SAN MATEO COUNTY
BHRS

Super User Guide

V 4.7

Table of Contents

INTRODUCTION

THANK YOU FOR BECOMING AN AVATAR SUPER USER.

What you learn as a Super User will not just benefit your team(s) but will also benefit your own use of Avatar. The Avatar Team's support for you as a Super User begins with classroom training and continues with monthly web and in person meetings. These monthly meetings are the forum to ask questions, make suggestions, hear about changes to Avatar and listen to your counterparts at other clinics and teams.

WHAT IS EXPECTED OF YOU AS AN AVATAR SUPER USER?

- If you are available, you will help other Avatar users at your location with common problems they encounter using Avatar.
- Apply some trouble-shooting skills to determine if a problem is with Avatar, a computer or network, or with the user's understanding of the application.
- If you can't solve a problem, submit a Help Desk ticket.
- If a co-worker needs coaching on how to finish a task in Avatar, provide some coaching.
- If a co-workers need more training/coaching than you are able to provide, contact the Avatar team to take over.
- Contact the Avatar team to report bugs and pass along suggestions for improvements.

HELP DESK

As a Super User, you are not expected to know all the answers. If you can't assist someone who needs help, contact the ISD Help Desk, and they will help you. You can then help your fellow employee. (This is how you will build your knowledge base over time.) If the situation is urgent, say so and you will get priority.

Phone number: 650-573-3400
eMail: ISDHelpDesk@co.sanmateo.ca.us

WHAT IF I CANNOT SOLVE AN ERROR/PROBLEM?

Many of the questions for Super Users will be along the line of "I knew how to do XYZ with a paper form but how do I do it **now**?" Many of those questions can be answered based on what we used to do on paper.

Let's look at an example – A clinician provides consultation to a Telecare Full Service Partnership Adult team about a Client they are treating. Where will the Clinician document her consultation? If the Client were being treated by another County Clinic team, the Clinician would document to that team's chart. However, because the Client's team is a contracted provider, in the paper system, the choice would be an episode quick open/close. The same answer is true for Avatar.

When the question goes beyond your knowledge and/or time, the suggestions below will assist the ISD Help Desk to troubleshoot the issue.

- If there is an error message, write down the message and error number (if available) so the Help Desk can better assist you.
  OR
- Take a screen shot and paste it in a Word document.
  - Pressing [Print Screen] takes a picture of the entire computer screen.
  - Pressing [Alt]+[Print Screen] takes a picture of the window/message/dialog box in the foreground.
  - Switch to a Word document and paste the picture ([Ctrl]+[V]) in the document. Add any information to the Word document that might help with troubleshooting, such as describing what the user was doing just before the error occurred.
  - Save the Word document.
  - Email the Word document as an attachment in GroupWise to the ISD Help Desk.
- For other errors/problems, provide the following:
  - Client Number
  - Date of Service
  - Program
  - Any other information you think might be helpful.

BILLING ISSUES

- Refer users to MIS.
  - Includes Financial Eligibility and UMDAP.
  - Admins are able to correct some Progress Note errors. Check the section on Error Correction for instructions.
  - Includes erroneous Progress Notes where the client or the episode number is incorrect or if the billing system has closed for the month.

COMMON PROBLEMS

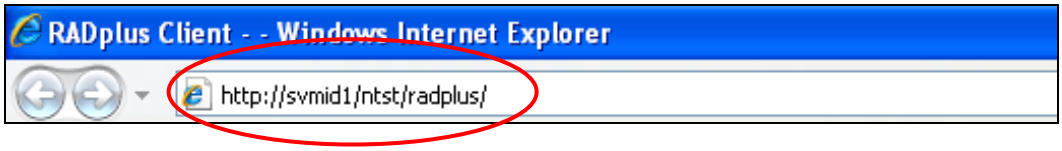
Login Issue - Forgot Password

User will call the ISD Help Desk to re-set their password.

Login Issue - Password doesn't work!

Check the Internet Explorer Address/URL. For the LIVE system it must be:
http://svmid1/ntst/radplus/

If anything else appears in the Address box, the user is trying to log in to the wrong system. The address should look like the one in the image below:



If the address is correct, check that the user is entering the password correctly.

- Passwords are Case Sensitive. Is Caps Lock on or off?
- Did the person recently re-set their password?

If you and the user are unable to figure it out after two tries, ask the user to call the ISD Help Desk to get their password reset.

The password for the Live system is not the same as for the Training system; users should receive a new temporary password via email. If not, contact the Help Desk.

- Users are required to enter a new password immediately upon signing on with the temporary password.
- An Avatar password must be a minimum of 8 characters, at least one alpha character and at least one number.
- Passwords are case sensitive.
- System Code (LIVE) must be in upper case.

Login Issue - Gray Screen on Login

Symptoms: User reports that after log on all the icons are grayed out.

The most common reason for the problem is that an Avatar Message Box opened that requires a response before Avatar can finish logging in.

Fix: Ask user to maximize the Avatar window. When they do that, they should see a Message Box displayed – normally it's a notification that they have a new To Do item in their list. Once they respond to the Message Box, they will be logged on to Avatar normally.

If the above does not work, check the computer's screen resolution. If the resolution is low (print and icons appear larger), the message box may not display. To check the screen resolution, follow these steps:

- From the desktop, right click and select **Properties**
- Click on the **Settings** tab
- Screen resolution should be at least 1024 x 768
- If you change the screen resolution, click on the command button **Apply** then **OK**

The symptom can also appear if the user already has an Avatar session open. Avatar does not allow more than one session for a user on the same computer.

Performance - Avatar screen appears frozen OR Screen locked up

Symptoms: Avatar appears unresponsive when trying to type or mouse click. Unresponsive should generally mean at least three (3) minutes when the user is unable to type or operate the system.

- Did the user close the window with the red Close  button?
- Is there a message box hiding behind the current window? Use Alt+TAB to scroll through open windows on your computer. If so, have the user respond to the message; that may unlock the screen.
- Did the user click the Get Signature button? This will lock the screen if a Signature Pad is not connected to the computer.
- Saving some forms and running some reports takes a long time. If the screen is unresponsive for less than 2 minutes, wait another minute before deciding it's an error.

Fix: There are several possible solutions.

- **Hidden dialog/message box**
  User presses [alt] + [tab] keys and they will see the next screen or program open. If an Avatar dialog box displays, respond to the prompt.
- **Report run time**
  User should let report run. They may minimize the window and choose another Avatar activity, or work with a different Windows application. They should not use the red 'x' to close the application before the report completes.
- **Slow System**
  ISD Help Desk should check user volume. If it is heavy then the user may need to wait 3-5 minutes. If the user can repeat their action at the end or beginning of the day they should be able to save or proceed within a few seconds.

Clear an Avatar Field

Symptoms: User has made an entry in an Avatar field by mistake and can't clear it.

Fix: Press F5 to clear Avatar Radio Buttons, check boxes, drop down lists and Process Search fields

Avatar "New To-Do List Item" made my document disappear.

Symptoms: User is working on an Avatar document. Without warning, the document disappears and a message box displays notifying the user that they have a new TO DO List item. After the user clears the message box, how do they get back to the document they were working on?

Fix: When the To Do List notification popped up, the user's Avatar document was minimized. The user should look in the MS-Windows task bar at the bottom of the screen for items opened to AVPMLIVE. If they click on the AVPMLIVE entry in the task bar, their document will re-appear.

TO DO List items don't show up on my list

Symptoms: User reports they are not receiving to-do items even though someone tells them they've sent the user a document to review.

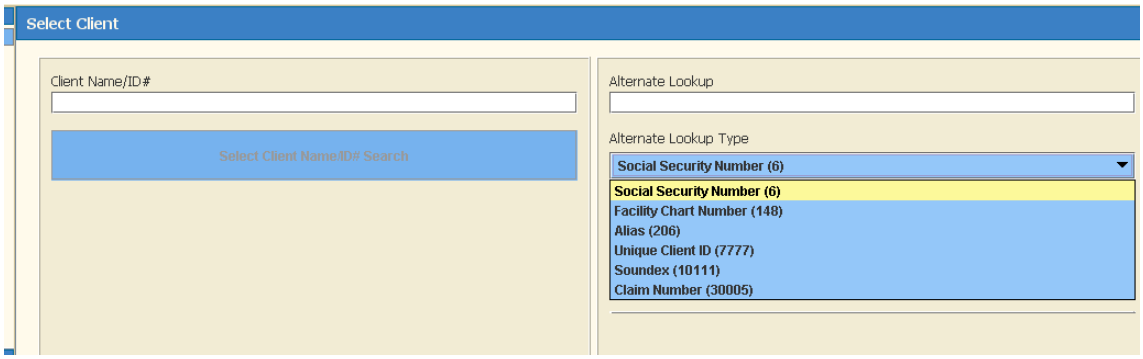
Fix: When a clinical document is saved as DRAFT, it does NOT send a TO DO item. Only when a document is finalized will the TO DO item be sent.

I Can't Find My Client Using the Select Client Screen

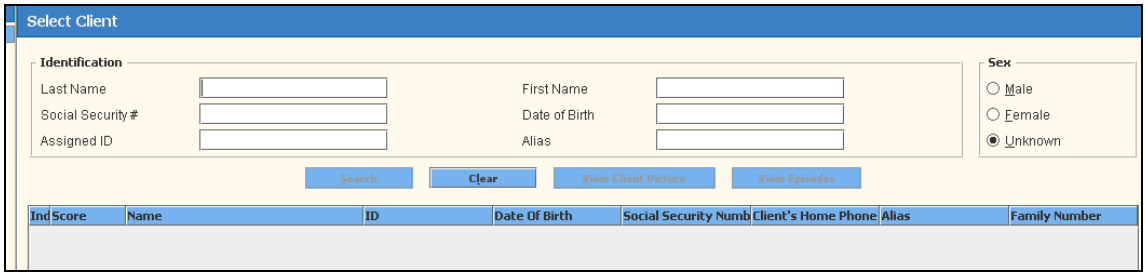
- Be sure the user enters the name using the correct format (no space between the comma and the Firstname):

  LASTNAME, FIRSTNAME

- From the Select Client Screen, use one of the Alternate Lookup Methods on the right hand side of the window. You may select to look for a client using a Social Security Number, Alias or Soundex. (Soundex will locate names that sound similar to the name the user enters. This is helpful in locating names where the user is unsure of the spelling.)



- A third option is to use the more detailed Select Client screen, which you can access via Avatar PM→Client Management→Episode Management→Call Intake. From this screen you can look up a client using a combination of criteria shown in the screen shot below:

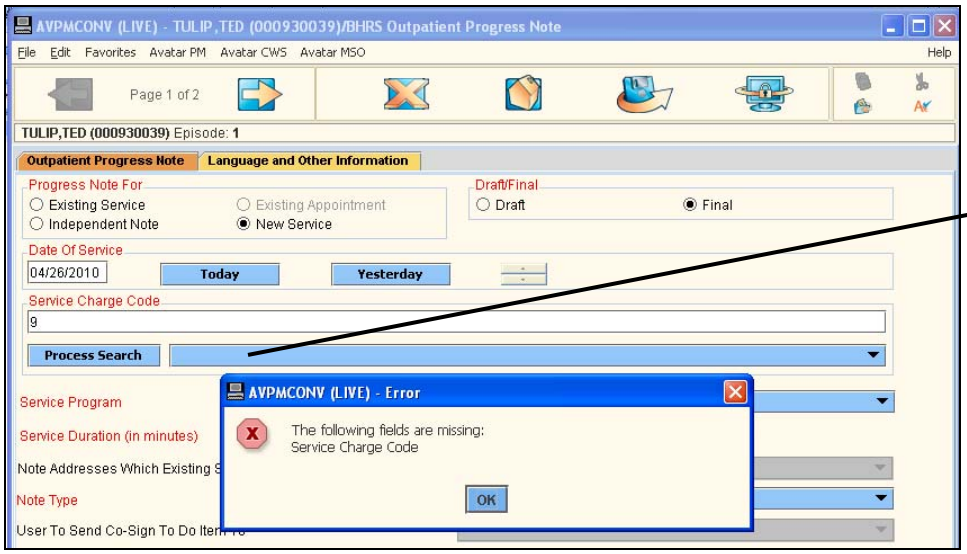


The fields are full or partial Last Name and/or First Name, Sex, Social Security Number, Date of Birth, MH ID (Assigned ID) and Alias.

Problems with Process Search Fields

Symptoms: User entered the Service Charge Code, but Avatar keeps indicating the field is missing when s/he clicks Final.

Fix: The User must click the Process Search button to generate a response to the information entered in the Service Charge Code text field then click OK to place the response in the blue bar. Only then does Avatar recognize that the information is entered in the field.

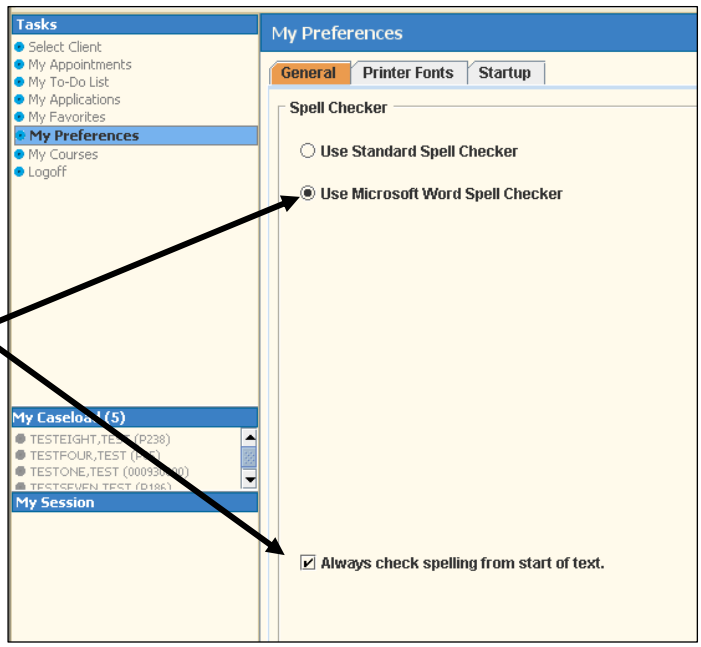


The response to clicking the Process Search button must appear here.

Spell Check is Not Catching My Typos

It is likely that a setting needs to be changed in My Preferences.

- Click the My Preferences link in the Tasks Frame on the left side of the Avatar Homepage.
- Check the Always Check Spelling from Start of Text checkbox. (It is also recommended to use the Microsoft Word Spell Checker. If the user stored special terms in Word's dictionary, Avatar will recognize those special terms.)



NOTE: [F7] is the universal shortcut key for spell check. Right-clicking in a text field displays a popup menu containing the Spell Check command.

Multiple Entry Table Issues

When you want to make an entry in the table, you ***add*** a new row to the table and then complete the related data fields below the table. This populates the rows in the table.

ADD, EDIT, AND DELETE ENTRIES IN THE TABLE

- **Add a Row:** Click the Add New Item button.
- **Edit a Row:** Select a row you wish to edit and click the Edit Selected Item button. The related fields below the table become populated with information from the row you selected and you can make changes directly in the fields.
- **Delete a Row from the Table:** Click a row to select it and then click the Delete Selected Item button to remove a row from the table.

COMMON MULTIPLE ENTRY TABLE MISTAKES

A common mistake when using a multiple entry table is forgetting to click the Add New Item button before starting to fill out fields for additional entries. If you enter new data without adding a new row, the new data you enter overwrites existing information in the active (highlighted) row in the table.

Another mistake is to leave blank rows in the table. (A possible reason for this might be double-clicking the Add New Item button.) When the user tries to submit the window, an error message displays. The blank row(s) must be deleted before the form can be saved.

HOW DO YOU FIND THE DRAFT OF ANY DOCUMENT?

1. Access the command that generates the document, such as Adult Admission Assessment, Treatment Plan, or BHRS Client Treatment and Recovery Plan.
2. In the Pre-Display screen, click the Edit button at the bottom of the screen to open the draft document.

MANAGING YOUR TO-DO LIST

What triggers To-Do list pop-ups?

- Send Notifications
- Saving a Progress Note, Assessment or Treatment Plan as DRAFT
- Assigning a Clinician as Primary Therapist or Primary Psychiatrist
- Saving a document as "Pending Approval" sends a To-Do list item to the supervising Clinician
- Selecting yourself or another Clinician for notification on an Avatar form; for example, the notification from the Transfer/Discharge form.

As discussed in the previous section (Common Problems), when a user receives a To-Do list notification, if s/he is working on an Avatar document or form, the document/form will minimize. Users must respond to the notification before returning to the document s/he was working on.

Clearing To-Do list items

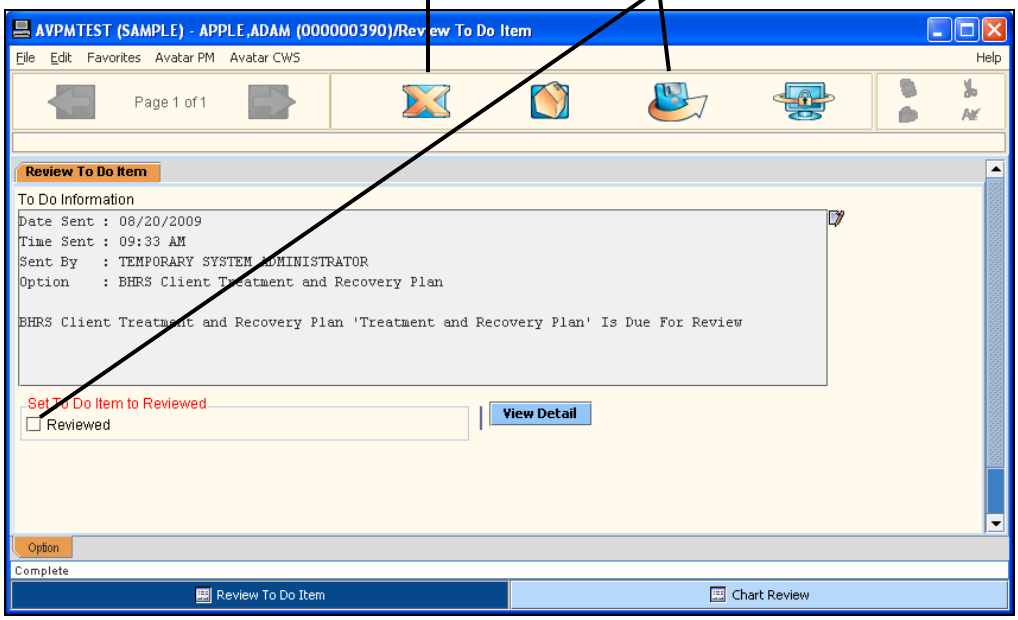
- **Manual method** – To-Do list entries can always be cleared manually. Many of them *have* to be cleared manually. These types of To Do list items include Notifications received using Send Notifications or Transfer/Discharge. Users also have to manually clear To Do list items from any Assessment (e.g. Diagnosis, CA/LOCUS, Admission, Annual, Special, etc.)

MARK A TO-DO ITEM AS REVIEWED AND COMPLETED (REMOVE FROM TO-DO LIST)

The Review To-Do Item report provides detail on the item that requires attention, as shown in the following figure. Choose from one of the two options below:

Click the Close icon to keep the item on your To-Do List to review later.

When you are ready to remove the item from your To Do list, click the Reviewed checkbox and click the Submit icon to mark the item as reviewed and remove it from your To-Do List.

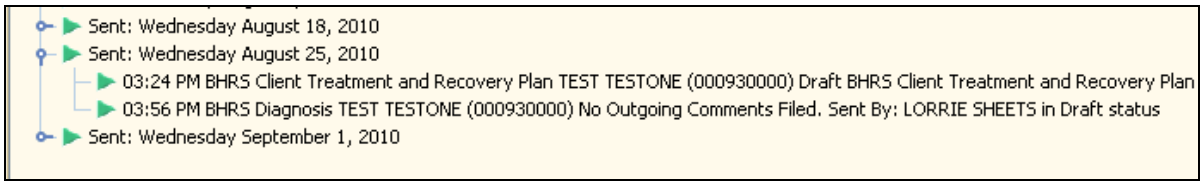


- **Automatic clearing –** If you open and Finalize a Treatment Plan, Progress Note, or Co-Sign a Progress Note *from the To-Do list entry*, the entry will be automatically removed from your To-Do list once you refresh it. Instructions on opening a document from a To-Do list entry are in the following section.

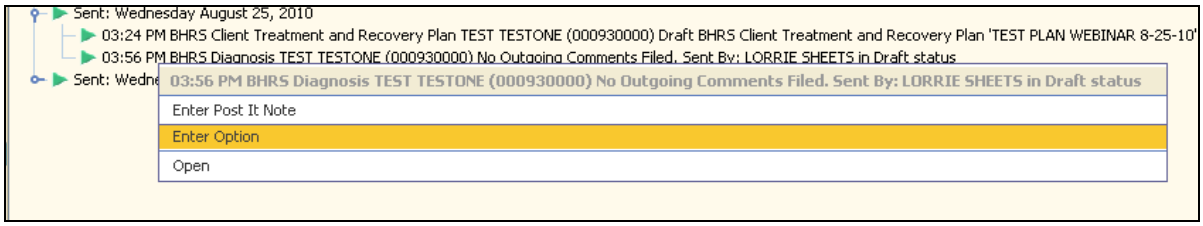
Use To-Do List item to open documents quickly

The illustration below shows two documents in DRAFT status – a Treatment Plan and a Diagnosis. If the To Do Notifications did not exist, the standard method to open the draft documents would be to select the Client, open the document type from the menus or My Favorites and then select the correct episode.

Use the To-Do list entry to avoid those steps.



From the To-Do list, right click on the entry listing the document left in Draft status. In the illustration below, the user selected the BHRS Diagnosis for TEST TESTONE.



The selections for the right click menu are:

- "Enter Post It Note" – Avatar has a "Post It Note" feature that we are not using. It allows users to write notes that are not part of the document – similar to attaching a Post It note on paper.
- "Enter Option" – Opens the document that created the To Do entry. In the example above, selecting "Enter Option" will open the BHRS Diagnosis form for client TEST TESTONE that was left in Draft by the user. With this method, users do not have to navigate through menus, select clients or episodes.
- "Open" – Opens the "Review To Do Item" form that allows users to manually clear the entry. It does NOT open the document itself.

HOW DO I FIND INFORMATION I PREVIOUSLY ENTERED IN AVATAR?

The two methods to find information in Avatar are **Reports** and **Chart Review**.

AVATAR Reports

Report Names in **bold** indicate reports most commonly used.

