



BHRS OUTPATIENT PROGRESS NOTES



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BHRS OUTPATIENT PROGRESS NOTES

IMPORTANCE of OUTPATIENT PROGRESS NOTES

Outpatient Progress Notes provide:

- **Evidence** that for each client encounter, there are **behavioral symptoms** or **functional impairments** that are **severe** enough to result in the **need for interventions** to be **provided** by a **clinician or team of clinicians**. Progress notes **describe** the **interventions** that help **reduce symptoms** or **improve functioning**; notes describe the **education** and/or **assistance with daily living skills** provided. Each note **needs to be able to “stand alone” (meet medical necessity)**.
- **Evidence** that there is a clear, ongoing record of the client’s condition. Notes describe the **interventions provided by staff**, and include the **client’s response to the interventions**, and the **progress that the client is making toward achieving his/her goals/objectives**.
- **Evidence** that for **each service** provided, there is a note to describe and document, the date **when** the service was provided, **what** type of service was provided, **where** the service was provided, **how** long the service lasted and **who** provided the service by a signature, credential and co-signature, if applicable.
- **Evidence** that there is **continuity** and **coordination** of care, **communication** among team members and **collaboration** with community resources, including primary care. Further, that all of this is reflected in a **comprehensive, client centered, recovery based and culturally competent electronic medical record**.
- **Evidence** that observations, client self report, and reports from others are documented in a manner that can be read and understood by another. Notes are written as if an attorney and/or the client/family will read the documentation. **Quotes** and **“stated/reported by”** are to be used when including information from others. Refrain from slang, subjective analysis, opinions or hearsay. And, in the electronic Avatar record, notes **must** be **legible** by using **mixed case letters**, **spell check**, **approved abbreviations**, and **minimal use of acronyms**. **You must be able to explain and/or defend any statement (s) made in a progress note**.
- **Evidence** that client confidentiality is being upheld by restricting access to specific types of progress note documentation, obtaining proper releases prior to disclosing information, by referring to relationships and **NOT** including the NAMES of family members/peers and/or classmates when documenting in progress notes.
- **Evidence** that the provider/clinician/practitioner of services is **practicing** and **documenting within his/her scope** and is eligible to claim the service.
- **Evidence** that **regulatory** and **compliance** standards for billing any service documented in the progress note are being **met**. This includes **completing all required fields**; notes that are **timely** and **finalized** and **include** the clinician’s **signature/co-signature**.
- **Evidence** that San Mateo BHRS has established professional and billing standards to protect and manage risk and demonstrate organizational and professional accountability when claiming reimbursement for services.

The following link can provide additional information about BHRS Outpatient Progress Notes:

<http://smchealth.org/avatarguides>



PURPOSE OF PROGRESS NOTES TRAINING

This training will introduce you to BHRS Outpatient Progress Notes and will help you:

- ◆ Understand how to complete the 2 Tab/BHRS Outpatient Progress Note. (Tab 1 has 2 pages.)
- ◆ Understand progress note terminology.
 - Different **types** of **service charge codes** and **location codes**
 - **LOCKOUT and NON-BILLABLE** locations and what is meant by “**Non-billable**”
 - Different **types** of **progress notes (all 3 with or without a required Co-signature)**:
 - **Standard**
 - **Disclosure** without Client Consent
 - **Restricted (No disclosure without consent)**
- ◆ Understand two types of Avatar Windows: Episode Selection Screen & Progress Note Pre-Display Screen.
- ◆ Understand that Progress Notes are **Episode** dependent. Understand how the “**rule of 3**” check will help you **select the correct episode** and document on the **correct** client.
- ◆ Learn the **importance** of, and **how to select, the correct service charge code and location code.**
- ◆ Understand that **some location codes do not describe a location at all.**
- ◆ Learn **how to record the service duration in minutes.**
- ◆ Learn **how to select the treatment plan and treatment plan barrier the progress note will address.**
- ◆ Learn **how to select a progress note template for use and modification.**
- ◆ Learn **how to compose** a note by **narrative, system template** or a **combination.**
- ◆ Learn **how to use** the **Text Editor** to **view, check spelling** or **edit** the note as you compose it.
- ◆ Learn **how to view previous progress notes (up to 1 year).**
- ◆ Learn **how to select the correct progress note type from the 6 different types of notes.**
- ◆ Learn **how to select the progress note status (DRAFT or FINAL) and learn to APPEND/EDIT the content of a note.**
- ◆ Learn **who can write and sign** a progress note and **when a co-signature is necessary.**
- ◆ Learn the **NEW** functions of “**MY TO DO LIST**” and **Co-Signatures.**
- ◆ Learn **how to document** that a service was provided in a **Language other than English on Tab 2.**
- ◆ Learn **how to rate the Severity of Client Symptoms** for each or **periodic** encounters on **Tab 2.**
- ◆ Learn **how to document services provided to a Group.** Understand the **rules** for **Group progress note** documentation when **entering the number of clients** and **participation of a co-practitioner.**
- ◆ **Learn how to EDIT a DRAFT progress note.**
- ◆ Learn the **Avatar Error Correction Request procedures** for when an **incorrect service charge code and/or incorrect location code** was used or when a **note was written on the wrong client.**
- ◆ Learn **how to run a Progress Note Report.**



OPENING AN AVATAR BHRS OUTPATIENT PROGRESS NOTE

PATH From the client's profile → Avatar CWS→ BHRS Progress Notes→ BHRS Outpatient Progress Note

⚠ Please NOTE: Even though you have selected the BHRS Outpatient Progress Note to begin a note, **if** the client has more than one open episode, an **Episode Selection Screen** will appear and you will be **required to select** the episode where you work so that your composed note will be saved/filed/submitted in this episode. Please take care when making the episode selection, selecting the wrong episode is an area of frequent error!

