CBHS Policies and Procedures

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San Francisco Health Network
COMMUNITY BEHAVIORAL HEALTH SERVICES

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POLICY/PROCEDURE REGARDING: **CBHS Medical Records Policy**

Issued By: Jo Robinson, MFT
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Manual Number: 3.10-2
References:

Substantive Revisions: Replaces Policy 3.10-2 dated May 1, 2008

Purpose
To maintain the accuracy and integrity of hybrid paper record and electronic health record (Avatar), for San Francisco Health Network – Community Behavioral Health Services.

Background
Community Behavioral Health Services (CBHS) updated its EHR software system from Avatar to myAvatar in October 2012. CBHS is currently in the process of acquiring electronic signature pads which will make the client record fully electronic in the future. Until the EHR is completely electronic, CBHS will continue to maintain a hybrid behavioral health record which includes both paper and electronic forms and documents.

Scope
This policy applies to all CBHS programs (mental health and substance abuse programs), including Contractors and Private Provider Network-Medication Clinic at Mission Mental Health Services. The larger Private Provider Network (PPN) is exempt from this policy.

Policy
CBHS staff documents services provided to clients in an accurate and timely manner in accordance with state and federal regulations, including all CBHS policies and procedures pertaining to client confidentiality, data security, and integrity of behavioral health records.

Procedures

1. **Behavioral Health Records**
   A behavioral health record is created with a BIS#/ID for each registered client who has been assessed/ treated in a mental health (MH) program or a substance abuse (SA) program.

   Definition of the hybrid behavioral health record
   The hybrid behavioral health record includes both paper and electronic documents. The hybrid chart contains forms that require client signatures, including forms that do not exist in Avatar,

and/or documents received from outside sources.

Civil-Service programs shall forward all closed hybrid paper records to Health Information Management (HIM) at 1380 Howard Street for processing and storage. CBHS contractors shall continue to be responsible for processing and storing their own closed hybrid paper records in accordance with CBHS policies and procedures.

Note: Prior to the implementation of Avatar, in July 2010, CBHS used Clinician Gateway (CG). Progress notes were documented in CG. Therefore, it is important to review all databases (e.g., CG, Avatar, paper chart) when responding to a request for the release of information.

Below is the pathway to obtain client record from CG. The CG Progress Notes Report is formatted by "Program" and "Client" for a selected time period.
Menu Path>CWS>Progress Notes>Clinicians Gateway Progress Notes Report

2. Authentication of Documents Created in Avatar

All CBHS staff and contractors must complete and submit the Certification and Verification for Staff ID Form and Electronic Signature Agreement Form to the DPH Compliance Office. Staff ID and password are used to authenticate user identity in Avatar. It also serves as an electronic signature for any and all entries made directly into Avatar. The password is valid for six (6) months. Renewal of the password renews the electronic signature on file.

Agencies wanting to use their own EHR must provide CBHS with their policy and procedure pertaining to electronic signatures.

3. Documents and Progress Notes in Draft

Staff must document all services provided to a CBHS client in Avatar.

DO NOT leave documents and progress notes in draft. All progress notes must be finalized within five (5) business days from the date of service. Only finalized documents are considered to be an official legal client record for the purposes of billing, request for client record, audits, and legal proceedings, etc.

In accordance with CBHS Policy 3.10-11: "CBHS Behavioral Health Progress Notes" staff should make every effort to complete and finalize progress notes on the same day of service. If that is not possible, then progress notes must be finalized within five (5) business days from the date of service. For a progress note that has not been finalized within 5 business days from the date of service, staff must note "Late Entry" at the beginning of the note.

Documents such as assessment, reassessment, treatment plan of care, etc., must be completed and finalized in accordance with CBHS policy and procedures, and California Code of Regulations, Title 9.

By submitting/clicking the document/progress notes as "FINAL," the staff's electronic signature is applied and the entry is considered complete. When an entry is finalized, Avatar does not allow it to be altered.

4. Appending/Adding an Addendum in Avatar

Once a progress note has been finalized, staff can revise the content by appending the note or adding additional information in the "Append" section.
Menu Path – CWS – Progress Notes – Append Progress Notes
Note: An addendum is defined as new information to be added to the original finalized entry. If additional information needs to be entered, label that information as "ADDENDUM" at the beginning of the note.

Once the note has been appended, the appended note will be displayed at the bottom of the original note in the append section. Note: submitting an appended entry does not generate a service in billing.

Note: Any progress notes requiring a co-signature cannot be appended after the supervisor has approved and co-signed the note. If the supervisor has erroneously approved and co-signed the note, then the staff has to re-write that note and resubmit to supervisor for approval and co-signature. For details, refer **to Appendix 27 - Avatar workflow for co-signature of Progress Note, Assessment, Reassessment, Treatment Plan of Care, and Closing Summary.** More importantly, the staff must fax an Avatar Correction Request Form to HIM for the deletion of services that were erroneously approved and billed.

5. Correcting Errors in Avatar

Staff is responsible for correcting errors made in Avatar by faxing the Avatar Correction Request Form to HIM at 415-252-3001 (i.e., entry on wrong client, wrong episode, duplicate BIS#/ID, etc.).

5.1 Information Entered on the Wrong Client

Protected Health Information (PHI) in a wrong client's record is a liability risk when PHI is disclosed inadvertently and/or used wrongfully.

- Any documents (i.e., assessment, treatment plan of care (POC), progress notes, etc.) entered in the wrong client's record **must be deleted as soon as possible.** Fax Avatar Correction Request Form to HIM for the deletion **immediately**.
- Staff must re-enter the information in the correct client's record.

5.2 Correcting BILLING Errors in Progress Notes When Bill is in "OPEN" Status

When the service is showing "OPEN" status in the Crystal Client Ledger, staff can use "Edit Service Information" to correct errors such as service code, program, duration, location, practitioner, etc. For details, refer to the "Edit Service Information Manual" posted online.

Edit Service Information in Avatar
Menu Path>Avatar PM/ Services/Ancillary/Ambulatory Services/Edit Service Information

5.3 How to Reduce Errors in Avatar

a. Before submitting documents and progress notes as "FINAL", staff must verify the **client's name, episode/Reporting Unit (RU), and date of service** to ensure the service is reported correctly.
b. Avoid opening multiple clients on the screen to minimize the chance of entering PHI in the wrong client's record.

6. Printout/Report

The printout/report from Avatar shall be considered the official legal document for the purposes of billing, request for client record, audits, and legal proceedings, etc. If a printed form is filed in the paper record, staff should **NOT write/add any information** on the printed copy. All changes/updates/ additions must be entered into Avatar.

Exception: Programs may be asked to print hard copies and file in paper records for audit and training purposes. Currently CBHS is keeping these copies in a paper record format until the electronic health record system is completely paperless.

7. Downtime Procedure

When the system is temporarily down, staff should document services on paper. When the system is up and running, staff is responsible for entering the information into Avatar.

