



AVATAR

**ASSESSMENT &
DISCHARGE/TRANSFER**

REFERENCE GUIDE



IMPORTANT

The links below provide additional information related to Avatar and Assessments:

1. Basic Documentation Training/BHRS Documentation Manual: For more about Assessments; Diagnosis; Medical Necessity; LOCUS/CALOCUS; Timelines; Assessment Location and Service Charge Codes and Progress Notes
<http://smchealth.org/sites/default/files/docs/BHS/QM/BHRSDocManual.pdf>

2. Online Training:

Introduction to the Avatar Electronic Medical Record
Assessments, Discharges & Transfers for Mental Health
Avatar Progress Notes for BHRS
Avatar Client Treatment & Recovery Plan for BHRS
www.smchealth.org/onlinetraining

3. Avatar CWS Manuals for Clinical Users and Avatar PM Manuals for Administrative Users:

Includes Update Client Data; Client Relationships; Client Alerts and Urgent Care Plan
<http://smchealth.org/avatar>

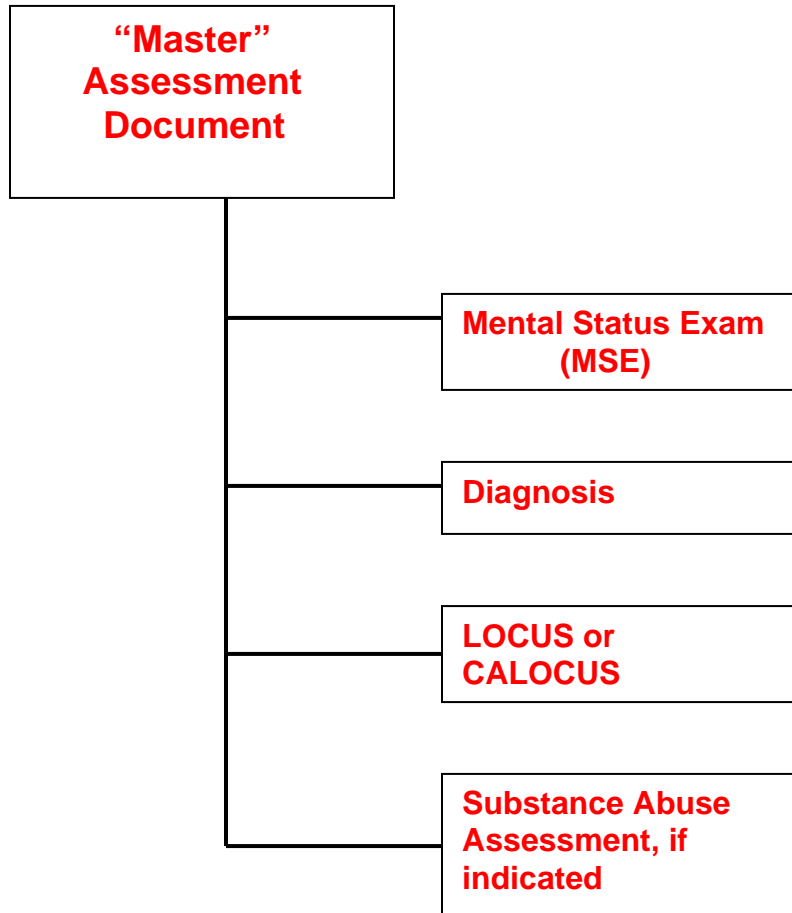


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Section 1: The Complete Assessment



Each assessment document that is connected to the “Master Assessment” must be completed and finalized (including obtaining a co-signature(s) from your supervisor) **before** the “Master Assessment” can be finalized.

The **complete** Assessment which includes the “Master” and up to 4 companion documents (as shown) are due by 60 days of the **Admission Date**.



Section 2: Types of Assessment and Timelines

A. Types of Assessments:

Assessments are “bundled” by **Age Group** and **Timeframe** (when they are due). The “**Master Assessment**” document has **required fields which are the same for each type**; however the **Child/Youth** and **Pre-to-Three** include much more detail in certain areas.

- The “**Master Assessment**” has 3 versions:
1.) Pre to Three; 2.) Child/Youth; 3.) Adult
- The **Annual/Update Assessment** has 2 versions:
1.) Child/Youth; 2.) Adult
- There is a **Special Assessment** that contract agencies complete if they are a *secondary* open program treating the client.
- There is also a **Physicians Initial Assessment (PIN)** that the Physician/NP completes. The PIN may be part of the assessment that the physician/NP completes or it can be a stand alone document if the client is receiving *only* medication support services.
- Usually, the client requires only **one** Admission Assessment. If a client is open to more than one program at the same time, only **one program** is required to perform the Admission Assessment.
- For clients receiving medication support services, the MD will either:
Complete the “Master Admission Assessment” OR
Copy the “Master” Admission Assessment and *append (add to) it* OR
Complete a separate Physicians Initial Assessment (PIN).
- **Assessment by “Assessing Team”**
For some programs, there are *specialized assessment teams* that complete the Admission Assessment; otherwise, it is the primary clinician's responsibility.
- **Assessment by “Receiving Team”**
If a client has already had an Admission Assessment completed and then is referred or transferred to another treatment program/team, the completed Admission Assessment *may* be accepted by the receiving program/team. The **clinician at the receiving program/team must review the assessment and then write a progress note to state “the assessment has been reviewed.”** Any **additional** or **amended information** must be completed on an **Avatar Update Assessment document** by a *clinical* staff member of the receiving program/team.

Section 3 demonstrates parts of the Adult “Master Assessment” and the companion assessment forms that make up the “Adult Admission Assessment Bundle”. The “**Master Assessments**” **function and flow the same**, however, there are additional fields in the Pre to Three and Child/Youth “Master Assessments” that are not present on the Adult Master Assessment document.



B. Assessment Timelines:

Admission Assessment Timelines:

Since the admission assessment may take several sessions to complete, ***all components must be completed by 60 days of the admission date.*** If documents are in “Draft” (to be completed), or “Pending” (awaiting a co-signature), you will see an item on your “To Do” list as a reminder to have the assessment and/or component(s) completed ***before*** the due date.

Check with your supervisor regarding how much time/number of visits your program calculates for completing all assessment documents. Some programs have a per visit timeframe, some supervisors limit to a certain number of hours for completing assessment interviewing and documentation. Always gauge your time by observing the client’s and/or parent/guardian’s ability to sit, understand and be patient with the assessment process.

Annual Assessment Timelines:

The *Annual Assessment* is required to validate and document any status quo or change in the client’s presentation of symptoms, behaviors and diagnoses, as well as the development of additional strengths.

The documents that are completed by the ***Care Coordinator*** and ***required*** for the ***Annual Assessment*** are the ***Annual/Update Assessment*** document, the ***Diagnosis*** and the ***LOCUS/CALOCUS***.

The Annual Assessment must be *done at least annually*, and is ***due on/before the anniversary date.*** This means the Annual can be completed any time during the ***six week window period prior to the anniversary date*** (but not before). If a client is open to 2 programs, only ***ONE*** program completes the Annual Assessment.

Assessment Updates:

Updates to the assessment can be done at any time and do not change the anniversary due date.

Talk with your program supervisor to determine your program's assessment process. Please refer to Attachment 1, Page 29, for more information about ***Anniversary Dates.***

Always write a *progress note* for your time under the service charge code of assessment.



Section 3: Who Can Perform Assessment Functions

A. Assessment Scope of Practice

Any clinical staff member who is assessing the client can perform assessment functions.

