Avatar Clinical Training

Mental Health

(Guide / Manual)

1380 Howard Street
1st Floor Training Room
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INTRODUCTION

Contact Information for Avatar Questions

Clinical Policy Questions: CBHS Quality Management Work Group
- Alexander Jackson alexander.e.jackson@sfdph.org
- Farahnaz (Farah) Farahmand: Farahnaz.farahmand@sfdph.org

Technical Questions: Technical Work Group
- Mauricio Torres mauricio.torres@sfdph.org

Avatar Champions
- Kellee Hom kellee.hom@sfdph.org

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

General Billing Questions:
- Billing Inquiry Line: (415) 255-3557
HIPPAA & Privacy Statement

Protected Health Information (PHI)

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

Learning Objectives

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

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

Welcome to The Department of Public Health’s WebConnect Portal
You have been issued a first time access password to activate your WebConnect account.

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

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

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

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

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

After clicking on “Start Setup” you will be presented with the 3 choices below. Please choose “Mobil phone.”
Choosing Mobile phone will take you to this screen

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

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”.

![Registration screen](image.png)

![Android installation](image.png)
Now (while DUO app is open on your phone) point your phone at the barcode displayed on your computer screen to activate DUO.

When you have successfully scanned the barcode, click Continue.
On completion of the setup you will see the following:

Please Click on "Save" and then "Continue to login"
After you have gone through setup the first time you will see the following after login in.

![Duo Push Authentication Method]

**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.”

![Login Request Image]

SF Dept of Public Health
Pulse Secure SSL VPN

paul zabriskie
75.6.228.43
San Francisco, CA, US
2:56:46 PM PDT
June 1, 2016

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

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

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

You will now proceed to your Home Page
Your home page

![WebConnect Home Page](image)

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

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Preferences</td>
<td>Help</td>
<td>Sign Out</td>
</tr>
</tbody>
</table>

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

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

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

**Sign Out** closes your WebConnect session and logs you out.
From your home page you click on The Netsmart Avatar Link to launch Avatar and Login to your Avatar account.

NetSmart Avatar

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

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

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

Phone: (415) 255-3788
Email: avatarhelp@sfdph.org

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

Logging into Avatar: Passwords

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

How can I remember my password?

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

Avatar Modules

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

**Episode Opening**

- MH OP Admission Bundle
  - Admission (Outpatient)
  - CSI Admission
  - Episode Guarantor Information
- CSI Assessment
- Contact Information
- Admission Referral Information
- Forms Bundle

**Episode Opening**

- Residential Admission Bundle
  - Admission
  - CSI Admission
  - Episode Guarantor Information
  - Admission Referral Information
  - Contact Information
  - Forms Bundle

**Family Registration (UMDAP)**

**Diagnosis (admission)**

**Assessment (As appropriate – see CBHS Policy)**
  - CANS CYF Assessment
  - Adult/Older Adult Assessment

**Diagnosis (update)**

**Treatment Plans (As appropriate – see CBHS)**
  - CYF 0/18 Treatment Plan of Care
  - Adult/Older Adult MH Treatment Plan of Care

**Closing Summary (As appropriate – see CBHS)**
  - Cans CYF Closing Summary
  - Adult/Older Adult Closing Summary

**Progress Notes (Group and Individual)**
  - Append Progress Note

**Discharge (Outpatient)**

**MH OP (END)**

**Discharge**

**MH Residential (END)**
Navigation

Avatar Home View
Avatar eLinks

Current Medications, Labs, Vitals
OVERVIEW OF EPISODE OPENING

Admission Bundles

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

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

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

- Admission
  (Path: Avatar PM)/Client Management/Episode Management)
- CSI Admission
  (Path: Avatar PM)/Client Management/Client Information)
- Episode Guarantor Information
  (Path: Avatar PM)/Client Management/Account Management)
- Admission Referral Information
  (Path: Avatar PM)/Client Management/Client Information)
- Contact Information
  (Path: Avatar PM)/Client Management/Client Information)
- Forms (not in bundle)
  (Path: Avatar PM)/Client Management/Client Information)
- Diagnosis (not in bundle)
  (Path: Avatar PM)/Client Management/Client Information)
If client’s social security number is unknown (or none), enter “000-00-0000”.
Admission (Outpatient) - continued
If Client is homeless, enter “homeless” in Address Line 1. Leave Address Line 2 blank. Then, add 9-digit zip code, city, county and state that correspond to program. See USPS.com to match zip code to address.

DO NOT enter special characters. For example:

1380 Howard St Apt 300

Primary Language is required. If this is not known, select “unknown”.
Note that “Smoker” status is required for reasons of “Meaningful Use”.

