Avatar Clinicians Manual
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# Santa Cruz Avatar

## Admission Form

Search for the Client

**CLIENT REGISTRATION & FINANCIAL Program of Admission**

CSI Admission and Cal-OMS Admission

Assessments: General Concepts

Psychosocial Assessment General Concepts

Santa Cruz Psychosocial Assessment Form

- Presenting Problem Tab
- Culture/Spirituality Tab
- Mental Health Hx Tab
- Risk Factors Tab
- Legal History Tab
- Medical Information Tab
- Client resources form
- Developmental History Tab
- CRAFFT/CAGE AID Tab
- Substance List Tab
- Trauma History Tab
- Strengths Tab
- Summary Tab

Assessment Updates

Risk Assessment Form

Mental Status Exam (MSE) Form

ASAM Form

ASI Form

CANS/ANSA Form

Diagnosis

The Santa Cruz County Integrated Treatment Plan

Treatment Plan Overview

Creating an Initial Treatment Plan

Printed Treatment Plan Workflows (what to do if you don’t have a signature pad)

Creating a Treatment Plan Update

Creating an Annual Plan

Discharging Clients
1) **Open the Link to Avatar:** You can do this a few different ways.
   a. Click on the Avatar icon located on your desktop.
   b. Go to the web address. For the UAT, it is https://santacruzuat.netsmartcloud.com/radplus/index.jsp.
   c. Go to the Avatar URL saved in your favorites.

2) The Avatar launch page will open. Click **Start Avatar**.

3) **IF AVATAR DOES NOT LAUNCH,** see the section titled **Java Errors** for more information.
4) **To log in:**

   a. Enter your **System Code** (all caps). For example, **UATEN** or **LIVEMH**. Note that your system code is determined by your agency and your role. The system code is different for different users.

   b. Enter your **username** (lowercase). This will be the first 6 letters of your last name (or less if your last name is shorter than 6 characters) followed by the first letter of your first name. For example: Mike Coopertown would be cooperm. (There may be some exceptions to this rule. See your supervisor or the help desk if you think you may have a different log in name.)

   c. Enter your **Password** (case sensitive). Typically, your password=your log in name if you are a first time user.

   d. **If this is your first login**, you will be immediately prompted to change your password. Your password must be 8 characters long. It may contain special characters (#$%&) and numbers.

   e. Once you have entered your Username and Password, Click **Sign In**.

   f. **If you forget your password:**
      
      i. After five tries, Avatar will deactivate your user account and you will no longer be able to log in, even with your correct password.
      
      ii. If this happens, your supervisor or an IT person can either reactivate your account so you can try again, or they can set a new password for you.

**Screen Lock and Sign Out**

1) **If you need to step away from your desk, remember to lock your screen** by clicking on Lock located in the upper right-hand corner of your screen. This will prevent unauthorized users from viewing client information in Avatar (HIPAA). When signing back into Avatar, type UAT or LIVE in the system code and then enter your user name and password.

*Always save when possible to avoid losing work to any surprises such as power surges.*
1) To sign out of Avatar, click on Sign Out. You will lose any unsaved data when you sign out, so make sure you save and close all open forms.

To Change Your Current Password

1) Locate the Forms & Data widget on your home view.
2) Click in the Search Forms field and type Change Current Password. Double click on the form name to open up the form.

3) Once you have opened up the form, in the **Current Password** field, enter your current password.
4) In the New Password field, enter your new password.
5) In the Re-Enter New Password field, enter your new password again.
6) On the left hand side of the screen, **click on the Submit Button**.

5) The form should close.

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**Submit Button**

Throughout Avatar, you will see the Submit button on most forms (or the “File” button for progress notes). Submit = Save & Close. DO NOT click the red and white "X". If you do this, the form will close without saving your data.
Java Errors and Problems Logging In

1) If you see the warning below, your Java is not set up. For help with this problem, contact the helpdesk at x4657 or hsamhhelp@co.santa-cruz.ca.us

HTTP Status 404 - /radplus/plugins/jre-6u21-windows-i586.exe&returnPage=application.jnlp&locale=en-US

- `type` Status report
- `message` /radplus/plugins/jre-6u21-windows-i586.exe&returnPage=application.jnlp&locale=en-US
- `description` The requested resource (/radplus/plugins/jre-6u21-windows-i586.exe&returnPage=application.jnlp&locale=en-US) is not available.

Apache Tomcat/5.5.20

2) If you see the message below, click Allow.
3) If you receive the popup below, click Save and then click Open.

a. If Avatar is telling that you need to update Java (seen usually at the login screen), you can make these messages disappear by:
   i. Going tcking the Avatar UAT login screen.
   ii. The go to Tools → Internet Options
b. Click on the Security Tab → Trusted Sites → Click on Sites

![Image of Internet Options window]

You should see the Avatar address in the window that appears (shown below). Click on Add, then click Close.

c. You should see the Avatar address in the window that appears (shown below). Click on Add, then click Close.
If none of these steps help or if you need further assistance, contact the helpdesk at x4657 or hsamhhelp@co.santa-cruz.ca.us
Avatar Home View and Menu Bar

1) Home View: Once you launch Avatar, the first screen that will appear is the *Home View*. You will see rectangles called **Widgets** arrayed on your desktop. Widgets show various types of information from Avatar. (See the Widgets section below for more information.)
6) **Menu Bar:** The *Menu Bar*, located at the top of the Avatar screen, is an important feature. It allows you to navigate between Forms, Chart Views, and your Home view. The Menu Bar contains the **Home Button that will return you to your Home View.** No matter where you are within the system, the Menu Bar displays any Forms or Charts that you have open. You can have multiple forms and charts open at once and they will all be listed here so you can toggle back and forth between them and the home view without using the windows task bar. The Menu Bar also contains your Preferences and Help menus. The User ID that is logged in is displayed in the upper right hand corner.

7) **Consoles or Multiple Home Views:** Depending on how your access is setup, you may have more than one view. These views are known as **Consoles** and are displayed in a row next to My Views. To switch between views, just click on the Console name. In the example, the Home Console is selected (highlighted in green).

8) **Roles:** A role is essentially a job category in Avatar. Examples of roles are ADPLicensedClinician, BHClinician, MHPrescriber. Your Avatar Role determines which console or consoles to which you have access. Your role also determines what forms you can work with, what you can view, which charts you can view, scheduling and many other functions.

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**Widgets**

1) **Widgets:** These are the small rectangles on your *Home View* and in the *Chart Overview*. Widgets show views of information from Avatar. Some Widgets provide handy views of commonly used information, like the Service History Widget. Other Widgets are interactive, like the My Calendar Widget and the My To Do’s Widget.
Santa Cruz Avatar

One way to think of a Widget is like a window or door in a house. If you look through the window, you can see into the house, although you cannot interact with anyone in the house. Some Widgets work like this. You can view information, but you cannot interact with it. Other Widgets are like a door, where information travels in and out of the house. They allow you to have interaction with the Avatar database.

2) Widgets are assigned by Role and may vary depending on your access. A role is essentially a job category in Avatar. Examples of roles are FVLClinician, FVLPrescriber. Your Avatar Role determines which Home Console or Consoles you have and which widgets you have on your console(s). Your role also determines what forms you can work with, what you can view, which charts you can view, scheduling and many other functions.
   a. If you have made changes to the layout of your widgets and want to return to the default layout, on the right side of the menu bar, reset your widgets to your default layout by clicking on the box icon shown.
   b. Click Reload Home View and then Apply to restore the widgets to their default layout.
   c. The Refresh Button: Many widgets have refresh button that you will need to click to update the widget. If you have made changes to any of the data displayed in a widget, you won’t see it until you have clicked the refresh button.
3) **Forms & Data Widget:** This Widget allows you to access forms in Avatar. There are several ways to search for forms using this Widget.

   a. **My Forms:** Here, you will see a list of forms that have been assigned to you, based on your Role. This is a list of forms that you will likely use *most often*, but it does not include all forms you can use. See below for information on how to add a form to this list using the Edit feature.

   b. **Recent Forms:** If a form is not already in the My Forms section of the Widget, *and* you have recently opened that form, it will appear in Recent Forms. However, if the form is already in the My Forms area, it will not appear in Recent Forms.

   c. **Browse Forms:** Click on Browse Forms to see a list of forms sorted by categories. Search for clinical forms in "Avatar CWS."

   d. **Search Forms:** You can also use the Search Forms box to find forms. Once you start typing, the matching forms will display dynamically.

   e. **Adding Forms to My Forms:** There are two ways to add a form to your My Forms list.

      i. You can click and drag a form from Recent Forms up to the My Forms section.
ii. Or you can click on Edit, located in the upper right of the widget.

This will open a new window. Type in the name of the form that you wish to add, then click on Add Form.

a. While in this window, you can also right click anywhere and add folders to organize your forms. Once you Right Click in the window, click Add Folder.

4) **My Clients Widget:** This Widget functions similarly to the Forms & Data Widget, with sections and links allowing different types of searches.
b. **My Clients:**
   i. The clients assigned to you are marked with an arrow symbol, >. Your caseload is here.
   ii. You may also temporarily add clients here (see below). These clients do not have an arrow next to them.

c. **Recent Clients:** Clients whose charts you have recently viewed. Note that this is not the same as clients assigned to your caseload. These can be any clients that you have recently looked at whether or not they are on your caseload.

a. Once you have opened a Client, the client’s name will appear in your Recent Clients list until you end the current session in Avatar.

b. **Search Clients:** Type in the last name or first name of your client to search. You will get a list of potential matches. Double click on the client name to open the chart.

c. **To add a Client to your My Clients list:** There are two ways to do this.
   i. Click and drag them up from the Recent Clients list or Click Edit, located in the upper right corner of the widget. (Note: Adding a client to your Recent Clients List, does not mean they are assigned to your caseload. To Assign a client to your caseload, use the Caseload Assignment form.)
   ii. **Click Edit:** This will open a new window where you can search for a Client and then add them to your Client list or remove the Client from the list. To add a Client, click on their name and then click the blue arrow in the center.
d. **Advanced Search:** Click on “advanced” to open up a window that allows a more targeted search for a client, with fields including DOB and SSN. Note that you only have to have three pieces of data to search for the client. With many forms in Avatar, before opening the form, you will first be asked to select a client using a similar search box.
5) **The My To Do’s Widget:** Your My To Do’s will show you forms that are saved in draft mode (i.e., documents that you need to complete, like progress notes) and messages from other staff. Most items, except for simple messages, are associated with a task that you need to complete. You must complete the task in order for the item to go away. See the section on Staff Messaging for more information.

6) **My Calendar Widget**
a. **Please Note: My Calendar Widget is NOT the Scheduling Calendar.** The My Calendar Widget is for viewing existing Client appointments and for launching progress notes only. Scheduling appointments must be done through the Scheduling Calendar.
b. The My Calendar Widget shows all the appointments you have on one day. Click on the arrows next to the date to move one day ahead or back.
c. One benefit of the My Calendar Widget is that you can right click on a client’s appointment and open the progress note form directly from your Home Console. The Progress Note form will be prepopulated with all of the appointment information, such as the client name, the date of the appointment and the service code.

