



**Avatar CWS
Quick Reference Guides**

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QUICK REFERENCE GUIDE—DESCRIPTION OF THE ICI PROCESS (FOR SITES THAT *DO NOT* USE CALL INTAKE)

Task	Procedure
Open Client to an ICI Episode	<ul style="list-style-type: none"> Follow the administrative procedures to open the client to an ICI episode (99XX).
Initial Contact Screening (ICI) Bundle	<p>The ICI Bundle has 3 parts:</p> <ul style="list-style-type: none"> Initial Contact Screening (ICI): Assess whether BHRS services are appropriate for a client. Update Client Data: Verify or edit basic demographic information. ICI Contact Note: Document time for MAA billing and productivity purposes.
Open the Client to a BHRS Episode	<ul style="list-style-type: none"> If the clinician determines that the client should be opened to an episode for treatment, close the 99XX episode and open a treatment-related episode at your site.

QUICK REFERENCE GUIDE—DESCRIPTION OF OFFICER OF THE DAY TOOLS

Task	Procedure
Call Intake	<ul style="list-style-type: none"> Can only be used with the following types of clients: <ul style="list-style-type: none"> Clients who have never been entered into the system. Clients who have a P#. Clients who have a permanent MR# but no open episodes.
Open Episode Call Intake	<ul style="list-style-type: none"> Can only be used for the following type of clients: <ul style="list-style-type: none"> Clients who have a permanent MR# and are currently opened to at least one episode.
Pre Admit Caseload Assignment	<ul style="list-style-type: none"> Use this feature to assign a P# client to a clinician’s caseload—usually so the clinician can contact the client and perform an ICI.
Initial Contact Screening (ICI)	<ul style="list-style-type: none"> Can only be used on the following clients: <ul style="list-style-type: none"> Clients who have a P# or MR#. <p><i>If brand new client, you must perform a Call Intake (to get the client into the system and give them a P#) before you can write an ICI.</i></p>
Assign Permanent MR#	<ul style="list-style-type: none"> Must be performed before a P# client can be open to a billable episode using the Admission (Outpatient) window.
Admission (Outpatient)	<ul style="list-style-type: none"> Use this window to open a client to a new episode.
O.D./W.I.C.C. Contacts	<ul style="list-style-type: none"> Used to log any open client issue for the next Officer of the Day / W.I.C.C. shift.

QUICK REFERENCE GUIDE—CALL INTAKE (NOT ALL TREATMENT TEAMS USE CALL INTAKE)

Task	Procedure
Menu Path	Avatar PM→Client Management→Episode Management→Call Intake
Perform a Client Search for a New Client's <i>First</i> Contact and Perform the Call Intake	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. If you search for a client by name, you must complete at least three fields, usually Last Name, First Name, and Gender) 3. Click the Search button. 4. If no match is found, click the New button to open the Call Intake window. <i>Avatar assigns a P# to the new client.</i> 5. Enter the Call Intake Information. 6. Click the Submit icon to save the Call Intake record.
Perform a Client Search for a New Client Who Has One Or More Contacts in the P# Status	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. 3. Click the Search button. <i>The client's name appears in the search results table together with their existing P#.</i> 4. Click OK. (Do not click New—New would erroneously assign a second P# to the client.) <i>The Pre-Display screen appears listing all contacts the client has had in the Call Intake status.</i> 5. Click the Add button to add a new Call Intake under the client's original P#. 6. Enter the Call Intake information. <i>BHRS does not use the Financial Investigation and Contact and Demographic Information tabs.</i> 7. Click the Submit icon to save the Call Intake record.

Task	Procedure
Perform a Client Search for a Returning Client with No Open Episodes (<i>First Contact</i>)	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. 3. Click the Search button. <i>The client's name appears together with their existing MR# (Client ID).</i> 4. Click the Episode Display button to open the client's Episode Report. 5. Check that there is a date in the Discharge Date column to verify that the client has no open episodes. 6. Close the Episode Report window. 7. In the Select Client screen, click OK. (Do not click New—New would erroneously assign a P# to a client who already has an MR#.) 8. Enter the Call Intake information. 9. Click the Submit icon to save the Call Intake record.

Task	Procedure
Perform a Client Search for a Returning Client with No Open Episodes (<i>Additional Contacts</i>)	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. 3. Click the Search button. <i>The client's name appears together with their existing MR# (Client ID).</i> 4. Click the Episode Display button to open the client's Episode Report. 5. Check that there is a date in the Discharge Date column to verify that the client has no open episodes. 6. Close the Episode Report window. 7. In the Select Client screen, click OK. (Do not click New—New would erroneously assign a P# to a client who already has an MR#.) <i>The Pre-Display screen appears listing all of the client's contacts in the Call Intake status.</i> 8. Click the Add button to add a new Call Intake under the client's original MR# (Client ID). 9. Enter the Call Intake information. 10. Click the Submit button to save the Call Intake record.

Task	Procedure
Perform a Client Search during a Contact from a Family Member or Other Interested Party	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. Use the name of the person the inquiry is about. 3. Click the Search button. 4. If no match is found, click the New button to open the Call Intake window. <i>Avatar assigns a P# to the prospective client.</i> 5. Make sure the prospective client's name appears in the Client Name field and enter the name of the person calling in the Caller Name field. 6. Enter the Call Intake information. 7. Click the Submit button to save the Call Intake record. <p>NOTE: Additional calls from family members or other interested parties should be entered under the P# assigned during the first call. You click OK, not New, in the Select Client screen to avoid creating a duplicate P# record for the client.</p>
Modify Call Intake Information	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→ Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. 3. Click the Search button. 4. Make sure the correct client is selected and click OK. 5. If there is more than one call intake for the client, select the appropriate row in the Pre-Display screen. 6. Click the Edit button. 7. Edit the data you want to change. 8. Click the Submit icon to save the changes.

