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# **Avatar Clinical Training**

## **Mental Health**

### **(Guide / Manual)**

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**1380 Howard Street**  
**1<sup>st</sup> Floor Training Room**



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# INTRODUCTION

## Contact Information for Avatar Questions

### **Clinical Policy Questions: CBHS Quality Management Work Group**

Alexander Jackson [alexander.e.jackson@sfdph.org](mailto:alexander.e.jackson@sfdph.org)

Farahnaz (Farah) Farahmand: [Farahnaz.farahmand@sfdph.org](mailto:Farahnaz.farahmand@sfdph.org)

### **Technical Questions: Technical Work Group**

Mauricio Torres [mauricio.torres@sfdph.org](mailto:mauricio.torres@sfdph.org)

### **Avatar Champions**

Kellee Hom [kellee.hom@sfdph.org](mailto:kellee.hom@sfdph.org)

### **General Avatar Questions:**

Avatar Help Desk: [avatarhelp@sfdph.org](mailto:avatarhelp@sfdph.org) (415) 255-3788

### **General Billing Questions:**

Billing Inquiry Line: (415) 255-3557

## HIPPA & Privacy Statement

### Protected Health Information (PHI)

- By law, you may only view, disclose, or inquire about PHI for patients/clients who are under your care (unless you have been authorized to otherwise do so in the course of work.)
- When coordinating care, care team members should share the minimum amount of PHI needed to improve outcomes or provide continuity of care for the client/patient.
- Prior to making any disclosures, staff shall verify the identity of the person requesting DPH PHI and the authority of any such person to have access to DPH PHI.
- All of these requirements apply to PHI in the Electronic Health Record ("EHR")

## Learning Objectives

By the end of the class you will learn how to:

- Log into Avatar and Navigate in CWS
- Use "Search for Option" and menu paths
- Manage home page, "My Favorites" and caseloads
- Read help messages
- Recognize "Required Fields" and different data entry options
  - Multiple Iteration Tabs
  - Dropdowns
  - Multiple Select Fields
- Save records in Draft, Pending Approval, and Final
- Co-sign assessments, treatment plans, and progress notes
- Find selected assessment types
  - Adult/Older Adult Assessments (MRD 90 with ANSA) (MH Adult providers)
  - CANS (MH/SA Child providers)
  - ASI assessment (SA providers)
- Enter Diagnoses (AXIS I-V) data
- Create a client treatment plan
- Define Problems, Goals, Objectives (SMART) and Interventions
- Access the treatment plan libraries and customize data entry
- Create a progress note
- Link a progress note to an existing treatment plan
- Use Progress Note Viewer to review progress note information

# AVATAR OVERVIEW

## Logging into WebConnect (Community Based Organizations)

### Welcome to The Department of Public Health's WebConnect Portal

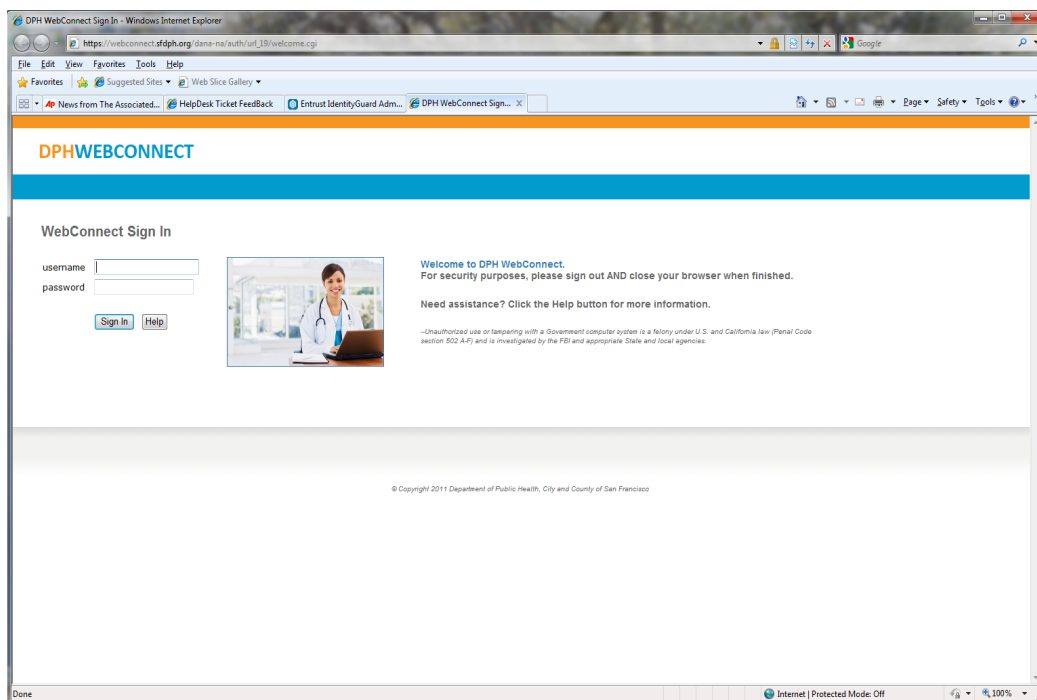
You have been issued a first time access password to activate your WebConnect account.

You will receive an e-mail with the temporary password.

Reminder: Please do not use SSL gateway from computers that have checkpoint VPN installed.

The URL for using WebConnect to access Avatar is below.

URL: **<https://webconnect.sfdph.org/partners>**





Upon first log in you will be asked to change your password.

Remember that passwords must contain at least a) one uppercase b) one lowercase letter c) one number and d) one special character. All passwords must be at least 10 characters long and may not contain your user name. The system will ask you to enter your new password twice to assure that no typos have occurred. In accordance with DPH policy you will be prompted to change your password every 90 days.

If you are logging in for the first time you will see the following screen

**DPH**WEBCONNECT



[What is this?](#) 

[Need help?](#)

Powered by Duo Security

## Protect Your SF Dept of Public Health Account

Two-factor authentication enhances the security of your account by using a secondary device to verify your identity. This prevents anyone but you from accessing your account, even if they know your password.


This process will help you set up your account with this added layer of security.


**Start setup**

After clicking on **“Start Setup”** you will be presented with the 3 choices below.

Please choose **“Mobil phone”**

**DPH**WEBCONNECT



[What is this?](#) 

[Need help?](#)

Powered by Duo Security

## What type of device are you adding?

☒ **Mobile phone** RECOMMENDED


☐ **Tablet** (iPad, Nexus 7, etc.)


☐ **Landline**

**Continue**

Choosing Mobile phone will take you to this screen

**DPHWEBCONNECT**





[What is this?](#) 

[Need help?](#)

Powered by Duo Security

### Enter your phone number

United States 

+1 (415) 555-1212 

ex: (201) 234-5678


☒ (415) 555-1212 This is the correct number


Back

Continue

After enter your cell phone number you will be asked to choose the type of phone. If you choose “Other (and cell phones)” you will be setting up to receive activation codes via text message.

**DPHWEBCONNECT**



[What is this?](#) 

[Need help?](#)

Powered by Duo Security

### What type of phone is (415) 555-1212 ?

☐ iPhone

☒ Android

☐ BlackBerry

☐ Windows Phone

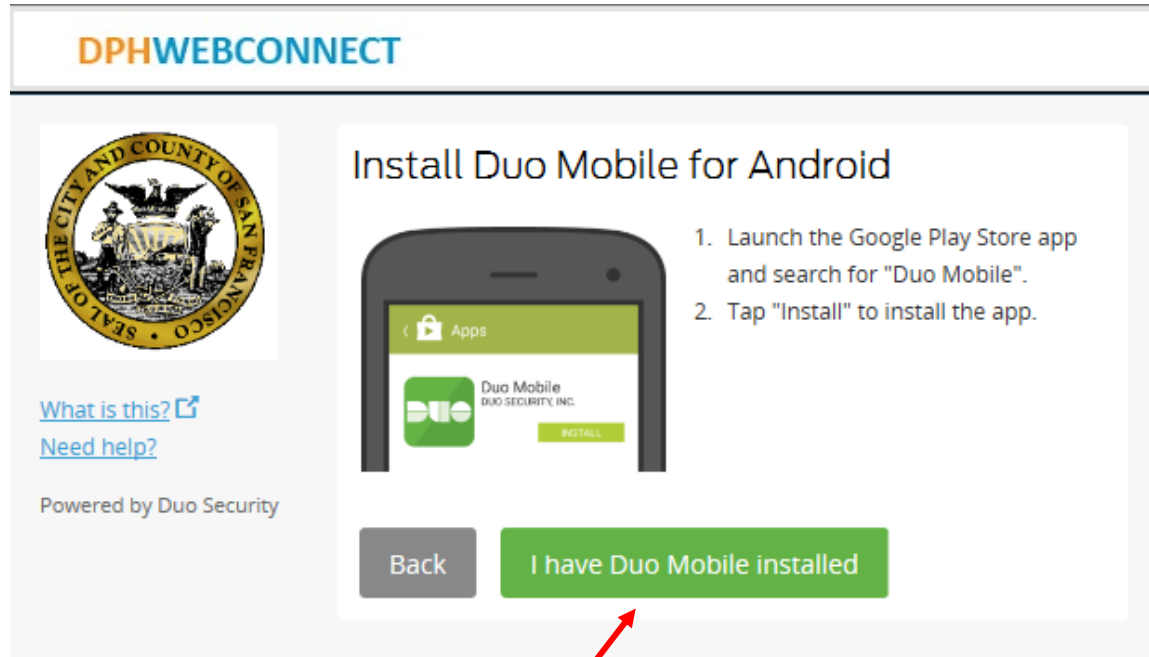
☐ Other (and cell phones)

Back


Continue



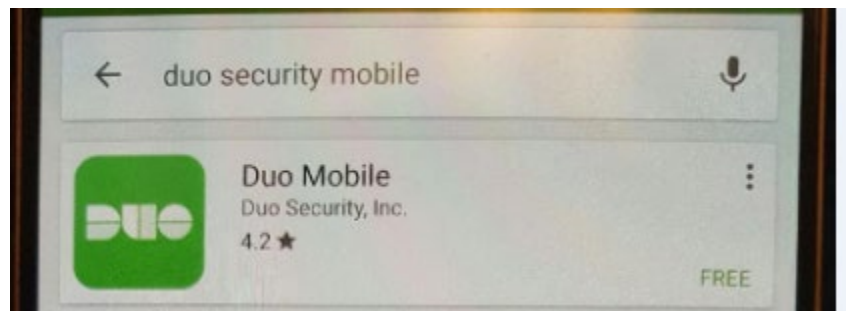
After selecting your phone type you will be asked install the appropriate mobile application



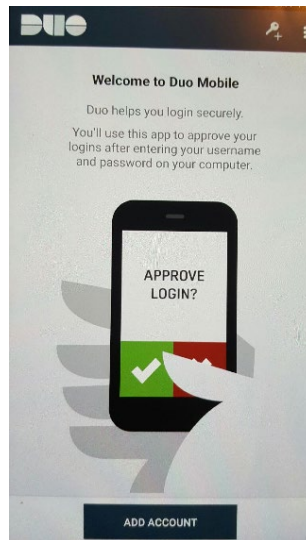
Click here **after the mobile app has been downloaded and installed.**

Go to the app store on your phone (Apple:  Android:  Google play)

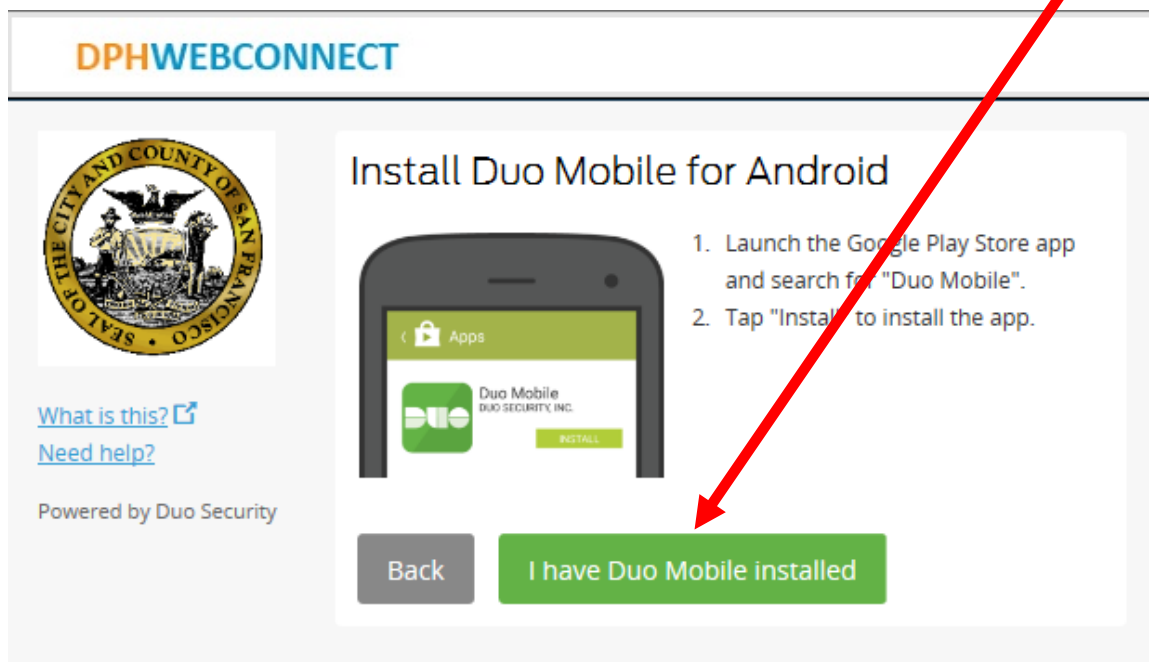
Search for mobile named "DUO SECURITY MOBILE" in your app store and install it.



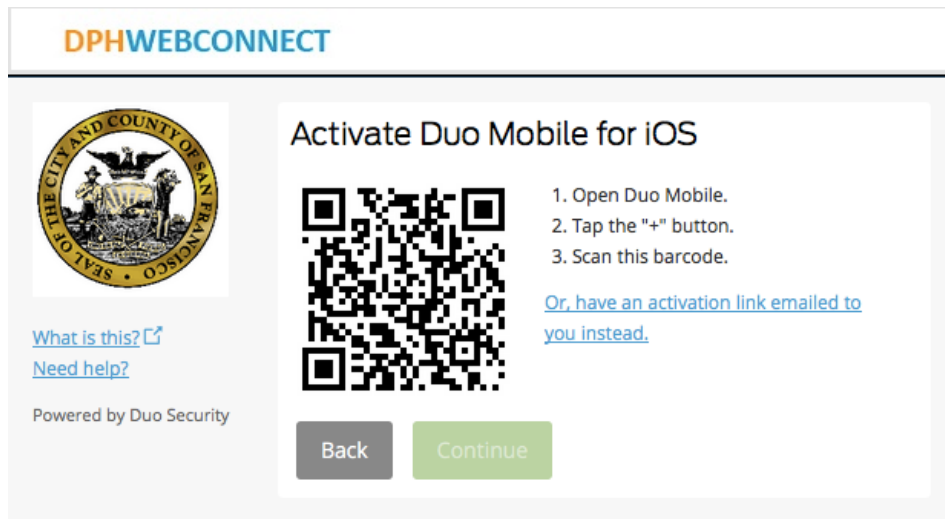
Once the app is installed on your mobile device, open it to get the following registration screen.



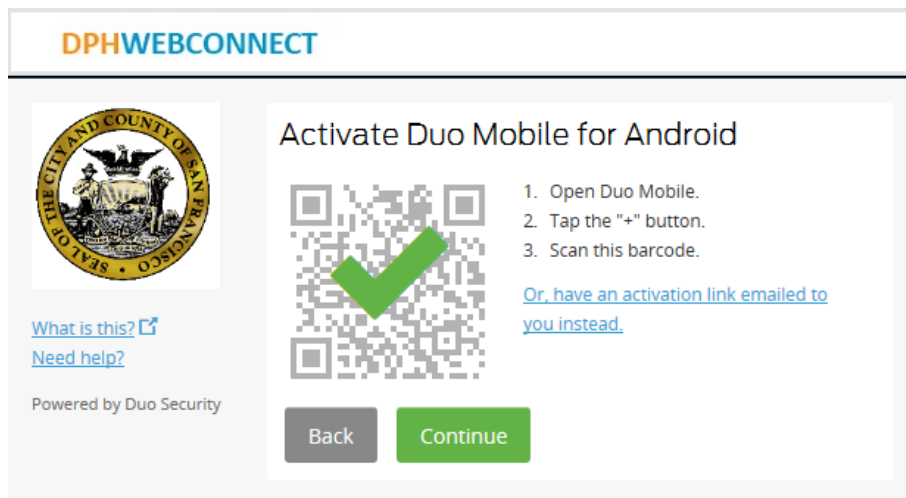
Click on “ADD ACCOUNT” and go back to your computer screen to click on “I have DUO Mobile Installed”.



Now (while DUO app is open on your phone) point your phone at the barcode displayed on your computer screen to activate DUO.




When you have successfully scanned the barcode, click Continue.



On completion of the setup you will see the following

Please Click on **“Save”** and then **“Continue to login”**

**DPHWEBCONNECT**




[What is this?](#) [Need help?](#)

Powered by Duo Security

## My Settings & Devices

My default device is:

Android (XXX-XXX-1212) 

☒ Automatically send me a:


☒ Duo Push

☐ Phone Call

This device can automatically receive a request when you need to log in with two-factor authentication.


**Save**

## My Devices

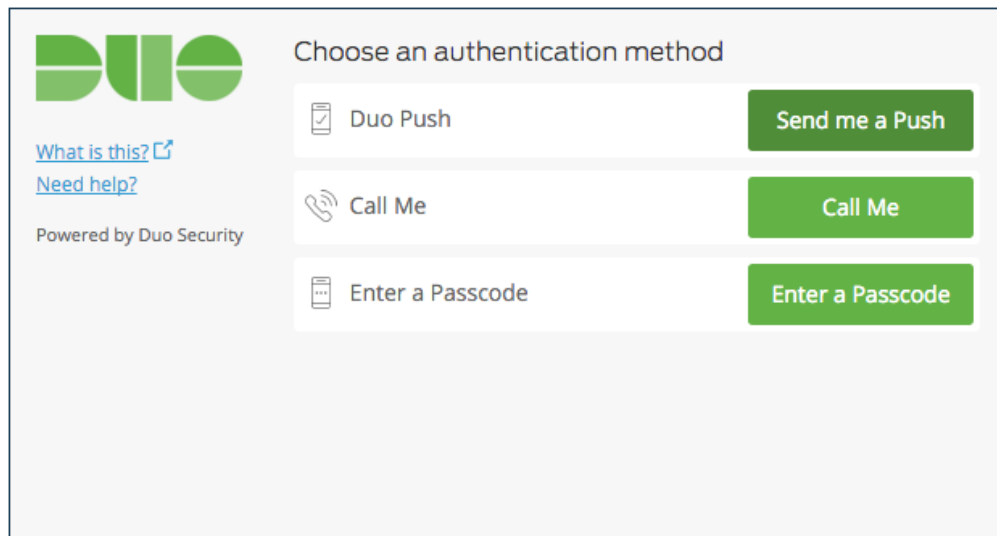
 Android (415) 555-1212

**Done**

Device successfully added!

**Continue to login** 

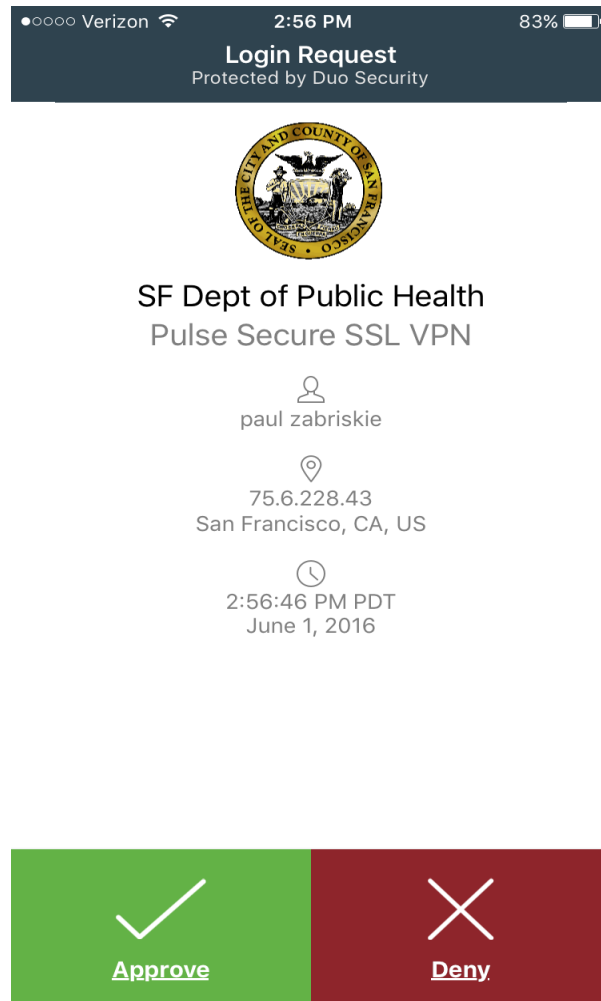
After you have gone through setup the first time you will see the following after login in.



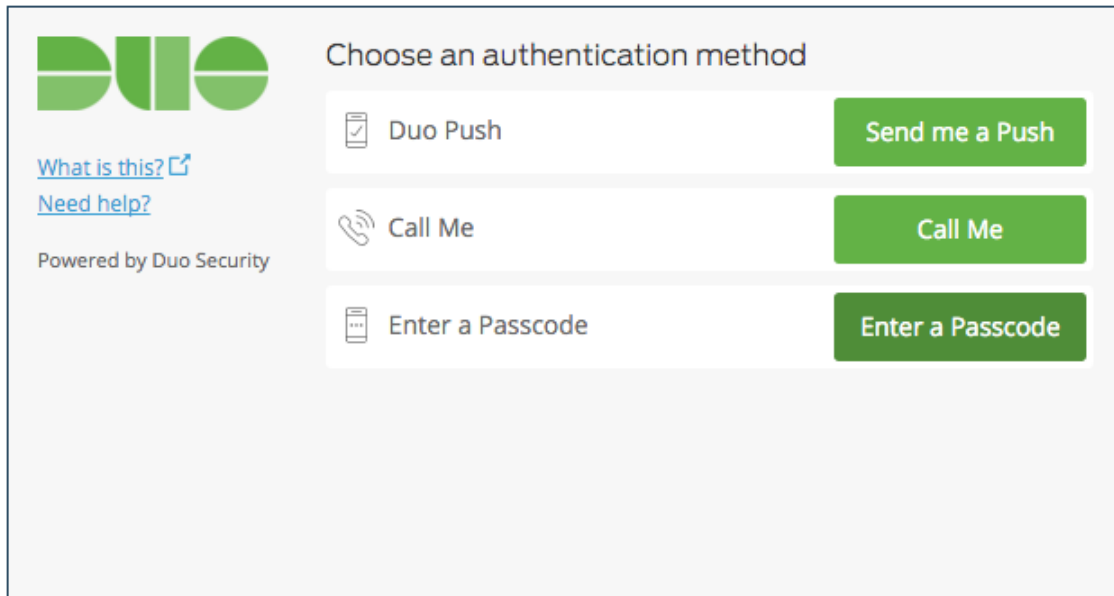
**Duo Push Authentication:** This is the recommended and easiest authentication method to use if you have a Smart Phone.

1. Click **Send me a Push**.
2. Press the green **Approve** box on your device to log in.
  - a. If you do not receive the Duo Push automatically, go into the Duo Mobile app and pull down to refresh

Your smart phone will display the following when you log on to WebConnect, click “Approve.”



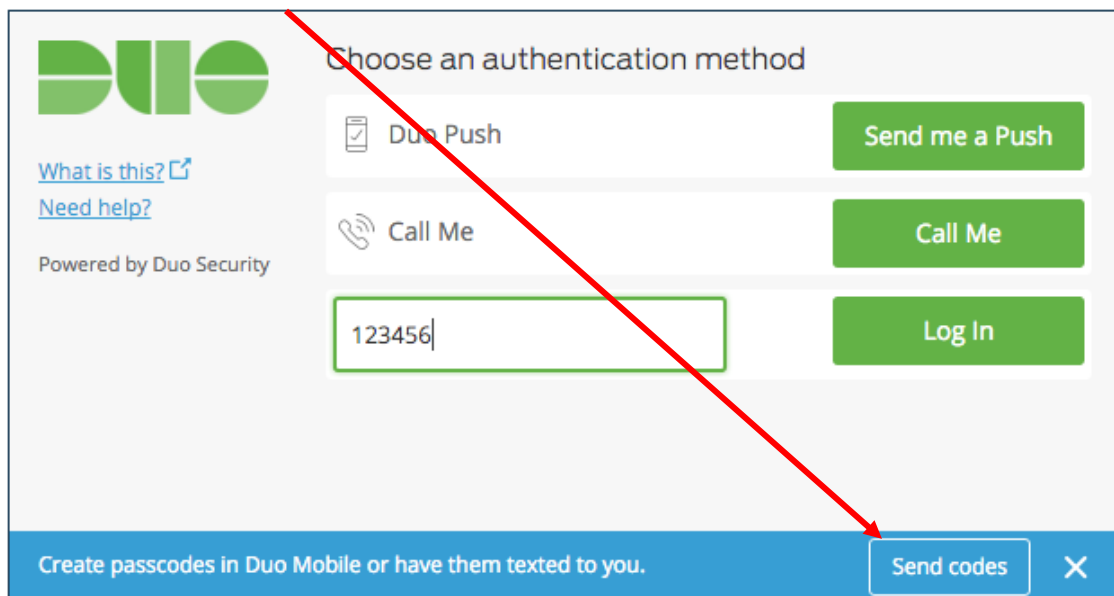
**Alternative Options for Authentication:** If you do not have a Smart Phone, or choose not to install the Mobile App, you have the option to Select **“Enter a Passcode”**



The image shows the Duo authentication interface. On the left is the Duo logo and links for 'What is this?' and 'Need help?'. The main heading is 'Choose an authentication method'. There are three rows of options, each with an icon, a label, and a green button:

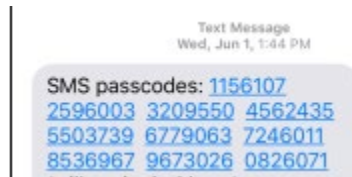
- Duo Push:** Icon of a smartphone with a checkmark. Button: 'Send me a Push'.
- Call Me:** Icon of a telephone handset. Button: 'Call Me'.
- Enter a Passcode:** Icon of a keypad. Button: 'Enter a Passcode'.

