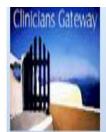
Clinician's Gateway

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.

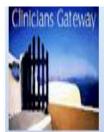
New Modules

Treatment Plans - Coming Soon!

MHSA (Data Forms and Submission): installed 2008

MAA Claiming - Individual Staff Log Form: installed 2007

v1.0 2/13/2009



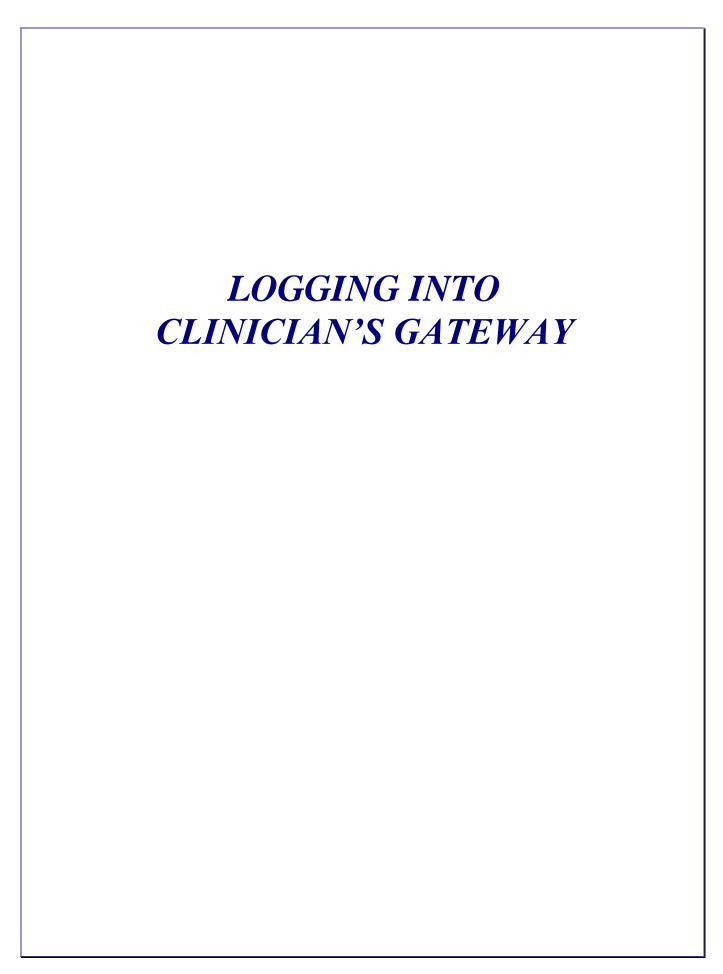
CLINICIAN'S GATEWAY

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.

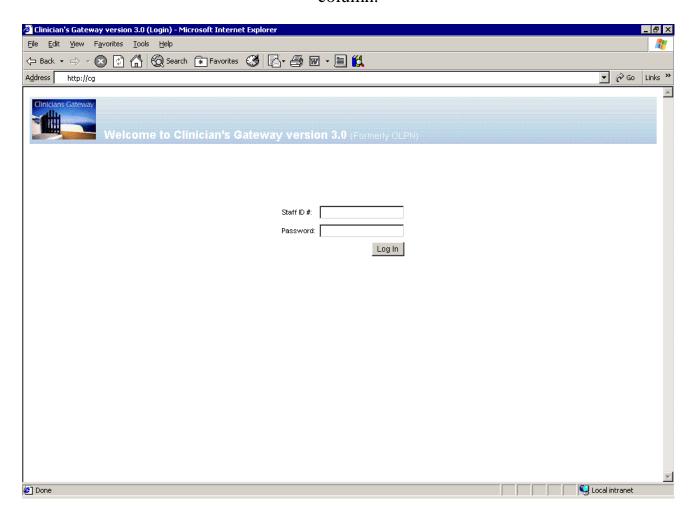
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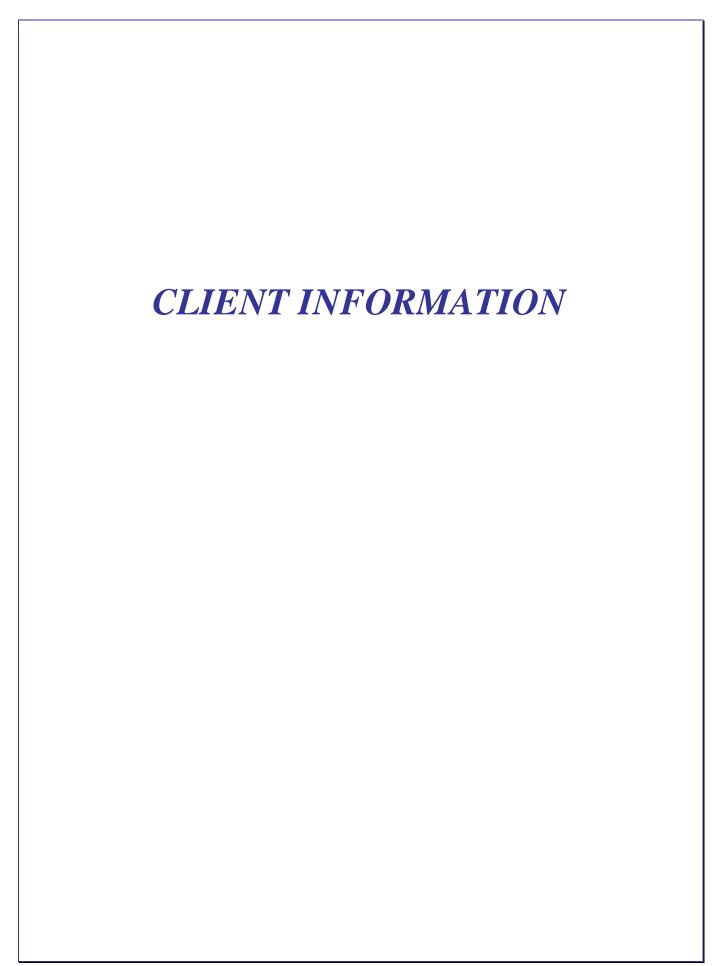


Login – Security

Find the link to this page at http://covenet, click on Clinician's Gateway in the right hand column.



- 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 seven 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.



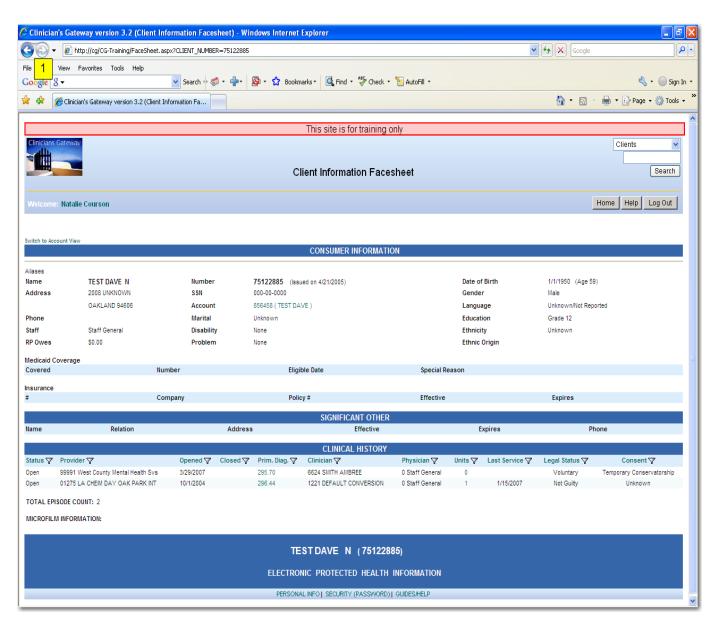
Client Face Sheet



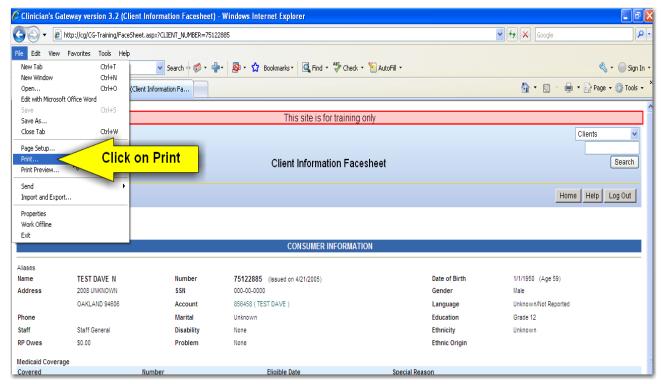
- 1 To get to the client Face Sheet, select "clients" from the drop list.
- 2 Type the clients' last name first, then first name. (with a space in between...do not use a comma)
- 3- Click on Search



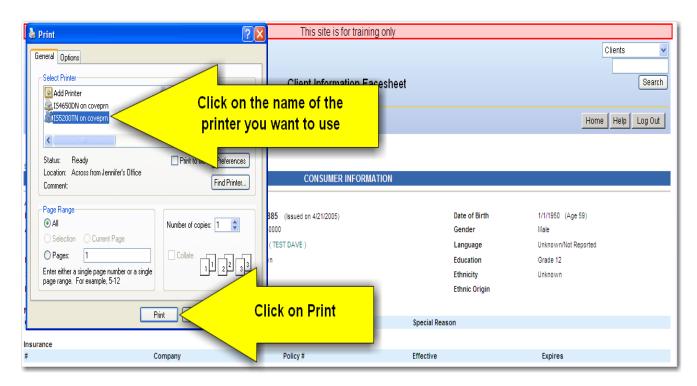
- 1 The search results screen will show the list of clients.
- 2 Click on the client's name to get the Face Sheet for that client.



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

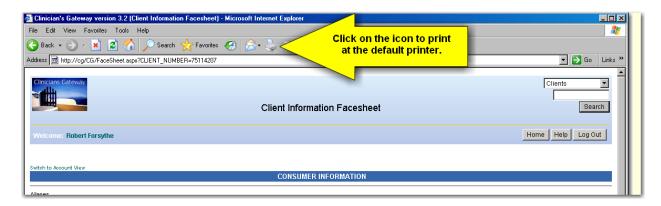


• Click on print.



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

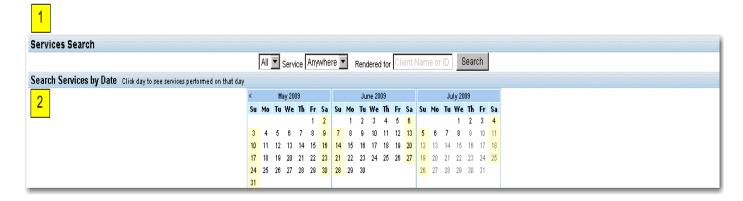
Alternately, you can use the printer icon and the Face Sheet will print at your default printer....



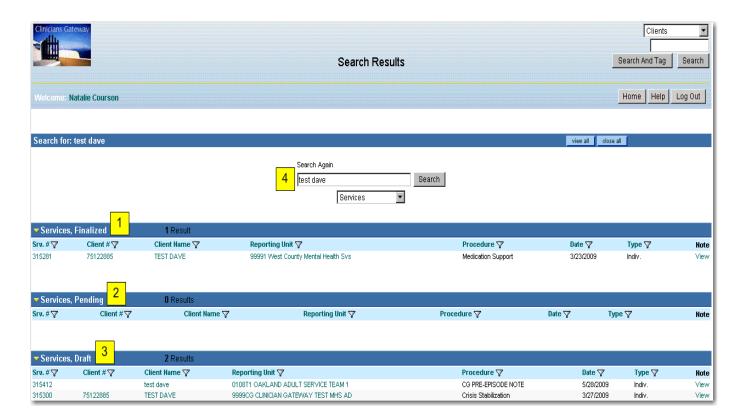
Client Services Search



- 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)
- 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 list (1) Finalized, (2) Pending, and (3) Draft services separately.

– You also have the option of searching for a different client's services from this page.

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. From your home screen, click on the "Search and Tag" button in the upper right hand corner.
- 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, if desired, 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 desired.
- 7. Click the Search button to assemble your results.

REVIEW, PRINT OR SAVE YOUR RESULTS

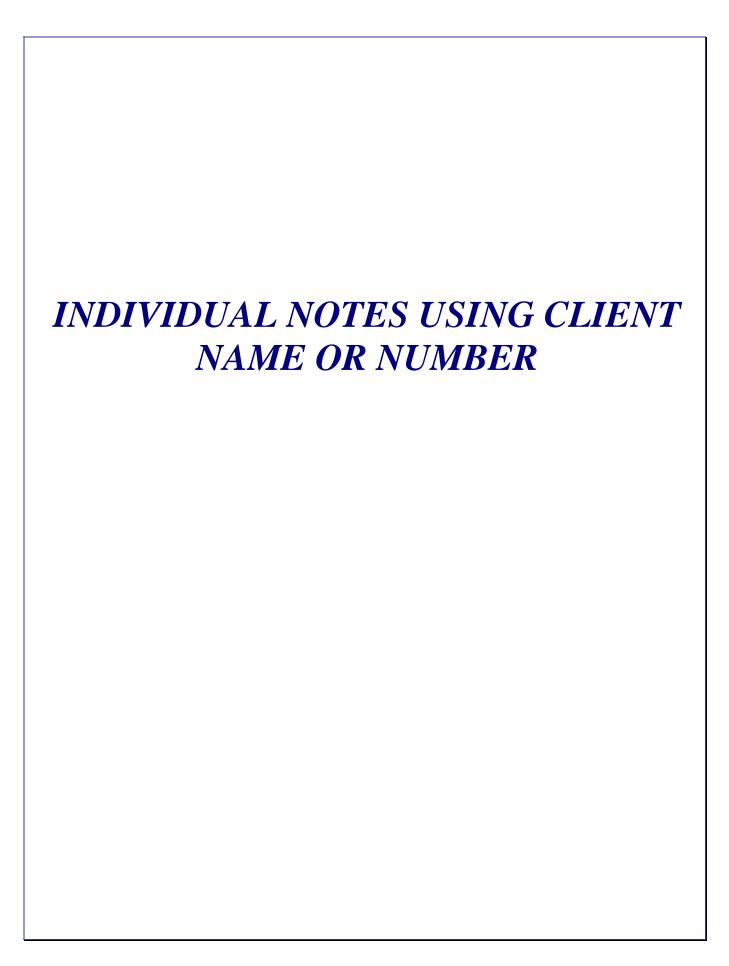
- 1. To sort your items by a certain topic, click the top of that column (e.g. Date of Service)
- 2. Check the items that you wish to view or save.
- 3. Click on one of the Review/Print buttons (all checked items or all results).
- 4. Choose "Open" to view them or "Save" as desired.
- 5. To read them, 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

