Admission Assessments

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Admission Assessments

In this lesson you will complete the admission assessment. You will learn the four assessment pieces that are attached to the main assessment window to form a complete, comprehensive assessment.

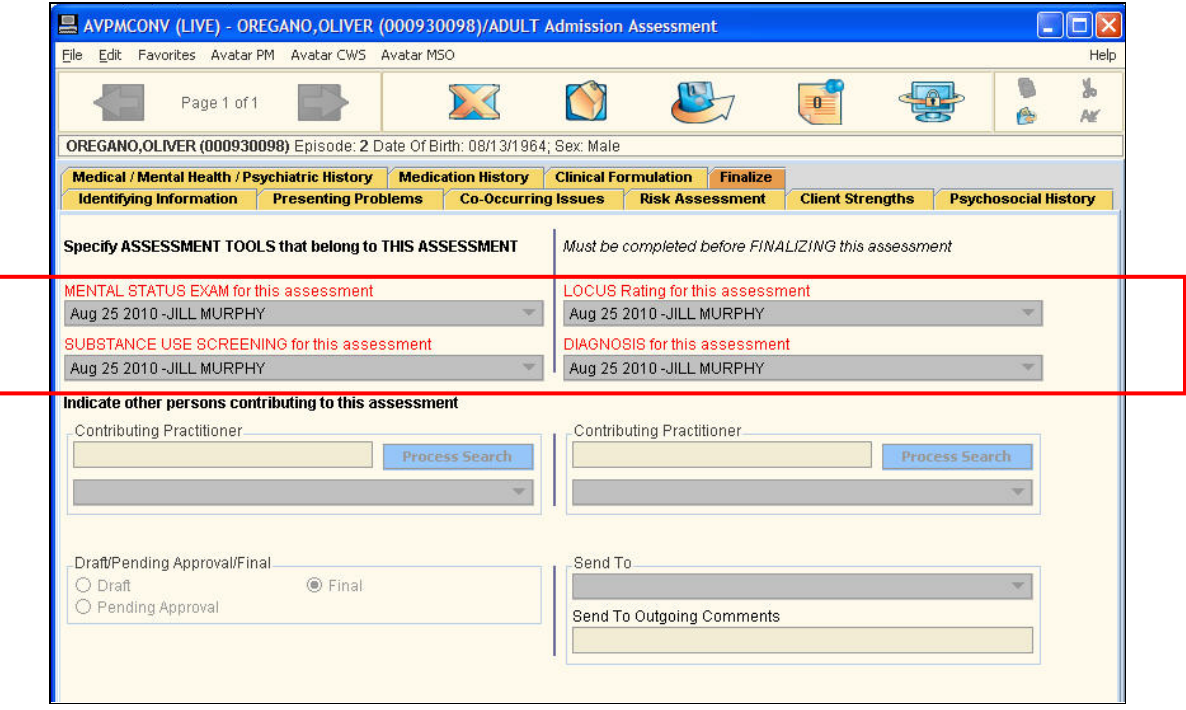
Lesson Objectives

- Understand the Admission Assessment window for both Adult and Youth
- Use the five windows that together make up a complete Admission Assessment
    - Adult / Child-Youth Admission Assessment
    - LOCUS/CALOCUS
    - Mental Status Exam (ADULT+PIN) / Mental Status/Behavioral Observation (YOUTH)
    - Substance Use
    - BHRS Diagnosis
- Use the ADULT or CHILD/YOUTH Special Assessment for clients returning to the same episode

LESSON SCENARIO

Adam Apple comes to the clinic to be assessed by the clinician assigned to him by the admitting program. The clinician meets with Adam during several sessions and completes (within 60 days) all the windows that make up the complete adult admission assessment: Admission Assessment, Mental Status and Behavioral Observation, LOCUS/CALOCUS, Substance Use Assessment, and Diagnosis. Until the full assessment is complete, the clinician sees an item in the Avatar To-Do list as a reminder to complete the assessment before the due date.

The Finalize tab of the Admission Assessment is where the clinician attaches the four other pieces of the assessments, completed within the last 60 days, to the admission assessment.

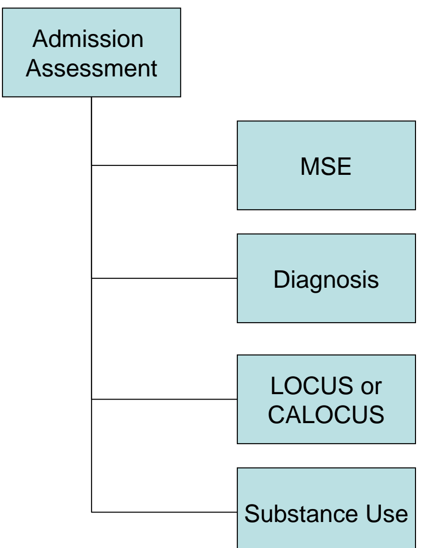


Understanding the Admission Assessment

The admission assessment is designed to provide a comprehensive clinical picture of the client and to establish medical necessity. This helps treatment teams and clients define problems, goals, objectives, and interventions. It also fulfills State and Federal requirements.

Assessments can only be performed for a client who has been admitted to an episode. There are five pieces that go together to make up a complete assessment:

- ADULT or CHILD/YOUTH Admission Assessment
- Mental Status Exam (ADULT+PIN) or Mental Status/Behavioral Observation (YOUTH)
- BHRS Diagnosis
- LOCUS or CALOCUS
- Substance Use Assessment (not required if no substance use is indicated in the admission assessment)



IMPORTANT

You must complete and submit each of these pieces as final within the last 60 days in order to finalize the admission assessment. If even one piece is not yet submitted as final, you will have to save the admission assessment as a draft, complete the missing piece then return to the admission assessment to submit it as final.

TIP! For Quality Management (QM)-guided assistance in completing any free text field, click the Help lightbulb icon next to the field.

UNDERSTANDING THE ADULT ADMISSION ASSESSMENT

Avatar's assessment features assists a clinician in determining what level of care is appropriate for a client, assessing immediate risks and collecting information about the clients personal and social circumstances.

Although the Adult and Child-Youth assessments follow the same general structure and workflow, there are a few fundamental differences. For example, the adult assessment includes a LOCUS while the child-youth assessment includes a CALOCUS.

WHO CAN PERFORM THIS FUNCTION?

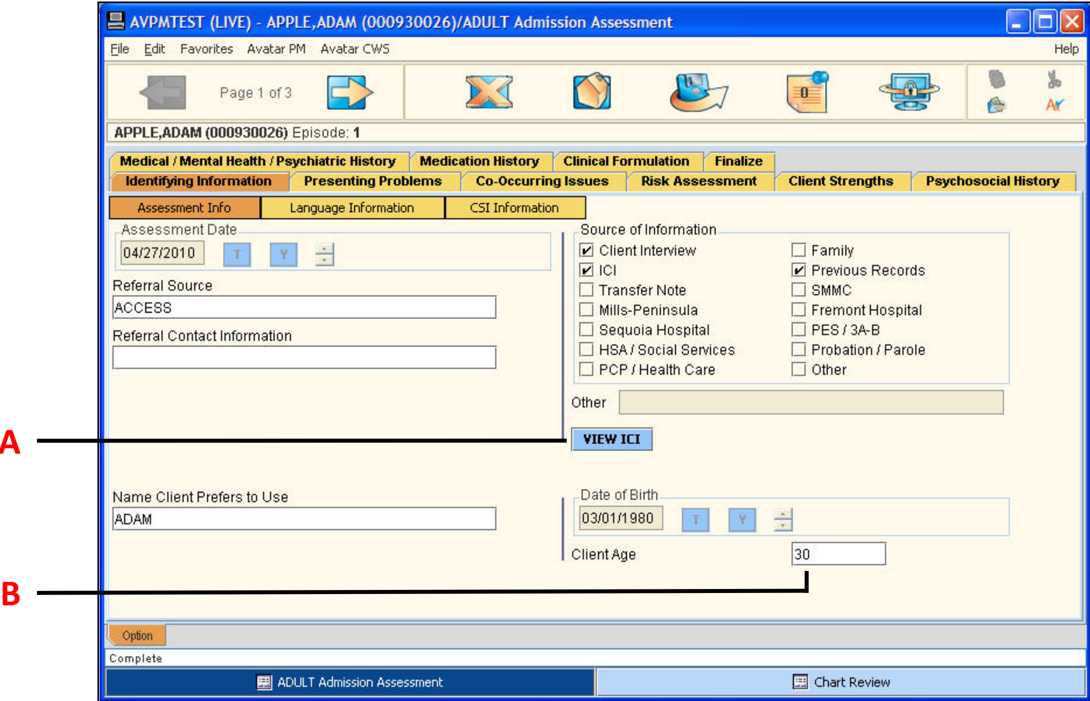
Any clinical staff member who is assessing the client can perform this function.

MENU PATH

Avatar CWS→Assessments→ADULT Admission Assessment

IDENTIFYING INFORMATION TAB PAGE 1 (ASSESSMENT INFO)

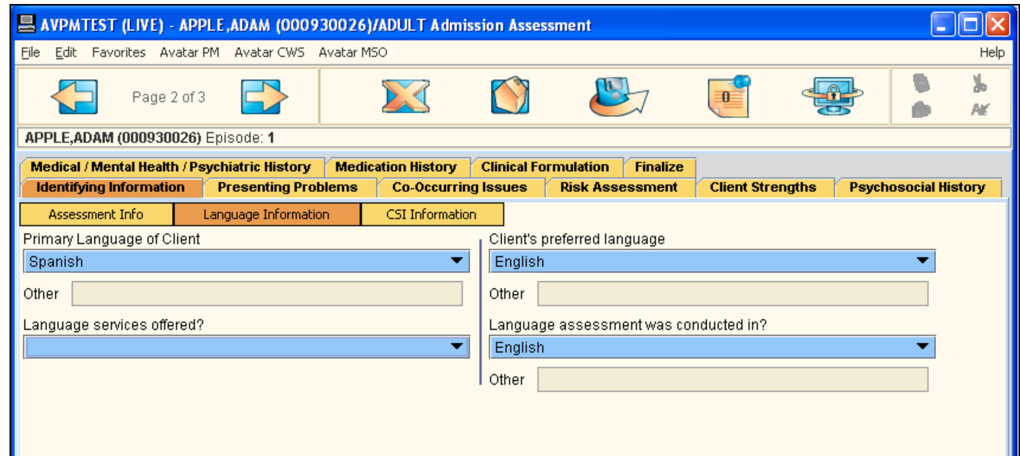
Use this page to document the date and source of the contact regarding the client. This page also includes a button that allows you to review the client's ICI information.



Field/Button	Description
A) View ICI	Clicking this button generates a report that displays all the information from the client's Initial Contact Screening (ICI).
B) Client Age	Client age does not auto-calculate; you must enter it manually.

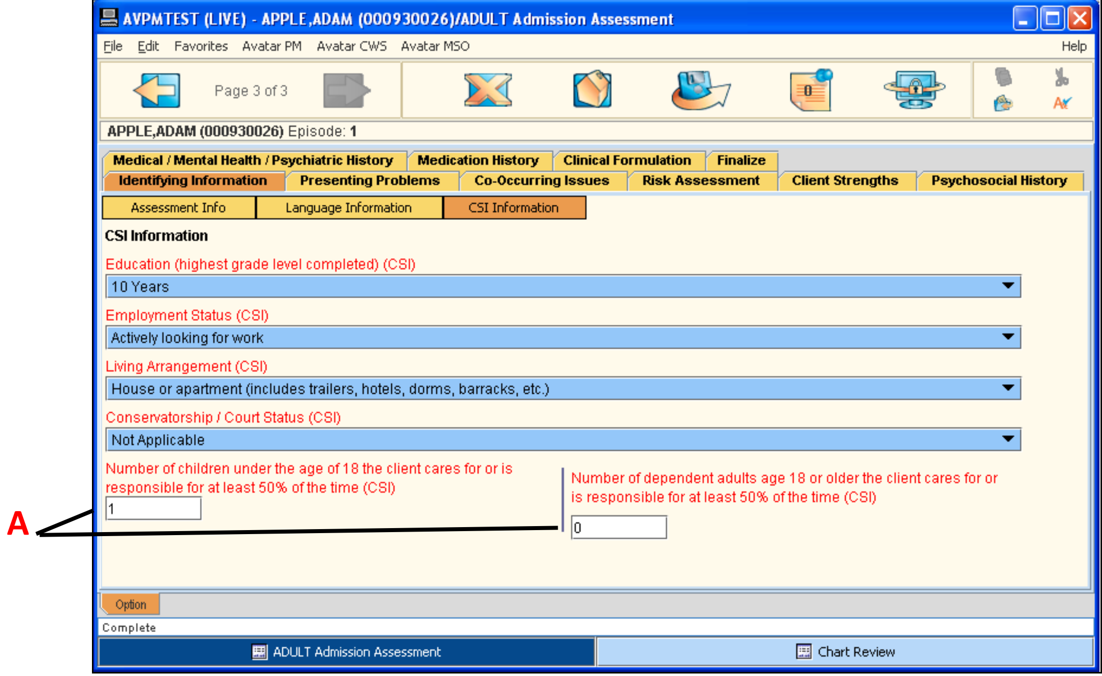
IDENTIFYING INFORMATION TAB PAGE 2 (LANGUAGE INFORMATION)

Use this page to document the client's primary and preferred language, and whether a translator was needed.



IDENTIFYING INFORMATION TAB PAGE 3 (CSI INFORMATION)

All fields on this page are required. Use this page to document the client's employment and education status, and to record education information for California State tracking purposes.

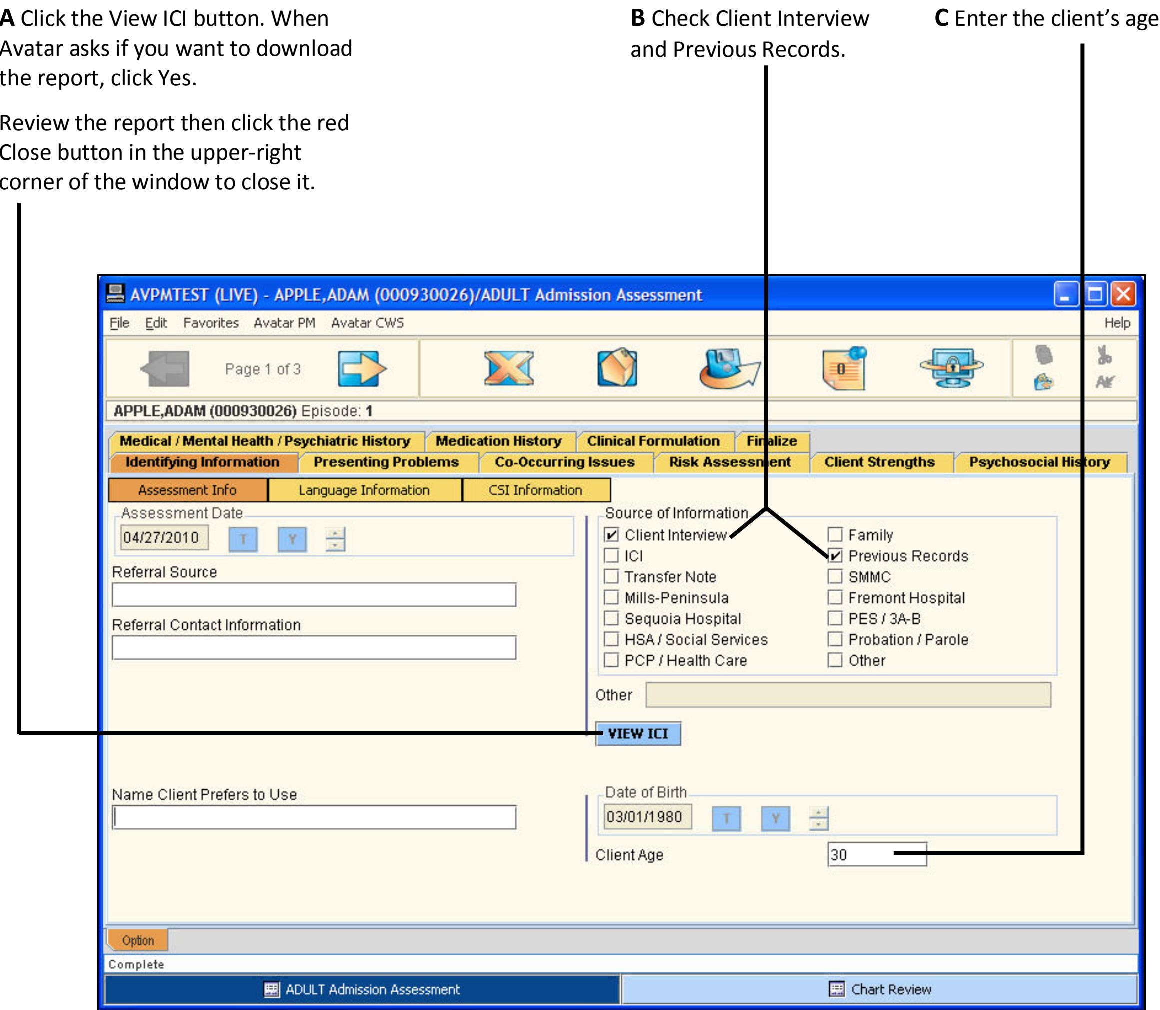


Field/Button	Description
A) Number of children under the age of 18 the client cares for…	If you are unable to assess the number of children or adults the client cares for at least 50% of the time, type 99 in that field.