QUICK REFERENCE GUIDE—OPEN EPISODE CALL INTAKE (NOT ALL TREATMENT TEAMS USE THIS FEATURE)

Task	Procedure
Menu Path	Avatar PM→Client Management→Episode Management→Open Episode Call Intake
Perform a Client Search in Call Intake	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Call Intake from the Menu Frame. 2. Enter the search information in the Select Client screen. 3. Click the Search button. <i>The client's name appears in the search results table.</i> 4. Click the Episode Display button to open the client's Episode Report. 5. Check that there is an episode that does not have a date in the Discharge Date column. 6. Close the Episode Report window. 7. In the Select Client screen, click the Cancel button to end the Call Intake process.
Perform an Open Episode Call Intake	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Open Episode Call Intake from the Menu Frame. 2. Enter the intake information. 3. Click the Submit icon to save the new intake information.
Edit the Open Episode Call Intake	<ol style="list-style-type: none"> 1. Make sure the client is active in the My Session Frame of the Avatar Homepage. 2. Choose Avatar PM→Client Management→Episode Management→Open Episode Call Intake from the Menu Frame. 3. Choose the desired call in the Pre-Display screen. 4. Click the Edit button. 5. Make the changes in the Open Episode Call Intake window. 6. Click the Submit icon to save the changes.

QUICK REFERENCE GUIDE—UPDATE CLIENT DATA

Task	Procedure
Menu Path	Avatar PM→Client Management→Client Information→Update Client Data
Update Client Data	<ol style="list-style-type: none"><li data-bbox="571 422 1393 478">1. If necessary, activate the client in your My Session Frame.<li data-bbox="571 478 1393 562">2. Choose Avatar PM→Client Management→Client Information→Update Client Data from the Menu Frame.<li data-bbox="571 562 1393 646">3. Update client data, as appropriate, on pages 1 and 2 of the Update Client Data tab.<li data-bbox="571 646 1393 714">4. Click the Submit button to save your changes.

QUICK REFERENCE GUIDE—PRE ADMIT CASELOAD ASSIGNMENT (NOT ALL TREATMENT TEAMS USE THIS FEATURE)

Task	Procedure
Menu Path	Avatar PM→Client Management→Episode Management→Pre Admission Caseload Assignment
Add a P# Client to a Clinician's Caseload	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame on the Avatar Homepage. 2. Choose Avatar PM→Client Management→Episode Management→Pre Admission Caseload Assignment from the Menu Frame. 3. Type all or part of the clinician's name in the Clinician Assignment text box. 4. Click the Process Search button to locate the clinician. 5. If necessary, choose the clinician from the search results list or click OK if the clinician's name appears in a message box. 6. Click the Submit icon.
Remove a P# Client from a Clinician's Caseload	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame on the Avatar Homepage. 2. Choose Avatar PM→Client Management→Episode Management→Pre Admission Caseload Assignment from the Menu Frame. 3. Click the clinician's name to select it. 4. Press [F5] to remove the name. 5. Click the Submit button.
Transfer a P# Client to a Different Clinician	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame on the Avatar Homepage. 2. Choose Avatar PM→Client Management→Episode Management→Pre Admission Caseload Assignment from the Menu Frame. 3. Type all or part of the clinician's name in the Clinician Assignment text box. 4. Click the Process Search button to locate the clinician. 5. If necessary, choose the clinician from the search results list or click OK if the clinician's name appears in a message box. 6. Click the Submit icon.

QUICK REFERENCE GUIDE—INITIAL CONTACT SCREENING (ICI)

Clients must have a P# or MH# or be opened to a 99.XX ICI episode before you can complete an Initial Contact Screening (ICI).

Task	Procedure
Menu Path	Avatar CWS→Assessments→Initial Contact Screening (ICI)
Call Information Tab	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Assessments→Initial Contact Screening (ICI) from the Menu Frame. <i>In some BHRS locations, the administrator completes the Call Information tab of the Initial Contact Screening (ICI) window when completing the Call Intake bundle or the Open Episode Call Intake bundle.</i> 2. If necessary, complete as many of the fields on this tab as possible. 3. Click the Forward icon to go to page 2. 4. Complete as much insurance and income information as possible. 5. Click the Forward icon to go to page 3. 6. Use any of the four report buttons to access existing information about this client. 7. Look over previously entered notes in the two text fields. <i>The Caller Request field populates from the last Call Intake logged.</i> <i>The Caller Intake Remarks field populates from the last Open Episode Call Intake.</i>
Collateral Contacts Tab	<ol style="list-style-type: none"> 8. Document any additional contact names and phone numbers on this tab.
Clinical Information Tab	<ol style="list-style-type: none"> 9. Complete as many of the fields on pages 1 and 2 of this tab as possible.
Legal History Tab	<ol style="list-style-type: none"> 10. Complete as many relevant fields on this page as possible.
Co-Occurring Issues Tab	<ol style="list-style-type: none"> 11. Selecting Yes to Substance Use activates the Current and Past Usage fields below. 12. Selecting Other on Current and Past Usage fields activates the Other text fields. 13. Click the Forward icon to go to page 2. 14. Document violence and current and past trauma.

