Avatar Clinical Training

Substance Use Disorder

(Guide / Manual)

1380 Howard Street
1st Floor Training Room
# Table of Contents

INTRODUCTION ............................................................................................................................................. 1  
  Contact Information for Avatar Questions............................................................................................... 1  
  HIPPAA & Privacy Statement .................................................................................................................... 2  
    Protected Health Information (PHI) ..................................................................................................... 2  
  Learning Objectives .................................................................................................................................. 2  

AVATAR OVERVIEW ...................................................................................................................................... 1  
  Logging into WebConnect (Community Based Organizations) ............................................................ 1  
    Welcome to The Department of Public Health's WebConnect Portal ................................................. 1  

NetSmart Avatar ......................................................................................................................................... 13  
  Avatar Log in ........................................................................................................................................... 14  
    Logging into Avatar: Passwords ......................................................................................................... 14  
  Avatar Modules ...................................................................................................................................... 14  
  Avatar Work Flow ................................................................................................................................... 15  
  Navigation ............................................................................................................................................... 16  
    Avatar Home View.............................................................................................................................. 16  
    Avatar Chart View .............................................................................................................................. 17  
    Avatar eLinks ...................................................................................................................................... 18  
    Current Medications, Labs, Vitals ...................................................................................................... 18  

TIMELY ACCESS ........................................................................................................................................... 19  
  Timely Access .......................................................................................................................................... 19  

OVERVIEW OF EPISODE OPENING .............................................................................................................. 21  
  Admission Bundles ............................................................................................................................... 21  
    SA Admission OP CalOMS Program Bundle .................................................................................... 21  
    SA Admission OP Non CalOMS Prgm Bundle .................................................................................. 21  
    SA Admission Res CalOMS Prgm Bundle ....................................................................................... 22  
    SA Admission Res Non CalOMS Prgm Bundle .............................................................................. 22  

