County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**SUPT**
	Policy Number	**SUPT-11-02**
	Effective Date	**08/10/21**
	Revision Date	**N/A**
Title: **AVATAR Electronic Health Record**	Functional Area: **Information Systems Management**	
Approved By: **Signed version available upon request** **Lori Miller, LCSW** Division Manager, Substance Use Prevention and Treatment Services		

BACKGROUND/CONTEXT:

An Electronic Health Record (EHR) is an electronic, real-time version of a client's treatment history that is available instantly and securely to authorized users. EHRs improve client care, care coordination, diagnostics and outcomes as well as increase practice efficiencies and cost savings. Substance Use Prevention and Treatment (SUPT) utilizes Avatar by Netsmart Software. Avatar is a cloud-based, web-accessible EHR system used for Sacramento County beneficiaries who receive substance use disorder treatment services. Avatar EHR includes Practice Management and Clinical Workstation modules.

All SUPT treatment providers are required to utilize an EHR system. SUPT highly recommends that treatment providers utilize the full Avatar EHR. In some situations, providers may be approved to use of an alternate EHR system. However, at a minimum, all SUPT treatment providers must utilize Avatar Practice Management and Service Requests and Assessments in the Avatar Clinical Workstation.

DEFINITIONS:

- **Avatar Clinical Workstation:** A module of the Avatar EHR, which includes the following electronic clinical documents, Service Requests, Substance Use Disorder (SUD) Assessments, Health Questionnaires, Treatment Plans, Progress Notes, and Order Connect.
- **Avatar Practice Management:** A module of the Avatar EHR, which includes claiming information, data reporting, and Perception Document Management.
- **Avatar Steering Committee:** Serves as the governing body of the Avatar system, which provides leadership, oversight, and strategic direction.
- **Avatar Team:** Comprised of County staff who provide project management, trainings, and technical assistance for the Avatar EHR system as well as preparing and submitting monthly claims to the California Department of Health Care Services.
- **Custodian of Record:** The individual or organization responsible for monitoring and maintaining both the integrity and confidentiality of health records, as well as the retention and destruction guidelines for a provider or program.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Requires all covered entities to prevent unauthorized access to protected health information.
- **Protected Health Information:** This term refers to a subset of confidential health information, including demographic information, collected from an individual.

PURPOSE:
The purpose of this policy and procedure is to outline SUPT guidelines, requirements, and timelines for Avatar Practice Management, Clinical Workstation, and hard copy and electronic document management.

DETAILS:
The Avatar Team provides project management, trainings, and technical assistance for the Avatar EHR system as well as preparing and submitting monthly claims to the State of California, Department of Health Care Services.

Avatar Email: Avatar@saccounty.net
Avatar webpage: https://dhs.saccounty.net/BHS/Avatar/Pages/Avatar.aspx

Avatar User Accounts
New Avatar users must submit a request to have an Avatar account created by the Avatar Team, which is unique to the user and shall not be shared with others. New Avatar users are required to complete Practice Management and Clinical Workstation trainings as applicable to the service provider/practitioner. To request a new user account, an *Avatar Account/User Training Form* should be completed and submitted to the Avatar Team. This form can be found on the Avatar training webpage:

Avatar Training/Registration Email: AvatarTrainingRegistration@saccounty.net
Avatar Training Webpage:
https://dhs.saccounty.net/BHS/Avatar/Pages/GI_Avatar_Training.aspx

The Avatar *Account/User Training Form* should also be completed and submitted to modify user accounts and to deactivate or reactivate an Avatar user account.

Please note: All Avatar users must comply with requirements as outlined in *P&P #QM-00-03* Avatar *Account Management and Password Protection.*

https://dhs.saccounty.net/BHS/Documents/BHS-Policies-and-Procedures/PP-BHS-QM-00-03-AVATAR-Account-Management-and-Password-Protection.pdf

AVATAR PRACTICE MANAGEMENT

Practice Management (PM) was the first module of Avatar to be implemented by SUPT. PM contains client record management information including claiming information, data reporting, and Perception Document Management (to scan non-Avatar generated documents into the EHR).