Now click on **“Send codes”**



This image shows the same Duo authentication interface as above, but with a passcode entered and a red arrow pointing to the 'Send codes' button. The 'Enter a Passcode' row now shows a text input field containing '123456' and a green button labeled 'Log In'. A red arrow originates from the top right of the interface and points down to the 'Send codes' button in the blue footer bar. The footer bar also contains the text 'Create passcodes in Duo Mobile or have them texted to you.' and a close icon (X).

In a few minutes, a text containing 10 passcodes will be sent to the cell phone that you setup previously. Any of the passcodes sent will work for an 80 hour period but each code may only be used once.



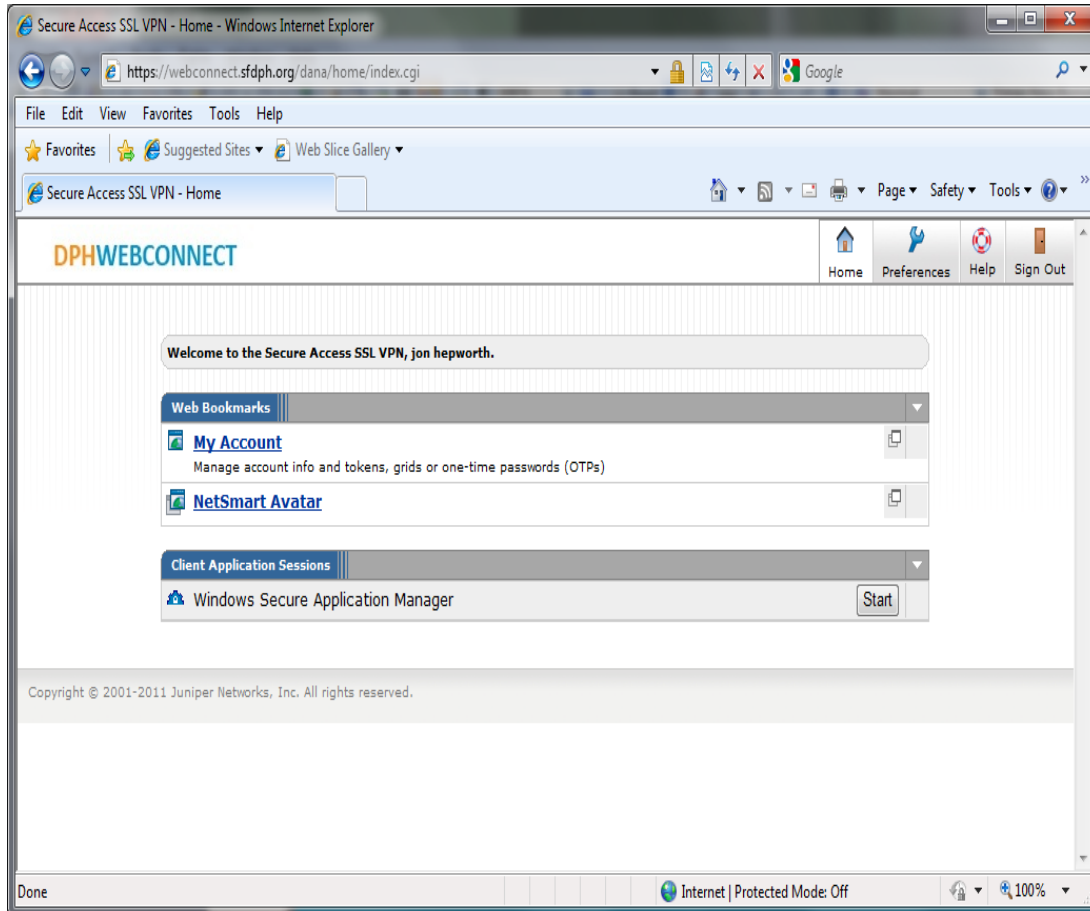
Enter **one** of the 10 **passcodes** sent in the text message and click on “**Log In**”

A screenshot of the Duo authentication interface. On the left is the Duo logo and links for "What is this?" and "Need help?". The main heading is "Choose an authentication method". There are three options: "Duo Push" with a "Send me a Push" button, "Call Me" with a "Call Me" button, and a text input field labeled "Enter your passcode (ex. 867539)". A red arrow points from the text input field to the "Log In" button. At the bottom, there is a blue bar with the text "Create passcodes in Duo Mobile or have them texted to you." and a "Send codes" button.

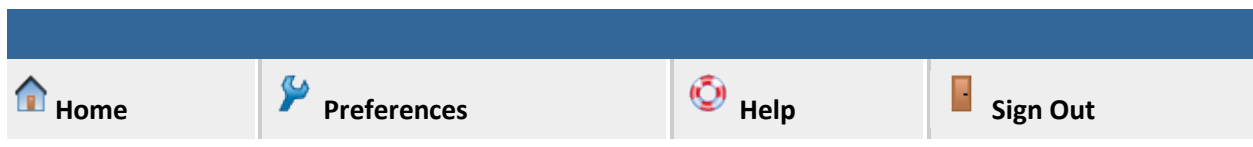
You will now proceed to your Home Page



## Your home page



Please note the 4 buttons on the upper right of your display



**Home** takes you back to your WebConnect Home page.

**Preferences** Takes you to a settings page that we advise that you leave as is.

**Help** Provides helpful tips on WebConnect Not on Avatar.

**Sign Out** closes your WebConnect session and logs you out.

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From your home page you click on The Netsmart Avatar Link to launch Avatar and Login to your Avatar account



Do not forget to logout of Avatar AND to Sign Out of WebConnect when you are done using the Avatar system.

Please be courteous to others and do not stay logged into to WebConnect and Avatar for extended periods of time when you are not actually using the system.



If you have any questions or difficulty logging in, call the Avatar Help Desk

Phone: (415) 255-3788

Email: [avatarhelp@sfdph.org](mailto:avatarhelp@sfdph.org)

Hours: Monday through Friday 8:00am to 5:00pm Pacific Time.

## Avatar Log in

### Logging into Avatar: Passwords

- Complex Passwords
- Must have at least
  - 1 upper case letter
  - 1 lower case letter
  - 1 number
  - 8 minimum and 16 maximum characters with no spaces
- Special characters (!@#\$%&\*) are NOT allowed
- Passwords must be re-set every six (6) months
- Protect your password as you protect your bank/ATM PIN number.

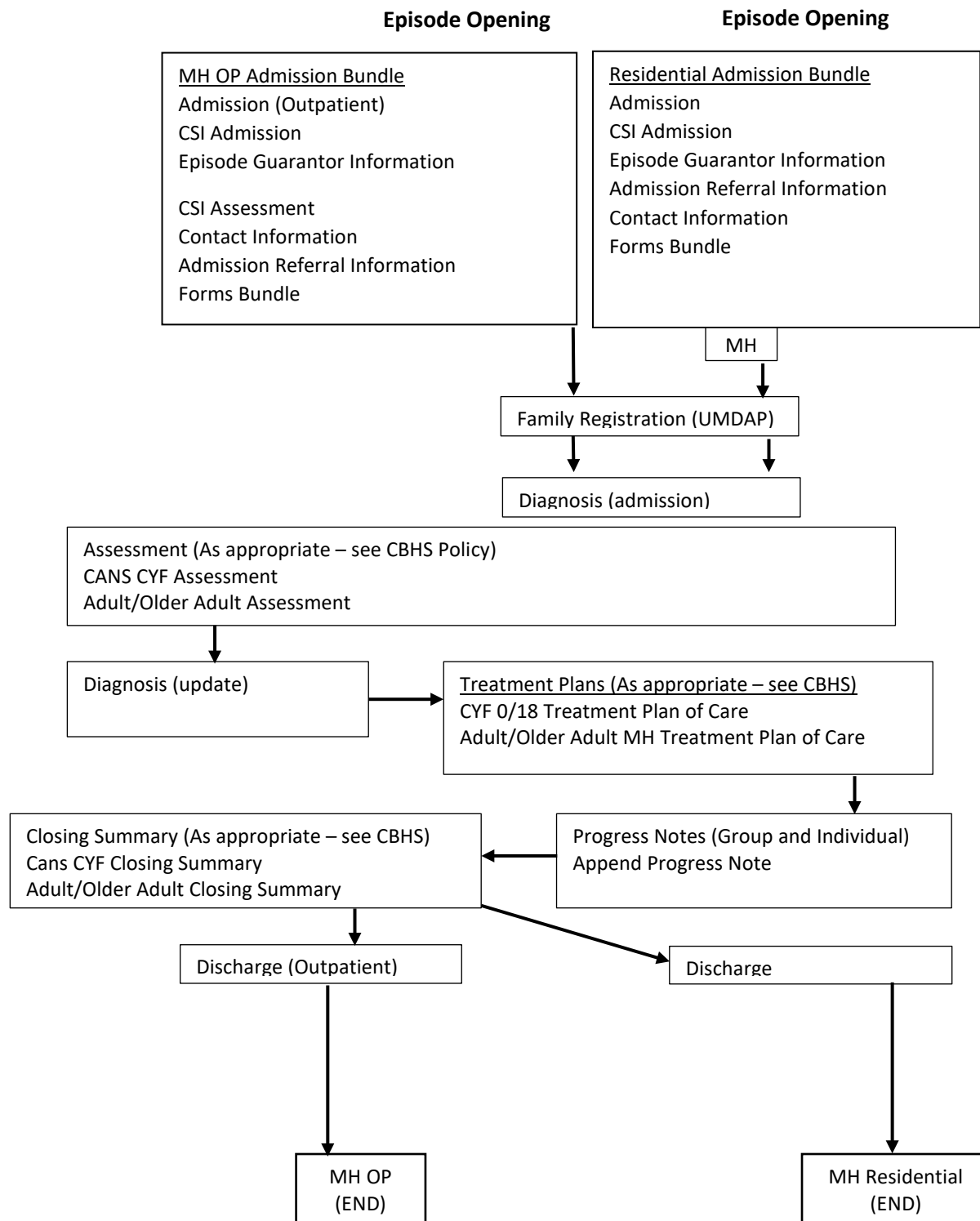
How can I remember my password?

- Substitute numbers or symbols for letters
- A favorite song title:  
Happy Birthday to You = H8pp1Birthd8y2u
  - Uses upper/lower case
  - "8" substituted for "a"
  - "1" substituted for "y"
  - "2" for "to"
  - "u" for "you"

## Avatar Modules

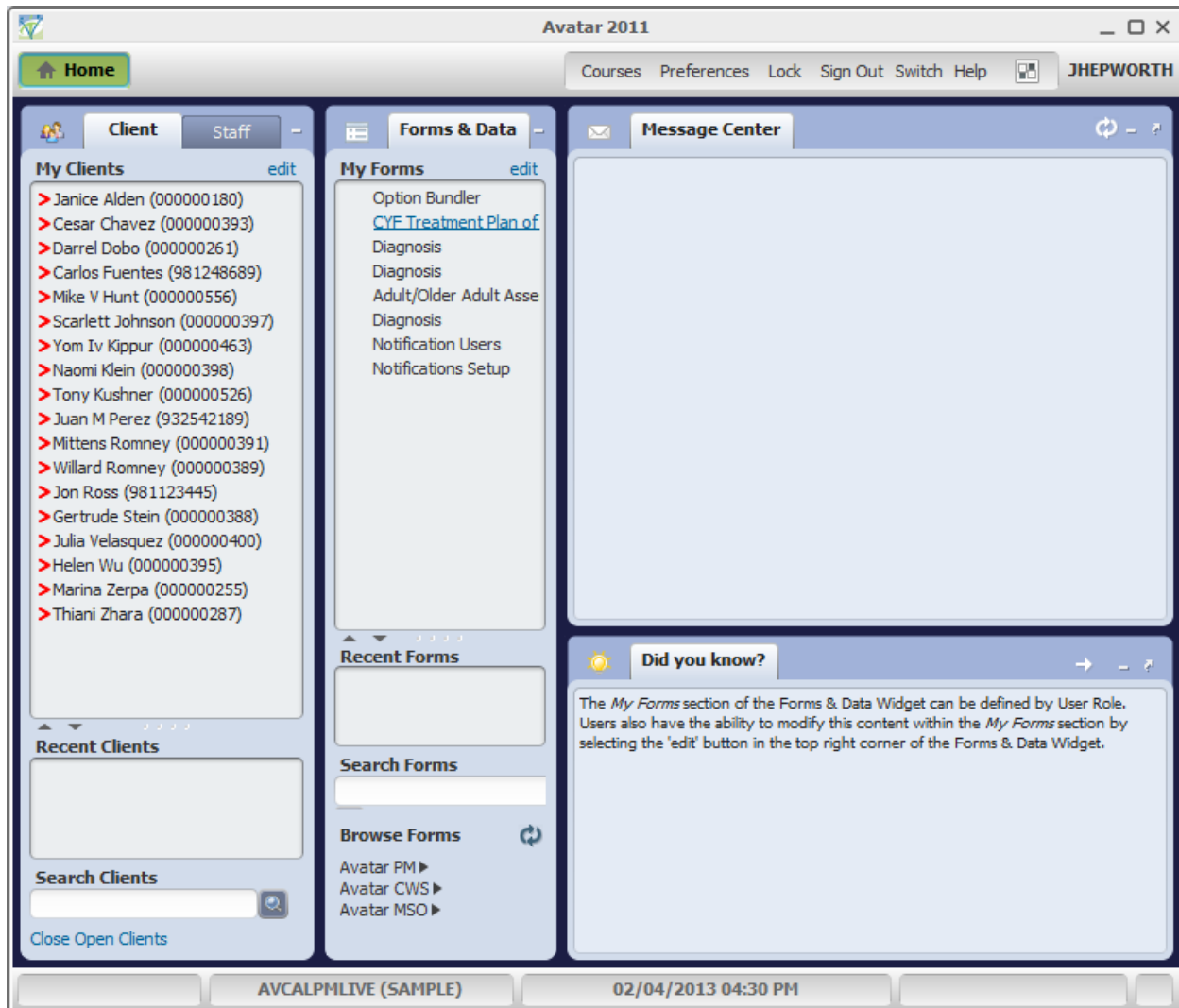
- PM – Practice Management
- CWS – Clinical Work Station
- MSO – MSO Managed Service Organization

## Avatar Work Flow




## Navigation


### Avatar Home View



## Avatar Chart View



**TESTCLIENTSUMMARY (000000001)**  
F, 35, 07/01/1980  
Ht: 5' 11.0", Wt: 280 lbs, BMI: 39

 Allergies (5)

Chart

Overview

**Adult Clinical**

- Initial Risk Assessment (A/OA)
- Adult/Older Adult Assessment (Short)
- Adult/Older Adult Assessment (Long)
- Diagnosis
- ANSA Outcomes Rating
- Adult/Older Adult Closing Summary
- Crisis Evaluation
- Adult/Older Adult MH Treatment Plan

**Adult Medical**

- Psychiatric Assessment Form
- Psychiatric Plan of Care
- ANSA Outcomes Rating
- Health Monitoring (Adult)

**Administrative**

- Admission (Outpatient)
- CSI Admission
- Episode Guarantor Information
- Admission Referral Information
- Contact Information
- Forms
- Update Client Data
- Discharge (Outpatient)
- MH Vocational Program Referrals / E

**Client Views**

- MHS 140

**CLIENT EPISODES**

Episode #	Program	Admission Date	Discharge Date
11	A Better Way-SF Outpatient (38GTOP)	2016-05-14	
10	SF Children MH AB3632 (38B13)	2016-04-27	2016-04-27
9	SFAF Stonewall Project-OP (89051)	2016-03-01	2016-04-06
8	Conard House Outpatient Services (89492)	2016-01-20	2016-03-14
7	AFS SF Therapeutic Visitation (38GSO1)	2016-01-12	
6	UCSF Primary Care Outreach (IPOCOM)	2015-11-23	2015-11-23
5	A BETTER WAY, INC. 0-5 OP (38GT05)	2015-05-01	2015-05-04
3	Fee for Service MFCC (38AP)	2015-02-28	
2	City College of San Francisco (38DM01)	2014-12-01	
1	ACCESS Screening	2010-07-01	

**Progress Notes**

Previous 30 days

Selection: All Notes

**BHAC Administrative - 04/22/2016 by Hans Anderson**

Individual Progress Notes

Progress Note For: New Service

Note Type: BHAC Administrative

Notes Field:

this is my ADM00 note

[Link page/return to Chart view](#)
[Current Medications, Lab Results, Vitals](#)

## Avatar eLinks

ELinks page/return to Chart view

Avatar eLinks

**CCMS Summary Page**  
Click here to see the patient's Coordinated Care Management System Summary.

**Enterprise Med List**  
We are unable to match your Avatar client to a DPH medical record number.

**Patient Membership**  
We are unable to match your Avatar client to a record in Patient Membership.

**CBHS Training Site**  
The Community Programs Training Unit offers several training programs that may help you with work and life.

**Invision/LCR**  
Invision/LCR

**DPH Provider Lookup**  
List of the DPH Providers

**Web Directory**  
DPH Staff

**Community Behavioral Health Services**  
Main page for Community Behavioral Health Services

ELinks page/return to Chart view
Current Medications, Lab Results, Vitals

## Current Medications, Labs, Vitals

Current Medications

Drug Name	Dosage	Start Date	End Date
RisperDAL	- 0.25 MG, Tablet, Oral (1)ea Three Times a Day	04/11/2016	05/10/2016
Benzotropine Mesylate	- 2MG, Tablet, Oral (1)ea Each Morning	09/17/2015	10/16/2015
fluPHENAZine HCl	- 5MG, Tablet, Oral (1)ea At Bedtime	09/17/2015	01/14/2016
Aspirin 81mg qAM	Non-prescribed, dosage unknown		
benazepril	Non-prescribed, dosage unknown		
carBAMazepine	Non-prescribed, dosage unknown		

Vitals

Recorded	BP (mmHg)	WT (lbs)	HT (in)	BMI
05/17/2015	130/85	280	71	39
09/17/2015	100/70	200	71	27.9
09/19/2015	135/85	290	71	40.4
02/04/2015	100/100	180	64.5	30.4
02/04/2015	1/1	123	71	17.2
06/03/2015	110/80	220	71	30.7
05/05/2015	130/95	250	71	34.9
04/08/2015	145/100	270	71	37.7
02/19/2015	141/191	0	0	0
02/19/2015	140/190	110	65.1	18.2

Lab Results

Name: TESTCLIENT\_SUMMARY ID: 000000001 Gender: Female DOB: 07/01/1980 Age: 35

Start Date: 05/17/2015 End Date: 05/16/2016 Filter By: No Filter Lab Test:

Lab Test	Collection Date	Results	Flag	Ref Range	Status	Clinician	Comments
Clonazepam (Klonopin)							
Clonazepam	04/11/2016	104 mU/L	A - Abnormal	12	A - Some, but not all	Berger, Reisel (10536)	Header: Detail:

ELinks page/return to Chart view
Current Medications, Lab Results, Vitals

---

# OVERVIEW OF EPISODE OPENING

## Admission Bundles

### MH Admission Outpatient Bundle

**(Path: Avatar PM/Client Management/Episode Management/MH Admission Outpatient Bundle)**

- Admission (Outpatient)  
(Path: Avatar PM/Client Management/Episode Management)
- CSI Admission  
(Path: Avatar PM/Client Management/Client Information)
- Episode Guarantor Information  
(Path: Avatar PM/Client Management/Account Management)
- CSI Assessment  
(Path: Avatar CWS/Assessments/Product Assessments)
- Admission Referral Information  
(Path: Avatar PM/Client Management/Client Information)
- Contact Information  
(Path: Avatar PM/Client Management/Client Information)
- Forms Bundle (not in bundle)  
(Path: Avatar PM/Client Management/Client Information)
- Diagnosis (not in bundle)  
(Path: Avatar PM)/Client Management/Client Information)

### MH Admission Residential Bed Mgmt Bundle

**(Path: Avatar PM/Client Management/Episode Management/MH Admission Residential Bed Mgmt Bundle)**

- Admission  
(Path: Avatar PM)/Client Management/Episode Management)
- CSI Admission  
(Path: Avatar PM)/Client Management/Client Information)
- Episode Guarantor Information  
(Path: Avatar PM)/Client Management/Account Management)
- Admission Referral Information  
(Path: Avatar PM)/Client Management/Client Information)
- Contact Information  
(Path: Avatar PM)/Client Management/Client Information)
- Forms (not in bundle)  
(Path: Avatar PM)/Client Management/Client Information)
- Diagnosis (not in bundle)  
(Path: Avatar PM)/Client Management/Client Information)



# ADMISSION BUNDLE FORMS

## Admission (Outpatient)

(Path: Avatar PM/ Client Management / Episode Management)

The screenshot shows the 'Admission (Outpatient)' form for a client named Carlos Fuentes. The form is divided into several sections. On the left, there is a sidebar with 'Admission', 'Demographics', and 'SF Additional Admission' tabs, along with a 'Submit' button and a set of icons. The main form area contains the following fields:

- Episode Number:** 1
- Client Name:** FUENTES, CARLOS
- Sex:** Male (selected)
- Date Of Birth:** 06/11/1952
- Age:** 60
- Preadmit/Admission Date:** 06/11/2012
- Preadmit/Admission Time:** 10:01 AM
- Program:** Westside Outpatient Clinic (89052)
- Type Of Admission:** First Admission
- Source Of Admission:** (empty dropdown)
- Presenting Problems-Secondary:** Attempt, Threat, Or Danger Of Homicide
- Presenting Problems-Tertiary:** (empty dropdown)
- Client's Living Arrangements:** (empty dropdown)
- Admitting Practitioner:** HEPWORTH, JON (050003)
- Attending Practitioner:** MUNOZ, PABLO (000031)
- Practitioner Type:** (empty dropdown)
- Facility Chart Number:** (empty dropdown)
- Social Security Number:** 236-84-9183
- Perform Discharge Alert:** Yes (selected)
- Type Of Alert:** Alert Parent/Guardian
- Disposition:** BHAC - Refer to Clinic
- Presenting Problems-Primary:** Alcohol + Drug Problems
- Disabilities-2:** Hearing (selected)

An arrow points from a text box at the bottom right to the Social Security Number field.

If client's social security number is unknown (or none), enter "000-00-0000".

Admission (Outpatient) - continued

Avatar 2011

Home

Carlos F

Courses

Preferences

Lock

Sign Out

Switch

Help

JHEPWORTH

**CARLOS FUENTES (981248689)**  
M, 60, 06/11/1952

Ep: 1 : Westside Out...  
Problem P: -  
DX P: 309.81 POSTTRA...

Location: homeless, San Fr...  
Attn. Pract.: MUNOZ,PABLO  
Adm. Pract.: HEPWORTH,JON

Allergies (0)

Chart

Admission (Outpatient)

Admission

Demographics

SF Additional Admission

Submit

0

Online Documentation

☐ Visual

☐ Hearing

☒ Speech

☐ Mobility

☐ Mental

☐ Developmentally Disabled

☐ Other

Disabilities-3

☐ None

☐ Visual

☐ Hearing

☐ Speech

☐ Mobility

☐ Mental

☐ Developmentally Disabled

☐ Other

Current Medications - 1

Current Medications - 2

Current Medications - 3

Received Copy Of Client Rights

☒ Yes

☐ No

Advanced Directive

☐ Yes

☒ No

Advanced Directive Note

Admission Note

Note/comment about client admission

Admission Department Time Out

Current Time

Hour

Minute

AM/PM

AVCALPLIVE (SAMPLE)

02/08/2013 09:43 AM

99%

## Admission (Outpatient) – continued

**CARLOS FUENTES (981248689)**  
M, 60, 06/11/1952  
Ep: 1 : Westside Out... Location: homeless, San Fr...  
Problem P: - Attn. Pract.: MUNOZ,PABLO  
DX P: 309.81 POSTTRA... Adm. Pract.: HEPWORTH,JON

Chart Admission (Outpatient)

**Admission**  
**Demographics**  
SF Additional Admission

Submit

Online Documentation

Client Last Name: FUENTES  
Client First Name: CARLOS  
Client's Middle Initial:   
Suffix:   
Prefix:   
Client's Address - Street: homeless  
Client's Address - Street 2:   
Client's Address - Zipcode: 94103-2649  
Client's Address - City: San Francisco  
Client's Address - County: San Francisco  
Client's Address - State: CALIFORNIA  
Client's Home Phone:   
Client's Work Phone:   
Client's Cell Phone: 415-123-4567  
Communication Preference:   
Regular Mail   
Home Phone   
Work Phone   
Cell Phone   
Primary Language: Spanish  
Client Race: Other Race  
Ethnic Origin: Mexican/Mexican American  
Religion: Unknown  
Place Of Birth: Panama City, Panama  
Country Of Origin: Mexico  
Maiden Name:   
Marital Status: Single / Never Married  
Education: 16 Years  
Employment Status: Not In Labor Force - Other Not ...  
Where do you go to receive Medical Services?  
Select from the drop down list below  
VA Medical Center

If Client is homeless, enter "homeless" in Address Line 1. Leave Address Line 2 blank. Then, add 9-digit zip code, city, county and state that correspond to program. See USPS.com to match zip code to address.

DO NOT enter special characters. For example:

1380 Howard St Apt 300

Primary Language is required. If this is not known, select "unknown".

