

Avatar Training

Quality Management
For
Managers and Supervisors

Overview of Avatar Quality Management

You are a Unit Chief, Supervisor or Manager; you have many demanding responsibilities, meetings and staff to oversee. Your clients are complex and your focus is on positive outcomes of care that meet your client's needs. You manage your staff and all of the Administrative, Fiscal and Clinical Avatar documentation requirements in an effective and efficient manner but it can be *so overwhelming*. Where do you start? What do you do? Who Do You Ask for Help? What Corrective Actions Must You Take? There's Got to be a Better Way!

Well, this Quality Management training is meant to help and provide you with the skills to tackle these issues. You will learn "***The Best Way***" to:

A. Perform Compliance Review of Caseloads

1. Overview *all* client cases through review of the **Documentation at a Glance Report**. You can view the client caseload for each clinician at your program, if treatment plan and assessment documentation is due/coming due, the coordinator, the date of last service (with no service for 90, 120 or 180 days highlighted).
2. Use Other Useful Reports to overview client cases; the **Program and Clinician Caseload Reports** include the last service date, primary diagnosis and any co-occurring diagnosis and provide quick views of basic caseload status. The **60 Day Documentation Due Report** may also be helpful to view caseloads.

B. Perform Quality Review of the Client's Chart

1. Get an in depth snapshot of a client's Avatar Chart through the **Dashboard Report**.
2. Review the Chart; Find documents in the Client's chart through Chart Review.

C. Take Corrective Actions:

1. Finalize DRAFT documents; close, transfer and/or assign Care Manager(s) or Coordinator (s).
2. Understand "TO DO", Notification, and Alert functions.
3. Assure current and accurate client data through the Update Client Data Form, Client Relationships and CSI Admission document.
4. Understand Error Correction functions.
5. Review utilization through the Units of Service Report.
6. Revisit Chart Review for the Legal Release of Documents through Reports and Abstracts
7. The Urgent Care Plan Bundle; Urgent Care Plan and Alert

The BHRS QM process of review is to start with the "**big picture**" view, looking at **documentation due** and if program **caseloads are correct**. The **Dashboard view of individual client records** is a more "**focused**" drill down view of **other important client information** that shows as **current** in Avatar.

There may be no "one size fits all" as the "Best Way" for *all* managers. The strategy, suggestions and tips may be *our* "Best Way" in BHRS QM. However, we are confident these on going trainings will provide you with what you need to know and do for effective and efficient program management. Continued encouragement and support will help you find the "Best Way" that works for **you** and **your leadership style**, a "Best Way" that depends on the *size of your program*, the *number and types of staff*, the *types of services* you provide and the *number and unique clients you serve*. Your continued feedback can help us, help you!

A. Perform Compliance Review of Caseloads

We will show you many Avatar reports that provide Program, Caseload, Clinician and Client information. Some reports may contain the same or similar information.

Is there a “Best Way” to monitor and audit using Avatar reports? Is there a “methodology” for selecting which Avatar reports to use? Is there a certain order and/or frequency that should be followed for monitoring? Who can perform monitoring and audit functions?

There are different types of reviews and monitoring activities:

In a **Compliance Review**, you will be able to quickly notice the compliance/non-compliance items by the presence/absence of items in boxes or that have green and/or red alerts. You will be able to notice trends if there are many of the same type of assessment or treatment plan documents out of compliance for many staff or if the non compliance items are connected to the caseload of specific clinicians.

- **The Documentation at a Glance Report and the Caseload Report are used for Compliance Reviews and will provide an overview of “where things are at”.**

The priority is to clean up caseload information so that caseloads are current and assigned appropriately.

Finalize documents that are in draft, develop treatment plans and assessments for those that are overdue or coming due.

Involve Clinicians in compliance reviews by having them monitor **their** caseload for compliance with due dates, consents, client information updates.

- **Most importantly you can use the Documentation at a Glance Report as a *proactive tool for monitoring that all required items and clients in the caseload are current and accurate.***

In a **Quality Review**, you are looking at *client specific information*. You can choose to select client records where there were no compliance deficiencies. You can select at least 1 client per clinician for this type of review. This type of review and the reports used are described in **Section B, Perform Quality Review of the Client’s Chart**

You will notice improvement once monitoring and oversight activities are consistent!

You can develop a peer review audit process and have clinicians audit another clinician’s caseload!

You can establish specific monthly and quarterly reviews to help keep on track and not fall behind!

BHRS QM will guide and support you through this process!

A. Perform Compliance Review of Caseloads

Example of a Caseload Compliance Review Tool

Date of Review				
Type of Review				
Review Area	yes	no	n/a	comment
Documentation at a Glance Are Caseloads for each clinician current and correct Are Clients missing from report, have they been added? Are there Clients that need to be discharged have they been? Are there any items “boxed” or in “red” or “green” and have they been assigned for correction? Are draft documents assigned to be FINALIZED? Is the Last service date active within the past 6 months? Are Anniversary Dates and Start Dates correct? Does each client have an assigned care coordinator? If Diagnosis has “No Entry” or Deferred has this been assigned for resolution?				
Transfer Do clients need to be transferred to another program, or clinician?				
Discharge Have clients with no services for more than 90, 120 and/or 180 days been assigned to be closed or discharged? <ul style="list-style-type: none"> • Is there a reason to remain open? • Have there been attempts to re-engage client? 				
Utilization Units of Service Do you notice trends in billing across clients or clinical staff? Is the Units of Service Report accurate for billed/non billed services?				
Error Correction If you notice any errors, have they been assigned for correction? Have previous requests for correction of errors been resolved?				
Notifications, Alert, To Do Have Clinicians been notified of need for correction? Have Alerts for missing documentation been created? Has YOUR “To Do” list been reviewed and cleared? Have any Unnecessary Alerts been Disabled?				
Day Treatment Authorization Report Have All services have been authorized?				
Clients Re-Opened within 45 Days Have any clients returned within 45 days of closing? Has the Closing been rescinded?				



You can create a Favorites folder for Reports/Tools suggested for monitoring:

Compliance Reviews

- Documentation at a Glance
- Caseload Report
- Notifications/Alerts
- Transfer/Discharge Bundle
- Assign/Reassign Practitioner
- BHRS Assign/Remove from Caseload
- BHRS Units of Service Summary Report

Quality Reviews

- Client Dashboard
- Client Relationships
- Update Client Data
- CSI Admit
- BHRS Diagnosis
- Urgent Care Bundle
- Progress Notes
- Error Correction



Suggested Process for Conducting Review/ Feedback Loop/ Progress Measures

“How” to Review Process

- You should run the **Documentation at a Glance Report** about once a month for ***your own benefit to view and understand*** the *current status of documentation due and last service dates* for each clinician’s caseload at your program. ****TIP: Pull the report on a Monday or Friday if possible when Avatar is not as busy.***
- You will ***see the scope of correction necessary.*** The **priority** should be on correction for those clients with no service for 60, 120 or 180 days. You can review, distribute, or send notification to clinicians though team meeting, supervision or require that clinicians run their own report that they initial/return back to you validating corrections have been made.
- You can focus your reviews on specific areas, like DRAFT, Consent, Treatment Plan, Assessment, and/or Progress Notes.
- Review **outcome** of corrections to caseload, documentation due, consents. Set a threshold for each quarter...how many clients/clinicians to review; is the need for corrections decreasing?
- Select clinicians with documentation *in compliance* to be part of Peer Review to audit the caseload of another clinician.

Correction Process

- Close/Transfer cases, if a case needs to remain open when there is no service being provided document in a progress note.
- Assign and assure that DRAFT documents get Finalized.
- Review Reports in Supervision with Clinician
- Review/Distribute Reports in Team Meeting
- Have the clinician who is responsible, correct/add/delete for their own caseload.
- Have an admin correct demographic data through the Client Relationships and/or Avatar Client Update document.

*If you want change, measure it.... benchmarks, goals, rewards, and correctional measures that you develop with Staff. “People will do what’s **inspected**, not expected”!*

1. Documentation at a Glance Report

The Documentation at a Glance Report will help you to *identify* and *complete documentation that is due or coming due*.

Documentation at a Glance Report:

Go to Avatar CWS→ Reports→ Documentation Status Reports→ Documentation at a Glance

You can request this report by *location, by staff, or by staff and location*.

The **Documentation at a Glance** report really does represent the **“Best Way” to view documentation due or coming due**.

- It provides a *comprehensive view of a clinician’s caseload*, total number of clients in the caseload, the client MR#, name, date of birth, address, phone, the client’s admit and anniversary date, the name of the care coordinator, the status, date, type and completed by for the treatment plan and assessment, the code/description of the primary diagnosis and the date of last service.
- A notice will appear in **red in the Last Service** date column if there has been **no service for more than 90, 120 and 180 days**.
- If an assessment or treatment plan is *past due* it will appear in **red and wrapped in a box** indicating **“attention is needed”**.
- If an assessment or treatment plan is *coming due* it will appear in *green and in a box* indicating *“attention is needed”*.
- If you are a Unit Chief, Supervisor or Manager and request the report by program, the report will appear on the screen and the names of all clinicians will appear on the side of the report. You can click on a clinician’s name to view their caseload.

Documentation At a Glance Report

FOR BULLINGALL AT ALL LOCATIONS

BULLINGALL

410401 SOUTH COUNTY ADULT

Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930000 TESTONE,TEST DOB: 5/8/1962 222 W 18 STREET JYO TEST AGAIN SAN MATEO, CA 94403 (P) 650-239-1172 (C) 123-456-8888 (H) 888-1234	05.01 10/6/2011		Draft Plan Type: Initial Status: Draft Start Date: 10/19/2011 Next due date: 4/30/2012	Adult Special Assmt Status: Final Date: 12/16/2011 Completed By: JEANNINE MEALEY	307.81 (ICD9) TENSION HEADACHE	2/9/2012

416800 EAST BAYSHORE ADULT

Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930003 TEST,TESTWO DOB: 4/30/1969 123 MAIN STREET SAN MATEO, CA 94403	11.01 5/20/2010		Draft Plan Type: Annual Status: Draft Start Date: 1/23/2012 Next due date: 11/1/2012	Adult Annual Status: Draft Date: 5/11/2010 Completed By:	No Entry	9/23/2011 OVER 90 DAYS

Documentation at a Glance Report Headings:

Client - Includes the Client Name, Mental Health #, Date of Birth, Address and Phone Numbers. *Have the clinician check that this information is correct. Complete update client data document if applicable. To Update Client Data: Avatar CWS→ Other Chart Entry → Update Client Data.*

Anniversary Date/Admit Date – Includes the current Anniversary Date on file in Avatar and the Admit Date to the program.

Care Coordinator – This is the person assigned as the Care Coordinator in Avatar. *Is this current/accurate? If there is none, assign. To Assign a Care Coordinator: Avatar PM→ Client Management→ Client Information→ Assign/Reassign Practitioners*

Treatment Plan - Shows the *current* Treatment Plan Status.

- Information includes the type of plan- initial, update or annual, the plan status- final or draft, date of the plan and who completed the plan.
- If the plan is **wrapped in a box**, it indicates that the plan is either **OVERDUE** or **COMING DUE**; *these items need to be addressed first.*
- Items appearing with *no box* are in compliance.
- If a client is *newly admitted*, this section will tell you the *date their first Treatment Plan is due.*

Without a current finalized treatment plan services cannot be billed!

Assessment Status – Shows the *last assessment* for the client.

- Information includes the type of assessment- admission or annual, assessment status- final or draft, date of assessment, and who completed the assessment.
- **The Physician Initial Assessment (PIN) is included as a valid assessment if it was completed within the window period for the annual assessment update.**
- If an assessment is *left in draft* then it will have a **draft indicator in red** and wrapped in a box.
- **Reassessments are due by the indicated anniversary date of each calendar year.**
- **Shows the LOCUS/CALOCUS information**

Primary Diagnosis - Displays *current* diagnosis code and *description* for the client in the identified program.

- If **“No Entry” a diagnosis for this client in this program needs to be completed using BHRS Diagnosis.**

Is the diagnosis present accurate?

To Add/Delete a Diagnosis: Avatar CWS→ Assessment→ BHRS Diagnosis

Last Service - Displays the *last service date* and *indicates in red* if service is *more than 90, 120 and 180 days old.*

2. Other Useful Reports to Perform Compliance Review of Caseloads

Program/Clinician Caseload Report:

You can request a Caseload Report through Avatar CWS→ Reports→ Caseload Reports→ and request by *Program* or *Clinician*.

If you select **Program** the report does display the caseloads by program and also by clinician. A total Program Client Count and then a Clinician Client Caseload Count is listed. If you select **Clinician**, the report displays only the clinician's caseload with the same count information.

Caseload Reports include the client name, MR #, sex, age, and now, the co-occurring diagnosis, the date of the next 26.5 if applicable, if the client is on medications, the primary diagnosis and the last service date.

Things to consider:

Is there any field in "red" indicating missing information?

Look at the last service date; is there active service within the past 6 months?

Is the clinician assignment of cases on this report correct?

Is there a deferred diagnosis that shows on this report?

Correction to the Caseload may have occurred after review of the documentation at a Glance Report. Running and over-viewing the Caseload Report ensures that all cases at your program are active. If any of the fields in the Caseload Report need to be **updated**, (a diagnosis or co-occurring diagnosis), then have the clinician update using the BHRS Diagnosis through Avatar CWS→ Assessment→ BHRS Diagnosis. If information needs to be **added**, (a client **to** a caseload), and/or **deleted**, (a client **from** a caseload), this function can be delegated to the admin or the clinician through Avatar PM→ Client Management→ Episode Maintenance→ BHRS Assign to Caseload **or** BHRS Remove from Caseload.

Please run another Caseload Report to be sure the necessary changes have taken place.

The Caseload Report reflects whatever input has been entered into Avatar. An accurate Caseload report can help determine caseload assignment when a new client is admitted. A clinician's caseload that includes active clients with services provided within the last 6 months, and includes current primary/co-occurring diagnoses meets BHRS QM compliance standards.

60 Day Documentation Due Report:

Go to Avatar CWS→ Reports→ Documentation Status Reports→ 60 Day Documentation Due

This report can be requested by *location*, by *staff* or by *staff and location*. The report shows clients recently admitted that have documentation due within 60 days of their admit date and shows only those clients where any field has something due. The report includes the client MR#, client name, admit date, the 60 day doc due date which would include the assessment and treatment plan documents and the assignment of a CCP.

If there is no CCP assigned or if documentation is due, assign to responsible staff!

Since the coordinator usually does the CCP and assessment documents, it is necessary to assign the CCP or negotiate with another program for a CCP to perform the assessment. For more detail about *other documents that may be due* request the next report: **Dashboard Report**.

B. Perform Quality Review of the Client’s Chart

You have been able to view the “big picture”. Now, it’s time to drill down and “focus” in on *client specific chart documentation*. The cases you select for the *Quality Chart Review* will **have** a current assessment and treatment plan. You are now reviewing the *appropriateness* and *quality of care*, assuring that *standards for documentation and care are being met*.

Example of Quality Chart Review Tool

Date of Review				
Type of Review				
Name of Reviewer				
Client				
Clinician Responsible				
Review Area	yes	no	n/a	comment
Dashboard – is Client Relationships Are the relationships, phone numbers correct and up to date? All Demographic info current? Has information been updated? Are there items identified as “CHECK STATUS”? Have they been checked?				
Assessment Assessment was completed on time and final, co-sign if appropriate? Describes functional impairments, signs & symptoms exhibited by client and match Diagnosis?				
Diagnosis Primary Diagnosis - Meets Medical Necessity? Is current and appropriate, co-signed if appropriate? Not deferred longer than 6 months? Appropriate for symptoms, behaviors & functional impairments exhibited by the client?				
Treatment Plan Was completed on time? Has co-sign if appropriate? Meets medical necessity & is consistent with diagnoses? Includes substance abuse goals, if applicable? Measureable Goals/Objectives and address barriers to client’s success? At least one goal addresses Primary Dx? Client has signed/plan was given or progress note describes why not?				
Consents for Treatment, Release of Info, & Medication (if needed) All 3 types of consents are current & entered in Avatar? Is an updated in Avatar consent needed? Are med consents consistent for all meds currently prescribed? (yearly)? Release of information (yearly- don’t forget school)				
Urgent Plan/Alert Is there an Urgent Plan or Alert that needs to be Disabled/Created?				
Financial				


Are any financial updates needed?				
Medications				
Medications are current, client is compliant?				
Review Progress Notes for Standards and Quality				
<ul style="list-style-type: none"> ▪ Are there Billed service notes for Non-Billable activities? ▪ Are Codes for Service Type Correct – any notes up coded? ▪ Are Location Codes correct? ▪ Does the service provided/documented match with the Duration for the service? Too long? <p>Any non-billed service that could have been? Are staff interventions appropriate? Is there evidence that the client is responding/benefitting from the service? Are there too many acronyms that you can't understand? Are all caps, abbreviations used? Are other staff/clients mentioned? Have error corrections been submitted? Resolved?</p>				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				

1. The Dashboard Report

The Client Dashboard Report is used for Quality Reviews because it is comprehensive and includes information and/or links to all areas of the client record. It is an *effective* and *efficient* snapshot of your client's critical clinical information in one page.

Avatar CWS → Reports → Client Dashboard. It is recommended that you request the Client Dashboard from the Chart Review screen.

The Dashboard Report is designed to be viewed "live" in Avatar and has **links to more information** once you click on any of the headers in blue.



