Avatar Clinical Training

Substance Use Disorder

(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

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Technical Questions: Technical Work Group

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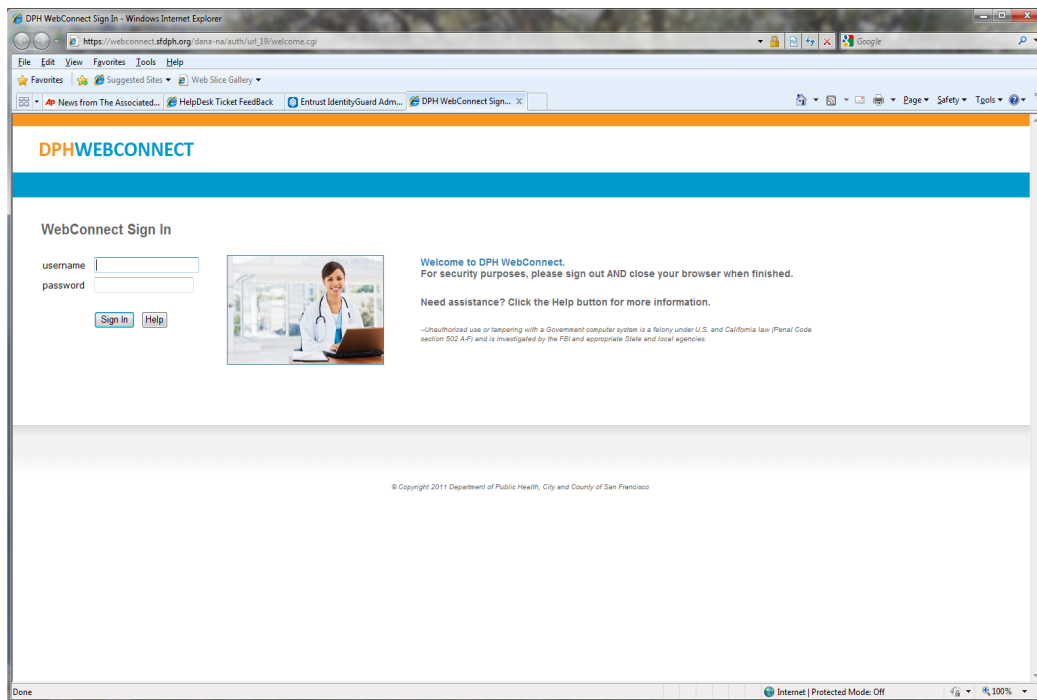
Upon first log in you will be asked to change your password.

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

DPHWEBCONNECT

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.

What is this?
Need help?

Powered by Duo Security

Start setup

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

Please choose "Mobil phone"

DPHWEBCONNECT

What type of device are you adding?

- ● **Mobile phone** RECOMMENDED
- ○ **Tablet** (iPad, Nexus 7, etc.)
- ○ **Landline**

What is this?
Need help?

Powered by Duo Security

Continue

Choosing Mobile phone will take you to this screen

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

After selecting your phone type you will be asked install the appropriate mobile application
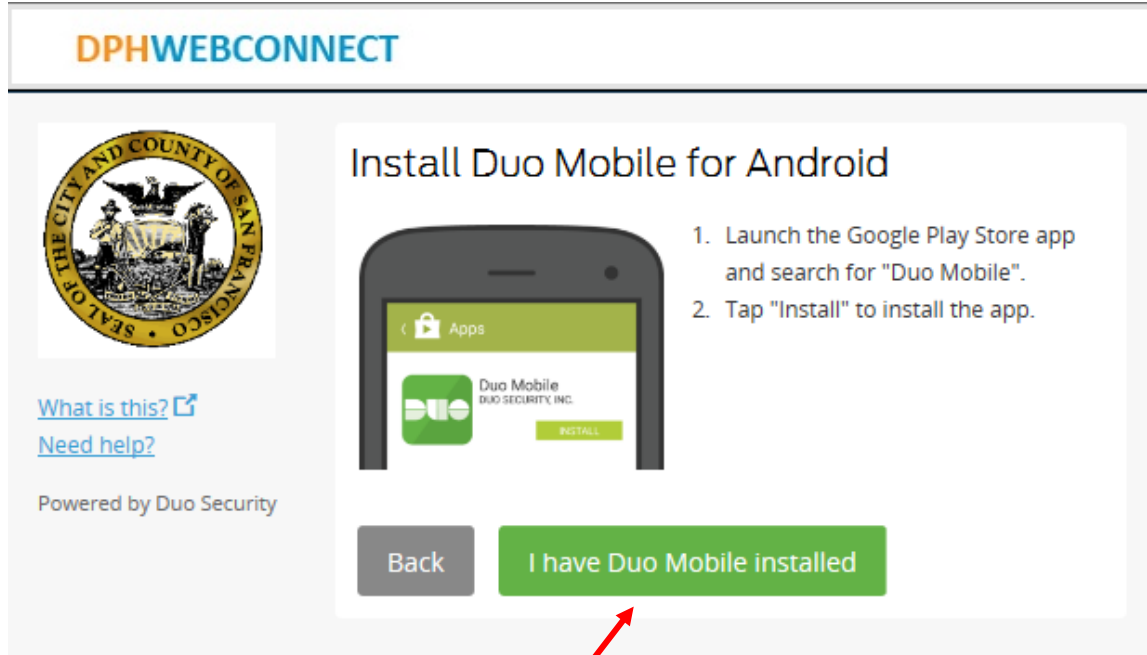
Click here **after the mobile app has been downloaded and installed**.

