PerformCARE

CYBER Instructional Guide for Behavioral Health Home (BHH) Users

To include Nursing Assessment, Quarterly Progress Update and Progress Note Functionality
(Last Updated: January 2017)
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I. Introduction
Behavioral Health Home (BHH) services became a part of the Children’s System of Care in 2014; the goal of the service is to integrate the services that address a youth’s physical health needs with their behavioral health, intellectual/developmental disability and/or substance use needs. BHH services look at a youth holistically; in the past, youth’s physical health needs were not cared for in a joint setting, along with their behavioral health needs. These needs were addressed separately. New staff is available at the CMO to assist families whose youth have been identified by the Child Family Team (CFT) as being appropriate for the new services. This new staff will look at the youth’s current services and status, as well as the youth’s current medical conditions, to develop a holistic approach to care. Families and youth will meet with nursing and wellness staff in an effort to decrease hospital admissions and improve the overall health of the youth.

This guide will review the new CYBER functionality that has been created to support the BHH services. This new functionality includes new forms and progress notes. This information will be viewable in the CYBER system to any provider that is currently working with the family and youth, except for Substance Use Treatment providers and Adolescent Housing providers.

*Please note: in order to have the ability to create the new documents and progress note types outlined in this guide, a user must have the CMONURS security group assigned to their user ID in Cyber. System Administrators at the agency have the ability to make this addition/change to a user’s profile.

Also to note: there is a new plan type available to CMO users that will be used to discharge a youth from BHH services. The UCM BHH Transition plan type should be used when the youth will remain with CMO, but is discharging from BHH. The Discharge Quarterly Progress Update is associated to it before submission; submission of the plan will discharge the youth from BHH and reopen the CMO authorization.
II. Accessing CYBER

Users must first log-into CYBER with their UserID and Password. The log-in screen can be found via the PerformCare website – www.performcarenj.org.

As a CYBER User I understand that my work will involve access to Protected Health Information (PHI) as defined by HIPAA (The Health Insurance Portability and Accountability Act) for the purpose of providing or arranging treatment, payment or other health care operations. I also acknowledge that I am engaged by a covered entity. I further acknowledge my responsibility to protect the privacy of and to guard against inappropriate use or disclosure this PHI by logging in as a CYBER User.

This is in compliance with "The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementation regulations. For more information on HIPAA please go to http://www.hhs.gov/ocr/hipaa/ "
III. Changes to the CMO Welcome Page

The new documents – Nursing Assessment and Quarterly Progress Update – will both appear in the Service Plans/Assessments links and associated grids. Both will appear on the Aging Report as coming due 3 calendar days prior to their due date. These documents will appear on the Welcome Page for the current owner – meaning the user who has the document currently assigned to them in the system.

*Due dates are as follows:

- Initial Nursing Assessment – 30 Calendar Days after the start of agency’s Tracking Element (Tracking Elements can be found on the youth’s Face Sheet, identified by the Tracking Elements tab)
- Update/On-going Nursing Assessment – completed on an annual basis
- Initial Quarterly Progress Update – 30 Calendar Days after the start of agency’s Tracking Element
- Update/On-going Quarterly Progress Update – 90 Calendar Days after the last approved Treatment Plan CFT date

A new treatment plan type – BHH Transition – was also added to the system and appears in the appropriate links and grids on the user’s Welcome Page. For example, a BHH Transition plan that is in draft will appear under the In Progress link/grid for the owner. The BHH Transition plan will be completed by the youth’s Care Manager; the Discharge Quarterly Progress Update will be associated to it prior to submission to PerformCare. The submission of both documents will discharge the youth from BHH services but will maintain the youth’s admission with the CMO.
IV. Accessing New Documents in the Youth’s Record

Users must first navigate to the correct record by either using a search function or by utilizing the Your Caseload button. *Please note: Nurses should only be accessing the records of youth identified by the CFT for BHH services; the family must have also consented for BHH services.

Once the user has located the correct record, they will click on the Treatment Plans Assessment button on the left-side of the screen. This will bring up the appropriate screen where the user will access existing plans and assessments, as well as create new documents.