Below is required question on client’s primary care provider.
Note that date of smoking status assessment is required.
CSI Admission
(Path: Avatar PM/ Client Management / Client Information)
# of Dependents (Children or Adult) is 0-98. Unknown = “99”
CSI Assessment
Episode Guarantor Information
(Path: Avatar PM / Client Management / Account Management)
Contact Information
(Path: Avatar PM / Client Management / Client Information)
Admission Referral Information
(Path: Avatar PM / Client Management / Client Information)
Forms Bundle
(Path: Avatar PM / Client Management / Client Information)

The following forms are available in order to collect client signatures electronically:
- Consent for BHS MH/SUD Services
- HIPAA Form
- Acknowledgement of Receipt of Materials
- Billing Authorization
- PFI Signature
- Advance Beneficiary Notice of Non-coverage

Other form (not in the bundle)
- PHI Authorization
- Medication Consent
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)

### Confidential Patient Information

<table>
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<th>Date of Diagnosis: 2/19/2016</th>
<th>Type of Diagnosis: Update</th>
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<tbody>
<tr>
<td>Rank</td>
<td>Description</td>
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<tr>
<td>Primary</td>
<td>Depression emotion</td>
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<tr>
<td>Axis IV</td>
<td>Primary Support Group</td>
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<tr>
<td>Axis IV</td>
<td>Social/Environmental</td>
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<tr>
<td>Axis IV</td>
<td>Educational</td>
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<tr>
<td>Axis IV</td>
<td>Occupational</td>
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<tbody>
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<td>Rank</td>
<td>Description</td>
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<tr>
<td>Primary</td>
<td>Depressed</td>
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TRANSFER CASELOAD

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

This form is used by supervisors to transfer cases from one clinician to another.
### Transfer Practitioner Caseload – continued

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<thead>
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<th>Client</th>
<th>Episode</th>
<th>Program</th>
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<td>981241004</td>
<td>2</td>
<td>Walden House Multi Service</td>
<td>07/19/2012</td>
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<tr>
<td>560</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>09/24/2012</td>
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<tr>
<td>561</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>09/24/2012</td>
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<tr>
<td>513</td>
<td>2</td>
<td>Westside Outpatient Clinic</td>
<td>09/24/2012</td>
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<tr>
<td>874</td>
<td>1</td>
<td>Bay Psychiatric Associate</td>
<td>01/09/2013</td>
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<tr>
<td>411</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>09/11/2012</td>
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</tbody>
</table>
CHILD, YOUTH, AND FAMILIES (CYF)

CANS CYF 6 thru 20 Assessment
(Path: Avatar CWS/Assessments/User Assessments/CANS 2.0)
CANS CYF 5/18 Assessment - continued

[Image of the CANS CYF 5/18 Assessment form]
CANS CYF 6 thru 20 Assessment Rpt

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

1. Presentation

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

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

Psycosis Conduct
Insufficiency/Acourbativity Somnolent
Depression Anger Control
Substance Use Attachment Difficulties
Anxiety Eating Disorders
Gastrointestinal Adjustment to Trauma

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

2. Trauma/Abuse

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

Trauma Events:

Sexual Abuse 0 Witness to School Violence 0
Physical Abuse 0 Natural or Man-Made Disaster 0
Emotional Abuse 0 War/Terrorism Affected 0
Neglect 0 Victim/Witness to Criminal Activity 0
Mental Trauma 0 Disruption in Caregiving/Afflict Losses 0
Violence in First Relations 0 Sexual/Criminal Exploitation 0
ADULT/OLDER ADULT (AOA)

Adult/Older Adult Assessment (Combined)
(Path: Avatar CWS/Assessments/Adult Assessments/ANSA)
**Adult/Older Adult Assessment (Combined) – continued**

**Priorities for Treatment**

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

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

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

<table>
<thead>
<tr>
<th>Behavioral Health Needs</th>
<th>Life Functioning and Acculturation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks / Risk Behaviors</th>
<th>Client Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use / Med Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Adult/Older Adult Assessment Combined Rpt
(Path: Avatar CWS / Assessments / Adult Assessments / ANSA)

San Francisco Department of Public Health
Community Behavioral Health Services

Adult/Older Adult Assessment (Combined) Report

Client Name: TESTCLIENT, SUMMARY Y SR DR
Client ID: 1
Program: ACCESS Screening (BHAC)
Episode #: 50
Admission Date: 12/19/2020
Discharge Date: None

Confidential Patient Information

Assessment Date: 1/30/2021
Assessment Type: Short
Assessment Category: Initial
Interpreter Serv Used: No
Language: Other:
Assessment By: Kimberly Vosiker (000089)
Service Program: ACCESS Screening
Assessment Status: Draft

