FREQUENTLY ASKED QUESTIONS (FAQs) - AVATAR CWS GO LIVE QUALITY MANAGEMENT

February 25, 2013

AUTHORIZATION

1. Do we still need to keep track of the newly signed service plans and submit this list over to the Access teams for re-authorization?
   Until further notice, please continue to submit authorization and reauthorization log sheets to the Access teams (Managed Care Authorization logs; Reauthorization Logs, etc.).

2. If a consumer is due for a re-authorization, do we simply use the Core Assessment to conduct a re-assessment?
   Yes.

CORE ASSESSMENT

1. What is the equivalent of the ACP or ACA that meets the standard for initial assessment?
   The initial assessment now includes a combination of documents located in different places. A complete initial packet includes the Core Assessment, MSE, Health Questionnaire, Client Plan, Diagnosis, and CSI Admission. Other documents may be needed if applicable (Vocational Assessment, CODA, CANS, LOCUS).

2. Aside from the items in Core Assessment that are required by Avatar (in red), what items does QM consider to be required?
   Items cannot be left blank. Red items are marked because they are prioritized and must be completed to submit/finalize a document. QM considers all items within the Core Assessment as necessary and required in order to complete a thorough assessment.

3. Where does the Coordination of Care plan and information go on the Core Assessment?
   Coordination of Care information has a dedicated home within Client Resources, where critical support resources can be easily located and updated. The types of support resources include personal and professional relationships. The comments text field within Client Resources is the appropriate place to document meeting dates and outcomes from Coordination Meetings. Please complete all fields and include both the name and agency for each resource (i.e. Dr. Smith, East Clinic).

4. Where in the Core Assessment should Safety Planning information be documented?
   Safety planning information should be documented in the "Comments" of the Risk Assessment section of the Core Assessment (i.e. Risk and Violence Comments). It should also be documented in the ongoing progress notes.

5. What information is to be included in the Presenting Reasons vs. Behavioral Health History section in the Core Assessment?.
   "Description of Current Presenting Reasons" should document the current issues the client is experiencing and should justify the need for mental health services. "Behavioral Health History" should document the behavioral health issues that the client experienced in the past, but are currently affecting the presenting problem of the client. Both of these sections are important parts of the "Presenting Reasons" section that documents Medical Necessity.

HEALTH QUESTIONNAIRE

1. What classifications require co-signatures for Health Questionnaires?
   All staff, within their scope of practice, can complete Health Questionnaires with the exception of Peer Staff, MHA-1, and MHA-2 level staff. Students require a co-signature on Health Questionnaires.

CLIENT PLAN

1. What Start and End dates must be entered on the Client Plan at time of intake vs. annual updates?
   Plan Date: Is the date the Client Plan is completed with the client (November 15, 2012).
   Plan End Date: Is the anticipated end date of Client Plan. Must be no more than one year from Plan Date (November 14, 2013)

PROGRESS NOTES AND SERVICE CODES

1. Does the progress note that supports completion of the Core Assessment need to say anything other than "Core Assessment completed – See Core Assessment dated…."?
   If the Core Assessment is completed in full in one session, it is sufficient to reference the completed Core Assessment in the progress note with a brief description of the presenting problem, any risk factors, and the Five Axis Dx.

If the Core Assessment is completed in multiple sessions, each progress note must reflect which sections of the document were completed and any salient issues associated with those sections. The note must stand up to demonstrating that an Assessment service was provided.

2. We would like to continue using DAP and SOAP for our progress notes at this point to minimize change. Is this acceptable?
   Yes, as long as required elements are included. Notes should include how the treatment goal is being addressed, what staff intervention took place and the client's response to interventions, specific risk factors (if any), and the plan for follow-up. (Answer the following questions in every note – where, what, who, when, how, by whom and follow up plan.) The note must tie back to the treatment plan goal and to the treatment code. Any particular language or cultural accommodations provided must be stated in each note.

3. How do we document an administrative discharge where no billable service is provided to the client?
   The Service Code for Non-billable activities (code 11111) is the appropriate code to use.

4. Do we use "Standard" note type for all progress notes? So if it's an intake note or discharge note, we just use standard?
   No – You would use the "Intake" note type for intake notes and the "Discharge" note type for Discharge notes. Use the "standard" progress note type unless one of the specialized note types applies (i.e. Intake, Discharge, etc.).

5. If we do not have a certified EBP by the county, we were told to use Unknown/Not Reported for EBP. Is this correct?
   EBPs may only be selected if approved by the County. However, Service Strategies that apply to the service should be used in the "EBP/SS" field. Service Strategies include Peer/Family Delivered Services, Psycho-education, Family Support, and Supportive Education. Service strategies are part of State definitions and not established at the local level.

6. What code do we use for Group Notes?
   Group Session (96520) and Group Therapy (96510) remain the appropriate codes for group services. Group session is used for rehabilitative skill-building groups. Group Therapy is used for groups facilitated by licensed staff and license waived staff that utilize therapeutic techniques.

7. Can support staff enter notes for Cancellations and No-shows?
   A process for support staff to document client cancellations and no-shows is being developed. Please wait for notification from Avatar.

DOCUMENT MANAGEMENT AND SCANNING

1. Are we required to keep a paper chart?
   Providers no longer have to print documents that are generated in Avatar, but a hard copy is still required for all other items until direction on scanning and retention of hard copy documents is provided. Hard copies of complete charts, including Avatar documents, will be requested in certain circumstances such as requests from Quality Management for Utilization Review (UR) purposes, targeted reviews, or other special circumstances (see memo from Uma Zykofsky, Division Clinical Lead, dated September 24, 2012).

