

## BHRS Avatar Documentation and Reports - The “Best Way” to:

Document/Report You Need	Task/Avatar Pathway to find What You Need	Description/Comments: Why You Need It
<b>Alert - Create</b> <i>Clinical alert also see Urgent Care Plan</i>	<b>Create Alert</b> CWS→ Other Chart Entry→ Client Alerts or through Urgent Care Bundle	<ul style="list-style-type: none"> <li>Can <b>add</b> a care message or care alert for a clinical or non-clinical issue or concern. <b>(alert pops up on chart – like a post-it note)</b></li> </ul>
<b>Alert - Disable</b>	<b>Disable Alert</b> CWS→ Other Chart Entry→ Client Alerts or through Urgent Care Bundle	<ul style="list-style-type: none"> <li>Disables an alert no longer active. To disable, highlight the alert, and then select edit and disable.</li> </ul>
<b>Admission Assessment: How to Complete (Adult or Child/Youth)</b>	<b>Complete Admission Assessment</b> CWS→ Assessment→ Age Appropriate Assessment Bundle CWS→ Progress Note→ BHRS Outpatient Progress Note <i>See Client Relationships and Update Client Data for “how to”</i>	<ul style="list-style-type: none"> <li>Bundle includes Master Assessment plus MSE, LOCUS/CALOCUS, BHRS Diagnosis, and if indicated Substance Abuse Assessment due by the end of 2 months of the intake period.</li> <li>Check Client Relationships and Update Client Data for any changes to information!</li> <li>Document service in Progress Note</li> </ul>
<b>Admission Assessment: View/ Print</b>	<b>View/Print Admission Assessment</b> Right click on Client→ Select Chart Review→ click Green Arrow of Abstracts→ Select Age Appropriate Assessment/PIN w(ALL)	<ul style="list-style-type: none"> <li>Can view ALL and print from screen</li> <li>Includes supporting assessment documents</li> </ul>
<b>Admission Assessment: How to Complete Pre to 3:</b>	<b>Complete Pre to Three Admission Assessment</b> CWS→ Pre to 3 Assessment→ BHRS Pre to 3 Diagnosis	<ul style="list-style-type: none"> <li>Includes Pre to 3 Master Assessment document and BHRS Pre to 3 Diagnosis</li> <li>Document service in Progress Note</li> <li>Update Client Data/Relationships if needed</li> </ul>
<b>Pre to 3: View/Print</b>	<b>View /Print Pre to 3</b> Right click on Client→ Select Chart Review→ click Green Arrow of Abstracts→ Select Pre to 3	<ul style="list-style-type: none"> <li>Can view ALL and print from screen</li> </ul>
<b>Admission: View Documentation Due</b> <i>A Quick Review for Recently Admitted Clients</i>	<b>View the 60 Day (Admission) Documentation Due Report</b> CWS→ Documentation Status Reports→ 60 Day Documentation Due Can also view <i>Annual Documentation Due</i> through same path <b>BUT the Documentation at a Glance Report is the “Best Way” to view Annual documentation due!</b>	<ul style="list-style-type: none"> <li>Shows status of documentation for clients admitted within past 60 days</li> <li>Can request by <i>location, staff or both staff and location</i></li> </ul>

<b>Anniversary Date: Update/Correct</b>	<b>Update/Correct the Anniversary Date</b> PM→ Client Management→ Episode Management→ Admission (Outpatient)	<ul style="list-style-type: none"> <li>▪ Use <i>only</i> if anniversary date shows as any date other than first of the month  <b>(Can find Anniversary Date on the Client Dashboard and/or Documentation at a Glance Report)</b></li> </ul>
<b>Annual Assessment Bundle: How to Complete</b>  <b>Annual Assessment: View/Print</b>	<b>Complete Annual Assessment Bundle</b> CWS→ Assessment→ Age Appropriate Annual/Update Assessment Bundle <b>Annual</b> Bundle <b>requires</b> LOCUS/CALOCUS & BHRS Diagnosis, Substance Abuse Diagnosis, if indicated. Check the status of Releases of Information/Consents, due Annually <b>View/Print</b> Right click on Client→ Select Chart→ click Green Arrow of Abstracts→ Select Age Appropriate Assessment/PIN w(ALL)	<ul style="list-style-type: none"> <li>▪ Annual Assessment Bundle is <b>due by client's anniversary date</b> and NOT a year from when Admission Assessment was done</li> <li>▪ Document service in Progress Note</li> <li>▪ Update Client Data/Client Relationships if needed</li> <li>▪ Update Releases/Consents</li> <li>▪ Can view ALL and print from screen</li> </ul>