Task	Procedure
Disposition Tab	<ol style="list-style-type: none"> 15. Document the date of the disposition and action to take. 16. Click the Forward icon to go to page 2. 17. If known, document the Program Referred To, Clinician who will be assigned to client, Appointment Date, Time, and Location, such as home visit or office.
Finalize Tab	<ol style="list-style-type: none"> 18. While the ICI process is open select Draft so you can continue to return to this ICI and add new information or make changes. 19. If the ICI process is complete select Final. 20. Click the Submit icon to save the information.
Modify an Initial Contact Screening (ICI)	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Assessment→Initial Contact Screening (ICI) from the Menu Frame. 2. In the Pre-Display screen, select the ICI you want to edit. 3. Click the Edit button. 4. You can change any fields except the ICI Date. 5. Click the Submit icon to save your changes.

QUICK REFERENCE GUIDE—ASSIGN A PERMANENT MR# (NOT ALL TREATMENT TEAMS USE THIS FEATURE)

Task	Procedure
Menu Path	Avatar PM→Client Management→Episode Management→Assign Permanent MR#
Assign an MR# (Client ID)	<ol style="list-style-type: none"> 1. If necessary, activate your P# client in the My Session Frame. 2. Choose Avatar PM→Client Management→Episode Management→Assign Permanent MR# from the Menu Frame. 3. Click the Assign Permanent MR# button. 4. When the message appears to auto assign the next ID number, click Yes. 5. Click the Submit icon to save the MR# (Client ID).

QUICK REFERENCE GUIDE—ADMISSION (OUTPATIENT)

Task	Procedure
Menu Path	Avatar PM→Client Management→Episode Management→Admission (Outpatient)
Conduct a Client Search	<ol style="list-style-type: none"> 1. Choose Avatar PM→Client Management→Episode Management→Admission (Outpatient) from the Menu Frame. 2. Enter the search information (usually Last Name, First Name, and Gender) in the Select Client screen. 3. Click the Search button. 4. If no match is found, click the New button. 5. If Avatar offers to auto assign an ID number, click Yes. (If you are admitting a P# client who has already been assigned a MR# (Client ID), you will not see this message.)
Perform an Admission (Admission (Outpatient) Window)	<ol style="list-style-type: none"> 6. Enter the Admission information. 7. Click the Submit icon to open the client to the episode.

QUICK REFERENCE GUIDE—SEND A NOTIFICATION TO ANOTHER USER'S TO-DO LIST

Task	Procedure
Menu Path	Avatar CWS→Other Chart Entry→Send Notifications
	<ol style="list-style-type: none"> 1. Make sure the client you wish to send a notification about is active in the My Session Frame. 2. Choose Avatar CWS→ Other Chart Entry→Send Notifications from the Menu Frame. 3. If you've sent a notification for this client before, you see a list of previous notifications in a Pre-Display screen. Click Add to create a new notification. 4. Enter today's date in the Date of Notification field. 5. Check one or more checkboxes in the Recipients field for the staff you wish to send the notification to. 6. In the Recipients Outgoing Comments field, type the message you want to appear in your recipient's To-Do List. 7. Click the Submit icon to save your changes and send the item to another person's To-Do List.

QUICK REFERENCE GUIDE—ADMISSION ASSESSMENTS (ADULT, CHILD/YOUTH, AND PRE-3)

Task	Procedure
Menu Path	Avatar CWS→Assessments→ADULT Admission Assessment Avatar CWS→Assessments→CHILD/YOUTH Admission Assessment Avatar CWS→Assessments→PRE-3 Admission Assessment
Writing the Assessment	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Assessments→<choose appropriate assessment> from the Menu Frame. 3. If the Episode Selection screen appears, select the episode you are writing the assessment for. 4. If Pre-Display appears, click Add to create a new assessment, or Edit to continue to work on an assessment you saved as Draft earlier. 5. Complete as many fields as you are able to assess on each of the tabs and pages. <i>In the Co-occurring tab, how you answer the substance use question controls whether or not a Substance Use assessment will be required or not.</i> 6. On the Finalize tab, select Mental Status Exam, Diagnosis, and LOCUS/CALOCUS sub-assessments from the dropdown lists. If any of the dropdowns are empty, that means that assessment has not been completed in the last 60 days. If there are any empty dropdown lists, follow these steps: <ol style="list-style-type: none"> a. Save the admission assessment as a Draft, and then open the appropriate sub-assessment. b. Complete the appropriate assessment and submit it as Final. c. Re-open the admission assessment and return to the Finalize tab. The dropdown list should now be populated with the assessment you just finalized. 7. Click the Final radio button and click the Submit icon to save the assessment.

QUICK REFERENCE GUIDE—MENTAL STATUS EXAM

Task	Procedure
Menu Path	Avatar CWS→Assessments→MENTAL STATUS EXAM (ADULT+PIN) Avatar CWS→Assessments→Mental Status/Behavioral Observation (YOUTH)
Mental Status Tab	<p><i>The primary difference between ADULT+PIN and YOUTH Mental Status Exam is the length of the assessment. Youths are assessed on a Mild-Moderate-Severe scale, where the Adult scale is simply Yes or No for observed symptoms and behaviors. Therefore, the adult assessment has fewer pages.</i></p> <ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Assessments→<choose the appropriate assessment> from the Menu Frame. 3. Go through each page and document only the symptoms and behaviors that you observe or know to be true at the time of the assessment. 4. Go to the Finalize tab. 5. Click Final. <p><i>A message appears notifying you that you will not be able to change this Mental Status Exam if you submit it.</i></p> <ol style="list-style-type: none"> 6. Click OK. 7. Click the Submit icon to save a finalized Mental Status Exam.