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

Search for mobile named "DUO SECURITY MOBILE" in your app store and install it.
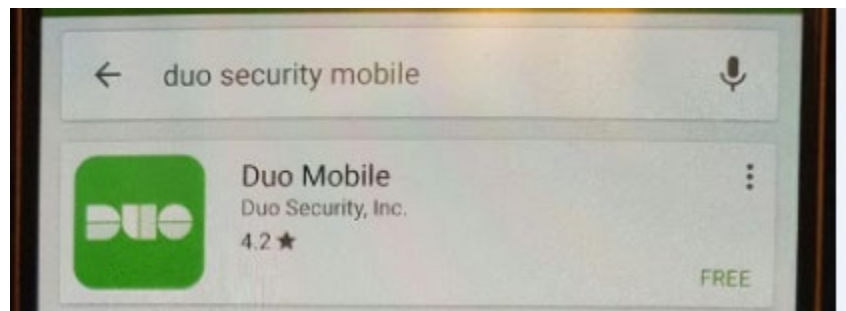
Once the app is installed on your mobile device, open it to get the following registration screen.
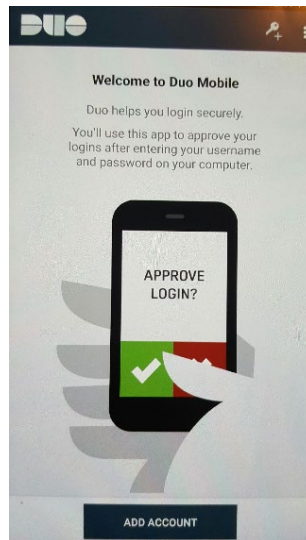
Click on "ADD ACCOUNT" and go back to your computer screen to click on "I have DUO Mobile Installed".
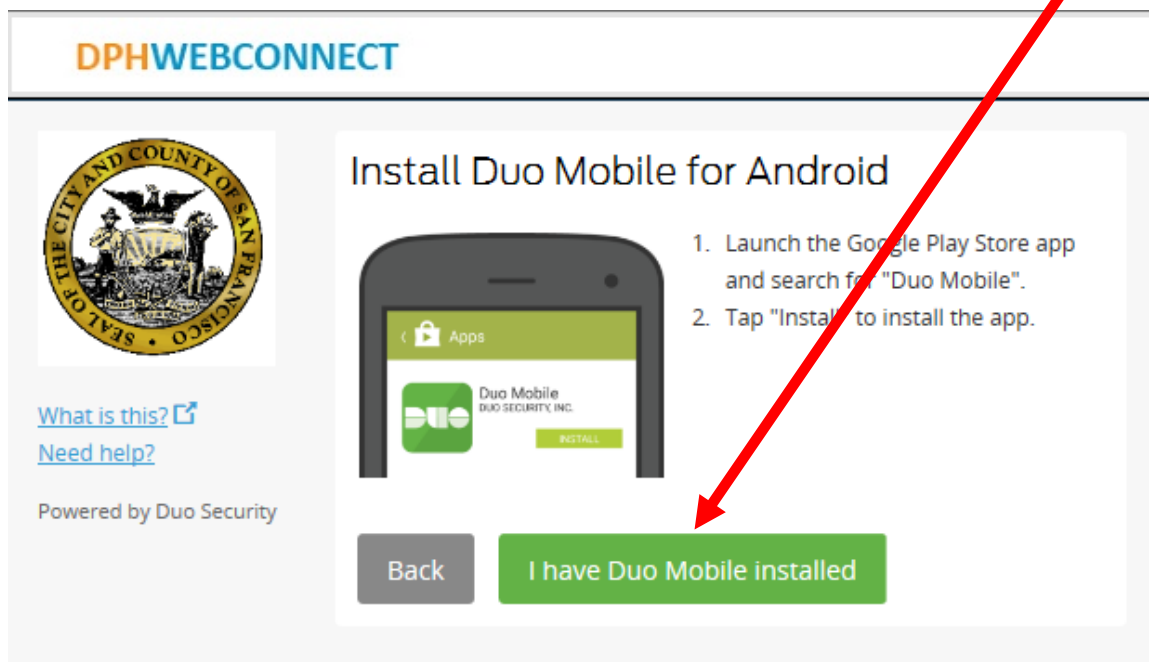
Now (while DUO app is open on your phone) point your phone at the barcode displayed on your computer screen to activate DUO.
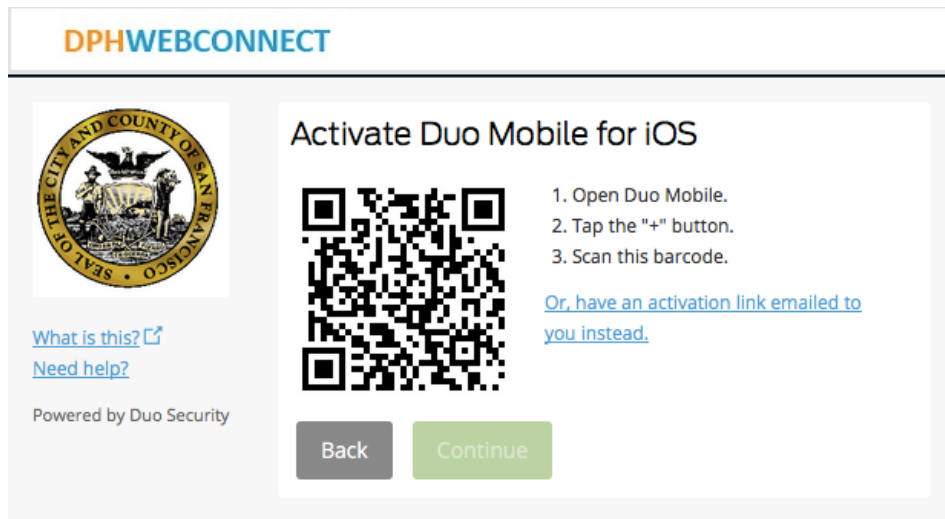
When you have successfully scanned the barcode, click Continue.

On completion of the setup you will see the following

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

After you have gone through setup the first time you will see the following after login in.
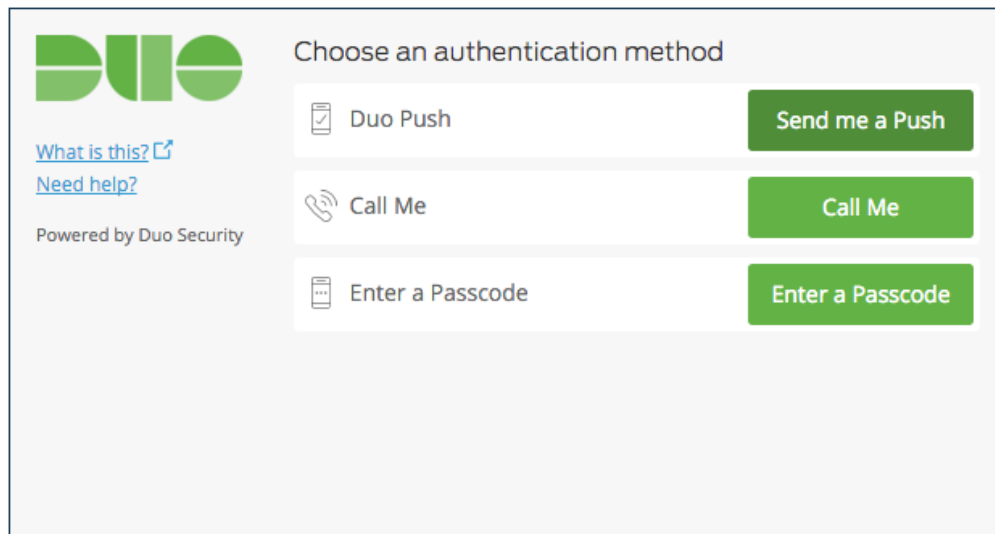
Duo Push Authentication: This is the recommended and easiest authentication method to use if you have a Smart Phone.
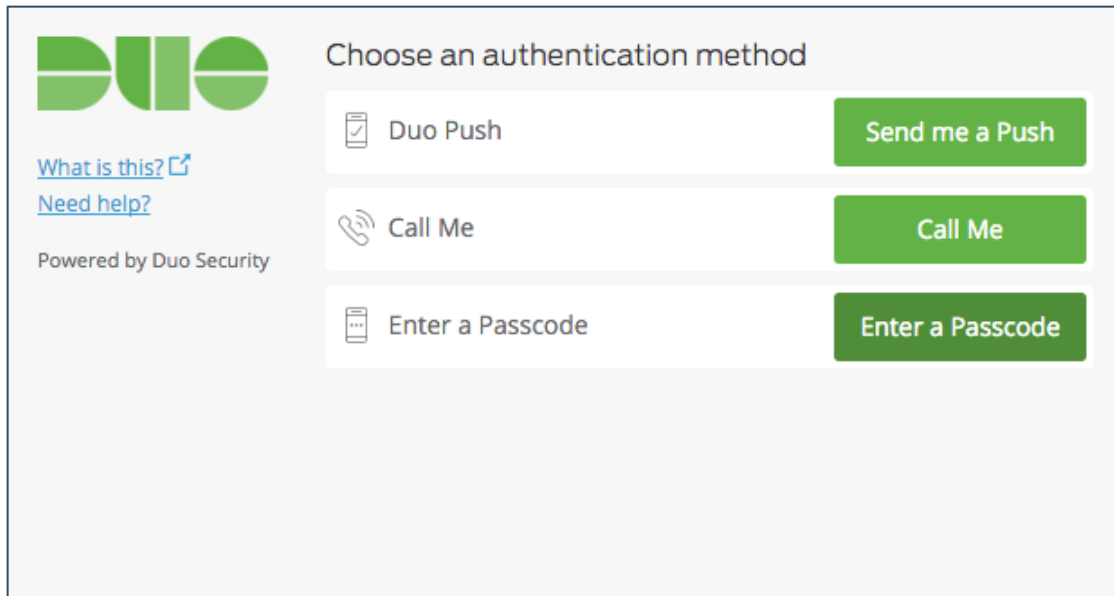
1. Click **Send me a Push**.

