Out-of-Home Providers Overview

Joint Care Review and the Youth Record
Objectives of this Training

• CSOC, PerformCare and CYBER
• Operational Work Flow from Admission through Transition*
• Welcome Page
• Locating the Youth Record/Assigning Youth to Staff
• Treatment Planning for OOH
• Understanding the Face Sheet
• Progress Notes/Doc Upload
• Historical Access/Reporting
• Contacting PerformCare
• References/Acronyms

*YouthLink is not provided in this training.
CSOC and PerformCare

The Children’s System of Care (CSOC) is a division of the Department of Children and Families in the State of New Jersey. The Division services youth with emotional and behavioral health challenges, children with developmental and intellectual disabilities and their families, as well as youth who are struggling with substance use challenges.

The Children’s System of Care is committed to providing these services based on the strengths and needs of the child and family in a family-centered, community-based environment.

PerformCare is the Contracted Systems Administrator or the CSA for the System of Care administering the services included within the System of Care in New Jersey.

Our staff include Member Service Specialists who are the first point of contact within the call center, a full clinical team including a dedicated Review team a dedicated unit just for DCP&P involved youth, and units for Billing and Eligibility, Reporting, Training and Quality Improvement.
What is CYBER

CYBER is an Internet-based repository (database) with security to manage and control access to youth records by multiple providers.

CYBER contains health information about children in the State of New Jersey with behavioral health, developmental and intellectual disability and substance use challenges. It also contains the work and documentation of the many providers who assist those youth.

You as a provider will be using the functions of CYBER to document admission and transition of youth in your care.
OOH Admission Process

- Admit through YouthLink* or manually entered admission:
  - ✓ Receive full edit access to the majority of Youth record (exception: Face Sheet)
  - ✓ View all historical plans, assessments, progress notes in youth record
  - ✓ Receive initial authorization (120 days)
  - ✓ Start of episode begins with admission date

*See References for YouthLink documentation
OOH Continued Stay Process

- All providers attend Child Family Team (CFT) meeting (Care Management, OOH, family, etc.)
- CMO documents CFT meeting in CFT progress note entered into youth record
- Submit Strengths and Needs Assessment within 30 days prior to JCR submission (*S&N is not reviewed and cannot be returned*)
- **Start JCR at least 2 weeks before due date** (every 90 days after initial)
  - Associate to Strength and Needs Assessment
  - Submit JCR to CMO
  - CMO submits to CSA
  - CSA reviews plan/assessment
  - OOH monitors for returned plans (Welcome page or plan approval screen)
  - **On approval OOH receives continuing stay authorization (90 days)**
OOH Transition Process

- CFT meeting determines youth will transition to another OOH
- CFT progress note is entered by CMO approving Transition decision
- OOH upload TJCR Checklist and required documents into youth record Doc tab
  - Use ‘Document Upload Crosswalk’ to determine appropriate documents
- Submit Strengths and Needs Assessment within 30 days prior to JCR submission (*S&N is not reviewed and cannot be returned*)
- **Start Transition JCR at least 2 weeks before due date** Submit TJCR to CMO / CMO submits to CSA
  - CSA reviews plan/assessment
  - OOH monitors for returned plans (Welcome page or plan approval screen)
  - **On approval, OOH receives 90 day continuing stay authorization and TJCR creates an OOH referral**
- Other OOH programs review referral and schedule to meet youth
- If youth is not admitted, continue to create JCR every 90 days for continuing stay
- Youth is admitted into another OOH
- Create DJCR with discharge date on or after exit
TJCR Checklist – Document Upload

**DOCUMENT UPLOAD REQUIREMENT CHECKLIST**
TRANSITIONAL JOINT CARE REVIEW (TJCR)

**YOUTH NAME:**
**CYBER ID:**
**DATE OF SUBMISSION:**

**PLEASE THOROUGHLY REVIEW THE FOLLOWING INFORMATION:** Immediately upon the TJCR treatment team meeting, the treating OOH provider shall complete and upload the following checklist along with the below identified required documents in order to assure that all necessary information is available for review at the time of the IOS determination. OOH provider should not submit the TJCR until all documents are uploaded and CMO enters their CFT Progress Note. TJCRs with incomplete documents will be returned.