A mental health case manager with a BA in Psychology can complete an assessment but can NOT complete the MSE, Diagnosis, and Clinical Formulation. **Only a “Licensed Practitioner of the Healing Arts” (LPHA) can complete the MSE, Diagnosis and the Clinical Formulation.**

LPHA staff include:

- MD/NP; and Licensed/Register/Waivered - Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, and Registered Nurse with Masters in Psych.
- Trainees in any of these categories may provide the Diagnosis; conduct a MSE & Clinical Formulation *with* a co-signature.

Annual Assessments are completed by the **current** “Care Coordinator”.

B. Co-Signature Process

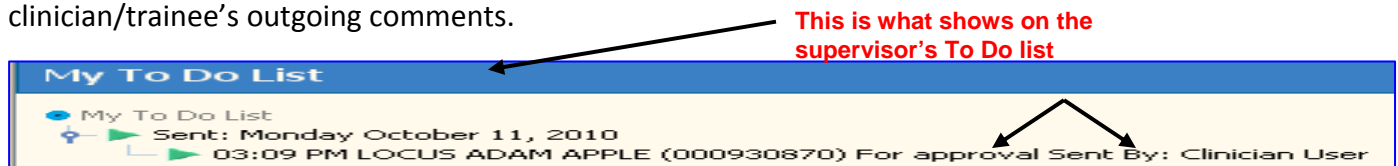
Any assessment document sent for a co-signature is still a “Draft” and can be edited.

Once any assessment document is completed, the clinician selects the supervisor in the “Send To” field (A) and writes a brief outgoing comment to the supervisor (B).

The clinician selects “Pending Approval” (C) and submits the assessment document.



The supervisor will receive a “To-Do” list item for **each** document to be approved/co-signed per the clinician/trainee’s outgoing comments.



For example, the MSE, LOCUS, Diagnosis, Substance Abuse Assessment, if indicated, and the Main Assessment will **each** have a separate “To-Do” item sent to the supervisor for approval/co-signature. The supervisor reviews **each** document and approves it or does not approve.

If the supervisor selects “Yes,” (approves), this makes that specific assessment document **FINAL**. The supervisor may notify the clinician the document was approved.

If the supervisor selects “No,” (disapprove), that assessment document reverts back to “Draft” and Avatar sends the “Draft” document as a “To-Do” item on the clinician/trainee’s “To-Do” list.

The clinician would then review the comments from the supervisor and update the “Draft” document.

The clinician then resends the revised document back to the supervisor for approval.

The supervisor once again reviews the revisions, and once approved, that document becomes finalized.



Sending the “Master Assessment” for Co-Signature:

Once each supporting assessment document has been approved by the supervisor and is FINAL, the clinician opens the Tab “FINALIZE” of the “Master Assessment” document.

Before sending to the supervisor for approval and co-signature, each of the “FINAL” supporting assessment documents must get attached to the “Master Assessment”.

To attach, select each assessment document in red, click on the drop down arrow and select the correct “Final” document. It will populate the box and show the date and clinician. (If the client is new, there should only be the document that the clinician has finalized). If there has been a previous assessment document, select the current appropriate document for *this* assessment.

The screenshot shows the 'Finalize' tab of the Avatar software. The 'Co-Occurring Issues' sub-tab is circled in red. Below the tabs, there are sections for 'Specify ASSESSMENT TOOLS' and 'Indicate other persons contributing to this assessment'. The assessment tools section includes dropdown menus for 'MENTAL STATUS EXAM', 'SUBSTANCE USE SCREENING', 'LOCUS Rating', and 'DIAGNOSIS', all showing 'Aug 25 2010 -JILL MURPHY'. The 'Indicate other persons contributing to this assessment' section has two search boxes with 'Process Search' buttons. A red arrow points to the 'Drop Down' label, and another red arrow points to the search box.

You can indicate other staff contributions to the “Master Assessment” by entering their last name, click process search, then *select* so that clinician’s name populates in the gray box.

Send the “Master Assessment” as “Pending” approval to the supervisor. A “To Do” item is sent to the supervisor to approve/co-sign the “Master Assessment”. The supervisor reviews the “Master Assessment” and clicks “Yes” to approve, or “No” to disapprove and which reverts the “Master Assessment” back to “Draft” and as a “To Do” for the clinician to make revisions. The clinician sends the revised “Master Assessment” back for supervisor approval so it can be FINAL. Once the supervisor approves the “Master Assessment” the process is completed.

IMPORTANT

You must wait for the supporting documents to be approved/co-signed by your supervisor and *then* attach to the “Master”.

You cannot submit the “Master Assessment” *without* having the finalized supporting assessment documents attached.

If *NONE* is answered on the Co-Occurring tab (circled in red), the Substance Abuse Assessment is not required and the drop down box for Substance Use Screening will be grayed out.



Section 4: The Assessment “Bundle”

Assessment documents are “bundled” together so that all the Assessment forms (or Avatar windows) related to the Assessment process are linked and open one after the other.

You will select the correct “Admission Bundle” that represents the age group of clients who receive services at your program.

You will always need to select the *episode* you are writing the assessment for and may need to select from the *pre-display screen* of other assessments within the episode if you are *adding a new assessment*, or *editing* an assessment. This is true for the “Master Assessment” document or any of the components.

You meet with the client, complete the “Master” assessment document and all assessment components, send for co signature if needed, FINALIZE.

MENU PATH

Avatar CWS→ Assessments→ **Age Appropriate Admission Bundle**

There are five pieces that go together to make up a complete assessment:

- ADULT or CHILD/YOUTH **Master Admission Assessment** Document
- **Mental Status Exam** (also used for the Physician Initial Assessment or PIN) or Mental Status/Behavioral Observation (YOUTH)
- **BHRS Diagnosis** (5 Axis DSMIV)
- **LOCUS** (Level of Care Utilization System) or CALOCUS (Child/Adolescent Level of care Utilization System)
- **Substance Use Assessment** (*required* only if the answers to substance abuse questions on the *Co-occurring* tab of the “master assessment” document indicate)
- **Progress Note**


The Admission Assessment “Bundle” *may* also include:

The Admission Assessment may include the use of testing procedures which require prior authorization and completion by the appropriate clinician consistent with his/her scope of practice.



IMPORTANT

You must *complete* and *submit* each of the required assessment documents as FINAL. If any one document is not submitted as final, save the assessment as a draft, complete the draft document and then return to the “Master Assessment” to submit it as final. The incomplete document will show as a “To Do” item for the clinician as a reminder to finalize it.

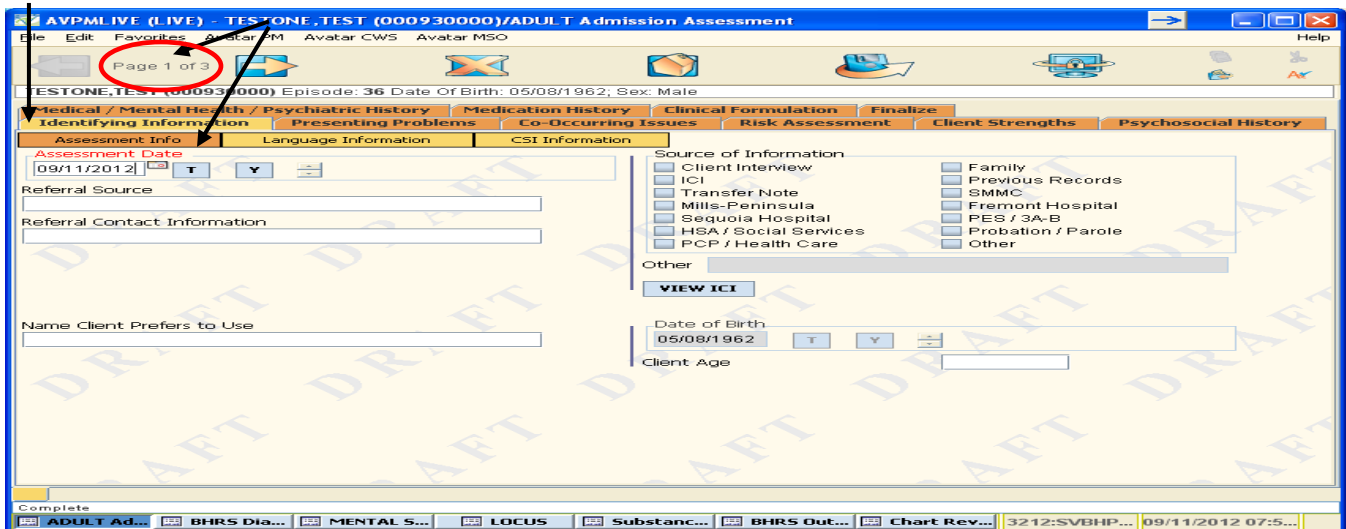
* **TIP!** Many of the assessment forms include a **Help** in the form of a light bulb  for the field the light bulb is attached to. To view this *Help Message*, hover over the light bulb with your mouse or click on it. The light bulb information will truly “enlighten you”!