7) **Service Request and Disposition Log Widget:** This widget shows entries from what was previously called the Access Log or Call Logging. Note that the client must be selected or highlighted on your home console in order to view data in the widget. Clicking on an entry on the widget will take you to the call log and you can read what happened for a single call or contact. This widget will be covered more in the Access/Alternate Gates class.
8) **Service History Widget:** This widget is on your *Home Console*. It is a quick view of recent services that you can conveniently access without having to open the client's chart. Note that a client must be selected (highlighted in green) in order to view the information in the Widget. Click *once* to highlight a client in your My Clients Widget (clicking twice will launch the chart, which you don't want to do with this case). Note that a client must have already had some services, or the widget will be blank.

![Service History Widget](image)

**Reports**

Reports are another way to see information from Avatar. They are different from Widgets in that their information is static. However, Reports can be created daily or even more often if needed. Reports can have an arrays of information that can be useful for a supervisor or a manager, such as productivity information or team caseload information. Reports can also be printed versions of one document, such as a treatment plan or an assessment.

**The Master Client Inquiry Report**

This is similar to a Face Sheet. You can access this report by going to My Forms, searching for Master Client Inquiry Report and double clicking it from the results. This opens a select Client window. Type in your Client’s name and then double click it in the results to get the report.
To open a chart, first you must select a Client. You can use the My Clients Widget to select one of the Clients in your My Clients list, Recent Clients list or search for a new Client under Search Clients. Once you have located the Client you wish to open, double click on the name to open the Chart View.

At the top of your screen, notice your links to any charts and forms that you may have open. There is also a link back to your Home View.
1) **Chart Overview:** When you first open the chart, you will see an array of widgets and a list of forms on the left. This screen is called the Chart Overview. Some of the widgets you will see are also in your Home View. Other Widgets are unique to the Chart Overview. Depending on your role (psychiatrist, licensed clinician, nonlicensed clinician, etc...) you may see a different array of widgets.

2) **Inquiry View:**
   a. **Forms:** In Chart Overview, you will see a list of forms to the left. If you click on one of these forms, you will see a view of all the other times the form has been filled out, including draft versions. This is called the Inquiry View.
   b. **If you need to access a form that is not listed,** you can open forms by clicking on the box that has a green cross on it. This will open the My Forms Widget (from your Home console).
Click on the plus sign to add a form that is not listed.

Click on a form to see the Inquiry View (completed documents, such as progress notes).

Click on “SC General Purpose Progress Note” to see the Inquiry View of the Note.
c. **Program Tabs:** In Inquiry View, you will see a set of tabs across the top of the Inquiry View. Each tab represents a different Program of Admission. Make sure you click on the correct Program of Admission (POA) when viewing documents. Similarly, when you open up a new form in the client’s chart, make sure you have the correct POA tab. If you have clicked on the wrong POA, the document will be misfiled.

d. **Sort and Filter Buttons:** At the top of the Inquiry View, underneath the program tabs, you will see bars or buttons that allow you to sort and filter documents in a variety of ways.
e. **To Open a Form from Inquiry View:** You must open a form in order to enter data. Once you have opened the Inquiry View for the form you want, for example SC General Purpose Progress note, you will see a small "Add" in the upper right-hand corner. Click **Add** to open a new progress note for the client. **IMPORTANT: Make sure you have clicked on the correct tab for your Program Of Admission**, for example LE – 00044 County Outpatient. Otherwise, your note will be filed incorrectly and people may not be able to find it. You also may not be able to complete the note.

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**Staff Messaging**

1) **Open the Staff Messaging Form:** To send a message, you must first open the Staff Messaging form. Open the form in your Forms & Data Widget.
2) A window will appear called **Select User ID/User Description**. Type in your last name and then double-click on your name. **IMPORTANT: You must TYPE IN YOUR OWN NAME, NOT THE RECIPIENT.** The recipient is the person you are sending the message to. (Think of it as "logging in" so you can send your message.)

3) **Click Add** when you see the Pre-Display for the form.

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**Pre-Display**

As with many forms in Avatar, before opening a form, Avatar will show you a *pre-display*. A pre-display shows you all the instances of this form being completed. For some forms, you will see a list of all instances when all staff have filled out the form. For other forms, you may only see all of the instances associated with a particular client. In the case of the Staff Messaging form, you will see only the times you have filled out the form.
4) A blank Staff Messaging form will open up.
   a. Enter the Date and the Subject.
   b. In the Send Notification To field, click on the people to whom you wish to send the message. Note that you may send a single message to multiple recipients.

c. **Required items:** Note that the labels for the Date, Subject and Send Notification To fields are in red font. In Avatar, red questions on forms are required.
5) In the Staff Messaging form, you also have the option of adding a specific client’s name, the program to which the client was referred, and detailed comments. Once you have entered all of the information you want, click Submit to send.

6) **To Do List**: This feature is helpful if someone’s My To Do’s becomes too full. For example, after a vacation or leave. To rapidly go through the list and delete what is not needed, run the report, To Do List. This can be found by typing “To Do List” in the Search Forms field in your Forms & Data Widget.

Once the first screen is opened, click “To Do List Maintenance” to run the report.
You will now see a list of every item. You may select items by checking them off on the left and then clicking "Remove Sel Rows" in the lower left-hand corner.

Click "Enable Col Resize" to see more of the information in the columns. If you want even more information about a specific item, click on that row, and then click "Display Row Detail."

**Notification Users Form**

If there is no one listed in the Send Notification to Field, you will need to go to the Notification Users form (located under Search Forms). You will use this form to add people to whom you can send messages.
1) Search for, and open up the Notification Users form in your My Forms Widget in your Home Console.

2) A window will appear called Avatar 2015 – Workflow Notification Users. Use the dropdown menu (the bar in the middle of the popup) and locate your name. Click OK.

3) To Add all Avatar Users in the county, Click on Lists in the menu on the left hand upper corner of the screen to add users to your Staff Messaging.

4) Click on Add New Item. You should now see a green row appear in the Workflow Notification Lists table.

5) Then click Select List.
6) Select the list titled “Everyone” and click “OK. When you click “Submit,” staff will not be able to send a message to anyone using the Avatar system.

**Multi-Iteration Lists**

In Avatar, you will sometimes see a table like the one in the Notification Users form. These tables or multi-iteration lists are for adding sets of information to Avatar. When you see a table like this, know that you will always have to add a new blank row before you can begin entering data.

**Exercise:**
1. Send a message to one or more users in the class.
2. View the message that was sent to you in your My To Do’s Widget.
3. Before clearing the item, you will want to read the message attached to the referral by clicking Review To Do Item.
Santa Cruz Avatar

Caseload Assignment Form

1) Search for the Caseload Assignment form in your My Forms Widget in your Home Console. Then Select the Caseload Assignment form by double clicking on the form name in the search results.

<table>
<thead>
<tr>
<th>Name</th>
<th>Menu Path</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Caseload Assignment</td>
<td>Avatar CWS / CWS Utilities</td>
</tr>
<tr>
<td>Caseload Assignment</td>
<td>Avatar CWS / CWS Utilities</td>
</tr>
</tbody>
</table>

2) A Select Client box will appear on the screen. In the search field, type in the name of the Client that you want to assign or remove from a caseload and then click enter. For this search, you can use either the first name or the last name of the client and Avatar will search dynamically for the name.

3) The Clients who are similar matches will appear in the large search results box. You can either double click on the Client you want or click on the Client’s name then click Select.
4) If the Client is not currently in your caseload, you will see the Non-Caseload Access message appear. Click on Yes.

5) You must now enter a reason for accessing the case. In this example, we used the reason “assigning case to staff”. Once you have entered your reason, click OK.
6) You will see another Non-Caseload Access message appear. This notifies you that your access date, time and reason have been recorded. Click OK. [Note that for some staff, this auditing function has been turned off. However, Avatar always records everything that you do. When you access records, make sure you have a legitimate reason for doing so. Just because you can see something, doesn’t mean you should see something.]

7) You may see a Pre-Display if the Client has previously been assigned to other staff, otherwise, you will go straight to the form.

8) Specify the action you wish to take, either adding or removing the client from your caseload.
9) Search for the Practitioner you wish to assign the Client (search for the Practitioner by last name), the Program of Service and the Type of Assignment.

10) Click on Submit.
Quick Tips and Shortcuts

1) **Lightbulbs** on forms: These symbols are a link to helpful information about filling in a particular question or field.

2) You can use the space bar to check or uncheck a box in a list field.

3) In a list field, use the arrow keys to move back and forth between check boxes.

4) On Home Console, you can click once on Client to select the client, and then go and search for a form to pull up with that Client (works on most forms).

5) Most forms that have a name search field require you to do the search by entering the last name. You can also use the Client number or practitioner number in name search fields.

6) In date fields, you can use T for today instead of entering a date. You can also use Y for Yesterday, “T-30” for 30 days in the past.

**Spell Check and Automatic Correction**

Spell Check is located under Preferences, in the upper right of your home screen. You can add words that you commonly use in this area and also set preferences. You can also use the dictionary to insert phrases that you use regularly. **Note:** If you set this up, be sure to use codes that are not common in regular language or contained within a word, otherwise when you do your spell check you may add phrases in places you do not want them to be! **Note:** this will only work on the machine that you have set up the dictionary on.
Wiki Help and Other Resources

Online documentation may be available for some forms. If it is available, there will be a link on the left side of the form.

Clicking on Help in the upper right of your home screen goes to general help resources.

Visit the Training Folder for available materials at i:\Shared\Training Materials/MyAvatar.

**Scheduling Calendar**

The Avatar Scheduling Calendar gives the user the ability to manage appointments at multiple sites for staff members, clients, and groups. In the Scheduling Calendar, you can create appointments, check
clients in and out for their appointments. You can also assign multiple practitioners to an appointment. Progress notes may be opened and written directly from the Scheduling Calendar with all of the information from the appointment auto populated into the form.

When to use your calendar: You are not required to use your own calendar if you are documenting services that are not routinely scheduled in an office setting (i.e. case management and other field contacts). However, you are strongly encouraged to do so because of the benefits it provides. Psychiatry, therapy and Access will use it as part of regular business.

Scheduling an Appointment in the Scheduling Calendar:

1. You are going to add a new appointment on today’s date for your calendar. Open up the Scheduling Calendar under My Forms, in the Forms & Data widget on the Home View.

2. The Scheduling Calendar allows you to view appointments for one day, one week, or one month. Click on the “Week” view.
3. You may see a list of several clinicians to the right of the calendar. If this is the case, click your name from the Clinician list on the left side of the Scheduling Calendar.

4. **Site:** A Site can be a workgroup or a location. If you don’t see your name, you may not be viewing the correct Site. Click on your assigned site to find your name.

5. Right Click on the calendar at the desired appointment time and then click “Add Appointment.”
6. The **Add New Appointment** form will open.
7. **Program:** This is the **Program of Service** under which you provide services, e.g. County – Adult Recovery, Encompass – Child Enhanced Sup Svcs, County – Child School. (The Program of Admission is noted in the “Episode” field.)

8. **Location Code:** For most programs, the **Location code** should auto-populate to “Office.” Change if needed.
9. **Service Code:** Select the Service Code. Note that you must first select the Program before the Service Code. This is because Avatar won’t know what Service Codes you can add to the appointment without knowing the Service Program. (E.g. only psychiatry can provide medication services.)