**MINIMAL REQUIREMENT:**
- TJCR Document Upload Requirement Checklist (along with required uploaded documents)
- CFT Note (approving TJCR)

**OTHER REQUIRED DOCUMENTS (see italicized information for requirement criteria):**
- Psychiatric Evaluation* (within the last six months**):
  - IS REQUIRED if youth is prescribed psychotropic medication;
  - IS REQUIRED if youth had a psychiatric hospitalization within the last six months.
  - IS REQUIRED if youth is actively seeing a psychiatrist.
  - *If the evaluation is more than six months old, CM must provide the evaluation along with an accompanying updated report from the treating psychiatrist. If youth is prescribed psychotropic medication, the report should specify current diagnosis, current medication name/dosage, and noted response to medication.
- A Neuropsychological Evaluation is acceptable in lieu of a psychiatric evaluation if youth is IDD eligible. Please see IDO Specific Evaluations and Reports on page 2 for requirements.
- Specialty Evaluations (within the last twelve months):
  - NOT REQUIRED if specialty criteria is not applicable to youth.
  - IS REQUIRED if youth presents with fire setting or sexual behavior needs and meets criteria "b" below.
    a. NOT REQUIRED if youth is currently being treated at a specialty treatment setting for the same treatment issue (e.g. step down treatment for sexual behavior). Instead, the treating provider may enter their treatment recommendations risk level directly within the TJCR.
    b. IS REQUIRED for all youth referred from a non-specialty treatment setting due to sexual behavior or fire setting OR youth referred from a specialty treatment setting if there is a new behavior that did not previously warrant a specialty evaluation.
- Fire Setting Evaluation (within last 12 months; must include documented risk level)
- Psychosocial Evaluation (within last 12 months; must include documented risk level)

☐ Substance Use (SU) Assessment (within last 30 days) **DO NOT UPLOAD SU ASSESSMENTS!**
☐ Substance Use Consent Form

☐ is REQUIRED if the youth presents with a substance use need.
☐ Due to disclosure protection under 42 CFR Part 11, CMO is required to submit substance use evaluations via fax to PerformCare at (877) 948-6599 along with the required Substance Use Consent Form which is located at http://www.performcarenj.org/provider/forms.aspx. Please check box if assessment was faxed so that PerformCare is aware that one was completed.

☐ IDO Specific Evaluations/Reports

☐ is REQUIRED if youth is deemed IDD Eligible:
  - Report(s) that capture the youth’s level of functioning and special needs within the domains of communication, mobility, life skills, cognition, sensory, and/or special equipment. Such reports may include, but are not limited to: psychological evaluation, IEP, FBA, Behavior Support Plan, Adaptive Functioning Assessment, etc.
  - C2C Application (required if youth is deemed IDD Eligible)
  - Child Adaptive Behavior Survey (CABS) (required if youth is deemed IDD Eligible or if the DD module was completed within the OOH Referral Request and as part of the TJCR. CABS must have been completed within the last six months)
  - Neuropsychological Evaluation within 6 months* (may be submitted in lieu of Psychiatric Evaluation):
    - IS REQUIRED if youth is prescribed psychotropic medication.
    - IS REQUIRED if youth had a psychiatric hospitalization within the last six months.
    - IS REQUIRED if youth is actively seeing a neurologist.
  *If the evaluation is more than six months old, CM must provide the evaluation along with an accompanying updated report from the treating neurologist. If youth is prescribed psychotropic medication, the report should specify current diagnosis, current medication name/dosage, and noted response to medication.

☐ Other Reports/Evaluations (as applicable):
  - Most recent IEP Cover Sheet which verifies classification type (required if educationally classified).
  - Medical reports (required if youth has a medical condition such as pregnancy, diabetes, allergies, cardiac condition, seizures, etc. Report must specify any special needs and accommodations that the youth requires).
  - Hospital Intake Assessment/Discharge Summary (if hospitalized within the last 6 months).
  - Court orders related to treatment*
  - Original EPS or Psychological Evaluation (that was used for current OOH placement)
  - Other documents that were utilized for purposes of IOS determination

*IF THE YOUTH IS INVOLVED WITH COURT, IN ADDITION TO UPLOADING APPLICABLE COURT DOCUMENT(S), PLEASE CLEARLY DOCUMENT THE STATUS OF COURT INVOLVEMENT, INCLUDING, BUT NOT LIMITED TO, COURT HEARINGS, LEGAL CHARGES, PROBATION INFORMATION, COURT ORDERS, SUBPOENAS, ETC. WITHIN THE TJCR.
The **Document Upload Crosswalk** is helpful in identifying and determining the type and subtype of the document being uploaded.

