Avatar NX Enhanced Care Management Training Guide

Sacramento County Avatar NX Training and Support

Purpose of this Training Guide:

Users must attend Avatar Enhanced Care Management (ECM) Provider Training before gaining access to the forms and reports shown in this guide. Enhanced Care Management is Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need individuals through coordination of services and comprehensive case management.

ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the ECM Populations of Focus.

This guide is designed to be an additional tool for Avatar users who have attended Avatar ECM Training. The Training Guide may change as Avatar trainings are updated. If you have any additional questions please contact Avatar Support at 916-876-5806 or Avatar@Saccounty.net.

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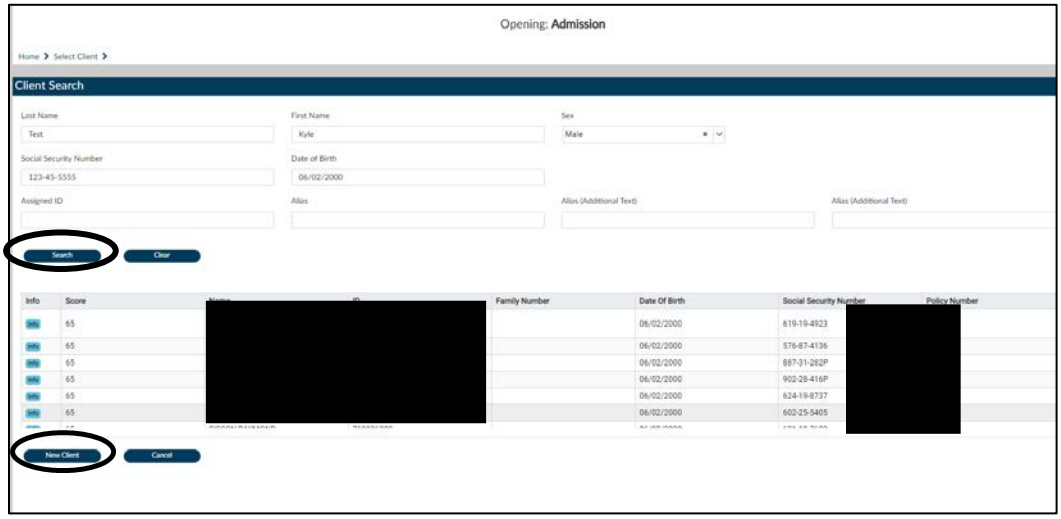
Admission

Admission Information

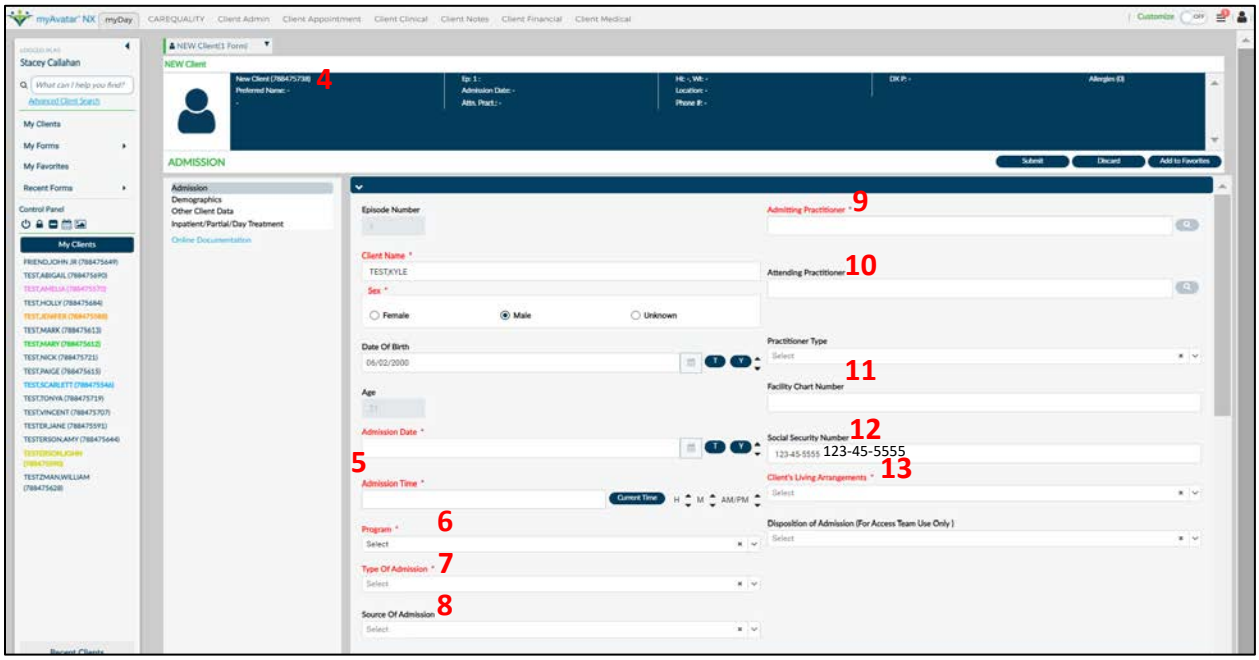
You will not be able to add any documentation into the client's chart until they have been admitted into your program. Once the client has been admitted that will create an open episode in your program. From there you will be able to add progress notes, client plans, and scanned documents. If the client has an existing Avatar ID you will want to use that ID to do the Admission, do not create a new Avatar ID for the client. If the client's name is misspelled or if they have had a name change, that can be fixed on the Update Client Data form.

Admission Form

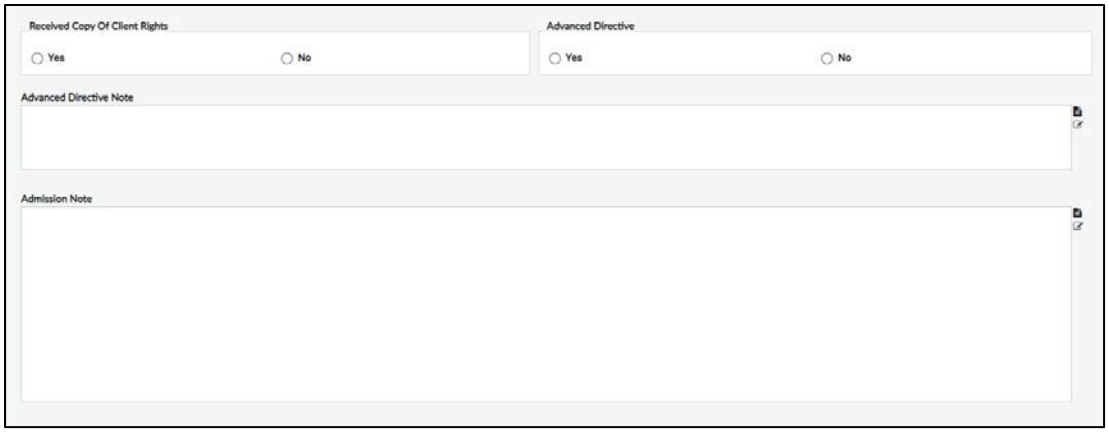
1. Search for the **Admission** form in the "What can I help you find?" search box and click to open.
2. Enter the client's information, you will need three fields completed to activate the "Search" button. Make sure to do a thorough search so that a duplicate client is not created. Additional pieces of information that can be used to search your client are date of birth, social security number, and Avatar ID number.
3. Click the Search button. Everyone meeting the criteria you entered will populate. If you see your client listed below double click on their name to enter a new admission for them. If they are not listed click on the "New Client" button. Make sure to enter the client's social security number and date of birth in the search criteria before clicking "New Client". If the client's name is misspelled you run the risk of creating a duplicate if the search was not thorough.



4. Any information you entered on the Search screen will populate into the form. If this is a new client the top header will say New Client and will generate an Avatar ID for the client. The new client will not be saved in Avatar until you click the Submit button.



5. Enter the **Admission Date and Time**.
6. Enter the **Program** for the admission. The programs listed will be programs within your system code.
7. Indicate the **Type of Admission**. Providers should use the option for Service Provider.
8. The **Source of Admission** is not required, however your agency may require that field be entered.
9. Enter the **Admitting Practitioner**. The client will populate on that practitioner's My Client widget.
10. The **Attending Practitioner** is not required, however entering an Attending Practitioner will allow the client to populate on the Attending Practitioner's My Client widget.
11. A **Practitioner Type** and **Facility Chart Number** are not required but can be entered if your agency uses these fields.
12. **Social Security Number** is not required, however this will be required for billing purposes. If the client does is not able to give you a social security number you can enter all 0's. This will still need to be in the correct format xxx-xx-xxxx.
13. Indicate the client's **Living Arrangements**.



14. The remaining fields below are not required but can be entered if your agency requires.
15. On the upper left hand side of the form are the different pages of the Admission form. Click on the demographics page.

16. The fields on this page are not marked red and required, however you will want to fill out as much demographic information as you can.
    a. Important fields to take note of on the Demographics page:
        i. Preferred Name: The client's first and last name must be their legal name, but if they prefer to go by a different name it can be entered here and will populate at the top of the client's chart once submitted. This is not a searchable field.
        ii. Client's Address: This field is not marked red and required, however it is required for billing purposes. Enter the client's full address, if they are homeless enter HOMELESS in the "Client's Address-Street" field and enter your agencies zip code, city, and state.
        iii. Alias: There are ten Alias fields available. If your client goes by any other name including a nickname, preferred name, or maiden name enter them in the Alias fields.
        iv. Marital Status: Indicate your client's current marital status in the drop down.
        v. E-mail: If your client has an e-mail address, this should be captured in this field.
17. Once you have filled out the demographics section to the best of your ability click "Submit" to save.

Admission Corrections

Once the form has been submitted you will not be able to delete the entry or make edits to the date or program. If the admission date or program was entered incorrectly you are able to contact Avatar@Saccounty.net and we can make the correction. If the admission was done in error, such as for the wrong client, please contact your Sacramento County Contract Monitor to request the change. If there is documentation in the episode further approval may be required. Make sure to encrypt any emails that are sent with client information such as the client name, SSN, or Avatar ID number.

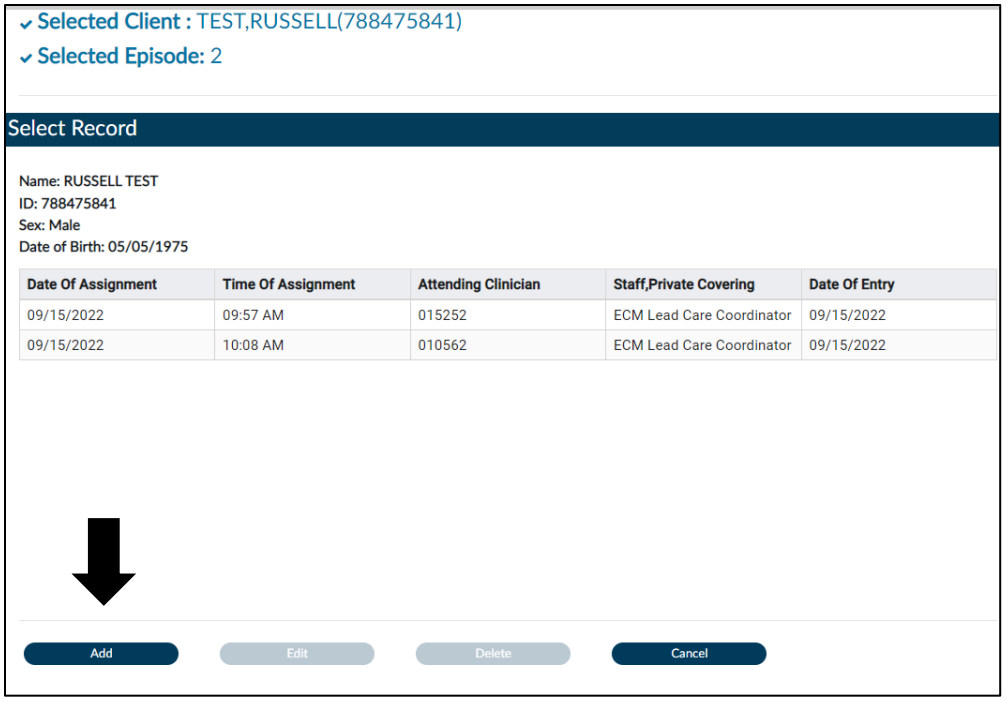
If the name was misspelled or any of their demographics entered in error such as SSN, DOB, phone number, or address, that can be fixed in the "**Update Client Data"** form.

Attending Practitioner

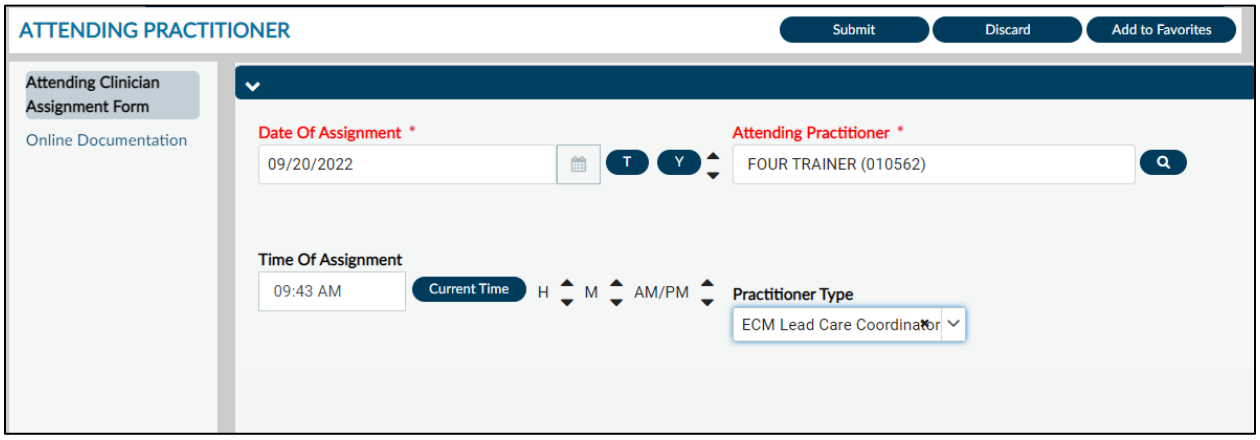
Additional Information

Clients receiving ECM services are required to have an ECM Lead Care Coordinator assigned to them for the duration of their episode. Attending Practitioner is the form used to add and update the Lead Care Coordinator information. This will also assign the client to the user's My Clients list. Only one ECM Lead Care Coordinator can be assigned at a time.

1. Open the **Attending Practitioner** form in Avatar
2. Select the ECM episode from the Episode pre-display.



3. If there has been an ECM Lead Care Coordinator previously entered you will see a pre-display of the previously entered ECM Lead Care Coordinators. Click Add to open the form to update the record.



4. Enter the “Date of Assignment” of when the client was assigned to the Avatar user
5. In the “Attending Practitioner” field, enter the name of the Avatar user who will be the ECM Lead Care Coordinator for the client
6. Enter the time of the Assignment, you can click the Current Time button to enter in the current time.
7. Select ECM Lead Care Coordinator from the Practitioner Type drop down.
8. Click submit to save the information.

Financial Eligibility

Financial Eligibility Information:

The Financial Eligibility form is where you enter the guarantors that will be paying for your client' services. Medi-Cal eligibility must be verified each time the client comes in for services. You will need to verify the Managed Care Plan your client is currently enrolled in and enter in the proper guarantor for that MCP.

Guarantor Order:

It is important to enter guarantors into Avatar in the correct order.

1. Other health care (Kaiser, Blue Cross, Sutter, etc.)
2. Medicare
3. Managed Care Plan *
4. County funds (Match)
    a. Mental Health providers will use Guarantor 20
    b. SUPT providers will use Guarantor 18

Each situation is unique to your client. If the client does not have one of the guarantors listed above you will skip that guarantor. If you need more clarification on which guarantors should be entered into Avatar ask your supervisor or contact Avatar-Fiscal@saccounty.net.

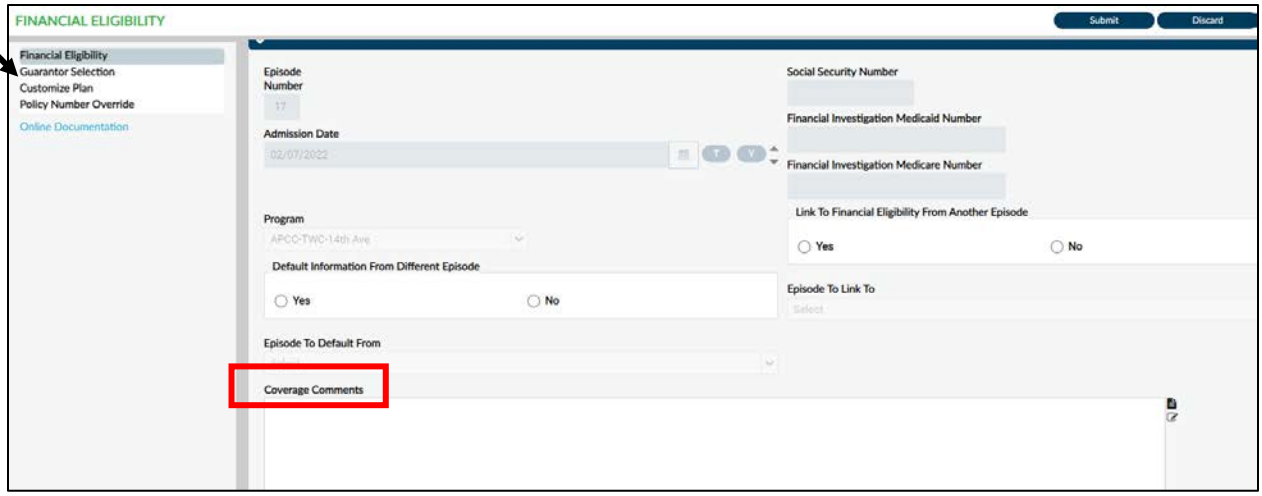
* Managed Care Plan Guarantors:

There are guarantors in Avatar that are specific to the Managed Care Plans that are different than the guarantors the treatment program enter. Below is a list of the Managed Care Plan guarantors that are approved for ECM services.

- Managed Care-Aetna (601)
- Managed Care-Anthem (602)
- Managed Care-HealthNet (603)
- Manage Care-Molina (604)

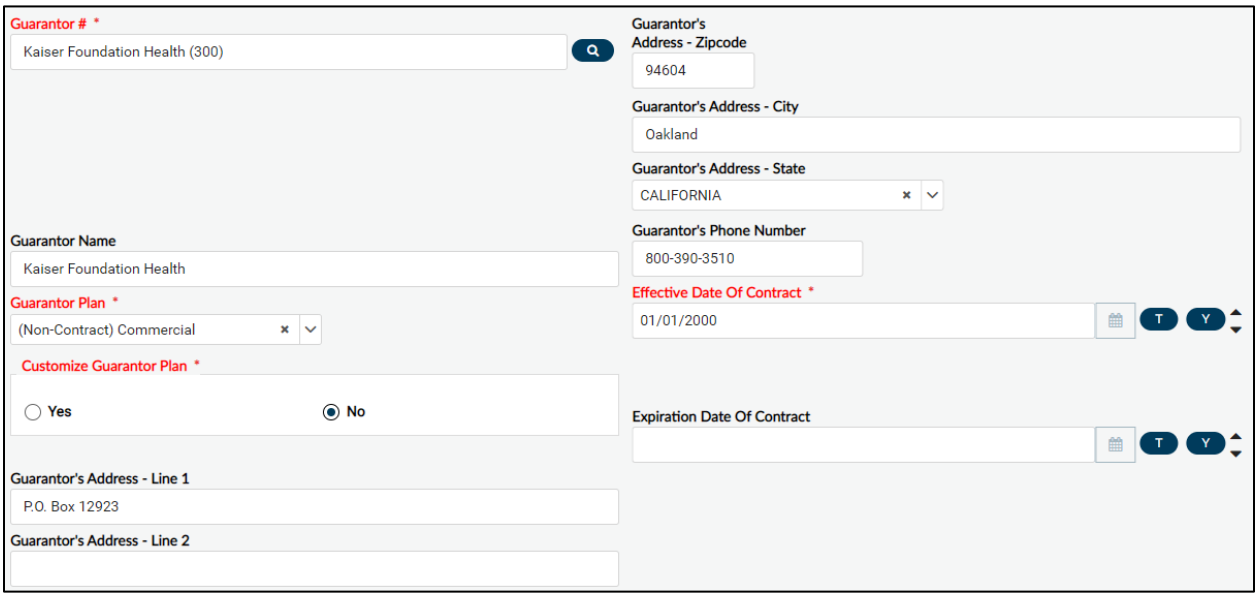
Financial Eligibility Form:

1. Open the "**Financial Eligibility**" form for your client.
2. The first page, "Financial Eligibility" will be greyed out. There is a "Coverage Comments" section. This can be used to enter comments whenever you update a client's financial eligibility.

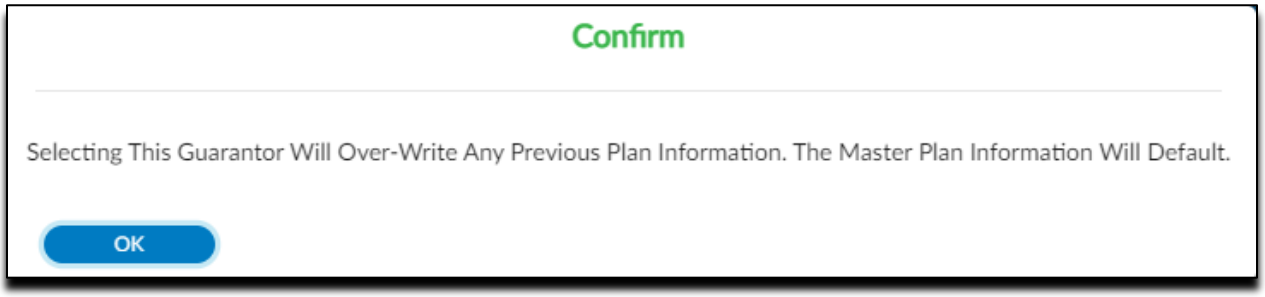


3. The second page is where the guarantors are entered into the system. Guarantors are added into a multi-iteration table. In order to enter information for your guarantors click the button for “Add New Item”. A green line will appear when the item is added. Do not click multiple times as that will insert blank rows. The system will see this as missing information. If an extra row is added in error, highlight the row and click “Delete Selected Item”.

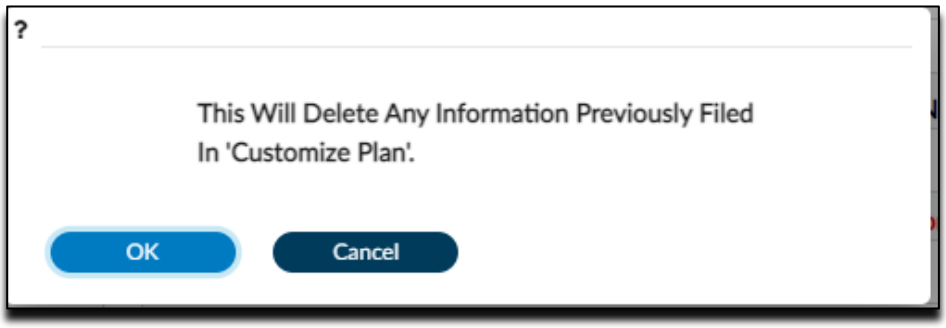
4. Once a new row is added you can fill in the form.



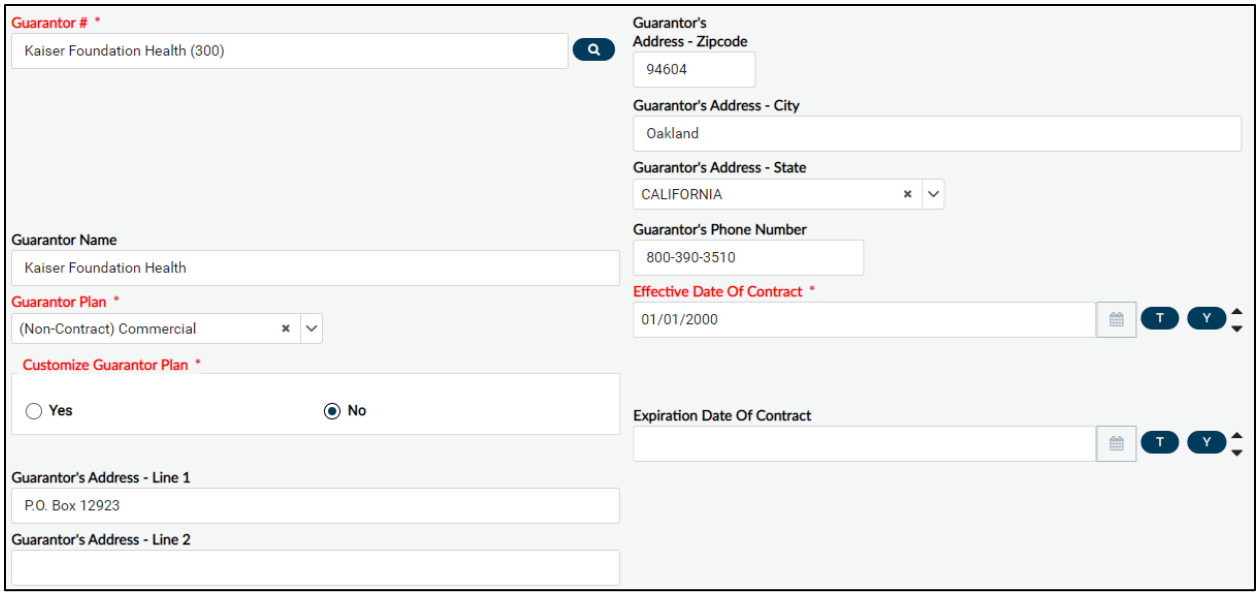
5. Enter the guarantor or guarantor code under the “Guarantor #” field. If you are unsure of the guarantor code you can run the “Guarantor by Class” report for a list of all guarantors listed in Avatar.
6. When the guarantor is added you will receive a pop-up stating the guarantor plan information will default click OK.



