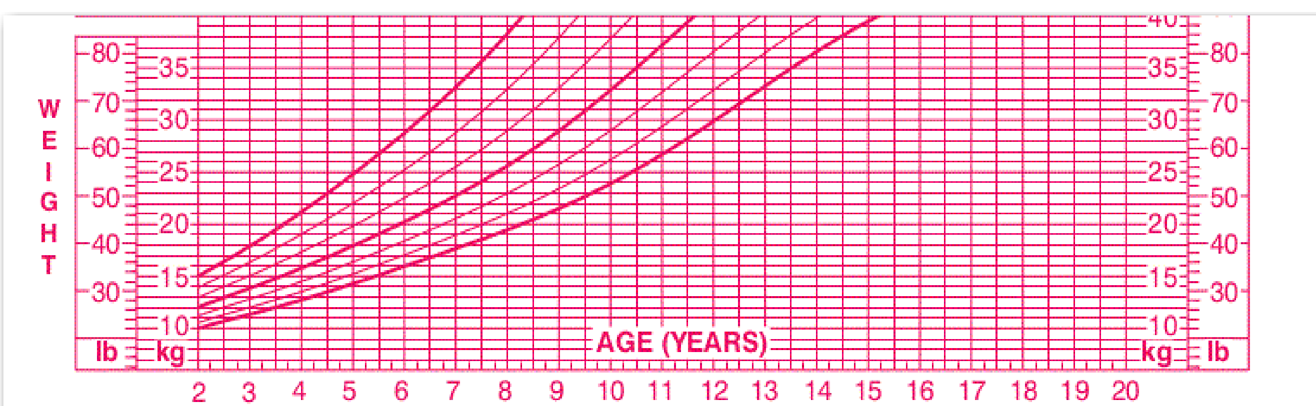


<u>Vital Signs Log:</u> displays Vital Signs over the entire history of client. (data from medical staff Vital Signs chart on notes)

Vital Signs Log for TEST, CINDYTWO T (75087772)

Service #	Date	Height	Weight	BMI	BP	Pulse
1410651	05/20/2014					
1182151	10/27/2012					
1182146	10/25/2012	69.0	150.0	22	125/92	78
1182141	10/24/2012					
1182140	10/23/2012	70.0	160.0	22	150/75	70
1182113	10/22/2012					
864829	10/14/2011	10	100	703	100/100	10
863396	10/13/2011	70	150	21	110	65
863407	10/13/2011	70	150	21	110	76
805825	07/25/2011	70	170	24	110/60	70
805828	07/25/2011	70	170	24	115/90	82
805591	07/24/2011	70	180	25	120/80	60
805592	07/24/2011	70	190	27	145/90	62

<u>Vital Signs Growth Chart:</u> Plots Height and Weight against average percentiles for ages 2 – 20.



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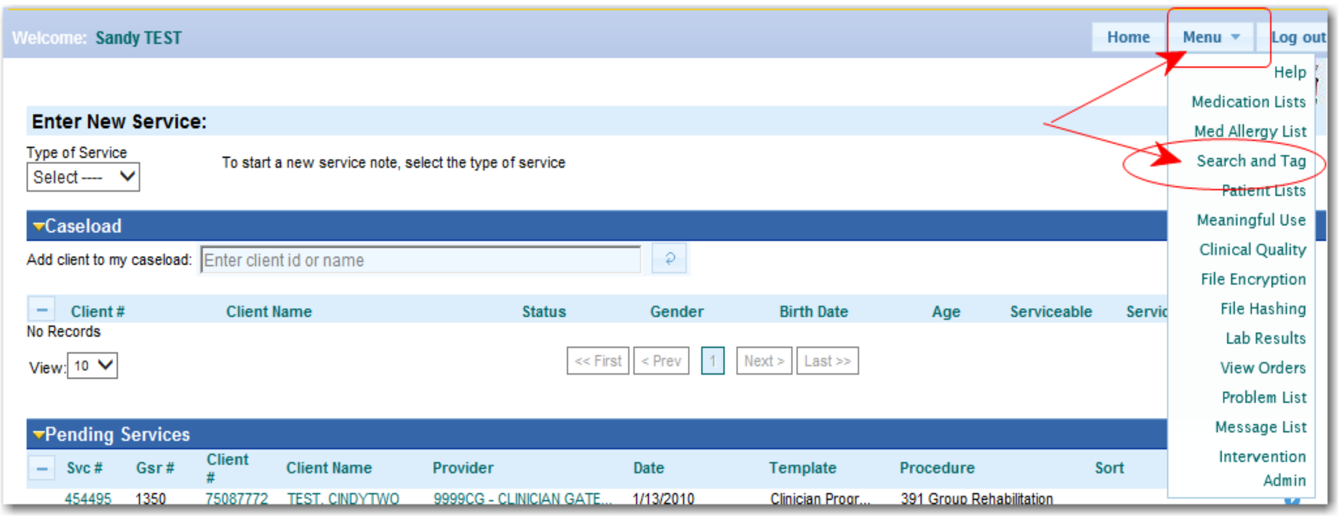
Search and Tag

Search and Tag is used to collect, display and save sets of service notes so they may be viewed in sequence, such as a client's history of services. Notes can be filtered by one or more parameters. (Client, Service Dates, Note Status, Text, Clinician, Procedure, Record Type, Reporting Unit, Location)

DEFINE YOUR SEARCH CRITERIA

1. The Search and Tag button is found in the Menu listing on the Home Page.



2. The Services radio button should be checked.
3. Select the first search parameter by clicking on the "Select Search Item" drop down menu. Click on the parameter that you wish search, such as "Client."
4. Click on "Lookup" and enter the specific search item

   i.e. if client enter: last name first name-no comma, click "Search for Clients," and wait for the list of possible clients to appear.

   Check the box for the appropriate client and click OK.
5. Choose your next parameter to narrow your search, by clicking on the "Select Search Item" drop down menu. Click on the parameter that you wish search, such as "Service Date." i.e.. choose whether you would want to see services on, between, after, or before a certain date and click on the calendars icons to define the dates.
6. Continue until you have narrowed your search as many ways as possible.
7. Click the Search button to assemble your results.

REVIEW, PRINT OR SAVE YOUR RESULTS

1. To sort your items by a certain topic, click the top of that column (e.g. Date of Service)
2. Check the items that you wish to view or save.
3. Click on one of the Review/Print buttons (all checked items or all results).
4. Choose "Open" to view them or "Save" as desired.
5. To read them, use the big blue arrows at the top of the page to move through the documents.
6. Click the Printer Icon or File/Print.

TO SAVE A COLLECTION

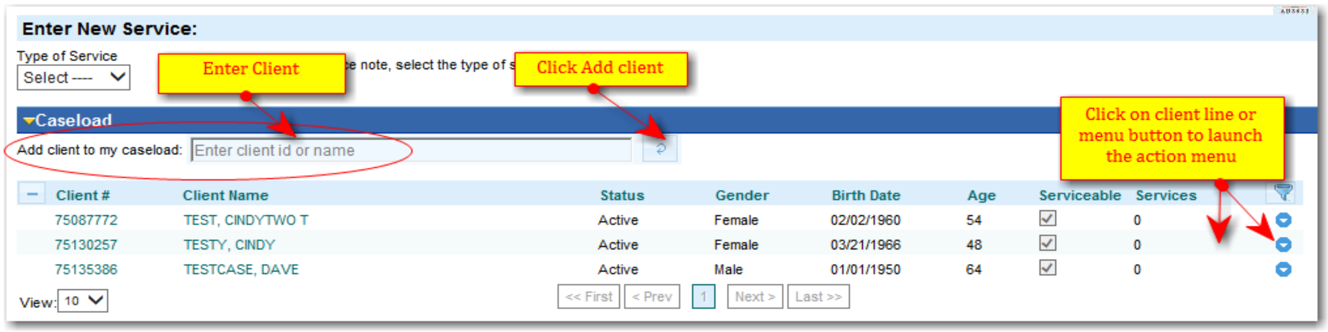
1. To retain your collection in Search and Tag for later reading, click the blue message "click here to add a new collection name"
2. Enter the name of the collection and click OK
3. Click the "Save Tagged" button and all items checked will be moved to the collection. You can do this multiple times or "tag" and move them all together.

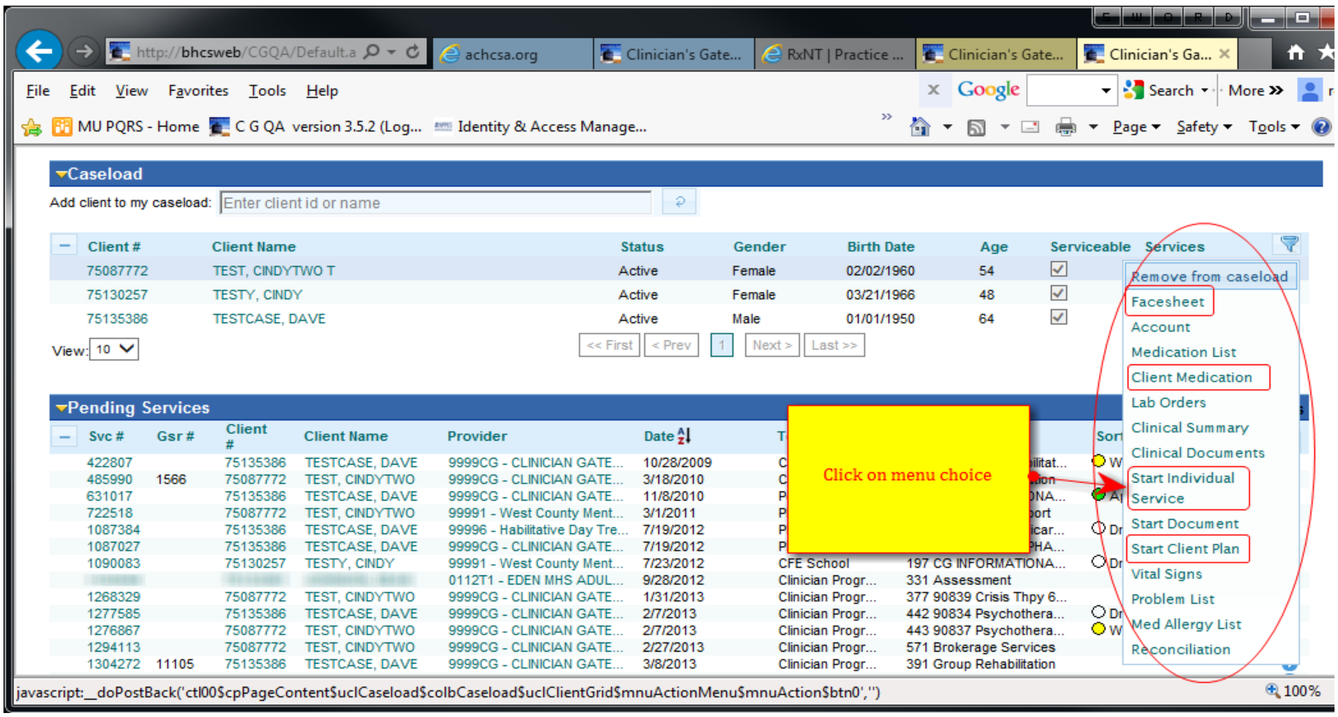
TO RETRIEVE A PREVIOUSLY SAVED COLLECTION

1. Click on the words *"select an existing collection name"*
2. The Drop Down menu indicator appears. Click on the down arrow.
3. Click on the collection that you would like to view.

Caseload Shortcut:

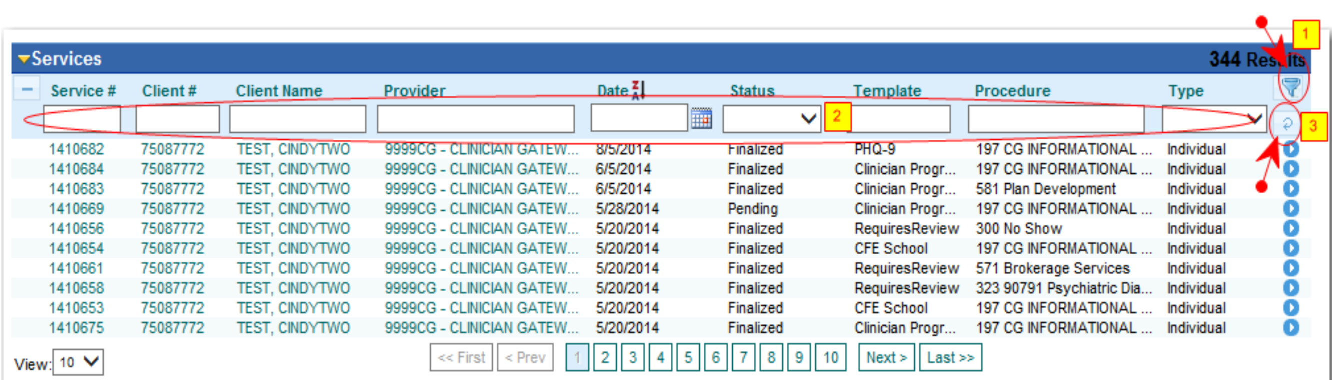
Build your custom caseload shortcut list on the Home Page. Use your caseload menu bar as a shortcut to start documentation using the menu bar. (Does not alter InSyst records)



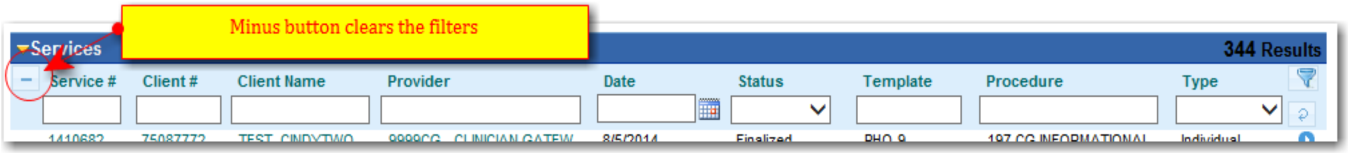


Enhanced Filtering can be done over multiple parameters at the same time.

- 1. Click the funnel (filter icon) to open the fields.
- 2. Then enter the texts you want to filter for.
- 3. Click the Arrow to activate the filter.

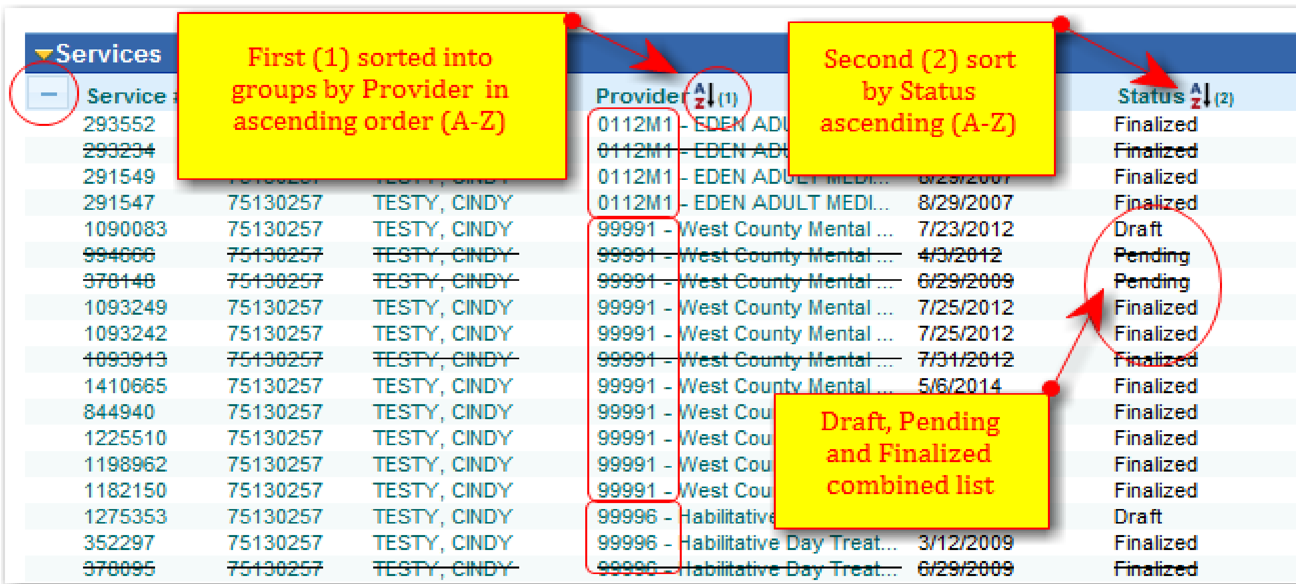


Remove Filters by clicking on the [-] button.

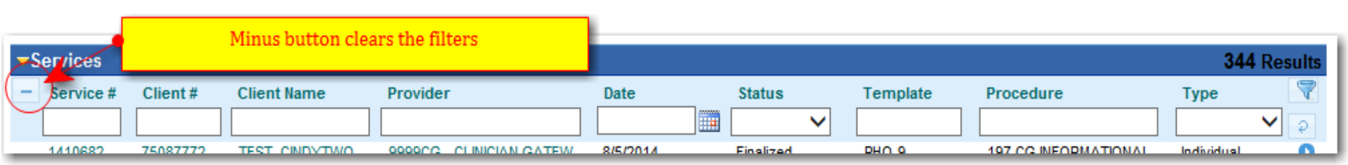


Enhanced Sorting can be done over multiple columns, in ascending or descending order. Sort Order will be retained for the next time you search!

- First click = ascending. A second click = descending. Third click = remove the sort.
- Click(s) on the column you want to be the first sort.
- Click(s) on the next column you want to be the second sort, etc.
- Your custom **sort order is retained** and applied to future searches of the same type.
- Minus button clears the sort order and restores date order as default.
- NOTE: All Status notes are now listed together (Finalized, Draft and Pending together)



Remove Sort Order by clicking on the [-] button.



INDIVIDUAL NOTES USING CLIENT NAME OR NUMBER

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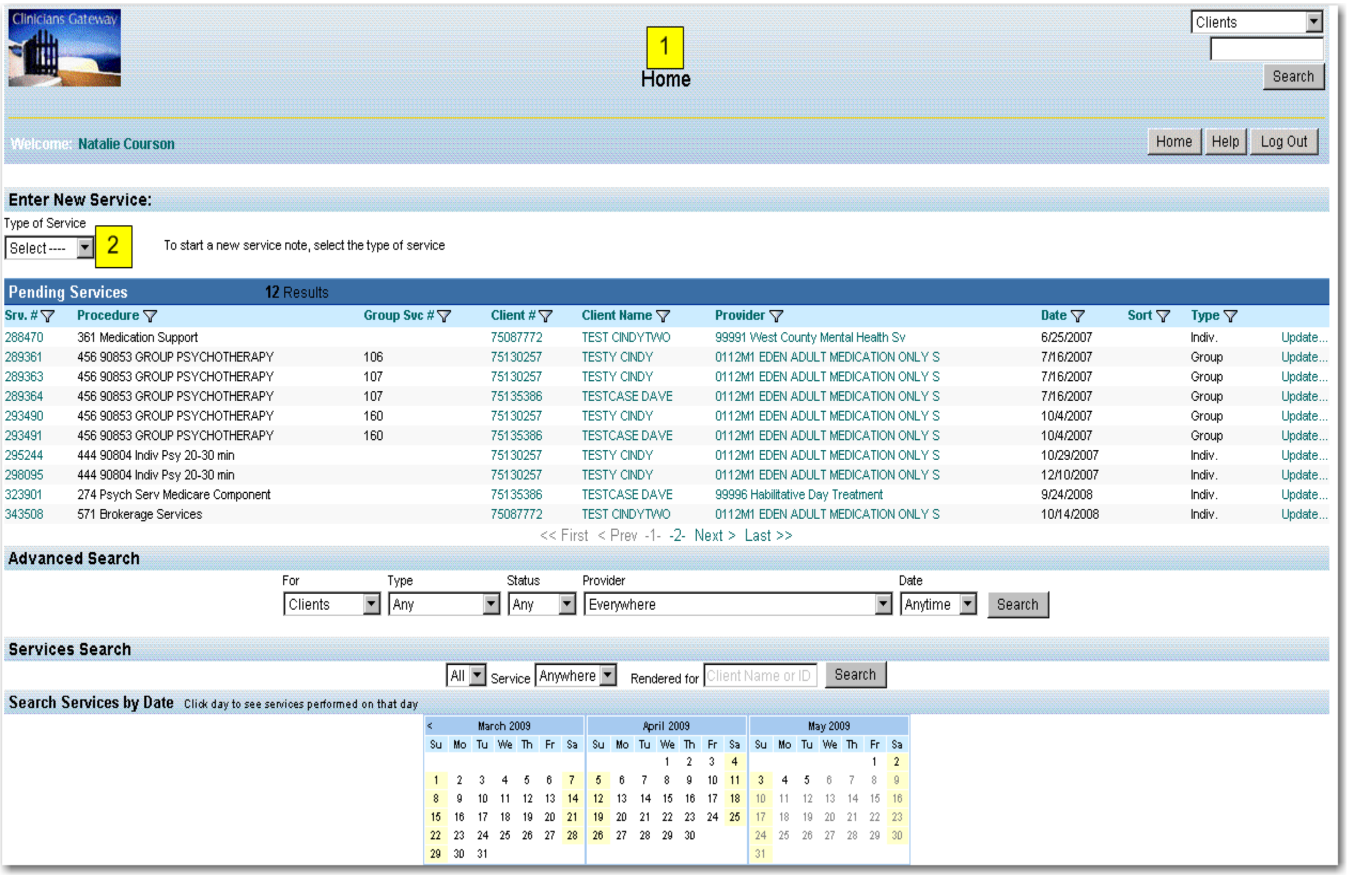
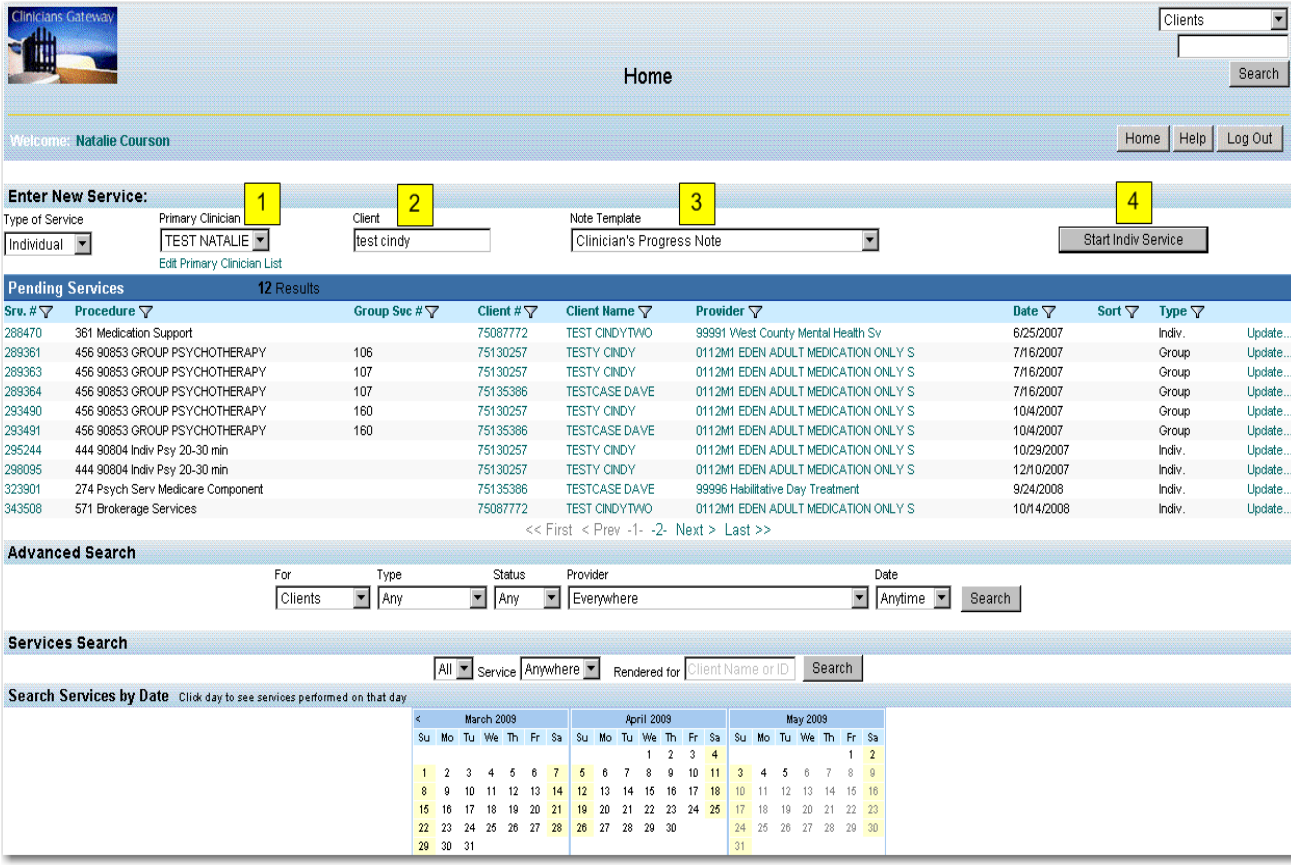
Individual Notes Using Client Name or Number



- **1** – This is your home page.
- **2** – Click on the drop arrow to select "Individual" for the type of service.

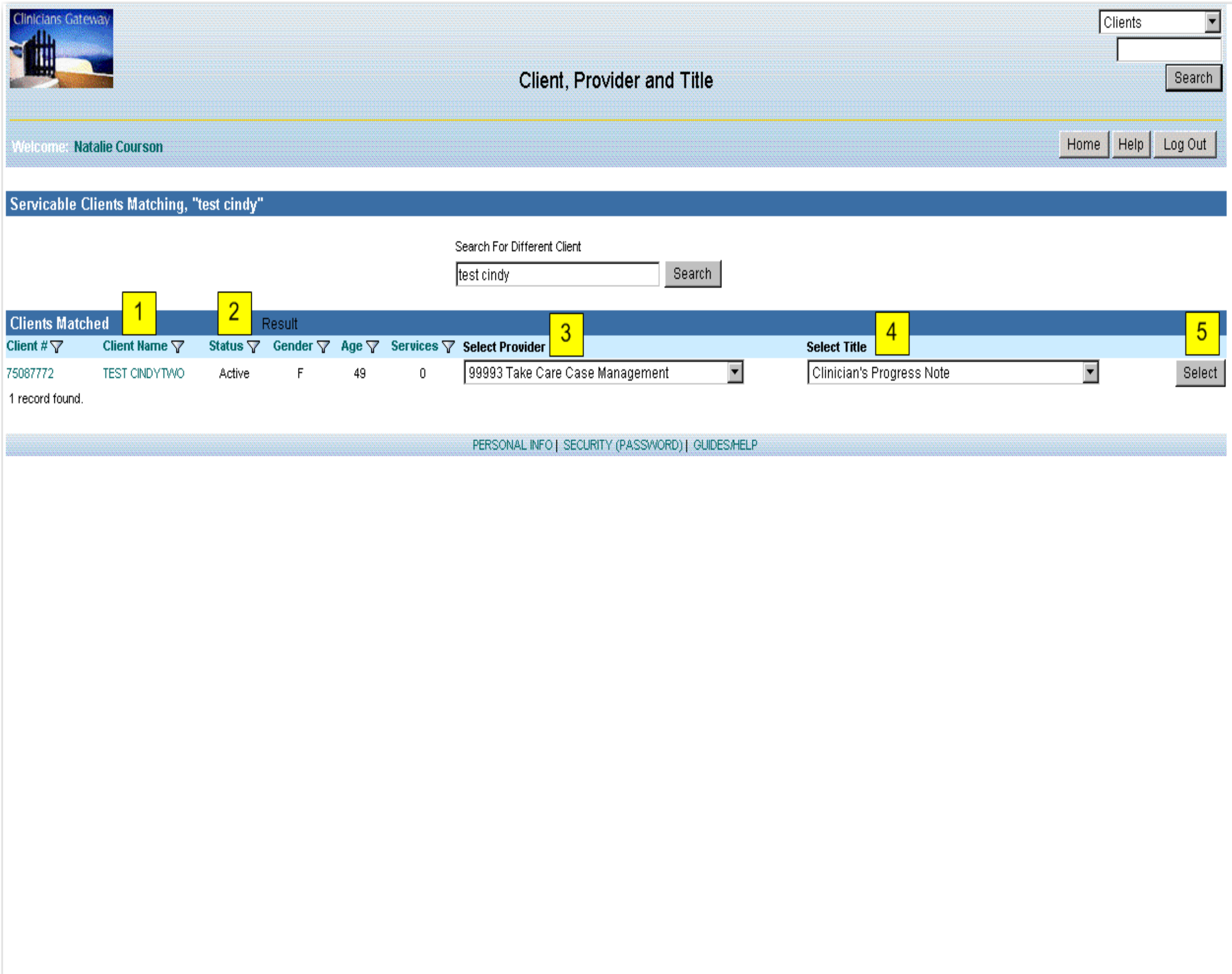


- **1** - Verify the Primary Clinician name is correct.

- **2** - Enter the client name (Last name then First name with no commas, ex. Mouse Mickey) or the client number.

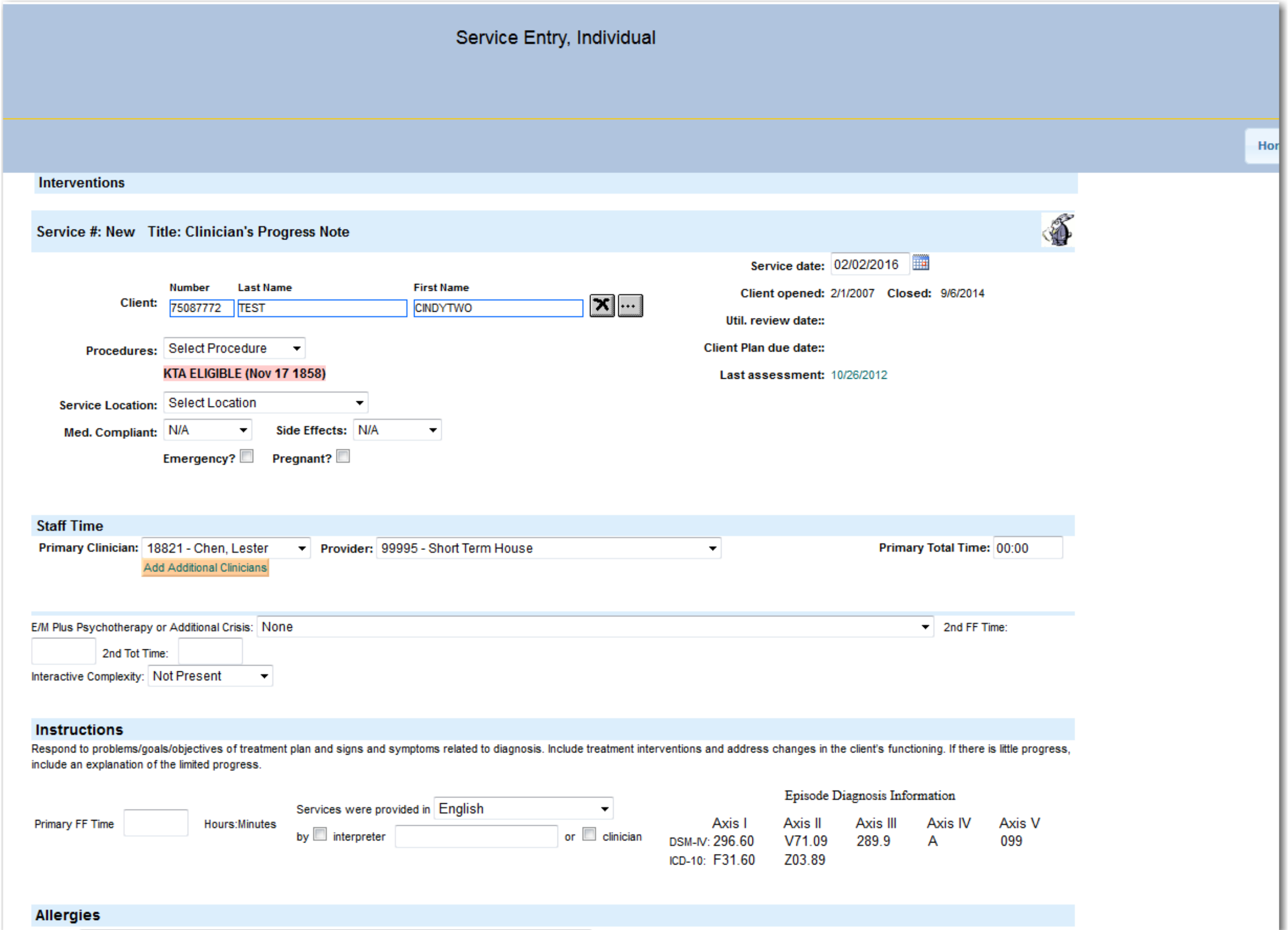
- **3** - Select the template name from the drop list.

- **4** - Click on “Start Indiv Service.”

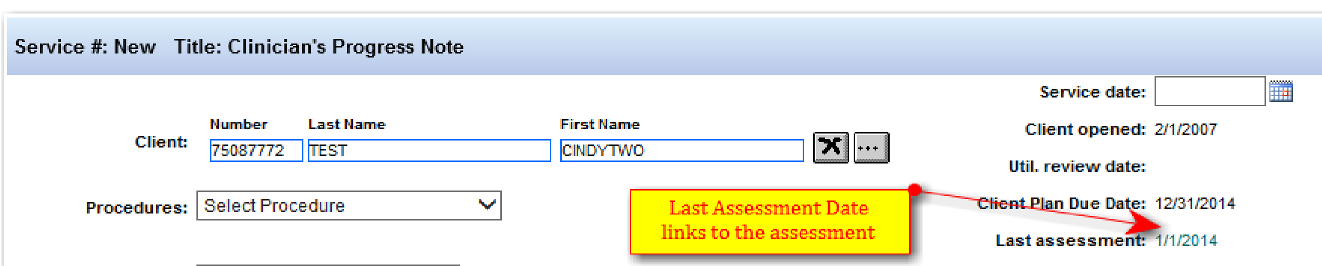


- **1** - Verify the client name.
- **2** – Verify the status for that client. "Active" indicates that the client has an open episode.
- **3** - Verify the appropriate provider name is indicated.
- **4** - Select the Title of the type of note you will enter.
- **5** – Click on "Select"

The Note Entry page looks like this:



Alert for Last Assessment Date displays the last Child, Adult or Physician Assessment. The date links to the assessment, opened on a new tab, for easy access.
(**** Remember to close the tab after viewing the assessment. An unused tab can time out - logging out your Clinician's Gateway session. You could lose your unsaved work. ****)



Alert for Katie A eligibility on note entry screen.

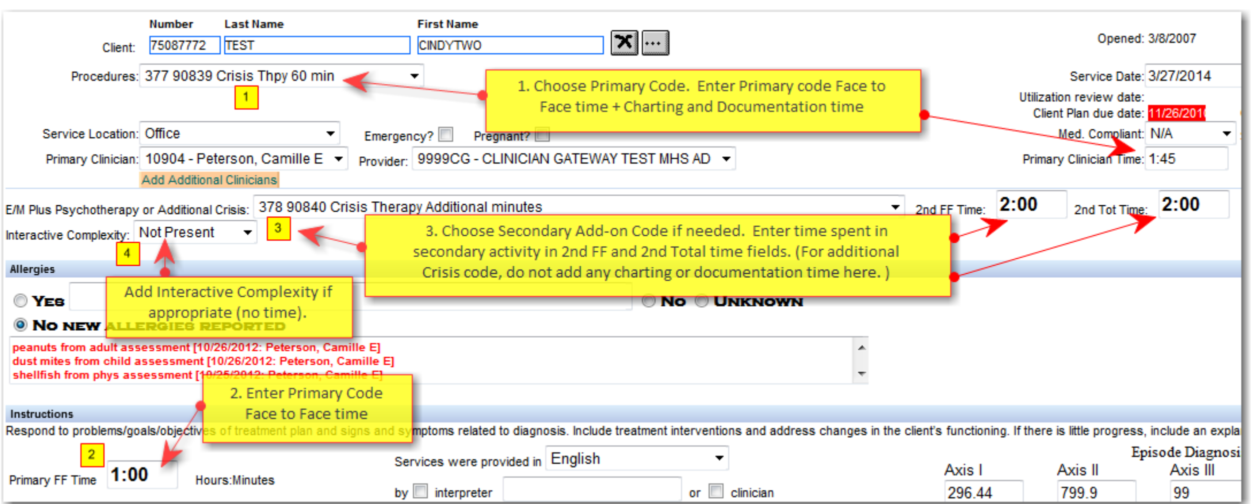
- 1 - When writing a progress note in Clinician's Gateway, first choose the Primary code matching the Face-to-Face time and complexity of the service. Enter the time spent <u>on that code's activity,</u> including charting and travel, in the "Primary Clinician Time" field. Codes have minimum time requirements. *For Crisis: record ALL Charting and Travel time in the Primary Clinician time field.*

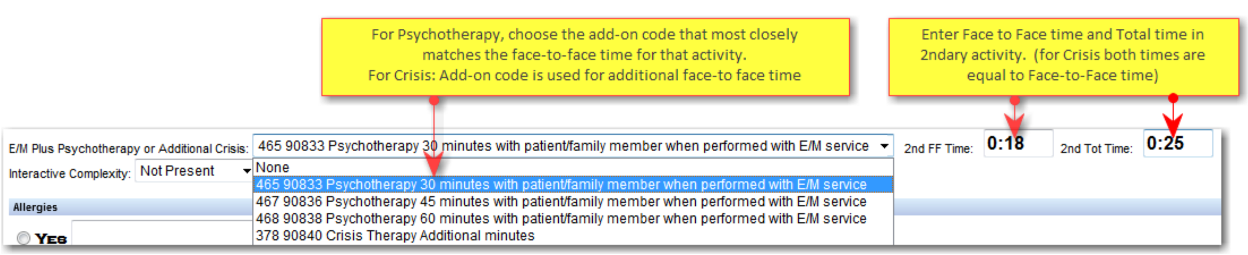
- 2 - Enter the Face-to-Face time in the "Primary FF Time" field below the "Instructions" line.

- 3 - Choose the Secondary add-on code for E/M Plus Psychotherapy or Additional Crisis. Enter the times spent on that activity into both the "2nd Face-to-Face" and "2nd Total Time" fields. *For Crisis: 2nd FF time = 2nd Total time (NO charting/ travel time)*

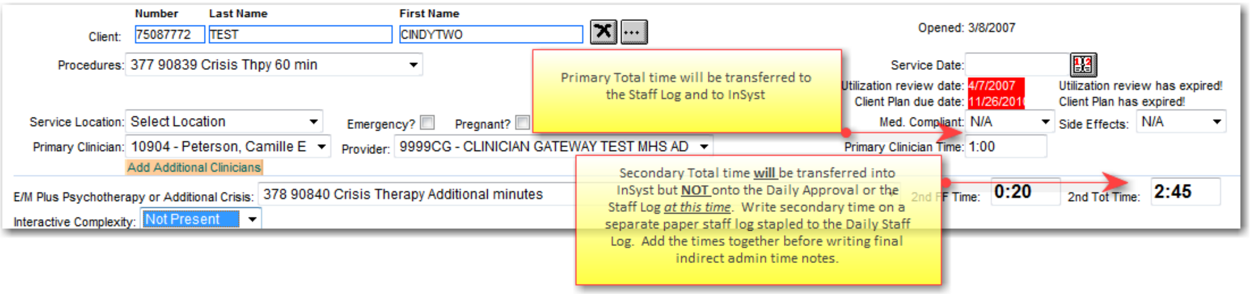
"Primary Clinician Time" + "2nd Total Time" = Total time for entire service.
"Primary FF Time" + "2nd FF Time" = Total Face-to-Face time for entire service.

- 4 - Some Procedures allow coding to indicate Interactive Complexity (no time recorded).