See [References](#) for the Instructional Guide to Document Upload

**OOH DOCUMENT UPLOAD CROSSWALK**

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th>CYBER DOC TYPE</th>
<th>CYBER DOC SUB-TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPS (if not in CYBER) or CCIS Psychosocial Assessment</td>
<td>Clinical</td>
<td>Community BPS Assessment</td>
</tr>
<tr>
<td>Neurology Update**</td>
<td>Clinical</td>
<td>Other Applicable Reports/Documents</td>
</tr>
<tr>
<td>Neuropsychological Evaluation</td>
<td>Clinical</td>
<td>Other Applicable Reports/Documents</td>
</tr>
<tr>
<td>OOH Referral Request (Document Upload Requirement Checklist)</td>
<td>Clinical</td>
<td>Other Applicable Reports/Documents</td>
</tr>
<tr>
<td>Other applicable evaluations/reports</td>
<td>Clinical</td>
<td>Other Applicable Reports/Documents</td>
</tr>
<tr>
<td>Psychiatric Update***</td>
<td>Clinical</td>
<td>Other Applicable Reports/Documents</td>
</tr>
<tr>
<td>Transition Joint Care Review (TJCR) (Document Upload Requirement Checklist)</td>
<td>Clinical</td>
<td>Other Applicable Reports/Documents</td>
</tr>
<tr>
<td>Substance Use Assessment</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Required if youth is deemed IDD Eligible or if the DD module was completed within the OOH Referral Request/SNA as part of the TJCR.**

***Required if Psychiatric/Neuropsychological Evaluation is more than six months old**
OOH Discharge Process (out of CSOC)

- CFT Meeting determines youth will transition out of CSOC OOH
- CFT Note is entered by CMO approving transition out
- Submit Strengths and Needs assessment within 30 days prior to JCR submission (*S&N is not reviewed and cannot be returned*)
- Create Discharge Joint Care Review with discharge date on or after actual exit
- **Submit DJCR with associated Strengths and Needs assessment to CMO**
  - CMO submits to CSA
  - CSA reviews plan/assessment
  - OOH monitors for returned plans (Welcome page or plan approval screen)
- **On approval - Youth is transitioned out of CSOC**
  - Youth remains open for 14 calendar days
  - Episode ends with Transition/Discharge date on plan
After logging in, OOH users land on the Welcome Page. The Welcome Page within CYBER allows users the ability to view OOH activity. 

• This is the CYBER Welcome screen that opens after logging into the system.*
• The Welcome Screen is the main access point for many of the different functions that are contained within CYBER.
• Login level of security determines access.
• To get from one place to another in CYBER, it just requires the user to point and left-click with their mouse on the appropriate menu item, link or button.

*User views, links and buttons may vary depending on the user type and security levels.
Welcome Page Links

OOH users have the following sections and links on the right-hand side of their Welcome Page described below:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Care Review</td>
<td>• Displays status of plans in progress through submission</td>
</tr>
<tr>
<td></td>
<td>• Aging Report displays Coming Due and Overdue plans</td>
</tr>
<tr>
<td>Assessments</td>
<td>• Displays assessments in progress</td>
</tr>
<tr>
<td>Authorizations</td>
<td>• Displays authorizations that will expire in the next 30 days</td>
</tr>
<tr>
<td>Admissions</td>
<td>• Admission summary for the program(s) specific to the user</td>
</tr>
<tr>
<td>Eligibility</td>
<td>• Displays youth eligibility</td>
</tr>
<tr>
<td>YouthLink View</td>
<td>• Displays statuses of referrals on YouthLink</td>
</tr>
<tr>
<td>Deactivated Users</td>
<td>(only for use by RESSUP and higher)</td>
</tr>
</tbody>
</table>

*Note: OOH users have the following sections and links on the right-hand side of their Welcome Page described below.*
Welcome Page Buttons

- In the top left of the Welcome Page, the System Admin information is displayed including the Security Administrator’s name and phone number.
  - FAQs – General information
  - CYBER Updates – system release information
  - Help – Service Desk contact information
  - Service Desk Form – link directly to the Service Desk Request Form

Below System Admin links there is a column of buttons:

**Youth/Child Search** is an alternate search option once you have left the Welcome Page.

**My Active Youth** is a function that allows an agency to assign specific youth to specific staff. Once youth are assigned, the staff need only click the button to view his/her assigned list.

**Out of Home** this area opens YouthLink, Messages and the Out-of-Home Provider map

**Provider Details** opens PIF, Annex A and other provider information

**Message Functions** displays YouthLink messages reflecting status changes for referrals

**System Functions** opens the Manage Access area where users can reset their passwords or Security Administrators can manage user IDs

**Reporting** is an area available to security Level 3 users only and contains existing reports for their agency or provider type

**Historical Access** is an area where users can view and print transitioned youth records (youth that are no longer open to the agency)

**Anomaly Management** lists various anomalies in the youth records such as missing address data, open to the provider but no Medicaid, no progress notes, etc.

