San Francisco Department of Public Health
Behavioral Health Information Systems
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Phone: 415.255.3788

Avatar Clinical Training

Mental Health

(Guide / Manual)

1380 Howard Street

1st Floor Training Room

Table of Contents

INTRODUCTION

Contact Information for Avatar Questions

Clinical Policy Questions: CBHS Quality Management Work Group

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General Avatar Questions:

Avatar Help Desk: **avatarhelp@sfdph.org** (415) 255-3788

General Billing Questions:

Billing Inquiry Line: (415) 255-3557

HIPPAA & 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)

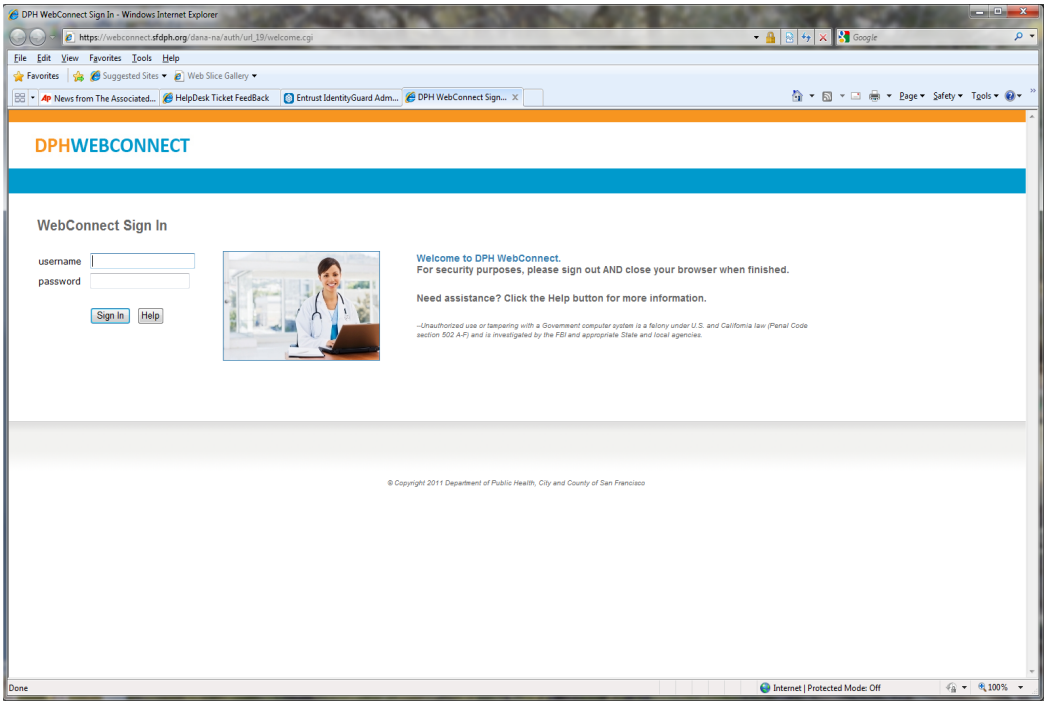
Welcome to The Department of Public Health's WebConnect Portal

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.

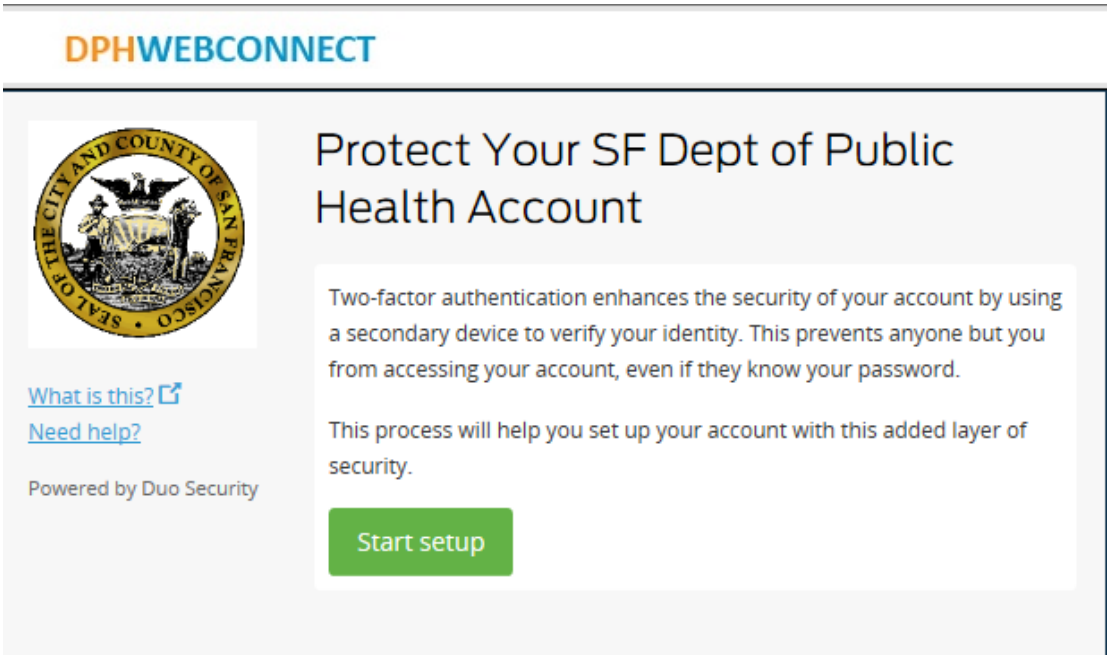
The URL for using WebConnect to access Avatar is below.
URL: **https://webconnect.sfdph.org/partners**



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

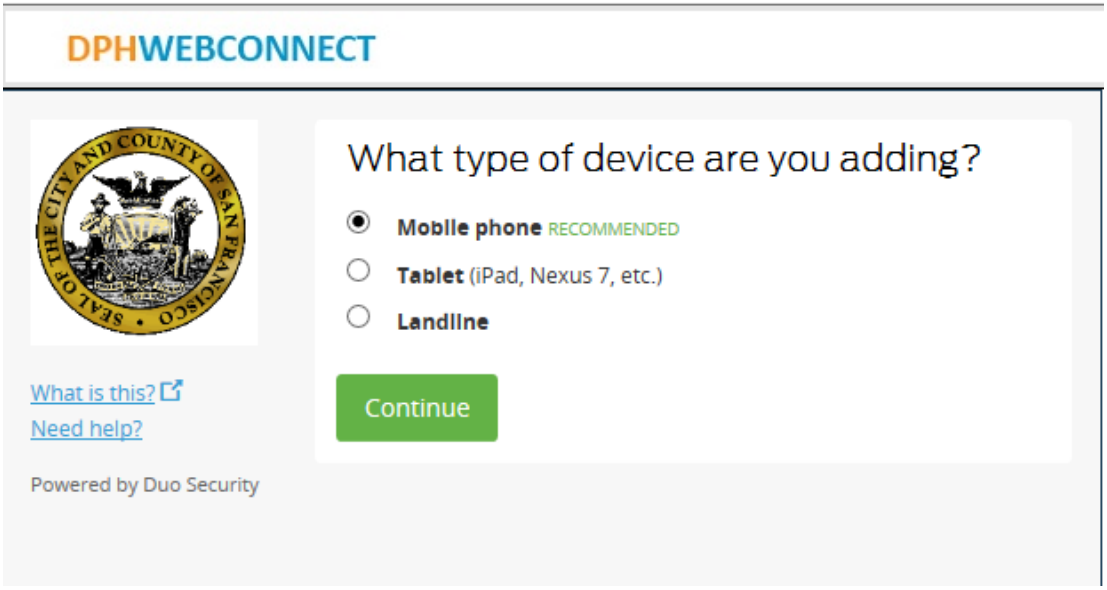
Remember that passwords must contain at least a) one uppercase b) one lowercase letter c) one number and d) one special character. All passwords must be at least 10 characters long and may not contain your user name. The system will ask you to enter your new password twice to assure that no typos have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

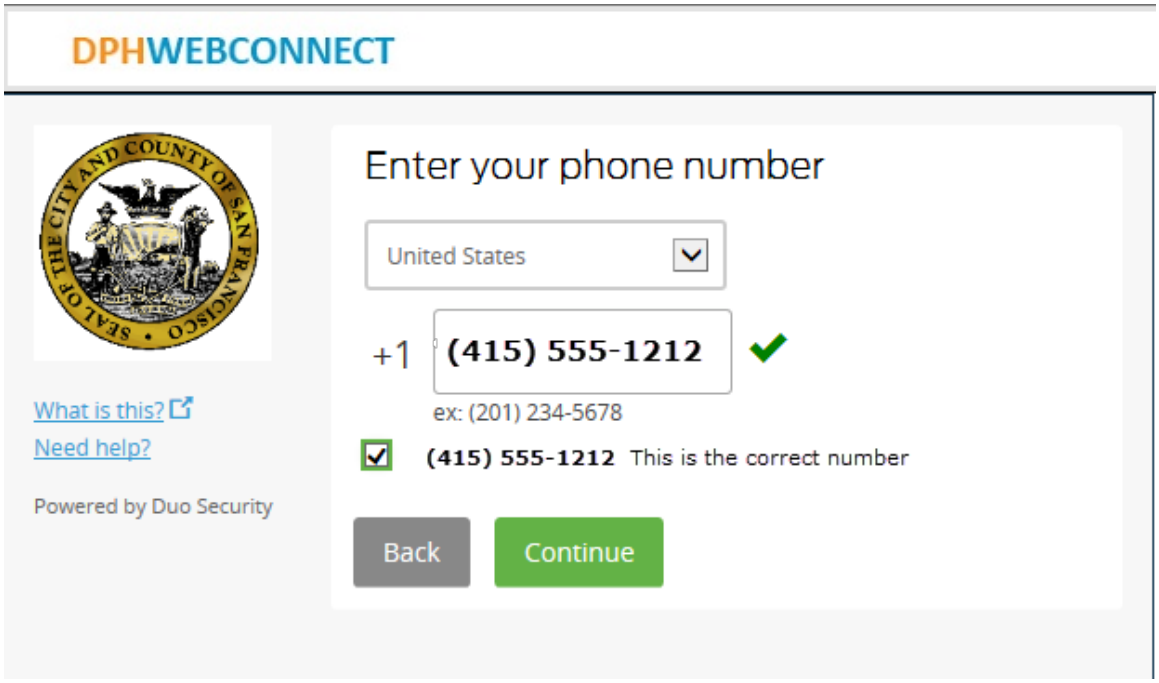


After clicking on **"Start Setup"** you will be presented with the 3 choices below.

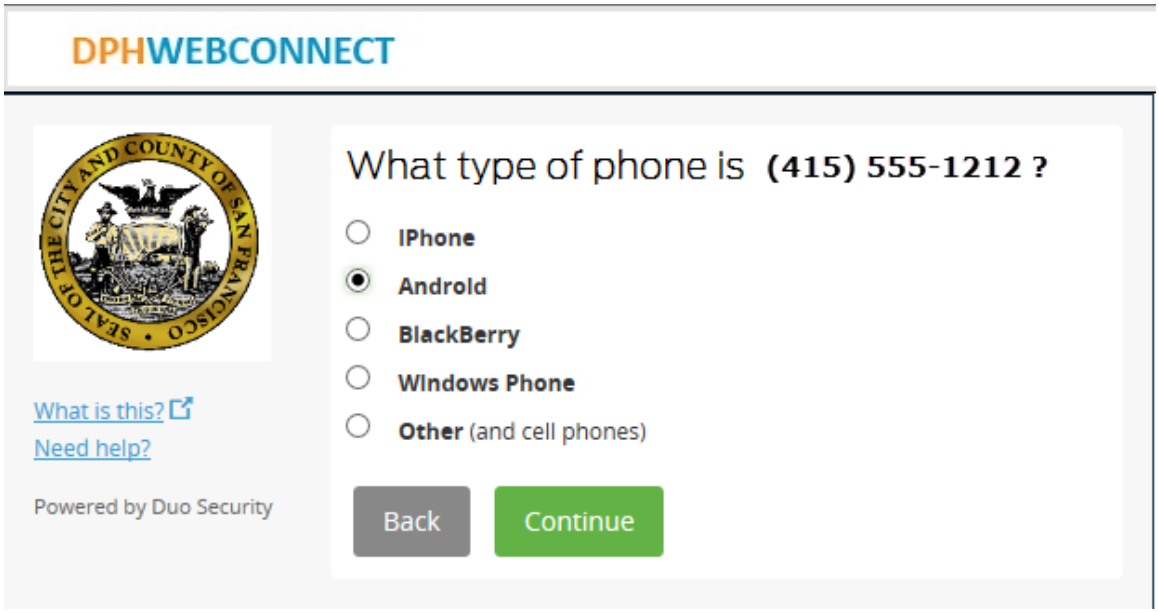
Please choose "Mobil phone"



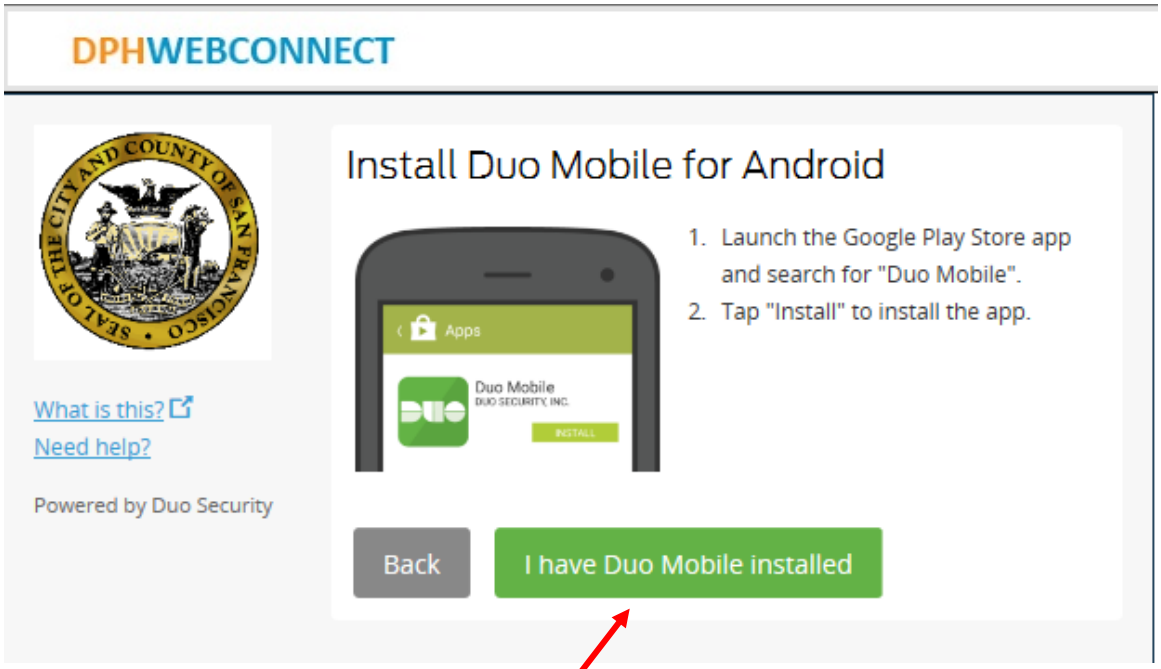
Choosing Mobile phone will take you to this screen



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.



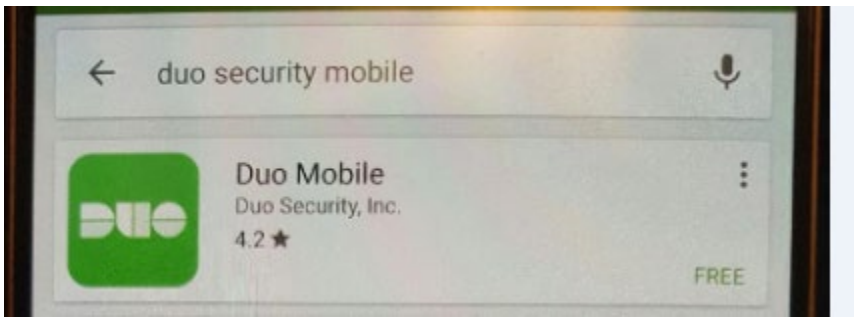
After selecting your phone type you will be asked install the appropriate mobile application



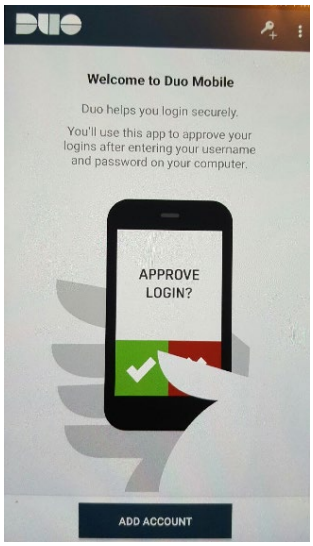
Click here **after the mobile app has been downloaded and installed**.

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

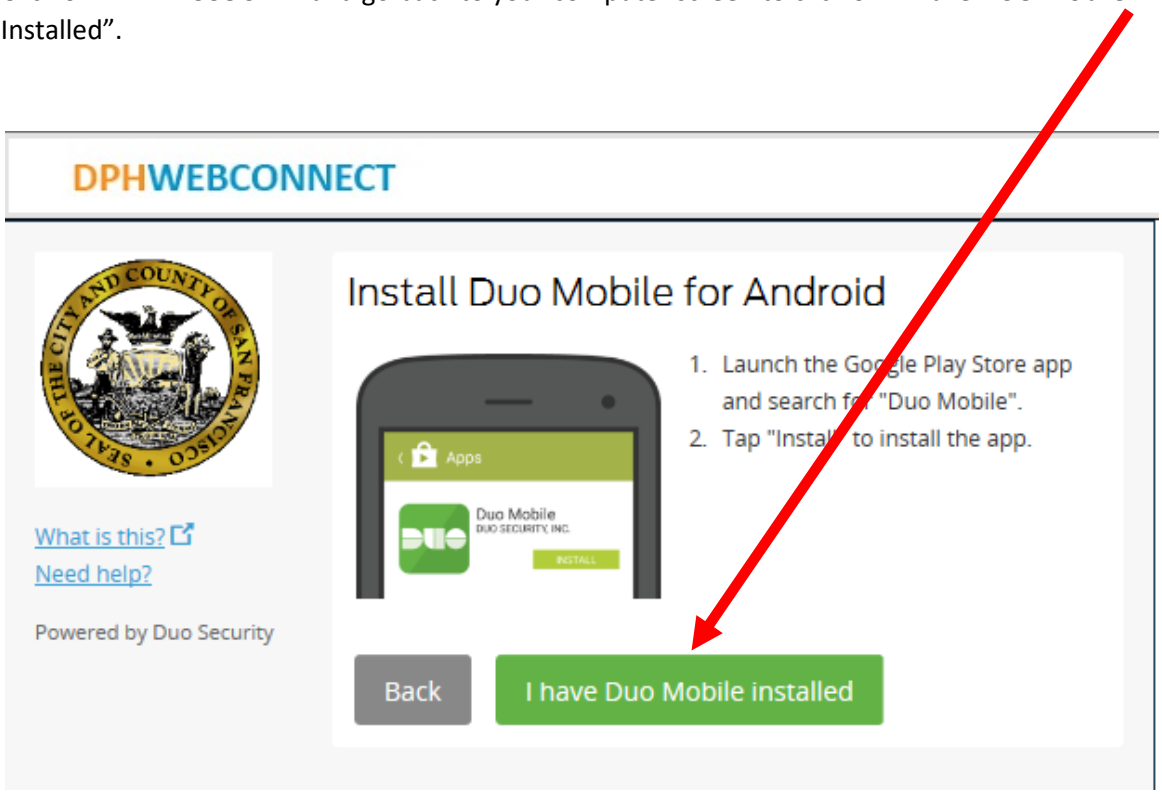
Search for mobile named “DUO SECURITY MOBILE” in your app store and install it.



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

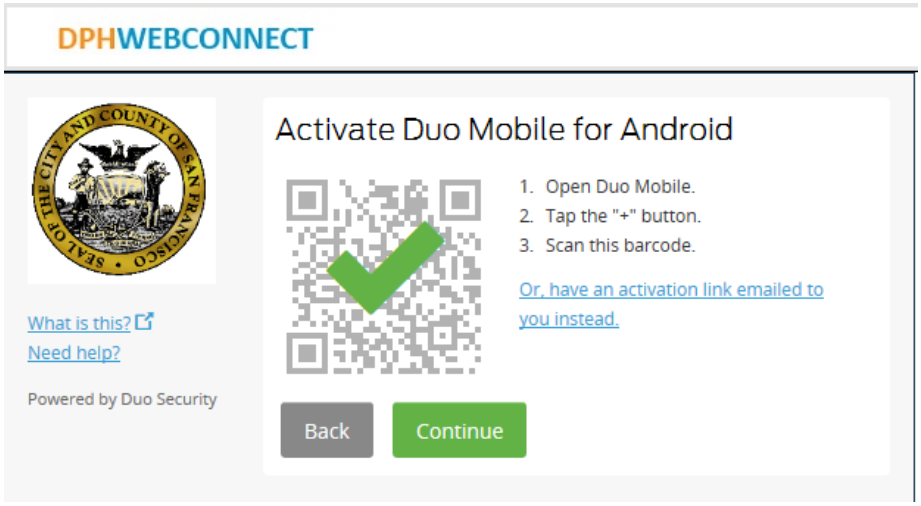


Click on “ADD ACCOUNT” and go back to your computer screen to click on “I have DUO Mobile Installed”.



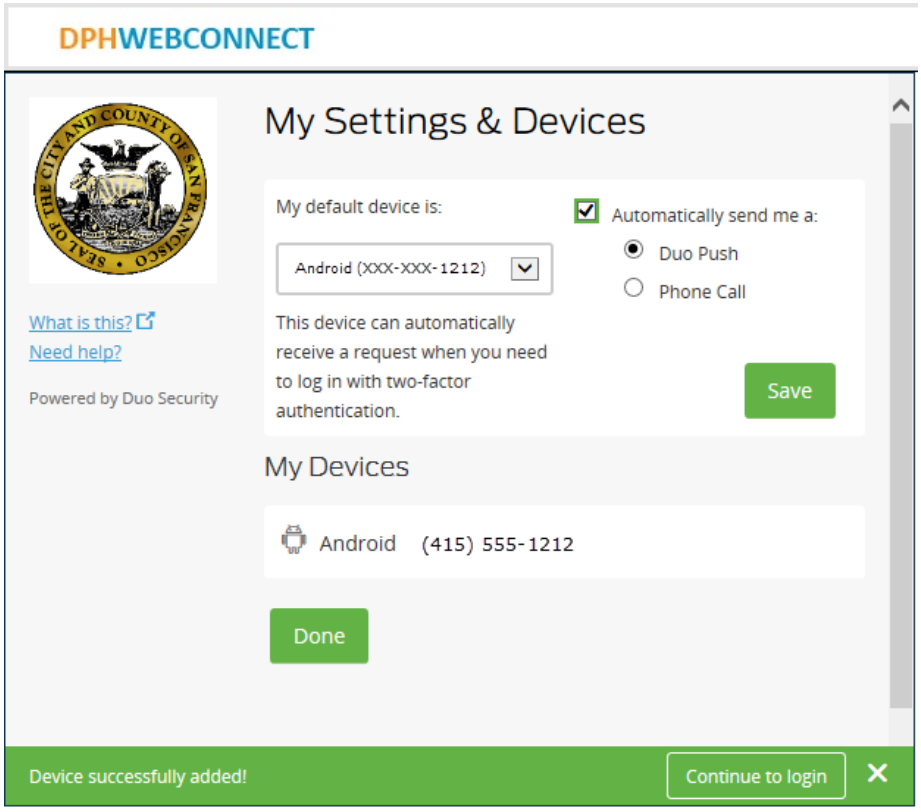
Now (while DUO app is open on your phone) point your phone at the barcode displayed on your computer screen to activate DUO.

When you have successfully scanned the barcode, click Continue.

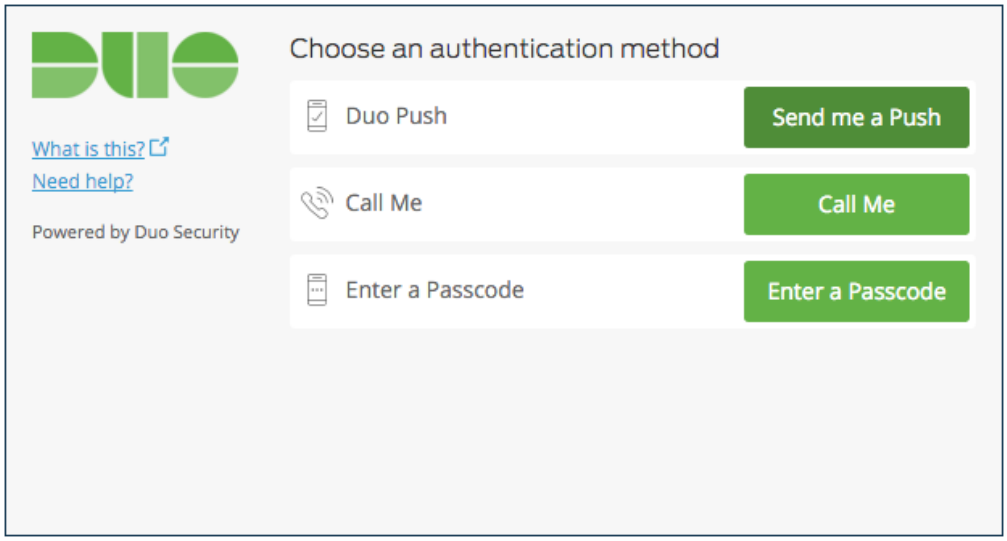


On completion of the setup you will see the following

Please Click on **"Save"** and then **"Continue to login"**



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



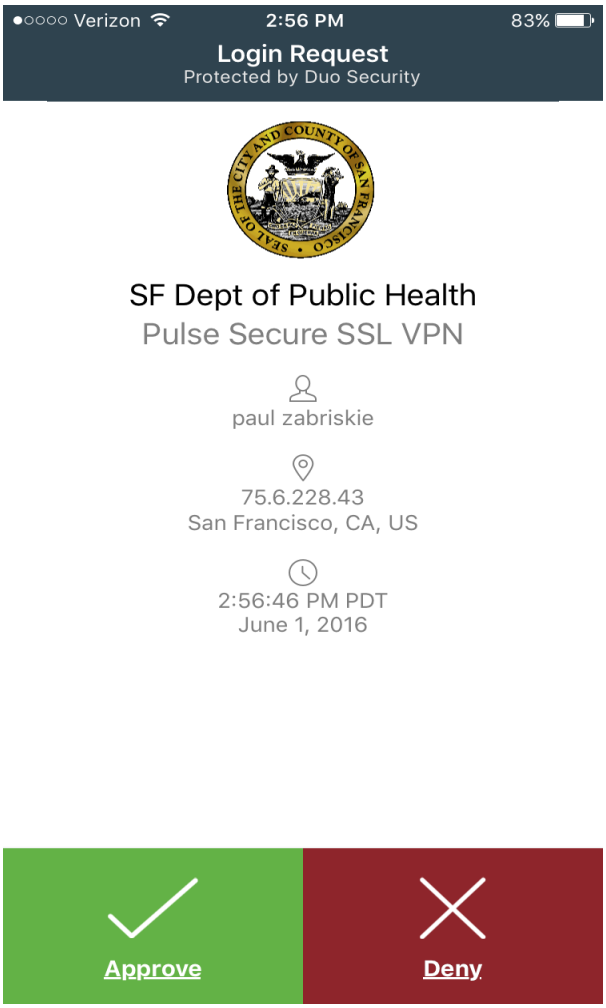
Duo Push Authentication:

This is the recommended and easiest authentication method to use if you have a Smart Phone.

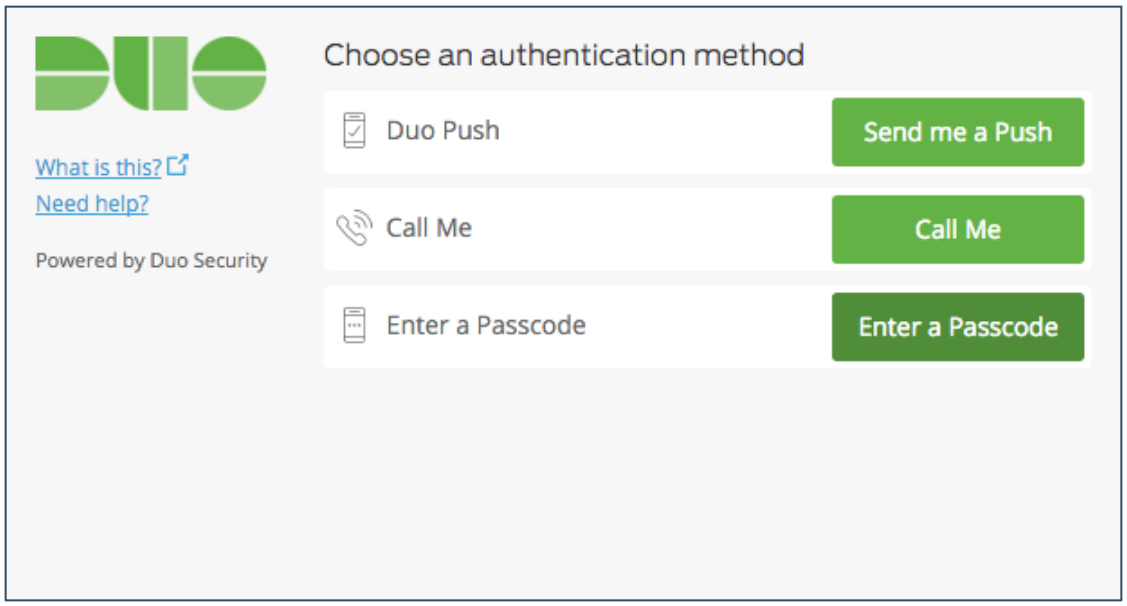
1. Click **Send me a Push**.

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

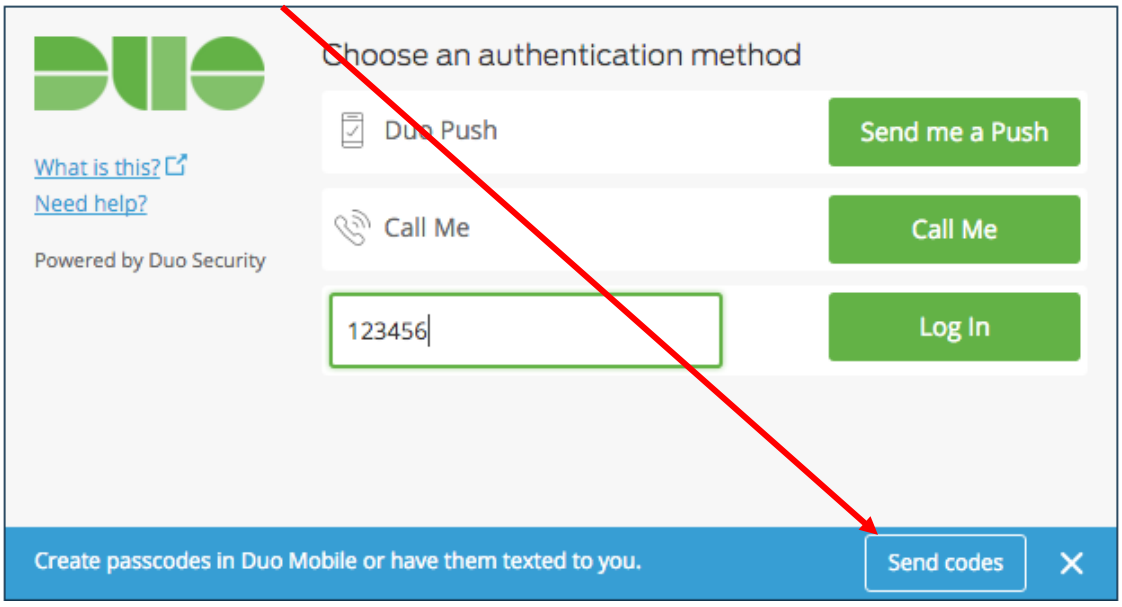
Your smart phone will display the following when you log on to WebConnect, click “Approve.”



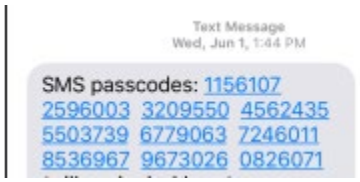
Alternative Options for Authentication: If you do not have a Smart Phone, or choose not to install the Mobile App, you have the option to Select **"Enter a Passcode"**



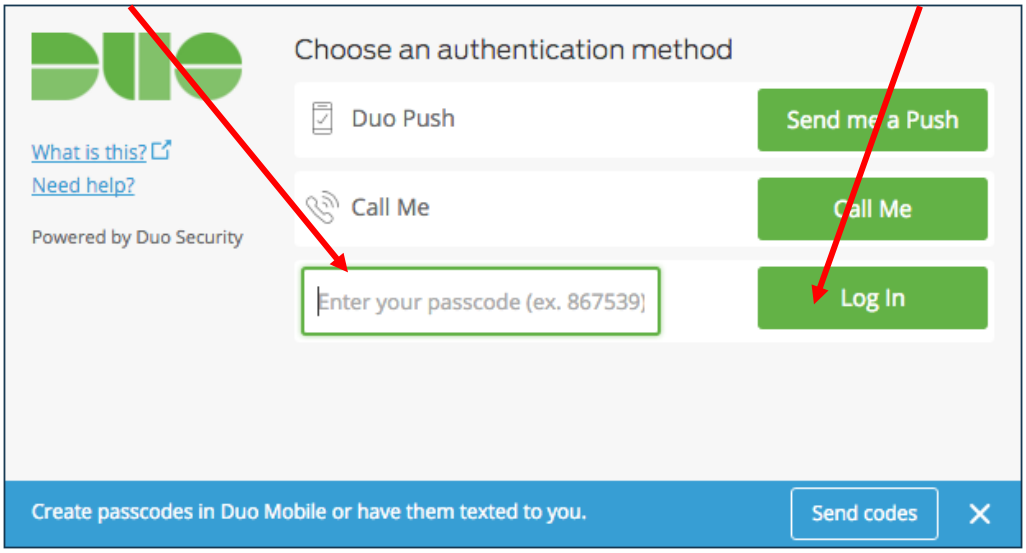
Now click on **"Send codes"**



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.

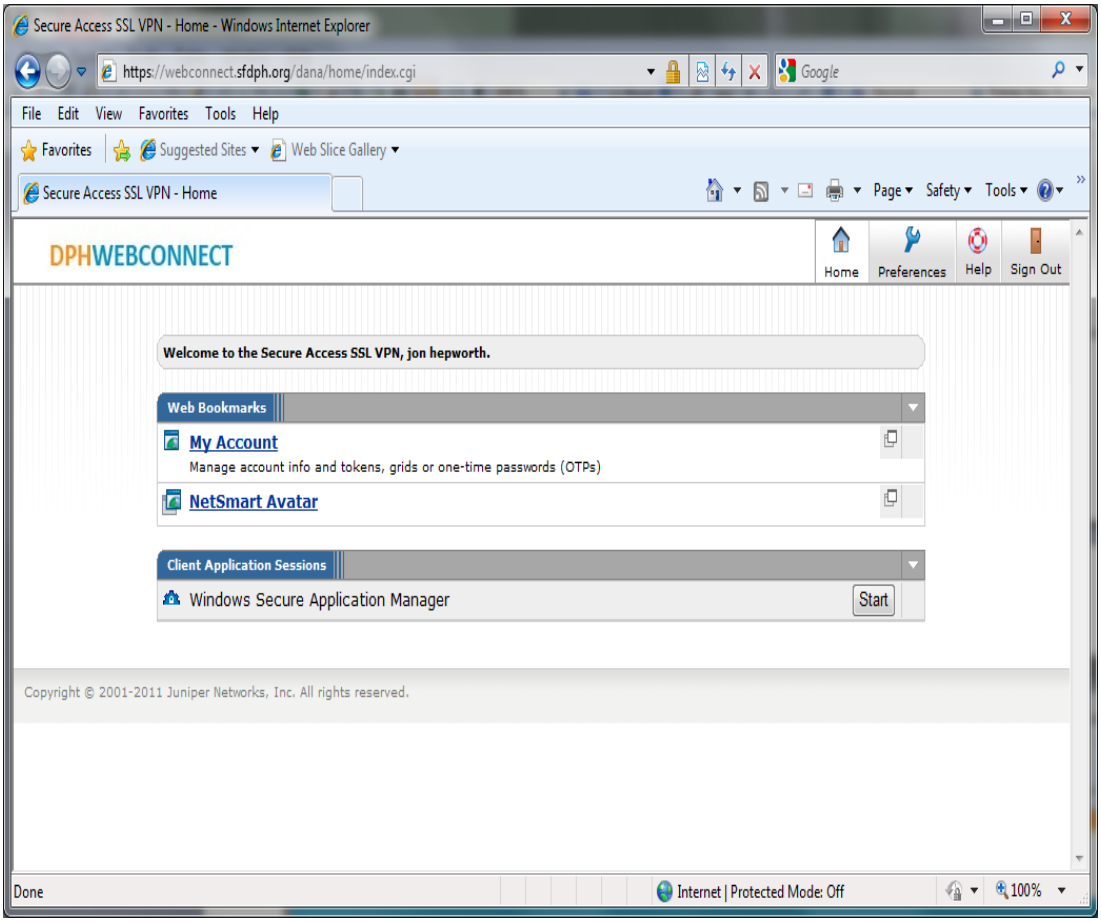


Enter **one** of the 10 **passcodes** sent in the text message and click on **"Log In"**



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.

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

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.

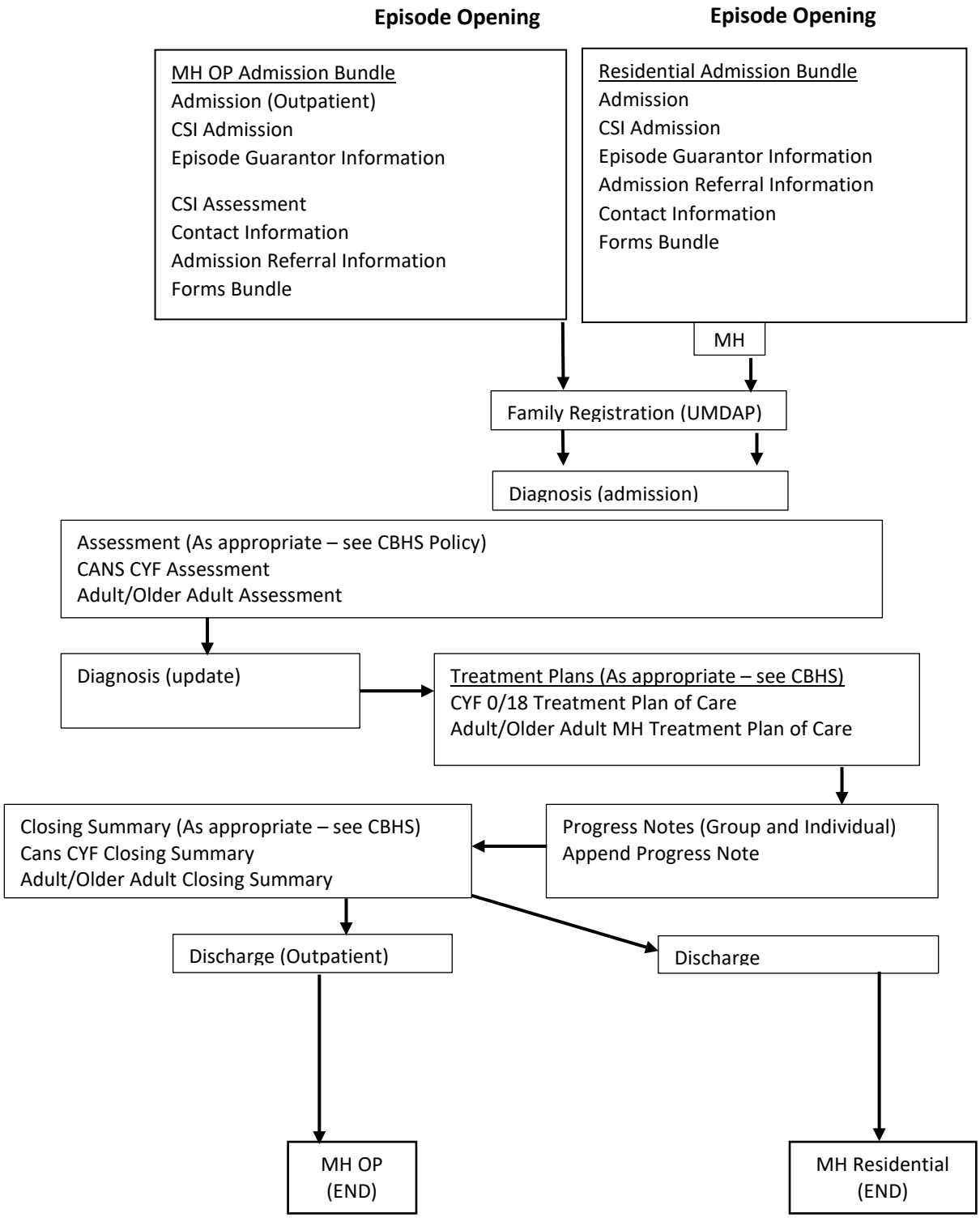
How can I remember my password?

- 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

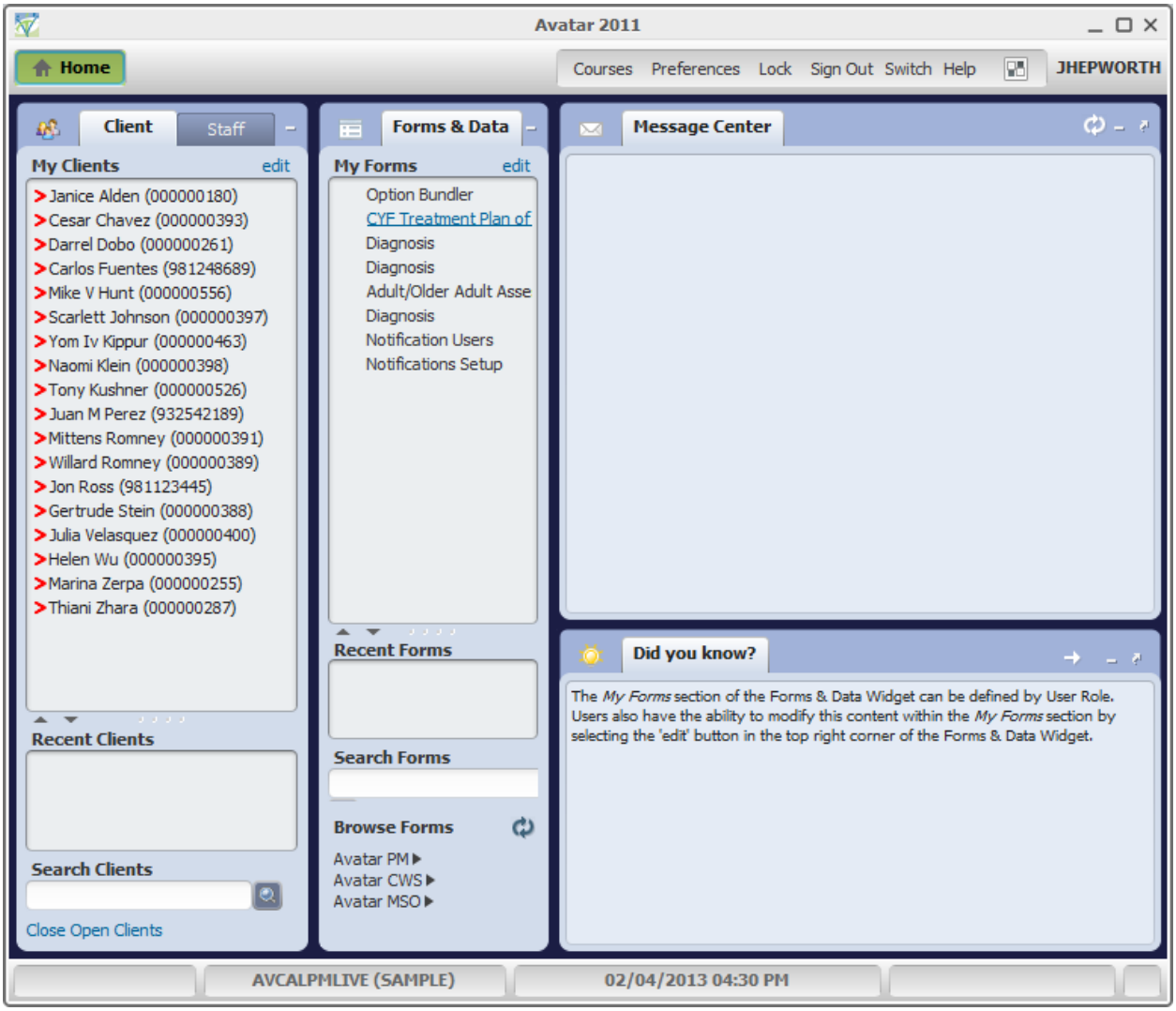
- PM – Practice Management
- CWS – Clinical Work Station
- MSO – MSO Managed Service Organization

Avatar Work Flow

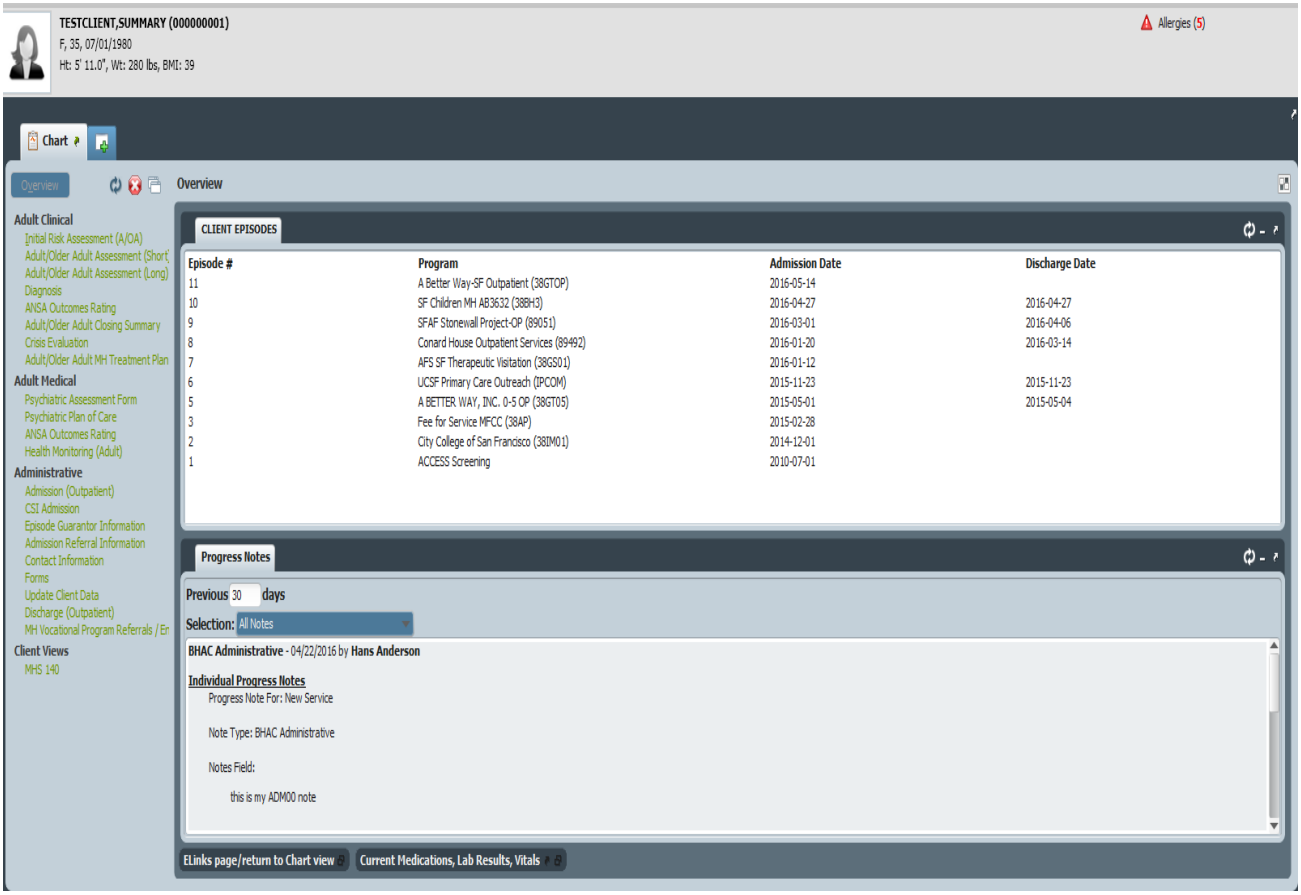


Navigation

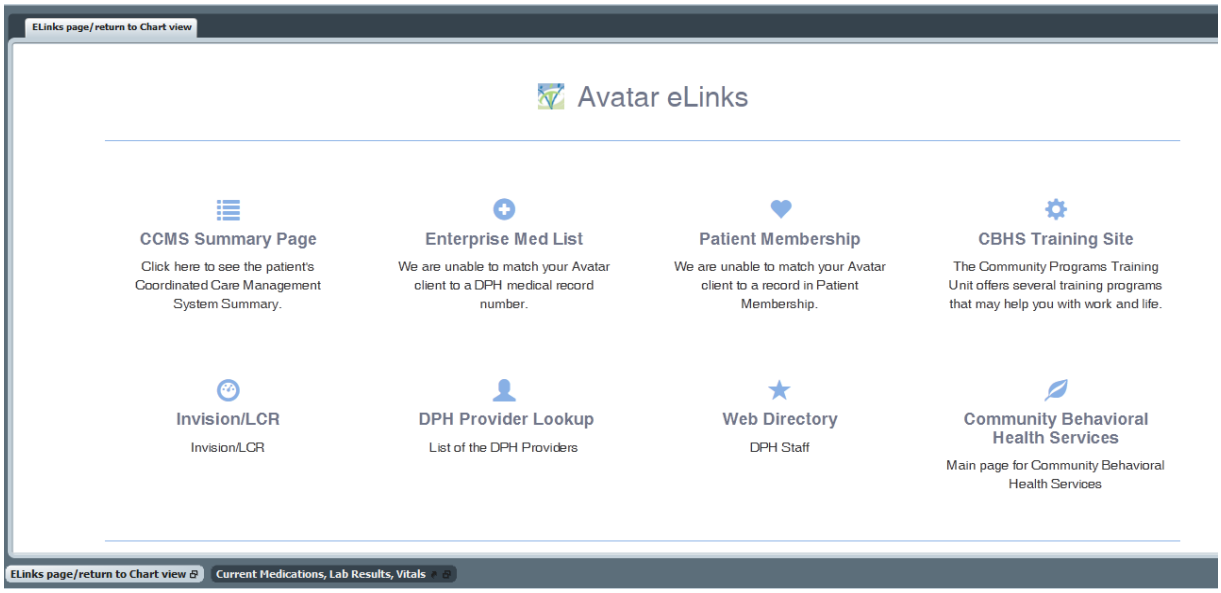
Avatar Home View



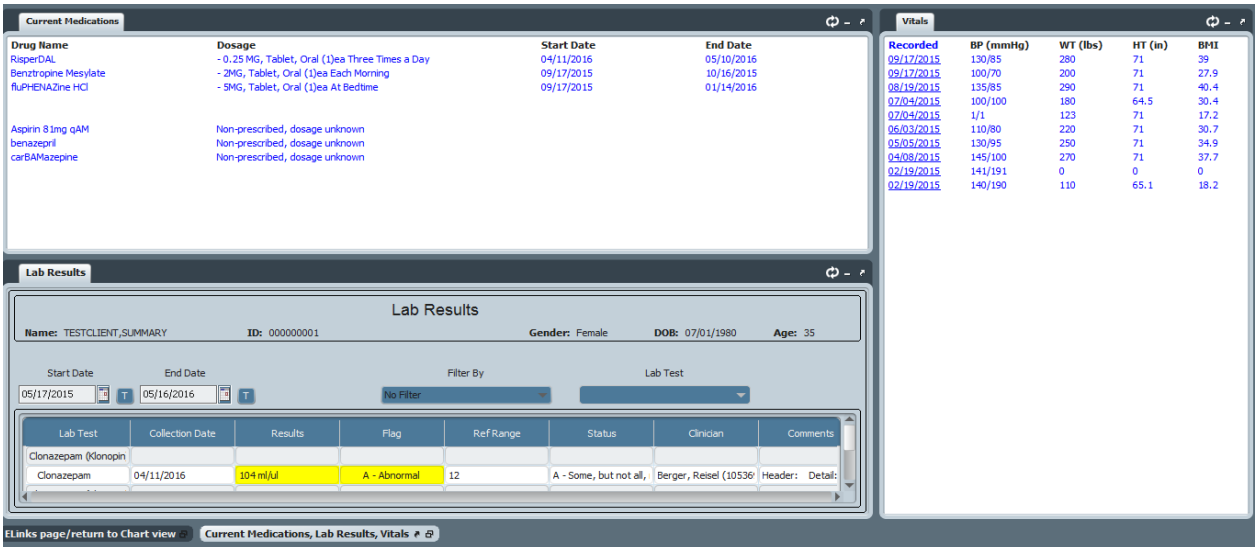
Avatar Chart View



Avatar eLinks



Current Medications, Labs, 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 I bundle
  (Path: Avatar PM)/Client Management/Client Information)