Claiming: Billable and Non-Billable Service Codes
All SUPT county-operated and contracted providers are required to accurately enter billable and non-billable service codes into Avatar for all service activities provided to clients. Accurate entry of service codes based on type of service provided is the basis for tracking, claiming, and paying for reimbursable service provisions.

The "*SUPT Service Code Definitions and Training Guide"* includes all SUPT billable and non-billable service codes, which can be accessed at:

https://dhs.saccounty.net/BHS/Documents/SUPT/GD-BHS-SUPT-Service-Codes-Definitions-and-Training-Guide.pdf

The tables below include codes to be used for non-billable service activities:

When a client	**Then use**
Fails to show for appointment and has not called	No Show Non-Billable Code: 90500
Calls to cancel an appointment prior to the appointment time	Cancellation Non-Billable Code: 90501

When staff	**Then use**
Fails to show for appointment and has not called	No Show Non-Billable Code: 90600
Calls to cancel an appointment prior to the appointment time	Cancellation Non-Billable Code: 90601
Attempts to engage client prior to provider start date (before first face-to-face)	Engagement Non-Billable Code: 22222
Performs administrative activities that cannot be reimbursed by Medi-Cal or other funding sources	Administrative Non-Billable Code: 11111

Data Reporting

Service providers should ensure accurate and timely entering of client information (e.g. CalOMS) into Avatar. Client data entered into Avatar is extracted and used for local, state, and federal data reporting requirements. Additionally, data entered into Avatar is used for monitoring and audit purposes.

Perception Document Management

To ensure a comprehensive electronic client chart, all paper clinical documents, non-Avatar generated paper records, and other key historical records (e.g. letters, hospital information, etc.) collected as part of ongoing care should be scanned into the client's Avatar EHR.

Service providers should designate a Custodian of Records who is responsible for monitoring and maintaining quality assurance standards, integrity of records, and confidentiality of Protected Health Information (PHI), including scanning records, verifying scanned records, and ensuring local, State, and Federal retention and destruction of records requirements.

Scanning of Records: The scanning of records must follow the designated, standard categories, and conventions established in Avatar. Documents should be scanned into the designated categories so that scanned records have a common convention and method to ensure that record retention and retrieval are not compromised. Examples of categories include, but are not limited to: System of Care Forms; Assessments; Client Correspondence; Court/Legal; Labs; Medication Consents; Labs; Hospital Discharge.

A comprehensive list of categories that are to be used when scanning, is available: https://dhs.saccounty.net/BHS/Documents/Utilization-Review/FM-BHS-QM-Sacramento_County_Scanned_Document_Management.pdf

Any new categories must be approved by the Avatar Steering Committee. New categories will be incorporated and ready for use only during established planned release cycles.

The staff member(s) performing the actual scan will:

- Ensure that all pages (front and back) successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.
- Affix a sticker at the top right corner of the page marked, "Scanned" and write the date the page was scanned on the sticker or initial and notate the date the document was scanned on the top right corner of the page.

The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 90 days to use and review the images. If any problem is detected, the paper record should be retrieved and rescanned.

Upon scan completion, the Custodian of Records should:

- Verify that scanned documents are scanned into the correct episode.
- Verify that the scanned document is an exact replica of the original document in its entirety.

Once paper documents are scanned into the EHR and verified by the Custodian of Records, such documents may be confidentially destroyed (California Civil Code 56.101). Client records are to be destroyed to preserve and assure confidentiality of PHI in compliance with Health Information and Portability and Accountability Act (HIPAA) regulations.

Retention and Destruction of Records: Every agency/provider will have a written policy and procedure that addresses the retention and disposal of all PHI, including hard copy PHI, electronic PHI and/or the hardware or electronic media on which it is stored. The policy and procedure must also include procedures for removal of electronic PHI from electronic media before the media are made available for re-use. See Title 45 Code of Federal Regulations 164.310(d)(2)(i) and (ii).

