Introduction to the Avatar Electronic Medical Record

Clinician Reference Guide

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Introduction to Avatar - Clinician Users

This reference guide focuses on how to **navigate** through the Avatar Electronic Medical Record and describes the types of entry fields used to input client data. Information is presented in sections; each section includes a written description, including visual screen shot examples. This is a companion to the online Internet and LMS "Introduction to the BHRS Avatar Electronic Medical Record Training" which is narrated and includes step by step demonstrations. The online training is located at: http://www.smchealth.org/onlinetraining. Clinical Users are also **required** to take the LMS/on-line HIPAA for BHRS- Mental Health, Progress Note, Client Treatment and Recovery Plan Trainings; The Assessment and Infoscriber trainings will be posted soon!

This reference guide will help you understand <u>how</u> Avatar works, <u>how</u> to navigate through Avatar Menus, and <u>what</u> the Avatar Menus, Commands and Tasks mean.

You will become fluent in the *language* of Avatar, understanding <u>what</u> *terms* and <u>which</u> *format* is required when you make an entry, or when you search for or request client reports.

You will learn <u>which</u> Avatar documents include important clinical/fiscal and administrative client data and <u>where</u> these documents are located.

You will learn <u>how</u> to create a Client Alert and Urgent Care Plan.

Once you have completed the training, you will be sent your password in an e-mail within 10 days. Information about passwords is located in Section 2.

Section 1: What is Avatar?

- San Mateo BHRS's Electronic Medical Record/Information System.
- Meets federal mandate to convert from paper to electronic medical records by 2015.
- Integrates clinical, fiscal, administrative and management information in one place.
- Provides access to client information 24/7- helps clinical teams make decisions & handle emergencies.
- Provides client care coordination for the treatment team.
- Improves quality & continuity of care.
- Minimizes time managing paper records and finding lost charts.
- Avatar software application from NetSmart Technologies is used by 28+ California counties.
- Has been operational in San Mateo County for more than 1 year; paper records for all clients open since 2004 have been scanned into the Avatar record.
- Clients with a Medical Record/ID # greater than 930000 have never had a paper chart.
- May need to request paper chart if looking for documentation prior to 2004.

Section 2: How Do I Login to Avatar?

Clinician User Login, About Passwords, Help Desk, Ethics/Your Role/Your Password

A. Clinician User Login – all BHRS Avatar Clinician Users

First:
Log-On to Windows.

Second:
Look to see if you can find the Avatar icon to determine if the Avatar application has or has not been installed on your computer.

This is the Avatar icon.
You can look for the Avatar icon on your desktop → click to open the application.
> Or

You can look for the Avatar icon through your START menu → click to open the application.
> Or

You can get yourself to the Avatar application if you click on the Internet Explorer icon and then enter http://svmid/ntst/radplus in the browser window.

Third:
When Avatar is launched it will open to the Avatar Homepage and you will need to Log-On. Look to the left for **User Authentication,** then click on it. This window will pop up:

System Code	You will be sent this
User ID	YOUR USER ID
Password	•••••••••••

With your **CAPS LOCK ON** you will enter the SYSTEM CODE; USER ID and PASSWORD that will be sent to you.

You will be prompted to enter **your own** password - 8 characters; at least 1 must be a number.
- **Write down your password**; Avatar gives you 3 tries, if you forget, if you didn't use the cap lock and/or if your log-in fails; your password will need to be reset by contacting the ISD Help Desk at (650) 573-3400.

* Avatar automatically locks you out after 30 minutes to 1 hour of no use - you may receive a warning that time has elapsed since last use; you can cancel the warning and remain active or if you need, just log back in. Windows will lock you out after 10 minutes of no use and you will need to re-enter your Windows password.

B. About Passwords

When you are sent your password and log-on for the first time, you will need to enter a personal password to replace the system-generated password. This will become your **active Avatar password for the LIVE system. Protect it!**

To create your personal password, you must comply with the following:

- Minimum 8 characters

- Must contain at least one numeric and one alpha character

- Case sensitive- recommended that you use all caps for the alpha characters

- You will be prompted to **change your password every 90 days**, the prompt will appear only once, so when the prompt appears, <u>change your password</u>. Once you password has expired it will not work and if you try and fail 3 times you will need to get your password reset through the Help Desk.

C. Help Desk

Forgot your password? Got locked out?
Contact ISD Help Desk at 650-573-3400   **ISDHelpDesk@co.sanmateo.ca.us**

D. Ethics/Your Role/Your Password

- The Password that you generate is <u>YOUR</u> signature.

- No one has Access to your password; however, it can be reset if you are locked out.

- **NEVER** give out your password; it is a HIPAA violation and sanctions may be applied.

- **Confidentiality** - If you know a client or family member, it is your professional obligation to report this to your supervisor. You will not be assigned this client and the medical record will be blocked/restricted to uphold strict confidentiality protections on behalf of the client.

- When you meet with your client, ask if they have a family member working for or receiving services from the BHRS system; if so, that medical record will also be blocked/restricted.

- While clinicians have access to the electronic medical records of all BHRS clients, off caseload activity can be monitored and access can be restricted if necessary.

☺ **Now you know how to Log-in to Avatar and get HELP!**
   Next, let's look at some of the *language* and *terms* used in Avatar and the **Avatar Menus, Task Options and Commands.**

Section 3: The Avatar Homepage

Menu Frame Options: Favorites, Avatar PM/CWS/MSO/Help

Look at the opening window, also known as the **Avatar Homepage.** This screen shot is what you will see when Avatar opens; the following pages will describe the Menu Options and Task Options in Avatar. You will learn how the Avatar homepage can be set to open with a "To Do" list as a reminder of items that you need to review and/or complete or you can set it to open with "Favorites" which is a shortcut to a list a documents that you use most frequently .

Menu Frame (A) **Tasks**, **Favorites**, **Avatar PM**, **Avatar CWS**, **Avatar MSO and all the way to the far right is Help.** Each option contains menus and sub menus that you will select to do your work.

A. Menu Frame

B. Task Bar Picture Icons

C. Tasks Frame NOW includes picture icons

D. My Caseload Frame

E. My Session Frame

The Avatar HomePage showing To Do items from the "Preferences" set up tab

When you click on **Tasks** in the **Menu Frame (A),** there will be a drop down list of options for you to select. The **Task Bar/Picture Icons** as shown in **(B)** and the **Tasks Frame (C)** include the *same* options.

⚠ You can select a task command from **any** one of these 3 places:
Menu Frame   Task Bar/Picture Icon   Tasks Frame

My Caseload Frame (D) Displays all active clients assigned to a clinician. Only clinicians have this frame. Clients remain in this frame until they are discharged or transferred to another clinician. If there are clients listed in the "My Caseload" frame, you can **scroll** to see **all** clients in the caseload **or** you can bring your curser in between the Caseload and Session frames and **expand** the caseload view. You will need to expand each time you open Avatar.

In addition, you will see indicators *preceding* a client name:
If the client is *new* to your caseload the client name will be *highlighted in yellow*.
If there are **NO** *To Do* items older than 24 hours there will be a ■.
If the client *HAS* To Do item(s) that are over 24 hours old, there will be 🔺.
If the client has one or more "To Do" items 🔴.

If you **right click** on a client, a pop up window displays menu options for Favorites, Avatar PM/CWS and Chart Review; you can select from here or you can select the same menu options from the Menu Frame at the top of the window.

Chart *has* __NO__ To Do items older than 24 hours (not shown)

New Client **highlighted** and with *TO DO more than 24 hours*

Chart *has* To Do items over 24 hours old

Charts __have one or more__ client "To Do" Items

You can select Chart Review from this Pop Up by right clicking on client either From My Caseload or My Session

Expand with your curser to see all clients   **Right click on the client name for menu options**

My Session Frame (E)
You can **also** right click on a client name in 'My Session' **(E)** for the pop up window that shows the menu options as described above. From this pop up window you can also remove a client from "My Session" if you don't plan to work with the client again in this session.

In the "My Session" frame of clients you are **currently** working on, the **ACTIVE** client will appear in **ORANGE**.

Right click on client name for options

My Session

● Client
  ▲ TESTON

TESTONE,TEST (000930000)
Favorites ▶
Avatar PM ▶
Avatar CWS ▶
Avatar MSO ▶
Chart
Remove from My Session

You can select Chart for Chart Review, or other options
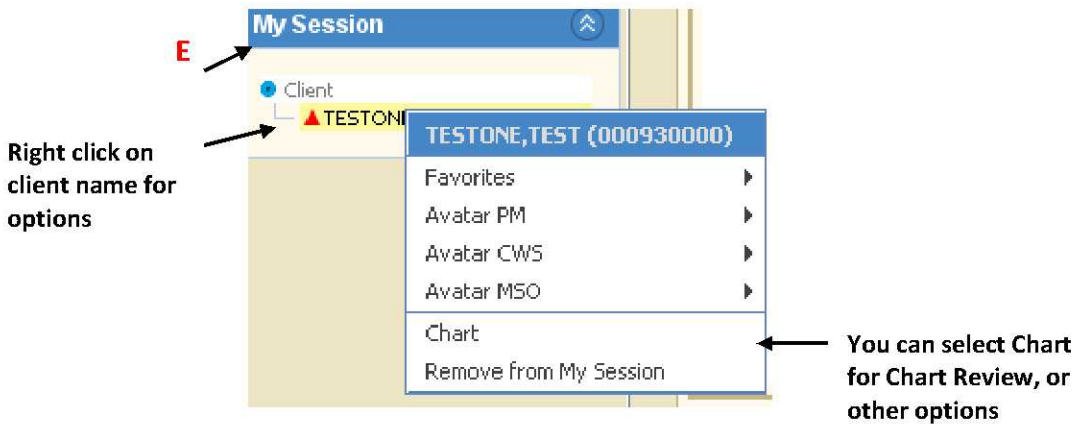
You will learn about "To Do" Items later in this manual, See page 15 and Section 12

Section 4: Avatar Menus

Tasks Menu Options, Select Client, Favorites, Lock, Log-Off, ?, HELP, My Session, Refresh

1. The Menu Frame has menus that contain every command in Avatar.

(A)   (B)   (C)   (D)

The Menu Frame

Tasks   Favorites   Avatar PM   Avatar CWS   Help

(A) Tasks Menu Options - The Tasks Menu in the Menu Frame, is a drop down menu that includes: **Select Client,** My Appointments (not used by BHRS), **My "To Do" List**, My Applications (not used by BHRS), **My Favorites**, **My Preferences**, My Courses (not used by BHRS), **Lock**, and **Logoff**

    * The menu options in **bold** are discussed in more detail starting on page 14.

(B) Favorites Menu - This menu is a shortcut that allows you to go *directly* to **a form or report** you use **most** frequently. Once you have selected your "favorites" and saved them, they are stored and available to you from any BHRS computer. Click on "Favorites" - the forms or reports you have set up will appear on your homepage screen; select one and the document or report will open. You can now right click on a client name in My Caseload or My Session and select a "Favorite" that you have saved.
* Please see Page 15 and Appendices # 2 on page 55 for How to Create Favorites.

(C) Avatar PM Menu - Practice Management – this menu contains Client Management, Utilities functions, and is the *administrative* area of Avatar, for example: business/billing, call intake, admission, family registration (UMDAP) and discharge tasks.

(D) <u>Avatar CWS Menu</u> - Clinical Work Station - this menu contains the clinical features: Assessments, Treatment Plans, Progress Notes, Infoscriber and Reports. *Any document or report open through CWS will also provide access to Chart Review where you can view the entire client's chart.* For clinicians, 90% of your work is through this menu; CWS provides a multidisciplinary, integrated view of client information. Remember, you can always right click on a client name in My Caseload or My Session, and select Chart for Chart Review from the pop up.

2. Other AVATAR Menu Resources

<u>Avatar MSO Menu</u> **-** This menu is designed for the private provider network to credential providers, authorize services, adjudicate claims, and reimburse providers**.**

<u>Avatar Infoscriber Menu</u> **-** This menu is the Electronic Prescription application for the MD to prescribe medication, review medication history, monitor drug/food interactions, display drug/allergy alerts. ***Special access is required. (Medications can be viewed through the client's face sheet report!)***

<u>Avatar Document Imaging Menu</u> **-** This menu allows Electronic Scanning of information. For example, if external clinical information is received from the hospital, it must be scanned in to the client's Avatar episode; or, if the client signs a paper version of the treatment plan, this plan must be scanned into the client's Avatar episode.

<u>Help Menu</u> - this menu links to online documentation and search options.

⚠ **Important:** Once you have logged in to Avatar, DO NOT use Internet Explorer's Back, Forward, Refresh, or Close buttons. If you do, Avatar will log off and you will lose any unsaved work!
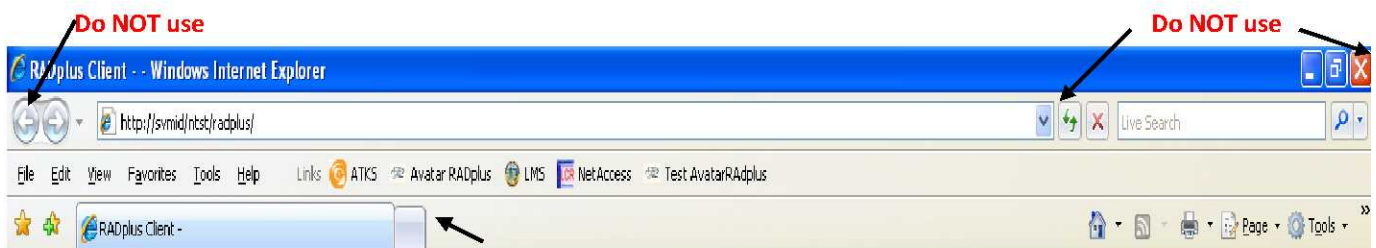
Section 5: Tasks Options

Details of the TASKS MENU (A) in the Menu Frame (1); the TASK BAR/PICTURE ICONS (B) and the TASKS FRAME (C)

(A) Click for drop down of Task Menu options.

1. Menu Frame

B. Task Bar Picture Icons

C. Tasks Frame

D. My Session

 ## Select Client

This is a quick way to look up clients, add clients to 'My Session', you must "Select Client" to request certain reports or documents. Client search results will show in the bottom half of the screen; the Up and Down arrows on the keyboard can be used to scroll through names and the Enter key can be used to highlight a row.

You can **Select a Client** by entering: *Medical Record Number, *LastName, *LastName,First (no space), *LastName,First JR (space only before title), *LastName,First MI (space only before middle initial), *Hyphen (Maria Lopez-Cantera), *Apostrophe (Angelo D'Marco), *Birth Date; or *Alternate Look Up: Social Security #; Alias - LastName,Alias; Soundex-Similar Sounding Name (e.g. Browne vs. Brown).

⚠ **Please see Appendices #1, for a step by step "how to" select a client.**

My "To Do" List

A list of To Do items will appear on your Avatar Homepage once you set Tab 3 in the "My Preferences" sub-menu. "My To Do List" is a reminder that you need to review or complete an important item. (Items left as DRAFT or pending co-signature that need to be finalized). "My To Do" function can also notify if a client has been added/deleted from clinician's caseload.

* Please see page 16 for setting up "To Do" in Preferences; Section 12, has more detailed information about "To Do" workflow functions.

My Favorites

The "Favorites" function is for you to create a short cut to YOUR most often used documents or reports. You create "favorites" by clicking on the "favorites" option until a folder appears on the Avatar homepage. Right-click on the "favorites" folder icon and choose "Add Folder" from the pop up menu. An *Input Dialog* box appears for you to type the name of the new folder, and then click OK. Next, place the mouse pointer over the "favorite" document or report you want to add from the Avatar CWS Menu. Left Click and hold down, while you drag the "favorite" document or report to just below the new folder. Then release the mouse button. Click the save button on the bottom of the screen. You can repeat this for each favorite you want to create for this folder or you can create additional folders and then add documents/reports to them.

* Please see Appendices 2, for other alternatives for creating 'Favorites".

My Preferences

This Avatar feature links to a window where you choose options for spell check and can specify which window opens first and appears on your Avatar homepage after you log in to Avatar.

Click on My Preferences and the window will open and show 3 tabs.

Under the **General** Tab, select - **Use Microsoft Word Spell Checker** and **ALWAYS** check spelling from start of text. Click Apply.

Skip the **Printer Fonts** Tab: It is NOT used by BHRS because changing these settings results in reports printing incorrectly!