The grid on this screen contains the following information:

- **Assessment Type** – Treatment Plan or specific Assessment type
- **Assessment Sub Type** – specific type of Treatment Plan
- **Assessment/CFT Date**
• Author
• Submitted to CSA Date – date the document was submitted to PerformCare; will be blank if still in draft with the agency
• Assessment ID
• Create Date – original creation date of the document

Double-clicking on a document in the grid will open it in a new window; any document that has been submitted and/or approved cannot be edited.

*Please note – if there is an existing BHH Transition Treatment Plan, Nursing Assessment or Quarterly Progress Updated in draft for the youth, the user will be unable to create another one.

Making a selection from the pull-down menu above the grid will allow the user to start a new document.

The new BHH-related documents have been added to this menu – Quarterly Progress Update and the Nurses Assessment. Clicking on any of these and then clicking “Add New” will open the new document. (The other options in this menu will be used by the CMO.)
V. The Nursing Assessment

This new assessment type will only be available for creation by those users with the CMONURS security designation on their profile; the agency’s System Administrator can adjust a user’s security as needed.

These users will have the ability to access all Nursing Assessments created by their agency, whether they are in progress or submitted; these users will be able to edit only those Nursing Assessments that are assigned to them. To see more information on assigning an Assessment to your own ID or to another user within your agency, please see page 32 – Plan Approval.

There are two Nursing Assessments available for creation in CYBER – the Initial and Update.

The Initial Assessment is due in CYBER 30 calendars after the start of the authorization (and opening of Tracking Elements).

The Update Assessment is completed on an annual basis.

Once the Nursing Assessment has been chosen as the new document type to create, it will appear in a new window (the Demographics tab will open by default).
The document is separated by tabs; clicking on the individual tabs will open them. As a user navigates between the tabs, the system will automatically save the document. There is a small arrow button next to the tabs, in the upper right-hand corner of the document. Clicking here will allow the user to navigate to the tabs that are not initially visible.

The buttons at the bottom of the assessment are standard across the CYBER system and are as follows;

- Save, Save & Close
- Select Action menu – Submit, Return, Transfer, Delete
  - Submit – will submit the document into the system; should only be used when the document is complete
  - Return – if the document was transferred within the agency for review or work, this will return the document to the author
  - Transfer – will transfer the document to another user within the agency for review or additional work; should be used when the document is in draft
  - Delete – will be available for use until the document has been submitted, at which time the user can no longer delete it
- Update Status – chosen after a selection is made in the Select Action menu
- Print – will only be active once the document has been saved; see page 35 for more information on printing
- Cancel – will cancel whatever actions the user has taken; if the user has not saved the document and clicks Cancel, the document will be (in effect) deleted
- View Review History – will show the user a history of who has owned the document and what the current status of the document is; users can use this area to check where the document is, if it has been submitted for review by PerformCare and if it has been approved or returned

The Demographics tab is predominately populated with information from the youth’s Face Sheet.

At the bottom of the accordion, the user will find the following required field;

- Assessment Completion Date – please enter the date on which the assessment was completed

There is a Refresh button on the left-side of the tab; if information on the youth’s Face Sheet has changed – such as their address – the user can update the information in this accordion by clicking this button, so that the most current demographic information is displaying in the Assessment.

The next tab is Health Care Providers. There are two main areas on this tab – Current Health Care Providers and Contacts.
The Current Health Care Providers grid must include the youth’s primary care physician and psychiatrist; these are required for submission. The Contacts grid may include information for individuals that are Child Family Team members such as contacts at the youth’s school or other medical care managers that are involved with the youth and family.

The first area is for Current Health Care Providers; clicking the Add Health Care Provider button below the grid will bring up the following window;

The Provider Type drop-down list will include the following options:
• Cardiologist
• Dentist
• Developmental Pediatrician
• Endocrinologist
• Gastroenterologist
• Hematologist
• Nephrologist
• Neurologist
• Other (specify – text box is required if Other is chosen)
• Primary Care Physician
• Psychiatrist
• Pulmonologist
• Vision Care

There is an option of “No identified current provider” to select, if the youth does not have current providers.

