Clinician's Gateway

Clinical
HANDS-ON INTRODUCTION TRAINING

Revised August 12, 2021

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What is Clinician's Gateway?

- Clinician's Gateway is an Integrated 'Online Progress Note System'.
- The primary objective of Clinician's Gateway is to allow HIPPA-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 SmartCare and is the first in a series of add-on packages that can be used instead of standard built in data entry screens for SmartCare.
- 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 in capturing all staff activity.
- Clinician's Gateway integrates progress notes with the SmartCare billing module and can be used for approximately 100% of the data entry into SmartCare.
- HIPP-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.

Commented [MMA1]: Change to SmartCare.

Commented [MMA2]: Change to SmartCare

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 (SMARTCARE)
- 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 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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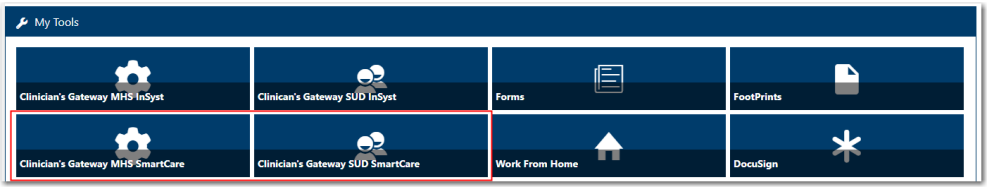
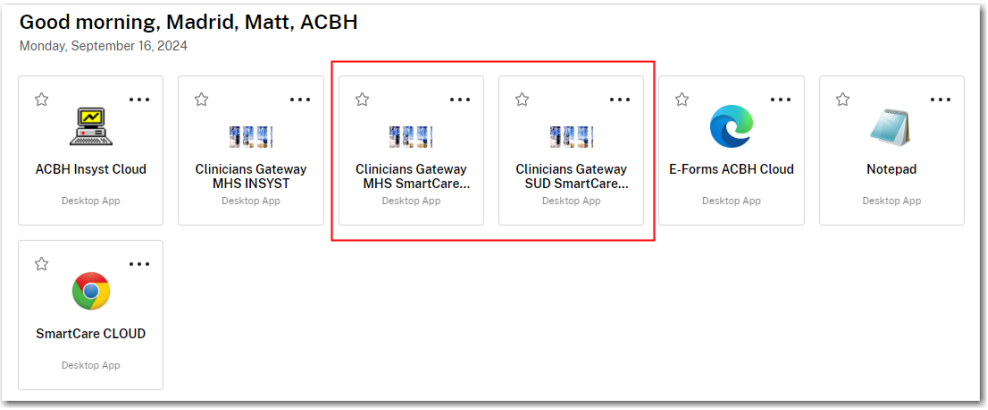
Logging into Clinician's Gateway

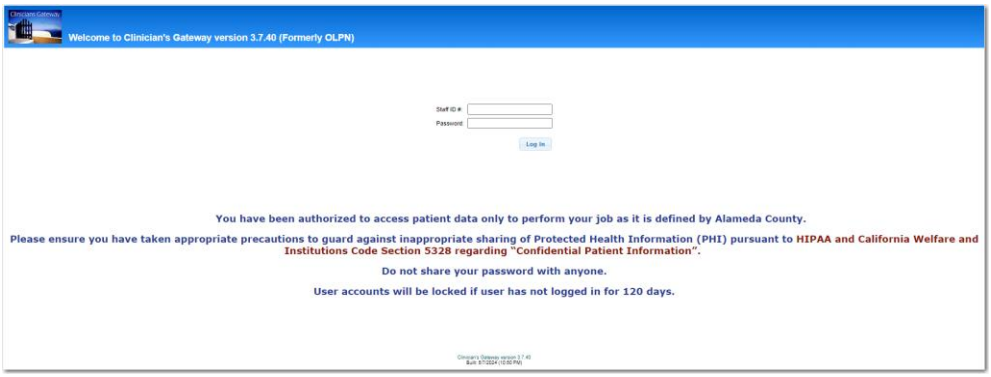
Login – Security

FOR ACBHD STAFF: Find the link to this page at https://acgovt.sharepoint.com/sites/BehavioralHealth, click on Clinician's Gateway MHS/SUD SmartCare under My Tools.



FOR CBO STAFF: Find the link via the web portal at https://bhcsportal.cloud.com. Click on Clinician's Gateway MHS/SUD SmartCare





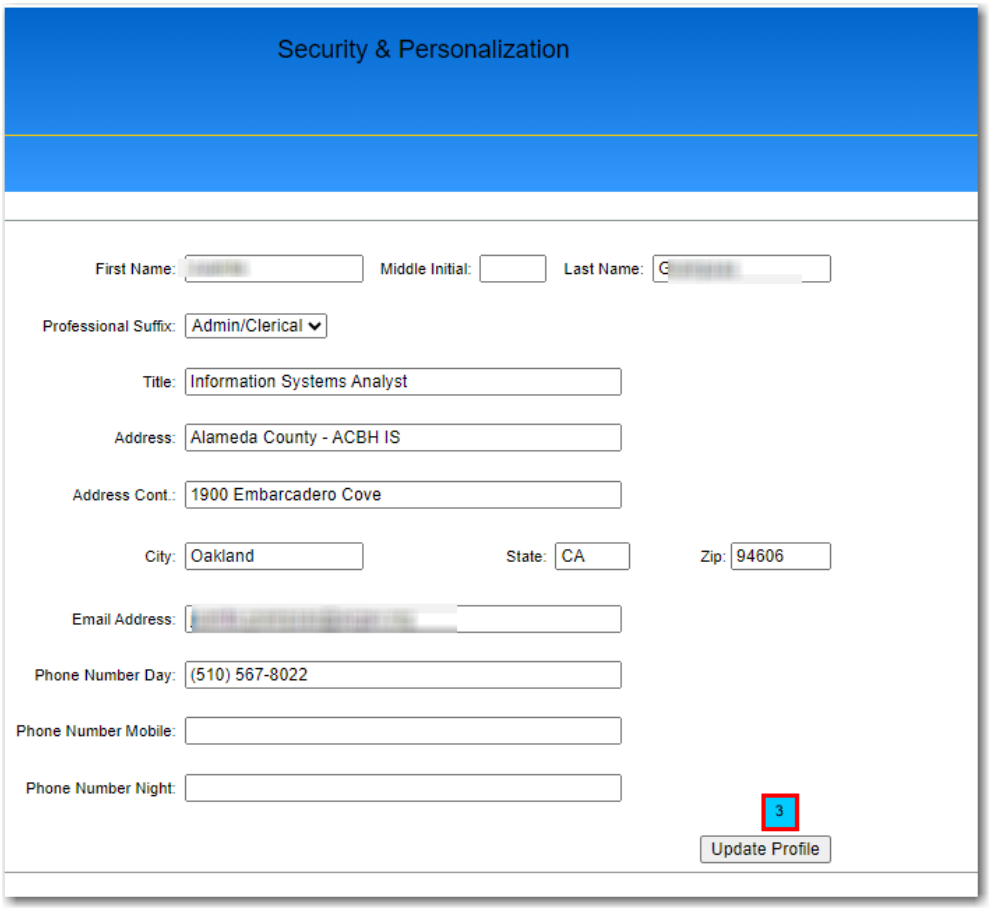
- **Log on page – This invokes your digital signature.**
- **Keep your password secure – Important: To be kept as secure as a bank card pin number.**
- **Passwords must be at least eight characters – one uppercase and one lowercase alpha character, and one numeric character.**
- **If you have three failed attempts at entering your password, your account will be locked, and you will need to contact the helpdesk at 510-817-0076 or HCSASupport@acgov.org for assistance.**
- **If you are accessing SUD environment you will see this banner at the top of each page**

Initial Login

1. **Sign into CG** using your SmartCare staff number and the password that was provided to you by the Help Desk. The first time you login, you will need to **update your password**. (8 characters or more, including at least 1 uppercase, 1 lowercase, and 1 number)

2. **Check personal information** via "Security/Password" at bottom of Home page

3. Make changes, if needed, and click "**update profile**" to retain changes. HINT: Use the "Tab" key to enter the Phone Number fields from the e-mail field to land in the correct spot.



4. The preferences tab is used to set the following:

1. **Print On Finalize – Defaulted (Yes)**
   - Yes - Print Service page will display after Finalizing, and with Daily Approval, all services will print under your Staff Log.
   - No - return to the Home Page after finalizing and with Daily Approval, only the summary on the Staff Log printout.

2. **Print On Save – Defaulted (No)**
   - Yes - Print Service page will display after saving.
   - No - return to the Home Page after saving

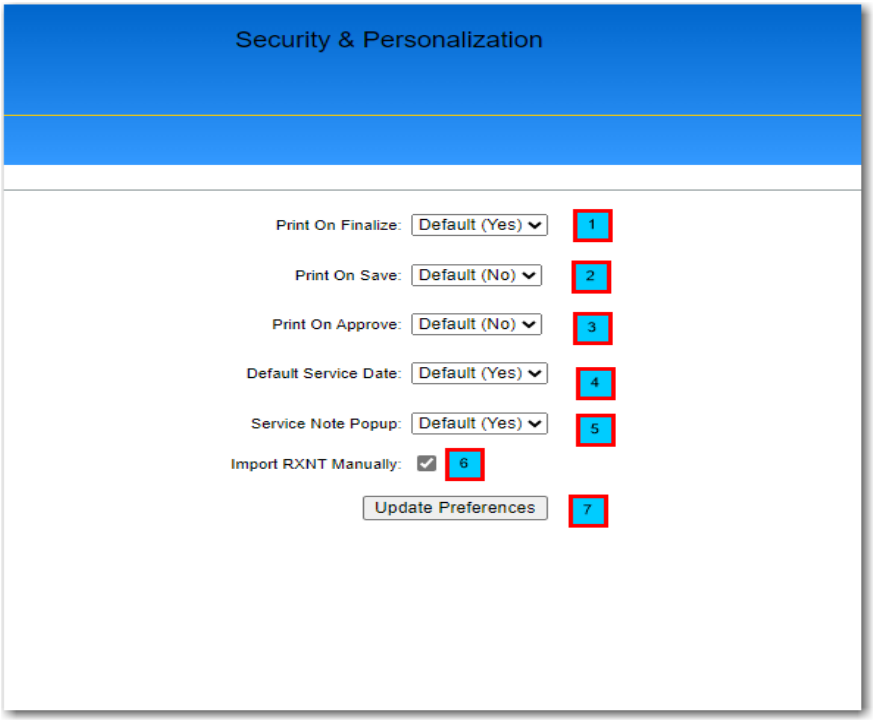
3. **Print on Approve – Defaulted (Yes)**
   a. Yes - Print Service page will display after approving.
   b. No - return to the Home Page after approving.

4. **Default Service Date – Defaulted (Yes)**
   a. Yes to default todays date on a note.
   b. No to start without a date selected.

5. **Service Note Popup – Defaulted (Yes)**
   a. Service Note Popup launches an Enlarged popup textbox when double-clicking a textbox. Select no to disable.

6. **Import RXNT Manually - Defaulted (Yes)**
   a. Import RXNT Manually means the prescriber pulls the day's prescription manually onto a note. If unchecked, then a draft note is created in CG with each prescription in RXNT

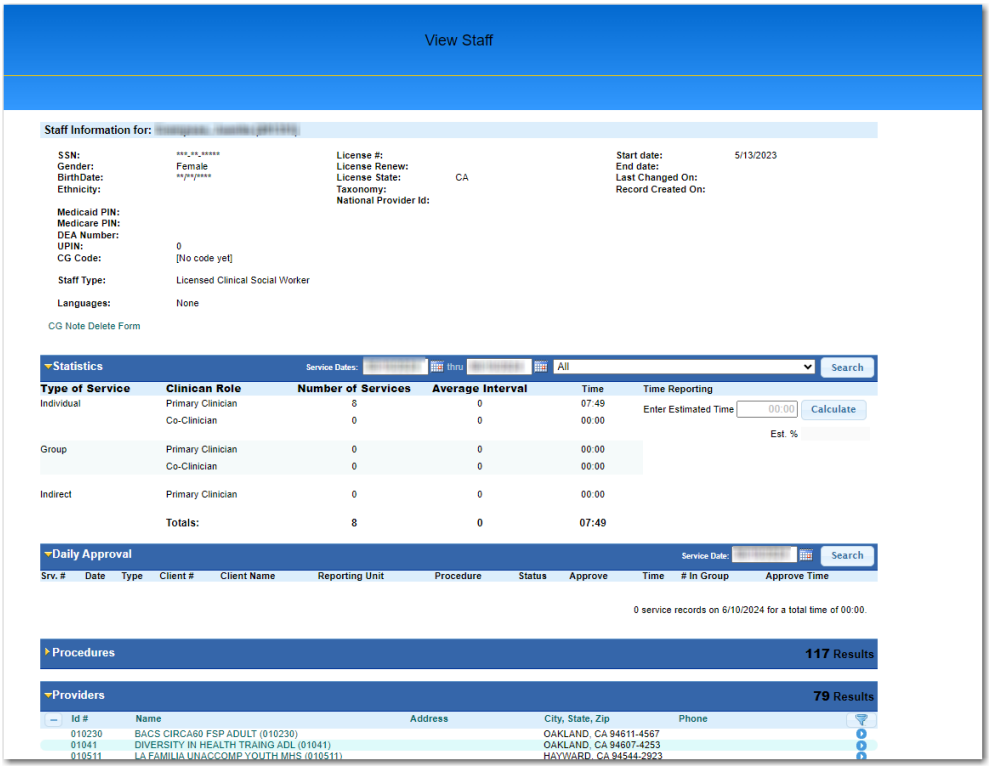
7. Click to Save changes



8. **Note the tabs for changing your password**, adding security questions, and seeing the expiration date for your electronic signature agreement.

9. Changing your password restarts the 90 day period before the next required password change.

10. **Check your staff information**. Click on your name on the Home page to bring up your staff view page.



11. **Verify basic staff information:** Basic staff information, displayed in the upper half of the page, will need to be updated via a SmartCare Staff Number Request Update form.

12. **Verify your Reporting Units:** To **view your reporting units**, click on the "Providers" bar. The designated RU's allow you to write a progress note into an RU. To update them, a supervisor submits a CG Authorization Update Request e-form.

Client Information

Client Search

1. You can use the global search tool located at the top right of all Clinician's Gateway Pages. Select "Clients" from the drop list. (Clients is also the default for this tool)

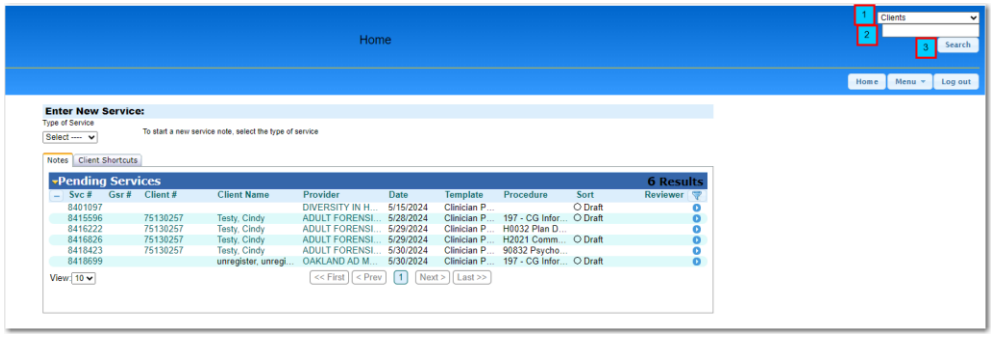
2. Type the client's last name first, then first name. (with a space in between…no need to use a comma)

    a. Alternately, you could type in the client's SmartCare ID number.

    b. Alternately, you could type in the client's Social Security Number preceded by the # sign (for example, #123-33-3333. You may use dashes or not.)

    c. If you are unsure on exact spelling you may use a percent (%) symbol as the wild card. For example, a client name Client Testerson can be found by searching 'Test% Client'

3. Click on Search



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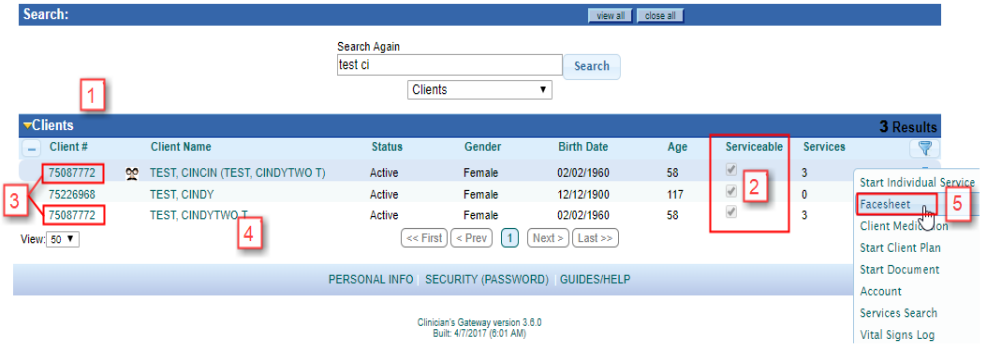


- The search results screen will show the list of clients.
  1. The list of "All" clients are all clients in Alameda County.
  2. The list of "Serviceable" clients are those clients for whom you can write a note.
  3. Notice that these two clients are the same person, because they have the same client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

Client Face Sheet

- To get the Face Sheet, either
  4. Click on the client's name or
  5. Click on the blue button at the far right of the row, to bring up the menu and then click on "Facesheet" for that client.

Client Information Facesheet

Action | Generate Patient Code

CONSUMER INFORMATION

Aliases: TEST, CINCIN
TESTING, CINDYCIN T.
TESTING, CINDYONETWO

Preferred: TESTONE, CINDYTWO
Name: TEST
CINDYTWO T.
Issued On: 10/8/2001
Address: 9999 STREET NW
FREMONT, CA 94538-0

Home Address:

Language: Chinese Dialect
Education: Grade 11
Marital: Never Married
Staff: Staff, General
Ethnic Origin: Non-Hispanic
Problem: None

Number: 75087772
Birth Date: 2/2/1960
Age: 64
SSN: 123-33-3333
Gender: Female
Account: 851701
TEST, CINDYTWO
Phone: (510) 999-9999 Ext:0
Ethnicity: Black
Disability: Physical Impairment
RP Owes: $0.00
Veteran: Unknown
Deceased On:

Care Team Members

5 Results

Name	Company	Phone	Role	Removal Date
Chen, Lester	County	(510) 567-8181	Case Manager	
Madrid, Matt	County	(510) 567-8079	Probation	
Test, Mary	County	(510) 567-8181	Social Worker	
TEST, Sandy	County	(510) 567-8181	Case Manager	
Tester Testeroo	Albany USD	(510) 999-9999	School Counselor	

View: 10 << First < Prev 1 Next > Last >>

Consumer Detail Alert

KTA Eligible From Nov 17 1858
OOC AB1299 Presumptive Transfer From Santa Barbara To Alameda County on Apr 1 2021
AlCo AB1299 Waivered Presumptive Transfer To Butte On Apr 20 2021

Medicaid Coverage

Covered	Medical Number	Insured Name	Eligibility Date	Eligible County	Special Reason

Insurance

#	Company	Policy #	Insured	Effective	Expires
2485	HEALTH PAC MCE	123333333		6/1/2012	8/31/2012

CONSUMER MESSAGES

	Effective	Expiration	Type	Author	Username	Status
TEST EMERGENCY						
	9/17/2021	11/16/2021	Incident	LESTER C	CHENL	Expired
	THIS IS A TEST					
Self Harm Risk						
	2/27/2020	2/27/2022	Suicide Watch	SHERYL	DIEDRICK	Expired
	this is only a test of the type fields					
Dangerous Client Alert						
	6/19/2009	12/18/2020	Incident	PETERSON C	PETERSONC	Expired
	Known to throw marshmallows unpredictably.					
THIS IS ONLY A TEST						
	8/28/2007	10/27/2007	Other	SHERYL DIEDRICK	DIEDRICK	Expired
	THIS IS ONLY A TEST					

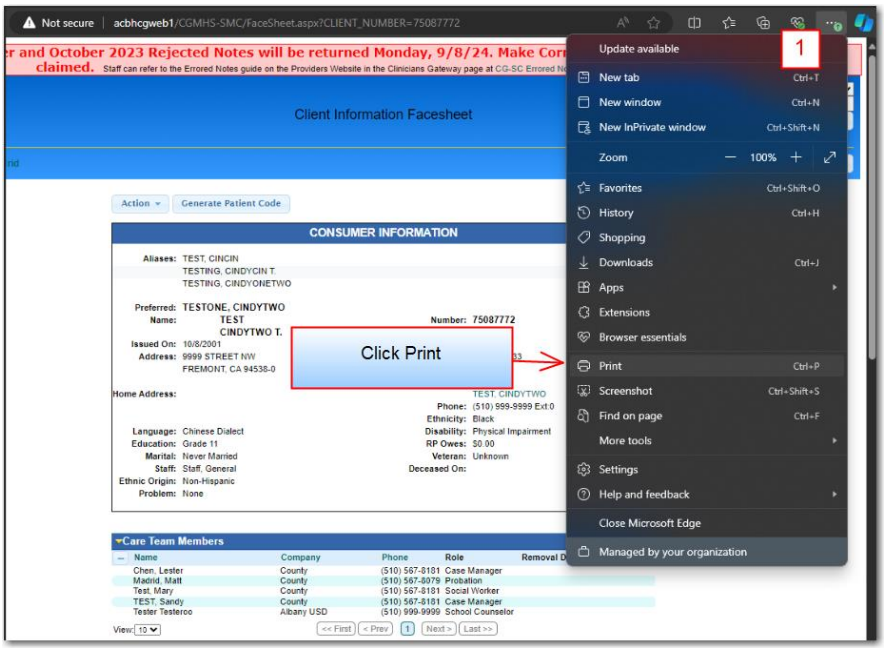
SIGNIFICANT OTHER / EMERGENCY CONTACT

Name	Relation	Full Address	Effective	Expires	Phone

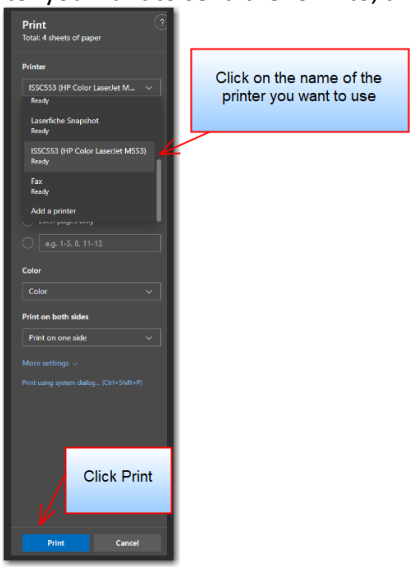
CLINICAL HISTORY

Results:9

Status	Provider	Clinician	Opened	Closed	Diag
Open	BACS FSP LIFT FORENSIC PROGRAM **Physician:** Staff, General **Med Coordinator:** **Svc Coordinator:** **Legal Status:** Voluntary	Chen, Lester **Primary Service:** **Last Service:**	8/30/2022 **Units:** 0		Z03.89
Open	BACS WOODROE PLACE CRT (81443) **Physician:** Staff, General **Med Coordinator:**	Chen, Lester **Primary Service:** **Last Service:**	6/4/2021 **Units:** 0		Z03.89



- To print the Face Sheet, click on the "…" button (**1**),
- Click on Print
- Then select the printer you want to send the form to, and click on "Print."

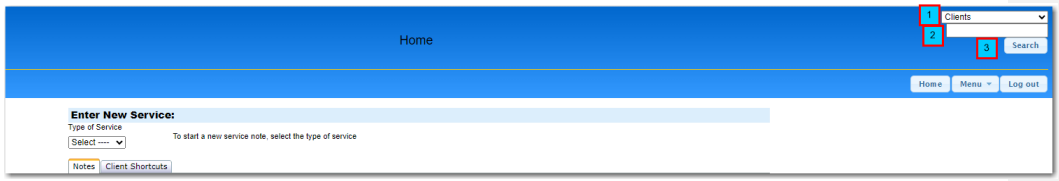


Client Services Search

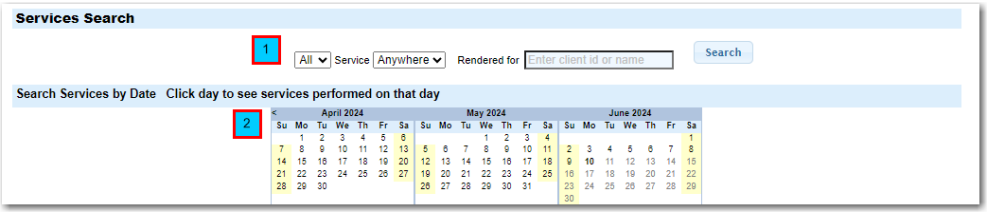
1. To create a list of Services for a client, select “Services” from the drop list.

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 SmartCare ID #.

3. Click on Search.

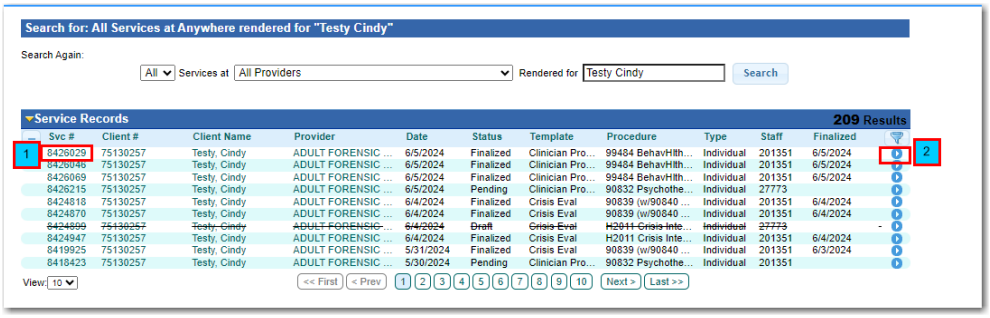


- Alternately, you can use the Services Search (**1**), or Search Services by Date (**2**), at the bottom of the Home Page



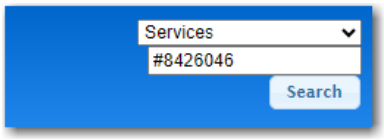
Search Results:

To read the note, click on the Service # (1) or click on the blue button. (2)



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.

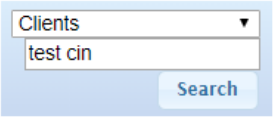


Medication Log

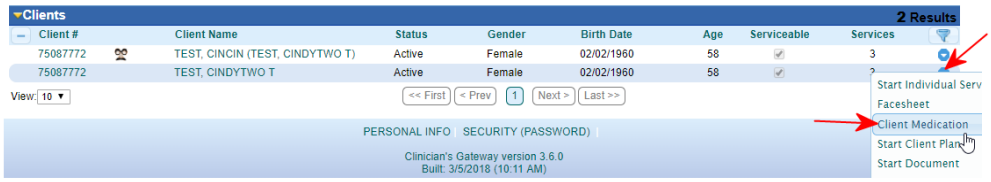
The Medication Log can be called up by two methods: either by using the Client Search/Action Button or by using the Client Medication Search.