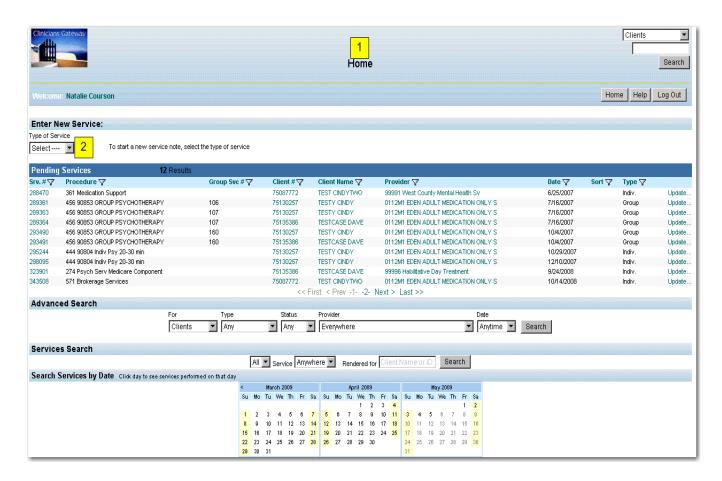
- 1. To retain your collection in Search and Tag for later reading, click the blue <u>message "click</u> here to add a new collection name"
- 2. Enter the name of the collection and click OK
- 3. Click the "Save Tagged" button and all items checked will be moved to the collection. You can do this multiple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

TO RETRIEVE A PREVIOUSLY SAVED COLLECTION

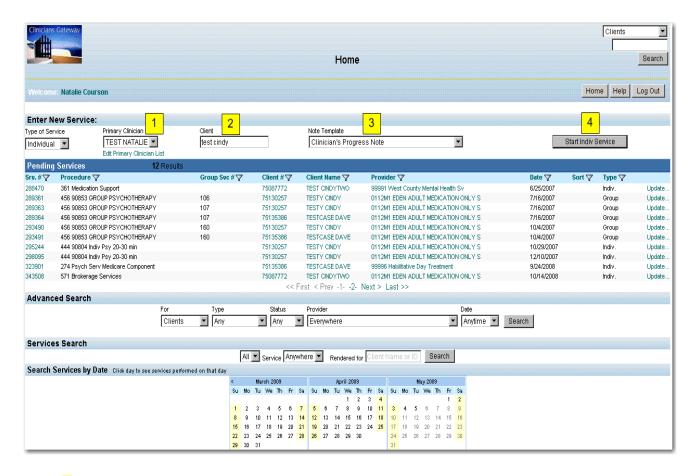
- 1. Click on the words "select an existing collection name"
- 2. The Drop Down menu indicator appears. Click on the down arrow.
- 3. Click on the collection that you would like to view.



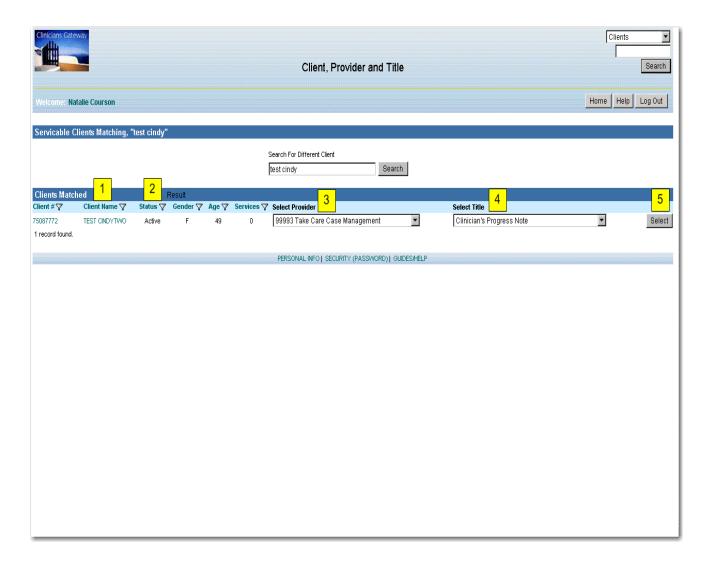
Individual Notes Using Client Name or Number



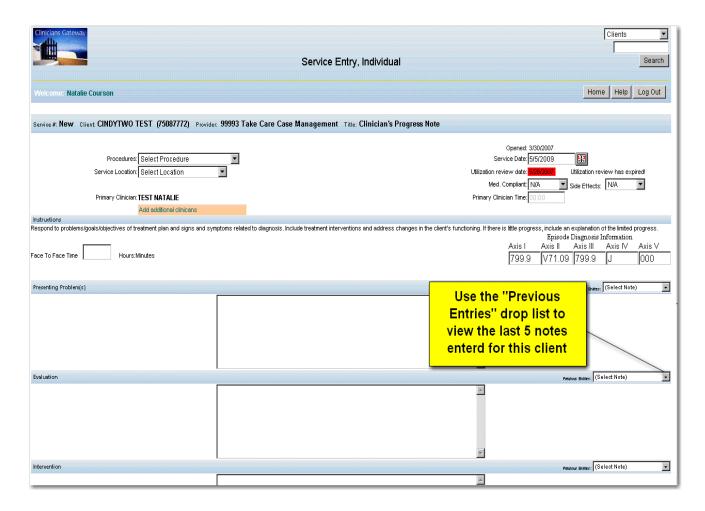
- 1 This is your home page.
- 2 Click on the drop arrow to select "Individual" for the type of service.



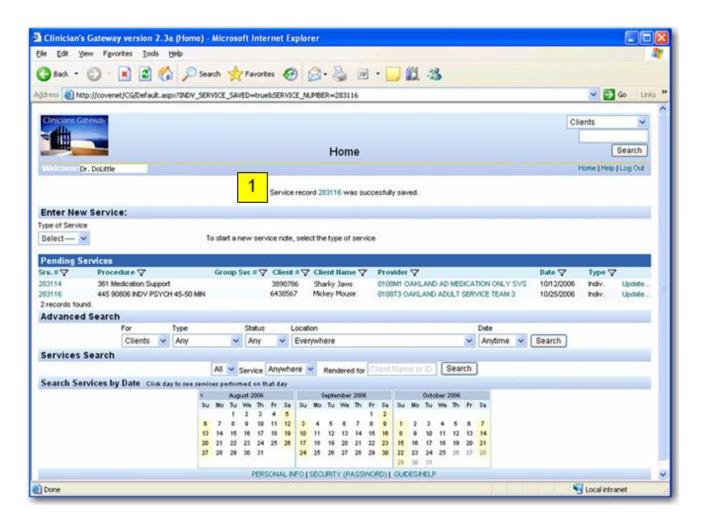
- 1 Verify the Primary Clinician name is correct.
- 2 Enter the client name (Last name then First name with no commas, ex. Mouse Mickey) or the client number.
- 3 Select the template name from the drop list.
- 4 Click on "Start Indiv Service."



- 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"



- 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 "Save as pending."



■ 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.

Notes: Draft versus Pending, Archive, and Finalize?

Drafts: Save as **Draft** when you have <u>incomplete</u> 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 <u>completed</u>, 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 <u>seal it with your electronic signature</u> and add it to your services that are <u>transferred nightly to InSyst for claiming.</u>

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 vour 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.

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.

blank

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

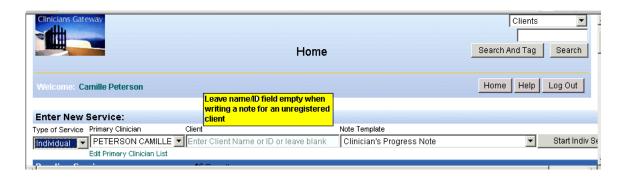
Informational only Notes can be used to write notes for clients using procedure code 197 and claiming zero minutes. Your time is billed as an indirect service. The procedure varies according to whether the client has an open episode or is registered.

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.

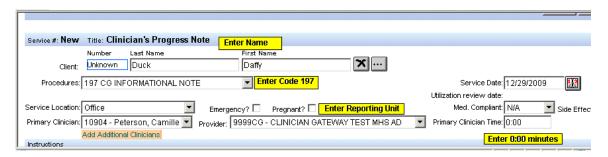
To write a note for a client who is not yet registered (Outreach – Treatment Refused by Prospective Client):

- 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.

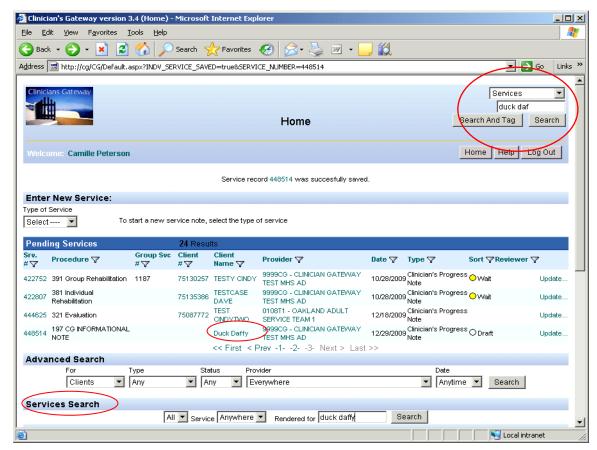
- 5. On the Service Entry Screen, enter the client's Last Name and First Name in their respective data field boxes.
- **6.** USE PROCEDURE CODE 197 INFORMATIONAL NOTE and enter 0 MINUTES time. Designate the Provider Reporting Unit from the drop down menu.



- 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.

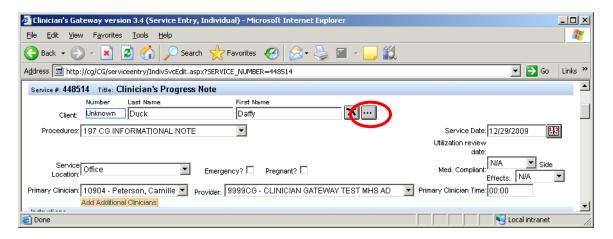
To recall the Draft note: (To add the client's # when available)

- **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

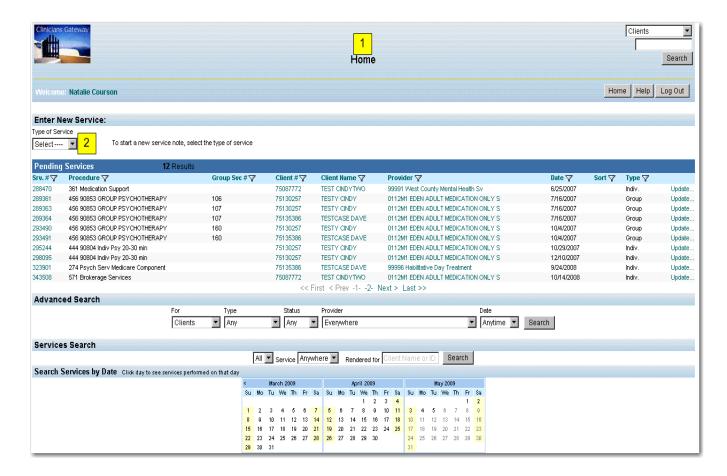
If you claimed your time on an Indirect service note, do not claim time now, or you will double claim.

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

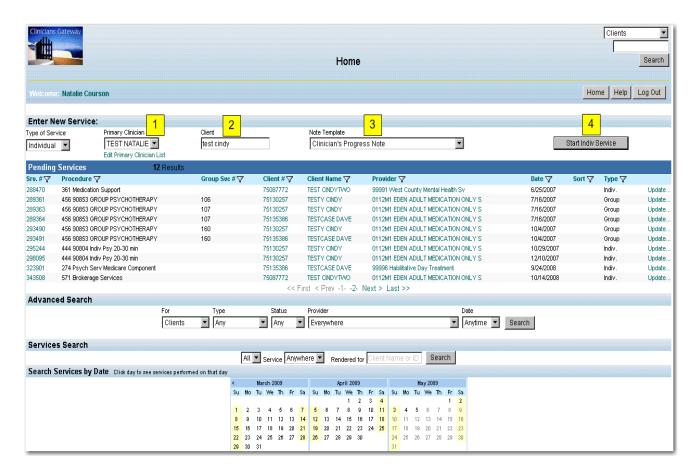
- 13. When the note is complete, check the "**Note Complete**" box.
 - 12.Click "Save as Pending." The note can be finalized if the service is within the episode dates. Otherwise it will remain as a Draft note in that client's records.

blank

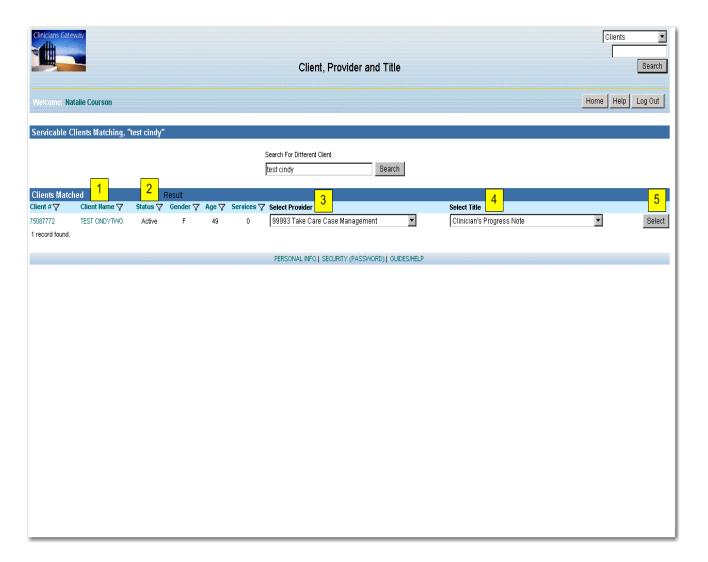
Co-staffed Individual Notes



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

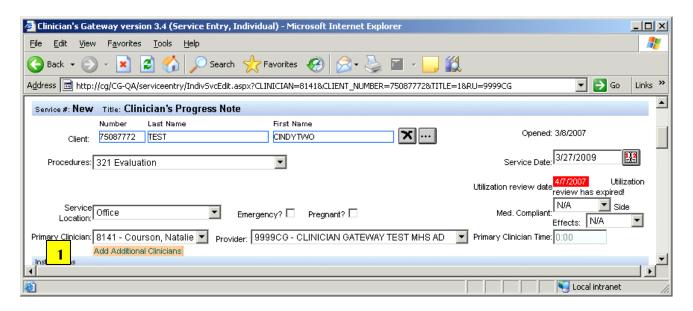


- 1 Verify the Primary Clinician name is correct.
- 2 Enter the client name (Last name then First name with no commas, ex. Mouse Mickey) or the client number.
- 3 Select the template name from the drop list.
- 4 Click on "Start Indiv Service."