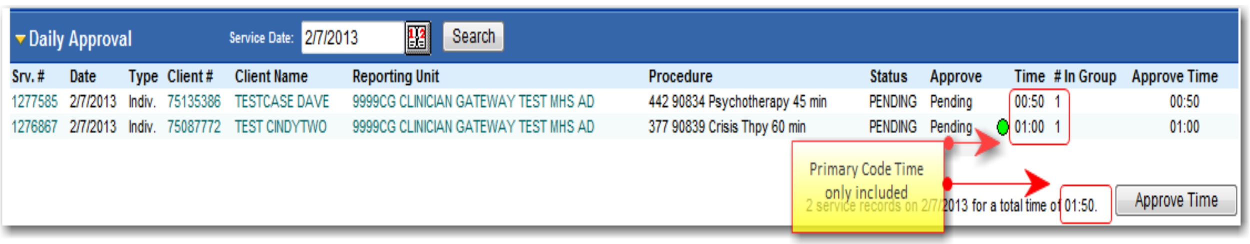


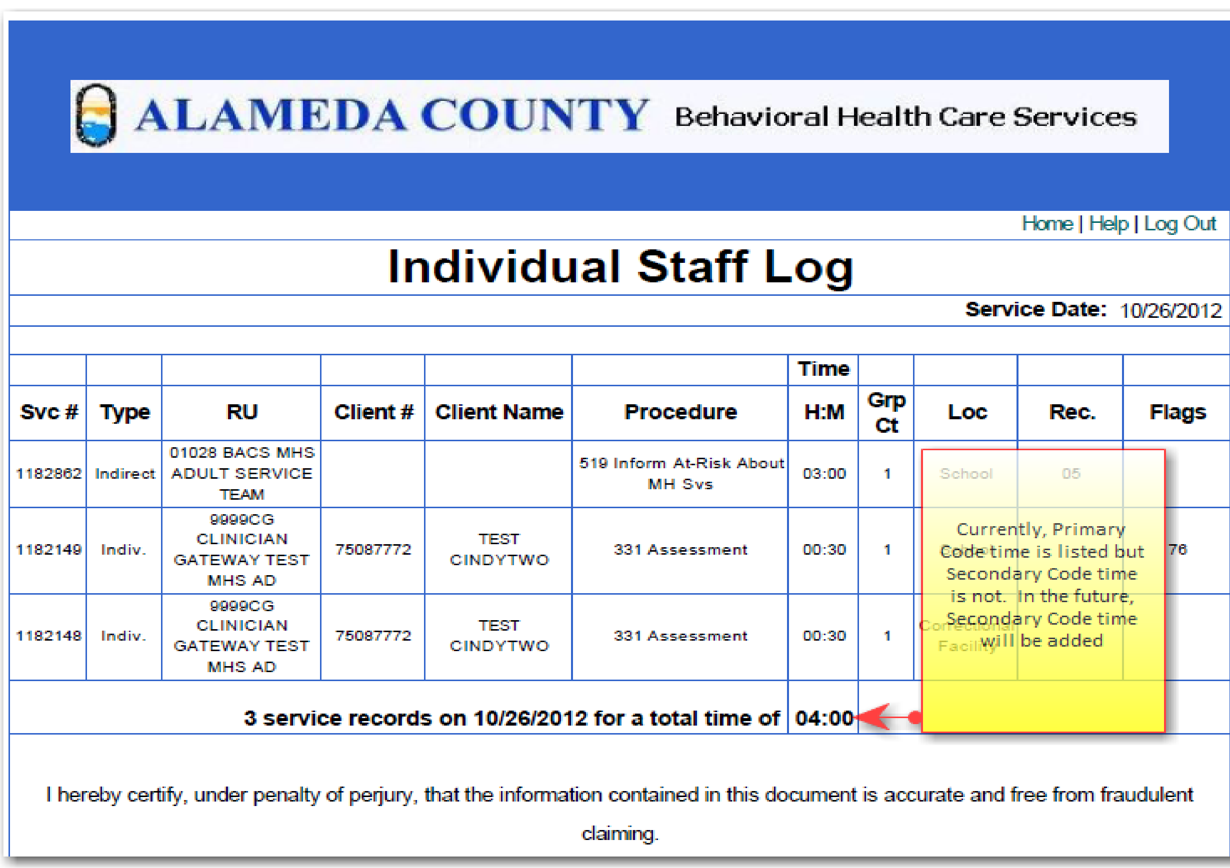


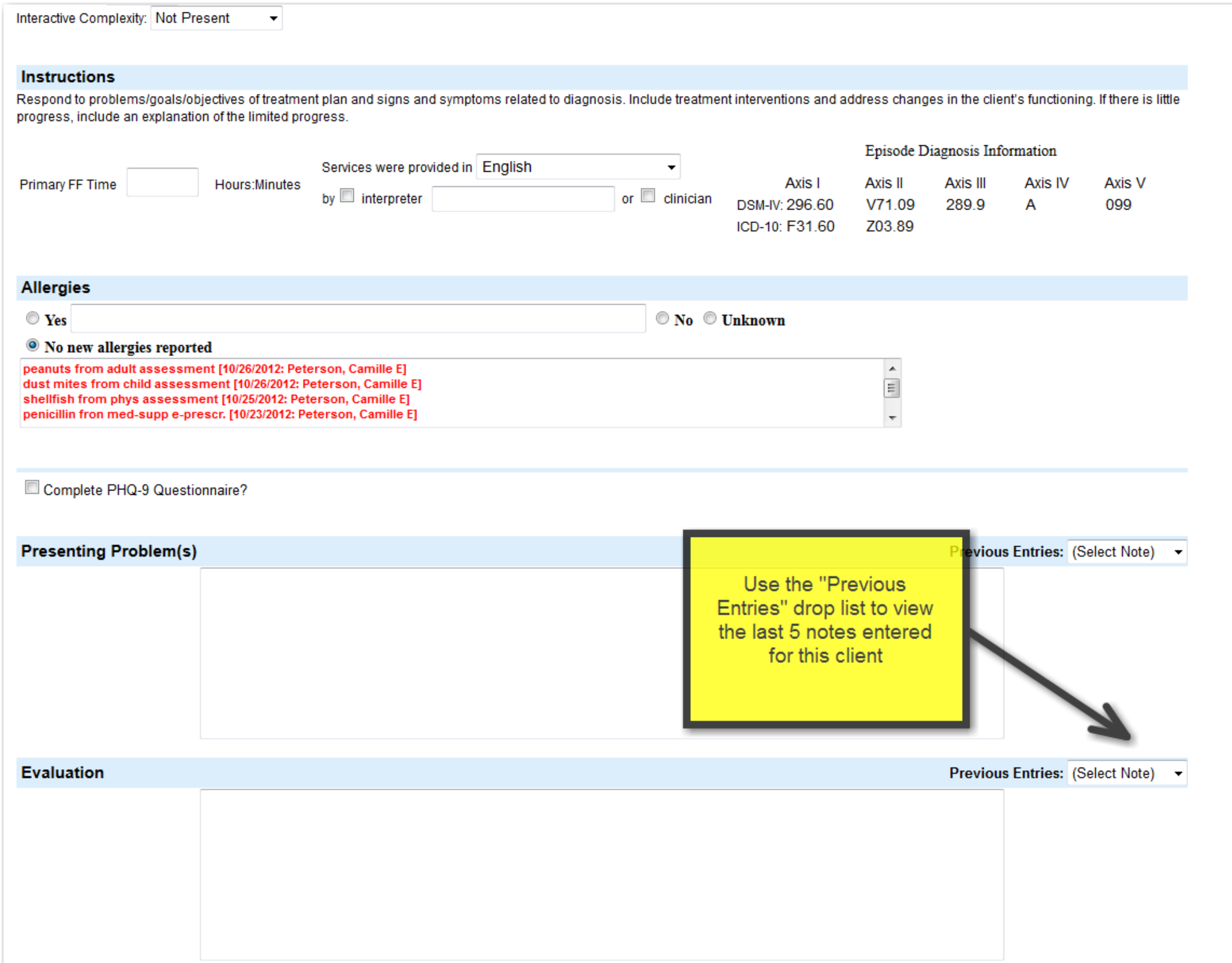
1. Both total Primary Clinician Time and total Secondary Add-On code time and will be transferred to InSyst for billing.



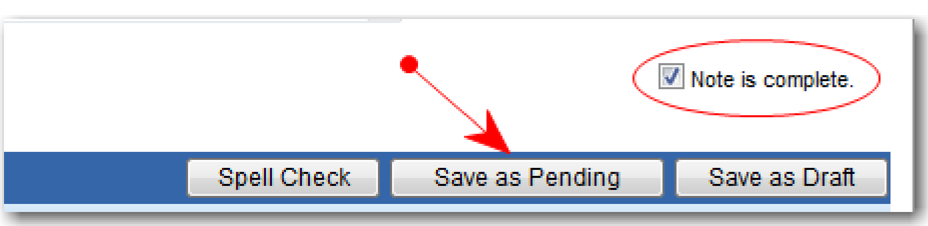
2. Only Primary Clinician Time is reported on the Daily Approval and Daily Staff Log at this time. In the future, secondary time will be included. Report secondary time on an old-style paper staff log form (MAA form) stapled to staff log.

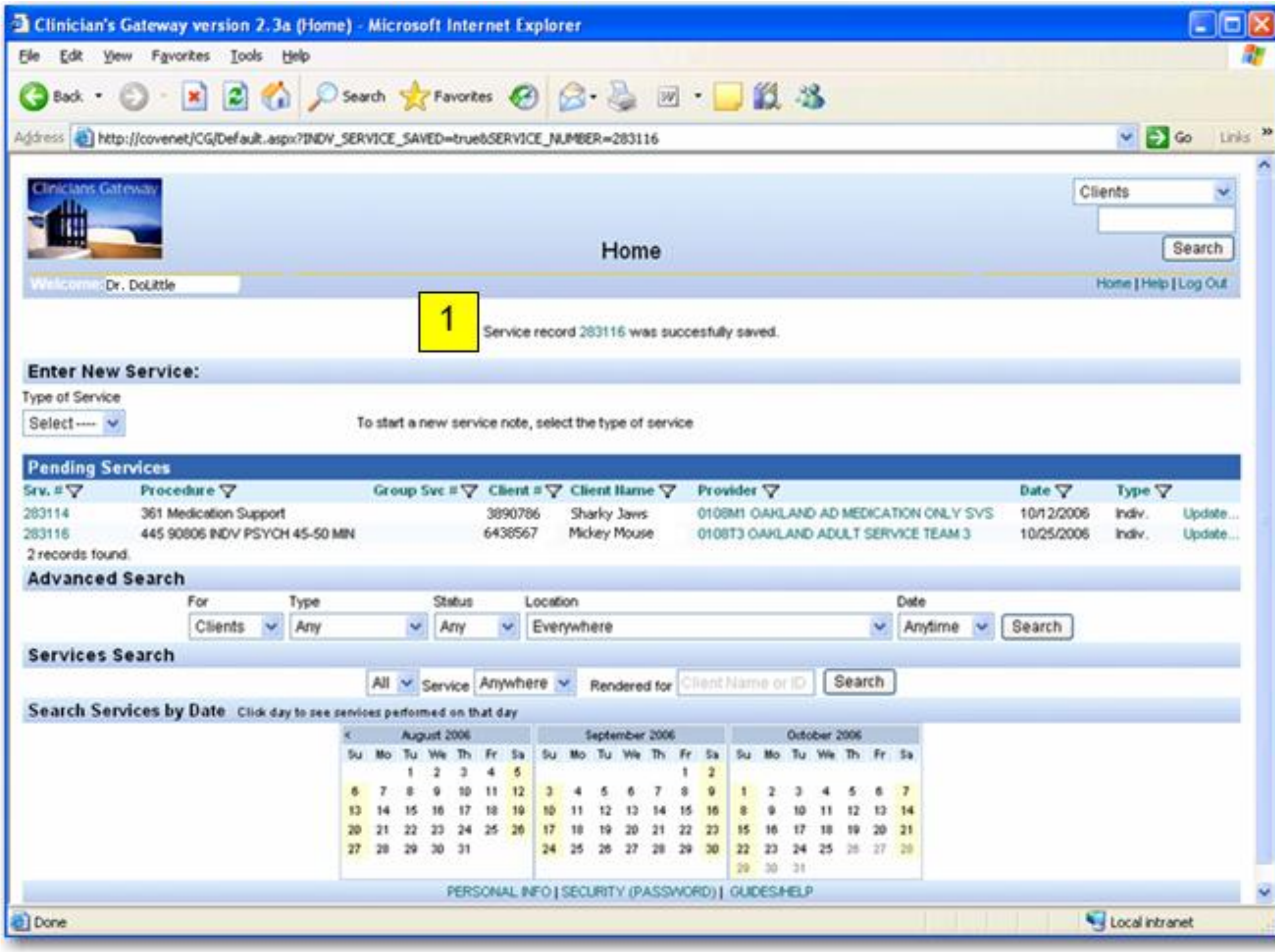






- Complete all of the progress note fields.
- Utilize the "previous entries" drop list to review or use information from the last five notes.
- Click on "Note is Complete" if available and "Save as pending" at the bottom of the page.





- **1** – The system message at the top of the window notifies you of a successful entry. If you do not see this message, your entry has not been saved.

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Notes: Draft versus Pending, Archive, and Finalize?

Drafts: **Save as Draft** when you have **incomplete** information. Perhaps you need to leave the note before finishing it. Perhaps you are writing a note for a client before they are registered or may never be registered (Pre-episode Note). Drafts can be found on your Home page Pending list or the View Staff page Draft list.

Pending: **Save as Pending** when the note has been completed, including client ID #. This note is ready to be finalized. Be sure to check the "Note is Complete" box before saving.

Archive: **Save to the Archive** when you want to store a Draft you *probably* will not need to retrieve. This will unclutter your Home page Pending list. Only Drafts may be stored to the Archive. Think of the Archive as an attic, a place to store things you *probably* will not need, however, you are not 100% sure. Drafts may be retrieved from the Archive via a services search or from the Drafts list on your View Staff page.

Finalized: When you are sure all of the information on a Note is correct and complete, including the client account # and your time, you may finalize. This will seal it with your electronic signature and add it to your services that are transferred nightly to InSyst for claiming.

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Draft Notes

1. **Draft Notes** are extremely flexible, can be saved before all the information is input, retrieved later and amended in multiple ways.

2. **Choose Individual Service** as you normally would on the Home page.
3. Enter the client's **name or number** (Name format is Last Name First Name with a space, not a comma)**, or leave it blank if the client does not have or has never had an open episode in your RU.**
4. **Choose your template** and
5. Click the **begin service** button.
6. On the Service Entry Screen, if you did not already **enter the client name**, fill in the Last Name and First Name fields. You can also **delete a client** using the **[X] button,** or **search for a new client** using the **Ellipsis [+++] button.** You will only be able to enter clients who have had episodes in your RU.
7. The **Procedure Code, Location and Clinician's time must be entered** in order to save it as a draft
8. Fill in as much or as little of the form as is appropriate.
9. **Incomplete forms may be saved as a Draft!** Just click "Save as Draft" in the lower right hand corner of the note.

When you know more information:

1. **Find the draft note** in multiple ways.
2. It will be listed in the **author's Home page Pending** Services List.
   Alternatively, using the **Search Box** in the upper right hand corner, choose Services, enter the name or client #, and click the Search button.
   You may also use the **Services Search** in the middle of your Home page.

3. **Changes to the note can be made in the fields of**:
   The client's name and account # can be updated: Use **[+++]** to search for (enter last name first name, click Search, and wait) and choose another client from the search results list.
   Procedure
   Location
   Clinician (after building your customized Primary Clinician List)
   Provider (RU = Reporting Unit)
   Clinician's **Time**
   Face-to-Face **Time**
   Additions to the **text** of the Progress Note

4. **When the Note is complete:**
   When the note is complete, check the "**Note Complete**" box at the bottom.
   Click the **Save as Pending** button.

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Archiving Draft Notes

Draft notes that will not be needed immediately can be sent to the Archive to remove them from your pending list. They can be recalled using a Services Search by client name.

Archiving the Note:

1. Write up your Draft Note as completely as possible.
2. Click the “Save as Draft” button.
3. Find the Draft Note in your Pending List on your Home Page or in the Draft List on your View Staff Page
4. Click “Update” or the specific Service # that you want to archive.
5. Click the “Archive” button in the lower right hand corner.
6. The service is no longer listed in your pending services list.

Recalling the Archived Note:

1. You can find the note in three ways:

    a. Do a Services Search from your Home Page (found in the middle of the page) using the client name (last name first name with no comma).
    b. Do a services search using the Search Box in the upper right hand corner by choosing “Services”, entering the client name (last name first name no comma) and clicking “Search”
    c. Look for the service in the Draft List on your View Staff page.

2. A search results list will appear. Find the service in the list.
3. Click on “View” or the service # of the desired Draft note.
4. Click the “Edit” button in the bottom right hand corner.
5. Make changes as needed. (Use the **[+++]** button to search for a new client if they now have a client account #. Use the **[X]** button to delete a client first if you need to replace one client account # with another).
6. Click the “Save as Draft” button to save changes and return it to your Pending List.

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Informational Notes – Procedure Code 197 - No time to be claimed

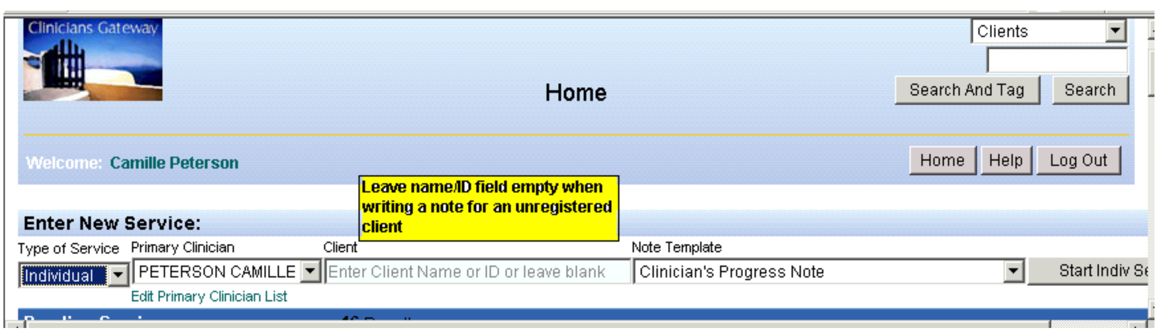
Informational only Notes can be used to write notes for clients using procedure code 197 and claiming zero minutes. Your time is billed as an indirect service. The procedure varies according to whether the client has an open episode or is registered.

To write a note for a registered client with an open episode in your Reporting Unit:

1. Write a progress note as usual, using Procedure Code 197, Informational Note
2. Enter zero minute's time. (actual data entry of 0 minutes required)
3. Write the note, check Note Complete and Save as Pending.
4. This note can be finalized and so will show up as a finalized service in the Electronic Health Record for the client.
5. It will show up on the Staff Log with zero minutes.
6. Write an Indirect service for your time.

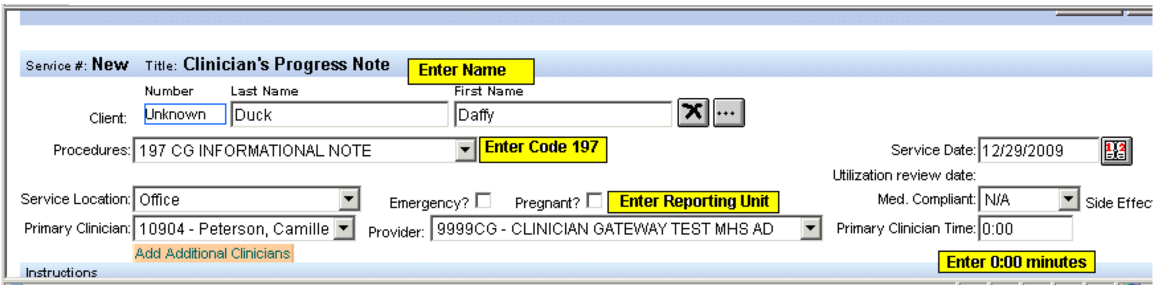
To write a note for a client who is not yet registered (Outreach – Treatment Refused by Prospective Client):

1. **Choose Individual Service** as you normally would on the Home page but
2. Leave the **Client Name/ID** field blank.



3. **Choose your template**
4. Click the **Start Individual Service** button.

5. On the Service Entry Screen, **enter the client's Last Name and First Name** in their respective data field boxes.
6. USE PROCEDURE CODE 197 – INFORMATIONAL NOTE and enter 0 MINUTES time. Designate the Provider Reporting Unit from the drop down menu.

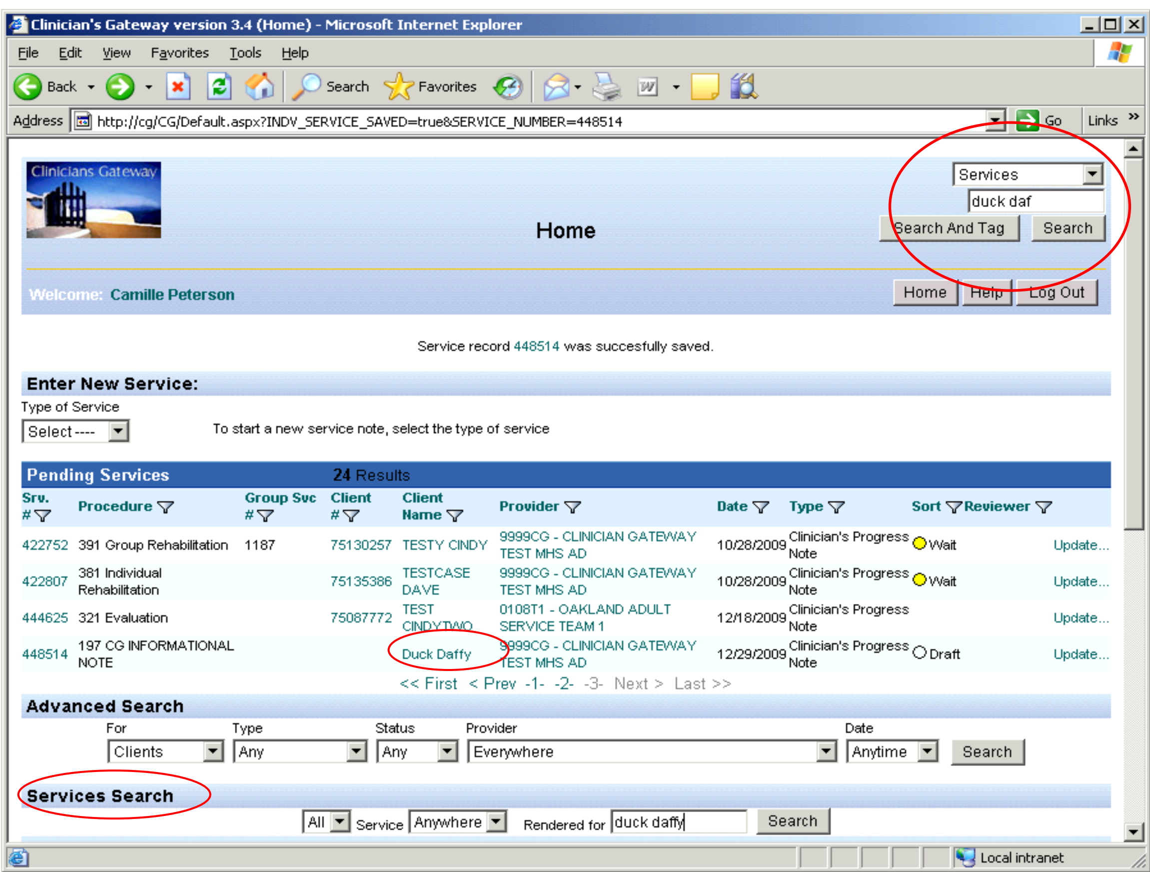


7. The **Procedure Code, Location, Provider, Date, and Clinician's time must be entered** in order to save it as a draft.
8. Fill in as much or as little of the form as appropriate.
9. **Save as a Draft!** Write an Indirect Service for your time.

To recall the Draft note: (To add the client's # when available)

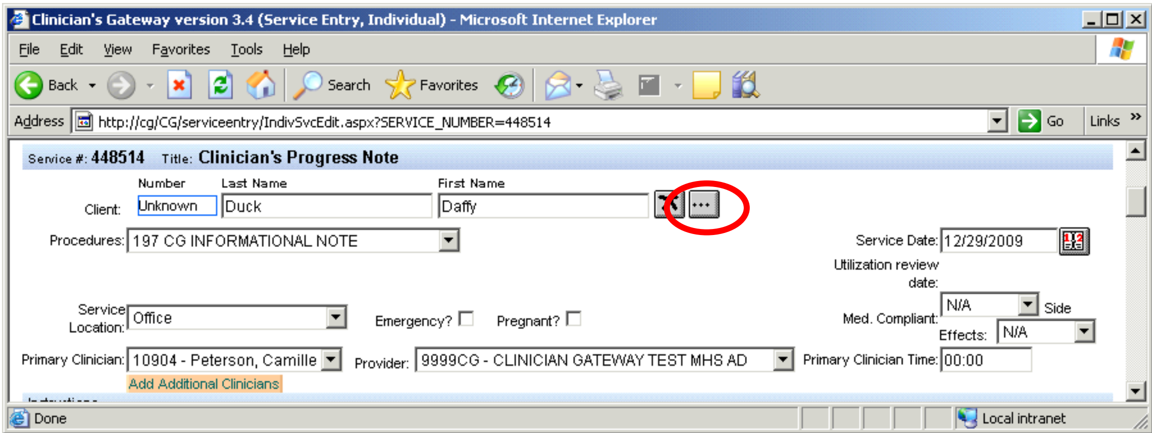
10. Find the note in one of three ways:

- Use the **Global Search** box in the upper right hand corner by choosing "Services" from the drop down menu and entering the client name (last name first name – no comma). Click the "Search" button.
- Look in the author's **Home Page Pending** List (or Staff View page Drafts list).
- Use the **Services Search** in the middle of the Home Page.



To update the Draft Note

11. **Update the client's name and account** number (after they have had an episode opened in your RU). You cannot type in the client's PSP number. Use the **[***]** button to search for the client (enter last name first name, click Search, wait). Choose the new client from the search results.



12. **Updates to the note can also be made in the fields of**:
    Procedure Code (do not change it if you claimed time on an indirect)
    Location
    Clinician (if you have built a customized Primary Clinician List)
    Provider (RU = Reporting Unit)
    Clinician's Time (do not change if you claimed time on an indirect)
    Face-to-Face Time
    Additions to the text of the Progress Note

If you claimed your time on an Indirect service note, do not claim time now, or you will double claim.

If the note is complete: (And the service falls within an open episode)

13. When the note is complete, check the "**Note Complete**" box.

12. Click "**Save as Pending.**" The note can be finalized if the service is within the episode dates. Otherwise it will remain as a Draft note in that client's records.

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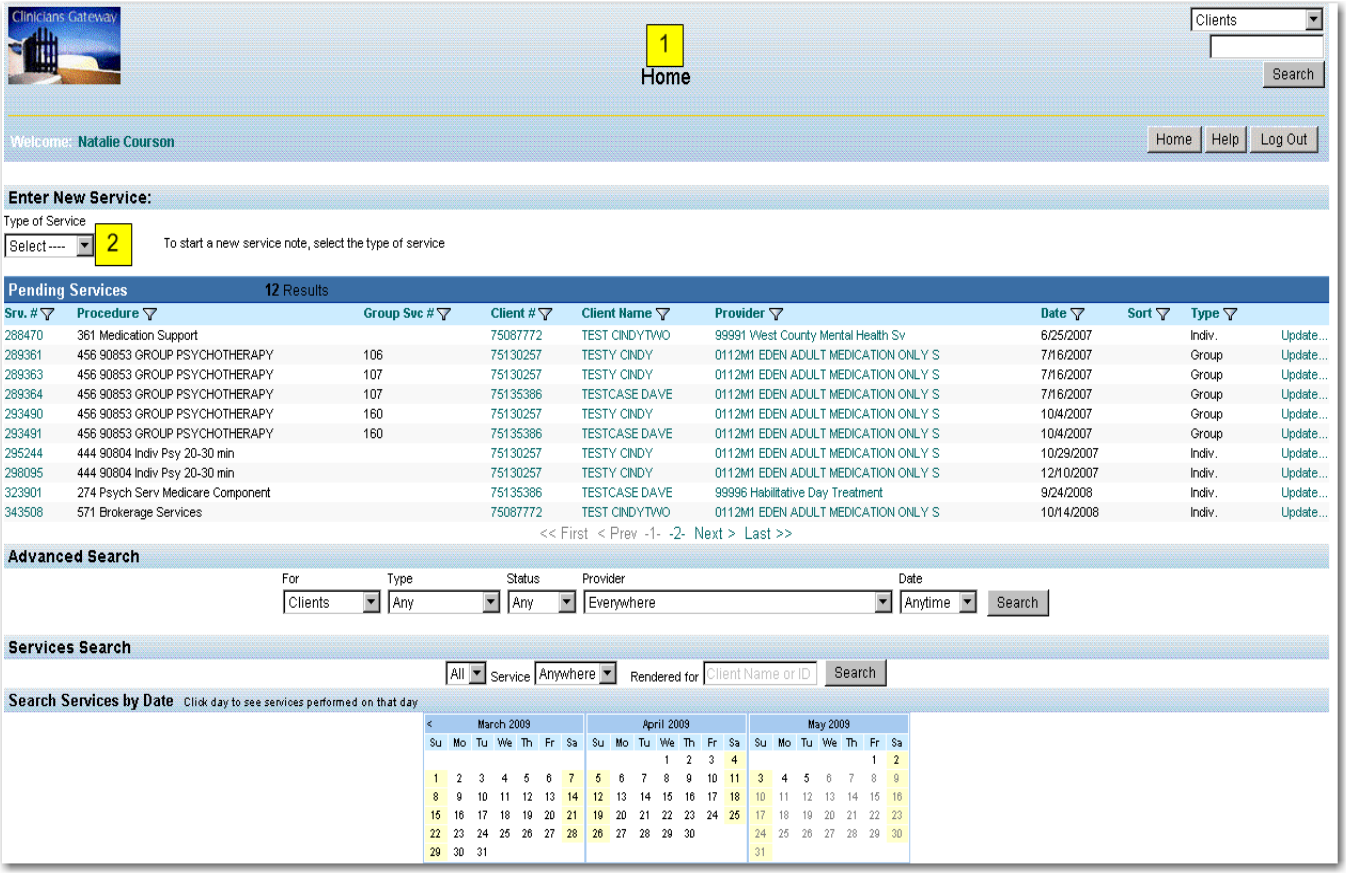
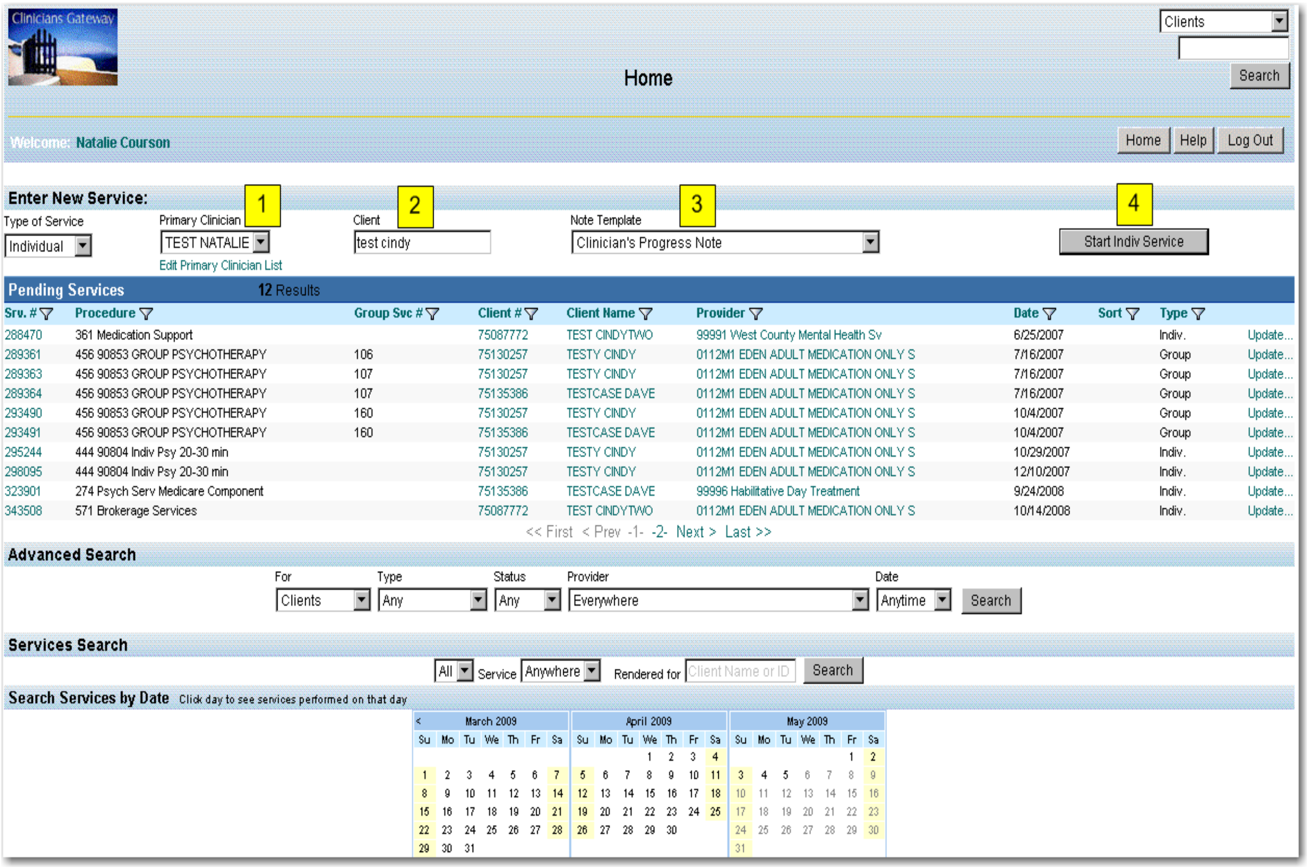
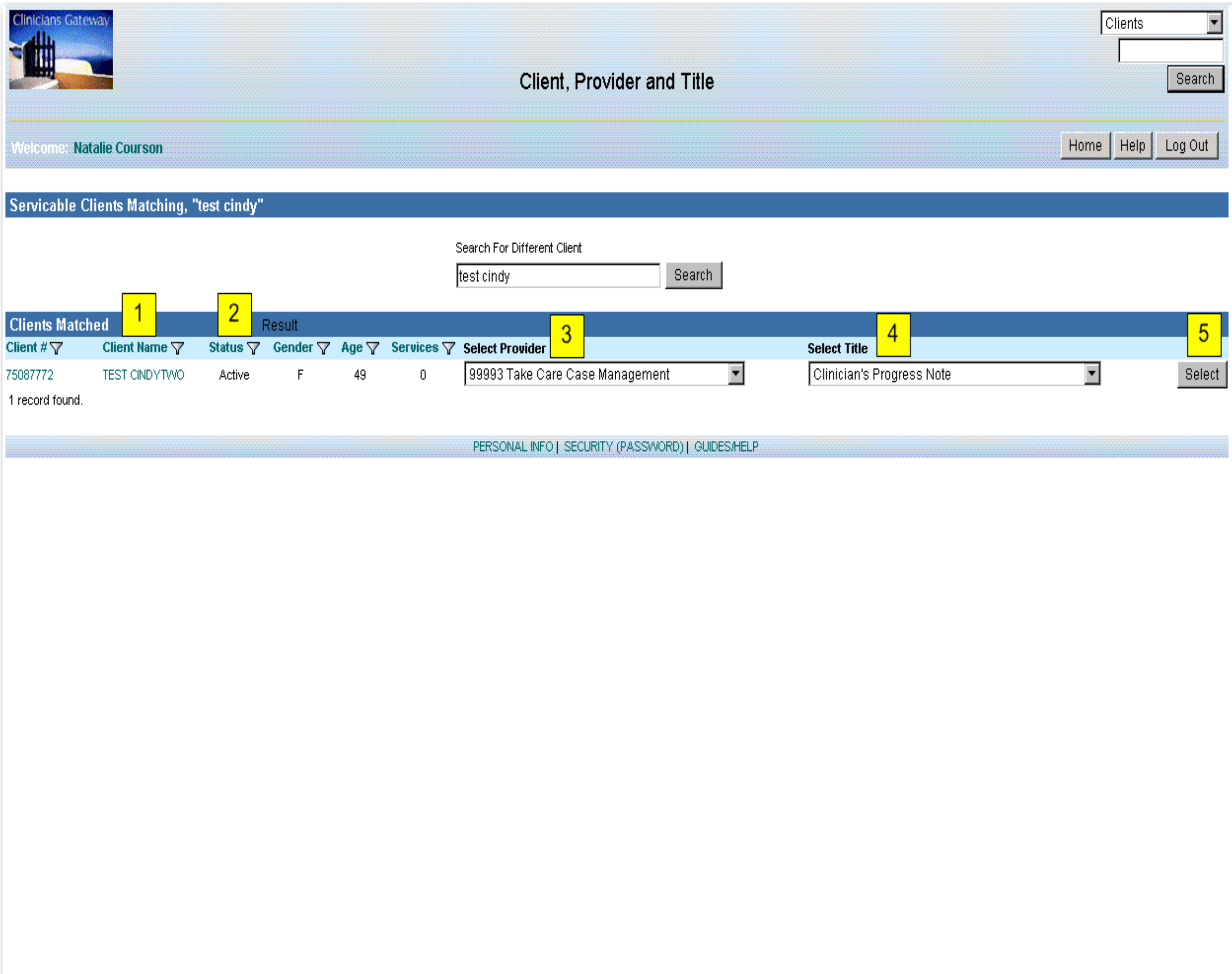
Co-staffed Individual Notes



- 1 – Start all notes from your home page.
- 2 – Click on the drop arrow to select “Individual” for the type of service.

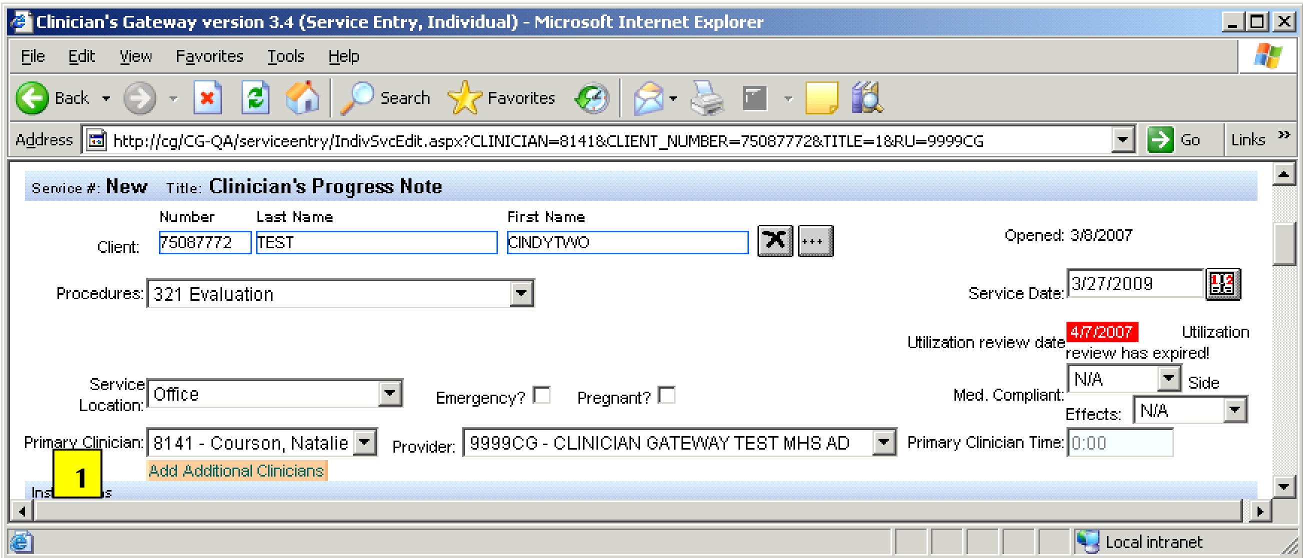


- **1** - Verify the Primary Clinician name is correct.
- **2** - Enter the client name (Last name then First name with no commas, ex. Mouse Mickey) or the client number.
- **3** - Select the template name from the drop list.
- **4** - Click on "Start Indiv Service."