1A. Presenting Problem

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

TEST

ANSA Ratings - Behavioral Health Needs

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>0</th>
<th>Interpersonal Problems Due to Personality</th>
<th>ND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>ND</td>
<td>Adjustment to Trauma</td>
<td>ND</td>
</tr>
<tr>
<td>Anxiety</td>
<td>ND</td>
<td>Mania</td>
<td>ND</td>
</tr>
<tr>
<td>Impulse Control</td>
<td>ND</td>
<td>Sleep Disturbance</td>
<td>ND</td>
</tr>
</tbody>
</table>
Assessment Diagnosis
(Path: Avatar PM/ Client Management/ Client Information)

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

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

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

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

***Do not use the Print Treatment Plan form to print Treatment Plans***
Starting the CYF 0/18 Treatment Plan of Care

Date Treatment Plan Started: 07/20/2015

Plan Type: Initial

Plan End Date: 07/19/2016

Last Updated: 07/20/2015

Clinical Guideline: Include child/youth and family’s goal(s), stated in their own words, which they identified as a priority.
Treatment Plan Problem List

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

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

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

3. Choose Participant Role.

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

5. Click each box to fill in additional participant information.

Plan Participants are individuals who participated in the plan development.

<table>
<thead>
<tr>
<th>Role</th>
<th>Staff ID</th>
<th>Participant Name</th>
<th>Plan Author</th>
<th>Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Role search results:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinician/Staff</td>
</tr>
<tr>
<td>2</td>
<td>Child/Youth</td>
</tr>
<tr>
<td>3</td>
<td>Parent/Guardian</td>
</tr>
<tr>
<td>4</td>
<td>Collateral (e.g., Teacher, PO)</td>
</tr>
</tbody>
</table>
Starting your Treatment Plan – Text entry

Strengths-based treatment planning

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

Discharge Planning

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

Launch Plan

Click "Launch Plan" to start your Treatment Plan.
1. Make sure the Treatment Plan is highlighted.

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

**Problem Code**

Search for a Problem Code (SNOMED) code using a keyword and select from the list.
Treatment Plan – Adding a Goal

To add a Goal for the selected Problem, click “Add New Goal.”

Select Goal Status from the drop-down list.

Date Opened defaults to today’s date.

If Status of Goal is “Achieved” or “Inactive,” enter the Date Closed.
Treatment Plan – Adding an Objective
Treatment Plan – Adding an Intervention

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

- Date Opened: 07/20/2015
- Date Closed: [Blank]
- Status: Active/New
- Select Intervention Status from the drop down list.

To add an Intervention, click “Add New Intervention.”

Description of Intervention appears here.
Treatment Plan – Adding Additional Problems

When the top of the Treatment Plan is highlighted, the “Add New Problem” button becomes active. Click “Add New Problem” to enter a new item.
Treatment Plan – Editing Items on your Treatment Plan

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

Clinical Guideline: Describe outcomes desired based on symptoms and associated impairments: e.g., "Reduce and manage ADHD symptoms"
Treatment Plan – Deleting items from your plan

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

Click the “Delete Selected Item” button to delete items from the Treatment Plan.
Treatment Plan – Saving/Submitting your Plan

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

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

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

Make sure to click "Back to Plan Page"
Treatment Plan – Saving/Submitting your Plan (continued)

![Image of Treatment Plan interface]

- Date Treatment Plan Started: 07/20/2015
- Last Updated By: Kimberly Voecker
- Parent/Youth Input:
  Clinical Guideline: Include child/youth and family's goal(s), stated in their own words, which they identified as a priority.
- Treatment Plan Status: Draft
- Client was linked to culture specific and/or linguistic services: Yes
- Last Updated: 07/20/2015
ADULT/OLDER ADULT MENTAL HEALTH TREATMENT PLAN OF CARE
Avatar User Guide: Adult/Older Adult MH Treatment Plan of Care

Overview

- **Purpose:** The purpose of the manual is to walk you through the new Adult/Older Treatment Plan of Care in the Avatar EHR System.

- **Rational:** The reason for moving to a new version of the treatment plan is to bring us into alignment with optimizing our use of electronic records with a focus on being able to use standardized fields in order to communicate in a meaningful way across our system.

- **Menu Path:** Avatar CWS>Treatment Planning>Adult/Older Adult MH Treatment Plan of Care
Starting the Adult/Older Adult MH Treatment Plan of Care
Treatment Plan Problem List
The federal government, as part of Meaningful Use, have required that problems be listed in a standardized format. They have adopted the Standardized Nomenclature Of MEDicine (SNOMED) codes. You can push a diagnosis to the problem list from the Diagnosis screen. It is also possible to add Problem codes here or once you launch the plan.

