



# Introduction to the Avatar Electronic Medical Record For AOD USERS Reference Guide





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## **TRANSITION PLAN/Conversion of Client Data**

(Daisy to Avatar/Paper to Avatar Scanning/Submission of Documents to MIS)

- 1. AOD clients will have a "Hybrid" chart meaning that some of the client's documents will live in a paper chart and some client documents will be completed on the computer or scanned and stored in the Avatar electronic medical record.
- 2. If you have a client that already exists in Avatar, then the current Avatar Client ID will continue to be used. (Client has Mental Health Avatar ID and they will have the same AOD Avatar ID).
- 3. A current client that is open in Daisy and transitioning to the Avatar system will be assigned an Avatar Client ID.
- 4. Demographic information and episodes for clients that have been opened to Daisy since July 2010 will be brought into the AOD Avatar system. The conversion of this data from *Daisy* **to** *Avatar* was completed in July, 2012.
- 5. Clients with "Private Pay" status will be excluded from the conversion to Avatar.
- 6. The "Private Pay" CalOMS Admission, Annual Update and Discharge" will be used for newly admitted **non-county** clients.
- 7. Clients opened using the Daisy CalOMS Admission document, and **then transitioning** *to* Avatar, will use the "Outside Provider/Private Pay" CalOMS Discharge document upon discharge. If a CalOMS Discharge is attempted, a pop up message appears "A CalOMS admission must be done first". Avatar does not recognize the CalOMS Admission that was done in Daisy. To prevent CalOMs errors, use the "Outside Provider/Private Pay CalOMS Discharge".
- 8. Required entry fields that were yellow in DAISY, will now be RED in Avatar.
- 9. AOD Counselors and Case Managers will be **restricted** to their **own** caseload. The exception is if coverage is needed due to illness/vacation or if a new client is being referred to a caseload. AOD Intake Staff and Clinical Managers will not be restricted to Caseload and can search for any client. The AOD Counselor/Case Manager will need support staff assistance to assign clients to their caseload.
- 10. Wherever you see the terms *therapist/clinician* in Avatar documents/reports, this refers to Case Manager/Counselor roles in AOD.
- 11. The Avatar Compliance and Consent form is an attestation that required documents have been completed. Be sure to complete this form in Avatar and then scan these documents into the Avatar electronic record.
- 12. The screen shot examples and other examples in this manual have been created using "Test" clients so the information *you* enter or episodes you may see for a "real" client may be different.
- 13. This reference guide is considered to be a working draft during the pilot and 6 month implementation phase. During this pilot phase, documents and reports will be tested. Your feedback will most certainly result in to forms, reports and this reference guide. Your feedback is necessary and valued. Please provide feedback to the Avatar implementation team and to Michele Friedman (650) 573-2668, mfriedman@smchealth.org.





#### Introduction to Avatar - AOD Users

#### Welcome to Avatar!

This reference guide focuses on how to **navigate** through the Avatar Electronic Medical Record and describes the types of entry fields used to input client data. Information is presented in sections; each section includes a written description, including visual screen shot examples. As a new Avatar User, you are required to take the "Introduction to the BHRS Avatar Electronic Medical Record Training" which is narrated and includes step by step demonstrations. Follow the paths for AOD Users. This training is located at: <a href="http://www.smchealth.org/onlinetraining">http://www.smchealth.org/onlinetraining</a>.

AOD Users are also **required** to take the online "HIPAA for BHRS- Mental Health and AOD" Training located at the same online site. Anyone may take the other online trainings for how to write Progress Notes and how to create the Client Treatment and Recovery Plan but they **MUST** be taken if they apply to the work you will be performing.

You will find information at this online site <a href="http://www.smchealth.org/avatar">http://www.smchealth.org/avatar</a> useful. There are links to Avatar reference guides, contact information and other resources.

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

You will learn which Avatar documents include important clinical/fiscal and administrative client data and where these documents are located. You will learn which documents are required to be scanned into Avatar.

You will learn <u>how</u> to contact the Access Call Center if you want to have a Client Alert placed on the client Avatar record. The Client Alert is an electronic pop up window but works like a "Post It Note" on a paper chart. The Client Alert will provide important information to other care providers if there is an urgent concern regarding a client's safety to self or others or other emergency.

You will learn about some important <u>reports</u> that will help you manage your client caseload (AOD Documentation at a Glance) and provide a snapshot of an individual client's AOD care (AOD Client Dashboard).

You will learn about <u>Chart Review</u> which is the client's legal Avatar Electronic Medical Record.

This reference guide does address the 7 levels of AOD treatment requirements and will clarify when paper or electronic Avatar documents are to be used.

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





# Section 1: What is Avatar?

- San Mateo BHRS's Electronic Medical Record/Information System.
- Avatar meets a Federal mandate to convert paper medical records to electronic medical records by 2015.
- Avatar integrates clinical, fiscal, administrative and management information in one place.
- Avatar provides access to client information 24/7- helps clinical teams make decisions and handle emergencies, and provides client care coordination for the treatment team.
- Avatar improves quality and continuity of care and minimizes the time managing paper records and finding lost charts.
- The Avatar software application was purchased from NetSmart Technologies and is used by 28+ California counties.
- Avatar has been operational in San Mateo County since July, 2010, for Mental Health programs.
- Demographic information and episodes for clients that have been opened to Daisy since July 2010 will be brought into an AOD Avatar record. The conversion of this data from *Daisy* to *Avatar* will occur in July, 2012.
- AOD providers will have a "hybrid" medical record/chart due to strict CFR 42 regulations. This means the chart for AOD clients will have paper documents and Avatar electronic documents.





## Section 2: How Do I Login to Avatar?

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

## A. How to Connect to the VPN

#### VPN Client v.5.0.0.2 Installation for Contractors

How to Uninstall Manually the Cisco VPN Client 5.0.0.2 Windows XP/Windows 7 - Cisco Systems – 32-bit machines

Complete these steps in order to install the Cisco VPN Client:

1. Exit all Windows programs and disable any Antivirus software.

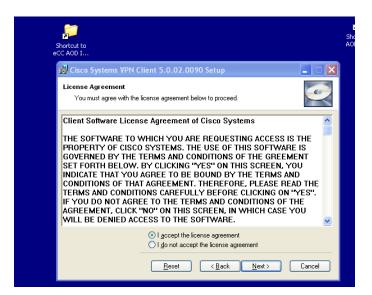
2. **OK**. If you have the installer on your local hard disk, navigate to it and double-click to run the installer.

The program displays the InstallShield Setup window.

Double click on **vpnclient\_setup.exe.** 



3. Accept Cisco license.



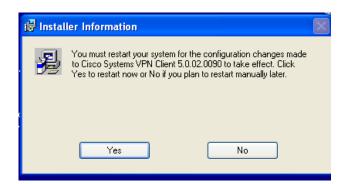




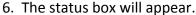
4, Program will install to C:\Program Files\Cisco Systems\VPN Client – click next, next and allow the program to install.

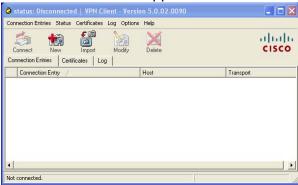
Once the program has installed you will see this message, click **Finish (depending on your system if may require your computer to reboot.** 





5. Once the machine has re-booted, go to **Start, All Programs Cisco VPN Client, click on the yellow padlock.** 







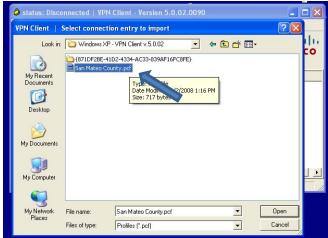




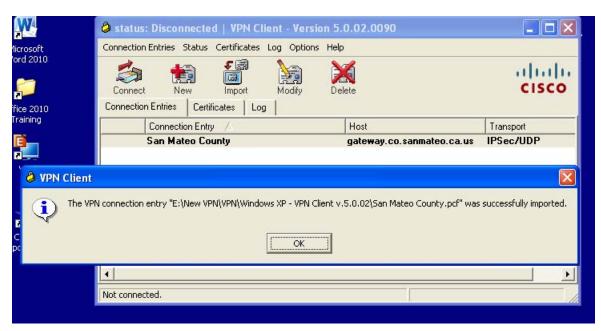


7. Select import – go back to where you have the Cisco installation files and select **San Mateo County.pcf**, then click **Open** 





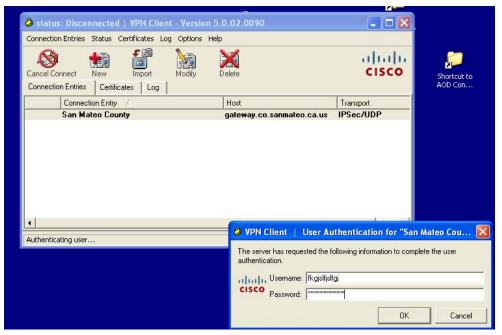
8. The VPN Client should read was imported successfully, Click Ok and the Connect



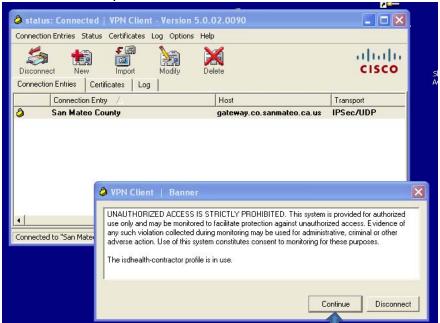
9. Enter your VPN username and password, then click connect







Once connected you will see the VPN Client Banner - Status Continue



Now you are ready to connect to Avatar. – Go to Ir ernet Explorer and type in – http://symid1/ntst.radplus or click on your deskt p Avatar icon.

# B. AOD User Login - all BHRS Avatar Users

#### First:

Log-On to Windows on your computer.





#### Second:

See if you have the Avatar icon to determine if the Avatar application has or has not been installed on your computer.



This is the Avatar icon.

You can look for the Avatar icon on your desktop  $\rightarrow$  click to open the application.

Or

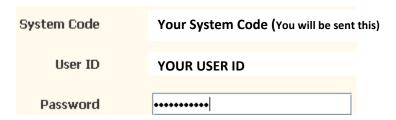
You can look for the Avatar icon through your START menu  $\rightarrow$  click to open the application.

Or

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

#### Third:

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



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

You will be prompted to enter **your own** password - 8 characters; at least 1 must be a number.

• Remember your password; Avatar gives you 3 tries to enter your password correctly. If you forget, if you didn't use the cap lock and/or if your log-in fails, your password will need to be reset by contacting the ISD Help Desk at (650) 573-3400.

**NOTE:** Avatar automatically locks your screen after 30 minutes to 1 hour of no use - you may receive a warning that time has elapsed since last use; you can cancel the warning and remain active or if you need, just log back in.

## C. About Passwords

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

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





- Minimum 8 characters
- Must contain at least one numeric and one alpha character
- Case sensitive- recommended that you use all caps for the alpha characters
- You will be prompted to change your password every 90 days. The prompt will appear only
  once, so when the prompt appears, <u>change your password</u>. Once your password has expired
  or if you forget your password you will need to get your password reset through the Help
  Desk.

## D. Help Desk



Forgot your password? Got locked out? Contact ISD Help Desk at 650-573-3400

ISDHelpDesk@co.sanmateo.ca.us

## E. Ethics/Your Role/Your Password

- The Password that you generate is **YOUR** signature.
- No one has access to your password; however, it can be reset if you are locked out.
- <u>NEVER</u> give out your password; it is a HIPAA violation and sanctions may be applied.
- <u>Confidentiality</u> If you know a client or family member, it is your professional obligation to report this to your supervisor. You will not be assigned this client and the medical record will be blocked/restricted to uphold strict confidentiality protections on behalf of the client.
- When you meet with your client, ask if they have a family member working for or receiving services from the BHRS system; if so, that medical record will also be blocked/restricted.
- Off caseload activity can be monitored and Avatar access can be restricted if necessary. Do
   Not Go Off Your Caseload! An exception may be if you are providing coverage for another
   clinician

ONOW you know how to Log-in to Avatar and get HELP!

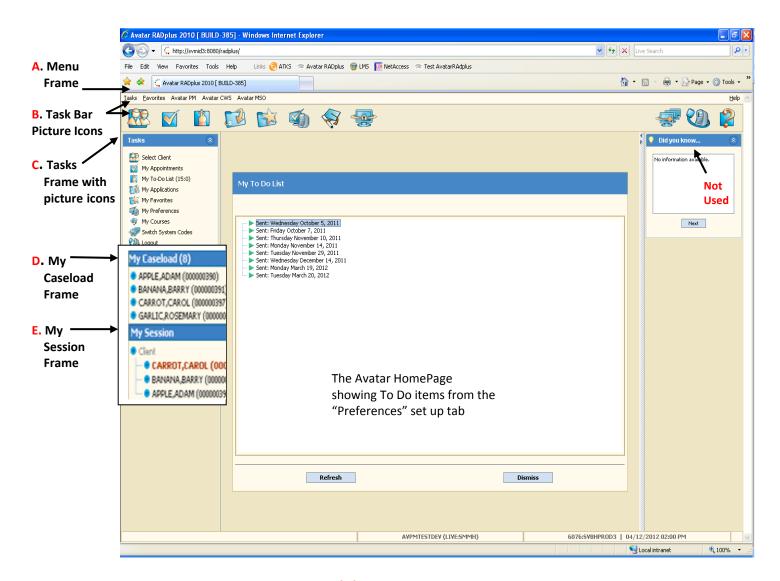




## **Section 3: The Avatar Homepage**

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

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



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

⚠ You can select a task command from **any** one of these 3 places:





Menu Frame Task Bar/Picture Icon Tasks Frame

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



Stay below this tab.

A. Menu Frame (A) Tasks, Favorites, Avatar PM, Avatar CWS, Avatar MSO and Help (locate on the right side of the Menu Frame). Each option contains menus and sub menus that you will select to do your work.

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



(A) <u>Tasks Menu Options</u> - The Tasks Menu in the Menu Frame, is a drop down menu that includes:

Select Client, My Appointments (not used), My "To Do" List, My Applications (not used), My Favorites, My Preferences, My Courses (not used), Lock, and Logoff

- (B) <u>Favorites Menu</u> This menu is a shortcut that allows you to go *directly* to a form or report you use most frequently. Click on "Favorites" the forms or reports you have set up will appear on your homepage screen; select one and the document or report will open. You can right click on a client name in My Caseload or My Session and select a "Favorite".
- \* Please see Appendix # 2 for How to Create Favorites.
- (C) <u>Avatar PM Menu</u> Practice Management this menu contains Client Management, Utilities functions, and is the *administrative* area of Avatar for tasks such as: business/billing, call intake, admission, family registration (UMDAP) and discharge tasks. **Much of the AOD work will be done through the Avatar PM Menu.**

<sup>\*</sup> The menu options in **bold** are discussed in more detail below.





(D) <u>Avatar CWS Menu</u> - Clinical Work Station - this menu contains the clinical features: Assessments, Treatment Plans, Progress Notes, Infoscriber (Medications) and Reports. **Some AOD work is through this menu**; CWS provides a multidisciplinary, integrated view of client information.

## **Other AVATAR Menu Resources**

<u>Avatar MSO Menu</u> - This menu is designed for the private provider network to credential providers, authorize services, adjudicate claims, and reimburse providers. It is not currently used for AOD tasks.

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

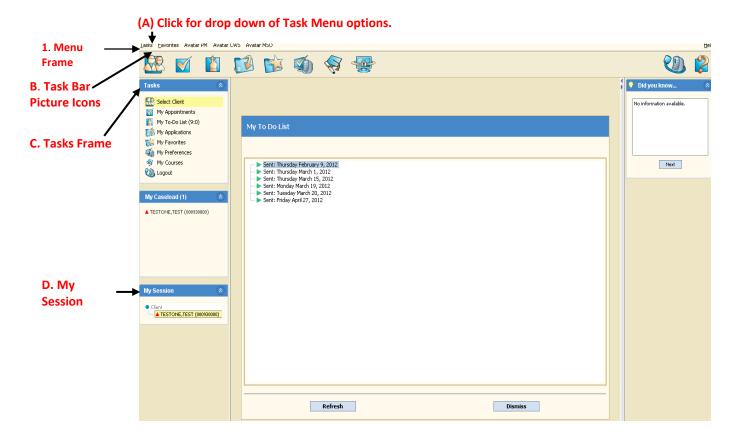
<u>Avatar Document Imaging Menu</u> - This menu allows electronic scanning of information to include electronic versions of paper that is normally included in a client's chart. For example, if external clinical information is received from a hospital, it must be scanned in to the client's Avatar episode; or, if the client signs a paper version of the treatment plan or consent, the plan or consent must be scanned into the client's Avatar episode.

**Help Menu** - this menu links to online documentation and search options.





## B. TASK BAR/PICTURE ICONS (B) and the TASKS FRAME (C)





# Select Client

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

#### You can **Select or Search for a Client** by entering:

- \*Avatar ID (aka Medical Record Number or MRN),
- \*LastName,
- \*LastName,First (no space),
- \*LastName, First JR (space only before title),
- \*LastName, First MI (space only before middle initial. Hyphen and apostrophe allowed within names),
- \*Birth Date;
- or \*Alternate Look Up:

Social Security #;

Alias - LastName, Alias;

Soundex-Similar Sounding Name (e.g. Browne vs. Brown).

⚠ Please see Appendix #1, for a step by step "how to" select a client





When you search for a client, you should only search for a client related to your job responsibilities!



## My "To Do" List

"My To Do List" is a reminder that you need to review or complete an important item. (E.g., Items left as DRAFT). "My "To Do" function can also notify if a client has been added/deleted from a caseload. You can set your Avatar Homepage to display your list of "To Do" items by going to "My Preferences", Tab 3.



# My Favorites

The "Favorites" function allows you to create a short cut to YOUR most often used documents or reports. Avatar has two ways to add Favorites to your list and you can learn about both of them in Appendix 2. Using Favorites will save you a lot of time getting to the documents and reports you use most often.



#### My Preferences

This Avatar feature allows you to choose options for spell check and to specify which window appears on your Avatar homepage after you log in to Avatar.

Go to the Tasks Frame (C), slide your cursor down to My Preferences and click. The window will open and show 3 tabs.

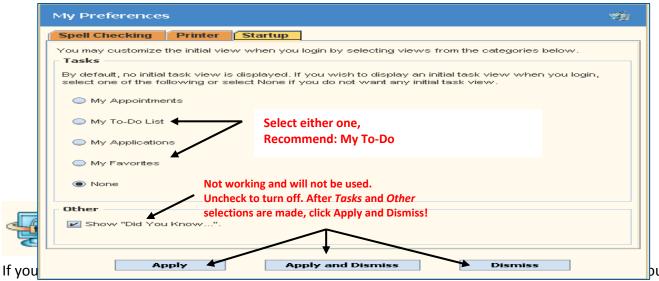
Under the **General** Tab, select - **Use Microsoft Word Spell Checker** and **ALWAYS check spelling from start of text**. Go to the bottom and Click **Apply**.

Skip the **Printer Fonts** Tab: It is NOT used. If you change any of these settings it would make reports print incorrectly!

Under the **Startup** Tab, Select Either **My "To Do"** or **"Favorites"** for the initial view that you will see on your Avatar Homepage screen when you open Avatar. **The setting of My Favorites is recommended!** When you are finished, at the bottom of the My Preferences window, make sure you **click Apply** to **save your changes or Apply and Dismiss** to apply the changes and close the window. If you want to exit the screen without saving your changes, **click Dismiss**.







leave your computer for short time. Locking the application restricts unauthorized access. You will be required to enter your Avatar Password to unlock Avatar when you return; however, the screen will be at the exact state where it was before it was locked.



#### <u>Logoff</u>

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

USE THIS METHOD, NOT the in the upper right corner of the Avatar window. Once you Logoff, you can then use the red close button in the upper right hand corner of Internet Explorer.



#### Help

Help provides <u>links</u> to online documentation and search options. The **question mark** provides a hyperlink that connects you with the most current versions of Avatar reference guides. When you click on Help and select "Search For Option", you can type in a few letters of the form or report name you need, then click the Search button at the bottom of the window. Avatar will provide a list of forms and reports matching the letters/words you entered for the search and you can go directly to that form from the list – or you can add it to your Favorites. You may need to try your search a few times if you are unsure about the specific name of the form/report you are looking for.

## Refresh Menus

There is no icon for this option. This command is found in the "Tasks" menu and will allow any new report or feature that may have been added while you have been working in Avatar, to become available in your menu or on your screen once you select refresh.



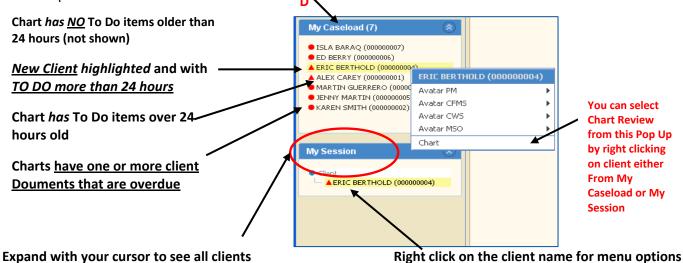


**C. My Caseload Frame (D)** Displays all active clients assigned to you. Clients remain in this frame until they are discharged or transferred to another program. If there are clients listed in the "My Caseload" frame, you can **scroll** to see **all** clients in the caseload **or** you can bring your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

In addition, you will see indicators *preceding* a client name:

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

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

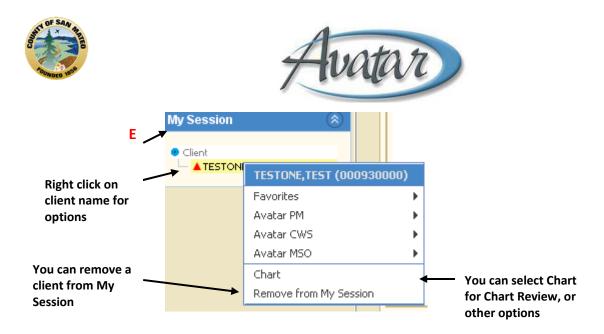


(Reminder: Do Not Go Off Your Caseload, except if you are providing coverage for another clinician!)

# D. My Session Frame (E)

My Session displays all clients you access/look at during your current session. When you logout, the My Session frame clears. You can right click on a client name in 'My Session' (E) for the pop up window that shows the menu options described above. From this pop up window you can also remove a client from "My Session" if you don't plan to work with the client again in this session. (Shown below)

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



You will learn about "To Do" Items later in this manual, See Section 12.

## E. Switch System Codes

Some Avatar users work for organizations that provide both Mental Health and AOD services. Those users have two System Codes assigned – one for Mental Health and one for AOD work. Clients enrolled in that program will have an episode opened for Mental Health services and another opened for AOD services.

Avatar users in these organizations must pay close attention to the type of information they are documenting in Avatar. If the information relates to AOD treatment, the staff person must document within the AOD episode using the AOD System Code. The same is true for Mental Health treatment where the user must document within the Mental Health episode using the Mental Health System Code.

AOD information will not be available when a user is logged in to the Mental Health System code. Mental Health information will not be available when a user is logged in to the AOD System Code.

The System Code for Mental Health is always "SMMH".

The AOD System Code is assigned by organization. For example, let's say the ACME Program provides both AOD and Mental Health services to County BHRS clients. The System Code for ACME's AOD work is "ACME" while the System Code for Mental Health work is "SMMH". A staff member would use the ACME System Code to complete an ASI or a CalOMS Admission document. If completing an annual Mental Health assessment for a client, the staff person would use the SMMH System Code.

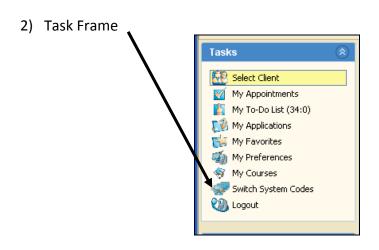
To help users move easily between System Codes, Avatar has a method called "Switch System Codes". This command is found in three places:

1) Picture Icon Bar

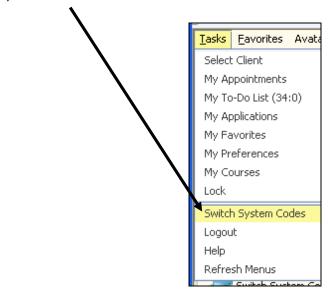








3) Task Menu in the Menu Frame



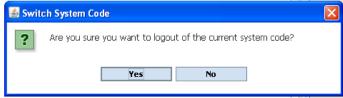
Switching System Codes is a short cut way of logging out and logging back in to Avatar to move between working on AOD or Mental Health documentation.

#### Switch System Codes:

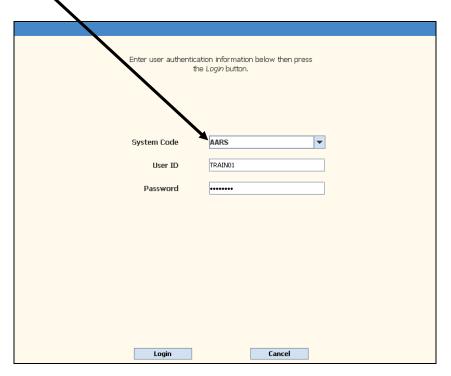
- 1) Before you switch system codes, be sure you have saved and closed any open Avatar forms.
- 2) Click on "Switch System Codes" using one of the three methods listed above.
- 3) Click on "Yes" in the dialog box that pops up. (See below.)







4) Select the correct System Code from the drop down list. Your User ID and Password are the same. Only the System Code changes



5) Click on the "Login" button to complete the process.

**○** You now know about Avatar Menus, Tasks Options and Avatar terms! You know How to Select a Client! You understand the need to complete or review your work through "To Do"! You can Create Favorites and Preferences! You know how to Lock and Logoff!



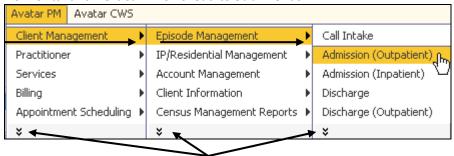


## **Section 4: Navigation Features in Avatar**

Some of the options and/or documents used in this manual may not be part of **your** Avatar menu. The examples may show a form, report or document that you may not use. **Please** follow along, **navigation features are the same!** 

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

Horizontal and Vertical Arrows lead to Sub-Menus



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

**B.** <u>Windows</u> When you open a client-related document, it opens in a *Client Window*. Many documents may be open within that 1 *client window*. For example, the screen shot below shows a *client window* that contains **open** documents for this client; look at the bottom, the <u>Urgent Care Plan</u> document is on the left, the <u>Client Alert</u> document is in the middle and <u>Chart Review</u> is on the right. (A)

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

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

When you open a *client window* be sure to use the **'Rule of 3'** checks to confirm you are viewing the correct client.

Rule 1: Client name is orange/active in "My Session";

Rule 2: Client name matches with client name in blue title bar and

Rule 3: Client name in the line just below the toolbar.