10. **Select the Client and Episode. You must do this in order.** Avatar won’t know what Episodes you have to pick from if you don’t select the client first.

11. Enter **CO-PRACTITIONER(S)** if applicable.

12. Enter **RECURRING APPOINTMENT** Fields as needed.
   a. Enter **Once** for a one time appointment.
   b. **Recurring appointments:**
      i. Enter **Weekly** for a weekly appointment.
      ii. The **Recurrence End By** field will open up.
      iii. Selecting **End After** allows you to elect to end the series after a certain number of sessions. Enter the number of sessions in the blank.
      iv. Selecting **No End** schedules the recurring appointments for a year.
      v. Note that you may go back and **delete all or part of a series** at a later time. To adjust a series, return to your Scheduling Calendar. Then, Right click on one of the appointments in the series. Select “Delete.” A list of all appointments in the series will pop up. You can then select which ones you want to delete. (If you want to delete all or most of the remaining appointments in the series, remember that pressing CTRL + A on your keyboard will select all of the check boxes in a list.)
      vi. To schedule an appointment **every other week**, enter “Other” under Recurrence Schedule and then “14” in the blank for Days.

13. Click the **Submit** button on the left side of the screen to save your appointment and return to the Scheduling Calendar.

14. Notice that the new appointment is now listed on the Calendar.
15. At this point you can right click within the appointment to see additional options.

16. One of the options is to right click to enter progress notes for the appointment, such as **SC General Purpose Progress** or **SC Med Service Progress Note**. When you open a progress note from an existing appointment, all of the information from the appointment is already added to the note, so you do not have to enter it again.

17. You can adjust the appointment time and date, or even the length of the appointment by clicking and dragging. If you have access to multiple calendars (e.g. reception or supervisors), you can even move appointments from one person’s calendar to another, by clicking and dragging the appointment.
18. When you are finished with the calendar, click on Dismiss and the bottom of the form.

19. Scheduling Calendar vs. the My Calendar Widget:

   (a) The Scheduling calendar is used to create appointments, find open appointments and view multiple schedules for a workgroup such as psychiatry staff or a service team. The My Calendar Widget allows viewing existing Client appointments.

   (b) Right clicking on individual appointments in both the Scheduling Calendar and the My Calendar Widget will launch the Individual Progress Note form, but not the Group Progress Note form. See the Group Progress Notes module for more information.

Finding an Existing Appointment in the Scheduling Calendar:

Unless you are a supervisor or in some clerical roles, you will not have access to other staff members calendars. However, you can check to see if a specific client has an upcoming appointment, or look for open appointments. You do this using a link in your Scheduling Calendar to open a special form for this purpose.

Steps

1. Open your Scheduling Calendar.
2. In the lower right-hand corner, look for the link to the Find Existing Appointments form. (Below the Today button.)
3. Once the form opens, you will see many questions designed to narrow down your search.
   a. Search Sites: this narrows down your search by site. For example, if you are looking for psychiatry appointment for North County Adults, click No. Co. Adult Psychiatry.
   b. Note that the button to submit the form is in the middle of the form and that the Submit button on the left of the form is grayed out and disabled.
4. To find a scheduled appointment for a specific client, enter the client’s name in the Client field.
5. To find an open appointment, search for the client RESERVED TIME. Appointments in Avatar must be scheduled with a client. RESERVED TIME is a "placeholder" client used to set aside
appointments in the calendar that have not yet been scheduled with an actual client. Below you can see the next 10 open appointments for Medication Management. They have all been scheduled with the “client” RESERVED TIME.

### Progress Notes

#### Opening a new progress note

There are several ways to open a new progress note.
1. From an existing appointment in the Scheduling Calendar. This is done by right clicking on the appointment and then clicking SC General Purpose Progress Note.
1. From the My Calendar Widget

2. From the Chart Overview, in the far upper right corner, click “add” to open a new progress note. (The “add” link is very tiny and faint.)
All of the above methods will open up the note for preselected client, and the client's name and (if any) appointment information will be automatically added to the progress note.

A blank progress note can also be opened by simply double-clicking the progress note form in the Forms & Data Widget.
Writing a new progress note

IMPORTANT: You must enter information and click items in order, or the form may not function correctly.

1. **Select Client:** Once you have opened the SC General Purpose Progress Note form, add the client’s name in the Select Client field, if the client was not preselected from an appointment.

2. **Select Episode (Program of Admission):**
   a. In the Drop-down list, select which Program of Admission is associated with the note/service, e.g. LE00044 MH COUNTY OUTPATIENT or County ADP Prevention HSA. (If the Program was not already entered from an appointment.)
   b. **IMPORTANT:** Make sure you select the correct episode or your note will be misfiled under the wrong program. Additionally, the note may not work correctly and you may not be able to finalize and submit it.

3. **Progress Note For:** Indicate whether this is an Existing Appointment or a New Service. If you click Existing Appointment, a list of available appointments for the client will pop up in the menu below, "Note Addresses Which Existing Service/Appointment."

4. **Progress Note Purpose:** Indicate either Outpatient Note, Residential Note or Information Note. Depending on which one of these you select, different parts of the progress note will be enabled or disabled.

5. **PRACTITIONER(S)/TIME:** Enter a duration for both Face-to-Face time and Other Time. Avatar will total the time under Total Duration. Enter the time in minutes. Note that **Face-to-Face time**
Santa Cruz Avatar

is the time spent in direct contact with the client. *Other Time* is all other time associated with the appointment including writing notes and travel time.

You should consult with your supervisor about which services are allowable for “Other Time” under your Program of Service.

6. **Service Information**: Note that the field for Service Charge Code will provide a list of options once you begin typing. For example, type "M" for a list of all mental health codes.

7. **Evidence Based Practices/Service Strategies**: enter the appropriate practices and strategies based on the requirements of your workflow.

8. **Language**: Enter the language in which the service was provided. Click "No" for English. Click "Yes" for other languages. If you click Yes, you will also indicate whether or not an interpreter was used and the language.
9. **Treatment Plan Elements section:**
   a. If there is a treatment plan for the client, you will select which plan elements the service you provided addresses.
   b. Start with the **Select Treatment Plan Version** menu to select which plan and goals/objectives you want to use for the note.

   ![Select Treatment Plan Version]

   c. After selecting the Treatment Plan Version that you want, click **Select T.P Item Note Addresses**, which will open a view of the treatment plan. Double click on the item in the Treatment Plan you want to address in the note. Avatar will add everything above what you select, up through the associated goal. **Typically, you will want to select an intervention.** When you do this, Avatar will also add the associated objective, goal and problem for that intervention. (See Treatment Plan section for more information.)
d. After you selected what portions of the treatment plan you want to address in the note, click Return. You will now see the items you selected in the box labeled Note Addresses Which Treatment Plan Problem box.

e. The Clear ‘Note Addresses Which Treatment Plan Problem’ Text button allows you to clear the treatment plan item you selected if you made an error.

10. Progress Note Section
a. Note Type: Select the type of note you are writing, which will vary depending on what you clicked in the Progress Note Purpose field.
a. Write the note in the blanks that are enabled (not greyed out).

b. Special types of notes: some notes, such as the information note or the residential note may have some blanks in the progress note disabled based on workflow. (IMPORTANT: If you click Information Note or Residential Note accidentally, some parts of the form won’t work for a routine progress note.)

c. Information note: this replaces the “Memo” type note in previous EMR systems. It is a place to note important information that is not associated with a billable service. Example: a message from a client’s family member letting the clinician know the client has been hospitalized. Example: client called to cancel her appointment because they are moving out town and she no longer wants services.
11. **Draft/Final and File Note**: Once the note has been written, you may select Draft or Final and then click file note.
   a. **Draft**: An item will be added to your To Do List to remind you to complete and finalize the note. Clicking on the Form in your To Do items will launch your draft the progress note for you to complete.
      i. In your My To Do’s **DO NOT click Review Draft Item**. This will not launch the progress note. In addition, you have started down a path that will delete the reminder without your completing the note. Also, if the chart is still open, this function will not work. (The chart must be closed for the draft notes to be relaunched.)

   b. **Final**: if you select Final, a picture that will be launched for you to proofread.

   c. After proofreading, you have three options:
      i. **Accept**: accepts the note as final and files it. You are done at this point.
      ii. **Reject**: rejects the note so that you can return it to draft status for editing (click “Draft” once you get back to the note).
iii. **Accept and Route:** accepts the note and routes it to a supervisor and/or one or more approvers for a co-signature.

1. **To Route to a Supervisor:** Enter the supervisor’s name in the blank. Then click *Add*. The supervisor’s name will appear in the list at the bottom of the window.

2. **To Route to one or more Approvers:** Enter the approvers’ names in the blank. Then click *Add* after each approver. The approvers’ names will appear in the list at the bottom of the window.

3. **What is the difference between a Supervisor and an Approver?** Avatar sends the document to the person you have designated as “Supervisor” first. When that person signs the document, it then goes to the approver(s). It is only after the “Supervisor” signs, that the document gets released to the Approvers. Your documents show up in your supervisor’s and approver(s) My To Do’s. From there, they can sign the document, or they can return it to you for corrections. If a supervisor/approver “rejects” a document for corrections, they will not sign it and it will return to your My To Do’s as a draft. There is an option for the supervisor/approver to write a short message indicating the required changes. Once you edit the document, finalize and submit or file once again and re-route to the supervisor/approvers.

4. **To Route to a Team:** This will route to all the members of a team, if the team has been set up in Avatar. Enter the team name in the blank. Then click *Add*.

5. Once routing has been set up, click **Submit**.
Print a Copy of a Progress Note

In Avatar, as with other electronic medical record systems, it is not necessary to print your note. Avatar keeps your notes and other documentation secure. However, if you do need a copy, use the following directions. After you are finished using your printed copy, shred it as it contains confidential information.

1. Open the Client’s Chart and the link on the left side of the chart overview for the progress note type you want, either SC General Purpose Progress Note, SC Med Service Progress Note or SC Group Service Progress Note.
2. Make sure you click on the correct Admission Program tab at the top of the screen.
3. This will bring up a pre display where you can select a Progress Note to print. If there are a lot of notes, you can use the various Sort/Filter buttons to narrow down your note search.

4. To the left of the note, you will see the word “print.” Click this to print the document.

5. Locate the Progress Note you would like to print and select print.

Writing a progress note to document your service for an Assessment or Treatment Plan

In Avatar, Assessments and Treatment Plans do not have a service or billing component. Therefore, you must write a progress note to account for the time spent meeting with the client and writing the assessment or treatment plan.

Below, is information about the unique characteristics of writing this type of note. See above for more detailed information on writing a progress Note.

1. **Progress Note Purpose:** Click **Outpatient Note**.
2. **Duration:** *Other Time* is non-face-to-face time that is associated with provision of service including writing notes, travel time and reviewing any documentation prior to the appointment. For an assessment or treatment plan, *Other Time* may be significant compared to Face-to-Face time.

3. **Treatment Plan Elements section:** This section will not apply to your note documenting the creation of a treatment plan or an assessment. Skip this section.

