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Videos

TheraNest offers great videos that are short and show you how to do things on the site. I recommend watching them and if you have questions afterwards I can help with those questions.

Logging In

- To open a TheraNest window go to: twuucc.theranest.com
- Your Wesleyan email is your user name.
- Pre-Prac students will have a temporary password and in the next few slides, we will show you how to change it.
**Agenda**

The agenda is where you will see all activity for the day in a detailed fashion.
My Profile Page and Preferences

After you log in you will be brought to this page. Where your name is you will want to click and choose “My Profile”

- If you need to change your password, go to the Change Password tab.
- **There are mandatory Preferences found on the “Preferences” tab that must be set.**
- You MUST have these selected.
- In addition, you MUST NOT synchronize your schedule to your other calendars.
Events are created for Days off, Lunches, Supervision, and Placeholders. They do not require notes. DO NOT create an event as a client. If you are trying to add a client, you must go to “Add New Client” that is covered later in here.

Schedule is covered under appointments made with clients ONLY
Settings for Calendar Preferences

- You MUST have multiple bookings turned OFF
- Make sure you are First on Staff list so you can find yourself faster

Set your schedule to only times you are open to see clients.
Adding a Client

- If Person is Already a Client Skip This Step
- Under the **Clients** TAB, you will need to click **ADD NEW CLIENT**.

Enter client’s name and select appropriate location. Click **Save & Add Case** if you want to start entering case notes now or click **Save Client** if you want to add the case notes later.
Booking a Client

- Once the person is a client, you can book them multiple ways. The two easiest ways are by the booking option inside the client’s profile or by double clicking on the open available spot.

Option 1

Option 2

Note: If you create a block for a person that is not on the client list it will be considered and EVENT and not a client. This will restrict you from being able to do notes or get credit for the session.
**Appointment Window**

1. When adding a client select a service type. Please do not have more than one Service type for each appointment.
2. To create repeat events, click on “Disabled”.
3. You can select a room and this will forbid another to book on same room for that hour. **NOTE:** This does not reserve a room in VAULT.
4. You may add notes here and they are saved within the clients’ record.

You can type part of a client’s first or last name and it will come up. If the clients name did not you, either misspelt it or they are not a client yet.

If you are seeing a Client, you must have it marked as such or you will not get credit for that hour.

**The room booking in TheraNest is what we go by, not VALT**

If there is a double booking in VAULT, let Nick know.
It is the responsibility of the THERAPIST to call the clients if they miss an appointment.

### Client Information

- Once you have added a client you will need to fill out all the information on this page, including household income if the client pays an amount that is different from the household price, put the price below it. You can only put on or the other.
To insert a family member, search for their name and then click add. They will then appear in the family area. This is for CLIENTS only (Fig 1). If they are a parent or someone who does not have their own file and just joining the session, put their name on the first page (DETAILS PAGE) at the bottom of the page under “Manage Household” (Fig.2).

- This is where you will put all the intake paperwork
- If you have a client who was seen prior to 2018 then you will scan and put this info in as well.
- The intake paperwork should be labeled “Intake”, if there is a consent, it needs to be scanned separately and labeled “consent”, if there is any release of information it needs to
be labeled “release”. Any other documents should be scanned, entered, and labeled to what it is. They need to be placed in GENERAL DOCUMENTS and not under NOTES.

To add documents, simply click on the disk icon or drag and drop. There is a 10MB limit (About 10 scanned pages) for each file. You can have multiple MB files in the document folder.

**If you do not know how to scan, look in the Handbook under scanning.**

**Client Notes**

- When making notes, please remember to put the correct day of the appointment in the box for “Date and Time”. You can then select the pull down menu and select the correct appointment time to link the notes and appointment.

- If you have more than one case for a client (Individual with one therapist and family with other) only close out your case. If you archive the file, the other therapist will not be able to access the file.
• To create multiple cases for the same file, see below. Please make sure to document the type of service for that case.