## C. Tabs

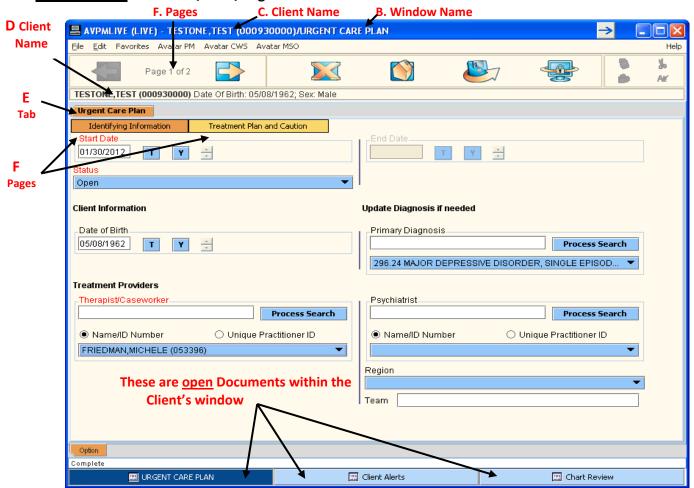
A document may be divided into *Tabs*. A *Tab* divides a window into smaller pieces (e.g. a tab is similar to a tab that would identify a section of a paper record). If there is more than one *Tab*, you must complete information for each *Tab*. You can switch between *Tabs*. The active *Tab*, the one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

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

## D. Pages

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

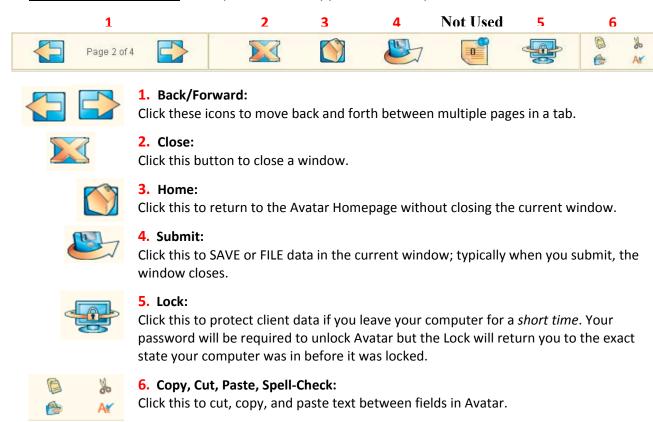
#### E. Screen Shot Windows/Tabs/Pages





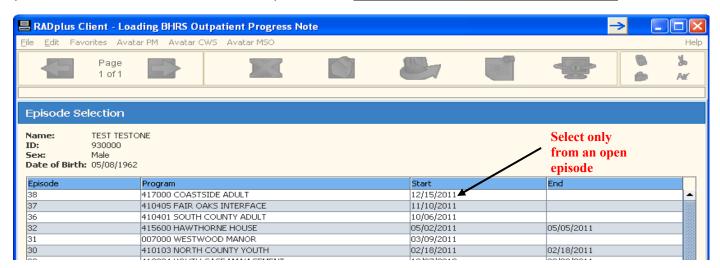


**F.** The Option Toolbar The option toolbar appears at the top of all windows in Avatar.



# **G. Selection Screens**

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



AOD ONLY programs will only show the open episode for their own program, an AOD program also providing MH services will show all episodes.





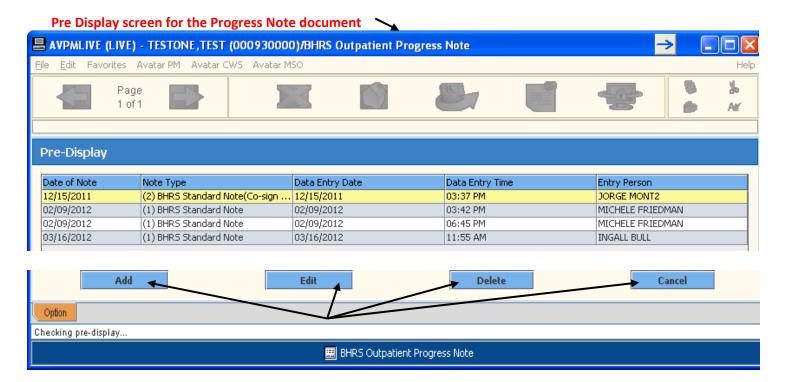
**Episode** - References to *episode* mean the opening (admit) and closing (discharge) at a *program*. A client may have <u>many</u> episodes of care. If the *Episode Display Screen* appears when you select a document or report, you **MUST** select the <u>correct open episode</u>, the **open episode**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

\* AOD ONLY programs will show the open episode for their own program and any previous episodes from their own program.

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

2. Pre-Display Selection Screen: This screen shows previous entries of documents (progress notes in the example below) that have been made, for example, a document in Draft that needs to be finalized. When you select *Progress Note* from the CWS Menu this pre-display screen of outpatient progress notes will open if there are previous progress notes saved in Draft. This screen provides 4 options: Select Add to create a new progress note; select Edit to edit a note that is in Draft; select Delete to remove a Draft document; select Cancel to leave the progress note option and return to the homepage.

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







# H. Format and Entry Types Used in Avatar

**1. Field Colors:** Field names are either <u>black</u> or <u>red</u>. Any field in **Red** is a <u>required field</u> and must be completed in order to submit information. For AOD users, whatever had been <u>required</u> and <u>yellow</u> in DAISY, is **RED** in Avatar!

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

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



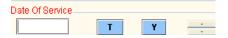
**NOTE:** If you are "Color Vision Deficient" you may submit a request to the Help Desk through your supervisor to have your Avatar "User Code" changed. All fields will then appear in **black** with required fields in **BOLD** and **UNDERLINED.** 

#### 2. Date Entry:

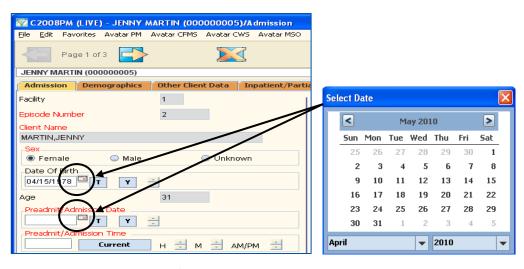
Dates are always saved in a MM/DD/YYYY format. When entering a date, you can type it in the format MMDDYYYY without including the slash ("/") separation character. On leaving the date field, Avatar will insert the slashes ("/") for you.

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

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



There is also a 'Date Picker' tiny calendar icon outside of the date entry box that brings up a calendar to select a Date. Once a date is selected it will default into the field.







**3. Single Select Entry Choice:** You are **only** able to **select one** from a radio button, drop down or check box.

Draft/Pending Approval/Final	
Draft	O Final
O Pending Approval	

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

As a result of the primary diagnosis the client has the following impairments:			
	Treatment is being provided to address,	or prevent, significant deterioration i	n an important area of life functioning
	School / Work Functioning	Social Relationships	Daily Living Skills
	✓ Ability to maintain placement	Symptom Management	

#### 5. Dropdown List Selection:

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

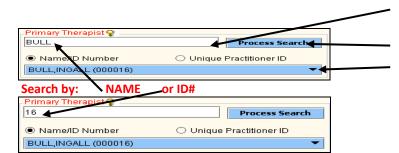


If the entry is for a required (red) dropdown list, you must make a selection.

#### 6. Process Search Entry:

<u>Process Search</u> requires you to make an entry in the blank white Search box to the left of the Process Search button (highlighted in blue), click the Process Search button, and then click on the correct selection so that it populates the blue box. Process search entries are common in Avatar; enter enough letters and/or numbers to identify the entry you're looking for. Examples of some searches are for staff member names, service type names/codes etc. The entry can be a number or few letters or the complete name of a person or service type. When the Process Search button is clicked, a pop up box displays the results matching your criteria and requires a selection to be made. Once you answer 'OK', or select the entry, it will populate the required blue Avatar field located below the Process Search button. You **MUST** <u>search</u> and <u>select</u>. If the blue field is empty, Avatar considers nothing was entered and you will not be able to submit your document.

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



- 1. You can enter a name or ID in the white box
- 2. Then click process search
- 3. Then choose the correct selection so it populates the blue box.





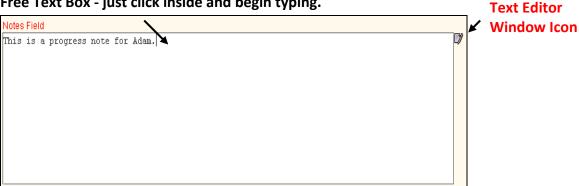
NOTE: You can clear an entry in a date, radio button, multi-select, drop-down list or process search field by making the field active and pressing the [F5] key.

#### 7. Free Text Box:

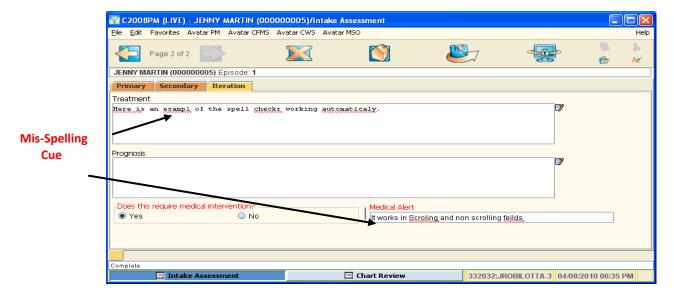
The **Notes Field** of the Outpatient Progress Note is an example of a *free text box*. A Free Text box allows you to enter as much text as needed in the box. Click once inside the text box and begin typing. Once the box is full, text can be viewed by scrolling vertically on the scroll bar that appears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

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





In scrolling and non scrolling text fields, any misspelled words will have a visual cue (the word(s) will be underlined in red), similar to Microsoft Word or Outlook. "Name" and "Process Search" fields do not have these indicators.

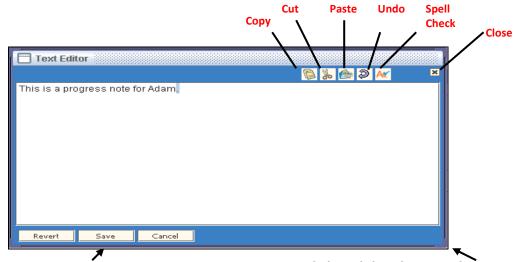






#### **Text Editor Window**

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



Be sure to save.

Click and drag here to change size of window.

#### COMMAND DESCRIPTION

**Copy** Copies selected text to the clipboard.

**Cut** Moves selected text to the clipboard.

**Paste** Pastes information from the clipboard to the location of the cursor.

Undo Reverses the last action.

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

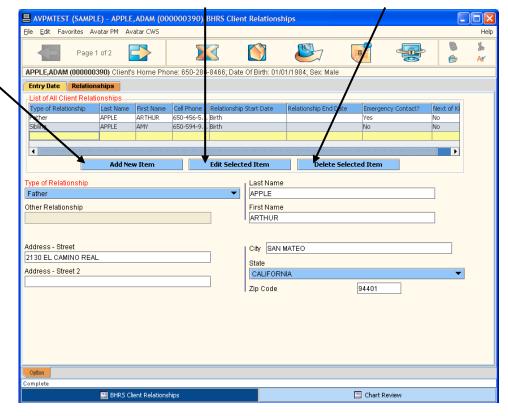
You **MUST** click **add new item** before adding a new row or filling out fields for the new entry. Be very careful as **existing information** will be overwritten if you do not click **ADD NEW ITEM!** 





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

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



#### To Add, Edit and Delete Entries in the Table

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

#### 9. Other Helpful Tips:

At top right of document: DO NOT USE the RED X to close a window in Avatar. The exception to the rule is for Reports. You have to use the RED X to close Crystal reports. Once you have logged out of Avatar, you can use the RED X as you normally do.

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

**Bundle**: Documents in a bundle are grouped together in forms/windows that are related within a process. An example is the AOD Admission Bundle (Outpatient). When you select that bundle, it opens all the Admission documents which include Admission (Outpatient), CalOMS Admission, Assign to Caseload and AOD Funding Source.





**Light Bulb** indicates that a Help message is provided for the field the Light Bulb is attached to. For example, the Light Bulb associated with the field Service Types displays a list of the Service Types and descriptions you can enter. To view the Help Message, hover over the light bulb with your mouse or click on it.



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



## **Important**

- Always look at the screen and the command you have selected to see what you are being asked to do: submit, save, file, apply, dismiss, add, ok or cancel.
- Usually a left click selects an option and a right click performs an action.

Now you know the **Avatar Menus**, **Tasks**, **Commands**, and **Toolbar Options!** You also know the Navigation Features and can enter data in the Format and Entry Types used in Avatar!





# <u>Section 5:</u> AOD and BHRS Information Sharing and Viewing (HIPAA Protocols/42 CFR, Part 2/ Access to Avatar and Client Information) Consents to Treatment; Releases of information; Notice of Privacy

#### A. 42 CFR, Part 2

- 42 CFR, Part 2 are federal regulations that govern confidentiality of alcohol/drug treatment and
  prevention records. Congress recognized that due to the stigma of addiction, heightened privacy
  protections were needed to encourage people to get treatment.
- Question: How can alcohol/drug treatment records be successfully incorporated into an electronic health records (Avatar) system when 42 CFR, Part 2 regulation has **strict** protections?
- Answer: **Client consent is required** to include alcohol/drug treatment information *without* violating 42 CFR, Part 2.
- General Rule: A program covered by 42 CFR, Part 2 may not disclose information that identifies
  a client directly or indirectly as having a current or past drug/alcohol problem, or as a
  participant in a Part 2 program, unless the client consents in writing or another exception
  applies.

#### B. HIPAA

- HIPAA sets minimum privacy protections for all health information held by:
  - \* Health care providers who transmit health information electronically in connection with "covered" transactions (such as billing, administration includes most alcohol/drug programs).
  - \* Health Plans and
  - \* Health Care clearinghouses
- Most alcohol/drug programs must comply with HIPAA as well as 42 CFR, Part 2, however, HIPAA
  is more permissive and allows many disclosures that 42 CFR, Part 2 does not.

#### C. What to do if 42 CFR, Part 2 and HIPAA impose different requirements?

- Follow both laws, if possible.
  - \* HIPAA *permits* disclosures of health information (including alcohol/drug treatment) *without consent* for treatment, payment and health care operations.
  - \* 42 CFR, Part 2 prohibits these disclosures without consent or other specific authorization.
- So follow 42 CFR, Part 2.

#### D. 42 CFR, Part 2 and State Laws

- States may not require disclosures prohibited by 42 CFR, Part 2 **BUT** States may impose *additional* confidentiality protections.
- Example;
  - \* Law in State X requires compliance with subpoena.
  - \* 42 CFR, Part 2 does **not** permit disclosure of information in response to a subpoena for alcohol/drug records unless the client consents or a court issues a specific order.





\* If there is no client consent or court specific order per 42 CFR, Part 2, then the alcohol/drug program would not comply with the subpoena without client consent because no State law may authorize or compel a disclosure that's prohibited by 42 CFR, Part 2.

#### E. What is a "Disclosure?"

- "Disclosure" refers to communication of *any* information, whether in writing, orally, electronically or by other means that contains client identifying information such as having a past or current alcohol/drug problem or having been a past or current client or even applied for services to a 42 CFR, Part 2 alcohol/drug program.
- Client identifying information includes name, address, social security number, fingerprints, photographs or other information by which client's identity can be determined with reasonable accuracy/speed.

#### F. Permitted Disclosures of 42 CFR, Part 2

#### Consent:

- \* May disclose most client information if the client signed a consent that complies with 42 CFR, Part 2 and if the consent hasn't expired or been revoked.
- \* Consent **must** be in writing (no oral consent) and in plain English.
- \* Consent must be completed on the proper form with all required fields filled in and contain:
  - Name or general designation of program(s) making the disclosure;
  - Name or title of individual(s) or name of organization(s) permitted to receive the disclosure (recipient)
  - Name of client whose information is being disclosed
  - Purpose of disclosure; how much and what kind of information to be disclosed
  - Signature of client and/or other authorized person
  - Date consent signed
  - Statement of client's right to revoke the consent except if the program relied on it
  - The date, event or condition of expiration if not previously revoked no longer than necessary to serve stated purpose
- \* Re-disclosure notice required by the disclosing party to recipient, must not re-disclose client information "unless further disclosure is expressly permitted by written consent of person to who it pertains"
- \* A single Part 2 consent form for disclosures to different recipients for different purposes is **permitted** as long as the form makes it clear what information may be given to which recipients for which purpose.
- \* A single Part 2 consent form can be used to authorize disclosure, as well as, authorize redisclosure of Part 2 information to other identified recipients.

#### Medical Emergency:

\* 42 CFR, Part 2 programs **may disclose** client identifying information **without** consent to medical personnel if there is an immediate threat to an individual's health, or if immediate medical intervention is required.





- \* Disclosure is permitted to medical personnel only. Medical personnel may re-disclose client identifying information without need of consent.
- \* Disclosure in medical emergency is not permitted to family members.
- \* Any health care provider treating a client for a medical emergency is allowed to make the determination that a medical emergency exists.

#### Internal Communication:

\* Disclosure without client consent OK:

<u>Within a program:</u> To entity with "administrative control" that needs information in connection with their duties or in order to provide the alcohol/drug services, like the billing department.

<u>Crime on program premises/against program personnel</u>: can report crimes committed or threatened on program premises or against program personnel. May only disclose suspect's name, address, last known whereabouts, status as a client of the part 2 program

<u>Court Order</u>: special provisions, subpoena alone does not satisfy 42 CFR, Part 2

<u>Research/Audit – Evaluation</u>: Disclosure of client identifying information permitted without consent but researchers are prohibited from using it for any other purpose or re-disclosing it except for back to the program. Disclosure for Auditor/Evaluator used for audit purpose and may be re-disclosed only back to program, pursuant to court order to investigate/prosecute the program (not a client) or Government agency overseeing Medical audit/evaluation

<u>Child Abuse/Neglect Reporting</u>: Disclosure is required by State law and 42 CFR, Part 2 permits disclosure per State law for the initial report and written confirmation of the report. 42 CFR, Part 2 does not permit disclosure of records for ongoing investigation, including confidential communications – without court order

<u>Duty to Warn</u>: found in State law, 42 CFR, Part 2 does not impose a duty to warn or duty to disclose but guides when disclosures may be made, not when they must be made.

<u>HIPAA's additional requirements</u>: A program may not put conditions on treatment, payment, enrollment or eligibility of benefits on client signing the consent nor can the program impose consequences for refusal to consent.





## **Section 6: Client Intake**

A. <u>Admission (Outpatient) NOT Bundled</u>: Please follow instructions for "1. ADMISSION (Outpatient) below.

**B.** <u>Admission Bundle</u>: The Admission Bundle includes the forms Admission (Outpatient); AOD Caseload Assignment; Client Relationships; CalOMS Admission; and AOD Funding Source. If you select the bundle, once you complete and submit a document, the next document in the series will automatically appear.

**Path for Admission Bundle:** GO TO Avatar PM→ Client Management→ Episode Management→ Admission Bundle

#### 1. ADMISSION (Outpatient)

The Select Client screen will pop up for you to search for the Client. (See screen shot below)

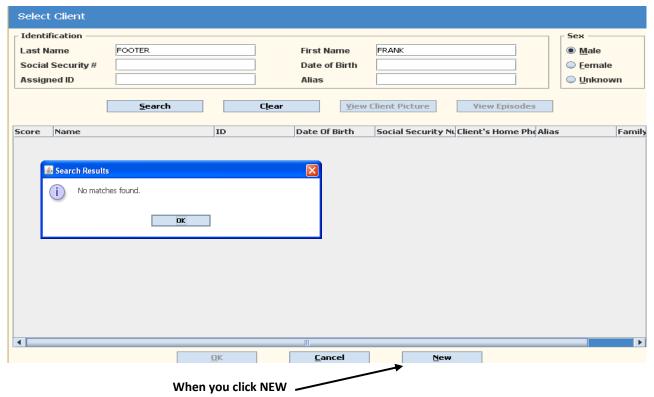
Enter the client's last name, first name, sex and then click search. Try to narrow your search by including as many **identifiers** as are available to you including an alias to avoid creating a duplicate record! If the pop up message indicates "None Found", click OK, go to the bottom and click on "New".

If the Search returns a list of names, review the list carefully. If none of the names in the list are the client, go to the bottom and click on "New".

It's possible that you may find the Client's information within the list. If you do, highlight the Client's name in the list, go to the bottom and click on "OK". If you find duplicate clients in Avatar, contact your BHRS Contract Analyst to correct the information.







Avatar will automatically assign the Client a unique numeric ID if the Client is new. A pop-up window will display asking to auto-assign the next ID number. Select "YES" to assign the ID number and continue with client registration.



If the client has any current or previous episodes with your Program/Team, a pre-display screen will display. You may select an admission episode you want to edit or you can select **ADD** to create a new admission.

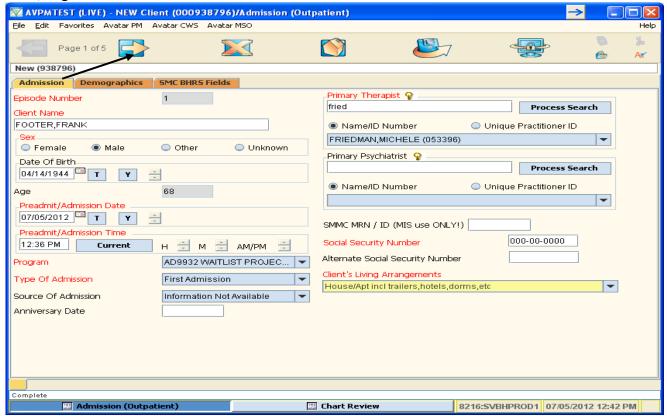
The Admission (Outpatient) document has 3 tabs. Tab 1/Admission has 3 Pages (5 pages show, only 3 pages used); Tab 2/Demographichs has 2 Pages; and Tab 3/SMC BHRS Fields has 1 Page.

If the client has other open episodes, some of the fields will be pre-populated.





Tab 1, Page 1 Admission



You will enter the RED/REQUIRED fields:

- Episode Number will auto populate
- Enter: Date of Birth
- Enter: Admission Date
- Select Current for Admission Time
- Select Program
- Select Type of Admission from the drop down arrows,
- Ignore Anniversary Date,
- For Primary Therapist (Counselor) enter the full last name or part of the last name of the Client's primary counselor, then click Process Search. Select the correct name from the list it displays so it populates the blue box,
- Enter: the Social Security Number Be sure to include the dashes (-).
- Select the *Client's Living Arrangements* from the drop down arrow



#### Important

Some Avatar users work for more than one organization that uses Avatar. Make sure you select the correct Counselor/Clinician name when assigning the Primary Therapist. Users who work at more than



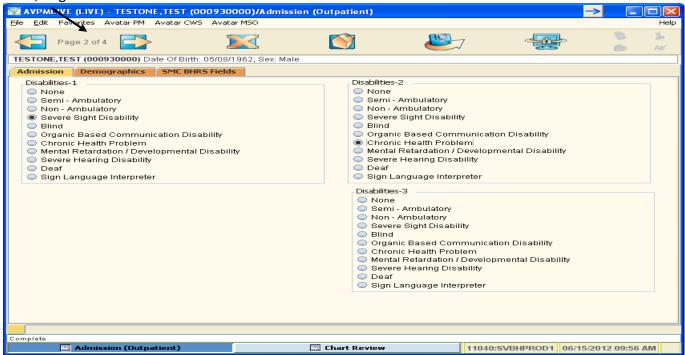


one Avatar organization will have two names in Avatar – each name will have a System Code attached to it. Select the staff name that corresponds to the System Code for your organization.

Example: Jane Solon works for ACME Inc and ZENITH Ltd who both have BHRS contracts. Jane has two names set up in Avatar – "Jane Solon ACME" and "Jane Solon ZENITH". When assigning a client to Jane, be sure to select the name that corresponds to your program – either ACME or ZENITH.

Go to the top of the screen and click the right arrow to go to Page 2 of Tab 1.

Tab1, Page 2 Disabilities

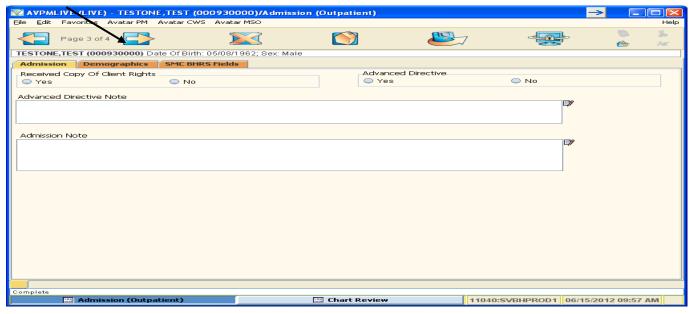


This screen allows entry for 3 different disabilities. If you select None in Disabilities 1, Disabilities 2 and Disabilities 3 will remain grey. A selection in Disabilities 1, allows an entry for Disabilities 2. If none is selected, Disabilities 3 remains grey. A selection for Disabilities 2, allows for an entry in Disabilities 3.

Tab 1, Page 3 Client Rights, Advanced Directive and Admission Note







Select "Yes" or "No" to indicate if the Client received a copy of "Notice of Privacy Practice" (Client Rights).

Normally the Advanced Directive field is **not** answered. If "Yes" is selected for Advance Directive, the Advance Directive Note box becomes RED/REQUIRED and you must enter a note in the field Advanced Directive Note. If you select "No" the Advance Directive Note box will turn grey.

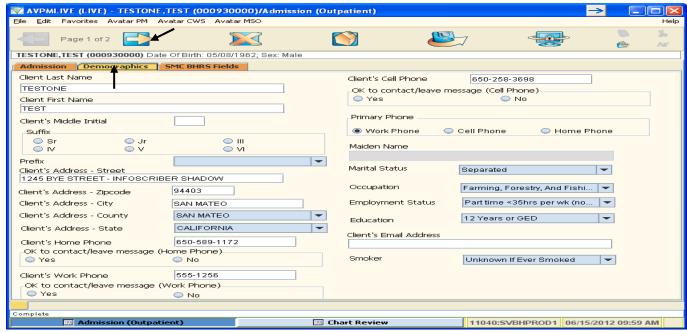
Write an Admission Note in the Free Text Box for any information related to the admission.

Next go to Tab 2, Demographics by clicking on the Demographics tab label.

Tab 2, Page 1 Demographics

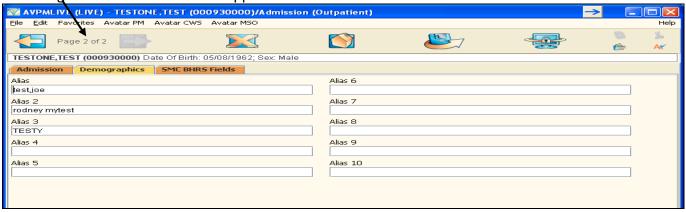






Enter all known information, then click the arrow to go to Page 2 of Tab 2

Tab 2 Page 2 Continue to enter all applicable information.



Tab 3, SMC BHRS Fields is not used.

# C. AOD Caseload Assignment:

Once you submit the Admission (Outpatient) document, the *next* form in the bundle is: AOD Caseload Assignment

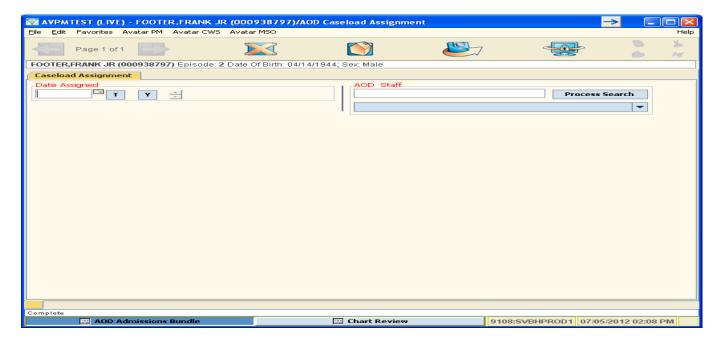
**Path:** Avatar CWS → New Options → AOD Caseload Assignment

Use this form to assign the Client to the Caseloads of all staff on the team that will work with this Client. Anyone who provides services to the client should have the client in his/her caseload. For some teams,





that will mean all counselors will be assigned to each client. Other teams may have only one or two staff persons assigned to a client.



- Date Assigned select the correct date
- AOD Staff Enter the AOD Staff by entering the complete name or a few letters of the last name, click Process Search and select the correct staff so it populates the blue box.

Click **Submit** to save the information. Continue adding the Client to the caseloads of all staff who will participate in the treatment of the Client.

If the client has already been assigned to a caseload and you need to change the caseload assignment please see *BHRS Assign to Caseload* in the Appendix.