EPISODE SELECTION SCREEN

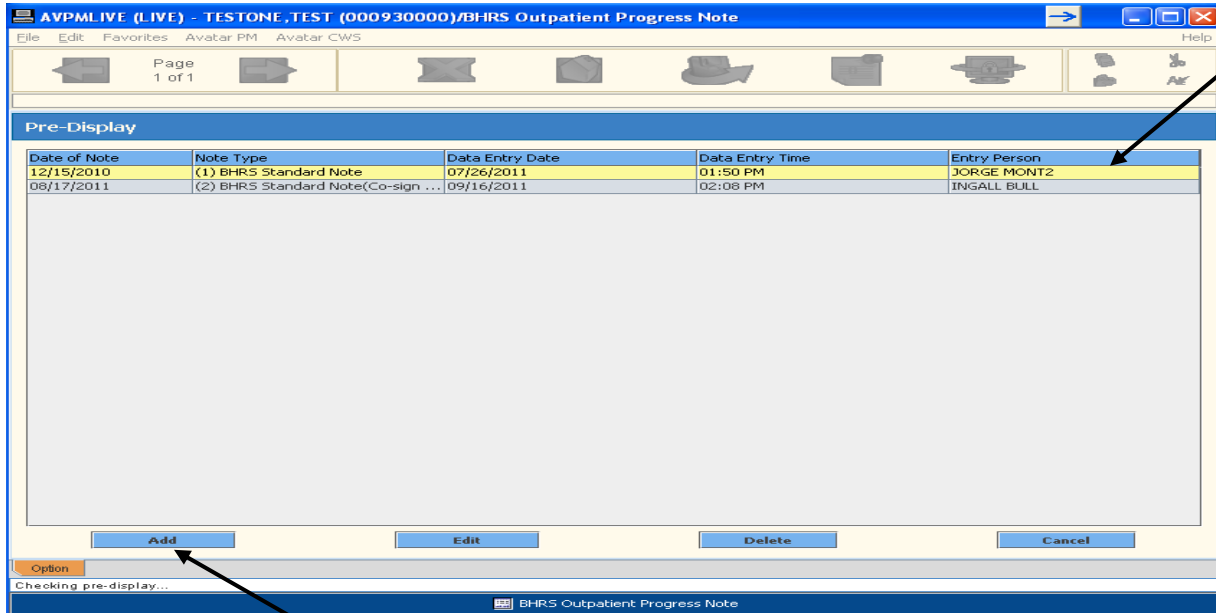
Click on the episode where you work and where the progress note will be saved, filed and/or submitted

Episode	Admit Date	Discharge Date	Program
3	07/15/2010		410401 SOUTH COUNTY ADULT
2	07/15/2010		410301 CENTRAL COUNTY ADULT
1	07/12/2010		410101 NORTH COUNTY ADULT

⚠ Please NOTE: Even though you have selected the BHRS Outpatient Progress Note to begin a new note, **if** there are previous Progress notes that have been saved as DRAFT, another screen will appear - the **Pre-Display Selection Screen**. This screen **displays DRAFT progress notes by date** and allows you to **ADD a new progress note** or EDIT or DELETE a progress note previously written.



PRE-DISPLAY SELECTION SCREEN



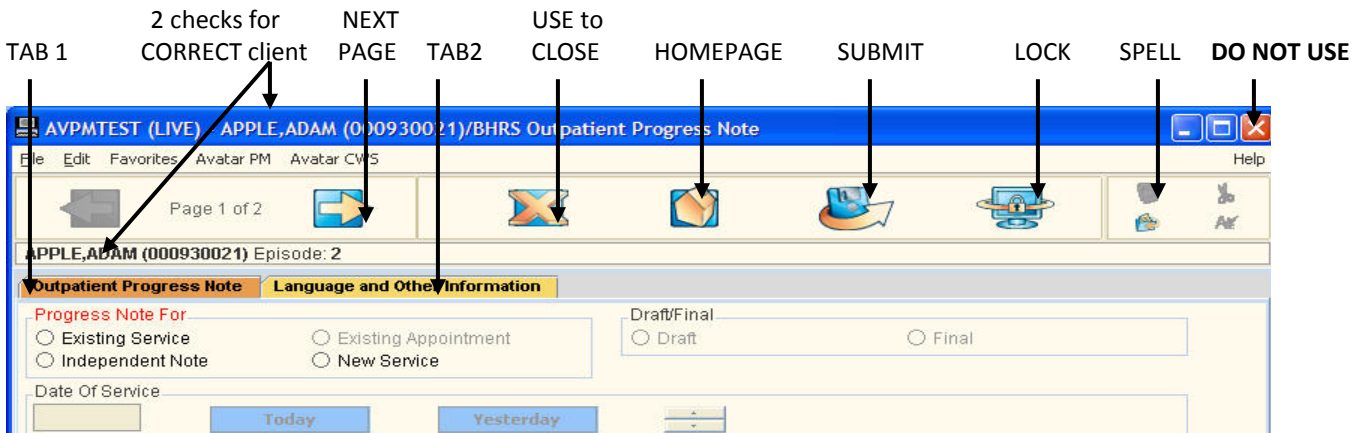
Select note to edit or delete

Click here to add a new note

The Pre-Display Screen will appear **ONLY** if there are previous DRAFT entries. When you select **ADD**, a new **BHRS Outpatient Progress Note will open**. If you select **EDIT**, the selected DRAFT progress note will open for editing. **DELETE** will delete that DRAFT note. **Cancel** will cancel the BHRS Outpatient Progress Note option and will bring you back to the Avatar Homepage.

In some cases, when you attempt to create a new progress note, both the **Episode Selection AND the Pre-Display Selection screens** will appear. Just make the appropriate selection for each screen and you will be able to add/open and compose your progress note.

Avatar Features of the BHRS Outpatient Progress Note form:





THE AVATAR BHRS OUTPATIENT PROGRESS NOTE - SCREEN SHOT OF TAB 1/PAGE 1

A Click on this arrow to go to Page 2 of Tab 1

B Progress Note For

C Date Of Service

D Service Charge Code

E LOCATION CODE: (if client is In Jail, Hospitalized, at REDWOOD HOUSE, or at PES use the LOCKOUT Location)

F SERVICE DURATION (in minutes)

G Note Addresses Which Treatment Plan Barrier

H SELECT T.P. Item Note Addresses

I

J REMOVE T.P. Item Note Addresses

SUBMIT button

* These fields refer to a GROUP Service which will be described on Page 15.



Description of the STANDARD BHRS Outpatient Progress Note:

Service/Clinical Information Tab: (A) This tab is orange when selected.