Retention of EHRs will meet State and Federal requirements for client record retention. All adult EHRs will be maintained for 20 years after the date of discharge. EHRs of minors will be maintained at least one year after the minor has reached the age of eighteen. For psychologists, client records are to be maintained for 20 (twenty) years from the patient's discharge date, or in the case of a minor, 20 (twenty) years after the minor reaches 18 years of age. Sacramento County will retain records for a period of 20 (twenty) years from date of discharge.

Agencies/providers must determine the appropriate method for their agency to dispose of PHI while ensuring confidentiality of the PHI. Some possible options to dispose of PHI include:

- For PHI in paper records, shredding, burning, pulping, or pulverizing the records so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed.
- For PHI on electronic media, clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding).

Agencies/providers must ensure that all staff involved in the retention and disposal of PHI has been trained on the agency/provider policy and procedures. This includes staff that are responsible for the disposal of PHI as well as staff that supervise those responsible for the disposal of PHI as well as volunteers. Agency/provider retention and disposal of PHI policy and procedures will be reviewed and monitored during site monitoring visits and is subject to review during audits.

AVATAR CLINICAL WORKSTATION

The AVATAR Clinical Workstation (CWS) module was implemented ("Go-Live") for SUPT service providers on March 1, 2021. The CWS contains electronic Avatar-generated clinical documents, which includes Service Requests, SUD Assessments, Health Questionnaires, Treatment Plans/Client Plans, Progress Notes, and Order Connect.

Please note: Providers risk fiscal disallowance if the required electronic documents below are not completed and finalized within the defined timeframes and conditions as specified below. Data elements for each electronic document are included and described in the *SUPT CWS Required Data Elements*.

Service Request: All treatment providers (providers using Avatar as well as providers using other approved EHRs) are required to utilize the "Service Request Response 2.0" Form in Avatar when a client requests services. Completed Service Request Response 2.0 Forms are used to track:

1. Time from service request to first assessment
2. Time from first assessment to a first treatment service (the SUD Assessment and Treatment Plan should be completed prior to first treatment).

Service Requests Completed by System of Care (SOC)

When a client walk-in or calls the SOC, staff is responsible for completing the following the day the client requests services:

- Query Avatar to see if the client is already in Avatar.
- If the client is already in Avatar, SOC staff should complete the "Service Request Response 2.0" Form in Avatar to open an episode.
- If the client is not in Avatar, SOC staff should complete a Pre-Admit Form to add the new client and create an Avatar client ID.

- Once the client has an Avatar client ID, SOC staff should complete the "Service Request Response 2.0" Form in Avatar to open an episode and assign the service request to a SOC clinician.

Service Requests Completed by Providers

When a client requests services from a contracted provider (walk-in or calls the provider directly), the provider is responsible for completing the following the day the client requests services:

- Query Avatar to see if the client is already in Avatar. This is important to avoid duplicate EHRs the same client. Provider should confirm date of birth and the social security number of the client to avoid duplication.
- If the client is already in Avatar, the provider should complete the "Service Request Response 2.0" Form in Avatar to open an episode.
- If the client is not in Avatar, the provider should complete an Admit Form to add the new client and create an Avatar client ID. Once the client has an Avatar client ID, the provider should complete the "Service Request Response 2.0" Form in Avatar to open an episode and assign the service request to a clinician.
- Once the Service Request is completed, the provider can conduct the SUD Assessment.

SUD Assessments

The SUD Assessment is a tool used to determine medical necessity, diagnosis, and level of care for substance use disorders. SUD Assessments are to be conducted by a Licensed Practitioner of the Health Arts (LPHA) or ADS Counselor I/II. The SUD Assessment includes the six Dimensions of the American Society of Addiction Medicine (ASAM) Criteria, which includes:

Dimension 1: Acute Intoxication and Withdrawal Potential
Dimension 2: Biomedical Conditions and Complications
Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications
Dimension 4: Readiness to Change
Dimension 5: Relapse, Continued Use or Continued Problem Potential
Dimension 6: Recovery/Living Environment

For each of the six Dimensions, all of the questions should be answered, comments/descriptions should be included, and scored appropriately (0=None, 1=Mild, 2=Moderate, 3=Severe).