<b>Assessment SPECIAL: What to Do?</b> <b>Assessment Team has completed the Assessment</b>	<b>"Assessment Team" has completed the Admission Assessment</b> Receiving clinician/team reviews assessment from referring specialized assessment team. Document the service in progress note; if assessment is accepted/if there is agreement with findings	<ul style="list-style-type: none"> <li>▪ Can be accepted by Clinical Treatment Program/Team or Contractor agency if they are a secondary program</li> <li>▪ If changes or updates needed, then complete an Assessment Update form (see below)</li> <li>▪ Update Client Data/Client Relationships</li> </ul>
<b>Assessment Update: How to Complete</b> <b>Assessment Updates: View/Print</b>	<b>Complete an Assessment Update(s)</b> CWS→ Age Appropriate Annual/Update Document <b>View/Print</b> Right click on Client→ Select Chart→ click Green Arrow of Abstracts→ Select Age Appropriate Assessment Updates(ALL)	<ul style="list-style-type: none"> <li>▪ Update the assessment as needed for any changes, <b>at any time</b></li> <li>▪ Document service in a Progress Note</li> <li>▪ Can view and print what has been selected</li> </ul>
<b>Assign Client to Caseload</b>	<b>BHRS Assign to Caseload</b> PM→ Client Management→ Episode Maintenance→ BHRS Assign to Caseload	<ul style="list-style-type: none"> <li>▪ Assigns new or existing client to a clinician caseload</li> </ul>
<b>Assign a Therapist; Coordinator, Doctor</b>	<b>Assign/Re-Assign Practitioner</b> PM→ Client Management→ Client Information → Assign/Re-assign Practitioners	<ul style="list-style-type: none"> <li>▪ Assigns/reassigns a practitioner for example a change in coordinator. <b>Must transfer out from one clinician and add to the new clinician for reassign transaction to be complete.</b> Do Not simply just assign!</li> </ul>

<p><b>Care Coordination: View</b></p> <p><b>Care Coordination: Update</b></p>	<p><b>View the Care Coordinator</b>  Can view through <i>Documentation at a Glance</i> or <i>Client Dashboard</i> Reports  Can also view through <i>Chart Review</i> screen→ Abstracts→ click Green Arrow of Care Coordinator</p> <p><b>Update Care Coordinator</b>  To Update/Change Care Coordinator see <b>pathway previous page</b></p>	<ul style="list-style-type: none"> <li>▪ Current care coordinator is responsible for annual assessment documents</li> <li>▪ Check reports to validate the <b>current</b> Care Coordinator or to <b>add if there is none!</b></li> <li>▪ If any changes are made, be sure to send notification to a previous coordinator or team</li> </ul>
<p><b>Caseload Review: How to View</b></p>	<p><b>View a Caseload by Documentation at a Glance Report</b>  CWS→ Document Status Reports→ Documentation at a Glance→ request by Location, Staff or both Location/Staff</p> <p><i>(To Add/Discharge client to/from caseload go to the heading in this grid)</i></p>	<ul style="list-style-type: none"> <li>▪ Helps You Determine Next Steps: <ul style="list-style-type: none"> <li>• Close/Discharge Cases</li> <li>• Add Cases Missing from the Report</li> <li>• Complete Draft documents to FINAL</li> <li>• Re-assign Staff or Clients</li> </ul> </li> <li>▪ Can view: Demographic, Anniversary/Admit Date, Care Coordinator, Diagnosis, LOCUS and CALOCUS, Status of Assessment and Treatment Plan and Date of Last Service</li> </ul>
<p><b>Chart Review: How to View</b></p>	<p><b>View Chart Review</b>  Right click on Client→ Select Chart Review <b>OR</b>  CWS→ Open any client document to access Chart Review</p>	<ul style="list-style-type: none"> <li>▪ Contains entire medical record for the client</li> <li>▪ Only finalized documents within episodes are present</li> </ul>