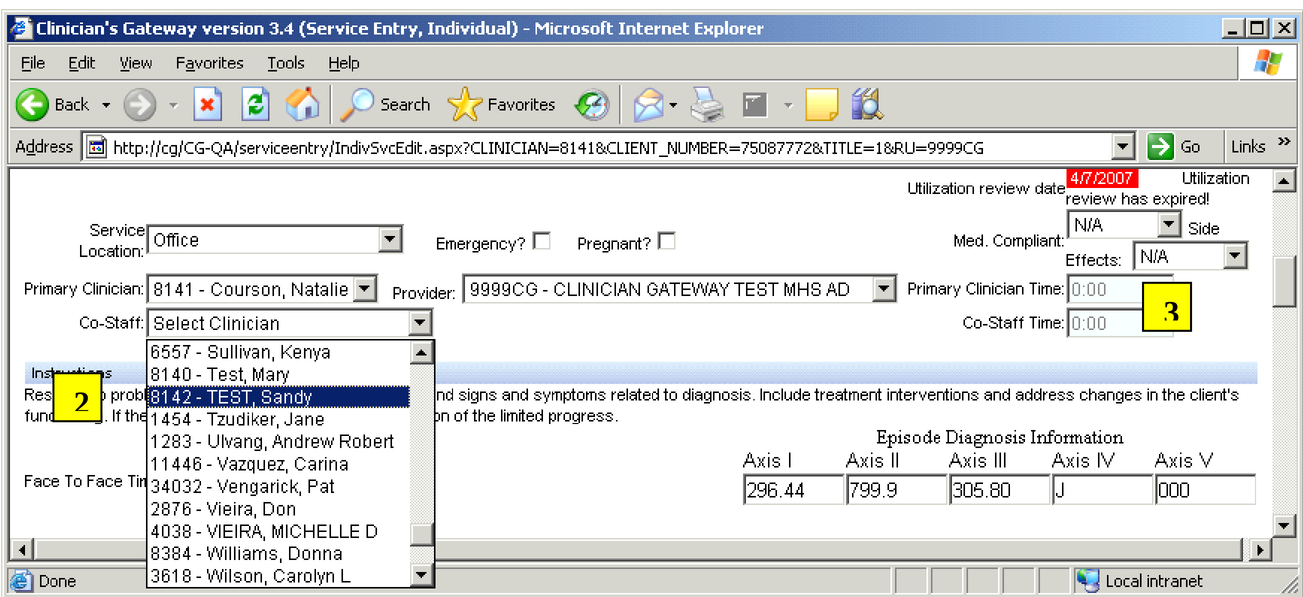


- **1** - Verify the client name.
- **2** – Verify the status for that client. "Active" indicates that the client has an open episode.
- **3** - Verify the appropriate provider name is indicated.
- **4** - Select the Title of the type of note you will enter.
- **5** – Click on "Select"

- Complete the billing information above the blue line.



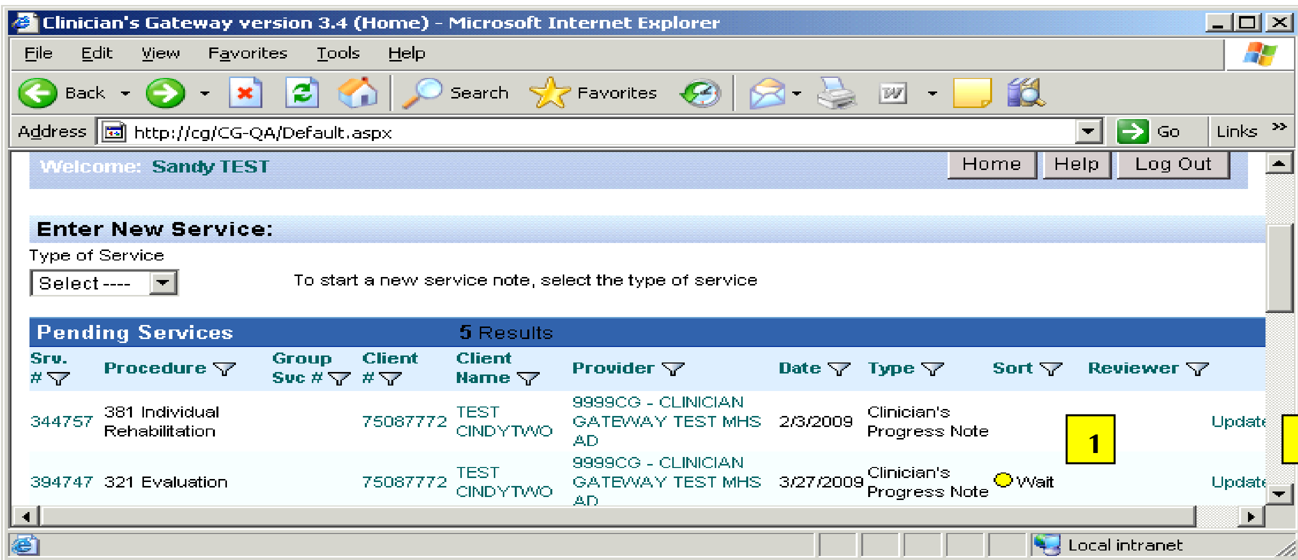
- **1.** Click on "Add Additional Clinician's."
- **2.** Choose the Co-staff from the drop down menu.
- **3.** Enter time for both clinicians



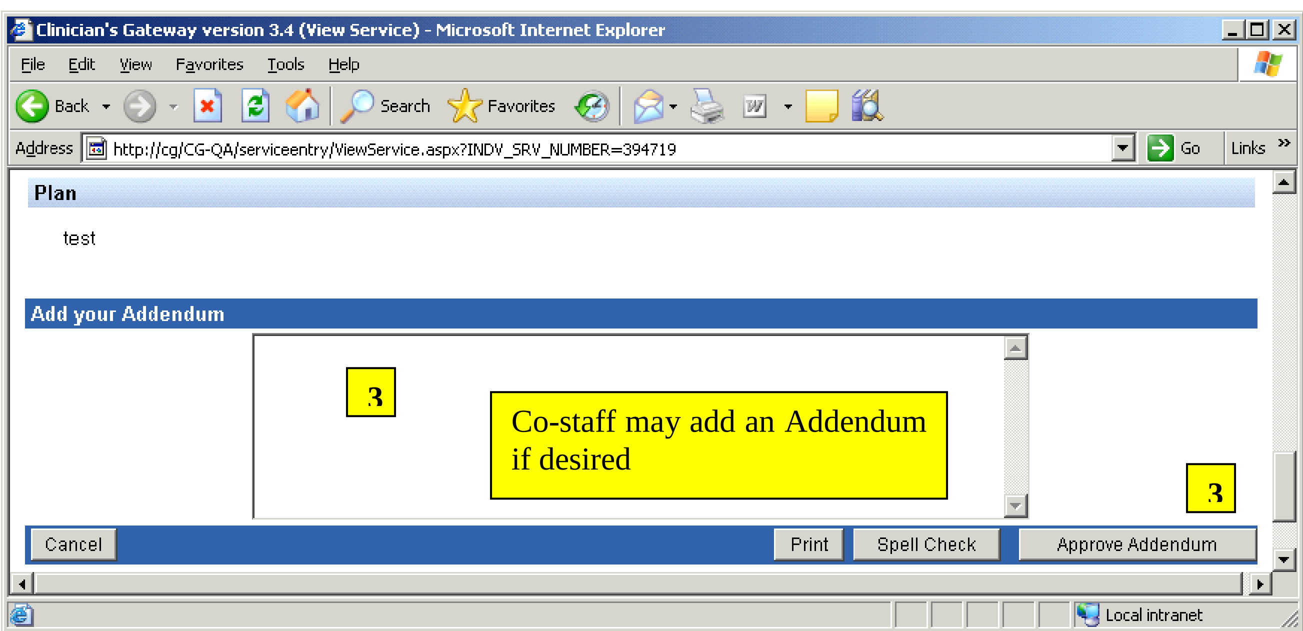
- Complete all of the progress note entries. Check "Note is Complete."
- Click on "Save as pending."

- **1** – The note will be listed on the primary and co-staff's pending lists with a yellow dot and the word "wait" which displays the message "Waiting for clinicians to approve this service" when pointed at with the cursor. This is an advisory message only. Either Clinician may finalize at any time.

- **2** - The co-staff have the opportunity to add an <u>optional</u> addendum to the note <u>before the Primary finalizes</u>. To add an addendum, click on "update."

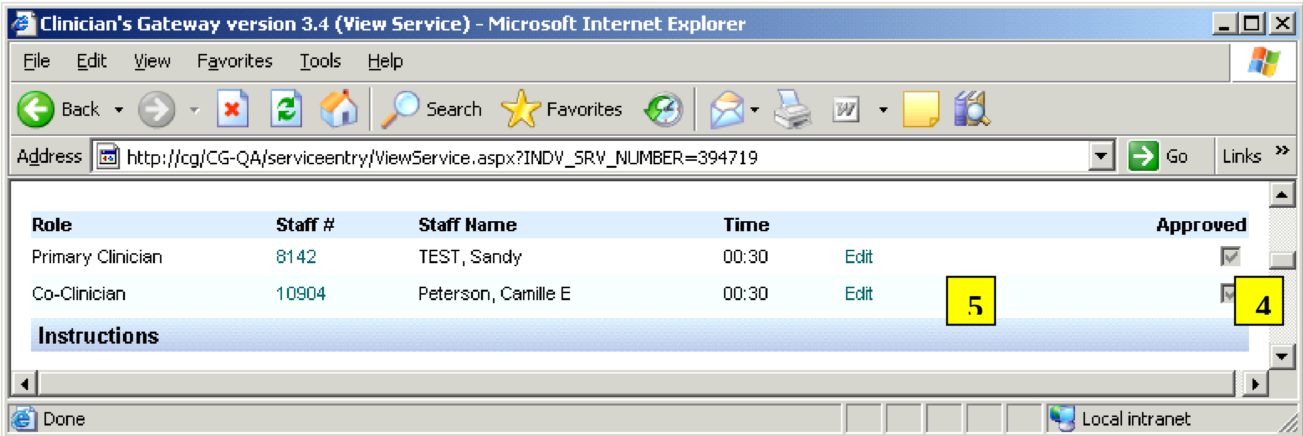


- **3** – If desired, add the addendum at the bottom of the note and click "Approve Addendum"

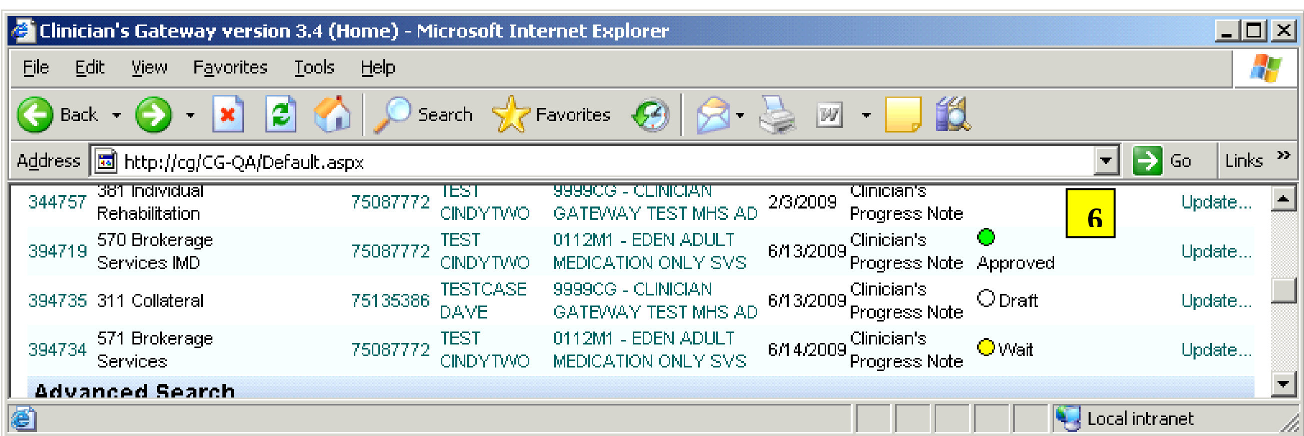


- **4** - When the co-staff approve their addendum, a checkmark is placed in the "Approved" checkbox at the top of the note. Co-staff approval is optional.

- **5** – Co-staff may edit their time before the Primary finalizes.



- **6** - If the Co-staff have added an addendum, the note disappears from the Co-staff's Home page Pending list. It is no longer available for editing. The dot on the Primary's Home page Pending list then turns green.

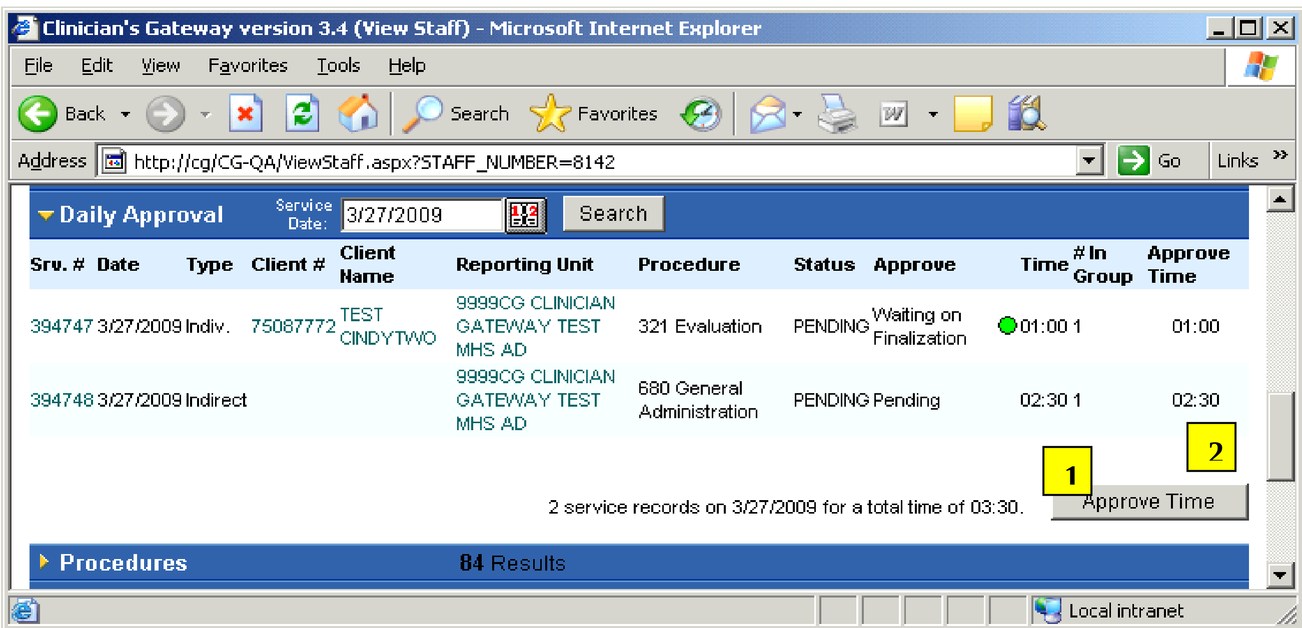


- The note will also disappear from the Co-staff's Home page Pending list when the Primary finalizes because it is no longer available to the Co-staff to edit.

CO-STAFF AND PRIMARY CLINICIANS CAN FINALIZE WHEN DESIRED. CO-STAFF WILL BE GIVEN TIME ON THEIR STAFF LOG ON THE DAY THAT THEY FINALIZE. (However, the time will be transferred into InSyst on the day the Primary finalizes.)

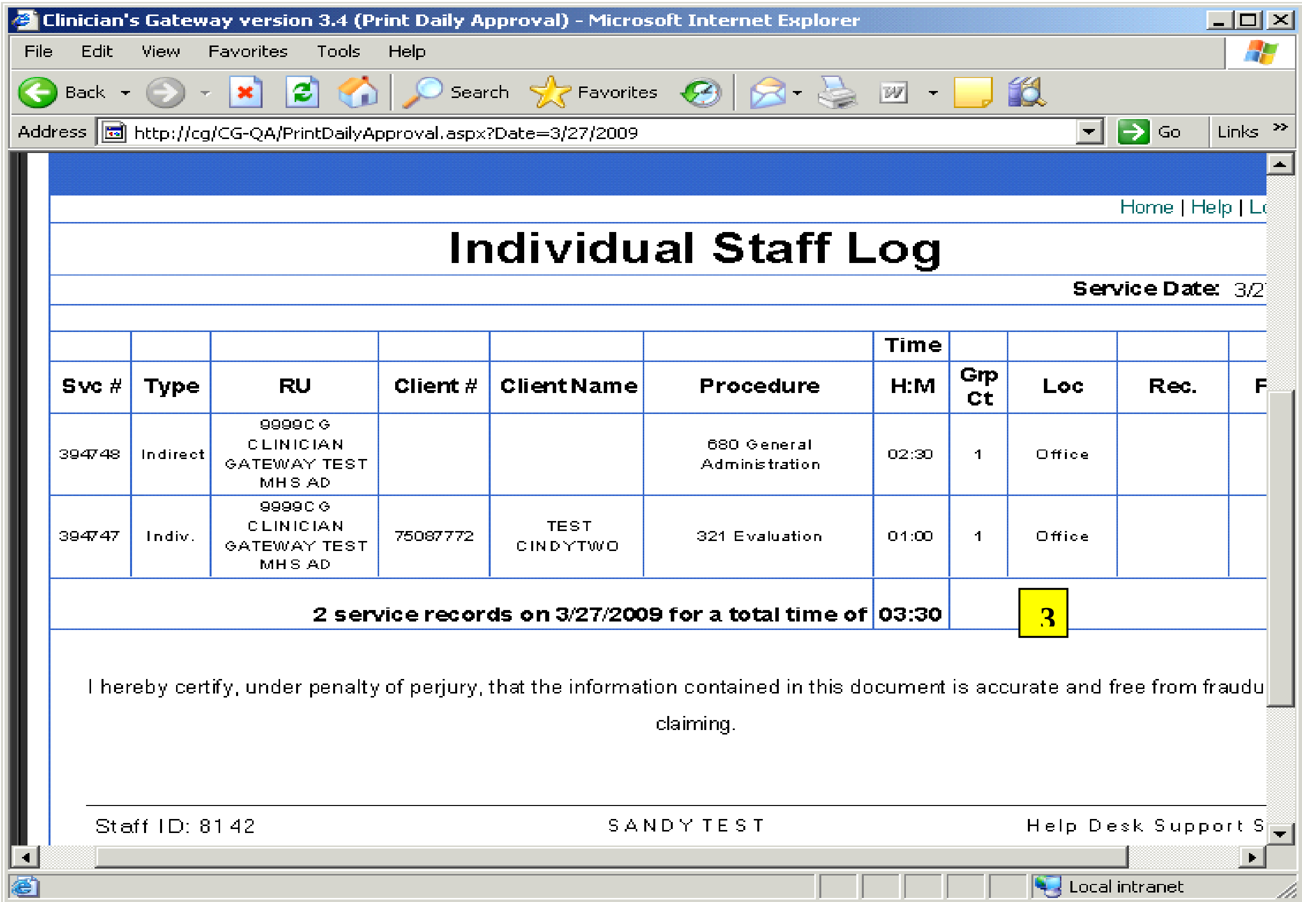
- **1** - The Co-staff and Primary will both see the service listed on their Daily Approval tally and added into their total time. In this example, the co-staff are given credit for the one hour of co-staff time, even though the Primary has not finalized. ("Waiting on Finalization")

- **2** – Click Approve Time to add the time to your Staff Log.



Note: Both primary and co-staff times are transferred to InSyst, the evening that the note is finalized by the primary clinician.

- **3** – The service is listed on the Co-Staff's log and the Co-Staff time is added to the Staff Log total time, whether or not the Primary has finalized.



Individual Staff Log

Service Date: 3/2

Svc #	Type	RU	Client #	Client Name	Procedure	Time H:M	Grp Ct	Loc	Rec.	F
394748	Indirect	9999CG CLINICIAN GATEWAY TEST MHS AD			680 General Administration	02:30	1	Office		
394747	Indiv.	9999CG CLINICIAN GATEWAY TEST MHS AD	75087772	TEST CINDYTWO	321 Evaluation	01:00	1	Office		
					2 service records on 3/27/2009 for a total time of	**03:30**		3		

I hereby certify, under penalty of perjury, that the information contained in this document is accurate and free from fraudu

claiming.

Staff ID: 8142 SANDY TEST Help Desk Support S

The time will appear on the InSyst reports the day after the Primary clinician finalizes, not on the day that the Co-Staff clinician finalizes.

The service is listed in the Primary Clinician's Finalized Services, not the Co-Staff's Finalized Services.

GROUP NOTES

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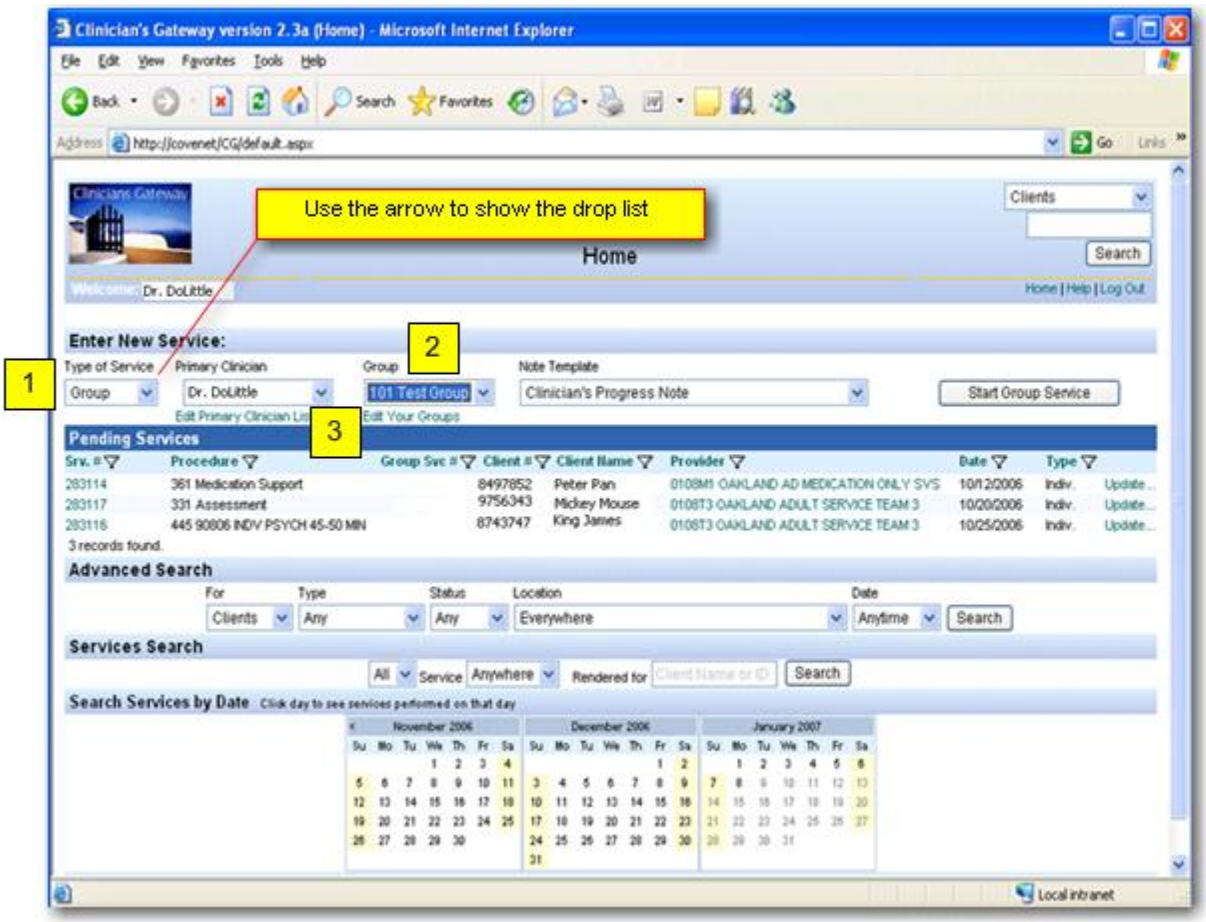
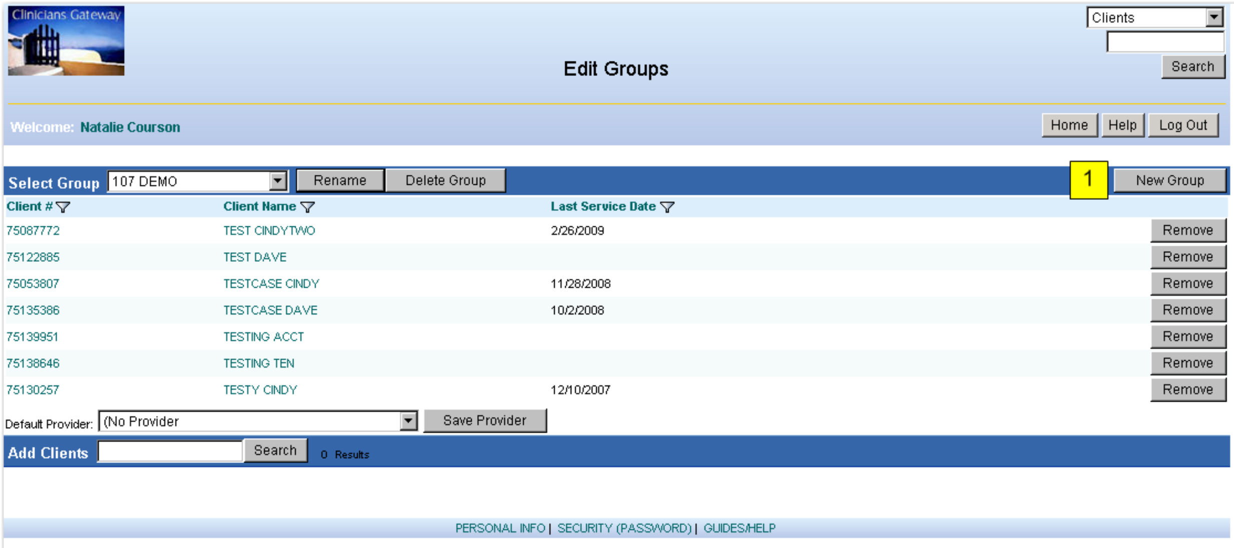
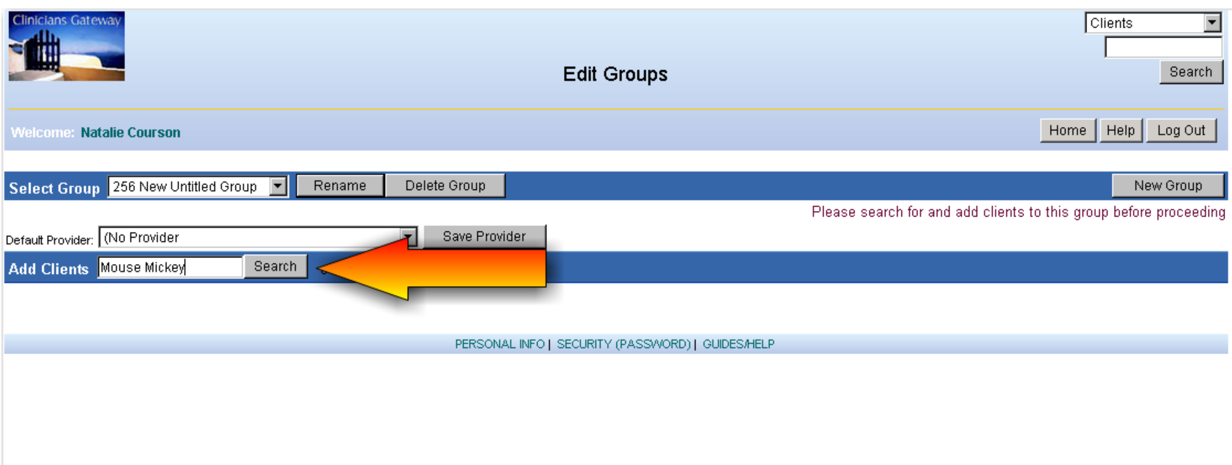
Group Notes



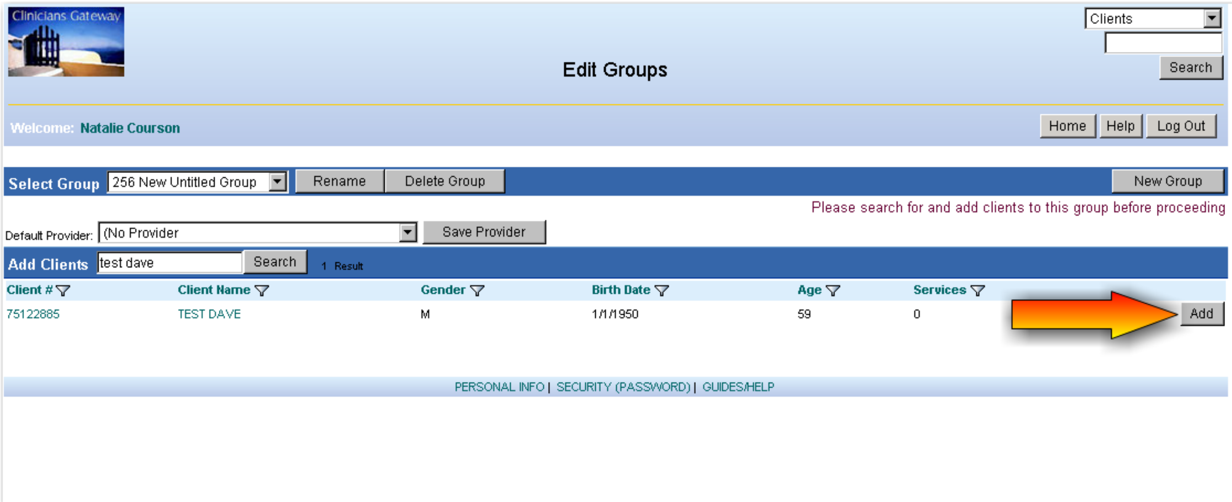
- **1** – Select "group" under "type of service."
- **2** – Select group description.
- **3** – If this is a new group then click on "Edit your groups"



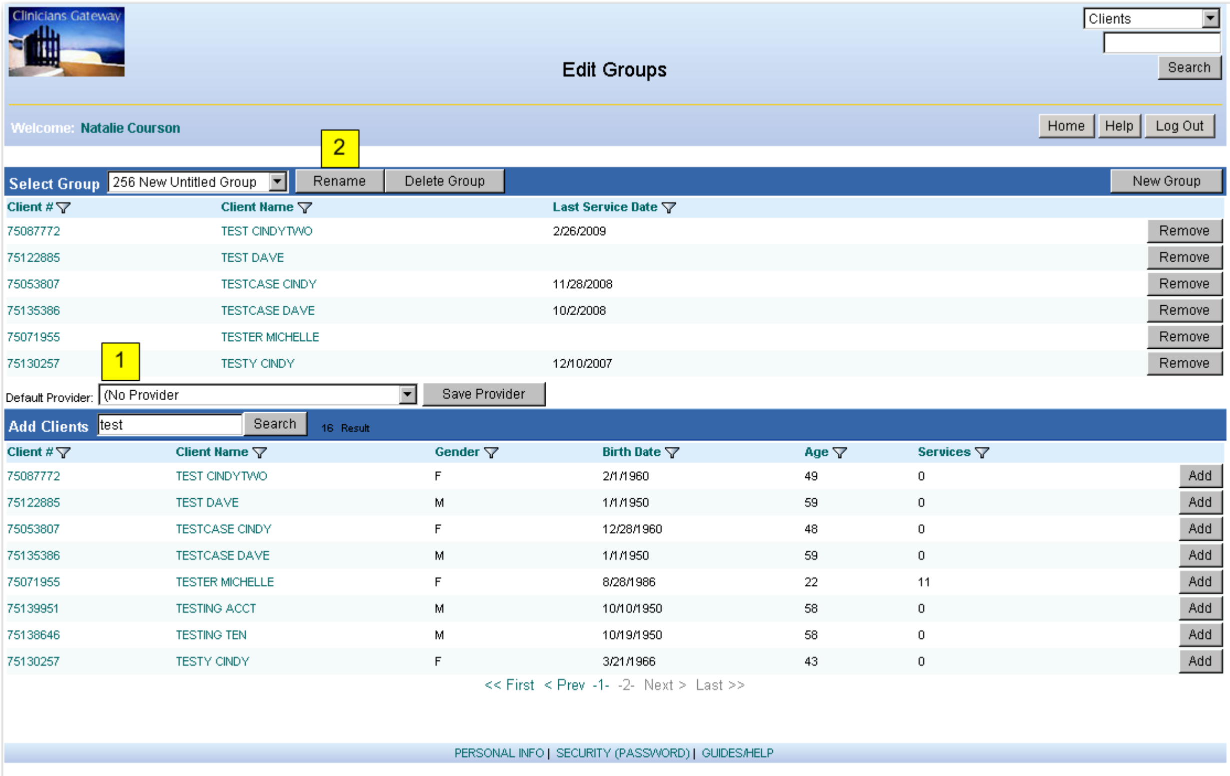
- **One** –Click on the "New group" button.



- Type in the clients name in the "Add Clients" field (Last name then first name, with a space between) then click on the "Search" button and wait for the list to populate.

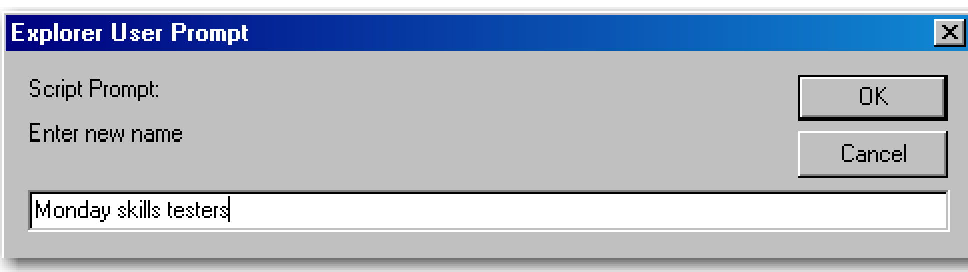


- When the client information appears, click on the “Add” button.
- Follow the same steps to add all of the other members to the group listing.



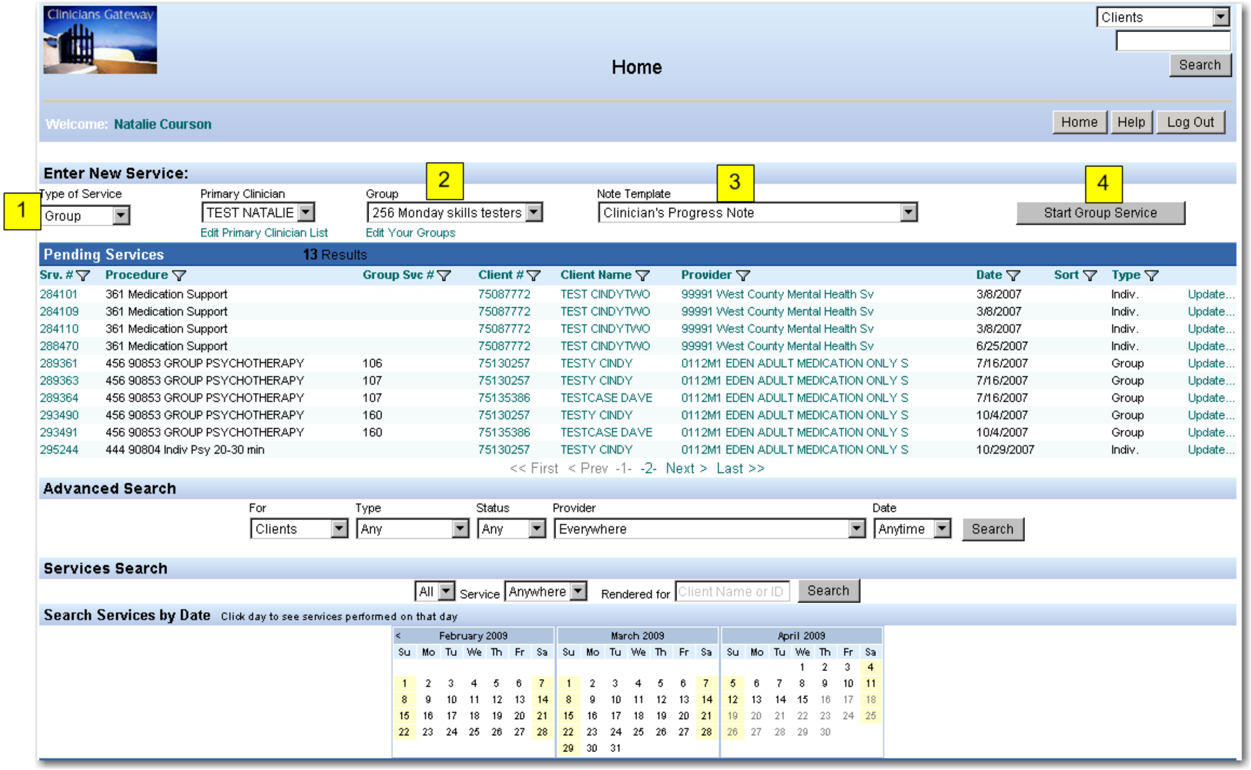
- **1**-Select a default provider from the drop list and click on Save Provider

- **2**-Click on Rename to enter the name of the group you have created. When naming the group, you can use names that remind you of the days the group meets, and the type of group they are…e.g. "Wednesday Rehab" or "Tue&Thu Skill Building"

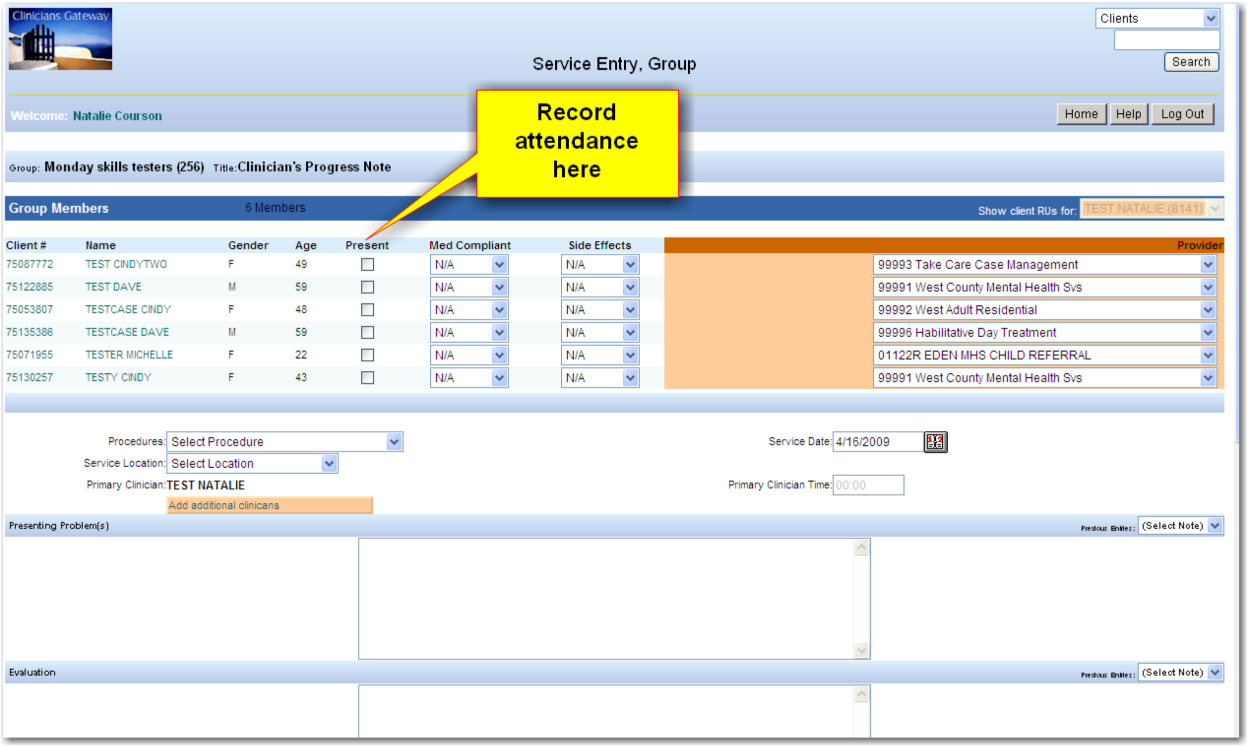


- Click on "OK" to save the name of the group.