Resource: ASAM Criteria: https://www.asam.org/asam-criteria/about

SUD Assessments Completed by SOC Staff

- The SOC clinician accepts and reviews the Service Request and schedules and completes the SUD Assessment.
- Upon completion of the SUD Assessment, SOC staff copies and pastes the SUD Assessment into the "SOC Response Comment" area of the Service Request.

- The Service Request is submitted to a contracted provider based on level of care.
- SOC staff completes the "SOC Pre-Admit Discharge."

Note: The service provider can contact SOC staff to have the SUD Assessment completed by SOC staff be scanned and loaded into the service provider's episode in Avatar.

SUD Assessments Completed by Service Providers
SUD Assessments are reported to the Department of Health Care Services; therefore, **all treatment providers** must enter SUD Assessments into Avatar, including providers who are utilizing another EHR.

Initial SUD Assessment
It is the expectation of Sacramento County that the SUD Assessment is completed immediately. However, SUD Assessments must be completed within the following timelines:

- Outpatient/Intensive Outpatient: within 30 days of admission intake
- Residential Treatment: within 10 days of admission intake
- Detox/Withdrawal Management: within 1 day of admission intake
- Opioid/Narcotic Treatment: within 1 day of admission intake

SUD Re-Assessments
To be completed within the following timelines or when a change in problem identification or focus of treatment occurs, whichever comes first.

- Outpatient/Intensive Outpatient: between the 5th and 6th month and every 12 months thereafter
- Residential Treatment: every 30 days
- Detox/Withdrawal Management: non-applicable
- Opioid/Narcotic Treatment: annually

Transferring/Discharge Clients to Different Level of Care: A new Service Request and SUD Assessment is required for clients who are transferred to a new service provider within the Sacramento County SUPT provider network. The new service provider should conduct the Service Request and SUD Assessment according to modality of service timelines (listed above) from the date of transfer. Transferring provider should coordinate with the new provider to ensure a "warm hand-off" and successful linkage and transfer.

Returning Clients: All clients discharged from Avatar and then re-opened, regardless of the time lapse, will be considered "new" and a new SUD Assessment must be completed according to modality of service timelines (listed above) from the new start date.

Health Questionnaire

A Health Questionnaire must be completed for all clients seeking treatment services and entered into the EHR; otherwise, the provider risks fiscal disallowance. The Health Questionnaire must be completed at the start of services. For youth, parents/caregivers/conservators/identified significant support person may provide the clinician/personal service coordinator with information to complete the EHR.

Health Questionnaires are to be completed within the following timelines:

- Outpatient/Intensive Outpatient: within 30 days of admission intake
- Residential Treatment: within 10 days of admission intake
- Detox/Withdrawal Management: within 48 hours of admission intake
- Opioid/Narcotic Treatment: upon first day of dosing

Relevant physical health conditions must be identified and updated as appropriate with referral to a primary care physician as needed or appropriate. If the client and/or caregiver indicates that they currently do not have a primary care physician, the provider must make efforts to provide information and support to ensure a linkage/referral is made. Health conditions, referrals, and linkage should be documented in the client's EHR. Allergies or lack of known allergies and adverse reaction(s) to medications should be documented in Avatar Order Connect.

The provider shall review the Health Questionnaire with the client to ensure that all areas are completed and accurate.

Health Questionnaire Components

Date: The date the form is completed. If it takes more than one day to complete the form, this date should reflect the date the form was started.

Gender: This is pre-populated based on the client's identified gender assigned at birth in the, "Update Client Data" section of the chart. Based on this selection, applicable information will be pre-populated by Avatar.

Currently Seeing a Primary Care Physician: Identify with a "yes' or "no" if the client is currently seeing by a primary physician.

Last Doctor Visit: Indicate the timeframe from the last doctor's visit as reported by the client. In addition, specify the reason for the last doctor visit.

Emergency Room (ER) Visits: Mark either "yes", "no" or "unknown" to identify any ER visits conveyed by the client in the preceding 12 months. Provide details for the ER visits.