Report Name	Description	Menu Path
MMEF Lookup by MedsID Description	Medi-Cal Eligibility information.	Avatar PM → Reports
Payor UMDAP		Avatar PM → Reports
BHRS Episode Display	By Client. Standard Episode Display. Includes ALL Episodes in Avatar (from July 1,2004 forward) – closed and open.	Avatar PM → Reports
BHRS Service Display	By Client and Episode. Standard Services report for Episode selected.	Avatar PM → Reports
BHRS Face Sheet	By Client and Episode. Standard Face sheet. IDs Care Coordinator and Anniversary Date. Also includes links to additional reports including: • Episode History, • Demographic History, • Diagnosis History, • Primary Therapist History, • Treatment/Services History, • Progress Notes (Last 6 months), • Client Relationships, • Medication History	Avatar PM → Reports
BHRS MIS ledger	By Client and Date Range. Shows all services recorded for the client for the date range. Indicates billing status as well.	Avatar PM → Reports
Patient Laboratory Labels	Prints labels to attach to Lab Corp laboratory orders.	Avatar PM → Reports
Program Census Report	By Team and Date.	Avatar PM → Reports

Report Name	Description	Menu Path
	Lists all clients open to the Program on the date selected. Includes Client ID, Name, Episode number, admit date, sex, date of birth, primary therapist, primary psychiatrist, first client alias.	
BHRS Client Financial Report	Select by Client and Episode. Displays Client Insurance coverage recorded for that Episode.	Avatar PM → Reports
BHRS Discharges by Date		Avatar PM → Reports
BHRS "P" Clients		Avatar PM → Reports
BHRS Program Guarantor Census Report		Avatar PM → Reports
BHRS Admits by Date Report		Avatar PM → Reports
Treatment Plan Report		Avatar CWS → Treatment Planning → Print Treatment Plan
Face Sheet	Same as previous Face Sheet. Selected by Client and Episode. Standard Face sheet. IDs Care Coordinator and Anniversary Date. Also includes links to additional reports including: • Episode History, • Demographic History, • Diagnosis History, • Primary Therapist History, • Treatment/Services History, • Progress Notes (Last 6 months), • Client Relationships, • Medication History	Avatar CWS → Reports
Progress Notes Report	By Client and Date Range. Displays all progress notes recorded for the date range regardless of episode of service. Navigation available so that Users can navigate to notes for a specific episode if they wish.	Avatar CWS → Reports

Report Name	Description	Menu Path
Progress Notes Report by Clinician	By Clinician and Date Range. Displays notes written by selected Clinician during the Date Range. Navigation available so that Users can review Notes in DRAFT as well as finalized notes.	Avatar CWS → Reports
Diagnosis Report		Avatar CWS → Reports
Infoscriber medications Report	By Client. Lists Client Allergies recorded in Infoscriber as well as Current Prescriptions. Prescription information includes Order Date, Drug name, dose, Prescriber name, number of refills, prescription end date and pharmacy name. Has links to two additional reports: • Rx History for Last Year, and • Non-Infoscriber Prescriptions	Avatar CWS → Reports
ADULT Admission Assessment Report		Avatar CWS → Reports → Assessment Reports
ADULT Annual Assessment Report		Avatar CWS → Reports → Assessment Reports
ADULT Special Assessment Report		Avatar CWS → Reports → Assessment Reports
LOCUS Report		Avatar CWS → Reports → Assessment Reports
Mental Status Exam Report		Avatar CWS → Reports → Assessment Reports
CHILD/YOUTH Admission Assessment Report		Avatar CWS → Reports → Assessment Reports
CHILD/YOUTH Annual Assessment Report		Avatar CWS → Reports → Assessment Reports
CHILD/YOUTH Special Assessment Report		Avatar CWS → Reports → Assessment Reports
CALOCUS Report		Avatar CWS → Reports → Assessment Reports
Mental Status and Behavioral Observation		Avatar CWS → Reports → Assessment Reports
Substance Use Assessment Report		Avatar CWS → Reports → Assessment Reports
Physician's Initial Assessment		Avatar CWS → Reports →

Report Name	Description	Menu Path
Report		Assessment Reports
Chapter 26.5 IEP Assessment Report	Select by Client and Assessment Date. The Assessment Dates field lists all assessments available to report.	Avatar CWS → Reports → Assessment Reports
PRE to 3 Admission Assessment Report		Avatar CWS → Reports → Assessment Reports
O.D. / W.I.C.C. Status Report		Avatar CWS → Reports
Skills and Assessment Referrals Report		Avatar CWS → Reports
Activity Tracking Report		Avatar CWS → Reports
Call Intake History Report		Avatar CWS → Reports
Medication Administration Record Report	By Client and Date Range. Report of Progress Notes written with for Medication Administration. Displays with most recent note first.	Avatar CWS → Reports
PRE to 3 Dx Report		Avatar CWS → Reports
Transfer/Discharge Request Report	By Client and Request Date. Request Date lists only those dates that have an existing Transfer/Discharge request.	Avatar CWS → Reports
Day Treatment Progress Notes Report		Avatar CWS → Reports
Authorization Tracking Report		Avatar CWS → Reports
Caseload Report by Program	Select by Program. Programs are listed by NAME and not by Program Number. Information listed by Primary Therapist and Primary Psychiatrist. One line of information per Client. Information per client is: • Name • Client ID • Age • CA/LOCUS • Level of Care • Co-occurring Dx • 26.5 Indicator	Avatar CWS → Reports → Caseload Reports

Report Name	Description	Menu Path
	• Next IEP Date if 26.5 • Primary Dx • Last Date of Service	
Caseload Report by Clinician	Select by Clinician. Lists all Clients for whom Clinician is Primary Therapist or Primary Psychiatrist. Format of report and information included same as previous Caseload Report.	Avatar CWS → Reports → Caseload Reports
Day Treatment Authorization Due	Select by Day Treatment Program	Avatar CWS → Reports

The Face Sheet and Medications reports are two of the most important reports in Avatar. This section reviews the two reports.

Reports: Face Sheet

Menu Path: Avatar CWS → Reports → Face Sheet
Avatar PM → Reports → BHRS Face Sheet

Even though the report names are different in the Avatar PM and CWS menus, they refer to the same report. We have only one version of this report.

The Client Face Sheet covers 70% of the information most users need to find about a Client. You must select both a Client and an Episode to run the report. Some of the information on the report is specific to the Episode and some of it is the same across episodes.

The report has 8 sections:

Section	Information in this section
1 – Client Demographics	Episode number, Client name, date of birth, address, phone numbers and languages.
2 – Episode Details	Provider and Team, Mode of Service, Admission Date, Assigned Therapist, Psychiatrist, Conservator/Court Status, Employment Status, Preferred Language, Years of Education
3 – Diagnosis for this Episode	Primary Diagnosis, Secondary Diagnosis, Diagnosis date, Axis 5 / GAF
4 – Financial, CCP and Due Dates	Insurance/Guarantors for episode, Consent to Treatment, Admission Assessment Date, Care Coordinator name, Anniversary Date
5 – 26.5, Special Populations, Contact Information	26.5 Eligibility, School, Special Population, Parent/Guardian name and phone, Next of Kin, Emergency Contact
6 – Additional Contacts	Board and Care Operator, Case Manager, Conservator, Primary Care Provider
7 – Discharge	Discharge Date, Discharge reason
8 – Report Links	Links to additional reports – Episodes, Diagnosis, Treatment/Services, Relationships, Demographics, Psychiatrist, Progress Notes, Medications

Section 1

Section 2

Section 3

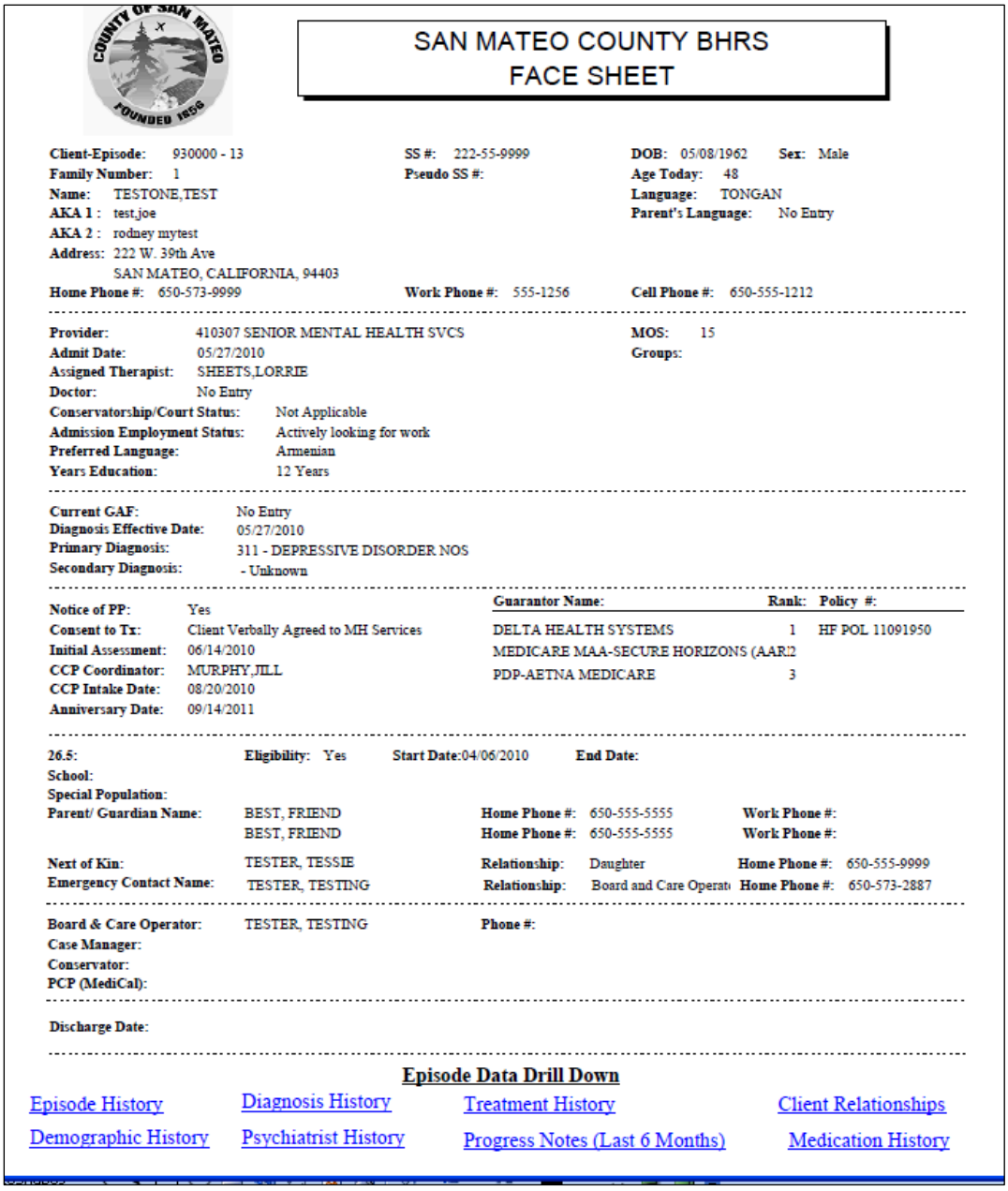
Section 4

Section 5

Section 6

Section 7

Section 8



SAN MATEO COUNTY BHRS
FACE SHEET

Client-Episode: 930000 - 13 **SS #:** 222-55-9999 **DOB:** 05/08/1962 **Sex:** Male
Family Number: 1 **Pseudo SS #:** **Age Today:** 48
Name: TESTONE,TEST **Language:** TONGAN
AKA 1 : test,joe **Parent's Language:** No Entry
AKA 2 : rodney mytest
Address: 222 W. 39th Ave
SAN MATEO, CALIFORNIA, 94403
Home Phone #: 650-573-9999 **Work Phone #:** 555-1256 **Cell Phone #:** 650-555-1212

Provider: 410307 SENIOR MENTAL HEALTH SVCS **MOS:** 15
Admit Date: 05/27/2010 **Groups:**
Assigned Therapist: SHEETS,LORRIE
Doctor: No Entry
Conservatorship/Court Status: Not Applicable
Admission Employment Status: Actively looking for work
Preferred Language: Armenian
Years Education: 12 Years

Current GAF: No Entry
Diagnosis Effective Date: 05/27/2010
Primary Diagnosis: 311 - DEPRESSIVE DISORDER NOS
Secondary Diagnosis: - Unknown

Notice of PP: Yes
Consent to Tx: Client Verbally Agreed to MH Services
Initial Assessment: 06/14/2010
CCP Coordinator: MURPHY,JILL
CCP Intake Date: 08/20/2010
Anniversary Date: 09/14/2011

Guarantor Name:	Rank:	Policy #:
DELTA HEALTH SYSTEMS	1	HF POL 11091950
MEDICARE MAA-SECURE HORIZONS (AAR	2	
PDP-AETNA MEDICARE	3	

26.5: **Eligibility:** Yes **Start Date:**04/06/2010 **End Date:**
School:
Special Population:
Parent/ Guardian Name: BEST, FRIEND **Home Phone #:** 650-555-5555 **Work Phone #:**
BEST, FRIEND **Home Phone #:** 650-555-5555 **Work Phone #:**
Next of Kin: TESTER, TESSIE **Relationship:** Daughter **Home Phone #:** 650-555-9999
Emergency Contact Name: TESTER, TESTING **Relationship:** Board and Care Operat **Home Phone #:** 650-573-2887

Board & Care Operator: TESTER, TESTING **Phone #:**
Case Manager:
Conservator:
PCP (MediCal):

Discharge Date:

Episode Data Drill Down

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

Three important pieces of information in the Face Sheet:

1. **Care Coordinator** – Face Sheet in Section 4 by line labeled "CCP Coordinator"
2. **Treatment Plan and Annual Assessment Due** - Face Sheet in Section 4 by line labeled "Anniversary Date"
3. **Client Financial information** – Get a quick overview of a Client's insurance in Section 4, Guarantor Name

In Section 8 at the bottom of the report are links to 8 additional reports. Click on a link (e.g., **Episode History**) to open the report. All of the reports listed are also available through the Reports menu to open individually.

Reports: Medication Record

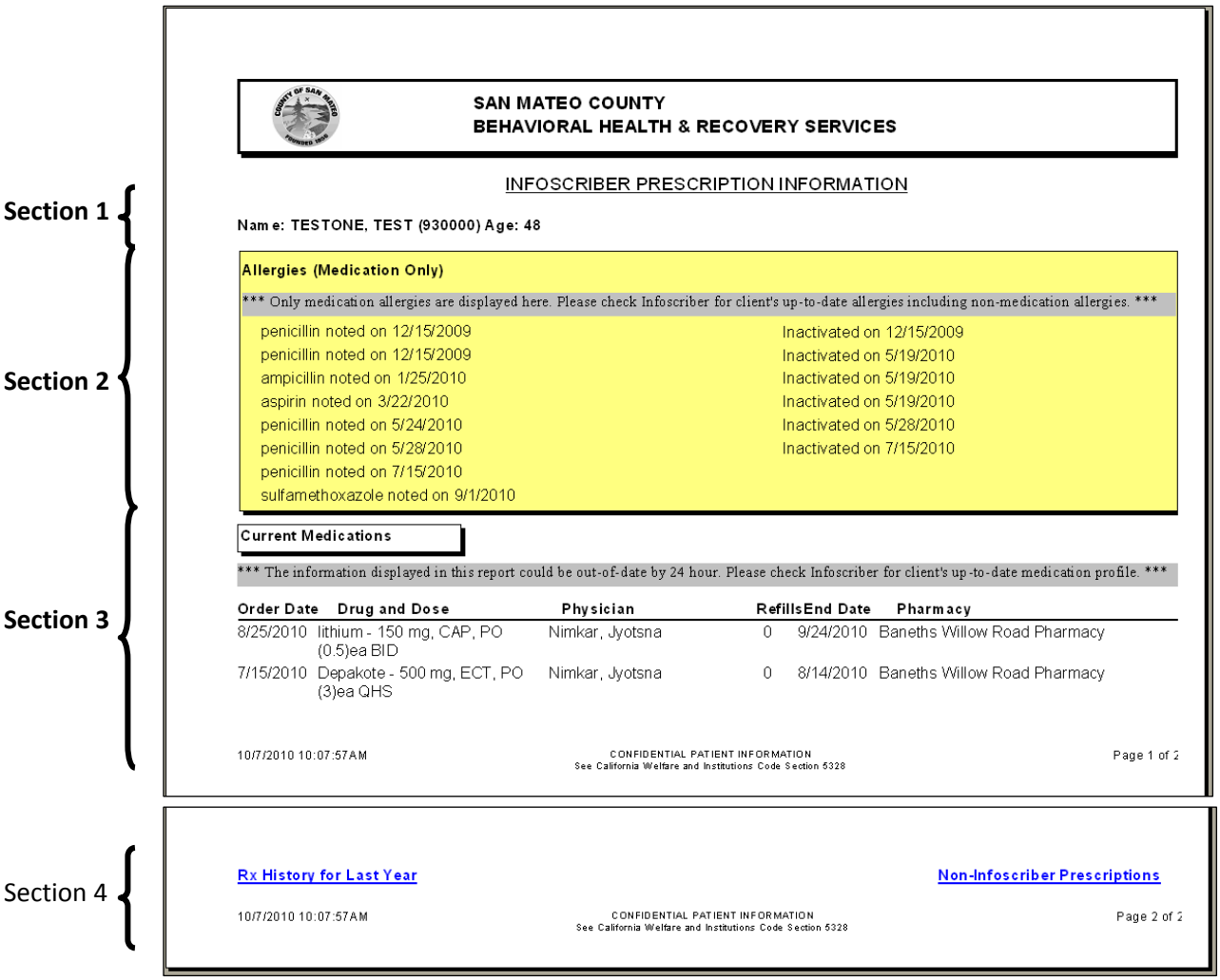
Avatar has two versions of the Medication Record: 1) **Infoscriber Medications Report** available from the Avatar CWS Reports menu, and 2) **Medication History** available as a link from the Face Sheet. The Infoscriber Medications Report is the complete medication record while the Medication History is an abbreviated list.

It is important to note that the most current information resides in Infoscriber. The prescription information in Avatar is updated nightly therefore ***both reports are current through the end of the previous day***. Details of the reports follow.

Infoscriber Medications Report

This report has four sections

Section	Information in this section
1 – Client Identifying information	Client name, ID and age
2 – Medication Allergies	This section only displays Medication Allergies. Other allergies recorded in Infoscriber are available for viewing within Infoscriber.
3 – Current Medications	Lists current prescriptions including Order Date, Drug and Dose, Prescribing Physician, Number of Refills, Prescription End Date and Pharmacy.
4 – Links to additional reports	Two reports are linked to this report – • Prescription history for the last year, - both continuing and discontinued medications, and • Non-Infoscriber prescriptions – any medications about which Client has informed his/her doctor and are recorded in Infoscriber.



Section 1

Section 2

Section 3

Section 4

SAN MATEO COUNTY
BEHAVIORAL HEALTH & RECOVERY SERVICES

INFOSCRIBER PRESCRIPTION INFORMATION

Name: TESTONE, TEST (930000) Age: 48

Allergies (Medication Only)

*** Only medication allergies are displayed here. Please check Infoscriber for client's up-to-date allergies including non-medication allergies. ***

penicillin noted on 12/15/2009	Inactivated on 12/15/2009
penicillin noted on 12/15/2009	Inactivated on 5/19/2010
ampicillin noted on 1/25/2010	Inactivated on 5/19/2010
aspirin noted on 3/22/2010	Inactivated on 5/19/2010
penicillin noted on 5/24/2010	Inactivated on 5/28/2010
penicillin noted on 5/28/2010	Inactivated on 7/15/2010
penicillin noted on 7/15/2010	
sulfamethoxazole noted on 9/1/2010	

Current Medications

*** The information displayed in this report could be out-of-date by 24 hour. Please check Infoscriber for client's up-to-date medication profile. ***

Order Date	Drug and Dose	Physician	Refills	End Date	Pharmacy
8/25/2010	lithium - 150 mg, CAP, PO (0.5)ea BID	Nimkar, Jyotsna	0	9/24/2010	Baneths Willow Road Pharmacy
7/15/2010	Depakote - 500 mg, ECT, PO (3)ea QHS	Nimkar, Jyotsna	0	8/14/2010	Baneths Willow Road Pharmacy

10/7/2010 10:07:57AM CONFIDENTIAL PATIENT INFORMATION See California Welfare and Institutions Code Section 5328 Page 1 of 2

Rx History for Last Year Non-Infoscriber Prescriptions

10/7/2010 10:07:57AM CONFIDENTIAL PATIENT INFORMATION See California Welfare and Institutions Code Section 5328 Page 2 of 2

Linked Report: Rx History for Last Year

Order Date	Drug and Dose	Physician	Refill	Action	End Date
7/15/2010	Lithium Carbonate - 300 mg, TAB, PO (2)ea PRN	Nimkar, Jyotsna	2	Discontinue	8/25/2010
	Instructions: Pl deliver the med to redwood house shelter				
7/14/2010	acetaminophen - 650 mg, TAB, PO (1)ea PRN-QID	Nimkar, Jyotsna	0	Discontinue	7/15/2010
7/2/2010	Risperdal - 2 mg, TAB, PO (1)ea QHS	Wallace, Mary Em	0	Discontinue	7/14/2010
6/27/2010	hydrOXYzine - hydrochloride 10 mg/5 mL, SYR, PO (1)mg PRN-Q4H	Nimkar, Jyotsna	0	Discontinue	7/2/2010
6/23/2010	hydrOXYzine - hydrochloride 10 mg/5 mL, SYR, PO (1)mg PRN-BID	Nimkar, Jyotsna	0	Change	6/23/2010
6/23/2010	hydrOXYzine - hydrochloride 10 mg/5 mL, SYR, PO (1)mg PRN-BID	Nimkar, Jyotsna	0	Discontinue	7/2/2010

Linked Report: Non-Infoscriber Prescriptions

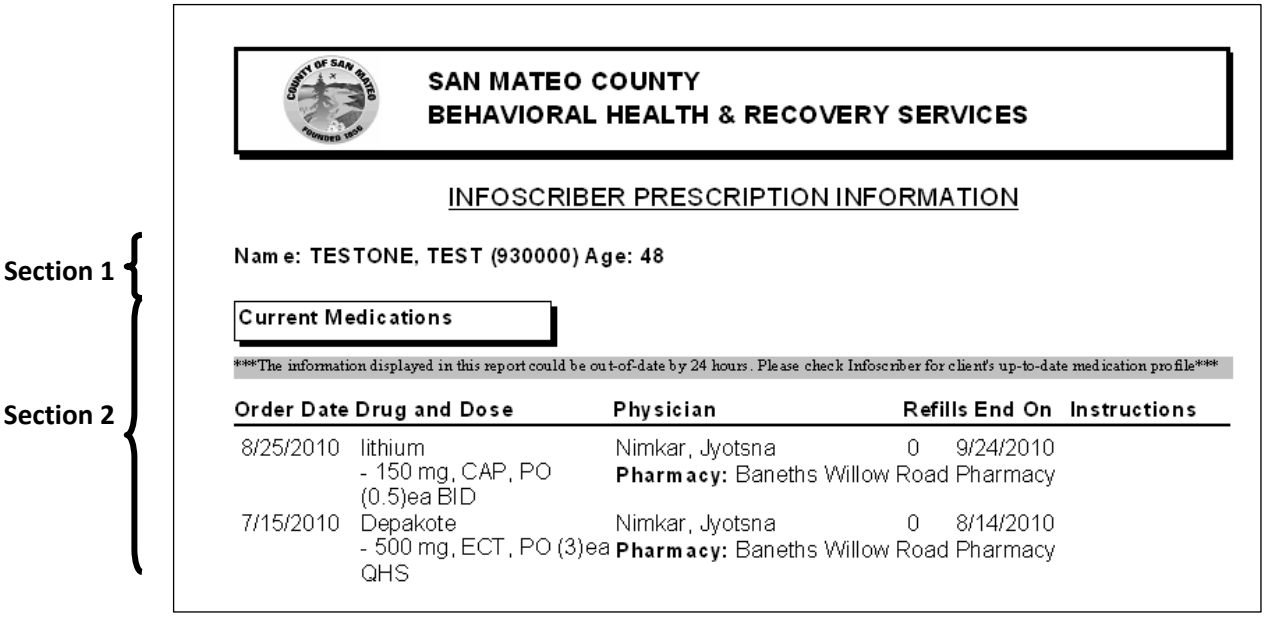
Non Infoscriber Prescriptions

Order Date	Drug / Description	End Date
	st john's wart	12/22/2009
	St. John's wort	4/21/2010
	penicillin	4/21/2010
	Herb	4/21/2010
	St John's Wort	4/23/2010
	metformin	5/19/2010
	aspirin-carisoprodol	4/23/2010
	Herbal Supplemental	5/19/2010
	metformin	5/28/2010
	metformin	7/15/2010
	metformin 2 tab PO	7/14/2010
	metformin	8/25/2010
	glucosamine	8/25/2010
	atenolol rx'd by Dr. Smith (PCP)	

Medication History Report

This report is available only through the report link in the Face Sheet. This report has two sections:

Section	Information in this section
1 – Client Identifying information	Client name, ID and age
2 – Current Medications	Lists current prescriptions including Order Date, Drug and Dose, Prescribing Physician, Number of Refills, Prescription End Date and Pharmacy.