Exercise 1 Complete the Identifying Information Tab

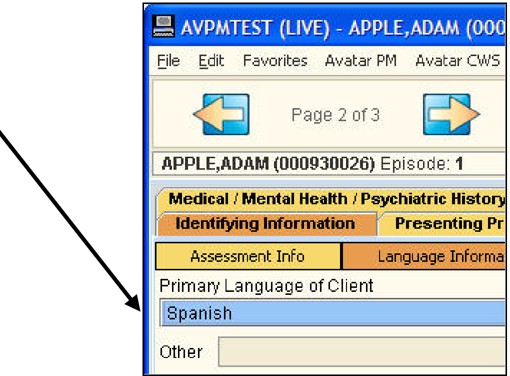
In this exercise you will review the client's ICI information and enter the clients identifying information. ***Before You Begin:*** *Select a sample client you are working with using the Select Client icon on the Task Bar. In this example the client is Adam Apple.*

1. Choose Avatar CWS→Assessments→ADULT Admission Assessment from the Menu Frame.
2. Follow these steps to enter the client's data in the Assessment Info tab:



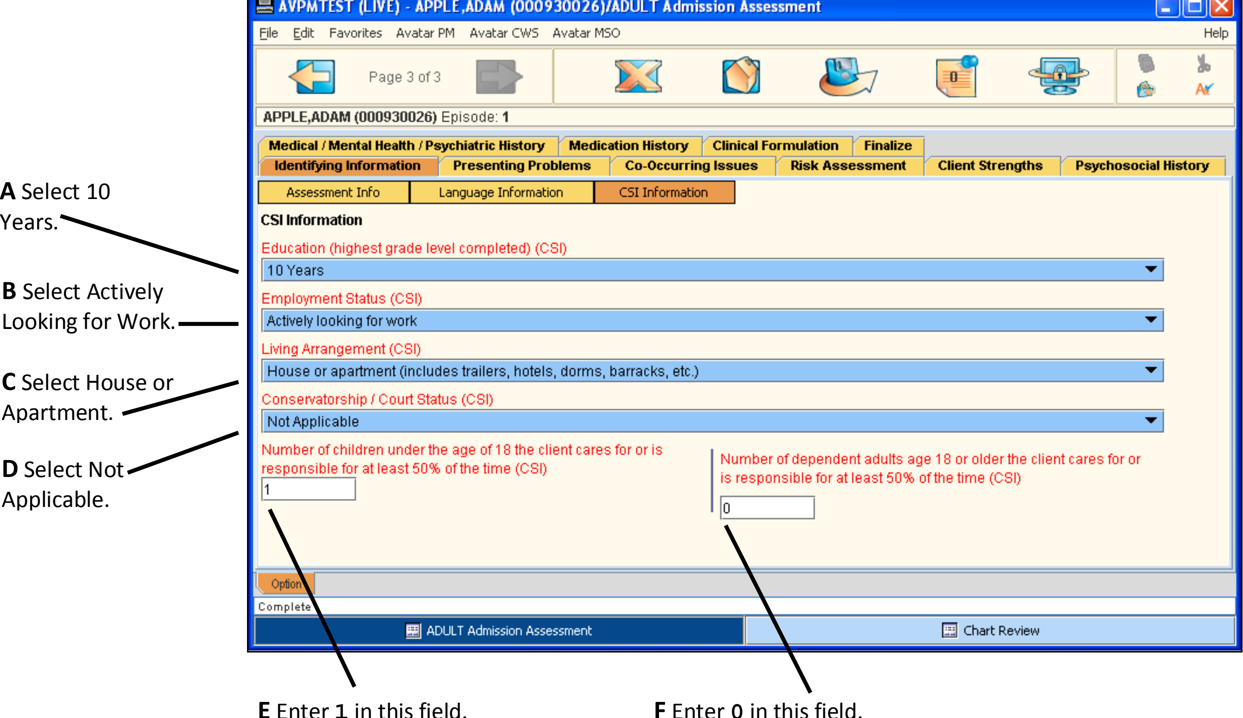
3. Click the Forward icon on the Option toolbar to go to page 2.

4. Select Spanish in the Primary Language of Client dropdown list.



5. Click the Forward icon on the Option toolbar to go to page 3.

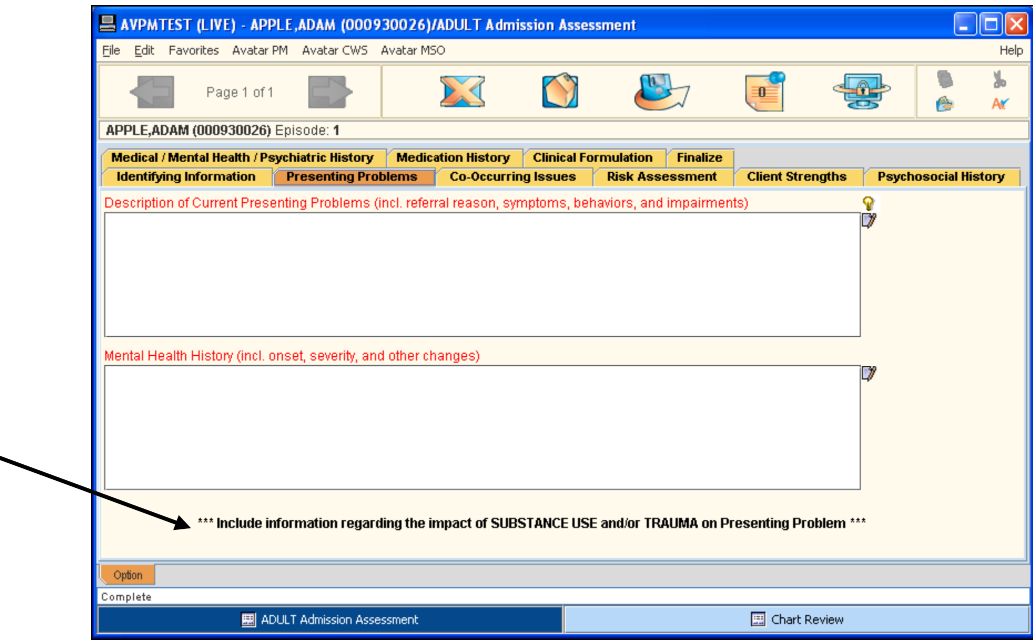
6. Follow these steps to complete the CSI information:



Leave this window open for the next exercise.

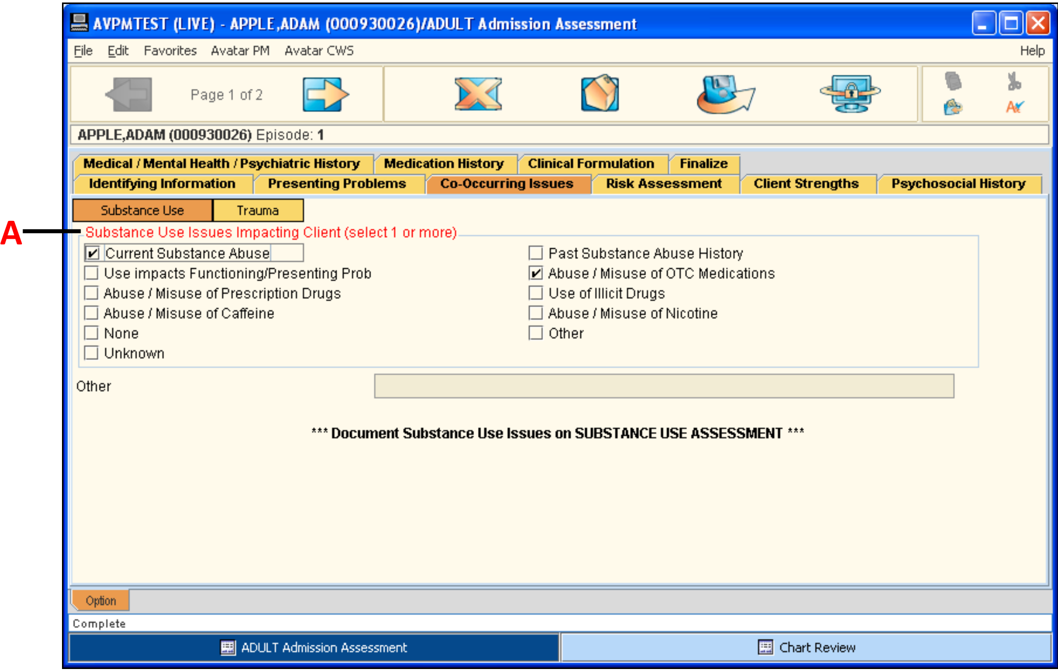
PRESENTING PROBLEMS TAB

As noted at the bottom of this tab, make sure to include information regarding the impact of substance use and/or trauma on presenting problems. All fields on this tab are required.



Co-Occurring Issues Tab Page 1 (Substance Use)

Document any substance use issues here.



Field	Description
A)Substance Use Issues	If you answer None on the Co-Occurring tab, it grays out the Substance Use assessment dropdown list on the Finalize tab. If you indicate Nicotine or Caffeine on the Co-Occurring tab, it makes the Substance Use dropdown list optional. Anything else makes the dropdown list required.

Co-Occurring Issues Tab Page 2 (Trauma History)

Document trauma history and related details on this page

Risk Assessment Tab Page 1

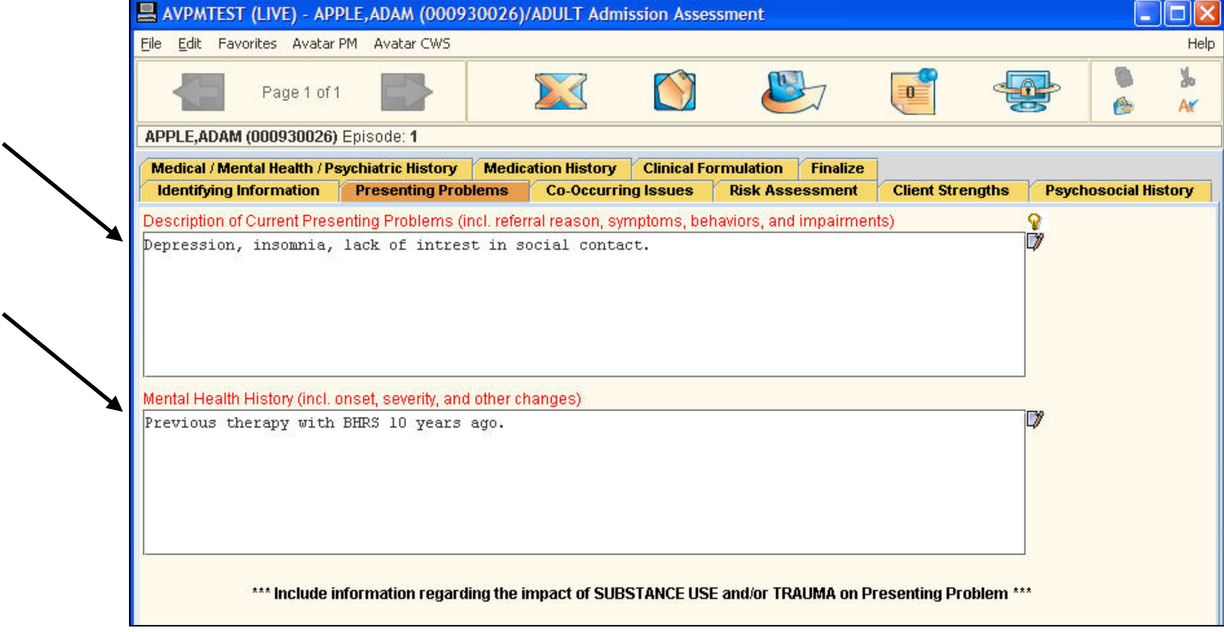
All fields are required on this page. If the client is negative for all elements click No, Denied, Undetermined, or Unknown for each entry.

Exercise 2 Complete Presenting Problems and Risk Assessment Tabs

In this exercise you will document the client's presenting problems, co-occurring issues, and risk assessment.

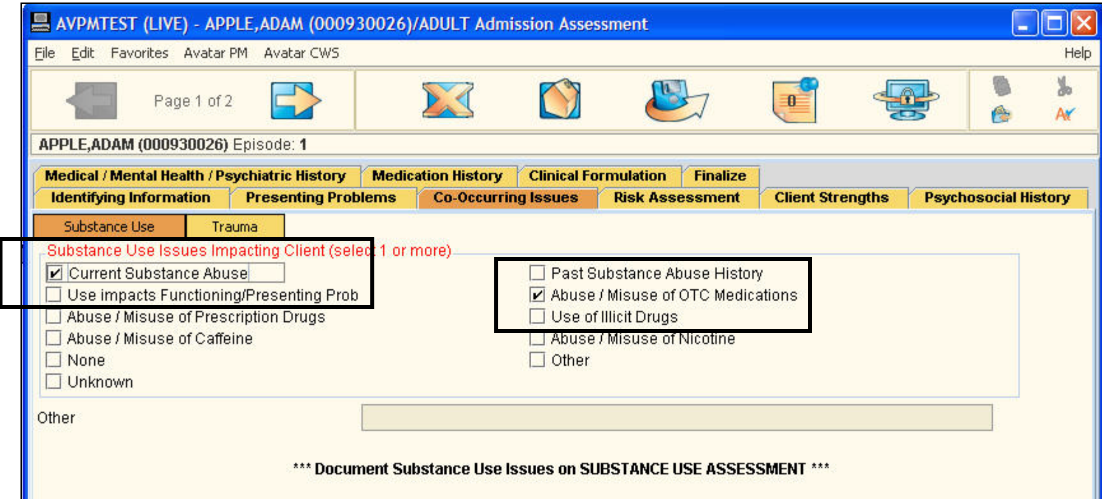
Before You Begin: *The ADULT Admission Assessment window should still be open from the last exercise.*

1. Go to the Presenting Problems tab.
2. Enter the information shown in the two text boxes.



3. Go to the Co-Occurring Issues tab.

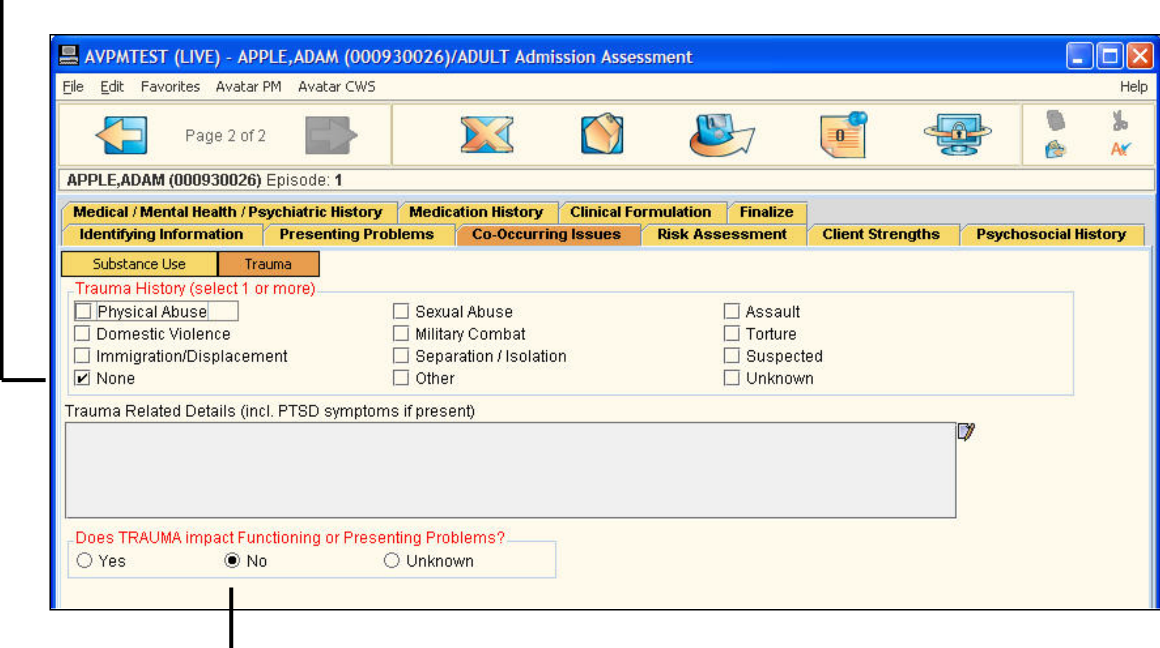
4. Check the checkboxes shown in the following illustration.



5. Click the Forward icon on the Option toolbar to go to page 2.

6. Follow these steps to complete page 2 of the Co-Occurring Issues tab:

A Click the None checkbox.



B Click the No option.

7. Click the Risk Assessment tab.

8. Follow these steps to complete the Risk Assessment tab:

AVPMTEST (LIVE) - APPLE,ADAM (000930026)/ADULT Admission Assessment

File Edit Favorites Avatar PM Avatar CWS Help

Page 1 of 1

APPLE,ADAM (000930026) Episode: 1

Medical / Mental Health / Psychiatric History | Medication History | Clinical Formulation | Finalize

Identifying Information | Presenting Problems | Co-Occurring Issues | Risk Assessment | Client Strengths | Psychosocial History

Risk of HARM TO SELF/SUICIDAL Thoughts/Behavior: Yes / Denied / Undetermined

Past HARM TO SELF/SUICIDAL Thoughts/Behavior: Yes / No / Unknown

Current HARM TO OTHERS/HOMICIDAL Thoughts: Yes / Denied / Undetermined

Past HARM TO OTHERS/HOMICIDAL Thoughts: Yes / No / Unknown

Access to FIREARMS / WEAPONS: Yes / Denied / Undetermined

Does SUBSTANCE USE impact risk?: Yes / No / Unknown

Current Domestic Violence Issues: Yes / No / Unknown

Past Domestic Violence Issues: Yes / No / Unknown

Engaged in Violent Acts? (physical, sexual, vandalism): Yes / No / Unknown

Victim of Violence?: Yes / No / Unknown

Risk and Violence Details

Option

Complete

ADULT Admission Assessment | Chart Review

A Choose Yes in this field.

B Choose Denied in these fields.

C Choose No in these fields.

D Select No for all of these factors.

Leave this window open for the next exercise.

Client Strengths Tab

Use this tab to document client strengths/assets/positive coping skills and sources of support in the life of the client.

Psychosocial History Tab Page 1

The first page of the Psychosocial History tab focuses on developmental issues, cultural background, and sexual orientation and identification. Because gender and sexual orientation are already addressed in the two option lists for gender and sexual orientation, it is only necessary to comment further on gender and sexual orientation in the Cultural/Spiritual/Lifestyle Background text field if you need to provide additional detail on these questions.

Psychosocial History Tab Page 2

Document the client's social, educational, employment, sexual, and criminal justice history on this page. When you see RESTRICTED next to a text field, this information will not print to any reports, including a printout of the assessment.