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.**

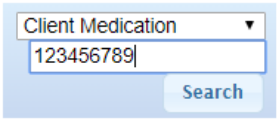


2. Click the "**Action Button** ", then click Client Medication**.**



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 are 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

RXNT Medications — **35** Results

Details	Entry Date	Drug Name	Dosage	Prescribing Doctor	Refills	Svc. Number
	24-May-2012	Zyprexa 10 mg Tab	1 po q am	Luisito Roxas	3	1038364
	12-Apr-2012	benztropine 1 mg Tab	take 1 tablet by mouth at bedtime	Luisito Roxas	3	1002637
	12-Apr-2012	levothyroxine 50 mcg Tab	take 1 tablet (50 mcg) by oral route once daily	Luisito Roxas	3	1002637
	12-Apr-2012	Zyprexa 20 mg Tab	1 q hs	Luisito Roxas	3	1002637

Local Medications — **73** Result

Svc. Number	Svc Date	Primary Clinician	Status	Note
1057040	6/14/2012	ROXAS LUISITO	FINALIZED	Will continue present medications since they do appear to be effective as long as she is taking them. Will adjust the dose as indicated. Noted no hand tremors while off Depakote. She might need a other mood stabilizer to help control her mood and outburst or increase the dose of her Zyprexa to target the mood. Also discussed the possibility of trying depot medications again specifically Risperdal Consta to maximize the compliance. . Compliance with medications was emphasized. dISCUSSED WITH cm. Medications: Zyprexa 10 mg q am and 20 mg q hs; Synthroid 50 mcg po q day. Cogentin 1 mg q hs RTC: 7/5@10:00
1044057	5/31/2012	ROXAS LUISITO	FINALIZED	Will continue present medications since they do appear to be effective as long as she is taking them. Will adjust the dose as indicated. Noted no hand tremors while off Depakote. She might need a other mood stabilizer to help control her mood and outburst or increase the dose of her Zyprexa to target the mood. . It will be easier for her to manage if she is less agitated. Compliance with medications was emphasized. Discussed with CM. Medications: Zyprexa 10 mg q am and 20 mg q hs; Synthroid 50 mcg po q day. Cogentin 1 mg q hs RTC: 6/14@11:00
1038364	5/24/2012	ROXAS LUISITO	FINALIZED	Will continue present medications since they do appear to be effective as long as she is taking them. Will adjust the dose as indicated. Noted no hand tremors while off Depakote. She might need a other mood stabilizer to help control her mood and outburst or increase the dose of her Zyprexa to target the mood. . It will be easier for her to manage if she is less agitated. Compliance with medications was emphasized. The patient was given Zyprexa 10 mg to calm her down and to help with the voices. Discussed need to go back to the board and care . Noted need to be stable for the next 2 weeks so she can celebrate the birthdays of her children in the hotel. She agreed then to go back to the board and care via a taxi. Discussed with CM. Medications: Zyprexa 10 mg q am and 20 mg q hs; Synthroid 50 mcg po q day. Cogentin 1 mg q hs RTC: 6/14@11:00 REFILL: PAYLESS PHARAMCY: ZYPREXA 10 MG TAB 1 Q AM #30 + 3 REFILLS

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 and Medical Provider Notes

Entering Vital Signs: Vital signs are entered via Medical Provider notes such as the Physicians Progress Note.

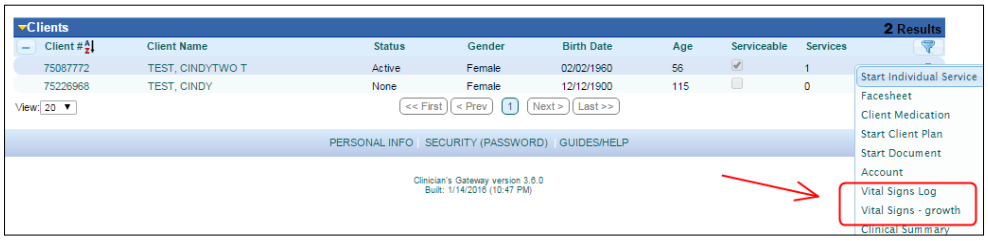
1. The newest reading is logged in the first column
2. The four most recent previous readings are automatically shown in the next four columns.
3. The Baseline Reading remains permanently in the last column

Vital Signs (Optional)

DOB: AGE:

DATE	1	02/16/2023	08/19/2021	2 09/15/2020	04/15/2019	3 Baseline Reading
VITAL SIGNS						
Height (inches)				75.	75.	69 10/23/2010
Weight (lbs) (q visit x 9 mo., then q 3 months)				160.0	165.0	160 10/23/2012
BMI (Fl-Up:)				19	20	22 10/23/2012
BP (mm Hg)					140/90	140/90 10/23/2010
Pulse (bpm)				100	80	75 10/23/2010
Smoking Status	○ Current every day smoker ○ Current some day smoker ○ Former smoker ○ Never smoker ○ Smoker, current status unknown ◉ Unknown if ever smoked ○ Heavy tobacco smoker ○ Light tobacco smoker ☐ Provided Brief Smoking Cessation Counseling ☐ Provided Referral to Smoking Cessation Services ☐ Prescribed Smoking Cessation Medication ☐ Other: (describe)					

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

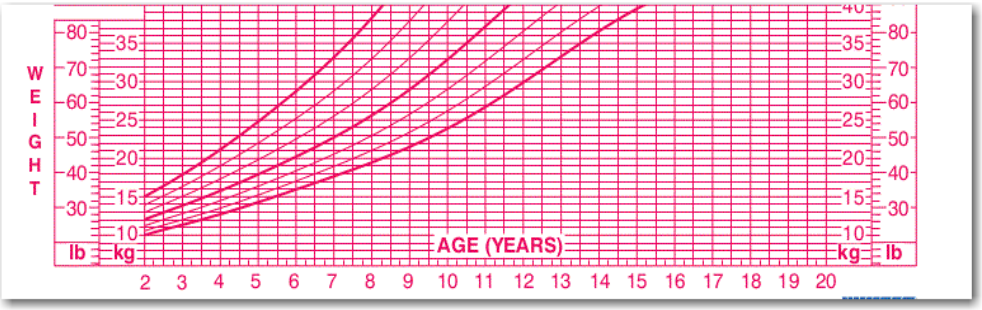


Vital Signs Log: displays Vital Signs over the entire history of client. (data from medical staff Vital Signs chart on notes)

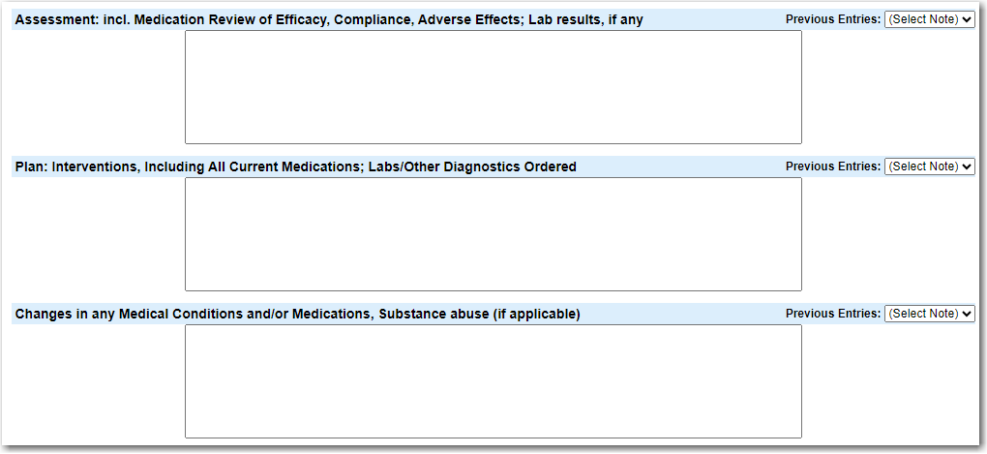
Vital Signs Log for TEST, CINDYTWO T (75087772)

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

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



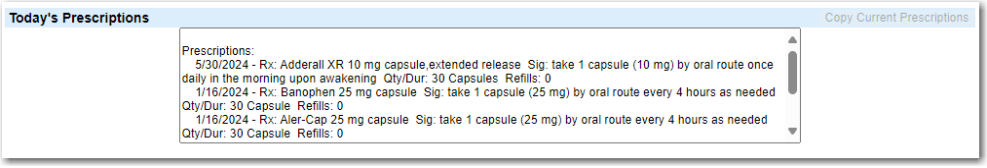
Entering Lab results and medications: Lab results and medications are entered via Medical Provider notes such as the Physicians Progress Note.



Prescribe via RxNT first and then click on the Copy Current Prescriptions button to bring today's prescriptions onto the note automatically.

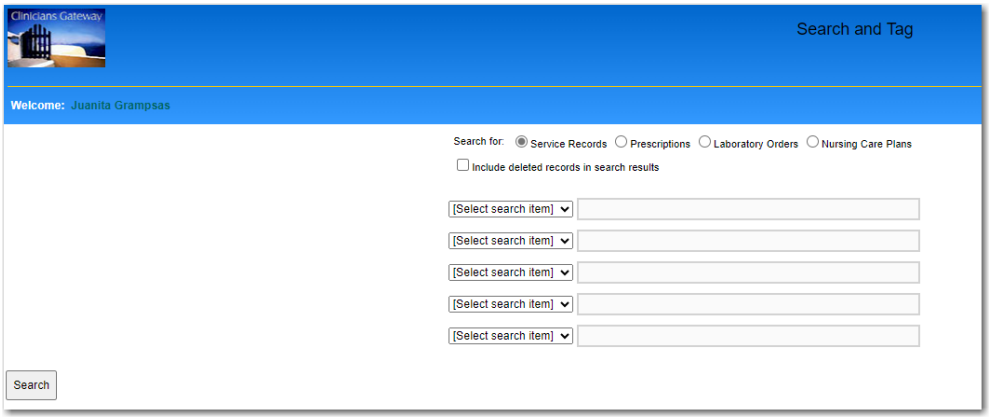
Before:

After:



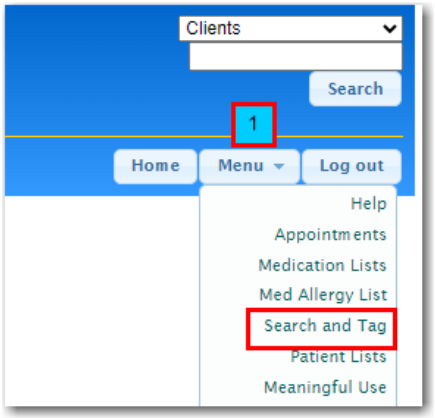
Search and Tag

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.

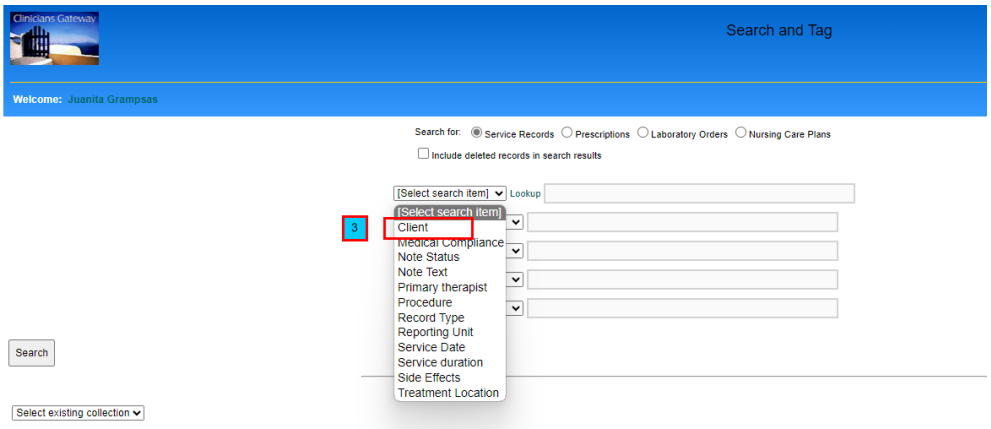


2. The Services radio button should be checked.

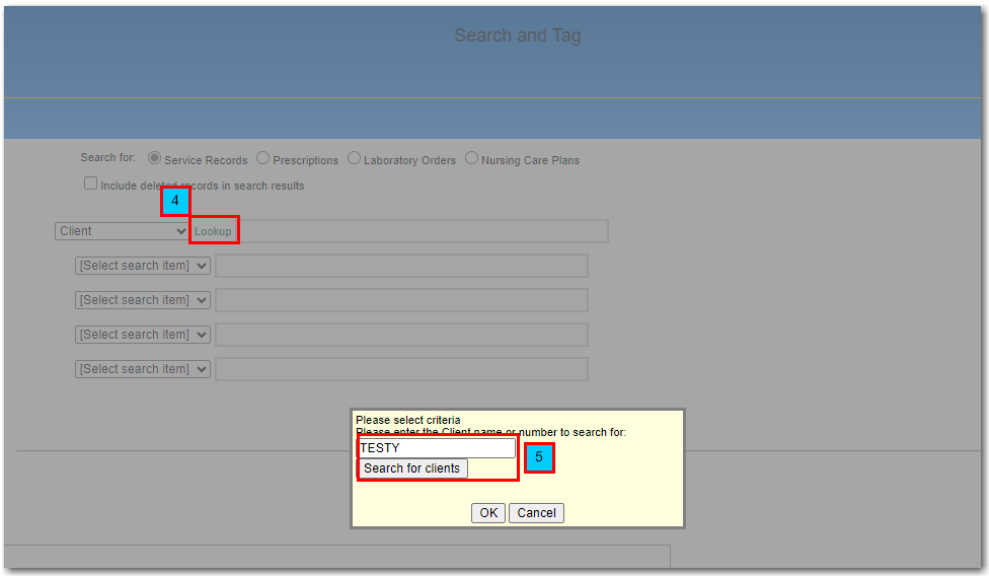
Search for: Service Records Prescriptions

Include deleted records in search results

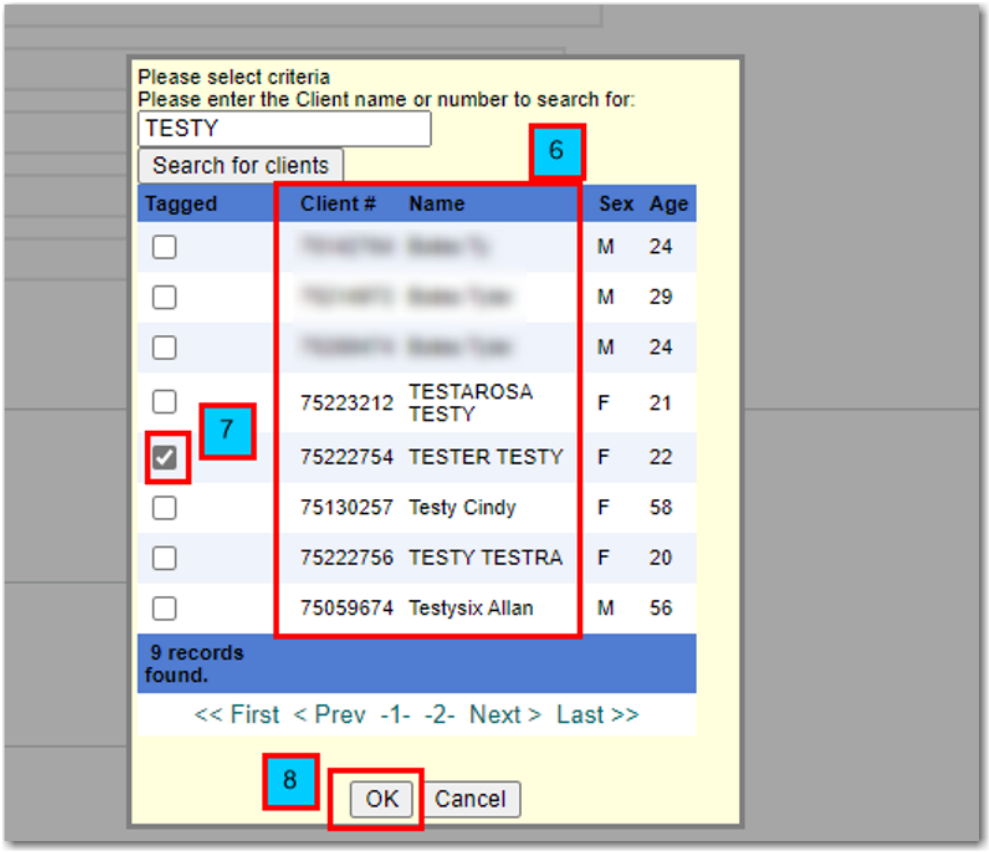
3. Select the first search parameter by clicking on the “Select Search Item” drop down menu. Click on the parameter that you wish to search, such as “Client.”



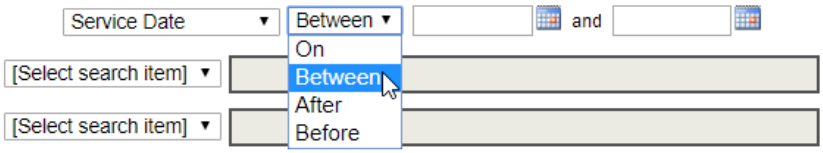
4. Click on “Lookup” and enter the specific search item
5. i.e. For Client; Search by Client Number or last name first name-no comma, click “Search for Clients”.



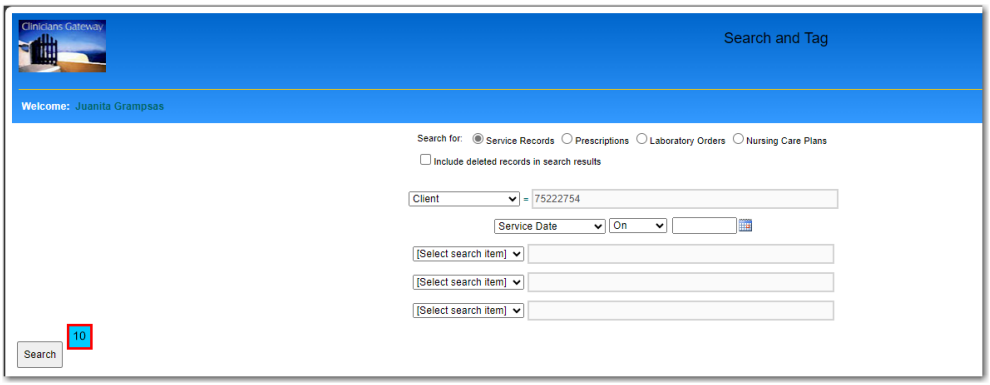
6. A list of matches for 'TESTY' come up.
7. Click the checkbox of the client you want.
8. Click on OK button



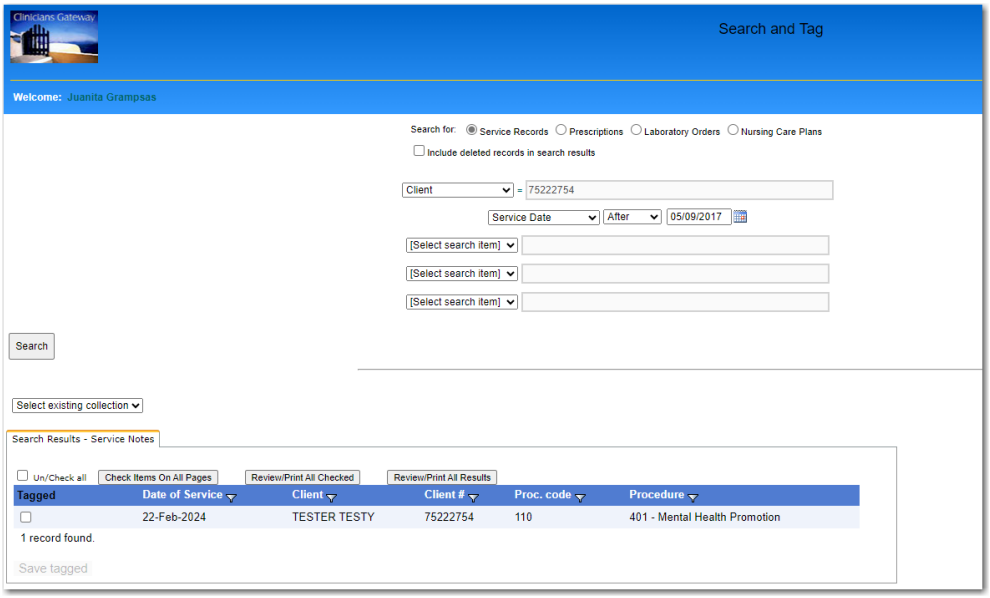
9. Continue until you have narrowed your search as many ways as possible.



10. Click the Search button to assemble your results.



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

Commented [MMA5]: Doesn't work, should we remove this section?

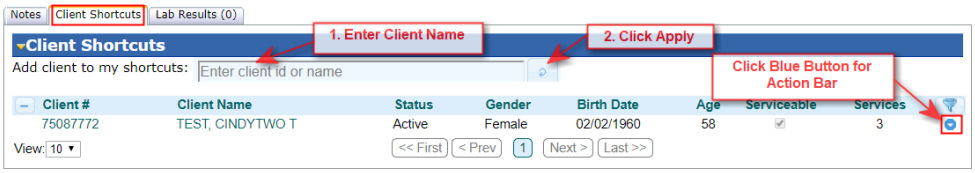
1. To retain your collection in Search and Tag for later reading, click the blue message “click here to add a new collection name”
2. Enter the name of the collection and click OK
3. Click the “Save Tagged” button and all items checked will be moved to the collection. You can do this multiple times or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

Client Shortcuts

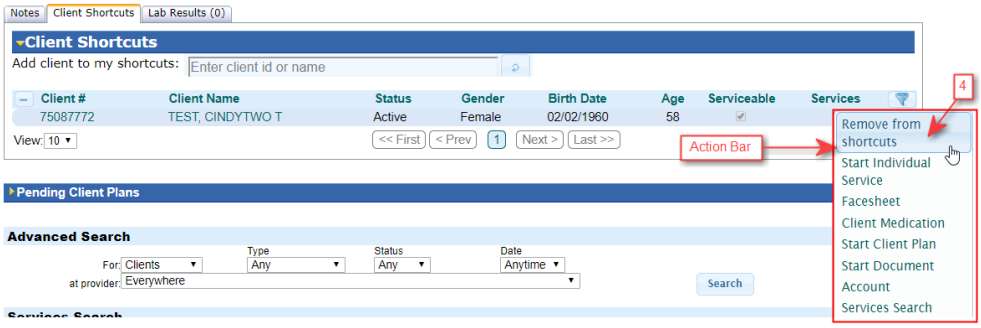
Build your custom client shortcut list on the Home Page (Does not alter SmartCare caseload records)



Above is the Client Shortcut tab on your home page. To add a client to you shortcuts; (1) enter client name to add to shortcuts, (2) click the apply button. Once added you can quickly access the Client Action Bar by clicking the Blue Button (3)

The Action Bar gives access to quick client information and common actions: view Facesheet, start a service or client plan, view medication log, etc…

When a client is added to the shortcuts, a new item is added to the top of the action bar. This action will remove this client from your shortcuts list (4)

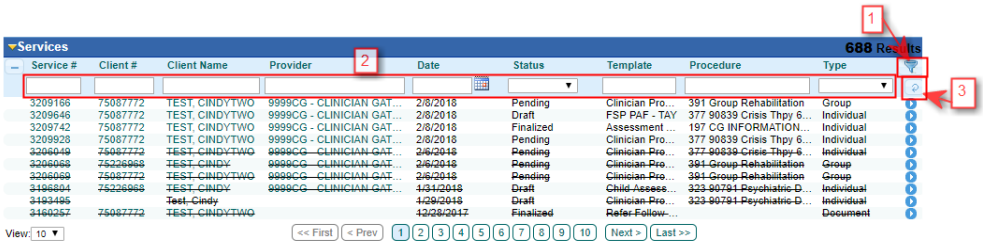


Filtering and Sorting

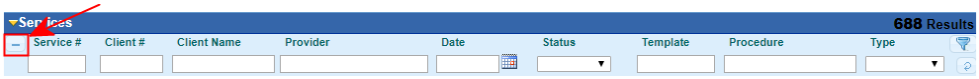
At any point when you have a large list of clients, services, etc. you may want to find specific information. This can be attained with the assistance of the various Filters and sorts.

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.



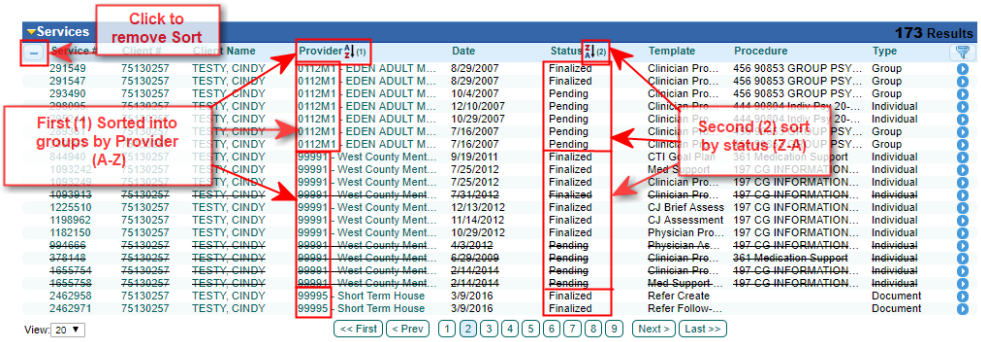
Remove Filters by clicking on the ⊟ button.



Enhanced Sorting can be done over multiple columns, in ascending or descending order.

<u>Sort Order will be retained</u> for the next time you search!

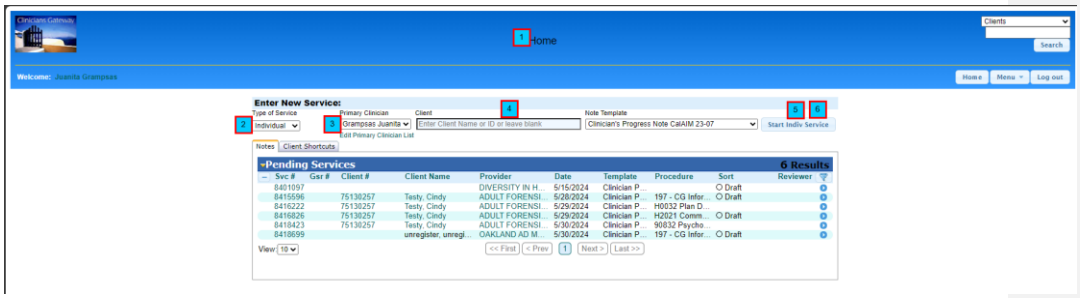
- First click = ascending. A second click = descending. Third click = remove the sort.
- Click(s) on the column you want to be the first sort.
- Click(s) on the next column you want to be the second sort, etc.
- Your custom **sort order is retained** and applied to future searches of the same type.
- Minus button clears the sort order and restores date order as default.
- Remove Sort Order by clicking on the ⊡ button.



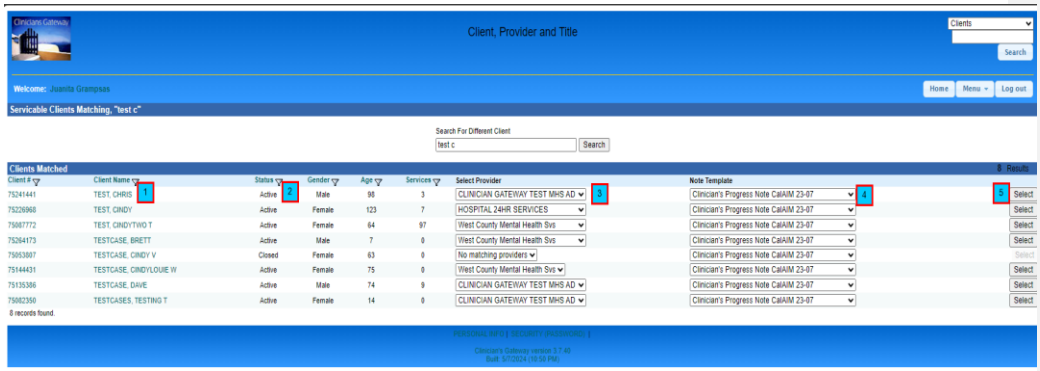
Individual Notes

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.
3. Verify the Primary Clinician name is correct.
4. Enter the client name (Last name then First name with no commas, ex. Mouse Mickey) or the client number.
5. Select the template name from the drop list.
6. 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:

Service Entry, Individual

Service #: New Title: Clinician's Progress Note CalAIM 23-07

Potential Harm: (Select One)

Service date: 06/10/2024

Client opened: 4/10/2018

Client: Number 75082350 Last Name TESTCASES First Name TESTING

Procedures: Select Procedure

Service Location: Select Location

Mode of Delivery: (Select One)

Med. Compliant: N/A Side Effects: N/A

Emergency? Pregnant/Post-Partum?

Principal Diagnosis: F23 Brief psychotic disorder

Billing time

Primary Clinician 201351 - Grampsas, Juanita

Provider: CLINICIAN GATEWAY TEST MHS AD

Add Additional Clinicians

Care Team Members 0 Result

Name	Company	Phone	Role	Removal Date
No Records				

View 10 << First < Prev 1 Next > Last >>

Add-on Codes: None Add-On Time: Enter the total duration for the add-on code. Units will be calculated.