Section 1

Section 2

SAN MATEO COUNTY
BEHAVIORAL HEALTH & RECOVERY SERVICES

INFOSCRIBER PRESCRIPTION INFORMATION

Name: TESTONE, TEST (930000) Age: 48

Current Medications

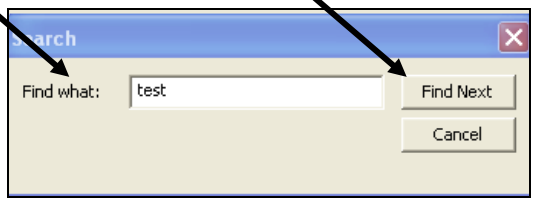
The information displayed in this report could be out-of-date by 24 hours. Please check Infoscriber for client's up-to-date medication profile

Order Date	Drug and Dose	Physician	Refills	End On	Instructions
8/25/2010	lithium - 150 mg, CAP, PO (0.5)ea BID	Nimkar, Jyotsna **Pharmacy:** Baneths Willow Road Pharmacy	0	9/24/2010	
7/15/2010	Depakote - 500 mg, ECT, PO (3)ea QHS	Nimkar, Jyotsna **Pharmacy:** Baneths Willow Road Pharmacy	0	8/14/2010	

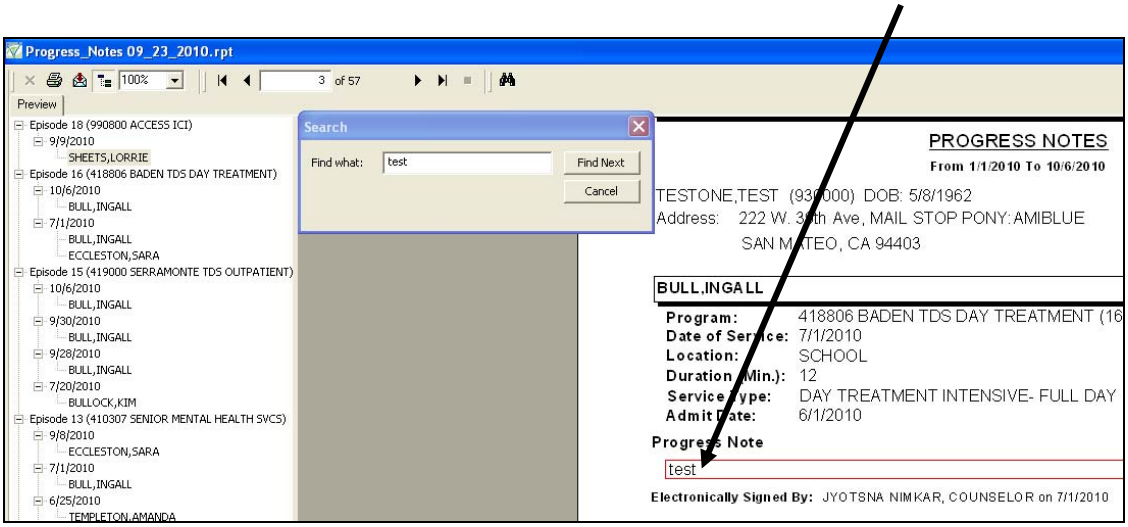
Search within a report

Avatar provides the ability to search for words and phrases within reports. The report menu bar at the top of every report has a binocular icon ( ).

When you click on the binocular icon, a Search box displays. Type the word or phrase you're searching for in the space labeled "Find what" and click "Find Next".



If the word or phase is found in the report, Avatar will highlight it by drawing a box around the text.

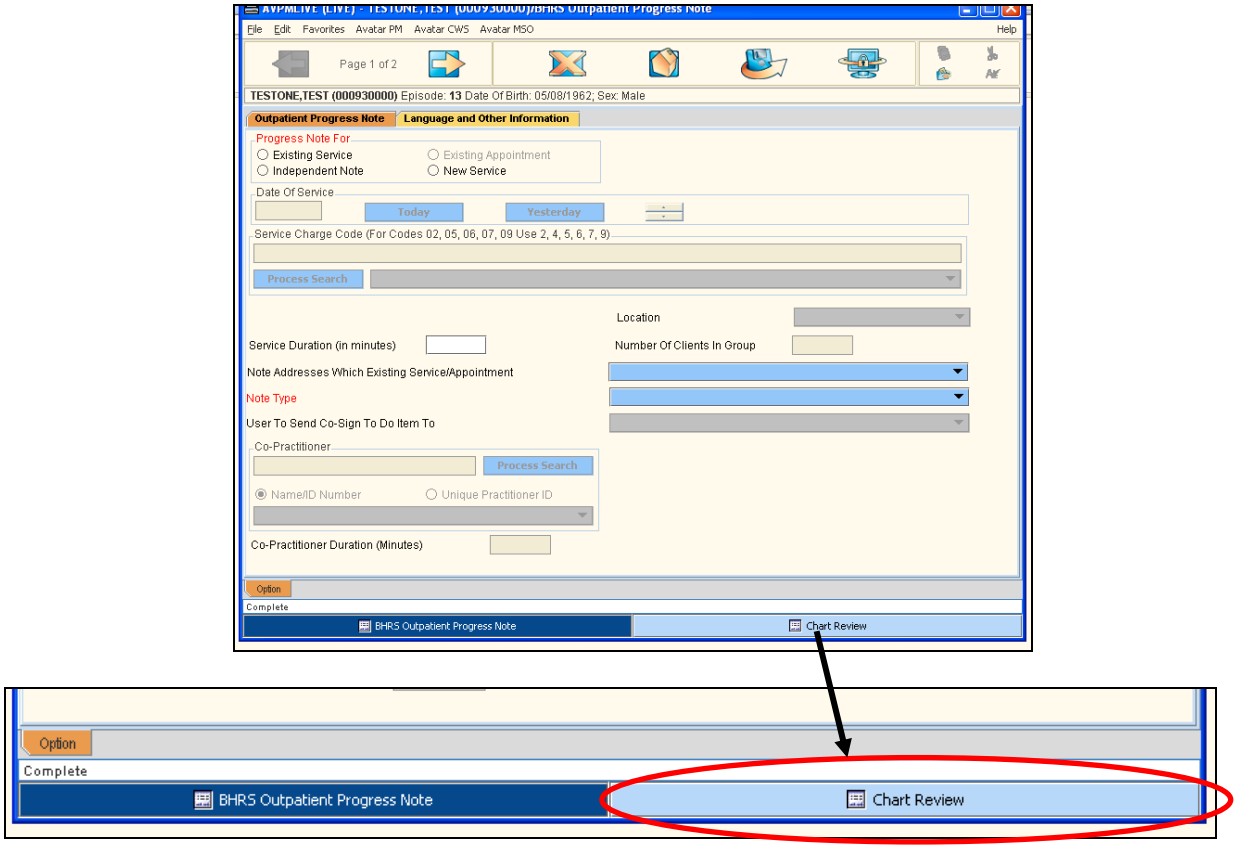


How Do I Find Information I Previously Entered in Avatar? (continued)

Chart Review

Chart Review allows you to review Client information saved in Avatar by all treatment team members for all episodes – provided you have security rights to review the document(s).

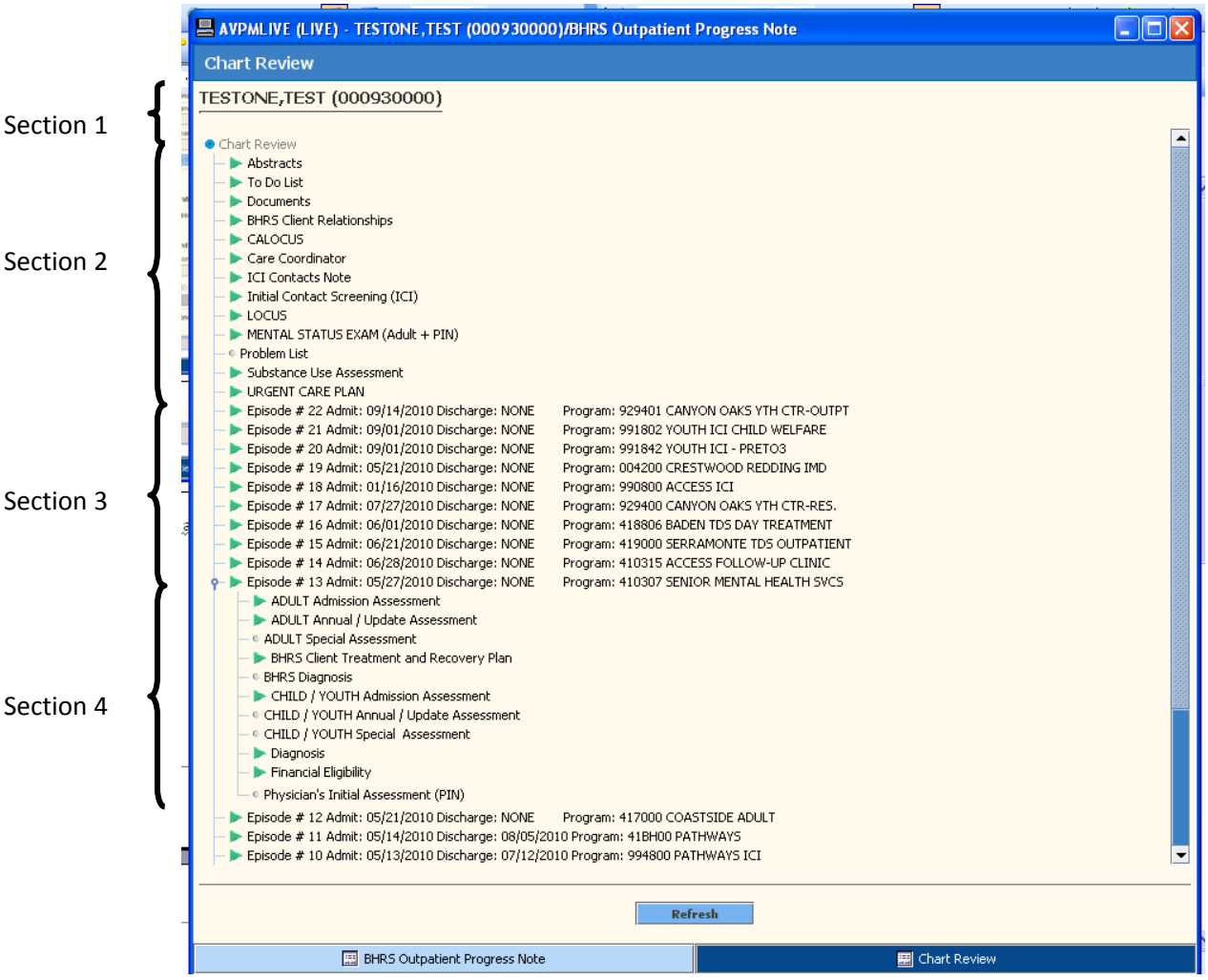
Start Chart Review by opening an Avatar form for a Client. Examples of Client forms are an episode opening, a financial, an assessment, a treatment plan, and a progress note. Once the form is open, click on the Chart Review bar at the bottom of the window as in the illustration below:



Click on the Chart Review bar to display the Client's chart.

The chart has 4 primary sections:

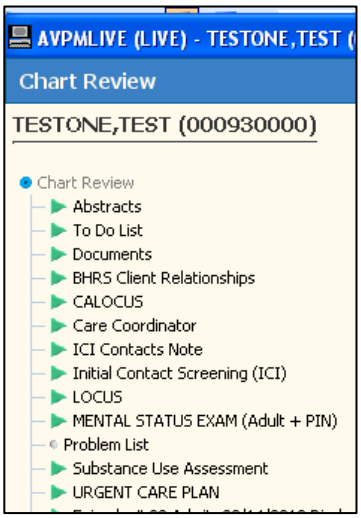
Section	Information in this section
1 – Client Identifying information	Client name, ID
2 – Non-Episodic	Contains information across episodes. It includes Progress Notes, To Do List, Scanned documents, Client Relationships, CA/LOCUS, Care Coordinator, ICI Contact Notes, Initial Contact Screening, Adult Mental Status Exam, Substance Use Assessments, Urgent Care Plan.
3 – Episodes	All of the episodes recorded in Avatar are listed in reverse order by episode number. Episode number, admission date, discharge date (if closed), and team.
4 – Episodic information	Within the episode, Avatar displays Assessments, Treatment Plan(s), Diagnoses, and Financial Eligibility.



Section 2 – Non-episodic information

This section includes information that is not tied to a single episode as well as information from multiple episodes. Any line with a green arrow next to it indicates an entry for that type of document – also called "the green arrow rule".

To see what's included in any of the lines, double click on the label.



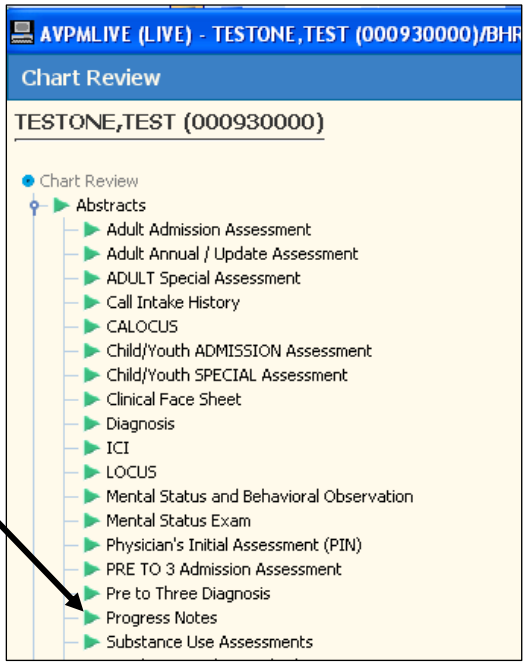
Abstracts – In Chart Review, the word "Abstracts" is a synonym for "Reports".

When you open this section by double-clicking on the word "Abstracts", a long list displays and each line has a green arrow next to it. The detail section of Abstracts is an exception to the green arrow rule. Within Abstracts, **every** entry has a green arrow next to it whether or not information is available for that report.

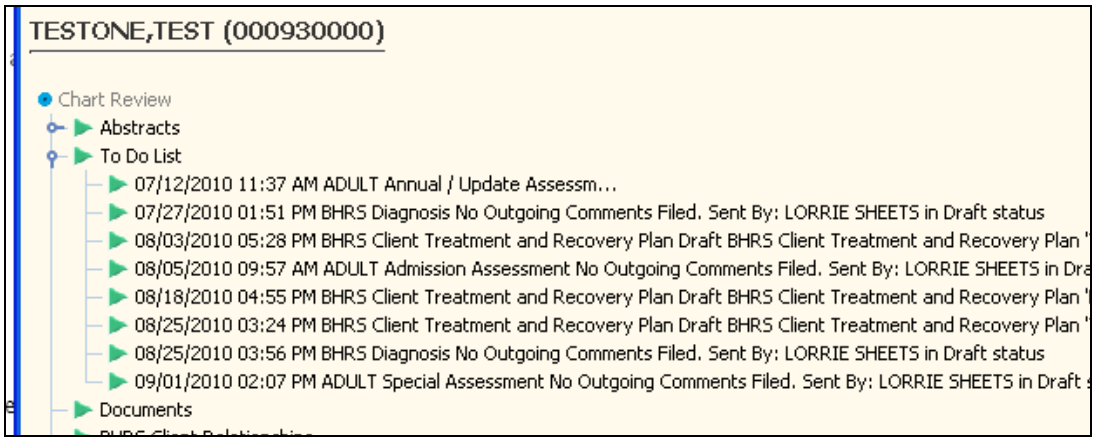
*The only report to use within Abstracts is **Progress Notes**.*

Close "Abstracts" in one of two ways:

- Double-click on the word "Abstracts", or
- Click on the key icon next to Abstracts green arrow.



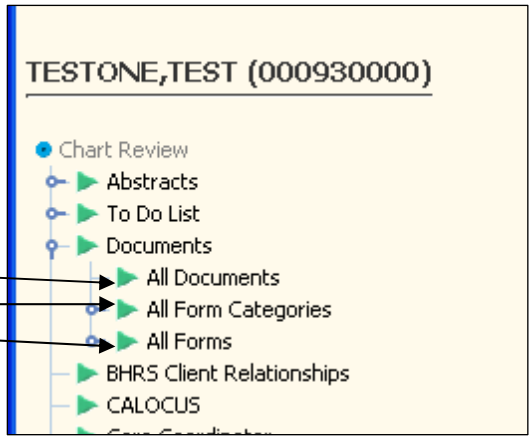
To-Do List – Will appear only if you have To Do entries for the Client's chart. You can take action on the entries just as you would from the standard To Do List.



Documents – View documents *scanned* into the Client's chart. This line will only display if the Client has scanned documents.

Users have the choice of viewing a list of

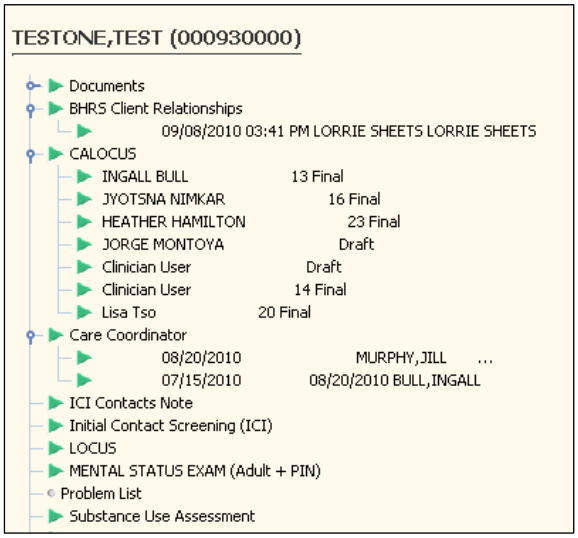
- ALL scanned documents
- Documents by Category
- Documents by Form names



Double click on your selection and choose a document from the list.

BHRS Client Relationships
CALOCUS
Care Coordinator
ICI Contacts Note
Initial Contact Screening (ICI)
LOCUS
Mental Status Exam (Adult + PIN)
Substance Use Assessment

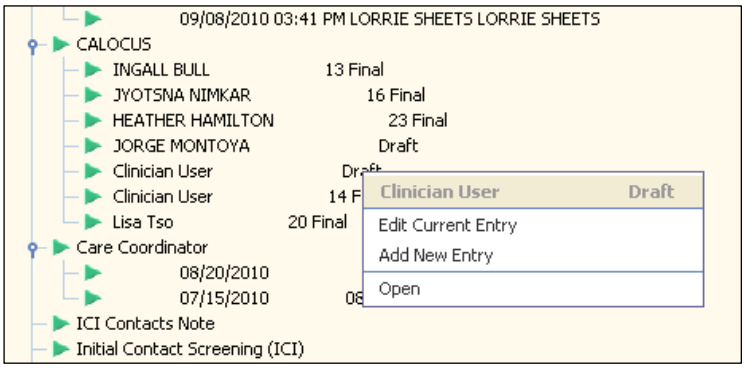
A green arrow next to one of the entries listed above means one or more documents exist for that form. In the screen shot on the right, you can see that one document exists for BHRS Client Relationships and seven documents exist for CALOCUS.



To view the document detail, double click on the entry to open a report.

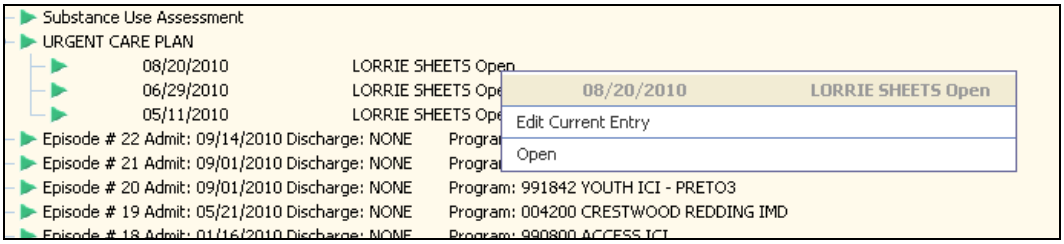
If the document is in Draft as you see for several of the CALOCUS documents in the illustration, you can open the document from Chart Review.

To edit the Draft document, right click on the entry and select “Edit Current Entry” from the menu displayed.



If you select “Open” from the menu, Avatar will display the information in a report.

Urgent Care Plan



Viewing Urgent Care Plans is similar to viewing any of the document types listed above. The difference is that Urgent Care Plans do not have a Draft/Final status and are therefore available for Edit as long as you have the security rights to do so.

When you double click on the Urgent Care Plan entry in Chart Review, Avatar displays the Start Date, Therapist and Status (“Open” or “Closed”) of all the Urgent Care Plans for that client. If you want to Edit one of the Urgent Care Plans, right click on the line you want to edit and select “Edit Current Entry” from the menu. If you want to see details of the plan, select “Open” to view a report of the plan.