**Training Information** – Training section of the PerformCare web page
Locating the Youth Record

There are two search functions within CYBER where you can input information to find a specific youth record.

• **Quick Search** on the Welcome Page

  ![Quick Search on the Welcome Page](image1.png)

  Enter the CYBER ID or use a partial name search.

  Type any part of a youth name and click Enter.

  (Mary Smith = Mar in First name field and Smi in the Last name field).

• **Youth/Child Search** on the Face Sheet

  ![Youth/Child Search on the Face Sheet](image2.png)
Go to the **Youth / Child Search** first to get to your list of **Active Agency Youth**. This will display a list of all youth open to the Agency.

The Active Agency Youth is a list of all youth open to the agency. The column headings can be clicked to sort, and the Print button allows the list to be exported and printed. Double-clicking on any row in the Active Agency Youth will open the Face Sheet for that youth’s Electronic Health Record.
**My Active Youth** is a selected list of youth assigned to a specific CYBER user. Each user may have their own My Active Youth list.

A designated user at your agency would:

- Review new Active Agency Youth
- Assign new youth to specific users
  - The Provider Tab creates My Active Youth lists for staff to assist users in locating youth easily.
- If youth is closed to agency, once reopened, re-assignment of youth is needed again to populate the My Active Youth list.
Suggested Workflow for Youth Management

1. Review Agency Active Youth using the icon
2. Click the youth record to open
3. Click Provider tab when the record opens
4. Add FSO user to the Provider tab with start date and click Accept
5. User can now access youth from their My Active Youth list
To create a new Treatment Plan, users will use the ‘Select Treatment Plan or Assessment type to create’ drop-down menu above the grid to select the document to create – a Treatment Plan or Strength And Needs Assessment. Once a selection is made, the user will click the Add New button, which will create the new document.

When the plan opens, the user can select the Treatment Type. The four plan types are listed in the dropdown menu.
Treatment plans, as well as assessments, are in an *accordion* format. In order to open an accordion section, the user will single-click on the section heading. Completing the same action when the accordion is open will close the section.
If the user’s agency has created a plan of care and it was previously approved by PerformCare, it will appear in this accordion to copy from.

Choosing to copy a previous plan will copy almost the entire document into a new plan. The diagnosis will not be copied, but must be selected and entered in the Diagnosis accordion.

**It is the user’s responsibility to review and edit the copied plan and make any necessary changes so that the information is accurate and current; copied plans with no updates will be returned.**

<table>
<thead>
<tr>
<th>COPY TREATMENT PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select a treatment plan to copy.</td>
</tr>
<tr>
<td>ID</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

[Copy Treatment Plan]
Demographics Accordion

Demographics accordion will automatically populate information about the youth, Parent/Guardian and Care management from the youth’s Face Sheet and record..

The Care Manager field may be a drop-down menu; this will occur if the youth has two open Care Managers in their record. In this case, the user should ensure that the current Care Manager is selected.

The ‘Refresh’ button is gray until the plan is saved once; then it will become available. If changes to the face sheet are made before the plan is submitted, the ‘Refresh’ button may be used to bring recently updated information from the face sheet into the plan.

The bottom of the accordion contains the two fields that are editable (and required) – the Child Family Team Date (CFT Meeting) and the Assessment Completion Date.
Youth Vision/Family Vision should include long-term goals for the youth, family and what the treatment team is working towards; if the team is working towards discharge, goals that need to be accomplished in order to discharge the youth should be included here. (The youth’s plan for the future should be specified here; if there is no family involvement, should reflect the youth’s vision/long-term plan.)

- The End Date is not a required field, but can be completed if there is an anticipated discharge date; Start Date is a required field and must be current.
Include the strengths of the youth as noted by each member of the treatment team; may also include the strengths of any members of the treatment team. Strengths should be positive qualities, skills, or abilities that can be built upon to attain the vision and address the needs; these strengths must be current strengths.

**Start date** and **Person Linked to Strength** are required fields; **End Date** is optional, if there is an anticipated discharge date that can be entered here.

Person Linked to Strength is a table that takes time to load. Type first three letters and wait for the list.
Adding New Person

To add a new person to Strengths, click the plus sign ‘+’, then when the ‘Add New Person’ screen opens, enter at minimum:

- First Name
- Last Name
- Check one ‘classification’ check box
- Enter one phone number
Needs

This area should reflect the priority needs that will be addressed as determined by the Child Family Team; each need must be entered separately – they cannot be combined.