# D. AOD/BHRS Client Relationships:

The next form in the Admission (Outpatient) bundle is BHRS Client Relationships

**Path:** Avatar PM→ Client Information→ BHRS Client Relationships

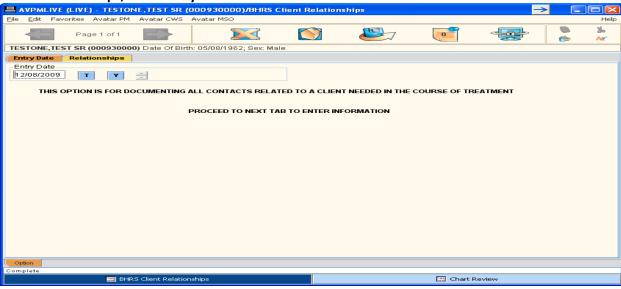
Client Relationships is the "container" of client contacts - non-treatment team individuals the client identifies as being involved in their life. The Client Relationship document allows entry of Emergency Contact, Parent/Guardian, Next of Kin, Spouse/Partner, Teacher, Parole Officer, Conservator, Sibling,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





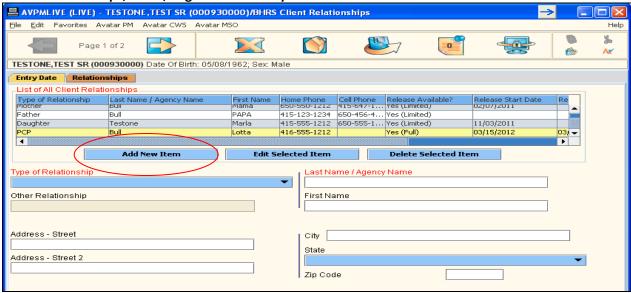
The AOD Client Relationships document has 2 tabs. Tab 1 requires an entry date. (See below.)

Client Relationships, Tab 1 Entry Date



Once you have entered the Date, click on Tab2, Relationships

Client Relationships; Tab 2, Page 1 Relationships



This screen shows information is entered and stored in a grid or *multiple entry table*. You must click *Add New Item* to add a new person to the table and then complete the related data fields below the table. Be careful so that **existing information does not get overwritten.** 

If entering Client Relationships as **not** part of the bundle, make sure the client is active in MY Session, then open the BHRS Client Relationships form.





To **Add a Person**, *Click* the **Add New Item** button. **Do not enter new data without adding the new row** or the new data you enter will overwrite existing information in the active highlighted row of the table!

To **Edit an existing Person/Relationship**, *select the row* you want to edit, *click Edit.* The related fields below the table become populated with that Person's information. Make changes by typing directly into the fields.

To **Delete an existing Person/Relationship,** *click on a row* to select it, *click Delete selected item* to remove the row from the table. A message will appear verifying that you want to delete the selected item, click YES.

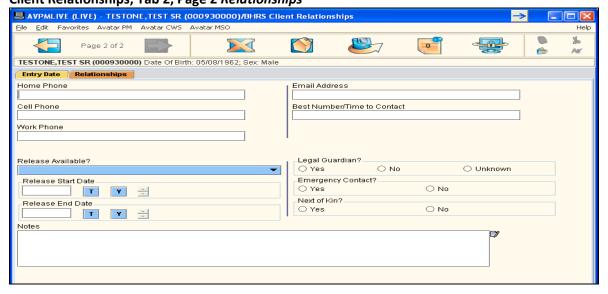
If you Add, Edit or Delete be sure to click Save/Submit so the changes will be saved.

Use Client Relationships to record a Consent to Release Information. If the person or organization for which you have a Release is not already in Client Relationships, add them to the form. In the section recording Release information indicate the following:

- Release Available? Selections are No, Yes (Limited), Yes (Full). Select the appropriate answer.
- Release Start Date Enter the Release Start Date
- Release End Date Enter the Release End Date
- Notes If you selected Yes (Limited), describe what information is and is not allowed by the
  release signed for this person/organization. Use the Notes field to clarify anything important to
  understand about the release.

Do not leave blank rows in the table; blank rows must be deleted before you can save the form!

Client Relationships; Tab 2, Page 2 Relationships







#### Continue to complete fields as applicable



Then, Submit

If Client Relationships information is not correct or has not been entered into Avatar, it can not be reported out and will not be available when you need to contact a client's relationship. Be sure to check in regularly with your client about the status of these contacts and update as necessary.

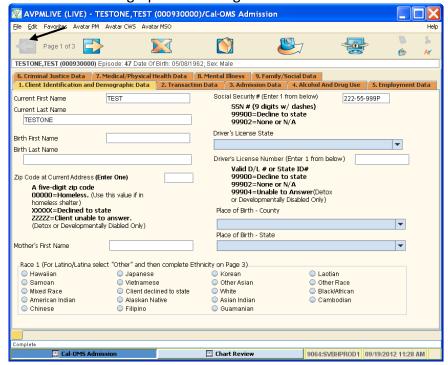
## E. CalOMS Admission:

As part of the Admission (Outpatient) bundle, this document opens automatically. If your program is required to perform a CalOMS Admission, the data required for CalOMS will be the *same* as what you entered in Daisy, but the "flow" of **asking and entering** CalOMS information into Avatar will be **different**. Be patient! It will just take a little while for you to make the adjustment to the Avatar flow.

<u>Path</u>: Avatar PM→ Client Management→ Client Information→ CalOMS Admission Bundle

There are 9 tabs for this document (remember to look for pages within each tab)

Tab 1, Client Identification and Demographic Data: Page 1



Enter the data in the applicable fields

Birth Last Name or First Name: use 99902 for none or not applicable





- Social Security Number: Enter 99900 for Client declines to state, 99902 for none or not applicable
- <u>Zip Code</u>: At current address, must be valid 5 digits. Enter 00000 for homeless, XXXXX for Client declined to state
- <u>County of Birth</u>: Used only if born in California. Enter a California county ONLY. Enter "Other" if born outside of California.
- State of Birth: Enter USA state ONLY or "Other" if born outside of USA.
- <u>Driver License #/State</u>: Enter 99900 if client declines to state driver's license number, 99902 to indicate none or not applicable.
- Mother's First Name: If unknown, use "Mother"

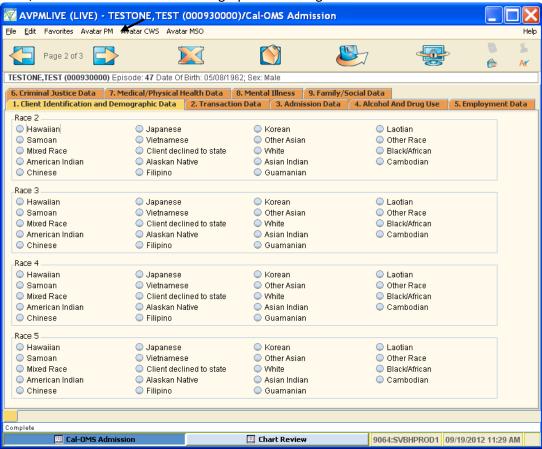
For any "Client Unable to Answer" use 99904; however, this answer and code are to be used only if the provider is Detox or Residential Detox.

Tab 1, Page 1 allows for 2 Race entries on this page, you may enter 3 additional "races" on the next page. When you complete Page 1, click the right arrow at the top to move to page 2.





Tab1, Client Identification and Demographic Data: Page 2



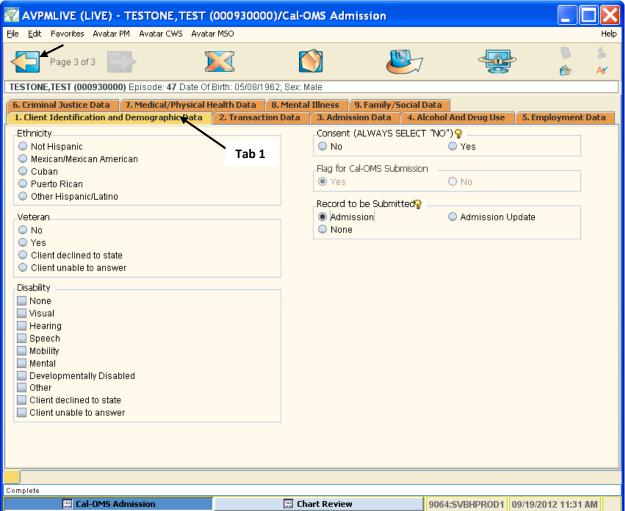
Allows additional entry for 4"races". Select actual races rather than "mixed race" category.

Click the right arrow at the top to move to Page 3





Tab1, Client Identification and Demographic Data: Page 3



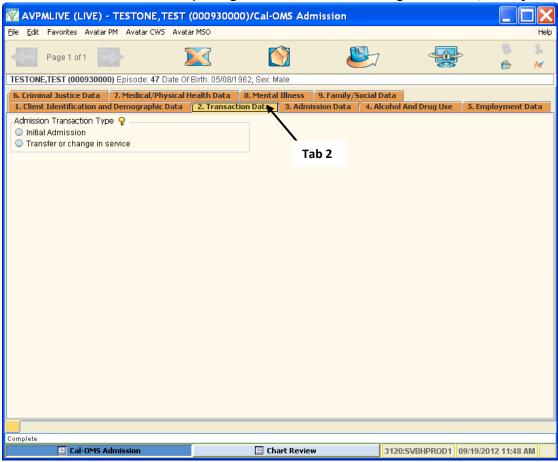
- Ethnicity select from list what client identifies with.
- Veteran status; "unable to answer"99904, used ONLY if provider is Detox or Residential Detox.
- <u>Disability</u>, may enter more than 1 disability, if applicable. "Unable to answer" 99904, used ONLY if provider is Detox or Residential Detox
- <u>"Consent"</u> default answer is "No" (click on light bulb). "Consent" identifies whether a client has given consent to be contacted in the future.
- <u>"Flag for CalOMS Submission"</u>, select "Yes". This indicates all CalOMS data will be flagged for submission to the State as required.

Next, Go to Tab 2, Transaction Data





Tab 2- Transaction Data - Only 1 Page Select if Initial or Change in Service/Transfer



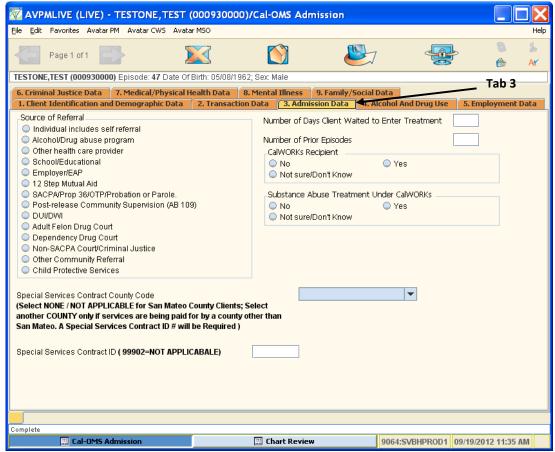
**Initial Admission**: New Admission or 30+ Days Interruption in Treatment Services. **Transfer/Change** with less than 30 Days Interruption in Treatment Services

Next go to Tab 3, Admission Data





Tab 3, Admission Data - Only 1 Page. Select the Source of Referral

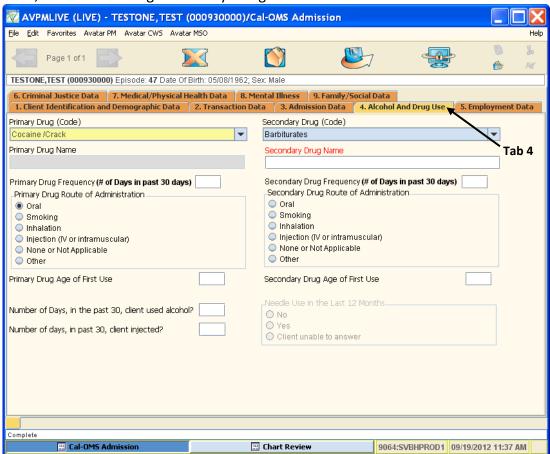


- Source of Referral select the primary referral source (select one).
- <u>Number of Days Waited to Enter Treatment</u>: enter the number of days on waiting list before being admitted to *your* treatment program due to limited capacity. Do not include days client was waiting in jail. Enter 99901 for Not Sure/Don't Know; Use 99904 if Client unable to answer and ONLY if provider is Detox or Residential Detox.
- <u>Number of Prior Episodes</u>: Enter the total number of prior episodes (0-99) in any alcohol or drug treatment/recovery program in which the client has participated. Enter 99900 if Client declined to state; 99901 for Not Sure/Don't Know. Use 99904 if Client unable to answer and ONLY if provider is Detox or Residential Detox.
- <u>CalWORKS Recipient</u>: Identifies if the Client is a CalWORKS recipient. Enter "Yes", "No" or "Not Sure/Don't Know".
- <u>Substance Abuse Treatment Under CalWORKS</u>: Identifies if the Client is undergoing substance abuse treatment under CalWORKS. Enter "Yes", "No" or "Not Sure/Don't Know".
- <u>Special Services Contract County Code:</u> Identifies if the paying county is *not* San Mateo County. If you make an entry, the Special Services Contract ID field below, becomes a *red*, *required* field.
- Special Services Contract ID: Enter the code, 99902 for none or not applicable.





Tab 4, Alcohol and Drug Use - Only 1 Page



#### **Enter Primary Drug of Choice:**

Select the Primary Drug by clicking on the arrow of the drop down box. What you select may require additional information, such as the Primary Drug Name and/or a required entry for Primary Route of Administration.

For example, if selection for Primary Drug of Choice is **alcohol**, drug name becomes grey but drug route automatically populates with oral.

If Cocaine/Crack is selected as the Primary Drug of Choice, then Primary Drug Route of Administration requires you to select multiple entries, as applicable.

To the Right of Primary Drug Entry is Secondary Drug. You will enter the same as for Primary Drug.

 <u>Primary/Secondary Drug Name</u> is required for Primary/Secondary Drug: If selections are any of the following you need to enter the drug name: Barbiturates, Inhalants, Other Amphetamines, Other Club Drugs, Other Hallucinogens, Other Opiates or Synthetic, Other sedatives or hypnotics, Other stimulants, Other Tranquilizers, Other (Specify), Over the Counter, Tranquilizers.





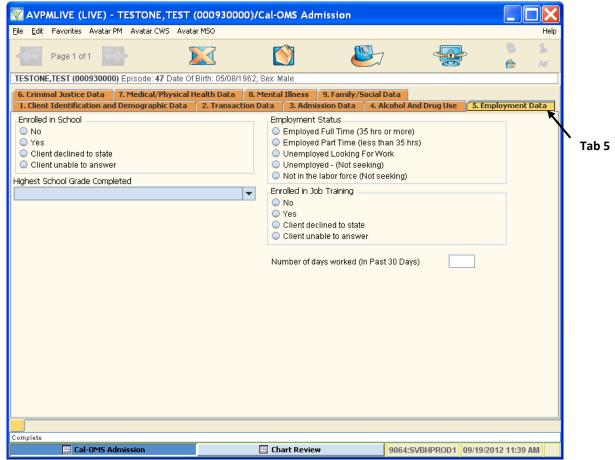
- <u>Primary Drug Frequency:</u> (Past 30 days), Enter the frequency for how many days in the past 30 days has the client used the Primary Drug. Enter (0-30) or 99902, for none/not applicable. For <u>Secondary Drug Frequency</u> (Past 30 days) *enter the same as for Primary Drug*.
- <u>Primary Drug Age of First Use:</u> Enter age from 5-105 or 99904 if client unable to answer and ONLY if provider is Detox or Residential Detox. For <u>Secondary Drug Age of First Use</u>, *enter the same as for Primary Drug*.
- For Alcohol Use in Past 30 days: Indicate alcohol frequency ONLY if the Primary and secondary Drugs are NOT alcohol. Enter 0-30, 99900 for client declined to state or 99904, if client unable to answer and ONLY if provider is Detox or Residential Detox. If alcohol *was* the primary drug, this field would be populated automatically with 99902.
- <u>Number of Days, in Past 30 Days that Client Injected</u>: Enter the number of days client used needles to inject drugs in the last 30 days. This entry field will ONLY become active if a drug can be injected. Enter 0-30, 99900 for Client Declined to State or 99904, for Client unable to answer and ONLY if provider is Detox or Residential Detox.
- <u>Needle Use in the Past 12 Months</u>: Enter "Yes", "No" or 99904, Client unable to answer and ONLY if provider is Detox or Residential Detox.

Now, Go to Tab 5, Employment Data





#### Tab 5, Employment Data-Only 1 Page



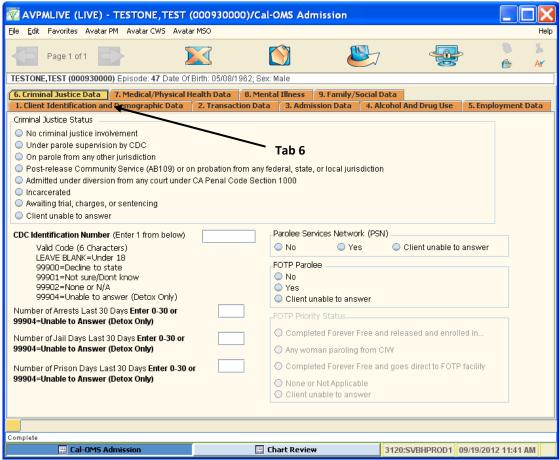
- <u>Enrolled in School</u>: Enter "Yes", "No" if Client currently enrolled in school. Select, Client Declined to State or Select, Client Unable to Answer ONLY if provider is Detox or Residential Detox.
- <u>Highest Grade Completed</u>: Enter the highest school grade completed (0-29) or 30+ years. Select by clicking on the arrow of the drop down box.
- Employment Status: Select the Client's current employment status.
- <u>Enrolled in Job Training</u>: Enter "Yes" or "No" if the Client is currently enrolled in Job Training.
   Select, Client Declined to State or Select, Client Unable to Answer ONLY if provider is Detox or Residential Detox.
- <u>Number of Days Worked in Past 30 Days</u>: Enter 0-30, 99900 for client declined to State or 99904, Client Unable to Answer ONLY if provider is Detox or Residential Detox

#### Go to Tab 6, Criminal Justice Data





### Tab 6, Criminal Justice Data-Only 1 Page



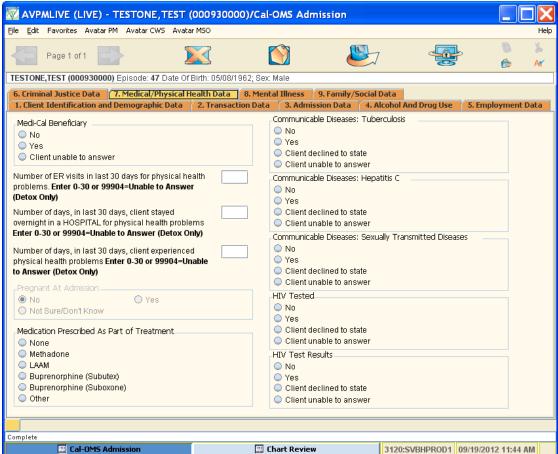
- <u>Criminal Justice Status</u>, select one from the list. if none, CDC ID # populates with 99902. For any other selection, enter the CDC ID #.
- Number times arrested in last 30 days,
- Number of days in jail past 30 days,
- Number of days in prison last 30 days.
- Parolee Service Network yes/no
- FOTP Parolee,
- FOTP Priority Status

## Go to Tab 7 Medical/Physical Health Status





Tab 7, Medical/Physical Health Data – Only 1 Page Enter data as applicable. If male client, Pregnant at Admission fields are grey.

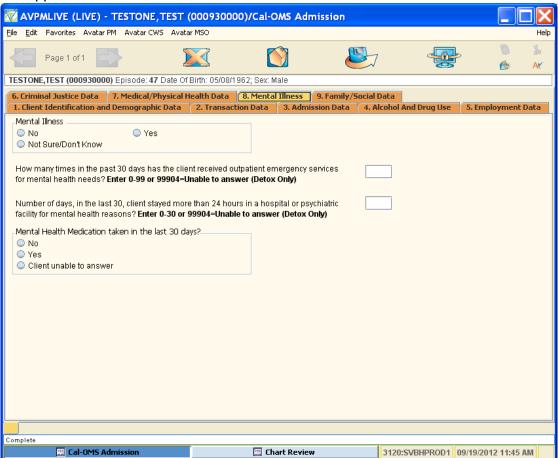


Go to Tab 8 Mental Illnesses





Tab 8, Mental Illness – Only 1 Page Enter data as applicable.

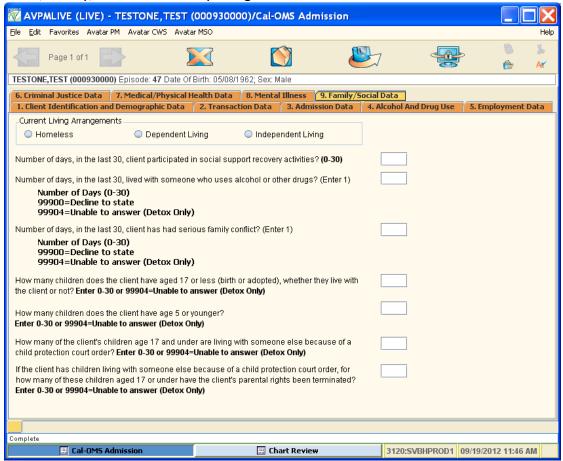


Go to Tab 9 Family/Social Data





#### Tab 9, Family/Social Data - Only 1 Page



Select Current Living Arrangements. Answer additional questions as applicable

Save the form by clicking on the Submit icon.

When saving, if you haven't completed all the fields, Avatar will display a prompt. Click on the button "Return to Form" to complete entry of CalOMS Admission. Avatar will display a list of the CalOMS fields that are incomplete.









# F. AOD Funding Source Information

Use this form to keep track of the funding source assigned to clients enrolled in your program. The form allows you to assign a funding source with Start/End dates and notes. Funding Source information can be changed as needed by your program to the point of allowing you to delete Funding Source assignment forms and enter new ones. The information recorded in this form is used to display Caseload and Program Census reports organized by Client funding Source.

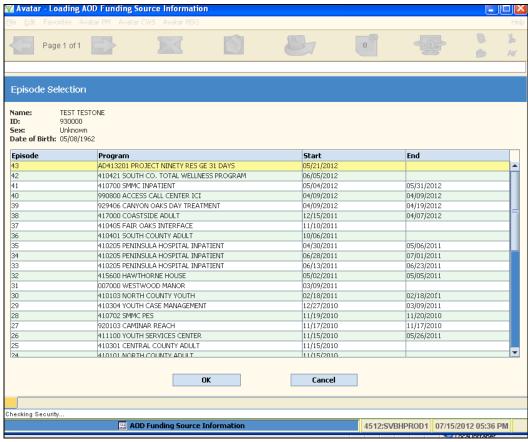
**Path**: Avatar PM → Client Management → Account Management → AOD Funding Source Information

When you select this form, if you do not have a client active in My Session, you will have to select one. . After your client selection, select the client's episode. Notice that the episode selection includes closed episodes. Make sure you are selecting the right episode to assign Funding Source Information

Highlight the correct episode and click on the button labeled "OK" at the bottom of the window.







If the client already has one or more Funding Sources assigned, the next screen displayed will be the Funding Source Information Pre-Display. Your options are:

ADD – Add a new Funding Source assignment for this client.

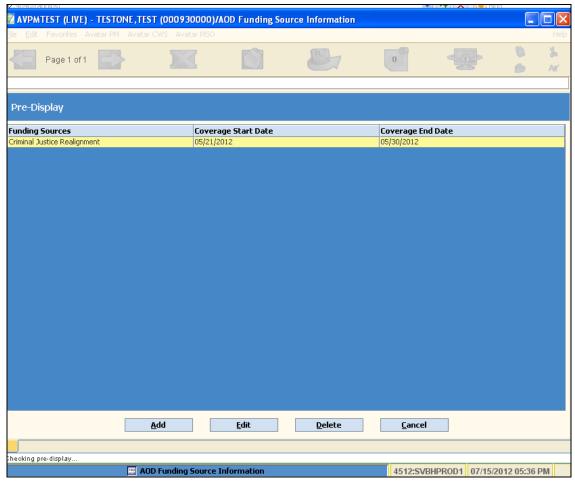
EDIT – Edit an existing Funding Source assignment for this client. Highlight the form you want to edit and click on the EDIT button at the bottom of the window.

DELETE – Delete an existing Funding Source assignment for this client. Highlight the form you want to delete and click on the DELETE button at the bottom of the window.

CANCEL – Allows you to Exit out of the option.







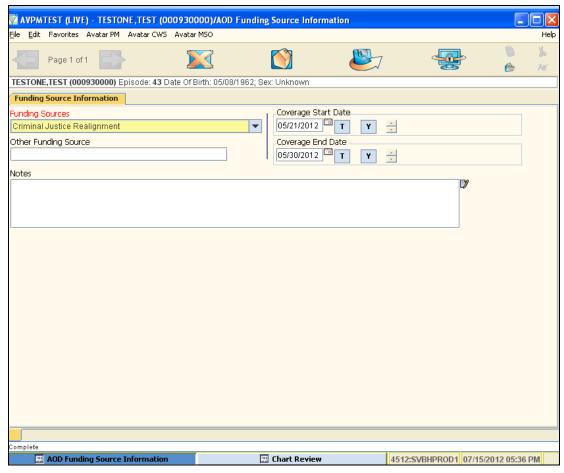
The Funding Source Information form is one page. The fields available to you are:

- **Funding Sources** A drop-down list of available funding sources. If the funding source you wish to assign is not in the list, select "Other" and type in a description of the funding source in the text field labeled "Other Funding Source".
- Coverage Start Date Enter the Start date for this funding source coverage.
- Coverage End Date Enter the End date for this funding source coverage if you know what the date is.
- **Notes** A free text field for you to record relevant information for this funding source.

Once the information is filled out, click on the Submit icon to save and exit the form.







# G. <u>Health Questionnaire</u>:

You will use the form you are currently using at your program. Be sure to scan this document into Avatar! See Section 19, Scanned Documents regarding scanning.

#### H. Allergies and Hypersensitivities

This form was developed to allow the ability to document your client's allergies and hypersensitivities.

Path: Avatar CWS→Other Chart Entry

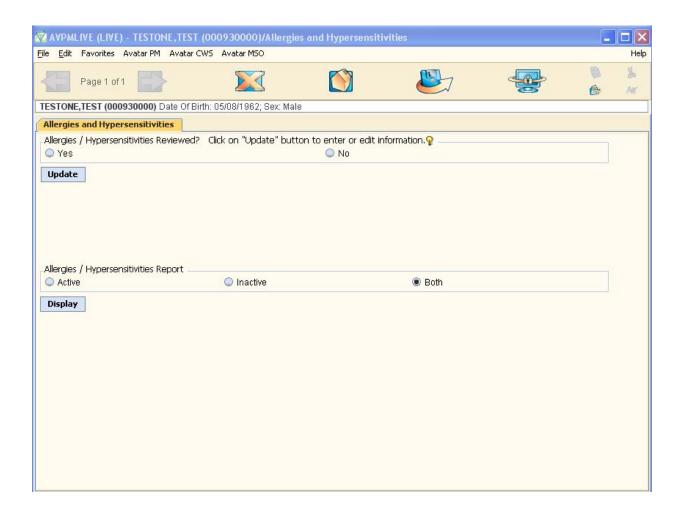
To add or update a client's allergy information, click on the "Update" button to open the data entry form. (See screen shot below.)

**TIP!** Click the Help light bulb icon for the list of allergen categories that can be used for recording client's allergies.





Once you have updated or reviewed the data entry form, click the "Yes" radio button on the opening screen to indicate you have reviewed the allergies / hypersensitivities, and then Submit / Save .







