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# **Avatar Clinical Training**

## **Substance Use Disorder**

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

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



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## Table of Contents

INTRODUCTION .....	1
Contact Information for Avatar Questions .....	1
HIPPAA & Privacy Statement .....	2
Protected Health Information (PHI) .....	2
Learning Objectives .....	2
AVATAR OVERVIEW .....	1
Logging into WebConnect (Community Based Organizations) .....	1
Welcome to The Department of Public Health’s WebConnect Portal .....	1
NetSmart Avatar .....	13
Avatar Log in .....	14
Logging into Avatar: Passwords .....	14
Avatar Modules .....	14
Avatar Work Flow .....	15
Navigation.....	16
Avatar Home View.....	16
Avatar Chart View .....	17
Avatar eLinks .....	18
Current Medications, Labs, Vitals .....	18
TIMELY ACCESS .....	19
Timely Access.....	19
OVERVIEW OF EPISODE OPENING .....	21
Admission Bundles.....	21
SA Admission OP CalOMS Program Bundle.....	21
SA Admission OP Non CalOMS Prgm Bundle .....	21
SA Admission Res CalOMS Prgm Bundle .....	22
SA Admission Res Non CalOMS Prgm Bundle .....	22
ADMISSION BUNDLE FORMS .....	23
Admission (Outpatient) .....	23
CalOMS .....	28
Episode Guarantor Information.....	29

---

Contact Information .....	30
Admission Referral Information .....	31
Forms Bundle.....	32
ADMISSION DIAGNOSIS .....	33
Diagnosis.....	33
Diagnosis by Client Report.....	34
TRANSFER CASELOAD .....	35
Transfer Practitioner Caseload .....	35
SUBSTANCE USE DISORDER ASSESSMENT (ADULT).....	37
ASI Input .....	37
ASI Summary Report:.....	39
ASI Composite Scores: .....	40
ASI Rating Graphs: .....	41
SUD Level of Care Recommendation.....	42
Printing the SUD Level of Care Recommendation.....	43
SUD Continuing Services Justification.....	44
SUD Continuing Svcs Justification.....	44
Printing the SUD Continuing Svcs Justification.....	45
SUD Treatment Plan of Care/Recovery Plan.....	46
SUD TPOC/Recovery Plan .....	46
SUD TPOC Signature Addendum .....	47
SUD TPOC/Recovery Plan Report .....	48
PROGRESS NOTES (GROUP AND INDIVIDUAL).....	49
Progress Notes Group and Individual Form.....	49
Progress Notes – Interns with Cosign.....	50
Progress Notes Without Pagebreaks.....	51
Append Progress Notes .....	52
PROGRESS NOTES (GROUP AND INDIVIDUAL).....	53
Individual Progress Notes User Guide .....	53
Introduction:.....	53
Entering Individual Notes: .....	54
Retrieving Draft Notes: .....	57

---

Group Registration .....	60
Group Progress Notes User Guide.....	62
Introduction: .....	62
Creating Group Progress Notes:.....	63
Individualize the Group Note: .....	68
SERVICE CORRECTIONS .....	78
Edit Service Information .....	78
DISCHARGE BUNDLES.....	79
Discharge (Outpatient) .....	79
Discharge .....	79
Demographics .....	80
REPORTS.....	81
MHS140 Report .....	81
Caseload by Clinician Report .....	82
Staff Activity By Program Detail Report.....	83
Crystal Client Ledger .....	84
Progress Notes in Draft Clinician Report .....	85
Group Notes Not Individualized Clinician.....	86
AVATAR DOCUMENTATION WEBSITE.....	87
KEYBOARD SHORTCUTS & STANDARD FORMATS.....	91
Avatar Admission (PM) Common Error List .....	93
Updated: April 23, 2012 .....	93
Avatar Clinical (CWS) Common Error List .....	94
Updated: April 23, 2012 .....	94
AVATAR CORRECTION REQUEST FORM .....	96
BLANK SAMPLE .....	96
AVATAR FAVORITES .....	97
Admissions.....	97
Assessments .....	98
Treatment Plans, Progress Notes, Discharge & Reports .....	99
Treatment Plan of Care .....	99
Progress Notes: .....	99

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Discharge:.....	99
Reports: .....	99

# INTRODUCTION

## Contact Information for Avatar Questions

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

Erik Dubon [erik.dubon@sfdph.org](mailto:erik.dubon@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

## HIPAA & 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

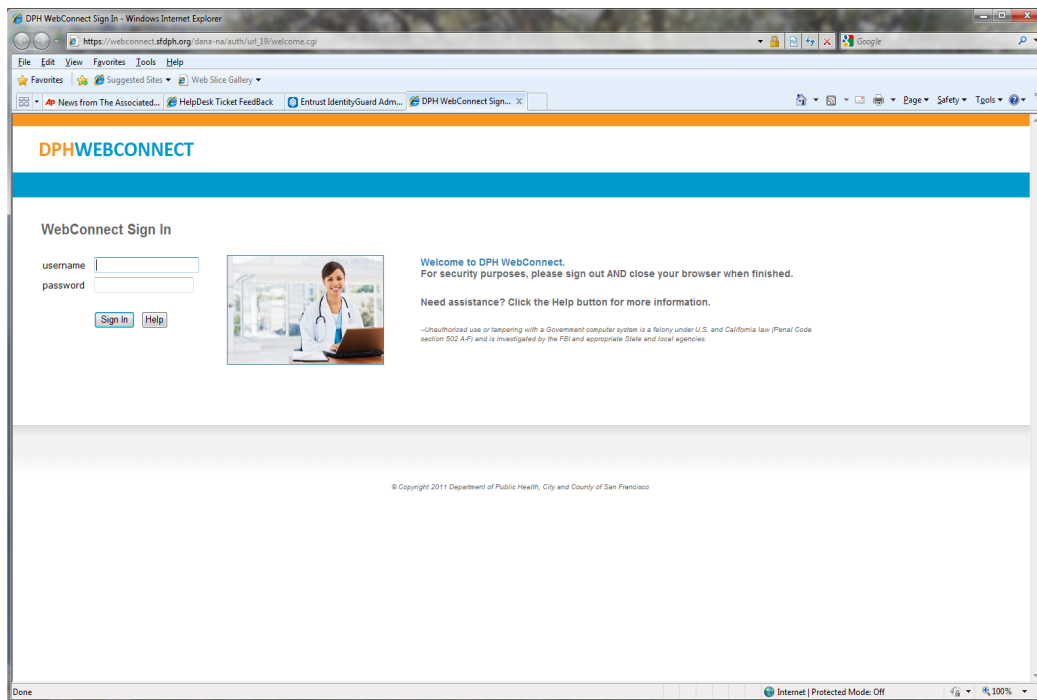
You have been issued a first time access password to activate your WebConnect account.

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

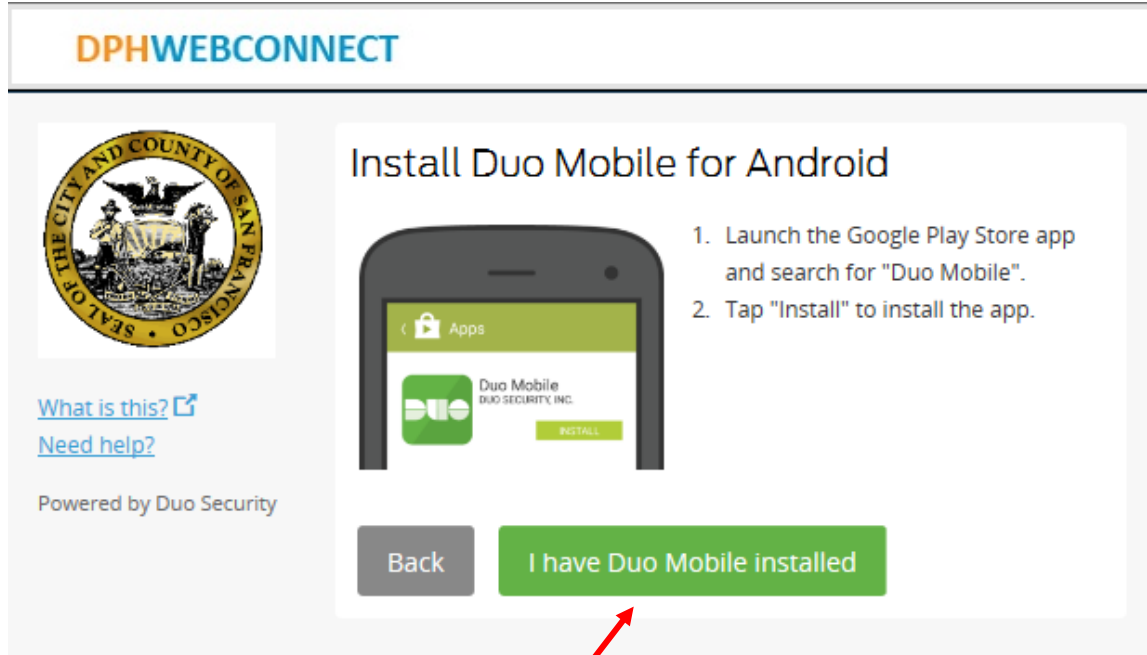
☐ Windows Phone

☐ Other (and cell phones)



Back

Continue

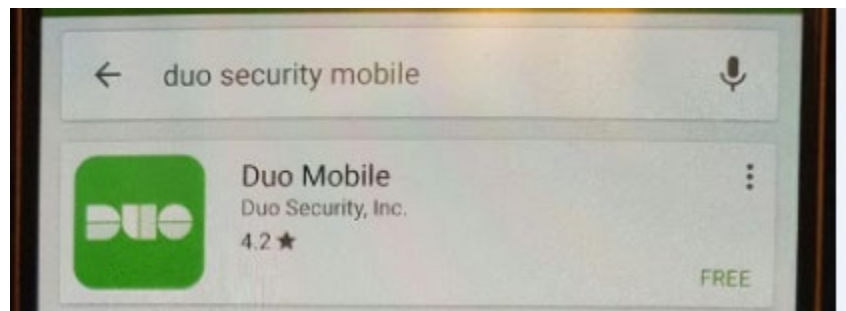
After selecting your phone type you will be asked to install the appropriate mobile application



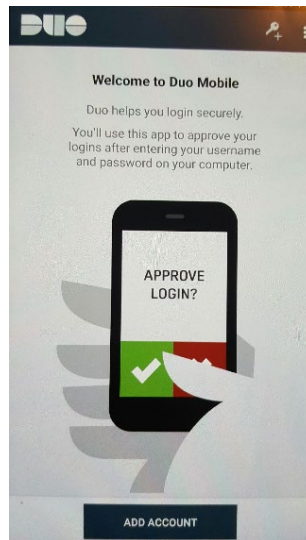
Click here **after the mobile app has been downloaded and installed.**

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

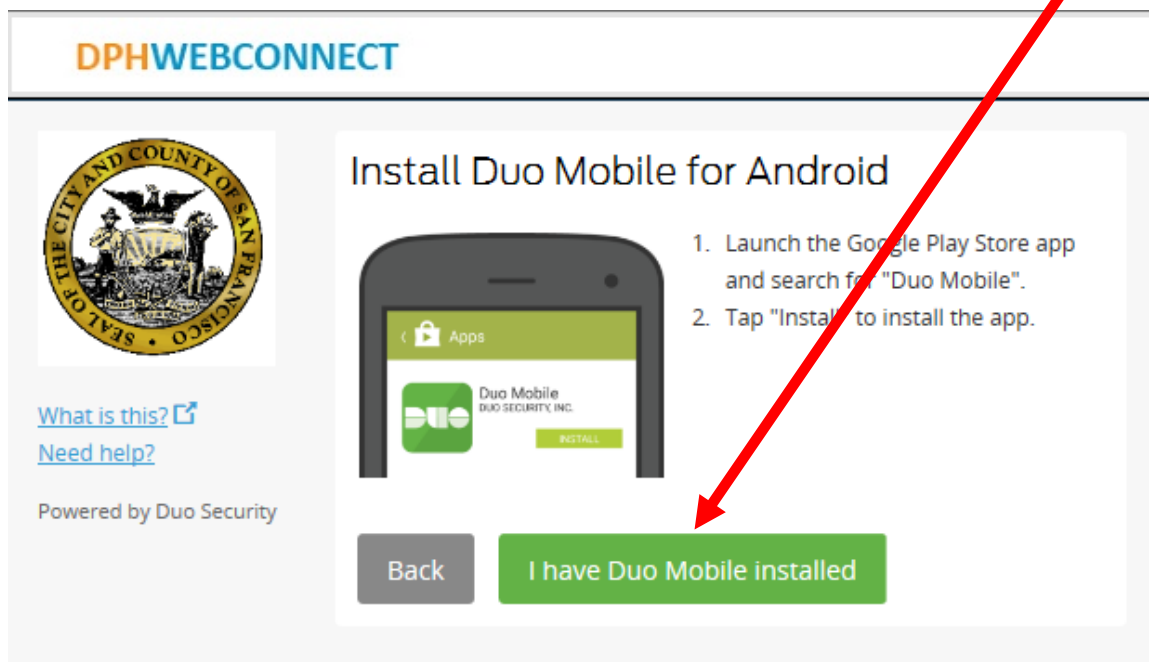
Search for mobile named "DUO SECURITY MOBILE" in your app store and install it.



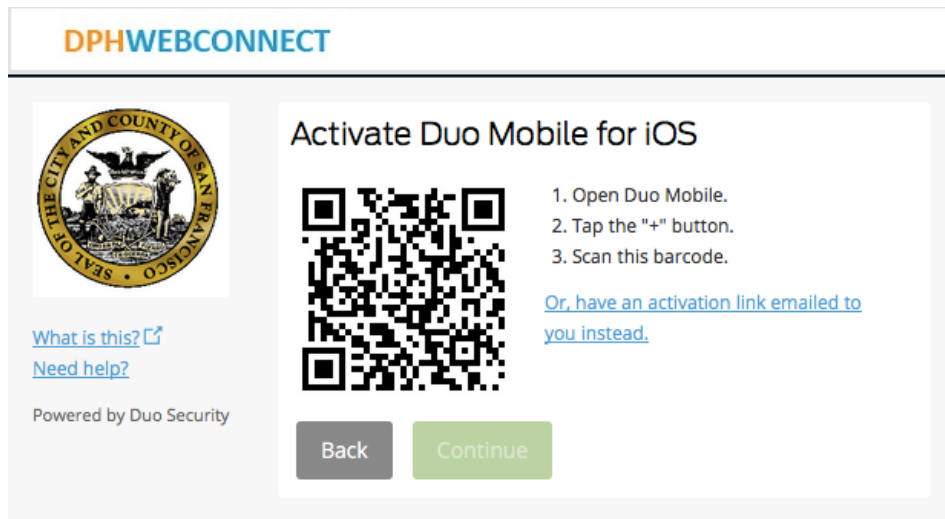
Once the app is installed on your mobile device, open it to get the following registration screen.