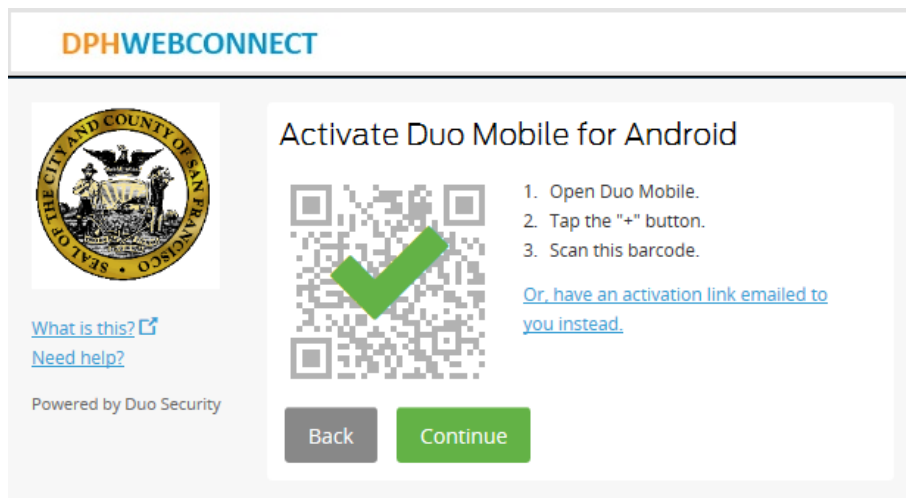2. Press the green **Approve** box on your device to log in.

   a. If you do not receive the Duo Push automatically, go into the Duo Mobile app and pull down to refresh

Your smart phone will display the following when you log on to WebConnect, click "Approve."
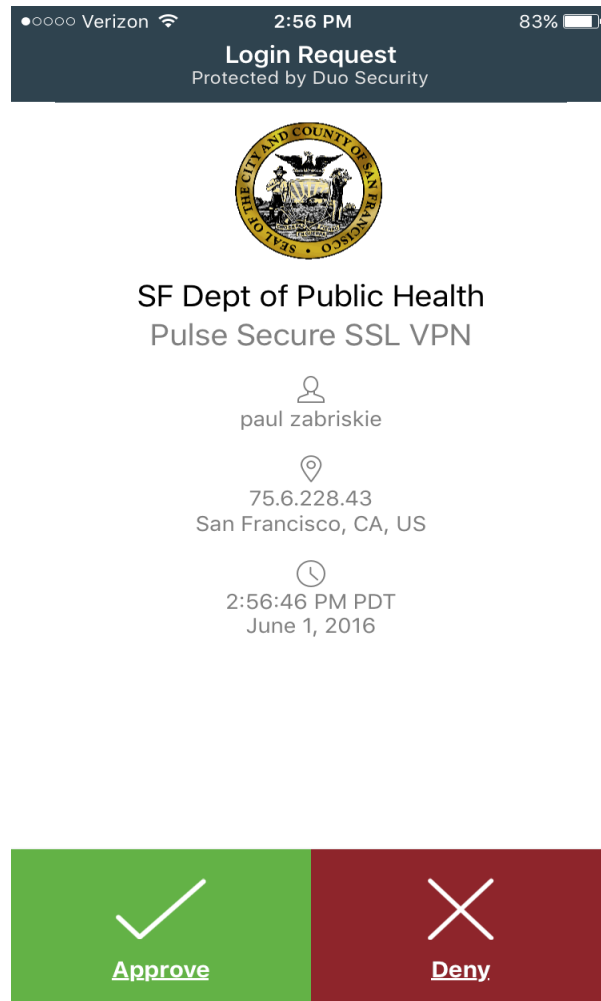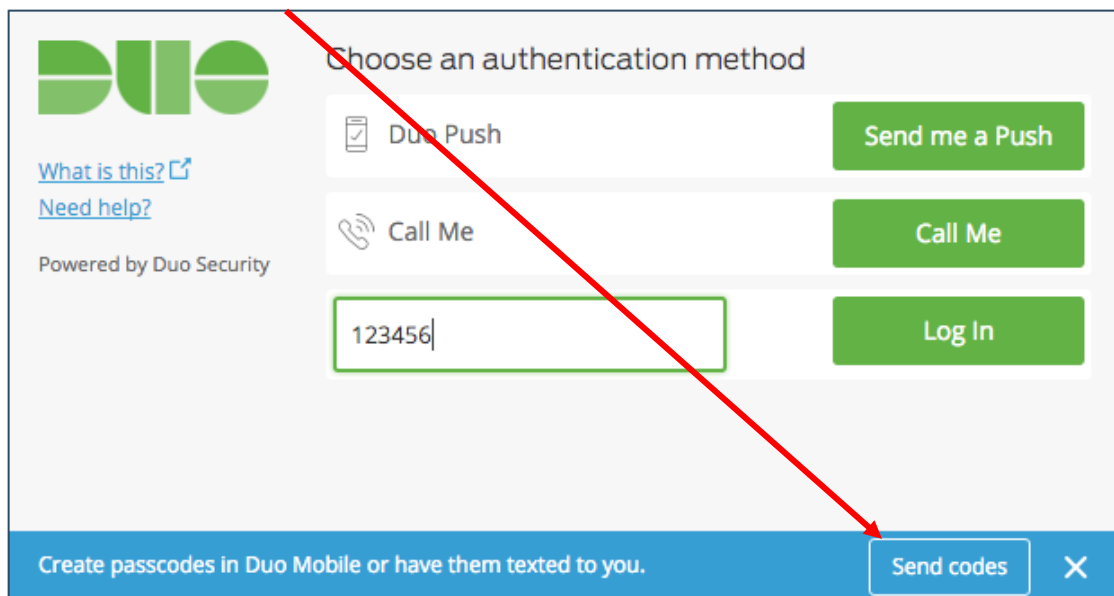
Alternative Options for Authentication: If you do not have a Smart Phone, or choose not to install the Mobile App, you have the option to Select **"Enter a Passcode"**

Now click on **"Send codes"**

In a few minutes, a text containing 10 passcodes will be sent to the cell phone that you setup previously. Any of the passcodes sent will work for an 80 hour period but each code may only be used once.
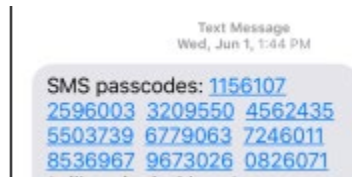
Enter **one** of the 10 **passcodes** sent in the text message and click on **"Log In"**