Include the needs that are identified on the Strength and Needs Assessment; should be specific as to the behaviors that are to be addressed in order for the youth to attain the vision.

The **Description**, **Start Date**, at **least one Domain** and **Progress** are all required fields; Progress must be in-line with the rest of the information documented in the SNA and JCR. The End Date may be entered if the need has been met; the target date may be the date the treatment team is planning to complete services to address the need, or it may be the planned discharge date.

It is important that providers elaborate on the status of each need so it is clear when a youth has achieved a task to the best of their ability and will begin to focus on another area of need.
Strategy

Users must first enter a **Strength** and **Need** to create the **Strategy**. Select the Strength to be utilized, the Need that will be addressed, and then enter in a description of the Strategy.

There **must be a strategy entered for every need entered**; each strategy must be entered individually.

Include information on what will be implemented to build on the youth’s strengths in order to address the needs and help the youth achieve the vision. Users can also include what type of supports – formal and informal – will be utilized to achieve the vision.
Barriers should reflect anything that would impede the implementation of strategies and/or make addressing the Needs difficult; if a new service is being requested on the plan and its purpose is to address the barrier, that information can be included here as well.

Barriers are not required on the plan and should only be utilized if barriers are present. (An example of a barrier would be lack of parent transportation or lack of family involvement.)
Unmet Needs may include what need is not being focused on at this time and what is preventing it from being addressed.

Unmet Needs are not required on the plan and should only be utilized if there are needs not being addressed, but need to be documented/tracked. These may be addressed in the future.
Diagnosis should reflect the most current diagnosis within the last 12 months.

The **Diagnosing Clinician**, **Date Diagnosis Rendered** and **Diagnosis** are all required fields.

To copy a diagnosis, expand and select the diagnosis in the top grid and click ‘Copy Diagnosis’.

To add a diagnosis, click on the ‘+’ button. This will bring up a search window, where users can search for the appropriate code using either the code itself or the description (partial searches are accepted).
Medications accordion has three required questions that must be answered Yes, No, or Unknown.

Clicking ‘Add Medications’ will open the yellow ‘Add/Edit Medication Comment for a Treatment’ window.

Users can add new medications or enter information about new medications using ‘Associate’ or ‘Add’ buttons.

Clicking Accept will add the new medication to the Available grid; the user will then need to Associate it to the plan.

Medications listed here must match those on the SNA and should reflect all current medications, to include changes in dosages.
Service Request

Service Request is not a required section. Continued stay within the facility does not need to be requested; it is assumed that if the user has submitted a routine JCR that the youth will remain admitted in the current program.

Service Request should not be included in a Discharge JCR because the youth is being discharged from care there are no additional services that should be requested.

Service Request can be used when warranted. If entered, a Service Request must be associated to a Need and a Strategy in the plan.
When selecting a TJCR an additional accordion appears - **Search for OOH Providers** – which allows the current OOH provider to choose other providers based upon the CFT discussion/agreement. Selected providers here are not a guaranteed match; the match is based upon the youth’s age, gender and clinical needs. The information provided in this accordion does assist the clinical reviewer in assessing the type of services that are being sought.

- Select the **Intesity of Service** and click Search Providers button. All providers in that IOS will be displayed.
- Click the row of the provider in the IOS Search
- Click **Add Provider**
- The Provider will be displayed in the Recommended Providers box below.
Support Attendees accordion allows for entry of all members who were invited/attended the last Child Family Team Meeting. This accordion must be updated in every JCR.

Type the first few letters into the Attendee Name field and wait for the list to pull up the menu names; Title, and Agency are required text fields; any text may be entered if the attendee is not a provider). Date Notified and How Notified are required.

A new individual can be entered in the Strengths accordion if they are not on the list.
**Notepad** accordion is used for communication with PerformCare as the plan is being reviewed.

**Returned Plans** - *if the plan is returned to the user for additional information, the Reviewer at PerformCare will list what is missing or what is necessary to include in the plan in order for it to be approved and services authorized. A progress note will also be entered with the same information.*

OOH users can add details in the Notepad to support the request for services, before submitting a plan.
**Facility Information** is for information about the OOH user’s agency where the youth is currently admitted, including an anticipated discharge date from the program.

*Please note: All Dates are required except for Actual Transition Date until Transition.*

A Treatment Team Meeting Date must be entered and must occur after the last JCR and prior to submission of the current JCR.