QUICK REFERENCE GUIDE—LOCUS/CALOCUS

Task	Procedure
Menu Path	Avatar CWS→Assessments→LOCUS Avatar CWS→Assessments→CALOCUS
Level of Care Utilization Tab	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Assessments→<choose the appropriate assessment> from the Menu Frame. 3. Go to each page and select a number for each rating scale question. Click the lightbulb icon for QM guidance on how to score each question. 4. After you answer each scoring question, go to page 6. 5. Click the Calculate Score button. A report window appears displaying the score. 6. Use the red X to close the report window. 7. Type the score in the Total Score field. 8. Go to the Finalize tab. 9. Click the Final radio button. <p style="text-align: center;"><i>A message appears notifying you that you will not be able to change this (CA)LOCUS if you submit it.</i></p> <ol style="list-style-type: none"> 10. Click OK. 11. Click the Submit icon to save the (CA)LOCUS.

QUICK REFERENCE GUIDE—SUBSTANCE USE ASSESSMENT

Task	Procedure
Menu Path	Avatar CWS→Assessments→Substance Use Assessment
Substance Use Assessment Tab	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Assessments→Substance Use Assessment from the Menu Frame. 3. If a Pre-Display screen appears listing previous assessments, click the Add button to start a new assessment. 4. Enter the appropriate date in the Date Assessed field. 5. Select Child/Youth or Adult in the Assessment Type field. 6. Select Yes or No for Urine Specimen for Tox Screening. If Yes enter a date and the results. (This field is grayed out for Child/Youth.) 7. Document client’s perception of drug use. 8. Document past attempts to stop and outcomes. 9. Click the Forward icon to go to page 2. 10. Enter as much information as you can assess in the four text fields. 11. Navigate to the Drug Use History tab.
To <i>Add</i> a New Drug to the Drug Use History tab	<ol style="list-style-type: none"> 1. Click the Add New Item button to add a row to the table. 2. Fill in each of the fields. <p><i>As you enter information, you will see the row populate.</i></p>
To <i>Delete</i> a Drug from the Drug Use History	<ol style="list-style-type: none"> 1. Click the drug you wish to delete in the Drug Use History table. 2. Click the Delete Selected Item button.
To <i>Edit</i> a Drug from the Drug Use History	<ol style="list-style-type: none"> 3. Click the drug you wish to edit in the Drug Use History table. 4. Click the Edit Selected Item button 5. Enter the changes in the fields below.
Finalize tab	<ol style="list-style-type: none"> 6. Select Draft if you plan to return to this assessment to make further changes. Choose Final to save the assessment (no further changes possible). Choose Pending Approval if you are an intern and need manager approval. If you select Pending Approval, you must select the name of your manager from the Send To dropdown field and provide Outgoing Comments. 7. Click the Submit icon to save the information.

QUICK REFERENCE GUIDE—BHRS DIAGNOSIS

Task	Procedure
Menu Path	Avatar CWS→Assessments→BHRS Diagnosis
Diagnosis Info and CSI Tab	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Assessments→BHRS Diagnosis from the Menu Frame. 3. If the client has more than one episode, choose the episode that this diagnosis relates to. 4. If a Pre-Display screen appears listing other diagnoses, click the Add button to start a new diagnosis. 5. Enter the date and time of the diagnosis. 6. Select Admission, Discharge, or Update for Type of Diagnosis. 7. Enter your name as the Diagnosing Practitioner. 8. Select Yes, No, or Unknown/Not Reported for Substance Abuse/Dependence (CSI). 9. Select Yes, No, or Unknown for Trauma (CSI). <i>If you answered Yes for Substance Use, you must document a Substance Use Diagnosis.</i> 10. If necessary, enter diagnosis in the Substance Use/Dependence Diagnosis field. 11. Click the Forward icon to go to page 2. 12. Enter an Axis I -1 diagnosis. 13. If necessary, fill in additional diagnosis fields. 14. In the Choose Field with Primary Diagnosis, select the Axis field containing the primary diagnosis. <i>That diagnosis will automatically populate in the Primary Diagnosis field.</i> 15. Enter Personality Features if appropriate. 16. Click the Forward icon to go to page 3. 17. Check as many Axis III conditions as necessary. 18. Click the Forward icon to go to page 4. 19. If any Axis IV diagnoses have been made, document them on this page. 20. In the Axis V field, you must select a GAF score. 21. Navigate to the Finalize tab.

Task	Procedure
Finalize tab	<ol style="list-style-type: none"> 1. Select Draft if you plan to return to this assessment to make further changes. Choose Final to save the assessment (no further changes possible). Choose Pending Approval if you are an intern and need manager approval. If you select Pending Approval, you must select the name of your manager from the Send To dropdown field and provide Outgoing Comments. 2. Click the Submit icon to save the information.