- Click on home to go back to the home page and start the group note.



- **1** – Select group under "Type of service."
- **2** - Select the group.
- **3** – Select note template.
- **4** – Click on "Start group service."

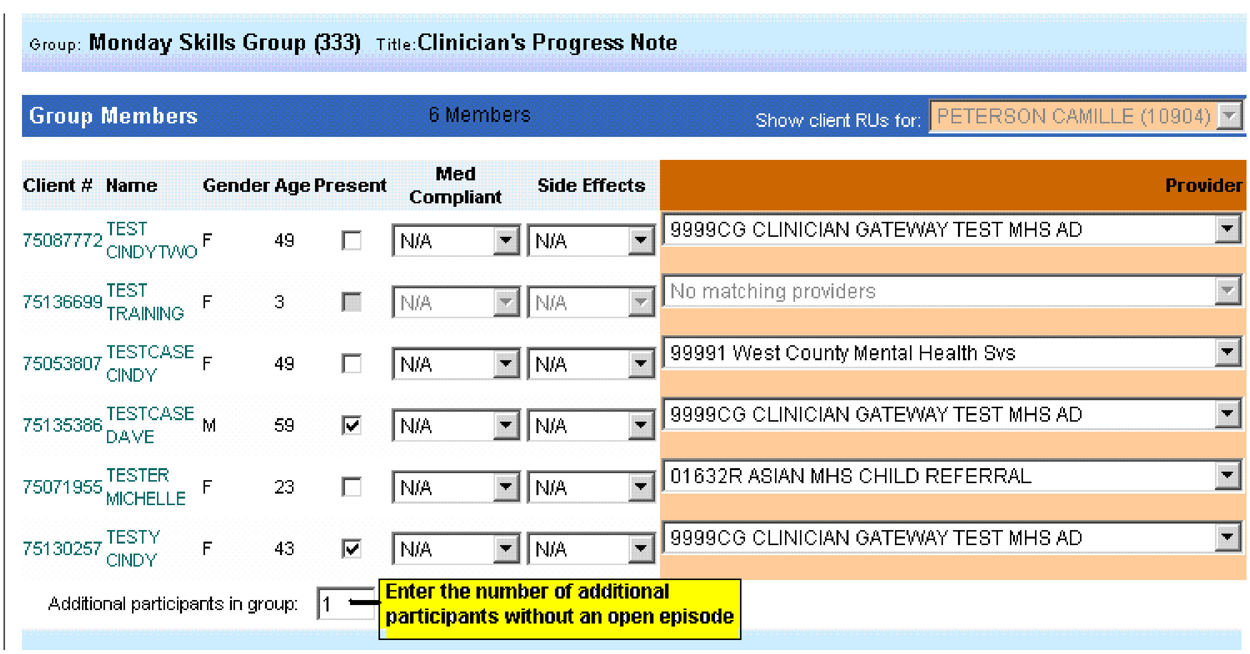


- Click on the square box under the “Present” column for each client in attendance. A check mark should appear.

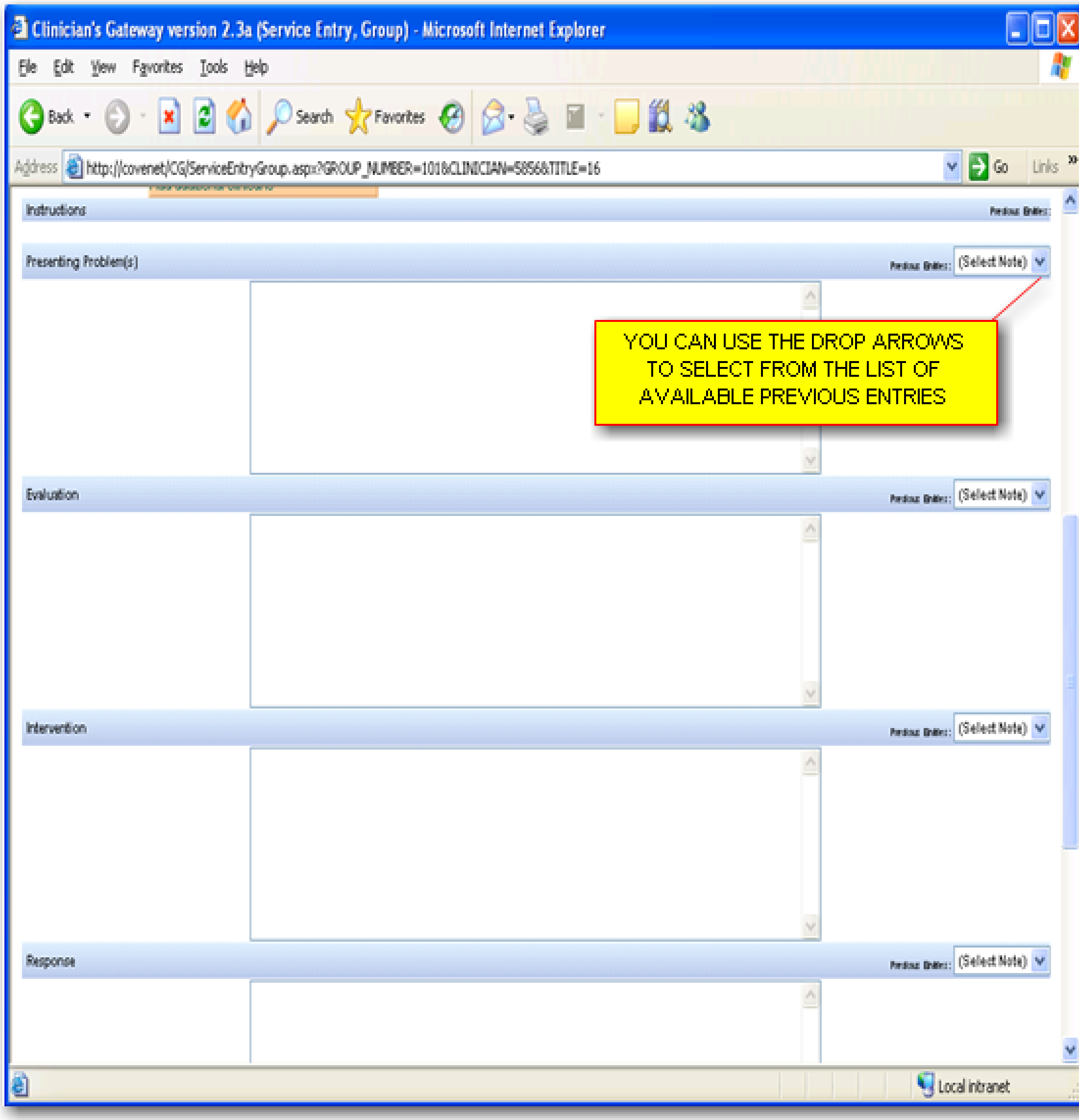
- Complete the fields for the procedure, service location, co-staff, service date, primary clinician time, and co-staff time (if co-staff were entered).

- **Be sure to select the correct provider for the client from the Drop list!**

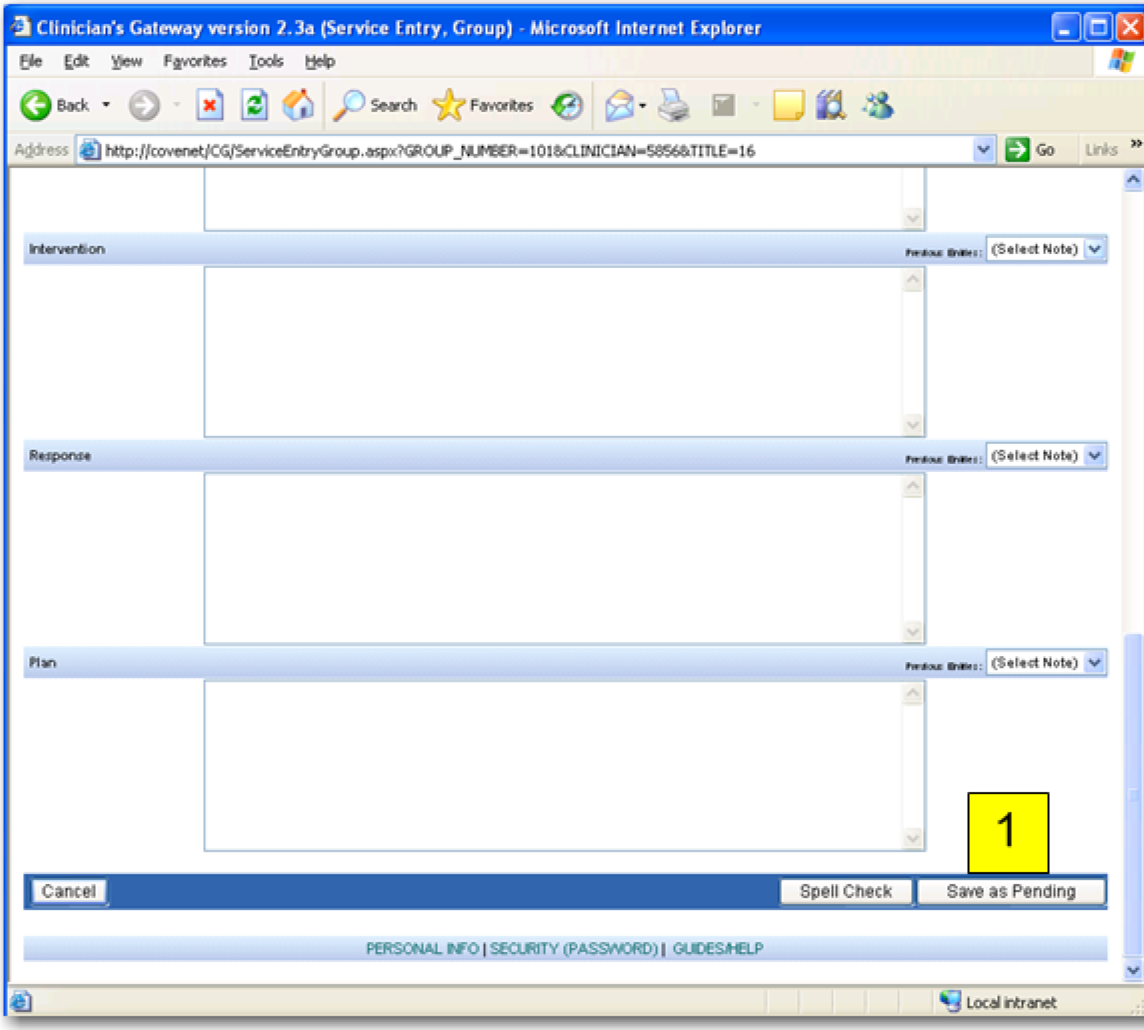
- Enter the number of additional participants (clients without open episodes)



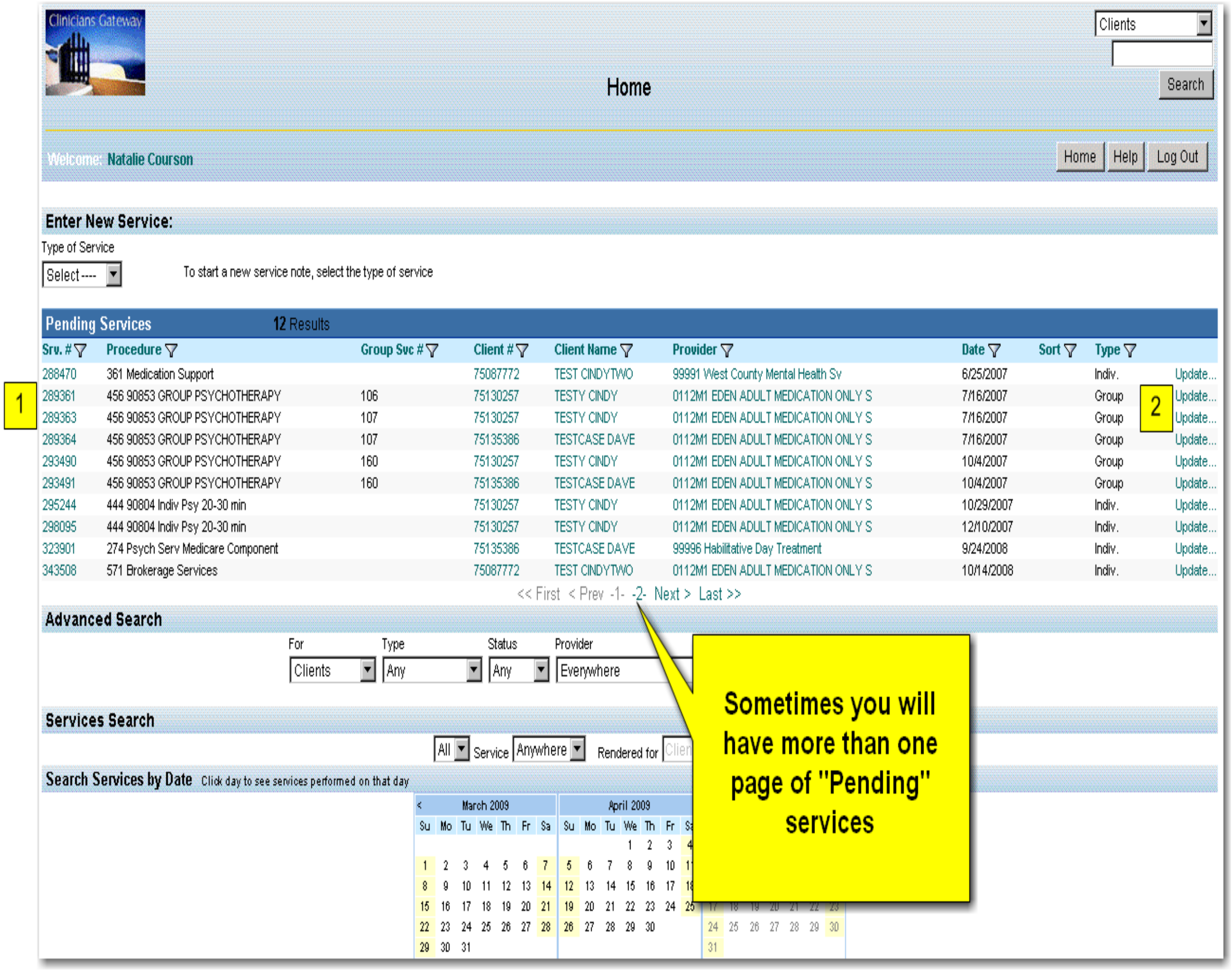
- Complete each text box as appropriate.



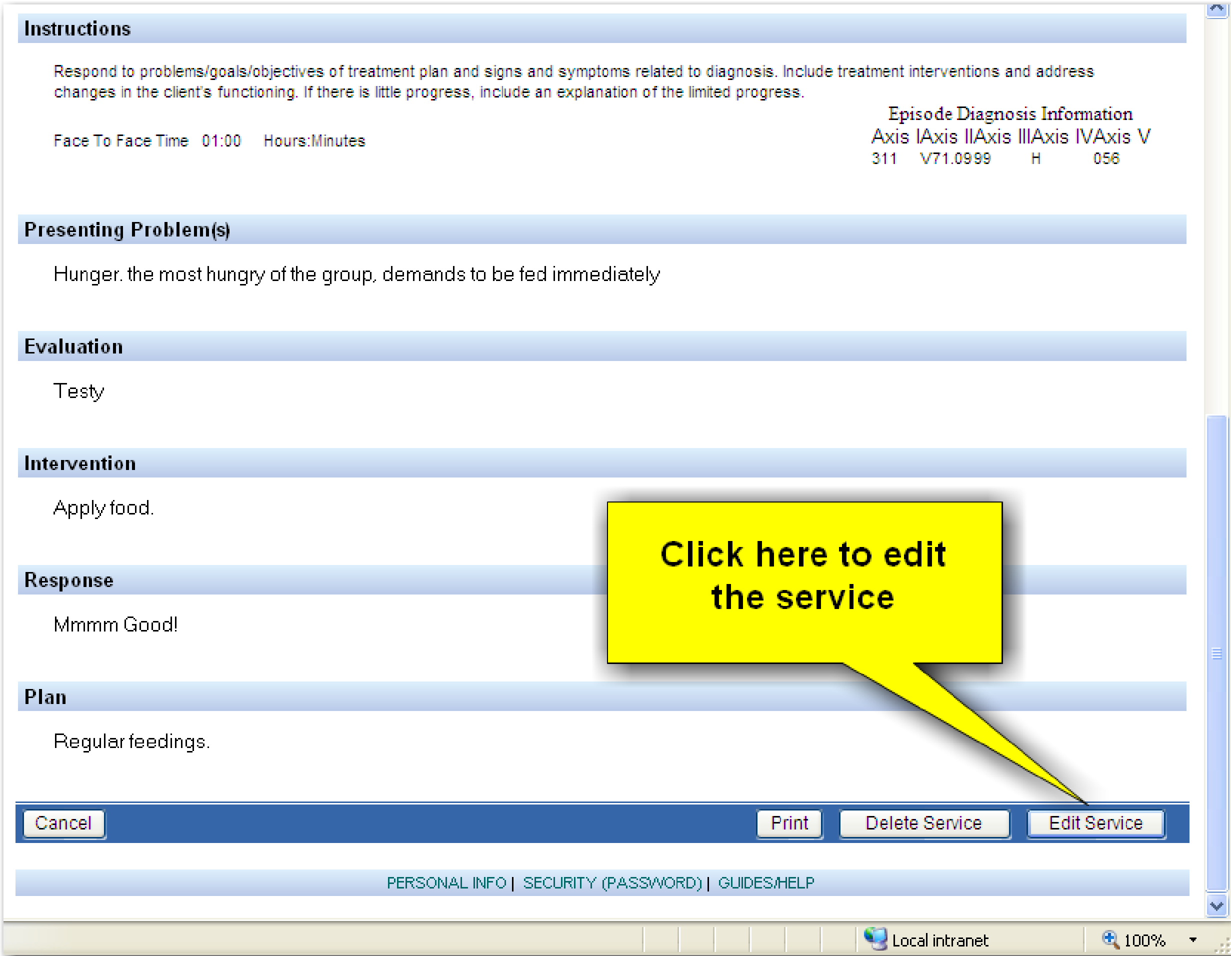
- View previous notes if desired.



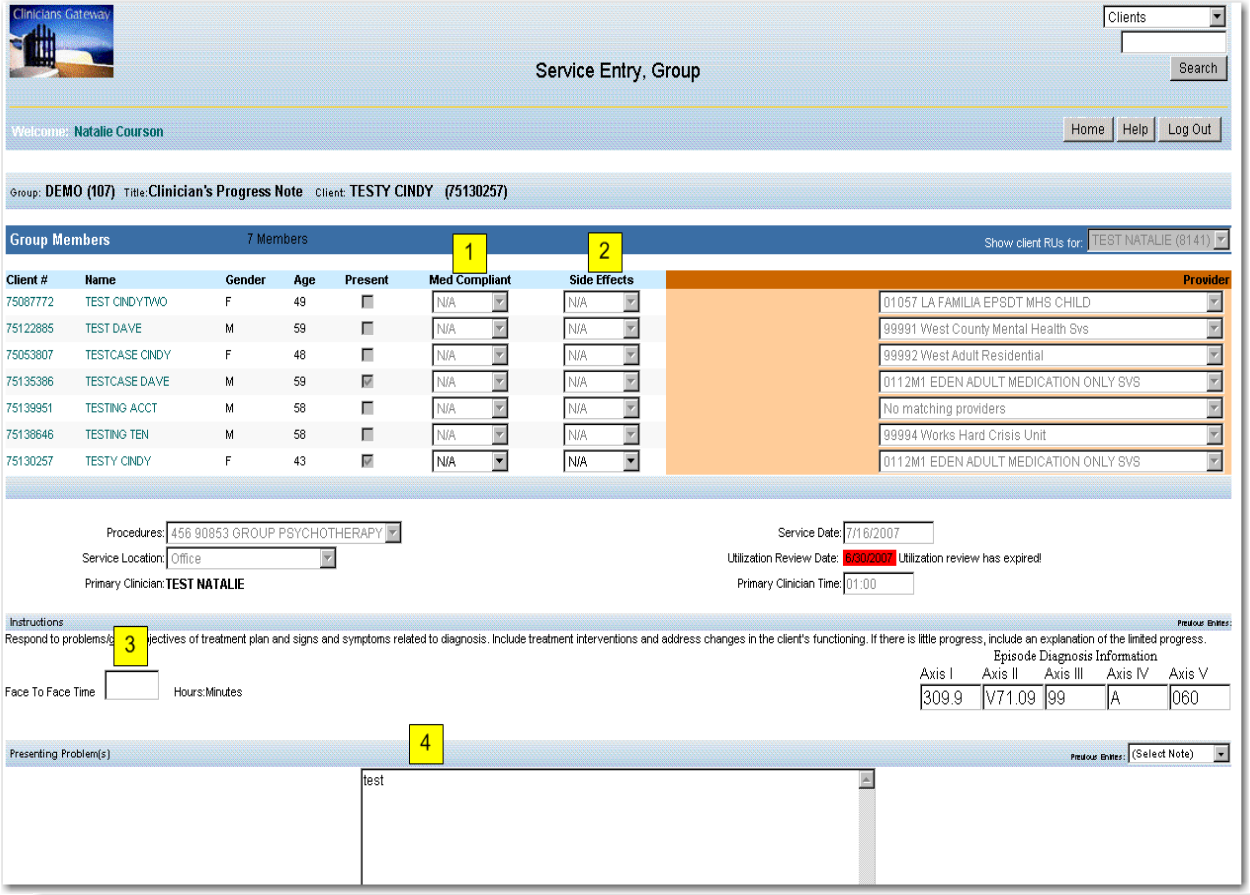
- **1** – When all of the fields have been completed click on the "Save as pending" button. (If your notes require review, refer to the notes review section of this users guide).

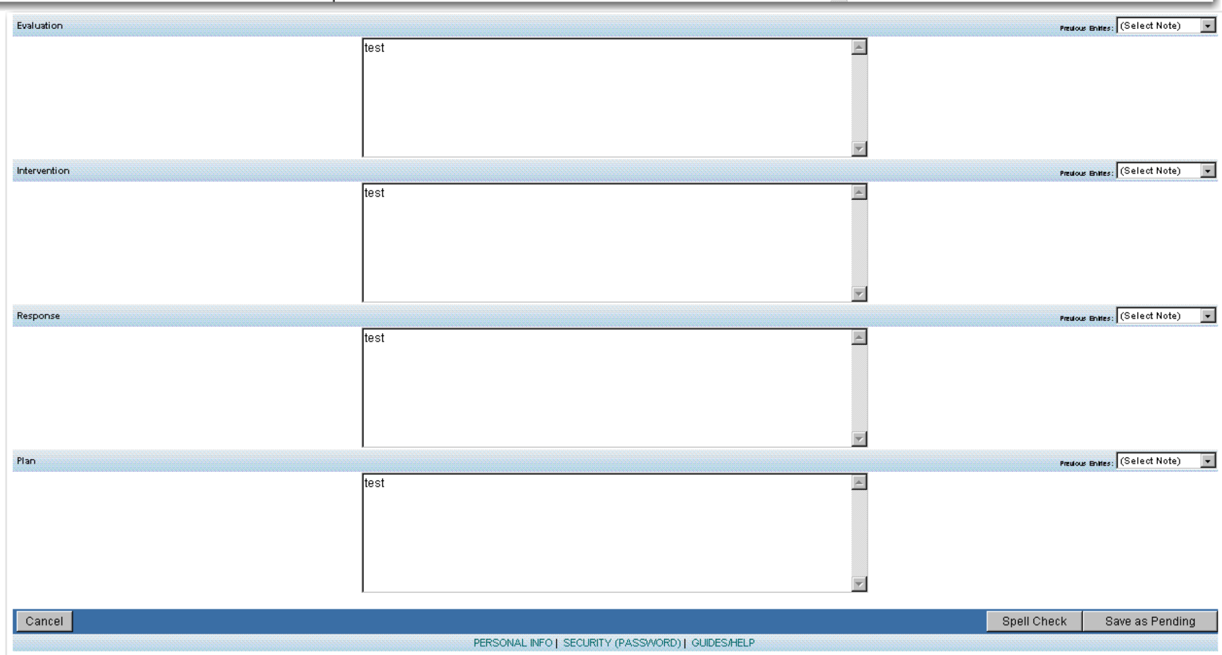


- **1**-You will see your group service listed in your Pending services.
- **2-**Click on “Update” to enter individual notes for each of the clients in the group.



On the next screen, click on "Edit Service" to add information for the client you have selected.





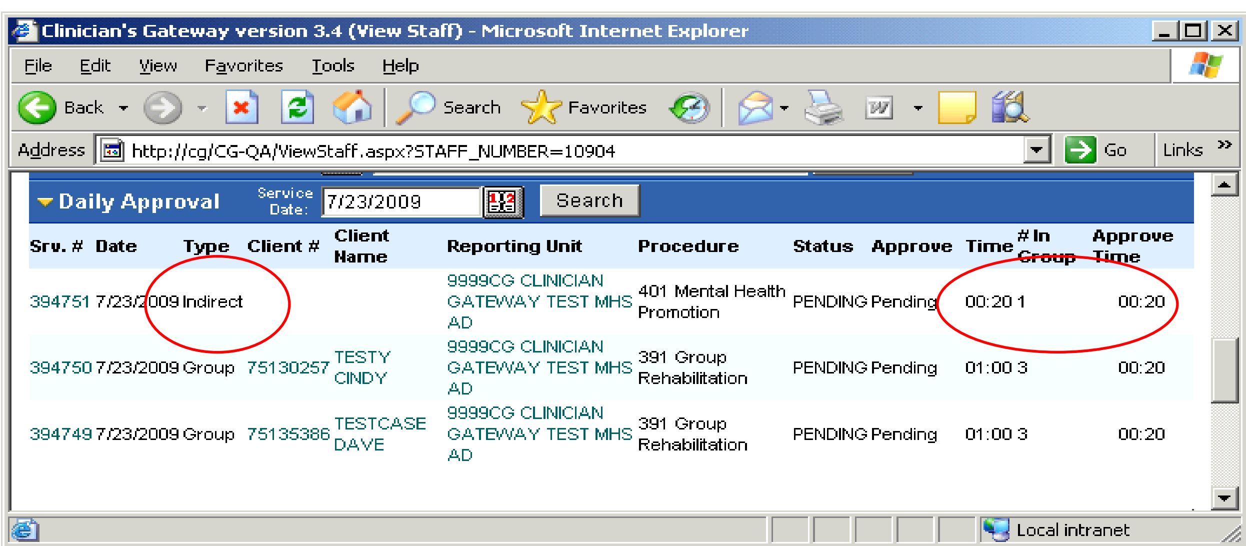
Now you can enter client specific notes for the group service. You will see that the (**1**) Med compliant and (**2**) Side effects drop lists can be utilized, (**3**) Face-to-Face time will need to be entered, and the (**4**)note fields can be used to enter additional information specific to that client.

Click on "Save as Pending" when your entries are completed.

Each individual service note will be listed separately on your Daily Staff Log.

Each service will be given part of the time, according to how many participants attended. If you gave services to clients who did not have an open episode, their time will not be added to your staff log. Write up their time as an indirect service.

To add the time to your Staff Log for the additional participants, write an indirect note for group time not given to opened clients listed on the Log.

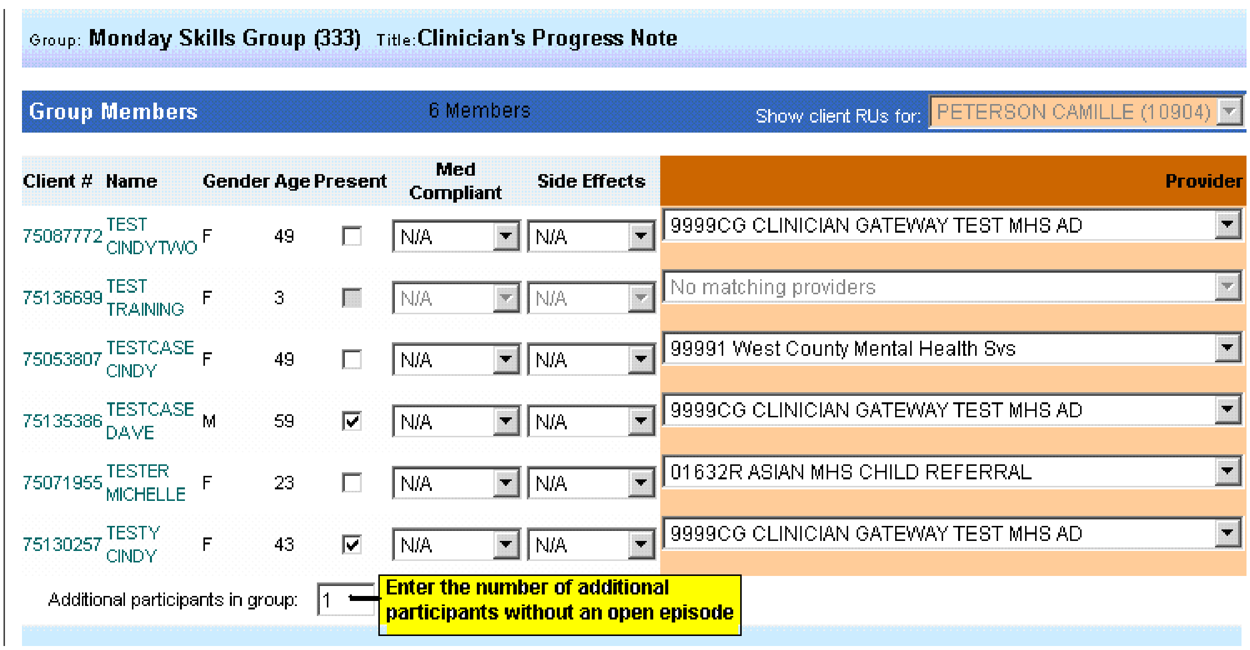


Additional Participants Feature

Occasionally, there will be a client in a group who does not have an open episode and cannot be claimed. Using the Additional Participants feature, the additional clients are added into the group total, increasing the accuracy of the claim for Medical billing. Only the part of the time dedicated to clients with open episodes is claimed. The remainder of the time can be reported using an Indirect service note for the clients without an open episode.

- Start the group note as usual. Click on the square box under the "Present" column for each open client in attendance. Verify the Reporting Units.

- **Enter the number of additional participants (clients without open episodes) into the "Additional Participants in group" field. CG will calculate the group total by adding the additional participants to the clients checked present.**



Group: **Monday Skills Group (333)** Title: **Clinician's Progress Note**

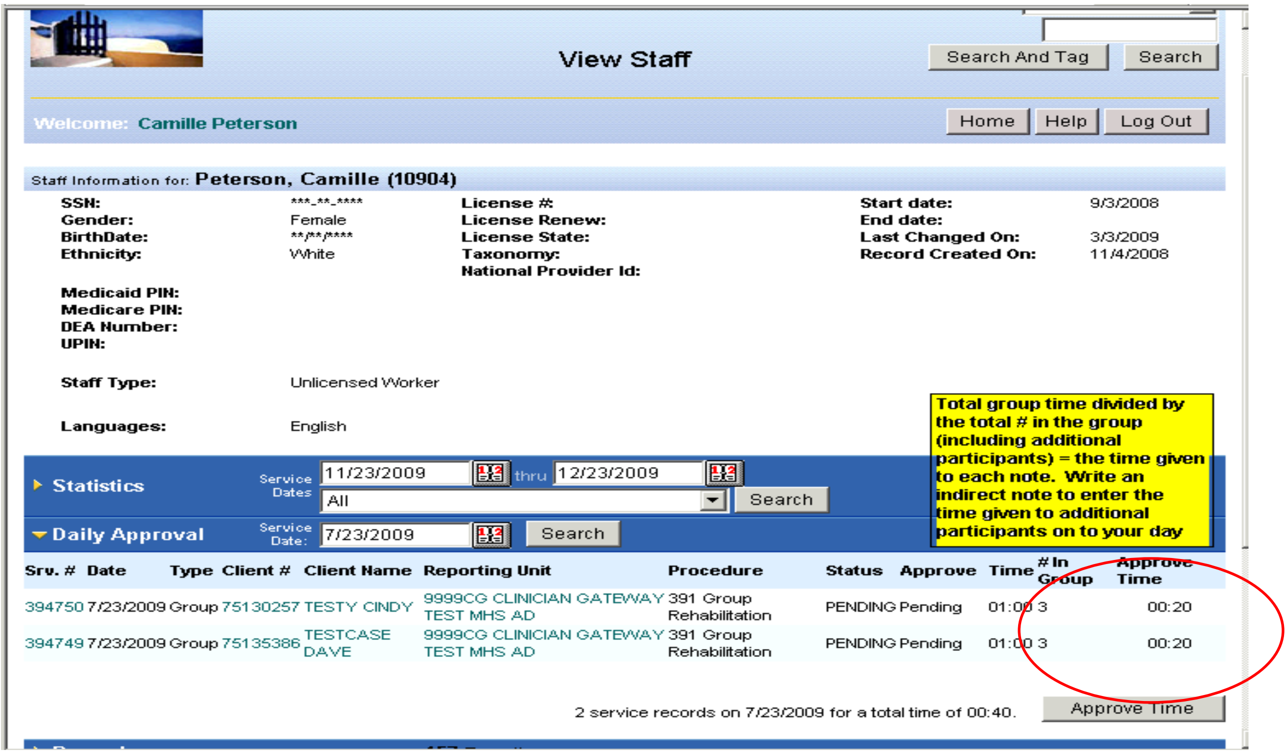
Group Members 6 Members Show client RUs for: PETERSON CAMILLE (10904)

Client #	Name	Gender	Age	Present	Med Compliant	Side Effects	Provider
75087772	TEST CINDYTWO	F	49	☐	N/A	N/A	9999CG CLINICIAN GATEWAY TEST MHS AD
75136699	TEST TRAINING	F	3	☐	N/A	N/A	No matching providers
75053807	TESTCASE CINDY	F	49	☐	N/A	N/A	99991 West County Mental Health Svs
75135386	TESTCASE DAVE	M	59	☑	N/A	N/A	9999CG CLINICIAN GATEWAY TEST MHS AD
75071955	TESTER MICHELLE	F	23	☐	N/A	N/A	01632R ASIAN MHS CHILD REFERRAL
75130257	TESTY CINDY	F	43	☑	N/A	N/A	9999CG CLINICIAN GATEWAY TEST MHS AD

Additional participants in group: 1

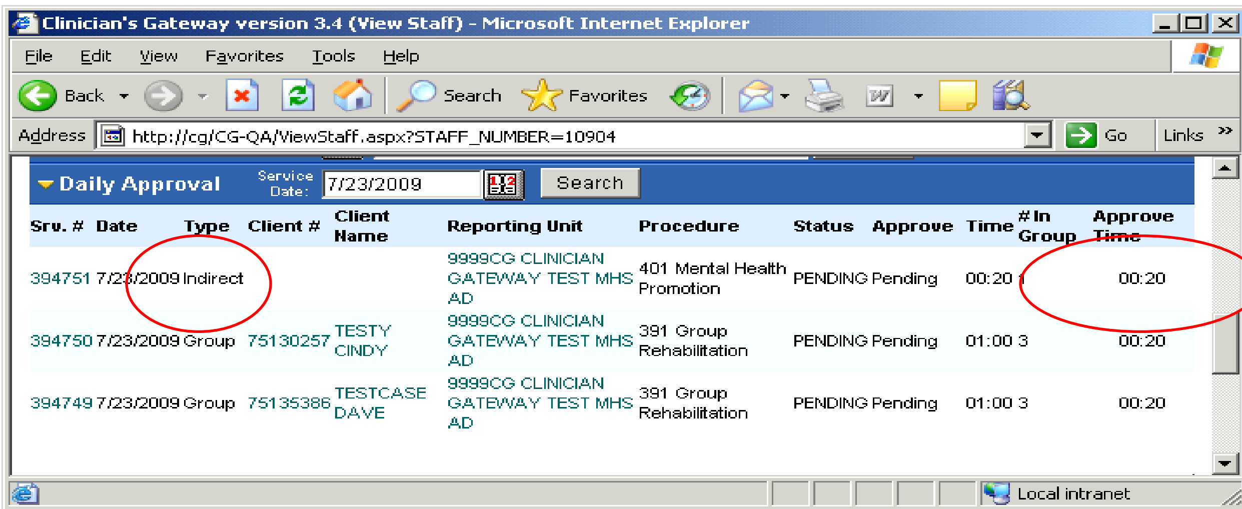
- Complete the group note and the individualizations as usual.

- Each individual service will be listed separately in Daily Approval.
- Each service will be given part of the total time, divided by how many total participants attended. (open clients plus additional participants)



- If you gave services to clients who did not have an open episode, their time will not be added to your staff log.

- To add the time to your Staff Log for the additional participants:
    - Write an indirect note.
    - Use an appropriate procedure code.
    - Use the amount of group time not given to opened clients already listed on your Daily Approval list and Staff Log.



The opened client's time plus the indirect time should equal your total group time. (In this example, 2 open clients at 20 minutes each, plus the indirect time for the unopened client at 20 minutes = 60 minutes total group

blank

Groups with Mixed Procedure Codes

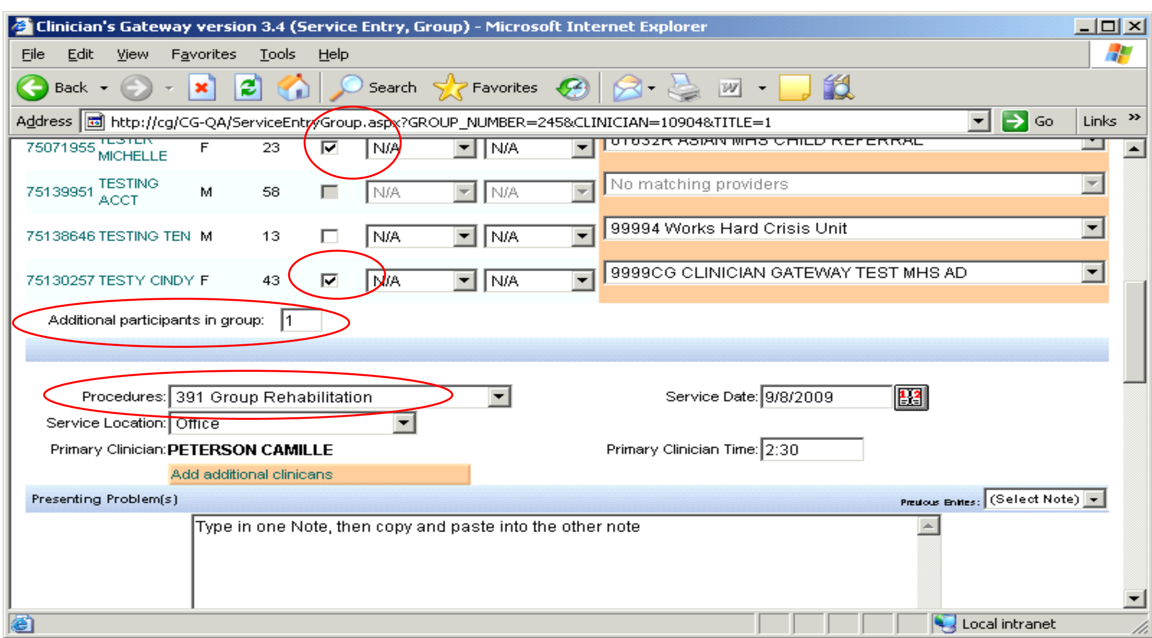
When different procedure codes are needed for individuals in a group such as an AB3632/non-AB3632 mixed group, the Additional Participants feature can be used to write group notes even when only one individual per code is present. The progress note will be in each client's electronic health record.