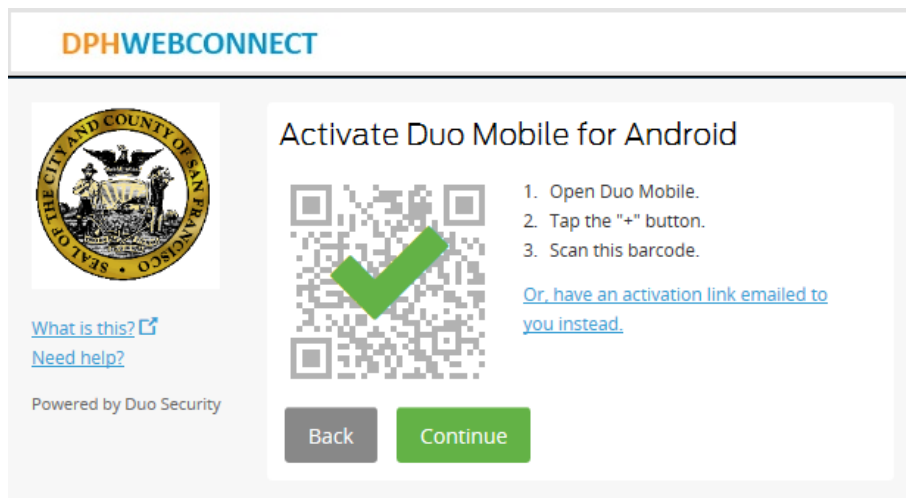
Click on “ADD ACCOUNT” and go back to your computer screen to click on “I have DUO Mobile Installed”.



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

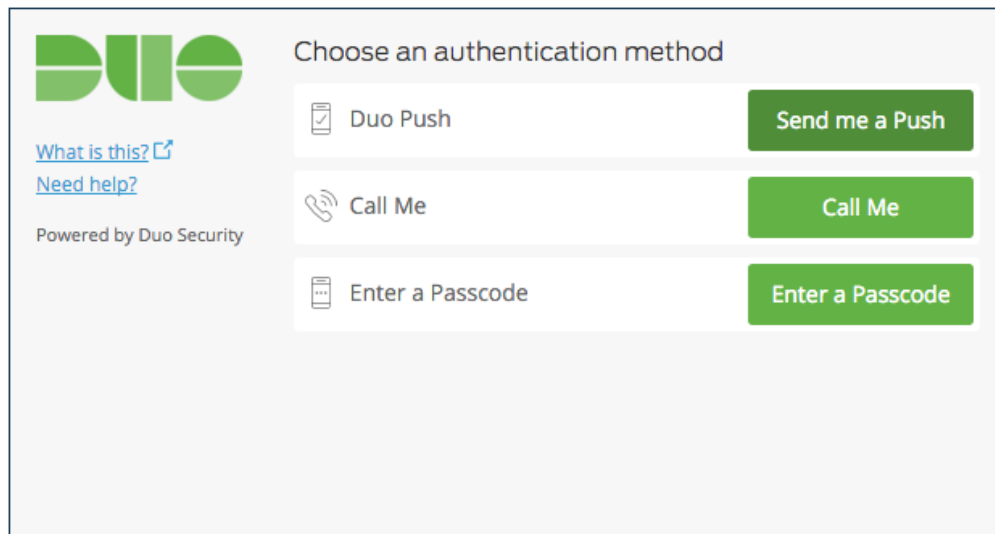
 Android (415) 555-1212

**Done**

Device successfully added!

**Continue to login** 

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

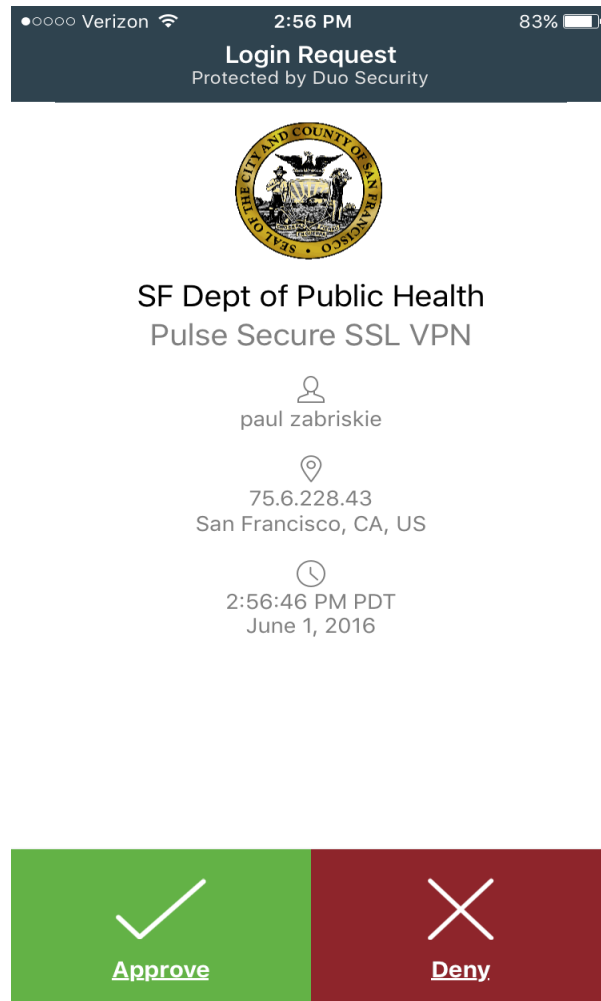


**Duo Push Authentication:** This is the recommended and easiest authentication method to use if you have a Smart Phone.

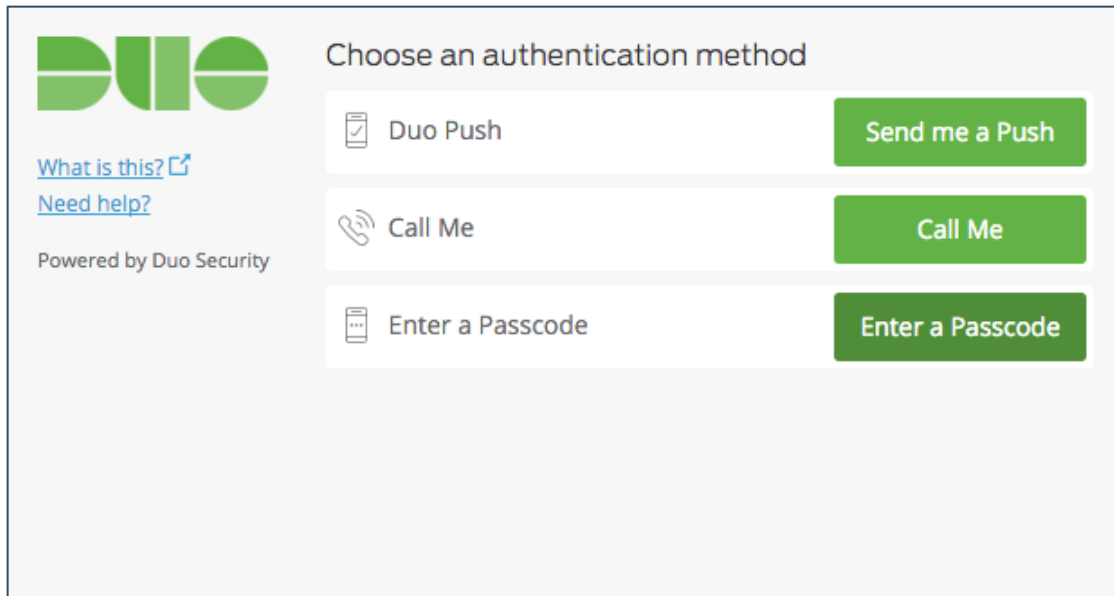
1. Click **Send me a Push**.
2. Press the green **Approve** box on your device to log in.
  - a. If you do not receive the Duo Push automatically, go into the Duo Mobile app and pull down to refresh



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



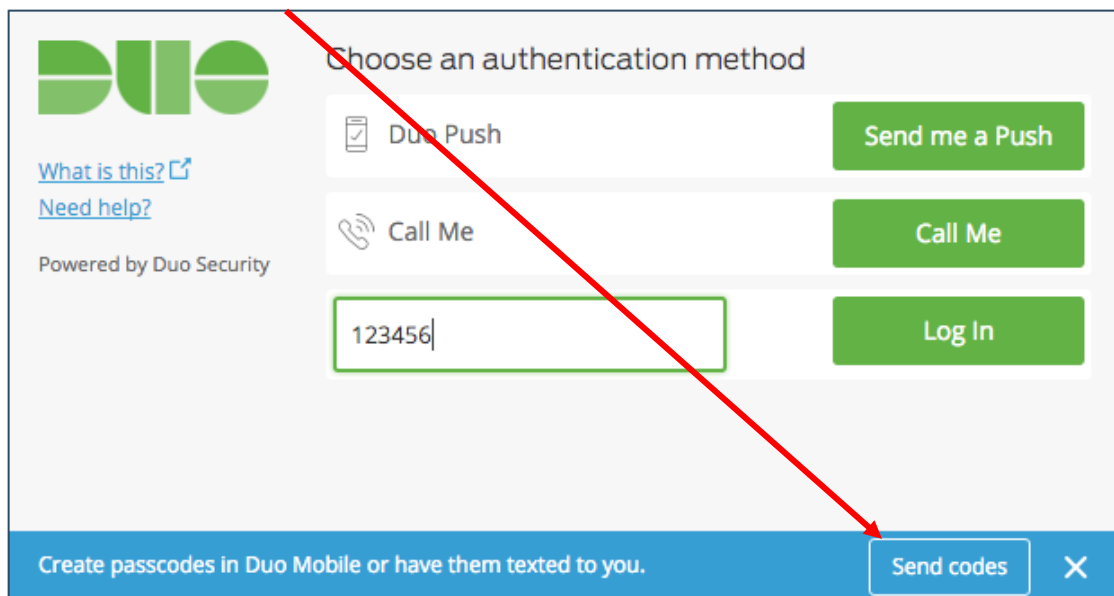
**Alternative Options for Authentication:** If you do not have a Smart Phone, or choose not to install the Mobile App, you have the option to Select **“Enter a Passcode”**



The image shows the Duo Security 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:

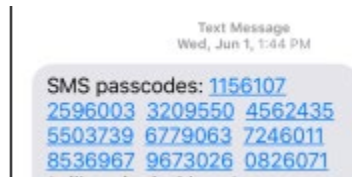
Icon	Label	Button
Smartphone with checkmark	Duo Push	Send me a Push
Phone handset	Call Me	Call Me
Keypad with dots	Enter a Passcode	Enter a Passcode

Now click on **“Send codes”**



This image shows the same Duo Security interface as above, but with a red arrow pointing from the 'Enter a Passcode' option to the 'Send codes' button in the bottom right corner. The 'Enter a Passcode' input field now contains the text '123456'. The bottom bar is blue and contains the text 'Create passcodes in Duo Mobile or have them texted to you.' and the 'Send codes' button.

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.

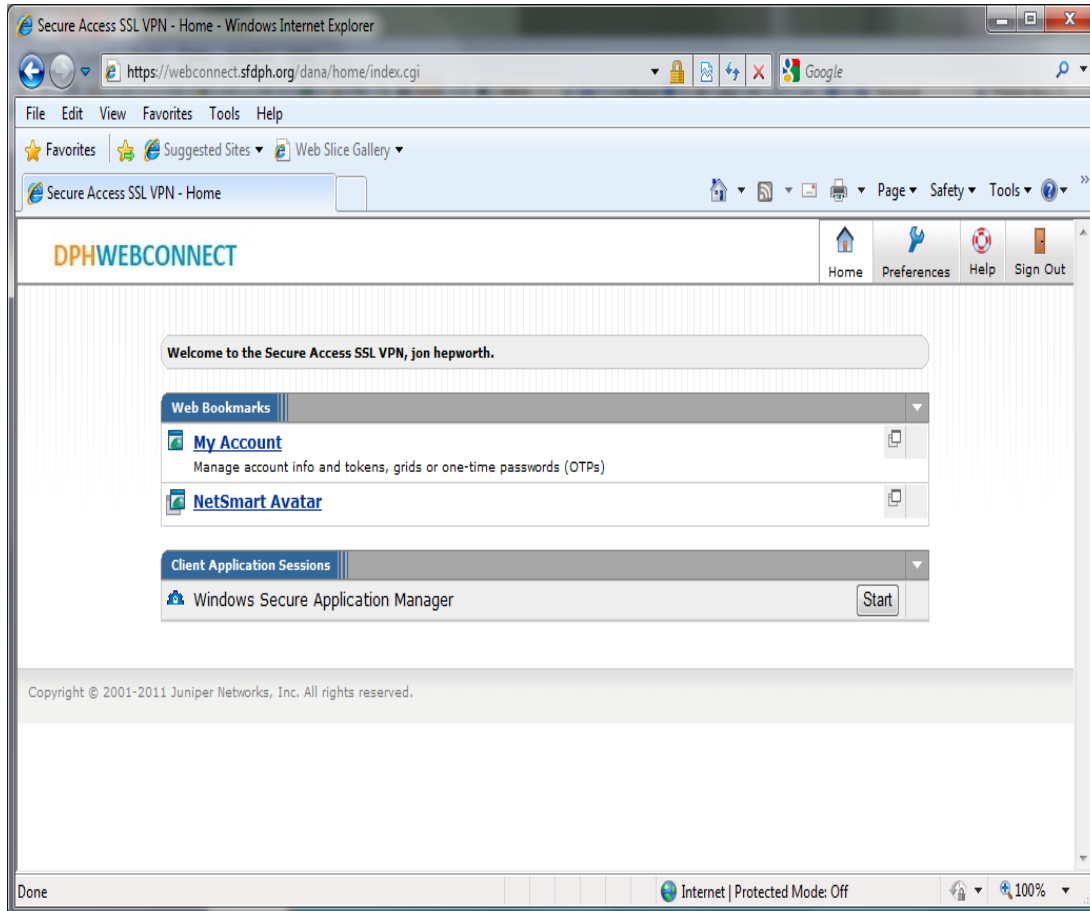


Enter **one** of the 10 **passcodes** sent in the text message and click on **“Log In”**

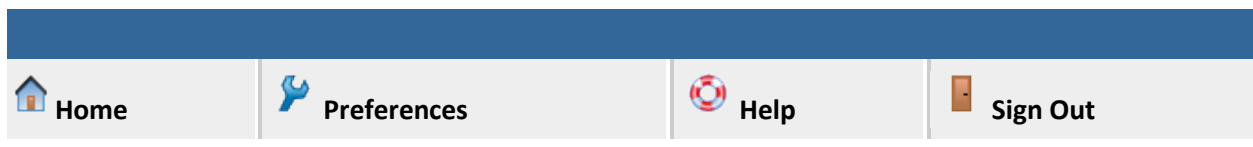
A screenshot of the Duo authentication interface. On the left is the Duo logo and links for "What is this?" and "Need help?". The main heading is "Choose an authentication method". There are three options: "Duo Push" with a "Send me a Push" button, "Call Me" with a "Call Me" button, and a text input 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

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?