<p><b>Client Dashboard: How to View</b></p> <p><b>Client Dashboard is the “Go To” place for a snapshot of the Client’s BHRS Services!</b></p>	<p><b>View Dashboard Report</b>  Right click on Client→ Select Chart Review → click Green Arrow of Abstracts→ click Client Dashboard <b>OR</b>  CWS→ Reports→ Client Dashboard <b>OR</b>  CWS→ Open any client document to access Chart Review→ click Green Arrow of Abstracts→ click Client Dashboard</p>	<ul style="list-style-type: none"> <li>▪ Complete any item in RED or Green</li> <li>▪ Check that <b>consents</b> are entered into Avatar</li> <li>▪ Review 5-6 progress notes for accurate location/service codes, quality</li> <li>▪ Items with <b>blue heading</b> will link you to more information</li> </ul> <p>Can View: Demographic, Coordinator, Anniversary, Treatment Consent, Guarantor, Urgent Care Plan, Emergency Contact Info, Authorization for Release of Info/Use of PHI, Status of Assessment and treatment plan, Current Medications, Allergy Info, Schooled MH, Open Episodes/Primary Diagnosis, Staff, Diagnosis/Treatment/Episode History, Progress Notes</p>

<p><b>Client Data: How to View (Demographics)</b> <b>Client Data: How to Update</b></p>	<p><b>View Client Data through Client Dashboard or Documentation at a Glance Report; also Reports (Ex: Face Sheet)</b> <b>Update Client Data</b> CWS→ Other Chart Entry→ Update Client Data <b>OR</b> PM→ Client Management→ Client Information→ Update Client Data <b>OR</b> CSI Admit→ CWS→ Assessment→ Update Assessment <b>OR</b> See below, <i>Client Relationships</i> if update is to a client <i>contact</i>!</p>	<ul style="list-style-type: none"> <li>▪ Run reports to review accuracy of data</li> <li>▪ Check with client regularly about status</li> <li>▪ Edit existing demographic information. Can add/delete, then submit changes</li> <li>▪ Enter new info in CSI portion and submit</li> </ul>
<p><b>BHRS Client Financial Report</b></p>	<p><b>Client Financial Report</b> PM→ Reports→ Client Financial Report</p>	<ul style="list-style-type: none"> <li>▪ Displays demographic and client insurance coverage for that episode by client &amp; episode</li> </ul>
<p><b>Client Relationships: How to View</b>  <b>Client Relationships: How to Update</b></p>	<p><b>View Client Relationships through Abstracts in Chart Review</b> Right click on Client→ Select Chart Review → click Green Arrow of Abstracts→ click Client Relationships or Client Dashboard <b>Update Client Relationships</b> PM→ Client Management→ Client Information→ Client Relationships</p>	<ul style="list-style-type: none"> <li>▪ Keeps a current profile of important people in the client’s life or who are connected to the client’s care, including emergency contacts.</li> <li>▪ Complete the multiple entry table then submit</li> </ul>
<p><b>Day Treatment: How to Complete Authorization Request</b>  <b>Day Treatment: How to View Authorization</b></p>	<p><b>Complete Day Treatment Authorization Request</b> CWS→ Other Chart Entry→ Day Treatment Authorization Request <b>View Day Treatment Authorizations</b> CWS→ Reports→ Day Treatment Reports→ Select from <i>Day Treatment Authorization Report</i> <i>Day Treatment Authorization Tracking</i> <i>Day Treatment Authorization Due</i> <b>OR</b> <i>Day Treatment Authorization Approvals:</i> Right click on Client→ Select Chart Review→ click Green Arrow of Abstracts→ click Day Treatment Authorization Approval</p>	<ul style="list-style-type: none"> <li>▪ From Pre-Display select add, complete form, then submit</li> <li>▪ Shows Day Treatment authorized services</li> <li>▪ Tracks authorization of Day Treatment Services and if authorization is <i>due</i>.</li> <li>▪ Shows Initial and Re-Authorization dates</li> </ul>