The note is written twice with each note having its correct procedure code. The clients who require the other procedure code are counted as "Additional Participants." CG will calculate the correct time for each individual.

For example: A group of three clients meets:

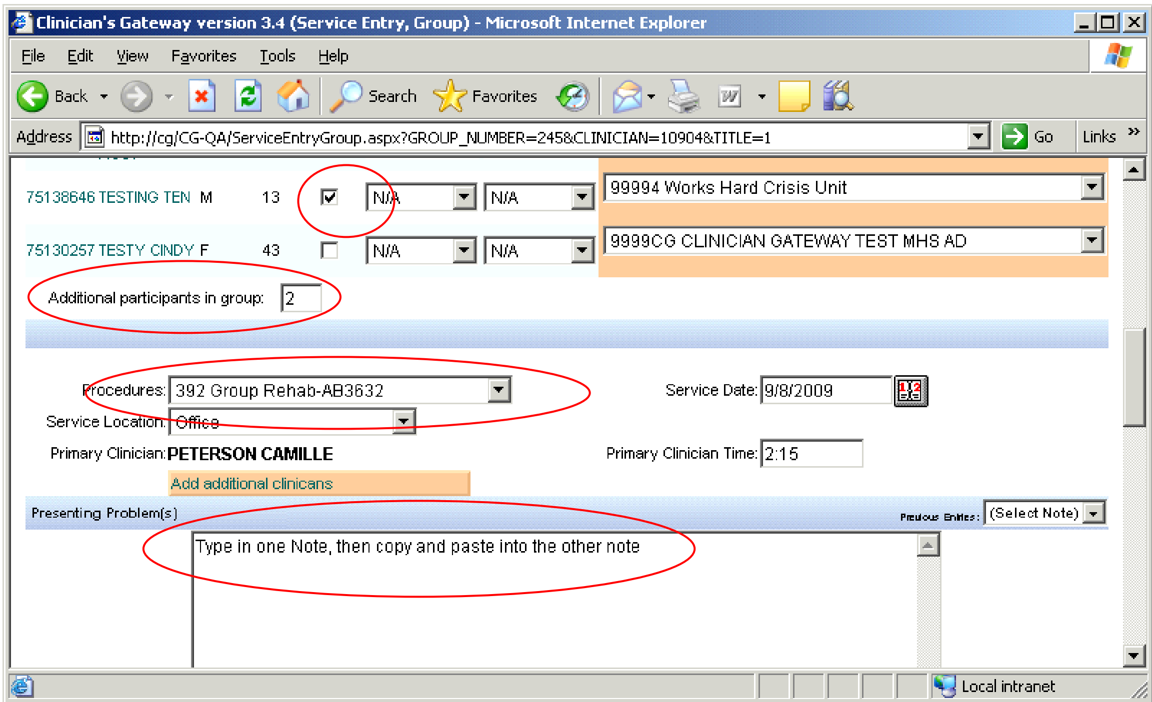
Two are not AB3632 eligible.
One is AB3632 eligible.

- Note One: Write the first note marking the two non-AB3632 clients present.
- Indicate that there is one additional participant (the AB3632 client) in the group.
- Use the non-AB3632 procedure code.



- CG will calculate that there are three total in the group and give 1/3rd of the time to each of these two clients).

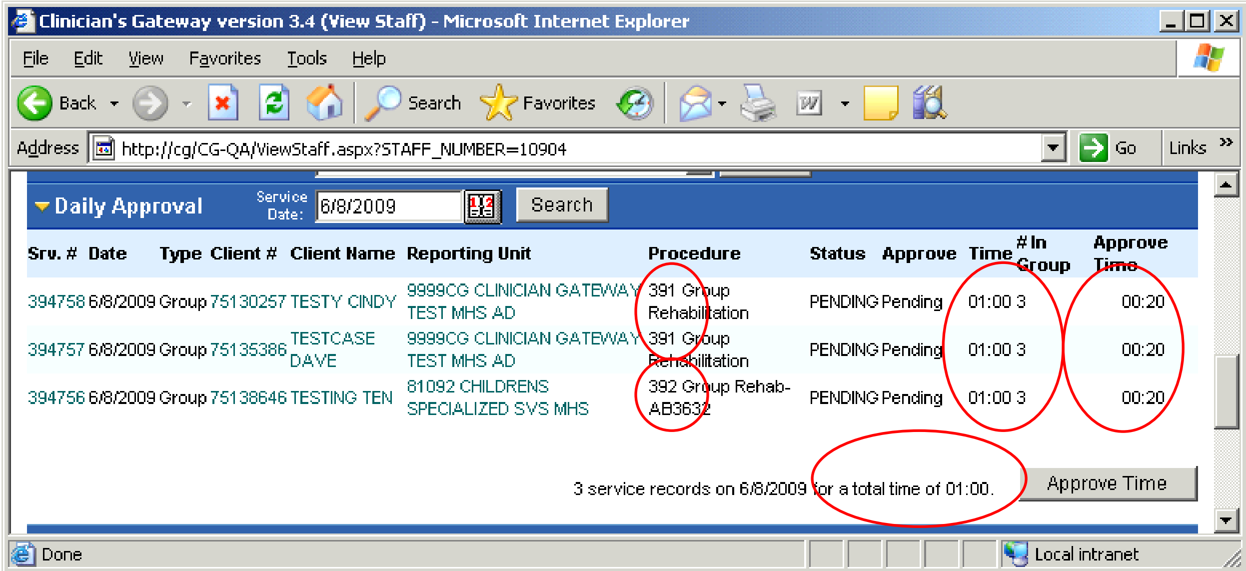
- Note Two: Write a second note marking the one AB3632 client present.
- Indicate that there are two additional participants (the non-AB3632 clients) in the group.
- Use the AB3632 procedure code.



- This client will also be given 1/3rd of the time.
- You can copy and paste the text from one note into the other. (You may want to open two sessions of CG and write these simultaneously.)

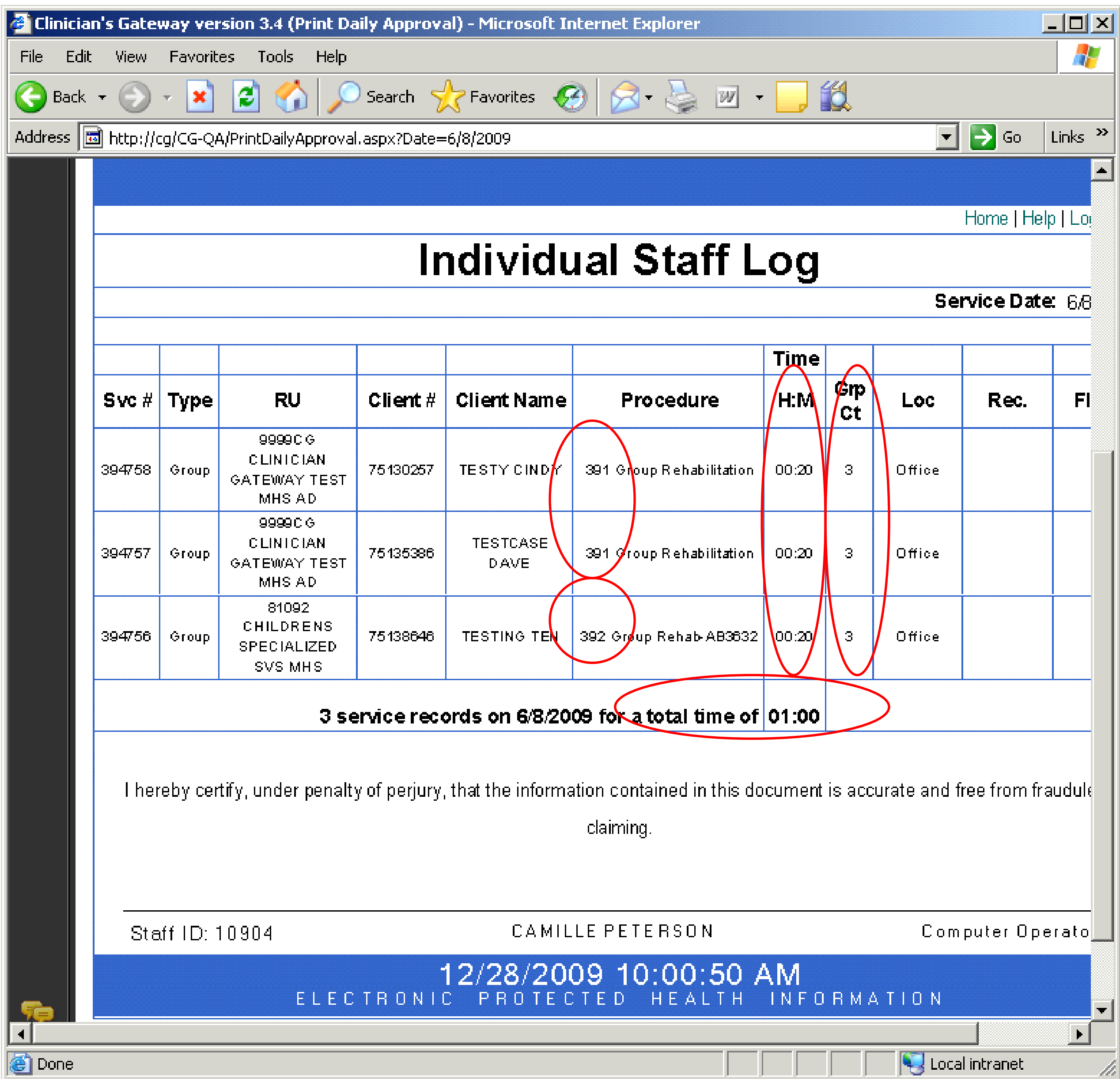
Make sure to write both notes!

Both notes will appear on the Daily Approval list and the Staff Log with the total time divided equally between all the attendees.


Clinician's Gateway version 3.4 (View Staff) - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://cg/CG-QA/ViewStaff.aspx?STAFF_NUMBER=10904
Go Links
Daily Approval
Service Date: 6/8/2009
Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve	Time	# In Group	Approve Time
394758	6/8/2009	Group	75130257	TESTY CINDY	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	3	00:20
394757	6/8/2009	Group	75135386	TESTCASE DAVE	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	3	00:20
394756	6/8/2009	Group	75138646	TESTING TEN	81092 CHILDRENS SPECIALIZED SVS MHS	392 Group Rehab-AB3632	PENDING	Pending	01:00	3	00:20

3 service records on 6/8/2009 for a total time of 01:00.
Approve Time
Done
Local intranet


Clinician's Gateway version 3.4 (Print Daily Approval) - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://cg/CG-QA/PrintDailyApproval.aspx?Date=6/8/2009
Go Links
Home | Help | Lo
Individual Staff Log
Service Date: 6/8

Svc #	Type	RU	Client #	Client Name	Procedure	Time H:M	Grp Ct	Loc	Rec.	Fl
394758	Group	9999CG CLINICIAN GATEWAY TEST MHS AD	75130257	TESTY CINDY	391 Group Rehabilitation	00:20	3	Office		
394757	Group	9999CG CLINICIAN GATEWAY TEST MHS AD	75135386	TESTCASE DAVE	391 Group Rehabilitation	00:20	3	Office		
394756	Group	81092 CHILDRENS SPECIALIZED SVS MHS	75138646	TESTING TEN	392 Group Rehab-AB3632	00:20	3	Office		

3 service records on 6/8/2009 for a total time of 01:00
I hereby certify, under penalty of perjury, that the information contained in this document is accurate and free from fraudule claiming.
Staff ID: 10904
CAMILLE PETERSON
Computer Operato
12/28/2009 10:00:50 AM
ELECTRONIC PROTECTED HEALTH INFORMATION
Done
Local intranet

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INDIRECT NOTES

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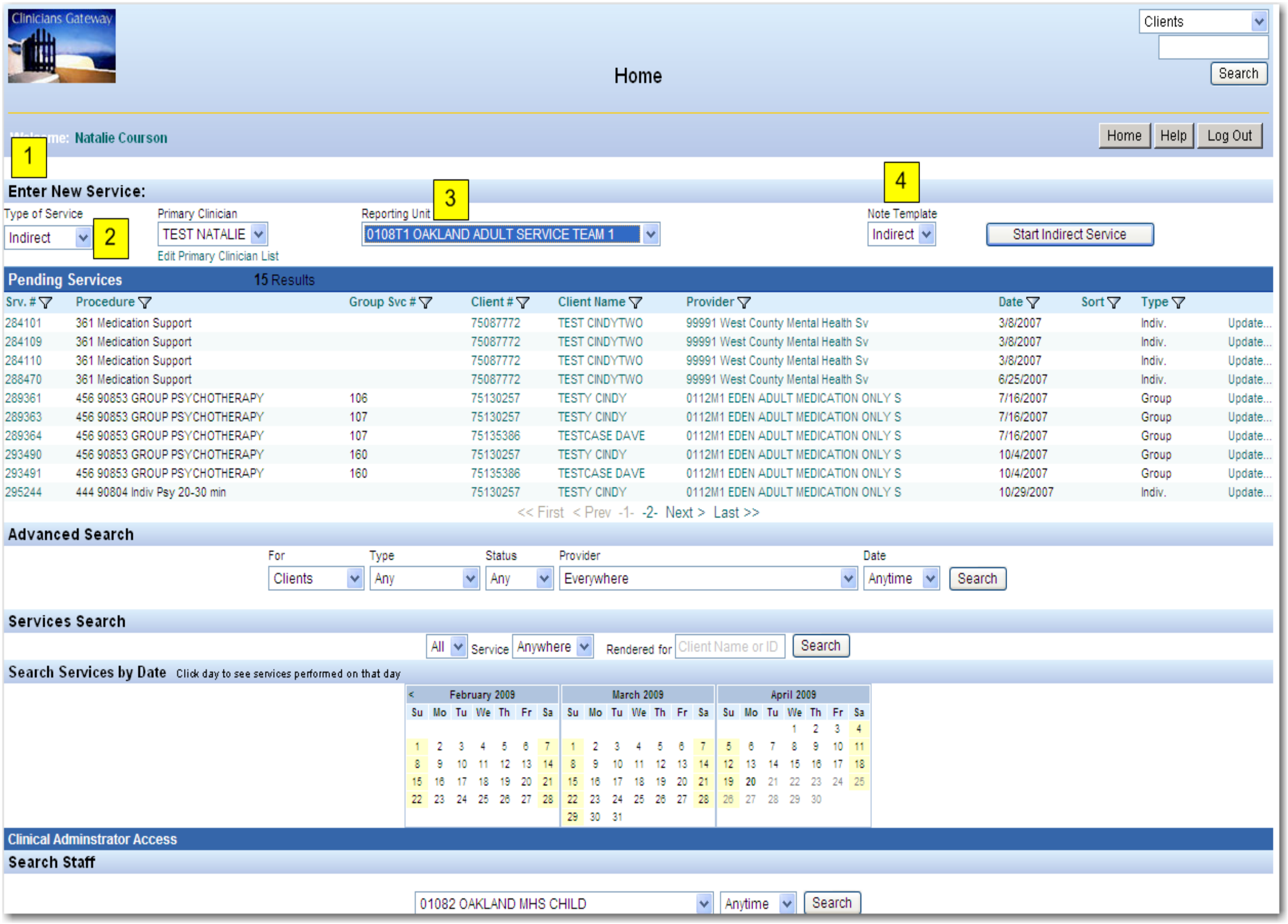
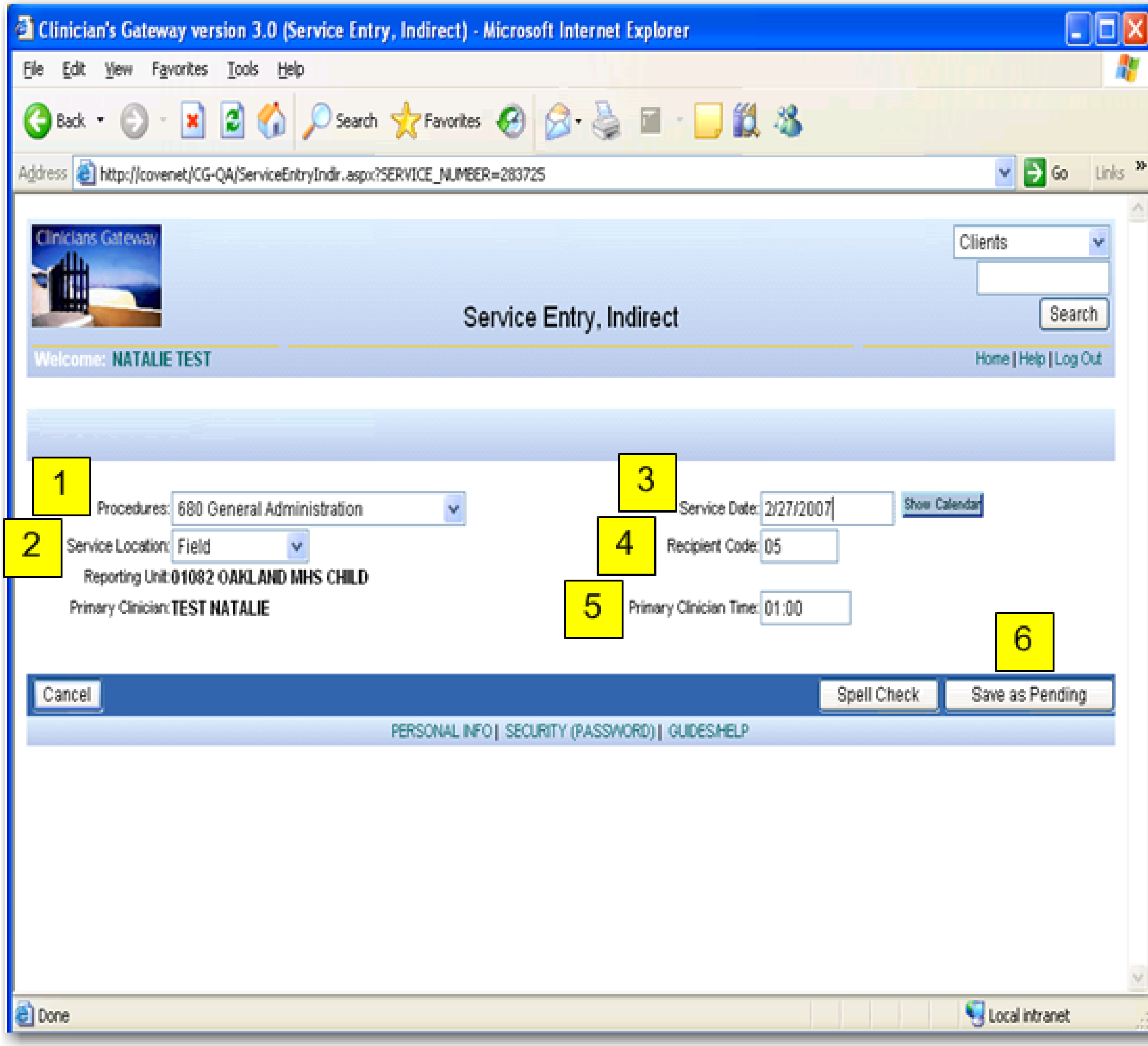
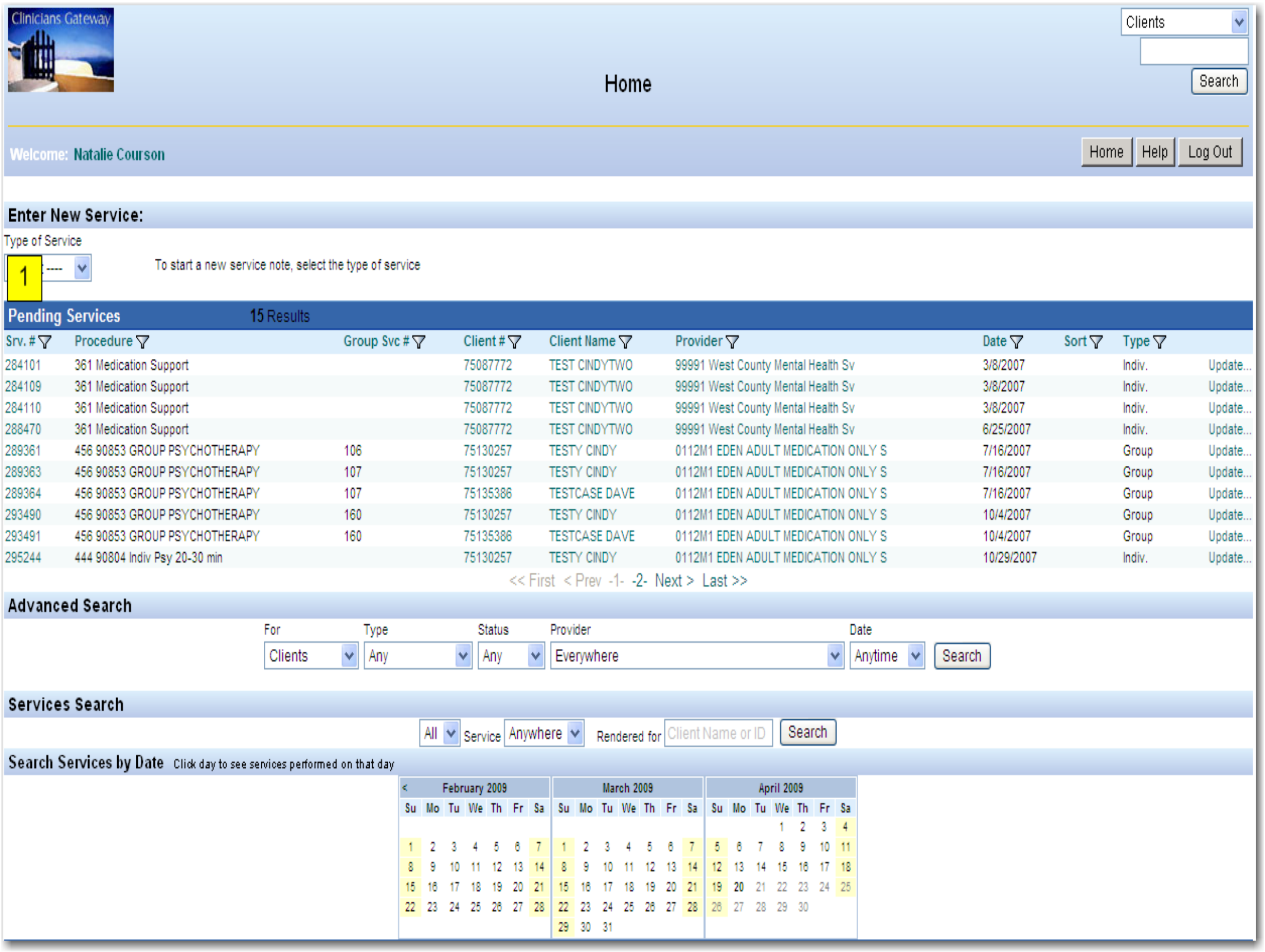
Indirect Notes



- **1** - From the "Enter new service" section, (**2**) click the "Type of service" drop arrow and select "Indirect"; (**3**) click the "Reporting unit" drop arrow and select the appropriate RU.
- **4** – Click on "Start indirect service."



- Select the appropriate procedure code (**1**), service location (**2**), Service date (**3**), Recipient code (**4**), and time (**5**).
- **6** – Click on "Save as pending."



- After you click "Save as pending" you will be returned to your "Home" screen, where you will see the pending services listed (**1**).

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INDIVIDUAL STAFF LOG FORM

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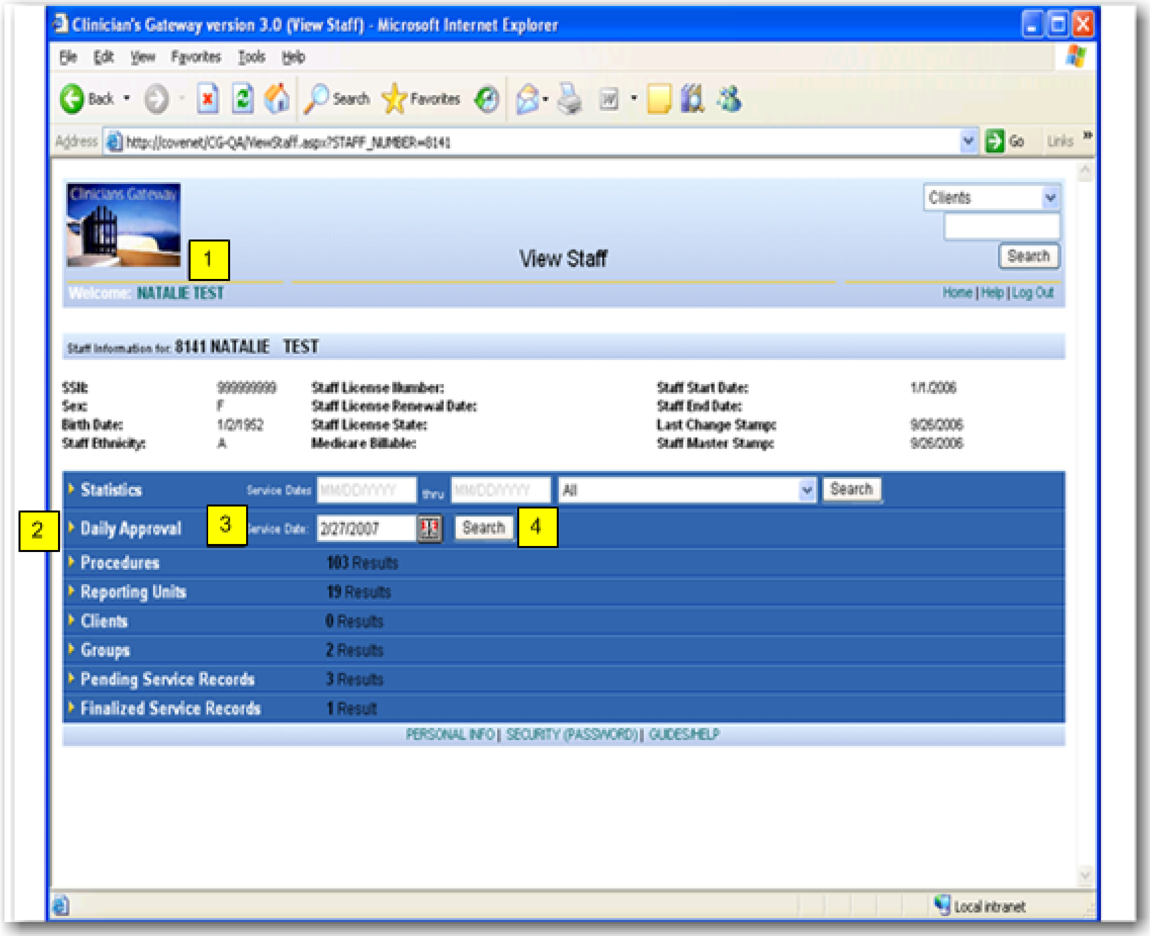
Approval printout



- **1** – From your home screen, click on your name to get the "View staff screen.

- **2** – In the daily approval section of the screen, enter the service date (**3**) for the staff log (MAA) you wish to create.

- **4** – Click on "Search."

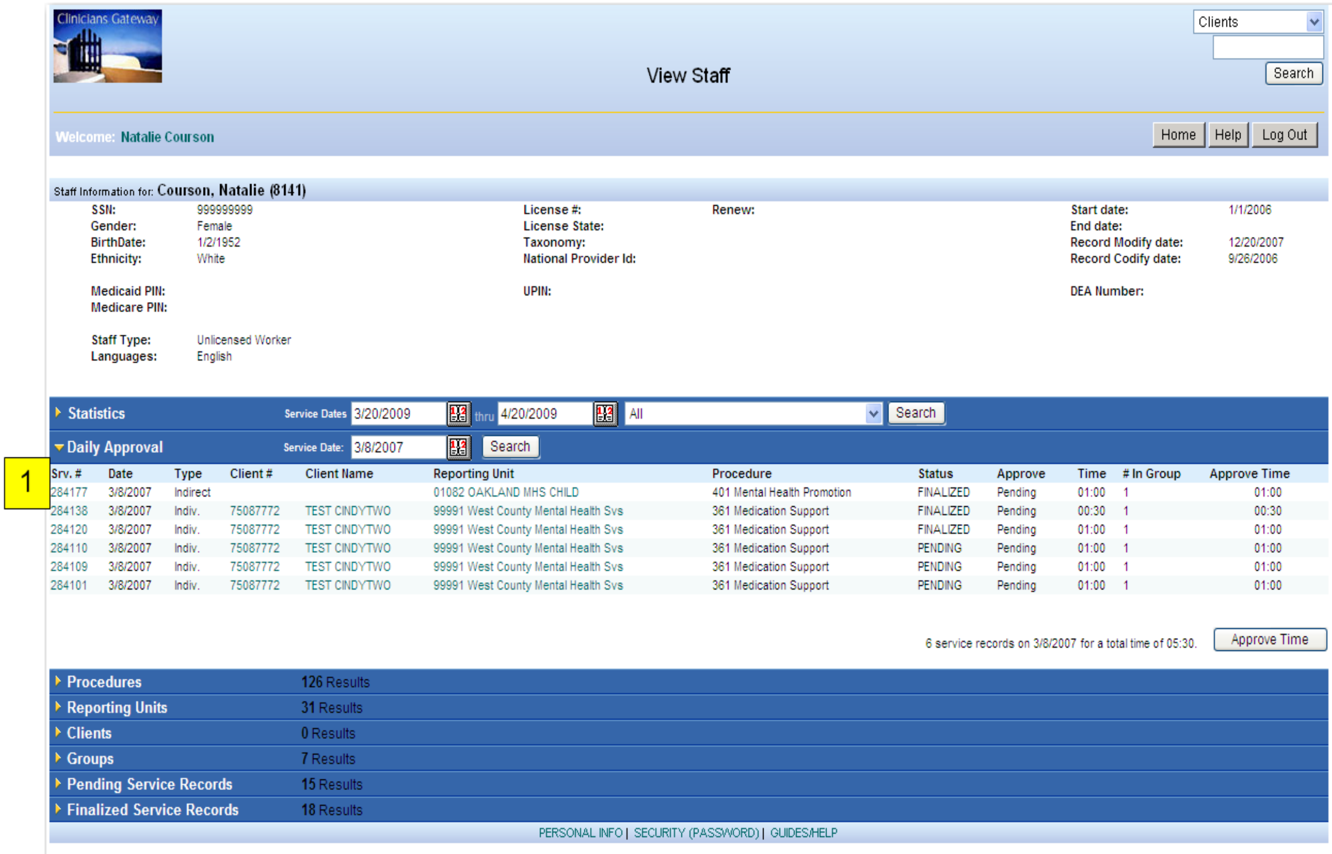
IMPORTANT!

It is very important that you review all of the information on the daily log before approving!

When you click on "APPROVE TIME", you are <u>finalizing</u> all of the services listed.

Finalized services cannot be changed!

IMPORTANT!

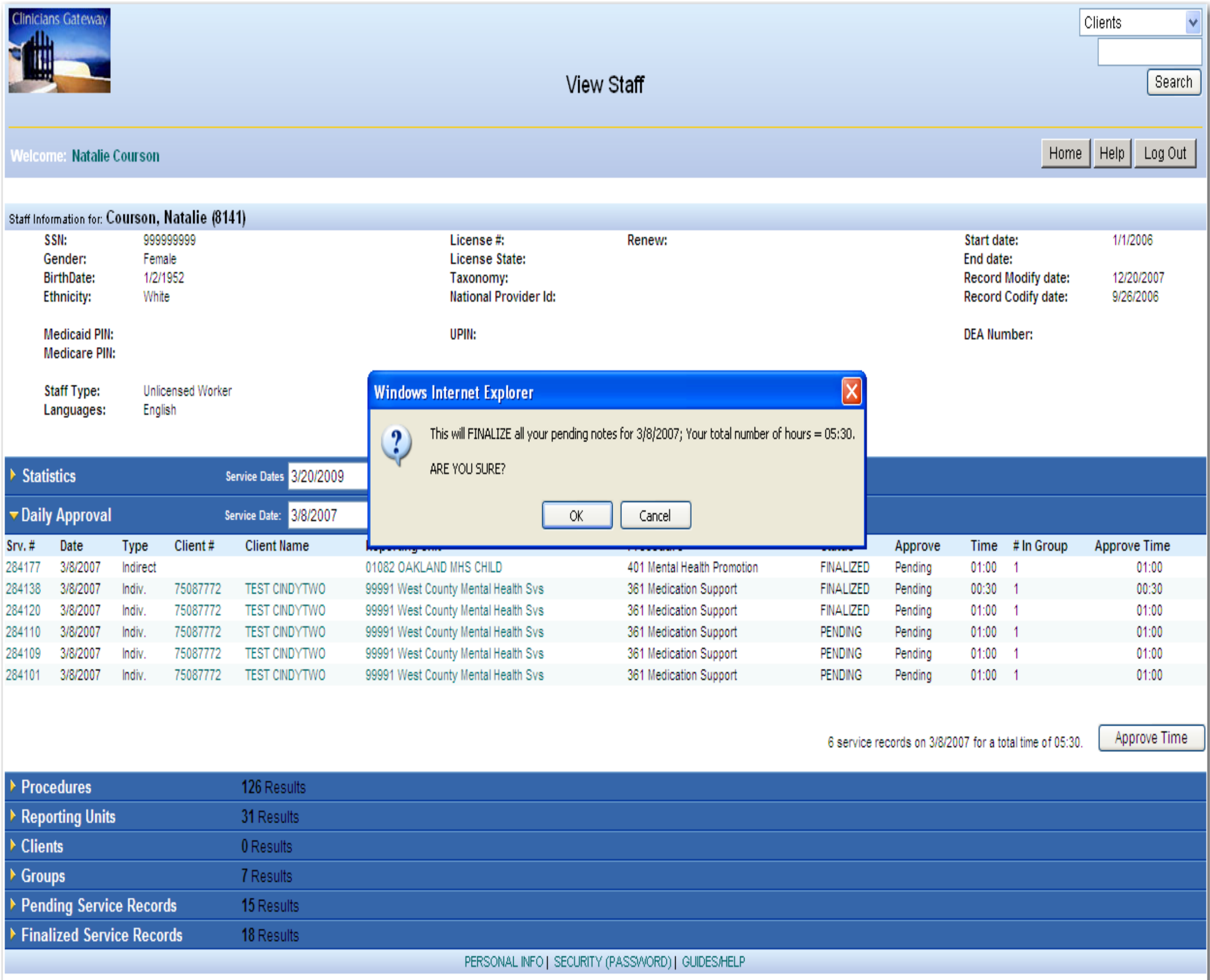


Please be sure to

REVIEW THE DAILY LOG BEFORE YOU CLICK ON "APPROVE TIME"

Once you click on "Approve Time," the Services are finalized.

- **1** - To edit any "Pending" note click on the "Srv. #"
  - Add any additional service to the log, click on "Home," and enter a new note.
  - Continue to repeat these steps until you are satisfied with the log----then click on the "Approve Time" button.

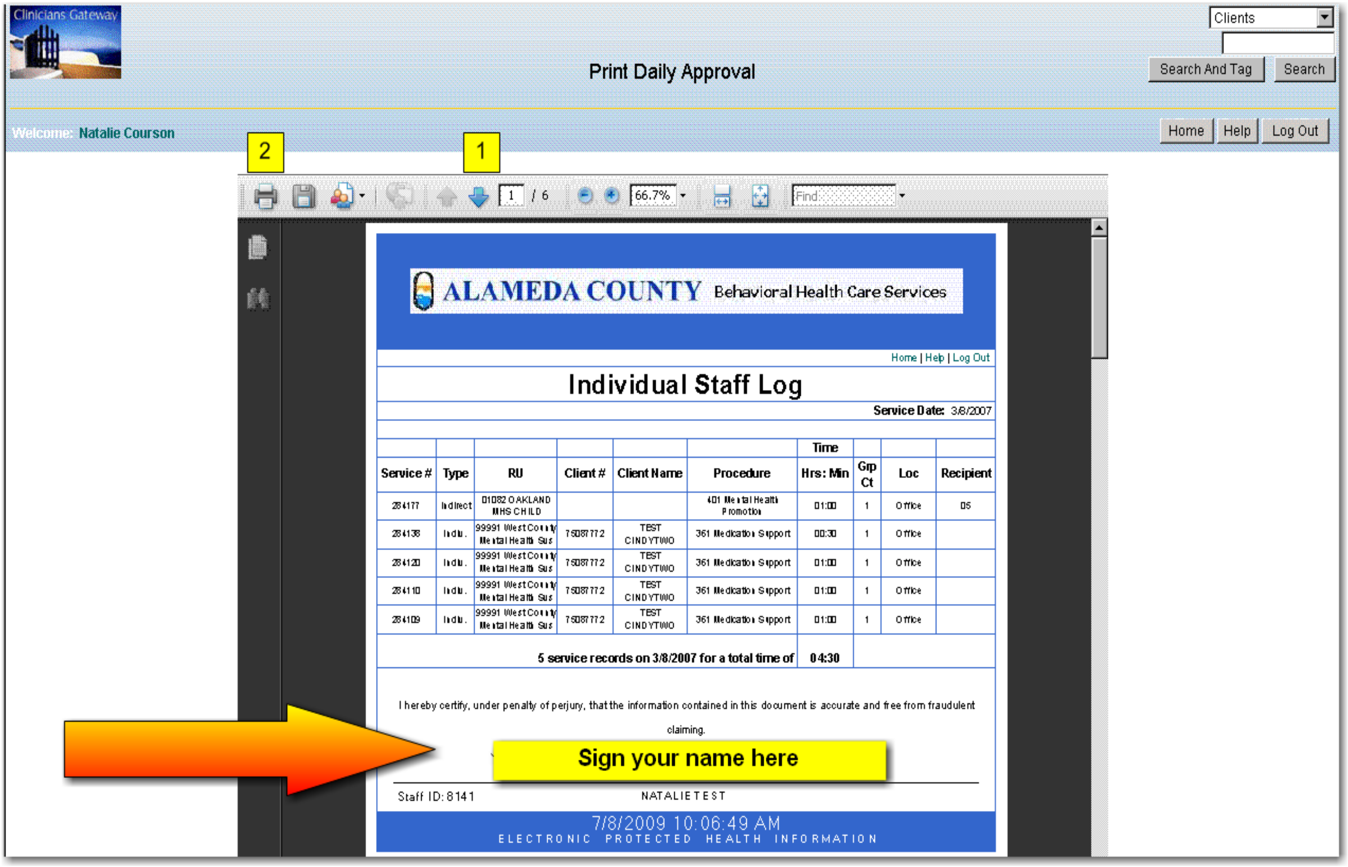


IMPORTANT!

REVIEW THE DAILY LOG BEFORE YOU CLICK ON "APPROVE TIME"

Once you click on "Approve Time," the service notes and log are finalized.

Service Notes are sealed with the clinician's Electronic Signature



1. Decide which pages to print using the blue arrows and page numbers.

2. Click on the printer icon – this will print the electronic Individual Staff Log form (MAA) as well as direct and indirect services.

3. You may specify which pages to print, eliminating unneeded pages.

All printed electronic Individual Staff Log (MAA) forms must be signed!

ALAMEDA COUNTY Behavioral Health Care Services

Home | Help | Log Out

Indirect		Service Number:	284177
		Service Date:	3/8/2007
		Recipient:	05
Provider:	01082 OAKLAND MHS CHILD	Location:	Office
Procedure:	401 Mental Health Promotion	Number in Group:	1
Primary Clinician:	8141 NATALIE TEST	Staff Time:	1 hr(s). 0 min(s).