## Admission (Outpatient) - continued

The screenshot shows the 'Admission (Outpatient)' form. On the left is a sidebar with 'Admission' and 'Demographics' sections. The main form area contains the following fields:

- Marital Status:** Not Married
- Education:** 19 Grade
- Employment Status:** "Unemployed, actively seeking ..."
- Occupation:** Extractive Occupations
- Smoker:** Former Smoker
- Alias:** MUNOZ, PABLO
- Alias 2:**
- Alias 3:**
- Alias 4:**
- Alias 5:**
- Primary Care Practitioner:** Voerler
- Practitioner Phone Number:** 415-255-3712
- Primary Care Notes (Old Primary Care Physician/Contact fi):** Primary Care notes box
- Select Team:**
- Is this the client's Health Home?:** Yes (selected), No

Two red arrows point from text boxes below to specific fields: one to the 'Smoker' dropdown and another to the 'Primary Care Practitioner' dropdown.

Note that "Smoker" status is required for reasons of "Meaningful Use".

Below is required question on client's primary care provider.

Admission (Outpatient) - continued

Online Documentation

Client Declined To Provide Information On The Following

☐ Ethnic Origin☐ Race☐ Language

Mother's Maiden Name

Mom

Protection Indicator

☐ Yes☐ No

Protection Indicator Effective Date

T

Y

Name Qualifier

☐ Keep Private☐ Unspecified

Smoking Status Assessment Date

04/07/2015

T

Y

Note that date of smoking status assessment is required.

## CSI Admission

(Path: Avatar PM/ Client Management / Client Information)

The screenshot shows a web-based form titled "CSI Admission" with a sidebar on the left and a main form area. The sidebar includes a "Submit" button and a section for "Online Documentation" with icons for adding documents. The main form area is divided into several sections for data entry:

- Birth Name (Last):** A text field containing "TEST".
- Birth Name (First):** A text field containing "KIMBERLY".
- Birth Name (Middle):** An empty text field.
- Birth Name (Suffix):** A section with radio buttons for "Sr", "Jr", "III", "IV", "V", and "VI".
- Mother's First Name:** A text field containing "MOTHER".
- Fiscally Responsible County For Client:** A dropdown menu with "San Francisco" selected.
- Place of Birth - County:** A dropdown menu with "Not California County" selected.
- Place of Birth - State:** A dropdown menu with "Arizona" selected.
- Place of Birth - Country:** A text field containing "United States" with a location pin icon.
- CSI Ethnicity:** A section with radio buttons for "Not Hispanic or Latino", "Unknown / Not Reported" (selected), and "Hispanic or Latino".
- Special Population:** A section with radio buttons for "Assisted Outpatient Treatment service(s) (AB 1421)", "(AB 3632) Individualized education plan (IEP) required service(s)", "Governor's Homeless Initiative (GHI) service(s)", "No special population services" (selected), and "Welfare-to-work plan specified service(s)".
- Legal Class:** A dropdown menu with "Voluntary" selected.
- County School:** An empty text field.
- Admission Necessity Code:** A section with radio buttons for "Emergency", "Planned (Prior Authorization)" (selected), and "Unknown/Not Reported".

CSI Admission – Continued

# of Dependents (Children or Adult) is 0-98. Unknown = "99"

Chart CSI Admission

CSI Admission

Submit

Online Documentation

Is Substance Abuse Affecting Mental Health?

☒ Yes ☐ No ☐ Unknown

Are Developmental Disabilities Affecting Mental Health?

☐ Yes ☐ No ☒ Unknown

Are Physical Health Disorders Affecting Mental Health?

☐ Yes ☒ No ☐ Unknown

Conservatorship/Court Status

☐ Temporary Conservatorship

☐ Lanterman-Petris-Short

☐ Murphy

☐ Probate

☐ PC 2974

☐ Representative Payee Without Conservatorship

☐ Juvenile Court, Dependent of the Court

☐ Juvenile Court, Ward - Status Offender

☐ Juvenile Court, Ward - Juvenile Offender

☐ Not Applicable

☒ Unknown/Not Reported

Preferred Language

English

Race (Select Up To Five)

☒ Asian Indian

☒ Black or African American

☐ Cambodian

Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time

3

Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time

99

Year Or Month/Year Of Birth

12/1988

## CSI Assessment

Chart

CSI Assessment

CSI Assessment

First Contact

Assessment Appointment

Assessment Start / End

Treatment Appointment

Treatment Start / Closure

Submit

Online Documentation

First Contact

Date Of First Contact To Request Services

T

Y

Referral Source

Assessment Appointment

Assessment Appointment First Offer Date

T

Y

Offer Dates must be entered in chronological order.

Assessment Appointment Second Offer Date

T

Y

Accepted Date must be equal to 1st / 2nd / 3rd Offer Date  
OR any date later than 3rd Offer Date

Assessment Appointment Third Offer Date

T

Y

Assessment Appointment Accepted Date

T

Y

Assessment Start / End

Assessment Start Date

T

Y

Assessment End Date

T

Y

Treatment Appointment

Treatment Appointment First Offer Date

T

Y

Offer Dates must be entered in chronological order.

Treatment Appointment Second Offer Date

T

Y

Accepted Date must be equal to 1st / 2nd / 3rd Offer Date  
OR any date later than 3rd Offer Date

Treatment Appointment Third Offer Date

T

Y

Treatment Appointment Accepted Date

T

Y

Treatment Start / Closure

Treatment Start Date

T

Y

Closure Reason

Beneficiary did not accept any offered assessment dates.

Beneficiary accepts offered assessment date but did not attend initial assessment appointment.

Beneficiary attends initial assessment appointment but did not complete assessment process.

Beneficiary completes assessment process but declines offered



## Episode Guarantor Information

(Path: Avatar PM / Client Management / Account Management)

Avatar 2011

Home Carlos F Courses Preferences Lock Sign Out Switch Help JHEPWORTH

**CARLOS FUENTES (981248689)**  
M, 60, 06/11/1952

Ep: 1: Westside Out... Location: homeless, San Fr...  
Problem P: - Attn. Pract.: MUNOZ,PABLO  
DX P: 309.81 POSTTRA... Adm. Pract.: HEPWORTH,JON

Allergies (0)

Chart Episode Guarantor Information

**Episode Guarantor Information**

Medi-Cal  
Medicare  
SF Health Access Program  
Patient Fee Liability  
Private Health Insurance  
San Francisco Health Plan  
Other Funding Sources  
Assignment of Benefits, R...

Submit

Client Name: FUENTES, CARLOS  
Subscriber's Social Security Number: 236-84-9183  
Date of Birth: 06/11/1952

Submission Type: ☒ New Eligibility Record ☐ Update an Existing Record

Program Type: ☒ Mental Health ☐ Alcohol Drug Program

Date of Entry / Update: 02/11/2013  
Change Effective Date:

Benefit Coverage:

- ☒ Medi-Cal
- ☐ Medicare
- ☐ SF Health Access Program
- ☒ Patient Fee Liability
- ☐ San Francisco Health Plan
- ☐ Private Health Insurance
- ☐ Other Funding Sources

**Medi-Cal**

Medi-Cal: ☒ Share-of-Cost ☐ Full Scope ☐ Restricted ☐ Out-of-County

Medi-Cal ID Number / CIN: 1234567890  
Coverage Effective Date: 02/11/2013  
Termination Date:

Out-of-County Name:

**Medicare**

Medicare: ☐ Part A: Hospital ☐ Part B: Outpatient ☐ Part C: HMO Plan ☐ Part D: Pharmacy


Medicare ID or HIC Number:  
Coverage Effective Date:  
Termination Date:

Authorization Number:

AVCALPMLIVE (SAMPLE) 02/11/2013 09:24 AM 99%

## Contact Information

(Path: Avatar PM / Client Management / Client Information)



**CARLOS FUENTES (981248689)**  
M, 60, 06/11/1952

Ep: 1 : Westside Ou...      Location: homeless, San F...

Problem P: -      Attn. Pract.: MUNOZ,PABLO

DX P: 309.81 POSTTR...      Adm. Pract.: HEPWORTH,JON

^ Allergies (0)

Chart

**Contact Information**

Client Information

**Contact Information**

Submit

**Contact Information**

Name	Contact Relationship to Client	Primary Cont...	Contact Living with Client	Contact Addr...	Contact...	Contact ..
mcgregor,fred	Provider	No		840 Haight st		
fuentes,daisy	Brother-In Law	Yes				

**Name**

**Contact Relationship to Client**

☐ Aunt  
☒ Brother-In Law  
☐ Brother

**Primary Contact**

☒ Yes      ☐ No

**Contact Living with Client**

☐ Yes      ☐ No

**Contact Address**

**Contact City**  
  
**Contact State**

**Contact Zip Code**   
**Contact Home Phone**   
**Contact Work Phone**   
**Contact Cell Phone**

**Comments**

Daisy can be found riding skateboard on larkin side of sfpl main wed 5-8:30pm.

## Admission Referral Information

(Path: Avatar PM / Client Management / Client Information)

The screenshot displays the Avatar 2011 software interface. At the top, the user is logged in as Jenny A. The main header shows the patient's name, JENNY AVATARNETSMART (000000001), and her date of birth, F, 35, 05/03/1977. The patient's location is 1380 Howard St... and the primary referral source is VOELKER, KIMBE... The patient's problem is listed as 1: ACCESS Scr... and the primary referral source category is Mental Health. The patient's phone number is 415-352-2000. The patient's state is CALIFORNIA. The patient's city is San Francisco. The patient's zip code is 94133. The patient's agency is Chinatown North Beach. The patient's street address is 729 Filbert Street. The patient's street address 2 is blank. The patient's contact is blank. The patient's allergies are listed as 1: THIS IS A TEST CLIENT !!!!! DO NOT USE. The patient's chart is available. The patient's admission referral information is being viewed. The patient's primary referral source is Chinatown North Beach. The patient's primary referral source category is Mental Health. The patient's primary referral source specialty is Mental Health. The patient's primary referral source phone number is 415-352-2000. The patient's primary referral source agency is Chinatown North Beach. The patient's primary referral source street address is 729 Filbert Street. The patient's primary referral source street address 2 is blank. The patient's primary referral source zipcode is 94133. The patient's primary referral source city is San Francisco. The patient's primary referral source state is CALIFORNIA. The patient's primary referral source contact is blank.

Avatar 2011

Home Jenny A Courses Preferences Lock Sign Out Switch Help JHEPWORTH

JENNY AVATARNETSMART (000000001)  
F, 35, 05/03/1977  
Ep: 1: ACCESS Scr... Location: 1380 Howard St... 1. THIS IS A TEST CLIENT !!!!! DO NOT USE  
Problem P: - Attn. Pract.: No Entry  
DX P: 300.11 CONVER... Adm. Pract.: VOELKER, KIMBE...

Chart Admission Referral Information

Primary Referral

- Secondary Referral
- Other Referral - 1
- Other Referral - 2

Submit

Primary Referral Source Code  
Chinatown North Beach

☒ ID Number  
☐ Name  
☐ Referral Source Category Code

Primary Referral Source Category  
Chinatown North Beach MH OP ..

Primary Referral Source - Specialty  
Mental Health

Primary Referral Source - Phone  
415-352-2000

Primary Referral Source - Agency  
Chinatown North Beach

Primary Referral Source - Street Address  
729 Filbert Street

Primary Referral Source - Street Address 2

Primary Referral Source - Zipcode  
94133

Primary Referral Source - City  
San Francisco

Primary Referral Source - State  
CALIFORNIA

Primary Referral Source - Contact

Online Documentation

## Forms Bundle

(Path: Avatar PM / Client Management / Client Information)

The following forms are available in order to collect client signatures electronically:

- Consent for BHS MH/SUD Services
- HIPAA Form
- Acknowledgemtn of Receipt of Materials
- Billing Authorization
- PFI Signature
- Advance Beneficiary Notice of Non-coverage

**Other form (not in the bundle)**

- **PHI Authorization**
- **Medication Consent**

**Consent for BHS MH/SUD Services**

**Consent**

**Submit**

**Generate Form in Selected Language**  
English

**Consent Date**  
02/23/2021

**Is client currently a minor?**  
☐ Yes ☐ No

**Participation**  
☐ Client/Parent/Other Agrees to Sign  
☐ Client/Parent/Other Refuses to Sign  
☐ Signature on Paper

**Client/Parent/Other Signature**  
  
**Click Here to Sign**

**Relationship to Client (if not client)**

**Witness 1: Name and Title**  
  
**Witness 1: Signature**  
  
**Click Here to Sign**

**Witness 2: Name and Title**  
  
**Witness 2: Signature**  
  
**Click Here to Sign**

**Is minor emancipated?**  
☐ Yes ☐ No

**Emancipated Subvalues**  
☐ Minor is married/has been married  
☐ Minor is on active duty w/US armed svcs  
☐ Minor is 14/older, emancipated by court

**Is minor 15 years of age/older and self-sufficient?**  
☐ Yes ☐ No

**Self-Sufficient Subvalues**  
☐ Living separate from parents/guardian  
**Place of residence of minor**  
  
**Place of residence of parents/guardian**  
  
☐ Managing own financial affairs  
**Place of bank account**  
  
**Place of employment**  
  
**Other source of financial support**

**Minor Signature**

# ADMISSION DIAGNOSIS

## Diagnosis

(Path: Avatar PM/ Client Management/ Client Information)

The screenshot shows the 'Diagnosis' form in the Avatar PM system. The form is divided into several sections:

- Left Sidebar:** Contains a 'Diagnosis' tab, a 'Submit' button, and a section for 'Online Documentation'.
- Top Section:** Includes 'Type Of Diagnosis' with radio buttons for 'Admission', 'Discharge', 'Onset', and 'Update'. It also has dropdowns for 'Select Episode To Default Diagnosis Information From' and 'Select Diagnosis Entry To Default Information From'.
- Date and Time Section:** Includes 'Date Of Diagnosis' with a date picker and 'Time Of Diagnosis' with a time picker and 'Current' button.
- Diagnoses Table:** A table with columns: Ranking, Description, Status, Estimated Onset, Classification, Resolved, Bill Order, ICD-9 Code, and ICD-10. Below the table are 'New Row' and 'Delete Row' buttons.
- Search and Crossmapping Section:** Includes a 'Diagnosis Search' field and a 'Code Crossmapping' section.

When you select “Admission” the date of admission will default into the “Date of Diagnosis” field.  
Diagnoses should be entered from most prevalent to least prevalent.

## Diagnosis by Client Report

(Path: Avatar CWS / Assessments / User Defined Assessments)

Diagnosis by Client Rep...

Select Client: TESTCLIENT,SUMMARY (1)

Episode

Episode # 1 Admit: 07/01/2010 Discharge: NONE Program: ACCESS Screening  
 Episode # 2 Admit: 12/01/2014 Discharge: NONE Program: City College of San Francisco (38MD1)  
 Episode # 3 Admit: 02/28/2015 Discharge: NONE Program: Fee for Service MFCC (38AP)  
 Episode # 5 Admit: 05/01/2015 Discharge: 05/04/2015 Program: A BETTER WAY, INC. 0-5 OP (38GT05)  
 Episode # 6 Admit: 11/23/2015 Discharge: 11/23/2015 Program: UCSF Primary Care Outreach (IPCOM)  
 Episode # 7 Admit: 01/12/2016 Discharge: NONE Program: AFS SF Therapeutic Visitation (38G501)  
 Episode # 8 Admit: 01/20/2016 Discharge: 03/14/2016 Program: Conard House Outpatient Services (89492)  
 Episode # 9 Admit: 03/01/2016 Discharge: 04/06/2016 Program: SFAF Stonewall Project-OP (89051)



San Francisco Department of Public Health  
Community Behavioral Health Services

### Diagnosis by Client Report TESTCLIENT,SUMMARY (1) ACCESS Screening Episode 1 - Admission date 7/1/2010

#### Confidential Patient Information

Date of Diagnosis: 2/19/2016

Type of Diagnosis: Update

Rank	Description	Diagnosing Practitioner	Status	Class	Bill Order	D SM-IV/ ICD-9	D SM-5/ ICD-10
Primary	Depression emotion	MUNOZ,PABLO (012170)	Active		1	311	F32.9
Axis IV Primary Support Group		No Entry	Axis IV Housing		No Entry		
Axis IV Social/Environmental		No Entry	Axis IV Economic		No Entry		
Axis IV Educational		No Entry	Axis IV Health Care Services		No Entry		
Axis IV Occupational		No Entry	Axis IV Legal System/Crime		No Entry		

Date of Diagnosis: 2/4/2016

Type of Diagnosis: Admission

Rank	Description	Diagnosing Practitioner	Status	Class	Bill Order	D SM-IV/ ICD-9	D SM-5/ ICD-10
Primary	Depressed	VOELKER,KIM BERLY (000089)	Active		1	311	F32.9

# TRANSFER CASELOAD

## Transfer Practitioner Caseload

(Path: Avatar PM/System Maintenance/Practitioner maintenance)

This form is used by supervisors to transfer cases from one clinician to another.

The screenshot shows the 'Avatar 2011' web application interface. The top navigation bar includes 'Home', 'Transfer Practi' (highlighted), 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', and 'Help'. The main content area is titled 'Transfer Practitioner Caseload'. On the left, there is a sidebar with a 'Transfer Practitioner Ca...' link, a 'Submit' button, and a section for 'Online Documentation' with icons for a folder, a printer, a document, a red 'X', a person, and a star. The main form area contains the following fields:

- Caseload Type:** Two radio buttons: 'Admitting Practitioner Caseload' (selected) and 'Attending Practitioner Caseload'.
- Transfer Caseload From:** A text field containing 'NAN DAME (000006)' with a search icon.
- Individual Or All Clients:** Two radio buttons: 'All' and 'Individual' (selected).
- Select Clients To Transfer:** A button.
- Transfer Caseload To:** A text field containing 'AVATAR02 TEST (000085)' with a search icon.
- Effective Date Of Transfer:** A date picker with 'T' and 'Y' buttons.
- Effective Time Of Transfer:** A time picker with 'Current', 'H', 'M', 'AM/PM', and a search icon.

Transfer Practitioner Caseload – continued

Avatar 2011 - Transfer Practitioner Caseload

Practitioner: DAME,NAN(000006)

Caseload Type: Admitting Practitioner Caseload

Client	Episode	Program	Admit Date
<input type="checkbox"/> 981241834	ALTERMAN, ERIC	2	Walden House Multi Service 07/19/2012
<input type="checkbox"/> 450	AMOS, TERRY IV	1	Westside Outpatient Clinic 09/24/2012
<input type="checkbox"/> 451	AMOS, TERRY MR	1	Westside Outpatient Clinic 09/24/2012
<input type="checkbox"/> 313	AMOS, TORI SR MR	2	Westside Outpatient Clinic 09/24/2012
<input checked="" type="checkbox"/> 574	APPLE, GRAPE MS	1	Bay Psychiatric Associate 01/08/2013
<input checked="" type="checkbox"/> 411	APPLESEED, JOHNNY	1	Westside Outpatient Clinic 09/11/2012
<input checked="" type="checkbox"/> 375	ARTOIS, STELLA VI DR	1	Westside Outpatient Clinic 08/07/2012
<input type="checkbox"/> 582	ARYASINGHA, CHANELLE	1	Westside Outpatient Clinic 01/01/2013
<input type="checkbox"/> 386	ASH, MATTHEW JR	2	Westside Outpatient Clinic 12/19/2012
<input type="checkbox"/> 532	AVATAR, CRYSTAL	1	Bay Psychiatric Associate 12/05/2012
<input type="checkbox"/> 531	AVATAR, DIANA	1	Bay Psychiatric Associate 12/05/2012
<input type="checkbox"/> 527	AVATAR, HELEN	1	FFS-Jewish Family and Chil 12/05/2012
<input checked="" type="checkbox"/> 533	AVATAR, JOHN	1	Bay Psychiatric Associate 12/05/2012
<input type="checkbox"/> 529	AVATAR, KENDRA	1	Walden House Multi Service 12/05/2012
<input type="checkbox"/> 528	AVATAR, SHOBNA	1	Bay Psychiatric Associate 12/05/2012
<input checked="" type="checkbox"/> 577	AZIZPEARSON, ISHMAEL	1	Westside Outpatient Clinic 01/09/2013
<input type="checkbox"/> 335	BACCHUS, FRANK	2	Bay Psychiatric Associate 11/14/2012

OK Cancel



# CHILD, YOUTH, AND FAMILIES (CYF)

## CANS CYF 6 thru 20 Assessment

(Path: Avatar CWS/Assessments/User Assessments/CANS 2.0)

**Chart** CANS CYF 6 thru 20 Assessment

**1 - Presentation**

- 2 - Trauma/Abuse
- 3 - Risk Behaviors
- 4 - Impact on Functioning
- 5 - Relevant History
- 6 - Child Strengths
- 7 - Caregiver Strengths
- 8 - Additional Caregivers
- 9 - Provider History
- 10 - Medical/Psychiatric
- 11 - Medication
- 12 - Developmental
- 13 - Formal Services/Interventions
- 14 - Mental Status Examination

**Date**  
02/23/2021

**Assessment Category**  
☐ Initial ☐ Mid Year ☐ Annual ☐ Closing  
☐ Screen

Click "Yes" to launch the CSI Assessment form and record the "Assessment Start Date".  
☐ Yes ☐ Not Applicable to My Program

I would like to start with a blank assessment.  
☐ Yes

**Sources of Information**  
☐ Client ☐ Family/Guardian  
☐ DHS/JPD ☐ School  
☐ Other

**Form Status**  
☒ Draft ☐ Pending Approval ☐ Final

**Team Member to Notify**  
[Dropdown menu]

**Team Member to Notify Outgoing Comments**  
[Text area]

Click "Yes" to launch the CSI Assessment form and record the "Assessment End Date".  
☐ Yes ☐ Not Applicable to My Program

When you see a **T** in the upper right-hand corner of a text box in this form, please right-click inside the text box to access the System Template

**Dates and Times Worked Toward Completing CANS**  
[Text area]

The provider submitting this assessment certifies that the information therein is current and in compliance with all the Federal, State, City and County of San Francisco regulations.

**Client Was Linked to Culture Specific and/or Linguistic Services**  
☐ Yes ☐ No

**Client Was Linked to Interpreter Services**  
☐ Yes ☐ No

**Language**  
[Dropdown menu]

**Other**  
[Text area]

**Current Presentation (Include symptoms, behaviors, onset, duration, severity, and family response to current situation)**  
[Text area]

**Diagnosis**  
CSI Assessment

**Submit**

[Icons: Home, Back, Forward, Print, Save, Star]

## CANS CYF 5/18 Assessment - continued

Chart

CANS CYF 6 thru 20 Assessment

5 - Relevant History

6 - Child Strengths

7 - Caregiver Strengt...

8 - Additional Caregiv...

9 - Provider History

10 - Medical/Psychiat...

11 - Medication

12 - Developmental

13 - Formal Services/...

14 - Mental Status Ex...

15 - Clinical Formulati...

16 - Priorities for Tre...

17 - Summary of Tre...

18 - CANS Screen

Submit

Diagnosis

CSI Assessment

List of Actionable Needs, Useful Strengths, and Buildable Strengths

Priorities for Treatment Needs

Presentation

☐ Anger Control

☐ Depression

Trauma Symptoms

Risk Behaviors

Impact on Functioning

Strengths to Build

Child Strengths

Caregiver Strengths

Strengths to Use

Child Strengths

Caregiver Strengths

## CANS CYF 6 thru 20 Assessment Rpt

(Path: Avatar CWS/Assessments/User Assessments/CANS 2.0)

Chart CANS CYF 6 thru 20 Assessment Report

CANS CYF 6 thru 20 Assessment

Process


Please Select a Client

TESTCLIENT,SUMMARY X SR DR (1)

Please Select an Episode

Please Select an Assessment Record

(Date / Assessment Category / Form Status / Data Entry By / Data Entry Date)

	San Francisco Department of Public Health Community Behavioral Health Services	<b>Client Name:</b> TESTCLIENT,SUMMARY X SR DR
	<b>CANS CYF 6 thru 20 Assessment Report</b>	<b>Client ID:</b> 1
		<b>Program:</b> Conversion Program(9999Z)
		<b>Episode #:</b> 52
		<b>Admission Date:</b> 11/14/2019
	<b>Discharge Date:</b> 3/21/2020	

### Confidential Patient Information

<b>Assessment Date:</b> 2/23/2021	<b>Assessment By:</b> Kellee Horn (003865)
<b>Assessment Category:</b> Initial	<b>Assessment Status:</b> Draft

#### 1. Presentation

*For each section, refer to CANS Scoring Manual for detailed Scoring Instructions*

**Key:**

- 0 = No current need; no need for action or intervention.
- 1 = History of suspicion of problems; requires monitoring, watchful waiting, or preventative activities.
- 2 = Problem is interfering with functioning requires action or intervention to ensure that the need is addressed.
- 3 = Problems are dangerous or disabling; requires immediate and/or intensive action.

Psychosis	Conduct
Impulsivity/Hyperactivity	Somatization
Depression	Anger Control
Substance Use	Attachment Difficulties
Anxiety	Eating Disturbances
Oppositional	Adjustment to Trauma

Severity of Use	Peer Influences
Duration of Use	Parental/Caregiver Influences
Stage of Recovery	Environmental Influences

#### 2. Trauma/Abuse

**Key:**

- 0 = No evidence of any trauma of this type.
- 1 = A single event or one incident trauma occurred, or suspicion exists of trauma experiences.
- 2 = Experienced multiple traumas or multiple incidents.
- 3 = Repeated, chronic, on-going and/or severe trauma with medical and physical consequences.

**Trauma Events**

Sexual Abuse	0	Witness to School Violence	0
Physical Abuse	0	Natural or Man-Made Disaster	0
Emotional Abuse	0	War/Terrorism Affected	0
Neglect	0	Victim/Witness to Criminal Activity	0
Medical Trauma	0	Disruption in Caregiving/Atch Losses	0
Witness to Family Violence	0	Parental Criminal Behavior	0

# ADULT/OLDER ADULT (AOA)

## Adult/Older Adult Assessment (Combined)

(Path: Avatar CWS/Assessments/Adult Assessments/ANSA)

**Adult/Older Adult Assessment (Combined)**

**1. PRESENTING PROBLEM**

- 2. RISK ASSESSMENT
- 3. PSYCHOSOCIAL AND F...
- 4. MENTAL HEALTH HIST...
- 5. SUBSTANCE USE
- 6. MEDICAL HISTORY
- 7. MEDICATIONS
- 8. CRIMINAL JUSTICE HI...
- 9. MENTAL STATUS EXAM
- 10. CLIENT STRENGTHS
- 11. CLINICAL FORMULAT...