<p><b>Day Treatment DAILY Progress Notes: How to Create</b>  <b>Day Treatment DAILY Progress Notes: How to View/Print</b></p>	<p><b>Create Day Treatment Daily Progress Notes</b> CWS→ Progress Notes→ Day Treatment Notes→ Day Treatment Daily Notes <b>View/Print</b> Right click on Client→ Select Chart Review→ click Green Arrow of Progress Notes (shows all finalized notes across all episodes)</p>	<ul style="list-style-type: none"> <li>▪ Select episode, select correct service charge code, enter daily note, submit</li> <li>▪ Select episode you want to view notes for</li> <li>▪ Print what has been selected</li> </ul>

<p><b>Day Treatment <i>Weekly</i> Progress Notes: How to Create</b></p> <p><b>Day Treatment <i>Weekly</i> Progress Notes: How to View/Print</b></p>	<p><b>Create Day Treatment <i>WEEKLY</i> Progress Notes</b> CWS→ Progress Notes→ Day Treatment Notes→ Day Treatment <i>WEEKLY</i> Notes</p> <p><b>View/Print</b> Right click on Client→ Select Chart Review→ click Green Arrow of Progress Notes (shows all <b>finalized</b> notes across all episodes)</p>	<ul style="list-style-type: none"> <li>▪ In Summary for the Week field, select the MONDAY date of the week you are writing the note for</li> <li>▪ You can view the daily notes for that week</li> <li>▪ Enter the note and submit</li> <li>▪ Select episode you want to view notes for</li> <li>▪ Print what has been selected</li> </ul>
<p><b>BHRS Diagnosis: How to Create/Update</b></p> <p><b>BHRS Diagnosis: How to View History</b></p>	<p><b>Create/Update BHRS Diagnosis</b> CWS→ Assessment→ BHRS Diagnosis (same link for new or update)</p> <p><b>View Diagnosis/History</b> Right click on Client→ Select Chart Review → click Green Arrow of Abstracts→ click Green Arrow of Diagnosis <b>OR</b> From Chart Review screen→ Client Dashboard → click blue header for Diagnosis History <b>OR</b> CWS→ Open any client document to access Chart Review→ click Abstracts→ click Green Arrow of Diagnosis <b>OR</b> CWS→ Reports→ Client Dashboard <b>OR</b> CWS→ Diagnosis Report</p>	<ul style="list-style-type: none"> <li>▪ Add new or update Diagnosis</li> <li>▪ Review previous diagnoses for accuracy or edit</li> <li>▪ Defer a Diagnosis for <i>no longer than 6 months</i></li> <li>▪ Primary Diagnosis must meet DMH criteria and Medical Necessity</li> <li>▪ Document service in a Progress Note</li> </ul>
<p><b>Discharge a Client</b></p>	<p><b>Discharge Client</b> CWS→ Other Chart Entry→ Transfer/Discharge Request- Select Episode, Type of Request, Reason for Request <b>OR</b> PM→ Client Management→ Episode Management→ Discharge</p>	<ul style="list-style-type: none"> <li>▪ Helps to maintain accurate caseload</li> <li>▪ Discharge clients with no service for more than 90, 120, 180 days</li> <li>▪ Document service in Progress Note</li> </ul>
<p><b>Discharges by Date Report</b></p> <p><b>Admissions by Date Report</b></p>	<p><b>Discharges by Date</b> PM→ Reports→ BHRS Discharges by Date</p> <p><b>Admissions by Date</b> PM→ Reports→ BHRS Admissions by Date</p>	<ul style="list-style-type: none"> <li>▪ Shows discharges by date</li> <li>▪ Shows admissions by date</li> </ul>
<p><b>Documentation at a Glance Report</b></p>	<p>CWS→ Reports→ Documentation Status Reports→ Documentation at a Glance Report <i>Request by location, by staff or by staff and location</i></p>	<ul style="list-style-type: none"> <li>▪ Helps identify documentation due or coming due that needs to be completed</li> <li>▪ Highlights areas needing improvement with red, green, boxes, or “no entry”</li> <li>▪ Check if all entries in all fields are correct</li> <li>▪ Beneficial tool for Supervisor <b>and</b> Clinician</li> <li>▪ Request report on Monday or Friday, lees busy days for Avatar</li> </ul>

<b>Episodes Display for Client</b>	<b>BHRS Episode Display</b> PM→ Client Management→ Episode Management→ BHRS Episode Display (Can also view through Chart Review)	<ul style="list-style-type: none"> <li>▪ Displays client episodes of care by Episode Number, Date, if Open or Closed</li> </ul>