2. What needs to be scanned? What are the scanning requirements for existing clients? New clients?
   Pending Executive Management decision and notification.

3. Do we still place MHSA paperwork in the chart?
   MHSA outcome forms (PAF, KET, 3M) and other MHSA related forms (Mode 60 Tracking, Family/Caregiver Services and Supports Index) must be scanned into the system.

4. For forms that need to be scanned into Avatar such as Consent to Treatment and Releases of Information: should they go into current episode or non episodic?
   Consents and releases should be scanned into the "Current episode".

5. Should we be scanning Suspected Child Abuse forms and sensitive documents into Document Management?
   A category was recently added to Document Management - "Court/Legal – Sensitive"; this category is excluded from the record and is where you will file APS/CPS reports or other sensitive documents that cannot be shared.

6. If a new staff starts today, but can't attend training until next Thursday, do they just save their notes until after trainings or will they complete notes on paper and scan them in?
   CWS training is currently offered at least twice weekly. We must have ALL notes and services in the Avatar system as much as is possible. Therefore, new staff notes should be held until they can be entered. This is the only way to keep all information in CWS. It is not advisable to scan this information in as it will not be accessible to other parts of the CWS user system.

DISCHARGE

1. There is no Discharge Summary in Avatar. Do we still to do a Discharge Summary?
   A discharge note (discharge note type) will replace the current Discharge Summary. A discharge diagnosis and CSI information are also required to complete the discharge process. If all elements of the discharge are not in place (updated CSI, updated diagnosis, and progress note), information will be incomplete and hold up billing services.

2. Does a Discharge Progress Note require co-signature?
   Discharge progress notes follow the same co-signature requirements as all progress notes (See Documentation Requirements Matrix). Only Student/Interns, Graduate Students, and MH Worker 1 level staff require co-signatures on progress notes.

TIMELINES

1. What are the due dates for assessments and other forms? What is due annually?
   This will vary and must be tracked based on type of document: Core Assessments, Service Plans, and Medication Service Plans must be updated annually; due dates on other documents may vary (i.e. CANS, LOCUS, and TBS Plans).

2. Is there a requirement to update diagnoses annually even if the diagnosis does not change?
   Yes, diagnoses must be updated annually and with any change in diagnosis. The annual updated Service Plan is always based on reassessment of the client.

PSYCHIATRIC SERVICES

1. When and how often is an Initial Psychiatric Assessment (IPA) completed? The Documentation Matrix completed by QM references initial packets, but it does not speak to what happens at subsequent sessions and at Discharge.
   The Initial Psychiatric Assessment (IPA) is completed at start of psychiatric service; the Psychiatric MSE and Medication Service Plan are completed at start of service and annually thereafter. Follow-up is documented in ongoing Medication progress notes and annually a psychiatric re-evaluation is the basis for the next Medication Service Plan.

2. How often is the Medication Service Plan completed?
   The Medication service plan must be completed: 1) Whenever medication is evaluated or prescribed as part of a client's plan for services, 2). At the time of medication reassessment, whether this is occurring as part of transfer, reopening, or for the annual documentation update, and 3) Whenever there has been a planned period without Medication Support Services, and the subsequent plan changes to include medication.

3. Medical students provide clinical services under supervision and rotate through clinical sites in one month shifts. Do we have a protocol for students to enter notes in Avatar?
   Medical students that rotate sites and staff that work less than 30 days at a worksite will not be trained in Avatar CWS. These students and staff will submit all progress notes and clinical documents for scanning into the CWS record. Billing will be entered through submission of daily Client Charge Input forms.

4. What forms are required for Psychiatric initial intake?
   An "Initial Psychiatry Bundle" has been created in CWS and includes the required intake forms. These forms include the 1) Psychiatric MSE, 2) AIMS, 3) Diagnosis entry, 4) Infoscriber, 5) Initial Psychiatric Assessment (IPA), and 6) Medication Service Plan. The bundle <u>does not</u> include the Progress note, which is also required to generate the billing for these assessment services. All items on these assessment forms must be addressed (items with a response of "none" must be completed and not left blank).

5. What forms are required annually for Psychiatric services?
   An "Annual Psychiatry Bundle" has been created in CWS and includes the required annual forms. These forms include the 1) Psychiatric MSE, 2) AIMS, 3) Diagnosis entry, 4) Infoscriber, adn 5) Medication Service Plan. The bundle <u>does not</u> include the Progress note, which is also required to generate the billing for these assessment services. All items on these assessment forms must be addressed (items with a response of "none" must be completed and not left blank).

DOCUMENT CORRECTION AND EDIT

1. Since the date can't be edited on the MSE how would corrections be made when there is an error in date?
   The MSE, like any other document, becomes a record when finalized. Only in a few instances would a finalized MSE be returned to Draft status by

Avatar. Such a request would have to be very soon after the error is discovered (i.e. wrong date; incomplete section of document) and not a matter of practice. An Independent Note would then be written to indicate the nature of the error and the reason that a new MSE was completed.

2. Should a clinician to be able to pull up/edit/finalize draft notes of another clinician?
   Avatar CWS may not block staff from editing the progress notes of another staff but this should never occur. Only the author of a progress note should alter or edit their own note. In special circumstances, supervisors may be permitted to add updates to notes when staff are unavailable.

MISCELLANEOUS

1. Can we stop using colored paper?
   Yes.

2. Is it ok to use the LIVE environment for training purposes with staff (i.e. creating mock Client Plan)?
   No. The LIVE environment is the actual client record and must never be used for training and/or testing. Please see QA-special tip email from Uma Zykofsky, Clinical Lead, 2/1/2013.