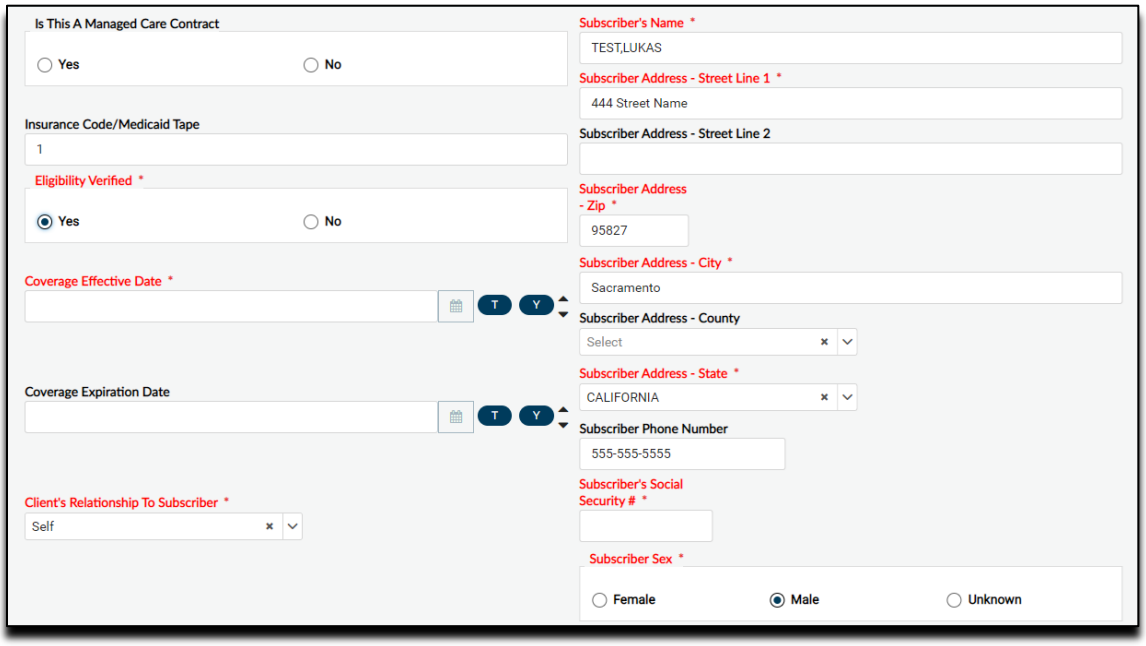
7. The guarantor’s information will default into the fields, DO NOT change this information.
8. Under “Customize Guarantor Plan” click “No”. Later we will show how to customize a guarantor. You will receive a pop-up when clicking “No”, click “OK”.



9. Under “Eligibility Verified”, this should always be “Yes”.
10. Enter the “Coverage Effective Date”, this will be the date of admission or when their coverage started.

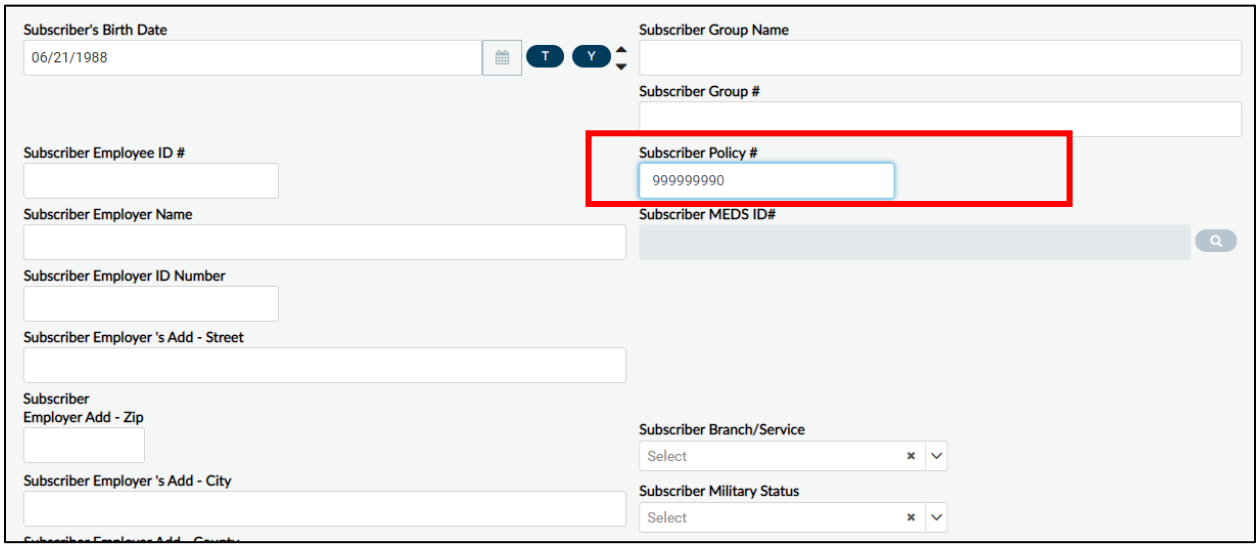


11. The next section will default the client's information from "Update Client Data" if there is missing information, close the form, go to "Update Client Data" and enter the information in there. Re-enter the "Financial Eligibility" form once you have submitted the changes. The defaulted information is based on the question "Client's Relationship To Subscriber" this will default to "Self". If the insurance plan is through a family member change the subscriber information to the family member's information.

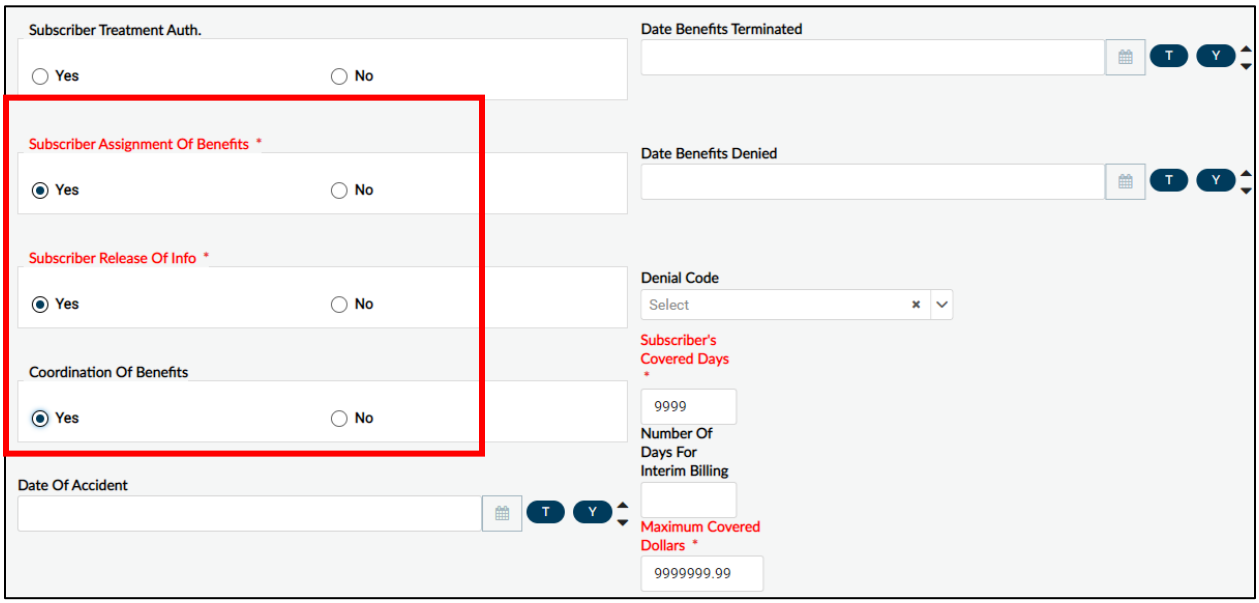


12. On the next section the only field that needs to be filled out is the "Subscriber Policy #". This field is not marked red and required however it is required for billing. This will be the client's policy number for their insurance or their CIN number for Medi-Cal. This is

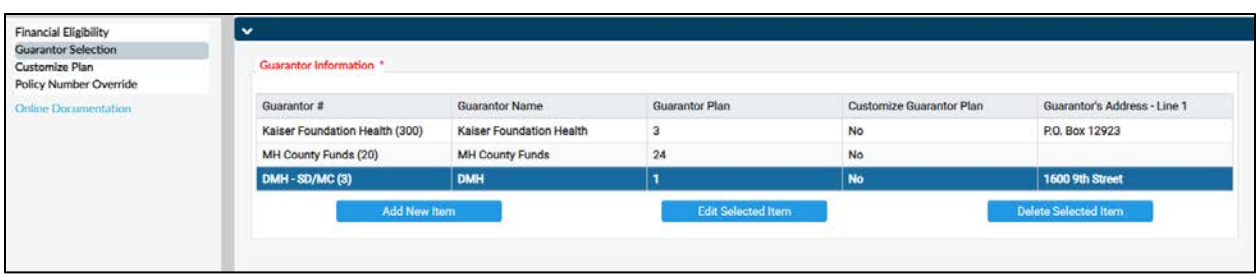
not required when entering the county funds guarantor since there will be no subscriber number.



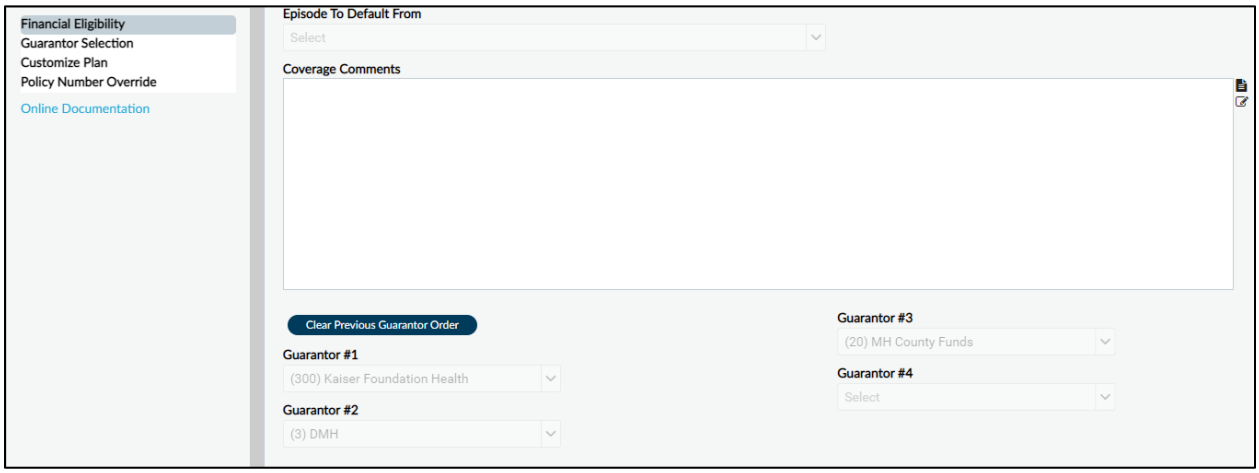
13. On the next section click “Yes” to the two red and required fields as well as the field below it. This allows the billing team to bill the guarantors.



14. No other fields on the form need to be filled out. Follow steps 4-14 for all other guarantors added for that client. Once completed, all guarantors entered will be listed in the multi-iteration table.

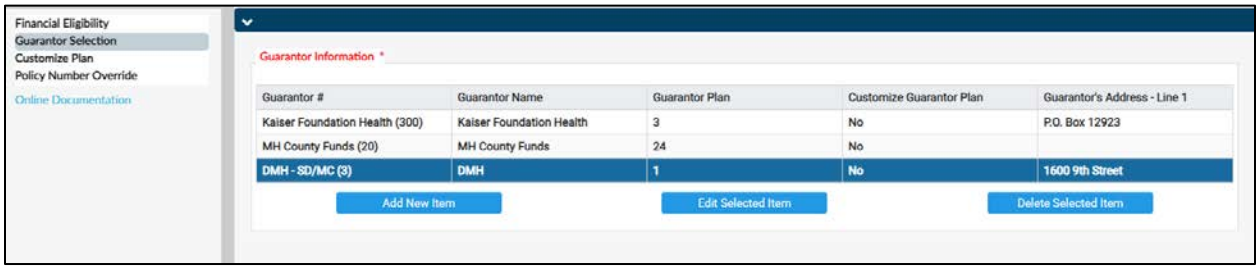


15. Go back to the first page of the form "Financial Eligibility".
16. The guarantor order will now be red and required. Each guarantor drop-down will list the guarantors you entered. Select each guarantor in the appropriate order based on the guarantor order shown at the beginning of this tip sheet. Click "Submit" to save.



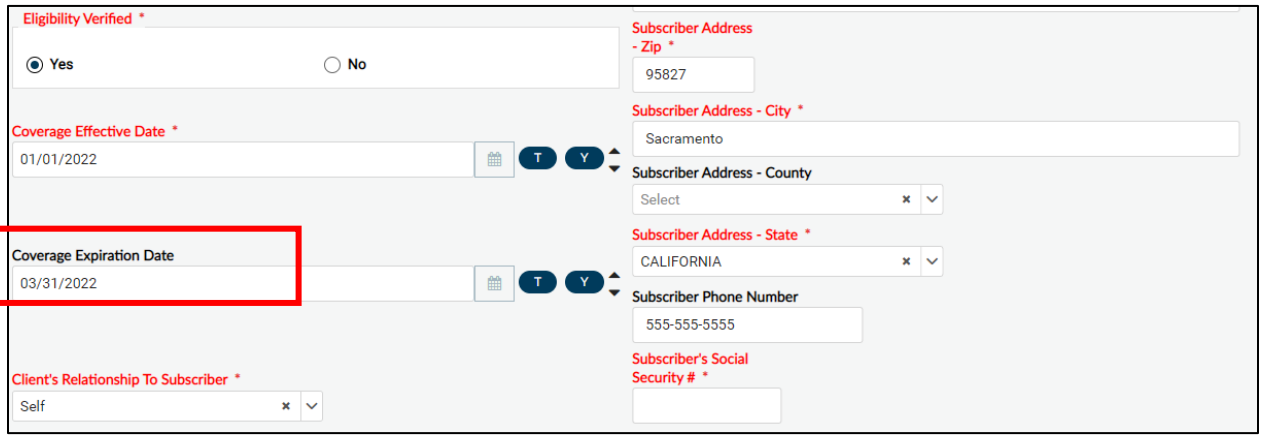
Removing a Guarantor:

If a client loses coverage on a particular guarantor you will want to end date the guarantor. It is important to have a record of the previous coverage for billing purposes. The steps below show how to end-date a guarantor.



Warning: Do not delete a guarantor if services have been entered for that guarantor, this can affect your billing. If a guarantor was entered in error, reach out to Avatar-Fiscal@saccounty.net for instruction on how to fix the error.

1. Open the “Financial Eligibility” form for the client you are working on.
2. Go to the second page of the form, “Guarantor Selection”.
3. Double click on the guarantor in the multi-iteration table to select it.
4. Scroll down to “Coverage Expiration Date”. Enter the date the coverage expired.



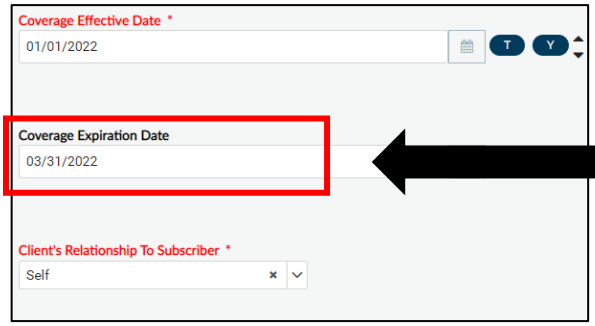
5. Repeat steps 3&4 for each guarantor that has expired.
6. Click “Submit” to save.

Customizing a Guarantor:

If a guarantor is end dated but later re-instated you will need to customize the entry. Below are the steps to customize a guarantor.

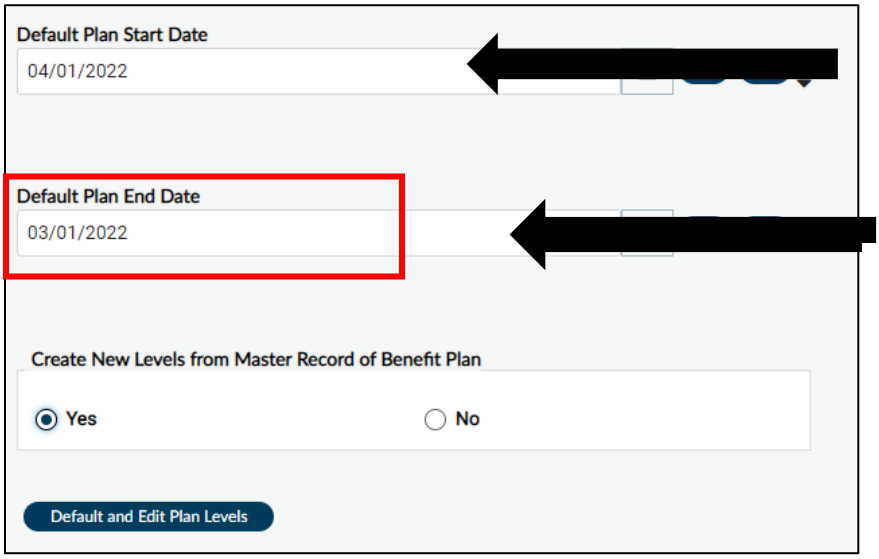
1. Open the “Financial Eligibility” form for the client you are working on.
2. Go to the second page of the form, “Guarantor Selection”.
3. Double click on the guarantor in the multi-iteration table that needs to be customized.
4. Under “Customize Guarantor Plan” switch the selection from “No” to “Yes”.

5. Scroll down to the “Coverage Expiration Date”. You will want to remove the date from this field since their coverage is no longer expired. You will want to save this date since we will later need to tell the system when the coverage previously expired. You can remove the date and write it on a scratch paper or use the shortcut on your keyboard “Crtl” “X” to cut the date and save it.



Remove this date

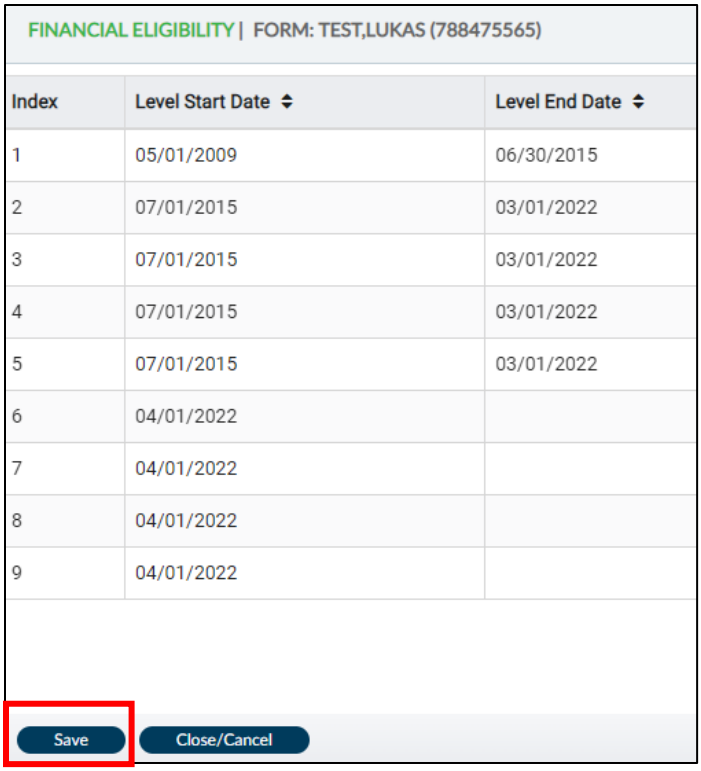
6. Scroll to the bottom of the page to the “Default Plan Start/End Date” section.
7. Enter the new plan start date under the “Default Plan Start Date” field and the date you copied in step #5 on the “Default Plan End Date” field. Click “Yes” on “Create New Levels from Master Record of Benefit Plan” and then the button “Default and Edit Plan Levels”.



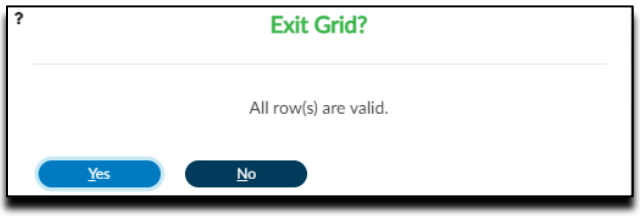
New plan start date

Date copied from coverage expiration date

8. A table will populate. The table is showing the default start date to each level of the guarantor plan, the end date you indicated (when they lost coverage) and the new start date. Click “Save”.



9. A pop-up will appear, click “Yes”.



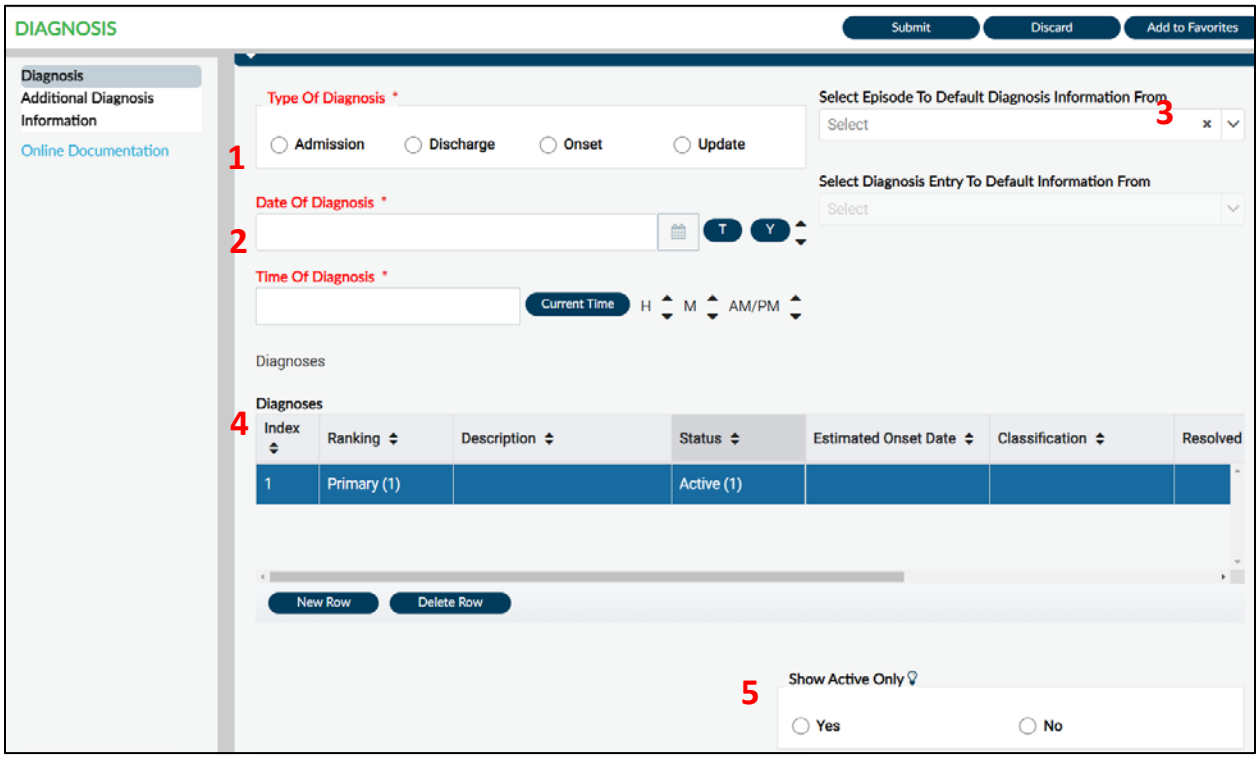
10. Continue steps 3-9 for each guarantor that needs to be customized. Click “Submit” to save.

Diagnosis

Diagnosis Information

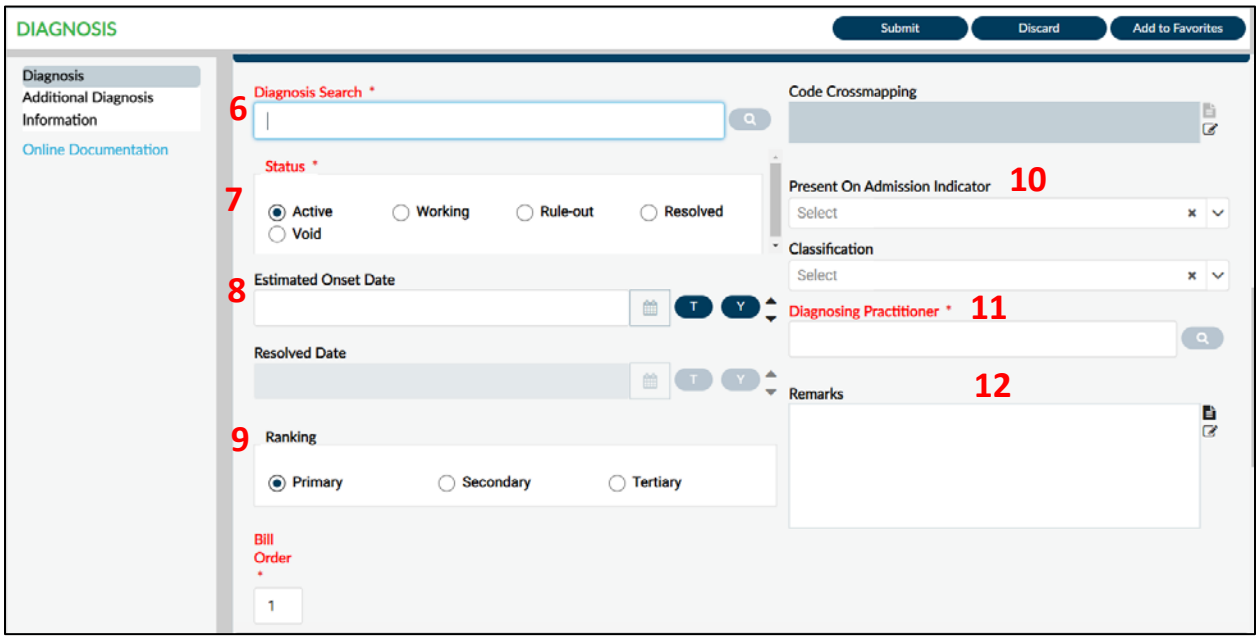
- All clients must have an active ICD-10 and DSM V diagnosis in the system that covers the service dates in order to successfully bill for services.
- Once a diagnosis has been saved you are not able to delete that record. You can change the status to Void which will terminate that diagnosis record.
- You can only have one primary diagnosis, but you can have multiple secondary and tertiary diagnosis.