<b>Face Sheet</b>	<b>View Client Face Sheet</b> CWS→ Reports→ Face Sheet <i>Request by Client and Episode</i>	<ul style="list-style-type: none"> <li>▪ Includes Demographics and Episode Drill Down Data</li> <li>▪ Suggest Client Dashboard be used instead</li> </ul>
<b>Financial - Update</b>	<b>Financial</b> PM→ Client Management→ Account Management	<ul style="list-style-type: none"> <li>▪ Review for accuracy, check with client</li> <li>▪ Update if necessary</li> </ul>
<b>Financial Eligibility Client Ledger MEDS Information Family &amp; UMDAP Management</b>	<b>Financial</b> PM→ Client Management→ Account Management→ Select the form you want	<ul style="list-style-type: none"> <li>▪ Review existing financial information by adding or deleting, then submit changes</li> <li>▪ Shows all services recorded for the client for the date range&amp; indicates billing status.</li> </ul>
<b>Medication Consents: Create/ Update Medication Consents</b>	<b>Create//Update Medication Consent</b> CWS→ Consents→ Verification of Consent to Medications	<ul style="list-style-type: none"> <li>▪ Assure Client has a signed med consent that reflects all meds currently taking. Due yearly!</li> <li>▪ Convert scanned med consent to an Avatar document so that it appears on Dashboard</li> <li>▪ If add new meds, add update to med consent , finalize a consent in draft</li> </ul>
<b>View/Print Medication Consents</b>	<b>View Current Medication Consents</b> Right click on Client → Select Chart Review→ click Green Arrow of Abstracts→ click on Green Arrow of CONSENTS Authorization for use or disclosure of PHI→ click on Green Arrow of the selected release you want to view/print	<ul style="list-style-type: none"> <li>▪ Can view/print releases <i>entered</i> into Avatar</li> <li>▪ May need to view scanned through Document Viewer</li> <li>▪ Releases must be updated/completed annually</li> </ul>
<b>Medications: Add NEW or EDIT</b>	<b>Add/Edit Medications</b> CWS→ Infoscriber→ Follow pathway throughout to add or edit existing medication fields including updates to Allergies	<ul style="list-style-type: none"> <li>▪ Can edit, discontinue meds, edit pharmacy information, etc.</li> <li>▪ Lists current Rx, order date, drug name, dose, prescriber name, # refills, Rx end date and pharmacy name.</li> <li>▪ Links to Rx history for last year and non Infoscriber medications</li> <li>▪ MAR report by client /date range, shows progress notes written for medication administration; most recent note is first.</li> </ul>
<b>View Current Medication</b>	<b>View Current Medications</b> CWS→ Reports→ Medical Reports→ Infoscriber Medication Report OR MAR Report OR View through Client Dashboard	

<p><b>Print Chart for Release</b></p>	<p><b>Print the Chart for Legal Release</b>  Right click on Client→ Select Chart Review→ click Green Arrow of Abstracts→ Click green arrows to open/view documents:</p> <ul style="list-style-type: none"> <li>▪ Assessments (All) – pulls all companion documents</li> <li>▪ Look in the <i>specific episode</i> for the Client Treatment and Recovery Plan (plan before 9/1/11) <b>or</b> if looking for a plan <i>after</i> 9/1/11, it will be listed as <b>“Plan Dates and Information”</b></li> <li>▪ For Progress Notes: see page 8</li> <li>▪ The <b>Documents</b> section <i>will</i> contain scanned documents, Consents and the status of Authorizations to Release; It is best to view and select by <b>“All Form Categories”</b></li> <li>▪ Go to CWS→ Reports→ InfoScriber Medication Report</li> </ul>	<ul style="list-style-type: none"> <li>▪ Chart Review is the only place for legal documents to be reviewed and selected for release and then printed</li> <li>▪ Chart Review shows only finalized documents</li> <li>▪ Restricted documents should not be printed/released</li> <li>▪ Within an episode, a small circle next to a document means there is <i>no</i> information</li> <li>▪ If the <b>Documents</b> feature does not work, go to Page 9 Scanned Documents</li> </ul>