SAN MATEO COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES
CLIENT DASHBOARD

Note:
 *Items Displayed in **RED** need attention
 *Items Displayed in **GREEN** are coming due

Client Demographic Information 2

TESTONE.TEST (930000) D.O.B. (5/8/1962)

Gender: Male SS #: 222-55-9999 Age Today: 49
 Address: 222 W 39 STREET Text Object CP Coordinator: BULL,INGALL
 SAN MATEO, CA 94403 Anniversary Date: 05/01
 (h) 650-589-1172 Treatment Consent: 9/21/2011
 (c) 123-456-8888
 (w) 555-1256

Language TONGAN AKA 1 : test.joe
 Preferred Language: Unknown / Not Reported AKA 2 : rodney mytest
 Ethnicity: Unknown / Not Reported Living Situation: Homeless, no identifiable residence
 Race: American Indian or Alaska Native,
 Asian Indian, Black or African
 American, Cambodian, Guamanian

URGENT CARE PLAN ON FILE

Start Date: 2/15/2012
 CONCERNED ABOUT CLIENT HE FELL 3 DAYS AGO think he s self medicating and is taking too much please observe
Caution: should not drive

Emergency Contact Info: (Contact Type: G=Guardian; E=Emergency; K=Next of Kin) [View all Contacts](#)

Name	Type	Relationship / Contact Info:	Date	Person / Organization
Bull Mama	G E	Mother (h) 650-550-1212 (w) 650-573-2563 (c) 415-647-1942	11/3/2011	TESTING 123
Bull PAPA	G E K	Father (h) 415-123-1234 (w) 650-445-2266 (c) 650-456-4567	8/3/2011	MICHELLE TESTONE
Bull Lotta		PCP (h) 416-555-1212		
SHEETS - COUNTY PROBATION LORRIE	E	Parole/Probation Officer (w) 650-222-3333 (c) 650-333-2222	2/7/2011	ingall
Testone Marla	G K	Daughter (h) 415-555-1212 (w) 408-555-1212 (c) 650-555-1212		

Authorization For Use of PHI 5

Date	Person / Organization
11/3/2011	TESTING 123
8/3/2011	MICHELLE TESTONE
2/7/2011	ingall

Assesmnt Status 6

Due on 5/1/2012

Current Medications (information is up to by 24 hours out-of-date. Please check Infoscriber for up-to-date medication profile) [Allergy Info](#)

Order Date	Refills	Drug / Dose / Prescriber / Pharmacy
1/18/2012	0	Adderall XR ; - 10 mg, ERC, PO (1)ea Dr. Phil aj, Robert Pharmacy: Walgreens Drug Store 00063
11/7/2011	0	Celexa ; - 40 mg, TAB, PO (1)ea QAM , Brendan Pharmacy: Ted's Village Pharmacy
10/24/2011	0	Prozac ; - 20 mg, CAP, PO (2)ea QAM Prescriber: Scherer, Brendan Pharmacy: Ted's Village Pharmacy

School Based Mental Health Info: 8

26.5: Yes Date: 11/9/2010
 Closed Date: 6/26/2012
 School District:
 JEFFERSON ELEMENTARY

Current Open Episodes / Primary Dx / Tx Plan Status (as of 04/03/2012) [Other Assigned Staff](#) [Dx History](#) [Tx History](#) [Episode Hx](#) [Progress Notes](#)

EP	Admit	Program	Primary Clinician	Psychiatrist	Dx	Last Service	Tx Plan Status
38	12/15/2011	417000 COASTSIDE ADULT	MEALEY,JEANINE	MEALEY,JEANINE	296.24	2/9/2012	Due on 5/1/2012
37	11/10/2011	410405 FAIR OAKS INTERFACE	SHEETS,LORRIE		No Entry		Due on 5/1/2012
36	10/6/2011	410401 SOUTH COUNTY ADULT	BULL,INGALL	SHEETS,LORRIE	307.81	4/3/2012	Due on 5/1/2012
31	3/9/2011	007000 WESTWOOD MANOR	FRIEDMAN,MICHELE		799.9A		No Tx plan Required
25	11/15/2010	410301 CENTRAL COUNTY ADULT	SHEETS,LORRIE		301.3	2/9/2012	Due on 5/1/2012
24	11/15/2010	410101 NORTH COUNTY ADULT	SHEETS,LORRIE		295.04	6/1/2011	Dra # 8/12/2011 - 8/12/2012
23	10/7/2010	410311 YOUTH TRANSITION SERVICES	SHEETS,LORRIE		No Entry		Dra # 6/16/2011 - 6/16/2012

4/3/2012 4:54:12PM

CONFIDENTIAL PATIENT INFORMATION
See California Welfare and Institutions Code Section 5328

Page 1 of 2

Details of the 9 Main Sections and 7 Links of the Dashboard Report:

1. **Client Demographic Information** – Includes information on the following: Client Name, MR#, Date of Birth, Age, Address, Phone Numbers, Race, Ethnicity, Language & Preferred Language, Gender, Social Security Number, CCP Coordinator, Anniversary Date, Living Situation, AKA Names, Treatment Consent Date (Avatar Consents only at this time.)

⚠ *If date for consent is absent, check to see if there is a scanned version. If none, than an **Avatar consent** is NEEDED. The “Best Way” is to create and enter into Avatar any paper/scanned consent. Check **all** demographic info for accuracy and with other reports, update if NEEDED.*

To Create a New Consent: Avatar CWS→ Consent→ Application for Services and Consent to Treatment

2. **Urgent Care Plan on File** – If the client has an Urgent Care Plan on file it will display in the upper right corner. (This report will only pull the **most recent, open** Urgent Care Plan.)

⚠ *Check to see if the Urgent Care Plan is still necessary. Disable if NEEDED!*

To Disable an Urgent care Plan: Avatar CWS→ Other Chart Entry→ Urgent Care Plan

3. **Guarantor Info** – Shows the **current payer information** on file.

⚠ *Check to see this is accurate, update if NEEDED.*

To Update Financial: Avatar PM→ Client Management→ Account Management→

4. **Emergency Contact Info** – Displays **information that has been entered in the Client Relationships** form in Avatar.

- Individuals included have been flagged as one of the following: Guardian (**G**), Emergency Contact (**E**), and/or Next of Kin (**K**).
- Individuals who are designated as urgent contacts (e.g., Probation Officer, Primary Care Physician, etc...) are also listed

[View All Contacts](#) – *This link will display all collateral contacts entered into Client Relationships.*

To Enter Information into Client Relationships: Avatar PM→ Client Management→ Client Information→ Client Relationships.

⚠ *Check with clients that all information is current and accurate, update if NEEDED.*

5. **Authorization For Use of PHI** – This section displays the **current status of the consent form, “Authorization for the Use of PHI.”** Consents for “use of PHI” for the **last 18 months** will display and items that are over a year old will display in **RED** to indicate that the consent has expired.

To Enter a New Consent for Authorization for Use or Disclosure of PHI: Avatar CWS→ Consent→ Authorization for Use or Disclosure of PHI

6. **Assessment Status** – Displays the **current assessment status**. If the client’s assessment is *almost due* it will display in **GREEN**; assessments that are **overdue** or left in “**Draft**” will display in **RED**.


⚠ *Check to see that assessment information is current, update/finalize if NEEDED.* “Check status” this means no document of this type in Avatar. Shows LOCUS/CALOCUS Information

NOTE: Documents left in draft are not considered complete, or a legal part of the client record!


7. **Current Medications** – Displays *currently prescribed medications from Infoscriber*. Information includes the date prescribed, # of refills left, medication name, dosage, prescriber, and pharmacy (pharmacy phone number will be added to this report later). Prescriptions that have been discontinued will not display in this section.

NOTE: InfoScriber information can be up to 24 hours old.

[Allergy Info](#) – This link will display all medication and non-medication allergies that have been entered into Infoscriber.

 *Check that this information is current, update if NEEDED.* You must have an Avatar account to update information in Infoscriber! Check with client to be sure they are taking what is prescribed.

8. **School Based Mental Health Info** – Displays current information regarding authorized School Based Mental Health services (formerly 26.5 Info.)

 *Check that this information is current, update if NEEDED.*

9. **Current Open Episodes / Primary Dx/ Tx Plan Status** – This section displays information about the **client's open episodes**. Information for *each episode* includes the *episode number; admit date, program name, primary clinician, psychiatrist, primary diagnosis, last service date, and treatment plan status*.

To View ALL Episodes: Avatar PM → Client Management → Episode Management → BHRS Episode Display

10. **Treatment Plan Information** – If the client's Treatment Plan for an episode is *almost due*, it will display in **GREEN**. Treatment Plans that are *overdue or left in "Draft"* will display in **RED**. "Check status" this means no document of this type in Avatar.

 ***There must be a current treatment plan in order for client services to be billed!***

10. **Last Service Date** – Displays in **RED** if the last service occurred *more than 90 days ago*.

Additional links in this section:


[Other Assigned Staff](#) – Displays the *names and roles of other staffs* that have this client on their caseloads and includes each staff member's program/team.

[Diagnosis History](#) – Displays the *complete history of primary diagnoses by episode*.

[Treatment History](#) – Will *display 90 days of service information by episode*.

[Episode History](#) – Displays client's *episode history since 7/1/2004*. (Run time up to 1+ min.)

[Progress Notes](#) – Displays *6 months of progress notes*. (Run time up to more than 1 min.)

 **Why is this The "Best Way"? This is an efficient way to view client specific data on *one page*; the status of the documentation and links to other places for more information *all from one screen!***

2. Chart Review

Review the Chart and Find Documents in the Client's Chart through Chart Review

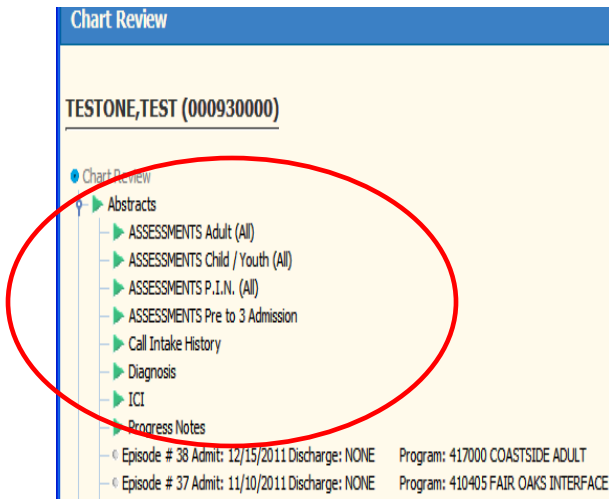
You can find documents in the Client's Chart by looking at Chart Review.

Chart Review shows a quick view of the client's entire chart.

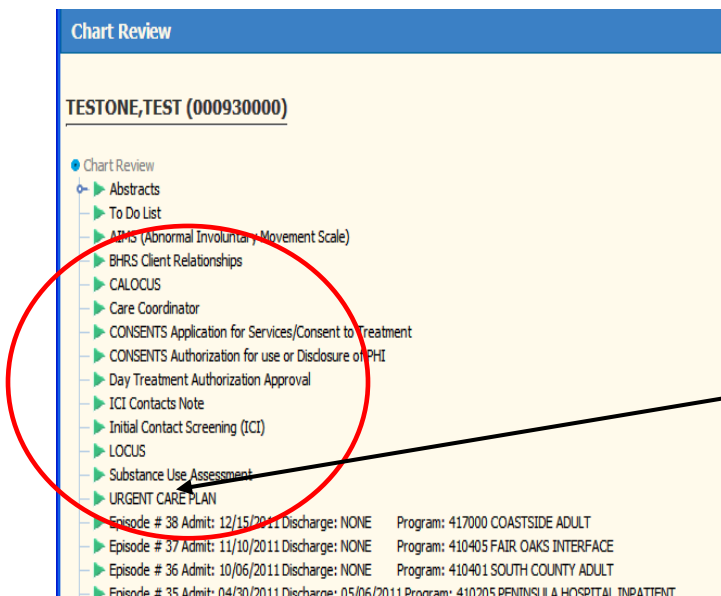
You can view episodes of treatment; **only finalized documents** within episodes will be present.

To open Chart Review another report or form must be open.

You can print from the Abstracts section in Chart Review.

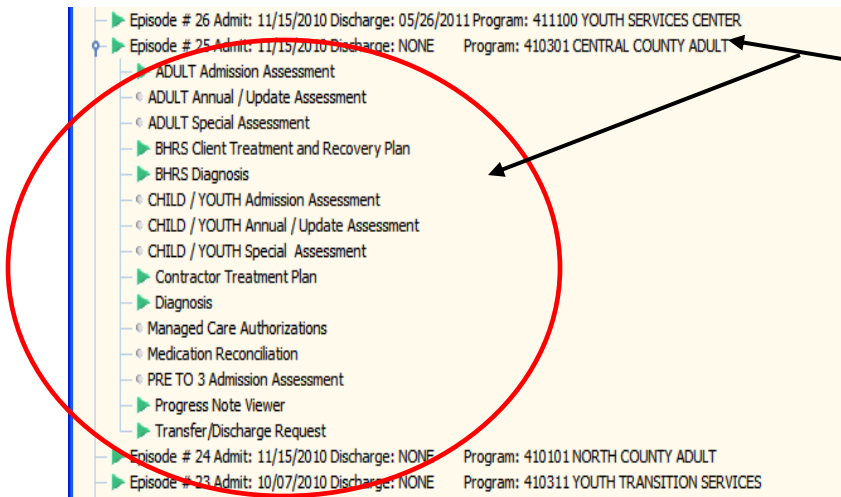


Abstracts: These are **reports** that pull together information from multiple areas of the Avatar system. Assessment Reports pull **all** the assessments on file for a client in reverse chronological order. Reports from Abstracts will include *all information and companion documents*. (Assessment includes MSE, Diagnosis, LOCUS, Substance Abuse Assessment if indicated- *all will show for date selected.*)



Client Level Documents: These are forms connected **only to a client**, not any particular program or episode, e.g. Consents, LOCUS/CALOCUS, ICI's, Substance Use Assessment.

FYI: The Urgent Care Plan will always sit above the last episode in the Chart review screen.



This shows documents for Episode 25

Episodic Level Documents: Episodes are displayed by episode number, admit and discharge dates, if the episode is open then NONE will show for the discharge date. Episodic documents include treatment plans, assessments, and diagnosis.

How to Open and View Chart Review Documents:

- A **Green triangle** by a document means there is **more information**. Click to open.
- A small circle, means there is **no** information.
- Clinical documents now have “print ready” reports associated with them.

Documents Section of Chart Review

You can view documents that have been scanned into the client’s Avatar chart.

The Documents section is located below Abstracts and To Do List when the Chart Review window opens. Double click on Documents- you can select to view:

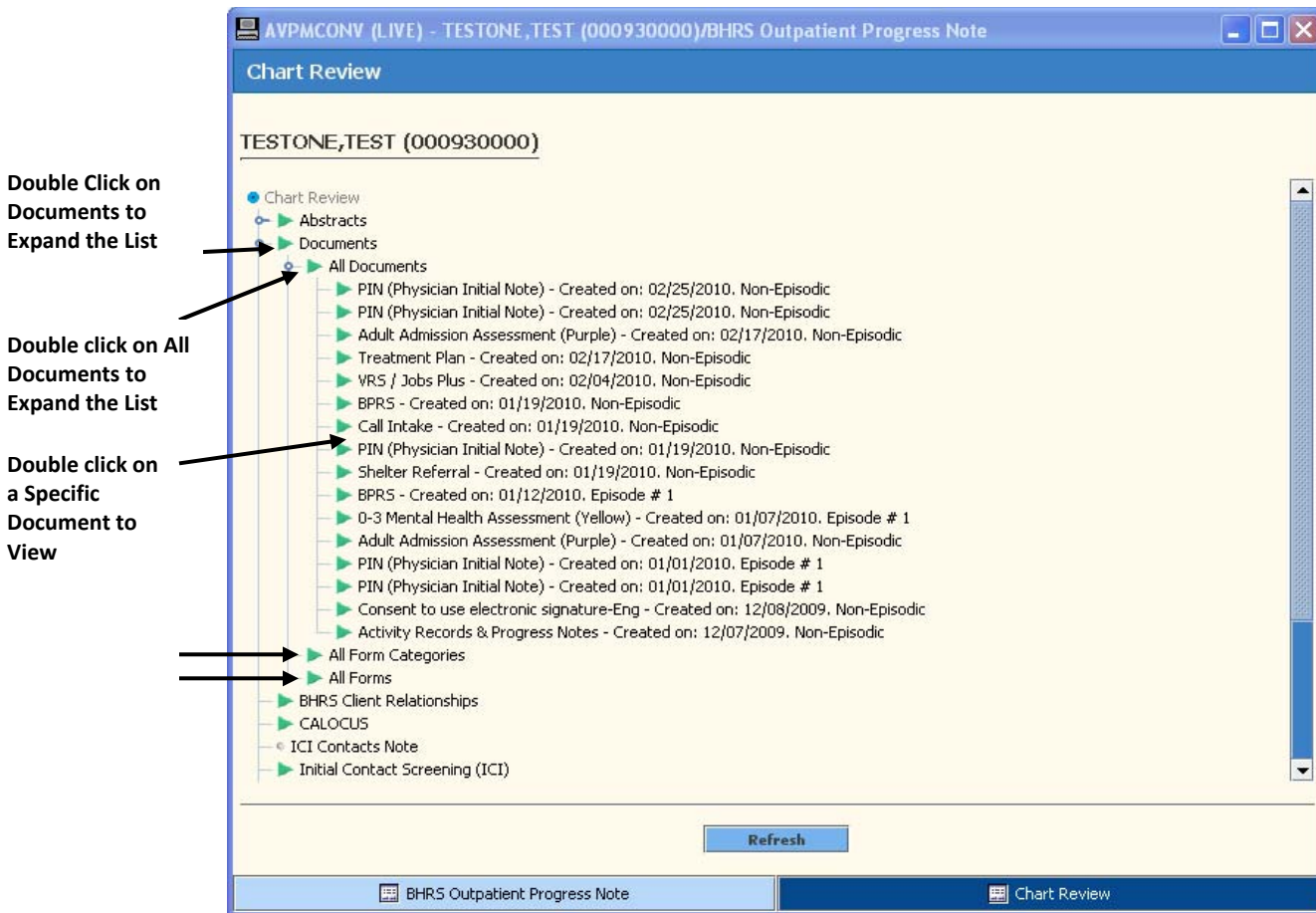
All Documents (All Scanned Documents) - A very long list, documents not sorted by date or type

All Form Categories (Documents by Category) – Documents are listed by category, click to open a category to find a document

All Forms (Documents by Form Names) – Documents by form name in alphabetical order, a very long list

When you are looking for the Treatment Plan in Chart Review, the green arrow in the episode may indicate BHRS Client Treatment and Recovery Plan. This refers to the old plan.