<table>
<thead>
<tr>
<th>Include in this plan?</th>
<th>Problem</th>
<th>Other</th>
<th>Type</th>
<th>Date Identified</th>
<th>Date of Onset</th>
<th>Time Of Onset</th>
<th>Status</th>
<th>Severity</th>
<th>Chronicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chronic anxiety</td>
<td></td>
<td></td>
<td>08/20/2015</td>
<td></td>
<td></td>
<td>Active (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Homeless single</td>
<td></td>
<td></td>
<td>10/06/2014</td>
<td></td>
<td></td>
<td>Active (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Posttraumatic disorder</td>
<td></td>
<td></td>
<td>10/06/2015</td>
<td></td>
<td></td>
<td>Active (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Geophagia (SN...</td>
<td></td>
<td></td>
<td>01/21/2016</td>
<td></td>
<td></td>
<td>Active (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Masked depression</td>
<td></td>
<td></td>
<td>01/27/2016</td>
<td></td>
<td></td>
<td>Active (A)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Optional: Plan Participants

<table>
<thead>
<tr>
<th>Role</th>
<th>Staff ID</th>
<th>Participant Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Staff ID</th>
<th>Participant Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>hom</td>
<td></td>
</tr>
</tbody>
</table>

4. A list of matches will appear.
5. Double click on the Staff Name you would like to enter.
6. Yes or No
7. Yes, to receive a to do item
   No, if not
Optional: Plan Participants

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Staff ID</th>
<th>Participant Name</th>
<th>Plan Author</th>
<th>Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician/Staff (1)</td>
<td>HOM,KELLEE (00...</td>
<td>HOM,KELLEE</td>
<td>Yes (Y)</td>
<td>Yes (Y)</td>
</tr>
<tr>
<td>Other (3)</td>
<td></td>
<td></td>
<td>No (N)</td>
<td>No (N)</td>
</tr>
</tbody>
</table>

New Row | Delete Row | Participant Name

Type Name Here | Ok | Cancel
Strengths, Impairments, and Plan for Discharge
Treatment Plan – Problem

Problem: Depressive disorder

- Date of Onset: 01/15/2016
- Date Problem Identified: 02/05/2016
- Date Closed

Status: Active
Components of the Problem Section
The following sections will populate the Problem List

**Problem Code** (see next page)

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

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

**Status** if Inactive or Resolved are selected they will drop off the list in future TPOCs
### Components of the Problem Section

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNOMED-192042008</td>
<td>(SNOMED-192042008) Acute post-trauma stress state</td>
</tr>
<tr>
<td>SNOMED-192061007</td>
<td>(SNOMED-192061007) Concentration camp syndrome</td>
</tr>
<tr>
<td>SNOMED-25944005</td>
<td>(SNOMED-25944005) Rape trauma syndrome: silent reaction</td>
</tr>
<tr>
<td>SNOMED-313182004</td>
<td>(SNOMED-313182004) Chronic post-traumatic stress disorder</td>
</tr>
<tr>
<td>SNOMED-317816007</td>
<td>(SNOMED-317816007) Stockholm syndrome</td>
</tr>
<tr>
<td>SNOMED-318784009</td>
<td>(SNOMED-318784009) Posttraumatic stress disorder, delayed onset</td>
</tr>
<tr>
<td>SNOMED-39093002</td>
<td>(SNOMED-39093002) Post-trauma response</td>
</tr>
<tr>
<td>SNOMED-443919007</td>
<td>(SNOMED-443919007) Complex posttraumatic stress disorder</td>
</tr>
<tr>
<td>SNOMED-446175003</td>
<td>(SNOMED-446175003) Acute posttraumatic stress disorder following military combat</td>
</tr>
<tr>
<td>SNOMED-446180007</td>
<td>(SNOMED-446180007) Delayed posttraumatic stress disorder following military combat</td>
</tr>
<tr>
<td>SNOMED-47505003</td>
<td>(SNOMED-47505003) Posttraumatic stress disorder</td>
</tr>
<tr>
<td>SNOMED-54231004</td>
<td>(SNOMED-54231004) Rape trauma syndrome</td>
</tr>
<tr>
<td>SNOMED-7397008</td>
<td>(SNOMED-7397008) Aggressor identification syndrome</td>
</tr>
</tbody>
</table>
Click the highlighted name of the Treatment Plan, then click "Add New Problem."
Treatment Plan - Adding a Goal

If Resolved is selected, you will be asked to enter "Date Closed".
Treatment Plan – Adding an Objective

If “Met” is selected, you will be asked to enter Date Met.
Treatment Plan – Adding an Intervention

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

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

If "Discontinue" selected, you will be asked to enter Date Discontinued.
# Treatment Plan – Editing Items

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

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

**Interventions**

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

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

---

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

**Intervention**

<table>
<thead>
<tr>
<th>Date Identified</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/17/2015</td>
<td>Continue</td>
</tr>
</tbody>
</table>

**Date Discontinued**
Treatment Plan – Deleting Items

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

Click to highlight the bottom level item and then select "Delete Selected Item".
Treatment Plan – Submitting and Saving
Treatment Plan – Submitting and Saving