Interactive Complexity: None

Contact/E-M Time, Service Language, Pre-Existing Diagnoses

Primary FF/Contact/E-M Time: Hours:Minutes

Services were provided in English by interpreter or clinician

Episode Diagnosis Information

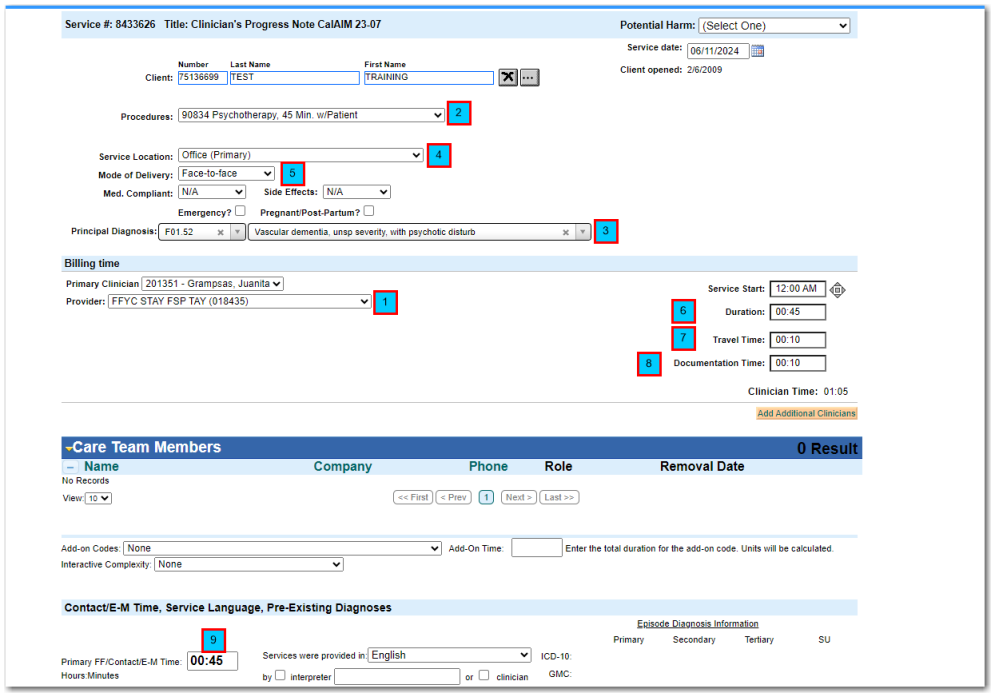
	Primary	Secondary	Tertiary	SU
ICD-10:	F23			
GMC:	99			
DSM 5:				

Starting the Note:

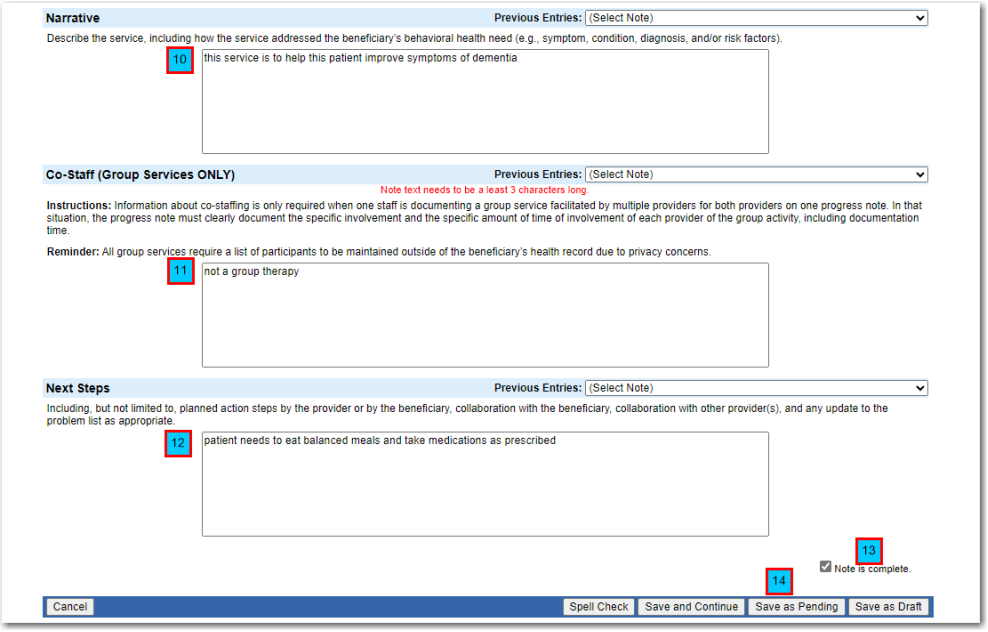
1. When writing a progress note in Clinician's Gateway, first choose the provider from the drop down.
2. Enter the Procedure code from the drop down.
3. Enter the Principal Diagnosis for the client.
4. Choose the Service Location, where the service is to be performed: Office, Field, Hospital etc
5. Choose mode of delivery: phone, In person
6. Enter the Service Start time and Duration of the service. The Duration usually matches the procedure entered in #2
    - The Service Start field will default to 12:00 AM and can be left as such, but your program may instead require that you accurately list the start time. Follow the "Using the Time Entry Widget" instructions on page 47.

7 and 8. Enter Travel time and documentation if applicable.

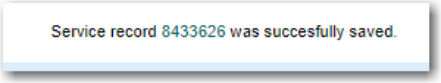
9. Enter the Face to Face time here. This usually matches the value for #6.



10. (For Progress Note specifically) Enter text on Narrative textbox. This describes the service
11. (For Progress Note specifically) Enter text on co-staff if it's a group service
12. (For Progress Note specifically) Enter text on Next Steps to describe an update to the problem and next steps.
13. Check 'Note is Complete' checkbox (only shows if you are doing a Daily Staff Log).
14. Click Save as Pending.



Once the service is saved you will be returned to the Home screen and see this message (unless you clicked Save and Continue, then you will stay on the same page).



Using the Time Entry Widget

The format for all time entry fields are HH:MM AM/PM.

1. When typing directly into the fields use a zero when necessary, (e.g typing 0806pm will display as 08:06 PM)

2. The widget to the right of the text box can default and adjust time

   - Clicking the center square will enter the Current Time

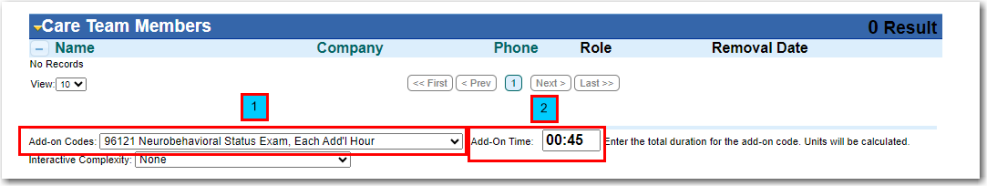
   - Clicking on the left and right arrows move between the hour, minute, and am/pm fields

   - Clicking either the up or down arrow will increase or decrease the value of the field selected

Adding a note with an Add-On code

Repeat steps 1-9 from above (starting a note)

1. In the add-on Code drop down, choose the add on code that goes with the primary code you chose for #2 (above)
2. In the Add-on Time text box, manually enter the number of minutes, i.e 45 minutes.



To Complete the note with an Add-On, Repeat steps 10-14 from above (starting a note)

How a note with an Add-On Code appears on the Staff Log

To view the note with the add-on code you created click on your name next to the 'welcome'

Once you click on your name you will see Daily Approval and your note with the primary code (time 1:05) and the add on code (time: 0:45) for a total of 1 hour and 50.

View Staff

Staff Information for: Grampsas, Juanita (201351)

SSN:	***-**-*****	License #:		Start date:	5/13/2023
Gender:	Female	License Renew:		End date:	
BirthDate:	**/**/****	License State:	CA	Last Changed On:	
Ethnicity:		Taxonomy:		Record Created On:	
		National Provider Id:			
Medicaid PIN:					
Medicare PIN:					
DEA Number:					
UPIN:	0				
CG Code:	[No code yet]				
Staff Type:	Licensed Clinical Social Worker				
Languages:	None				

CG Note Delete Form

Statistics — Service Dates: 05/11/2024 thru 06/11/2024 All Search

Type of Service	Clinican Role	Number of Services	Average Interval	Time
Individual	Primary Clinician	8	0	07:49
	Co-Clinician	0	0	00:00
Group	Primary Clinician	0	0	00:00
	Co-Clinician	0	0	00:00
Indirect	Primary Clinician	0	0	00:00
	Totals:	8	0	07:49

Time Reporting: Enter Estimated Time 00:00 Calculate

Est. %

Daily Approval — Service Date: 06/11/2024 Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve Time	# In Group	Approve Time
84336266	11/2024	Indiv.	75136699	TEST TRAINING	018435 FFYC STAY FSP TAY (018435)	96116 (w/96121 Add-on) Neuro-behavioral Status Exa	PENDING	Pending 01:05	1	01:05
84336266	11/2024	Indiv.	75136699	TEST TRAINING	018435 FFYC STAY FSP TAY (018435)	96121 Neurobehavioral Status Exam, Each Add'l Hour	PENDING	Pending 00:45	1	00:45

1 service record on 6/11/2024 for a total time of 01:50. Approve Time

If you click 'approve time' button, you will see the individual Staff log with the times. Please be aware one row for the Primary code and another row for the add on code.

REMEMBER THAT APPROVING TIME WILL FINALIZE ANY PENDING NOTES!!!

Print Daily Approval

1 of 3

ALAMEDA COUNTY Behavioral Health Care Services

Home | Help | Log Out

Individual Staff Log

Service Date: 6/11/2024

Svc #	Type	RU	Client #	Client Name	Procedure	Time H:M	Grp Ct	Loc	Rec.	Flags
8433626	Indiv.	018435 FFYC STAY FSP TAY (018435)	75136699	TEST TRAINING	96116 (w/96121 Add-on) Neuro-behavioral Status Exa	01:05	1	Office (Primary)		
8433626	Indiv.	018435 FFYC STAY FSP TAY (018435)	75136699	TEST TRAINING	96121 Neurobehavioral Status Exam, Each Add'l Hour	00:45	1	Office (Primary)		
2 service records on 6/11/2024 for a total time of						**01:50**				

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

Grampsas, Juanita, Admin/Clerical **6/11/2024** **Licensed Clinical Social Worker**

6/11/2024 12:58:11 PM

ELECTRONIC PROTECTED HEALTH INFORMATION

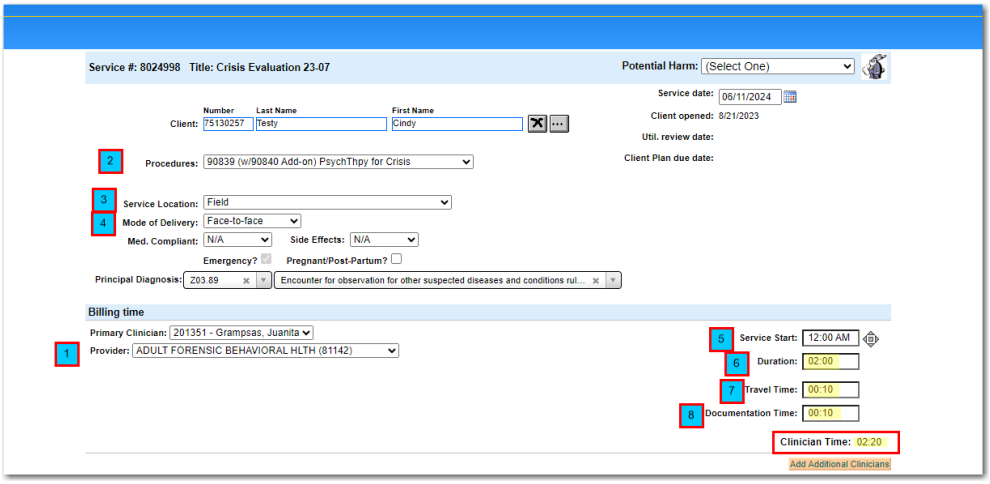
Codes: Add-on Codes and Time

Certain procedure codes exist that are designed to be used in sets. Total Time (including documentation and travel) and Face-to-Face[1] times are now recorded for each code. Please refer to QA training resources on the ACBHCS Providers website for coding guidelines.

SITUATION ONE: Note with automatic add on code

1. Choose the right provider from the drop down
2. When writing a progress note in Clinician's Gateway for a **Crisis service**, **first choose the** 90839 **Primary code (With 90840 add on).** Documentation and Travel will be added to Primary Code time.
   The total time for this procedure code is from 30 to 74 min but if it takes longer than that, system will automatically add the add-on code 90840
3. Add the service location: i.e field, hospital etc
4. Choose mode of delivery: face to face, video, telephone etc
5. Change the service start time or leave it as default (12:00 AM).

Example: (2:00) service duration time and 20 minutes documentation + travel time = 2:20 Clinician's time.



In this case above we have added more time (2 hours) than what procedure code 90839 allows (max 74 minutes), in this case the system automatically adds the add-on code 90840. The user doesn't have to manually add the add on, its automatically done.

In the Daily Approval section the service with the automatic addon is shown as 1 row only. To get to the Daily Approval section, click on your name next to the 'Welcome' top left.

Note that the status is still Pending, once you click on Approve time button, it will Finalize the note and the service will transfer to SmartCare.

View Staff

Staff Information for: Grampsas, Juanita (201351)

SSN:	***-**-****	License #:		Start date:	5/13/2023
Gender:	Female	License Renew:		End date:	
BirthDate:	**/**/****	License State:	CA	Last Changed On:	
Ethnicity:		Taxonomy:		Record Created On:	
		National Provider Id:			
Medicaid PIN:					
Medicare PIN:					
DEA Number:					
UPIN:	0				
CG Code:	[No code yet]				
Staff Type:	Licensed Clinical Social Worker				
Languages:	None				

CG Note Delete Form

Statistics — Service Dates: 05/12/2024 thru 06/12/2024 All Search

Type of Service	Clinican Role	Number of Services	Average Interval	Time
Individual	Primary Clinician	0	0	00:00
	Co-Clinician	0	0	00:00
Group	Primary Clinician	0	0	00:00
	Co-Clinician	0	0	00:00
Indirect	Primary Clinician	0	0	00:00
	Totals:	0	0	00:00

Time Reporting
Enter Estimated Time 00:00 Calculate
Est. %

Daily Approval — Service Date: 06/11/2024 Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve Time	# in Group	Approve Time
80249986	11/2024	Indiv.	75130257	Testy Cindy	81142 ADULT FORENSIC BEHAVIORAL HLTH (81142)	90839 (w/90840 Add-on) PsychThpy for Crisis	PENDING	Pending 02:20	1	02:20

1 service record on 6/11/2024 for a total time of 02:20. Approve Time

Once you have clicked on the Approve time button in the Daily Approval, then you should see the Individual Staff Log as below.

As mentioned earlier the Primary procedure time and add on are combined into one row.

ALAMEDA COUNTY Behavioral Health Care Services

Home | Help | Log Out

Individual Staff Log

Service Date: 6/11/2024

Svc #	Type	RU	Client #	Client Name	Procedure	Time H:M	Grp Ct	Loc	Rec.	Flags
8024998	Indiv.	81142 ADULT FORENSIC BEHAVIORAL HLTH (81142)	75130257	Testy Cindy	90839 (w/90840 Add-on) PsychThpy for Crisis	02:20	1	Field		E/
1 service record on 6/11/2024 for a total time of						**02:20**				

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

Grampsas, Juanita, Admin/Clerical **6/11/2024** **Licensed Clinical Social Worker**

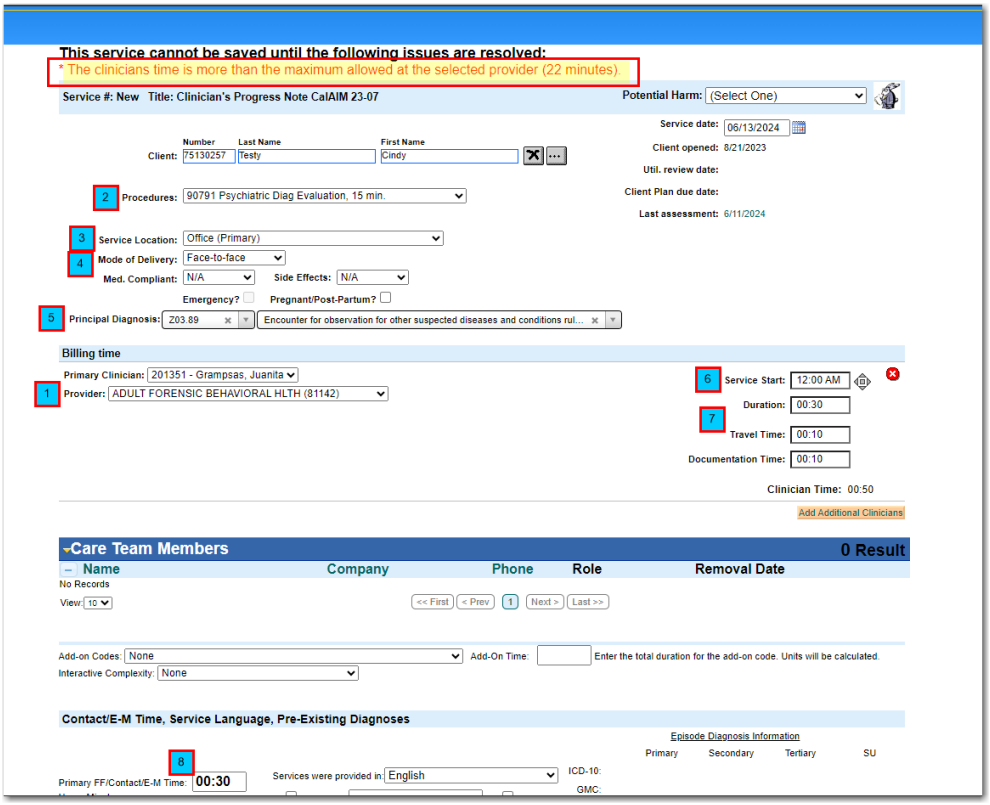
6/12/2024 1:39:58 PM
ELECTRONIC PROTECTED HEALTH INFORMATION

SITUATION TWO: CPT service codes putting more time than allowed for that Primary Code

1. Choose the right provider from the drop down
2. When writing a progress note in Clinician's Gateway, **first choose the 90791 Primary code.** Documentation and Travel will be added to Primary Code time.
3. Add the service location: i.e field, hospital etc
4. Choose mode of delivery: face to face, video, telephone etc
5. Add principal diagnosis

6. Change the service start time or leave it as default (12:00 AM).
7. Add the Duration i.e 30 min (more than the 22 min allowed for this procedure code. Add the Travel time and Documentation time)
8. Under the Contact/E-M Time heading, enter primary FF/Contact/E-M time (usually this matches duration time, in this case 30 minutes)
9. Fill out the rest of the form: Narrative, Co-Staff (Group Services ONLY) and Next Steps.
10. Make sure to check the checkbox 'Note is Complete'
11. Save by clicking on 'Save as Pending

The total time for this procedure code MAX 22 minutes, if you go above 22 minutes you will get an error like in screenshot below. In this case you need to manually add an add on code. Please see below: Situation THREE.



Narrative Previous Entries: (Select Note)

Describe the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

htrhjtrjhtr

Co-Staff (Group Services ONLY) Previous Entries: (Select Note)

9

Instructions: Information about co-staffing is only required when one staff is documenting a group service facilitated by multiple providers for both providers on one progress note. In that situation, the progress note must clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time.

Reminder: All group services require a list of participants to be maintained outside of the beneficiary's health record due to privacy concerns.

jytrjytrfjyt

Next Steps Previous Entries: (Select Note)

Including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s), and any update to the problem list as appropriate.

jytrfjytjyt

10 Note is complete.

11

Cancel | Spell Check | Save and Continue | Save as Pending | Save as Draft

SITUATION THREE: CPT service code adding second code or modifier (interactive complexity, child bed day, conrep home visit)

Case: Interactive Complexity

Login to Clinician Gateway Mental Health. Clinician's Gateway version 3.7.42 (Home)

Open a note for a specific client. Select all required fields from the drop down: Provider, Procedure, Location, mode of delivery, principal diagnosis, duration, travel time and documentation time.

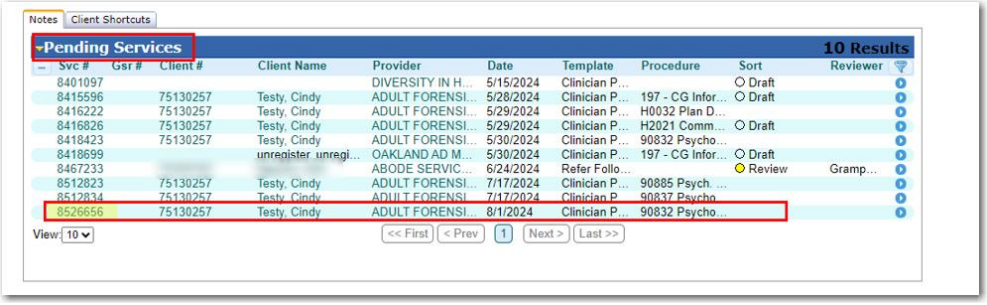
Welcome: Juanita Grampsas
Home Menu Log out
Service #: 8526656 Title: Clinician's Progress Note CalAIM 23-07
Potential Harm: (Select One)
Service date: 08/01/2024
Client opened: 8/21/2023
Last assessment: 6/4/2024
Number Last Name First Name
Client: 75130257 Testy Cindy
(Smartcare #: 75130257)
Procedures: 90832 Psychotherapy, 30 min. w/Patient
Service Location: Field
Mode of Delivery: Face-to-face
Med. Compliant: N/A Side Effects: N/A
Pregnant/Post-Partum?
Principal Diagnosis: F01.511 Vascular dementia, unspecified severity, with agitation
Billing time
Primary Clinician: 201351 - Grampsas, Juanita
Provider: ADULT FORENSIC BEHAVIORAL HLTH (81142)
Service Start: 12:00 AM
Duration: 00:30
Travel Time: 00:10
Documentation Time: 00:10
Clinician Time: 00:50
Add Additional Clinicians

Under the section Care Team members under Interactive Complexity drop down select the code listed i.e 90785 + Interactive Complexity.

Care Team Members 0 Result
Name Company Phone Role Removal Date
No Records
View: 10
<< First < Prev 1 Next > Last >>
Add-on Codes: None Add-On Time: Enter the total duration for the add-on code. Units will be calculated.
Interactive Complexity: 90785 + Interactive Complexity

Fill out remaining sections of the form, make sure to include Primary FF/Contact/E-M Time: Hours: minutes, list any allergies and add the progress notes : Narrative, Co-Staff (Group Service ONLY) and Next Steps. Once everything has been completed, check on 'Note is complete' checkbox and click on button 'Save as Pending'.

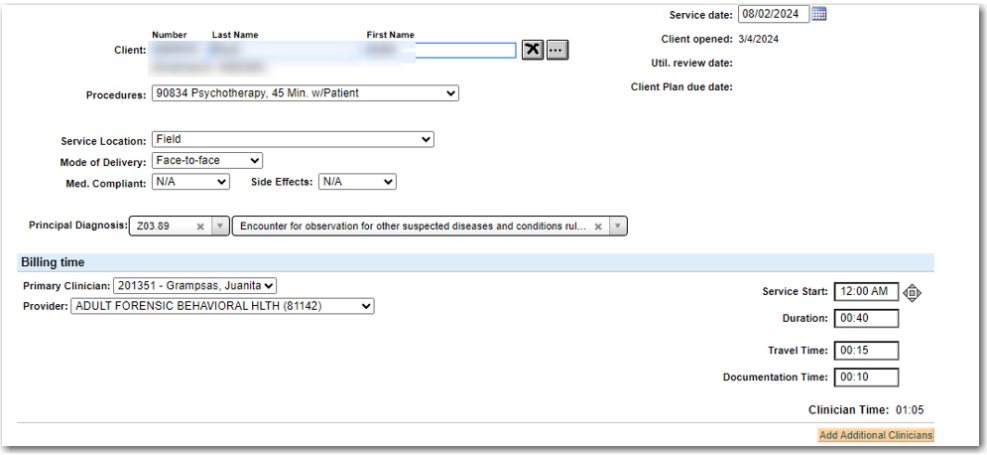
If no errors, your note should be under Pending Services (Click on Home button)



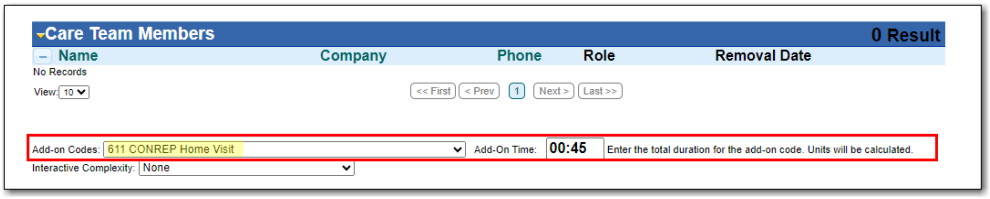
Case: Conrep home visit (MHS ONLY)

Login to Clinician Gateway Mental Health. Clinician's Gateway version 3.7.42 (Home).

Open a note for a specific client. Select all required fields from the drop down: Provider, Procedure, Location, mode of delivery, principal diagnosis, duration, travel time and documentation time.

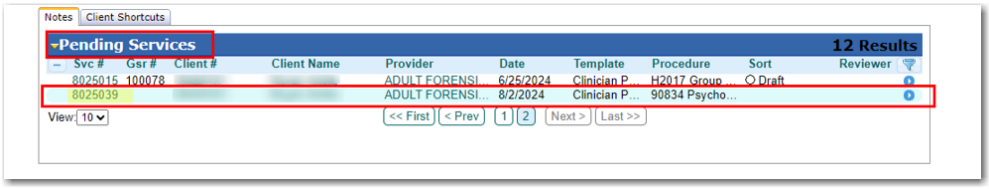


Under the section Care Team members under Add-On Codes drop down menu, select the 611 CONREP Home Visit. Enter the amount of minutes of the home visit in the Add-on Time text box.



Fill out remaining sections of the form, make sure to include Primary FF/Contact/E-M Time: Hours: minutes, list any allergies and add the progress notes : Narrative, Co-Staff (Group Service ONLY) and Next Steps. Once everything has been completed, check on 'Note is complete' checkbox and click on button 'Save as Pending'.

If no errors, your note should be under Pending Services (Click on Home button)

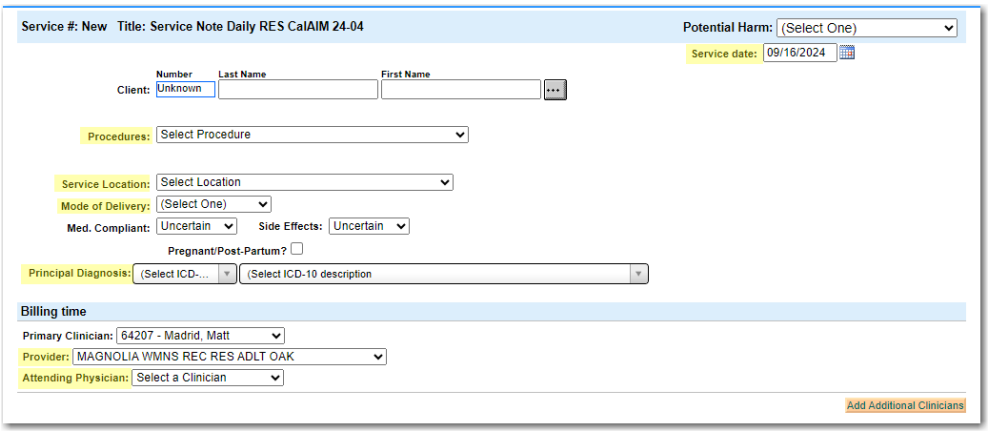


Case: Child Bed Day (SUD ONLY)

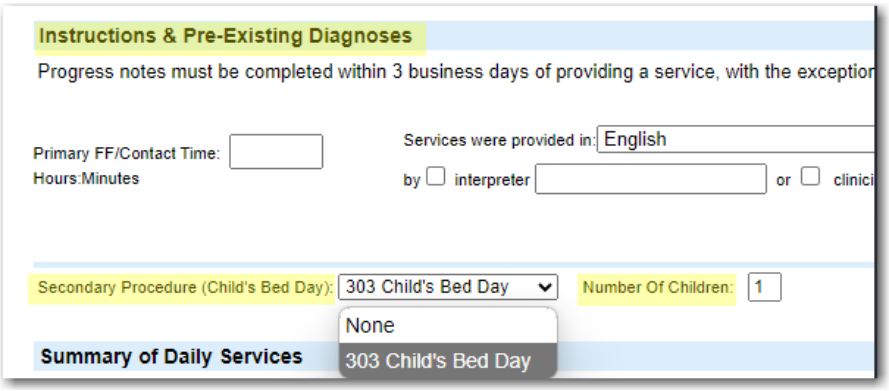
Login to Clinician Gateway Substance Abuse Disorder: Clinician's Gateway version 3.7.42 (Login).

Under Type of Service drop down select : Individual, enter client name and choose template from the drop down menu. The only template that has the Child Bed Day field is the Service Note Daily RES CalAIM 24-04. Click on the 'Start Indiv Service' button to open the form.

Select all required fields from the drop down: Provider, Attending Physician, Procedure, Location, mode of delivery, principal diagnosis. Make sure the Service Date is accurate.



Under Instructions & Pre-Existing Diagnoses is the field Secondary Procedure (Child's Bed Day). Set the dropdown to 303 Child's Bed Day, then enter the Number of Children after that field appears.



Pending versus Draft, 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.

Finalize: 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 SmartCare for claiming.