If there is a green arrow next to Plan Dates and Information this refers to the new Client plan implemented 9/1/2011



Scanned Documents:

You may be searching for a document that has been scanned into the Client's Chart.

To Find Clinical Document Viewer: Avatar CWS→ Document Manager→ Clinical Document Viewer.

To view scanned documents, your selection options are to search/view all documents that have been scanned for:

- A specific client for a specific episode
- A specific client for all episodes
- By a specific staff or by all staff
- By the entire chart, legal medical record or category/form
- You will be able to view documents one by one and can print from the Clinical Document Viewer

Why is this The Best Way?

Because you now you know **how to find finalized documents** that have been entered into the client's Avatar chart which you **can print and release legally if there is authorization to do so.**

C. Take Corrective Actions

1. Finalize Draft Documents, Close, Transfer, and/or Assign Care Manager(s)

A. FINALIZE: Documents in Draft as Priority

For any document that needs to be Final, select the client, select the document, select the episode; At the pre-display window, select the document and then select edit, the document will open. Make your entry and then submit as final.

If a co-signature is necessary for an assessment or treatment plan, save as draft, send to supervisor where indicated on the form, send an e-mail to supervisor to inform co-sign is needed ASAP for any outdated documents.

Progress notes are no longer required to be saved as draft. They can be submitted as final with the “send to” the supervisor selected from the drop down as indicated. If the supervisor agrees with the note, there is nothing more to do. The note is final.

If the supervisor wants some change to the note, it will be sent back to the clinician in Draft form and the note will appear as a clinician’s to do item. The clinician will make the changes; submit as final with the “send to” to the supervisor. The process will repeat.

Go to Documents in Chart Review; Review Progress Notes for any left in draft or Run a Progress Note report for Episode and Date Range. Finalize any DRAFT Progress Notes.

B. Correct the Caseload by Closing or Transferring a case and must request from the supervisor.

Avatar CWS→ Other Chart Entry→ Transfer/Discharge Bundle

The Transfer/Discharge Bundle includes the BHRS Diagnosis which must be completed in order to discharge a client from the caseload. The Transfer/Discharge request has 4 tabs. Tab1, Transfer/Discharge Request:

AVPMLIVE (LIVE) - TESTONE, TEST SR (000930000)/Transfer/Discharge Request

Page 1 of 1

TESTONE, TEST SR (000930000) Episode: 23 Date Of Birth: 05/08/1962; Sex: Male

Transfer / Discharge Request Supervisor Authorization Status Receiving Clinic Approval Status Notify

Type of Request
 Discharge Transfer

Transfer To

If client requests services in future
 Return Directly to Region
 Re-evaluated by ACCESS
 Unable to Determine At This Time

Current Treatment Information and Alerts

Transfer / Discharge Reason

Requested By Process Search

Name/ID Number Unique Practitioner ID

Date of Request 04/24/2012 T Y

Option Complete

Transfer/Discharge Request Chart Review

The **Requesting Clinician** completes information on the **first tab, Transfer/Discharge Request tab**. Type of Request, Discharge or Transfer is selected;

If Transfer, Enter Transfer to location; Select if client requests services in the future, if applicable;
 If Discharge, Select if client requests services in the future, if applicable;
 Enter Current Treatment Information and Alerts;
 Enter Transfer/Discharge reason;
 Process Search entry, requested by you;
 Date of Request fills in automatically

Click the submit button; the clinician’s request will appear on the Supervisor’s My To Do List

Once the submit button is selected, the BHRS Diagnosis document appears.

- In anticipation of approval by the supervisor, complete the BHRS diagnosis.
- If your discharge request is later approved, *remember to create a progress note documenting the discharge and the reason for it.*

Tab 2, Supervisor Authorization Status:

This tab is **completed by the supervisor after the supervisor has reviewed the Discharge/Transfer Request** submitted by the clinician that is on their To Do list.

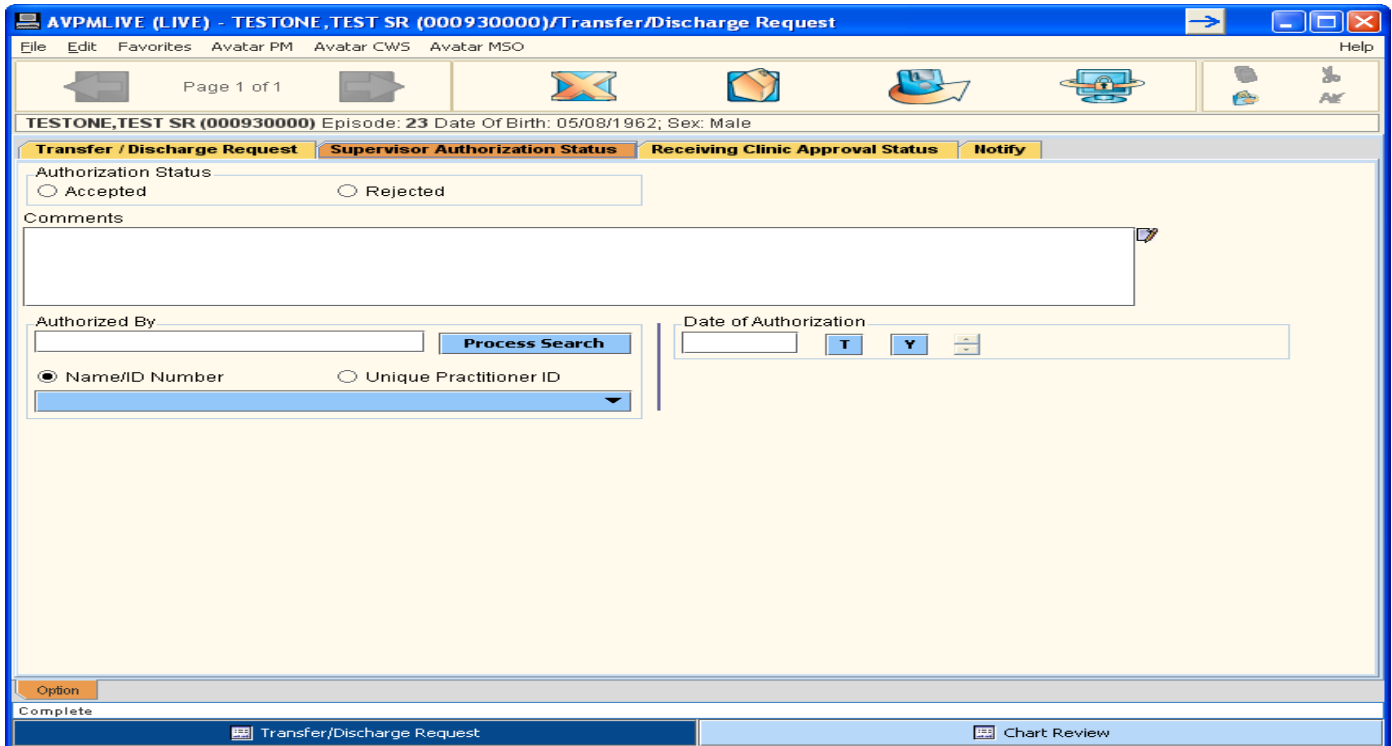
The supervisor will select the Authorization Status: Accepted or Rejected. If rejected enter Comments in the Comment box.

Enter authorized by through Process Search entry;

Enter Date of Authorization

Submit

Is this a transfer request, the supervisor navigates to Tab 4 Notify and selects the supervisor of the receiving clinic and clicks submit.



Tab 3, Receiving Clinic Approval Status:

The **Request of Transfer by the clinician's supervisor will appear on the receiving Clinic's Supervisor "To Do" List.** After reviewing the request and information related to the transfer, the receiving Clinic's Supervisor completes Tab 3. The receiving Supervisor selects if they Accept or Reject the Transfer Request; Comments are entered if rejected; Process Search entry is made for Approved/Rejected By; Date of Approval/Rejection is entered; Process Search for "Assigned To" clinician at the receiving transfer location is entered.

The receiving Supervisor navigates to Tab 4, Notify, and enters the name of supervisor who made the request and if possible, the clinician who made the original request and submits.

The screenshot shows the 'Request Approval' tab in the AVPMLIVE (LIVE) - TESTONE,TEST SR (000930000)/Transfer/Discharge Request interface. The patient information at the top is TESTONE,TEST SR (000930000) Episode: 23 Date Of Birth: 05/08/1962; Sex: Male. The 'Request Approval' section includes a 'Status' field with radio buttons for 'Accepted' and 'Rejected'. Below this is a large 'Comments' text area. There are two 'Approved / Rejected By' fields, each with a 'Process Search' button and radio buttons for 'Name/ID Number' and 'Unique Practitioner ID'. A 'Date of Approval/Rejection' field is also present. At the bottom, there is an 'Assigned To' field with a 'Process Search' button and radio buttons for 'Name/ID Number' and 'Unique Practitioner ID'. The 'Option' dropdown is set to 'Complete'.

This is **Tab 4, Notify** and is **completed by the clinician's supervisor to accept or reject the discharge and/or transfer of a case.** Tab 4 is also completed by a receiving clinic's supervisor when accepting and/or rejecting a case for transfer to notify the Supervisor and/or Clinicians who submitted the request.

The screenshot shows the 'Notify' tab in the AVPMLIVE (LIVE) - TESTONE,TEST SR (000930000)/Transfer/Discharge Request interface. The patient information at the top is TESTONE,TEST SR (000930000) Episode: 23 Date Of Birth: 05/08/1962; Sex: Male. The 'Notify' section includes a 'Send for Approval' text area and a 'Send for Approval Outgoing Comments' text area. The 'Option' dropdown is set to 'Complete'.

The **Transfer/Discharge Request BUNDLE** to correct the caseload **also includes the BHR5 diagnosis** that must be entered for any client transferred/discharged.

Sometimes “To Do List “notifications will continue after the supervisor has authorized and sent the Transfer/Discharge document along. The Check boxes on the notification list do NOT clear when the form is saved. You must clear the User Notification selections to avoid sending redundant notifications

If **bundle** is selected the BHR5 Diagnosis document will appear once the Transfer/Discharge request is submitted. **To do the BHR5 Diagnosis: Avatar CWS→ Assessments→ BHR5 Diagnosis**

C. Correct a Caseload by BHR5 Assign to Caseload.

BHR5 Assign to Caseload: Avatar PM→ Episode Management→ BHR5 Assign To Caseload

1 Tab, Caseload Assignment, Page1 Adds a Clinician to a Treatment Team

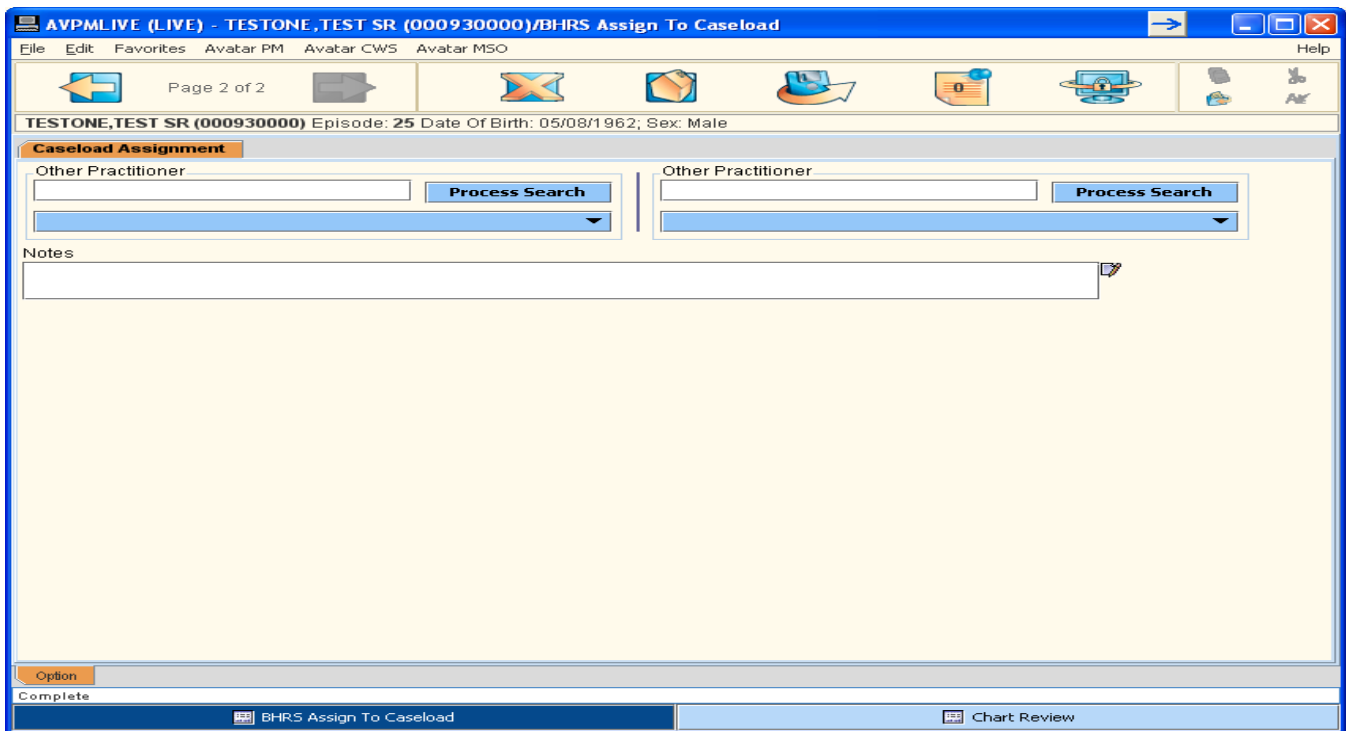
The screenshot shows a web application window titled "AVPMLIVE (LIVE) - TESTONE,TEST SR (000930000)/BHR5 Assign To Caseload". The browser address bar shows the URL. The page content includes a header with "Page 1 of 2" and navigation icons. Below the header, the patient information is displayed: "TESTONE,TEST SR (000930000) Episode: 23 Date Of Birth: 05/08/1962; Sex: Male". The main form area is titled "Caseload Assignment" and contains several sections for adding team members:

- Initial Assignment Date:** A date field set to "04/24/2012" with "T" and "Y" buttons.
- Case Manager/Other:** A text input field, a "Process Search" button, and a dropdown menu.
- Family Partner/Other:** A text input field, a "Process Search" button, and a dropdown menu.
- Nurse/Other:** A text input field, a "Process Search" button, and a dropdown menu.
- ARM Clinician/Other:** A text input field, a "Process Search" button, and a dropdown menu.
- Other Practitioner:** A text input field, a "Process Search" button, and a dropdown menu.

Each of these sections also includes a "Notes" field with a text area and a small icon. At the bottom of the form, there is an "Option" tab and a "Complete" button. The footer of the application shows "BHR5 Assign To Caseload" and "Chart Review" buttons.

Client must be active in My Caseload, Process Search for team member, add a note to explain the assignment including the reason for the assignment and the assignment date. Click Submit.

Caseload Assignment Page 2, if needed!