Last Colon Screening: Indicate the timeframe from the client's last colon screening or if they have never had a colon screening.

Conditions: Identify any known medical conditions that the client has ever experienced. Indicate the onset and details and describe the medical conditions and current treatment the client is receiving.

Gender Specific Questions: Choose the client's gender specific questions. Provide information describing any existing health conditions, dates (to the best knowledge of the client/caregiver) and current treatments. The gender specific questions are generated based on the client's identified gender assigned at

birth in the, "Update Client Data" section of the chart.

Dental: Indicate the timeframe from the last visit to the dentist and whether "yes", "no" or "unknown" if the client has any dental problems, ever had oral surgery or has any dental problems.

Hearing: Indicate "yes", "no" or "unknown" if the client has any hearing problems. Provide details on the hearing problems. Indicate the timeframe from the last hearing test and provide details on the hearing test and hearing issues.

Vision: Indicate "yes", "no" or "unknown" if the client has any visual problems, timeframe from the last exam and whether "yes", "no" or "unknown" if the client wears any type of corrective lenses/ contacts, and provide any details on vision problems.

Caffeine and Tobacco: Indicate the client's caffeine intake and/or tobacco intake, select the client's smoking habits and identified tobacco products that the client uses. Solicit from client if is interested in a smoking cessation program. Provide detail on tobacco use.

Treatment Plans ("Client Plan" in Avatar)

The Treatment Plan is developed utilizing the completed SUD Assessment, the SUD diagnosis/es, and level of care in collaboration with the clinician, client, and parent/caregiver/or identified significant support person. Seeking and obtaining client input is crucial to successful treatment outcomes and the "in their own words" section of the Treatment Plan should be used for the client to provide input.

The Treatment Plan should be individualized, culturally competent and holistic to address time-defined treatment goals. The client's and parent/caregiver/or significant support person's strengths and challenges should be documented and the service provider should make every effort to follow strength-based, recovery-oriented treatment planning.

The Treatment Plan must include evidence of the client's and significant support person's willingness and agreement to participate in the plan for treatment by obtaining electronic signatures. The client's signature is required if in the opinion of the staff the client is mature enough to participate intelligently in the treatment. Signatures serve to confirm agreement and participation.

The Treatment Plan must be completed, electronically signed, and finalized by staff identified in the Avatar CWS Documentation Requirements Matrix (Licensed Practitioner of the Health Arts (LPHA) or ADS Counselor I/II.) Staff who are not licensed or licensed waived/registered require approval (signature) by an LPHA before submitting as final.

Treatment Plans are to be developed and signed within the following timelines:

Service Modality	Primary Counselor Signature	LPHA Signature	Client Signature
Outpatient/Intensive Outpatient	30 days of admission intake	15 days from Counselor signature	30 days from Counselor signature
Residential Treatment	10 days of admission intake	10 days of admission intake	10 days of admission intake
Detox/Withdrawal Management	48 hours of admission intake	48 hours of admission intake	48 hours of admission intake
Opioid/Narcotic Treatment	28 days of admission intake	14 days of admission intake	28 days of admission intake

A Treatment Plan is not required if the client leaves treatment and the case is closed prior to the due date according to service modality timelines above. For example, if a client is admitted to Residential Treatment and leaves on day five, a Treatment Plan would not be required since the due date would be day 10.

Updated Treatment Plans

- Residential Treatment: As needed. Subsequent Treatment Plans are completed when a change in problem identification or focus of treatment occurs (additional SUPT services/lower levels, mental health services, housing, legal services/CPS).
- All Other Modalities: No later than 90 days after signing the Initial Treatment Plan, and no later than every 90 days thereafter, or when a change in problem identification or focus of treatment occurs, whichever comes first.

If, for some reason, the signature cannot be obtained electronically, the hard copy of the Treatment Plan/Updated Treatment Plan may be signed and scanned into the EHR. The reason that signature(s) were unable not obtained electronically should be documented in the Treatment Plan and Progress Notes.

Once signatures have been obtained by these parties, the Treatment Plan is considered complete and cannot be altered in any way.