Save and Continue: Quick save while continuing to work on Note that may take a few hours to complete. You may want to save frequently if you have lost notes in the past. This saves a draft note, unless already in pending status, with all the current information on note and stays on the edit page so you may continue working. **Please be aware if you leave date blank and use save and continue it will enter todays date**

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:

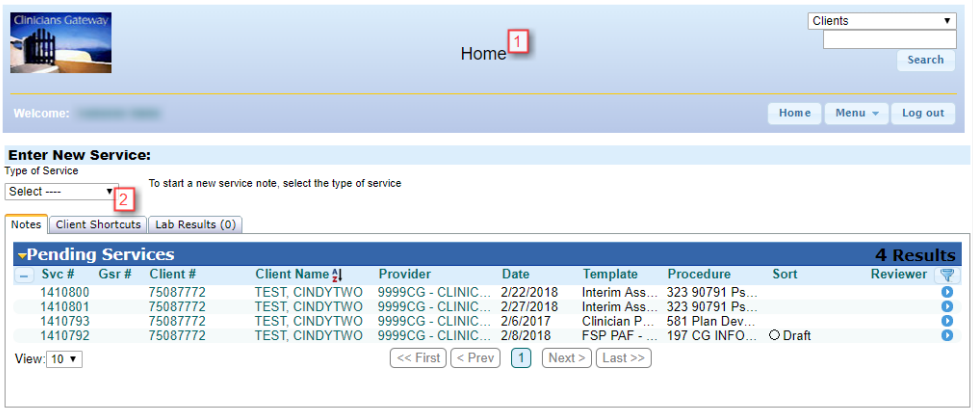
1. Write up your Draft Note as completely as possible.
2. Click the "Save as Draft" button.
3. Find the Draft Note in your Pending List on your Home Page or in the Draft List on your View Staff Page
4. Click "Update" or the specific Service # that you want to archive.
5. Click the "Archive" button in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

Recalling the Archived Note:

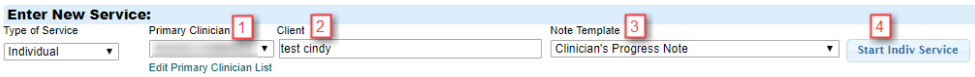
1. You can find the note in three ways:
    a. Do a Services Search from your Home Page (found in the middle of the page) using the client name (last name first name with no comma).
    b. Do a services search using the Search Box in the upper right hand corner by choosing "Services", entering the client 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.

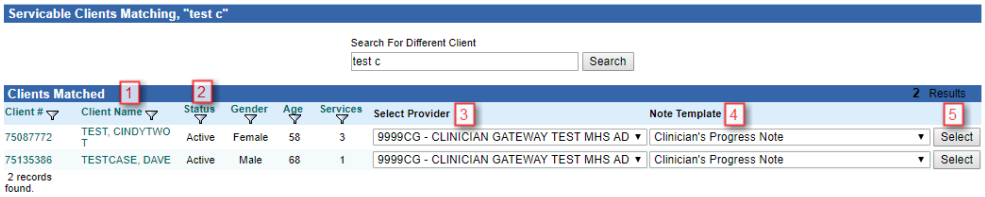
Co-staffed Individual Notes



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

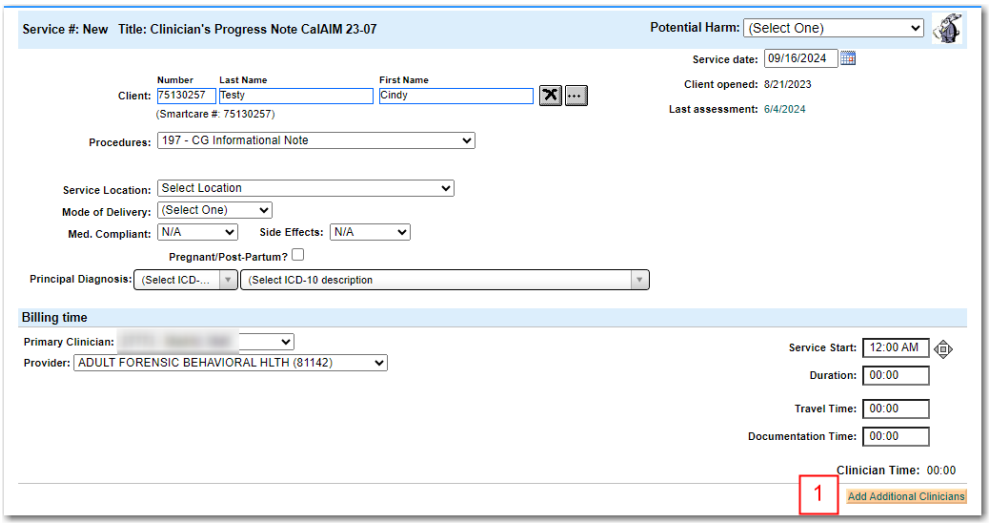


1. Verify the Primary Clinician name is correct.
2. Enter the client name (Last name then First name with no commas, ex. Mouse Mickey) or the client number.
3. Select the template name from the drop list.
4. Click on "Start Indiv Service."

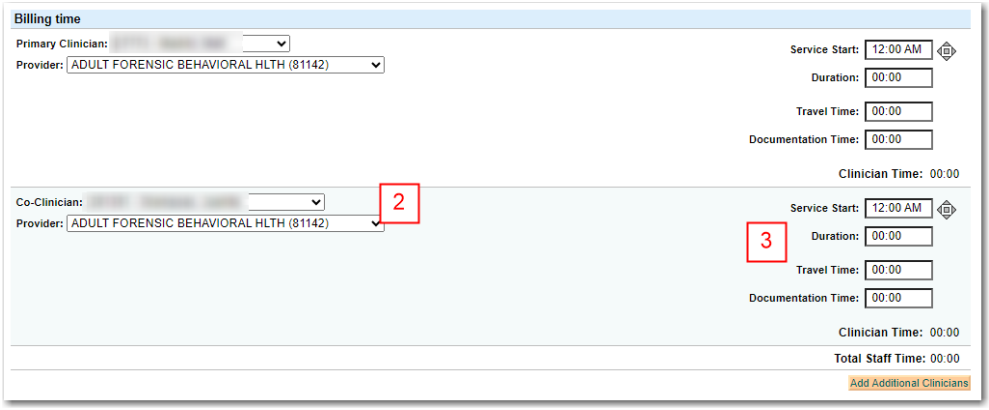


1. Verify the client name.
2. Verify the status for that client. "Active" indicates that the client has an open episode.
3. Verify the appropriate provider name is indicated.
4. Select the Title of the type of note you will enter.
5. Click on "Select"

- Complete the billing information above the Staff Time Section.



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

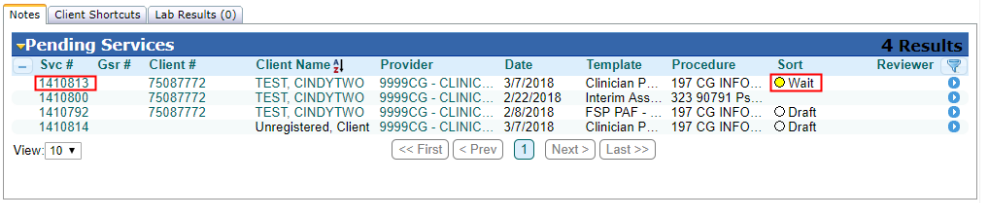


- Complete all of the progress note entries. Check “Note is Complete.”
  ***Note is complete is only visible if you have ‘Daily Approval’**
- Click on “Save as pending.”

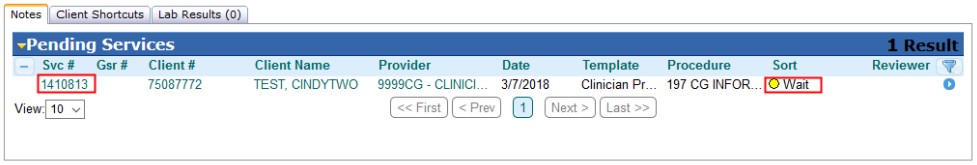
- The note will be listed on the primary and co-staff’s pending lists with a yellow dot and the word “wait” which displays the message “Waiting for clinicians to approve this service” when pointed at with the cursor. This is an advisory message only.

- Best Practice is that co-staff review and approve their addendum to the notes before the Primary Clinician finalizes this service.

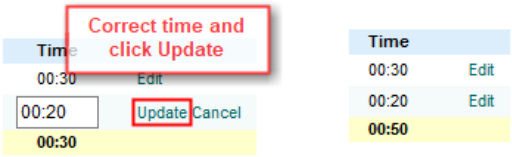
- **Primary Staff**:



- **Co-Staff:**

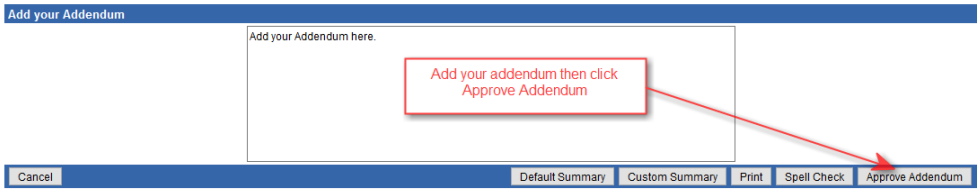


- The co-staff have the opportunity to edit their time and add an <u>optional</u> addendum to the note <u>before the Primary finalizes</u>.
- To edit, click the service #
- Co-staff may edit their time before the Primary finalizes.

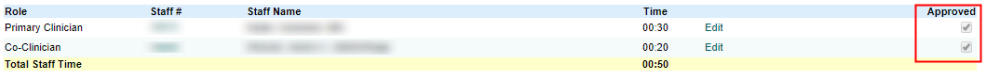


- Add the addendum at the bottom of the note and click “Approve Addendum”

- Best Practice is that co-staff review and approve their addendum to the notes before the Primary Clinician finalizes this service.

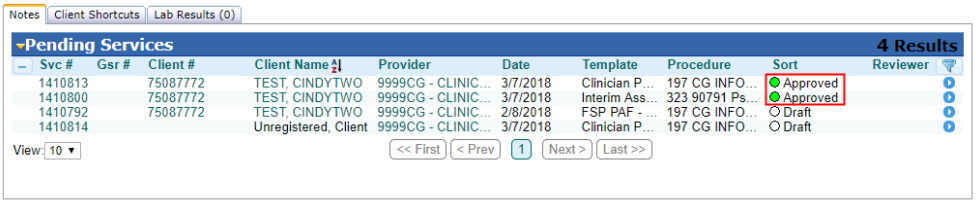


- When the co-staff approve their addendum
  1. A checkmark is placed in the “Approved” checkbox at the top of the note
     *Note: Co-staff approval is optional.



  2. The note will disappear from the Co-Staff’s Home Page Pending service list. It is no longer available for editing.

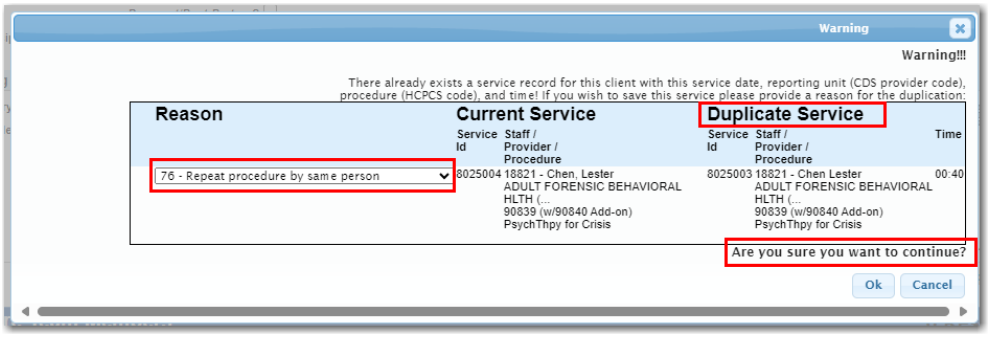
  3. The dot on the Primary’s Home Page Pending list then turns green.



4. The Primary Clinician then finalizes the note and the services drop into SmartCare for both primary and co-staff.

Duplicate Notes

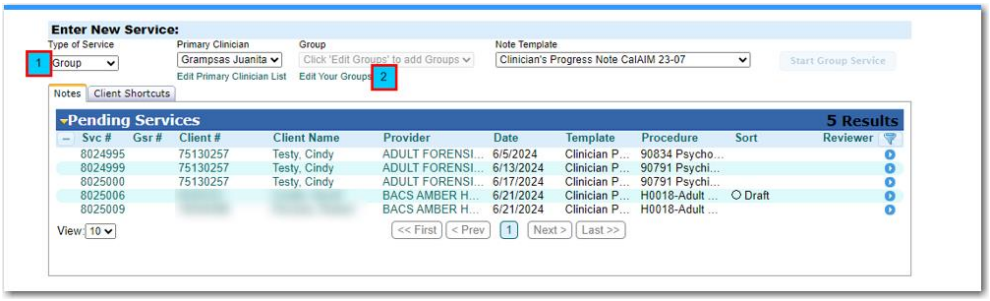
When you create duplicate notes for same patient with same clinician, same date and same duration, you may get a popup like the one below were you need to state the reason for the duplicate.



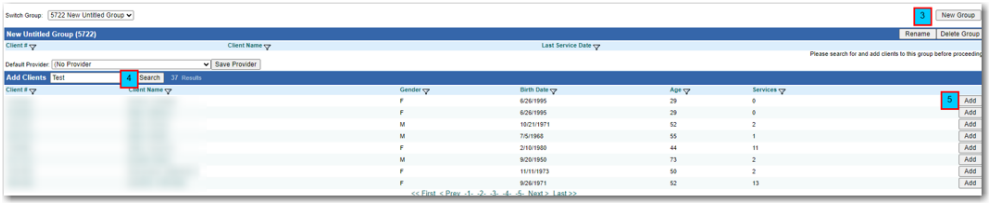
Group Notes

Creating Groups

1. Select “group” under “type of service.”
2. If this is a new group then click on “Edit your groups”

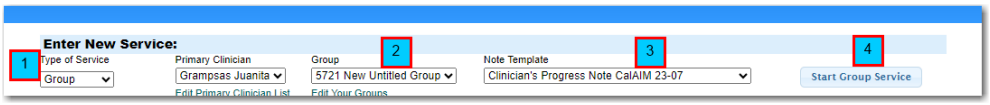


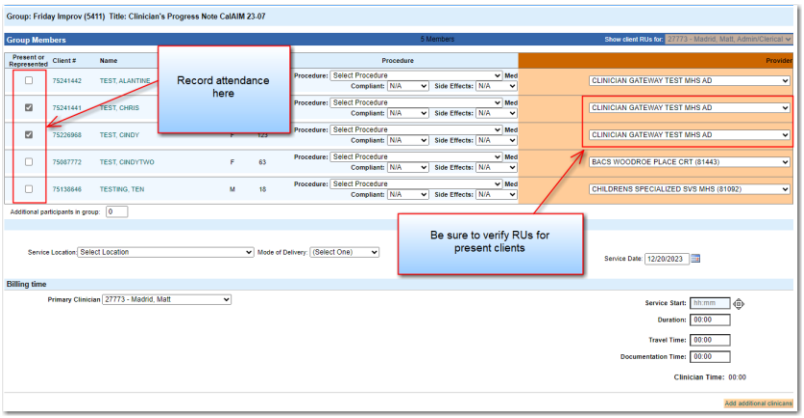
3. To create a new group click on the button ‘New Group’
4. Type in the client’s name in the “Add Clients” field (Last name then first name, with a space between) then click on the “Search” button and wait for the list to populate.
5. When the client information appears, click on the “Add” button.
   (The client will move above to the group section)



Writing Group Note

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

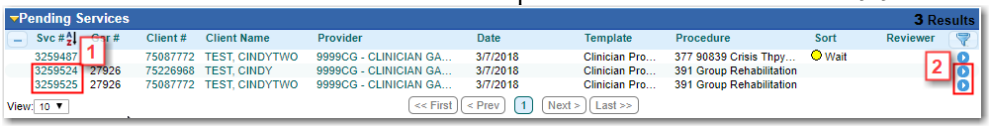




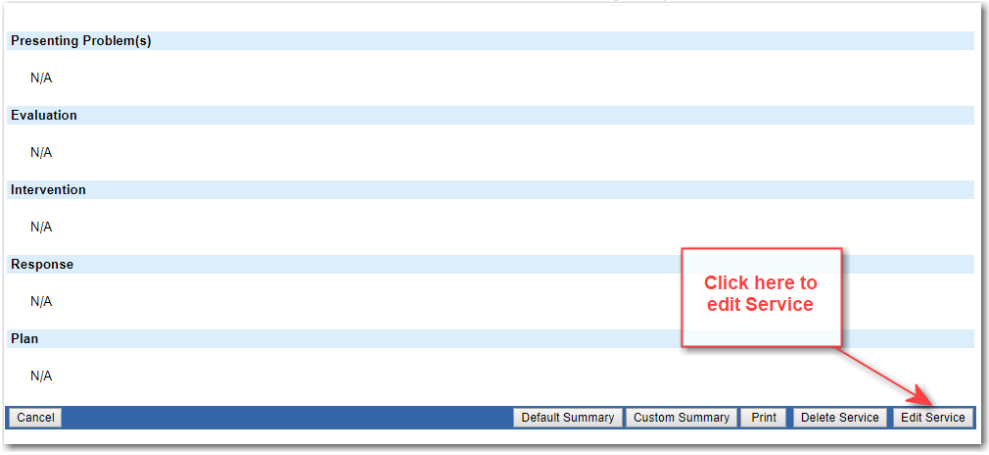
- Click on the square box under the “Present” column for each client in attendance. A check mark should appear.
- Complete the fields for the procedure, service location, co-staff, service date, service start, duration, travel time, documentation, and co-staff time (if co-staff were entered).
- **Be 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.

- When all of the fields have been completed click on the "Save as Draft" button.



- You will see your group service listed in your 'Pending Services' split into individual notes for each client present.
- Click on the Service Number (1) or the blue action button (2) to view/edit the 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.

Group: testing SMC 7/17 (5646) Title: Clinician's Progress Note CalAIM 23-07 Client: Individual: 8190833

Group Members — 4 Members — Show client RUs for: 27773 - Madrid, Matt, Admin/Clerical

Present or Represented	Client #	Name	Gender	Age	Procedure	Provider
			Male	39	Procedure: Select Procedure Med; Compliant: N/A; Side Effects: N/A	ADULT FORENSIC BEHAVIORAL HLTH (81142)
☑			Male	79	Procedure: H2017 Group Psychosocial Rehab, per 15 Min.er 1 Med; 1 Compliant: N/A; Side Effects: N/A 2	ADULT FORENSIC BEHAVIORAL HLTH (81142)
			Male	53	Procedure: Select Procedure Med; Compliant: N/A; Side Effects: N/A	ADULT FORENSIC BEHAVIORAL HLTH (81142)
☑			Male	28	Procedure: H2017 Group Psychosocial Rehab, per 15 Min.er 1 Med; Compliant: N/A; Side Effects: N/A	ADULT FORENSIC BEHAVIORAL HLTH (81142)

Additional participants in group: 0

Service Location: Office (Primary) Emergency? ☐ Mode of Delivery: Face-to-face

Service Date: 12/20/2023
Util. review date 9/21/2022

Billing time

Primary Clinician: 27773 - Madrid, Matt

Service Start: 12:59 PM
Duration: 00:15
Travel Time: 00:00
Documentation Time: 00:00
Clinician Time: 00:15

3

Previous Entries:

Add-on Codes: None Add-On Time: Enter the total duration for the add-on code. Units will be calculated.
Interactive Complexity: None

Contact/E-M Time, Service Language, Pre-Existing Diagnoses — Previous Entries:

4

Primary FF/Contact/E-M Time: Hours:Minutes

Services were provided in English
by ☐ interpreter or ☐ clinician

Episode Diagnosis Information

	Primary	Secondary	Tertiary	SU
ICD-10:	F41.9	F43.10	F11.20	
GMC:				
DSM 5:				

Primary ICD-10 and DSM 5 do not match - you must update SmartCare or CG

Narrative — Previous Entries: (Select Note)

Describe the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

5

Client Specific Narrative

Co-Staff (Group Services ONLY) — Previous Entries: (Select Note)

Instructions: Information about co-staffing is only required when one staff is documenting a group service facilitated by multiple providers for both providers on one progress note. In that situation, the progress note must clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time.

Reminder: All group services require a list of participants to be maintained outside of the beneficiary's health record due to privacy concerns.

N/A

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**) Add On codes and time can be added if necessary, (**4**) Face-to-Face time will need to be entered, and the (**5**) note fields can be used to enter additional information specific to that client.

Assign to be reviewed by

Reviewer: Select Reviewer

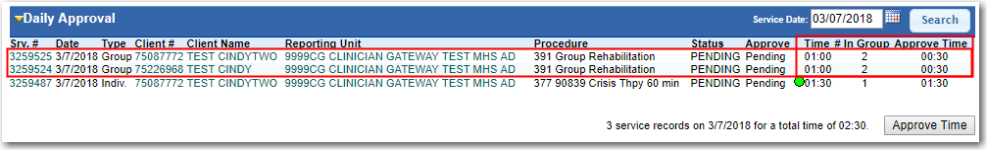
Notes:

Cancel | Spell Check | Submit for review | Save as Pending

Click on "Save as Pending" when your entries are completed. If you need your notes reviewed, you will instead select a reviewer and click "Submit for Review".

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.



Daily Approval

Service Date: 03/07/2018 Search

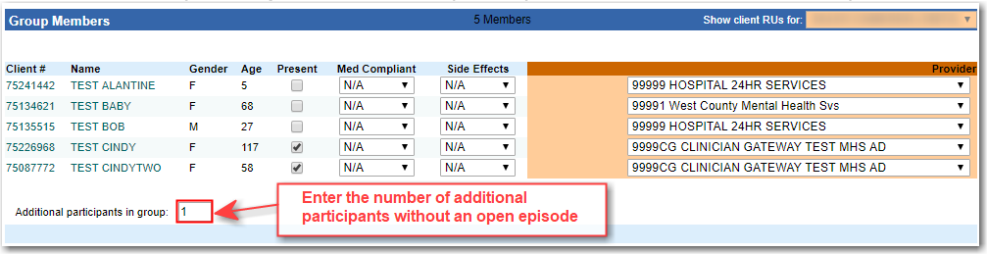
Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve	Time	# In Group	Approve Time
3259525	3/7/2018	Group	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	2	00:30
3259524	3/7/2018	Group	75226968	TEST CINDY	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	2	00:30
3259487	3/7/2018	Indiv.	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	377 90839 Crisis Thpy 60 min	PENDING	Pending	01:30	1	01:30

3 service records on 3/7/2018 for a total time of 02:30. Approve Time

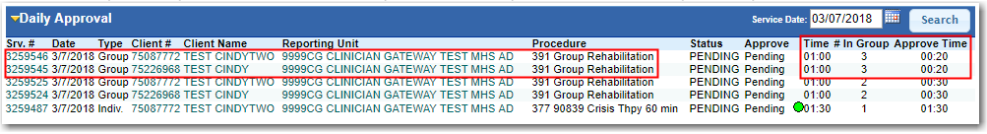
Additional Participants Feature

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.**

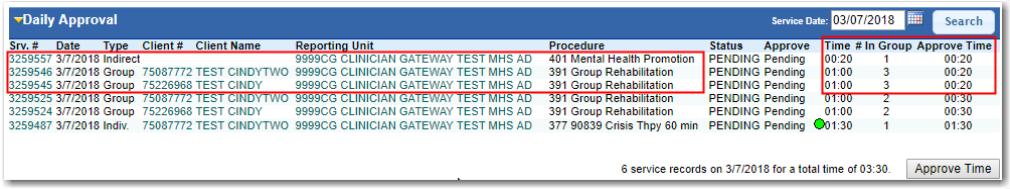


- Complete the group note and the individualizations as usual.
- Each individual service will be listed separately in Daily Approval.
- Each service will be given part of the total time, divided by how many total participants attended. (open clients plus additional participants)



- If you gave services to clients who did not have an open episode, their time will not be added to your staff log. Notice two services were given 20 minutes for the 01:00 spent. Time given to each note equals the total time divided by the number in group. 01:00/3 = 00:20.
- Note: 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. (see next page)

- 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



Daily Approval — Service Date: 03/07/2018 — Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve	Time	# In Group	Approve Time
3259557	3/7/2018	Indirect			9999CG CLINICIAN GATEWAY TEST MHS AD	401 Mental Health Promotion	PENDING	Pending	00:20	1	00:20
3259546	3/7/2018	Group	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	3	00:20
3259545	3/7/2018	Group	75226968	TEST CINDY	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	3	00:20
3259525	3/7/2018	Group	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	2	00:30
3259524	3/7/2018	Group	75226968	TEST CINDY	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	2	00:30
3259487	3/7/2018	Indiv.	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	377 90839 Crisis Thpy 60 min	PENDING	Pending	01:30	1	01:30

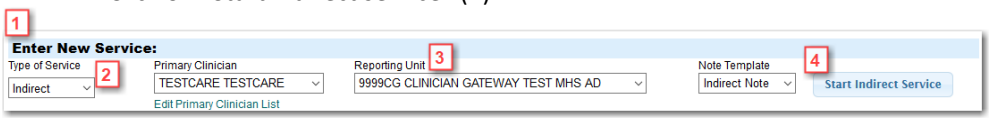
6 service records on 3/7/2018 for a total time of 03:30. Approve Time

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

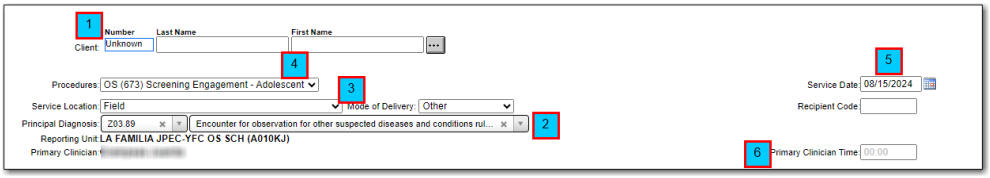
Indirect Notes

Indirect Notes

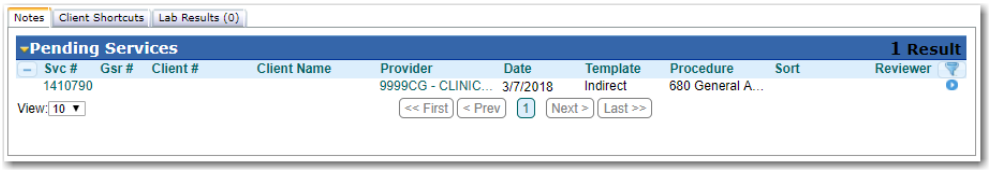
- From the "Enter new service" (**1**) section, click the "Type of service" (**2**) drop arrow and select "Indirect"; click the "Reporting unit" (**3**) drop arrow and select the appropriate RU.
- Click on "Start indirect service."(**4**)



- (**1**) If no client is involved with the Indirect Service, leave the client field blank (it will default to "AAA-INDIRECT SERVICE CLIENT (80002450)" when transferring to SmartCare). If an **unregistered** client is involved, type their name in the Last Name and First Name fields (again, the service will transfer to SmartCare with the "AAA" client). If a **registered** client is involved, click on the "…" button and follow the prompts to look up and add the client to the note (the registered client will be attached to the service instead of the "AAA" client).
- Select diagnosis (2), service location (**3**), Procedure(**4**), Service date (**5**), and primary Clinician time. (**6**) Enter notes as needed
- 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.



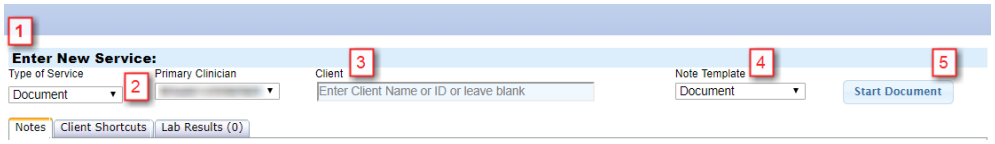
Documents

What is a Document?

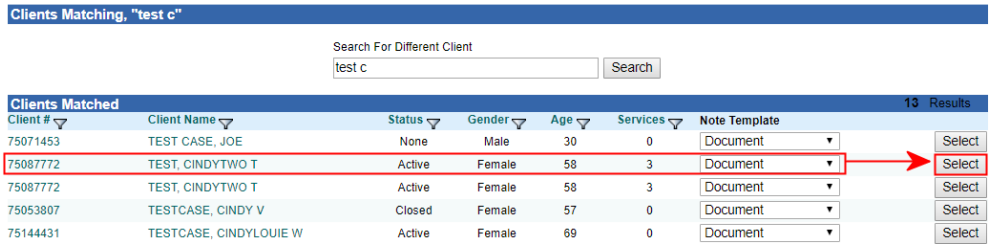
A Document is a note for a client that will not be tracking time or entered under a procedure code. Depending on the agency, Environment (MHS or SUD), and Staff configuration you will only see a select set of templates under Documents.