QUICK REFERENCE GUIDE—BHRS CLIENT TREATMENT AND RECOVERY PLAN

Task	Procedure
Menu Path	Avatar CWS→Treatment Plans→BHRS Client Treatment and Recovery Plan
Create an Overall Goal	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Treatment Plans→BHRS Client Treatment and Recovery Plan from the Menu Frame. 3. If the Episode Selection screen appears, choose the episode to which this treatment plan applies. 4. If the Pre-Display screen appears, click the Add button to add a new treatment plan. 5. For plan name, use the name the client wants to be called plus the word Plan. (i.e. ADAM’S PLAN AUGUST 2010) 6. Enter the Client’s Overall Goal. 7. Select a Plan Type. 8. Enter a Plan Start Date. <i>The Plan End Date autofills based on the client’s anniversary date</i> 9. Go to page 2. 10. Select at least 1 service strategy. 11. Go back to page 1 and click the File/Save button. 12. If Avatar asks “Do you want to default plan information from a previously entered plan?” select Yes if you want to bring existing Problems, Goals, and Interventions over for use in this plan. Otherwise, choose No. 13. When the Data Filed message appears, click OK.

Task	Procedure
Create a Barrier/ Problem	<ol style="list-style-type: none"> 1. Go to the Barriers to Recovery/Problems tab. 2. Type a new problem in the Barrier/Problem field. 3. Click the File/Save button. 4. When the Data Filed message appears, click OK. <p>OPTIONAL:</p> <ol style="list-style-type: none"> 5. If you want to add an additional Problem/Barrier, click the Select the blue Barrier/Problem to Edit dropdown bar and click the empty space. <p><i>This clears the Barrier/Problem text field so you can enter an additional Barrier/Problem</i></p> <ol style="list-style-type: none"> 6. Repeat steps 2-5 for each additional Barrier/Problem you want to add.
Create a Goal	<ol style="list-style-type: none"> 1. Go to the Goals tab. 2. Verify the correct Barrier/Problem for the goal you are writing is in the Select Barrier/Problem link dropdown list. 3. Type a new goal in the Goal field. 4. Click the File/Save button. 5. When the Data Filed message appears, click OK. <p>OPTIONAL:</p> <ol style="list-style-type: none"> 6. If you want to add an additional Goal, click the blue Select Goal to Edit dropdown bar and click the empty space. <p><i>This clears the Goal text field so you can enter an additional Goal</i></p> <ol style="list-style-type: none"> 7. Repeat steps 2-7 for each additional Goal you want to add.
Create an Objective	<ol style="list-style-type: none"> 1. Go to the Objectives tab. 2. Verify that the Problem and Goal are correct for the Objective you are about to write. 3. Type a new objective in the Objective field. 4. Click the File/Save button. 5. When the Data filed message appears, click OK. <p>OPTIONAL:</p> <ol style="list-style-type: none"> 6. If you want to add an additional Objective, click the blue Select Objective to Edit dropdown bar and click the empty space. <p><i>This clears the Objective text field so you can enter an additional Objective</i></p> <ol style="list-style-type: none"> 7. Repeat steps 2-7 for each additional Goal you want to add.

Task	Procedure
Create an Intervention	<ol style="list-style-type: none"> 1. Go to the Interventions tab. 2. In the Select Library dropdown list, select BHRS Interventions. 3. Click the Select From Library button. <i>The Tx Plan Selections screen appears</i> 4. Check as many Interventions as needed for this plan. 5. Click the OK button. <i>Notice in the blue Select Intervention to Edit dropdown list, the first Intervention you checked has a *NS in front of it. NS stands for Not Saved.</i> 6. Select a Duration for the Intervention. 7. Click the File/Save button. 8. If you checked additional Interventions on the Tx Plan selection screen, select the next Intervention from the blue Select Intervention to Edit dropdown list. If none of them have a *NS in front of them, this means you have successfully saved all Interventions. 9. Repeat steps 6-9 for as many Interventions as you have.
Add yourself as the plan author/ Participant	<ol style="list-style-type: none"> 1. Go to the Participation tab. 2. Select Primary Therapist or Psychiatrist from the Role dropdown list. 3. Type your last name in the Select Staff Member field (NOT the red Name field) and tap [Enter]. 4. Select Yes for Plan Author and Notification Required. 5. Click the File/Save button. 6. When the Data Filed message appears, click OK.
Preview the Plan	<ol style="list-style-type: none"> 1. If you are finished creating the Treatment Plan, go back to page 1 of the BHRS Client Treatment and Recovery Plan. 2. Click the Print Client Plan button to review your work. A Draft watermark will appear across the page. Click the Red X to close the preview window. 3. Review the Treatment Plan to see if everything is correct.
Sign the Plan	<ol style="list-style-type: none"> 4. Go to page 3 of the BHRS Client Treatment and Recovery Plan tab. 5. In the Did Client Sign Plan field, select Electronically Signed or Signed Printed Copy. 6. In the Client Signature Date field, enter the date the client is signing the Treatment Plan. <ol style="list-style-type: none"> a. If the client is electronically signing, click the Signature 1 button, use the signature pad to collect client signature, and click OK. b. If client is signing a hard copy, go to the Print the Plan steps.

Task	Procedure
Save the Plan as Final (no further changes possible)	<ol style="list-style-type: none"> 1. Go to page 1 of the BHRS Client Treatment and Recovery Plan tab. 2. In the Treatment Plan Status field at the bottom of the screen, select Final. 3. Click the File/Save button. 4. Avatar will notify you that no further changes will be possible. Click Yes to continue. 5. When the Data Filed message appears, click OK.
Print the Plan	<ol style="list-style-type: none"> 6. Go to page 1 of the BHRS Client Treatment and Recovery Plan tab. 7. Click the Print Client Plan button to generate an on-screen print preview of the plan for the client. Click the printer icon in the top left corner to print a hard copy for the client.
Close the Plan	<ol style="list-style-type: none"> 8. Click the Exit Treatment Plan to close the window.
FOR HARD COPY SIGNATURES ONLY	
Sign the Plan	Have the client sign the hard copy of the treatment plan.
Scan the Plan into Avatar (for hard copy signatures only)	Give the signed copy of the plan to your administrative staff to scan into Avatar.
Give the Original Copy to the Client	Give the hard copy to the client to take home.