**Date of Assessment/Rating**  
b9/10/2020

**Assessment Type**  
☐ Short ☐ Long

**Assessment Category**  
☐ Initial ☐ Annual Assessment Update

**I would like to start with a blank assessment**  
☐ Yes

**Client was linked to Interpreter Services**  
☐ Yes ☐ No

**Status - Draft / Pending Approval / Final**  
☒ Draft ☐ Pending Approval ☐ Final

**Supervisor to Notify**  
[Dropdown menu]

**Supervisor to Notify Outgoing Comments**  
[Text area]

**Attestation:**  
The provider submitting this assessment certifies that the information therei is current and in compliance with all Federal, State and City and County of San Francisco regulations.

**Language**  
[Dropdown menu]

**Other**  
[Text area]

**1A. PRESENTING PROBLEM**  
Include A) identifying info, B) criteria to justify DSM dx including current SYMPTOMS, BEHAVIOR, IMPAIRMENTS IN FUNCTIONING, duration, frequer severity, C) impact on life / behavior leading the client to seek services, D) client's primary concern / goal, E) cultural explanation for problem / illness in client's own words, (if EPSDT, state why child/youth will not progress developmentally as appropriate without treatment).

**Update Client Data**

## Adult/Older Adult Assessment (Combined) – continued

### Priorities for Treatment

There are five boxes below, labelled with one of the five domains of the ANSA. Each box contains the name of all ANSA items in that domain which you rated as actionable (i.e., either a 2 or a 3). If there are no ANSA items in the box, that implies that you did not rate any ANSA items as actionable.

Next to each ANSA item in the domain box is a blank checkbox. **Please click the checkbox of each ANSA item you will focus on and help the client improve on during the course of treatment.**

You may have "maintenance" clients in your caseload, that is, clients for whom you have no expectations for improvement. Such a client cannot have any ANSA item rated as a 3. If you consider a client to be "maintenance," click on the checkboxes in both "Box 1" and "Box 2" in the maintenance section below. If there are not checkboxes in either Box 1 or 2, that implies the client has an ANSA item rated as a 3.

#### Behavioral Health Needs

#### Life Functioning and Acculturation

#### Risks / Risk Behaviors

#### Client Strengths


#### Substance Use / Med Compliance

## Adult/Older Adult Assessment Combined Rpt

(Path: Avatar CWS / Assessments / Adult Assessments / ANSA)

Search Forms

Name	Menu Path
Adult/Older Adult Assessment (Combined)	Avatar CWS / Assessments / Adult Assessments/ANSA
Adult/Older Adult Assmnt Combined Report	Avatar CWS / Assessments / Adult Assessments/ANSA

 <p>San Francisco Department of Public Health Community Behavioral Health Services</p> <p><b>Adult/Older Adult Assessment (Combined) Report</b></p>	<p><b>Client Name:</b> TESTCLIENT,SUMMARY Y SR DR</p> <p><b>Client ID:</b> 1</p> <p><b>Program:</b> ACCESS Screening (BHAC)</p> <p><b>Episode #:</b> 59</p> <p><b>Admission Date:</b> 12/19/2020</p> <p><b>Discharge Date:</b> None</p>
--	---

### Confidential Patient Information

<p><b>Assessment Date:</b> 1/30/2021</p> <p><b>Assessment Type:</b> Short</p> <p><b>Assessment Category:</b> Initial</p> <p><b>Interpreter Svc Used:</b> No</p> <p><b>Language:</b></p> <p><b>Other:</b></p>	<p><b>Assessment By:</b> Kimberly Voelker (000089)</p> <p><b>Service Program:</b> ACCESS Screening</p> <p><b>Assessment Status:</b> Draft</p>
--	---

### 1A. Presenting Problem

Include A) identifying info, B) criteria to justify DSM dx including current SYMPTOMS, BEHAVIOR, IMPAIRMENTS IN FUNCTIONING, duration, frequency and severity, C) impact on life / behaviors leading the client to seek services, D) client's primary concern / goal, E) cultural explanation for problem / illness in client's own words, (if EPSDT state why child/youth will not progress developmentally as appropriate without treatment).

TEST

### ANSA Ratings - Behavioral Health Needs

ND=No Data; 0=No Evidence; 1=Mild History, Sub-Threshold Watch; 2=Moderate-Need for action;  
3=Severe-Need for immediate/intensive action

Psychosis	0	Interpersonal Problems Due to Personality	ND
Depression	ND	Adjustment to Trauma	ND
Anxiety	ND	Mania	ND
Impulse Control	ND	Sleep Disturbance	ND

## Assessment Diagnosis

(Path: Avatar PM/ Client Management/ Client Information)

In order to get the diagnosis to print out as part of your assessment, “add” a new Diagnosis, and select “Update” as the type of diagnosis. Enter a diagnosis date that is on or after the date on the Assessment.

The screenshot shows a 'Diagnosis' window with a list of dates. The first date, 07/01/2010, is highlighted in green. Below the list are three buttons: 'Add', 'Edit', and 'Cancel'. A red arrow points to the 'Add' button.

The screenshot shows the 'Diagnosis' form. The 'Type Of Diagnosis' section has four radio buttons: 'Admission', 'Discharge', 'Onset', and 'Update' (which is selected). The 'Date Of Diagnosis' section has a date input field, a 'T' button, a 'Y' button, and a dropdown arrow. The 'Time Of Diagnosis' section has a time input field, a 'Current' button, and buttons for 'H', 'M', and 'AM/PM'. A red arrow points to the 'Date Of Diagnosis' field.

Use the date of the assessment.

## CYF MENTAL HEALTH TREATMENT PLAN OF CARE

## Avatar User Guide - CYF 0/18 Treatment Plan of Care

### Purpose:

The purpose of the manual is to walk you through the CYF 0/18 Treatment Plan of Care in the Avatar EHR System.

### Menu Path:

Avatar CWS>Treatment Planning>**CYF 0/18 Treatment Plan of Care**

Report Menu Path: Avatar CWS>Treatment Planning>CYF 0/18 Treatment Plan of Care Report

**\*\*\*Do not use the Print Treatment Plan form to print Treatment Plans\*\*\***

Avatar 2015 - Form Search

Enter text to find in option name: 0/18

Form	Menu Path
CYF 0/18 Treatment Plan of Care	Avatar CWS / Treatment Planning

Search Open Add to My Forms Dismiss



## Starting the CYF 0/18 Treatment Plan of Care

**CBHS, DEMO (999049104)**  
F, 7, 01/01/2008

Ep: 1 : CCDC Child Development Ctr (38744)  
Problem P: -  
DX P:

Location: , ,  
Attn. Pract.: No Entry  
Adm. Pract.: VOELKER, KIMBERLY


Allergies (0)

**CYF 0/18 Treatment Plan of Care**

**CYF 0/18 Treatment Pla...**


Submit

Online Documentation


Date Treatment Plan Started  
07/20/2015  Enter Date Treatment Plan Started

Choose Plan Type  
Initial


Plan Type

Plan End Date  
07/19/2016  Enter Plan End Date (See Light Bulb)

Client was linked to culture specific and/or linguistic services  
☐ Yes ☐ No

Last Updated  
07/20/2015 

Last Updated By  
Kimberly Voelker

Parent/Youth Input   
Clinical Guideline: Include child/youth and family's goal(s), stated in their own words, which they identified as a priority.

Treatment Plan Status  
☒ Draft ☐ Pending Approval  
☐ Final

Team Member To Notify

## Treatment Plan Problem List

Below is the Treatment Plan “Problem List” which is a federal requirement for Meaningful Use (i.e. not language we would have chosen). Items generate based on a library called SNOMED (which is medically based). You will add a “problem code” once you launch the plan (**see page 8**). It will then populate into this list. Do not search/add codes here.

Problem List

	Include in this plan?	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved
1	<input type="checkbox"/>	Attention d...				01/12/2015		Active (A)			

Items here generate once you add problems to the Treatment Plan

~~Next Row~~ Delete Row

Do not add to the Problem List here, choose Add Problem after you launch your Plan

## Adding Plan Participants

Plan Participants

4. Click the Staff ID box to search for Clinician/Staff member

5. Click each box to fill in additional participant information

2. Click inside this box to select from Participant Role list

1. To add a Plan Participant, click "New Row"

3. Choose Participant Role

Plan Participants are individuals who participated in the plan development

	Role	Staff ID	Participant Name	Plan Author	Notification
1					

New Row Delete Row

Role search results:

Code	Description
1	Clinician/Staff
2	Child/Youth
4	Collateral (e.g., Teacher; PO)
3	Parent/Guardian

Select Cancel

## Starting your Treatment Plan – Text entry

Strengths-based treatment planning

Clinical Guideline: Describe how child/youth and family strengths (as identified in CANS assessment) inform treatment plan goals and how interventions delivered will draw upon these strengths.

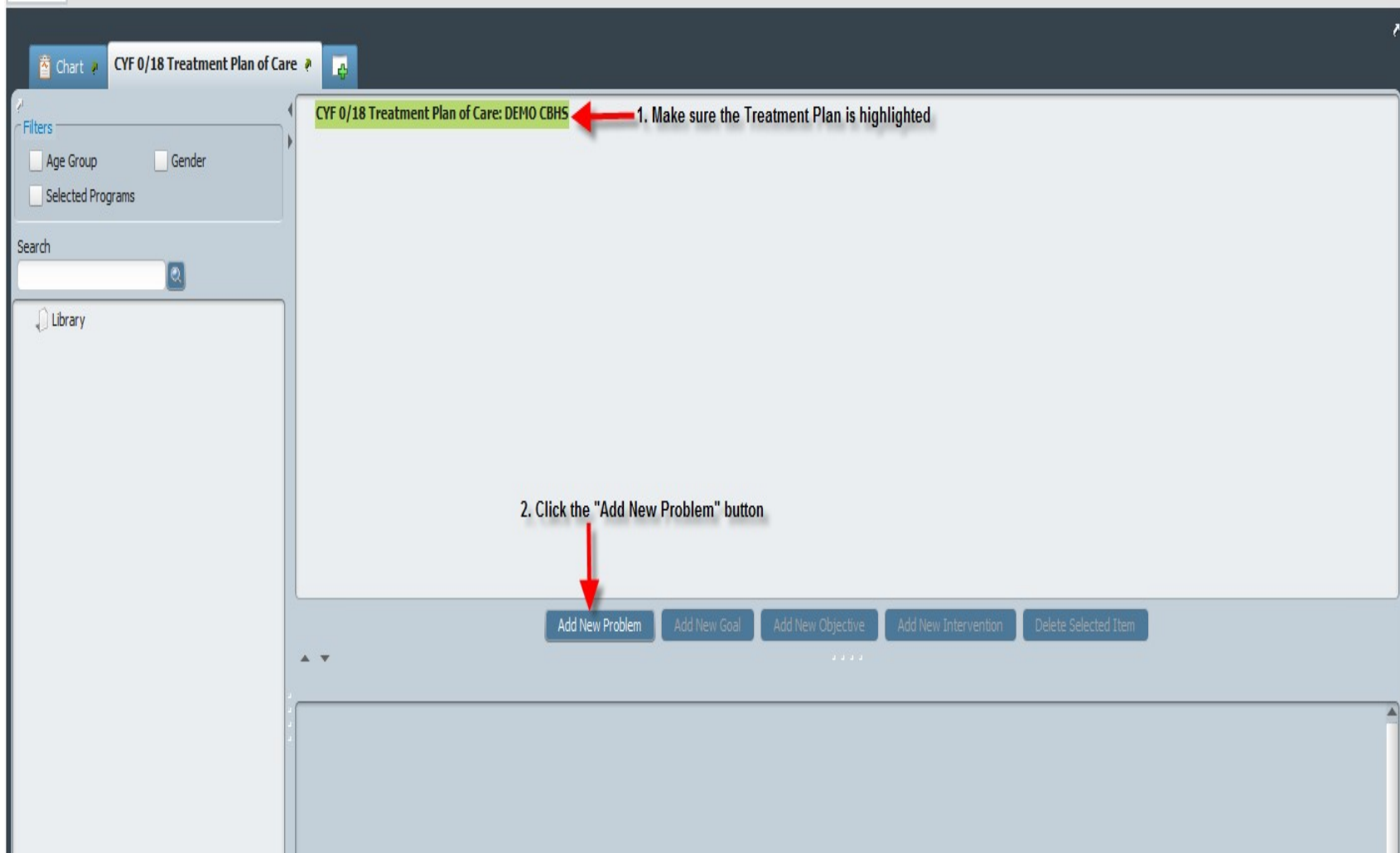
Discharge Planning

Clinical Guideline: What will it look like when the child/youth and family are maintaining treatment gains without further intervention(s)?

Launch Plan

Click "Launch Plan" to start your Treatment Plan

## Treatment Plan Problem Section – Adding a Problem



## Treatment Plan Problem Section – Adding a Problem (continued)

**CYF 0/18 Treatment Plan of Care: DEMO CBHS**

**<New Problem>** New problem to be defined

**Filters**

- ☐ Age Group
- ☐ Gender
- ☐ Selected Programs

**Search**

**Library**

No library available at this time

**Clinical Guideline:** Goals, Objectives, and Interventions will be developed for each "Problem Code". Only "Problems" that are a focus of treatment should be included in this field. It is recommended the client's Diagnosis be entered here (e.g. ADHD combined type). Psychosocial stressors (e.g. homeless family) can also be included if it is a primary focus of treatment.

**Buttons:** Add New Problem, Add New Goal, Add New Objective, Add New Intervention, Delete Selected Item

**Problem Code**

adhd

**Search for a Problem Code (SNOMED) code using a keyword and select from the list**

Code	Value
SNOMED-161464003 (SNOMED-161464003)	H/O: psychiatric disorder
SNOMED-31177006 (SNOMED-31177006)	Attention deficit hyperactivity disorder, combined type
SNOMED-35253001 (SNOMED-35253001)	Attention deficit hyperactivity disorder, predominantly inattentiv...
SNOMED-36456004 (SNOMED-36456004)	Mental state finding
SNOMED-406506008 (SNOMED-406506008)	Attention deficit hyperactivity disorder
SNOMED-429950008 (SNOMED-429950008)	Family history of attention deficit hyperactivity disorder
SNOMED-444613000 (SNOMED-444613000)	Adult attention deficit hyperactivity disorder
SNOMED-7461003 (SNOMED-7461003)	Attention deficit hyperactivity disorder, predominantly hyperactiv...

**Date Added to Treatment Plan**

07/20/2015

**Status**



## Treatment Plan Problem Section – Adding a Problem (continued)

**CYF 0/18 Treatment Plan of Care: DEMO CBHS**

**Problem: Attention deficit hyperactivity disorder, combined type** Clinical Guideline: Describe symptoms and associated impairments: e.g., "Client displays symptoms of hyperactivity

**Description of Problem**

Information that will be added to the Treatment Plan Problem List (see page 4)

Clinical Guideline: Only "Active" problems will generate into the Treatment Plan Problem List (see page 4). In future Treatment Plans, you can change the status to "Resolved," etc.

Clinical Guideline: Approximate "Date of Onset" is based on clinical interview and reported duration of symptoms. If unknown, enter date assessment was conducted.

Clinical Guideline: For new TPOC, status will be "Active-New. For future TPOC, status could be Active-Continued (still working towards goals); "Achieved" (goal reached - will record and drop in future plan) and "Inactive" if no longer a focus of treatment.

**Problem Code**  
(SNOMED-31177006) Attention deficit hyperactivity disorder, combined type

**Date of Onset**

**Status (Problem List)**  
Active

**Description of Problem**  
Attention deficit hyperactivity disorder, combined type  
Clinical Guideline: Describe symptoms and associated impairments: e.g., "Client displays symptoms of hyperactivity/impulsiveness and inattention that interfere with his ability to pay attention, do well in school"

**Date Added to Treatment Plan**  
07/20/2015

**Status**  
Active - New

## Treatment Plan – Adding a Goal

CYF 0/18 Treatment Plan of Care

CYF 0/18 Treatment Plan of Care: DEMO CBHS

Problem: Attention deficit hyperactivity disorder, combined type Clinical Guideline: Describe symptoms and associated impairments: e.g., "Client displays symptoms of hyperactivity"

Goals

Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"

Description of Goal appears here

To add a Goal for the selected Problem, click "Add New Goal"

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

Goal

Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"

Date Opened 07/20/2015 T Y Date Opened defaults to today's date

Date Closed T Y If Status of Goal is "Achieved" or "Inactive", enter the Date Closed

Status Active - New Select Goal Status from the drop down list



## Treatment Plan – Adding an Objective

The screenshot displays the 'CYF 0/18 Treatment Plan of Care' interface. The left sidebar shows a 'Gender' checkbox and a search icon. The main content area shows a tree view with 'CYF 0/18 Treatment Plan of Care: DEMO CBHS' expanded, revealing 'Problem: Clinical Guideline: Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., ?Individual therapy 1x/week with client t', 'Goals', and 'Objectives'. A red arrow points to the 'Objectives' section, with the text 'Description of Objective appears here' below it. Another red arrow points to the 'Add New Objective' button in the bottom toolbar, with the text 'To add an Objective, click "Add New Objective"' above it. The bottom section shows the 'Objective (Expected Behavioral Change)' form. It includes a text area for the objective description, a 'Date Opened' field with a calendar icon and a dropdown menu (showing 'T' and 'Y'), and a 'Date Closed' field with a calendar icon and a dropdown menu (showing 'T' and 'Y'). A red arrow points to the 'Date Opened' dropdown with the text 'Date Opened defaults to today's date'. Another red arrow points to the 'Date Closed' dropdown with the text 'If Status of Objective is "Achieved" or "Inactive" enter Date Closed'. To the right of the form is a 'Status' dropdown menu (showing 'Active - New') with a red arrow pointing to it and the text 'Select Objective Status from the drop down list'.

CYF 0/18 Treatment Plan of Care

CYF 0/18 Treatment Plan of Care: DEMO CBHS

Problem: Clinical Guideline: Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., ?Individual therapy 1x/week with client t

Goals

Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"

Objectives

Clinical Guideline: Operationalize change in quantifiable language: e.g. "Client will not run in the school hallway 3 out of 7 days"

Description of Objective appears here

To add an Objective, click "Add New Objective"

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

Objective (Expected Behavioral Change)

Clinical Guideline: Operationalize change in quantifiable language: e.g. "Client will not run in the school hallway 3 out of 7 days"

Date Opened 07/20/2015 T Y Date Opened defaults to today's date

Date Closed T Y If Status of Objective is "Achieved" or "Inactive" enter Date Closed

Status Active - New Select Objective Status from the drop down list

## Treatment Plan – Adding an Intervention

**CYF 0/18 Treatment Plan of Care: DEMO CBHS**

**Problem:** Attention deficit hyperactivity disorder, combined type    Clinical Guideline: Describe symptoms and associated impairments: e.g., "Client displays symptoms of hyperactivity/i

**Goals**

  Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"

**Objectives**

  Clinical Guideline: Operationalize change in quantifiable language: e.g., "1) Client will increase homework completion rate from 50% to 80%; 2) Client will not run in the school hallway 3 out of 7 days; 3) Client w

**Interventions**

  Clinical Guideline: Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., "Individual therapy 1x/week with client to build skills to increase attention; F

**Description of Intervention appears here**

**To add an Intervention, click "Add New Intervention"**

Buttons: Add New Problem, Add New Goal, Add New Objective, **Add New Intervention**, Delete Selected Item

**Intervention (Describe type, frequency, expected duration of intervention and to whom it will be applied)**

Clinical Guideline: Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., "Individual therapy 1x/week with client to build skills to increase attention; Family therapy 1x/week to implement behavioral interventions to generalize skills to home; Collateral session 1x/week with teacher to implement behavioral interventions to generalize skills to classroom; case management to link client to programs/supports that will help him reach treatment goals; psychiatric evaluation and medication support, if indicated"

Date Opened: 07/20/2015    Status: Active - New

Date Closed:    If Status of Intervention is "Achieved or "Inactive" enter Date Closed

Select Intervention Status from the drop down list



## Treatment Plan – Editing Items on your Treatment Plan

CYF 0/18 Treatment Plan of Care

Problem: Attention deficit hyperactivity disorder, combined type    Clinical Guideline: Describe symptoms and associated impairments: e.g., "Client displays symptoms of hyperactivity/i

Goals

Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"

Objectives

Clinical Guideline: Operationalize change in quantifiable language: e.g., "1) Client will increase homework completion rate from 50% to 80%; 2) Client will not run in the school hallway 3 out of 7 days; 3) Client w

Interventions

Clinical Guideline: Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., "Individual therapy 1x/week with client to build skills to increase attention; Fa

Click and highlight an item on the Treatment Plan to edit. Notice Goal is selected and now available for editing.

Add New Problem   Add New Goal   Add New Objective   Add New Intervention   Delete Selected Item

Goal

Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"

Edit Text

Date Opened  
07/20/2015   T   Y

Status  
Active - New

Date Closed  
T   Y

Edit Status

## Treatment Plan – Deleting items from your plan

**CYF 0/18 Treatment Plan of Care: DEMO CBHS**

- Problem:** Attention deficit hyperactivity disorder, combined type **Clinical Guideline:** Describe symptoms and associated impairments: e.g., "Client displays symptoms of hyperactivity/irritability"
- Goals**
  - Clinical Guideline:** Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"
- Objectives**
  - Clinical Guideline:** Operationalize change in quantifiable language: e.g., "1) Client will increase homework completion rate from 50% to 80%; 2) Client will not run in the school hallway 3 out of 7 days; 3) Client will..."
- Interventions**
  - Clinical Guideline:** Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., "Individual therapy 1x/week with client to build skills to increase attention; Family therapy 1x/week to implement behavioral interventions to generalize skills to home; Collateral session 1x/week with teacher to implement behavioral interventions to generalize skills to classroom; case management to link client to programs/supports that will help him reach treatment goals; psychiatric evaluation and medication support, if indicated")

**Click and highlight the section you would like to delete. You must delete from the bottom up. For example, if you would like to delete a Goal for a specific problem, you must first delete the Intervention, then Objective, then Goal.**

**Click the "Delete Selected Item" button to delete items from the Treatment Plan**

Buttons: Add New Problem, Add New Goal, Add New Objective, Add New Intervention, Delete Selected Item

**Intervention (Describe type, frequency, expected duration of intervention and to whom it will be applied)**

Clinical Guideline: Include services that will be delivered (you cannot bill codes unless they are written in treatment plan: e.g., "Individual therapy 1x/week with client to build skills to increase attention; Family therapy 1x/week to implement behavioral interventions to generalize skills to home; Collateral session 1x/week with teacher to implement behavioral interventions to generalize skills to classroom; case management to link client to programs/supports that will help him reach treatment goals; psychiatric evaluation and medication support, if indicated")

Date Opened: 07/20/2015

Date Closed:

Status: Active - New

## Treatment Plan – Saving/Submitting your Plan

The screenshot shows a web form for creating a treatment plan. It includes fields for 'Date Opened' (07/20/2015) and 'Date Closed', and a 'Status' dropdown menu set to 'Active - New'. At the bottom right, there are two buttons: 'Back to Plan Page' and 'Exit to Home View'. Red arrows and text boxes provide instructions: one arrow points to the 'Back to Plan Page' button with the text 'Make sure to click "Back to Plan Page"', and another arrow points to the 'Exit to Home View' button with the text '"Exit to Home View" brings you back to your Avatar Home View'. A red box highlights the text 'Click "Back to Plan" Page located on the bottom of the Treatment Plan page' with an arrow pointing to the 'Back to Plan Page' button.

Date Opened  
07/20/2015

Date Closed

Status  
Active - New

Click "Back to Plan" Page located on the bottom of the Treatment Plan page

Make sure to click "Back to Plan Page"

Back to Plan Page

Exit to Home View

"Exit to Home View" brings you back to your Avatar Home View



## Treatment Plan – Saving/Submitting your Plan (continued)

The screenshot shows a web-based form titled "CYF 0/18 Treatment Plan of Care". On the left sidebar, a "Submit" button is circled in red, with a red arrow pointing to it and the text "Click 'Submit'" below. Below the sidebar is a section labeled "Online Documentation". The main form area contains several fields: "Date Treatment Plan Started" (07/20/2015), "Last Updated By" (Kimberly Voelker), "Parent/Youth Input" (Clinical Guideline: Include child/youth and family's goal(s), stated in their own words, which they identified as a priority.), "Plan Type" (Initial), "Plan End Date" (07/19/2016), "Client was linked to culture specific and/or linguistic services" (radio buttons for Yes and No), "Last Updated" (07/20/2015), "Treatment Plan Status" (radio buttons for Draft and Final, with "Draft" selected), "Choose Status" (radio button for Pending Approval), and "Team Member To Notify" (a dropdown menu). A red arrow points from the "Choose Status" label to the "Draft" radio button.

Chart CYF 0/18 Treatment Plan of Care

CYF 0/18 Treatment Pla...

Submit

Click "Submit"

Online Documentation

Date Treatment Plan Started  
07/20/2015 T Y

Last Updated By  
Kimberly Voelker

Parent/Youth Input  
Clinical Guideline: Include child/youth and family's goal(s), stated in their own words, which they identified as a priority.

Plan Type  
Initial

Plan End Date  
07/19/2016 T Y

Client was linked to culture specific and/or linguistic services  
☐ Yes ☐ No

Last Updated  
07/20/2015 T Y

Treatment Plan Status  
☒ Draft ☐ Final

Choose Status  
☐ Pending Approval

Team Member To Notify

# ADULT/OLDER ADULT MENTAL HEALTH TREATMENT PLAN OF CARE

## Avatar User Guide: Adult/Older Adult MH Treatment Plan of Care

### Overview

- **Purpose:** The purpose of the manual is to walk you through the new Adult/Older Treatment Plan of Care in the Avatar EHR System.
- **Rational:** The reason for moving to a new version of the treatment plan is to bring us into alignment with optimizing our use of electronic records with a focus on being able to use standardized fields in order to communicate in a meaningful way across our system.
- **Menu Path:** Avatar CWS>Treatment Planning>**Adult/Older Adult MH Treatment Plan of Care**

The screenshot shows a search interface with a search bar containing 'Adult/Older Adult M'. Below the search bar is a table with two columns: 'Name' and 'Menu Path'. The table contains one row with the text 'Adult/Older Adult MH Treatment Plan of Care' in the 'Name' column and 'Avatar CWS / Treatment Planning' in the 'Menu Path' column. At the bottom of the table, there are navigation buttons: '<= Previous 25', '1 through 1 of 1', and 'Next 25 =>'.