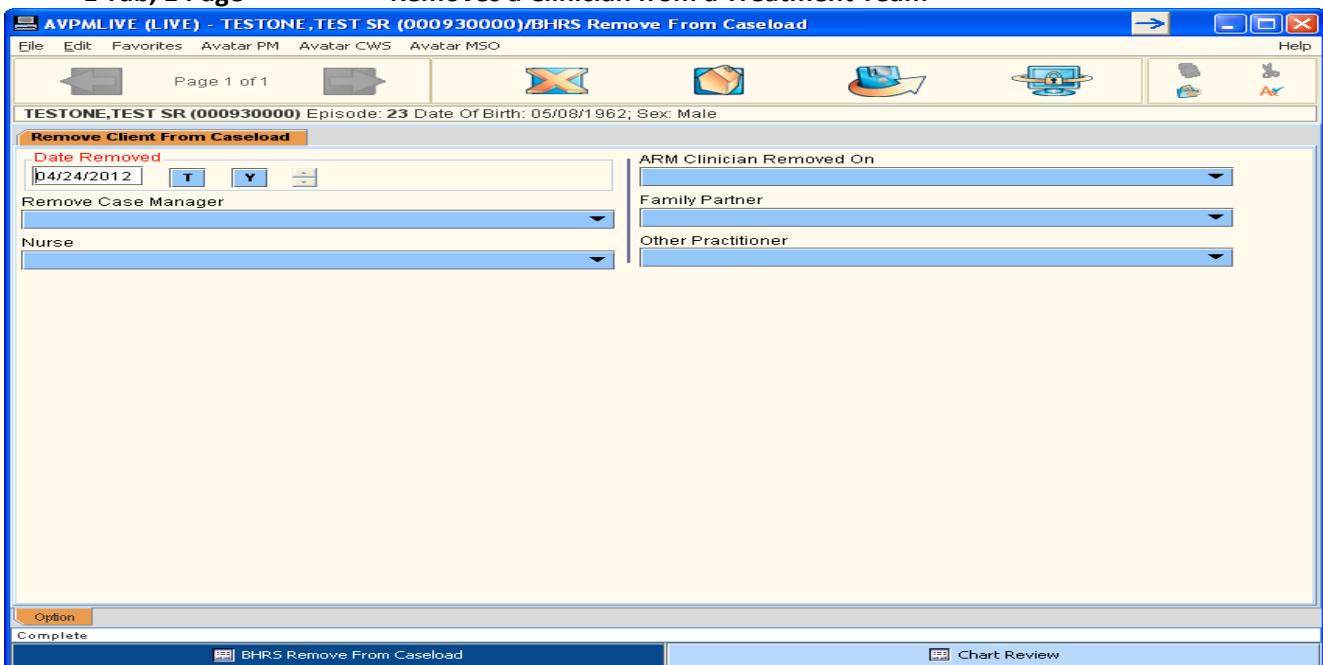


D. Correct a Caseload by BHRS Remove from Caseload

BHRS Remove from Caseload: Avatar PM → Client Management → Episode Maintenance → Remove from Caseload

1 Tab, 1 Page

Removes a Clinician from a Treatment Team



Client must be active in My Session. In blue drop down field, click the name of the clinician once; press the [F5] key on the keyboard to remove the clinician's name. If there is a note related to the team member, delete it. Click submit to save the change

E. Correct a Caseload by Caseload Assign/ReAssign Practitioner

Avatar PM → Client Information → Assign/ReAssign Practitioners → Attending Practitioner

I Tab, 1 Page

AVPMLIVE (LIVE) - TESTONE, TEST SR (000930000)/Attending Practitioner

Page 1 of 1

TESTONE, TEST SR (000930000) Episode: 36 Date Of Birth: 05/08/1962; Sex: Male

Attending Clinician Assignment Form

Date Of Assignment

Time Of Assignment

Attending Practitioner

Process Search

Name/ID Number Unique Practitioner ID

Practitioner Type

Option

Complete

Attending Practitioner

Chart Review

F. Correct a Caseload by Discharging Clients

Discharge Client: Avatar PM → Client Management → Episode Management → Discharge (Outpatient)

Enter information on the Discharge tab and add a comment if appropriate. Click Demographics tab, enter any changes to the client's demographic information; Click Submit to save the changes

C. Take Corrective Actions

2. “To Do”, Notifications and Alert Functions

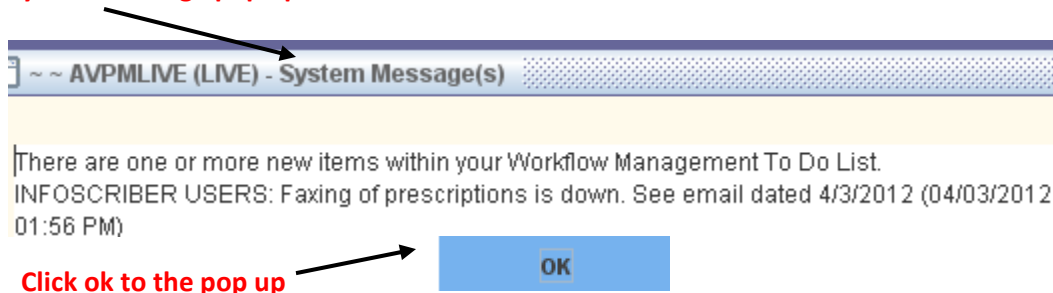
A. Workflow – The Function of the “To Do” List

The “To Do” List or “My To Do List” is considered a Workflow Management Tool. The “To Do” list helps you keep track of, view and manage Draft documents that need to be completed and submitted as FINAL. Only finalized documents are considered part of the client’s formal electronic medical record and appropriate for billing; the To Do function makes sure to remind you of a document’s status. To be sure you are current and up to date with finalizing and obtaining co-signatures for your documentation always set your “preferences” to have your Avatar homepage open with the “To Do” screen. References for this are on page_____ and in Appendices_____

1 System Message Pop Up:

When you log on and open to Avatar, you may see there is a **system message pop up** that states **“There are one or more open items within your Workflow Management To Do List”**. This lets you know there are draft documents to be completed and finalized. You can click “ok” to the pop up.

System message pop up



B. “To Do” Draft Documents:

- The “To Do” list is arranged by date with the most current at the top.
- There can be multiple documents that were submitted as DRAFT on the same date that need to be finalized; until you open the to do item you will not know if the date represents a single or multiple documents that need to be finalized.
- As documents get reviewed and finalized they will fall off or clear from the “To Do” list.
- An item on the To Do list shows by time submitted, type of document, client name/ID#, comments or specifics about the document and the clinician/staff who submitted the document.

C. “To Do” Co-Signature:

The Avatar “Workflow” feature is also used when a document must be approved or co-signed by a supervisor before it can be submitted as FINAL. Trainees are able to look at their To Do List to track documents sent for co-signature and/or track documents returned from a supervisor.

This is true for the treatment plan and assessment documents. Once a document that requires a co-signature is submitted as DRAFT, a “To Do” list item is generated for the supervisor responsible to review, approve/co-sign the document so that it can be Finalized. When the supervisor co-signs and finalizes the document, no further changes to the document can be made. If the supervisor does not

approve/co-sign the item because there is some change (s) to be made, the supervisor will send the item back to the clinician. The clinician will receive this document back as a "To Do" list item with a message from the supervisor of what needs to be done. The document must then be re-submitted to the supervisor for approval/co-sign so it can be finalized.

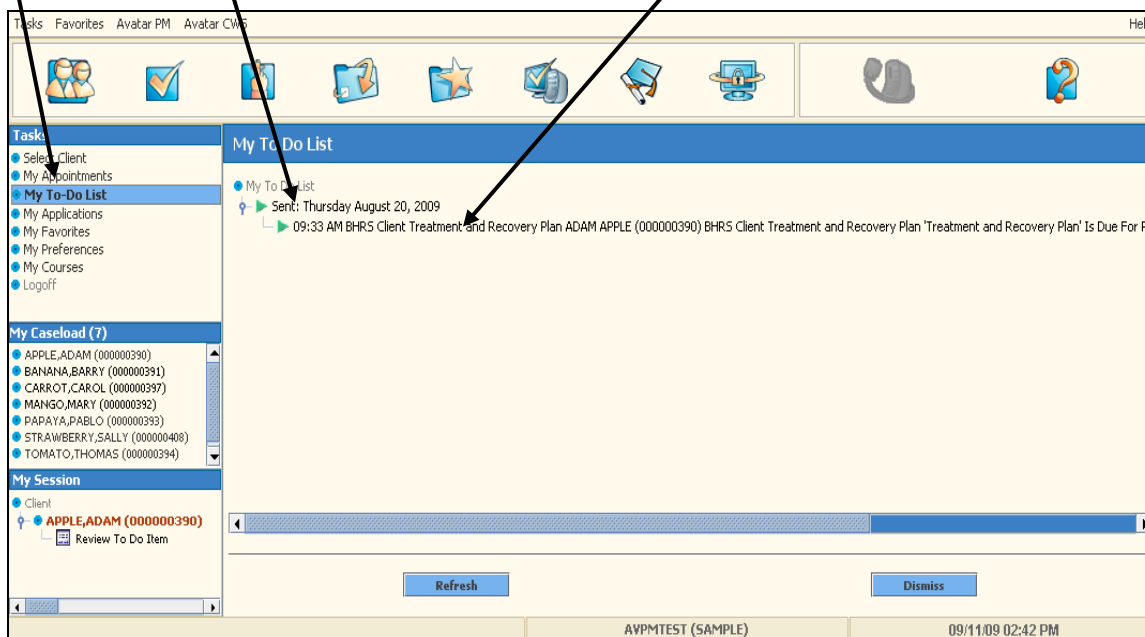
D. Viewing the Contents of a To Do Item:

- Right click on the green triangle of a To Do Item and three choices are presented:
 - Enter Post it Note** – this is NOT used
 - Enter Option** – click this, and the DRAFT document that created the "TO Do" entry will open. The document can be completed and submitted as Final. The entry will automatically be removed from the "To Do List" once the screen is refreshed. To refresh, click refresh on the bottom left hand side of the homepage.
 - Open** – click this, and the "Review To Do Item" report will open; users can manually clear the entry.

Click the My To-Do List

Double-click on date to see items needing your attention.

Right Click on an item and select 'Enter Option' to directly open the screen that needs attention



E. Review To Do Items:

If you just need to **review** an item on the To Do list, you can double click on the item, then click View Detail. Once the item is viewed, click the reviewed checkbox under the red **Set To Do Item to Reviewed**, then submit.

Review To Do Item

To Do Information

Date Sent : 03/20/2012
Time Sent : 01:00 AM
Sent By : TEMPORARY SYSTEM ADMINISTRATOR
Option : Client Treatment and Recovery Plan (New)

Client Treatment and Recovery Plan (New) 'practice number two' Is Due For Review On 05/01/2012

Set To Do Item to Reviewed

Reviewed

View Detail

View Detail provides a view of the document in report form through Crystal reports. No changes will be able to be made to the document in this view.

To refresh and see that the item has cleared, click refresh on the bottom left hand side of the homepage. The To Do List feature saves time and is less tedious for users. This is a short cut to navigating through menus, or episode selections to get to a Draft item to complete.

My To Do List Items can also be viewed from Chart Review

B. Notifications

Avatar CWS → Other Chart Entry → Notifications

AVPMLIVE (LIVE) - TESTONE, TEST SR (000930000)/Send Notifications

File Edit Favorites Avatar PM Avatar CWS Avatar MSO

Page 1 of 1

TESTONE, TEST SR (000930000) Date Of Birth: 05/08/1962; Sex: Male

Send Notifications

Date of Notification

Today Yesterday

Choose the Recipient/s and Enter a Message

A To-Do List item will be sent to the recipient/s

Recipients

Recipients Outgoing Comments

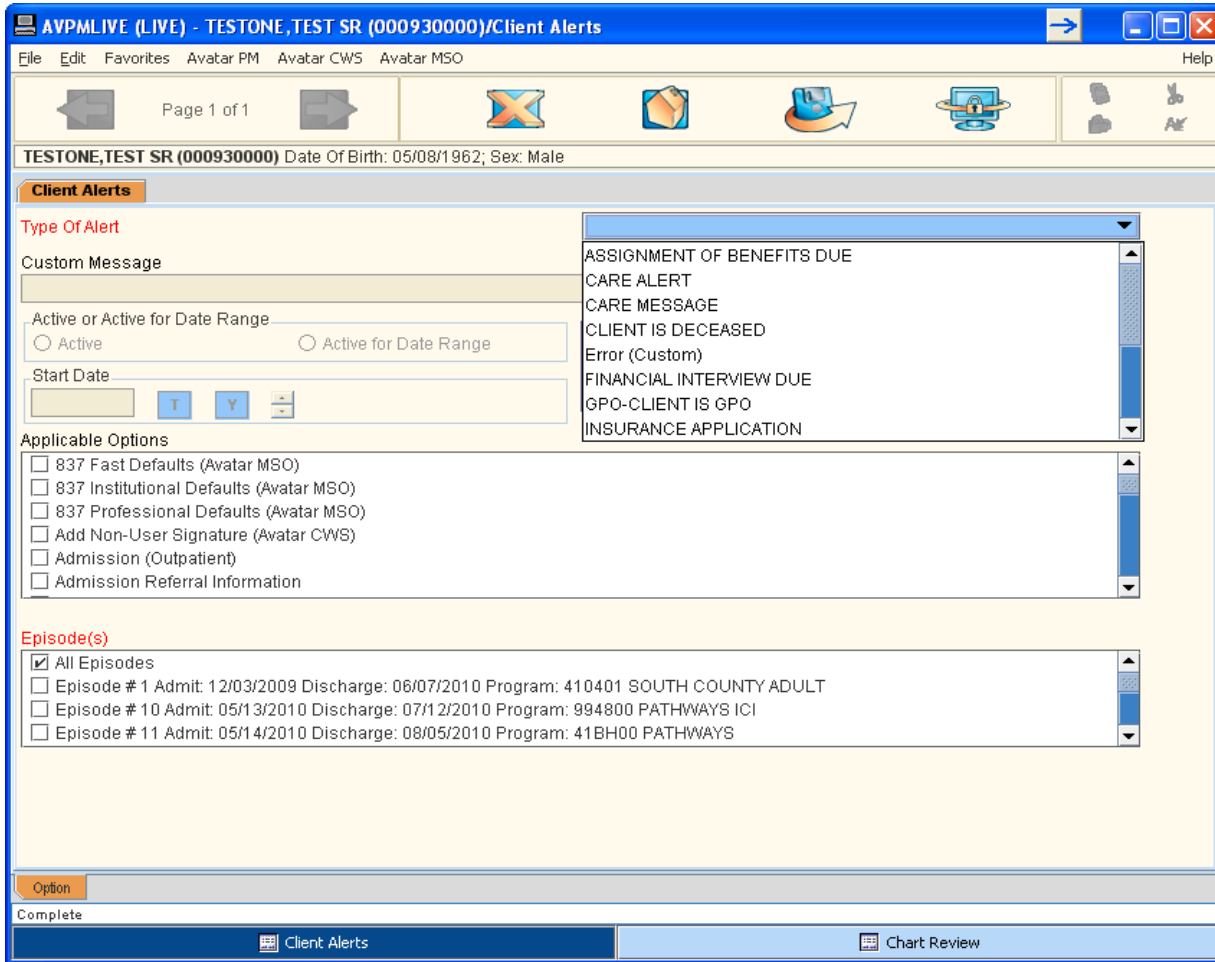
Option

Complete

Send Notifications Chart Review

Client you want to send a notice about should be active in My Session. Select ADD; check one or more checkboxes in Recipient field for staff you wish to send notification to. In Recipients Outgoing Comments field type message that will appear in recipient's to Do List.

C. Alerts
Avatar CWS → Other Chart Entry → Alerts



C. Take Corrective Action

3. Assure *Current and Accurate Client Data*

A. Update Client Data

Generally Clients' demographic information is recorded by Admins but Clinicians also have a form Update Client data. The form is the same for both users.

Avatar PM → Client Management → Client Information → Update Client Data *or*
Avatar CWS → Other Chart Entry → Update Client Data

The form has 1 Tab, 2 Pages

Tab 1 Page 1

The screenshot shows a web browser window titled "AVPMLIVE (LIVE) - TESTONE, TEST SR (000930000)/Update Client Data". The browser's address bar and menu bar are visible. The page content includes a navigation bar with "Page 1 of 2" and several icons. Below this is a header for the client: "TESTONE, TEST SR (000930000) Date Of Birth: 05/08/1962; Sex: Male". The main form area is titled "Update Client Data" and contains the following fields and options:

- Client Name:** TESTONE, TEST SR
- Client Last Name:** TESTONE
- Client First Name:** TEST
- Client's Middle Initial:** [Empty]
- Suffix:** Sr Jr III IV V VI
- Prefix:** [Dropdown menu]
- Sex:** Female Male Other Unknown
- Date Of Birth:** 05/08/1962
- Social Security Number:** 222-55-9999
- Alternate Social Security Number:** [Empty]
- Smoker:** Unknown If Ever Smoked
- Client's Email Address:** [Empty]
- Client's Address - Street:** 1245 BYE STREET
- Client's Address - Zipcode:** 94402
- Client's Address - City:** SAN MATEO
- Client's Address - County:** SAN MATEO
- Client's Address - State:** CALIFORNIA
- Client's Home Phone:** 650-589-1172
- Client's Work Phone:** 555-1256
- Client's Cell Phone:** 650-258-3698
- Primary Phone:** Work Phone Cell Phone Home Phone
- Primary Language (Access Only):** TONGAN
- Client Race (Access Only):** Samoan
- Ethnic Origin (Access Only):** Not Of Hispanic Origin

At the bottom of the form, there is an "Option" section with a "Complete" button. The browser's status bar at the very bottom shows "Update Client Data" and "Chart Review" buttons.