#### **UPDATE PAGE**

To enter new entry, click on "New Row" button at the bottom of the window. Avatar will add a blank row. Fill in the applicable information for the fields:

- Allergen/Reactant your choices are "Animal", "Drug", "Environment", "Food", "Latex", "Other", "Plant". Type in one of the choices to indicate the category that applies to the allergen/reactant you are recording.
- Date Recognized enter the date. Double click within the field to show a calendar for date selection.
- Status select "Active". Double click within the field to display the available answers.
- **Reactions** double click within the field to display and select your answers. You may select more than one of the reactions listed.
- Reaction Severity double click within the field to display and select your answers. You may
  only select one of the severities listed.
- **Comments** type in the name of the specific allergen(s) in this field. If you type in more than one, separate the words or phrases by a comma. For example, if a client is allergic to plants, type in the names of the specific plants in comments Grasses, Cedar trees, pollen.

To edit an existing field, click inside it.

To **delete** a row, highlight the row by clicking on a field within the row and click on the blue "Delete Row" button on the bottom of the window.

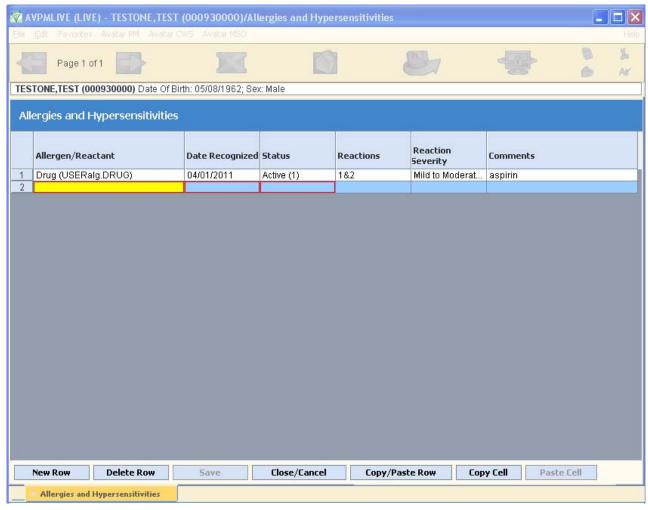
Make sure you **save** the information you've entered by clicking on the blue "Save" button on the bottom of the window. Once you save the information, the data entry form will and the opening form will display.

To **exit** the data entry form without saving it, click on the blue "Close/Cancel" button on the bottom of the window.

**TIP!** Remember also to click "Submit" to save into the system. Saving allergy and hypersensitivity information is a two step process: 1) Click the "**Save**" button within the data entry form, and 2) **Submit** the form when exiting.





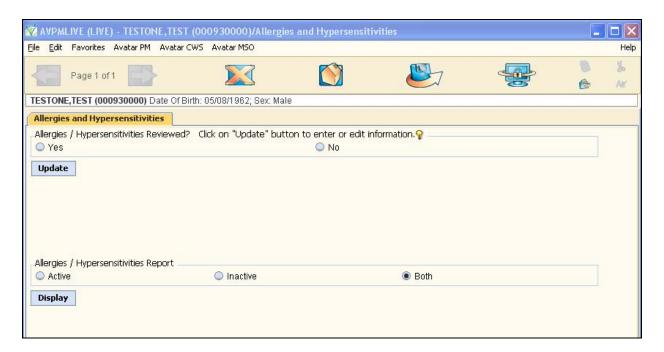






# THE ALLERGIES / HYPERSENSITIVITIES REPORT

The report will display all of the allergy and hypersensitivity information recorded for the client. To view the report, from the opening screen (see screen shot below), look at the section titled "Allergies / Hypersensitivities Report". Since there are no Inactive entries available in the system, the radio button of "Both" as status for running the report will be the default. To open the report, click the "Display" button.







The report will look similar to the screen shot below:

Run Date: 6/25/2012						Page 1 of 1
		А	vatar CWS v4.	.0a		·
			Sample Repo	rt		
			Header			
	Client	Allers	ries / Hyn	er sensiti vit	ies	
		_		gies/Hypersens		
	including A	ctive and	illacuve Allei	gies/ityperseits	idvides	
Client Name: TEST, TESTONE	STONE Client ID: 6					
A llergen/R eactant	Status	Active Allergy	Date Recognized	Reaction Severity	Reactions	Comments
Orug	Active		6/4/2012	Mild to Modei	Itching&Rash	M otrin
Drug	Inactive		6/4/2012	Mild	Congestion	Benadryl
		Alle	ergies Revie	-wed		
Review Date Review Time	Reviewed By:		Reviewed			
						1

**Remember** also to click "Submit" to save new entries and modifications into the system. Saving allergy and hypersensitivity information is a two step process: 1) Click the "Save" button within the data entry form, and 2) Click the Submit icon to exit the form.





# **Section 7: Waitlist Management**

#### **Waitlist Admission**

BHRS set up a special program code for each agency to track clients on the waitlist. The special program code is easily identifiable because it starts with "AD99" instead of "AD41". If you are unable to find your waitlist program code in Avatar, contact your agency's analyst or submit a Help Desk ticket (650-573-3400). A list of Waitlist Program Codes is in the Appendix of this document.

Add a client to your waitlist by following the instructions for the form "Admission (Outpatient)". See Section 6 – A. Admission (Outpatient) for detailed instructions.

## **Waitlist Discharge**

When a client is closed out of the waitlist, use the standard "Discharge (Outpatient)" form. See Section 8 – A. Discharge (Outpatient) for detailed instructions.

Notice that the selections for the field "Type of Discharge" contain entries specific to the AOD waitlist. See the screen shot below:



# **Waitlist Reports**

To review a list of all clients on the waitlist for your program/agency, use the Caseload Report by Program (Path: Avatar CWS → Reports → Caseload Reports → Caseload Report by Program). Make sure you select your waitlist program – the one that starts with "AD99".





# **Section 8: Client Discharge**

**A.** <u>Discharge (Outpatient) NOT Bundled</u>: Please follow instructions included below for the Discharge (Outpatient) form.

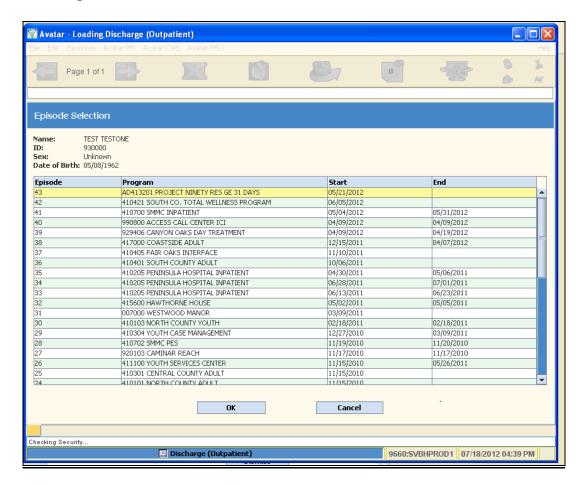
**Path:** Avatar PM→ Client Management→ Episode Management→ Discharge (Outpatient)

# B. AOD Discharge Bundle:

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

# **Discharge (Outpatient)**

Once you have selected the client to discharge, select the episode for discharge by highlighting the episode and clicking on the "OK" button at the bottom of the window.

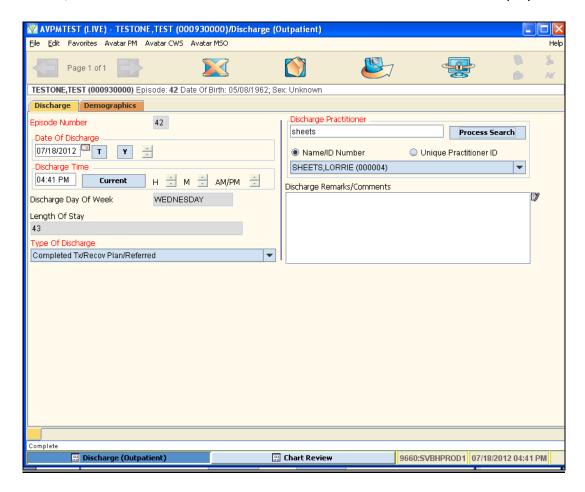






The Discharge (Outpatient) form requires the following information:

- **Date of Discharge** use the standard Avatar features to select the discharge date.
- Discharge Time click on the blue Current button.
- Type of Discharge select the correct response from the drop down list.
- **Discharge Practitioner** enter the full last name or part of the last name of the discharge counselor, then click Process Search. Select the correct name from the list displayed.



When the form is complete, click on the Submit icon to save and complete the discharge.

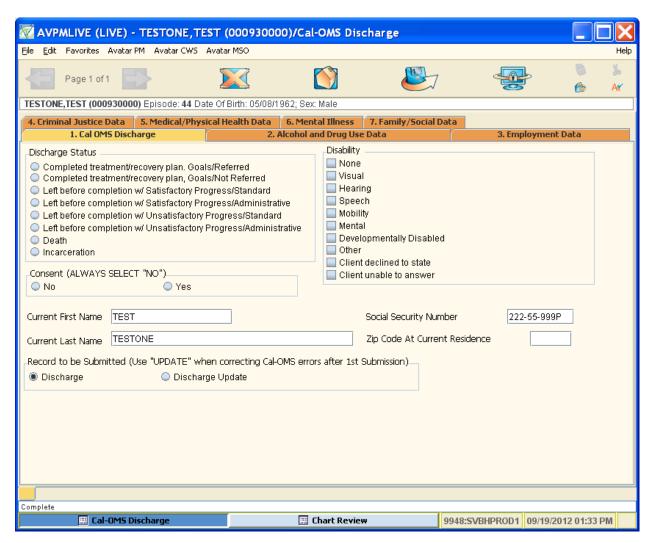
## C. CalOMS Discharge:

Avatar will not allow you to open the CalOMS Discharge form unless a CalOMS Admission form has been submitted for the Client. If no CalOMS Admission is recorded, you will receive an error message like the one displayed below.









#### **Data Fields & Elements**

**Discharge Status**: Select status from the list.

**Consent**: Select whether the client has given consent to be contacted in the future.

- No
- Yes

**Disability**: Select the client's disability or disabilities from the multiple-selection data element.





**Current First Name**: This is a 20 character free-text data element. This information defaults from the client's admission episode.

- Enter client's current first name
- Enter 99904 if the client is unable to answer

**NOTE**: If middle name or initial is present in this field, **remove** the middle name and **ONLY** leave client's Current First Name.

**Current Last Name**: This is a 40 character free-text data element. This information defaults from the client's admission episode.

- Enter client's current last name
- Enter 99904 if the client is unable to answer

**Social Security Number**: This is a special-text data element. This information defaults from the client's admission episode and can be edited.

- Enter the client's social security number.
- Enter 99900 to indicate that the client declines to state their social security number
- Enter 99902 to identify None or Not Applicable
- Enter 99904 if the client is unable to answer

**Zip Code at Current Residence**: This is a zip code data element.

- Enter 5-digit zip code of the client.
- Enter 00000 (all zeroes) to indicate that the client is homeless.
- Enter XXXXX to indicate that the Client Declines to State their zip code.

Enter ZZZZZ to indicate that the Client is Unable to Answer.

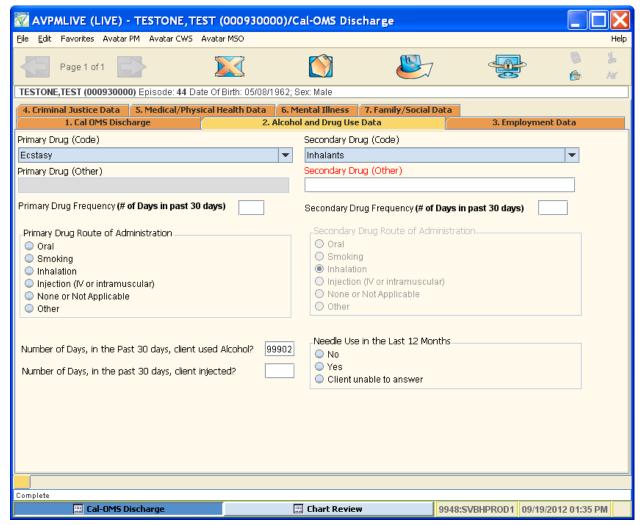
**NOTE**: Zip Code at Current Residence can only be '00000' if Current Living Arrangements is 'Homeless'

### **Record to be Submitted:**

- Default is Discharge
- Discharge Update: If updating an episode without having received a CalOMS Error Correction report contact the designated CalOMS Admin Staff to verify if discharge was accepted at the State. Wait for response prior to continuing the update for further instruction on selecting this radio button.







#### **Data Fields & Elements**

**Primary Drug (Code):** Select the client's primary drug of use from the dropdown list. Selecting a primary drug code enables the 'Primary Drug Frequency' and 'Primary Drug Route of Administration' fields. Selecting 'Other (specify)' or a drug code that requires a drug name enables and makes the 'Primary Drug Name' field required.

**Primary Drug Name**: This is a 50 character free-text data element. Enter the client's primary drug name.

NOTE: Primary Drug (Code) selected identifies if name is required

Primary Drug Frequency: Enter the frequency of the client's primary drug use.

- Enter value 0-30
- Enter 99902 for None or Not Applicable

**Primary Drug Route of Administration**: Select the client's route of primary drug administration from the list.





**NOTE**: Depending on the drug of choice, route of administration is defaulted. Example – Alcohol is the drug of choice, system defaults route of administration to 'Oral'.

Primary Drug Age of First Use: Enter the client's age of first drug use.

- Enter value 5-105
- Enter 99904 for Client Unable to Answer

Secondary Drug (Code): Select the client's secondary drug of use from the dropdown list. Selecting a secondary drug code enables the secondary drug frequency and secondary drug route of administration fields. Selecting 'None' disables the remaining fields on this page and enters 99902 in the secondary frequency, and secondary drug age of first use. Selecting 'Other (specify)' or a drug code that requires a drug name enables and makes the 'Secondary Drug Name' field required.

**Secondary Drug Name**: This is a 50 character free-text data element. Enter the client's secondary drug name.

**NOTE**: Secondary Drug (Code) selected identifies if name is required

**Secondary Drug Frequency**: Enter the frequency of the client's secondary drug use.

- Enter value 0-30
- Enter 99902 for None or Not Applicable

**Secondary Drug Route of Administration**: Select the client's route of secondary drug administration from the list.

**NOTE**: Depending on the drug of choice, route of administration is defaulted. Example – Inhalants is the drug of choice, system defaults route of administration to 'Inhalation'.

Secondary Drug Age of First Use: Enter the client's age of first drug use.

- Enter value 5-105
- Enter 99902 None or Not Applicable

**Alcohol Frequency**: Enter the frequency of the client's alcohol use.

- Enter value 0-30
- Enter 99902 for None or Not Applicable. (Auto populates based on Primary or Secondary Drug (Code) of 'Alcohol'

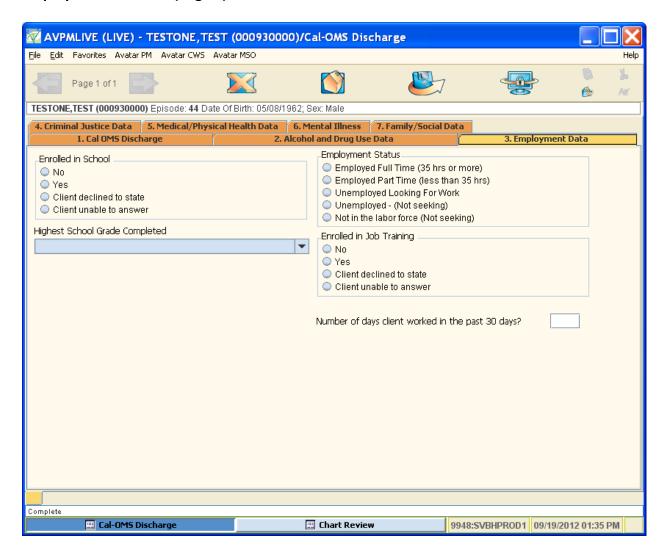
Needle Use: Enter the frequency of the client's IV use.

- Enter value 0-30
- Enter 99900 for Client Declined to State
- Enter 99904 Client Unable to Answer





#### **Employment Data Tab (Page 1)**



#### **Data Fields & Elements**

**Employment Status**: Select the client's employment status from the list.

**NOTE**: If client's age is 14 years old or less the Employment Status cannot be 'Employed Full Time (35hrs or more)'

Work Past 30 Days: Enter the number of days worked the client has had in the past 30 days.

- Enter 0-30
- Enter 99900 for Client Declined to State
- Enter 99904 for Client Unable to Answer

**Enrolled in School**: Select whether the client is enrolled in school.

- No
- Yes
- Client Declined to State





• Client Unable to Answer

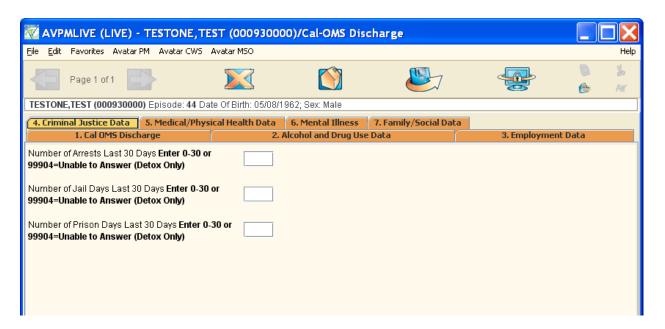
**Enrolled in Job Training**: Select whether the client is enrolled in job training.

- No
- Yes
- Client Declined to State
- Client Unable to Answer

**Highest School Grade Completed**: Select the client's highest school grade completed from the dropdown list.

- Enter Value 0-29
- 30+ Years
- Client Declined to State
- Client Unable to Answer

#### **Criminal Justice Data Tab (Page 1)**



#### **Data Fields & Elements**

Number of Arrests Last 30 Days: Enter the number of times the client has arrested in the last 30 days.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

**Number of Jail Days Last 30 Days**: Enter the number of days the client has spent in jail in the last 30 days.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

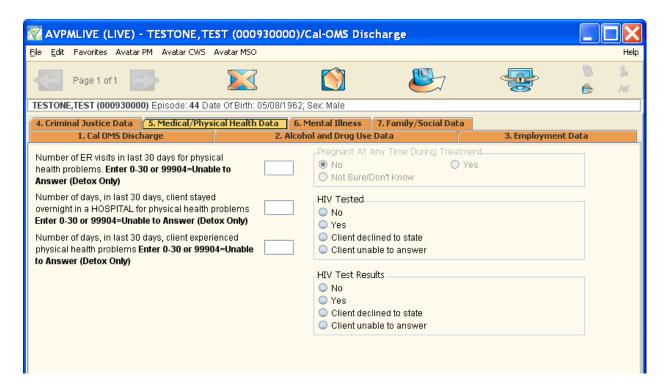
**Number of Prison Days Last 30 Days**: Enter the number of days the client has spent in prison in the last 30 days.





- Enter 0-30
- Enter 99904 for Client Unable to Answer

#### Medical/Physical Health Data Tab (Page 1)



#### **Data Fields & Elements**

**Emergency Room Last 30 Days**: Enter the number of times the client has been in an emergency room in the last 30 days.

- Enter 0-99
- Enter 99904 for Client Unable to Answer

**Hospital Overnight Stay Last 30 Days**: Enter the number of times the client has been in the hospital room in the last 30 days.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

**Medical Problems Last 30 Days**: Enter the number of medical problems the client has had in the last 30 days.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

**Pregnant at Any Time During Treatment**: Select if the client was pregnant at the time of their admission. This field is enabled and required for female clients

- No
- Yes





• Not Sure/Don't Know

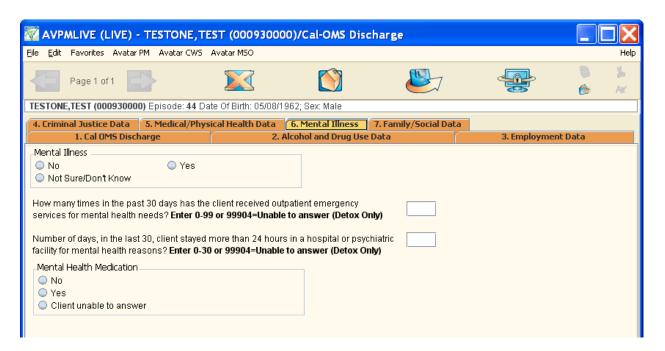
HIV Tested: Select whether the client has been tested for HIV.

- No
- Yes
- Client Declined to State
- Client Unable to Answer

HIV Test Results: Select the test results if the client has been tested for HIV.

- No
- Yes
- Client Declined to State
- Client Unable to Answer

### Mental Illness Tab (Page 1)



### **Data Fields & Elements**

Mental Illness Diagnosis: select whether the client has mental illness.

- No
- Yes
- Not Sure/Don't Know

**Emergency Room Use / Mental Health**: Enter the number of emergency room visits the client has made for mental health issues.

- Enter 0-99
- Enter 99904 for Client Unable to Answer





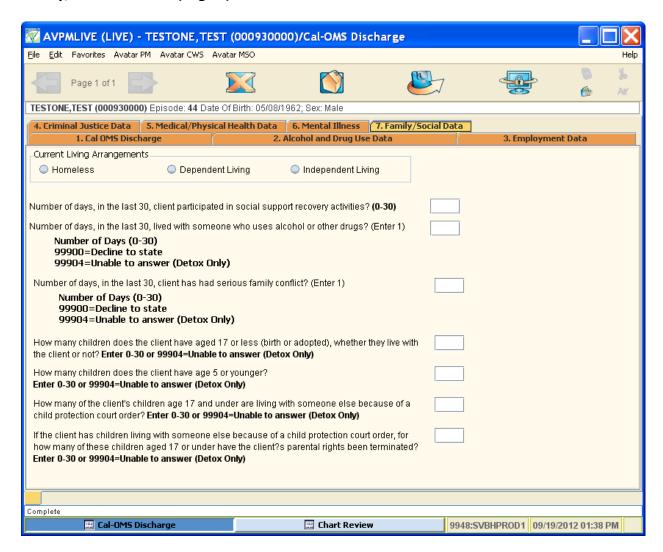
**Psychiatric Facility Use**: Enter the number of days in the last 30 days the client has stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

**Mental Health Medication**: Select whether the client has taken prescribed medication for mental health needs in the last 30 days.

- No
- Yes
- Client Unable to Answer

#### Family/Social Data Tab (Page 1)



#### **Data Fields & Elements**





**Social Support**: Enter the number of days in the last 30 days the client has participated in any social support recovery activities.

• Enter 0-30

**Current Living Arrangements**: Select the client's current living arrangement.

**NOTE**: Current Living Arrangements can only be 'Homeless' when Zip Code at Current Residence is '00000'

**Living with Someone**: Enter the number of days in the last 30 days the client has lived with someone who uses alcohol or drugs.

- Enter 0-30
- Enter 99900 for Client Declined to State
- Enter 99904 for Client Unable to Answer

**Family Conflict Last 30 Days**: Enter the number of days in the last 30 days the client had serious conflicts with their family.

- Enter 0-30
- Enter 99900 for Client Declined to State
- Enter 99904 for Client Unable to Answer

Number of Children Age 17 or Younger: Enter the number of children age 17 or younger.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

Number of Children Age 5 or Younger: Enter the number of children age 5 or younger.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

**Number of Children Living with Someone Else**: Enter the number of children who are living with someone else.

- Enter 0-30
- Enter 99904 for Client Unable to Answer

**Number of Children Living with Someone Else and Parental Rights Terminated**: Enter the number of children who are living with someone else and parental rights are terminated.

- Fnter 0-30
- Enter 99904 for Client Unable to Answer

Once you have completed entering the CalOMS Standard Discharge, Click the **Submit/Save** icon.

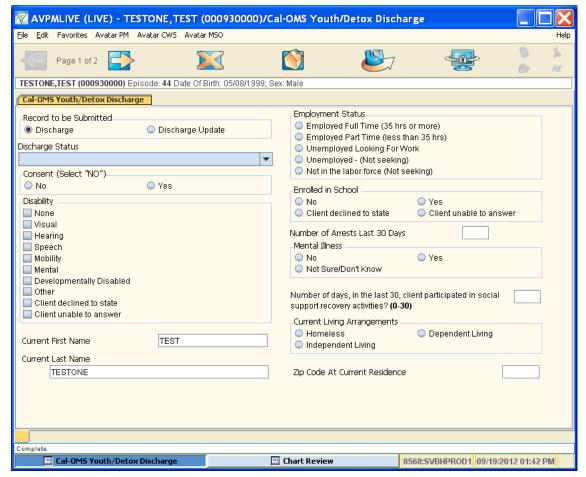
**IMPORTANT**: After submitting the system will save the data and load the next option of the bundle. This may take several seconds, **DO NOT EXIT** option. Wait for the next screen to load

## D. CalOMS Youth/Detox Discharge:

Avatar will not allow you to open the CalOMS Youth/Detox Discharge form unless a CalOMS Admission form has been submitted for the Client and the client is under 18 years old.







# Data Fields & Elements Record to be Submitted:

- Default is Discharge
- Discharge Update: If updating an episode without having received a CalOMS Error Correction report contact the designated CalOMS Admin Staff to verify if discharge was accepted at the State. Wait for response prior to continuing the update for further instruction on selecting this radio button

**Discharge Status**: Select status from the list.

**Consent**: Select whether the client has given consent to be contacted in the future.

- No
- Yes

**Disability**: Select the client's disability or disabilities from the multiple-selection data element.

**Current First Name**: This is a 20 character free-text data element. This information defaults from the client's admission episode.

- Enter client's current first name
- Enter 99904 if the client is unable to answer

**NOTE**: If middle name or initial is present in this field, **remove** the middle name and **ONLY** leave client's Current First Name.





**Current Last Name**: This is a 40 character free-text data element. This information defaults from the client's admission episode.

- Enter client's current last name
- Enter 99904 if the client is unable to answer

**Social Security Number**: This is a special-text data element. This information defaults from the client's admission episode and can be edited.

- Enter the client's social security number.
- Enter 99900 to indicate that the client declines to state their social security number
- Enter 99902 to identify None or Not Applicable
- Enter 99904 if the client is unable to answer

**Employment Status:** Select the client current status

**Enrolled in School:** Select the correct option for the client

**Number of Arrests Last 30 days:** Enter a number 0-30 or 99904 = Client Unable to Answer (Detox or Developmentally Disabled only)

Number of Days in Past 30, Client participated in Social Support Activities: Enter a number 0-30

**Current Living Arrangements:** Select 1 (**Note:** if Homeless zip code MUST be 00000)

**Zip Code at Current Residence**: This is a zip code data element.

- Enter 5-digit zip code of the client.
- Enter 00000 (all zeroes) to indicate that the client is homeless (Also use this code if Client is in a Homeless Shelter)
- Enter XXXXX to indicate that the Client Declines to State their zip code.

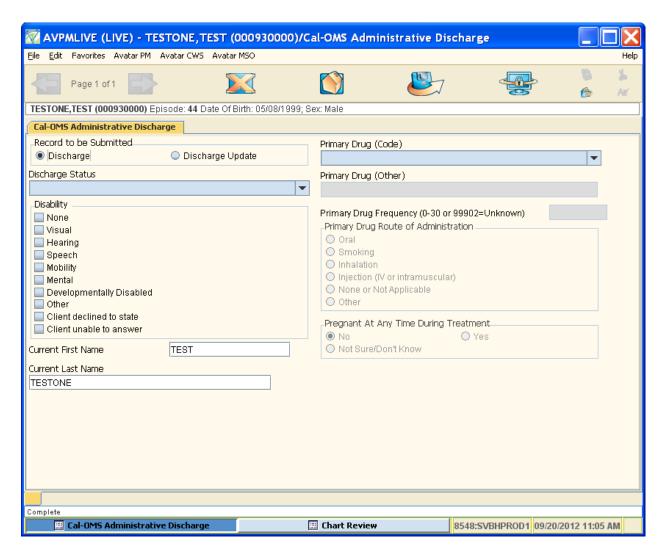
Enter ZZZZZ to indicate that the Client is Unable to Answer.