<p><b>Progress Note: Append/Add Content to a completed Progress Note</b></p>	<p><b>Progress Note Billing Correction: Append/Add Content</b>  CWS→ Progress Notes→ Append Progress Note</p>	<ul style="list-style-type: none"> <li>▪ Can only append a FINAL note or note that did not require co-signature</li> <li>▪ For important <i>content</i> information to be added or if there is an error in the <i>content</i></li> <li>▪ Appended information that is added is attached to the original progress note</li> </ul>
<p><b>Progress Note: Correct Billing Errors</b></p>	<p><b>Progress Note Error Correction Request (Billing Correction)</b>  CWS→ Progress Notes→ Progress Note Error Correction Request</p> <p>Date of Service, Service Duration, Service Charge Code/Type of Service, # in Group, Location Code, Duplicate Entry, Wrong Co-Practitioner, Wrong Episode, Wrong Client</p>	<ul style="list-style-type: none"> <li>▪ Helps for submission of accurate claims, Request a change to 1 or many fields, then select/enter corrected information and submit.</li> <li>▪ If you are correcting a progress note are that does not show in list, Check the box “Progress Note Not in List” explain details on tab two.</li> <li>▪ Explain for Other Client’s PHI Disclosure</li> </ul>
<p><b>Progress Note: How to Create Nurses, also see MAR Day Treatment, also see Day Treatment</b></p>	<p><b>How to Create Progress Notes</b>  CWS→ Progress Notes→ BHRS Outpatient Progress Note  Or select specified note you want to write, MAR/Day Treatment</p>	<ul style="list-style-type: none"> <li>▪ Records service that was provided to meet fiscal and risk standards</li> <li>▪ Create note for <i>any</i> service provided (billed or non-billed)</li> <li>▪ Create note to document completion of assessment and treatment plans including updates</li> </ul>

<p><b>Progress Notes: How to View/Print for Legal Release</b></p>	<p><b>How to View Progress Notes through Reports</b> CWS→ Reports→ Progress Notes (will <b>not</b> show contents of restricted notes)</p> <p><b>How to View Progress Notes through Chart Review</b> Right click on Client → Select Chart Review→ click on Green Arrow of Abstracts→ click Progress Notes (<b>will</b> show contents of restricted notes)</p> <p><b>View Progress Notes through the Client Dashboard Report</b> Right click on Client → Select Chart Review→ click on Green Arrow of Abstracts→ click Client Dashboard or Reports→ Client Dashboard</p> <p><b>View Progress Notes through Page 2 of the Outpatient Progress Note Document</b> CWS→ Progress Notes → BHRS Outpatient Progress Notes</p>	<ul style="list-style-type: none"> <li>▪ Request Progress Note Report by client and date range</li> <li>▪ Includes only <b>finalized</b> Progress Notes across all episodes</li> <li>▪ View/print progress notes</li>   <li>▪ The Progress Notes Header in <b>BLUE</b> is a link that displays 6 months of progress notes across episodes</li>   <li>▪ Click on the blue tab in the upper right hand corner to view up to 12 months of progress notes- <b>will</b> show content of restricted notes</li> </ul>
<p><b>Rescind a Closing</b></p>	<p><b>Rescind a Closing</b> Contact Help Desk 650-573-3400 or <a href="mailto:isdhelpdesk@smchealth.org">isdhelpdesk@smchealth.org</a></p>	<ul style="list-style-type: none"> <li>▪ You will be instructed <i>how</i> or <i>if</i> you can rescind once you leave a message.</li> </ul>