Electronic signature on file

Staff ID 8141 NATALIE TEST Info Systems Analyst - Operations Manager

4/20/2009 3:08:32 PM
ELECTRONIC PROTECTED HEALTH INFORMATION

ALAMEDA COUNTY Behavioral Health Care Services

Home | Help | Log Out

Clinician's Progress Note		Service Number:	284138		
		Service Date:	3/8/2007		
Provider:	99991 West County Mental Health Svs	Location:	Office		
Procedure:	361 Medication Support	Number in Group:	1		
Client:	75087772 TEST CINDYTWO	Med Compliant?	N/A	Side Effects?	N/A
Primary Clinician:	8141 NATALIE TEST	Staff Time:	0 hr(s).	30 min(s).	
Instructions		Record Stamp:	3/8/2007 1:52:41 PM		

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Face To Face Time 0 Hours:Minutes

Episode Diagnosis Information

Axis I	Axis II	Axis III	Axis IV	Axis V
296.60	V71.09	99	A	099

Presenting Problem(s)

test

Evaluation

test

Intervention

test

Response

test

Plan

test

Electronic signature on file

Staff ID 8141 NATALIE TEST Info Systems Analyst - Operations Manager

TEST CINDYTWO (75087772) 4/20/2009 3:08:32 PM
ELECTRONIC PROTECTED HEALTH INFORMATION

PRINTING

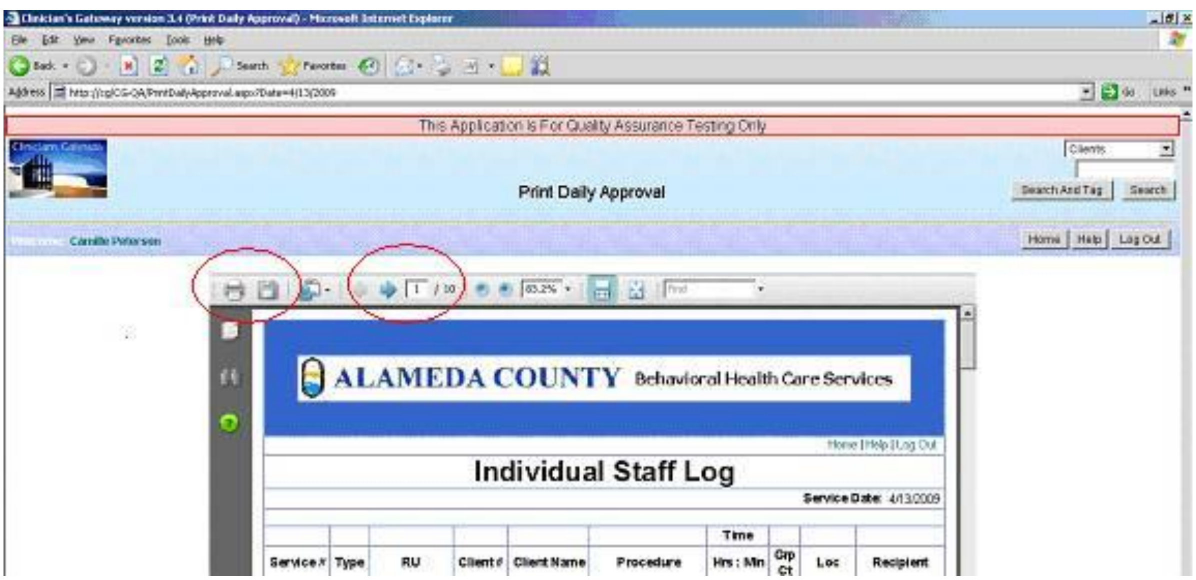
blank

Printing from Daily Approval

To print your Staff Log and progress notes after Daily Approval, use the printer icon and blue arrows above and adjacent to their images. (Circled below) Do not use File/Print

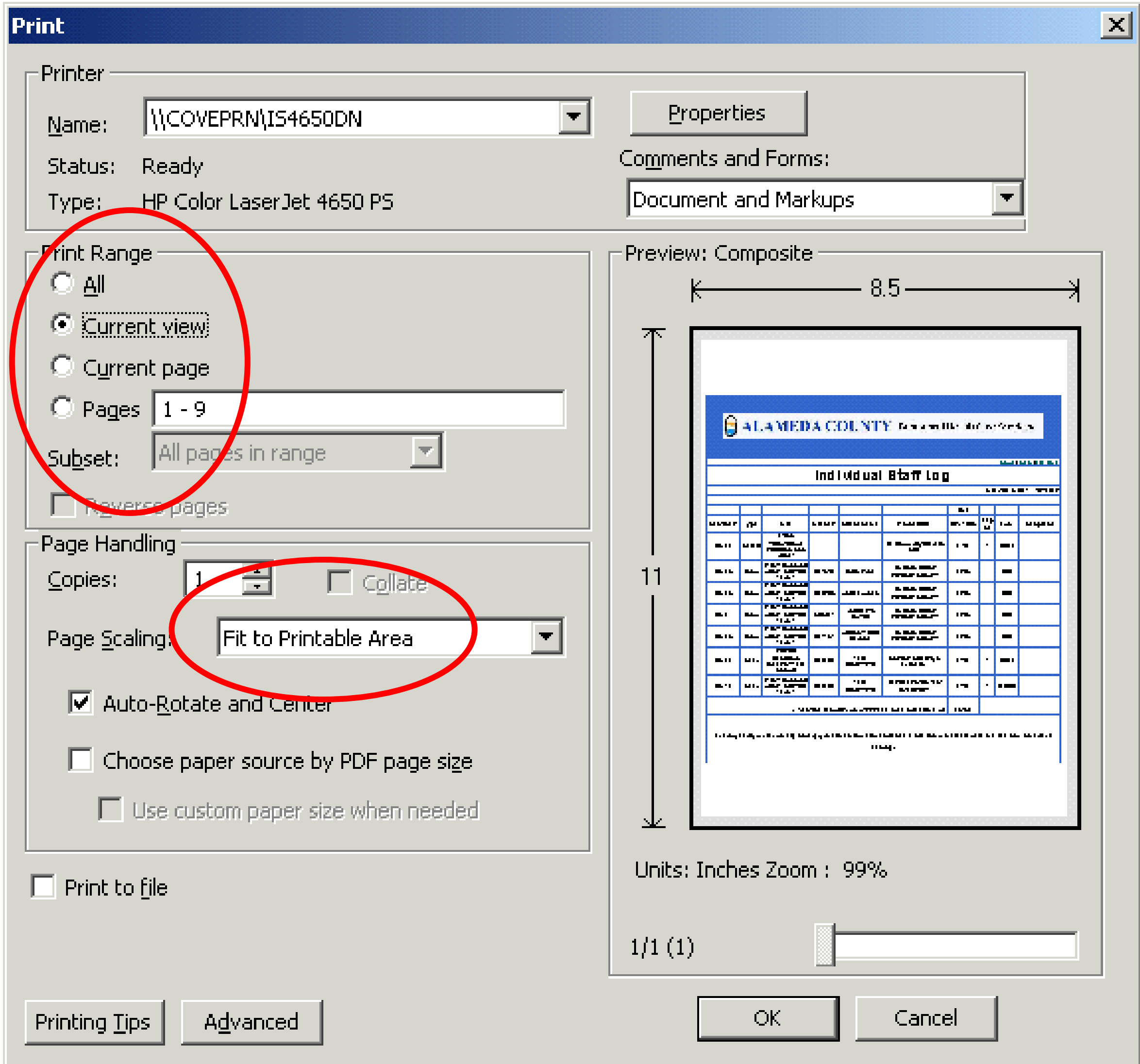
- First, decide which pages to print. Use the set of blue arrow icons and page numbers (circled in red below) located above the staff log to navigate through the pages.

- Then use the printer icon (also circled in red) to bring up the printing menu.

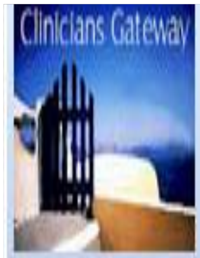


- Use the printing menu to designate which pages to print.

After clicking the Print icon next to the Staff Log image, choose the pages you wish to print in the Print Range box. The Staff Log will be the first page.



- Designate the pages you wish to print.
- Check that the page scaling is set to “Fit to Printable Area.” If not the outer edges of the document may be cut off.

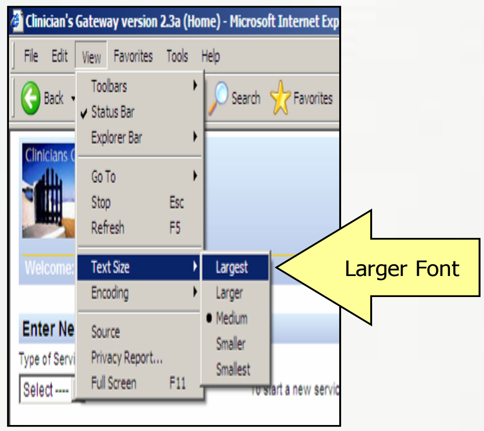


Gateway Tips

Here are some special Tips to help you to get the full benefits from Clinician's Gateway.

Creating a Larger Font for Viewing on Screen and for Printing…

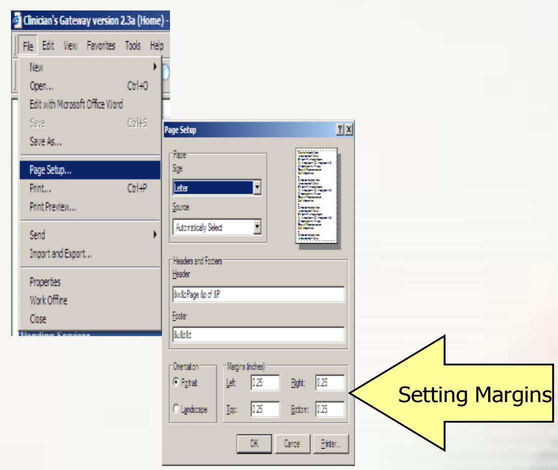
•In Internet Explorer, you can set the Font Size Larger by selecting "View-Font Size-Largest" on the Menu Bar. This feature may need to be reset whenever you login to your PC.



Setting Margins so all the Information is Displayed when Printing…

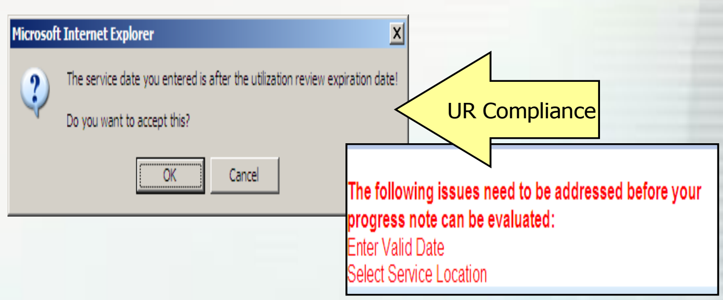
•In Internet Explorer, you can change your Margins by selecting "File-Page Setup", change the Left=0.25, Right=0.25, Top=0.25, and Bottom-0.25. This feature should stay once it is set.

•The Header is needed to print client info on the OLPN



UTILIZATION REVIEW..

•It is very important that you keep all Client Record in Compliance. When ever you see the Utilization Review up-to-date. Make sure your Client Assessments and Service/Treatment Plans are completed in a timely manner.



Have Questions? Need Help? Contact your Administrative Support Person.

v1.0
2/13/2009

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DELETING NOTES

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- Are there any requirements for having a note deleted?
  - Yes. If an error is made to any billing information, the note has to be deleted from VAX and redone by the clinician/physician in Clinician's Gateway. We can not modify any notes that have been finalized. Notes are deleted **ONLY** if there is an error in any of the billing information such as:.
    - Wrong client number
    - Wrong staff number
    - Wrong procedure code
    - Wrong reporting unit
    - Wrong service hours
    - Wrong service date
    - Wrong treatment location
    - Wrong number of clients in group
  - Incorrect text is **NOT** an acceptable reason for deleting electronic notes.

- What do I do to get my note deleted?

  If it is before 4p.m. on the day that the note has been finalized:
  - Print the note out and write "DELETE" diagonally across the middle of the page
  - Write the reason for deletion (from list above) on the Request to Delete CG Note.
  - FAX the note & Request form immediately to the IS Dept. at (510) 567-8161
  - Contact the helpdesk via phone at (510) 567-8181 (tie line 38181) to inform them that a "Clinician's Gateway Same Day Delete" has been faxed.

  If it is after 4p.m. of the day that the note has been finalized:
  - Print the note out and write "DELETE" diagonally across the middle of the page
  - Write the reason for deletion (from list above) on the Request to Delete CG Note.
  - Have the designated staff person in your office delete the InSyst Service Record and complete the middle section on the Request to Delete CG Note
  - FAX the note & Request form immediately to the IS Dept. at (510) 567-8161

Be sure to fax delete requests as soon as an error is discovered. If notes are faxed after the service has been claimed, the note cannot be deleted.

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ALAMEDA COUNTY Behavioral Health Care Services

Request to Delete Clinician's Gateway Note

CG Service Number: ______________________ Service Date: ______________________

Service RU: ______________________ Clinician Staff Number: ______________________

Clinician Name: ______________________ Signature: ______________________

Reason: ____

This is a: ☐ Same-Day Delete ☐ NON Same-Day Delete ☐ Already Claimed Delete-Contact Prov. Reln.

NOTE: This deletion will affect the total hours on your Individual Staff Log (MAA form). If you have already printed the form, you need make any corrections necessary and reprint the form.

<u>Use For "NON Same-Day" or "Already Claimed" deletes only:</u>
(To be completed by staff who are deleting the InSyst service record or requesting deletion of an already claimed service. Fill in *<u>one</u>* date below.)

InSyst Service Delete Date: ______________________

Provider Relations Contact Date: (date Provider Relations was asked to reverse already claimed service) ______________________

Staff Name: ______________________

Signature: ______________________

INSTRUCTIONS:

Please fill out a separate form for each service delete requested. There are three kinds of deletes, **Same-Day, NON-Same-Day,** and **Already Claimed** deletes. A **Same-Day** delete is for a service that was **FINALIZED TODAY** and can only be done before the 5 PM transfer from CG to InSyst. A **NON Same-Day** delete is for a service that was **FINALIZED** before today, and has **TRANSFERRED** to InSyst. **Already Claimed** Deletes are for services that have already been claimed. Contact Provider Relations to begin the process of reversing the claim before asking the Help Desk to delete the note. If a note has not been finalized and is still pending, the Help Desk cannot delete it, you must delete it yourself.

If this is a **Same-Day** delete, call the Help Desk **immediately** at 3-8181 or 510-567-8181 so that the service can be deleted from Clinician's Gateway before it is transferred to InSyst. Note that the Help Desk closes at 4:30 PM.

1. Print out **the first page** of the note you want deleted.
2. Draw a diagonal line across the note.
3. Write "Please delete this note" and the reason for the deletion.
4. If you have printed any copies of the note that have gone into the client's chart, be sure to mark on the note that it has been deleted from the system, but do not remove from chart.
5. Sign the note. If this is a **Same-Day** delete, skip to step 8.
6. Give the note and this form to the proper staff to either delete the service from InSyst or contact Provider Relations.
7. Responsible staff should sign and date this form that the service was deleted or Provider Relations was contacted.
8. Fax this form and a copy of the note to IS at 3-8161 or 567-8161.

For IS Use ONLY

Log # ______________ Date deleted: ______________ Name: ______________

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CONSUMER/CLIENT LIFE PLAN
TREATMENT PLAN

blank

Consumer/Client Life Plan, Treatment Plan

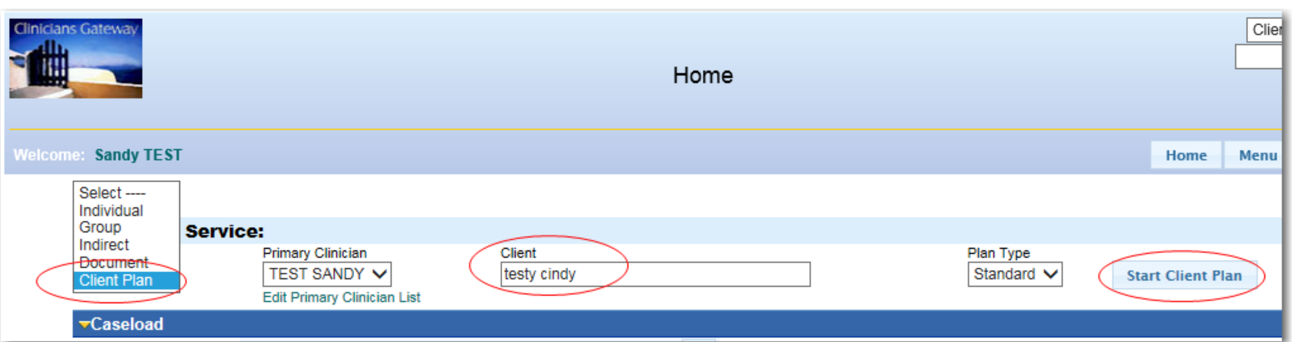
The **electronic treatment plan** in Clinician's Gateway is based on the principles of Wellness, Recovery and Resilience with family, client and consumer involvement while also addressing the need to establish medical necessity for treatment.

The Consumer/Client Life Plan consists of two main sections: the Medical Necessity documentation and the Client Plan. Throughout the Plan, some items will be brought forward for reference, such as Risks and Needs to address, and Goals and Objectives to reference.

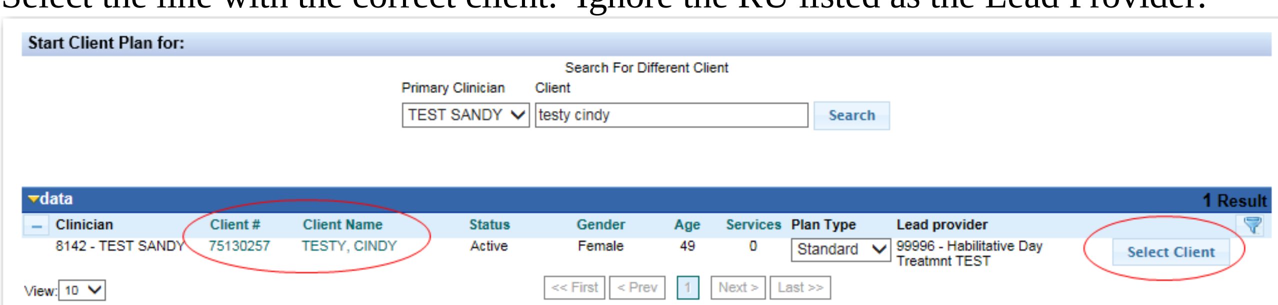
The **GENERAL PROCEDURE** is:

1. Write the Plan (using correct RU and End Dates to match InSyst).
2. Submit for approvals by licensed, supervisor and medical staff as needed.
3. **Obtain approvals** in Clinician's Gateway.
4. Print for Client Signature. (after submitting for approval the Plan doesn't say "Pending")
5. Add the client signature date in CG.
6. Finalize the Plan.
7. Submit the all the required Annual Documents with the Approved Treatment Plan signed by the client to supervisorial staff.
8. Support staff enters Plan approval into InSyst and scans the entire plan.
9. "Edit" the Plan when objectives are achieved. Minor edits are allowed without re-approval.
10. Revise and obtain new signatures/approvals as needed during the plan year.
11. Renew the Plan at the end of every year for the next year as needed.

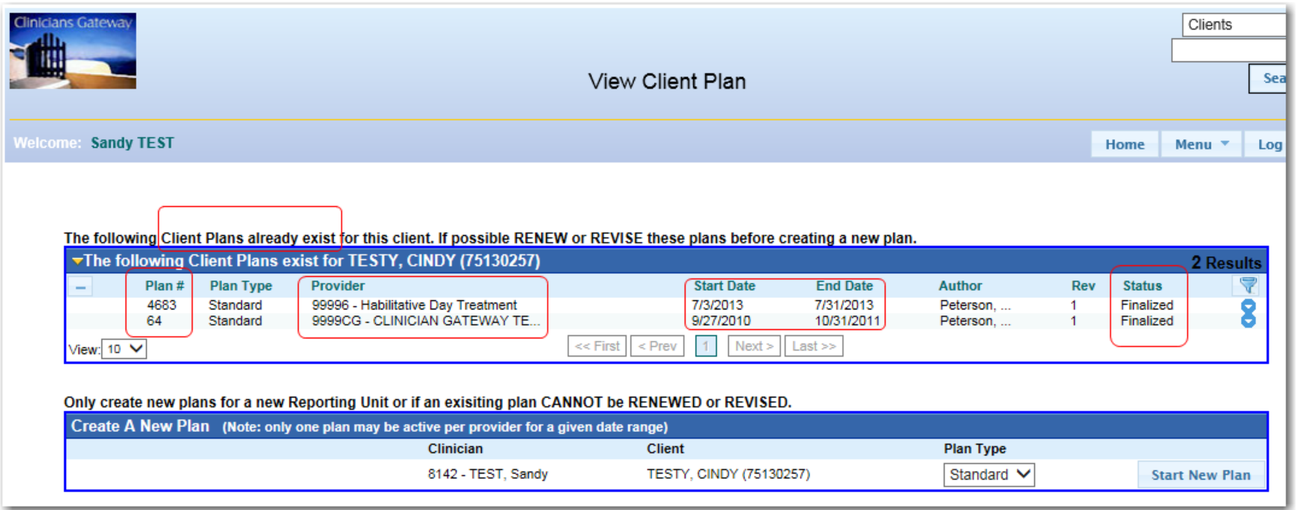
To **start writing a Plan**, Choose "Client Plan" from the Enter New Service menu on your Home page, enter the client name and click the "Start" button.



Select the line with the correct client. Ignore the RU listed as the Lead Provider.



The View Client Plans window will display Plans that already exist: Note the Plan ID #, the reporting unit, the start and end dates, and the status of the plan (New, Authorizing, or Finalized)

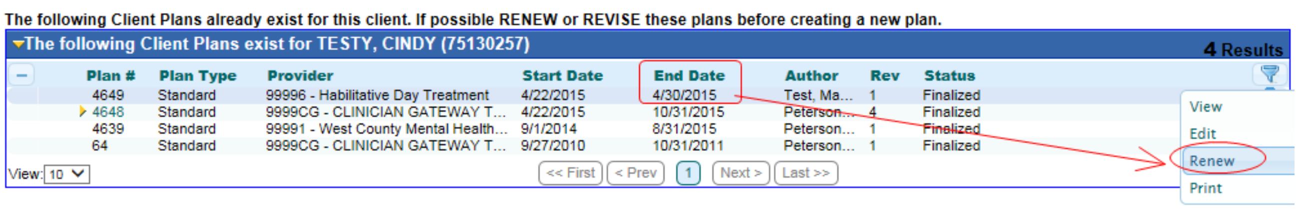


First, Try to Renew or Revise.

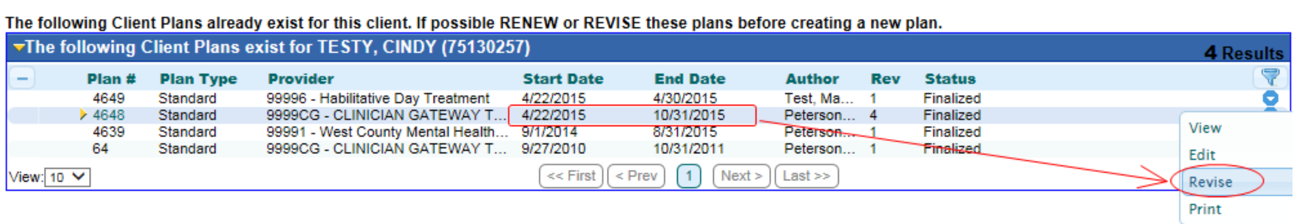
Revise a plan in the same reporting unit that is still in effect.

Renew a plan in the same reporting unit that has ended within the last six months or will be ending soon.

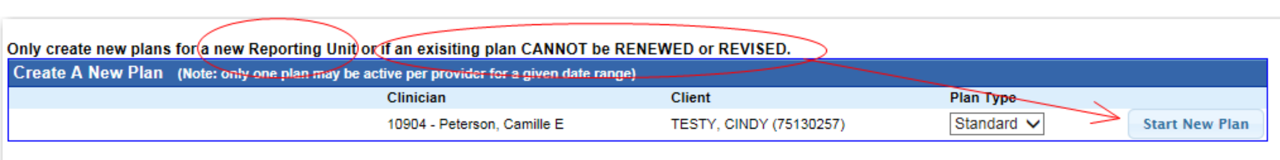
This Plan can be RENEWED because its End Date is recent;



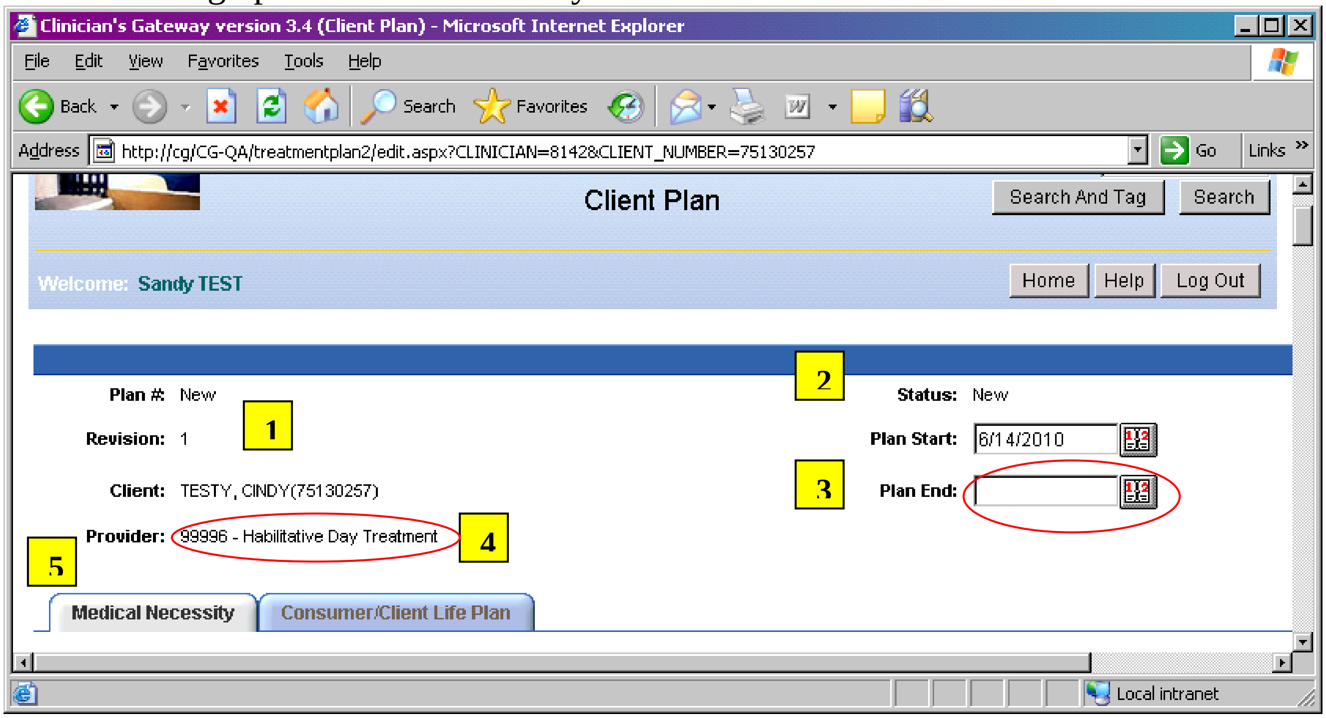
This Plan can be REVISED because it is still in effect:



Only Use Start New Plan for a new reporting unit or if a previous plan can't be Revised or Renewed!



This will bring up the Client Plan entry screen.



1. The Plan # is "New" before it is submitted for authorization. When submitted, it will be given a unique identifying number. Each time the plan is revised, the plan # will change.

   The "Revision" number will tell you if it is revision #1, 2, 3, etc.

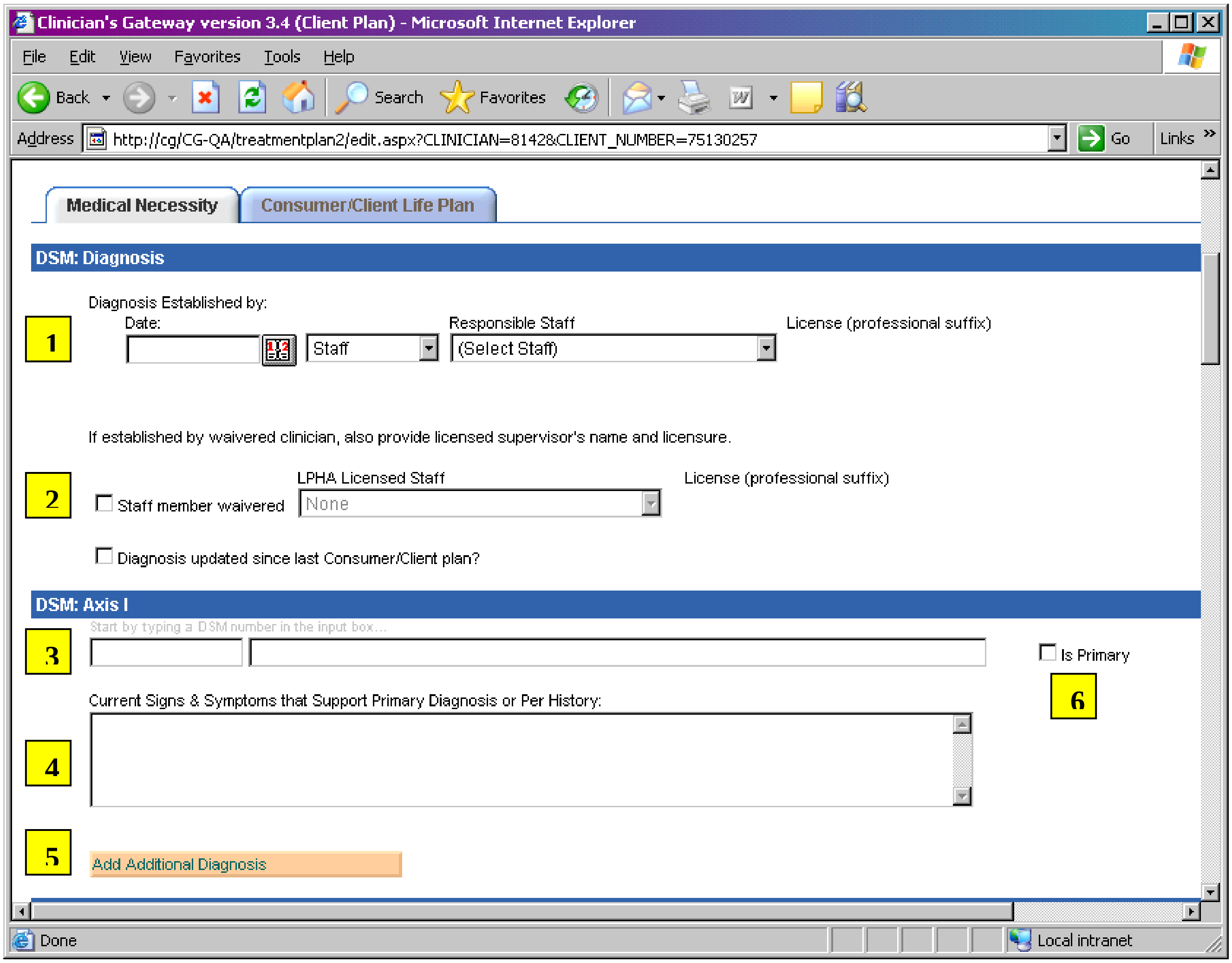
2. The Status can be "New" before submitting for authorization, "Authorizing" if submitted or "Finalized" after approved by approvers and finalized by the clinician.

3. The Plan Start Date will default to today's date. Back dating is not allowed.

   Enter the Plan End Date to match InSyst. An easy way to find it is to start a progress note in CG and look at the UR date below the Service Date. This is generally calculated by starting with the beginning of the month that the episode was opened, then entering the last day before one year later. (ex. If opened Jun 15th, calculate from Jun 1 to May 31. Enter the End Date of May. 31st using the calendar icon.)

4. **Choose the Correct Reporting Unit** for the client.

5. Fill out the Medical Necessity tab.



1. Enter the date and name of the person establishing the diagnosis, whether BHCS or outside staff.

2. Enter the licensed supervisor if the responsible person is waivered.

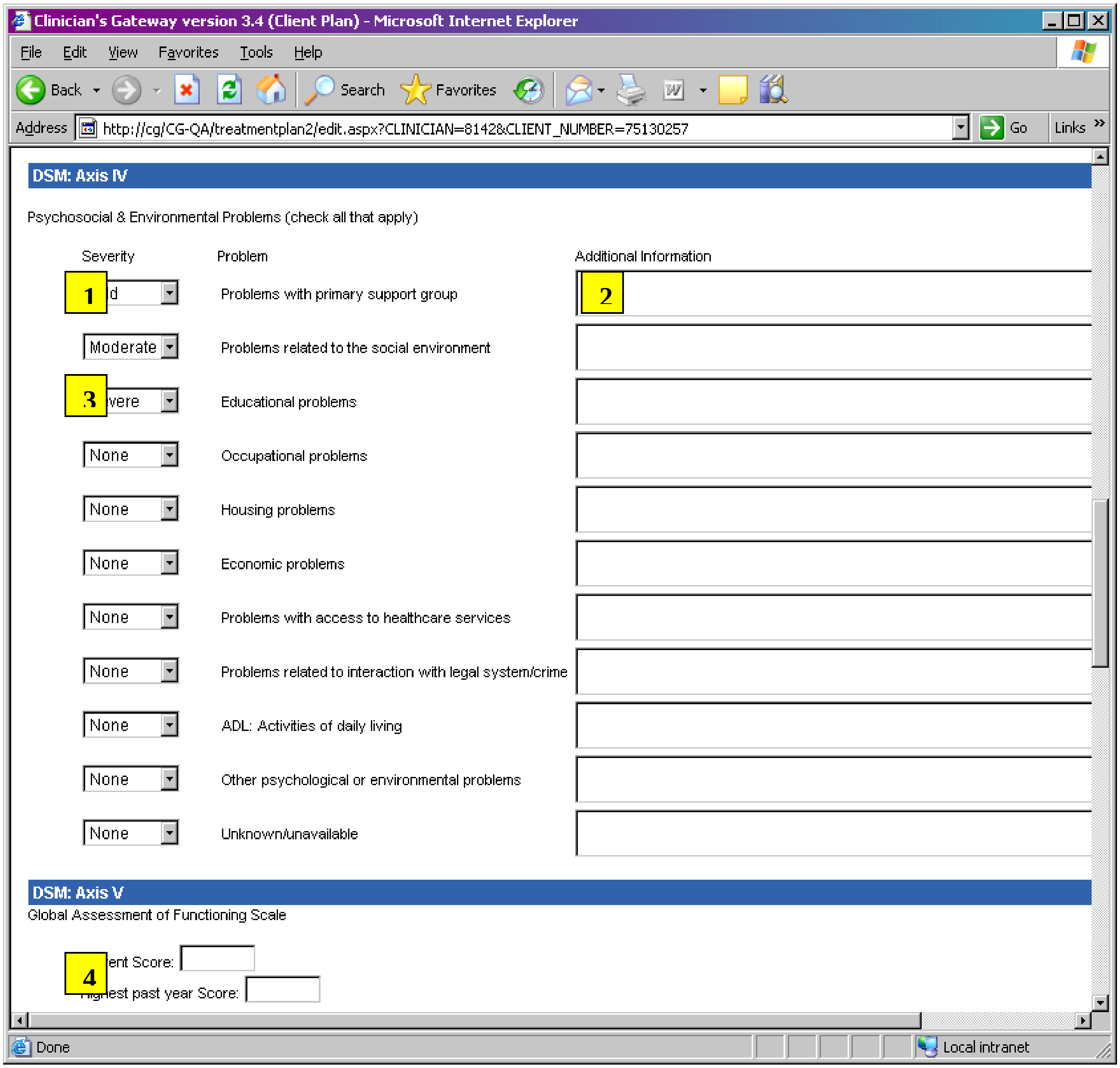
3. For Axis I, II, and III, enter the diagnosis by typing the first number of the DSM code and arrowing down through the list of possible diagnoses. Choose “None” to erase your choice if needed.

4. Enter current signs, or per history.

5. Click “Add Additional Diagnosis, if needed.

6. Check the “Is Primary” box for only one diagnosis between Axis I and II.

7. Proceed to Axis IV and V



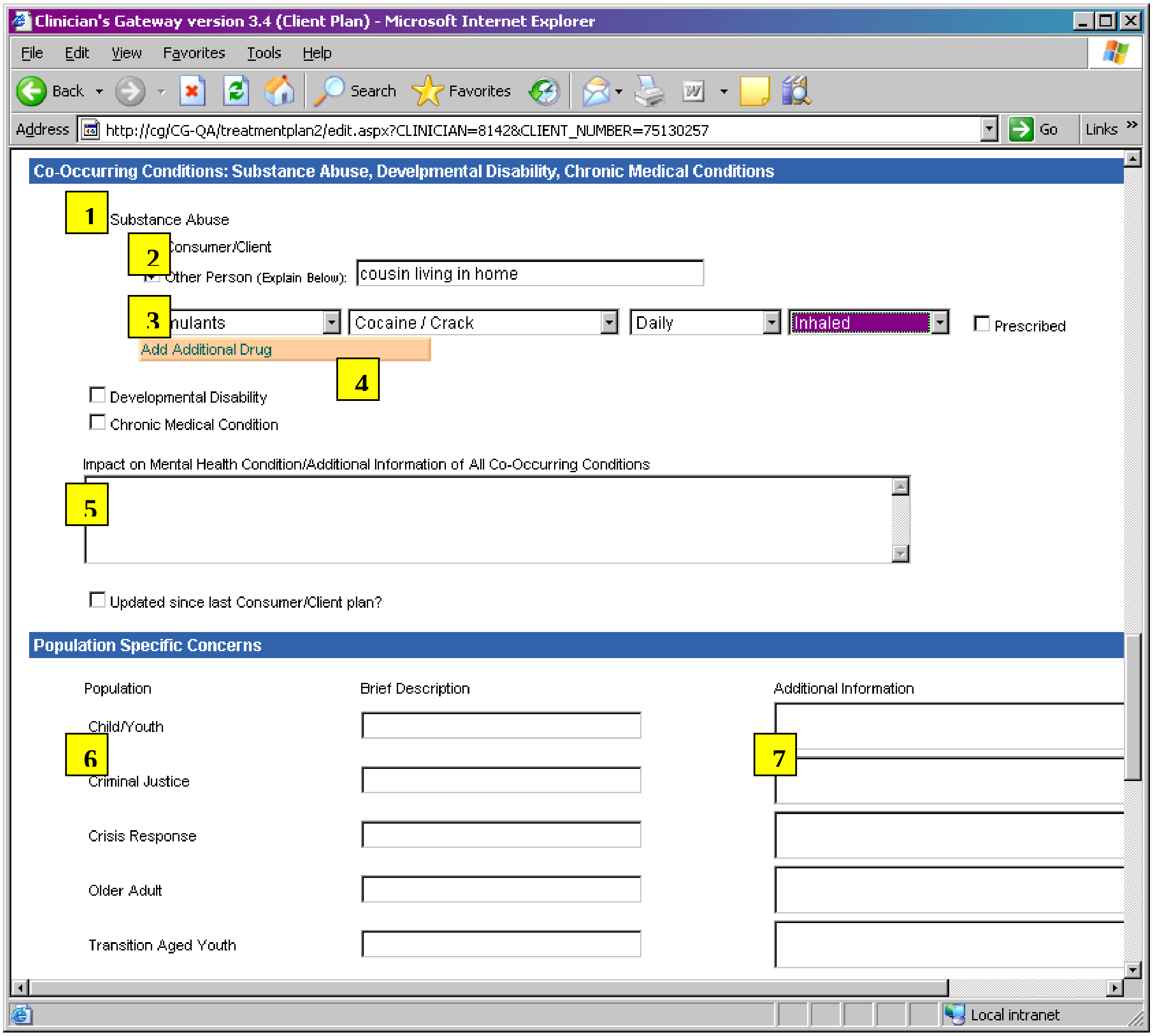
1. Choose a severity rating for problems that may exist.

