



Annual and Update Assessments

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Annual and Update Assessments

In this lesson you will learn when an Annual Assessment and an Update Assessment are appropriate for a youths and adults, and you will examine the details of the information needed in these assessments.

NOTE: Since the annual and update assessments are very similar to the admission assessments, there are no hands-on exercises or Concept Reviews for this lesson.

Lesson Objectives

- Understand the Annual / Update Assessment window for both Adult and Youth
- Understand how to create both an annual and update assessment for a client

LESSON SCENARIO

Susan Sunshine has been a client for one year. At her next appointment, her clinician re-evaluates Susan and documents changes in the Annual/Update Assessment window. Susan's clinician can use this window for both required annual assessments and also to create an update assessment at any point during Susan's treatment.

AVPMCONV (LIVE) - SUNFLOWER,SUSAN (000930131)/ADULT Annual / Update Assessment

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SUNFLOWER,SUSAN (000930131) Episode: 3 Date Of Birth: 07/13/1960; Sex: Female

Identifying Information Annual Updates Risk Assessment Medication History (OPTIONAL) Clinical Formulation Finalize

Assessment Information CSI Information

Assessment Date: 08/31/2010 T Y

Assessment Type: Annual Update

Client Age: 25

Source of Information:

<input checked="" type="checkbox"/> Client Interview	<input type="checkbox"/> Family	<input type="checkbox"/> ICI	<input type="checkbox"/> Previous Records
<input type="checkbox"/> Transfer Note	<input type="checkbox"/> SMMC	<input type="checkbox"/> Mills-Peninsula	<input type="checkbox"/> Fremont Hospital
<input type="checkbox"/> Sequoia Hospital	<input type="checkbox"/> PES / 3A-B	<input type="checkbox"/> HSA / Social Services	<input type="checkbox"/> Probation / Parole
<input type="checkbox"/> PCP / Health Care	<input type="checkbox"/> Other		

Other: _____

Document changes in client demographic information in the UPDATE CLIENT DATA option

Document changes in client's collateral contacts in the CLIENT RELATIONSHIPS option

UNDERSTANDING ADULT ANNUAL / UPDATE ASSESSMENT

Annual assessments are required to ensure that changes in a client's symptoms, behaviors, diagnosis, development of additional strengths, and intervening disclosures, crises, and hospitalizations are documented. Additionally, the Annual/Update Assessment form provides the periodic reporting elements required by the California Department of Mental Health (DMH) for statistical purposes.

You use Update Assessments to provide new or additional information, at any time, to the client's assessment.

Depending on the assessment type, different pieces of the assessment are required for the complete annual or update assessment as follows:

Assessment Type	Pieces required for a complete assessment
Annual	LOCUS, BHRS Diagnosis, and if indicated on page 2 of the Annual Updates tab, Substance Use Assessment. Each of these must have been completed within the last 30 days.
Update	The ADULT Annual / Update Assessment window is all that is required.
Special Assessment	Only for clients returning from a contract agency or within 1 year of a discharge from all BHRS episodes. (See the Admission Assessments lesson for details.)

NOTE: For child/youth, see CHILD/YOUTH Annual/Update Assessment later in this lesson.

WHO CAN PERFORM THIS FUNCTION?

Only Clinical staff working directly with the client can perform an assessment.

MENU PATH

Avatar CWS→Assessments→ADULT Annual / Update Assessment

Avatar CWS→Assessments→ADULT Special Assessment

IDENTIFYING INFORMATION TAB PAGE 1 (ASSESSMENT INFORMATION)

Begin to document client identifying information on this page.

A

B

C

Field	Description
A) Assessment Type	<p>Annual: Yearly assessment that is due at client’s anniversary date.</p> <p>Update: Can be performed at any point between annual assessments if client’s circumstances have changed.</p>
B) Client Age	Manually enter the client’s age in this field.
C) Other	If Other is checked in the Source of Information field, this field becomes required.

IDENTIFYING INFORMATION TAB PAGE 2 (CSI INFORMATION)

All fields on this page are required. Document the client’s education, employment status, living arrangement, and conservatorship/court status on this page.

ANNUAL UPDATES TAB PAGE 1 (ANNUAL UPDATES)

If the Admission Assessment was done in the same episode as the Annual Assessment, Client Strengths/Assets/Positive Coping Skills will automatically populate from the Admission Assessment. Always verify the information copied over from another assessment is accurate.

Update any client information that has changed since the last Annual Assessment or Admission Assessment. All fields on this page are required.

A —

Field	Description
A) Client Strengths/Assets/ Positive Coping Skills	This field autofills with information from the Admission Assessment if the Annual Assessment is being created for the same episode.

ANNUAL UPDATES TAB PAGE 2 (SUBSTANCE USE INFORMATION)

Update any client information that has changed since the last Annual Assessment or Admission Assessment. All fields on this page are required.