A screenshot of a software interface showing a section labeled 'Adult/Older Adult MH Treatment Plan of Care'. The interface includes fields for 'Plan Effective Date' and 'Plan End Date', along with options to select 'Yes' or 'No' for various statements about the client. The effective date is set to 02/05/2016, and the end date is set to 02/04/2017.
Printing the TPOC

San Francisco Department of Public Health
Community Behavioral Health Services

Adult/Older Adult MH Treatment Plan of Care

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

Confidential Patient Information

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

Plan Type: Initial
Plan Status: Draft
Discharge Date:
Progress Notes Group and Individual Form

Progress Notes

(Path: Avatar CWS/Progress Notes)
Progress Notes requiring Cosignature

Note: This is an intern note with “cosign” note type selected. Supervisor name is selected from
Progress Notes Without Pagebreaks
(Path: Avatar CWS / Progress Notes)

Note: This is a report of progress notes
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:

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.

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”

6. Type in **Notes Field**
Scroll down on page to see the following:

8. **Select Service Program**
   (Do not select “EPISODE”)

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

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

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

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

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

10. **If client is ≤ 18 yrs, then select appropriate CYF treatment plan and paste into box on right.**
    If client is adult, then the “Select T.P. Version” will not work. Go back to “Notes Field” above and hand-type reference to relevant part of Tx Plan.
Below, an item from the CYF Treatment Plan is selected and linked to the progress note.

Clicking “Return” delivers you back to progress note.
Below, selected objective from Children’s Treatment Plan is linked to progress note.
Below, if there is no Children’s Treatment Plan to link (or if using a plan for adults) – type reference to plan in Notes Field.
In this example, user selects “draft” and then clicks “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.
Retrieving Draft Notes:

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

1. Enter client name.
2. Select episode
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.

“Append Progress Note” function allows addition of comment to a finalized note by author. Except – interns are not allowed to append finalized notes that have been approved by supervisor.
Group Registration
(Path: Avatar PM / Appointment Scheduling / Group Management)
## Group Registration - continued

### Group Member Assignment

<table>
<thead>
<tr>
<th>Client</th>
<th>Episode Number</th>
<th>Group Assignment Start Date</th>
<th>Group Assignment End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>WALKER, JOHNNY</td>
<td>1</td>
<td>08/02/2012</td>
<td>01/22/2013</td>
</tr>
<tr>
<td>JASMINE, PRINCESS</td>
<td>1</td>
<td>08/02/2012</td>
<td>08/15/2012</td>
</tr>
<tr>
<td>TOM, JERRY</td>
<td>1</td>
<td>08/02/2012</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information

- **Client:** WALKER, JOHNNY (336)
- **Episode Number:** 1
- **Admit Date:** 06/27/2011
- **Group Assignment Start Date:** 08/02/2012
- **Group Assignment End Date:** 01/22/2013
**Group Progress Notes User Guide**

**Introduction:**

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

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

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

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

Work begins on the “Group” section and then continues on the “Individual” section.
Creating Group Progress Notes:

1. Go to Progress Notes (Group and Individual) and begin at Group Default Notes.

2. At Date of Group, enter service date.

3. At Practitioner, enter clinician name “last,first”.

4. At Progress Note For, select ONLY New Service. Choose “New Service” for billable or non-billable (no show or admin).

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

6. Do NOT click File Note button.

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

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

9. At Note Type, select “Group” or other appropriate code from drop-down list.

10. If intern, select Note Type code that includes “cosign”. Then select supervisor from “User To Send Co-sign…” box.
12. At **Service Charge Code**
Enter word/code (e.g. "DBT Group Therapy").

See Jan 2013 CPT Code changes.

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

14. **Do NOT** click “File Note”.

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

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

16. Enter **Practitioner Face To Face Time (in minutes)** group.
Enter total time without multiplying by number of clients.
In the example above 63 minutes was time counted from first client arrival till last client departure from group session.

**Do NOT** multiply “63 minutes” (Number of clients) Avatar will automatically calculate individual client service charge.

Then add **Practitioner Doc and Travel Time (in minutes)**.
After filing group note these numbers cannot be changed.
Adding walk-in and Removing the no-show client from group session:

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:

20. When finished writing note, click on either of the two “File Note” buttons.
Below is image of user leaving the Group Default Notes section and selecting Individual Progress Notes section

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.

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.

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

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

5. Note that Avatar has re-coded Progress Note For as “Existing Service”.
6. After selecting note, edit the **Notes Field** by adding a 2nd 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”.
Individualize the Group Note:

Finalizing the progress note:

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

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

10. Click “OK”
Now, a single note remains in limbo. Note belongs to client, Garrett Trey.

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

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.