**NOTE**: Zip Code at Current Residence can only be '00000' if Current Living Arrangements is 'Homeless'





## E. CalOMS Administrative Discharge:



# Data Fields & Elements Record to be Submitted:

- Default is Discharge
- Discharge Update: If updating an episode without having received a CalOMS Error Correction report contact the designated CalOMS Admin Staff to verify if discharge was accepted at the State. Wait for response prior to continuing the update for further instruction on selecting this radio button

**Discharge Status**: Select status from the list.

**Disability**: Select the client's disability or disabilities from the multiple-selection data element.

**Current First Name**: This is a 20 character free-text data element. This information defaults from the client's admission episode.

- Enter client's current first name
- Enter 99904 if the client is unable to answer





**NOTE**: If middle name or initial is present in this field, **remove** the middle name and **ONLY** leave client's Current First Name.

**Current Last Name**: This is a 40 character free-text data element. This information defaults from the client's admission episode.

- Enter client's current last name
- Enter 99904 if the client is unable to answer

**Primary Drug:** Select the Primary Drug (This field controls the following fields)

- Primary Drug (Other): May be required depending on what is selected in the Primary Drug field.
- **Primary Drug Frequency:** Enter a number 0-30 or 99902=Unknown
- **Primary Drug Route of Administration:** Select 1 from the list (If more than one applies, select most frequently used)

**Pregnant at Any Time During Treatment:** Defaults to "No" if client is Male, otherwise select one.

## F. Remove from Caseload – Use AOD Caseload Assignment:

<u>Path</u>: Avatar PM→ New Options → AOD Caseload Assignment

When a Client is discharged from your program, s/he should also be removed from the caseloads of all Counselors assigned. When the Avatar episode is discharged, the Client will be removed from the caseloads of the Primary Counselor and Supervisor. To remove other Counselors assigned to the Client, open the AOD Caseload Assignment form.

Once you select the correct episode, the Pre-display screen displays listing all the Counselors assigned to this client. Highlight a Counselor's name and click on the blue DELETE button at the bottom of the screen. Continue highlighting counselor names and deleting them until the Client is removed from all caseloads.

- **G.** <u>AOD Continuing Care Plan</u>: You will use the form you are currently using at your program. Be sure to scan this document into Avatar! See Section 19, Scanned Documents regarding scanning.
- **H.** <u>AOD Exit Survey</u>: You will use the form you are currently using at your program. Be sure to scan this document into Avatar! See Section 19, Scanned Documents regarding scanning.





## **Section 9: CalOMS processing in Avatar**

If your program is NOT required to collect and report CalOMS data for your clients (e.g. DUI and DEJ programs), you will not use Outside Provider CalOMS. Proceed to Section 11, Assessments and Treatment Planning.

## A. Clients opened before Avatar "Go-Live" date

In the transition from Daisy to Avatar, your program has a number of clients who were admitted in Daisy and will be discharged in Avatar. In the transition to Avatar, AOD Client IDs were changed - however CalOMS expects the same Client ID on CalOMS annual updates and discharges as was used for the admission. The term "mid-stream clients" applies to this set of clients.

The Avatar team has (or will) supply your program with a report and a spreadsheet of all mid-stream clients. The report and spreadsheet will contain all the information your team will needs to enter CalOMS information via Outside Provider CalOMS – specifically, client name, admission date, Avatar ID, Daisy ID and CalOMS FSN.

**NOTE**: For Discharges prior to your Avatar Go-Live date, complete the client's discharge process in DAISY.

The outline of the process to track and discharge mid-stream clients is below:

- 1. Report of your open clients up to the day before your Avatar GO-LIVE date will be provided
  - a. Report will include necessary information that will be needed to match client record at the state level (this information must be entered exactly as provided)
- 2. Complete the Outside Provider Cal-OMS Discharge form. See Section 13 for instructions on Outside Provider CalOMS. (all fields must be completed prior to saving form)
- 3. Complete the Avatar form "Discharge (Outpatient)" to close the episode for your team.

# B. Clients opened on or after Avatar "Go-Live" date

Clients admitted/opened to your program using Avatar will follow the standard Admission and Discharge procedures.

- 1. Provider completes Cal-OMS form as part of the Admission, Annual Update, and Discharge bundles.
- 2. Weekly (Monday), run a Provider Cal-OMS Error Report for your agency via Avatar. This report displays any errors found in any CalOMS Admission, Annual Update and Discharge forms for the last week.





3. Correct errors indicated in the file by returning to the appripriate Cal-OMS form and correcting the data as indicated. Use CalOMS Admission, CalOMS Annual Update or CalOMS Discharge forms as needed.

## C. Private Pay clients opened on or after Avatar "Go-Live" date

If your program is required to collect and report CalOMS data on admission, annually and on discharge, County Clients will be admitted, tracked and discharged in Avatar. Private Pay clients will NOT be admitted, tracked and discharged in Avatar using standard forms.

However, the State still requires you to report CalOMS data on Private Pay clients. Avatar supplies the functionality to record the information using Outside Provider CalOMS Admission, Outside Provider CalOMS Annual Update and Outside Provider CalOMS Discharge.

Outside Provider CalOMS Admission requires a unique Client identifier. Because a unique identifier will not be assigned automatically by Avatar, you will have to assign and keep track of the unique identifier for each Private Pay client. To ensure that the identifiers you assign will not overlap with identifiers from other agencies, the beginning of the identifier should include the System Code used for your agency. For example, if your system code is "AOD", each of the unique identifiers you assign will start with "AOD" such as AOD10001.

Your agency will be responsible for assigning and tracking the identifier for each Private Pay client. The Avatar team has a sample Excel spreadsheet available to every agency to track identifiers and the necessary CalOMS information.

- 1. Provider completes needed Cal-OMS form
  - a. Outside Provider Cal-OMS Admission
  - b. Outside Provider Cal-OMS Annual Update
  - c. Outside Provider Cal-OMS Discharge
- 2. All Information needs to be available prior to beginning form entry. (Avatar will not allow you to complete the form unless all information is complete)
- 3. Once form is submitted you will be unable to edit the form

#### E. CalOMS Error Correction

CalOMS Error Reports are available every two weeks for agencies to review and correct any errors found in their CalOMS data submissions.

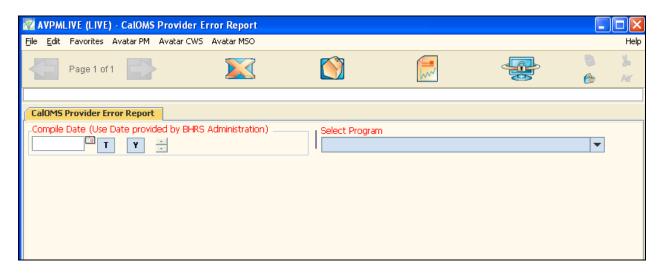
The menu path for this report is:





Avatar PM → Client Management → Client Information → CalOMS Information → CalOMS Provider Error Report

A screen shot of the report form is below:



Every agency has at least two contact people who are notified via email whenever BHRS "compiles" a CalOMS report. The email always includes the "Compile Date" required to select the Error Report.

Enter the date from the email as the Compile Date. In the field "Select Program", select the program from the drop-down list. Only programs for your agency will display. Both the Compile Date and Program are required to run the error report.

Use the error report to correct CalOMS entries as directed. The corrections should be made within ten days of the compile date. If you have questions or problems with the error report, please contact your BHRS Contract Analyst.





# **Section 10:** Private Pay Clients – Outside Provider CalOMS

# A. Outside Provider CalOMS Admission:

**Path:** Avatar PM → Client Management → Client Information → CalOMS Information → Outside Provider CalOMS Admission

The Outside Provider CalOMS Admission form has the same requirements as the standard CalOMS Admission form. See Section 9 Client Intake, E. CalOMS Admission for specific instructions.

## B. <u>Outside Provider Annual Update</u>:

**Path:** Avatar PM → Client Management → Client Information → CalOMS Information → Outside Provider CalOMS Annual Update

The Outside Provider CalOMS Annual Update form has the same requirements as the standard CalOMS Annual Update form. See Section 13 Assessments and Treatment Planning, G. CalOMS Annual Update for specific instructions.

# C. Outside Provider Discharge:

**Path:** Avatar PM → Client Management → Client Information → CalOMS Information → Outside Provider CalOMS Discharge

The Outside Provider CalOMS Discharge form has the same requirements as the standard CalOMS Discharge form. See Section 10 Client Discharge, B. CalOMS Discharge for specific instructions.

# D. Outside Provider Reports:

**Path:** Avatar PM → Client Management → Client Information → CalOMS Information





# **Section 11: Assessments and Treatment Planning**

## Admission Assessment Forms (ASI, AC-OK) are not part of the Admission Bundle

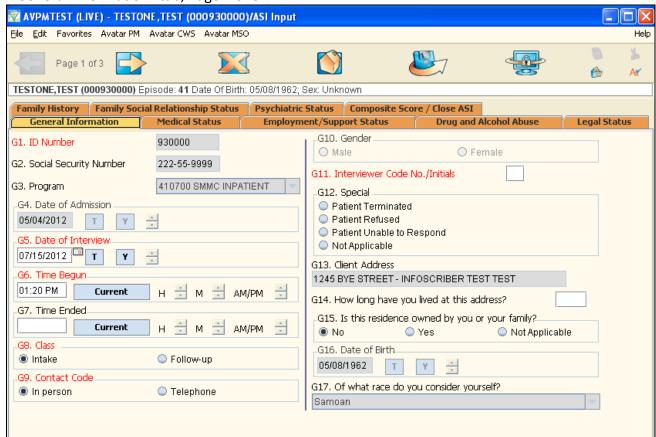
**A.** <u>ASI</u> - the ASI form in Avatar is used only with Adult Clients. See the instructions below for the Adolescent ASI.

Path: Avatar CWS → ASI

Complete the form as you normally would. The ASI has nine (9) tabs. The last tab labeled "Composite Score/Close ASI", calculates the ASI scores and allows you to Close the assessment. Once an assessment is closed, you can no longer change any of the answers.

Screenshots of the first and last pages of the ASI are below:

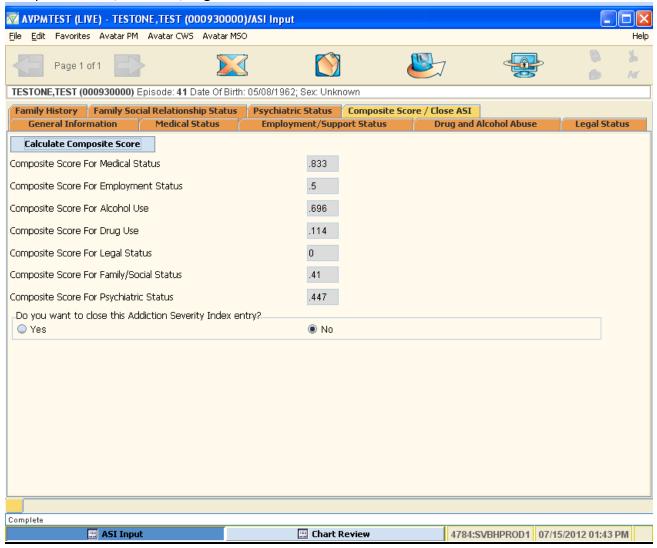
"General Information" tab, Page 1 of 3







#### Composite Score/Close ASI, Page 1 of 1



**B.** <u>Adolescent ASI</u>— continue using the same tool for Adolescent ASI as you did with DAISY. When the assessment is complete, please scan the report into Avatar.

# C. AC-OK COD for Adults

**Path**: CWS→ Assessments→ AC OK COD for Adults

If the client has more than one episode with your agency, Avatar will display the Episode Selection Screen. Select the episode for which the AC OK is being done. If the client has another AC OK assessment in Draft, Avatar will show the Pre-Display screen.

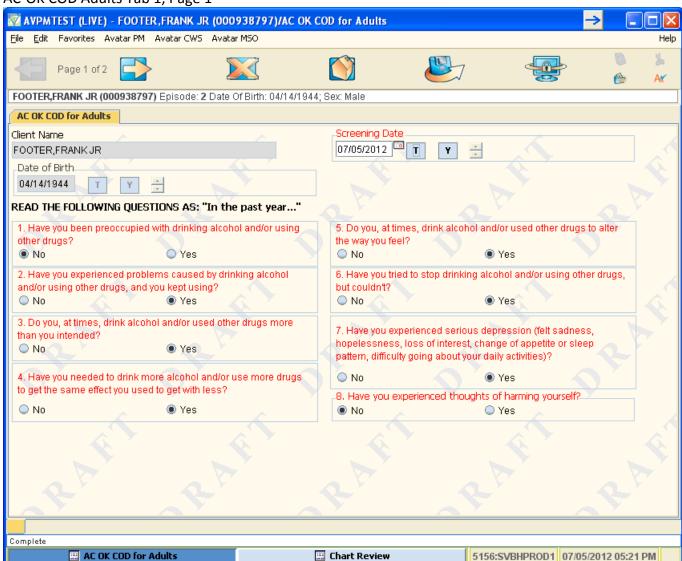




- Add a new assessment, select ADD at the bottom of the screen.
- Edit an assessment highlight the assessment to be edited and select EDIT at the bottom of the screen.
- Delete an assessment highlight the assessment to be deleted and select DELETE at the bottom of the screen. Only assessments in DRAFT can be deleted from the Pre-Display. Once an assessment is saved as "Final", it cannot be deleted.
- Cancel out of the assessment select CANCEL at the bottom of the screen.

If the client has no other AC OK Assessments in DRAFT, the Assessment will open to the first page of the form. AC-OK COD for Adults is a 1 Tab, 2 page document

#### AC-OK COD Adults Tab 1, Page 1





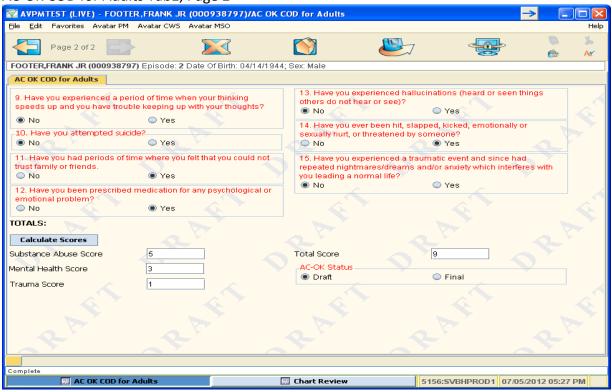


Enter the screening date.

Select the correct answers for questions 1-8

Go to Tab 1, Page 2

AC-OK COD for Adults Tab1, Page 2



Select the correct answers for questions 9-15

Click on Calculate Scores. If this is the first time you're calculating a score for any AC-OK, there will be a pop up.



Click "Ok". It may take a few minutes to calculate.

The report will look like the screen shot below. Enter the values from the report into the Substance Abuse, Mental Health, Trauma and Total boxes on the form.







#### AC-OK-COD Scores By Domain for Adults

er scores for each domain in the cooresponding fields on the AC-OK-Adult

Substance Abuse	5
Mental Health	3
Trauma	1
	_

Scoring:
One (1) "Yes" answer on any of the three (3) domains (Mental Health, Trauma Related Mental Health Issues, and Substance Abuse) indicates that an additional assessment(s) is needed in that domain.

Select the AC-OK Status – either "Draft" or "Final". Save the assessment as Draft if you plan to come back to it to finish it at another time. Save the assessment as Final if you are finished answering the questions and calculating the scores.



Save the AC-OK by clicking on the Submit icon

# D. AC OK COD Adolescents/TAY

Path: CWS→ Assessments→ AC OK COD for Adolescents/TAY

If the client has more than one episode with your agency, Avatar will display the Episode Selection Screen. Select the episode for which the AC OK is being done. If the client has another AC OK assessment in Draft, Avatar will show the Pre-Display screen.

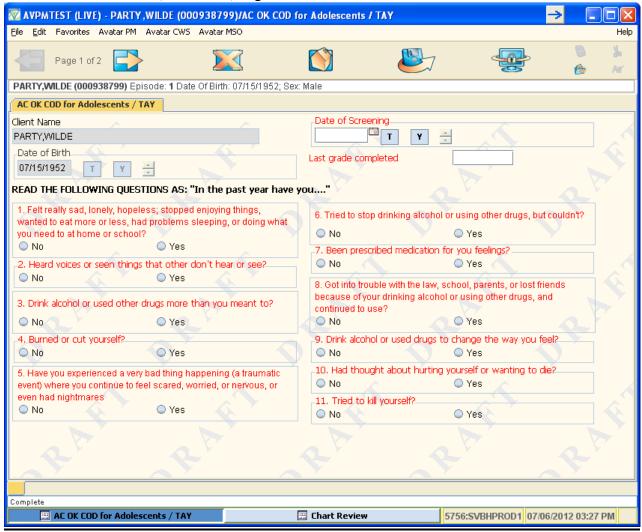
- **Add** a new assessment select ADD at the bottom of the screen.
- Edit an assessment highlight the assessment to be edited anad select EDIT at the bottom of the
- **Delete** an assessment highlight the assessment to be deleted and select DELETE at the bottom of the screen. Only assessments in DRAFT can be deleted from the Pre-Display. Once an assessment is saved as "Final", it cannot be deleted.
- **Cancel** out of the assessment select CANCEL at the bottom of the screen.

If the client has no other AC OK Assessments in DRAFT, the Assessment will open to the first page of the form.





AC-OK COD Adolescents/TAY Tab 1, Page 1



Enter the Date of Screening and the Last grade the client completed.

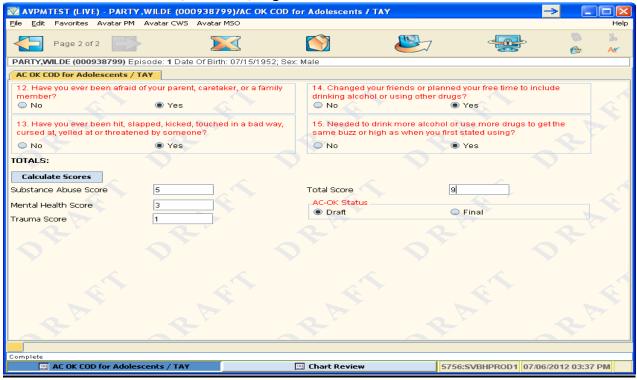
Select the correct answers for questions 1-11





Go to Tab 1, Page 2

AC-OK COD for Adolescents/TAY Tab1, Page 2



Select the correct answers for questions 12-15

Click on the blue Calculate Scores button. If this is the first time you're calculating a score for any AC-OK, there will be a pop up.



Click "Ok". It may take a few minutes to calculate.

The report will look like the screen shot below., Enter the values from the report into the Substance Abuse, Mental Health, Trauma and Total boxes on the form.







#### AC-OK-COD Scores By Domain for Adults

Enter scores for each domain in the cooresponding fields on the AC-OK-Adult Substance Abuse 5
Mental Health 3
Trauma 1

TOTAL: 9

Scoring:

One (1) "Yes" answer on any of the three (3) domains (Mental Health, Trauma Related Mental Health Issues, and Substance Abuse) indicates that an additional assessment(s) is needed in that domain.

Select the AC-OK Status – either "Draft" or "Final". Save the assessment as Draft if you plan to come back to finish it at another time. Save the assessment as Final if you are finished answering the questions and calculating the scores.



Save the AC-OK by clicking on the Submit icon

## E. Diagnosis: If applicable to your program

The PM Diagnosis form has 1 Tab and 3 Pages

**Path:** Avatar PM→ Client Management→ Client Information→ Diagnosis

If you do not have an active client in "My Session", the "Select Client" screen displays. Enter the client's ID number and click "OK" to select the client.

The episode selection screen displays for you to select the correct episode for the client's diagnosis. Once you have selected the client and episode, the Diagnosis form pops up

#### Or

Right click on the Client name in My Caseload or My Session.

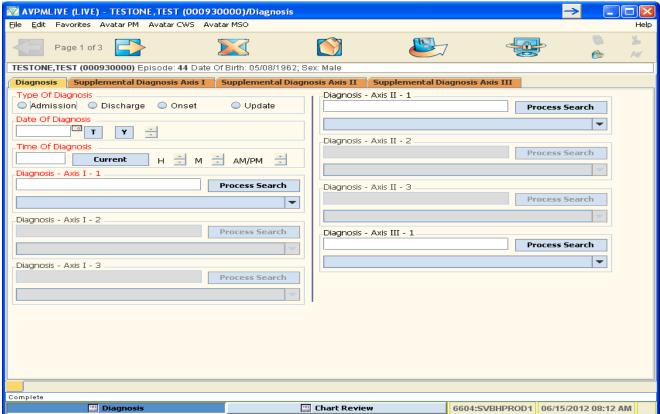
**Path:** Avatar PM→ Client Management→ Client Information→ Diagnosis

Select the correct episode from the episode selection screen.





#### PM Diagnosis Tab 1/Page 1



#### Tab 1/Page 1:

Select the type of Diagnosis: Admission, Discharge, Onset, Update

Enter the *Date of Diagnosis* – the date diagnosis was made.

Time of Diagnosis - If you know the time the diagnosis was made, enter it in the field. If you do not know the time of diagnosis, click on the blue button labeled "Current".

**Diagnosis Axis I – 1 (primary) is a required field.** This field is a Process Search so enter a *diagnostic code* or a *few letters* of the *diagnosis description*. Click the blue Process Search button and select the correct diagnosis from the displayed list so that it fills in the blue box.

Following Axis I-1, are two additional Axis I diagnosis fields. Enter Axis I, second diagnosis (Axis I-2) and Axis 1 third diagnosis (Axis I-3) (if applicable) following the same procedure as for Axis I-1..

**Diagnosis Axis II – 1 is not a** *required* **field**. This field is a Process Search so enter a *diagnostic code* or a *few letters* of the *diagnosis description*. Click the blue Process Search button and select the correct diagnosis from the displayed list so that it fills in the blue box.

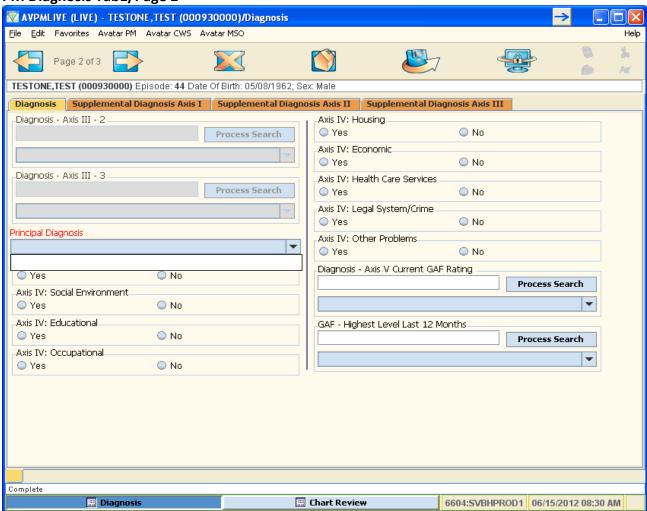
Following Axis II-1, are two additional Axis II diagnosis fields. Enter Axis II second diagnosis (Axis II-2) and Axis II third diagnosis (Axis II-3) (if applicable) following the same procedure as for Axis II-1.





**Diagnosis Axis III – 1 is not a** *required* **field**. This field is a Process Search so enter a *diagnostic code* or a *few letters* of the *diagnosis description*. Click the blue Process Search button and select the correct diagnosis from the displayed list so that it fills in the blue box. The entry fields for a secondary or third Axis III Diagnosis are on Page 2

PM Diagnosis Tab1/Page 2



#### Tab 1/Page 2:

**Principal Diagnosis** is a **required** field. Click on the down arrow on the right hand side of the box to display all of the diagnoses entered for this client in Axis I and II. Select the client's Principal Diagnosis from this list.

Axis IV: Select Yes or No to rate each dimension.

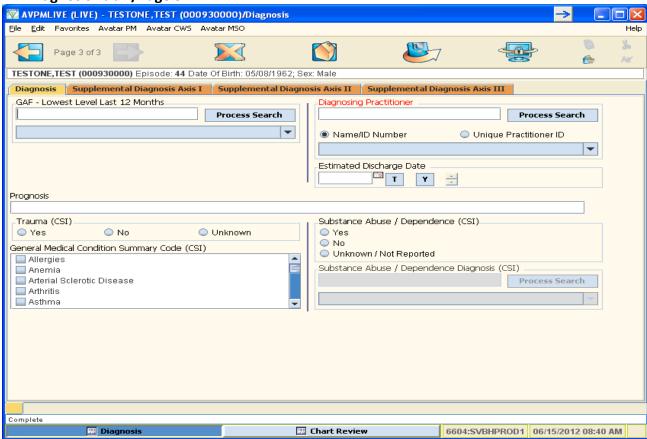




**Axis V: Diagnosis/Current GAF:** Enter the number, Click Process Search and select the correct rating to fill in the blue box.

**GAF- Highest Level 12 Months:** Enter the number, Click Process Search and select the correct rating to fill in the blue box.

PM Diagnosis Tab 1/Page 3



#### Tab 1/Page 3:

- **GAF- Lowest Level 12 Months:** Enter the number, Click Process Search and select the correct rating to fill in the blue box.
- **Prognosis:** Enter Prognosis
- **Trauma:** Select the correct response; this is a CSI field..
- **General Medical Condition Summary Code**: Select any that apply to the client and for which there is evidence from an MD or equivalent. This is a CSI field.
- **Diagnosing Practitioner**: Enter the name or few letters of the name of the diagnosing practitioner. Click Process Search and select so that the practitioner name populates into the blue box.
- Estimated Discharge Date: Enter the Date





- Substance Abuse/Dependence: If you answer "yes", the field becomes required and you must provide an entry for the next question: Substance Abuse/Dependence Diagnosis. This is a CSI field
- Substance Abuse/Dependence Diagnosis: You must enter a diagnostic code or a few letters of the dependence diagnosis, Click Process Search and select the diagnosis so that it fills in the blue box.



Click on the **Submit** icon to Save the form.

## F. CalOMS Annual Update

If you have clients who continue in treatment for one year or more, complete the CalOMS Annual Update on the client's anniversary in treatment. The Documentation At A Glance will indicate the due date for this document.

The menu path for the annual update is:

Avatar PM → Client Management → Client Information → Cal-OMS Info → Cal-OMS Annual Update

# G. **Update Client Data**

Generally Clients' demographic information is recorded by support staff. Counselors/clinicians have access to the same form to Update Client data.

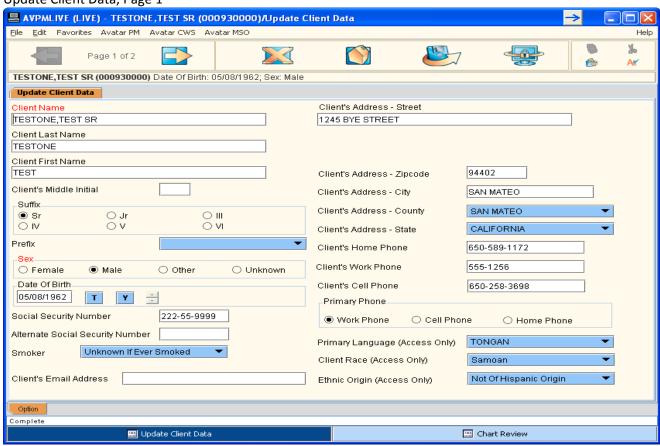
<u>Path</u>: Avatar PM→ Client Management→ Client Information→ Update Client Data *or* Avatar CWS→ Other Chart Entry→ Update Client Data

This document has 1 Tab and 2 Pages:





Update Client Data, Page 1

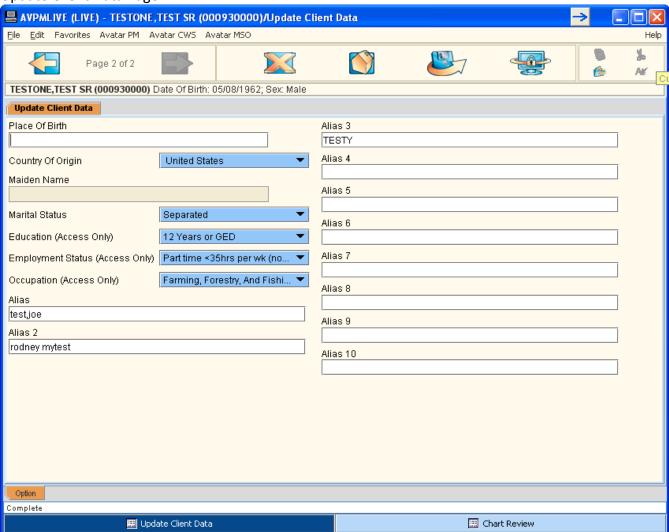


Update client data as applicable on page I





Update Client Data Page 2



Update Client Data as applicable on page 2.