**Text Box – Required**
Justify if youth/family/caregiver/custodian were not involved in development and review of plan. This should include specific information regarding the circumstances surrounding the lack of family, etc. involvement.
Exam accordion contains information about the youth’s latest medical examinations; dates entered should not be more than one year old.
**Target Behaviors/Discharge** should include information on the discharge plan, both short- and long-term plans, if applicable. There must be a working discharge plan entered in this section, along with current recommendations for post-discharge treatment and youth’s progress toward the discharge goal(s).

If the user is completing a TJCR, specific information that describes why the youth is being recommended for another level of care and any recommendations for treatment after the transition should be detailed in this accordion.

This should include:

- Treatment needs that were addressed in current episode of care and any previous episodes of OOH treatment
- Treatment interventions that were successful and/or unsuccessful in current episode of care and any previous episodes
- Behaviors/needs that warrant a different OOH intensity of service
- The youth/young adult’s perspective on proposed transition (when applicable)
- Justification as to why another OOH treatment episode is in the youth and family’s best interest
- Barriers for reintegrating the youth to the community at this time
- Community reintegration plan for child/youth/young adult
All sections of the Family/Natural Support Engagement Plan are required for JCR and TJCRs.

The plan must document visitation plans, family therapy plans, who is approved to participate has permission to visit and who is not permitted to visit and any reasons for restriction.

This section is not required for the Discharge JCR.
If the youth is reported as missing from the program, this should be supported by the appropriate information being documented in the associated Assessment.

If the user is completing a DJCR, the date entered in Actual transition date will be the date that CYBER will enter as the transition date (End date) into the Episodes tab of the youth’s Face Sheet. This date must be the current date or a date in the past. A future date cannot be entered.

Below the field for Actual transition date, the user will find a drop-down list of reasons for discharge; this field is required to submit the DJCR. The options are as follows:

- AMA Discharge (youth is being discharged against the advice of the provider)
- AWOL
- Higher IOS
- Hospitalization
- Independent Living
- Juvenile Detention/JJC
- Lateral IOS
- Lower IOS
- Return Home
- Shelter
- Transition to DDD
- Other/Successful (if ‘Other’ is selected a Comment is required)
- Other Unsuccessful (if ‘Other’ is selected a Comment is required)
Associated Assessment

The Treatment Plan will attempt to associate to a current Strength and Needs Assessment (SNA) to be submitted.

The Assessment must be submitted within the last 30 days (prior to the plan being submitted).

_The CFT meeting date in the plan must also match the Assessment Date entered in the assessment._ If it is outside of that time-frame, the system will be unable to associate it.

The SNA should reflect the information documented in the JCR and vice versa; all information should reflect the youth’s current level of functioning and should document what has taken place since the last JCR.

<table>
<thead>
<tr>
<th>ASSOCIATED ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AssociatedID</strong></td>
</tr>
<tr>
<td>Strengths And Needs Assessment</td>
</tr>
</tbody>
</table>

[Table image]
Action Buttons

Save: saves the document at the current point and the document remains open. Users are encouraged to save often so that information is not lost if there is an internet connectivity or CYBER issue.

Save & Close: button saves and closes the document at the current point.

Submit: will submit the document either for internal or CMO review depending on user’s security levels.

Cancel: If the plan has not been saved the use of Cancel will close the document and any changes the user just made will be lost.

Delete: deletes the document only if it has never been submitted to CMO.

Print: will be active once the document has been saved.

Return: returns the document to anyone who has been assigned to the plan.

Transfer: allows a user to send the document to any other user within the agency.

View Treatment Plan Review History: displays who is currently assigned to the document and the current status.
Locating Returned Plans

Returns can cause delays to authorization and transitioning. 7-10 days after a plan is submitted, it is important to check to see the status of a plan. When a plan is submitted to CMO, it may take from 1 to 3 days to reach the CSA after submission. PerformCare has 5 business days to review a plan. The next plan cannot be started until the prior plan is approved. If a plan is returned, it must be reviewed and re-submitted. There are two places to easily locate returned plans:

Welcome Page – if the agency is using the My Active Youth function, returned plans will appear on the welcome page under Joint Care Review – Rejected.

Plan Approval window – Click Plan Approval button on the left side and the pink window will open. Click Doc Type – ALL and the filtered plans will appear. Click the PLANTYPE column heading to sort and identify returned plans.

Progress Notes – Following a plan review a CSA progress note will be entered into the record with the results of the review.
The Face Sheet contains core information about the youth.