Name	Menu Path
Adult/Older Adult MH Treatment Plan of Care	Avatar CWS / Treatment Planning



## Starting the Adult/Older Adult MH Treatment Plan of Care

The screenshot shows a web-based form titled "Adult/Older Adult MH Treatment Plan of Care". The form includes several sections with red annotations and arrows:

- Plan Effective Date:** A date field containing "05/15/2015". A red arrow points from a text box on the left to this field.
- Plan Type:** A dropdown menu with the text "Select 'Initial' or 'Update'". A red arrow points from the same text box on the left to this field.
- Plan End Date:** A date field containing "5/15/16". A red arrow points from the same text box on the left to this field.
- Text Box:** A pink text box on the left contains the text: "Plan Effective and End Date are based on Episode Opening (Anniversary Date)".
- Will automatically populate with who last updated the plan:** A pink text box with a red arrow pointing to the "Last Updated" field.
- Last Updated:** A date field.
- Last Updated By:** A text field.
- Treatment Plan Status:** Radio buttons for "Draft", "Final", and "Pending Approval".
- Team Member To Notify (for Pending Approval):** A dropdown menu.
- Client was linked to culture specific and/or linguistic services:** Radio buttons for "Yes" and "No".
- Client has been informed of the Grievance/Appeal process at least annually:** Radio buttons for "Yes" and "No".
- Client has been informed of the DPH Notice of HIPPA Privacy Practices at least annually:** Radio buttons for "Yes" and "No".

## Treatment Plan Problem List

The federal government, as part of Meaningful Use, have required that problems be listed in a standardized format. They have adopted the Standardized Nomenclature Of MEDicine (SNOMED) codes. You can push a diagnosis to the problem list from the Diagnosis screen. It is also possible to add Problem codes here or once you launch the plan.

▼

Problems **Do not add to the Problem List here.**

	Include in this plan?	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	
1	<input type="checkbox"/>	Chronic anxiet...				08/20/2015		Active (A)			
2	<input type="checkbox"/>	Homeless singl...				10/06/2014		Active (A)			
3	<input type="checkbox"/>	Posttraumatic ...				10/06/2015		Active (A)			
4	<input type="checkbox"/>	Geophagia (SN...				01/21/2016		Active (A)			
5	<input checked="" type="checkbox"/>	Masked depre...				01/27/2016		Active (A)			

New Row

Delete Row

## Optional: Plan Participants

The Clinician would enter their name here in order to get a notification in their To Do Items, that a Treatment Plan is about to expire.

1. Double click in the Role box and then double click on the correct role.

2. You can search for Staff ID by entering staff ID or by last name, first.

3. Click Tab.

4. A list of matches will appear.

5. Double click on the Staff Name you would like to enter.

6. Yes or No

7. Yes, to receive a to do item No, if not

## Optional: Plan Participants

You can enter other participants, for example, other staff members, family members, etc.

Plan Participants

	Role	Staff ID	Participant Name	Plan Author	Notification
1	Clinician/Staff (1)	HOM,KELLEE (00...	HOM,KELLEE	Yes (Y)	Yes (Y)
2	Other (3)		t	No (N)	No (N)


New Row Delete Row

Participant Name


Type Name Here

Ok Cancel


## Strengths, Impairments, and Plan for Discharge

Client Strengths 

▼

**Impairments** 

<input checked="" type="checkbox"/> Psychiatric Symptom Severity	<input type="checkbox"/> Current RISK
<input checked="" type="checkbox"/> Behavioral Issues	<input checked="" type="checkbox"/> Basic Needs
<input checked="" type="checkbox"/> Homeless/Housing	<input checked="" type="checkbox"/> Substance Abuse/Dependence
<input checked="" type="checkbox"/> Social/Family/Relationship/Role Stressor	<input type="checkbox"/> Medical/Health
<input checked="" type="checkbox"/> Language Barriers	<input type="checkbox"/> Legal Status/Criminal Involvement
<input checked="" type="checkbox"/> Employment/Education/Daily Activities	

**Plan for Discharge or Step-Down** 

Launch Plan

## Treatment Plan – Problem

**Adult/Older Adult MH Treatment Plan of Care**

**Filters**

- ☐ Age Group
- ☐ Gender
- ☐ Selected Programs

Search

Library

**Adult/Older Adult MH Treatment Plan of Care: MINNIE TEST**

**Problem: Depressive disorder**

Buttons: Add New Problem, Add New Goal, Add New Objective, Add New Intervention, Delete Selected Item

**Problem Code**  
Depressive disorder

**Date of Onset**  
01/15/2016

**Treatment Plan Problem Description**  
Depressive disorder

**Date Problem Identified**  
02/05/2016

**Date Closed**

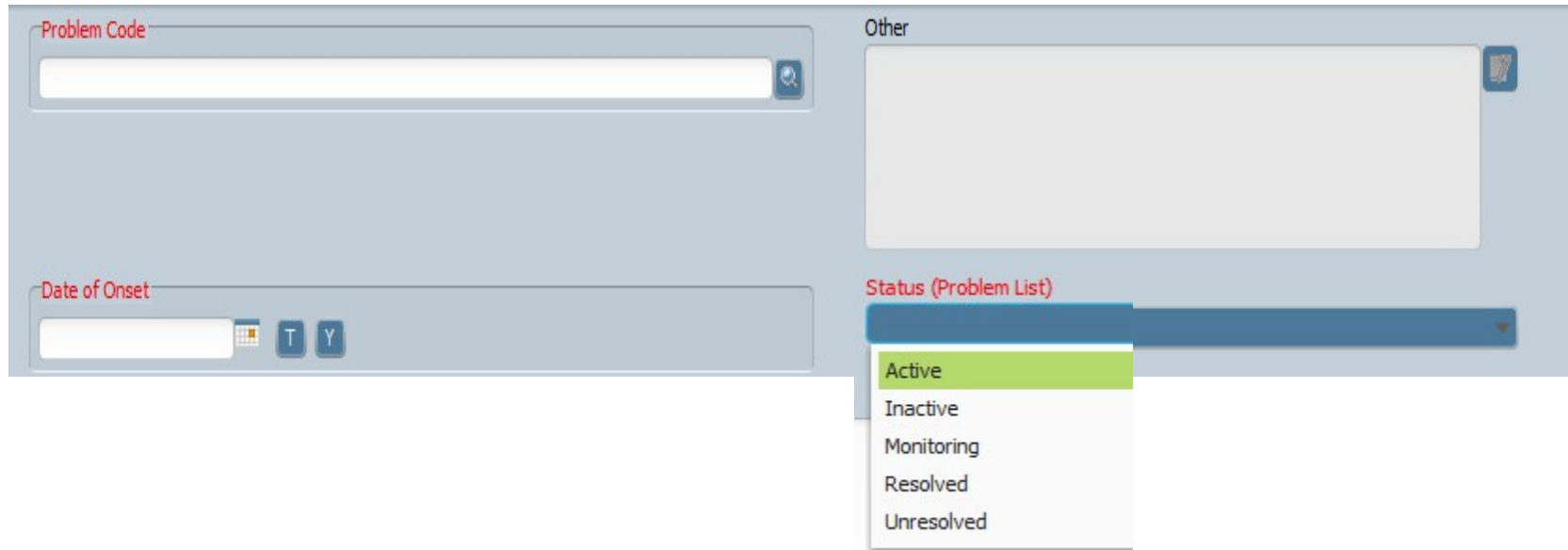
**Other**

**Status (Problem List)**  
Active

**Status**  
Active

## Components of the Problem Section

The following sections will populate the Problem List



The screenshot displays a form with four main sections:

- Problem Code:** A text input field with a magnifying glass icon on the right.
- Date of Onset:** A date selection field with a calendar icon and buttons for 'T' (Today) and 'Y' (Yesterday).
- Other:** A large, empty text area with a magnifying glass icon on the right.
- Status (Problem List):** A dropdown menu currently showing 'Active' (highlighted in green), with other options being 'Inactive', 'Monitoring', 'Resolved', and 'Unresolved'.

**Problem Code** (see next page)

**Other** only becomes active if the Problem Code is “Other”

**Date of Onset** can be date of assessment

**Status** if Inactive or Resolved are selected they will drop off the list in future TPOCs



## Components of the Problem Section

Problem Code: You can search by DSM IV, DSM 5, ICD 9, ICD 10 description or code. It will display a SNOMED code.

Problem Code

Other

Code	Value
SNOMED-192042008	(SNOMED-192042008) Acute post-trauma stress state
SNOMED-192061007	(SNOMED-192061007) Concentration camp syndrome
SNOMED-25944005	(SNOMED-25944005) Rape trauma syndrome: silent reaction
SNOMED-313182004	(SNOMED-313182004) Chronic post-traumatic stress disorder
SNOMED-317816007	(SNOMED-317816007) Stockholm syndrome
SNOMED-318784009	(SNOMED-318784009) Posttraumatic stress disorder, delayed onset
SNOMED-39093002	(SNOMED-39093002) Post-trauma response
SNOMED-443919007	(SNOMED-443919007) Complex posttraumatic stress disorder
SNOMED-446175003	(SNOMED-446175003) Acute posttraumatic stress disorder following military combat
SNOMED-446180007	(SNOMED-446180007) Delayed posttraumatic stress disorder following military combat
SNOMED-47505003	(SNOMED-47505003) Posttraumatic stress disorder
SNOMED-54231004	(SNOMED-54231004) Rape trauma syndrome
SNOMED-7397008	(SNOMED-7397008) Aggressor identification syndrome

<= Previous 25

1 through 13 of 13

Next 25 =>



## Treatment Plan – Adding Additional Problems

The screenshot displays a treatment plan for an "Adult/Older Adult MH Treatment Plan of Care: SUMMARYONE TESTCLIENTAVATAR". The plan is structured as follows:

- ▼ **Problem:** Symptoms of anxiety interfere with client's ADLs.
- ▼ **Goals**
  - ▼ Reduce symptoms of anxiety.
- ▼ **Objectives**
  - ▼ Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.
- ▼ **Interventions**
  - Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

At the bottom of the interface, there are five buttons: "Add New Problem", "Add New Goal", "Add New Objective", "Add New Intervention", and "Delete Selected Item". A red arrow points from the "Add New Problem" button to the highlighted title bar at the top. A pink callout box with the text "Click the highlight the name of the Treatment Plan, then click 'Add New Problem.'" is connected to the arrow by a red line.

## Treatment Plan - Adding a Goal

Adult/Older Adult MH Treatment Plan of Care: SUMMARYONE TESTCLIENTAVATAR

Problem: Symptoms of anxiety interfere with client's ADLs.

Goals

- Reduce symptoms of anxiety.

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

Goal related to Problem (Include Client's own words)

Reduce symptoms of anxiety.

Date Identified 08/17/2015 T Y

Date Closed T Y

Status

- Active
- Active
- Inactive
- Resolved

If Resolved is selected, you will be asked to enter "Date Closed"

## Treatment Plan – Adding an Objective

▼ **Adult/Older Adult MH Treatment Plan of Care: SUMMARYONE TESTCLIENTAVATAR**

▼ **Problem: Symptoms of anxiety interfere with client's ADLs.**

▼ **Goals**

▼ Reduce symptoms of anxiety.

▼ **Objectives**

Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.

Add New Problem   Add New Goal   Add New Objective   Add New Intervention   Delete Selected Item

The section should a)list specific quantifiable/observable outcomes, b)describe how the objective will be measured/demonstrated;  
 c)relate to the mental health needs/symptoms/behaviors; and d)state the specific functional impairment.

**Objective**

Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.

Date Identified: 08/17/2015   T   Y

Date Met:   T   Y

**Status**  
 Unmet  
 Met  
 Partially Met  
 Unmet

If "Met" is selected, you will be asked to enter Date Met.

## Treatment Plan – Adding an Intervention

**Adult/Older Adult MH Treatment Plan of Care: SUMMARYONE TESTCLIENTAVATAR**

- ▼ Problem: Symptoms of anxiety interfere with client's ADLs.
  - ▼ Goals
    - ▼ Reduce symptoms of anxiety.
      - ▼ Objectives
        - ▼ Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.
          - ▼ Interventions
            - Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

Buttons: Add New Problem, Add New Goal, Add New Objective, Add New Intervention, Delete Selected Item

---

This section should describe the proposed treatment interventions including a) modality (individual, group, case management), b) proposed frequency, c) duration, d) and how they address the functional impairments.

**Intervention**

Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

Date Identified: 08/17/2015 [Calendar] [T] [Y]

Date Discontinued: [Calendar] [T] [Y]

Status: Continue (selected), Continue, Discontinue

If "Discontinue" selected, you will be used to enter Date Discontinued.

## Treatment Plan – Editing Items

**Adult/Older Adult MH Treatment Plan of Care: SUMMARYONE TESTCLIENTAVATAR**

- ▼ **Problem: Symptoms of anxiety interfere with client's ADLs.**
  - ▼ **Goals**
    - ▼ Reduce symptoms of anxiety.
  - ▼ **Objectives**
    - ▼ Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.
  - ▼ **Interventions**
    - Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

Click to highlight the item you would like to edit and change the text below.

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

---

This section should describe the proposed treatment interventions including a) modality (individual, group, case management), b) proposed frequency, c) duration, d) and how they address the functional impairments.

**Intervention**

Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

Date Identified

Status
Continue

Date Discontinued

## Treatment Plan – Deleting Items

Adult/Older Adult MH Treatment Plan of Care: SUMMARYONE TESTCLIENTAVATAR

Problem: Symptoms of anxiety interfere with client's ADLs.

Goals

- Reduce symptoms of anxiety.

Objectives

- Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.

Interventions

Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

You must delete starting from the bottom. In order to delete an objective, you must first delete the intervention that is attached to it.

Click to highlight the bottom level item and then select "Delete Selected Item"

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

This section should describe the proposed treatment interventions including a) modality (individual, group, case management), b) proposed frequency, c) duration, d) and how they address the functional impairments.

Intervention

Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.

Date Identified 08/17/2015 T Y

Date Discontinued T Y

Status Continue

## Treatment Plan – Submitting and Saving

Adult/Older Adult MH Treatment Plan of Care: MINNIE TEST

Add New Problem

Add New Goal

Add New Objective

Add New Intervention

Delete Selected Item

Problem Code

Depressive disorder

Date of Onset

01/15/2016

Treatment Plan Problem Description

Depressive disorder

Date Problem Identified

02/05/2016

Date Closed

Other

Status (Problem List)

Active

Status

Active

Back to Plan Page

Exit to Home View



## Treatment Plan – Submitting and Saving

Chart **Adult/Older Adult MH Treatment Plan of Care**

**Adult/Older Adult MH Tre**

Submit

Plan Effective Date  
02/05/2016 T Y

Plan Type Initial

Plan End Date  
02/04/2017 T Y

Client was linked to culture specific and/or  
☐ Yes

Client has been informed of the Grievance/  
☐ Yes

Online Documentation




## Printing the TPOC

**Search Forms**

adult m

Name	Menu Path
Adult/Older Adult MH Treatment Plan of Care	Avatar CWS / Treatment Planning
Adult/Older Adult MH POC Report	Avatar CWS / Treatment Planning

<= Previous 25      1 through 2 of 2      Next 25 =>

 <p>San Francisco Department of Public Health Community Behavioral Health Services</p> <p><b>Adult/Older Adult MH Treatment Plan of Care</b></p>	<p><b>Name:</b> TESTCLIENTAVATAR,SUMMARYONE</p> <p><b>Client ID#:</b> 999047242</p> <p><b>Episode #:</b> 1    <b>Episode Opening Date:</b> 1/10/2015</p> <p><b>Episode Program:</b> CBHS Pharmacy (38CXR)</p> <p><b>Print Date:</b> 8/17/2015</p>
	<p align="center"><b>Confidential Patient Information</b></p>
<p><b>Date Treatment Plan Started:</b> 8/12/2015</p> <p><b>Date Treatment Plan Finalized:</b></p> <p><b>Plan End Date:</b> 8/12/2016</p> <p><b>Last Updated:</b> 8/17/2015</p>	<p><b>Plan Type:</b> Initial</p> <p><b>Plan Status:</b> Draft</p> <p><b>Discharge Date:</b></p>

# Progress Notes Group and Individual Form

## Progress Notes

(Path: Avatar CWS/Progress Notes)

The screenshot shows the Avatar 2011 web application interface for entering progress notes. The top navigation bar includes 'Home', 'Carlos F', 'Progress Notes', 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and 'JHEPWORTH'. The main content area is titled 'Progress Notes (Group and Individual)' and features a sidebar with 'Individual Progress Notes' and 'Group Default Notes' sections. The 'Individual Progress Notes' section includes a 'Submit' button and a 'Notes Field' with a 'Type in this box.' prompt. The main form area contains several fields: 'Select Client' (with a dropdown showing 'FUENTES, CARLOS (981248689)'), 'Group Name or Number' (with a dropdown), 'Note Date' (with a date picker), 'Select Episode' (with a dropdown showing 'Episode # 1 Admit : 06/11/2012 Discharge : None Program'), 'Select Note To Edit' (with a dropdown), 'Progress Note Entry' (with radio buttons for 'Existing Service', 'Existing Appointment', and 'New Service'), 'Note Addresses Which Existing Service/Appointment' (with a text area), 'Note Type' (with a dropdown showing 'MH Adult'), and 'User To Send Co-Sign To Do Item To' (with a text area). The bottom status bar shows 'AVCALPHLIVE (SAMPLE)', '02/07/2013 01:02 PM', and '108%' zoom level.

## Progress Notes requiring Cosignature

The screenshot shows the Avatar 2011 web application interface for entering progress notes. The top navigation bar includes 'Home', 'Carlos F', 'Progress Notes', 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and 'JHEPWORTH'. The main content area is titled 'Progress Notes (Group and Individual)' and contains a sidebar on the left with 'Individual Progress Notes' and 'Group Default Notes' sections. The main form area includes fields for 'Select Client' (Fuentes, Carlos (981248689)), 'Group Name or Number', 'Note Date', 'Select Note To Edit', 'Progress Note Entry' (with radio buttons for 'Existing Service', 'Independent Note', 'Existing Appointment', and 'New Service'), 'File Note', 'Notes Field' (with a text area and a link to 'ADP Regulation for documenting progress towards treatment goals'), 'Date Of Service' (02/07/2013), 'Location' (Office), and 'Note Type' (MH Adult (Cosign)). A 'User To Send Co-Sign To Do Item To' field is also present, with 'Pablo Munoz' selected. Two blue arrows point from a note box at the bottom to the 'Note Type' and 'User To Send Co-Sign To Do Item To' fields.

Avatar 2011

Home Carlos F Progress Notes Courses Preferences Lock Sign Out Switch Help JHEPWORTH

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Select Client  
Fuentes, Carlos (981248689)

Group Name or Number

Note Date

Select Note To Edit

Progress Note Entry

Progress Note For

Existing Service  
Independent Note  
Existing Appointment  
New Service

File Note

Notes Field

Type in this box. Note that intern selects Note Type that is "Cosign" along with supervisor name (Pablo Munoz in example, above).

ADP Regulation for documenting progress towards treatment goals

Note Addresses Which Existing Service/Appointment

Note Type

MH Adult (Cosign)

User To Send Co-Sign To Do Item To

Pablo Munoz

Date Of Service

02/07/2013

Location

Office

AVCALPMLIVE (SAMPLE) 02/07/2013 01:11 PM 108%

Note: This is an intern note with "cosign" note type selected. Supervisor name is selected from

## Progress Notes Without Pagebreaks

(Path: Avatar CWS / Progress Notes)

The screenshot shows the Avatar 2016 software interface. At the top, there's a navigation bar with 'Home', 'summary T', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and a user icon 'MJAVIER'. Below this, a client profile section displays 'TESTCLIENT,SUMMARY (000000001)', 'F, 36, 07/01/1980', and 'Ht: 5' 11.0", Wt: 280 lbs, BMI: 39'. To the right, there's a section for 'Allergies (5)'. The main area is titled 'Progress Notes Without Pagebreaks' and contains a 'Process' button, a 'Select Client' dropdown (showing 'TESTCLIENT,SUMMARY (1)'), a 'Select Episode' dropdown (showing 'Episode # 11 Admit: 05/14/2016 Discharge: NONE Program: A Bett...'), and date pickers for 'Start Date' (05/14/2016) and 'End Date' (03/03/2017).

Note: This is a report of progress notes

The screenshot shows a printed report from the San Francisco Department of Public Health, Community Behavioral Health Services. The title is 'Progress Notes Without Pagebreaks' followed by 'A Better Way SF Outpatient (38GTOP)' and 'From 5/14/2016 To 3/3/2017'. Below this is a black bar with the text 'Confidential Patient Information'. The report contains the following information:

<b>Client Name:</b> TESTCLIENT,SUMMARY	<b>Client ID:</b> 1
<b>Episode #:</b> 11	<b>Admission Date:</b> 05/14/2016
<b>Discharge Date:</b>	

**Service Date** (or Note Date if Independent Note): 8/9/2016  
**Service Code:** Independent Note

**Practitioner:** TURNER,JOSEPH A (014450) PhD/PsyD  
 I have electronically completed and signed this note.

**FTF:** min **Doc/Trav:** min

**This service was provided in the client's preferred language of** English

**Status:** Draft **Finalized Date:** 8/9/2016 **Note Type/For:** MH CYF / Independent Note

**Progress Note:**

## Append Progress Notes

(Path: (Avatar CWS / Progress Notes)

The screenshot displays the 'Avatar 2016' software interface. At the top, there is a navigation bar with 'Home', 'summary T', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and a user profile 'MJAVIER'. Below this, a patient summary is shown for 'TESTCLIENT,SUMMARY (000000001)', a female, 36 years old, born 07/01/1980. Her height is 5' 11.0" and weight is 280 lbs, resulting in a BMI of 39. The summary also lists 'Ep: 11 ...', 'Location: HO...', 'Problem P: -', 'Attn. Pract.: No ...', 'Adm. ...', 'DX P: ...', and 'TU...'. A red triangle icon indicates 'Allergies (5)'. The main area is titled 'Append Progress Notes' and features a large, empty text box for entering notes. To the left of the text box is a sidebar with a 'Submit' button, a set of icons (including a magnifying glass, a document, a trash can, a star, and a star with a checkmark), and a link to 'Online Documentation'. At the bottom of the interface, a status bar shows 'AVCALPMLIVE (LIVE)', the date and time '03/03/2017 05:25 PM', and a zoom level of '128%'. A small red text box at the bottom of the main area reads 'New Comments to Be Appended to the Original Note'.

# PROGRESS NOTES (GROUP AND INDIVIDUAL)

## Individual Progress Notes User Guide

### Introduction:

This document guides users through the “Individual” progress notes pathway in Avatar.

For direction on writing group progress notes, go to “[Group Progress Notes User Guide](#)”

Usually, after completing a one-on-one session with a client, the clinician will then write an individual note about the session. The form used for this purpose is “Progress Notes (Group And Individual)”.

The progress notes form has 2 sections, “Group” and “Individual”.

When writing about the Individual note, the “Group” section of the form is disregarded or ignored.

## Entering Individual Notes:

The screenshot shows the 'Progress Notes (Group and Individual)' window in the Avatar 2011 application. The interface includes a sidebar with 'Individual Progress Notes' and 'Group Default Notes' options. The main area contains fields for 'Select Client', 'Select Episode', 'Progress Note Entry' (with radio buttons for 'Existing Service', 'Existing Appointment', 'Independent Note', and 'New Service'), 'File Note', 'Notes Field', and 'Note Type'. Red 'X' marks are placed over the top right section of the form, indicating a 'forbidden zone' to be avoided.

**1. Go to **Progress Notes (Group and Individual)** Begin at **Individual Progress Notes** section.**

**2. **IMPORTANT!!!****  
Be sure to skip the top 4 fields displayed on the upper right side of form.  
This "forbidden zone" becomes activated only when doing group progress notes.  
Please see Group Progress Notes user guide for instruction.