Diagnosis Form

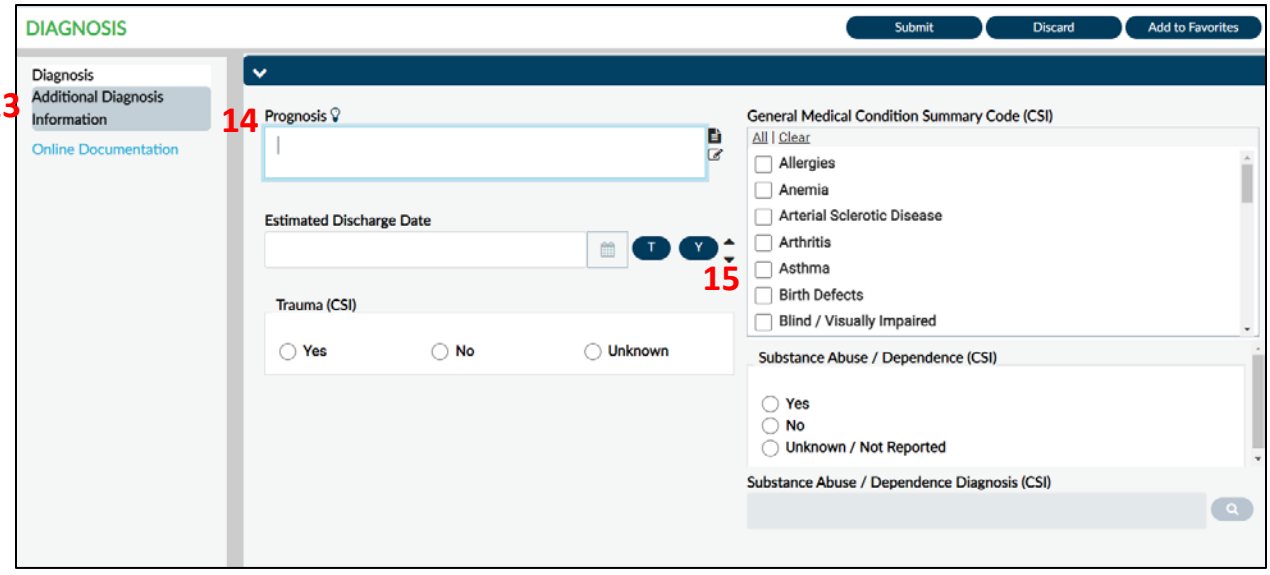


1. Indicate the type of diagnosis this will be. If you choose Admission the date will default to the admission date, this can be changed if needed.
2. Enter the date and time of the diagnosis. Keep in mind the date and time of the diagnosis must be before the date and time of any services for that client.
3. You are able to default a previous diagnosis if there is one on file for that client. Choose the episode the diagnosis is in and the diagnosis that you would like to default. If there is no diagnosis on file for the client the drop down will be blank.

4. The Diagnosis multi-iteration table will display the diagnosis information you enter below. Click New Row to begin. A row can be deleted until the diagnosis has been submitted. Once a diagnosis has been submitted you are not able to delete the row.
5. If there is a voided diagnosis on file for that client you can choose the option to only show active diagnosis.



6. Enter the diagnosis description or ICD-10 code and click the search button  . The more specific the search is the more narrow your search results will be. Make sure the diagnosis you choose includes an ICD-10 and DSM-5 code.
7. Your diagnosis will default to Active status. In order to bill for services your diagnosis will have to be in either Active or Working status. If a diagnosis needs to be removed you can change the status to Void.
8. The Estimated Onset Date is not required but can be entered. We do not use the Resolved Date, that will be greyed out.
9. The Ranking will default to Primary for your first diagnosis, the bill order will show as one. Do not change this information as it can affect your billing. Any diagnosis entered after the Primary can be set as Secondary or Tertiary diagnosis.
10. Present on Admission Indicator will default to Yes, that can be changed if needed. Choose the Classification for the diagnosis you've entered.
11. Enter the Diagnosing Practitioner.
12. Enter any remarks regarding the diagnosis.
13. There is an additional page to the Diagnosis form, Additional Diagnosis Information.

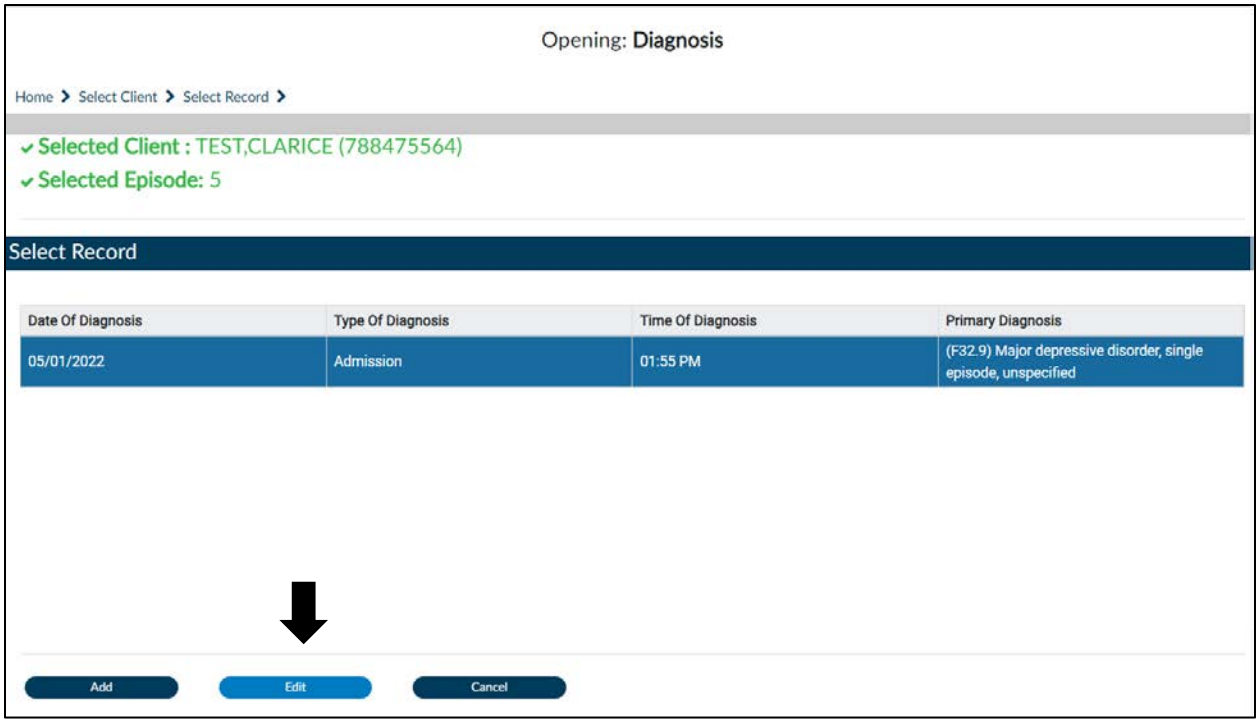


14. The Prognosis and Estimated Discharge Date are not required, however you are able to enter that information.
15. The CSI fields are required for Mental Health programs but not required for Alcohol and Drug programs.
16. Click Submit to save.

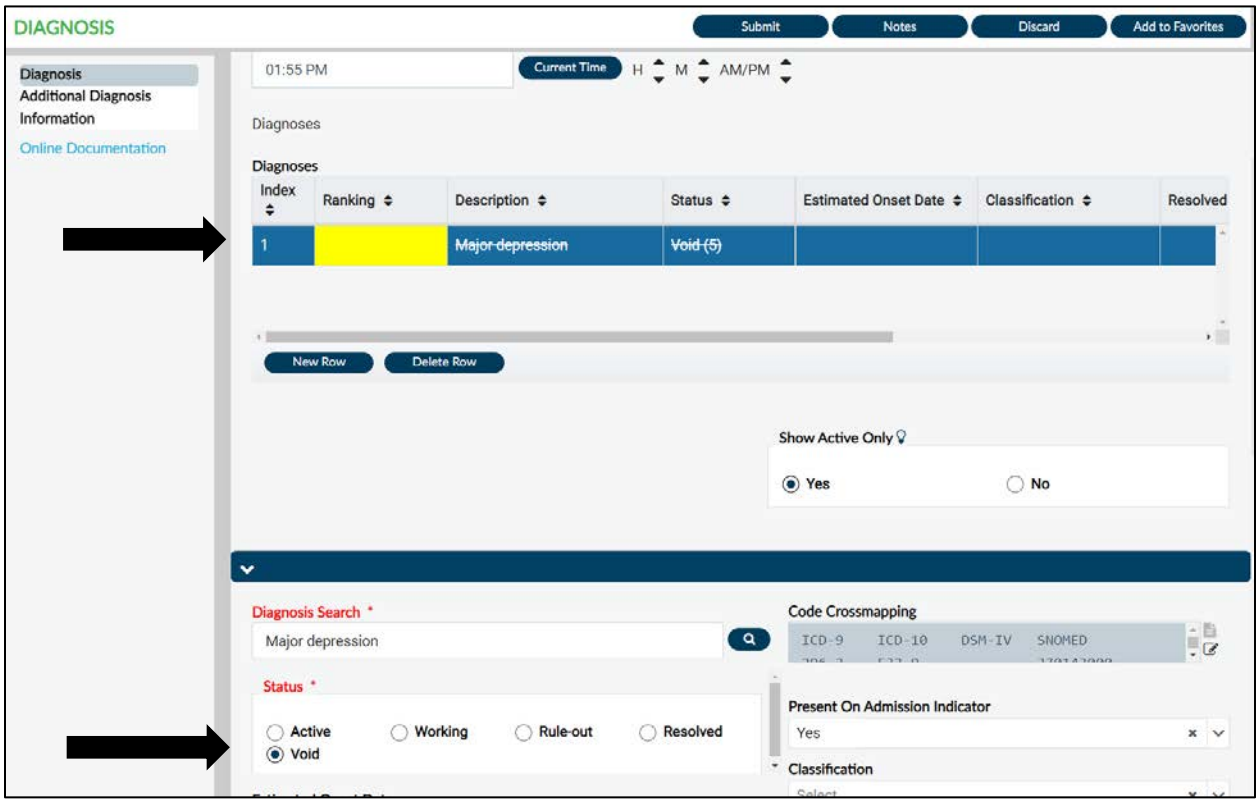
Voiding a Diagnosis

If a diagnosis was entered in error, you are not able to delete the record but you can change the status to Void. Keep in mind, if a diagnosis has been voided, an Active diagnosis still needs to be on file for that client. Make sure to void the diagnosis before entering the new diagnosis.

1. Open the Diagnosis form in Avatar. This will bring you to a pre-display where you are able to choose your episode. Double click on your episode. A second pre-display will show each of the Diagnosis entries entered for that client's episode.



2. Click on the diagnosis that needs to be voided or highlight the entry and click on the Edit button.
3. Highlight the diagnosis on the multi-iteration table that needs to be voided.
4. Change the status from Active to Void

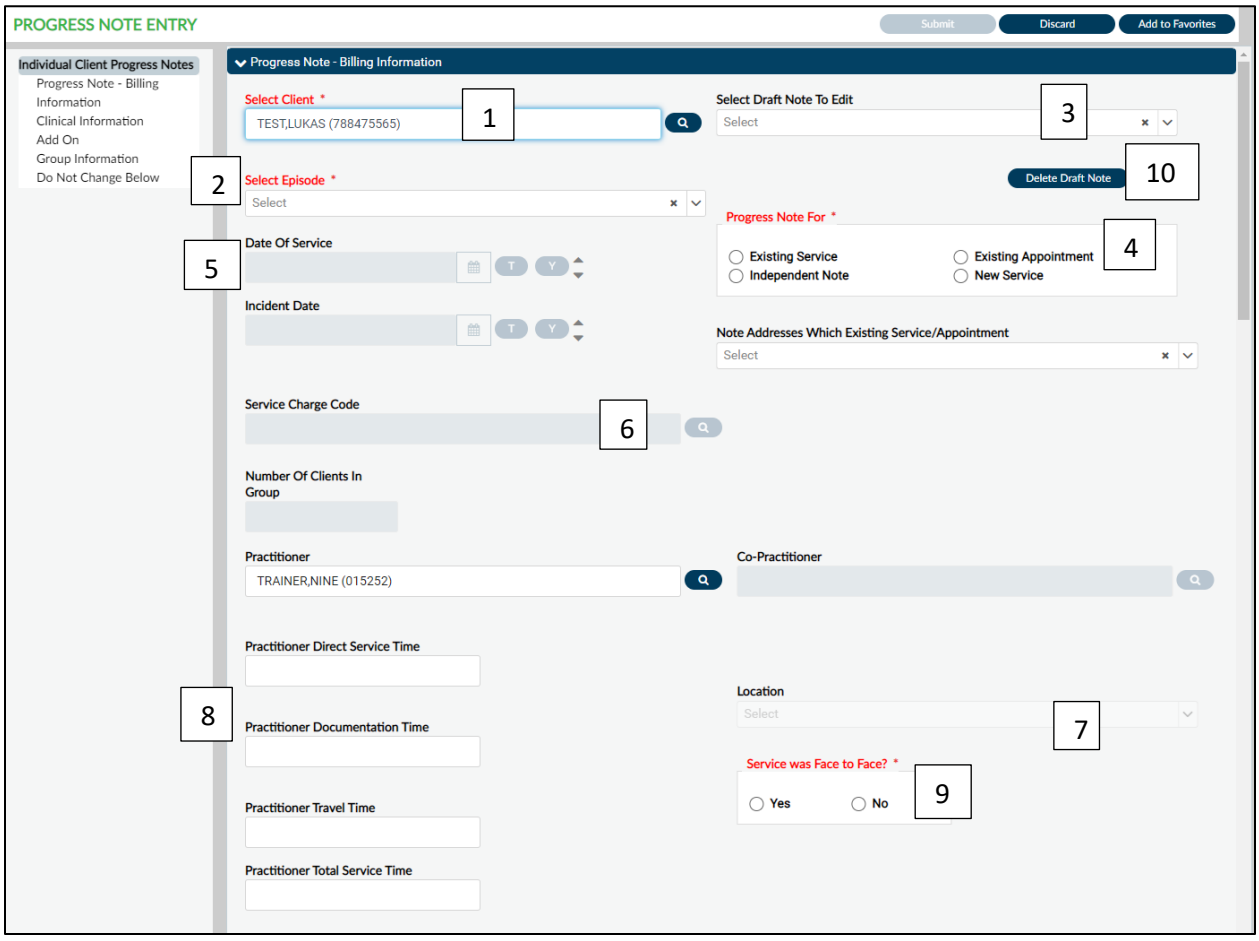


5. Click the New Row button to add the new correct diagnosis entry.
6. Click Submit to save.
7. If a diagnosis has been voided it will show as a 0 diagnosis on the pre-display.

Progress Note Entry

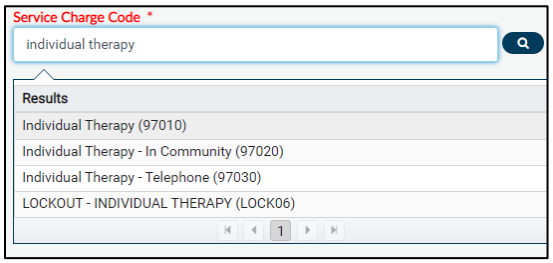
The Progress Note Entry form has two pieces to it. The top portion of the form (steps 1-9), contain the service information. This portion of the form will generate a billable or non-billable service charge. The bottom portion of the form (steps 11-19) is the documentation portion. This portion is where you will document your service activities. For information on the documentation requirements please contact QMInformation@saccounty.net.

This form will only be used by programs that enter documentation in Avatar NX. If your agency uses a different EHR for documentation you will not use this form.

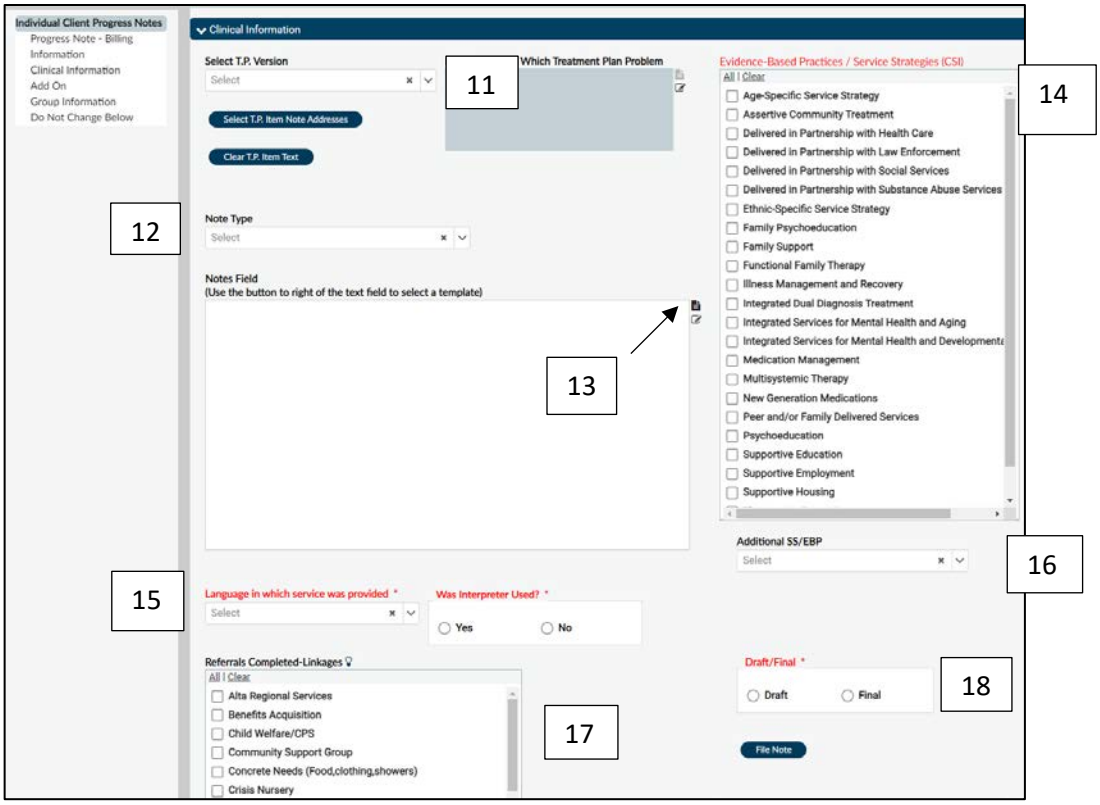


1. Open the **Progress Note Entry** form for the client you are working on. If you select your client prior to opening the form your client's name will populate. Your name will also populate in the Practitioner field. Make sure not to enter anyone into the Co-Practitioner field. If there was a co-practitioner they will have to do their own progress note.

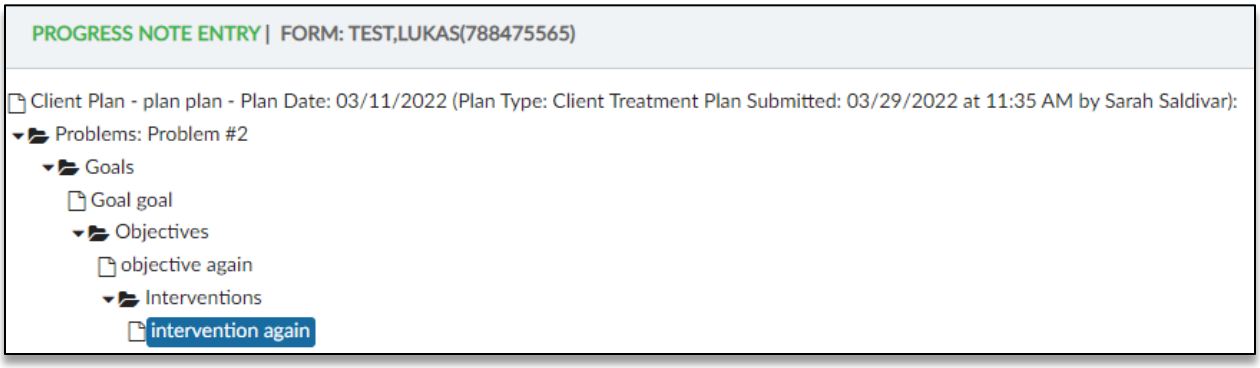
2. Select your Episode from the drop down.
3. If you have a note in Draft status you can find it in the Select Draft Note To Edit drop-down. If you do not have any notes in Draft there will be nothing in the drop down. If you are creating a new progress note you will not need to select anything from the drop-down.
4. Progress Note For is where you select the type of progress note you are entering.
    a. Existing Service- Used primarily for corrections. This is used if a service charge has been entered and a progress note needs to be attached to the service.
    b. Independent Note- Used primarily by Sacramento County MHTC. This note will not create a billable or non-billable service.
    c. Existing Appointment- Used in conjunction with the Avatar Scheduling Calendar. This option will allow you to link a progress note to an appointment. Choose the appointment you want to link from the drop-down below.
    d. New Service- Most of the time this will be the option chosen. This will generate a new service charge, either billable or non-billable.
5. Enter the Date of the service. If Independent Note was chosen you will enter the Incident Date.
6. Enter the service code. This is a search field, when the service code is entered you will double click on the service below.



7. Select the Location of the service.
8. Enter the Direct Service Time, Documentation Time, and Travel Time. When you tab through the sections it will calculate your Total Service Time at the bottom. Make sure not to change the Total Service Time.
9. Indicate whether the service was Face to Face. This means the clinician was face to face with the client, not with a family member or caregiver. This option would be marked Yes if the clinician chose Telehealth as the location.
10. If a draft progress note needs to be deleted you are able to delete the note. Once the note has been finalized you are no longer able to delete the note. There are two representatives from each agency with the permissions to void progress notes. If a finalized progress note needs to be voided you will need to contact that person at your agency to void the note for you.



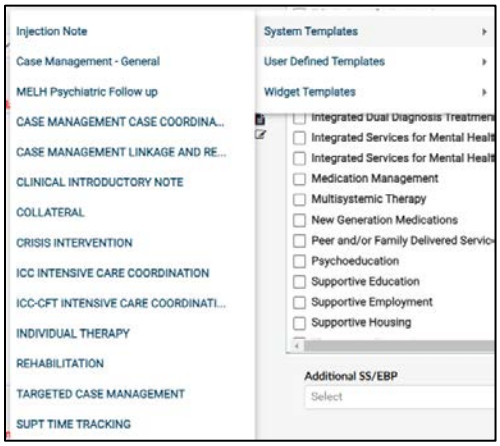
11. You are able to link the client's client plan to the progress note. Click on the T.P. drop down and choose the treatment plan type. Click on the Select T.P. Item Note Addresses button, an outline of your most current treatment plan will populate. If there is no outline, that is because there is no treatment plan for that episode. Click on the section of the treatment plan that this progress note is addressing. Click Return at the bottom of the page to get back to the progress note. If the wrong section is chosen you can click on the Clear T.P. Item Text button.



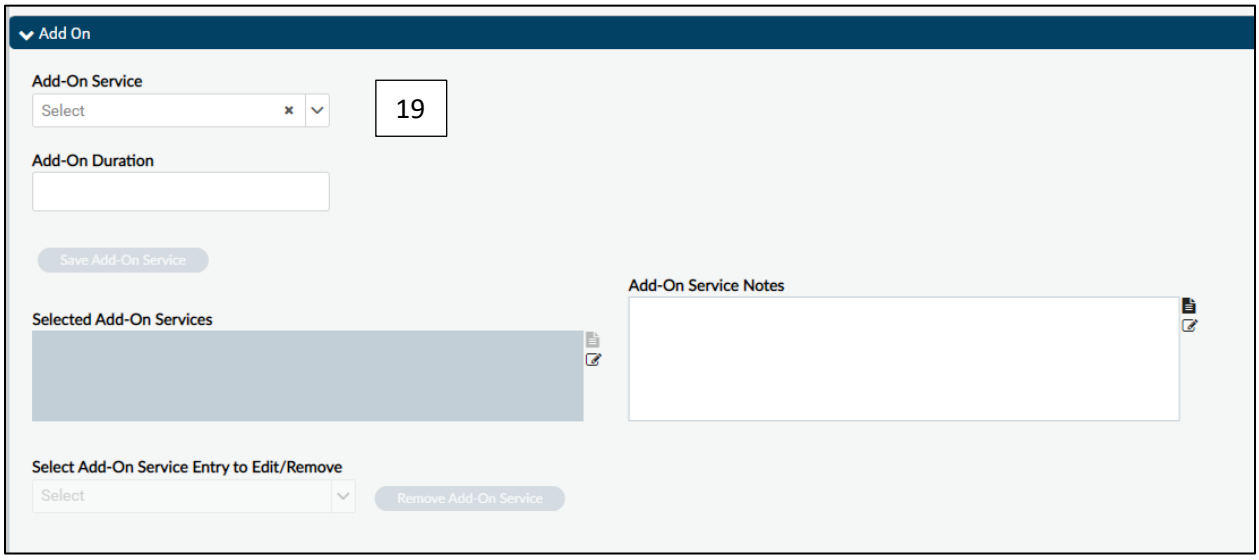
12. Choose your Note Type from the drop-down. If you require a co-signature, the note types will say co-signature next to each note type. If there are no note types in the drop

down, please have your supervisor contact QM Staff Registration to update your staff registration paperwork.

13. The Notes Field is where you enter your documentation. There are templates available for certain note types. To access the templates, click on the template icon to the right of text field, select System Templates, and click on the Template available.



14. Check with your agency to find out which EBP's you should be using. Each agency has specific EBP's that they use, make sure you are selecting something appropriate to your agency. If no EBP's were used check the box for Unknown. This field is required for state reporting.
15. Choose the language the service was provided in and indicate whether there was an interpreter used.
16. These EBP's are Sacramento County specific, this does not get reported to the state and therefore is not a required field. Your agency may however collect this data, make sure to check with your agency to find out which EBP's you should be using. Each agency has specific EBP's that they use, make sure you are selecting something appropriate to your agency.
17. Mark any referrals (if applicable) you may have made to your client that pertain to this progress note.
18. The Workflow Control is where you are able to save your work. Your work will not be saved until you click the File Note button. You will have to save your work in either Draft or Final Status. Draft status means you are still working on the note and will need to come back to it. Final status means you have completed the note, if you require a co-signer by choosing Final you are sending the note to your supervisor. If you do not require a co-signer the note will be finalized and no longer editable.