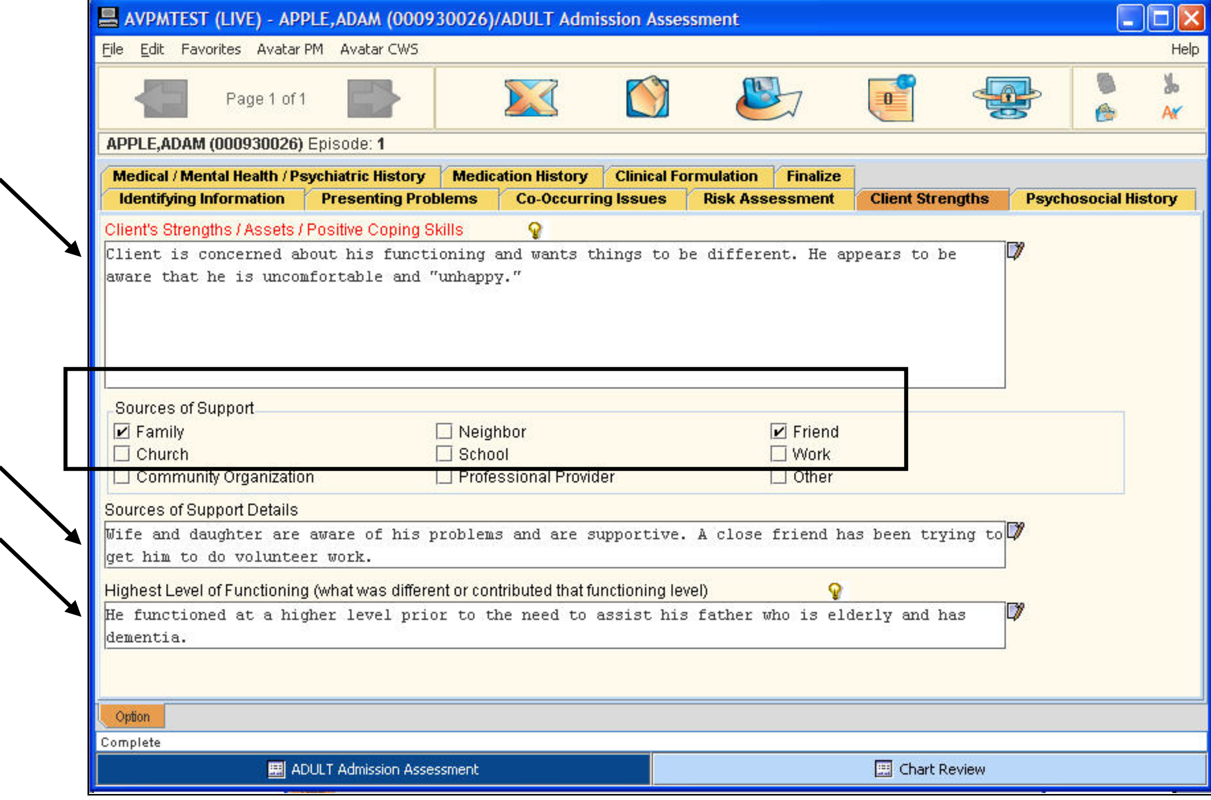
Sexual History / HIV Risk (RESTRICTED)

Client had unprotected sex with multiple partners.

Exercise 3 Document Client Strengths and Psychosocial History

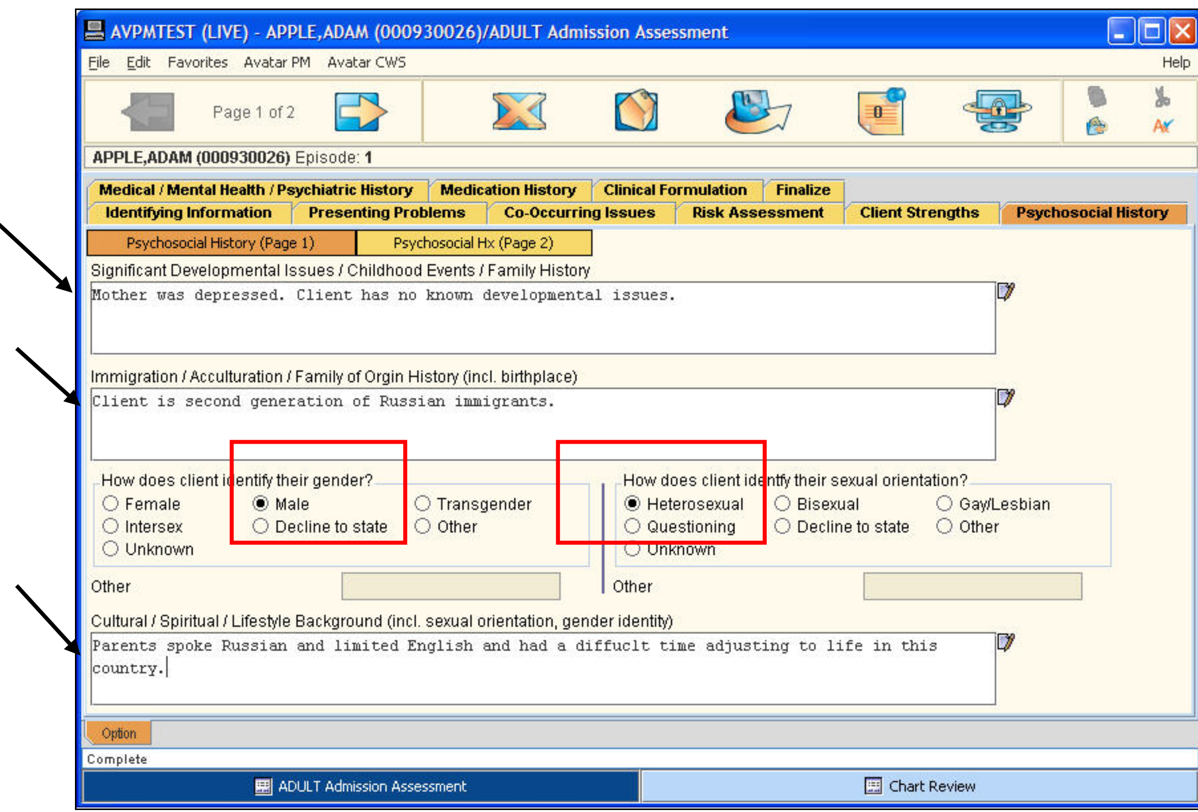
In this exercise you will complete the Client Strengths and Psychosocial History tabs.
Before You Begin: *The ADULT Admission Assessment window should still be open from the last exercise.*

1. Go to the Client Strengths tab.
2. Enter the information in the text fields as shown in the following figure and check Family and Friend in the Sources of Support area.



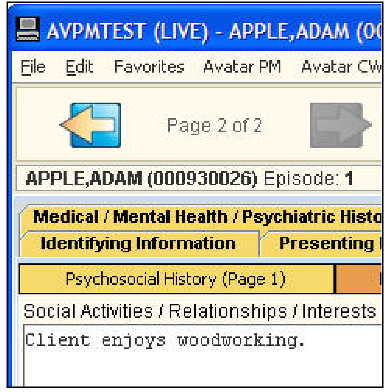
3. Go to the Psychosocial History tab.

4. Enter the information in the text boxes and make the choices in the lists shown in the following illustration:



5. Click the Forward icon on the Option toolbar to move to page 2.

6. Enter the text in the Social Activities/Relationships/Interests text box shown here.



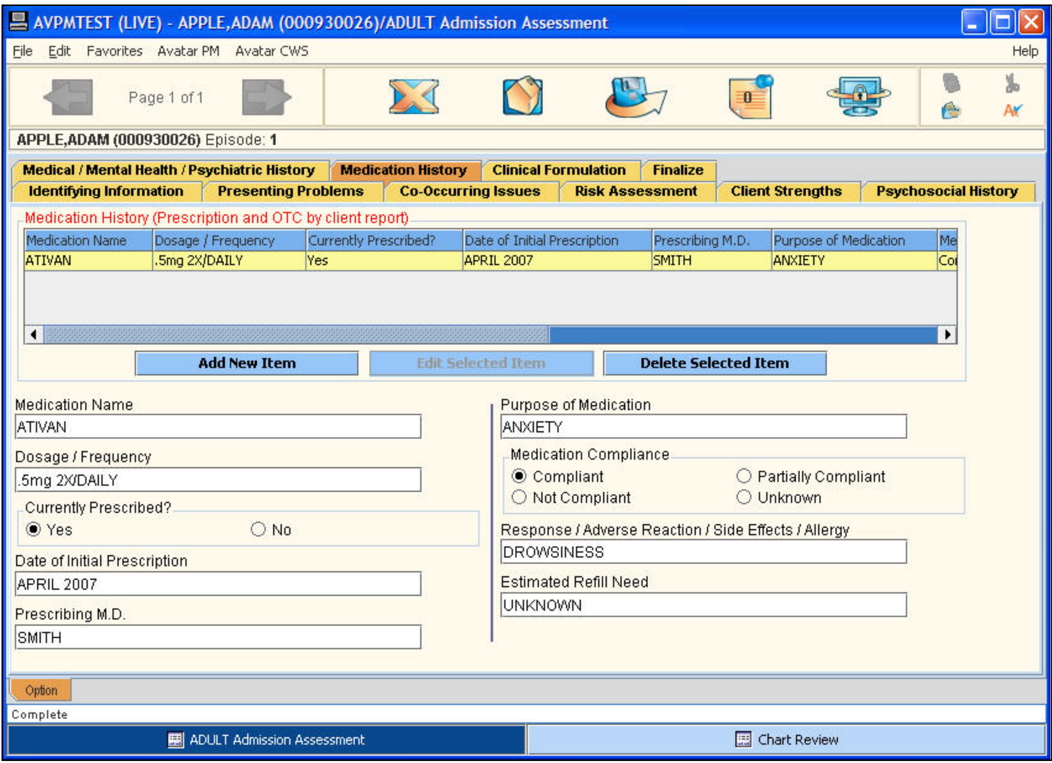
Leave the ADULT Admission Assessment window open for the next exercise.

Medical/Mental Health/Psychiatric History Tab

Medical, mental health, and family history are documented on this tab. Note that specific medication history is documented on the Medication History tab.

Medication History Tab

This page allows you to document the medication history of a client. For detailed information on how to add, edit, or delete items from a multiple entry table, see Lesson 6 in the *Introduction to Avatar* manual.



Clinical Formulation Tab Page 1 (Formulation)

Use this page to document the areas treatment address and the clinical formulation.

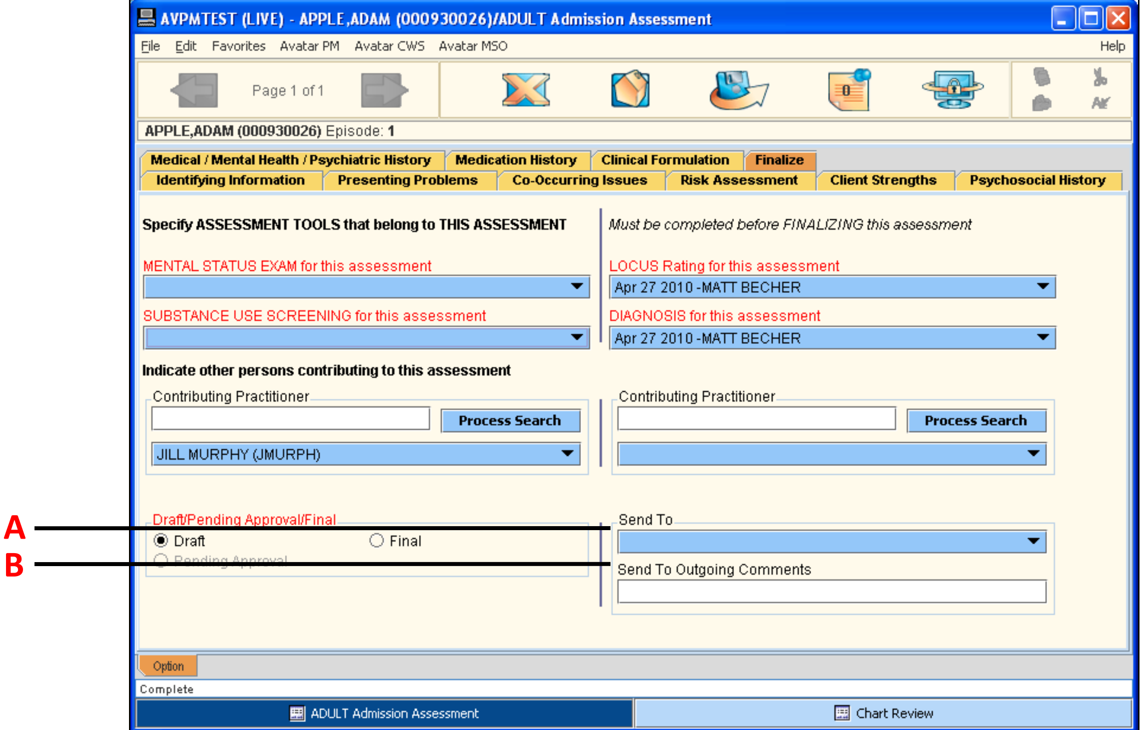
FINALIZE TAB

Use this tab to attach previously completed assessments to the main Admission Assessment.

IMPORTANT

If any of the assessment dropdown lists on this page are empty, it means that the specific assessment has not been completed in the last 60 days. To correct this so that the assessment can be submitted as Final, you must save this Admission Assessment window as a Draft, then open and complete the missing assessment, and save it as Final. You can then re-open the Admission Assessment window in order to see the assessment dropdown lists populate with Clinician Name and Date for any assessment completed within the last 60 days.

If you selected None for the ALCOHOL and/or DRUG USE on the Co-Occurring Issues tab, the Substance Use assessment is no longer required on this page.



Field	Description
A) Send To	Licensed clinical staff members typically do not use this field. If you are an intern or need manager approval for this assessment, the list of BHRS staff members in this field is populated with the colleagues you are likely to work with, including those who would approve your assessments. If you need to add a person, contact the ISD Department.

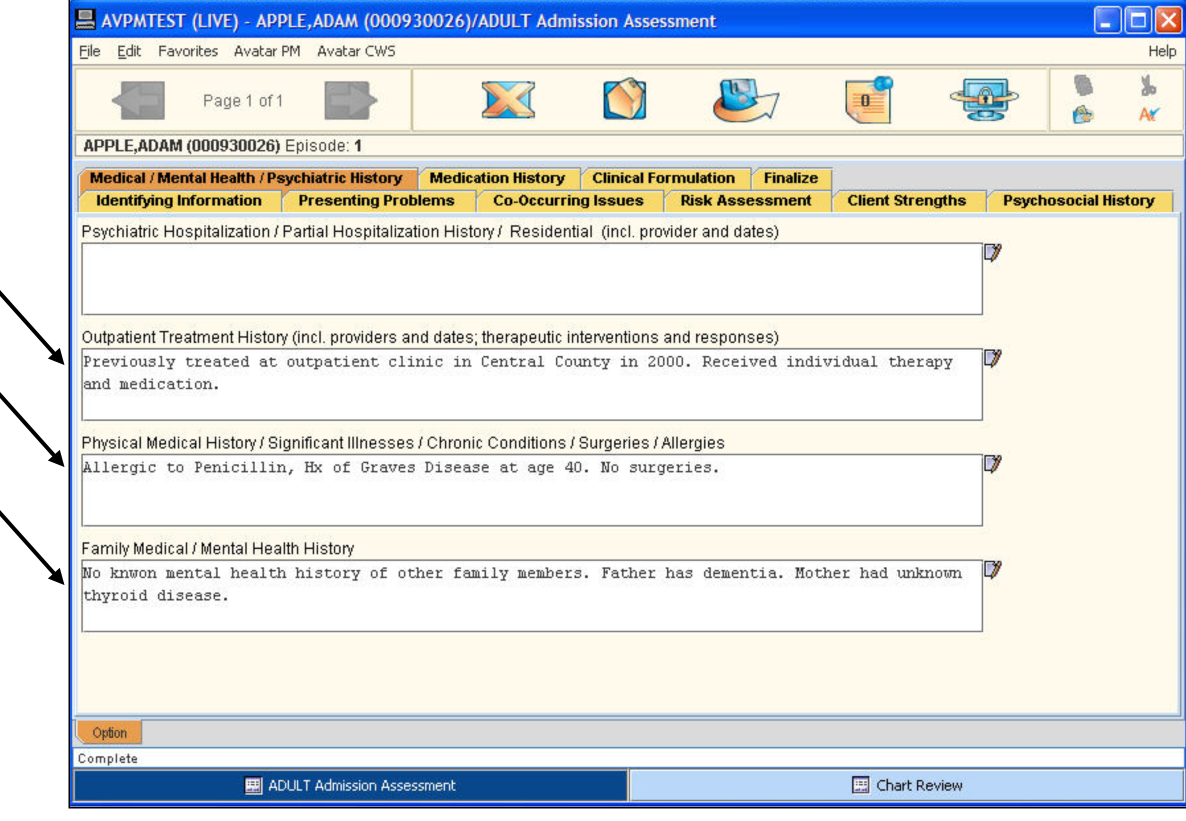
Field	Description
B) Send To Outgoing Comments	Licensed clinical staff members typically do not use this field. If you are an intern or need manager approval for this assessment, provide any comments you have here for the BHRS staff member you're sending this assessment to.

Exercise 4 Complete the Medical/Mental Health/Psychiatric History, Medication History, Clinical Formulation, and Finalize Tabs

In this exercise you will enter the client information for four of the assessment tabs.

Before You Begin: *The ADULT Admission Assessment window should still be open from the last exercise.*

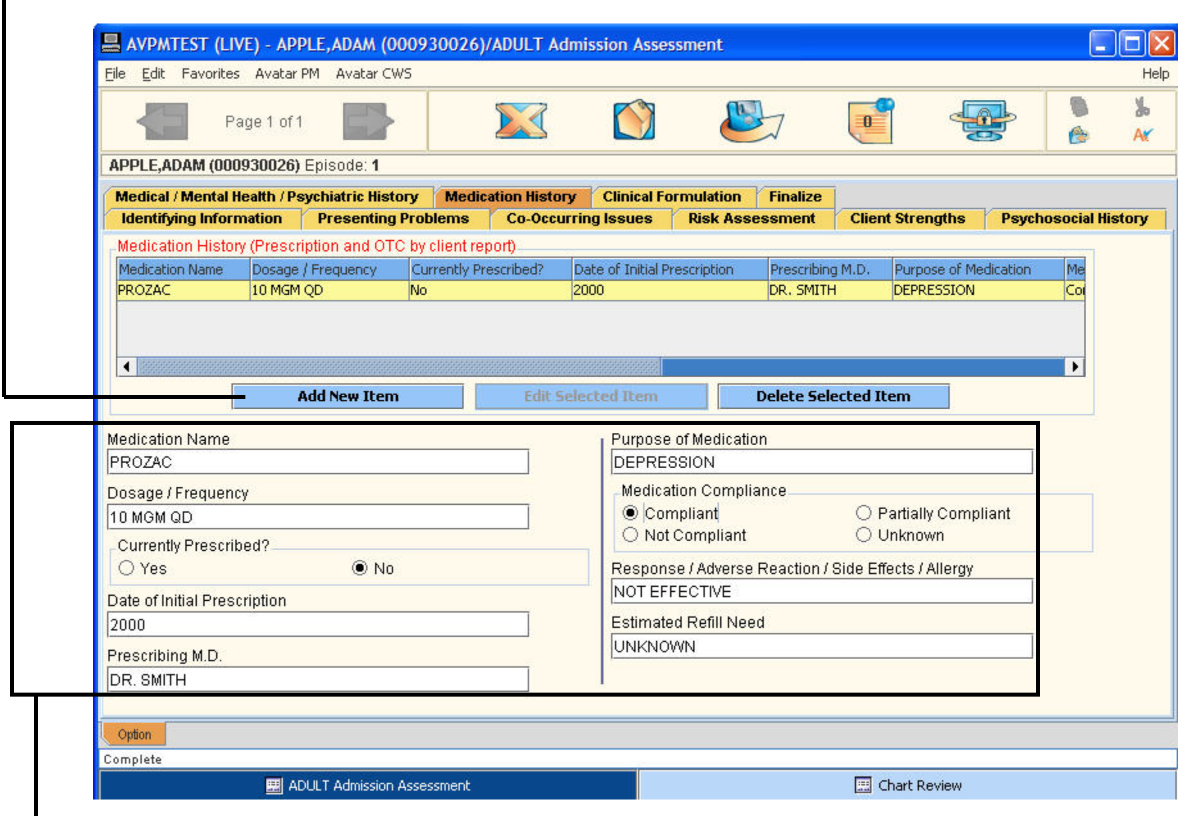
1. Switch to the Medical/Mental Health/Psychiatric History tab.
2. Enter the information shown in the text boxes in the following illustration.