Under the **Startup** Tab, Select Either **My "To Do"** or **"Favorites"** for the initial view that you will see on your screen when you open Avatar. The setting of My "To Do" is recommended!
When you are finished, at the bottom of the My Preferences window,

> **Always Click Apply** to **save your changes,**
> **Click Apply and Dismiss** to apply the changes and close the window, or
> **Click Dismiss** to close the My Preferences window without making any changes.
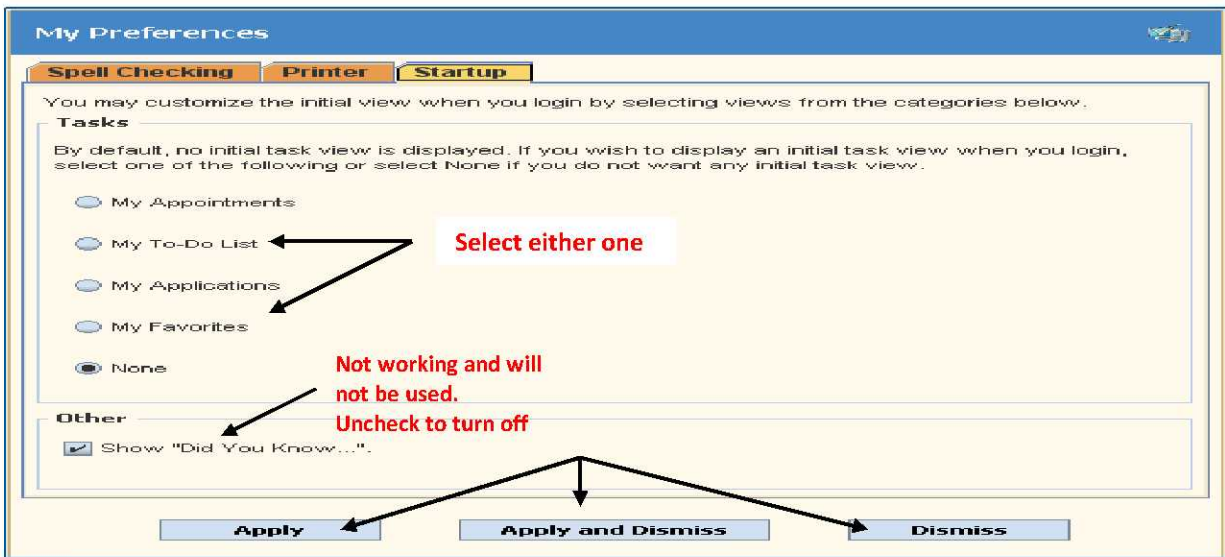
Lock Application

If you click on the "Lock" application, client information will be protected and cannot be viewed if you leave your computer for short time. Locking the application restricts unauthorized access. You will be required to enter your Avatar Password to unlock Avatar when you return; however, the screen will be at the exact state where it was before it was locked.

Logoff

You should *log off* when you are leaving the office at the end of the day so the system will shut down properly. When you *logoff* the Avatar application closes completely. When the message appears asking if you are sure you want to logoff, click the "Yes" button at the bottom of the window.

USE THIS METHOD, __NOT__ the ☒ in the upper right corner of the Avatar window. **Once you Logoff, then use the red ☒ close button in the upper right hand corner of Internet Explorer.**

Help

Help provides *links* to online documentation and search options - this is currently under construction. The **question mark** provides a hyperlink that connects you with the most current versions of Avatar reference guides used for CWS functions. You will find the Assessment, Progress Notes, Client Treatment & Recovery Plan and others if you click on the question mark and select the guide you want to view, or you can go directly to: http://smchealth.org/avatarguides .

Refresh

There is no icon for this option. This command will allow any new report or feature that may have been added to Avatar, while Avatar has been in use, to become available in your menu or on your screen once you have *refreshed* your screen.

☺ **You now know about Avatar Menus, Tasks Options and Avatar terms! You know How to Select a Client; Manage your work through "To Do"; Create Favorites and Preferences, Lock and Logoff!**
Next we'll look at *Avatar Navigation Features*. You will need to use these features to enter client information for any clinical document, to request reports and/or to create a Client Alert or Urgent Care Plan if you need to communicate about a client issue or concern.

Section 6: Navigation Features in Avatar

A. Arrows/Sub-Menus Avatar Menus can be expanded to present more options. If a menu has an **arrow on the right it means there is a sub-menu**; if you drag the cursor horizontally through the sub-menus, you can view more options and then click to choose your selection.

Horizontal and Vertical Arrows lead to Sub-Menus

There are double arrows (called chevrons) that also expand menus. You can slide your cursor vertically down and click on **the double arrows, the menu will expand to show more choices**.

B. Windows When you open any document a *Client Window* will open. Many documents may be open within that 1 *client window*. For example, the screen shot on page 17 shows a *client window* that contains **open** documents for this client; look at the bottom, the Urgent Care Plan document is on the left, the Client Alert document is in the middle and Chart Review is on the right. **(A)**

The *window name* appears in the blue title bar at the top; this is the Urgent Care Plan document **(B)** and the client's name and MR# are present **(C)**. If you click on Client Alert, the *window name* will change to *that* document. You can switch between documents within a *client window*.

Please Note: The client's name, MR#, date of birth and sex are also present in the line just below the toolbar **(D)** and, the client's name should appear orange or active in the "My Session" frame.

⚠️ When you open a *client window* be sure to use the **'Rule of 3'** checks to view information on the correct client. (Client name is **orange**/active in "My Session"; it matches with client name in blue title bar and client name in the line just below the toolbar!)

C. Tabs

A document may be divided into *Tabs*. A *Tab* divides a window into smaller pieces (e.g. a tab is similar to a tab that would identify a section of a paper record). If there is more than one *Tab*, you must complete information for each *Tab*. You can switch between *Tabs*. The active *Tab*, the one that you are working in, will always be orange. This screen shot shows only 1 *Tab*. **(E)**

You may notice a "Flag" shows on a Tab. The "flag" indicates one or more of the required fields is missing an entry or contains an incomplete entry. The "flag" alerts you to open the tab; there will be a "flag" next to the field that requires an entry. "Flags" will not appear as you are making an entry but when you submit, a pop up message will notify you there is a missing field.

D. Pages

A *Tab* may contain more than one *Page*. If all fields within a tab cannot fit into a single screen, Avatar divides the tab into multiple *Pages*. If there is more than one *Page* within a tab, <u>you must complete information for each *Page*</u>. The active *Page* you are working in will always be orange. The screen shot on the next page shows there are 2 *Pages*. **(F)**

E. Screen Shot Windows/Tabs/Pages

These are open Documents within the Client's window

F. The Option Toolbar The option toolbar appears at the top of all windows in Avatar.
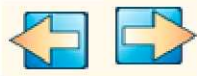
1. Back/Forward:
Click these icons to move back and forth between multiple pages in a tab.

2. Close:
Click this button to close a window.

3. Home:
Click this to return to the Avatar Homepage without closing the current window.

4. Submit:
Click this to SAVE or FILE data in the current window; typically when you submit, the window closes.

5. Lock:
Click this to protect client data if you leave your computer for a *short time*. Your password will be required to unlock Avatar but the Lock will return you to the exact state your computer was in before it was locked.

6. Copy, Cut, Paste, Spell-Check:
Click this to cut, copy, and paste text between fields in Avatar.

G. Selection Screens

1. Episode Selection Screen: When you try to open a document or report for a client that has more than one active episode, an Episode Selection screen will appear and require you to select the episode you want your document to be entered in, usually, this is the *episode for the program where you work*.

Episode - References to *episode* mean the opening (admit) and closing (discharge) at a **program**. A client may have <u>many</u> episodes of care. If the *Episode Display Screen* appears when you select a document or report, you **MUST** select the <u>correct open episode</u>, the **open episode** for the program you want to obtain or submit client information. In an open episode, the discharge date will be blank or NONE; closed *episodes* (showing a discharge date) have historical information.

Program - References to *program* mean the place/site where you are assigned to work or where you want to obtain or submit client information.

2. Pre-Display Selection Screen: This screen shows **previous entries** of progress notes that have been made. Sometimes it shows a document in Draft that needs to be finalized; sometimes it shows other documents and their status (urgent care plan/client alerts). This pre-display screen of outpatient progress notes will open if there are previous progress notes when you select *Progress Note* from the CWS Menu. This screen provides 4 options: Select **Add to create a new progress note**; select **Edit to edit a note that is in Draft**; select **Delete to remove** an item not yet finalized; select **Cancel to leave** the progress note option and return to the homepage.

NOTE: Once you have submitted an item as final, it is recorded in the Avatar system and can only be viewed - it cannot be edited or deleted.

H. Format and Entry Types Used in Avatar

1. Field Colors: Field names are either _black_ or _red_. Any field in **Red** is a _required field_ and must be completed in order to submit information.

If you are working in a document and a field or command is Gray you will not be able to select that option. For example, to exit the treatment plan, you must click on the Exit Treatment Plan box at the bottom of the window and not the [icon] that is grayed out at the top of the window

You must look at the document to see if there are alternatives to exit or submit!

* If you are "Color Vision Deficient" you may submit a request to the Help Desk through your supervisor to have your Avatar "User Code" changed. All fields will then appear in **black** with required fields in **BOLD** and **UNDERLINED.**

2. Date Entry:

Dates are always saved in a MM/DD/YYYY format.

You can click the **T** or **Y** button to automatically enter <u>T</u>oday's or <u>Y</u>esterday's date.

You can double click inside the date box and a calendar will appear so that you can select a date that will populate into the date box.

There is a **new 'Date Picker' tiny calendar** icon outside of date entry box that brings up a calendar for selecting a Date. Once a date is selected it will default into the field.
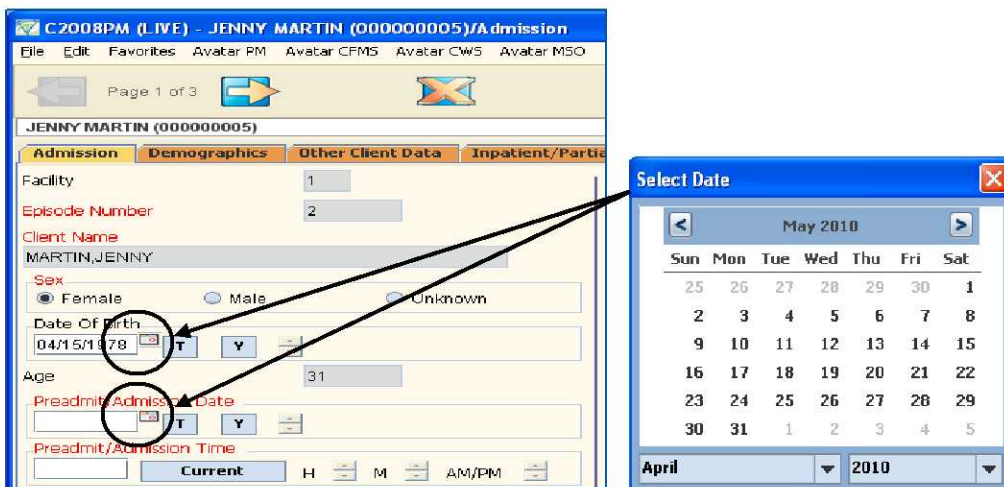
3. Single Select Entry Choice: You are only able to *select one* from the *radio buttons/drop downs* or *check box*.

Draft/Pending Approval/Final
- ● Draft   ○ Final
- ○ Pending Approval

4. Multiple Select Entry Choice: You can *select many* as applicable.

As a result of the primary diagnosis the client has the following impairments:

Treatment is being provided to address, or prevent, significant deterioration in an important area of life functioning

☐ School / Work Functioning   ☑ Social Relationships   ☑ Daily Living Skills
☑ Ability to maintain placement   ☑ Symptom Management

5. Dropdown List Selection:

Dropdown lists provide a *menu of choices* that you can select from to fill an entry field. Below is an example of an Avatar drop down list. Click the arrow to see the choices, then click on your selection.

Presenting Problems-Primary
Thought Disorder ▼

You can *clear a dropdown field* if you click once in the light blue area and *tap the [F5] key*.

If the entry is with a required (red) dropdown list, you *must* make a selection and the entry cannot be cleared!

6. Process Search Entry:

Process Search requires you to make an entry in the blank white box; then click Process Search, and then click the correct selection so that it populates the blue box. Process search entries are common in Avatar; some require staff member names, service type names/codes etc. The entry can be a number or few letters or the complete name of a person or service type. When process search is clicked, a pop up box requires a selection to be made or requires you to validate that what is in the pop up box is correct. Once you answer 'OK', or select the entry, it will populate the required blue Avatar field. You **MUST** search and select. If the blue field is empty, Avatar considers nothing was entered and you will not be able to submit your document.

Some BHRS Staff may have their name listed twice with two different ID #s (e.g., one ID # is for services the county pays for through the Contractor/Private Provider Network while the other ID # is for services the county pays for through county operations. **You should always choose the lower of the two numbers.**

Primary Therapist
BULL   Process Search
● Name/ID Number   ○ Unique Practitioner ID
BULL,INGALL (000016) ▼

Search by name or ID#

You can enter a name or ID in the white box;

then click process search, then choose the correct selection so it populates the blue box.

Primary Therapist
16   Process Search
● Name/ID Number   ○ Unique Practitioner ID
BULL,INGALL (000016) ▼

7. Free Text Box:

The Notes Field of the Outpatient Progress Note is an example of a _free text box_. A Free Text box allows you to enter as much text as needed in the box. Click once inside the text box and begin typing. Once the box is full, text can be viewed by scrolling vertically on the scroll bar that appears on the right hand side of the box.

You can also view the text by clicking on the <u>Text Editor</u> icon (pad/pencil) at the upper right hand corner. The Text Editor expands the view of the entire note. The Text Editor allows you to make changes to the note. (e.g., cut, copy, paste, undo, spell check). You must save any changes to the text before you close out of the Text Editor window.

Free Text Box - just click inside and begin typing.

Text Editor Window Icon

Notes Field

This is a progress note for Adam.
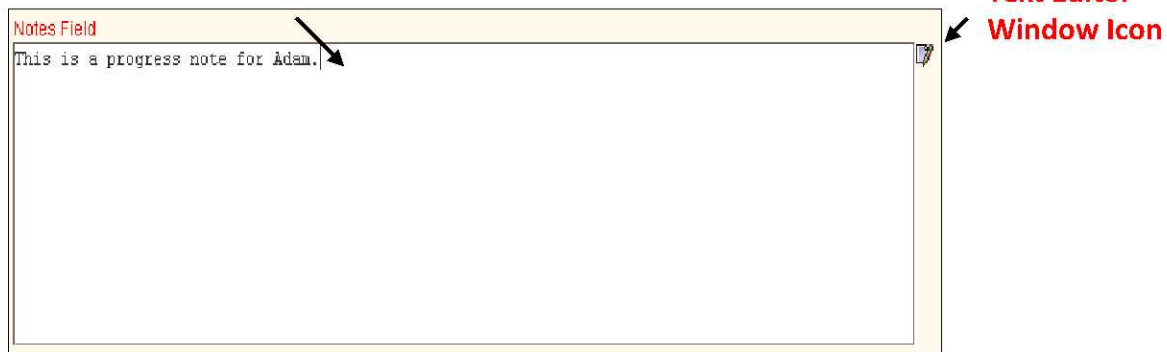
In _scrolling_ and _**non scrolling text fields**_, any _**misspelled words will have a visual cue**_, similar to Microsoft Word or Outlook. "Name" and "Process Search" do not have these indicators.

Mis-Spelling Cue
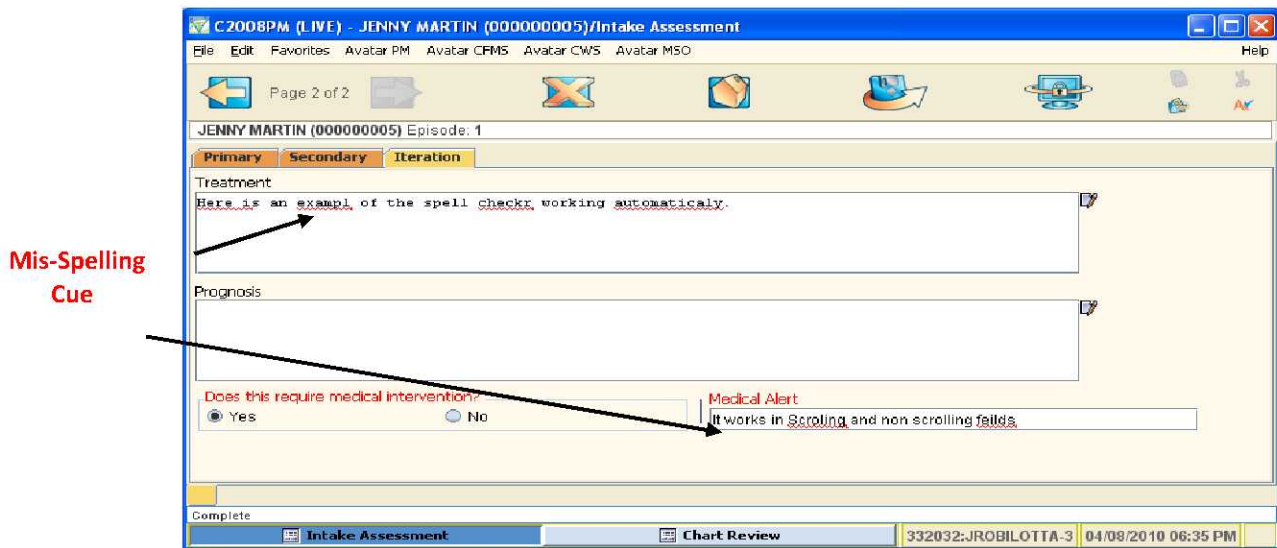
Text Editor Window

If you are working with a field that requires typing more text than you can see in the text area, you can use the Text Editor Window icon to expand the text area.