19. Certain service codes allow for add-on services. If the service code you are using allows for an add-on these fields (or parts of these fields) will become enabled. Make sure you are following documentation guidelines when using add-ons. For any questions on when it is appropriate to use an add-on code please contact QMInformation@saccounty.net.

Accessing a Draft Progress Note

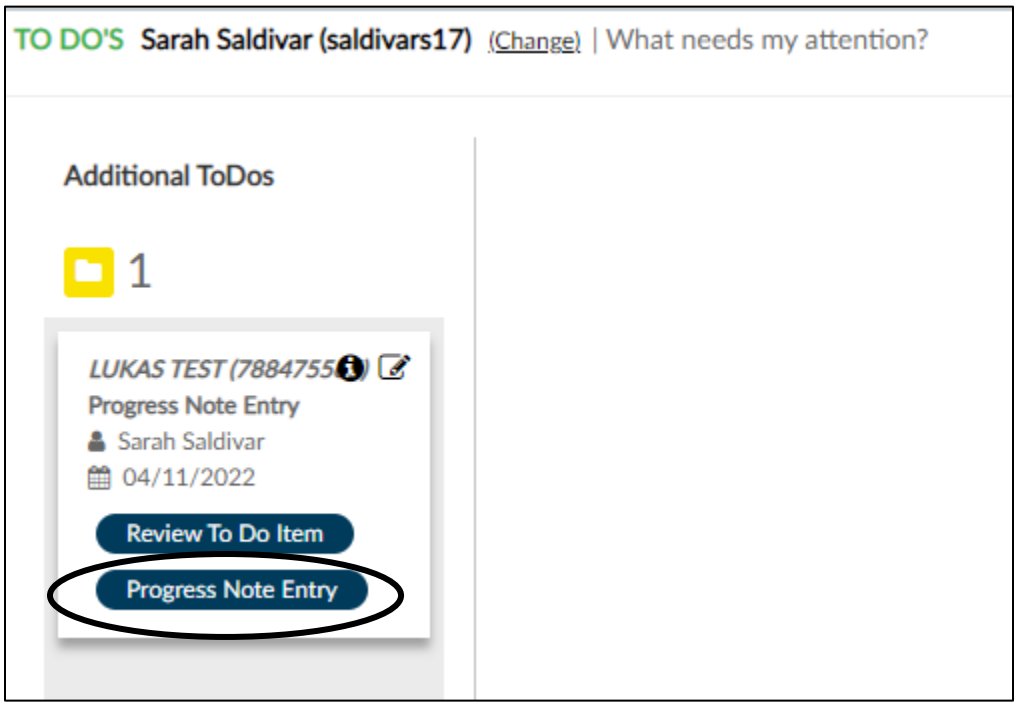
There are several ways to access a progress note that was filed as a draft. Below are three different ways to access a progress note saved in draft.

My To Do's Widget

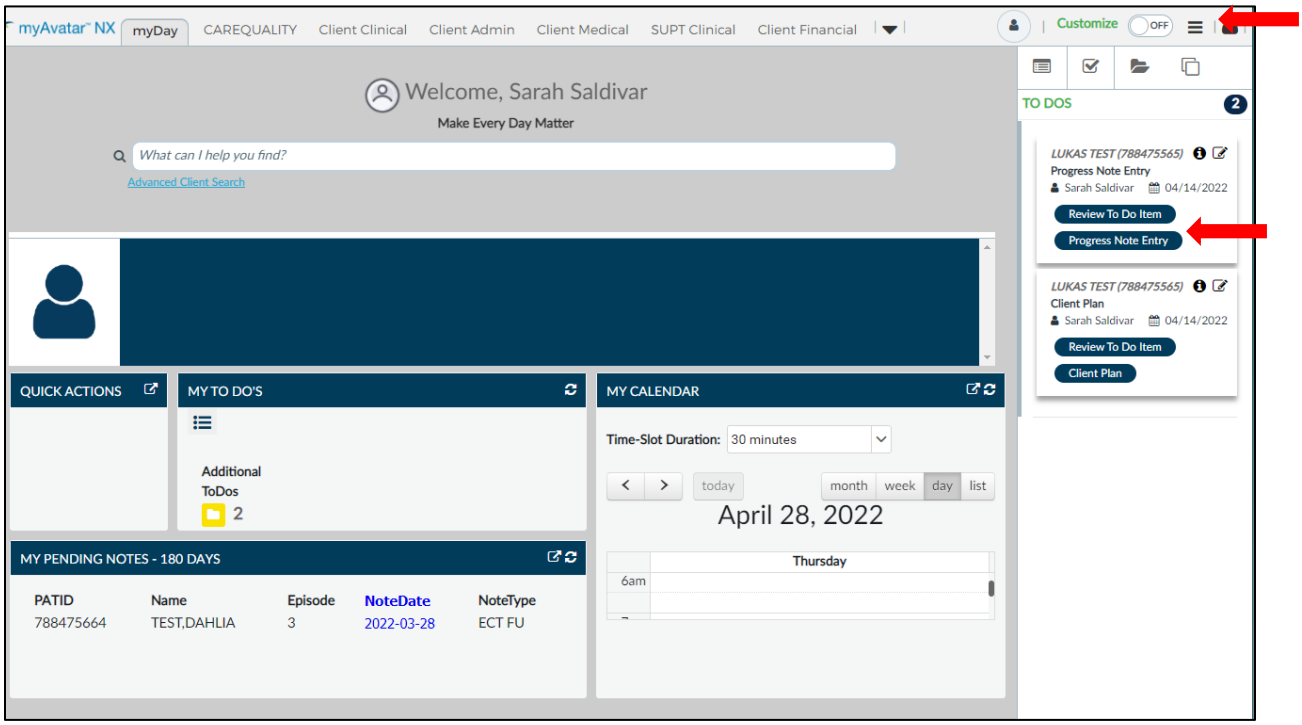
The **My To Do's widget** is located on your myDay view. It will list any items you either need to review or have been left in draft status.

1. To access a note in draft, click on the Additional ToDos button.

2. A new window will open and display a list of your ToDos. Clicking on the form name will take you back to the draft item.

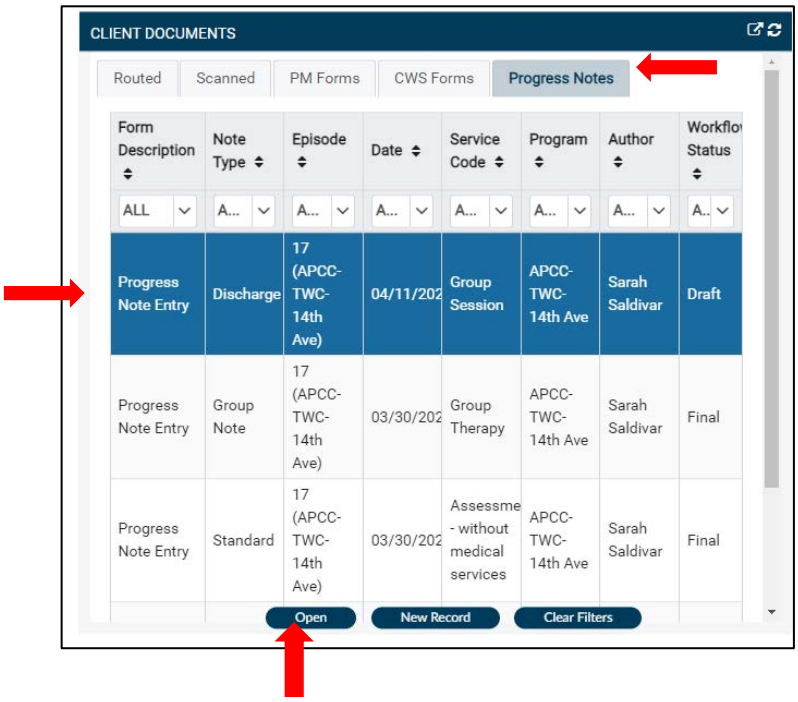


3. Your ToDos can also be accessed through the My Activity section, selecting the ToDos tab. Clicking on the form name will take you back to the draft item.



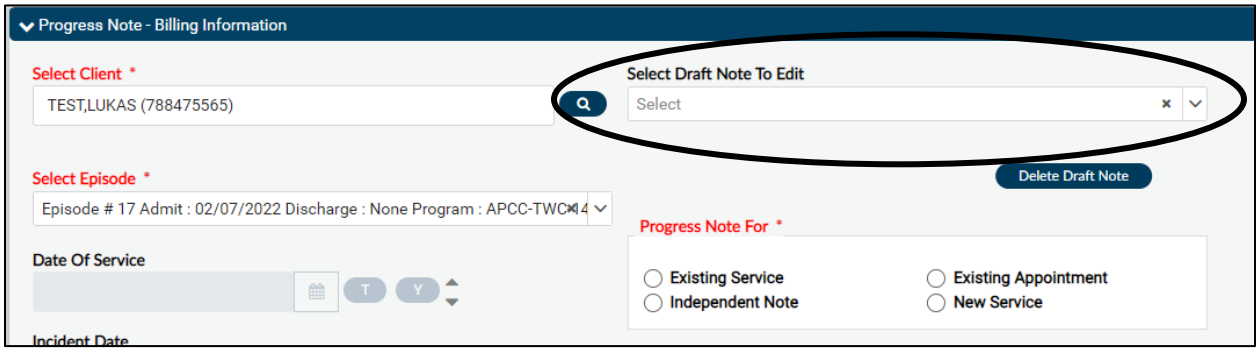
Client's Dashboard

Open the client's dashboard and locate the Client Document widget on the left-hand side. Find the note you need to edit, click on the row to highlight it and click the Open button on the bottom of the widget.



Blank Progress Note Entry Form

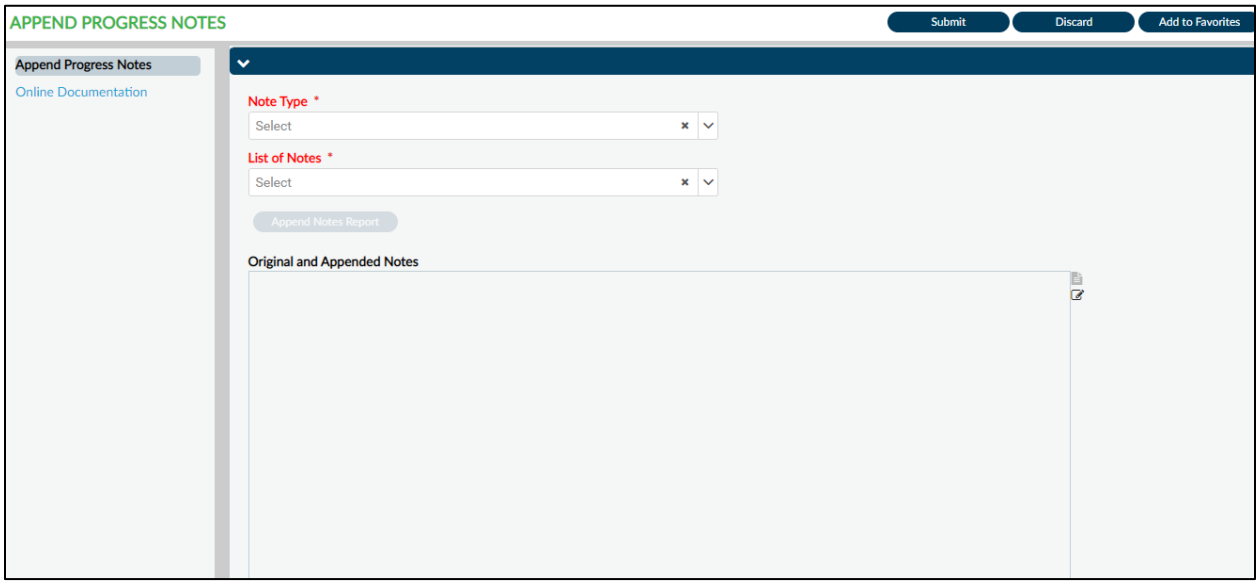
From the myDay view open the **Progress Note Entry** form. You can highlight your client prior to open it specifically for that client or enter in the client's information once the form has been opened. Select the appropriate episode on the Episode drop-down. Click on the Select Draft Note To Edit drop-down. Select the draft note you want to edit.



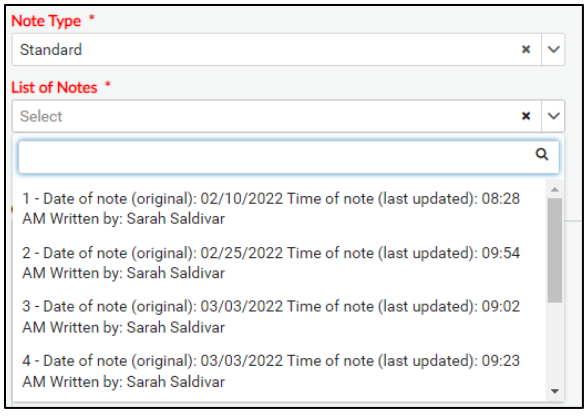
Append Progress Notes

Once a note has been finalized you cannot edit the note, however in certain circumstances you can append a progress note. You cannot change the content of the original note, you can only add additional information. In order to append a progress note it has to be within 45 days of the note and you are only able to append a note if you do not require a co-signature for progress notes. You can access **Append Progress Note** by opening the **Append Progress Note** form.

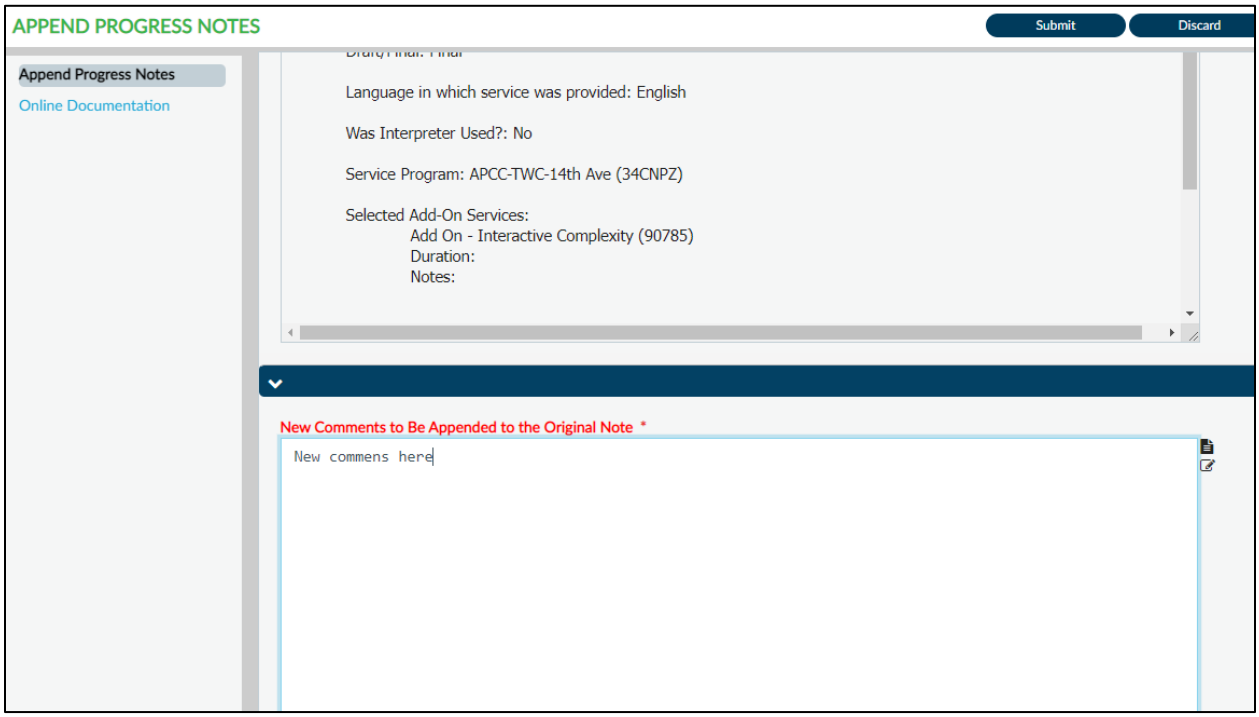
This form will only be used by programs that enter documentation in Avatar NX. If your agency uses a different EHR for documentation you will not use this form.



1. Locate the note you wish to append. You will locate the note by choosing the note type and then find your note in the list of Notes drop-down. Click on the note that needs to be appended.



2. The original content of the note will populate below. This cannot be edited. Below the original note there will be a section for you to add new comments. Add your comments and click Submit to save.

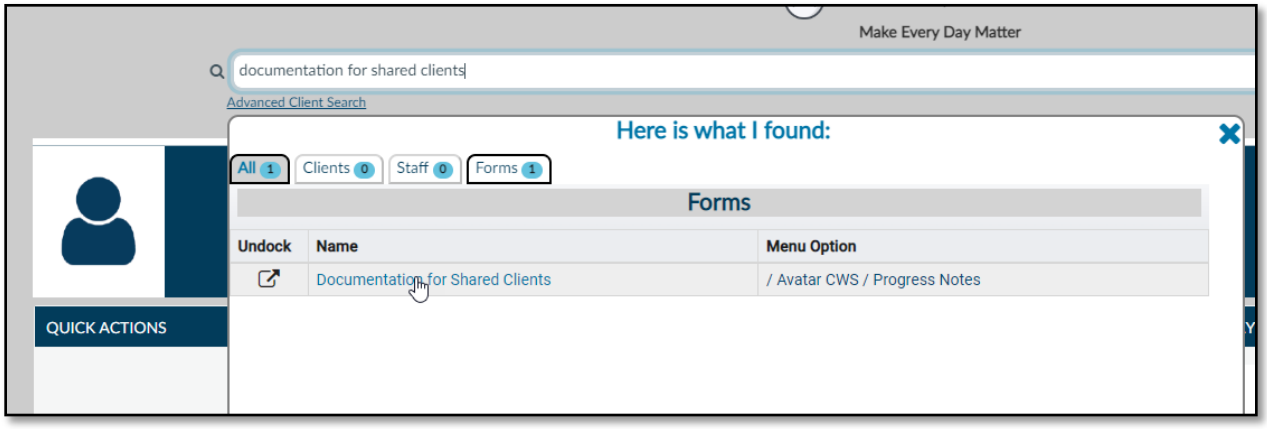


Documentation for Shared Clients

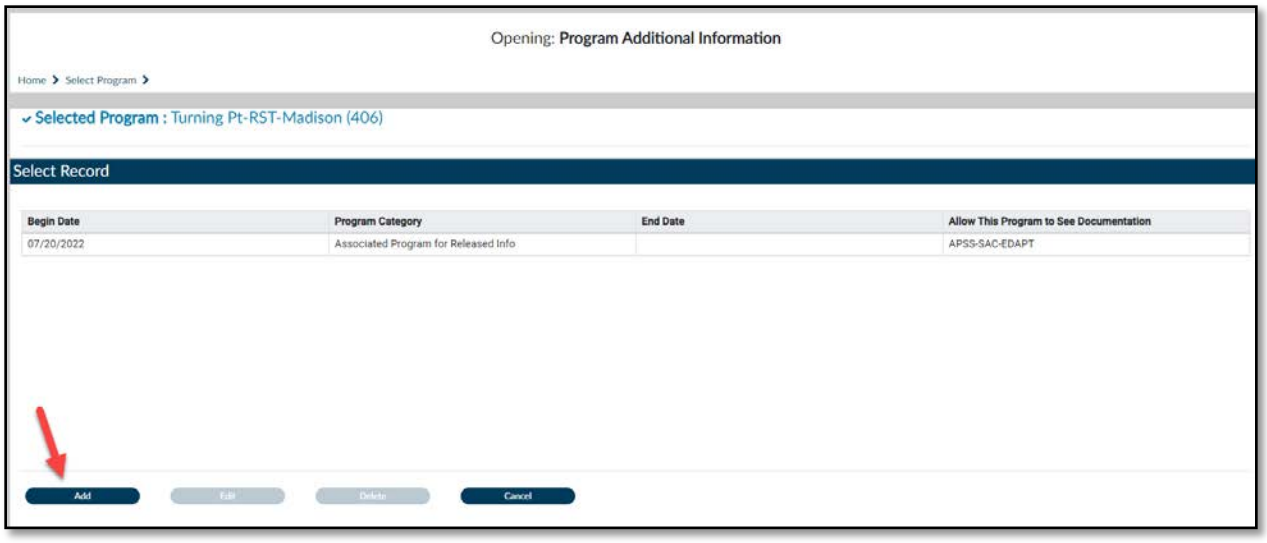
This form will only be used by programs that enter documentation in Avatar NX. If your agency uses a different EHR for documentation you will not use this form.

This form is for the sharing of Progress Notes and Mobile Assessments from one program to another. You will be able to view in a report the information that is selected. ECM Providers will be able to access Outpatient documentation by using this form. The client must already be admitted into the ECM episode prior to launching the **Documentation for Shared Clients** form.

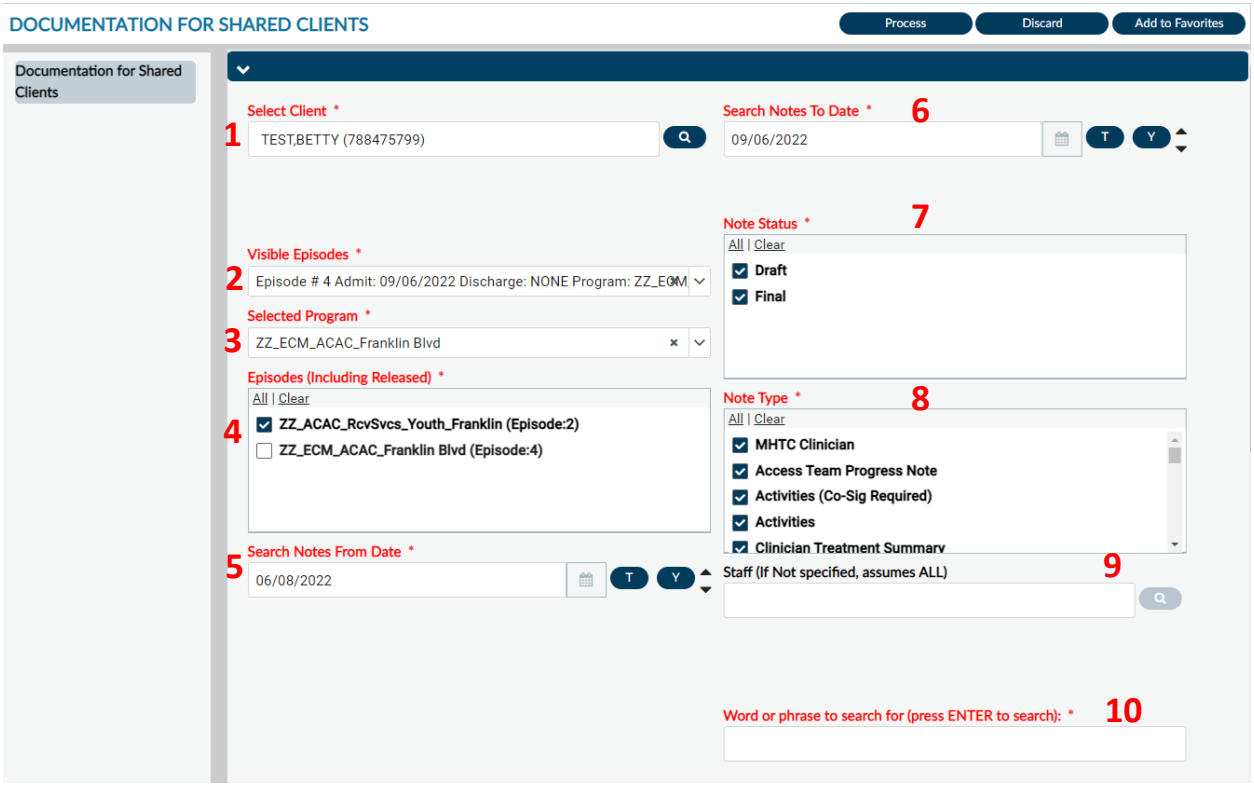
From the "**What can I help you find?"** Search box type in **"Documentation for Shared Clients"**



If there is already a saved record you will come to a pre-display and from there you will select "Add". If there are no previous records, you will go directly into the form.

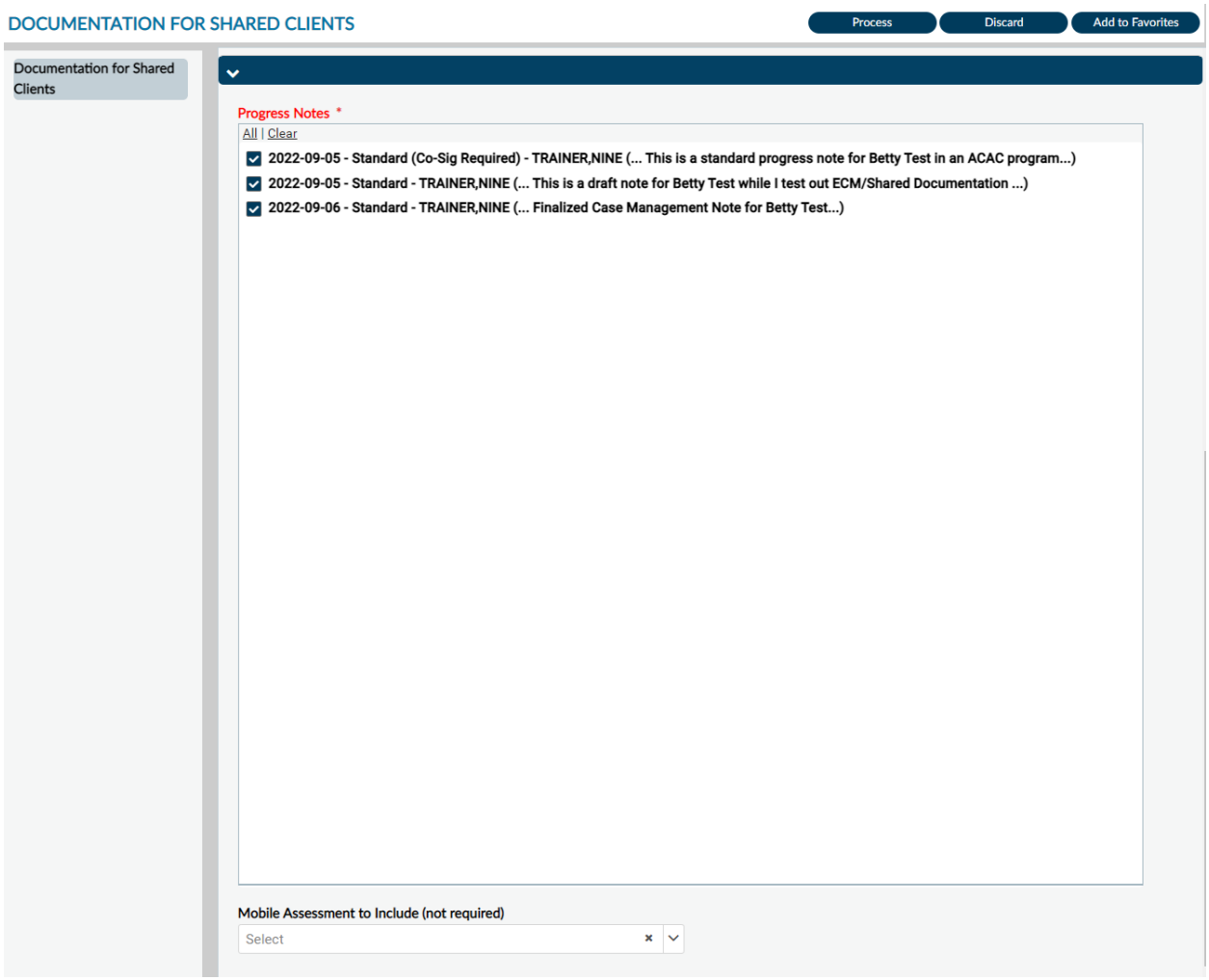


Once in the form you will need to select all of the options to narrow the search results.