Chart Review Section 3 – Episodes

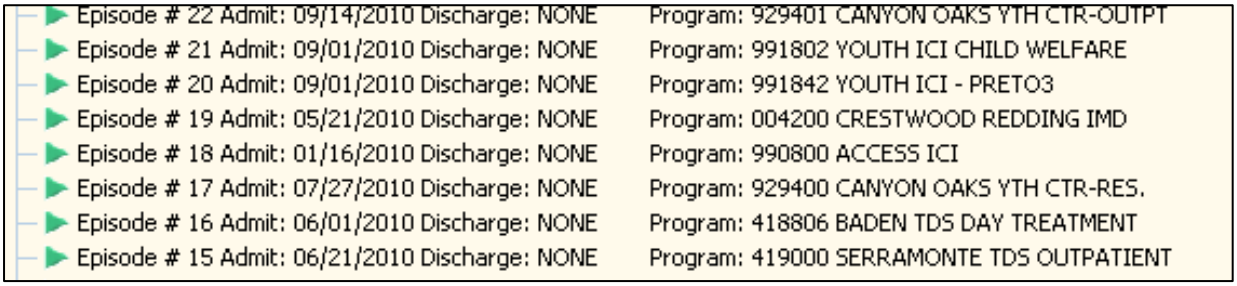
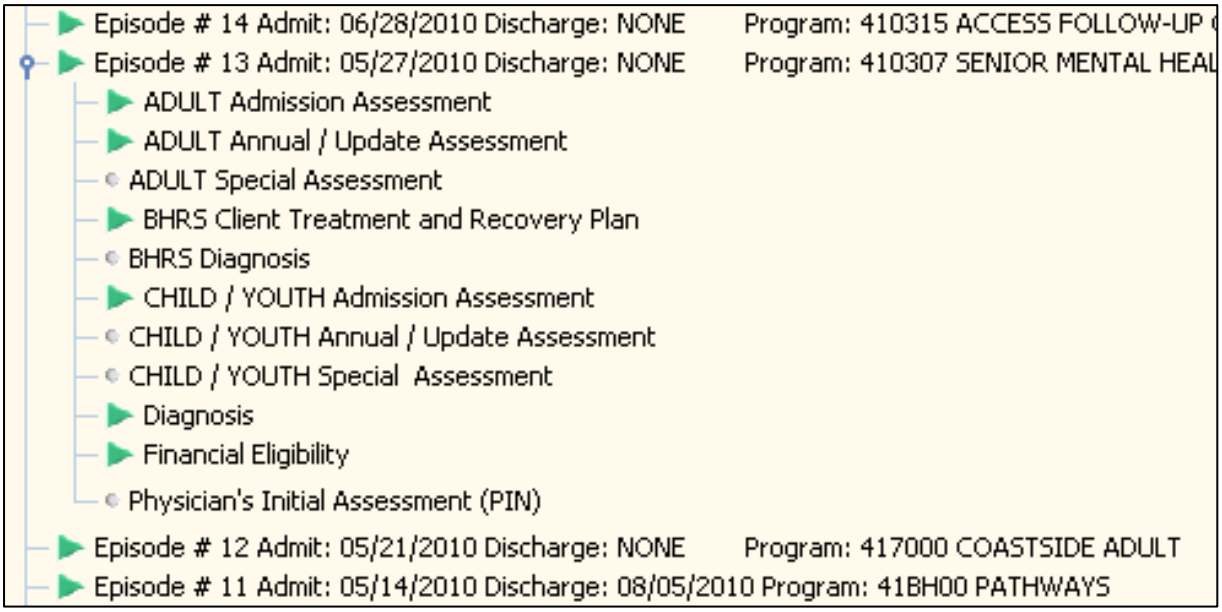


Chart Review displays all episodes for a Client. The information for each episode includes Episode number, Admission Date, Discharge Date (if there is one), and Program. All Episodes have a green arrow next to them. Episodes are an exception to the green arrow rule – the green arrow does not indicate that one or more episodic documents are filed for that Client and episode.

Chart Review Section 4 – Episodic Information

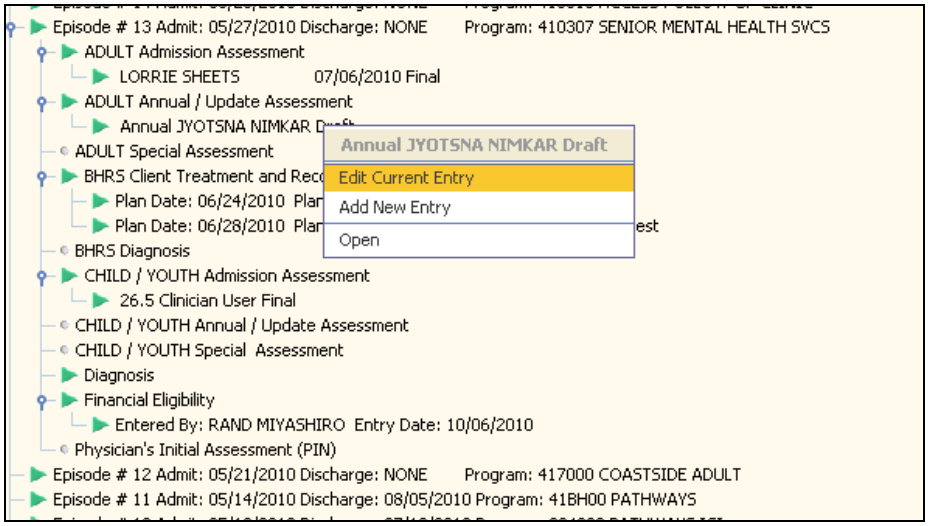


The list of document types is the same for each episode. If the Client is an Adult, within the Episode detail you will still see the Child/Youth documents listed and vice versa.

The document types include two Diagnoses – BHRS Diagnosis and Diagnosis. The BHRS Diagnosis is the form filled out by Clinicians in CWS. The Diagnosis entry is the form from Avatar Cal-PM that Administrative Staff traditionally filled out. It was used to enter the diagnosis for Clients set up from VAX. It is used by Contracted Provider teams as well.

Double click on the green arrow or on the Episode information line to view documents saved within the episode. The green arrow rule applies for document types displayed within episodes. If there is a green arrow next to a document type, one or more of that document type is available to view. Therefore, the green arrows in the illustration above mean that Episode 13 has at least one Adult Admission Assessment, Adult Annual Assessment, Treatment plan, etc. for the Client.

To view what documents exist for each document type, double click on the document type (e.g. Adult Special Assessment, BHRS Diagnosis, Child / Youth Admission Assessment). To review specific documents, follow the same instructions for opening documents in Section 2 of Chart Review.

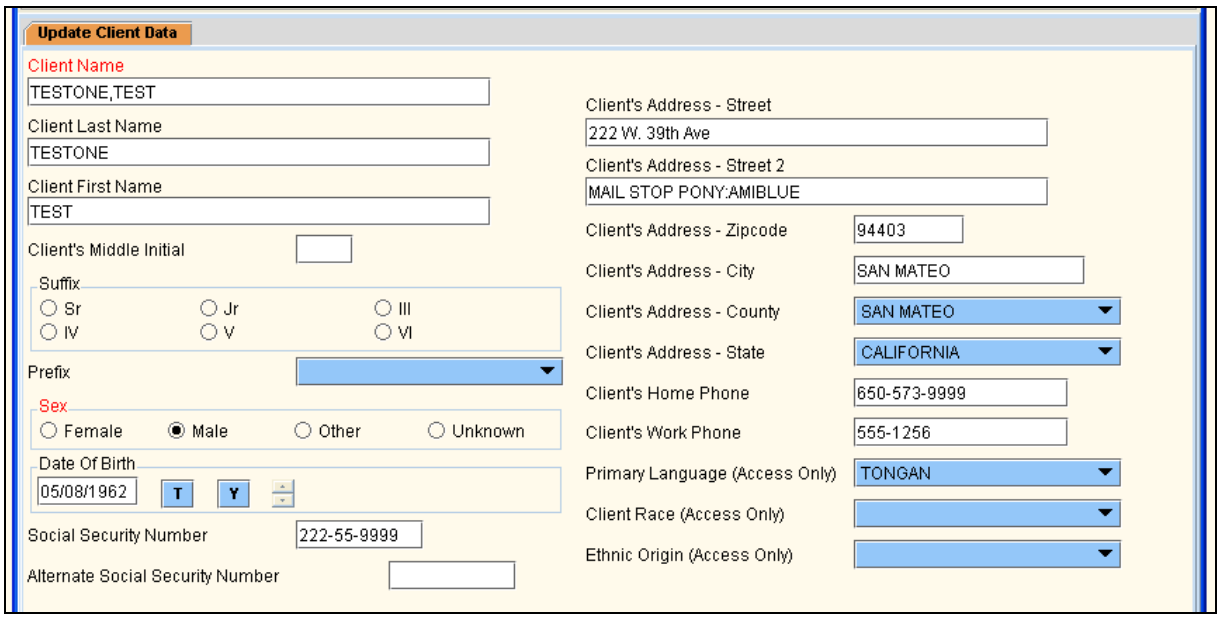


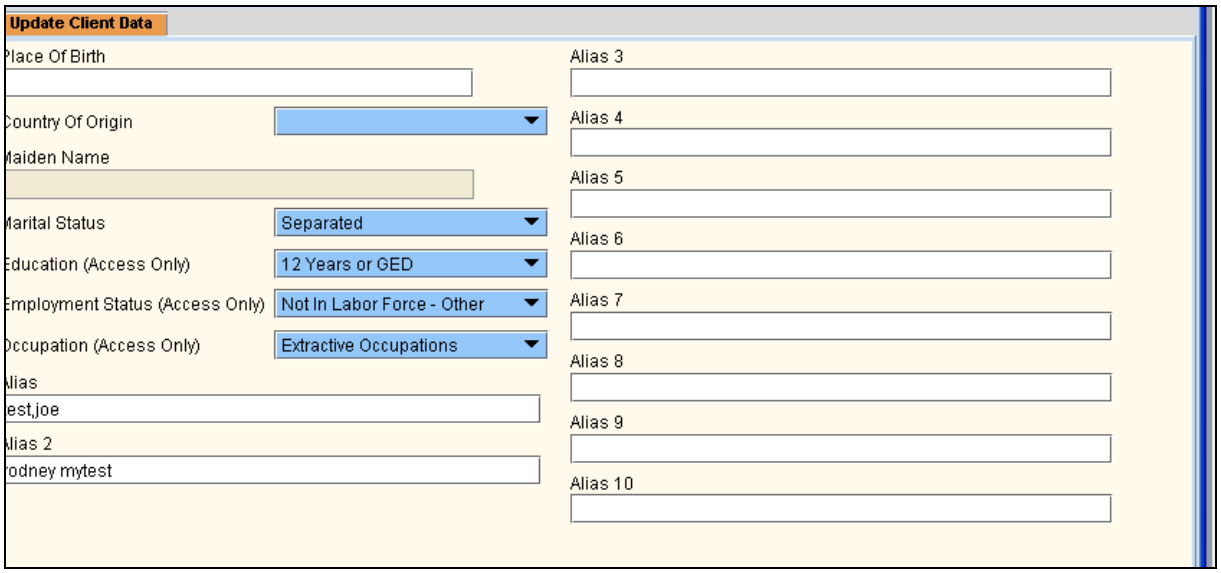
CLIENT INFORMATION AND MANAGEMENT

Demographic Information

Generally, Clients' Demographic Information is recorded by Admins, however, Clinicians have a form named "Update Client Data" available. If you find out about any demographic changes, especially address and phone number, you can use this form to change the information for the Client. The alternative is to ask one of the Admins to make the change.

Menu Path: Avatar CWS → Other Chart Entry → Update Client Data





Client Relationships

Menu Path: Avatar PM → Client Management → Client Information

Client Relationships is the repository of all non-treatment team people involved in the Client's life. Record Emergency Contact, Parent/Guardian, Next of Kin, Spouse/Partner, Teacher, Parole Officer, Conservator, Sibling, Family Members, Primary Care Physician – anyone you feel is important to have information about within the Client record.

The Client Face Sheet and any report that shows information about important contacts for a Client pulls from this form. If it isn't recorded here, it can't be reported.

For each client you can record:

Name
Type of relationship
Address
Phone numbers – home, work and cell
eMail address
Best time to contact
Release available? – No, Yes – Full, Yes – Limited
Legal Guardian
Emergency Contact
Next of Kin

Information is stored in a multiple entry table. Users need to understand how the tables work to avoid overwriting existing information.

MULTIPLE ENTRY TABLE ISSUES

When you want to make an entry in the table, you add a new row to the table and then complete the related data fields below the table. This populates the rows in the table.

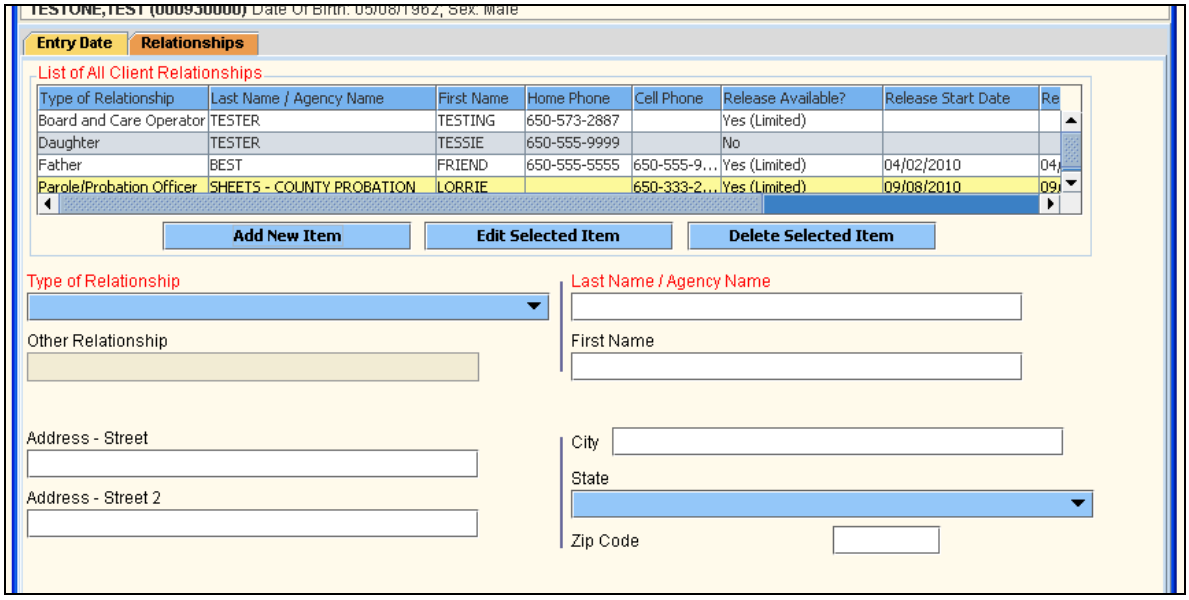
ADD, EDIT, AND DELETE ENTRIES IN THE TABLE

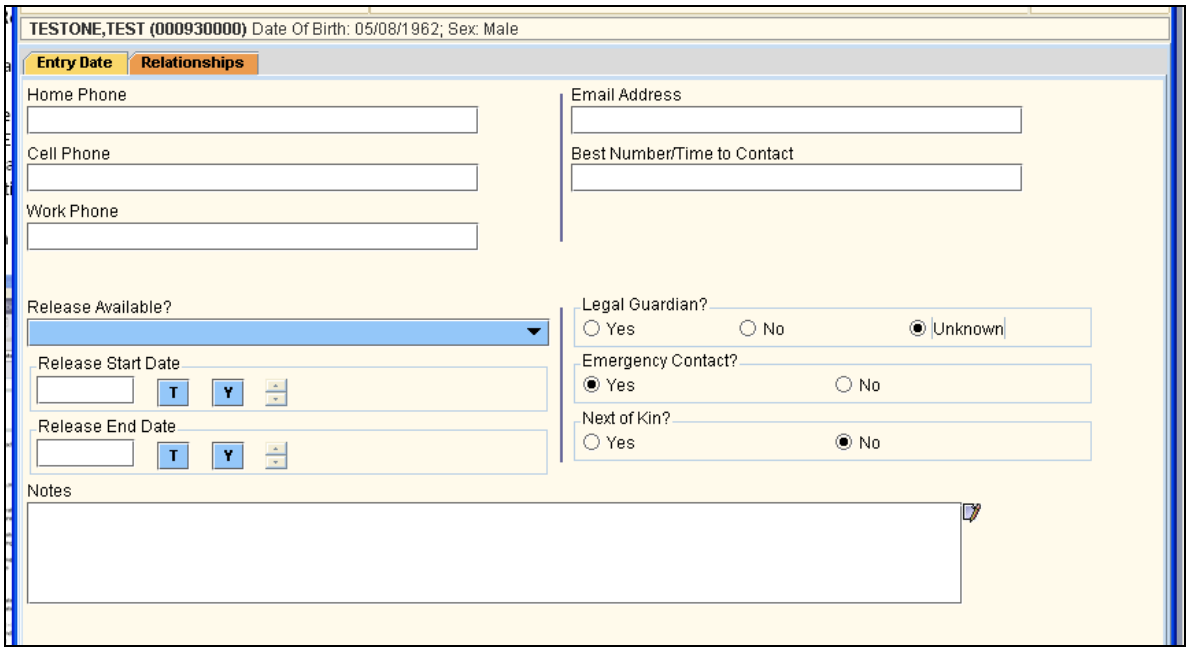
- **Add a Row:** Click the Add New Item button.
- **Edit a Row:** When you select a row you wish to edit and then click the Edit Selected Item button, the related fields below the table become populated and you can make changes directly in the fields.
- **Delete a Row from the Table:** Click a row to select it and then click the Delete Selected Item button to remove a row from the table.

COMMON MULTIPLE ENTRY TABLE MISTAKES

A common mistake when using a multiple entry table is forgetting to click the Add New Item button before starting to fill out fields for additional entries. If you enter new data without adding a new row, the new data you enter overwrites existing information in the active (highlighted) row in the table.

Another mistake is to leave blank rows in the table. (A possible reason for this might be double-clicking the Add New Item button.) Blank rows in a multiple entry table have to be deleted before you can save a form.





26.5 Information and Tracking

Menu path: Avatar PM → New Options → Chapter 26.5 Eligibility Tracking

The 26.5 Eligibility form is intended to be used by Admins based on information provided by Clinicians. The form tracks a Client's status from referral to assessment to placement to IEP closure.

The form is not fully implemented yet. The Central Assessment Team and the Avatar Team are working to have it in place by the end of November, 2010.

Transfer / Discharge Request

This form is part of a Bundle which means when you open the Transfer / Discharge Request, the BHRS Diagnosis form opens also. Just as Clinicians had to provide a diagnosis on the paper forms, they still have to provide a diagnosis in the electronic medical record.

The most common complaint about the Transfer / Discharge Request is that a user will continue to get To-Do List notifications after s/he has authorized and sent the document along. The check boxes on the Notification list do NOT clear when you Save the form. Users have to clear the User Notification selections to avoid sending redundant notifications.

UNDERSTANDING CLIENT ALERTS

This option allows you to notify anyone in the BHRS system about some issue with a client. The alert appears when you select that client or open a window for that client. You can set up an alert to display for a certain period of time, such as a week, month, or up to eighteen months.

Administrators can use alerts as reminders that administrative items are due for a client, such as a financial interview. Clinicians can use an alert as a complement to an Urgent Care Plan, notifying staff that there is an urgent situation regarding a client that they need to be aware of.

MENU PATH

Avatar PM→RADplus Utilities→Client Alert Management Urgent→Client Alerts

ALERTS ENABLED BY ADMINISTRATORS

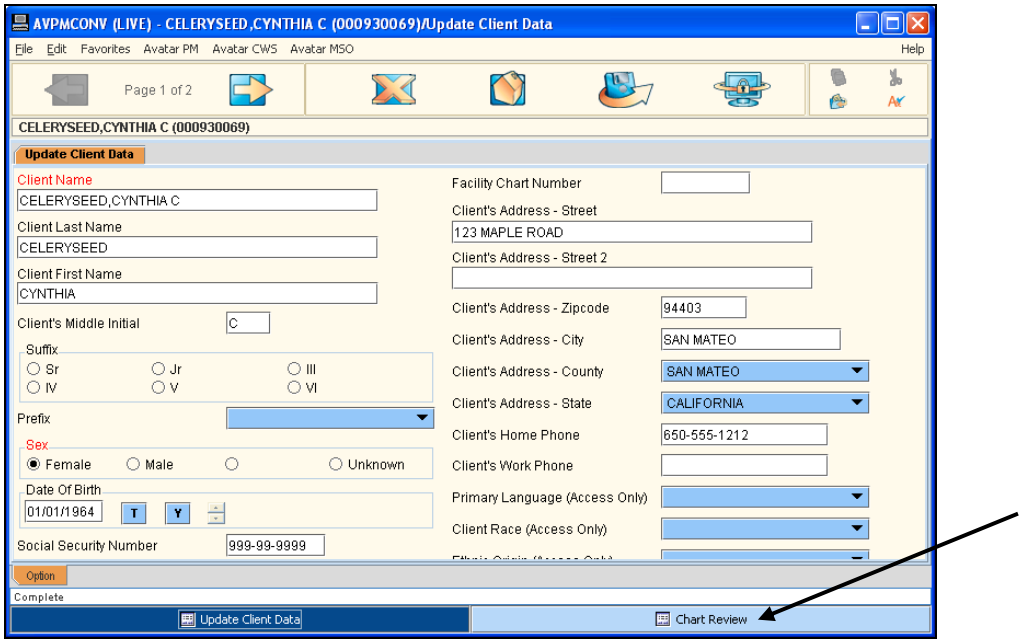
Type of Alert	Message
Assignment of Benefits	Please print and get client to sign.
Error (Custom)	BHRS does not use this option.
Financial Interview Due	Ask client to make appointment for financial interview.
Insurance Application	Have client complete insurance application.
UMDAP/Financial Due	Ask client to complete or make an appointment for an UMDAP.
Update Client Demographics	Update client demographics using Update Client Data.
Warning (Custom)	BHRS does not use this option.

ALERTS ENABLED BY CLINICIANS

Type of Alert	Message	Action
Care Message	Please review Urgent Care Plan in Chart Review for Information	Only clinicians need to respond to this alert.
Care Alert	HIGH PRIORITY-Please review the Urgent Care Plan in Chart Review	Administrators and clinicians should review the client's Urgent Care Plan immediately. (See page 34, "How to View an Urgent Care Plan.")

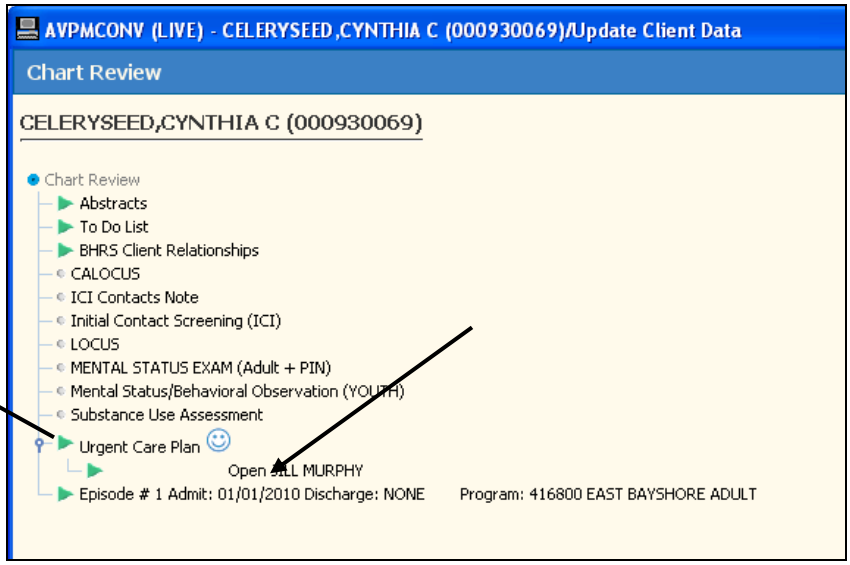
How to View an Urgent Care Plan

You view an Urgent Care Plan through Avatar's Chart Review feature. Chart Review is available through any Avatar window. All Avatar windows have a Chart Review button in the bottom-right corner of the window as shown in the following figure.