Activate the client in My Session, Update client data on pages 1 and 2. Click Submit to save changes

Update Client Data Tab 1 Page 2

AVPMLIVE (LIVE) - TESTONE,TEST SR (000930000)/Update Client Data

File Edit Favorites Avatar PM Avatar CWS Avatar MSO Help

Page 2 of 2

TESTONE,TEST SR (000930000) Date Of Birth: 05/08/1962; Sex: Male

Update Client Data

Place Of Birth	<input type="text"/>	Alias 3	<input type="text" value="TESTY"/>
Country Of Origin	United States	Alias 4	<input type="text"/>
Maiden Name	<input type="text"/>	Alias 5	<input type="text"/>
Marital Status	Separated	Alias 6	<input type="text"/>
Education (Access Only)	12 Years or GED	Alias 7	<input type="text"/>
Employment Status (Access Only)	Part time <35hrs per wk (no...	Alias 8	<input type="text"/>
Occupation (Access Only)	Farming, Forestry, And Fishi...	Alias 9	<input type="text"/>
Alias	<input type="text" value="test,joe"/>	Alias 10	<input type="text"/>
Alias 2	<input type="text" value="rodney mytest"/>		

Option

Complete

Update Client Data | Chart Review

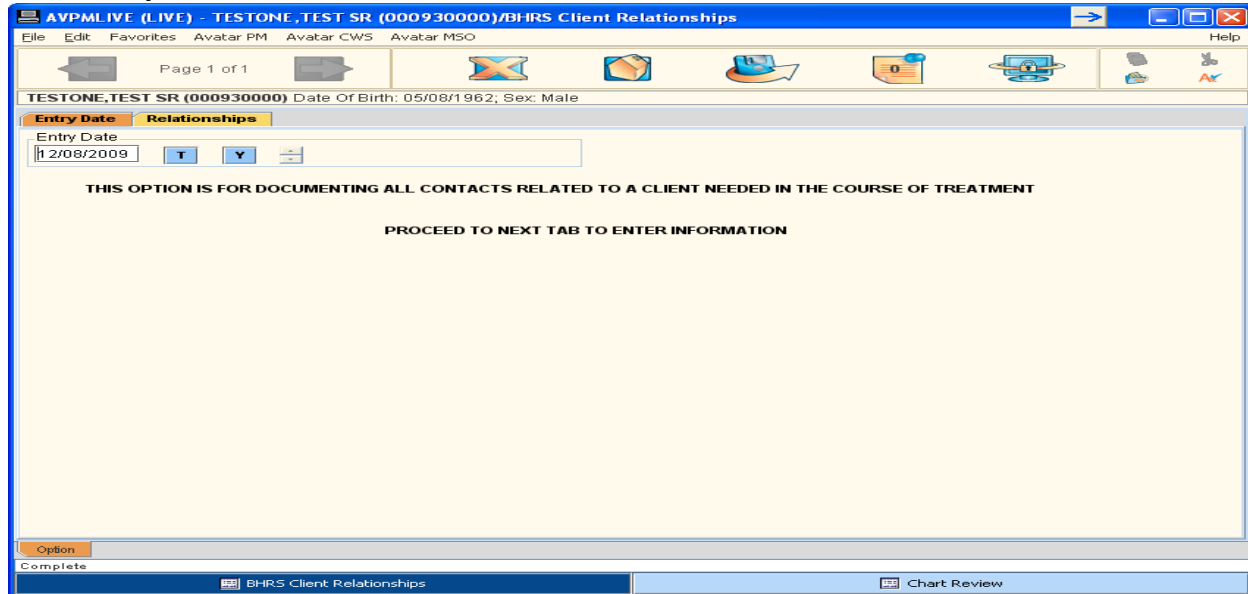
Activate the client in My Session, Update client data on pages 1 and 2. Click Submit to save changes

B. Client Relationships

Avatar PM → Client Information → BHRS Client Relationships

Client Relationships is the repository of **all non-treatment team people involved in the Client's life**. The Client Relationship document allows entry of Emergency Contact, Parent/Guardian, Next of Kin, Spouse/Partner, Teacher, Parole Officer, Conservator, Sibling, Family Members, Primary Care Physicians; anyone you feel is important to have information about and exist within the client record. **The client's Face Sheet and the Dashboard Report pull from this document.**

Tab 1 Entry Date



If information isn't correct or reported in Client Relationships, it can't be reported out. Information is entered and stored in **multiple entry tables**. You need to add a new row to the table and then complete the related data fields below the table so that you do not overwrite existing information.

Make sure the client is active in MY Session, then

To **Add a Row**, Click the **Add New Item** button. Do not enter new data without adding the new row or the new data you enter will overwrite existing information in the active highlighted row of the table!

To **Edit a Row**, select the row you want to edit, click **Edit**, the related fields below the table become populated and you can make changes directly in the fields.

To **Delete a Row**, click on a row to select it, click **Delete selected item** to remove the row from the table. A message will appear verifying that you want to delete the selected item, click YES.

If you Add, Edit or delete be sure to click Submit so the changes will be saved.

Do not leave blank rows in the table; blank rows must be deleted before you can save the form!

Client Relationships; Tab 2, Relationships, Page 1

To Add, click new item, a new row appears, complete fields on Page 1 and 2

To Edit, highlight the row, click edit, fields on Page 1 and Page 2 populate, change then submit

Client Relationships; Tab 2 Relationships; Page 2

 You can also Update Client Information through CSI Admission (PM- Client Info- CSI Admission

C. Take Corrective Actions

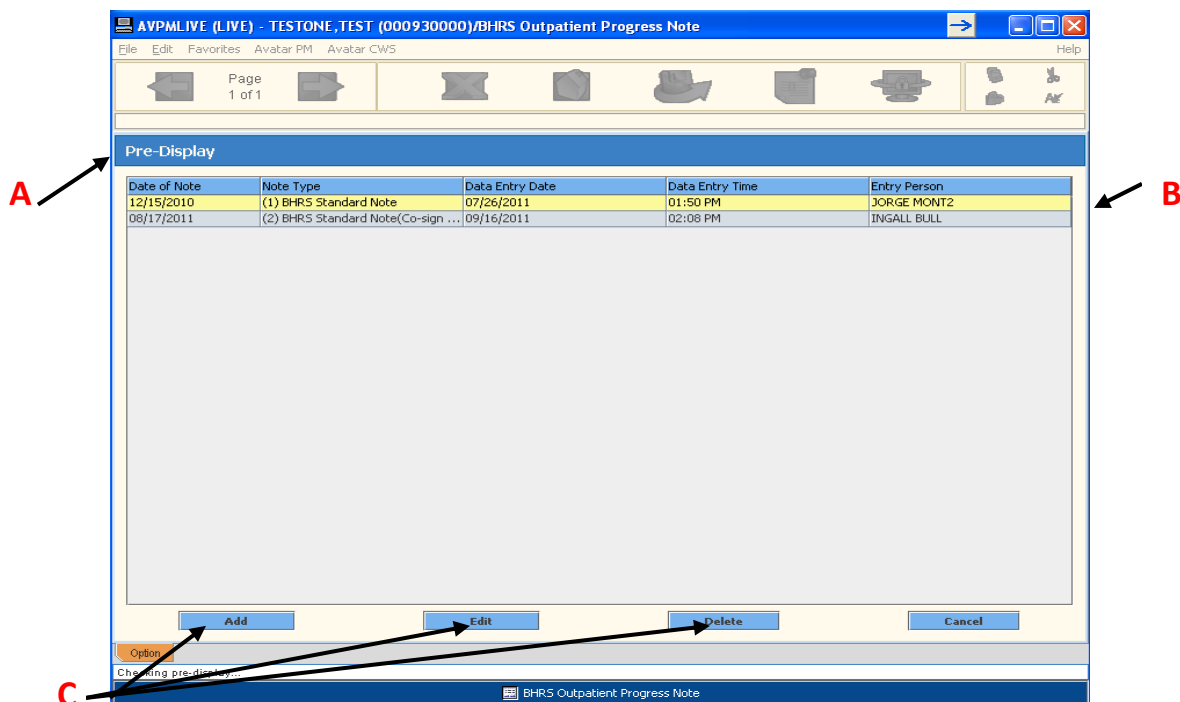
4. Understand Error Correction Functions

A. Progress Note Edits, Additions (append), Correction of Errors

Edit Draft Progress Notes

- Notes that have been submitted as DRAFT can be edited.
- DRAFT notes can be edited either through a Client's Pre-Display Screen or the Clinician's To-Do List.

Edit – Using Client's Pre-Display Screen



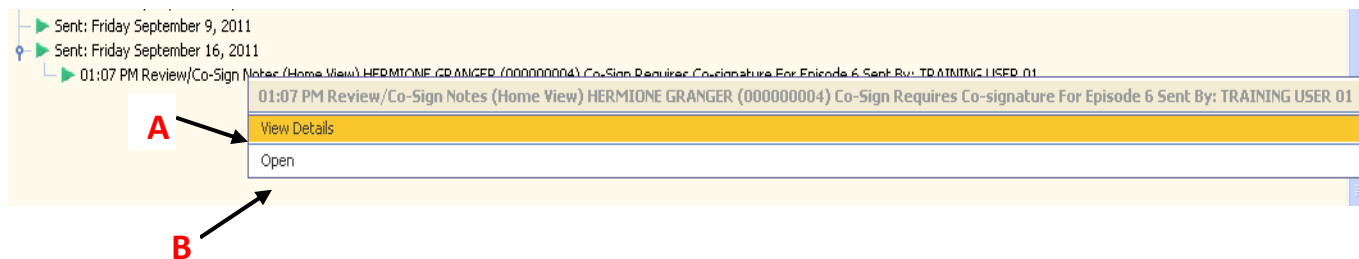
PATH Avatar CWS → Outpatient Progress Note

Once you have selected a **client** and the **correct episode**, the **Pre-Display Screen (A)** will appear if there are any progress notes in **Draft (B)**.

The bottom of the Pre-Display Screen has the options: **Add, Edit Delete (C)**.

Click on the selected progress note you want to **Edit (B)** then click the Edit option **(C)**, the selected progress note will open. Make the edits you want, then, **submit the edits from the open progress note document. You can submit as Final or keep in Draft.**

EDIT - Using Clinician's To-Do List



Clinician To-Do List: Once the clinician's Avatar Home Page is set to the To-Do Screen, 'To- Do' items will appear by date.

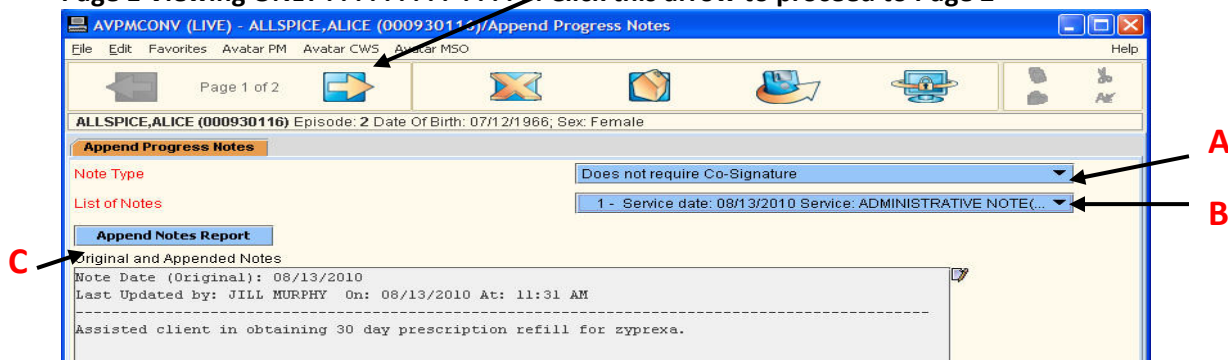
- To view the contents of a To-Do list item, right-click on the item and select "View Details."
- To **EDIT the note**, either double-click on the item, or right-click on the To-Do list item and select open
- Locate the DRAFT note to be edited by **right clicking on each To-Do item**; contents of the To-Do items can be **viewed (A)**, right click and view until you find the correct note.
- Select **OPEN (B)** by **right clicking on the correct note**. Edit the note then submit as Final or Draft

Append (Add To) A Progress Note

Screen Shot for Tab 1/Page 1

⚠ If some **important information needs to be added to the content** of a note or if there is an **error in the content** of a note **AND** the note has been submitted as **FINAL**, the **note CANNOT be edited**. Instead, the **clinician will need to append the information to the already finalized note**.

Page 1 Viewing ONLY Click this arrow to proceed to Page 2



PATH Avatar CWS → Progress Notes → Append Progress Note

You can narrow the search for the note you need to append by selecting the Note Type – Standard, Disclosure, or Restricted. **You can ONLY append a FINAL note and a note that did not require a co-signature!**

All 6 types of Notes will show in the drop-down, however, **ONLY those progress notes that Do Not Require a Co-Signature (A) can be appended.** (See below for how to handle progress notes with co-signatures that need to be appended.)

After selecting one of the three types of 'Does Not Require a Co-Signature' (A), progress notes, a list of notes **by date and type** will appear in the dropdown box (B).

On this page, **Page 1**, select the progress note to be appended; it will **only open for viewing (C)**.

Append (Add To) A Progress Note

Screen Shot for Tab 1/Page 2



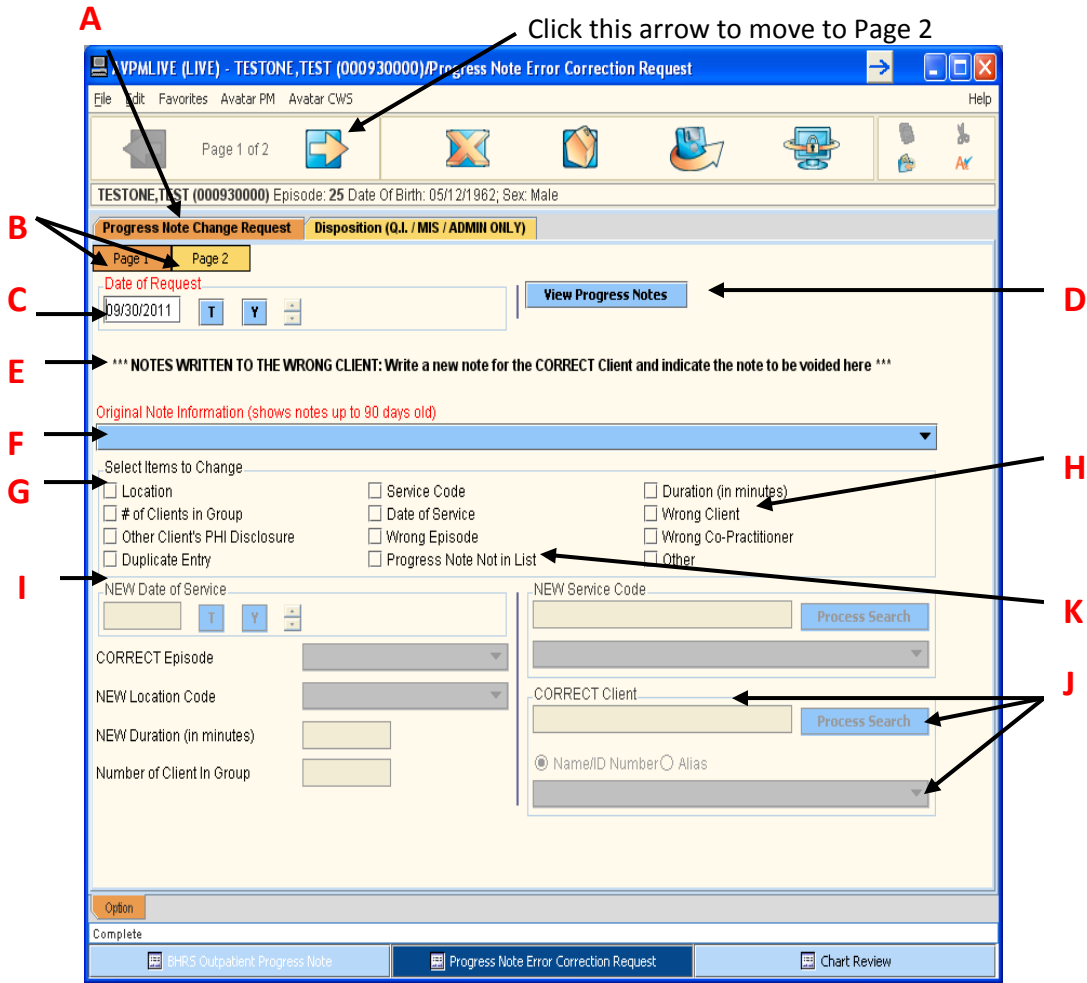
On this page, **Page 2**, you will enter the **additional information/correction to the content**, in the box **New Comments to be Appended to the Original Note (A)**

Click Submit (B); the appended note will be attached to the original and can be viewed by through the Progress Note Report

! Please NOTE

- The **Append** note function can be **used for outpatient service notes including Group notes.**
- **Appended information that is added is attached to the original note.**
- **Any clinician can append a progress note, even if they did not write the original note.**
- The **Append** note function **CANNOT be used if a note originally required a co-signature.**
- If **information** needs to be **added or corrected** to the **content of a Final note that required a co-signature**, a **new note must be written** to address mistakes or additions of the original note's content.

Error Correction Screen Shot for Progress Note Error Correction Request Tab1/Page1



If errors are made to the Date of Service, Service Duration, Service Charge Code/Type of Service, Group Service entries or Location Code, a Progress Note Error Correction Request must be completed and submitted so that the service is billed correctly. This form is also used when requesting to correct errors in other categories e.g. Other Client’s PHI Disclosure, Duplicate Entry, Wrong Co-Practitioner, Wrong Episode.

PATH Avatar CWS → Progress Notes → Progress Notes Error Correction Request

Select the client for whom the original progress note was written.

Once the Progress Note Error Correction Request is selected, the first screen that may appear is the **Episode Selection** screen if the client has more than 1 episode. You will select the episode where you work, or the program where the note was submitted in.

Select the episode the note was written for.

Once the client has been selected and the correct episode, another screen may appear, the **Pre-Display** screen that shows **other Progress Note Error Correction Requests**.

The Pre-Display Screen will show:

Date of Request	Requestor	Disposition	Disposition by	Disposition Date
-----------------	-----------	-------------	----------------	------------------

At the bottom of the Pre-Display screen there will be options to **ADD, which is to ADD a NEW Request; Edit, to Edit a Request where there has not yet been a Disposition, Disposition By and/or Disposition Date completed or Cancel, which Cancels option** and returns the screen to the Avatar homepage.

The Progress Note Error Correction Request form is a 1 Tab/2 page document. Once both pages of Tab 1 are completed and submitted, the Progress Note Error Correction Request is automatically routed to ADMIN/QM or MIS staff. ADMIN/QM/MIS staff will then process the request through entry on Tab 2. **ONLY the 2 pages of Tab 1 are required to be completed by staff.**

Complete only the 1st Tab: **Progress Note Change Request (A)** - This Tab has 2 Pages.

Tab 1/Page 1 (B) - Page 1 is orange/active. To move to Page 2, click the yellow Page 2 box to the right of the Page 1 orange box. When you click on this box, it will become orange/active. You can switch between pages of this tab; the active page will be orange. You can also move to Page 2 by clicking on the arrow above the tab.