*Please note: the user must add information for the youth’s current Primary Care Physician and Psychiatrist, unless the check box for “No identified current provider” is selected; if that box is selected, the requirements are overridden.*

The drop-down for Date of Last Visit contains the following options:

• Within last 30 days
• Within last 60 days
• Within last year
• More than 12 months in the past

Once a contact has been entered, all fields are required – unless “No identified current provider” has been selected. The contact will be saved to the grid once the user clicks Save; double-clicking on it from the grid will open it back up for the assigned user to edit or delete. Information can only be edited by the user that is the current owner of the document; information can only be deleted prior to the submittal of the assessment.

The second grid is for Contacts; the individuals listed here are those involved in the youth’s care (typically those that attend the Child Family Team meeting but may be otherwise involved as well). Users will find the following help text above the grid – “Please add DCP&P Case Worker, School Contact Person, Special Child Health Services, MCO Care Manager and all other medical care managers, as well as all other contacts that apply.” Users should enter any appropriate contact information here.

Clicking on the Add Contact button will bring up the following screen;
Please note: All of the fields in the Add New Contact window are required.

The next tab of the assessment is Medical History.

This area is utilized to document any and all medical conditions that the youth has been diagnosed with. The list includes conditions such as asthma, eating disorders, spina bifida, cardiovascular and neurological disorders, and developmental disabilities such as cerebral palsy. Users will find that the list is organized into categories or groups; if one item under a category heading is selected, the main heading for that category is also selected. For example, when a user checks off Cerebral Palsy, Developmental Disability will be auto-selected by the system. (At least one selection from the list is required.)

**The user must select at least one condition from the list in order to submit the Assessment.**

Below the list of BHH Current Medical Conditions is an area that lists Additional Current Medical Conditions; this list will include Cardiovascular Disorder, Endocrine Disorder and Respiratory Disorder. If any of these conditions are checked off, the associated text box becomes active and is then required.
### Additional Current Medical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dermatologic Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Endocrine Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gynecologic Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HEENT Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hematologic Disorder</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Immunologic Disorder</strong></td>
<td></td>
</tr>
</tbody>
</table>

There are also questions regarding tobacco use by the youth and/or family members which are required questions.

### Use of Tobacco Products:

**Smoking tobacco or chewing tobacco**

<table>
<thead>
<tr>
<th>Frequency during the past 6 months</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Describe Use of Tobacco Products:**

**Is there family use of tobacco products?**

**Is there smoking indoors?**

### Use of E-Cigarettes:

<table>
<thead>
<tr>
<th>Frequency during the past 6 months</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

User should also document any allergies the youth may have in the appropriate section; any allergies should be detailed in the box given. The text box is required if any allergies are selected.
There is also an area at the end of the tab where the user can document any additional health concerns that have been shared with them by the youth and/or family. This is a required field; if there is no additional information to document, the user can enter “N/A”.

The next tab will house Diagnosis information.

The user must enter the Diagnosing Clinician’s name and the date the diagnosis was rendered. Users are not required to enter in a diagnosis; users **must** select a condition on the Medical History tab, under the BHH Current Medical Conditions section.

When the user enters the Diagnosis Clinician’s name, they will either get a menu or choices to pick from (these are Clinicians who have been entered into CYBER in the past) or they will need to enter a new name. In the event that a user needs to enter a new Clinician, they will click on the “+” button. This will bring up a new window, in which the user
will enter the Clinician’s information – first and last name, address, contact type and one method of contact (work number, 24 hour service number, etc).

Clicking the “+” button will bring up the Search Diagnosis window.

![Search Diagnosis window](image)

This window will allow the user to search the system for the appropriate code; it is recommended that, unless the user knows the exact code or description that they enter in a partial search – meaning the first number of the code, the first few letters of the diagnosis description; this will ensure the user will receive results from the search. By default, the option to Crosswalk DSM-IV codes is selected. This allows users to enter in the DSM-IV code and the search function will return the associated ICD-10 code, if one exists.