Click Submit to save changes





## **Section 12: AOD Consent and Compliance Tracking**

The purpose of this document is to record that important clinical documents are completed and the date each document was completed. The documents tracked by this form are:

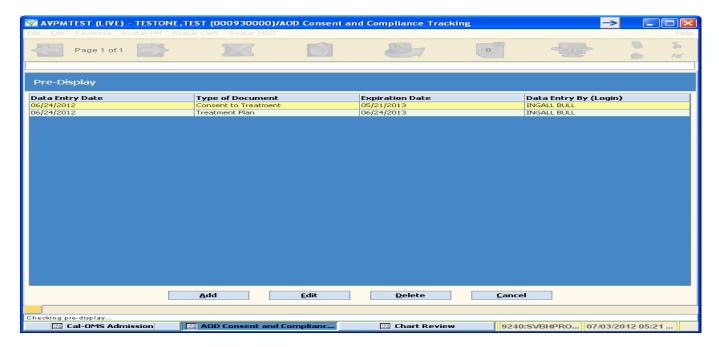
- Consent for Treatment
- Consent to Share ASI
- Client Treatment Plan
- Adolescent ASI

Remember that even thought these documents are not a separate form in Avatar, they are still required. When information for these documents is entered, Avatar reports can display what documents are complete, what documents are missing and what documents are expiring. After the document is reviewed with the client and signed, it is ready to record in the Consent and Compliance Tracking form.

**Path:** PM Client Management → Client Information → AOD Consent and Compliance Tracking

If the client has previous documents entered into this option, a Pre-Display screen will appear first. You have the option to Add a new entry, Edit an existing entry, Delete an entry or Cancel out of this screen. Remember: You cannot edit an expired entry!

You can add a new entry by selecting ADD



When you select ADD, a new blank form will display similar to the screen shot below.

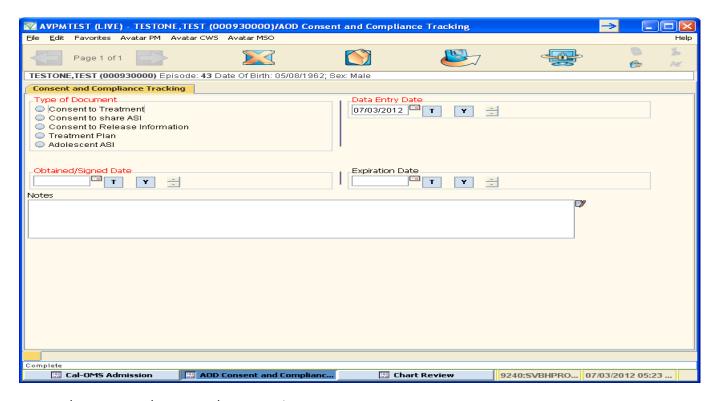




- Type of Document (required )— select the type of document whose information you're entering.
- Data Entry Date (required) date you're recording the information. Click on the blue button labeled "T" to enter today's date.
- Obtained/Signed Date (required) enter the date the document was signed.
- Expiration Date (not required) if the document has an expiration date, enter it here. An example of such a document is the Treatment Plan.

Save the form by clicking on the **Submit** icon.

Follow these same instructions for all document types listed on the Avatar AOD Consent and Compliance Tracking document.



Remember to scan the paper document into Avatar.





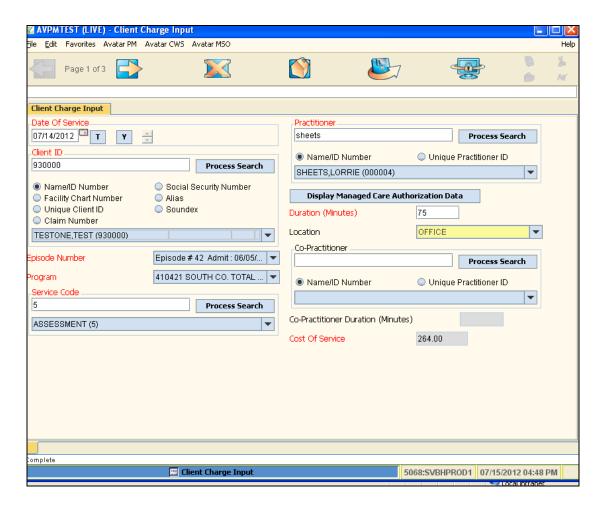
# **Section 13: Service Delivery**

## A. Service Charge Entry:

Use the Avatar "Service Charge Entry" form to record Outpatient Services provided to clients.

**Path**: Avatar PM → Ancillary/Ambulatory Services → Client Charge Input

To enter services faster, organize the service charge slips in order by client, date of service and counselor.



Even though the form has three pages in one tab, fill out the information on Page 1 only.

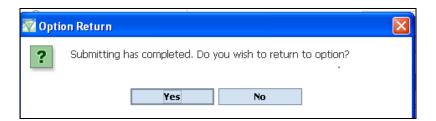
- Date of Service Enter the date of service
- **Client ID** Enter the client's Avatar ID or last name then click the blue "Process Search" button. Select the client from the list displayed.





- **Episode Number** Click on the down arrow for a list of all active episodes for this client. Select the appropriate episode.
- **Program** When the episode is selected, the Program/Team name automatically fills in.
- **Service Code** Enter the service code or the first few letters of the service code description and click the blue "Process Search" button. Select the service code from the list displayed.
- **Practitioner** Enter the Counselor's ID or last name and click the blue "Process Search" button. Select the Counselor from the list displayed.
- **Duration** Enter the number of minutes for the service.
- **Location** This field will be populated with the default location for the service. If the location is different, click on the down arrow to display a list of locations. Select the appropriate location for this service.
- **Co-Practitioner** If another counselor participated in providing the service, enter the Counselor's ID or last name and click the blue "Process Search" button. Select the Counselor from the list displayed.

Click on the Submit icon to save the service. Avatar displays a pop-up window giving you the option of returning to the form to enter the next set of service information. If you have additional services to enter, click on "Yes". If you are done entering services, click on "No".



### **B. Recurring Client Charge Input:**

The Avatar form "Recurring Client Charge Input" is used mostly for Intensive Outpatient and Residential services. It can be used for Outpatient Services only if one client has the same service provided multiple days in a row for the same duration, provider and location.

Recurring Client Charge Input is a fast method to record the same service provided to a client over multiple days. An example of this type of service entry is: Client Adam Apple attended Intensive Outpatient Services every weekday for a week. Using Recurring Client Charge Input allows you to enter the information once and apply it to all five days of the week.

**Path**: Avatar PM → Services → Ancillary/Ambulatory Services → Recurring Charge Input

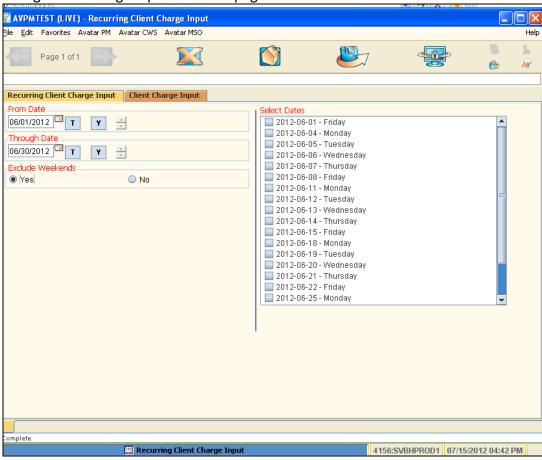
Often these services are organized by attendance slips. To enter services faster, organize the service charge slips in order by client, date of service and counselor.





This Avatar form has two tabs: Tab 1 is "Recurring Client Charge Input" and Tab 2 is "Client Charge Input".

Tab 1 "Recurring Client Charge Input" has one page.



Enter the "From Date" or starting date and the "Through Date" or ending date for the services you are recording. You have the option to include or exclude weekends in the display of dates.

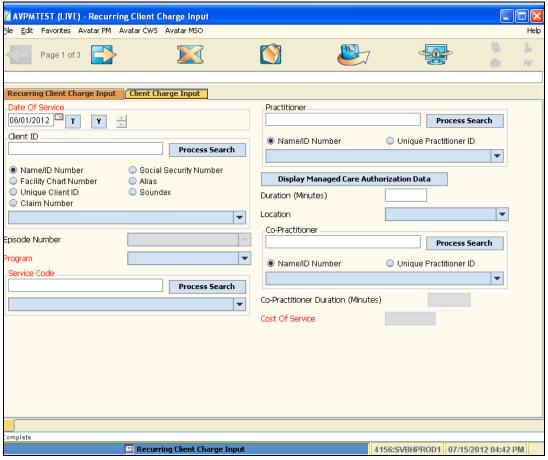
After entering data in the three fields, the "Select Dates" box will be populated with the date and day of the week specified in the From/Through Dates. Click on the check box next to the dates to include a service for that date. If you want to include ALL of the dates, click the box next to the first date then press CTRL + A. If you want to include some of the dates and not all, click on the box next to the dates services were provided.

When you are satisfied the dates are correct, click on Tab 2 "Client Charge Input".





Tab 2 Client Charge Input



Record the service information on this page. The information requested is the same as requested for Client Charge Input.

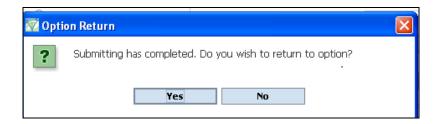
- Client ID Enter the client's Avatar ID or last name then click the blue "Process Search" button.
   Select the client from the list displayed.
- **Episode Number** Click on the down arrow for a list of all active episodes for this client. Select the appropriate episode.
- **Program** When the episode is selected, the Program/Team name automatically fills in.
- **Service Code** Enter the service code or the first few letters of the service code description and click the blue "Process Search" button. Select the service code from the list displayed.
- **Practitioner** Enter the Counselor's ID or last name and click the blue "Process Search" button. Select the Counselor from the list displayed.
- **Duration** Enter the number of minutes for the service.
- Location This field will be populated with the default location for the service. If the location is
  different, click on the down arrow to display a list of locations. Select the appropriate location
  for this service.





• **Co-Practitioner** – If another counselor participated in providing the service, enter the Counselor's ID or last name and click the blue "Process Search" button. Select the Counselor from the list displayed.

Click on the Submit icon to save the services. Avatar displays a pop-up window giving you the option of returning to the form to enter the next set of service information. If you have additional services to enter, click on "Yes". If you are done entering services, click on "No".



If you select to continue entering services, you have the option of setting new From/Through Dates or leaving the dates entered for the previous set of services.

### C. Urinalysis (UA):

Whatever form or process used by your program will continue. There is currently no Avatar option to capture UA's.

# D. Request/Receive Referral

**AOD Referral Process Options:** 

- 1. AOD Referral
- 2. AOD Proof of Enrollment
- 3. AOD Proof of Discharge

These three options are used to record the entire referral process electronically, capturing referral, proof of enrollment, and proof of discharge information for the client. These three options need to be completed in order shown above so that information flows from one to the next correctly. All three forms are "Client Based" and are not attached to a specific episode of care. Due to the requirements of 42 CFR, once these documents are filed as final they will no longer be editable and will be blocked from view by staff except those that have been sent a notification. There are specific reports that will allow AOD staff to access past referral information.

All the forms required for this process are located in the following menus:

Path: Avatar CWS/Other Chart Entry/AOD Referrals

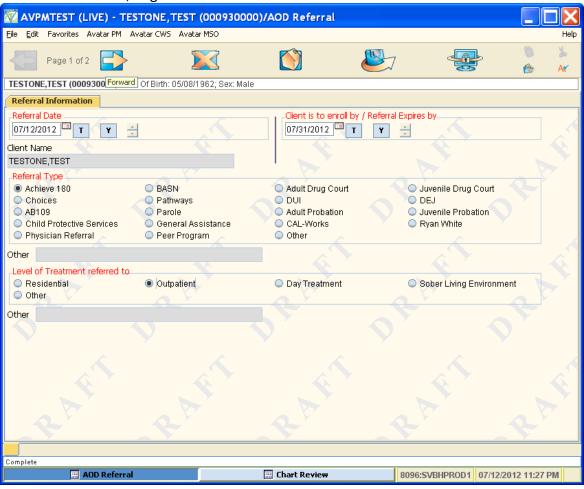




# **AOD Referral (Initiated by AOD Staff)**

All fields in **RED** are required to be able to complete this form.

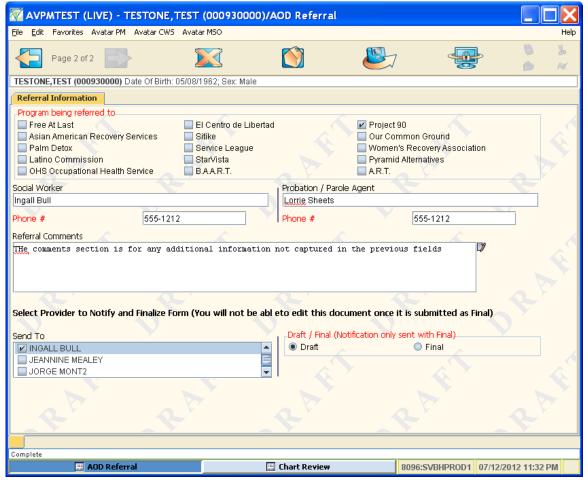
"Referral Information" tab, Page 1 of 2







"Referral Information" tab, Page 2 of 2



Before saving the form, be sure to select the name(s) of the Providers to notify.

In the field "Draft / Final", if you select **Draft**, the form will be saved in its current state and will NOT send notifications to any provider. Saving an AOD Referral as Draft means you want to return to the form to edit it before sending the referral.

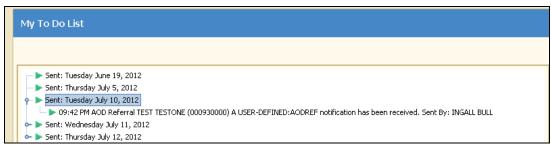
In the field "Draft / Final", if you select **Final**, the form will be saved once you click on the "Submit" icon and the people selected in the "Send To" field will be notified. You will not be able to edit this document after this point.

Once the form is saved as Final, the selected recipient(s) will receive a To Do List notification.

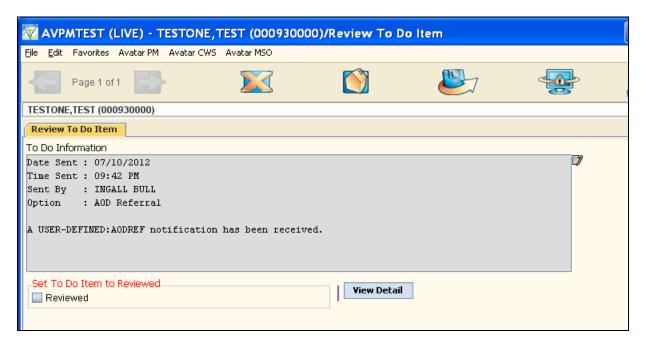
The referral recipient will double click on the To Do list item for more information.







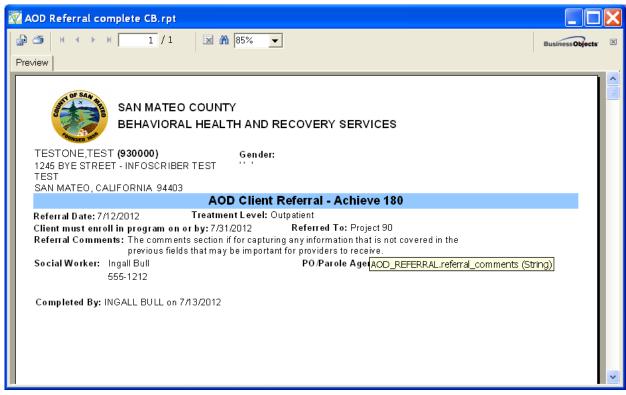
After double-clicking on the notification, the recipient will see a display similar to the screen shot below:



Click on the blue View Detail button to review the complete referral.







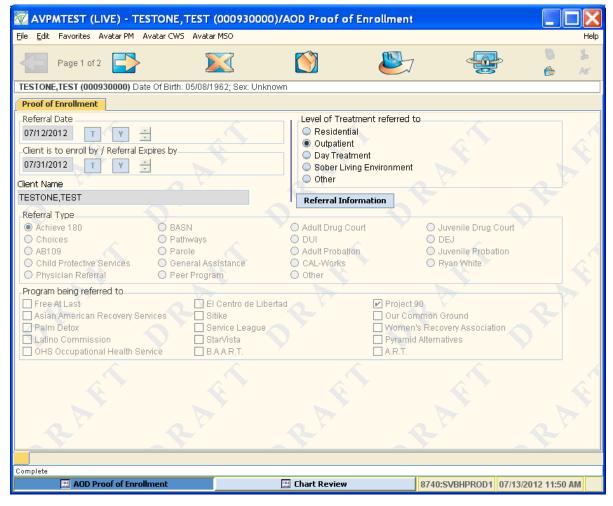
## **AOD Proof of Enrollment (Completed by Provider)**

Once the Client arrives at the Provider's program, the provider completes the AOD Proof of Enrollment form. Pre-selected information will automatically flow into this form from the last referral on file. The first page of this tab displays basic information about the referral. Click on the blue "Referral Information" button for more information.

The first page displays the information contained in the original referral.



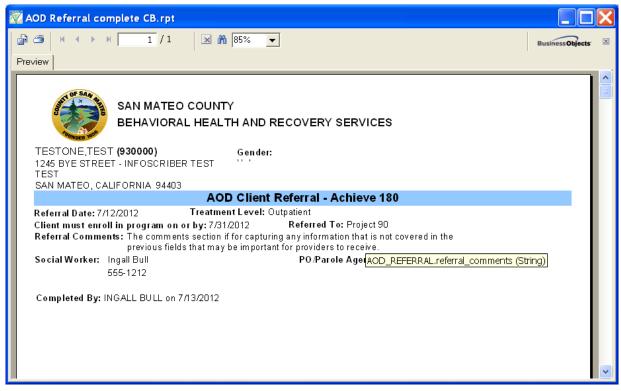




The report of referral information will look similar to the screen shot below:



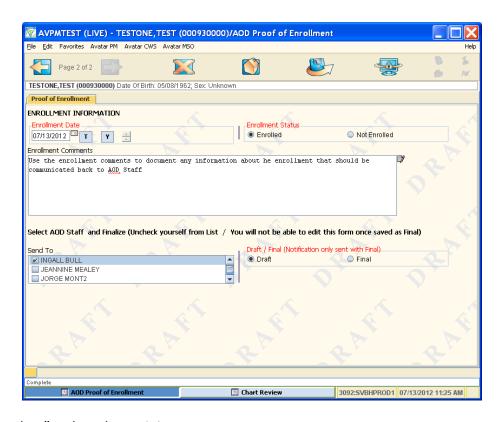








On page 2 of "AOD Proof of Enrollment", document the Date and Status of the enrollment. Use the enrollment comments to document any information about the enrollment that should be communicated back to AOD Staff.



In the field "Send To", select the recipient.

In the field "Draft / Final", selecting **Draft** will save the form in its current state and will NOT send notifications to any provider. Saving an AOD Proof of Enrollment as Draft means you want to return to the form to edit it before sending the referral.

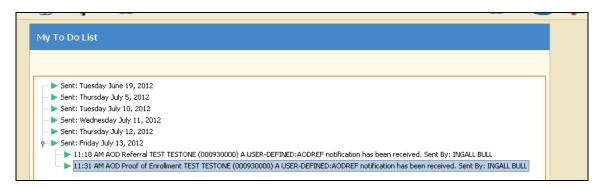
In the field "Draft / Final", selecting **Final** will save the form when you click on the "Submit" icon and the people selected in the "Send To" field will be notified. You will not be able to edit this document after this point.

Once the form is saved as Final, the selected recipient(s) will receive a To Do List notification.

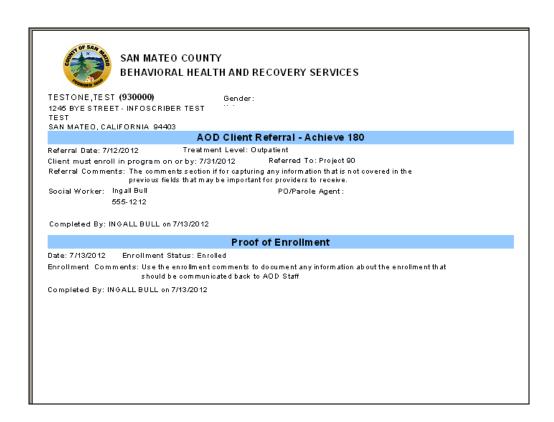




The referral recipient will double click on the To Do list item for more information.



From "View Details" in the To Do List, the report of referral information will look similar to the screen shot below:

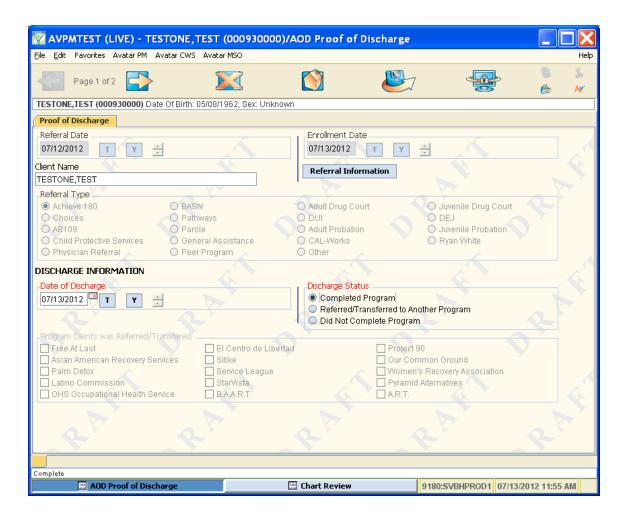






# **AOD Proof of Discharge (completed by Provider)**

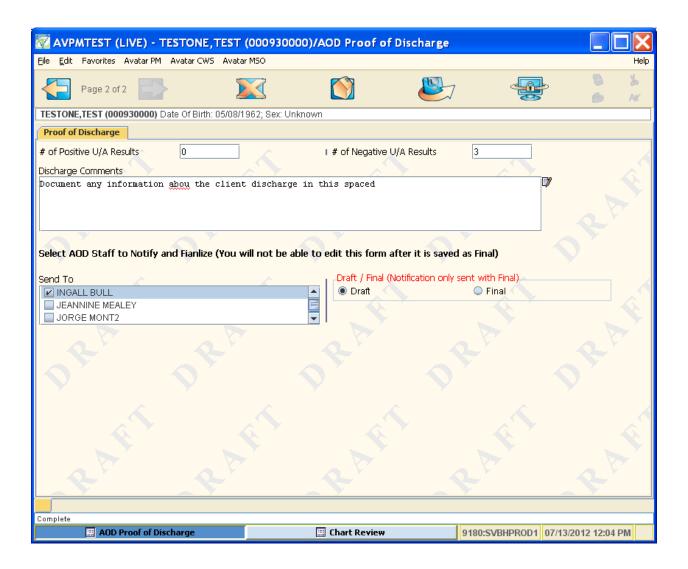
This form is used to document when the client is discharged from your program. Clicking on the blue "Referral Information" button will give you more information about Referral and Enrollment Information. Fill out as much information as you have regarding the client's discharge. On Page 1, the fields at the top of the form are filled in automatically. In the "Discharge Information" section, the fields "Date of Discharge" and "Discharge Status" are required.







On Page 2, the only required field is "Draft/Final Status". On Page 2 you can enter the number of positive and negative urinalysis results. In addition, the "Discharge Comments" field provides room to communicate any additional important discharge information to AOD staff. Be sure to select a recipient, select "Final" and submit the form. The AOD staff selected in the "Send To" field will be notified of the discharge.

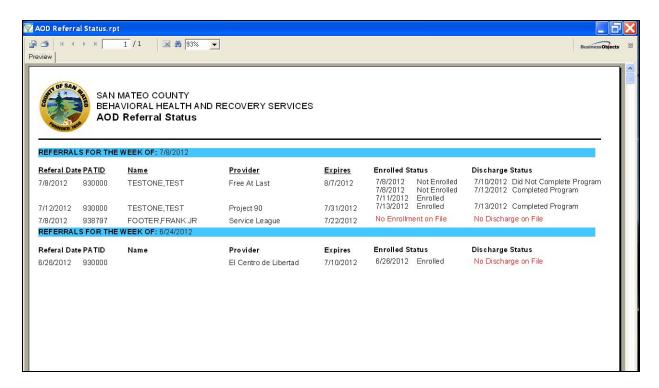






# **Referral Tracking Report (for AOD Use Only)**

This report will track the status of all of the referrals in the system for all AOD clients.



### Client Referral Tracking (for AOD and Provider Staff) (not created yet)

This report will allow staff at agencies to view the referral status of clients referred by AOD to their agency. AOD Staff will be able to run this report for any client. Provider Staff will be restricted to clients they are currently serving.

# E. MCE Authorization Request/Approval

The MCE authorization process is managed within Avatar. The process is initiated by the client's treatment team/agency using the form "MCE Authorization Request".

**Path**: Avatar CWS → Other Chart Entry → Authorizations → AOD Authorizations → MCE Authorization Request.

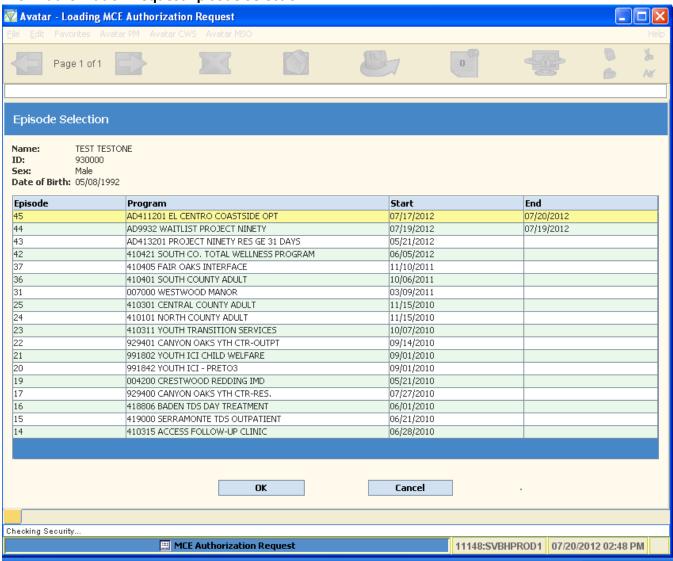
Because the authorization is related to a Client, you must have a client selected or select a client as the first step.

The authorization is also related to a Client's episode so the second step is to select the correct episode for the Authorization.