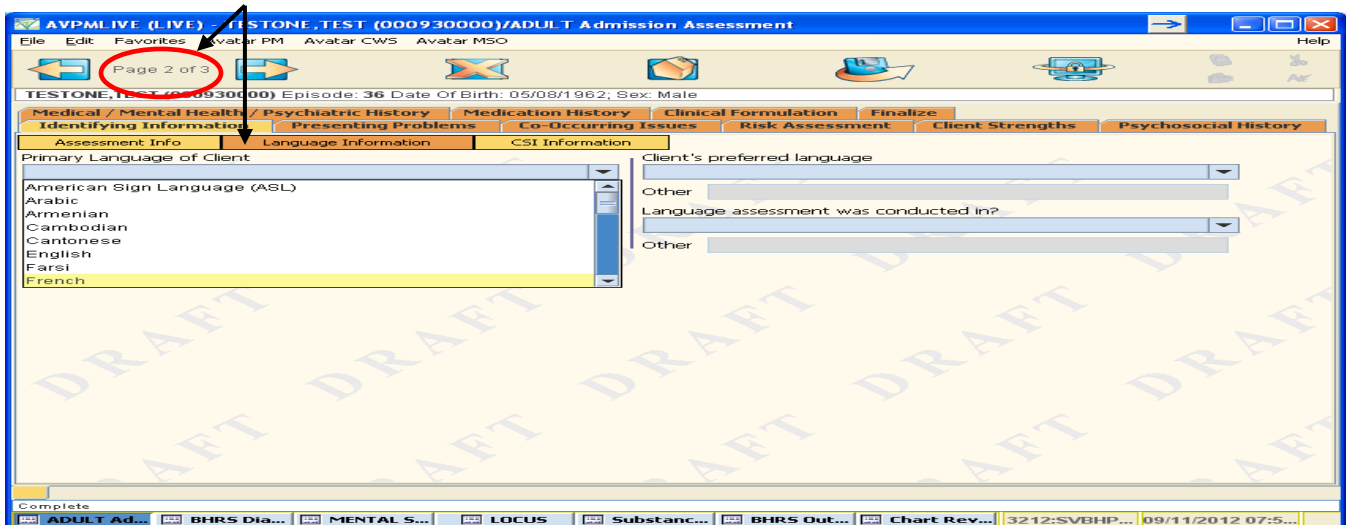
A. Master Assessment Document:

Current "Master Assessment" documents include multiple tabs. Be sure to complete *all* pages within each tab. To illustrate how to complete the assessment documents some of the assessment tabs and functions will be demonstrated. Each Tab has a name for example below, the Tab **Identifying Information**. Some *Tabs* have more than one page, for example the *Identifying Information* tab below shows there are 3 pages (circled in red). Click on each page within each tab and complete the appropriate fields.

Assessment Information Page- Includes the Assessment Date, Referral Information, Sources of Assessment Information, the Name the Client Prefers to Use, Client Date of Birth and Age



Language Information Page- Includes the Client's Primary and Preferred Language and Language Assessment was conducted in, if applicable.

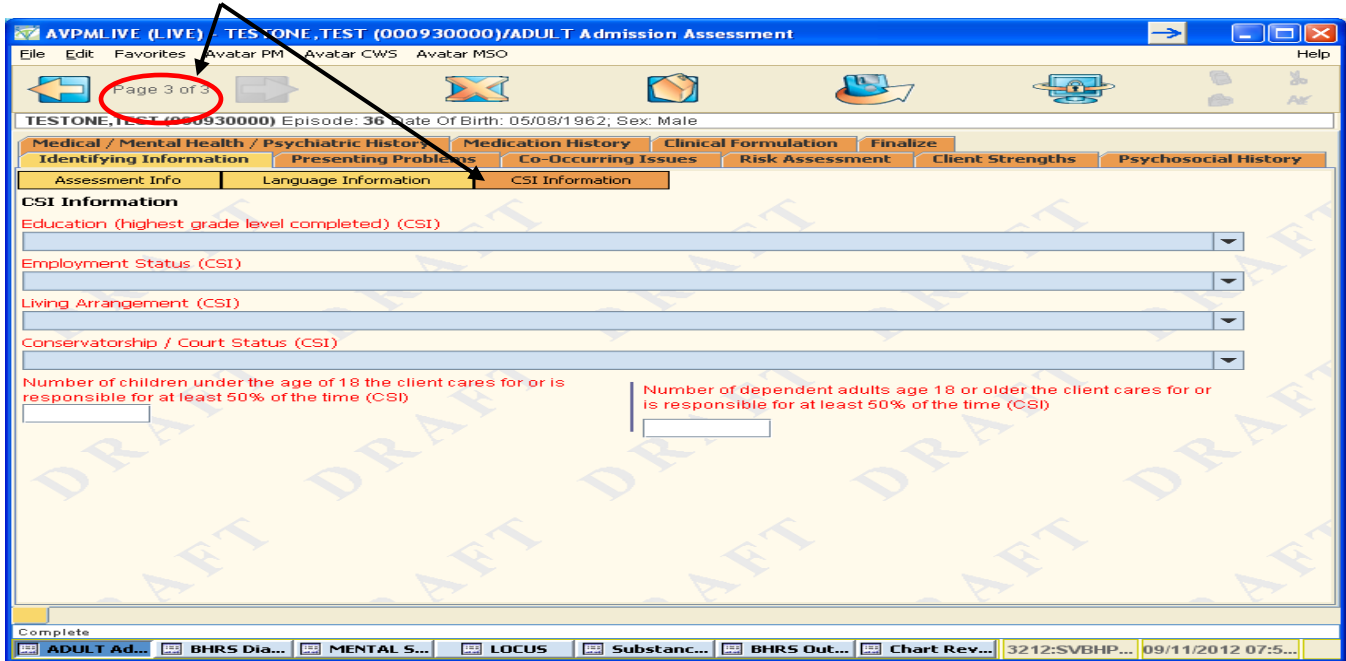




Tab: California Statistical Information Page

There are many required fields to complete for California Statistics Information. These are *Red/Required fields* regarding the client’s education level, employment status, living arrangements, and court/legal status and dependent responsibility.

* The clinician should also check contact information to make sure that it is up-to-date and stays current.



After all tabs and pages of the assessment are completed, the *Clinical Formulation* provides the summary and/or conclusion of the assessment process:

The Clinical Formulation is the clinician's interpretation of the assessment data and interactions with the client to formulate the rationale for providing medically necessary services. The clinical formulation also tells why it makes sense to provide the treatment you have selected.