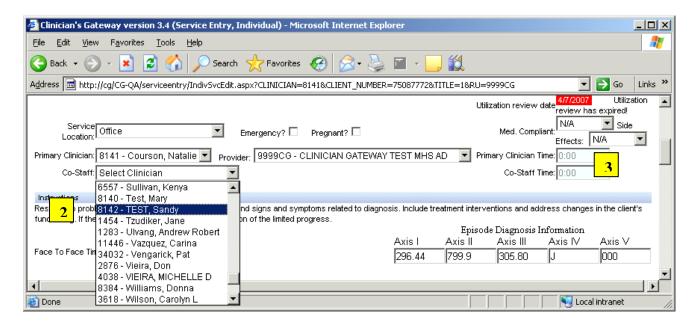


- 1 Verify the client name.
- 2 Verify the status for that client. "Active" indicates that the client has an open episode.
- 3 Verify the appropriate provider name is indicated.
- 4 Select the Title of the type of note you will enter.
- 5 Click on "Select"

• Complete the billing information above the blue line.

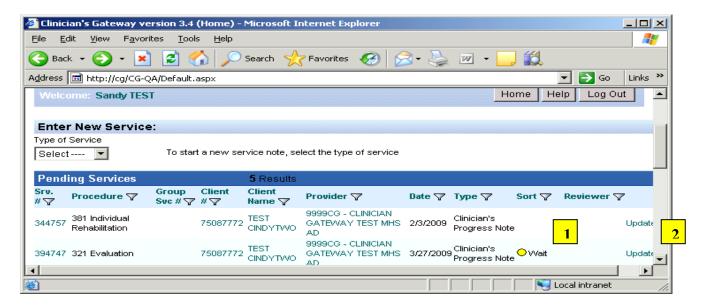


- 1. Click on "Add Additional Clinician's."
- 2. Choose the Co-staff from the drop down menu.
- 3. Enter time for both clinicians

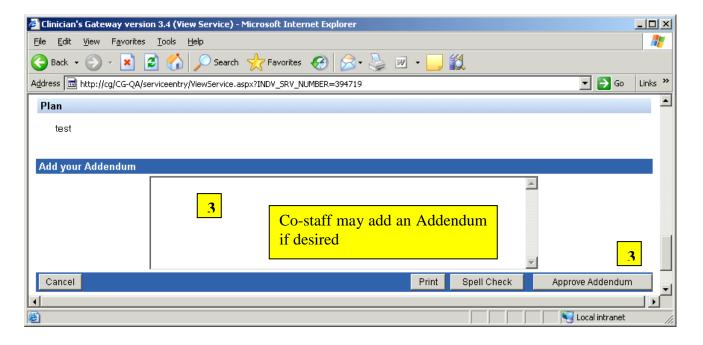


- Complete all of the progress note entries. Check "Note is Complete."
- Click on "Save as pending."

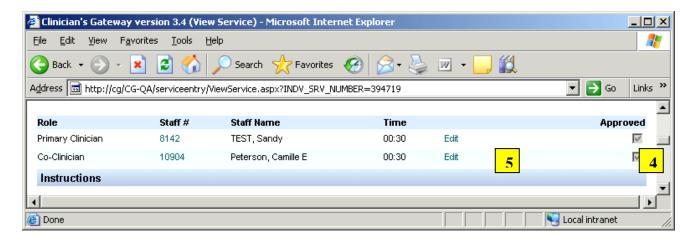
- 1 The note will be listed on the primary and co-staff's pending lists with a yellow dot and the word "wait" which displays the message "Waiting for clinicians to approve this service" when pointed at with the cursor. This is an advisory message only. Either Clinician may finalize at any time.
- 2 The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



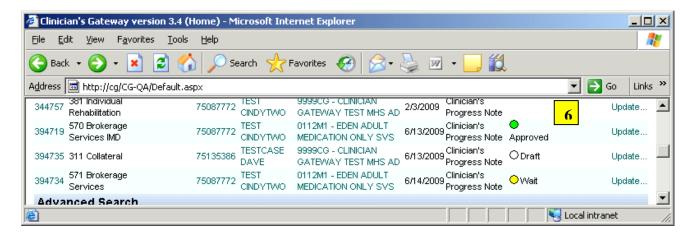
■ 3 – If desired, add the addendum at the bottom of the note and click "Approve Addendum"



- 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.



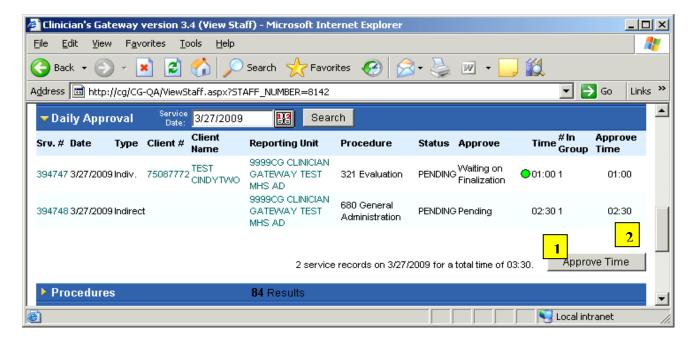
• 6 - If the Co-staff have added an addendum, the note disappears from the Co-staff's Home page Pending list. It is no longer available for editing. The dot on the Primary's Home page Pending list then turns green.



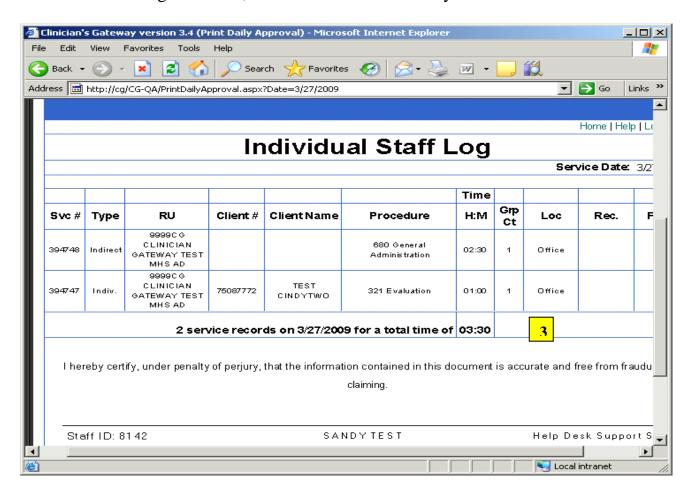
• The note will also disappear from the Co-staff's Home page Pending list when the Primary finalizes because it is no longer available to the Co-staff to edit.

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.

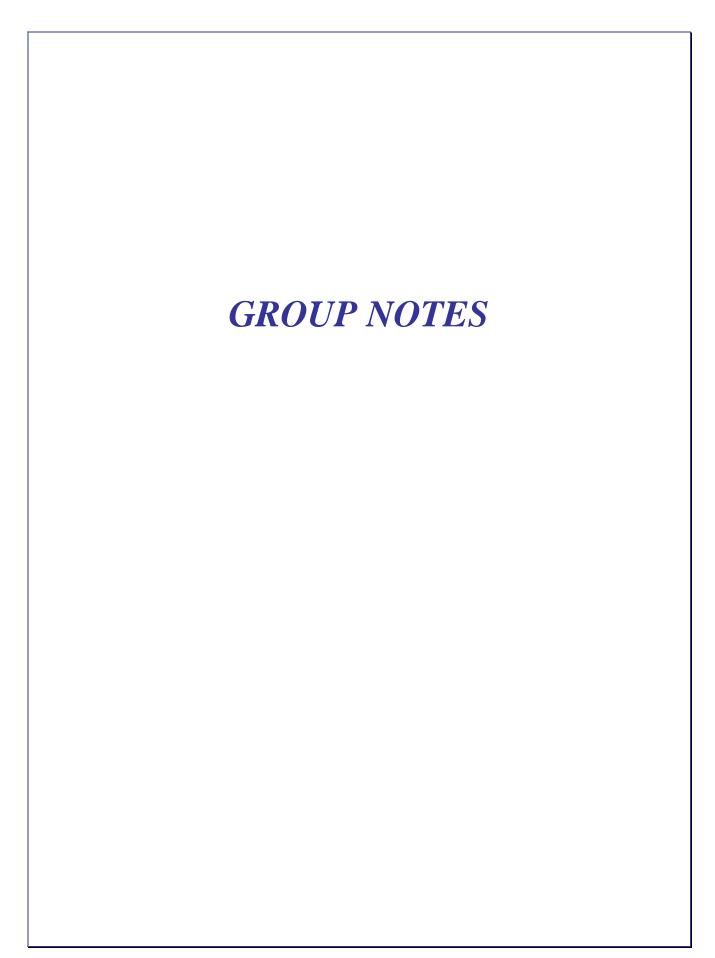


■ 3 – The service is listed on the Co-Staff's log and the Co-Staff time is added to the Staff Log total time, whether or not the Primary has finalized.



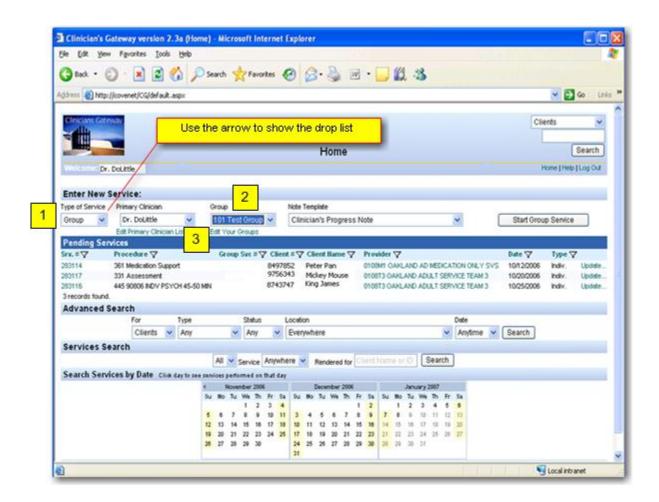
The time will appear on the InSyst reports the day after the Primary clinician finalizes, not on the day that the Co-Staff clinician finalizes.

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



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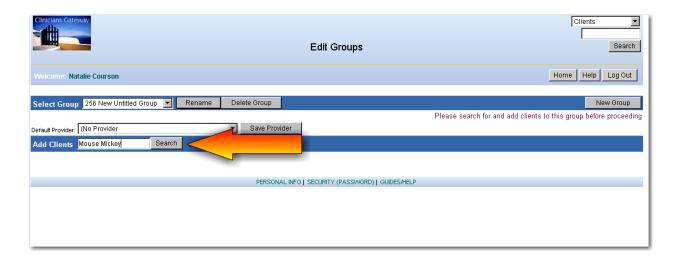
Group Notes



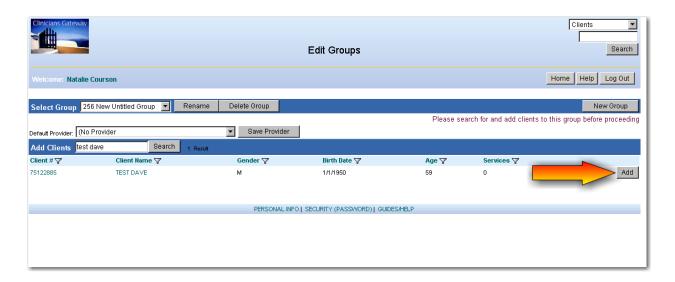
- **1** Select "group" under "type of service."
- 2 Select group description.
- 3 If this is a new group then click on "Edit your groups"



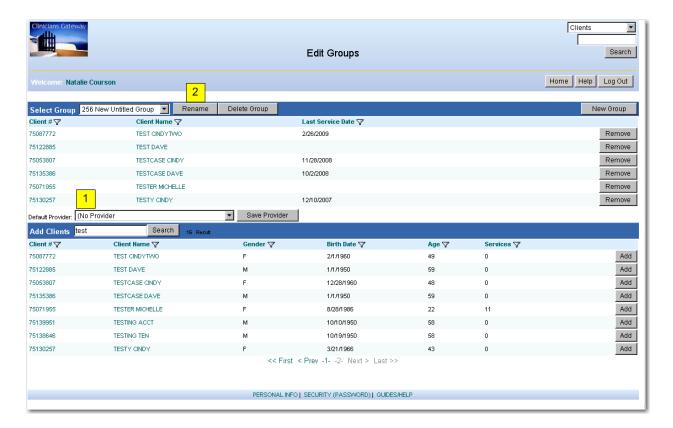
• One –Click on the "New group" button.



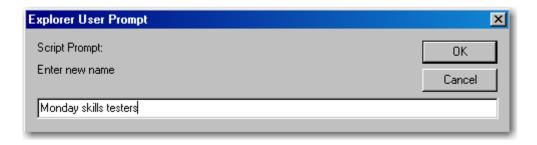
• Type in the clients name in the "Add Clients" field (Last name then first name, with a space between) then click on the "Search" button and wait for the list to populate.



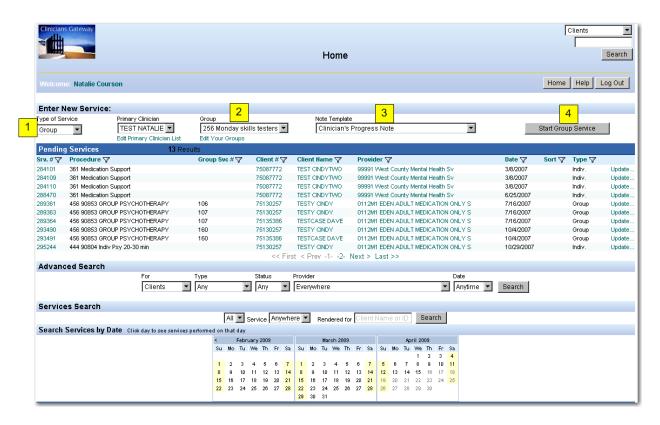
- When the client information appears, click on the "Add" button.
- Follow the same steps to add all of the other members to the group listing.