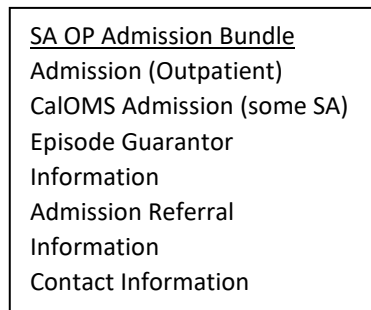
- Substitute numbers or symbols for letters
- A favorite song title:  
Happy Birthday to You = H8pp1Birthd8y2u
  - Uses upper/lower case
  - "8" substituted for "a"
  - "1" substituted for "y"
  - "2" for "to"
  - "u" for "you"

## Avatar Modules

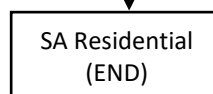
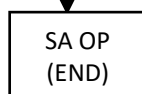
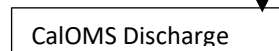
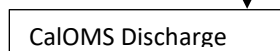
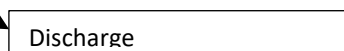
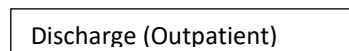
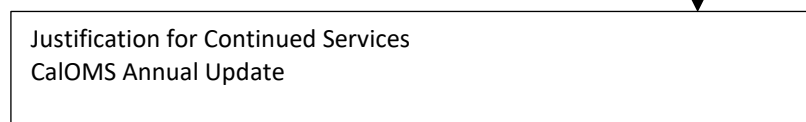
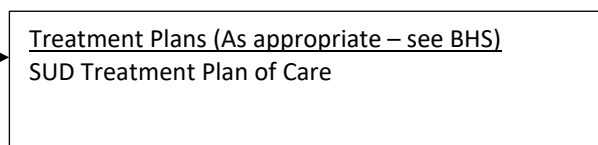
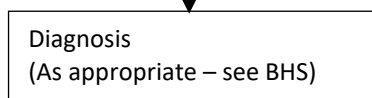
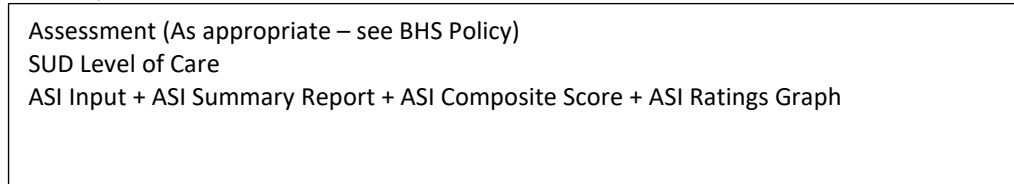
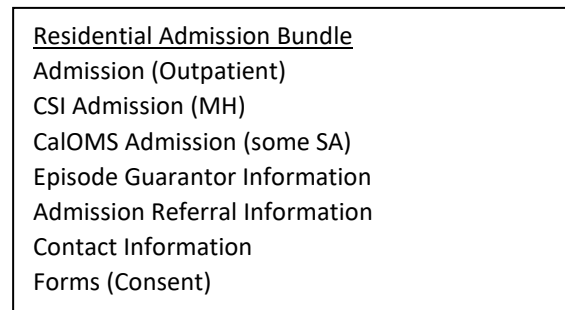
- PM – Practice Management
- CWS – Clinical Work Station
- MSO – MSO Managed Service Organization

## Avatar Work Flow

### Episode Opening

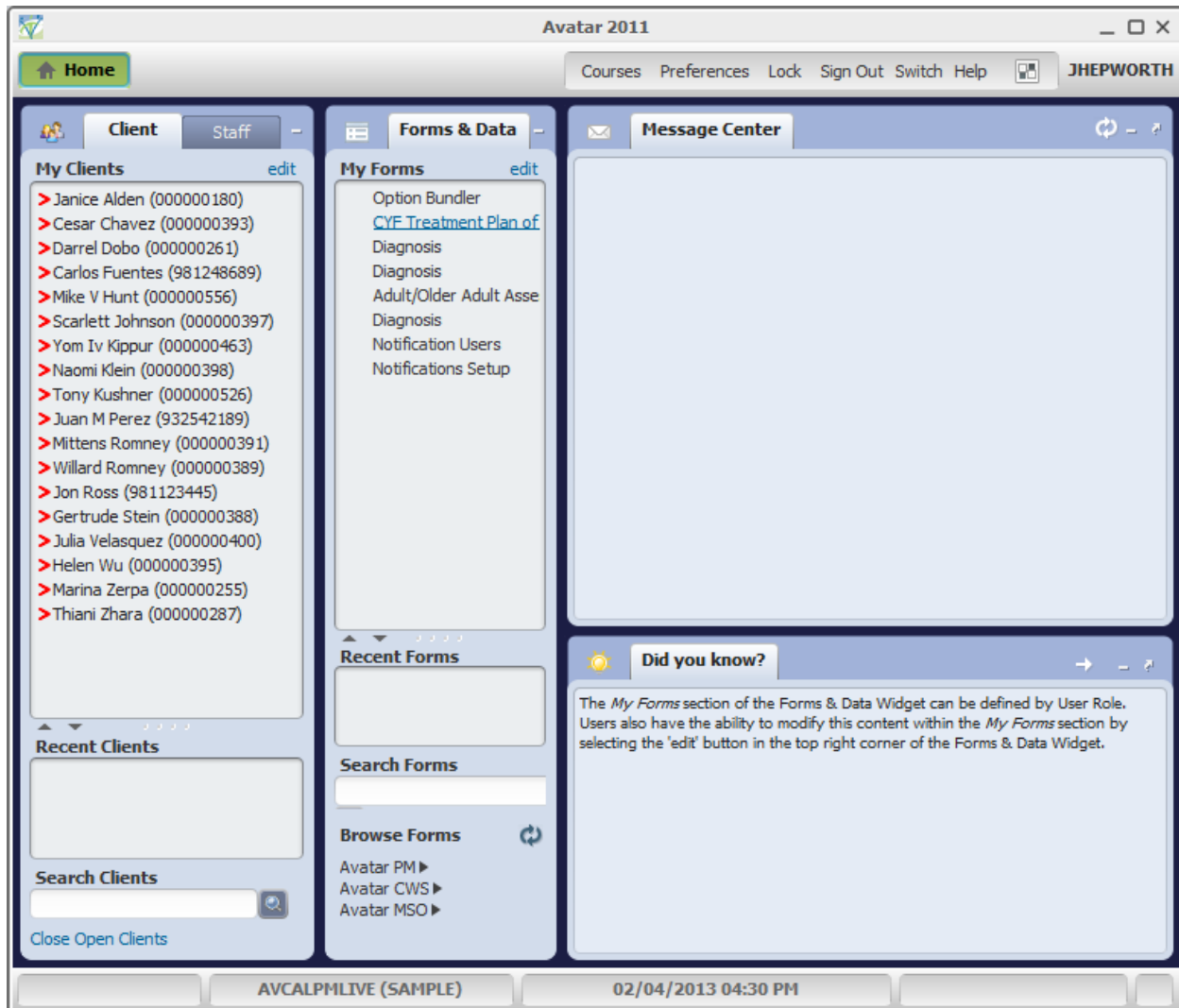


### Episode Opening



## 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

[Links 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
05/17/2015	100/70	200	71	27.9
08/19/2015	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:

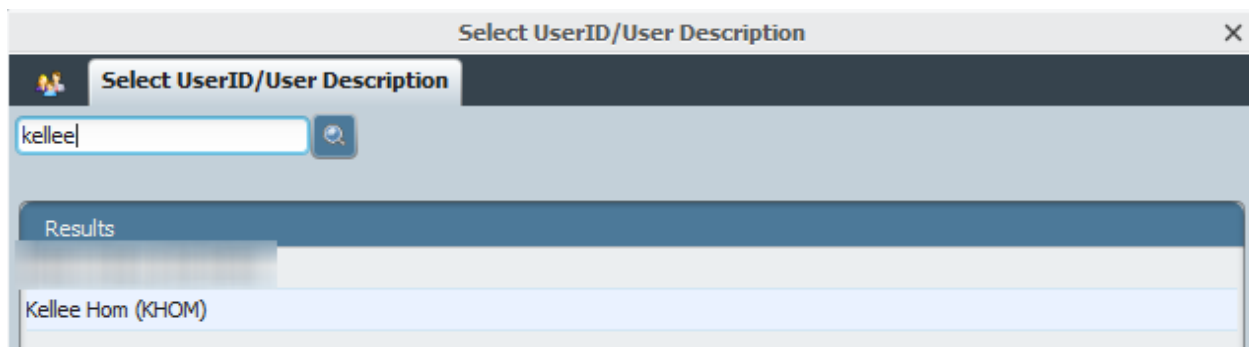
ELinks page/return to Chart view
Current Medications, Lab Results, Vitals

# TIMELY ACCESS

## Timely Access

(Path: Avatar PM/ New Forms)

BHS requires that Programs record the time to first offered appointment in accordance with the Department of Health Care Services requirement that clients are offered an appointment within 10 business days. Record the date of request for services and date of first offered appointment on the Timely Access Screen. You may exceed the 10 days if you attest that the client is not in crisis and is able to wait beyond the 10 days for services.



The screenshot shows a window titled "Select UserID/User Description" with a close button (X) in the top right corner. Below the title bar is a search bar containing the text "kellee" and a magnifying glass icon. Below the search bar is a section labeled "Results" which contains a single entry: "Kellee Hom (KHOM)".



The screenshot shows the bottom of the dialog box with four buttons: "Add", "Edit", "Delete", and "Cancel". A red arrow points from the "Add" button to a text box below.

Click "Add" to log a new entry.

## Timely Access (continued)

Timely Access

Submit

First Request for Services

Walk-in / Call-in Time

Walk-in / Call-in Program

Type of Service Requested

☐ Outpatient
 ☒ SUD Residential
 ☐ Withdrawal Mgmt

Registered Client Name

Check: this box if client is not registered.

☐ Yes

Non-Registered Client Name

Non-Registered Client Date of Birth

Appointment Date Offered

Appointment Type

Primary Language

Select Outpatient Program

Select SUD Residential Program

Select Withdrawal Mgmt Program

Click "Yes" if appointment date offered does not follow this requirement: within 10 business days for Outpatient, within 10 calendar days for Residential and within 48 hours for Withdrawal Mgmt. Enter your rationale below.

☐ Yes (If you choose "Yes" in error, click "Yes" again, then press the "F5" Key to clear option.)

Rationale

Notes

# OVERVIEW OF EPISODE OPENING

## Admission Bundles

### SA Admission OP CalOMS Program Bundle

**(Path: Avatar PM/Client Management/Episode Management/SA Admission OP CalOMS Program Bundle)**

- Admission (Outpatient)  
(Path: Avatar PM)/Client Management/Episode Management)
- CalOMS 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 (Consent)  
(Path: Avatar PM)/Client Management/Client Information)

### SA Admission OP Non CalOMS Prgm Bundle

**(Path: Avatar PM/Client Management/Episode Management/SA Admission OP Non CalOMS Prgm Bundle)**

- Admission (Outpatient)  
(Path: Avatar PM)/Client Management/Episode Management)
- 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 (Consent)  
(Path: Avatar PM)/Client Management/Client Information)

---

## SA Admission Res CalOMS Prgm Bundle

**(Path: Avatar PM/Client Management/Episode Management/SA Admission Res CalOMS Prgm Bundle)**

- Admission  
(Path: Avatar PM)/Client Management/Episode Management)
- CalOMS 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 (Consent)  
(Path: Avatar PM)/Client Management/Client Information)

## SA Admission Res Non CalOMS Prgm Bundle

**(Path: Avatar PM/Client Management/Episode Management/SA Admission Res Non CalOMS Prgm Bundle)**

- Admission  
(Path: Avatar PM)/Client Management/Episode Management)
- 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 (Consent)  
(Path: Avatar PM)/Client Management/Client Information)

# ADMISSION BUNDLE FORMS

## Admission (Outpatient)

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

**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

**Admission (Outpatient)**

**Admission**  
Demographics  
SF Additional Admission

Submit

Online Documentation

**Episode Number** 1

**Client Name** FUENTES, CARLOS

**Sex**  
☐ Female ☒ Male ☐ Other ☐ Unknown

**Date Of Birth** 06/11/1952

**Age** 60

**Preadmit/Admission Date** 06/11/2012

**Preadmit/Admission Time** 10:01 AM Current H M AM/PM

**Program** Westside Outpatient Clinic (89052)

**Type Of Admission** First Admission

**Source Of Admission**

**Admitting Practitioner** HEPWORTH, JON (050003)

**Attending Practitioner** MUNOZ, PABLO (000031)

**Practitioner Type**

**Facility Chart Number**

**Social Security Number** 236-84-9183

**Perform Discharge Alert** ☒ Yes ☐ No

**Type Of Alert**

**Alert Parent/Guardian**

**Disposition** BHAC - Refer to Clinic

**Presenting Problems-Primary** Alcohol + Drug Problems

**Presenting Problems-Secondary** Attempt, Threat, Or Danger Of Homicide

**Presenting Problems-Tertiary**

**Client's Living Arrangements**

**Disabilities-2**  
☐ None ☐ Visual ☒ Hearing ☐ Speech ☐ Mobility

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

Allegies (0)

Chart Admission (Outpatient)

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

Submit

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  
Marital Status: Single / Never Married  
Education: 16 Years  
Employment Status: Not In Labor Force - Other Not ...