A copy of the Treatment Plan Report must be provided or offered to the client and parent/caregiver/or identified significant support person upon completion. The Treatment Plan Report must be offered in the client's preferred language and in English. It must be documented that the Treatment Plan Report was offered and whether the client received a copy of that document. Subsequent copies upon request must be made available to the client or parent/caregiver/identified significant person.

Please note: All non-emergency services provided after the provider start date for clients without a Treatment Plan will be disallowed. All services claimed in which the Treatment Plan did not meet requirement criteria will be disallowed if not corrected in the Avatar EHR billing and claiming system.

Treatment Plan Components

Diagnosis: A diagnosis from the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a corresponding California Department of Health Care Services approved International Classification of Disease (ICD) Code must be documented in the diagnosis section. This diagnosis must be consistent with the SUD Assessment and presenting substance use issue. The DSM and ICD Code must be updated annually at minimum, whenever changes arise, and at discharge.

Problem Statements: The Problem Statement identifies the client's specific impairment or distress in life functioning that is related to the substance use diagnosis. The Problem Statement should be correctly matched with the appropriate Dimension. The client's Stage of Readiness to Change from the SUD Assessment should be noted next to, and match, each Problem Statement in the Treatment Plan.

Goals: Must be achievable, address the Problem Statements, and match the Stage of Readiness for Change for each problem.

Objectives: Includes the outcomes that will bring about change and meet the treatment goals. Developed collaboratively between the counselor and client. Objectives must be SMART: **S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-bound and must address the client's substance use condition (symptoms, behaviors, and functional impairment)

Interventions Action Steps: Action Steps are strategies and actions that will be taken by the client, significant others, and the provider. Developed collaboratively between the counselor and client. Action steps include counselor interventions and tasks the client has agreed to carry out, including frequency and duration. Action Steps help achieve the goal and are built upon the client's strengths. Action Steps must be SMART: **S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-bound.

Target Dates: Are agreed upon by the counselor and client for accomplishment of Action Steps and Goals.

The Treatment Plan and/or Updated Treatment Plan starts when both the client and counselor have signed it. There must also be documentation in a Progress Note of the EHR describing the client's participation and agreement with the Treatment Plan.

Progress Notes

Progress Notes are a description of direct and indirect service activities including billable and non-billable contacts. Progress Notes also convey information from collateral resources, consultation contacts, and coordination with other system providers and agencies. Progress Notes must support the applicable service but should be brief and succinct. Long narratives and lengthy descriptors should be avoided. County approved abbreviations may be used in Progress Notes (see BHS Abbreviations and Acronyms).

Timeline for Progress Notes

Progress Notes must be completed within **7 calendar days** of the service session. Progress Notes are considered final once submitted into Avatar CWS or electronic

health record systems. In the Avatar CWS and other electronic health record systems, the submission of a Progress Note is also the mechanism for service billing. A progress note later than 2 weeks from the date of service may be subject to non-reimbursement for the service provided.

Progress Note Components

Date of Service: Enter the date the service occurred. Note that "entry date" is recorded in Avatar and electronic health record systems. Entry date is used to confirm timely submission of progress notes.

Service Charge Code: Enter or select the applicable Service Charge Code. See Sacramento County Service Code Definitions/Training Guide for updated list of Service codes, code definitions, and training information. A separate progress note must be written for each service billing (i.e. multiple notes may be needed for different service activities occurring during one client contact or session).

Service Location: Enter or select the applicable Service Location. Location options are predefined through Department of Health Care Services Client Services Information (CSI) data requirements.

Practitioner Name and Signature: Practitioner name and professional classification are automatically entered in Avatar CWS and electronic health record systems. The practitioner's signature or electronic signature is required on all notes and are automatically entered upon finalizing the progress note

Duration: Enter total duration of service time in minutes. Direct service time, Documentation time, and Travel time must be entered separately, if applicable. Documentation time includes the time it took to complete the progress note for the service. Travel time is the round-trip travel time from agency office to service location. Travel time can only be counted for services where a billable activity occurs.