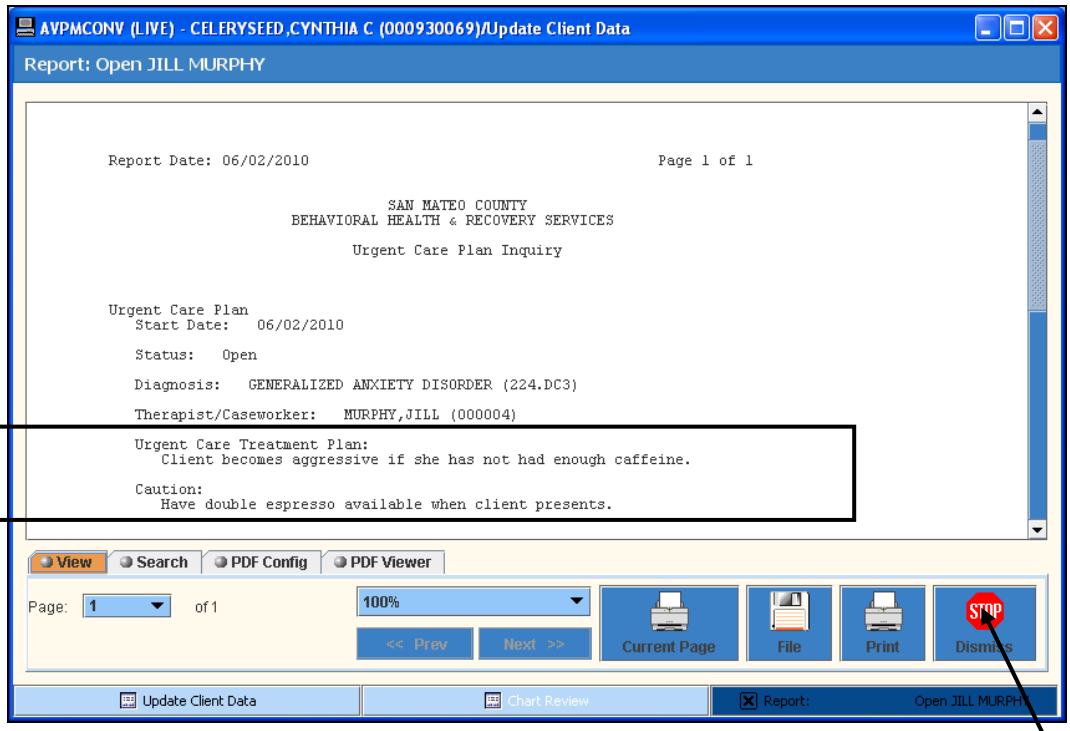


When you click the Chart Review bar, the following window appears. To see a list of names of clinicians who have created urgent care plans for the client, double-click on the entry labeled "Urgent Care Plan". The Urgent Care Plan Status (Open/Closed) and the name of the Clinician who created the alert displays. (The most recent alert is at the top of the name list.)

Double-click Urgent Care Plan to display the list of clinicians who have created Urgent Care Plans for this client.

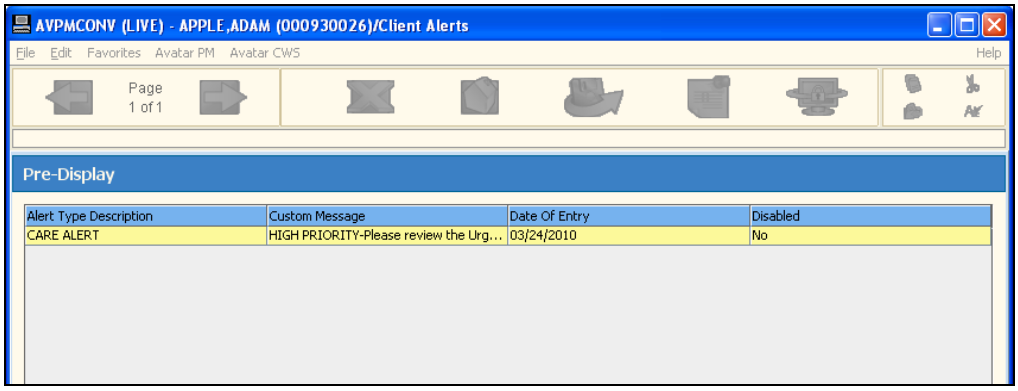


Following is an example of an urgent care screen.



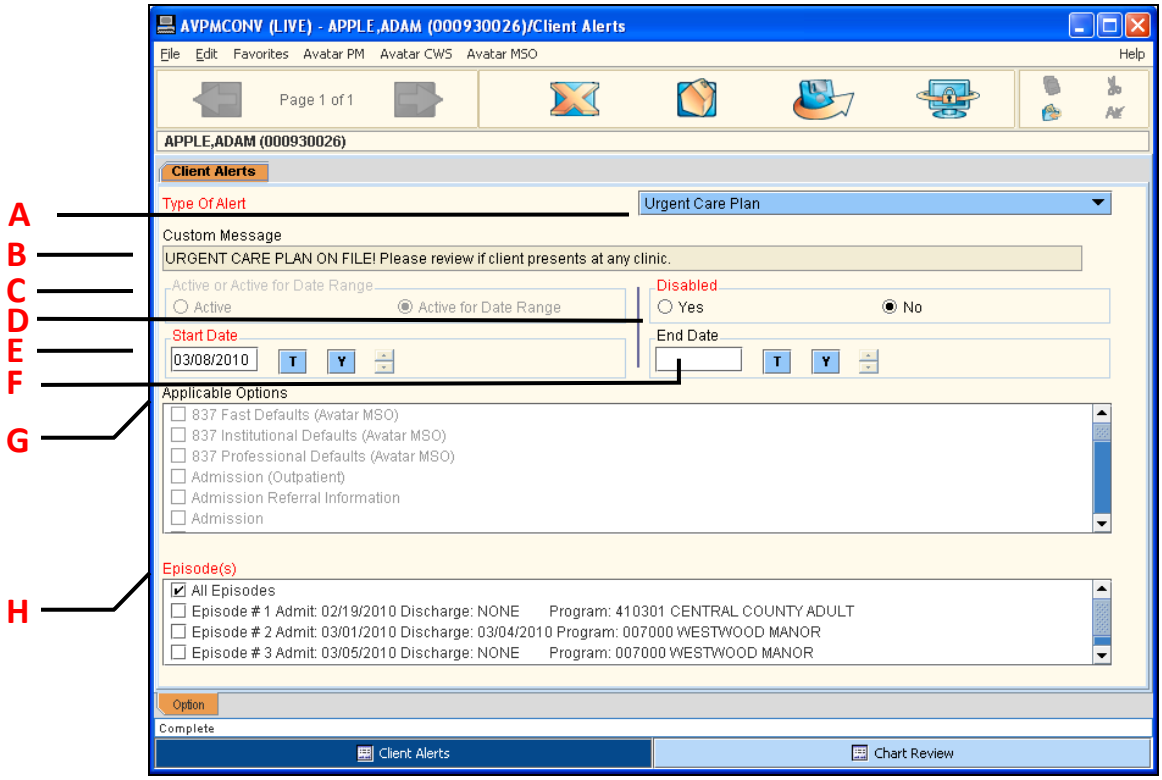
Close the Urgent Care Plan with this button.

When you access Client Alerts, you may see a screen like the figure below. This screen appears if alerts have been created for the client in the past. Notice there is a Disabled column that lets you know if an alert is disabled.



CLIENT ALERTS TAB

This tab allows you to designate the type of alert, how long it will last, and which options and episodes will trigger the alert to appear.



Field	Description
A) Type of Alert	Choose the alert you want to use from the dropdown list.
B) Custom Message	This field displays the text of the chosen Type of Alert.
C) Active or Active for Date Range	This field defaults to Active for Date Range and you cannot change it.
D) Disabled	Allows you to disable an alert without deleting it.
E) Start Date	Enter the date the alert should begin to appear.
F) End Date	Enter the date the alert should stop appearing. This should never be more than 18 months from the Start Date.
G) Available Options	This field is set to All Options so the alert will display for the first window that is opened, no matter what window that is.
H) Episode(s)	Select which episode(s) you want the client alert to appear in. By default, All Episodes is selected.

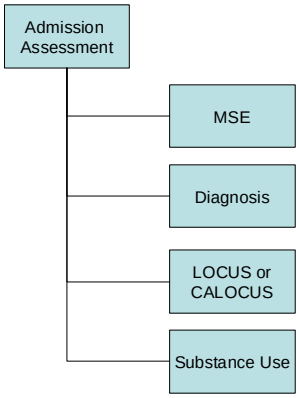
Sequester / Block Charts

When you need to sequester or block access to a Client's chart, send a request via email to the Quality Management group. They will determine the action to take and instruct the Avatar team accordingly.

ASSESSMENTS

ADMISSION ASSESSMENTS

There are five pieces that together make up a complete Admission Assessment: The main assessment and up to 4 companion document.



- ADULT or CHILD/YOUTH Admission Assessment special considerations
    - **Co-Occurring Tab:**
        - If you answer None on the Co-Occurring tab, it grays out the Substance Use assessment dropdown list on the Finalize tab and is not required for this assessment.
        - If you indicate some form of substance use or abuse and/or impaired functioning, it makes the Substance Use dropdown list required.
        - Other answers may allow you to add a substance use assessment but it is not required and is left to clinicians' clinical judgment.
- **Companion Documents**
    - Mental Status Exams (**Required for all Admission Assessments**)
        - Mental Status Exam (ADULT+PIN) is for use with the Physicians Initial Assessment and Adult Admission Assessments only
        - Mental Status/Behavioral Observation (YOUTH) is for use with the CHILD/YOUTH Admission Assessment only
        - These Mental Status Exams are not interchangeable. If a clinician does the wrong one by mistake they will have to redo their work in the correct document
    - BHRS Diagnosis (**Required for all assessments)**
    - LOCUS or CALOCUS (**Required for all assessments)**
    - Substance Use Assessment (**not required if no substance use is indicated in the admission assessment**)

IMPORTANT: You must complete and submit the MSE, Diagnosis, LOCUS/CALOCUS, and Substance Use (if required) assessments in order to finalize the Admission Assessment. You then make choices from the dropdown lists on the Finalize tab. This links the diagnoses to the main Admission Assessment and allows the user to finalize the assessment.

Assessment - Common Problems

- **Symptom:** I am unable to finalize my assessment because it cannot see one of my companion documents.
    - **Solutions:**
    - The companion document is not submitted as final. Go back and finalize the document.
    - For staff that require co-signature and have submitted their documents as "Pending Approval" their supervisors need to approve their document so they are available for the assessment.
    - They completed the wrong version of the Mental Status Exam
    - The user completed and finalized one or more companion documents while the Assessment was open. Submit the Assessment as a Draft and Open it again. The companion documents will be available in the drop down lists.
- **Symptom:** I cannot set my documents to Final because Avatar tells me I have required elements to complete.
    - **Solution:** Avatar will prompt you with a list of items that need to be completed these Items will need to be completed before Avatar will allow you to save your assessment as final. The most common fields that get overlooked are contained in the Co-Occurring tab and the Risk Assessment tab.

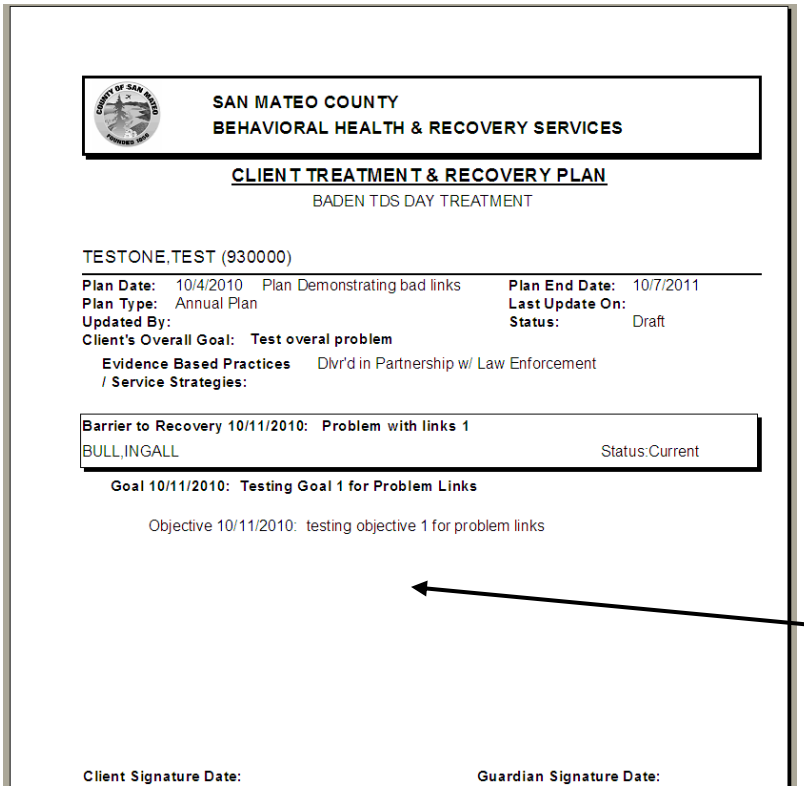
TREATMENT PLANS

TREATMENT PLANS – HOW, WHY, WHEN, WHERE OF TX PLANS

- **Symptom:** The Treatment Plan won't let me go to the next tab without saving but the Submit button is missing.
  - **Solution:** You have to click the File/Save button in the upper-left corner for each tab instead of using the Submit button.
- **Symptom:** The Close button on the Option toolbar is inactive in the Treatment Plan window.
  - **Solution:** Click the blue Exit Treatment Plan button within the screen.
- **Symptom:** My Treatment Plan does not print correctly.
  - **Solution:** The Problem, Goal, Objective, and Interventions are not linked correctly OR Intervention does not print.

Treatment Plans - Correcting Bad Links

When Treatment Plan items are linked incorrectly, it can be very confusing to the end user to figure out how to correct the problem. The most common problem is linking the Interventions directly to the Problem. This causes the treatment plan to omit the Interventions from the report. Below are the steps required to correct this issue.


SAN MATEO COUNTY
BEHAVIORAL HEALTH & RECOVERY SERVICES

CLIENT TREATMENT & RECOVERY PLAN
BADEN TDS DAY TREATMENT

TESTONE,TEST (930000)

Plan Date: 10/4/2010 Plan Demonstrating bad links **Plan End Date:** 10/7/2011
Plan Type: Annual Plan **Last Update On:**
Updated By: **Status:** Draft
Client's Overall Goal: **Test overal problem**
Evidence Based Practices / Service Strategies: Dlvr'd in Partnership w/ Law Enforcement

Barrier to Recovery 10/11/2010: Problem with links 1
BULL,INGALL Status:Current

Goal 10/11/2010: Testing Goal 1 for Problem Links

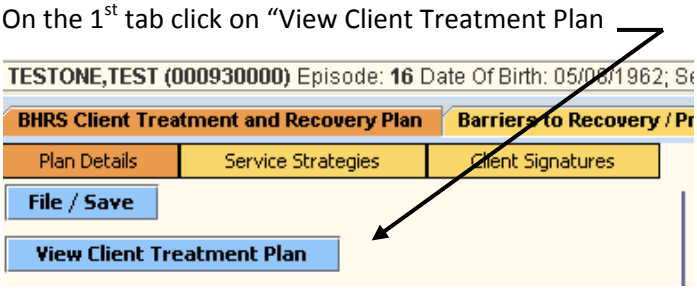
Objective 10/11/2010: testing objective 1 for problem links

Client Signature Date: **Guardian Signature Date:**

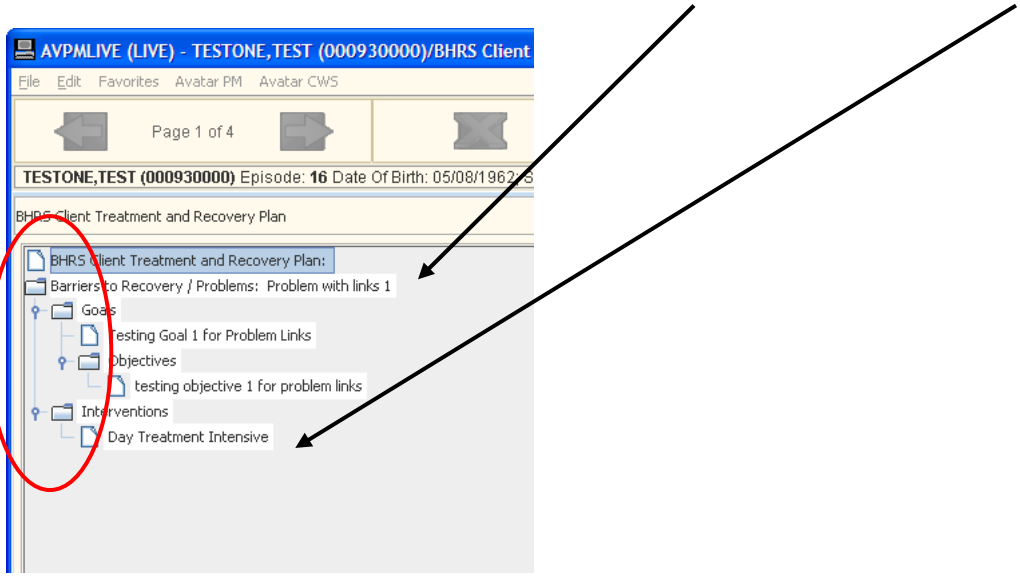
Interventions are not printing on the report.

1. Open the Treatment Plan that needs to be corrected.

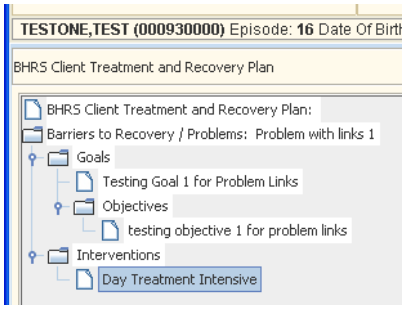
2. On the 1st tab click on “View Client Treatment Plan



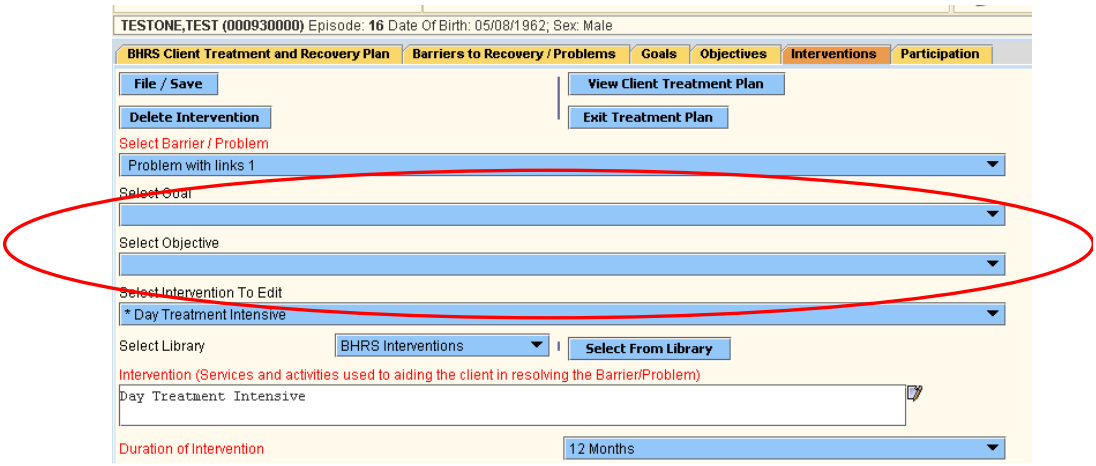
This example shows the Interventions is linked directly to the Problem instead of the Objective



4. To Correct: Select the intervention to be corrected and press Return at the bottom of the window

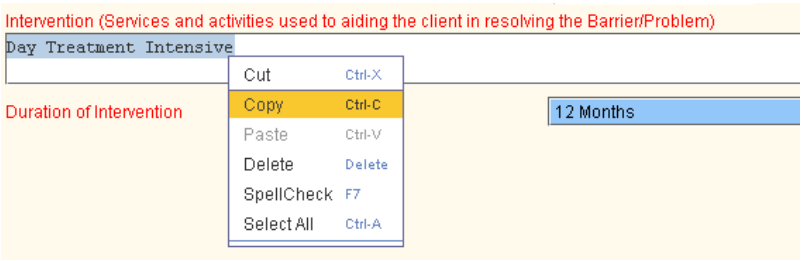


5. This will take you to the Interventions tab for the selected Intervention in the Treatment Plan.
6. As you can see, this Intervention is not linked to the objective or goal, because the fields are empty.