3. Go to the Medication History tab.

4. Follow these step to complete the Medication History:

A Click the Add New Item button to create a new yellow row in the multiple entry table.

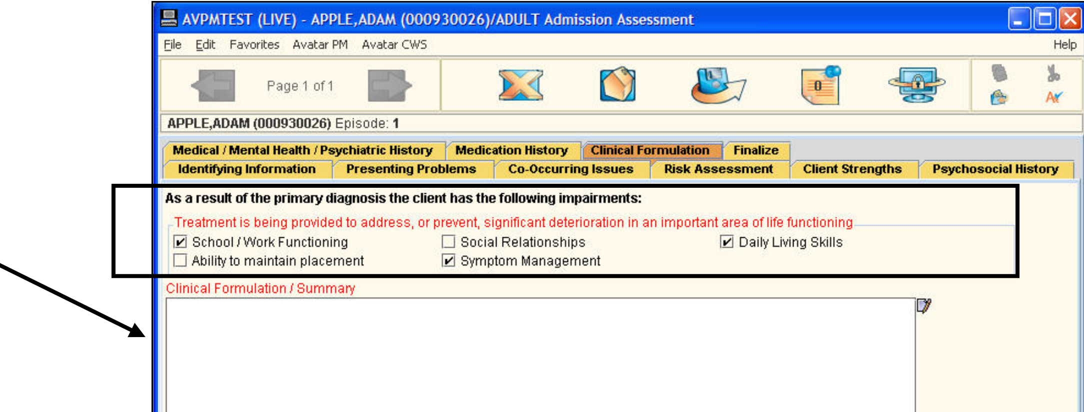


B Enter the information in the text fields as shown here, and choose No in the Currently Prescribed area and Compliant in the Medication Compliance field.

Notice that data appears in the multiple entry table as you enter it here.

5. Go to the Clinical Formulation tab.

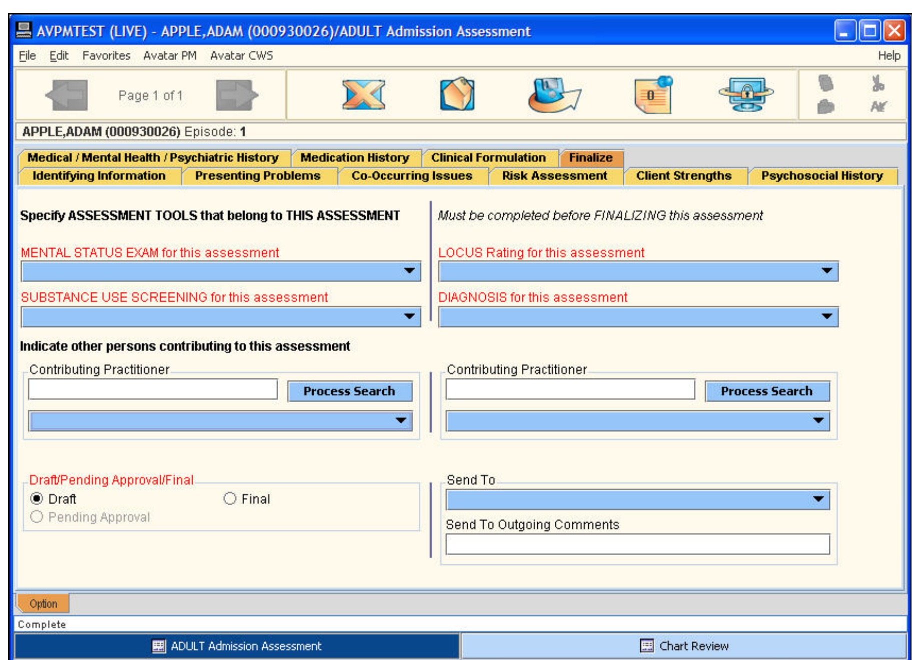
6. Check School/Work Functioning, Symptom Management, and Daily Living Skills. Enter a Clinical Formulation/Summary in the text box.



7. Go to the Finalize tab.

8. Check the dropdown boxes for each of the four assessments to see if any assessments have been completed in the last 60 days.

Because we haven't completed any other pieces of the assessment within the last 60 days, all of the dropdown lists are empty.



Remember that you must complete all required assessments before you can finalize the main Admission Assessment.

9. Verify that Draft is selected.

10. Click the Submit icon to save what you completed so far as a Draft.

UNDERSTANDING THE CHILD/YOUTH ADMISSION ASSESSMENT WINDOW

Many of the screens in the Child/Youth Admission Assessment are the same as the Adult Admission Assessment.

NOTE: If you need to admit a Child/Youth into BHRS, follow steps in the Quick Reference Guide—Admission Assessments (Adult, Child/Youth, and Pre-3).

There are some differences which are explained on the next few pages.

WHO CAN PERFORM THIS FUNCTION?

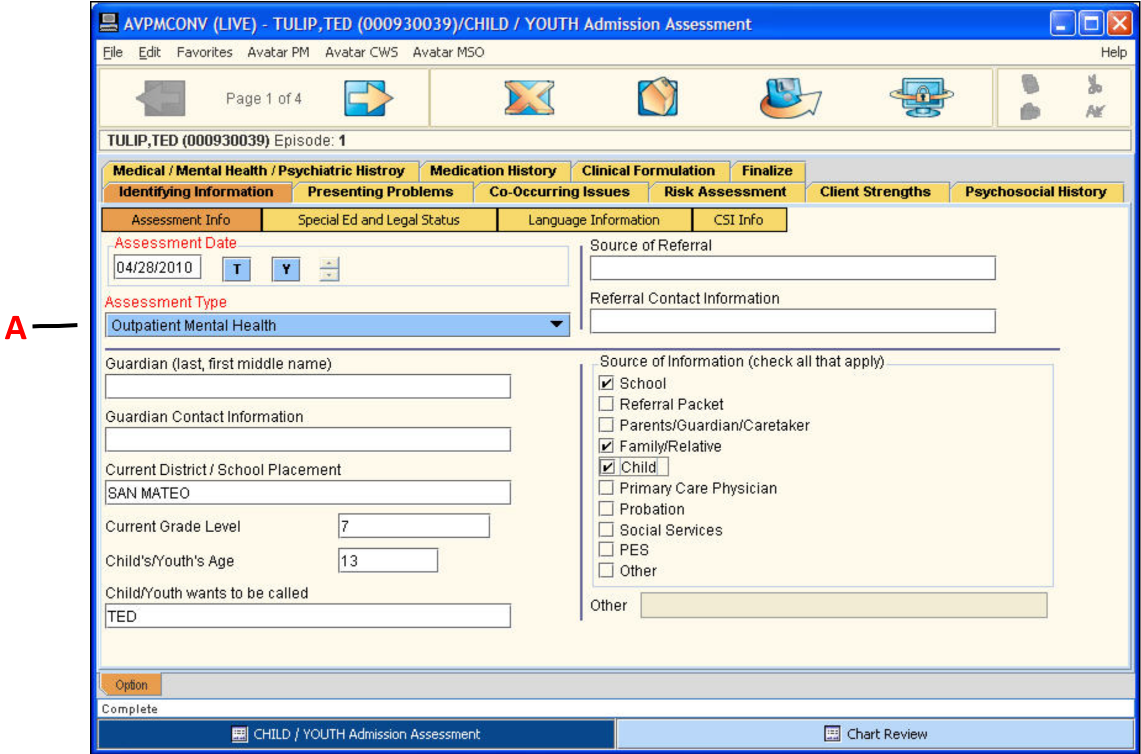
Any clinical staff member who is assessing the client can perform this function.

MENU PATH

Avatar CWS→Assessments→CHILD/YOUTH Admission Assessment

Identifying Information Tab Page 1 (Assessment Info)

Use this page to collect basic identifying information, such as assessment type and sources of information.



Field/Button	Description
A) Assessment Type	**26.5:** For clients who have been referred for Mental Health assessment from a school district (must be authorized prior to assessment). **Change in Level of Care:** Client is being reassessed for purposes of changing level of care (e.g. Outpatient to Residential). **Outpatient Mental Health:** Standard Mental Health Assessment for Youth.

Identifying Information Tab Page 2 (Special Ed and Legal Status)

Use this page to document special education eligibility and legal status.

Identifying Information Tab Page 3 (Language Information)

Document the primary and preferred languages of the client and the client's family on this page, as well as whether language services were offered.

IDENTIFYING INFORMATION TAB PAGE 4 (CSI INFO)

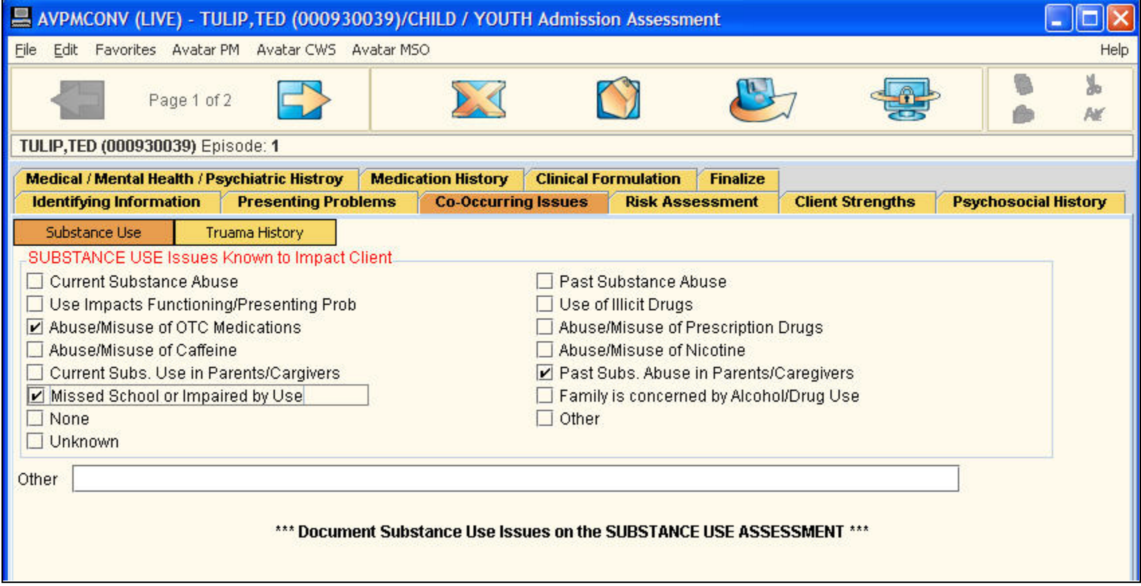
All CSI information on this page is required. Document highest grade completed, employment status, living arrangement, conservatorship/court status, and number of children and/or dependent adults the client cares for at least 50% of the time.

PRESENTING PROBLEMS TAB

As stated at the bottom of this tab, indicate if trauma or substance use impacts the presenting problem. Document the description of the presenting problems, behavioral/mental health history, and current/past living situation on this tab.

CO-OCCURRING ISSUES TAB PAGE 1 (SUBSTANCE USE)

Like the adult assessment, this tab directly controls whether a substance use assessment is necessary. Selecting None disables the substance use assessment on the Finalize tab. Making choices such as caffeine or nicotine makes the substance use assessment optional on the Finalize tab. Selecting boxes such as those checked in the picture below makes the Substance Use Screening assessment required.



CO-OCCURRING ISSUES TAB PAGE 2 (TRAUMA HISTORY)

Document any client or family trauma on this page. All fields except the Child/Family Trauma Related Details field are required.

RISK ASSESSMENT TAB

All fields on this page are required except the Risk and Violence Details field.

CLIENT STRENGTHS TAB

Document client's and client's family strengths and sources of support on this tab.

Psychosocial History Tab Page 1

Record the client's developmental and acculturation history as well as gender identity/sexual orientation information on this page.

Psychosocial History Tab Page 2

Because gender identity and sexual orientation are addressed on the previous page, it is only necessary to comment further in the cultural/spiritual/lifestyle background text field about gender or sexual orientation if you need to provide more detail.

Also use this page to document social activities/relationships (including gang affiliation), education, and juvenile justice history.

Medical/Mental Health/Psychiatric History Tab Page 1

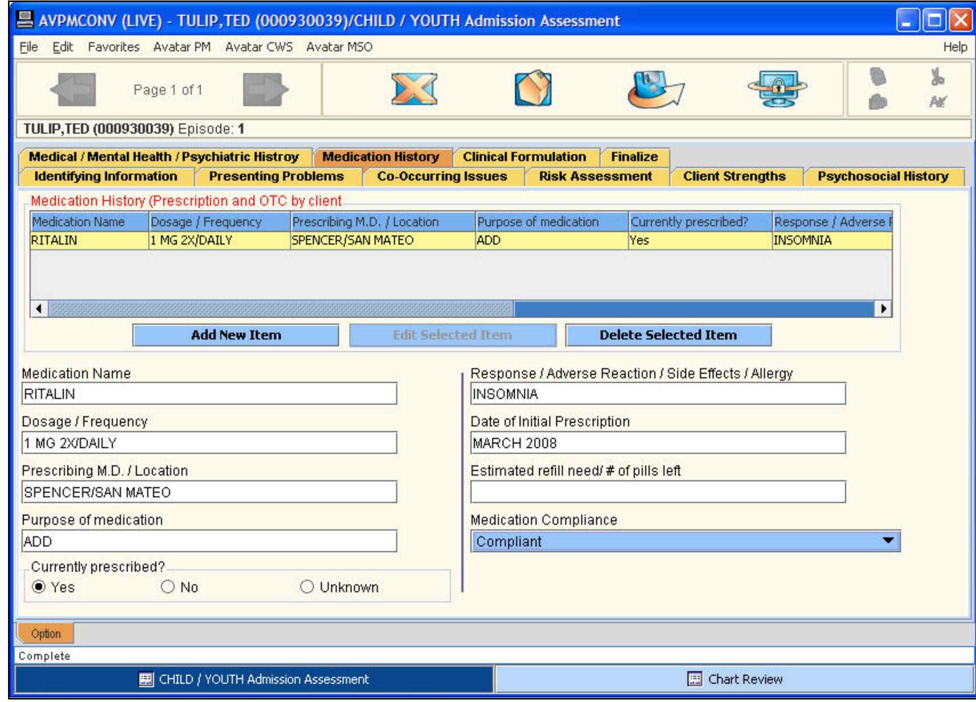
Document any hospitalization/residential placement, outpatient treatment, and medical/illness history on this page.

Medical/Mental Health/Psychiatric History Tab Page 2

Record any client allergies and encopresis/enuresis status on this page.

Medication History Tab

Record the client's medication history on this tab. For more detail on how to work with a multiple entry table, see Lesson 6 in the *Introduction to Avatar* manual.



CLINICAL FORMULATION TAB PAGE 1 (FORMULATION)

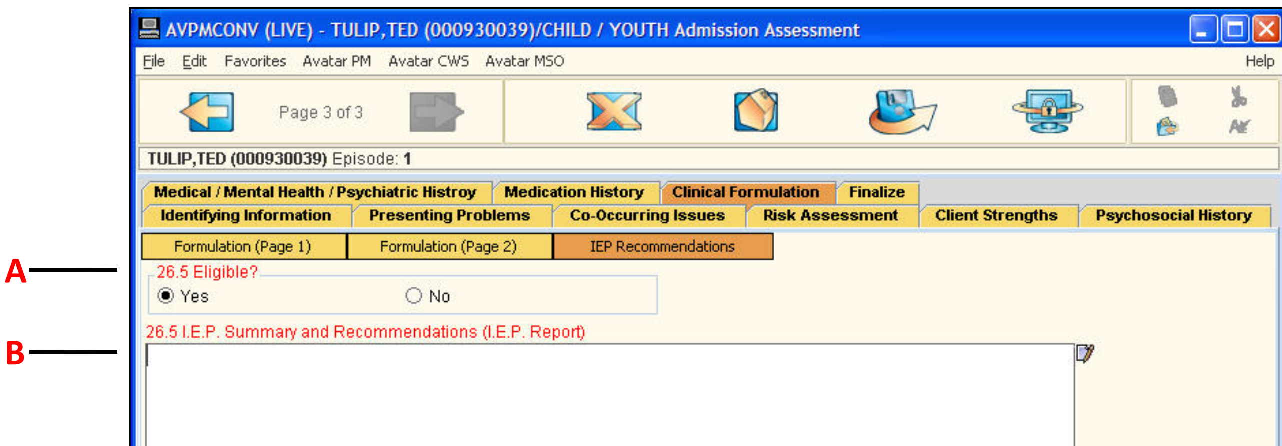
Formulate what the client, the client's family, or the school sees as a successful outcome of treatment. You can also record risk evaluation details and the client's state of change status.

CLINICAL FORMULATION TAB PAGE 2 (FORMULATION)

This page is used to document impairments based on the primary diagnosis, as well as the clinical formulation. All fields on this page are required.

CLINICAL FORMULATION TAB PAGE 3 (IEP RECOMMENDATIONS)

Document 26.5 eligibility, IEP summary and recommendations, and service needs on this page.



Field	Description
A) 26.5 Eligible?	This field only becomes available if you select 26.5 for the assessment type on the Identifying Information tab.
B) 26.5 I.E.P. Summary and Recommendations	This field only becomes available if you select 26.5 for the assessment type on the Identifying Information tab.

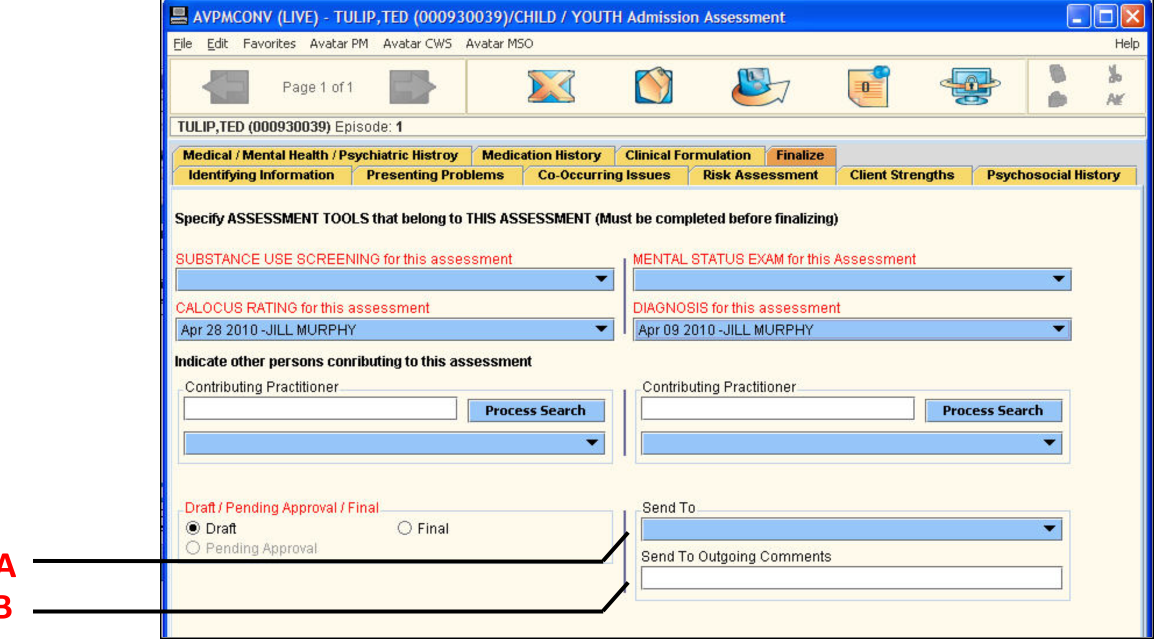
INALIZE TAB

Use this tab to attach the other previously completed assessments to the overall Admission Assessment.