QUICK REFERENCE GUIDE—BHRS OUTPATIENT PROGRESS NOTE/APPEND PROGRESS NOTES

Task	Procedure
Menu Path	Avatar CWS→Progress Notes→BHRS Outpatient Progress Note Avatar CWS→Progress Notes→Append Progress Notes
Document the Session's Details	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→Progress Notes→BHRS Outpatient Progress Note from the Menu Frame. 3. If necessary, choose the episode to which the note relates. 4. If the Pre-Display screen appears, click the Add button to create a new note. 5. In the Progress Note For field, you will choose New Service most of the time. <i>In rare cases where a client has been discharged from all open episodes and then a service is performed, you can select Independent Note to create a non-billable note to document the service provided.</i> 6. Complete the following fields: <ul style="list-style-type: none"> • Date of Service • Service Charge Code (type the code or part of the service description, i.e. 9 or GROUP, and tap [enter]) • Service Duration (always in minutes) • Location (includes Missed Visit and Voicemail) • Note Type 7. Navigate to page 2.
Attach an Element of Treatment Plan to Progress Note (optional)	<ol style="list-style-type: none"> 8. Click the Select T.P. Item Note Addresses button. 9. Select an item of the Treatment Plan that this note will address then click the Return button.
Compose the Progress Note	<ol style="list-style-type: none"> 10. Type your note in the Notes Field. Click the right mouse button anywhere in the white note area and select System Templates to insert a QM-approved template in the notes field.
Document Language Information (if service not in English)	<ol style="list-style-type: none"> 11. Go to the Language and Other Information tab. 12. Document the language the service was provided in. 13. If desired, rate up to two of your client's symptoms.
Save as Draft or Final	<ol style="list-style-type: none"> 14. Return to the Outpatient Progress Note tab, page 2. 15. Select Draft or Final. NOTE: Interns and other staff who need their note co-signed will ALWAYS select Draft 16. Click the Submit icon to save the note.

<p>Append a Progress Note (used to correct an error in the content of a note you submitted as Final)</p>	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Progress Notes→Append Progress Notes from the Menu Frame. 2. If the Episode Display screen appears, choose the episode to which this note refers. 3. Choose the Note Type. 4. Choose the note you want to append from the List of Notes dropdown list. 5. Click the Forward icon to move to page 2. 6. Type the information you want to append to the original note. 7. Click the Submit icon to save the information.
<p>Run a Progress Note Report</p>	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Reports→Progress Notes Report from the Menu Frame. 2. Enter the start and end dates to specify the range of notes you want to see. 3. Click the Process icon to generate the report. 4. After viewing the report, click the Close button in the upper-right corner of the report window to close it.

QUICK REFERENCE GUIDE—BHRS OUTPATIENT PROGRESS NOTE (FOR THERAPY GROUPS)

Task	Procedure
Menu Path	Avatar CWS→Progress Notes→BHRS Outpatient Progress Note
Document the Session's Details	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Progress Notes→BHRS Outpatient Progress Note from the Menu Frame. 2. In the Progress Note For field, always select New Service. 3. Complete the following fields: <ol style="list-style-type: none"> a. Date of Service b. Service Charge Code. For groups you must use one of the following codes: <ul style="list-style-type: none"> • 10 - Group Therapy • 50 - Assessment Group • 70 - Rehab. Group • 120 - Collateral Group • 150 - Medication Group c. Service Duration (always in minutes) d. Location (defaults to OFFICE, but can be changed by using the dropdown box, including Missed Visit or Voicemail. e. Number of Clients in Group (Remember to always use the same number for each participant's progress note to ensure proper billing.) f. Note Type 4. Navigate to page 2.
Attach an Element of Treatment Plan to Progress Note (optional)	<ol style="list-style-type: none"> 5. Click the Select T.P. Item Note Addresses button. 6. Select an item of the treatment plan that this note addresses and click the Return button.
Compose the Progress Note	<ol style="list-style-type: none"> 7. Type your note in the Notes Field. Always start with the default part of the note that describes what the entire group did, followed by the piece specific to the client you are writing the note for. You can click the right mouse button anywhere in the white note area and select System Templates to insert a QM-approved template in the notes field.
Document Language Information (if service not in English)	<ol style="list-style-type: none"> 8. Go to the Language and Other Information tab. 9. Document the language the service was provided in.
Save as Draft or Final	<ol style="list-style-type: none"> 10. If necessary, go back to the Outpatient Progress Note tab, page 2. 11. Select Draft or Final. 12. Click the Submit icon to save the note. 13. Repeat steps 1-13 for each participant in the group.

