Avatar Process Improvement Meeting Minutes

6/16/2022
9:00 AM - 10:00 AM

Meeting Identity and Mission:	Inclusive, collaborative, agenda driven Continued Process Improvement meeting focused on new state and federal requirements, as well as improving client care and staff experience.
Opportunity to:	Share both our voice and needs to impact processes & procedures, create and modify forms and workflows, develop reports and widgets
Commitment to:	Bring information back to the groups we represent, gather input and test current projects to ensure they meet our needs
Meeting Website:	Click here for meeting agendas and minutes. Avatar Resources / Meetings

Get Involved!	**•To add agenda items, complete the AVATAR request form; contact is David.chicoine@santacruzcounty.us** **•Housekeeping items – Please use the raise hand function or the chat box if you have questions, comments, concerns.**

AGENDA ITEMS>>>

Introductions **TIME: 5 minutes** **STAFF: Nancy**

1. **Next meeting – June 30, 2022**
2. **Introductions: name, program**

Announcements

- **Agendas and meeting minutes are posted on the Avatar Webpage, Meetings Subpage.**
- **The Santa Cruz County BH QI Department will be having CalAIM office hours** starting in July, every two weeks on Friday, from 9 AM-10 AM. This will be a virtual meeting. More information about how to attend coming soon.
- **Avatar CalAIM Meeting forming** – A new Avatar meeting specific to CalAIM will be starting soon, hopefully July 7. It will meet every two weeks, on alternate Thursdays, opposite our regular Avatar Process Improvement Meeting. In this CalAIM-specific meeting, we will discuss restructuring Avatar and revisioning workflows in the light of CalAIM. All are invited. Please let Nancy know if you are interested and she will put you on the meeting invite. The meeting will be every Thursday at 9 am (on alternate weeks from this meeting).

Project Status and Updates

1. **California Advancing and Innovating Medi-Cal (CalAIM) discussion** **Staff: ALL** **Time: 15 mins**
    a. **Treatment Plans/Problem List** - Treatment plans for many programs will go away, replaced by a problem list. Medical necessity and "plan" will be part of the narrative that the note. Medical necessity

will not need to be in every single note. We are waiting for more specificity from the state about what progress notes must contain.

b. **Required Problem List Elements from CalAIM (below are direct quotes from CalAIM information provided by the state)**
   i. "Diagnoses identified by a provider acting within their scope of practice, if any;
   ii. "Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable;
   iii. "Problems identified by a provider acting within their scope of practice, if any;
   iv. "Problems or illnesses identified by the beneficiary and/or significant support person, if any;
   v. "The name and title of the provider that identified, added, or removed the problem;
   vi. "The date the problem was identified, added, or removed."
   vii. In addition:
      1. "Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition;
      2. "DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice."