1. Enter the Shared Client by searching via name, Avatar ID, Date of birth, etc
2. Select the open ECM episode.
3. Select your ECM program.
4. Click on the boxes next to the episodes you would like to view documentation from. All ECM episodes will have ECM in the beginning.
5. Enter the start date for timeframe you are searching for
6. Enter the date you would like to end the search.

7. Select whether you would like to see notes in Draft Status, Final Status or both.
8. Here you can select which note type(s) you would like to view. To select all note types, click the “All” button. All note types will then be selected.
9. Enter the name of a specific staff member, if you leave this field blank it will search for all staff.
10. Hit the “space bar” then the “enter” keys on your keyboard to search for all Progress Notes/Mobile assessments. You can also enter a specific word or key phrase to search for.



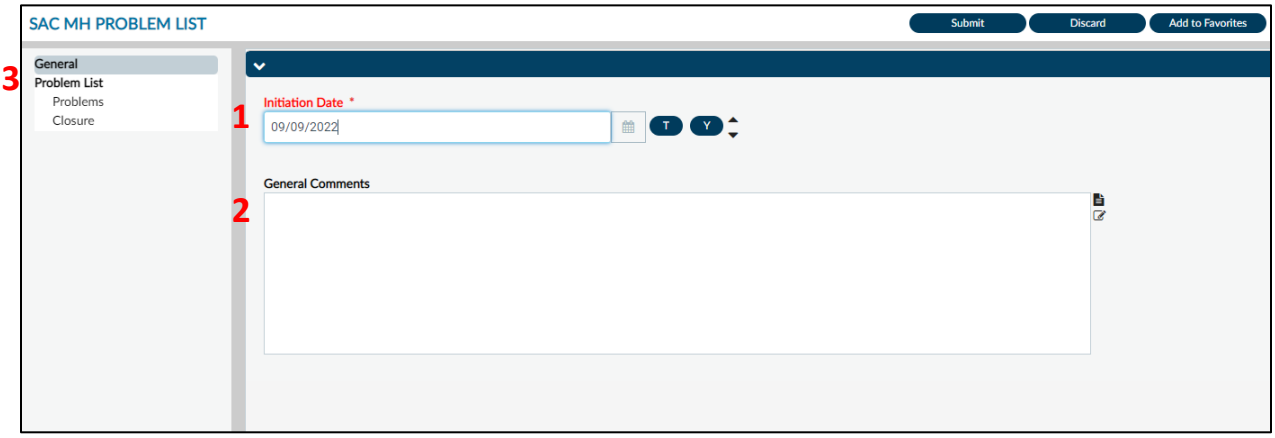
Problem List

Problem List Information:

As part of the updates to the California Medi-Cal system CalAIM initiative, Sacramento County Behavioral Health Services is moving forward with implementing The Problem List effective August 1, 2022. The **Problem List** will correlate with the Diagnosis. The Diagnosis Entry would still need to be completed as that ties to claiming. There are some services that have a mandate for treatment plans (i.e., federal or payer associated requirements); however, this may replace a Client Plan in some instances. For questions on documentation requirements for this form please contact QMInformation@saccounty.net.

This form will only be used by programs that enter documentation in Avatar NX. If your agency uses a different EHR for documentation you will not use this form.

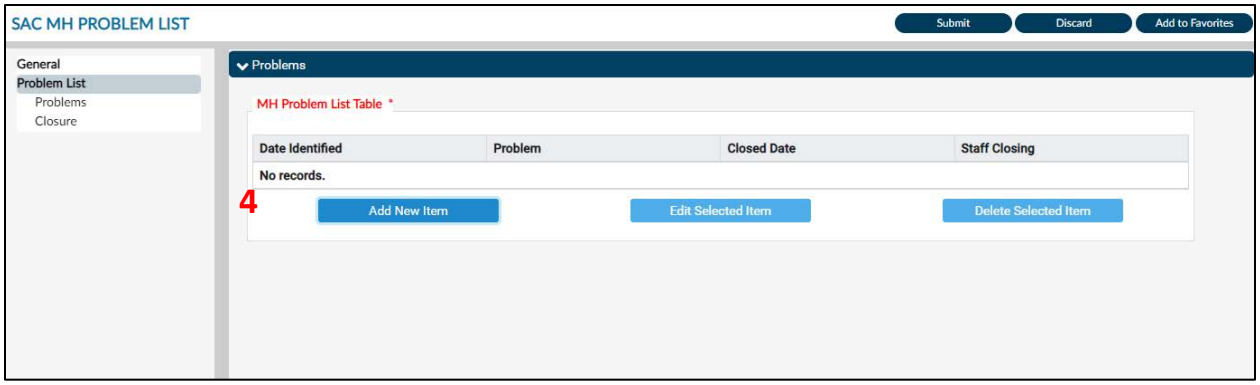
Problem List Form



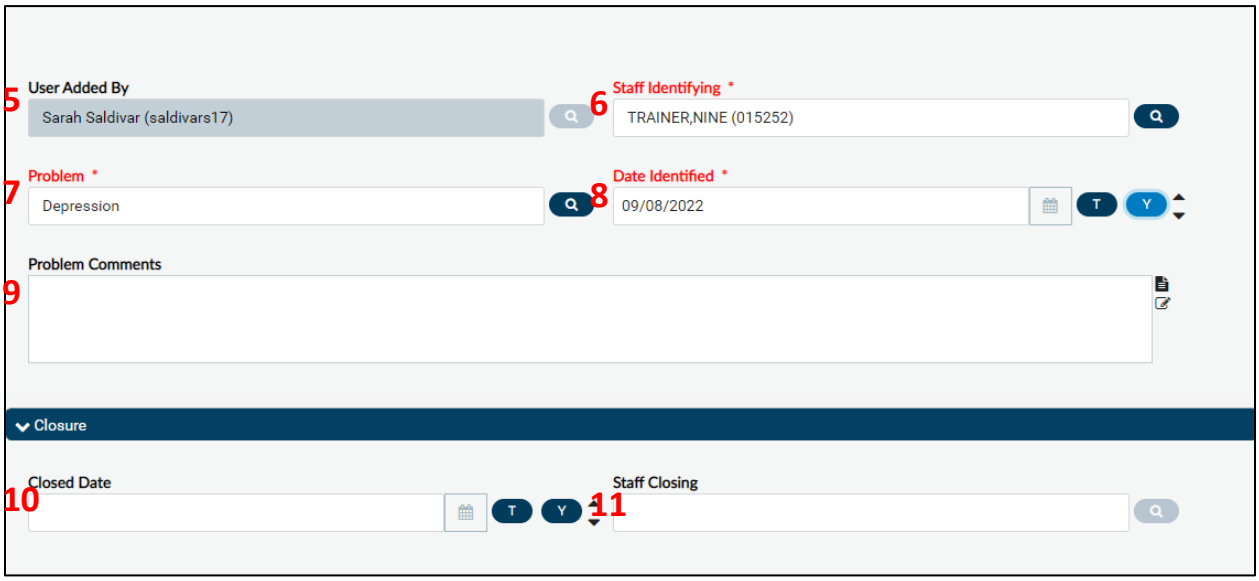
The name of the Problem List form is different depending on if you are a MH or SUPT provider

a. SUPT Providers will launch the Problem List via the **SAC SUPT Problem List** form
b. Mental Health Providers will launch via the **SAC MH Problem** List form

1. Enter the Initiation Date for the Problem List
2. Enter any general comments in this field.
3. This will take you to an additional page where you will enter the specific Problems for your client.



4. The Problem List multi-iteration table will display the problem information you enter below. Click Add New Item to begin. A row can be deleted until the diagnosis has been submitted. Do not delete a problem that has been resolved or closed, only one that has been entered in error.

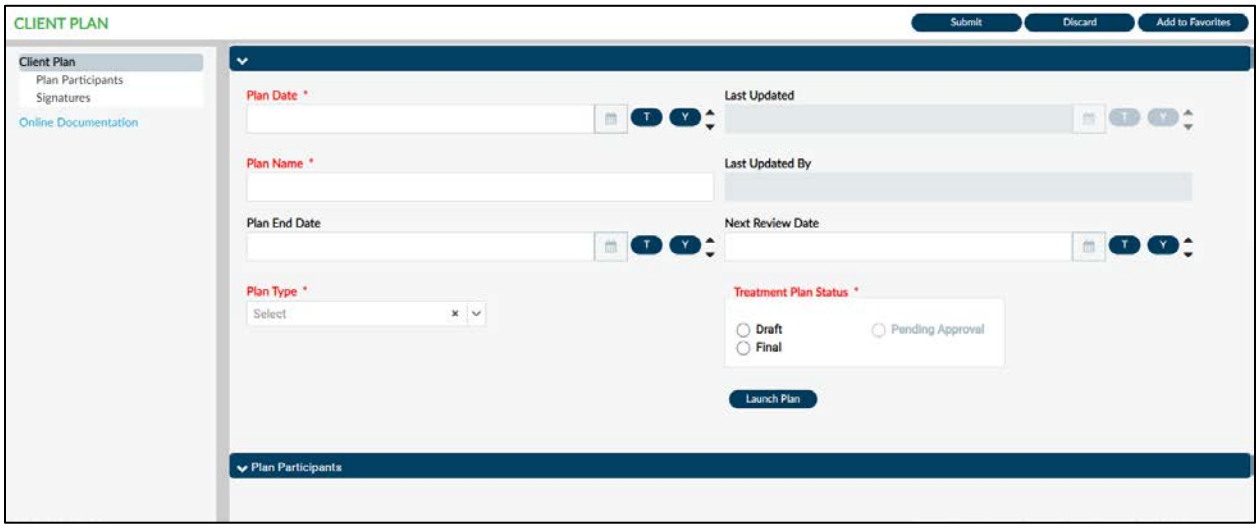


5. This will automatically populate with the name of the user who has added the problem
6. Enter the name of the staff that has identified the problem
7. Enter the diagnosis description or ICD-10 code and click the search button  . The more specific the search is the more narrow your search results will be. Make sure the diagnosis you choose includes an ICD-10 and DSM-5 code.
8. Enter the date the problem was identified.
9. Any additional comments about this problem can be identified in this field.
10. If the problem has been closed, select a previous entered problem in the mutli-iteration table in section 4 and click “Edit Selected Item”, this will enable you to enter the Closure Date in this field.
11. Enter the name of the staff who is closing out this problem item.
12. You can add additional problems by repeating steps 4-11
13. Once you have finished, click Submit at the top of the form.

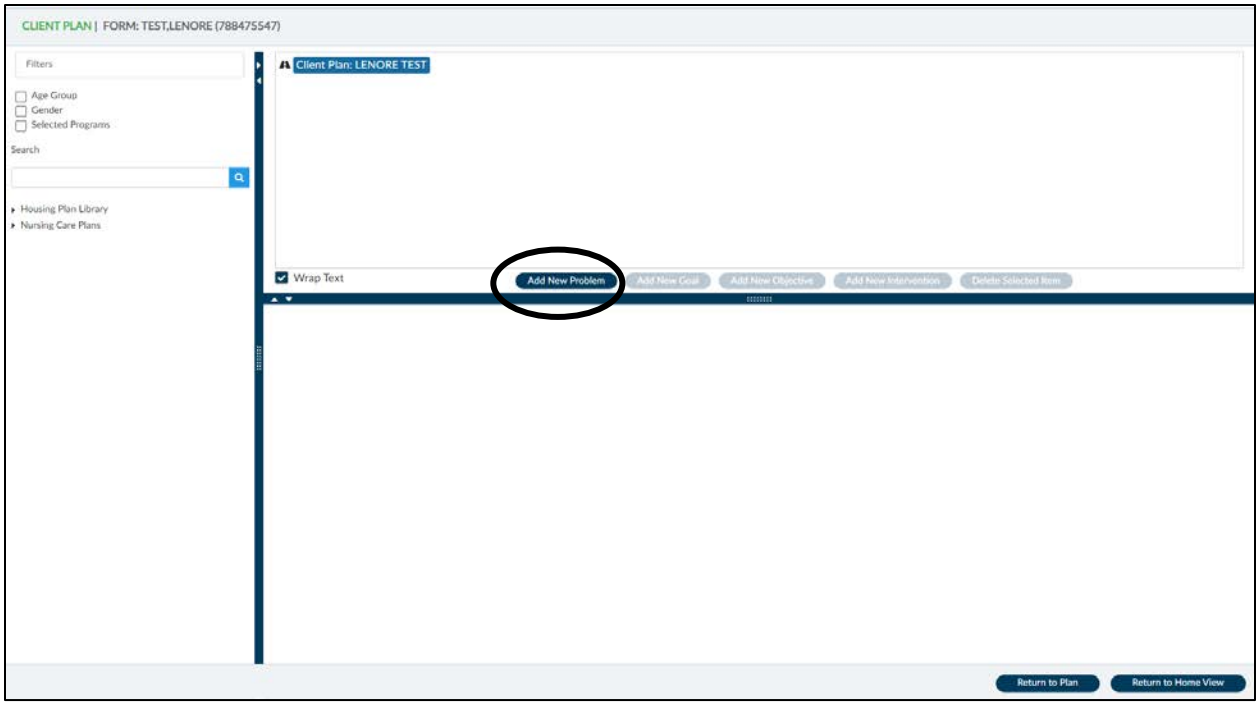
Client Plan

This guide is designed to be a tool to help users navigate through the newly designed **Client Plan** form in Avatar. For any questions regarding documentation requirements when filling out this form please contact QMInformation@saccounty.net.

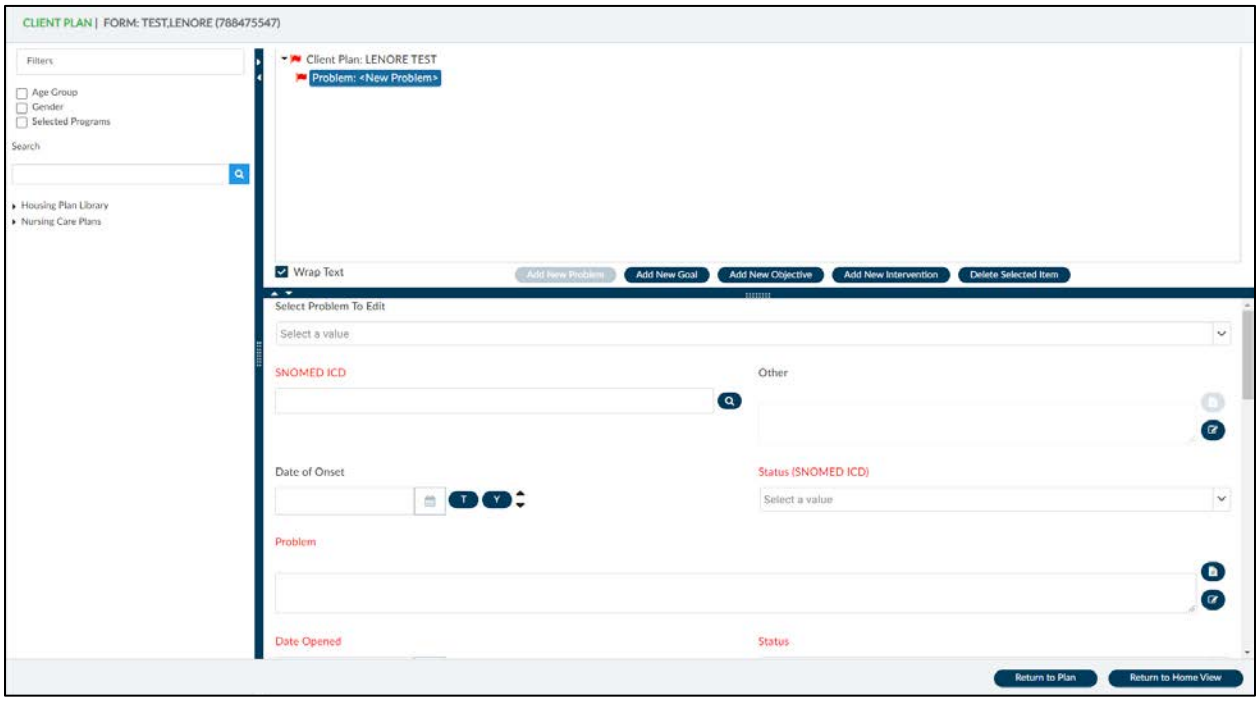
This form will only be used by programs that enter documentation in Avatar NX. If your agency uses a different EHR for documentation you will not use this form.



1. Open the **Client Plan** form
2. Enter your Plan Date. Once you enter in a plan date the End Date and Next Review Date will automatically populate. The Plan End Date will default to one year from your Plan Date and the Next Review Date will default to 45 days before the Plan End Date.
3. Enter a Plan Name and choose a plan type.
4. Choose your Treatment Plan Status. This should remain in Draft until it is completed, then it can be switched to Final or Pending Approval if you require a Co-signature.
5. Click on the Launch Plan button. Steps 1-4 must be completed before you are able to choose **Launch Plan**.

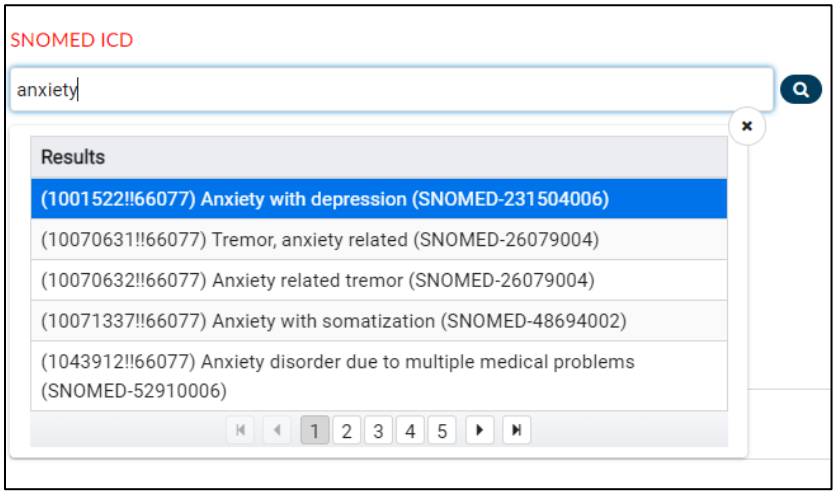


6. Click on Add New Problem

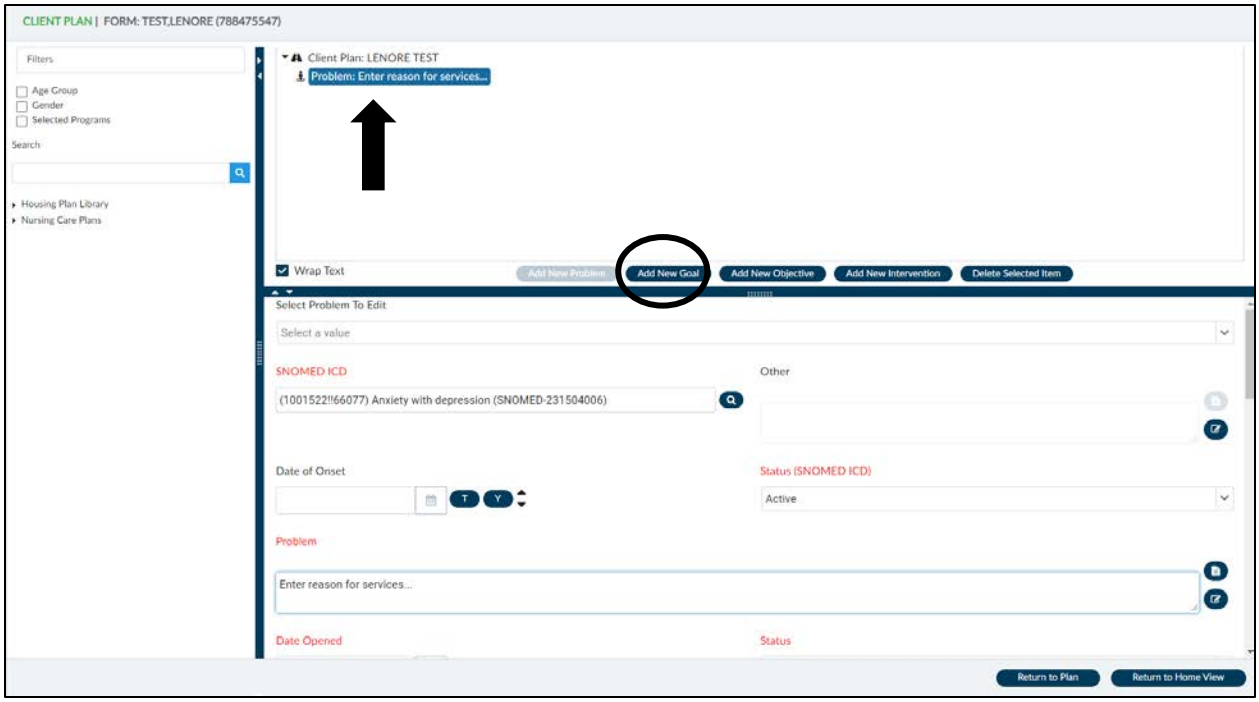


7. The Select Problem to Edit drop-down will be blank unless a problem was added in the CORE assessment. If you are choosing an existing problem select that problem from the drop-down. If it is a new problem select the blank line.

8. Under the SNOMED ICD type in the SNOMED ICD code you are addressing. The field is a look up field so options will populate as you enter in data. For example, if you type "Anxiety" into the field, all codes that include the word Anxiety will populate. The more detailed of a search you enter the more narrow your search results will be. If you type in the ICD 10 code, it will crosswalk to the SNOMED code. Please note once the plan has been submitted in either Draft or Final status the SNOMED code cannot be changed.

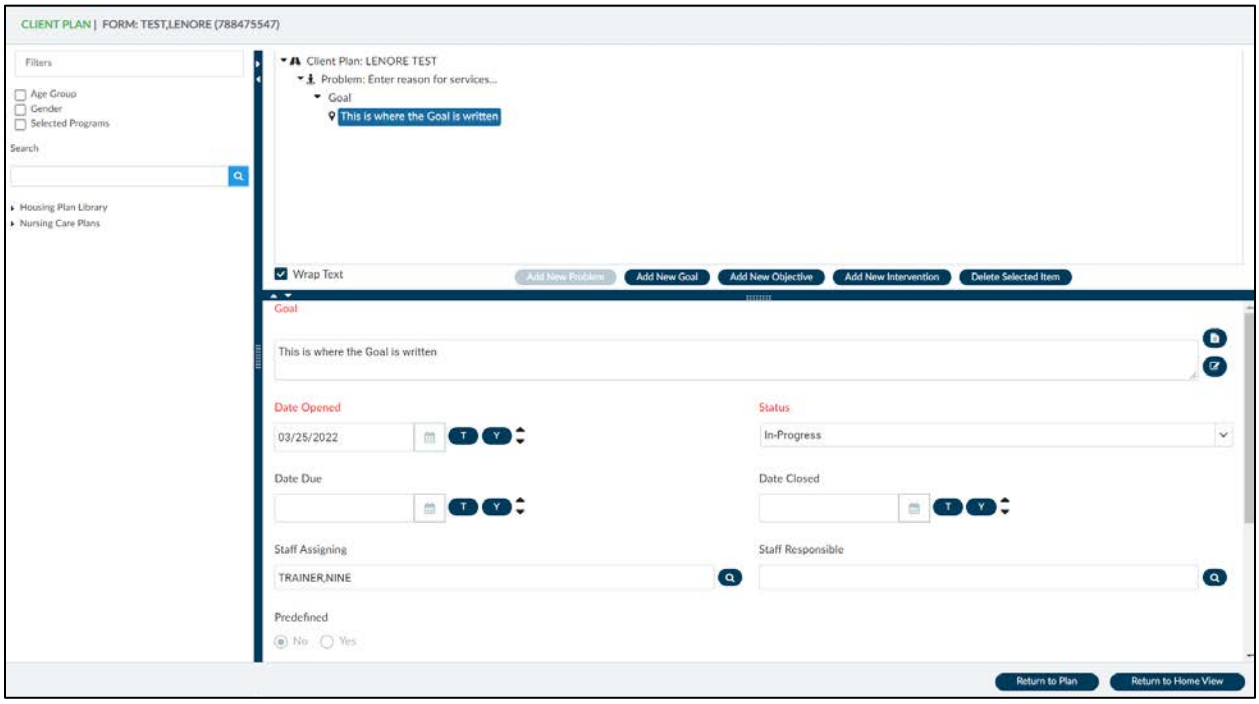


9. The Date of Onset field is not required, however you are able to enter a date if applicable.
10. Under the Problem field address your client's reason for service. Make sure your reason for service meets all documentation requirements per Quality Management.
11. Enter the Status of the plan under Status and Status (SNOMED ICD). The Status (SNOMED ICD) has only one choice available, Active status.
12. Enter the Date Opened. The Date Due and Date Closed are not required.
13. Enter the Staff Responsible, Staff Assigning, and Non-Staff Responsible Party.
14. Indicate the Functional Area/Life Domain for this reason for service.
15. Enter the Clients Reason for Services in Their Own Words. This field is not marked red and required to save the form, however; it is required per QM's documentation requirements.
16. Indicate all Sources of Information that apply for this reason for service.
17. Once you have completed this section click on Add New Goal. See screen shot below. It is important that you enter each piece in order. For example, you would want to enter your goal before your objectives and interventions, that way they are linked to the goal.