QUICK REFERENCE GUIDE—CONSENT FORMS

Task	Procedure
Menu Path	Avatar CWS→Consents→<choose desired consent>
Complete the Consent Fields	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Sessions Frame. 2. Choose Avatar CWS→Consents→<choose desired consent> from the Menu Frame. 3. If the Pre-Display screen appears, click the Add button to add a new consent. 4. Complete as many fields as possible. 5. If you are using a signature pad, gather the appropriate signatures now. 6. Click the Submit button to view a completed copy of the consent form in Crystal Reports. 7. Click the Print icon to print a hard copy of the consent for the client. (If the client will be signing a paper consent, print two copies—one for the client and one for scanning.) 8. If you did not use a signature pad, have the client sign the hard copies of the consent form. 9. Give one copy to the client and if the client signed the paper form, give one copy to your administrator for scanning.
Scan the Signed Consent Form into Avatar (Only for hard copy signed consents; administrators usually scan the consents.)	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Document Management→POS Scan from the Menu Frame. 2. In the Client field, type the client's last name in LASTNAME,FIRSTNAME format and tap the [Enter] key. 3. Enter the date the document is scanned. 4. In the episode field, select Non-Episodic. 5. In the Form field, select the type of consent you are scanning from the dropdown list. 6. Click the Scan button.

QUICK REFERENCE GUIDE—TRANSFER/DISCHARGE REQUEST

Task	Procedure
Menu Path	Avatar CWS→New Options→Transfer/Discharge Request Bundle
How the Clinician Initiates a Request	<ol style="list-style-type: none"> 1. Make sure your client is active in the My Session Frame. 2. Choose Avatar CWS→New Options→Transfer/Discharge Request Bundle from the Menu Frame. 3. If the Episode Selection screen appears, choose the correct episode. 4. If the Pre-Display screen appears, click the Add button to start a new request. 5. The requesting clinician completes the information on Transfer/Discharge Request tab. 6. Go to the Notify tab. 7. The requesting clinician selects the supervisor’s name from the Send for Approval list and enters Outgoing Comments. 8. Click the Submit icon. <p>NOTE: If your discharge request is later approved, remember to create a Progress Note documenting the discharge and the reason for it.</p>
Complete a Discharge Diagnosis	<p><i>After you submit the Transfer/Discharge Request, the BHRS Diagnosis window opens.</i></p> <ol style="list-style-type: none"> 1. For type of Diagnosis, select Discharge. 2. See the BHRS Diagnosis quick reference guide for steps on how to complete a diagnosis. 3. When you have completed all tabs click the Submit icon to save the diagnosis.

Task	Procedure
<p>How the Requesting Clinician's Supervisor Reviews and Accepts or Rejects the Request</p>	<p><i>The clinician's request will appear on the supervisor's My To-Do list.</i></p> <ol style="list-style-type: none"> 1. Make sure the client is active in the My Session Frame. 2. Choose Avatar CWS→New Options→Transfer/Discharge Request from the Menu Frame. 3. Review the request details on the Transfer/Discharge Request tab. 4. Go to the Supervisor Authorization Status tab. 5. Accept or reject the request, enter your name in the Authorized By field, and enter a comment and date for your decision. 6. If this is a transfer request, navigate to the Notify tab and select the Supervisor of the receiving clinic. 7. Click the Submit icon.
<p>How the Receiving Clinic's Supervisor Reviews and Accepts or Rejects the Request</p>	<p><i>The requesting clinician's supervisor's request will appear in the receiving supervisor's My To-Do list</i></p> <ol style="list-style-type: none"> 1. Make sure the client is active in the My Session Frame. 2. Choose Avatar CWS→New Options→Transfer/Discharge Request from the Menu Frame. 3. Review the request details on the Transfer/Discharge Request tab. 4. Go to the Receiving Clinic Approval Status tab. 5. Accept or reject the request, enter your name in the Authorized By field, and enter a comment and date for your decision. 6. Navigate to the Notify tab. 7. Select the Supervisor who made the transfer request, and if possible the clinician who made the original request. 8. Click the Submit icon.

QUICK REFERENCE GUIDE—URGENT CARE PLAN AND CLIENT ALERT

Task	Procedure
Menu Path	Avatar CWS→Other Chart Entry→URGENT CARE PLAN Bundle
Create an Urgent Care Plan	<ol style="list-style-type: none"> 1. Make sure the client is active in the My Session Frame. 2. Choose Avatar CWS→Other Chart Entry→ URGENT CARE PLAN Bundle from the Menu Frame. <i>If there are previous Urgent Care Plans, the Pre-Display screen appears showing a history.</i> 3. Click Add to create a new plan. 4. In the Status field, select Open from the dropdown list. (If you are closing the plan, make sure to document the reason the plan is being closed in the Urgent Care Treatment Plan text field on page 2.) <i>A dialog box appears reminding you to create a Client Alert when you complete the Urgent Care Plan.</i> 5. Click OK to continue. 6. Enter your name in the Therapist/Caseworker field. 7. Click the Forward icon to go to page 2. 8. Type the plan in the Urgent Care Treatment Plan text field. 9. If necessary, make an entry in the Caution field. 10. Click the Submit icon on the Option toolbar to save the Urgent Care Plan.
Create a Client Alert	<p><i>When you submit the Urgent Care Plan, the Client Alert window appears.</i></p> <ol style="list-style-type: none"> 1. If necessary, click Add to create a new alert. 2. In the Type of Alert field, select Care Alert (critical information) or Care Message (important information) from the dropdown list. 3. Select a start and end date for the alert. (The alert should never exceed 18 months.) 4. In the Episode(s) field, select a specific episode where the alert will appear or leave All Episodes checked. 5. Click the Submit icon on the Option toolbar to activate the Client Alert.