The Dashboard, the default tab for all providers, displays current information drawn from different locations in the youth’s Face Sheet tabs and other parts of the record.
Progress Notes

Progress Notes are used to document a youth’s status or achievements during the course of care. Essential to the youth record, updated information is valuable to all providers working with the youth.

Click New Progress Note
• Select Notation Type
• Enter Date
• Enter Time activity started
• Enter Duration (how long was the activity)
• Enter details of the note in the text box
• Commit or Save Draft

If Note is in draft:
• Select Show My Draft Progress Notes
• Double click to reopen note for editing, click Commit
Document Upload

Document Upload is CYBER functionality that allows certain users to upload or view uploaded documents in a youth’s record. Uploaded documents can be found on the Doc Tab of a youth’s Face Sheet. Users with the ability to upload and view documents need to have certain security attached to their ID in CYBER.

Access to this functionality is managed by your CYBER Security Administrator.
## Document Types for OOH Upload

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Sub-Type</th>
<th>Upload?</th>
<th>View?</th>
<th>Examples of Acceptable Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>O Clinical Summary Template</td>
<td>Y</td>
<td>Y</td>
<td>BPS Assessment completed outside of CYBER</td>
</tr>
<tr>
<td></td>
<td>O Clinical Updates</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Community Bio Psychosocial Assessment</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Cover Letter with SRTU Checklist</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O IEP/Educational Info</td>
<td>Y</td>
<td>Y</td>
<td>IEP cover sheet</td>
</tr>
<tr>
<td></td>
<td>O Medical Information</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O OOH-CABS (13 pages)</td>
<td>Y</td>
<td>Y</td>
<td>In support of CSAP-IDD</td>
</tr>
<tr>
<td></td>
<td>O Other Applicable Reports/Documents</td>
<td>Y</td>
<td>Y</td>
<td>TJCR Doc Upload Checklist</td>
</tr>
<tr>
<td></td>
<td>O Psychiatric Evaluation</td>
<td>Y</td>
<td>Y</td>
<td>Psychiatric Eval</td>
</tr>
<tr>
<td></td>
<td>O Psychological Evaluation/Assessment</td>
<td>Y</td>
<td>Y</td>
<td>Psychological Eval</td>
</tr>
<tr>
<td></td>
<td>O Specialty Assessment/Evaluation</td>
<td>Y</td>
<td>Y</td>
<td>Specialty Evals such as Fire Setting</td>
</tr>
<tr>
<td>Court Orders/Subpoenas</td>
<td>O CMO 14 Day Plans</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Court Orders for Information/Appearance</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Court Ordered Guardianship</td>
<td>N</td>
<td>Y</td>
<td>Dispositional Court Order</td>
</tr>
<tr>
<td></td>
<td>O Court Ordered Treatment/Eval</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Subpoenas</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Intermediate Unit</td>
<td>O IU Admission Note</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O IU Consent Form</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O IU Interventionist Supporting Document (ISD)</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

*CABS must have been completed within the last six months.*
1. Click **Add New Document** button
   - File Upload window will appear
2. Click **Select Type of Document** – Clinical
3. Click **Select Subtype of Document**
   - Clinical Summary template
   - Clinical Updates
   - Community Bio Psychosocial Assessment
   - IEP/Educational Info
   - Medical Information
   - Other Applicable Reports/Documents
   - Psychiatric Evaluation
   - Psychological Evaluation/Assessment
   - Specialty Assessment/Evaluation
4. Enter a comment into the **Comment** text box
   - Date of assessment, the specific type of specialty assessment/evaluation, applicable dates for a court order, or IEP effective date.
5. Click **Browse**
   - Clicking on the Browse button will open up the user’s local files and allow a search
6. Click **Upload**
Two Important Facts

- Uploaded files **cannot exceed 20 MB in size**;
  - Error message will be unable to complete the upload
  - Split a large document into two separate files
  - Re-scan documentation into two (or more) separate files in order to upload the information into the record
- The only documents that can be uploaded into a youth record are files with file extensions: .PDF, .BMP, .GIF, .JPEG, .JPG, .PNG, .TIF, .TIFF.
  - All other formats will be rejected and the user will need to convert their document into one of the accepted formats.

**Acceptable file formats:**

- **.PDF** – Portable Document Format
- **.BMP** – Bitmap Image File
- **.GIF** – Graphic Interchange Format
- **.JPEG or .JPG** – Joint Photographic (Experts) Group
- **.PNG** – Portable Network Graphics
- **.TIF or .TIFF** – Tagged Image Format (File)
File Naming Conventions

Make a pdf or scan the document into a pdf, .bmp, .gif, .jpeg, .jpg, .png, or .tif

Name the document as per the convention – Youth’s CYBERID - Document Type - Date Completed.