2. Information is required for any item marked as mild to severe. Text will not be saved when no severity rating is chosen.

3. Axis IV problems marked as “Severe” will be displayed in the Objectives section of the Plan.

4. GAF scores are required.

5. Co-occurring conditions and Population specific concerns are addressed next.



1. Check all co-occurring conditions. Additional fields will open. Co-occurring conditions will be displayed in the Objectives section of the Plan.

2. Mark if it is the consumer/client or another person in their life, adding who that other person is.

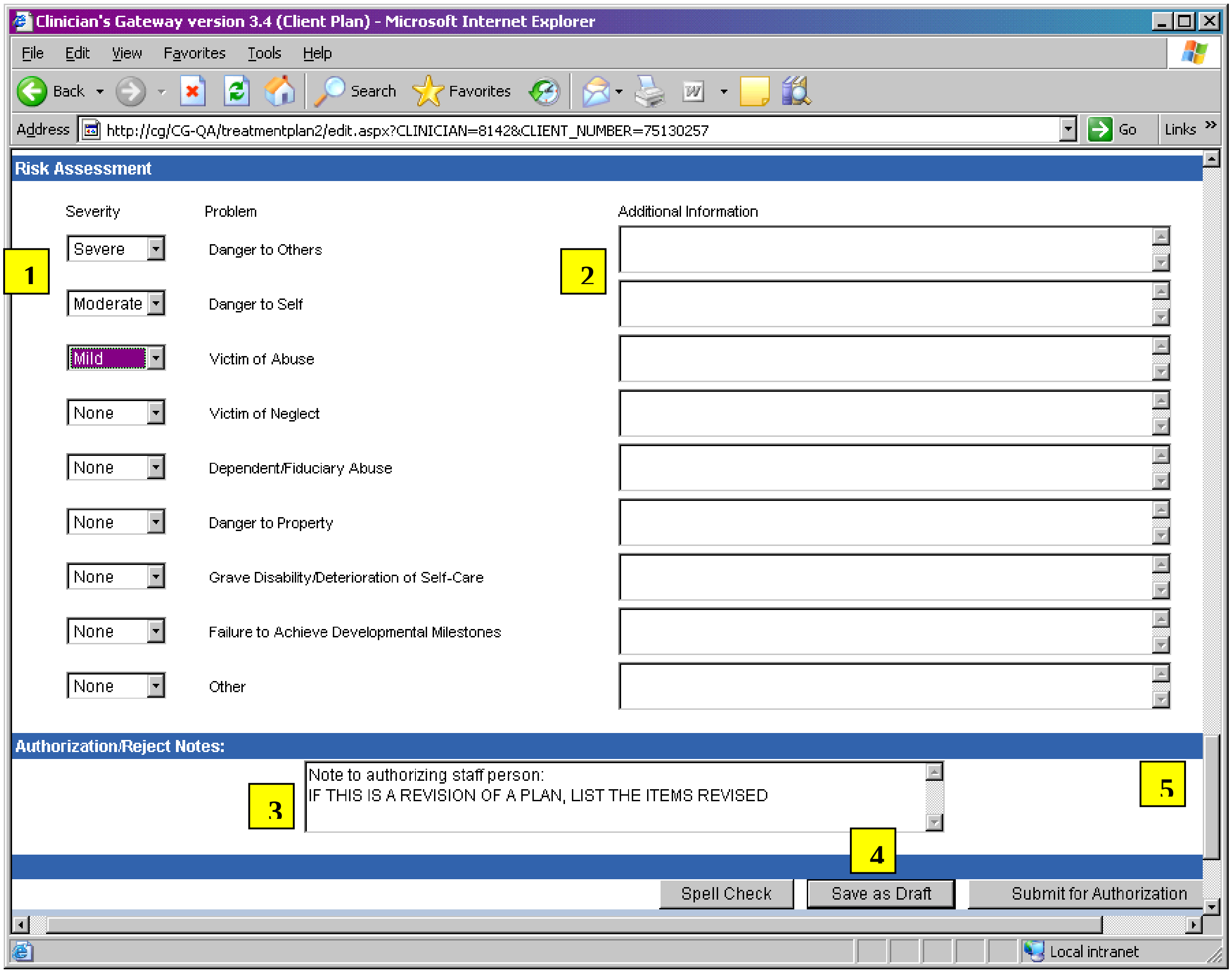
3. Fill in details of the condition

4. Click the “Add Additional” button if needed.

5. Describe the impact of these conditions on the Mental Health.

6. Add a brief description of any Population specific concerns. The brief description will be displayed in the Objectives section of the Plan.

7. Additional information may be added to describe the concern.



1. Note the severity of the Risks.

2. Additional information is required for severe risks.

3. Add a note to the staff persons who will be asked to authorize the Plan. If this is a revision of the Plan, list the items revised so that they know what to look for.

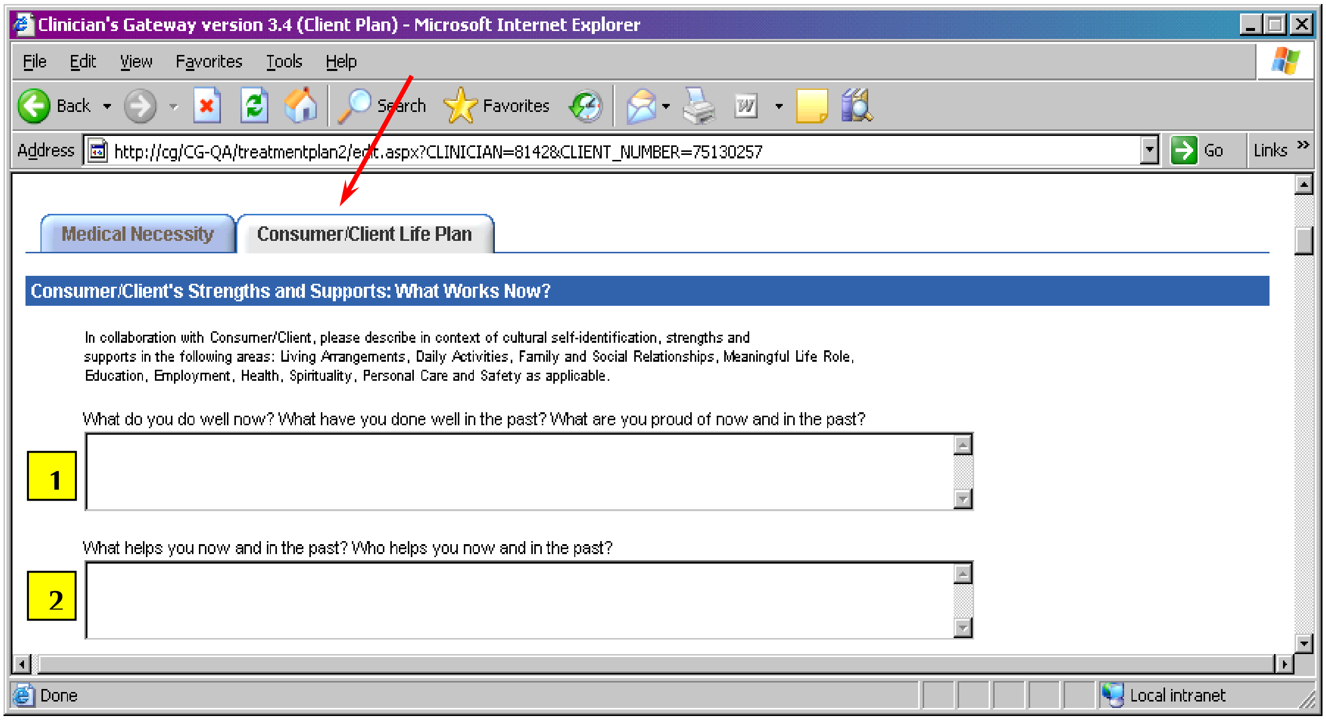
4. Save as Draft if not finished or wish to safeguard your work so far.

5. Move to the top of the page to work on the Life Plan section. (The **Home key** on your keyboard is a convenient way to do this. The “End” key takes you to the bottom of the page.)

6. Click on the Consumer/Client Life Plan tab to begin working on this section.

Blank

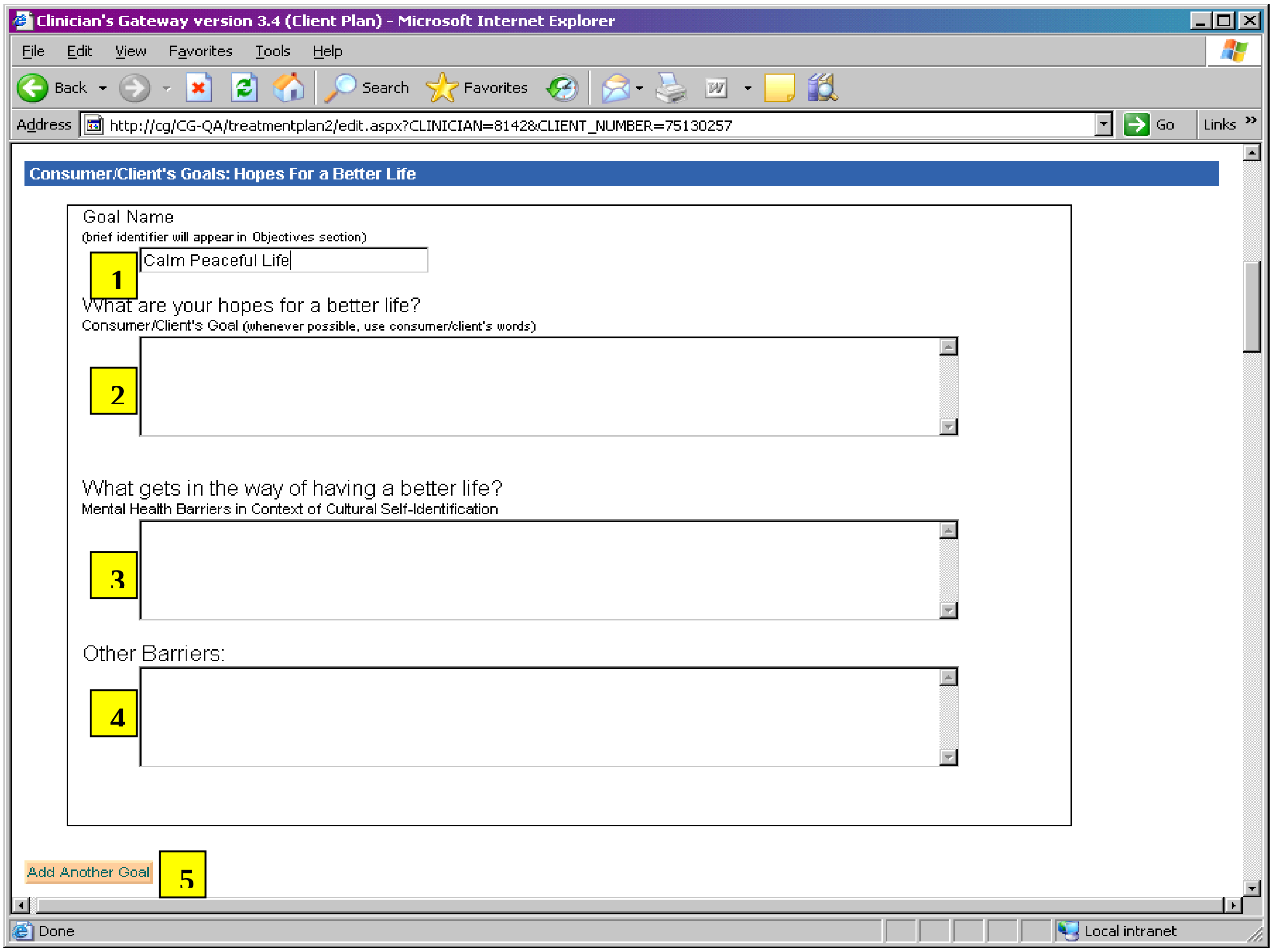
Consumer/Client Life Plan Tab



1. Enter the **Consumer/ Client's strengths**. You may return to add to this section as you work through the goals and objectives, as more strengths come to light.

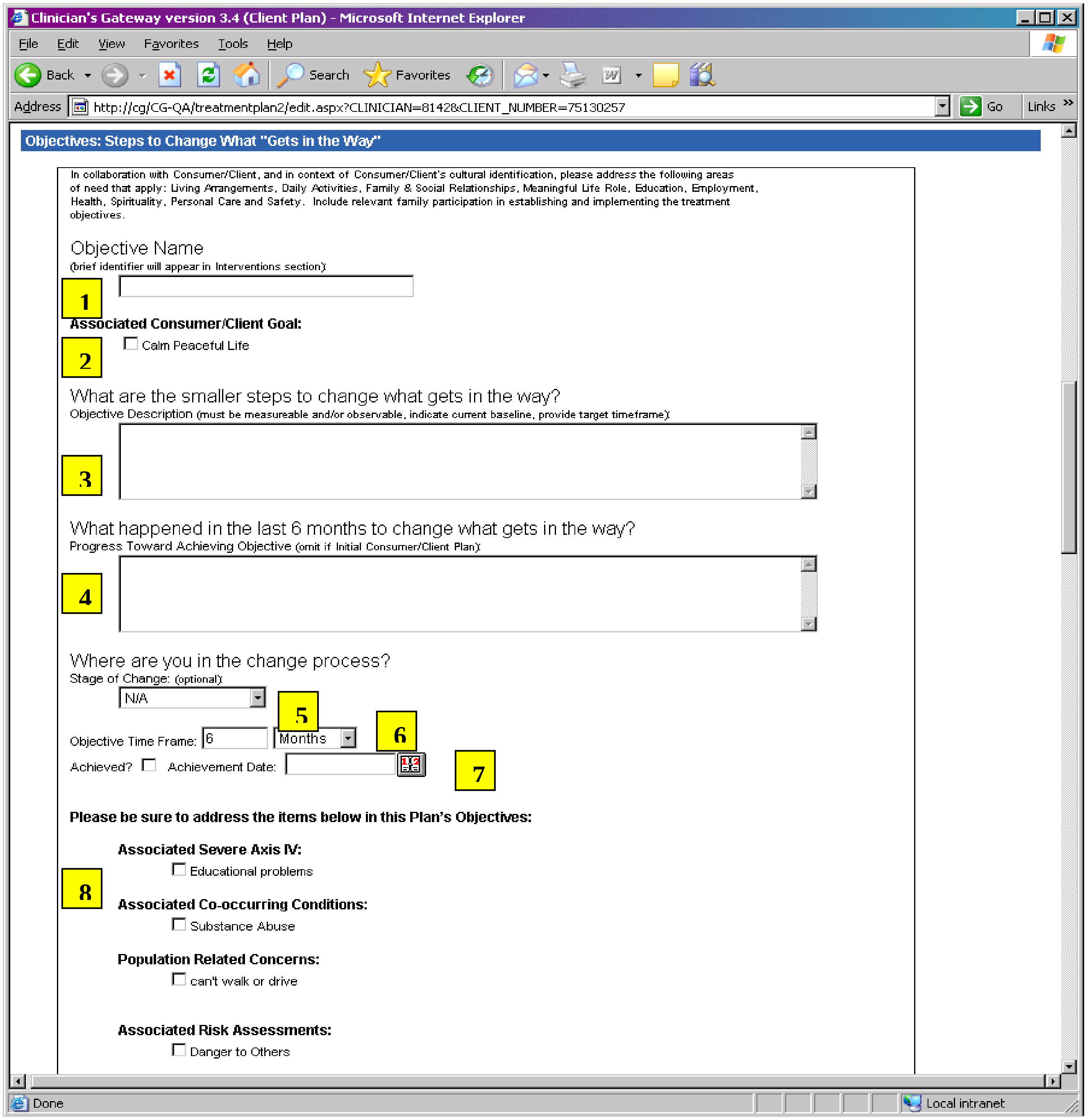
2. Enter the **Consumer/Client's supports.** You may return to add to this section as you work through the goals and objectives, as more supports come to light.

GOALS



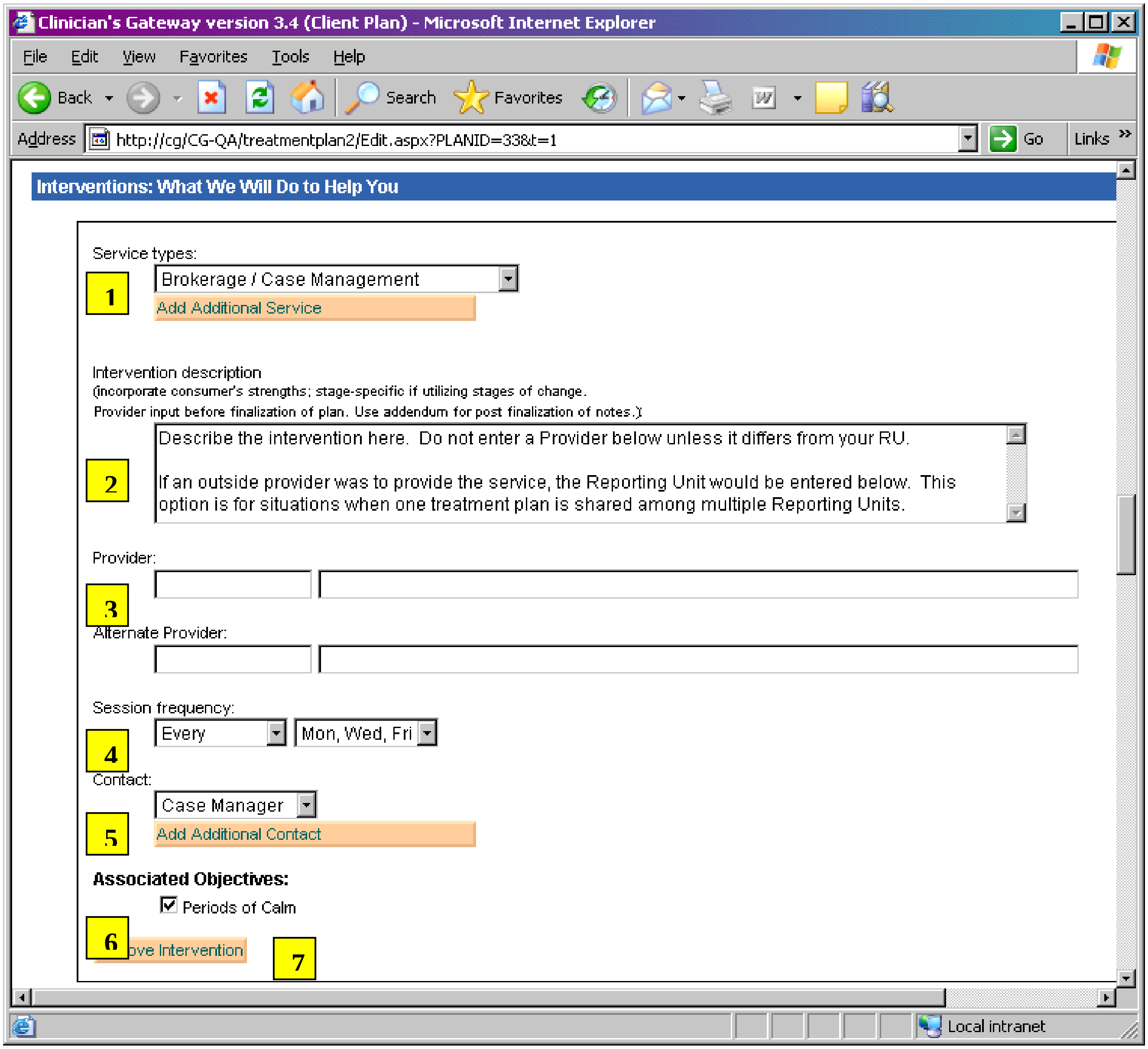
1. Name the Goal. This name will appear in the Objectives section,
2. Describe the Goal.
3. Describe Mental Health Barriers to the Goal.
4. Describe other barriers to the Goal.
5. Add another Goal if appropriate
6. Continue on to the Objectives section.

OBJECTIVES



1. Name the Objective. This name will appear in the Interventions section.
2. Check any Goals associated with this Objective.
3. Describe the steps involved with this Objective.
4. Describe any changes to barriers in the last year if this is a revision of a Life Plan.
5. Indicate the Stage of Change using the drop down menu.
6. Define the Time Frame for the Objective.
7. Mark and date it as achieved if appropriate.
8. Check all of the concerns associated with this Objective.
9. Add another Objective if desired.

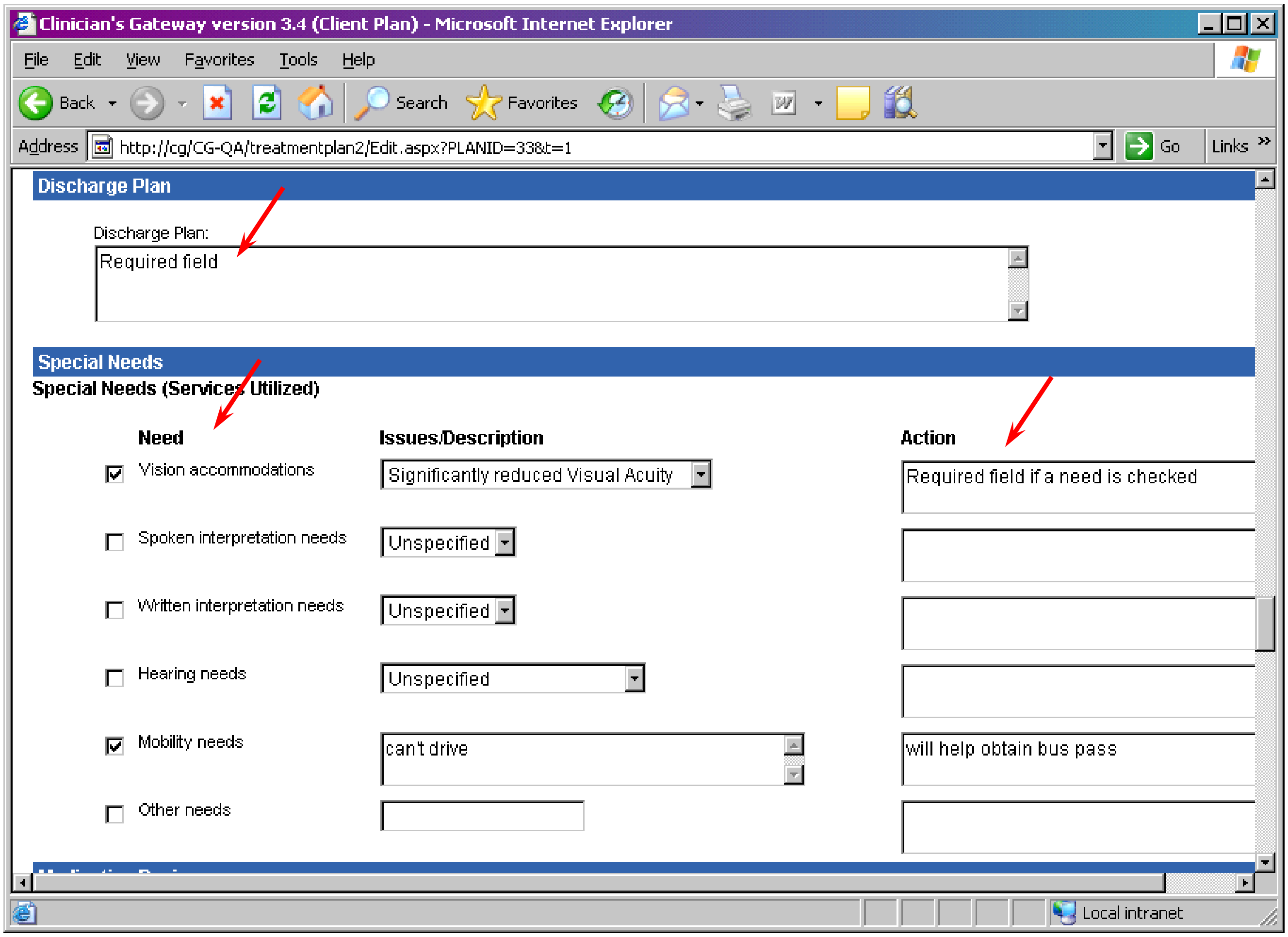
INTERVENTIONS



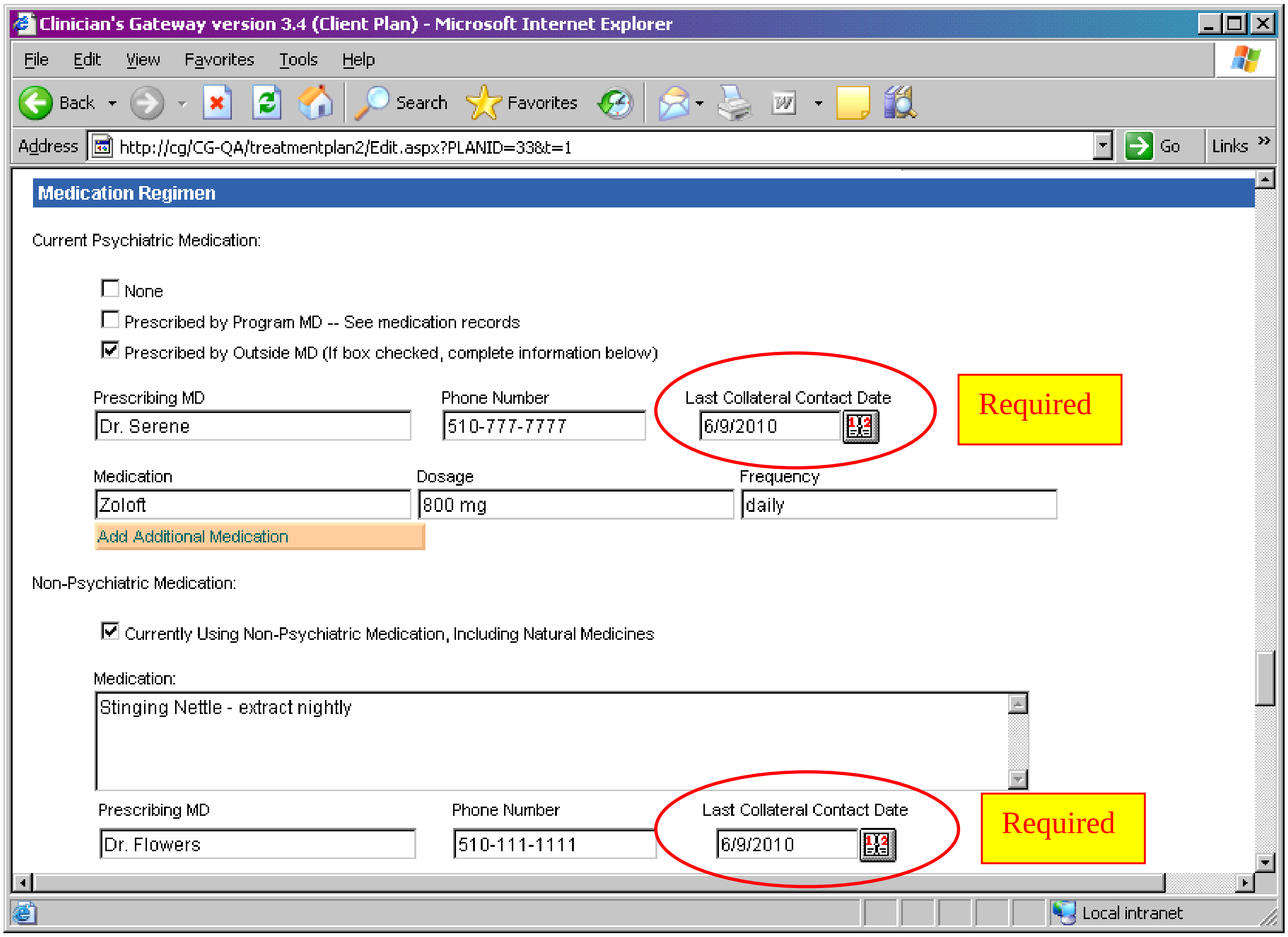
1. Define the types of service offered for this intervention. Multiple types can be listed per intervention.
2. Describe the intervention. Interventions to be carried out by other providers (shared Plan situations) may be described. Staff from the defined Provider can enter notes here.
3. If an outside provider is providing the intervention, enter that Reporting Unit here by typing part of the name or RU #. Arrow down the list to find the provider and click to insert.
4. Define the session frequency.
5. List all of the contact types involved.
6. Check off all Objectives that are associated with this intervention. More than one may be checked. Only the checked items will appear on the printed copy of the Plan.
7. Add or remove Interventions if desired.

1. **The Discharge Plan is required.**

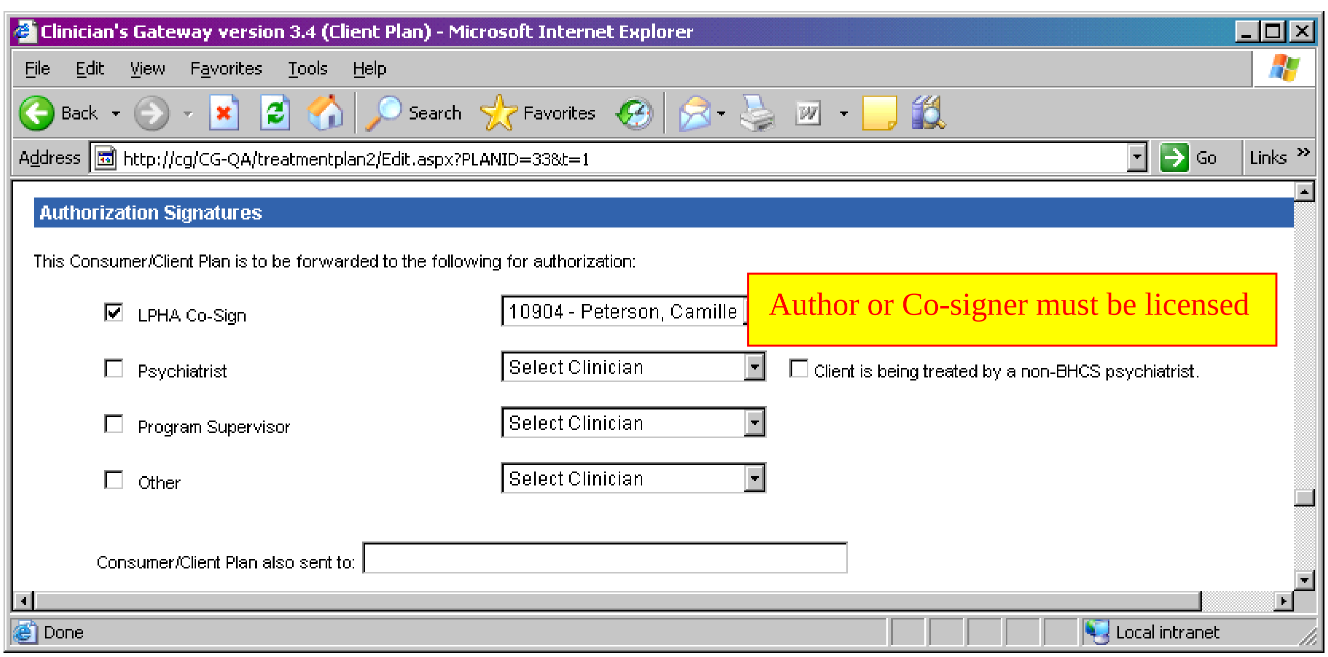
2. Check and define any **Special Needs**. A description of the action to be taken is required if a Need has been checked.



Fill in any **Medication information**. Any medication noted must be accompanied by the last date of contact with an outside provider.



Check and define all staff who are required to authorize the Plan. **If the author of the Plan is not a licensed professional (LPHA), an LPHA co-signature is required.**



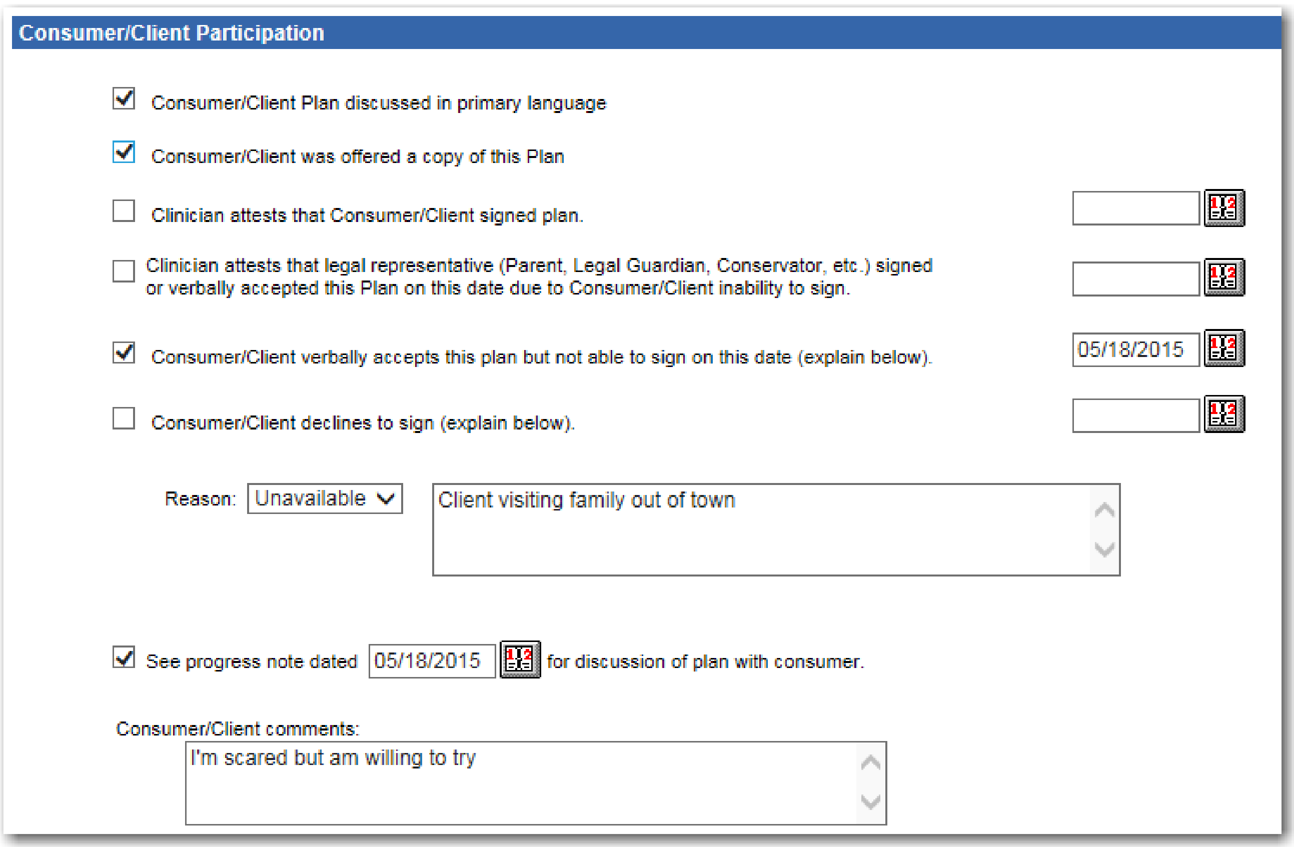
Fill out the **Consumer/Client Participation** Section now AND after authorization. After authorization, you will return to this section to add the client signature date.

Check and date all applicable fields. This information can also be added after the Plan has been authorized.

If the Consumer/Client is unable to sign, write the reason under, "Declines to sign"

Enter the date of the progress note that the Plan was discussed with the Consumer/Client

Use the consumer/client comment box if the consumer/client wishes to add their own comments.



Consumer/Client Participation

- [x] Consumer/Client Plan discussed in primary language
- [x] Consumer/Client was offered a copy of this Plan
- [ ] Clinician attests that Consumer/Client signed plan.
- [ ] Clinician attests that legal representative (Parent, Legal Guardian, Conservator, etc.) signed or verbally accepted this Plan on this date due to Consumer/Client inability to sign.
- [x] Consumer/Client verbally accepts this plan but not able to sign on this date (explain below). 05/18/2015
- [ ] Consumer/Client declines to sign (explain below).

Reason: Unavailable

Client visiting family out of town

- [x] See progress note dated 05/18/2015 for discussion of plan with consumer.

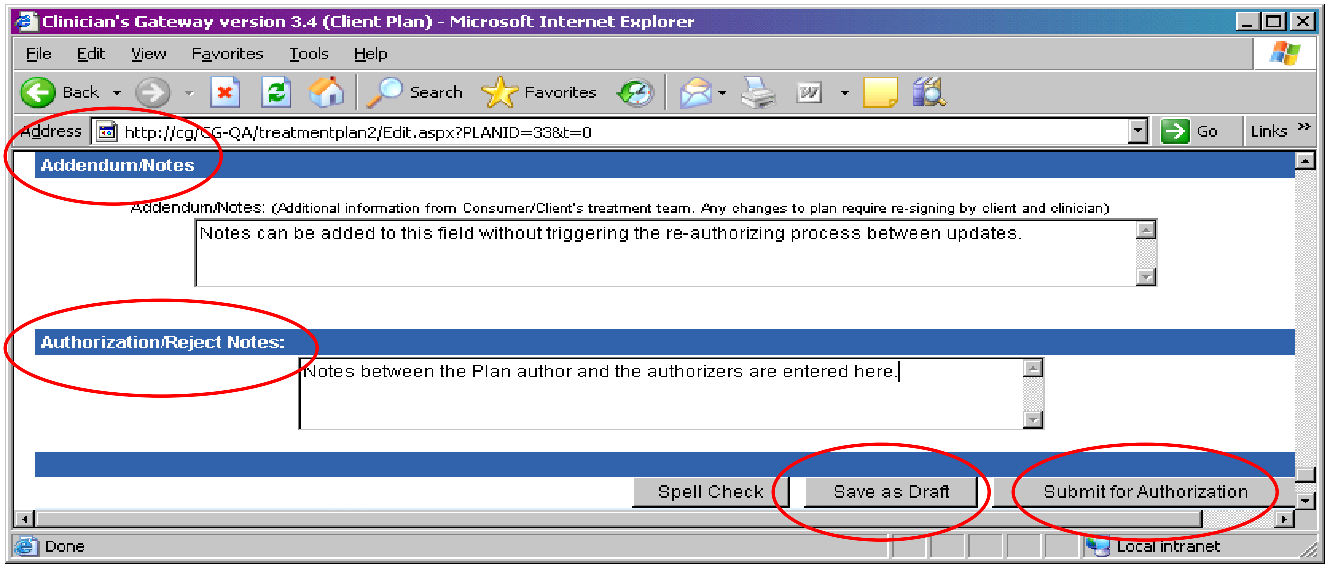
Consumer/Client comments:

I'm scared but am willing to try

NOTES: The last section is an area for notes which will __not__ be printed when the Plan is printed.

Addendum/Notes may be entered without triggering re-authorization.

