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What is the change? All Avatar progress note writers will start using a new progress note form starting March 1, 2017.
Why are we making this change? The change is required by Medicare and will improve HIPAA compliance.
Who does this change impact? All staff writing progress notes in Avatar.

Finding the New Progress Note
 You can find the new progress note two places in AVATAR: From the client's **"Chart"** (1) and **Search Forms (2)**
The Name of the Progress Note Form is: "Progress Notes with Face to Face"

Use arrows to Tab over to your program, click on your program

Then, Click ADD

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Or "Search Forms" for "Face to Face"

Name	Menu Path
BHRS Outpatient Progress Note	Avatar CWS / Progress Notes
Append Progress Notes	Avatar CWS / Progress Notes
Progress Note Error Correction Request	Avatar CWS / Progress Notes
Progress Notes with Face to Face	Avatar CWS / Progress Notes
Progress Notes Report	Avatar CWS / Reports / Progress Note Reports
Progress Notes Report by Clinician	Avatar CWS / Reports / Progress Note Reports
Day Treatment Progress Notes Report	Avatar CWS / Reports / Progress Note Reports

Progress Note Fields

Choose the Progress Note Entry type:
New Service- for open clients
Independent Note- for closed clients, most fields greyed out, write note in the note field and add the date of the service.

Location:
 When determining which location type to code:
 • First consider where the client is located,
 • Then consider your location.
 Please refer to the Mental Health Documentation Manual (page 20) for Location Code
DO NOT select any location code starting with XX or ZZ

Your program or the program that you are documenting to

To finish a progress note left in draft

Service Time Client Present in Person- This is only the time that client is physically present.

Other Billable Service Time- charting billable progress note, travel, phone contact with client, collateral contacts, other services where the client is not present.

Other Non-Billable Service Time- If the service is a billable service, you may include non billable time and do not need to write a separate progress note: e.g. CPS reporting, group prep, listening to voicemail. If the entire service is 55 leave blank.

Notes Field

PROGRESS NOTES DESCRIBE: The BEHAVIOR and GOAL ADDRESSED. Include the observations, the client’s self-report, and report from others. Document the reports made by others involved in the care; state a report was offered by a parent, or state that the client reported. **INTERVENTIONS and PURPOSE.** Describe how you addressed a client’s need with standard of care methods and Include how the intervention supports client. For example, “a safety plan was developed to stabilize the crisis.”

Describe the client’s **RESPONSE** to the intervention or the outcome or result of the service. **PLAN,** The Plan addresses any immediate needs and next steps towards goals that can be addressed before the next session or during the next session.

Use a “System Template” by right clicking in the Note Field.

Disclosure w/o Consent/Not Treatment

Family or Significant Other

Other/Name of Family Member or Significant Other

Mother

Reason for Disclosure w/o Consent/Not Treatment

Other Reason

Reason for Restricting Release of this Note

New features were added to make it easier to indicate if a progress note should be restricted from release or if a disclosure was made without client consent. This feature puts us in compliance with HIPAA and California Confidentiality Law.

Who did you Disclose to W/O Consent/Not Treatment To

- CPS
- APS
- Police/law enforcement
- DMV
- Family or significant other
- Other
- For other and Family Member State Name of Person

Reason for Disclosure W/O Consent/Not Treatment

- Abuse reporting
- Current risk of harm to self
- Current threat of harm to others/duty to warn/protect
- Death reporting
- Gravely Disabled
- Health concern/ Mandated report
- Lapses of consciousness
- Urgent safety/crisis situation
- Welfare check
- Other
- For other reason _____

Reason for Restricting Release of this Note

- HIV status
- Family member/significant support person/others shared confidential information but requested not to share with client.
- Sharing with client would be detrimental/might result in serious risk of harm to client or others.
- Youth client's request to restrict-sexual history (not abuse),
- Youth client's request to restrict -AOD use/treatment.
- Youth client's request to restrict- HIV.
- Youth client's request to restrict -private/personal information.

Documenting Language is now required. This is a MediCal requirement.

Most will check Yes for service was in English.

Language Information for Contact

Was this contact in English?

Yes No

Language: French

Other Language: _____

Language Services Offered?

Yes-Accepted No

Yes-Declined Clinician/Staff Provided

Interpreter Agency or Interpreter Name

Mr Interpreter

Draft/Final

Draft Final

If the service was **not** in English, you will be asked to complete additional questions. These fields will allow us to demonstrate we are meeting the client's language needs.

Watch the video to learn how to use the new progress note at <http://cdn.smchealth.org/FacetofacePN12.31.16v5.mp4>