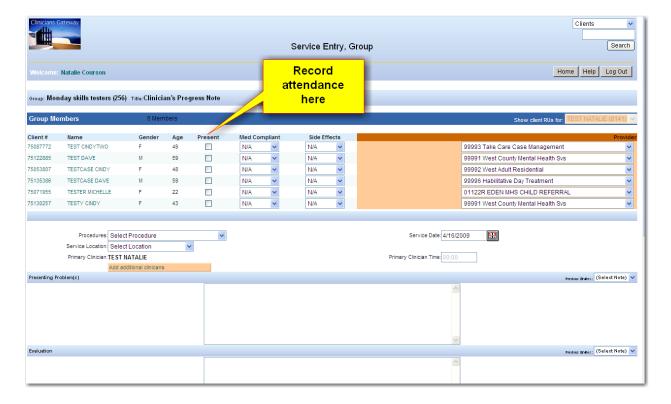
- 1-Select a default provider from the drop list and click on Save Provider
- 2-Click on Rename to enter the name of the group you have created. When naming the group, you can use names that remind you of the days the group meets, and the type of group they are...e.g. "Wednesday Rehab" or "Tue&Thu Skill Building"



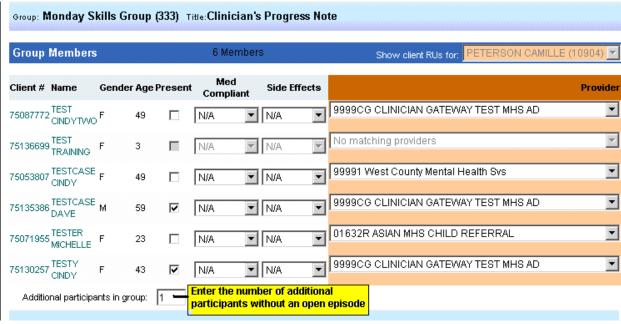
- Click on "OK" to save the name of the group.
- Click on home to go back to the home page and start the group note.



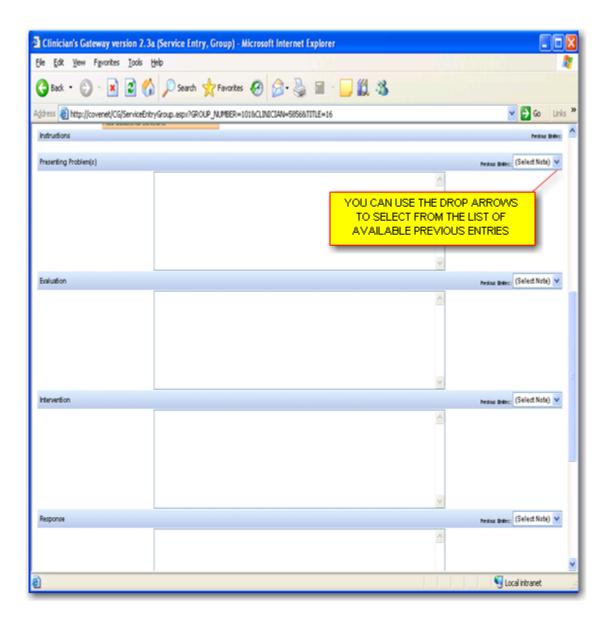
- 1 Select group under "Type of service."
- 2 Select the group.
- 3 Select note template.
- 4 Click on "Start group service."



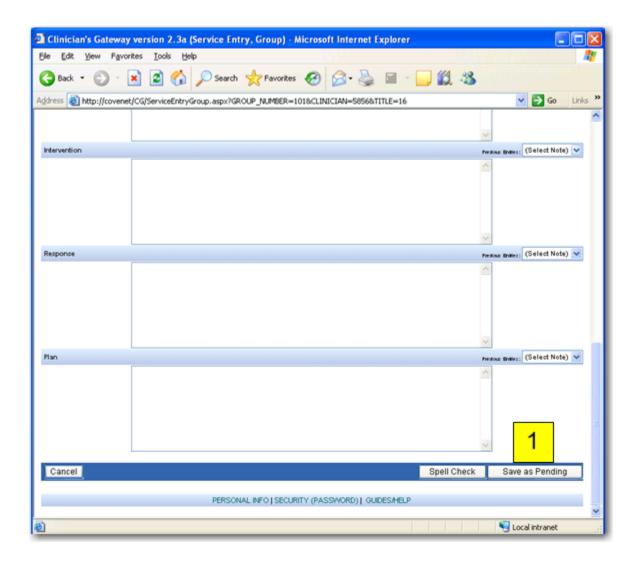
- Click on the square box under the "Present" column for each client in attendance. A check mark should appear.
- Complete the fields for the procedure, service location, co-staff, service date, primary clinician time, and co-staff time (if co-staff were entered).
- Be sure to select the correct provider for the client from the Drop list!
- Enter the number of additional participants (clients without open episodes)



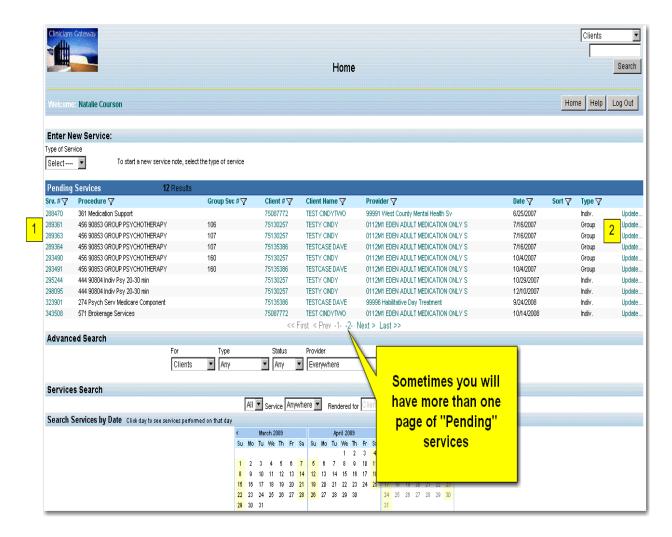
• Complete each text box as appropriate.



• View previous notes if desired.



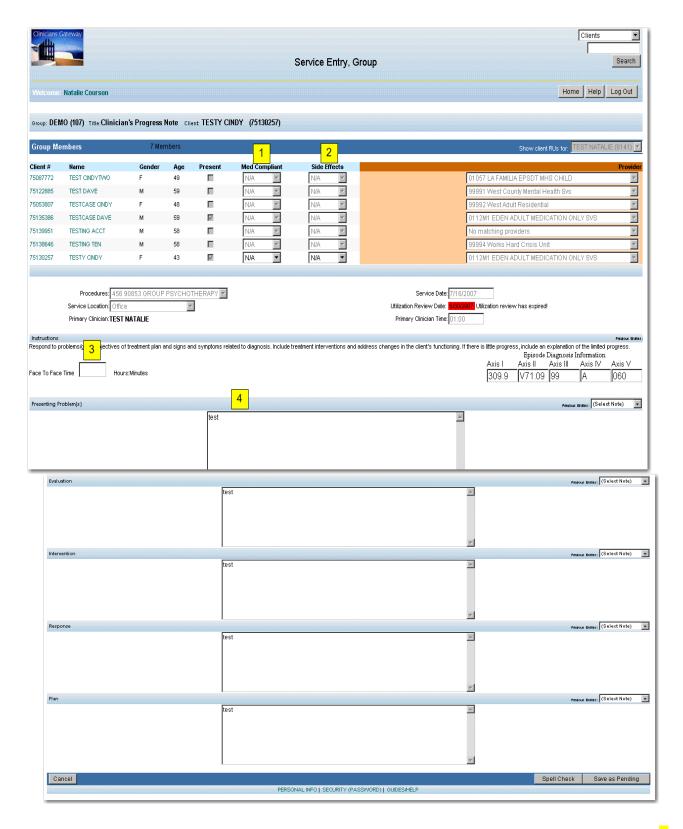
■ 1 — When all of the fields have been completed click on the "Save as pending" button. (If your notes require review, refer to the notes review section of this users guide).



- 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.

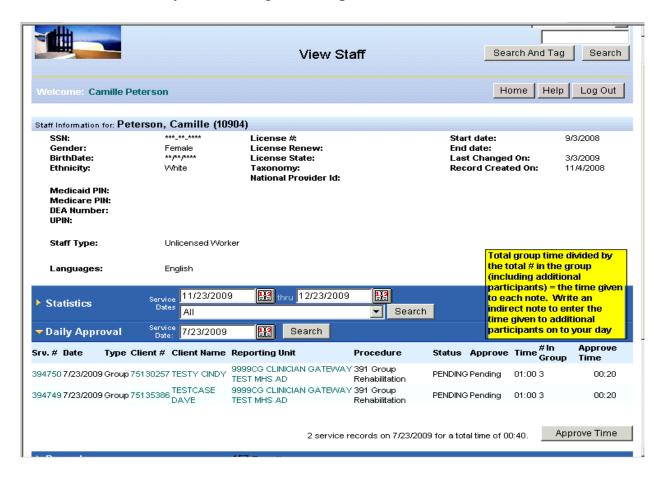


Now you can enter client specific notes for the group service. You will see that the (1) Med compliant and (2) Side effects drop lists can be utilized, (3) Face-to-Face time will need to be entered, and the (4)note fields can be used to enter additional information specific to that client.

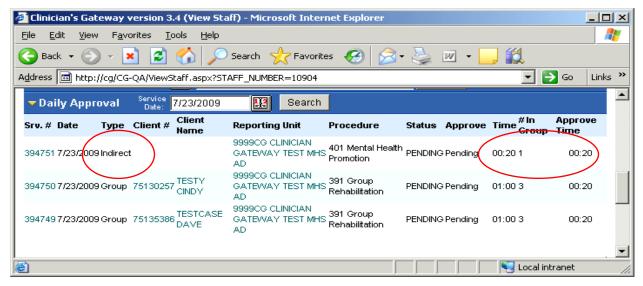
Click on "Save as Pending" when your entries are completed.

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.



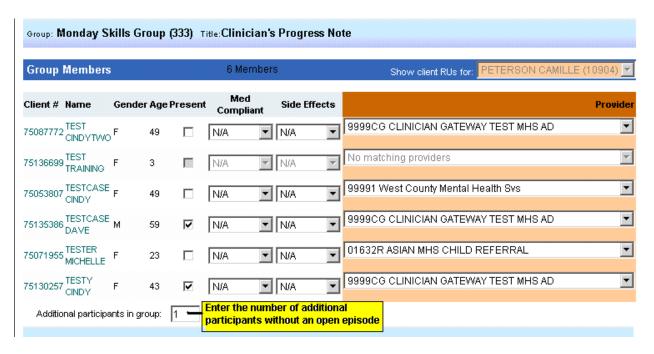
To add the time to your Staff Log for the additional participants, write an indirect note for group time not given to opened clients listed on the Log.



Additional Participants Feature

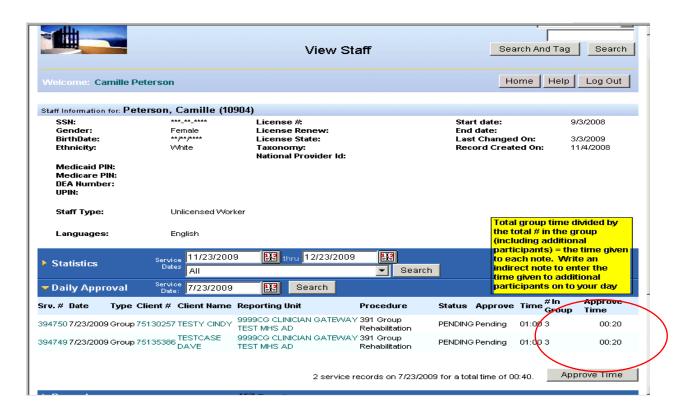
Occasionally, there will be a client in a group who does not have an open episode and cannot be claimed. Using the Additional Participants feature, the additional clients are added into the group total, increasing the accuracy of the claim for Medical billing. Only the part of the time dedicated to clients 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.



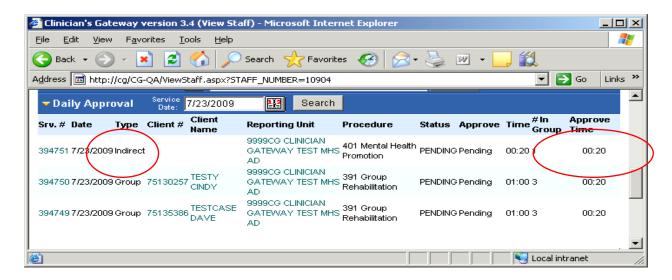
Complete the group note and the individualizations as usual.

- 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

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.

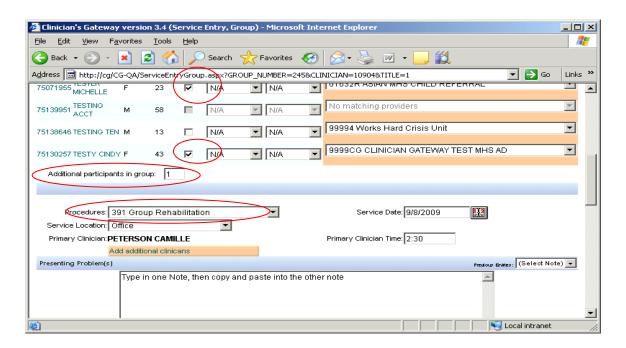
The note is written twice with each note having its correct procedure code. The clients who require the other procedure code are counted as "Additional Participants." CG will calculate the correct time for each individual.

For example: A group of three clients meets:

Two are not AB3632 eligible.

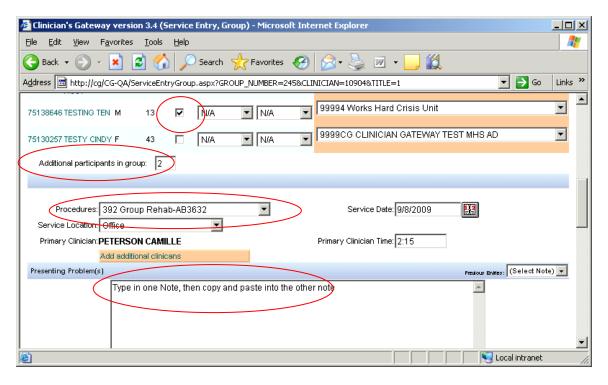
One is AB3632 eligible.

- 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).

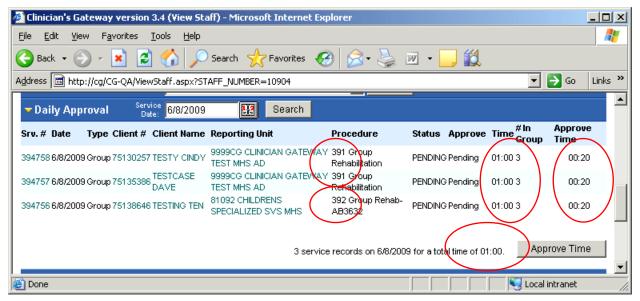
- Note Two: Write a second note marking the one AB3632 client present.
- Indicate that there are two additional participants (the non-AB3632 clients) in the group.
- Use the AB3632 procedure code.