- For example, a user uploading a Transition ISD for youth 23456, which was signed on January 1, 2019 should name the file 23456 PsychEval 01012019.

Browse for the document - once a file is selected, the user will see it appear in the Selected Files area. Check the size of the document.

- Clicking the Upload button will run the upload; the user will see the progress bar and the percentage number will increase as the upload is completed.

- If the upload is successful, the user will be brought back to the youth’s Doc Tab, where the file will be listed.
Document Upload Grid

OPEN the Document - Double-clicking on a record in the grid will open up the document in a new window; users may be asked if they want to open or save the document, depending upon the type of document they have selected. The selected document may be printed by simultaneously clicking Ctrl/P.

CLOSE the Document - In order to close the document once it has been opened, the user must click on the “X” in the upper right-hand corner of the document window. If the user clicks on the back button in their browser, they will be logged out of the system.

Users will see an Images Magnification scroll bar to the right of the grid. If there is a picture file in the youth’s record, the user can utilize this scroll bar to magnify the image. The user must select the file from the grid by single-clicking on it, and then change the magnification; double-clicking on the file in the grid will then open it with the corresponding magnification.

If a document is uploaded to CYBER in error, the user must submit a written request to PerformCare using the Customer Service Request Form at www.performcarenj.org/ServiceDesk in order to have the document corrected in the youth’s record. Only PerformCare has the ability to correct uploaded documents.
Historical Access of Youth Record

**Historical Access** allows users to access, read and print youth information that was previously open and is now closed. From the Welcome Page, clicking Historical Access will bring up an alphabetical list. Clicking Face Sheet button will take the user to the youth record.
References - Links

PerformCare Training web page: http://www.performcarenj.org/provider/training.aspx

OOH Section: https://www.performcarenj.org/provider/training.aspx#ooh

Annex A Addendum Section: https://www.performcarenj.org/provider/training.aspx#annexa
  • Guide to the Annex A Addendum

General Section: http://www.performcarenj.org/provider/training.aspx#general
  • Document Upload, Face Sheet Design

Security Section: http://www.performcarenj.org/provider/training.aspx#security
  • CYBER Password Reset Functionality, Security Administrator Guide, Role Based Security

Forms: https://www.performcarenj.org/provider/forms.aspx
  • See the OOH providers section for forms: CABS (Provider version), TJCR Checklist, etc.

Clinical Criteria: https://www.performcarenj.org/provider/clinical-criteria.aspx
  • Clinical Criteria for all levels of care
Out-of-Home OOH Plan Types
SNA – Strength and Needs Assessment
DJCR – Discharge Joint Care Review (plan for transition out of CSOC)
JCR – Joint Care Review (routine 90 day plan for continued stay)
TJCR – Transition Joint Care Review (plan to transition to other OOH within CSOC)
NOCSA – Plan type for OOH that is not reviewed by CSA

Behavioral Health Services
IIC – Intensive in-Community provider
BA – Behavior Analyst
MRSS – Mobile Response and Stabilization Services
CMO – Care Management Organization
FSO – Family Support Organization
OOH – Out-of-Home Provider
CCIS – Children’s Crisis Intervention Services
PHP – Partial Hospital Provider
MST Multisystemic Therapy
FFT – Family Functional Therapy

CSOC – Children’s System of Care
PC – PerformCare
Clinical, Billing or Technical issues or questions should be reported to the Service Desk.

Click the link for the secure Customer Service Request Form

www.performcarenj.org/ServiceDesk

Complete the form by identifying:

- The Requestor’s name (person reporting the issue), agency and contact information
- Select a type of issue
- Describe the question, technical problem or issue
- Upload screenshots of the issue or identify youth records
Secure Email

Request Form replies may be communicated via Secure Email. Review the *Quick Reference Guide to Secure Email* on how to register and open secure emails.

Need Assistance?

Training questions? Email the PerformCare Training Unit:
  • PCNJTraining@performcarenj.org

PerformCare:
  • Phone 1-877-652-7624
  • Customer Service Request Form
    www.performcarenj.org/ServiceDesk

Policy and Contracting questions: 1-609-888-7200
  • CSOC Service Line Manager
  • Annex A Contracting

Important Contact Information for CSOC Providers:
  • http://www.performcarenj.org/pdf/provider/training/general-csoc/important-contact-information-for-csoc-providers.pdf
Care is the heart of our work.