MH Admission Residential Bed Mgmt Bundle

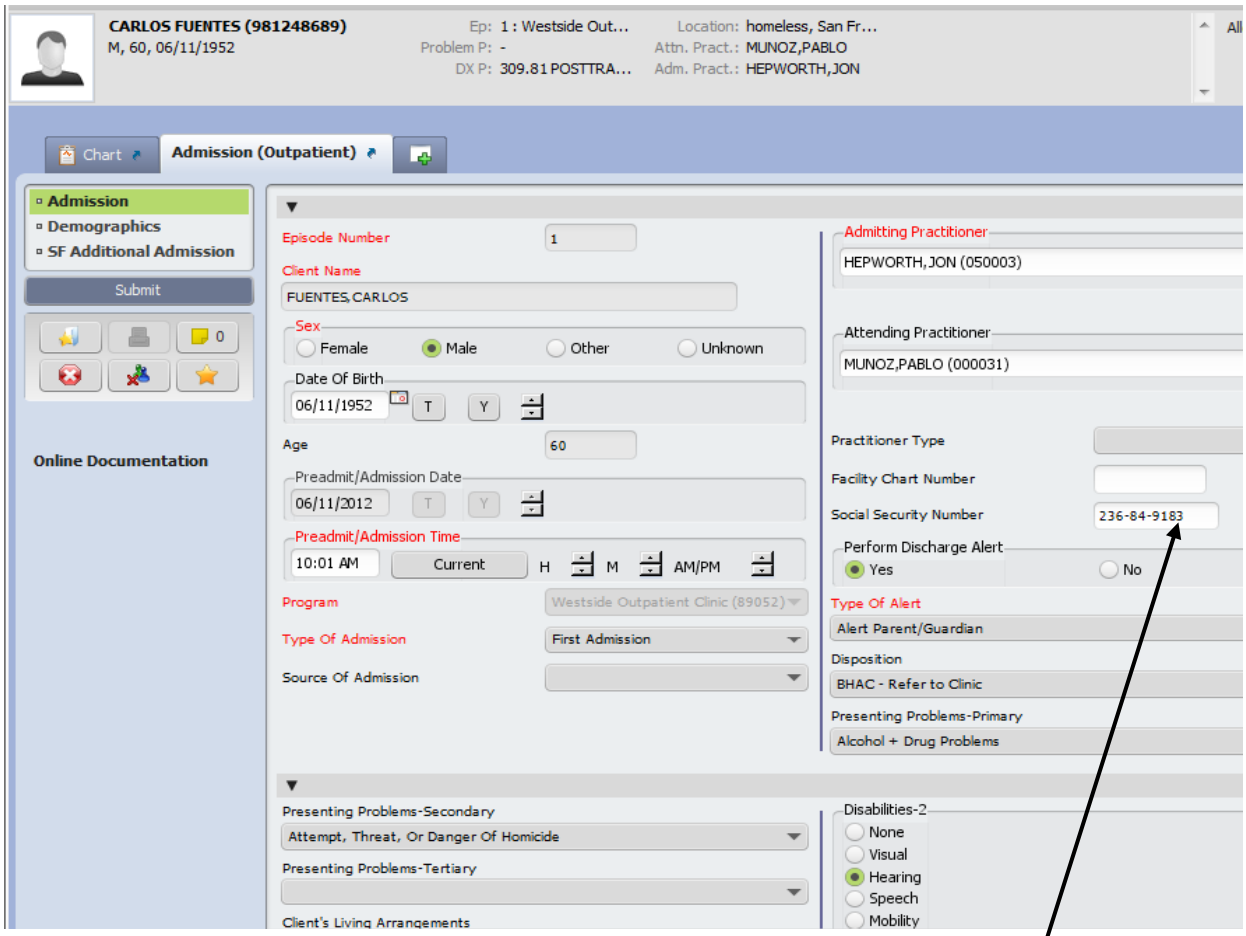
(Path: Avatar PM/Client Management/Episode Management/MH Admission Residential Bed Mgmt Bundle)

- 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

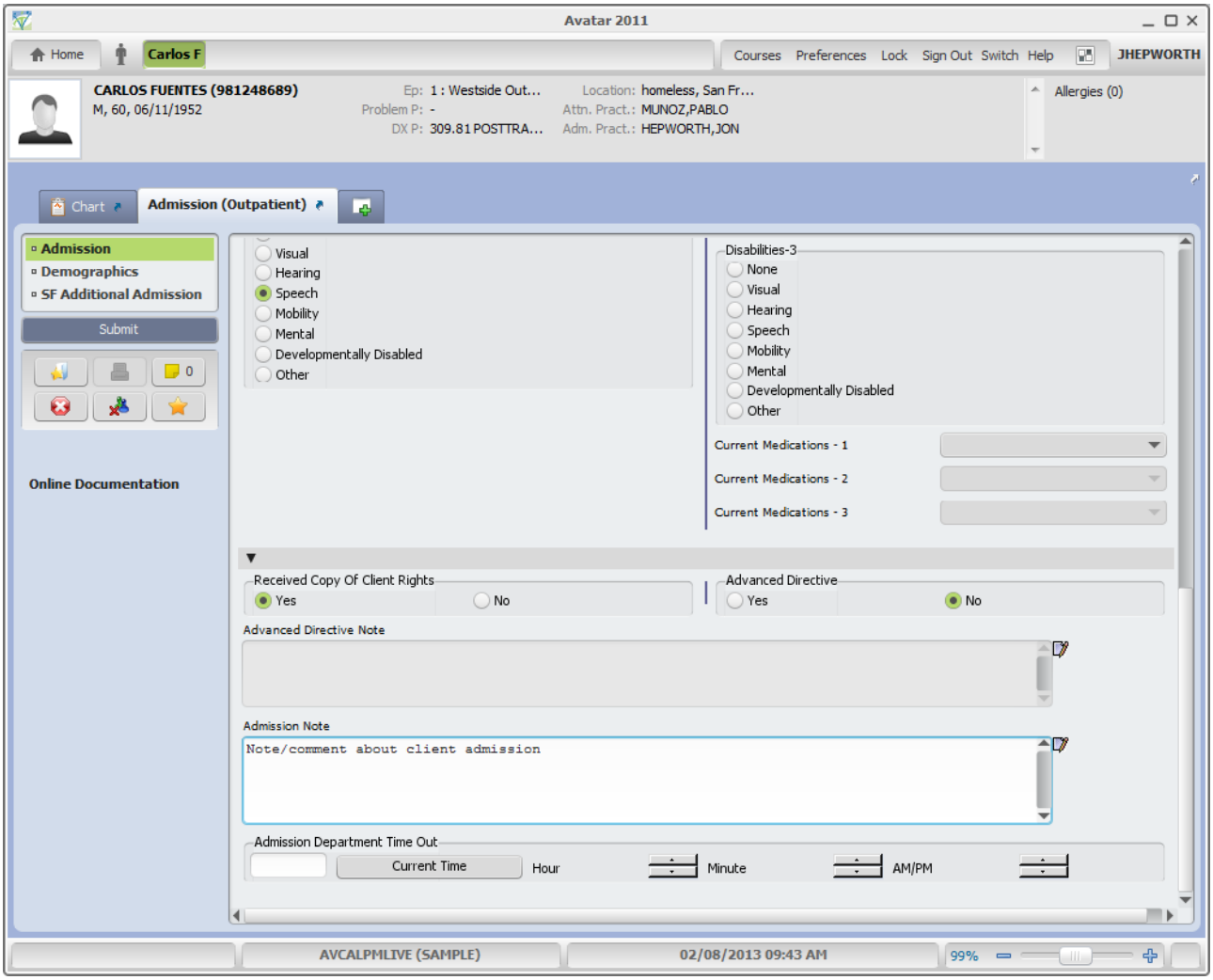
Admission (Outpatient)

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

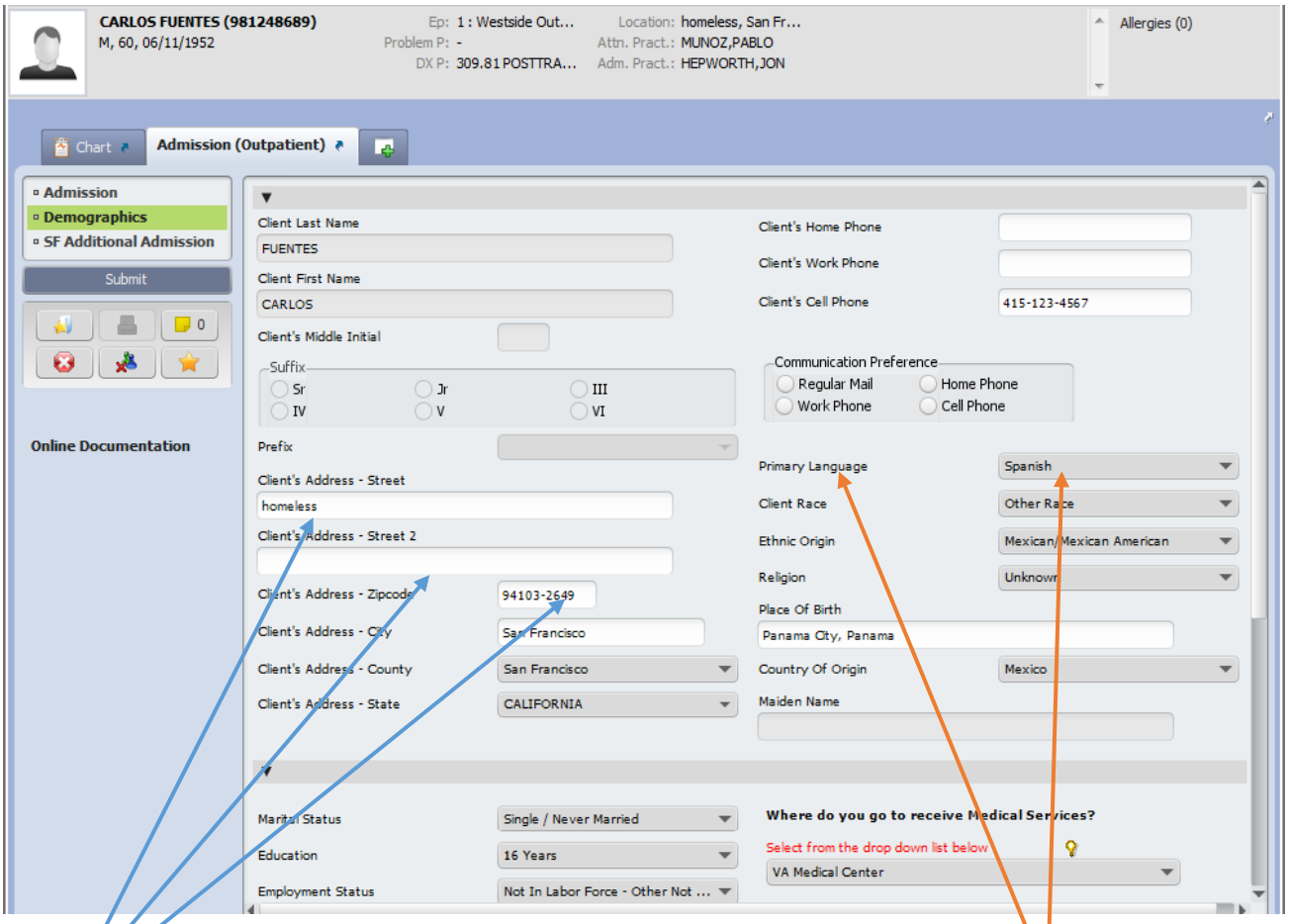


If client's social security number is unknown (or none), enter "000-00-0000".

Admission (Outpatient) - continued



Admission (Outpatient) – continued



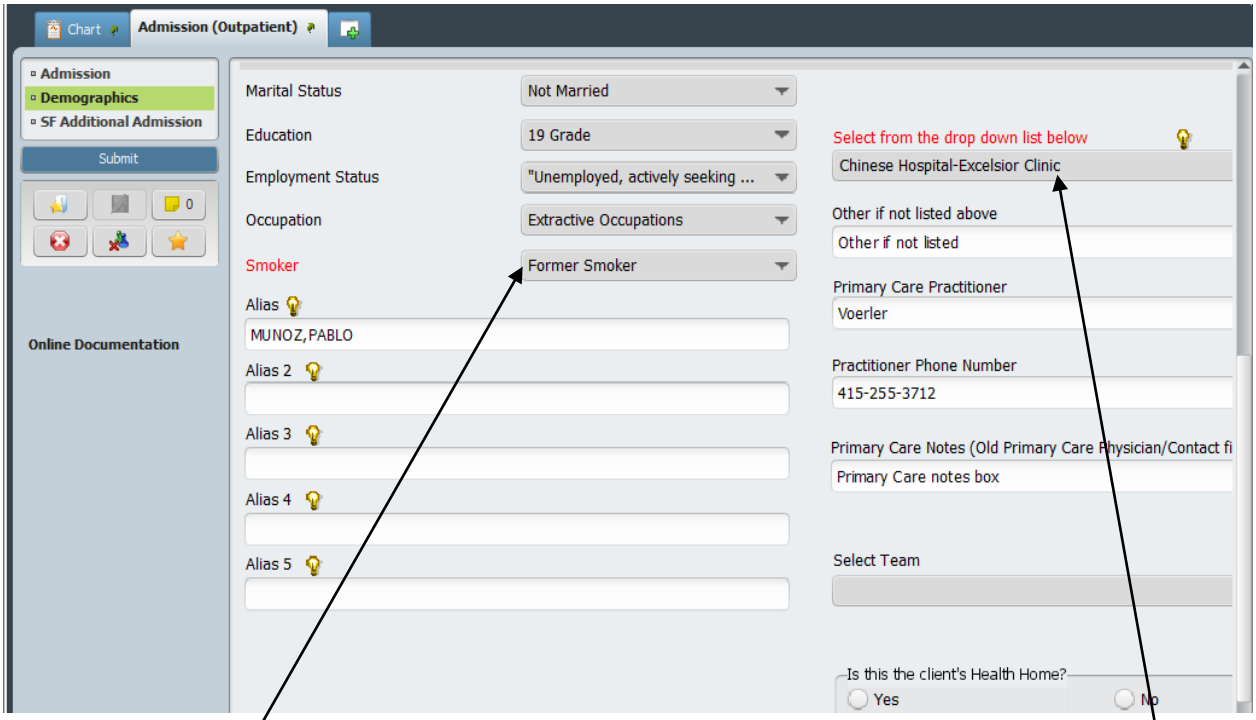
If Client is homeless, enter "homeless" in Address Line 1. Leave Address Line 2 blank. Then, add 9-digit zip code, city, county and state that correspond to program. See USPS.com to match zip code to address.

DO NOT enter special characters. For example:

1380 Howard St Apt 300

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

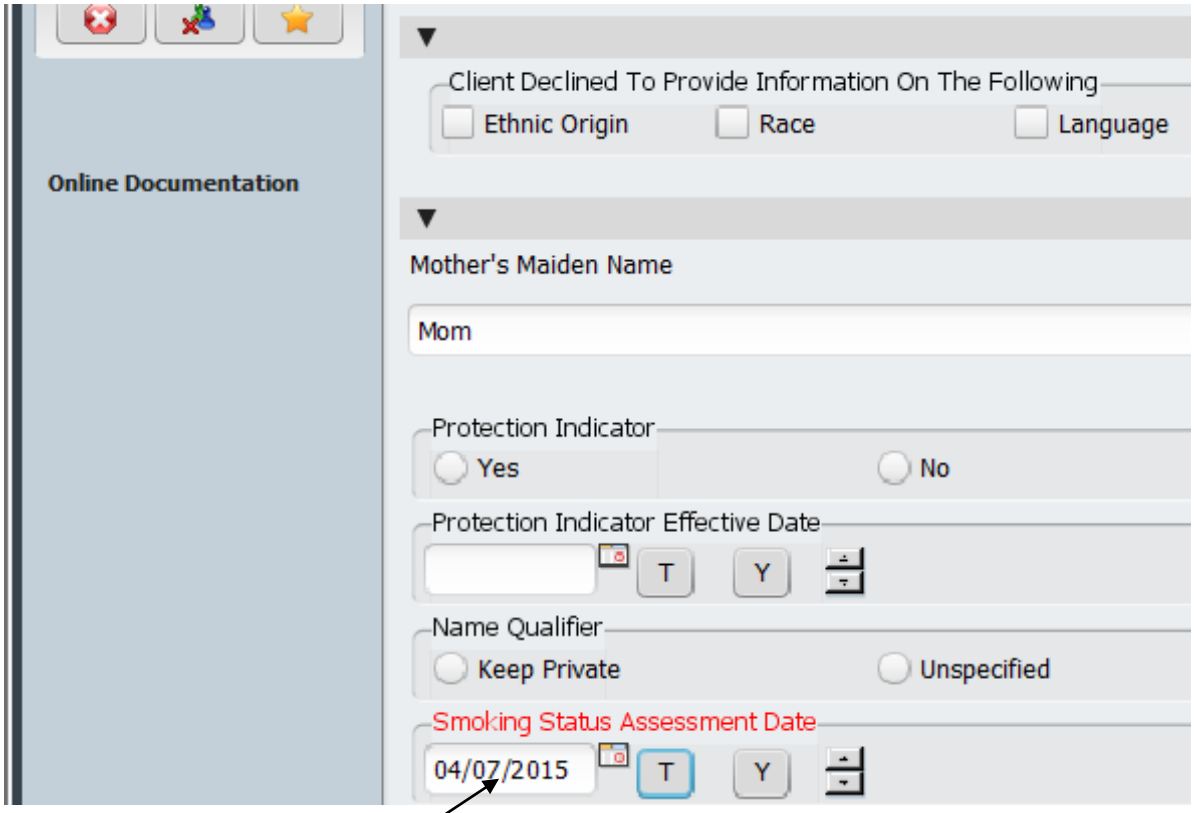
Admission (Outpatient) - continued



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

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

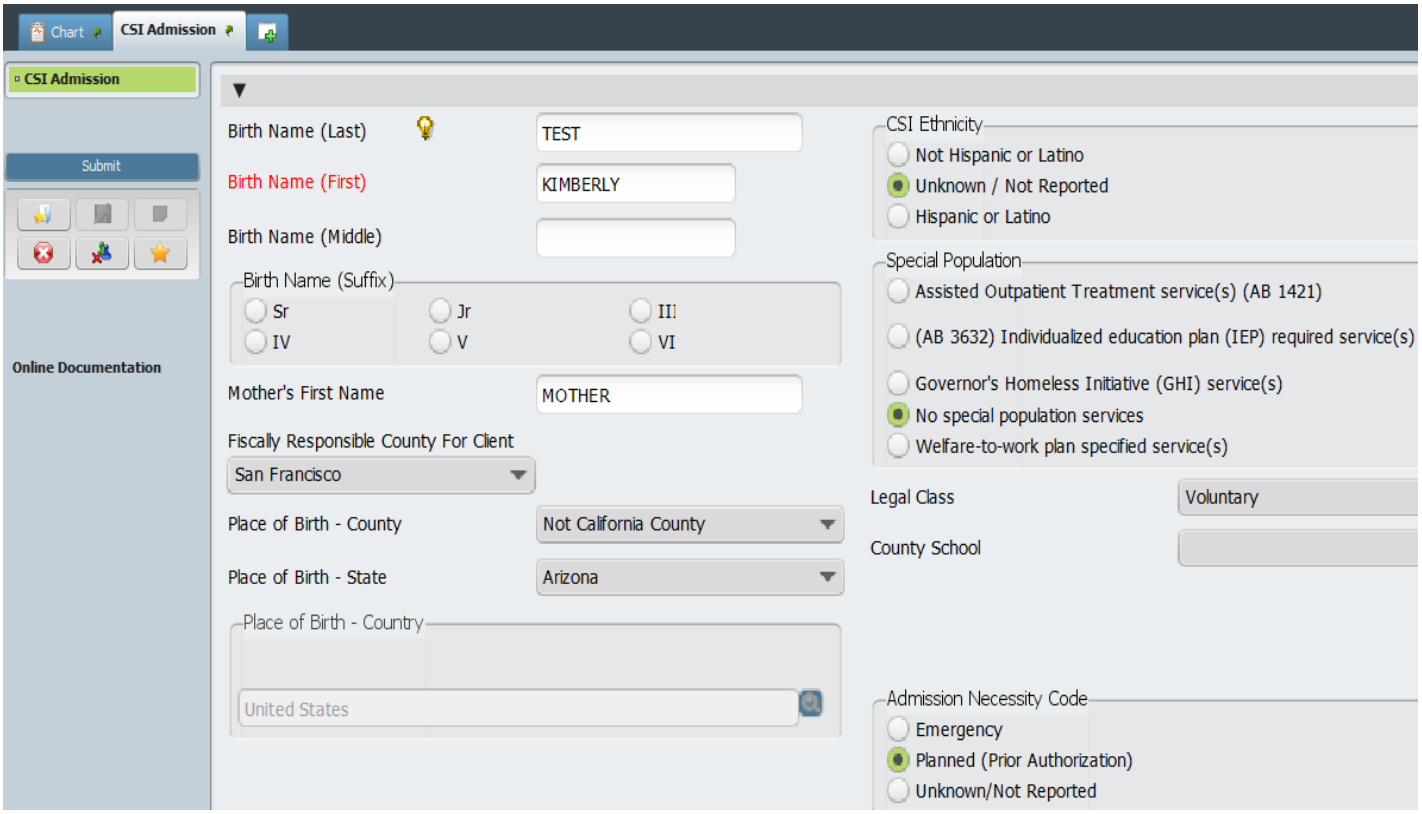
Admission (Outpatient) - continued



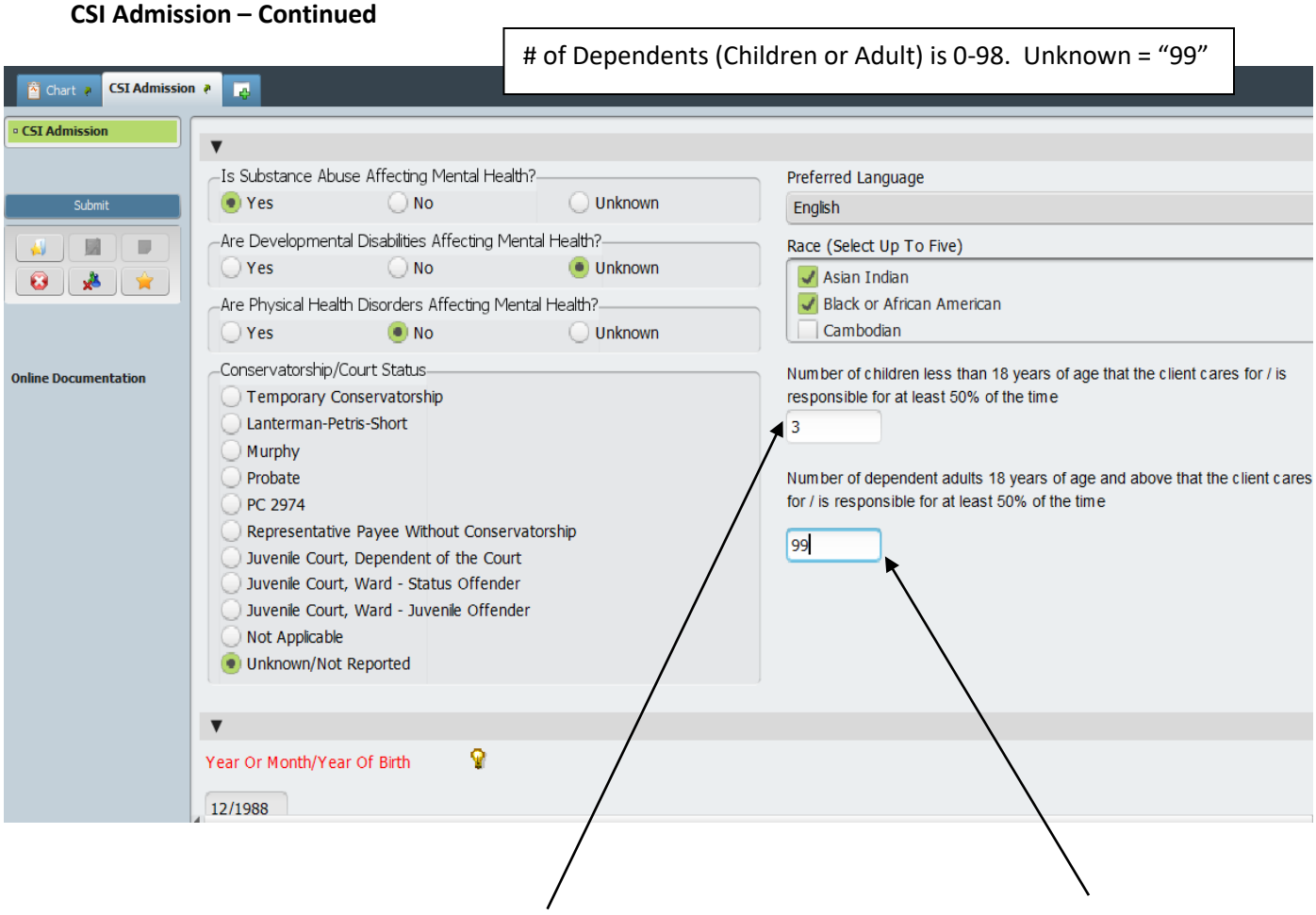
Note that date of smoking status assessment is required.

CSI Admission

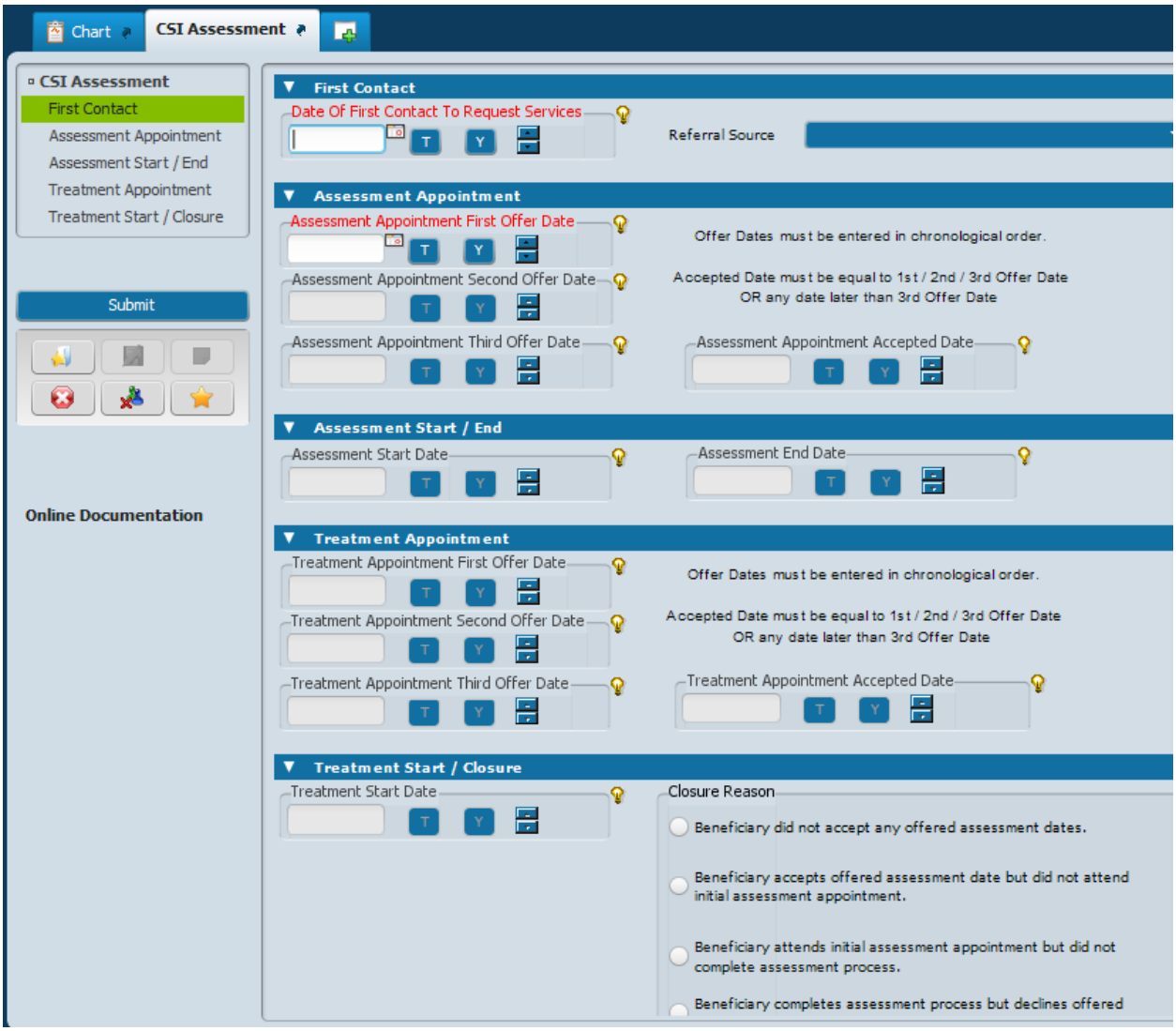
(Path: Avatar PM/ Client Management / Client Information)



CSI Admission – Continued

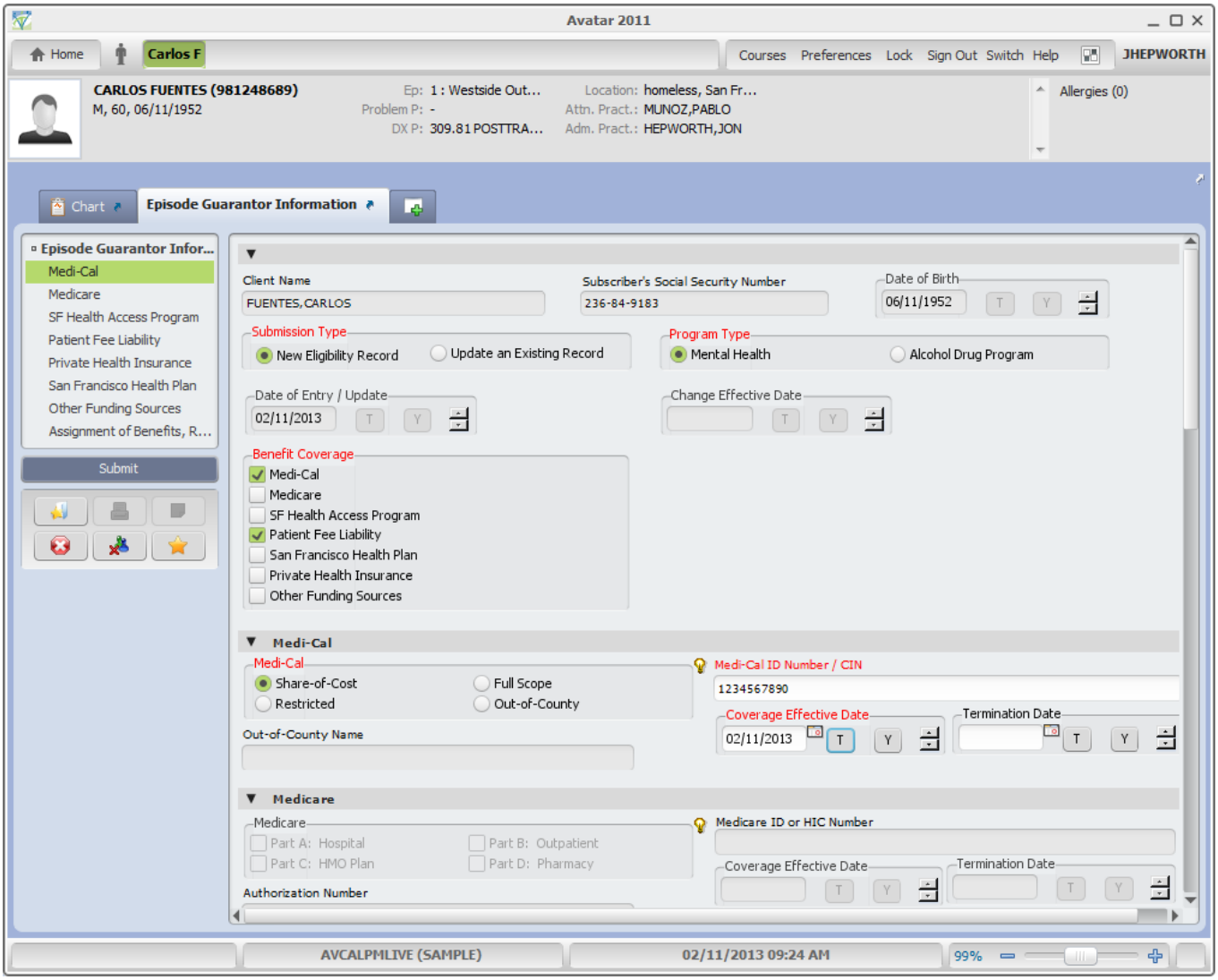


CSI Assessment



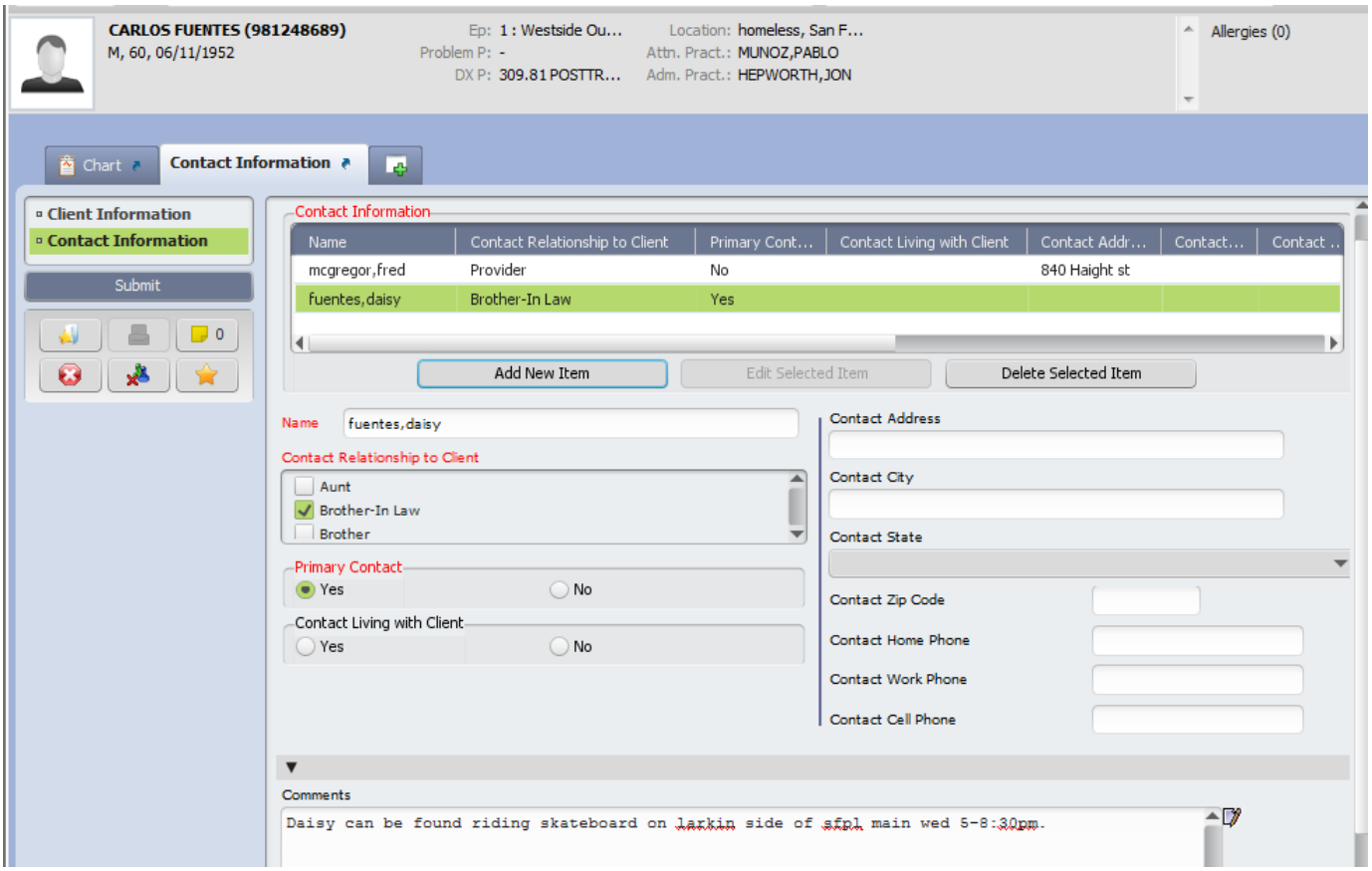
Episode Guarantor Information

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



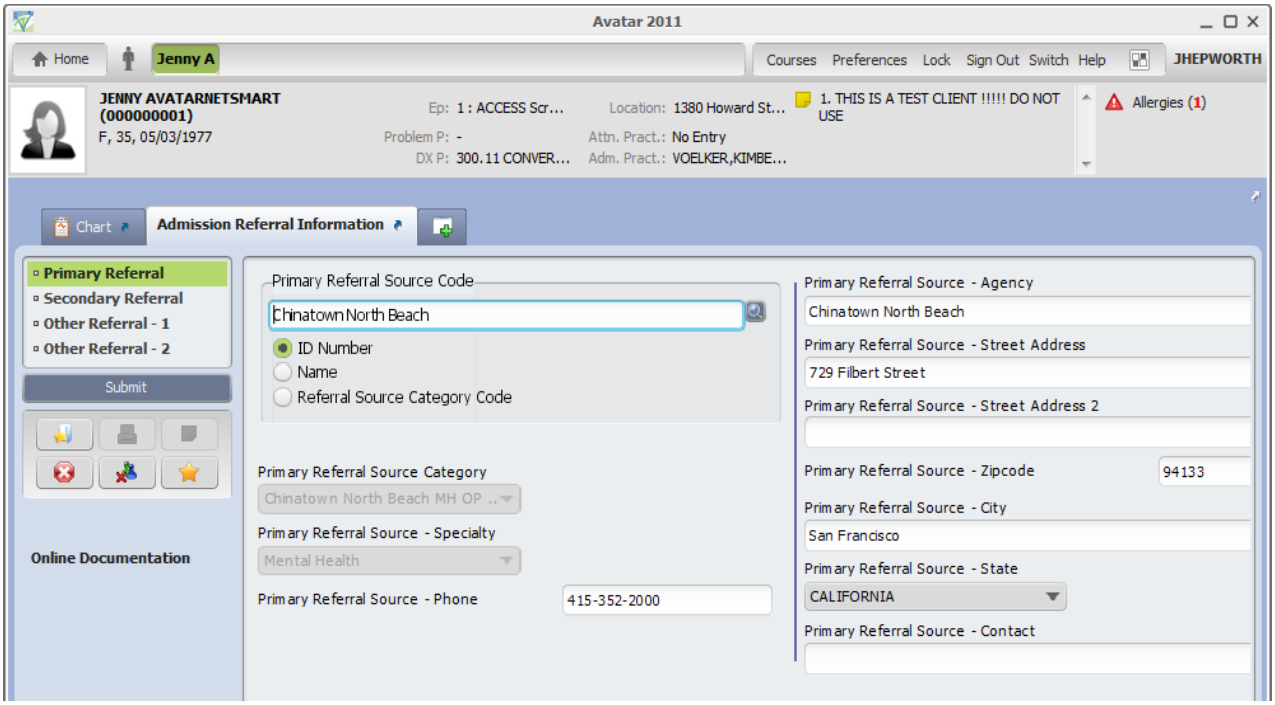
Contact Information

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



Admission Referral Information

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



Forms Bundle

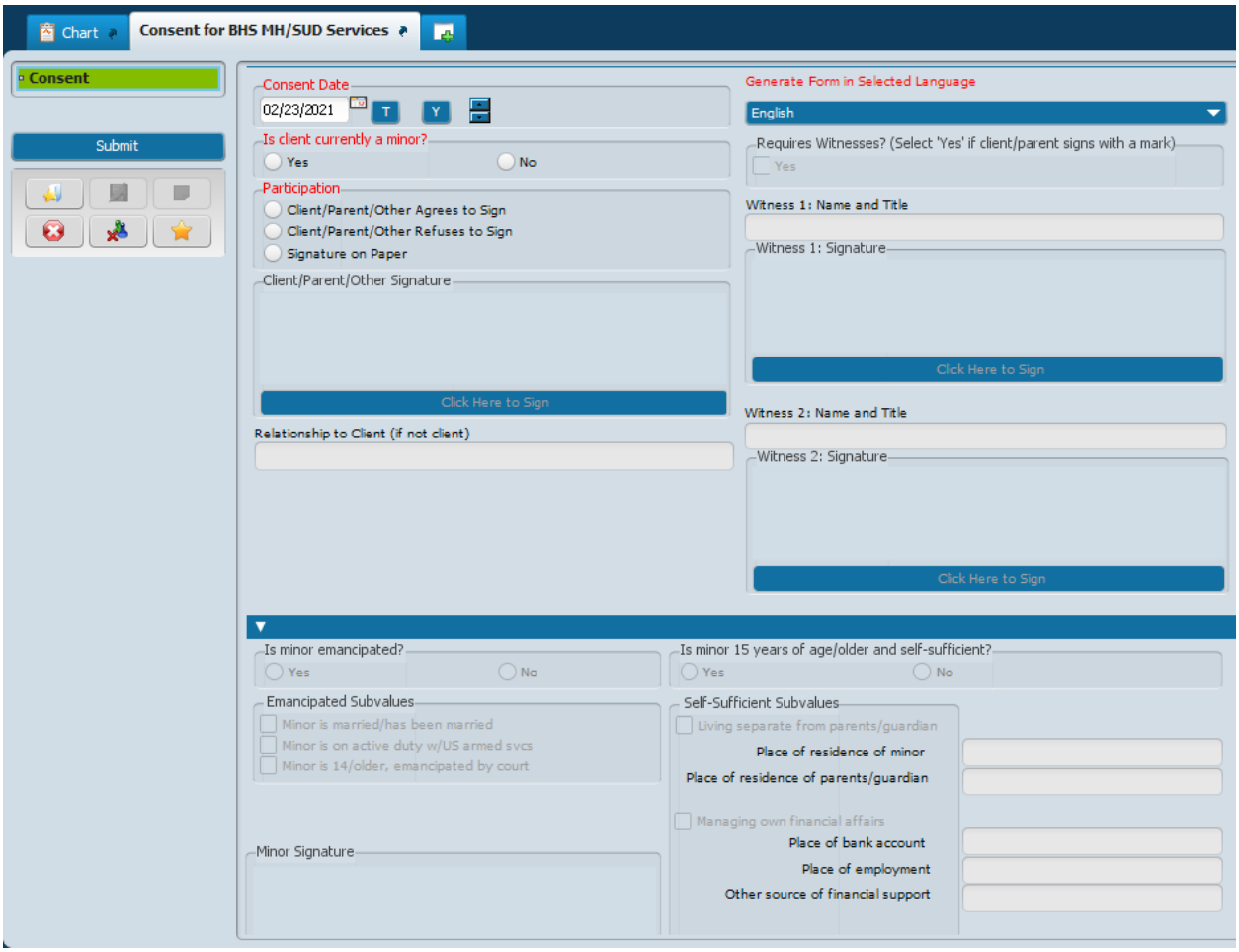
(Path: Avatar PM / Client Management / Client Information)

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

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

Other form (not in the bundle)

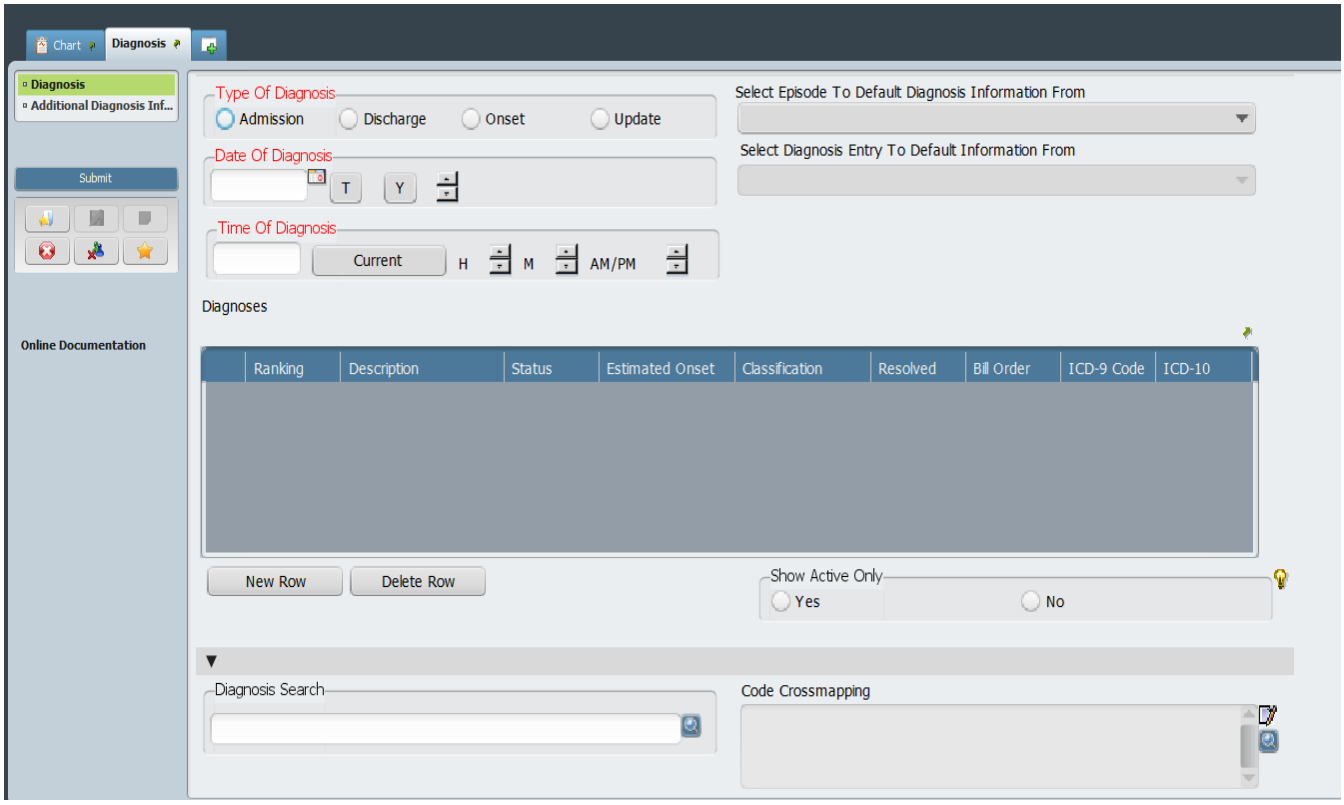
- **PHI Authorization**
- **Medication Consent**



ADMISSION DIAGNOSIS

Diagnosis

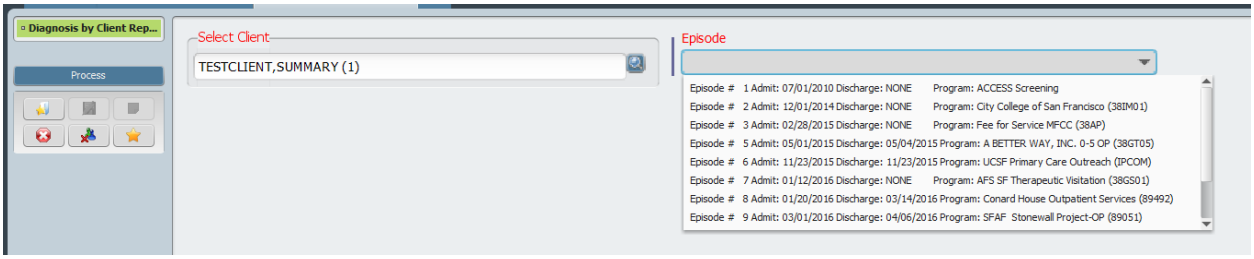
(Path: Avatar PM/ Client Management/ Client Information)



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)



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	DSM-IV/ ICD-9	DSM-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

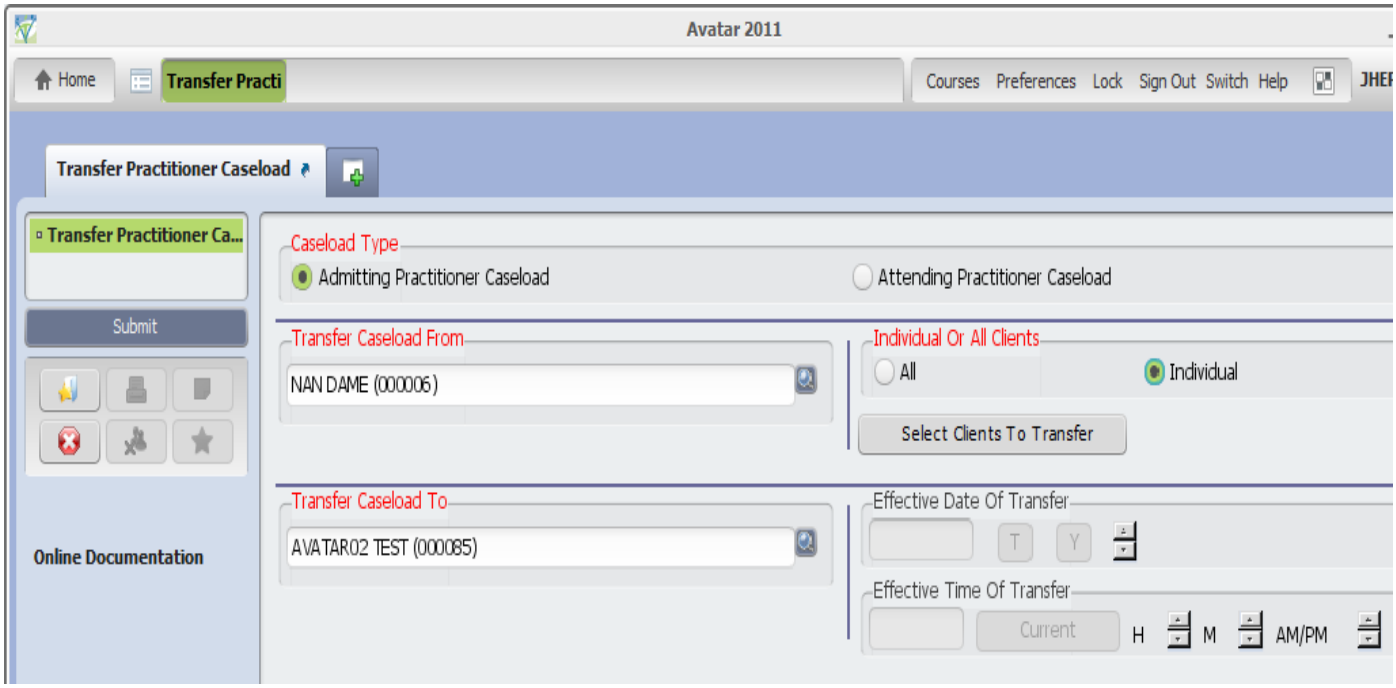
Rank	Description	Diagnosing Practitioner	Status	Class	Bill Order	DSM-IV/ ICD-9	DSM-5/ ICD-10
Primary	Depressed	VOELKER,KIMBERLY (000089)	Active		1	311	F32.9