Starting a document

- From the 'Enter new service' section (**1**); click the 'Type of service' (**2**) drop arrow and select 'Document'; enter the clients name or number (**3**); Select the correct 'Note Template'.
- Click on 'Start Document.'(**5**)

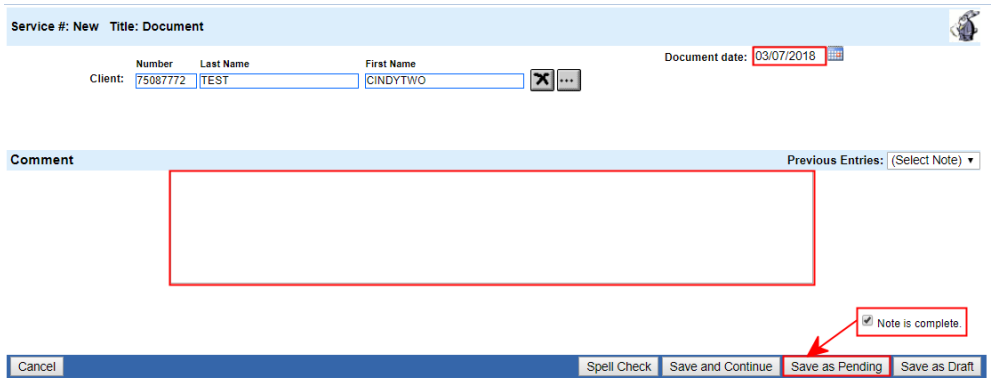


- If there are multiple results find the correct client and click select



Completing the Document

- The Document Must have a Client
- Fill in the Document Date
- Complete all Notes Fields that may be required based on the document Template
- Follow the same procedures to finalize a document as you would a Note.



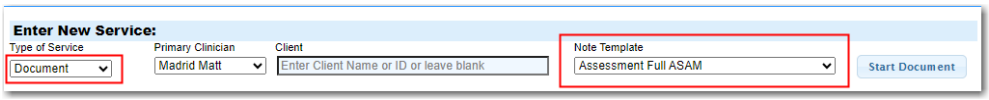
SUD Specifics Notes, Forms, and Authentication

Forms

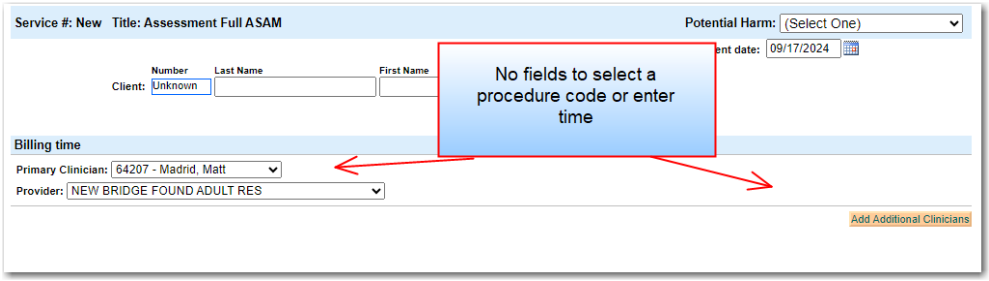
Some Service Note Types will be referred to as Forms. These Notes will all have Zero time and time spent will be entered on your Progress/Service Daily Note.

Forms will still be entered under Documents with the following Templates:

- Timeliness Tracking
- ALOC Initial/Review
- Assessment Full ASAM
- Diagnosis Form
- Discharge Plan
- Discharge Summary



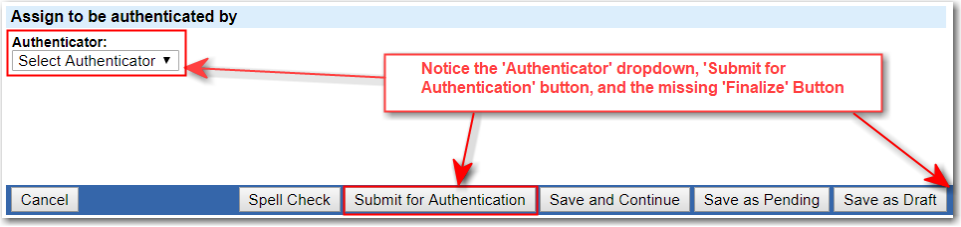
When entering one of these forms there will be no fields to select a procedure code or enter time. These will be entered on the Progress/Service Daily Note.



When a form is completed, it may be require to be submitted for Authentication in order to be finalized. (e.g. Assessment Full ASAM or Diagnosis Form).

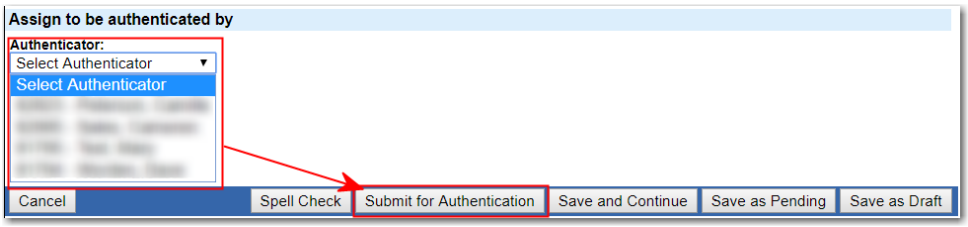
Authentication

At the bottom of specific Forms you will notice you are unable to finalize. You will need to use the 'Submit for Authentication' button.

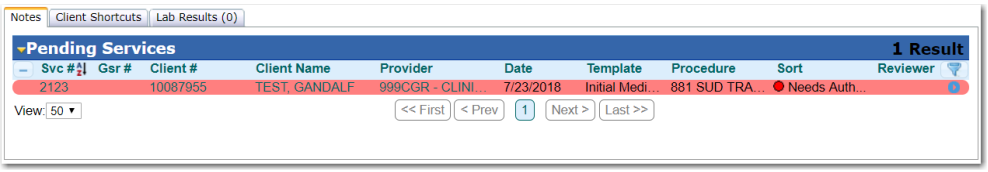


The Steps for Authentication are similar to notes that require review:

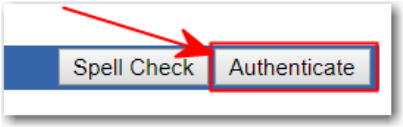
1. Complete the form
2. Select Authenticator from the drop down and click 'Submit for Authentication'
   - **Note the dropdown will have specific staff based on the Note Template, RU, and Staff Mask in SmartCare**
   - **If you are included in the dropdown you may submit to yourself**



3. There will be a 'Pending Authentication' service on your home page and the home page of the Authenticator.



4. The Authenticator will then open the service and select 'Edit Service'.
5. After reviewing and making any necessary edits the Authenticator can then click 'Authenticate'. ***Authenticate will Finalize the Note.**

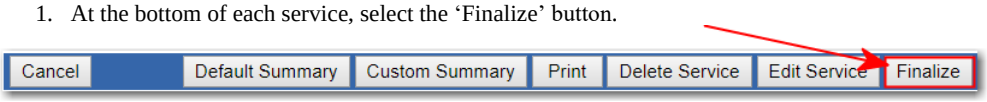


Finalizing Notes

Without Review Required

When you are not required to submit your notes for review, you will Finalize your Note one of two ways:

1. At the bottom of each service, select the 'Finalize' button.



2. Or if your profile is setup with Daily Approval Follow the steps in the section Individual Staff Log (Daily Approval)

Note in SUD 'Authenticate' will also Finalize a Note

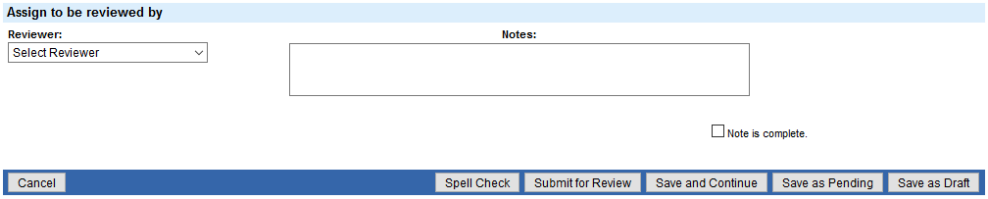
With Review Required

CG account Setup for Review Required

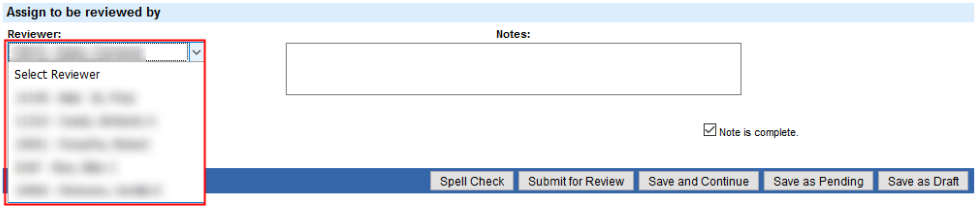
For Staff who need their notes approved by Supervisor:
Add 'Review Required' to their CG account
For Supervisor who will review the notes for Staff:
Add 'Can Review' to their CG account
RU# required to be added to Staff and Supervisor CG accounts

Procedure: Staff creates Progress note and Supervisor "Accepts" the notes

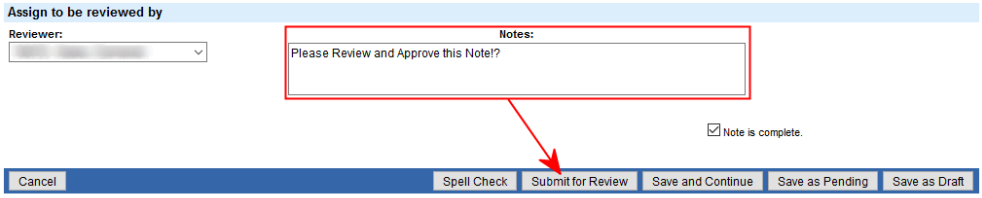
1. At bottom of the Progress note (after completing the note boxes), complete the "Assign to be reviewed by" section:



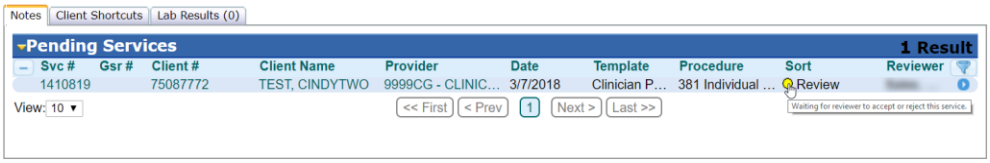
2. Select Reviewer from the drop down box:



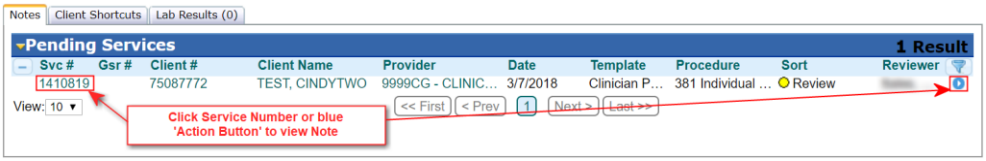
3. Complete Notes and click “submit for review.” Note is sent to Supervisor for review and approval:



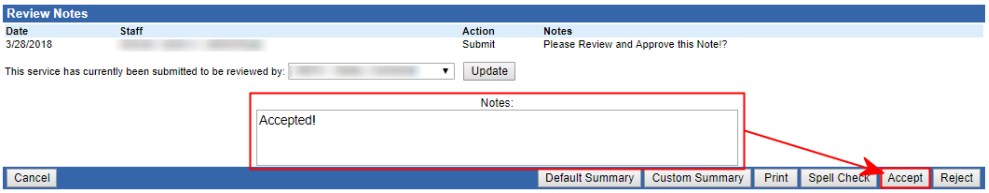
4. The Progress Note appears in “pending services” of the Supervisor’s home page and waiting for approval:



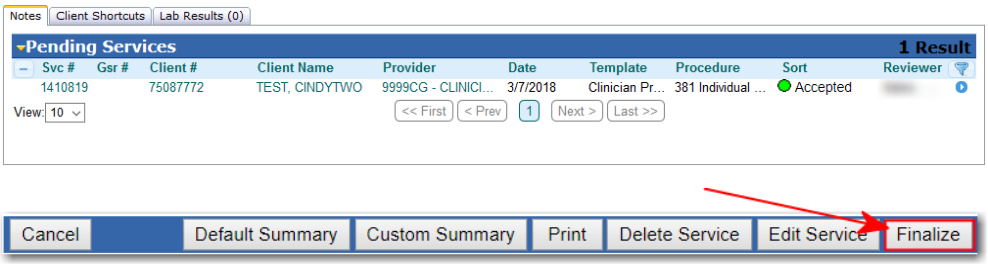
5. The Supervisor will need to review the note. First click the service # or the Blue Button



6. At the bottom of the note complete ‘Review Notes’ section with comments, then click ‘Accept’. Depending on how CG is setup the note will then be Finalized (in which case, you are all done!), or the note will be removed from the Supervisor’s ‘Pending Services’ section of their home page and updates the note on the Staff’s ‘Pending Services’ (proceed to step 7).



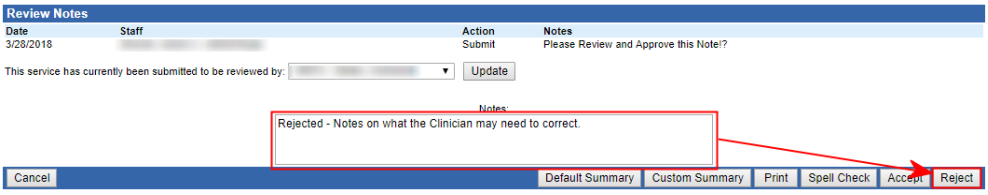
7. Note is now ready to be "Finalized" via Individual Staff Log (Daily Approval) or opening the note and selecting 'Finalize': *Unless you intend to make changes, do not click 'Edit Service' if you have review required and it's been approved. If you do you will be required to resubmit for approval.



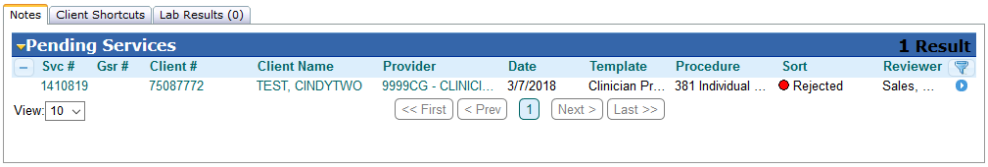
Procedure: Staff creates Progress note and Supervisor "Rejects" the notes before "Accepting" the note

1. Follow steps 1 through 5 above

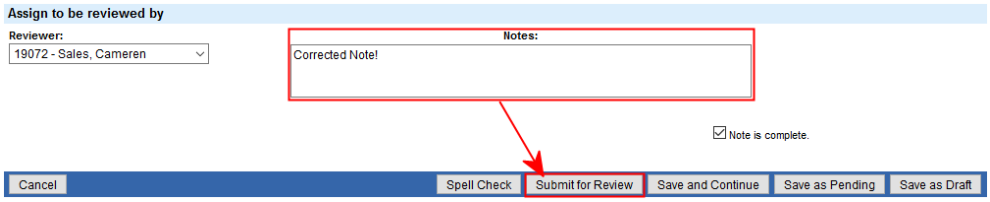
6. At the bottom of the note complete 'Review Notes' section with comments, then click 'Reject'. The note will be removed from the Supervisor's 'Pending Services' section of their home page and updates the note on the Staff's 'Pending Services'



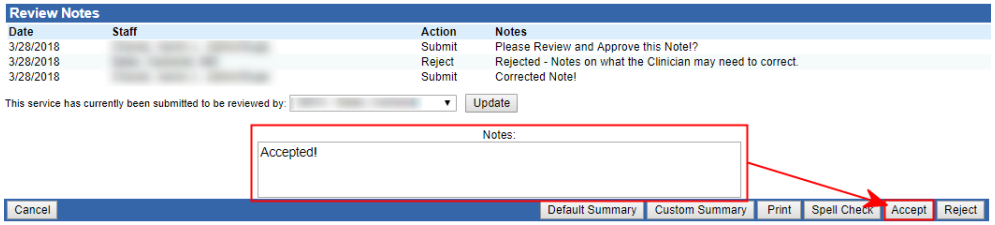
Supervisor 'Rejected' the note:



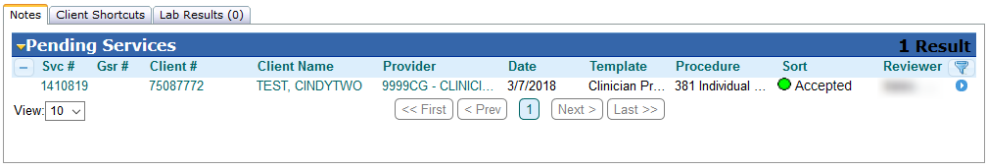
7. Staff will open note to view. Click 'Edit service', Make necessary changes, verify the correct Supervisor is listed in the 'Reviewer' box and complete the 'notes' section with comments back to the Supervisor. Click 'Submit for Review'. The note is sent to Supervisor for review and approval:



8. Supervisor will open the note. At the bottom of note complete 'Review Notes' section with comments, then click 'Accept'. Depending on how CG is setup the note will then be Finalized (in which case, you are all done!), or the note will be removed from the Supervisor's 'Pending Services' section of their home page and updates the note on the Staff's 'Pending Services' (proceed to step 9).



Supervisor 'Approved' the note:



9. Note is now ready to be 'Finalized' and the Staff can view the note to see Supervisor's comments:

Review Notes

Date	Staff	Action	Notes
3/28/2018	[illegible]	Submit	Please Review and Approve this Note!?
3/28/2018	[illegible]	Reject	Rejected - Notes on what the Clinician may need to correct.
3/28/2018	[illegible]	Submit	Corrected Note!
3/28/2018	[illegible]	Accept	Accepted!

Cancel | Default Summary | Custom Summary | Print | Delete Service

Individual Staff Log (Daily Approval)

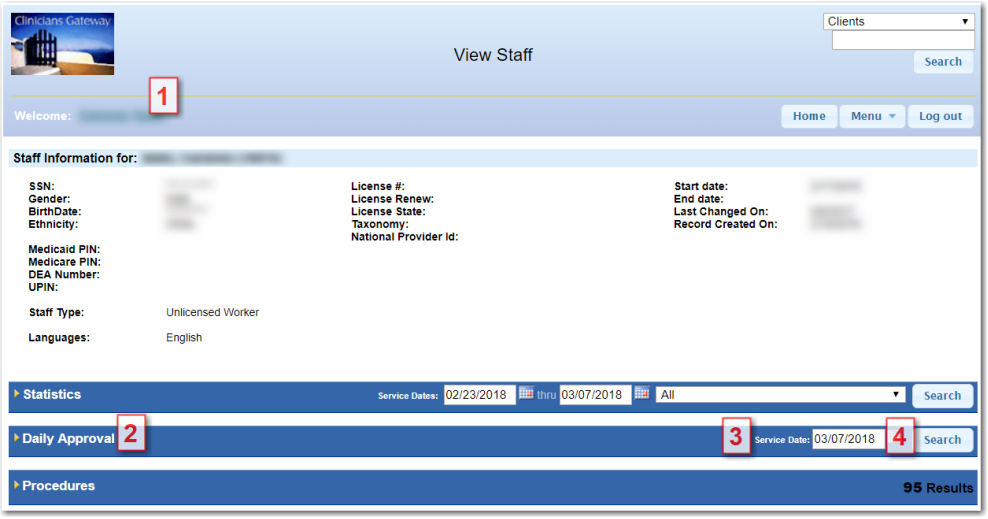
Approval printout and Finalizing Notes

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

2. In the daily approval section of the screen,

3. Enter the service date 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!

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.

Daily Approval — Service Date: 03/07/2018 — Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve	Time	# In Group	Approve Time
3259557	3/7/2018	Indirect			9999CG CLINICIAN GATEWAY TEST MHS AD	401 Mental Health Promotion	PENDING	Pending	00:20	1	00:20
3259546	3/7/2018	Group	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	3	00:20
3259545	3/7/2018	Group	75226968	TEST CINDY	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	3	00:20
3259525	3/7/2018	Group	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	2	00:30
3259524	3/7/2018	Group	75226968	TEST CINDY	9999CG CLINICIAN GATEWAY TEST MHS AD	391 Group Rehabilitation	PENDING	Pending	01:00	2	00:30
3259487	3/7/2018	Indiv.	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	377 90839 Crisis Thpy 60 min	PENDING	Pending	01:30	1	01:30

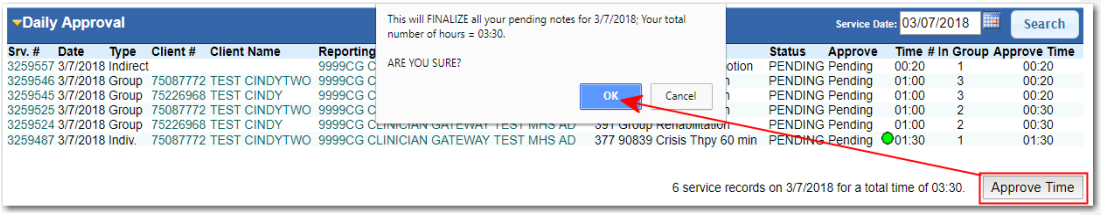
6 service records on 3/7/2018 for a total time of 03:30. Approve Time

- 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!

IMPORTANT!

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



Once you click on "Approve Time," the service notes 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.

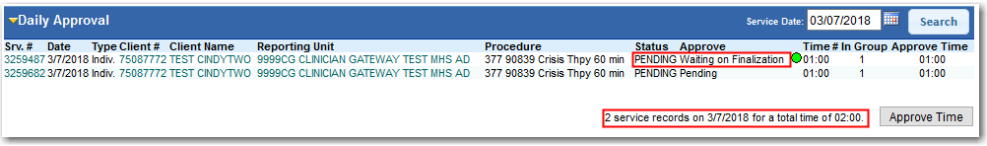
2. Click on the printer icon – this will print the electronic Individual Staff Log form (MAA) as well as direct and indirect services. You may specify which pages to print, eliminating unneeded pages.

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

Co-staff Individual Logs

PRIMARY CLINICIANS MUST FINALIZE THE NOTE FIRST. CO-STAFF WILL BE UNABLE TO GET TIME ON THEIR STAFF LOG UNTIL THE PRIMARY FINALIZES. (Time will ONLY be transferred into SmartCare on the day the Primary finalizes.)

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

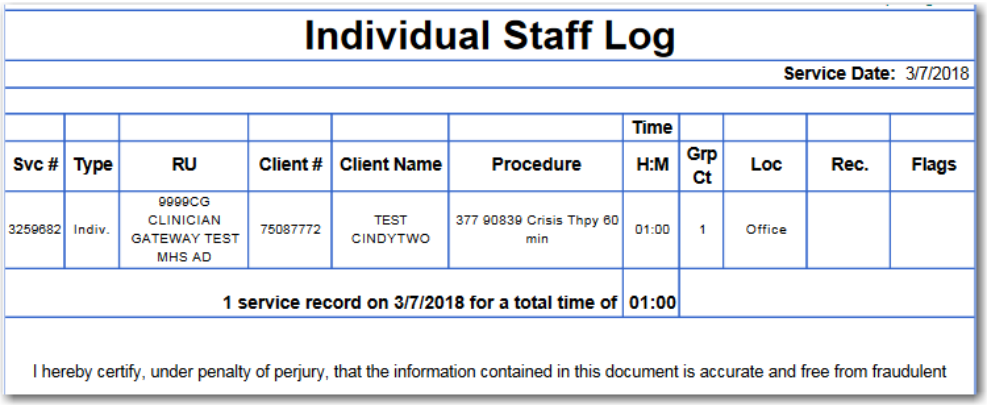


Daily Approval — Service Date: 03/07/2018 — Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve Time	# In Group	Approve Time
3259487	3/7/2018	Indiv.	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	377 90839 Crisis Thpy 60 min	PENDING Waiting on Finalization	01:00	1	01:00
3259682	3/7/2018	Indiv.	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	377 90839 Crisis Thpy 60 min	PENDING Pending	01:00	1	01:00

2 service records on 3/7/2018 for a total time of 02:00. — Approve Time

- If you attempt to Approve Time before the primary you will notice the service will not be displayed on your Staff Log's print out



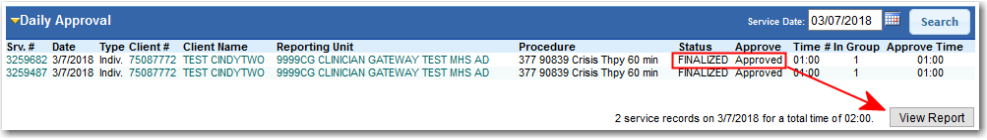
Individual Staff Log

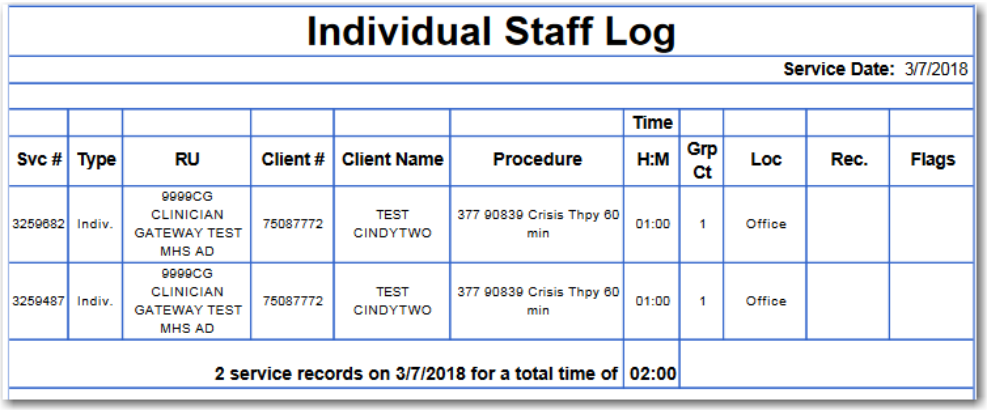
Service Date: 3/7/2018

Svc #	Type	RU	Client #	Client Name	Procedure	Time H:M	Grp Ct	Loc	Rec.	Flags
3259682	Indiv.	9999CG CLINICIAN GATEWAY TEST MHS AD	75087772	TEST CINDYTWO	377 90839 Crisis Thpy 60 min	01:00	1	Office		
1 service record on 3/7/2018 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 fraudulent

- Inform the Primary clinician they will need to finalize their service
- Once the service is Finalized (**1**) return to Daily Approval and View Report (**2**)





Individual Staff Log

Service Date: 3/7/2018

Svc #	Type	RU	Client #	Client Name	Procedure	Time H:M	Grp Ct	Loc	Rec.	Flags
3259682	Indiv.	9999CG CLINICIAN GATEWAY TEST MHS AD	75087772	TEST CINDYTWO	377 90839 Crisis Thpy 60 min	01:00	1	Office		
3259487	Indiv.	9999CG CLINICIAN GATEWAY TEST MHS AD	75087772	TEST CINDYTWO	377 90839 Crisis Thpy 60 min	01:00	1	Office		
2 service records on 3/7/2018 for a total time of						**02:00**				

****Note:**

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

The time will appear on the SmartCare 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.