You will now proceed to your Home Page

Your home page
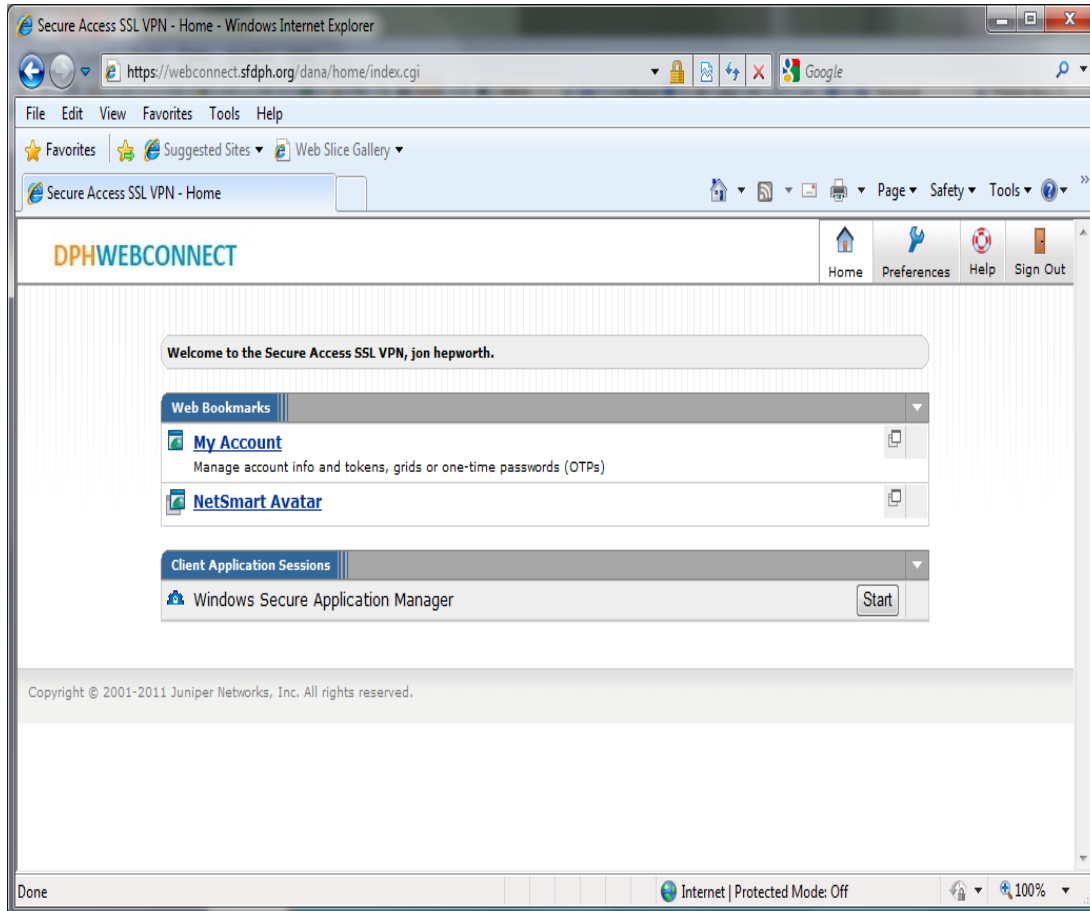
Please note the 4 buttons on the upper right of your display
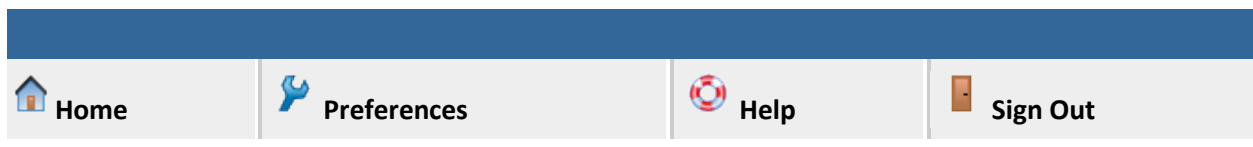
Home takes you back to your WebConnect Home page.

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

Help Provides helpful tips on WebConnect Not on Avatar.

Sign Out closes your WebConnect session and logs you out.

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

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

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
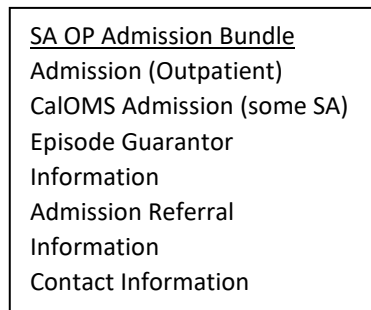 - "8" substituted for "a"
  - "1" substituted for "y"
  - "2" for "to"
  - "u" for "you"

Avatar Modules

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

Avatar Work Flow

Episode Opening   **Episode Opening**

SA OP Admission Bundle
Admission (Outpatient)
CalOMS Admission (some SA)
Episode Guarantor
Information
Admission Referral
Information
Contact Information

Residential Admission Bundle
Admission (Outpatient)
CSI Admission (MH)
CalOMS Admission (some SA)
Episode Guarantor Information
Admission Referral Information
Contact Information
Forms (Consent)

Assessment (As appropriate – see BHS Policy)
SUD Level of Care
ASI Input + ASI Summary Report + ASI Composite Score + ASI Ratings Graph

Diagnosis
(As appropriate – see BHS)

Treatment Plans (As appropriate – see BHS)
SUD Treatment Plan of Care

Justification for Continued Services
CalOMS Annual Update

Discharge (Outpatient)   Discharge

CalOMS Discharge   CalOMS Discharge

SA OP
(END)

SA Residential
(END)

Navigation

Avatar Home View

Avatar Chart View

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

⚠ Allergies (5)

Chart

Overview | 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 / En

Client Views
MHS 140

CLIENT EPISODES

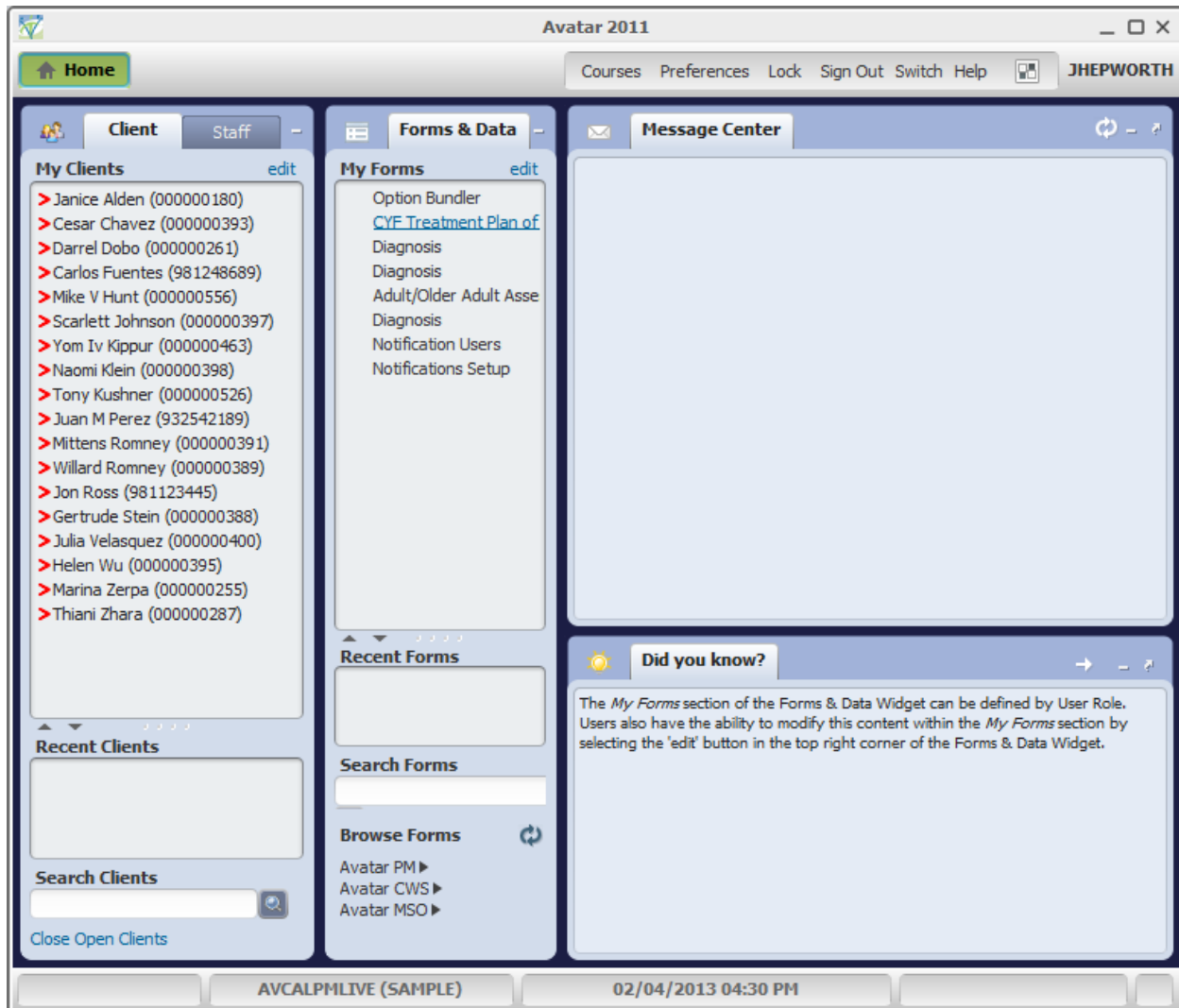| Episode #	Program	Admission Date	Discharge Date
11	A Better Way-SF Outpatient (38GTOP)	2016-05-14	
10	SF Children MH AB3632 (38BH3)	2016-04-27	2016-04-27
9	SFAF Stonewall Project-OP (89051)	2016-03-01	2016-04-06
8	Conard House Outpatient Services (89492)	2016-01-20	2016-03-14
7	AFS SF Therapeutic Visitation (38GS01)	2016-01-12	
6	UCSF Primary Care Outreach (IPCOM)	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 (38IM01)	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