Once the appropriate code is found in the Diagnosis grid, the user can double-click on it in the grid to add it to the assessment; depending upon the code the user may need to add additional, more specific information about the diagnosis into the Comments field. Clicking “OK” will also add the selected diagnosis to the assessment.

The Medications accordion will allow users to document all medications that the youth is currently taking.
Please note that the questions at the top of the accordion are required – the options of Yes, No and Unknown are available.

To add medications, users will click on the Add button, which will bring up a new window.

Here, users can associate existing medications that have been entered previously into the youth’s record or add new – both functions can be completed using the buttons at the bottom of the window.
To associate a medication to this assessment (new or existing), the user will need to single-click on the record in the top grid (Available Medications) and click the Associate button at the bottom of the window. Doing this will take the medication record and place it into the bottom grid – Associated Medication, which will then place it into the Assessment.

To add a new medication - click the Add button to bring up a new window.

Users will enter the name of the medication into the first field; as the user types, a menu will appear with a list of matching medications to choose from – prescription and over the counter medications will appear, along with available dosages. All fields in this window are required; once the Medication Name, Prescriber, Actual Dosage, Frequency and Reported Date are entered, the user will then associate the medication with an existing diagnosis from the youth’s record. Clicking off the box next to the diagnosis in the grid will select it; multiples can be selected when appropriate. Clicking “Accept” will add the medication to the Available Medications grid.

The Medical Treatment Plan tab is next.
Users will find questions that pertain to the youth’s current dietary needs and physical activity/restrictions, as well as screenings that may have been completed.

There are a number of questions in the Medical Treatment Plan; all are required. Depending upon what options are chosen, the user may need to provide additional information. Certain selections will list “specify below” to indicate that more information is required in the Description text box below the question.

There is an area titled Prescribed Health Monitoring and Maintenance Activities in Home, School and Community.
Each area is defaulted to a selection of “None”; if the user makes a different selection, the Comments area associated to it is required.

There is also an area dedicated to Depression Screening, towards the bottom of the tab.

Was depression screening obtained?

Date of Screen

Center for Epidemiologic Studies Depression Scale Score (0-60)
CES-DC Scale (Ages 12-17), CES-D Scale (Ages 10-20)

Date of Follow-up Plan
If the screen was positive, a follow-up plan must be identified and documented on the same date of the screen. One or more of the methods below must be described. Please note that the threshold for a positive depression screen is 16 for CES-D and 15 for CES-DC.

Additional Evaluation

Suicide Risk Assessment

Referral to a practitioner who is qualified to diagnose and treat depression

If a screening was completed, the user must enter the date of the screening and the scale score. If a screening was not completed (Date of Screen is left blank), the remainder of the fields are no longer required.

**Please note that the threshold for a positive depression screen is 16 for CES-D and 15 for CES-DC.

The Medical Services Utilization tab is where users will document how often the youth is being hospitalized, taken to the ER, or had any surgeries.
Areas of documentation include hospitalizations for physical health concerns, day surgeries, psychiatric hospitalizations, psychiatric screenings, emergency room or urgent care use for physical health concerns and CSOC Out of Home treatment, psychiatric partial hospitalization, mobile response and stabilization services, mental health outpatient services, and substance use-related treatment.

Each of the menus has the following options available:

- None
- None in past 12 months, but one or more prior to last 12 months
- One to three in past 12 months
- More than three in past 12 months
  - *Please note that the Summary text box is required for each selection if anything other than “None” is chosen.

The final tab in the assessment is Existing Auths.
Here, the user will find a list of all authorizations that are present in the youth’s record; this is a copy of the Authorizations grid from within the youth’s record. (Please note that BHH users will see all authorizations for services except those related to Substance Use treatment.)

VI. The BHH Quarterly Progress Update
The Quarterly Progress Update assessment will also be accessible via the Treatment Plans Assessments screen from within the youth’s record.

Users will make a selection from a Discharge, Initial or Update Quarterly Progress Update.