Factors that inform the clinical formulation and that must be considered when creating a client plan include: the diagnosis, cultural factors including the role of religion and spirituality as appropriate, co-occurring issues, medical necessity, resources, strengths, and client’s social support system.

The Clinical Formulation is a summary document that should be hopeful, positive and recovery oriented. These are the statements that justify medical necessity; that as a result of the primary diagnosis the client is impaired in the functional impairments of *school/work; ability to maintain placement; social relationships; symptom management and daily living skills. Describe in a brief narrative synopsis of assessment data.*



Tab Finalize:

You must link the other assessment components to this "Master" in order to FINALIZE the Assessment! This "Master" requires the FINAL Diagnosis, the FINAL LOCUS/CALOCUS, the FINAL Mental Status Exam, and the FINAL Substance Use Assessment, if applicable.

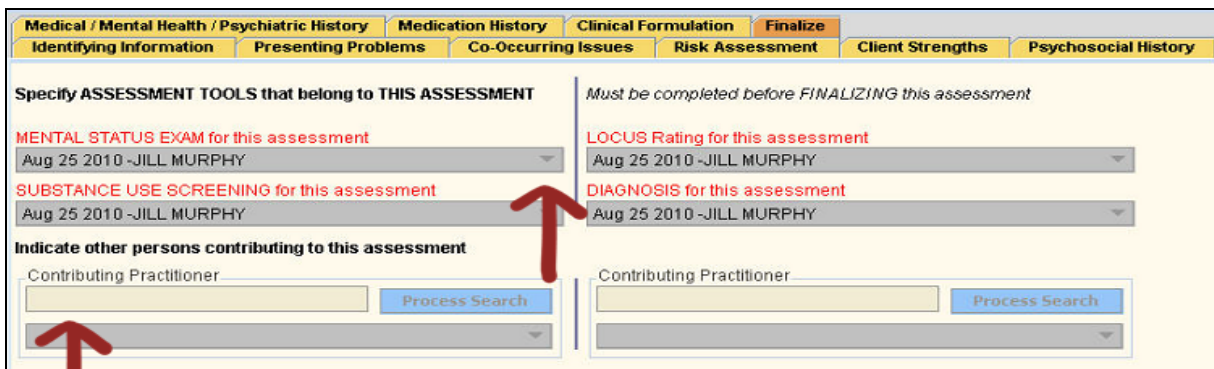
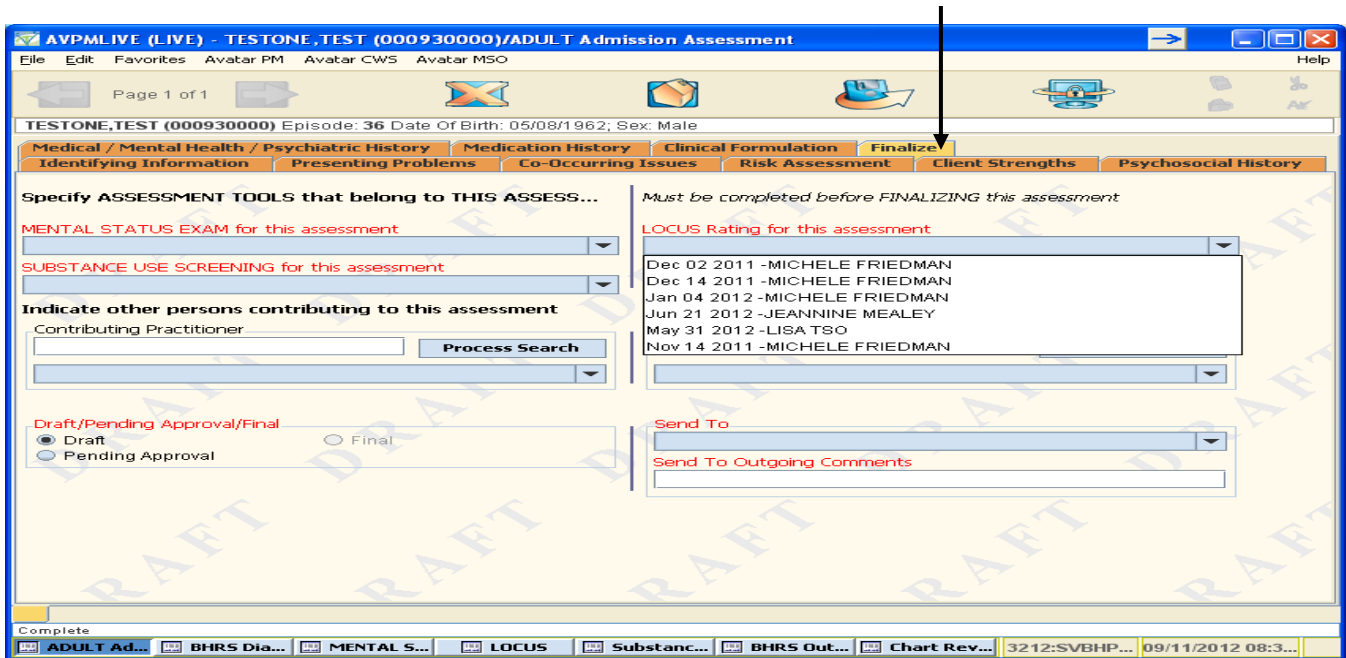
Click on the dropdown arrow of the specific assessment.

Select the correct FINAL document.

Once selected, that FINAL document will show in the grey box with the date and by whom.

Then the "Master" must be FINALIZED. You must enter the Status of the "Master" as FINAL, Draft or Pending (if pending, you must send to your supervisor by selecting their name from the drop down "Send To" and provide an entry in the field, Send to Outgoing Comments).

You can indicate any other staff that contributed to the master assessment by entering their last name, click process search, then select the clinician so their name appears in the grey box.





B. BHRS Diagnosis:

The BHRS Diagnosis is the next document in the bundle that must be completed. A pre-display screen may appear for you to select to ADD, Edit, or Delete a Diagnosis. A 5-Axis diagnosis is required. If a Diagnosis was previously completed in Avatar, the last diagnosis on file for each Axis will automatically appear in the field.

Review the information from a previous diagnosis to determine if it is still accurate and edit the diagnosis accordingly.

Only an LPHA or therapist intern can diagnose.

LPHA staff include:

- MD/NP; and Licensed/Register/Waivered - Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, and Registered Nurse with Masters in Psych.
- Trainees in any of these categories may provide the Diagnosis *with* a co-signature.

Menu Path: Avatar CWS → Assessments → BHRS Diagnosis

The BHRS Diagnosis document has 3 tabs.

Tab 1, Diagnosis includes 4 pages. The DSM headings in blue are a *hyperlink* to the **online DSM IV**.

Tab 1 Diagnosis Page 1: Diagnosis Info and CSI

The screenshot displays the Avatar software interface for entering a BHRS Diagnosis. The window title is "AVPMLIVE (LIVE) - TESTONE,TEST (000930000)/BHRS Diagnosis". The interface shows a patient record for TESTONE,TEST (000930000) with fields for Date of Diagnosis, Time of Diagnosis, Type of Diagnosis, Diagnosing Practitioner, and Substance Abuse/Dependence (CSI) data. A blue hyperlink "DSM-IV-TR Online" is visible. A large "DRAFT" watermark is overlaid on the screen. Arrows point from the text above to the "DSM-IV-TR Online" link and the "Diagnosis Info and CSI" tab.