4. **Progress Note Section**
   a. **Note Type:** Select *Progress Note*.

   b. Write the note in the content blanks that are highlighted.

   c. **For an assessment,** it is sufficient to write a brief note indicating that you met with the client and completed an assessment. Although you *may* write information in the other blanks, it is not required and you can simply type “NA”.
d. **For a treatment plan, you *may* want to write information about client presentation and response. Consult with your supervisor about the requirements for completing this note.**
Deleting a Draft Progress Note

If you make an error and your progress note is still in Draft form, you can delete the note yourself. Only the original author of the draft note can delete the note in this manner. Once the note has been Finalized and Filed, you will need to send a message to the helpdesk to have the note deleted.

Steps

6. Open the Client’s Chart and Navigate to the SC General Purpose Progress Note link as shown. This will bring up a pre display where you can select a Draft Progress Note.
7. Locate the Draft Progress Note you would like to delete and select “Edit”.

8. The SC General Purpose Progress Note form will open. Observe the highlighted areas and verify that this is the Draft Progress Note you would like to delete.
9. Select “Delete Draft Note” to delete.

Using the Append Progress Notes Form to Add to a Progress Note

If you have already filed and signed a note, Avatar does provide an opportunity to add to the text of the note using the Append Progress Notes form. Once the Append form has been completed, the added information will appear as an addendum at the end of the Progress Note in Avatar.

If you need to void (delete) a note or change the service code contact the QA help desk at at 454-4468 or askQI@santacruzcounty.us. If you need to change the client name (wrong client), or change the time spent, contact the IT helpdesk.

To avoid having to add to or make changes to services, it is important to take time to look over your notes before finalizing them.

1. Select the Append Progress Notes form. A Select Client window will open up. Enter the name or number of your client to open the form.
2. You will next see a pre-display of the client’s episodes. Select the appropriate episode.

3. Select the Note Type or category of your note.

4. In List of Notes, select the note you wish to append.

(IMPORTANT: If you have routed a progress note for a supervisor and are waiting for a co-signature, the progress note will not appear in the List of Notes. Ask your supervisor to “Reject” the note, which will put it back in your My To Do’s in Draft form. You can then make your changes and submit the note again.)
5. The Original and Appended Notes section of the form will be populated with information from your Progress Note. In terms of note content, only the Intervention portion of your original note will be shown here. This does not mean that the Client Presentation, Client Response and Follow-Up sections are not there, just that you cannot see them in this particular window.

6. In the New Comments to Be Appended to the Original Note section, add your comments. You may want to add a notation about which section of the note your comments belong to.

7. Once you have submitted the form, your changes will show at the end of the note when the note is printed and when the note is viewed in the chart.
Understanding Client Admissions and Workflow Through the System

1. Avatar has two types of programs, Programs of Admission (POA’s) and Programs of Service (POS’s). A Program of Admission is a broad admission that covers many services provided in an agency. A Program of Service is narrower. Service provision (notes, billing) is completed under a Program of Service (service teams, psychiatry, substance abuse treatment programs, etc...). Clients are no longer “opened” to Programs of Service (as with prior EMR systems). Once the appropriate Program of Admission is opened, service delivery commences. The appropriate Program of Service is noted in the progress notes.
2. This concept is slightly different in Substance Use Disorders treatment (SUD) vs. Behavioral Health (BH) treatment.
   a. In BH treatment, a Program of Admission is a broad “episode” that encompasses the entire time a client receives services from County BH or an entire contract agency. It can go on for many years.
   b. In SUD treatment, due to different confidentiality regulations, the Program of Admission is narrower and only specific to the particular treatment facility or program where the client is getting services.
   c. For each Program of Admission, there is only one Program of Service.
**Client Registration & Financial Program of Admission**

Client Registration & Financial is the first Program of Admission for all clients in Avatar. No services are associated with this Program of Admission. It exists to allow the client to be entered into the system and assignment of a client number only.

The main takeaway is that the **Client Registration & Financial Opening needs to be paired with another Program Of Admission** (e.g. LE00044 MH COUNTY OUTPATIENT or County ADP Prevention HSA) order to provide billable services.

**County – Pre Admit Outpatient Program of Admission**

1. This unique Program of Admission allows for limited services prior to the client receiving an Access Assessment and formally entering treatment. This allows for extended assessment periods for clients, as well as services for individuals who may never qualify for treatment, but require acute or crisis services. Some examples of the type of service allowed under County – Pre Admit Outpatient:
   a. Field crisis for a non-open client
   b. Jail crisis
   c. Crisis residential services
   d. Extended assessments for children under five
   e. Assessment services when the assessment is provided over a longer period of time, i.e. more than one visit is needed to determine whether client meets criteria for services

2. Under this **Program of Admission**, services may be provided for up to 60 days (or 90 days for children under 5). After 60 (or 90) days, the client must be discharged or admitted to another Program of Service.
Client Reg & Financial

- Client or representative calls or comes in for services, or a referral is received.
- Client opened to the Client Registration & Financial Program of Admission.
- Client number assigned.
- Info noted in Service Request and Disposition Log.
- Assessment appointment scheduled.
- No services are billed.

Pre-Admit

- Unclear if client qualifies for services and an extended assessment is done over multiple sessions.
- Client receives services, but no assessment is done. Client may not qualify. Examples: jail, crisis services, adult stepdown facility, extended assessment.
- Client closed after 60 or 90 days.
- Service provision (billable services) allowed.

LE - 00044 COUNTY OUTPATIENT

- Client has had an Access Assessment and had been determined to meet medical necessity criteria for services.
- Client referred in for services. e.g. psychiatry, therapy, case management.
- If client was previously opened to Pre-Admit, Pre-Admit is closed when LE - 00044 County Outpatient is opened.
Service Request and Disposition Log (SRADL):

1. Previously called the Access Log or Call Logging
2. Services are initiated by either the client, or a representative (parent, guardian, hospital, contract agency). When the client or a representative contacts County Behavioral Health with a request for services, this must be noted in the Service Request and Disposition Log. This is a state requirement.
3. Features:
   a. There are clerical and clinical sections on the form. The person filling out the clerical section of the form will file it in "draft" format. The person completing the form "activates" the clinical section by clicking a radio button and then completes and finalizes the form.
   b. There are Behavioral Health and Substance Use Disorder questions in the SRADL form, because clinicians from all agencies and contractors will be using the form.
4. There is an associated widget, The Service Request and Disposition Log Widget where all entries in the SRADL are shown for a particular client. Clicking on an entry in the SRADL widget opens a single log entry for viewing or, if the entry has not been finalized, for editing. (Click on the blue date, which is where the link to the form is.)

5. If you are assigned a client that is new to services, there may be information in the SRADL Widget that will be helpful to you.

Admission Form

Search for the Client

To help you understand admissions, you will add a brand new client to Avatar, using the Admission form. For the purposes of this exercise, you will admit the client to Client Registration & Financial and then to LE-00044 MH County Outpatient. These are Programs of Admission (POA’s or Admission Programs).

1. Go to your Forms & Data Widget and search for the Admission form. Type “admission” into the Search Forms field in the the forms & Data Widget. Double click on the form when it appears on the
list. Note that you want to select “Admission”. There are other forms with similar names that you do not want to choose.

2. A Select Client Window will pop up. Before Avatar will open the Admission form for you, you will need to search for the client. This is because you want to see if the client is already in the system before admitting the client.

3. Type in three pieces of information in order to search for the client. Once 3 pieces of information are entered, the Search button will activate. (Even if you know you're adding a brand-new client, Avatar will want you to enter the information and perform the search.)
4. Click **Search**. (If there are matches to your search, the names will appear and you can either double click on a name to select a client, or click on the name then click the Select button.) For the purposes of this exercise, you will enter a brand-new client. Even if the name you have selected is already in Avatar, you will treat this as a new client. However, try to pick a unique name if you can.

5. If the client name is not in Avatar at all, a pop-up window will appear, letting you know that no matches have been found for your client. **Click OK. The New Client button will activate.**
6. **Click New Client** on the Search Client window to launch the Admission form.
7. Avatar will ask if you want **Auto Assign Next ID Number**. Click **Yes**. Avatar will now open the Admission form.

**Complete the Admission Form**

1. **Admission Risk Assessment tab**

   Once the Admission form is opened, fill in the open fields **Identification and Treatment Information tab**. Remember, **items in red are required**. You will not be able to submit (save and finalize) the form unless those items are answered.

   At the time of publication of this document, there are several questions on the Admission form that we will not be collecting. Below is a list and description of items that are needed for California State Data collection and what items you do not need to answer.

   a. **Identification and Treatment Information**

      i. **Client Name** will be auto populated from the Search Client window.

      ii. **Sex** will be auto populated from the Search Client window if you used this parameter to search for the client. Otherwise, add this information in. "Other" = transgender, intersex, gender fluid, etc. "Unknown" = unknown gender.
iii. **Date of Birth:** Although not a required question, do your very best to gather this information. This will help identify the client and ensure the client is not entered into Avatar multiple times.

iv. **Social Security Number:** Although not a required question, do your very best to gather this information. This will help identify the client and ensure the client is not entered into Avatar multiple times.

v. **Program:** For the purposes of this exercise, first open the client to **CLIENT REGISTRATION & FINANCIAL.**

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**CLIENT REGISTRATION & FINANCIAL Program of Admission**

Client Registration & Financial is the first Program of Admission for all clients in Avatar. No services are associated with this Program of Admission. It exists to allow information to be entered into Avatar prior to the client coming in for services. It also allows a client number to be assigned.

vi. **Type of Admission:** Enter **First Admission.**

vii. **Source Of Admission:** Although not required by Avatar, this item is required for data collection. Do your very best to answer this question if at all possible.

viii. **Initial Point of Contact:** This is you. **Enter your ID** here by typing in your last name and pressing Enter. Typically, this is the first **clinical staff person** encountering the client.

ix. **Lead Provider:** This is the person who will eventually be working with the client as the main contact person. Enter this information if you know who this person is. If you are practicing in avatar, add your own name. This field will add the client to the clinician’s My Clients Widget.

x. Skip the following: Practitioner Type, Disposition, Perform Discharge Alert, Type Of Alert.
b. **Presenting Problems/Disabilities tab:** Only answer the Disabilities questions in this section. Skip the Presenting Problems questions and the Current Medications questions. **Skip the remaining tabs and the Compliance Indicators section. Move on to the Demographics tab.**

2. **Demographics tab:** None of these items are “required” for you to Submit the form. However, complete as many as you can. Client race/ethnicity are required items.

3. **Complete a new admission in a different program:** You will now complete another admission for your client. This time, you will open the client to your Program of Admission. For Adult or Children’s Behavioral Health, the program is LE-00044 MH County Outpatient.
   a. Double click on the Admission form from your Forms & Data Widget.
   b. You will again see the Search Client window. Enter three data points for your client (e.g. last name, first name, sex). Then press search. Double-click on your client’s name when it shows in the search window.
   c. You will see a Pre-Display listing all of your client’s prior admissions. Since this is a brand-new client, you will only see one admission listed, your prior admission to Client Registration & Financial.
   d. In the Pre-Display, **click Add** in the lower left-hand corner.
4. The Admission form will launch.
5. Admit the client LE – 00044 MH County Outpatient. This admission is done for service provision. Client Registration & Financial is an administrative Program of Admission only. No billing or progress notes can be done under Client Registration & Financial.
6. **Type of Admission will be First Admission** since this is the **first admission** to the LE – 00044 MH County Outpatient POA.