- Discharge – to be completed when the youth is being discharged from services; will be submitted along with the UCM BHH ISP-Transition document.
- Initial – to be entered into Cyber 30 calendar days after the start date of the authorization (and Tracking Element)
- Update – to be entered into Cyber 90 calendar days after the last Treatment Plan’s Child Family Team Meeting date

Clicking on the appropriate option from the menu above the grid, and then clicking Add New, will open up the new document. By default, the document will open up to the Demographics tab.
Please note that only one Quarterly Progress Update can be in draft within a youth’s record at one time; if one exists and the user attempts to create another one, they will receive an error message and will need to continue working on the draft or delete it. (Users can only edit or delete Progress Updates that are currently assigned to them. To learn more about how to assign the Progress Update to yourself or to other users within your agency, please see page 32.)

Users with the appropriate security designation on their profile in Cyber (CMONURS) will have the ability to see all in progress Quarterly Progress Updates created by their agency, as well as all submitted Updates created by any CMONURS in any agency.

The Demographics tab will contain the demographic information on the youth from the Face Sheet of the record.

Towards the bottom of the accordion, the user will find the following required fields;

- Assessment Completion Date – please enter the date on which the associated assessment was completed.

There is a Refresh button on the left-side of the accordion; if information on the youth’s Face Sheet has changed – such as their address – the user can update the information in this accordion by clicking this button, so that the most current demographic information is displaying in the Assessment.

The next tab is Copy Goals, which will allow users to copy the goals from any previously submitted Quarterly Progress Update from their agency.
The user will select the Progress Update they want to copy from, and click the Copy button at the bottom. Please note: any goals listed as “Other” that are in Completed or Discontinued status will not copy over. Copied over goals will appear in the next tab.

*Please note: if the user has already entered goals into the Goals tab, and then chooses to use the Copy functionality, all information that has been manually entered will be over-written (i.e. deleted).

The next tab is for Goals documentation.

This area allows the user to document the youth and family’s objectives in relation to daily health goals – in an effort to improve the daily behaviors that impact the youth’s health.

There are three areas in which the user will document goals; the grids are titled as follows –
• Youth/Family Daily Health Maintenance Behavior Goals
• Youth/Family Health Promoting Behavior Goals
• Youth/Family Wellness Goals

Clicking the Add Goals button beneath each grid will open up a new Add/Edit window. (below example is for the Daily Health Maintenance Behavior Goals)

For the Youth/Family Daily Health Maintenance Behavior Goals, the user must make a selection from the Goals menu as follows;

• Complies with physical activity plan (routine activity, prescribed activities or restrictions)
• Complies with prescribed dietary plan (healthy eating, prescribed diet or dietary restrictions)
• Complies with prescribed medications (oral, inhalation, injection, other)
• Other (specify)
  o If the user selects this option, they must enter information into the additional fields; please note – the field labeled “Identifier for Other” must include an integer (number). This is for tracking purposes; each goal entered as Other will be tracked using this number, which will make analysis of change easier than if only tracked by text alone.
• Regularly carries medication devices (inhaler, Epi-pen, glucose monitoring, other)
In the Frequency and Stages of Change areas, the user must select the appropriate measurement for the goal; these are required fields.

There is a Comments box available for any additional information regarding the goal, frequency and/or stage of change that needs to be documented.

*Please note that the user must enter at least two Youth/Family Daily Health Maintenance Behavior Goals in order to submit the Update.

The next area, Youth/Family Health Promoting Behavior Goals grid, will operate in the same manner as the previous grid.

Clicking on the Add Goal button will bring up the following Add/Edit window.

In this window, the user must enter the Goal;

- Advocates for his/her health care needs and speaks with health care professionals to better design the medical treatment plan
- Communicates age-appropriate understanding of his/her medical condition and the need for medical or self-care
- Complies with required lab and blood tests
- Other (specify)
If the user selects this option, they must enter information into the additional fields; please note – the field labeled “Identifier for Other” must include an integer (number). This is for tracking purposes; each goal entered as Other will be tracked using this number, which will make analysis of change easier than if only tracked by text alone.