18. Enter the client's Goal, make sure to follow all documentation guidelines per Quality Management.
19. The Date Opened will populate based on what you entered in the previous screen.
20. Due Date and Date closed are not required.
21. The Staff Assigning will automatically populate to your name. Enter the staff responsible in the Staff Responsible field, this may be you or may be a supervisor.
22. Enter the client's Strengths and Barriers to Recovery and Client's Goals in Their Own Words. These fields are not marked red and required to save the form, however; they are required per QM's documentation requirements.

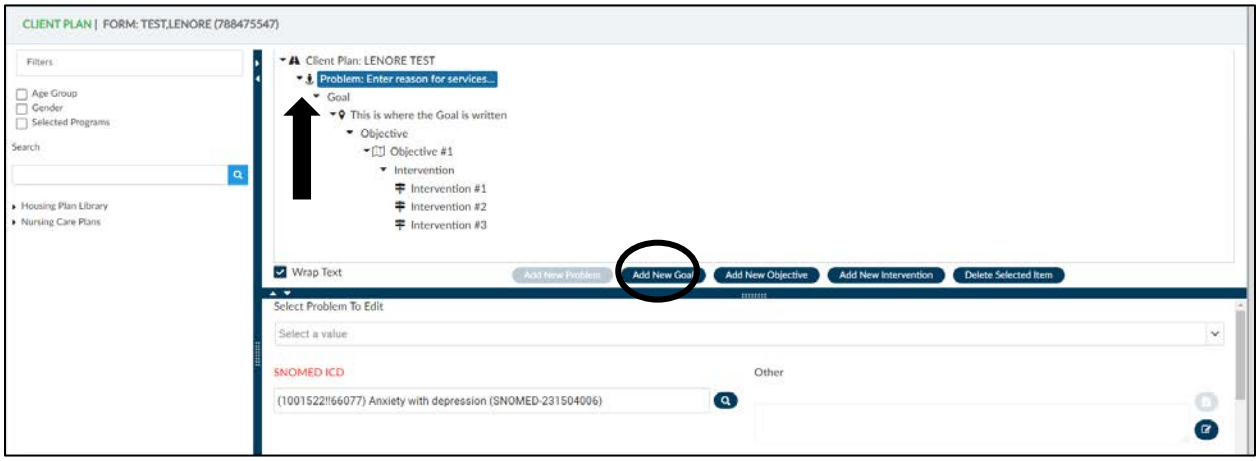
The screen shot below shows the Goal Section. Once you have entered your Goal click on Add New Objective.



23. Enter the client's Objective make sure to follow all documentation guidelines per Quality Management.
24. The Date, Status, and Staff fields are the same fields that are found in the Goals section.
25. Enter the Client's Objectives in their own words. This section is not red and required to save the form, however; it is required per QM's documentation requirements.
26. Additional Objectives can be added to your goal. To do this you would click on your Objective in the display above and then click on Add New Objective once you have completed the Interventions for the first Objective.

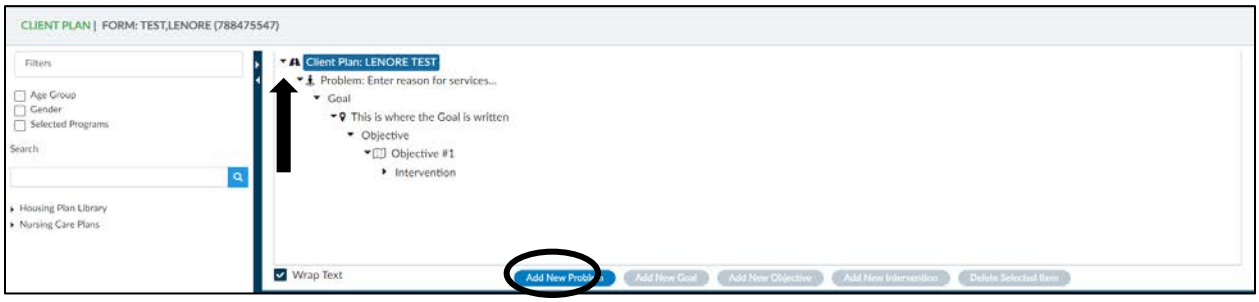
27. Click Add New Intervention to add an Intervention to your Objective.
28. Enter the Intervention make sure to follow all documentation guidelines per Quality Management.

29. Indicate the Type of Intervention
30. Enter the Duration and Frequency of the Intervention.
31. Additional Interventions can be added to your objective. To do this you would click on Add New Intervention once you have completed your first Intervention.
32. Additional Goals can be added to your Reasons for Services. After entering the Objective and Intervention you can click on your Reasons for Services at the top of the plan and then click Add New Goal.



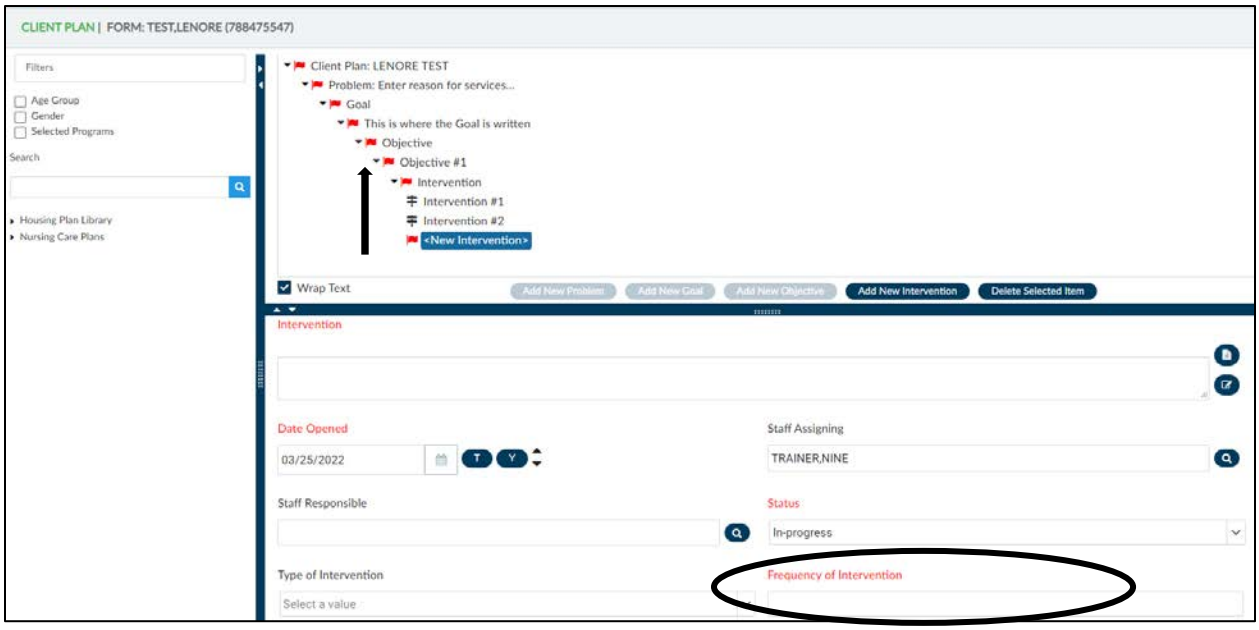
A New Goal section will be added to your Plan. You are able to follow those same steps to add additional Objectives or Interventions.

33. The same process is done if a new reason for service needs to be added. Click on the Client Plan name on the top of your plan and then click Add New Problem.

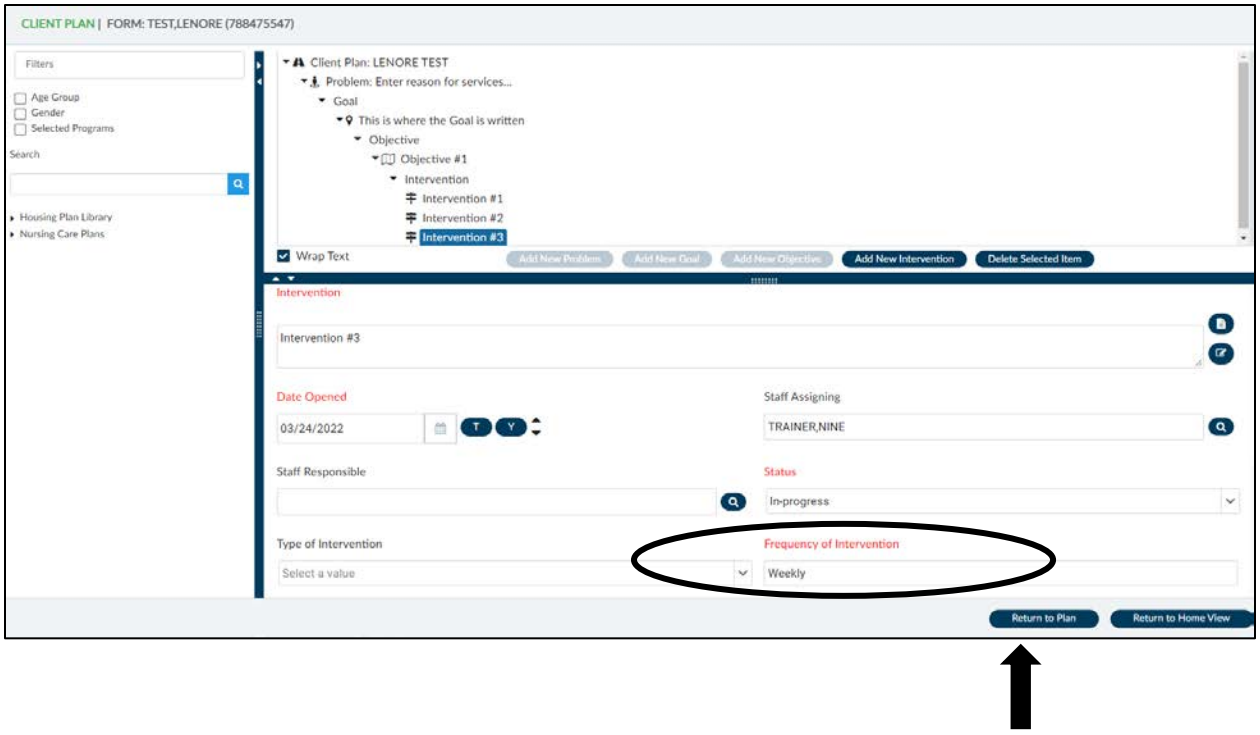


34. If at any point a section needs to be removed you can highlight the section above and then click on the Delete Selected Item button. Please note if a section needs to be deleted it has be deleted from the bottom up. For example, if a Goal needs to be deleted you would need to first delete the Intervention, then the Objective, and finally the Goal.

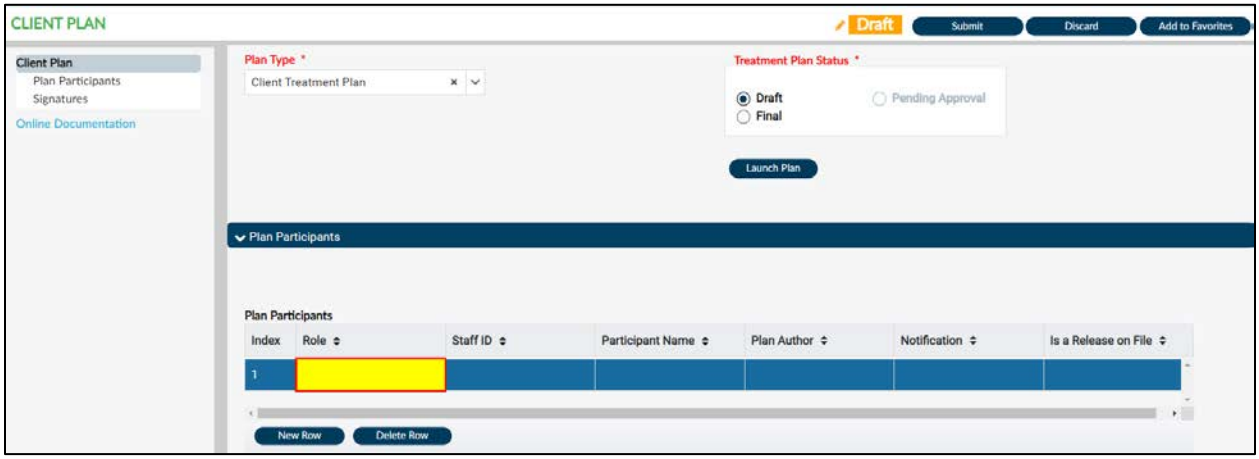
35. Each time you add a new item red flags will appear at the top until you have entered all red and required fields for that item.



36. Once all of the red and required fields in that section have been completed the red flags will go away.

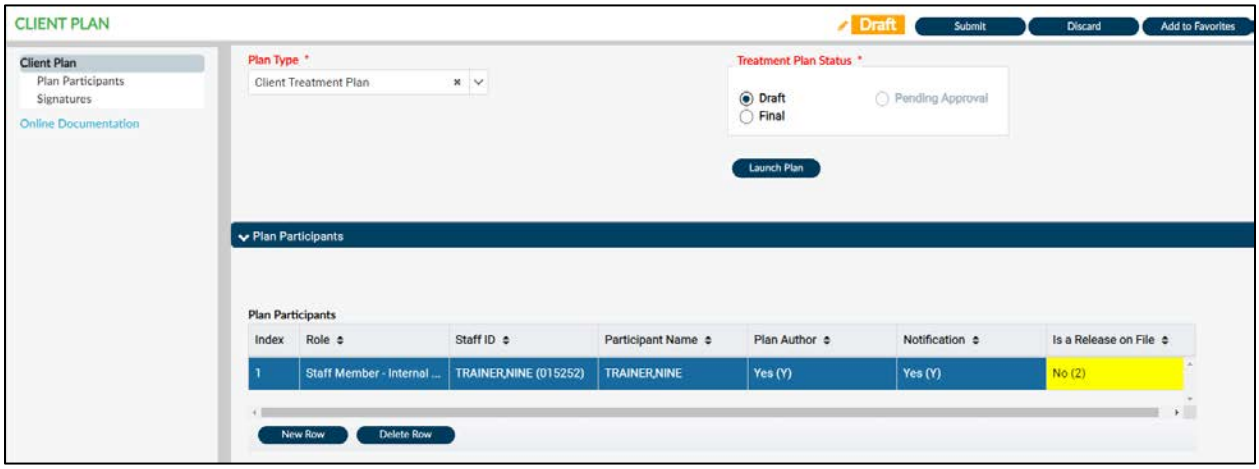


37. Once you have completed your client plan click the Back to Plan Page button on the bottom right of the page. On the Plan Page enter in your Plan Participants.

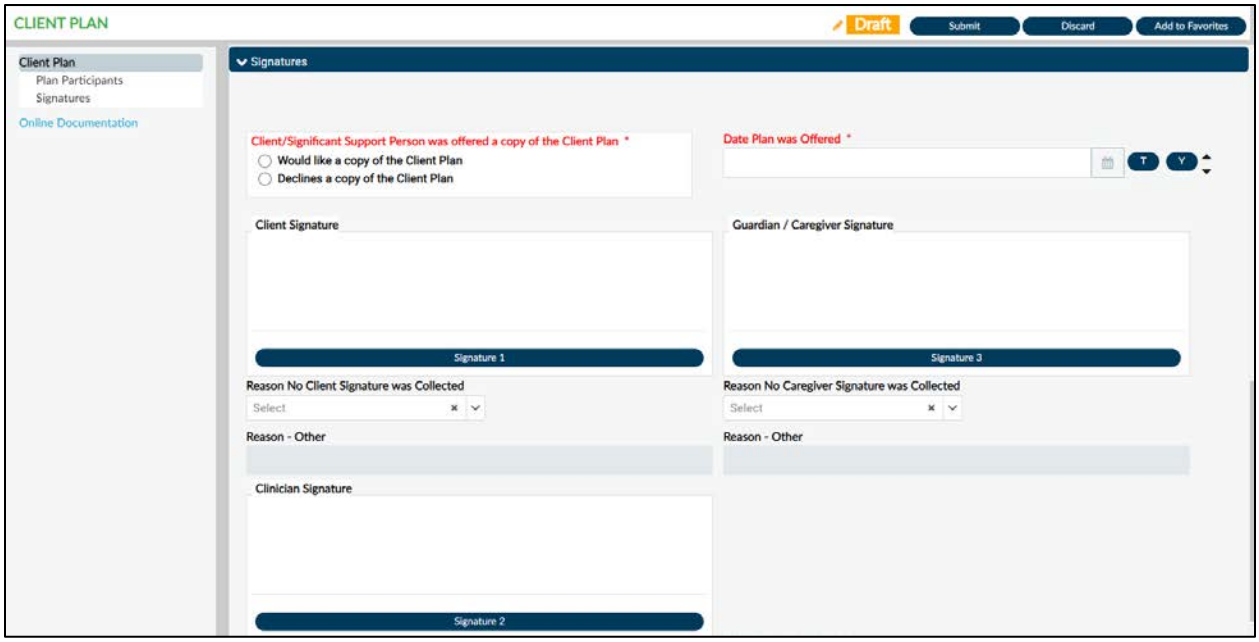


38. Double click on the Role field and choose the participant role.
39. Double click on Staff ID and enter the staff ID of the participant if the participant is a staff member or enter last name, first name (no spaces) and tab or hit Enter to populate the field.
40. Double click on Participant Name and type in the participants name into the text box. Click Ok. If the participant is a staff member this will automatically populate based on what you entered into Staff ID.

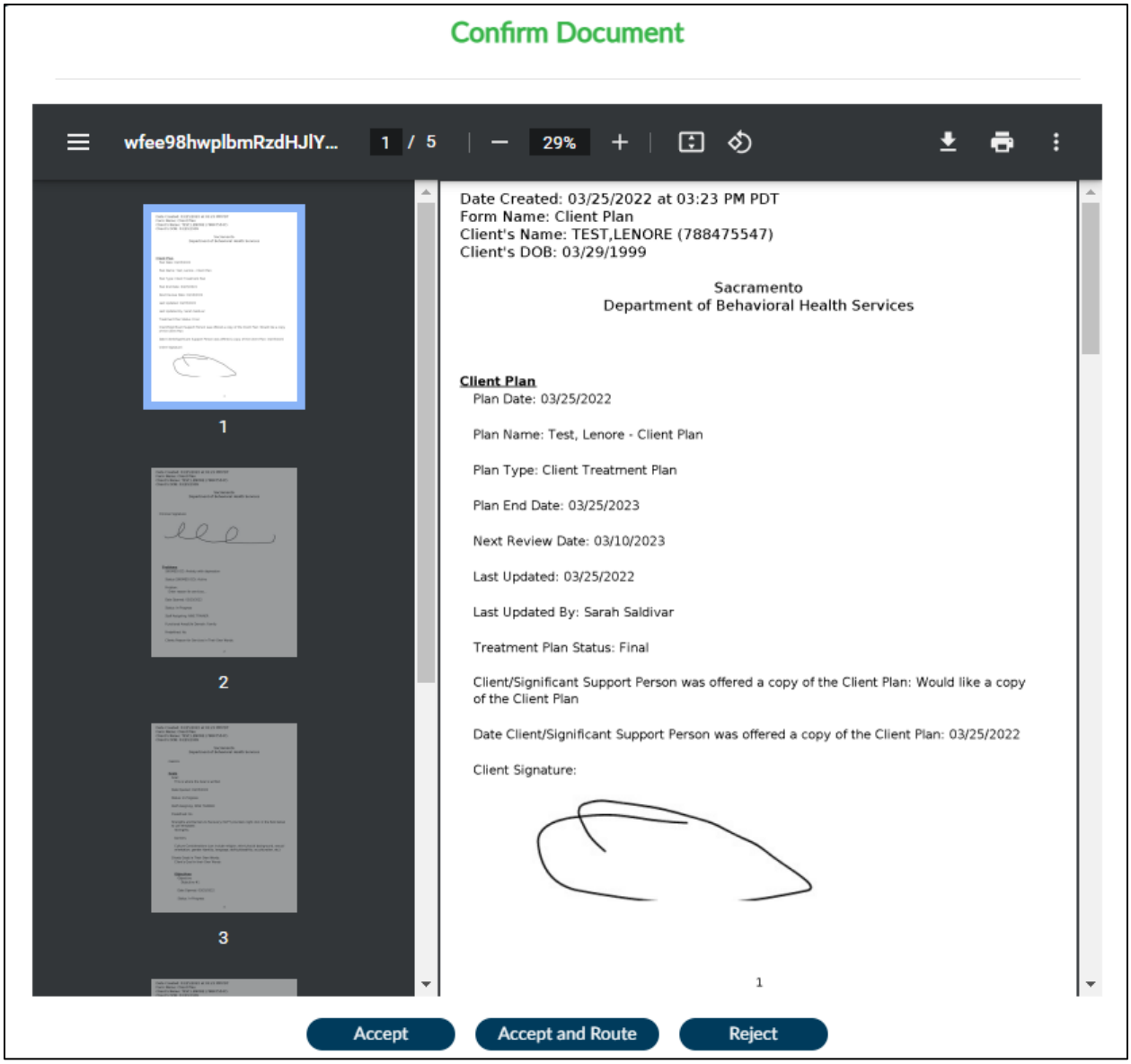
41. Double click on the Plan Author field and indicate whether the participant is the plan author by selecting Yes or No.
42. Double click on Notification and indicate whether this participant should be notified on the Next Review Date by selecting Yes or No.
43. Double click on Is a Release on File and indicate whether a release of information is on file for this participant by selecting Yes or No.
44. To add a new participant click New Row below the table.



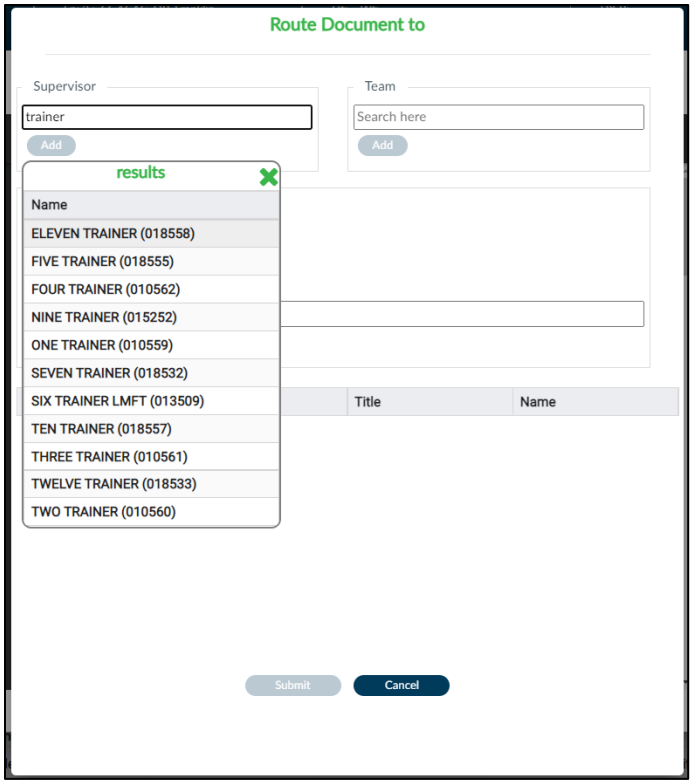
45. Scroll down the page and enter the client's Discharge Planning.
46. At the very bottom of the page you will sign the plan, and have the client, and caregiver if applicable sign the plan, click on the Signature button to open the signature box. If they are not able to sign the plan choose a reason from the drop-down. If you choose Other, the Reason-Other box will become enabled. The client signatures should be completed after the client plan has been completed.
47. The client should be offered a copy of the Client Plan. Indicate the date a copy was offered and indicate whether the client accepted it.



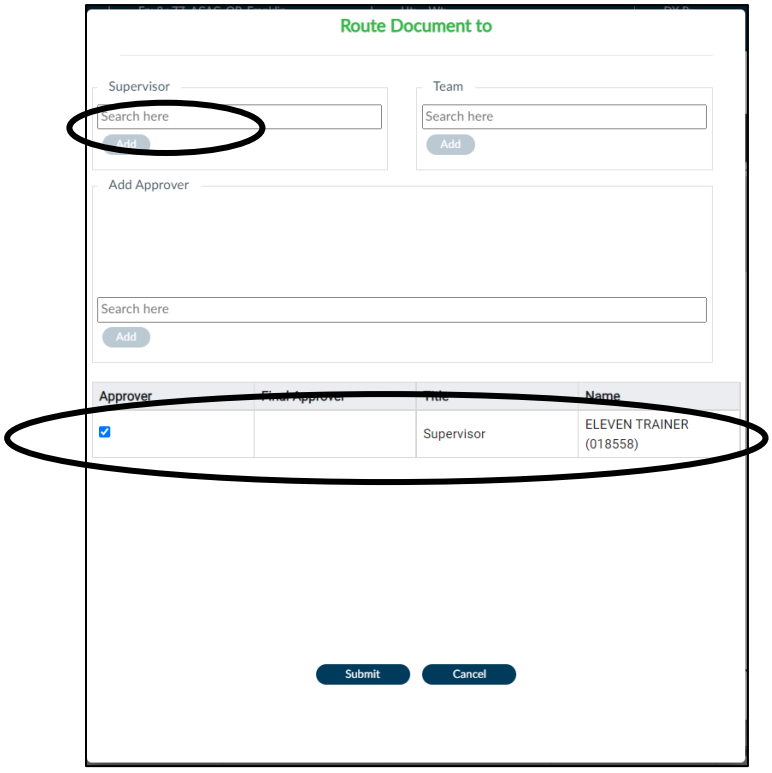
48. Once the plan has been completed, scroll back up to the top of the page, change the status from Draft to Final. Submit to save.
49. If you require a co-signer you will be prompted to Accept and Route your plan once you click Submit. You can review your plan from this screen. If you wish to send it to your supervisor click Accept and Route, if you wish to make any changes click Reject and it will take you back to the Client Plan.