<p><b>Release of Information “HIPAA”: How to Complete on Paper</b></p> <p><b>How to Complete in Avatar</b></p> <p><b>View/Print Releases</b></p>	<p><b>HIPAA Consent Form section</b> <b>Complete Release of Information on Paper</b> Instructions located at <a href="http://smchealth.org/bhrs-documents">http://smchealth.org/bhrs-documents</a></p> <p><b>Complete Release of Information in Avatar:</b> CWS→ Consents→ Request for Access to PHI</p> <p><b>View/Print Release</b> Right click on Client → Select Chart Review→ click Green Arrow of Abstracts→ click on Green Arrow of CONSENTS Authorization for use or disclosure of PHI→ click on Green Arrow of the selected release you want to view/print</p>	<ul style="list-style-type: none"> <li>▪ <b>Paper:</b> Have client sign, Admin to scan, <b>also</b> must enter data into Avatar BHRS Client Relationships!</li> <li>▪ <b>Avatar:</b> Complete form, have client/witness to sign with signature pad, submit</li>   <li>▪ Can view/print releases <i>entered</i> into Avatar</li> <li>▪ May need to view scanned through Document Viewer</li> <li>▪ Releases must be updated/completed annually</li> </ul>
<p><b>Remove from a Caseload</b></p> <p><b>Review Caseload <i>after</i> Case(s) Removed (discharged/transferred)</b></p>	<p><b>Remove from a Caseload</b> PM→ Client Management→ Episode Maintenance→ BHRS Remove from Caseload</p> <p><b>View Caseload after Cases Removed</b> CWS→ Reports→ Caseload Report → by Program or Clinician</p>	<ul style="list-style-type: none"> <li>▪ Helps keep caseload accurate</li> <li>▪ Complete fields, then submit</li> <li>▪ Assures caseloads are accurate</li> <li>▪ In response to findings on Documentation at a Glance, once client cases have been closed, the <i>Caseload Report</i> provides a quick view of the updated current caseload.</li> </ul>



<b>Review Productivity (Program/Staff)</b>	<b>PM→ Services→ Service Reports</b> → then select from below  Detail of Visits by Client and Program; Service Summary by Episode Program; Service Summary by Treatment Program; Services by Provider and Group Code; Services by Program and Group Code; Service by Program and Age Group; Client Service Report; BHRS Units of Service by Practitioner; BHRS Units of Service by Program; BHRS Units of Service Summary, BHRS MAA Summary	<ul style="list-style-type: none"> <li>▪ Shows the number and types of service units provided by clinician, by program etc</li> <li>▪ Will not show units of co-provided services</li> </ul>
<b>Scanned Documents: View</b>	<b>Scanned Documents</b> CWS→ Document Manager→ Clinical Document Viewer ▪ Many scanned documents should be entered into an Avatar document so they show up on the Dashboard/Doc at a Glance Reports; makes it easier to audit the chart	<ul style="list-style-type: none"> <li>▪ Select by type of document, program, restriction, by categories/forms, then process and view results of your search</li> </ul>
<b>Send Notifications</b>	<b>Send Notification</b> CWS→ Other Chart Entry→ Send Notifications <b>OR</b> PM→ Client Management→ Episode Management→ Send Notifications	<ul style="list-style-type: none"> <li>▪ Notify staff about an action taken or needed</li> <li>▪ Select <b>add</b> to send a <i>new</i> notification</li> <li>▪ Can edit or delete a notification</li> </ul>
<b>“To Do”:</b> <b>To Do List: Chart Review</b>  <b>To Do List: Avatar Homepage</b>  <b>To Do: Task Frame</b>  <b>To Do: My Caseload</b>  <b>To Do: Workflow Management Pop Up</b>	<b>TO DO</b> Right click on client name→ Chart Review→ click on Green Arrow of To Do Set “Preferences” start up tab to have the Avatar homepage open with the “To Do” screen Task Frame of Avatar Homepage shows My To Do List (X:Y)  Clients are listed with indicators that there are “To Do” items  Click ok to the system message pop up when Avatar Homepage first opens	<ul style="list-style-type: none"> <li>▪ Helps you keep track of, view and manage DRAFT documents; those needing co-sign</li> <li>▪ Must finalize a To Do item for it to drop off.</li> <li>▪ Lists items by date with most current on top</li>  <li>▪ This means there are X number of <i>total</i> “To Do” items and Y number of “To Do” items added in the last 24 hours</li> <li>▪ This symbol 📌 represents “To Do” items over 24 hrs old, with yellow highlight, then new client with To Do more than 24 hours old.</li> <li>▪ System message pop up states, “there are 1 or more items open within your workflow management “To Do” list.</li> </ul>