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

Avatar eLinks

Current Medications, Labs, 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.

Click "Add" to log a new entry.

Timely Access (continued)

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)

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

Admission (Outpatient) - continued

Admission (Outpatient) – continued

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

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

Admission (Outpatient) - continued

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

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

Admission (Outpatient) - continued

Note that date of smoking status assessment is required.

CalOMS
(see separate hand out)

Episode Guarantor Information

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

Contact Information

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

Admission Referral Information

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

Forms Bundle

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

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

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

Other form (not in the bundle)

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

ADMISSION DIAGNOSIS

Diagnosis

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

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

Diagnosis by Client Report

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

San Francisco Department of Public Health
Community Behavioral Health Services

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

Confidential Patient Information

Date of Diagnosis: 2/19/2016   **Type of Diagnosis:** Update

Rank	Description	Diagnosing Practitioner	Status	Class	Bill Order	DSM-IV/ ICD-9	DSM-5/ ICD-10
Primary	Depression emotion	MUNOZ,PABLO (012170)	Active		1	311	F32.9

Axis IV Primary Support Group	No Entry	Axis IV Housing	No Entry
Axis IV Social/Environmental	No Entry	Axis IV Economic	No Entry
Axis IV Educational	No Entry	Axis IV Health Care Services	No Entry
Axis IV Occupational	No Entry	Axis IV Legal System/Crime	No Entry

Date of Diagnosis: 2/4/2016   **Type of Diagnosis:** Admission

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

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

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

Transfer Practitioner Caseload – continued

SUBSTANCE USE DISORDER ASSESSMENT (ADULT)

ASI Input

(Path: Avatar CWS/ASI)

ASI Input – continued

ASI Summary Report:

(Path: Avatar CWS/ASI)

Avatar_ASI_Summary_Report.rpt

Preview

General

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.

g frd

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

	Score
MEDICAL:	0.00
EMP/SUP:	0.00
ALCOHOL:	0.00
DRUG:	0.00
LEGAL:	0.00
FAM/SOC:	1.00
PSYCH:	0.00
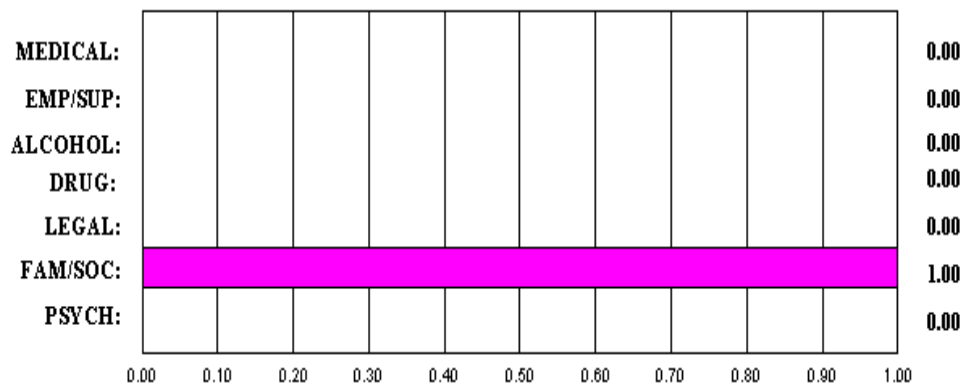
This profile is based on the last 30 days of the individual's life.
It is used primarily for research and initial treatment planning.

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	33	Slight problem, treatment probably not

ASI Rating Graphs:

(Path: Avatar CWS/ASI)

SUD Level of Care Recommendation

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

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

SUD Level of Care Recommendation Report

Client Name: TESTCLIENT,SUMMARY Y SR DR
Client ID: 1
Program: HR360 Pre Admit
Episode #: 54
Admission Date: 5/31/2020
Discharge Date: 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)

Printing the SUD Continuing Svcs Justification

San Francisco Department of Public Health
Community Behavioral Health Services

SUD Level of Care Recommendation Report

Client Name: TESTCLIENT,SUMMARY Y SR DR
Client ID: 1
Program: HR360 Pre Admit
Episode #: 54
Admission Date: 5/31/2020
Discharge Date: None

Confidential Patient Information

LOC Date: **7/31/2020**
LOC Time: **08:13 AM**
LOC Type: **Residential Reauthor**
Completed by: **Mauricio Torres**

Record Status: **Final**
Finalized Date: **7/31/2020**
Finalized Time: **08:24 AM**

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)

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)

SUD TPOC/Recovery Plan Report

San Francisco Department of Public Health Behavioral Health Services **SUD Treatment Plan of Care**	**Name:** TESTCLIENT,SUMMARY Y SR DR **Client ID#:** 1 **Episode #:** 54　**Episode Opening Date:** 05/31/2020 **Episode Program:** HR360 Pre Admit **Plan Effective Date:**　8/26/2020

Confidential Patient Information

Treatment Plan is valid until 12/17/2020

Treatment Plan Date : 8/26/2020	**Plan Type:** Initial　**Status :** Final
Date Treatment Plan Finalized: 9/18/2020	**Treatment Plan End Date :** 12/17/2020

Primary Counselor Name:　　TORRES,MAURICIO

Client Strengths

Strengths

Long Term Goals

Long term

Type and Frequency of Counseling/Services

Res, op

Goals and Action Steps

　Dimension: 2 - Physical Health

　Target Date:　　　**Focus of Treatment?:** No

　Problem/Concern:

　　blah

Goals and Action Steps

　Dimension: 1 - Intoxication/Withdrawal

　Target Date: 11/24/2020　**Focus of Treatment?:** Yes

　Problem/Concern:

PROGRESS NOTES (GROUP AND INDIVIDUAL)

Progress Notes Group and Individual Form

(Path: Avatar CWS/Progress Notes)

Progress Notes – Interns with Cosign

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.