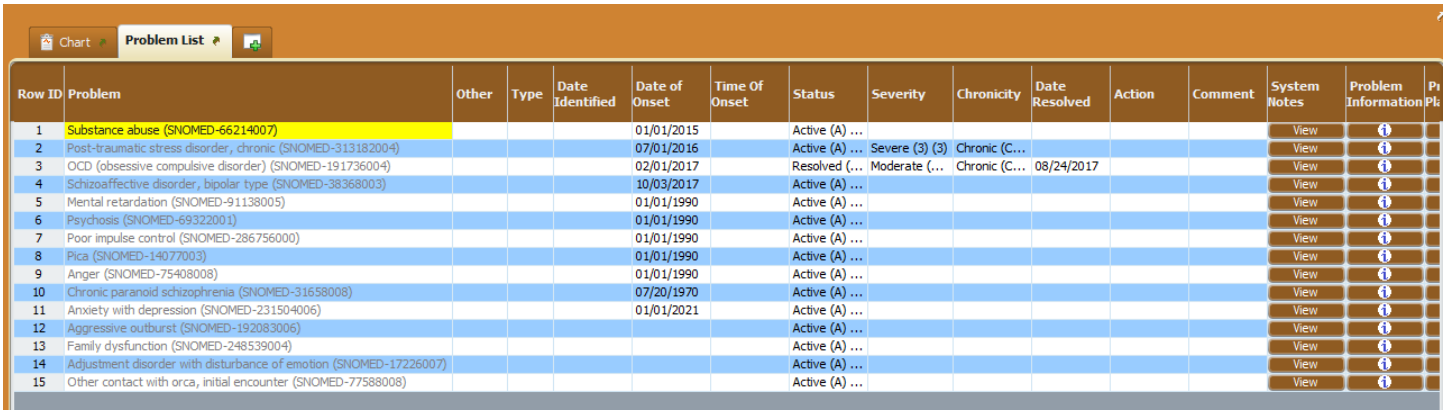


Chart | Problem List

Row ID	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes	Problem Information
1	Substance abuse (SNOMED-66214007)				01/01/2015		Active (A) ...						View	
2	Post-traumatic stress disorder, chronic (SNOMED-313182004)				07/01/2016		Active (A) ...	Severe (3) (3)	Chronic (C...				View	
3	OCD (obsessive compulsive disorder) (SNOMED-191736004)				02/01/2017		Resolved (...	Moderate (...	Chronic (C...	08/24/2017			View	
4	Schizoaffective disorder, bipolar type (SNOMED-38368003)				10/03/2017		Active (A) ...						View	
5	Mental retardation (SNOMED-91138005)				01/01/1990		Active (A) ...						View	
6	Psychosis (SNOMED-69322001)				01/01/1990		Active (A) ...						View	
7	Poor impulse control (SNOMED-286756000)				01/01/1990		Active (A) ...						View	
8	Pica (SNOMED-14077003)				01/01/1990		Active (A) ...						View	
9	Anger (SNOMED-75408008)				01/01/1990		Active (A) ...						View	
10	Chronic paranoid schizophrenia (SNOMED-31658008)				07/20/1970		Active (A) ...						View	
11	Anxiety with depression (SNOMED-231504006)				01/01/2021		Active (A) ...						View	
12	Aggressive outburst (SNOMED-192083006)						Active (A) ...						View	
13	Family dysfunction (SNOMED-248539004)						Active (A) ...						View	
14	Adjustment disorder with disturbance of emotion (SNOMED-17226007)						Active (A) ...						View	
15	Other contact with orca, initial encounter (SNOMED-77588008)						Active (A) ...						View	

c. **Progress notes -** We are waiting for more clarification and specifics about what needs to be in progress notes with CalAIM. QI is mindful of how this will impact line staff. Clarification – Note due on day 3. Day 1 is the date of service. There may be some cultural shifts where staff need scheduled, dedicated time to get their notes done on a regular basis, rather than trying to do notes during "free time."
   i. Discussion: It is important to have a communication plan before we add progress note aging updates to LIVE, which led to a general conversation about communication.

d. Psychosocial Changes – Our current psychosocial appears to meet the needs of CalAIM, but a more detailed look at our psychosocial is needed.

e. Mental Status Exam – No changes anticipated to workflows or requirements. (Our MSE may be changing because of changes to medical progress notes that are not related to CalAIM.)

f. Diagnosis Form – Shall we permit non-LPHA staff access to form? With CalAIM, they *can* add certain Z codes, but not anything else. Avatar will not *prevent* anyone from adding a diagnosis that is outside their scope of practice, so training would be needed.

g. Monitoring Tools will need to be updated to reflect CalAIM changes. Discussion:
   i. For example, reports that monitor Timeliness for progress notes.
   ii. QI UR forms need updating. Possibly we can develop an Avatar report that gives you the info you want to pull for a UR review.
   iii. CalAIM changes include payment reform. Billing/reimbursement will be on a "per service" basis which means it will be even more important to document and get paid for all services we provide. We will need to develop reports/monitoring tools to look at per service measures, looking for trends at an aggregate level, so we can see what the patterns are.