IMPORTANT

If any of the assessment dropdown lists on this page are empty, this means that the specific assessment has not been completed in the last 60 days. To correct this so that the assessment can be submitted as Final, you must save this Admission Assessment window as a Draft then open and complete and finalize the Mental Status and Behavioral Observation, Substance Use, LOCUS, or Diagnosis windows. You can then re-open this Admission Assessment window in order to see the assessment dropdown lists populate with Clinician Name and Date for any assessment completed within the last 60 days.

Choices you make on the Co-Occurring Issues tab determine whether or not the Substance Use Screening field is unavailable, optional, or required.



Field	Description
A) Send To	If you are an intern or need manager approval for this assessment, the list of BHRS staff members in this field is populated with the colleagues you are likely to work with including those who would approve your assessments. If you need to add a person, contact the ISD Department.
B) Send To Outgoing Comments	If you are an intern or need manager approval for this assessment, enter any comments you have for the BHRS staff member you're sending this assessment to.

UNDERSTANDING THE ADULT OR CHILD/YOUTH SPECIAL ASSESSMENT WINDOW

The Special Assessment is primarily used by the Interface Team. It is also used when a client returns to the County from an outside contractor, or when the client returns less then 1 year from last discharge.

Many of the screens in this window are the same as the adult or youth assessments, but it is not as comprehensive as a full admission assessment. The highlights are explained below.

WHO CAN PERFORM THIS FUNCTION?

Any clinical staff member who is assessing the client can perform this function.

MENU PATH

Avatar CWS→Assessments→ADULT Special Assessment

Avatar CWS→Assessments→CHILD/YOUTH Special Assessment

CURRENT CLINICAL INFORMATION TAB PAGE 3 (CO-OCCURRING ISSUES)

How you answer the Substance Use Issues field controls whether or not a substance use assessment is required or not. If you answer None, Substance Use becomes deactivated on the Finalize tab. If you answer yes to Nicotine or Caffeine abuse, Substance Use becomes an optional field. If you answer yes to any other Substance Use Issue, Substance Use becomes required on the Finalize tab.

FINALIZE TAB

The Finalize tab in this assessment works exactly as it does in an ADULT or CHILD/YOUTH Admission Assessment. See the Finalize tab section for those assessments for details.

UNDERSTANDING THE LOCUS WINDOW

The Levels of Care Utilization System (LOCUS) is used by BHRS as treatment planning and utilization management tools. Scores on the LOCUS are based on the clinical needs of clients and help ensure that clients receive the types and amount of services that correspond to the clinical need.

WHO CAN PERFORM THIS FUNCTION?

Only clinical staff can perform this function.

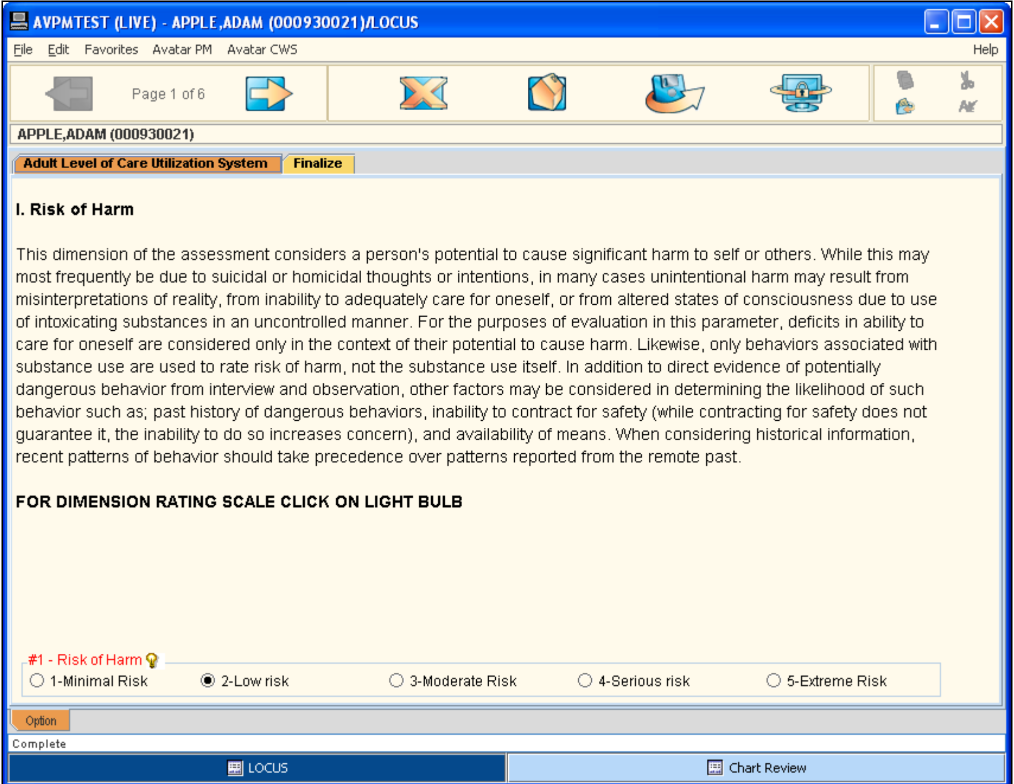
MENU PATH

Avatar CWS→Assessments→LOCUS

ADULT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 1

Score the client's risk of harm on this page.

TIP! For any of the pages in this tab, click the Help lightbulb icon for QM guidance on how to score the LOCUS.



Adult Level of Care Utilization System Tab Page 2

Score the client's functional status on this page.

Adult Level of Care Utilization System Tab Page 3

Score the client's medical, addictive, and psychiatric co-morbidity on this page.

Adult Level of Care Utilization System Tab Page 4

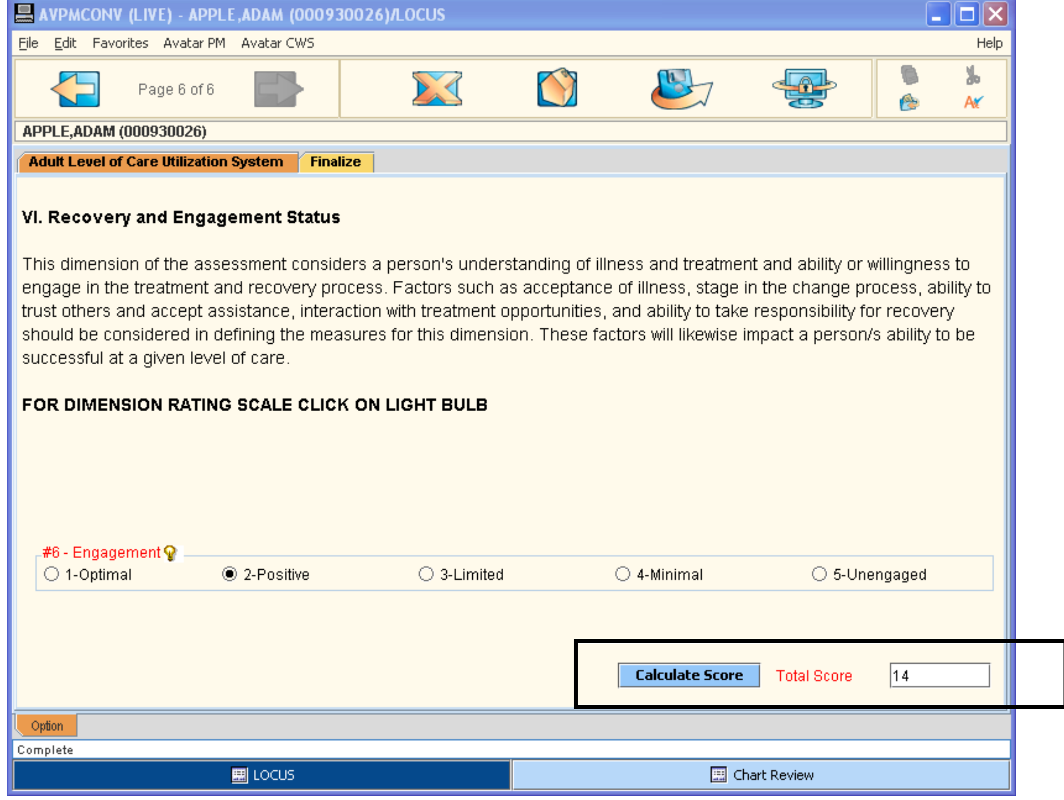
Score the client's recovery environment on this page.

Adult Level of Care Utilization System Tab Page 5

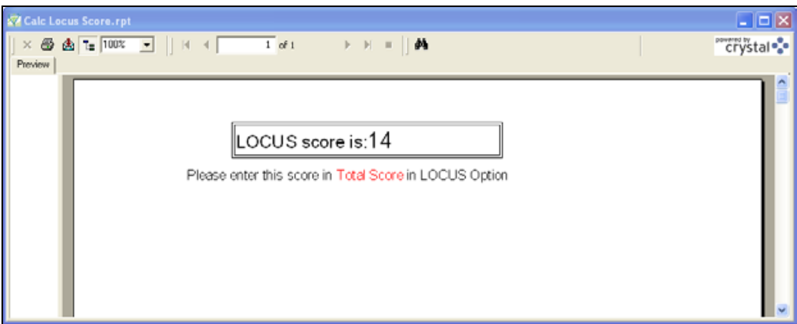
Score the client's treatment and recovery history on this page.

Adult Level of Care Utilization System Tab Page 6

Score the client's recovery and engagement status on this page.

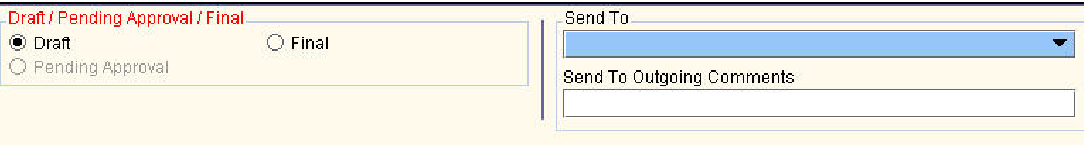


After choosing an option in the Engagement field, click the Calculate Score button to generate a report that calculates the Total Score as shown in the following figure. Type this number in the Total Score field.



FINALIZE TAB

Use this tab to submit the information as a Draft or Final. If you are an intern and need to get manager approval for this assessment, you have the option to select Pending Approval and designate a staff member to send the assessment to for review and provide outgoing comments.

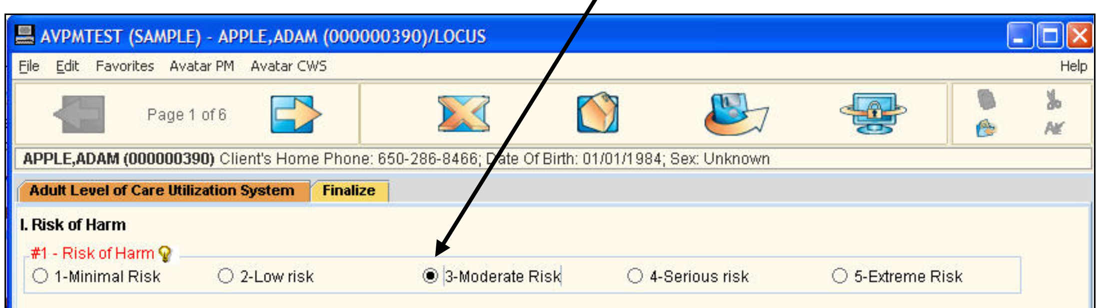


Exercise 6 Write a LOCUS Assessment

In this exercise you will complete a LOCUS assessment.

Before You Begin: *Select a sample client you are working with using the Select Client icon. In this example the client is Adam Apple.*

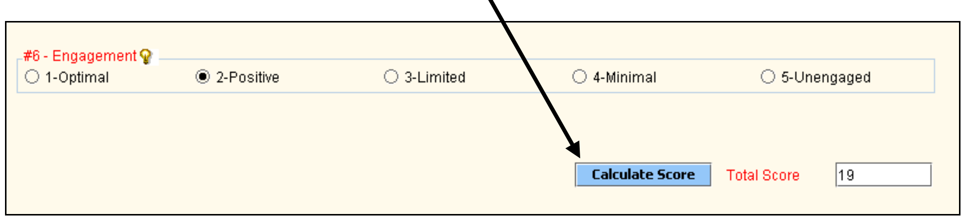
1. Choose Avatar CWS→Assessments→LOCUS from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new LOCUS assessment.
3. Choose Moderate Risk in the Risk of Harm field, as shown here.



4. Click the Forward icon on the Option toolbar to move to page 2.
5. In the Functional Status field, Select 3-Moderate.
6. Click the Forward icon on the Option toolbar to move to page 3.
7. In the Medical, Addictive and Psychiatric Co-Morbidity field, choose 2-Minor.
8. Click the Forward icon on the Option toolbar to move to page 4.
9. Select 4-Highly in the Environmental Stressors field and 2-Supportive in the Environmental Support fields.
10. Click the Forward icon on the Option toolbar to move to page 5.
11. Choose 3-Moderate/Equivocal in the Treatment and Recover History field.
12. Click the Forward icon on the Option toolbar to move to page 6.
13. Choose 2-Positive in the Engagement field.

    Next you will generate a report that calculates the LOCUS score and you'll enter the score in the LOCUS window.

14. Click the Calculate Score button.



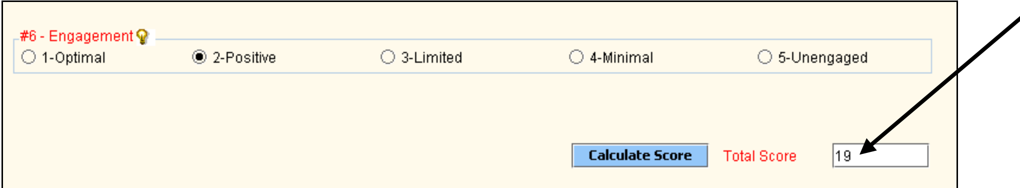
Avatar asks if you want to download the report.

15. Click OK to download the report.

    The score that appears in the report window.

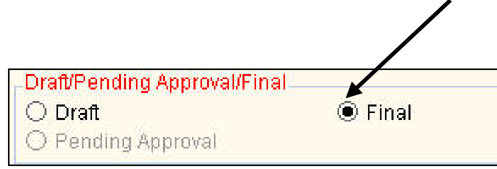
16. Click the Close button in the upper-right corner of the report window.

17. In the Total Score field, type the number from the report window. (If you used the scoring indicated in the exercise, it should be 19.)



18. Click the Finalize tab.

19. Click the Final radio button.



20. When the message appears indicating that selecting Final prevents future edits, click OK.

21. Click the Submit icon on the Option toolbar to save your work.

Understanding the CALOCUS Window

BHRS uses the Child and Adolescent Levels of Care Utilization System (CALOCUS) as a treatment planning and utilization management tool. The clinical needs of clients are the basis of the scores on the CALOCUS and this helps ensure that clients receive the types and number of services that correspond to their clinical needs. This tool is now an important part of our system and it is integrated into the timeline structure of important clinical documents. In addition, the CALOCUS is useful in authorizing day treatment services.

TIP! For any the CALOCUS pages, click the Help lightbulb icon for QM guidance on how to score the CALOCUS.

Who Can Perform This Function?

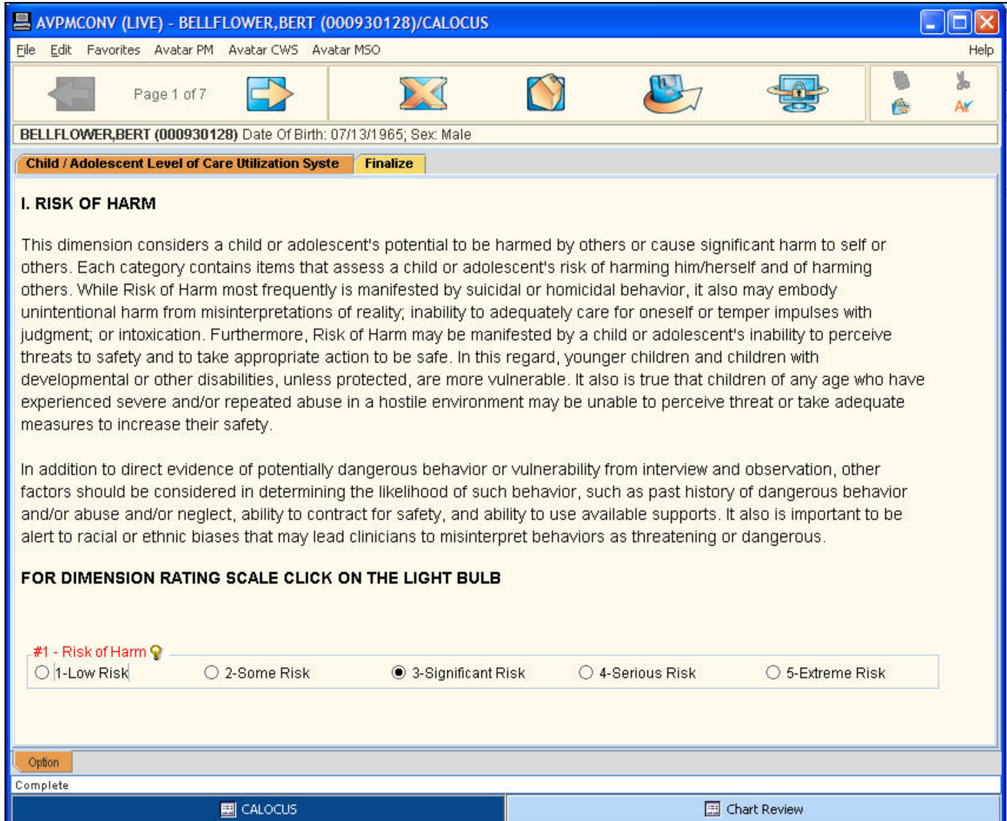
Only clinical staff members can perform this function.