QUICK REFERENCE GUIDE—TDS DAY TREATMENT DAILY NOTE

Task	Procedure
Menu Path	Avatar CWS→Progress Notes→Day Treatment Notes→Day Treatment Daily Note
Service Information	<ol style="list-style-type: none"> 1. Choose Avatar CWS→Progress Notes→Day Treatment Notes→Day Treatment Daily Note from the Menu Frame. 2. In the Select Client field, type the client’s LASTNAME,FIRSTNAME and tap [Enter]. 3. Select a TDS episode from the Select Episode dropdown list. 4. In the Progress Note For field, select New Service. 5. In the Week of Service field, enter the <i>Monday</i> date of the week you are writing the note for. 6. In the Date of Service field, enter the actual date of the daily note. 7. In the Location field, select the location of the service from the dropdown list. 8. In the Service Charge Code field, choose from one of the following codes and tap [Enter]. 1081 – Day Treatment Intensive Half Day 1085 – Day Treatment Intensive Full Day 1091 – Day Rehabilitation Half Day 1095 – Day Rehabilitation Full Day 9. In the Service Duration field, enter the length of the service in minutes. <i>It is only necessary to use the Select Draft Note To Edit field if you are working on a Day Note you previously saved as Draft.</i> 10. Click the Forward icon to go to page 2
Daily Progress Note	<ol style="list-style-type: none"> 11. In the Services Provided Today, select at least one checkbox. 12. In the Notes Field, type the Daily Note. 13. Click the Forward icon to go to page 3.
Finalize	<ol style="list-style-type: none"> 14. In the Note Type field, select either Does Not Require or Requires Co-Signature. 15. In the Draft/Final field, select either Draft or Final. 16. Click the File Note button to save your work. 17. If you are finished writing notes, click the Close icon on the Options toolbar. OR If you want to write a note for another client, return to page 1 and repeat these steps.

QUICK REFERENCE GUIDE—TDS DAY TREATMENT WEEKLY NOTE

Task	Procedure
Menu Path	Avatar CWS→Progress Notes→Day Treatment Notes→Day Treatment Weekly Note
	<ol style="list-style-type: none"><li data-bbox="581 491 1333 573">1. Choose Avatar CWS→Progress Notes→Day Treatment Notes→Day Treatment Weekly Note from the Menu Frame.<li data-bbox="581 596 1357 678">2. In the Summary for the Week of field, select the Monday date of the week you are writing the weekly note for.<li data-bbox="581 701 1365 842">3. In the Weekly Summary field, write your weekly note. (You can click the View Daily Notes button to generate a report that shows all the Daily Notes for that week.)<li data-bbox="581 865 1081 894">4. In the Status field, select Draft or Final.<li data-bbox="581 917 1130 947">5. Click the Submit icon to save your changes.

QUICK REFERENCE GUIDE—TDS DAY TREATMENT AUTHORIZATION

Task	Procedure
Menu Path	Avatar CWS→Other Chart Entry→Day Treatment Authorization
Clinical Information Page 1	<ol style="list-style-type: none"> 1. Make sure the client is active in the My Session Frame. 2. In the Authorization Request Date, select today's date. 3. For Authorization Type, select Initial Authorization or Re-Authorization. 4. Select your TDS from the Day Treatment Provider field. 5. Document the Symptoms/Behaviors/Strengths in the text field. 6. Document PES Visits/Hospitalizations. 7. Click the Forward icon to go to page 2.
Clinical Information Page 2	<ol style="list-style-type: none"> 8. Document the Current Medications. 9. Select Yes, No, or Unknown for Developmental Disabilities. 10. Select Yes, No, or Unknown for Substance Use. 11. Select Yes, No, or Unknown for Physical Health Disorders. 12. If necessary, document Substance Use Details. 13. Click the Forward icon to go to page 3.
Clinical Information Page 3	<ol style="list-style-type: none"> 14. In the Current Diagnosis field, select the working diagnosis from the dropdown list. 15. In the Current CALOCUS field, select the working CALOCUS score from the dropdown list. 16. Document your Assessment of progress toward client's goals. 17. Click on the Requested Services tab.
Requested Services	<ol style="list-style-type: none"> 18. Select Intensive or Rehab for the Day Treatment Services Requested. 19. In the Start Date field, select the date after the previous authorization end date. 20. Select Full Day or Half Day. 21. Enter the # of Days Per Week. 22. Enter the authorization end date 23. In the Send To field, check a box next to the staff who approves your Day Treatment Authorizations. 24. In the Send To Outgoing Comments field, type a comment to send to the staff who approves your day treatment authorizations. 25. Click the Submit icon to send your authorization request.

QUICK REFERENCE GUIDE—TDS DAY TREATMENT AUTHORIZATION APPROVAL

Task	Procedure
Menu Path	Avatar CWS→Other Chart Entry→Day Treatment Authorization Approval
Approve the Authorization Request	<ol style="list-style-type: none"> 1. Make sure the client’s name appears in the My Session Frame. 2. Choose Avatar CWS→Other Chart Entry→Day Treatment Authorization Approval from the Menu Frame. <i>You may see a Pre-Display screen of previous authorization.</i> 3. If you are returning to an authorization to complete it, select that authorization and click Edit. 4. If you are reviewing a new authorization click Add. <i>When you add a new authorization, the information for Authorization Request Date, Day Treatment Provider, and Authorization Type fields autofill.</i> 5. To review the Authorization request click the Review Authorization Request button. <i>This runs a report of the requestor’s authorization. This report includes the clinical information and the last CALOCUS and the current primary diagnosis.</i> 6. Click the Close button in the upper-right corner of the report window. 7. Complete the fields for the authorization approval. 8. If you need further information from the clinician to complete the authorization, you can make that request through phone or email and then document the additional information in the Comments field on page 2. 9. When you complete the authorization approval, select Final in the Status field and click the Submit icon.