- Recognizes and reports changes in symptoms and seeks assistance when necessary (parent, school nurse, babysitter, etc.)
- Refills prescriptions in a timely manner

The Frequency and Stages of Change areas are required fields; one option must be selected for each Entity under Stages of Change.

There is a Comments box available for any additional information regarding the goal, frequency and/or stage of change that needs to be documented.

*Please note that the user must enter at least two Youth/Family Health Promoting Behavior Goals in order to submit the Update.

The Add Wellness Goal area is next on this tab; at least two Wellness Goals must be entered.

Clicking on the Add button will bring up the Add/Edit Wellness Goal window.

Users must first select a Dimension for the Wellness Goal. Selections in the drop-down are as follows;
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- Emotional
- Environmental
- Financial
- Intellectual
- Occupational
- Other (specify)
  - If the user selects this option, they must enter information into the additional fields; please note – the field labeled “Identifier for Other” must include an integer (number). This is for tracking purposes; each goal entered as Other will be tracked using this number, which will make analysis of change easier than if only tracked by text alone.
- Physical
- Social
- Spiritual

The Frequency and Stages of Change are also required; one option must be selected for each Entity under Stages of Change.

The Barriers tab is next; this area allows the user to document any and all barriers to treatment and youth/family success in implementing changes to their health behaviors.

The grid will contain the following, with checkboxes; the user should select any that apply. Selecting a barrier will activate the associated comments box, which must then be filled out with details.

- Access to Care Barriers
  - Transportation
  - Need for identified primary care provider
  - Need for identified specialist physician
  - Need for identified psychiatrist
  - Special medical equipment required (oxygen, wheelchair, other)

The grid will contain the following, with checkboxes; the user should select any that apply. Selecting a barrier will activate the associated comments box, which must then be filled out with details.
There is also a comments box where the user can add additional information.

- **Insurance Barriers**
  - Lack of insurance funding
  - Inadequate insurance funding
  - Other (specify)

- **Knowledge and Viewpoint Barriers**
  - Caregiver lacks knowledge or understanding of how to manage youth’s medical condition
  - Youth lacks knowledge of how to manage his/her medical condition
  - Reservations about the side effects of treatments (past, present, future)
  - Other (specify)

- **Psychological Barriers**
  - Trauma associated with past medical treatment impacting compliance or access to care
  - Health care avoidant behavior due to underlying anxious, depressive or psychotic symptoms
  - Other (specify)

- **Cultural Barriers**
  - Language barrier
  - Other (specify)

- **Economic Barriers**
  - High copays, other costs of care
  - Caregiver work schedule
  - Other (specify)

- **Healthcare System Barriers**
  - Insufficient healthcare provider hours or accessibility
  - Dissatisfaction with current healthcare provider
  - Other (specify)

- **Other Barriers**
  - Two “other” lines are available for additional documentation

The Healthcare Measures tab is where a user will input measures such as a youth’s BMI, Blood Pressure, medical action plans and information on the plan that is being developed for transitioning the youth into the adult healthcare system (if the youth is older than 16).
The following physical health metrics will be required in order to submit the Update:

- Blood Pressure – Diastolic (mm HgG)
- Blood Pressure – Systolic (mm Hg)
- BMI
- Height (inches)
- Weight (lbs.)

Double-clicking on the entries in the grid allow the user to enter information into each of these areas.

This tab also includes information regarding action planning – i.e. the plan that will be followed or put into place to avoid future hospitalizations. There are also questions which ask for information regarding school attendance, grades and collaboration with the youth’s school nurse.

The next tab – Healthcare Utilization – will contain information regarding what type of care the youth has received from the medical community (primary care physician, emergency care, etc.) within the last 90 days.
The first area, as seen in the above example, documents the youth’s routine care in the last 90 days. Other sections follow that document treatments (such as smoking cessation and substance use treatment), emergency care within the last 90 days, substance use and smoking cessation assessments, and documentation of any follow-up appointments the youth may have attended after treatment.