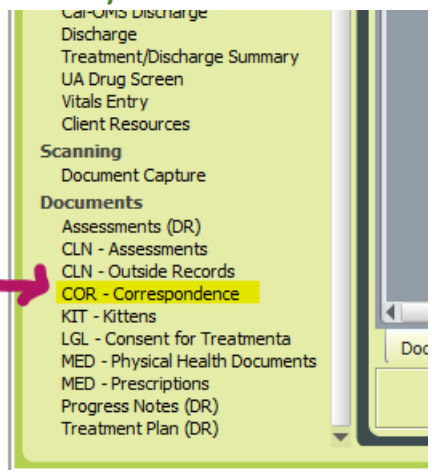
h. <u>What is our input regarding adapting to these changes?</u>
   i. Communication re CalAIM to staff
      1. Announcements should be clear, with instructions.
      2. Possibly a Teams meeting.
      3. A list of what's the same. What's different.
      4. An Avatar page specific to CalAIM is being developed.
      5. QI will be establishing office hours for questions. However, QI isn't going to be able to always provide a black and white answers. The good news is that this creates more flexibility for programs to work on what they are doing in the way that best serves their clients.
   ii. CalAIM is currently being discussed in management level meetings. The expectation is that ppl will go back to their agency or team and provide information to line staff.
   iii. Programs switching from weekly to daily notes will need training.
   iv. Prior to CalAIM, when two clinicians provide a joint service (e.g., two clinicians facilitating a group together, or two clinicians working together on a crisis) they each need to do a separate note. With CalAIM, one clinician may write the note for both staff members providing the service. The note should describe what each clinician did.
   v. The concept of being able to provide clinically indicated services, to any client, at any time, is a new one, and will need careful messaging and training.
   vi. Some Avatar programs, for example, County Pre-Admit, are not connected to certain service codes. This is because prior to CalAIM, preadmit services could not include things like rehab counseling or case management. With CalAIM, service codes will need to be added to certain programs. For example, case management, rehab counseling and psychotherapy be added to County Pre-Admit. Are there other programs like this that would need other codes added?

i. "Lockouts," that is, the inability to bill for certain services at certain locations, is not changing as far as we know at this time. An example of a lockout would be the inability to bill for most outpatient services, such as case management, when a client is in psychiatric inpatient.
j. Discussion about SNOMED codes and Z Codes. Staff will need training re the use of these new codes.
k. Timeliness changes - State will require most progress notes to be completed within three days of the service provided. Crisis notes need to be done in 24 hours.
   i. Due to the rapid rollout of CalAIM we do not believe the state is expecting 100% compliance on this beginning 7/1/22.
   ii. We need to provide broad communication around these items so that staff understand the new requirement. We can address this by agency.
   iii. We still need to work out how holidays and work schedules factor into these changes. Guidance from the state is not clear at this point. We will likely need to agree on our own standards

around this, and then ensure that people are adhering to the standards. The standard will likely be universal. Too difficult to track different work schedules different holidays for different agencies, etc.

l. SUDS and Mental Health will collaborate to make joint decisions regarding some of these changes. Workgroups will be made with key stakeholders who are in both Mental Health and SUDS.
   i. Reports will change to reflect timeliness.
   ii. Most staff are already completing their notes within the 3 day business day timeframe.

2. Proposed New Filing Category for Scanned Correspondence in Chart STAFF: Nancy 10 mins



a. See UAT, test client #11 for an example of how this looks.
b. Other possible categories: NOABD's, ISS Screening tool, financial documents, specific intake documents and Hospital summaries.
c. Subcommittee to be convened to discuss this very detailed project in a smaller group.
   i. Goal of workgroup: To find out where paperwork should live. Streamline the process. Clerical needs clarification about what forms go where. There is a problem of some forms currently being filed based on who turned them in, which is not a functional system. Clerical doesn't usually know who turns in documents for scanning.
   ii. Participants: Maya Jarrow (Janus), Flor Perez (County Clerical), Dave Chicoine, Nancy Mast, Claire Friedman, Others? MA staff? Children's programs?
   iii. Could this be discussed in a UR meeting?
   iv. Some agencies have their own, different protocols around what gets discussed where.
   v. Other possible categories: Requests for letters of completion of service (Sarah Tisdale) – SUD programs provide these to clients frequently.
   vi. Question: Is it appropriate to even have 5150 forms in a chart? QI team to discuss.
   vii. Suggestion: paper routing slip that people attached to documents to be scanned that explains which category they go into