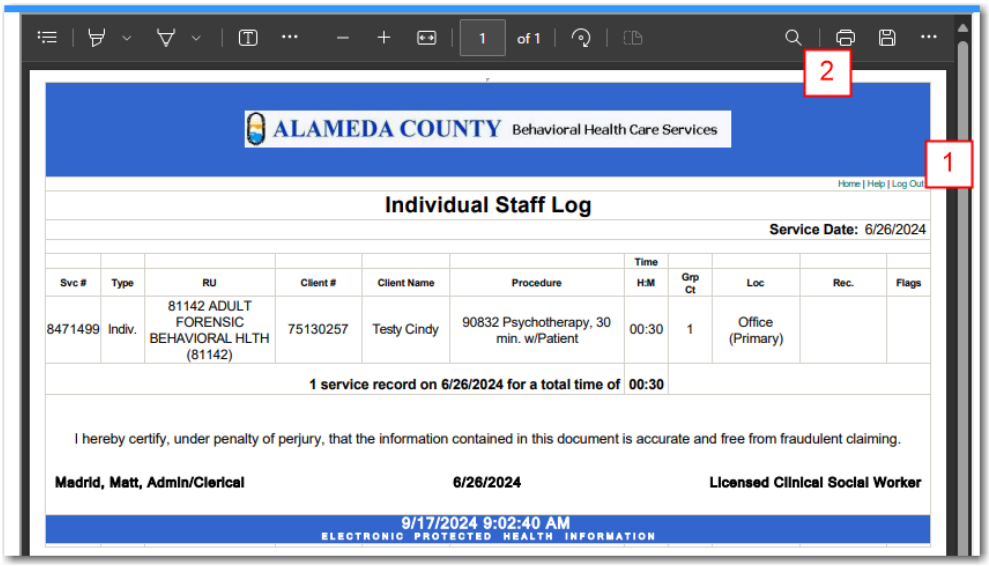
Printing

Printing from Daily Approval

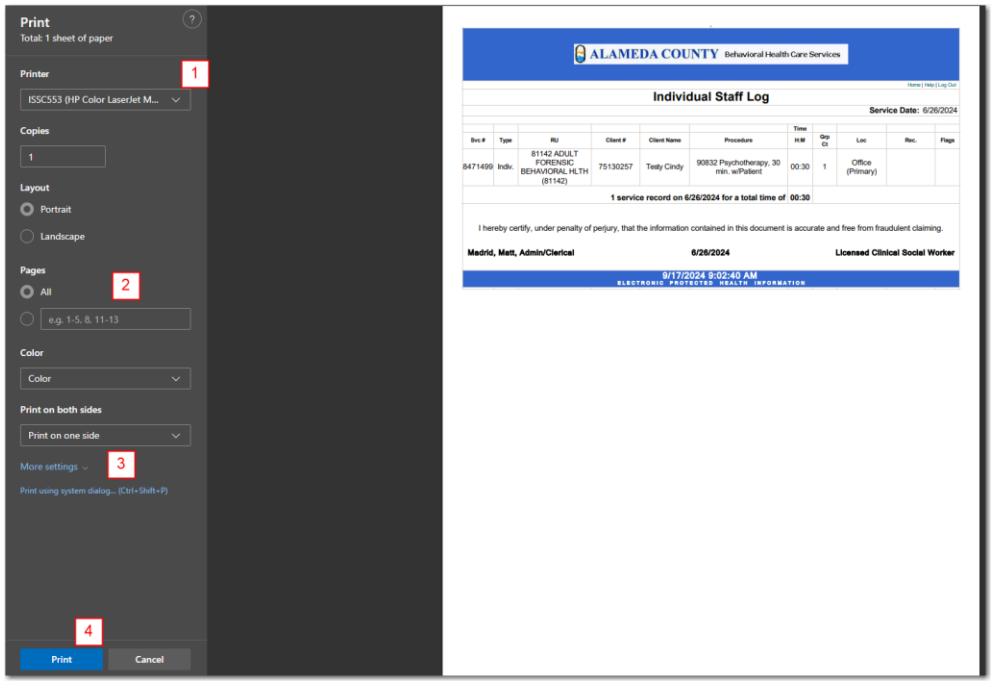
To print your Staff Log and progress notes after Daily Approval, use the printer icon adjacent to the image. Do not use File/Print

1. First, decide which pages to print. You can scroll through document using the iner

2. Then use the printer icon to bring up the printing menu.



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.



1. Select your Printer

2. Chose which pages to print (I selected current page to print only page 1)

3. Click on More Settings to change settings like scale, paper size, quality, etc.

4. Click ‘Print’

Deleting a Note

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 SmartCare and redone by the clinician/physician in Clinician's Gateway. We cannot 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?

- Submit a 'Service Delete Request' eform
  - Complete the form and click submit
  - You will receive a Pending request in your email
  - Contact the Help Desk via phone at **510-817-0076** to inform them that the request has been submitted so they may process as soon as possible

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

Note Delete Requests are found in BHCS E-Forms in the Clinicians Gateway section.

Contact Information

Do Not delete a Service if only the body of the note needs to be corrected, just do an addendum.

SmartCare-CG Service Delete Request

Please complete this form and allow 3 business days for processing. This Service Delete Request form is to be used for requesting SmartCare Service and Clinicians Gateway Service Notes to be Deleted by the ACBH IS Support Group.

Use the TAB key to navigate through each field. Click on the GREEN circles for help on each field. When you have completed the form, click on the "**Submit Service Delete Request**" button. The completed form will be emailed to Information System Desk (HCSASupport@acgov.org) and you will receive a copy for your records. Note: To process another request, simply press the Refresh icon or the F5 key to reload the form.

Today's Date :	09/17/2024
Time Submitted:	04:54 PM
Clinician's First Name :	
Clinician's Last Name :	
Clinician's Phone / Ext :	
Clinician's Email :	
Select Provider Name (dba) - acronyms not used:	
Enter Name of Clinic / Program :	
Select The Type of User :	

Clinician's Gateway Note Deletion Request

Please fill out a separate e-form for each service delete requested. There are two kinds of deletes:

A. **Submitted / Transferred Service** - A Submitted Service delete is for a service that was TRANSFERRED or ENTERED into SmartCare.
B. **Already Claimed Deletes** - Already Claimed Deletes are for services that have already been claimed.

Follow the claims correction process found on the Providers website (http://www.acbhcs.org/providers/Forms/Forms.htm). If a Clinicians Gateway note has not been finalized and is still pending, the Information Systems Desk cannot delete it, you must delete it yourself.

1. Indicate if this is either a Submitted Service or an Already Claimed service that you want deleted. If this is an Already Claimed note, use the Claims Correction Form (CCF) instead.

2. Indicate the Service Details / Clinician's Staff Number and the Reason for the deletion.

3. If you have printed any copies of the service note that have gone into the client's electronic chart, be sure to mark on the note that it has been deleted from the system, but do not remove from the paper chart.

4. If the service was entered via Clinicians Gateway, you can either scan a copy of the note and attach it to this form as an electronic document OR copy the web address of the note from Clinician's Gateway and paste it into the available web address field below.

5. Submit this form. You will receive a confirmation. ACBH Billing and Benefits Support will evaluate the request, erroring out the service and forwarding it to the ACBH IS Support Desk to delete the corresponding CG note if applicable. If the service has already been claimed, BBS will refer the request to the CCF process.

Indicate if this deletion is for the Submitted / Transferred or Already Claimed:
- ☐ Submitted / Transferred Delete
- ☐ Already Claimed Delete

Group Delete Information

- Service Type (MHS / SUD)
- Is this a Group Delete Note: No
- 2-CG Service Number : (Please confirm the service number, once submitted this number cannot be changed)
- Client ID Number :
- Service Date :
- Service Program :
- Clinician's Staff Number :
- If this note was re-entered and finalized, check the box. ☐ Yes
- Reason for Note Deletion, (Please specify): (If corrected note already re-entered, describe the difference between the deleted note and the corrected note)".

Supporting Documentation

You can either scan a copy of the note and attach it to this form as an electronic document OR copy the web address of the note from Clinician's Gateway and paste it into the available web address field below.

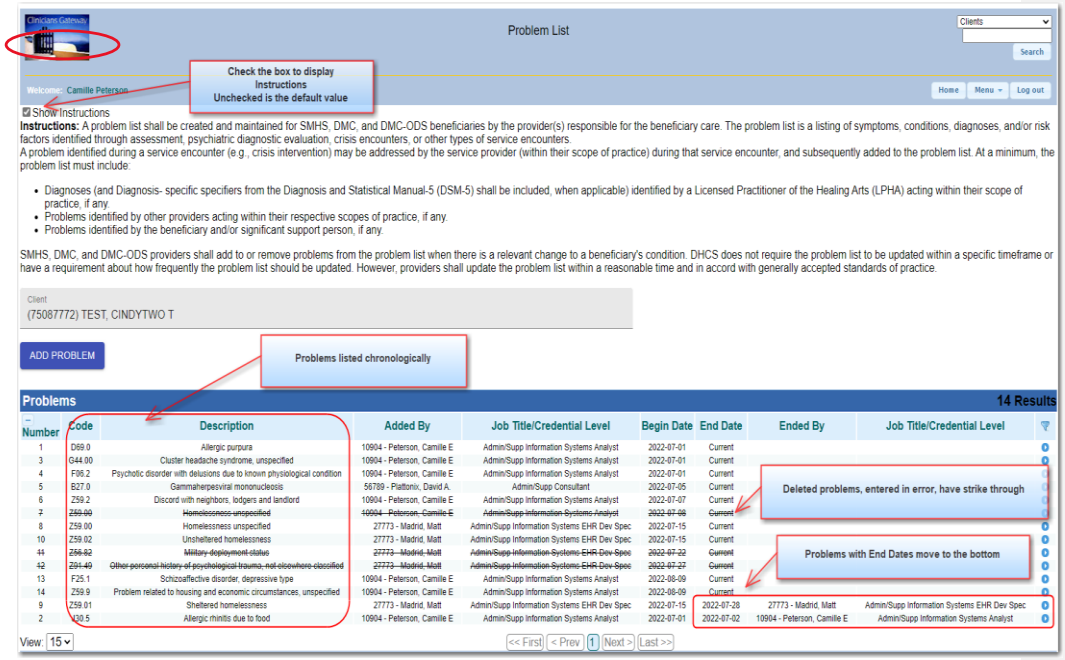
- CG Note Link (URL):
- File Attachment : upload (6 MB max)

Submit Service Delete Request | Cancel and Exit Form

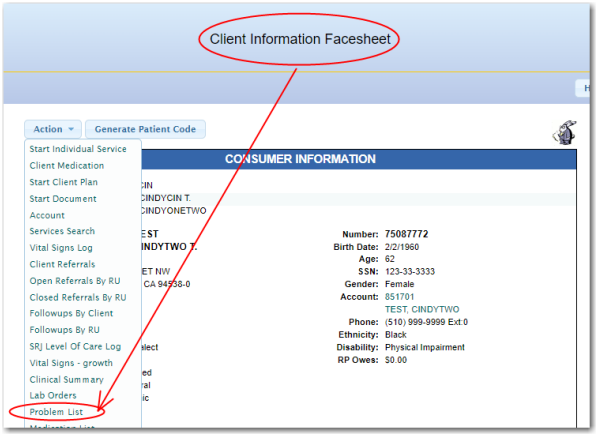
Problem List

The Problem List is a dynamic log which is available to record problems for a client.

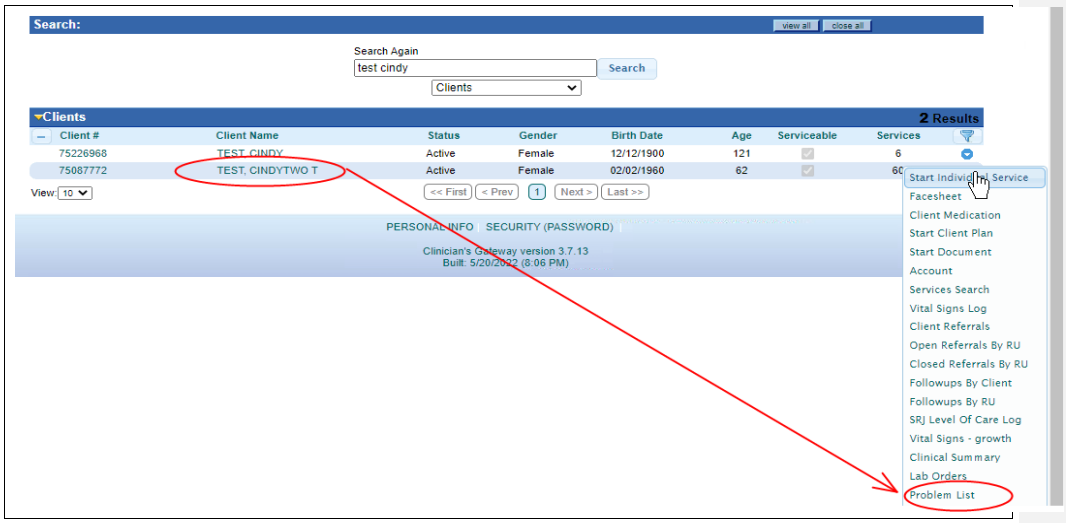
- The Problem list is accessible by all clinicians who have access to the client according to security protocols.
- Problems may be added and ended by multiple, different staff over time
- Staff who add or end problems are automatically pre-populated into the Problem List
- Active problems are listed at the top of the chart
- End-dated problems are moved to the bottom of the chart
- Current problems will populate onto the Progress Note edit screen for reminders
- Availability to add specific problem codes will be governed by the staff type



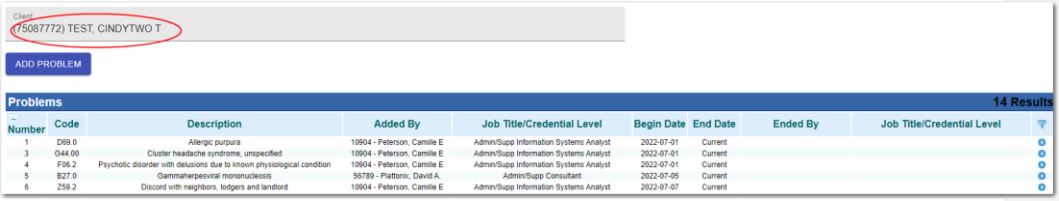
The Problem List may be accessed via the Action menu from the Client Facesheet or the Client Search Results



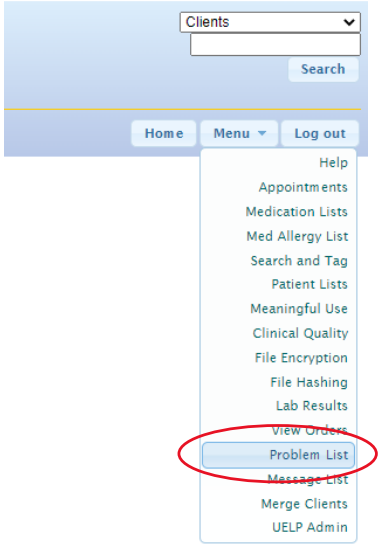
Using Client Search Results – Find the Problem List on the Action Menu



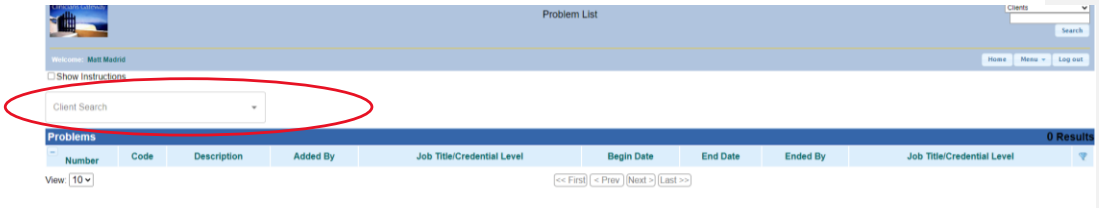
The Client Problem List screen displays referencing the client.



Alternately, you can select the Problem List from the Menu dropdown on any page in CG.



When you start from the Menu drop down, the Problem List page appears but the client is not yet identified. Enter the client name or number in the Client Search box and select the correct option when it appears in the dropdown.



The Problem List would then show as it does below with the option to “Add Problem”.

Client
(75087772) TEST, CINDYTWO T

ADD PROBLEM

Problems 14 Results

Number	Code	Description	Added By	Job Title/Credential Level	Begin Date	End Date	Ended By	Job Title/Credential Level
1	D69.0	Allergic purpura	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current		
3	G44.00	Cluster headache syndrome, unspecified	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current		
4	F06.2	Psychotic disorder with delusions due to known physiological condition	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current		
5	B27.0	Gammaherpesviral mononucleosis	56789 - Plattonix, David A.	Admin/Supp Consultant	2022-07-05	Current		
6	Z59.2	Discord with neighbors, lodgers and landlord	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-07	Current		

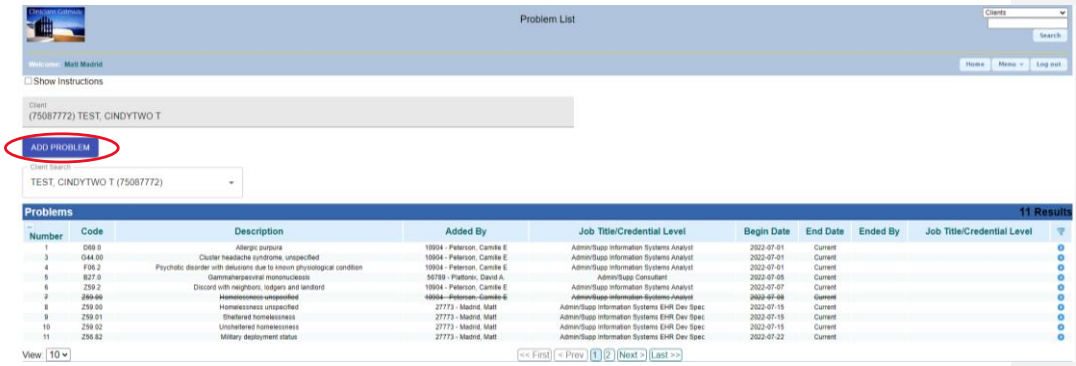
Problems (Codes & Descriptions) will be available in a drop down and Clinicians Gateway Users should be able to search and select by code or description.

Problems will only be able to be "Added By" and "Ended By" staff practicing within their license type scope. See table below.

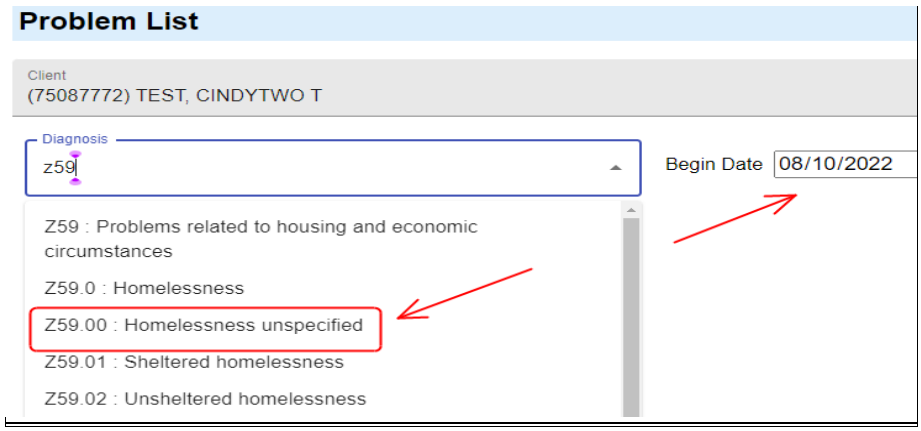
- Behavioral Health diagnoses (DSM/ICD10 Diagnosis) (Select F Codes allowed by professional BH staff)
- Physical Health conditions (ICD10/SNOMED Codes) (Only allowed by doctors, NP, CNS, PA)
- Social Determinants of Health Needs (SDoH) (Select Z Codes Z55-Z65 can be added by any staff)

Job Title/ Credential Level In ShareCare	**Job Title/ Credential Level In Clinicians Gateway**			
Doctors Advanced Practice Med with Rx	Doctors NP, PA, CNS, Pharmacist	Social Determinants of Health (SDoH)	Behavioral Health Dx (DSM/ ICD10 Diagnosis)	Physical Health conditions (ICD10/ SNOMED Codes)
Licensed Clinical Staff Licensed Clinical Psychologist Waivered Clinical Psychologist Registered MH Intern Graduate Student	LMFT, LCSW, LPCC Licensed Clinical Psychologist Waivered Clinical Psychologist AMF, ASW, APCC Graduate Student	Social Determinants of Health (SDoH)	Behavioral Health Dx (DSM/ ICD10 Diagnosis)	
Certified AOD Counselors Registered AOD Counselors Unlicensed Staff Medical Staff Peer Support Specialist (we need to add)	SUDCC SUDRC MHW, QMHW, MHRS PT, LVN, RN	Social Determinants of Health (SDoH)		

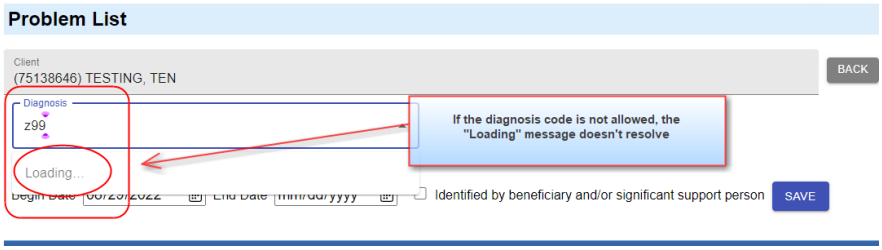
To add a problem to the problem list, click on the “Add Problem” button.



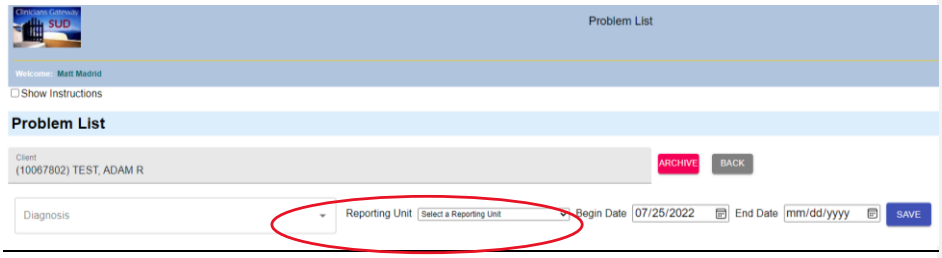
After clicking on “Add Problem”, the page below appears. Find a Diagnosis by starting to type either the ICD-10 code or the description into the dropdown labeled “Diagnosis”. Click on the correct option when it appears in the dropdown. Select the begin date.



If you are not allowed to use a code, the Diagnosis drop down list will remain in “Loading” status.

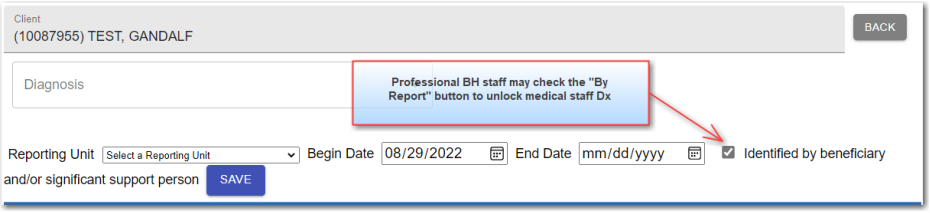


Please note for SUD users, there is an additional Reporting Unit field as seen below. This field is required. This field determines viewing privileges. Viewing is restricted according to 42CFR pt. 2 regulations. Staff will only be allowed to see problems reported within their RUs.

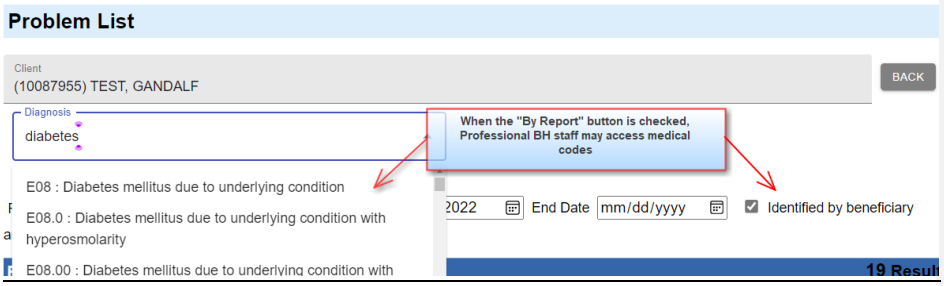


A "By Report" checkbox is available for use by Professional BH staff. This checkbox allows Professional BH staff to add any problem that is allowed for the medical staff when it has been identified by beneficiary and/or other significant support person.

- Check the "Identified by beneficiary and/or significant support person checkbox.

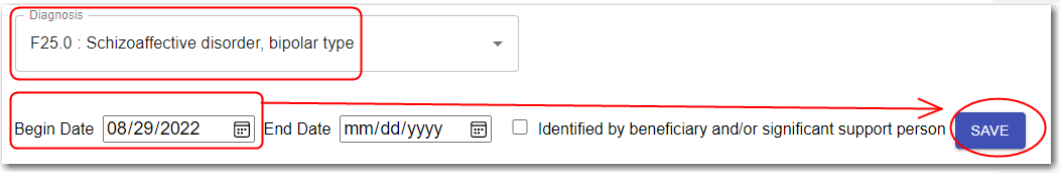


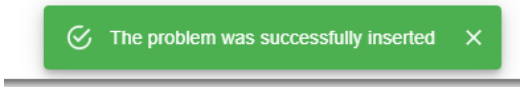
- Search for the diagnosis that is usually restricted to medical staff. SAVE your choice!



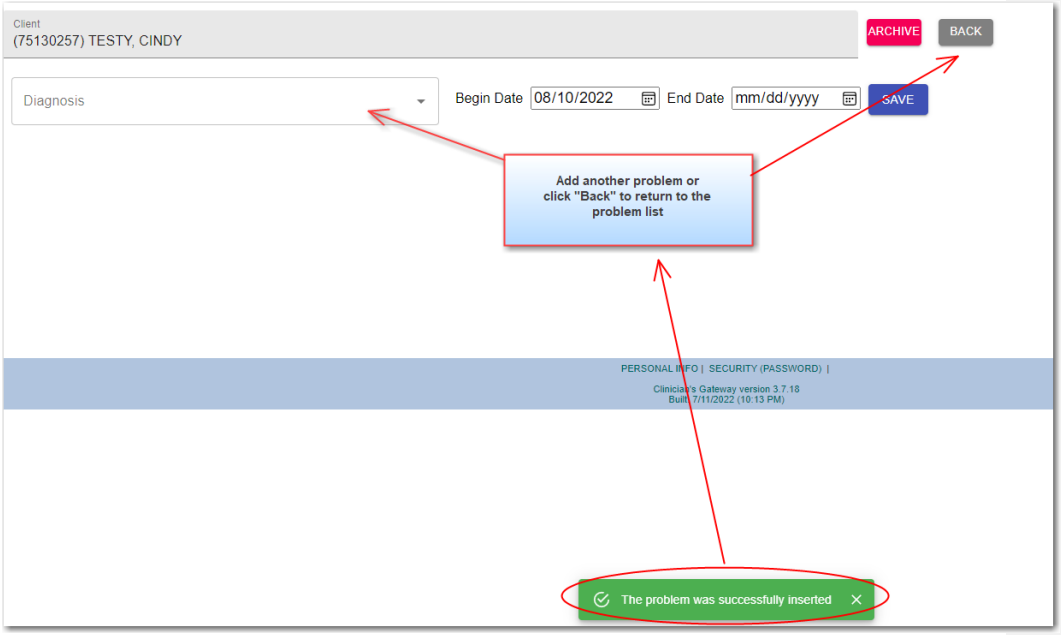
- An icon (raised hand) will appear on the Problem List to indicate that the problem was "By Report" (Identified by beneficiary and/or other significant support person)

Select the Begin Date (required) and click Save. You should see a message appear at the bottom of the screen that says the problem was successfully inserted to the list.



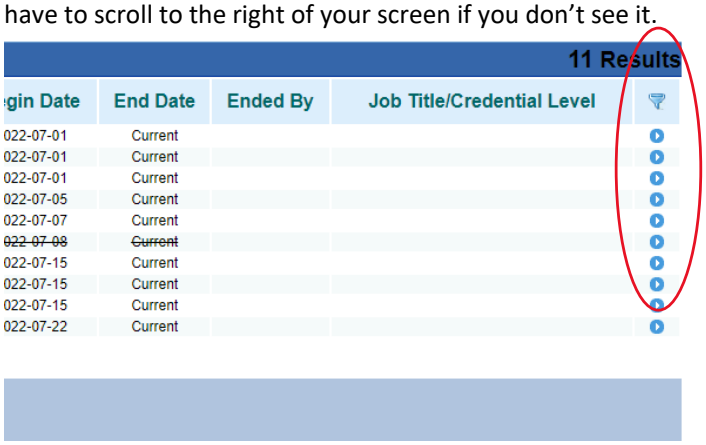


You may now add additional problems or click the Back button to return to the Problem List page



END DATING A PROBLEM

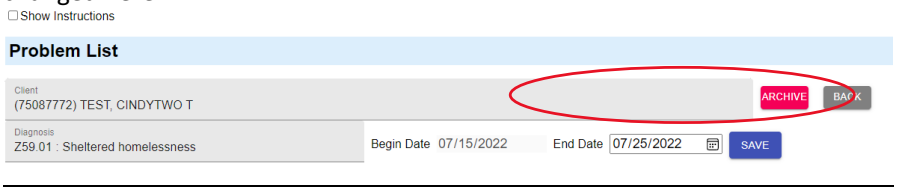
To add or update the end date (and update the reporting unit if in SUD) to an existing problem, click on the blue button to the very right of the specific problem. You may have to scroll to the right of your screen if you don't see it.