ADMISSION BUNDLE FORMS ...................................................................................................................... 23  
  Admission (Outpatient) .......................................................................................................................... 23  
  CalOMS ................................................................................................................................................... 28  
  Episode Guarantor Information.............................................................................................................. 29
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Information</td>
<td>30</td>
</tr>
<tr>
<td>Admission Referral Information</td>
<td>31</td>
</tr>
<tr>
<td>Forms Bundle</td>
<td>32</td>
</tr>
<tr>
<td>ADMISSION DIAGNOSIS</td>
<td>33</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>33</td>
</tr>
<tr>
<td>Diagnosis by Client Report</td>
<td>34</td>
</tr>
<tr>
<td>TRANSFER CASELOAD</td>
<td>35</td>
</tr>
<tr>
<td>Transfer Practitioner Caseload</td>
<td>35</td>
</tr>
<tr>
<td>SUBSTANCE USE DISORDER ASSESSMENT (ADULT)</td>
<td>37</td>
</tr>
<tr>
<td>ASI Input</td>
<td>37</td>
</tr>
<tr>
<td>ASI Summary Report</td>
<td>39</td>
</tr>
<tr>
<td>ASI Composite Scores</td>
<td>40</td>
</tr>
<tr>
<td>ASI Rating Graphs</td>
<td>41</td>
</tr>
<tr>
<td>SUD Level of Care Recommendation</td>
<td>42</td>
</tr>
<tr>
<td>Printing the SUD Level of Care Recommendation</td>
<td>43</td>
</tr>
<tr>
<td>SUD Continuing Services Justification</td>
<td>44</td>
</tr>
<tr>
<td>SUD Continuing Svcs Justification</td>
<td>44</td>
</tr>
<tr>
<td>Printing the SUD Continuing Svcs Justification</td>
<td>45</td>
</tr>
<tr>
<td>SUD Treatment Plan of Care/Recovery Plan</td>
<td>46</td>
</tr>
<tr>
<td>SUD TPOC/Recovery Plan</td>
<td>46</td>
</tr>
<tr>
<td>SUD TPOC Signature Addendum</td>
<td>47</td>
</tr>
<tr>
<td>SUD TPOC/Recovery Plan Report</td>
<td>48</td>
</tr>
<tr>
<td>PROGRESS NOTES (GROUP AND INDIVIDUAL)</td>
<td>49</td>
</tr>
<tr>
<td>Progress Notes Group and Individual Form</td>
<td>49</td>
</tr>
<tr>
<td>Progress Notes – Interns with Cosign</td>
<td>50</td>
</tr>
<tr>
<td>Progress Notes Without Pagebreaks</td>
<td>51</td>
</tr>
<tr>
<td>Append Progress Notes</td>
<td>52</td>
</tr>
<tr>
<td>PROGRESS NOTES (GROUP AND INDIVIDUAL)</td>
<td>53</td>
</tr>
<tr>
<td>Individual Progress Notes User Guide</td>
<td>53</td>
</tr>
<tr>
<td>Introduction</td>
<td>53</td>
</tr>
<tr>
<td>Entering Individual Notes</td>
<td>54</td>
</tr>
<tr>
<td>Retrieving Draft Notes</td>
<td>57</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Group Registration</td>
<td>60</td>
</tr>
<tr>
<td>Group Progress Notes User Guide</td>
<td>62</td>
</tr>
<tr>
<td>Introduction:</td>
<td>62</td>
</tr>
<tr>
<td>Creating Group Progress Notes:</td>
<td>63</td>
</tr>
<tr>
<td>Individualize the Group Note:</td>
<td>68</td>
</tr>
<tr>
<td>SERVICE CORRECTIONS</td>
<td>78</td>
</tr>
<tr>
<td>Edit Service Information</td>
<td>78</td>
</tr>
<tr>
<td>DISCHARGE BUNDLES</td>
<td>79</td>
</tr>
<tr>
<td>Discharge (Outpatient)</td>
<td>79</td>
</tr>
<tr>
<td>Discharge</td>
<td>79</td>
</tr>
<tr>
<td>Demographics</td>
<td>80</td>
</tr>
<tr>
<td>REPORTS</td>
<td>81</td>
</tr>
<tr>
<td>MHS140 Report</td>
<td>81</td>
</tr>
<tr>
<td>Caseload by Clinician Report</td>
<td>82</td>
</tr>
<tr>
<td>Staff Activity By Program Detail Report</td>
<td>83</td>
</tr>
<tr>
<td>Crystal Client Ledger</td>
<td>84</td>
</tr>
<tr>
<td>Progress Notes in Draft Clinician Report</td>
<td>85</td>
</tr>
<tr>
<td>Group Notes Not Individualized Clinian</td>
<td>86</td>
</tr>
<tr>
<td>AVATAR DOCUMENTATION WEBSITE</td>
<td>87</td>
</tr>
<tr>
<td>KEYBOARD SHORTCUTS &amp; STANDARD FORMATS</td>
<td>91</td>
</tr>
<tr>
<td>Avatar Admission (PM) Common Error List</td>
<td>93</td>
</tr>
<tr>
<td>Updated: April 23, 2012</td>
<td>93</td>
</tr>
<tr>
<td>Avatar Clinical (CWS) Common Error List</td>
<td>94</td>
</tr>
<tr>
<td>Updated: April 23, 2012</td>
<td>94</td>
</tr>
<tr>
<td>AVATAR CORRECTION REQUEST FORM</td>
<td>96</td>
</tr>
<tr>
<td>BLANK SAMPLE</td>
<td>96</td>
</tr>
<tr>
<td>AVATAR FAVORITES</td>
<td>97</td>
</tr>
<tr>
<td>Admissions</td>
<td>97</td>
</tr>
<tr>
<td>Assessments</td>
<td>98</td>
</tr>
<tr>
<td>Treatment Plans, Progress Notes, Discharge &amp; Reports</td>
<td>99</td>
</tr>
<tr>
<td>Treatment Plan of Care</td>
<td>99</td>
</tr>
<tr>
<td>Progress Notes:</td>
<td>99</td>
</tr>
</tbody>
</table>

Updated: April 23, 2012
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>99</td>
</tr>
<tr>
<td>Reports</td>
<td>99</td>
</tr>
</tbody>
</table>
INTRODUCTION

Contact Information for Avatar Questions

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

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

**Technical Questions: Technical Work Group**

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

**Avatar Champions**

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

**General Avatar Questions:**

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

**General Billing Questions:**

Billing Inquiry Line: (415) 255-3557
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”.

Install Duo Mobile for Android

1. Launch the Google Play Store app and search for “Duo Mobile”.
2. Tap “Install” to install the app.

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.”