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

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 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:

Progress Notes (Group and Individual)

- **Individual Progress Notes**
- **Group Default Notes**

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

Date Of Service
02/25/2013 T Y

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

Service Program
Westside Outpatient Clinic (89052)

Service Charge Code

INDIVIDUAL PSYCHOTHERAPY 45-74 MINS (90806)

Online Documentation

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

Select T.P. Version

CYF Treatment Plan of Care

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Problem'

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

Location
Office

Practitioner Face to Face Time (minutes)   53

Practitioner Doc and Travel Time (minutes)   19

Practitioner

HOM,KELLEE (000015)

Note Addresses Which Treatment Plan Problem

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.

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.

Retrieving Draft Notes:

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

Progress Notes (Group and Individual) ↗

Individual Progress Notes
Group Default Notes

Submit

Online Documentation

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Prob

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

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

▼

Draft/Final
○ Draft   ○ Final

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

File Note

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)

Below is selected note.

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

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

Group Registration

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

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 invidualize). The form used for this purpose is "*Progress Notes (Group and Individual)*".

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

Work begins on the "Group" section and then continues on the "Individual" section.

Creating Group Progress Notes:

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

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

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

8. At "**User To Send Scratch Note To-Do Item To**", select your own name.

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

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

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

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

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

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

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.

Courses   Preferences   Lock   Sign Out   Switch   Help

Individual Progress Notes
□ Group Default Notes

Submit

14. Do NOT click "File Note".

Online Documentation

15. Enter the total number of clients attending "group session".

Service Program   Westside Outpatient Clinic (89052)

Service Charge Code

DBT GROUP THERAPY (H2015GD)

Location   Office

File Note

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

Number Of Clients In Group

Add Client To Group

Client To Be Added To Group

Episode Number

Practitioner Face to Face Time (minutes)   63

Practitioner Doc and Travel Time (minutes)   24

Co-Practitioner

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

Do NOT multiple "63 minutes" x (Number of clients).
Avatar will automatically calculate individual client service charge

Then add "**Practitioner Doc and Travel Time (in minutes)**".
After filing group note, these numbers cannot be changed.

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

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

Avatar 2011 - Group Notes ×

Are you sure you want to remove LEWIS,JOHN(292) from the group session?

Yes   No
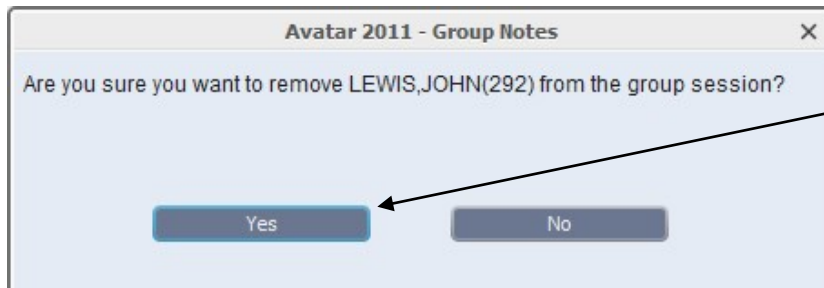
19 After selecting client name for removal (above), Dialogue box appears. This confirms your intent to remove client from this group session:

Group Default Notes

Submit

Online Documentation

Group Name Or Number

File Note

Note

Group Service Member Information

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

▼

Service Program

Service Charge Code

Location

File Note

Practitioner Face to Face Time (minutes)

Practitioner Doc and Travel Time (minutes)

Co-Practitioner
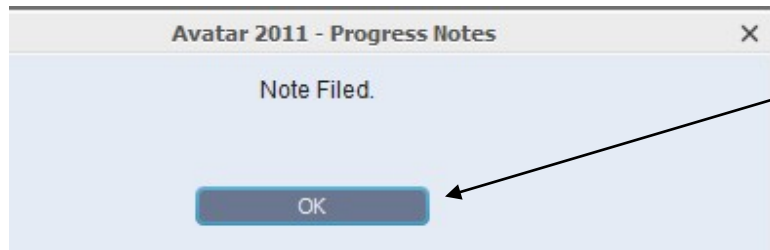
21. The "Note Filed" alert will appear. Click "OK" to complete the process. Now your work on the **Group Default Notes section** is done.

You can close progress notes now and then resume instruction on the following page (8) at a later time.

Or, you can continue the process right now by following steps 22 and 23.

Below is image of user leaving the **Group Default Notes** section and selecting **Individual Progress Notes** section
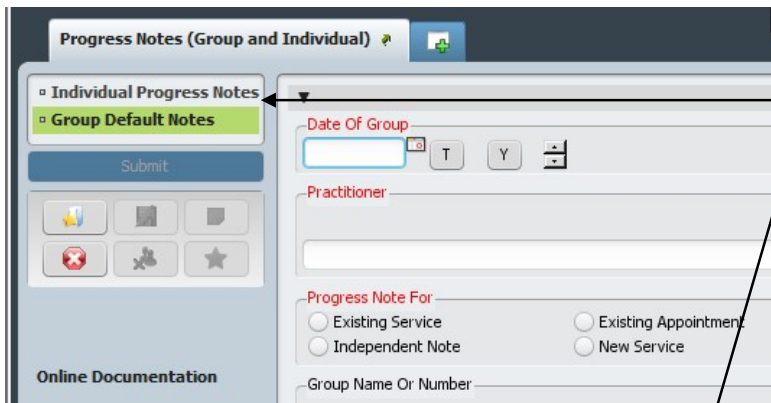
22. If you move to "Individual Progress Notes" section, in order to individualize notes per instructions that follow, Avatar will display a warning that unsaved data will be lost
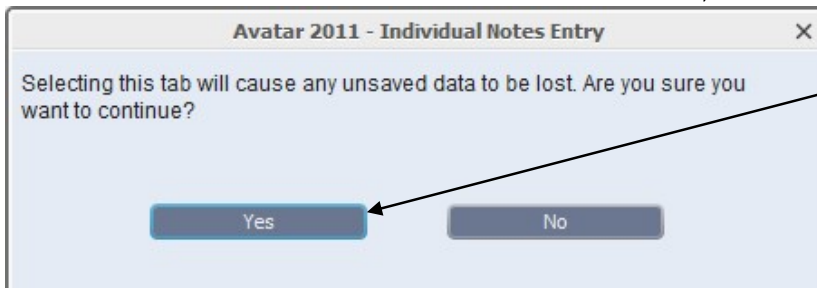
23. Go ahead and click "Yes" if you have already filed group note.

Individualize the Group Note:

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

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

6. After selecting note, edit the **Notes Field** by adding a 2nd paragraph relevant to client "Frank McCourt".

Avatar — □ ×

🏠 Home   ☰ **Progress Notes**   JHEPWORTH

Progress Notes (Group and Individual) ⟲   ➕

▫ **Individual Progress Notes**
▫ **Group Default Notes**

Submit

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

Type the 2nd paragraph about client Frank McCourt...

Online Documentation

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

─Date Of Service─
03/05/2013   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% ⊟ ▬▬ ➕

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

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

Finalizing the progress note:

9. Scroll downward and Select "Final" and then click "File Note".

Progress Notes (Group and Individual)

▫ **Individual Progress Notes**
▫ Group Default Notes

Submit

Clear 'Note Addresses Which Treatment Plan Problem' Text.