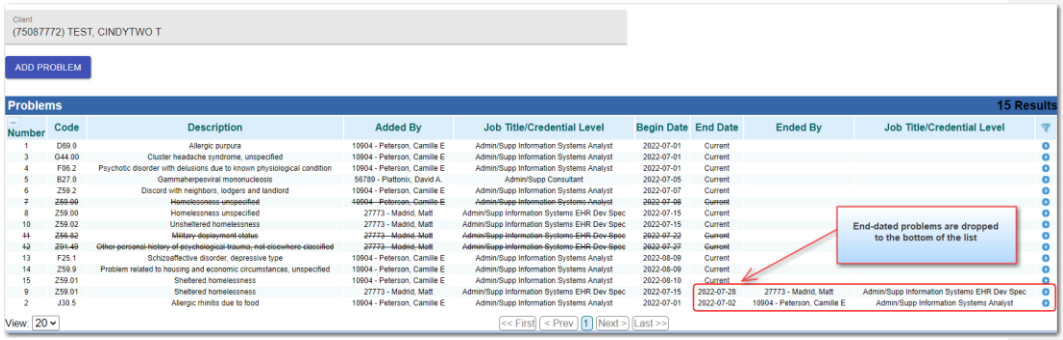
11 Results

gin Date	End Date	Ended By	Job Title/Credential Level
022-07-01	Current		
022-07-01	Current		
022-07-01	Current		
022-07-05	Current		
022-07-07	Current		
~~022-07-08~~	~~Current~~		
022-07-15	Current		
022-07-15	Current		
022-07-15	Current		
022-07-22	Current		

Enter an End Date and click Save. You should see a message at the bottom of your screen that says the problem was successfully updated. Note that no other fields can be changed here.



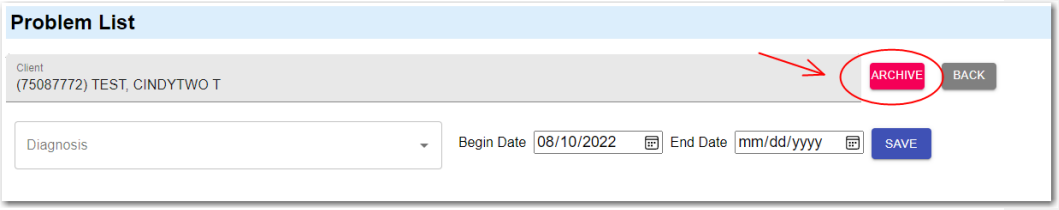
When end-dated, the problem moves to the bottom of the Problem List.



Number	Code	Description	Added By	Job Title/Credential Level	Begin Date	End Date	Ended By	Job Title/Credential Level
1	D69.0	Allergic purpura	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current		
3	G44.00	Cluster headache syndrome, unspecified	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current		
4	F06.2	Psychotic disorder with delusions due to known physiological condition	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current		
5	B27.0	Gammaherpesviral mononucleosis	56789 - Plattonix, David A.	Admin/Supp Consultant	2022-07-05	Current		
6	Z59.2	Discord with neighbors, lodgers and landlord	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-07	Current		
~~7~~	~~Z59.00~~	~~Homelessness unspecified~~	~~10904 - Peterson, Camille E~~	~~Admin/Supp Information Systems Analyst~~	~~2022-07-08~~	~~Current~~		
8	Z59.00	Homelessness unspecified	27773 - Madrid, Matt	Admin/Supp Information Systems EHR Dev Spec	2022-07-15	Current		
10	Z59.02	Unsheltered homelessness	27773 - Madrid, Matt	Admin/Supp Information Systems EHR Dev Spec	2022-07-15	Current		
~~11~~	~~Z56.82~~	~~Military deployment status~~	~~27773 - Madrid, Matt~~	~~Admin/Supp Information Systems EHR Dev Spec~~	~~2022-07-22~~	~~Current~~		
~~12~~	~~Z91.49~~	~~Other personal history of psychological trauma, not elsewhere classified~~	~~27773 - Madrid, Matt~~	~~Admin/Supp Information Systems EHR Dev Spec~~	~~2022-07-27~~	~~Current~~		
13	F25.1	Schizoaffective disorder, depressive type	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-08-09	Current		
14	Z59.9	Problem related to housing and economic circumstances, unspecified	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-08-09	Current		
15	Z59.01	Sheltered homelessness	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-08-10	Current		
9	Z59.01	Sheltered homelessness	27773 - Madrid, Matt	Admin/Supp Information Systems EHR Dev Spec	2022-07-15	2022-07-28	27773 - Madrid, Matt	Admin/Supp Information Systems EHR Dev Spec
2	J30.5	Allergic rhinitis due to food	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	2022-07-02	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst

REMOVING PROBLEMS ADDED IN ERROR

The Archive button is available to certain defined staff in CG. It is used to remove a problem that was erroneously added to a client. It is not for end-dating a problem. Staff who can enter problems onto the Problem List, will be able to remove errors using the Archive button.



An archived problem can only be seen by IS staff. The row will be marked with a strike-through.

Problems

Number	Code	Description	Added By	Job Title/Credential Level	Begin Date	End Date	Ended By
1	D69.0	Allergic purpura	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current	
3	G44.00	Cluster headache syndrome, unspecified	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current	
4	F06.2	Psychotic disorder with delusions due to known physiological condition	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-01	Current	
5	B27.0	Gammaherpesviral mononucleosis	56789 - Plattonix, David A.	Admin/Supp Consultant	2022-07-05	Current	
6	Z59.2	Discord with neighbors, lodgers and landlord	10904 - Peterson, Camille E	Admin/Supp Information Systems Analyst	2022-07-07	Current	
~~7~~	~~Z59.00~~	~~Homelessness unspecified~~	~~10904 - Peterson, Camille E~~	~~Admin/Supp Information Systems Analyst~~	~~2022-07-08~~	~~Current~~	

Consumer/Client Life Plan – Treatment Plan

Starting the Client 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 plan types: the Medication Plan and the Universal Client Plan. Throughout these Plans, 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 SmartCare episode cycle. Include Client Participation information before submitting for approval.)
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 all the required Annual Documents with the Approved Treatment Plan signed by the client to supervisorial staff.
8. Support staff enters Plan approval into SmartCare and scans the entire plan.
9. "Edit" the Plan when objectives are achieved. Minor edits are allowed without re-approval.
10. **Revise:** modify current plan and obtain new signatures/approvals as needed during the plan year.
11. **Renew:** Renew the Plan, before the end date of the current plan, for the next year as needed.

A special note from the BHCS QA Department:

Once a Licensed, Waivered or Registered LPHA (including doc's) sign the Plan and then have the Client sign the Plan it is compliant for documentation requirements (if done by due date).

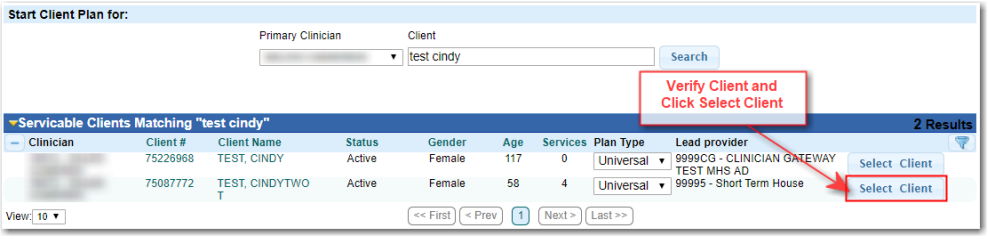
This can be accomplished by printing, have the client sign and routing to be scanned for data entry.

We have Clinic supervisors who are doing a great job of reviewing Plans by requiring the Plans to be forwarded to them for review. However, this does not need to hold up the finalization process for Licensed, Waivered and Registered LPHA's. Please note, if a revision is requested by the Supervisor—then the clinician will need to do so, re-sign with the new date, and again obtain the client signature. This too will be scanned into the client record (an auditor will see both Plans, but audit the most recent).

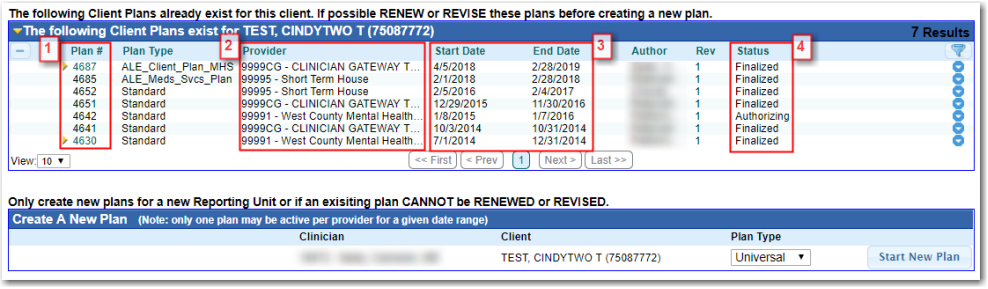
Please remember--It is crucial that anytime a printed CG document is modified by hand (such as a client signature) that it be scanned into the client record as this becomes part of the Medical Record. It MUST be uploaded—or we are not maintaining an accurate Medical Record. Regardless of the reason (such as the document says "pending", "draft", etc.) a document routed for uploading into Laserfiche by a clinicians—MUST always be uploaded.

To start writing a Plan, Choose “Client Plan” from the Enter New Service menu on your Home page, enter the client # or name. Choose plan type and click “Start”.

Select the line with the correct client, you may get multiple clients. *Ignore the RU listed as the Lead Provider.



The View Client Plans window will display Plans that already exist: Note the Plan # (**1**), the reporting unit (**2**), the start and end dates (**3**), and the status(**4**) of the plan (New, Authorizing, or Finalized)

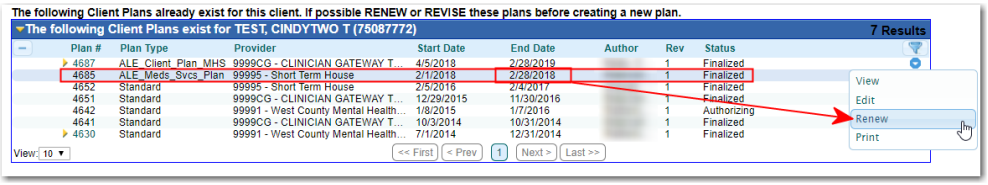


First, Try to Renew or Revise.

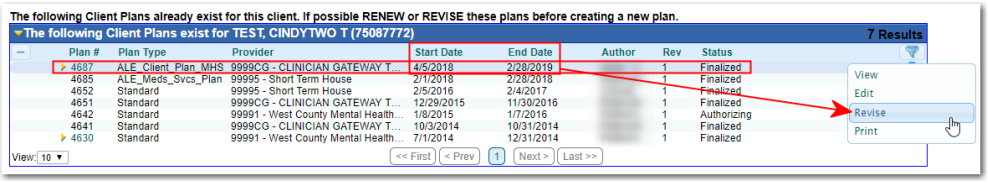
Revise a plan in the same reporting unit that is still in effect.

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;

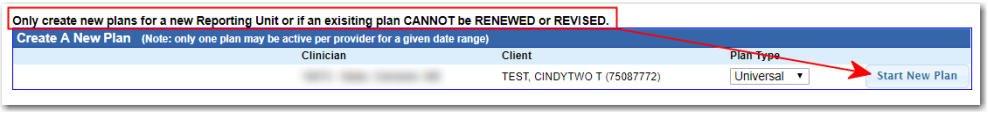


This Plan can be REVISED because it is still in effect:

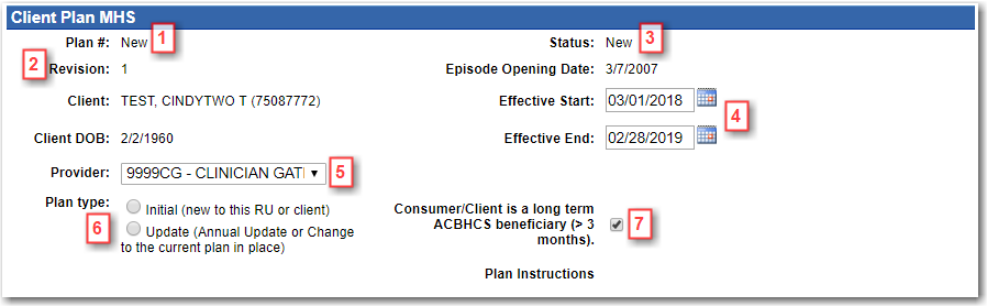


***SUD Will only use New and Revise**

<u>Only Use Start New Plan</u> 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.

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

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

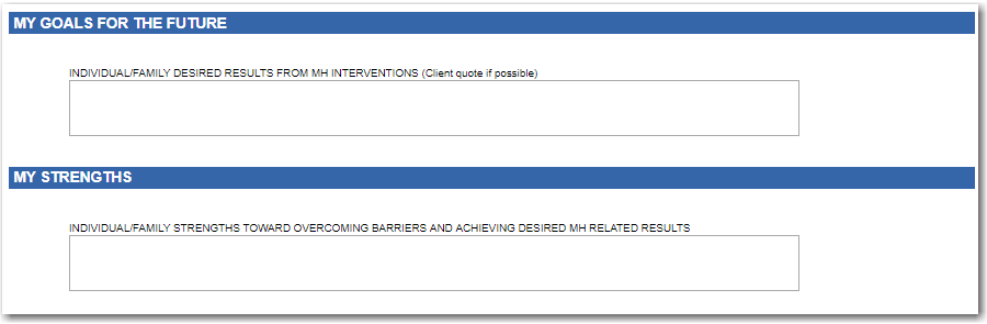
4. The Effective Start and Effective End automatically default to cover the one year starting with the first day of the episode opening month. End dates can be changed if your program uses shorter time frames. ***Verify the dates are correct (SUD will be 90 day plans)**

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

6. Mark Initial if it is the first plan for the client in this Reporting Unit. Mark Update if it is an annual update or a revision of the current plan during the effective period.

7. If the Client is not a long term beneficiary of Alameda County BHCS (receiving services less than 3 months), then uncheck the box.

Fill in Goals, Strengths, Challenges*, Objectives, Modalities, and Specific Services.



***Challenges section is specific to Universal Plan**

CHALLENGES

Area of Challenges: Community Life, Family Life, Safety School/Education, Vocational, Independent Living, ADLs, Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.

(Select)

Level of Challenges: Moderate, Severe

(Select)

Specific Challenges or Functional Impairments related to MH Diagnosis's Signs & Symptoms: [For Case Mgt, must indicate need for C/M service, i.e. ct. is homeless. Also, must indicate (1) which severe Symptoms/Impairments/Barriers resulting from MH Diagnosis that prevents client from accessing/maintaining needed services, or (2) for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.]

Add Another Challenge

Use 'Add Another Challenge' button to add more challenges as needed.

OBJECTIVES

Obj#	Short–Term Mental Health Objectives: Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning. (Note: these are ALWAYS MENTAL HEALTH Objectives - even when providing Case Management Services.)	Target Date: (12 months unless specified)	At Reassessment: (Optional) When appropriate indicate level of improvement, date and initial.
1		12 Months	Not Improved Somewhat Improved Very Much Improved Met Date: Initials:

Add Another Objective

Use 'Add Another Objective' button to add more objectives as needed.

The Objecitves will be displayed on the progress notes for reference.

Revisions can be made during the Effective Period to add or change Objectives, or mark the level of improvement, or accomplishment of the Objective.

Service Modality and Specific Services for each modality

1. Select the correct Service Modalities as needed.
2. For each Modality selected, there will be a section to annotate the specific services for that modality

The Modality and Services sections vary based on Plan type

Modality and Services sections specific to the Medication Plan:

SERVICE MODALITIES

MODALITY	FREQUENCY	DURATION
☑ Medication Mgmt	Every / Month and As Needed	12 Months
☑ Other: Testing	Every / Week and As Needed	12 Months
☐ Other:	Every / Week and As Needed	12 Months

SPECIFIC SERVICES FOR EACH MODALITY

MODALITY	Detailed Intervention(s)
Medication Mgmt	Detailed Interventions provided to client and/or significant support may include but are not limited to: ☑ Evaluation of clinical effects of medication. ☑ Medication regimen adjustment. ☑ Obtaining informed consent for medication (inform of risks and benefits, discuss alternative treatments and obtain signed informed consent). ☑ Medication education (re proper use, benefits, risks and side effect management of medications). ☑ Medication prescribing, administration or dispensing. ☑ Medication related consultation with providers. ☑ Phone calls to client and/or significant support persons about medications. ☑ Phone calls to pharmacy and transmitting medication orders (re communicate with pharmacy, prepare prescription orders for transmission, authorize prescription refills, and resolve issues related to client's prescriptions). ☑ Counseling (Supportive Psychotherapy) and Coordination of Care (Referrals). Additional Comments:
Testing	

Modality and Services sections specific to the Universal Plan:

SERVICE MODALITIES

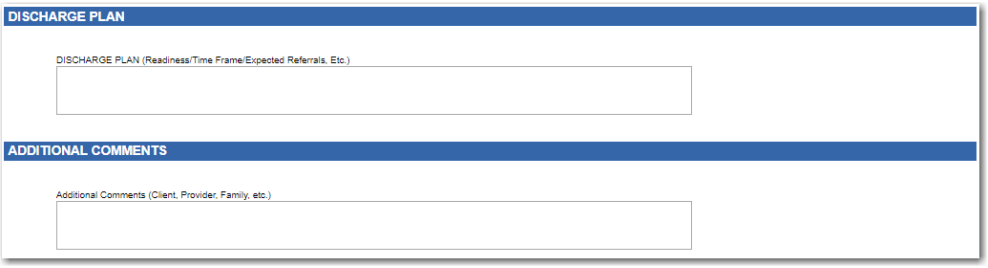
MODALITY	FREQUENCY	DURATION
☑ Collateral	Every Week and As Needed	12 Months
☑ Case Mgmt	Every Week and As Needed	3 - 12 Months
☐ Indiv Rehab	Every Week and As Needed	12 Months
☐ Group Rehab	Every Week and As Needed	12 Months
☐ Indiv Therapy	Every Week and As Needed	12 Months
☑ Group Therapy	Every Week and As Needed	12 Months
☐ Family Therapy	Every Week and As Needed	12 Months
☐ Multi Family Grp Therapy	Every Week and As Needed	12 Months
☐ Medication Mgmt	Every Month and As Needed	12 Months
☐ Collateral Family Grp	Every Week and As Needed	12 Months
☐ TBS	Every Week and As Needed	3 - 12 Months
☐ Katie A. (ICC)	Every Week and As Needed	3 - 12 Months
☐ Katie A. (IHBS)	Every Week and As Needed	3 - 12 Months
☐ Day Rehab	Every Day and As Needed	6 - 12 Months
☐ Crisis Residential	Every Week and As Needed	3 - 12 Months
☐ Adult Residential	Every Week and As Needed	6 - 12 Months
☐ Crisis Stabilization	Every Week and As Needed	3 - 12 Months
☑ Other Testing	Every Week and As Needed	12 Months
☐ Other	Every Week and As Needed	12 Months

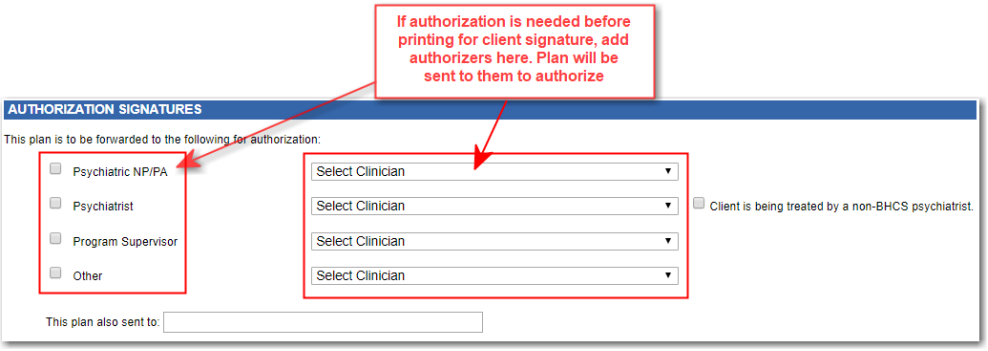
SPECIFIC SERVICES FOR EACH MODALITY

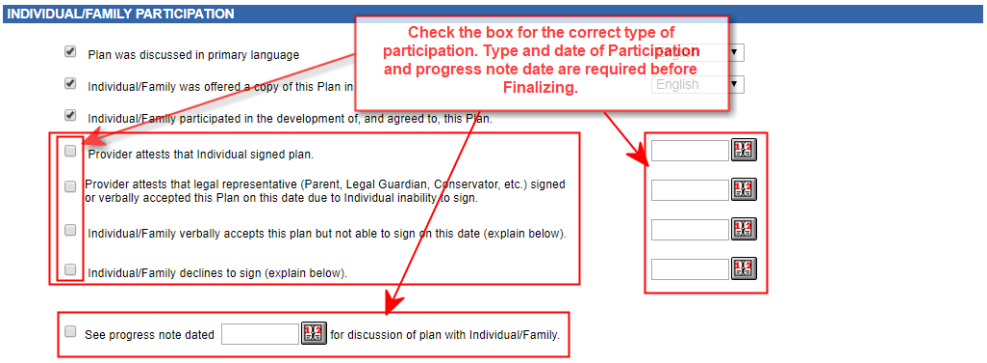
MODALITY	Detailed Intervention(s)(For Case Management indicate as relevant: linkage to and monitoring of community support services for _____(i.e. homeless, joblessness, medical illness, or substance abuse) will result in client achieving their Mental Health Objectives # and # listed above)
Collateral	
Group Therapy	
Case Mgmt	
Testing	

Discharge Plan, Authorizing, and Client Participation

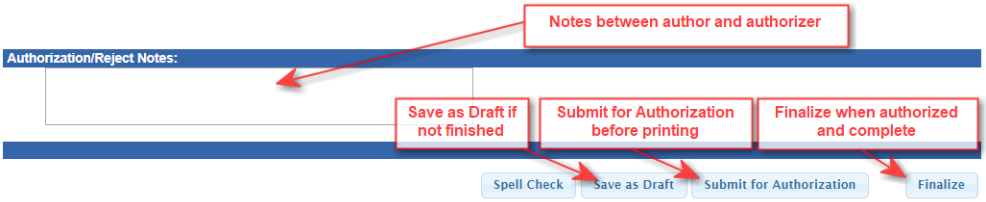
Finish by entering the Discharge Plan, Additional Comments, Authorizations, and Participation sections.



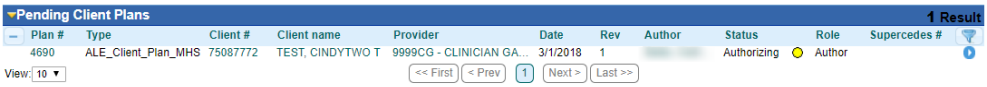




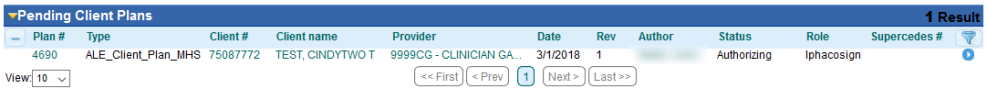
After completing the plan, “Submit for Authorization”. (At this point you could bring up the plan and “Print for Signature”. This procedure is described later after authorizations are described.)



When the Plan is “Saved” or “Submitted”, it will appear on the Home page of the author and the authorizers. Notice the yellow dot near Authorizing, this means it has been submitted but not authorized by one the selected Authorizers.

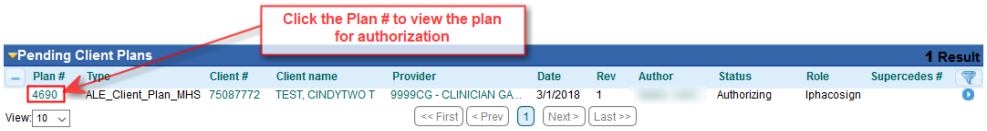


The role column displays if you are the author or one of the authorizers.

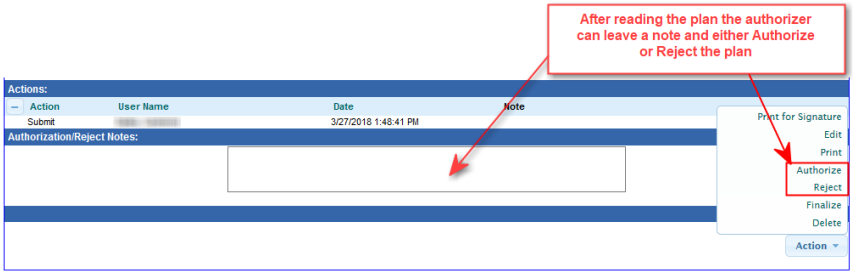


Obtain Authorizations. After “Submit for Authorization”, the plan appears on the Pending Client Plans list on the authorizer’s Home page. The authorizer should click the plan ID # or its blue button to open the plan for approval.

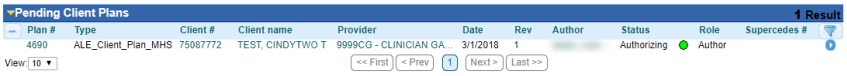
***If the author of the plan doesn’t need any approvers, they may Finalize the plan after the client or representative signature date has been added to the Participation section.



The authorizer brings up the plan to review it. Using the Action Button they either Authorize, Reject, or possibly Finalize the Plan. (Only Finalize if all authorizers have approved the plan, and you are the last one.)

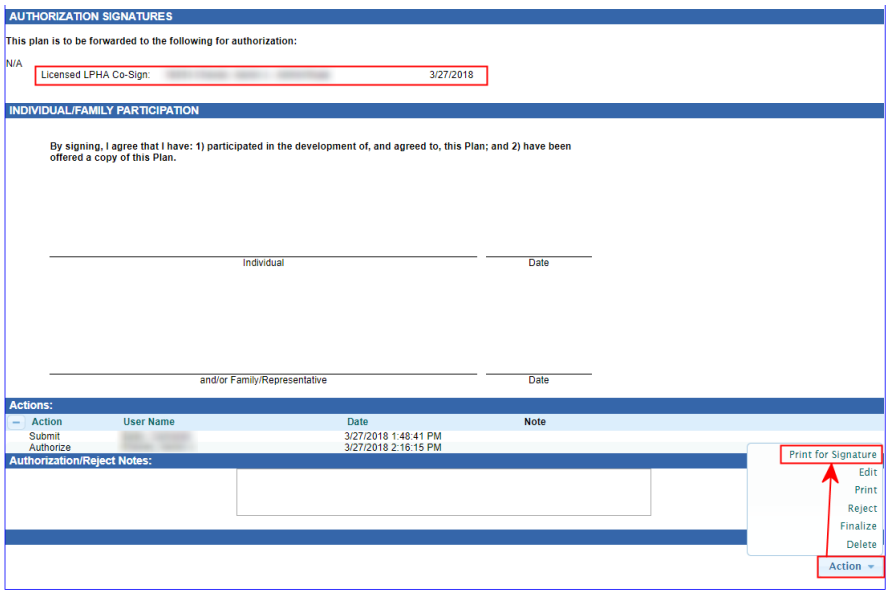


The Green dot tells me my plan was authorized. All it needs is the individual or family signature.

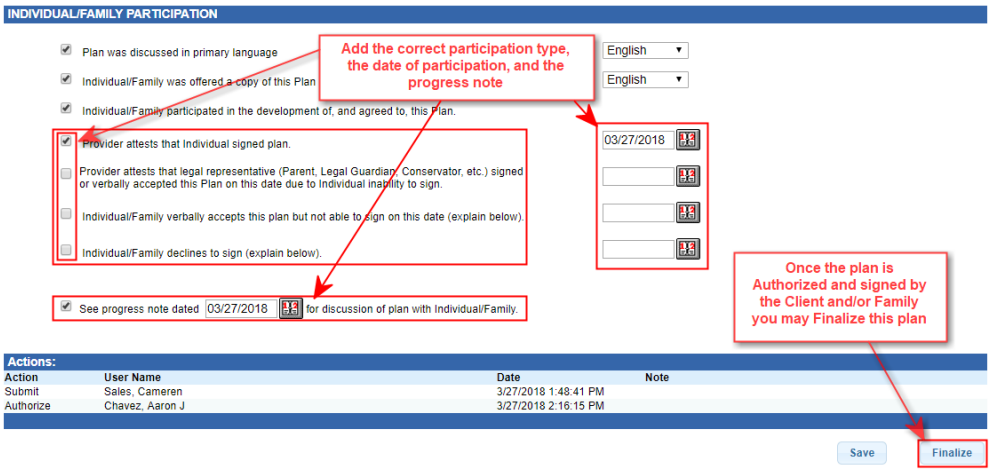


***If the author of the plan doesn't need any approvers, they may Finalize the plan after the client or representative signature date has been added to the Participation section.