**3. At **Select Client**, enter client name.**

**3. At **Select Episode****  
Choose client's corresponding episode

**4. At **Progress Note For****  
select "New Service".

**5. Select **Note Type****

**5a. Interns only**  
Select Note Type = "Cosign".  
Then, select supervisor name from "User To Send Co-Sign To Do Item To"

**6. Type in **Notes Field****

Scroll down on page to see the following:

The screenshot displays the 'Progress Notes (Group and Individual)' form in the Avatar Clinical MH system. The form is divided into several sections with various input fields and dropdown menus. Numbered callouts (7-12) provide instructions for data entry:

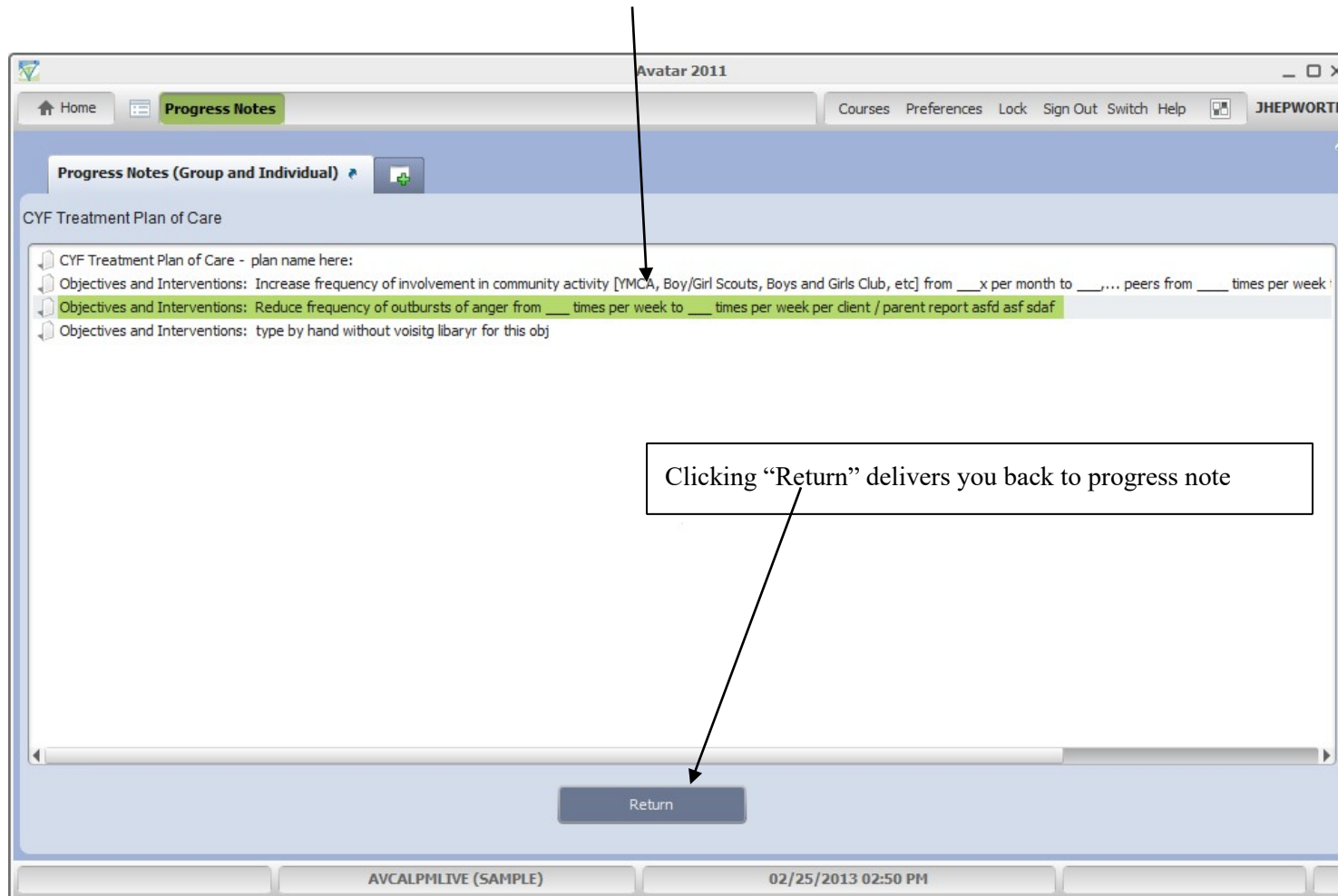
- 7. Select **Date of Service****  
(Field becomes disabled If **Practitioner** is not selected )
- 8 Select **Service Program****  
(Do not select "EPISODE")
- 9 Enter **Service Charge Code**.**  
Please see Jan 2013 CPT code changes.
- 10** If client is  $\leq 18$  yrs, then select appropriate CYF treatment plan and paste into box on right.  
If client is adult, then the "Select T.P. Version" will not work. Go back to "Notes Field" above and hand-type reference to relevant part of Tx Plan.
- 11. Enter **Location** :**  
"Office" if contractor site.  
"CMHC" if civil service site
- 12. Enter Practitioner Face to Face Time (in minutes).**  
Enter Practitioner Doc and Travel Time (in minutes).  
Note: Avatar will not stop you from typing up to "a million minutes" by mistake.

The form fields shown include:

- Date Of Service:** 02/25/2013
- Service Program:** Westside Outpatient Clinic (89052)
- Service Charge Code:** INDIVIDUAL PSYCHOTHERAPY 45-74 MINS (90806)
- Location:** Office
- Practitioner:** HOM, KELLE (000015)
- Practitioner Face to Face Time (minutes):** 53
- Practitioner Doc and Travel Time (minutes):** 19
- Select T.P. Version:** CYF Treatment Plan of Care
- Select T.P. Item Note Addresses:** (Empty box)
- Clear 'Note Addresses Which Treatment Plan Problem':** (Button)



Below, an item from the CYF Treatment Plan is selected and linked to the progress note.



Below, selected objective from Children's Treatment Plan is linked to progress note.

Avatar 2011

Home Progress Notes Courses Preferences Lock Sign Out Switch Help JHEPWORTH

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Date Of Service: 02/25/2013 T Y

Service Program: Westside Outpatient Clinic (89052)

Service Charge Code: INDIVIDUAL PSYCHOTHERAPY 20-44 MINS (90804)

Location: Office

Practitioner Face to Face Time (minutes): 39

Practitioner Doc and Travel Time (minutes): 17

Practitioner: HOM, KELLE (000015)

Note Addresses Which Treatment Plan Problem

Select T.P. Version: CYF Treatment Plan of Care

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Problem' Text.

Objectives and Interventions-> Reduce frequency of outbursts of anger from \_\_\_ times per week to \_\_\_ times per week per client / parent report asfd asf sdf

Below, if there is no Children's Treatment Plan to link (or if using a plan for adults) – type reference to plan in **Notes Field**.

The screenshot shows the 'Avatar 2011' web application interface for entering progress notes. The top navigation bar includes 'Home', 'Progress Notes', 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and a user profile 'JHEPWORTH'. The main section is titled 'Progress Notes (Group and Individual)' and contains a sidebar with 'Individual Progress Notes' and 'Group Default Notes' options, a 'Submit' button, and 'Online Documentation' links. The central area is a large text box for notes, with an arrow pointing to it from the text above. Below the notes box are several form fields: 'Date Of Service' (02/25/2013), 'Location' (Office), 'Service Program' (Westside Outpatient Clinic (89052)), 'Service Charge Code' (INDIVIDUAL PSYCHOTHERAPY 45-74 MINS (90806)), 'Practitioner' (HOM, KELLE (000015)), and 'Practitioner Face to Face Time (minutes)' (48). There are also fields for 'Practitioner Doc and Travel Time (minutes)' (24) and 'Note Addresses Which Treatment Plan Problem'. The bottom status bar shows 'AVCALPMLIVE (SAMPLE)', the date and time '02/25/2013 02:54 PM', and a zoom level of '99%'.

In this example, user selects “draft” and then click’s “File Note” with intent of returning to finalize. User can then close Avatar and return at later time to edit draft note.

Avatar 2014

Home Progress Notes Preferences Lock Sign Out Switch Help

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Problem' Text.

[ADP Regulation for documenting progress towards treatment goals](#)

Draft/Final  
☒ Draft ☐ Final

Select Draft Note To Edit

File Note

Delete Draft Note

**'Delete Draft Note' button to be used for Individual Progress Notes only**


13. Select Draft or Final. Then, click “File Note”  
“Draft” status allows additional editing of note.  
“Final” status prevents further editing.  
“Delete Draft Note” allows user to delete her/his draft progress note.

AVCALPMLIVE (LIVE) 02/19/2015 03:20 PM 144%

## Retrieving Draft Notes:







If note has been saved as draft, retrieve by returning to Progress Notes (Group and Individual).

The screenshot displays the Avatar 2011 web application interface for Progress Notes. The top navigation bar includes 'Home', 'Progress Notes' (highlighted), 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and the user 'JHEPWORTH'. The main content area is titled 'Progress Notes (Group and Individual)' and features a sidebar with 'Individual Progress Notes' and 'Group Default Notes' sections, a 'Submit' button, and 'Online Documentation' links. The central form is divided into several sections: 'Select Client' with a text input containing 'CARLOS FUENTES (981248689)' and a callout '1. Enter client name.'; 'Select Episode' with a dropdown menu showing 'CARLOS FUENTES (981248689)' and a callout '2. Select episode'; 'Progress Note Entry' with radio buttons for 'Existing Service', 'Independent Note', 'Existing Appointment', and 'New Service'; and a 'Notes Field' with a text area and a link to 'ADP Regulation for documenting progress towards treatment goals'. On the right side, there are fields for 'Group Name or Number', 'Note Date' (with a calendar icon), 'Select Note To Edit' (a dropdown), 'Note Addresses Which Existing Service/Appointment' (a dropdown), 'Note Type' (a dropdown), and 'User To Send Co-Sign To Do Item To' (a dropdown).

Progress Notes (Group and Individual) 

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Problem

3. Click on the gray bar immediately below “Select Draft Note To Edit”  
All draft notes for client will appear.

Selected note will populate fields with information  
(No need to click the “Draft” radio button).

▼

Draft/Final  
☐ Draft ☐ Final

File Note

Select Draft Note To Edit

Delete Draft Note *'Delete Draft Note' button to be used for Individual Progress Notes only*

Entry Date: 03/20/2015 Service: HOM,KELLEE(000015) Note Type: BHAC Screening Note Time: 03:15 PM

Evidence-Based Practices / Service Strategies (CSI)

☐ Age-Specific Service Strategy  
☐ Assertive Community Treatment  
☐ Delivered in Partnership with Health Care

Co-Practitioner Face to Face Time (minutes)

Co-Practitioner Doc and Travel Time (minutes)

Below is selected note.

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Type note in this box. If treatmentplan is not linked to progress note via ~~TR~~-linking tool below, then type "note addresses specific part of treatment plan such as objective X ", etc. Continue working on this note.

The Provider submitting this progress note certifies that the services provided are supported by appropriate documentation and comply with applicable Federal, State, and City and County of San Francisco regulations.

If service was conducted in the client's preferred language other than English, indicate which language

Language  Other

Date Of Service  Location

4. After edits are complete, select "Final" and click "File Note".

Draft/Final

☐ Draft ☒ Final

File Note

**“Append Progress Note”** function allows addition of comment to a finalized note by author. Except – interns are not allowed to append finalized notes that have been approved by supervisor.

# Group Registration

(Path: Avatar PM / Appointment Scheduling / Group Management)

Avatar 2011

Home

Carlos F

Oakes B

Courses

Preferences

Lock

Sign Out

Switch

Help

JHEPWORTH

Oakes behavior mgmnt/fri pm (000153)

Group Registration

Group Registration

Group Member Assignm...

Submit

Online Documentation

Group Name

Oakes behavior mgmnt/fri pm

Group Registration Date

08/02/2012

T

Y

AVCALPMLIVE (SAMPLE)

02/07/2013 01:24 PM

108%



Group Registration - continued

Oakes behavior mgmnt/fri pm (000153)

Group Registration

Group Registration

Group Member Assignm...

Submit

Online Documentation

Group Member Assignment

Client	Episode Number	Group Assignment Start Date	Group Assignment End Date
WALKER,JOHNNY (326)	1	08/02/2012	01/22/2013
JASMINE,PRINCESS (1...	1	08/02/2012	08/15/2012
TOM,JERRY (346)	1	08/02/2012	

Add New Item

Edit Selected Item

Delete Selected Item

Client

WALKER,JOHNNY (326)

Group Assignment Start Date

08/02/2012

T

Y

Group Assignment End Date

01/22/2013

T

Y

Episode Number

Episode # 1 Admit : 06/27/201

Avatar Clinical MH Training 2-24-2021

Page | 92

## Group Progress Notes User Guide

### Introduction:

This document guides users through the “Group” progress notes pathway in Avatar.

For direction on writing Individual progress notes, go to “[Individual Progress Notes User Guide](#)”

Usually, after completing a group session, the clinician will then write a group note (and then individualize). The form used for this purpose is “*Progress Notes (Group and Individual)*”.

The progress notes form has 2 sections, “Group” and “Individual”.

Work begins on the “Group” section and then continues on the “Individual” section.

## Creating Group Progress Notes:

1. Go to **Progress Notes (Group and Individual)** Begin at **Group Default Notes** section.

2. At **Date of Group** enter service date

3. At **Practitioner** enter clinician name "last,first"

4. At **Progress Note For** Select **ONLY** "New Service" Choose "New Service" for billable or nonbillable (no show or admin)

5. At **Group Name or Number** enter group and view names of group members in grey box to the immediate right.

6. Do NOT click **File Note** button

7. In text box labeled **Note**, type initial paragraph/s about group session

8. At **User To Send Scratch Note To** select your own name.

9. At **Note Type**, select "Group" or other appropriate code from dropdown list

10. If intern, select **Note Type** code that includes "cosign". Then select supervisor from "User To Send Co-Sign..." box)

The screenshot shows a web-based form for creating group progress notes. The form includes fields for Date of Group (03/05/2013), Practitioner (HOM, KELLE (000015)), Progress Note For (Existing Service, Independent Note, New Service), Group Name Or Number (Westside Bipolar Support Group W am (143)), and a list of group members (TREY, GARRETT (281) Episode: 1, LEWIS, JOHN (292) Episode: 1, MCCOURT, FRANK (981243989) Episode: 1). There is a 'File Note' button and a 'Note' text box. The form also has a 'User To Send Scratch Note To' dropdown and a 'Note Type' dropdown. The bottom of the form shows the user's name (AVCALPHIVE (SAMPLE)) and the date/time (03/05/2013 09:41 AM).

11. At **“Service Program”** box, select desired program name. Do NOT select “EPISODE”

12. At **“Service Charge Code”** Enter word/code (e.g. “DBT Group Therapy”).  
See Jan 2013 CPT Code changes

13. At **“Location”**, select as appropriate.

14. Do NOT click “File Note”.

15. Enter the total number of clients attending “group session”.

16. Enter **“Practitioner Face To Face Time (in minutes)”** for group. Enter total time without multiplying time by number of clients. In the example above 63 minutes was time counted from first client arrival till last client departure from group session.  
  
Do NOT multiply “63 minutes” (Number of clients). Avatar will automatically calculate individual client service charge.  
  
Then add **“Practitioner Doc and Travel Time (in minutes)”**. After filing group note these numbers cannot be changed.

Service Program: Westside Outpatient Clinic (89052)

Service Charge Code: DBT GROUP THERAPY (H2015GD)

Location: Office

Practitioner Face to Face Time (minutes): 63

Practitioner Doc and Travel Time (minutes): 24

Co-Practitioner:

Number Of Clients In Group: [ ]

Add Client To Group

Client To Be Added To Group: [ ]

Episode Number: [ ]

AVCALPMLIVE (SAMPLE) 03/05/2013 09:56 AM 99%

Adding walk-in and Removing the no-show client from group session:

Avatar 2011

Home Progress Notes Courses Preferences Lock Sign Out Switch Help JHEPWORTH

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Service Program Westside Outpatient Clinic (89052)

Service Charge Code

Practitioner Face to Face Time (minutes) 63

Practitioner Doc and Travel Time (minutes) 24

Co-Practitioner

Number Of Clients In Group

Add Client To Group

Client To Be Added To Group

Episode Number

Remove Client From Group

Removal Selection

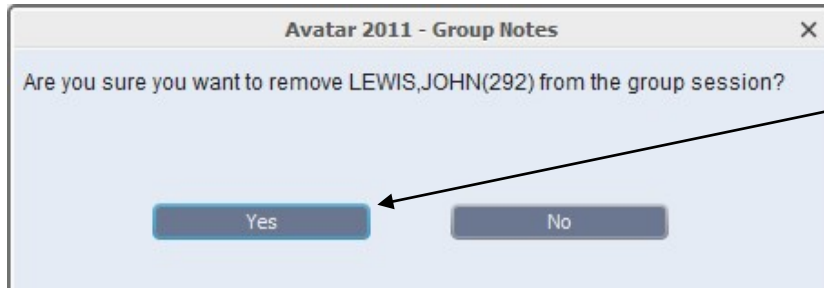
LEWIS,JOHN(292)  
MCCOURT,FRANK(981243589)  
TREY,GARRETT(281)

17. Click “Add Client To Group” button to add walk-in client to group session

Note: Walk-in activity is independent of Group Membership. This means that it is not necessary for walk-in client to become an official group member.

18. Click “Remove Client From Group” button to remove ‘no-show’ client (e.g., John Lewis) from group session

AVCALPMLIVE (SAMPLE) 03/05/2013 10:01 AM 99%



19 After selecting client name for removal (above), Dialogue box appears. This confirms your intent to remove client from this group session:

Group Progress Notes

Group Default Notes

Submit

Online Documentation

Group Name Or Number

File Note

Note

Service Program

Service Charge Code

Location

File Note

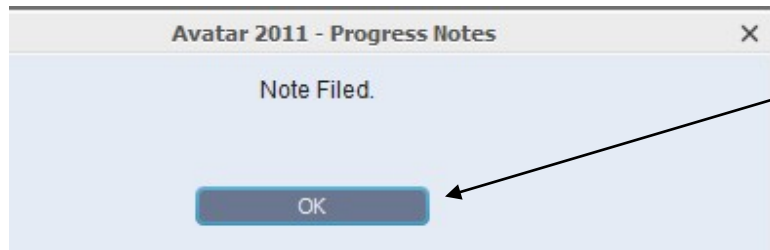
Group Service Member Information

Practitioner Face to Face Time (minutes)

Practitioner Doc and Travel Time (minutes)

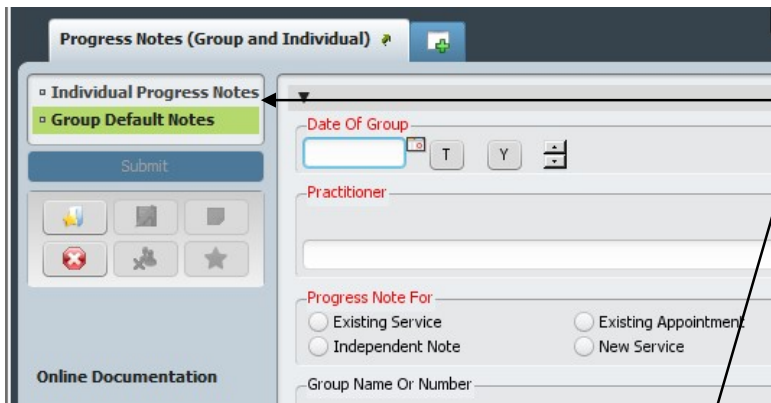
Co-Practitioner

20. When finished writing note, click on either of the two "File Note" buttons.

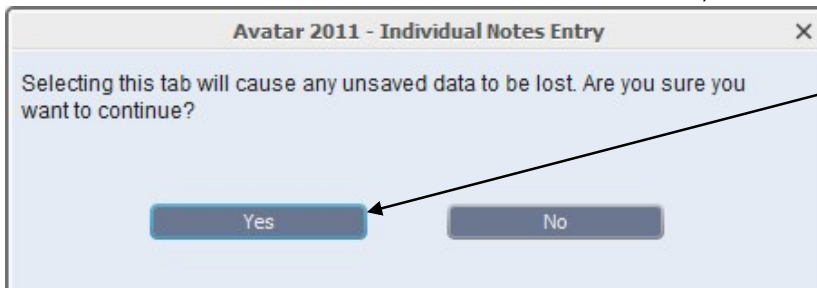


21. The “Note Filed” alert will appear. Click “OK” to complete the process. Now your work on the **Group Default Notes section** is done. You can close progress notes now and then resume instruction on the following page (8) at a later time. Or, you can continue the process right now by following steps 22 and 23.

Below is image of user leaving the **Group Default Notes** section and selecting **Individual Progress Notes** section



22. If you move to “Individual Progress Notes” section, in order to individualize notes per instructions that follow, Avatar will display a warning that unsaved data will be lost



23. Go ahead and click “Yes” if you have already filed group note.

## Individualize the Group Note:

After Group Note has been filed, go to “Individual Progress Notes” section to individualize the group note.

Avatar 2011

Home Progress Notes Courses Preferences Lock Sign Out Switch Help JHEPWORTH

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Select Client

Select Episode

Progress Note Entry

Progress Note For

Existing Service Existing Appointment  
Independent Note New Service

File Note [ADP Regulation for documenting progress towards treatment goals](#)

Notes Field

Group Name or Number

Westside Bipolar Support Group W am (143)

Note Date

03/05/2013 T Y

Select Note To Edit

Service Date: 03/05/2013 DBT GROUP THERAPY (H2015GD) MCCOURT,FRANK(981243589)  
Service Date: 03/05/2013 DBT GROUP THERAPY (H2015GD) TREY,GARRETT(281) HOM,KELI

Note Type

User To Send Co-Sign To Do Item To

1. On right side of page, enter Group Name/Number.

2. Enter the correct “Note Date” (date that note was written).

3. Click on **Blue-outlined** grey box labeled “Select Note To Edit” and select your group note that Avatar has transformed into multiple individual notes - one for each group member.

These individualized group notes are in limbo. The next step is to save each of these notes as draft or final.

AVCALPMILIVE (SAMPLE) 03/05/2013 10:15 AM 99%



In example, below – the individualized group note for client, Frank McCourt is selected.

Avatar 2011

Home Progress Notes Courses Preferences Lock Sign Out Switch Help JHEPWORTH

Progress Notes (Group and Individual)

Individual Progress Notes Group Default Notes

Select Client

4. Selected note belongs to client Frank McCourt. Selection is Green.

5. Note that Avatar has re-coded Progress Note For as "Existing Service".

Progress Note Entry

Progress Note For

Existing Service Existing Appointment Independent Note New Service

File Note ADP Regulation for documenting progress towards treatment goals

Notes Field

1st paragraph/ about the group sessio. Type in this box.

Select Note To Edit

Service Date: 03/05/2013 DBT GROUP THERAPY (H2015GD) MCCOURT, FRA...

Service Date: 03/05/2013 DBT GROUP THERAPY (H2015GD) MCCOURT, FRANK(981243589)

Service Date: 03/05/2013 DBT GROUP THERAPY (H2015GD) TREY, GARRETT(281) HOM, KELI

Note Type

Group

User To Send Co-Sign To Do Item To

AVCALPMLIVE (SAMPLE) 03/05/2013 10:16 AM 99%

6. After selecting note, edit the **Notes Field** by adding a 2<sup>nd</sup> paragraph relevant to client “Frank McCourt”.

7. Scroll to bottom of page to see that Practitioner Face to Face Time and Doc/Travel Time boxes are empty. This data is not lost, but hidden from view. There is no need to re-enter time.

8. Select T.P. version to link to a children’s treatment plan. Note that adult treatment plans are not linkable to progress note via this mechanism.

For adults - scroll upward to type Tx Plan reference in “Notes Field”.

Finalizing the progress note:

9. Scroll downward and Select “Final” and then click “File Note”.

Progress Notes (Group and Individual)

Individual Progress Notes

Group Default Notes

Submit

Clear 'Note Addresses Which Treatment Plan Problem' Text.

Draft/Final

☐ Draft

☒ Final

Select Draft Note To Edit

File Note

Delete Draft Note

*'Delete Draft Note' button to be used for Individual Progress Notes only*

Co-Practitioner

Box below confirms that note has been filed for client, Frank McCourt.

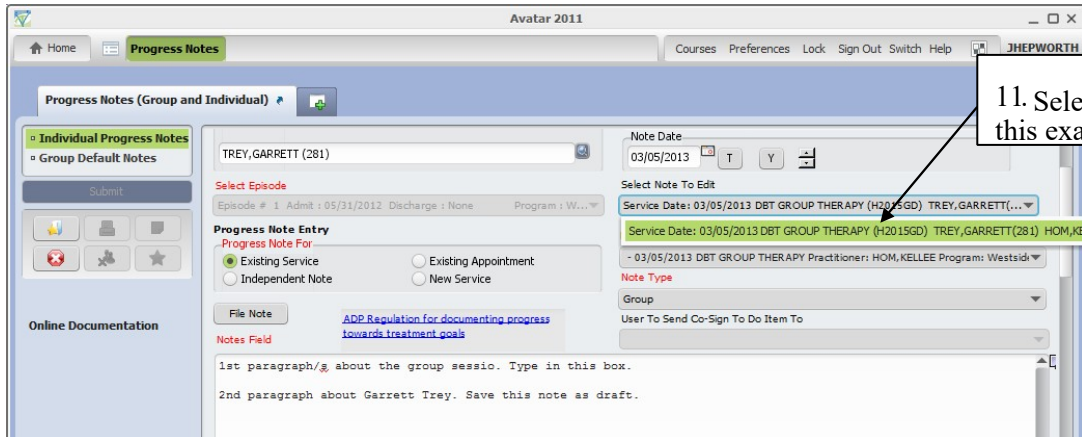
Avatar 2011 - Progress Notes

Note Filed.

OK

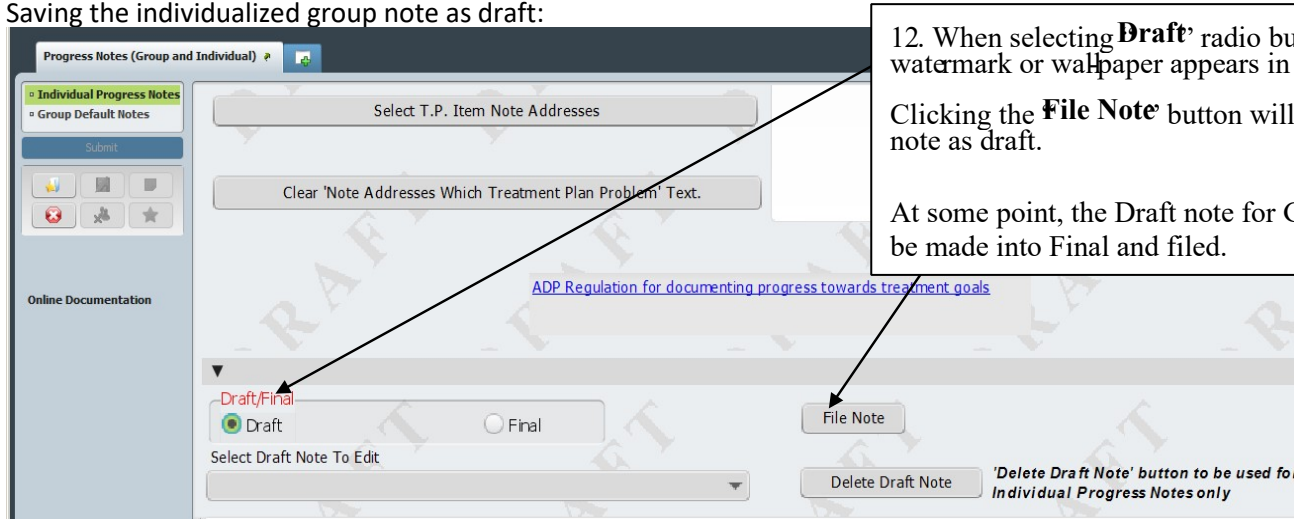
10. Click “OK”

Now, a single note remains in limbo. Note belongs to client, Garrett Trey.