50. A box will appear which will allow you to choose who to route the document to. Click on the Supervisor field and enter your supervisor's last name. Single click on their name on the drop-down.



51. Click the Add button below the supervisor's name. This will drop them down to the Approver box. Click Submit to route the document to your supervisor.

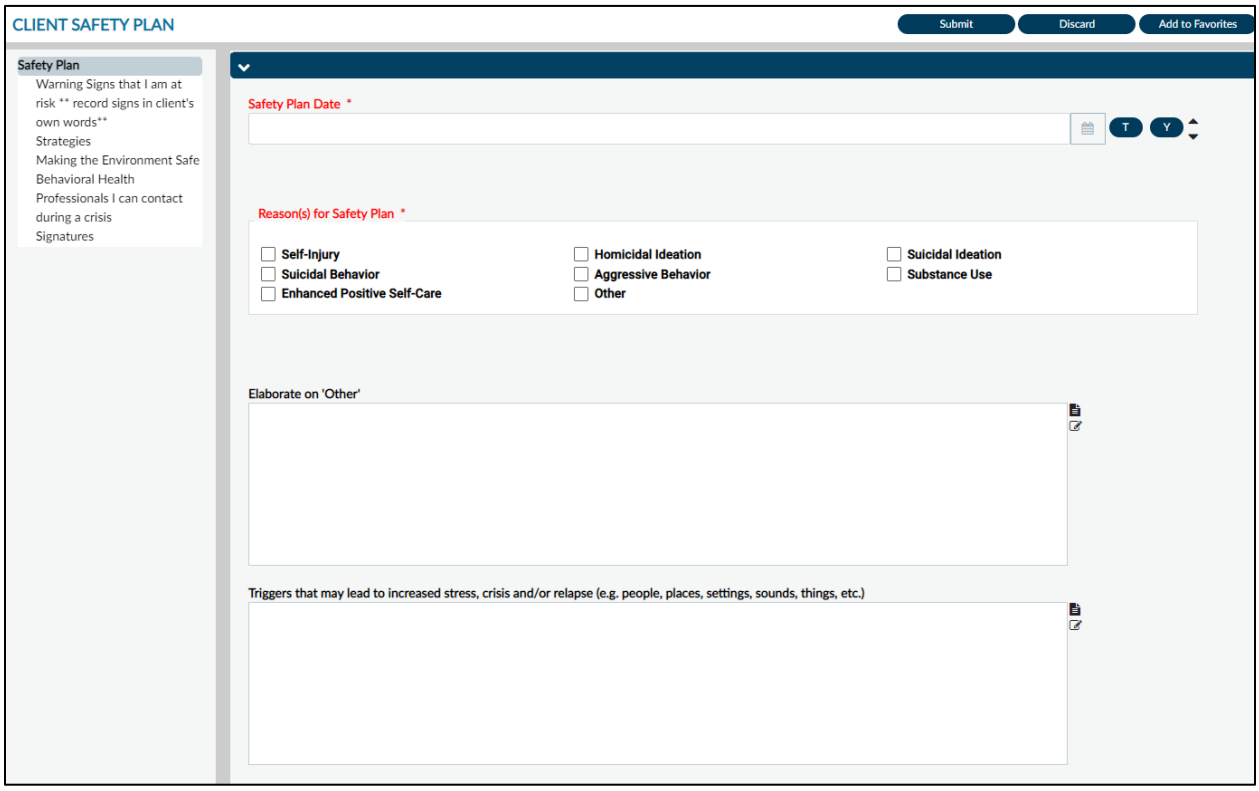


Client Plan Report

52. If your client would like a copy of the Client Plan, you can run the **Client Plan Report** by searching **Client Plan Report** in the What can I help you find? search box.
53. Search for the Client.
54. Select the episode the Client Plan was entered in.
55. Select the Treatment Plan from the drop down, it will display the date, name of the Treatment Plan, author name, and the status of the plan.
56. Click Process and the Client Plan Report will run in a new window where it will be available to print or export.

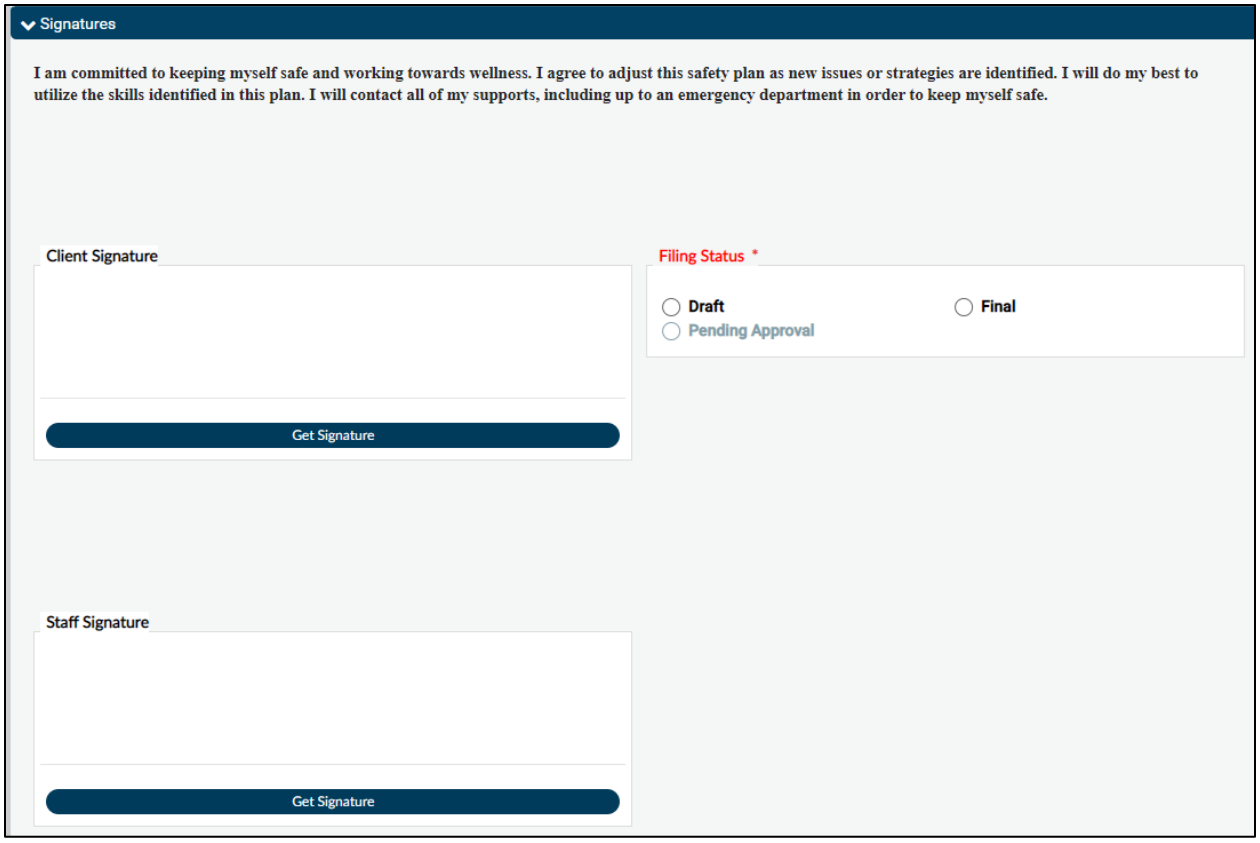
Client Safety Plan

The Client Safety Plan document detailing warning signs for self-harm, coping skills, and prosocial activities that provide healthy alternatives, support people a beneficiary can reach out to for support during crisis, professionals whom the beneficiary can contact when they are in crisis, and ways to make their environment safe.



Launch by searching for **Client Safety Plan** in the What can I help you find? Search bar.

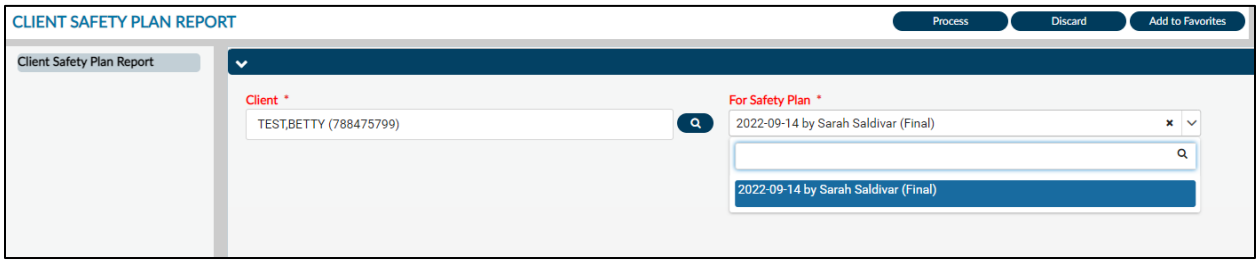
1. Enter the date that the Safety Plan was created
2. Select all of the reason(s) for the safety plan in the multi-select field by clicking in the box to the left of each item.
3. Complete the rest of the text boxes on this page with the required information.



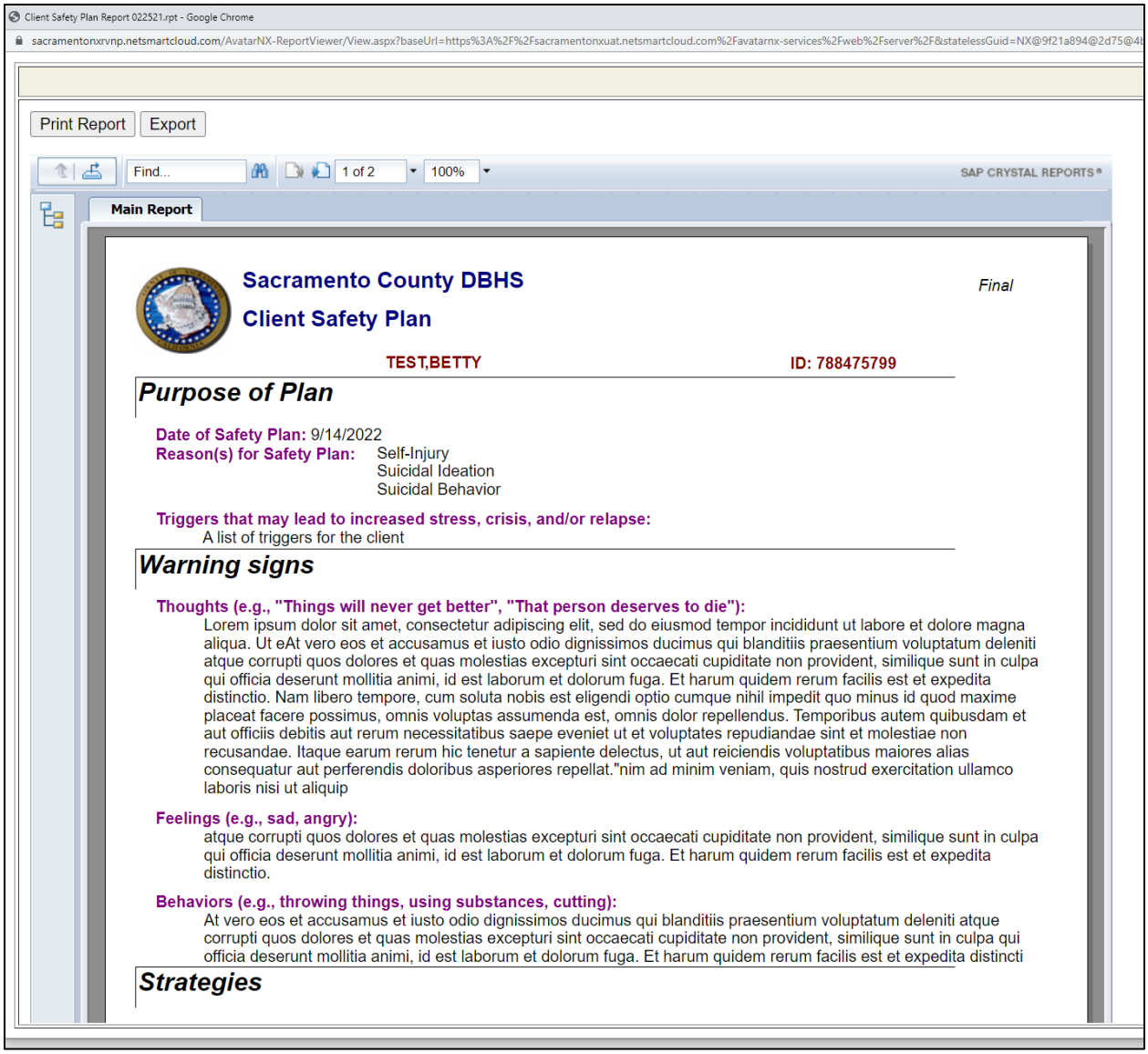
4. The Client Safety Plan requires signatures from both the client and staff. Click the **Get Signature** button and sign with your computer mouse/touchpad or signature pad.
5. Select the filing status and submit the form. If finalized it will take you to the document routing screen.

Client Safety Plan Report

This will generate a report of the Client Safety Plan that can be printed and given to your client.



1. Enter the client's information
2. Select the Client Safety Plan you wish to generate a report for.
3. Click the Process button and the report will generate in a separate window.



Example of a Client Safety Plan report

Corrections Process

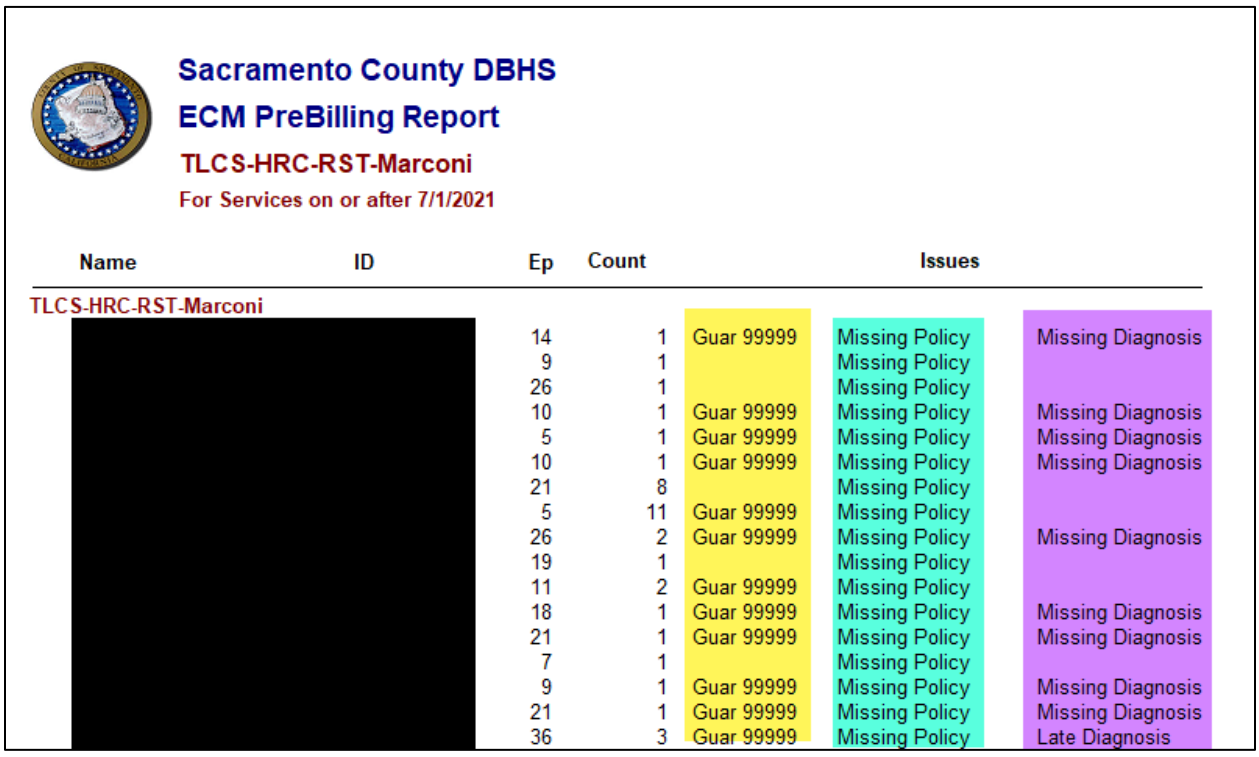
The Corrections process for ECM programs is currently a work in progress. This training guide will be updated with additional information when it has been received from Sacramento County.

If you have any questions regarding billing in Avatar reach out to the Avatar Billing Team at Avatar-Fiscal@saccounty.net

ECM Pre-Billing Report

The first step in identifying potential issues with your services is to identify any possible errors. Staff can run the ECM Pre-Billing reports to identify errors with a service before they are billed.

- Run the report by searching for **ECM PreBilling Report** in the *What can I help you find?* search bar.



Sacramento County DBHS
ECM PreBilling Report
TLCS-HRC-RST-Marconi
For Services on or after 7/1/2021

Name	ID	Ep	Count	Issues		
TLCS-HRC-RST-Marconi						
[redacted]		14	1	Guar 99999	Missing Policy	Missing Diagnosis
		9	1		Missing Policy	
		26	1		Missing Policy	
		10	1	Guar 99999	Missing Policy	Missing Diagnosis
		5	1	Guar 99999	Missing Policy	Missing Diagnosis
		10	1	Guar 99999	Missing Policy	Missing Diagnosis
		21	8		Missing Policy	
		5	11	Guar 99999	Missing Policy	
		26	2	Guar 99999	Missing Policy	Missing Diagnosis
		19	1		Missing Policy	
		11	2	Guar 99999	Missing Policy	
		18	1	Guar 99999	Missing Policy	Missing Diagnosis
		21	1	Guar 99999	Missing Policy	Missing Diagnosis
		7	1		Missing Policy	
		9	1	Guar 99999	Missing Policy	Missing Diagnosis
		21	1	Guar 99999	Missing Policy	Missing Diagnosis
		36	3	Guar 99999	Missing Policy	Late Diagnosis

This report will show any service that is no claimed and has a balance with one or more of the following issues

1. **Guarantor 99999** – This indicates there may be an issue with the staff member's practitioner taxonomy/licensing.
2. **Missing Policy** – The policy number in Financial Eligibility is missing. Resolve this issue by going into the Financial Eligibility form and updating the missing information. **Note:** The policy number for the Managed Care Plan should be the client's Medi-Cal CIN number.
3. **Missing or Late Diagnosis** – This will indicate there is no diagnosis or the diagnosis entered may not be covering all dates of services.

For additional ECM specific reports please see the Report Inventory report in Avatar. All ECM specific reports will have ECM in the beginning of the report name. Below is a list of the current ECM reports in Avatar NX at the time this guide was created:

ECM and Outreach Counts Report
ECM and Outreach Details Report
ECM Services by Client
ECM Summary of Services YTD

Editing and Deleting Services:

If there is an issue with a service and it needs to be edited or deleted you will have to complete either an ECM Claims Correction spreadsheet or an OCDR spreadsheet depending on the actions required.

ECM Claims Correction Spreadsheet (CCS)- The CCS spreadsheet should be completed and sent to the Avatar Billing team at Avatar-Fiscal@saccounty.net if an **Open** service needs to be **edited** or if a **Claimed** service needs to be **voided, replaced,** or **deleted**.

The CCS is located on the Avatar website at https://dhs.saccounty.gov/BHS/Avatar/Pages/GI-Claiming.aspx

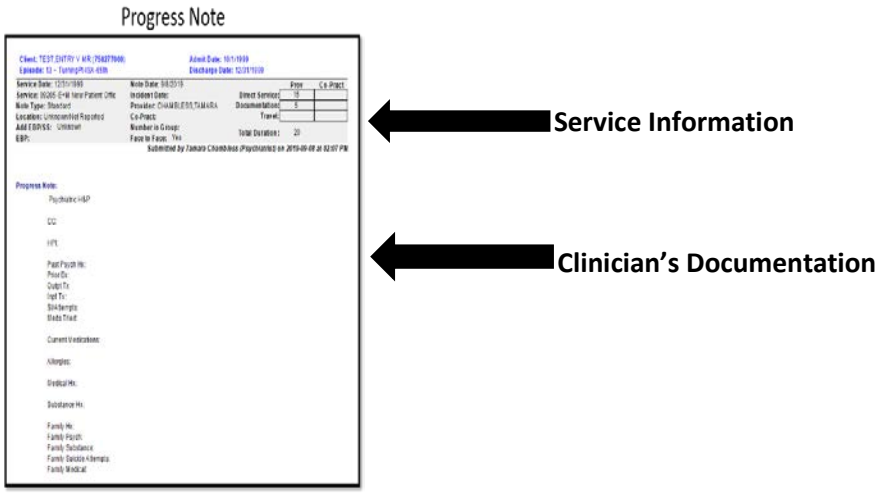
OCDR Process- The OCDR spreadsheet is done to delete a service that is in **Open** or **Closed** status. A service may need to be deleted the service is a duplicate, the service was entered in error, or the service is in closed status and cannot be edited. OCDR's are sent to QM for Mental Health programs (OCDR@saccounty.net) or Sacramento County SUPT from SUPT programs (SUPT-OCDR@Saccounty.net).

The OCDR spreadsheet is located on the Avatar website:
https://dhs.saccounty.gov/BHS/Avatar/Pages/GI-Claiming.aspx

Orphaned Progress Notes:

This process will only be used by programs that enter documentation in Avatar NX. If your agency uses a different EHR for documentation you will not use

Most services in Avatar are generated by entering a progress note. When a clinician enters a progress note for a client there are two pieces to the form. The top portion of the Progress Note Entry form generates a service charge and the bottom portion of the form is the clinician's documentation for the service.

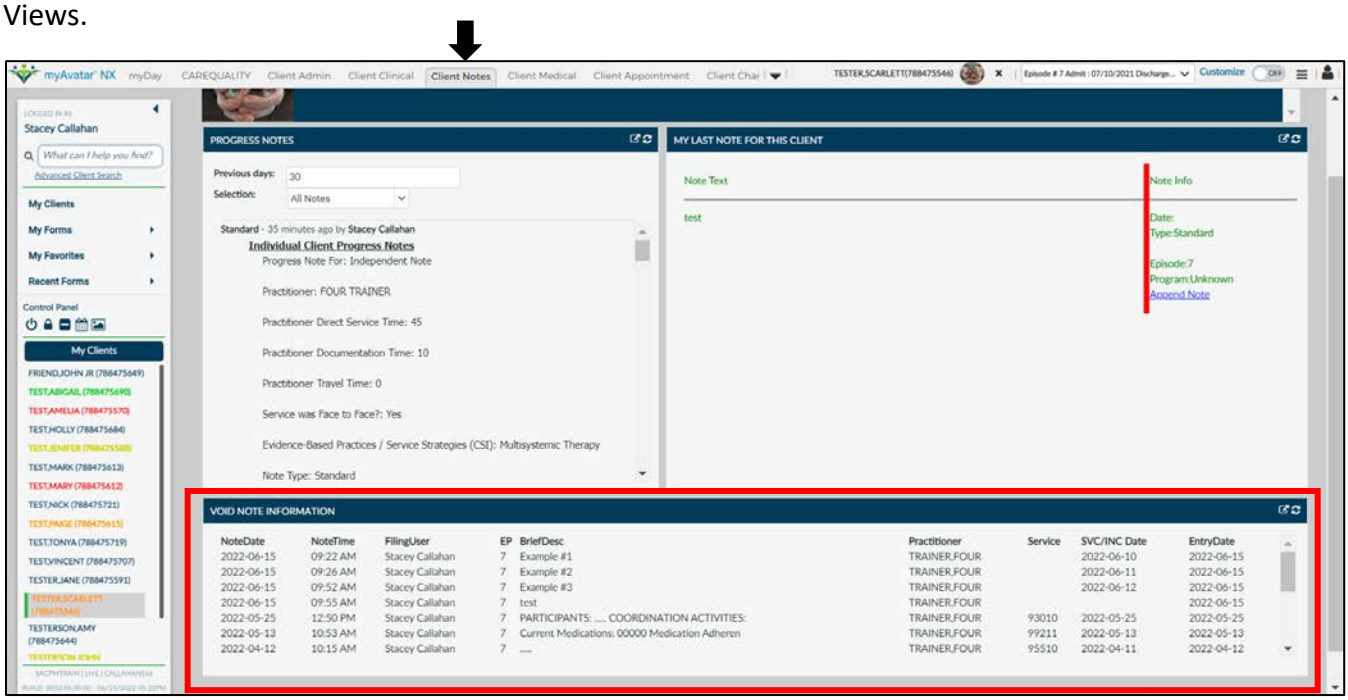


When a service is removed by going through the OCDR or CCS process that creates an Orphaned Progress Note, the progress note has no services attached to it. In order to fix this a new service needs to be created by using the Client Charge Input form and attached to the progress note using the Attach Individual Notes to Existing Services/Appointments form.

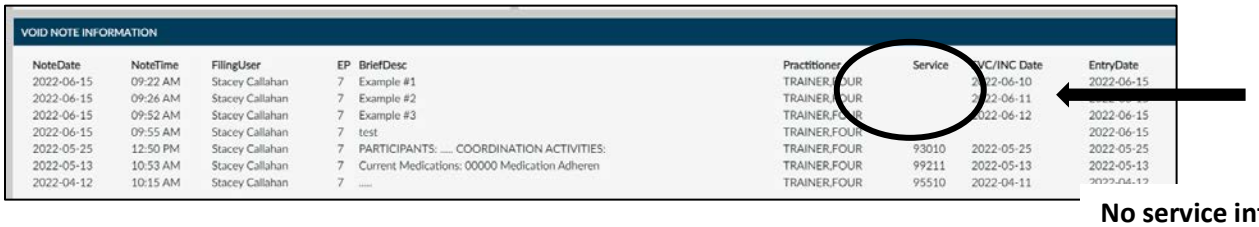
Tools for locating Orphaned Progress Notes

Void Note Information Widget

The Void Note Information Widget is located in your Client Notes Console under your My Views.