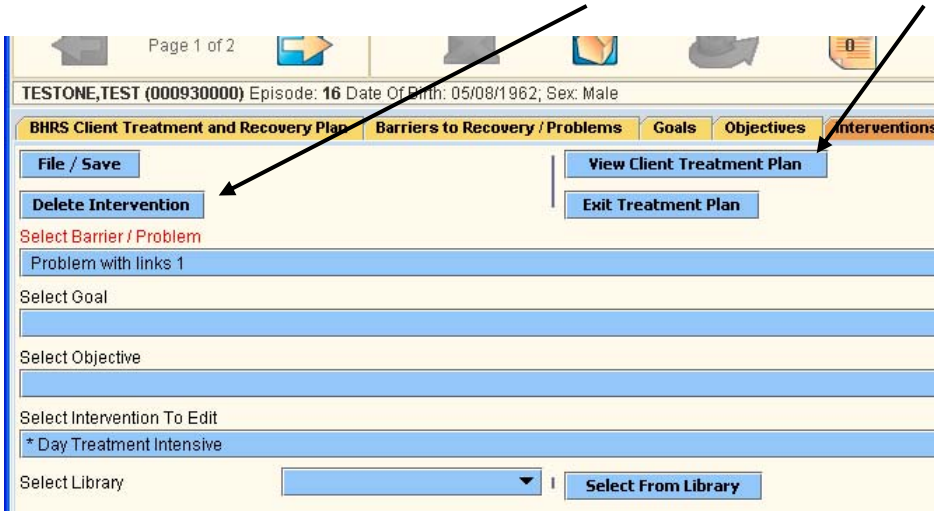


When the Treatment Plan items are linked incorrectly, fields like the Goal and Objective will be empty

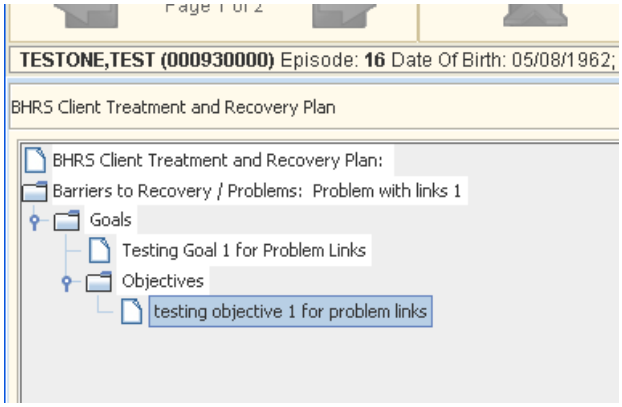
7. Highlight and Copy the text in this item



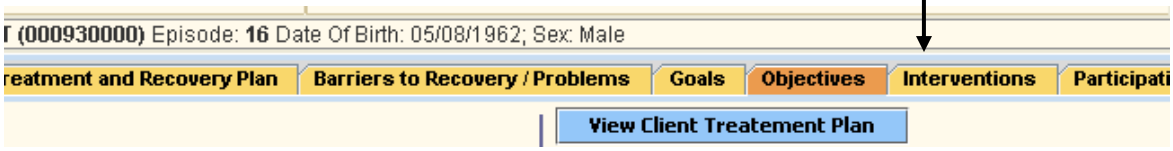
8. Delete this intervention once you have copied it. Then click on "View Client Treatment Plan"



9. Select the Objective you want to link the intervention to. Click on return at the bottom of the window. This will take you to the Objectives Tab for that Objective



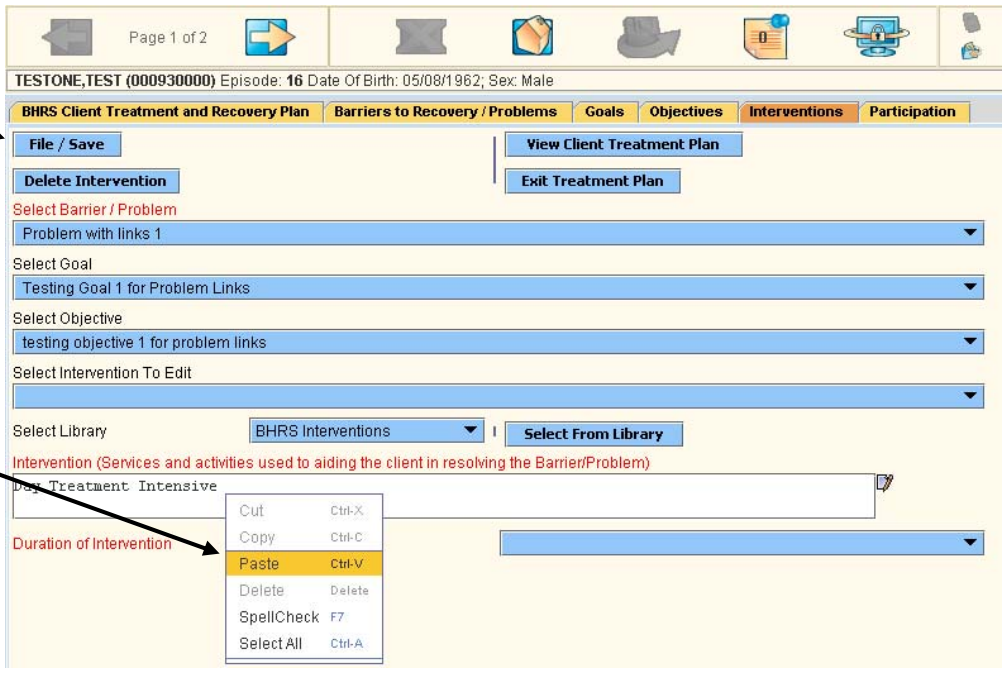
10. Immediately click on the Interventions tab.



11. Paste in the Intervention you copied and click on File/Save. You have now corrected a broken link

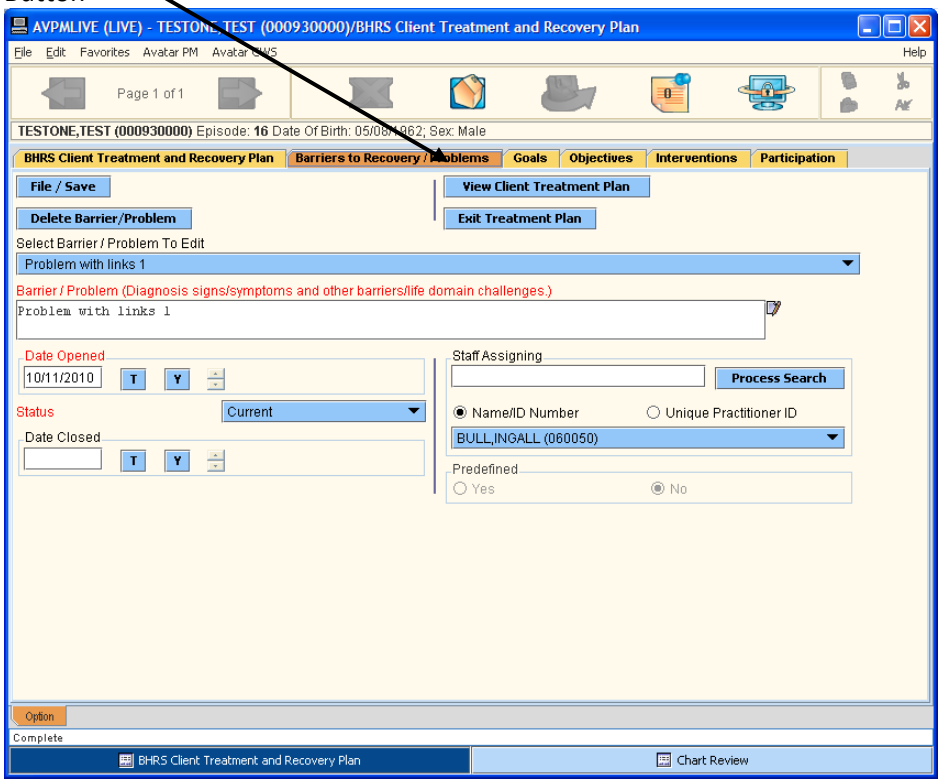
Click on File/Save to save the correction

Paste the intervention

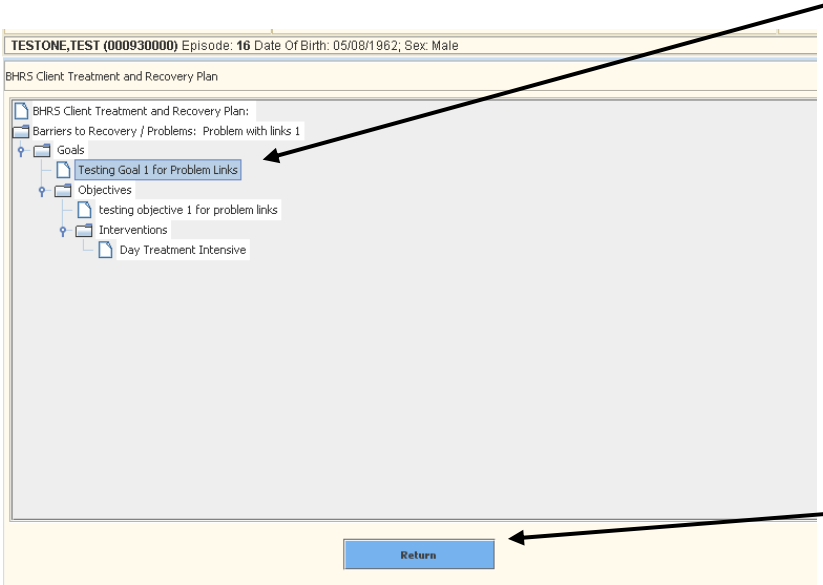


Treatment Plans - Linking multiple elements

1. To begin linking multiple elements in a Treatment Plan Click on the “View Client Treatment Plan Button”

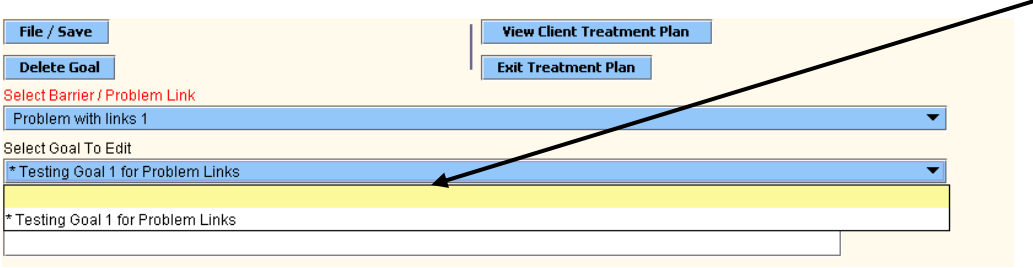


2. Click on the level you want to an additional item to. (In this case, the goal)

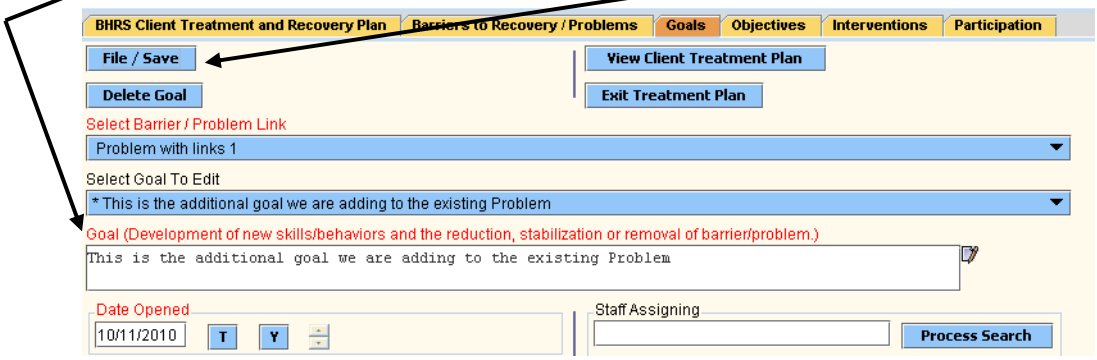


Clicking on “Return” will take you to that spot in the Treatment Plan

3. Click on the field “Select Goal to Edit” and then select the blank line to start a new goal.



4. Type in your new goal and then click on File/Save



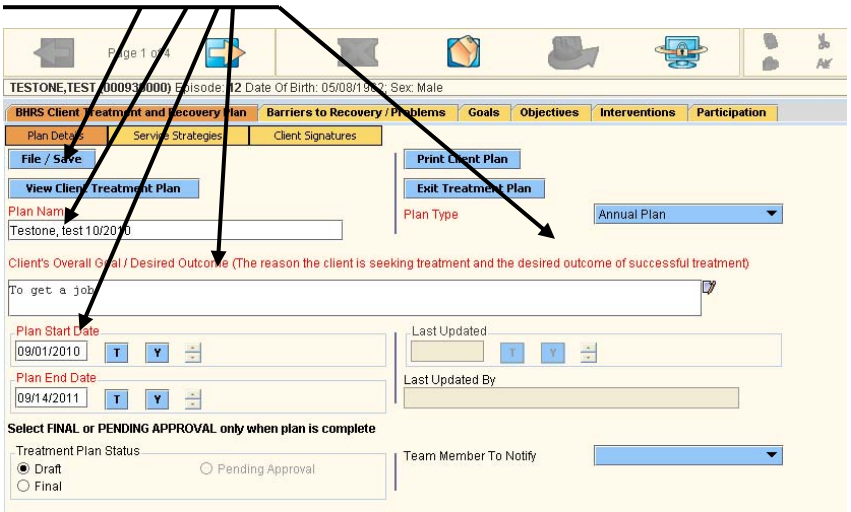
5. You can now add Objectives and Interventions for this goal by working through the tabs in the usual manner.

2. Treatment Plans – Updating and Editing Treatment Plans

Completing annual treatment plans and/or updating existing plans review is made simpler by bring information forward from a previous plan.

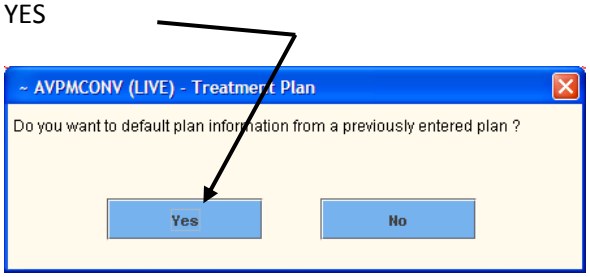
Start a new plan for the correct episode. Complete the required fields for the first tab, including service strategies

Set the document as DRAFT and FILE/SAVE

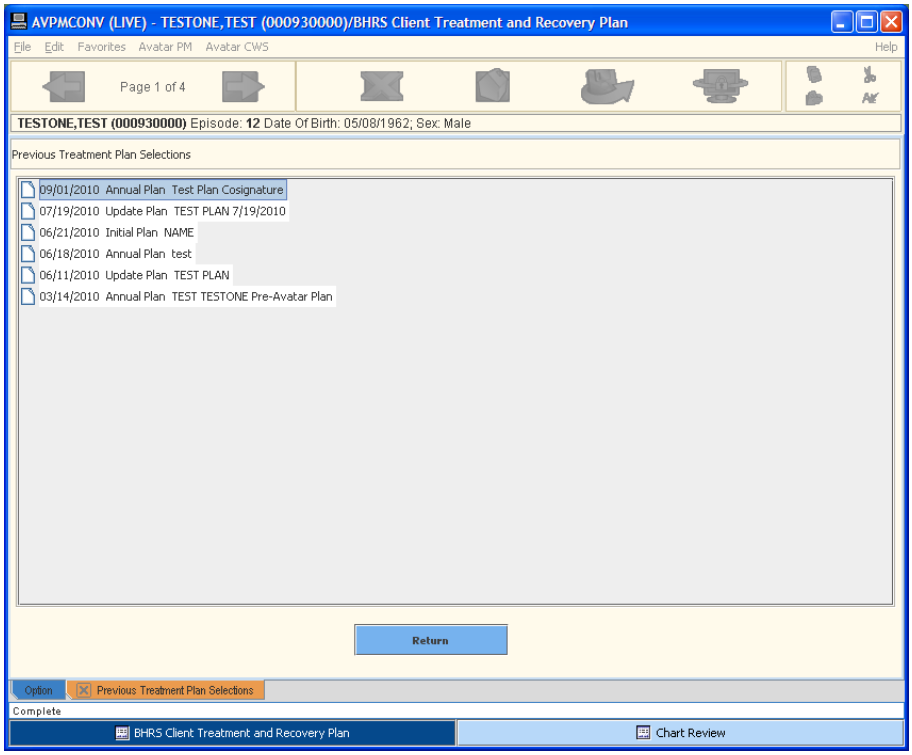


(**NOTE: BHSR Client Treatment and Recovery Plan will only default information from the same episode**)

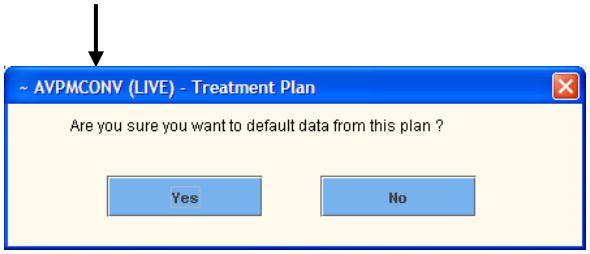
When you save your plan Avatar will ask if you want to default information from a previous plan. Click on YES



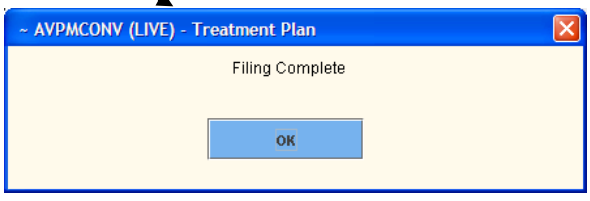
Avatar will open up a screen with a list of plans to choose from, displaying the date, type and plan name. (**Generally you should choose the most recent date since that will be your last plan**)



This dialogue box allows you to opt out of coping plan info.



This dialogue box confirms that the plan was copied

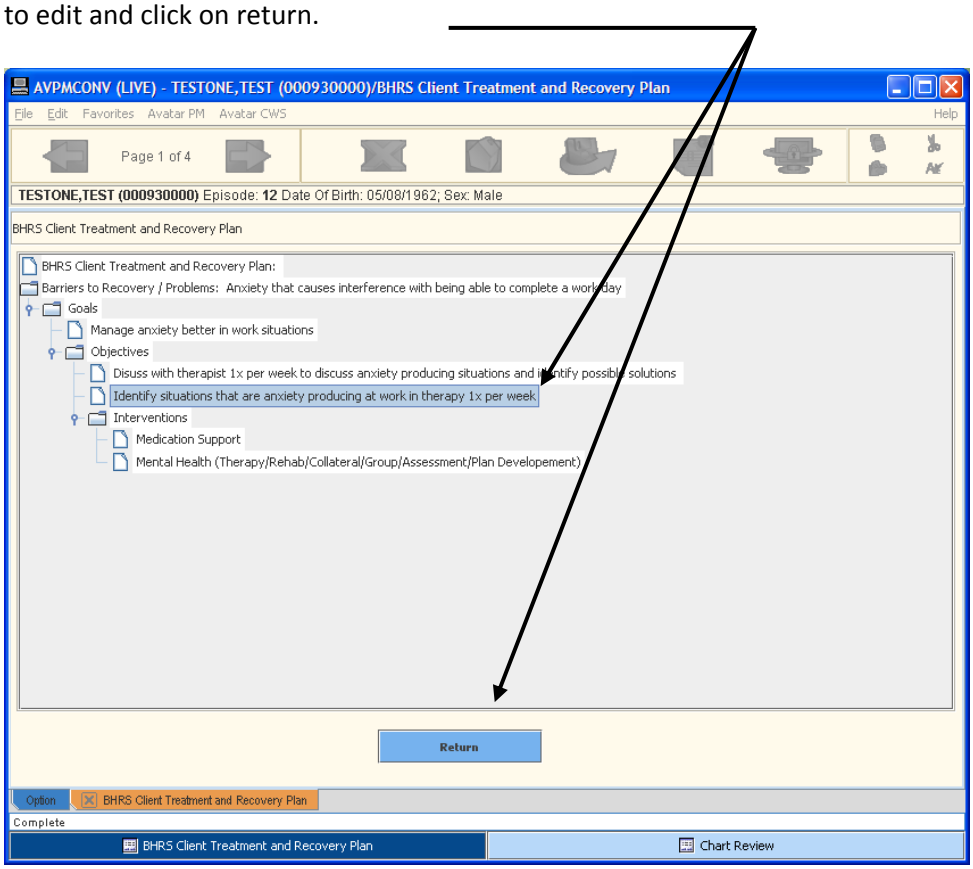


3. Editing Previous Problems, Goals, Objectives, and Interventions

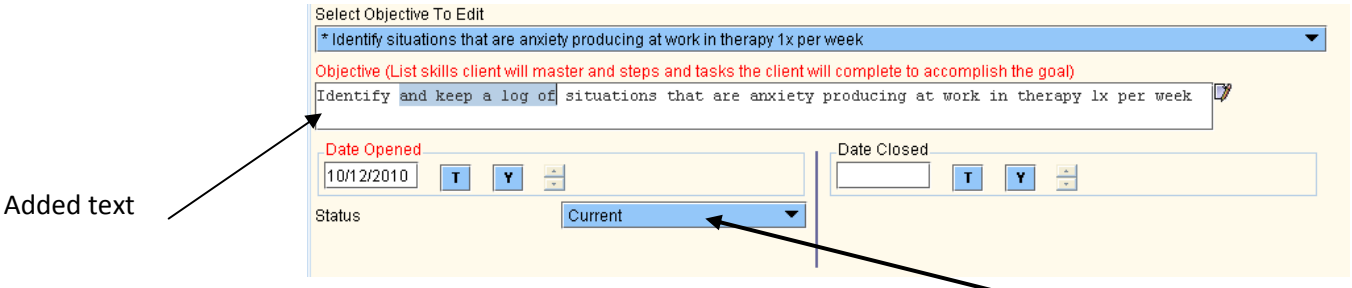
There are a number of functions that you can perform when updating an Annual Plan.

- Edit exiting goals to be more relevant to the client needs or wishes.
- Close items because they are no longer relevant or have been completed.

Use “View Client Treatment Plan” to review the information you just imported. Select the item you want to edit and click on return.



When editing an item you can add or delete text. Save your change using File/Save.

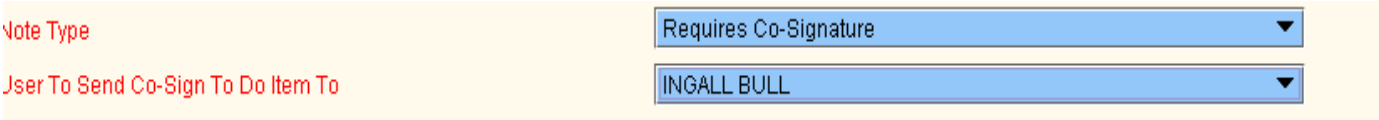


When closing an item, change the value in the Status field to Closed.
Closing an Item will also close the linked items that follow but not the items that are above. For example closing an Objective will close any Interventions linked to it but not the Goal that it is linked to.

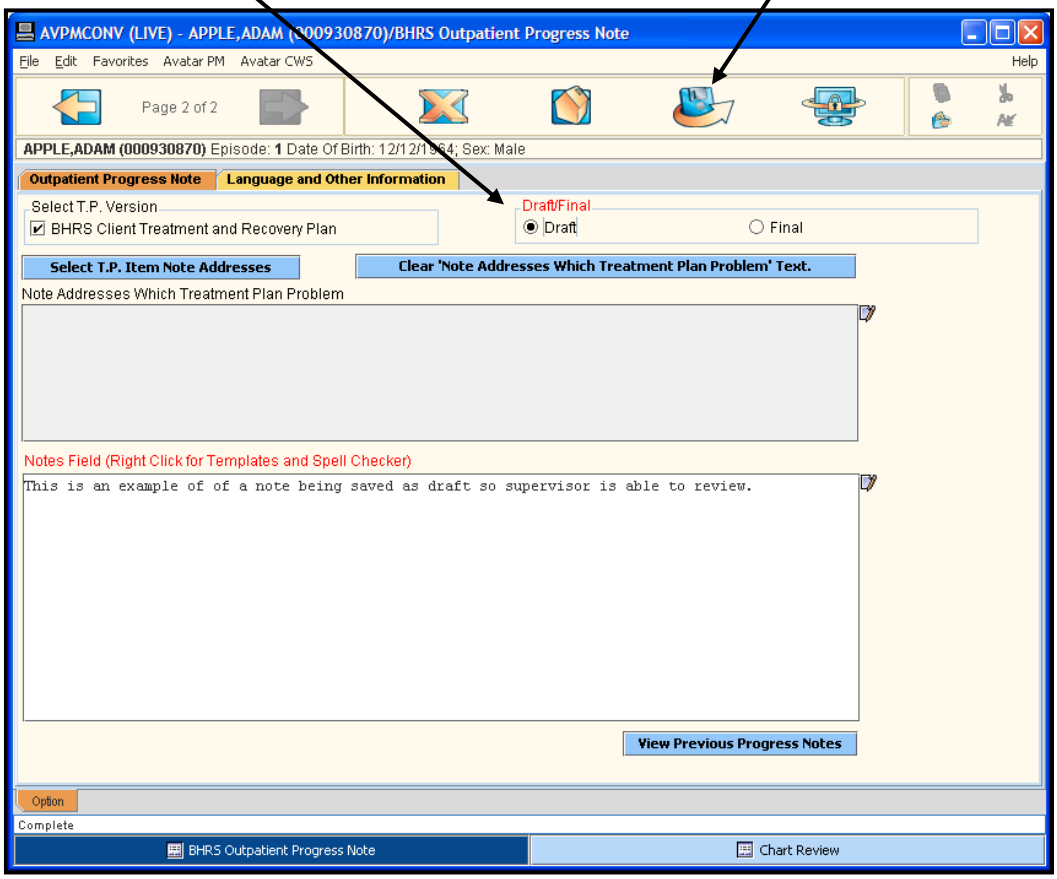
PROGRESS NOTES

CO-SIGNING PROGRESS NOTES

When the clinician writes their progress note they indicate that the document requires co-signature and selects the supervisor to send the note to.