The Discharge Criteria tab will be available in the Quarterly Progress Update – Discharge document and will be completed prior to the youth being discharged from services. This document is submitted to PerformCare by the youth’s Care Manager; it is associated to the new UCM-BHH Transition ISP.
VII. New Progress Notes

The BHH-specific progress notes were put into Cyber in late 2014; they can be accessed and created from the Progress Notes area of the youth’s record. Clicking on the Progress Notes button from the left-side button bar of the youth’s record will bring up the Progress Notes screen.

Users with the CMONRS security assigned to their ID will have the ability to create two BHH-specific progress note types:

- **BHH Nursing**
  - Face-to-Face
  - Collateral Contacts
- **BHH Wellness Coach**
  - Face-to-Face
  - Collateral Contacts

*Please note: these are new progress note types for BHH documentation. Prior to this release, there were two types available – BHH Nursing and BHH Wellness Coach; they will now be in a read-only status. Only the types listed above may be created new.

To create a new note, the user will click on the New Progress Note button in the upper right-hand corner, above the progress notes grid. Doing this will open a new note; this is where the user will choose the appropriate note type.

Users may see different note types in this menu, depending upon their security settings.

Once the note type has been chosen, the user will fill in the date, time and duration fields; these are completed with information related to the activity they are documenting. For example, if the user is documenting a face-to-face meeting with the family, they would enter the date of that meeting, start time of the meeting and meeting duration. Users can then enter their documentation into the white space of the note window. Users have the option of saving the progress
note in draft prior to committing it to the record; please note that if a progress note is in draft form, the author is the
only user who has access to it until it is committed. Once committed, it cannot be edited or deleted from the record.

If the user is looking for a certain note type, such as their own BHH-related notes, they can utilize the Filter function –
accessible via the Filter Notes button above the grid. Clicking this will bring up the following window;

![Filter Progress Notes Window](image)

The information that will appear in the drop-downs for Type of Progress Note and Author of Progress Note will only be
those that are present in the record. Users can complete any of the fields to complete the filter.

Clicking Accept will then apply the filter to the progress notes grid.

Users can also print out progress notes from CYBER; please see page 34 for more information on printing.
VIII. Plan Approval
Plan Approval is an area of CYBER that is used to manage the documents that are currently with the user’s agency; they have not been submitted or approved by PerformCare. Users with the CMONRS security attached to their user ID will have the ability to access the Nursing Assessments and Quarterly Progress Updates that have been created by their agency as long as they are not submitted to PerformCare.

This area can be accessed by clicking on the Plan Approval button, which is on the left-side button bar from within a youth’s record. (If a number appears on the button, it indicates that the user has that many documents currently assigned to them.)

At the top of the screen, users will find the Plan Selection Grid. By default, this area will show any plans or assessments that the user has access too – CMO (or UCM) treatment plans, OOH Referral Requests, Assessments and BHH documents. These documents are currently in the system for the user’s agency and have not yet been submitted to PerformCare; selections made here fuels the types of documents that the user will see and access in the next areas of the screen.

Once the user selects BHH, BHH QPU (Quarterly Progress Update) and Nursing Assessment will appear here in the Plan Type area; options will appear for the user to choose from such as QPU – Initial, QPU – Update, QPU – Trans/Dis for Progress Updates and Nursing – Initial, Nursing – Update for the Nursing Assessment. The selections made from here are what fuel the filtered plans and assessments that appear in the next grid – Filtered Plans.
This top area also contains a number of filter options for this screen.

The Doc Type menu gives the user the option to look at Treatment Plans, Assessments or All. If the user makes a selection here, it will cause the Plan grid (to the left of the menu) to show only what is applicable and available to the user. For example, if the user were to select ASMT, or Assessments, the Plan grid would only show those Assessment types that are available for the user to select – which is only Assessment or BHH in this instance.

Next to this area are the check-boxes for time-frames. These time-frames are associated with when the document is due. If the user enters a time frame into the boxes here, they will be unable to select any of the other options listed.

The user also has the option of choosing to look at the plans or assessments for a specific program; this menu will only have more than one program available if the user’s CYBER ID is associated with more than one program.