![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

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**

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)
CalOMS Discharge
SA OP (END)

Discharge
CalOMS Discharge
SA Residential (END)
Navigation

Avatar Home View
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)

[Image of a screenshot of a software interface for Timely Access.
This interface includes sections for First Request for Services, Registered Client Name, Type of Service Requested, Appointment Date Offered, Appointment Type, Primary Language, and Rationale and Notes.

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

Yes (If you choose "Yes" in error, click "Yes" again, then press the "F2" key to clear option.)

Rationale

Notes]
OVERVIEW OF EPISODE OPENING

Admission Bundles

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

- Admission (Outpatient)
  (Path: Avatar PM)/Client Management/Episode Management)
- CalOMS Admission
  (Path: Avatar PM)/Client Management/Client Information)
- Episode Guarantor Information
  (Path: Avatar PM)/Client Management/Account Management)
- Admission Referral Information
  (Path: Avatar PM)/Client Management/Client Information)
- Contact Information
  (Path: Avatar PM)/Client Management/Client Information)
- Forms (Consent)
  (Path: Avatar PM)/Client Management/Client Information)

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

- Admission (Outpatient)
  (Path: Avatar PM)/Client Management/Episode Management)
- Episode Guarantor Information
  (Path: Avatar PM)/Client Management/Account Management)
- Admission Referral Information
  (Path: Avatar PM)/Client Management/Client Information)
- Contact Information
  (Path: Avatar PM)/Client Management/Client Information)
- Forms (Consent)
  (Path: Avatar PM)/Client Management/Client Information)
SA Admission Res CalOMS Prgm Bundle
(Path: Avatar PM/Client Management/Episode Management/SA Admission Res CalOMS Prgm Bundle)

- Admission
  (Path: Avatar PM)/Client Management/Episode Management)
- CalOMS Admission
  (Path: Avatar PM)/Client Management/Client Information)
- Episode Guarantor Information
  (Path: Avatar PM)/Client Management/Account Management)
- Admission Referral Information
  (Path: Avatar PM)/Client Management/Client Information)
- Contact Information
  (Path: Avatar PM)/Client Management/Client Information)
- Forms (Consent)
  (Path: Avatar PM)/Client Management/Client Information)

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

- Admission
  (Path: Avatar PM)/Client Management/Episode Management)
- Episode Guarantor Information
  (Path: Avatar PM)/Client Management/Account Management)
- Admission Referral Information
  (Path: Avatar PM)/Client Management/Client Information)
- Contact Information
  (Path: Avatar PM)/Client Management/Client Information)
- Forms (Consent)
  (Path: Avatar PM)/Client Management/Client Information)
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”.

---

Avatar Clinical SUD Training 3-2-2021
Admission (Outpatient) - continued

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.
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
- 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
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)

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

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
<th>Diagnosing Practitioner</th>
<th>Status</th>
<th>Class</th>
<th>DSM-IV/ICD-9</th>
<th>DSM-5/ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression emotion</td>
<td>Munoz, Pablo (012170)</td>
<td>Active</td>
<td>1</td>
<td>311</td>
<td>F32.9</td>
</tr>
</tbody>
</table>

Axis IV Primary Support Group
Axis IV Social/Environmental
Axis IV Educational
Axis IV Occupational