Authorizers and their signature dates are shown in the Authorization Signature section near the end of the plan. After Authorization then bring up the plan and "Print for Signature" of the client or representative. (After "Submit", the "Pending" banner disappears and you can print it for the signature without "Pending" splashed across it.)



After the Client/Family Signs, bring up the plan and enter the client participation. From the Action bar choose "Edit". This is a "Mini-Edit" which will not require you to submit for authorization again.



After the plan is authorized and signed by the individual and/or family, you can click 'Finalize'.

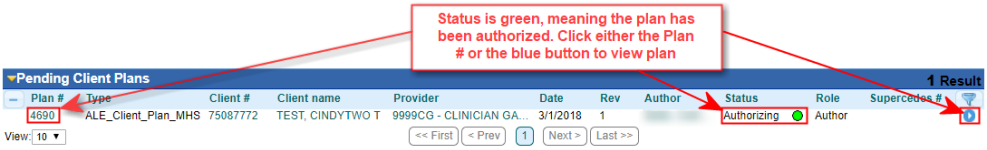
***** FINALIZE IT. *****

CONGRATULATIONS!

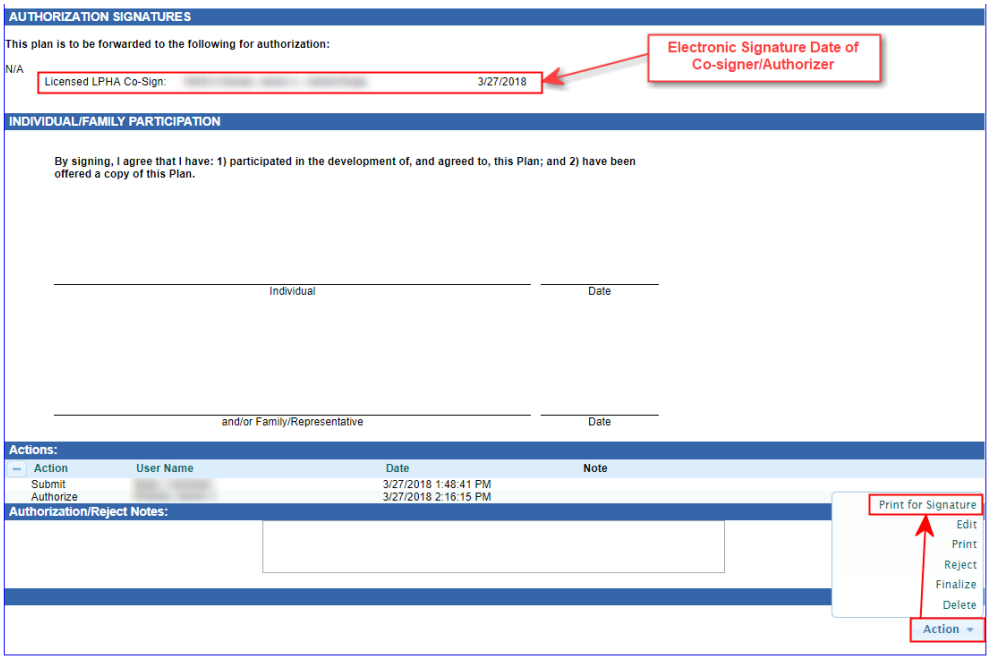
Print for Client Signature

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 or the blue button.

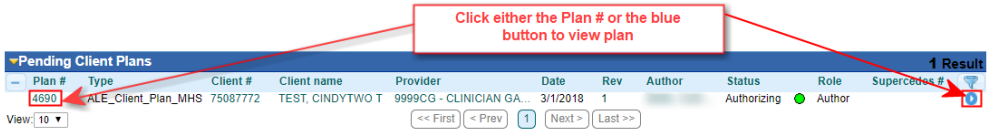


The Plan appears on your screen. From the Action Bar, Click "PRINT FOR SIGNATURE".

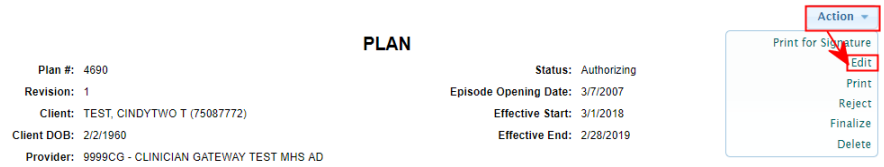


(You can Print, Edit, Reject, Finalize or Delete from this screen via the Action bar. "Edit" will allow you to Submit for Authorization. Editing also requires you to resubmit the Plan for authorization.)

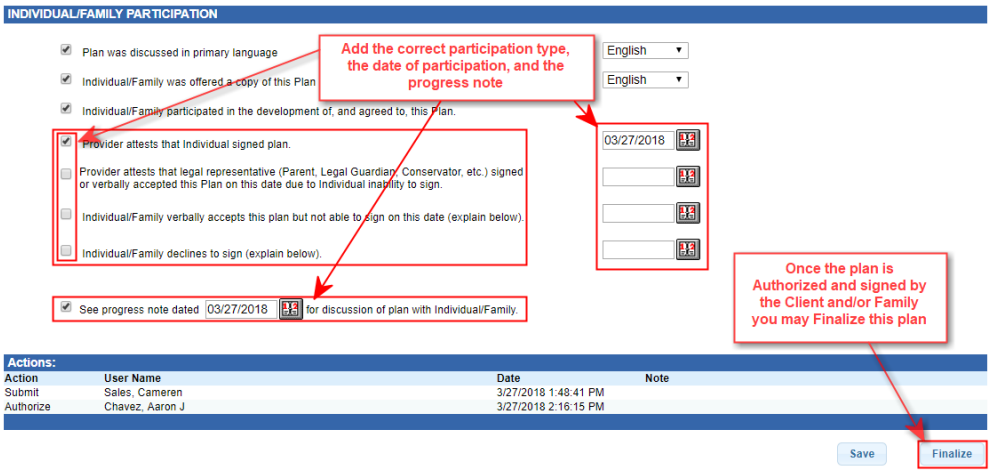
RETURN TO THE PLAN TO ADD THE CLIENT SIGNATURE DATE AFTER IT IS OBTAINED. This edit will not trigger another round of authorizing. First, View the Plan by clicking on the Plan Number.



Click "Edit" on the Action bar.



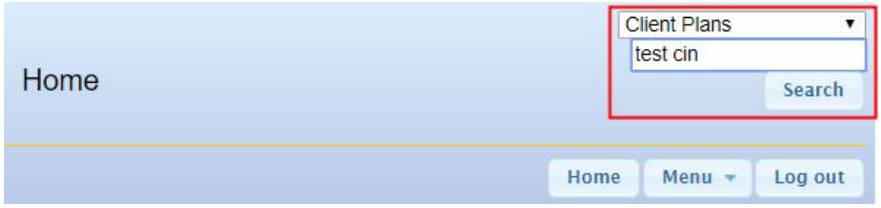
Add Individual/Family Participation and date the signatures. Then you can click 'Finalize'.



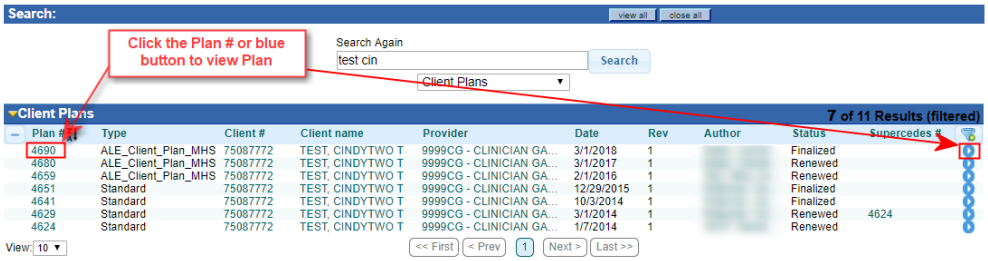
The Plan is removed from the Pending Client Plan list on the Home page after it is finalized.

Viewing, Editing, and Revising a Finalized Plan

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”.



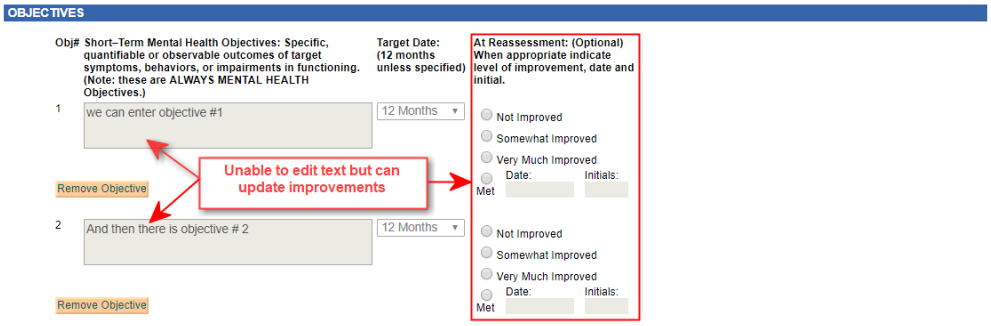
Search Results are displayed. Click on the Plan number or its blue button to view it. Note that this Plan’s Status is now “Finalized”.

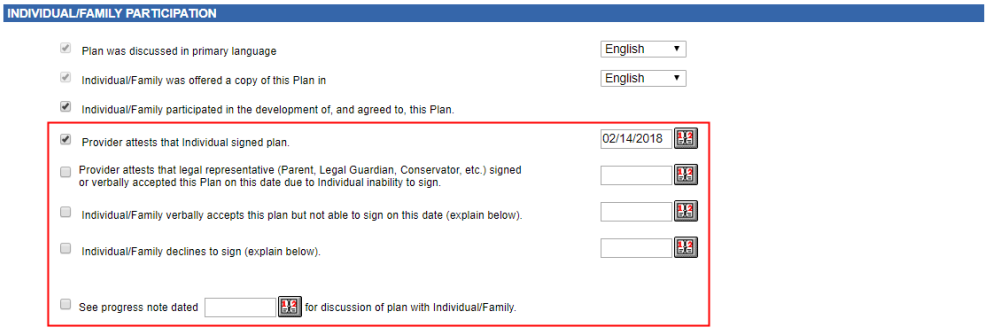


If the plan is in the middle of the Effective Period, then the Finalized Plan may be Printed, Edited or Revised. (can’t renew it yet)

Edit: A **Finalized Plan** 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.
- Client signatures may be added.





Revise: Any substantial change is a Revision and

- Revisions must be re-authorized and re-signed by the client.
- Revisions are given a new Plan #.
- New Revisions of Plans supersede earlier versions.

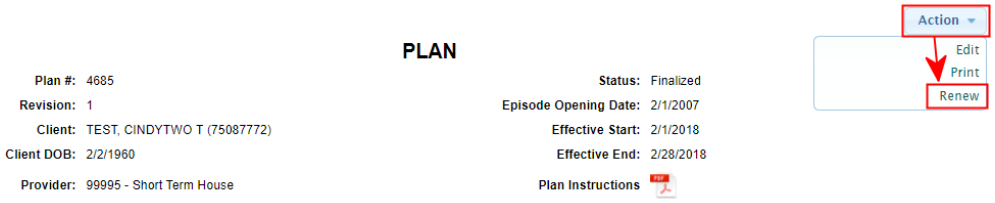
From the Action Bar, click on Revise.

- Change **any** of the fields in the plan.
- Send for Authorization
- Obtain authorizer's signatures.
- Print for Signature.
- Add Client signature information to Plan.
- Finalize Plan.

Renewing Client Plan

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

- From the Action Bar, click the Renew button.



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

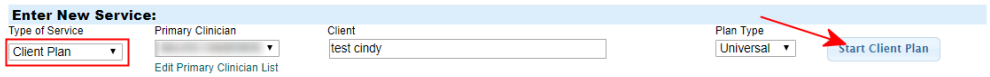
1. Once a note is Finalized, it may be viewed and revised by any clinician. If the clinician revises the Plan, they are the new author of the Plan.

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

Concurrent Treatment Plans

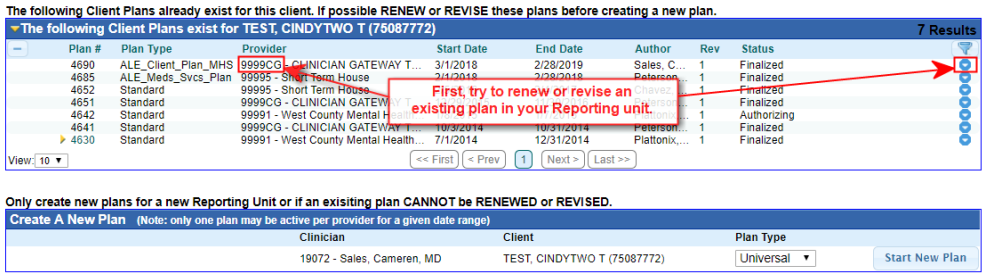
Plans may now be active in more than one reporting unit concurrently.

Start writing the plan as usual

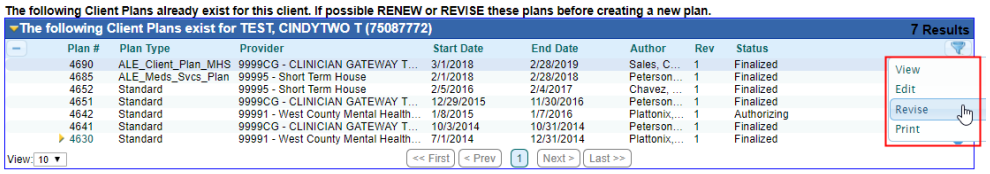


A grid of existing plans will be presented from which to choose.

- **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)

Use “Start New Plan” only if you need a new RU or the existing plan is too old.

Only create new plans for a new Reporting Unit or if an exisiting plan CANNOT be RENEWED or REVISED.

Create A New Plan (Note: only one plan may be active per provider for a given date range)

Clinician	Client	Plan Type	
[illegible]	TEST, CINDYTWO T (75087772)	Universal	Start New Plan

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

Cannot save form until the following issues are resolved:

* Warning! Another plan (# 4690) can be renewed or revised. This plan will not be able to be finalized.

The following Client Plans exist for TEST, CINDYTWO T (75087772) — 8 Results

Plan #	Plan Type	Provider	Start Date	End Date	Author	Rev	Status
4691	ALE_Client_Plan_MHS	9999CG - CLINICIAN GATEWAY T...	5/1/2018	2/28/2019	[illegible]	1	Authorizing
4690	ALE_Client_Plan_MHS	9999CG - CLINICIAN GATEWAY T...	3/1/2018	2/28/2019	[illegible]	1	Finalized

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

Your work will be lost!

Troubleshooting

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 510-817-0076 or HCSASupport@acgov.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.

Client Signature details are incorrect:

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

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

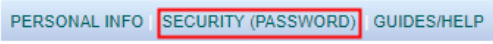
Authorizer Signatures not showing:

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

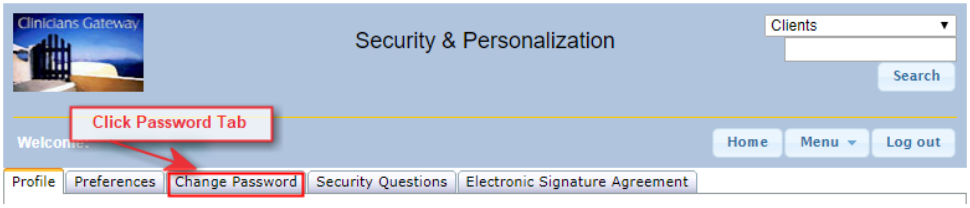
Changing your Password

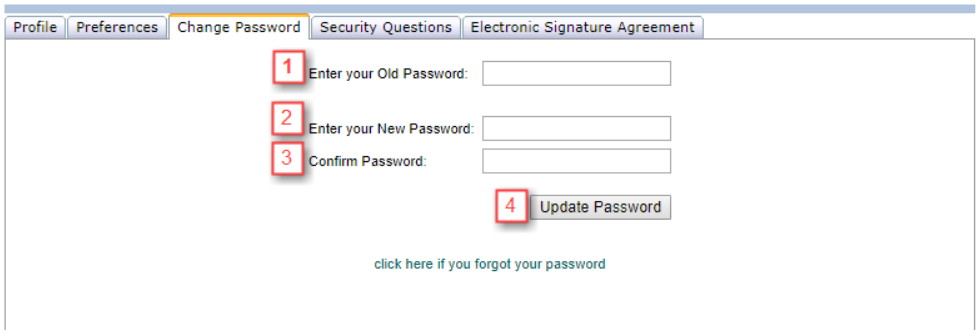
Changing your password

- 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"

Errored Notes

The Flow for Errored Notes Processing

When transferring notes into SmartCare (the billing system), the system may block the transfer if the note is missing required information. If this happens, the note with errors will be returned to Clinicians Gateway for corrections.

1. CG User finalizes the service

2. Finalized CG services are processed nightly for export to SmartCare

3. Services are added to a staging table and checked for errors

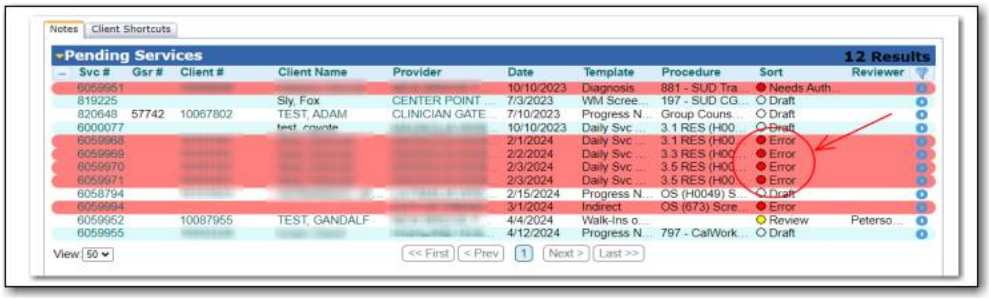
4. Services passing the validation checks are transferred to SmartCare.

5. Services with errors are tagged with their error message.

6. Services with errors are reverted to Draft Status in CG and returned to the Pending Services list in CG with an Error icon attached. Departed Staff notes are also sent to the assigned supervisor.

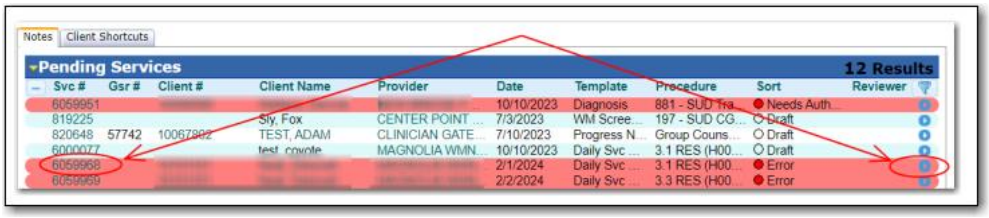
7. When viewing the note the error message is displayed.

Example of what an Errored note will look like when is returned back to Clinicians Gateway.

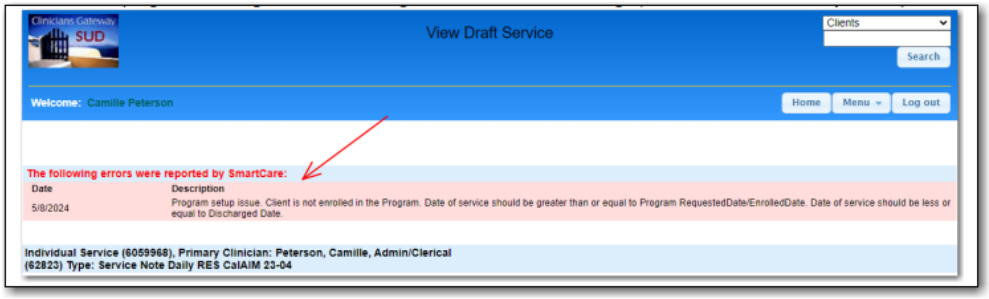


Fixing Errored Notes

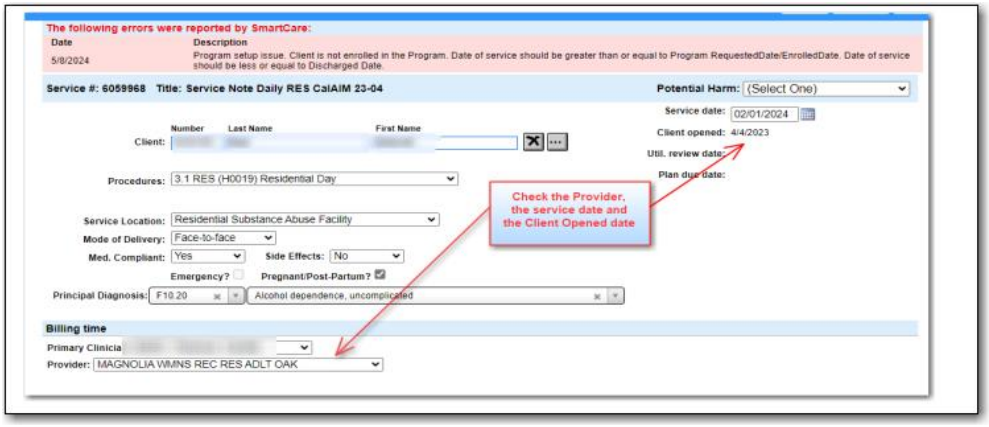
1.To see the error message and work on the note, click on the Service # or blue button.



2.The errors are displayed at the top of the note on the View Draft Service Screen. In this example, the client is not enrolled in the program on the note, on the date of the service on the note. In this example, you would research whether the program is wrong, the service date is wrong or the enrollment is wrong. (CG or SmartCare errors possible)

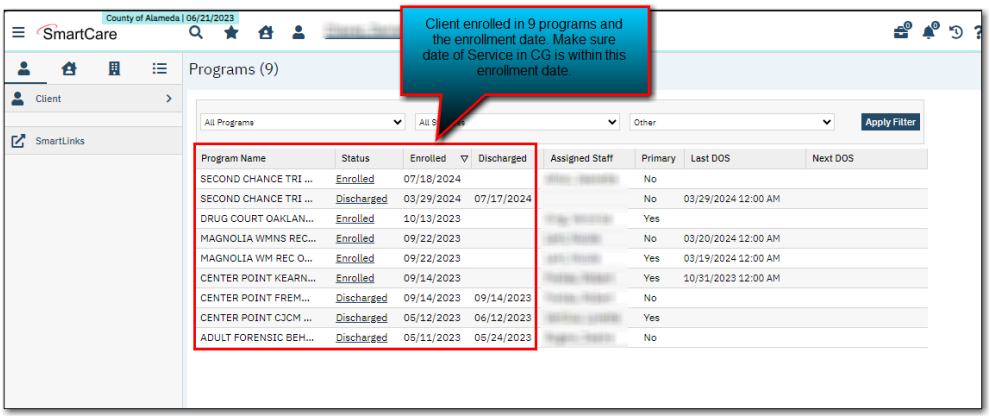


3.To work on the note, click the Edit Service Button at the bottom of the Page.



For this particular example, check the Provider (Program) and make sure the client is enrolled in the program in SmartCare.

Login to SmartCare, lookup the client, go to Programs for this client and make sure the client is enrolled in the program: in this example Magnolia WMNS Rec RES ADLT OAK and service date of 4/4/23 in Clinicians Gateway is after the enrollment date for this program. You can see Enrollment date in Smartcare 09/22/2023



When corrections have been made, Finalize the note again via the Finalize button or Daily Approval (Staff Log).

Possible Validation errors and courses of action:

Validation Error messages - User Friendly	Possible Courses of Action
Duration cannot be negative.	Add time for primary procedure code duration
Duration cannot be zero.	Add time for primary procedure code duration
Duplicate Service Exists.	Check for duplicate service, verify date and procedure on note
Duration DateTimeIn should not be greater than DateTimeOut.	Do not publish - should never happen
ClientId is Inactive/Deleted/Merged	Check SmartCare current client ID #, update note
Program setup issue. Client not enrolled in program on date of service.	Check enrollment dates and programs in SmartCare
ProgramId is Inactive/Deleted.	Check program on note for currently active program or contact IS Support to escalate to BBS Data Inegrity Unit
Client is not enrolled in the Program.	Check enrollment dates and programs in SmartCare
Clinician not authorized in the Program	Contact IS Support to research if program is assigned to the staff
Procedure Code not authorized in the Program	Contact IS Support to report to BBS Data Integrity Unit
Date of service should be greater than or equal to Program Enrolled Date.	Check enrollment dates and programs in SmartCare, update note or enrollments as needed
Date of service should be less or equal to Discharged Date.	Check enrollment dates and programs in SmartCare, update note or enrollments as needed
Procedure Code not allowed for this Program on this date.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Procedure Code setup issue.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
ProcedureCodeId is Inactive/Deleted.	Refer to the ACBHD QA list of allowed procedure codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Procedure Code not authorized in the Program	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Procedure Code not allowed for this Program on this date.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Procedure Code not allowed for this Staff Licensure.	Refer to the ACBHD QA list of allowed procedure codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Duration should be in between Procedure Codes Min and Max Values.	Refer to the ACBHD QA list of allowed procedure codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Diagnosis Code is Missing	Add Diagnosis Code to service note

Validation Error Messages	Possible Courses of Action
Location not allowed for this Procedure.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
LocationId is Inactive/Deleted.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Please notify IS Helpdesk to correct mapping for Place of Service for this Location.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Location not allowed for this Program.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Clinician is Inactive/Deleted.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Contact IS Helpdesk to research Clinican setup	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
ICD10Code is missing.	Add ICD-10 Dx code to note
DSMV Code is not setup for this ICD-10 Code.	Contact IS Support to research and possibly escalate to System Applications Unit
DSMV Code is not available with Billable Flag setup for this ICD-10 Code. Please contact the IS Helpdesk.	Contact IS Support to research and possibly escalate to System Applications Unit
ICD-10 Code is not allowed for the Fiscal Year of Service.	Refer to the ACBHD QA list of allowed diagnosis codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Invalid ICD10Code/DSMVCodeId.	Refer to the ACBHD QA list of allowed diagnosis codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Invalid DSMVCodeId.	Refer to the ACBHD QA list of allowed diagnosis codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
ICD10Code2 is missing.	Add second diagnosis code for test results to Recovery Incentives note
DSMV Code is not setup for the additional ICD-10 Code.	Recovery Incentives 2nd Dx code message. Contact IS Support to research and possibly escalate to System Applications Unit
DSMV Code is not available with Billable Flag setup for the additional ICD-10 Code. Please contact IS Helpdesk	Recovery Incentives 2nd Dx code message. Contact IS Support to research and possibly escalate to System Applications Unit
Additional ICD-10 Code is not allowed for the Fiscal Year of Service.	Recovery Incentives 2nd Dx code message. Refer to the ACBHD QA list of allowed diagnosis codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Invalid ICD10Code2/DSMVCodeId2.	Recovery Incentives 2nd Dx code message. Refer to the ACBHD QA list of allowed diagnosis codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Invalid DSMVCodeId2.	Recovery Incentives 2nd Dx code message. Refer to the ACBHD QA list of allowed diagnosis codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
Additional ICD-10 Code exists, but primary ICD-10 is missing.	Recovery Incentives Dx code message. Add primary Dx code to note. If needed, contact IS Support to research and possibly escalate to System Applications Unit

Validation Error Messages	Possible Courses of Action
Add-On Procedure Code 1 is not allowed with the Primary Procedure Code.	Contact IS Support to research and possibly escalate to BBS Data Integrity Unit
AddOnProcedureCodeStartTime1 is missing.	This is defaulted as the same time as the primary. Should not happen
Add-On Procedure Code duration or unit is missing.	Add duration to Add-on code
AddOnProcedureCodeUnitType1 is missing.	This should not happen. CG defaults the unit type
Add-On Procedure Code 2 is not allowed with the Primary Procedure Code.	Refer to the ACBHD QA list of allowed procedure codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
AddOnProcedureCodeStartTime2 is missing.	This is defaulted as the same time as the primary. Should not happen
Add-On Procedure Code duration or unit is missing.	Add duration to Add-on code
AddOnProcedureCodeUnitType2 is missing.	This should not happen. CG defaults the unit type
Add-On Procedure Code 3 is not allowed with the Primary Procedure Code.	Refer to the ACBHD QA list of allowed procedure codes and update note as needed. If needed, contact IS Support to research and possibly escalate to BBS Data Integrity Unit
AddOnProcedureCodeStartTime3 is missing.	This is defaulted as the same time as the primary. Should not happen
Add-On Procedure Code duration or unit is missing.	Add duration to Add-on code
AddOnProcedureCodeUnitType3 is missing.	This should not happen. CG defaults the unit type

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:	**510-817-0076**
E-mail: (7:30AM-4PM)	HCSASupport@acgov.org
Fax Number:	(510) 567-8161
County Tie Line Fax:	38161