11. Select sole remaining note “In Limbo”. Note in this example belongs to client “Garrett Trey”.

Saving the individualized group note as draft:

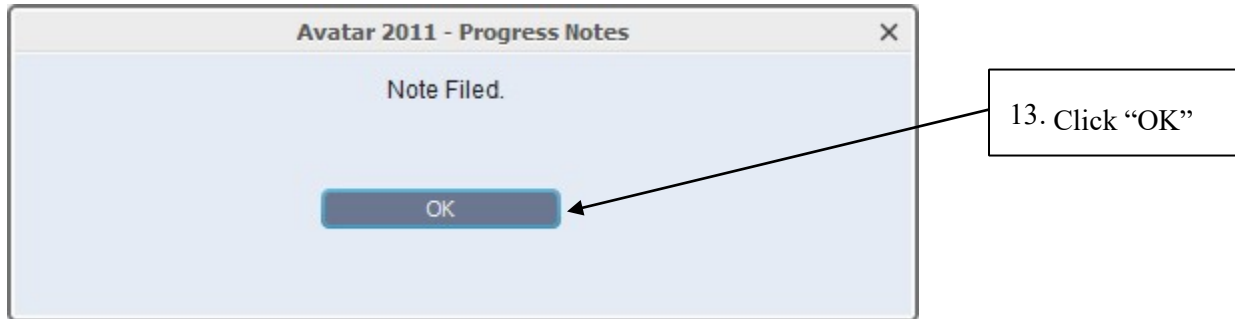


12. When selecting **Draft** radio button, the “DRAFT” watermark or wallpaper appears in background.

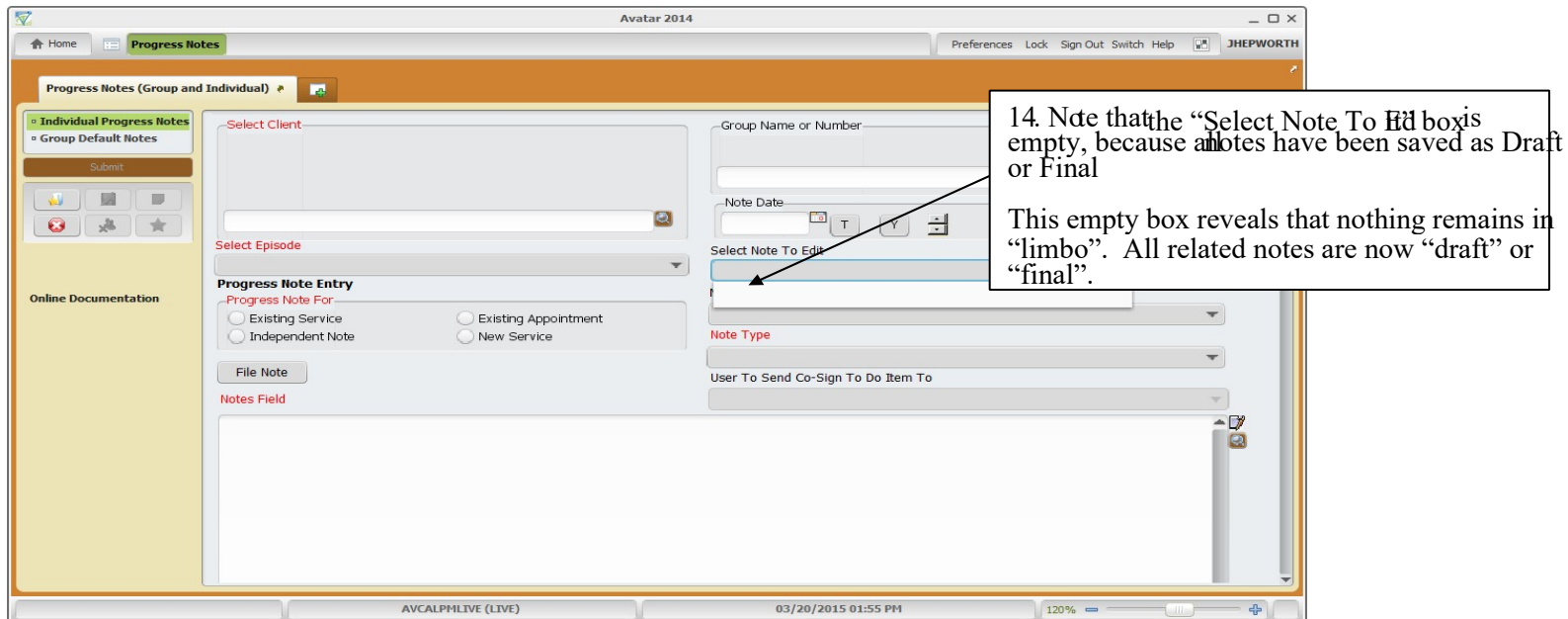
Clicking the **File Note** button will save Garrett Trey’s note as draft.

At some point, the Draft note for Garrett Trey must be made into Final and filed.

This box, below is confirmation that note was filed.



Below is an image of an empty "Select Note To Edit" box:



Retrieving draft note for Garrett Trey:

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Select Client

GARRETT TREY (281)

Select Episode

Episode # 1 Admit: 05/31/2012 Discharge: None Program: v

Episode # 1 Admit: 05/31/2012 Discharge: None Program: Westside Outpatient Clinic (89052)

Progress Note For

☐ Existing Service ☐ Existing Appointment  
☐ Independent Note ☐ New Service

File Note

Notes Field

Note Date

Select Note To Edit

ises Which Existing Service/Appointment

Note Type

User To Send Co-Sign To Do Item To

ADP Regulation for documenting progress towards treatment goals

Avatar 2011

Home Progress Notes

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Select I.P. Item Note Addresses

Clear Note Addresses Which Treatment Plan Problem Text.

Draft/Final  
☒ Draft ☐ Final

Select Draft Note To Edit

Entry Date: 03/05/2013 Service Date: 03/05/2013 DBT GROUP THERA...

Evidence-Based Practices / Service Strategies (CSI)

☐ Age-Specific Service Strategy  
☐ Assertive Community Treatment  
☐ Delivered in Partnership with Health Care

AVCALPMLIVE (SAMPLE) 03,

16. Scroll down to “Select Draft Note To Edit” (blue outlined grey box) at bottom of page. This box contains all draft notes for client – regardless of origin as group or individual.

17. After note is selected, the “Draft” status appears



Making final edits.

The screenshot shows the Avatar 2011 web application interface. The top navigation bar includes 'Home', 'Progress Notes', 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and a user profile 'JHEPWORTH'. The main content area is titled 'Progress Notes (Group and Individual)' and has a sidebar with 'Individual Progress Notes' and 'Group Default Notes'. The 'Individual Progress Notes' section is active, showing a 'Select Client' dropdown with 'TREY, GARRETT (281)' selected. Below this is a 'Select Episode' section with 'Episode # 1', 'Admit : 05/31/2012', 'Discharge : None', and 'Program : W...'. The 'Progress Note Entry' section has two columns of radio buttons: 'Existing Service' (selected), 'Independent Note', 'Existing Appointment', and 'New Service'. A callout box points to the 'Existing Service' radio button with the text: '18. Make final edits. Remember that the Time (minutes) is saved in Avatar, but hidden from user's view.' To the right of the radio buttons is a 'Select Note To Edit' dropdown. Below the radio buttons is a 'File Note' button and a link: 'ADP Regulation for documenting progress towards treatment goals'. The 'Notes Field' is a large text area containing two paragraphs: '1st paragraph/s about the group sessio. Type in this box.' and '2nd paragraph about Garrett Trey. Save this note as draft. Now, |continue editing this note.' The bottom status bar shows 'AVCALPLIVE (SAMPLE)', the date and time '03/05/2013 10:43 AM', and a zoom level of '99%'.



Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

Clear 'Note Addresses Which Treatment Plan Problem' Text.

Draft/Final  
☐ Draft ☒ Final

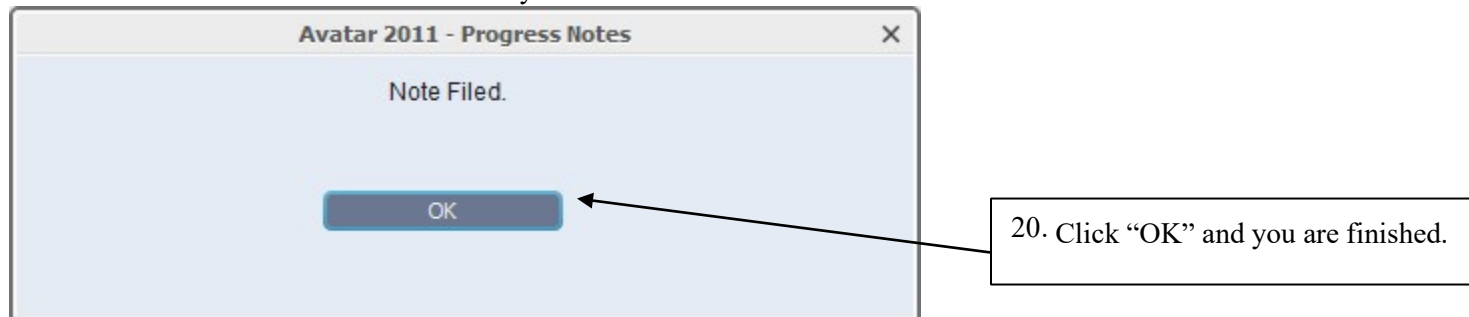
Select Draft Note To Edit

File Note

Delete Draft Note

*'Delete Draft Note' button to be used for Individual Progress Notes only*

Confirmation that note has been successfully filed:



Note: an "Intern" note that is final + approved by supervisor cannot be appended.

# SERVICE CORRECTIONS

## Edit Service Information

(Path: Avatar PM / Services / Ancillary / Ambulatory Services)

Edit Service Information

Edit Service Information

Submit

Online Documentation

Client ID

Episode Number

Service Code

Program

Location

Duration (Minutes)

Cost Of Service

Co-Practitioner 2

Diagnosis 1

Co-Practitioner 2 Duration (Minutes)

Service Start Date

Service End Date

Service Selection Default

Select Service(s) To Edit

Practitioner

Modifiers

Co-Practitioner

Co-Practitioner Duration (Minutes)

Evidence-Based Practices / Service Strategies (CSI)

Additional Service Information

# VOCATIONAL REFERRALS

## MH Vocational Program Referrals/Enrollments

(Path: Avatar PM / New Forms)

MH Programs are expected to assist clients by referring or enrolling them into Vocational Programs.

The screenshot shows a web application interface for "MH Vocational Program Referrals / Enrollments". The form is titled "Vocational Program Referrals and Enrollments" and includes a brief description: "The collection of the information applies to Adult Outpatient Mental Health Programs. Vocational programs, in this case, are defined as any vocational, training, educational, volunteer, or employment activity." The form is divided into several sections: "Referral or Enrollment?" with radio buttons for "Referral" (selected) and "Enrollment"; "Date of Referral / Enrollment" with a date picker set to "05/31/2016" and a time selector; "Referral / Enrollment Type" with radio buttons for "Vocational Program", "Training/Education", "Volunteer", and "Paid Employment"; and "Confirmed By" with a text input field. Below these sections are four rows of input fields: "Vocational Program", "Other", "Training/Education", and "Other" for both "Referral" and "Enrollment" types. The interface includes a sidebar with a "Submit" button and a "Referrals / Enrollments" tab.

# DISCHARGE BUNDLES

## Discharge (Outpatient)

(Path: Avatar PM / client Management / Episode Management)

### Discharge

The screenshot shows the 'Discharge (Outpatient)' form in the Avatar PM system. At the top, patient information for Carlos Fuentes (981248689) is displayed, including his date of birth (06/11/1952) and current episode (1: Westside Outpatient...). The form is divided into several sections: a left sidebar with 'Discharge' and 'Demographics' tabs, a main data entry area, and a right section for practitioner and remarks. The main area includes fields for 'Date Of Discharge' (02/07/2013), 'Discharge Time' (01:32 PM), 'Discharge Day Of Week' (THURSDAY), 'Length Of Stay' (241), and 'Type Of Discharge' (No Further Care Needed At This Facility). The right section includes a 'Discharge Practitioner' dropdown (NAN DAME (000006)) and a 'Discharge Remarks/Comments' text area with the placeholder text 'type comments about discharge'.

**Patient Information:**  
Name: CARLOS FUENTES (981248689)  
DOB: M, 60, 06/11/1952  
Ep: 1: Westside Outpatient ...  
Location: homeless, San Francisco, ...  
Problem P: -  
DX P: 309.81 POSTTRAUMATIC ...  
Attn. Pract.: MUNOZ, PABLO  
Adm. Pract.: HEPWORTH, JON  
Allergies (0)

**Discharge (Outpatient) Form:**

- Episode Number:** 1
- Date Of Discharge:** 02/07/2013
- Discharge Time:** 01:32 PM
- Discharge Day Of Week:** THURSDAY
- Length Of Stay:** 241
- Type Of Discharge:** No Further Care Needed At This Facility
- Discharge Practitioner:** NAN DAME (000006)
- Discharge Remarks/Comments:** type comments about discharge

## Discharge (Outpatient) - continued

### Demographics

The screenshot displays the Avatar 2011 software interface. At the top, the user is logged in as 'Carlos F'. The client's information is shown as 'CARLOS FUENTES (981248689)', born 'M, 60, 06/11/1952'. The location is 'homeless, San Francisco,...'. The problem is listed as '309.81 POSTTRAUMATIC...'. The attending practitioner is 'MUNOZ, PABLO' and the admitting practitioner is 'HEPWORTH, JON'. The 'Allergies (0)' section is empty.

The main section is titled 'Discharge (Outpatient)' and contains a 'Demographics' sub-section. The 'Demographics' section includes the following fields:

- Client Last Name: FUENTES
- Client First Name: CARLOS
- Client's Middle Initial: [Empty]
- Suffix: [Radio buttons for Sr, Jr, III, IV, V, VI]
- Prefix: [Dropdown menu]
- Client's Address - Street: homeless
- Client's Address - Street 2: [Empty]
- Client's Address - Zipcode: 94103-2649
- Client's Address - City: San Francisco
- Client's Address - County: San Francisco
- Client's Address - State: CALIFORNIA
- Client's Home Phone: [Empty]
- Client's Work Phone: [Empty]
- Client's Cell Phone: [Empty]
- Client's Email Address: [Empty]
- Communication Preference: [Radio buttons for Email, Regular Mail, Home Phone, Work Phone, Cell Phone]
- Primary Language: [Dropdown menu]
- Client Race: [Dropdown menu]
- Ethnic Origin: [Dropdown menu]
- Religion: [Dropdown menu]
- Place Of Birth: [Empty]
- Country Of Origin: [Dropdown menu]
- Maiden Name: [Empty]
- Marital Status: Single / Never Married
- Education: [Dropdown menu]
- Alias 7: [Empty]
- Alias 8: [Empty]

The bottom of the interface shows the file name 'AVCALPHIVE (SAMPLE)', the date and time '02/07/2013 01:33 PM', and the zoom level '108%'.

## Child Youth and Family

### CANS CYF 5/18 Closing Summary

(Path: Avatar CWS / Assessments / User Defined Assessments / CANS)

**CANS CYF 5/18 Closing Summary**

**1 - Closing Summary**

- 2 - Child Behavioral / E...
- 3 - Impact on Functioning
- 4 - Risk Behaviors
- 5 - Child Strengths
- 6 - Caregiver Strengths ...
- 7 - Foster Caregiver Re...
- 8 - Medication
- 9 - Summary of Treatm...
- 10 - Discharge Plan

**Date**  
11/10/2015

**Completion Date**  
[ ]

**Age Category**  
☐ 0 - 4 ☒ 5 - 18

**Type of Assessment**  
Closing

**Last Date of Service**  
[ ]

**Program**  
CCDC Child Dev Center (38746)

**Draft / Pending Approval / Final**  
☒ Draft ☐ Pending Approval ☐ Final

**Team Member to Notify**  
Kellee Hom

**Team Member to Notify Outgoing Comments**  
Kellee Hom

**Submit**

## CANS CYF Closing Summary Rpt

(Path: Avatar CWS / Assessments / User Defined Assessments / CANS)

Chart CANS CYF 5/18 Closing Summary CANS CYF Closing Summary Rpt


CANS CYF Closing Summary

Process

Patient ID: TESTCLIENT,SUMMARY (1)

Episode: Episode # 1 Admit: 07/01/2010 Discharge: NONE Program: ACCES..

Select Assessment Date: 02/28/2015

 <p>San Francisco Department of Public Health Community Behavioral Health Services</p> <p><b>CANS CYF Closing Summary Report</b></p>	<p><b>NAME:</b> TESTCLIENT,SUMMARY</p> <p><b>Client ID #:</b> 1</p> <p><b>Episode Program:</b> ACCESS Screening</p> <p><b>Episode #:</b> 1</p> <p><b>Print Date:</b> 05/23/2016</p>
---	---

### Confidential Patient Information

Assessment Date: 2/28/2015  
Assessment Practitioner: Kimberly Voelker

Episode Opening Date: 7/1/2010

Last Date of Service:

#### CLINICIAN INFORMATION

Name of Clinician: VOELKER,KIMBERLY

Type of License /

Registration / Title: Unlicensed Worker

Clinician Address: 1380 Howard St

San Francisco, CA 94103-2638

Telephone: 415-503-4730

Assessment Date: 2/28/2015

Program of Service: A Better Way (38GI2)

Completion Date

Assessment Status: Draft

#### I. CHILD BEHAVIORAL / EMOTIONAL NEEDS (refer to CANS Manual for detailed Scoring instructions)

Key: 0 = no evidence or no reason to believe item requires any action. 1 = needs watchful waiting, monitoring or possibly preventive action.  
2 = needs action. Strategy needed to address problem/need. 3 = needs immediate / intensive action. Immediate safety concern / priority for intervention.

Psychosis 1  
Impulse/Hyperactivity 1  
Depression 1  
Anxiety  
Oppositional

Conduct  
Substance Use  
Somatization  
Anger Control

#### Trauma Symptoms

Affect Regulation  
Intrusions  
Attachment  
Dissociation  
Adjustment to Trauma

## ADULT / OLDER ADULT

### Adult/Older Adult Closing Summary

(Path: Avatar CWS / Assessments / Adult Assessments/ANSA)

**1. CLOSING SUMMARY**

- 1a. Behavioral Health N...
- 1b. Life Domain Functio...
- 1c. Danger To Self Or Ot...
- 1d. Risk Behaviors
- 1e/1f. Substance Use R...
- 1g. Medication Complia...
- 1h. Acculturation
- 1i. Client Strengths

Submit

Date of assessment/rating: 02/28/2015

Assessment Type: Adult/Older Adult Closing Summary

Program of Service: A Better Way (38GI2)

Opening date: 02/28/2015

Last Date of Service: [Empty]

Status - Draft / Pending Approval / Final

☒ Draft ☐ Pending Approval ☐ Final

Supervisor to Notify: Kellee Hom

Supervisor to Notify Outgoing Comments: asdfasdf

(to be completed if client was seen more than 5 times). In addition, rate client on ANSA items.

1. Summary of treatment (including interventions, responses/ treatment progress toward goals, and other clinically relevant information)


2. Discharge plans, including reason for discharge, condition on discharge and referrals.

Closing Summary



## Adult/Older Adult Closing Summary Rpt

(Path: Avatar CWS / Assessments / Adult Assessments/ANSA)

 <p>San Francisco Department of Public Health Behavioral Health Services</p> <p><b>Adult/Older Adult Closing Summary</b></p>	<p><b>Client Name:</b> TESTCLIENT,SUMMARY</p> <p><b>Client ID:</b> 1</p> <p><b>Program:</b> ACCESS Screening (BHAC)</p> <p><b>Episode #:</b> 1</p> <p><b>Admission Date:</b> 7/1/2010</p> <p><b>Discharge Date:</b> None</p>
---	--

### Confidential Patient Information

<p><b>Assessment Date:</b> 2/27/2015</p> <p><b>Assessment Type:</b> Adult/Older Adult Closing Summary</p>	<p><b>Assessment By:</b> Kimberly Voelker (000089)</p> <p><b>Service Program:</b> A Better Way (38GI2)</p> <p><b>Assessment Status:</b> Draft</p>
---	---

1. Summary of Treatment (including interventions, responses / treatment progress toward goals, and other clinically relevant information)
2. Discharge plans, including reason for discharge, condition on discharge and referrals.

Closing Summary:

#### 1a. Behavioral Health Needs

NA= Not Applicable; ND=No Data; 0=No Evidence; 1=Mild. History/sub-threshold, watch;  
2=Moderate. Need for action; 3=Severe. Need for immediate/intensive action.

- Psychosis
- Depression
- Anxiety
- Adjustment to trauma
- Impulse control
- Interpersonal problems

# REPORTS

## MHS140 Report

(Path: Avatar PM/Client Management/Client Information)

Report : MHS140  
County: San Francisco

Client Information Face Sheet  
SUMMARY TESTCLIENT (1)

Run Date: 5/23/2016  
Page 1 of 1

Name: TESTCLIENT,SUMMARY      Number: 1      Birthdate: 07/01/1980      Age: 35  
Address: Homeless      SSN: 111-11-1199      Sex: F  
San Francisco, UT 94103      Other ID#:      Language:Korean  
Phone: 415-412-1923      Marital: Not Married      Education: 19 Grade  
Disability: No Entry      Ethnicity: Korean  
Hispanic Origin: Non- Hispanic

Aliases: MUNOZ,PABLO  
RP Owes \$0.00

Cost Data: Last 6 Months:      Last 12 Months:      Last 24 Months:

OPEN EPISODES									
Ep#	Reporting Unit	Telephone	Opening	Last Service	Closing	DSM-4	ICD-10	Clinician	
12	IPCOM UCSF Primary Care Outreach (IPCOM)	Unknown	05/22/2016					NAVARRO-SIMEON,B ERNADETTE (013531)	
11	38GTOP A Better Way-SF Outpatient (38GTOP)	415-715-1050	05/14/2016					TURNER,JOSEPH A (014450)	
7	38GS01 AFS SF Therapeutic Visitation (38GS01)	415-856-0116	01/12/2016			311		TURNER,JOSEPH A (014450)	
3	38AP Fee for Service MFCC (38AP)	Unknown	02/28/2015	03/10/2016		301.81	F60.81	ANDERSON,HANS (013179)	
2	38IM01 City College of San Francisco (38IM01)	415-239-3975	12/01/2014			296.50	F31.30	HOM,KELLEE (003865)	
						305.50	F11.90		
						E929.5	W56.21XS		
						305.60	F14.90		

The MHS140 Report shows the entire episode history of selected client.

## Caseload by Clinician Report

(Path: Avatar CWS / Reports)

The Caseload by Clinician Report shows the list of clients for the clinician that is logged into Avatar. You can select Admitting Practitioner/Primary Clinician for the ongoing clinician or Attending Practitioner/Physician for the MD or NP.



San Francisco Department of Public Health  
Community Behavioral Health Services

### Caseload by Clinician Report

Admitting Practitioner/Primary Clinician  
Kellee Hom (003865)

#### Confidential Patient Information

Client Name	Client ID	Age	Race	Epi#	Admitting Practitioner	Attending Practitioner	Episode Opening	Last Service Date	Active/Inactive?
SF SU Student Success Program (38HQIN)									
TESTTEST,SUMTEST	999049104	14	No Entry	1	HOM,KELLEE	No Entry	5/30/2015		NO SERVICES
Total caseload for program: SF SU Student Success Program (38HQIN) :						1			

## Staff Activity By Program Detail Report

(Path: Avatar PM/Operations Reports)

This report lists all finalized services provided by the staff who is logged in for the specified time frame. It will show the total of Number of Services and time.

Only direct services that are entered via progress notes appear on report. Report does not display “MAA” or Indirect services

San Francisco Department of Public Health  
Community Behavioral Health Services

(PSP117-I)

**Individual Staff Activity by Service Date**  
**Services Provided between 1/1/2010 and 5/23/2016**  
**by KELLEEE HOM (003865)**

**Confidential Patient Information**

Service Date	Client or Group Name	Epi #	Service Code/Description	Time (Min)	Co-Staff?	# in Group
<b>Program: ACCESS Screening</b>						
04/11/2016	TESTCLIENT,SUMMARY (1)	1	ADM00 NO SHOW	6		
Subtotal for 4/11/2016				6		
Subtotal for Program BHAC				6		

## Crystal Client Ledger

(Path: Avatar PM/Operations Reports)

This report shows all services (via Progress Notes and other data entry) provided to selected client during selected time period.

Charge per service is also displayed.