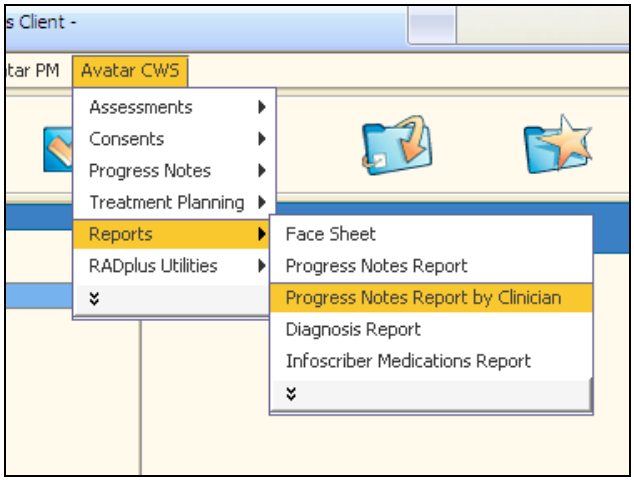


Because Avatar does not allow a note to be edited when it is sent for co-signature, the trainee will save the note as draft initially. Then submit the note.



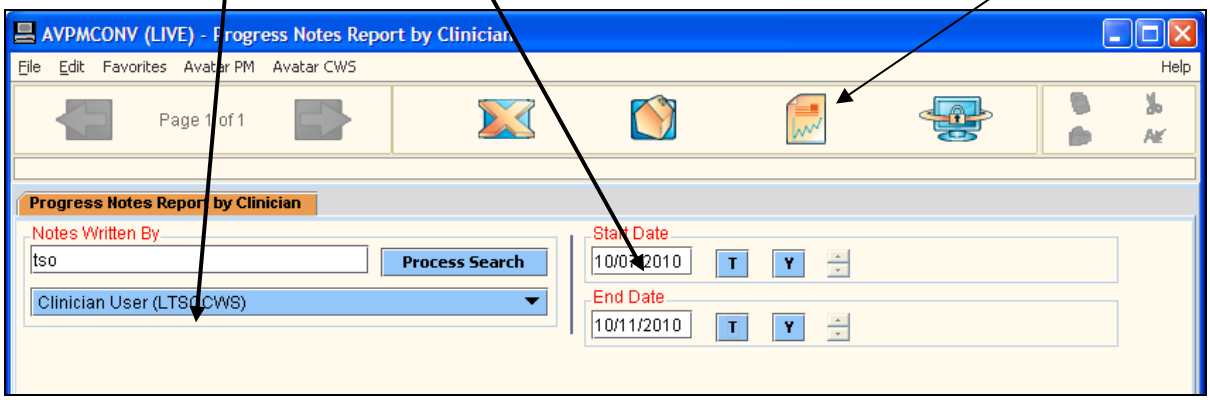
The trainee/clinician will then let the supervisor know that they have notes in draft. This should be done in person, via GroupWise or voicemail.

The Supervisor can review the notes using “Progress Notes Report by Clinician” report

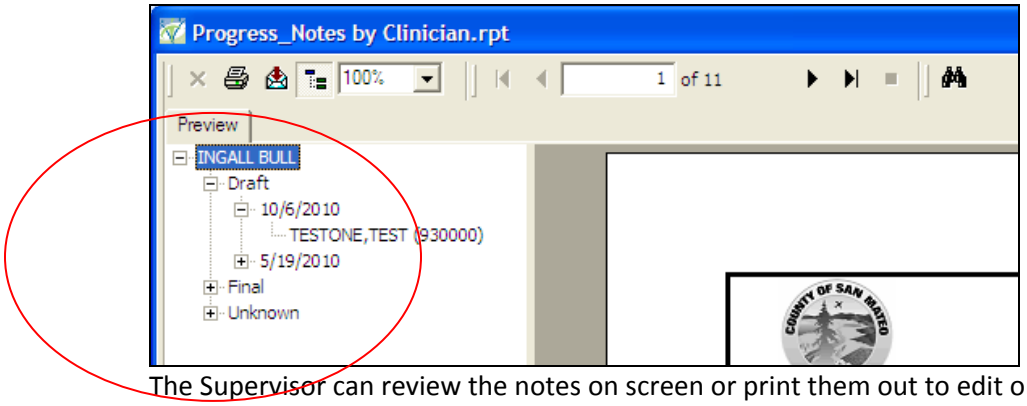


Enter the name of the clinician and a date range

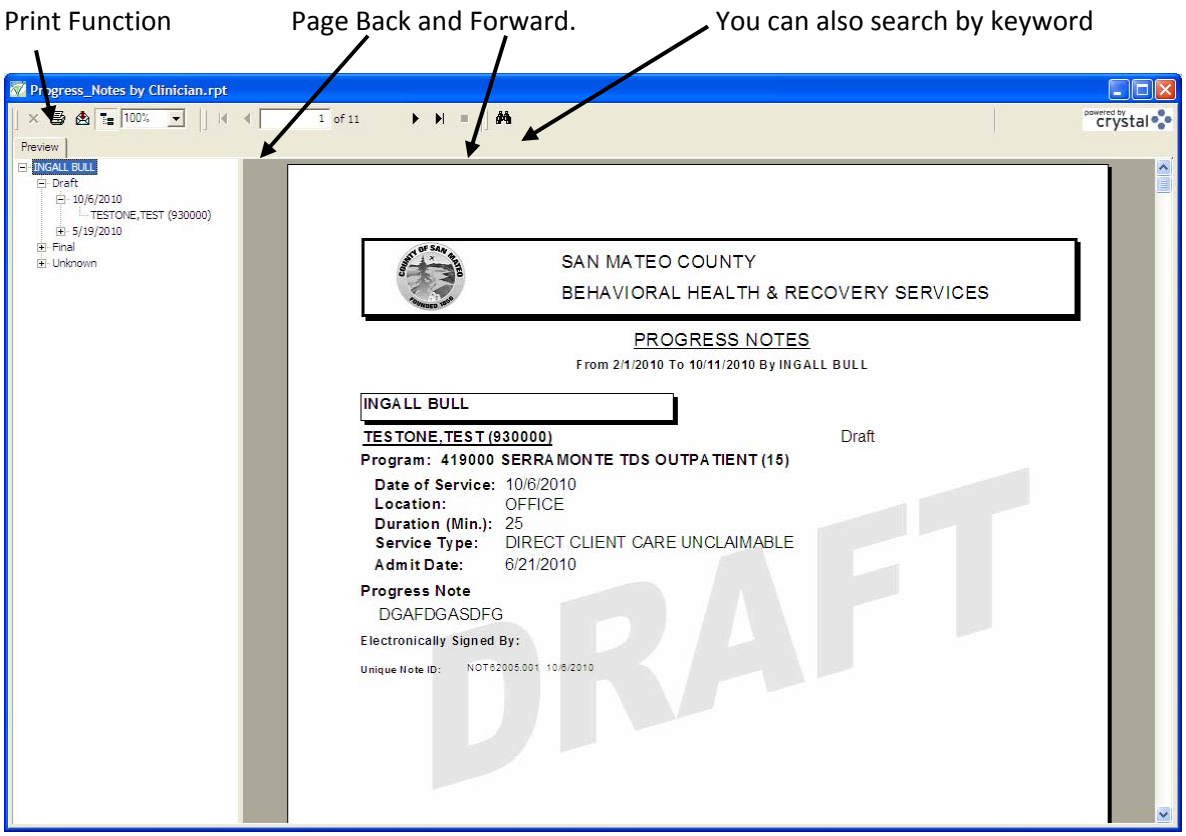
Process the report



The pane on the left side of the Crystal Reports screen will have the Clinician’s name. Click on the plus signs to see additional information. **(TIP: Draft notes are first in the order)**



The Supervisor can review the notes on screen or print them out to edit on the report.



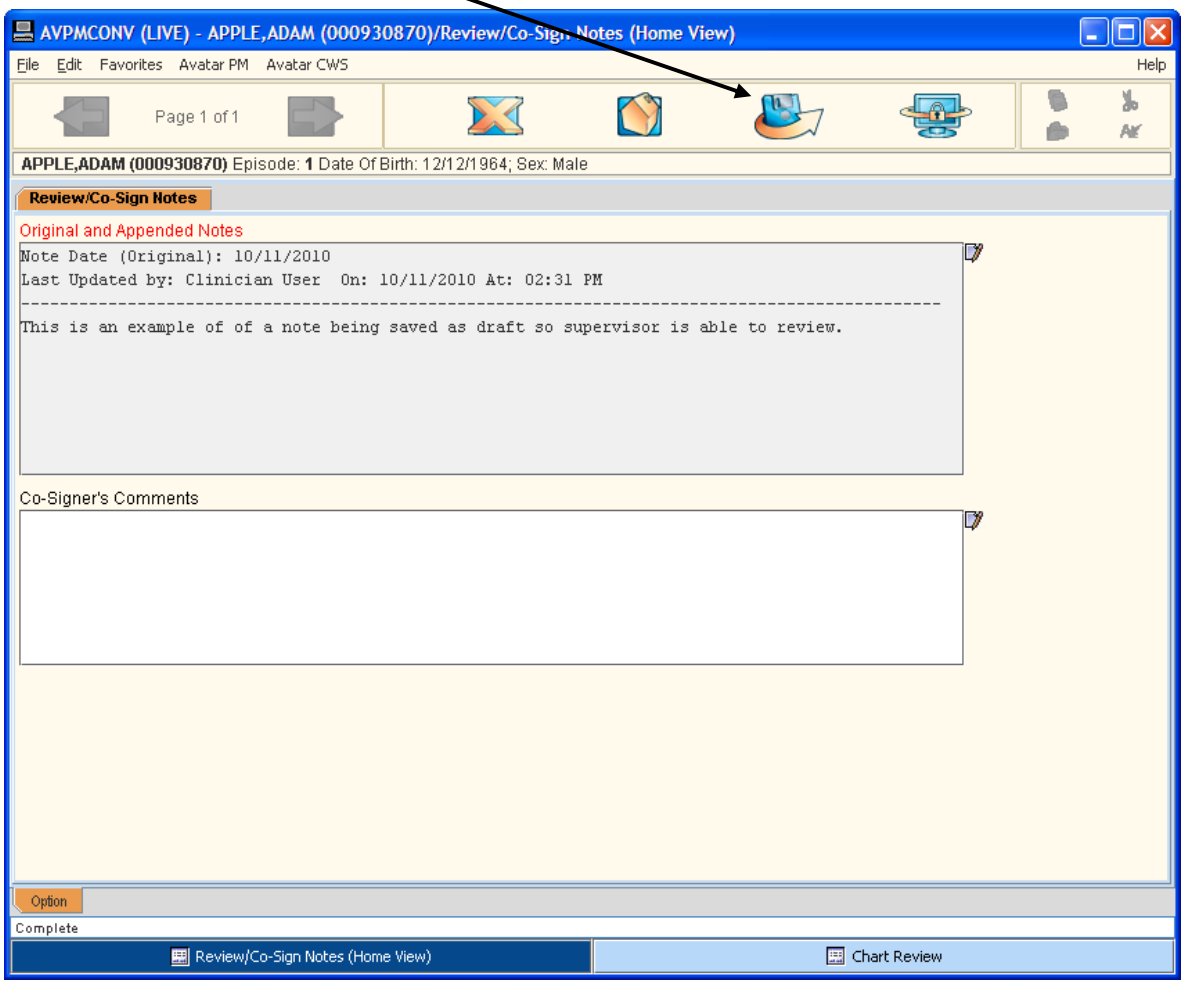
Once the supervisor has reviewed the note they can instruct the trainee to return to the note and submit it as final.

Once the note is submitted as Final, the supervisor will get the To-Do List notification in your To-Do list

Double-Click on the item to open the co-signature option

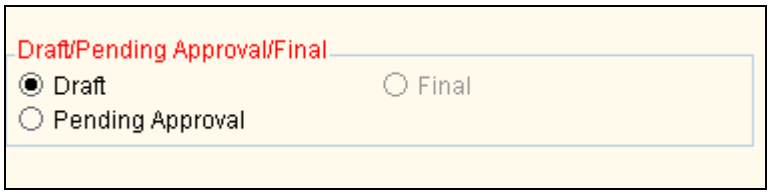
You will seethe original note information and there is a place to comment. **(Note: this is not required and Co-Signers Comments are part of the chart documentation)**

To Co-Sign the note click on Submit



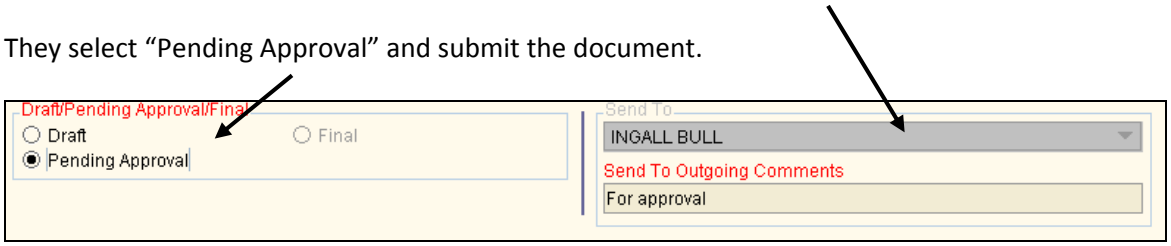
CO-SIGNING ASSESSMENTS AND OTHER CLINICAL DOCUMENTS

Co-signing Assessments and other clinical documents works differently than the progress note. The major difference is when the clinician submits a document for co-signature it is still in a draft status and can be edited if need be. The setup of clinicians and supervisors needs to be correct for this to work properly. A clinician or trainee who requires co-signature will have "Pending Approval" instead of "Final" for any document. **(If a Clinician/Trainee does not have "Pending Approval" contact the ISD Help Desk immediately)**



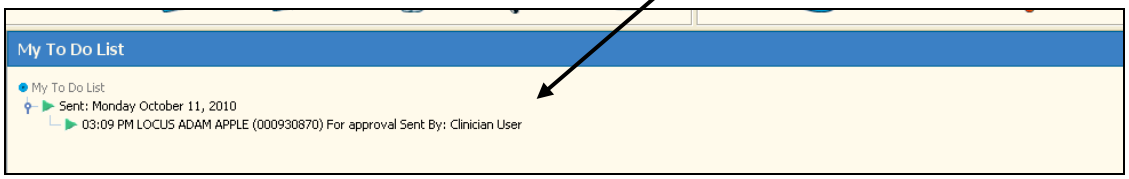
When the trainee completes a document they select their supervisor in the "Send To" field and write a brief outgoing comment that will be displayed on the supervisor's to-do list

They select "Pending Approval" and submit the document.



The Clinician/Trainee will be prevented, at this time, from editing the document any further.

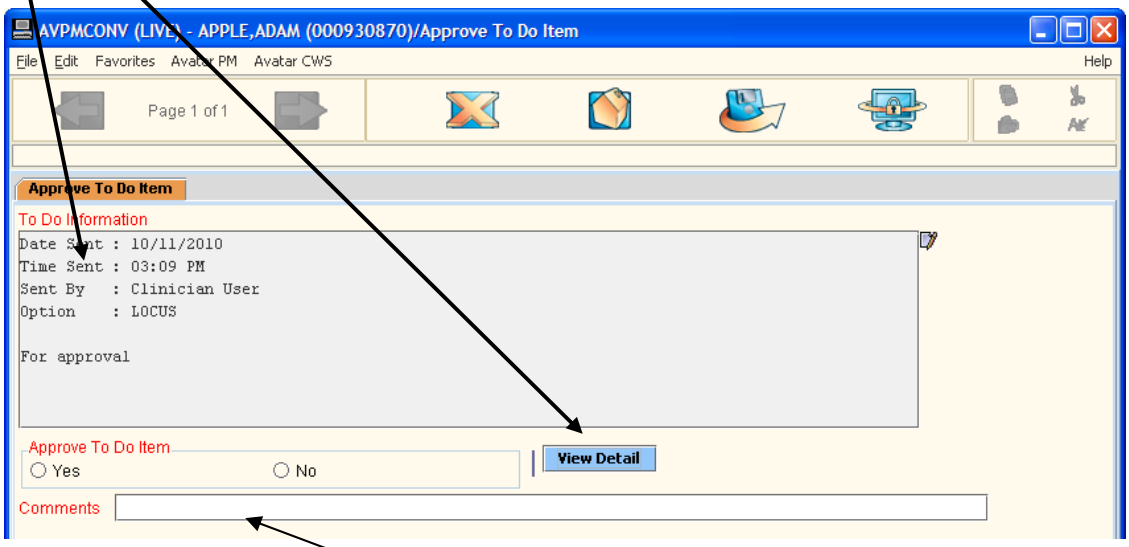
The supervisor will receive a to-do list item for the document to be approved with the clinician/trainee's outgoing comments.



Double-click on the to-do list item to open the approval screen.

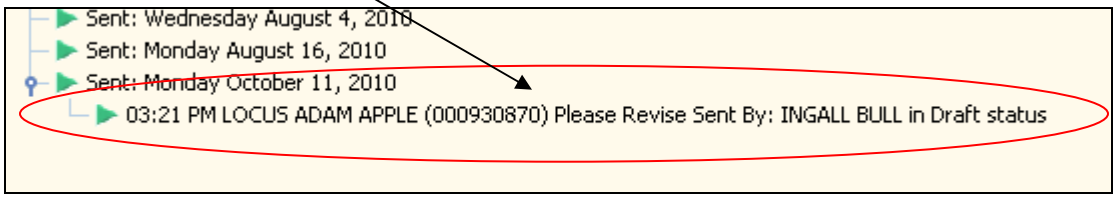
The To-Do Information Window shows document information (**date, time, user, and outgoing comments**)

View Detail will run a report of the document for viewing.



Approve To-Do Item and Comments. **"Yes"** makes the document final.

"No" reverts the document back to draft. When you submit the To Do Item with "No", Avatar sends it back t the clinician/trainee's to-do list as a draft document.



Once the clinician/trainee has completed the document they can send it back for approval. When the Supervisor approves the document it will be in final status.

CORRECTING ERRORS IN CLINICAL DOCUMENTATION

There are a variety of methods for correcting clinical documents. Please review the following processes so you will know where to find the procedure if clinical documents need correction.

CORRECTING A PROGRESS NOTE

There are two sections of a progress note where a mistake might occur—the content of the actual note or an error in the billing section of the note, such as code, date of service, or duration of service.

CORRECTING DRAFT NOTES

If a progress note is still in draft status the clinician can edit most of the information in the note.

- To correct Episode and/or Client clinician needs to write a new progress note for the correct Episode or Client.
- Delete the draft note with the wrong information.

CORRECTING FINAL NOTES

Errors that need to be corrected to final note are

- Disclosure of PHI information for another client
- Wrong Client, Episode, or Date of Service
- Duplicate progress note
- Service information (service code, location, duration, # of clients in a group)

- Clinician should complete the "Progress Note Error Correction Request" for this note, requesting the note be corrected
- Original incorrect note will be voided and/or service deleted

VOIDING A PROGRESS NOTE (Removing from client record)

Progress notes will only be voided for specific reasons

- Disclosure of another client's PHI in the content of the note
- Progress note was written on the wrong client, or episode

APPENDING A PROGRESS NOTE

If there is an error in the note itself, the clinician should use the Append Progress Notes feature to make the correction. Follow these steps to use the Append Progress Notes window:

1. Avatar CWS→Progress Note→Append Progress Notes
2. If the Select Client screen appears, type all or part of the client's name in LASTNAME,FIRSTNAME format and tap the [Enter] key.
3. If necessary, choose the client from the list.
4. Click the OK button at the bottom of the screen.
5. If the Select Episode screen appears, click once on the episode that contains the progress note error and click the OK button.

   The Append Progress Notes window appears.

6. In the Note Type field, select whether the mistake was made in a note that did or did not require a co-signature.
7. In the List of Notes field, select the Progress Note where the mistake occurred.
8. The note will appear in the Original and Appended Notes field. Verify that this is the note you want to correct.
9. Click the Next Page icon to go to page 2.
10. In the New Comments to be Appended to the Original Note field, type the correction to the note. The information will append to the end of the original note.
11. Click the Submit icon to save the changes.

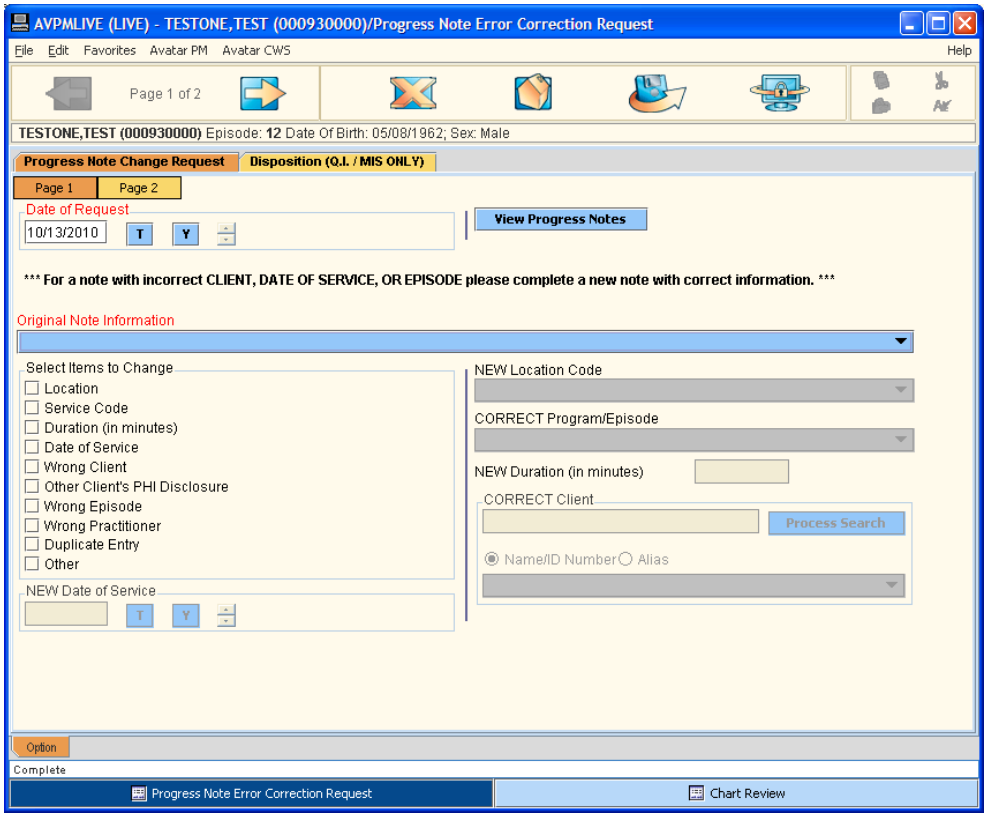
PROGRESS NOTES ERROR CORRECTION REQUEST (COMING SOON)

A new option called Progress Note Error Correction Request is being added to avatar to help streamline the correction of documentation errors. To request a correction in a progress note the clinician will complete this option.