Progress Note for: Always click **New Service** (B)

Independent Note is only checked in rare instances when:

- 1) A client has been discharged from all open episodes.
- 2) A progress note must be written to document an event related to this client.
- 3) A supervisor directs a clinician to document an event using the independent note. (This is never billed.)

Date of Service: **Today's Date** (C)

Enter the Date of the Service. Choose one of the following:

- Enter manually in the format 00/00/0000.
- Click "T" for today or "Y" for Yesterday.
- Double-click inside the date box which will bring up a calendar where you can select the correct date.
- You will notice there is a ***tiny calendar icon*** outside of date entry box that brings up a calendar for selecting a date. Once a date is selected it will default into the field.

NEVER enter A FUTURE DATE

Service Charge Code/Type of Service: (D)

There are several ways to enter the **Service Charge Code/Type of Service:**

The Service Charge Code box is a **process search** entry. This requires an entry into the white field, a click on the process search box, then a selection of the correct service or code which will populate the blue Service Charge Code/Type of Service box. An entry can be a **number**, a **few letters**, or a **complete word** that represents the Service Type/Charge Code. A question box may appear for you to select the correct service code or to validate the selection that you've made. Your selection will populate the solid blue Service Charge Code/Type of Service box. **There must be a valid entry in the blue Service Charge Code/Type of Service box located under the light bulb to continue.**

- 💡 **The YELLOW light bulb is a HELP that has information to help you select the correct Service Charge Code.**

The light bulb is sensitive and if you hover the mouse near it, the service types and the service charge codes, as well as, descriptions and examples of the service charge codes appear in **yellow**. Clicking **on** the light bulb, opens a black/white screen shot for longer viewing.

⚠ Please NOTE:

Some services are important to document but CANNOT be claimed for reimbursement. Most of these non-billable services are administrative. The **service charge code for any service that is NON-BILLABLE is Code 55.**



- Your credentials and employment class determine the services you can provide.
- Service Charge Codes are specifically configured for each program. You will only be able to select a Service Charge Code if it is a service that your program is authorized to provide. For instance, a Day Treatment program may be set up/authorized to provide MH/CM services **in addition** to Day Treatment, but an outpatient program would not be set up to provide Day Treatment services. Day Treatment services would not appear as a selection in the outpatient program's drop down service charge code list.

Location Code (E)

- **Location** is a dropdown field to select **where the client was located when the service was provided**.
- The location field **defaults** to **OFFICE**. You can make your selection of **location** if you click on the black arrow in the drop down box.
- Some location codes are not actual locations. These are: Phone, Voicemail/Fax/Email, and Missed Visit.

 The YELLOW light bulb is a HELP that has information to help you select the correct Location Code.

The light bulb is sensitive and if you hover the mouse near it, location types, descriptions, and additional information appear in yellow. Clicking **on** the light bulb, opens a black/white screen shot for longer viewing.

Location codes are very important because some are **“Lock Outs”** and/or may be **non-billable**. A service considered a “Lock-Out” or “non-billable location” cannot be reimbursed, and must be properly coded to prevent fraudulent billing!

Locations that result in an outpatient services being “Locked Out”: For example, if a client is receiving services in an inpatient psychiatric unit, inpatient services are considered to be all-inclusive services and are claimed by the hospital. If an outpatient service is provided on the same day that inpatient services are claimed, the all-inclusive inpatient service will “Lock Out” and prevent the claim for the outpatient service.

- Please see the Location Code dropdown list or the Light Bulb **HELP** for additional “Lock Outs”. Also, the BHRS Documentation Manual (link on page 1) is an additional reference to understand “Lock-Outs”.

There are **two non-billable location codes** that are **not actual locations, but are used that way**: These are **Voicemail/ Fax/Email** and **Missed Visit**. Use these as the Location code when applicable, and then you should use the **non-billable Service Charge Code (55)** for the **service type**.

- **While a client is receiving inpatient mental health services, only case management to assist with discharge/ placement may be claimed as a billable service. Any other service provided while the client is receiving inpatient services should be coded using the lockout location code “Psychiatric Hospital” and the non-billable service charge code (55). Jail is another example of a Lock Out location.**




Service Duration (F)

- Enter the exact service duration in minutes. Do not round up minutes! Try not to have all progress note durations end in zero (0) or five (5).
- Enter the total amount of clinician time: face-to-face time with client, time spent providing documentation and travel time, if applicable. **For Medicare clients, ONLY face-to-face time may be included in the service duration.**
- You may wish to complete the Service Duration field **after** you have written the progress note.

Note Addresses Treatment Plan Barrier (G)

Select Treatment Plan Version

- **Client Treatment and Recovery Plan (New)** is a plan created in Avatar on or after 9/1/11. In Chart Review, the new plan is listed in the episode as **Plan Dates and Information**.
- **BHRS Client Treatment and Recovery Plan** is a current plan not yet updated to the Avatar Client Treatment and Recovery Plan (New). In Chart Review, it will show in an episode as BHRS Client Treatment and Recovery Plan
- Once selected, a pop up screen with treatment plans from **this episode** appears.
- If more than one plan exists, click to **open the correct plan that this progress note** will address.

 **IMPORTANT:** If there is **NO treatment plan to select from, write the progress note for the service provided BUT inform your supervisor AND update/create a treatment plan ASAP.**

- Once the correct Treatment Plan is open, click on the box: **Select T.P. Item Note Addresses (H)**, select the item and then click the Return button on the bottom of the screen.
- The selected treatment plan item will appear in the grayed, view only text field box to the right **(I)**.
- **Remove T.P. Item Note Addresses (J)** is used to clear the information in the text field box **(I)**.

* Please see the next page for a view of Note Addresses Treatment Plan Barrier.

This section of the progress note **((G), (H), (I), and (J))** is intended to **demonstrate continuity** between the **treatment plan (barriers, goals and objectives identified and agreed to by the client)** and the **services** that are being **provided and documented** in each **progress note** (the **interventions provided by the clinician**). **This linkage is important.** Put another way, **if an item is included on the current treatment plan it must be addressed in one or more progress notes.** Conversely, if an **intervention** is **documented** in a progress note **but is not included** on the **treatment plan**, the **treatment plan** should be **updated right away to include the item being addressed in the progress note.**

 **IMPORTANT**

Services provided and documented in a progress note when there is NO or an EXPIRED Client Treatment and Recovery Plan (New) will not be submitted for reimbursement!