Avatar\_Cal\_PM\_Client\_LedgerRdef SF PJM.rpt

San Francisco DPH  
1380 Howard St  
San Francisco CA, 94015

**Client Account Ledger**

Client Name: [DECLINED,VISA](#)      [Diagnosis History](#)  
 Client ID : 394      [Graph of Charges & Payments By Month](#)  
 Selected Episode: Program: Westside Outpatient Clinic (89052) Admit Date: 8/14/2012 Discharge Date:

Date of Service	Service Description	Full Charge	Practitioner	Guarantor Name	Guarantor Liability	Guarantor Payments	Claim Number
12/17/2013	GROUP PSYCHOTHERAPY	\$ 95.10	000063	CSM Default Payor	\$ 95.10	\$ 0.00	Open
02/21/2014	INDIVIDUAL PSYCHOTHERAPY 45-74 MINS	\$ 336.02	000106	CSM Default Payor	\$ 336.02	\$ 0.00	Open
02/21/2014	INDIVIDUAL PSYCHOTHERAPY 45-74 MINS	\$ 221.90	000172	CSM Default Payor	\$ 221.90	\$ 0.00	Open
02/21/2014	GROUP PSYCHOTHERAPY	\$ 85.59	000172	CSM Default Payor	\$ 85.59	\$ 0.00	Open
Totals					\$738.61	\$0.00	

## Progress Notes in Draft Clinician Report

(Path: Avatar CWS / Progress Notes)



San Francisco Department of Public Health  
Community Behavioral Health Services

### Progress Notes in Draft Clinician Report

Kellee Hom (003865)

From 1/1/2014 To 5/23/2016

#### Confidential Patient Information

##### ACCESS Screening

Client Name: TESTCLIENT, SUMMARY	Client ID: 1
Episode #: 1	Admission Date: 07/01/2010
Discharge Date:	
Service Date (or Note Date if Independent Note): 5/30/2015	
Service Code: NO SHOW (ADM00)	
Service Program: ACCESS Screening	
Practitioner: HOM, KELLEE (003865) PhD/PsyD	FTF: 10 min Doc/Trav: min
Location: Other Place of Service	
Status: Draft	Note Type/For: BHAC Administrative / New Serv

Progress Note:  
TEST

Total Notes in Draft for HOM, KELLEE for ACCESS Screening : 1

## Group Notes Not Individualized Clinician

(Path: Avatar CWS / Progress Notes)

Group Notes Not Individualized Clinician

Group Notes Not Individua

Process

UserID

KHOM

End Date

T

Y

Start Date

T

Y



San Francisco Department of Public Health  
Community Behavioral Health Services  
**Group Notes Not Individualized**  
Service Dates Between 1/1/2016 and 5/23/2016

**No Data Found For [REDACTED] Between 1/1/2016 and 5/23/2016**

**Confidential Patient Information**

Group #	Group Name	Note Date	Client Name	Client ID	Epi #	Service Date	Service Code	Claim Date	Claim #	Guar ID
---------	------------	-----------	-------------	-----------	-------	--------------	--------------	------------	---------	---------

Total Notes For : 0

# AVATAR DOCUMENTATION WEBSITE

URL address: [www.sfdph.org/dph/](http://www.sfdph.org/dph/)

At the search box, type “avatar”. Then, press enter key.

Select “**SF Avatar User Documentation**” link.

You will see the page, below.

Save the page as an internet favorite.

The screenshot shows the San Francisco Department of Public Health website. The header includes the department name, a search bar, and navigation links like 'News & Media', 'SFPDP Foundation', and 'Contact Us'. Below the header is a navigation menu with categories such as 'About DPH', 'Our Services', 'Our Programs', 'Healthy Living', 'Records, Permits & Licensing', 'Knowledge Sharing & Collaboration', 'Diseases & Conditions', and 'Tools'. The main content area is titled 'Our Programs' and lists several resources: 'Avatar User Support' (with a link to 'Take our Avatar Champion Survey'), 'Training Videos' (with a link to 'Avatar Help Desk on Vimeo'), 'Training Schedules' (listing dates from March to June 2015), 'DSM 5' (with links to 'DSM 5 Avatar Presentation', 'DSM 5 Recommended Schedule', and 'DSM IV to DSM 5 Crosswalk'), and 'Forms' (listing various request and verification forms). A 'HELPFUL LINKS' sidebar on the right contains links to 'Avatar Notice of Action (NOA) Letters' and 'Avatar Data Collection Forms'.

San Francisco Department of Public Health

Search

Frequently Asked Questions

Where do I go for treatment?

Need quality Health care? Join the SF Health Network

Our Programs

Avatar User Support

Take our Avatar Champion Survey

Training Videos

Avatar Help Desk on Vimeo

Training Schedules

Avatar March 2015  
Avatar April 2015  
Avatar May 2015  
Avatar June 2015

DSM 5

DSM 5 Avatar Presentation  
DSM 5 Recommended Schedule  
DSM IV to DSM 5 Crosswalk

Forms

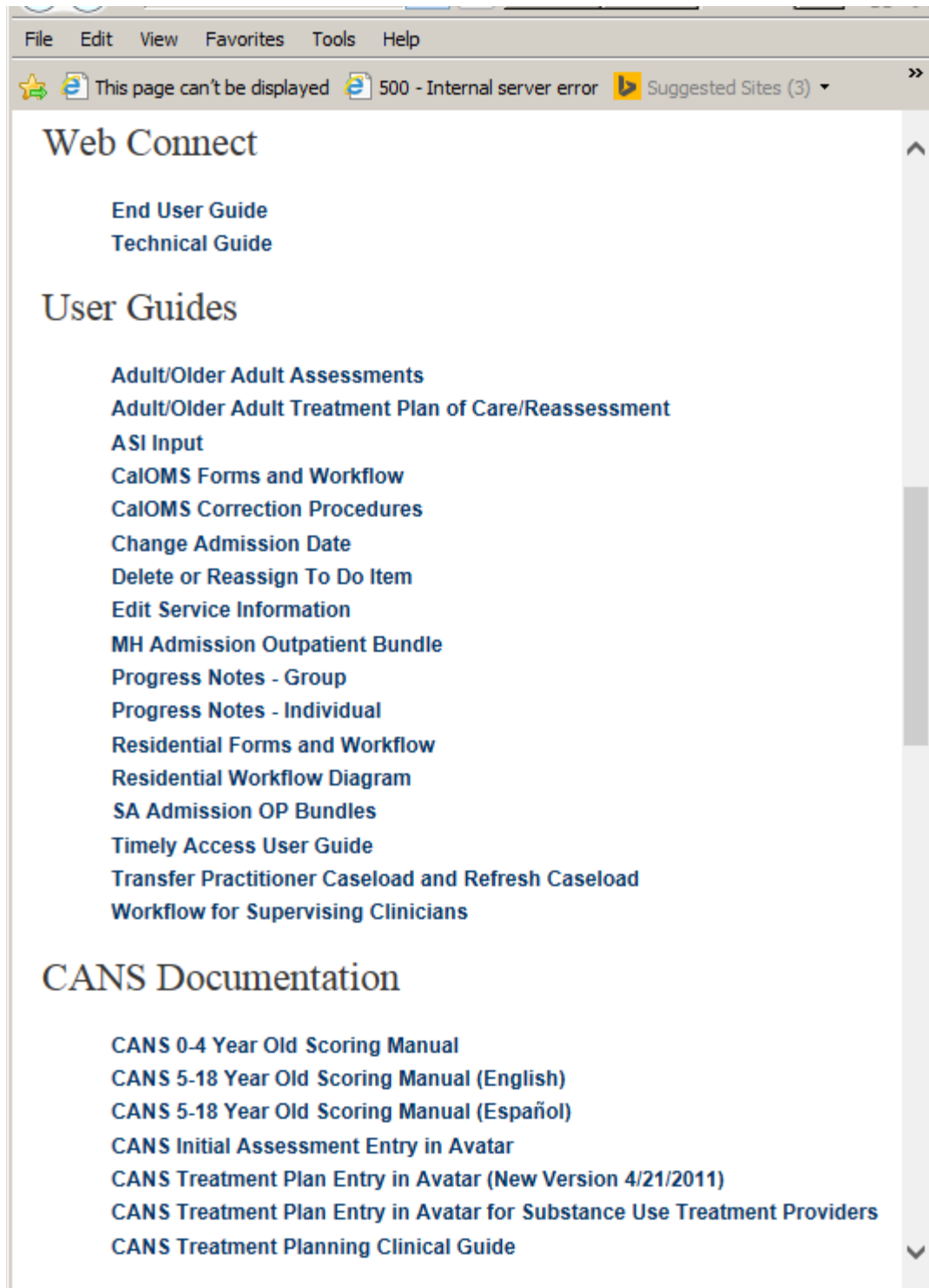
CBHS Computer Account and Training Request Form  
Certification and Verification for Staff ID  
User Confidentiality, Security and Electronic Signature Agreement  
Avatar Correction Request Form  
Avatar Correction Procedure

HELPFUL LINKS

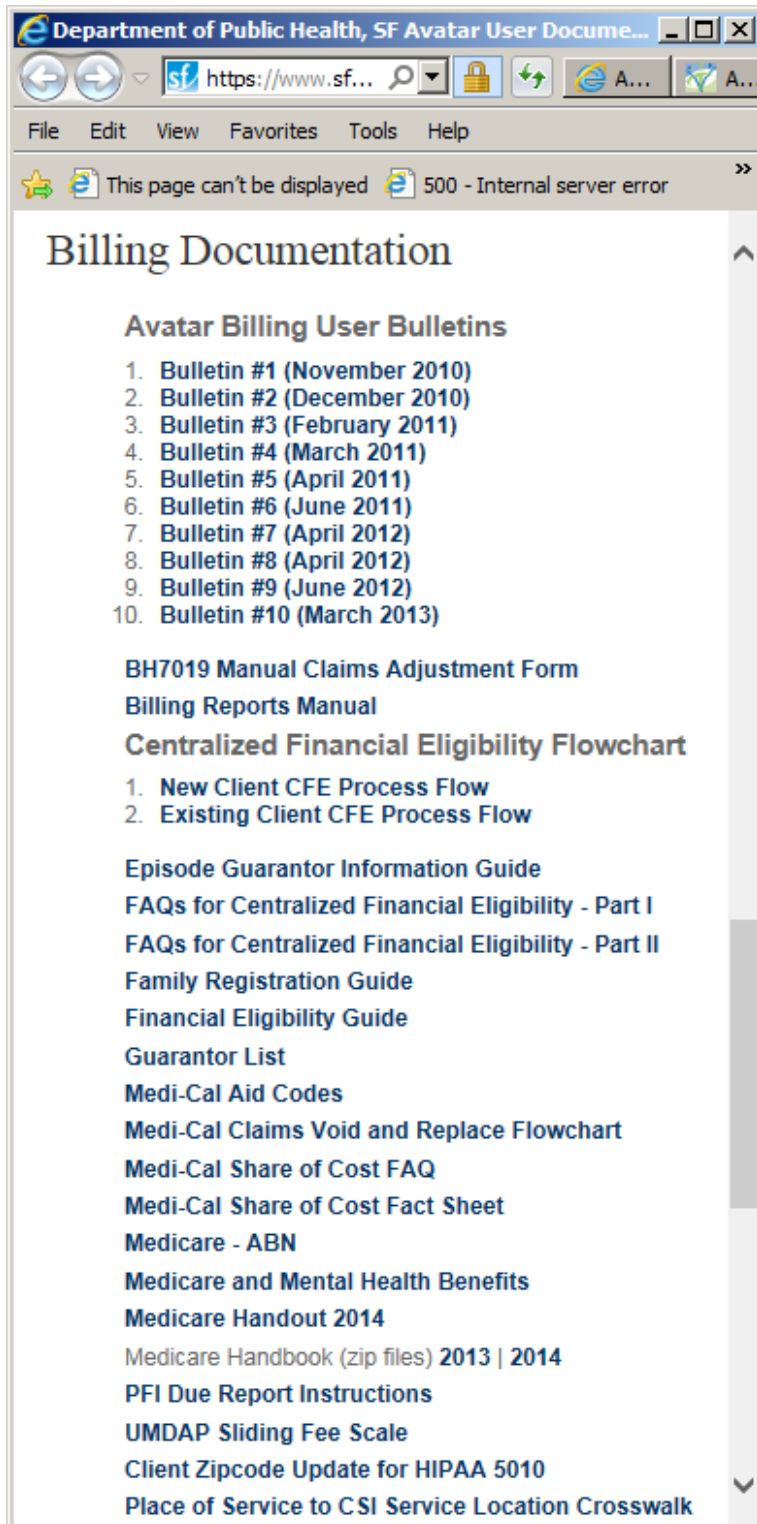
Avatar Notice of Action (NOA) Letters  
Avatar Data Collection Forms



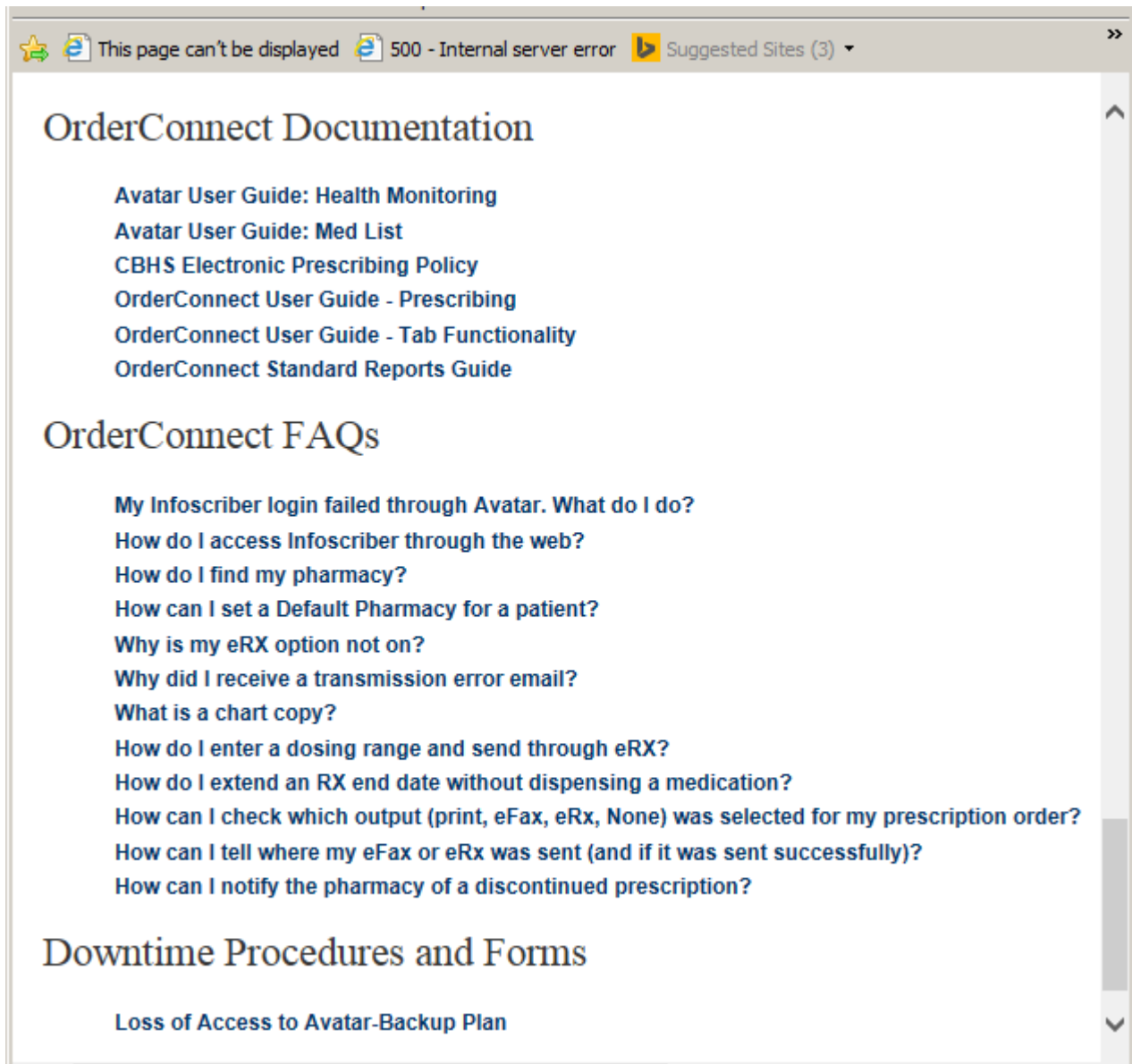
## Avatar Documentation Website (continued)



## Avatar Documentation Website (continued)



## Avatar Documentation Website (continued)



For all Avatar questions call or email:

**AVATAR HELP LINE: (415) 255-3788**

**AVATAR E-mail: [avatarhelp@sfdph.org](mailto:avatarhelp@sfdph.org)**

Go to website below for access to Avatar instructional videos:

**<http://www.vimeo.com/avatarhelpdesk>**

## KEYBOARD SHORTCUTS & STANDARD FORMATS

KEY	EFFECT
ALT + TAB	Switch between open items on your computer
Arrow Keys	Arrow down in drop-down list to select
CTRL + A	Copy ALL or Select ALL in multi-select boxes
CTRL + C	Copy Selected (highlighted) text
CTRL + END	Move insertion point to the end of the field
CTRL + HOME	Move insertion point to the beginning of the next field
CTRL + LEFT ARROW	Move insertion point to the beginning of the previous word
CTRL + RIGHT ARROW	Move insertion point to the beginning of the next word
CTRL + SHIFT (with any arrow key)	Highlight a block of text on your screen
CTRL + E	To exit without filing/saving
CTRL + L	To lock the application
CTRL + N	To open notes (where notes are supported)
CTRL + S	Save/Submit your data
CTRL + V	Paste selected text
CTRL + X	Cut selected text
END	Move insertion point to the end of the sentence
F1	Display help
F5	Clear selected item (from radio button or other data selection– based field)
F6	Open the next tab in a data input document
HOME	Move insertion point to the beginning of the sentence
Pg Dn	Move to the previous page in a tab
Pg Up	Move to the next page in a tab
Print Screen key	Print entire image displayed on monitor
ALT + Print Screen key	Print only the active window
Spacebar	To choose a radio button option if curser is on it (having tabbed from previous field)
SHIFT + TAB	Move backward through data fields
TAB	Move forward through data fields
Windows Key + D	Show Desktop
Windows Key + M	Minimize All open Windows

**KEYBOARD SHORTCUTS & STANDARD FORMATS (continued)**

FIELD TYPE	DATA ENTRY FORMAT
Name: <i>No spaces before or after the comma</i>	LAST,FIRST LAST,FIRST JR (PUNCTUATION: Can use ' and - ) LAST,FIRST MI
Date:	MM/DD/YYYY – this format will default based on the date entered.  Date can be entered as M/D/YY or MM/DD/YYYY or MM/DD or MMDD where the current year is assumed.  Slash “ / ” can be replaced during entry with dash “ – ”.  Click T or Y for Today or Yesterday, respectively.  Double-click in the date field to view clickable calendar option.  Enter T + # (where # is the number of days added to today’s date.)  Enter T - # (where # is the number of days in the past .)
Time: <i>Avatar does not use military time</i>	To enter 8:00 AM/PM – type 8A or 8P, respectively. To enter 8:30 AM/PM – type 8:30A or 8:30P, respectively.  Or click on “Current” button to enter the current time. Arrow buttons (pointing up or down) will increase or decrease the hour or minute.
Dollar Amounts:	Enter whole dollar amounts without decimal. Enter incremental dollar amounts with decimal and cent amount. Dollar sign, spaces & commas are not required.  Example: Enter 10 for \$10.00 Example: Enter 10.03 or \$10.03

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## Avatar Admission (PM) Common Error List

Updated: April 23, 2012

- 1) Creating new client record before adequately searching for an existing client record. Result is duplication and incomplete client record.
- 2) Selecting wrong client
- 3) Selecting wrong episode
- 4) Selecting wrong program name
- 5) Creating duplicate episode
- 6) Admission Screen:
  - a) Misspelling client name
  - b) Entering wrong admission date
  - c) Selecting wrong admission program or selecting program name containing “(episode)” instead of the “RU#”
- 7) Cal-OMS Admission Screen:
  - a) Missing Birth First Name or Birth Last Name (Correction = enter client’s Birth First (or Last) Name; 99902 for None or Not Applicable; 99904 for Client unable to answer)
  - b) Missing Social Security Number: (Correction = format 123-45-6789; 99900 for ‘Client declines to state’; 99902 for None or Not Applicable; or 99904 for Client unable to answer)
  - c) Missing Zip code at client’s current residence (Correction = Must enter valid 5 digit zip code; 00000 for ‘homeless’; XXXXX for ‘Client declined to state’; or ZZZZZ for Client unable to answer)
  - d) Missing Driver’s License Number: (Correction = Client’s driver license number; 99900 for client declines to state; 99902 for None or Not Applicable; or 99904 for Client unable to answer)
  - e) Creating an UMDAP for Substance Abuse client when not applicable
- 8) Diagnosis:
  - a) Entering wrong “Date of Diagnosis.” The date of diagnosis must cover the date of admission.
  - b) Leaving “Diagnosis – Axis II-1” blank: Type in “V71.09” for “No Diagnosis on Axis II”

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# Avatar Clinical (CWS) Common Error List

Updated: April 23, 2012

1. Assessments:

- a. Selecting wrong client
- b. Selecting wrong episode
- c. Selecting wrong program name
- d. Entering wrong date of assessment
- e. Entering wrong "Completion Date"
- f. Finalizing assessment that still needs review

2. Diagnosis:

- a. Selecting wrong client
- b. Selecting wrong episode
- c. Entering wrong "Date of Diagnosis." The date of diagnosis must cover the date of admission.
- d. Leaving "Diagnosis – Axis II-1" as blank or null (Correction = type "V71.09" for "No Diagnosis")

3. Treatment Plans:

- a. Selecting wrong client
- b. Selecting wrong episode
- c. Selecting wrong program
- d. Entering wrong "Plan of Care Date"
- e. Finalizing Treatment Plan that still needs review

4. Progress Notes (Individual):

- a. Selecting wrong client
- b. Selecting wrong episode
- c. Selecting wrong “Note Type”
- d. Entering wrong “Date of Service”
- e. Selecting wrong “Service Program”
- f. Selecting wrong “Service Charge Code”
- g. Entering wrong practitioner time (FTF and Doc/Travel)
- h. Finalizing progress note that still needs review
- i. For clinicians requiring co-signature, not selected their supervisor in the “User To Send Co-Sign To Do Item To”

5. Progress Notes (Group):

- a. Failure to begin at “Group Default Notes” tab
- b. Entering wrong “Date of Group”
- c. Selecting wrong “Note Type”
- d. Selecting wrong “Service Program”
- e. Selecting wrong “Service Charge Code”
- f. Forgetting to add “walk-in” client to group (session)
- g. Forgetting to remove a “no-show” client from group (session)
- h. Selecting wrong episode when adding walk-in clients to group (session)
- i. Entering wrong practitioner time (FTF and Doc/Travel)
- j. Finalizing progress note that still needs review
- k. For clinicians requiring co-signature, not selected their supervisor in the “User To Send Co-Sign To Do Item To”



# AVATAR CORRECTION REQUEST FORM

## BLANK SAMPLE

To type in data, click on the grey shaded box.



Department of Public Health  
City and County of San Francisco  
Community Behavioral Health Services

Request Date:	
Requestor Name:	
Phone Number:	
E-Mail:	

### Avatar Correction Request Form

Complete only portions relevant to your request. Fax to (415) 252-3001

Program Name:	Reporting Unit Number:
Clinician Name:	Staff ID:
Client Last Name:	Client First Name:
Client ID/BIS:	Date of Birth:
Episode Number:	

Merge	BIS Number	Other versions of Client Name (if applicable)		BIS Number	Other versions of Client Name (if applicable)
Duplicate #1			Duplicate #4		
Duplicate #2			Duplicate #5		
Duplicate #3			Duplicate #6		

Assessment / Reassessment	
Date of Assessment:	
Type of Assessment	(e.g. CANS CYF Initial Assessment, A/OA (short) w/ANSA Ratings, Psych Eval)
If requesting to move from one episode to another (for same client) complete the following	
Move from episode:	Move to episode:
Wrong Client Name:	If information was entered in wrong client record
Reason for correction:	

Treatment of Plan of Care (POC)	
Date of POC:	
Indicate CYF or AOA:	
If requesting to move from one episode to another (for same client) complete the following	
Move from episode:	Move to episode:
Wrong Client Name:	If information was entered in wrong client record
Reason for correction:	

Progress Note *						
For Duplicate Note Deletions, staff must provide specifics of note to be deleted: 1) DATE and 2) TIME of when note was written						
Service Date:		Procedure Code:		Duration:		Note Date:
						Note Time:
Reason for correction:						

Other (specify)	
Date of Document:	
Reason for correction:	

\* Note: These procedures only correct the information in the clinical record. You may also need to correct billing / claims information via regular procedure. 73

CBHS Avatar Correction Request Form rev. 11/28/12

## AVATAR FAVORITES

### Admissions

MH Admission Outpatient Bundle\*

MH Admission Residential Bed Mgmt Bundle\*

SA Admission OP CalOMS Program Bundle\*\*

SA Admission OP Non CalOMS Prgm Bundle\*\*

SA Admission Res CalOMS Prgm Bundle\*\*

SA Admission Res Non CalOMS Prgm Bundle\*\*

Admission

Admission (Outpatient)

Admission Referral Information

Cal-OMS Admission\*\*

Cal-OMS Annual Update\*\*

Contact Information

CSI Admission\*

Diagnosis

Family Registration\*

Financial Eligibility

Forms (consent)

Update Client Data

\* = Mental Health programs only

\*\* = Substance Abuse programs only

## Assessments

Adult/Older Adult Assess Long w/DX\*

Adult/Older Adult Assessment (LONG)\*

Adult/Older Adult Assessment (SHORT)\*

Adult/Older Adult Initial Risk Assessment\*

Adult/Older Adult Initial Risk Assessment Rpt\*

Adult/Older Adult Closing Summary\*

ASI Input [Addiction Severity Index]\*\*

ASI Composite Scores\*\*

ASI Ratings Graph\*\*

ASI Summary Report\*\*

CANS CYF Closing Summary [Child and Adolescent Needs and Strengths]\*

CANS CYF Closing Summary Rpt\*

CANS CYF Initial Assess with DX Bundle\*

CANS CYF Initial Assessment\*

CANS CYF Initial Assessment Rpt\*

CANS CYF Reassessment\*

\* = Mental Health programs only

\*\* = Substance Abuse programs only

## Treatment Plans, Progress Notes, Discharge & Reports

### Treatment Plan of Care

Adult/Older Adult TPOC/Reassess w/DX

Adult/Older Adult Treatment Plan of Care/Reassessment

CYF Treatment Plan of Care

CYF 0-4 Treatment Plan of Care

### Progress Notes:

Group Registration

Progress Notes (Group and Individual)

Progress Note Viewer

Progress Notes Without Pagebreaks

Append Progress Note

Edit Service Information

### Discharge:

Cal-OMS Discharge\*\*

Cal-OMS Youth/Detox Discharge\*\*

Discharge Alert

Discharge

Discharge (Outpatient)

### Reports:

MHS 140 [ Soon to be renamed as "Client Face Sheet"]

Batch File Episode Report

Staff Activity Report

Service List by Program/Client

\* = Mental Health programs only

\*\* = Substance Abuse programs only