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:   
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.

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

Admission (Outpatient) - continued

The screenshot shows a web-based form titled "Admission (Outpatient)". On the left is a sidebar with a "Submit" button and "Online Documentation" link. The main form area contains several sections:

- Demographics:** Includes fields for Marital Status (Not Married), Education (19 Grade), Employment Status ("Unemployed, actively seeking ..."), Occupation (Extractive Occupations), and Smoker status (Former Smoker).
- Aliases:** A section labeled "Smoker" with a lightbulb icon, followed by five "Alias" fields. The first alias is "MUNOZ, PABLO".
- Primary Care:** Includes a dropdown for "Select from the drop down list below" (Chinese Hospital-Excelsior Clinic), "Other if not listed above", "Other if not listed", "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", and a radio button question "Is this the client's Health Home?" with "Yes" and "No" options.

Two arrows originate from text boxes below the form: one points to the "Smoker" dropdown, and the other points to the "Primary Care" section.

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.

## CalOMS

(see separate hand out)

## Episode Guarantor Information

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

The screenshot shows the 'Avatar 2011' software interface. At the top, there's a navigation bar with 'Home', 'Carlos F', 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and 'JHEPWORTH'. Below this, a header section displays client information: '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...', and 'Adm. Pract.: HEPWORTH,JON'. A 'Chart' button and 'Episode Guarantor Information' tab are visible. The main form area is titled 'Episode Guarantor Information' and contains several sections: 'Medi-Cal' (selected in the left sidebar), 'Medicare', 'SF Health Access Program', 'Patient Fee Liability', 'Private Health Insurance', 'San Francisco Health Plan', 'Other Funding Sources', and 'Assignment of Benefits, R...'. The 'Medi-Cal' section includes fields for 'Client Name' (FUENTES, CARLOS), 'Subscriber's Social Security Number' (236-84-9183), 'Date of Birth' (06/11/1952), 'Submission Type' (New Eligibility Record), 'Program Type' (Mental Health), 'Date of Entry / Update' (02/11/2013), 'Change Effective Date', 'Benefit Coverage' (Medi-Cal, Patient Fee Liability), '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', 'Medicare' (Part A: Hospital, Part B: Outpatient, Part C: HMO Plan, Part D: Pharmacy), 'Medicare ID or HIC Number', 'Coverage Effective Date', 'Termination Date', and 'Authorization Number'. A 'Submit' button is at the bottom left. The status bar at the bottom shows 'AVCALPHIVE (SAMPLE)', '02/11/2013 09:24 AM', and '99%'.

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

Allegies (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  
☒ Share-of-Cost ☐ Full Scope  
☐ Restricted ☐ Out-of-County

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

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:

AVCALPHIVE (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



 0

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 Address

Contact City

Contact State

Contact Zip Code

Contact Home Phone

Contact Work Phone

Contact Cell Phone

Contact Relationship to Client

☐ Aunt  
☒ Brother-In Law  
☐ Brother

Primary Contact

☒ Yes      ☐ No

Contact Living with Client

☐ Yes      ☐ No

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 referral source category is 300.11 CONVER... The patient's attention is noted as No Entry. A warning message states: 1. THIS IS A TEST CLIENT !!!!! DO NOT USE. The patient has one allergy listed: Allergies (1).

The Admission Referral Information form is displayed below the patient information. It includes a left sidebar with a 'Primary Referral' section containing 'Secondary Referral', 'Other Referral - 1', and 'Other Referral - 2'. The main form area contains the following fields:

- Primary Referral Source Code: Chinatown North Beach
- 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:
- Primary Referral Source - ID Number: ☐ (selected)
- Primary Referral Source - Name: ☐
- Primary Referral Source - 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

The form also includes a 'Submit' button and a 'Chart' button. The 'Online Documentation' section is visible at the bottom left.

## 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

Minor Signature

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



# 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' with icons for help, print, and other functions.
- Form Fields:**
  - Type Of Diagnosis:** Radio buttons for Admission (selected), Discharge, Onset, and Update.
  - Date Of Diagnosis:** A date picker showing the month, year, and day.
  - Time Of Diagnosis:** A time picker showing the time in HH:MM:SS format, with a 'Current' button.
  - Select Episode To Default Diagnosis Information From:** A dropdown menu.
  - Select Diagnosis Entry To Default Information From:** A dropdown menu.
- 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 buttons for 'New Row' and 'Delete Row'.
- Show Active Only:** Radio buttons for Yes and No.
- Diagnosis Search:** A text input field with a search icon.
- Code Crossmapping:** A text input field with a search icon.

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. At the top, there's a navigation bar with 'Home', 'Transfer Practi' (highlighted), 'Courses', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and a user profile 'JHE'. Below this is a 'Transfer Practitioner Caseload' header with a plus icon. On the left, a sidebar contains 'Transfer Practitioner Ca...' (highlighted), a 'Submit' button, a set of icons (document, printer, folder, etc.), and 'Online Documentation'. The main form area has several sections: 'Caseload Type' with radio buttons for 'Admitting Practitioner Caseload' (selected) and 'Attending Practitioner Caseload'; 'Transfer Caseload From' with a dropdown menu showing 'NAN DAME (000006)'; 'Individual Or All Clients' with radio buttons for 'All' and 'Individual' (selected), and a 'Select Clients To Transfer' button; 'Transfer Caseload To' with a dropdown menu showing 'AVATAR02 TEST (000085)'; 'Effective Date Of Transfer' with fields for month, year, and day; and 'Effective Time Of Transfer' with a 'Current' button, hour/minute dropdowns, and an 'AM/PM' dropdown.

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

# SUBSTANCE USE DISORDER ASSESSMENT (ADULT)

## ASI Input

(Path: Avatar CWS/ASI)

**NOAM CHOMSKY (000000270)**  
M, 72, 05/11/1940

Ep: 3 : HAFc Western Additi...  
Problem P: -  
DX P: No Entry

Location: Under the freeway, San ...  
Attn. Pract.: No Entry  
Adm. Pract.: DAME,NAN

Allergies (0)

Chart Adult/Older Adult Assessment (Short) **ASI Input**

General Information

Medical Status

Employment/Support S...

Drug and Alcohol Abuse

Legal Status







Family History

Family Social Relations...

Psychiatric Status

Composite Score / Clos...

Submit



**G1. ID Number**

270

**G2. Social Security Number**

234-78-9836

**G3. Program**

HAFc Western Addition Poly D...

**G4. Date of Admission**

05/16/2012 T Y

**G5. Date of Interview**

T Y

**G6. Time Begun**

Current H M AM/PM

**G7. Time Ended**

Current H M AM/PM

**G8. Class**

☒ Intake ☐ Follow-up

**G9. Contact Code**

☒ In person ☐ Telephone

**G10. Gender**

☒ Male ☐ Female

**G11. Interviewer Code No./Initials**

**G12. Special**

☐ Patient Terminated  
☐ Patient Refused  
☐ Patient Unable to Respond  
☐ Not Applicable

**G13. Client Address**

Under the freeway San Francisco, CA 9410

**G14. How long have you lived at this address?**

**G15. Is this residence owned by you or your family?**

☐ No ☐ Yes ☐ Not Applicable

**G16. Date of Birth**

05/11/1940 T Y

**G17. Of what race do you consider yourself?**

Alaskan Native

**G18. Do you have a religious preference?**

Atheist

**G19. Have you been in a controlled environment in the past 30 days?**

☐ No ☐ Jail

**G21. Shipley C.Q.**

**G22. Shipley I.Q.**

**G23. Beck Total Score**

**G24. SCL - 90 Total**

## ASI Input – continued

Chart

ASI Input

General Information

Medical Status

Employment/Support S...

Drug and Alcohol Abuse

Legal Status

Family History

Family Social Relations...

Psychiatric Status

Composite Score / Clos...

Submit

0

Online Documentation

D1. Age Of First Alcohol Use (any use at all) 16  
D1. Alcohol Use Past 30 Days (any use at all) 8  
D1. Alcohol Years of Use (any use at all) 30  
D1. Date of Last Alcohol Use (any use at all) 10/09  
D2. Age Of First Alcohol Use (to intoxication) 16  
D2. Alcohol Use Past 30 Days (to intoxication) 0  
D2. Alcohol Years of Use (to intoxication) 29  
D2. Date of Last Alcohol Use (to intoxication) 12/08  
D3. Age Of First Heroin Use 24  
D3. Heroin Use Past 30 Days 30  
D3. Heroin Years of Use 32

D3. Heroin Route of Admin  
☐ Oral ☐ Nasal ☐ Smoking  
☐ Non-IV Injection ☐ IV Injection  
D3. Date of Last Heroin Use 03/15  
D4. Age Of First Methadone Use  
D4. Methadone Use Past 30 Days  
D4. Methadone Years of Use  
D4. Methadone Route of Admin  
☐ Oral ☐ Nasal ☐ Smoking  
☐ Non-IV Injection ☐ IV Injection  
D4. Date of Last Methadone Use  
D5. Age Of First Other Opiates/Analgesics Use  
D5. Other Opiates/Analgesics Use Past 30 Days  
D5. Other Opiates/Analgesics Years of Use

D5. Other Opiates/Analgesics Route of Admin  
☐ Oral ☐ Nasal ☐ Smoking  
☐ Non-IV Injection ☐ IV Injection  
D5. Date of Last Other Opiates/Analgesics Use

D7. Sedatives/Hypnotics/Tranquilizers Years of Use  
D7. Sedatives/Hypnotics/Tranquilizers Route of Admin  
☐ Oral ☐ Nasal ☐ Smoking  
☐ Non-IV Injection ☐ IV Injection

## ASI Summary Report:

(Path: Avatar CWS/ASI)

The screenshot shows a software window titled "Avatar\_ASI\_Summary\_Report.rpt" with a BusinessObjects logo in the top right. The window has a toolbar with navigation icons and a "1 / 2" indicator. On the left is a "Preview" pane with a "General" tab. The main content area displays a "Substance Abuse Evaluation" report. The report header includes "Avatar CWS 2004", "Sample Report", and "Header". The title "Substance Abuse Evaluation" is centered. Client information is listed on the left: "Client Name: CHOMSKY,NOAM", "Client Address: homeless San Francisco, CA 94103", "Client Phone:", "Client SS#: 234-78-9836", and "Interview Date: 8/8/2012". Client ID# 270 and Date of Admission 5/1/2012 are on the right. The report is divided into sections: "PRESENTING SITUATION" (describing Noam Chomsky as a 72-year-old Alaskan Native male with religious and medical history), "MEDICAL STATUS", "EMPLOYMENT/SUPPORT STATUS", "DRUG/ALCOHOL USE" (noting methadone use at age 23), and "LEGAL STATUS".

Avatar CWS 2004  
Sample Report  
Header

### Substance Abuse Evaluation

**Client Name:** CHOMSKY,NOAM  
**Client Address:** homeless San Francisco, CA 94103  
**Client Phone:**  
**Client SS#:** 234-78-9836  
**Interview Date:** 8/8/2012

**Client ID#:** 270  
**Date of Admission:** 5/1/2012

#### PRESENTING SITUATION

Noam Chomsky is a 72-year-old Alaskan Native male born on May 11, 1940. He stated his religious preference is Atheist. He has lived at his present address for 4 years and 6 months. He has been in a medical treatment program for 06 days of the past 30.

gfrd

#### MEDICAL STATUS

#### EMPLOYMENT/SUPPORT STATUS

#### DRUG/ALCOHOL USE

Mr. Chomsky admitted the first time he used the following substances was at age:

methadone - 23 years old

#### LEGAL STATUS

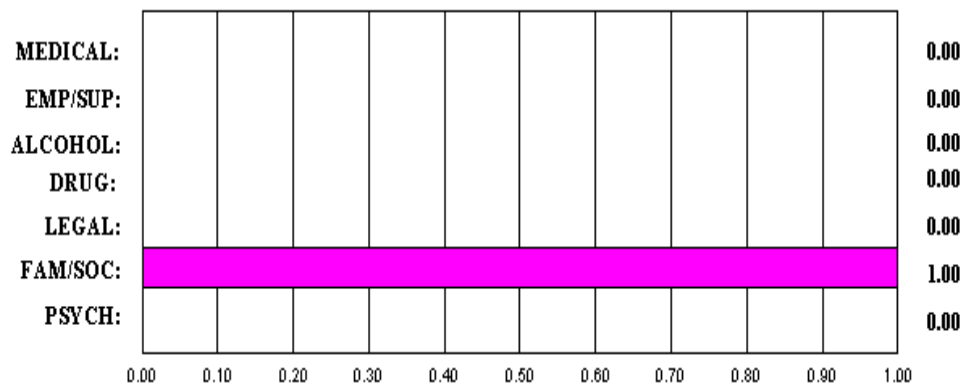
## ASI Composite Scores:

(Path: Avatar CWS/ASI)

### Addiction Severity Index Composite/Severity Scores

Client Name: SANDERSON,GRACE  
Client SS#:   
Client ID: 117  
Interview Date: 3/19/2010

#### Composite Scores



This profile is based on the last 30 days of the individual's life.  
It is used primarily for research and initial treatment planning.