TRANSFER CASELOAD

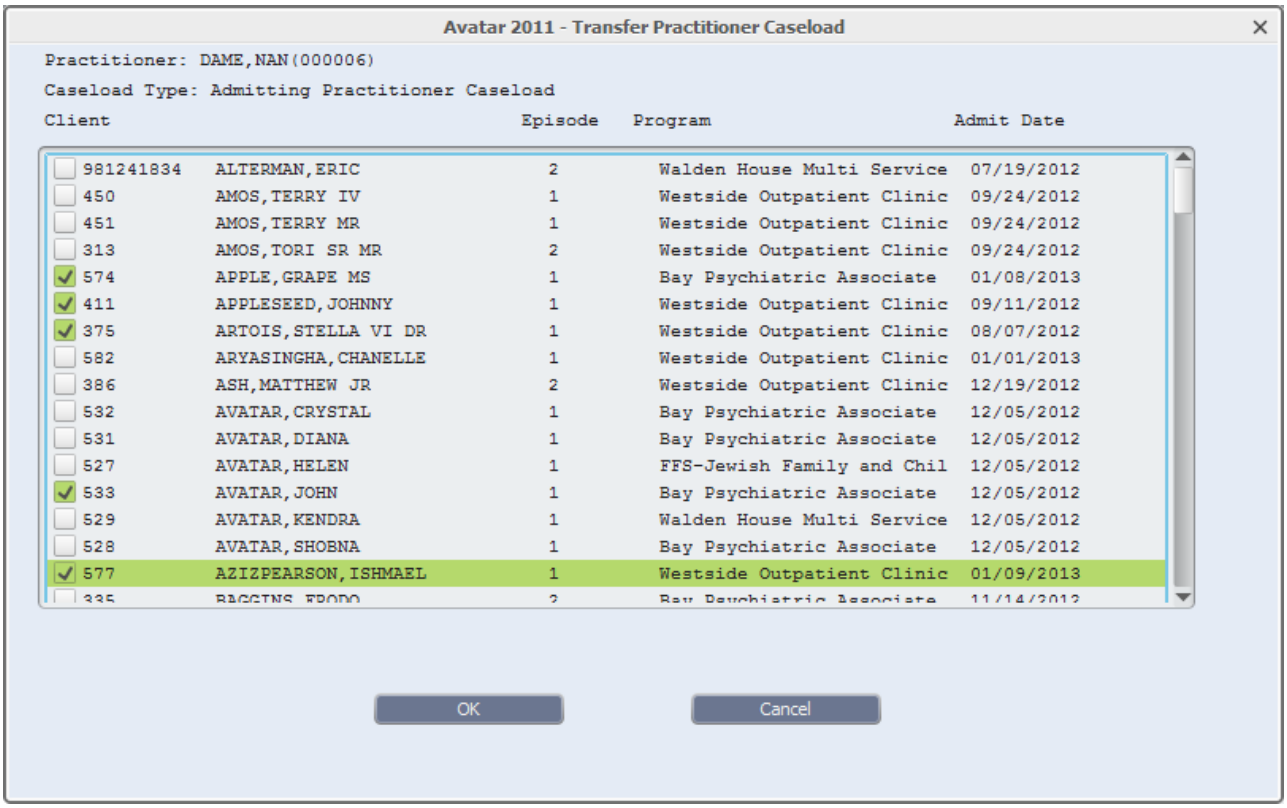
Transfer Practitioner Caseload

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

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



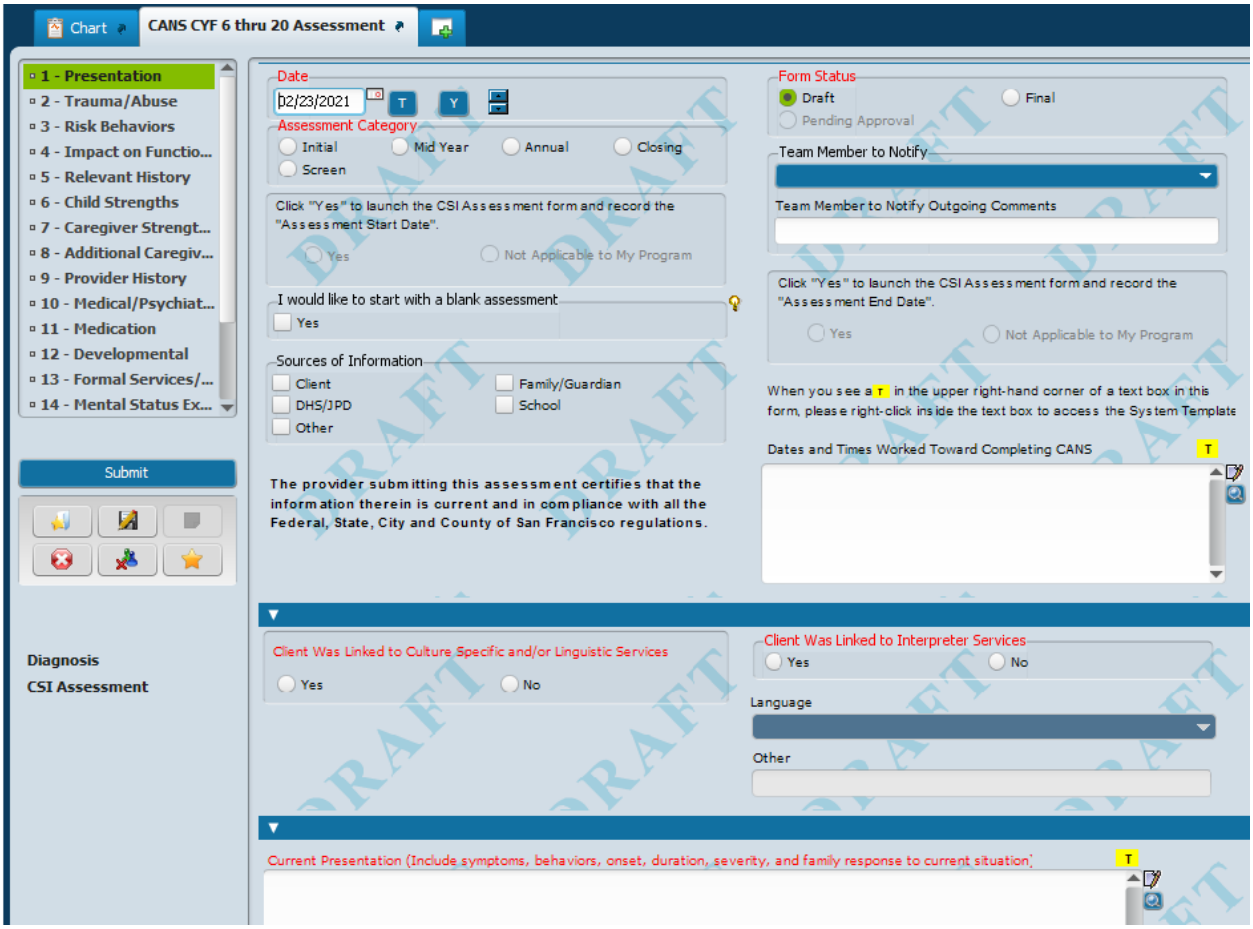
Transfer Practitioner Caseload – continued



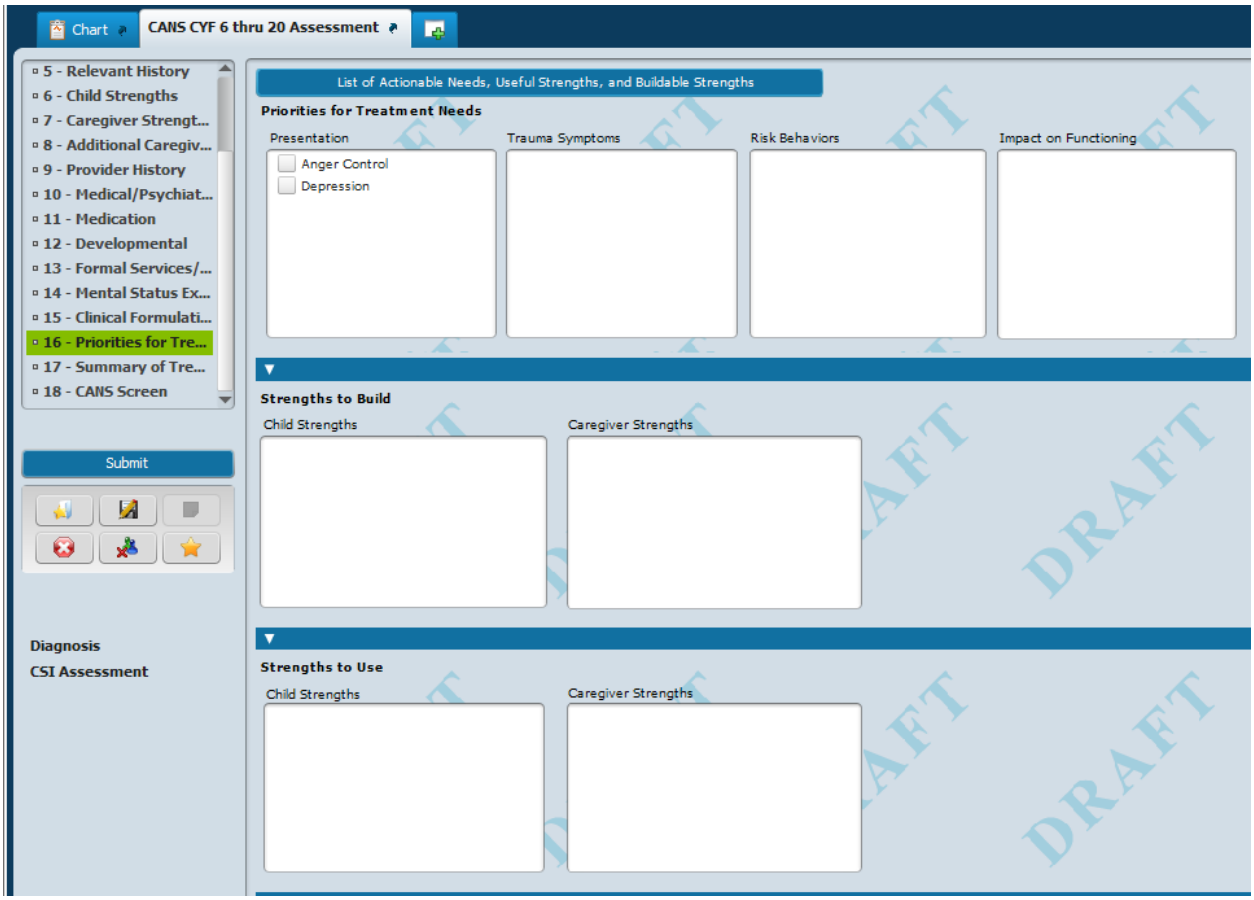
CHILD, YOUTH, AND FAMILIES (CYF)

CANS CYF 6 thru 20 Assessment

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

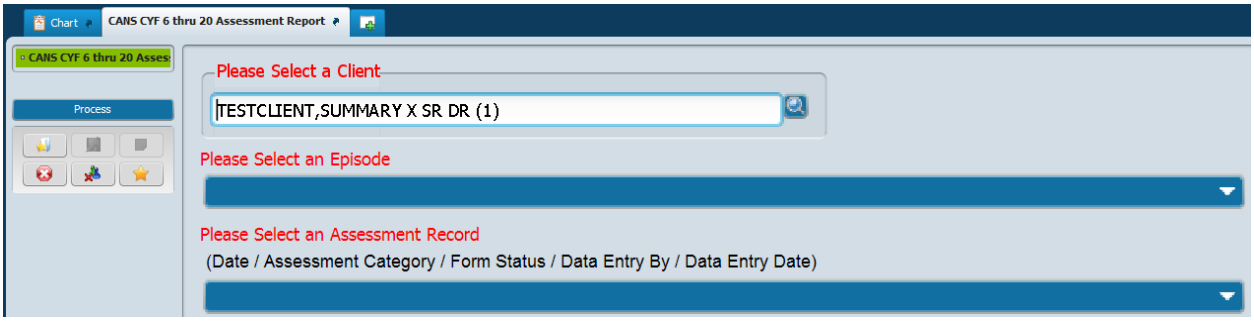


CANS CYF 5/18 Assessment - continued



CANS CYF 6 thru 20 Assessment Rpt

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



San Francisco Department of Public Health
Community Behavioral Health Services

CANS CYF 6 thru 20 Assessment Report

Client Name: TESTCLIENT,SUMMARY X SR DR
Client ID: 1
Program: Conversion Program(9999Z)
Episode #: 52
Admission Date: 11/14/2019
Discharge Date: 3/21/2020

Confidential Patient Information

Assessment Date: 2/23/2021 **Assessment By:** Kellee Hom (003865)
Assessment Category: Initial **Assessment Status:** 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.

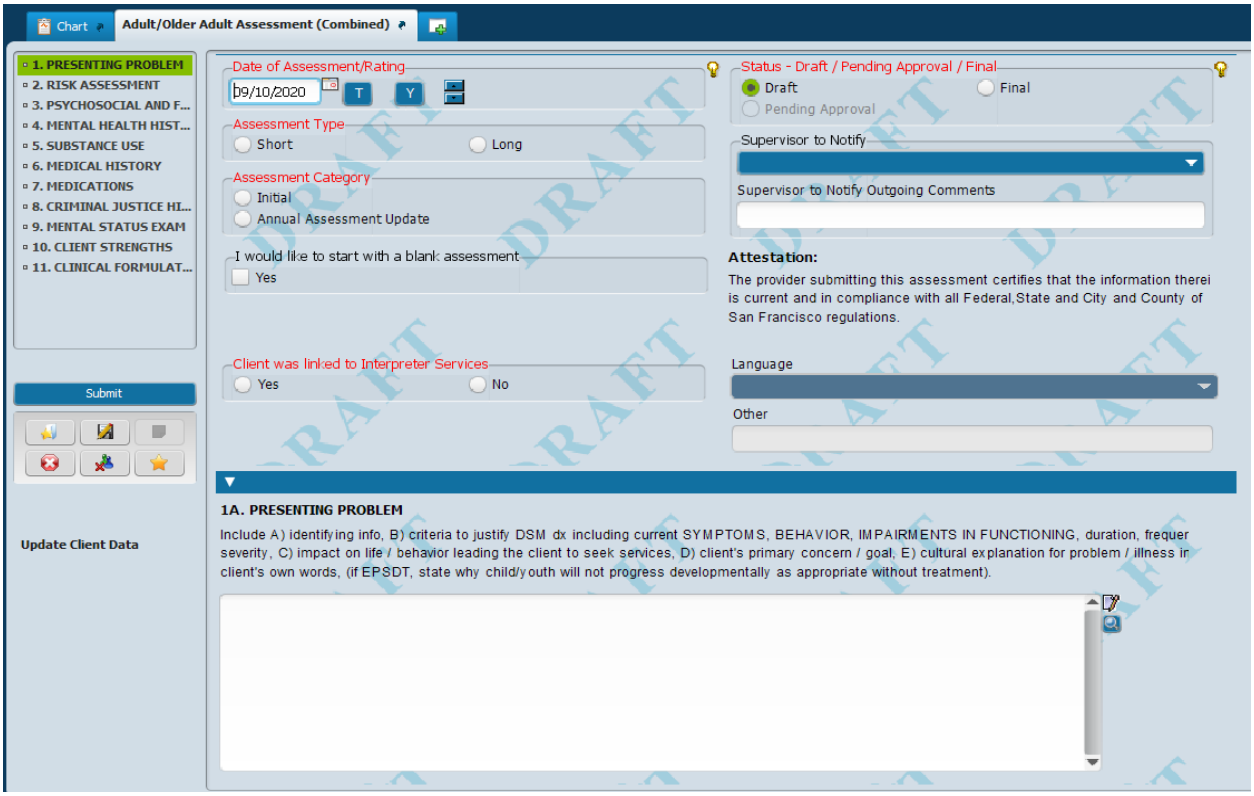
Trauma Events

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/Attch Losses	0
Witness to Family Violence	0	Parental Criminal Behaviors	0

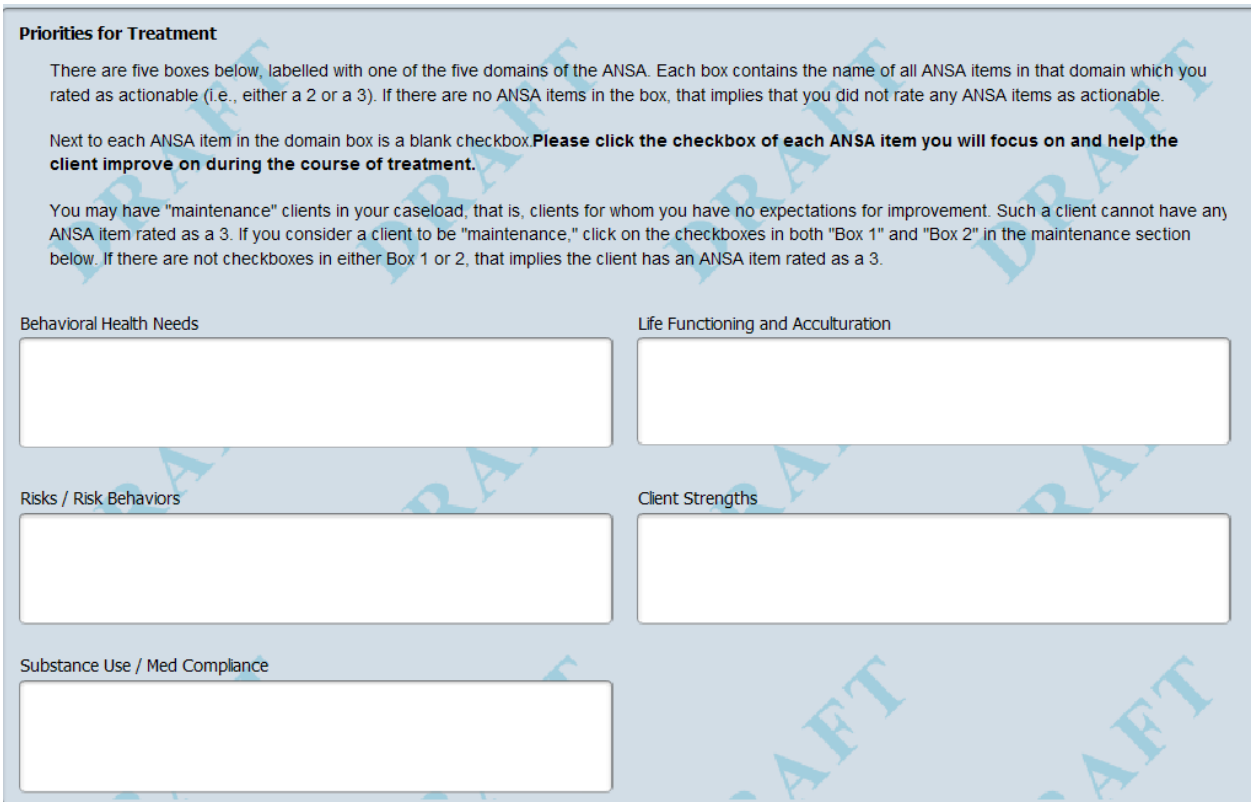
ADULT/OLDER ADULT (AOA)

Adult/Older Adult Assessment (Combined)

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



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

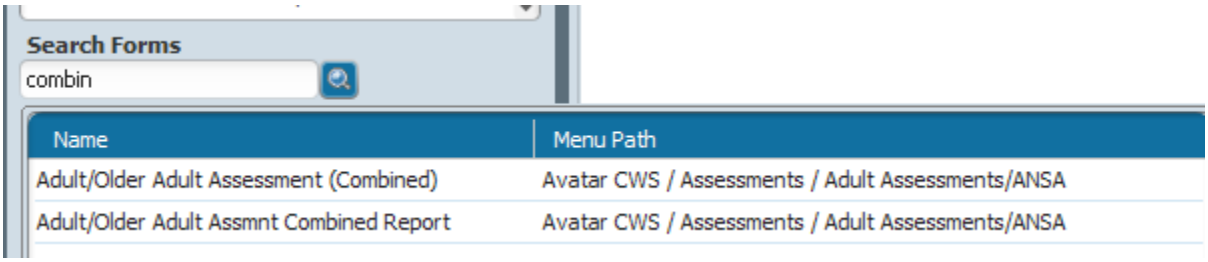
Risks / Risk Behaviors

Client Strengths

Substance Use / Med Compliance

Adult/Older Adult Assessment Combined Rpt

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



San Francisco Department of Public Health
Community Behavioral Health Services

Adult/Older Adult Assessment (Combined) Report

Client Name: TESTCLIENT,SUMMARY Y SR DR
Client ID: 1
Program: ACCESS Screening (BHAC)
Episode #: 59
Admission Date: 12/19/2020
Discharge Date: None

Confidential Patient Information

Assessment Date: 1/30/2021
Assessment Type: Short
Assessment Category: Initial
Interpreter Svc Used: No
Language:
Other:

Assessment By: Kimberly Voelker (000089)
Service Program: ACCESS Screening

Assessment Status: Draft

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

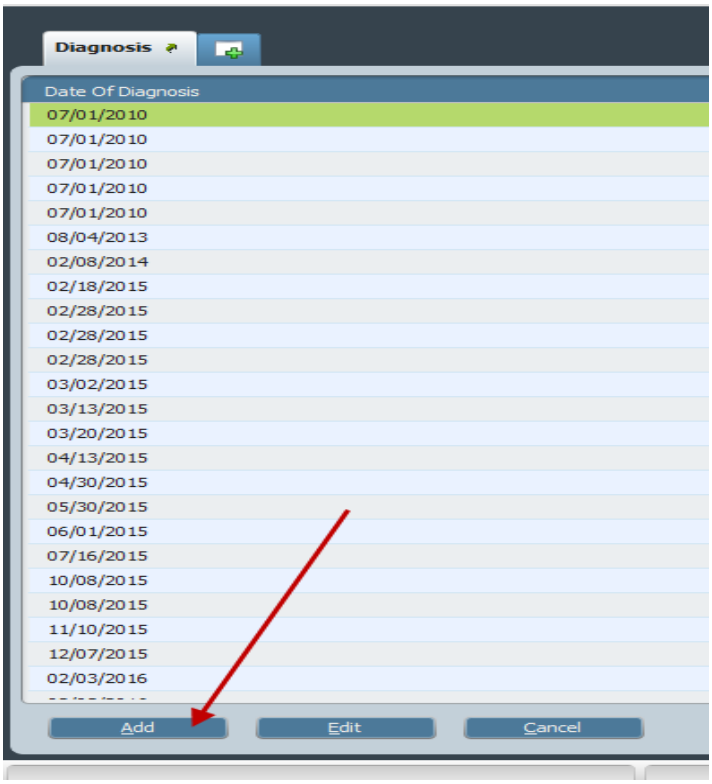
ND=No Data; 0=No Evidence; 1=Mild History, Sub-Threshold Watch; 2=Moderate-Need for action; 3=Severe-Need for immediate/intensive action

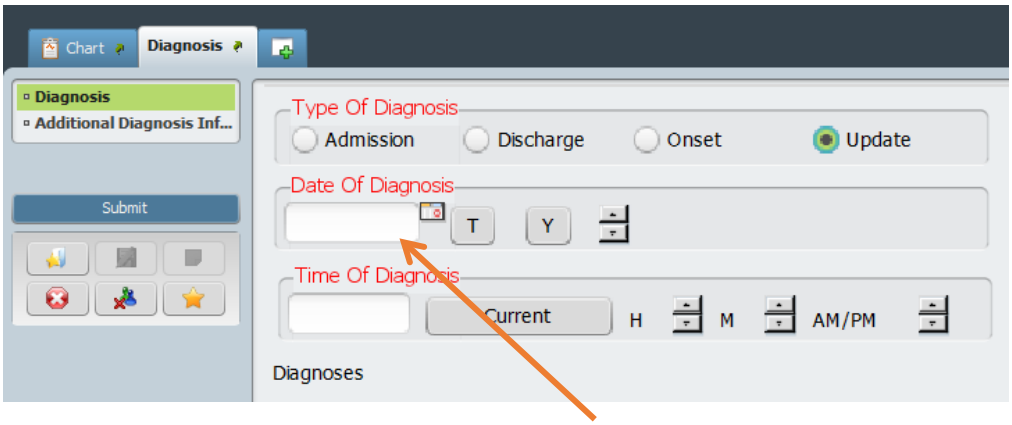
Psychosis	0	**Interpersonal Problems Due to Personality**	ND
Depression	ND	**Adjustment to Trauma**	ND
Anxiety	ND	**Mania**	ND
Impulse Control	ND	**Sleep Disturbance**	ND

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.





Use the date of the assessment.

CYF MENTAL HEALTH TREATMENT PLAN OF CARE

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

Purpose:

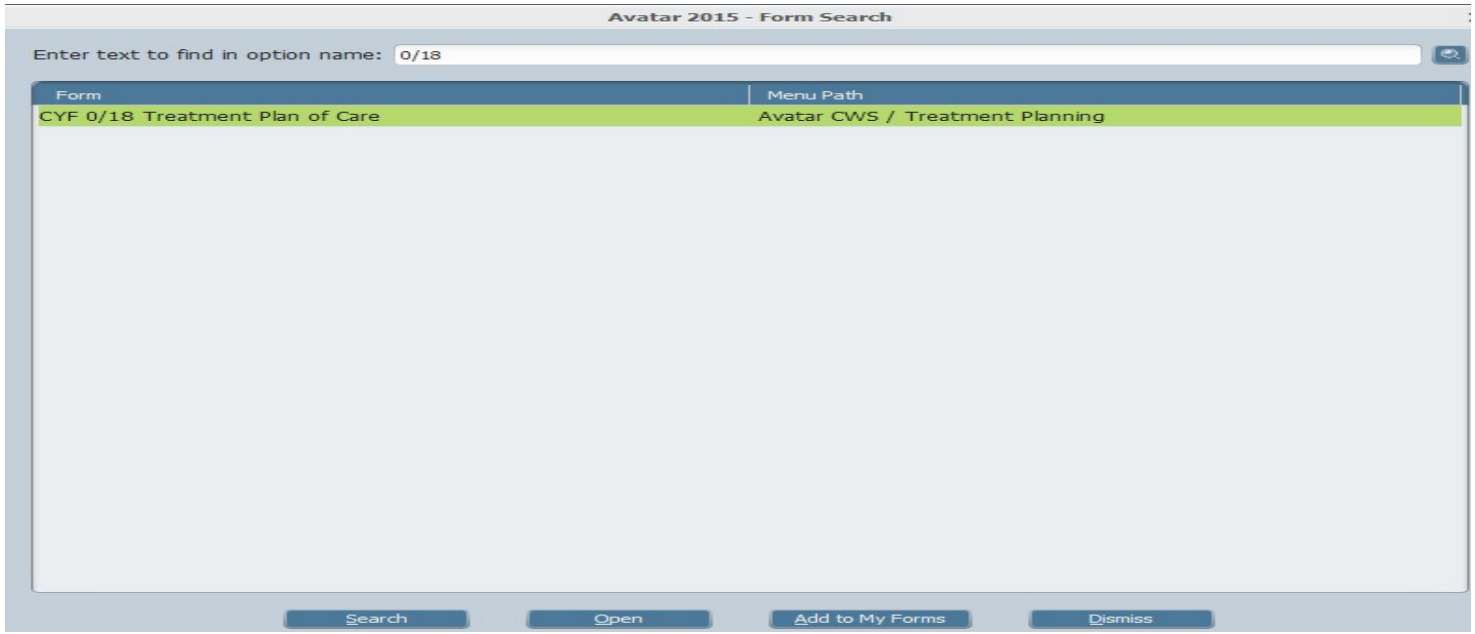
The purpose of the manual is to walk you through the CYF 0/18 Treatment Plan of Care in the Avatar EHR System.

Menu Path:

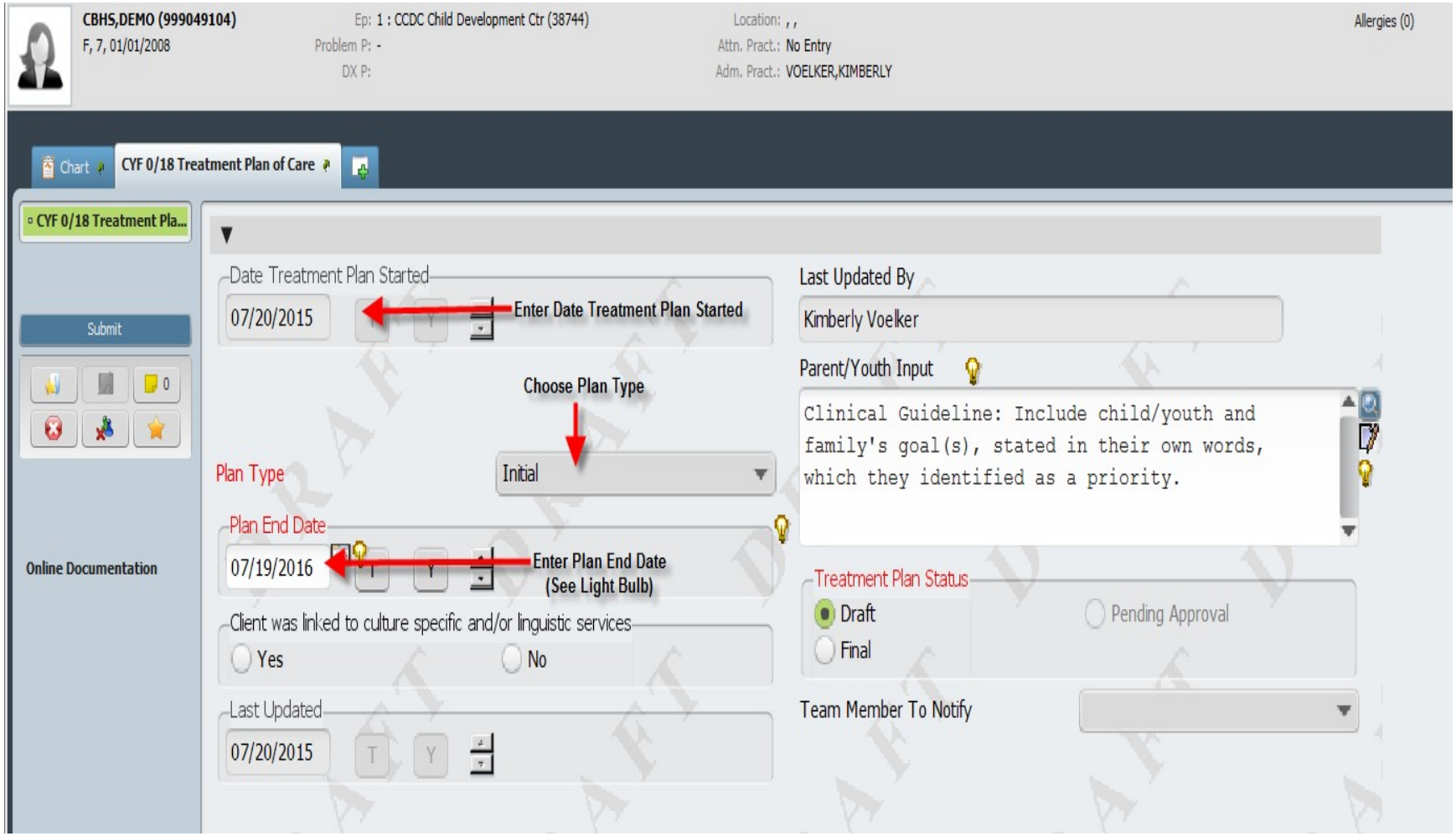
Avatar CWS>Treatment Planning>**CYF 0/18 Treatment Plan of Care**

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*****

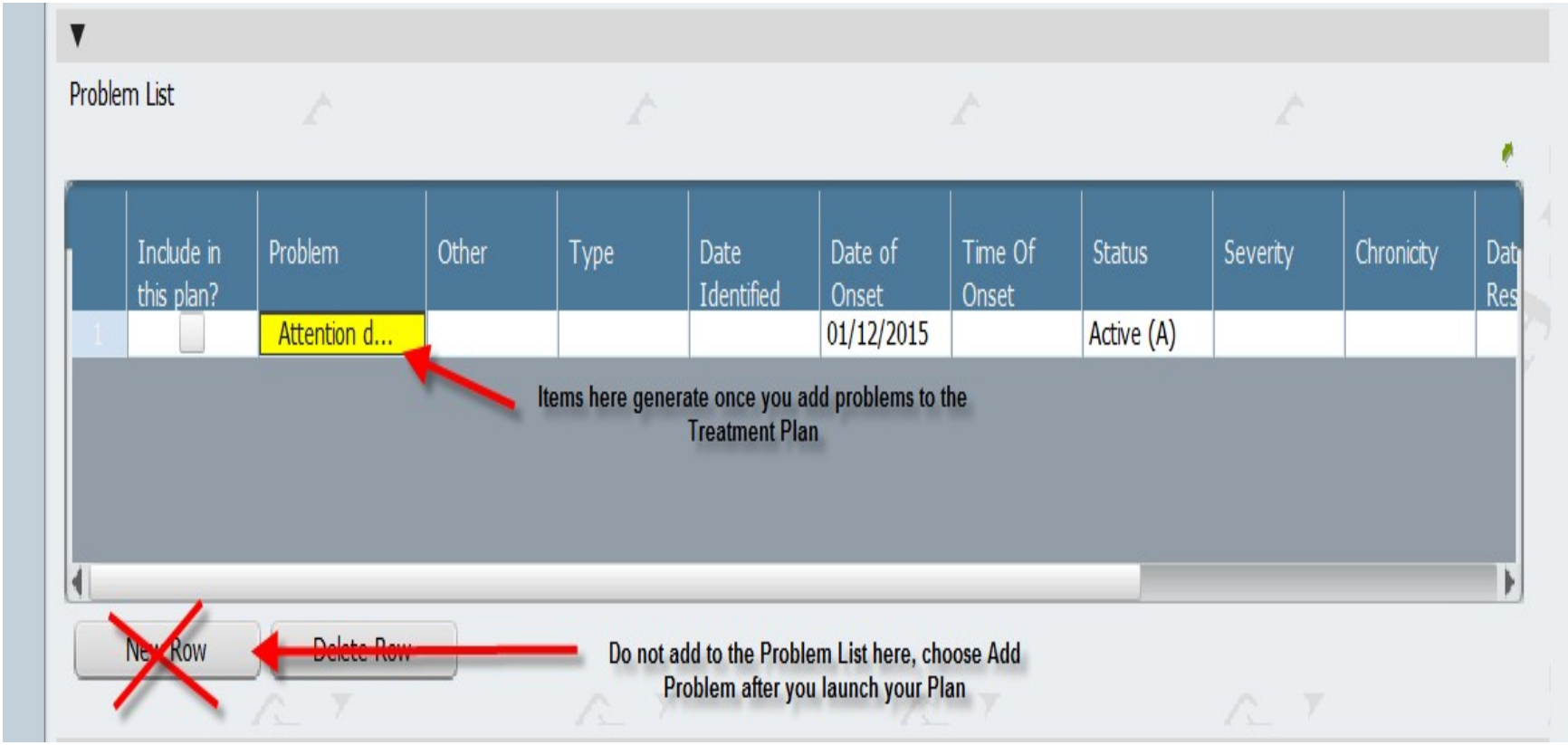


Starting the CYF 0/18 Treatment Plan of Care

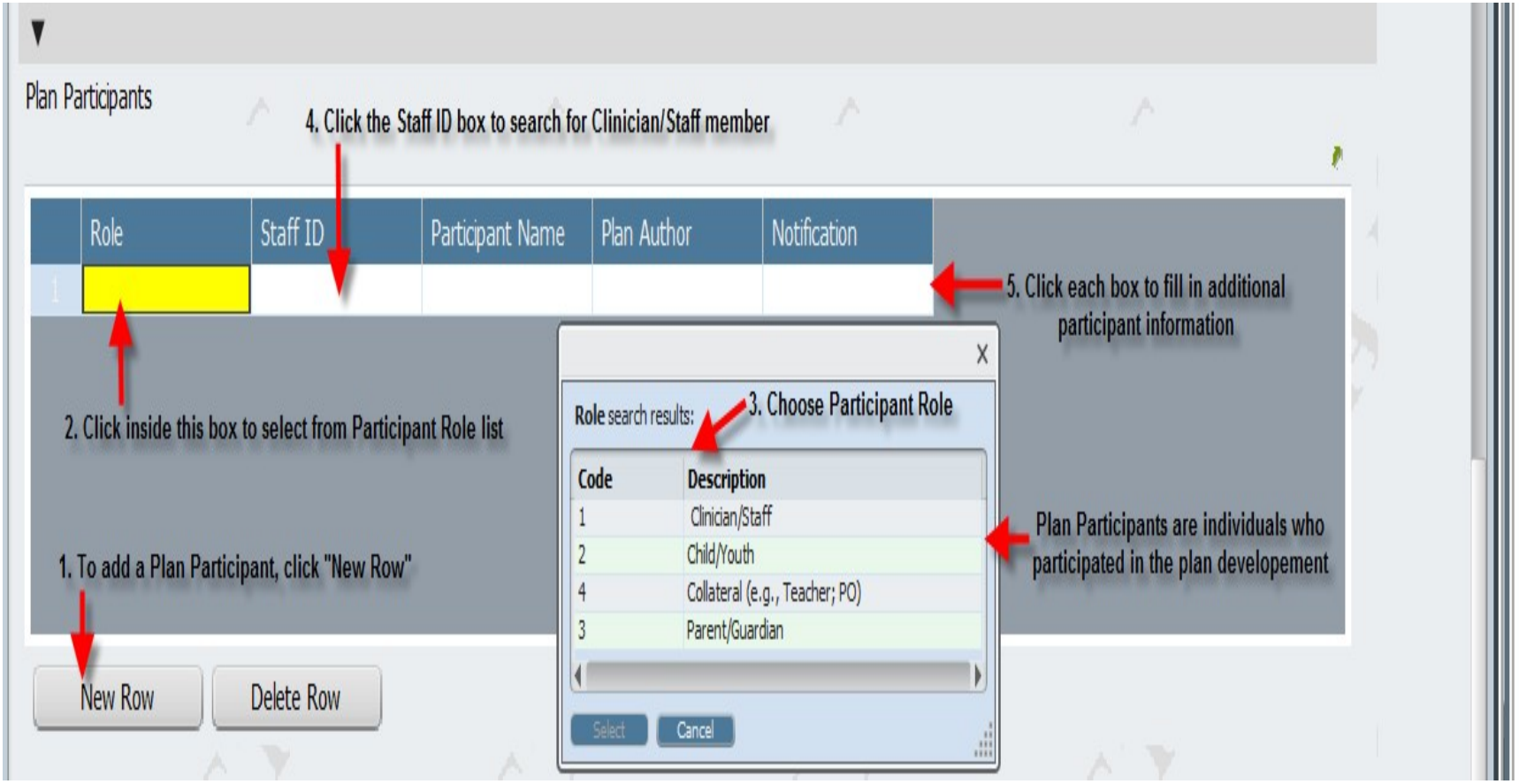


Treatment Plan Problem List

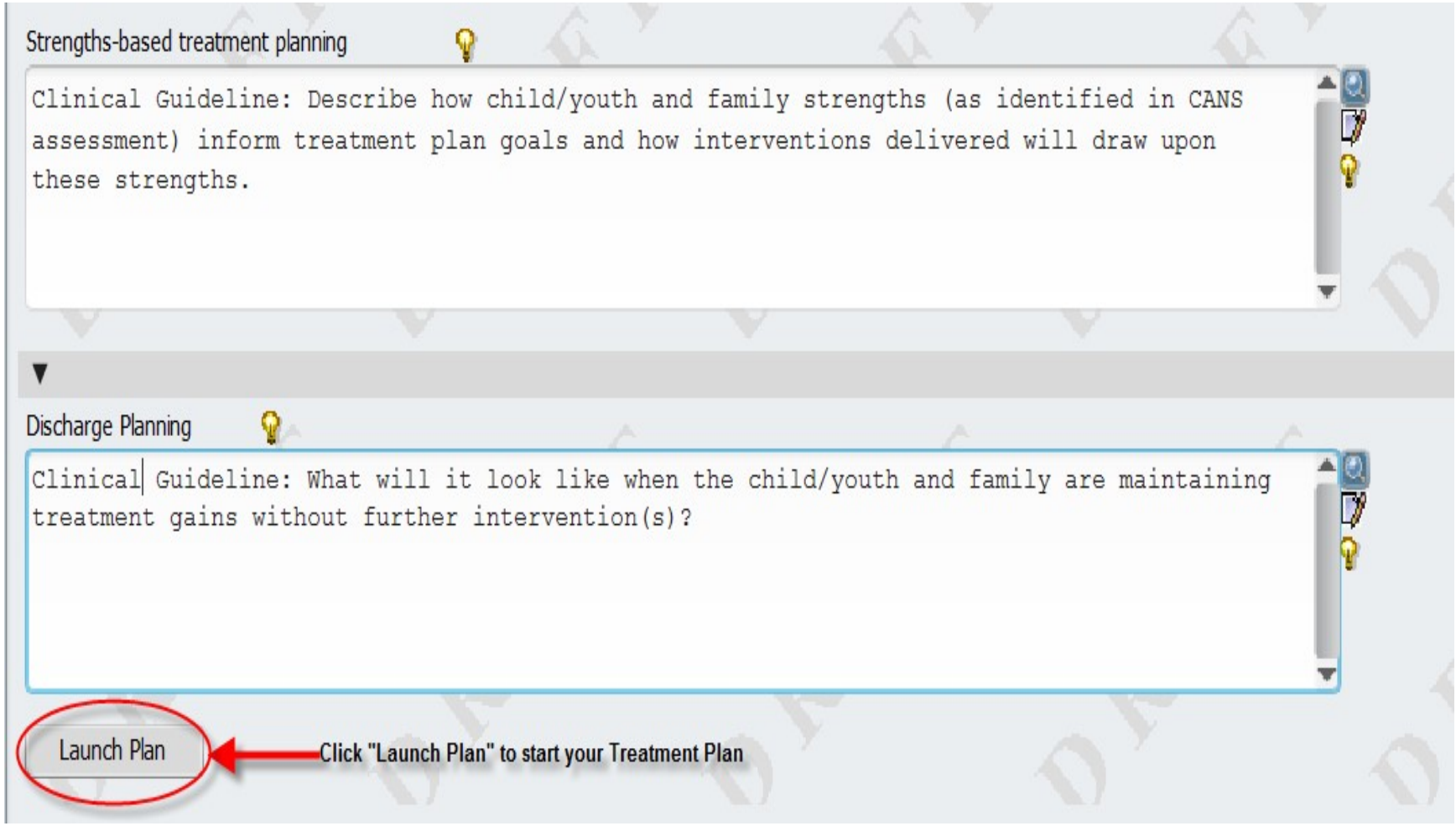
Below is the Treatment Plan "Problem List" which is a federal requirement for Meaningful Use (i.e. not language we would have chosen). Items generate based on a library called SNOMED (which is medically based). You will add a "problem code" once you launch the plan (**see page 8**). It will then populate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



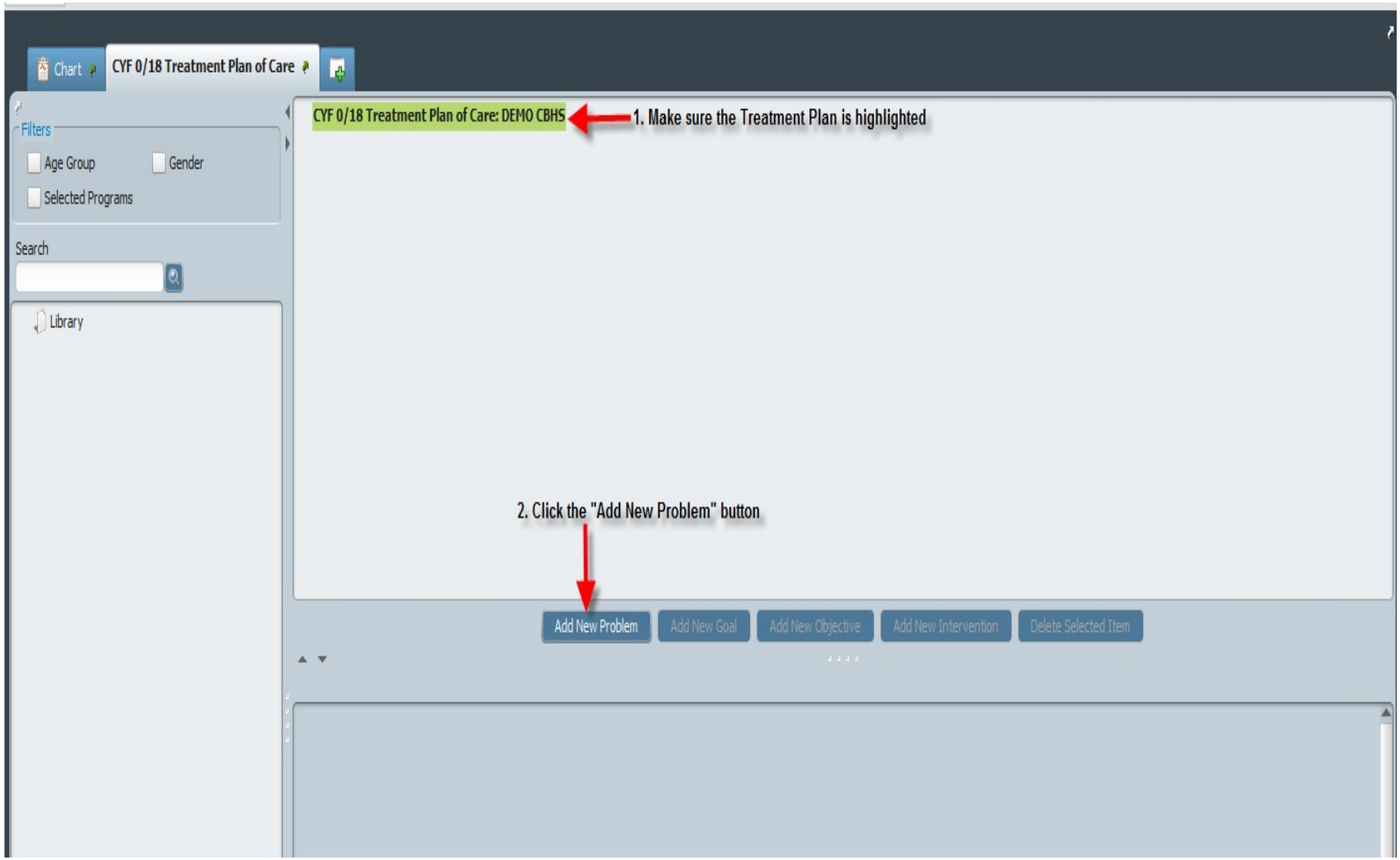
Adding Plan Participants



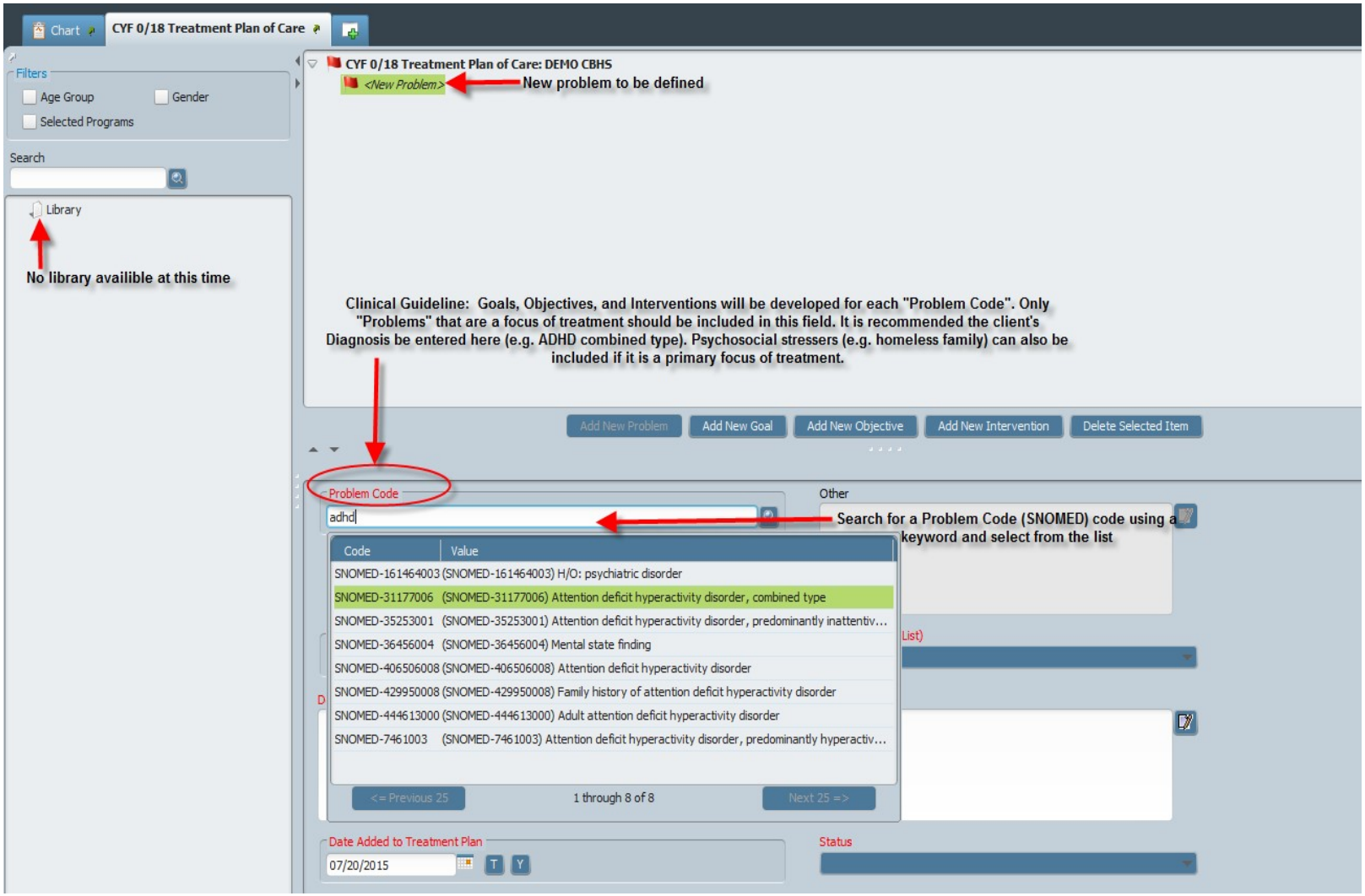
Starting your Treatment Plan – Text entry