13. Click “OK”

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

14. Note that the “Select Note To Edit” box is empty, because all notes have been saved as Draft or Final.

This empty box reveals that nothing remains in “limbo”. All related notes are now “draft” or “final”.

Retrieving draft note for Garrett Trey:

15. At Individual Progress Notes section, enter Client Name and select Episode.
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.

18. Make final edits. Remember that the Time (minutes) is saved in Avatar, but hidden from user’s view.
Individualize the Group Note:

19. Now, save note as “Final” and click “File Note”

20. Click “OK” and you are finished.

Confirmation that note has been successfully filed:

Note: an “Intern” note that is final + approved by supervisor cannot be appended.
SERVICE CORRECTIONS
Edit Service Information
(Path: Avatar PM / Services / Ancillary / Ambulatory Services)
VOCATIONAL REFERRALS
MH Vocational Program Referrals/Enrollments
(Path: Avatar PM / New Forms)

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

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

Discharge
Demographics
Child Youth and Family

CANS CYF 5/18 Closing Summary
(Path: Avatar CWS / Assessments / User Defined Assessments / CANS)
**CANS CYF Closing Summary Rpt**
(Path: Avatar CWS / Assessments / User Defined Assessments / CANS)

---

**San Francisco Department of Public Health**
**Community Behavioral Health Services**

**CANS CYF Closing Summary Report**

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

**Assessment Date:** 2/28/2015
**Assessment Practitioner:** Kimberly Voelker
**Episode Opening Date:** 7/1/2010
**Last Date of Service:**

**CLINICIAN INFORMATION**
**Name of Clinician:** VOELKER, KIMBERLY
**Clinician Address:** 1380 Howard St
San Francisco, CA 94103-2638
**Telephone:** 415-503-4730

**Assessment Date Completion Date**
**Program of Service Assessment Status**
2/28/2015 A Better Way (3&G12) Draft

---

**CONFIDENTIAL PATIENT INFORMATION**

---

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

<table>
<thead>
<tr>
<th>Key: 0 = no evidence or no reason to believe item requires any action</th>
<th>1 = needs watchful waiting, monitoring or possibly preventive action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 = needs action, strategy needed to address problem/need</td>
<td>3 = needs immediate / intensive action, immediate safety concern / priority for intervention</td>
</tr>
</tbody>
</table>

- **Psychosis**
- **Impulse Hyperactivity**
- **Depression**
- **Anxiety**
- **Oppositional**

---

**TRAUMA SYMPTOMS**

- **Affec Regulation**
- **Infusions**
- **Attachment**
- **Dissociation**
- **Adjustment to Trauma**

---
ADULT / OLDER ADULT

Adult/Older Adult Closing Summary
(Path: Avatar CWS / Assessments / Adult Assessments/ANSA)
Adult/Older Adult Closing Summary Rpt
(Path: Avatar CWS / Assessments / Adult Assessments/ANSA)

San Francisco Department of Public Health
Behavioral Health Services

Adult/Older Adult Closing Summary

Confidential Patient Information

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

Assessment By: Kimberly Voelker (000089)
Service Program: A Better Way (38G12)
Assessment Status: Draft

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

Closing Summary:

1a. Behavioral Health Needs

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>0</td>
<td>No Data</td>
</tr>
<tr>
<td>1</td>
<td>Mild. History/sub-threshold, watch</td>
</tr>
<tr>
<td>2</td>
<td>Moderate. Need for action</td>
</tr>
<tr>
<td>3</td>
<td>Severe. Need for immediate/intensive action</td>
</tr>
</tbody>
</table>

- Psychosis
- Depression
- Anxiety
- Adjustment to trauma
- Impulse control
- Interpersonal problems
The MHS140 Report shows the entire episode history of selected client.
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.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Client ID</th>
<th>Age</th>
<th>Race</th>
<th>Epi#</th>
<th>Admitting Practitioner</th>
<th>Attending Practitioner</th>
<th>Episode Opening</th>
<th>Last Service Date</th>
<th>Active/ Inactive?</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF SU Student Success Program (38HGIN)</td>
<td>999049104</td>
<td>14</td>
<td>No Entry</td>
<td>1</td>
<td>HOM,KELLEE</td>
<td>No Entry</td>
<td>5/30/2015</td>
<td></td>
<td>NO SERVICES</td>
</tr>
</tbody>
</table>

Total caseload for program: SF SU Student Success Program (38HGIN): 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.