#### Interviewer Severity Scores

MEDICAL:	01	No real problem, treatment not indicated
EMP/SUP:	67	Considerable problem, treatment necessary
ALCOHOL:	89	Extreme problem, treatment absolutely necessary
DRUG:	89	Extreme problem, treatment absolutely necessary
LEGAL:	01	No real problem, treatment not indicated
FAM/SOC:	67	Considerable problem, treatment necessary
PSYCH:	00	No real problem, treatment not indicated



## ASI Rating Graphs:

(Path: Avatar CWS/ASI)

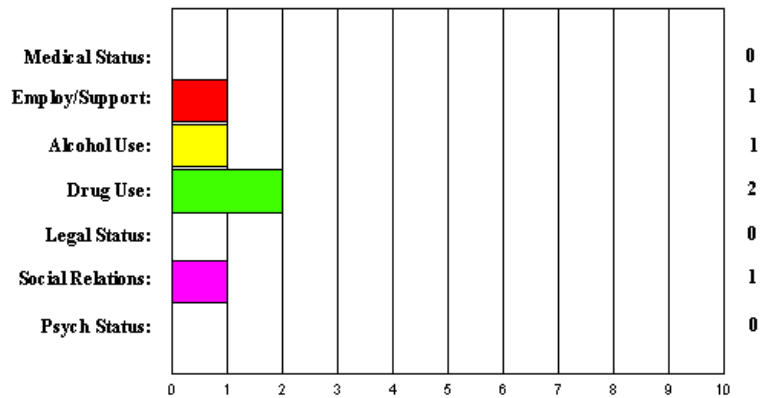
review

City and County of San Francisco  
CBHS

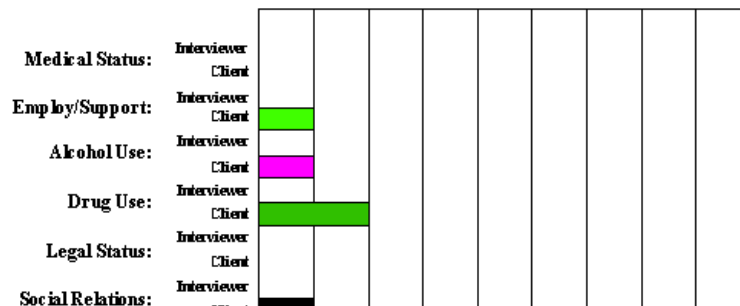
### Addiction Severity Index Severity/Rating Graphs

**Client Name:** SANDERSON,GRACE  
**Client Address:** 450 California Ave San Francisco, CA 94109  
**Client Phone:** 555-555-5247  
**Client SS#:**  
**Interview Date:** 3/19/2010  
**Client ID#:** 117  
**Date of Admission:** 3/3/2010

#### Severity Profile Graph



#### Interviewer/Client Rating Graph



## SUD Level of Care Recommendation

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

**SUD Level of Care Recommendation**

**Initial**

- Dimension 1
- Dimension 2
- Dimension 3
- Dimension 4
- Dimension 5
- Dimension 6
- Placement Summary

**Submit**

**LOC Date**

**Time of LOC**

**Draft/Final**

**Type of LOC**

**Practitioner**

**Why is client seeking services today (in their own words)**

**If Not Applicable/Incomplete, select reason**

**Collateral Information (Youth)**

**Comments**

**Initial LOC for residential srvc created at other program?**

**Reauthorization Type**

## Printing the SUD Level of Care Recommendation

### SUD Level of Care Recommendation Report

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

	San Francisco Department of Public Health Community Behavioral Health Services
	<b>SUD Level of Care Recommendation Report</b>
<b>Client Name:</b> TESTCLIENT,SUMMARY Y SR DR	
<b>Client ID:</b> 1	
<b>Program:</b> HR360 Pre Admit	
<b>Episode #:</b> 54	
<b>Admission Date:</b> 5/31/2020	
<b>Discharge Date:</b> None	

### Confidential Patient Information

LOC Date:	7/31/2020	Record Status:	Final
LOC Time:	08:13 AM	Finalized Date:	7/31/2020
LOC Type:	Residential Reauthor	Finalized Time:	08:24 AM
Completed by:	Mauricio Torres		

Completed by a LHPA or consulted face to face with LHPA :

Why is the client seeking services today?

#### DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

1. Date of last use:
2. Number of days used in the past 30 days:
3. Number of days injected in the last 30 days:
4. Current, severe, life threatening withdrawal symptoms:
5. In the absence of current, acute withdrawal, is there a current pattern of substance use that has potential for withdrawal with abrupt reduction or cessation of substances known to be associated with acute withdrawal?
6. Night sweats:
7. History of seizure:
8. Current hand tremors:

Dimension 1 Comments/Rationale

# SUD Continuing Services Justification

## SUD Continuing Svcs Justification

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

**Justification**

Submit

A new justification cannot be created earlier than 5 months and no later than 6 months from the Justification Date.

Today's Date: [Date Picker]

Status - Draft / Pending Approval / Final

☒ Draft ☐ Pending Approval ☐ Final

Team Member to Notify: [Dropdown]

Team Member to Notify Outgoing Comments: [Text Area]

**Prognosis without continued treatment:**

☐ Return to increased drug use  
☐ Health harmed by drug use  
☐ Increased risk of danger to self/others  
☒ Failure to complete court requirements  
☐ Loss of housing  
☐ Becoming/remaining dependent Public Asst

☐ Exposure/spread of HIV, TB, Hepatitis, etc  
☒ Mental health harmed by drug use  
☐ Involvement with criminal justice system  
☐ Decreased follow-thru w/regular activity  
☐ Breakdown family unit/social support  
☒ Other

**Other Detail**

Write text here: [Text Area]

**Client is working on the following Dimensions:**

☒ 1 - Acute Intoxication and W/D  
☐ 2 - Biomedical Conditions  
☐ 3 - Emotion, Behavioral, Cognitive  
☒ 4 - Readiness to change  
☐ 5 - Relapse Potential  
☐ 6 - Recovery/Living Environment

**Client's progress towards tx goals**

Write text here: [Text Area]

**I recommend that the client continue receiving tx services:**

☐ Yes ☐ No

## Printing the SUD Continuing Svcs Justification

	San Francisco Department of Public Health Community Behavioral Health Services	<b>Client Name:</b> TESTCLIENT,SUMMARY Y SR DR
	<b>SUD Level of Care Recommendation Report</b>	<b>Client ID:</b> 1 <b>Program:</b> HR360 Pre Admit <b>Episode #:</b> 54 <b>Admission Date:</b> 5/31/2020 <b>Discharge Date:</b> None

### Confidential Patient Information

LOC Date:	7/31/2020	Record Status:	Final
LOC Time:	08:13 AM	Finalized Date:	7/31/2020
LOC Type:	Residential Reauthor	Finalized Time:	08:24 AM
Completed by:	Mauricio Torres		

Completed by a LHPA or consulted face to face with LHPA :

Why is the client seeking services today?

#### DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

1. Date of last use:
2. Number of days used in the past 30 days:
3. Number of days injected in the last 30 days:
4. Current, severe, life threatening withdrawal symptoms:
5. In the absence of current, acute withdrawal, is there a current pattern of substance use that has potential for withdrawal with abrupt reduction or cessation of substances known to be associated with acute withdrawal?
6. Night sweats:
7. History of seizure:
8. Current hand tremors:

Dimension 1 Comments/Rationale

Dimension 1 Rating:

# SUD Treatment Plan of Care/Recovery Plan

## SUD TPOC/Recovery Plan

(Path: Avatar CWS / Treatment Planning)

Chart

SUD Treatment Plan of Care

Plan Date / Type

Goals and Action Steps

Submit

Treatment Plan of Care Date

06/13/2018

T

Y

Plan Type

☒ Initial
 ☐ Update

Draft Pending Approval Final

☒ Draft
 ☐ Pending Approval
 ☐ Final

Team Member to Notify

Team Member to Notify Outgoing Comments

Client Strengths

Strengths

Long Term Goals (Including clients own words)

Goals

Type and Frequency of Counseling/Services

What services will be provided

Goals and Action Steps

Dimension	Problem	Focus of Treatment?	Target Date	Goals	Client Action Steps	Staff Action Steps	Resolved Notes
4 - Read...	Client'...	Yes					

Add New Item

Edit Selected Item

Delete Selected Item

Dimension

☐ 1 - Intoxication/Withdrawal  
☐ 2 - Physical Health  
☐ 3 - Mental Health  
☒ 4 - Readiness to change  
☐ 5 - Relapse/Increased harm  
☐ 6 - Recovery/Living environment  
☐ Other focus Finance/Education/Emp/Legal

Problem

Client's significant other requested that they seek treatment, but client does not think their alcohol use is a problem.

Focus of Treatment?

☒ Yes
 ☐ No
 ☐ Deferred
 ☐ Resolved

Target Date  
t+90 T Y

Goals

Decrease fighting with significant other from 7 days per week to 4 days per week.

Client Action Steps

Client will agree to go to 90 meetings in 90 days.

Staff Action Steps

Staff will provide individual counseling to support client once per week.

Resolved Notes

**Use this field to indicate if a client is unavailable to sign, declines to sign, or if you are not using Signature Pads and the client signs on paper. If you want to collect the client signature electronically, use the SUD TPOC Signature Addendum.**

When finalizing, please select "Signature on Paper" option if a signature pad has not been installed.

Capture Client/Other Legal Representative signature by using the SUD TPOC Signature Addendum form.

Client/Legal Representative Participant

☐ Client/Other is Unavailable to Sign  
☐ Client/Other Declined to Sign  
☐ Signature on Paper

If NO CLIENT SIGNATURE, document in progress note and enter date of progress note in box below.

## SUD TPOC Signature Addendum

(Path: Avatar CWS / Treatment Planning)

Chart SUD Treatment Plan of Care SUD TPOC Signature Addendum

Addendum To SUD Treat

Submit

Date of Addendum

Treatment Plan Date

Person Signing

Client

Signature

Click Here to Get Signature

## SUD TPOC/Recovery Plan Report

 <p>San Francisco Department of Public Health Behavioral Health Services</p>	<p><b>SUD Treatment Plan of Care</b></p>	
	<p><b>Name:</b> TESTCLIENT,SUMMARY Y SR DR  <b>Client ID#:</b> 1  <b>Episode #:</b> 54    <b>Episode Opening Date:</b> 05/31/2020  <b>Episode Program:</b> HR360 Pre Admit  <b>Plan Effective Date:</b> 8/26/2020</p>	
<b>Confidential Patient Information</b>		
<b>Treatment Plan is valid until</b> 12/17/2020		
<b>Treatment Plan Date :</b> 8/26/2020 <b>Date Treatment Plan Finalized:</b> 9/18/2020		<b>Plan Type:</b> Initial <b>Status :</b> Final <b>Treatment Plan End Date :</b> 12/17/2020
<b>Prim ary Counselor Name:</b> TORRES,MAURICIO		
<b>Client Strengths</b> <div style="border: 1px solid black; padding: 2px;">Strengths</div>		
<b>Long Term Goals</b> <div style="border: 1px solid black; padding: 2px;">Long term</div>		
<b>Type and Frequency of Counseling/Services</b> <div style="border: 1px solid black; padding: 2px;">Res, op</div>		
<b><u>Goals and Action Steps</u></b> <b>Dimension:</b> 2 - Physical Health <b>Target Date:</b> <b>Focus of Treatm ent?:</b> No <b>Problem/Concern:</b> <div style="border: 1px solid black; padding: 2px;">blah</div>		
<b><u>Goals and Action Steps</u></b> <b>Dimension:</b> 1 - Intoxication/Withdrawal <b>Target Date:</b> 11/24/2020 <b>Focus of Treatm ent?:</b> Yes <b>Problem/Concern:</b>		



# PROGRESS NOTES (GROUP AND INDIVIDUAL)

## Progress Notes Group and Individual Form

(Path: Avatar CWS/Progress Notes)

The screenshot displays 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 contains a 'Submit' button and a 'Progress Note Entry' form. The 'Progress Note Entry' form includes a 'Select Client' dropdown menu with 'FUENTES, CARLOS (981248689)' selected, a 'Select Episode' dropdown menu with 'Episode # 1 Admit : 06/11/2012 Discharge : None Program' selected, and a 'Progress Note For' section with radio buttons for 'Existing Service', 'Existing Appointment', 'Independent Note', and 'New Service' (selected). Below this is a 'Notes Field' with a text area for 'Type in this box.' and a 'File Note' button. The 'Draft/Final' section at the bottom has radio buttons for 'Draft' and 'Final' (selected), and a 'File Note' button. The right side of the form includes a 'Group Name or Number' text field, a 'Note Date' field with a calendar icon, a 'Select Note To Edit' dropdown menu, and a 'Note Addresses Which Existing Service/Appointment' text field. The 'Note Type' section has a dropdown menu with 'MH Adult' selected and a 'User To Send Co-Sign To Do Item To' text field. The bottom status bar shows 'AVCALPHLIVE (SAMPLE)', '02/07/2013 01:02 PM', and '108%' zoom level.

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)

Select Episode  
Episode # 1 Admit : 06/11/2012 Discharge : None Program

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  
Type in this box.