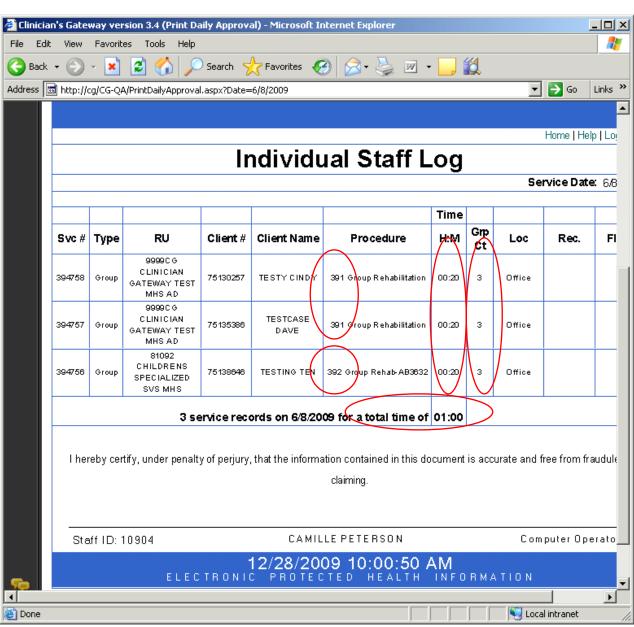


- This client will also be given $1/3^{rd}$ of the time.
- You can copy and paste the text from one note into the other. (You may want to open two sessions of CG and write these simultaneously.)

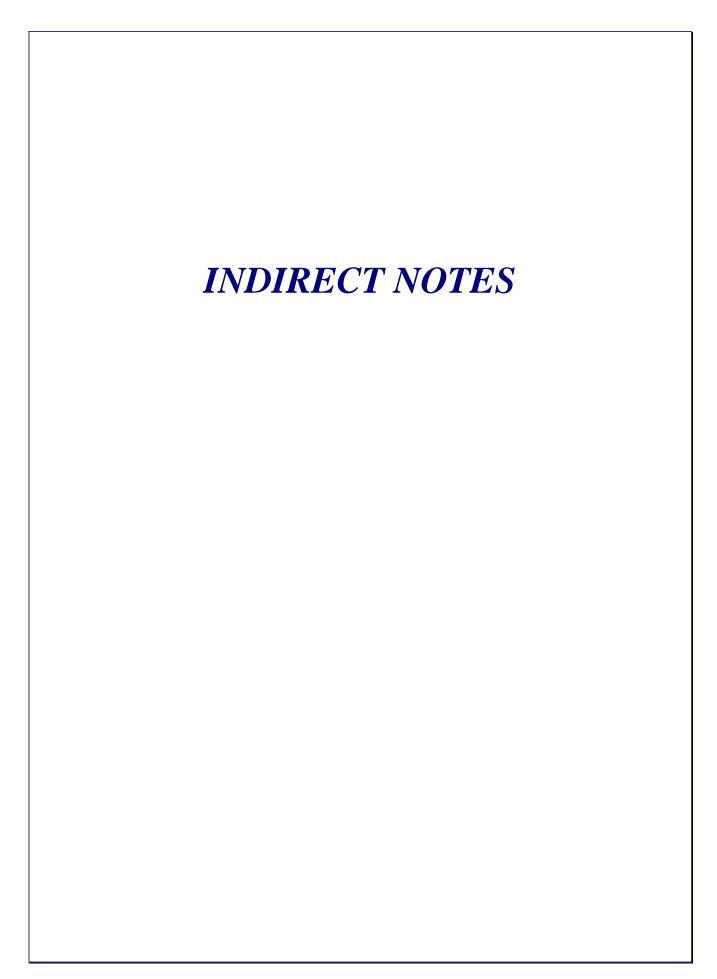
Make sure to write both notes!

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





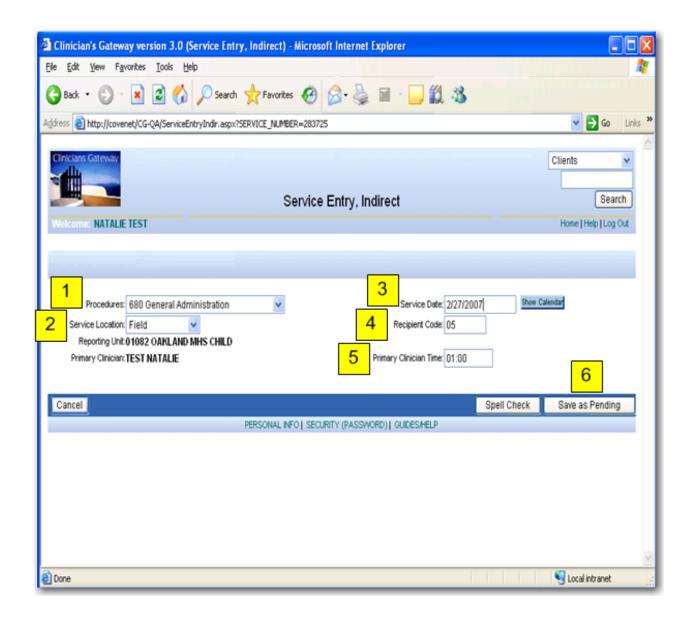
blank



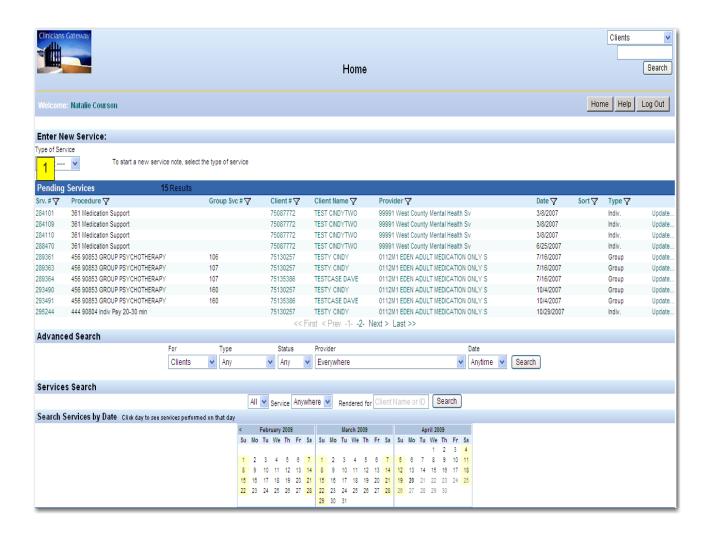
Indirect Notes



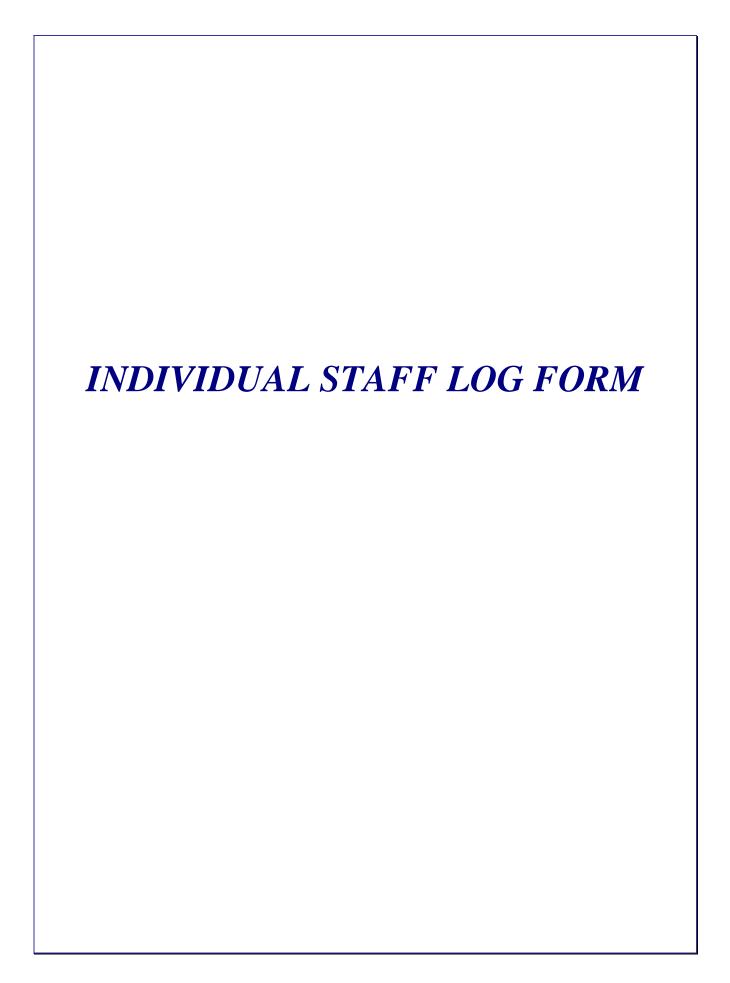
- 1 From the "Enter new service" section, (2) click the "Type of service" drop arrow and select "Indirect"; (3) click the "Reporting unit" drop arrow and select the appropriate RU.
- 4 Click on "Start indirect service."



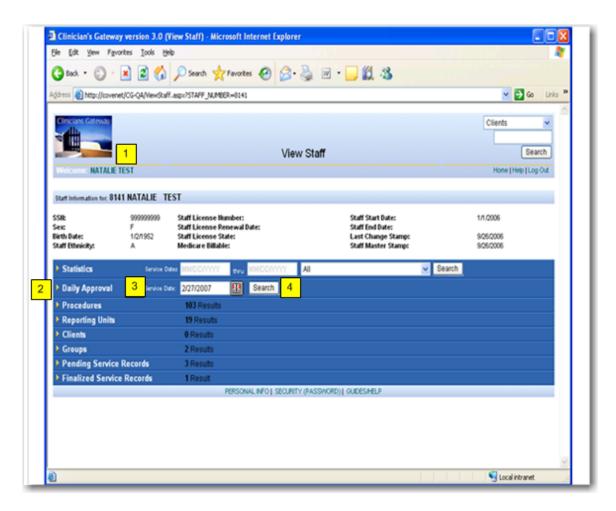
- Select the appropriate procedure code (1), service location (2), Service date (3), Recipient code (4), and time (5).
- **6** Click on "Save as pending."



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



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."

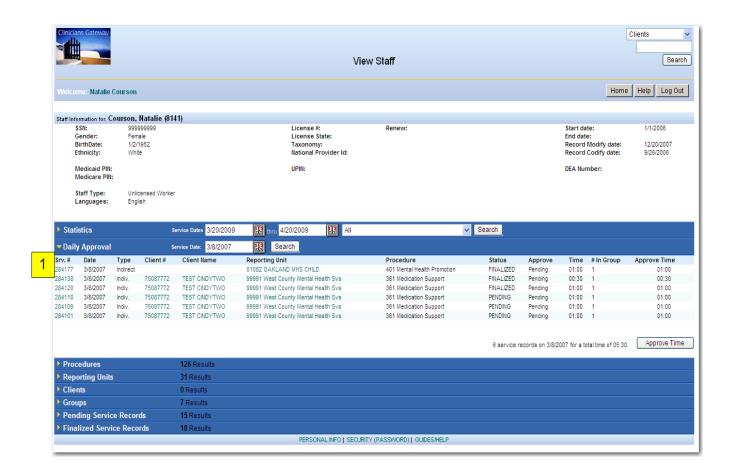
IMPORTANT!

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 finalizing all of the services listed.

Finalized services cannot be changed!

IMPORTANT!

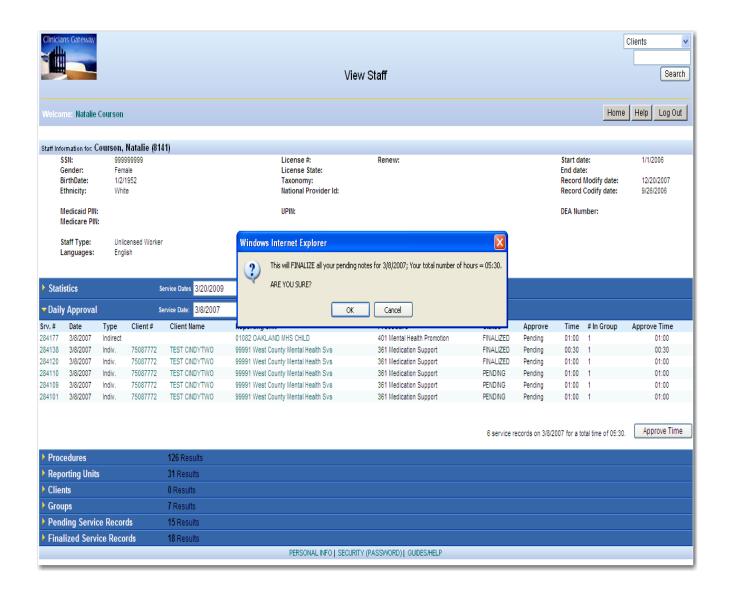


Please be sure to

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.

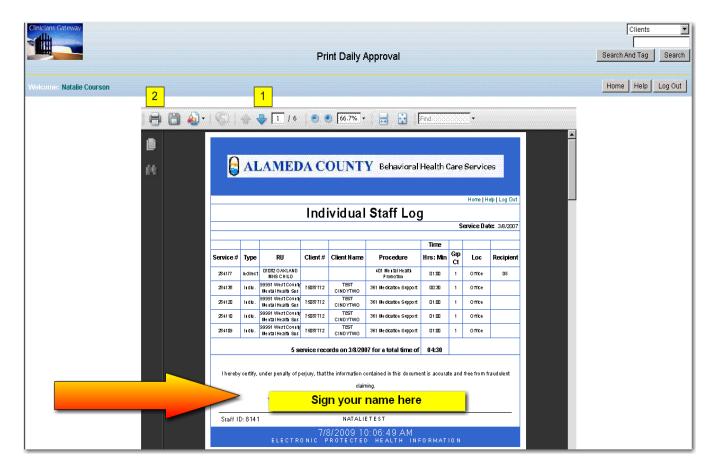


IMPORTANT!