8. PART I – MENTH HEALTH (MH)

Required Chart Forms in CBHS Behavioral Health Records

The CBHS Comprehensive Documentation Manual (2012) serves as the policy and procedures for documentation requirements. Staff must document services using standardized chart forms in Avatar. Staff should continue to use existing paper chart forms that are currently not available in Avatar.
CBHS Comprehensive Documentation Manual 2012 is posted online at:
http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSmnuPolyproc.asp

Mental Health Outpatient & Residential Services

Adult/Older Adult (AOA) & Children, Youth, and Family (CYF) Outpatient & Residential Avatar Clinical and Administrative Forms

MH Designated Record Set (Appendix MH1 to MH 26)

A. Avatar Clinical MH Chart Forms

Appendix MH1 - Adult/Older Adult Initial Risk Assessment
Appendix MH2- Adult/Older Adult Assessment/ANSA (SHORT & LONG)

Appendix MH3 - CYF CANS 5/18 Single Contact; CANS CYF 0-4 Single Contact
Appendix MH4 - CYF CANS 5/18 Assessment, 0-4 Infant Toddler Assessment
Appendix MH5 - CYF CANS 5/18 Reassessment, 0-4 Infant Toddler Reassessment

Appendix MH6- Psychiatric Evaluation Form

AppendixMH7- Diagnosis: Admission, Update, Discharge

Appendix MH8 to MH10 require signature – File forms in chart
Appendix MH8- Adult/Older Adult Treatment Plan of Care/Reassessment
Appendix MH9 - CYF Treatment Plan of Care, 0-4 Infant Toddler Treatment Plan of Care
Appendix MH10 - Psychiatric Plan of Care

Appendix MH11 - Health Monitoring

Appendix MH12 & MH13 require signature – File forms in chart
Appendix MH12 - AOA Informed Consent for Psychotropic Medication
Appendix MH13 - CYF Informed Consent for Psychotropic Medication

Appendix MH14 - Med List

Appendix MH15- Medication Sheet (Dispensed or Administered) – ***No Avatar form***
Appendix MH15A *Medication Sheet (Dispensed or Administered) – Paper form*
Appendix MH15B *Order Connect/Infoscriber "Medication Administration Record (MAR)" -available as an Infoscriber report*

Appendix MH16 - Progress Notes (Group & Individual)

Appendix MH17 – Adult/Older Adult Closing Summary
Appendix MH18 - CYF CANS Closing Summary, 0-4 CYF CANS Closing Summary
Appendix MH19 – CYF MD Closing Summary

B. Avatar Administrative Chart Forms

Appendix MH20 - MH Admission Outpatient Bundle
Appendix MH21 - Consent for Community Behavioral Health Services (MH &SA)
Appendix MH22 - Acknowledgement of Receipt of Materials (MH & SA)
Appendix MH23 - Authorization for Use or Disclosure of Protected Health Information (MH &SA) (if applicable)
Appendix MH24 - Episode Guarantor Information
Appendix MH25- UMDAP Sliding Fee Determination
Appendix MH26 - Consent for Billing

Avatar Workflow

Appendix MH27 - Avatar workflow for co-signature of Progress Note, Assessment, Reassessment, Treatment Plan of Care, and Closing Summary

Appendix MH1: Adult/Older Adult Initial Risk Assessment

Purpose: The initial risk assessment is used to triage and to determine medical necessity and guidance for accepting or referring client. It provides a comprehensive evaluation of client's current presenting problems/symptoms/impairments, mental status, substance abuse issues, and the formulation of recommendations for further treatment, referrals, and disposition.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.

When: When appropriate for use, complete the form accordingly.

Procedure:
Menu Path>CWS>Assessments>Adult Assessments/ANSA>Initial Risk Assessment (AOA)

a. Document the information using the "Initial Risk Assessment (AOA)" Form in Avatar. Further sessions(s) may be necessary to complete a full clinical database assessment using the long version of "Initial Assessment/ANSA" in Avatar.

b. All items on the assessment form must be completed. Do not leave any items blank. If it is not applicable, enter N/A or none.

c. Staff must finalize the assessment.

d. An assessment completed by an unlicensed staff, interns, or anyone who is not registered with the licensing board or licensed waived, must have their assessment with diagnosis form co-signed by a Licensed Practitioner of the Healing Arts (LPHA).

e. Provide "Admission" diagnosis.
Note: Unlicensed staff and not registered interns cannot establish a diagnosis. Only staff identified as a Licensed Practitioner of the Healing Arts (LPHA) can establish a diagnosis.

Diagnosis Form in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis

Document the diagnosis information using "Diagnosis" form in Avatar.
Staff must check off the type of diagnosis: Admission, Update or Discharge

- Staff must complete the diagnosis with 5 Axes required for the "Admission" at assessment and at "Discharge." Check off "Update" when there is a change in diagnosis.
- Staff must check off the "Principal Diagnosis."

Diagnosis Report in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis by Client Report
Print "Diagnosis" form.

Initial Risk Assessment Report in Avatar
Menu Path>CWS>Assessments>Adult Assessments/ANSA>Adult/Older Adult Initial Risk Assessment Report
Print the report.

Appendix MH2: Adult/Older Adult Assessment (SHORT & LONG)

Purpose: An assessment is used to document medical necessity and functional impairments for specialty mental health services.

An assessment includes narrative and quantitative indicators of symptoms, functioning, and context used to determine medical necessity for specialty mental health services.

a. A comprehensive chronology of the client's mental illness up to the present.
b. Current presenting problems/symptoms.
c. Current Mental Status.
d. Formulation of a DSM-IV diagnosis.
e. Formulation of recommendations for further treatment, referrals, disposition.

Assessment Forms: Menu Path>CWS>Assessments>Adult Assessments/ANSA>

- Adult/Older Adult Assessment long with diagnosis
- Adult/Older Adult Assessment short with diagnosis
- Adult/Older Adult Assessment (Long)
- Adult/Older Adult Assessment (Short)

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.

When: An assessment is to be completed at the beginning of a new episode of care.

Adult Residential Treatment Program:
Residential facilities may accept assessments completed by an Outpatient or Inpatient provider at the time of admission. However, the Adult Residential Treatment Program must complete their own assessment and diagnosis within 24 hours from the date of admission. If the client is admitted to the facility over the weekend (late Friday night – Sunday), then the assessment shall be completed by the next business day.

Procedure:

a. Document the information using the appropriate assessment form in Avatar. All items on the assessment must be completed. Do not leave any items blank. If it is not applicable, enter N/A or none.

b. Unlicensed staff and not registered interns cannot establish diagnosis. Unlicensed staff and not registered interns must use Adult/Older Adult Assessment LONG or SHORT version without diagnosis. LPHA must complete the diagnosis page.

c. Staff must finalize the assessment.

d. Complete the Diagnosis at the same time.

e. In order to bill for an assessment (completing an assessment form does not generate a bill), staff has to document the service in the progress note.

f. An assessment completed by an unlicensed staff and/or a not registered intern must be co-signed by a Licensed Practitioner of the Healing Arts (LPHA).

Assessment Reports in Avatar:

Menu Path>CWS>Assessments>Adult Assessments/ANSA>

- Adult/Older Adult Assessment SHORT Report
- Adult/Older Adult Assessment LONG Report

Print the selected report.

APPENDIX MH3: CANS CYF 5/18 Single Contact; CANS CYF 0/4 Single Contact

Purpose: The CANS CYF 5/18 Single Contact and CANS CYF 0/4 Single Contact assessment are used to document medical necessity and functional impairments for specialty mental health services for clients who are only seen one time.

The assessment includes narrative and quantitative indicators of symptoms, functioning, and context used to determine medical necessity for specialty mental health services.

Who: All licensed and unlicensed staff/not registered interns with Avatar Clinical Work Station access. Only staff certified in the Child and Adolescent Needs and Strengths (CANS) can complete the indicators in this assessment. All uncertified CANS users may only complete the narrative sections.