Face-to-Face Service: Select "yes" or "no" as appropriate. Select "yes" if a service was provided to the client face to face.

Evidence-Based Practices (EBPs): At least two of the following EBPs must be used and pre-approved by Sacramento County SUPT: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Therapy, and Psycho-Education.

Service Strategies:
Service strategies used by SUPT include the following five evidence-based practices: Cognitive Behavioral Therapy, Relapse Prevention, Psycho-Education, Motivational Interviewing, and Trauma Informed Treatment.

Progress Note Type: Select the applicable Note Type (i.e. Standard, Medication, Intake, Discharge, Group Note, and Clinician Treatment Summary). Note Type should be "Standard" unless a specialized service that fits another category is provided. Note Type is independent of Service Code claimed and does not affect billing.

Language in Which Service Was Provided: Select the language the service was provided in. If multiple languages are spoken during a service please clarify in the progress note narrative.

Use of Interpreter: Select "yes" or "no" as appropriate. If the staff providing the direct service is providing interpretation "yes" should be selected.

Group Services: Group services must indicate the number of clients

participating in the group. In Avatar CWS, "Number of Clients in Group" must be used to identify the number of participants so that duration can be accurately apportioned to each client. If a group is co-facilitated, the second facilitator can only bill and be identified as "Co-Practitioner" if his or her non-duplicative role is defined in the narrative of the note. **Note:** "Preparation time" is not accepted as billable time for group services.

Discharge Notes: The Discharge Note Type should be selected and the applicable Service Charge Code used for the service is selected. Discharge notes are billable only if a billable service is provided in that final contact (i.e. case closed with final Individual Therapy service). If no contact has been made with the client for an extended period then the Discharge note is considered "administrative" and the Non-billable Service code (11111) should be selected. See Policy and Procedure QM-10-28 Discharge Process for more information.

Clinical Introductory Progress Note: Written at the first face to face contact, or very soon thereafter, providing an overview of the client and his/her SUD condition. A complete note includes, but is not limited to: the identity of the client, including age, ethnicity, and other significant demographic information, the referral source, presenting condition, including symptoms, behaviors, and level of functioning, need for services/medical necessity and level of care justification, client strengths, supports, and a plan for subsequent services. If a client indicates a primary language other than English, or a physical disability, the provider will offer an accommodation to provide culturally and linguistically competent services and note this in the clinical introductory progress note. If a client refuses such accommodation, this refusal will be documented in the clinical introductory progress note.

Cultural and Linguistic Accommodations: Must be offered to the client and on behalf of the family/caregiver. This must be documented in every note when a language other than English is indicated. If the provider is trained and proficient in English and the target language then the progress note must specify the language spoken during the session. When an interpreter is necessary the progress note shall include the following: the language the session was conducted in, language services offered, the name of the interpreter, how interpretation was conducted. If a provider is using a client's family member for interpretation document the emergency situation and circumstances where no other means of interpretation or communication was available. Should the client elect a family member as the interpreter, there must be documentation of the clinical decision to make that decision and documentation demonstrating efforts to offer an independent interpreter. Sacramento County prohibits the use of children as interpreters under all circumstances. See Cultural Competence & Ethnic Services Policy and Procedure "Procedure for Access to Interpreter Services" for more information.

Interventions: A description of the interventions used, client's response to the interventions and progress made toward treatment goals/ objectives by the client and family (when applicable) must be reflected in the notes. Progress notes should document relevant clinical decisions, when decisions are made, and alternative

approaches for future interventions. Each progress note claimed must demonstrate how services provided reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning, allowed a child to progress developmentally as individually appropriate or for clients under the age of 21, corrected or ameliorated the condition. Each progress note claim must relate to the qualifying diagnosis and identified functional impairments as well as should be medically necessary.

Discharge Summary: Should include a written summary of the treatment episode including duration of treatment, reason for discharge and discharge prognosis, and recommendations for follow-up care and referral.

There are two types of Residential Progress Notes:

1. **Clinical Services:** Individual narrative summaries that describe the beneficiary's progress as identified in the treatment plan, including challenges, goals, action steps, objectives, and/or referrals. Clinical services include intake, individual counseling, group counseling, family therapy, collateral services, crisis intervention services, treatment planning, and discharge services.