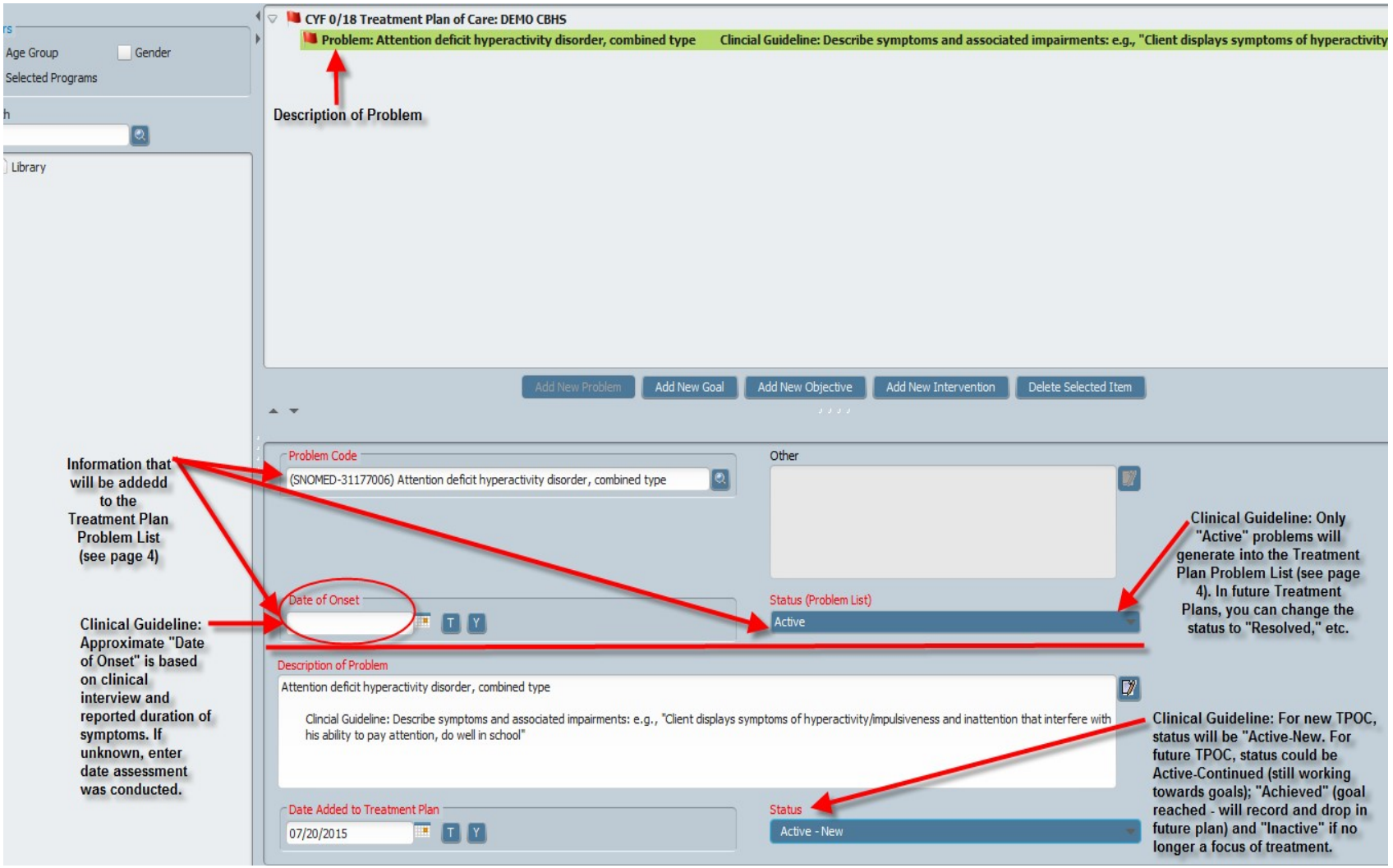
Treatment Plan Problem Section – Adding a Problem



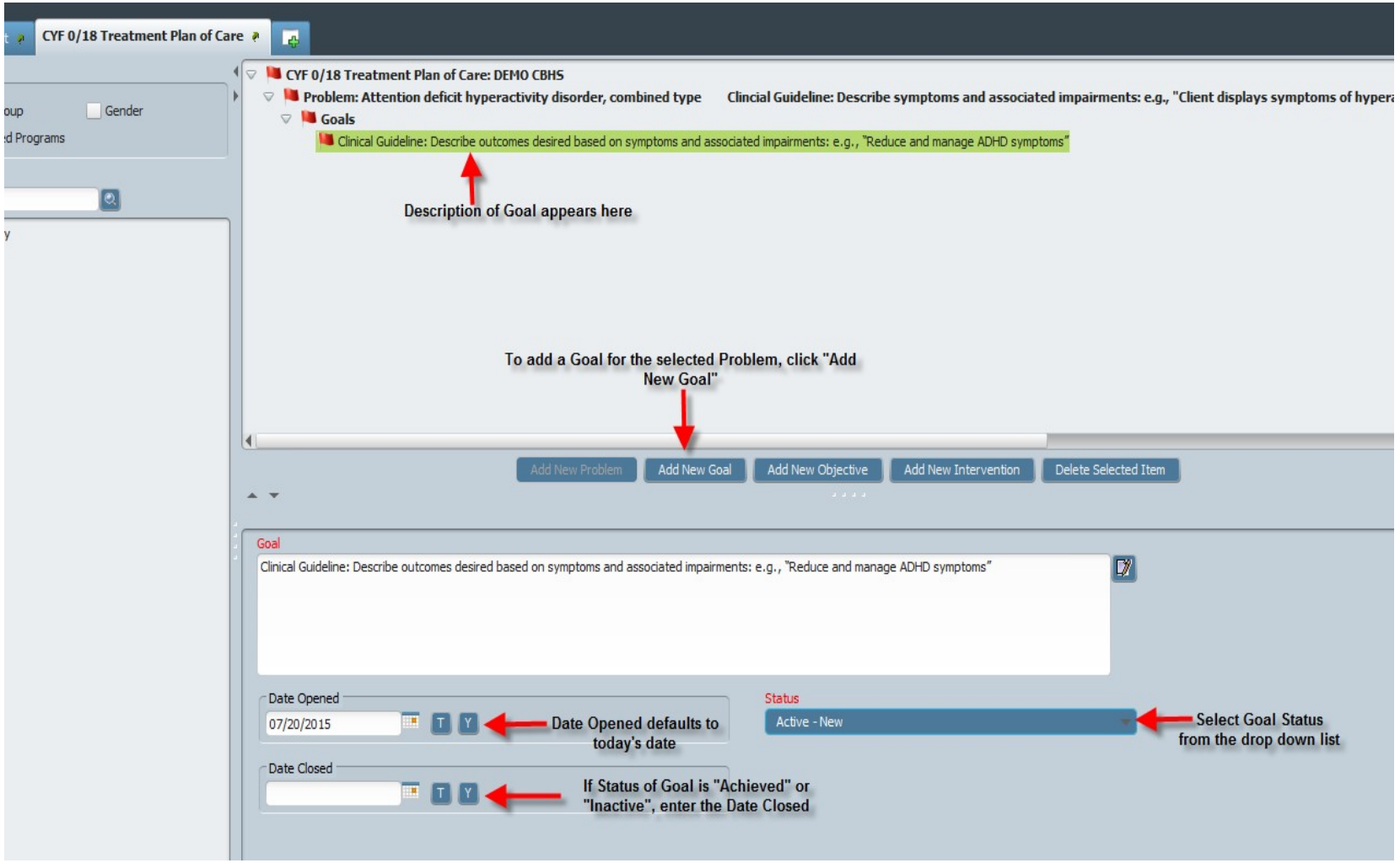
Treatment Plan Problem Section – Adding a Problem (continued)



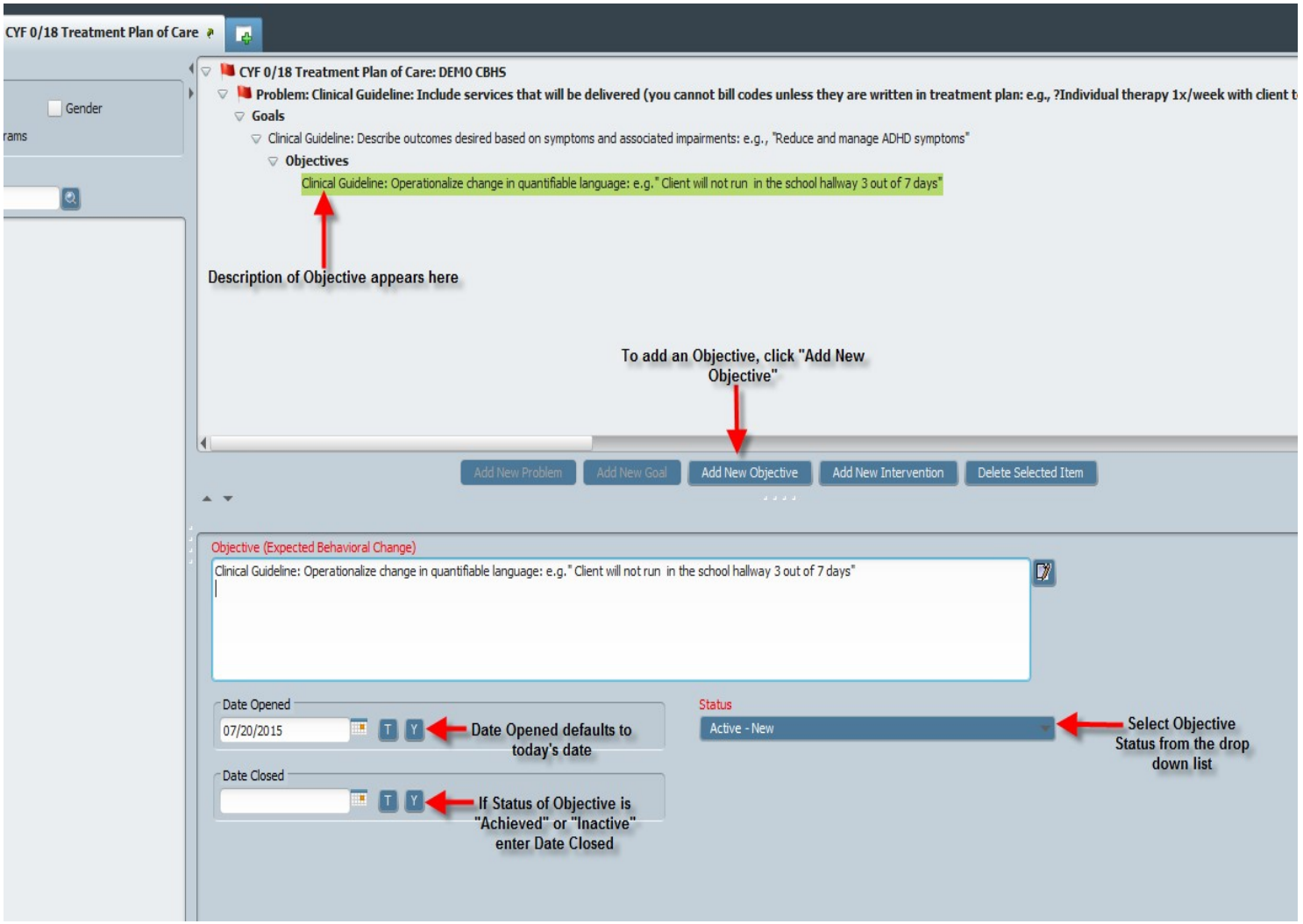
Treatment Plan Problem Section – Adding a Problem (continued)



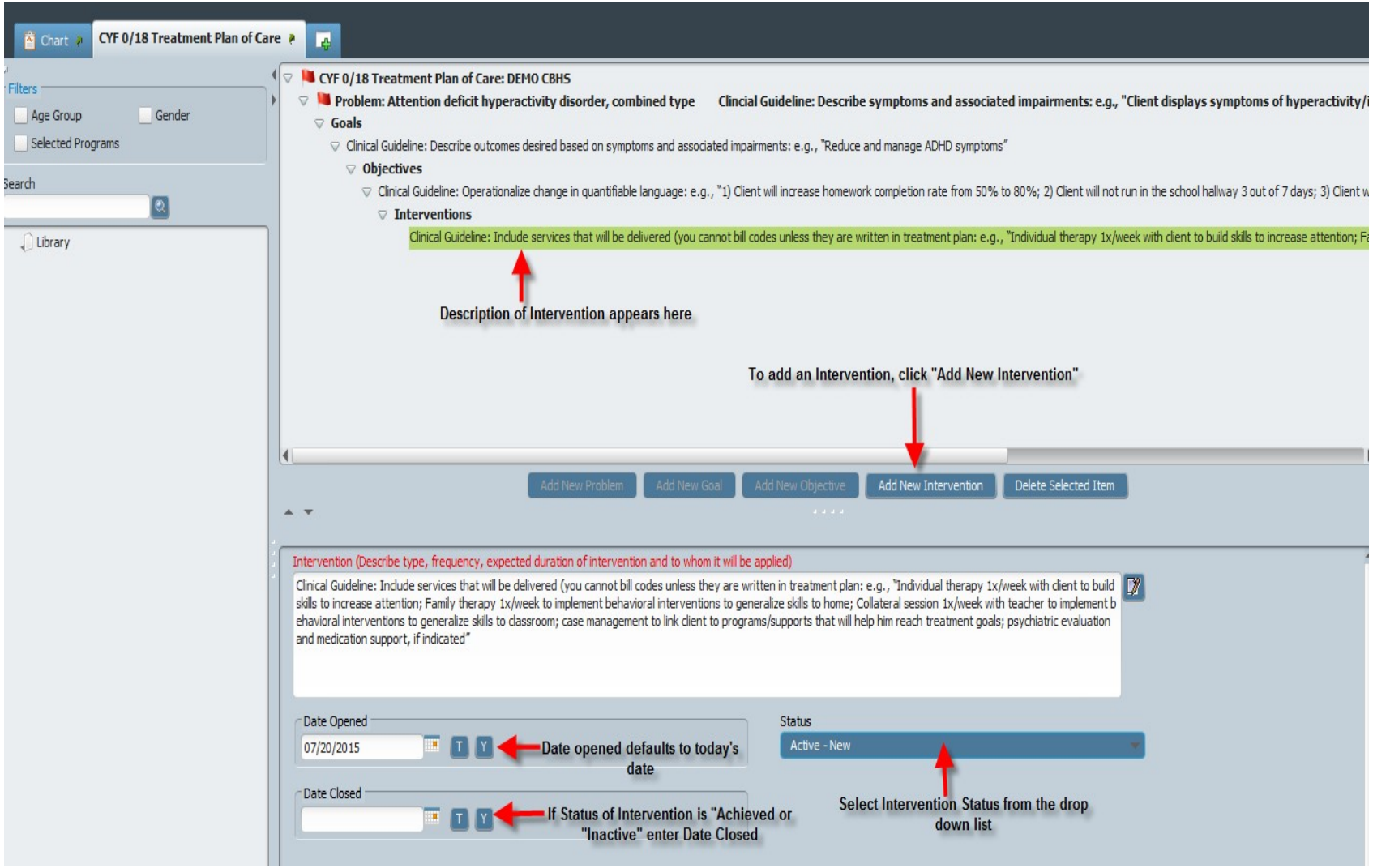
Treatment Plan – Adding a Goal



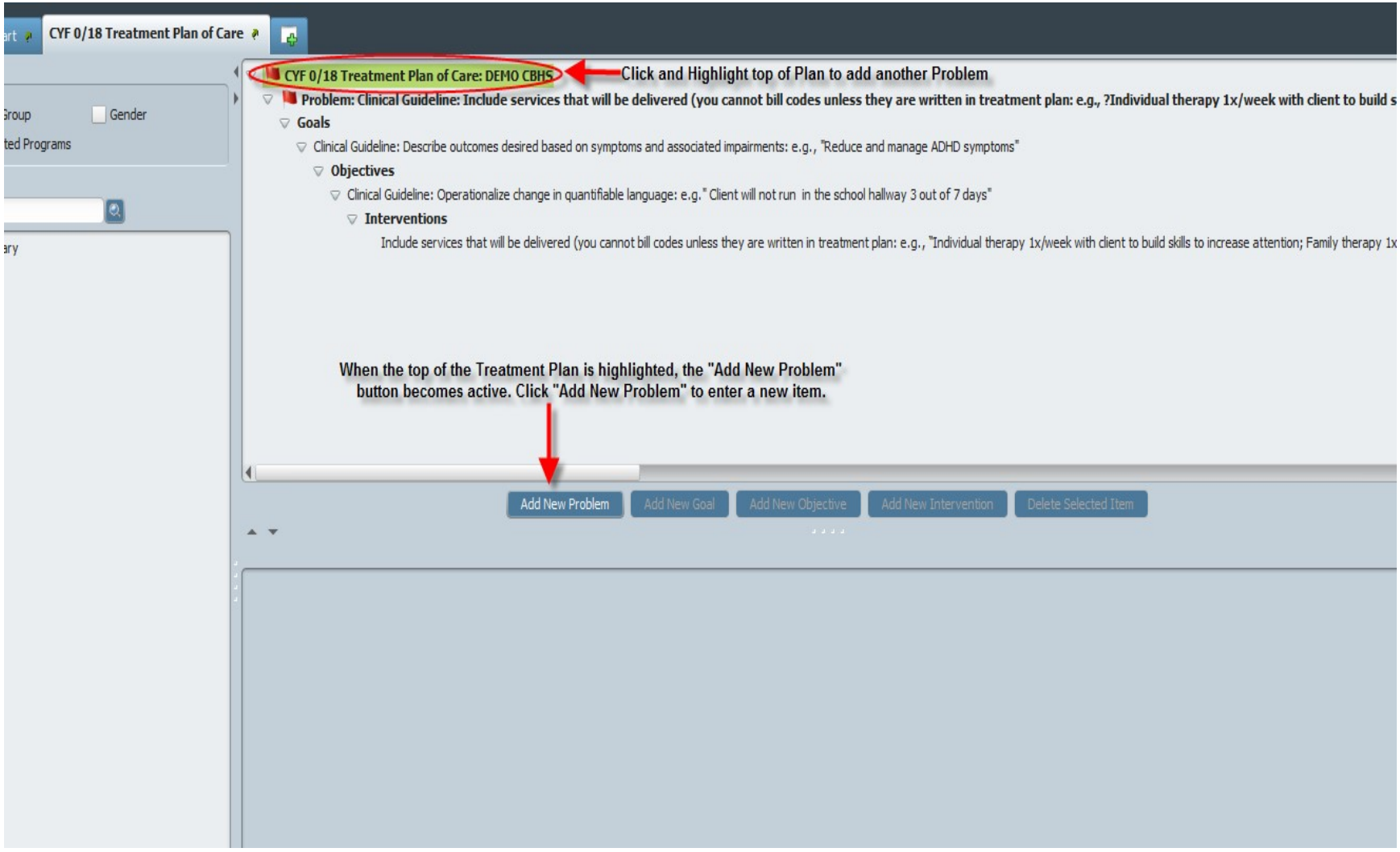
Treatment Plan – Adding an Objective



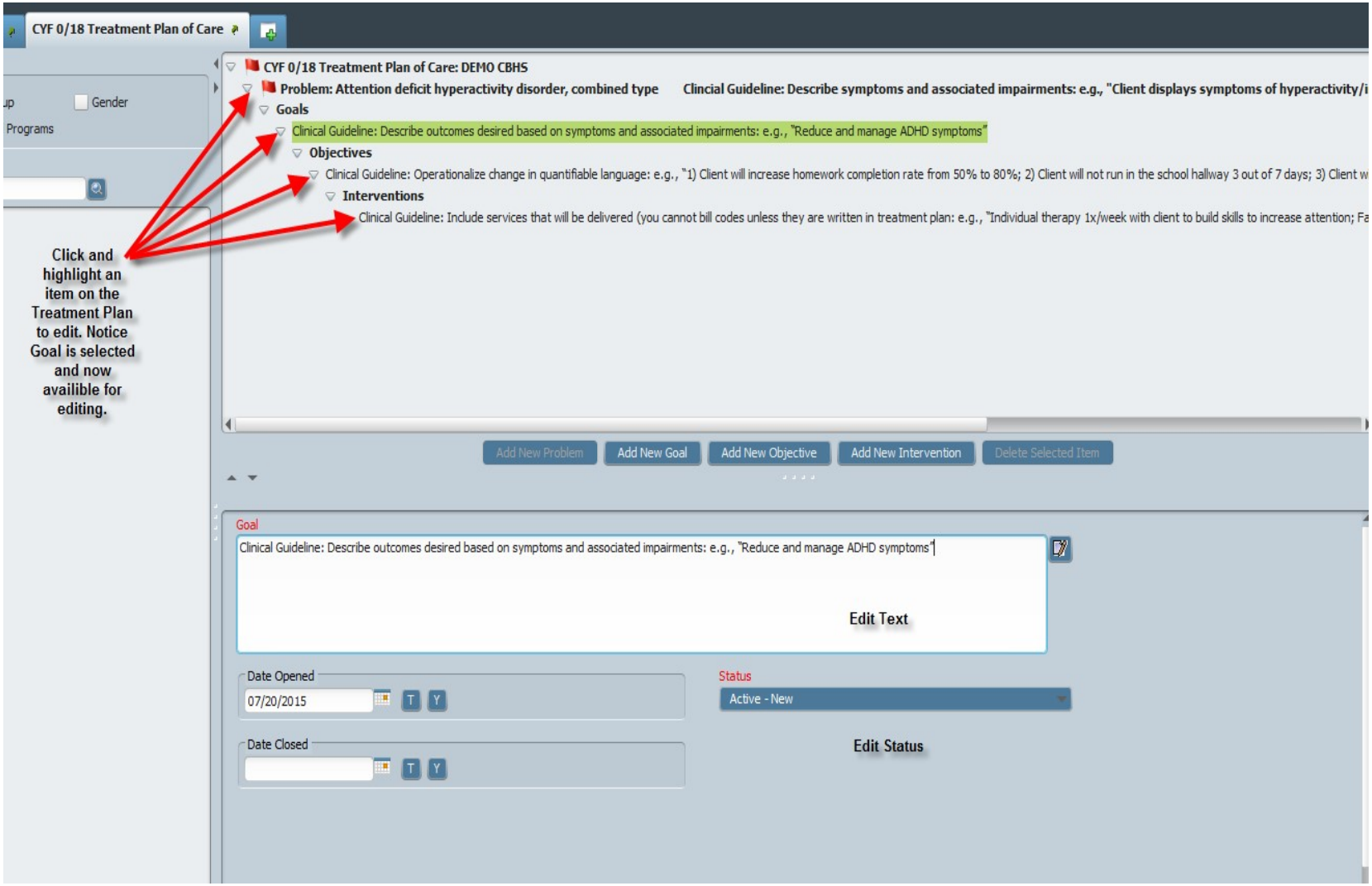
Treatment Plan – Adding an Intervention



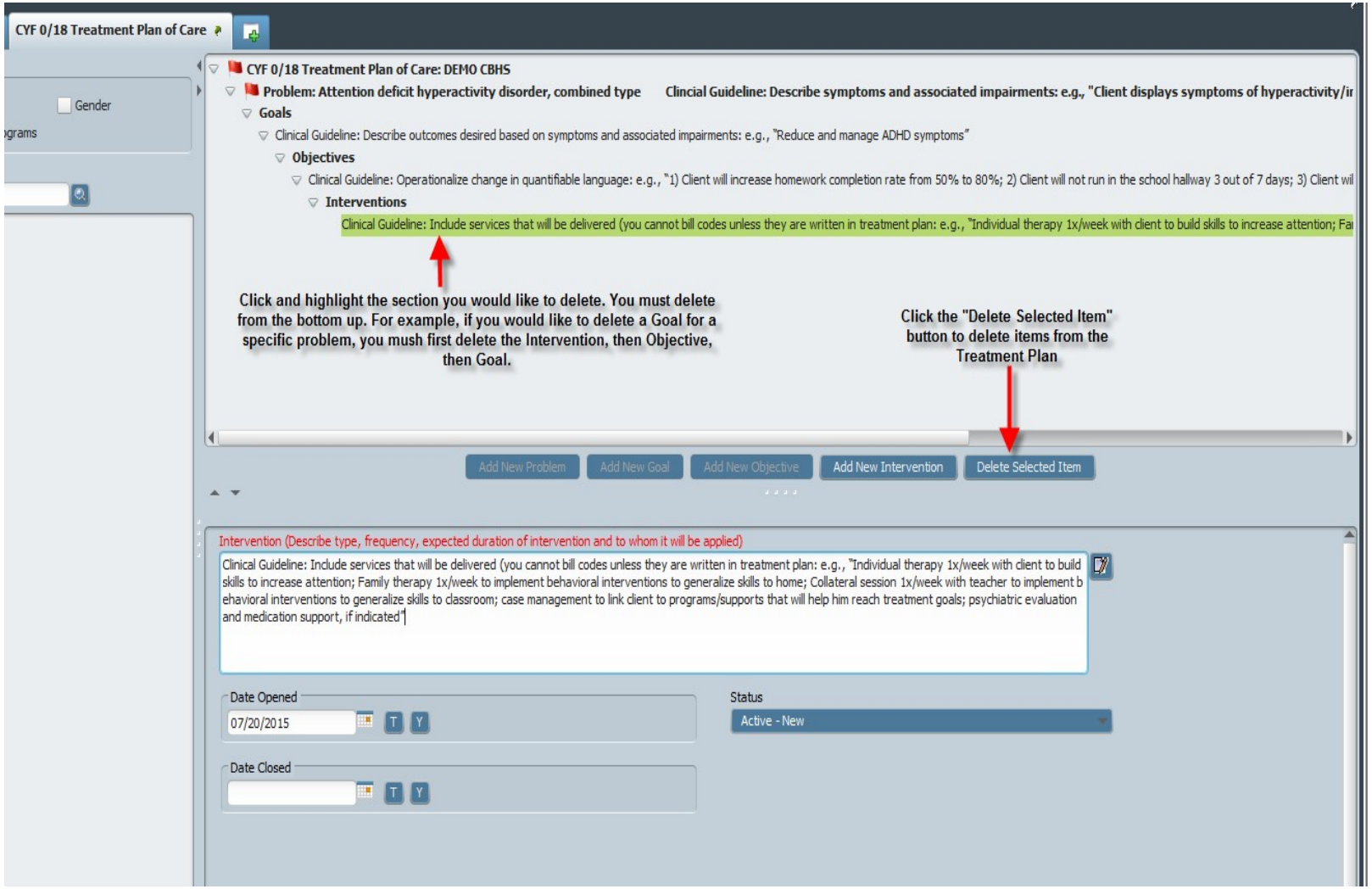
Treatment Plan – Adding Additional Problems



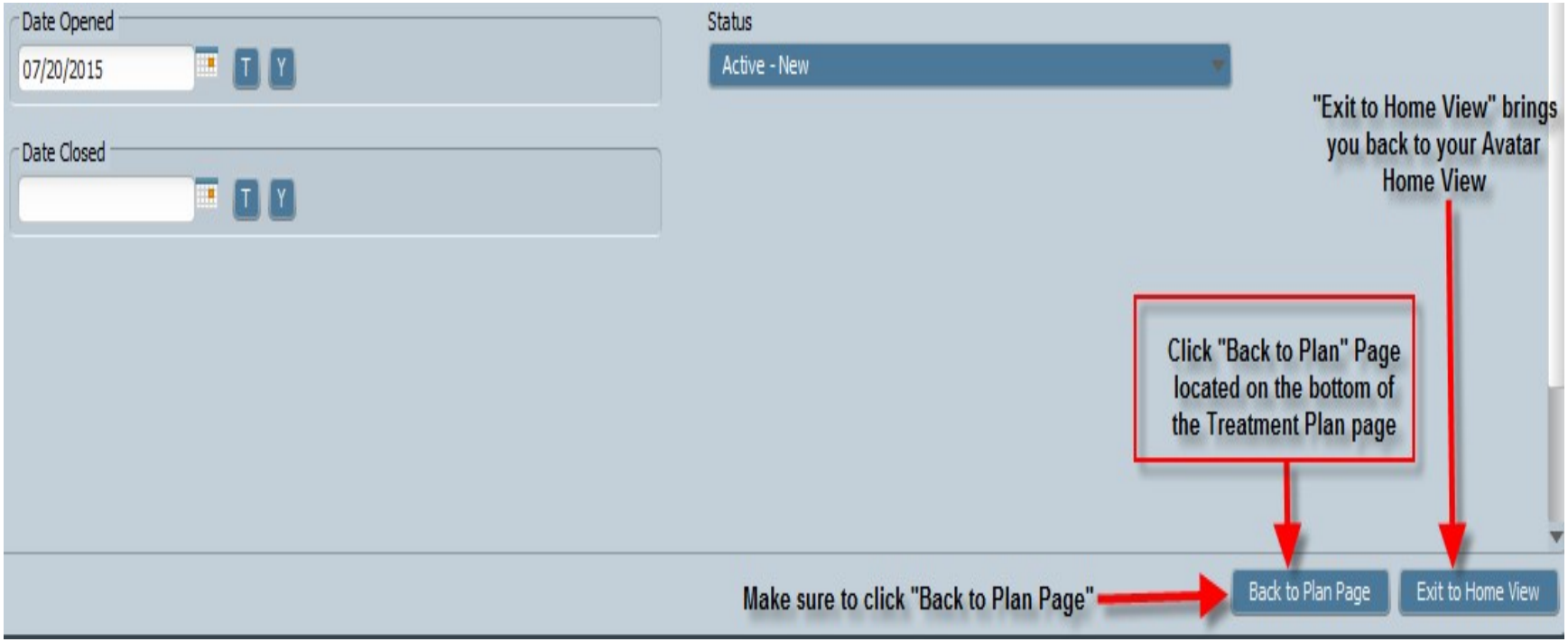
Treatment Plan – Editing Items on your Treatment Plan



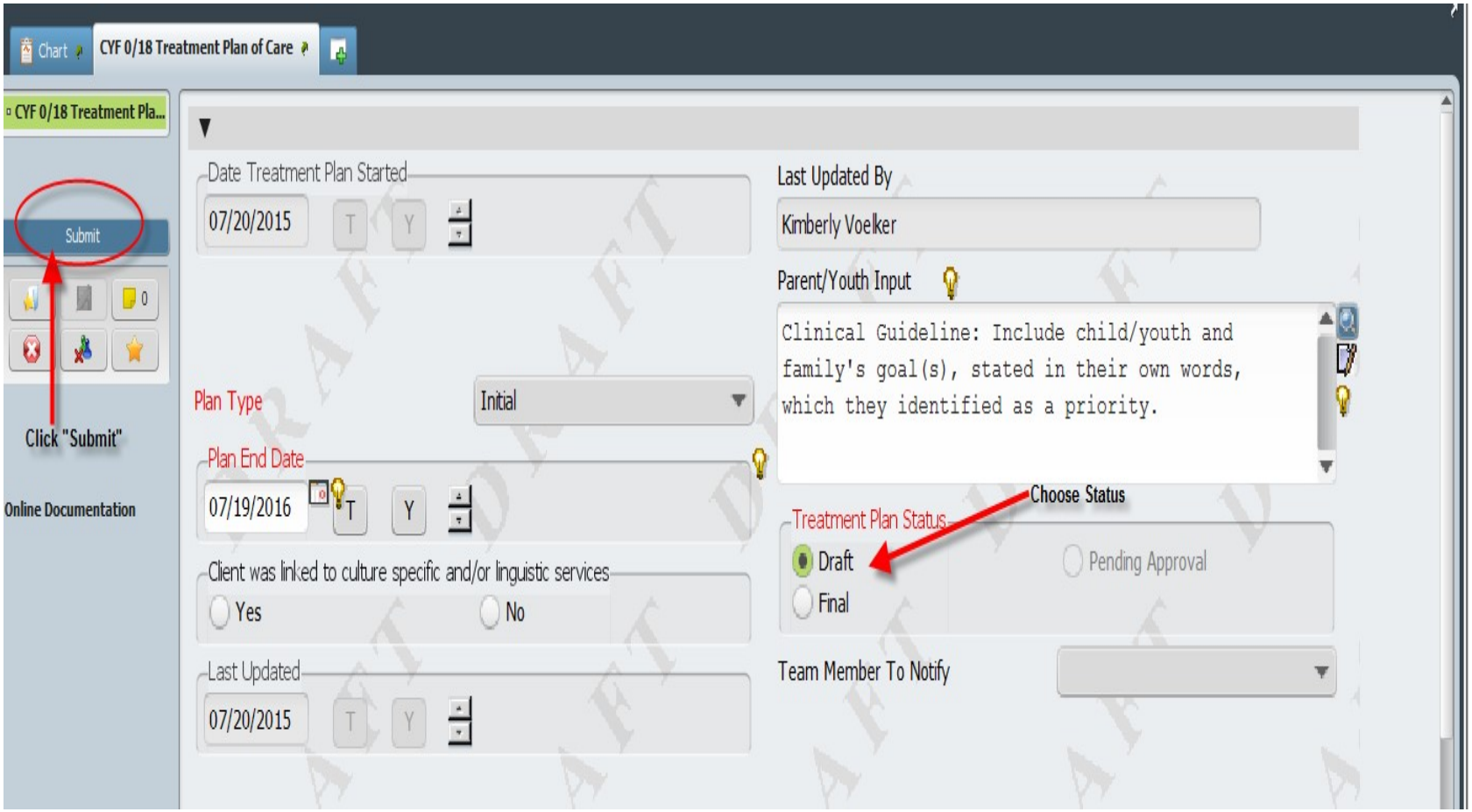
Treatment Plan – Deleting items from your plan



Treatment Plan – Saving/Submitting your Plan



Treatment Plan – Saving/Submitting your Plan (continued)

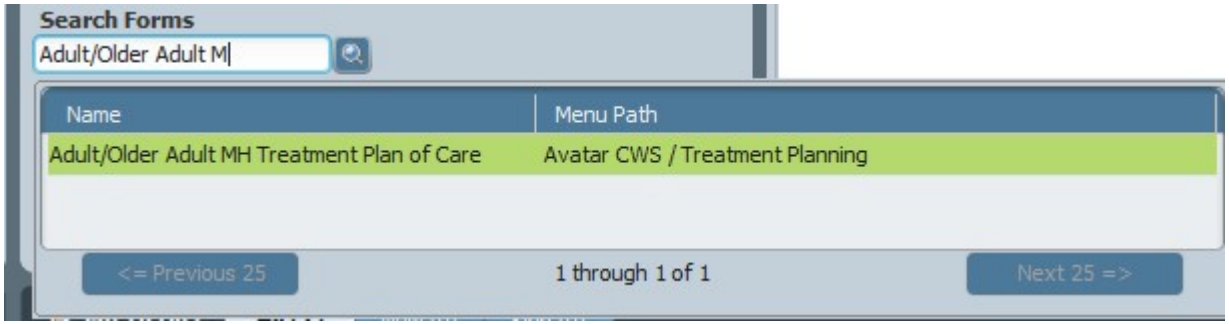


ADULT/OLDER ADULT MENTAL HEALTH TREATMENT PLAN OF CARE

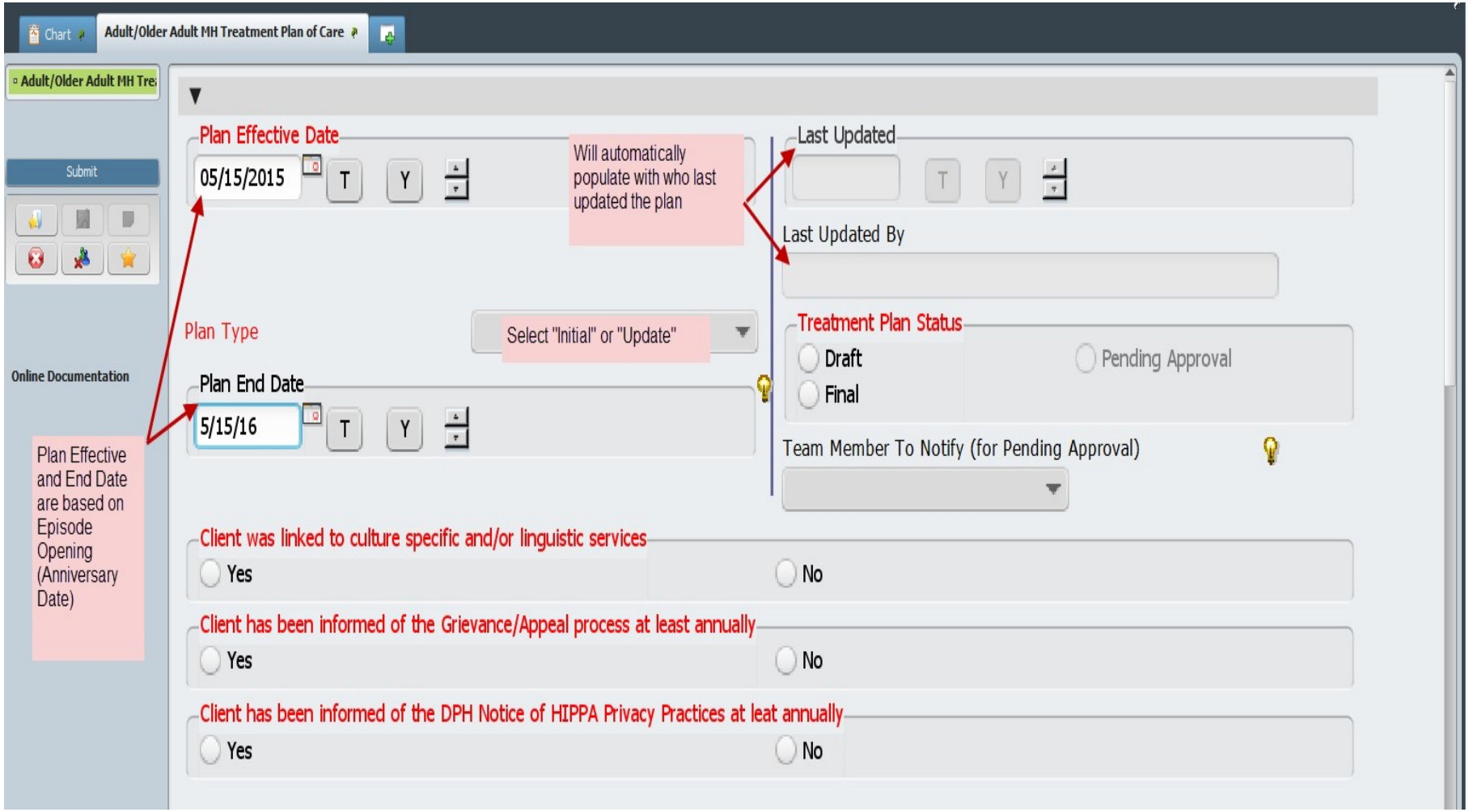
Avatar User Guide: Adult/Older Adult MH Treatment Plan of Care

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**

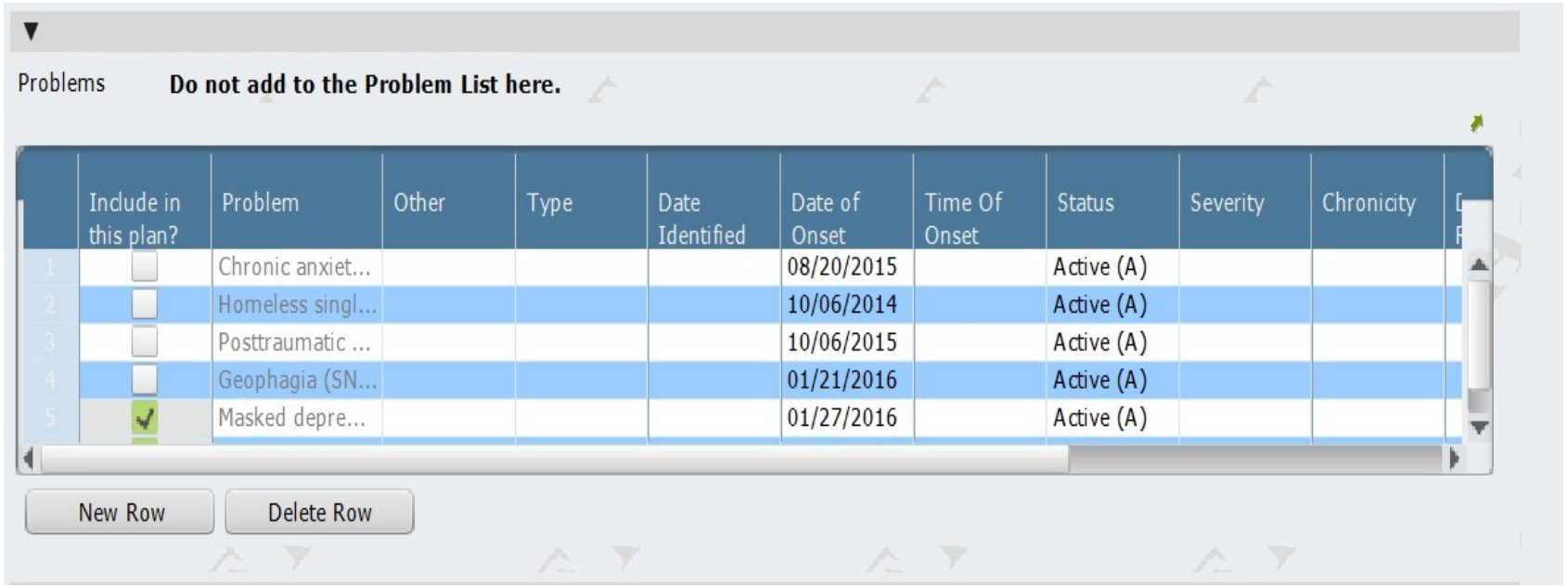


Starting the Adult/Older Adult MH Treatment Plan of Care

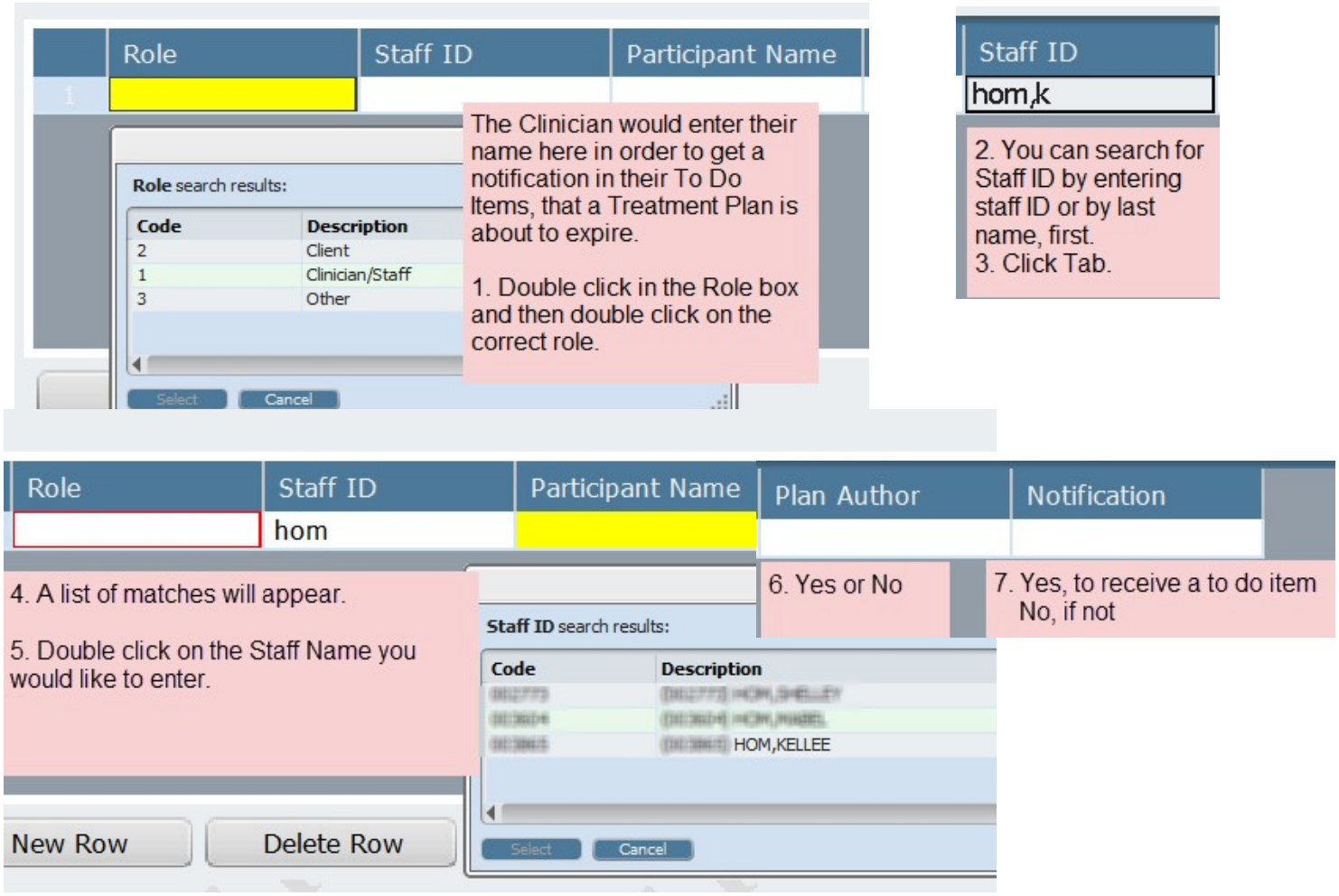


Treatment Plan Problem List

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.

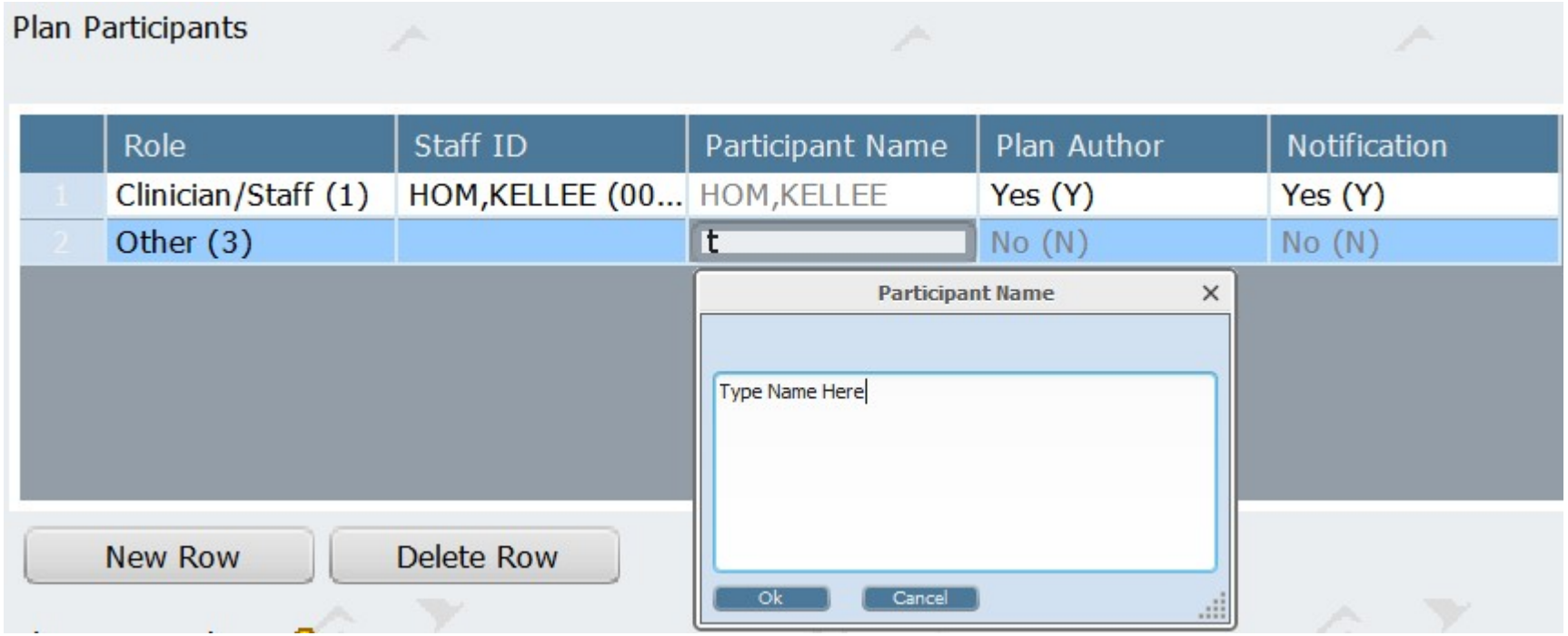


Optional: Plan Participants

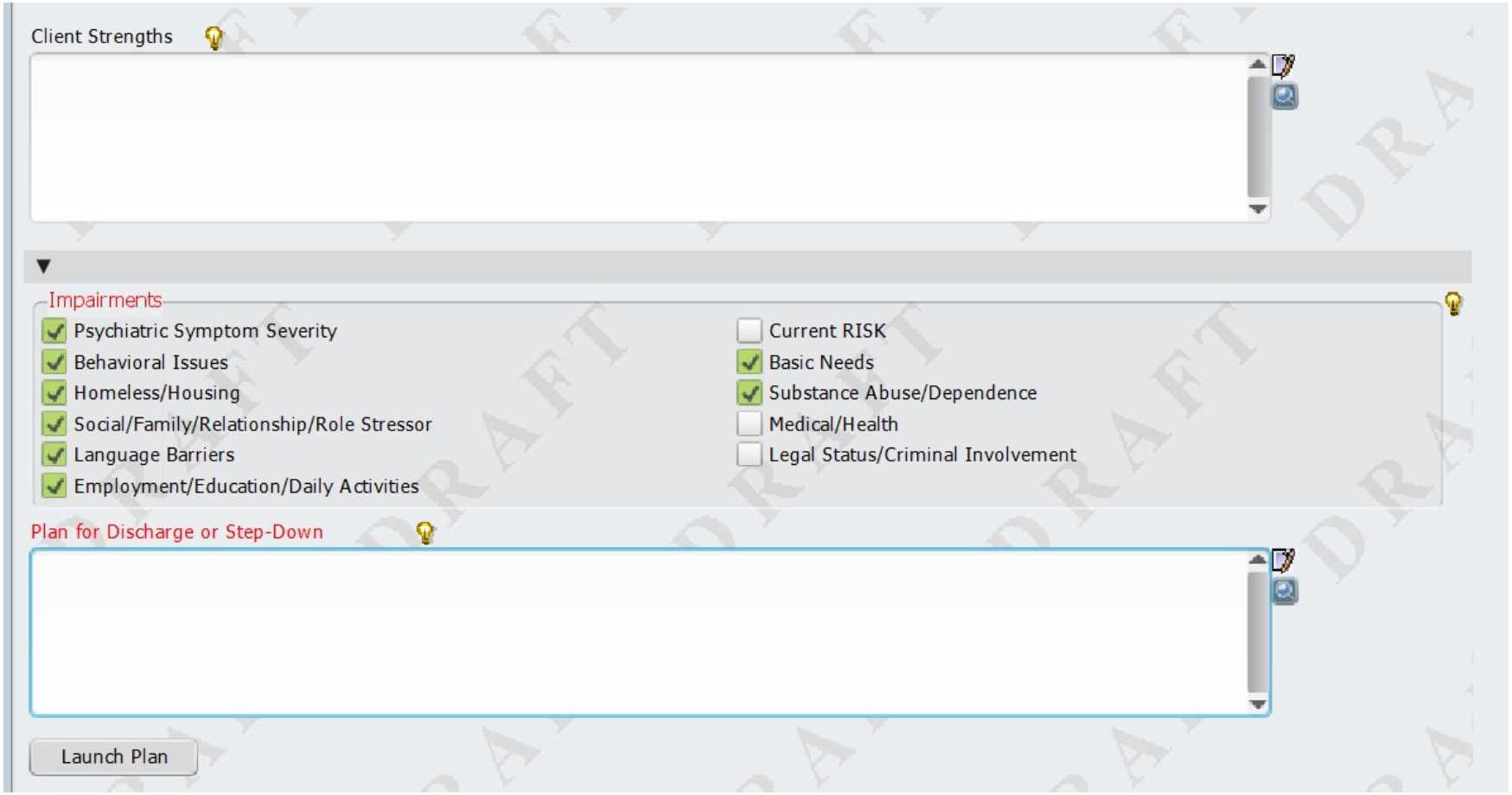


Optional: Plan Participants

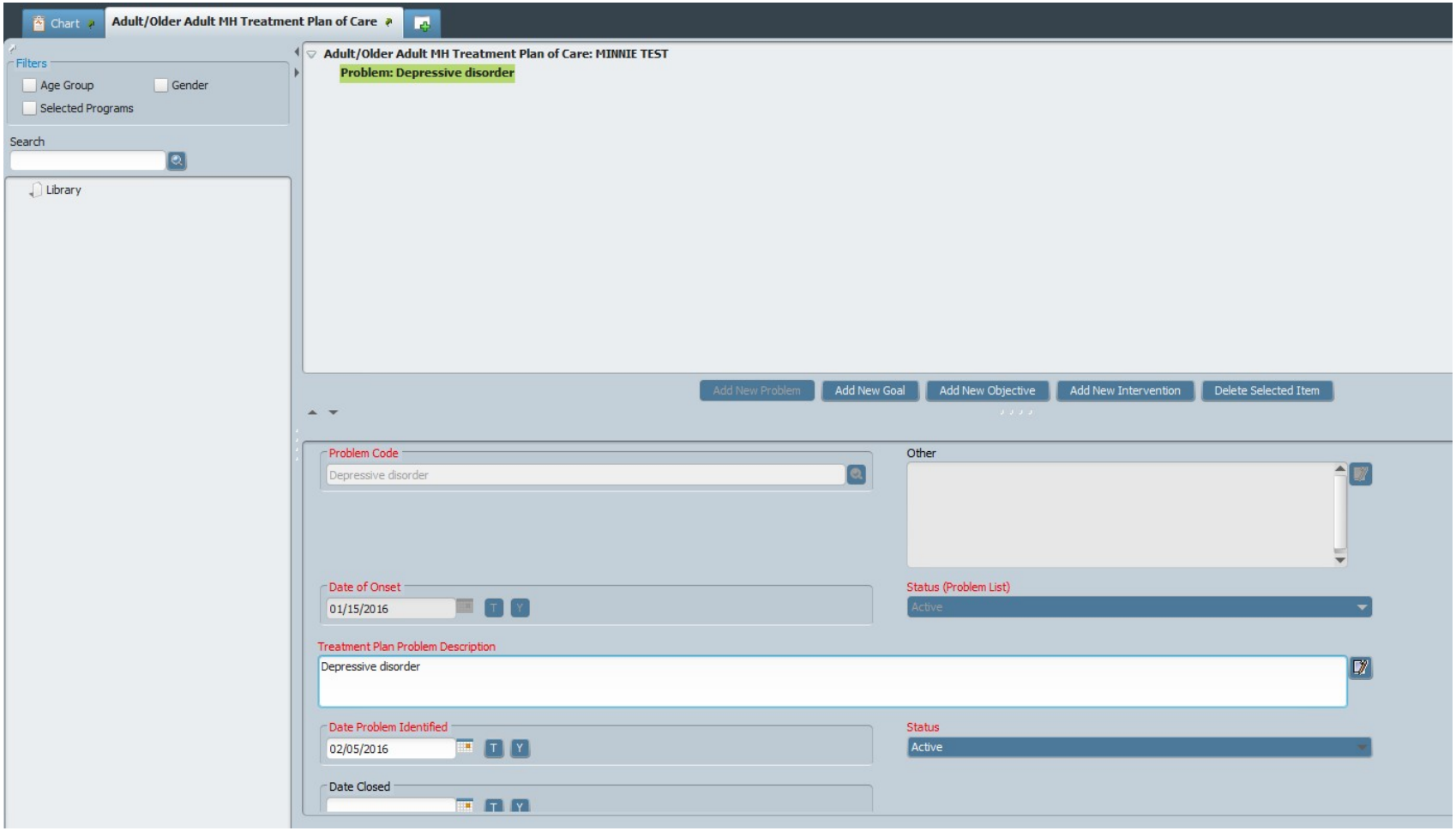
You can enter other participants, for example, other staff members, family members, etc.