Tab 1 Diagnosis Page 2: Axis I and II Diagnoses and Primary Axis I

AVPM LIVE (LIVE) - TESTONE,TEST (000930000)/BHRS Diagnosis

Page 2 of 4

TESTONE,TEST (000930000) Episode: 36 Date Of Birth: 05/08/1962; Sex: Male

Diagnosis Additional and Provisional Diagnosis Finalize

Diagnosis Info and CSI Axis I and II Axis III Axis IV and V

Axis I - 1
305.20 CANNABIS ABUSE

Axis II - 1
301.9 PERSONALITY DISORDER NOS

Choose Field with Primary Diagnosis
Primary Diagnosis - Must Match Axis I or Axis II

Diagnosis entered here must match Axis I - 1 or Axis II - 1

Personality Features #1
Personality Features #2

Tab 1 Diagnosis Page 3: Axis III General Medical Conditions

AVPM LIVE (LIVE) - TESTONE,TEST (000930000)/BHRS Diagnosis

Page 3 of 4

TESTONE,TEST (000930000) Episode: 36 Date Of Birth: 05/08/1962; Sex: Male

Diagnosis Additional and Provisional Diagnosis Finalize

Diagnosis Info and CSI Axis I and II Axis III Axis IV and V

Axis III - General Medical Conditions

Axis III - General Medical Condition Summary Code (CSI)

- Allergies
- Anemia
- Arterial Sclerotic Disease
- Arthritis
- Asthma
- Birth Defects
- Blind / Visually Impaired
- Cancer
- Carpal Tunnel Syndrome
- Chronic Pain

Axis III - Other

Hyperlink to DSM IV



Tab 1 Diagnosis Page 4: Axis IV and V Psychosocial and Environmental Problems and GAF

Tab 2, Additional and Provisional Diagnosis includes 2 pages

Tab 2, Additional and Provisional Diagnosis Page 1: Additional Diagnoses



Tab 2, Additional and Provisional Diagnosis

Page 2: Provisional Diagnoses

Tab 3, Finalize

SUBMIT

Select Status as Draft or FINAL. If Pending, select supervisor from "Send To" drop down and enter a Comment



C. Mental Status Exam (MSE):

The next document in the age appropriate assessment bundle that you selected is the Mental Status Exam (MSE).

For Child/Adolescent this is called the Mental Status/Behavioral Observation (Youth).


A pre-display screen may appear for you to select to ADD, Edit or Delete a MSE.

The Mental Status Examination (MSE) is an important part of the clinical assessment process in psychiatric practice.

- The Mental Status Exam (MSE) is a structured way of observing and describing a client's current state of mind, under the domains of Risk, General Appearance/Speech, Motor Activity/Mood, Intellect/Affect, Behavior/Flow of Thought, Content of Thought/Hallucinations, Delusions/Sensorium, and Insight and Judgment.
- In Avatar, there are descriptions and help guides to help you complete the MSE.
- All **behaviors** and **symptoms** in the MSE document are rated **only if they are known to exist or were observed over the assessment period**.
- Rate the fields that apply to your client. If an item does **not** apply, you may check the box next to **Within Normal Limits**.
- **Only an LPHA can complete the MSE.**

Menu Path:

For Adult: Avatar CWS→ Assessment→ Mental Status Exam (Adult+ PIN) or as part of Adult Bundle
For Child Youth: Avatar CWS→ Assessment→ Mental Status/Behavioral Observation (Youth) or as part of the Child/Youth Assessment Bundle

*** TIP!** Each page of the MSE includes a **Help** in the form of a light bulb  for the field the light bulb is attached to. To view this *Help Message*, hover over the light bulb with your mouse or click on it.

The Mental Status Exam includes 2 Tabs: Tab 1, Mental Status Exam contains multiple pages and Tab 2 is to FINALIZE the MSE. You will follow the same ratings for all pages. Enter any comments, on the last page of the MSE, and then go to Tab 2, Finalize.



Tab 1, Mental Status Exam

Page 1: Current Concerns of Risk

Tab 1, Mental Status Exam

Page 8: Comments

Tab 2, Finalize

Select Status as Draft or FINAL. If Pending, select supervisor from "Send To" drop down and enter a Comment



D. LOCUS/CALOCUS:

The next document in the bundle is the LOCUS/CALOCUS. The “Level of Care Utilization System” (LOCUS) and the “Child and Adolescent Levels of Care Utilization System” (CALOCUS) are used by BHRS as a treatment planning and utilization management tool.

Scores on the LOCUS/CALOCUS are based on the clinical needs of clients and help ensure that clients receive the types and amount of services that correspond to structure and supports that are needed. There are 6 dimensions to rate the client's needs and functioning. There is a description of the dimension and then a detailed rating scale.

*** Special training is required to perform the CA/LOCUS; once trained anyone can conduct the LOCUS/CALOCUS. If you conduct the LOCUS/CALOCUS on paper, you MUST ENTER into Avatar.**

*** LOCUS/CALOCUS is required annually.**

Menu Path:

For Adult: Avatar CWS→ Assessment→ LOCUS or as part of Adult Bundle

For Child Youth: Avatar CWS→ Assessment→ CALOCUS or as part of the Child/Youth Assessment Bundle

The LOCUS/CALOCUS screen opens for you to select to ADD, Edit or Delete. The LOCUS/CALOCUS has 2 Tabs. Tab 1, Adult Level of Care Utilization System - 6 pages and Tab 2 is to FINALIZE. Each page has an area to rate with the explanation of how to rate the client.

Page 1: Risk of Harm

I. Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as: past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.

FOR DIMENSION RATING SCALE CLICK ON LIGHT BULB

Click on the light bulb or help to open and there are details about the ratings, 1- Minimal through 5-Extreme Risk.


#1 - Risk of Harm

1-Minimal Risk 2-Low risk 3-Moderate Risk 4-Serious risk 5-Extreme Risk

Page 4 of the Adult LOCUS has 2 ratings: Environmental Stressors and Environmental Support. If using the paper version, these ratings are added together, if LOCUS is performed using Avatar, the rating score will be calculated electronically for you (see next page).



Once you have completed the ratings for all 6 Dimensions:

Click the **Calculate Score** button, a report window appears **displaying the score**. You can close the **report** window by using the Red . Then *type* the score in the **Total Score** field. Go to the next Tab, Finalize.

Tab 2, Finalize

Enter the Date, Select Status as Draft, or Final.

If Final, a message appears notifying you that you will not be able to change this LOCUS/CALOCUS if you submit it. Click OK

If Pending, select supervisor from “Send To” drop down and enter a comment in “Outgoing Comment”

Submit 

E. Substance Abuse Assessment, when indicated:

The requirement for performing a Substance Abuse Assessment is prompted by the answers given on the “Master Assessment” document. This means if “**Yes**” is answered for *current use* or *recent history* with *drugs/ alcohol* the prompt is to **screen more thoroughly for co-occurring substance abuse issues**. However, a substance abuse screening can be done at anytime if the clinician determines a need or if requested by the client. You can document the client's drug use history on this page.

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

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

Path: Avatar CWS→ Assessments→ Substance Abuse Assessment

When you select the Substance Abuse Assessment, the screen opens to the Pre-Display for you to select Add, Edit or Delete. The same Substance Abuse Assessment document is used for Adults or Child/Youth

The Substance Abuse Assessment has 3 Tabs. Tab 1, Substance Abuse Assessment – 2 pages



Tab 1, Substance Abuse Assessment Page 1: Assessment Type Then complete Page 2 of Tab 1

Substance Use Assessment | Drug Use History | Finalize

Date Assessed: 09/11/2012 | Assessment Type: Child/Youth Adult

Did Client Supply a Urine Specimen for Tox Screening? Yes No

Date of Tox Screen: [Redacted]
Results of Tox Screen: [Redacted]

Document substances client typically uses on DRUG USE HISTORY tab.