Be sure to save.

Click and drag here to change size of window.
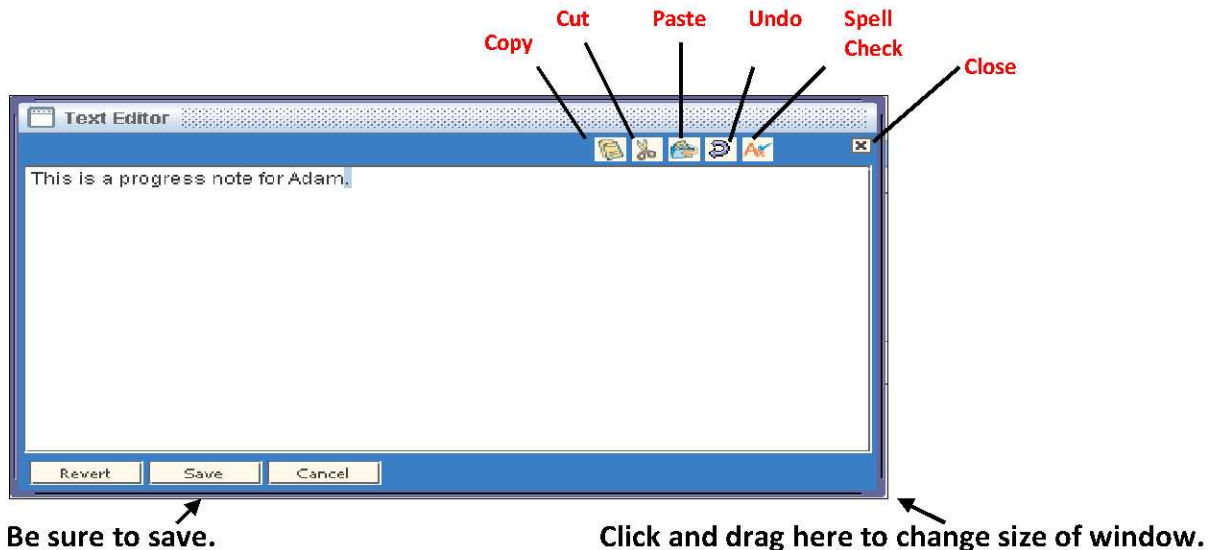
COMMAND	DESCCRIPTION
Copy	Copies selected text to the clipboard.
Cut	Moves selected text to the clipboard.
Paste	Pastes information from the clipboard to the location of the cursor.
Undo	Reverses the last action.

8. Multiple Entry Table Entry: A multiple entry table is a feature used in Avatar for gathering lists of similar information, such as a list of a client's medications or a list of a client's family members/other relationships. To make an entry, you must add a new row to the table and then complete the related fields of data, which are then stored in the table.

You **MUST** click *add new item* before adding a new row or filling out fields for the new entry. Be very careful as **existing information will be overwritten** if you do not click **ADD NEW ITEM!**

Selecting a row and clicking the *Edit Selected Item* button opens the related fields for editing.

Selecting a row and clicking the *Delete Selected Item* button removes the row from the table.

Clicking the *Add New Item* button adds a new blank row to the table.

To Add, Edit and Delete Entries in the Table

When you select a row you want to edit and then click the Edit Selected Item button, the related fields become active so you can make changes. You can select a row and click the Delete Selected Item button below the table to remove a row from the table.

9. Other Helpful Tips:

At top right of document: DO NOT USE the RED X in Avatar; it is ok to use it for Crystal reports.

File / Save or **Submit** button is how documents are saved/submitted in Avatar; it is also how to move to the next tab or to close a document.

Bundle: Documents in a bundle are grouped together in windows serially that are related within a process, such as the Admission Bundle (Outpatient) which contains all the assessment documents, LOCUS, Diagnosis, Master and MSE.

Light Bulb is a Help that provides more information for a subject area for example, Service Types and Service Locations. You can hover over the light bulb to see information or click on it.

Home ✋ returns you to the Avatar homepage without closing the current window that is open.

⚠️**Important**
- Always look at the screen and the command you have selected to see **what you are being asked to do**: save, file, apply, dismiss, add, ok or cancel?
- Usually a **left click is to *select an option*** and a **right click is to *perform an action.***

☺ Now you know the **Avatar Menus**, **Tasks**, **Commands**, and **Toolbar Options**; you also know the **Navigation Features** and can enter data in the **Format** and **Entry Types** used in Avatar. **You are now ready to view the Client's Electronic Medical Record and locate the documents and reports that have been entered into Avatar!**

Section 7: The Client's Medical Record and Avatar Reports

A. About Reports

If you imagine a client's paper chart that has sections for assessments, consents, treatment plans, medications and progress notes, well, Avatar ***reports*** is how you can view these completed documents.

You request a report through Avatar CWS ↓ Reports; slide your cursor horizontally and/or vertically to select the report you need. **Look to see what is required to submit the report you are requesting; some reports require a certain date range, a specific program, episode selection or clinician ID.** The ***Client's Dashboard Report*** and ***Chart Review*** include most of the clinical, fiscal and administrative client information.

B. The Crystal Report Application

Crystal Reports is a software application that gathers information already entered into Avatar and presents it in a comprehensive, easy to view report format. You can select a report to view a section of the chart or a specific document and can print the document or section from the Avatar report screen. Sometimes there may not be any information when you run a report. For example, if a client is not on any medication, the Avatar medication report would be blank – the same as in a paper record where there the medication sheets would be blank.

C. The Crystal Report Submit Icon and Report Pop Up Messages

Click on this **Report Submit** icon when you are requesting a report. The Report Submit icon has a squiggly line and will be present on many reports that you request. Once you click on the Report Submit icon these report pop up messages may appear:
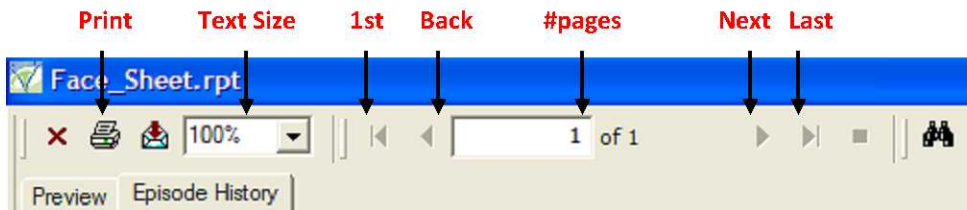

AVPMLIVE (SAMPLE) - AVPMLIVE (SAMPLE) - Download Report

? Report does not exist for workstation. Download report from server?

OK   Cancel

Click, OK to this pop up message to download the report.

Then, this following pop up message may appear to let you know the report is in process:

AVPMLIVE (SAMPLE)

Loading report file from server...

P l e a s e   W a i t . . .

D. Standard Report Toolbar

Reports use a standard toolbar as shown below:

Print   Text Size   1st   Back   #pages   Next   Last

Face_Sheet.rpt

✕ 🖨 ⬇ 100% ▾ | ⏮ ◀ 1 of 1 ▶ ⏭ ■ | 🔍

Preview | Episode History |

You can print from the report screen, increase the screen size, view the total number of pages in the report and the current page you are viewing; you can also move forward and back through the pages.

When you run any report it may take some time to download as all the information is being gathered from various places in the Avatar system.   **Be Patient!**

Section 8: The Client Dashboard Report

A. Understanding the Client Dashboard Report

The Client Dashboard Report gives you a snapshot of your client's critical clinical information in one page. This report is designed to be viewed "live" in Avatar and has links to more information about your client than is displayed on this page alone. This document explains the various sections of the report and how to read the information presented. Below, there is an example of the report as it will appear when you run it in Avatar.

B. Screen Shot of the Dashboard Report

C. Details of the 9 Main Sections and 7 Links (in blue) to More Information

1. **Client Demographics** - Includes information on the following: Client Name, Date of Birth, Age, Address, Phone Numbers, Race, Ethnicity, Language & Preferred Language, Gender, Social Security Number, CCP Coordinator, Anniversary Date, Living Situation, AKA Names, Treatment Consent Date (Avatar Consents only at this time.)

2. **Urgent Care Plan** - If a client has an Urgent Care Plan on file it will display in the upper right corner. (This report will only pull the *most recent*, open Urgent Care Plan.)

3. **Guarantor Information** - Shows the current payer information on file.

4. **Emergency Contact Information** - Displays information that has been entered in the Client Relationships form in Avatar. Individuals included have been flagged as one of the following: Guardian (**G**), Emergency Contact (**E**), and/or Next of Kin (**K**). In addition, it lists individuals who are designated as urgent contacts (e.g., Probation Officer, Primary Care Physician, etc...)
   ► [View All Contacts](#) - This link will display all collateral contacts entered into Client Relationships. You can find Client Relationships at **Avatar PM/Client Management/Client Information**.

5. **Authorization For Use of PHI** - This section displays the current status of the consent form "Authorization for the Use of PHI." Consents for the last 18 months will display and items that are over a year old will display in **RED** to indicate that the consent has expired.

6. **Assessment Status** - Displays the current assessment status. If the client's assessment is almost due it will display in **GREEN** and assessments that are overdue or left in "Draft" will display in **RED**. (NOTE: **Documents left in draft are not considered complete, or part of the client record.**)

7. **Current Medications -** Displays currently prescribed medications from Infoscriber. Information includes the date prescribed, # of refills left, medication name, dosage, prescriber, and pharmacy (pharmacy phone number will be added later). Prescriptions that have been discontinued will not display in this section. (NOTE: **Infoscriber information can be up to 24 hours old.**)
   ► [Allergy Info](#) - This link will display all medication and non-medication allergies that have been entered into Infoscriber.

8. **School Based Mental Health Information** - Displays current information regarding authorized School Based Mental Health services (formerly 26.5 Info.)

9. **Current Open Episodes/Primary Dx/Tx Plan Status** - This section displays information about the client's open episodes. Information for each episode includes episode number, admit date, program name, primary clinician, psychiatrist, primary diagnosis, last service date, and treatment plan status.
   a. **Treatment Plan Information** - If the client's Treatment Plan for an episode is almost due, it will display in **GREEN.** Treatment Plans that are overdue or left in "Draft" will display in **RED**.
   b. **Last Service Date** - Displays in **RED** if the last service occurred more than 90 days ago.
   c. **Additional links in this section**:
      i. [Other Assigned Staff](#) – Displays the names and roles of other staff who have this client on their caseloads and each staff member's program/team.
      ii. [Dx History](#) - Displays the complete history of primary diagnoses by episode entered into Avatar.
      iii. [Tx History](#) - Will display 90 days of service information by episode.
      iv. [Episode Hx](#) - Displays client's episode history since 7/1/2004. (Run time up to 1+ min.)
      v. [Progress Notes](#) - Displays 6 months of progress notes. (Run time up to more than 1 min.)

D. Dashboard Report Locations Abstracts Section of Chart Review and Avatar CWS/Reports
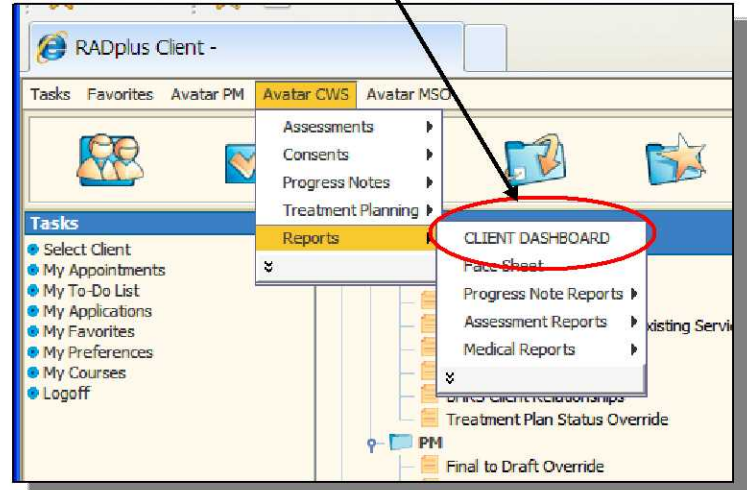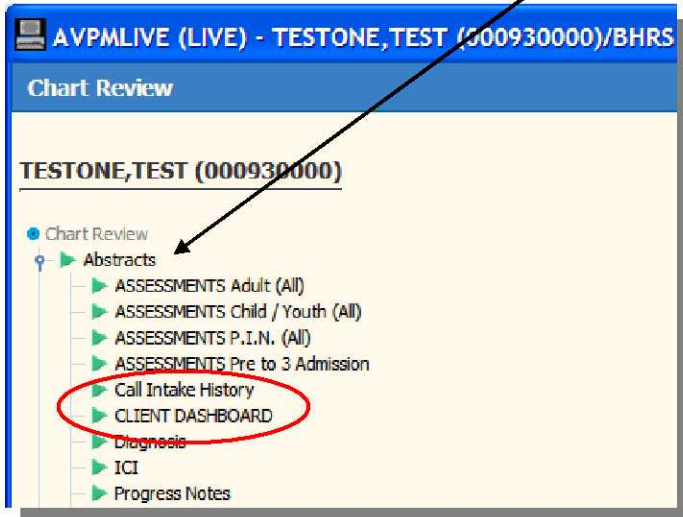
Section 9: Chart Review

A. How to Find the Chart Review Screen

The blue title bar of the window below shows that this is the client's Face Sheet report window. On the bottom left section of the window is the Face Sheet and on the **bottom right in light blue is Chart Review**. When you click on Chart Review it becomes dark blue and is active. Chart Review will always appear at the bottom right hand side when another document gets opened in any window you are working in. *Any report or form that you open will bring up the Chart Review screen.* You can switch between screens.

Face Sheet Report window

Face Sheet   **Chart Review**
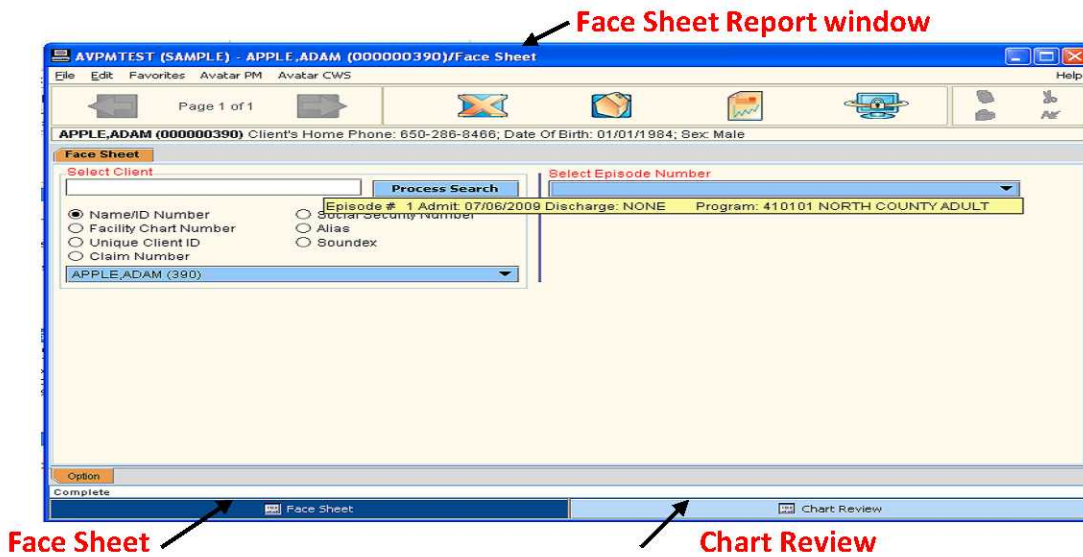
You can also Launch Chart Review as stand alone function without having to first open another option! The Menu Path is **CWS→ Reports→ Chart Review.** You can *also Right click on a client either in "My Caseload" or "My Session" and select Chart for Chart Review.*

From Chart Review, you can **exit** the screen by **clicking on Dismiss.**

RIGHT click on the client's name in *either* My Caseload or My Session.