When: The CANS CYF 5/18 Single Contact and CANS CYF 0/4 Single Contact are to be completed at intake.

Procedure:

CANS CYF Single Contact Assessment Forms in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>CANS>

a. Document the information using the appropriate assessment form in Avatar.
- **CANS CYF 5-18 Single Contact**
- **CANS CYF 0-4 Single Contact**
- **CANS CYF Single Contact with Diagnosis**
- **CANS CYF Infant Toddler Single Contact with Diagnosis**

b. All items on the assessment form must be completed. All items with check boxes including "0,1,2,3" are to be scored according to the San Francisco Comprehensive CANS Scoring Manual.
c. Staff must finalize the assessment.
d. Complete the Diagnosis at the same time.
Note: Unlicensed staff and not registered interns cannot establish diagnosis. Unlicensed staff and not registered interns must use the CANS CYF single contact form (without diagnosis). LPHA must complete the diagnosis page.
e. In order to bill for an assessment (completing an assessment form does not generate a bill), staff has to document the service in the progress note.
f. The assessment completed by an unlicensed staff and a not registered intern must be cosigned by a Licensed Practitioner of the Healing Arts (LPHA).

Assessment Reports in Avatar:

Menu Path>CWS>Assessments>User Defined Assessments>CANS>

- CANS CYF Single Contact Report
- CANS Infant Toddler Single Contact Report

Print the selected report.

Appendix MH4: CYF CANS Assessments

Purpose: The CYF CANS Assessment is used to document medical necessity and functional impairments for specialty mental health services.

The assessment includes narrative and quantitative indicators of symptoms, functioning, and context used to determine medical necessity for specialty mental health services.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access. Only staff certified in the Child and Adolescent Needs and Strengths (CANS) can complete the indicators in this assessment. All uncertified CANS users may only complete the narrative sections.

When: Initial Assessment must be completed no later than 60 days from the date of opening.

Procedure:

Assessment Forms in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>CANS>

a. Document the information using the appropriate assessment form in Avatar.

- CANS CYF Initial Assessment with Diagnosis Bundle
- CANS CYF 5/18 Initial Assessment
- CANS Infant Toddler Initial Assessment with Diagnosis Bundle
- CANS CYF 0/4 Initial Assessment

- CANS CYF Single Contact with Diagnosis
- CANS Infant Toddler Single Contact with Diagnosis
- CANS CYF 5/18 Single Contact
- CANS CYF 0/4 Single Contact

b. All items on the assessment form must be completed. All items with check boxes including "0,1,2, 3" are to be scored according to the San Francisco Comprehensive CANS Scoring Manual.

c. Staff must finalize the assessment.

d. Complete the Diagnosis at the same time.
Note: Unlicensed staff and not registered interns cannot establish diagnosis. Unlicensed staff and not registered interns must use CANS CYF Assessment (without diagnosis). LPHA must complete the diagnosis form.

e. In order to bill for an assessment (completing an assessment form does not generate a bill), staff has to document the service in the progress note.

f. The assessment completed by unlicensed staff and not registered interns must be cosigned by a Licensed Practitioner of the Healing Arts (LPHA).

Assessment Reports in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>

- CANS CYF Initial Assessment Report
- CANS Infant Toddler Initial Assessment Report

Print the selected report.

Appendix MH5: CYF CANS Reassessments (aka: Outpatient Treatment Report)

Purpose: To document information for the purposes of reassessment/justification for continued services. This CYF CANS reassessment includes narrative and quantitative indicators of symptoms, functioning, and context used to establish continued medical necessity for on-going mental health services. This form also acts as a PURQC form for reauthorization.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.
Only staff who are certified in the Child and Adolescent Needs and Strengths (CANS) Protocol can complete the indicators in this reassessment. All uncertified CANS users complete narrative sections.

When: The reassessment must be completed at least annually or as needed.

Procedure:
Reassessment Forms in Avatar
Menu Path>CWS>Assessments>User Defined Assessments>CANS>

a. Document the information using the appropriate reassessment form in Avatar.
   - CANS CYF Reassessment/OTR with Diagnosis
   - CANS CYF 5/18 Reassessment/OTR
   - CANS Infant Toddler Reassessment/OTR with Diagnosis
   - CANS CYF 0/4 Reassessment/OTR

b. All items on the reassessment form must be completed. All items with check boxes including "0, 1,2, 3" are to be scored according to the San Francisco Comprehensive CANS Scoring Manual.

c. Staff must finalize the reassessment.

d. Complete the Diagnosis at the same time.
   Note: Unlicensed staff and not registered interns cannot establish diagnosis. Unlicensed staff and not registered interns must use the CANS CYF Reassessmen/OTR (without diagnosis).

e. In order to bill for a reassessment (completing a reassessment form does not generate a bill), staff has to document the service in the progress note.

f. The reassessment completed by unlicensed staff and/or not registered interns must be cosigned by a Licensed Practitioner of the Healing Arts (LPHA).

Reassessment Reports in Avatar
Menu Path>CWS>Assessments>User Defined Assessments>CANS>
- CANS CYF Reassessment/OTR Report
- CANS Infant Toddler Reassessment/OTR Report

Print the selected report.

Appendix MH6: Psychiatric Evaluation Form

Purpose: To document a client's psychiatric history and current evaluation for medication.

The Psychiatric Evaluation Form documents the complete history and evaluation of a client's past and current psychiatric condition; history and risk of violence, suicide, drug abuse; medical/surgical history including prescribed medications, OTC medications, and medication allergies.

Who: Physicians and Nurse Practitioners with Avatar Clinical Work Station access.

When: The Form is to be completed at the beginning of an episode and updated as needed.

Procedure:

Psychiatric Evaluation Form in Avatar
Menu Path>CWS>MD and Health Monitoring>Psychiatric Evaluation Form

a. Document the information using the Psychiatric Evaluation Form in Avatar. All items on the form must be completed. Do not leave any items blank. If it is not applicable, enter N/A or none.

b. Staff must finalize the assessment.

a. Complete the Diagnosis at the same time.

b. In order to bill for the evaluation (completing the Psychiatric Evaluation form does not generate a bill), staff has to document the service in the progress note.

Psychiatric Evaluation Form Report
Menu Path>CWS>MD and Health Monitoring>Psychiatric Evaluation Form Report
Print the report.

Appendix MH7: Diagnosis: Admission, Update, Discharge

Purpose: An included DSM IV diagnosis is required to establish medical necessity at assessment.

Who: MD, licensed, registered, and waived staff with Avatar Clinical Work Station access.

When: Diagnosis established at assessment, annual reassessment, discharge, or as needed, by staff within the scope of practice.

Procedure:

Diagnosis Form in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis

a. Document the diagnosis information using "Diagnosis" Form in Avatar.
b. In order to bill for services, staff must provide a diagnosis at admission. The "Admission Diagnosis" must cover the first service date.
c. Staff must check off the type of diagnosis: Admission, Update or Discharge
    - Staff must complete a 5-axis DSM IV diagnosis required for the "Admission" at assessment and at "Discharge." Check off "Update" when there is a change in diagnosis.
    - Staff must check off the "Principal Diagnosis."
d. Different staff must use "Add" to enter diagnosis information; same staff must use "Add" if entering diagnosis on a different date; the "Edit" function is only used to amend or change diagnosis made by a particular staff on a particular date.

Note: Unlicensed/not registered interns and administrative staff cannot establish diagnosis.

Diagnosis Report in Avatar:
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis by Client Report
Print the "Diagnosis" form.