Strengths, Impairments, and Plan for Discharge

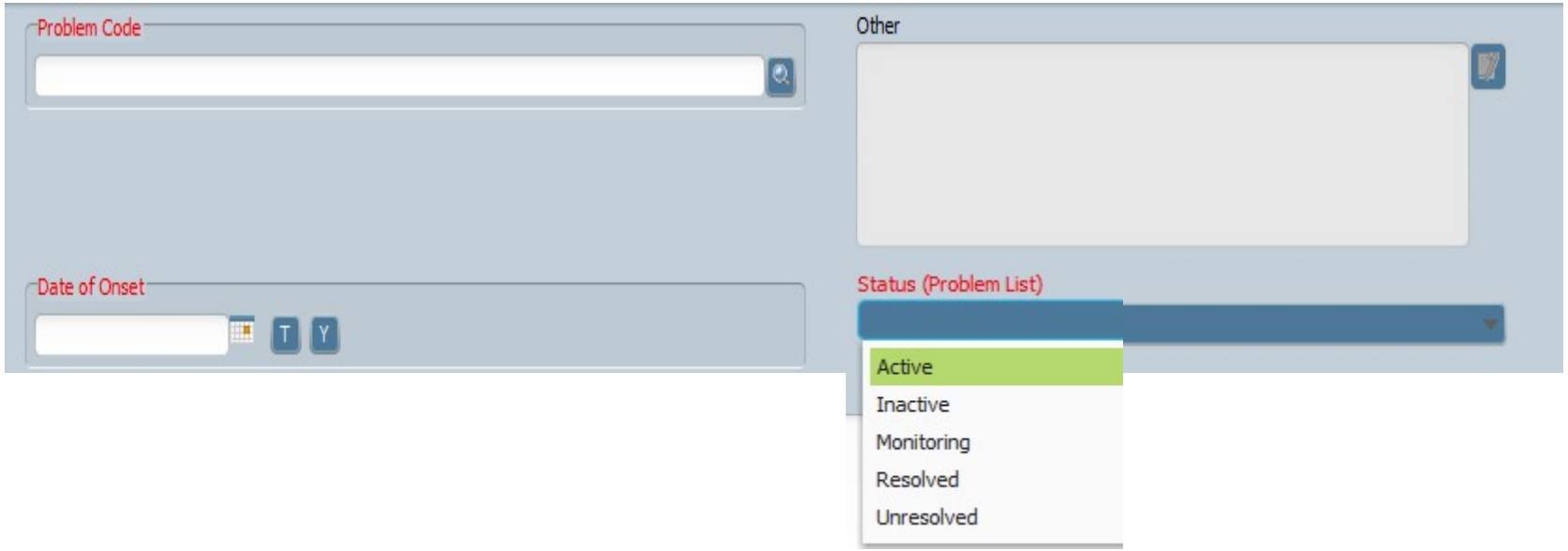


Treatment Plan – Problem



Components of the Problem Section

The following sections will populate the Problem List



Problem Code (see next page)

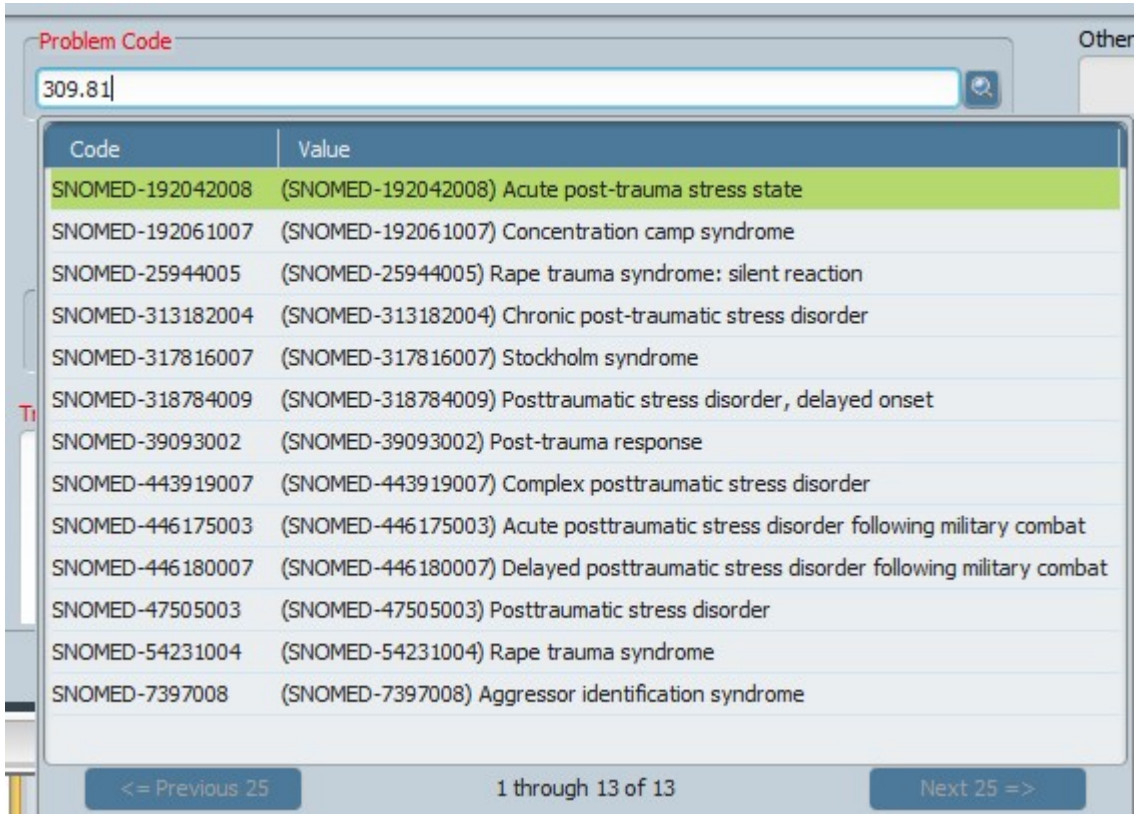
Other only becomes active if the Problem Code is “Other”

Date of Onset can be date of assessment

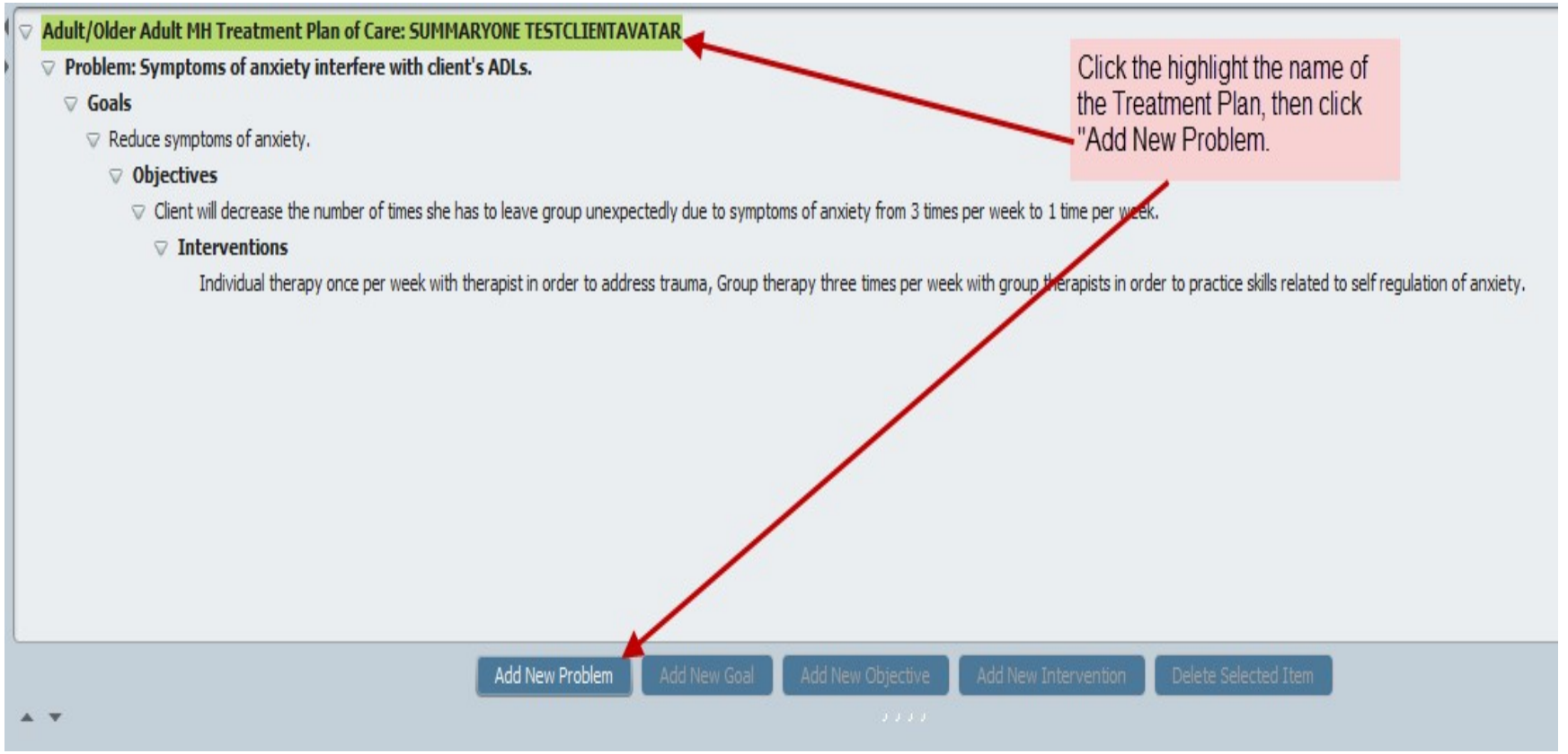
Status if Inactive or Resolved are selected they will drop off the list in future TPOCs

Components of the Problem Section

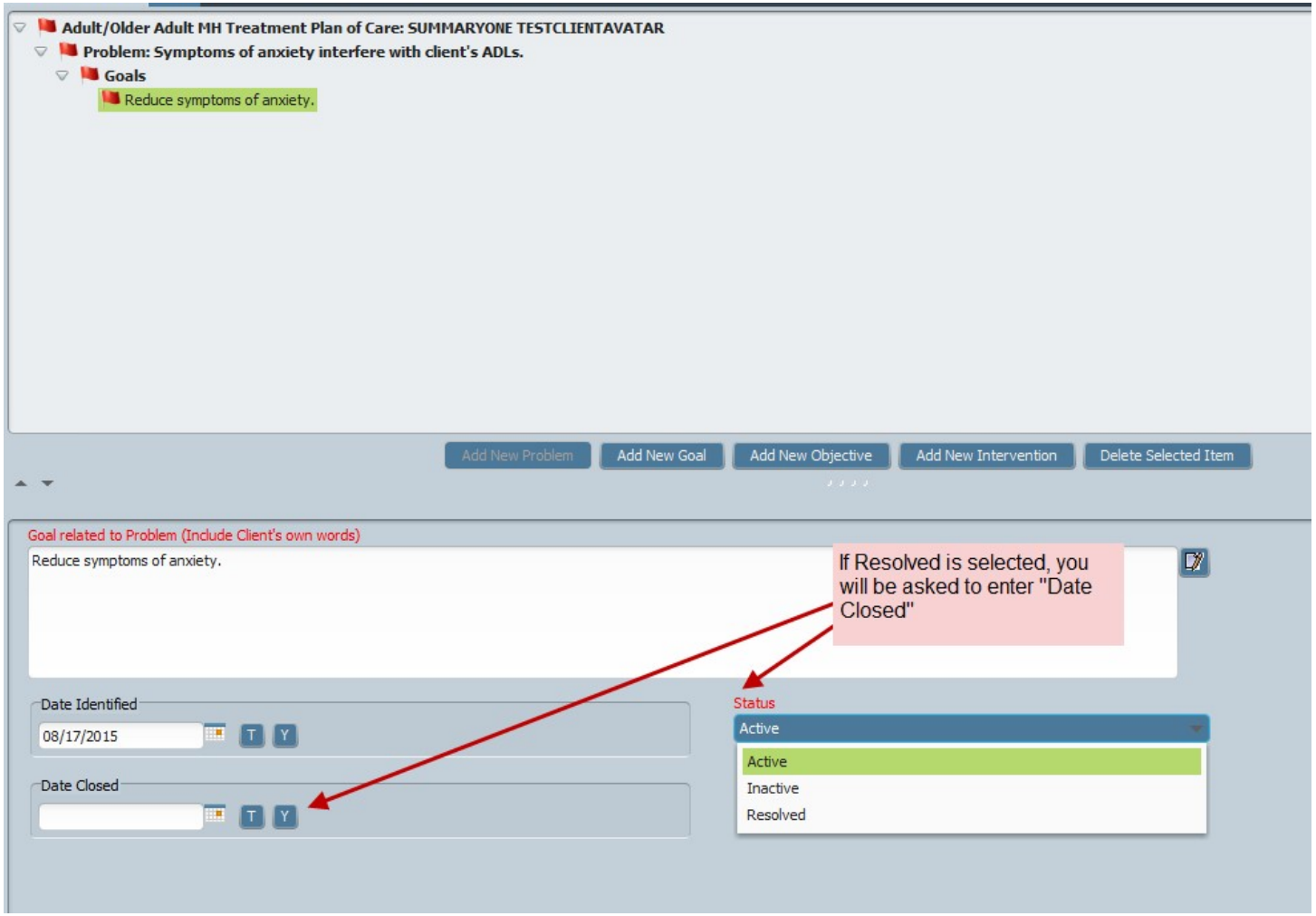
Problem Code: You can search by DSM IV, DSM 5, ICD 9, ICD 10 description or code. It will display a SNOMED code.



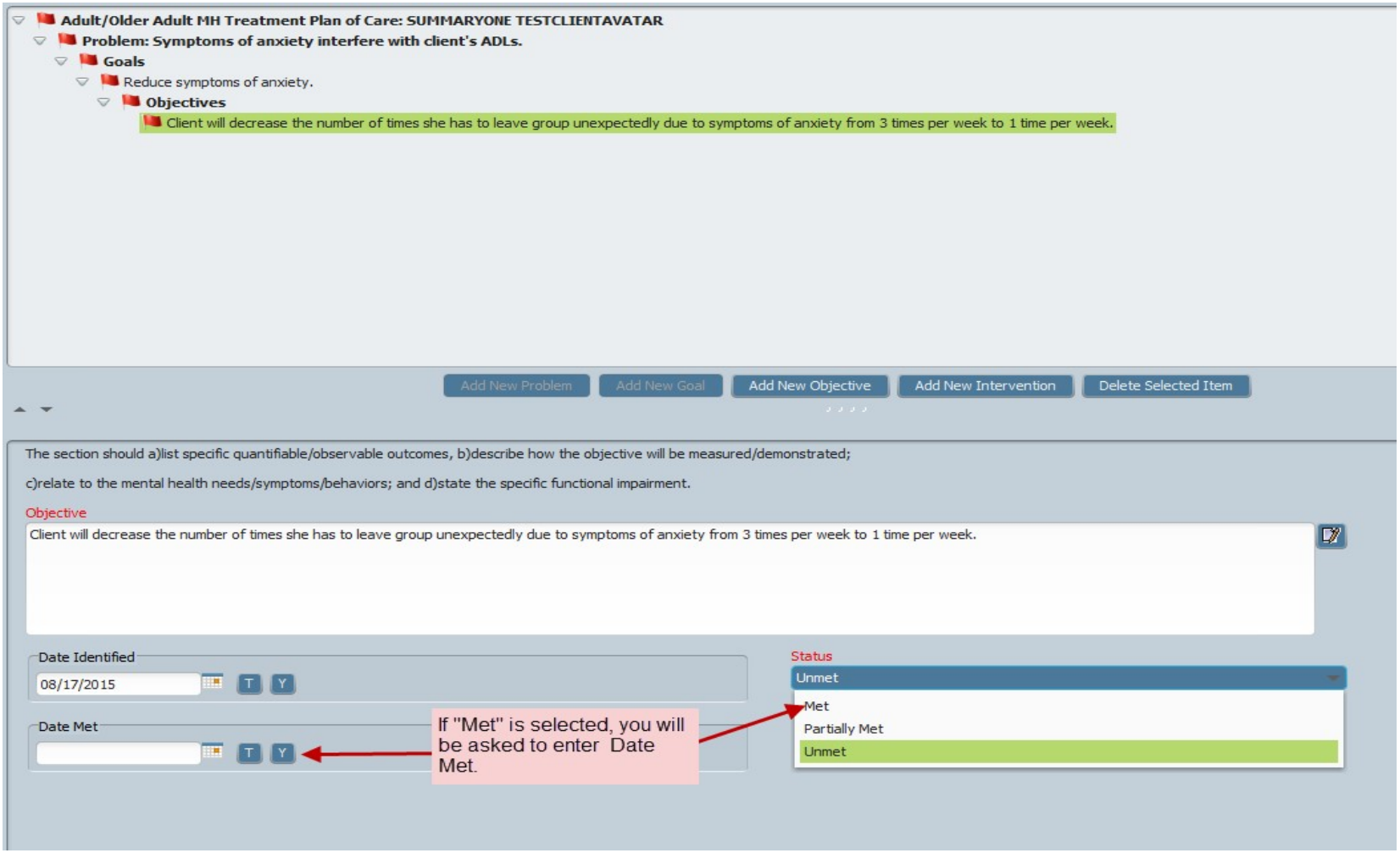
Treatment Plan – Adding Additional Problems



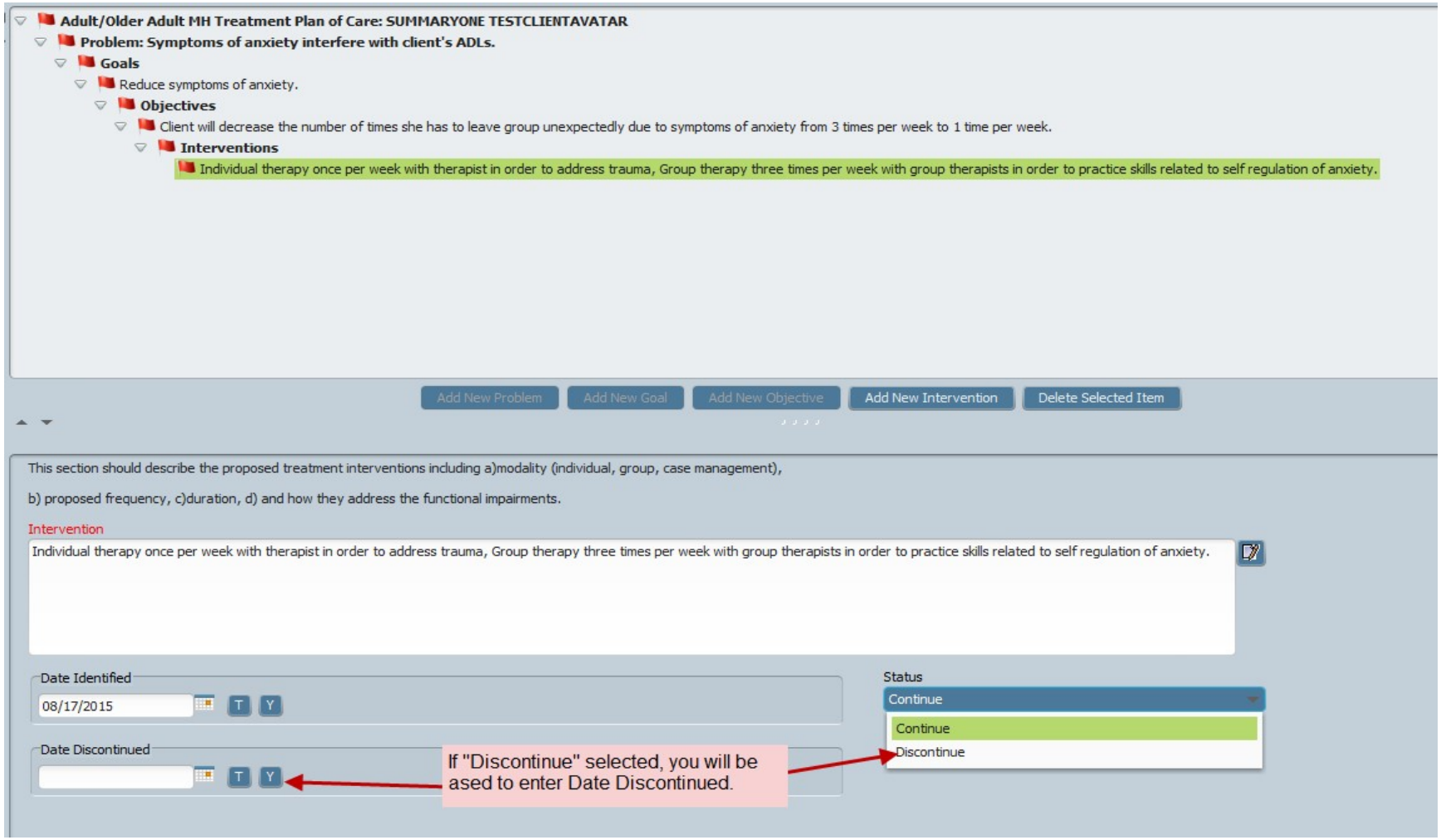
Treatment Plan - Adding a Goal



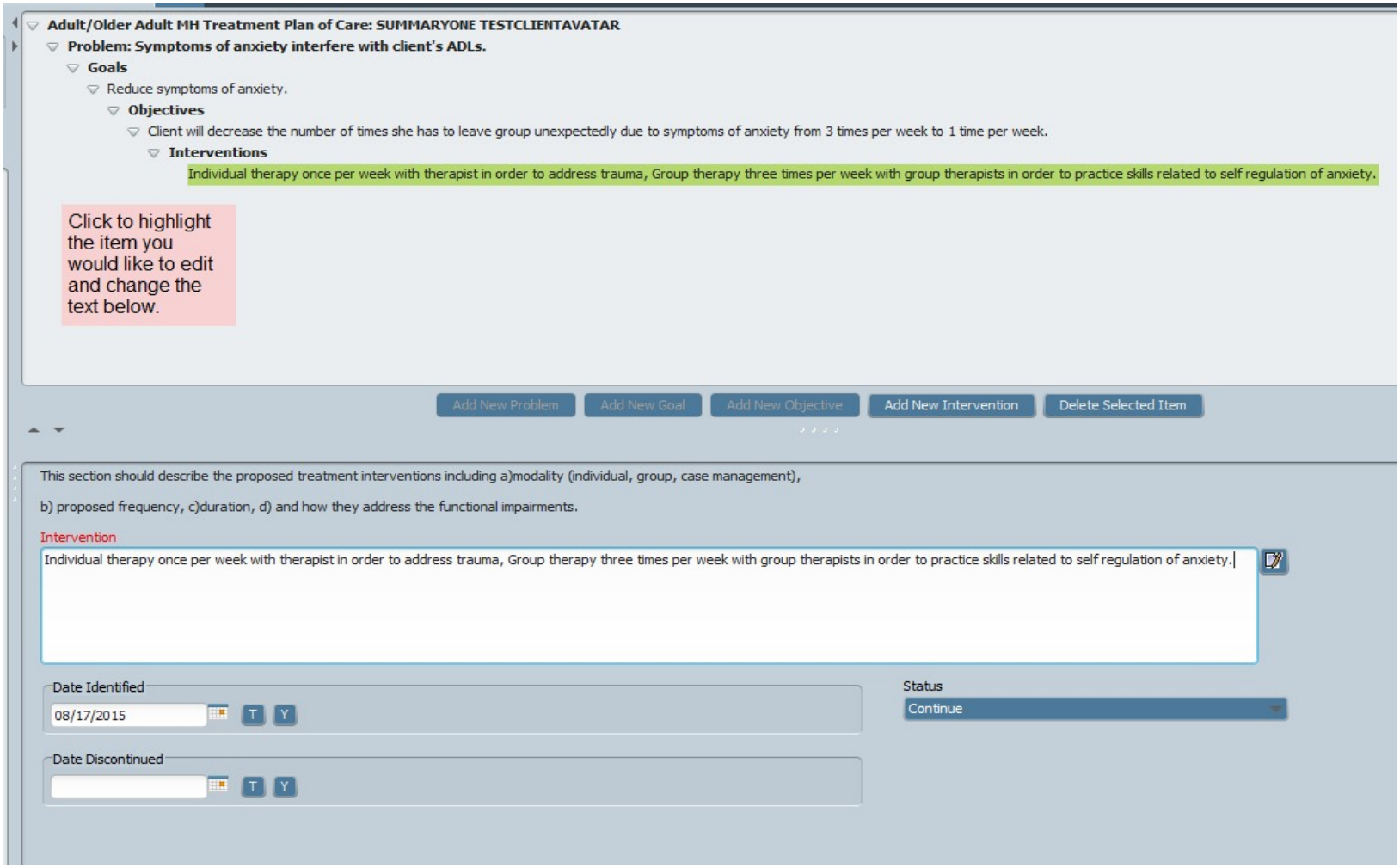
Treatment Plan – Adding an Objective



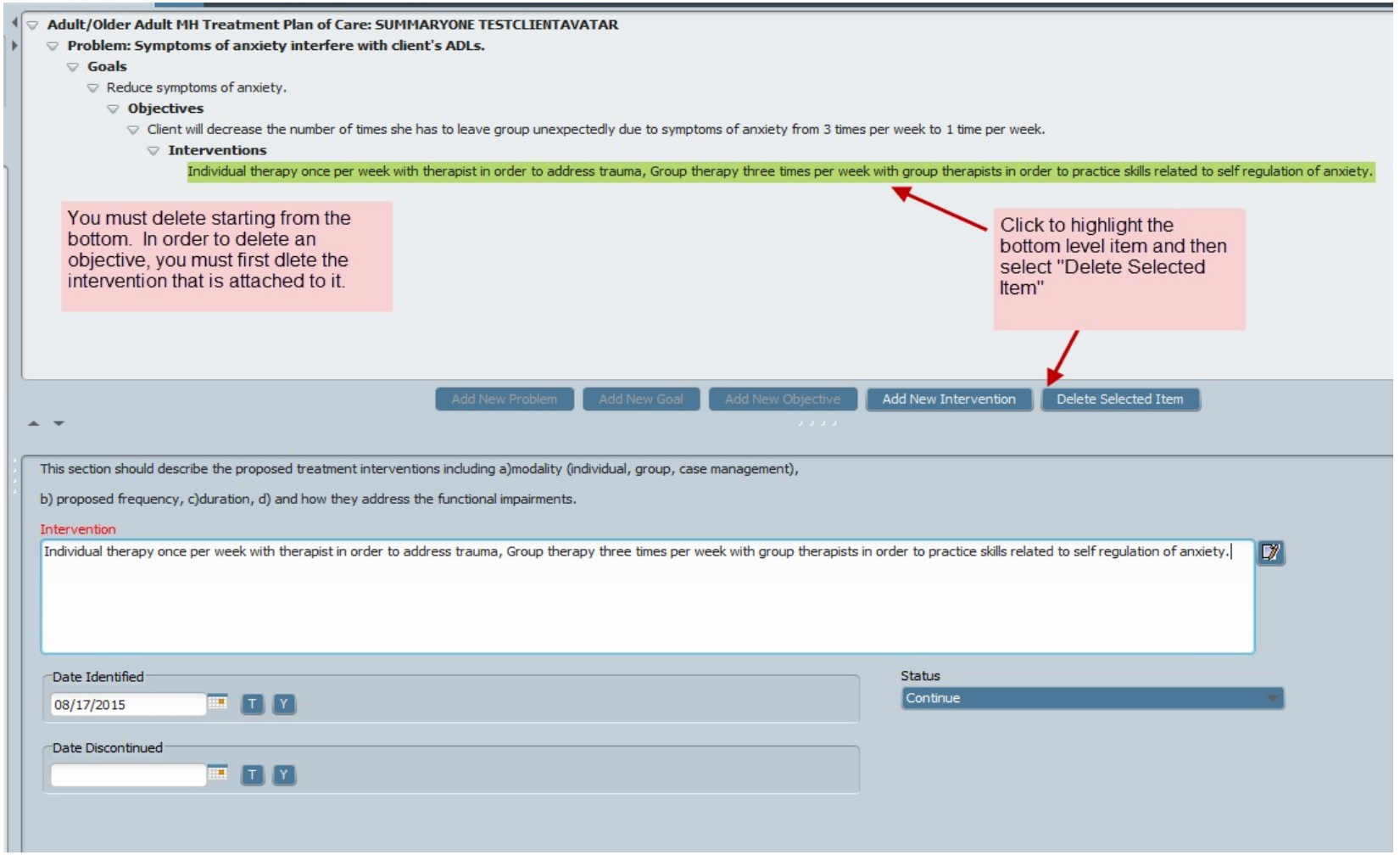
Treatment Plan – Adding an Intervention



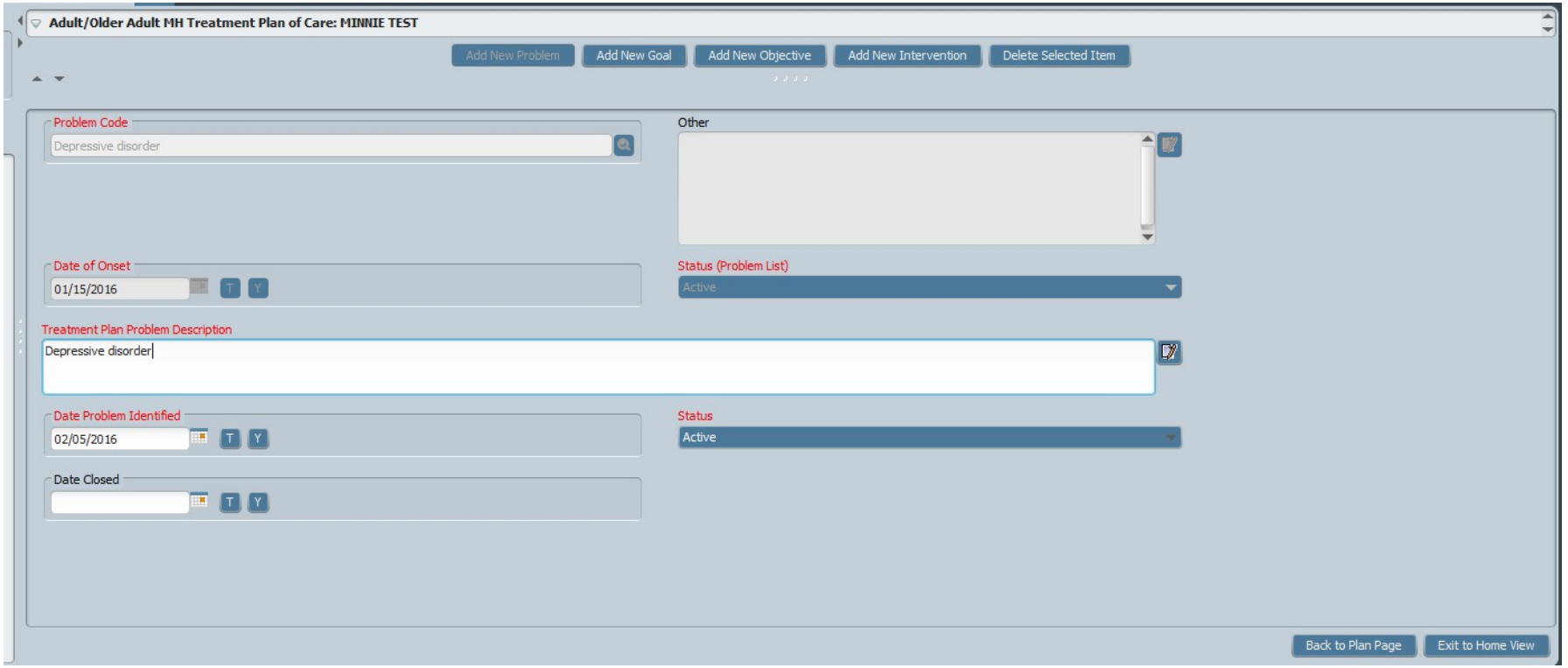
Treatment Plan – Editing Items



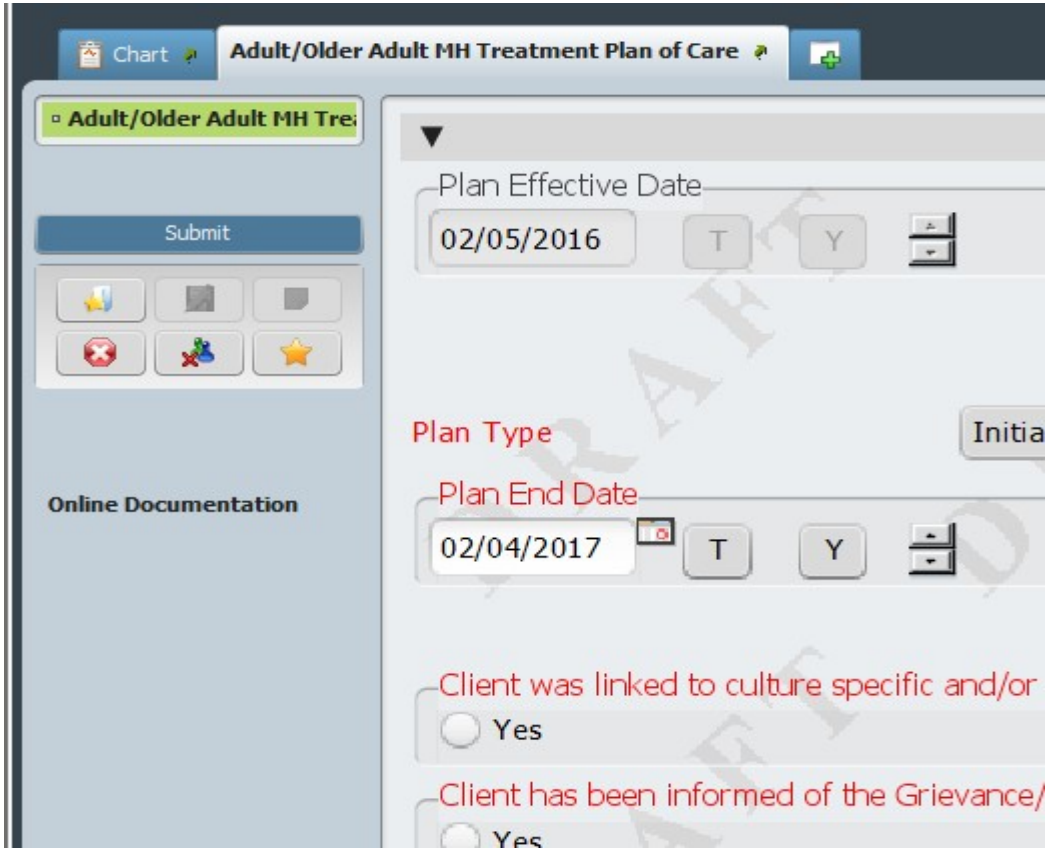
Treatment Plan – Deleting Items



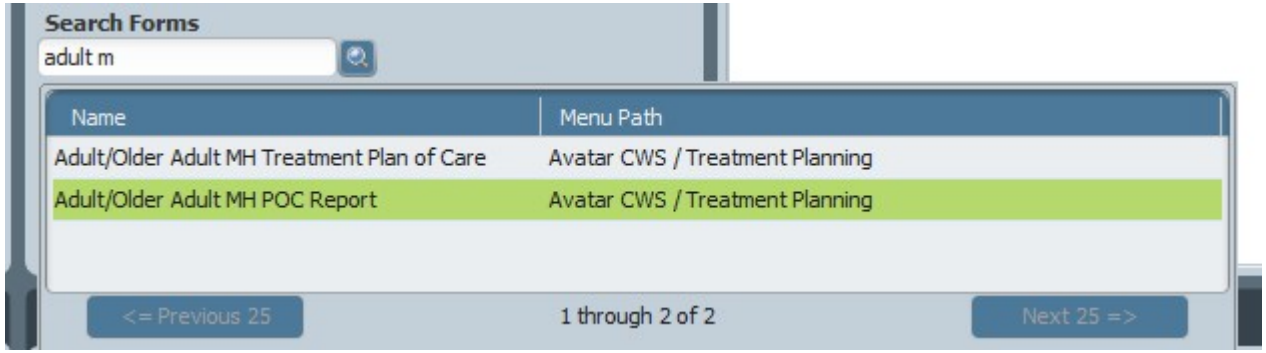
Treatment Plan – Submitting and Saving



Treatment Plan – Submitting and Saving



Printing the TPOC



San Francisco Department of Public Health
Community Behavioral Health Services

Adult/Older Adult MH Treatment Plan of Care

Name: TESTCLIENTAVATAR,SUMMARYONE
Client ID#: 999047242
Episode #: 1 **Episode Opening Date:** 1/10/2015
Episode Program: CBHS Pharmacy (38CXRX)
Print Date: 8/17/2015

Confidential Patient Information

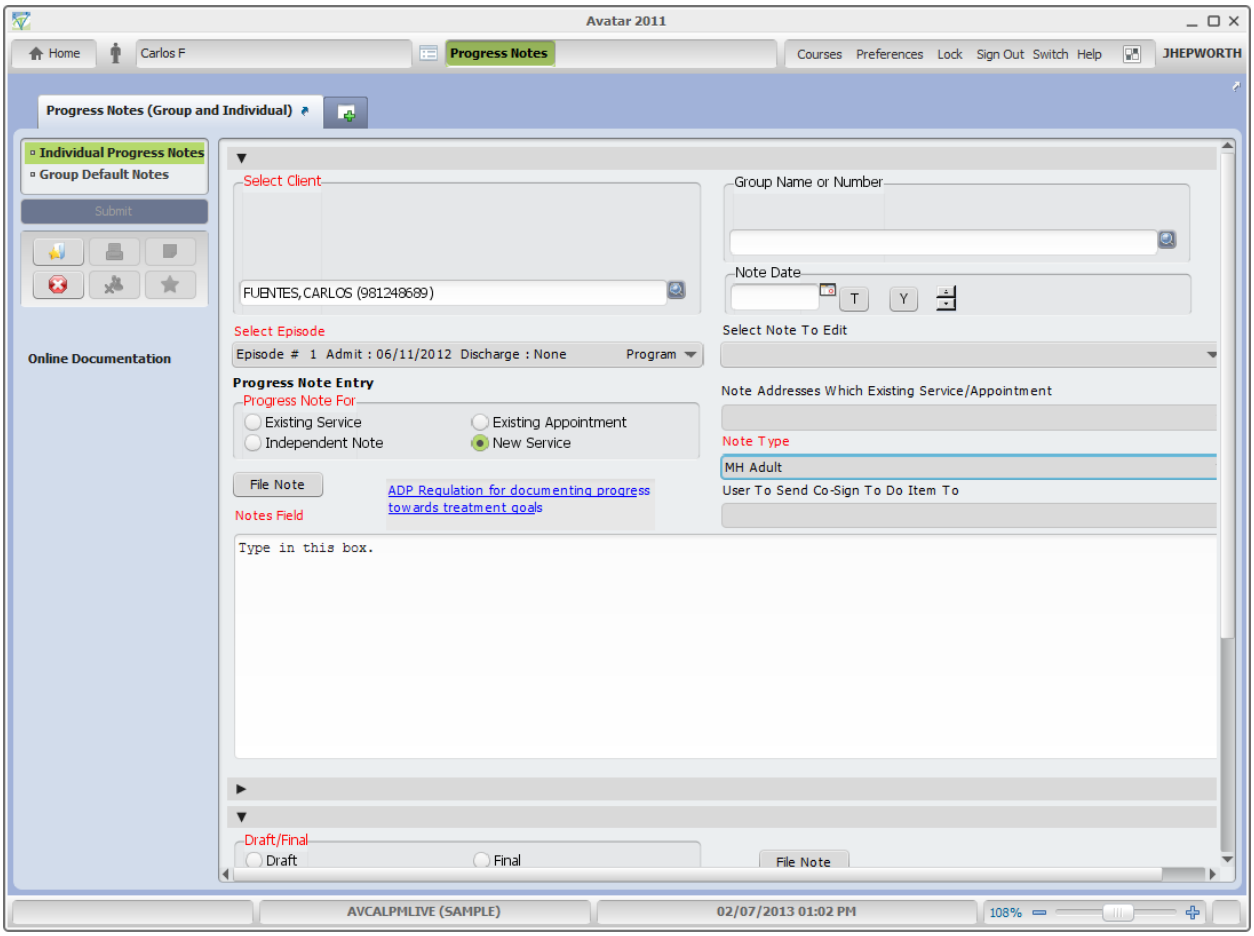
Date Treatment Plan Started: 8/12/2015
Date Treatment Plan Finalized:
Plan End Date: 8/12/2016
Last Updated: 8/17/2015

Plan Type: Initial
Plan Status: Draft
Discharge Date:

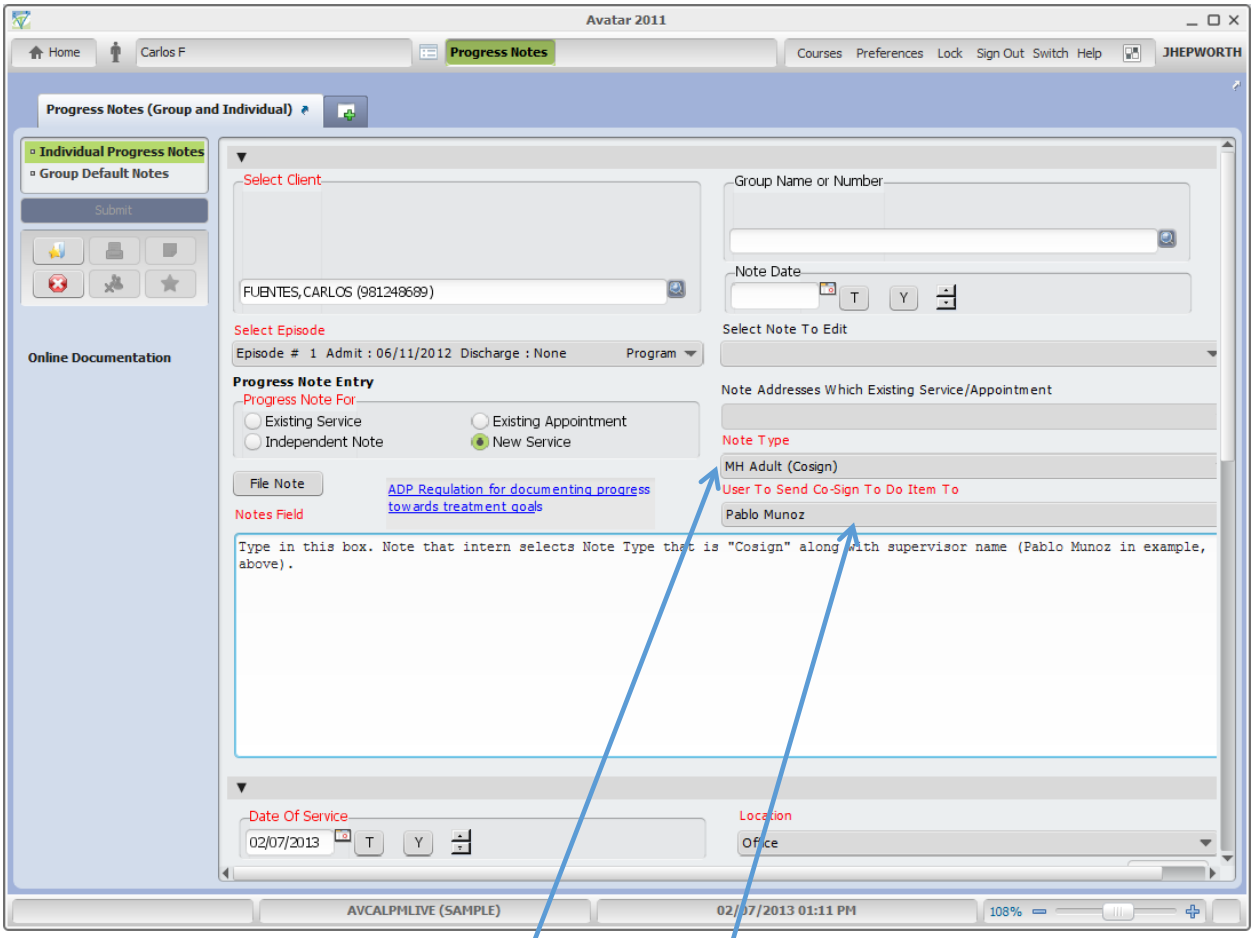
Progress Notes Group and Individual Form

Progress Notes

(Path: Avatar CWS/Progress Notes)



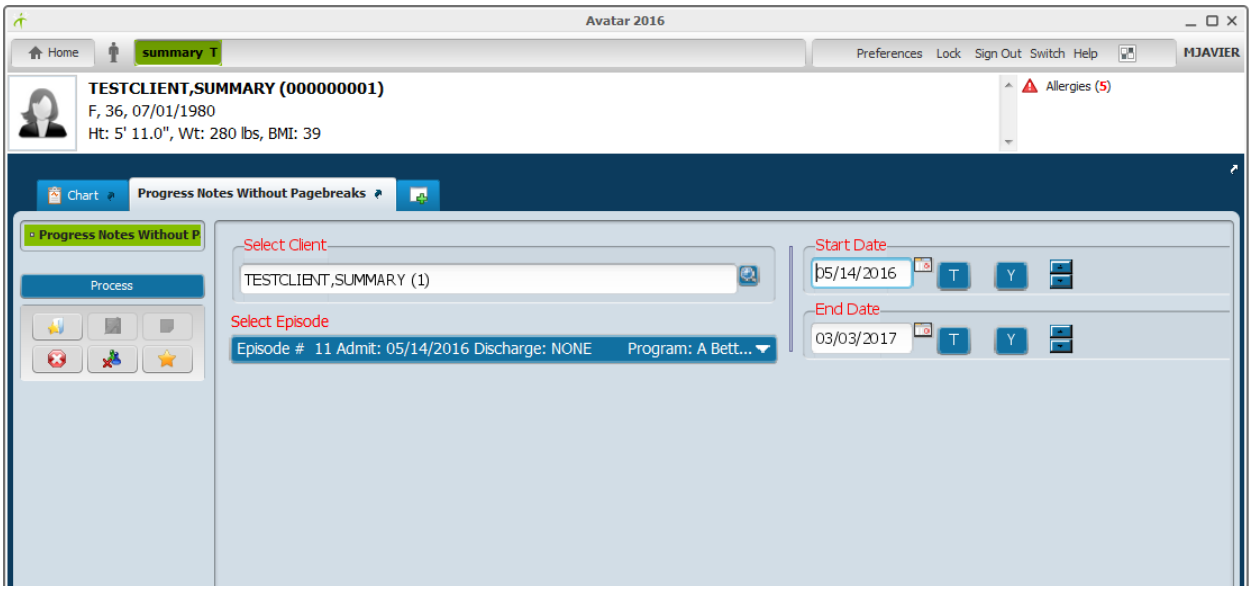
Progress Notes requiring Cosignature



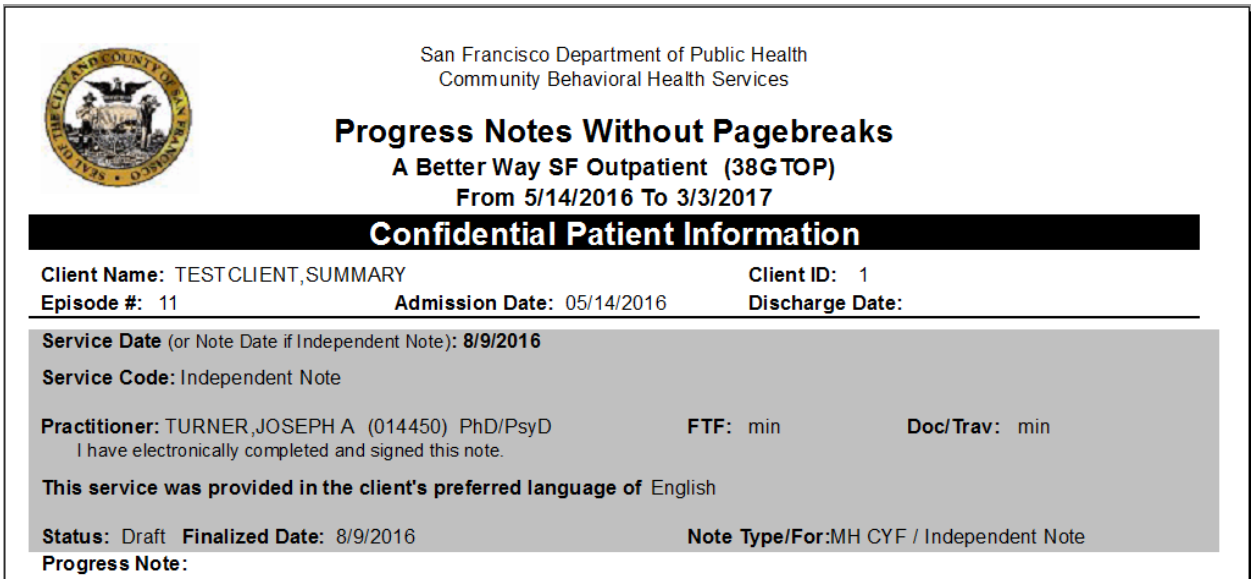
Note: This is an intern note with "cosign" note type selected. Supervisor name is selected from

Progress Notes Without Pagebreaks

(Path: Avatar CWS / Progress Notes)



Note: This is a report of progress notes



San Francisco Department of Public Health
Community Behavioral Health Services

Progress Notes Without Pagebreaks
A Better Way SF Outpatient (38GTOP)
From 5/14/2016 To 3/3/2017

Confidential Patient Information

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

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

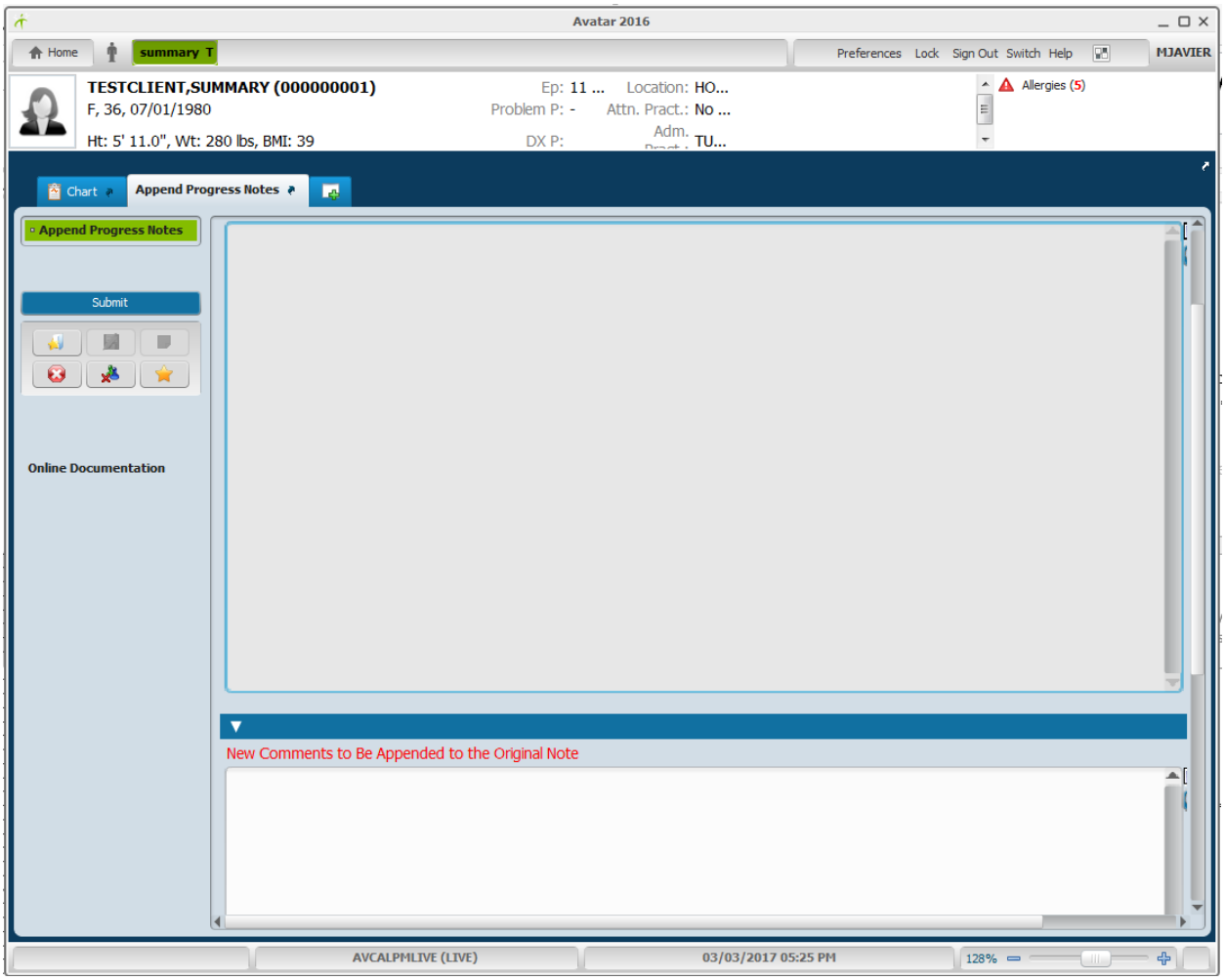
Practitioner: TURNER,JOSEPH A (014450) PhD/PsyD **FTF:** min **Doc/Trav:** min
I have electronically completed and signed this note.