You can select Chart Review from this Pop Up
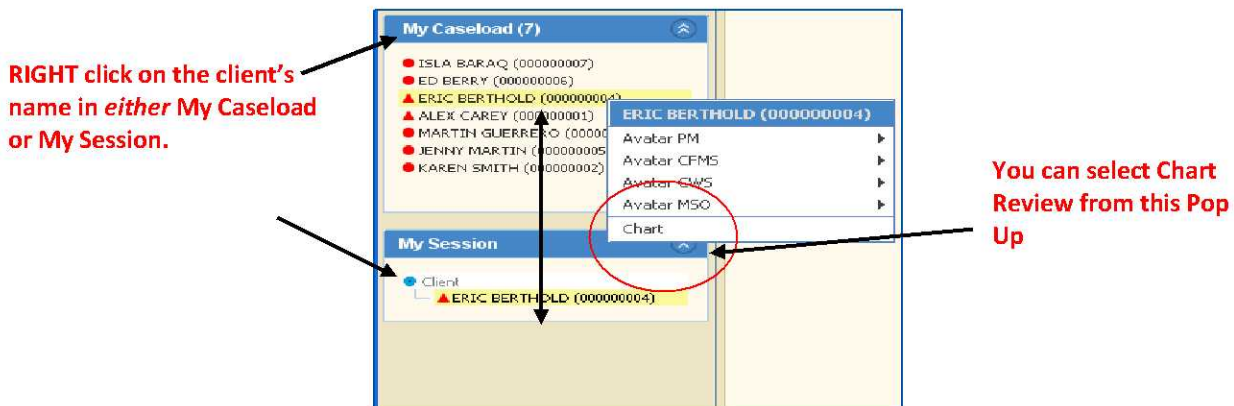
B. Information in the Chart Review Screen

Chart Review shows a quick view of the client's <u>entire</u> chart. You can view episodes of treatment and ONLY finalized documents within the episodes. Documents for release get printed from Chart Review.

* **Abstracts:** These are reports that pull together information from multiple areas of the Avatar system. A report from Abstracts will include all information and companion documents. (Assessment includes MSE, Diagnosis, LOCUS, Substance Abuse Assessment if indicated- all will show for date selected.)

* **Client Level Documents:** These are forms connected only to a client, not any particular program or episode, e.g. consents, LOCUS/CALOCUS, ICI's, Substance Use Assessment.

* **Episodic Level Documents:** Episodes are displayed by episode number, admit and discharge dates, if the episode is open then NONE will show for the discharge date. Episodic documents include treatment plans, assessments, and diagnosis. (All) means all components connected to assessment documents will be present (e.g. MSE, LOCUS/CALOCUS, Diagnosis, Substance Abuse Assessment, and Assessment Master)

C. Chart Review Screen Shot
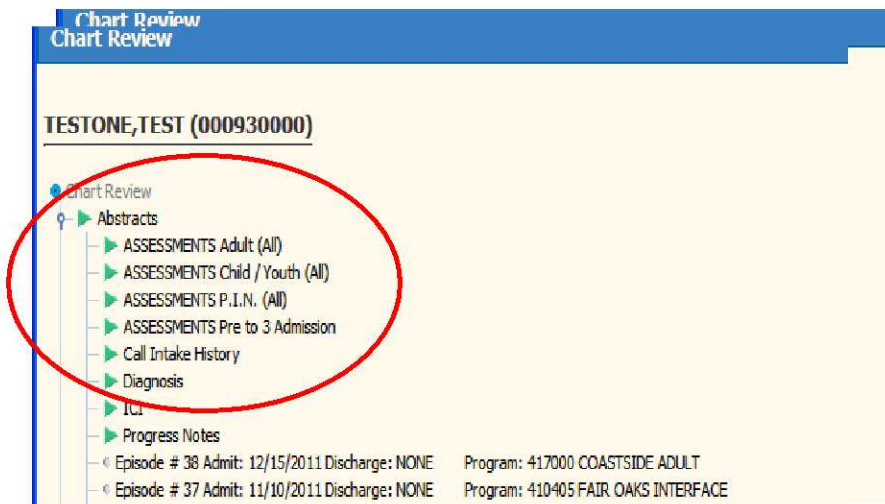
ABSTRACTS

Abstracts are reports that pull together information from multiple areas of the system. We have added new assessment reports that will pull all of the assessments on file for a client in reverse chronological order. This will eliminate the need to search through the episodes for the assessments on file. These reports also include all of the information in the assessment and the companion documents.

Chart Review

TESTONE,TEST (000930000)

● Chart Review
○ ▶ Abstracts
  ▶ To Do List
  ▶ AIMS (Abnormal Involuntary Movement Scale)
  ▶ BHRS Client Relationships
  ▶ CALOCUS
  ▶ Care Coordinator
  ▶ CONSENTS Application for Services/Consent to Treatment
  ▶ CONSENTS Authorization for use or Disclosure of PHI
  ▶ Day Treatment Authorization Approval
  ▶ ICI Contacts Note
  ▶ Initial Contact Screening (ICI)
  ▶ LOCUS
  ▶ Substance Use Assessment
  ▶ URGENT CARE PLAN
  ▶ Episode # 38 Admit: 12/15/2011 Discharge: NONE   Program: 417000 COASTSIDE ADULT
  ▶ Episode # 37 Admit: 11/10/2011 Discharge: NONE   Program: 410405 FAIR OAKS INTERFACE
  ▶ Episode # 36 Admit: 10/06/2011 Discharge: NONE   Program: 410401 SOUTH COUNTY ADULT
  ▶ Episode # 35 Admit: 04/30/2011 Discharge: 05/06/2011 Program: 410205 PENINSULA HOSPITAL INPATIENT

CLIENT LEVEL

Client Level forms are not associated with any particular program or episode; they are connected only to the client. These forms include consents, LOCUS or CALOCUS, ICI's, Substance Use Assessment and others.

Chart Review Screen, continued

▶ Episode # 26 Admit: 11/15/2010 Discharge: 05/26/2011 Program: 411100 YOUTH SERVICES CENTER
○ ▶ Episode # 25 Admit: 11/15/2010 Discharge: NONE   Program: 410301 CENTRAL COUNTY ADULT
    ▶ ADULT Admission Assessment
    ○ ADULT Annual / Update Assessment
    ○ ADULT Special Assessment
    ▶ BHRS Client Treatment and Recovery Plan
    ▶ BHRS Diagnosis
    ○ CHILD / YOUTH Admission Assessment
    ○ CHILD / YOUTH Annual / Update Assessment
    ○ CHILD / YOUTH Special Assessment
    ▶ Contractor Treatment Plan
    ▶ Diagnosis
    ○ Managed Care Authorizations
    ○ Medication Reconciliation
    ○ PRE TO 3 Admission Assessment
    ▶ Progress Note Viewer
    ▶ Transfer/Discharge Request
▶ Episode # 24 Admit: 11/15/2010 Discharge: NONE   Program: 410101 NORTH COUNTY ADULT
▶ Episode # 23 Admit: 10/07/2010 Discharge: NONE   Program: 410311 YOUTH TRANSITION SERVICES

EPISODE LEVEL

Episode level documents include Treatment Plans, Assessments, Diagnosis and others.

D. How to Open and View Chart Review Documents

- **A green triangle** by a document means there is **more information**.
- **A small circle** means there is **no** information.
- Clinical documents now have "print ready" reports associated with them.
- In the **DOCUMENTS** Section of Chart Review, you can view documents that have been scanned into the client's Avatar chart. The **DOCUMENTS** Section is located below Abstracts and the "To Do" List when the Chart Review window opens. Double click on **DOCUMENTS**- you can select to view: *All Documents* (A very long list, documents not sorted by date or type); *All Form Categories* (Documents are listed by category); or *All Forms* (Documents by form name in alpha order, a very long list).

⚠ If this feature **DOCUMENTS**, does not work, you can go to Section 13, for instructions about the Avatar Clinical Document Viewer so you can search for and view scanned documents.

⚠ When you are looking for a Treatment Plan in Chart Review, the *green arrow in the episode* may indicate BHRS Client Treatment and Recovery Plan. This refers to an *old plan*.

- If there is a green arrow next to **Plan Dates and Information**, this refers to the **new client plan** implemented 9/1/2011.

Section 10: Documentation at a Glance

A. Documentation at a Glance Report

The *Documentation at a Glance Report* is a helpful report for both clinicians and supervisors. This report will provide you with information about the current status of Client Treatment Plans, Assessments, Diagnosis and Last Service information for a *primary clinician's caseload* or *program*. This report will also indicate items that are overdue or coming due by wrapping a box around the item needing attention. It is the best way to get a quick look at your caseload and the status of each client's documentation and due dates!

B. Path: CWS Reports→ Documentation Status Reports → Documentation at a Glance.

You may select the report by
>**Location:** shows all clients by all clinicians for a selected program,
>**Staff:** shows all clients assigned to a specific staff person for all programs, or
>**Staff *and* Location:** shows all clients for a selected staff person at the selected program.

To request the report, click on the Report Icon

The report may take some time and there may be one or more pop up windows that ask if it's ok to "download from the server" or if you "want to return to the option". You can answer "Yes" to these pop up windows. **Please use this report frequently!**

C. Screen Shot of *Documentation at a Glance Report*

410401 SOUTH COUNTY ADULT

Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930000 TESTONE,TEST DOB: 5/6/1902 222 W 39 STREET JYO TEST AGAIN SAN MATEO, CA 94403 (h)650-639-1112 (c)121-455-8888 (w)555-1255	05/01 10/6/2011	BANKS,MICHAELA	Draft — Plan Type: Initial Status: Draft StartDate: 10/19/2011 Next due date: 4/30/2012	Adult Special Assmt Status: Final Date: 12/18/2011 Completed By: JEANNINE MEALEY	007.01 (ICD 9) TENSION HEADACHE	2/9/2012

416300 EAST BAYSHORE ADULT

Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930003 TEST,TESTTWO DOB: 4/30/1989 123 MAIN STREET SAN MATEO, CA 94403	11/01 5/20/2010	ECCLESTON,SARA	Draft — Plan Type: Annual Status: Draft StartDate: 1/23/2012 Next due date: 11/1/2012	Adult Annual Status: Draft Date: 5/11/2010 Completed By: DEBORAH DALLON	No Entry	9/23/2011 OVER 90 DAYS

D. Report Headings

- **Client:** Includes the Client Name, Mental Health #, Date of Birth, address and phone numbers.

- **Anniversary Date / Admit Date -** Current Anniversary date on file in Avatar and the Admit Date to the program. ***Please see Appendices #3 for more information about Anniversary Dates.**

- **Care Coordinator:** Person assigned as the Care Coordinator in Avatar.

- **Treatment Plan:** Shows the Type of Treatment Plan, (Initial or Annual) and the *current* Treatment Plan Status (Final, Draft, or Pending). If this Item is *wrapped in a box*, it indicates that the **plan is** either **OVERDUE** or **COMING DUE** and these Items need to be addressed first. Items appearing with no box are in compliance. If a *client is newly admitted*, this section *will tell you the date* their *first Treatment Plan is due.*

- **Assessment Status:** Will show information regarding the *last assessment for the client.* Information included is **Type of Assessment** (Initial, Update or Annual), **Assessment Status** (Final, Draft or Pending), the **Date of Assessment** and **who** completed the document. If an *assessment is left in draft* then it will have a *draft indicator in red. Reassessments are due* by the indicated *anniversary date* of each calendar year.

- **Primary Diagnosis:** Displays **current Diagnosis Code and Description** for the client in the identified program. If *"No Entry"* you need to **complete a diagnosis** for this client in this program using **BHRS Diagnosis.**

- **Last Service:** Displays the **last service date** and *indicates if that service is more than 90 days old*.

- **Now includes LOCUS/CALOCUS scores**

Section 11: The Face Sheet Report

A Report Submit Icon

B Client

C Episode

A. Path: Avatar CWS ↓ Reports → Face Sheet, click

You can see that this report requires the Client Name **(B)** and Episode **(C)** to be entered. You will then go to the **Report Submit** icon **(A)** in the toolbar and click.

B. Details of the Face Sheet Report: The Face Sheet Report opens to the *Preview Screen tab*.

Preview Tab   This top portion includes demographic information, language, therapist, and diagnosis.

The bottom portion of the Face Sheet Report includes the name of the coordinator, 26.5 eligibility, guarantor information, emergency contacts, and client relationships.

		Guarantor Name:	Rank:	Policy #:
Notice of PP:	Temporarily Unavailable			
Consent to Tx:	Temporarily Unavailable	NON-RECOVERABLE	1	
Initial Assessment: 06/15/2011				
CCP Coordinator: MEALEY,JEANNINE				
CCP Intake Date: 11/15/2010				
Anniversary Date: 05/01				

26.5: Yes	26.5 Eligibility Date: 11/9/2010	Next IEP Due: 11/9/2011
School District: BRISBANE ELEMENTARY		Closed Date: 6/26/2012

Contact Info:

| Name	Relationship:		Guardian	Next of Kin	Emerg. Contact
LORRIE SHEETS - COUNTY PROBATION	Parole/Probation Officer	(w) 650-222-3333 (c) 650-333-2222	No	No	Yes
Mama Bull	Mother (h) 650-550-1212 (w) 650-573-2563 (c) 415-647-1942		Yes		Yes
PAPA Bull	Father (h) 415-123-1234 (w) 650-445-2266 (c) 650-456-4567		Yes	Yes	Yes
Marla Testone	Daughter (h) 415-555-1212 (w) 408-555-1212 (c) 650-555-1212		Yes	Yes	No

C. Episode Data Drill Down Reports

⚠ Data Drill Down categories are highlighted in blue; when you click on a category link, a report is generated which will open a new tab on the face sheet screen, next to the Preview tab.

Episode Data Drill Down

Episode History	Diagnosis History	Treatment History	Client Relationships
Demographic History	Psychiatrist History	Progress Notes (Last 6 Months)	Medication History

Details of the Episode Data Drill Down:

- **Episode History**: Shows all episodes, open and closed; it is better to view from CHART REVIEW, Section 9, page 30.
- **Demographic History**: Shows past and current demographic status.
- **Diagnosis History**: Shows entry date, which person entered, diagnosis, principal diagnosis and diagnosing practitioner.
- **Psychiatrist History**: Shows date assigned, practitioner type, practitioner name, date entered and who entered.
- **Treatment History**: Shows service date, service type/code, practitioner, practitioner ID, duration, location for the selected episode.
- **Progress Notes (Last 6 Months):** Shows progress notes for past 6 months _across episodes_.
- **Client Relationships**: Shows contacts, next of kin and if releases are on file.
- **Medication History:** Shows order date, drug and dose, prescriber, pharmacy, refills, when Rx ends, instructions; _**may be out of date by 24 hrs; it is better to check Infoscriber Report.**_
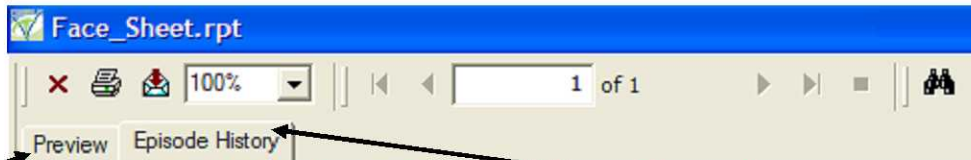
Click here to return to full view/select new link   *New tab*

D. View Reports from Episode Data Drill Down

To view a report, click on a link, the report will process and then open, you will also notice that a *new tab* opens next to the Preview tab. The Episode History link was selected and here is the tab. **The Preview tab will bring you back to the full view of the Face Sheet where you can *close the report* or *select another drill down link.***

E. ⚠ Important Use **ONLY** the *Preview tab* to access other Data Drill Down reports. If the ❌ is used, you will be kicked out and will need to re-order the Face Sheet Report! **GO TO PREVIEW TAB!**

You can print information from the Episode Data Drill Down screens but **NEVER** consider the information to be appropriate for a legal release of information.

For legal releases you MUST select and print documents from the specific Avatar report menu. (Progress Note Report, Assessment Report, etc)

F. Closing the Face Sheet Report:

When you are ready to close the Preview screen of Face Sheet Report, you _can_ close Crystal Reports with the ❌.

When you close the Crystal Report window, the following message appears.
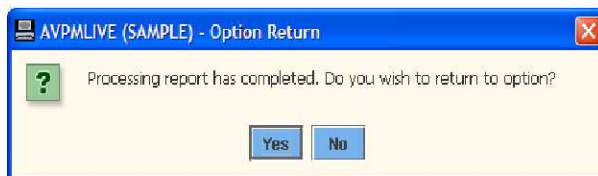
Always click **"Yes"**.