Example: Note Addresses Treatment Plan Barrier Screen Shot

Select the treatment plan

Selected barrier populates read only box.

Please NOTE: Entries for the fields * Co-Practitioner, * # of Clients and * Co-Practitioner Duration (minutes) will be explained in the Section on “Group” Progress Notes – Page 16.

* Missing “Required Field” Indicators

- All fields in any document are important and should be completed if there is information to do so.
- There is a *new* Avatar feature is to “Flag” each empty required field and each Tab where the field appears when the document is saved.
- “Flags” will make it *easier to find what is missing from a document saved as DRAFT*, or if a document has some fields *incomplete or missing an entry*.
- The “Flag” *will not appear* as you are entering information.
- When you submit your document, if any required fields are missing data, a message box notifies you there is a missing field.
- Click OK and a *visual indicator* or “Flag” appears *next to each missing field*, and *each tab* containing a missing required field (s).
- When *all required fields are filled in*, the flag on the tab will clear. If none of the tabs on a form have a “Flag”, all required fields have been filled in.

Now, you’re ready to write your note. You must go to the next page of Tab 1. Bring your cursor below the toolbar and click the arrow. The next page shows a screen shot of Page 2, Tab 1 and the entry fields that must be completed to finalize and submit your progress note.



SCREEN SHOT OF PROGRESS NOTE TAB 1/PAGE 2

The screenshot shows the Avatar software interface for a progress note. The window title is "AVPMLIVE (SAMPLE) - ANOTHER_CLIENT (000000163)/BHRS Outpatient Progress Note". The interface includes a menu bar (File, Edit, Favorites, Avatar PM, Avatar CWS, Avatar MSO, Help), a toolbar with navigation icons, and a main content area. The main content area has tabs for "Service / Clinical Information" and "Language and Additional Information". A large "Notes Field" is the central focus. Below it are fields for "Note Type" (with a dropdown menu), "SEND TO (for Co-signature Only)" (with a dropdown menu), and "Option" (with a dropdown menu). A "Draft/Final" section contains radio buttons for "Draft" and "Final". A "View Previous Progress Not..." button is located in the upper right corner of the Notes Field. Annotations A-F point to various elements: A points to the Notes Field, B points to the View Previous Progress Not... button, C points to the pad/pencil icon in the Notes Field, D points to the Note Type dropdown, E points to the Draft/Final radio buttons, and F points to the SEND TO dropdown. A "SUBMIT button" label is also present in the top right corner of the screenshot.

Notes Field (A)

- The **Notes Field (A)** is a **free text box**. You can type free text and compose the progress note for the service provided to the client. Make sure your documentation matches with the description of the Service Charge Code/ Service Type you selected.
You can write as much content as needed in the free text box. You will be able to view what has been written by scrolling vertically in a scroll bar that appears once the Notes Field is full.
The pad/pencil icon, the **Text Editor (C)** is located near the upper right hand corner of the Notes Field box. The Text Editor box is another way to view the entire contents of what you have written. Spell check and cut/paste options are also available in Text Editor. You can view, make and save any changes, then exit the Text Editor.
- The **narrative** of the progress note should describe the **client symptoms, behaviors and strengths**, the **clinician's interventions**, the **client's response to the interventions**, the **plan** for subsequent services, **progress** toward goals/objectives, and a description of **significant changes** in client status.
- **Right clicking** anywhere in the white of the note field will pop up a box where **QM approved System Templates** can be selected. These **System Templates** represent the different **Service Charge Codes**.
- The **System Templates** are **guides** that **prompt** the clinician to document a service so that **all the required regulatory elements** for that service will be included.
- Once a System Template is selected, it will populate into the Notes Field.



- Type the content by placing your cursor under the header of each prompt.
- A **progress note** may be: **narrative only, a note using the System Template, or a note containing both narrative and System Template components.**
- If there is already some narrative in the Notes Field and **then** a System Template is selected, a pop up box will appear with the question, “Do you want to **erase** what is in the Notes Field or **append** by adding the template?” Answer ‘append’ and then complete your note using the prompts.

View Previous Progress Notes (B)

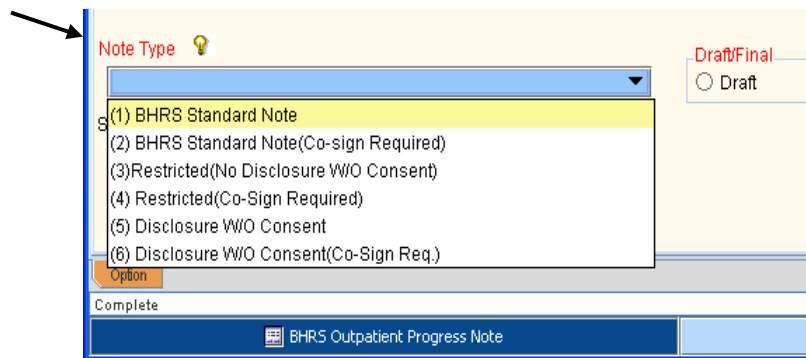
This option allows you to view up to 1 year of previous progress notes. When you click on this box a Progress Note Report will be generated that includes progress notes across all episodes.

Reports sometimes take a few minutes, be patient. Reports are downloaded through an application called Crystal. There may be 1 or 2 pop up screens that appear during this process, asking if it’s ok to download from the server or if you want to return to the option. You can answer ‘yes’.

At the top of the progress notes report screen you will see a white box with 1 of XX notes. For the next note, click the first arrow to the right of the box. The second right arrow with the line brings you immediately to the last note. For a previous note, click the first arrow to the left. The second arrow on the left with the line brings you back to page 1.

Once you are ready to leave this report screen YOU MAY USE THE RED X TO EXIT. In general, this is the exception to the rule, you may exit any and ONLY Crystal reports using the RED X.

Note Type (D)



This is a dropdown box to select from **6 TYPES of NOTES**

The new note types **allow clinicians to indicate when a note should be restricted** and to **allow for the tracking of disclosures**. Notes numbered 1, 3 and 5 **DO NOT** require supervisor co-signature (the others do).