Online Documentation

▼

Draft/Final
○ Draft   ● Final   File Note

Select Draft Note To Edit

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

Co-Practitioner

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

Avatar 2011 - Progress Notes   ✕
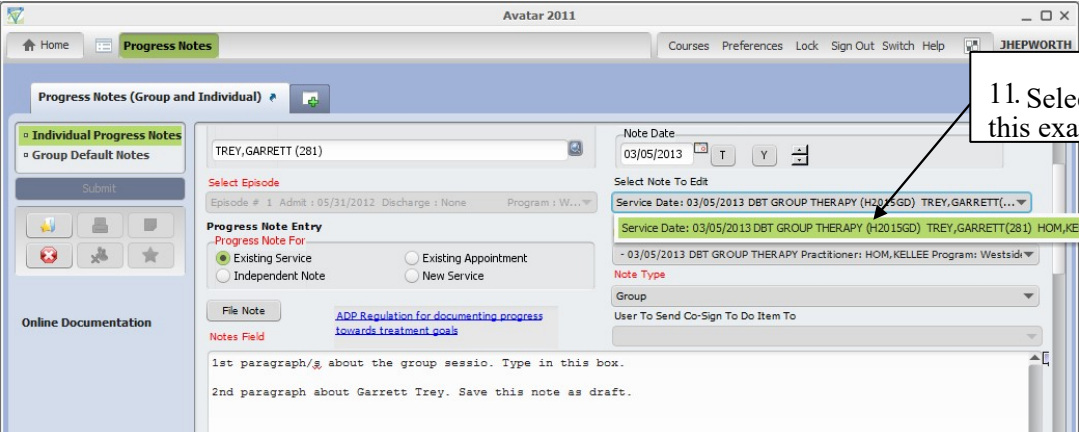
Note Filed.

10. Click "OK"

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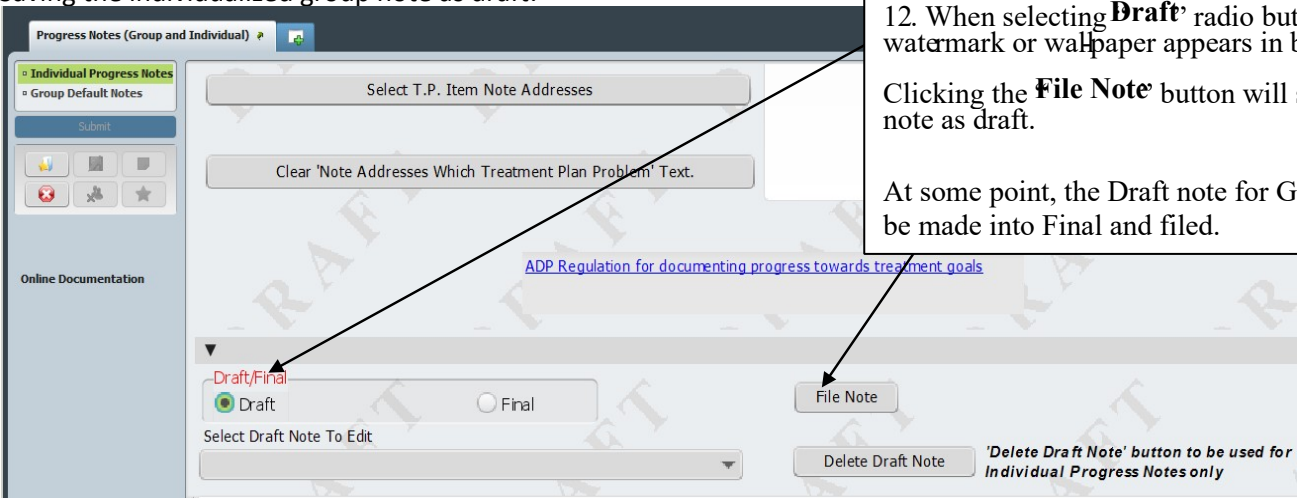
Now, a single note remains in limbo. Note belongs to client, Garrett Trey.

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

Saving the individualized group note as draft:

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

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

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

This box, below is confirmation that note was filed.

13. Click "OK"
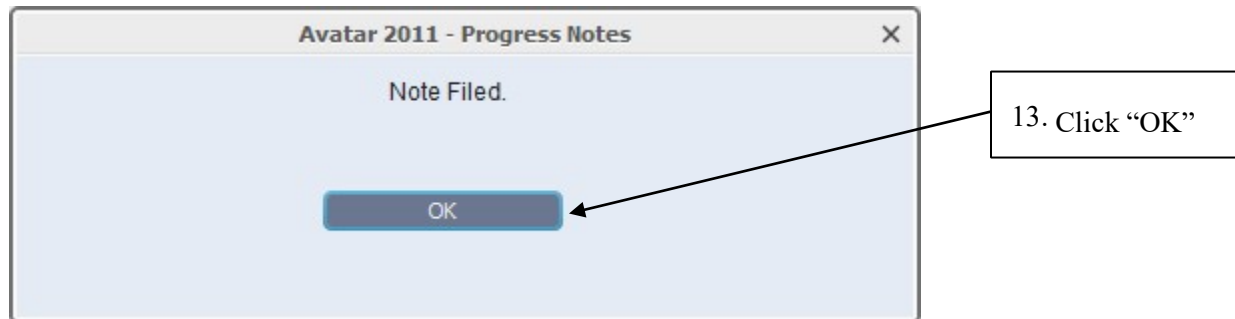
Below is an image of an empty "*Select Note To Edit*" box:

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".
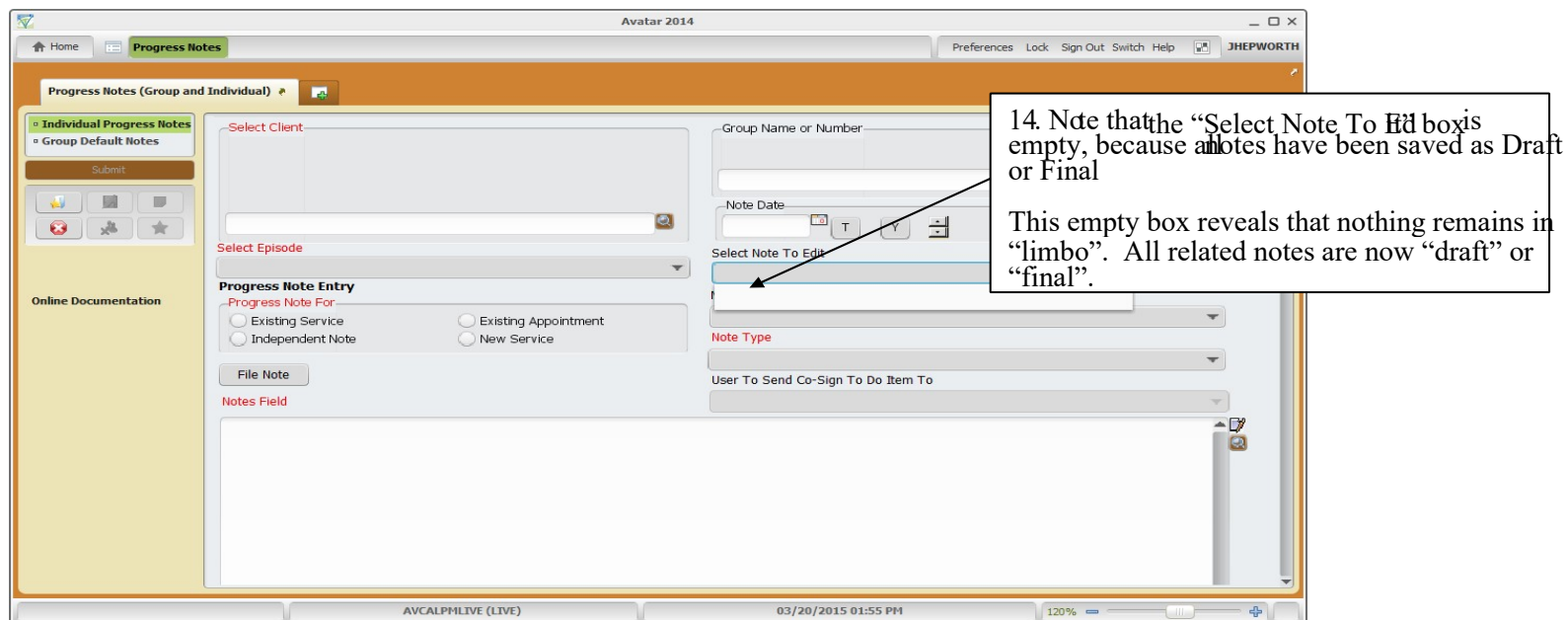
Retrieving draft note for Garrett Trey:

.