Date of Request: (C) - Defaults to Today's Date

View Progress Notes: (D) - Runs a report of progress notes in the selected episode for this client which serves as a reference point.

****ALERT: NOTES WRITTEN TO THE WRONG CLIENT: (E)**

An alert or prompt to write a new note for the correct client

Must select the Original Note Information (up to 90 days): **(F)** Progress note selected will be voided

Must also check Wrong Client **(H)** in Items to Change **(G)**

Must also select the CORRECT client through process search entry: **(J)**

Original Note Information: (F) – Displays a list of progress notes up to 90 days, in the episode selected, for this client. The **note to be corrected is selected**. If the note to be corrected is NOT among those in the 90 day listing, be sure to you are looking in the correct episode. If the episode is correct, then check the entry **Progress Note Not in List (K)** in Select Items to Change **(G)**.

The Original Note information will show:

Date of Service	Service Type	Location	Duration	Clinician	Unique Note ID
-----------------	--------------	----------	----------	-----------	----------------

Select Items to Change: (G) – Select 1 or more Progress Note Items to Change. Items selected here will require the corrected information to be entered in the corresponding field(s) below in **(I) NEW** which have now become RED required entry fields. (New note with the correct information ONLY for a note written on the Wrong Client).

Fields to Indicate Correct Information: (I) – The fields in this section become enabled and will require an entry if it was selected as an Item(s) to be changed (above). For each item checked to change **(G)**, you must put an entry in the correction field **(H)**.

- **Date of Service** – provide the actual date the service was provided.
- **Correct Episode** – select the correct episode from the drop down.
- **New Location** – select the correct location from the drop down.
- **New Duration (in minutes)** – enter the correct duration in minutes.
- **# Clients in Group** – enter the total number of clients that attended the group.
- **New Service Code** – this a process search entry, must put an entry into the white box, click process search, select the correct service code. If the correction changes from an “Individual” to “Group” code, then change/correction to # clients in group must also be made.
- **Correct Client** – this is a process search entry, must put entry into the white box, click process search, select the correct client, this note will be voided and the service deleted; write a new progress note for the correct client.
- **Duplicate Entry** – one of the progress notes submitted will be deleted; the progress note will remain in the Avatar system and the client’s medical record; the progress note can be appended to state that it is a duplicate.

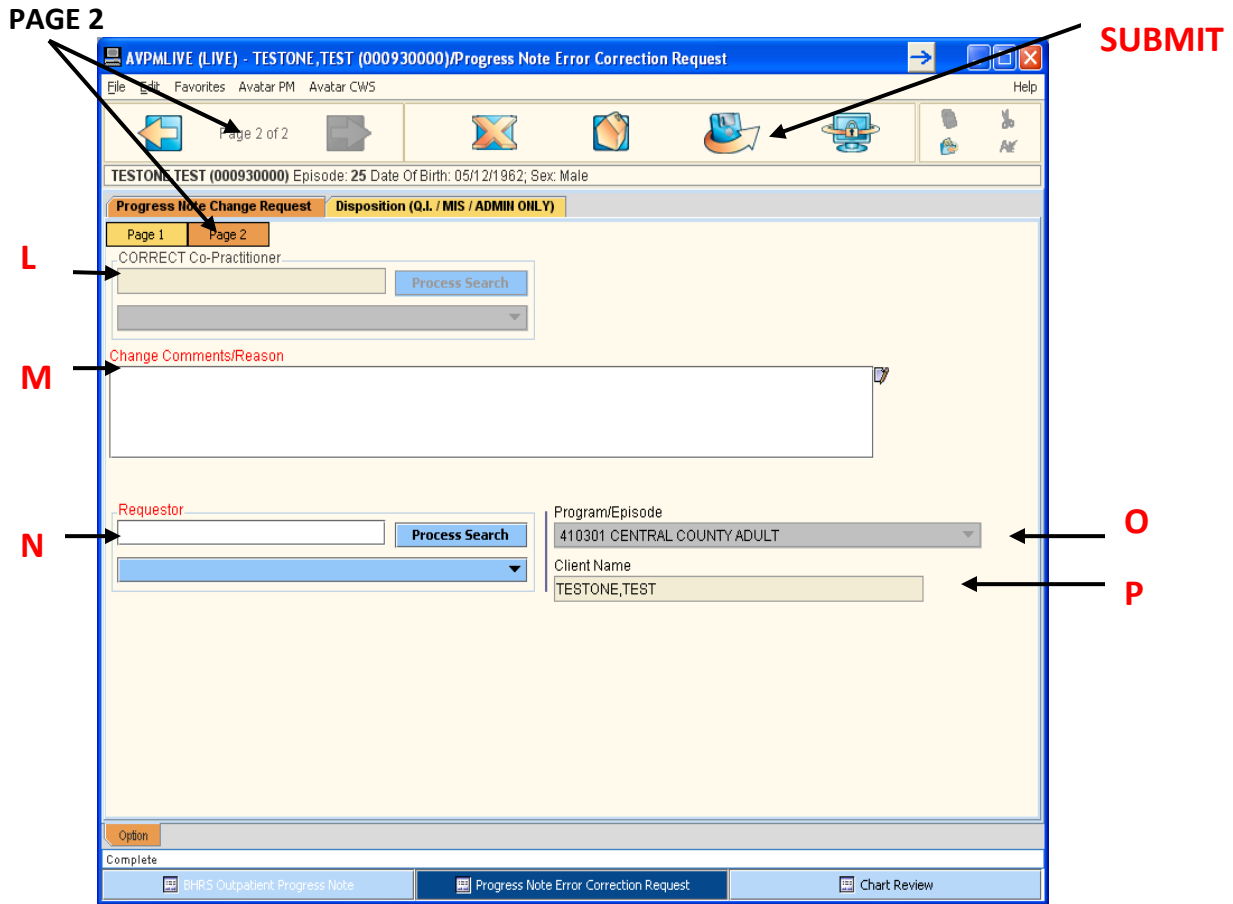
There are no entry fields for corrections to items in (H): Other Client’s PHI Disclosure, Progress Note Not in List, Other. Please explain correction needed, reason(s) and/or comments for change on Page 2.

Entry for the Correct Co-Practitioner – this is a process search entry, must put entry into the white box, click process search, and select the correct Co Practitioner. This field is selected as an Item to Change **(H)** on Page 1 but the correction is entered on Page 2.

To Continue to Tab 1/Page2 click the yellow Page 2 box to the right of Page 1 or click the arrow in the area just above the Tab Progress Note Change Request.

Error Correction

Screen Shot for Progress Note Error Correction Request Tab1/Page2





Correct Co-Practitioner (L) - this is a process search entry, must put entry into the white box, click process search, and select the correct Co-Practitioner. This field is selected as an Item to Change (H) on Page 1 but the correction is entered here on Page 2

Change Comments/Reasons: (M) – **All requests must include a reason for the request.** This is a free text box to indicate the reason(s) for the request and any other information you wish to share that is related to the request.

Requestor: (N) – this is a process search box to enter the clinician’s last name in the white box, click process search and select the requesting clinician, most likely yourself, who is making the request.

Program/Episode: (O) – this is a dropdown to select correct episode/program

Client Name: (P) – the clients name will automatically fill this box

SUBMIT:  click this icon to submit the request, and then click  to Close.

Correcting an Initial Contact Screening (ICI)

You can always return to any ICI window and make a change or correction at any time. The only field you cannot change is the original date of the ICI.

Correcting an Admission or Annual Assessment (ADULT AND YOUTH)

You can only correct an assessment that is in Draft. Corrections are only necessary for a critical field mistake, such as suicide, risk, or violence information. The steps are the same for correcting an error in an Admission or Annual Assessment. To correct a critical field error, use the following steps:

1. Choose Avatar CWS→ Assessments→ ADULT Annual/Update Assessment.

OR

Choose Avatar CWS→ Assessments→ CHILD/YOUTH Update Assessment.

2. In the Assessment Type field, select Update from the dropdown list.

Information from certain Admission Assessment fields will automatically populate to the fields.

3. Make any necessary corrections.

4. Go to the Finalize tab.

5. Attach the correct Substance Use, LOCUS, and Diagnosis assessments from the dropdown lists.

6. In the Draft, Pending Approval, Final field, select Final.

7. Click the Submit icon on the Option toolbar to save the changes.

Correcting a Physician's Initial Assessment (PIN)

Doctors will note any corrections to the PIN in a Progress Note.

Correcting a LOCUS/CALOCUS

You correct any mistake in a LOCUS or CALOCUS by creating a new LOCUS/CALOCUS. Generally the LOCUS/CALOCUS with the most recent finalized date is the working version.

Correcting a Substance Use Assessment

You correct any errors in the Substance Use Assessment by creating a new Substance Use Assessment.

Information from the previous Substance Use window populates into the new window, so you do not need to re-type everything. Make the corrections in the new Substance Use window and submit the changes as final.

Correcting a BHRS Diagnosis

Correct a BHRS Diagnosis by creating a new one. The most recent diagnosis populates to Avatar PM for billing.

If you have an incorrect non-billable diagnosis, notify your Unit Chief. The Unit Chief will contact QM or MIS.

Correcting the Mental Status and Behavioral Observation Assessment

To correct an error in this window, complete a new Mental Status and Behavioral Observation.

Correcting a Treatment Plan

If the error is minor, document the mistake in a progress note.

If the mistake is critical, create a new Treatment Plan. When Avatar asks if you want to default from the previous plan, select Yes. You will see any previous Barriers, Interventions, and so forth in the dropdown lists so you do not need to re-type them. Remember that the original Treatment Plan will remain in the system for audit purposes.

Correcting a Discharge

If a client is mistakenly discharged from an episode, you must contact the ISD Help Desk at 650-573-3400 so that they can undo the discharge.

Correcting a Mistake in Consent Forms

Many times, corrections to consents are not mistakes as much as changes, such as consent for a certain family member being changed or revoked. For any changes to consents, go to the window for the type of consent you want to change and create a new consent to override the previous one. When you submit the consent, a new consent with the proper changes displays and you can print it and give it to your client.

Documentation on Wrong Client

You may find that you completed the information correctly, but you submitted the document as final for the wrong client. **Do Not Re-Document for the Correct Client!**

For all clinical documents except progress notes, contact the ISD Help Desk at 650-573-3400 and request that the clinical document be moved from Client A to Client B. Make sure to provide the client's name and MR#.

Duplicate Draft Documents

Sometimes you may discover that you started the same clinical document as a draft twice for the same client. If the documents are still in draft, use the following steps:

- For Treatment Plans ONLY: a. Contact the ISD Help Desk to have the draft plan deleted.
- For all other clinical options:
 - a. Open the relevant document window.

The Pre-Display window should appear showing all draft copies.

- b. Select the extra draft you wish to delete by clicking it once and click the Delete button.

You cannot undo this action.

C. Take Corrective Action

5. Review Utilization

Units of Service Report

Avatar PM→ Services→ Service Reports→ various service reports to select

**Detail of Visits by Client and Program
Service Summary by Episode Program
Services Summary by Treatment Program
Services by Provider and Group Code
Services by Program and Group Code
Services by Program and Age Group
Client Service Report
BHRS Units of Service by Practitioner
BHRS Units of Service by Program
BHRS Units of Services Summary
BHRS MAA Services**

C. Take Corrective Action

6. Urgent Care Bundle (Urgent Care Plan and Client Alerts)

You may have a need to create a client alert about a special problem or concern that you have encountered.

You want other users to be aware of the situation when they open or view the client's electronic medical record.

A. Client Alerts:

Client Alerts are similar to Post It Notes that have been used on a paper chart. The Client Alert is a way users can view important information or issues that need attention. The alert may be set by any Avatar user; once created there will be a pop up window that contains the alert message, for example, "**Client enrolled in Total Wellness**".

The Client Alert pop up window will appear upon opening any document or report. A Client Alert can display for certain periods of time, such as a week or months. Client Alerts do not end until they are disabled.

Client Alerts may be simple and non clinical statements or requests, for example, "Client is GPO" or "Update client demographics". Other Client Alerts are clinical concerns that may be urgent and require the development of an Urgent Care Plan (high priority).

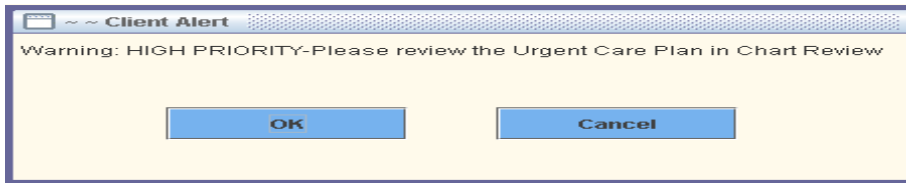
It would be inappropriate for the Client Alert pop up window to contain the sensitive client information regarding the specific clinical risk, concern and/or instructions as Avatar screens may be seen by a client/guardian who is present when the clinician is working in Avatar. The Care Message or Care Alert type of Client Alert will actually direct a user to the Urgent Care Plan to view this sensitive information. The clinician may want other practitioners to know of the concern but not the client/guardian.

The **Care Message** or **Care Alert** is usually enabled by Clinicians.

1. Care Message: Includes a routine concern or information about the client that other clinicians should be aware of, for example, "the client is refusing to take meds". This message will not show in the Care Message Alert pop up window. The Care Message pop up window includes this direction: "**Please Review Urgent Care Plan for Information**". The Urgent Care Plan describes the alert information/concern and may include instructions regarding what needs to be done.

2. The Care Alert: Includes information about a more urgent concern or safety issue, for example, "monitor client as danger to other". The Care Alert pop up window includes this direction: "**High Priority- Please Review Urgent Care Plan in Chart Review**". The clinician will view the Urgent Care Plan as soon as possible and without the client/guardian viewing!

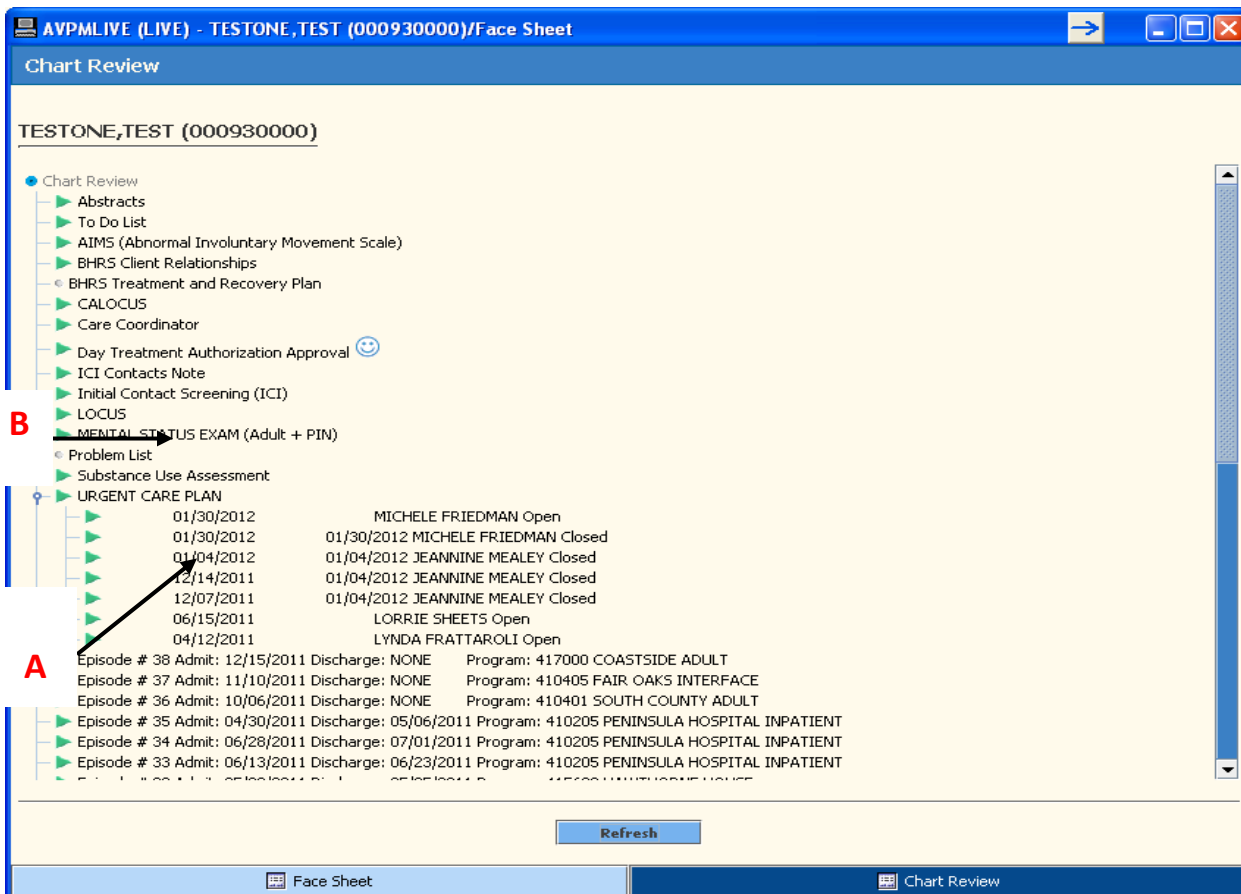
1. **Example of Client Alert Pop Up Window**



← Example of Care Alert pop up Warning - Click OK, then go to Chart Review screen!

B. How to View the Urgent Care Plan: (as directed by the Care Alert or Care Message pop up window)

- The Urgent Care Plan is located **above the latest episode (A)** in the Chart Review screen.
**Remember, in order to get to the Chart Review screen you must open any document or report!*
- The Urgent Care Plan is listed by date with the **most current date at the top**. Click on the green arrow **(B)** to view and read the Urgent Care Plan.