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

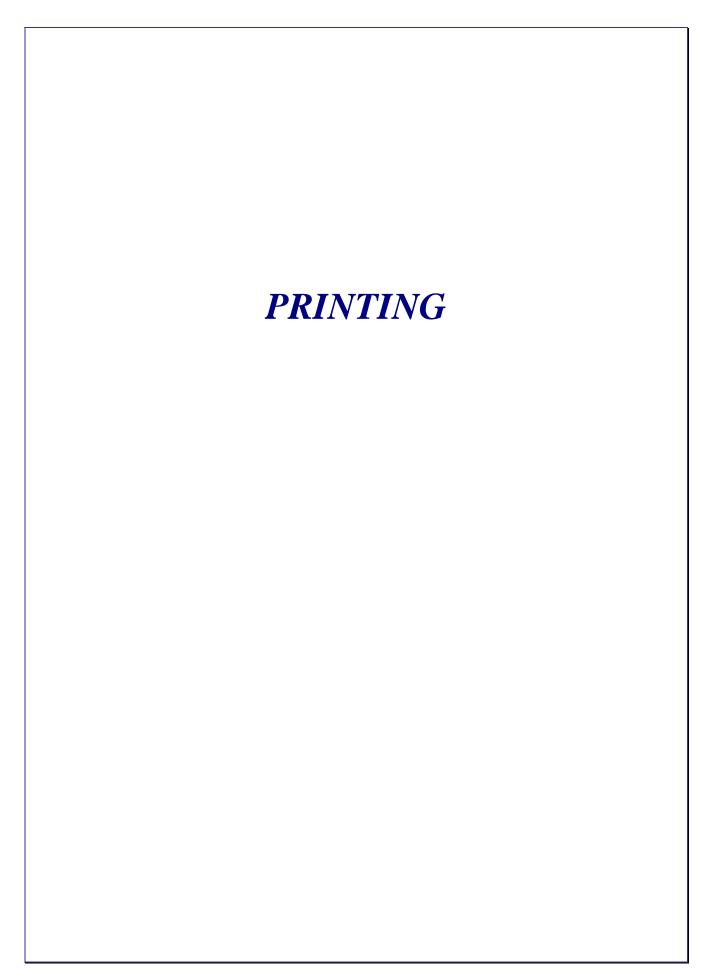


- 1. Decide which pages to print using the blue arrows and page numbers.
- 2. Click on the printer icon this will print the electronic Individual Staff Log form (MAA) as well as direct and indirect services.
- 3. You may specify which pages to print, eliminating unneeded pages.

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

ALA	AMEDA COUNTY Behavior	al Health Car	e S	ervic	es			
			Н	ome H	elp L	og Out		
		Service Number:	284177					
Indirect		Service Date:	e: 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 Info Systems Analyst - Operations Staff ID 8141 NATALIE TEST Manager								
	4/20/2009 3:08:32 PM ELECTRONIC PROTECTED HEALTH INFO				4 dila	igei		

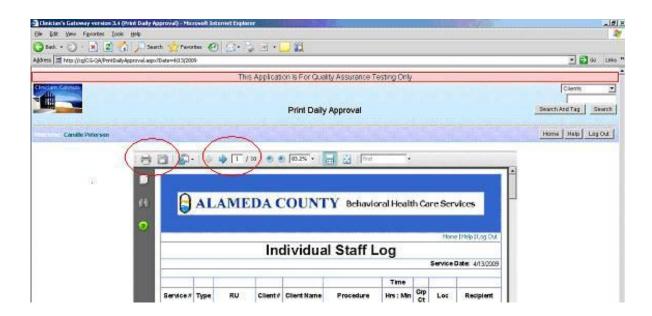
ALAMEDA COUNTY Behavioral Health Care Services Home | Help | Log Out Service Number: 284138 Clinician's Progress Note Service Date: 3/8/2007 Provider: 99991 West County Mental Health Svs Office Location: Procedure: 361 Medication Support Number in Group: Side Client: 75087772 TEST CINDYTWO Med Compliant? N/A N/A Effects? 8141 NATALIE TEST Primary Clinician: 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. Episode Diagnosis Information Axis IAxis IIAxis IIIAxis IVAxis V Face To Face Time 0 Hours:Minutes 296.60V71.0999 Presenting Problem(s) test **Evaluation** test Intervention test Response test Plan test Electronic signature on file Info Systems Analyst - Operations Staff ID 8141 NATALIE TEST Manager TEST CINDYTWO (75087772) 4/20/2009 3:08:32 PM ELECTRONIC PROTECTED HEALTH INFORMATION



Printing from Daily Approval

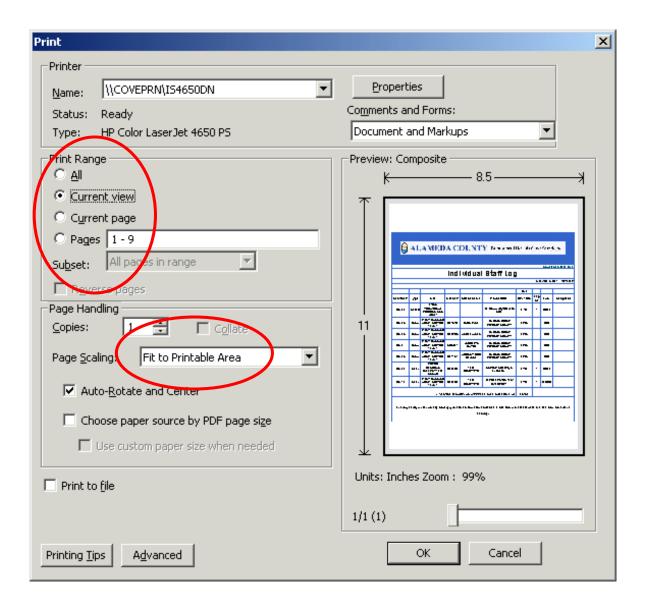
To print your Staff Log and progress notes after Daily Approval, use the printer icon and blue arrows above and adjacent to their images. (Circled below) Do not use File/Print

- 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.

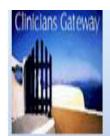


• Use the printing menu to designate which pages to print.

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...

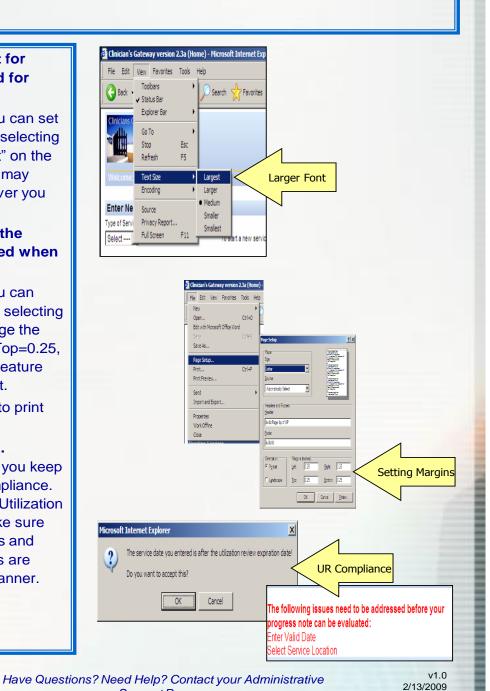
•In Internet Explorer, you can set the Font Size Larger by selecting "View-Font Size-Largest" on the Menu Bar. This feature may need to be reset whenever you login to your PC.

Setting Margins so all the Information is Displayed when Printing...

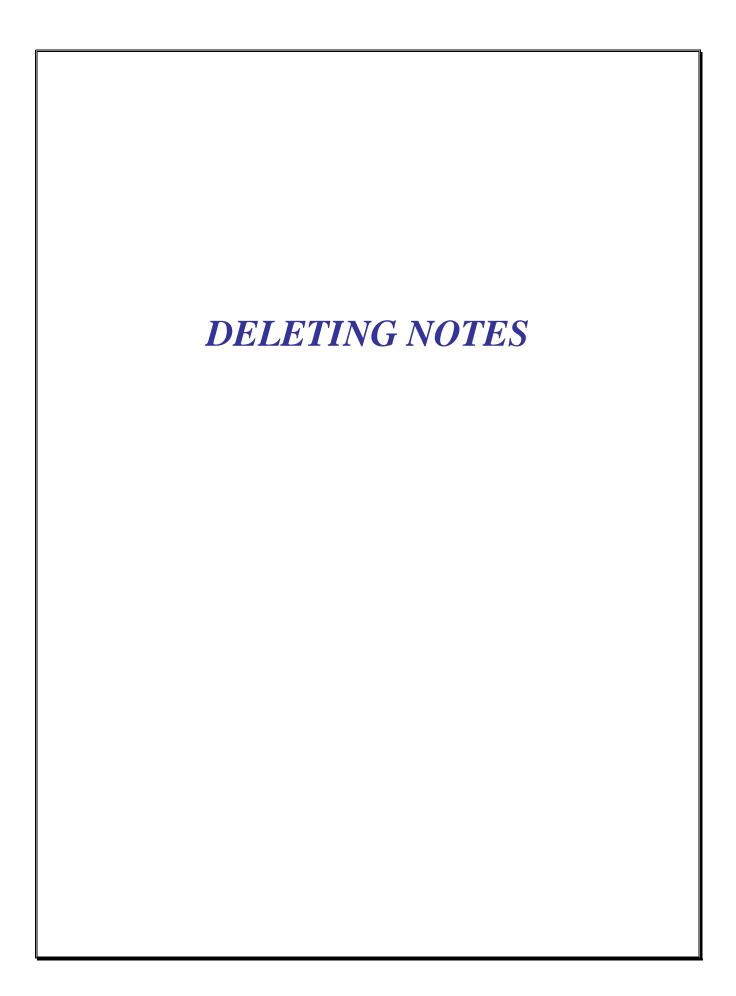
- •In Internet Explorer, you can change your Margins by selecting "File-Page Setup", change the Left=0.25, Right=0.25, Top=0.25, and Bottom-0.25. This feature should stay once it is set.
- •The Header is needed to print client info on the OLPN

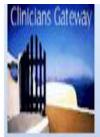
UTILIZATION REVIEW...

•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.



Support Person.





CLINICIAN'S GATEWAY

- 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 <u>ONLY</u> 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 "<u>Clinician's</u> 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.

ALAMEDA COUNTY Behavioral Health Care Services

Request to Delete Clinician's Gateway Note

00 0 to N orl or	Out to But							
CG Service Number:	Service Date:							
Service RU:	Clinician Staff Number:							
Clinician Name:	Signature:							
Reason:								
This is a:								
☐ Same-Day Delete	☐ NON Same-Day Delete							
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.								
Use For NON Same-Day deletes only (To be completed by staff deleting the								
InSyst Service Delete Date:								
Staff Name:								
0: /								

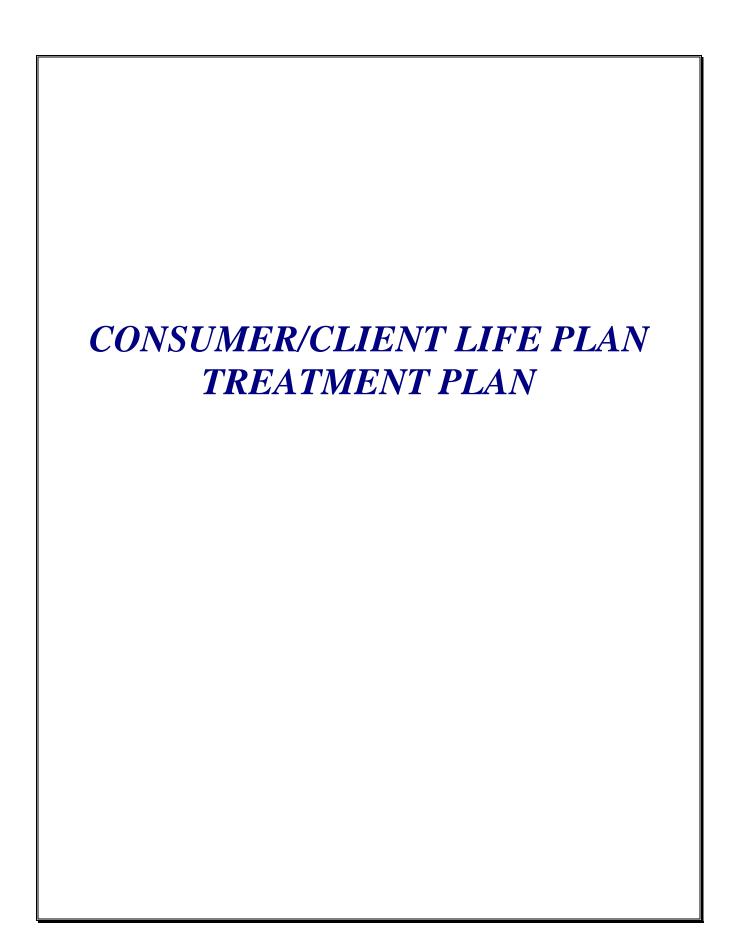
INSTRUCTIONS:

Please fill out a separate form for each service delete requested. There are two kinds of deletes, a **Same-Day** delete and a **NON Same-Day** delete. 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** previous to today, and has already been **TRANSFERRED** to InSyst. If a note has not been finalized and is still listed as 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 your input staff and have them delete the service from InSyst.
- 7. Input person should sign and date this form that the service was deleted.
- 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:	



Consumer/Client Life Plan, Treatment Plan

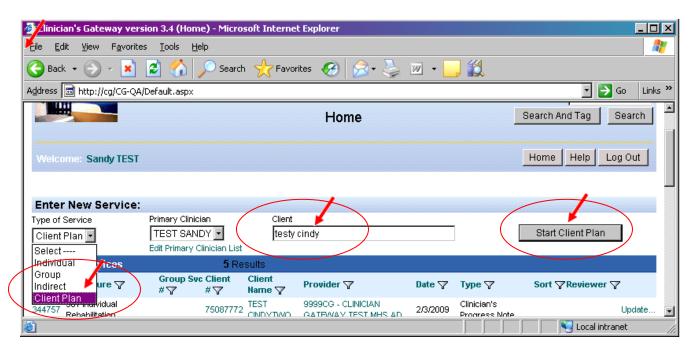
The **electronic treatment plan** in Clinician's Gateway is based on the principles of Wellness, Recovery and Resilience and family, client and consumer involvement while also addressing the need to establish medical necessity for treatment.

The Consumer/Client Life Plan consists of two main sections: the Medical Necessity documentation and the 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.