Avatar 2011

🏠 Home   ▤ **Progress Notes**

Progress Notes (Group and Individual) ↗   ➕

□ **Individual Progress Notes**
□ **Group Default Notes**

Submit

Online Documentation

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.

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Problem' Text.

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

▼

Draft/Final
◉ Draft   ○ Final

Select Draft Note To Edit

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

Evidence-Based Practices / Service Strategies (CSI)

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

AVCALPMLIVE (SAMPLE)   03,

Making final edits.

18. Make final edits. Remember that the Time (minutes) is saved in Avatar, but hidden from user's view.

Progress Notes (Group and Individual)

- Individual Progress Notes
- Group Default Notes

Submit

Online Documentation

Clear 'Note Addresses Which Treatment Plan Problem' Text.

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

Draft/Final
- ○ Draft   ● Final   File Note

Select Draft Note To Edit

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

Co-Practitioner

Confirmation that note has been successfully filed:

Avatar 2011 - Progress Notes   ✕

Note Filed.

OK

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

DISCHARGE BUNDLES

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

Discharge

Discharge (Outpatient) - continued

Demographics

REPORTS

MHS140 Report

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

```
Report : MHS140                    Client Information Face Sheet              Run Date: 5/23/2016
County: San Francisco              SUMMARY TESTCLIENT (1)                     Page 1 of 1
-----------------------------------------------------------------------------------------------
Name: TESTCLIENT,SUMMARY       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:
```

Ep#	Reporting Unit		Telephone	Opening	Last Service	Closing	DSM-4	ICD-10	Clinician
12	IPCOM	UCSF Primary Care Outreach (IPCOM)	Unknown	05/22/2016					NAVARRO-SIMEON,BERNADETTE (013531)
11	38GTOP	A Better Way-SF Outpatient (38GTOP)	415-715-1050	05/14/2016					TURNER,JOSEPH A (014450)
7	38GS01	AFS SF Therapeutic Visitation (38GS01)	415-656-0116	01/12/2016			311 301.81	F60.81	TURNER,JOSEPH A (014450)
3	38AP	Fee for Service MFCC (38AP)	Unknown	02/28/2015	03/10/2016		296.50	F31.30	ANDERSON,HANS (013179)
2	38IM01	City College of San Francisco (38IM01)	415-239-3975	12/01/2014			305.50 E929.5 305.60	F11.90 W56.21XS F14.90	HOM,KELLEE (003865)

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

Caseload by Clinician Report

(Path: Avatar CWS / Reports)

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

San Francisco Department of Public Health
Community Behavioral Health Services

Caseload by Clinician Report

**Admitting Practitioner/Primary Clinician
Kellee Hom (003865)**

Confidential Patient Information

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

Staff Activity By Program Detail Report

(Path: Avatar PM/Operations Reports)

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

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

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)

San Francisco Department of Public Health
Community Behavioral Health Services

Progress Notes in Draft Clinician Report
Kellee Hom (003865)

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

Confidential Patient Information

ACCESS Screening

Client Name:	TESTCLIENT,SUMMARY	**Client ID:**	1
Episode #: 1	**Admission Date:** 07/01/2010	**Discharge Date:**	

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

Progress Note:
TEST

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

Group Notes Not Individualized Clinician

(Path: Avatar CWS / Progress Notes)

San Francisco Department of Public Health
Community Behavioral Health Services
Group Notes Not Individualized

Service Dates Between 1/1/2016 and 5/23/2016

No Data Found For ▓▓▓▓ Between 1/1/2016 and 5/23/2016
Confidential Patient Information

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

Total Notes For : 0

AVATAR DOCUMENTATION WEBSITE

URL address: www.sfdph.org/dph/

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

Select "**SF Avatar User Documentation**" link.

You will see the page, below.

Save the page as an internet favorite.

Avatar Documentation Website (continued)

File   Edit   View   Favorites   Tools   Help

This page can't be displayed   500 - Internal server error   Suggested Sites (3) ▾

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

Avatar Documentation Website (continued)

Department of Public Health, SF Avatar User Docume...

File   Edit   View   Favorites   Tools   Help

This page can't be displayed   500 - Internal server error

Billing Documentation

Avatar Billing User Bulletins

1. Bulletin #1 (November 2010)
2. Bulletin #2 (December 2010)
3. Bulletin #3 (February 2011)
4. Bulletin #4 (March 2011)
5. Bulletin #5 (April 2011)
6. Bulletin #6 (June 2011)
7. Bulletin #7 (April 2012)
8. Bulletin #8 (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)

For all Avatar questions call or email:

AVATAR HELP LINE: (415) 255-3788

AVATAR E-mail: avatarhelp@sfdph.org

Go to website below for access to Avatar instructional videos:

http://www.vimeo.com/avatarhelpdesk

KEYBOARD SHORTCUTS & STANDARD FORMATS

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

KEYBOARD SHORTCUTS & STANDARD FORMATS (continued)

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

Avatar Admission (PM) Common Error List

Updated: April 23, 2012

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

2) Selecting wrong client

3) Selecting wrong episode

4) Selecting wrong program name

5) Creating duplicate episode

6) Admission Screen:

   a) Misspelling client name

   b) Entering wrong admission date

   c) Selecting wrong admission program or selecting program name containing "(episode)" instead of the "RU#"

7) Cal-OMS Admission Screen:

   a) Missing Birth First Name or Birth Last Name (Correction = enter client's Birth First (or Last) Name; 99902 for None or Not Applicable; 99904 for Client unable to answer)

   b) Missing Social Security Number: (Correction = format 123-45-6789; 99900 for 'Client declines to state'; 99902 for None or Not Applicable; or 99904 for Client unable to answer)

   c) Missing Zip code at client's current residence (Correction = Must enter valid 5 digit zip code; 00000 for 'homeless'; XXXXX for 'Client declined to state'; or ZZZZZ for Client unable to answer)

   d) Missing Driver's License Number: (Correction = Client's driver license number; 99900 for client declines to state; 99902 for None or Not Applicable; or 99904 for Client unable to answer)

   e) Creating an UMDAP for Substance Abuse client when not applicable

8) Diagnosis:

   a) Entering wrong "Date of Diagnosis." The date of diagnosis must cover the date of admission.

   b) Leaving "Diagnosis – Axis II-1" blank: Type in "V71.09" for "No Diagnosis on Axis II"

Avatar Clinical (CWS) Common Error List
Updated: April 23, 2012

1. <u>Assessments</u>:

    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. <u>Diagnosis:</u>

    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. <u>Treatment Plans:</u>

    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. <u>Progress Notes</u> (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. <u>Progress Notes</u> (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

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

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

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