The AssignedTo menu allows the logged in user to look for plans and assessments that are assigned to a specific user in their agency; Supervisors and Managers may use this menu to look for the plans and assessments that are currently “In Progress” and are assigned to a user that is no longer with the agency (and has been deactivated). Using this function allows the Supervisor or Manager to locate the documents and reassign them to other users within the agency.

*Please note: If the user is in this screen for an extended period of time, there is a possibility that new plans and assessments have been entered into the system but are not appearing on this screen (the grids will not automatically refresh). To see if new documents have been entered, clicking on the Refresh button will refresh the filter parameters, which will refresh the Filtered Plans grid.

<table>
<thead>
<tr>
<th>Filtered Plans (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAN</td>
</tr>
<tr>
<td>BHH</td>
</tr>
<tr>
<td>BHH</td>
</tr>
<tr>
<td>BHH</td>
</tr>
</tbody>
</table>

The Filtered Plans grid will show all Nursing Assessments and Progress Updates (based upon the filters chosen above) that are still within the agency and have not been submitted to the CSA for approval. The grid will show the type of Plan and Plan Type, the status of the document (In Progress indicates that it is still with the author), who currently owns the document (Assigned To), the name and ID of the youth, who the requestor or author of the document is, and the due date (when applicable). Users will also find Return History by scrolling to the right in the grid. If the document has been returned by the CSA, the name of the CSA Reviewer that returned the document will appear here. (This will be the most
recent return; in order to see a full history, the user will need to open the document and click on the History button. See page 8 for more details.)

*The Quarterly Progress Update is associated to the CMO (UCM) ISP; if the ISP has been returned the user will find it here. To find the reason for the return, the user will need to open up the ISP and go into the Comments accordion for more information on the return.

Users can assign a plan or assessment to themselves, even if it is currently assigned to another user; keep in mind that Plan Level 1 users can only assign documents to themselves here. Plan Level 2 and 3 users can assign plans and assessments to any users within the agency. In order to assign a document to the logged-in user, the document must be selected in the grid (by single-clicking on it) and then the user will click on the Assign button, below the grid. Once the document has been assigned to the user, it will appear in the My Plans grid at the bottom of the window. (Documents that have been submitted to the CSA will not appear on this screen.)

*If you are in need of more information regarding security, or setting security up for new or existing users, please see the appropriate training on the Training page of the PerformCare website; training #102 is for System Administrators and reviews each security level and how to assign them to a user’s profile.
IX. Printing

Both the Nursing Assessment and the Quarterly Progress Update can be printed from Cyber, as long as they have been saved. Progress Notes can also be printed from the system.

Both documents will have a Print button at the bottom of the document window; Progress Notes will have print options above the progress note grid.

Clicking this button will generate the print version of the document; users will receive a warning message that the report may take a moment to load, due to the amount of data contained in the document. Once the report generation is complete, it will open in a new tab.

Users can scroll through the pages manually, or use the page selection tool at the top of the tab.

Users have the ability to print directly from Cyber, using the print icon to the right-side of the tool bar at the top of the tab (the blue diskette with the green arrow); it is **highly recommended** that users do not print directly from Cyber. Doing so will take an extended period of time. Users can export the document to an Adobe PDF file, using the Export menu at the top of the tab (see the screenshot below). Choosing PDF from the menu will generate the file; this can then be printed or saved on the user’s computer.
X. Outcomes Report

A new outcomes report is available for the Quarterly Progress Update, for any user with the CMONURS security level attached to their Cyber ID.

Outcomes reports do just that – report on outcomes. This report will detail the youth’s progress in terms of their goals, as well as the current barriers that the family is experiencing and changes to the youth’s vital health measurements (BP, BMI, etc.).

To access the report, the user will single-click on the Progress Update that they want to build the report from – this is most often the most recent document. Then, they will click on the Outcomes Report on the left-side of the grid. The report will then generate in a new window.

The first page of the report will contain demographic information for the youth, much like the first tab of the Quarterly Progress Update. After that, the report will contain graphical representations of the youth’s progress (see below), as well as any appropriate text that has been entered into the selected Progress Update.

The report can be printed, just as other documents can be. Please see page 35 for more information on printing.