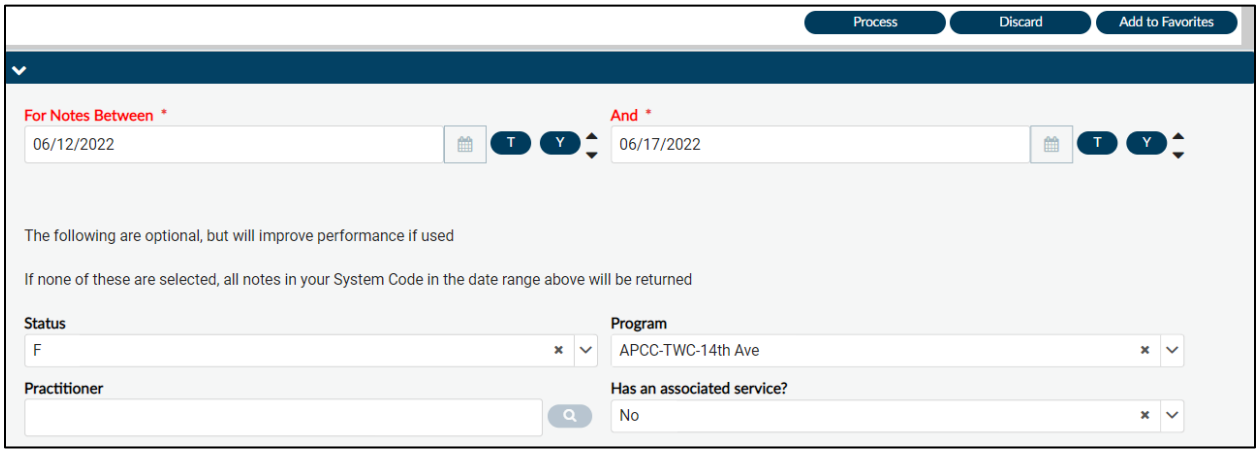
This widget will show all progress notes for your client. If there is missing service information for the progress note you will know you have an orphaned progress note.

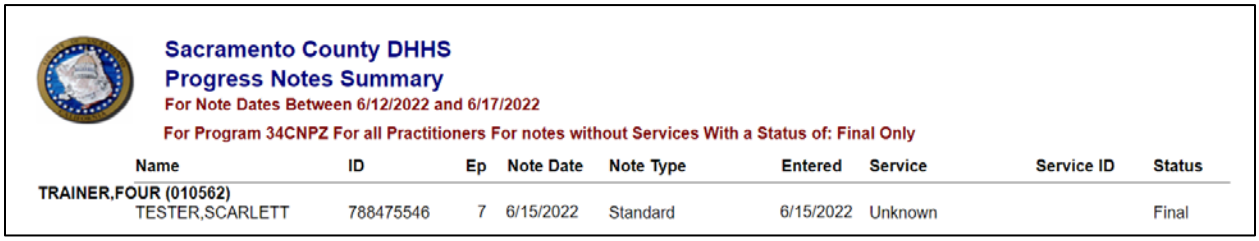


No service information

Progress Note Summary Report

Enter the criteria for the note you are looking for. Under “Status” choose “F” for Final and under “Has an associated service?” choose “No”. By pulling notes in Final status with no service attached this will show any orphaned notes.



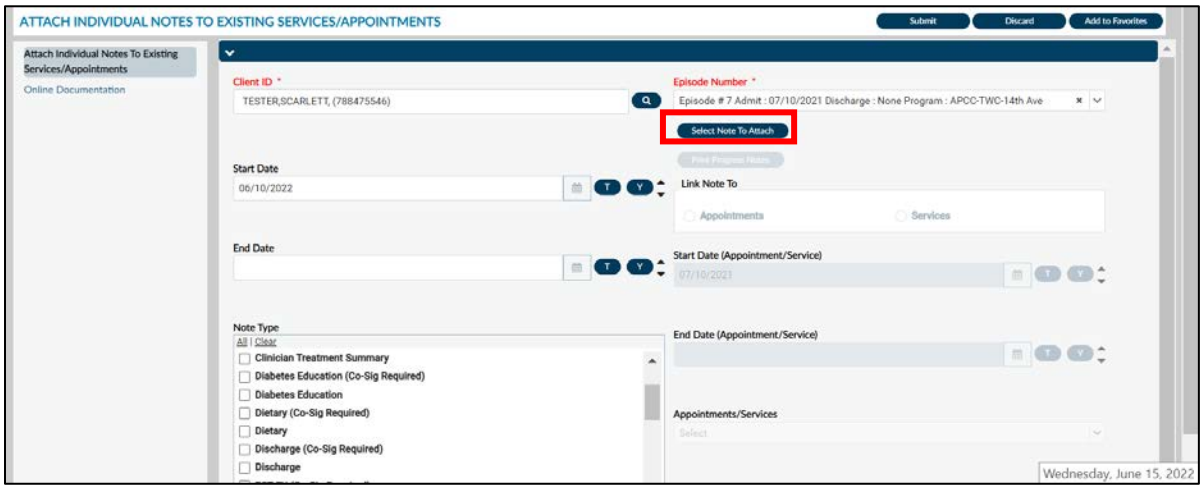


Sacramento County DHHS
Progress Notes Summary
For Note Dates Between 6/12/2022 and 6/17/2022
For Program 34CNPZ For all Practitioners For notes without Services With a Status of: Final Only

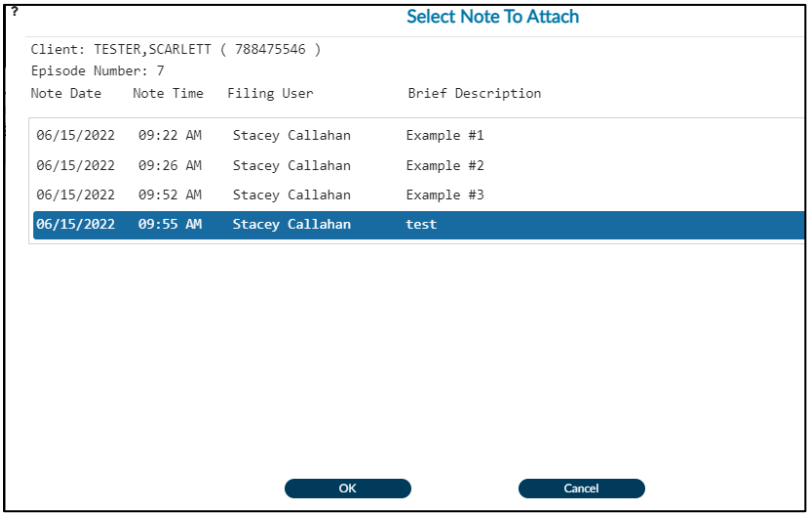
Name	ID	Ep	Note Date	Note Type	Entered	Service	Service ID	Status
TRAINER,FOUR (010562)								
TESTER,SCARLETT	788475546	7	6/15/2022	Standard	6/15/2022	Unknown		Final

Attaching a Service to an Orphaned Note

1. After the incorrect service has been removed by the OCDR or CCS process, open the Client Charge Input form and enter a new service with the correct service information for your client.
2. Open the "Attach Individual Notes to Existing Services/Appointments" form.
3. Enter the Client ID and episode number to enable the other sections of the form.

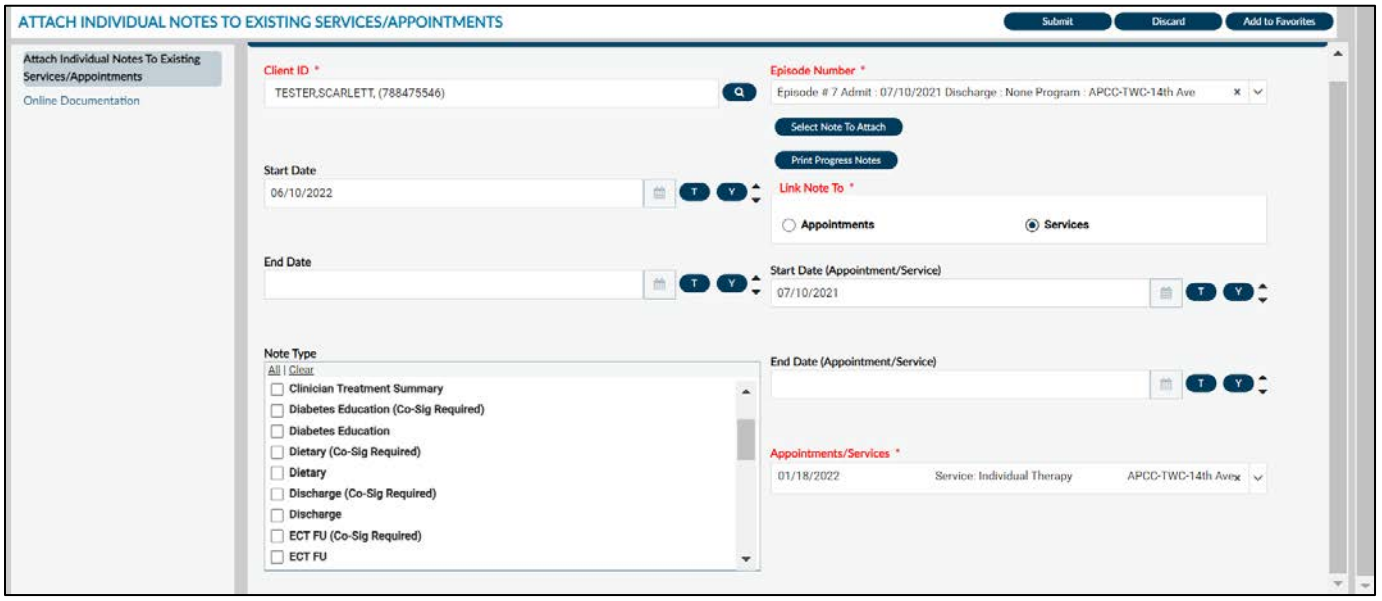


4. The Start Date will default to the Admission date. You can change the Start Date and enter an End Date to narrow your search. On the left hand side of the form you are entering information for the orphaned progress note. You can put as much or as little criteria as you choose.
5. Once you've entered the date range and/or criteria click on the Select Note to Attach button. A box will populate that shows any orphaned notes that fit your search criteria. Choose the note that needs to be attached to the service. Click OK.



6. There is an option to print the note. You can use this to verify you selected the correct note.

7. Choose what you want to link the note to. In most cases you will select Service. Selecting Appointment will link the note to an appointment created in the Scheduling Calendar. Only agencies who use the Avatar Scheduling Calendar would use this option.
8. The bottom right-hand section is where you will enter in your service information. The Start Date will default to the admission date. You are able to update the criteria to the date of the service.
9. Click on the Appointment/Services drop-down to choose the service you want to link to the progress note. This will be the service you entered into the Client Charge Input form. Click Submit to save.



Voiding a Progress Note

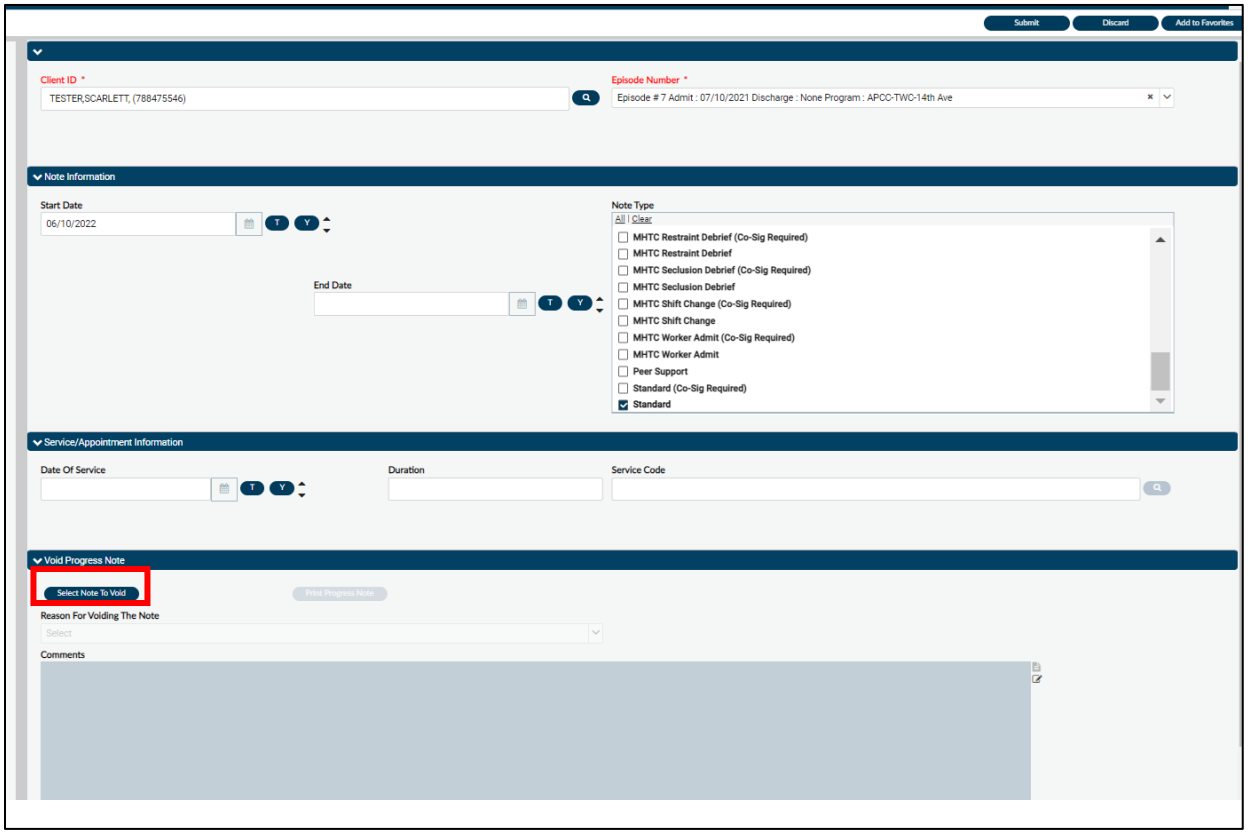
There may be times when you do not want to attach a new service to a progress note. If the note was done in error, for the wrong client, or if there are too many documentation errors you may want to void the service and progress note altogether. In this instance you would follow the same OCDR or CCS process, but instead of creating and attaching a new service you will void the progress note.

The permissions to void a progress note will not be given to everyone who attends corrections training. The Authorized Approver at your site will have to specifically request those permissions for your account. Only two representatives at each program will have the ability to void progress notes.

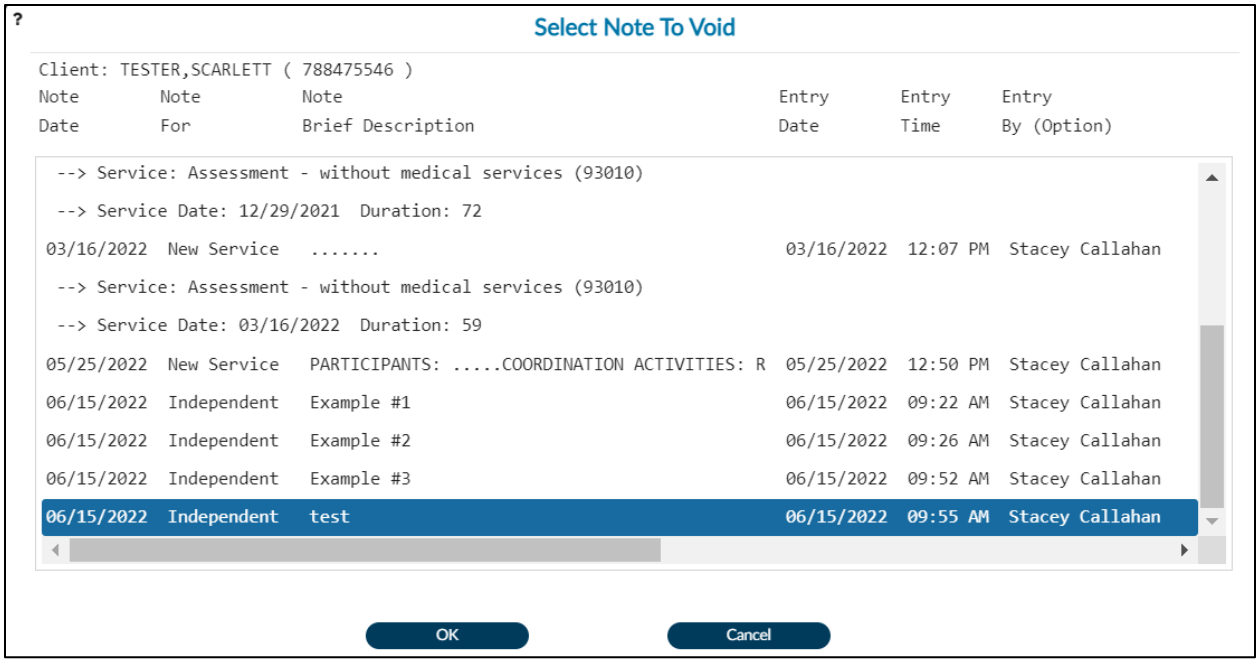
Steps to Voiding a Progress Note:

1. Open the Void Progress Notes form. Enter the client ID and episode number.

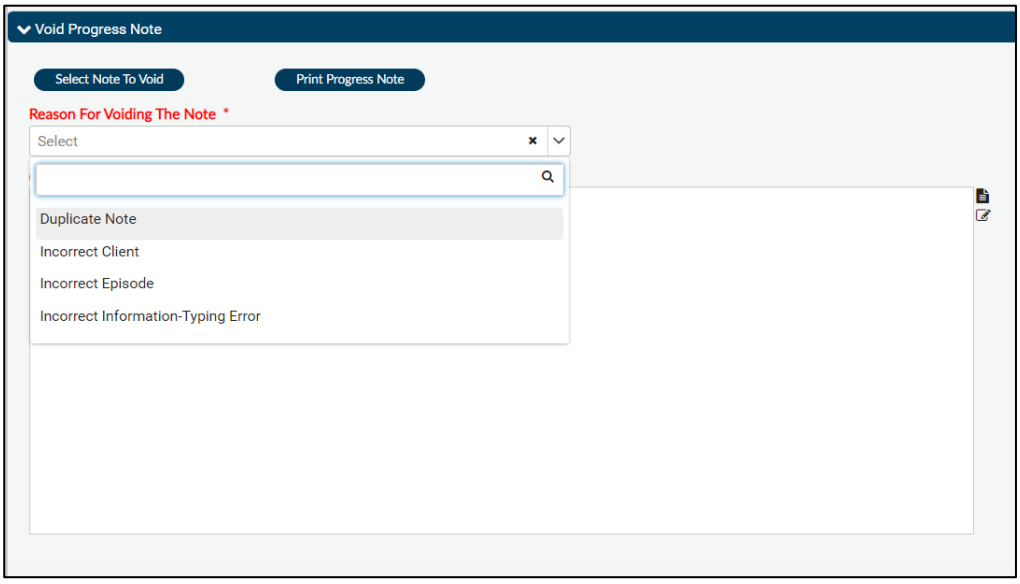
2. Enter your Note Information. This criteria will help you locate the orphaned progress note. You can enter as much or as little criteria as you choose.
3. If the service information is still attached to the note you can enter the service information. If the service has already been deleted you can leave this section blank.



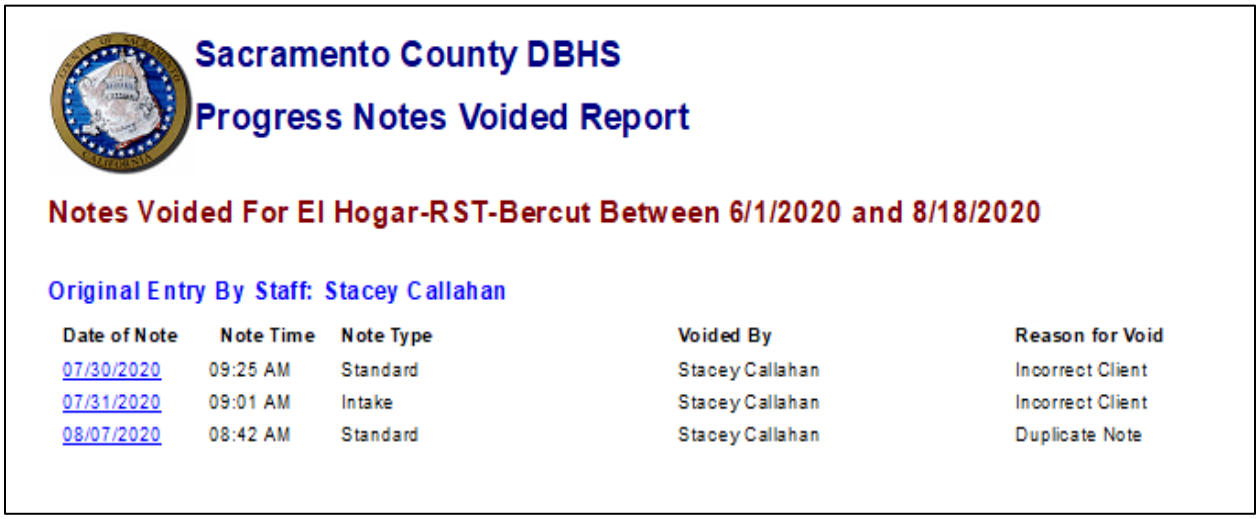
4. Click the Select Note To Void button. A box will populate that includes all progress notes (orphaned and non-orphaned notes) that fits the criteria you entered above. Choose the note that needs to be voided. You can figure out which note needs to be voided by viewing the details of each note. In the example below, the last note has no service information below it. That would be the note that needs to be voided. Click on your note then click OK.



5. Once a note is chosen the bottom Void Progress Note portion of the form will become enabled. You can click the Print Progress Note button to view the note details and print the note for your records.
6. Choose your reason for voiding the note from the drop down. Below that enter your comments. Each agency may require different information in the Comments section. Click Submit to save.



7. You can run the “Progress Notes Voided Report” to view any progress notes that have been voided at your agency.



Sacramento County DBHS

Progress Notes Voided Report

Notes Voided For El Hogar-RST-Bercut Between 6/1/2020 and 8/18/2020

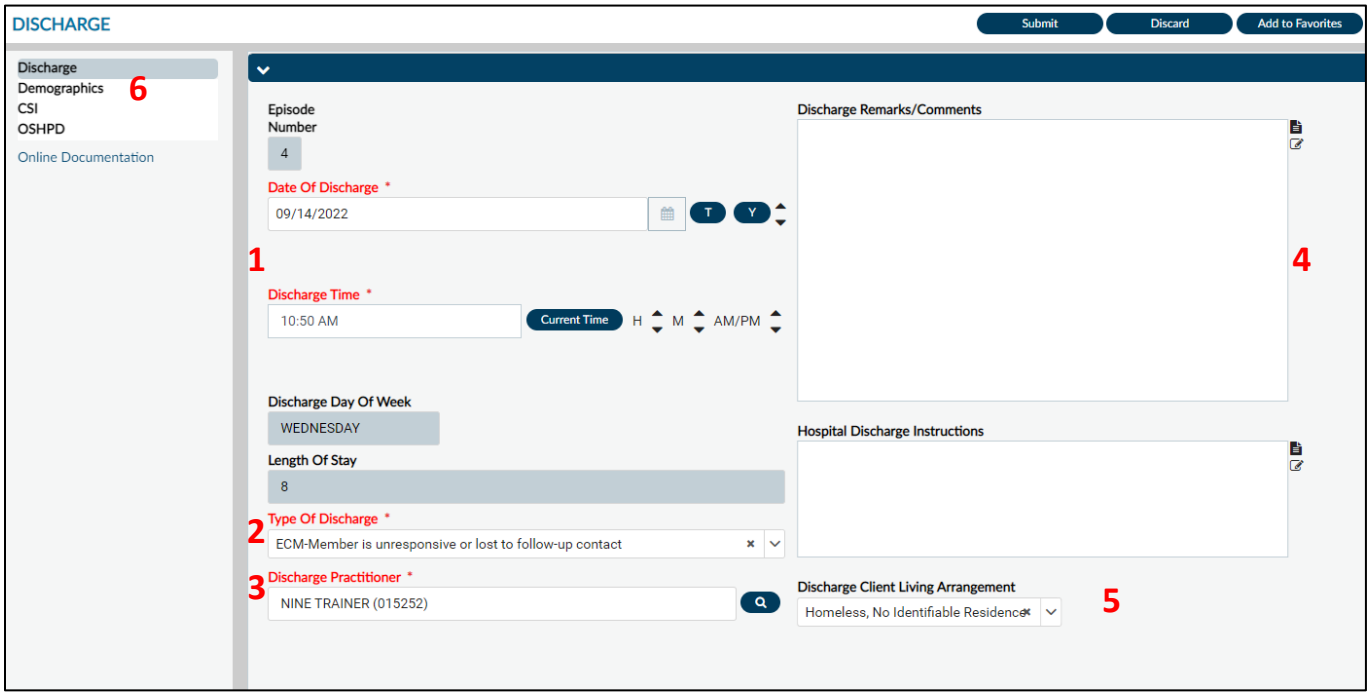
Original Entry By Staff: Stacey Callahan

Date of Note	Note Time	Note Type	Voided By	Reason for Void
07/30/2020	09:25 AM	Standard	Stacey Callahan	Incorrect Client
07/31/2020	09:01 AM	Intake	Stacey Callahan	Incorrect Client
08/07/2020	08:42 AM	Standard	Stacey Callahan	Duplicate Note

Discharge

Discharge Information

- When a client no longer requires ECM services or they lose ECM/Medi-Cal eligibility they will need to be discharged from the ECM program.
- Make sure that all of the required elements are completed before completing the discharge form including Discharge Diagnosis, etc.
- If a discharge has been completed in error, you will need to send a request to your Contract Monitor to back out the discharge.



Open the Discharge form and enter the client's information. In the pre-display, select the ECM program you are discharging.

1. Enter the date and time of the discharge.
2. Select the type of discharge from the drop down menu. There are ECM specific discharge types, choose the appropriate option from that list. These options begin with "ECM"

   ECM-Member has met their ECM Care Plan goals

   ECM-Member is ready to transition to a lower level of care

   ECM-Member is unresponsive or lost to follow-up contact

   ECM-Member wishes to discontinue services

3. Enter in the name of the discharging practitioner.
4. Indicate any discharge remarks/comments in the text boxes.
5. Select the client's current living arrangement from the drop down menu.

6. Go to the Demographics page and update any information for your client that requires updating.
7. You will not need to enter data in the CSI or OSHPD pages.
8. Click the submit button to discharge your client from your program.