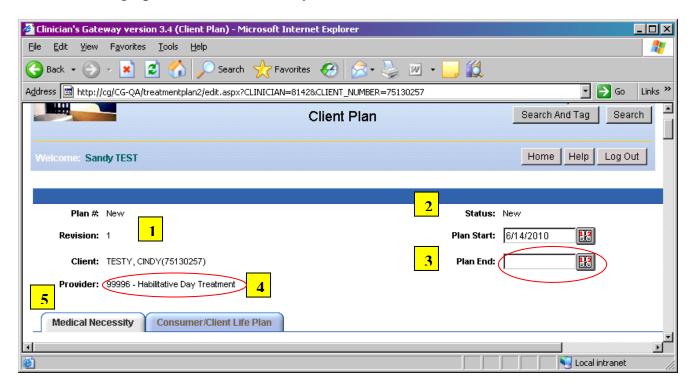
The **general procedure** is:

- 1. Write the Plan (using correct RU and End Dates to match InSyst).
- 2. Submit for Approval.
- 3. Print for Client Signature. (before submitting for approval the Plan will say "Pending")
- 4. Finalize the Plan in CG after signatures are noted and approvals obtained in CG.
- 5. Enter Plan approval into InSyst.
- 6. "Edit" the Plan when objectives are achieved. Minor edits are allowed without re-approval.
- 7. Revise and obtain new signatures/approvals as needed.
- 8. Renew the Plan every six months 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.



This will bring up the Client Plan entry screen.



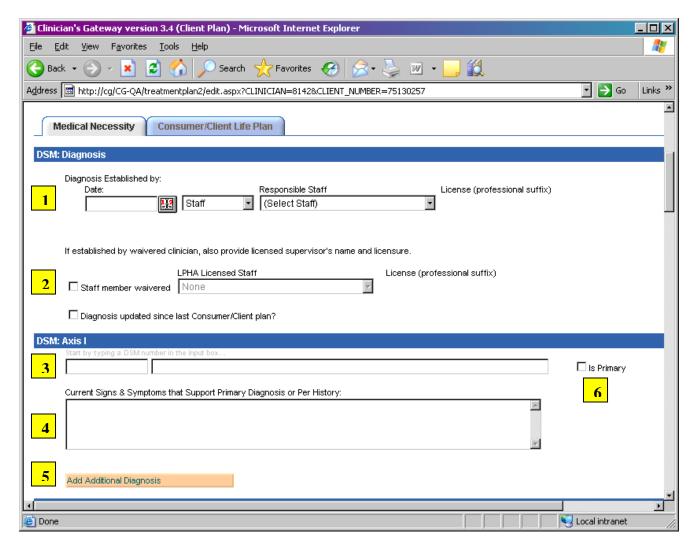
1. The Plan # is "New" before it is submitted for authorization. When submitted, it will be given a unique identifying number. Each time the plan is revised, the plan # will change.

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

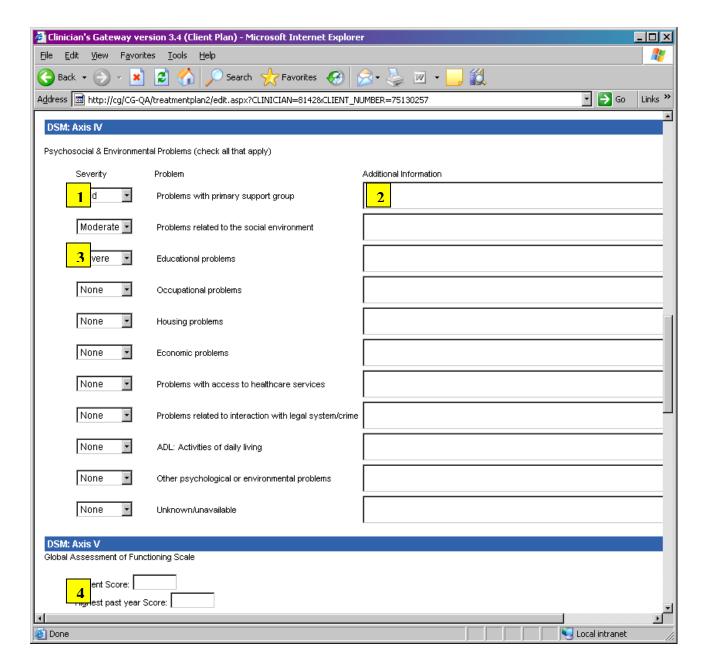
- 2. The Status can be "New" before submitting for authorization, "Authorizing" if submitted or "Finalized" after approved by approvers and finalized by the clinician.
- 3. The Plan Start Date will default to today's date. Back dating is not allowed.

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 of the sixth month (ex. If opened Jun 15th, calculate from Jun 1 to Nov 31. Enter the End Date of Nov. 31st using the calendar icon.)

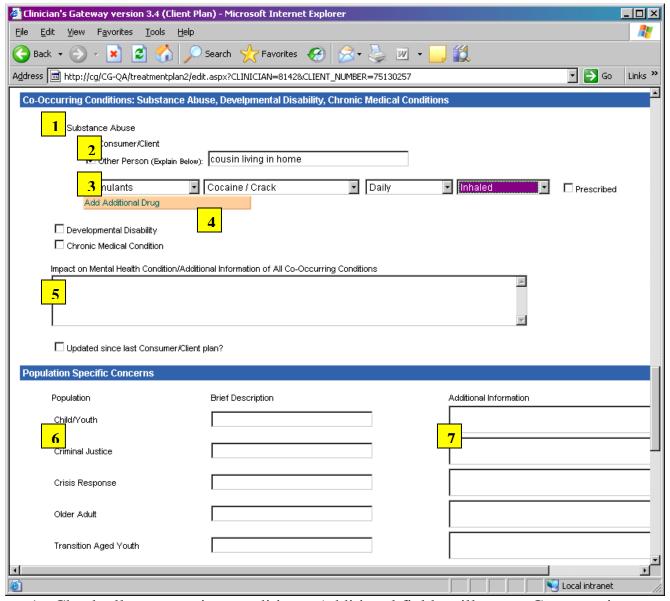
- 4. Choose the Correct Reporting Unit for the client.
- 5. Fill out the Medical Necessity tab.



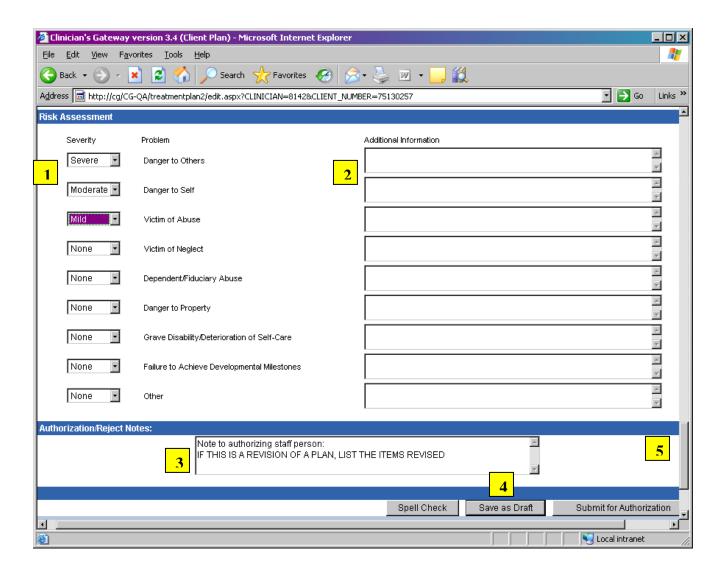
- 1. Enter the date and name of the person establishing the diagnosis, whether BHCS or outside staff.
- 2. Enter the licensed supervisor if the responsible person is waivered.
- 3. For Axis I, II, and III, enter the diagnosis by typing the first number of the DSM code and arrowing down through the list 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.
- 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.

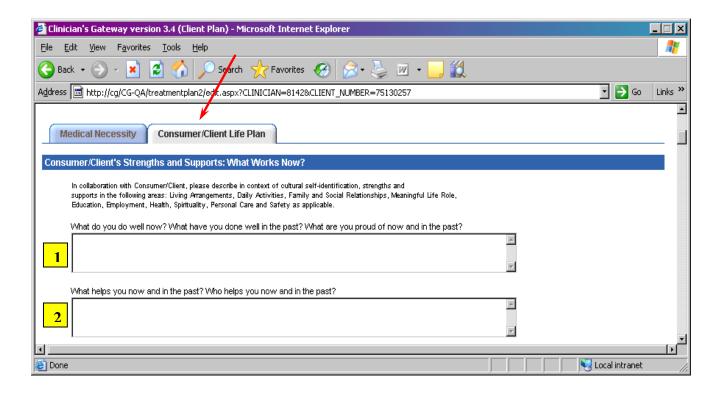


- 1. Check all co-occurring conditions. Additional fields will open. Co-occurring conditions will be displayed in the Objectives section of the Plan.
- 2. Mark if it is the consumer/client or another person in their life, adding who that other person is.
- 3. Fill in details of the condition
- 4. Click 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.



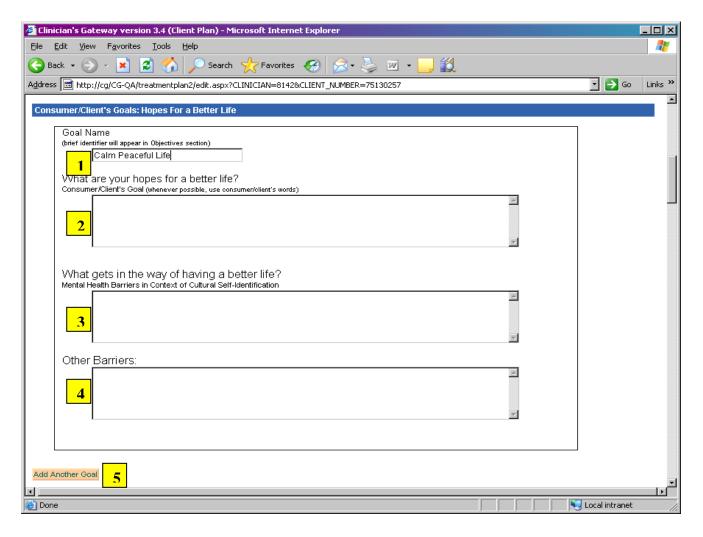
- 1. Note the severity of the Risks.
- 2. Additional information is required for severe risks.
- 3. Add a note to the staff persons who will be asked to authorize the Plan. If this is a revision of the Plan, list the items revised so that they know what to look for.
- 4. Save as Draft if not finished 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.

Consumer/Client Life Plan Tab



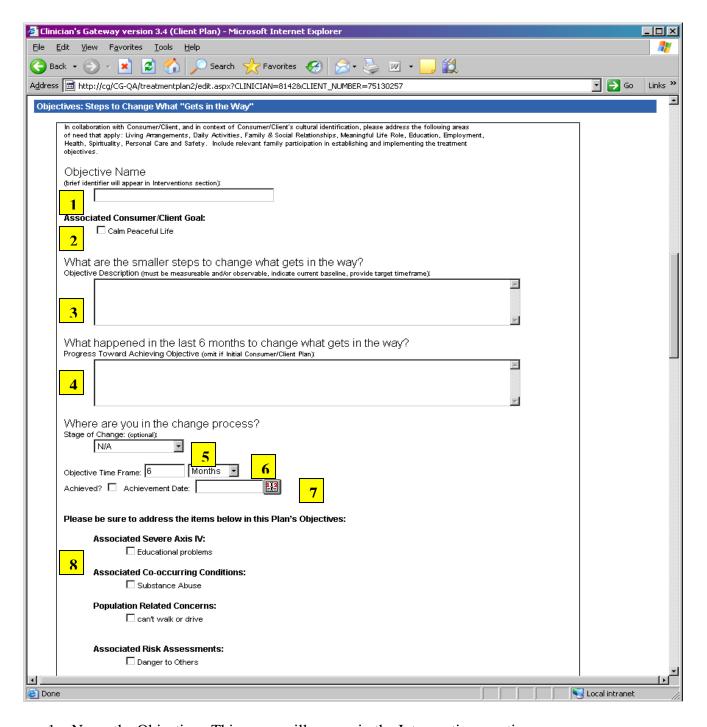
- 1. Enter the **Consumer**/ **Client's strengths**. You may return to add to this section as you work through the goals and objectives, as more strengths come to light.
- 2. Enter the **Consumer/Client's supports.** You may return to add to this section as you work through the goals and objectives,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

GOALS



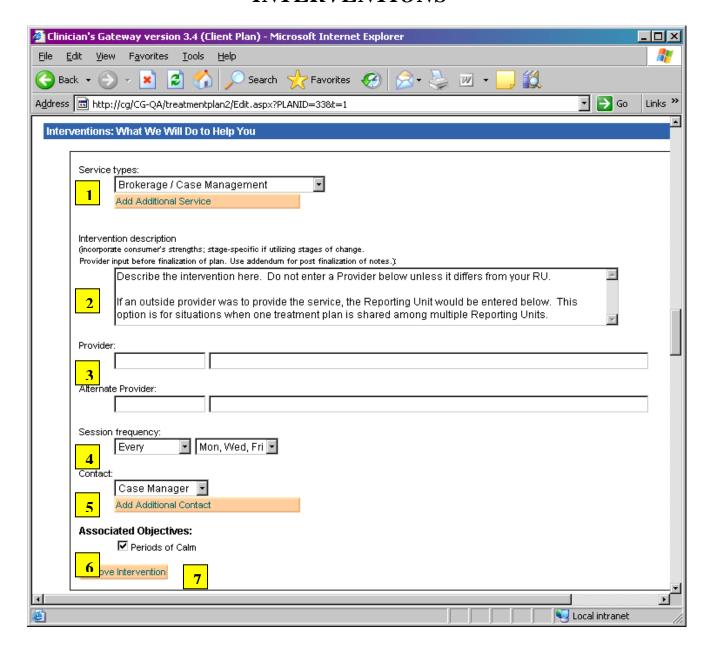
- 1. Name the Goal. This name will appear in the Objectives section,
- 2. Describe the Goal.
- 3. Describe Mental Health Barriers to the Goal.
- 4. Describe other barriers to the Goal.
- 5. Add another Goal if appropriate
- 6. Continue on to the Objectives section.

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 6 months 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.