- **(1) BHRIS STANDARD NOTE - This is the type of progress note for documenting most services.**



- **(3) RESTRICTED - NOT FOR DISCLOSURE WITHOUT CLIENT CONSENT**

Cannot Be Disclosed unless there is a RELEASE/CONSENT from the CLIENT. Selecting this type for a progress note means information will be restricted and the clinician/clinical team will review and determine if release is necessary and if so, get a release from the client prior to releasing it.

Use the Restricted- Not for Disclosure Without a Client Consent Note Type ONLY FOR progress notes containing information:

- About HIV status.
- Given in confidence by a family member/significant support person who requests that it not be shared with the client.
- That, if disclosed to the client, might result in serious risk to the person who provided the material (even if the person disclosing did not request restriction).
- That a youth client requests be restricted – such as sexual behavior (not abuse), AOD use/treatment, HIV fears and other private or personal information. Use with caution in these situations.

- **(5) DISCLOSURE WITHOUT CONSENT/NOT TREATMENT**

Can be disclosed without a client release/consent; note does not contain restricted information or information related to Treatment/Payment or Operations.

Information in this note type can be released without the consent of the client: to the family/significant other in an urgent, safety/crisis situation like a current threat of harm to others or death reporting; to the police/other law enforcement; to CPS or APS, even if the reporting is mandated by law; to the DMV for lapses of consciousness.

The same definitions apply to the note types numbered 2, 4 and 6 except that those notes are selected if a supervisor Co-Signature is required.

- 💡 The YELLOW light bulb on the right side of the Note Type dropdown box is a HELP that has information to help you select the correct Progress Note Type. The light bulb is sensitive and if you hover the mouse near it, the note type and descriptions/examples of note types will appear, in yellow. Clicking **on** the light bulb, opens a black/white screen shot for longer viewing.

DRAFT/FINAL (E)

DRAFT:

- Notes in Draft prior to 9/16/11 when the new Avatar function, Changes to Co-Signature Workflow was implemented.
- Notes in DRAFT because your supervisor continues to requests this despite new Co-Signature function dated 9/16/11.
- Notes that can be completed later.
- Notes that can be edited.



When DRAFT is selected, the watermark automatically appears in the background.

FINAL:

- Notes NOT requiring a Co-Signature or those that HAVE BEEN Co-Signed by Supervisor.
- Notes after 9/16/11, your supervisor has implemented the new Avatar function- Changes to Co-Signature Workflow in Progress Notes.
- Must SAVE/SUBMIT and send to billing.
- NO FURTHER CHANGES TO THE NOTE ARE POSSIBLE.

SEND TO (for Co-Signature Only) (F)

- This is a dropdown box where the **name of the supervisor/staff person responsible for Co-Signing** the progress note will populate in the blue field. The **SEND TO box gets activated by the NOTE TYPE selection** (if requires Co-Signature) and the scope/privileges that were set up when the clinician was first hired.

⚠ Please NOTE: New Avatar function for Co-Signatures:

- **As of 9/16/11**, a trainee/intern can submit progress notes as FINAL.
- Once the note is submitted, it will appear on the Supervisor’s To-Do list.
- The **supervisor** will open the progress note from **their** To-Do list and will see the **Co-Signature screen**.
- The supervisor selects “YES” to **approve** the note (no comments can be made). Once that happens, the progress note **status is FINAL**.
- If the supervisor selects, “NO” and **does not approve** the note, the supervisor will **write comments** in the “Co-Signer’s Comments” text box.
- The **status** of the progress note will **change to DRAFT**.



- Once the supervisor hits **Submit**, this returns the note as **DRAFT** along with the **supervisor's comments back to the original writer as a new To-Do item**.
- The progress note can be **modified, saved as FINAL with co-signature required**, and then **sent back** to the **supervisor** who **will approve or not**.
- **The process will repeat until the progress note is approved, co-signed, and FINALIZED.**



If you did not want to enter the Service DURATION until after you wrote the progress note, you **must go to Tab 1/Page 1 and enter the Duration in minutes.**



SUBMIT

You **MUST** click the **SUBMIT** button to **SAVE/Submit** the note as either **DRAFT** or **FINAL**. Avatar synchronizes data at 4a each night. Progress notes that **have not been SAVED** or **SUBMITTED** are **erased** during the synchronization process and will have to be written again.



THE AVATAR BHRS OUTPATIENT PROGRESS NOTE - SCREEN SHOT OF TAB 2

A

SUBMIT Button

AVPMLIVE (SAMPLE) - ANOTHER,CLIENT (000000163)/BHRS Outpatient Progress Note

File Edit Favorites Avatar PM Avatar CWS Avatar MSO Help

Page 1 of 1

ANOTHER,CLIENT (000000163) Episode: 1 Date Of Birth: 12/09/2008; Sex: Male

Service / Clinical Information **Language and Additional Information**

Language Information for Contact

Was this contact in a language OTHER than English?
 Yes No

Language Services Offered?
 Yes No
 Bilingual Clinician Declined

Language [dropdown]
 Other Language [text box]

Interpreter's Name [text box]

Periodic Client Rating of Symptom Severity (1 is better, 10 is worse)

Symptom #1 [dropdown] Other [text box]

Rating Scale #1
 1 2 3 4 5
 6 7 8 9 10

Symptom #2 [dropdown] Other [text box]

Rating Scale #2
 1 2 3 4 5
 6 7 8 9 10

Option

Complete

BHRS Outpatient Progress Note Chart Review

B

C

Tab 2/ Language and Additional Information (A): This tab is optional; it provides supplemental information:

- **Language (B)**
 Complete this tab if the service was **provided in a language other than English**. If **YES** is checked, then the **LANGUAGE** fields become required. You must **specify** the **language** (from the dropdown list or enter it in box if not on dropdown list), if **language services** were **offered**, and if an **interpreter** was **used** or the staff **provided** the **service** in the **client's preferred language**.
- **Periodic Rating of Symptom Severity (C):** Allows clinician to **monitor** and **track 2 client symptoms** from session to session, or over periodic intervals of time. The severity rating is from 1 (better) to 10 (worse). Severity rated per client report or clinician observation.