**MCE Authorization Request Episode Selection** 

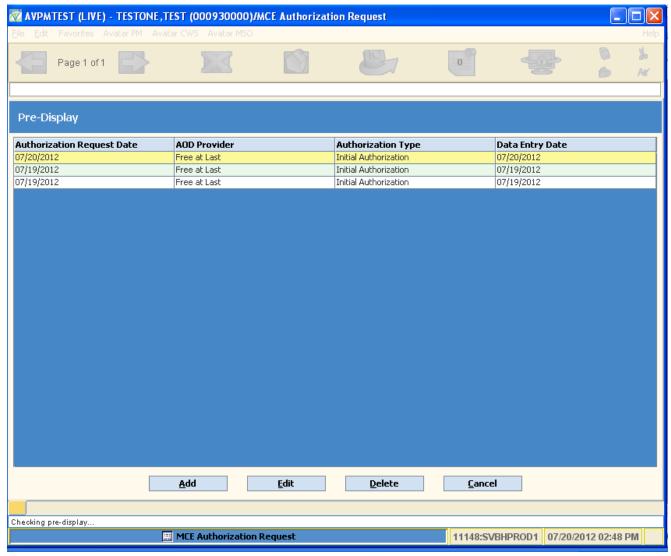


#### **MCE Authorization Request Pre-Display**

If the client has existing authorization requests, the next screen is a Pre-Display of previous authorization requests for your episode. From the Pre-Display you have the option to ADD a new authorization, EDIT an existing authorization, DELETE an authorization, or CANCEL out of the form.







#### **Authorization Request Information**

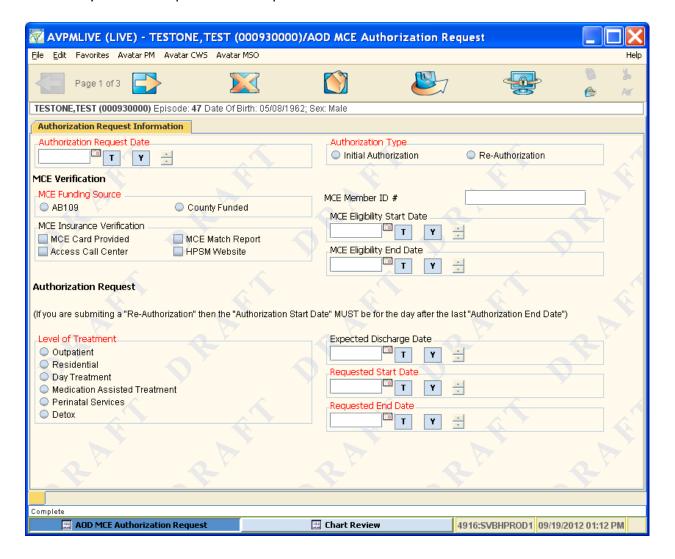
The Authorization Request has one tab with three pages. On page 1 (see screen shot below), every field EXCEPT "Secondary Drug of Choice" is required.

- Authorization Request Date enter the correct date.
- Authorization Type either Initial or Re-Authorization.
- MCE Funding Source either AB109 or County Funded.
- MCE Insurance Verification choose how you verified MCE coverage.
- MCE Member ID # enter number on card
- MCE Eligibility Start Date enter date coverage begins
- MCE Eligibility End Date enter date when coverage is ending





- Level of Treatment Indicate the correct level of treatment requested.
- Expected Discharge Date if applicable, enter expected discharge date
- **Requested Start Date** enter the authorization start date. For Re-Authorizations, the date is one day after the expiration of the previous authorization.

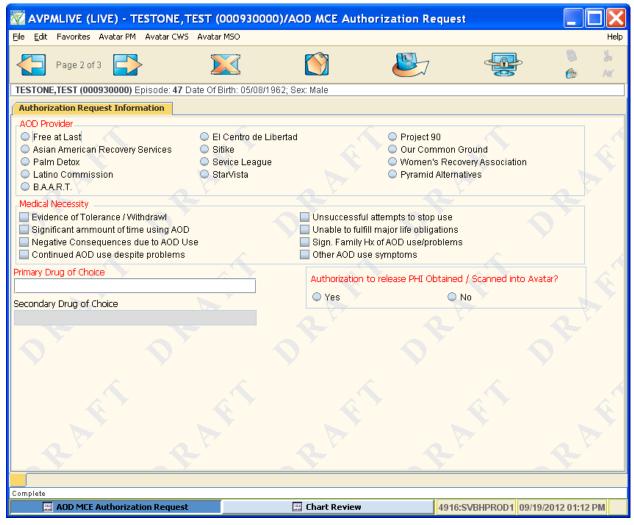


On page 2 (see screen shot below), every field EXCEPT "Secondary Drug" text box is required.

- Requested End Date enter the authorization end date.
- AOD Provider select your program.
- Medical Necessity select one or more Medical Necessity criteria that apply to the client.
- **Primary Drug of Choice** enter client's primary drug of choice.
- **Secondary Drug of Choice** enter client's secondary drug of choice if appropriate.
- Authorization to release PHI scanned into Avatar? select "Yes" or "No" as applicable.





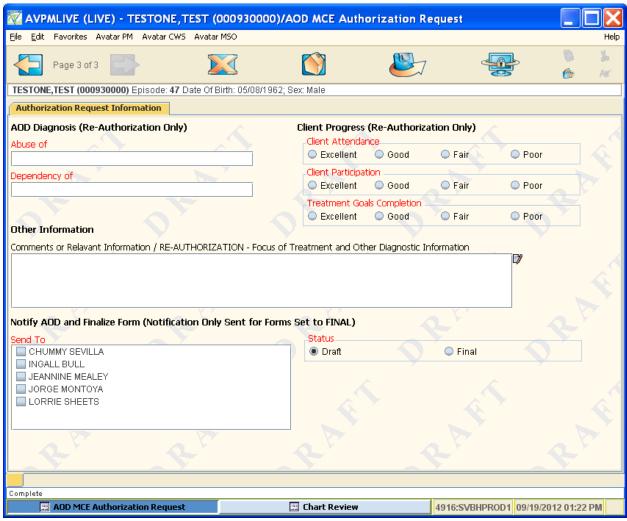


On page 3 (see screen shot below), every field EXCEPT "Comments or Relevant Information" text box is required

- **AOD Diagnosis Abuse of** required for re-authorizations. Free text field. Enter in the appropriate answer.
- **AOD Diagnosis Dependency of –** required for re-authorizations. Free text field. Enter in the appropriate answer.
- **Client Attendance** select the radio button indicating appropriate answer.
- Client Participation select the radio button indicating appropriate answer.
- Treatment Goals Completion select the radio button indicating appropriate answer.
- **Comments or Relevant Information** free text field to enter comments or information relevant to the request.
- **Send To** select the recipient from the list. If the person you want to send the list to is not in the list, submit a Help Desk ticket to request the person be added to your list.
- Status select Draft or Final. The recipient will be notified only after you save the form as Final







#### **MCE Authorization Approval**

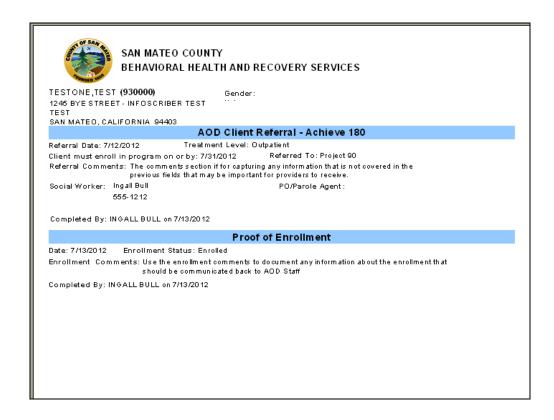
The recipient of the Authorization Request will receive a notice in his/her To Do List. To review the details, double click on the To Do list item.







By double clicking on the blue "View Details" button in the To Do List, the report of referral information will look similar to the screen shot below:

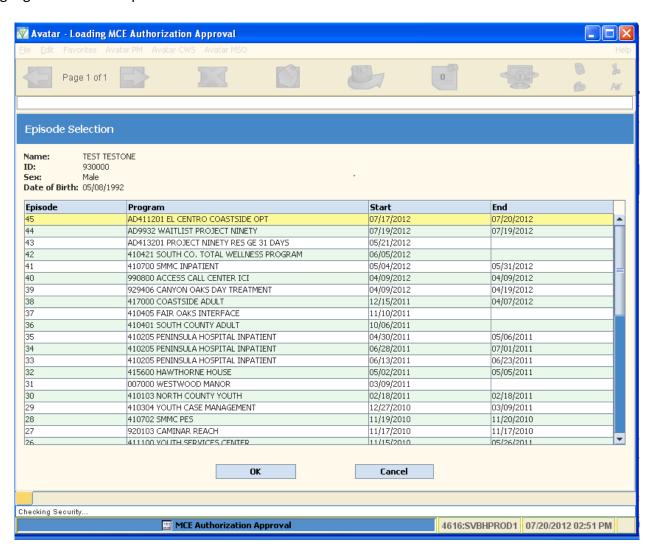






Before opening the MCE Authorization Approval form, make sure you have the client selected. When the form is opened, if the Client has more than one episode for your program, step one is to select the episode for the authorization (see screen shot below).

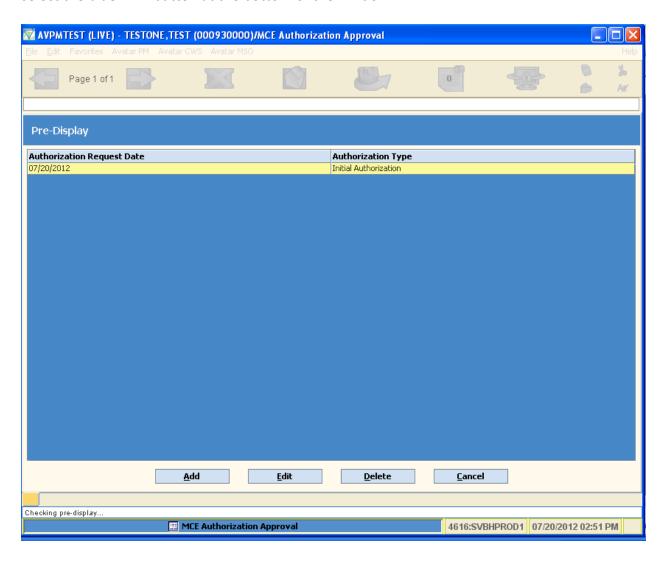
Highlight the correct episode and click on the blue "OK" button at the bottom of the window.







If the client has existing authorization requests, the next screen is a Pre-Display of previous authorization requests for your episode. From the Pre-Display, select the authorization to review for approval and select the blue EDIT button at the bottom of the window.

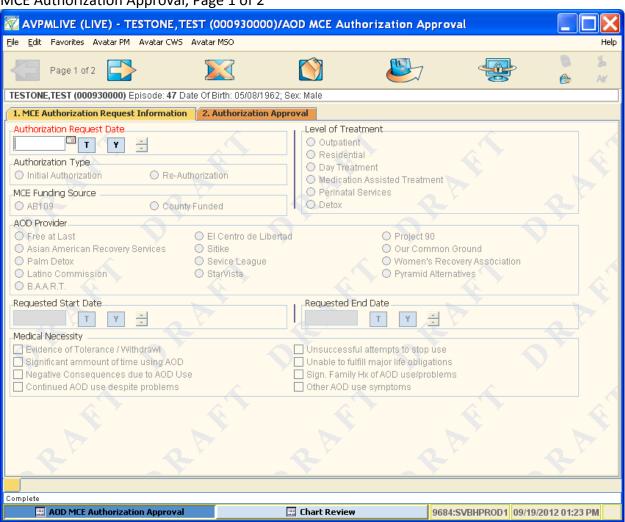






Information on the first tab "MCE Authorization Request Information" is a display of information contained in the Authorization Request. Review the information on the two pages of this tab.

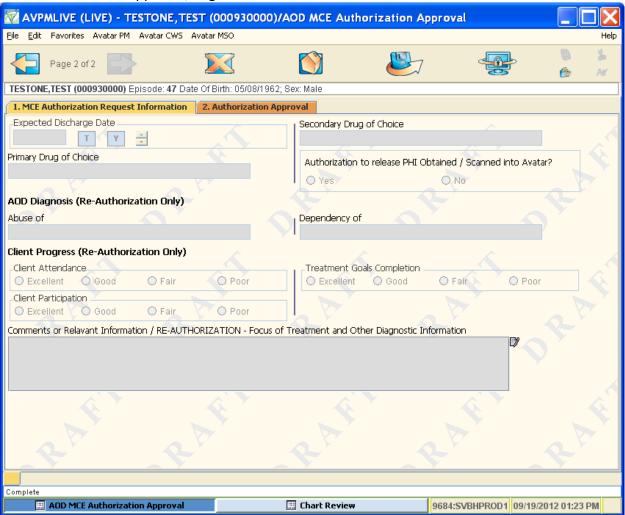
MCE Authorization Approval, Page 1 of 2







MCE Authorization Approval, Page 2 of 2





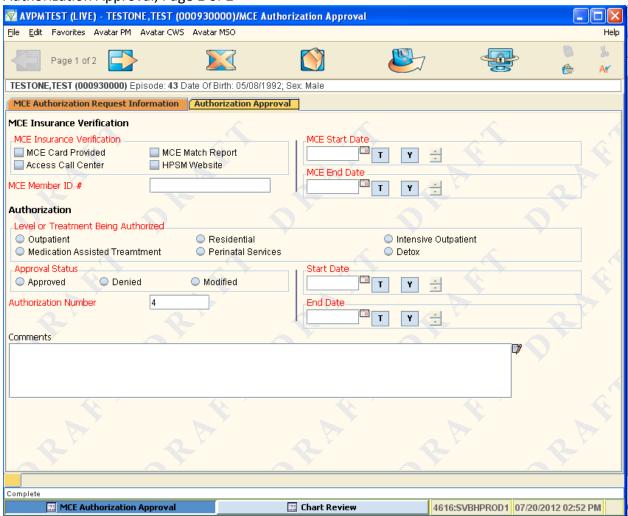


**Authorization Approval** tab - Based on the information submitted for the Authorization Request, complete the Authorization Approval. See screen shot below.

#### Fields to Complete

- MCE Insurance Verification May pre-populated with information from provide
- MCE Start Date May pre-populated with information from provide
- MCE End Date May pre-populated with information from provide
- MCE member ID May pre-populated with information from provide
- Level of Treatment being authorized
- Approval Status
- Authorization Number Automatically generated by Avatar
- Start Date
- End Date
- Comments

Authorization Approval, Page 1 of 2





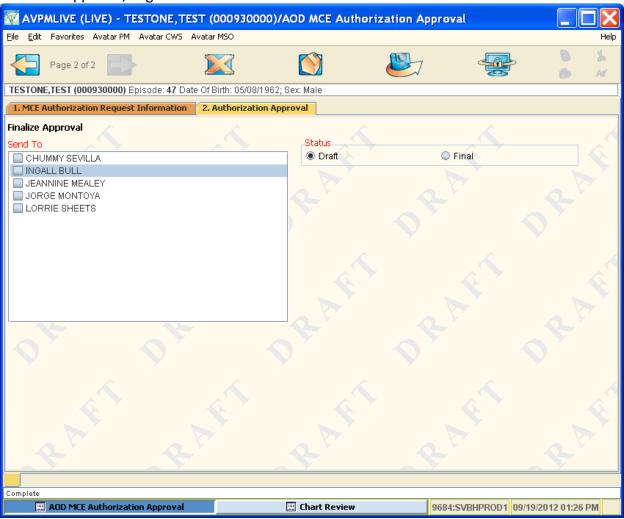


On the second page of the Authorization Approval tab, select the recipient of the authorization action and select whether to leave the authorization in Draft or Final.

If you select Draft, you expect to return to the form to complete it. No notification is sent to the selected recipient.

If you select Final, you have completed the authorization. The notification is sent to the selected recipient and the authorization can no longer be edited.

Authorization Approval, Page 2 of 2







### F. Group Registration and Group Member Assignment

You register counseling groups and assign members to the group to track group membership and attendance.

**Path**: Avatar PM → Appointment Scheduling → Group Management → Group Registration

### Using the Select Group Screen for a New Group

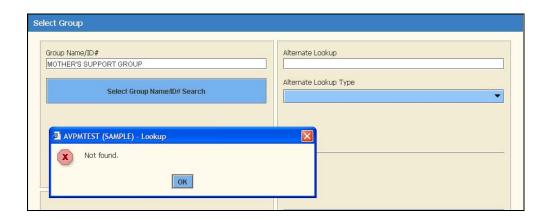
When you select the Group Registration command, the first screen you see is the Select Group screen, as shown in the following figure. This is where you begin the process to register a new group or update an existing group. If Avatar does not find the group name, as shown in the following figure, you proceed to create the new group.

**NOTE:** Groups with similar names may appear in the Select Group list at the bottom of the screen. Make sure your new group name is unique before you start the new group. Within the Group Name, include your System Code (e.g. "EC" for El Centro, "P90" for Project Ninety), day(s) the group meets, and a short descriptive title. For example, a group that meets every Thursday afternoon at Star Vista for Parents in Recovery would be named "SV THURS PARENTS IN RECOVERY".



#### **IMPORTANT**

You must enter the group name in all caps in order for it to carry over to the Group Registration screen. If the group name is not in all caps in the Group Registration screen, when you click the Submit icon, Avatar displays an error message asking you to enter the group name.

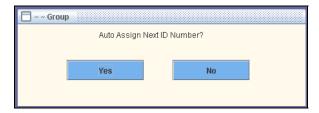






# **Assigning a Group ID Number**

When you begin creating the new group, Avatar offers to auto assign the next group ID number. Click on the blue "Yes" button.



# **Group Registration Tab**

This is where you register the group name and the date the group is created.



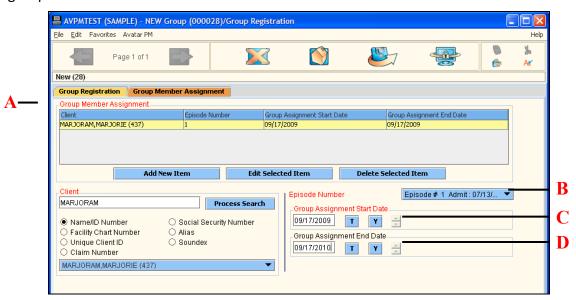
FIELD	DESCRIPTION
A) GROUP NAME	THE GROUP NAME MUST BE IN ALL CAPS.
B) GROUP REGISTRATION DATE	THIS IS THE DATE THE GROUP IS CREATED.





### **Group Member Assignment Tab**

Once you enter the group name and registration date, you are ready to add members to the group. You use a multiple entry table to add clients to the group and to specify the episode number to which the client's group sessions will be billed.



FIELD	DESCRIPTION
A) GROUP MEMBER ASSIGNMENT	A CLIENT MUST HAVE AN ACTIVE EPISODE TO BECOME A GROUP MEMBER.
B) EPISODE NUMBER	CHOOSE THE EPISODE TO WHICH THE BILLING WILL BE ASSIGNED.
C) GROUP ASSIGNMENT START DATE	This is the start date of the <i>client's</i> assignment to the group.
D) GROUP ASSIGNMENT END DATE	THIS IS THE END DATE FOR A SELECTED MEMBER'S PARTICIPATION IN THE GROUP. YOU MIGHT ENTER A DATE HERE FOR A CLIENT WHO IS ATTENDING A COURT-MANDATED THERAPY GROUP THAT MUST BE COMPLETED WITHIN A SPECIFIC TIME FRAME.

#### Adding a New or Removing an Existing Permanent Group Member

If a client wants to join a group on a full-time basis after the group is created, go back into Group Registration and add the person via the Group Member Assignment tab.

If a client wants to permanently drop out of a group after the group is created, go back into Group Registration and delete the client via the Group Member Assignment tab.





# **Printing a Group List**

See the Quick Reference Guide—Registering Therapy Groups for the procedure for printing a roster.

Task	Procedure
Menu Path—Print the List of Group Members	Avatar PM→Appointment Scheduling→Group Management→Group Member Listing
Printing a Roster	<ol> <li>Choose Avatar PM→Appointment Scheduling→Group Management→Group Member Listing from the Menu Frame.</li> </ol>
	2. Click the Individual radio button.
	3. Conduct a Process Search to locate the group.
	4. Click the Process icon on the Option toolbar.
	<ol><li>When the roster appears, click the Print button at the bottom of the screen.</li></ol>
	6. When the Print dialog box appears, click the Print button.
	7. When the Printing Complete message appears, click OK.
	8. Click the Stop/Dismiss button at the bottom of the screen.
	9. When the Option Return message appears, click Yes.
	10. Click the Close icon on the Option toolbar to close the window.

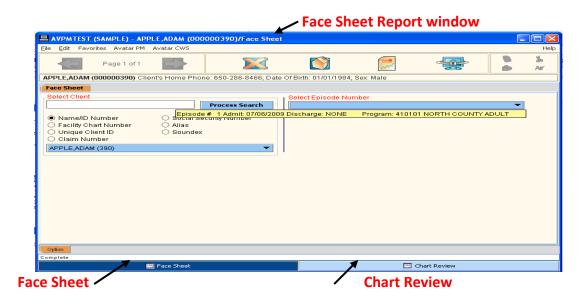




#### **Section 14: AOD Chart Review**

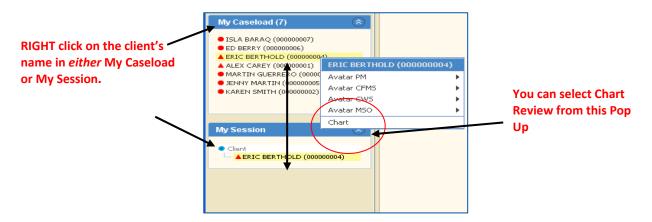
# A. How to Find the AOD Chart Review Screen

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



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

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





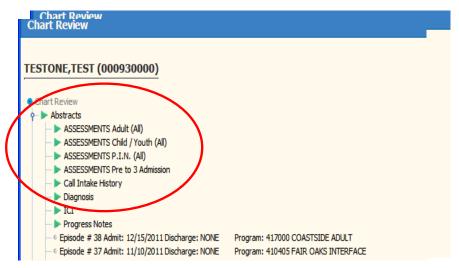


### B. Information in the Chart Review Screen

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

- \* Abstracts: These are reports that pull together information from multiple areas of the Avatar system. A report from Abstracts will include all information and companion documents. For example, Assessment includes MSE, Diagnosis, LOCUS, Substance Abuse Assessment if indicated- all will show for date selected.
- \* Client Level Documents: These are forms connected only to a client, not any particular program or episode.
- \* Episodic Level Documents: Episodes are displayed by episode number, admit and discharge dates, if the episode is open then the discharge date will display "NONE". Episodic documents include treatment plans, ASI, and diagnosis.

### C. Chart Review Screen Shot



#### **ABSTRACTS**

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



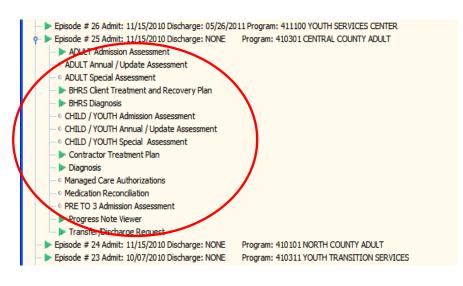




#### **CLIENT LEVEL**

Client Level forms are not associated with any particular program or episode; they are connected only to the client.

#### **Chart Review Screen, continued**



#### **EPISODE LEVEL**

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

#### D. How to Open and View Chart Review Documents

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

⚠ If this feature **DOCUMENTS**, does not work, you can go to the Avatar Clinical Document Viewer (Section 19) so you can search for and view scanned documents.





# **Section 15:** Scanned Documents

### A. Scanning and Importing Documents

Avatar provides Point of Service (POS) scanning and document importing, which is *scanning on demand*. POS indicates that you can easily scan documents into Avatar just at the time you need to.

Scanning client episode-related documents into Avatar assures that key clinical information can be electronically shared throughout the organization. It eliminates the cost of managing and storing paper-based records, and it improves client quality of care by providing access to one comprehensive source of client information, the electronic health record.

The following list provides examples of documents that you would typically scan into Avatar.

- Assignment of Benefits
- Insurance Cards
- Driver's Licenses
- Adolescent ASI
- Consent Forms
- Signed Client Treatment Plans

Menu Path: Avatar CWS→Document Management→POS Scan

#### **DOCUMENT IMAGING AND ARCHIVING - POS WINDOW**

Use this window to describe the document you are scanning or importing.







FIELD/BUTTON	DESCRIPTION
A) Type	Select Client from the dropdown list to view documents related to a specific client or select Staff to view documents scanned by a particular staff member.
B) Client	Type the last name of the client whose record you are attaching the scanned document to and tap [Enter] to retrieve the full client name. If there is more than one client with the same last name, use the dropdown list to select the correct client.
C) Episode	1MPORTANT
	Make sure you select the correct episode to scan these documents into. ALL documents will be scanned or imported into an Episode.
D) Origination Date	The Origination Date is the date of the document. If a document requires signatures of both the clinician and the client and the client signs at a later date than the clinician, the date of the clinician's signature is the document date.
E) Form	<u> </u>
	Select the category that matches the type of document you are scanning. Choosing the correct form category is essential to allow others to retrieve the document in the future.
F) Scan	Click the Scan button to begin the scanning process
G) Import	Click the Import button to import a document

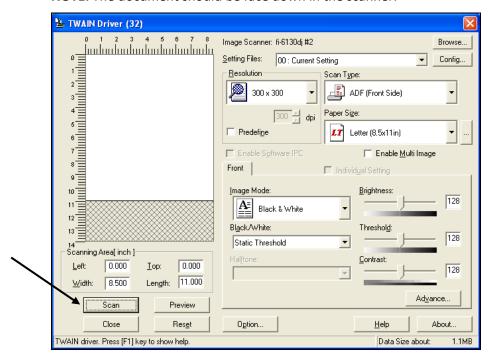




### **Scanning Documents**

Clicking the Scan button in the Document Imaging and Archiving – POS window displays the dialog box shown in the following illustration. Clicking the Scan button in this dialog box begins the scan.

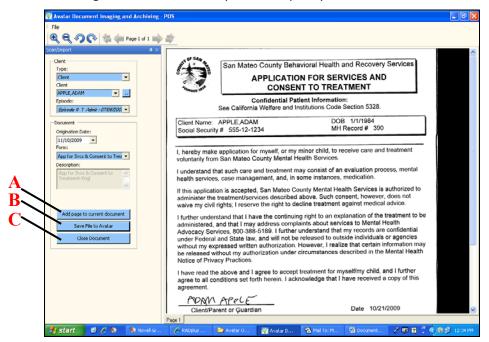
**NOTE:** The document should be face down in the scanner.







When the scan is complete, you see the scanned document displayed in the Document Imaging and Archiving – POS window. Verify that the quality of the scan is readable.



BUTTON	DESCRIPTION
A) ADD PAGE TO CURRENT DOCUMENT	USE THIS FEATURE IF A PAGE IS MISSING FROM A DOCUMENT, IF A PAGE IS DAMAGED DURING THE SCANNING PROCESS, OR IF THE SCANNED IMAGE OF A PAGE IS POOR QUALITY.
B) SAVE FILE TO AVATAR	USE THIS BUTTON TO SAVE THE SCANNED DOCUMENT INTO AVATAR.
C) CLOSE DOCUMENT	IF THE SCANNED DOCUMENT QUALITY IS POOR, CLICK THE CLOSE DOCUMENT BUTTON AND RE-SCAN THE DOCUMENT.