Client's Perception of Substance Use
Clients' perception of substance use field. THIS IS NEW TEXT TO THE ASSESSMENT. I have written enough to wrap to the next line in the field this one needed a little more

Past Attempts to Stop Using and Outcomes
THIS IS A TEST OF CLIENT PAST ATTEMPTS. I have written enough to wrap to the next line in the field this just made it.

Tab 2, Drug Use History

Substance Use Assessment | Drug Use History | Finalize

Drug Use History

Drug Name	Route of Administration	Current Usage Level, Amount, Frequency	Date of Last Use	Stage of Change
Alcohol	Inhalation&Oral&Other	1 gallon	yesterday	5-Maintenance
Amphetamines	Inhalation	twice a month	weekend 2/26/11	2-Contemplation
OTC Medicines	Intranasal (Snorted)			
Other	Intranasal (Snorted)			
Other	Smoked			

Buttons: Add New Item, Edit Selected Item, Delete Selected Item

Drug Name: [Dropdown]
Other Drug: [Text Field]

Route of Administration: Inhalation Intravenous (I.V.) Oral Smoked Intranasal (Snorted) Topical Other

Other Route: [Text Field]

Age of 1st Use: [Text Field]
Current Usage Level, Amount, Frequency: [Text Field]
Highest Usage Level, Amount, Frequency: [Text Field]
Date of Last Use: [Text Field]
Stage of Change: [Dropdown]

Tab 3, Finalize

Substance Use Assessment | Drug Use History | Finalize

Draft/Pending Approval/Final

Draft Pending Approval Final

Send To: [Dropdown]

Select Status as **Draft** or **FINAL**. If **Pending**, select supervisor from "Send To" drop down.





Section 5: Finding the Status of Assessments

A. Documentation at a Glance Report:

The Documentation at a Glance Report will help you to **identify** and **complete documentation that is due or coming due**.

Documentation at a Glance Report:

Menu Path: Avatar CWS → Reports → Documentation Status Reports → Documentation at a Glance

You can request this report by *location*, by *staff*, or by *staff and location*.

- This report provides a *comprehensive view of a clinician's caseload*, total number of clients in the caseload, the client MR#, name, date of birth, address, phone, the client's admit and anniversary date, the name of the care coordinator, the status, date, type and completed by for the treatment plan and assessment, the code/description of the primary diagnosis and the date of last service.
- A notice will appear in **red** in the **Last Service** date column if there has been **no service for more than 90, 120 and 180 days**.
- If an assessment or treatment plan is **past due** it will appear in **red and wrapped in a box** indicating **"attention is needed"**.
- If an assessment or treatment plan is *coming due* it will appear in *green and in a box* indicating *"attention is needed"*.

This Documentation at a Glance Report shows the status of an assessment that is in Draft.

410401 SOUTH COUNTY ADULT						
Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930000 TESTONE,TEST DOB: 5/8/1982 212 W 39 STREET JYO TEST AGAIN SAN MATEO, CA 94401 (P) 650-699-1172 (H) 103-488-4888 (M) 655-1256	05/01 10/6/2011	BANKS,MICHAELA	Draft Plan Type: Initial Status: Draft StartDate: 10/19/2011 Next due date: 4/30/2012	AdultSpecial Assmt Status: Final Date: 12/16/2011 Completed By: JEANNINE MEALEY	007.01 (ICD9) TENSION HEADACHE	2/9/2012
416800 EAST BAYSHORE ADULT						
Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930003 TEST,TESTTWO DOB: 4/30/1989 113 MAIN STREET SAN MATEO, CA 94401	11/01 5/20/2010	ECCLESTON,SARA	Draft Plan Type: Annual Status: Draft StartDate: 1/23/2012 Next due date: 11/1/2012	AdultAnnual Status: Draft Date: 5/11/2010 Completed By: DORRAH BALLON	No Entry	9/23/2011 OVER 90 DAYS

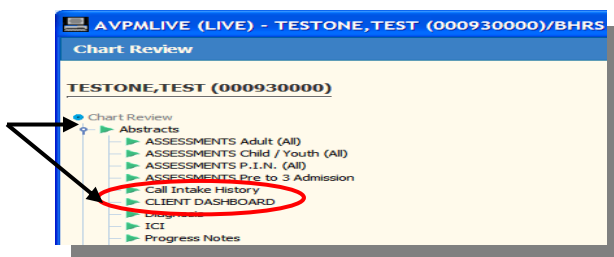


Assessment Status – Shows the *last assessment* for the client.

- Information includes the type of assessment- admission or annual, assessment status- final or draft, date of assessment, and who completed the assessment.
- **The Physician Initial Assessment (PIN)** is included as a valid assessment if it was completed within the window period for the annual assessment update.
- If an assessment is *left in draft* then it will have a **draft indicator in red** and wrapped in a box.
- **Reassessments** are *due by the indicated anniversary date of each calendar year*.
- Shows the LOCUS/CALOCUS information

B. Dashboard Report:

Menu Path: Avatar CWS→ Reports→ Client Dashboard. It is recommended that you request the Client Dashboard from the Chart Review screen.



This Dashboard Report is designed to be viewed “live” in Avatar, as shown below the status of the assessment is in draft.

**SAN MATEO COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES
CLIENT DASHBOARD**

Client Demographic Information
TESTONE.TEST (930000) D.O.B. (5/8/1962)
 Gender: Male SS #: 222-55-9999 Age Today: 50
 Address: 1245 BYE STREET - INFOSCRIBER TEST SAN MATEO, CA 94403
 (h) 650-589-1172 (c) 650-258-3888 (w) 555-1256
 Language: TONGAN AKA 1 : testjoe
 Preferred Language: Unknown / Not Reported AKA 2 : rodney mytest
 Ethnicity: Unknown / Not Reported Living Situation: Homeless, no identifiable residence
 Race: American Indian or Alaska Native, Asian Indian, Black or African American, Cambodian, Guamanian

URGENT CARE PLAN ON FILE

Start Date: 2/15/2012
 CONCERNED ABOUT CLIENT HE FELL 3 DAYS AGO think he s self medicating and is taking too much please observe
Caution: should not drive
 Start Date: 6/2/2012
 The quick brown fox jumped over the lazy sleeping dog.
Caution:

Guarantor Info
 1) NON-RECOVERABLE POW

Emergency Contact Info: (Contact Type: G=Guardian, E=Emergency, K=Next of Kin) [View all Contacts](#)

Name	Type	Relationship / Contact Info:
Bull Mama	G E	Mother (h) 650-550-1212 (w) 650-573-2563 (c) 415-647-1942
Bull PAPA	G E K	Father (h) 415-123-1234 (w) 650-445-2266 (c) 650-455-4587
Bull Lotta	G E K	PCP (h) 415-555-1212
SHEETS - COUNTY PROBATION OFFICER	E	Parole/Probation Officer (w) 650-222-3333 (c) 650-333-2222
LORRIE TESTONE Marla	G K	Daughter (h) 415-555-1212 (w) 408-555-1212 (c) 650-555-1212

Authorization For Use of PHI

Date	Person / Organization
6/2/2012	hello there testing
5/23/2012	ingall bull
5/16/2012	Jeannine
11/3/2011	TESTING123
8/3/2011	MICHELLE TREHAN
8/3/2011	ME
2/7/2011	ingall

Assesmnt Status

Adult Admission Status: Draft
 Date: 6/2/2012
 Completed By: LORRIE SHEETS

Current Medications (information is up to by 24 hours out-of-date. Please check info for up-to-date medication profile) [Allergy Info](#)