Draft/Final  
☐ Draft  
☒ Final

File Note

Group Name or Number

Note Date

Select Note To Edit

Note Addresses Which Existing Service/Appointment

Note Type  
MH Adult

User To Send Co-Sign To Do Item To

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

## Progress Notes – Interns with Cosign

The screenshot displays the Avatar 2011 software interface for entering progress notes. The window title is "Avatar 2011". 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)". On the left, there is a sidebar with "Individual Progress Notes", "Group Default Notes", a "Submit" button, and "Online Documentation". The main form 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)

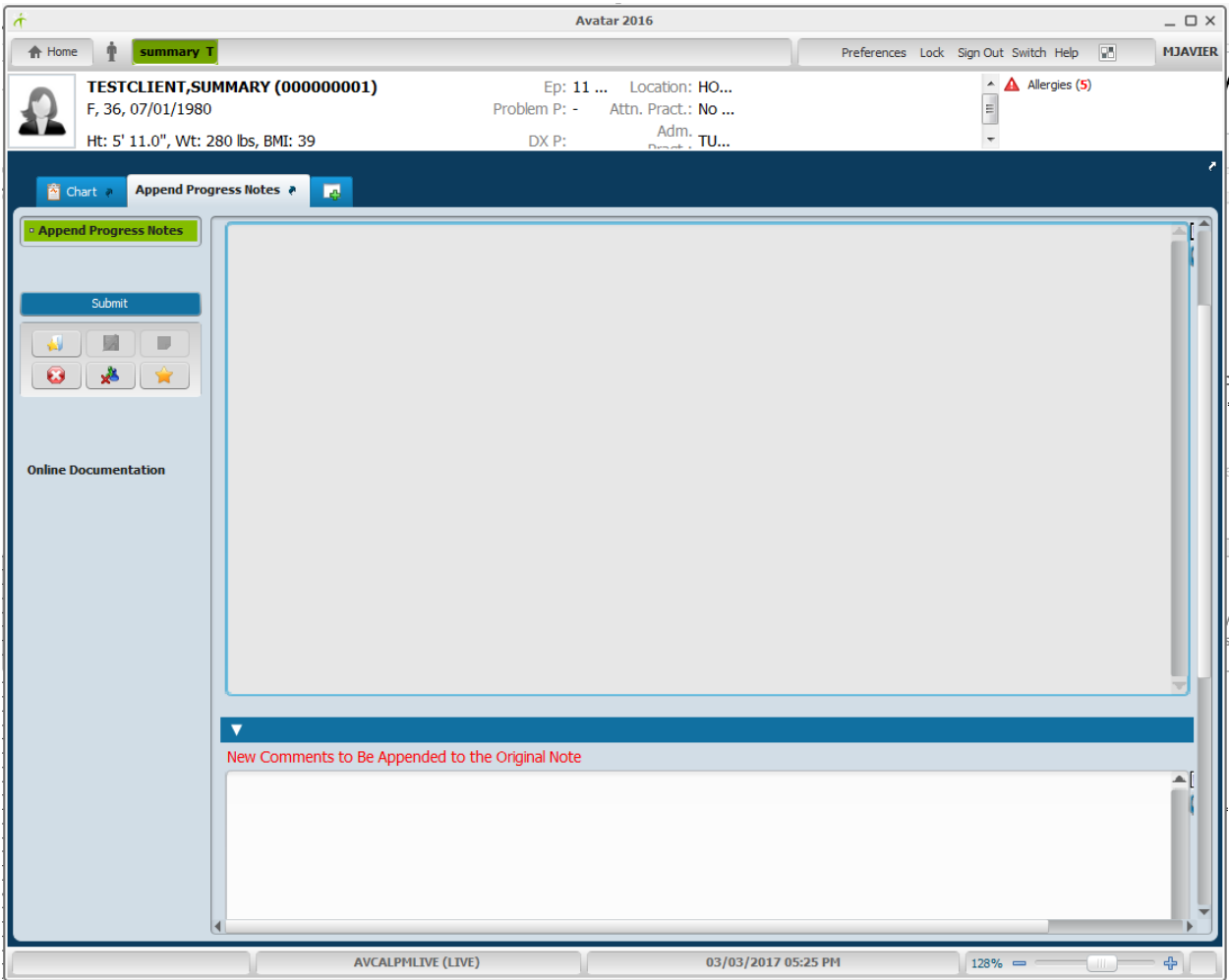
The screenshot shows the Avatar 2016 software interface. At the top, there's a navigation bar with 'Home', 'summary T', 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and a user profile 'MJAVIER'. Below this, a patient summary card for 'TESTCLIENT,SUMMARY (000000001)' displays demographics: 'F, 36, 07/01/1980', '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 and a 'Select Client' dropdown menu. Below this, a 'Select Episode' section shows 'Episode # 11 Admit: 05/14/2016 Discharge: NONE Program: A Bett...'. To the right of this, there are date pickers for 'Start Date' (05/14/2016) and 'End Date' (03/03/2017), each with 'T' and 'Y' buttons.

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' with the subtitle 'A Better Way SF Outpatient (38GTOP)' and the date range 'From 5/14/2016 To 3/3/2017'. A black bar highlights the section 'Confidential Patient Information'. Below this, the report lists: 'Client Name: TESTCLIENT,SUMMARY', 'Client ID: 1', 'Episode #: 11', 'Admission Date: 05/14/2016', and 'Discharge Date:'. A grey box contains service details: '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', and a statement 'I have electronically completed and signed this note.' Below this, it states 'This service was provided in the client's preferred language of English'. At the bottom, it shows 'Status: Draft', 'Finalized Date: 8/9/2016', and 'Note Type/For:MH CYF / Independent Note'. The report ends with '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:

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'), 'Notes Field', and a 'Note Type' dropdown. Red 'X' marks are placed over the 'Group Name or Number', 'Note Date', 'Select Note To Edit', and 'Note Addresses Which Existing Service/Appointment' fields. Arrows point from numbered callout boxes to specific parts of the interface.

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 shows the 'Progress Notes (Group and Individual)' form. On the left, there are tabs for 'Individual Progress Notes' (selected) and 'Group Default Notes'. Below these are icons for a red X, a trash can, and a star. The main form area contains several fields and sections:

- Date Of Service:** A date picker showing 02/25/2013. Callout 7 points to this field.
- Service Program:** A dropdown menu showing 'Westside Outpatient Clinic (89052)'. Callout 8 points to this field.
- Service Charge Code:** A text field containing 'INDIVIDUAL PSYCHOTHERAPY 45-74 MINS (90806)'. Callout 9 points to this field.
- Location:** A dropdown menu showing 'Office'. Callout 11 points to this field.
- Practitioner Face to Face Time (minutes):** A text field containing '53'.
- Practitioner Doc and Travel Time (minutes):** A text field containing '19'.
- Practitioner:** A text field containing 'HOM,KELLEE (000015)'.
- Select T.P. Version:** A dropdown menu showing 'CYF Treatment Plan of Care'. Callout 10 points to this field.
- Select T.P. Item Note Addresses:** A button.
- Clear 'Note Addresses Which Treatment Plan Problem':** A button.
- Note Addresses Which Treatment Plan Problem:** A section for additional notes.

Callout 12 points to the 'Practitioner Face to Face Time' and 'Practitioner Doc and Travel Time' fields.

**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.

**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.

**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.

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.

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.

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



## Retrieving Draft Notes:

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

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

1. Enter client name.

CARLOS FUENTES (981248689)

Select Episode

2. Select episode

CARLOS FUENTES (981248689)

Episode # 1 Admit : 06/11/2012 Discharge : None Program : W...

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

Note Date

Select Note To Edit

Note Addresses Which Existing Service/Appointment

Note Type

User To Send Co-Sign To Do Item To

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

Draft/Final

☐ Draft
☐ Final

File Note

Select Draft Note To Edit

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

Delete Draft Note

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

ctitioner

Co-Practitioner Face to Face Time (minutes)

Co-Practitioner Doc and Travel Time (minutes)

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).

Below is selected note.

The screenshot shows a web interface for "Progress Notes (Group and Individual)". On the left sidebar, there are two tabs: "Individual Progress Notes" (selected) and "Group Default Notes". Below the tabs is a "Submit" button and a set of icons for document management. The main content area has a text box with the instruction: "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." Below the text box is a certification statement: "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." Underneath is a language selection section: "If service was conducted in the client's preferred language other than English, indicate which language". It includes a "Language" dropdown menu and an "Other" text input field. At the bottom, there are fields for "Date Of Service" and "Location".

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

This screenshot shows a close-up of the bottom of the form. It features a "Draft/Final" status section with two radio buttons: "Draft" (unselected) and "Final" (selected, indicated by a green dot). To the right of the radio buttons is a button labeled "File Note". Arrows from the text box above point to the "Final" radio button and the "File Note" button.

**"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

## 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:

The screenshot shows the 'Progress Notes (Group and Individual)' form. The left sidebar has 'Individual Progress Notes' and 'Group Default Notes' (selected). The main form has the following fields and callouts:

- 1.** Go to **Progress Notes (Group and Individual)** Begin at **Group Default Notes**.
- 2.** At **Date of Group** enter service date (03/05/2013).
- 3.** At **Practitioner** enter clinician name "last,first" (HOM,KELLEE (000015)).
- 4.** At **Progress Note For** Select ONLY "New Service". Choose "New Service" for billable or nonbillable (no show or admin). (Existing Service, Existing Appointment, Independent Note, New Service).
- 5.** At **Group Name or Number** enter group and view names of group members in grey box to the immediate right. (Westside Bipolar Support Group W am (143)).
- 6.** Do NOT click **File Note** button.
- 7.** In text box labeled **Note**, type initial paragraph/s about group session. (1st paragraph/s, about the group sessio. Type in this box.).
- 8.** At **User To Send Scratch Note To-Do Item To** select your own name. (KHOM).
- 9.** At **Note Type**, select "Group" or other appropriate code from dropdown list. (Group).
- 10.** If intern, select **Note Type** code that includes "cosign". Then select supervisor from "User To Send Co-Sign..." box. (TREY, GARRETT (281) Episode: 1, LEWIS, JOHN (292) Episode: 1, MCCOURT, FRANK (981243989) Episode: 1).

At the bottom of the form, it says 'AVCALPHLIVE (SAMPLE)' and '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 multiple “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

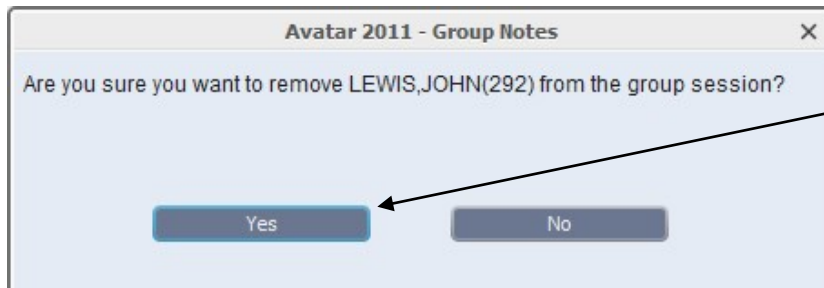
LEWIS,JOHN(292)  
MCCOURT,FRANK(981243589)  
TREY,GARRETT(281)

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

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



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

Group Name Or Number

Group Service Member Information

File Note

Note

Service Program

Service Charge Code

Location

File Note

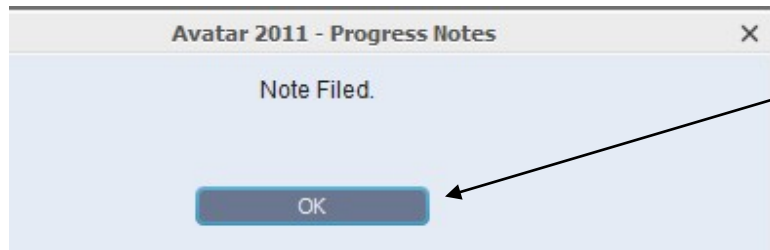
Practitioner Face to Face Time (minutes)

Practitioner Doc and Travel Time (minutes)

Co-Practitioner

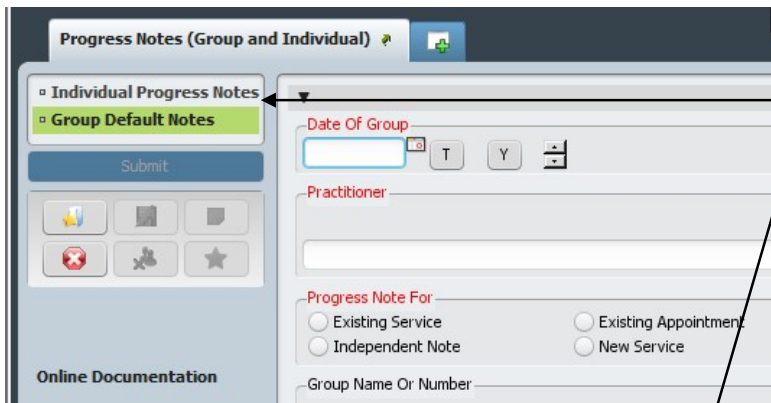
Online Documentation

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

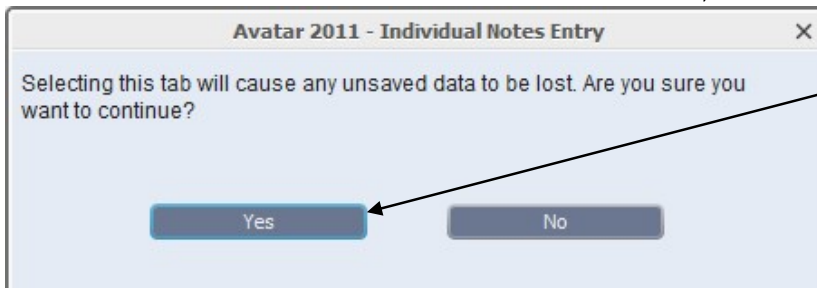


21. The “Note Filed” alert will appear. Click “OK” to complete the process. Now your work on the **Group Default Notes section** is done. You can close progress notes now and then resume instruction on the following page (8) at a later time. Or, you can continue the process right now by following steps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

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

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

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".

Select Episode

Episode # 1 Admit : 06/19/2012 Discharge : None Program : W...

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.

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,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%

Avatar

Home Progress Notes

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...

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”.

Date Of Service  
03/05/2013 T Y

Service Program  
Westside Outpatient Clinic (89052)

Service Charge Code  
DBT GROUP THERAPY (H2015GD)

Location  
Office

Practitioner Face to Face Time (minutes)

Practitioner Doc and Travel Time (minutes)

Practitioner  
HOM,KELLEE (000015)

03/05/2013 10:20 AM 99%

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

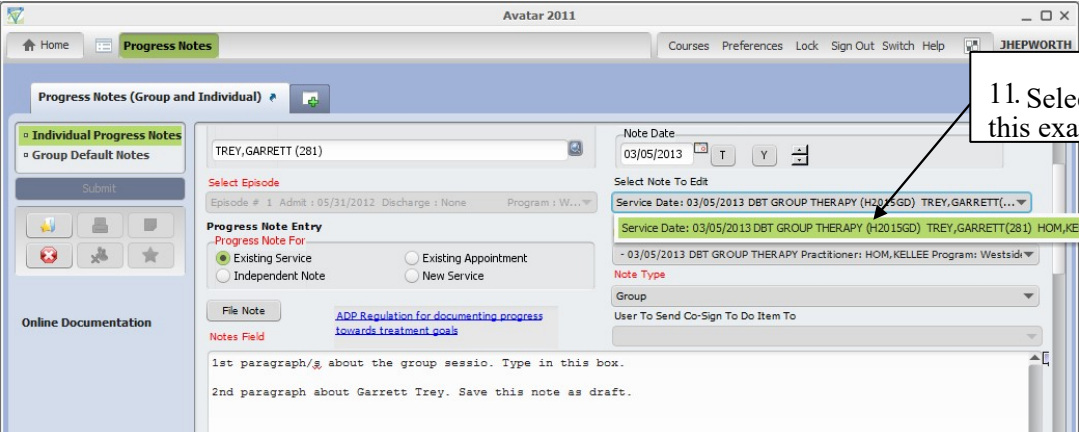
Note Filed.