3. New Form Being Developed to Replace the SC Med Service Progress Note – This will add a diagnosis to the Med Note as well as other automation that doctors want. STAFF: Dr. Threlfall 10 mins

a. If the diagnosis is added, it's not clear that this connects to the diagnosis form, creating double work. Gian to look into a ScriptLink solution for this.
b. Form will also have an MSE that will replace our current MSE. Form will be simpler. Docs will fill out inside their medical note, but it will be in the chart as a separate document. Non-medical staff would fill it out separately, just like our current MSE.
c. Discussion:
   i. Committee recommendations: Medical line staff, including nonphysician practitioners such as RNs who use the form should be involved, as well as representatives from DMC programs. Sara Tisdale will reach out to those individuals, including Anthony Jordan, DMC manager. Other medical directors should be involved in this project. Information about the medical note was discussed in the last medical directors meeting.

ii. Question about whether MSE question or questions inside the new medical note will be required. There are some staff members that use this note that are not LPHA's such as RNs. The answer is: these fields will not be required and can be skipped by staff who do not use them.

iii. Workflows will not change in terms of who completes medical progress notes. Nonmedical LPHA clinicians will still need to complete the separate MSE when they assess clients.

Action Items

1.

Parking Lot

1. Project list review and update for new year.
2. ROI Avatar forms. IT working to separate Spanish/English versions because combining was causing the report to take too long to run.
3. Possible updates to Evidence Based Practices (EBPs) question in progress notes. Keep in parking lot for now since CalAIM will change this most likely. Topic: Use of evidence-based practices in the General Purpose Progress note to meet the state requirement of Documenting Coordination of Care –DHCS for MH requires demonstration of coordination of physical and mental health care.
4. DMC RTAR Form (Residential Pre-Authorization Form) – Conversion from Paper Form to Avatar Form STAFF: Amanda Crowder - This paper form is used for authorizing residential substance use treatment placements. There is a tight legal timeframe on these placements and having this info in Avatar would be helpful for tracking. We may need to hold off on this as this procedure may change with Cal-AIM.
5. DMC-ODS Pre-Admit Workgroup Report Out STAFF: Sarah Tisdale The primary task of this workgroup is currently specifications for the Avatar version of the ASAM Screening tool.
6. Documenting TBS Authorization History. Adiana Bare working on this?
7. Tracking Adult Residential and Crisis Residential Timeliness: Telos, EDC and Casa Pacific must measure time between request for the bed, approval of transfer, and actual client date of client's admission. I.e., when there is a request for a bed in one of these programs, how long does it take for the approval of the bed, and how long does it take to actually get the client into that facility. This is a request from EQRO state auditors.
8. Children's Intensive Support Services (ISS) assessment and tracking (Stan Einhorn) Meeting to be organized.
9. PENDING Netsmart Solution: Request to update the SC MH Short Treatment plan to have the headings in both English and Spanish like the other treatment plans. All sections except Interventions have been moved to LIVE. There is a problem adding only the intervention section that has been reported to Netsmart.
10. Documenting TBS Authorization History (Stan Einhorn) - Adriana Bare working on this
11. Avatar "NX" (new version of Avatar coming) - Move to parking lot until NX development by Netsmart is more advanced. IT Staff going to a conference on this. IT dept has been having regular meetings with Netsmart re NX.
12. CANS/ANSA Spanish question labels in Spanish - Question labels are translated and can be viewed in UAT. Lightbulbs are on hold. We are waiting for information from Community Data Roundtable which may have the information we need for lightbulbs. Lauren Fein is project manager for CANS/ANSA and is taking the lead on that.
13. Tracking Adult Residential and Crisis Residential Timeliness (Dave)