THE AVATAR BHRS OUTPATIENT PROGRESS NOTE: GROUP

SCREEN SHOT OF PROGRESS NOTE TAB 1/PAGE 1 for GROUP NOTE

GROUP PROGRESS NOTES are completed following the same instructions and screen shot descriptions as presented for the STANDARD Outpatient Progress Note, Pages 5 through 14, however, there are 3 additional required fields to be completed, when applicable (Co-practitioner may not be applicable to some groups).

Group Services are important clinical interventions. The **Type of Group**, **Number of Clients represented** in the **Group**, and **Co-Practitioner Participation MUST be CODED CORRECTLY**.



Description of the GROUP BHRS Outpatient Progress Note:

Tab 1/Page 1:

Service Charge Code/Type of Service (A)

- The following are **Service Charge Codes/Service Types** for a **GROUP** service:
 - Collateral Group** - Code 120 – (e.g. skills development for parents of youth with open charts)
 - Assessment Group** - Code 50 – (e.g. welcome/orientation with focus on Assessment activities)
 - Rehab Group** - Code 70 – (e.g. care, smoking cessation, healthy living led by non-medical clinician)
 - Therapy Group** - Code 10 – (e.g. symptom reduction, functional improvement, CBT, DBT)
 - Medication Group** - Code 150 – (e.g. led by MD/RN, medication info, impacts of medications)
- An entry is made in the white field of the Service Charge Code box **(A)**, either the Service Charge Code number or a few letters or word for the service type.
- Click the process search box, and **select the correct GROUP service**. This service will populate into the blue field box. **There must be an entry in the blue field box for a valid Group service.**
- The **'GROUP' selection will activate the field: # of Clients in Group (D)**: This field will **now be a required (red) field; you will enter the number of clients that participated in the group.** (See below, under **Please NOTE**).
- **The Service Duration in minutes (C) is entered for the clinician's face-to-face Group time, documentation time and travel time, if applicable.**
- If there is a **Co-Practitioner who participated or assisted with the Group**, the last name of the practitioner is entered into the white Co-Practitioner box **(E)**; then click on the process search box, then go to the arrow of the dropdown box, Name/ID Number **(F)**, **Select the correct Clinician/Co-Practitioner name and it will populate into the blue box (F).** Only 1 Co-Practitioners can be selected at this time.
- The **Co-Practitioner Duration in Minutes (G) will now be a required field.** The Co-Practitioner time will not include documentation time. The entry of **Duration for the Co-Practitioner will be less time** than what was entered for the lead Group facilitator's time. The lead Group facilitator will record the same time for the Co- Practitioner in each client's record.

Tab 1/Page 2:

Please complete the fields on this page in the same way the Standard note is documented on Page 10 through 13. **There ARE System Templates that can be selected for specific Group Service Charge Codes.**



Please NOTE:



of Clients in Group

- If a **Family Group** is provided, **ONLY count CLIENTS, not total number of individuals in the Group** (5 members in the Family Group, 2 are Clients, # of Clients in Group = 2; 2 notes are written, entry is 2).



- If a **Group** consists of some **BHRS clients** and some **non-BHRS clients**, the **# of Clients in the Group is the total number of individuals in the Group, even though some are not BHRS clients.** (Group with 7 BHRS Clients & 5 non BHRS individuals; the Total # of client's in Group = 12; only 7 notes are written, but the entry is 12).
- **Do not use the Group Service Charge code if only 1 member was present.** If you do meet with that one client, document the session using the appropriate code (e.g.7 not 70).
- **Do NOT use a Group progress note to record a "No Show".** Use non-billable Service Charge code 55 to record the client's absence.

⚠ Co-Practitioner Duration

- **Co-Practitioner Duration, time in minutes, will be less than Practitioner time.** (Face-to-face time of Group, travel time, if applicable CAN be claimed. Co-Practitioner CANNOT claim documentation time).

⚠ OTHER

⚠ Practitioner and Co-Practitioner(s) must be able to provide and claim the specified Group service based on their scope of practice.

⚠ When documenting in the Notes Field, Tab1/Page2, the Name of the Group/Type of Group and Group Description will be the same for all Group members.

It is acceptable to create a common group note that includes the **Name, Content, Description, Format, Intent, Focus**

You may copy these elements from a Word document and paste them into the Group progress note for each client.

The **remainder** of the Group progress note would be the **individual, client-specific behaviors, client participation, client response to interventions, and plan.** (e.g. Client unable to focus, easily irritated, distracted by others, appears to be responding to internal stimuli, highly participatory and motivated, good eye contact, attended group with homework completed)