<table>
<thead>
<tr>
<th>Program: ACCESS Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Date</td>
</tr>
<tr>
<td>04/11/2016</td>
</tr>
<tr>
<td>Subtotal for 4/11/2016</td>
</tr>
<tr>
<td>Subtotal for Program BHAC</td>
</tr>
</tbody>
</table>
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.
Progress Notes in Draft Clinician Report

(Path: Avatar CWS / Progress Notes)

Confidential Patient Information

ACCESS Screening

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>TESTCLIENT, SUMMARY</th>
<th>Admission Date:</th>
<th>Client ID:</th>
<th>1</th>
<th>Discharge Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode #: 1</td>
<td>07/01/2010</td>
<td>Service Date (or Note Date # Independent Note): 5/30/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Code:</td>
<td>NO SHOW (ADM80)</td>
<td>FTE: 10 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Program:</td>
<td>ACCESS Screening</td>
<td>Doc/Trev: min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner:</td>
<td>HOM,KELLEE (003865) PID/PayO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location:</td>
<td>Other Place of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td>Draft</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Progress Note:
TEST

Total Notes in Draft for HOM,KELLEE for ACCESS Screening : 1
Group Notes Not Individualized Clinician
(Path: Avatar CWS / Progress Notes)
AVATAR DOCUMENTATION WEBSITE

URL address:  www.sfdph.org/dph/

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

Select “SF Avatar User Documentation” link.

You will see the page, below.

Save the page as an internet favorite.
Avatar Documentation Website (continued)

Web Connect

- End User Guide
- Technical Guide

User Guides

- Adult/Older Adult Assessments
- Adult/Older Adult Treatment Plan of Care/Reassessment
- ASI Input
- CalOMS Forms and Workflow
- CalOMS Correction Procedures
- Change Admission Date
- Delete or Reassign To Do Item
- Edit Service Information
- MH Admission Outpatient Bundle
- Progress Notes - Group
- Progress Notes - Individual
- Residential Forms and Workflow
- Residential Workflow Diagram
- SA Admission OP Bundles
- Timely Access User Guide
- Transfer Practitioner Caseload and Refresh Caseload
- Workflow for Supervising Clinicians

CANS Documentation

- CANS 0-4 Year Old Scoring Manual
- CANS 5-18 Year Old Scoring Manual (English)
- CANS 5-18 Year Old Scoring Manual (Español)
- CANS Initial Assessment Entry in Avatar
- CANS Treatment Plan Entry in Avatar (New Version 4/21/2011)
- CANS Treatment Plan Entry in Avatar for Substance Use Treatment Providers
- CANS Treatment Planning Clinical Guide
Billing Documentation

Avatar Billing User Bulletins
1. Bulletin #1 (November 2010)
2. Bulletin #2 (December 2010)
3. Bulletin #3 (February 2011)
5. Bulletin #5 (April 2011)
6. Bulletin #6 (June 2011)
7. Bulletin #7 (April 2012)
9. Bulletin #9 (June 2012)
10. Bulletin #10 (March 2013)

BH7019 Manual Claims Adjustment Form
Billing Reports Manual
Centralized Financial Eligibility Flowchart
1. New Client CFE Process Flow
2. Existing Client CFE Process Flow

Episode Guarantor Information Guide
FAQs for Centralized Financial Eligibility - Part I
FAQs for Centralized Financial Eligibility - Part II
Family Registration Guide
Financial Eligibility Guide
Guarantor List
Medi-Cal Aid Codes
Medi-Cal Claims Void and Replace Flowchart
Medi-Cal Share of Cost FAQ
Medi-Cal Share of Cost Fact Sheet
Medicare - ABN
Medicare and Mental Health Benefits
Medicare Handout 2014
Medicare Handbook (zip files) 2013 | 2014
PFI Due Report Instructions
UMDAP Sliding Fee Scale
Client Zipcode Update for HIPAA 5010
Place of Service to CSI Service Location Crosswalk
Avatar Documentation Website (continued)

OrderConnect Documentation

- Avatar User Guide: Health Monitoring
- Avatar User Guide: Med List
- CBHS Electronic Prescribing Policy
- OrderConnect User Guide - Prescribing
- OrderConnect User Guide - Tab Functionality
- OrderConnect Standard Reports Guide

OrderConnect FAQs

- My Infoscriber login failed through Avatar. What do I do?
- How do I access Infoscriber through the web?
- How do I find my pharmacy?
- How can I set a Default Pharmacy for a patient?
- Why is my eRX option not on?
- Why did I receive a transmission error email?
- What is a chart copy?
- How do I enter a dosing range and send through eRX?
- How do I extend an RX end date without dispensing a medication?
- How can I check which output (print, eFax, eRx, None) was selected for my prescription order?
- How can I tell where my eFax or eRx was sent (and if it was sent successfully)?
- How can I notify the pharmacy of a discontinued prescription?