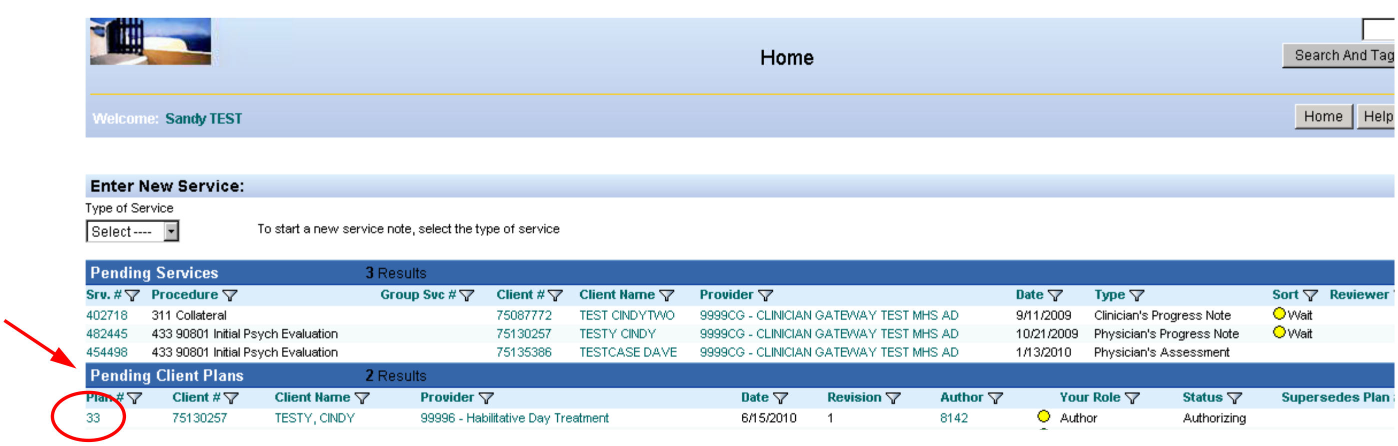
The Authorization notes are only seen by the author and the authorizers of the Plan.



Save as Draft if incomplete
or Submit for Authorization if complete. (Can submit before the client signs)

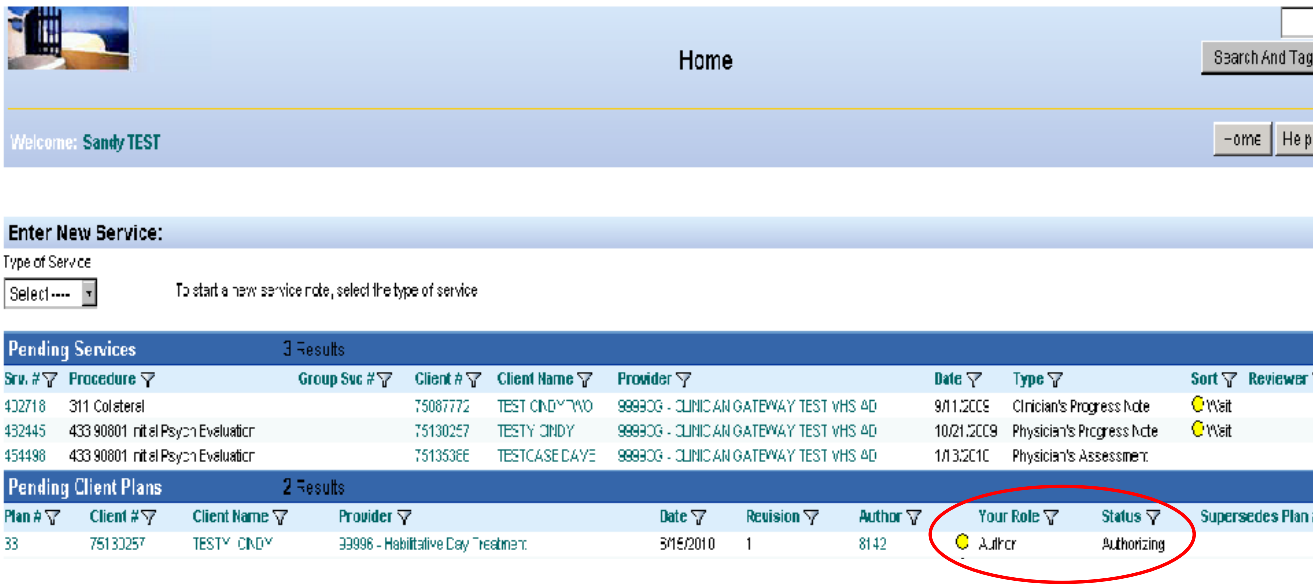
The Plan will now appear on the Home Page, in the list of Client Plans, with its unique Plan number.

Client Plans are listed below Pending services.

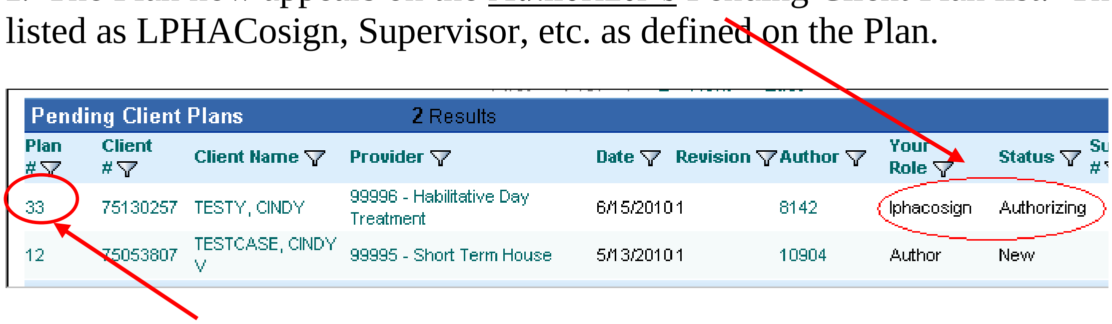


AUTHORIZING THE PLAN

1. After “Submitting for Authorizing” the yellow dot on the Author’s Home page indicates that they are waiting for Plan authorization. The status has changed from “New” to “Authorizing”.



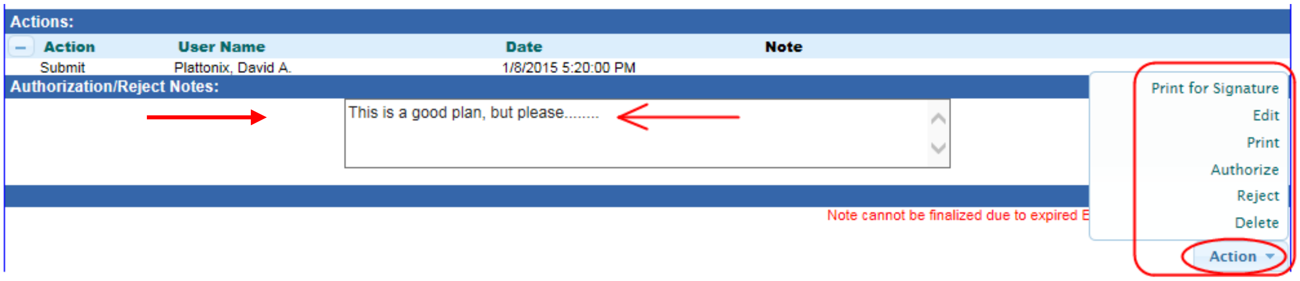
2. The Plan now appears on the Authorizer’s Pending Client Plan list. Their role is listed as LPHACosign, Supervisor, etc. as defined on the Plan.



3. The Authorizer views the Plan by clicking on the Plan number.

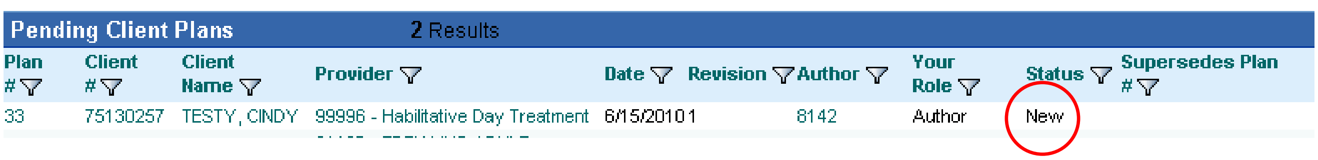
4. The Authorizer reviews the Plan. At the bottom of the screen they can see notes from the Author.

5. The Authorizer is required to write a note to the Author. The Authorizer then Authorizes, Rejects, or Deletes.



6. After Authorizing or Rejecting it, the Plan is removed from the Authorizer's Home page.

7. A "**Rejected**" Plan will have the status returned to "New" on the Author's Home page.



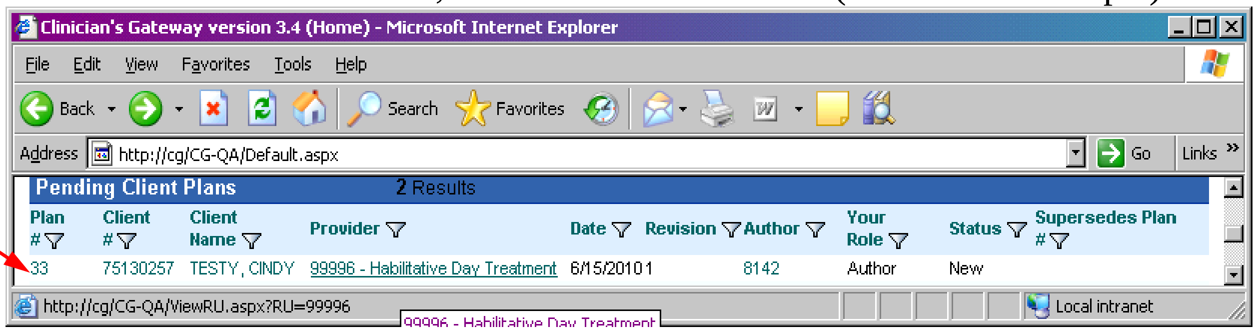
8. The Author works on the Plan after reading the Authorizer's notes and resubmits the Plan for Authorization until it has been Authorized.

9. An "**Authorized**" Plan will have a green dot and the status of "Authorizing" on the Author's Home page.
   a. "Edits" are restricted to minor changes now.
   b. Major changes would be handled by finalizing the plan and then revising it.

PRINT FOR CLIENT SIGNATURE

BEFORE PRINTING, SUBMIT THE PLAN AND GET APPROVALS. (When the Plan has not yet been submitted for approval the Plan will have "Pending" splashed across it)

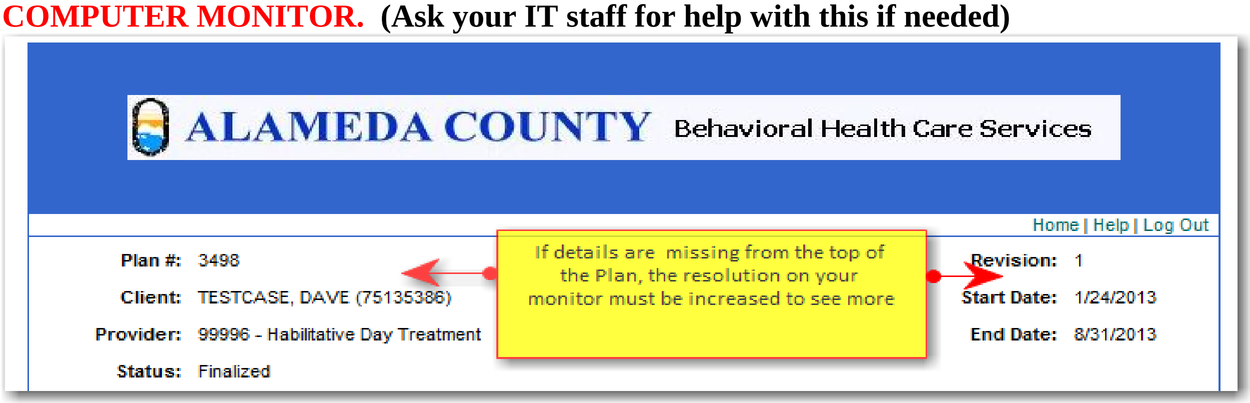
AFTER APPROVED, VIEW IT TO ACCESS THE "PRINT FOR SIGNATURE" BUTTON. To view the Plan, click on its Plan Number (# 33 in this example).



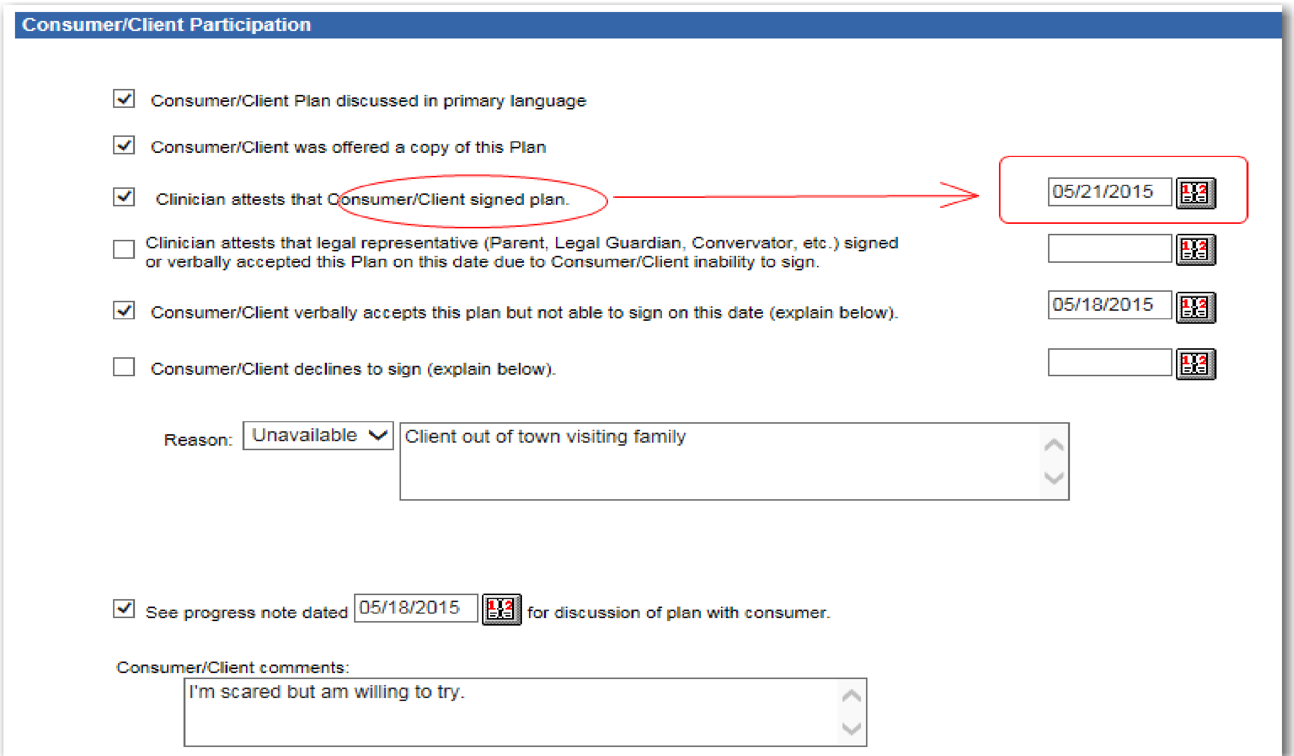
The Plan appears on your screen. From the Action Bar, Click "PRINT FOR SIGNATURE".

(You can Print, Edit, Reject, Finalize or Delete from this screen via the Action bar. "Edit" will allow you to Submit for Authorization. Editing also requires you to resubmit the Plan for authorization.)

IF THE PLAN DETAILS ARE MISSING, INCREASE THE RESOLUTION ON YOUR COMPUTER MONITOR. (Ask your IT staff for help with this if needed)

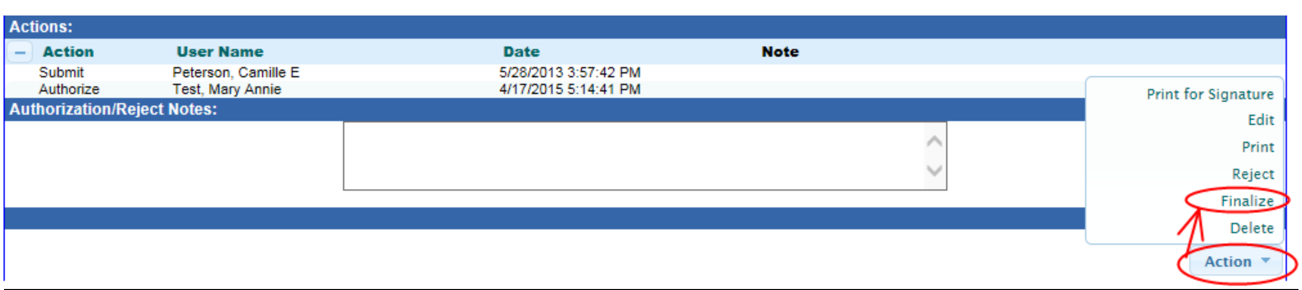


10.RETURN TO THE PLAN TO ADD THE CLIENT SIGNATURE DATE AFTER IT IS OBTAINED. This edit will not trigger another round of authorizing.



11.The Plan is now ready to be **Finalized** by the Author or the Supervisor. (Have the client sign if not already done and update the Plan with the information) First, View the Plan by clicking on the Plan Number.

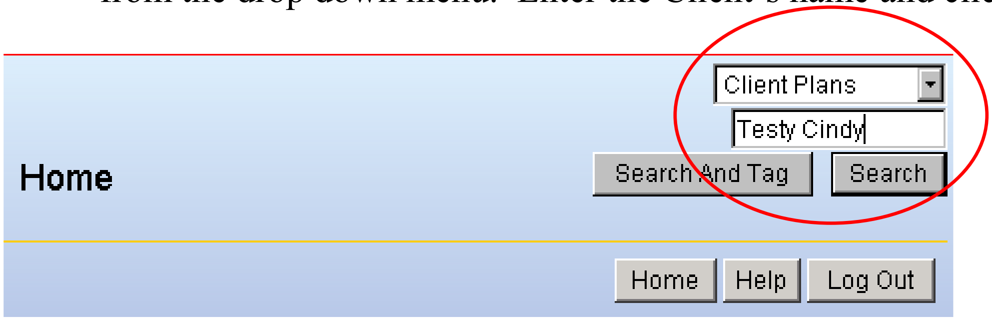
12. Click “Finalize” Via the Action bar.



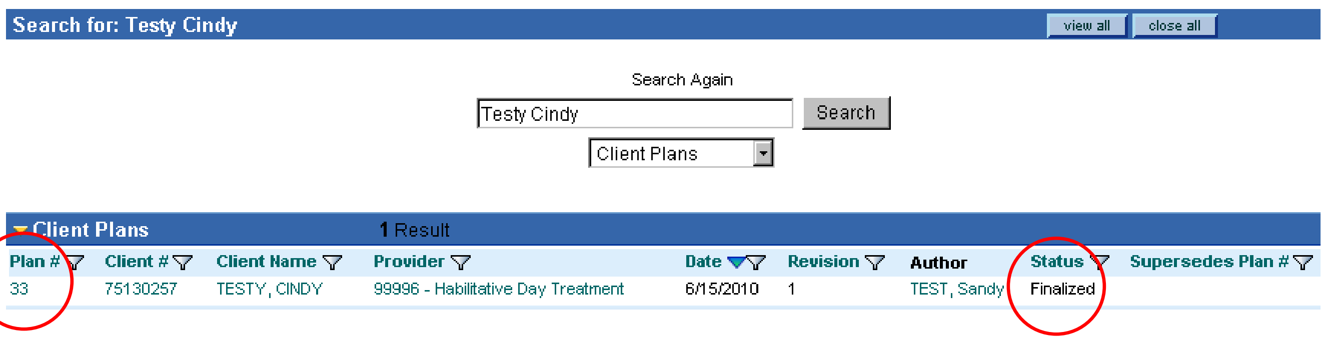
12. The Plan is removed from the Pending Client Plan list on the Home page.

VIEWING, EDITING AND REVISING A FINALIZED PLAN

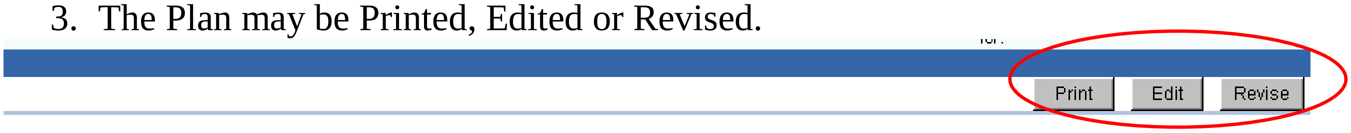
1. Use the Global Search function to Search for a Plan. Choose "Client Plans" from the drop down menu. Enter the Client's name and click "Search".



2. Search Results are displayed. Click on the Plan number to view it. Note that the Status is now "Finalized".

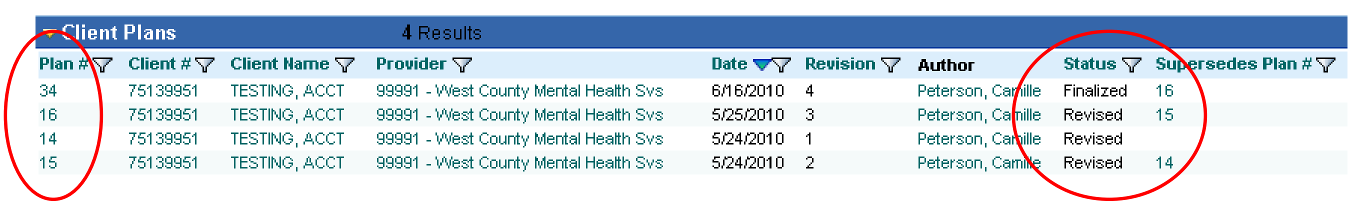


3. The Plan may be Printed, Edited or Revised.



4. A **Finalized note** may be **edited in minor ways** only. (Objectives may be marked as achieved, Plans sent to an additional person may be noted, Addenda for future planning may be written)

5. **Any substantial change is a Revision** and must be re-authorized and re-signed by the client. New Revisions of Plans supersede earlier versions.



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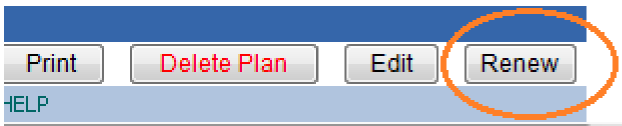
RENEWING OF PLANS

During the 30 days preceding and following a plan's expiration date, an additional button will appear. A "Renew Plan" button will be available.



1. Click the Renew button.

2. All of the entries from the previous plan will be brought forward into the new plan.

3. After you make revisions, obtain the signatures and approvals just the same as when you make a new plan or revise a plan.

CHANGING THE AUTHOR OF THE PLAN

1. Once a note is Finalized, it may be viewed and revised by any clinician. If the clinician revises the Plan, they are the new author of the Plan.

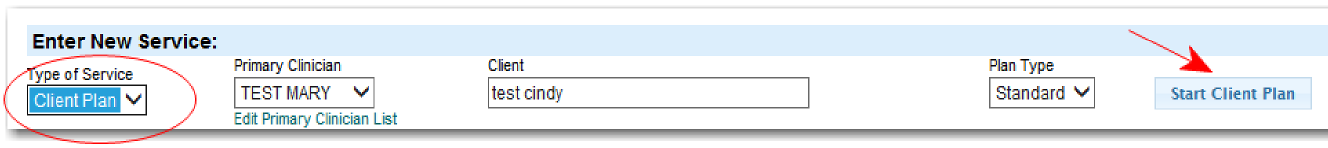
2. The Information Systems Help Desk can change the author of the Plan on request.

blank

Concurrent Treatment Plans:

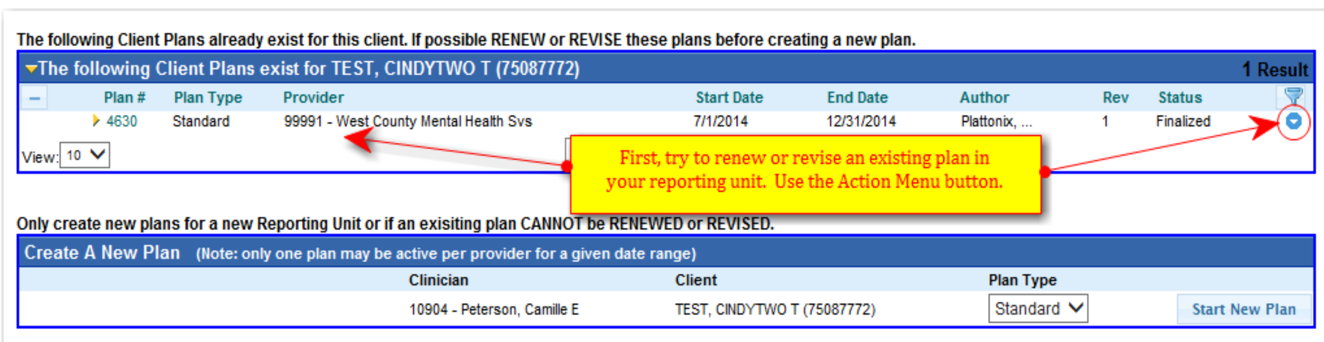
Plans may now be active in more than one reporting unit concurrently.

Start writing the plan as usual

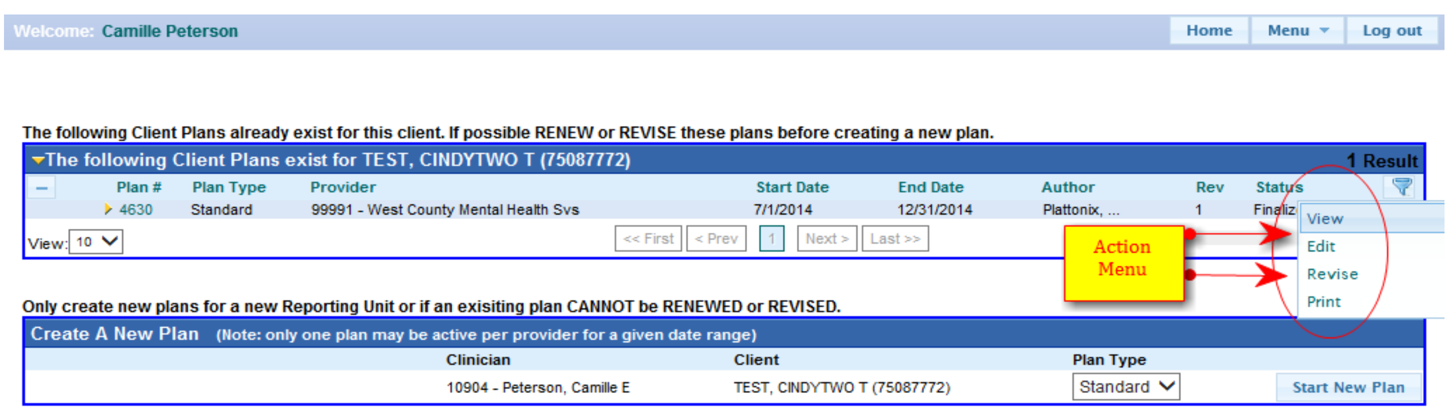


A grid of existing plans will be presented from which to choose.

- **First try to renew or revise an existing plan in your reporting unit.**

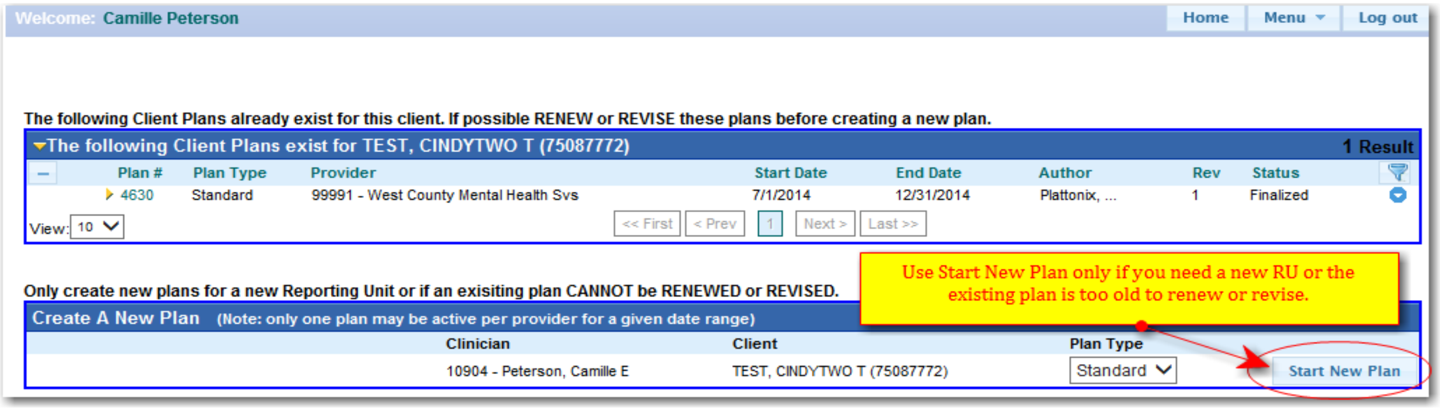


- **The Action Menu will tell you if you can Renew or Revise the plan**

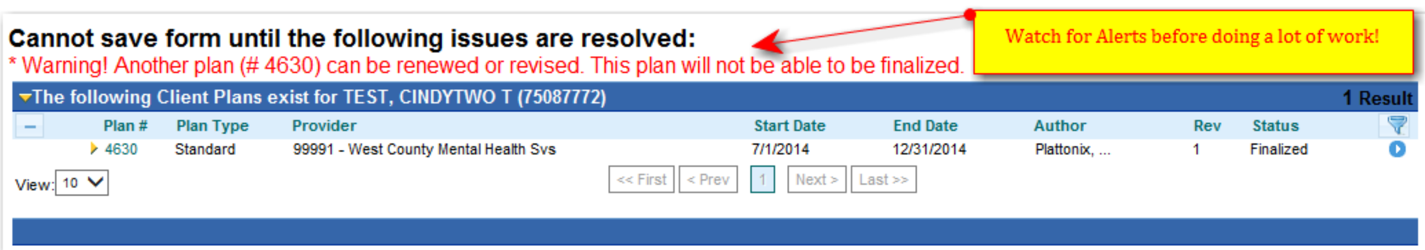


(Continued on next page)

- <u>**Use “Start New Plan” only if you need a new RU or the existing plan is too old.**</u>



- **You will be warned if the “New Plan” cannot be finalized** due to a pre-existing plan



- If you work on a plan that cannot be finalized, you will not be able to finalize it.

  <u>**Your work will be lost!**</u>

Trouble Shooting

Client Plan End Dates:

Normally clinician's will have to set the end date to the end month 12 months from the Start Date, but sometimes this data is entered incorrectly.

If the plan has been finalized, the user must send a Treatment Plan Change Request to the BHCS Help Desk at 567-8161 or his@acbhcs.org .

Client Plan Start Dates:

These can usually be changed by doing a Revision or Renewal. Revision allows a new start date to be entered during the plan year. A Renewal starts after the end of the existing plan. Start Dates cannot be back dated.

If the Start Date needs to be earlier, then we must have a Change Request along with a signed paper Plan faxed or emailed to the Helpdesk indicating an earlier client signature. We can then do a QA override to attest to the Start Date change.

Incorrect Reporting Unit:

If the Plan has not been finalized, reject the Plan, Edit it, and change the RU. If the Plan has been finalized, either do a new revision to change the RU, or submit a Treatment Plan Change Request form to the Help Desk.

Revision being used when a Renewal was intended: (Revisions keep the same end date while Renewals start after the current plan's end date)

Delete the Revision, go to the previous plan and click Renew.

If the dates don't match up we can adjust the end Date of the previous plan to cover the period for auditing purposes only.

Plan Submitted for Authorization not appearing on Supervisor's Home page:

Verify the Reporting Unit is set correctly. If not Staff must Reject the plan and update to the correct Reporting Unit and Submit for Authorization again.

Verify that the Checkboxes are checked next to the authorizer's names in the "Authorization Signatures" section. Click "Submit for Authorization" button.

<u>Client Signature details are incorrect:</u>

Edit the plan. Go to the **Consumer/Client Life Plan**

Go down to **Consumer/Client Participation** and fill out the appropriate responses.

<u>Authorizer Signatures not showing:</u>

Verify that the Checkboxes are checked next to the authorizer's names in the "Authorization Signatures" section. Then click "Submit for Authorization".

PASSWORDS

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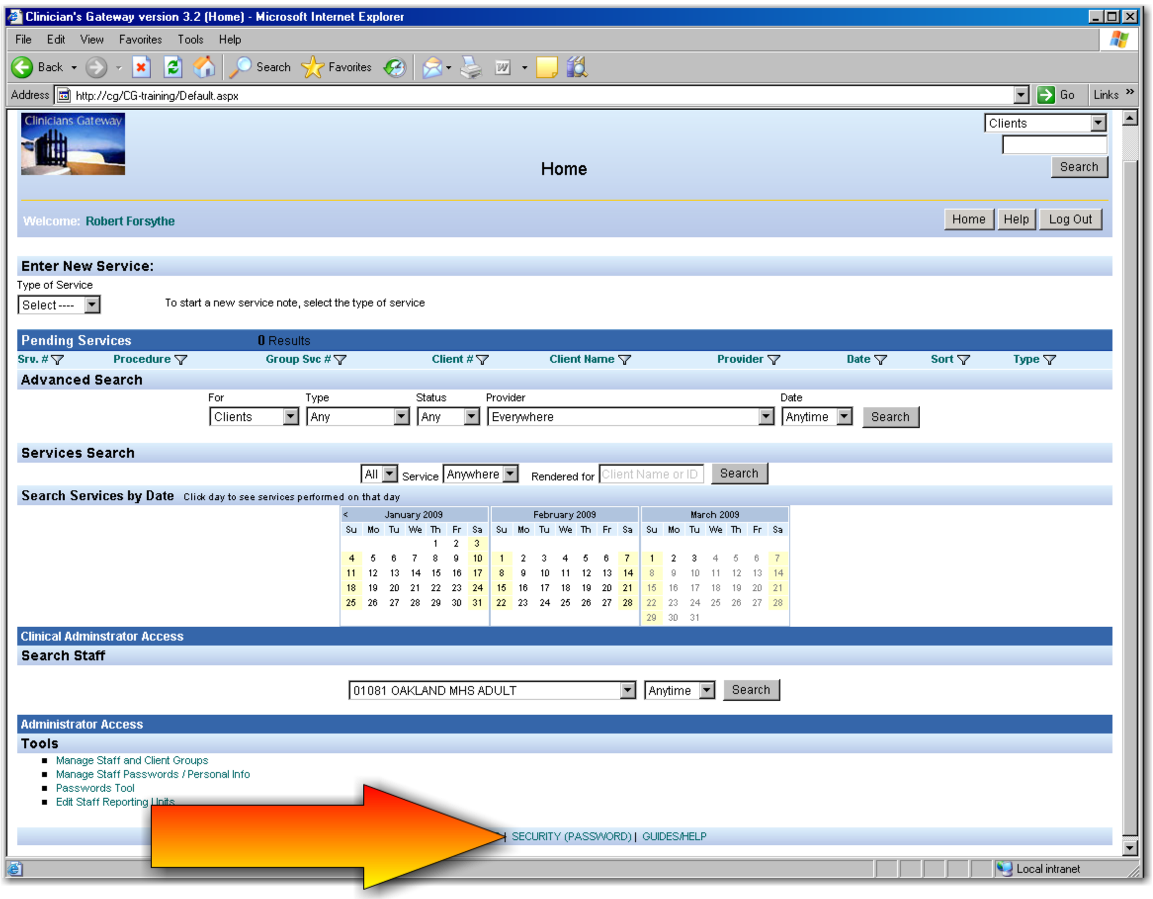
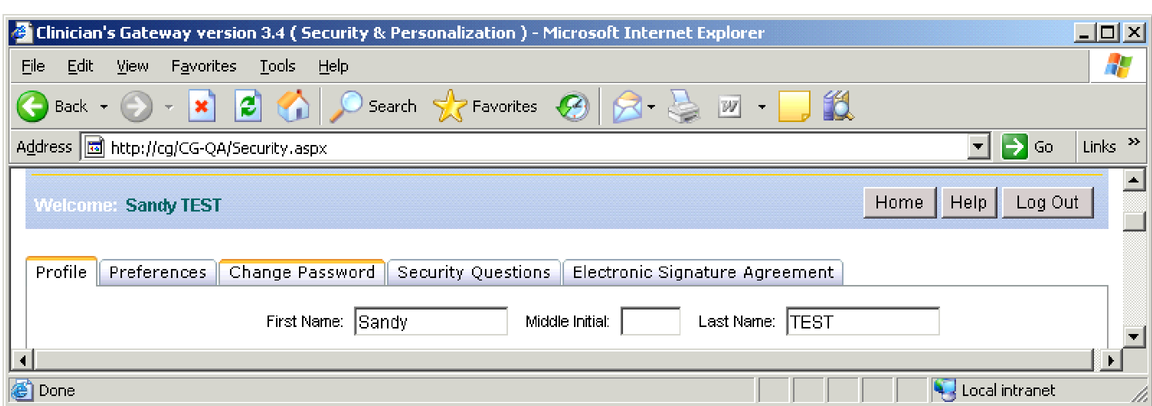
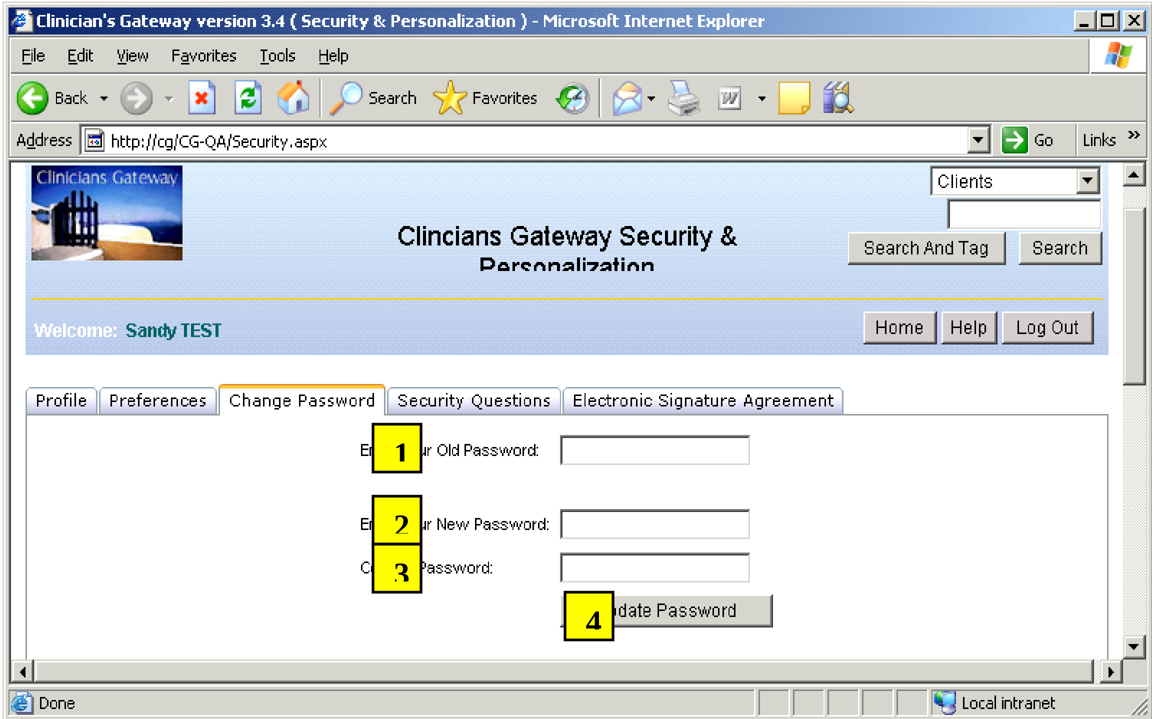
Changing your password



- ➢ **Click on security from the bottom of the home page.**
- ➢ **Choose the "Change Password" tab**





1 – **Enter your current password in the first field.**

2 – **Enter your new password in the second field. (Your password must contain at least one uppercase alpha, one lowercase alpha, and one numeric character. It also must be at least eight characters in length).**

3 – **Re-enter your new password in the third field to confirm the change.**

4 - **Click on "Update password"**

If you have any questions or problems operating the Clinician's Gateway program, please do not hesitate to call our Help Desk, which is available from 8:30 AM until 5:00 PM Monday through Friday.

Help Desk Telephone:	(510) 567-8181
County Tie Line:	38181
E-mail: (7:30AM-4PM)	his@acbhcs.org
Fax Number:	(510) 567-8161
County Tie Line Fax:	38161