Menu Path

Avatar CWS→Assessments→CALOCUS

Child / Adolescent Level of Care Utilization System Tab Page 1

Score the client's risk of harm on this page.



CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 2

Score the client's functional status on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 3

Score the client's co-morbidity on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 4

Score the client's recovery environment on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 5

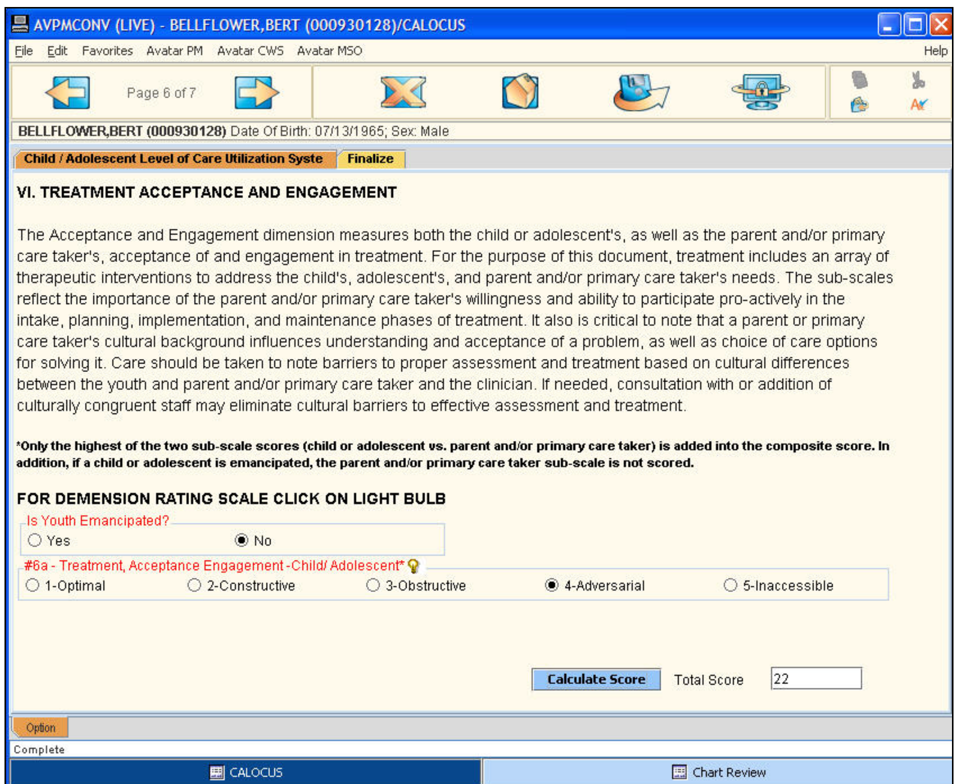
Score the client's resiliency and treatment history on this page.

CHILD / ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM TAB PAGE 6

On this page you indicate if the client is emancipated and you score the first Treatment, Acceptance Engagement field.

IMPORTANT

Go to page 7 to score the second Treatment, Acceptance Engagement field and then return to page 6 and click the Calculate Score button to generate a report that gives you the total CALOCUS score. Make a note of the score and enter it in the Total Score field.

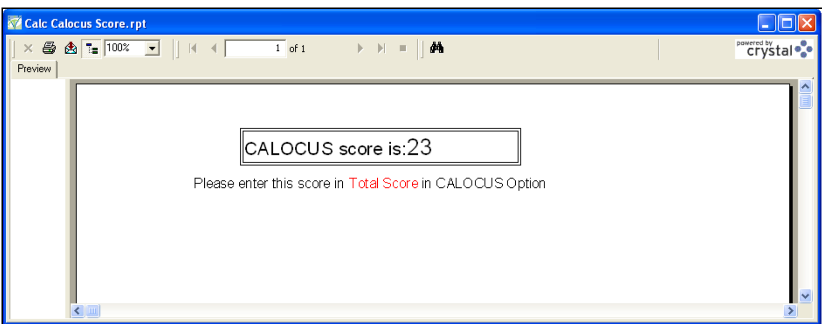


Child / Adolescent Level of Care Utilization System Tab Page 7

Score the second Treatment, Acceptance Engagement field on this page then return to page 6 to generate the report that calculates the score.

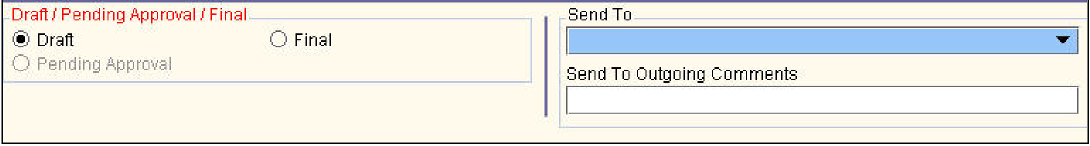
CALOCUS Report

The following illustration is an example of the Calc Calocus Score report.



Finalize Tab

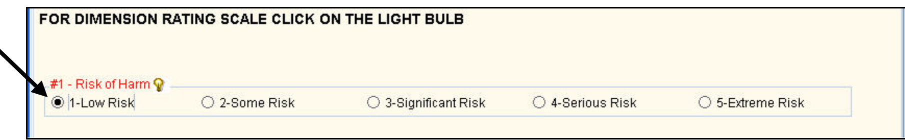
Use this tab to submit the information as a Draft or Final. If you are an intern and need manager approval for this assessment, you have the option to select another staff member to send the assessment to for review and to provide outgoing comments.



Exercise 7 Write a CALOCUS Assessment

In this exercise you will complete a CALOCUS assessment.
Before You Begin: *Think of a fictitious client name you can use for this exercise. In this example Adam Apple is the client.*

1. Choose Avatar CWS→Assessments→CALOCUS from the Menu Frame.
2. Choose 1-Low Risk in the Risk of Harm field.

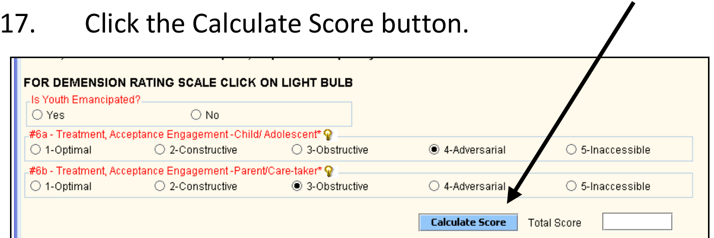


3. Click the Forward icon on the Option toolbar to move to page 2.
4. Select the 5-Severe rating for the Functional Impairment field.
5. Click the Forward icon on the Option toolbar to move to page 3.
6. Choose 3-Significant in the Co-morbidity field.
7. Click the Forward icon on the Option toolbar to move to page 4.
8. Select the 4-Highly rating for Environmental Stressors field and 2-Supportive for the Environmental Support field.
9. Click the Forward icon on the Option toolbar to move to page 5.
10. Choose 4-Poor in the Resiliency and Treatment History field.
11. Click the Forward icon on the Option toolbar to move to page 6.
12. Choose No for Is Youth Emancipated?
13. Choose 4-Adversarial in the #6a, Child/Adolescent field.
14. Click the Forward icon on the Option toolbar to move to page 7.
15. Choose 3-Obstructive in the #6b, Parent/Care-taker field.
16. Click the Back icon on the Option toolbar to return to page 6.

CALCULATE THE CALOCUS SCORE

Next you will generate a report that calculates the CALOCUS score and you'll enter the score in the CALOCUS window.

17. Click the Calculate Score button.



Avatar asks if you want to download the report.

18. Click OK to download the report.

19. Note the score that appears in the report window.

20. Click the Close button to close the report window.

21. Enter the score in the Total Score field. (If you used the scoring indicated in the exercise, it should be 23.)

22. Click the Finalize tab.

23. Click the Final radio button.

24. When the message appears indicating that selecting Final prevents future edits, click OK.

25. Click the Submit icon on the Option toolbar to save your work.

Understanding the Mental Status Exam (Adult + PIN) Window

As the name indicates, you use this window as a piece of the Adult Assessment *or* PIN (for either Adult or Youth). For a youth mental status exam, use the Mental Status/Behavioral Observation (YOUTH) window.

NOTE: All behaviors and symptoms in this window are only rated if they are known to exist or were observed at the time of the interview. A non-response to any field indicates that the symptom or behavior was not known or observed.

There are 8 pages in the Mental Status and Behavioral Observation tab, broken down into Risk, Appearance/Speech, Motor Activity/Mood, Intellect/Affect, Behavior/Flow of Thought, Content of Thought/Hallucinations, and Delusions/Sensorium/Insight and Judgment. Only rate the fields in this tab that apply to your client. If an item does not apply, you may check the box next to Within Normal Limits.

Who Can Perform This Function?

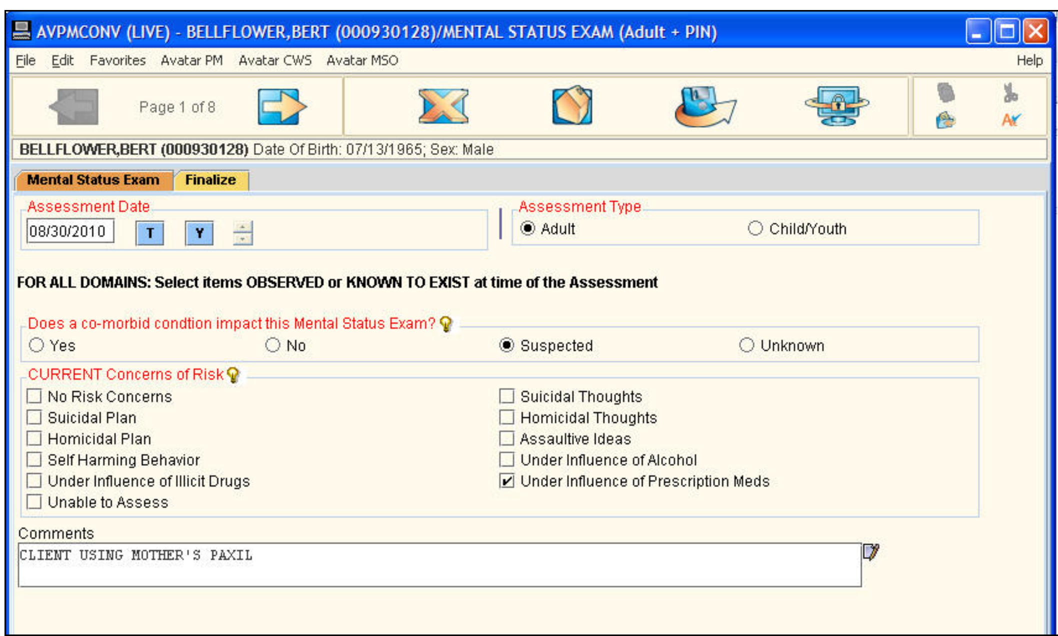
A physician, licensed/waivered psychologist, licensed/registered clinical social worker, licensed/registered marriage and family therapist, or registered nurse with a master's degree in a mental health related field.

Menu Path

Avatar CWS→Assessments→Mental Status Exam (Adult + PIN)

Mental Status Exam Tab Page 1

Use this page to document the date and the type of assessment as well as any Current Concerns of Risk.



MENTAL STATUS EXAM TAB PAGE 2

Use this page to document General Appearance and Speech.

MENTAL STATUS EXAM TAB PAGE 3

Use this page to document Motor Activity and Mood.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 4

Use this page to document Intellect and Affect.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 5

Use this page to document Behavior and Flow of Thought.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 6

Use this page to document Content of Thought and Hallucinations.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 7

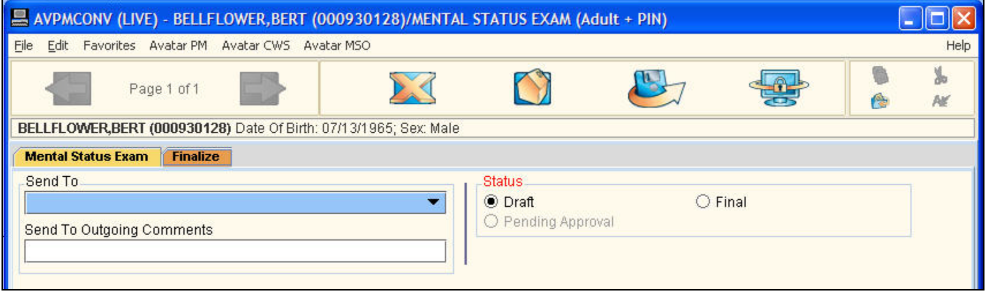
Use this page to document Delusions, Sensorium, and Insight and Judgment.

MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE

The Comments field for Insight and Judgment appears on this page.

FINALIZE TAB

Use this tab to submit the information as a Draft or Final. You have the option to select another staff member to send the Mental Status and Behavioral Observation assessment to for review and to provide outgoing comments.

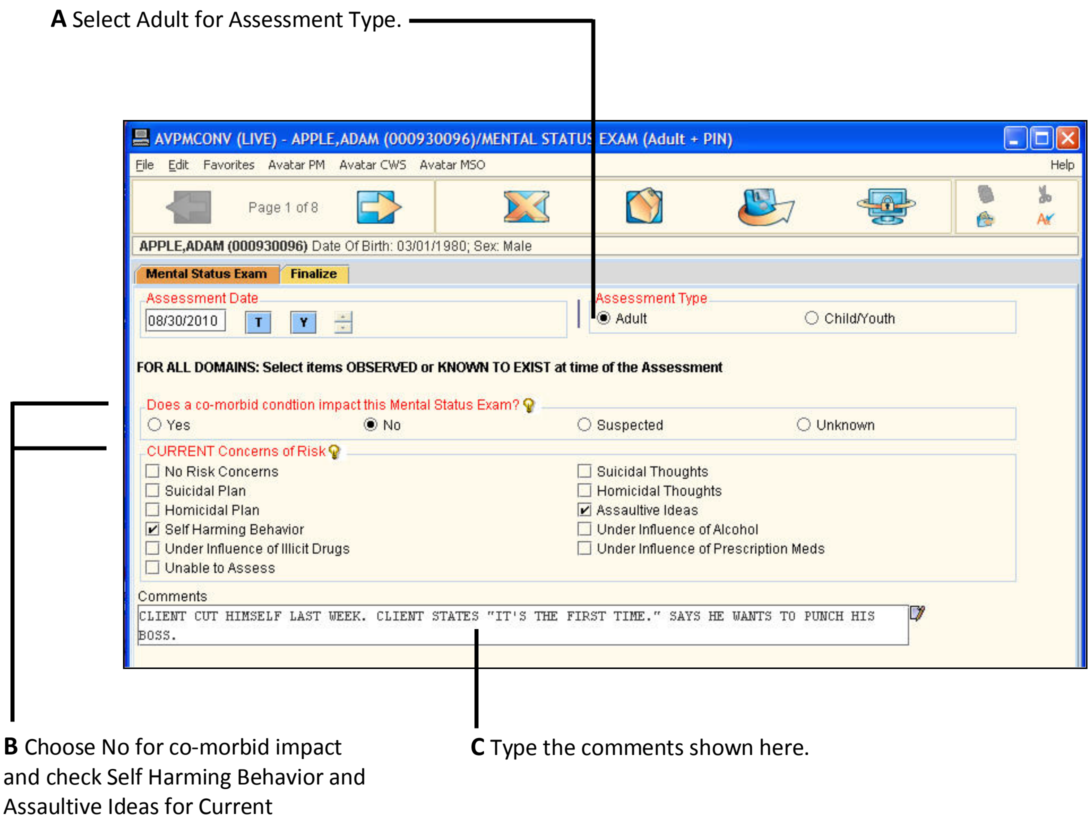


Exercise 8 Write a Mental Status Exam

In this exercise you will complete a Mental Status Exam based on elements you observed directly while working with the client.

Before You Begin: *Select the sample client you are working with. In this example the client is Adam Apple.*

1. Choose Avatar CWS→Assessments→Mental Status Exam (Adult + PIN) from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new Mental Status Exam.
3. Follow these steps to rate the client's risk characteristics:



Rate General Appearance and Speech

4. Click the Forward icon on the Option toolbar to go to page 2.
5. Choose Within Normal Limits for General Appearance and Soft and Slowed for Speech.
6. Click the Forward icon on the Option toolbar to go to page 3.

Rate the Client's Motor Activity and Mood

7. Choose Tremor for Motor Activity and Anxious and Irritable for Mood.
8. Click the Forward icon on the Option toolbar to go to page 4.

Rate Intellect and Affect

9. Choose Poor Abstraction and Poor Vocabulary for Intellect and choose Within Normal Limits for Affect.
10. Click the Forward icon on the Option toolbar to go to page 5.

Document Behavior and Flow of Thought

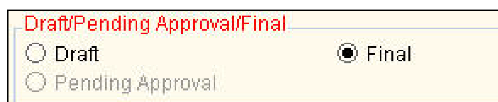
11. Choose Evasive for Behavior and choose Blocking and Incoherence for Flow of Thought.
12. Click the Forward icon on the Option toolbar to go to page 6.

Enter Content of Thought and Hallucinations Details

13. Choose Within Normal Limits for Content of Thought and Auditory for Hallucinations.
14. Click the Forward icon on the Option toolbar to go to page 7.

Document Delusions, Sensorium, and Insight and Judgment

15. Choose Mood Congruent for Delusions, Within Normal Limits for Sensorium, and Poor Judgment for Insight and Judgment.
16. Click the Finalize tab.
17. Click the Final radio button.



18. When the message appears indicating that selecting Final prevents future edits, click OK.
19. Click the Submit icon to save your work.

Understanding Mental Status/Behavioral Observation (YOUTH)

NOTE: All behaviors and symptoms in this window are only rated if they are known to exist or were observed at the time of the interview. A non-response to any field indicates that the symptom or behavior was not known or observed.

There are 14 pages in the Mental Status and Behavioral Observation tab, broken down into Co-Morbid/Risk, Appearance, Motor Activity, Speech, Mood/Intellect, Affect, Behavior, Thought, Sensorium, and Insight and Judgment. On each of these pages, details only become available to fill out if you indicate there is a problem by selecting Yes at the beginning of each section. Only rate the fields in this tab that apply to your client. If an item does not apply, you may leave the field blank.

IMPORTANT

If you choose Yes to the Immediate Concerns of Risk Field, and you complete the page and then later decide to select No, Avatar will clear all selections in that section and you will need to re-enter them.

If you select an item by mistake, press the [F5] key to clear an option. Required fields cannot be cleared. If you select Yes for a required field by mistake, you cannot clear it. Select No instead.

Who Can Perform This Function?