- The progress Note change Request has 2 pages
- Depending on the request, either M.I.S. or your ADMIN will make the correction
- You may be contacted to provide further information

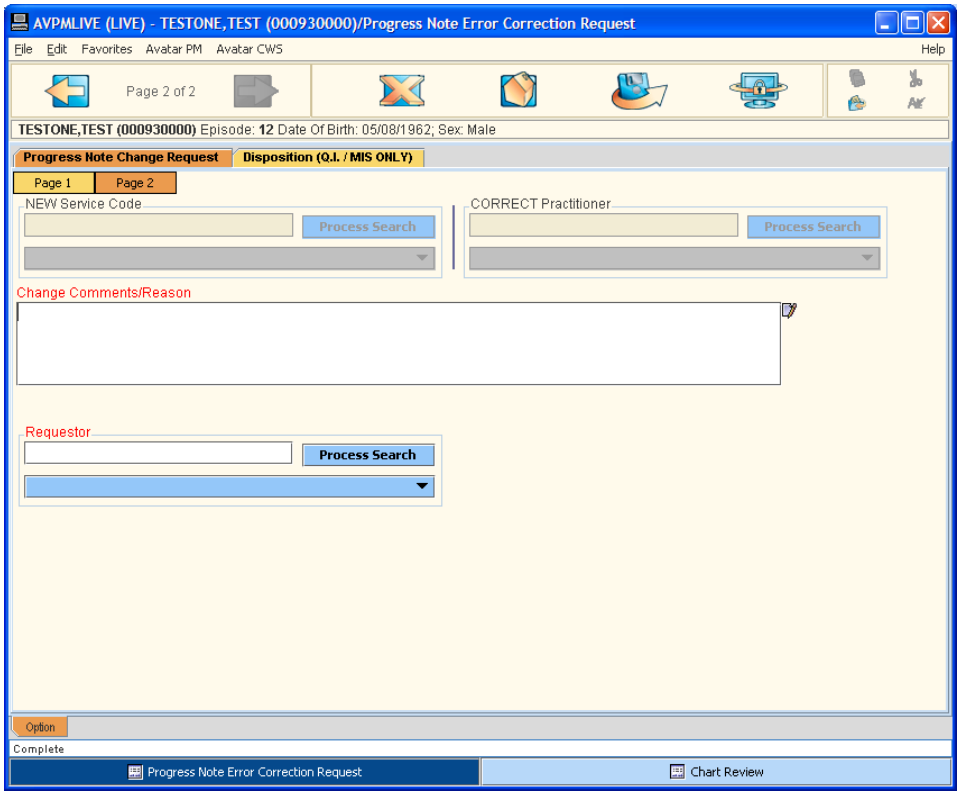
Original Note Information - Shows a list of progress notes for a client for the last calendar year

Select Items to Change - When the clinician selects items to change it will enable the corresponding field to enter the correct information



Change Comments/Reason - Document reason for request or anything that person making correction may need to know in addition to information already provided.

Requestor - Staff making the request



ERROR IN SERVICE INFORMATION (I.E. SERVICE CODE, DATE OF SERVICE, DURATION OF SERVICE)

Notify your administrator of the mistake, providing the Client Name, Episode #, Date of Service, incorrect entry and what the correct entry should be. Administrators can make corrections to some billing errors, or the administrator will contact MIS to correct the errors if necessary.

CORRECTING AN INITIAL CONTACT SCREENING (ICI)

You can always return to any ICI window and make a change or correction at any time. The only field you cannot change is the original date of the ICI.

CORRECTING AN ADMISSION OR ANNUAL ASSESSMENT (ADULT AND YOUTH)

Corrections are only necessary for a critical field mistake such as suicide, a risk issue, or violence information. The steps are the same for correcting an error in an Admission or Annual Assessment. To correct a critical field error, use the following steps:

1. Avatar CWS→Assessments→ADULT Annual/Update Assessment
   OR
   Avatar CWS→Assessments→CHILD/YOUTH Update Assessment
2. In the Assessment Type field, select Update from the dropdown list.

   Information from certain Admission Assessment fields will automatically populate to the fields.

3. Make any necessary corrections.
4. Go to the Finalize tab.
5. Attach the correct Substance Use, LOCUS, and Diagnosis assessments from the dropdown lists.
6. In the Draft/Pending Approval/Final field, select Final.
7. Click the Submit icon to save the changes.

CORRECTING A PHYSICIAN'S INITIAL ASSESSMENT (PIN)

Doctors note any corrections to the PIN in a Progress Note.

CORRECTING A LOCUS/CALOCUS

Any mistake in a LOCUS or CALOCUS needs to be corrected by creating a new LOCUS/CALOCUS. Generally the LOCUS/CALOCUS with the most recent finalize date is the working version.

CORRECTING A SUBSTANCE USE ASSESSMENT

Any errors in the Substance Use assessment need to be corrected by creating a new Substance Use Assessment. Information from the previous Substance Use assessment will populate into the new window, so you do not need to re-type everything. Make the corrections in the new Substance Use window and submit the changes as Final.

CORRECTING A BHRS DIAGNOSIS

Making a correction to the BHRS Diagnosis window requires that you complete a new BHRS Diagnosis window. The most recent diagnosis populates to Avatar PM for billing.

If you have an incorrect non-billable diagnosis, notify your Unit Chief. The Unit Chief will contact QM or MIS.

CORRECTING THE MENTAL STATUS AND BEHAVIORAL OBSERVATION ASSESSMENT

To correct an error in this window, you will have to complete a new Mental Status and Behavioral Observation (Avatar CWS→Assessments→Mental Status and Behavioral Observation).

CORRECTING A TREATMENT PLAN

If the error is minor, document the mistake in a Progress Note.

If the mistake is critical, you will need to create a new Treatment Plan (Avatar CWS→Treatment Planning→BHRS Client Treatment and Recovery Plan). When Avatar asks if you want to default from the previous plan, select Yes. You will see any previous Barriers, Interventions, and so forth in the dropdown lists, so you do not need to re-type everything. Remember that the original Treatment Plan will remain in the system for auditing purposes.

CORRECTING A MISTAKE IN CONSENT FORMS

Many times, corrections here are not mistakes so much as changes, such as consent for a certain family member being changed or revoked. For any changes to Consents, go to the specific Consent window where you will create a new consent that overrides the previous one. A new consent with the proper changes will print. You can then give the consent to your client.

CORRECTING A DISCHARGE

If a client is mistakenly discharged from an episode, you must contact the Help Desk at 650-578-7150 so that they can undo the discharge.

DOCUMENTATION ON WRONG CLIENT

You may find that you have completed the correct information, but entered and submitted as final for the wrong client.

IMPORTANT

DO NOT RE-DO THE DOCUMENT FOR THE CORRECT CLIENT!

For all clinical documents except Progress Notes, contact the ISD Help Desk and inform them of the error. They will assign the problem to an eCC Team member for correction. In some cases clinical documents can be moved form one client to another. Make sure to provide the clients' names and Medical Record #s along with the documents affected. .

DUPLICATE DRAFT DOCUMENTS

Sometimes you may discover that you started the same clinical document as a draft for the same client. If the documents are still in Draft, use the following steps:

- **Treatment Plans ONLY:** Contact the ISD Help Desk and 650-573-3400 to report the problem with Client name, MH#, Episode and Start Date of Treatment Plan.
- **All Other Clinical Documents:** Open the particular document window. The Pre-Display window should appear showing all draft copies. Select the extra draft you wish to delete by clicking it once and then clicking the Delete button. You cannot undo this action.

INFOSCRIBER

INFOSCRIBER FREQUENTLY ASKED QUESTIONS

1. I sent my Rx to the wrong pharmacy. How do I get the order to the correct pharmacy?

   Reorder the medication(s) and send it to the correct pharmacy. Have the clinical or admin staff call the wrong pharmacy to cancel / disregard the incorrect Rx.

2. The pharmacy that I need is not on the selection list. What do I do?

   Contact the ISD Help Desk at 573-3400 or email isdhelpdesk@co.sanmateo.ca.us with the pharmacy name, location, phone number if known, and one of the InfoScriber analysts will add the pharmacy to the database. If a prescription needs to be sent right away, then either call in the Rx or print it for the patient, and then notify the ISD Help Desk.

3. The Rx that I just sent has the wrong sig / quantity. How do I correct this?

   Discontinue the wrong entry and send the output to the pharmacy. Then enter in the correct information as a new prescription.

4. How do I see that the Rx order I sent out is successful?

   Launch InfoScriber Reports. Run the report called "Rx Transmission Log" for the desired criteria. The report shows the status of the transaction. Keep in mind that transactions will take some minutes due to transactions needing to be processed by multiple systems. For example, faxing Rx can take up to 45 minutes if the fax line at the pharmacy is busy and the system has to keep trying to send.

5. How do I resend the Rx order if the pharmacy said they never got the original one?

   Resending can be done either from the Print tab on the Rx Profile page of the client, or from the Rx Transmission Log report.

   From the Print tab, click the checkbox in the Prescription column for the desired order entry. Change the drop down selection from Print to either Fax or eRx and click the "Go" button. Verify or change the pharmacy destination as necessary. Click "Send Fax" or "Send eRx" button.
   From the Rx Transmission Log report, click the "Resend" button on the desired order. Verify or change the pharmacy destination as necessary. Click "Send Fax" or "Send eRx" button.

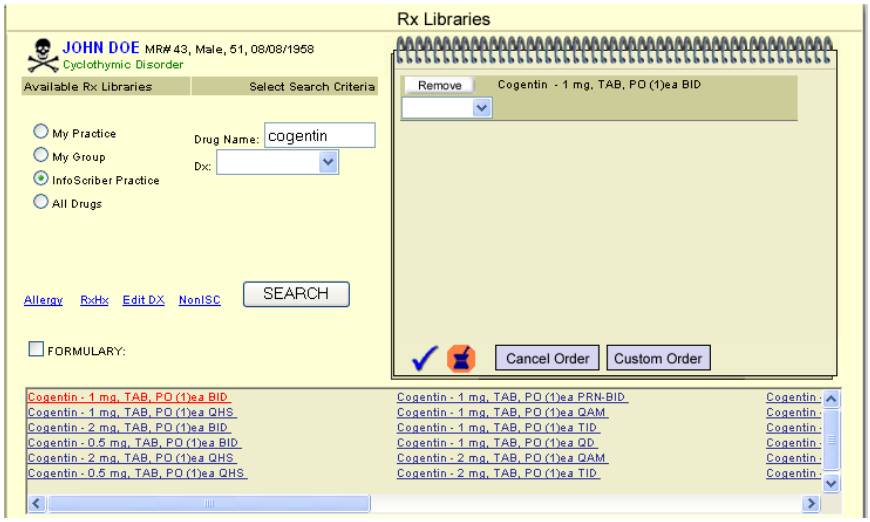
6. How do I tell what the drug strength abbreviation means?
   At the Custom Order page during prescribing, click on "Abbr." hyperlink under the Special Instructions box and Titrate button. A popup will appear with the list of abbreviation meanings. If viewing a drug order from a patient's Rx Profile, click on the medication name hyperlink. The medication detail popup will display the full description.

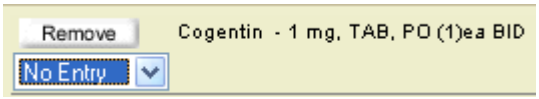
InfoScriber (ISC) Easy Reference Guide

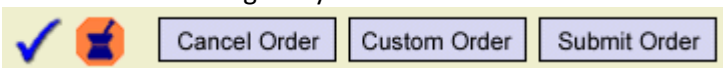
To Order New Rx

1. Click Go. 

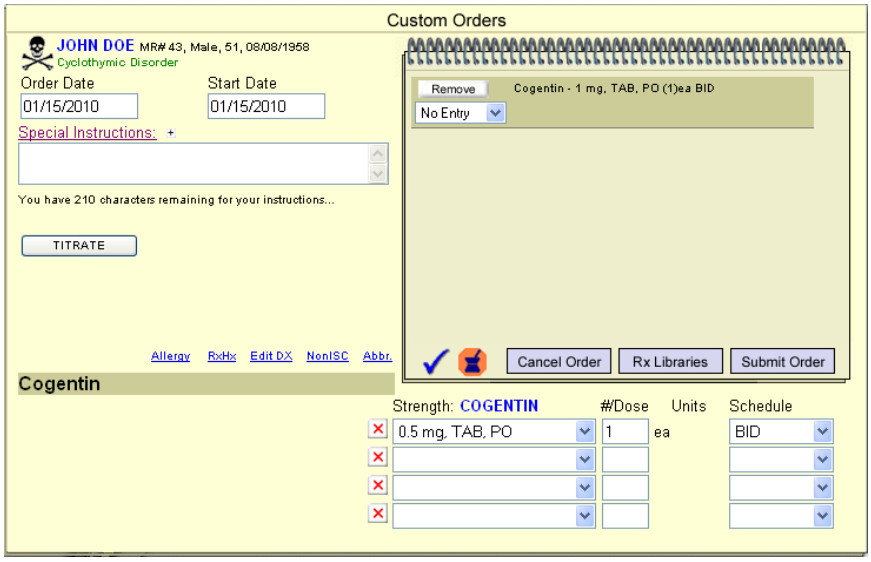
2. Select search library, type in drug name and click Search.
3. Select desired drug entry.



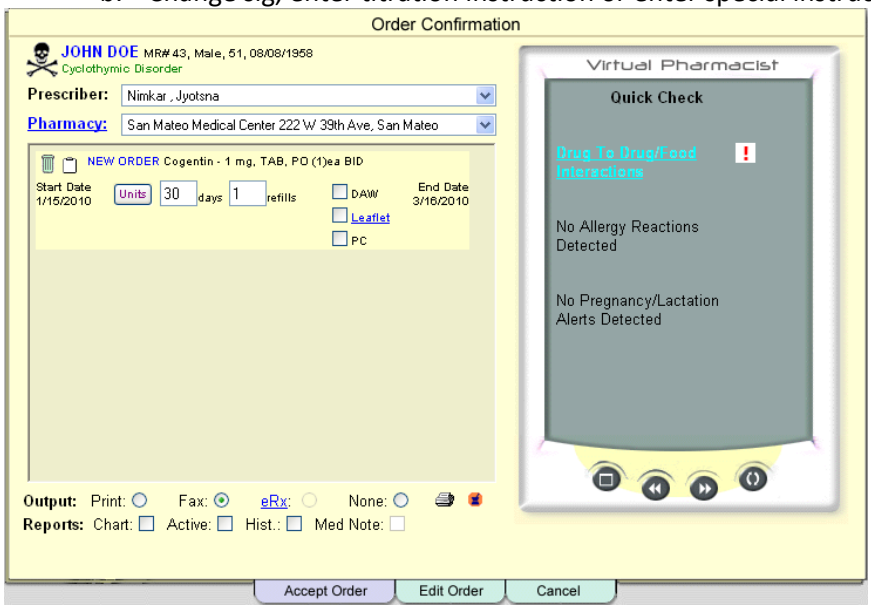
4. Repeat as necessary for multiple drugs.
5. Select Dx from drop down list under drug entry. 

6. Click Submit Order. 

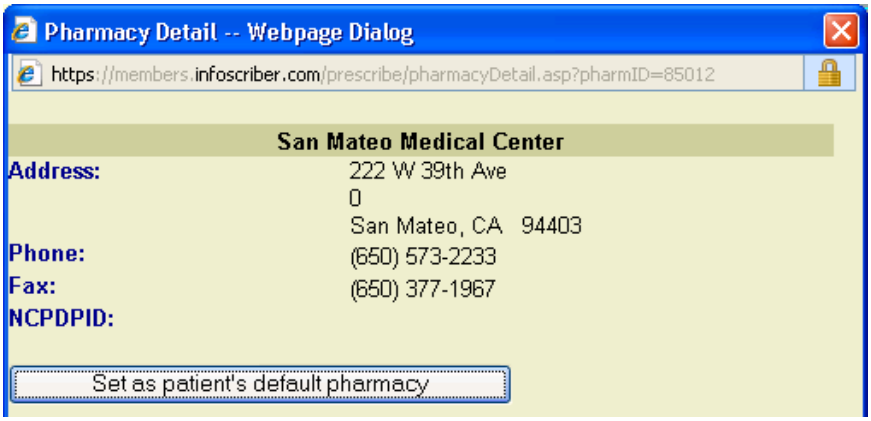
    a. If modification is needed, click Custom Order.



b. Change sig, enter titration instruction or enter special instructions, then click Submit Order.

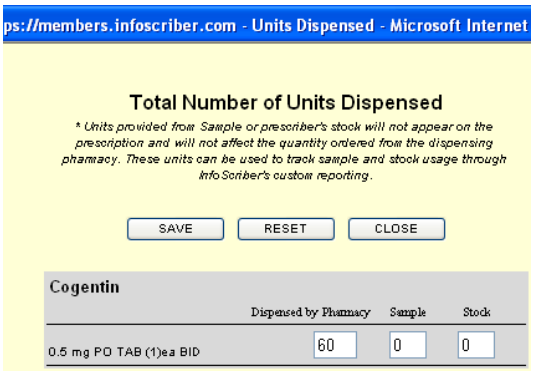


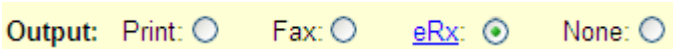
7. Ensure pharmacy is correct. If default pharmacy is incorrect, select correct one, click the blue Pharmacy hyperlink and click “Set as patient’s default pharmacy” button.



8. Change number of refills, enter comments, etc. as needed. Quick Check area on the right gives information about interactions / reactions if present.

   If needed, click the Units button  to customize number of units to dispense.

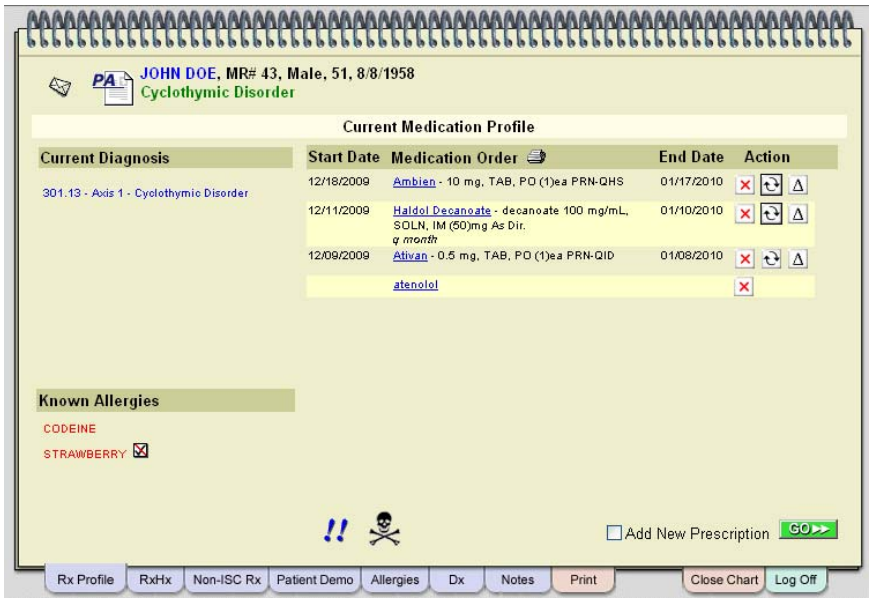


9. Select appropriate output. 

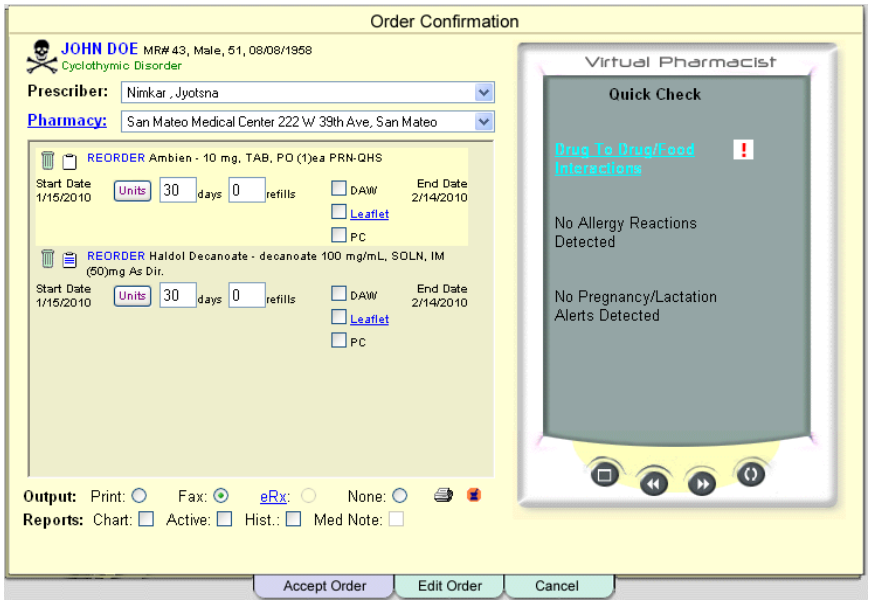
Click Accept Order. 

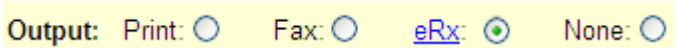
To Refill Rx

1. Click on the Reorder action button(s)  for the desired medication(s).



2. Click Go. 
3. Ensure pharmacy is correct.
4. Change # of refills / quantities / comments / etc. as needed.



5. Select appropriate Output. 

6. Click Accept Order. 

Rx Cheat Sheet Guide

Desired Rx	InfoScriber Input
Artane	trihexyphenidyl
Atarax	hydroxyzine
Compazine	prochlorperazine
Desyrel	trazodone
Dexedrine	Dexedrine Spansule
Elavil	amitriptyline
Etrafon	amitriptyline-perphenazine
Lactulose	strength - 10 g/15 ml syr
Luvox	fluvoxamine
Maalox	Maalox Regular Strength
Metamucil	3.4 g/11 g pwdr
Milk of Magnesia	8% Susp, PO (that's the common strength used)
Multivitamin	multivitamin -> Multiple Vitamins, tab
Multivitamin	Multivitamin-Minerals -> Therapeutic Multiple Vitamins with Minerals tab
Noctec	chloral hydrate
Prolixin	fluphenazine
Seroquel IR	Seroquel
Serzone	nefazodone
Sinequan	doxepin
Stelazine	trifluoperazine
Thorazine	chlorpromazine
Triavil	amitriptyline - perphenazine
Venlafaxin	venlafaxine, tab or ERT
Vitamin E	vitamin E -> 400 IU cap