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)



PROGRESS NOTES (GROUP AND INDIVIDUAL)

Individual Progress Notes User Guide

Introduction:

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

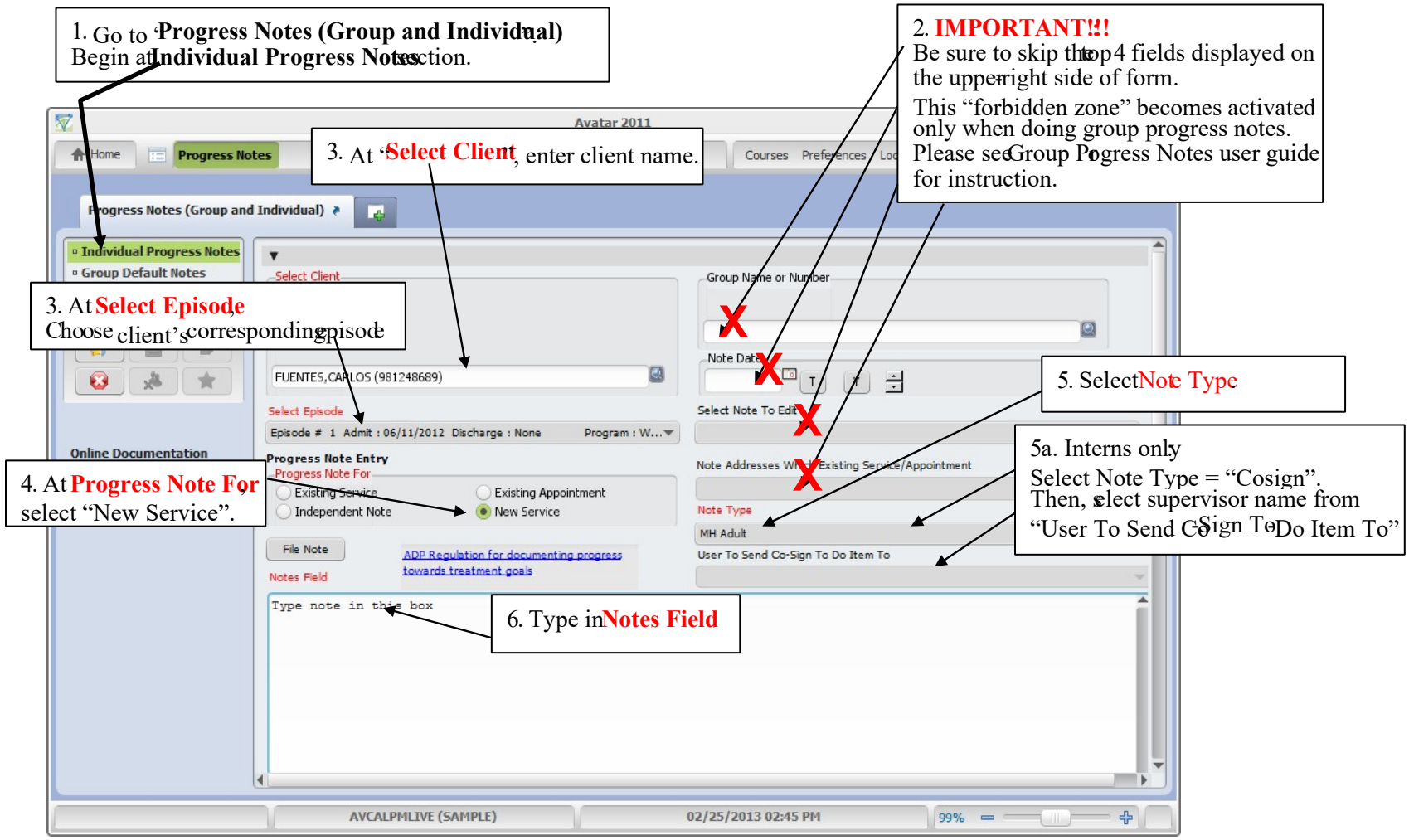
For direction on writing group progress notes, go to "Group Progress Notes User Guide"

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)".

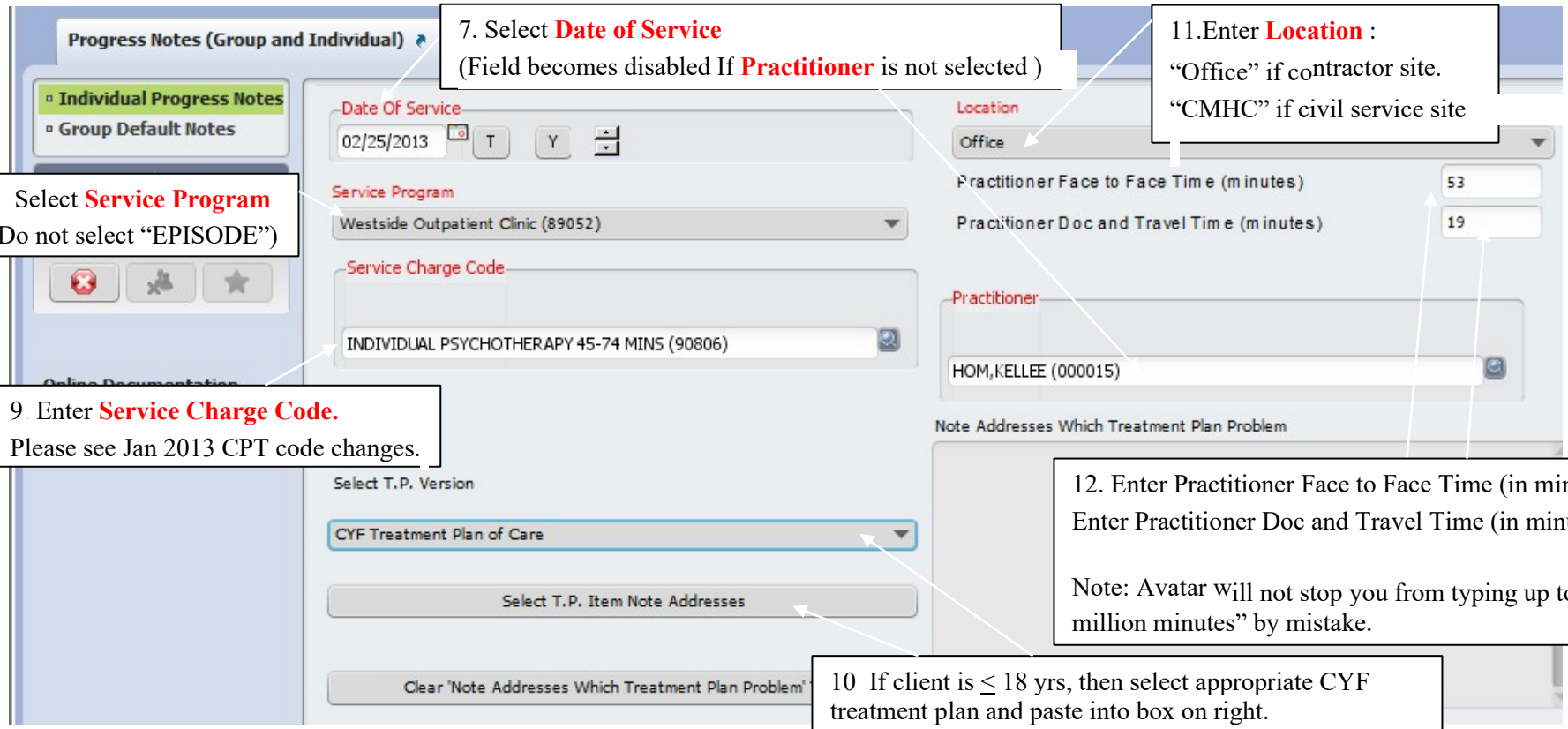
The progress notes form has 2 sections, "Group" and "Individual".

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

Entering Individual Notes:



Scroll down on page to see the following:



7. Select **Date of Service**
(Field becomes disabled If **Practitioner** is not selected)

11.Enter **Location** :
"Office" if contractor site.
"CMHC" if civil service site

8 Select **Service Program**
(Do not select "EPISODE")

9 Enter **Service Charge Code.**
Please see Jan 2013 CPT code changes.

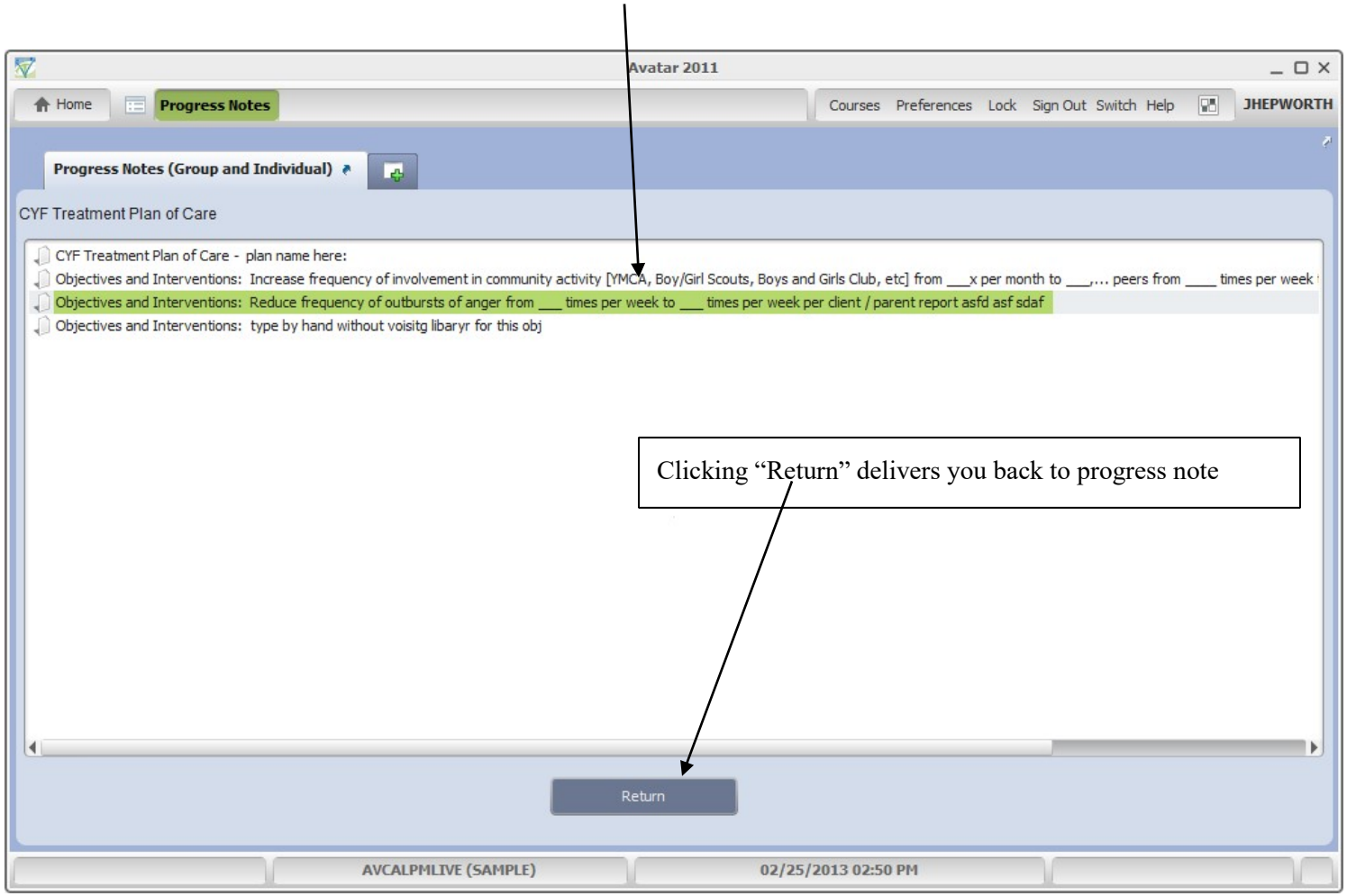
12. Enter Practitioner Face to Face Time (in minutes).
Enter Practitioner Doc and Travel Time (in minutes).

Note: Avatar will not stop you from typing up to "a million minutes" by mistake.

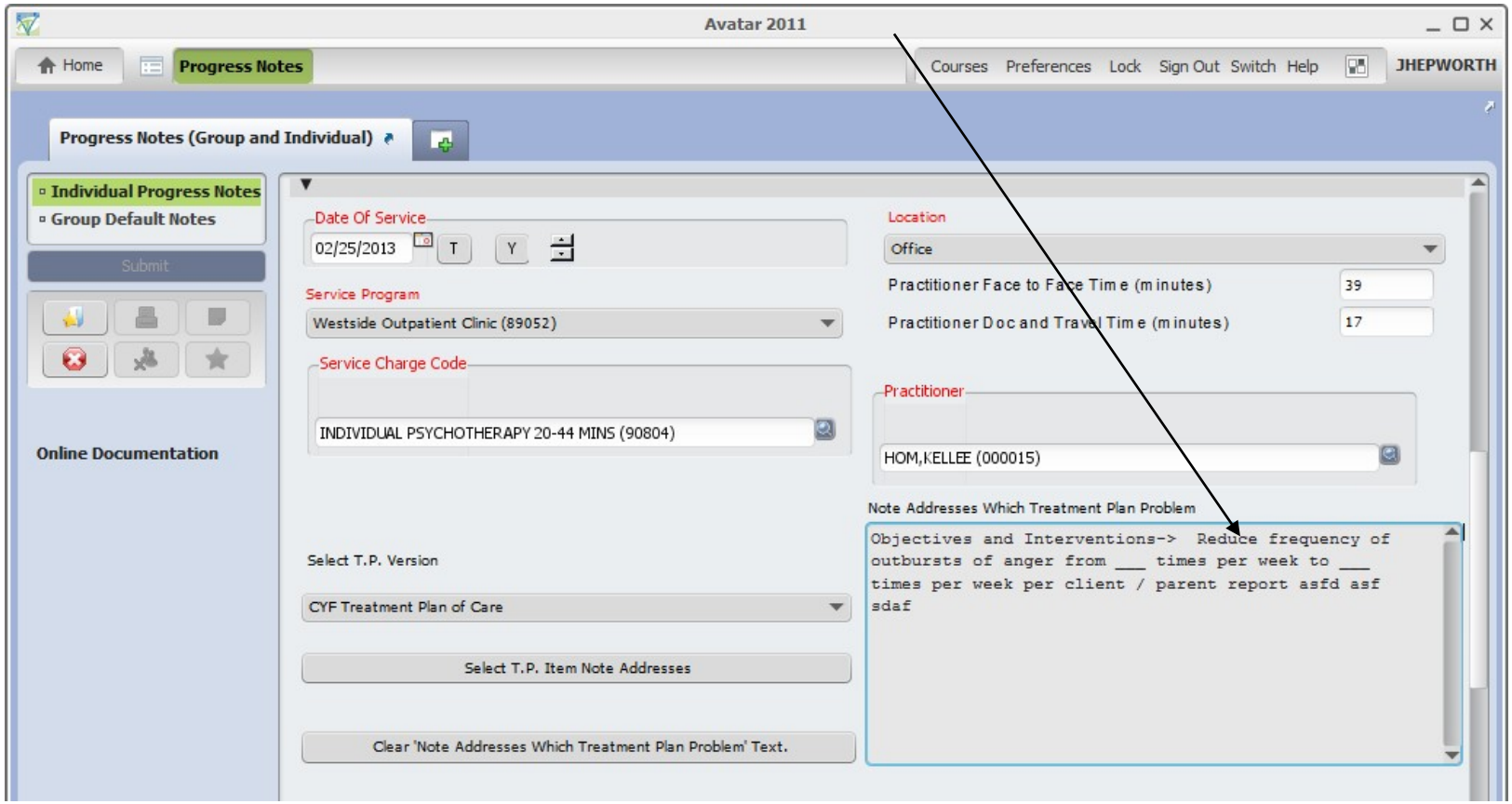
10 If client is ≤ 18 yrs, then select appropriate CYF treatment plan and paste into box on right.

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.

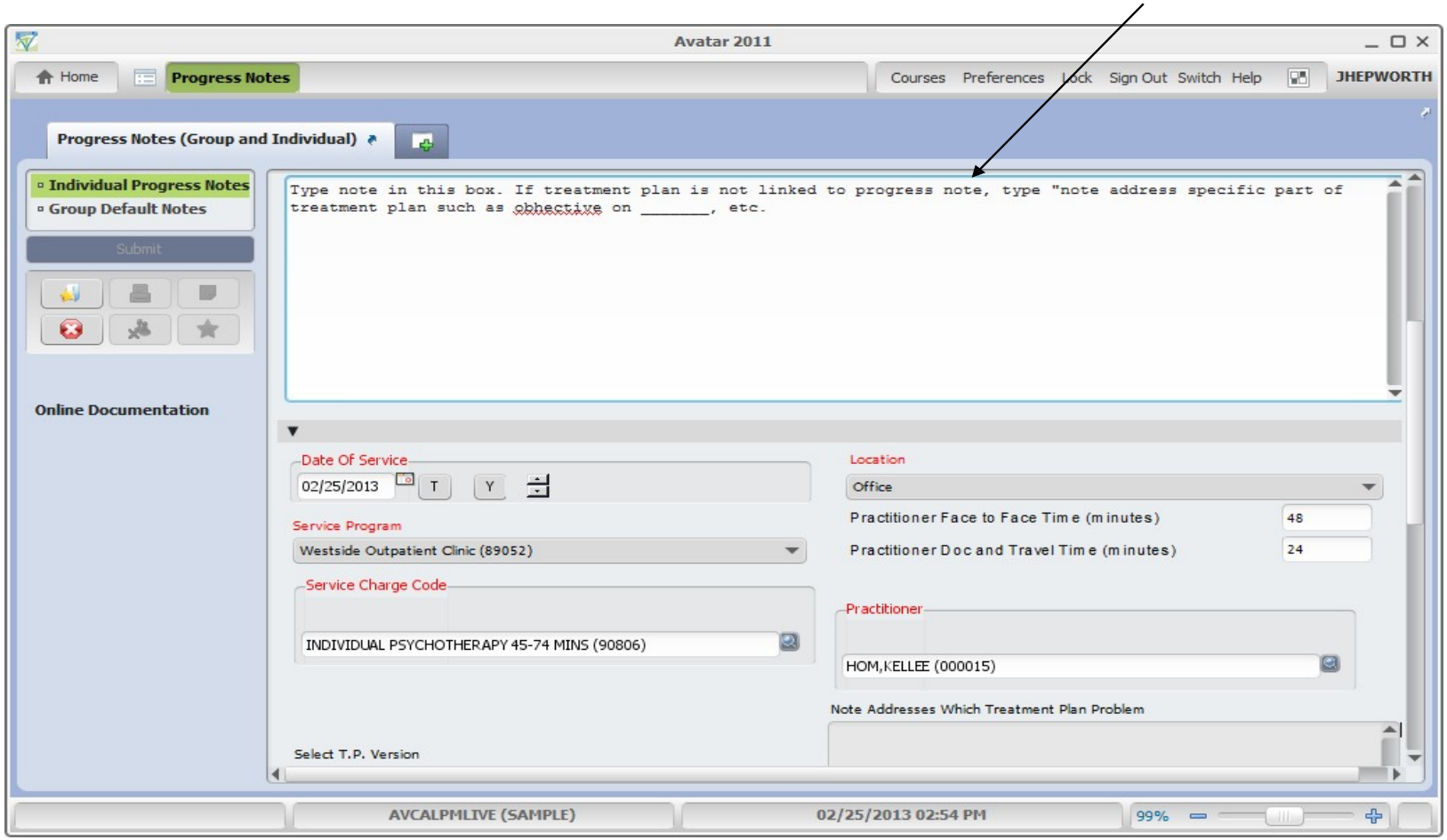
Below, an item from the CYF Treatment Plan is selected and linked to the progress note.



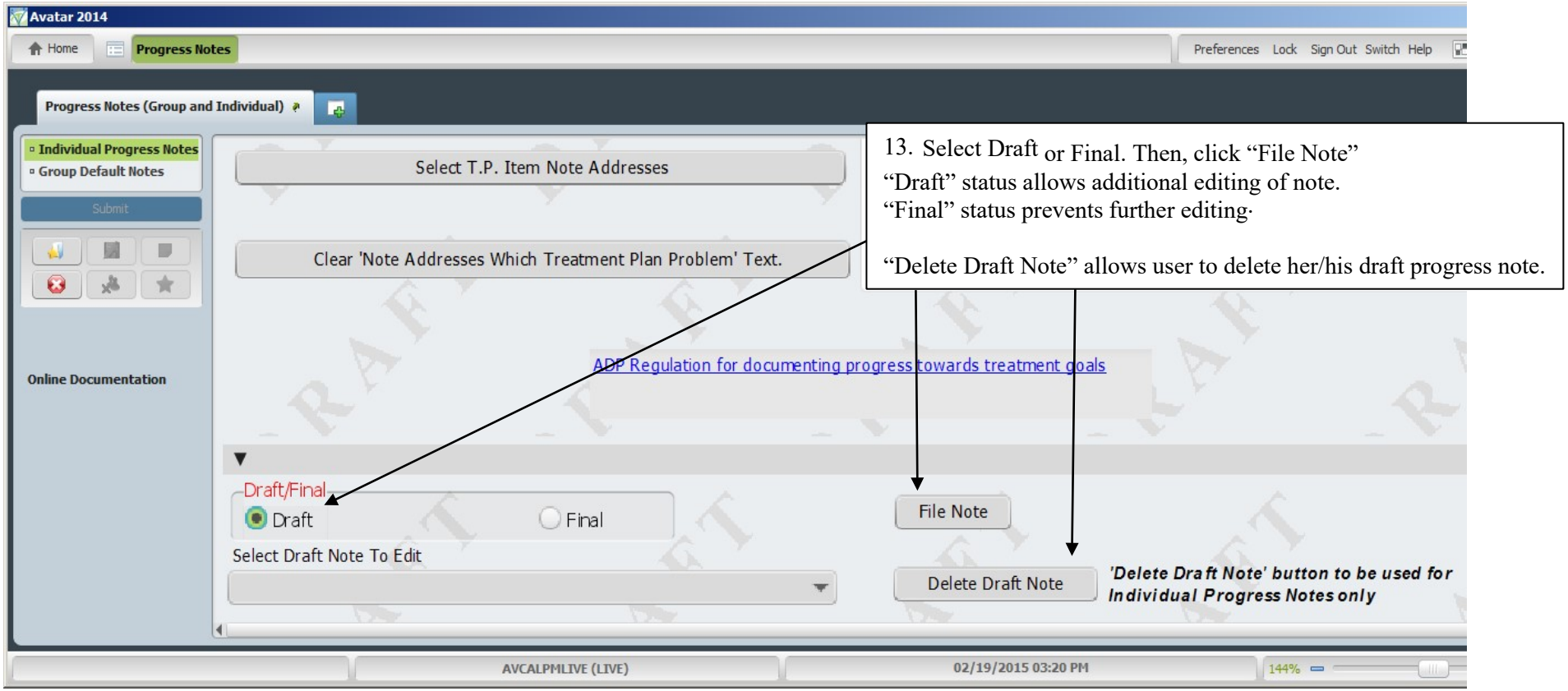
Below, selected objective from Children's Treatment Plan is linked to progress note.



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**.

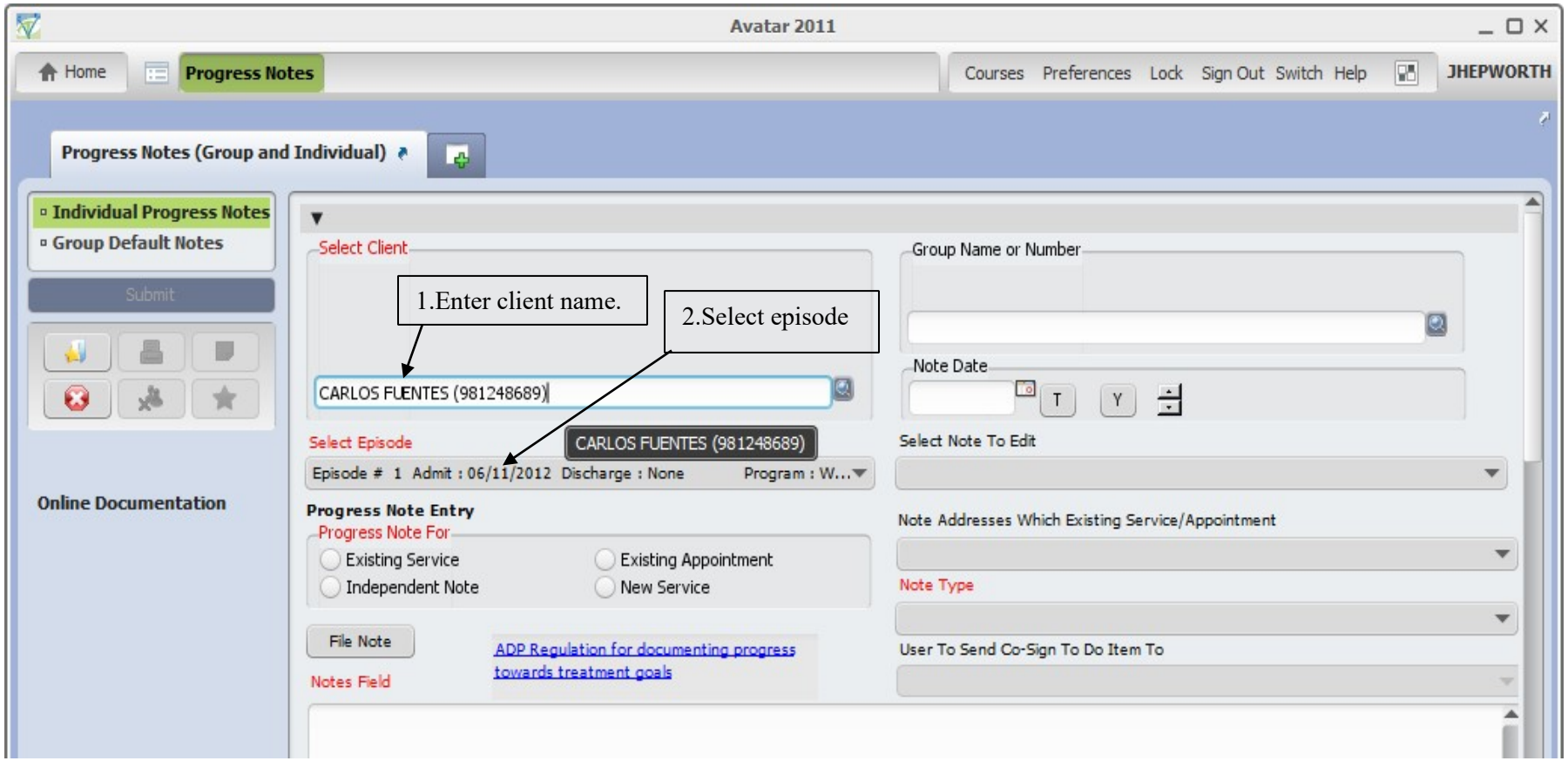


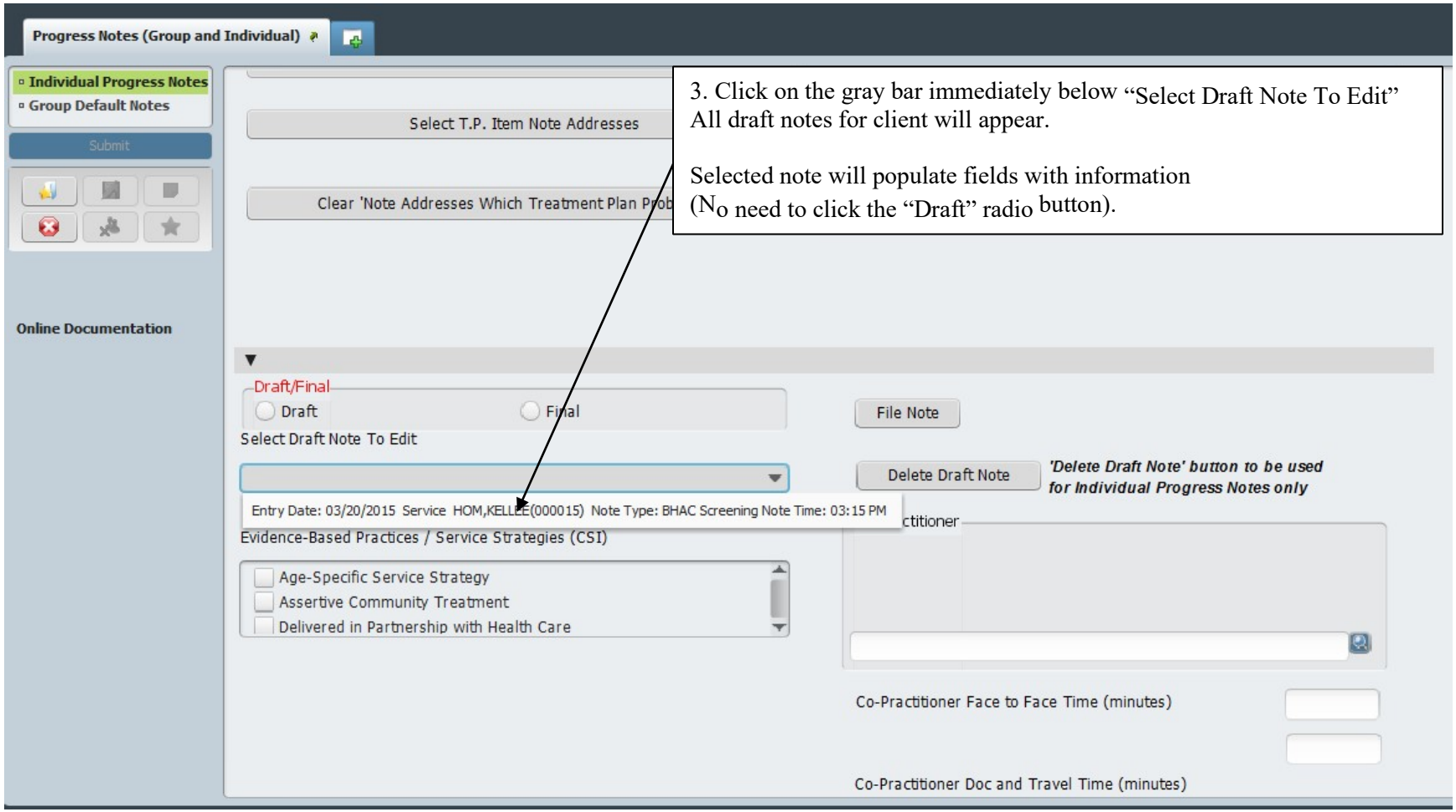
In this example, user selects “draft” and then click’s “**File Note**” with intent of returning to finalize. User can then close Avatar and return at later time to edit draft note.



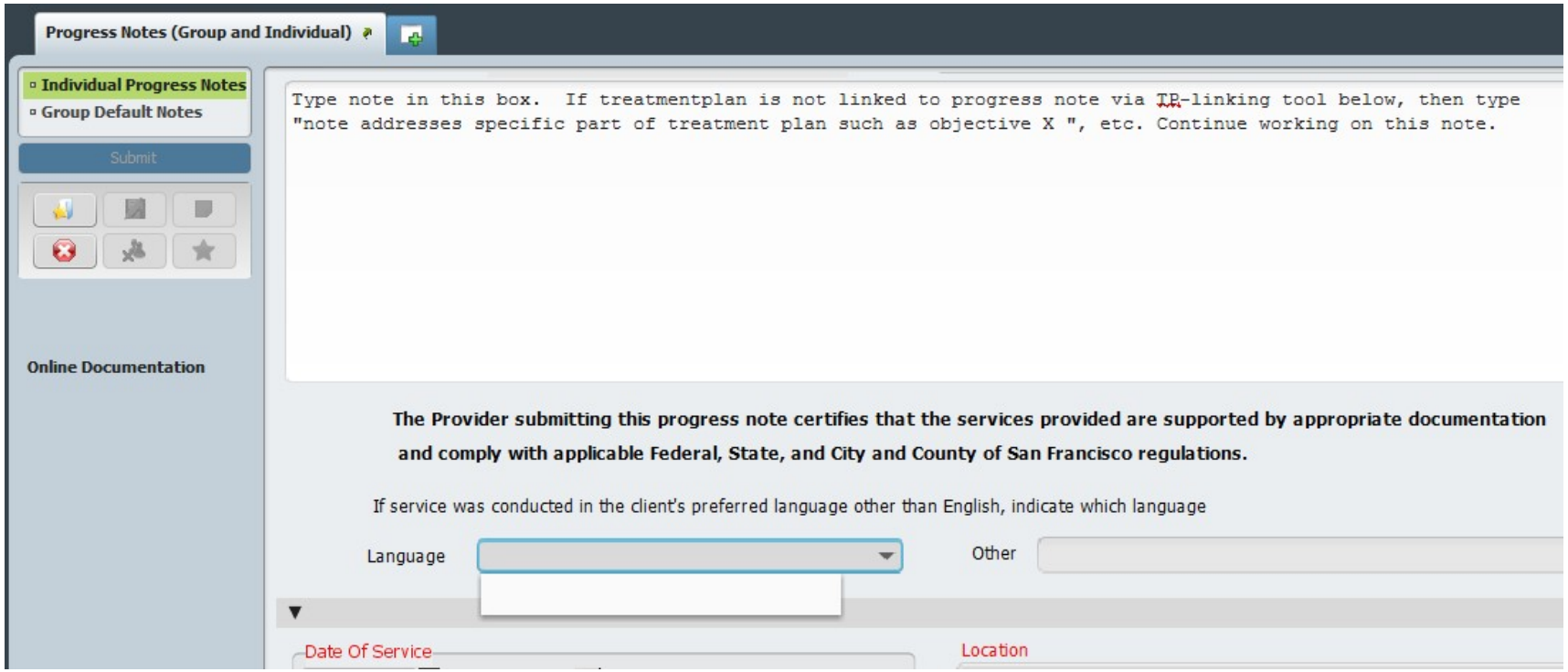
Retrieving Draft Notes:

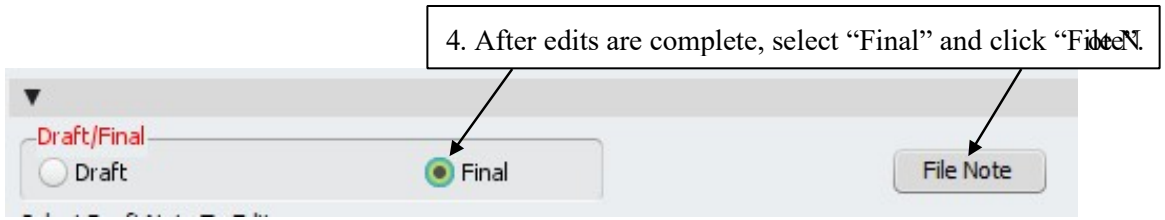
If note has been saved as draft, retrieve by returning to Progress Notes (Group and Individual).




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 Prob
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.

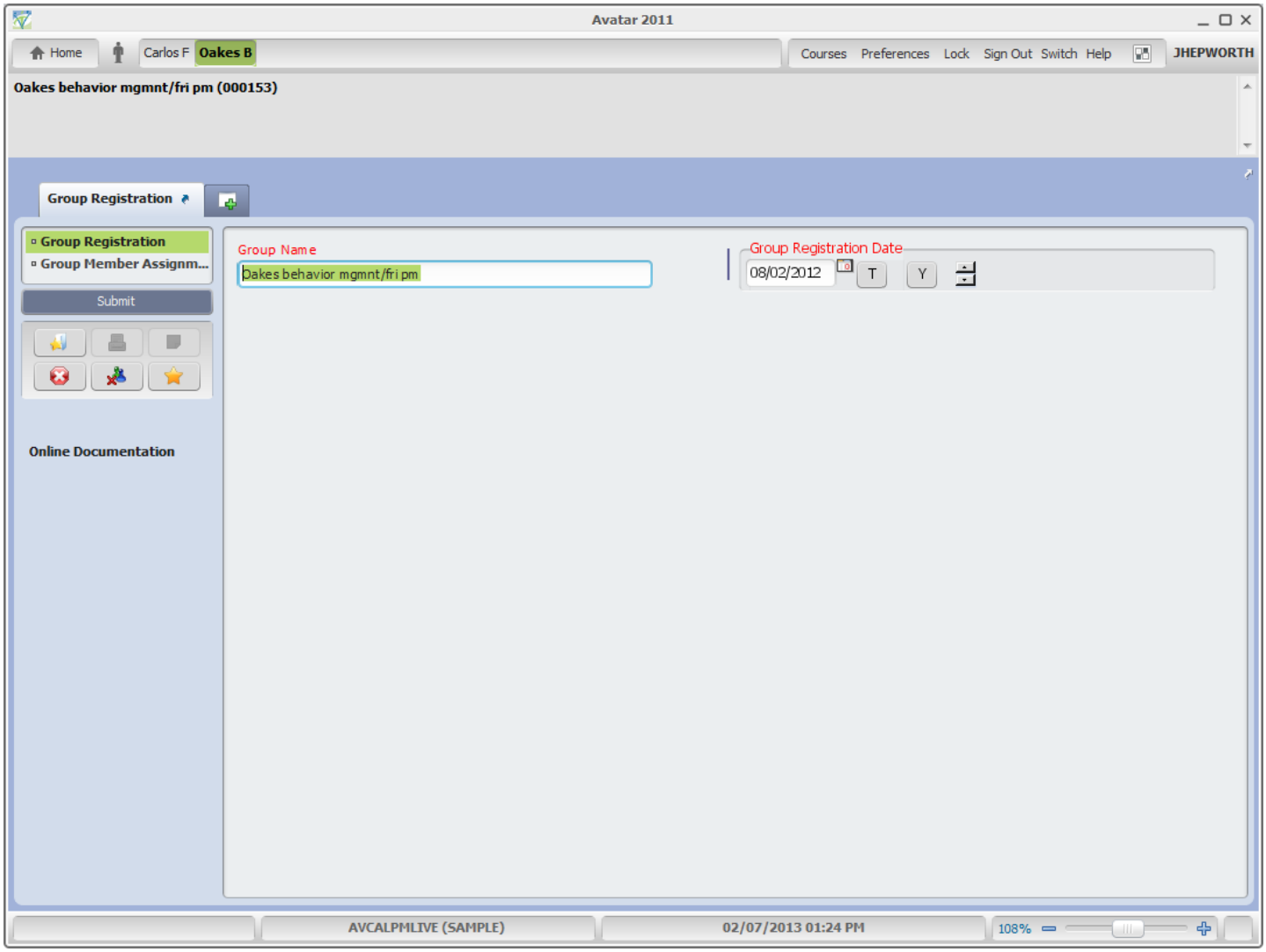




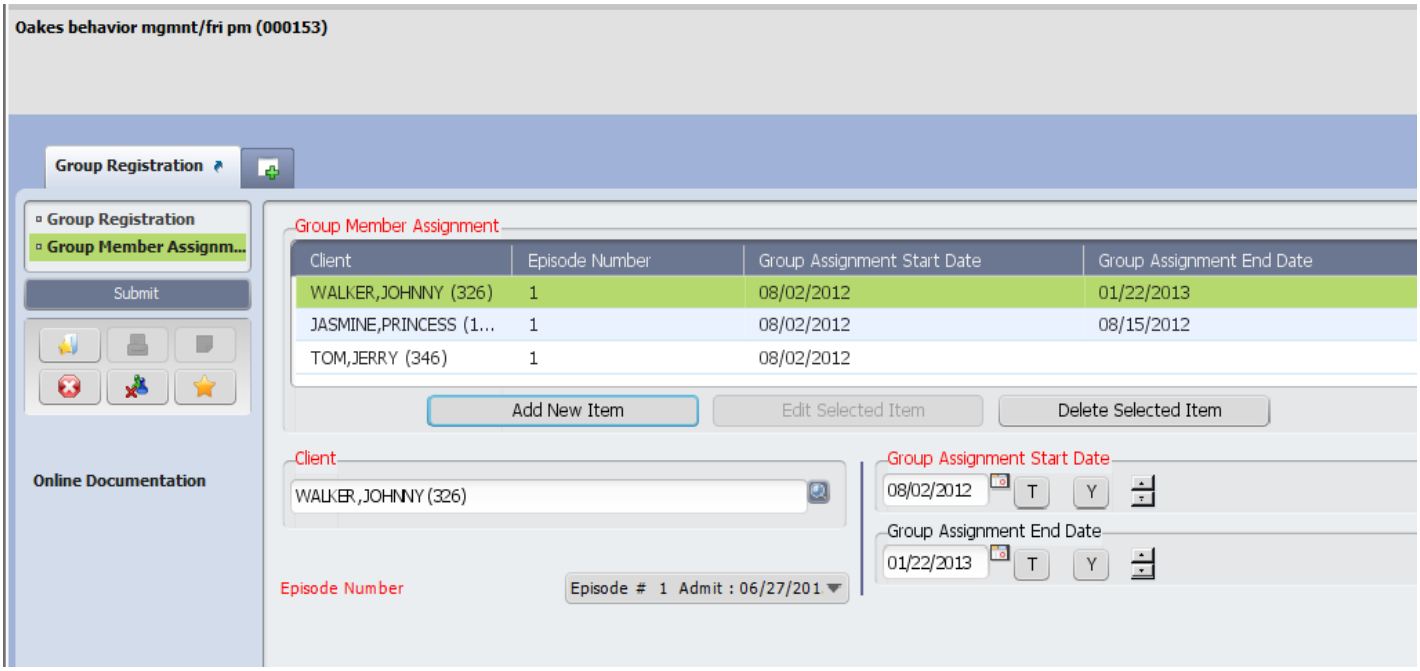
"Append Progress Note" function allows addition of comment to a finalized note by author. Except – interns are not allowed to append finalized notes that have been approved by supervisor.