Click the ❌ **Close** button in the upper-right corner of the Face Sheet window to exit the report. Then you will be at the screen where you first requested the Face Sheet report and you **_can/should_** close this window by clicking the ✖ Close icon.

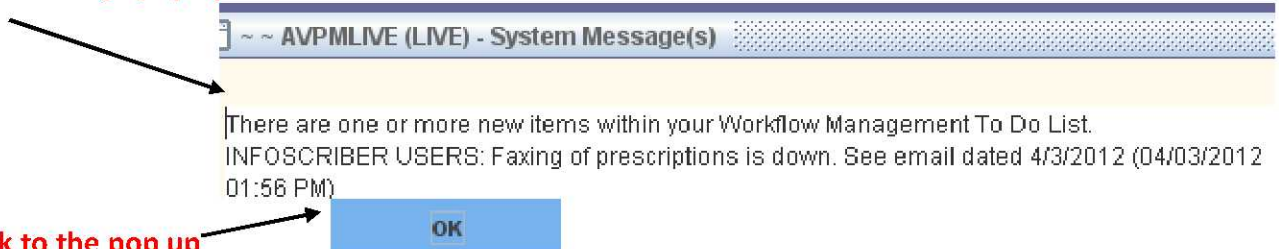## Section 12: Workflow – The Function of the "To Do" List

The "To Do" List or "My To Do List" is considered a Workflow Management Tool. The "To Do" list helps you keep track of, view and manage Draft documents that need to be completed and submitted as FINAL. Only finalized documents are considered part of the client's formal electronic medical record and appropriate for billing; the To Do function makes sure to remind you of a document's status.

To be sure you are current and up to date with finalizing and obtaining co-signatures for your documentation always set your "preferences" to have your Avatar homepage open with the "To Do" screen.

A. System Message Pop Up

When you log on and open to Avatar, you may see there is a **system message pop up** that states *"There are one or more open items within your Workflow Management To Do List".* This lets you know there are draft documents to be completed and finalized. You can click "ok" to the pop up.

System message pop up

~ ~ AVPMLIVE (LIVE) - System Message(s)

There are one or more new items within your Workflow Management To Do List. INFOSCRIBER USERS: Faxing of prescriptions is down. See email dated 4/3/2012 (04/03/2012 01:56 PM)

Click ok to the pop up

OK

B. "To Do" *Draft Documents*

- The "To Do" list is arranged by date with the most current at the top.
- There can be multiple documents that were submitted as DRAFT on the same date that need to be finalized; until you open the "To Do" item you will not know if the date represents a single or multiple documents that need to be finalized.
- As documents get reviewed and finalized they will fall off or clear from the "To Do" list.
- An item on the To Do list shows by time submitted, type of document, client name/ID#, comments or specifics about the document and the clinician/staff who submitted the document.

C. "To Do" *Co-Signature:*

The Avatar "Workflow" feature is also used when a document must be approved or co-signed by a supervisor before it can be submitted as FINAL. Trainees are able to look at their To Do List to track documents sent for co-signature and/or track documents returned from a supervisor.

This is true for the treatment plan and assessment documents. Once a document that requires a co-signature is submitted as DRAFT, a "To Do" list item is generated for the supervisor responsible to review, approve/co-sign the document so that it can be Finalized. When the supervisor co-signs and finalizes the document, no further changes to the document can be made. If the supervisor does not

approve/co-sign the item because there is some change (s) to be made by the trainee, the supervisor will send the item back to the clinician. The clinician will receive this document back as a "To Do" list item with a message from the supervisor of what needs to be done. The document must then be re-submitted to the supervisor for approval/co-sign so it can be finalized.

D. <u>Viewing the Contents of a "To Do" Item</u>

▶ Right click on the green triangle of a To Do Item and three choices are presented:
- **<u>Enter Post it Note</u>** - this is NOT used.
- **<u>Enter Option</u>** - click this, and the DRAFT document that created the "To Do" entry will open.
  - The document can be completed and submitted as Final.
  - The entry will automatically be removed from the "To Do List" once the screen is refreshed.
  - To refresh, click refresh on the bottom left hand side of the homepage.
- **<u>Open</u>** - click this and the "Review To Do Item" report will open; users can manually clear the entry.

Click the My To Do List command.

Double-click on date to see items needing your attention.

Right Click on an item and select 'Enter Option' to directly open the screen that needs attention.
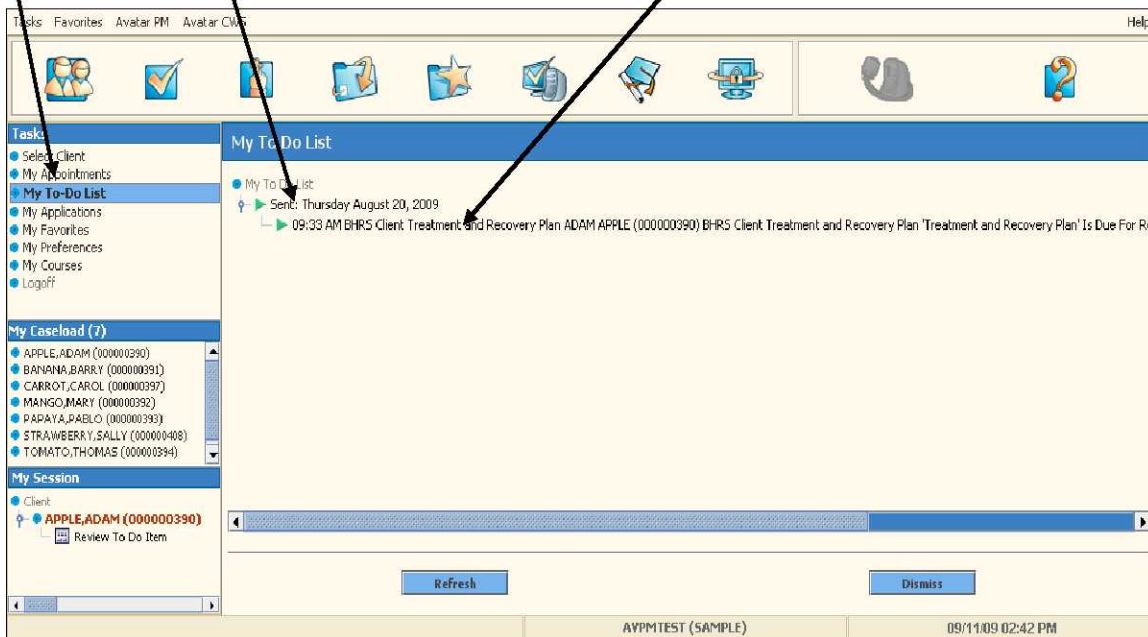
E. Reviewing "To Do" Items

If you just need to *review* an item on the "To Do" list, you can double click on the item, then click View Detail. Once the item is viewed, click the Reviewed checkbox under the red **Set To Do Item to Reviewed**, **then submit.**

View Detail provides a view of the document in report form through Crystal reports. No changes will be able to be made to the document in this view.

To refresh and see that the item has cleared, click the refresh button on the bottom left hand side of the homepage.

You will find the "To Do" list feature saves time and is less tedious. It provides a short cut so that you do not have to navigate through many menus, or episode selections, just to get to a Draft item to complete.

My "To Do" list Items can also be viewed from Chart Review.

Section 13: Scanned Documents

A. Viewing Scanned Documents

Avatar allows any authorized user to search for, view and print scanned documents.

B. Understanding the Clinical Document Viewer Window

- **Path:** Avatar CWS → Document Management → Clinical Document Viewer

- **Access:** Any BHRS staff member can access Clinical Document Viewer. However, some documents, such as HIV status, are restricted to certain staff only.

  Clinical Document Viewer has 2 tabs:

- **Screen Shot of Clinical Document Viewer Tab 1 – Search**

- **Tab 1: Search Tab (A)**
  - **Select Type of Search:** Select Client for documents related to this client or Staff for documents scanned by specific staff. **(B)** Then Select All (scanned by all staff) or Individual Client **(C).**
  - **Select Client:** Enter a few letters of the client's name, if more than one name appears click to make it populate the select client field **(D).**
  - **Episode:** Select a specific episode or to see all documents for this client, **select ALL (E) is pre selected.**
  - **Form Selection:** You can search for a document by Entire Chart, Legal Medical Record or by Categories/Forms **(F).**
  - **Click Process (G). Please be patient; this may take some time!**

- **Screen Shot of Clinical Document Viewer Tab 2 – Results**
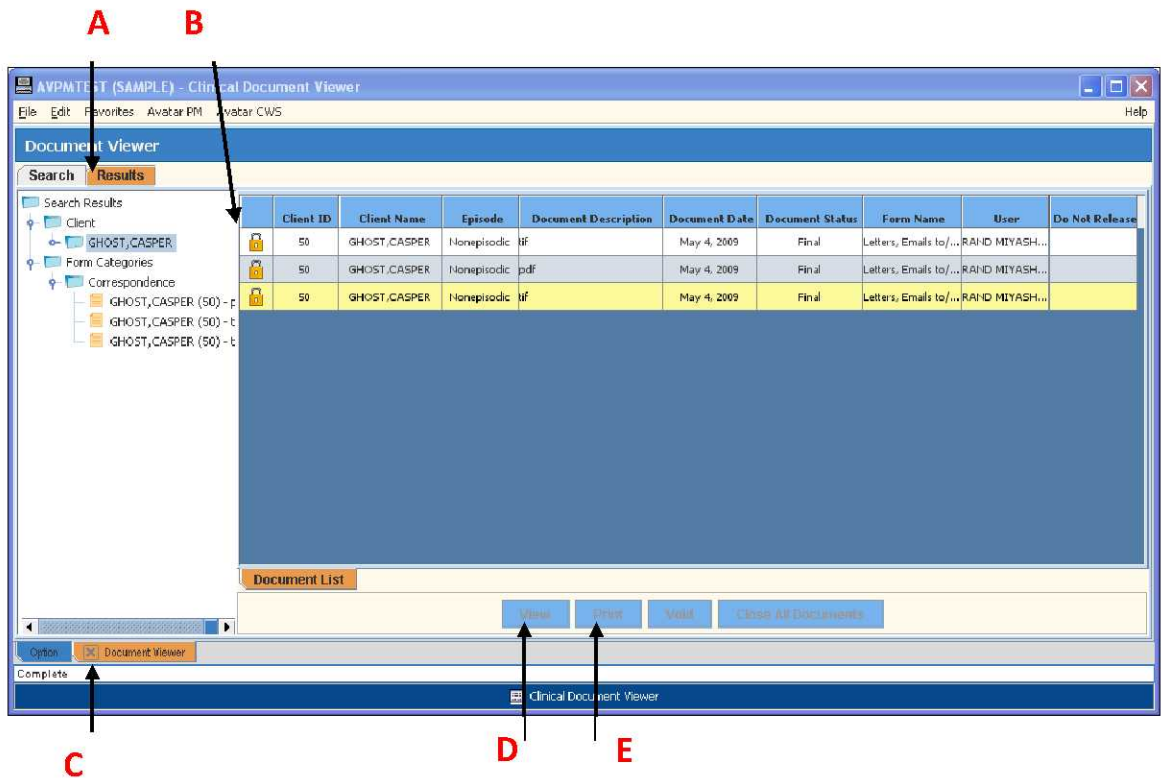
- **Tab 2: Results Tab (A)**
  - **Lock icon (B):** Document is restricted and not available to view or print.
  - **Document Viewer Tab (C):** *Bottom left* - brings you back to the search screen; you can perform another search or click the close icon to exit and return to the Avatar homepage.
  - **View button (D):** You can view the scanned document on your screen
  - **Print (E):** You can print a paper copy of the scanned document; some restricted documents can be viewed but not printed.

Section 14: Urgent Care Bundle (Client Alerts and Urgent Care Plans)

A client alert is created to address a special problem or concern about a client. It allows others to be aware of the situation when they open or view the client's electronic medical record.

A. Client Alerts

Client Alerts are similar to Post It Notes that have been used on a paper chart. The Client Alert is a way users can view important information or issues that need attention. The alert may be set by any Avatar user; once created there will be a pop up window that contains the alert message, for example, **"Client enrolled in Total Wellness"**.

The Client Alert pop up window will appear upon opening any document or report. A Client Alert can display for certain periods of time, such as a week or months. Client Alerts do not end until they are disabled.

Client Alerts may be simple and non clinical statements or requests, for example, "Client is GPO" or "Update client demographics". Other Client Alerts are clinical concerns that may be urgent and require the development of an Urgent Care Plan (high priority).

It would be inappropriate for the Client Alert pop up window to contain the sensitive client information regarding the specific clinical risk, concern and/or instructions as Avatar screens may be seen by a client/guardian who is present when the clinician is working in Avatar.

When the clinician wants other practitioners, but not the client/guardian, to know of the concern, a Care Message or Care Alert type of Client Alert will direct a user to the Urgent Care Plan to view this sensitive information. **The Care Message** or **Care Alert** is usually enabled by clinicians.

Care Message: Includes a routine concern or information about the client that other clinicians should be aware of, for example, "the client is refusing to take meds". This message will not show in the Care Message Alert pop up window. The Care Message pop up window includes this direction: **"Please Review Urgent Care Plan for Information".** The Urgent Care Plan describes the alert information/ concern and may include instructions regarding what needs to be done.

Care Alert: Includes information about a more urgent concern or safety issue, for example, "monitor client as danger to other". The Care Alert pop up window includes this direction: **"High Priority- Please Review Urgent Care Plan in Chart Review"** The clinician will view the Urgent Care Plan as soon as possible and without the client/guardian viewing**!**

Example of the Client Alert Pop Up Window
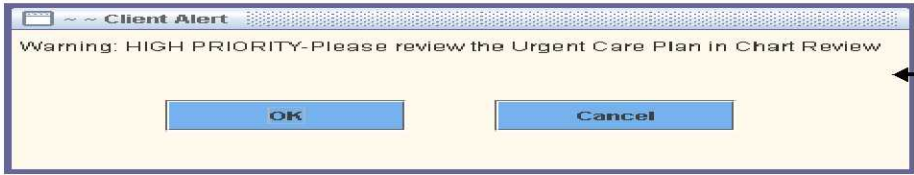
Example of Care Alert pop up Warning - Click OK, then go to Chart Review screen!

B. How to View the Urgent Care Plan (as directed by the Care Alert or Care Message pop up window)

- The Urgent Care Plan is located **above the *latest episode* (A)** in the Chart Review screen.
- *** Remember, *in order to get to the Chart Review screen you must open any document or report!***

- The Urgent Care Plan is listed by date with the ***most current date at the top.* Click on the green arrow (B) to view and read the Urgent Care Plan.**

Chart Review Screen Shot: Shows View of Urgent Care Plans

Screen Shot: Example of an Opened Urgent Care Plan

C. How to Create a Client Alert and Urgent Care Plan

1. CLIENT ALERT

- Select the client.
- **PATH:** Avatar CWS → Other Chart Entry → Urgent Care Plan Bundle
- The bundle will open to the document to create a Client Alert; if other alerts have been made, there will be a *Pre-Display Screen* (shown below) that lists the *other Client Alerts* that have been created.
- The Client Alerts Pre-Display screen includes: the *Description* or *Alert Type*, the *Custom Message*, the *Date* of *Entry* and if the *Alert is Enabled/Active* or *Disabled/Closed*.
- At the bottom of this screen there are options for you to select:
  - **ADD** is to add a *new* **Client Alert.**
  - **EDIT** is to **edit an alert that is active** and/or to **disable an active alert.**
  - **DELETE** is to delete an Alert.
  - **CANCEL** will cancel this option and return you to the homepage.