Appendix MH8: Adult/Older Adult Treatment Plan of Care/Reassessment

Purpose: To capture the Treatment Plan of Care (POC) information as well as information necessary for the purposes of reassessment/justification for continued services.

The client's Treatment Plan of Care outlines the goals, objectives, interventions and timeframes for diminishing or preventing deterioration of the impairment(s) that has been identified through the assessment and reassessment process and clinical formulation.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.
Only staff that are certified in the Adult Needs and Strengths Assessment (ANSA) can complete the ANSA outcomes ratings. All uncertified ANSA users may complete the narrative sections.

When:

MH Outpatient

- The initial POC must be completed either prior to a planned service, or no later than 60 days from the date of opening, and updated annually thereafter.
- POC is finalized and immediately begins on the date that both LPHA and client sign the finalized POC.
- If the client's signature cannot be obtained, the LPHA signs the finalized POC and documents date(s) of attempt on the plan and the reason(s) in the progress notes. Ongoing attempts to obtain the client's signature must be made and documented throughout the course of treatment.
- If the client signs the finalized POC at a later date, the POC's anniversary date will still be on the date the LPHA finalized and signed the POC.
- The POC must be updated any time when there is a significant development or change in the focus of treatment.

Adult Residential Treatment Program

- POC must be completed for each client receiving services at the residential facility and updated every 6 months.
- POC is finalized and immediately begins on the date that both LPHA and client sign the finalized POC.
- If the client's signature cannot be obtained, the LPHA may sign the finalized POC and documents date(s) of attempt on the plan and the reason(s) in the progress notes. Ongoing attempts to obtain the client's signature must be made and documented throughout the course of treatment.
- If the client signs the finalized POC at a later date, the POC's renewal date will still be on the date the LPHA finalized and signed the POC.
- The POC must be updated any time when there is a significant development or change in the focus of treatment.
- POC must be specifically tailored to client's current acuity and treatment service needs.
- For residential facilities providing day rehabilitation and/or day treatment intensive services in the same program, the POC must include types/modality of services such as day rehabilitation, day treatment intensive, medication support services, etc.

Procedure:

Menu Path>CWS>Treatment Planning>Adult/Older Adult Treatment Plan of Care/Reassessment

Document the information using the Adult/Older Adult Treatment Plan of Care/Reassessment form in Avatar.

Two Plan Type: Select one of the following plans:

1. Mental Health Initial Tx Plan w/ ANSA – Mental Health providers would select this option to complete the client's initial treatment plan. It includes the initial ANSA ratings.

2. Mental Health Annual Update w/ ANSA & Justification – Mental Health providers would select this option to complete the annual treatment plan update. This forms stands as the annual reassessment. It also includes the Justification for Continued Services and the ANSA.

   Note: This form has been bundled with the Diagnosis Screen, which means that after the staff has completed this form, the Diagnosis Screen will appear. Diagnosis is required for reassessment in order to meet MediCal standards. Date of diagnosis and date of reassessment must match.

Key Points of TPOC Documentation:

1. Focus of Treatment
   - Objectives/Interventions must focus on impairments which are related to an Included Diagnosis.
2. The Client's Goal
   - The client should be central in planning for the treatment and recovery.
3. Objectives must be specific, observable or measurable
   - The plan of care must contain goals or objectives which are specific and observable or measurable.
4. Progress toward goals
   - Progress notes must contain interventions, client response to interventions, client progress toward treatment plan goals/objectives, other relevant assessment information and clinical decisions.

Staff must update client "Diagnosis" at reassessment.
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis

Staff must finalize the POC.

Client must sign the POC as evidence of participation in the plan of care.

The POC completed by unlicensed staff and/or not registered interns must be cosigned by a Licensed Practitioner of the Healing Arts (LPHA).

Staff must file a copy of the POC with client's signature in the chart.

The POC should include the following information in order to meet MediCal standards and HIPAA requirements.

- The client is given a copy of the POC on request.
- The client has been informed on how to obtain the DPH Notice of Privacy Practices.

Adult/Older Adult Treatment Plan of Care/Reassessment Report in Avatar:
Menu Path>CWS>Treatment Planning>Adult/Older Adult POC/Reassessment Report
Print POC/Reassessment Report

Appendix MH9: CYF Treatment Plan of Care, CYF 0-4 Treatment Plan of Care

Purpose: To document the Treatment Plan of Care (POC) information.

The client's Treatment Plan of Care outlines the goals, objectives, interventions and timeframes for diminishing or preventing deterioration of the impairment(s) and documenting improvement(s) that has been identified through the assessment and reassessment process and clinical formulation.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.
Only staff who are certified in the Child and Adolescent Needs and Strengths (CANS) Protocol can complete the indicators in this POC. All uncertified CANS users may complete the narrative sections.

When:

- The initial POC must be completed either prior to a planned service, or no later than 60 days from the date of opening, and updated annually thereafter.
- POC is finalized and immediately begins on the date that both LPHA and client sign the finalized POC.
- If the client's signature cannot be obtained, the LPHA signs the finalized POC and documents date(s) of attempt on the plan and the reason(s) in the progress notes. Ongoing attempts to obtain the client's signature must be made and documented throughout the course of treatment.
- If the client signs the finalized POC at a later date, the POC's anniversary date will still be on the date the LPHA finalized and signed the POC.
- The plan must be updated any time when there is a significant development or change in the focus of treatment.

Procedure:

Menu Path>CWS>Treatment Planning>CYF Treatment Plan of Care
Menu Path>CWS>Treatment Planning>CYF 0-4 Treatment Plan of Care

Staff documents the information using the appropriate CYF Treatment Plan of Care form in Avatar.

Staff must finalize the POC.

Client/parent/guardian must sign the POC as evidence of participation in the plan of care.

The POC completed by an unlicensed staff/trainee must be cosigned by a LPHA.

Staff must file a copy of POC with client/parent/guardian signature in the chart.

The POC should include the following information in order to meet MediCal standards and HIPAA requirements.

- The client is given a copy of the POC on request.
- The client has been informed on how to obtain a copy of the DPH Notice of Privacy Practices.

Treatment Plan of Care Report in Avatar:
Menu Path>CWS>Treatment Planning>Print Treatment Plan

a. Select as appropriate:
   - CYF 0-4 Treatment Plan of Care
   - CYF Treatment Plan of Care
   - **DO NOT** select "Client Treatment Plan."
b. Print Treatment Plan of Care Report

Appendix 10: Psychiatric Plan of Care

Purpose: To document the Psychiatric Plan of Care information.

The Psychiatric Plan of Care (Meds Only):

a. Evaluates current Medical Necessity.
b. Current presenting problems/symptoms.
c. Provides treatment objectives and quantifiable intervention plans.
d. Update a DSM diagnosis and ANSA/CANS MD at the same time.

Who: Psychiatrists and Prescribers with Avatar Clinical Work Station access.

When:

- When a prescriber is the primary service provider, the Psychiatric Plan of Care is to be completed either prior to a planned service or no later than 60 days from the date of opening, and updated annually thereafter.
- The POC is finalized and immediately begins on the date that both the prescriber and client/guardian sign the finalized POC.
- If the client's/guardian's signature cannot be obtained, the prescriber signs the finalized POC and documents date(s) of attempt on the plan and the reason(s) in the progress notes.
- If the client/guardian signs the finalized POC at a later date, the POC's anniversary date will still be on the date the prescriber finalized and signed the POC.
- The plan must be updated any time when there is a significant development or change in the focus of treatment.