Example of an Urgent Care Plan

AVPMLIVE (LIVE) - TESTONE,TEST (000930000)/BHRS Outpatient Progress Note

Report: 01/31/2012 MICHELE FRIEDMAN Open

Report Date: 01/31/2012 Page 1 of 1

SAN MATEO COUNTY
BEHAVIORAL HEALTH & RECOVERY SERVICES
URGENT CARE PLAN Inquiry

Urgent Care Plan
Start Date: 01/31/2012
Status: Open
Date of Birth: 05/08/1962
Primary Diagnosis: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE WITH PSYCHOTIC FEATURES (296.24)
Therapist/Caseworker: FRIEDMAN,MICHELE (053396)
Urgent Care Treatment Plan:
Client is possible danger to others. He has been hostile, aggressive and argumentative with others. Becomes agitated and has threatened vague harm to others on one occasion
Caution:
client has not taken his meds for 1 week and is at risk.

View Search PDF Config PDF Viewer

Page: 1 of 1 100%

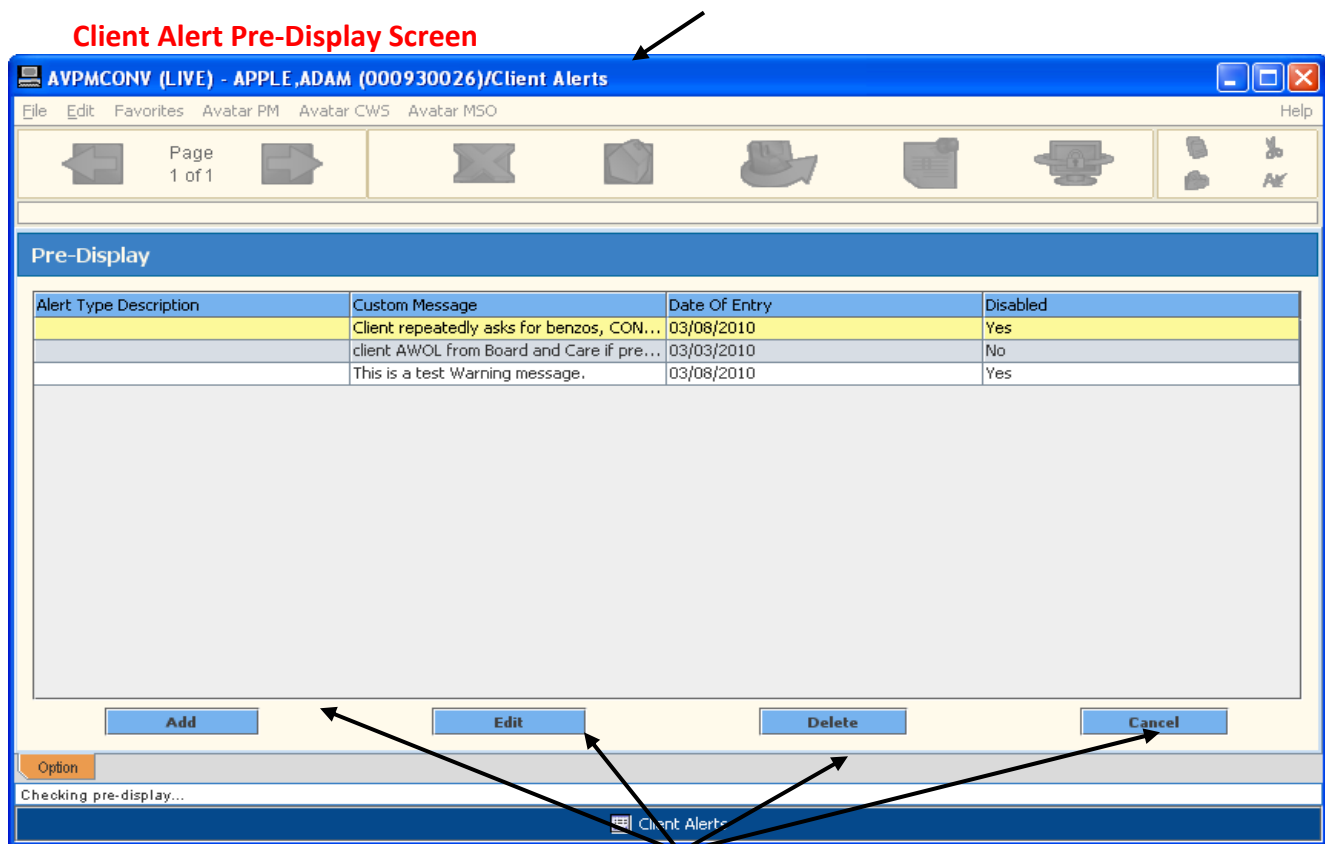
<< Prev Next >> Current Page File Print Dismiss

BHRS Outpatient Progress Note Chart Review Report: 01/31/2012

C. Create a Client Alert and Urgent Care Plan

1. CLIENT ALERT

- Select the client.
- **PATH:** Avatar CWS → Other Chart Entry → Urgent Care Plan Bundle
- The bundle will open to the document to create a Client Alert; if other alerts have been made, there will be a **Pre-Display Screen** that **shows the other Client Alerts** that have been created.
- The **Client Alerts Pre-Display** screen includes: the **Description** or **Alert Type**, the **Custom Message**, the **Date of Entry** and if the **Alert is Enabled/Active** or **Disabled/Closed**.
- At the bottom of this screen there are options for you to select:
 - **ADD** is to add a **new Client Alert**.
 - **EDIT** is to **edit an alert that is active** and/or to **disable an active alert**.
 - **DELETE** is to delete an Alert.
 - **CANCEL** will cancel this option and return you to the homepage.



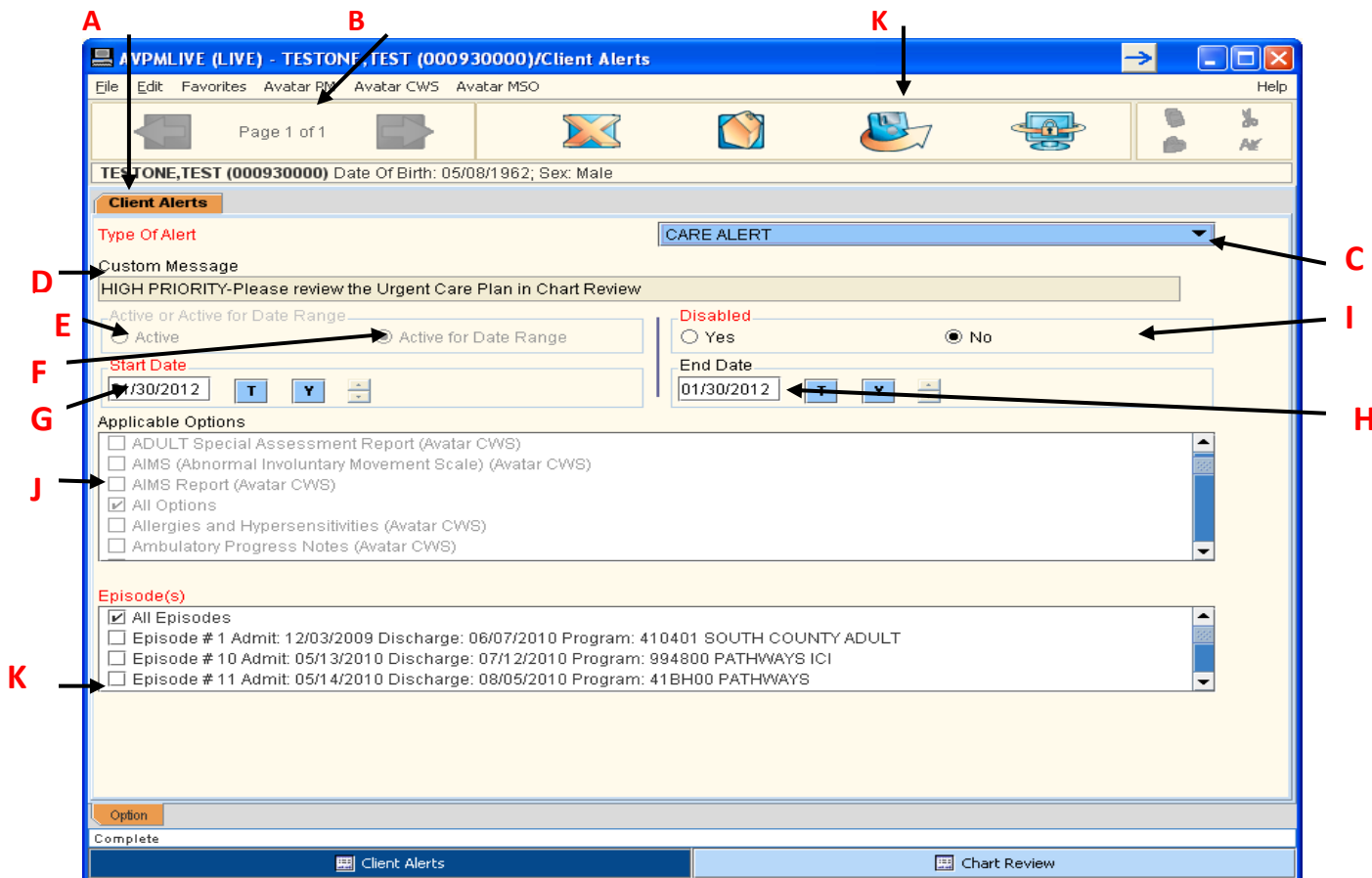
Select **ADD**; the Client Alert document will open

How to Complete the Client Alert: Screen Shot Tab 1, Client Alerts,

The **Client Alert document** has 1 tab **(A)** and 1 page **(B)**; Select the **Type of Alert (C)**

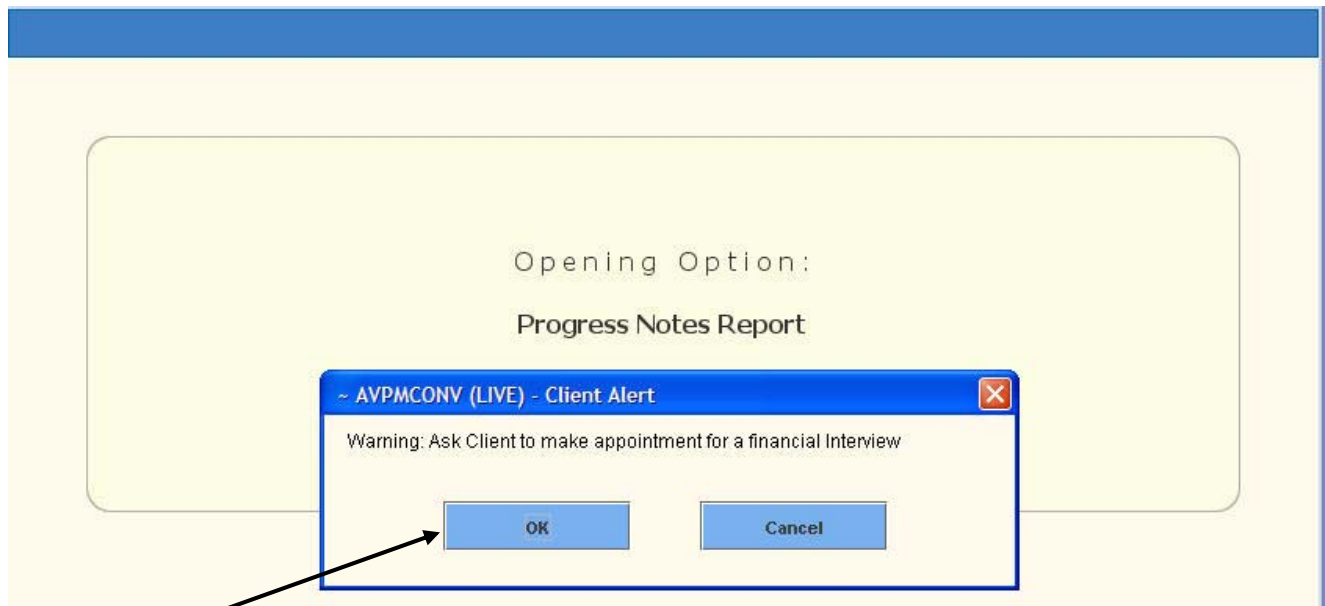
Assignment of Benefits Due	Financial Interview Due	Stop do not link to episode 1
Care Alert	GPO	Total Wellness
Care Message	insurance Application	UMDAP Financial Due
Client is Deceased	Stop do not link this episode	Update client demographics
Error (custom)	Stop do not link to episode 1 or 2	Warning (custom)

- The Alert will fill in the **custom message (D)** box if custom is not a selection. *Do NOT select custom error as it will lock you out of all functions and you will need to call the help desk. If Warning is selected then there must be an entry in the custom warning in the custom message box (red/required).*
- Select **Active or Active for a Date Range:** If **Active (E)** is selected you will be *unable to make an entry for the start and end date.* The warning remains active until a status changes.
- If **Active for Date Range (F)** is selected, the **Start Date (G)** and **End Date (H)** will automatically be entered with today's date. The **End Date (H) can be changed manually for however long you set it.**
- **Disabled: (I)** this is *how you close an active alert that has no end date.*
- **Applicable Options: (J)** allows you to *set how the Alert will appear. Select All options.*
- **Episodes: (K)** allows you to select *which episodes will be impacted* by the Alert.
- **Submit: (L)** you will know the Alert has been set once you reopen Avatar. The pop up will appear and require you to click OK.



1. Example of a **simple Client Alert** that **does not** require an Urgent Care Plan:

- Select Financial Interview Due from the description or alert type drop down options.
- The Custom Message Box will fill in automatically with “Ask Client to Make Appointment for a Financial Interview”.
- Active for Date Range will fill in automatically.
- Disabled Defaults to No; select “YES” to close an active Alert or an Alert that had no End Date.
- The Start Date and End Date are filled in automatically with today’s date.
- You can change the End Date manually for however long you want the Alert set for.
- The fields Applicable Options and Episodes are pre-set to ALL.
- There is **no further action required except to SUBMIT** the Alert.



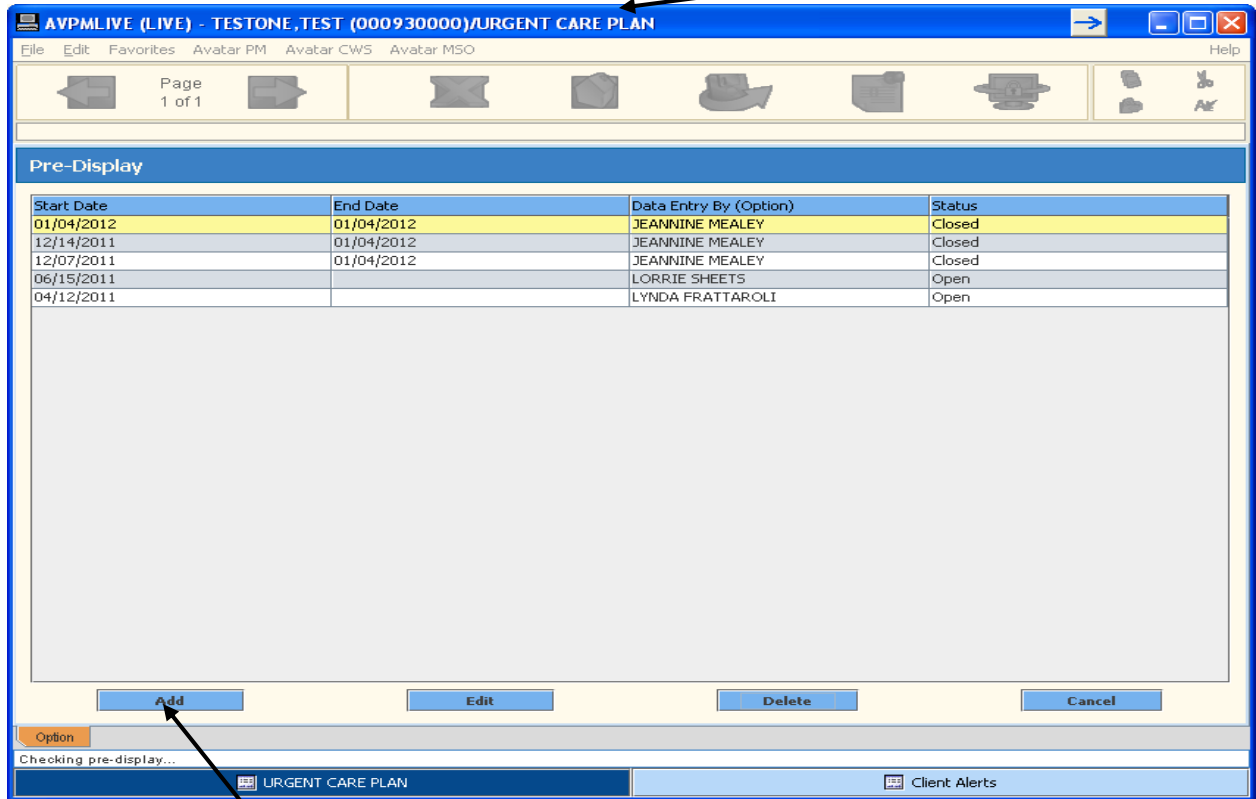
* When any document or report in Avatar is opened, this alert will pop up. Click OK.