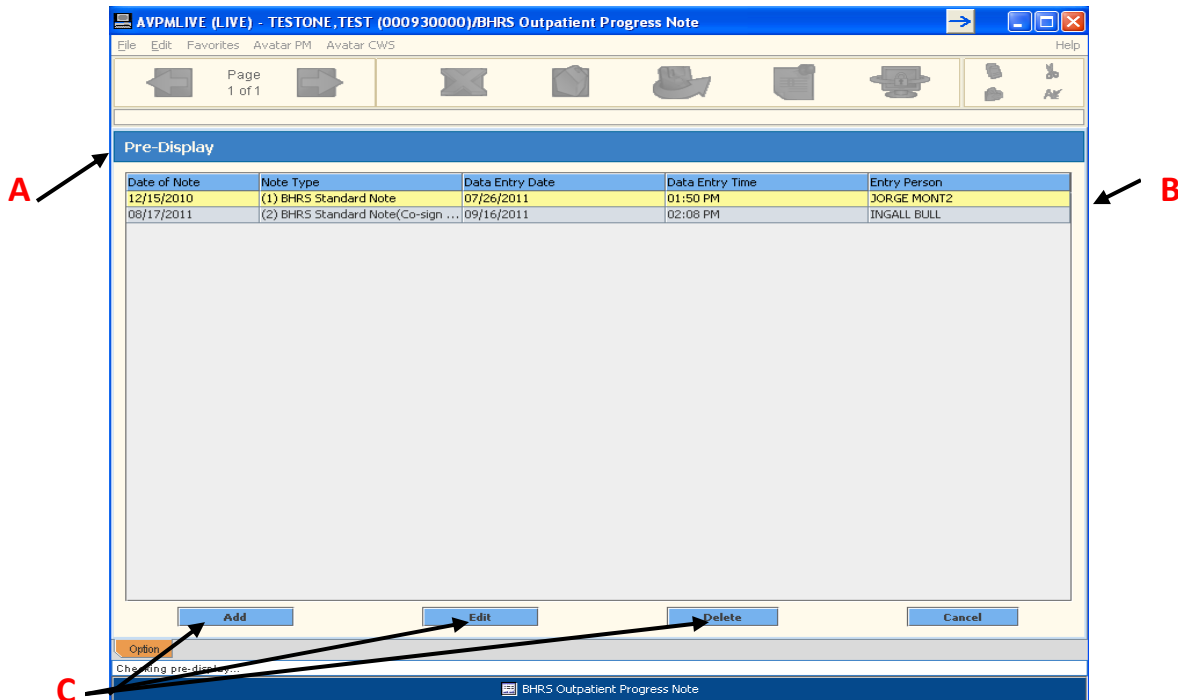


PROGRESS NOTE EDITS, ADDITIONS (APPEND), CORRECTION OF ERRORS

Edit Draft Progress Notes

- Notes that have been submitted as DRAFT can be edited.
- DRAFT notes can be edited either through a Client's Pre-Display Screen or the Clinician's To-Do List.

Edit – Using Client's Pre-Display Screen



PATH Avatar CWS → Outpatient Progress Note

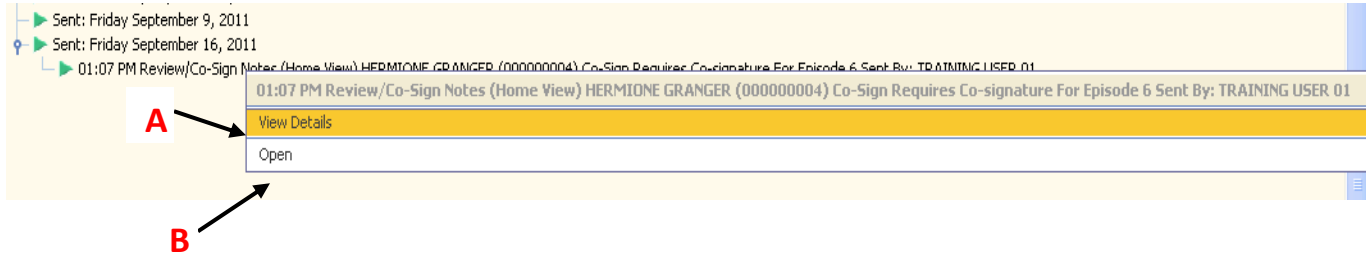
Once you have selected a **client** and the **correct episode**, the **Pre-Display Screen (A)** will appear if there are any progress notes in **Draft (B)**.

The bottom of the Pre-Display Screen has the options: **Add, Edit Delete (C)**.

Click on the selected progress note you want to **Edit (B)** then click the Edit option **(C)**, the selected progress note will open. Make the edits you want, then, **submit the edits from the open progress note document**. **You can submit as Final or keep in Draft.**



EDIT - Using Clinician's To-Do List



Clinician To-Do List: Once the clinician's Avatar Home Page is set to the To-Do Screen, 'To-Do' items will appear by date.

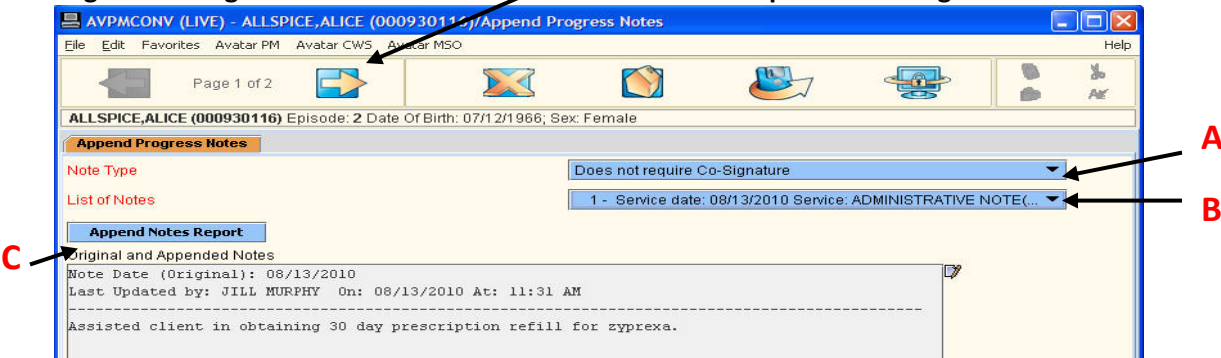
- To view the contents of a To-Do list item, right-click on the item and select "View Details."
- To **EDIT the note**, either double-click on the item, or right-click on the To-Do list item and select open
- Locate the DRAFT note to be edited by **right clicking on each To-Do item**; contents of the To-Do items can be **viewed (A)**, right click and view until you find the correct note.
- Select **OPEN (B)** by **right clicking** on the **correct note**. Edit the note then submit as Final or Draft

Append (Add To) A Progress Note

Screen Shot for Tab 1/Page 1

⚠ If some important information needs to be added to the content of a note or if there is an error in the content of a note **AND** the note has been **submitted as FINAL**, the note CANNOT be edited. Instead, the clinician will need to append the information to the already finalized note.

Page 1 Viewing ONLY Click this arrow to proceed to Page 2



PATH Avatar CWS → Progress Notes → Append Progress Note

You can narrow the search for the note you need to append by selecting the Note Type – Standard, Disclosure, or Restricted. **You can ONLY append a FINAL note and a note that did not require a co-signature!**



All 6 types of Notes will show in the drop-down, however, **ONLY those progress notes that Do Not Require a Co-Signature (A) can be appended.** (See below for how to handle progress notes with co-signatures that need to be appended.)

After selecting one of the three types of 'Does Not Require a Co-Signature' (A), progress notes, a list of notes **by date and type** will appear in the dropdown box (B).