![Client Admission Form](image)

7. Return to your Home Console and notice that the client has been added to your caseload in your Clients & Staff Widget.
8. Open the chart of the client you just admitted. Do this by double clicking on the client name. In your client’s chart, see the two admissions you just completed in the Client Episodes Widget.

**CSI Admission and Cal-OMS Admission**

1. The CSI and Cal-OMS forms in Avatar are for inputting demographic data for Behavioral Health and Substance Abuse Treatment Services, respectively.
2. This information is completed when the client is initially opened to services, and then annually by the clinician. Staff providing direct service delivery, such as coordinators and therapists, complete annual updates.
3. Paper forms are available for situations where there is no access to a computer or where the client is providing this information directly.
4. If you are the person completing the Access or Intake Assessment, you may need to complete a CSI or Cal-OMS form. Unless a clerical person has already done this for you, you will need to do the form yourself.
5. **Do your best to answer the questions on the form. GATHER AT LEAST:** Last Name, First Name, DOB, SSN, gender.

6. **YOU DO NOT HAVE TO ANSWER:** Questions about Problems and Medications. These are covered elsewhere in Avatar.

7. **Update Client Data form:** CSI information is updated at least annually and when CSI information changes. This is done by the Lead Provider for the client using the Update Client Data form.

8. **CSI Widget:** This Widget is in the client chart and tells you if key information still needs to be collected. If the background of the Widget is yellow, there are items missing. The Widget background turns green when all of the information has been collected.

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**Assessments: General Concepts**

1. Assessments in Avatar are made up of multiple groupings of forms. For example, the Psychosocial Assessment consists of the main Psychosocial Assessment form, plus the Diagnosis form, Risk Assessment, MSE, Drug Grid (Children’s) and Diagnosis.

2. Some of these forms are required and some are completed only in certain circumstances. For example, only licensed and waivered staff complete the Diagnosis form.

In the diagram below, see how the Psychosocial Assessment and the Crisis Assessment have several associated forms in common.
3. Form Bundling
   a. For forms like the Psychosocial Assessment, it and some of its associated forms can be opened up automatically using bundling.
   b. Sequential vs Non-sequential Bundling: With sequential bundling, forms are opened up one at a time, in order, as they are completed. With non-sequential bundling, forms are opened up simultaneously and the clinician can choose which forms to complete first, or even move around between the various open forms until they are completed and finalized.
   c. **Type in the word Bundle in the Search Forms field** in your Forms & Data Widget on your Home Console to see the various bundles that are available. Note the various sequential and concurrent bundles available. Click on one of the Concurrent bundles to see all of the forms that are available.
Psychosocial Assessment General Concepts

1. **Tabs**: The Psychosocial Assessment form is organized into tabs that address related types of information. For example, there are separate tabs for Mental Health History, Legal History and Trauma History. As you complete the form, you can click on the separate tabs to complete the information needed. It is recommended that you move through the form, one tab at a time, in order, because of certain question logic in the assessment. However, you may return to a tab to add information at any time.

2. **Sections**: Some tabs have many questions and are subdivided into sections. These are set apart with gray bars at the top of the section. You can click on the triangle at the left of each section divider to open up or collapse the section.
3. **Required Questions**: In the Psychosocial Assessment, some questions are required and others are optional, although you are strongly encouraged to answer as many questions as possible, including those that are optional. Questions in **red** are required.

4. **Lightbulbs**: Throughout this and other documents, you will see a small light bulb symbol. If you hover over the symbol, you will see instructions on how to answer the question.

5. **Question Logic**: Some questions are required depending on the answers to other questions. For example, in the **Legal History** tab, the first question is required. Depending on the answer to the first question in the tab, subsequent questions are either required or disabled. In the example below, because the clinician clicked "No" to the first question about any legal involvement, all the other questions are not required and in fact are "grayed out" or **disabled**. No information can be entered into these questions.
6. The Psychosocial assessment is unique in that it has a Backup Form button that will save the form while it is open. The button is on the left, just underneath the Submit button.

Santa Cruz Psychosocial Assessment Form

Open up a new Psychosocial Assessment SC form for your client. Click once on your client (in the My Clients Widget) to highlight the client, then double-click on the link to the form (found in My Forms). If the client is open to multiple admissions, you will see a pre-display with a list of those admissions. Select the POA under which you provide services, e.g. ME – 00044 MH County Outpatient. The Psychosocial Assessment SC form will open. For training purposes, pick a client that has not had a prior assessment. See the section titled Assessment Updates for information on how to do an Update when there are previous assessments for the client.

Presenting Problem Tab
1. **Date Fields:** In the Presenting Problem section, enter the Assessment Date. Click "Today" or "Yesterday", or for a different date, type it in.

   ![Assessment Date](image)

   Dates can be entered in Avatar by clicking the "T" or "Y" next to the date blank (today or tomorrow). You can also type in the letter T and press enter. Also, use addition or subtraction to enter dates. For example, entering T-4 gives you a date from four days ago.

2. In the **Type of Assessment** field, select the appropriate type of assessment.

3. In the **Assessment for what population field**, select the appropriate population.

4. **Question Logic for population:** Note that there is a great deal of question logic associated with the “population” question, so make sure you click the correct box for this item. Various questions are required or disabled depending on the answer. If you change the answer to this question mid-way through the assessment, some text boxes may clear and you will lose your data.

5. **Draft/Final:** Next, skip to the very end of the assessment, to the last question at the bottom of the Summary Tab. Select Draft in the Draft/Final field radio button. At this point you have completed all the tasks necessary to save your document as a draft and return to it at a later time. Now return to the Presenting Problem Tab.

6. **Complete the Presenting Problem** (What made client/child come for services?) and **Describe any functional Impairments** fields.
7. **Text Editor:** If the text box requires a lengthy answer, you can pop out the text editor to see more of the field by clicking the associated icon. Click “Save” to close the popout.

8. **Search Function:** Click the tiny magnifying glass to search for a word or phrase in your text.

### Culture/Spirituality Tab
Complete data entry for the Describe the client’s/child’s cultural practices and spiritual beliefs question and Describe the client’s/child’s gender roles and sexuality question, as appropriate.

### Mental Health Hx Tab
1. **Source(s) of clinical information field:** This brief field is a chance to list the types of information you are using to complete the assessment. Examples: client report, hospital records, family. Note that you only have about 20 characters in this field. If you need to discuss sources of information more thoroughly, use the larger narrative box in this section.
2. **This tab contains questions with radio buttons and checkboxes.** Here are some helpful hints for working with these types of fields.
   a. In *list fields* that contain multiple check boxes, you can use Ctrl and A to select all. To unselect all use Ctrl and D.
   b. Use the arrow keys to move around in a checkbox field.
   c. You can use the space bar to check or uncheck a box.
   d. Use F5 button to uncheck a radio button.

### Risk Factors Tab
1. The Risk Factors Tab contains question logic that turns various questions on and off. In addition, answering "yes" to certain questions launches another form, the Risk Assessment Form.
2. In the Risk Factors Tab, in the Violence Risk Section click "Yes" to the question, Current danger to others/homicidal ideation." A pop-up will direct you to open up the Risk Assessment. If this is an error or you want to come back to the Risk Assessment later, you may click “No” and return to the Psychosocial Assessment form. However, you will need to complete the Risk Assessment form at some point if answered “yes” to any of the trigger questions.
3. Note that the questions on the form differentiate between current and past suicidal/homicidal behaviors/ideation. Only current suicidality, homicidality and/or grave disability trigger the risk assessment.

### Legal History Tab
Note the embedded logic for current and past legal involvement. The first question about history of, or current legal involvement, activates the rest of the questions in the section.

### Medical Information Tab

**Client resources form**

The question regarding primary care provider launches a window to the Client Resources form.
The Client Resources form allows support people, family and other providers such as medical doctors to be entered into Avatar. View client resources in the Client Resources Widget on the Home console.

Pregnancy and Postpartum Sections: For Janus Perinatal Program only.

Developmental History Tab
Answer these questions as appropriate.

CRAFFT/CAGE AID Tab
1. CRAFFT section (for children/youth):
   a. If the client is a child, the CRAFFT is enabled but not required. This is because it is required for children 12 and over only.
   b. The last question on the CRAFFT enables associated question logic. If two or more questions are answered “Yes” in the CRAFFT, then you will be prompted to complete the Drug Grid form.
   c. If you are required to complete the Drug Grid form, you will skip the Substance List Tab (next tab on the psychosocial), otherwise, you must complete the Substance List Tab, regardless of client age. (There is a single item that will allow you to enter “None” for substances.)
2. CAGE AID section (for adults):
a. The CAGE AID is either required (adults) or disabled (children).
b. Note that you do not complete the Drug Grid form for Adults. Instead, complete the Substance List Tab, which is the next tab on the psychosocial.

**Substance List Tab**

1. Required for:
   a. Adults, and  
   b. Children for whom the Drug Grid was not completed.  
   c. If a Drug Grid was completed for a child, then this tab is not required.

2. This tab is for listing **all substances used, not just those abused**. For example, if the client drinks one cup of coffee per week, this should still be noted.

3. **If the client uses no substances at all, you must still complete the tab.** In this case, check, “None” on the substance list. Everything else on the form is disabled and greyed out, so you will not have to enter any more data on this tab.

4. The Substance List Tab contains a **multi-iteration list**. Information about each substance the client uses/abuses has its own line in the list. To add a substance to the list, you must first create a new line by clicking Add New Item.

5. Make sure that the client is asked about the following: alcohol, caffeine, tobacco/nicotine, CAM (complementary and alternative medications), OTC drugs, and illicit substances. This is a Medi-Cal requirement.

6. **Begin by adding a new row to the multi-iteration list by clicking Add New Item** to start a new row. (For each new substance, you will begin by adding a new row.)

7. Fill out the rest of the row. Note that you will need to answer the questions for each substance in order, for the list to work properly.
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Substance Use Hx Tab: Note the question logic based on the answer to the first question on the page.

Trauma History Tab
Answer questions as appropriate.

Strengths Tab
1. Describe client’s/child’s current or past strengths to achieve goals: This question is for documenting strengths specific to the client’s anticipated ability to achieve treatment plan goals. Examples are resiliency, motivation.
2. Describe what the client/child feels is important in their life: This question is appropriate for noting what motivates the client and other issues that are important to the client. It allows the clinician to enter items that may be personally motivating for the client, but that are not appropriate for the prior question such as: playing video games, smoking, hobbies.

Work/School Tab: Answer questions as appropriate.

Family/Social Tab: Answer questions as appropriate.

Summary Tab
1. **Note that there are two “Summary” fields.** Either one or the other is activated depending on whether or not the client will be recommended for services. Both will not be activated at the same time on the form.

   ![Image of a completed form with a diagnosis and summary fields]

   **IMPORTANT:** These two fields are either enabled or disabled by the question above them, "Is client being referred to/re-authorized for services?"

   If you click "Yes", the field, "Clinical summary of recommended services..." will be **enabled**.

   If you click "No", the field, "Clinical summary, explain reason for denial..." will be **enabled**.