Client Treatment Plan

Behavioral Definitions is the presenting problem. The presenting problem indicates why the client is being referred to, or is receiving, behavioral health services. Presenting problems include mental health, substance abuse, intellectual disability and trauma.
Goals of a Treatment Plan

Goals are located at the bottom of the treatment plan and they automatically go to the notes section for you to select for the session. You can input as many goals as you would like. Make sure to save each time you move between these pages because they will not save if you click any links / tabs.

<table>
<thead>
<tr>
<th>Client Goals</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal #1: Wesleyan</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>Objective: Reduce Test anxiety</td>
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</tr>
<tr>
<td>Intervention: Building on Strengths</td>
<td></td>
</tr>
<tr>
<td>Intervention: Talk Therapy</td>
<td></td>
</tr>
<tr>
<td>Intervention: Supportive Relationships</td>
<td></td>
</tr>
<tr>
<td>Intervention: Stress Management</td>
<td></td>
</tr>
<tr>
<td>Intervention: Strength Focus/Utilizing</td>
<td></td>
</tr>
<tr>
<td>Intervention: Framing</td>
<td></td>
</tr>
<tr>
<td>Intervention: Processing</td>
<td></td>
</tr>
<tr>
<td>Intervention: Journaling</td>
<td></td>
</tr>
</tbody>
</table>

Closing a Treatment Plan Goal

- Once a client reaches a goal, you will need to mark it as complete. If a goal has been unsuccessful or client no longer wishes to work on that goal, you can mark it as deferred. If a client is ready to quit you, need to mark all the goals to the appropriate response.
- To close out a case the treatment plan must be in order.
# Closing Notes

When a client is finished with therapy, you need to close the notes. There may be more than one set of notes for a client if they are being seen as a couple/family. If so, just close your notes and do not archive.

## Client Notes Other

There are forms created for assessment results and blank spaces to input release of information. The forms that we used to have on paper will be listed.
Archiving

Archiving is like putting a client’s folder into the area where we have terminated clients. You cannot archive a client with open treatment plan or notes. (See notes on how to close)

Once a client is archived, you will no longer see it on your active client list.

If you have appointments in the future, you will have to delete those. Just archiving does not take them off.
Once archived, a client can be unarchived later.

Ledger / Payment

- You can input payment by creating a new invoice, then putting in the payment, even if the payment is $0 (this is the only way if the payment is $0) or you can choose to “write off” if the client do not pay when they are supposed to.
- You can also choose to put in the payment by clicking on payment on the dashboard.
- Please put the number on the receipt in the correct spot in the invoice. If it is a write off please say why (No cash, only had credit card, forgot, etc.)
Reports

Reports are a great way to find out information:

- Missing Notes
- Clients
- Client types and how many sessions
- Client retention rate
- Missing Assessments (for intakes)
- How many Assigned / Closed Cases

There are more reports than these, but these you will use most often.
Most used report will be the Missing Notes Section. You will need to put in the specific date and your name.

**Missing Progress Notes**

**About This Report**

This report identifies kept appointments for which no progress notes have yet been entered. You can enter notes directly from this report by clicking the Enter Notes button.

Learn more in this in-depth article.

<table>
<thead>
<tr>
<th>Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>From</td>
</tr>
<tr>
<td>04/01/2018</td>
</tr>
<tr>
<td>To</td>
</tr>
<tr>
<td>04/30/2018</td>
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</table>

<table>
<thead>
<tr>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nick Mims</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>--All--</td>
</tr>
</tbody>
</table>

Tips & Do’s/Don’ts

• SAVE is your best friend. You always want to be hitting save.

• If you are seeing a client who is part of a family, do not hit archive on a client because you are finished.

• Put “BLOCK” down for a break in the day or if you are off for a day, you are normally scheduled. Please do not use the all-day event because it is not as visible as putting the BLOCK event in.

• If you are going to be out for a day or week, put it in the schedule ASAP. We tend to get busy and forget.