Procedure:

Menu Path>CWS>MD and Health Monitoring>Psychiatric Plan of Care
Menu Path>CWS>MD and Health Monitoring>Psych Plan of Care/CANS MD / Dx

Client/guardian must sign the Psychiatric Plan of Care form as evidence of participation in the plan of care. In order to bill planned mental health services, a plan with client's/guardian's signature must be in place within the specified timeframe.

Staff must finalize the Psychiatric Plan of Care form.

If the client's/guardian's signature cannot be obtained, document date(s) of attempt on the plan and the reason(s) in the progress notes. Ongoing attempts to obtain the client's signature must be made and documented throughout the course of treatment.

Staff must file the form with the client's/guardian's signature in the chart.

The form should include the following information in order to meet MediCal standards.

- The client/guardian is given a copy of the plan of care form on request.

Psychiatric Plan of Care Report
Menu Path>CWS>MD and Health Monitoring>Psychiatric Plan of Care Report
Print the Psychiatric Plan of Care Report

Appendix MH11: Health Monitoring (Adult) & (Child)

Purpose: The Health Monitoring tool allows for documentation of health monitoring parameters including:

- Vital signs
- Metabolic monitoring parameters
- Smoking status
- Linkage with primary care
- Pertinent lab work

Who: All users with a clinical level permission have access to view and enter data into this tool.

When: Once a year for clients receiving medications or when clinically indicated.

Procedure:

Menu Path>Avatar CWS>MD and Health Monitoring>Health Monitoring (Adult)
Menu Path>Avatar CWS>MD and Health Monitoring>Health Monitoring (Child)

Smoking status and linkage with primary care are not required entries. They are entered at the Admission (Outpatient) Demographic section or Update Client Data.

No report available in Avatar.

Appendix MH12: Adult/Older Adult Informed Consent for Psychotropic Medication

Purpose:

1. To serve as a legal record of client's consent for all psychotropic medications currently prescribed by a BH prescriber.
2. To document that the client has been offered information about the medications being prescribed.

Responsibility for Documentation:

1. The consent form in English can be printed in Avatar. See Menu Path listed below. The paper consent form (MM05) is available in threshold languages.
2. The prescriber has the primary responsibility for filling out the form once the client has received language-appropriate information about the medication.
3. A new form must be executed when any new medications are added.
4. File the completed form with client's signature in the chart.
5. A copy of the consent form should be given to the client for his/her records.

Instructions:

1. The client is to receive information about the medication(s) before the form is completed.
2. This form can accommodate up to 5 medications, assuming the client consents to all.
3. The medication(s) and dosage range(s) are entered into the table.
4. For changes in dose range or route, modifications can be made on this form by having the client initial and date in the appropriate column. For adding new medications, a new form should be used.
5. If the client consents to medications, check the applicable box.
    a. If the client agrees, the patient and prescriber sign and date at the bottom.
    b. If the client cannot or will not sign, the prescriber fills in the reason and signs at the bottom with a witness. The prescriber documents continued attempts to obtain a signature by initialing and dating the appropriate line.
    c. If the client is willing to document refusal of medications, this box can be checked and the prescriber and client can sign and date at the bottom.
6. If the client signs with a mark, a witness is needed.
7. A client may withdraw consent at any time by notifying the prescriber. The reason for the withdrawal should be documented in the progress notes, and the medication order should be discontinued.
8. Paper form - The top white consent form is to be filed in the client's chart. The bottom yellow copy is to be given to the client/parent/guardian/conservator.

Avatar "Adult/Older Adult Informed Consent for Psychotropic Medication" form
Menu Path>PM>Client Management>Client Information>Forms>Consent Medication Adult

a. The client signs the consent form.
b. File a copy in the client's chart.

Appendix MH13: CYF Informed Consent for Psychotropic Medication

Purpose:

1. To serve as a legal record of client's consent for all psychotropic medications currently prescribed by a BH prescriber.
2. To document that the client has been offered information about the medications being prescribed.

Responsibility for Documentation:

1. The consent form is updated annually.
2. The consent form in English can be printed in Avatar. See Menu Path listed below. The paper consent form (MM05) is available in threshold languages.
3. The prescriber has the primary responsibility for filling out the form once the client has received language-appropriate information about the medication.
4. A new form must be executed when any new medications are added.
5. File the completed form with client's/parent's/guardian's signature in the chart.
6. A copy of the consent form should be given to the client/parent/guardian.

Instructions:

1. The parent/legal guardian is to be informed about the medication before the form is completed.
2. If the parent/legal guardian agrees, the parent/legal guardian and prescriber sign and date at the bottom of the consent form.
3. A minor under 18 years of age cannot consent for medication unless she/he is an emancipated minor.
4. A parent/legal guardian may withdraw consent at any time by notifying the prescriber. The reason for the withdrawal should be documented in the progress notes and the medication order should be discontinued.

Avatar "CYF Informed Consent for Psychotropic Medication" form
Menu Path>PM>Client Management>Client Information>Forms>Consent Medication CYF

a. Click "Consent Medication CYF" box.
b. Print the consent form.

Appendix MH14: Med List

- **Medication History**
- **Med List and Allergies**

Purpose: To serve as the official medication record of all CBHS clients as of January 1, 2011. Information is accessible electronically throughout the CBHS system of care, including all crisis, residential and mental health clinics.

Access: All staff with Avatar Clinical Work Station access

Procedure: MDs and prescribers enter the client's medications and allergies into Infoscriber. The medication information is then transmitted to Avatar as a "Med List."

Two reports are available in Avatar:
Menu Path>CWS>Med List

- **Medication History:** Chronological list of all prescribing events (medication changes, reorders, and discontinuation) and medication allergies.
- **Med List and Allergies:** The official current medication list and allergies for clinicians and facility transfers.

Select and print the report.

Appendix MH15: Medication Sheet (Dispensed or Administered)

Purpose: To document medications administered in the clinic or dispensed from the clinic to take home.

The medication sheet is not to be confused with the Prescriber's Orders. After the prescriber has ordered a medication to be administered or dispensed to a client in the clinic, the order should be transcribed from Infoscriber onto the Medication Sheet. Each time the medication is administered or dispensed it should be documented on the Medication Sheet.

Who: Medication providers.

When: This form is completed for each medication dispensed or administered.

Procedure:

This form has not been created in Avatar. Staff may choose to use the paper form (Appendix MH15A) or the Order Connect/Infoscriber "Medication Administration Record (MAR)" (Appendix MH15B) for documenting medications administered in the clinic or dispensed from the clinic to take home.

Appendix MH15A: Medication Sheet (Dispensed or Administered) Form, MRD 17- rev 08/16/04
Staff can obtain this form from the supply room located at 1380 Howard Street, 2nd floor.

Appendix MH15B: The Order Connect/Infoscriber (MAR) is available as an Infoscriber report.

For Medications Administered in the Clinic:

a. The medication, dosage, frequency, and route are entered in the first column of the page for MRD 17.
b. The person administering the medication (physician, nurse, psychiatric technician, and pharmacist) documents the date, time, injection site (if applicable) and their initials in the appropriate column. (The site and route codes are indicated at the bottom of the MRD 17 form)
c. Signature and initials of persons(s) administering medications are recorded on the form.