   If you fill in the blank with your summary, and then change your mind and click the other button, everything in your summary will be erased.

   ![Image of the question and answer options]

   **a. Clinical summary of recommended services**

      This field is activated if the client is authorized for services. This is where the justification for referral into services (or reauthorization for services) is entered. Although no diagnosis is entered in the psychosocial assessment, discussion of diagnosis is appropriate for this field, if you wish to do so.

   **b. Clinical Summary, explain reason for denial...**

      This field is activated if the client is determined to not meet medical necessity and will be referred out. The reasons for this are documented here.

   **c. Where is the diagnosis?** Remember that assessments in Avatar are made up of multiple forms. A Psychosocial Assessment consists of the main Psychosocial Assessment form, plus the Diagnosis form, Risk Assessment, MSE, and Drug Grid (Children’s). Only licensed and waivered staff complete the Diagnosis form (and the MSE).
d. **How do I bill for the service?** There is no place to enter service or billing information on the psychosocial. You will write a progress note documenting the service. See the section titled, “Writing a progress note to document your service for an Assessment or Treatment Plan,” for more information about how to write this note.

2. **Finalize the document:** At the end of the Summary tab, Select Final.

3. If all required fields are answered, the Confirm dialog box will be presented. Select OK. The Draft watermark will be removed. Select Submit. The Confirm Document dialog box and TIFF (picture of the completed assessment) is displayed.

4. If you have missed one or more required fields, a window will pop up telling you which questions you still need to answer. There will also be red flags on the tabs for the sections that have the missing questions.

5. As with the Progress Note form, you will have the opportunity to proofread. You may:
   a. **Accept** the psychosocial as final and file it,
   b. **Reject** the psychosocial so that you can return it to draft status and edit some more,
   c. **Accept and Route** the psychosocial to a supervisor for approval. If you require a co-signature for your assessment, this notifies your supervisor who can then sign. Your supervisor may also need to complete a diagnosis and an MSE if you are not a licensed practitioner.

### Assessment Updates

If your client has had a previous Psychosocial Assessment under your Program of Admission, information the prior assessment will be auto populated into your current assessment. You may then edit the document, updating the previous information.

If the client has had more than one Psychosocial Assessment, you Avatar will present a list of all of the client’s prior Assessments in the Admission Program. You may then select which prior assessment to use.

To select an assessment from which to auto populate your new assessment:

1. Select the Psychosocial Assessment SC form in your Forms & Data Widget.
2. You will see a window listing all of the open episodes for the client. Select the episode associated with the services you provide.
3. You will then see Pre-Display listing all of the prior assessments for your client. Click on the assessment you want to use, to highlight in green. Then click Add, in the lower left hand corner of the window.

### Risk Assessment Form
**When to complete the form:**

1. In the Psychosocial Assessment, The Risk Assessment is completed when certain questions about danger to self/suicidality, danger to others/homicidality, and grave disability are answered “Yes.”
2. It is always required when completing a Crisis Assessment.
3. It may also be used in other instances. For example, ongoing assessment of a therapy client with frequent suicidal ideation. Consult with your supervisor if you think using this form might be helpful in your clinical work.
4. Make sure you ask clients about access to weapons such as firearms when discussing a plan to harm themselves or others. Discuss in the Comments section(s) of the form.

**Mental Status Exam (MSE) Form**

1. *When to complete the form:* The MSE is always required when completing the Crisis Assessment. It is also required for the Psychosocial Assessment if you are licensed. Otherwise, your supervisor may need to complete the form.
2. It may also be used in other instances. For example, ongoing assessment of a therapy client, so that changes in status and presentation can be compared from session to session.
3. The form consists primarily of check boxes.
4. *Note that text fields at the end of sections are optional.*
5. Supplementary questions in the Questions Tab are also optional.

**ASAM Form**

The American Society of Addiction Medicine Criteria (ASAM) assesses the client for placement and facilitates creation of substance abuse treatment plans. It is used by ADP treatment programs. If clients have consented to share their records, the ASAM results will be viewable in Avatar. The ASAM assesses five broad levels of treatment. These levels are medical management, the level of structure, safety, security and intensity of treatment.

ASAM criteria addresses the client’s needs, obstacles and liabilities, as well as the client’s strengths, assets, resources and support structure

**ASI Form**

The Addiction Severity Index (ASI) is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client’s life that may contribute to their substance-abuse problems.
It is the most commonly used addiction assessment tool by state agencies and treatment providers and is performed at intake.

A completed ASI calculates a severity rating scale allows the interviewer to determine the seriousness of a client’s problem. The higher the score is, the greater the need for treatment.

**CANS/ANSA Form**

1. The CANS/ANSA is completed in conjunction with the Access Assessment and then every six months. The six-month an annual due dates are determined by the date of the original Coordinated Care Date or Access Assessment.
2. View the form by searching CANS/ANSA in the Forms Widget.
3. Lightbulbs provide guidance regarding how the questions are answered.
4. A printable report is available to provide to the client.
5. Three separate age groups have been integrated into one form in Avatar (0-5, 6-17, and 18+).
6. The modules of the CANS/ANSA are integrated into the body of the form. If a trigger question for a module is scored 1, 2 or 3, the items of the module will be activated, and the required items will be highlighted in red.
7. The first tab is “Overview”. On this tab, select the appropriate Client Current Age Group. When you select the age group, the form activates the items throughout the form that apply only to that specific age group. All other items are deactivated. As in any other form, required items appear in red, optional items appear in black and disabled items appear in gray.
8. On the “Overview” tab, there is a “Draft/Final” item. Select “Draft” as you complete the assessment. Changes may be made until “Final” is selected and submitted.
9. A paper version of the form is available for field use. Once you return to the office, enter the data into the Avatar form.

**Diagnosis**

For training purposes, pick a client that does not have a previous diagnosis.

1. Search for the Diagnosis form using the Search Forms field in the Forms and Data Widget.
2. The Select Client window will open up. Enter the client’s LAST NAME, FIRST NAME in the search field to see a list of clients. Double click on the client you want.
3. You will see a pre-display that shows all the episodes the client is open to. Remember that you will need to pick the correct episode for the services you provide. For County Behavioral Health clients, the Program of Admission is LE – 00044 County BH Outpatient. Double-click on the episode applicable to the current diagnosis.
4. A blank Diagnosis Form will open.
5. Enter appropriate information in the required Type of Diagnosis, Date of Diagnosis (MM/DD/YY) and Time of Diagnosis (HH:MM) fields. Since this is a new diagnosis, the date
of diagnosis will be the opening date for the episode. If you were adding a diagnosis after admission, you would enter the current date. If you need to find out the client’s date of admission, click back to your Home Console and look at the Client Episodes Widget for the date.

6. Since this is a new diagnosis, there will not be a diagnosis from which to default. However, if you are working with a client who has a previous diagnosis, you will be prompted to choose whether or not you want to select information from a prior diagnosis. Use the Select Episode To Default Diagnosis Information From and Select Diagnosis Entry To Default Information From drop-down menus to do this. If you select a default diagnosis, any previous diagnoses for this client will be added to the form.

7. Below the Diagnosis multi-iteration section, select New Row.

8. Enter a diagnosis to search in the Diagnosis Search field. Select the search button to the right of the field or click Enter. Double-click on the most appropriate diagnosis entry. Note that this list of diagnoses that pops up comes from the ICD-10 (currently). This list is web
based, so the list may take a few seconds to pop up. In addition, the Diagnosis Search pulls from a list of more than 10,000 diagnoses. To narrow down your diagnosis and get a smaller list from which to choose, type in accurate diagnosis as you can. For example, type "major depression" rather than just "depression."

9. **Enter the Status Field.** The Status field defaults to “Active”. Select another status if appropriate. Note that the primary diagnosis must be Active. In addition, any diagnosis for which you are providing services must be Active. If a diagnosis becomes resolved, you can return to the diagnosis form to resolve it.

10. **Enter Estimated Onset Date.** Although this question is not required here, it is required for the treatment plan, so you will want to enter this information. Typically, it is very difficult to identify an exact date of onset for a psychiatric diagnosis. Enter Jan. 1 for the month and date. Enter the closest approximate year. e.g. 01/01/1990.

11. **Enter Present on Admission Indicator,** if applicable.

12. **DO NOT ENTER Classification. THIS NO LONGER APPLIES.**

13. Enter the required **Diagnosing Practitioner (this is you),** the Ranking and any appropriate Remarks.
14. The **Bill Order** will default to 1.
   1. The bill order determines which diagnoses are attached to services first. For Mental Health services, make sure that the first diagnosis is an included mental health diagnosis. For example, schizophrenia, bipolar illness, depression.
   2. For subsequent diagnoses, the bill order should default to 2 or 3. If not, you should type in the Bill Order in the Bill Order blank.
   3. Note that Avatar wants the bill order and the ranking to match. If they don’t, you will not be able to complete the form.

15. The Diagnosis multi-iteration table will now look like this:

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Description</th>
<th>Status</th>
<th>Estimated Onset</th>
<th>Classification</th>
<th>Resolved</th>
<th>Bill Order</th>
<th>ICD-9 Code</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Major depression single</td>
<td>Active</td>
<td>11/10/2015</td>
<td></td>
<td>1</td>
<td>1</td>
<td>296.20</td>
<td>F32.9</td>
</tr>
</tbody>
</table>

16. **Add To Problem List:** Enter **Yes**. By clicking **Yes** you add this diagnosis to the problem list that is used in creating the treatment plan. Typically, you will click **Yes** when answering this question.

17. On the **Additional Diagnosis Information** section, if applicable, enter **Prognosis**, **Estimated Discharge Date**, **Trauma (CSI)**, **General Medical Condition Summary Code (CSI)**, **Substance Abuse / Dependence (CSI)**, **Substance Abuse / Dependence Diagnosis (CSI)**.

18. Click Submit.

**The Santa Cruz County Integrated Treatment Plan**

Integrated treatment planning is part of the movement toward integrated care. An integrated treatment plan shared across agencies, teams and providers creates improved opportunities for coordinated treatment planning and service provision.
Integrated treatment planning allows multiple treatment providers to set shared goals. The goals are set within the context of the multiple treatment modalities the client may be receiving at any given time.

Integrated treatment has been shown to improve outcomes such as: reduced substance use, improved psychiatric symptoms and functioning, and decreased hospitalizations, decreased hospitalizations, increased housing stability, fewer arrests and improved quality of life.

In Avatar, Santa Cruz County Behavioral Health will create a treatment plan that contains goals across agencies and providers, with teams and treatment providers adding goals as needed. If clients wish to participate and sign a consent form, treatment plans for Behavioral Health and Substance Use Treatment will be viewable by each agency.