OK

10. Click “OK”

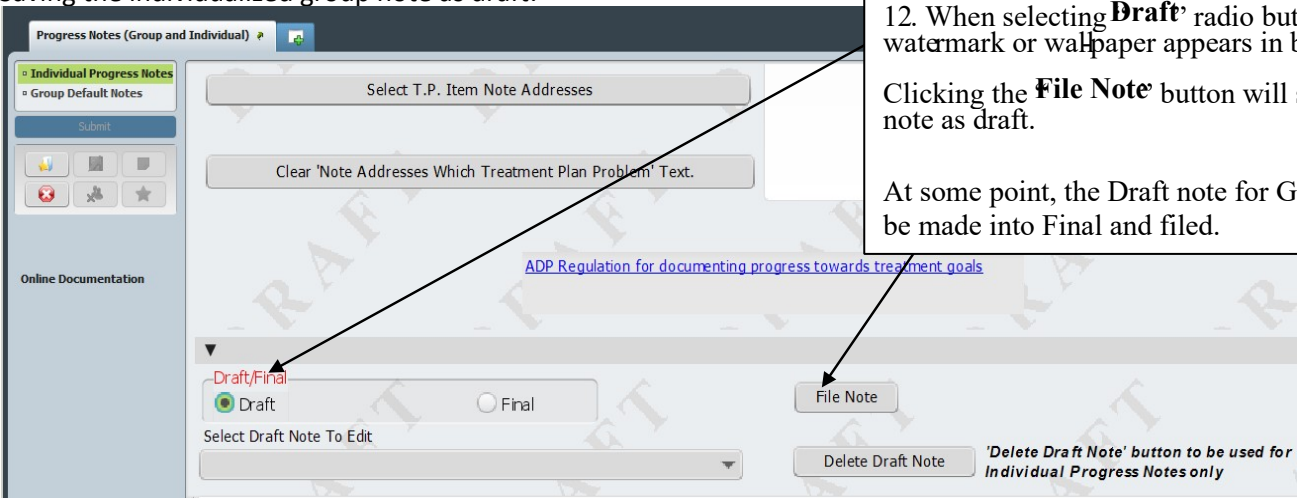


Now, a single note remains in limbo. Note belongs to client, Garrett Trey.



The screenshot shows the Avatar 2011 Progress Notes interface. The client name is TREY, GARRETT (281). The note date is 03/05/2013. The service date is 03/05/2013 DBT GROUP THERAPY (H2015GD). The note type is DBT GROUP THERAPY. The note is currently in a "Draft" state. A callout box points to the "Draft" state with the text: "11. Select sole remaining note 'In Limbo'. Note in this example belongs to client 'Garrett Trey'."

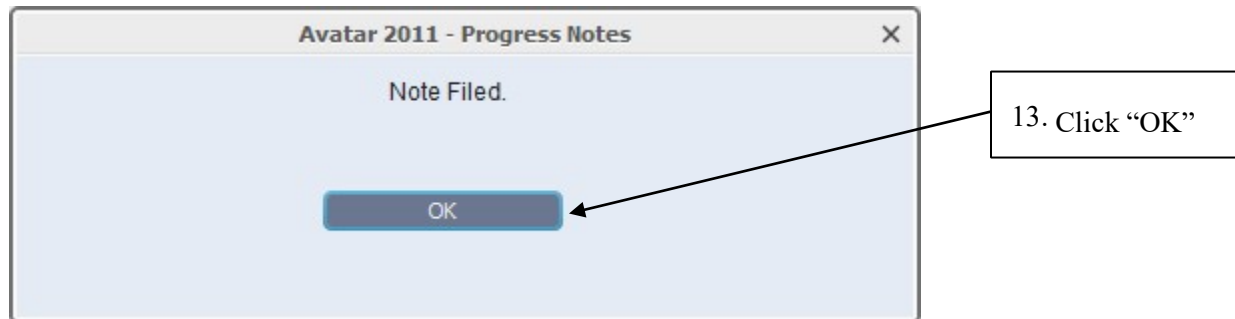
Saving the individualized group note as draft:



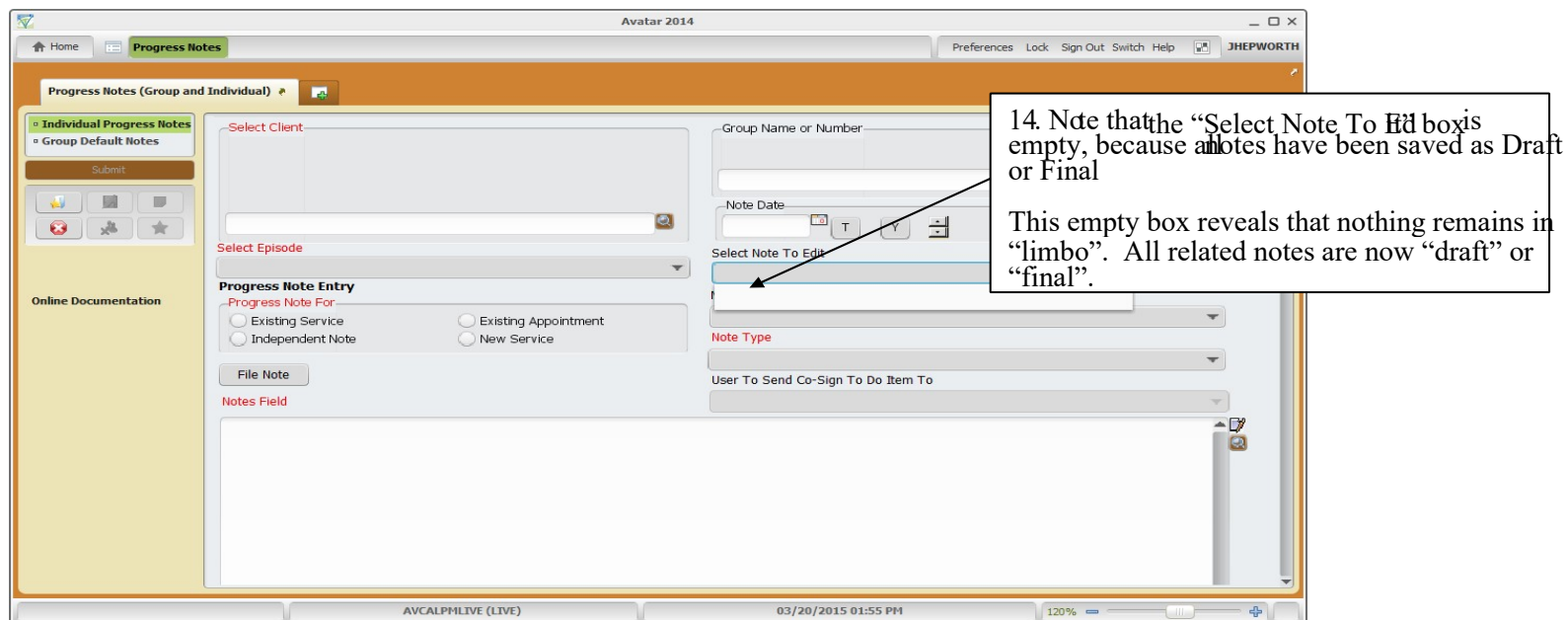
The screenshot shows the Avatar 2011 Progress Notes interface with the note in a "Draft" state. The background has a "DRAFT" watermark. A callout box points to the "Draft" state with the text: "12. When selecting **Draft** radio button, the 'DRAFT' watermark or wallpaper appears in background. Clicking 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:

The screenshot displays the 'Progress Notes (Group and Individual)' interface. On the left sidebar, under 'Online Documentation', there are buttons for 'Individual Progress Notes' and 'Group Default Notes', a 'Submit' button, and a set of icons. The main content area is titled 'Select Client' and shows 'GARRETT TREY (281)' in a search field. A callout box with the text '15. At Individual Progress Notes section, enter Client Name and select Episode' has arrows pointing to the client name and the 'Select Episode' dropdown. The 'Select Episode' dropdown is open, showing a list of episodes. The first episode, 'Episode # 1 Admit: 05/31/2012 Discharge: None Program: Westside Outpatient Clinic (89052)', is highlighted. Below the episode list, there are radio buttons for 'Existing Service', 'Existing Appointment', 'Independent Note', and 'New Service'. To the right of the episode list, there are fields for 'Note Date', 'Select Note To Edit', 'Progress Note For', 'Note Type', and 'User To Send Co-Sign To Do Item To'. A 'File Note' button and a link to 'ADP Regulation for documenting progress towards treatment goals' are also visible.

Progress Notes (Group and Individual)

Individual Progress Notes  
Group Default Notes

Submit

Online Documentation

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

ADP Regulation for documenting progress towards treatment goals

Note Date

Select Note To Edit

ises Which Existing Service/Appointment

Note Type

User To Send Co-Sign To Do Item To

The screenshot shows the Avatar 2011 software interface for Progress Notes. The top navigation bar includes 'Home' and 'Progress Notes'. The main content area is titled 'Progress Notes (Group and Individual)' and features a sidebar with 'Individual Progress Notes' and 'Group Default Notes'. The 'Draft/Final' status is set to 'Draft'. The 'Select Draft Note To Edit' section is highlighted with a blue border, showing 'Entry Date: 03/05/2013' and 'Service Date: 03/05/2013 DBT GROUP THERA...'. Below this, the 'Evidence-Based Practices / Service Strategies (CSI)' section lists three options: 'Age-Specific Service Strategy', 'Assertive Community Treatment', and 'Delivered in Partnership with Health Care', all of which are unchecked.

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.

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

Select Client  
TREY, GARRETT (281)

Select Episode  
Episode # 1 Admit : 05/31/2012 Discharge : None Program : W...

Progress Note Entry  
Progress Note For  
☒ Existing Service ☐ Existing Appointment  
☐ Independent Note ☐ New Service

Note Addresses Which Existing Service/Appointment  
03/05/2013 DBT GROUP THERAPY Practitioner: HOM, KELLEE Program: Westside

Note Type  
Group  
User To Send Co-Sign To Do Item To

Notes Field  
1st paragraph/s about the group sessio. Type in this box.  
2nd paragraph about Garrett Trey. Save this note as draft. Now, |continue editing this note.

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

AVCALPMLIVE (SAMPLE) 03/05/2013 10:43 AM 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

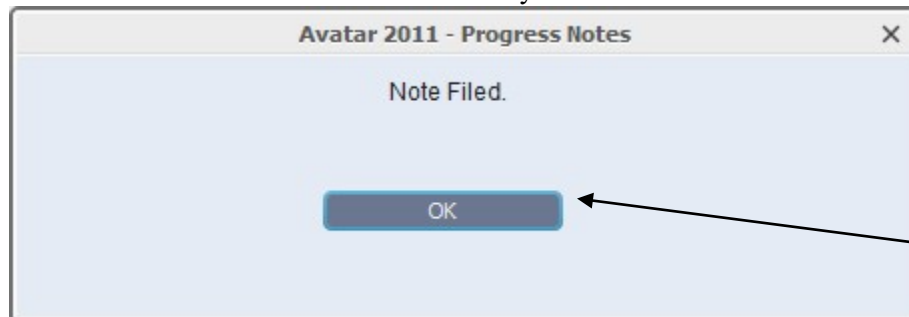
Select Draft Note To Edit

File Note

Delete Draft Note

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

Confirmation that note has been successfully filed:



20. Click "OK" and you are finished.

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)

The screenshot shows the 'Edit Service Information' form. On the left is a sidebar with a 'Submit' button and 'Online Documentation' link. The main form area contains the following fields and sections:

- Client ID:** A text input field.
- Episode Number:** A dropdown menu.
- Service Start Date:** A date picker with 'T' and 'Y' buttons.
- Service End Date:** A date picker with 'T' and 'Y' buttons.
- Service Selection Default:** Radio buttons for 'All' and 'None'.
- Select Service(s) To Edit:** A button.
- Service Code:** A text input field.
- Practitioner:** A text input field.
- Program:** A dropdown menu.
- Location:** A dropdown menu.
- Duration (Minutes):** A text input field with a lightbulb icon.
- Cost Of Service:** A text input field with a lightbulb icon.
- Modifiers:** A text input field with a lightbulb icon.
- Co-Practitioner:** A text input field.
- Co-Practitioner Duration (Minutes):** A text input field.
- Co-Practitioner 2:** A text input field.
- Diagnosis 1:** A text input field.
- Co-Practitioner 2 Duration (Minutes):** A text input field.
- Evidence-Based Practices / Service Strategies (CSI):** A list of checkboxes:
  - ☐ Age-Specific Service Strategy
  - ☐ Assertive Community Treatment
  - ☐ Delivered in Partnership with Health Care
  - ☐ Delivered in Partnership with Law Enforcement
  - ☐ Delivered in Partnership with Social Services
- Additional Service Information:** A text input field with a lightbulb icon.

# 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 episode details (1: Westside Outpatient...). The form is divided into several sections: a left sidebar with 'Discharge' and 'Demographics' tabs, a main form area with fields for 'Episode Number', 'Date Of Discharge', 'Discharge Time', 'Discharge Day Of Week', 'Length Of Stay', and 'Type Of Discharge', and a right sidebar for 'Discharge Practitioner' and 'Discharge Remarks/Comments'. The 'Date Of Discharge' is set to 02/07/2013, 'Discharge Time' is 01:32 PM, 'Discharge Day Of Week' is THURSDAY, and 'Length Of Stay' is 241. The 'Type Of Discharge' is set to 'No Further Care Needed At This Facility'. The 'Discharge Practitioner' is listed as NAN DAME (000006). The 'Discharge Remarks/Comments' field contains the text 'type comments about discharge'.