For Medications Dispensed from the Clinic (Stock/Individual Client Meds from Outside Pharmacies)

a. The medication, dosage, frequency, and route are entered in the first column of the page.
b. The person dispensing the medication (physician, nurse, pharmacist) documents the date, time, quantity dispensed, and their initials in the appropriate column.
c. Signature and initials of person(s) dispensing medications are recorded on the bottom of the page.

Appendix MH15A for the Medication Sheet (Dispensed or Administered) Form, MRD 17 – rev 08/06/04

City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES

Name:

BIS#

RU#

MEDICATION SHEET (*Dispensed or Administered*)

Medication, Dosage, Frequency, Route (Indicate Quantity if Dispensed)	Date, Time, Injection Site, Qty, Initials	Date, Time, Injection Site, Qty, Initials	Date, Time, Injection Site, Qty, Initials	Date, Time, Injection Site, Qty, Initials	Date, Time, Injection Site, Qty, Initials

_____ ( ) _____ ( )
Signature initials Signature initials

_____ ( ) _____ ( )
Signature initials Signature initials

INJECTION SITE: (R or L) D-Deltoid T-Thigh G-Gluteal

ROUTE: PO-Oral SQ-Subcutaneous IM-Intramuscular

Appendix MH15B

City and County of San Francisco Community Behavioral Health Services - Medication Administration Record for February, 2014

AVATARSAMPLE, CLIENT
MR: 99900/104
DOB: 02/15/1989

(000) 000-0000

Allergies: CATS, FOOD, PROTEIN-RICH, penicillin
Primary Dx: 295.90 Schizophrenia Undifferentiated Type
SSN: 000-00-0000
Payor:
MediCaid#:
MD:

Nurse/Monitor's Signature: | Initials | Staff#

Medication/Tx	Hrs	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
clonazePAM 0.5 mg, TAB, PO, Take one (1) tablet Twice a Day Start Date: 02/26/2014																																
		Please bubble pack and deliver to 992 Mission																														
FLUoxetine 20 mg, CAP, PO, Take one (1) capsule Daily Start Date: 02/26/2014																																
		Please bubble pack and deliver to 992 Mission																														
Haldol Decanoate decanoate 100 mg/mL, SOLN, IM, Inject one hundred fifty (150) mg solutions Every 4 Weeks Start Date: 02/26/2014																																
multivitamin Multiple Vitamins, TAB, PO, Take one (1) tablet Daily Start Date: 02/26/2014																																
		Please bubble pack and deliver to 992 Mission																														

Appendix MH16: Progress Notes (Group & Individual)

Purpose:

- To document the progress of the individual in attempting and/or accomplishing personal goals/interventions as recorded on the Treatment Plan of Care.
- To support the CPT and HCPCS code used for billing.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.

When: Document each billable and non-billable service provided. Staff must make every effort to complete progress notes on the same day as the session. All progress notes must be finalized within 5 business days from the date of service. After 5 business days, note "late entry" at the beginning of the progress note.

Procedures:

Menu Path>CWS>Progress Notes>Progress Notes (Group and Individual)

a. Document the service using the "Progress Notes (Group & Individual)" in Avatar. Avatar instruction manual and user guide are posted at www.sfdph.org
b. The staff member must select the correct service code in the correct program code/report unit and on the correct client. **Before clicking the "Submit" button / "File Note" button, the staff member must verify the name of client, the date of service, and the program code/reporting unit.**
c. The progress note must support the CPT or HCPCS code used for billing.
d. Document, code, and bill must be a service that the program is authorized to provide.
e. For each service provided in a language other than English, the staff member must document in the first sentence of the note by stating "This session was conducted in (X) language."
f. Staff must make every effort to complete progress notes on the same day as the session. All progress notes must be finalized within 5 business days from the date of service. After 5 business days, note "late entry" at the beginning of the progress note.
g. For each group note staff member must document an "individualized" note of the client.
h. If the staff member notices an error in the progress note, the staff member is responsible for submitting an Avatar Correction Request Form for correction.
i. Use the spell check function.
j. For detailed documentation requirements for Individual and Group progress notes, refer to CBHS Comprehensive Documentation Manual 2012 at: http://www.sfdph.org/dph/comupg/oservices/mentalHlth/cbhs/default.asp

Printing progress notes:

- **Progress Notes Viewer –**
  Menu Path>CWS>Progress Notes>Progress Note Viewer

Note: Do not print progress notes from the "Progress Notes without Pagebreaks" Report as the report does not include the appended entries.

Appendix MH17: Adult/Older Adult Closing Summary

Purpose: To summarize the treatment and effects of services received in one episode of care. The Closing Summary is a record, in summary form, of services received in one episode (admission and discharge) of care and the effects of these services.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access.
All certified ANSA users and unlicensed staff must complete all items including narrative sections of the summary of treatment, medication, discharge plan, etc.

Staff members certified as ANSA users must also complete all ANSA required indicators of symptoms, functioning, etc.

All uncertified ANSA users and unlicensed staff members must complete all narrative sections of the summary of treatment, medication, discharge plan, etc., as required on the Closing Summary.

When: The Closing Summary is to be completed at the conclusion or termination of each episode of care.

Closing Summary Requirements:

a. A Closing Summary is required for clients who have received more than five services for the episode, i.e., A closing summary is required at the sixth service.
b. A Closing Summary is **NOT** required for clients who have received five or less services. Document the disposition in the progress note.

Definition of the closing date:
The closing date is the last entry date listed in the "Crystal Client Ledger." This entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed as the last entry, use the date of "NO SHOW" as the closing date.

Procedure:
Adult/Older Adult Closing Summary Form
Menu Path>CWS>Assessments>Adult Assessments/ANSA>Adult/Older Adult Closing Summary

a. Document the information using the AOA Closing Summary in Avatar. All items on the Closing Summary must be completed.

b. Staff must finalize the Closing Summary form.

c. Complete ANSA Ratings.

d. Complete the discharge diagnosis using "Diagnosis" form in Avatar. Check off the diagnosis box: "Discharge."
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis

e. ***MH Outpatient:*** Staff must also complete the "Discharge (Outpatient)" for closing the episode of the reporting unit. The closing date is the last entry date listed in the "Crystal Client Ledger." This entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed as the last entry, the date of "NO SHOW" is the closing date.
Menu Path>PM>Client Management>Episode Management>Discharge Outpatient
Menu Path>PM> Client Management>Account Management>Crystal Client Ledger

f. ***Residential:*** Complete "Discharge" for closing the episode of the reporting unit.
Menu Path>PM>Client Management>Episode Management>Discharge

g. ***Non Residential:*** Complete "Discharge (Outpatient)" for closing the episode of the reporting unit by using the last entry date listed in the "Crystal Client Ledger". This entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed at the last entry, the date of "NO SHOW" is the closing date.
Menu Path>PM>Client Management>Episode Management>Discharge Outpatient
Menu Path>PM> Client Management>Account Management>Crystal Client Ledger

Closing Summary Report in Avatar:
Menu Path>CWS>Assessments>Adult Assessments/ANSA>Adult/Older Adult Closing Summary Report
Print Adult/Older Adult Closing Summary Report

Appendix MH18: CYF CANS Closing Summary

Purpose: To summarize the treatment and effects of services received in one episode of care.

The CYF Closing Summary is a record, in summary form, of services received in one episode (admission and discharge) of care and the effects of these services.

Who: All licensed and unlicensed staff with Avatar Clinical Work Station access. Staff members certified in the Child and Adolescent Needs and Strengths (CANS) Protocol must complete indicators of symptoms, functioning, etc. All uncertified CANS/unlicensed staff must complete all narrative sections of the summary of treatment, medication, discharge plan, etc., as required on the Closing Summary.