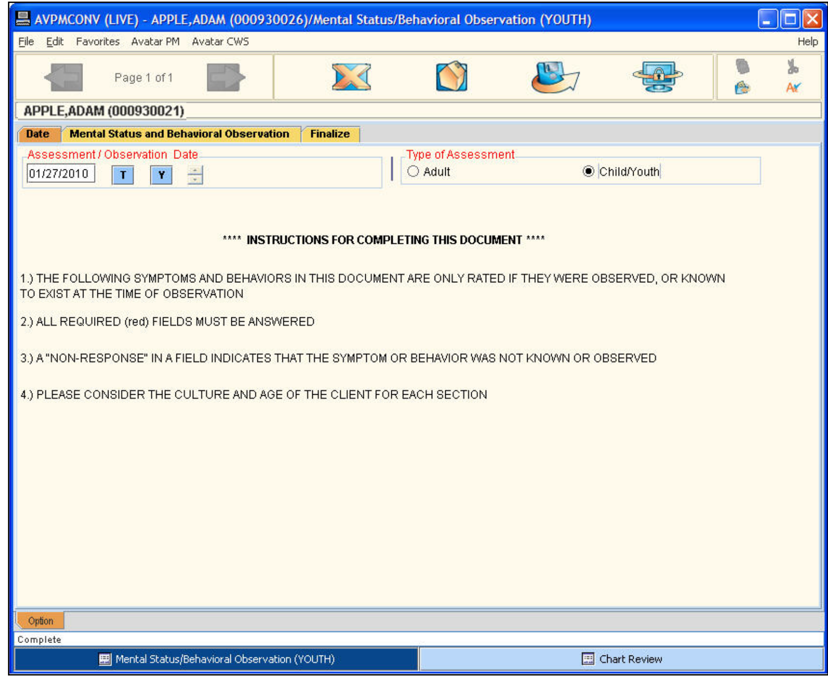
A physician, licensed/waivered psychologist, licensed/registered clinical social worker, licensed/registered marriage and family therapist, or registered nurse with a master's degree in a mental health related field.

Menu Path:

Avatar CWS→Assessments→Mental Status/Behavioral Observation (YOUTH)

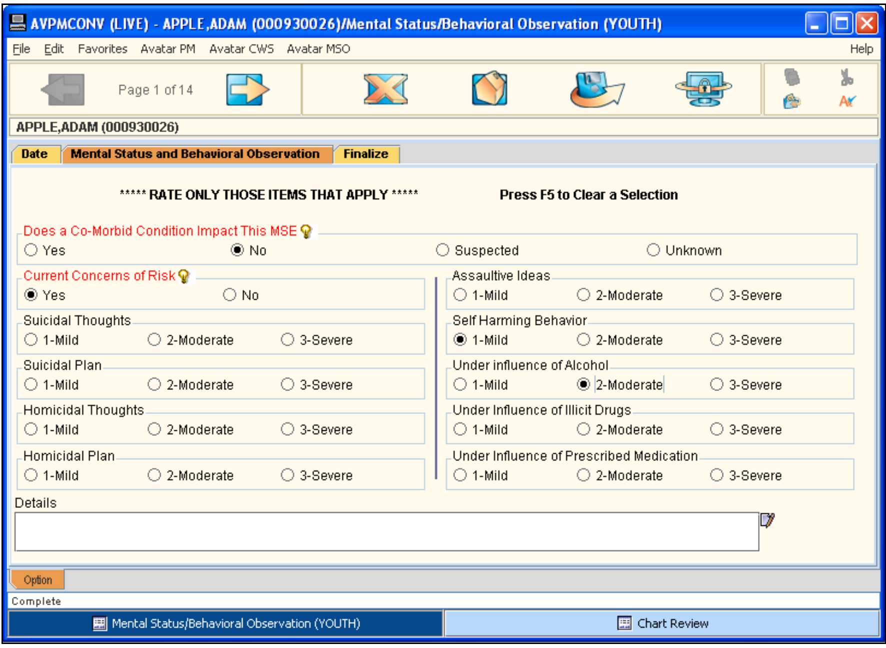
DATE TAB

Use this tab to document the date and the type of assessment. Note the instructions for completing this document.



MENTAL STATUS AND BEHAVIORAL OBSERVATION TAB PAGE 1

Use this page to document whether a co-morbid condition impacts this assessment and any current concerns of client risk.



Mental Status and Behavioral Observation Tab Page 2

This page focuses on the client's general appearance.

Mental Status and Behavioral Observation Tab Page 3

This page focuses on the client's motor activity.

Mental Status and Behavioral Observation Tab Page 4

This page focuses on the client's speech characteristics.

Mental Status and Behavioral Observation Tab Page 5

This page focuses on the client's mood and intellect.

Mental Status and Behavioral Observation Tab Page 6

This page focuses on the client's affect.

Mental Status and Behavioral Observation Tab Page 7

This page focuses on the client's behavior.

Mental Status and Behavioral Observation Tab Page 8

This page focuses on the client's flow of thought.

Mental Status and Behavioral Observation Tab Pages 9, 10, 11, 12

Pages 9-12 focus on the client's content of thought. Page 11 allows you to document hallucinations, and page 12 documents delusions. If you need to document any of the choices on these pages, you must select Yes to Content of Thought Within Normal Limits field on page 9. This will activate all fields on pages 9-12.

Mental Status and Behavioral Observation Tab Page 13

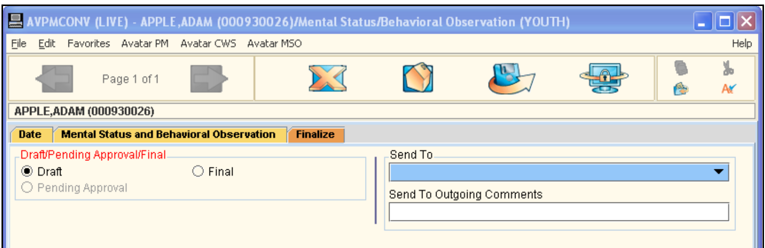
This page focuses on sensorium information.

Mental Status and Behavioral Observation Tab Page 14

This page focuses on the client's insight and judgment.

Finalize Tab

Use this tab to submit the information as a Draft or Final. You have the option to select a staff member to send the assessment to for review and to provide outgoing comments.



Exercise 9 Write a Mental Status/Behavioral Observation (YOUTH) Assessment

In this exercise you will complete a Mental Status/Behavioral Observation based on elements you observed directly while working with the client.

Before You Begin: *Select the sample client you are working with using the Select Client icon. In this example the client is Adam Apple.*

1. Choose Avatar CWS→Assessments→Mental Status/Behavioral Observation (YOUTH) from the Menu Frame.

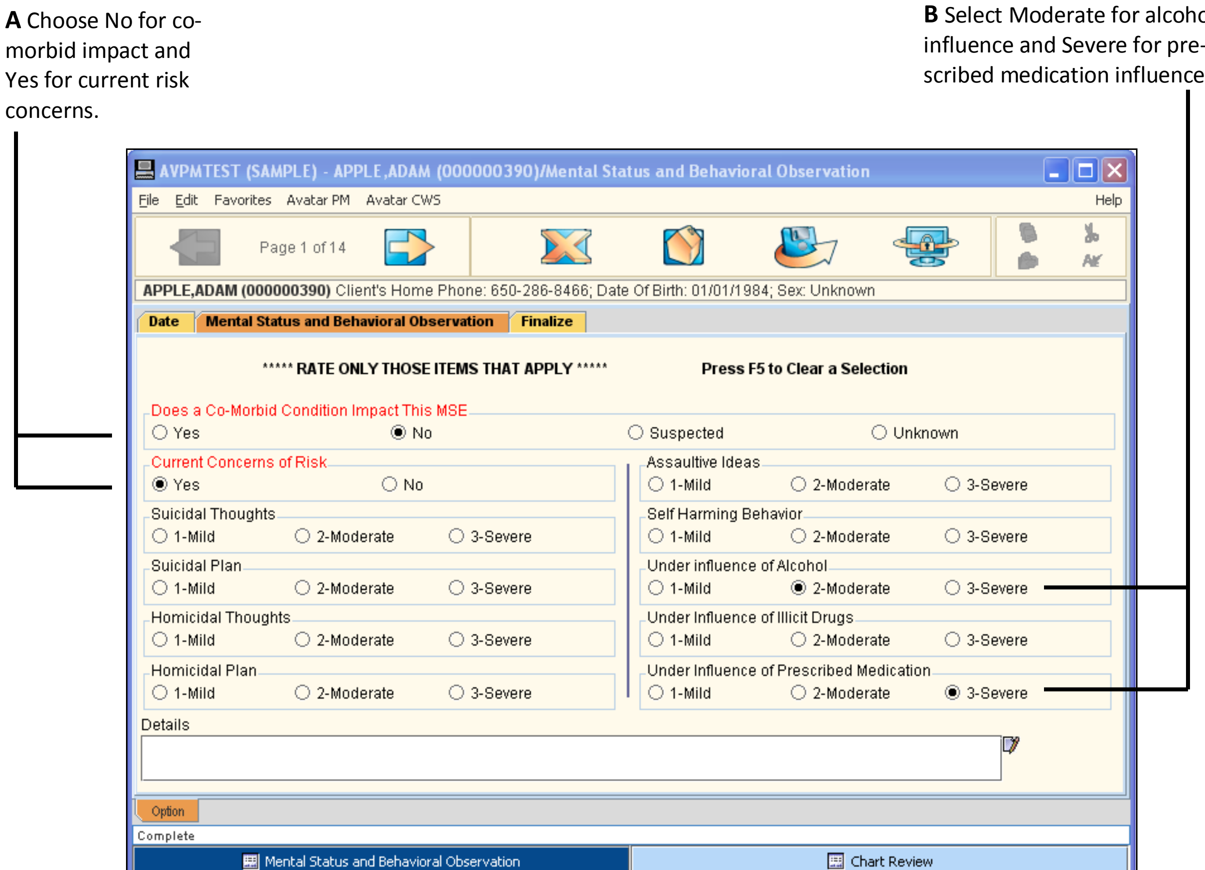
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new mental status assessment.

   The Type of Assessment field defaults to Child/Youth and you cannot change it.

Document Risk Concerns

3. Click the Mental Status and Behavioral Observation tab.

4. Follow these steps to rate the client's risk characteristics:



Rate General Appearance and Motor Activity

5. Click the Forward icon on the Option toolbar to go to page 2.
6. Choose Yes in General Appearance within Normal Limits.
7. Click the Forward icon on the Option toolbar to go to page 3.
8. Choose Yes in Motor Activity within Normal Limits.

Enter the Client's Speech Characteristics

9. Click the Forward icon on the Option toolbar to go to page 4.
10. In SPEECH within Normal Limits, select No.
11. Only check the following items:

    Slowed, select Moderate

    Slurred, select Severe

Rate Mood and Intellect

12. Click the Forward icon on the Option toolbar to go to page 5.
13. In MOOD (Self Report) within Normal Limits, select No.
14. Only check the following item: Depressed, select Moderate.
15. In INTELLECT within Normal Limits, select Yes.

Document Affect and Behavior

16. Click the Forward icon on the Option toolbar to go to page 6.
17. In AFFECT within Normal Limits, select Yes.
18. Click the Forward icon on the Option toolbar to go to page 7.
19. In BEHAVIOR within Normal Limits, select Yes.

Enter Flow of Thought Details

20. Click the Forward icon on the Option toolbar to go to page 8.
21. In FLOW OF THOUGHT within Normal Limits, select No.
22. Only check the following item: Incoherence, select Mild

Rate Content of Thought

23. Click the Forward icon on the Option toolbar to go to page 9.
24. In CONTENT OF THOUGHT within Normal Limits, select Yes.
25. Click the Forward icon on the Option toolbar to go to page 10.

    Because you selected Yes to normal Content of Thought on the previous page, the fields on this page are not active.

26. Click the Forward icon on the Option toolbar to go to page 11.

    Because you selected Yes to normal Content of Thought on the previous page, the fields on this page are not active.

27. Click the Forward icon on the Option toolbar to go to page 12.

    Because you selected Yes to normal Content of Thought on the previous page, the fields on this page are not active.

RATE SENSORIUM

28. Click the Forward icon on the Option toolbar to go to page 13.
29. In SENSORIUM within Normal Limits field, select No.
30. Only check the following items:

    Clouding of Consciousness, select Yes

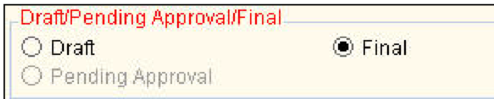
    Poor Recent Memory, select No

DOCUMENT INSIGHT AND JUDGMENT

31. Click the Forward icon on the Option toolbar twice to go to page 14.
32. In INSIGHT AND JUDGMENT within Normal Limits, select Yes.

SUBMIT THE MENTAL STATUS AND BEHAVIORAL OBSERVATION

33. Click the Finalize tab.
34. Click the Final radio button.



35. When the message appears indicating that selecting Final prevents future edits, click OK.
36. Click the Submit icon to save your work.

Understanding the Substance Use Assessment Window

Use this window to collect information about the client's substance use, including an initial screening, drug history, and the client's perceptions of drug use.

IMPORTANT

If you select None on page 1 of the Substance Use/Trauma tab for the Child/Youth Admission Assessment or None on the Co-Occurring Issues tab on the Adult Admission Assessment, the Substance Use Assessment is not required.

Who Can Perform This Function?

Only clinical staff can perform this function.

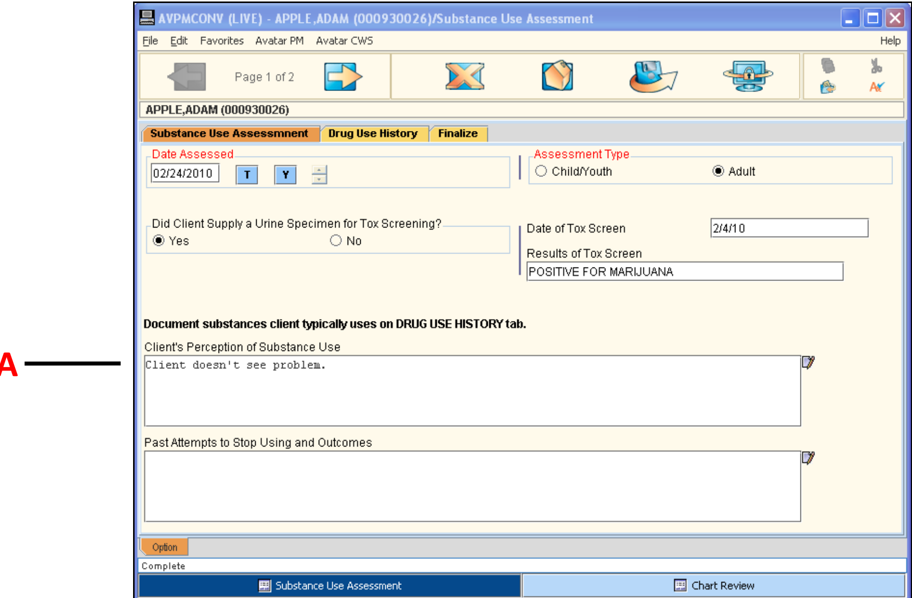
Menu Path

Avatar CWS→Assessments→Substance Use Assessment

Substance Use Assessment Tab Page 1

Document the date and type of assessment as well as the client's perception of substance use and past attempts to stop.

NOTE: Document any substances that the client typically uses, not on this page, but on the Drug Use History tab.



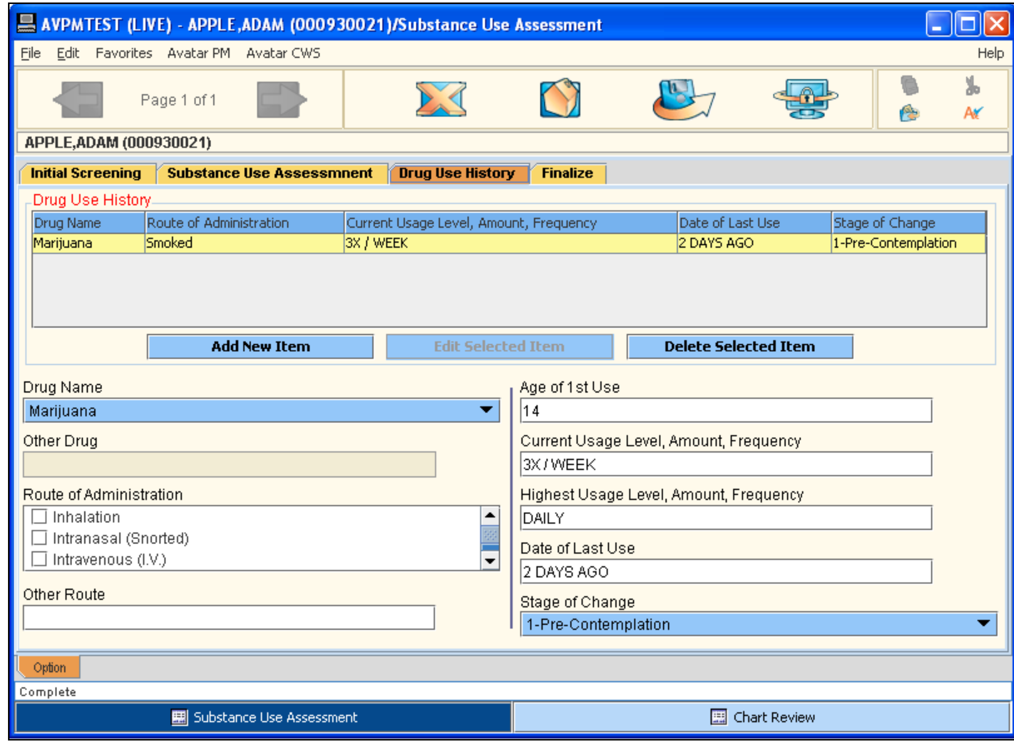
Field	Description
A) Client's Perception of Substance Use	If there is a previous Substance Use Assessment for this client, this field automatically populates from the previous assessment. Modify the information if appropriate.

Substance Use Assessment Tab Page 2

Document how substance use affects mental health, the client's highest level of sobriety, current state of change, and family history of substance use.

Drug Use History Tab

Document the client's drug use history on this page. For details on how to work with information in a multiple entry table, like the one on this page, see Lesson 6 in the *Introduction to Avatar* manual.