2. **Non-Clinical Services:** A daily summary of non-clinical educational activities or services. Non-clinical services include:
    - Patient Education: Meditation, life skills, social skills, community enrichment, exercise, etc.
    - Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment (transportation service alone does not justify billing for a daily rate).

Residential providers must document all clinical and non-clinical services. There are two options recommended and residential providers should select one option into the agency practices.

Option One:

- Document each service with an individualized Progress Note. Services requiring a Progress Note include Intake, Individual Counseling, Group Counseling, Patient Education, Family Therapy, Collateral Services, Crisis Interventions, Treatment Planning, Discharge Services, Case Management, and Physician Consultation.
- Use a Transportation Log including; date of transportation, time out and in, purpose of trip and signature with printed name and date of person logging the transportation.

Option Two:

- Develop a Patient Education daily note template to include:
    - Type of each service, topic, time in and time out.
    - Daily summary progress note for listed services relating progress or lack of progress.
- If transportation services are included provide the following; date of transportation, time out and in, purpose of trip and signature with printed name and date of person logging the transportation (transportation service alone does not justify billing for a daily rate). The daily note must be completed by a treatment staff who provided one of the claimable services for the day claimed.

- Document all other services including Intake, Individual Counseling, Collateral Services, Crisis Interventions, Treatment Planning, Group Counseling, Discharge Services, Physician Consultation and Case Management with an individual progress note recorded by the LPHA or counselor who performed the service.

Reference: SUPT P&P #03-07 DMC-ODS Residential Treatment Services

Services Provided By Two or More Practitioners at One Point in Time
When services are being provided to a client by two or more persons at one point in time, each person should document his/her own individual progress note including service code, service time, documentation and travel time. There must be documentation of each persons' involvement in the context of the client's needs and describe how each role was separate, distinct, and medically necessary.

Appending/Correcting Progress Notes: If critical content or information is left out of a Progress Note, the note may be "appended" (Use Append Note function in Avatar CWS) in order to justify the service code or time claimed. Corrections for open or closed charge services that has not claimed must be submitted to Behavioral Health Quality Management on the Open Charge Deletion Request (OCDR) form. Corrections for services already claimed must be submitted to the Department of Health Services Fiscal Services on the Claims Correction Spreadsheet. Refer to the Instructions on How to Edit or Delete a Service Claim Document. In some cases services may need to be re- entered as a non-billable activity so that documentation exists for completed service activities.

REFERENCE(S)/ATTACHMENTS:
Avatar Email: Avatar@saccounty.net
Avatar webpage: https://dhs.saccounty.net/BHS/Avatar/Pages/Avatar.aspx

Avatar Training/Registration Email: AvatarTrainingRegistration@saccounty.net
Avatar Training Webpage:
https://dhs.saccounty.net/BHS/Avatar/Pages/GI_Avatar_Training.aspx

Scanned Documents Management
https://dhs.saccounty.net/BHS/Documents/Utilization-Review/FM-BHS-QM-Sacramento_County_Scanned_Document_Management.pdf

SUPT Service Code Definitions and Training Guide
https://dhs.saccounty.net/BHS/Documents/SUPT/GD-BHS-SUPT-Service-Codes-Definitions-and-Training-Guide.pdf

ASAM Criteria: https://www.asam.org/asam-criteria/about

SUPT CWS Required Data Elements

RELATED POLICIES:
P&P #QM-00-03 Avatar Account Management and Password Protection
SUPT P&P #03-07 DMC-ODS Residential Treatment Services

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	SUPT Administration		SUPT Prevention Providers
X	SUPT County Counselors	**X**	SUPT Adult Treatment Providers
	SUPT Collaborative Courts	**X**	SUPT Youth Treatment Providers
X	SUPT System of Care		Alcohol and Drug Advisory Board
X	SUPT Administrative Support Staff	**X**	BHS Avatar Team
	SUPT Options for Recovery	**X**	BHS Quality Management

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