**Treatment Plan Overview**

1. Integrated Treatment Planning and Due Dates
   a. The **annual date** (due date) for the treatment plan will be shared. For legacy clients (clients already receiving treatment) the treatment plan will likely be the date on which the County annual coordination plan was due. For new clients, the annual date will be the date of the Access Assessment.
   b. As clients are opened to new services, goals will be added to the plan. These goals can be viewed by all of the treatment providers for the client. If a new goal is added in the middle of a client’s annual cycle, that goal will still expire at the annual date. This means that some goals may be in effect for less than a year.
   c. For example, a new client has an Access Assessment on January 15, 2017. The client is referred to case management and psychiatry. The case manager completes a treatment plan. The goals initiated by the case manager are valid from January 15, 2017 through January 14, 2018.
   d. Then, on July 15, 2017 the client begins psychotherapy. The psychotherapist adds treatment plan goals to the treatment plan already in effect. Those psychotherapy goals are in effect from July 15, 2017 through January 14, 2018.
2. There are two pages to the **Treatment Plan form**.
   a. The first page is for all information relevant to the treatment plan, except the goals, which are on the second page.
   b. On the **first page**, the following items are addressed:
      i. Plan name
      ii. dates
      iii. type of plan
      iv. client strengths/challenges
      v. plan participants
      vi. problems to be addressed (diagnoses)
   c. The **second page** of the treatment plan is opened by clicking "Launch Plan Builder." This is the area where Goals, Objectives, and Interventions are written.
   d. Once the plan has been finalized, Avatar will create a document that can be viewed in the client's chart.

3. **Treatment Plans for monolingual clients**: For clients who do not speak English, the clinician should type **both English and Spanish** into the plan. The format is [English text] / [Spanish translation text]. For each item, the English first, then a slash, then the Spanish text.

   **Creating an Initial Treatment Plan**
In this Module, you will first create an Initial Treatment Plan for a client. This is the first treatment plan for any client coming into services. After creating an Initial Treatment Plan, you will create an Update. Finally, you will create an Annual Plan, resolving items from the prior plan.

1. If you have not already done so, open your client's chart. In the chart view, find a link for SC MH Treatment Plan. Double-click on the link.

2. This will open up the display area for any previously written treatment plans. However, you should see a blank page because no treatment plan has yet been written for your client.

3. In the far upper right hand corner, click on Add to create the first treatment plan for your client. The first page of the Treatment Plan form will open.

4. Plan Naming Conventions
   a. Because goals will be added throughout the plan year, it is important to give plans names that identify and differentiate them from each other. Each time new goals are added, the plan is given a new name. Each new plan, with its new goals, interventions and/or objectives has a different name to separate it from the prior plan. Plan Names indicate the date range for the plan (when the plan starts and when it expires) and what type of plan it is (initial, annual, update).

   Examples:

   04/05/16 – 04/06/17  Initial
   04/05/16 – 04/06/17  Update 1
   04/05/16 – 04/06/17  Update 2
   04/05/17 – 04/06/18  Annual
   04/05/17 – 04/06/18  Update 1

   For the purpose of this exercise, you will be creating an Initial Treatment Plan. Choose an initial date at least one month ago. (After you create this plan, you will create an updated plan with a new goal with today’s date.)

5. In the Plan Type field, click the down-arrow to reveal the drop-down menu. Single-click to select Initial.
6. Note the “MH Treatment Plan Documentation” link which points to helpful clinical information about filling out a Treatment Plan.

MH Treatment Plan Documentation

7. At this point, the Last Updated field and the Last Updated By field are disabled and blank. This is because this is the first treatment plan for your client.

8. In the Plan Date field, enter the beginning date of the plan, which is the date the client was opened to services. (See the Client Episodes Widget to get the date.) Enter the date in MM/DD/YYYY format or use the calendar icon to select a date, then tab or click out of the field. The Plan End Date and Next Review Date should auto-populate after tabbing out of the Plan Date field. The Plan End Date will automatically be entered as one year minus one day from now. The Review Date will be one month from the Plan End Date. Note that on the Review Date, a message will be sent to you in your My To Do’s, reminding you that the plan is due.

9. Answer the required question Was This Treatment Plan Discussed in a Language Other Than English? If Yes, complete the required fields Language and Interpreter or Bilingual Provider?
10. **Problems Section (Table):**
   a. The problems section is a multi-iteration table. You will add each of the client's problems as one line on the table.
   b. Problems will be auto populated into the table from existing diagnoses for the client. You may also add problems when you complete the treatment plan.
   c. Use the scroll bar on the bottom of the table to navigate across each row in the table. Double-click on the entry of your choice, or single-select the item of your choice and click the Select button. For your Treatment Plan, you may use any preexisting problems, or you may add new problems. For this exercise, you will practice adding a new problem.
   d. **Enter a new problem** by clicking the **New Row** button.
      i. For each problem added, you must create a new row in the table.
      ii. **Type in a problem in the column titled "Problem."** Then click Enter on your keyboard. A list of potential diagnoses/problems will pop up. You can enlarge this window containing the list of diagnoses by clicking and dragging in the lower right-hand corner of pop up window. Click on the diagnosis/problem you want in your table. The selected/chosen problem will be entered in the Problem field.
   e. **DO NOT USE THE TYPE FIELD.** This no longer applies with ICD-10 diagnoses.

<table>
<thead>
<tr>
<th>SNO MED CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In Avatar, Problems can be both Diagnoses or other types of problems called SNOMED Codes. Only licensed staff can add Diagnoses. This is done through the Diagnosis form, not in the Treatment Plan. If you are a nonlicensed staff person, by the time you are ready to complete the client's first treatment plan, the Diagnosis form will have been completed by someone else. These diagnoses will show up in the Treatment Plan form. You can choose to create your treatment plan with the diagnoses (or Problems) already in Avatar, or you may add your own Problems, or SNOMED Codes to work on at this time. Examples of SNOMED Codes are social isolation, homelessness, family stress. Do note that if you choose to work on a problem like this, you must tie the problem back to the client's diagnosis in the Treatment Plan and in your other documentation. For example, if you choose the problem of social isolation, you should document how this problem ties back to the client’s diagnosis of depression or anxiety.</td>
</tr>
</tbody>
</table>

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f. Double-click in the **Date Identified** field to activate the field. This is an optional field. Enter a date if appropriate.

g. Enter the **Date of Onset**. This is a required field. Typically, you will not know the exact date of onset. **Pick the closest approximation that you can for the year.** Month and day are January 1st. **For example, 01/01/1972.**

h. **Status field:** For a new problem, the status will be **Active.**

i. **Severity field:** To activate the field, double-click on the entry of your choice, or single-select the item of your choice and click the Select button.

j. After adding all of the client problems, if appropriate, in the “**Include in this plan?**” column, check on all the checkboxes for those problems you wish to include in this treatment plan.

k. **IMPORTANT:** You must add your problems on this page. Do not add problems on the plan builder page.

![Plan Participants Section](image)

11. **Plan Participants Section:** The Plan Participants Section is also a multi-iteration table. You will add each of the plan participants (client, parent, guardian, etc…) as one line on the table.

   a. **Enter each participant** by clicking the **New Row** button. (For the first row in the table, you will enter yourself as the clinician.)

   b. Double-click in the **Role field** to activate the field. Click **Staff** in the pop-up window.

   c. In the **Staff ID** field type in your last name and click enter. Your name should automatically auto populate into **Staff ID and Participant Name fields.**

   d. Enter **Yes** in the **Plan Author field.**

   e. Enter **Yes** in the **Notification field.** By doing this, you will set up a notification reminder for when the treatment plan is due next year. This reminder will appear in your My To Do’s on the notification date.

   f. **To add your client (or another participant) click New Row.**

      i. Double-click in the **Role** field to activate the field. Click **External Participant** in the pop-up window.

      ii. Skip the **Staff ID field.**

      iii. In the **Participant Name field**, type the name of the client.

      iv. Enter **No** in the **Plan Author field.**

      v. Enter **No** in the **Notification field.**
a. **Signature Field:**
   a. If you have an electronic signature pad available, click “Sign” to activate the signature pad for your client to sign. Your client will sign on the pad and then Avatar will import the signatures into the document.
   b. **STAFF DO NOT USE THE SIGNATURE PAD:** You sign when you finalize and submit the document, just like you sign other forms in Avatar.
   b. **Add your supervisor if needed:** If you are required to have a supervisor sign off on your plan, you may add that person to the plan as well.
   c. **IF YOU DO NOT HAVE A SIGNATURE PAD OR YOUR CLIENT CANNOT COME INTO THE OFFICE:** Once you have completed a draft of the plan, you will print out a copy of the plan, have the client sign the plan and then the plan will be scanned into the client's chart. See the next section for more information about workflows with printed treatment plans.

12. In the **Date client was offered a copy of the treatment plan field**, enter the date.
13. If the client does not sign the treatment plan, enter the reason why in the next field titled **If client has not signed the treatment plan, please explain:**
14. Add **Additional Comments About Client’s Support System** as needed.
15. Add information about the client's **Strengths** and **Challenges** in the appropriate fields. You are not ready to move on to the second page of the Treatment Plan where you will add goals, objectives and interventions.
16. In the **Treatment Plan Status field**, select **Draft** status radio button. Then click the **CLICK HERE to Launch Plan Builder** button.
17. You should now see the **Treatment Plan Builder** portion of the form with your problems from the Problem List on the first page displayed.

![SC MH Treatment Plan: JERRY MAKINEN](image)

**Red Flags:** The red flags you see tell you that the goal has not been completed. As you write the treatment plan goals, objectives and interventions, use the red flags to help you see items you may have missed. **All of the red flags must be gone before you can finalize and submit your treatment plan.**

18. Click to highlight one of the problems brought over from the first page of the Treatment Plan. **IMPORTANT:** Do not add problems on this page. Your problems should be added on the previous page and checked to bring them over to the Plan Builder Page. The problem selected will be highlighted green and the problem code, Date of Onset, and Status (Problem List) fields are populated/disabled.

19. **Add the Date Opened, Date Due and Staff Responsible to the highlighted Problem.** The Date Closed field should remain blank. The **Status should remain Open.** **Date Closed** is not required for a new plan because all the problems, goals, objectives and interventions are open. In an annual plan, when you resolve goals, etc... you change the Status to Resolved and enter the end date for the goal, etc...
20. **Add a New Goal**: With the Problem you want still highlighted in green, click Add New Goal and a blank goal will pop up for you to write in.

**IT IS VERY IMPORTANT TO CLICK ON THE PROBLEM, GOAL, OBJECTIVE ABOVE WHERE YOU WANT THE NEXT ITEM TO BE, SO THEY ARE ASSOCIATED CORRECTLY WITH EACH OTHER.** In the example above, the Problem: Recurrent major depression, moderate, is highlighted in green. This must be highlighted like this to write a goal for this particular problem.
a. Enter the goal in the field below titled **Goal**.

b. **Date Opened**: This is the opening date of the plan. If you forgot the opening date, look at the Client Episodes Widget. The Opening Date for the plan is the Admit Date.

c. The status of the goal should be **Open**.

d. **Date Closed** is not required for a new plan.

e. **Date Due** is the end date for the plan.

f. Enter **Staff Assigning** and **Staff Responsible**. Typically you would be the Staff Assigning and Staff Responsible. Check with your supervisor to see if your workflow involves staff assigning items to other staff besides yourself.
21. **New Objective:** You will now add a new objective to the goal you just wrote.
   a. First, click on the goal you just wrote – the text in the view of the goals above. The text of the goal should now be highlighted in green. This way, your goal will be associated with the new objective.
   b. Click the **Add New Objective** button to open a blank objective.
   c. Enter the data in the **Objective field**, including Baseline field.
   d. Enter a date in the **Date Opened, Date Due and Staff Responsible**.

