Instructions for Avatar UR

These instructions are to be utilized in conjunction with the "Sacramento County Electronic Utilization Review Tool" (01/03/19)

Section A CSI Admission/Update Client Data- The following information can be located on the "Client Data Sheet"

- CSI/Update Client Data (In addition, a report for the provider agency/program will be run for "Missing CSI" information for all clients within a specified time frame.)
- Start Date
- Prescription and Allergy Information
- Medications from that provider

Section B Client Resources/Coordination of Care- This can also be located by running the "Client Resources Report." In addition you could find Releases of Information (ROI's) by reviewing this section.

Section C Mental Status Exam- This refers to the Clinical Mental Status Exam and can be found in either the "Adult Mental Status Exam Report" or "Child Mental Status Exam Report."

Section D Diagnosis- The Diagnosis can be located on the "Client Data Sheet'' and the primary diagnosis can also be located in the "Diagnosis and Movement History Report" and the "Core Assessment Report."

Section E Core Assessment- This can be located by viewing the "Core Assessment Report." Low/ Moderate Intensity Adult Providers document the assessment components within the Annual Assessment Progress Note.

Section F Health Questionnaire- This can be located by viewing either the "Adult Health Questionnaire Report" or "Child Health Questionnaire Report." Please remember that some child clients may have had the "Adult Health Questionnaire" completed, depending on their age and level of functioning.

Section G Client Plan/Treatment Plan- This can be located by viewing the "Client Plan Report."

Section H CODA/Substance Abuse- (For clients where substance abuse/use is indicated) this can be located by viewing the "CODA Report."

Section I LOCUS- (Adult Clients, when applicable) this can be located by viewing the "LOCUS Report."

Section J-Child and Adolescent Needs and Strengths & Pediatric Symtom Checklist 35-
CANS- (Ages 6 through 20) This can be located by viewing the "CANS 50 and Sacramento Supplemental Report."
PSC-35-(Ages 3 through 18) This can be located within the scanned document category "Assessments" or hard copy provided by the agency.

Section K Initial Psychiatric Assessment/Psychiatric Assessment- (For clients who have received/are receiving medication services) this can be located by viewing the "Initial Psychiatric Assessment Report." This may also be found in the Initial Psychiatric Assessment progress note. You can verify that the client is receiving

medication services through the provider by viewing the "Client Data Sheet" for a list of medications or review the progress notes to determine if any psychiatric services have been provided. Please note that having an initial psychiatric assessment does not necessarily mean that medications have been prescribed. You would also need to verify using the above directives.

Section L Psychiatric Mental Status Exam- (For clients who have received/are receiving medication services) this can be located by viewing the "Psychiatric Mental Status Exam Report." This may also be found in the Initial Psychiatric Assessment progress note however, ensure that all domains are included and completed. You can verify that the client is receiving medication services through the provider by viewing the "Client Data Sheet" for a list of medications or review the progress notes to determine if any psychiatric services have been provided. Please note that having an initial psychiatric assessment does not necessarily mean that medications have been prescribed. You would also need to verify using the above directives.

Section M Medication Service Plan- (For clients who have received/are receiving medication services) this can be located by viewing the "Medication Service Plan Report." If client is receiving medication services through the provider you could confirm this by viewing the "Client Data Sheet" for a list of medications. Remember if medication(s) are prescribed, there must be a finalized Medication Service Plan.

Section N Vitals- (For clients who have received/are receiving medication services) this can be located by viewing the "Vitals Entry." It is not within the scope of practice of the UR to determine if the vitals were appropriately completed and/or addressed. This is to simply verify if they have been entered into the appropriate section of the chart.

Section O Scan Document Section/Collateral Information- If this section is missing from the left side of the screen, there are no scanned documents saved into the chart. Remember to choose the appropriate episode for the time frame when looking for information within the scanned documents. If there are documents scanned into the "Non-Episodic" section of the Scanned items, please make a note of this as reportable.

ICC-CFT and Timeliness-Review the Progress Note Abstract or "Client Services Report (Single Client)" or in the scanned documents. Any form used to document the CFT process will need to be uploaded into Avatar's Document Category "Child and Family Team Info" within the client's episode, typically this should be titled, **Child and Family Team Meeting Attendance Form.**

Section P Clinical Progress Notes- There are several reports to view for progress notes.

- You may run the "Progress Note by Service Chart" to view notes in consecutive order.
- Another option is to open a tab and use the "Progress Notes Client Report" to view notes.
- If you are looking for specific types of notes, you can choose the "Progress Note Search" function and search for notes using a specific work or phrase.
- When reviewing notes, please ensure to choose the appropriate episode and date range for the review.

Section Q Medication Services Progress Notes-There are several options for viewing these notes.

- You may run the "Progress Note by Service Chart" to view notes in consecutive order.
- Another option is to open a tab and use the "Progress Notes Client Report" to view notes.

- If you are looking for specific types of notes, you can choose the “Progress Note Search” function and search for notes using a specific work or phrase.
- When reviewing notes, please ensure to choose the appropriate episode and date range for the review.

Section R General Documentation-This refers to the overall chart, any breaches of confidentiality where ROI’s were not on file for example and information released, or other person’s information randomly in the client’s chart. Review/verify that all documentation and billed services in the chart justifies medical necessity. In review, does reason for service/presenting reasons match the diagnosis/goals/billed services in the chart.