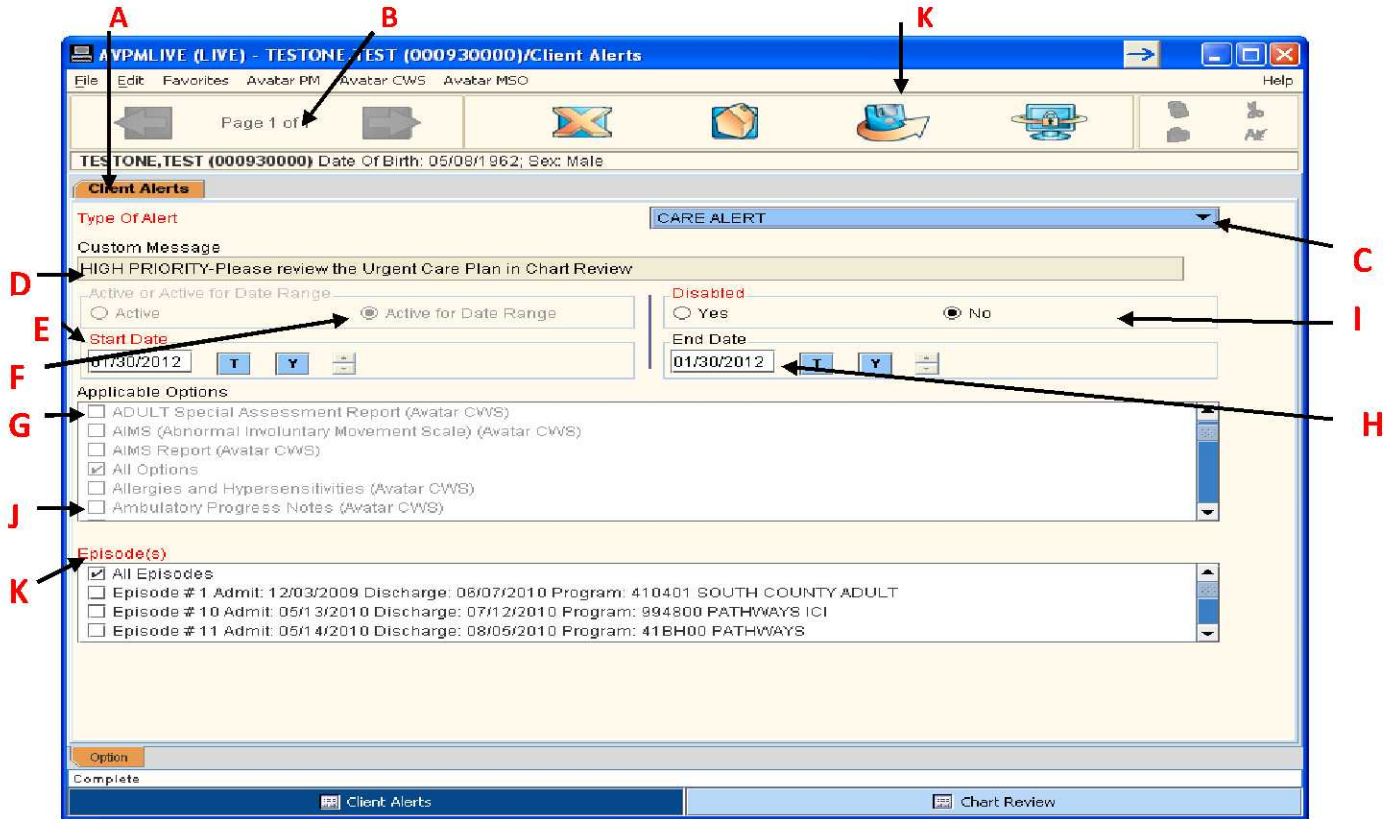**Screen Shot: Client Alert Pre-Display Screen**

Select **ADD;** the Client Alert document will open.

Screen Shot: Client Alert, Tab 1

How to Complete a Client Alert

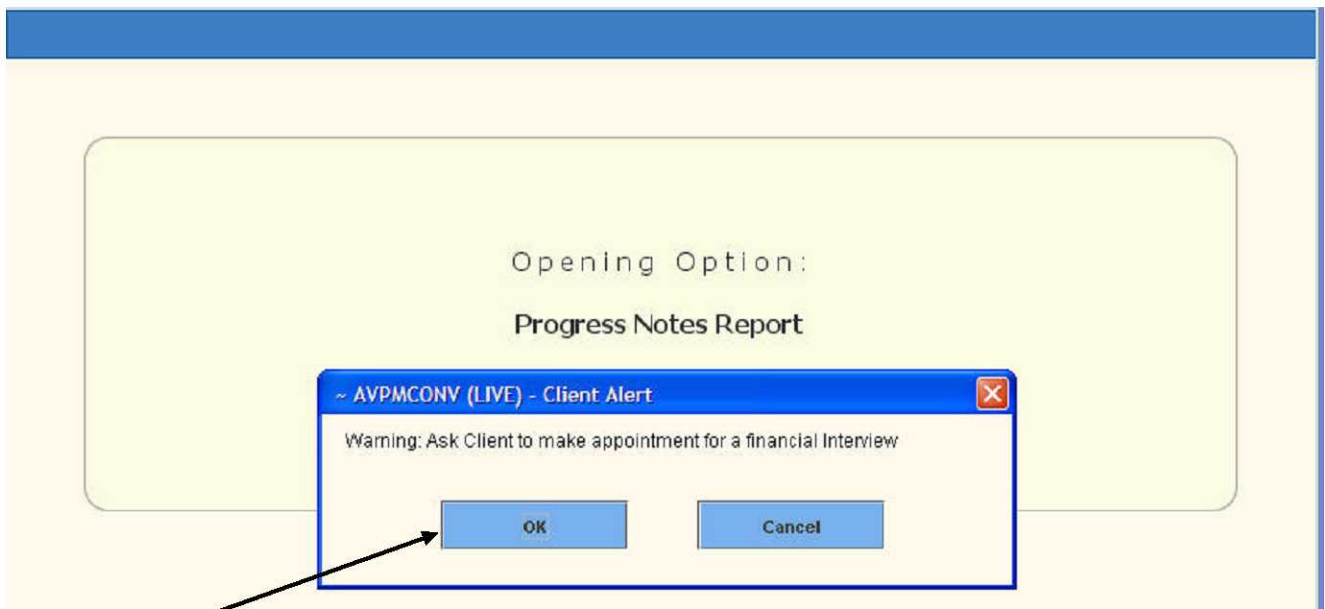The **Client Alert document** has 1 tab **(A)** and 1 page **(B)**; Select the **Type of Alert (C)**

Assignment of Benefits Due	Financial Interview Due	Stop do not link to episode 1
Care Alert	GPO	Total Wellness
Care Message	insurance Application	UMDAP Financial Due
Client is Deceased	Stop do not link this episode	Update client demographics
Error (custom)	Stop do not link to episode 1 or 2	Warning (custom)

- The Alert will fill in the **custom message (D)** box if custom is not a selection. *Do NOT select custom error as it will lock you out of all functions and you will need to call the help desk. If Warning is selected then there must be an entry in the custom warning in the custom message box* (red/required).
- Select **Active** or **Active for a Date Range**: If *Active* **(E)** is selected you will be *unable to make an entry for the start and end date*. The warning remains active until a status changes.
- If **Active for Date Range (F)** is selected, the *Start Date* **(G)** and *End Date* **(H)** *will automatically be entered with today's date*. The **End Date (H) can be changed manually for however long you set it**.
- **Disabled**: **(I)** this is *how you close an active alert that has no end date*.
- **Applicable Options: (J)** allows you to *set how the Alert will appear. Select All options*.
- **Episodes: (K)** allows you to select *which episodes will be impacted* by the Alert.
- **Submit: (L)** you will know the Alert has been set once you reopen Avatar. The pop up will appear and require you to click OK.

2. CLIENT ALERT that *DOES NOT* REQUIRE an Urgent Care Plan

- Select Financial Interview Due from the description or alert type drop down options.
- The Custom Message Box will fill in automatically with "Ask Client to Make Appointment for a Financial Interview".
- Active for Date Range will fill in automatically.
- Disabled Defaults to No; select "YES" to close an active Alert or an Alert that had no End Date.
- The Start Date and End Date are filled in automatically with today's date.
- You can change the End Date manually for however long you want the Alert set for.
- The fields Applicable Options and Episodes are pre-set to ALL.
- There is **no further action required except to SUBMIT** the Alert.

Opening Option:

Progress Notes Report

~ AVPMCONV (LIVE) - Client Alert

Warning: Ask Client to make appointment for a financial Interview

[OK]   [Cancel]

* When any document or report in Avatar is opened, this alert will pop up. Click OK.

## 3. CARE ALERT that *DOES* REQUIRE an Urgent Care Plan

- Select "**Care Alert**".
- The Custom Message Box fills in automatically, for example
  "**HIGH PRIORITY - Please Review the Urgent Care Plan in Chart Review**".
- Active automatically is filled in; Disabled Defaults to No.
- Select "YES" to close an active Care Alert.
- The fields Applicable Options and Episodes are pre-set to ALL.
- SUBMIT.

D. How to Create an Urgent Care Plan

* Once the Care Alert has been submitted, the Urgent Care Plan screen will automatically pop up with the Urgent Care Plan document, or if there have been other Urgent Care Plans, an Urgent Care Plan *Pre-Display* screen will appear.
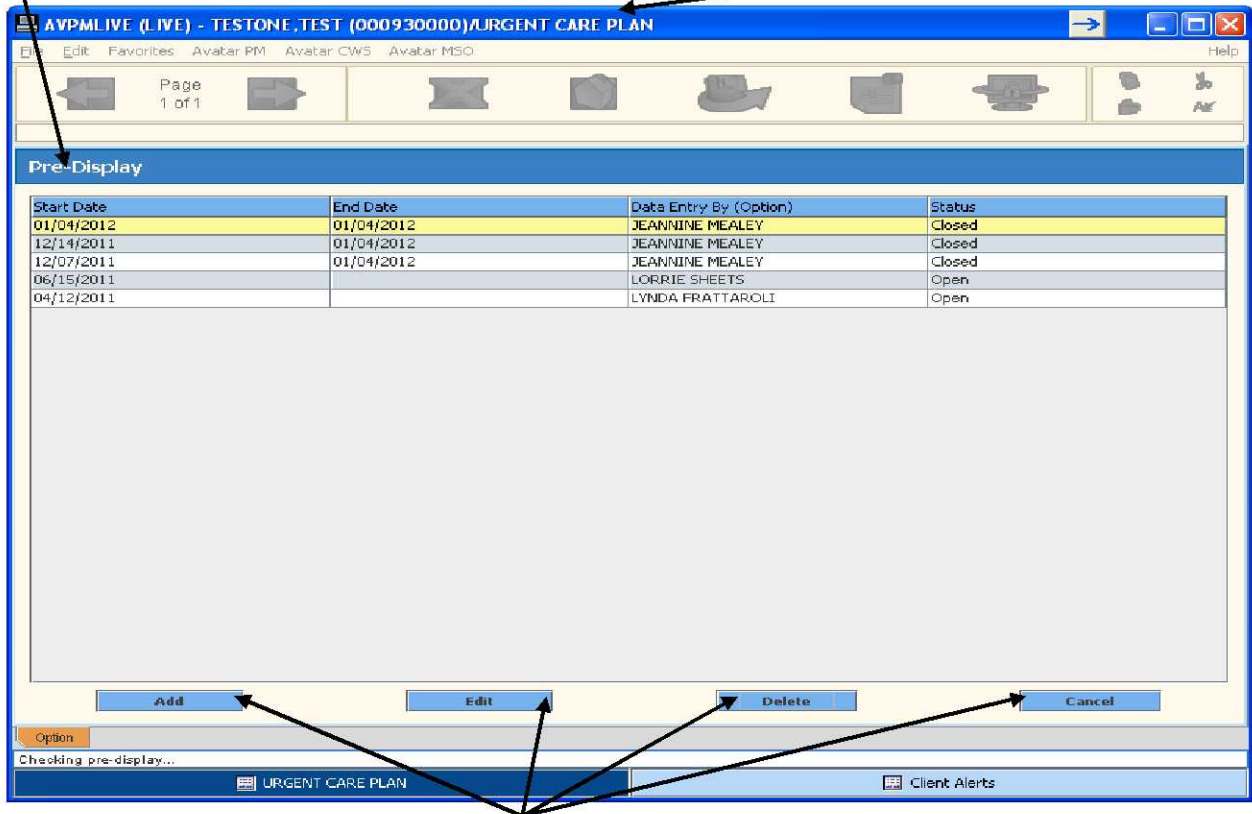
- The top of the **Urgent Care Plan Pre-Display** screen displays *Start Date, End Date, Data Entry By* and *Status of the Urgent Care Plan as Open* or *Closed.*

- At the bottom of the screen are options for you to select:

    ADD is to add a *NEW* Urgent Care Plan.
    EDIT is to *edit* an *Active Urgent Care Plan* or *change* the *STATUS* and **CLOSE** an Urgent Care Plan.
    DELETE is to delete an urgent care plan.
    CANCEL is to cancel this option and return you to the homepage.

- **Select ADD**

The URGENT CARE PLAN contains 1 Tab **(A)** and has 2 pages **(B) and (C).**
Screen Shot of Urgent Care Plan Page 1: Identifying Information

Page 1: (B) Identifying Information
- Entry fields on the left side of the form are red/required fields.
- Start Date: **(D)** Date of Birth **(F)** and Primary Diagnosis **(I)** will automatically fill in.
- Select Status: **(E)** Status will default to Open; Select CLOSED to close an Urgent Care Plan that has been open.
- **Therapist/Caseworker**: **(G)** A process search entry, enter letters of the last name or entire last name of person in the white box, click process search, select the correct Therapist/Caseworker so that the name populates the blue box.
- The right hand side of the Urgent Care Plan includes **entry boxes that are optional.**
- **End Date: (H)** You can enter a date or leave this blank.
- **Diagnosis: (I)** This **fills in automatically**, you can update the diagnosis if needed by entering the code in the white primary diagnosis box, click process search, then select the correct diagnosis so that it appears in the blue box. If you update the diagnosis, the next box, psychiatrist, will become a red required field to enter who updated the diagnosis.
- **Psychiatrist: (J)** Optional process search type entry, enter psychiatrist if diagnosis was updated.
- **Region (K):** You can select the region from the drop down.

Screen Shot of Urgent Care Plan Page 2: Treatment Plan and Caution (A).

A   E
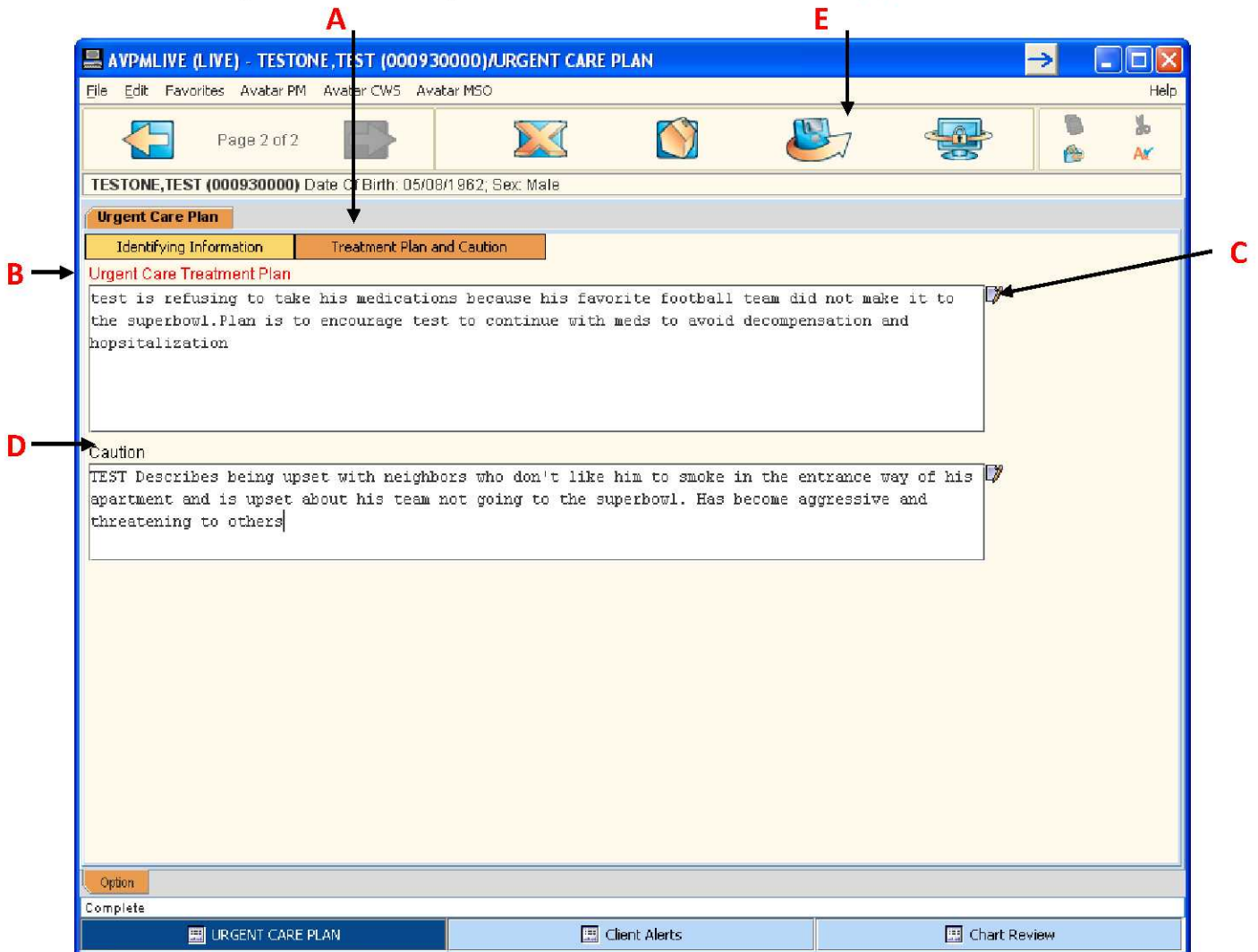
Page 2: Treatment Plan and Caution (A)
- **Urgent Care Treatment Plan: (B)** This is a free text box for a narrative description of the concern.
- **Text Editor: (C)** This provides an expanded view of the text and spell check.
- **Caution: (D)** This is an optional free text box to include cautions.
- **Submit: (E)** Submits the Urgent Care Plan.