Downtime Procedures and Forms

- Loss of Access to Avatar-Backup Plan

For all Avatar questions call or email:

AVATAR HELP LINE: (415) 255-3788
AVATAR E-mail: avatarhelp@sfdph.org

Go to website below for access to Avatar instructional videos:

http://www.vimeo.com/avatarhelpdesk
# KEYBOARD SHORTCUTS & STANDARD FORMATS

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

<table>
<thead>
<tr>
<th>FIELD TYPE</th>
<th>DATA ENTRY FORMAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>LAST, FIRST&lt;br&gt;LAST, FIRST JR (PUNCTUATION: Can use ‘ and -)&lt;br&gt;LAST, FIRST MI</td>
</tr>
<tr>
<td>Date:</td>
<td>MM/DD/YYYY – this format will default based on the date entered. &lt;br&gt;Date can be entered as M/D/YY or MM/DD/YYYY or MM/DD or MMDD where the current year is assumed.&lt;br&gt;Slash “ / ” can be replaced during entry with dash “ – “.&lt;br&gt;Click T or Y for Today or Yesterday, respectively.&lt;br&gt;Double-click in the date field to view clickable calendar option.&lt;br&gt;Enter T + #&lt;br&gt;(where # is the number of days added to today’s date.)&lt;br&gt;Enter T - #&lt;br&gt;(where # is the number of days in the past.)</td>
</tr>
<tr>
<td>Time:</td>
<td>To enter 8:00 AM/PM – type 8A or 8P, respectively.&lt;br&gt;To enter 8:30 AM/PM – type 8:30A or 8:30P, respectively.&lt;br&gt;Or click on “Current” button to enter the current time.&lt;br&gt;Arrow buttons (pointing up or down) will increase or decrease the hour or minute.</td>
</tr>
<tr>
<td>Dollar Amounts:</td>
<td>Enter whole dollar amounts without decimal. Enter incremental dollar amounts with decimal and cent amount. Dollar sign, spaces &amp; commas are not required.&lt;br&gt;Example: Enter 10 for $10.00&lt;br&gt;Example: Enter 10.03 or $10.03</td>
</tr>
</tbody>
</table>
Avatar Admission (PM) Common Error List

Updated: April 23, 2012

1) Creating new client record before adequately searching for an existing client record. Result is duplication and incomplete client record.

2) Selecting wrong client

3) Selecting wrong episode

4) Selecting wrong program name

5) Creating duplicate episode

6) Admission Screen:
   a) Misspelling client name
   b) Entering wrong admission date
   c) Selecting wrong admission program or selecting program name containing “(episode)” instead of the “RU#”

7) Cal-OMS Admission Screen:
   a) Missing Birth First Name or Birth Last Name (Correction = enter client’s Birth First (or Last) Name; 99902 for None or Not Applicable; 99904 for Client unable to answer)
   b) Missing Social Security Number: (Correction = format 123-45-6789; 99900 for ‘Client declines to state’; 99902 for None or Not Applicable; or 99904 for Client unable to answer)
   c) Missing Zip code at client’s current residence (Correction = Must enter valid 5 digit zip code; 00000 for ‘homeless’; XXXXX for ‘Client declined to state’; or ZZZZZ for Client unable to answer)
   d) Missing Driver’s License Number: (Correction = Client’s driver license number; 99900 for client declines to state; 99902 for None or Not Applicable; or 99904 for Client unable to answer)
   e) Creating an UMDAP for Substance Abuse client when not applicable

8) Diagnosis:
   a) Entering wrong “Date of Diagnosis.” The date of diagnosis must cover the date of admission.
   b) Leaving “Diagnosis – Axis II-1” blank: Type in “V71.09” for “No Diagnosis on Axis II”
Avatar Clinical (CWS) Common Error List

Updated: April 23, 2012

1. **Assessments:**
   a. Selecting wrong client
   b. Selecting wrong episode
   c. Selecting wrong program name
   d. Entering wrong date of assessment
   e. Entering wrong “Completion Date”
   f. Finalizing assessment that still needs review

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

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

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

**BLANK SAMPLE**

---

## Avatar Correction Request Form

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

<table>
<thead>
<tr>
<th>Program Name:</th>
<th>Reporting Unit Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Name:</td>
<td>Staff ID:</td>
</tr>
<tr>
<td>Client Last Name:</td>
<td>Client First Name:</td>
</tr>
<tr>
<td>Client ID/BIS:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Episode Number:</td>
<td></td>
</tr>
</tbody>
</table>

### Merge / BIS Number

- Duplicate #1
- Duplicate #2
- Duplicate #3

### Other versions of Client Name

- Duplicate #4
- Duplicate #5
- Duplicate #6

### Assessment / Reassessment

- **Date of Assessment:**
- **Type of Assessment:** (e.g. CANS-CYF Initial Assessment, A/GA (short) w/ANSR 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 *

- **Service Date:**
- **Procedure Code:**
- **Duration:**
- **Note Date:**
- **Note Time:**
- **Reason for correction:**

### Other (specify)

- **Date of Document:**
- **Reason for correction:**

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

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