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Attendees

Claire Friedman (Sobriety Works), Cybele Lolley (County QI), Cynthia Nollenberger (County Adult MH), Dagny Blaskovich (Volunteer Center), Dave Chicoine (County QI), Flor Perez (County Reception), Gian Wong (County IT), Julie Krokidas-Wooden (Sobriety Works), Karen Hackett (County Psychiatry), Kayla Gray (Healing the Streets/Psychiatry), Maya Jarrow (Janus QI), Nancy Mast (County QI), Paulina Uribe (Janus – QI Analyst/Admissions), Robert Annon (County Adult MH), Stan Einhorn (County Childrens BH)

APPENDIX: CalAIM Information

Here is some general information about CalAIM and the changes we anticipate related to this new legislation.

1. The purpose of the CalAIM initiative is to streamline paperwork. Recoupment is to be based primarily on findings of "fraud, waste and abuse" rather than errors that are made in good faith such as an accidentally forgotten signature. In addition, we anticipate changes in medical necessity, the ability to bill for services prior to assessment, and treatment plan changes.
2. CalAIM proposes a new "no wrong door" focus which allows any client, with any diagnosis, to present at any service entity and receive services, which are now billable under CalAIM. This will create changes in workflows, assessment, case management and much more. The expectation is that if the client needs referral to another type of service, the case management and other activities designed to assess and then link the client to the proper services, are all billable. Note that clients will still have to meet criteria to receive services. The new regs allow us to bill for services we might provide while helping someone who does not qualify get to where they need to be.
3. Part of our adaptation to this is going to be customizing Avatar so we can still monitor things like timeliness, but these tools need to be updated so they can be aligned with all new thinking about clinical services. California DHCS has contracted with CAL MHSA to provide informative webinars to county QI staff weekly and we are currently going through the series.
4. There will be more guidance coming from the state including a manual created by CAL MHSA for line staff that describes the new documentation requirements.

DHCS Priority SDOH Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	*Inadequate drinking-water supply*
Z59.00	*Homelessness unspecified*
Z59.01	*Sheltered homelessness*
Z59.02	*Unsheltered homelessness*
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	*Food insecurity*
Z59.48	*Other specified lack of adequate food*
Z59.7	Insufficient social insurance and welfare support
Z59.811	*Housing instability, housed, with risk of homelessness*
Z59.812	*Housing instability, housed, homelessness in past 12 months*
Z59.819	*Housing instability, housed unspecified*
Z59.89	*Other problems related to housing and economic circumstances*
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Use of Z-Codes for clients being served prior to the establishment of a formal diagnosis: As part of the CalAIM "no wrong door" policy, we will be able to provide services and bill for things like case management, navigation, linkage and even psychotherapy prior to establishment of a formal diagnosis. DHCS describes these potential clients as, "persons with potential health hazards related to socioeconomic and psychosocial circumstances." This ability to provide reimbursable services for clients prior to diagnosis is especially impactful for clinicians encountering clients who are homeless, in crisis, on the streets, etc.... Counselors who are not LPHA's would be able to use Z codes to facilitate billing. Below is a link to a DHCS document that further describes these codes.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

Row ID	Problem	Status	Date of Onset
1	Food insecurity (SNOMED-733423003)	Active (A)	05/18/2022
2	Homelessness (SNOMED-32911000)	Active (A)	05/18/2022

Problem search results:

Code	Description
197963!!66199	Interpersonal problem (SNOMED-225706007)
327791!!66199	Interpersonal relationship problem without mental disorder (SNOMED-160822004)
327792!!66199	Interpersonal relationship problem, no mental disorder (SNOMED-160822004)
78912470!!66199	Witness to interpersonal violence (SNOMED-365448001)
81079!!66199	Interpersonal problem, not elsewhere classified (SNOMED-56098000)
Other	Specify Other