2. Example of a **Care Alert that REQUIRES an Urgent Care Plan:**

- Select: **Care Alert.**
- The Custom Message Box fills in automatically:
“HIGH PRIORITY- Please Review the Urgent Care Plan in Chart Review”.
- Active automatically is filled in; Disabled Defaults to No.
- Select “YES” to close an active Care Alert.
- The fields Applicable Options and Episodes are pre-set to ALL.
- **SUBMIT.**

D. Urgent Care Plan

* Once the Care Alert has been submitted, the Urgent Care Plan screen will automatically pop up with the Urgent Care Plan document or if there have been other Urgent Care Plans, an Urgent Care Plan *Pre-Display* screen will appear.



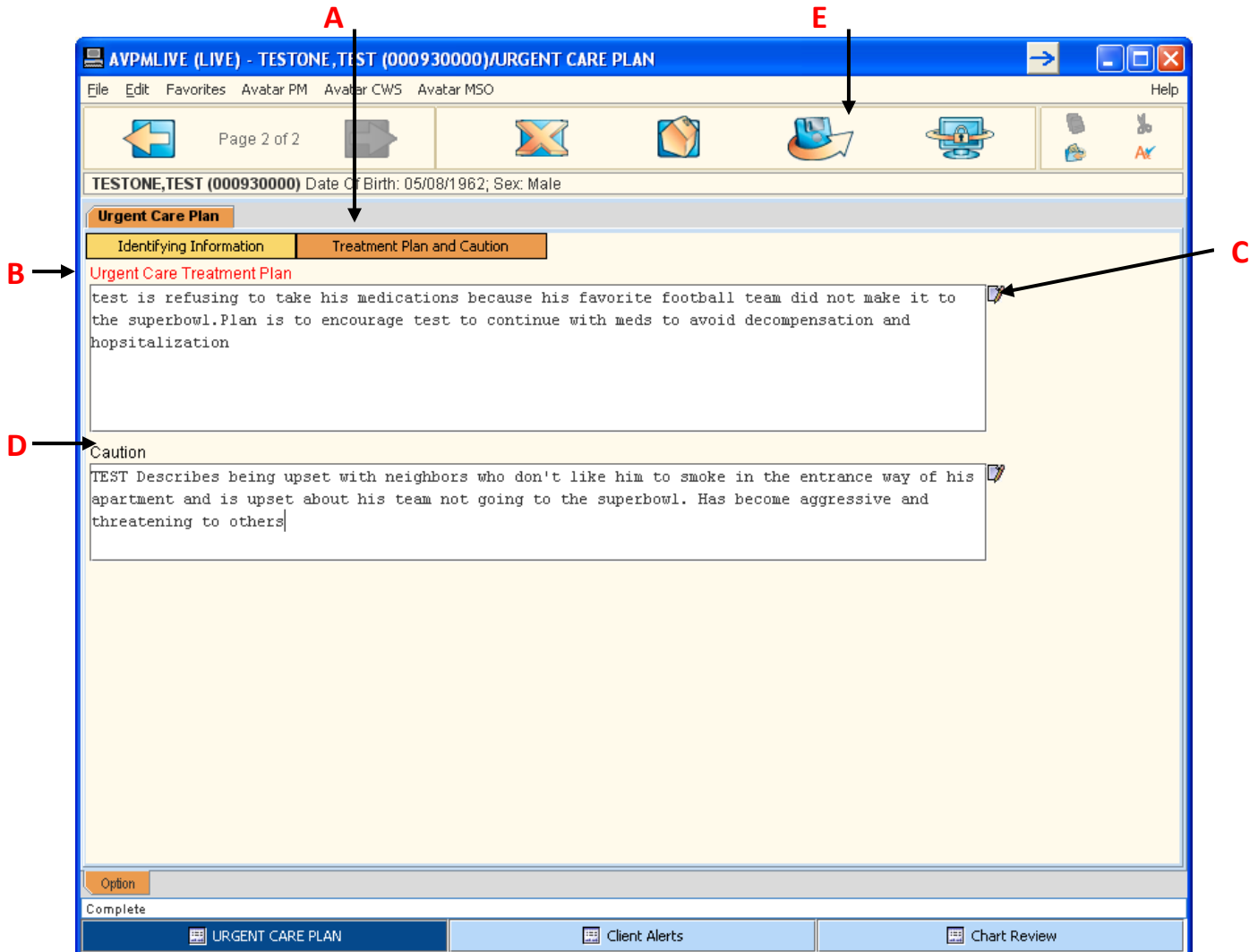
- The **Urgent Care Plan Pre-Display** screen displays **Start Date, End Date, Data Entry By** and **Status of the plan as Open or Closed**
- At the bottom of the screen are options for you to select:
ADD is to add a **NEW Urgent Care Plan**.
EDIT is to **edit an Active Urgent Care Plan** or **change the STATUS** and **CLOSE** an Urgent Care Plan.
DELETE is to delete an urgent care plan.
CANCEL is to cancel this option and return you to the homepage.
- **Select ADD**

The URGENT CARE PLAN contains 1 Tab (A), 2 pages (B) (C). Screen Shot of Urgent Care Plan Page 1:

Page 1: (B) Identifying Information.

- Entry fields on the left side of the form are red/required fields.
- Start Date: (D) Date of Birth (F) and Primary Diagnosis (I) will automatically fill in.
- Select Status: (E) Status will default to Open; Select CLOSED to close an Urgent Care Plan that has been open.
- **Therapist/Caseworker: (G)** A process search entry, enter letters of the last name or entire last name of person in the white box, click process search, select the correct Therapist/Caseworker so that the name populates the blue box.
- The right hand side of the Urgent Care Plan includes **entry boxes that are optional.**
- **End Date: (H)** You can enter a date or leave this blank.
- **Diagnosis: (I)** This **fills in automatically**, you can update the diagnosis if needed by entering the code in the white primary diagnosis box, click process search, then select the correct diagnosis so that it appears in the blue box. If you update the diagnosis, the next box, psychiatrist, will become a red required field to enter who updated the diagnosis
- **Psychiatrist: (J)** Optional process search type entry, enter psychiatrist if diagnosis was updated per above
- **Region (K):** You can select the region from the drop down.

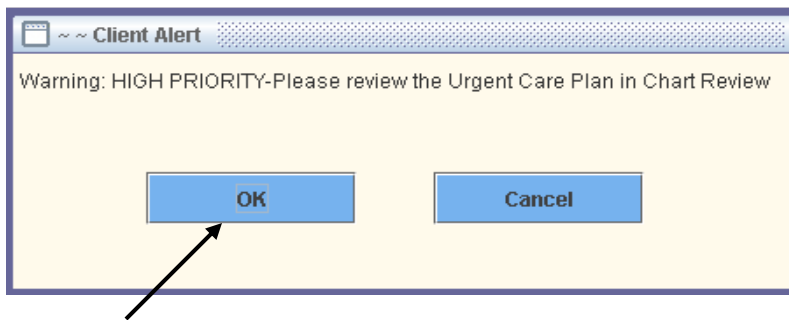
Screen Shot: Urgent Care Plan Page 2: Treatment Plan and Caution (A).



Page 2: Treatment Plan and Caution (A)

- **Urgent Care Treatment Plan: (B)** This is a free text box for a narrative description of the concern.
- **Text Editor: (C)** This provides an expanded view of the text and spell check.
- **Caution: (D)** This is an optional free text box to include cautions.
- **Submit: (E)** Submits the Urgent Care Plan.

Once the Urgent Care Plan and Alert have been completed and submitted, the warning pop up ALERT will appear with any document or report that is opened. The pop up screen will warn users: **“HIGH PRIORITY - Please Review the Urgent Care Plan in Chart Review.”**



Click ok to this message AND

BE SURE TO VIEW THE URGENT CARE PLAN THROUGH THE CHART REVIEW SCREEN!

3. How to VIEW the Urgent Care Plan

The Urgent Care Plan is viewed through the Chart Review screen. You must open any document or report in order to get to the Chart Review window. Please see page 33

IMPORTANT: Close/Disable Urgent Care Plan

- Always remember to **Close an Urgent Care Plan** and/or **Disable a Client Alert.**
- Select Stop or Dismiss and that will get you out of that screen.
- To Deactivate or Disable Urgent Care Plan or Care Alert, **SELECT the Urgent Care BUNDLE.**
- **Select EDIT: Change Status to CLOSE; enter today's date.**

APPENDICES

San Mateo County Mental Health Services
State Department of Mental Health

A. Medical Necessity Criteria for Specialty Mental Health Services

California Code of Regulations Title 9. Division 1—Department of Mental Health 1830.205

To be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, clients must meet all 3 criteria (diagnostic, impairment, & intervention related). A. DIAGNOSTIC CRITERIA Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

- o Pervasive Developmental Disorders, except Autistic Disorder which is excluded
- o Attention Deficit and Disruptive Behavior Disorders
- o Feeding & Eating Disorders of Infancy or Early Childhood
- o Elimination Disorders
- o Other Disorders of Infancy, Childhood, or Adolescence
- o Schizophrenia & Other Psychotic Disorders
- o Mood Disorders
- o Anxiety Disorders
- o Somatoform Disorders
- o Factitious Disorders
- o Paraphilias
- o Gender Identity Disorders
- o Eating Disorders
- o Impulse-Control Disorders Not Elsewhere Classified
- o Adjustment Disorders
- o Personality Disorders, excluding Antisocial Personality Disorder
- o Medication-Induced Movement Disorders

B. IMPAIRMENT CRITERIA Must have one of the following as a result of the mental disorder(s) identified in the diagnostic (A) criteria; must have one, either 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individual appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

C. INTERVENTION RELATED CRITERIA Must have **all, 1, 2, and 3 below**:

1. The focus of the proposed intervention is to address the condition identified in impairment criteria “B” above, and
2. It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare-based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance abuse component. The intervention must be consistent with, and necessary to, the attainment of the specialty MH treatment goals.

EXCLUDED DIAGNOSES

- o Mental Retardation
- o Motor Skills Disorder
- o Communication Disorders
- o Autistic Disorder (Other Pervasive Developmental Disorders are included)
- o Tic Disorders
- o Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- o Mental Disorders Due to a General Medical condition
- o Substance-Related Disorders
- o Sexual Disorders
- o Sleep Disorders
- o Antisocial Personality Disorder
- o Other Conditions that May Be a Focus of Clinical Attention

A consumer may receive services for an included diagnosis when an excluded diagnosis is also present.

QI-Policies\06-01 Attach C Medical Necessity.doc Page 2 of 2

Service Charge Codes

ASSESSMENT (5), ASSESSMENT GROUP (50)

- Assessment/Medical Necessity
- Assessment/Diagnosis/MSE (by LPHA)
- Behavioral or Needs Assessment
- CA/LOCUS
- Co-Occurring Assessment
- Conduct Psych Test (by PhD/PsyD)
- Review external information for assessment

PLAN DEVELOPMENT (6)

- Develop client's Treatment & Recovery Plan
- Gain Treatment & Recovery Plan approval
- Monitor Treatment & Recovery Plan goal, progress
- Update/Modify client's Treatment & Recovery Plan

REHABILITATION(7), REHAB GROUP (70)

- Address Behavioral Health goal
- Address Behavioral Sx, impact of/on physical health
- Coping skills training
- Daily living skills training
- Social skills training

TARGETED CASE MANAGEMENT (51)

- Access/Monitor/Evaluate services
- AOD Services Referral/Access/Monitor
- Communicate to assess needs
- Community Referral/Access/Monitor
- Coordinate w/others to access service
- Education Referral/Access/Monitor
- Locate funding for living arrangement
- Medical Needs Referral/Access/Monitor
- MH Services Referral/Access/Monitor
- Referral to address current needs
- Social Support Referral/Access/Monitor
- Vocational Referral/Access/Monitor

COLLATERAL (12), COLLATERAL GROUP (120)

- Address client's MH w/significant support person
- Parent training w/significant support person
- Psycho-educate significant support person

CRISIS INTERVENTION (2)

- Assess mental status/immediate crisis
- Danger to Self/Other addressed/resolved
- Gravely Disabled addressed/resolved
- Stabilize immediate crisis

INDIVIDUAL (9), FAMILY (41) & GROUP (10) THERAPY (by LPHA, Trainee, RN w Psych MS)

- Address Treatment & Recovery Plan goals

UNBILLABLE SERVICES (55)

- Clerical task
- Close a chart
- CPS/APS report
- Deceased client
- Discharge Note
- Family member referral
- No service provided - missed visit ("no show")
- Rep-Payee functions
- Review/Prepare chart for release of information
- Schedule appointments
- Send or receive email, voicemail and/or facsimile
- SSI paperwork no client present
- Tarasoff Report
- Translation only
- Transportation of client
- Prepare for court
- Testify in court
- Wait in court
- Write a letter for court

ALWAYS
USE CODE
55
FOR NON-
BILLABLE
ACTIVITIES.

MEDICATION SUPPORT (15), MED GROUP (150) (by MD, NP, RN, LVN or LPT)

- Address health issues impacted by psychotropic meds or functional impairments
- Address psychiatric symptoms/meds
- Evaluate med side effects/effectiveness
- Medication education
- Obtain Informed Consent for Medication
- Physician Initial Note (PIN)
- Develop Trt Plan with med support intervention

RN INJECTIONS (16) (by MD,NP,RN,LVN or LPT)

- Injection

RN INJECTIONS (19) (by MD,NP,RN,LVN or LPT)

- Injection of Risperdal Consta or Invega Sustenna

MD TIME THAT IS NOT MEDICARE

BILLABLE (17) (Not face-to-face, by MD or NP)

- Client not present
- Chart review
- Reports/letters- not SSI

C. Location Codes Are Very Important to Claim for Services.

- **BHRS needs to document correctly for billable services; we also need to document non-billable services.**
- **Using the correct location code allows us to indicate those services that are not reimbursable in order to avoid “take-backs” and penalties from auditors.**

The setting in which a client resides can make services non-reimbursable; these are called LOCK-OUT LOCATIONS.

A few settings make some services non-reimbursable while other services provided there are reimbursable.

- When deciding the location, if a client is in a LOCK-OUT LOCATION, select the lockout regardless of your location.

For example, your client is in jail and you are in your office, select jail because it is a lock-out location.

- When a lock-out location, a missed visit or a voicemail/fax/email is entered, the BHRS information system will block or “lock out” the service claim from billing.

Common BILLABLE Location Codes

GPO- JAIL/YOUTH SERVICESCENTER (Billing is not blocked, youth is awaiting placement)

HEALTH FACILITY/PCP/SNF (Billing is not blocked for a client with a medical condition.)

FIELD (Staff person’s location)

OFFICE (Staff Person’s location - Your main worksite) TDS Staff use OFFICE when at their assigned school worksite.

PHONE (Staff speaking to a person on the phone -Billable)

SCHOOL (Staff person’s location – but NOT for TDS staff members)

NON-BILLABLE LOCATIONS

- **MISSED VISIT** (Billing is blocked for all No Show/Client not at office/home/field)
- **VOICEMAIL/FAX/EMAIL** (Billing is blocked for Listening to/Sending/Leaving Voicemail/Fax or for Reading/Creating E-Mail)

LOCKOUT LOCATIONS

IMD/MHRC (Billing is blocked.)

JAIL/YOUTH SERVICES CENTER (Billing is blocked)

PSYCHIATRIC HOSPITAL (Billing is blocked – for all but Case Management services related to finding placement.)

REDWOOD HOUSE (Billing is blocked for all but Case Management and Medication Support services.)

SKILLED NURSING FACILITY – PSYCH (Billing is blocked.)

LOCATION TYPES EXAMPLES

Location	Example
26.5 Youth Out-of-State	
Age-Specific Community Center	Senior Center, Teen drop-in center
Client's Job Site	VRS, Safeway, Longs
Faith-Based	Church, temple, mosque
Field Location away from the clinician's usual place of business.	Coffee shop
Health Facility/PCP/SNF Primary care or general health care provider, including services to patients in a medical bed in a hospital, emergency room & public health clinic.	Fair Oaks Clinic, Edison Clinic, Daly City Clinic, Willow Clinic, ER
Home – Private residences, hotels	Belmont Studios, Industrial Hotel
Homeless Shelter	Services provided at the shelter. Spring Street Shelter, Clara Mateo, Maple St.
IMD/MHRC (Client's location)	Cordilleras, 3rd floor
Jail/Youth Services Center (Correctional Facilities – Client's location here supersedes clinician's location.) Exception: Clients on GPO (general placement order) are not counted as being in a "Correctional Facility." If client is on GPO (general placement order) use GPO - Jail/Youth Services Center .	Maguire Facility/ Jail, Youth Services Center (non-GPO), Camp G, Camp K
Missed Visit	All "No Shows" in all locations
Mobile Service	Mobile Clinic
Non-Traditional Location	Park bench, on street, under bridge,
Office The clinician's assigned work site/clinic. Does not include phone.	All county clinics, TDS sites
Other Community Location Formalized community meeting areas.	Friendship Center, Heart & Soul,, Pyramid Alternatives
PES (Psychiatric Emergency Services)	Client's Location
Phone Does not include video conferencing or voicemails (see below).	
Psychiatric Hospital Inpatient – (Client's location here supersedes clinician's location.)	3AB, Mills-Peninsula, St. Mary's
Redwood House (Medsup/Casemgmt) This is billable.	Client's Location
Redwood House (Billing Blocked)	Client's Location
Residential Care- Adults/Licensed Community Care Facility	Redwood House, Cordilleras Suites, Hawthorne House, Wally's Place, WRA
Residential Care- Children/Residential Care Facility	COYC, Foster homes, Receiving Home
School Not TDS staff, TDS uses "Office"	K-12
Skilled Nursing Facility –Psych	Client's Location
Telehealth "Telemedicine"- Clinician and client are in two different locations	(e.g. video camera, video conferencing).
Voicemail/Fax/Email (Billing Blocked)	Receive or send Voicemail, email or Fax