Order Date	Refills	Drug / Dose / Prescriber / Pharmacy
6/2/2012	0	Vallium ; - 10 mg, TAB, PO (1)ea BID Prescriber: Cabaj, Robert Pharmacy: Walgreens Drug Store 00063
4/6/2012	0	lithium ; - 300 mg, CAP, PO (1)ea BID Prescriber: Cabaj, Robert Pharmacy: Walgreens Drug Store 00063
1/18/2012	0	Adderall XR ; - 10 mg, ERC, PO (1)ea BID Prescriber: Cabaj, Robert Pharmacy: Walgreens Drug Store 00063

Current Open Episodes / Primary Dx / Tx Plan Status (as of 06/07/2012) [Other Assigned Staff](#) [Dx History](#) [Tx History](#) [Episode Hx](#) [Progress Notes](#) [ICI Notes](#)

EP	Admit	Program	Primary Clinician	Psychiatrist	Dx	Last Service	Tx Plan Status
37	11/10/2011	410405 FAIR OAKS INTERFACE	BULL,INGALL		309.81		Was Due 5/1/2012
36	10/6/2011	410401 SOUTH COUNTY ADULT	BULL,INGALL	SHEETS,LORRIE	305.20	6/2/2012	Draft 4/18/2012 - 5/1/2013
31	3/9/2011	007000 WESTWOOD MANOR	FRIEDMAN,MICHELE		799.9A		No Tx Plan Required
25	11/15/2010	410301 CENTRAL COUNTY ADULT	SHEETS,LORRIE		301.3	2/9/2012	Was Due 5/1/2012

CA/LOCUS Date: 5/31/2012 26.5: Yes Date: 11/06/10
 Score: 7 Closed Date: 6/26/2012
 0-6 Hours School District: JEFFERSON ELEMENTARY

School Based Mental Health Info:



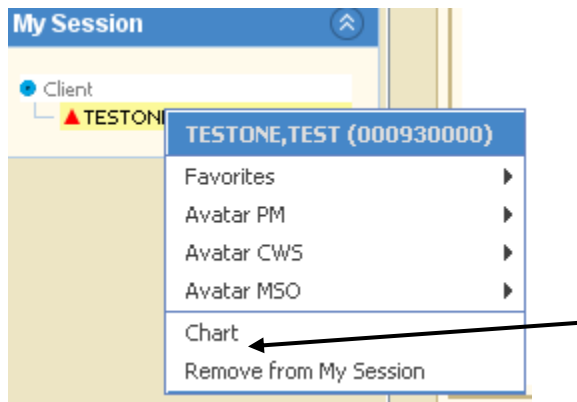
Assessment Status – Displays the *current assessment status*. If the client’s assessment is *almost due* it will display in **GREEN**; assessments that are *overdue* or left in “*Draft*” will display in **RED**.

⚠ *Check to see that assessment information is current, update/finalize if NEEDED.* “Check status” this means no document of this type in Avatar. Shows LOCUS/CALOCUS Information

NOTE: Documents left in draft are not considered complete, or a legal part of the client record!

Section 6: Finding Completed Assessments

Chart Review – You can find a quick view of the client’s entire chart by looking at Chart Review. To access Chart Review, right click on the client’s name in My Session, click to open Chart Review.

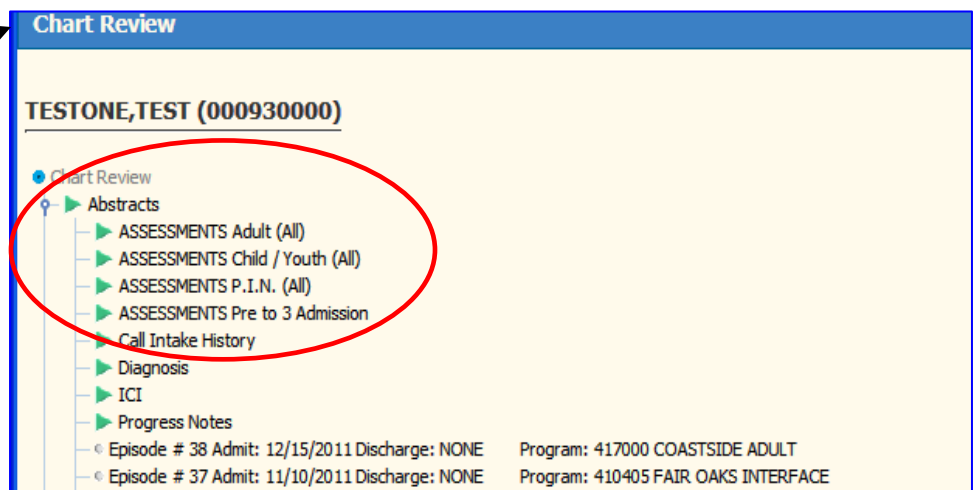


OR

Whenever *any* Avatar document is open, Chart Review is available. Look at the bottom right of the window, You can click on Chart Review to open it or switch between Chart Review and whatever document or report you have open.

From Chart Review:

Once the Chart Review screen appears look for Abstracts. The Abstracts section of Chart Review contains reports that pull together information from multiple areas of Avatar. Assessment Reports pull **all** the assessments on file for a client in reverse chronological order. Reports from Abstracts will include **all information and companion documents**.

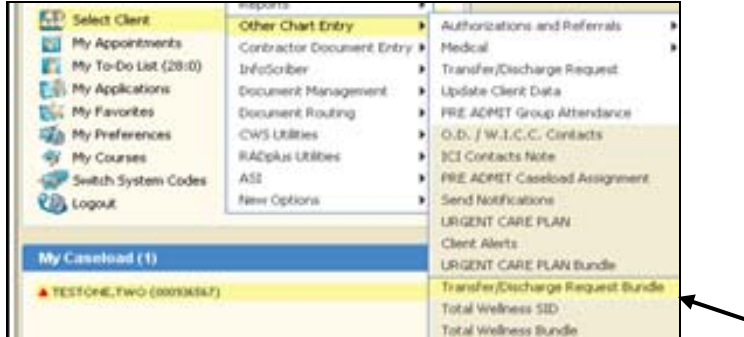


(Assessment includes MSE, Diagnosis, LOCUS, Substance Abuse Assessment if indicated- **all will show for date selected.**) The green arrow by a document means there is more information. You can print from the document once it is opened.



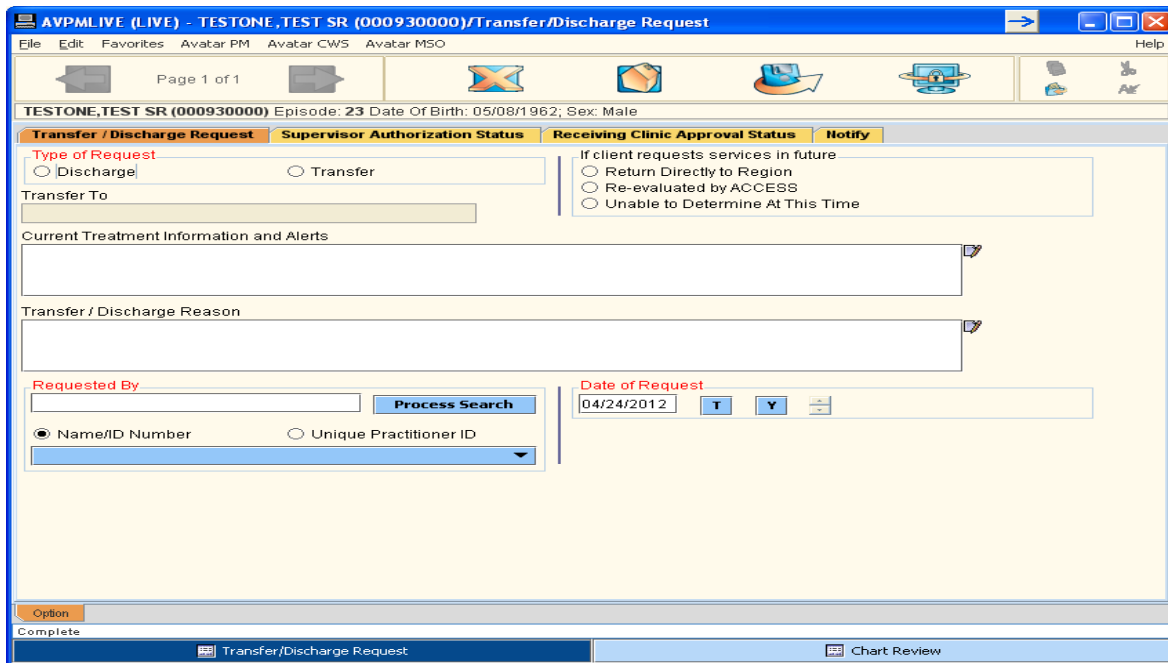
Section 7: Avatar Transfer/Discharge Process