When: The Closing Summary is to be completed at the conclusion or termination of each episode of care.

Definition of the closing date:
The closing date is the last entry date listed in the "Crystal Client Ledger." This entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed as the last entry, use the date of "NO SHOW" as the closing date.

Closing Summary Requirements:

a. A CANS Closing Summary is required for clients whose cases have been opened for more than 30 calendar days after the completion of the Initial CANS Assessment or the most recent CANS OTR / Reassessment.

b. Staff must finalize the Closing Summary form.

c. A CANS Closing Summary is **NOT** required if, at the date of discharge, the case has been opened for less than 30 calendar days after the completion of the most recent CANS Initial Assessment or CANS OTR / Reassessment. Document the disposition in the progress note.

d. Complete the discharge diagnosis using "Diagnosis" form in Avatar.
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis

e. **MH Outpatient:** Complete "Discharge (Outpatient)" for closing the episode of the reporting unit. The closing date is the last entry date listed in the "Crystal Client Ledger." This entry could be a billable or non-billable service.
Menu Path>PM>Client Management>Episode Management>Discharge Outpatient
Menu Path>PM>Client Management>Account Management>Crystal Client Ledger

Procedure:
Closing Summary Forms in Avatar:

Menu Path>CWS>Assessments>User Defined Assessments>CANS>CANS CYF 5/18 Closing Summary
Menu Path>CWS>Assessments>User Defined Assessments>CANS>CANS CYF 0/4 Closing Summary

Document the information using the appropriate CYF Closing Summary form in Avatar.

- CANS CYF Closing Summary with Diagnosis
- CANS CYF 5/18 Closing Summary
- CANS Infant Toddler Closing Summary with Diagnosis
- CANS CYF 0/4 Closing Summary

All items on the Closing Summary must be completed. All items with check boxes including "0, 1, 2, 3" are to be scored according to the San Francisco Comprehensive CANS Scoring Manual.

CYF Closing Summary Reports:

Menu Path>CWS>Assessments>User Defined Assessments>CANS>CANS CYF Closing Summary Report

Menu Path>CWS>Assessments>User Defined Assessments>CANS>CANS Infant Toddler Closing Summary Report

Print the selected report:

- CANS CYF Closing Summary Report
- CANS Infant Toddler Closing Summary Report

Appendix MH19: MD Closing Summary

Purpose: To summarize the treatment and effects of services received in one episode of care when the case has been a medication services only case and the medication services are ending.

Who: MDs and Prescribers

When: The Closing Summary is to be completed at the conclusion or termination of each episode of care.

Closing Summary Requirements:

A MD Closing Summary is required for clients whose cases have been opened with an MD or prescriber being the only clinician managing the case, and the client is ending medication services, with no other additional services being provided in that episode.

A MD Closing Summary is **NOT** required if, the client is ending medication services, but continuing therapy or case management services with another clinician in the same episode.

Definition of the closing date:
The closing date is the last service entry date listed in the "Crystal Client Ledger." This entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed as the last entry, use the date of "NO SHOW" as the closing date.

Procedure:
MDs and prescribers who have been providing medication services only and the services are ending need to complete the MD Closing Summary and enter a closing Diagnosis.
MDs and prescribers must finalize the Closing Summary form.

Avatar MD Closing Summary Forms:

- MD Closing Summary w/Dx Form
  Menu Path>CWS>MD and Health Monitoring>MD Closing Summary w/Dx

- MD Closing Summary Form
  Menu Path>CWS>MD and Health Monitoring >MD Closing Summary

MD Closing Summary Report
Menu Path>CWS>MD and Health Monitoring>MD Closing Summary Report
Print MD Closing Summary Report.

Appendix MH 20- MH Admission Outpatient

Purpose: The admission process initiates a new client admission or a re-admit client record in Avatar.

Who: Authorized Avatar users.

When: Complete at intake and review/update the client data annually from the date of opening.

Procedures:

A. Menu Path>PM>Client Management>Episode Management>MH Admission Outpatient Bundle

Staff may complete all required forms in the bundle accordingly or staff may choose to enter each individual form separately as required for the admission. The required forms are:

- Admission
- Demographics
- SF Additional Admission
- CSI
- Contact Information
- Episode Guarantor Information

B. Menu Path>PM>Client Management>Client Information

As required by the state, staff must review and update client data annually (i.e., address/phone number, etc.) from the date of opening.

If there is no change in any client's data, staff must confirm by clicking "submit" so that the data can be included in the report to the state.

Appendix MH21 - Consent for Community Behavioral Health Services Mental Health/Drug and Alcohol Treatment Programs

Purpose:

To document the consent to participate in mental health (MH) and substance abuse (SA) treatment by the client or the client's legal representative.

The signed consent form is a legal document that establishes the proof of consent in writing.

Who:

Clinician, Counselor, and other Program Staff shall inform the client about the "Consent for Behavioral Health Services" and obtain signature from the client/legal representative/minor seen under minor consent, parent, and/or legal guardian.

All licensed, unlicensed, and administrative staff with Avatar PM Access can print this Form in Avatar.

When: The consent form is to be completed at intake.

- CYF requires the provider to update the consent form annually.
- AOA requires the consent form for each episode of care.

Procedure:

Avatar "Consent for Community Behavioral Health Services" Form for MH and SA services Menu Path>PM>Client Management>Client Information>Forms>CBHS Consent for Treatment

Click "CBHS Consent for Treatment" box.
Print the Form.

- Paper form is available in threshold languages.
- CYF requires the provider to update the consent form annually.
- AOA requires the provider to complete the consent form for each episode of care.
- The provider is responsible for ensuring the consent form is completed.
- The provider is responsible for making sure the consent form is signed by the client or the client's legal representative.
- When a minor is being treated under minor consent, the minor signs this form.
- If the client is able to sign but refuses, a note should be made on the signature line of the consent form. The provider should also document it in the progress note.
- If the client is not able to give consent for treatment, the legal representative who gives consent for the client must sign and indicate the relationship with the client on the form.
- If the client does not have a legal representative and is unable to provide his or her full signature, his or her mark must be witnessed by two people. Each witness must sign and print his or her name and title. It is recommended that the witness should be a professional employee of the

provider who understands the role of a witness in the event that there is a dispute over whether consent was obtained. If the witness is someone other than staff, he or she needs to indicate the relationship with the client.

- A copy should be given to the client or the client's legal representative.
- File the completed signature form in the paper record.

Appendix MH22 - Acknowledgement of Receipt of Materials

Purpose:

This Form is used to track the required documents:
a. The client has been informed and given the DPH Notice of HIPAA Privacy Practices.
b. The client has been informed about and offered the Grievance Process & Appeal Process handout.
c. Mental Health Services
    - The client has been informed about and offered materials about an Advance Health Care Directive (if applicable).
    - The client has received a copy of the Guide to Medi-Cal Mental Health Services and the CBHS Providers List.
    - The client does not want a copy of the Guide to Medi-Cal Mental Health Services and the CBHS Providers List.
d. Substance Abuse Services
   The client has received materials:
    - Client Rights
    - Sliding Fee Scale
    - Building Rules (if applicable)
    - Inventory of Personal Belongings (if applicable)

Who:

Clinician, Counselor, and other Program Staff shall inform the client about the "Acknowledgement of Receipt of Materials." The client/legal representative/parent/legal guardian initials and signs the form. All licensed, unlicensed, and administrative staff with Avatar PM Access can print this form.