Date of Diagnosis: 2/14/2016
Type of Diagnosis: Admission

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
<th>Diagnosing Practitioner</th>
<th>Status</th>
<th>Class</th>
<th>DSM-IV/ICD-9</th>
<th>DSM-5/ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depressed</td>
<td>Voelker, Kimberly (000059)</td>
<td>Active</td>
<td>1</td>
<td>311</td>
<td>F32.9</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Client</th>
<th>Name</th>
<th>Episode</th>
<th>Program</th>
<th>Admit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>981241004</td>
<td>ALTERMAN, ERIC</td>
<td>2</td>
<td>Walden House Multi Service</td>
<td>07/19/2012</td>
</tr>
<tr>
<td>460</td>
<td>AMOS, TERRY IV</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>09/24/2012</td>
</tr>
<tr>
<td>461</td>
<td>AMOS, TERRY MB</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>09/24/2012</td>
</tr>
<tr>
<td>313</td>
<td>ANOS, TORI SD MD</td>
<td>2</td>
<td>Westside Outpatient Clinic</td>
<td>09/24/2012</td>
</tr>
<tr>
<td>874</td>
<td>APPLE, GRAPE ME</td>
<td>1</td>
<td>Bay Psychiatric Associate</td>
<td>01/08/2013</td>
</tr>
<tr>
<td>411</td>
<td>APPLESKID, JOHNNY</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>09/11/2012</td>
</tr>
<tr>
<td>875</td>
<td>ARTOIS, STELLA V T DR</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>08/07/2012</td>
</tr>
<tr>
<td>582</td>
<td>AVASTIGMA, CHANNELE</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>01/01/2013</td>
</tr>
<tr>
<td>386</td>
<td>ASH, MATTHEW JR</td>
<td>2</td>
<td>Westside Outpatient Clinic</td>
<td>12/13/2012</td>
</tr>
<tr>
<td>532</td>
<td>AVATAR, CRYSTAL</td>
<td>1</td>
<td>Bay Psychiatric Associate</td>
<td>12/05/2012</td>
</tr>
<tr>
<td>531</td>
<td>AVATAR, DIANA</td>
<td>1</td>
<td>Bay Psychiatric Associate</td>
<td>12/05/2012</td>
</tr>
<tr>
<td>527</td>
<td>AVATAR, HELEN</td>
<td>1</td>
<td>FFS-Jewish Family and Child</td>
<td>12/05/2012</td>
</tr>
<tr>
<td>607</td>
<td>AVATAR, JOHN</td>
<td>1</td>
<td>Bay Psychiatric Associate</td>
<td>12/05/2012</td>
</tr>
<tr>
<td>529</td>
<td>AVATAR, KENDRA</td>
<td>1</td>
<td>Walden House Multi Service</td>
<td>12/06/2012</td>
</tr>
<tr>
<td>528</td>
<td>AVATAR, SHOBNA</td>
<td>1</td>
<td>Bay Psychiatric Associate</td>
<td>12/05/2012</td>
</tr>
<tr>
<td>877</td>
<td>AZIZDEARSH, ISMAEL</td>
<td>1</td>
<td>Westside Outpatient Clinic</td>
<td>01/09/2013</td>
</tr>
</tbody>
</table>

Avatar Clinical SUD Training 3-2-2021
SUBSTANCE USE DISORDER ASSESSMENT (ADULT)

ASI Input

(Path: Avatar CWS/ASI)
### ASI Input – continued

![ASI Input Diagram]

<table>
<thead>
<tr>
<th>Question</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of First Alcohol Use (any use at all)</td>
<td>16</td>
</tr>
<tr>
<td>Alcohol Use Past 30 Days (any use at all)</td>
<td>8</td>
</tr>
<tr>
<td>Alcohol Years of Use (any use at all)</td>
<td>30</td>
</tr>
<tr>
<td>Date of Last Alcohol Use (any use at all)</td>
<td>10/09</td>
</tr>
<tr>
<td>Age of First Alcohol Use (to intoxication)</td>
<td>16</td>
</tr>
<tr>
<td>Alcohol Use Past 30 Days (to intoxication)</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Years of Use (to intoxication)</td>
<td>29</td>
</tr>
<tr>
<td>Date of Last Alcohol Use (to intoxication)</td>
<td>12/08</td>
</tr>
<tr>
<td>Age of First Heroin Use</td>
<td>24</td>
</tr>
<tr>
<td>Heroin Use Past 30 Days</td>
<td>30</td>
</tr>
<tr>
<td>Heroin Years of Use</td>
<td>32</td>
</tr>
<tr>
<td>Date of Last Other Opiates/Analgesics Use</td>
<td></td>
</tr>
<tr>
<td>Other Opiates/Analgesics Route of Admin</td>
<td></td>
</tr>
<tr>
<td>Sedatives/Hypnotics/Tranquilizers Years of Use</td>
<td></td>
</tr>
<tr>
<td>Sedatives/Hypnotics/Tranquilizers Route of Admin</td>
<td></td>
</tr>
</tbody>
</table>
ASI Summary Report:
(Path: Avatar CWS/ASI)

Substance Abuse Evaluation

Client Name: CHOMSKY, NOAM
Client Address: homeless San Francisco, CA 94103
Client Phone: 234-78-9836
Client SSN: 345-67-8900
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 66 days of the past 30.