Field	Description
A) Substance Use Issues Impacting Client	If you check any of the boxes as shown in the previous picture, the Substance Use Assessment becomes required on the Finalize tab. If you check None, the Substance Use Assessment is not necessary on the Finalize tab.
B) Changes in Client's Substance Use Status	If you select Yes, the Substance Use Assessment becomes required on the Finalize tab.

ANNUAL UPDATES TAB PAGE 3 (TRAUMA INFORMATION)

Trauma details are documented on this page. All fields are required, and information from the Admission Assessment (if in the same episode) automatically populates to the Trauma History and Trauma Details fields. Always verify the information copied to the assessment is accurate.

RISK ASSESSMENT TAB

Use this tab to assess the client's current and past risk of harm and current and past violence issues.

MEDICATION HISTORY (OPTIONAL) TAB

The information in this table autofills from the Admission Assessment. For a detailed explanation of how to add, edit, or delete information in a Multiple Entry Table, see Lesson 6 in the *Introduction to Avatar* manual.

AVPMCONV (LIVE) - LILAC, LUCY (000930129)/ADULT Annual / Update Assessment

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LILAC, LUCY (000930129) Episode: 1 Date Of Birth: 07/13/1955; Sex: Female

Identifying Information Annual Updates Risk Assessment Medication History (OPTIONAL) Clinical Formulation Finalize

Medication History (Prescription and OTC by Client Report)

Medication Name	Dosage / Frequency	Currently Prescribed?	Date of Initial Prescription	Prescribing M.D.	Purpose of Medication	Me
celexa	20 mg	Yes	7/2/10	tsai	depression	Co
klonopin	0.5 mg	Yes	7/2/10	Dr. Smith	anxiety	Co

Add New Item Edit Selected Item Delete Selected Item

Medication Name: klonopin
Dosage / Frequency: 0.5 mg
Currently Prescribed? Yes No
Date of Initial Prescription: 7/2/10
Prescribing M.D.: Dr. Smith

Purpose of Medication: anxiety
Medication Compliance: Compliant
Response / Adverse Reaction / Side Effects / Allergy: none
Estimated Refill Need: 3 mo

CLINICAL FORMULATION TAB

Use this tab to document the client's impairments and to document your annual clinical formulation.

FINALIZE TAB

Use this tab to submit the information as Draft or Final. If you are an intern and need a manager's 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.

Date/clinician name in the assessment dropdown lists on this page are available from assessments completed in the last 30 days only. If a clinician did not previously complete an initial assessment, the other parts of the Admission Assessment Bundle (Substance Use Assessment, LOCUS Assessment, and Diagnosis Assessment) need to be completed and finalized before the assessment can be submitted as final.



IMPORTANT

If you know you have submitted all related assessments as final within the last 60 days but you don't see them in the dropdowns on this tab, save this window as a draft and re-open the ADULT Annual / Update window. This refreshes the content in the dropdown fields.

AVPMCONV (LIVE) - LILAC,LUCY (000930129)/ADULT Annual / Update Assessment

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Page 1 of 1

LILAC,LUCY (000930129) Episode: 1 Date Of Birth: 07/13/1955; Sex: Female

Identifying Information Annual Updates Risk Assessment Medication History (OPTIONAL) Clinical Formulation Finalize

Specify ASSESSMENT TOOLS that belong to THIS ASSESSMENT (Must be completed before finalizing)

SUBSTANCE USE SCREENING for this assessment
Aug 27 2010 -TRAIN TRAINING6

DIAGNOSIS for this assessment
Aug 05 2010 -TRAIN TRAINING6

LOCUS Rating for this assessment
Aug 27 2010 -TRAIN TRAINING6

Send To

Send To Outgoing Comments

Draft/Pending Approval/Final
 Draft Final
 Pending Approval

CHILD/YOUTH ANNUAL / UPDATE ASSESSMENT

Annual assessments are required to ensure that changes in a client's symptoms, behaviors, diagnosis, development of additional strengths, and intervening disclosures, crises, and hospitalizations are documented. Additionally, the Annual/Update Assessment window provides the periodic reporting elements required by the California Department of Mental Health (DMH) for statistical purposes.

You use Update Assessments to provide new or additional information, at any time, to the client's assessment.

NOTE: For adult, see ADULT Annual/Update Assessment.

WHO CAN PERFORM THIS FUNCTION?

Only Clinical staff working directly with the client can perform an assessment.

MENU PATH

Avatar CWS→Assessments→CHILD/YOUTH Annual / Update Assessment

IDENTIFYING INFORMATION TAB PAGE 1 (IDENTIFYING INFORMATION)

Document basic identifying information here.