On this page, **Page 1**, select the progress note to be appended; it will **only open for viewing (C).**

Append (Add To) A Progress Note

Screen Shot for Tab 1/Page 2



On this page, **Page 2**, you will enter the **additional information/correction to the content**, in the box **New Comments to be Appended to the Original Note (A)**

Click Submit (B); the appended note will be attached to the original and can be viewed by through the Progress Note Report

Please NOTE

- The **Append** note function can be **used for outpatient service notes including Group notes.**
- Appended information that is added is attached to the original note.
- Any clinician can append a progress note, even if they did not write the original note.
- The **Append** note function **CANNOT be used if a note originally required a co-signature.**
- If **information** needs to be **added or corrected** to the **content of a Final note that required a co-signature**, a **new note must be written** to address mistakes or additions of the original note's content.



Error Correction Screen Shot for Progress Note Error Correction Request Tab1/Page1

If errors are made to the Date of Service, Service Duration, Service Charge Code/Type of Service, Group Service entries or Location Code, a Progress Note Error Correction Request must be completed and submitted so that the service is billed correctly. This form is also used when requesting to correct errors in other categories e.g. Other Client’s PHI Disclosure, Duplicate Entry, Wrong Co-Practitioner, Wrong Episode.

PATH Avatar CWS → Progress Notes → Progress Notes Error Correction Request

Select the client for whom the original progress note was written.

Once the Progress Note Error Correction Request is selected, the first screen that may appear is the Episode Selection screen if the client has more than 1 episode. You will select the episode where you work, or the program where the note was submitted in.

Select the episode the note was written for.



Once the client has been selected and the correct episode, another screen may appear, the **Pre-Display** screen that shows **other Progress Note Error Correction Requests**.

The Pre-Display Screen will show:

Date of Request	Requestor	Disposition	Disposition by	Disposition Date
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At the bottom of the Pre-Display screen there will be options to **ADD**, which is to **ADD a NEW Request**; **Edit**, to **Edit a Request where there has not yet been a Disposition, Disposition By and/or Disposition Date completed** or **Cancel**, which **Cancels option** and returns the screen to the Avatar homepage.

The Progress Note Error Correction Request form is a 1 Tab/2 page document. Once both pages of Tab 1 are completed and submitted, the Progress Note Error Correction Request is automatically routed to ADMIN/QM or MIS staff. ADMIN/QM/MIS staff will then process the request through entry on Tab 2. **ONLY the 2 pages of Tab 1 are required to be completed by staff.**

Complete only the 1st Tab: **Progress Note Change Request (A)** - This Tab has 2 Pages.

Tab 1/Page 1 (B) - Page 1 is orange/active. To move to Page 2, click the yellow Page 2 box to the right of the Page 1 orange box. When you click on this box, it will become orange/active. You can switch between pages of this tab; the active page will be orange. You can also move to Page 2 by clicking on the arrow above the tab.

Date of Request: (C) - Defaults to Today's Date

View Progress Notes: (D) - Runs a report of progress notes in the selected episode for this client which serves as a reference point.

****ALERT: NOTES WRITTEN TO THE WRONG CLIENT: (E)**

An alert or prompt to write a new note for the correct client

Must select the Original Note Information (up to 90 days): **(F)** Progress note selected will be voided

Must also check Wrong Client **(H)** in Items to Change **(G)**

Must also select the CORRECT client through process search entry: **(J)**

Original Note Information: (F) – Displays a list of progress notes up to 90 days, in the episode selected, for this client. The **note to be corrected is selected**. If the note to be corrected is NOT among those in the 90 day listing, be sure to you are looking in the correct episode. If the episode is correct, then check the entry **Progress Note Not in List (K)** in Select Items to Change **(G)**.

The Original Note information will show:

Date of Service	Service Type	Location	Duration	Clinician	Unique Note ID
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Select Items to Change: (G) – Select 1 or more Progress Note Items to Change. Items selected here will require the corrected information to be entered in the corresponding field(s) below in **(I) NEW** which have now become RED required entry fields. (New note with the correct information ONLY for a note written on the Wrong Client).

Fields to Indicate Correct Information: (I) – The fields in this section become enabled and will require an entry if it was selected as an Item(s) to be changed (above). For each item checked to change **(G)**, you must put an entry in the correction field **(H)**.

- **Date of Service** – provide the actual date the service was provided.
- **Correct Episode** – select the correct episode from the drop down.
- **New Location** – select the correct location from the drop down.
- **New Duration (in minutes)** – enter the correct duration in minutes.
- **# Clients in Group** – enter the total number of clients that attended the group.
- **New Service Code** – this a process search entry, must put an entry into the white box, click process search, select the correct service code. If the correction changes from an “Individual” to “Group” code, then change/correction to # clients in group must also be made.
- **Correct Client** – this is a process search entry, must put entry into the white box, click process search, select the correct client, this note will be voided and the service deleted; write a new progress note for the correct client.
- **Duplicate Entry** – one of the progress notes submitted will be deleted; the progress note will remain in the Avatar system and the client’s medical record; the progress note can be appended to state that it is a duplicate.

There are no entry fields for corrections to items in (H): Other Client’s PHI Disclosure, Progress Note Not in List, Other. Please explain correction needed, reason(s) and/or comments for change on Page 2.

Entry for the Correct Co-Practitioner – this is a process search entry, must put entry into the white box, click process search, and select the correct Co Practitioner. This field is selected as an Item to Change **(H)** on Page 1 but the correction is entered on Page 2.

To Continue to Tab 1/Page2 click the yellow Page 2 box to the right of Page 1 or click the arrow in the area just above the Tab Progress Note Change Request.



Error Correction Screen Shot for Progress Note Error Correction Request Tab1/Page2

PAGE 2

Correct Co-Practitioner (L) - this is a process search entry, must put entry into the white box, click process search, and select the correct Co-Practitioner. This field is selected as an Item to Change (H) on Page 1 but the correction is entered here on Page 2

Change Comments/Reasons: (M) – **All requests must include a reason for the request.** This is a free text box to indicate the reason(s) for the request and any other information you wish to share that is related to the request.

Requestor: (N) – this is a process search box to enter the clinician’s last name in the white box, click process search and select the requesting clinician, most likely yourself, who is making the request.

Program/Episode: (O) – this is a dropdown to select correct episode/program

Client Name: (P) – the clients name will automatically fill this box

SUBMIT:  click this icon to submit the request, and then click  to Close.