When: This Form is completed at intake.

Procedure:

Avatar "Acknowledgement of Receipt of Materials" Form
Menu Path>PM>Client Management>Client Information>Forms>CBHS Receipt of Materials

Click "CBHS Receipt of Materials" box.
Print the Form.

- Paper Form is available in threshold languages.
- Client/legal representative/parent/legal guardian initials and signs the appropriate item.
- If signed by someone other than the client, state the legal relationship to the client.
- File the completed signature form in the paper record.

Appendix MH23 – Authorization for Use or Disclosure of Protected Health Information

Purpose: To request or disclose the client's Protected Health Information (PHI).

Who: Clinician, Counselor, Other Program Staff

When: To be completed only:

- When a provider needs to request or disclose the client's health information.
- When the client wants access to his/her medical record.

Note: DO NOT ask the client to sign a blank form for later use.

Procedure:

Avatar "Authorization for Use or Disclosure of Protected Health Information" Form
Menu Path>PM>Client Management>Client Information>Forms>CBHS Disclosure of PHI

Click "CBHS Disclosure of PHI" box.
Print the form.

- Paper form is available in threshold languages (MRD 04).
- Client/legal representative/parent/legal guardian completes all items with asterisk (*) on the form in order to be considered as a valid authorization.
- Client must be able to understand what they are consenting to.
- The client/legal representative/parent/legal guardian must sign the form. If signed by someone other than the client, state the legal relationship to the client.
- File the completed signature form in the paper record.
- A copy is given to the client/legal representative.

Note: DPH Privacy Policy Matrix – Sharing Protected Health Information for Treatment Purposes provides guidelines as to whether an authorization **is or is not** necessary before client's health information may be shared.

Appendix MH24 - Episode Guarantor Information (EGI)

Purpose:

The EGI is used to gather benefit coverage information from clients who receive mental health and substance abuse services in order to get reimbursement from the respective payer sources. The EGI form is part of the Outpatient Admission Bundle process which is used to register a client into the Avatar system.

The EGI paper form is also used for gathering a client's financial and eligibility coverage information prior to entering data into Avatar at a later time. The form corresponds to the fields of the EGI form in Avatar.

Menu Path>Avatar PM>Client Management>Account Management>Episode Guarantor Information

Who: Authorized Avatar users.

When: At intake.

Procedure:

The CBHS Billing Unit generates a "Benefit Coverage Report" daily based on the data entered by all clinics or programs. Billing staff verifies the coverage information before entering the data into Financial Eligibility records.

The form is available at Forms Control Unit, 1380 Howard Street, 2nd Floor – Mail Room, San Francisco, CA 94103. Telephone: 415-255-9313.

Appendix MH25 - UMDAP Sliding Fee Determination

Purpose:

Only mental health programs enter UMDAP (Uniform Method for Determining Ability to Pay) financial information in Avatar Family Registration form. For these reasons, a separate **UMDAP Sliding Fee Determination** paper form was developed to facilitate gathering client information for the purposes of determining a client's UMDAP liability amount and to document the following: reasons(s) for changing the patient fee amount payable; the Program Director's agreement with the adjustment made; and the client or their responsible party's agreement to pay their UMDAP.

Who: Authorized Avatar users.

When: At intake.

Procedure:

Avatar "UMDAP Sliding Fee Determination" Form
Menu Path >Avatar PM> Client Management>Family and UMDAP Management / Family Registration

The responsibility of obtaining a client's financial information and signature from the client or the responsible party lies with the clinic coordinators or clinicians on the initial visit and must be updated annually. That same data will be entered into the Family Registration Form in Avatar at the same time or later. The signed copy must be filed in the client's chart.

The form is available at Forms Control Unit, 1380 Howard Street, 2nd Floor – Mail Room, San Francisco, CA 94103. Telephone: 415-255-9313.

Appendix MH26 - Consent for Billing

Purpose:

The "Client Consent for Billing" Form is signed by the client or the responsible party, to document the consent and authorization for the release of protected health information (PHI) for billing purposes, agreement for coordination of healthcare benefits, and assignment of benefits (i.e., health coverage payments) to the SF Department of Public Health.

Who: Authorized Avatar users.

When: At intake.

Procedure:

Two types of the "Consent for Billing" Forms:

1. The "Consent for Billing" Form is used for clients who do not have an UMDAP liability which includes Full-scope Medi-Cal with no monthly Share-of-Cost (SOC), and no Other Health Coverage (OHC), Medicare and Medi-Cal (Medi-Medi) with no SOC, SF Health Plan enrollees with co-pays, etc.

2. The "UMDAP Sliding Fee Determination" Form has the "Consent for Billing" at the bottom of the form. This Form is used by clients who have an annual UMDAP liability.

Note: Clients need to sign only one "Consent for Billing" Form.

The Form is available at Forms Control Unit, 1380 Howard Street, 2nd Floor – Mail Room, San Francisco, CA 94103. Telephone: 415-255-9313.

Appendix MH 27: Avatar workflow for co-signature of Progress Note, Assessment, Reassessment, Treatment Plan of Care, and Closing Summary

The following is the recommended workflow for supervisors in reviewing and co-signing the work of a supervisee (including non-waivered/non-registered trainees and unlicensed staff).

I. Progress Notes:

1) Step 1: The supervisee submits the note as "Final" to the supervisor.
2) Step 2: The supervisor sees supervisee's note
    a. Note will appear on the supervisor's "To-Do" list;
    b. Click the item to open review window;
    c. Review the note, if needed, write appropriate comments in the "Comment" section, which could be as simple as "I concur with the note";
    NOTE1: Writing a comment is not required; however, if a comment is present, it becomes a viewable part of the medical record.
    NOTE 2: Because the supervisor will not be able to see the Procedure Code, Location, and FTF/DOC time within the "To-Do" Information box, these items should be reviewed within the Progress Note Widget.
    d. When the supervisor clicks the word "Yes" and presses "Submit", this is equivalent to co-signing the note. If the supervisor does not agree with the note, click "No" and press "Submit." This note will be returned to the supervisee as a "Draft Note" on the supervisee's "To-Do" list.
    e. Once the note has been returned to draft, the supervisee can make necessary corrections and resubmit (see Step 1 above).
    NOTE: The supervisor's comments can only be seen in the "Progress Note Viewer", and not in the Progress Note Widget of "Chart View."

II. Assessment, Treatment Plan (TPOC), and Closing Summary:

1) Step 1: supervisee submits Assessment/TPOC/Closing Summary as "Pending Approval"; this item will then appear on supervisor's "To-Do" list.
2) Step 2: supervisor clicks open the "Pending" Assessment/TPOC/Closing Summary; click "View Detail" to review the full document; "Comment" is required, with limited word count, and this comment will appear on supervisee's "To-Do", although it does not stay as part of the medical record.
3) Step 3: at Step 2, when supervisor chooses "Yes" to approve, this document will reappear on supervisee's "To-Do" as "Final"; if supervisor chooses "No", the document will appear as "Draft" on supervisee's "To-Do" list.
4) Step 4: for the approved Assessment/TPOC/Closing Summary on the "To-Do", supervisee still needs to click open, check "Reviewed", and submit to let it be filed out of the "To-Do" list; for the unapproved ones, trainee will continue to improve the draft document, and repeat Step 1.

Contact Person: Manager, Health Information Management, 415-255-3488

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