Group Registration

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



Group Registration - continued



Group Progress Notes User Guide

Introduction:

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

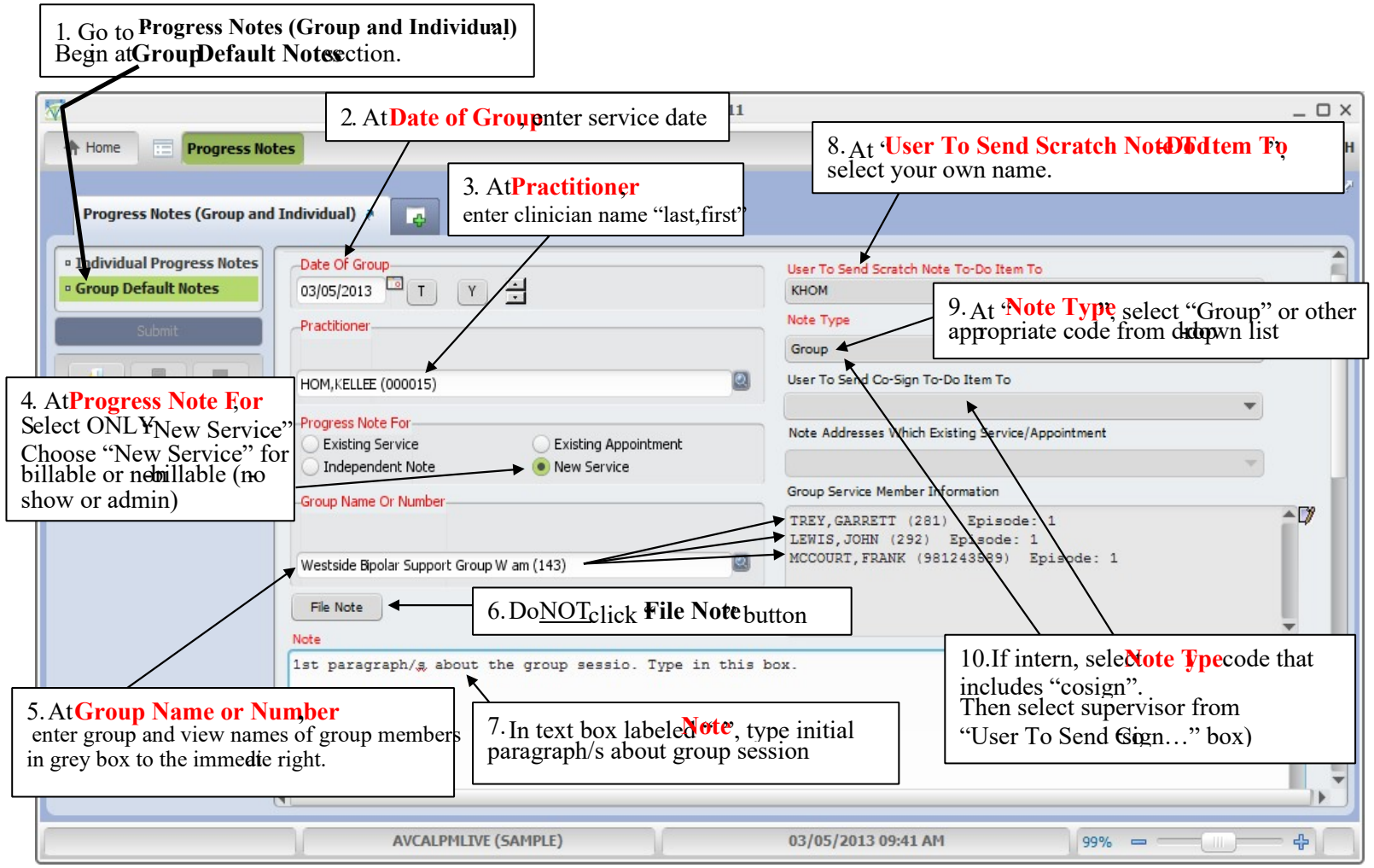
For direction on writing Individual progress notes, go to “Individual Progress Notes User Guide”

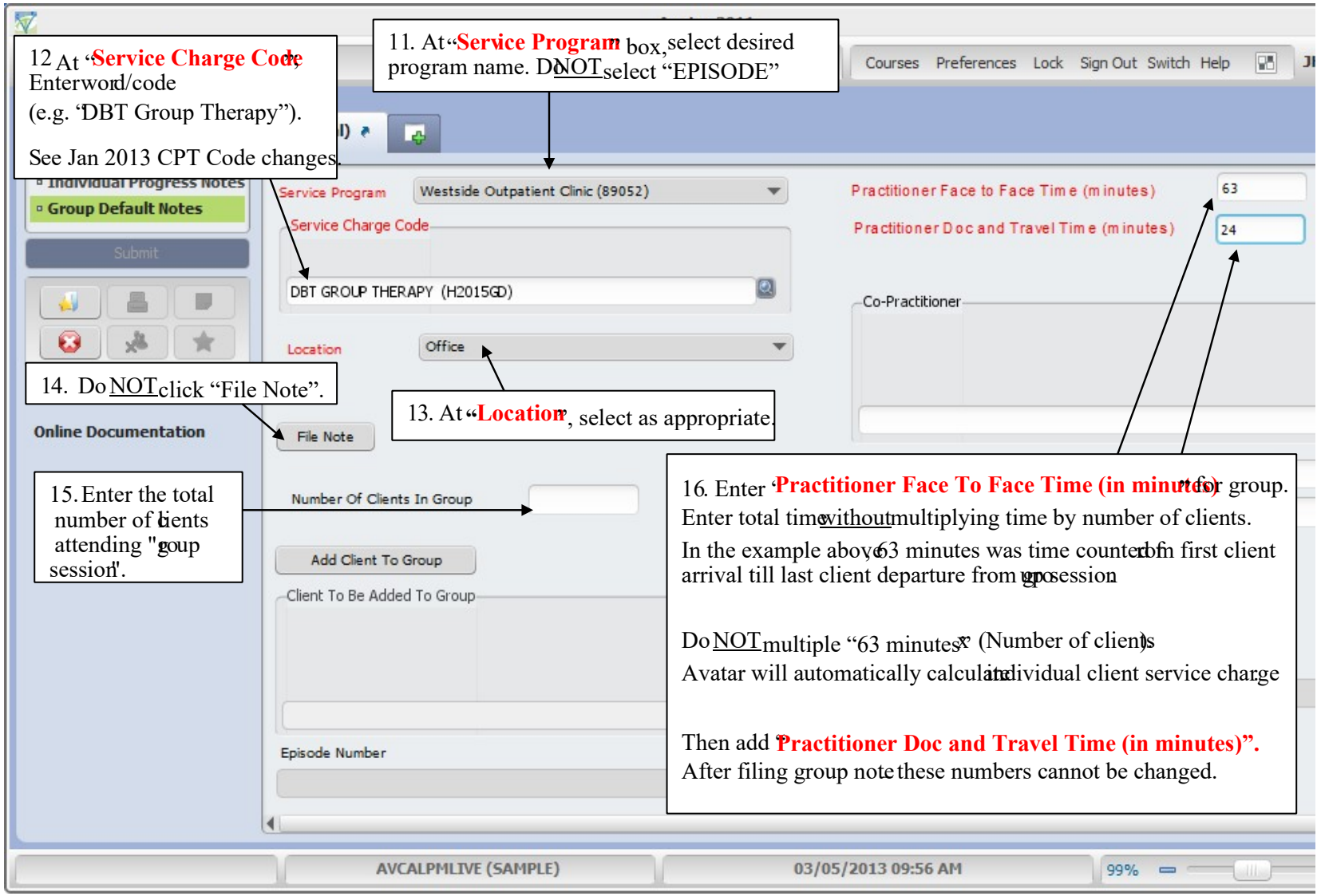
Usually, after completing a group session, the clinician will then write a group note (and then invidualize). The form used for this purpose is “*Progress Notes (Group and Individual)*”.

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

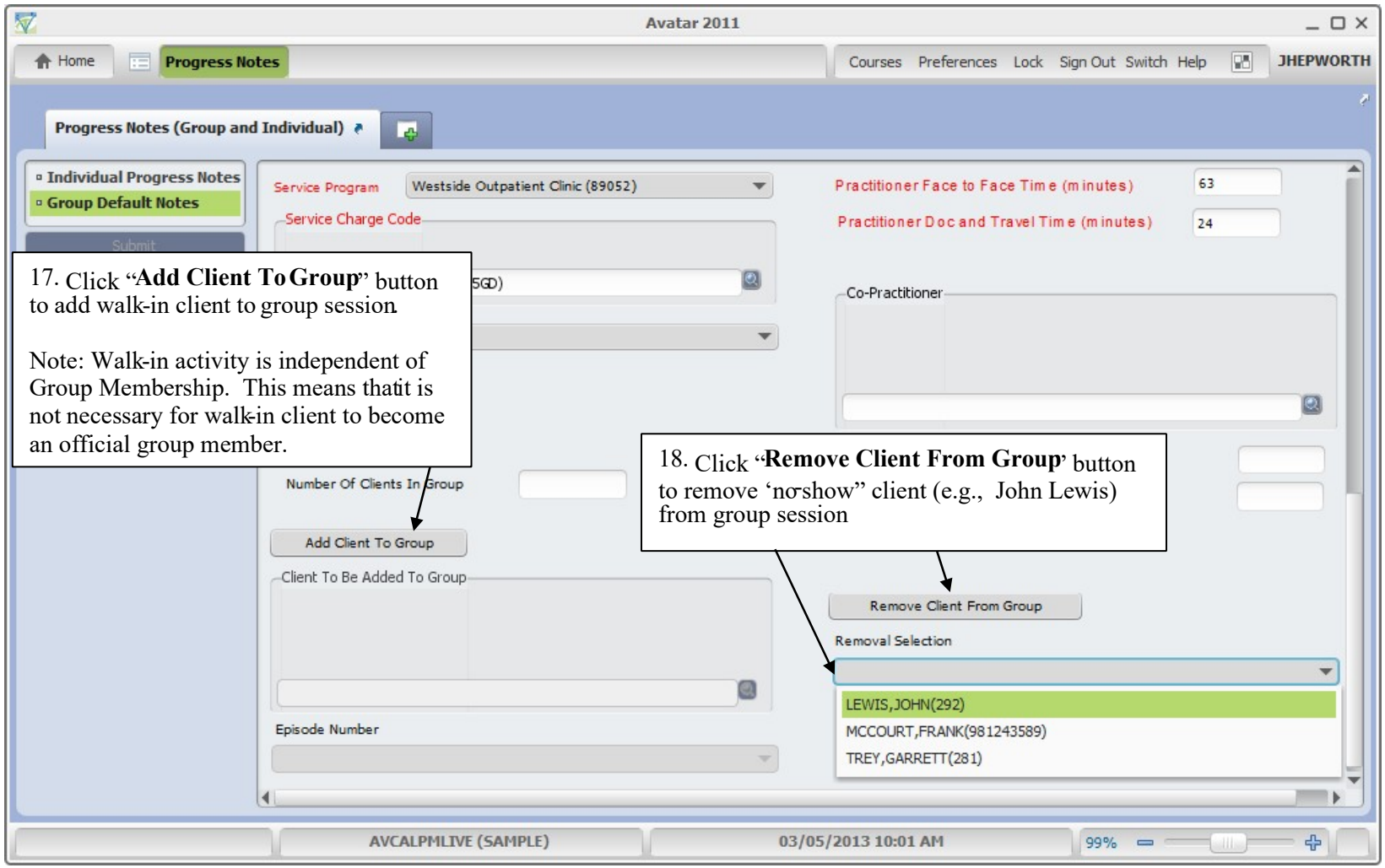
Work begins on the “Group” section and then continues on the “Individual” section.

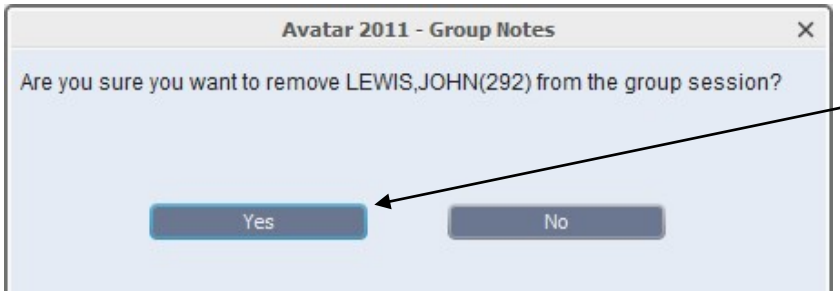
Creating Group Progress Notes:



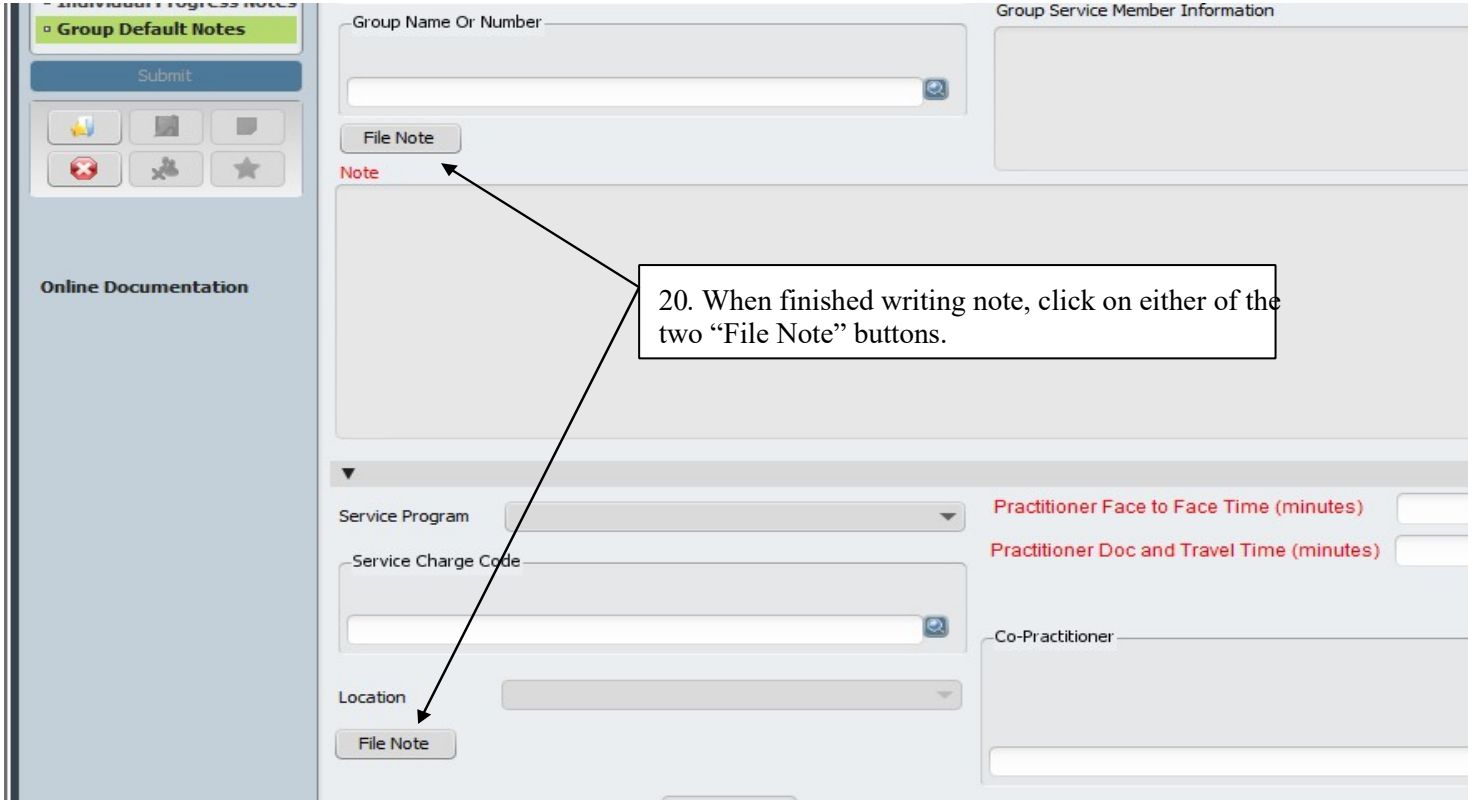

12 At "Service Charge Code", Enter word/code (e.g. "DBT Group Therapy").
See Jan 2013 CPT Code changes.
11. At "Service Program" box, select desired program name. Do NOT select "EPISODE"
Courses Preferences Lock Sign Out Switch Help
Individual Progress Notes
Group Default Notes
Submit
Service Program
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
14. Do NOT click "File Note".
13. At "Location", select as appropriate.
Online Documentation
File Note
15. Enter the total number of clients attending "group session".
Number Of Clients In Group
Add Client To Group
Client To Be Added To Group
Episode Number
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 multiple "63 minutes" x (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.
AVCALPMLIVE (SAMPLE)
03/05/2013 09:56 AM
99%

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

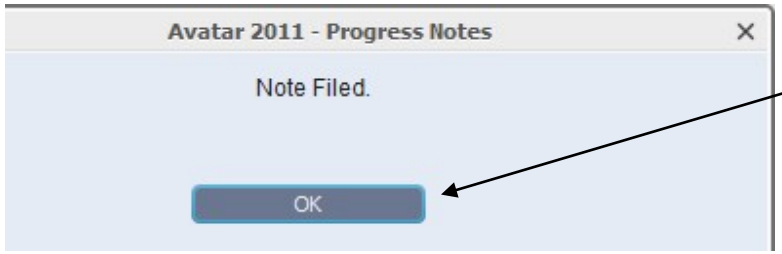




19 After selecting client name for removal (above), Dialogue box appears. This confirms your intent to remove client from this group session:

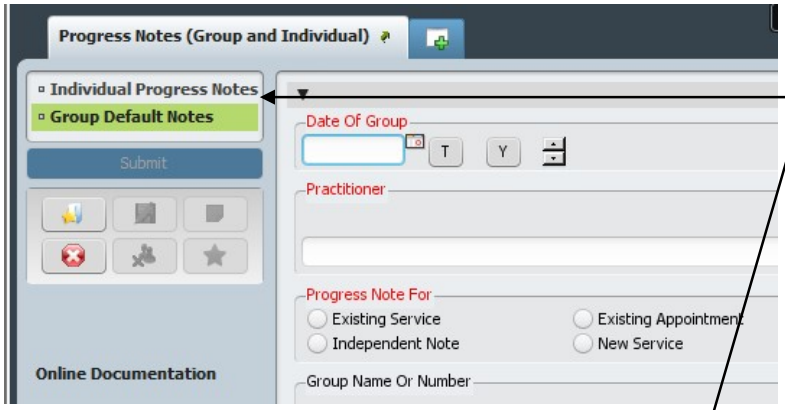


20. When finished writing note, click on either of the two "File Note" buttons.

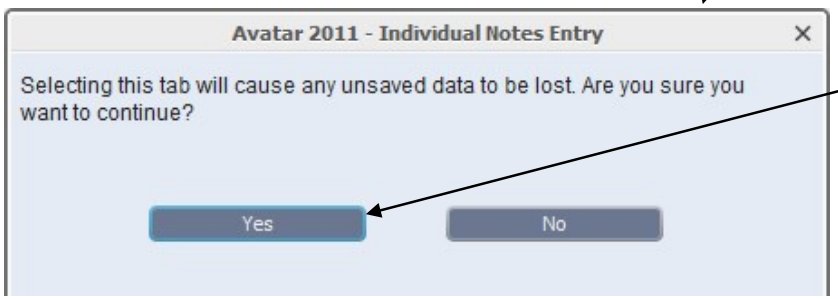


21. The "Note Filed" alert will appear. Click "OK" to complete the process.
Now your work on the **Group Default Notes section** is done.
You can close progress notes now and then resume instruction on the following page (8) at a later time.
Or, you can continue the process right now by following steps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

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



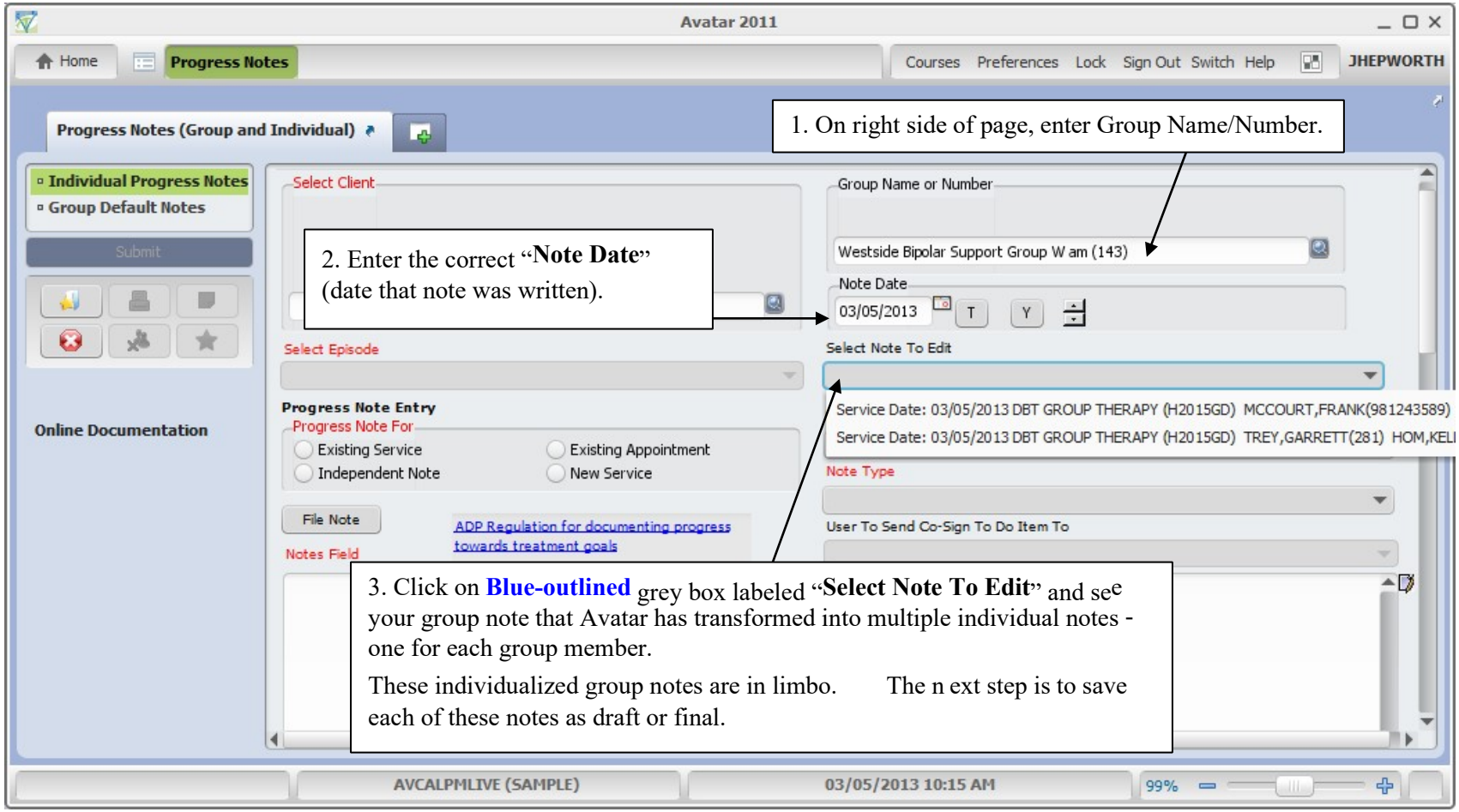
22. If you move to "Individual Progress Notes" section, in order to individualize notes per instructions that follow, Avatar will display a warning that unsaved data will be lost



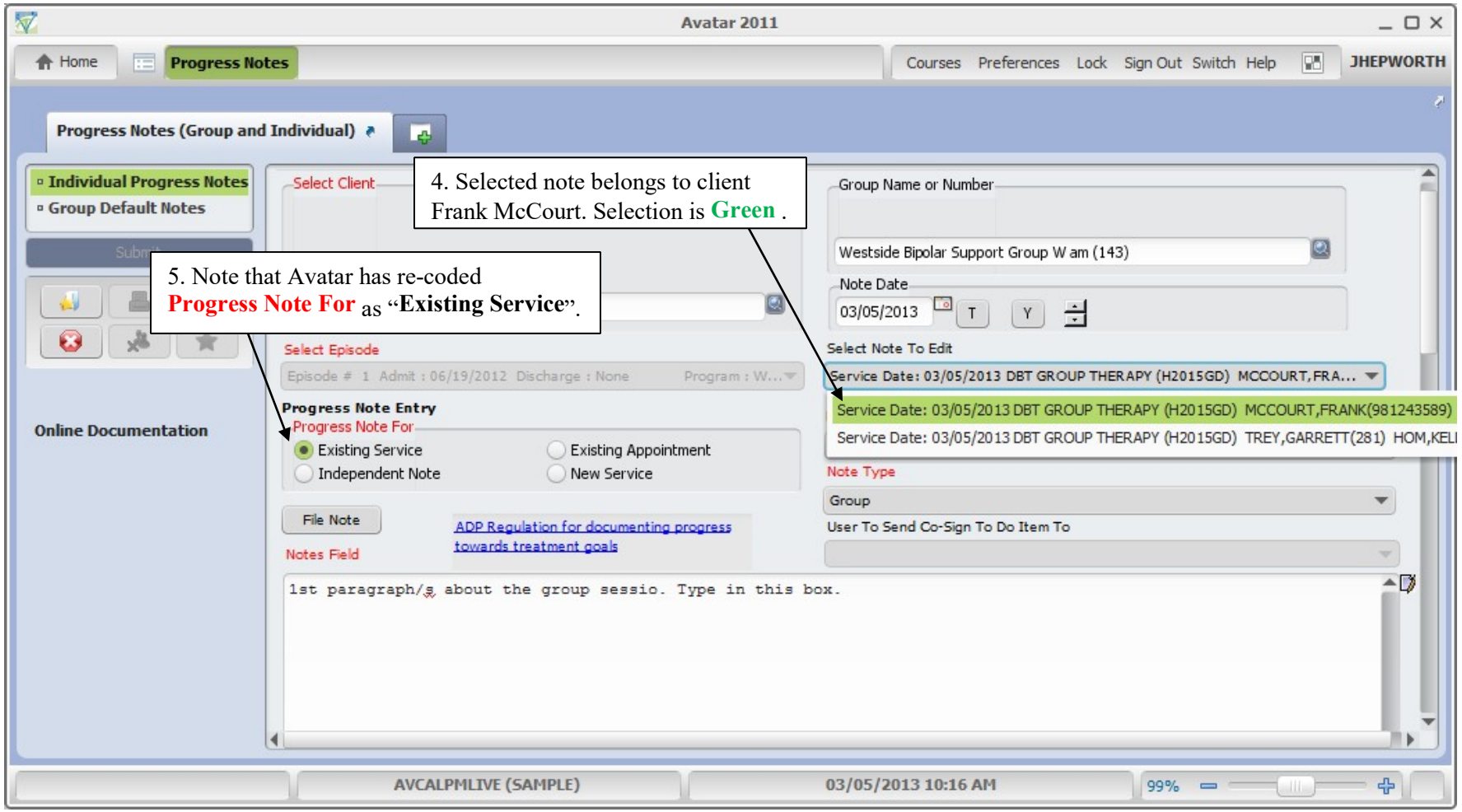
23. Go ahead and click "Yes" if you have already filed group note.

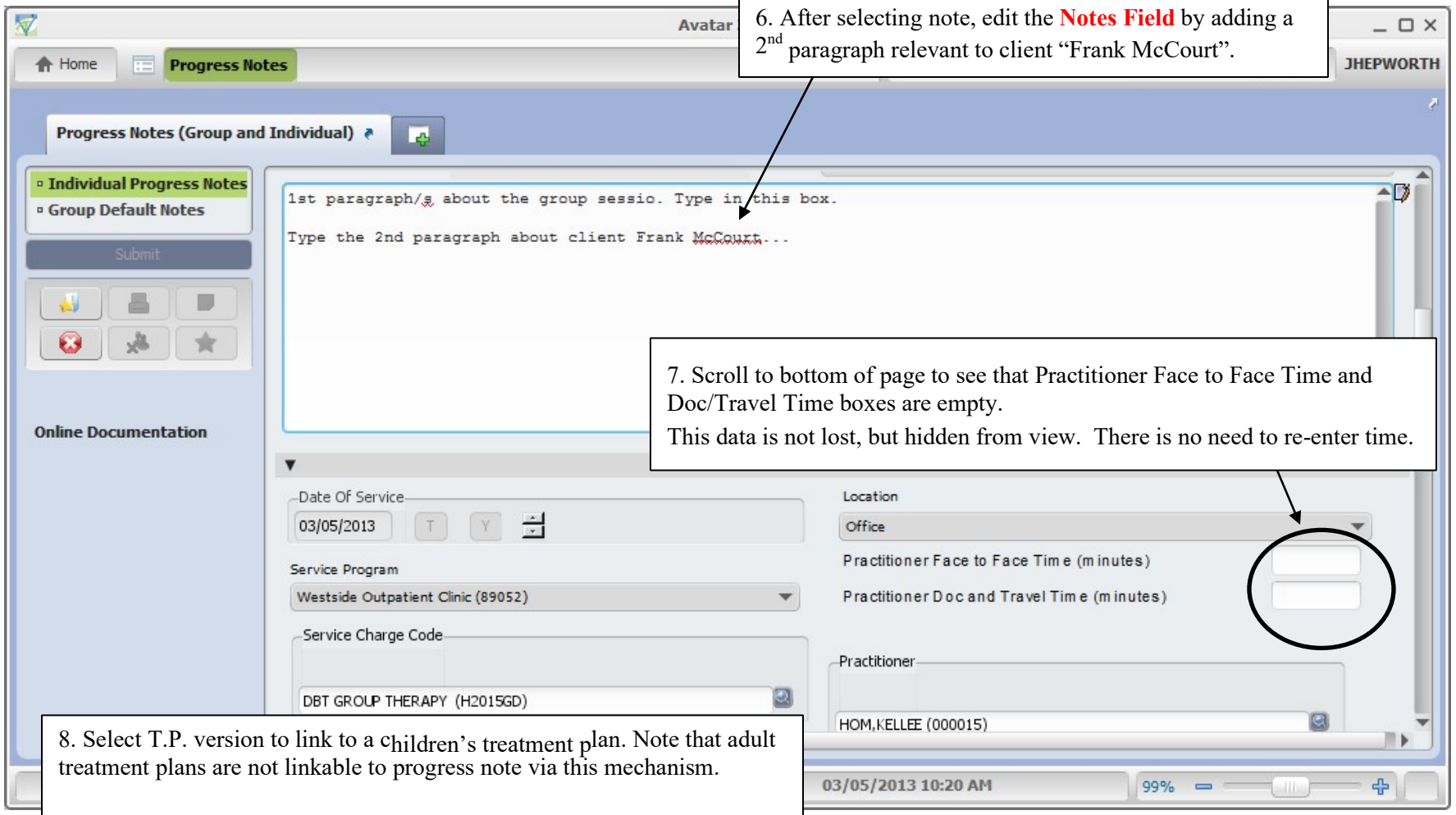
Individualize the Group Note:

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

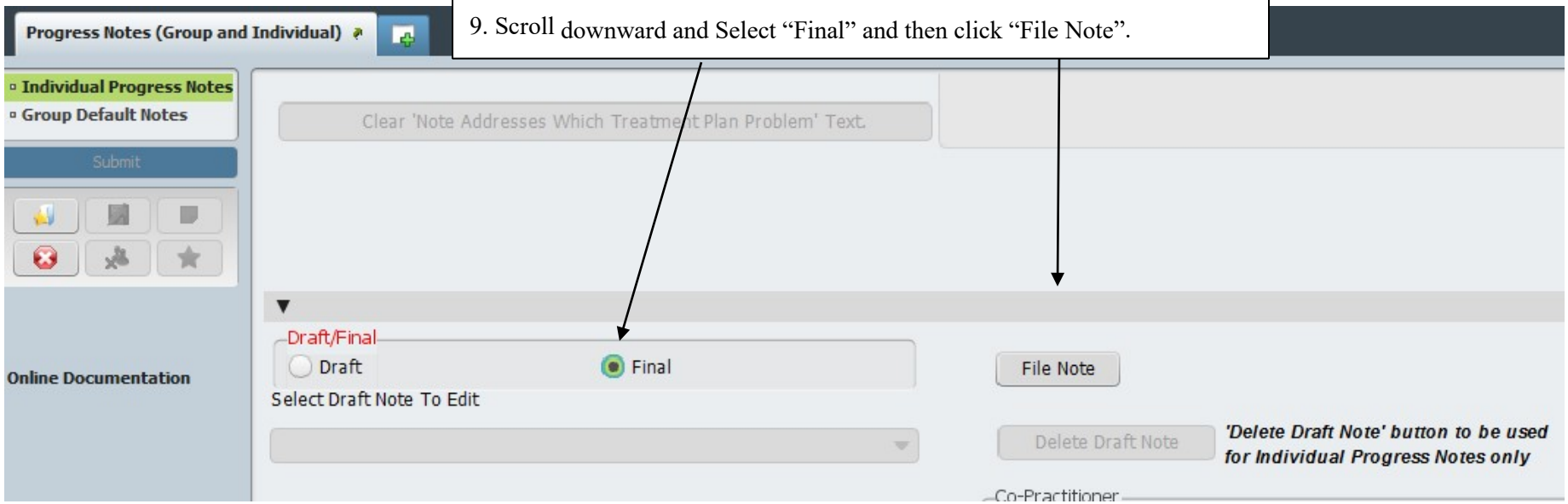


In example, below – the individualized group note for client, Frank McCourt is selected.

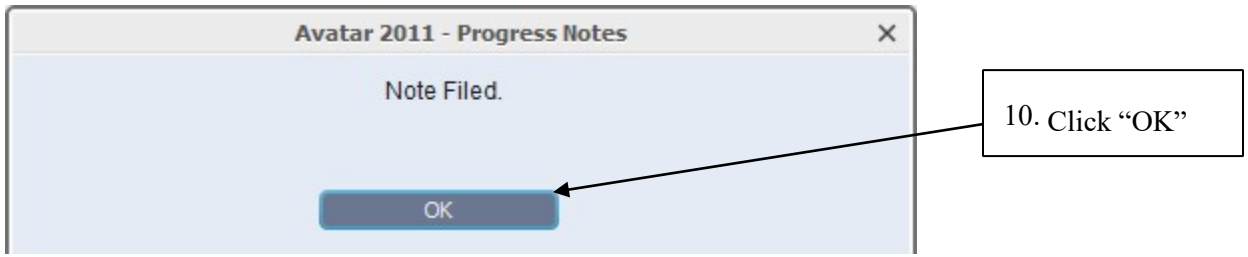



6. After selecting note, edit the Notes Field by adding a 2nd paragraph relevant to client "Frank McCourt".
Avatar
Home
Progress Notes
JHEPWORTH
Progress Notes (Group and Individual)
Individual Progress Notes
Group Default Notes
Submit
Online Documentation
1st paragraph/s about the group sessio. Type in this box.
Type the 2nd paragraph about 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.
Date Of Service
03/05/2013
Location
Office
Practitioner Face to Face Time (minutes)
Practitioner Doc and Travel Time (minutes)
Service Program
Westside Outpatient Clinic (89052)
Service Charge Code
DBT GROUP THERAPY (H2015GD)
Practitioner
HOM,KELLEE (000015)
03/05/2013 10:20 AM
99%
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".

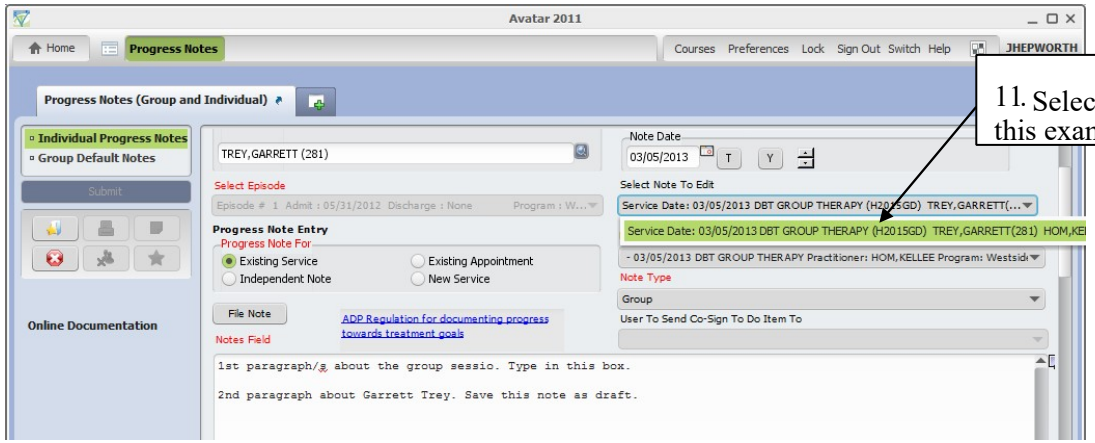
Finalizing the progress note:



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

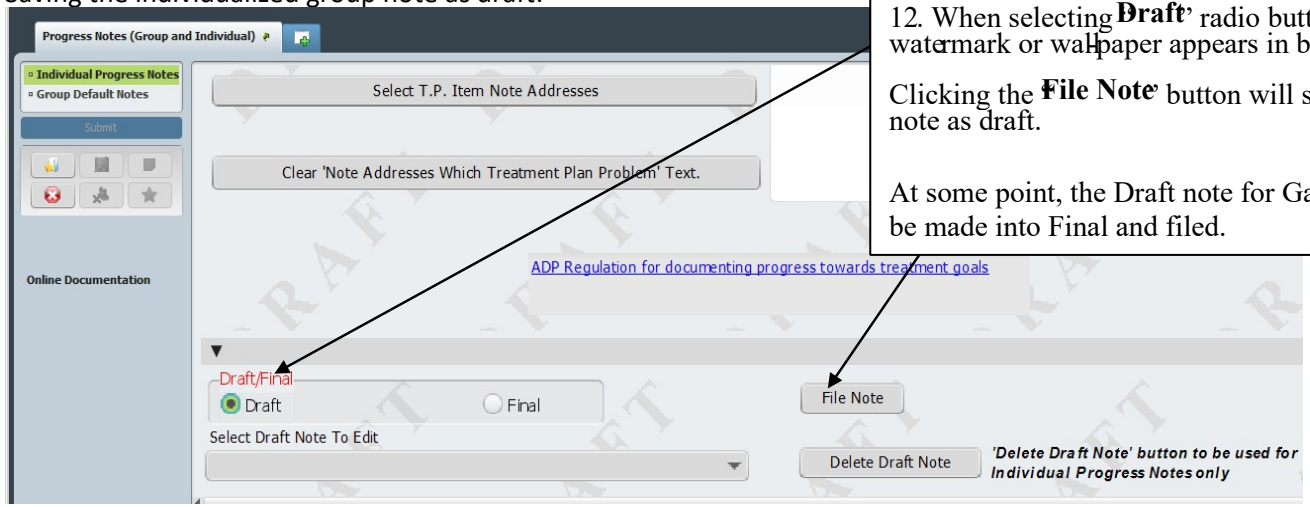


Now, a single note remains in limbo. Note belongs to client, Garrett Trey.



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

Saving the individualized group note as draft:

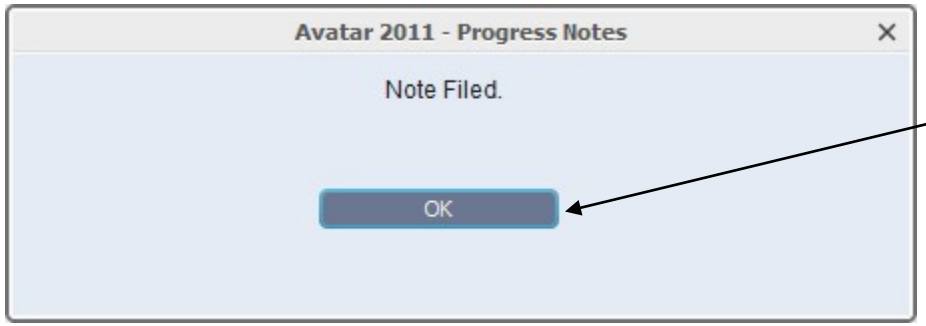


12. When selecting "**Draft**" radio button, the "DRAFT" watermark or wallpaper appears in background.

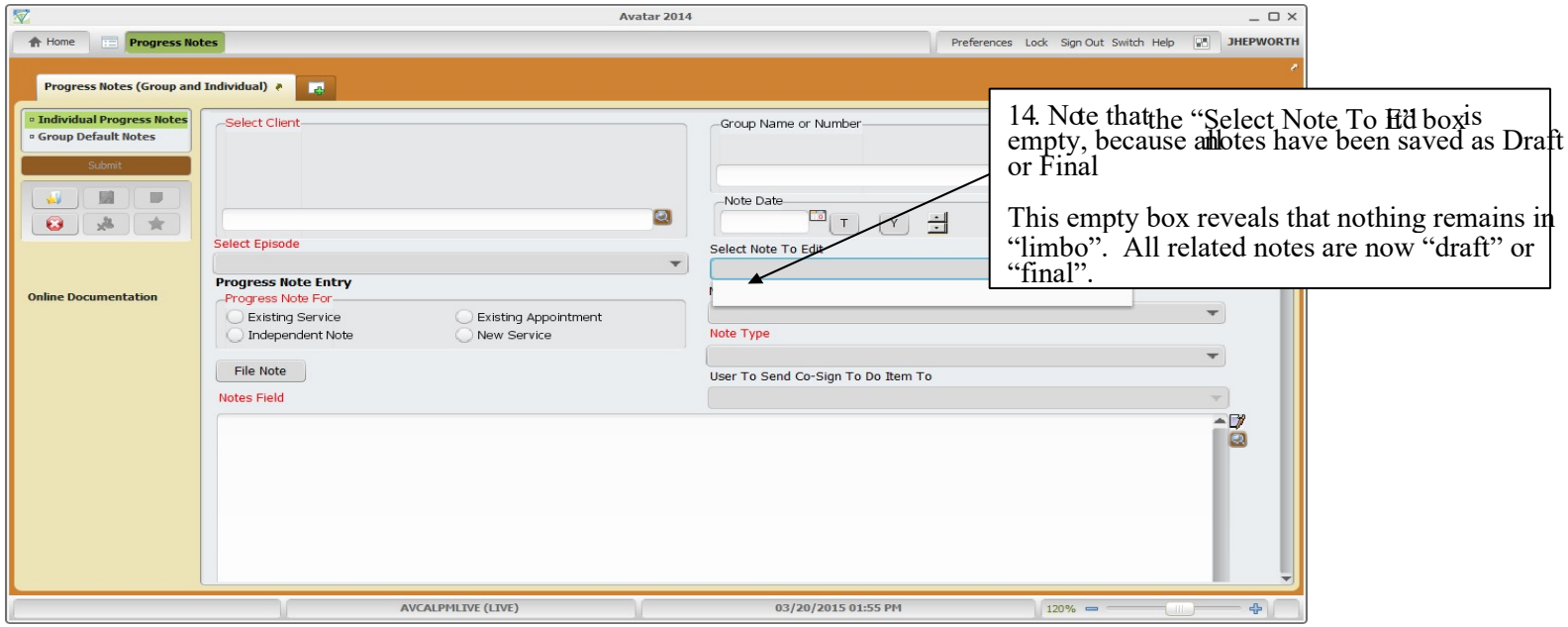
Clicking the "**File Note**" button will save Garrett Trey's note as draft.

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

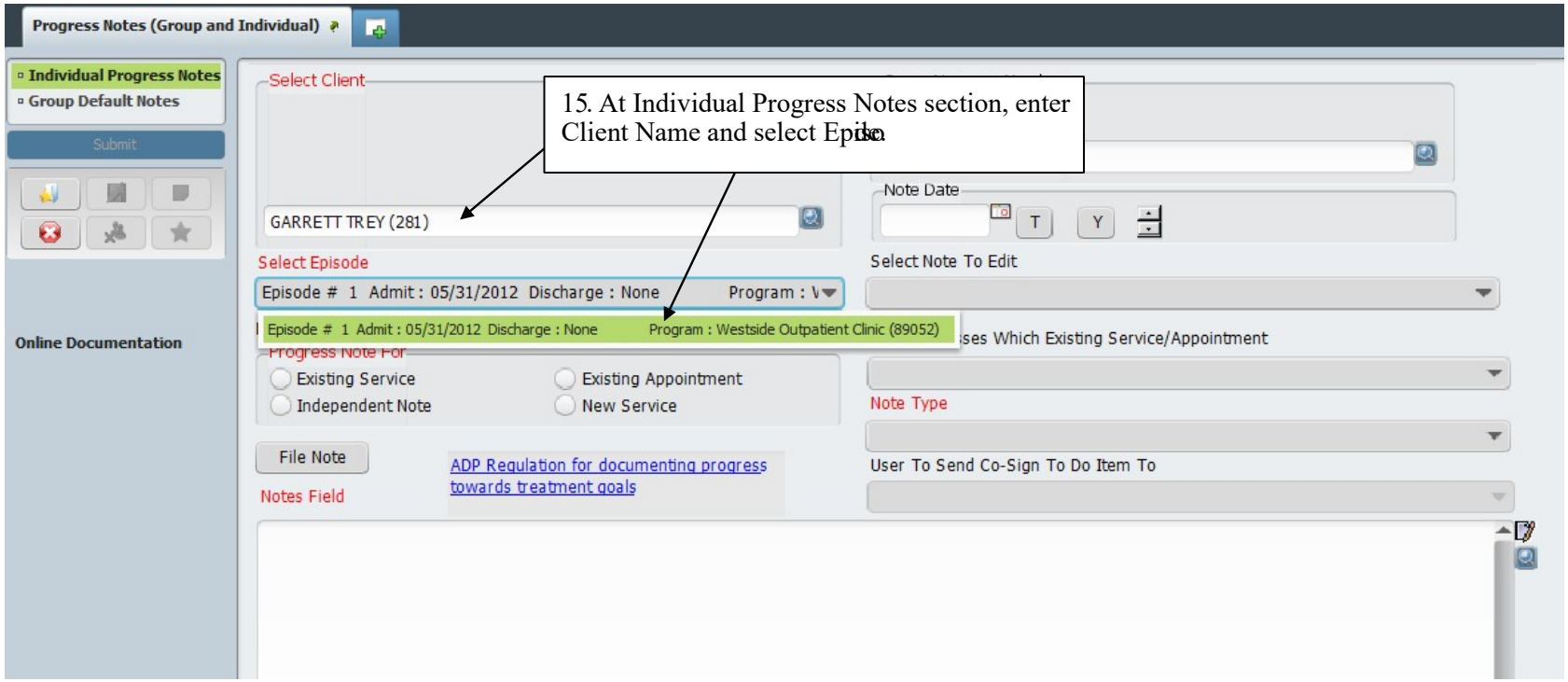
This box, below is confirmation that note was filed.



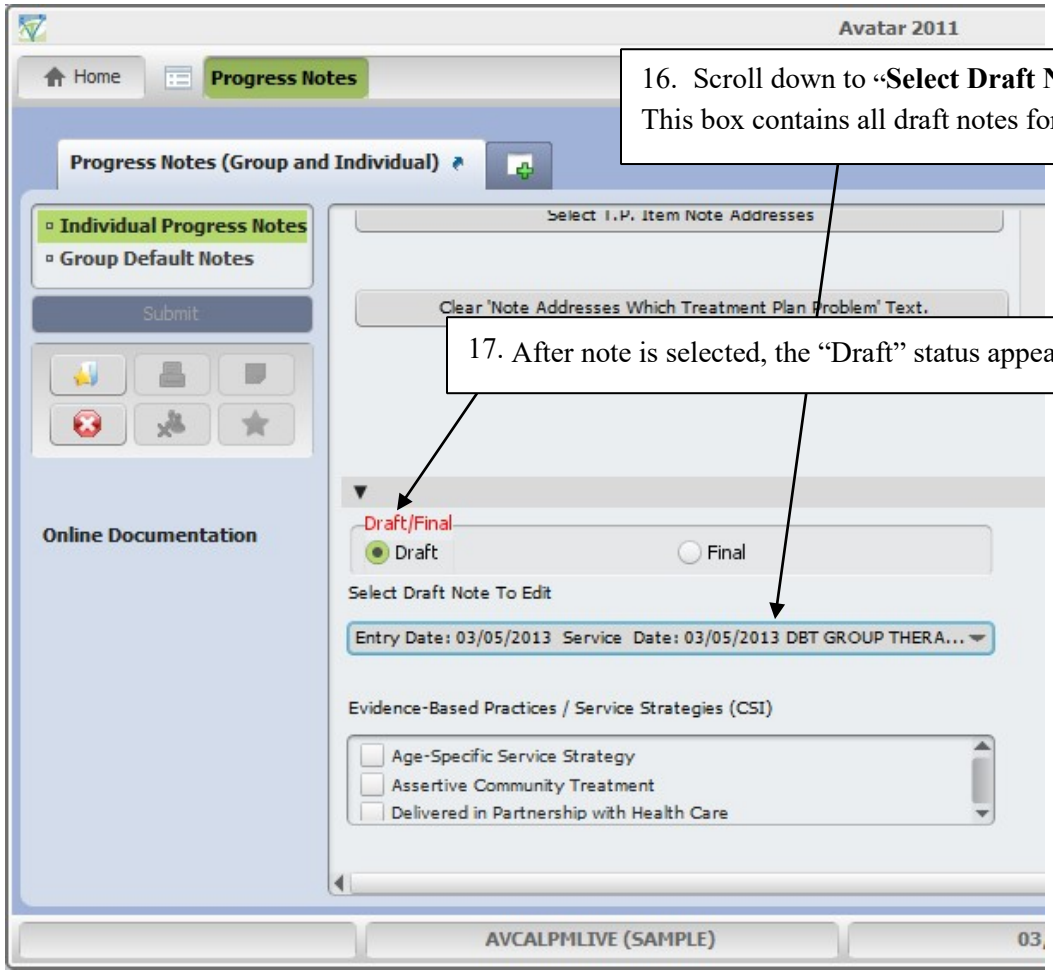
Below is an image of an empty "*Select Note To Edit*" box:



Retrieving draft note for Garrett Trey:



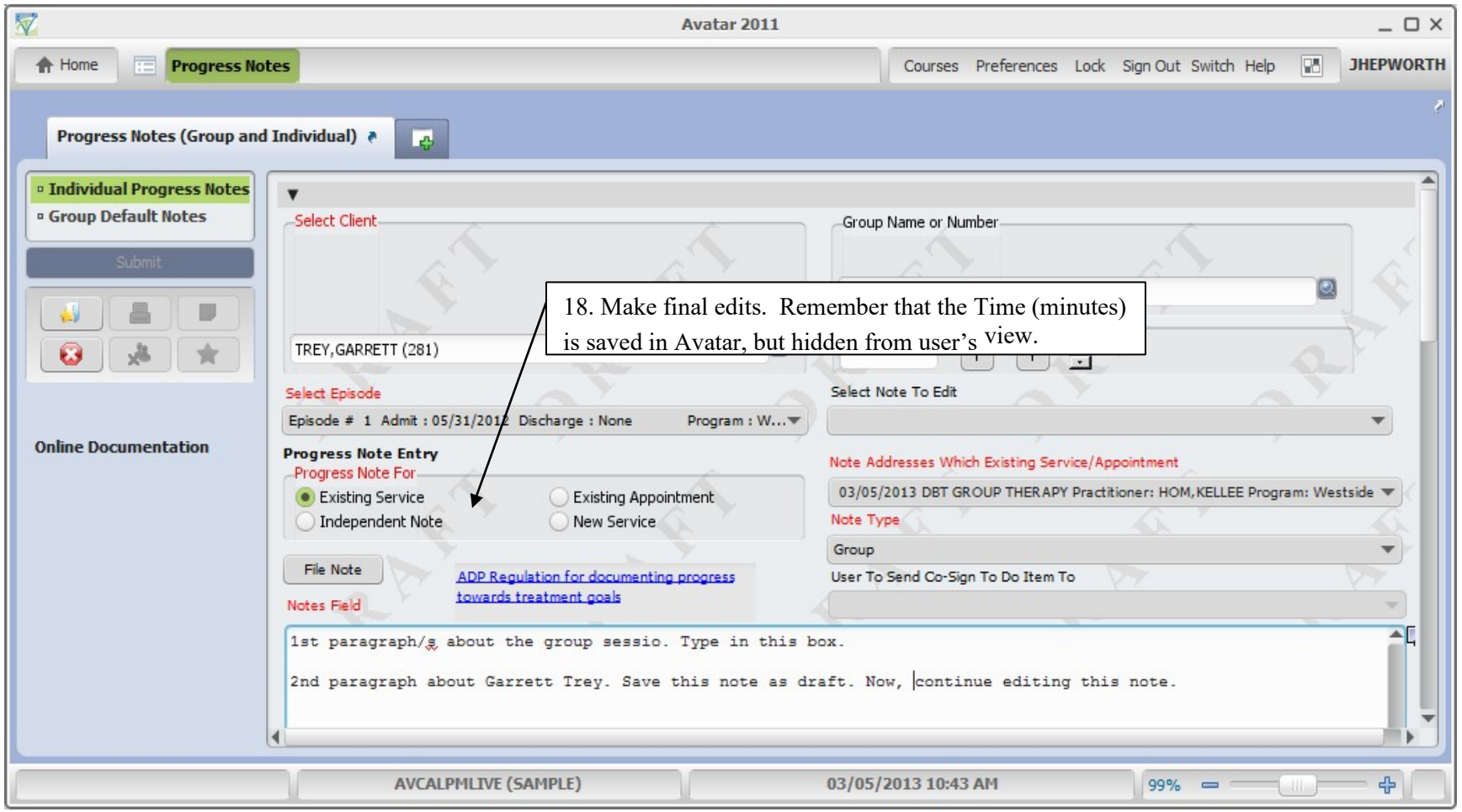
.

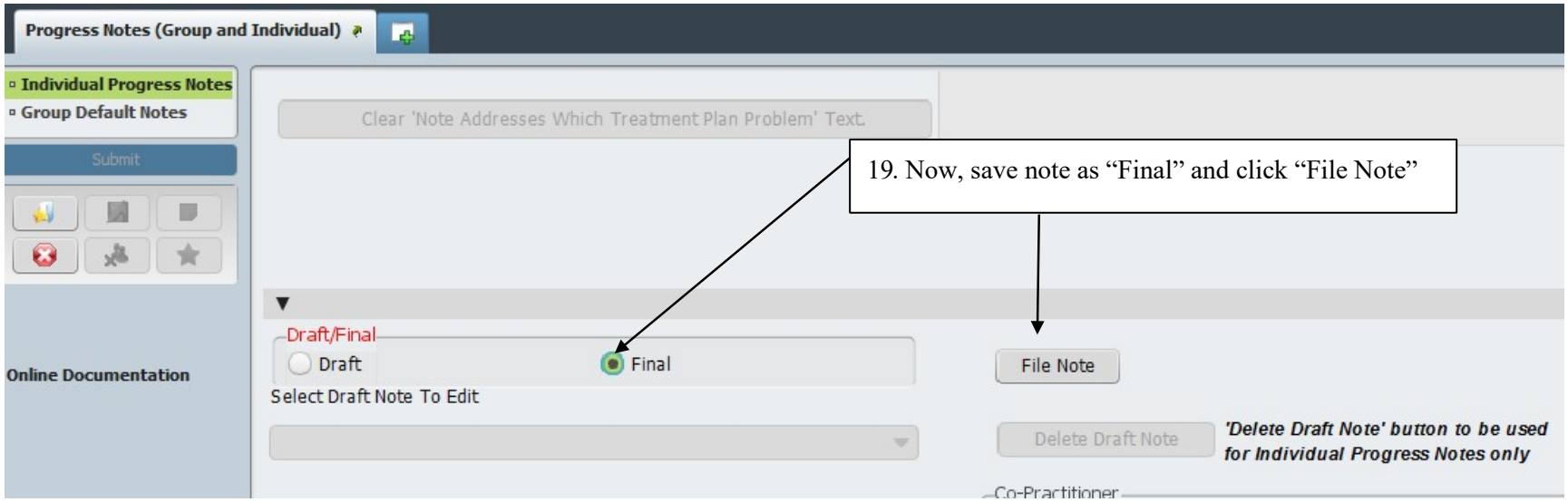


16. Scroll down to "**Select Draft Note To Edit**" (blue outlined grey box) at bottom of page. This box contains all draft notes for client _ regardless of origin as group or individual.