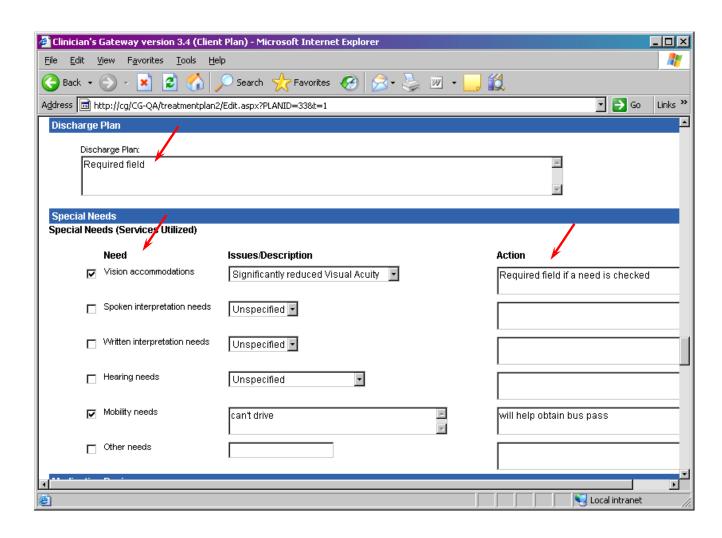
INTERVENTIONS



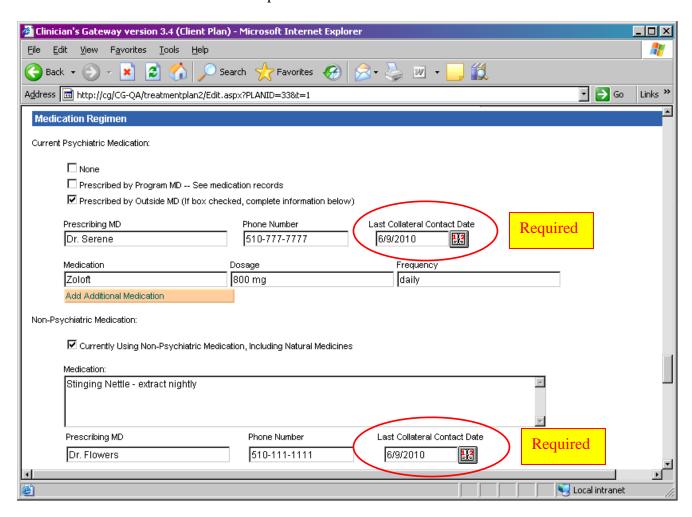
- 1. Define the types of service offered for this intervention. Multiple types can be listed per intervention.
- 2. Describe the intervention. Interventions to be carried out by other providers (shared Plan situations) may be described. Staff from the defined Provider can enter notes here.
- 3. If an 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.

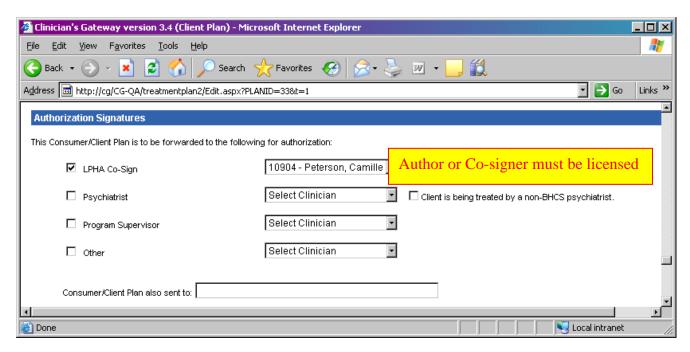
2. Check and define any **Special Needs**. A description of the action to be taken is required if a Need has been checked.



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.



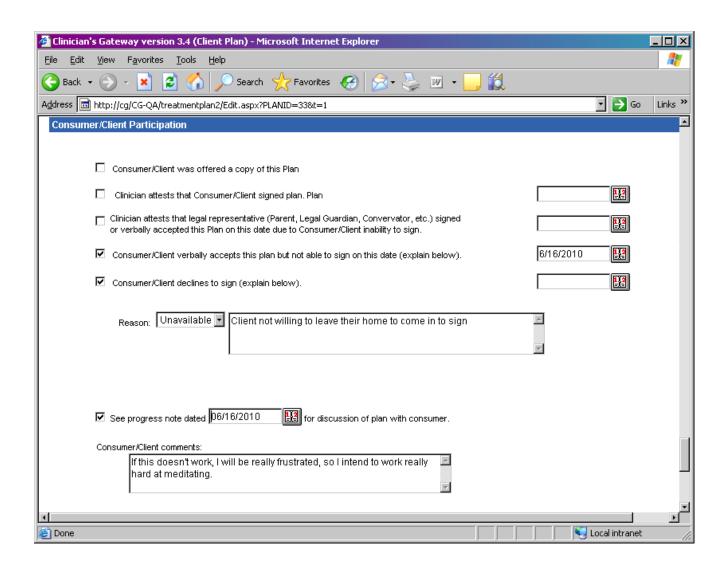
Fill out the **Consumer/Client Participation** Section now or after authorization.

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

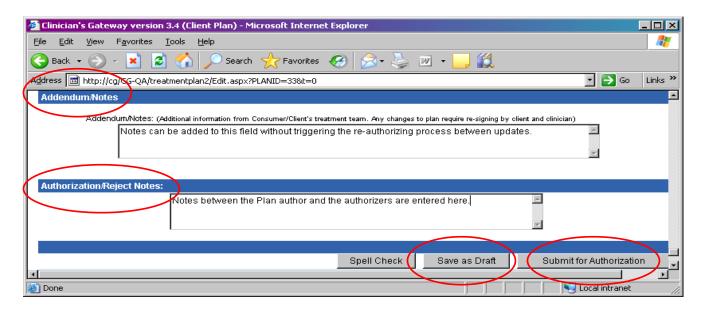
Use the consumer/client comment box if the consumer/client wishes to add their own comments.



NOTES: The last section is an area for notes which will <u>not</u> be printed when the Plan is printed.

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

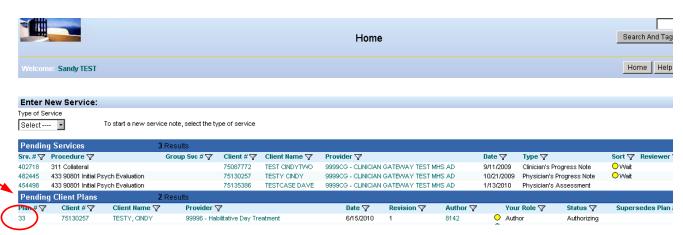
The Authorization notes are only seen by the author and the authorizers of the Plan.



Save as Draft if incomplete or Submit for Authorization if complete. (Before or after 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.



PRINT FOR CLIENT SIGNATURE

FIRST SAVE THE PLAN OR SUBMIT THE PLAN. (When the Plan has not yet been submitted for approval by the supervisor, etc., the Plan will have "Pending" splashed across it)

THEN VIEW IT TO INVOKE THE PRINT BUTTON.

To view the Plan, click on it's Plan Number (# 33 in this example).



The Plan appears on your screen.

You can Print, Delete or Edit from this screen using the buttons at the bottom of the page.



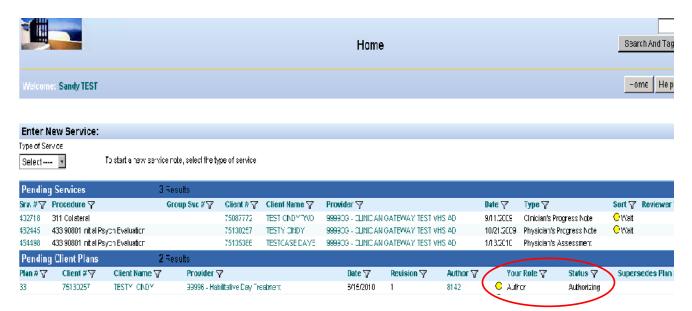
Editing will allow you to Submit for Authorization.

Editing also requires you to resubmit the Plan for authorization.

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AUTHORIZING THE PLAN

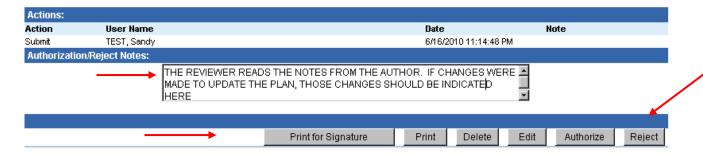
1. After "Submitting for Authorizing" the yellow dot on the Author's Home page indicates that they are waiting for Plan authorization. The status has changed from "New" to "Authorizing".



2. The Plan now appears on the <u>Authorizer's</u> 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 are notes from the Plan Author. The Authorizer is required to write a note to the Author.
- 5. The Authorizer has options to Print, Delete, Edit (minor), Authorize or Reject.



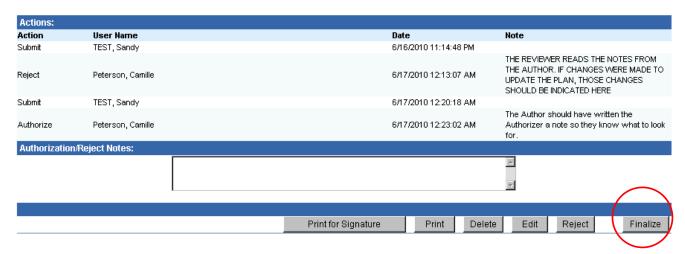
- 6. After Authorizing or Rejecting it, the Plan is removed from the Authorizer's Home page.
- 7. A "**Rejected**" Plan will have the status returned to "New" on the Author's Home page.



- 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. "Edits" are restricted to minor changes now. Major changes would be handled by finalizing the plan and then revising it.



- 10. The Plan is now ready to be **Finalized** by the Author. (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.
- 11. Click "Finalize" at the bottom of the Page. (after reading the notes)



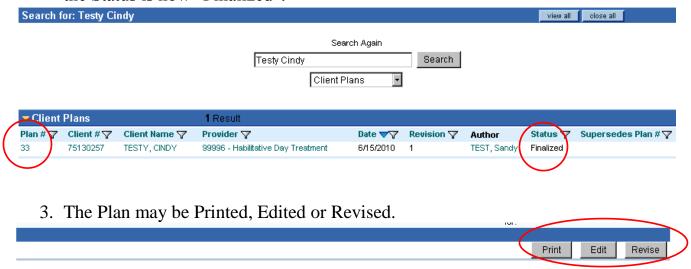
12. The Plan is removed from the Pending Client Plan list on the Home page.

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".



- 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.



RENEWING OF PLANS ANNUALLY OR AT 6 MONTHS

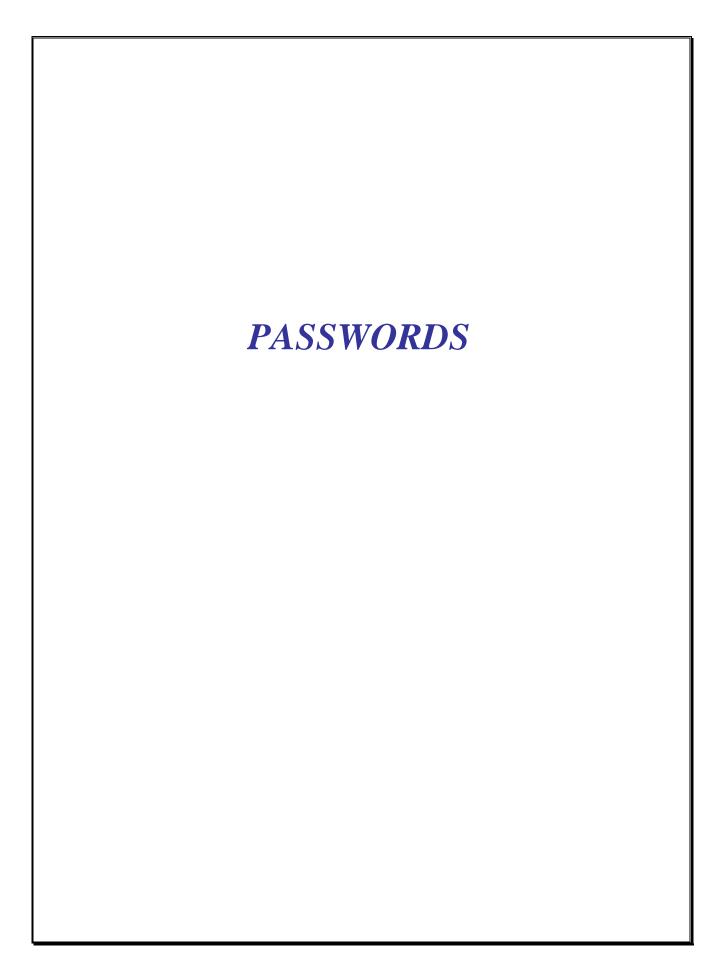
During the 30 days preceding and following a plan's expiration date, an additional button will appear. A "Renew Plan" button will be available.



- 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.

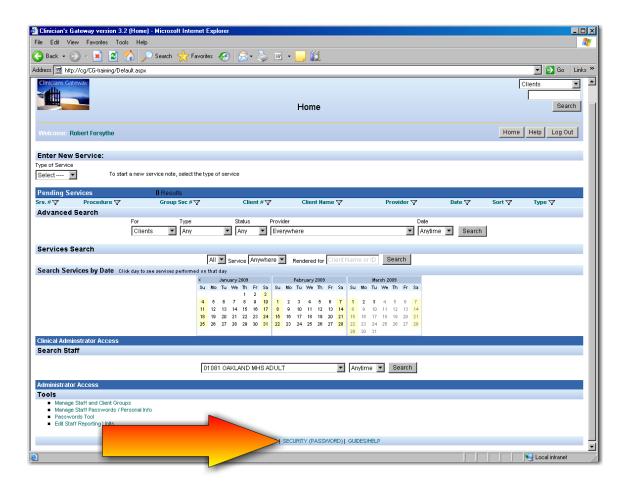
CHANGING THE AUTHOR OF THE PLAN

- 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.

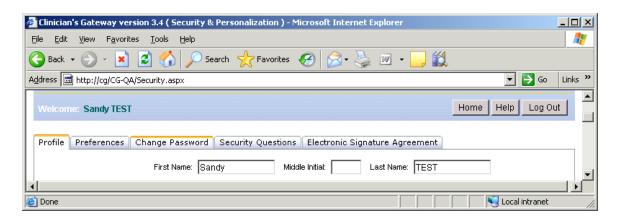


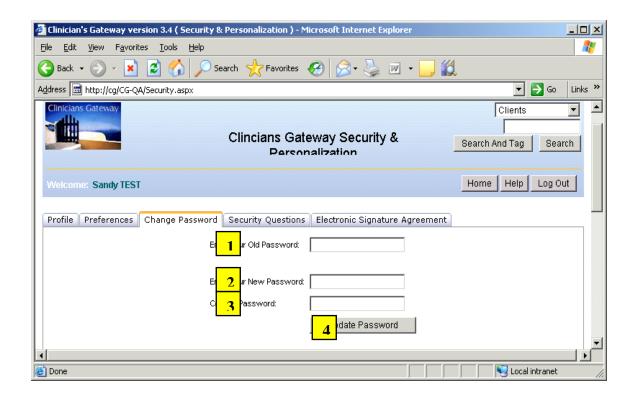
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Changing your password



- > 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 seven characters in length).
- 3 Re-enter your new password in the third field to confirm the change.
- 4 Click on "Update password"