Once the Urgent Care Plan and Alert have been completed and submitted, the warning pop up ALERT will appear with any document or report that is opened. The pop up screen will warn users: **"HIGH PRIORITY - Please Review the Urgent Care Plan in Chart Review."**
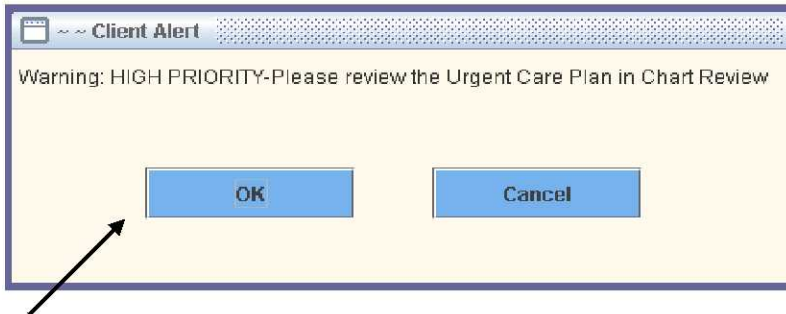
Click ok to this message AND
BE SURE TO VIEW THE URGENT CARE PLAN THROUGH THE CHART REVIEW SCREEN!

E. How to VIEW the Urgent Care Plan

The Urgent Care Plan is viewed through the Chart Review screen. You must open any document or report in order to get to the Chart Review window. The Urgent care plan will sit above the last episode.
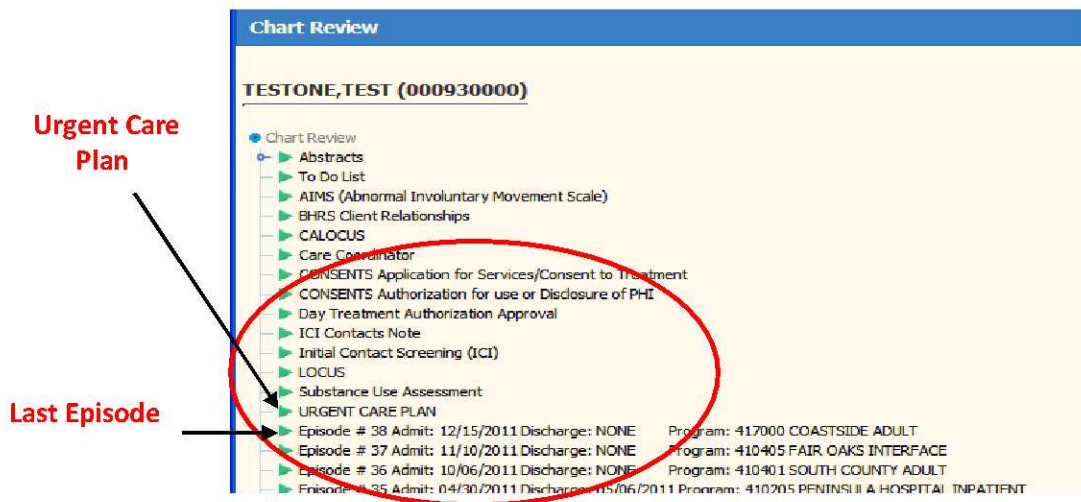
⚠️ **IMPORTANT: To Close/Disable an Urgent Care Plan**
- Always remember to **Close an Urgent Care Plan** and/or **Disable a Client Alert**.
- Select Stop or Dismiss to get out of the screen.
- To *Deactivate* or *Disable Urgent Care Plan/Care Alert*, SELECT the Urgent Care BUNDLE.
- Select EDIT: Change Status to CLOSE; enter today's date.

Section 15: Appendices

1. Select Client Screen and Alternative Lookup Methods

To add a client to the My Session Frame, you must use the Select Client command from either the Tasks Frame or Task Bar or Picture Icon.

The screen shot below shows Select Client is highlighted in blue, in the upper left. The Select Client screen requires an entry in the Client Name/ID# field. Enter the client name with last name first, followed by a comma (no space), and then the first name. Use the following examples as a guide when entering client names:

- LAST,FIRST
- LAST,FIRST JR (type a space before the title)
- LAST,FIRST MI (type a space before the middle initial)
- ID# - This number refers to the client's Medical Record Number, also known as MR # or Client ID. If you know the number, you can type it here

You can use hyphens for names such as MARIA LOPEZ-CANTERA. You can use an apostrophe for names such as ANGELO D'MARCO.

Once the client name is entered, click on the blue Select Client ID Search, the client's name will appear in the Select Client box below. Sometimes more than one client pops up with the same last name and you will need to narrow down your search.

The Avatar 2010 Select Client Screen: *Client search results* now show in the ***bottom half of the screen***; alternative look-up is still there. The ***Up*** and ***down*** *arrows on the keyboard* can be used to *scroll through names* and the *Enter key* can be used to *highlight a row.*

You can narrow your search for a client by trying any of these **alternative lookup methods**:

Item	Description
Social Security Number	Search for client by social security number.
Facility Chart Number	This is the SMMH MR#. The latest entries are from December, 2009. This list is not currently kept up to date.
Alias	Search for a client by alias. If possible aliases are entered in Avatar in this format: LASTNAME,ALIAS
Unique Client ID	BHRS does not use this item.
Soundex	Search for client with similar sounding names. For example, if you enter *Brown*, Soundex would also locate clients named *Browne*.
Client Name Shortcut	If you are not sure how to spell a client's name, you can use shortcuts to display a list of clients to choose from. For example, you can type *S,J* for all clients whose last names begin with S and first names starts with J, or type *SM* to see all clients whose last name begins with *SM*.

Client Name Shortcut

2. Quick Reference for Favorites

Task	Procedure
Add Commands to My Favorites	1. Choose Help →Search for Option from the Menu Frame. *The Option Search screen appears.* 2. In the Enter Text to Find in Option Name field, type the text string you are searching for. 3. Click the Search button. 4. Click the row in the results table for the command you want to add to My Favorites. 5. Click the Add to Favorites button at the bottom of the screen. *The Add Favorite window appears.* 6. Click OK. 7. Repeat steps 2 – 5 to add more commands to your favorites. 8. When you are finished adding commands to your favorites, click the Dismiss button at the bottom of the Option Search screen.
Organizing Favorites into Folders	1. Click the My Favorites link in the Tasks Frame on the left side of the Avatar Homepage. 2. Right-click the Favorites folder icon and choose Add Folder from the popup menu. *The Input dialog box appears.* 3. Type the name of the new folder and click OK. 4. Place the mouse pointer over the favorite you want to add to the new folder. 5. Click and drag the favorite just below the new folder and then release the mouse button. 6. Repeat step 5 for each favorite you want to place in the folder. 7. *The folder has a small icon in front of it. Clicking that icon expands and collapses the contents of the folder.* 8. Click the Save button at the bottom of the My Favorites screen. 9. *If you right-click a client name in the My Caseload Frame or the My Session Frame, you will now see a Favorites command in the popup menu, which you can use to access your favorites if you wish.*

Most commonly Used *Favorites*

Lookup ONLY	Administrative Staff	Clinical Staff
Face Sheet	Call Intake Bundle	Initial Contact Screening
Chart Review	Admission Bundle (Outpatient)	All Admission Documents
Urgent Care Plan Bundle	Discharge Bundle	Consents
	Update Client Data	Client Treatment/Recovery Plan
	Episode Display	BHRS Outpatient Progress Notes
	Face Sheet	Reports: Dashboard
	Diagnosis	Documentation at a Glance
	Contractor Treatment Plan	Chart Review
	Contractor Locus Entry	Face Sheet
	Client Ledger	
	BHRS Client Financial Report	
	Payer UMDAP Report	
	POS Scan/Document Viewer	

💡 You can create a <u>Favorites folder</u> for Reports/Tools suggested for monitoring:

Compliance Reviews
- **Documentation at a Glance**
- **Caseload Report**
- **Notifications/Alerts**
- **Transfer/Discharge Bundle**
- **Assign/Reassign Practitioner**
- **BHRS Assign/Remove from Caseload**
- **BHRS Units of Service Summary Report**

Quality Reviews
- **Client Dashboard**
- **Client Relationships**
- **Update Client Data**
- **BHRS Diagnosis**

- **Urgent Care Bundle**
- **Progress Notes**
- **Error Correction**
- **CSI Admit**

3. **About Anniversary Dates**

INTAKE DATE

The Intake Date is the first date of claimed outpatient services for a "new" client. A "new" client is any individual admitted for outpatient services for which there is **not** a current outpatient treatment episode. The individual may have received previous services from BHRS and still be considered a "new" client.

INTAKE PERIOD

The Intake Period is two months following the Intake Date. During this time, a thorough assessment is completed, a CA/LOCUS is completed, and a Client Treatment & Recovery Plan is completed. The availability of community resources and social support systems to meet the individual's needs are evaluated. Generally, Assessment and Plan Development services are provided until the client care plan is completed. However, other services may be provided and should be coded based on the service provided.

ANNIVERSARY DATE

The anniversary date is the date an updated treatment plan, Annual Assessment, and CA/LOCUS is completed. These documents must be completed every year while the client continues to receive services.
- The Anniversary Date is the first day of the month of intake.
- The Anniversary Date follows the client throughout a continuous course of outpatient treatment anywhere in the BHRS system of care.

WINDOW PERIOD for DUE DATES

The window period for completing the Annual Assessment and all other Treatment/Recovery Plans is 6 weeks <u>prior</u> to the Anniversary Date. Plans and Annual Assessments completed and signed during the window period are effective for one year. Writing required annual documents earlier than 6 weeks before the anniversary date is too soon! **The requirement to update documentation annually is not met when written <u>prior</u> to the window period.**

SUMMARY

A chart must have all of the following items completed on time to avoid disallowance of services:
- Admission Assessment and CA/LOCUS completed within two months of the Intake Date.
- Initial Client Treatment and Recovery Plan completed within two months of the Intake Date.
- When an existing client is opened to a new team/program the new provider must complete a Client Treatment & Recovery Plan within two months of the opening.
- Annual Assessment and the CA/LOCUS updated annually during the 6 week window period prior to the anniversary date.
- The Client Treatment and Recovery Plan updated annually during the 6 week window period prior to the anniversary date.

These timelines are mandated and fixed for each client. Assessments may be amended or have additional material added at any time and Treatment & Recovery Plans may be amended at any time. These subsequent changes do not affect the **established timelines** and new dates shall not be entered into the computer.

4. Using Shortcuts

The following table displays several shortcuts you can use in navigating through Avatar windows.

Keyboard Shortcuts	Action
[Ctrl]+[E]	Exits window without submitting
[Ctrl]+[S]	Submits (saves) window
[Page Down]	Moves one page forward on current tab
[Page Up]	Moves one page back on current tab
[Ctrl]+[Page Down]	Moves one tab forward on current window
[Ctrl]+[Page Up]	Moves one tab back on current window
[F6]	Move from tab to tab within a window
[Enter]	Same as clicking OK or Yes
[F5]	Clears the selected value from a dropdown field
Arrow Keys	Arrow through dropdown menu to select command
[Tab]	Move forward one field
[Shift]+[Tab]	Move backward one field
[Spacebar]	Selects radio button option if your cursor is on it.

Keyboard Shortcuts for Text Fields	Action
[Home]	Moves cursor to the beginning of text in a field
[End]	Moves cursor to the end of text in a field
[Ctrl]+[Home]	Moves the cursor to the beginning of the next field
[Ctrl]+[End]	Moves the cursor to the end of the field
[Ctrl]+[→]	Moves cursor to the beginning of next word
[Ctrl]+[←]	Moves cursor to the beginning of previous word
[Shift] with any arrow key	Selects (highlights) text one letter at a time
[Ctrl]+[Shift] with arrow key	Selects (highlights) one word at a time
[Ctrl]+[C]	Copy selected (highlighted) text
[Ctrl]+[X]	Cut selected (highlighted) text
[Ctrl]+[V]	Paste selected (highlighted)text
[F7]	Spell check

Field	Proper Convention

Date	Avatar always saves dates in MM/DD/YYYY format.
	You can type shortcuts as follows:
	    020609 becomes 02/06/2009
	    112308 becomes 11/23/2008

Time	Avatar always saves times in HH:MM AM/PM.
	You can use military time as follows:
	    0123 becomes 01:23 AM
	    1345 becomes 1:45 PM

Phone Numbers	Must be typed in the following format: 650-555-1212 If you don't type the dashes, Avatar adds them for you.
Social Security Numbers	Must be typed in the following format: 555-12-4345 You must type the dashes for social security numbers. If not, you will see a message prompting for the correct format.

Address – Street	Do not use punctuation or special symbols, such as the pound sign (#) in addresses.
	    123 MAIN ST APT 3
	The following abbreviations are accepted:
	    ST, AVE, BLVD, WAY, CT.

Address – City	Type the full name of the city with no abbreviations. SAN MATEO
Address – State	Always a 2 letter abbreviation (CA, OR, NV).
Address – Zip	Always a 5 number code (94501).
Red field	Field is required and must be completed before a window can be submitted.
Black field	Field is standard and should be completed if possible.
Grey field	Field is not available. This can be because information is populating from another screen or you must complete a field or select a checkbox somewhere in the current window before inputting.

5. Example of a Caseload Compliance Review Tool

Date of Review Type of Review				
Review Area	**yes**	**no**	**n/a**	**comment**
Documentation at a Glance **Are Caseloads for each clinician current and correct** Are Clients missing from report, have they been added? Are there Clients that need to be discharged have they been? Are there any items "boxed" or in "red" or "green" and have they been assigned for correction? Are **draft** documents assigned to be FINALIZED? Is the Last service date active within the past 6 months? Are Anniversary Dates and Start Dates correct? Does each client have an assigned care coordinator? If Diagnosis has "No Entry" or Deferred has this been assigned for resolution?				
Transfer Do clients need to be transferred to another program, or clinician?				
Discharge Have clients with no services for **more than** 90, 120 and/or 180 days been assigned to be closed or discharged? • Is there a reason to remain open? • Have there been attempts to re-engage client?				
Utilization Units of Service Do you notice trends in billing across clients or clinical staff? Is the Units of Service Report accurate for billed/non billed services?				
Error Correction If you notice any errors, have they been assigned for correction? Have previous requests for correction of errors been resolved?				
Notifications, Alert, To Do Have Clinicians been notified of need for correction? Have Alerts for missing documentation been created? Has YOUR "To Do" list been reviewed and cleared? Have any Unnecessary Alerts been Disabled?				
Day Treatment Authorization Report Have All services have been authorized?				
Clients Re-Opened within 45 Days Have any clients returned within 45 days of closing? Has the Closing been rescinded?				

6. Example of Quality Chart Review Tool

Date of Review				
Type of Review				
Name of Reviewer				
Client				
Clinician Responsible				
Review Area	**yes**	**no**	**n/a**	**comment**
Dashboard – is Client Relationships Are the relationships, phone numbers correct and up to date? All Demographic info current? Has information been updated? Are there items identified as "CHECK STATUS"? Have they been checked?				
Assessment Assessment was completed on time and final, co-sign if appropriate? Describes functional impairments, signs & symptoms exhibited by client and match Diagnosis?				
Diagnosis Primary Diagnosis - Meets Medical Necessity? Is current and appropriate, co-signed if appropriate? Not deferred longer than 6 months? Appropriate for symptoms, behaviors & functional impairments exhibited by the client?				
Treatment Plan Was completed on time? Has co-sign if appropriate? Meets medical necessity & is consistent with diagnoses? Includes substance abuse goals, if applicable? Measureable Goals/Objectives and address barriers to client's success? At least one goal addresses Primary Dx? Client has signed/plan was given or progress note describes why not?				
Consents for Treatment, Release of Info, & Medication (if needed) All 3 types of consents are current & entered in Avatar? Is an updated **in Avatar** consent needed? Are med consents consistent for all meds currently prescribed? (yearly)? Release of information (yearly- don't forget school)				
Urgent Plan/Alert Is there an Urgent Plan or Alert that needs to be Disabled/Created?				
Financial Are any financial updates needed?				
Medications Medications are current, client is compliant?				
Review Progress Notes for Standards and Quality				
▪ Are *Billed* service notes for *Non-Billable* activities? ▪ Are *Codes for Service Type Correct –* any notes **up coded**? ▪ Are *Location Codes* correct? ▪ Does the service provided/documented match with the *Duration* for the service? **Too long?**				

Any non-billed service that could have been? Are staff interventions appropriate? Is there evidence that the client is responding/benefitting from the service? Are there too many acronyms that you can't understand? Are all caps, abbreviations used? Are other staff/clients mentioned? Have error corrections been submitted? Resolved?				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				
Date:				

7. Correct Your Work: Finalize Draft Documents, Close, Transfer, and/or Assign Care Manager(s)

A. FINALIZE: *Documents in Draft* as Priority

For any document that needs to be Final, select the client, select the document, select the episode; At the pre-display window, select the document and then select edit, the document will open. Make your entry and then submit as final.