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#: 117
Client ID: 3/9/2010

Composite Scores

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: 39 Extreme problem, treatment absolutely necessary
DRUG: 39 Extreme problem, treatment absolutely necessary
LEGAL: 01 No real problem, treatment not indicated
FAM/SOC: 67 Considerable problem, treatment necessary
PSYCH: 39 Extreme problem, treatment absolutely necessary
ASI Rating Graphs:
(Path: Avatar CWS/ASI)

Addiction Severity Index
Severity/Rating Graphs

Client Name: SANDEPSON, GRACE
Client Address: 450 California Ave San Francisco, CA 94109
Client Phone: 555-355-5247
Client ID#: 117
Date of Admission: 3/20/2010
Interview Date: 2/19/2010

Severity Profile Graph

Medical Status: [Graph showing severity levels]
Employment/Support: [Graph showing severity levels]
Alcohol Use: [Graph showing severity levels]
Drug Use: [Graph showing severity levels]
Legal Status: [Graph showing severity levels]
Social Relations: [Graph showing severity levels]
Psych Status: [Graph showing severity levels]

Interviewer/Client Rating Graph

Medical Status: [Graph showing interviewer and client responses]
Employment/Support: [Graph showing interviewer and client responses]
Alcohol Use: [Graph showing interviewer and client responses]
Drug Use: [Graph showing interviewer and client responses]
Legal Status: [Graph showing interviewer and client responses]
Social Relations: [Graph showing interviewer and client responses]
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)

<table>
<thead>
<tr>
<th>San Francisco Department of Public Health Community Behavioral Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUD Level of Care Recommendation Report</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>TESTCLIENT,SUMMARY Y SR DR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client ID: 1</td>
<td></td>
</tr>
<tr>
<td>Program: HP360 Pre Admit</td>
<td></td>
</tr>
<tr>
<td>Episode #: 54</td>
<td></td>
</tr>
<tr>
<td>Admission Date: 5/31/2020</td>
<td></td>
</tr>
<tr>
<td>Discharge Date: None</td>
<td></td>
</tr>
</tbody>
</table>

## Confidential Patient Information

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

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

**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: 9/31/2020
Discharge Date: None

Confidential Patient Information

LOD Date: 7/31/2020
LOD Time: 08:13 AM
LOD 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 seizures:
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.

**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:** TEST CLIENT, SUMMARY Y SR DR  
**Client ID:** 1  
**Episode #:** 54  
**Episode Opening Date:** 05/31/2020  
**Episode Program:** HR 360 Pre Admit  
**Plan Effective Date:** 8/26/2020

### Confidential Patient Information

**Treatment Plan is valid until:** 12/17/2020

<table>
<thead>
<tr>
<th>Treatment Plan Date:</th>
<th>8/28/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Treatment Plan Finalized:</td>
<td>9/18/2020</td>
</tr>
<tr>
<td>Plan Type:</td>
<td>Initial</td>
</tr>
<tr>
<td>Status:</td>
<td>Final</td>
</tr>
<tr>
<td>Treatment Plan End Date:</td>
<td>12/17/2020</td>
</tr>
</tbody>
</table>

**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:** 9/18/2020

**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:**

---

Avatar Clinical SUD  Training 3-2-2021  Page | 48
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

San Francisco Department of Public Health
Community Behavioral Health Services

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

Confidential Patient Information

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

Service Date (or Note Date if Independent Note): 8/9/2016
Service Code: Independent Note
Practitioner: TURNER,JOSEPH A (014450) PhD/PsyD
I have electronically completed and signed this note.
This service was provided in the client's preferred language of English
Status: Draft
Finalized Date: 8/9/2016
Note Type/For: MH CYF / Independent Note

Avatar Clinical SUD Training 3-2-2021
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 CoSign To Do Item To”

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

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

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

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

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

10. If client is \( \leq 18 \) yrs, then select appropriate CYF treatment plan and paste into box on right.
    If client is adult, then the “Select T.P. Version” will not work. Go back to “Notes Field” above and hand-type reference to relevant part of Tx Plan.

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.
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).
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.

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

#### 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>

#### Online Documentation

- **Client:** WALKER, JOHNNY
- **Episode Number:** 1
- **Note:** Episode # 1 Admit: 06/27/2013
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)**
   Begin at **Group Default Notes** section.

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

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

4. At **Progress Note For** Select ONLY “New Service” Choose “New Service” for billable or 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** 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 Sign…” box.)
At "Service Charge Code" box, select desired program name. Do NOT select "EPISODE".

See Jan 2013 CPT Code changes.

12 At "Service Charge Code" box, select desired program name. Do NOT select "EPISODE".

At "Service Program" box, select desired program name. Do NOT select "EPISODE".