**Patient Information:**  
Name: CARLOS FUENTES (981248689)  
DOB: M, 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, Current, H, M, AM/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 patient's name is 'CARLOS FUENTES (981248689)', born 'M, 60, 06/11/1952'. The location is 'homeless, San Francisco, ...'. The attending practitioner is 'MUNOZ, PABLO' and the admitting practitioner is 'HEPWORTH, JON'. The 'Discharge (Outpatient)' tab is selected. The 'Demographics' section is active, showing fields for: Client Last Name (FUENTES), Client First Name (CARLOS), Client's Middle Initial, Suffix (radio buttons for Sr, Jr, III, IV, V, VI), 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, Client's Email Address, Communication Preference (radio buttons for Email, Regular Mail, Home Phone, Work Phone, Cell Phone), Primary Language, Client Race, Ethnic Origin, Religion, Place Of Birth, Country Of Origin, Maiden Name, Marital Status (Single / Never Married), Education, Alias 7, and Alias 8. The status bar at the bottom shows 'AVCALPHIVE (SAMPLE)', the date and time '02/07/2013 01:33 PM', and a zoom level of '108%'.

Avatar 2011

Home Carlos F Courses Preferences Lock Sign Out Switch Help JHEPWORTH

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

Chart Discharge (Outpatient)

Discharge  
Demographics  
Submit

Online Documentation

Client Last Name  
FUENTES

Client First Name  
CARLOS

Client's Middle Initial

Suffix  
☐ Sr ☐ Jr ☐ III  
☐ IV ☐ V ☐ VI

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

Client's Email Address

Communication Preference  
☐ Email ☐ Regular Mail ☐ Home Phone  
☐ Work Phone ☐ Cell Phone

Primary Language

Client Race

Ethnic Origin

Religion

Place Of Birth

Country Of Origin

Maiden Name

Marital Status  
Single / Never Married

Education

Alias 7

Alias 8

AVCALPHIVE (SAMPLE) 02/07/2013 01:33 PM 108%



# 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- # in Staff? 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
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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.

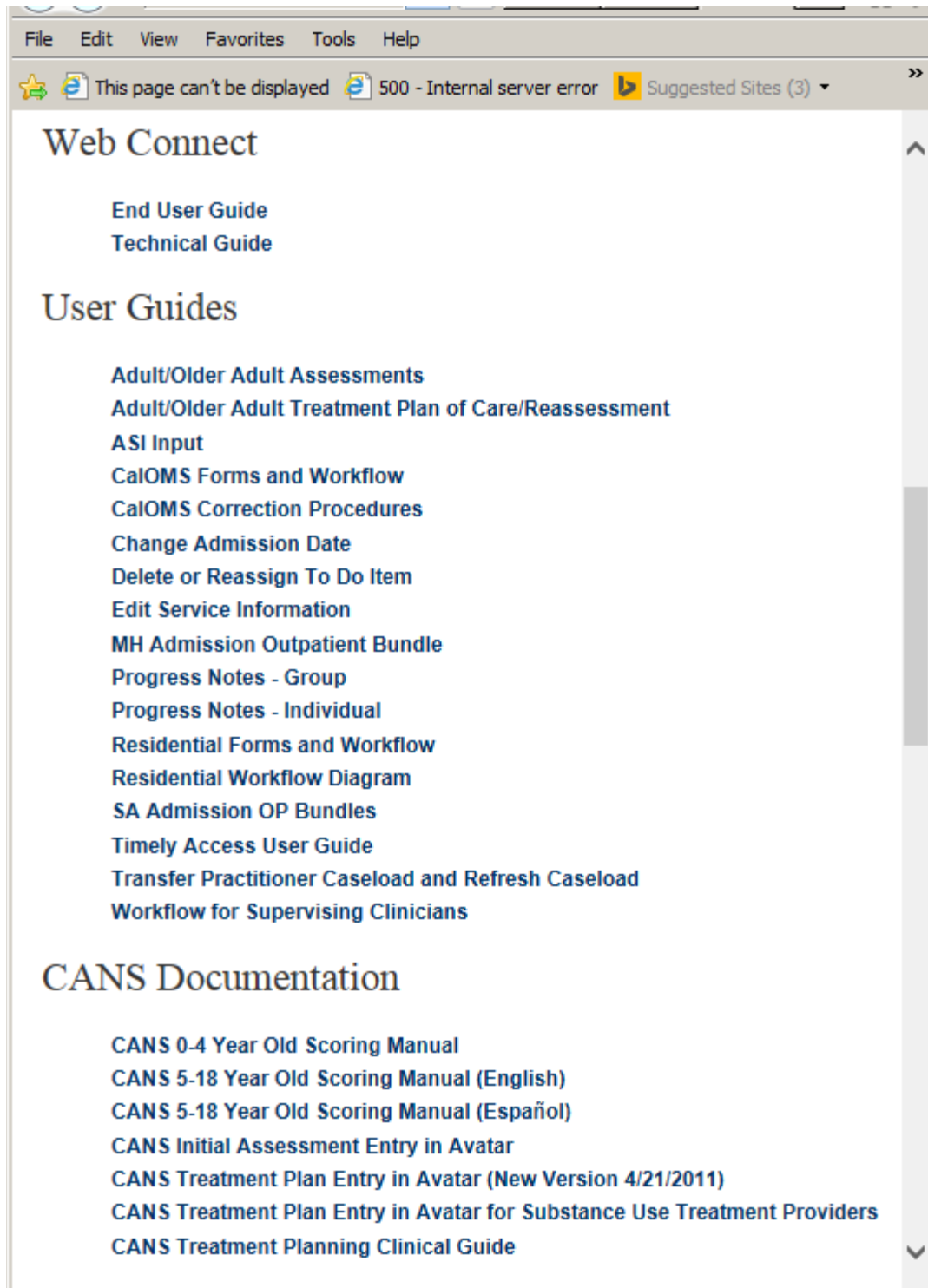
Select “**SF Avatar User Documentation**” link.

You will see the page, below.

Save the page as an internet favorite.

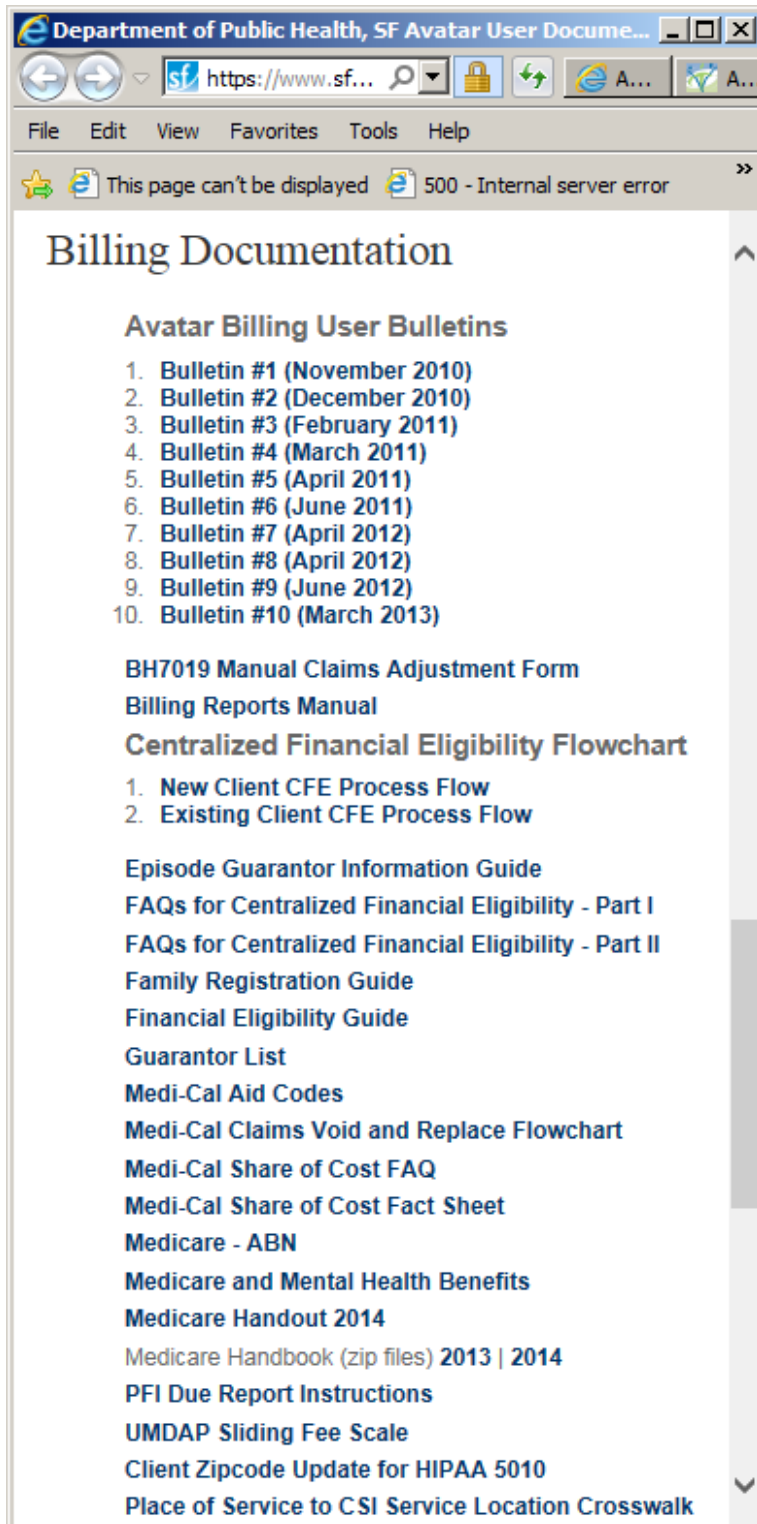
The screenshot shows the San Francisco Department of Public Health website. The header includes the department name, a search bar, and navigation links like 'SF Health Network', 'Laguna Honda', 'News & Media', 'SFPDH Foundation', and 'Contact Us'. Below the header is a navigation menu with categories 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' with links for March, April, May, and June 2015, 'DSM 5' with links for 'DSM 5 Avatar Presentation', 'DSM 5 Recommended Schedule', and 'DSM IV to DSM 5 Crosswalk', and 'Forms' with links for 'CBHS Computer Account and Training Request Form', 'Certification and Verification for Staff ID', 'User Confidentiality, Security and Electronic Signature Agreement', 'Avatar Correction Request Form', and 'Avatar Correction Procedure'. A 'HELPFUL LINKS' sidebar on the right contains links for 'Avatar Notice of Action (NOA) Letters' and 'Avatar Data Collection Forms'.

## Avatar Documentation Website (continued)

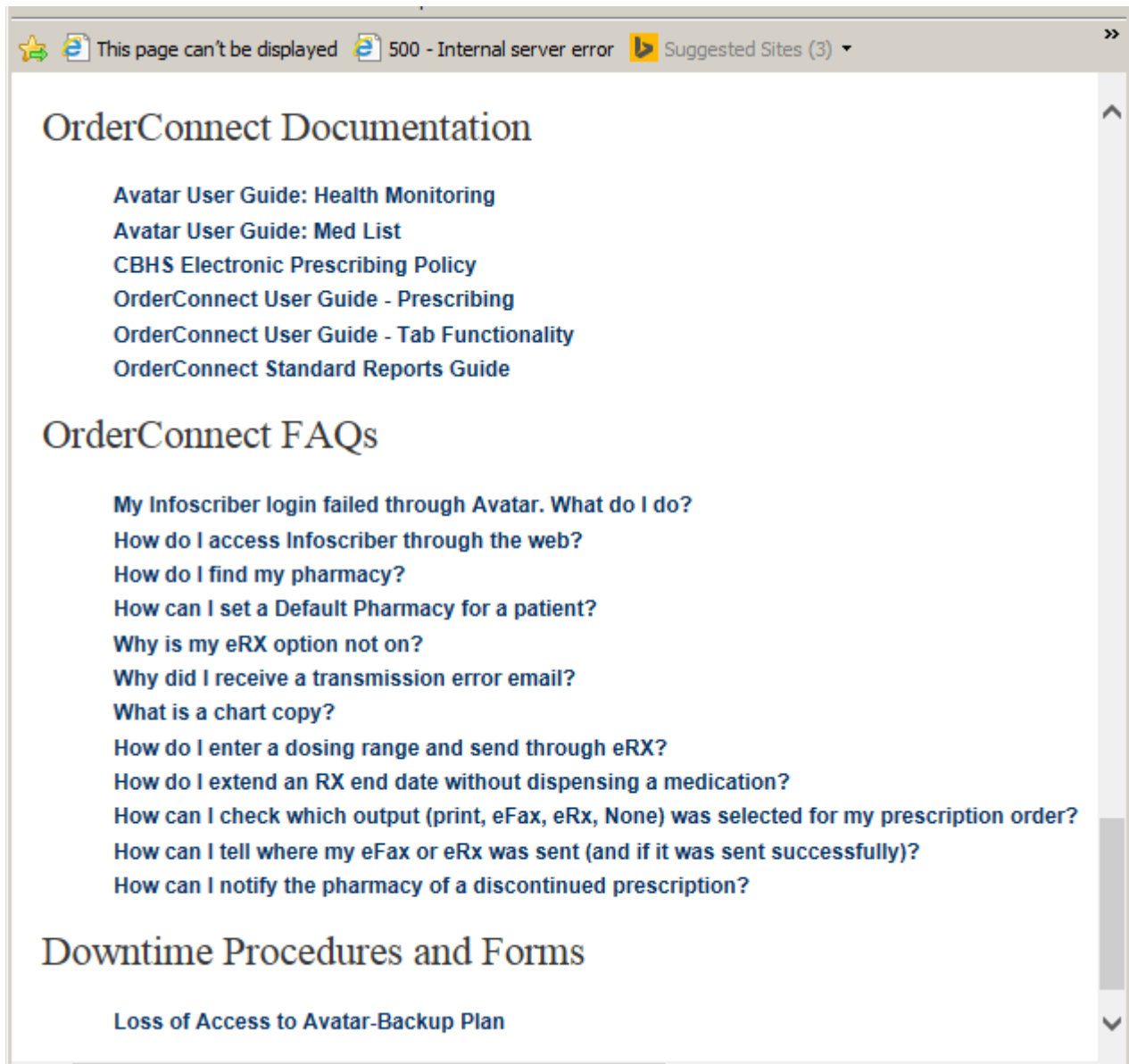




## Avatar Documentation Website (continued)



## 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