<b>Transfer a Client</b>	<b>Transfer Client</b> CWS→ Other Chart Entry→ Transfer/Discharge Request	<ul style="list-style-type: none"> <li>▪ Complete Tab 1 and Tab 2 , send to receiving clinic for approval</li> </ul>

<p><b>Treatment Consents: How to Create</b></p> <p><b>View/Print</b>  <i>To view scanned consents, see scanned documents previous page</i></p>	<p><b>Create <i>New</i> Treatment Consent</b>  CWS→ Consent→ Application for Services and Consent to Treatment</p> <p><b>View/Print</b>  Chart Review→ Documents→ Consent /Legal→ Look for Treatment Consent by Date, print</p>	<ul style="list-style-type: none"> <li>▪ Assure client has a scanned or Avatar Consent for Treatment in record.</li> <li>▪ Should convert scanned Treatment Consent to an Avatar document so that it can appear on Dashboard; makes it easier to audit a chart</li> </ul>
<p><b>Treatment Plan: How to Create</b></p>	<p><b>Create Client Treatment and Recovery Plan</b>  CWS→ Treatment Planning→ Client Treatment and Recovery Plan</p>	<ul style="list-style-type: none"> <li>▪ Create a Treatment Plan, Edit a draft plan, Finalize a draft plan</li> <li>▪ Document service in a Progress Note using Plan Development</li> <li>▪ Have client sign plan with signature pad or scan client’s paper signature page into Avatar</li> </ul>
<p><b>Treatment Plan: View/Print</b></p>	<p><b>View/Print</b>  Right click on Client→ Select Chart Review→ View Treatment Plan from specified Episode→ click on Green Arrow of BHRS Client Treatment and Recovery Plan (plan created prior to 9/1/11) <b>OR</b> click on Green Arrow of “<b>Plan Dates and Information</b>” (Treatment Plan as of 9/1/11)</p>	<ul style="list-style-type: none"> <li>▪ Print copy of Plan , give to client</li> </ul>
<p><b>Treatment Plan: Append/Update</b>  <b>NOT CURRENTLY IN USE</b></p>		
<p><b>Urgent Care Plan: Create</b></p> <p><b>View Urgent Care Plan</b></p>	<p><b>Create Urgent Care Plan</b>  CWS→ Other Chart Entry→ Urgent Care Plan or through Urgent Care Plan Bundle (<i>Requires Alert if bundle not selected!</i>)</p> <p><b>View Urgent Care Plan</b>  Right click on Client→ Select Chart Review→ click on Green Arrow of Urgent Care Plan→ select the Plan you need to view</p> <p><b>OR</b>  From Chart Review→ click Green Arrow of Abstracts→ click Green Arrow of Client Dashboard→ Most current, on file Urgent Care Plan appears in red in the upper right hand corner of the Client Dashboard</p>	<ul style="list-style-type: none"> <li>▪ Create Urgent Clinical Plan for others to follow regarding an important client risk or concern</li> <li>▪ URGENT CARE PLAN is identified by all caps and is located above <i>latest</i> episode in Chart Review, most current date is listed first</li> </ul>

<b>Urgent Care Plan: Disable</b>	<b>Disable Urgent Care Plan</b> CWS→ Other Chart Entry→ Urgent Care Plan	<ul style="list-style-type: none"> <li>▪ Disables Urgent Care Plan that no longer applies.</li> <li>▪ To disable, select an open plan from pre-display screen, select edit, select to <b>close</b> Urgent Plan from Status drop down of Tab1, enter the end date, and submit.</li> </ul>
<b>Verbal Authorization for Release of PHI to Family?</b>	Complete CWS→ Consents→ Verbal Authorization to Release PHI to Family	<ul style="list-style-type: none"> <li>▪ Select which information client is giving verbal authorization to release and to whom client is designating information is released to.</li> <li>▪ Client and Clinician sign using the signature pad and submit</li> </ul>