### **B. Viewing Scanned Documents**

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

### C. <u>Understanding the Clinical Document Viewer Window</u>

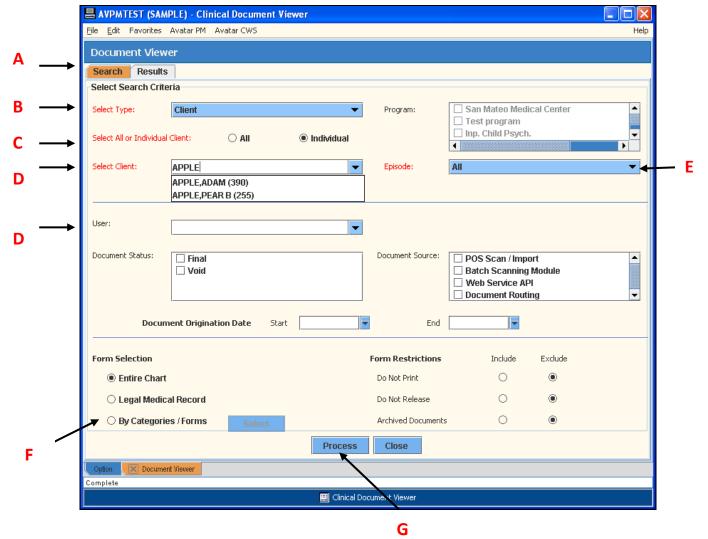
- Path: Avatar CWS → Document Management → Clinical Document Viewer
- **Access:** Any BHRS staff member can access Clinical Document Viewer. However, some documents, such as HIV status, are restricted to certain staff only.

Clinical Document Viewer has 2 tabs:

Screen Shot of Clinical Document Viewer Tab 1 – Search



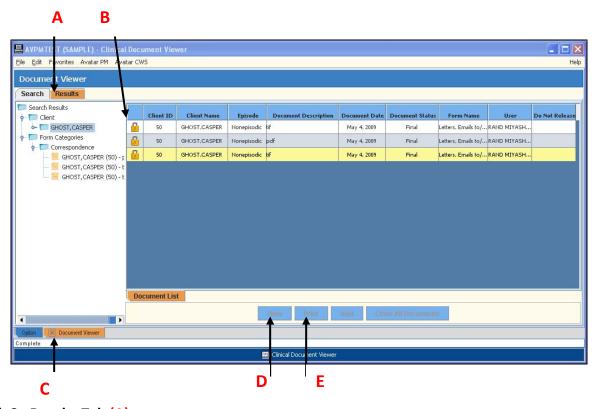








- Tab 1: Search Tab (A)
  - Select Type of Search: Select Client for documents related to this client or Staff for documents scanned by specific staff. (B) Then Select All (scanned by all staff) or Individual Client (C).
  - **Select Client**: Enter a few letters of the client's name, if more than one name appears click to make it populate the select client field (D).
  - **Episode:** Select a specific episode or to see all documents for this client, **select ALL (E) is pre selected.**
  - Form Selection: You can search for a document by Entire Chart, Legal Medical Record or by Categories/Forms (F).
  - Click Process (G). Please be patient; this may take some time!
- Screen Shot of Clinical Document Viewer Tab 2 Results



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





### Section 16: The AOD Client's Electronic Medical Record and AOD Avatar Reports

#### A. About AOD Reports

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

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

#### **B. The Crystal Report Application**

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

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

Click on this **Report Submit** icon when you are requesting a report. The Report Submit icon has a squiggly line and will be present on many reports that you request. The first time you request a report from your computer, Avatar will display the pop-up message below:



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

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

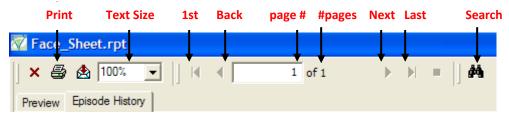






## D. Standard Report Toolbar

Reports use a standard toolbar as shown below:



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

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



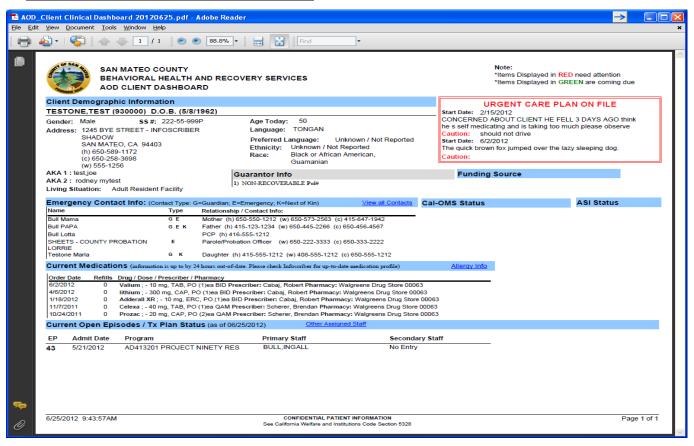


### Section 17: The AOD Client Dashboard Report

#### A. <u>Understanding the Client Dashboard Report</u>

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

#### B. Screen Shot of the Dashboard Report



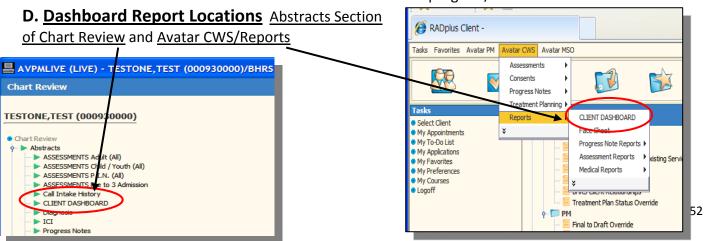
## C. <u>Details of the Main Sections and Links to More Information (in blue)</u>

- 1. Client Demographics Includes information on the following: Client Name, Date of Birth, Age, Address, Phone Numbers, Race, Ethnicity, Language & Preferred Language, Gender, Social Security Number, Living Situation, Alias/AKA Names,
- 2. Urgent Care Plan If a client has an Urgent Care Plan on file it will display in the upper right corner. (This report will only pull the *most recent*, open Urgent Care Plan) \*See Section 25 re: Client Alerts/Urgent care Plan
- 3. Guarantor Information Shows the current BHRS financial information on file.





- **4. Funding Source** Shows the current Funding Source selected for the client at your team.
- **5. Emergency Contact Information** Displays information that has been entered in the Client Relationships form in Avatar. Individuals included have been flagged as one of the following: Guardian (**G**), Emergency Contact (**E**), and/or Next of Kin (**K**). In addition, it lists individuals who are designated as urgent contacts (e.g., Probation Officer, Primary Care Physician, etc...)
  - View All Contacts This link will display all collateral contacts entered into Client Relationships. You can find Client Relationships at Avatar PM/Client Management/Client Information.
- **6.** <u>CalOMS Status</u> Displays whether or not a client's CalOMS admission record has been submitted and whether or not a CalOMS Annual Update or Discharge form must be submitted.
- 7. <u>ASI Status</u> Displays whether or not an ASI has been completed for this client and the date it was completed.
- **8. Current Medications** Displays currently prescribed medications from Infoscriber. Information includes the date prescribed, # of refills left, medication name, dosage, prescriber, and pharmacy (pharmacy phone number will be added later). Prescriptions that have been discontinued will not display in this section. (NOTE: **Infoscriber information can be up to 24 hours old.**)
  - ► <u>Allergy Info</u> This link will display all medication and non-medication allergies that have been entered into Infoscriber.
- **9. Current Open Episodes /Tx Plan Status** This section displays information about the client's open episodes. Information for each episode includes episode number, admit date, program name, primary clinician, psychiatrist, primary diagnosis, last service date, and treatment plan status.
  - a. **Treatment Plan Information** If the client's Treatment Plan for an episode is almost due, it will display in **GREEN**. Treatment Plans that are overdue will display in **RED**.
  - b. **Last Service Date** Displays in **RED** if the last service occurred more than 90 days ago. This information will be included only for those clients for whom services are recorded in Avatar. Generally, only fee-for-service clients will have service information for your team.
  - c. Additional links in this section:
    - i. Other Assigned Staff Displays the names and roles of other staff who have this client on their caseloads and each staff member's program/team.







#### **Section 18:** AOD Documentation at a Glance Report

#### A. <u>Documentation at a Glance Report</u>

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

#### B. <u>Path</u>: CWS Reports → Documentation Status Reports → Documentation at a Glance.

You may select the report by

**Location:** shows all clients by all clinicians for a selected program,

Staff: shows all clients assigned to a specific staff person for all programs, or

**Staff and Location:** shows all clients for a selected staff person at the selected program.

To request the report, click on the Report Icon



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

## C. Screen Shot of AOD Documentation at a Glance Report



SAN MATEO COUNTY

BEHAVIORAL HEALTH AND RECOVERY SERVICES

#### AOD Programs: Documentation At a Glance Report

for AD419601 ADDICTION RESEARCH TREATMENT

#### AD419601 ADDICTION RESEARCH TREATMENT

BULL,INGALL					
Client	Admit Date	Treatment Consent	Cal-OMS Status	ASI Status	Treatment Plan
930001 TESTINGTHREE, TEST DOB: 6/15/1977 9855 OAK ST San Mateo SAN MATEO, CA 94403 (h) 650-573-2541	6/11/2011 # of Days 377	6/11/2011	Admission: 6/14/2012 Annual: 6/14/2012		Start Date: 6/20/2012 End Date: 6/20/2012

Total for BULL, INGALL: 1





#### D. Report Headings

- Client Includes the Client Name, Avatar ID#, Date of Birth, address and phone numbers.
- Admit Date Admit Date to the program and the number of days since admission.
- Treatment Consent Date the Consent to Treatment was signed.
- CalOMS Status Displays the type of CalOMS document and the date it was submitted.
- ASI Status Displays information regarding the *last ASI for the client*. Information included is Assessment Status (Final, Draft), the Date of Assessment and who completed the document. If an *assessment is left in draft* then it will have a *draft indicator in red*.
- Treatment Plan: Displays the Start and End Dates of the current Treatment Plan.
- **Primary and Secondary Drugs of Choice** Displays drug names entered in CalOMS for primary and secondary drugs of choice.
- Last Service: Displays the last service date and indicates if that service is more than 90 days old.





#### **Section 19: Units of Service**

#### A. Units of Service Report

The **Units of Service Report** is a helpful report for administrators and financial staff. This report will provide you with information about the type and number of services provided to your clients during the report period selected. This report is a good way to check that all services have been entered correctly. Use it to compare to the service reports submitted to BHRS. In addition, it shows the type and number of services provided by Financial Class assigned to clients.

#### B. <u>Path</u>: Avatar PM → Reports → AOD UoS by Program and Funding Source.

You select the report by

**Program:** select from a drop down list of your programs, Start Date: beginning date of service to include, and

End Date: last date of service to include.

To request the report, click on the Report Icon



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

#### C. Screen Shot of AOD Units of Service by Program and Funding Source

AOD INTRO LAS20120712\_v11.doc





### **Section 20:** AOD Caseload Report

### **Program/Clinician Caseload Report:**

You can request a Caseload Report through Avatar CWS $\rightarrow$  Reports $\rightarrow$  Caseload Reports $\rightarrow$  and request by *Program* or *Clinician*.

If you select **Program** the report does display the caseloads by program and also by clinician. A total Program Client Count and then a Clinician Client Caseload Count is listed. If you select **Clinician**, the report displays only the clinician's caseload with the same count information.

#### Things to consider:

Is there any field in "red" indicating missing information? Look at the last service date; is there active service within the past 6 months? Is the clinician assignment of cases on this report correct?

Correction to the Caseload may have occurred after review of the Documentation at a Glance Report. Reviewing the Caseload Report ensures that all cases at your program are active. If any of the fields in the Caseload Report need to be **updated**, (e.g., a diagnosis), then update using the BHRS Diagnosis through Avatar PM  $\rightarrow$  Client Information  $\rightarrow$  Diagnosis.

If information needs to be **added**, (a client **to** a caseload), and/or **deleted**, (a client **from** a caseload), this function can be delegated to the admin or the clinician through Avatar PM→ Client Management→ Episode Maintenance→ BHRS Assign to Caseload **or** BHRS Remove from Caseload.

Please run another Caseload Report to be sure the necessary changes have taken place.

The Caseload Report reflects the current information in Avatar. An accurate Caseload report can help determine caseload assignment when a new client is admitted. A clinician's caseload that includes active clients with services provided within the last 6 months, and includes current primary/co-occurring diagnoses meets BHRS QM compliance standards.





## **Section 21: Additional Reports**

### **Admission and Discharge Report**

This report will list all clients Admitted to and Discharged from a selected program between the Start/End dates entered by the report requester. Users are required to select a Program and to enter a Start and End date for the report.

Menu Path: Avatar PM → Reports → Admission and Discharge Report

## **AOD Provider Waitlist**

Menu Path: Avatar PM → Reports → AOD Provider Waitlist

#### **AOD DATAR**

Menu Path: Avatar PM → Reports → AOD DATAR





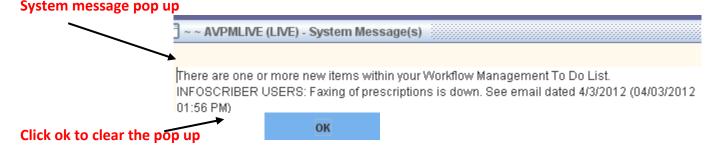
#### Section 22: AOD Workflow – The Function of the "To Do" List

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

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

#### A. System Message Pop Up

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



### B. "To Do" Draft Documents

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

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

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

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

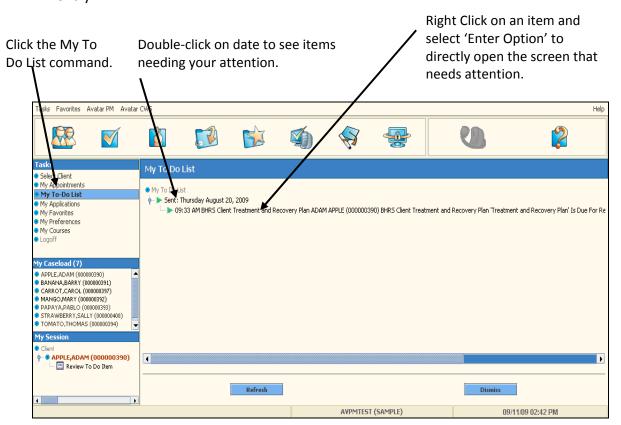




approve/co-sign the item because there is some change (s) to be made by the trainee, the supervisor will send the item back to the clinician. The clinician will receive this document back as a "To Do" list item with a message from the supervisor of what needs to be done. The document must then be resubmitted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

#### D. Viewing the Contents of a "To Do" Item

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

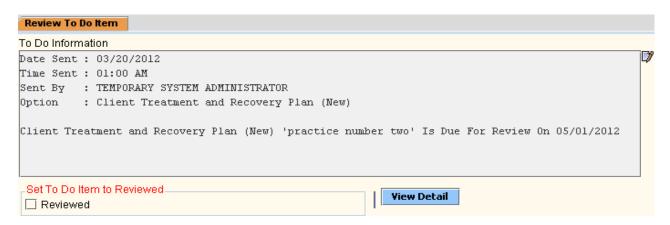






### E. Reviewing "To Do" Items

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



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

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

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

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





#### **Section 23: Client Alerts**

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

#### **A. Client Alerts**

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

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

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

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

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

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

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

#### **Client Alert**

#### The **Client Alert** categories are:

Assignment of Benefits Due Financial Interview Due Stop do not link to episode 1

Care Alert GPO Total Wellness

Care Message insurance Application UMDAP Financial Due
Client is Deceased Stop do not link this episode Update client demographics

Error (custom) Stop do not link to episode 1 or 2 Warning (custom)





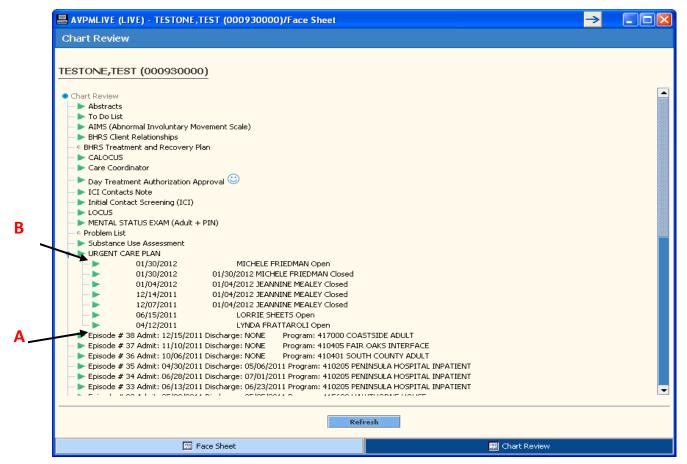
#### **Example of the Client Alert Pop Up Window**



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

- The Urgent Care Plan is located **above the** *latest episode* (A) in the Chart Review screen.
- \* Remember, in order to get to the Chart Review screen you must open any document or report!
- The Urgent Care Plan is listed by date with the *most current date at the top*. Click on the green arrow (B) to view and read the Urgent Care Plan.

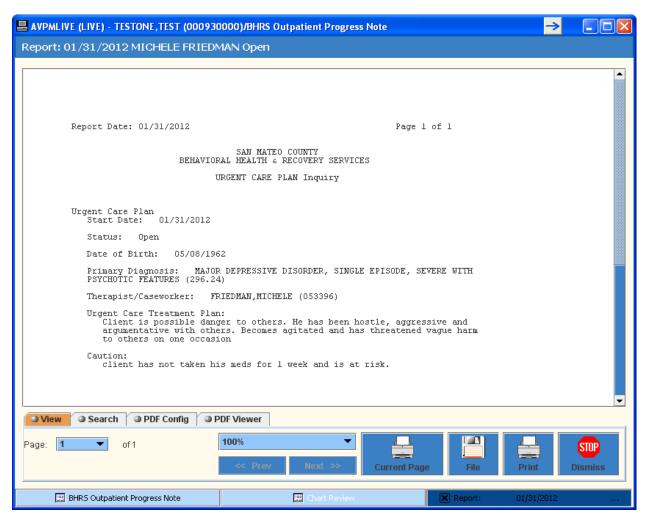
**Chart Review Screen Shot: Shows View of Urgent Care Plans** 





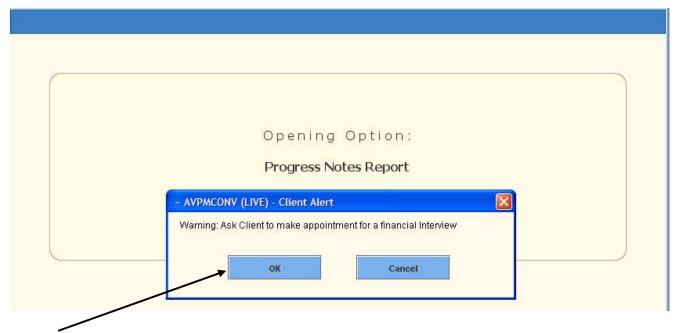


#### Screen Shot: Example of an Opened Urgent Care Plan









<sup>\*</sup> When any document or report in Avatar is opened, this alert will pop up. Click OK.

Once the Access call center has created an Urgent Care Plan and Alert, you will see the warning pop up ALERT whenever any document or report is opened. The pop up screen will warn users: "HIGH PRIORITY - Please Review the Urgent Care Plan in Chart Review."



Click ok to this message AND

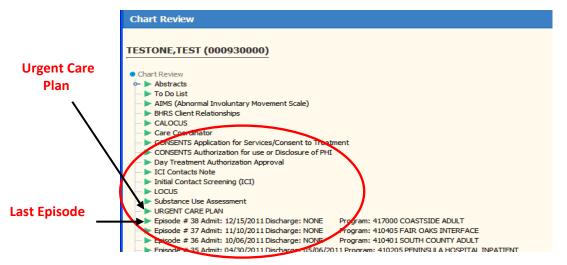
#### BE SURE TO VIEW THE URGENT CARE PLAN THROUGH THE CHART REVIEW SCREEN!

#### **How to VIEW the Urgent Care Plan**

The Urgent Care Plan is viewed through the Chart Review screen. You must open any document or report in order to get to the Chart Review window or you can right click on the name of a client in My caseload or My Session and click on Chart for Chart Review. The Urgent care plan will sit above the last episode.







# **⚠** IMPORTANT: To Close/Disable an Urgent Care Plan

• Contact the Access Call Center and request to <u>Close an Urgent Care Plan</u> and/or <u>Disable a</u> <u>Client Alert that is no longer valid</u>.





## **Section 24: Appendices**

#### 1. Select Client Screen and Alternative Lookup Methods

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

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

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

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

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

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



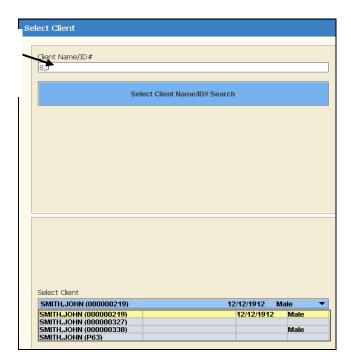




You can narrow your search for a client by trying any of these alternative lookup methods:

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

#### Client Name Shortcut







## 2. Quick Reference for Favorites

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





## Most commonly Used Favorites

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

AOD Staff	





## 3. <u>Using Shortcuts</u>

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

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

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





Field	Proper Convention
Date	Avatar always saves dates in MM/DD/YYYY format.
	You can type shortcuts as follows:
	020609 becomes 02/06/2009
	112308 becomes 11/23/2008
Time	Avatar always saves times in HH:MM AM/PM.
	You can use military time as follows:
	0123 becomes 01:23 AM
	1345 becomes 1:45 PM
Phone Numbers	Must be typed in the following format:
	650-555-1212
	If you don't type the dashes, Avatar adds them for you.
Social Security Numbers	Must be typed in the following format:
	555-12-4345
	You must type the dashes for social security numbers. If
	not, you will see a message prompting for the correct
	format.
Address – Street	Do not use punctuation or special symbols, such as the
	pound sign (#) in addresses.  123 MAIN ST APT 3
	The following abbreviations are accepted:
	ST, AVE, BLVD, WAY, CT.
Address – City	Type the full name of the city with no abbreviations.
Address – City	SAN MATEO
Address – State	Always a 2 letter abbreviation (CA, OR, NV).
Address – Zip	Always a 5 number code (94501).
Red field	Field is required and must be completed before a window
	can be submitted.
Black field	Field is standard and should be completed if possible.
Grey field	Field is not available. This can be because information is
	populating from another screen or you must complete a
	field or select a checkbox somewhere in the current
	window before inputting.





#### 4. How to Connect to the VPN

#### VPN Client v.5.0.0.2 Installation for Contractors

How to Uninstall Manually the Cisco VPN Client 5.0.0.2 Windows XP/Windows 7 - Cisco Systems – 32-bit machines

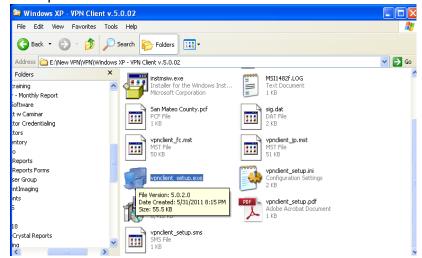
Complete these steps in order to install the Cisco VPN Client:

1. Exit all Windows programs and disable any Antivirus software.

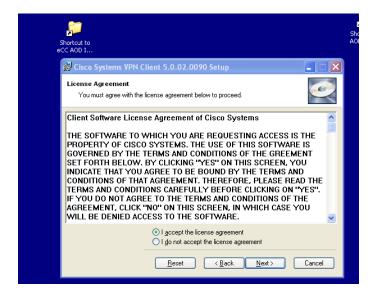
2. **OK**. If you have the installer on your local hard disk, navigate to it and double-click to run the installer.

The program displays the InstallShield Setup window.

Double click on **vpnclient\_setup.exe.** 



3. Accept Cisco license.



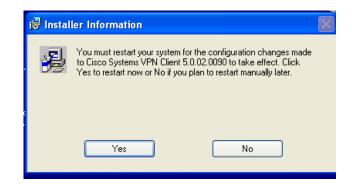




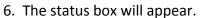
4, Program will install to C:\Program Files\Cisco Systems\VPN Client – click next, next and allow the program to install.

Once the program has installed you will see this message, click **Finish (depending on your system if may require your computer to reboot.** 





5. Once the machine has re-booted, go to **Start, All Programs Cisco VPN Client, click on the yellow padlock.** 



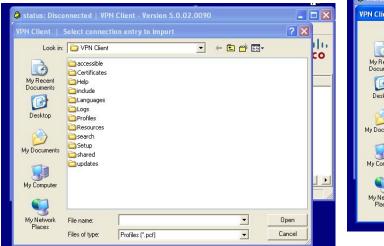


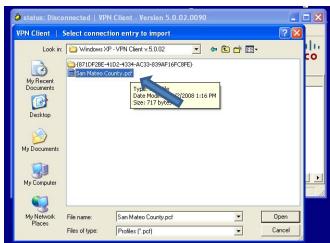




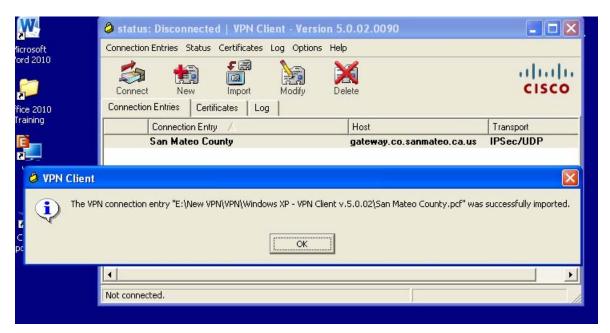


7. Select import – go back to where you have the Cisco installation files and select **San Mateo County.pcf**, then click **Open** 





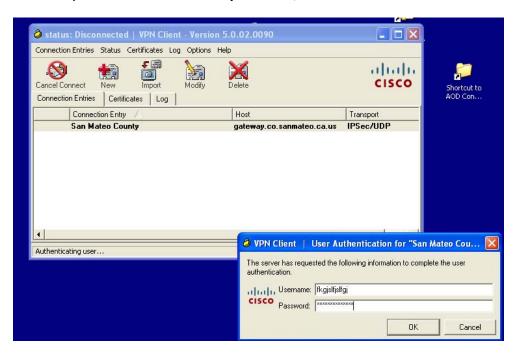
8. The VPN Client should read was imported successfully, Click Ok and the Connect



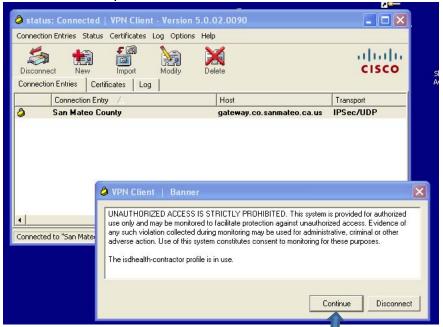




9. Enter you VPN username and password, then click connect



Once connected you will see the VPN Client Banner - Status Continue



Now you are ready to connect to Avatar. – Go to Ir ernet Explorer and type in – http://svmid1/ntst.radplus or click on your deskt p Avatar icon.





# **Agency Waitlist Program Names and Codes**

AD9907 WAITLIST <b>OCG</b> ADULT PROGRAM
AD9910 WAITLIST <b>FREE AT LAST</b> CENTER
AD9912 WAITLIST <b>EL CENTRO DE LIBERTAD</b>
AD9914 WAITLIST <b>LATINO COMMMISSION</b> RES.
AD9918 WAITLIST <b>SITIKE</b>
AD9920 WAITLIST <b>STARVISTA – INSIGHTS</b>
AD9921 WAITLIST STARVISTA – ARCHWAY
AD9924 WAITLIST <b>OCG</b> ADOLESCENT RWC
AD9932 WAITLIST PROJECT NINETY
AD9934 WAITLIST <b>HILLSIDE HOUSE</b> -PERINATAL
AD9935 WAITLIST WOMEN'S RECOVERY ASSOCIA
AD9936 WAITLIST PALM AVE DETOX
AD9937 WAITLIST HOPE HOUSE
AD9940 WAITLIST <b>FREE AT LAST</b> RESIDENTIAL
AD9950 WAITLIST <b>FREE AT LAST</b> RESIDENTIAL
AD9963 WAITLIST STARVISTA FIRST CHANCE
AD9971 WAITLIST PYRAMID ALTERNATIVES
AD9973 WAITLIST AARS
AD9985 WAITLIST OCCUPATIONAL HEALTH SVCS
AD9995 WAITLIST <b>BAART</b>
AD9996 WAITLIST <b>ART</b>

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