11. At "Service Program" box, select desired program name. Do NOT select "EPISODE".

Enter word/code (e.g. "DBT Group Therapy").

1. At "Service Charge Code" box, select desired program name. Do NOT select "EPISODE".

At "Service Charge Code";
Enter word/code (e.g. "DBT Group Therapy").

See Jan 2013 CPT Code changes.

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)" for group.

Enter total time without multiplying time by number of clients. In the example above, 63 minutes was time counted from first client arrival till last client departure from group session.

Do NOT multiple "63 minutes" (Number of clients).

Avatar will automatically calculate individual client service charge.

Then add "Practitioner Doc and Travel Time (in minutes)".

After filing group note, these numbers cannot be changed.
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.
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.

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”.
Finalizing the progress note:

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

10. Click “OK”

Box below confirms that note has been filed for client, Frank McCourt.
Now, a single note remains in limbo. Note belongs to client, Garrett Trey.

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

Saving the individualized group note as draft:

12. When selecting Draft radio button, the “DRAFT” watermark or wallpaper appears in background. Clicking the File Note button will save Garrett Trey’s note as draft.

At some point, the Draft note for Garrett Trey must be made into Final and filed.
This box, below is confirmation that note was filed.

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”.

Individualize the Group Note:

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”

Confirmation that note has been successfully filed:

20. Click “OK” and you are finished.

Note: an “Intern” note that is final + approved by supervisor cannot be appended.
SERVICE CORRECTIONS

Edit Service Information

(Path: Avatar PM / Services / Ancillary / Ambulatory Services)
DISCHARGE BUNDLES
Discharge (Outpatient)
(Path: Avatar PM / client Management / Episode Management)

Discharge

[Image of discharge form]

Episode Number: 1
Date Of Discharge: 03/07/2013
Discharge Time: 01:32 PM
Discharge Day Of Week: THURSDAY
Length Of Stay: 241
Type Of Discharge: No Further Care Selected AT This Facility

Discharge Practitioner: HMAI DAME (0000006)
Discharge Remarks/Comments: Type comments about discharge
Discharge (Outpatient) - continued

Demographics
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.

Confidential Patient Information

<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>TESTTEST, SUMTEST</td>
<td>990450104</td>
<td>14</td>
<td>No Entry</td>
<td>1 HOM, KELLEE</td>
<td>No Entry</td>
<td>5/30/2015</td>
<td>NO SERVICES</td>
<td></td>
</tr>
<tr>
<td>Total caseload for program: SF SU Student Success Program (38HGIN)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
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 (003866)
From 1/1/2014 To 5/23/2016

Confidential Patient Information
ACCESS Screening

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

Service Date (or Note Date # Independent Notes): 5/30/2015
Service Code: NO SHOW (ADM00)
Service Program: ACCESS Screening
Practitioner: HOM,KELLEE (003866) PND/PsyD
Location: Other Place of Service
Status: Draft

Note Type/For: BHAC Administrative / New Service

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

Updated: April 23, 2012

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

2) Selecting wrong client

3) Selecting wrong episode

4) Selecting wrong program name

5) Creating duplicate episode

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

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

8) Diagnosis:
   a) Entering wrong “Date of Diagnosis.” The date of diagnosis must cover the date of admission.
   b) Leaving “Diagnosis – Axis II-1” blank: Type in “V71.09” for “No Diagnosis on Axis II”
Avatar Clinical (CWS) Common Error List
Updated: April 23, 2012

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

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

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

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

BLANK SAMPLE

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>

<table>
<thead>
<tr>
<th>Merge</th>
<th>BIS Number</th>
<th>Other versions of Client Name (if applicable)</th>
<th>BIS Number</th>
<th>Other versions of Client Name (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate #1</td>
<td></td>
<td></td>
<td>Duplicate #4</td>
<td></td>
</tr>
<tr>
<td>Duplicate #2</td>
<td></td>
<td></td>
<td>Duplicate #5</td>
<td></td>
</tr>
<tr>
<td>Duplicate #3</td>
<td></td>
<td></td>
<td>Duplicate #6</td>
<td></td>
</tr>
</tbody>
</table>

Assessment / Reassessment

Date of Assessment: [ ]
Type of Assessment: [e.g. CANS CYF Initial Assessment, A/GA (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: [ ]
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: [ ]
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.

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