• If you get a client and you forgot to reschedule your client that hour, it is YOUR responsibility to call the new client and schedule.

• It is NOT acceptable to text or have lengthy conversations with clients from the TWCCC. Your offsite may allow this but we do not. Keep any conversations you have short.
How to Create Progress Notes

*Please Note: The workflow for creating Notes is slightly different when a client has multiple cases and a therapist can access more than one case. We will discuss that below also. The first part addresses a single client with a single case, which is usually the case.*

While you can create a progress note at any time by clicking “Notes” next to the client's name on the client list, the easiest way is to tie the note to a specific appointment by starting from the Agenda.

Once an appointment is scheduled, it will appear on the Agenda (like the one shown above).

If the appointment has passed, [Use the Missing Progress Notes Report to find all sessions that are missing a Progress Note.](#) Alternatively, simply go to the desired date in the top left corner of the Agenda.

Click "Add Progress Note" on the Agenda and you will be taken to the notes section for the client, and automatically placed in a new Progress Note with the date and time of the session shown on the appointment section. Select the therapist that completed the client's appointment to the right of Therapist(s).
When entering information into the **Mental Status** and **Risk Assessment** areas, you can type in the fields and select from the list that appears, or enter in a new phrase.

You will notice that **Diagnostic Impressions** from the Initial Assessment & Diagnostic Code tab and a **History of Treatment Goals** also appear. You can add or edit these by clicking the Treatment Plan tab or the Initial Assessment & Diagnostic Codes tab.

Once you start typing in the note, a message will appear in the top right corner letting you know that a draft is being saved. If you were to leave the page without pressing the green **Save** button at the top right, you can still retrieve the note by clicking "View Draft Copies of This Note". Loaded drafts disappear after the note is finally saved.

Make sure to connect the date of the notes to the date of the session under **Service Date/Time and Appointment** pull down menu. If this is omitted it could lead to you showing up with missing notes on all reports. This happens when you do the notes on a different day other than the day of an appointment.
Supplement Material / Appendix

What Happens When My Client Has Multiple Cases?

Multiple cases for the same client are rare. Please make sure you have not mistakenly created multiple cases instead of new notes. When clicking "Add Progress Note" from the agenda you will be presented with a case window where TheraNest will ask you which case you wish to write a note.

If you have mistakenly created multiple cases, click Notes under Actions on the Case Notes page to see the progress notes in each case. If you have entered notes mistakenly in an extra case, you can either copy or paste them over to the correct case (on its Progress Notes tab), or pull a PDF of those progress notes to upload into the client's Clinical Documents section. Then you can delete the extra case.

If you did intend to have multiple cases, select the radio button next to the desired case and click, "enter notes for selected case."

We recommend that you name the cases to make it easier to know where your notes go. You can do this on the Case Info tab (first tab in the case note section) after clicking Notes.

Now cases will show up with different case names in the case list to reduce confusion.
To enter notes in any of the cases, click **Details**, and then click **Progress Notes** tab.

**Note:** If you have multiple cases assigned to different therapists, each therapist will only see the case(s) assigned to them in this list and will not see other cases assigned to another therapist.

**Allowing the Agenda to Know the Default Case for an Appointment**

while you can have multiple cases for a client, the Agenda can still be able to go directly to the appropriate case when you click **Add Progress Notes** on the Agenda.

You can do this by appropriately setting the service type on the **Case Info** tab of the case (first tab), and the assigned staff under the **Assign Staff** tab of the clients main details/demographic section.

Click the **Case Info** tab of the case and set the service type (optional).
Click the **Assign Staff** tab in the client's main details/demographic section, and set the assigned staff for the specific case.

Now when you set a schedule on the calendar, it will use the staff member assigned to know which case note to open when you click **Add Progress Note** from the Agenda.

In the above case, it will open the progress note for case assigned to when you click **Enter Note**. However, if Dr. Jackson is assigned to both cases, it will go back to the Case List page. Setting the service type (if different) may then be required if you want the agenda to automatically go to the right note.