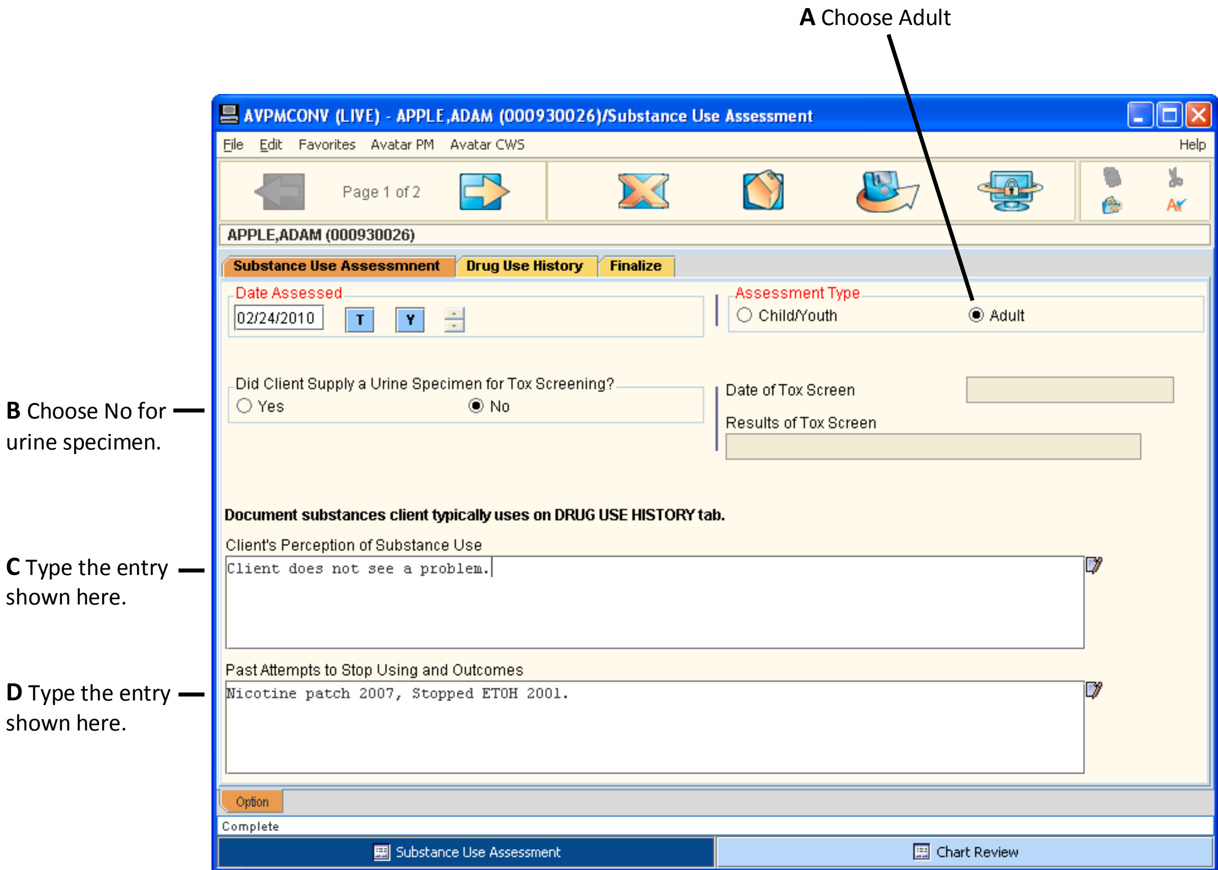
Finalize Tab

Use this tab to submit the information as a Draft or Final. If you are an intern and need manager approval for this assessment, you have the option to select a staff member to send the Substance Use Assessment to for review and to provide outgoing comments.

Exercise 10 Write a Substance Use Assessment

In this exercise you will complete a Substance Use assessment, including drug use history.
Before You Begin: *Select a sample client you are working with using the Select Client icon. In this example Adam Apple is the client.*

1. Choose Avatar CWS→Assessments→Substance Use Assessment from the Menu Frame.
2. If the Pre-Display screen appears, click the Add button in the lower-left corner to create a new Substance Use assessment.
3. Follow these steps to complete page 1 of the Substance Use Assessment tab:



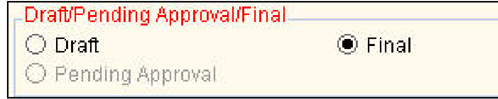
4. Click the Forward icon on the Option toolbar to go to page 2.
5. In Does Substance Use Interfere/Exacerbate MH Problems field, type **`Yes, heavy alcohol use increases suicidal thoughts`**.
6. In Highest Level of Sobriety field, type **`1 year clean 1999`**.
7. In Client's Current Stage of Change field, type **`Pre-contemplation`**.
8. In Family History of Substance field, type **`None`**.

Complete the Drug Use History

9. Click the Drug Use History tab.
10. Click the Add New item button to add a row to the table.
11. In the Drug Name field, select Amphetamines from the dropdown list.
12. In the Route of Administration field, select Oral.
13. In Age of First Use field, type **16**.
14. In Current Usage Level, type **2x/week**.
15. Click the Add New Item button to add another drug.
16. In Drug Name field, select Cocaine from the dropdown list.
17. In Route of Administration field, select Intranasal (Snorted).
18. In Age of First Use field, type **17**.
19. In Current Usage Level, type **None**.
20. In Highest Usage Level, type **Daily 1 Gram**.
21. In Date of Last Use field, type **November 2008**.
22. In State of Change field, select Maintenance from dropdown list.

Finalize the Assessment

23. Click the Finalize tab.
24. Click the Final radio button.



25. When the message appears saying that Final prevents future edits, click OK.
26. Click the Submit icon to save your work.

UNDERSTANDING BHRS DIAGNOSIS

This window collects DSM-IV diagnoses for Axis I and II (Diagnosis), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning). Provisional (rule out) diagnoses can also be documented and the primary diagnosis is identified here.

On any of the pages in the Diagnosis tab, you can click a blue underlined link to access the official DSM-IV website. Clicking these links opens a new window on top of Avatar.

If a Diagnosis was previously completed in Avatar, the last diagnoses on file for each axis will automatically appear in the field. Review the information from a previous diagnosis to determine if it is still accurate and edit the diagnosis accordingly.

IMPORTANT

When you see CSI next to a field, it indicates that it is State required information and the information will be visible in public reports.

WHO CAN PERFORM THIS FUNCTION?

Only clinical staff can perform this function.

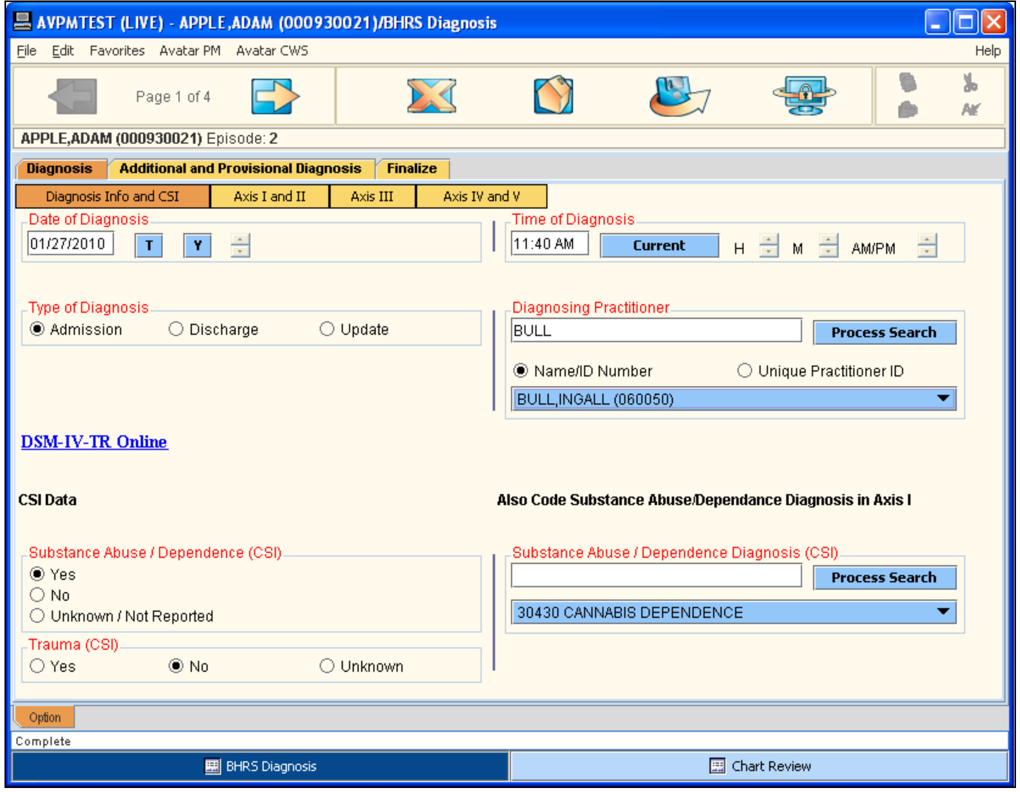
MENU PATH

Avatar CWS→Assessments→BHRS Diagnosis

Diagnosis Tab Page 1 (Diagnosis Info and CSI)

All fields on this page are required. Document the diagnosis assessment, including Type of Diagnosis and Diagnosing Practitioner. The CSI fields at the bottom of the page are for California State required statistical purposes. If substance abuse is indicated, you must enter a substance abuse diagnosis. BHRS diagnoses begin on page 2.

NOTE: If there is a previous diagnosis for this episode, the information autofills the current diagnosis. Modify this information as appropriate.

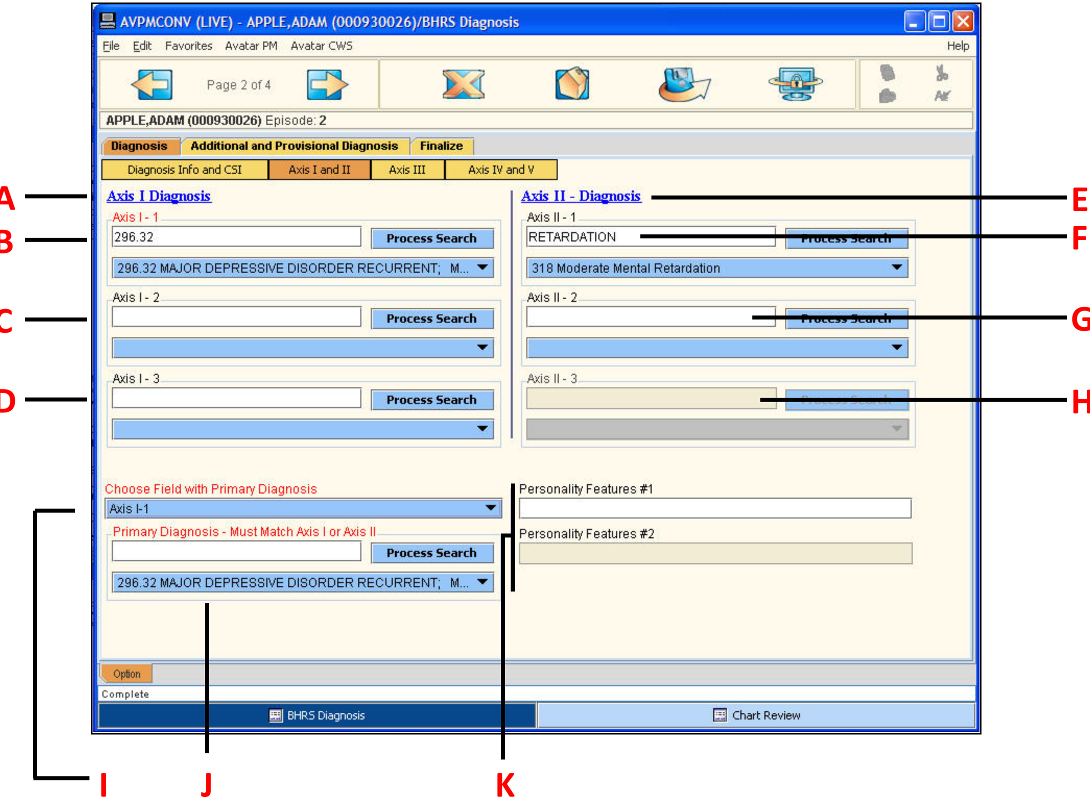


DIAGNOSIS TAB PAGE 2 (AXIS I AND II)

Use this page to document the Axis I and Axis II diagnoses. If you do not know a code or official name for a specific diagnosis, you can use the blue Axis I Diagnosis and Axis II Diagnosis links at the top of the page to access the official DSM-IV website.

In the Axis fields, you can type all or part of the code number or description. In the example below, *296.32* was typed in the Axis I Diagnosis field to get the result Major Depressive Disorder Recurrent. In the Axis I-2 Diagnosis field, *Retardation* was typed to produce results in the dropdown menu with that keyword anywhere in the diagnosis. Click a choice in the menu to populate that diagnosis in the field.

Avatar will not allow you to make a diagnosis to the wrong Axis, for example, Major Depressive Disorder cannot be entered in an Axis II field.



Field/Link	Description
A) Axis I Diagnosis link	Click this link to access Axis I codes and definitions from the official DSM-IV website, which will open in a separate window on top of Avatar.
B) Axis I – 1	Type a DSM-IV code or part of the Axis 1 diagnosis name in this field and tap the [Enter] key.
C) Axis I – 2	Type a DSM-IV code or part of the secondary Axis 1 diagnosis name in this field and tap the [Enter] key.

Field/Link	Description
D) Axis I – 3	This field will only become active if diagnoses are entered in the Axis I – 1 and Axis I – 2 fields.
E) Axis II – Diagnosis link	Click this link to access Axis II codes and definitions from the official DSM-IV website, which will open in a separate window on top of Avatar.
F) Axis II – 1	Type a DSM-IV code or part of the Axis II diagnosis name in this field and tap the [Enter] key.
G) Axis II – 2	Type a DSM-IV code or part of the secondary Axis II diagnosis name in this field and tap the [Enter] key.
H) Axis II – 3	This field will only become active if diagnoses are entered in the Axis II – 1 and Axis II – 2 fields.
I) Choose Field with Primary Diagnosis	Select a diagnosis in the Axis I or Axis II fields as the primary diagnosis. The primary diagnosis must always match a Axis I or Axis II diagnosis.
J) Primary Diagnosis	This field auto-populates based on the choice you make in the Choose Field with Primary Diagnosis field.
K) Personality Features #1 and #2	These are personality traits. For example, if a client shows narcissistic traits that are not enough for a full diagnosis, you would type Narcissistic Features in this field.

Diagnosis Tab Page 3 (Axis III)

Axis III general medical condition information is required. You may check one or more checkboxes that apply. *No General Medical Condition* is an option in this list. If you select the checkbox next to Other, the Axis III-Other text field becomes required.

IMPORTANT

If you check Other from the Axis III list, you must click inside the Axis III-Other text field to activate it.

Diagnosis Tab Page 4 (Axis IV and V)

For official descriptions and explanations of the Axis IV and Axis V questions on this page, use the blue Axis IV – Psychosocial and Environmental Problems and Axis V – Global Assessment of Functioning links at the beginning of each Axis section. These links open a web page with official DSM-IV information.

- Choosing Yes for an Axis IV entry indicates the *client does have a problem* in that area.
- In the Axis V GAF dropdown field, the first number in parenthesis, (31) for example, is the GAF score.

ADDITIONAL AND PROVISIONAL DIAGNOSIS TAB PAGE 1

You use this page to document additional Axis I, Axis II, and Axis III diagnoses. The Axis I and II fields on this tab are only available if you used all of the related fields on the Diagnosis tab.

You only need Axis-III here if you need to call out something that's not in the checkboxes on page 3 of the Diagnosis tab.

ADDITIONAL AND PROVISIONAL DIAGNOSIS TAB PAGE 2 (RULE OUT DIAGNOSES)

Use this page to document any Rule Out diagnoses for Axis I or II, if necessary.

FINALIZE TAB

Use this tab to submit the information as a Draft or Final. If you are an intern and need to get manager approval for this assessment, you have the option to select another staff member to send the assessment to for review and provide outgoing comments.

Exercise 11 Write a BHRS Diagnosis Assessment

In this exercise you will complete a diagnosis assessment.
Before You Begin: *Select a sample client to work with.. In this example Adam Apple is the client.*

1. Choose Avatar CWS→Assessments→BHRS Diagnosis from the Menu Frame.
2. If the Episode Selection screen appears, choose the episode that relates to this diagnosis.
3. If the Pre-Display screen appears, click the Add button to create a new Diagnosis.
4. In Type of Diagnosis, select Admission.
5. In Substance Abuse/Dependence field, select Yes.
6. In Trauma field, select No.
7. In Substance Abuse/Dependence Diagnosis field, type **`CANNABIS`** and tap the [Enter] key.
8. In the dropdown box, select 304.30 CANNABIS DEPENDENCE.

ENTER AXIS I AND AXIS II DIAGNOSES

9. Click the Forward icon to go to page 2.
10. In Axis I-1 field, type **`296.8`** and tap the [Enter] key.
11. In the search result dropdown list, select 296.8 BIPOLAR DISORDER NOS.
12. In Axis I-2 field, type **`BORDERLINE`** and tap the [Enter] key.
13. In the search result dropdown list, select 301.83 BORDERLINE PERSONALITY DISORDER.

14. In the Choose Field with Primary Diagnosis field, select Axis I-1 from the dropdown list.

15. Click the Forward icon to go to page 3.

16. In Axis III – General Medical Condition Summary Code field, check Arthritis and Asthma.

17. Click the Forward icon to go to page 4.

ENTER AXIS IV AND V DIAGNOSES

18. In Axis IV – Primary Support Group field, select Yes.

19. In Axis IV – Social Environment field, select Yes.

20. In Axis IV – Housing, select Yes.

21. In Axis IV – Economic, select Yes.

22. In Axis IV – Legal system, select Yes.

    You need a quick reminder of the Axis V GAF codes.

23. Click the blue Axis V – Global Assessment of Functioning link to open the official DSM-IV codes in a new Internet Explorer window.

24. Close the window when you are finished to return to Avatar.

25. In Axis V – Current GAF Rating field, select (41) 41-50 Serious Symptoms or Impairment.

26. Click the Additional and Provisional Diagnosis tab.

27. You do not need to document any additional diagnoses.

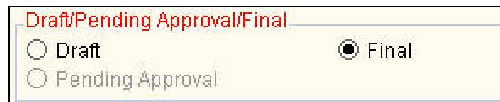
28. Click the Forward icon to go to page 2.

    You do not have any provisional (rule out) diagnoses.

SAVE THE ASSESSMENT AS A DRAFT

29. Click the Finalize tab.

30. Click the Final radio button.



31. Click the Submit icon to save your work.

Concept Review: Admission Assessments

See the appendix for answers.

1. How many different windows make up the complete admission assessment?
2. What happens to the Substance Use dropdown list in the Finalize tab if you select None on the Co-Occurring Issues tab?
3. If an assessment dropdown field is empty on the finalize tab, what is the problem?
4. True or False: You use the Medication History tab to prescribe medications for a client.
5. What do the lightbulb icons do?

APPENDIX—CONCEPT REVIEW ANSWERS

1. There are 5—Admission Assessment, LOCUS/CALOCUS, Substance Use, BHRS Diagnosis, Mental Status Exam (Adult + PIN) or Mental Status/Behavioral Observation (YOUTH).
2. The dropdown list becomes disabled.
3. That type of assessment has not been completed and finalized in the last 60 days
4. False. MDs use Infoscriber to prescribe medications. Clinicians and administrators can run the Infoscriber Medications report to see a current list of prescribed medications.