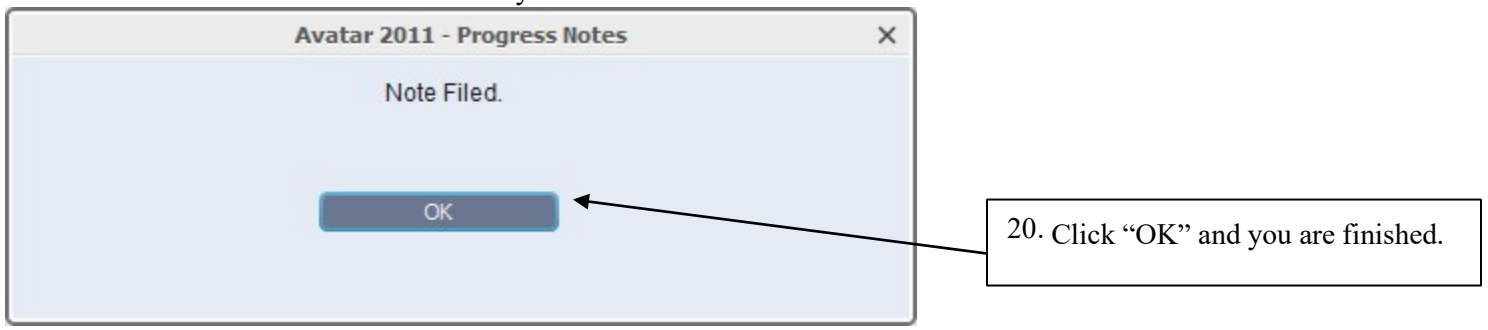
17. After note is selected, the "Draft" status appear s

Making final edits.





Confirmation that note has been successfully filed:

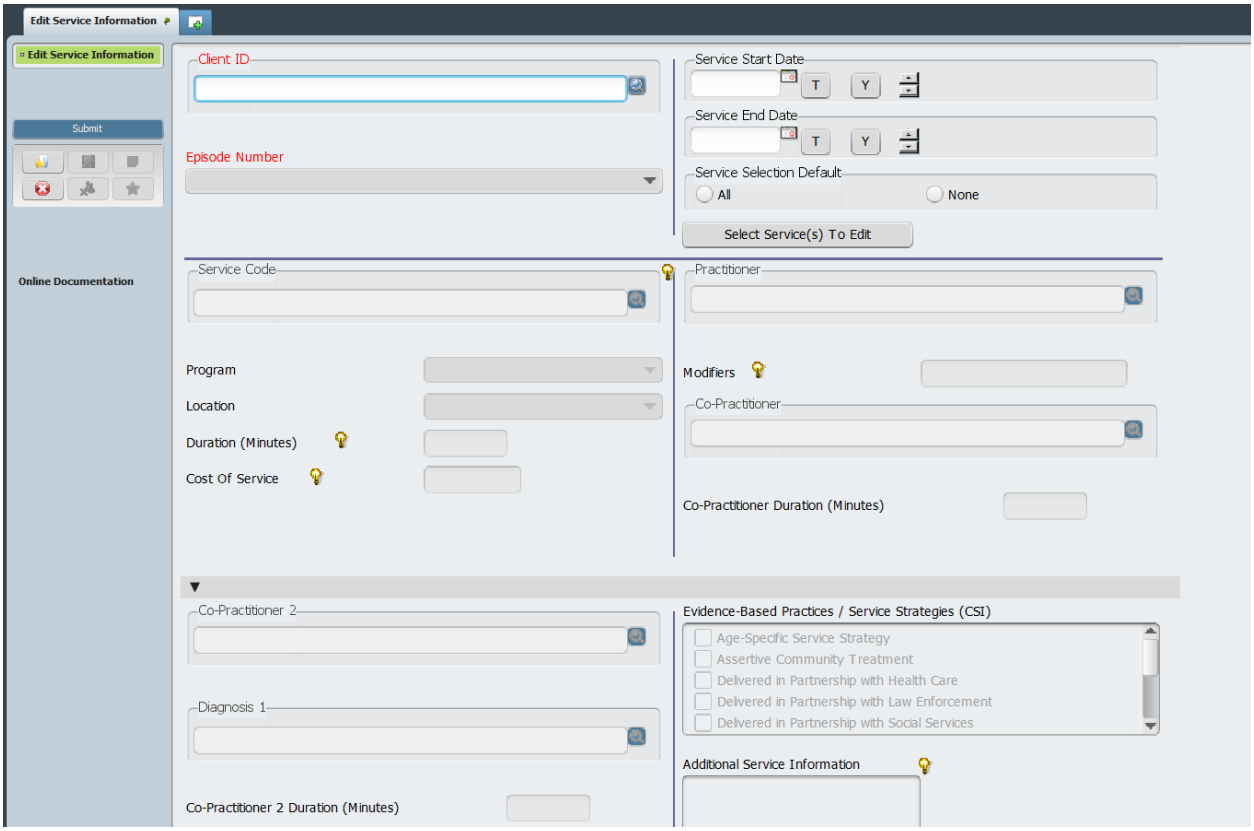


Note: an "Intern" note that is final + approved by supervisor cannot be appended.

SERVICE CORRECTIONS

Edit Service Information

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

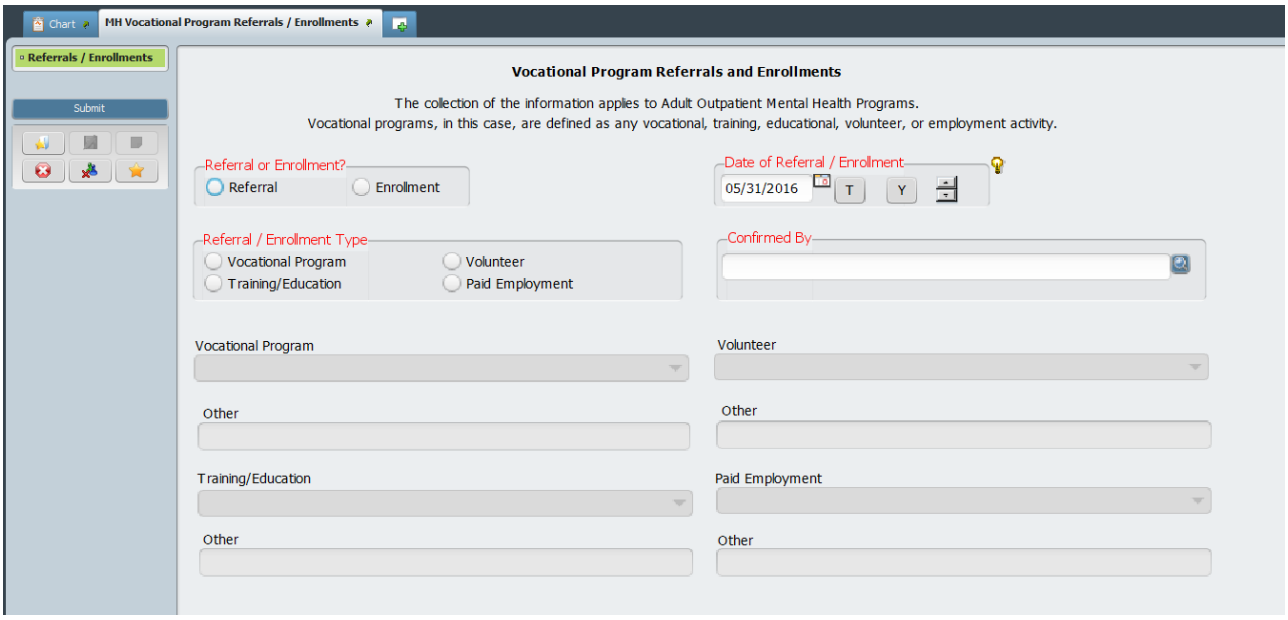


VOCATIONAL REFERRALS

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.

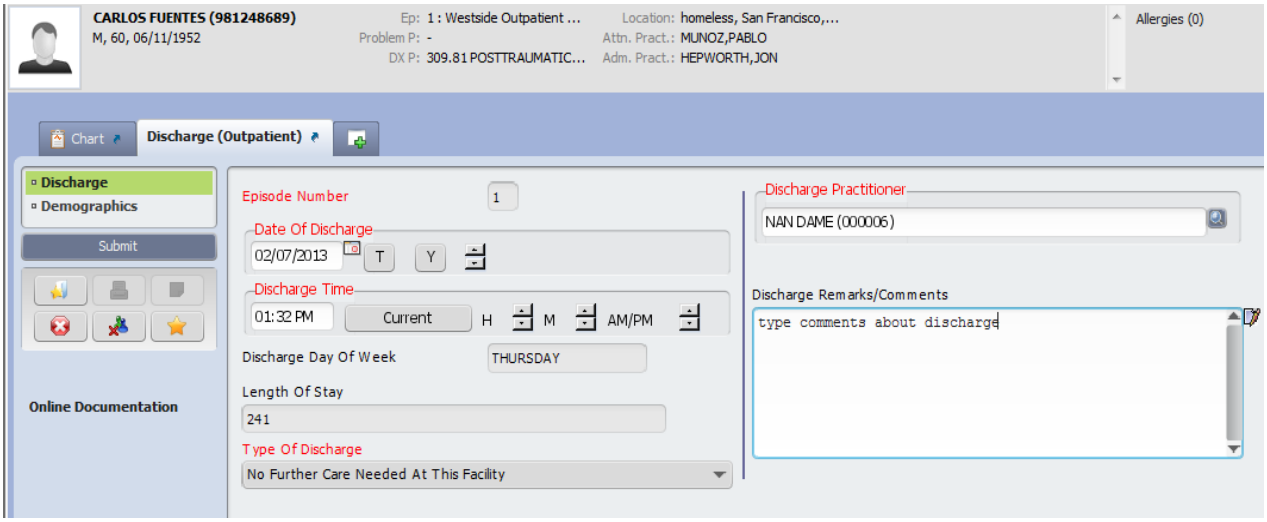


DISCHARGE BUNDLES

Discharge (Outpatient)

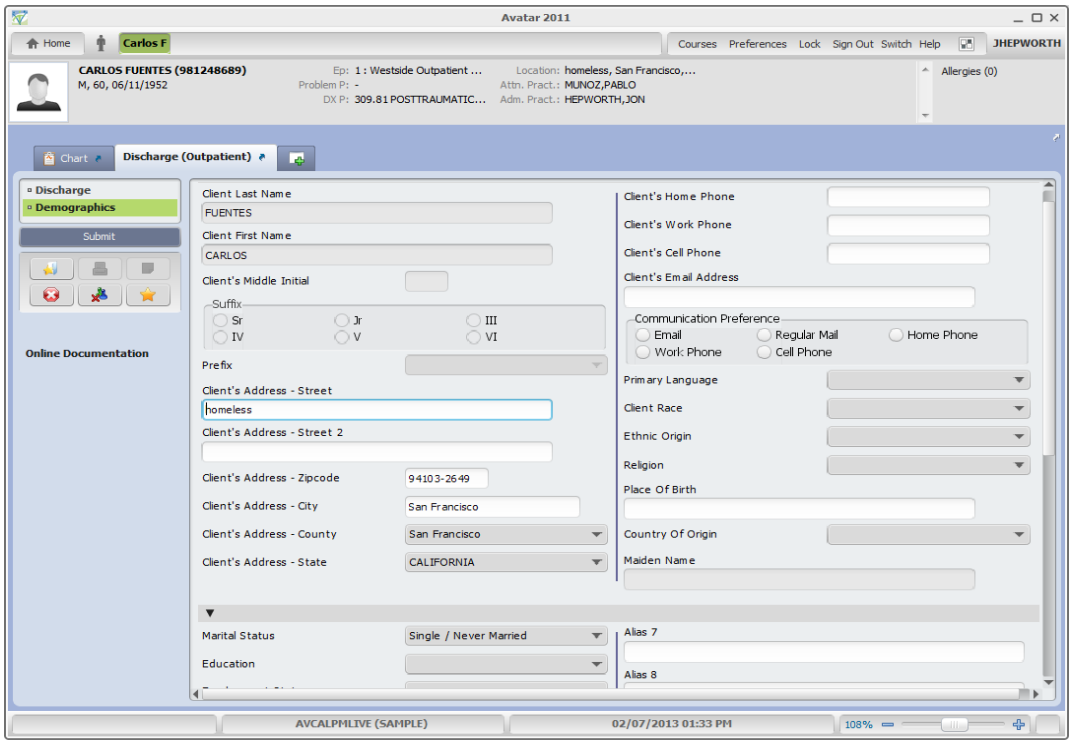
(Path: Avatar PM / client Management / Episode Management)

Discharge



Discharge (Outpatient) - continued

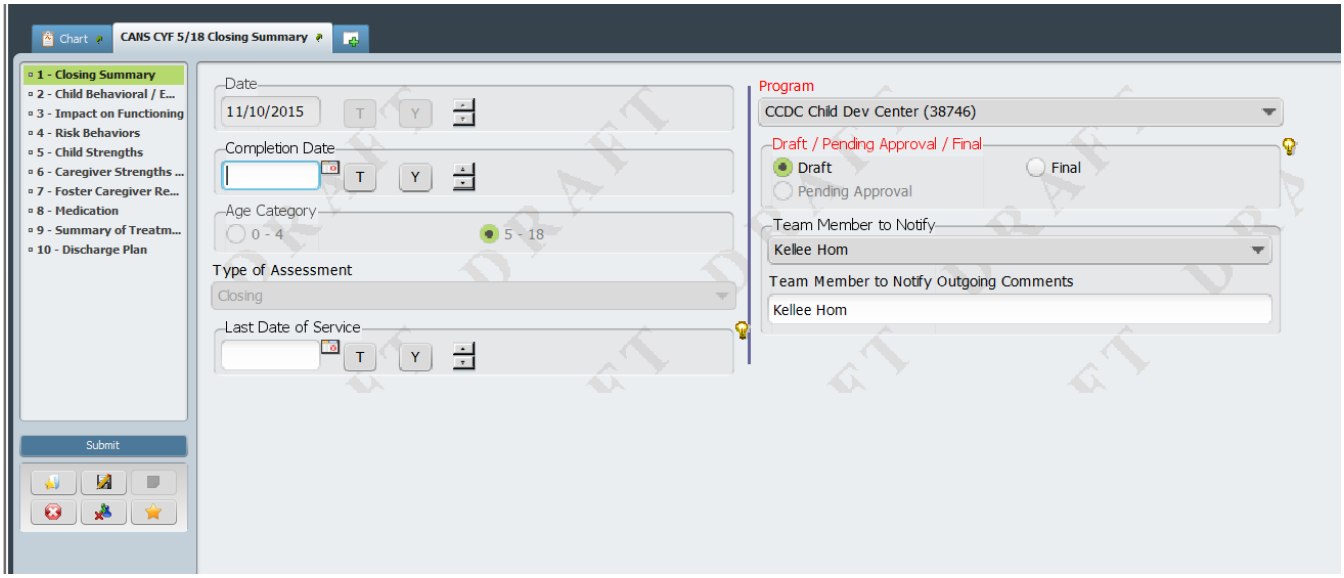
Demographics



Child Youth and Family

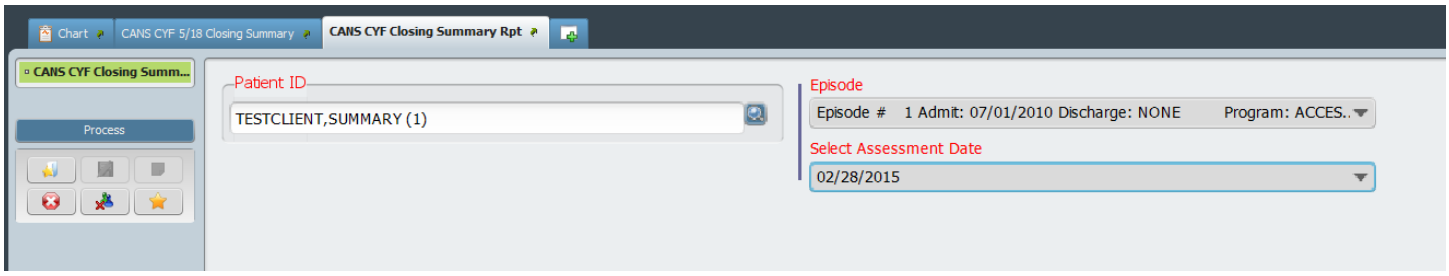
CANS CYF 5/18 Closing Summary

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



CANS CYF Closing Summary Rpt

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



San Francisco Department of Public Health
Community Behavioral Health Services

CANS CYF Closing Summary Report

NAME: TESTCLIENT,SUMMARY
Client ID #: 1
Episode Program: ACCESS Screening
Episode #: 1
Print Date: 05/23/2016

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
Clinician Address: 1380 Howard St
San Francisco, CA 94103-2638
Telephone: 415-503-4730

Type of License / Registration / Title: Unlicensed Worker

Assessment Date 2/28/2015
Completion Date
Program of Service A Better Way (38GI2)
Assessment Status Draft

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

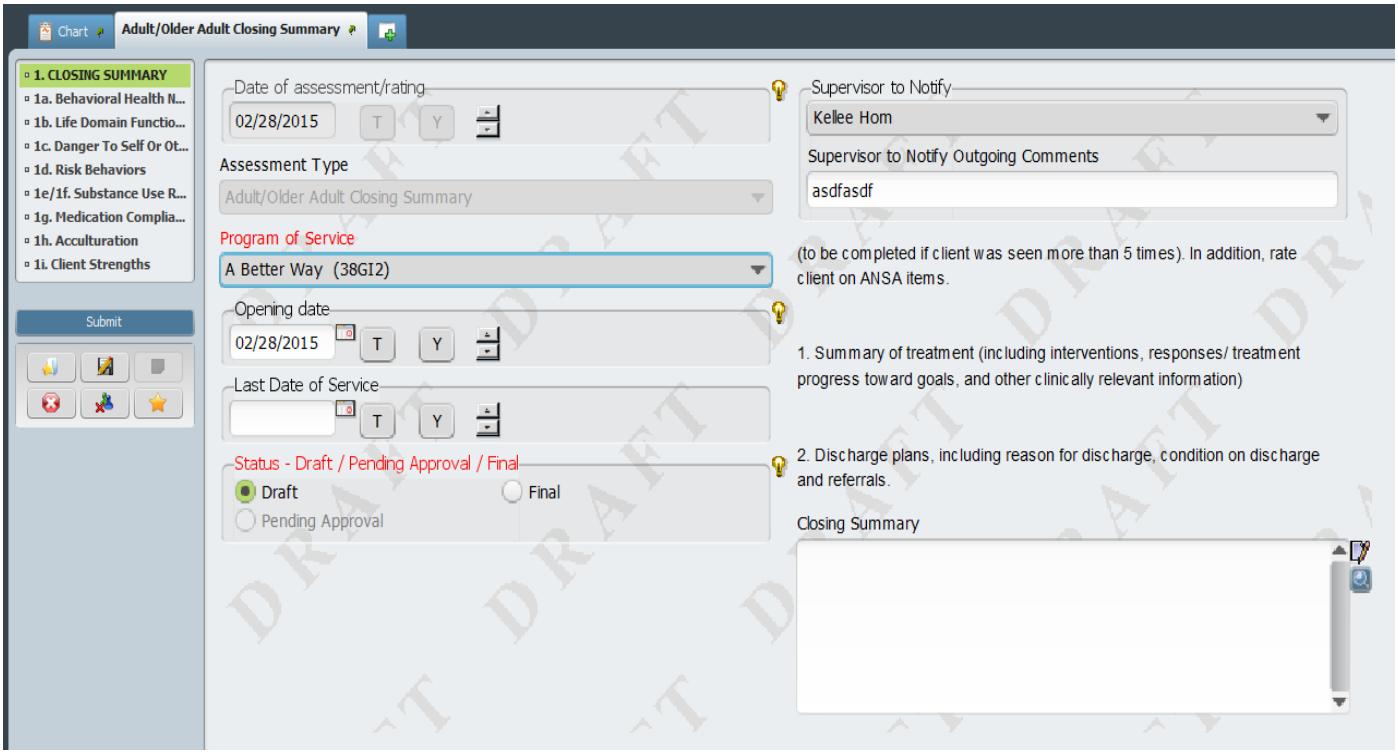
Key:0 = no evidence or no reason to believe item requuires any action. 1 = needs watchful waiting, monitoring or possibly preventive action.
2 = needs action. Strategy needed to address problem/need. 3 = needs immediate / intensive action. Immediate safety concern / priority for intervention.

Psychosis	1	Conduct	**Trauma Symptoms**
Impulse/Hyperactivity	1	Substance Use	Affect Regulation
Depression	1	Somatization	Intrusions
Anxiety		Anger Control	Attachment
Oppositional			Dissociation
			Adjustment to Trauma

ADULT / OLDER ADULT

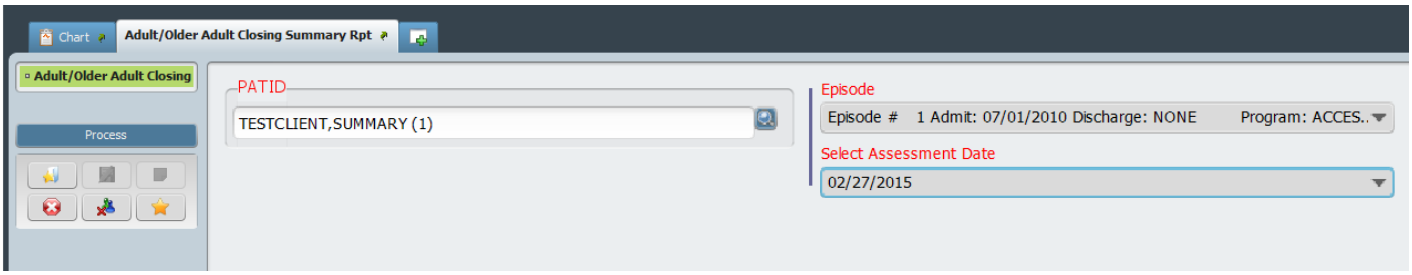
Adult/Older Adult Closing Summary

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



Adult/Older Adult Closing Summary Rpt

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



San Francisco Department of Public Health
Behavioral Health Services

Adult/Older Adult Closing Summary

Client Name: TESTCLIENT,SUMMARY
Client ID: 1
Program: ACCESS Screening (BHAC)
Episode #: 1
Admission Date: 7/1/2010
Discharge Date: None

Confidential Patient Information

Assessment Date: 2/27/2015
Assessment Type: Adult/Older Adult Closing Summary

Assessment By: Kimberly Voelker (000089)
Service Program: A Better Way (38GI2)
Assessment Status: Draft

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 — Client Information Face Sheet — Run Date: 5/23/2016
County: San Francisco — SUMMARY TESTCLIENT (1) — Page 1 of 1

Name: TESTCLIENT,SUMMARY
Address: Homeless
San Francisco, UT 94103
Phone: 415-412-1923

Number: 1
SSN: 111-11-1199
Other ID#:
Marital: Not Married
Disability: No Entry

Birthdate: 07/01/1980 Age: 35
Sex: F
Language:Korean
Education: 19 Grade
Ethnicity: Korean
Hispanic Origin: Non- Hispanic

Aliases: MUNOZ,PABLO
RP Owes $0.00

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

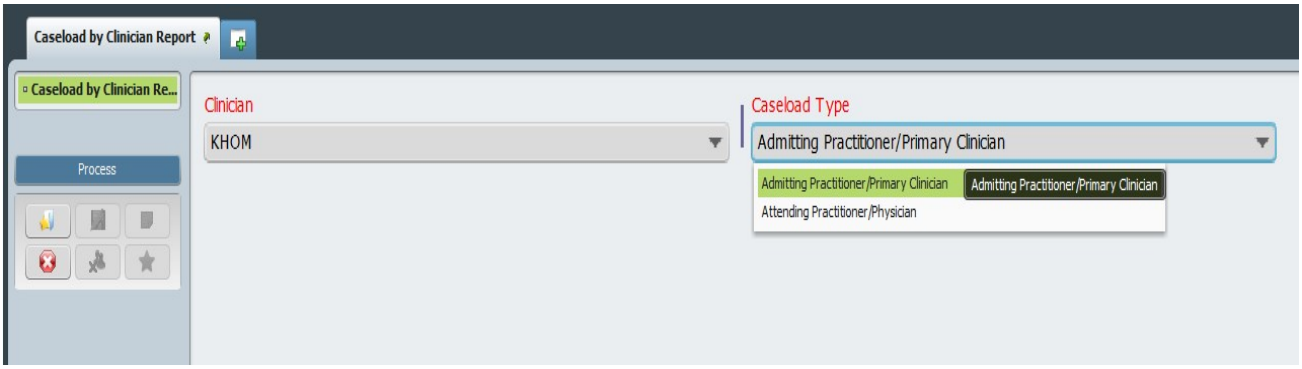
OPEN EPISODES

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,BERNADETTE (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)	415-656-0116	01/12/2016			311 301.81	 F60.81	TURNER,JOSEPH A (014450)
3	38AP	Fee for Service MFCC (38AP)	Unknown	02/28/2015	03/10/2016		296.50	F31.30	ANDERSON,HANS (013179)
2	38IM01	City College of San Francisco (38IM01)	415-239-3975	12/01/2014			305.50 E929.5 305.60	F11.90 W56.21XS F14.90	HOM,KELLEE (003865)

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

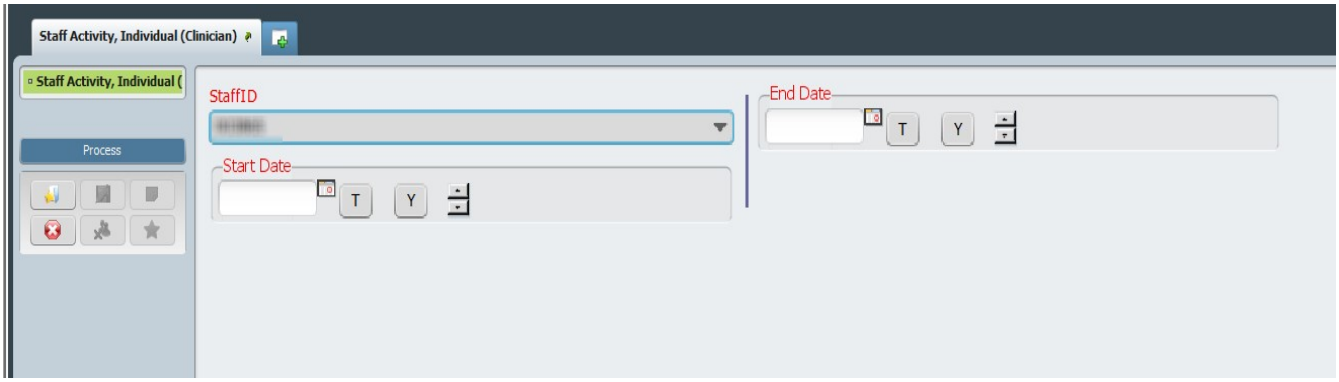
Admitting Practitioner/Primary Clinician
Kellee Hom (003865)

Confidential Patient Information

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

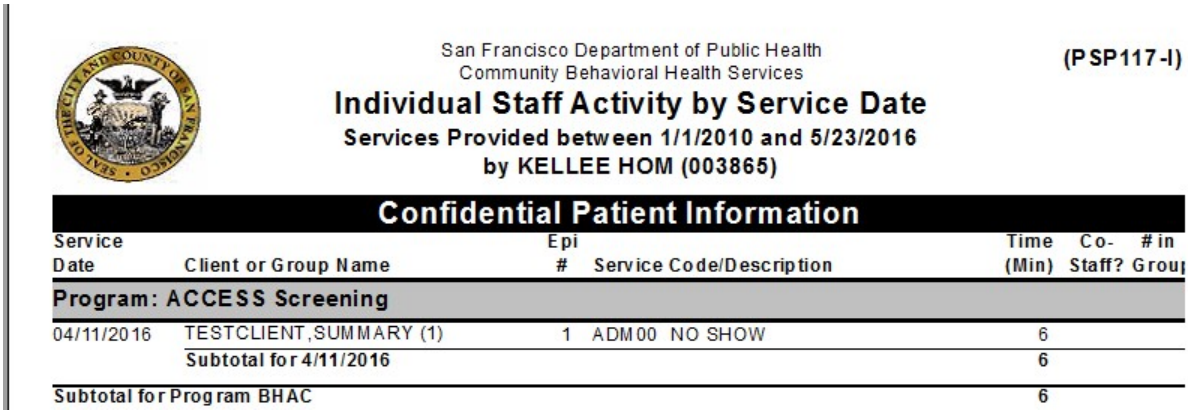
Staff Activity By Program Detail Report

(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 KELLEE HOM (003865)

Confidential Patient Information

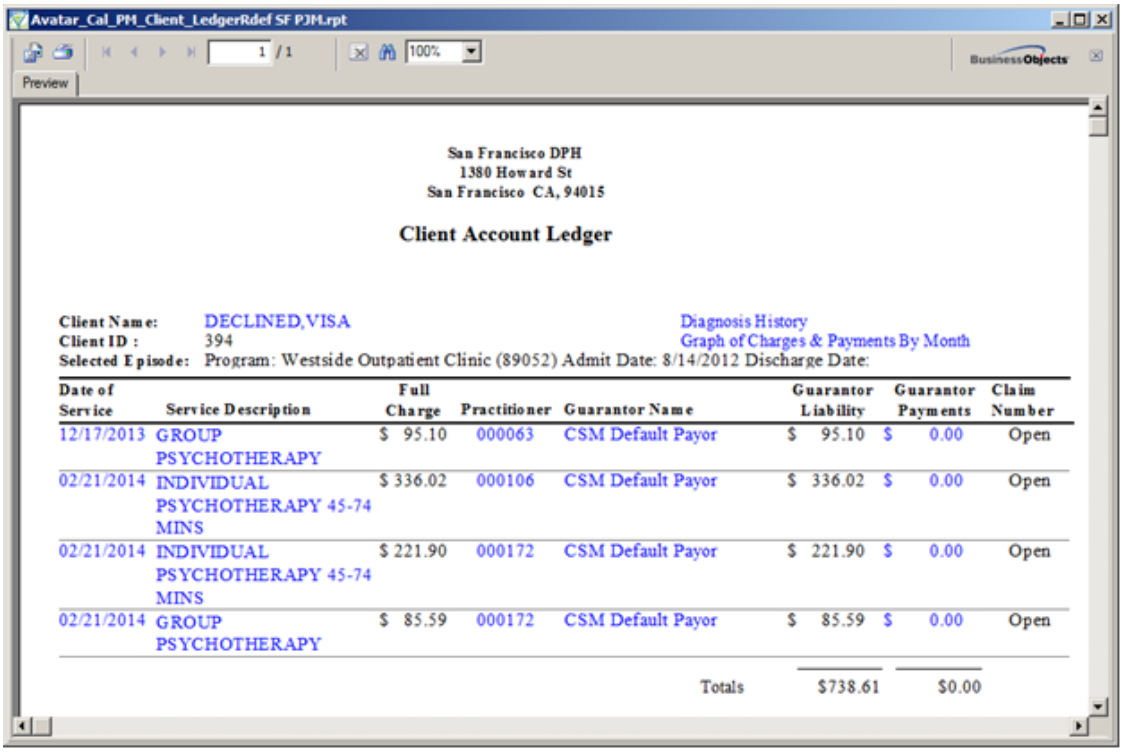
Service Date	Client or Group Name	Epi #	Service Code/Description	Time (Min)	Co-Staff?	# in Grou
Program: ACCESS Screening						
04/11/2016	TESTCLIENT,SUMMARY (1)	1	ADM00 NO SHOW	6		
	Subtotal for 4/11/2016			6		
Subtotal for Program BHAC				6		

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

Preview

San Francisco DPH
1380 Howard St
San Francisco CA, 94015

Client Account Ledger

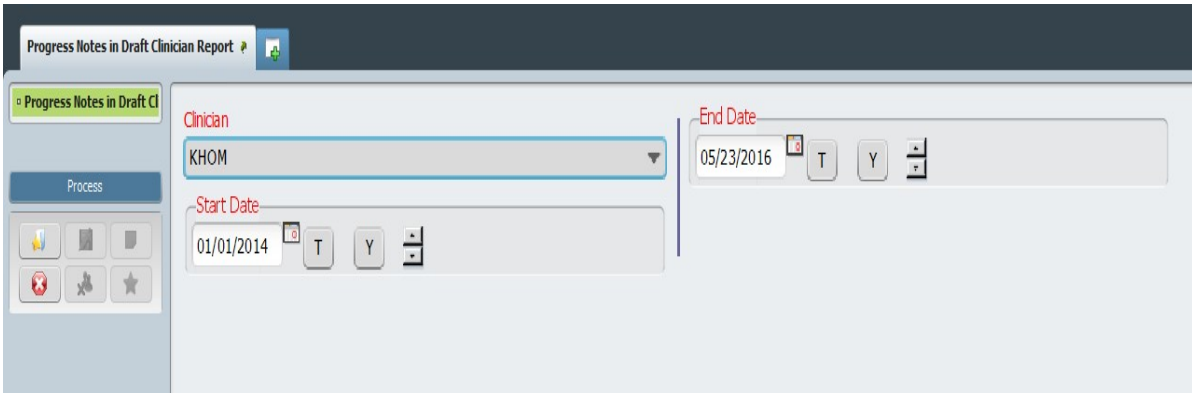
Client Name: DECLINED,VISA
Client ID : 394
Selected Episode: Program: Westside Outpatient Clinic (89052) Admit Date: 8/14/2012 Discharge Date:

Diagnosis History
Graph of Charges & Payments By Month

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:**

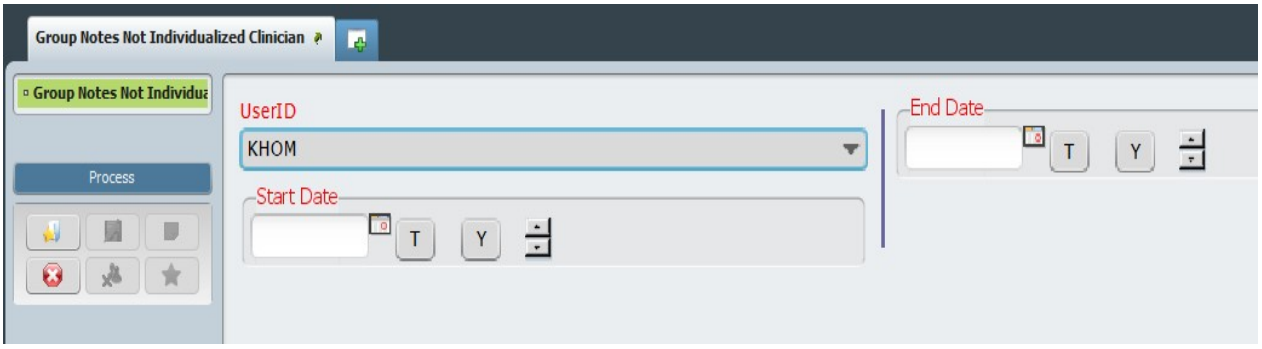
Service Date (or Note Date if Independent Note): **5/30/2015**
Service Code: NO SHOW **(ADM00)**
Service Program: ACCESS Screening
Practitioner: HOM,KELLEE (003865) PhD/PsyD — **FTF:** 10 min — **Doc/Trav:** min
Location: Other Place of Service
Status: Draft — **Note Type/For:** BHAC Administrative / 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)



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

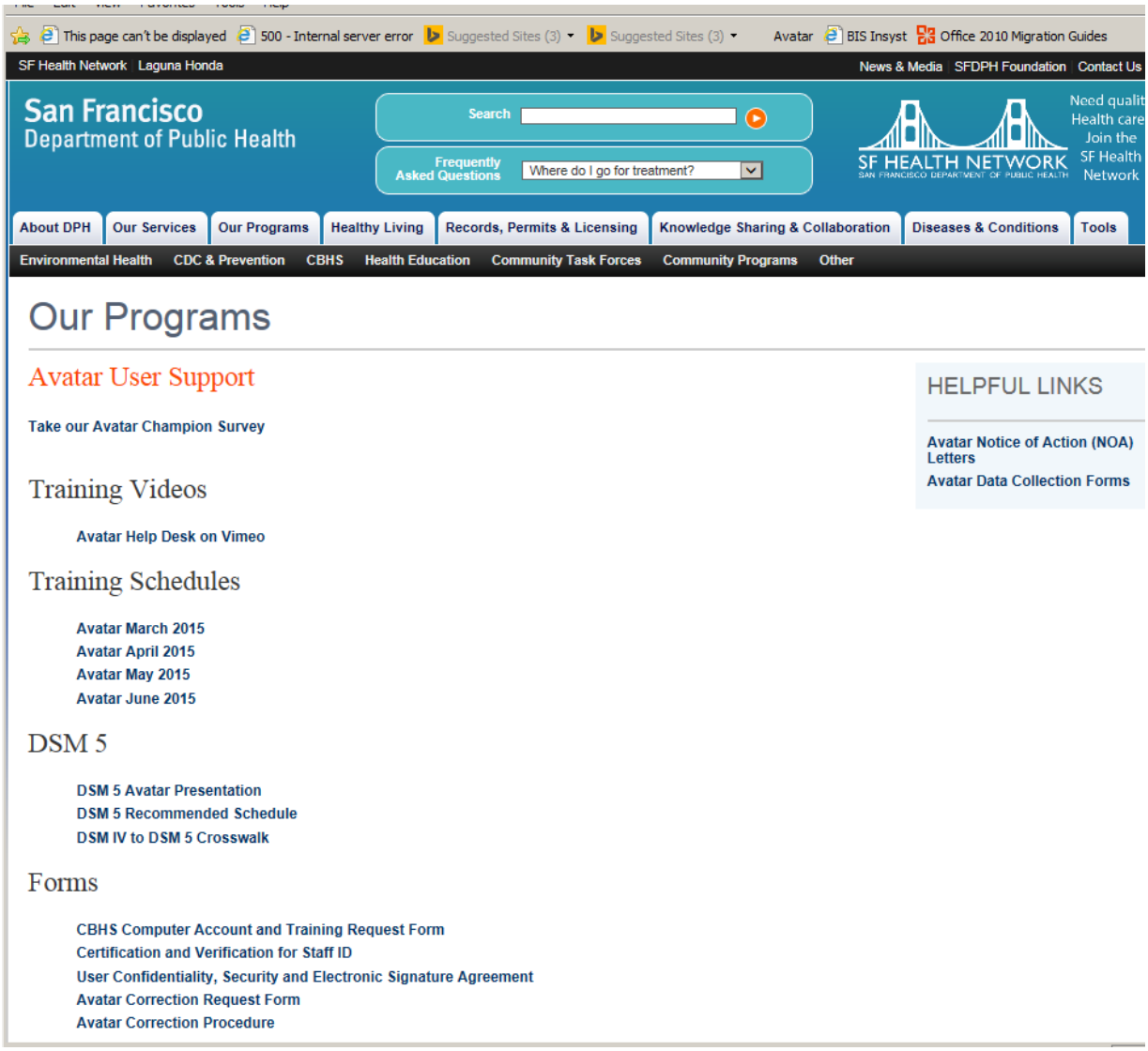
URL address: www.sfdph.org/dph/

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

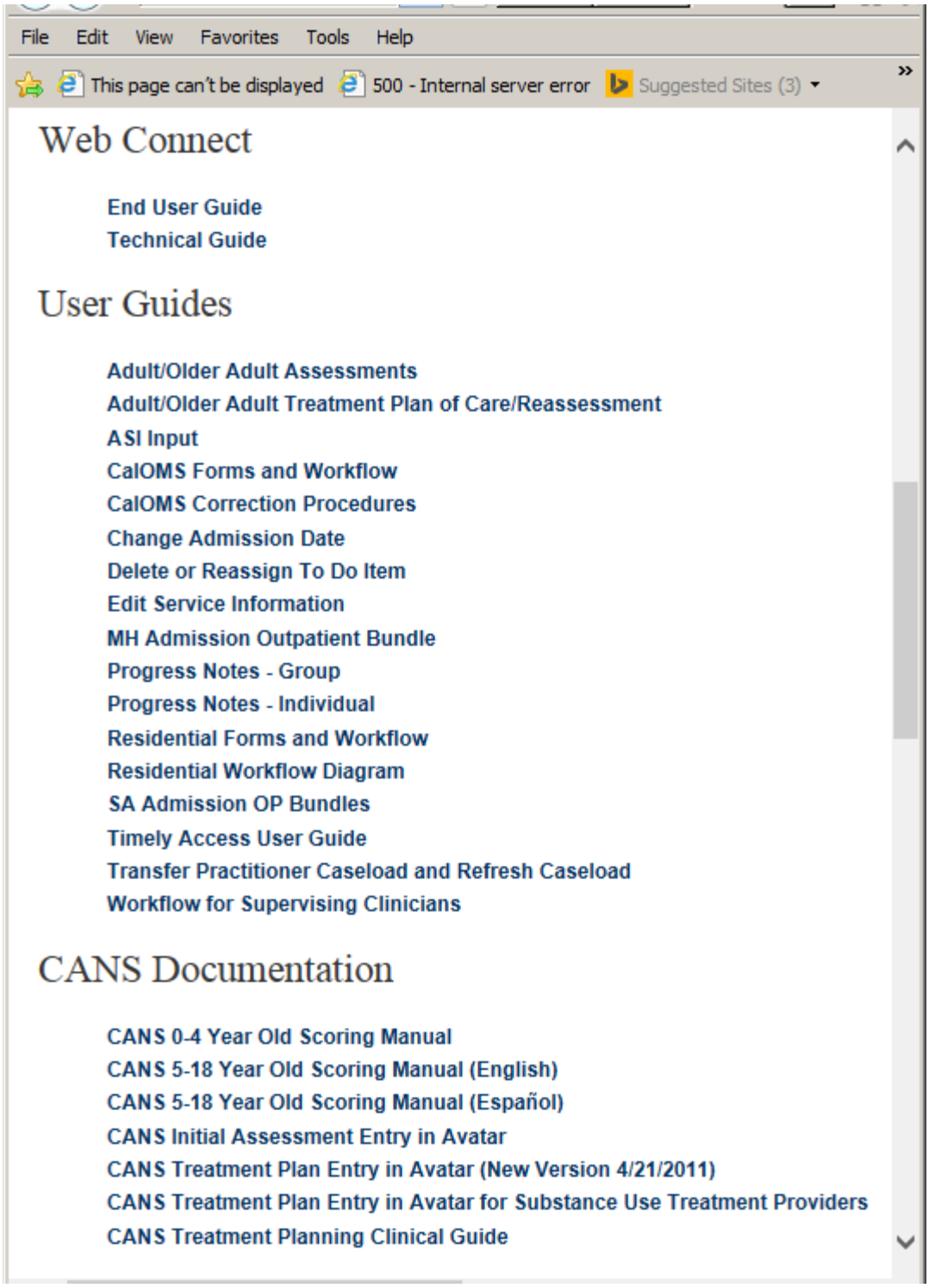
Select “**SF Avatar User Documentation**” link.

You will see the page, below.

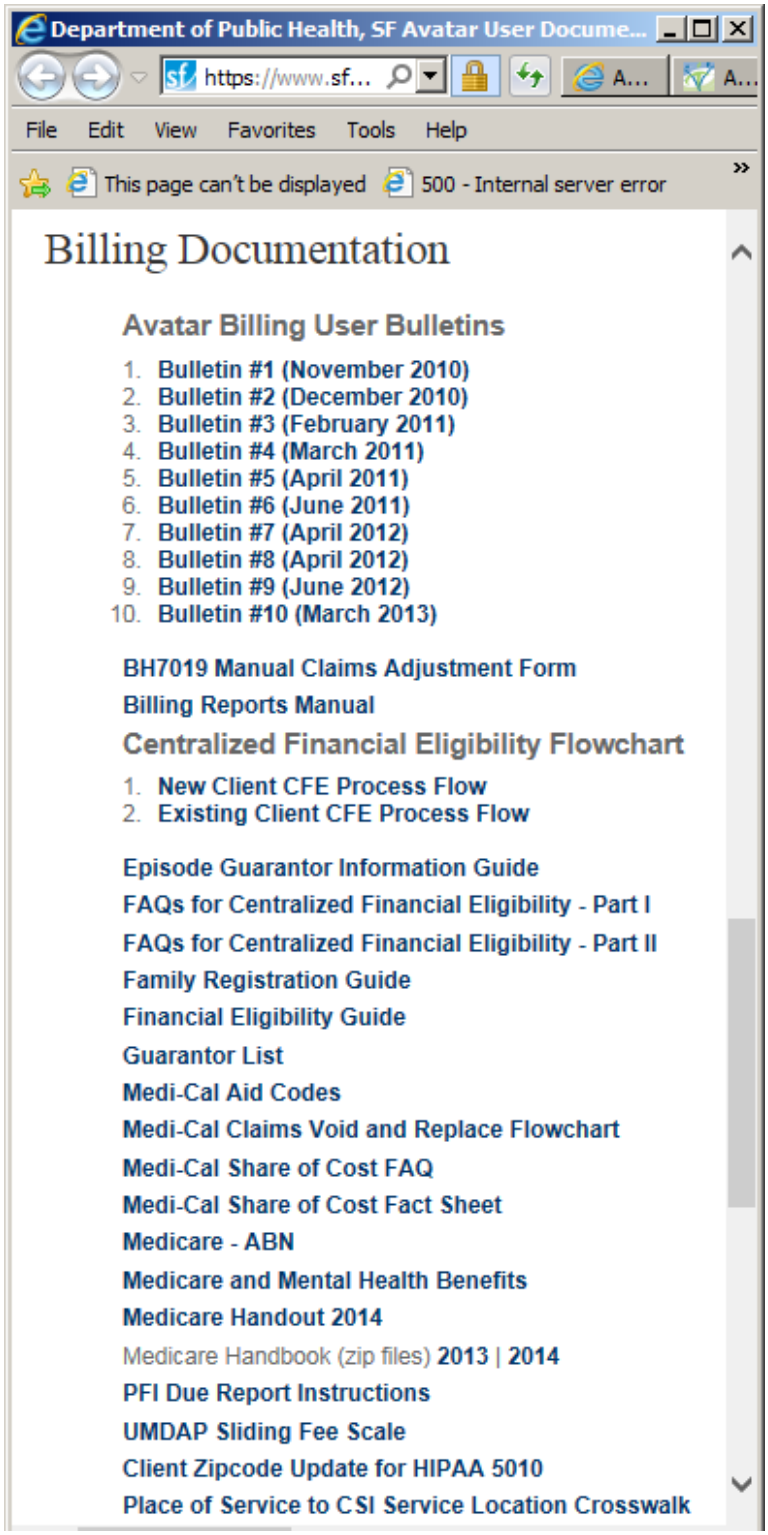
Save the page as an internet favorite.



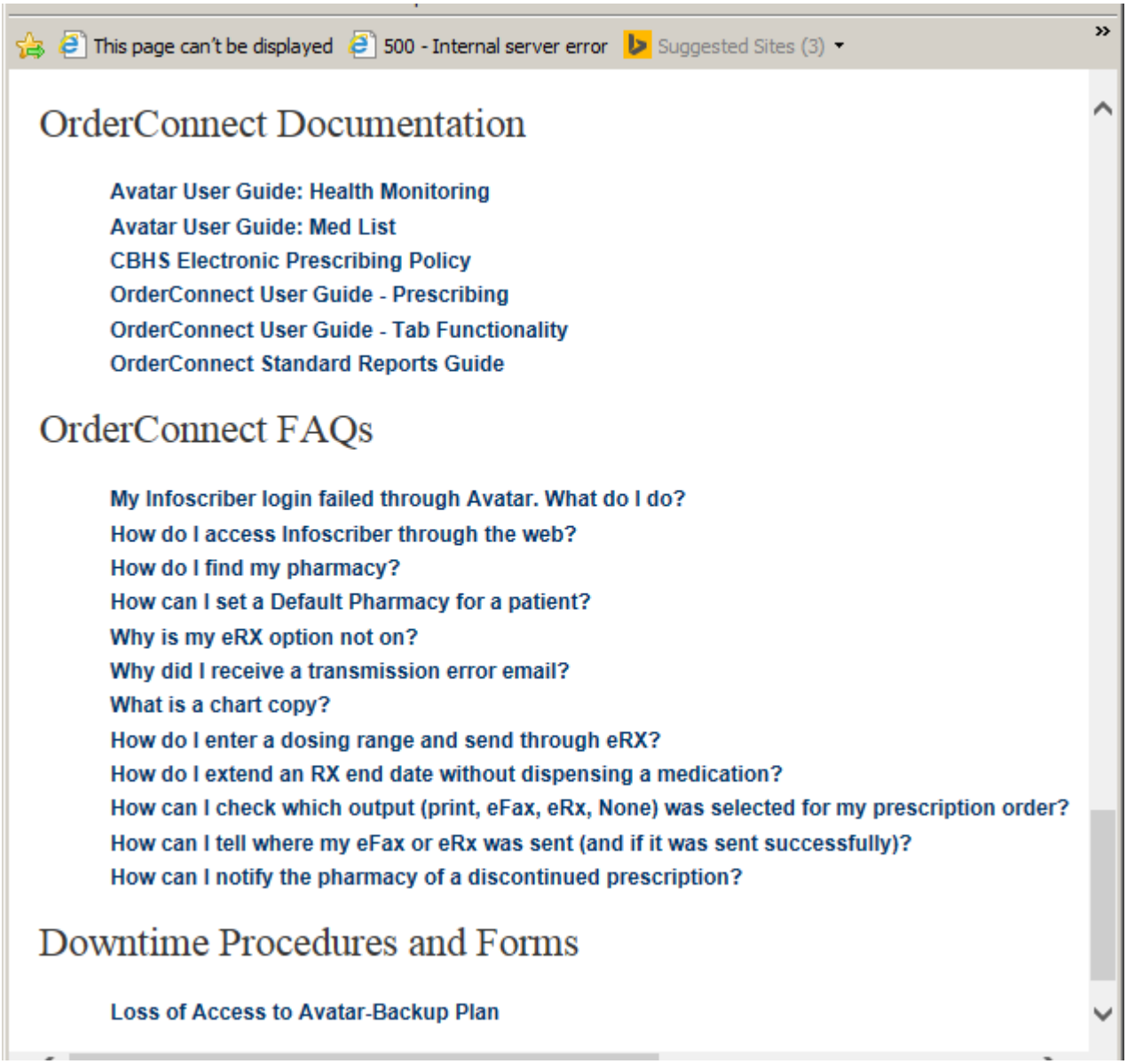
Avatar Documentation Website (continued)



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

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: *No spaces before or after the comma*	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: *Avatar does not use military time*	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

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"

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