If a co-signature is necessary for an assessment or treatment plan, save as draft, send to supervisor where indicated on the form, send an e-mail to supervisor to inform co-sign is needed ASAP for any outdated documents.

Progress notes are no longer required to be saved as draft. They can be submitted as final with the "send to" the supervisor selected from the drop down as indicated. If the supervisor agrees with the note, there is nothing more to do. The note is final.

If the supervisor wants some change to the note, it will be sent back to the clinician in Draft form and the note will appear as a clinician's to do item. The clinician will make the changes; submit as final with the "send to" to the supervisor. The process will repeat.

Go to Documents in Chart Review; Review Progress Notes for any left in draft or Run a Progress Note report for Episode and Date Range. Finalize any DRAFT Progress Notes.

B. Correct the Caseload by *Closing* or *Transferring* a case and you MUST request from *your* supervisor.

Avatar CWS→ Other Chart Entry→ Transfer/Discharge Bundle

The Transfer/Discharge Bundle includes the BHRS Diagnosis which must be completed in order to discharge a client from the caseload. The Transfer/Discharge request has 4 tabs. Tab1, Transfer/Discharge Request:

The **Requesting Clinician** completes information on the **first tab, Transfer/Discharge Request tab**.

Type of Request, Discharge or Transfer is selected;

If Transfer, Enter Transfer *to* location; Select if client requests services in the future, if applicable;

If Discharge, Select if client requests services in the future, if applicable;

Enter Current Treatment Information and Alerts;

Enter Transfer/Discharge reason;

Process Search entry, requested by you;

Date of Request fills in automatically

Click the submit button; the clinician's request will appear on the Supervisor's My To Do List

Once the submit button is selected, the BHRS Diagnosis document appears.

- In anticipation of approval by the supervisor, complete the BHRS diagnosis.
- If your discharge request is later approved, *remember to create a progress note documenting the discharge and the reason for it.*

Tab 2, Supervisor Authorization Status:

This tab is **completed by the supervisor after the supervisor has reviewed the Discharge/Transfer Request** submitted by the clinician that is on their To Do list.

The supervisor will select the Authorization Status: Accepted or Rejected. If rejected enter Comments in the Comment box.

Enter authorized by through Process Search entry;

Enter Date of Authorization

Submit

Is this is a transfer request, the supervisor navigates to Tab 4 Notify and selects the supervisor of the receiving clinic and clicks submit.
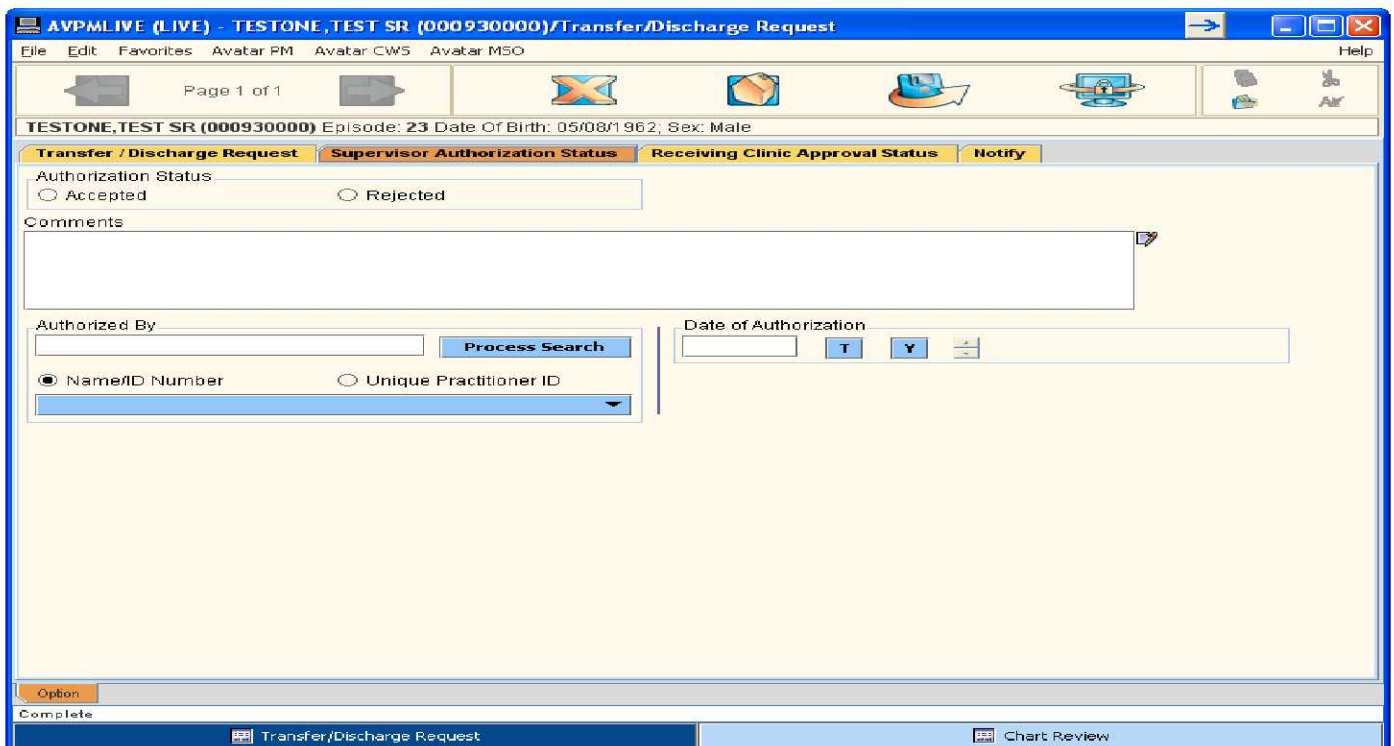
Tab 3, Receiving Clinic Approval Status:

The **Request of Transfer by the clinician's supervisor will appear on the** *receiving Clinic's Supervisor "To Do" List.* After reviewing the request and information related to the transfer, the receiving Clinic's Supervisor completes Tab 3. The receiving Supervisor selects if they Accept or Reject the Transfer Request; Comments are entered if rejected; Process Search entry is made for Approved/Rejected By; Date of Approval/Rejection is entered; Process Search for "Assigned To" clinician at the receiving transfer location is entered.
The receiving Supervisor navigates to Tab 4, Notify, and enters the name of supervisor who made the request and if possible, the clinician who made the original request and submits.
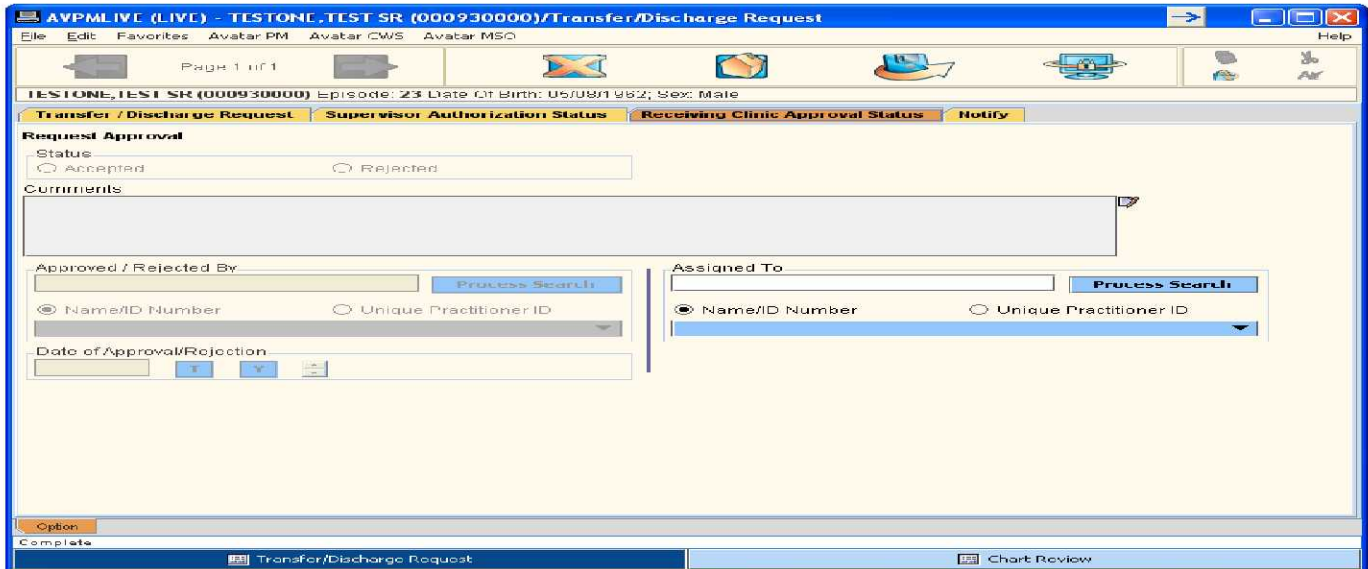
This is **Tab 4, Notify** and is **completed by the clinician's supervisor to accept or reject the discharge and/or transfer of a case**. Tab 4 is also completed by a receiving clinic's supervisor when accepting   and/or rejecting a case for transfer to notify the Supervisor and/or Clinicians who submitted the request.
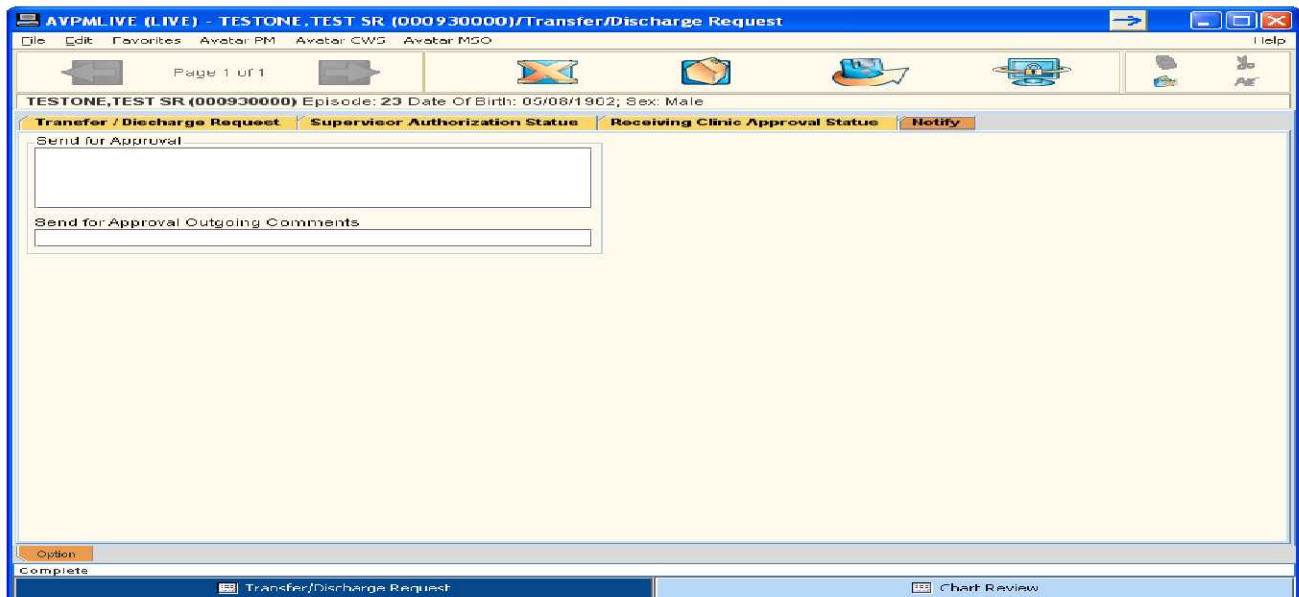
The **Transfer/Discharge Request BUNDLE** to correct the caseload *also includes the BHRS diagnosis* that must be entered for any client transferred/discharged.

Sometimes "To Do List "notifications will continue after the supervisor has authorized and sent the Transfer/Discharge document along. The Check boxes on the notification list do NOT clear when the form is saved. You must clear the User Notification selections to avoid sending redundant notifications

If *bundle* is selected the BHRS Diagnosis document will appear once the Transfer/Discharge request is submitted.
To do the BHRS Diagnosis: Avatar CWS→ Assessments→ BHRS Diagnosis

C. **Correct a Caseload by *BHRS Assign to Caseload*.**

BHRS Assign to Caseload: Avatar PM→ Episode Management→ BHRS Assign To Caseload

> **1 Tab, Caseload Assignment, Page1   Adds a Clinician to a Treatment Team**

Client must be active in My Caseload, Process Search for team member, add a note to explain the assignment including the reason for the assignment and the assignment date. Click Submit.

Caseload Assignment Page 2, if needed!

D. Correct a Caseload by *BHRS Remove from Caseload*

BHRS Remove from Caseload: Avatar PM→ Client Management→ Episode Maintenance→ Remove from Caseload

       1 Tab, 1 Page   **Removes a Clinician from a Treatment Team**

Client must be active in My Session. In blue drop down field, click the name of the clinician once; press the [F5] key on the keyboard to remove the clinician's name. If there is a note related to the team member, delete it. Click submit to save the change

E. Correct a Caseload by *Caseload Assign/ReAssign Practitioner*

Avatar PM→ Client Information→ Assign/ReAssign Practitioners→ Attending Practitioner

I Tab, 1 Page

F. Correct a Caseload *by Discharging Clients*

Discharge Client: Avatar PM→ Client Management→ Episode Management→ Discharge (Outpatient)

Enter information on the Discharge tab and add a comment if appropriate. Click Demographics tab, enter any changes to the client's demographic information; Click Submit to save the changes

8. Assure *Current and Accurate Client Data*

A. Update Client Data

Generally Clients' demographic information is recorded by Admins but Clinicians also have a form Update Client data. The form is the same for both users.

Avatar PM→ Client Management→ Client Information→ Update Client Data *or*
Avatar CWS→ Other Chart Entry→ Update Client Data

The form has 1 Tab, 2 Pages

Tab 1 Page 1

Activate the client in My Session, Update client data on pages I and 2. Click Submit to save changes

Update Client Data Tab 1 Page 2

Activate the client in My Session, Update client data on pages I and 2. Click Submit to save changes

9. Client Relationships

Avatar PM→ Client Information→ BHRS Client Relationships

Client Relationships is the repository of **all non-treatment team people involved in the Client's life.** The Client Relationship document allows entry of Emergency Contact, Parent/Guardian, Next of Kin, Spouse/Partner, Teacher, Parole Officer, Conservator, Sibling, Family Members, Primary Care Physicians; anyone you feel is important to have information about and exist within the client record. **The client's Face Sheet and the Dashboard Report pull from this document.**

Tab 1 Entry Date

If information isn't correct or reported in Client Relationships, it can't be reported out. Information is entered and stored in **multiple entry tables**. You *need to add a new row to the table* and then complete the related data fields below the table so that you do not overwrite existing information.
Make sure the client is active in MY Session, then
To **Add a Row**, *Click* the **Add New Item** button. Do not enter new data without adding the new row or the new data you enter will overwrite existing information in the active highlighted row of the table!
To **Edit a Row**, *select the row* you want to edit, *click **Edit**,* the related fields below the table become populated and you can make changes directly in the fields.
To **Delete a Row,** *click on a row* to select it, *click **Delete selected item*** to remove the row from the table. A message will appear verifying that you want to delete the selected item, click YES.
If you Add, Edit or delete be sure to click Submit so the changes will be saved.
Do not leave blank rows in the table; blank rows must be deleted before you can save the form!

Client Relationships; Tab 2, *Relationships*, Page 1

To Add, click new item, a new row appears, complete fields on Page 1 and 2
To Edit, highlight the row, click edit, fields on Page 1 and Page 2 populate, change then submit

⚠️**You can also Update Client Information through CSI Admission (PM- Client Info- CSI Admission)**