22. **New Intervention:** You will now add a new intervention to the goal you just wrote. This section is similar to the Objective section. Make sure you click and highlight in green, the text from the Objective you just wrote, before clicking Add New Intervention.

23. Click **Back to Plan Page** once you are done writing your goals, objectives and interventions. Remember, all of the red flags should disappear if you have filled in all the required fields.
24. If you are finished with your Treatment Plan, in the **Treatment Plan Status** field, select the **Draft or Final** radio button. As with other Avatar documents, if you select Draft, the Treatment Plan will show up on your **To Do List** to remind you to complete and finalize the Treatment Plan. You can re-open your draft by clicking on the link.

![Treatment Plan Status](image)

25. Select the **Submit** button in the Navigation pane on the left.

26. **Final:** As with other Avatar forms, if you select Final, a picture of the Treatment Plan will be launched for you to proofread. After proofreading, you have three options: Accept, Reject or Reject and Route. You may also route to a supervisor or others.

27. **Printing a Copy of Your Treatment Plan:**
   a. Return to your client’s chart.
   b. Click on **SC MH Treatment Plan** to open the Treatment Plan Inquiry View.
   c. Click **Report** for a preview of the printed version of the treatment plan. **DO NOT CLICK PRINT.** This will print what you see on the page, which is not formatted.

![Edit Print Report](image)

d. You will now see a formatted version of the Treatment Plan which you can print out and give to the client.

![Application Icons](image)
e. The report is going to launch in a separate window. Click on this to open the report. Note that it may take several minutes to generate a report. Be patient.

f. Once you have the report opened, click on the little picture of the printer in the upper left-hand corner of your screen to print.
g. See below for information about the workflow with printed treatment plans where you do not have a signature pad.

Printed Treatment Plan Workflows (what to do if you don’t have a signature pad)

This workflow applies if you do not have a laptop and signature pad. If you meet with your client off site, you will want to create a draft of your Treatment Plan first to take to the client. Avatar allows you to print a Treatment Plan Report (above) from a draft. Do not finalize the report until you obtain the signature. If the client approves and signs the plan, you will also sign it. Then, when you return to the
office, turn in the signed copy in to a clerical staff who will scan in the document and route electronically to the client’s chart.

Once you have done this, reopen to the Draft Treatment Plan.

In the **Date client was offered a copy of the treatment plan** field, enter the date the client signed.

In the blank where it says, “If client has not signed the treatment plan, please explain,” explain that the client signed a paper plan that was then scanned in.

Then finalize and submit the Treatment Plan to Avatar.

### Creating a Treatment Plan Update

You will now create a Treatment Plan Update for your client. You will create an update when you want to add goals mid-year for the client. For example, you are a therapist. Your client already has a case manager and a psychiatrist and they’ve completed the tx plan a while ago. You are starting services somewhere mid-year in the Tx Plan cycle. You want to add your goals, etc... to the existing plan.

1. **Open a Treatment Plan form** from the client’s chart.  
   a. **Open the client’s chart** if you have not already done so.  
   b. **Click SC MH Treatment Plan** in the list of forms on the left in the Chart Overview. You should now see an **inquiry view** of the Treatment Plan you just completed.  
   c. **Click Add** in the upper right-hand corner of the screen to open a new form.  
   d. **Click Yes** when you see the pop up asking if you want to, “**default plan information from a previously entered plan**.”
e. **Default From Previous:** You will see a second pop up that provides a list of previous Treatment Plans for the client (the long bar with the plan name on it). For your client, there will be only one previous plan, but for other clients, you may see a whole list of other plans. If there is more than one plan, you will typically want to pick the most recent plan. An exception would be if there is a plan for short-term treatment, such as a psychiatric step down facility. You may want to not use this since the treatment is targeted and specific.

f. **Enter Plan Date:** You will see a third pop up asking you to enter the plan date. This is the first day you began services for the client. Click **OK**.
Santa Cruz Avatar

g. You will see yet a fourth pop up asking if you are sure you want to default information from a previous plan. Click Yes.

2. Enter the Plan Name: In this case, you are creating the first update for your treatment plan. The plan title will have the same start and end dates as your previous plan, plus "Update 1".

For example, if your initial plan was titled:

04/05/16 – 04/04/17 Initial

Your plan update will be titled:

04/05/16 – 04/04/17 Update 1

3. In the Plan Type field, you will select Update.

4. The Plan End date and the Review Date are auto populated with information from the initial plan. Note that the goal(s), objective(s) and/or intervention(s) you add today still expire on the Plan End Date and that the timeframe for your additions may be less than one year.

5. Was This Treatment Plan Discussed in a Language Other Than English? Notice that this question is pre-populated from the previous plan.

6. Problems Section (Table): In the Problems Section, you will see the client's previously entered problems/diagnoses. You may choose to leave this section as is, add a problem or, check off a problem that was previously left off of the Treatment Plan. Select or add problems according to your
treatment needs. You won’t be able to “uncheck” any problems because they are “in use” for the previously written goal(s), objective(s) and intervention(s).

7. **Plan Participants Section:** If needed, add your name and any additional Plan Participants. **DO NOT DELETE ANY PLAN PARTICIPANTS, to add yourself or other participants, click “new row.”**

8. Complete the rest of the fields on the page, click **Draft** and then click the **CLICK HERE to Launch Plan Builder** button to go to the Treatment Plan Builder portion of the form with your problems from the Problem List on the first page displayed.

9. You will now see the previous goals, objectives and interventions.

10. **To Add a new Goal, Objective or Intervention:**
    a. **IT IS VERY IMPORTANT TO CLICK ON THE PROBLEM, GOAL, OBJECTIVE ASSOCIATED WITH THE ITEM YOU WANT TO ADD, SO THEY ARE ASSOCIATED CORRECTLY WITH EACH OTHER.**
    b. In the example below, to add a new Objective to the Goal, “reduce overall level, frequency and intensity and anxiety...,” the text of the goal is highlighted in green. This must be highlighted like this to write a new Objective for this particular problem.

**Red Flags:** Remember to clear all the red flags before going back to the Plan Page. Red Flags tell you that the goal/objective/intervention has not been completed. **All of the red flags must be gone before you can finalize and submit your treatment plan.**
11. Click **Back to Plan Page** once you are done writing your goals, objectives and interventions. Remember, all of the red flags should disappear if you have filled in all the required fields.

12. If you are finished with your Treatment Plan, in the **Treatment Plan Status** field, select the **Final** radio button.

### Creating an Annual Plan

This describes how to create an Annual Update for your client. This is similar to completing an Update, but you will resolve any problems, goals, objectives and interventions before continuing.

1. **Open a new Treatment Plan form** from the client’s chart by clicking, “Add” in the Treatment Plan inquiry view.
   a. **Open the client’s chart** if you have not already done so.
   b. **Click SC MH Treatment Plan** in the list of forms on the left in the Chart Overview. You should now see an **Inquiry view** of the Treatment Plan you just completed.
   c. **Click Add** in the upper right-hand corner of the screen to open a new form.
   d. **Click Yes** when you see the pop up asking if you want to, “default plan information from a previously entered plan.”


  ![Default Plan Information Pop Up](image)

  **Do you want to default plan information from a previously entered plan?**

  ![Yes No Buttons](image)

  **Yes**  **No**

  ![Yes Button](image)

  **Yes**

  ![No Button](image)

  **No**

  ![Default From Previous](image)

  **Default From Previous:** Select the most recent shared plan. An exception would be if there is plan for short-term treatment, such as a psychiatric step down facility. You may want to not use this since the treatment is targeted and specific.
f. **Enter Plan Date:** You will see a third pop up asking you to enter the plan date. This is the annual date, one year from the plan date for the Initial Plan and one day after the Initial Plan expires.

![Avatar 2015 - Plan Date](image)

Click **OK**.

g. You will get a warning that you are entering a future date. This is OK. You may create an Annual plan up to one month prior to the expiration date of the previous plan. Additionally, it is good practice to begin the plan well in advance of the deadline to allow time for edits and to obtain needed signatures. Click **OK**.

![Avatar 2015 - Plan Date](image)

h. You will see another popup asking if you are sure you want to default information from a previous plan. Click **Yes**. The new plan will open.

![Avatar 2015 - Treatment Plan](image)

2. **Enter the Plan Name:** In this case, you are creating the Annual plan for your client. The plan title will have the same month and day the previous plan(s), just one year later.

For example, if your Initial plan was titled:
Your Annual plan will be titled:

04/05/17-04/04/18 Annual

3. In the **Plan Type** field, you will select **Annual**.

4. The Plan End date and the Review Date are auto populated with information from the previous plan. **YOU WILL NEED TO ADJUST THE PLAN END DATE WHICH SHOULD BE ONE YEAR MINUS ONE DAY FROM THE PLAN DATE.**

The plan dates will initially look like this. Note that the Plan End Date is incorrect.

You will need to adjust the Plan End Date to one year later. The Next Review Date will automatically change.

As with previous plans, add problems if needed. Add plan participants if needed. Edit the Strengths and Challenges as needed.

Note that the goal(s), objective(s) and/or intervention(s) you add today still expire on the Plan End Date and that the timeframe for your additions may be less than one year.
7. Click Draft and then click the CLICK HERE to Launch Plan Builder button to go to the Treatment Plan Builder portion of the form. You will now see the previous goals, objectives and interventions by you and by others.

8. **Resolve** any problems, goals, objectives and interventions that are no longer needed.
   a. Change Status from “Open” to “Resolved”
   b. Date Closed = Date Due

9. **Add New Goals, Objectives and Interventions**
10. Complete the plan using the same directions as with the Initial Plan and with Updates.

### Discharging Clients

Your first step is to complete a Progress Note OR complete a Treatment/Discharge Summary. You do not have to do both.

1. **Complete a Final Progress Note if billable services are provided in the final contact with the client.**
   If you have a final session/meeting with the client where you provide billable services, you will want to complete final progress note to document, as well as create a service charge for, the service. Include the discharge date in the note. You can only bill if you have interaction with the client on the date of closing that meets documentation criteria for Medi-Cal Specialty MH Services.

2. **Complete the Treatment/Discharge Summary form.** The Treatment/Discharge Summary form is a non-billable note where you can provide information about the course of treatment, reasons for discharge, client response to treatment, etc.. Note that there are sections on the form that may not apply to your workflow. Consult with your supervisor on how to best fill out this form.

3. **Remove the client from your caseload using the Caseload Assignment form.**

4. **Check to see if your client is open to other services within your Program of Admission.** For example, for County Mental Health (LE – 00044 Mental Health Outpatient), check to see if the client has a therapist, a psychiatrist, or any other provider associated with the Admission Program.

5. **If the client is discharging completely from all services within your Program of Admission, send a message to your supervisor that the Discharge form is necessary.** ONLY DO THIS IF YOU ARE THE LAST PROVIDER TO CLOSE THE CLIENT. If the client is still getting other services at your agency, the discharge form is not necessary. For most episodes (e.g. LE-00044 MH County Outpatient), you will use the Discharge form. (For the County – Pre Admit Program of Admission, you will use the “Pre Admit Discharge form”, not the regular Discharge form.)