AVMPCONV (LIVE) - GERANIUM, GEORGE (000930126)/CHILD / YOUTH Annual / Update Assessment

Page 1 of 2

GERANIUM, GEORGE (000930126) Episode: 3 Date Of Birth: 07/13/1966; Sex: Male

Identifying Information Annual Updates Risk Assessment Medication History Clinical Formulation / Summary Finalize

Identifying Information CSI Data

Assessment Date: 08/06/2010

Assessment Type: Annual Update

Guardian (last, first middle name): GARDEN, FRANK

Guardian Contact Information: 650-555-1212

Current District / School Placement: DALY CITY

Current Grade Level: 10

Child's/Youth's Age: 16

Source of Information (check all that apply):

- School
- Referral Packet
- Parents/Guardian/Caretaker
- Family/Relative
- Child
- Primary Care Physician
- Probation
- Social Services
- PES
- Other

Other: _____

Document any changes in client's demographic information in the UPDATE CLIENT DATA option

Document any changes to client's collateral contact information in the CLIENT RELATIONSHIPS option

IDENTIFYING INFORMATION TAB PAGE 2 (CSI DATA)

All fields on this page are required. The information on this page is for state tracking. You should complete all fields on this page. Document the client's education, employment status, living arrangement, and conservatorship/court status on this page.

ANNUAL UPDATES TAB PAGE 1 (ANNUAL UPDATES)

All fields on this page are required. Document any updates to Psychosocial History, Psychiatric and Medical History, and Child/Youth and Family Strengths and Assets on this page.

NOTE: I.E.P. fields are included in reports to school districts and are available to other locations outside of San Mateo BHRS.

ANNUAL UPDATES TAB PAGE 2 (SUBSTANCE USE INFORMATION)

Use this page to indicate known substance use issues and to indicate changes in substance use since the last assessment.

AVPMCONV (LIVE) - GERANIUM, GEORGE (000930126)/CHILD / YOUTH Annual / Update Assessment

Page 2 of 3

GERANIUM, GEORGE (000930126) Episode: 3 Date Of Birth: 07/13/1966; Sex: Male

Identifying Information | **Annual Updates** | Risk Assessment | Medication History | Clinical Formulation / Summary | Finalize

Annual Updates | **Substance Use Information** | Trauma Information

A SUBSTANCE USE Issues Known to Impact Client

Current Substance Abuse
 Use Impacts Functioning/Presenting Prob
 Abuse/Misuse of OTC Medications
 Abuse/Misuse of Caffeine
 Current Subs. Use in Parents/Cargivers
 Missed School or Impaired by Use
 None
 Unknown

Past Substance Abuse
 Use of Illicit Drugs
 Abuse/Misuse of Prescription Drugs
 Abuse/Misuse of Nicotine
 Past Subs. Abuse in Parents/Caregivers
 Family is concerned by Alcohol/Drug Use
 Other

Other: _____

Change in Substance Use Status (since last assessment)

Yes
 No
 Unknown

*** Document any changes in SUBSTANCE USE in the SUBSTANCE USE ASSESSMENT ***

Field	Description
A) SUBSTANCE USE Issues Known to Impact Client	<p>If you check any of the boxes as shown in the above picture, the Substance Use Assessment becomes required on the Finalize tab.</p> <p>If you check None, the Substance Use Assessment is not necessary on the Finalize tab.</p>

ANNUAL UPDATES TAB PAGE 3 (TRAUMA INFORMATION)

Document any trauma history and details in the life of the client or the family.

RISK ASSESSMENT TAB

Use this tab to document past and current risk of harm and past and current violence issues.

MEDICATION HISTORY TAB

The information in this table automatically populates from the Admission Assessment. For a detailed explanation of how to add, edit, or delete information on a Multiple Entry Table, see Lesson 6 in the *Introduction to Avatar* manual.

CLINICAL FORMULATION/SUMMARY TAB PAGE 1 (FORMULATION)

Use this page to document the client's impairments, indicate whether it's probable that the client will progress developmentally, and to document your clinical formulation.

CLINICAL FORMULATION/SUMMARY TAB PAGE 2 (SPECIAL EDUCATION)

If you answer Yes in the 26.5 Eligible field, all other fields on this page become required.

FINALIZE TAB

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

Date/clinician name in the assessment drop down lists on this page are available from the last 60 days only. If a clinician has not previously completed an initial assessment, the other parts of the Admission Assessment bundle (Substance Use Assessment, CALOCUS, and Diagnosis Assessment) need to be completed and finalized before the assessment can be submitted as final.



IMPORTANT

If you know you have submitted all related assessments as final within the last 60 days but don't see them in the dropdowns on this tab, save this window as a draft and re-open the CHILD/YOUTH Annual/Update Assessment window. This refreshes the content in the dropdown fields.

In the following picture, the Substance Use Assessment is not required because None was selected on page 2 (Substance Use) of the Annual Updates tab.

AVPMCONV (LIVE) - GERANIUM, GEORGE (000930126)/CHILD / YOUTH Annual / Update Assessment

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GERANIUM, GEORGE (000930126) Episode: 3 Date Of Birth: 07/13/1966; Sex: Male

Identifying Information Annual Updates Risk Assessment Medication History Clinical Formulation / Summary Finalize

Choose the NAME and DATE on each of the ASSESSMENT TOOLS that belong to this assessment

SUBSTANCE USE SCREENING for this assessment

CALOCUS RATING for this assessment

DIAGNOSIS for this assessment

Send To

Send To Outgoing Comments

Draft / Pending Approval / Final

Draft Pending Approval Final