Avatar CWS → Other Chart Entry → Transfer/Discharge Bundle



A. Discharge:

To discharge a client from your program and **not** send the client to another program, complete Tab 1 of the “Transfer / Discharge Request ”by selecting “Discharge” and “Unable to Determine At this Time” regarding the need for future services. Complete the Discharge Reason, Process Search entry is requested by you. The Date of the Request fills in automatically and then go to the Notify tab, select your supervisor’s name in the field, “Send for Approval” then submit. Your request will appear on your Supervisor’s “My To Do” List. And once you submit, the BHRS Diagnosis document appears. In anticipation of approval by the supervisor, complete the BHRS diagnosis and create a progress note documenting the discharge and reason for it. Sometimes the supervisor approves the discharge but asks support staff to complete the BHRS Diagnosis. Please find out the process where you work.





B. Transfer: Avatar CWS→ Other Chart Entry→ Transfer/Discharge Bundle

To transfer a client to another BHR program, and then discharge the client to your program once the client is connected, the current clinician opens the “Transfer/Discharge Request Bundle”, and chooses “Transfer” and enters the “Transfer To” location. The current clinician completes pertinent Current Treatment Information and Alerts, the Transfer Reason, in the Process Search entry, the transfer is requested by you; the Date of the Request fills in automatically. Next, go to the Notify tab and select your supervisor’s name in the field, “Send for Approval” then submit. Your request will appear on your Supervisor’s “My To Do” List. Once submitted, the BHR Diagnosis document appears. In anticipation of approval by your supervisor, you can complete the BHR diagnosis but must create a progress note documenting the transfer request and reason for it.

Once your supervisor receives the request, they complete Tab 2 “Supervisor Authorization Status” and “Accept” or “Reject” the request. They enter comments and then go to the “Notify” tab and submit the Transfer Request to the Supervisor at the receiving clinic. They also notify you regarding the status of the request.



The Request for Transfer appears on the Receiving Supervisor's "To Do" list. This supervisor reviews the request and information and then goes to Tab 3 "Receiving Clinic's Approval Status". This supervisor "Accepts" or "Rejects" the transfer, enter comments, assigns a clinician at their clinic to connect with the client and then enters in the "Notify" tab, the name of the sending supervisor and clinician and the "Transfer Status" as "Accepted". If the request is rejected the supervisor must document a reason for the decision in a progress note and notify as described above.

AVPMLIVE (LIVE) - TESTONE, TEST SR (000930000)/Transfer/Discharge Request

Page 1 of 1

TESTONE, TEST SR (000930000) Episode: 23 Date Of Birth: 05/08/1962; Sex: Male

Transfer / Discharge Request Supervisor Authorization Status Receiving Clinic Approval Status Notify

Request Approval

Status
 Accepted Rejected

Comments

Approved / Rejected By [] Process Search
 Name/ID Number Unique Practitioner ID

Assigned To [] Process Search
 Name/ID Number Unique Practitioner ID

Date of Approval/Rejection [] [] [] []

Option
Complete

Transfer/Discharge Request Chart Review

The receiving supervisor sets up an appointment for the client and opens the episode, and assigns a new clinician, MD, and coordinator.

AVPMLIVE (LIVE) - TESTONE, TEST SR (000930000)/Transfer/Discharge Request

Page 1 of 1

TESTONE, TEST SR (000930000) Episode: 23 Date Of Birth: 05/08/1962; Sex: Male

Transfer / Discharge Request Supervisor Authorization Status Receiving Clinic Approval Status Notify

Send for Approval []

Send for Approval Outgoing Comments []

Option
Complete

Transfer/Discharge Request Chart Review

Once the client has been successfully opened and seen by the new program, the sending supervisor must request that support staff at their program close the client's episode.



Don't forget the client should only be closed once the client has successfully been connected to the new clinic.

This client remains open to the clinician and MD until the transfer is approved and successful and the receiving clinic confirms the client has been opened and seen by the new clinic.

When a transfer request is accepted, review the client's chart, assign a clinician and reassign the care coordinator, if needed. Set the client up with the welcoming group.

Never reject a transfer request due to limited staffing.

Never put a transfer client on a wait list.

Never wait for a transfer client to show up or call the clinic to make an appointment.

The check boxes on the "Notify Tab" in the "Send for Approval Box do not automatically clear. To avoid sending redundant notifications, uncheck the box.

Refer:

To refer a client and have the client remain open at your program, write a comment stating that this is a referral and the client will remain open at your program.



Attachment 1: About Anniversary Dates

INTAKE DATE

The Intake Date is the first date of claimed outpatient services for a “new” client. A “new” client is any individual admitted for outpatient services for which there is **not** a current outpatient treatment episode. The individual may have received previous services from BHRS and still be considered a “new” client.

INTAKE PERIOD

The Intake Period is two months following the Intake Date. During this time, a thorough assessment is completed, a CA/LOCUS is completed, and a Client Treatment & Recovery Plan is completed. The availability of community resources and social support systems to meet the individual's needs are evaluated. Generally, Assessment and Plan Development services are provided until the client care plan is completed. However, other services may be provided and should be coded based on the service provided.

ANNIVERSARY DATE

The anniversary date is the date an updated treatment plan, Annual Assessment, and CA/LOCUS is completed. These documents must be completed every year while the client continues to receive services.

The Anniversary Date is the first day of the month of intake.

The Anniversary Date follows the client throughout a continuous course of outpatient treatment anywhere in the BHRS system of care.

WINDOW PERIOD for DUE DATES

The window period for completing the Annual Assessment and all other Treatment/Recovery Plans is 6 weeks prior to the Anniversary Date. Plans and Annual Assessments completed and signed during the window period are effective for one year. Writing required annual documents earlier than 6 weeks before the anniversary date is too soon! **The requirement to update documentation annually is not met when written prior to the window period.**

SUMMARY

A chart must have all of the following items completed on time to avoid disallowance of services:

- * Admission Assessment and CA/LOCUS completed within two months of the Intake Date.
- * Initial Client Treatment and Recovery Plan completed within two months of the Intake Date.
- * When an existing client is opened to a new team/program the new provider must complete a Client Treatment & Recovery Plan within two months of the opening.
- * Annual Assessment and the CA/LOCUS updated annually during the 6 week window period prior to the anniversary date.
- * The Client Treatment and Recovery Plan updated annually during the 6 week window period prior to the anniversary date.

These timelines are mandated and fixed for each client. Assessments may be amended or have additional material added at any time and Treatment & Recovery Plans may be amended at any time. These subsequent changes do not affect the **established timelines** and new dates shall not be entered into the computer.